CARDIFF AND VALE UNIVERSITY HEALTH BOARD

PUBLIC Quality Committee

30th November 2026 at 9am via Microsoft Teams

CHAIRS INFORMED AGENDA

09:00	1	Preliminaries	Assurance / Approval or Noting&Information	Presenters
	1.1	Welcome, Introductions & Apologies for Absence		Ceri Phillips
	1.2	Declarations of Interest		Ceri Phillips
	1.3	Minutes of the last meeting held: *27.10.2026*		Ceri Phillips
	1.4	Action Log – following meeting held on: *27.10.2026*		Ceri Phillips
09:05	**2**	**Strategy: Providing Outstanding Quality**		
0 mins	2.1	Board Assurance Framework (BAF)	Assurance	Matt Phillips
09:05	**3**	**Shaping our Quality, Value & Sustainability**		
10 mins	3.1	Impact and Learning from 2026 Summer Heatwaves – a CAV Perspective	Assurance / Noting	David Fluck / Aled Roberts
10 mins	3.2	Specialist Weight Management Service Changes	Assurance / Noting	Emma Cooke
09:25	**4**	**Shaping our Population Health and Place-Based Partnerships**		
0 mins	4.1	Good Food and Movement Implementation Plan 2026-28 - *Appendices can be found in the Supporting Documents folder linked here.*	Noting / Information	Claire Beynon
0 mins	4.2	Childhood and Teenage Immunisations Strategic Plan 2027-30 - *Appendices can be found in the Supporting Documents folder linked here.*	Noting / Information	Claire Beynon
10 mins	4.3	Equity, Equality, Experience and Patient Safety Action Plan - Six-Month Update	Assurance	Claire Beynon
09:35	**5**	**Shaping our Future Clinical Services**		
10 mins	5.1	Clinical Services Strategic Portfolio: Quarter 2 Update	Assurance	Emma Cooke
10 mins	5.2	Cardiac Services Implant Update	Assurance	David Hanna
10 mins	5.3	JACIE Inspection Update	Assurance	Katie Innes / Keith Wilson
10:05	**6**	**Quality Performance Reporting**		

15 mins	6.1	Integrated Performance Report (IPR) - *Appendices can be found in the Supporting Documents folder linked here.*	Assurance	Jason Roberts / Angela Hughes
10:20	**7**	**Item for Oversight / Scrutiny**		
20 mins	7.1	Clinical Board Highlight Reports: ○ *Medicine Clinical Board* ○ *Specialist Services Clinical Board* ○ *PCIC Clinical Board* ○ *CD&T Clinical Board* ○ *Children & Women Clinical Board* ○ *Surgery Clinical Board* ○ *Mental Health Clinical Board* *Clinical Board QSE minutes can be found in the Supporting Documents folder linked here.*	Assurance	Execs
10 mins	7.2	Summary of Recent Healthcare Inspectorate Wales (HIW) Inspection Reports	Assurance	Jason Roberts / Angela Hughes
5 mins	7.3	Annual Reports: *i)* Director of Public Health Annual Report – *Let's Stop Cancer Before It Starts*	Assurance	Claire Beynon
10:55	**8**	**Mental Health**		
10 mins	8.1	Mental Health Act Exception Report	Assurance	David Seward
10 mins	8.2	Mental Health Measure Monitoring Report including Care and Treatment Planning Update	Assurance	Samuel Barrett
11:15	**9**	**Policies for Approval**		
	9.1	*No policies for approval.*		
11:15	**10**	**Items for Noting and Information**		
0 mins	10.1	Infection Prevention and Control (IPC) Group highlight report - *IPCG minutes can be found in the Supporting Documents folder linked here.*	Noting	Jason Roberts
0 mins	10.2	Safeguarding Steering Group (SSG) highlight report - *SSG minutes can be found in the Supporting Documents folder linked here.*	Noting	Jason Roberts
11:15	**11**	**Any Other Business**		
5 mins	11.1	Health Impact Assessments (HIAs) – Verbal Update	Assurance	Claire Beynon
11:20	**12**	**Review of Meeting**		

	12.1	*Board and Committee Self-Assessment link*		Ceri Phillips
	12.2	**Time and date of the next meeting:** *26th January 2027 at 9am via MS Teams*		
	12.3	**Declaration before moving into private session:** *To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]*		

Draft Minutes of the Public Quality Committee
Held on 27th October 2026 via MS Teams

To view the meeting: **https://youtu.be/fP0cuzWM1kE**

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Claire Beynon	CB	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
Chris Bown	CB	Chief Executive Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Lauranne Cullen	LC	Regional Director – Llais
David Fluck	DF	Executive Medical Director
Natasha Goswell	NG	Deputy Executive Nurse Director
Angela Hughes	AH	Assistant Director of Patient Experience
Alison James	AJ	Lead Nurse - Children, Young People and Family Health Services
Helen Luton	HL	Director of Nursing and Multi-Professional Teams – Clinical Diagnostics and Therapeutics (CD&T)
Matt Phillips	MP	Director of Corporate Governance
Clare Quinn	CQ	Director of Psychology and Psychological Therapies for the Mental Health Clinical Board
Judi Rhys	JRH	Independent Member – Third Sector
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Rachna Upadhya	RU	Independent Member - General
Kirsty Williams	KW	UHB Chair
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Chloe Evans	CE	Mental Capacity Act (MCA) Project Lead
Stephen Riley	SR	Independent Member – University
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness

QC 26/10/1.1	**Welcomes, Introductions & Apologies** Ceri Phillips (CP), the Committee Chair, welcomed everyone to the meeting in English & Welsh and apologies for absence were noted.	
QC 26/10/1.2	**Declarations of Interest** No declarations of interest were raised.	
QC 26/10/1.3	**Minutes of the Committee meeting held on 29.09.2026** The minutes of the Committee meeting held on 29.09.2026 were received. **The Committee resolved that:** a) The minutes of the meeting held on 29.09.2026 were approved as a true and accurate record of the meeting.	

QC 26/10/1.4	**Action Log** The Action Log following the meeting held on 29.09.2026 was received and discussed. **The Committee resolved that:** a) The Action Log from the meeting held on 29.09.2026 was noted.	
QC 26/10/1.5	**Committee Chair's Actions** No Chair's Actions were raised.	
	Strategy: Providing Outstanding Quality	
QC 26/10/2.1	**Board Assurance Framework** **The Committee resolved that:** A) The BAF was noted.	
	Shaping our Quality, Value & Sustainability	
QC 26/10/3.1	**Discharge Advice Letters (DALs)** Alex Scott (AS), the Assistant Director of Quality and Patient Safety, presented the report and highlighted the following: • Discharge Advice Letters (DALs) were highlighted as a vital mechanism for communicating treatment, diagnoses and prescribing information when patients transfer from secondary to primary/community care • Historically, DALs completion and submission had been poor, with letters remaining in draft and limited data available to monitor compliance • DALs had now been embedded within the Electronic Prescribing and Medicines Administration (EPMA) system, with the draft function removed from 1st September 2026 to ensure letters were clinically signed off and submitted before discharge medication was dispensed • It was confirmed that this change had not adversely affected discharge times and had significantly strengthened compliance for patients discharged with take-home medication • A new DALs dashboard provides Clinical Boards with oversight of compliance and discharge efficiency, including the timing and completion of letters • Further work was required to provide equivalent assurance for patients discharged without take-home medication, although the overall position had significantly improved David Fluck (DF), the Executive Medical Director, noted the revised process represented a significant improvement, with implementation less problematic than initially anticipated. Further work was underway to review the quality and consistency of discharge information, alongside national work to agree the required content of discharge summaries. Judi Rhys (JR-IM), the Independent Member – Third Sector, asked who held responsibility for signing off DALs. JR-IM also asked whether there were any specific area of concern or hotspots. AS confirmed that clinical teams were responsible for signing off DALs. AS responded that although historical data was limited, previous reports indicated that up to 40% of DALs may have remained in draft. The revised process ensured that take-home medication could not be dispensed without a signed DAL. Further work was required to ensure equivalent oversight for patients discharged without medication.	

	Angela Hughes (AH), the Assistant Director of Patient Experience, highlighted the ambition to achieve 100% compliance in providing patients with copies of their discharge information. AH suggested that patient preferences for receiving information electronically or on paper should be captured to support patient involvement, reduce postal costs, and enable improved monitoring of compliance. Kirsty Williams (KW), the UHB Chair, asked for more clarity on ownership, next steps, and timescales for addressing the remaining gaps. AS responded that the new DALs dashboard provided Clinical Boards with improved oversight and scrutiny of performance, with Clinical Board Directors continuing to support delivery. Practical work was underway to enable printed DALs to be provided across wards. **Circulate a note to Committee members providing further assurance on the remaining gaps and next steps, including timescales, responsibilities, provision of DALs to patients discharged without medication – ACTION.** KW commented that DALs seemed dependent on patients discharged with medication. KW asked how Clinical Boards would be held accountable for monitoring and delivering ongoing improvements. CP responded that the existing group would continue to oversee and monitor progress. CP suggested that AH link in with this group regarding her previous suggestions. Paul Bostock (PB), the Chief Operating Officer, commented that the Executive team would hold Clinical Boards to account for performance through the Executive Review meetings. DF added that improvement had been driven through the weekly Clinical Board leadership meetings, with continued senior oversight. Separate work on the quality of discharge summaries remained ongoing. **The Committee resolved that:** a) Recurrent updates on DALs were no longer required, whilst ongoing monitoring of DALs performance and quality would continue.	
QC 26/10/3.2	**Update on Fuller Report Recommendations** Helen Luton (HL), the Director of Nursing and Multi-Professional Teams – CD&T, presented the report to the Committee and highlighted the following: • The local gap analysis against the Fuller recommendations (1-21) continued to be reviewed and updated, with further progress demonstrated. • Established controls remained in place, including CCTV, controlled swipe access, routine audits, quarterly access reviews and incident reporting, with oversight through the Human Tissue Authority (HTA) Compliance Group and Clinical Board governance arrangements. • Further progress had been made on the winter capacity plan to ensure compliance with the recommendations, supported by Capital, Estates & Facilities and Procurement teams. • Outstanding security improvements including an additional contingency lock, CCTV coverage and swipe-out controls, were progressing towards completion by the end of November, following minor delays in sourcing equipment. • An annual report covering regulated activity, including mortuary services and HTA incidents, would be presented to the Committee in February 2027 • In relation to safeguarding, an interim staff briefing and memo had been developed pending the national approach to training, with ESR Level 1 and 2 training expected to incorporate the relevant Fuller recommendations.	

	• A further gap analysis had been undertaken against relevant Ockenden recommendations relating to maternal, foetal and perinatal care after death, with work progressing to address this. DF asked when the next HTA inspection would be. HL responded that work on the Fuller recommendations had commenced ahead of the previous HTA inspection, placing the UHB in a positive position. HTA inspections could take place without notice, with inspection readiness maintained through monthly Regularly Compliance Group meetings and ongoing monitoring of regulatory KPIs. Rachna Upadhya (RU), the Independent Member – General, asked about the adequacy of winter mortuary storage capacity, particularly if additional refrigeration was delayed. RU also asked whether the interim safeguarding briefing and memo provided sufficient assurance pending implementation of the All-Wales training arrangements. HL advised that winter capacity arrangements were in the final stages of development, with a suitable location identified and procurement underway. Confidence was expressed that the arrangements would meet the Fuller recommendations. Regarding safeguarding, HL noted that the interim briefing and memo had been reviewed and were considered appropriate pending national guidance. These would be discussed at the Safeguarding Steering Group (SSG), with further consideration given to ensuring effective communication and dissemination across Clinical Boards. RU asked whether existing CCTV arrangements provided adequate security coverage. HL was assured that existing CCTV coverage and security controls were considered adequate, with regular footage audits and quarterly access reviews in place. The additional CCTV covering refrigeration areas would provide a further layer of security in line with the Fuller recommendations. KW endorsed the proposal for an annual report to come to the Committee. **The Committee resolved that:** a) The UK Government update on 15th July 2026 and the national direction for strengthened mortuary security, governance, accountability and safeguarding was noted; b) The evidence of substantial local progress against Fuller recommendations 1-21 was noted; c) The mitigations related to safeguarding arrangements were acknowledged; d) The review of the Ockenden recommendations in relation to maternal, fetal and peri-natal care after death was noted; e) Continued oversight through Quality Committee was supported, with a further update following confirmation of completed works or via annual regulatory compliance report for all regulated activity in CD&T Clinical Bord which would include mortuary activity.	
	Shaping our Population Health and Place-Based Partnerships	
QC 26/10/4.1	**Looked After Children Assessment Backlogs Update** Alison James (AJ), the Lead Nurse - Children, Young People and Family Health Services, presented the report and highlighted the following: • Significant progress had been made in reducing the backlog of statutory health assessments for Looked After Children, despite increasing demand. • Medical workforce capacity remained a challenge, although the recruitment of trainee medical staff was expected to improve resilience and assessment capacity.	

	• Delays in notifications from Local Authorities continued to impact compliance with the 28-day assessment requirement, with work ongoing to address this with partners. • Out-of-area placements remained challenging due to reliance on host UHBs to undertake assessments, whilst statutory responsibility remained with the UHB. • Progress had been supported by the transfer of under-five reviews to the Health Visiting Team, with continued improvements in assessment compliance. Claire Beynon (CB), the Executive Director of Public Health, highlighted the positive work being undertaken by the Public Health team in partnership with Cardiff Council, supported by Welsh Government (WG) funding under the Marmot programme. KW expressed concern that statutory requirements were still not being consistently met. KW asked about the extent to which non-compliance was attributable to internal capacity pressures versus delays and challenges involving partner organisations. KW asked about the costs associated with out-of-area assessments and whether reciprocal charging arrangements were in place for children within CAV from other areas. KW also asked whether further partnership working could support more children to remain within their local communities, where safe and appropriate, to improve continuity of care and access to support. AJ responded that retaining Looked After Children within CAV remained a priority, although local placement availability presented challenges requiring further partnership working. A dedicated nurse was in place to monitor the health needs of children placed outside the area. Improvement plans were in place for each stage of the assessment process, alongside partnership working to improve early notification of children entering care. Benchmarking against models across the UK was also underway. JR-IM asked whether sufficient health visiting capacity was available to undertake under-five assessments and whether alternative staff groups could provide support if required. JR-IM also asked what mechanisms were available to improve the timeliness of assessments for children placed outside the area. AJ advised that a previous pilot of a dedicated Health Visiting Team for Looked After Children had proved unsustainable due to workforce pressures. Redistributing assessments across existing Health Visitor caseloads, supported by additional training, was considered a more sustainable approach. AJ explained that improving the timeliness of out-of-area assessments remained challenging, with continued partnership working and accountability arrangements with host UHBs identified as key to improvement. JR provided the following additional comments: • The workforce model had been revised to enable trained Health Visitors to undertake assessments previously carried out by a limited number of doctors. • Further benchmarking was underway to explore alternative workforce models, including the potential role of School Nurses. • Delays in Local Authority notifications continued to impact assessment timeliness. It was agreed that the established partnership group would review opportunities to improve communication and early notification, including digital solutions. **The Committee resolved that:** a) The update on Children Looked After was noted.	
	Shaping our Future Clinical Services	

QC 26/10/5.1	**Eating Disorder Service Review Update** Clare Quinn (CQ), the Director of Psychology and Psychological Therapies for the Mental Health Clinical Board, presented the report and highlighted the following: • The purpose of the report is to highlight progress made over the previous six months and ongoing work to achieve sustainable improvements. • Significant progress had been made in strengthening governance, leadership, multidisciplinary working, workforce recruitment and clinical oversight. • Assurance remained qualified, with continued variation in practice, particularly around physical health monitoring, clinical documentation and alignment of treatment pathways with national guidance. • A further review of 10 cases in September identified previously recognised risks and reinforced the need for continued improvement and consistent implementation of actions. • Work was underway to redesign the clinical model and treatment pathways, including the integration of two services previously operating under separate directorates. Additional specialist expertise had been secured, with a commencement date of 15th December 2026. • Identified risks continued to be monitored through established governance arrangements, the risk register and Improvement Programme. No new complaints or critical incidents had been reported during the previous three months. • Continued senior oversight, repeat audits and evidence of completed patient-level actions would be required before full assurance could be provided. RU acknowledged the improvements made but expressed concern regarding gaps in physical health monitoring, given the potential for rapid patient deterioration. RU asked for more assurance that weekly multidisciplinary reviews and escalation arrangements had addressed identified gaps and that all patients at significant clinical risk were receiving appropriate monitoring. CQ could not provide full assurance yet regarding physical health monitoring, but that dedicated clinical space had been established within one of the Community Mental Health Teams (CMHTs), alongside staff training, to strengthen physical health monitoring and address gaps in care pathways. Further progress and assurance was anticipated at a future meeting. PB reminded the Committee that the service had previously been considered unsafe, with closure deemed to present greater risk. Whilst significant improvements had been made, further work was required to address remaining gaps. Progress continued to be closely monitored, with a clear pathway towards achieving a safe service. KW asked about the remaining barriers and risks to sustaining improvement. CQ confirmed that significant cultural improvements had been made, although challenges remained in bringing together teams from different directorates. Further barriers included the need to modernise the service, align with national recommendations and implement changes. Additional expertise and external benchmarking were expected to support continued improvement and provide greater assurance. PB acknowledged that resistance to adopting alternative models of care and external benchmarking remained a key risk. The importance of supporting the incoming Service Manager to drive cultural change and improvements was emphasised. **Provide a further update to the Committee on progress against the closure of the remaining assurance gaps – ACTION.** **The Committee resolved that:**	

	a) The progress made within the Tier 3 Eating Disorder Service improvement programme was noted, including strengthened governance, leadership, workforce recruitment and multidisciplinary oversight; b) The findings of the September 2026 assurance review and the continuing requirement to strengthen consistency in physical health monitoring, clinical documentation and treatment pathway delivery was noted; c) Assurance was received that identified risks were being actively monitored through the established governance framework, risk register and improvement programme. d) Continued senior oversight, repeated audit activity and evidence of completed patient-level actions will be required before full assurance can be achieved.	
	Quality Performance Reporting	
QC 26/10/6.1	*No items.*	
	Items for Oversight / Scrutiny	
QC 26/10/7.1	**Clinical Board Highlight Reports** JR presented the reports to the Committee and highlighted the following: • Patient Tracking and Lost to Follow Up – significant concerns were identified across Specialist Services, Surgery and CD&T, with patient validation and harm reviews underway. The absence of a comprehensive digital tracking system was recognised. A wider review of existing processes and a coordinated improvement plan would be progressed through the Lost to Follow Up programme. • Mental Health Act Compliance – statutory non-compliance relating to documentation and delays in medication-related professional support was highlighted. Whilst immediate controls had been implemented, further assurance was required. Urgent work was underway to address staffing pressures within the Mental Health Legislation Assurance office. • Urgent and Emergency Care - Sustained operational pressures and deterioration in some performance measures were reported, with business continuity arrangements activated across the organisation and Medicine. • Prison Healthcare - Ongoing concerns regarding service sustainability were highlighted, particularly following notice of the proposed termination of the existing primary care Service Level Agreement. Work was underway to strengthen relationships between Primary Care and Mental Health services, alongside consideration of an external review and benchmarking exercise. • Workforce Pressures - Sustained vacancies, sickness absence and maternity leave across several services were identified as increasing risks to patient safety and service delivery. These risks would need to be considered within Executive reviews of vacancies. • Infection Prevention and Control (IPC) - Outbreaks of scabies, fleas and bed bugs within Mental Health services were being managed alongside IPC and specialist pest control teams. Some bed capacity remained closed, impacting patient flow and resulting in out-of-area placements. • Healthcare Inspectorate Wales (HIW) - Concerns had been raised regarding the sustainability of quality improvements within Meadow and Daffodil, particularly IPC, documentation and statutory training compliance. The services had been escalated to a *Service of Concern*, requiring increased scrutiny and assurance. PB provided the following additional comments: • A contract had been awarded to 36 Degrees to undertake an independent review of the prison healthcare model, including service delivery, culture and working relationships. The review was expected to commence shortly and take 8–12 weeks. • Significant concerns were highlighted regarding outpatient management, with 1.1 million follow-up appointments undertaken in the previous year, 69,000 patient's overdue follow-up appointments and 58,000 patients on Patient Initiated Follow-Up (PIFU)/SOS pathways.	

	• Approximately 2,000 outpatient appointments remained without recorded outcomes at any given time, presenting potential patient safety risks. Weekly monitoring had commenced to identify outcomes and ensure patients requiring follow-up were appropriately tracked. • Approximately 2,000–2,500 appointments had been cancelled monthly across Ophthalmology and Orthopaedics, contributing to patient confusion, missed appointments and potential loss to follow-up. • The need for a comprehensive outpatient transformation programme was emphasised, including reviewing the clinical necessity of follow-up appointments, improving pathway management and reducing unnecessary activity. A comprehensive improvement plan would be developed and presented to the Committee in early January. **Develop an organisation-wide plan to address outpatient follow-up, uncashed appointments and patients lost to follow-up, including how follow-up activity can be transformed and reduced where appropriate – ACTION.** CP welcomed the proposed outpatient transformation plan and emphasised the need to review the necessity of follow-up appointments and explore alternative approaches, including virtual consultations and telephone support. KW asked how outpatient transformation would align with WG requirements and address performance gaps against other organisations. KW highlighted the importance of strengthening links with the People & Culture (P&C) Committee, particularly regarding the impact of sickness absence on patient safety and workforce pressures. JR-IM requested that reports include clearer explanations of acronyms and abbreviations. JR-IM highlighted concerns regarding the potential loss of accreditation for the Endometriosis Service beyond December 2026 and the associated risks to patients. JR-IM highlighted the continued reporting of incomplete DALs as a significant risk, despite improvements and assurance earlier in the meeting. Chris Bown (CB-CEO), the Interim Chief Executive Officer, provided assurance that the necessary actions to secure endometriosis accreditation had been identified and would be implemented, alongside wider opportunities to strengthen regional service provision. CB-CEO emphasised the need for outpatient transformation, including greater use of digital solutions, reducing unnecessary follow ups and redirecting resources towards care that delivered greater patient benefit. KW highlighted the need for clearer, more specific actions in the Clinical Board AAA highlight reports, including defined timescales and accountable leads. DF explained that progress had been made in discharge summary completion, with improved visibility and monitoring through timestamping, although further work was required. CB raised concern regarding sepsis management and the number of NRIs and suggested a future audit against NICE guidelines to provide further assurance. **Review the existing sepsis audit arrangements and bring the findings back to Committee to provide further assurance on compliance with sepsis guidelines and identify any areas for improvement – ACTION.**	

	The Committee resolved that: A) The Clinical Board Highlight Reports were noted for assurance.	
QC 26/10/7.2	**Clinical Effectiveness Committee (CEC) Highlight Report** AS introduced the report from September's CEC meeting and highlighted the following: • Presentations were received in relation to the National Audit of Metastatic Breast Cancer and the National Primary Breast Cancer Audit, highlighting data collection and reporting challenges following the transition to the Welsh Clinical Portal (WCP). • The transition meant for the metastatic cancer audit, there was only data available for 4 of the 10 KPIs, whilst in primary breast cancer all 10 were available. Additionally, the audits related to data from 2021-23, which meant some information was outdated. • Adjuvant therapies data was collected and submitted by Velindre on behalf of organisations across Wales but provided an inaccurate oversight of the proportion of CAVUHB patients who had access to these therapies. This was being addressed with Velindre and would be corrected moving forward. • Strong performance was reported in Clinical Nurse Specialist involvement, multidisciplinary team working and three-year survival rates, which were above or in line with national averages. • Performance below national averages were identified in breast-conserving surgery, offers of immediate reconstruction surgery and reoperation rates. • Work was ongoing with plastic surgery to put in place a flat perforation pathway to offer women great choice following mastectomy, for breast conserving surgery and offering lumpectomy to a greater proportion of women. • Local audit demonstrated improvements in immediate reconstruction rates from 15% to 25%. Further scrutiny of reoperations and consideration of enhanced imaging was underway to improve surgical outcomes. CP asked for further clarification around Wales being limited to receiving the annual report with data relating to care provision three years prior. AS responded that this was not unusual for their national audits, with more national audits moving towards being able to report data with a relatively small time lag. The wider cancer audits were moving to this approach, however the Welsh transition to WCP restricted this and was a national issue. From early 2027, they would receive quarterly reports. KW highlighted the need for the UHB to challenge national audit data limitations but recognised strong clinical outcomes and opportunities to improve patient experience and quality. KW sought further assurance regarding reoperation rates, and emphasised the need for clear, definitive improvement actions rather than proposals under consideration, to demonstrate measurable progress against national benchmarks. AS responded that delivery of triple diagnostic clinics was below the national average, which reflected challenges in delivering mammograms alongside other diagnostic assessments. Wider radiography improvements, including 3D mammography and service standardisation, were underway. **Circulate a note providing greater clarity on the specific improvement actions to improve benchmarking nationally, particularly in relation to breast surgery/re-operation rates – ACTION.** KW highlighted the significant impact of reoperations on patient experience and surgical capacity.	

	CB emphasised the importance of breast cancer prevention, particularly modifiable risk factors including obesity, smoking, physical inactivity and alcohol consumption. CB asked how long it would be before the 10 indicators become available, and whether they had a plan for improvement on data quality. AS responded that progress towards all 10 national indicators remained dependent on the national Cancer Informatics Programme, led by NHS Performance & Improvement (P&I), but the UHB continued to support this work. JR-IM raised concern regarding the prolonged transition to the new WCP, which continued to hamper data reporting and service improvement. **The Committee resolved that:** A) The assurance provided by the clinical performance reported in the national audits and the improvement work that was underway to address requisite improvement was noted.	
QC 26/10/7.3	**Summary of Recent Healthcare Inspectorate Wales (HIW) Inspection Reports** AS presented the report and highlighted the following: • No secondary care HIW inspections had taken place since the previous meeting. One dental clinic inspection was reported, with positive findings and minor recommendations relating to policies and environmental improvements. • Primary Care follow-up arrangements were in place to oversee improvement plans and provide assurance on actions arising from inspections. • Ongoing oversight of secondary care HIW improvement plans continued through Clinical Board scrutiny and Executive Performance reviews. • Recurring Mental Health inspection themes included environmental concerns, documentation, risk assessments and mandatory training compliance. Work was underway to strengthen the accountability framework across wards and provide sustained assurance. **The Committee resolved that:** A) The actions taken in response to recent HIW inspection findings across primary care services were received for assurance. B) The progress of associated improvement plans was noted. C) The continued organisational learning arising from inspection activity was endorsed.	
QC 26/10/7.4	**Public Services Ombudsman for Wales Annual Letter 2025-26** AH presented the report and highlighted the following: • Across NHS Wales, complaints to the Ombudsman increased by 42%, with hospital clinical treatment remaining the most common reason for complaints. • CAVUHB received 230 complaints, with 216 closed and 38 interventions, representing an 18% intervention rate, compared with the Welsh average of 22%. No public reports were issued. • Clinical treatment accounted for 52% of complaints, with other themes including appointments, mental health, patient lists and referral to treatment. • The Ombudsman made 86 recommendations, with 71% of recommendations due during the reporting period completed within agreed timescales, slightly above the Welsh average of 69%. Improving compliance remained a priority. • A newly appointed Ombudsman Lead would support training across Clinical Boards, strengthening understanding of recommendations, evidence requirements and compliance monitoring. • The importance of robust, objective investigations, openness, transparency and compliance with the statutory Duty of Candour was emphasised.	

	• Arrangements were in place to monitor compliance and share learning across Clinical Boards, including lessons from Ombudsman reports relating to other organisations. • The annual letter provided reasonable assurance, although further improvement was required in the timely completion and evidencing of recommendations. KW sought further assurance on the specific actions planned to improve compliance with Ombudsman recommendations and demonstrate measurable improvement in the next annual letter. AH responded that work was underway to strengthen compliance with Ombudsman recommendations, including earlier engagement with Clinical Boards, clearer evidence requirements, regular monitoring and improved data tracking. Greater emphasis was placed on raising awareness of mandatory compliance, with early improvements already evident. CB asked what 'premature complaints' meant in Appendix D. CB asked about the proportion of complaints relating to staff attitude and behaviour. AH clarified that premature complaints referred to cases submitted to the Ombudsman before the UHB had an opportunity to investigate, which were subsequently referred back. AH responded that complaints related to staff attitude and behaviour were monitored, with a listening campaign being developed to strengthen communication and support difficult conversations. Unacceptable behaviour would be addressed through appropriate professional processes. **The Committee resolved that:** a) The Health Board's compliant, intervention and recommendation-compliance performance was noted; b) Continued monitoring of outstanding and future Ombudsman recommendations through established governance arrangements was supported.	
QC 26/10/7.5	**Annual Reports** Duty of Candour Annual Report 2025/26: Application of the Process, Themes, Trends and Staff Survey Findings AH presented the report and highlighted the following: • The Duty of Candour Report provided partial assurance - whilst processes were established, further work was required to demonstrate compliance, transparency and organisational learning. • Of the 216 Duty of Candour records reviewed, 178 (82%) had been closed, with the remainder under investigation or awaiting review or closure. • Key themes included delays in referrals and follow-ups, diagnostic failures, surgical care, patient deterioration, pressure damage, medication incidents and falls. • Concerns were identified around handover arrangements, accountability and communication between teams, highlighting the need for improved patient tracking and escalation processes. • Gaps in recording and evidencing compliance with statutory requirements were identified, particularly around patient communication, written notifications and sharing investigation outcomes. • A staff survey identified that 80% of respondents were aware of the Duty of Candour, although only 54% felt confident undertaking conversations, highlighting the need for further training and support.	

	• Improvement priorities included timely incident reviews and harm assessments, strengthened documentation, staff training and improved communication with patients and families. • Further work was required to move beyond procedural compliance and demonstrate meaningful learning, openness and improvements in patient experience. JR highlighted concerns regarding Duty of Candour compliance, including inconsistent interpretation of requirements, gaps in documented evidence and incident backlogs potentially delaying the identification of patient harm. JR noted that a dedicated improvement group and framework would be established, with Clinical Boards held accountable for strengthening compliance and demonstrating sustained improvement. CB noted concern that 20% of the staff survey respondents did not know what the Duty of Candour was and 52% had not received the training. CB asked whether the Duty of Candour training was mandatory and whether specific staff groups should be prioritised. AH clarified that the Duty of Candour survey included non-clinical staff, with plans to repeat and better target the survey to improve representation. Targeted training was underway across professional groups, including nursing, medical and therapy staff, with further priorities to be identified across Clinical Boards. The mandatory status of training would be confirmed, with continued emphasis on practical, case-based training to strengthen staff confidence and compliance. KW emphasised the need for a cultural shift in Duty of Candour, moving beyond procedural compliance towards meaningful learning, improved practice and patient outcomes. KW sought assurance that the improvement plan would focus on measurable impact, with clear Clinical Board accountability and future reporting to demonstrate sustained progress. **The Committee resolved that:** a) The report was received for assurance; b) The recommendations to improve the process and assurance were endorsed.	
	Mental Health Legislation	
QC 26/10/8.1	**Consent** Natasha Goswell (NG), the Deputy Executive Nurse Director, presented the report and highlighted the following: • The Welsh Risk Pool (WRP) National Review of Decision Making and Consent provided reasonable assurance, with full compliance in policy management and consent forms, partial compliance in procedure specific patient information and training, and non-compliance in monitoring and review. • Gaps were identified in the absence of a consistent UHB-wide audit and peer review programme. • Overall training compliance exceeded the 85% standard, although medical and dental staff compliance remained below the required level. • An electronic consent pilot was being developed within General Surgery to strengthen monitoring and assurance. • A Consent Assurance Programme was planned for March 2027, supported by quarterly reporting to the Committee. Progress against the improvement action plan would be overseen by the Consent Lead and Consent Group. CB asked about progress towards adopting the All-Wales peer review tool and methodology for consent monitoring, as referenced in the report.	

	NG responded that the All-Wales consent peer review programme was scheduled for rollout from March 2027. CP asked about the actions being taken to address low consent training compliance amongst medical and dental staff. NG responded work was underway to improve medical and dental consent compliance and representation within the Consent Group, with Clinical Boards being asked to nominate representatives. JR highlighted that medical training compliance reporting was affected by a national issue with incompatible ESR and Shared Services systems, potentially understating actual compliance. Work was ongoing locally and nationally to resolve this. **The Committee resolved that:** a) The WRP's overall Reasonable Assurance rating was received for assurance, whilst noting the areas of patrial and non-compliance identified in the review; b) The action plan developed in response to the recommendations was noted, including the priority actions relating to Procedure Specific Patient Information Leaflets (PSPIL) governance, training compliance and the establishment of a UHB-wide consent audit and peer-review programme; c) The continuing assurance gap arising from non-compliance in monitoring and review was noted, and the need for sustained executive and Clinical Board oversight; d) Quarterly progress reports would be received setting out delivery against the action plan, training compliance by staff group, audit findings, outstanding risks, escalations and evidence that improvements have been completed and sustained.	
QC 26/10/8.2	**Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS)** NG presented the report and highlighted the following: • The Q2 Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) report highlighted improvements following the June 2026 Supreme Court judgement, with DoLS referrals reducing from 522 to 337 and waiting lists from 59 to 11. • Average waiting times for best interest allocation reduced from 13 to 4 days, reflecting strengthened referral processes, communication and training. • Declining mandatory MCA training compliance remained a key concern, with Clinical Board improvement plans in place and regular monitoring arrangements established. • Independent Mental Capacity Advocate (IMCA) referrals reduced by 50% compared with the previous year, and reduced Section 39D activity reflected fewer DoLS authorisation. The reason for fewer long-term accommodation referrals remained unclear and would continue to be monitored. • The MCA team would operate at reduced capacity until April 2027, with prioritisation arrangements in place to manage demand. • Implementation of the All-Wales Advocacy Contract had been deferred until April 2027. CP suggested that mandatory training compliance be referred to the P&C Committee for further review. **Confirm why the number of MCA advice/support requests attributed to Corporate/Executive areas was comparatively high – ACTION.**	

	Raise the recurring issues regarding training compliance with the P&C Committee, including consideration of barriers to compliance and the distinction between statutory, mandatory and other training requirements – ACTION. AS suggested that the high number of Corporate and Executive MCA referrals may reflect the team's involvement in patient safety incidents and mortality reviews. JR-IM noted that the volume of statutory and mandatory training was recognised as a potential barrier to completion and highlighted the need for more engaging approaches. AH added that low mandatory training compliance was highlighted as a risk to the WRP reimbursement, with compliance below 80% requiring an improvement trajectory before Learning from Events reports could be approved. CB-CEO recognised the significant volume of mandatory training was a barrier and highlighted the need to review and clearly distinguish between statutory, mandatory and optional training requirements to ensure expectations were realistic and manageable. **The Committee resolved that:** a) The Q2 position for MCA and DoLS activity was noted, including the impact of the AGNI judgement, the reduction in referrals and waiting times, and the continued monitoring of IMCA referral trends; b) The decline in mandatory MCA training compliance was noted; c) A further update on the impact of Clinical Board action plans would be received, including areas of continuing non-compliance, at the next reporting cycle; d) The mitigations in place for reduced MCA Teams capacity and the revised implementation date of 1st April 2027 for the All-Wales Advocacy Contract were noted.	
	Policies for Approval	
QC 26/10/9.1	*No policies for approval.*	
	Items for Noting / Information	
QC 26/10/10.1	*No items for noting / information.*	
	Any Other Business	
QC 26/10/11.1	**To bring an update on EPMA back to a future Committee (either Quality Committee or the Finance and Performance Committee) – ACTION.**	
	Review of the Meeting	
QC 26/10/12.1	Committee members were asked to fill out the Committee Self-Effectiveness survey.	
	Date & Time of Next Meeting:	
QC 26/10/13.1	*30th November at 9am via MS Teams*	

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Cardiff and Vale University Health Board

Board Assurance Framework

Updated 26 Nov 26

Introduction

The Board Assurance Framework (BAF) is the tool and document that seeks to articulate what strategic risks an organisation has identified that will, if not addressed, prevent it from delivering its strategy.

There is no definitive format, and it is intended that the below pages present in as clear a manner as possible the alignment between CAVUHB's 4 strategic objectives, the strategic portfolios that are led by the Executives in order to turn the strategy into delivery over the course of the strategy, the strategic risks that have been defined to best articulate the major themes that could prevent the delivery of the strategy, and the Board's Committees that are charged with seeking assurance on and scrutinising the delivery of each strategic objective.

While each strategic risk aligns to a Committee, the risks themselves are applicable to all 4 strategic objectives and have a whole organisation perspective and impact. Each has a risk appetite as determined by the Board.

Each risk seeks to identify the potential cause and effect of a manifestation of the risk becoming an issue. This 'uncontrolled' assessment makes use of a simple 5 x 5 scoring guide for likelihood against impact:

Likelihood / Impact	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Severe (5)
Almost Certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Moderate (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare (1)	1	2	3	4	5

Each risk is then assessed for the different controls and assurance measures or mechanisms that are in place, as well as identifying where there may be gaps in these facets. Once these have been applied a new assessment, using the above scoring system again, is then made.

However, the BAF is not a definitive mechanism or science. It is a vehicle for the organisation to articulate and expose some of the strategic level impacts on delivering the strategy, and for the Board and Committees to pull through and scrutinise those elements that are appropriate.

Finally, the BAF seeks to articulate the activity taking place relevant to each risk for assurance.

This document looks to capture and present this information so that the Board and members of the public can see all of the above information, the trends in scoring, the actions being undertaken and every change made to the document between one Board meeting and the next through the use of track changes.

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Strategic Objectives

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Strategy	Putting People First	Providing Outstanding Quality			Delivering in the Right Places	Acting for the Future
Committee	People and Culture	Quality			Digital and Infrastructure	Finance and Performance
	Audit and Assurance | Charitable Funds | Remuneration and Terms of Service					
Strategic Portfolio	Shaping our People and Culture	Shaping our Population Health and Place based Partnerships	Shaping our Quality, Value and Sustainability	Shaping our Future Clinical Services	Shaping our Future Infrastructure	Shaping our Future Generations
Strategic Risk Theme	People	Quality			Digital	Sustainability
		Health Equity			Infrastructure	

Shaping Our Future Wellbeing

Strategic Objectives

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Cardiff and Vale University Health Board

Strategic Objectives			
Putting People First	**Providing Outstanding Quality**	**Delivering in the Right Places**	**Acting for the Future**
We will be a great place to train, work and live, where we listen to and empower people to live healthy lives. By 2035, colleagues would recommend us a great place to work, our workforce will reflect the diversity of our communities and more people will be living healthier lives.	We will provide outstanding services which are equitable, timely and safe, where people are treated with kindness and are supported to achieve the outcomes that matter to them. We will have reduced inequities in prevention, improved access to clinical services and clinical outcomes.	By 2035 we will be using real time integrated data to inform joint decision making and multi-disciplinary team working, giving people access to and ownership of their data to enable them to manage their health and wellbeing. We will be well on our journey to provide care in the right place, in facilities that are fit for purpose, flexible and promote recovery.	We will work to ensure that what we do today does not compromise the wellbeing of our future generations. We will protect the environment and develop and use new technologies, treatments and techniques to provide the best possible health outcomes and sustainable health care into the future. By 2030 we will have reduced the Health Board's carbon footprint by 34% and will have increased our research and clinical innovation activities.
People will feel valued, developed, supported and engaged. We will have an inclusive culture where the diversity of the Health Board's people will be representative of the Health Board's local populations. Through our integrated population health improvement programme, we will enable and empower people to live healthy lives and reduce their risk of ill health.	Focus on minimising inequity in healthy behaviours, preventative services, access to clinical services, and health outcomes, to reduce current unfair, unjust differences experienced by people in the community Deliver outstanding quality of care every time - from the most complex care for the most critically ill to routine care that prevents and protects against ill health and disease – addressing physical and mental health needs. Achieve the best outcomes for patients in line with what matters most to them, their families and carers. Develop the Health Board's approach to continuous quality to improvement and make the best use of the Health Board's resources.	To achieve digital maturity enabling the Health Board to connect and communicate, supporting shared decision making in the planning and delivery of health care services. Refresh and deliver the Health Board's programme for creating integrated health and care facilities in our local communities where people can access the information and support they need under one roof. With Cardiff University and NHS partners, develop the Health Board's plans for ensuring hospitals providing acute care are fit for the future. Develop more shared infrastructure with public and private sector partners to get best value for the Health Board's investment.	Develop and expand the Health Board's research, teaching and innovation portfolios in collaboration with Cardiff University and other partners. Contribute to the development of and adopt cutting-edge and novel treatment, techniques and technologies where they deliver improved patient outcomes and improved value. Maximise the Health Board's contribution to the foundational economy Deliver the Health Board's carbon emissions targets and fully support active and sustainable travel for staff and visitors to patients. Promote, reward and embed successful waste reduction as part of our quality programme of continuous improvement.

Shaping Our Future Wellbeing

Strategic Risks – Overview

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Cardiff and Vale University Health Board

What will prevent Cardiff and Vale University Health Board from delivering its strategy?
If any of the below risk themes cannot be controlled, then the strategic objectives are unlikely to be met.

Strategic Risk	Risk Appetite Target Risk	Gross Risk *(no controls)*	Net Risk *(after controls)*	Context	Executive Lead(s)
Quality	Cautious 10	25	15	Our ultimate priority - to continuously, reliably, and sustainably meeting the needs of the population that we serve. Our organisation will focus on delivering assurance on the six domains of quality with the ultimate aim of providing outstanding care to our patients. We will strive to deliver Safe; Timely; Effective; Efficient; Equitable and Person-Centred Care.	Exec Dir Nursing Exec Medical Dir Exec Dir AHPs and Health Science Chief Operating Officer
Health Equity	Open 12	16	12	One of our two statutory responsibilities as a Health Board is to improve the health and well-being of our local population. The overall aim of our strategy is: 'Working together, we will help improve lives so that by 2035 people are healthier and unfair differences in health outcomes are reduced.' The goal is to improve health outcomes by reducing inequity in indicators of healthy behaviours and increasing the use of preventative services and access to clinical services.	Exec Dir Public Health
People	Open 12	20	16	The most important asset of any organisation. Through the delivery of the People and Culture Plan, our strategy will be delivered with a key focus on these core People risks: Attract, Recruit, Retain | Culture | Wellbeing	Exec Dir People
Digital	Cautious 20	25	20	Data is integral to our strategy. It empowers informed decision making about what we need to do, why, when and how we perform. Delivering our digital and data transformation road map will introduce actionable insights and capabilities that enable clinicians and patients in any setting delivery of safe, high-quality care, improving productivity, efficiency and communication through person centric digital solutions. The security, management and accessibility of data is essential.	Dir Digital

Shaping Our Future Wellbeing

Strategic Risks – Overview

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Infrastructure	Open 15	**25**	**20**	The Health Board has the largest hospital in Wales, a footprint across dozens of locations and integrated service locations with key partners. We must shape our future infrastructure to ensure facilities are fit for the delivery of modern healthcare, intelligent integration takes place with partners and the service is delivered in the right locations for our population.	Exec Dir Finance
Sustainability	Cautious 10	**25**	**20**	Sustainable, efficient services are a legal requirement, improve quality and ensure a sustainability of service for now and future generations. By articulating the strategy through the integrated mid-term plan and the proper alignment of resources and consideration of the environment the Health Board will meet its statutory duty and ensure value in delivery.	Exec Dir Finance

Risk Appetite			
Avoid	Avoidance of risk and uncertainty is a key organisation objective	Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (VFM)
Minimal	Preference for ultra-safe delivery options which have a low degree of inherent risk and only for limited reward potential	Seek	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)
Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential reward	Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

Strategic Risks – Quality

Strategic Risk	Strategic Portfolio	Exec Leads	Committee	Date Added
Quality	Shaping our Quality, Value & Sustainability	Exec Dir Nursing | Exec Medical Dir | Chief Operating Officer Exec Dir Therapies and Health Science	Quality	30 Sep 24

Risk

There is a risk that workforce, digital, capacity and estate constraints, combined with weak escalation and organisational learning, lead to inconsistent and unsafe care, resulting in avoidable harm, poorer patient outcomes, long waits, reduced patient experience and diminished public trust.

Cause	Impact
Workforce Vulnerabilities in our Workforce including availability, retention, culture and leadership can impact on our ability to deliver safe effective timely and patient centred care **Digital Enablers** The absence of a joined up digital patient record and patient management system has resulted in omissions in care and disruption to patient pathways Ability to deliver effective care is impacted by outdated systems related to digital technology, clinical coding The challenge in accessing real time data to track care against a robust evidence base means that the organisation is dependent on retrospective data to inform its response to quality risk. The lack of data relating to population health and protected characteristics means that we are unable to effectively measure variation in outcomes. **Capacity and demand** Ability to deliver timely care is significantly impacted by the backlog of referrals following the covid-19 pandemic and the mismatch between demand and recurrent capacity within many clinical services. Pressure within the urgent and emergency care pathway is driven by extended length of stay. Opportunities to maximise out of hospital services have not been fully realised. **Environment** The ageing environment is leading to challenges including to disruption to services and Infection prevention and control risks and poor patient experience **Whole Systems approach** Gaps in our clinical governance structure means that risk is not clearly articulated and Escalated and that mitigation is often localised rather than delivered at an organisational level. **Improvement and learning capability** Learning from events is often undertaken at departmental level with infrequent evidence of embedding organisational learning	**Safe** The UHB continues to see a number of same cause patient safety incidents, complaints, redress cases and claims where the harm to patients is potentially avoidable. These include health care associated infections, failure to ensure continuity in clinical pathways, failure to recognise the deteriorating patient, failure to escalate, issues with communication and Never Events. The health, safety and welfare of our staff is not universally maintained. **Timely** Long waiting times for planned care and diagnostics means care is delivered at inappropriate timescales with a potential consequence of progression of disease, worsening wellbeing and associated psychosocial impact on patients and families. Care is ultimately costlier to provide. **Effective** Benchmarked data associated with national clinical audits demonstrates that we don't universally benchmark in the top 30% of organisations nationally for performance and outcomes. The pressure on estates, workforce capacity and wellbeing will impact on our ability to provide care in line with evidence base. **Efficient** The Health Board is not meeting some of its productivity and efficiency ambitions, including in relation to outpatients and length of stay. Care may be being delivered which does not provide value to the patient, wider population and health economy. Care can be duplicative and wasteful. Care is often delivered with a disproportionate focus on intervention vs prevention. Constraints around workforce availability results in a reliance on non UHB staff to provide core. **Person Centred** The Health Board is striving to deliver care that meets the patients right to empathy, compassion, privacy, dignity and respect. In some areas patient experience is below our ambition, for example in the Emergency Department which is below the 85% target in all but one measure. The Health Board is seeking to ensure patients and families views are sought and play a role in improving services.

Strategic Risks – Quality

.		**Equitable –** Our health outcomes between different population groups (e.g. most deprived and least deprived and different ethnic groups indicate that we have more work to do on this aspect of quality. We have developed an 'Equity, Equality and Patient Safety Framework for the Health Board' this describes a framework for change, provides examples of best practice from across the world, and finally outlines the key actions each Clinical Board has committed to. For example, our data collection of protected characteristics is poor, and each Clinical Board will need to make improvements in this area. Using a co-production approach supports equity.	
Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 10

Controls	Assurances
Safe – Corporate Quality and Safety team have oversight of all UHB patient safety incidence, the Duty of Candour supports systematic scrutiny of all incidents reported as having caused moderate harm and above. Quality Committee and the groups that report into the committee provide oversight of emerging trends. The clinical safety group brings together the clinical boards and clinical advisory groups to support the development of strategy and policy to deliver quality aligned to current risk. The Shaping our Future Quality Excellence Programme is designed to address emerging patient safety themes. The Theatres Together programme is overseeing improving work in theatres that has emerged from the recent theatres review. **Timely**- Planned Care programme and Operational Performance meetings delivering on plans to reduce waiting times. Patients prioritised in line with Health Board criteria – Urgent and Emergency Care; Cancer and Time-Critical; planned (in referral order). Recovery plans are in place for diagnostic long waits such as endoscopy and non-obstetric ultrasound. **Effective –** The Clinical Effectiveness Committee provides oversight of national clinical audit outcomes and improvements and implementation of NICE and HW guidance. Clinical Boards are bringing an overview of their local arrangements to providing continuous focus of national audit data and use it to transform clinical pathways as has been done in stroke and hip fracture. Work is planned as part of the Sharping our Future Quality Excellence – Quality Management System Project to standardise the collection of national audit data and to embed it into quality governance structures.	• Clinical Board Performance Meetings • Integrated Performance Report • QSE • Clinical Effectiveness Committee • Clinical Safety Group • Risk registers • Executive Reviews • People and communities experience framework • CIVICA • Benchmarking Information (Clinical) • Get It Right First Time • Peer Reviews • HIW and external assurance • PSOW REPORTS • WRP assessments • Accessibility standards • Equity, Equality, Experience and Patient Safety Framework and Action Plan at Quality Committee • Assurance of CAVHIS Business Case Implementation in 2024/25 • AMaT • Shaping Our Future Quality Excellence

Strategic Risks – Quality

Efficient – operational programmes in planned care and urgent and emergency care focused on delivering best practice. Benchmarking and use of GIRFT central to programme. Productivity and Efficiency ambitions in place and monitored. **Person Centred –** Value Based Healthcare programme supporting projects and programmes focused on delivering value to patients. The UHB is rolling out a new PROM platform "Promptly" throughout the organisation to provide reliable opportunities to collect this information. **Equitable –** We monitor performance against the actions outlined in the Equity, Experience and Patient Safety Framework and Action Plan. This goes to Quality Committee every six months.	
Gaps in Controls	**Gaps in Assurances**
A recent advisory audit of Clinical Governance demonstrated gaps in reporting and escalation The availability of data to support benchmarking and monitoring of performance is limited by poor coding compliance Participation in a number of National Clinical Audits is sub optimal with poor case ascertainment and data quality The availability of data relating to protected characteristics means that measures of variation in outcomes by population is limited. The Development of the Quality management system is underway, but this is a two-year programme to embed this work	The control gaps identified mean that assurance at Committee and Board level is undermined and so the Committee work is being reviewed and redeveloped.

Risk Post-Controls and Mitigation			
Impact: 5	Likelihood: 3	Net Risk: 15	

Shaping Our Future Wellbeing

Strategic Risks – Quality

GIG CYMRU NHS WALES
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Cardiff and Vale University Health Board

Actions			
What	**Lead**	**By**	**Update**
Deliver stroke improvement plan to address quality concerns in acute stroke pathway	PB	31/03/27	• Business case approved for stroke model, funding to be released from Q4 2024/25 • Delays in recruitment for agreed stroke post • Recruitment is now underway to the additional posts, but it will be some time before all posts are in place. There is continued focus on stroke performance and a real increase in regional working to deliver sustainable models moving forwards. • Stroke performance remains stable – new SSNAP measures to be reported to Board in August. • Go-live of phase of regional thrombectomy service in July 25 • Performance is consistent despite operational pressures. Increases in thrombolysis rates, work remains on % in time. Detailed review of thrombectomy undertaken • Stroke summit highlighted improvements in performance for some parts of pathway alongside increased challenges – particularly rehab length of stay. Work ongoing • Stroke Summit 16th June - agreed actions were to continue on all workstreams, review SRC's accommodation and clinical model and facilitate Exec colleagues' conversations with available data in the stroke dashboard. • Improvement work continues under new leadership of Specialist Clinical Board. Challenges remain across pathway and ongoing discussion with JCC on next phase of thrombectomy plan
Develop and deliver improvement plan for cancer and long waiting patients, including a plan to reduce diagnostic waiting times.	PB	31/03/27	• Delivery against revised trajectories is monitored internally and by WG • Challenging position in select specialities including ophthalmology • End of year positions in Cancer and 104 weeks for 24/25 good in comparison to recent years but still too long and not in line with WG expectations. Revised plans in place to deliver reduction during 2025/26 • Cancer performance remains best in Wales – further work to do to reach 75% • Long waits significantly reduced, meeting agreed trajectories for each quarter. • Q2 performance slightly ahead of trajectory for 104 week waits. • On-track of 450 patients waiting longer than 104 weeks by end of March. • Diagnostic challenges mean improvements will be delivered but not to the level previously expected • End of year position significantly improved for 156 weeks, 104 weeks and 8-week waits • Recurrent demand and capacity mismatches will lead to worsening of position in 26/27 without further investment • Delivering productivity and efficiency opportunities key to mitigating position

			• Working closely with national colleagues to maximise productivity opportunities, backlog forecast position improved from April 2026. Still expect 104-breaches in challenges specialities. • Non-recurrent Welsh Government funding has been provided for in year schemes against some specialities. This funding is less than requested, work underway to re-profile revised 104 end of year position. • Full funding has been received, delivery in progress to achieve no more than 309 >104 week waits by the end of the year
Develop and deliver long term proposal for ITU capacity – Strategic Outline Case in production	PB	31/09/26	• The design development continues. However, discussions are ongoing with WG in relation to a combined ITU/Haematology and Hybrid theatres schemes. • Interim plan for releasing capacity on 3rd floor in progress through discretionary capital programme – work to C1 to accommodate Cardiology from C3 has commenced and is due to complete October 2025, releasing capacity ahead of the ITU work • C1 work will completed in December. Planning in place to install updated UPS • C1 work completed. UPS completed. • Detailed request for funding for C3 refurbishment, and indicating plans for subsequent A3, B3 upgrades, will be sent to WG in Q4 • Completion of proposal has been delayed due to capacity pressures, aiming for submission in Q2 26/27 • Programme Business Case will be re-reviewed at Value and Benefits Realisation Group in October. • Approved at VBRG, for onward governance routes
Deliver the Theatres Together Programme which includes important quality elements such as the WHO checklist and productivity improvements	PB	31/03/2027	• Theatres Together Programme is underway, and updates provided through Board. Initial focus on 6 immediate actions and cultural priorities • Work on further tranches now underway • Progress made across programme with improvements in staff feedback. • A number of capital and estates improvements have been delivered with wider programme in development • Theatre efficiency and utilisation improvements form significant part of future work • Significant positive feedback from staff engagement sessions – indicating embedded improvements • Programme continues with an increased focus on productivity, efficiency and best practice
Review, design and improve mental health services which are noted to carry risks to quality	PB/DF	31/03/2027	• External consultancy appointed to support with review of mental health services – work ongoing • Plans for neurodevelopment services undergoing significant scrutiny

Strategic Risks – Quality

			• 3-year ND waits for children and young people likely to be >450 by March 2026 – working with WG and NHS P&I. • 3-year ND waits reducing for end of life but will increase in 26/27 • Implementation phase of transformation work to begin in 26/27 • Transformation plans developing and being delivered. Consideration of phase 2 opportunities from external support. Focus on out of area placements • Transformation Board is established and delivering. Initial progress on key measures, including Care and Treatment Plans and Out of Area have been promising
Length of stay and continuity of care	PB	31/03/2027	• Length of stay programme in place – aiming to deliver, as a minimum, mean peer performance in medicine non-elective by the end of March 2026/27. • Performance and productivity board in place to monitor and drive change • Work continues with additional support from Shaping Change as part of Integrated Improvement Programme
Development of a Quality Outcomes Framework- To support a data informed approach to quality	JR/ RS	31.06.25	• Meetings underway with corporate teams to agree quality indicators • Work to extrapolate data relating to patient safety incidents commenced • Plan to develop a first draft by Q1 with digital support by June 2025 • Publication of a UHB mortality dashboard • Publication and analysis of clinical board and directorate mortality dashboards
Development of the Quality prospectus to populate the quality academy – Up skill staff across the clinical boards in patient safety review technique, improvement planning and clinical governance	JR	31.03.26	• PSLR training developed • Improvement plan training in development • Human factor prospectus planning • Development of a quality academy • Accredited audit training in place
Monitoring of the Equity, Equality, Experience and Patient Safety Action Plan and progress against actions by Clinical Boards	CB	Every six months	• Paper for Quality Committee on progress against the action plan. • Early discussions with Public health around equity measures as part of the quality outcome framework

Strategic Risks – Health Equity

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Health Inequity	Shaping our Population Health and Place Based Partnerships	Executive Director of Public Health	Quality	29 July 2021

Risk

There is a risk that insufficient investment in prevention, worsening socio-economic determinants, inequitable access and poor data limit the Health Board's ability to address inequalities, resulting in widened life expectancy gaps, higher morbidity in deprived populations and increased long-term demand on services.

Cause	Impact
Risk: a lack of investment in prevention • Our organisation aims to shift spending from reactive hospital care towards prevention and proactive care in community settings. However, secondary care continues to receive an increasing share of NHS funding, leaving prevention under-resourced. Addressing this imbalance is essential for our long-term sustainability. • There is currently a lack of capacity to deliver evidence-based interventions at scale to tackle smoking, obesity, vaccination, alcohol, substance use etc. that drive the huge disparities in health outcomes we see across Cardiff and the Vale of Glamorgan. • There is also currently a lack of capacity to undertake more substantial work on the wider determinants of health with partners, such as improving housing, educational attainment and employment. • There is currently a lack of investment in prevention: the Faculty of Public Health recommends 15 public health consultants for a population of 500,000, we employ 5.5 WTE. **Risk: worsening socio-economic determinants of health** Health inequalities are well documented across the UK and arise in multiple ways, including structural issues e.g. income, employment, education and housing and unhealthy behaviours due to the environment, social norms and income levels. Worsening socio-economic determinants in the UK are impacting on health needs and outcomes in general, but particularly for those most vulnerable in our communities. People living in the most deprived areas die earlier on average and live more of their lives in poor health; this is well recognised and deeply entrenched, but it is	**Impact: widened life expectancy gaps and higher morbidity in deprived populations** The risks identified above contribute to worse health outcomes and a worsening of the gap in life expectancy and healthy life expectancy between different members of our population. **Impact: increased long-term demand on services** Health inequalities are already estimated to cost £3-4 billion annually in Wales through higher welfare payments, productivity losses, lost taxes, and additional illness. The total annual cost associated with inequality in hospital service utilisation to the NHS in Wales is estimated to be £322 million, equivalent to 8.7% of the total hospital service expenses, driven largely by higher service use among people living in more deprived areas compared to those living in the least deprived (Cost of health inequality to the NHS in Wales - Public Health Wales) A lack of investment in prevention will cause an increase in future health service costs associated with health inequities. The 2026 Cost of Smoking in Wales Report highlights the significant costs of smoking - to the NHS, social care, in lost productivity and to the environment. In 2022/23, smoking cost Wales more than £1.56 billion. Nearly one-third of all smoking-related cost (£489.8 million; 31.4%) is concentrated in the most deprived fifth. Prevention funding also needs to be sustainable and planned for the longer-term so that innovative approaches to reducing health inequities, such as through the work of the Cardiff and Vale Health Inclusion Service (CAVHIS), can continue to

Strategic Risks – Health Equity

preventable. Risk factors interact and multiple aspects of disadvantage come together, increasing the disease burden and widening equity gaps. Moreover, disadvantage experienced in childhood is often compounded and exacerbated through adult life and therefore often passes inter-generationally.

- Examples of the impacts of these inequities on health include:Areas with higher unemployment have greater incidence of suicide; and people living in the most deprived areas experience the largest increase in mental illness and self-harm.
- In 2021, in England, the *undiagnosed* diabetes rate was double for those in the bottom Index of Multiple Deprivation quintile compared to the top. This presents a challenge for the NHS in finding those with an unmet need for healthcare.
- Lower levels of immunisation in the population have significantly increased the risk of outbreaks of diseases like measles. These will impact disproportionately more on our most deprived communities, with direct risks to health and by further negatively impacting on wider determinants such as education or employment.
- Smoking is a major contributor to health inequalities; smoking prevalence is typically higher in areas of greatest deprivation and has a significant influence on morbidity and mortality. In Wales in 2020-2022, 14.5% of deaths in adults aged 35+ and living in the most deprived areas of Wales were attributable to smoking, compared to 7.7% of those living in the least deprived areas. In Cardiff and Vale in the same period, 9.8% of all deaths in adults aged 35+ were attributable to smoking, involving 5,573 admissions to hospital.

Risk: inequitable access to services

Access to, or experience of, services, public information or healthcare sites that may be relevant / pertinent to particular health and wellbeing needs, continues to be inequitable, including as a result of discrimination. The 'Inverse Care Law' has been recognised for over 50 years, with those experiencing disadvantage consistently experiencing more challenges in accessing health services. Inequity of access to healthcare continues to be evident in Cardiff and the Vale of Glamorgan.

build on progress made, maximise impact and ensure that achieved gains are not reversed.

Taking preventative action on health inequities can reduce premature mortality, reduce social disparities, and reduce the absolute time in ill-health for people in our communities. For example, using a NHS service such as 'Help Me Quit' can increase a person's chance of successfully quitting smoking. , By locating 'Help Me Quit' clinics in areas where smoking prevalence and deprivation are highest and delivering clinics on different days and at different times of day, barriers to accessing these services can be further reduced.

This preventative action can in turn reduce the burden on and costs to the Health Board and social care, while enabling our population to be more productive in our working lives. Spending on prevention has a superior return on investment when compared with acute hospital services. There is strong evidence that areas that invest more in prevention and community care see 15% lower non-elective admission rates and 10% lower ambulance conveyance rates, together with lower average activity for elective admissions and EU attendances.

Changing both the distribution of resources and the operating model to deliver preventative care closer to home will also support the UHB to fulfil its organisational priorities as described in its Strategy, because they are derived from the changing needs of the population.

Strategic Risks – Health Equity

Risk: limited and poor quality data Evidence suggests that key population groups with multiple vulnerabilities include: • Some people in minority ethnic groups, especially some people in Black and Asian populations • People living in (or at risk of) deprivation and poverty • People in insecure/low income/informal/low-qualification employment, especially women. • People who are marginalised and socially excluded, such as people experiencing homelessness and other inclusion health groups However the quantity and quality of data on the health needs, outcomes and experiences of people from these and other disadvantaged groups is highly limited. This impacts on our ability to both understand and mitigate health inequities using evidence-based and effective approaches.	

Uncontrolled Risk			
Impact: 4	Likelihood: 4	Gross Risk: 16	Target Risk: 12

Controls	**Assurances**
1. Statutory duty • The Health Board has a statutory duty to improve the health and well-being of the local population. • The Socio-economic Duty places a legal responsibility on public bodies in Wales when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. • **2. Role as an employer** • In our Equality, Inclusivity and Human Rights Policy, we have an active programme, which sets out the organisational commitment to promoting equality, diversity and human rights in relation to employment, and ensuring staff recruitment is conducted in an equal manner. • Our Strategic Equality Objectives and Plan 'Shaping our Inclusive Culture 2024-2028', has a number of key delivery objectives and is premised on the basis of embedding equality, diversity and human rights, and Welsh language, into UHB business processes.	Board papers Committee papers to Quality Committee e.g. updates on Equity, Equality, Experience and Patient Safety Framework. Committee papers to People and Culture and Quality and Safety Committees e.g. updates on Welsh Language Standards. Risk Registers Integrated Performance Report Papers to Senior Leadership Team (SLT)

Strategic Risks – Health Equity

- All our Executives have taken up a leadership role as an Inclusion Ambassador covering different characteristics, including those specified in the Equality Act 2010.
- The Head of Equity and Inclusion is a member of the Public Sector Equality Network, improving the collaboration between public sector organisations in the area. The UHB also now has an Equity & Inclusion Manager, together supporting Clinical and Service Boards, including with awareness and training on completing Equality Impact Assessments.

3. Our Strategy and plans

- The refreshed UHB Strategy 'Shaping our Future Wellbeing' shines a light on the issue of equity at the strategic level.
- 'Shaping our Inclusive Culture 2024-2028' is closely aligned with the UHB's Strategy 'Shaping our Future Wellbeing'.
- The Cardiff and Vale Long-term Public Health Plan 2024 – 2035 sets out how the UHB intends to achieve its ambitions of increasing life expectancy, reducing inequity and shifting more focus to prevention.
- Through our Public Services Board (PSB) and Regional Partnership Board (RPB) plans we already prioritise areas of work to tackle inequalities and the refreshed needs assessments for both PSBs and RPB have further identified collective actions.
- The future UHB organisational direction supports the 'shift upstream' by committing to develop an Integrated Community Health System, underpinned by care pathways that begin with prevention; prevention is a 'brilliant basic'.
- An 'Equity, Equality, Experience and Patient Safety' action plan was approved by Board in May 2024, covering 24 initial actions across the Clinical Boards that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. Progress on actions is reported to Quality Committee on a 6-monthly basis (most recent update provided in April 2026). Ongoing review is undertaken to identify outstanding actions and create future actions using the framework.

4. Public Health priorities to reduce health inequalities

The Public Health Team have agreed three immediate priorities that will influence health inequalities (and other work that we will need to bring forward when capacity allows). Work to tackle inequalities needs to take place over prolonged time periods. We continue to work with PSB and RPB partnerships to address the three priority areas where we know we can make a significant impact on reducing health inequalities: smoking, vaccination and obesity. The Amplifying Prevention Board, held jointly with Local Authority (LA) partners, provides governance oversight of this collective action and works to remove any blocks to it. The priority areas are:
- preventing obesity (focus 0-5 years)
- reducing smoking rates

- increasing levels of vaccination (using an outreach model to reduce inequity in uptake). These priority areas are being developed through UHB-wide work, including: • The UHB is continuing to implement and periodically review its strategy to tackle the lower and unequal uptake of vaccination in our most deprived communities, using an intelligence driven approach and involving targeted, behaviourally informed communications and engagement. • The establishment of a Strategic Diabetes Programme Board is a key element to reducing health inequalities. It recognises that diabetes exacerbates health inequalities and aims to reduce the incidence of Type 2 diabetes and eliminate avoidable associated harms. • The UHB has developed a co-ordinated programme of action to reduce smoking in areas/populations where prevalence is highest (often where levels of deprivation are high). It has also taken strong action to introduce enhanced enforcement of no smoking legislation on hospital sites across Cardiff and the Vale of Glamorgan, including introducing innovative approaches that are evidence-based but have not been delivered locally before. This is helping to protect vulnerable people and signpost people to stop smoking support services. **5. Patient engagement and feedback** The All-Wales People's Experience Framework was launched in April 2025. There are now several methods being used to gather feedback with the aim of ensuring all patients can contribute (available from the Patient Experience SharePoint pages). Training tools and guidance are also now available to support staff in engaging more effectively with patients and service users, helping them gather meaningful feedback about their experiences. These are complemented by feedback-in-focus sessions held across sites to support patients, staff and carers in completing and understanding the many ways we collect feedback, offering support where needed.	
Gaps in Controls	**Gaps in Assurances**
There is an ongoing need to improve the routine collection of protected characteristics to support the introduction of new indicators. This will need to be addressed by each Clinical Board.	Monitoring data (e.g. on protected characteristics). A Population Health Management System to reduce inequalities by identifying those at risk. Ability to share information between Health Board teams on patient characteristics.

Risk Post-Controls and Mitigation			
Impact: 4	Likelihood: 3	Net Risk: 12	

Strategic Risks – Health Equity

Actions			
What	**Lead**	**By**	**Update**
Within the UHB and through our PSB and RPB partnerships, continue to develop and deliver a suite of focused preventative actions to tackle inequalities in health.	Claire Beynon	2026/27	**Updates:** • Across the UHB, work continues to meet targets in the existing Equity, Equality, Experience and Patient Safety Plan, especially in relation to data collection to support data availability, linkage and analysis. The most recent updates on this work were presented to the Quality Committee in April 2026 and the next update on this work will be presented in November 2026. • On October 5th the Patient Experience team held the first People and Community Reference Group meeting. This initial meeting was held with key stakeholders to set the scene and identify future group members. Future meetings will include, Health Board staff, Third Sector organisations, volunteers and those with lived experience. Meetings will be held every four months, with the first being 15th Feb 2027 focusing on Accessible Information Standards and BSL Legislation. • Increased activity to ensure people who smoke and who want to stop are referred to 'Help Me Quit' is underway. This includes providing additional capacity to support hospital in-patients, increased promotion of the service across Cardiff and the Vale of Glamorgan and targeted work with those living in hostels. • In the Cardiff City and South Primary Care Cluster of Cardiff, where vaccination uptake is the lowest in the region, focused work has begun to understand barriers to uptake. A community survey found that 40% of parents do not feel sufficiently informed about vaccinations for their children and 27% reported that they did not feel that family and friends supported vaccinations. Two collaborative (professionals and community) workshops discussed this and other insights and now have an action plan to implement as part of a task and finish approach. This includes further research conducted by the Public Health team in partnership with the Himilo Alliance (a voluntary collaboration of Somali led organisations) and the co-production of communications materials. • The Childhood & Teenage Immunisations Strategic Action Plan has been approved by the Strategic Immunisations Group and will be reviewed by the UHB's Senior Leadership Team and the Quality Committee in November. Equity is a cross-cutting theme of this. • Cardiff and Vale Health Inclusion Service (CAVHIS), working in partnership with the Immunisations team and Medicine Clinical Board, has launched its 2026 winter outreach respiratory clinics, delivering flu/pneumococcal vaccinations along with spirometry screening for, and treatment of, previously undiagnosed chronic respiratory conditions. • CAVHIS, working in partnership with the UHB's Department of Sexual Health (DOSH) has launched joint women's sexual health and Long-Acting Reversible Contraception (LARC) outreach clinics in various hostels and probation settings across Cardiff, with the aim of increasing the uptake of sexual health screening and increasing access to contraception. • A Health Needs Assessment on Inclusion Health has been undertaken for the Vale of Glamorgan. This will now be used to inform understanding of health and wellbeing needs in relation to health inclusion groups and future service development.

			• A Health Needs Assessment for Veterans living in Cardiff and the Vale of Glamorgan has now begun, with quantitative and qualitative data collection ongoing. • The Cardiff and Vale 'Warm and Well at Home' project began in October. This aims to offer targeted support for warmer homes to some older adults who have an existing health condition that has the potential to be made worse by cold temperatures. The project has additionally targeted the support to people who are living in parts of Cardiff and Vale with the highest levels of deprivation, as measured by the Welsh Index of Multiple Deprivation (WIMD). The project, developed through the RPB, is a collaboration between the UHB's Public Health Team, the RPB team, Independent Living Services (Cardiff Local Authority), the Wellbeing Matters Service (Vale of Glamorgan Local Authority), and Third Sector partners. It aims to support people to keep their homes warm this winter by maximizing their income and improving their home energy efficiency, whilst also offering holistic health and wellbeing support for falls, smoking and vaccination. **Planned actions:** • Refresh sections of the Population Needs Assessments or undertake Health Needs Assessments for the population that highlight health inequalities and actions that can be taken to reduce these and share these with appropriate partners (e.g. RPB and PSB). • Refresh the UHB's Vaccination Equity Strategic Plan and embed equity as a cross-cutting theme in strategic action plans to address vaccination uptake in childhood, teenage and adult populations.
Advocate for more resources for prevention as a percentage of the total health board budget.	Claire Beynon	2026/2027	**Planned actions:** • Continue to advocate for increased resources for prevention to improve the health and wellbeing of the local population. • Ongoing work on the business plans that would allow full implementation of evidenced based interventions to reduce health inequalities for smoking and obesity, to include time frame for benefits. • Suggest a methodology that supports the collection of data on spend on preventative activities, with a focus on primary prevention.
Improve the routine data collection in relation to equality and inequity across the UHB.	Claire Beynon	2026/2027	**Update:** • Following the recently completed "Reducing Health Inequalities – Ethnicity Data Internal Audit Report", a meeting has now been held to develop a plan to action the audit's recommendations. Leads for each action will be meeting regularly to take forward this work. **Planned actions:** • Request further analyses of aspects of access to health services by Welsh Index of Multiple Deprivation. • Expect Clinical Boards to take responsibility for understanding their data in relation to protected characteristics, and to take positive action in relation to this.

Strategic Risks – People

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
People	Shaping our People and Culture	Rachel Gidman	People and Culture	Revised 01/05/26

Risk

There is a risk that gaps in workforce planning, productivity, leadership and culture undermine workforce capability, capacity and engagement, resulting in an inability to maintain safe, affordable, high-quality services and deliver strategic transformation.

Cause	Impact
Domain 1: Workforce Sustainability **a) Workforce supply and capacity (recruitment, retention, skills)** • Workforce planning not aligned to demand and capacity (activity planning). • Variable workforce planning capability and inconsistent use of data to inform decisions. Workforce plans are not consistently aligned to future service models, productivity assumptions and population need, increasing reliance on short-term mitigations. • Limited workforce redesign (continued reliance on traditional models). Limited triangulation of workforce, quality, demand and finance data to identify emerging risks early. • Persistent gaps in critical and specialist roles creating service fragility Governance/compliance pressures (ESR/data quality, establishment control, safer staffing, mandatory training, professional registration, legal compliance) divert capacity Limited alignment between education, training and future workforce requirements **b) Workforce productivity and deployment (rostering, job planning, bank/agency optimisation)** • Lack of a unified E-Rostering system limits productivity and safe redeployment Variation in roster compliance and job planning impacting delivery of agreed KPIs. • Suboptimal temporary staffing controls increase cost and risk **c) Workforce affordability (pay bill, agency, variable pay)** • Over reliance on agency and variable pay • Financial constraints limit recruitment, growth and transformation	**Patient experience and outcomes will deteriorate, including:** • Increased waiting times and delays to treatment • Increased length of stay and delayed discharges • Increased patient safety risk linked to staffing gaps and fatigue • Reduced continuity of care and patient experience **Workforce performance will deteriorate, including:** • Increased sickness absence (**>5.5% target**) • Increased turnover and reduced retention (**>10% turnover**) • Reduced productivity and increased reliance on temporary staffing (< required 30% reduction for agency and 10% for Bank) • Worsening staff engagement and wellbeing (<74% target engagement score) **Financial and operational performance will deteriorate, including:** • Increased agency and variable pay spend • Inefficient workforce deployment impacting service delivery **Organisational sustainability and reputation will be impacted, including:**

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Strategic Risks – People

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Cardiff and Vale University Health Board

d) Sickness absence and wellbeing-related capacity loss • High and/or persistent sickness absence reduces workforce capacity and resilience • Mitigation through temporary staffing increases cost and reduces continuity of care. **Domain 2: Culture, leadership, wellbeing & workforce experience** • Limited integration of workforce, culture, wellbeing and EDI data reduces early identification of risk Absence of clear, organisational leadership and management expectations and standards leads to inconsistent behaviours and accountability. • Variable management capability impacts staff experience, performance and retention. Psychological safety, dignity and respect concerns affect staff wellbeing and willingness to speak up. • Cultural signals are not consistently triangulated to inform proactive intervention. • Wellbeing model is predominantly reactive, with limited preventative interventions • Sustained operational pressure /inefficient systems reduce wellbeing, engagement and increases burnout risk. Inequity in workforce experience and outcomes across staff groups.	• Reduced ability to recruit and retain staff in critical roles • Widening inequalities in workforce experience and outcomes • Reduced staff trust and engagement **Strategic delivery will be compromised:** • Delay or failure to deliver service transformation and organisational priorities

Uncontrolled Risk			
Impact: 5	Likelihood: 4	Gross Risk: 20	Target Risk: 12

Controls	**Assurances**
Overarching: • People & Culture Plan aligned to UHB strategic priorities. • Workforce Planning Training programme in place. • Annual Plan with key deliverables, supported by Clinical Board delivery plans. • Speak up Safely system, SUS/WIC. • Clinical Board/CEF – bank and agency reduction plans • Strategic plans aligned to EDI priorities. • Medical & Dental workforce workplan. • Temporary pay controls in Clinical Boards.	Overarching: **People and Culture Committee** oversight of workforce risks, performance and delivery **Monitoring of People and Culture Plan** deliverables and performance trends (including KPIs) **Annual Plan reporting**, on workforce risks and delivery **External assurance**, including Welsh Government oversight and performance reviews,

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• Managing attendance at work policy and training. **Domain 1 Controls: Workforce Sustainability** • Nursing workforce forecasting and safer staffing processes to identify and escalate capacity risks Recruitment, onboarding and retention approaches, including use of workforce data to inform interventions. • Workforce risks incorporated within IMTP and Annual Plan processes Improved education commissioning process. • Bank and agency governance/controls to manage use, authorisation and cost. • Sickness absence case management, OH/EHWS support and return-to-work processes. • Education, training and talent development pathways to support workforce pipeline **Domain 2 Controls: Culture, leadership, wellbeing & workforce experience** **Leadership & Culture** • Leadership development and OD interventions, supporting capability to lead teams effectively under pressure. • Raising Concerns / Speaking Up Safely framework, supporting staff voice and response. **Wellbeing** • Integrated health and wellbeing model (preventative, early intervention, specialist support). Occupational Health and Employee Wellbeing Services **Equality, Inclusion & Workforce Experience** • Strategic Equality Plan, Anti-Racist Action Plan and WRES, • Welsh Language Standards. **Engagement & Insight** • Staff survey and engagement mechanisms. • Wellbeing, Employee Relations and engagement data	**Domain 1 Assurances: Workforce Sustainability** • Workforce reporting (including Nursing Staff in Post) tracking vacancy, supply and capacity risks • Recruitment, retention and workforce experience data, including exit questionnaires and new starter insight . • Workforce planning outputs within Annual Plan and service planning processes. Workforce and financial performance data (including temporary staffing usage and cost) **Domain 2 Assurances: Culture, leadership, wellbeing & workforce experience** **Leadership & Culture Assurance** • Staff Survey and staff engagement data (leadership, psychological safety, dignity and respect). • Employee relations data and themes. • Speak Up / Work in Confidence data. **Wellbeing** • Occupational Health and Employee Wellbeing Service data (demand, access, outcomes) • Sickness absence data (including stress-related absence **Equality & Workforce Experience Assurance** • WRES, Strategic Equality Plan and Anti-Racist Action Plan reporting, • Analysis of differential workforce experience (disciplinary, progression, access to opportunity). **Triangulated Insight** • Increasing triangulation of workforce, culture, wellbeing and EDI data to identify risk and hotspots.

Strategic Risks – People

Gaps in Controls	Gaps in Assurances
Workforce Sustainability • No consistent, organisation-wide workforce planning framework (standards, tools, governance). • Variable workforce planning capability resulting in reactive decision-making. • Stronger controls for nursing than other staff groups (e.g. medical, AHP, A&C) • Over-reliance on temporary staffing and short-term mitigations. • Sickness absence controls more focused on case management than prevention • Limited integration of digital, automation and role redesign into workforce planning. • External workforce supply constraints (national shortages) increase residual risk. • Sustained operational pressure increases demand for cover, stressing existing controls. • Talent management and succession planning is not consistently defined.	**Workforce Sustainability** • Limited assurance on the quality and use of workforce plans to inform decision-making. • Assurance focused on current-state metrics, rather than future sustainability and modelling. • Inconsistent assurance across staff groups (stronger for nursing than others). • Limited outcome-based assurance on sickness absence reduction. • Limited assurance on effectiveness of actions to reduce reliance on temporary staffing beyond activity/cost monitoring. • Limited visibility of digital and workforce productivity impact.
Domain 2: Culture, leadership, wellbeing & workforce experience **Leadership & Culture** • No agreed organisational leadership and management standards • Inconsistent management capability, particularly in leading teams under sustained pressure and supporting staff wellbeing • No organisational cultural dashboard to monitor risk systematically. **Wellbeing** • Wellbeing model remains predominantly reactive • Increasing demand and complexity within Occupational Health and Employee Wellbeing Services. • Limited organisational controls to address sickness absence at a structural level.	**Domain 2: Culture, leadership, wellbeing & workforce experience** **Leadership & Culture** • Limited assurance on leadership and management capability, beyond staff perception measures. • No structured mechanism (e.g. dashboard) to identify emerging cultural risks early. **Insight and Early Warning** • Limited triangulation of workforce, culture, wellbeing and EDI data for early risk identification. • Reliance on developing workforce analytics capability to provide sustainable organisational cultural intelligence and early warning reporting. •

Strategic Risks – People

• No organisational Wellbeing Framework. **Workforce Experience, Access & Inclusion** • Inconsistent communication and access to information and support. • Variable awareness of, and access to, wellbeing and support services. • Inconsistent clarity of support pathways for staff and managers. • Inequities in workforce experience and outcomes not consistently addressed.	**Wellbeing** • Assurance focused on service demand/activity, not preventative impact or outcomes. **Equality & Workforce Experience** • Limited assurance on differential experience and outcomes across staff groups,

Risk Post-Controls and Mitigation		
Impact: 4	Likelihood: 4	Net Risk: 16

Actions			
What	**Lead**	**By**	**Update**
Agree and publish an organisation-wide Workforce Planning Framework (scope, required inputs/outputs, templates, scenario rules, governance/approvals, annual cycle and escalation), plus additional targeted short training/implementation plan for managers.	Donna Davies	Sept-26	HEIW Workforce Planning methodology has been adopted, supported by their online introductory training. HEIW are sponsoring workforce planning and data analytical training for people & culture leads. Workforce planning is being integrated as part of annual planning process with service and finance.
Medical & Dental workforce deployment, including implementation of a unified E-Rostering system, robust job planning, implementation of the Welsh Resident Doctor Contract (WRDC), etc	Martyn Capel	Aug-27 (phase 2)	**Medical Variable Pay** – System development work has been completed in conjunction with Patchwork, delivering enhanced functionality including the introduction of vacancy controls. This new capability enables the review of bank and agency shift requests prior to their live publication, providing improved oversight and assurance over medical staffing deployment. Discussion with Clinical Board Directors ongoing. **E-Rostering** – A two-year implementation plan has been developed to support the full organisation-wide rollout of RL Datix/Allocate. The solution will be deployed across the entire UHB covering all medical grades from FY1 through to consultant level.

Strategic Risks – People

			Job Planning – Achieving the Welsh Government 90% performance target continues to present a significant challenge. A procurement exercise will be undertaken in December to identify an alternative Job Planning system, as the current solution does not provide sufficient digital support, requiring staff to manually follow up with departments and clinicians.
Continue to reduce the reliance on temporary workforce through agency and bank reduction & improve monitoring through development of a dashboard.	Lianne Morse	Mar-27	P&C Committee receive updates via Workforce KPI report (bi-monthly) Board receive updates via IPR.
Strengthen leadership accountability and early intervention through a consistent, data-led attendance management and wellbeing approach to sustainably reduce sickness absence.	Katrina Griffiths	Mar-27	This is being supported by a significant increase in attendance management training for managers, with capacity increased to 400 places per month. This will strengthen managers' confidence and capability to address absence proactively, apply processes consistently and fairly, and ensure colleagues are connected with appropriate wellbeing support at the earliest opportunity. Improved use of workforce intelligence will enable targeted action in areas experiencing higher or persistent sickness absence, alongside continued oversight of emerging trends and underlying causes. Progress will be monitored through training uptake and completion, sickness absence trends, long- and short-term absence profiles, areas of higher absence, and evidence of timely management intervention, with escalation where sustained improvement is not being achieved.
Develop and implement organisational leadership and management standards, including defining how capability will be assessed and assured at organisational level in collaboration with HEIW national work.	Claire Whiles	Mar-27	Organisation-wide Leadership and Management Capability Assessment completed, identifying priority capability requirements and informing a targeted improvement programme. Implementation has commenced through targeted management development, the Line Manager Framework, Manager Passport and capability baseline, strengthening future organisational assurance and alignment with emerging HEIW national work.

Strategic Risks – People

Develop a proportionate organisational cultural dashboard, drawing on existing data sources, to support early identification and monitoring of cultural risk.	Claire Whiles	March-27 (phase 2)	Board Development discussions reaffirmed support for the phased development of the Cultural Early Warning System (CEWS), recognising the requirement for dedicated digital and analytical capability to progress beyond the initial phase. A development blueprint is being prepared, with discussions underway with Digital Health and Intelligence (DH&I) to secure dedicated support. Phase 1 dashboard pilots continue, alongside implementation of the Values Based Teams toolkit and associated support.Progression to subsequent phases remains dependent on securing the necessary digital and analytical capacity..
Redesign and implement an organisational wellbeing model to ensure appropriate balance between preventative, early intervention and specialist support.	Claire Whiles	March-27	An Organisational Wellbeing Design Group has been established following discussion at People and Culture Committee. Four workstreams have been identified to inform the development of a more sustainable organisational wellbeing model, balancing prevention, early intervention and specialist support. Proposals will return to Committee in March 2027. In parallel, procurement of an Employee Assistance Programme (EAP) is underway, incorporating access to 'in the moment' wellbeing support and counselling to complement and strengthen the existing internal provision. Online GP access also included in EAP offer.
Transition from WTD% payments to AfC Average payments, aligned to national programme of work to ensure the UHB are legally compliant.	Lianne Morse	Mar-27	National Programme Board to be established, paper going to the National W&OD Directors peer group on 19/06/26. NHSWE currently obtaining legal advice regarding interpretation and impact on terms and conditions.
Organisational readiness for the new Future Workforce Solution (replacement for ESR), prior to implementation	Lianne Morse	Dec-26	NWSSP will commence working with CAV from September 2026. Priority is currently with organisations that are early adopters of the system.
Develop and implement an organisational response to the Workforce Equality Standards (WES), establishing clear priorities, accountability and assurance arrangements.	Claire Whiles	Jan-27	. The WES report was presented to People and Culture Committee in September 2026, with organisational priorities identified. Engagement with senior leaders is progressing to establish executive sponsorship and organisational ownership. An implementation framework is being developed to clarify corporate support, Clinical Board and management responsibilities, accountability and reporting arrangements. The key remaining risk

			is the capacity to embed and deliver improvements consistently across the UHB, with implementation and assurance arrangements yet to be established.

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Digital	Shaping our Future Digital Services	Director Digital and Health Intelligence (D&HI)	Digital and Infrastructure	4 October 2022

Risk

There is a risk that legacy systems, underinvestment and limited digital capability constrain transformation, resulting in inefficient care delivery, increased cyber risk, missed productivity opportunities and failure to realise strategic ambitions.

Cause	Impact
CAVUHB IT and digital services are known to be historically underfunded resulting in a legacy and deficit in infrastructure, applications and informatics capability that has built up over at least a decade (e.g. our core applications for UEC, inpatients and outpatients were developed in-house-c20 years ago). There are plans to rectify these issues however they are unachievable with the current resource (people, finance) allocation We have some capability in human resources but insufficient capacity or funding to execute the digital and data transformation plans and road map. Existing resources are fully consumed with tactical short-term on the day-to-day urgency of UHB operational needs Recruitment of suitably skilled D&HI staff is a national challenge as well as affecting CAV. This often requires the use of interim agency support in key areas, especially whilst we continue with legacy solutions as we are tied to old	Colleagues need mobile, scalable, agile solutions that enable data collection and sharing. This is unachievable whilst we are locked into legacy. Legacy Lock makes improving our cyber posture more challenging (e.g. securing our data) The impact of not managing this risk is that the improvements in safety, quality, outcomes, productivity and financial efficiency that staff and patients expect from D&HI cannot be fully realised, therefore putting at risk the deliverability of the SOFW Strategy.

technologies. This of itself diminishes further our existing capacity as resources need to be familiarised with the technical environment and then supervised. Historically CAV has looked to provide much of its core IT and digital services inhouse. This is not always necessarily the optimum route however 'legacy lock' and the resource to support forward plans keeps us where we are. Meanwhile with new initiatives the technical estate grows and the gap between what we have and what we can support/refresh widens.	

Uncontrolled Risk

Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 20

Controls	Assurances
• Digital strategy approved by Board in 20/21 with roadmap for 21/22/23 - these will be refreshed by April 2025 • Roadmap to support the strategy shared with DHIC covering 2024/27 - these will be refreshed by April 2025 as part of the Digital Foundations PBC work • Digital components described in IMTP – focussed on in year national and clinical board priorities • £466K is being invested by CAVUHB in the development of a Digital Programme Business Case (PBC) to seek All Wales Major Capital Funding alongside a Business Justification case (BJC) for phase 1 of the 5 annual phases. This work will complete in 12 months. • The work will deliver a clear trajectory, costs and plans on how CAV will achieve its target of HIMSS[1] Level 3 in pursuit of its intention towards a modular EPR, consistent with national and regional initiatives. The capabilities the PBC and business justification cases will describe are harmonious with and would segue into any nationally agreed and funded EHR solutions through interoperability and concordance with the "All Wales" Infrastructure review. ○ Work is expected to begin Oct/Nov 2024. ○ This follows positive discussions with WG IIB and NHS CDIO,	• All Controls are shared and discussed with the DHI Committee which meets quarterly. • The Digital Foundations case was scrutinised and approved by the Investment Group and Strategic Leadership Board. • The Director D&HI shared the intentions of the Digital Foundations investment case and updated WG's chief digital officer, whilst the DoF has discussed with IIB Lead. Both are supportive of approach and our intentions • Recruitment and procurement is underway for the resource to produce the PBC and BJCs • Risk register articulates the risks of not being able to deliver digital solutions to support delivery of healthcare (1) • Internal audit report highlights the risk in delivering digital strategy citing the investment challenges that will prevent full implementation.

• An audit by Audit Wales on our approach and plans for Digital Transformation has now been completed. This audit has concluded that CAVUHB has a clear digital ambition and recognises digital as a key enabler of service quality, safety and sustainability. However, there are areas where greater clarity is needed for some Members of the Board on how this ambition will be achieved. Despite this, the Board shows strong ownership of digital transformation and has put governance arrangements in place to highlight key digital risks and priorities. The Audit makes several recommendations, which are detailed below.	
Gaps in Controls	**Gaps in Assurances**
Current annual discretionary funding is insufficient to cover the maintenance upkeep of the core infrastructure and there is no headroom for innovation	Unable to currently provide assurance that the finance will be provided

Risk Post-Controls and Mitigation		
Impact: 5	Likelihood: 4	Net Risk: 20

Actions			
What	**Lead**	**By**	**Update**
Internal investment case to support the Digital Foundations case approved	Director of DHI	Mar 26	Programme Business Case completed and shared with WG setting out detailed roadmap plans and the associated costs, funded accessed by annual Business Justification Cases to WG's Major capital budget. Statement of works produced against which a suitable external partner will be sought Digital Foundations Programme Business Case and supporting Business Justification Cases for Year 1 (of the 5 year case) complete. PBC being taken through the internal governance process comprising Capital Management Group, Value & Benefits Realisation Group, Senior Leadership Team, F&P and D&I committees before presenting to the November Board meeting and thereafter submission to Welsh Government for their consideration/approval. The existing Digital Foundations PBC seeks funding from the all Wales major capital budget but has a revenue tail which is currently unfunded. additional work is taking place, including detailed discussion with

			each Clinical Board, to identify the funding source to enable the PBC to progress through internal CAV UHB governance process – this will likely not happen until the new financial year. May 26: Meeting with WG's Head of Capital, CAV DoF and CAV DoD took place on 13/05/26 to provide update and share summary information in advance of a formal submission if agreed by CAV Board following due governance process. July 26: Capital bids invited by WG specifically to address Estates Backlog and DIgital Maintenance (back-log) costs, resulting in CAV submitting a digital maintenance bid for £7.8m in June 2026. There has been no further update on the consideration of the Digital Foundations PBC and associated year 1 BJCs submitted earlier in the year.
Development of the Digital Programme Business case to support the digital foundations ambitions is underway.	Director of DHI	May 26	External partner identified and service procured which has enabled the works to commence on the Programme Business Case. Co-production approach with all Clinical Boards and corporate services involved via workshops taking place during May and June 2025. July 25: Draft plans and outputs from workshops shared with Clinical Boards for comment prior to feeding into the Programme Business Case in Sept/October 25. Digital Foundations work to support the development of the Programme Business Case and supporting Year 1 Business Justification Cases complete. Workshops held with input from all Clinical Boards and services to ensure full co-production and alignment with the organisation's strategic objectives. Nov 25: Further scoping and detailed workshop being held with each Clinical Board during November and December to capture the detail of where savings can be made arising from automation and digital changes which will be used to off-set the revenue shortfall. The DF PBC has been shared with digital team at WG following the Digital presentation made at the November IQPD meeting. The intention is to submit the final case to Board for approval prior to formally submitting to WG for consideration via the Infrastructure Investment Board Jan 26 – additional work to identify the funding source for the associated revenue costs – especially in year 1 of the PBC means that the process will slip into 26/27. Decisions on allocating WG major capital are not expected until well into Qtr 1 26/27. May 26: An updated PBC and Year 1 BJCs have been developed and are in the process of working through the internal governance process having been reviewed by the D&I committee, SLT and Value & Benefits Realisation Group and Capital Management Group, with the case to be considered at the Finance & Performance Committee prior to submission to Board on 28/05/26. July 26: Audit Wales have completed their audit into CAV's Digital Transformation, resulting in 8 specific recommendations: Strengthen strategic delivery and affordability Develop the Board's understanding of Digital Improve assurance over digital and cyber risks Establish a clear approach to AI

			Build workforce readiness for digital transformation Have clear contingency plan for funding digital transformation Embedding how it works with staff and patients in its digital developments Reporting on digital programme benefits The management response to the above recommendations sets out the actions to be taken, which will be shared in more detail at the D&I committee meeting in August 2026.

Strategic Risks – Infrastructure

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Infrastructure	Shaping our Future Infrastructure	Exec Dir Finance	Digital and Infrastructure	12 November 2018

Risk

There is a risk that ageing estate, insufficient capital investment and delays in major programmes impair service environments and infrastructure, leading to safety risks, service disruption, poor experience and inability to modernise services.

Cause	Impact
• Significant proportion of the estate is over-crowded, not suitable for the function it performs, or falls below condition B (assessed regularly on an all-Wales basis by NHS Shared Services Partnership). • Investment in replacing facilities and proactively maintaining the estate has not kept up the requirements, with compliance and urgent service pressures being prioritised. • Lack of investment in IT also means that opportunities to provide services in new and efficient ways are not always possible and core infrastructure upgrading is behind schedule. • Insufficient resource to provide a timely replacement programme, or meet needs for small equipment replacement • Lack of timely decisions regarding the development of strategic business cases required to address the significant estates challenges we face.	• The health board is not able to always provide services in an optimal way, leading to increased inefficiencies and costs. • Service provision is regularly interrupted by estates issues and failures. • Patient safety and experience is sometimes adversely impacted. • Medical equipment is replaced in a risk priority order where possible, insufficient resource for new equipment or timely replacement. • Staff facilities needed to support good staff wellbeing are inadequate in many areas.

Uncontrolled Risk

Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 15

Strategic Risks – Infrastructure

Controls	Assurances
• Estates strategic plan in place which sets out how over the next ten years, plans will be implemented to secure estate, which is fit for purpose, efficient and is 'future-proofed' as much as possible, recognising that advances in medical treatments and therapies are accelerating. This will be updated following the conclusion of the conditions survey, clinical services plan and the site masterplanning work. • Statutory compliance estates programme in place • The strategic plan sets out the key actions required in the short, medium and long term to ensure provision of appropriate estates infrastructure. • The annual capital programme is prioritised based on risk and the services requirements set out in the IMTP/annual plan, with regular oversight of the programme of discretionary and major capital programmes. The 2026/27 Capital Plan will be submitted for Board with the Annual plan • Medical Equipment prioritisation is managed through the Medical Equipment Group and there is a process in place for rapid decision making if there is a urgent need to replace a piece of equipment. This is managed within the remit of the Capital Management Group. • Business Case production or delivery is managed through the Capital Management Group/Investment and benefits realisation group . • Welsh Governments stated priorities are Theatres including Vascular/MTC theatres, Haematology including BMT and ITU refurbishment. • Welsh Government has agreed regarding the Shaping Our Future Acute Hospital Programme a series of activities which will support the Health Board to refresh its estates strategy.	• The Health board teams including estates and capital team work with Welsh Government to identify opportunities to improve the estate sustainability and manage any emergent or urgent risks. • The statutory compliance areas are managed and monitored within the Health Board • The Capital Management Group, Senior Leadership Team the Digital and Infrastructure committee and Finance & Performance Committee
Gaps in Controls	**Gaps in Assurances**
• The current annual discretionary capital funding is insufficient to meet all the priorities identified through risk assessment, Annual Plan and Strategic ambitions of the organisation. • further impact the teams and resources available • Traceability of Medical Equipment • The Welsh Government capital funds are insufficient to meet the capital requirement	• the regular statutory compliance surveys remedial works .

Risk Post-Controls and Mitigation		
Impact: 5	Likelihood: 4	Net Risk: 20

Strategic Risks – Infrastructure

Actions			
What	**Lead**	**By**	**Update**
Infrastructure risk management	Geoff Walsh	Q2	The Vision document is due to be considered by the Board prior to submission to Welsh Government for consideration. WG have confirmed that the following the completion of the Vision Document that an addendum to the PBC issued in 2021 for the 'Future Hospitals' programme would be sufficient for their purposes of considering the next stages. WG have included in the correspondence what detail they require. It is anticipated that the addendum would be developed for consideration at the UHB May 2027 Board. The condition survey has been reviewed with all D & Dx elements identified, reviewed against th Estate Risk register and a prioritisation of the remedial works has been developed. A paper with the proposed plan is being considered by the D & I Committee in November 2026 BMT/Haematology Strategic Outline Case submitted to WG in June 2026 The feedback from WG is that they require further information specifically with respect to the relationship between the proposed development and the proposal within the vision document for the redevelopment of UHW A final response from JACIE is awaited . PBC for ITU refurbishment has now been endorsed by VBRG and will be considered by SLT and Board in November 2026 prior to submission to WG for scrutiny. Theatres refurbishment no progress on the Business Case Development. However, funding for 2nd phase of refurbishment included in Discretionary capital programme. Ophthalmology theatres business case Project team established, and design team appointed. Clinical Board have issued a revised project mandate. Commencement of the Park View (Ely) health and wellbeing centre has been delayed whilst the legal documentation is considered and agreed. It is anticipated that the site work will commence on November 16th 2026. i Capital management group to oversee a review of medical equipment risk across the assets and support the development of a management plan Q4 26/27 Work with Welsh Government to highlight and mitigate risks and opportunities to manage infrastructure issues in a proactive and sustainable way.

Strategic Risks – Infrastructure

Estate utilisation a programme of decommission, disposal or demolition is undertaken to minimise the estate and infrastructure which the Health Board needs to maintain.	Geoff Walsh	As per individual actions	Decommission priorities – Denbeigh and Carmarthen house have been vacated, and planning permission is being sought for their demolition. Tenders are due to return on 18th November 2026 and a bid to WG for slippage funding to progress the works in 2026/27 has been made. Demolition of Brecknock House and the Sports and social club is complete Disposal plans – Rookwood the UHB continue to work with the successful bidder to exchange contracts following approval of a revised offer by the Board of Trustees. Roath Clinic and Fairwater Road sites have been declared surplus to requirements by the HB. Approval to proceed to dispose of the properties is awaited from WG. Clinical service plans are being developed for the future of the ALAS and other Rookwood legacy services as well as Treforest. These are expected to be in place with a site solution by Q4 26/27 Education and clinical service plans are being developed with Cardiff University to develop a future model of delivery for dental education, training and service provision. Q3 26/27 Estates planning around the Dental Hospital will be undertaken in light of the future model. From Q4 26/27. Decommissioning of the Tenovus building in conjunction with Cardiff University
Condition Survey	Geoff Walsh	Nov 26	Develop a management and action plan for the results of the condition survey in two parts, firstly the highest risk issues (Category D & Dx) and then for all other issues identified in the survey. Highest risk management plan to be approved in Q3 26/27. Whole report management plan to be developed in following 9 months and used to inform the 27/28 capital programme for Welsh Government and the Health Board.

Strategic Risks – Sustainability

Strategic Risk	Strategic Portfolio	Exec Lead	Committee	Date Added
Sustainability	Shaping our Future Generations	Exec Dir Finance	Finance and Performance	1 April 2022

Risk

There is a risk that persistent financial pressures and limited progress on service redesign and decarbonisation undermine long-term sustainability, resulting in continued external intervention, investment paralysis, failure to meet statutory duties and weakened organisational resilience.

Cause	Impact
Decarbonisation and Climate	
The world has breached the 1.5°C pathway set by the Paris Agreement in 2024. Growing evidence shows that the magnitude of climate impacts is increasing day by day, and Cardiff is projected to be one of the most affected cities in the UK. Emissions Gap: Cardiff and Vale UHB remains significantly off trajectory against Welsh Government decarbonisation targets. Whilst emissions reduced to 198,711 tCO_2e in 2025/26, the organisation does not currently have a clear line of sight to achieving the Strategic Delivery Plan targets or the Shaping Our Future Wellbeing objective of reducing directly controlled emissions by 40% by 2027. Adaptation Gap: Climate risks are increasing in frequency and severity, particularly heatwaves, flooding and extreme weather events, whilst organisational climate adaptation maturity remains at an early stage of development. Due to with there is Increasing Climate Impacts on Workforce Wellbeing, Patient Care and Service Resilience.	Emission Gap Impact : Failure to meet Welsh Government requirements, increased financial and reputational risk, continued growth in emissions and reduced contribution to NHS Wales decarbonisation ambitions. Decisions made today may also create long-term carbon lock-in, making future decarbonisation more difficult and costly. Adaptation Gap Impact : Increased disruption to healthcare delivery, infrastructure, workforce wellbeing and patient care. Reduced organisational resilience and increased operational and financial pressures associated with climate impacts. Evidence from the 2025 and 2026 Heatwave Staff Impact Surveys demonstrates that climate change is already affecting Cardiff and Vale UHB operations. Extreme heat has impacted workforce wellbeing, productivity, patient care, infrastructure and service delivery across multiple clinical and corporate services. In 2026, 89.3% of respondents reported high thermal discomfort, 87.0% reported reduced productivity, 36.4% reported heat-related health issues, and 43.8% reported disruption to services during heatwave periods. Staff also reported cancelled clinics and procedures, overheating clinical environments, equipment failures, medication storage issues, increased patient demand and deterioration in patient conditions during periods of extreme heat. Climate change is no longer a future risk. Increasing heatwaves and other climate hazards are already affecting workforce wellbeing, patient safety, operational performance and healthcare delivery, creating additional financial and service pressures across the UHB.

Strategic Risks – Sustainability

Finance	
The conditions required to stabilise the financial position are not yet sufficiently developed or embedded.. The Health Board continues to operate with a significant structural deficit, with recurrent expenditure growth exceeding available resources and insufficient progress in aligning service delivery, workforce and capacity with the funding available. The Health Board has developed financial modelling illustrating a potential three-year sustainability trajectory through service re-design, productivity improvement, workforce optimisation and better alignment of capacity with population need. However, the modelling remains dependent on significant assumptions and enabling actions that have yet to be translated into sufficiently developed, quantified and deliverable clinical, operational and workforce plans.It therefore represents a potential improvement trajectory rather than an assured route to financial sustainability. Planned deficit of £86.5m in 2026/27. Following a £9.1m reduction in the Welsh Risk Pool forecast liability, the control total forecast has reduced to £77.4m Key contributors to the financial sustainability risk include: - Recurrent cost growth across workforce, pay, prescribing, Continuing Healthcare and demand exceeding available funding growth. - Insufficient progress in delivering recurrent, cash-releasing savings and reducing the underlying expenditure base. - Continued operational commitments and expenditure growth without corresponding recurrent funding or offsetting efficiencies. - The requirement for significant Executive and Board decisions to translate financial opportunities into deliverable programmes with clear accountability, milestones and quantified benefits.	I Failure to address the underlying financial sustainability risk could result in: - continued failure to meet statutory financial duties, including the requirement to achieve financial balance over a rolling three-year period and secure an approvable financial plan. - Further deterioration in the underlying financial position and increasing financial pressures in subsequent years, limiting the organisations ability to establish a sustainable recovery trajectory. - continued or escalated Welsh Government intervention, with increased external scrutiny and potential further requirements for corrective action. - Reduced ability to invest in service transformation, workforce development, digital infrastructure and estate improvements to support longer-term sustainability. - Increased risk to service quality, access and operational resilience if financial pressures necessitate unplanned or short-term corrective measures rather than clinically informed service redesign. - Reduced organisational flexibility and capacity to deliver the Health Board's strategic objectives and respond to changing population needs.

Strategic Risks – Sustainability

Uncontrolled Risk			
Impact: 5	Likelihood: 5	Gross Risk: 25	Target Risk: 10

Controls	**Assurances**
Decarbonisation and Climate	
A decarbonisation action plan is in place to deliver decarbonisation actions aligned with the NHS Wales Decarbonisation Strategic Delivery Plan (SDP) 2021-2030. As the SDP has currently been refreshed, a new Sustainability and Climate Response Plan is under development to reflect the changes. SusQI has been implemented to embed sustainability in Q&I projects. The Welsh Government has mandated yearly reporting, such as Decarbonisation Co-Ordination Reporting and Emission Reporting, along with all other health boards in Wales. The Welsh Government has made it mandatory to report qualitatively on progress regarding climate adaptation. A Working group has been established to identify pathways for climate risk assessment and climate adaptation pathways.	Sustainability and Climate Response plan is under development and will be overseen by Finance and performance committee The first draft of CAV UHB climate adaptation framework and plan has been signed off by SLT as a working plan. The final version will be submitted to Welsh Government by end of the financial year. Successful in outline stage of the NIHR-funded HASTE research bid with the Institute of Occupational Medicine, Met Office and UKHSA. This is a research study to understand and design adaptation approaches for heat impacts on health care delivery.
Finance	
Scheme of Delegation and financial governance framework for expenditure approval. Annual Operational Plan aligned to savings requirements and control totals. Savings Program monitoring through:	Monthly financial reports and savings delivery updates to the Finance & Performance Committee. Board receives monthly Integrated Performance Report including financial risk assessment.

Strategic Risks – Sustainability

– Senior Leadership Team – Monthly Executive performance reviews / Finance deep dives – CEO-chaired Financial Summits Finance Business Partnering providing forecasting, reporting and corrective action support. Monthly Finance & Performance Committee scrutiny. Internal audit reviews of financial controls, planning and budget management. Workforce controls and recruitment approval processes aligned to financial plan compliance.	Internal audit provides assurance on the adequacy of financial systems and controls. Welsh Government oversight through Targeted Intervention with regular feedback. Forecasts and financial deep-dives reviewed by SLT and Management Executive.
Gaps in Controls	**Gaps in Assurances**
Decarbonisation and Climate	
Given the complexity of decarbonisation actions across various departments of the UHB, there is a lack of continuous, robust monitoring. This would require the establishment of a digital climate change programme dashboard, setting of qualitative and quantitative KPIs aligned with targets, and a seamless data collection process for all decarbonisation actions. Sustainability needs to be embedded in decision-making. The business plan template needs to capture sustainability from decarbonisation and climate risk perspectives and should be given appropriate weight. Climate Impacts needs to be included in appropriate risk registries, and risk thresholds needs to be set.	Delivery of decarbonisation and climate adaptation programmes continues to be constrained by limited dedicated resource and organisational capacity.
Finance	
No approved medium-term financial strategy addressing the recurrent deficit. No formal decommissioning framework for low-value or unaffordable services. Internal commissioning and demand management not sufficiently developed.	No independent validation of savings assumptions or deliverability. Insufficient triangulation of financial, workforce, activity and quality data.

Strategic Risks – Sustainability

Structural savings pipeline incomplete and over-reliant on non-recurrent measures. Weak enforcement of accountability for non-delivery of financial targets. Decision-making not consistently aligned with affordability constraints.	Improving but limited benefits-realisation reporting for previous investments.

Risk Post-Controls and Mitigation			
Impact: 4	Likelihood: 5	Net Risk: 20	

Actions

What	Lead	By	Update

Report Title:	Impact and learning from 2026 summer heatwaves – a CAV perspective		Agenda Item No:		3.1
Meeting:	Quality Committee	Public	X	Meeting Date:	30/11/26
		Private			
Lead Executive Title:	Executive Medical Director				
Report Author/s Title:	Associate Medical Director Patient Safety and Clinical Effectiveness				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

This report highlights the internal (to CAV) clinical, environmental and infrastructure impacts of the 2026 summer heatwaves. This paper should be considered alongside the strategic climate adaptation plan in preparation by Dr Tom Porter and Arjun Padmavathy.

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

Board/Committee Response Required *(please select only one)*					
Assurance		**Approval**		**Information/Noting**	X

Recommendations

- Consideration of formal Board by Board preparedness/Forward plan for Health board wide heatwave resilience. E.g. Address humidity in theatres during hot weather events.
- Provision of heatwave response plans for clinical areas - including consideration of air conditioning in ward, OPD and assessment areas.
- Consideration of staff wellbeing at elevated temperatures - provision of cooling solutions, specific cool down areas and hydration stations. Ongoing proactive review of uniform policy at temperature thresholds.
- Consideration of optimal temperatures for productivity of clinical workers and safety of inpatient population and a plan to deliver these temperatures year-round (summer and winter).
- Consideration of refined markers of impact of extreme heat/extreme weather upon health that can be tracked within Health Board systems.
- This report should be read in conjunction with the Effects of Heatwave questionnaire undertaken by Arjun Padmavathy circulated to all healthcare workers in CAV and a paper in preparation by Dr Tom Porter setting out a strategic climate adaptation response for the Health Board.

Governance Route *(please list all other Committee/Groups this report has been to)*

***Where** it's been:*	*No other forum as yet*
***When** it went:*	
***What** decision was made:*	*Nil at present*

Main Report

Background & Current Situation

Datix - Key Themes

1. Excessive temperatures across wards and clinical areas

Numerous inpatient wards reported temperatures between approximately 30°C and 36°C, despite mitigation measures such as fans, closed blinds, reduced lighting, increased hydration rounds and relaxed uniform policies. Staff and patients consistently reported significant discomfort, with concerns about dehydration, heat stress and inability to maintain a safe clinical environment.

Examples included:

- Teenage Cancer Unit, UHW: temperatures of 30°C at 23:30, remaining 28°C at 01:00 despite fans and cooling measures.
- Ward C5, UHW: prolonged extreme heat affected both patients and staff, with reports of staff feeling faint, headaches and low blood pressure in patients.

East 7, East 8 and West 2, UHL: wards escalated daily to Silver Command and the Medicine Clinical Board due to extreme temperatures and lack of air-conditioning.

- Maternity Unit, UHW: temperatures reached 36°C and remained above 35°C into the night.
- Critical Care A3S, UHW: temperatures ranged from 30.7°C to 33.4°C despite portable air-conditioning units.

2. Clinical activity cancellations and service disruption

Several services were unable to continue normal operations because temperatures exceeded safe operating limits. Reported impacts included:

- Cancellation of planned cardiac and thoracic surgery lists on 25 and 26 June due to conditions on Ward C5, resulting in treatment delays and increased lengths of stay.
- Closure of NVA3 in Radiology, causing cancellation of GA ERCP procedures.
- Orthodontic outpatient clinics cancelled because clinical temperatures exceeded 34°C.
- Two paediatric occupational therapy clinics cancelled because room temperatures reached approximately 32°C.
- Temporary loss of CT scanning capacity when both CT rooms exceeded operational temperature limits.
- Issues with condensation in theatres has also been highlighted which has been recognised widely and escalated Nationally.

3. Risks to staff wellbeing

Many incidents highlighted the effect of heat on staff health and working conditions.

Reported issues included:

- Staff experiencing headaches, excessive sweating, dizziness, feeling faint and difficulty carrying out duties.
- Staff working in offices exceeding 34°C at Butetown Medical Practice. Particular concerns were raised for staff who were pregnant, had epilepsy, or were experiencing menopause symptoms.
- Repeated concerns regarding the absence or insufficiency of air-conditioning and cooling resources.

4. Impact on patients

Patient impacts reported included:

- Discomfort, inability to sleep and increased agitation.
- Increased risk of dehydration requiring enhanced hydration measures.
- Delays to treatment due to cancelled operations and clinics.
- Concern about suitability of clinical environments for vulnerable groups, including children and critically ill patients.

One incident from the Cystic Fibrosis Centre, UHL described a patient remaining anxious and unsettled throughout a hot night despite multiple cooling interventions.

5. Infrastructure and equipment failures

The heatwave affected infrastructure, diagnostics and supplies.

Examples included:

- Elevated temperatures within the Blood Transfusion Laboratory, UHL, requiring reagents to be moved into refrigeration and temporary air-conditioning to be sourced. Harm was assessed as moderate.
- CT scanner downtime due to overheating of scan rooms.
- Disposal of enteral feed stock and concerns regarding nutritional supplement quality after office temperatures exceeded safe storage requirements. Financial losses reported totalled approximately £1,451.48.
- Portable air-conditioning units supplied to Radiology were reported as unsuitable because of excessive noise and infection-control concerns.

The incidents recorded in Datix indicate that the June 2026 heatwave created a widespread system pressure affecting multiple Clinical Boards, hospitals and community services. The recurring themes were:
- Sustained ward temperatures above acceptable levels.
- Insufficient cooling and air-conditioning capacity.
- Staff wellbeing concerns.
- Patient discomfort and safety risks.
- Cancellation of clinical activity.
- Impact on diagnostics, laboratories and equipment.
- Escalation to organisational command structures (including Silver Command and business continuity processes in some areas).

Deaths – Key Themes
A small number of the excess inpatient deaths examined have the effects of the heatwave implicated in Part 1a of the MCCD.
However a larger number of deaths (see below) have the effects of heat implicated in the cause of death, but not as a major contributor.

1. JN
- o Admitted with hyperthermia (44°C), low GCS and subsequently developed severe multi-organ failure.
- o Coroner referral states heat stroke as a cause of death and the reason for notification.

1. PS
- o Admitted with suspected heatstroke (>42°C temperature) and underlying sepsis.
- o Death was referred to the Coroner as being related to heatstroke, although pneumonia, COPD and multi-organ failure also featured in the clinical course.

1. JT
- o Long ICU admission for severe pancreatitis and multi-organ failure.
- o A planned ERCP was delayed when a procedure list was cancelled because of the heatwave and a room temperature of 40°C. The referral notes that the clinical impact of this delay is difficult to determine, given the severity of his underlying illness.

1. PT (Rapid Review)
- o Review raised concerns about the patient being in a very hot room with a large window and low fluid intake during a red weather warning, alongside significant comorbidities including CKD.
- o The review asks what impact the hot environment may have had and notes that improved ventilation or cooling might have been beneficial.

Assessment and Summary
The report suggests that the impact of the heatwave was not confined to isolated locations but represented a health-board-wide resilience and estate-management challenge with consequences for patient care, workforce wellbeing and operational continuity.
Notable incidents with the greatest operational impact were the cancellation of cardiac/thoracic surgery lists, closure of radiology procedure rooms, temporary CT scanner outage, blood bank temperature excursions, and prolonged overheating of multiple inpatient wards.

Whilst there was a notable mortality spike during the heatwave period, the preliminary review did not identify a clear direct link between the excess deaths and the heatwave overall. However, several individual cases were highlighted where heatstroke, extreme environmental temperatures, dehydration concerns, or heat-related service disruption may have contributed in part at least, to a patient's death.
Interestingly, excess deaths were not described in every period defined as a heatwave in the summer of 2026. This suggests that the population adjusted to the effects of heat over the course of the summer. There is also a reciprocal reduction seen in deaths in July which may suggest that deaths that would have happened at a later date were brought forward during the June heatwave. This is a view shared when triangulating informally with the Medical Examiner for Wales.

One may conclude that measuring deaths may not be the most useful means of measuring the impact of heatwaves upon health.
Perhaps hospital/general practice attendances are impacted in a heatwave and the case mix of attendees may be affected. Attendances may even reduce - however the patients who do attend during a heatwave may attend with higher acuity of illness and have an element of decompensation of frailty, or chronic disease related symptoms.

Appendices:

Nil appended – please refer to strategic climate adaptation plan (SLT, 15th October 2026)

Strategic Alignment – Shaping Our Future Wellbeing:

Putting People First	X	Providing Outstanding Quality	
Delivering in the Right Places	x	Acting for the Future	x

Impact Assessment
Risk: No
No risk assessments carried out at this point in relation to the themes within this paper
Safety: Yes
See content of paper in relation to safety of staff and patients in heatwave circumstances in future summers (and in other extreme weather circumstances)
Financial: No
Not applicable in the first instance – but there will be financial implications of future planning for extreme weather resilience
Workforce: Yes
Implications within this report for workplace and workforce safety
Legal: No
Reputational: Yes
CAV is a significant employer and has a responsibility for future health planning. Planning for extreme environmental conditions should be part of CAV preparedness work.
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: No
No EHIA undertaken – significant issues of health equity should be considered in population health planning for equitable care in extreme environmental stress
Decarbonisation: Yes
Extreme environmental events are inextricably linked to global warming and therefore actions to decarbonize health care will contribute to global efforts to decarbonise
Welsh Language: No

Report Title:	Specialist Weight Management Service Changes		Agenda Item No:		3.2
Meeting:	Quality Committee	Public	x	Meeting Date:	30/11/2026
		Private			
Lead Executive Title:	Executive Director of AHPs, Health Science and Community Development				
Report Author/s Title:	Director of Operations CD&T				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

The Committee is advised of the proposed temporary restriction of new specialist referrals to urgent and high-priority patients and the planned validation and clinical prioritisation of the existing waiting list. The specialist service is not closing, and appropriate dietetic-led weight-management support will remain available. Engagement has taken place with clinical, primary-care and stakeholder groups; communications and patient-support arrangements are being developed, with monitoring proposed for access, equality impacts, patient experience, concerns and complaints.

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

Board/Committee Response Required ***(please select only one)***					
Assurance		**Approval**		**Information/Noting**	x

Recommendations

The Committee is asked to:

1. **Note** the significant demand and capacity pressures affecting the Adult Specialist Weight Management Service;
2. **Note** the proposal to temporarily restrict specialist access to urgent and high-priority patients using revised clinical criteria;
3. **Note** the planned validation and clinical prioritisation of the existing waiting list;
4. **Note** that alternative dietetic-led weight-management support will continue to be available;
5. **Note** the engagement undertaken with clinical, primary-care and stakeholder groups and the feedback incorporated into implementation; and
6. **Note** the arrangements being developed regarding the work underway with Communications, Concerns and Patient Experience to support safe implementation and manage the impact on patients and the public.

Governance Route ***(please list all other Committee/Groups this report has been to)***	
Where *it's been:*	*Management Executive Meeting; Primary and Secondary Care Interface Meeting*
When *it went:*	*06/07/2026; 23/09/2026*
What *decision was made:*	*Approved; Approved*
Main Report *Background & Current Situation*	

1. Purpose

The purpose of this paper is to advise the Quality Committee of planned changes to the referral criteria for the Adult Specialist Weight Management Service (SWMS), the rationale for the change, and the arrangements being put in place to mitigate the potential impact on patients.

The proposed change will temporarily restrict new referrals into the specialist service to patients meeting revised urgent or high-priority clinical criteria. Routine referrals to the specialist service will be suspended during this period. The Specialist Weight Management Service itself is **not closing**, and alternative dietetic-led weight management support will continue to be available.

The Committee is asked to note the proposed change, the engagement undertaken ahead of implementation and the arrangements being developed with Communications, Concerns and Patient Experience to support patients, the public and referring clinicians.

2. Background and reasons for change

The Adult Specialist Weight Management Service was commissioned in 2015 to provide multidisciplinary specialist support for people with complex weight-management needs, with capacity for approximately 200 new patients each year.

Demand has increased substantially. This reflects increasing prevalence of obesity, increased clinical and public interest in NICE-approved obesity medication, including GLP-1/GIP therapies, and increased requirements for post-bariatric follow-up. Referral demand has increased approximately seven-fold while specialist capacity has remained broadly unchanged.

During 2025/26, the service received 966 referrals, compared with capacity for approximately 160–200 new specialist assessments per annum. More than 680 patients are currently being managed by the service, more than 1500 patients are waiting for an initial assessment and forecast waiting times for new patients now exceed 10 years.

Continuing to add routine referrals to an increasingly long waiting list is not considered clinically safe or sustainable. It limits the service's ability to provide timely intervention to patients with the greatest clinical need and creates a risk that patients with severe obesity-related disease or a time-critical requirement for weight loss wait alongside patients with substantially lower clinical risk. The service's formal risk assessment currently scores the position at 16, with the proposed controls intended to reduce this to 9.

The proposed change is intended to move towards clinical risk-based prioritisation of finite specialist capacity, improving access for those patients most at risk of significant morbidity or mortality.

3. Proposed change

Routine referrals to the Adult Specialist Weight Management Service have been temporarily suspended. New referrals will instead be clinically triaged against revised prioritisation criteria, with specialist access focused on urgent and high-priority patients.

Examples of priority groups include:

- patients requiring weight loss to support transplantation or other time-critical surgery;
- people with serious cardiovascular, respiratory or cancer-related conditions;
- people with severe obesity-related comorbidity or advanced disease; and
- high-risk post-bariatric patients requiring specialist nutritional assessment.

The change does not remove the wider weight-management offer. Patients who do not require specialist multidisciplinary intervention will continue to have access, where appropriate, to dietetic-led services providing nutritional, behavioural and lifestyle support. Shared decision-making and individual support will form part of this alternative pathway.

Existing patients on the waiting list

Alongside the change for new referrals, the service plans to validate and clinically review the existing specialist waiting list.

Patients will be contacted to establish their current needs and will be risk-stratified against the revised criteria. Those with the greatest clinical need will be prioritised for specialist assessment. Lower-risk patients will be offered a shared decision-making process through the dietetic-led weight-management pathway and consideration of alternative support.

Complex or clinically uncertain cases can be considered through the specialist multidisciplinary team to support consistent decision-making while allowing individual circumstances to be taken into account.

4. Engagement and consultation

The proposal was endorsed by Management Executive on 6th July 2026; and The Primary and Secondary Care Interface Meeting on 23rd September 2026.

Recognising the potential impact on patients and referrers, engagement has taken place in advance of implementation across clinical and operational stakeholders. Primary care and PCIC colleagues have reviewed the proposals and identified important practical considerations. These points have been accepted as principles to be reflected in the final pathway and communications.

The proposals, including the proposed approach to reviewing the existing waiting list, have also been discussed with Bro Taf Local Medical Committee. Following

consideration by the full LMC, feedback received on 11th November 2026 confirmed that it was content for the work to progress.

The service has engaged with secondary-care referrers, Llais, UHB Communications and the Concerns Team. A full Equality and Health Impact Assessment has also been completed.

5. Patient and public impact

The Health Board recognises that this is a significant change for some patients.

In particular, people who have waited for specialist assessment or anticipated access to GLP-1/GIP treatment may find that they do not meet the revised specialist criteria. This may understandably result in disappointment, increased enquiries and potential complaints.

Mitigating actions include:

- continued access to appropriate dietetic-led weight-management services;
- shared decision-making with patients about alternative support;
- multidisciplinary consideration of complex or exceptional cases;
- provision of information in Welsh and English and accessible formats;
- ongoing assessment of referral patterns and access across protected characteristics and groups experiencing health inequalities;
- monitoring patient feedback, concerns and complaints; and
- regular review of the revised prioritisation arrangements.

6. Communication and public enquiry management

The UHB Communications, Concerns and Patient Experience functions are supporting implementation planning because of the potential sensitivity of the change.

A communications and handling approach is being developed to provide clear and consistent information regardless of whether a patient contacts the specialist service, primary care or another part of the Health Board. Planning includes communications for primary and secondary care and arrangements for responding to wider public or media interest.

This work will seek to ensure that communications make clear that the specialist service has not closed, explain why clinical prioritisation is necessary, describe what will happen to patients who are already waiting and identify what alternative support remains available.

7. Monitoring and assurance

Following implementation, the service proposes to monitor:

- referral patterns and demand;
- waiting-list size and waiting times;
- access for urgent and higher-risk patients;
- uptake of specialist and alternative interventions;

- equality and health-inequality impacts;
- patient experience;
- concerns and complaints; and
- workforce and operational impacts.

The intended benefits are improved access for the highest-risk patients, more equitable allocation of specialist capacity, reduced waits and more appropriate utilisation of specialist obesity medication. Continued oversight is proposed through CD&T quality and safety governance.

Appendices:

Strategic Alignment – Shaping Our Future Wellbeing:

Putting People First		Providing Outstanding Quality	
Delivering in the Right Places		Acting for the Future	

Impact Assessment
Risk: Yes
Risk assessment and EHIA completed
Safety: Yes
Risk assessment and EHIA completed
Financial: No
No immediate concern. Financial impact upon the dietetics service will be monitored.
Workforce: No
No immediate concern. Impact on the dietetics service will be monitored.
Legal: No
Reputational: Yes
Restricting routine specialist referrals and reviewing the waiting list may be perceived as reduced access to care, leading to complaints, adverse media coverage and reduced public confidence. Mitigations, outlined in sections 4–7, include stakeholder engagement, clear communication of the clinical rationale and alternative support, and monitoring of patient feedback and complaints.
Socio Economic: Yes - *https://www.gov.wales/socio-economic-duty-guidance*
Referenced in the EHIA
Equality & Health: Yes
An Equality and Health Impact Assessment has been completed. The changes aim to prioritise specialist access according to clinical need, while recognising the potential to widen health inequalities. Mitigations include alternative dietetic-led support, accessible bilingual information and multidisciplinary review of complex cases. Access, patient experience and equality impacts will be monitored, as outlined in sections 4–7.
Decarbonisation: No
Welsh Language: No

Report Title:	Good Food and Movement Implementation Plan (2026-2028)		Agenda Item No:		4.1
Meeting:	Quality Committee	Public	X	Meeting Date:	30/11/2026
		Private			
Lead Executive Title:	Executive Director of Public Health				
Report Author/s Title:	Principal Public Health Practitioner Consultant in Public Health Medicine				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

1. Cardiff and Vale University Health Board through the Public Health Team plays a significant and crucial role in obesity prevention.
2. We are making great progress (outlined below) through the Good Food and Movement Framework and Implementation Plans.
3. Through strengthened shared leadership, ownership and through strategically aligned plans and programmes of work we are changing the influences that affect what we eat and how we move in Cardiff and the Vale of Glamorgan.

Board/Committee Response Required *(please select only one)*					
Assurance		**Approval**		**Information/Noting**	X

Recommendations

Quality Committee are asked to:

- NOTE the Good Food and Movement Implementation Plan (2026-2028)

Governance Route *(please list all other Committee/Groups this report has been to)*

***Where** it's been:*	*Senior Leadership Team*
***When** it went:*	*05/11/2026*
***What** decision was made:*	*Approved*

Main Report

Background

- In 2019, both Cardiff and the Vale of Glamorgan Public Service Boards committed to developing a combined strategic approach to healthy weight, bringing food and movement together. Over time this approach has evolved, and in 2023, following extensive stakeholder workshops to agree our system priorities, this concluded with the evolution into the current Good Food and Movement Framework (Appendix 1) which describes our

shared vision, approach, where we have agreed to prioritise our collective efforts, and how we work together to deliver change over the six-year period (2024-2030).

- Two-yearly Implementation Plans outline the actions we have agreed to take with our partners such as Cardiff Council, Vale of Glamorgan Council, Met Sport, and the third sector (C3SC and GVS). By working collaboratively, we will reduce levels of obesity in the population across Cardiff and the Vale of Glamorgan.
- Good Food and Movement uses a whole system approach. This is because obesity is a complex challenge. There is no one solution, no one quick fix or one single organisation that can solve the complex challenge of obesity alone. Good Food and Movement brings different parts of the system together, working collaboratively so that we all pull in the same direction towards our shared vision; *'Together we will create environments, settings and opportunities that enable good food and movement for everyone in Cardiff and the Vale of Glamorgan'*
- There is shared ownership of actions. The Public Health Team take a lead convening and co-ordinating role, they also lead some specific actions, however, many other partners are driving the work that is creating real and tangible change.
- Shared leadership and governance for Good Food and Movement is in place through the Cardiff and Vale of Glamorgan Implementation Group that is responsible for progressing the actions. In addition, and at a more senior strategic level, to ensure accountability, connection and mechanisms for unblocking challenges there is a dedicated Leadership and Enabling Change Group in Cardiff and leadership arrangements in place through the Vale of Glamorgan Council Senior Leadership Team.

Current Situation

- The first Good Food and Movement Implementation Plan (2024-2026) (Appendix 2) has recently concluded. Progress highlights from 2024-2026 include:
  - Strengthened opportunities to embed Good Food and Movement through the town planning system, including through improvements to the two Replacement Local Development Plans.
  - Advertising and Sponsorship Policies that restrict high fat, sugar, and salt (HFSS) adverts developed by Vale of Glamorgan Council and Cardiff Council.
  - Community food growing mapping completed in the Vale of Glamorgan improving visibility of growing spaces and community growing pilot site progressed as part of the development of wider Cardiff Council Community Growing Plan.
  - Good Food and Movement Schools Working Group established bringing together partners such as Healthy Schools, Play, Public Health, Dietetics, Community Focused Schools and Met Sport building shared understanding of stakeholder roles, links to schools, how whole school approaches to food and physical activity are currently being supported.
  - Food access and poverty-focused work through the Vale Food partnership, including feasibility research into cooperative food buying, improved access to support information, and behaviour-change pilots in local pantries.
  - Development of an Activity Finder for Cardiff, tested with a range of activity providers and connectors, creating a central resource hub that will connect people to physical activity opportunities.
  - Range of tools used to understand how the 'Good Food and Movement System' is changing including a maturity matrix against core components of a whole system approach and through a commissioned social network analysis.

The next Good Food and Movement Implementation Plan has been developed with our partners for 2026-2028 (Appendix 3). It describes what we will do over the next two years to build on the progress we have already made.

Appendices:

- Appendix 1 - Good Food and Movement Framework (2024-2030)
- Appendix 2 - Good Food and Movement Implementation Plan (2024-2026)
- Appendix 3 - Good Food and Movement Implementation Plan (2026-2028)

Strategic Alignment – Shaping Our Future Wellbeing:			
Putting People First	X	Providing Outstanding Quality	X
Delivering in the Right Places		Acting for the Future	X

Impact Assessment
Risk: No
Not applicable
Safety: No
Not applicable
Financial: No
Not applicable
Workforce: No
Not applicable
Legal: No
Not applicable
Reputational: No
Not applicable
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Not applicable
Equality & Health: Yes
Previous Equality Health Impact Assessment undertaken for Move More, Eat Well.
Decarbonisation: Yes
This work supports the decarbonisation agenda
Welsh Language: Yes
Key resources are bilingual

Report Title:	Childhood & Teenage Immunisations Strategic Plan		Agenda Item No:		4.2
Meeting:	Quality Committee	Public	x	Meeting Date:	30/11/2026
		Private			
Lead Executive Title:	Dr Claire Beynon, Executive Director of Public Health				
Report Author/s Title:	Emma Davies-McIntosh, Principal Public Health Practitioner Anna Howells, Consultant in Public Health				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

Improving childhood and teenage vaccination uptake has been identified for targeted intervention by Welsh Government. This joint Health Board strategic plan provides a collaborative and evidence-based approach to meeting these targets.

The Senior Leadership Team (SLT) approved this plan on 5 November 2026. Progress against the plan will be monitored through existing immunisation governance structures and integrated performance reporting. The Quality Committee are asked to note this plan.

Board/Committee Response Required ***(please select only one)***

To confirm the action Members are being asked to take considering the AAA Framework

Assurance		**Approval**		**Information/Noting**	X

Recommendations

Recommendations should be clear, actionable, and aligned to the AAA summary above.

The Quality Committee is requested to:

- **Note** the Childhood & Teenage Immunisations Strategic Plan and
- **Provide leadership** to promote vaccination through individual and professional spheres of influence.

Governance Route ***(please list all other Committee/Groups this report has been to)***

***Where** it's been:*	Immunisations Operational Board Strategic Immunisations Group (SIG) Strategic Leadership Team (SLT)
***When** it went:*	April 2026 May 2026 November 2026
***What** decision was made:*	Approved by the Strategic Leadership Team on 5 November 2026.

Main Report

Background & Current Situation

Vaccines are one of the **most successful public health interventions of all time**. Vaccination is the most important thing we can do to protect children against ill health, and it is a **cornerstone of giving every child the best start in life**.

Despite this, uptake across most childhood and teenage vaccination programmes in Cardiff and the Vale of Glamorgan fall below the Wales average and national targets. This increases the risk of vaccine-preventable disease outbreaks in the region, which pose a significant **health risk and resource cost**. Modelling by Public Health Wales has identified that in the event of a positive measles case we would be at high risk of sustained community transmission and resulting outbreak. **Inequalities in vaccination uptake also persist**, widening the gap in health outcomes between those living in the most deprived and least deprived areas.

This challenge has been recognised by the **targeted intervention expectations** set by Welsh Government for childhood and teenage vaccinations:

- Percentage of children up to date with scheduled vaccinations by age 5 to be in line with the all-Wales average *(current CAVUHB uptake 83.6%, All Wales 87.2%)*.
- HPV vaccine uptake rate for children by the age of 15 to be in line with all-Wales average *(current CAVUHB uptake 76.8%, All Wales 76.9%).*

Multiple teams and Clinical Boards are involved in the promotion and delivery of childhood and teenage vaccination programmes. Coordinated engagement and collaboration with numerous external partners is also required, including local authorities, education providers and the third sector.

A **joint Cardiff and Value University Health Board (CAVUHB) strategic plan** is needed to **align working, make best use of existing resources and drive increases in vaccination uptake** to meet targeted intervention requirements.

The plan **does not require additional funding** to implement. It aims to make best use of the funding that has been allocated for vaccination programmes across the Health Board.

About the strategic plan

The aim of the strategic plan is to protect children and young people by increasing vaccination uptake through equitable, safe, innovative, timely and person-centred delivery.

The strategic plan outlines four objectives drawn from the National Immunisations Framework for Wales:

- **Equity:** Promote vaccine equity among children and young people by reducing gaps in uptake between socioeconomic groups and ethnic minority groups.
- **Access:** Provide equitable access to vaccinations through better models of vaccine delivery, closer to the community, more flexible and acceptable.
- **Communications and Engagement:** Increase vaccine confidence and literacy by providing accurate and timely communications, and developing and supporting targeted community engagement with populations experiencing health inequalities.
- **Data and Digital:** Establish and operationalise integrated data and intelligence systems that allow effective sharing, analysis, and action on vaccination data, driving targeted interventions that improve vaccination uptake across priority populations.

One year delivery plans will support practical actions to deliver the above. Progress against the plan will be **monitored through existing immunisation governance structures** and **integrated performance reporting**.

The strategic plan was developed by the Public Health Team in collaboration with representatives from several teams across Clinical Boards. Feedback from external partners was also sought.
Appendices:
1. FINAL DRAFT - Childhood & Teenage Immunisations Strategic Action Plan
Strategic Alignment – Shaping Our Future Wellbeing:

Putting People First	x	Providing Outstanding Quality	x
Delivering in the Right Places	x	Acting for the Future	x

Impact Assessment
Risk: Yes
Risks have been outlined in the strategic plan. Identified risks to delivery include misalignment between national policy expectations and local delivery capacity, reliance on national digital and data systems and system-wide partnerships and vaccine hesitancy due to increasing misinformation.
Safety: Yes
Increasing childhood and teenage vaccination uptake is an important aspect of improving safety for our patients, staff and wider population. A better protected patient population helps reduce the risk of vaccine preventable disease outbreak and consequent impact on patients, staff and the wider population.
Financial: Yes
Childhood and teenage vaccination programmes are cost effective interventions. Health protection interventions which include immunisation average a return on investment (ROI) of around £34. The cost of measles vaccination and control ranges from £0.13-£0.74 per person, while the estimated cost of measles treatment ranges between £159-£356 per case.
Workforce: Yes
Failure to implement this joint strategic plan could result in duplication of efforts across the workforce which would lead to inefficient use of Health Board resources.
Legal: No
Reputational: Yes
Failure to implement this joint strategic plan and increase vaccination uptake increases the risk of disease outbreaks. The consequent risk of bed closures for infection control purposes causes reputational risk.
Socio Economic: Yes - *https://www.gov.wales/socio-economic-duty-guidance*
A focus on equity underpins the strategic action plan, to help address current inequalities in vaccination uptake seen between our most and least deprived areas.
Equality & Health: Yes
Equality and health has been considered throughout the development of this strategic plan, with a specific focus on addressing current inequalities in vaccination uptake seen between our most and least deprived areas.
Decarbonisation: Yes
Increasing childhood and teenage vaccination uptake helps prevent ill health in our population, reducing carbon emissions through avoiding healthcare use. A focus on accessibility of vaccinations and delivery closer to the community can potentially reduce car / other transport journeys.
Welsh Language: Yes
The strategic plan includes a focus on communications and engagement, including making a commitment to focus on the language preferences and requirements of our population.

Report Title:	Equity, Equality, Experience and Patient Safety Action Plan - Six-Month Update		Agenda Item No:		4.3
Meeting:	Quality Committee	Public	x	Meeting Date:	30.11.2026
		Private			
Lead Executive Title:	Executive Director of Public Health				
Report Author/s Title:	Consultant in Public Health				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select <u>one</u> category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

The accompanying Action Plan provides details on a number of actions that have been completed since the last update to Board, alongside updates on the remaining actions developed on this plan.

Actions reported as fully completed in this update relate to:

- Supporting Patients Whilst Waiting
- New model for inclusion health based on need
- Using 'Amplifying Prevention' to increase immunisation
- Work with Public Health Wales to consider the implications of implementing the Health Equity Action Framework for Primary Care
- Consider local implications of Prevention Based Health and Care Framework, in particular the ABCD+ Programme in relation to Cardiovascular risk management
- Development of a local strategy and framework for peer workers.

Two actions remain on hold with no currently identified ways to progress them:

- Scope a pilot of variation in Medical Examiner Referrals by postcode
- Examining EU waits by demographics

Other actions remain ongoing or planned and are outlined in the Action Plan.

Board/Committee Response Required ***(please select only one)***

Assurance	X	**Approval**		**Information/Noting**	

Recommendations

The Committee is requested to:

a) Note the progress made on completed and ongoing actions in the Action Plan.
b) Agree to receive further updates at Committee in six months.
c) Note the change of name of the Equity, Equality, Experience and Patient Safety Action Plan to the 'Equity Plan'.

Governance Route ***(please list all other Committee/Groups this report has been to)***

***Where** it's been:*	No others
***When** it went:*	N/A
***What** decision was made:*	N/A

Main Report

Background:

Health inequalities are systematic differences in health between different groups of people in society, that are avoidable and unfair ('health inequities').

Addressing inequity is part of our Health Board Strategy 'Working together, we will help improve lives so that by 2035 people are healthier and unfair differences in health outcomes are reduced' Home - Shaping our Future Wellbeing. As a provider of prevention, primary and community care, secondary and tertiary health services, the Health Board also has a duty to look for and address inequalities in the access to, experience and outcomes from our services. As such, inequity is also included on the Health Board's Board Assurance Framework (BAF), as '*there is a risk that insufficient investment in prevention, worsening socio-economic determinants, inequitable access and poor data limit the Health Board's ability to address inequalities, resulting in widened life expectancy gaps, higher morbidity in deprived populations and increased long-term demand on services'.*

In recognition of this, in 2023, a three-step process – the 3i Framework – was developed, to support staff within the Health Board to help tackle issues around equity, equality, experience and patient safety in Cardiff and Vale University Health Board. An accompanying Support Pack was also developed to assist them with applying the framework in practice.

The **aim** of this work is to support staff in the Health Board to deliver equitable and excellent preventative and clinical services/approaches.

The **objectives** are to**:**
• To reduce variation in health outcomes
• To reduce variation in access to services
• To reduce variation in quality of services
• To have a workforce that is representative of the population, who have an equitable experience of work, career development and personal growth at CAVUHB

The Health Board identified a number of initial actions that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. These 24 projects were described in the first action plan. The actions needed were identified as organisation wide: Planned Care, Equitable Employee Experience, Unscheduled Care, Maternity Care, Prevention, Analytics, Primary Care, Representation, Mental Health and Patient Safety. Since that time, regular updates on the actions in this plan have been brought to this Committee.

Update:

Since the last update presented to Committee in April 2026, there have been a number of actions that have been completed. These are outlined in the accompanying Action Plan, alongside updates on the remaining actions that were originally developed on this plan.

Since the last update, the Public Health Team have also begun work to develop a more embedded and streamlined Health Board-wide approach to developing and reporting work on equity. This approach will continue to be developed, in collaboration with other Health Board teams, over the coming year, with the aim of identifying new, and strengthening existing, co-ordinated actions on equity. As part of this work, it is also proposed that the Equity, Equality, Experience and Patient Safety Action Plan is renamed as the 'Equity Plan'.

Updates on the Action Plan and this wider work will continue to be brought to this Committee on a six-monthly basis. Reporting on this and wider work on equity is also regularly provided through the Health Board's Board Assurance Framework (BAF).

Appendices:

1) Equity, Equality, Experience and Patient Safey Action Plan (November 2026 Update)

Strategic Alignment – Shaping Our Future Wellbeing:

Putting People First	x	Providing Outstanding Quality	x
Delivering in the Right Places	x	Acting for the Future	x

Impact Assessment
Risk: Yes
Inaction on inequity poses a risk of widening health inequalities in Cardiff and the Vale of Glamorgan. This risk is included in the Health Board's Board Assurance Framework, with full details of the risk, alongside controls and actions in relation to it.
Safety: Yes
Patient safety actions within the action plan seek to reduce variation in patient safety and quality of reporting incidents.
Financial: No
Workforce: Yes
There are actions within this plan which relate to workforce, aiming to understand more about, and working to reduce, any inequities in relation to our workforce.
Legal: Yes
The Health Board has responsibilities under legislation, including through the Equality Act 2010, the Socio-economic Duty, and the Well-being of Future Generations (Wales) Act 2015, to consider and reduce unfair inequalities in health outcomes, access to services and experiences of care. This Action Plan supports work towards this.
Reputational: Yes
There is a reputational risk if the Health Board does not fulfil its legal duties, as well its aims and commitments to all our communities, as outlined in our Strategy Home - Shaping our Future Wellbeing. Work on this Action Plan supports a reduction of this risk.
Socio Economic: Yes - *https://www.gov.wales/socio-economic-duty-guidance*
See legal above.
Equality & Health: Yes
This Action Plan has been developed to support a reduction in health inequalities.
Decarbonisation: No
Welsh Language: Yes
This Action Plan has included actions in relation to the Welsh language.

Equity, Equality, Experience and Patient Safety

Action Plan (update November 2026)

The 3I Framework

Beynon, Scott, Whiles, Hughes, Jones, and Roberts, 2023

Identify:
Acknowledge and understand the differential experience, access to health services, health inequity and inequality for local people and our employees

Output – summary of equity and excellence priorities

Intelligence for action: Use community engagement and qualitative insights to understand lived experience and improve quantitative data collection on equity and use both sources to co-produce service improvements that deliver equity and excellence

Output – co-produced intervention based on data and evidence

Interventions tailored to need:
Integrate equity, equality experience and patient safety improvements into existing and new work programmes, staff development initiatives and policies

Output – interventions integrated into routine practice

Version 5.0 November 2024

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Introduction

People often think that tackling inequities is someone else's business, or think that it is too difficult or that they are doing all they can already.

In 2023 an Equity, Equality, Experience and Patient Safety Framework support pack was produced and released, to support individuals and teams to make a positive difference. The support pack was developed by our staff, for our staff to help tackle issues around equity, equality, experience and patient safety in Cardiff and Vale Health Board.

The aim: To deliver equitable and excellent preventative and clinical services/approaches.

The objectives:

- To reduce variation in health outcomes
- To reduce variation in access to services
- To reduce variation in quality of services
- To have a workforce that is representative of the population, who have an equitable experience of work, career development and personal growth at CAVUHB

Cardiff and Vale University Health Board take seriously our responsibility to our patients, staff, volunteers, and community with regard to equity, equality, experience and patient safety.



Our main responsibilities as a Health Board are two-fold:

- Firstly, we are here to help people live well - from having a healthy start in life through to maintaining health in later years.
- Secondly, we are here to provide excellent care and treatment for people who need healthcare services to keep well or recover to get well.

As a provider of prevention, primary and community care, secondary and tertiary health care services, we can look for and address inequalities in the access to, experience of and outcomes from our services.

Ensuring we collect the data we need to be able to find and address inequalities is fundamental and will be supported by our digital transformation over the coming years.

We can also be a listening organisation and take the time to understand what services our communities need and co-design those services with our communities so that they are fit for purpose and drive a reduction in health inequalities. We can look after and promote the health and wellbeing of our staff in the same way that we look after our patients.

A three-step process – **The 3I Framework** – was developed to help staff think through how their services could make a difference *(see Figure 1 to the right).*

The Health Board identified a number of projects that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. This list is not exclusive, but guides the organisation to deliver on strategically important work. If local teams wish to make service improvements this should be supported.

This action plan sets out these areas of focus for Cardiff and the Vale University Health Board, providing updates six months on from the previous update.

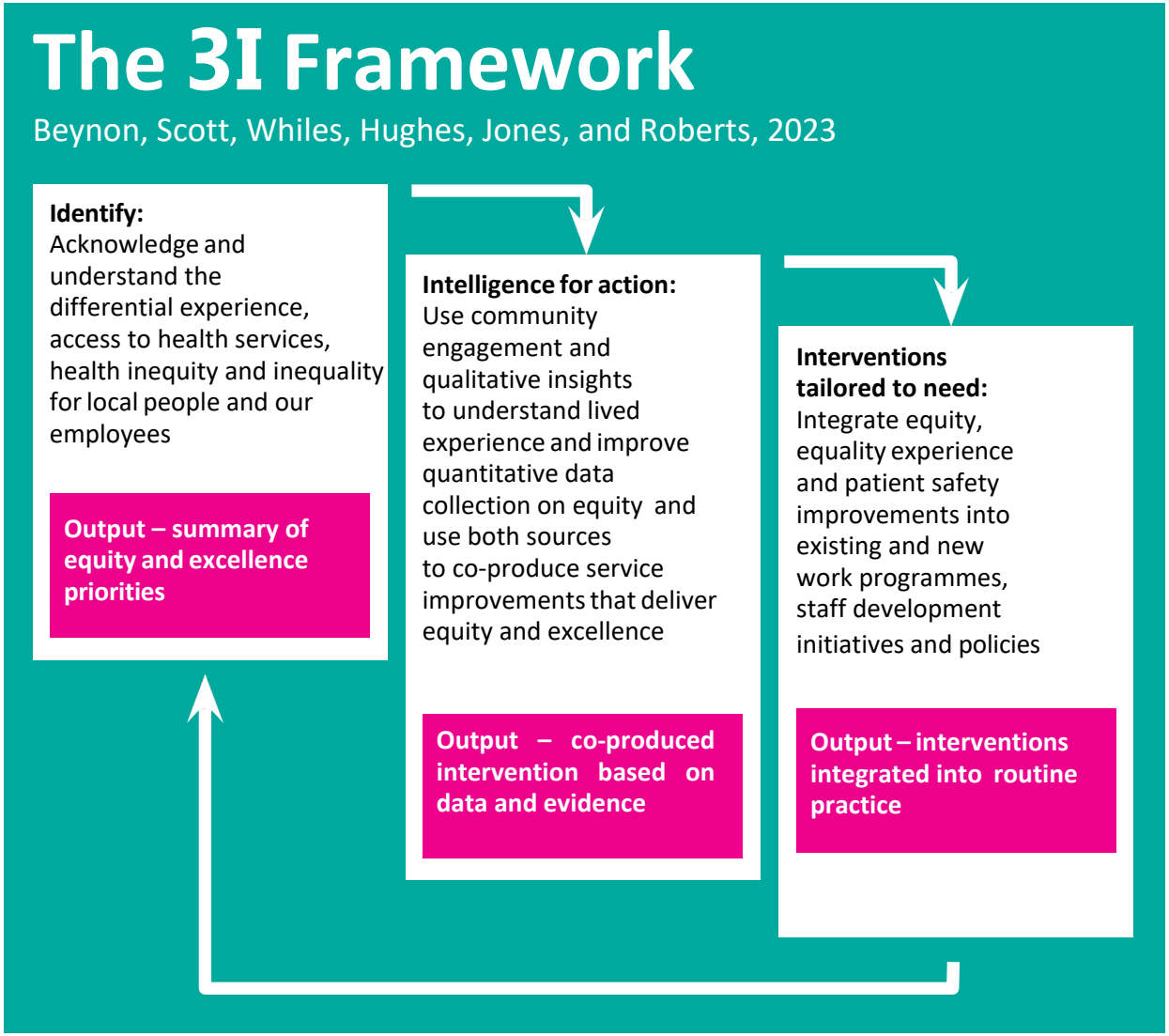

Figure 1: Three I Framework: a three-step tool to support teams in making positive changes to equity, equality, experience and patient safety in Cardiff and Vale University Health Board

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Planned Care	**Steven Thomson** *PROMS Programme Manager (Digital Health and Intelligence)*	Analysis of PROMs by protected characteristics	Work is being undertaken to link PROMs data to protected characteristics data as this is not routinely collected as part of PROMs. Data to be moved to the Cardiff and Vale Warehouse and checks are in place to establish the data being returned in Fast Healthcare Interoperability Resources (FHIR) (correct) format- currently xls. Work is ongoing with the National team and DHCW to ensure correct FHIR format. Once the format is correct the team are working to store the PROMS data in the Cardiff and Vale warehouse and FHIR repository. Digital exclusion: New system allows collection of PROMs from paper transcription or over the phone. PROMs can also be reported via iPads in waiting room or by friend or relative with digital access.	PROMs data stored within CAV FHIR repository March 2027. Model in warehouse to allow data to link with CAV systems June 2027.	
Planned Care	**Emma Cooke** *Deputy Director of Therapies and Health Sciences*	Supporting Patients Whilst Waiting work	Welsh Government 3Ps Policy explicitly requests that all Health Boards establish a single point of contact for patients waiting for treatment. CAV UHB's single point of contact service (named locally as the Waiting Well Support Service) is now fully operational and current work focuses on bringing together existing teams into one to increase the offer to more patients. The implementation of bringing the teams together commenced in October 2026.	March 2026	January 2025 (single point of contact team established)
Equitable Employee Experience	**Claire Whiles** *Assistant Director (Organisational Development, Wellbeing and Culture)*	Embedding and enaction of the Anti-Racist Action Plan (e.g. policy review)	The Health Board's approach has evolved from WRES to the broader Workforce Equality Standard (WES), providing a more intersectional approach to workforce equality while continuing to support delivery of the Anti-racist Wales Action Plan. Following the latest assessment, Leadership & Progression and Wellbeing & Safety have been identified as priority areas, having been assessed as 'severe'. The next phase will focus on embedding these priorities across the Health Board, with clearer organisational ownership and targeted action to improve progression, representation, wellbeing and safety.	Quarter 4 2026/27	

Action Plan

			The intended impact is a measurable reduction in inequalities in staff experience and workforce outcomes, including fairer progression and representation, reduced disparities in experiences of harm, and greater and more consistent confidence among staff to speak up. Progress will increasingly be assessed through changes in outcomes and narrowing gaps between staff groups, rather than activity alone.		
Equitable Employee Experience	**Claire Whiles** *Assistant Director (Organisational Development, Wellbeing and Culture)*	Establishing and growing Employee Resource Groups (Networks)	Work is underway to refresh and strengthen the Health Board's Staff Networks, with meetings taking place with Network Leads to help shape the future approach. This includes strengthening governance and accountability, protected time and resources for Network activity, and how Networks connect with and influence the wider organisation. A Staff Network relaunch event is being planned for January 2027, providing an opportunity to re-establish the Networks, raise their profile and strengthen engagement across the Health Board. The overall aim is to create sustainable and supported Networks that provide a strong employee voice, improve staff experience and contribute to wider organisational and inclusion priorities.	Quarter 4 2026/27	
Unscheduled Care	**Katja Empson** *Consultant (Emergency Unit)*	Examining EU waits by demographics e.g. ethnicity to support 6 goals of urgent and emergency care	Due to organisational constraints this is not possible at present. Nevertheless, e-triage has been implemented in the department and some data on ethnicity is now being collected. Unable to progress without further operational support.	On Hold	
Unscheduled Care	**Katja Empson** *Consultant (Emergency Unit)*	New model for inclusion health based on need	CAVHIS In-reach services are now established and providing support within the Emergency Unit Safeguarding Hub.		Completed

Action Plan

Maternity Care	**Judith Cutter** *Consultant Midwife (Maternity)*	Supporting people with obesity in pregnancy	Guideline has recently been updated to include a pathway for women who conceive whilst using GLP-1 medications which involves early support around diet and lifestyle in pregnancy. The healthy pregnancy service supporting women with a raised BMI in pregnancy to be evaluated and outcomes measured through the development of a dataset within the maternity informatics system. Maternity to be represented in the 'plus size pathway' workshop. The session will bring together representatives from across Cardiff and Vale UHB and supporting services to understand the current provision for plus-size patients, identify good practice, and capture gaps, risks and variation.	March 2026 Currently on hold (aim for 2027) December 2026	Ratified June 2026
Maternity Care	**Judith Cutter** *Consultant Midwiife (Maternity)*	Understanding the needs of ethnic minority people	Maternity Services has joined the Welsh Government's Diverse Cymru Cultural Competency Scheme to educate staff on cultural inclusivity and to use as a tool to assess and improve all areas of Maternity care for global majority families. Diverse Cymru has awarded maternity a 'Sliver accreditation'.  CAVUHB Cultural Competence Scheme We launched the Rapid Access service which enables women where English is not the first language to attend the obstetric assessment unit without needing a prior appointment or phone call. This will help reduce any language barriers and delays in access for maternity care. The women's wellbeing clinic also offers psychology support for women seeking sanctuary and survivors of harmful practices, a further development of this clinic is ongoing with support from WG VAWDASV funding. The psychology service is to be formally evaluated by WG.	2026 February 2026 Funding bid March 2027 March 2027	March 2026 Launched June 2026

Action Plan

Prevention	**Anna Howells** - *Consultant in Public Health Medicine (Public Health Team)*	Using 'Amplifying Prevention' to increase immunisation	Partnership working to increase immunisation has been embedded via the Amplifying Prevention Board which meets on a regular basis. Examples of work include collaboration to address digital challenges impacting the accuracy of school list data, and a focus on working with education colleagues and schools to address low uptake. This included a secondary schools MMR catch-up project to provide on-site catch-up clinics for staff and pupils, the learning from which is being applied to a school vaccination champions project. The Vaccine Equity Strategic Plan has been refreshed and drafted. This was informed by insights from community and third sector partners, particularly in areas of high deprivation and low vaccination uptake. Equity also underpins the Childhood + Teenage Immunisations Strategic Plan (approved by Senior Leadership Team (SLT) on 5 Nov 2026), taking an equitable approach to improving access, communications and engagement and the data and digital landscape which supports increasing vaccination uptake.		Completed
Prevention	**Suzanne Wood** *Consultant in Public Health Medicine (Public Health Team)*	Using 'Amplifying Prevention' to reduce obesity	Cardiff Leadership and Enabling Change Group is well established and strengthening connections at a senior strategic level. Vale of Glamorgan Council's Senior Leadership Team are undertaking the leadership and enabling change function for Good Food and Movement and feeding into Vale PSB.	Ongoing	
Analytics	**Tom Porter** *Consultant in Public Health Medicine (Public Health Team)* **Kerry Ashmore**	Development of a dashboard	The development of a health equity indicator dashboard remains on the Business Intelligence Team's development list, but it is among many completing priorities for development resource and has not itself been prioritised to progress yet. While PowerBI licences have been granted to the Public Health Team this has highlighted the wider barriers to completion of the dashboard. Indicators for the dashboard have been identified by the Public Health team, including indicators	Q4 26/27 (CAV PHM options paper)	

	Head of Business Intelligence (Digital and Health Intelligence) **David Thomas** *Director of Digital and Health Intelligence* **Dave Price** *Head of Architecture and Analytics*		for the domains of prevention, health behaviours, access to clinical services and health outcomes. Fewer than half of these indicators (6/13) have data available, due to current limitations in availability and processing of internal UHB-held data. The majority of indicators with data available are where data is collated by external organisations and is already publicly available. In order to progress the dashboard, we need to expedite the development of automated data flows and analytics capacity related to population health within the Public Health Team and UHB more widely. To this end, in conjunction with the Public Health Team Data Analyst, we are in the process of developing a Cardiff and Vale Public Health Digital and Health Intelligence strategy in conjunction with key internal and external stakeholders (started Q4 25/26). One of the major strands of the strategy will be to scope and develop solutions to automating data flows, in alignment with the UHB Digital strategy, and emerging national and local approach to Population Health Management, which will support development of live, interactive dashboards such as the equity dashboard. A critical dependency in the development of such approaches is unified national and local data architecture and flows, with the national specification and implementation of this currently being scoped. In the meantime, a paper setting out potential options in Cardiff and Vale is being developed by TP in Q4 26/27.		
Primary Care	**Huw Brunt** *Consultant in Public Health Medicine (Public Health Team)*	Action 1: Work with Public Health Wales to consider the implications of implementing the Health	Liaison with Public Health Wales through the Wales Primary Care Interest Group. Good understanding gained of how framework can be used to inform service developments which promote equity and reduce inequalities. Framework being used to inform primary care service developments through cluster-level meetings, planning and actions.	Q4 2025/26	Completed

Action Plan

		Equity Action Framework for Primary Care-	Health Equity Action Framework for Primary Care review meetings were due to take place between Public Health Wales and PCIC but cancelled by Public Health Wales; to be rescheduled.		
Primary Care	**Huw Brunt** *Consultant in Public Health Medicine (Public Health Team)*	Action 2: Consider local implications of Prevention Based Health and Care Framework, in particular the ABCD+ Programme in relation to Cardiovascular risk management	Cluster-level project 'Living well with long-term conditions in Cardiff and the Vale' commenced. A total of four clusters will be delivering the project. PCIC leading, supported by Public Health Team. Blood pressure monitor loan scheme now fully operational across Cardiff and the Vale of Glamorgan. Evaluation framework enhanced and rolled out. Updates given at cluster meetings and Wales Public Health Conference to raise awareness. GMS Quality Improvement projects ongoing focused on cardiovascular disease prevention.	Q4 2025/26	Completed
Primary Care	**Emma Holmes** *Head of Nutrition and Dietetics* **Catherine Washbrook-Davies** *Strategic Lead for Community Dietetics*	Consider diabetes prevention programme expansion	• Six of the nine primary care clusters have been actively involved in the All Wales Diabetes Prevention Programme (AWDPP). Funded either through the Welsh Government grant, Strategic Programme for Primary Care (SPPC) or cluster funding. The remaining clusters had not committed any funding, although there had been expressions of interest. • From 1st April 2026 the team has 2.45wte HCSWs in post, providing limited activity across the Health Board. • National AWDPP outcome data has been published indicating it is a successful model. • Funding from Welsh Government, due to end on 31st March 2027 • SPPC funding was secured until 31 March 2027. Funding past 1 April 2027 unknown. • A business case to support full AWDPP delivery across CAVUHB was submitted to Senior Leadership Team (SLT) and Value and Benefits Realisation Group (VBRG) in Dec 26, not taken forward. Proposal made to cluster leads with option appraisal, no agreement for cluster funding	Ongoing	

Action Plan

			from 1 April 2026. • Decision agreed to implement a primary care refer in model to enable all clusters to access the AWDPP service with the understanding that referral numbers and waiting list would be monitored and reported. • Direct referral process shared with clusters and to be added to Community Health pathways. • To utilise Business Intelligence System (BIS) to understand referral patterns across the clusters.		
Representation	**Claire Whiles** *Assistant Director (Organisational Development, Wellbeing and Culture)*	Understanding current workforce demographics (Workforce Race Equality Standard)	The transition from WRES to the Workforce Equality Standard (WES) provides the Health Board with a broader, intersectional understanding of workforce representation and progression. WES has identified Leadership and Progression as an area of severe inequity, with workforce diversity not yet translating consistently into equitable progression or senior leadership representation. Our focus is therefore on identifying and addressing barriers at key progression and appointment points, strengthening inclusive recruitment and progression approaches, and embedding accountability across the organisation. The intended outcome is a measurable narrowing of inequalities in progression and appointment outcomes and improved representation within leadership, with WES used to monitor progress and impact.	Q4 2026/27	
	Claire Whiles *Assistant Director (Organisational Development, Wellbeing and Culture)*	Proactive community outreach to promote UHB as an employer	The UHB continues to proactively promote employment opportunities and widen access to NHS careers through targeted community outreach and partnership working and the provision of apprenticeship opportunities. Activity has focused on supporting individuals who face barriers to employment, including people with disabilities, those experiencing homelessness, individuals living in areas of deprivation, minority ethnic communities and care-experienced young people.	Ongoing	

Action Plan

			1. The UHB remains committed to Project SEARCH, now in its sixth year, providing supported work placements for approximately nine individuals with learning disabilities and/or autism each year to help them progress into employment or further education. 2. Collaborative work with organisations such as Llamau and Huggard has continued to raise awareness of NHS career opportunities and provide employability support for individuals experiencing housing insecurity. 3. During the reporting period, 80+ ad hoc work experience placements were facilitated, alongside a Pharmacy Careers Taster Session attended by 15 participants. 4. In partnership with Youth Cymru, the UHB also delivered the Summer Jobs Programme, providing paid work placements for young people aged 16-20 who face significant barriers to employment. 5. As an Anchor Institution, the UHB continues to engage with schools, colleges and community organisations, promoting NHS careers, apprenticeships, volunteering opportunities and inclusive recruitment practices that support local communities and contribute to reducing inequalities. 6. Strengthened partnerships with Cardiff Commitment, Cantonian High School and Audiology services to develop innovative career engagement opportunities, providing students with meaningful insight into NHS careers through collaborative projects, workplace learning and targeted outreach activity. 7. Strengthened the Health Board's apprenticeship offer through close collaboration with the Digital Academy, developing new opportunities within digital services and supporting learners to access sustainable career pathways within the NHS.		
Mental Health	**Sam Barrett** *Director of Operations*	Development of a local strategy and framework	The Mental Health Clinical Board has co-produced and implemented a Peer Support Worker framework and induction toolkit, supported by dedicated peer leadership, supervision arrangements, referral pathways and monthly co-	2025	Completed

Action Plan

	(Mental Health Clinical Board)	for peer workers	reflection sessions, providing a sustainable model for integrating peer workers across services.		
Patient Safety	**Alexandra Scott** *Assistant Director of Quality and Safety (Patient Safety team)*	Understand variation in quality and patient safety reporting	The replacement of a Datix analytical tool nationally has halted the ability to scrutinise Datix, however a solution is now being progressed and the UHB is developing a tool for neighbouring health boards to inform their commissioning work. This will allow us to generate a list of postcodes which can then be made available for scrutiny.	June 2027	
		Scope a pilot of variation in Medical Examiner Referrals by postcode	Discussed with Medical Examiner but they are not able to progress. To consider potential to progress within the UHB once power BI analysis of Datix information is enabled. Until an alternative approach can be resourced, this action is on hold indefinitely. Given this, to be removed as an action from the plan.	On hold: to be removed from Action Plan.	

Action Plan

Actions Recorded as Completed at February 2026 Update

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Planned Care	**Adam Wright** ***Head of Service Planning (Operations)***	Examining waiting lists by postcode (Welsh Index of Multiple Deprivation – WIMD) to aid prioritisation	Overall, there is no evidence of inequalities of waiting, with the exception of 104+ week waiters. Here the most deprived decile represent more long waiters relative to the proportion in the population but with caveat of small sample size. Requested update on if this is a new result vs 2 previous times exercise performed and if it has influenced how the team are prioritizing waiting lists.		Complete
Analytics	**Tom Porter** *Consultant in Public Health Medicine (Public Health Team)* **Kerry Ashmore** *Head of Business Intelligence (Digital and Health Intelligence)* **David Thomas** *Director of Digital and Health Intelligence* **Dave Price** *Head of Architecture and Analytics*	Identification of potential indicators	Potential equity indicators have been identified and shared with the Business Intelligence team. A discussion was held with the BI team and due to service pressures this was the agreed course of action- they will give the Public Health Team access to PowerBI licenses to develop dashboards. Initial dashboard to be developed by Tom Porter.		15th Apr 2024
Primary Care	**Huw Brunt** *Consultant in Public Health Medicine (Public Health Team)* **And Rebecca Lewis** *(Principal Public Health Practitioner, Public Health Team)*	Scope how to identify unmet need e.g. cardiovascular risk	Two actions identified: Action 1: Work with Public Health Wales to consider the implications of implementing the Health Equity Action Framework for Primary Care Action 2: Consider local implications of Prevention Based Health and Care Framework, in particular the ABCD+ Programme in relation to Cardiovascular risk management		Complete

Action Plan

Actions Recorded as Completed at July 2025 Update

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Equitable Employee Experience	**Claire Whiles** *Assistant Director (Organisational Development, Wellbeing and Culture)*	Benchmarking and progress monitoring e.g. Employers Network for Equality and Inclusion (ENEI)	Financial challenges have made taking work forward with ENEI or other external organisations difficult; however, new KPIs included in the annual plan report around equity, inclusion, and the Welsh language will mean that the Health Board can monitor progress more effectively. This will ensure that we are on track and can address any issues promptly.		Quarter 4 2024/2025
Unscheduled care	**Katja Empson** *Consultant (Emergency Unit)*	Analysis of frequent users by postcode (WIMD)	The Business Intelligence Department hold a Frequent Attendees report that collates by post code, which can be refreshed, but it's not currently scrutinised. This information is available for us by the frequent attenders team who work to put in place management plans for the more complex and/or high frequency attenders.		10/04/24
Prevention	**Suzanne Wood** *Consultant in Public Health Medicine (Public Health Team)*	Using 'Amplifying Prevention' to increase immunisation and reduce obesity	• Progress report for the Good Food and Movement Implementation Plan shows that the majority of actions were in train during 2024/25. • Consultation on the Cardiff Replacement Local Development Plan was held. Cardiff and Vale UHB submitted a response to include the priorities and commitments of the Good Food and Movement Framework. • Research completed by the PHIRST INSIGHT Team enabling insight around unhealthy food advertising from young people, residents and stakeholders (key to system change) to be gathered. Unhealthy food advertising on University Hospital of Wales site bus stops restricted. In Vale of Glamorgan schools, 425 extra-curricular physical activity / sport sessions were facilitated during 2024/25, resulting in 7930 attendances/participations. The offer was based on consultation with young people.		April 2025 April 2025 March 2025 March 2025
Primary Care	**Huw Brunt** *Consultant in Public Health Medicine* **And Rebecca Lewis** *(Principal Public Health Practitioner)*	Scope how to identify unmet need e.g. cardiovascular risk	Additional data items are being regularly added to PHW's Primary Care Clusters Dashboard, which benefit clusters in identifying unmet need. A Place Based Planning pilot has been completed, led by regional planning and PCIC. Lessons learned are being considered and will inform future cluster planning.		Complete Complete

Action Plan

Representation	**Claire Whiles** *Assistant Director (Organisational Development, Wellbeing and Culture)*	Listening to understand barriers, challenges and views	The 2024 Staff Survey results have been received, and the Equity & Inclusion team has been given access to the raw data to better understand our workforce's experiences. With the improved dashboard functionality, the survey results can now be broken down by various characteristics, providing more detailed insights.	Complete	Quarter 4 2024/2025
Mental Health	**Dan Crossland** *Director of Operations (Mental Health Clinical Board)*	Training and self-certification commissioned from Diverse Cymru	There are 20 service areas in the Mental Health Clinical Board undertaking training and self-certification at various stages. As of December 2023, 2 Clinical Board level trainings were completed. We were aiming for submission of the remaining service areas to Diverse Cymru for review by Q1 of 2024-25. This is now complete. We had confirmation recently that the MHCB has won a Bronze Award with Distinction! We also had a silver award for Psychology and Psychological Therapies Directorate and a Bronze 'foundation' for our Headroom 1st Episode Psychosis service.	Complete	2024
Mental Health	**Dan Crossland** *Director of Operations (Mental Health Clinical Board)*	Work with Police and Crisis Care Concordat to improve and understand shared ethnicity recording.	We have requested a report to cover Welsh Language compliance (would they prefer to speak in Welsh), preferred language and Ethnicity report by team. Our data set does match the police one now in terms of detail.	Complete	2024
Patient Safety	**Alexandra Scott** *Assistant Director of Quality and Safety (Patient Safety team)*	Undertake a baseline assessment of National audit data set to identify measures of inequity.	The work around measures of inequity in national audit is complete, however it is limited to only a few indicators relating to long term conditions. While useful, these don't provide a systems wide approach beyond these conditions.		2025

Next Steps

Work to be undertaken to complete the actions outlined above

University Health Board to be updated of progress in six months time



Report Title:	Clinical Services Strategic Portfolio: Quarter 2 Update		Agenda Item No:		5.1
Meeting:	Quality Committee	Public	X	Meeting Date:	30.11.2026
		Private			
Lead Executive Title:	Executive Director of Allied Health Professionals, Health Scientists and Community Development and Chair of the Clinical Services Portfolio Board				
Report Author/s Title:	Deputy Director of Strategy, Planning and Partnerships				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT

ADVISE

ASSURE

The Clinical Services Portfolio is making good progress from strategy development and programme mobilisation into coordinated delivery. The Clinical Services Plan (CSP) has launched, Internal Audit has provided Substantial Assurance on its development, and the Portfolio Board assessed the Quarter 2 position as amber moving towards green. The Board has agreed a widened scope to ensure all clinical transformation programmes and plans are bought into scope alongside oversight of critical enablers and dependencies to ensure a clear line of sight to delivery. In addition, the Board has agreed an approach to service level planning to ensure one consistent approach for clinical services planning to ensure effective translation of the CSP into plans across the organisation.

Board/Committee Response Required *(please select only one)*

Assurance	**X**	**Approval**		**Information/Noting**	

Recommendations

The Quality Committee is asked to:

- **receive assurance** on the Quarter 2 portfolio position and note the progress in moving the Clinical Services Plan into implementation;
- **note** the principal risks relating to delivery capacity, service sustainability, enabling-plan alignment, partnership dependencies and benefits realisation;
- **note** the decisions taken by the Clinical Services Portfolio Board on 6 November 2026 and the actions now being progressed; and
- **support** continued quarterly assurance reporting focused on quality outcomes, service sustainability, equity and patient experience.

Governance Route *(please list all other Committee/Groups this report has been to)*

***Where** it's been:*	Clinical Services Portfolio Board
***When** it went:*	6 November 2026
***What** decision was made:*	The Board noted the Quarter 2 amber-to-green position and Substantial Assurance audit opinion; endorsed the lessons learned; agreed the scope of plans and transformation programmes to include Mental Health; supported a consistent approach to service-level planning approach; and supported clearer alignment of clinical service planning and oversight of key enablers to CSP delivery

	including; workforce, digital, estates, finance, research and innovation and organisational design plans and programmes.

Main Report
Background & Current Situation

Purpose and overall position

This report provides the quarterly assurance update from the Clinical Services Portfolio Board held on the 6 November 2026, drawing on the Quarter 2 portfolio assessment and the portfolio Board discussion. The overall position across the portfolio is amber moving towards green due to the good progress being made in launching the Clinical Services Plan and mobilising the principal programmes. The focus now shifts from strategy and governance into coordinated delivery, management of interdependencies, detailed service planning, decision making and demonstrable outcomes.

Clinical Services Plan

The CSP is the key strategic plan for delivery of our strategy and describes our future model of care and early priorities.

Internal Audit provided Substantial Assurance on the development of the CSP. The associated lessons-learned exercise has now been completed and will inform implementation, engagement and future planning across the portfolio.

As the portfolio progresses to delivery, priority areas are now clearly informing the development of the annual plan for 27/28 and a number of key actions are visible in our interim Integrated Improvement Plan for 26/27.

The remainder of this year will focus on further embedding the CSP principles and model of care within our developing planning processes, including service planning, cross cutting strategic plans, impact assessments, business cases, job descriptions and within the developing Performance Management Framework. This will bring our plan to life through planning, decision making, delivery and performance management.

Service Planning

The Portfolio agreed in principle a consistent approach across service planning that will span across traditional primary, secondary and tertiary services. Taking a commissioning led approach, it will begin with a refreshed baseline assessment of all commissioned services. The baseline will consider quality, workforce, demand and capacity, infrastructure, finance and strategic dependencies.

This process will support the effective decision making around service redesign for care closer to home, delivery of care across regional footprints (SEW) and specialised and tertiary services and is therefore critical for informing current and future transformation programmes and ensuring a more objective approach to assessing service sustainability and planning in partnership.

In addition, a number of cross cutting strategic plans will be reported in through the portfolio to ensure consistency, this includes the Babies, Children and Young Peoples Plan and the development of a life-course healthy-weight strategic plan which is proposed for inclusion in next years annual plan.

Clinical Transformation Programmes

- Community by Design and Urgent and Emergency Care programme governance has been combined to ensure dependencies can be clearly identified and managed with work focused on delivering single point of access for urgent and emergency care, integrated neighbourhood teams, the integrated care model and development of a strategic investment case for shifting care into the community.
- Mental Health Transformation has been reset from 12 workstreams into four coordinated areas and will now be a standing item within portfolio oversight.
- South East Wales (SEW) agreed programmes through the Joint Committee are progressing, including progress made in regional orthopaedics, ophthalmology and cellular pathology in addition to the Velindre complex oncology partnership.

Critical Enablers – designing our organisation to deliver

The Board supported closer alignment of workforce, digital and estates programmes and plans to enable delivery of the Clinical Services Plan. Key areas of work are:

- **Organisational redesign:** The newly appointed Programme Director will establish the programme and define its approach and timetable, ensuring that the organisational operating model supports delivery of the single integrated model of care. The strategic planning, commissioning and performance function will be a critical component of this work. The work to refresh the Performance Management Framework (PMF) will support oversight of plan delivery through the annual planning process.
- **Digital and technology-enabled care:** Developed in response to winter planning, a virtual smart care pilot will use home monitoring and support from acute physicians to care for people at home who would otherwise need hospital admission. It will align with Community by Design supporting a test of a new urgent model of care, delivering care closer to home.
- **Estates infrastructure:** Work is under way to align community and acute estates infrastructure planning with the service planning work directly informing planning with partners on community infrastructure and the redevelopment of UHW which is in early planning phase.
- **Data and analytics:** Developing approaches to demand and capacity modelling and work with SAIL to support the development of a population health management system will be critical to informing service plans and programmes.

Communication, engagement and co production

Over the next quarter work will further strengthen our communications taking opportunities to showcase the work underway and the ongoing planning with our staff, communities and partners. Dedicated engagement sessions will continue to run face to face and online.

Working closely with the Chair of the new Healthcare Professionals forum will be critical to ensuring the CSP is brought to life.

Progress will also be monitored via the UHB Shaping Our Future Wellbeing Collaborative, which provides a forum for community and partner voices to inform service change and strategy delivery. Following a vote by members, Norma Mackie is proposed as Chair in her capacity as a community representative, subject to Board endorsement and subsequent Cabinet Minister approval.

Key risks the portfolio is monitoring

- Capacity remains the principal cross-portfolio risk for successful delivery. Planning, clinical, analytical, finance and programme resources are limited relative to the scale of transformation required.
- Specialised and tertiary services require a stronger evidence base on quality, clinical outcomes, critical mass, workforce, finance, demand, infrastructure and commissioning specifications to ensure appropriate future planning.
- Regional orthopaedics remains dependent on confirmation of Welsh Government revenue funding for the Llantrisant Health Park and associated hip and knee arthroplasty model for SEW.
- Wider clinical engagement needs strengthening to ensure teams understand how local delivery contributes to the Clinical Services Plan
- Reporting needs to demonstrate benefits and outcomes, not simply programme activity, with clearer measures of quality, access, experience, equity, productivity and sustainability. Performance management and analytics would support this.

Next quarter

Priorities are;

- to test and begin implementing the commissioning-led service-planning approach and refresh the baseline assessment of services;
- ensure the enabling programmes are aligned and supporting developing plans and programmes,
- ensure the maturing planning processes clearly support alignment with the CSP model of care and principles,
- ensure the Performance Management Framework strengthens delivery oversight.
- Focus on enhancing communications and engagement with staff, communities and partners through face-to-face and online sessions and work with the Healthcare Professionals Forum.
- The Portfolio Board will also support alignment with the emerging National Clinical Services Plan as this develops.

Strategic Alignment – Shaping Our Future Wellbeing:			
Putting People First	X	Providing Outstanding Quality	X
Delivering in the Right Places	X	Acting for the Future	X

Impact Assessment
Risk: Yes
Key portfolio risks are described in the main report, including delivery capacity, fragmented dependencies, specialist-service sustainability evidence and regional funding dependencies. These are managed through programme and portfolio governance.
Safety: Yes
Service sustainability, safe pathways, workforce fragility and clinical outcomes are central to the portfolio approach. Future service plans will incorporate quality impact assessment evidence and identify mitigation where change is required.
Financial: Yes
Major transformation and specialised-service programmes have financial implications and some require investment. No approval of expenditure is sought through this paper.
Workforce: Yes

Clinical leadership, planning, finance, analytical and programme capacity are material delivery constraints. Workforce requirements will be incorporated into specialty-level service plans and enabling-plan alignment as well as in specific redesign programmes
Legal: No
Future material service-change proposals will follow required consultation, legal and decision-making processes.
Reputational: Yes
There is reputational risk if the Clinical Services Plan does not translate into visible delivery or engagement is insufficient. Stronger communications, engagement and outcome reporting are planned mitigations.
Socio Economic: Yes
Future service planning will assess access, population need and inequalities, including how the location and model of care affect people experiencing socio-economic disadvantage.
Equality & Health: Yes
Decarbonisation: Yes
Future service models will consider prevention, care closer to home, digital delivery, estate utilisation, travel and resource use. Detailed impacts will be assessed through individual service plans and programmes.
Welsh Language: Yes
Future communications will meet Welsh Language Standards. Detailed impacts will be addressed through service-level planning and programmes.

Report Title:	Cardiac Implant Update		Agenda Item No:		5.2
Meeting:	Quality Committee	Public	X		30.11.2026
		Private			
Lead Executive Title:	Chief Operating Officer				
Report Author/s Title:	Clinical Board Director, Specialist Services				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

Evidence presented within this report demonstrates that the Cardiac Device Service has moved from a reactive response to identified patient safety concerns towards a structured improvement and governance framework. Improvement plans, revised operating procedures, strengthened leadership arrangements, enhanced clinical oversight, implementation of Fysicon and Scan4Safety, and dedicated recovery actions for remote monitoring are in place and operating as intended. These controls have resulted in measurable improvements in stock management, patient pathway oversight, workforce stability, and a significant reduction in the remote monitoring backlog, providing assurance that risks are being actively managed and mitigated.

Board/Committee Response Required ***(please select only one)***					
Assurance	X	**Approval**		**Information/Noting**	

Recommendations

a) Take assurance that the recovery and improvement programme is progressing as intended and delivering demonstrable improvements in governance, patient safety and operational performance.
b) Note that controls established in response to previous incidents are embedded within routine operational practice and are subject to ongoing monitoring and oversight.
c) Support continued delivery of the remaining improvement actions, including workforce stabilisation, digital optimisation and completion of demand and capacity reviews to sustain long-term service resilience.

Governance Route ***(please list all other Committee/Groups this report has been to)***

***Where** it's been:*	*Specialist Services Clinical Board Executive Review*
***When** it went:*	*Various during 25/26*
***What** decision was made:*	*Formal presentation to Quality Committee*

Main Report
Background & Current Situation

This paper provides an updated position on the Cardiac Device Service and outlines the progress made since the previous report. The service continues to focus on recovery, sustainability, and improvement of patient pathways whilst addressing longstanding workforce and operational challenges.

Significant progress has been achieved in reducing the home monitoring backlog through the additional support of two locum staff members. This intervention has enabled a sustained reduction in outstanding work and improved the timeliness of patient monitoring and follow-up activity.

Leadership capacity within the service has also been strengthened with the appointment of a new Head of Service, who has now commenced in post. A key priority for the new Head of Service is the stabilisation of the workforce through improved recruitment, retention, workforce planning, and the establishment of a sustainable operating model. This work will support service resilience, enhance governance arrangements, and provide a stronger platform for future service development and performance improvement.

While challenges remain, the service is demonstrating positive momentum, with improvements in operational performance, strengthened leadership, and a clear focus on delivering a sustainable and high-quality cardiac device service.

Since August 2023, the Specialist Services Clinical Board has been made aware of multiple concerns within the Device Service.

- On 23rd August 2023, concerns were raised that eight "out of date" devices had been implanted in patients between July 2024 and October 2024. This was reported to Welsh Government as an NRI in October 2024. All patients were seen in clinic, informed under Duty of Candour and assured they were at minimal, if any risk of harm. This conversation was reiterated in a letter given to them that also reinforced previous discharge advice and guidance. Immediate actions included all out-of-date devices being removed from the store. A robust Stock Management SOP has also subsequently been devised and embedded in practice.

- A cluster of five incidents were reported between March and April 2025 of patients on the "routine" waiting list for elective pacemaker box change who presented to the Emergency Unit or to Device Clinic having reached end of elective replacement indicator (ERI), when the battery has or is nearing depletion. The root cause was found to be appointment scheduling by administration rather than clinical staff, not appropriate for the ERI capacity.

  Key action in response to this was establishing a weekly operational meeting and validation work of all patients with the potential to have had deferred appointments outside of acceptable lead time parameters and risk of falling into this category.

  Through these further concerns became apparent:

- Demand / capacity constraints and failures in systems and processes to include an effective tracking system.

- Whilst the validation work was ongoing a patient presented to hospital as an unrelated emergency admission. A routine device check prior to theatre indicated that she also fell into the high-risk category of ERI patients but had not been picked up as part of the validation work. It was not initially clear why but on further investigation it became evident that patients who did not attend (DNA'd) their appointments had been

automatically removed from the follow up list by the PMS system. Given the status of some of the patients within the device service, such as those who might be pacing dependent, this was raised as a further serious clinical risk.

- Home monitoring had been considered a partial safety net since standard in 2023. Through the operational meetings, concerns were raised by the Cardiac Physiology team in May 2025, however, that there was a backlog in reviewing Home Monitoring. The backlog related to transmissions and delays in reviewing and acting on red flags raised via the Home Monitoring system, also resulting in clinical risk. This was subsequently reinforced by several Datix to include an incident where one of the failings was a missed alert 21 weeks earlier and is currently being investigated as an NRI. An urgent recovery plan to address and eliminate this backlog was initiated.

- As part of the above work to address the Home Monitoring concern it became apparent that there was a disconnection issue with a cohort of patients being home monitored (1320 out of 5029). This also needed to be addressed.

- In January 2026 a further incident highlighted that not all devices implanted in patients were programmed correctly and activated to alert. This affected over 800 patients.

- In February 2026, a coroner's inquest was held into the death of a patient who died in April 2024 from the effects of untreated endocarditis, likely caused by a longstanding soft tissue infection at the site of a pacemaker implanted in May 2023. Despite the patient attending the Cardiac Physiology department on a number of occasions prior to his death and indication of defect, the patient was not escalated to a consultant for review which would probably have led to earlier diagnosis of the endocarditis. A Regulation 28 Prevention of Future Deaths notice was issued by the coroner in relation to concerns within the service including:
  1. Lack of guidance on when pacemaker data should trigger cardiology review
  2. Limited physiologist knowledge of infective endocarditis
  3. Inconsistent gathering of clinical information and implant site checks during clinic visits
  4. How clinical findings were documented and communicated

Expired Devices
PSLR now closed with a robust Improvement Plan in place to include an SOP for Stock management with a clear process from stock selection in the storeroom to final checks during the implant procedure.

ERIs
Weekly operational meetings and validation work of all patients with the potential to have had deferred appointments outside of acceptable lead time parameters were initiated with immediate effect.

An SOP for Device Clinic appointment scheduling was devised. This is based on the *British Heart Rhythm Society* guidelines and emphasizes that the responsibility is on clinical not administrative personnel to schedule appointments.

DNAs
Several years ago, an automatic removal algorithm was developed in collaboration with all Directorates in the UHB to help appropriately manage patients within the follow up cycle who repeatedly DNA'd their appointments in line with Welsh Government RTT guidance. It was identified that several clinics within the device service fell into this process. However, these clinics should not have been included in the algorithm due to the nature of the patients' health needs. As soon as this was identified, these unsafe auto removal practices were ceased and any patients who DNA appointments are written to (with a copy to their GP). No patient is removed from the follow up system unless they have been reviewed by a consultant and it is safe to do

so. In order to reduce the number of DNA's, text reminders are now embedded in the service, and this has resulted in a measurable reduction in DNA's. Validation of the 2024 and 2025 patients is predominantly complete. 90 patients identified as requiring either a telephone call to discuss whether follow up has been relocated or a face-to-face clinic appointment to be sent. These clinics have begun and will continue to run during November and December (supported with the Locums).

Patient Listing and Waiting Times:
Demand and capacity modelling for the device implant service (new implants and box changes) has been completed, with agreed standardisation of booking rules for each consultant

Systems and processes for adding patients to the waiting list for new implants and box changes have also been reviewed. To further strengthen the process, an electronic waiting list card is planned for implementation to improve transparency, consistency, and real-time oversight of patients awaiting device implantation. The electronic waiting list card has not yet been introduced and remains in the planning phase. Prior to implementation, the service lead, Mr Jason O'Neill, will discuss the proposed approach with the Consultant group. Subject to agreement, the electronic waiting list card is expected to go live in early December.

Post Implant Follow-Up:
It was necessary to review all device patients' scheduling to ensure they had appropriately timed follow-up appointments. Priority was given to the highest-risk patients based on device dependency and time since implant. In addition, a demand and capacity assessment of the outpatient device follow-up service will commence w/c 23/11 to establish current service requirements, identify capacity gaps, and inform future service planning and sustainable management of follow-up activity.

Throughout the review of the incidents which have occurred in the service, a key theme has been the risk associated with the use of paper records and spreadsheets to track patients. The lack of a structured digital system is open to error and a key safety risk

Fysicon has now been successfully embedded for all new patients entering the Cardiac Device Service pathway. During implementation, a number of issues were identified relating to the migration and entry of follow-up patients into the system. These issues have been escalated and are the subject of ongoing discussions with Fysicon. A site visit is scheduled for early December to review the outstanding challenges, agree solutions, and support full optimisation of the system across all patient pathways

Remote Monitoring:
The capability to undertake remote monitoring of devices has been in place within physiology for 25 years. More recently, in 2023 the service was funded to provide remote monitoring to patients with high voltage systems (ICD and CRT-D). There has also been a change in BHRS guidelines promoting remote monitoring for all patients including remote only follow up for certain devices. This has resulted in:

- A significant increase in patient volume,
- Increased transmission burden,
- A higher number of alerts (both those that require action to be taken and those which do not), which has increased the need for triage, prioritisation, and filtering to identify clinically significant events,
- An increase in findings from remote monitoring which require clinical decision-making, including medication changes, urgent reviews, or escalation to other services,
- Increases in administrative workload, and
- Data management and governance.

The cumulative effect has placed strain on staffing levels, requiring reconsideration of workforce models, skill mix, and clinic structures.

To address the home monitoring concerns an urgent review of all outstanding downloads was initiated, with a signed off and escalation process implemented. Daily review was also implemented with a longer-term goal of a physiologist being dedicated to this work stream. Patients subject to incorrect disconnection and programming were reviewed and contacted with appropriate action taken as a separate work stream.

Whilst disconnected patients and alert configuration gaps have been systematically identified and actioned, with dedicated clinical resource now in place to manage alerts and disconnections and refresher training having been delivered, significant progress has been made in addressing the remote monitoring backlog. The backlog has reduced from 1,360 outstanding transmissions to 552, with the oldest outstanding reviews now dating from September 2026. This improvement has been supported through the deployment of two full-time locum Cardiac Physiologists dedicated to the service. Whilst this represents a substantial reduction in clinical risk, a backlog remains and ongoing workforce capacity will be required to ensure timely review of remote monitoring transmissions and maintain a sustainable service. To provide resilience and align staffing levels with comparable centres, the workforce review will continue to consider the requirement for additional Band 7 Cardiac Physiologist resource to support the home monitoring service and the increasing demand associated with remote monitoring activity.

Stock Control:
The device service holds a significant volume of high-cost stock. From the initial incident in August 2024, it was identified that there was no standard operating process (SOP) in place for the management of stock in order to prevent devices from going out of date and a lack of adequate checking processes of expiry dates of devices prior to implantation. An SOP has now been developed and issued to all staff with a clear expectation of compliance with the SOP.

In addition, Scan4Safety (a digital stock control system) has been adopted within the service, with the aim of improving traceability of devices and reducing error risk.

Administrative Support:
To support the service, the physiologists are supported by an administrative team of 1 x band 4 team lead, 3 x band 3 clinic coordinators and 2 x band 2 receptionists.

The administrative functions are a combination of paper and computer based. The referrals for most services are received on paper; the electronic referrals are received digitally but subsequently need to be printed for access in clinic. As noted above, existing patients within the device service are managed via spreadsheets that are updated by the Clinical Lead or physiologist in clinic to guide booking appointments.

Historically, turnover within the team has been high and recruitment has presented ongoing challenges. However, significant progress has been made through a successful recruitment programme, with substantive appointments made into previously vacant posts, helping to stabilise the workforce establishment. The team is now better positioned to deliver a sustainable service, with a reduced reliance on temporary bank staffing. These improvements have been supported by revised line management arrangements, enhanced training and development opportunities, and a proactive approach to workforce planning and recruitment, strengthening both resilience and continuity within the service.

Summary
Overall, in the last 18 months, the service has moved from reactive risk management to a more structured, proactive operating model. In addition to the locum investment, the new Professional Lead is in post. We have also recruited one WTE Band 7 (EP) and a second candidate has been identified.

Next Steps

- Continue optimisation of Fysicon and digital patient tracking processes.
- Implement the electronic waiting list card to strengthen oversight and governance.
- Complete the device follow-up demand and capacity review and develop a sustainable service model.
- Eliminate the remaining remote monitoring backlog and establish sustainable workforce arrangements.
- Develop a comprehensive performance, quality and safety dashboard.
- Progress workforce and leadership review to support long-term service sustainability.
- Continue transition from paper-based processes to fully digital workflows
- Maintain oversight through regular reporting to the Clinical Board and Quality Committee

Appendices:

- 5.2b - Stock Management SOP Updated (002)
- 5.2c - ID 73028 Cardiac Devices Improvement Plan (002)

Strategic Alignment – Shaping Our Future Wellbeing:

Putting People First		Providing Outstanding Quality		**X**
Delivering in the Right Places		Acting for the Future		

Impact Assessment
Risk: Please select
Safety: Please select
Financial: Please select
Workforce: Please select
Legal: Please select
Reputational: Please select
Socio Economic: Please select - *https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: Please select
Decarbonisation: Please select
Welsh Language: Please select

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Standard operating procedure for management of device stock

Policy	Procedure	Protocol	Guideline
N	Y	N	N

Classification of document:
Area for Circulation: All areas that devices are implanted
Reference number:
Version Number: 1
Original/previous Ref number:
Author Name and Job Title: Mike Henson, Service Manager
Responsible Officer: Name and Job Title: Sarah James Lead Physiologist for the Cardiac Device Service

Date issued:
Review details:

Version Number	Date of Review	Reviewer Name	Completed Action	Approved By	Date Approved	New Review Date
1						

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Disclaimer

When using this document please ensure that the version you are using is the most up to date either by checking on the Trust database for any new versions or if the review date has passed please contact the author.

Introduction

The purpose of this procedure document is to provide guidance for all Cardiac Physiology staff on the safe and effective management of cardiac implantable device stock within the store room and implantation areas.

The Lead Physiologist for the Cardiac Device Service and the identified Physiologist stock team are responsible for the management of all device stock held in cardiac physiology. The Lead Physiologist for the Cardiac Device Service (LPCDS) will be responsible for ensuring compliance; this includes appropriately administered documentation and accurately accounting for the stock.
All Cardiac Physiologists will be responsible for device selection on a daily basis, when supporting device implants.
Regular audits will be undertaken both physically and electronically by the management team ensuring any actions necessary are undertaken in a timely and efficient manner.

A standard approach to the management of stock will be followed to ensure compliance with Standing Financial Instructions and Audit Regulations

	Action	**Rationale**
(a)	A stock register will be populated with the details of all purchased stock and will contain the following information. • Supplier • Product Description • Product Code • Date of expiry This will be maintained and updated as any changes occur by the LPCDS. Implementation of Scan4 Safety will support this.	• A full and accurate inventory will always be available. • A consistent approach to data presentation. • Compliance with Audit Regulations and SFI • Expiry dates can be viewed electronically
(b)	The LPCDS will discuss any proposed amendments to stock and bulk orders with the Service Manager before any changes are implemented.	• To ensure all changes are properly documented and signed off. • To ensure the stock register is updated appropriately and changes documented. • Visible audit trail.

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(c)	No new stock from unapproved companies will be accepted into the department without the appropriate approval by the Head of Procurement and/or Directorate Manager.	• To ensure compliance with bulk order agreements • Maintain control of stock held
(d)	Stock levels will be agreed in line with the tender process. Procurement to actively support and provide usage levels etc. Any variances or changes in circumstances following the tender process will need to be approved.	• Ensure no over ordering resulting in purchased stock going out of date.
(e)	A limited selection of Consignment stock will be held for complex procedures and historic device connectors. Each company will be required to sign a consignment agreement. This will include the company undertaking regular stock checks to include appropriate stock levels and expiry dates. The company will be responsible for all levels of stock control including • Expiry Date • Stock Levels • Stock rotation • Removal of out-of-date stock replacing with new • Replenishment of used consignment stock Full inventory to be recorded and held in Cardiac Physiology.	• This will ensure consignment stock is efficiently managed and expiry dates monitored. Any expired devices / leads should be removed immediately by industry. • Expired stock should not be used under any circumstance.
(f)	Expiry date checks will be undertaken routinely and by way of physical bi-monthly audits and recorded appropriately. Electronic data checks will be undertaken bi-monthly and will run alternatively with the physical checks. Scan4 safety will be embedded in the service to support stock management and provide highlight reports.	• Any discrepancy can be identified, investigated and rectified in a timely manner. • Capture expiring items to ensure exchanges are facilitated appropriately • Expired stock should be promptly identified and immediately removed for circulation. • Expired stock must not be implanted under any circumstance.

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(g)	When selecting devices and leads for implantation, staff must check the device types, device connectors, lead type and expiry dates. Expired stock must not be used under any circumstance. Any expired stock must be immediately removed from the store cupboard and given to the LPCDS for escalation. All Physiologists will be responsible for this on checking stock prior to implantation.	• Capture expiring items • Ensuring expired items are not implanted
(h)	Cardiac physiologists will be responsible for selecting stock in correct order based on expiry date. If stock is identified with a shelf life of < 6 weeks, this needs to be escalated to the LPCDS and action taken to ensure it's either used before the expiry date, exchanged where possible or removed from circulation.	• Minimise the risk of expired stock through usage in date order. Reducing the risk of expired stock being implanted. • Capture and escalate expired stock
(i)	During tender processes for bulk purchase specific instruction regarding the replacement/ exchange of devices with 6 months longevity will be included at no financial detriment to the organisation.	• Minimise the chance of expired stock in circulation • Reduce wastage / financial deficit

The flow diagram below outlines the process from the store room to final checks during the implant procedure.

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Flow Chart: Device System Selection Process

1. **Clinician Identification**
    - The clinician identifies the required device in advance of the planned procedure.
2. **Device Retrieval**
    - On the day of the procedure, the physiologist retrieves the appropriate device and associated leads from the designated storeroom.
3. **Device Selection**
    - The physiologist selects the required device and compatible leads in accordance with the clinical requirements of the procedure.
4. **Initial Verification**
    - Prior to leaving the storeroom, the physiologist undertakes an initial verification of the device and leads, confirming:
        - Connector compatibility
        - Correct device type
        - Appropriate lead type
        - Valid expiry dates
5. **Transfer to Procedural Area**
    - The physiologist transfers the device and leads to the designated procedural environment:
        - Pacing Theatre **or**
        - Cardiac Catheter Laboratory **or**
          (as determined by the planned procedure)
        - Ward / outpatient area
6. **WHO Checklist Initiation**
    - The lead clinician initiates the WHO Surgical Safety Checklist (Appendix 1) prior to the commencement of the procedure.
7. **Traceability (Scan4Safety)**
    - The physiologist scans the device and leads using the Scan4Safety system to ensure full traceability.

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8. **Final Verification**

   - Immediately prior to implantation, the physiologist and consultant jointly undertake a final verification of the device and leads, confirming:
     - Connector compatibility
     - Correct device type
     - Appropriate lead type
     - Valid expiry dates

Appendix 1

WHO Surgical Safety Checklist

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Improvement Plan

Datix reference: **73028**
Executive Director(s) Responsible:
Improvement Plan Approved By:

Action number	Root Cause/Recommendation	Recommended Action	Is the Action Strong / Medium / Weak? (See hierarchy of interventions)	Designation of Person Responsible for the Action	Timeframe for Completion of the Action:	Evidence of Progress and Completion
Immediate actions						
1. 2. 5. 9.	Cardiff & Vale UHB should develop a Medical Devices Management Policy that includes Implantable Medical Devices in its scope. Cardiff & Vale UHB should appoint a dedicated Medical Device Safety Officer. Local acquisition policies and processes should be established for cardiac implant devices Formal device verification should take place before implantation as outlined in NatSSIPs2.	- Working with the UHB to implement scan for Safety - Monitoring & Compliance: Highlight reports produced by scan for safety to steer further improvement/ development - Stock management standard operating procedure (SOP). Share the updated SOP widely across the directorate and ensure it is signed off collaboratively by the	Strong	Directorate Management Team, Cardiothoracic clinical director Lead Physiologist Cardiac Device service Dr P O'Callaghan Consultant	Jan 2026 Planned 27/05/26 May/ June 2026	Phase 1 of scan for safety completed – assigning to patient Phase 2 training confirmed for the 27/05/2026 (scanning stock/ inventory and waste management) Stock management SOP updated May 2026 to be cascaded in June Q& S. Hard copy to be provided on departmental notice board. Cardiac Physiologists to sign acknowledgement

		Directorate Team, Device Consultants and Cardiac Physiology team. SOP should be saved on the shared folder and shared with all cardiac physiologists. Obtain staff signatures of acknowledgement. - Lead physiologist for Cardiac devices to link in and feedback to the wider C&V UHB work - Identification of 2 physiologists responsible for stock management - Further development of WHO checklist to clearly include device stock. Consider daily team briefings to discuss the patients listed. - Open communication: Promote regular team meetings, feedback through structured forums - Develop a device specific induction pack to include		Cardiac Physiologist team	Begun April 2026 April 2026 23/06/26 Expected Aug 2026 Ongoing	Weekly Cardiac physiologist breakfast meeting set up to provide monthly teams meetings and regular training Two Cardiac Physiologists identified responsible for stock management and one hour protected time for stock check every Monday morning initiated Cardiac Device implant Teams meeting for all stakeholders arranged for 23/06/2026. This will include discussions around development of WHO checklist and daily team briefings Band 7/ 8 physiologist to be identified to produce Device service induction pack When indicated completion of datix and MHRA reporting DMT exploring a new 'SOP forum' to annually review and update

		SOP's and remote monitoring access etc. - DMT currently exploring a 'SOP forum' to annually discuss and review all SOP'S. - Work with the recently appointed UHB Medical Device Safety Officer (MDSO). Awaiting further communication on the role and expectation of the MDSO.				local policies and procedures. Awaiting further information.
4.	Bulk purchasing of implantable medical devices should only take place after consideration the lifetime of current stock and new stock in consultation with the professionals who use the devices.	- Review of current practice and national implant guidelines - Work with UHB to implement Scan for Safety. Produce highlight reports to regularly audit usage and current stock levels. Consider critical levels - Implement stock management SOP - Consignment stock agreements, companies to	Strong	Directorate Management Team Dr P O'Callaghan Consultant Lead Cardiac devices Lead Physiologist Cardiac Device service	Begun May 2026 Completed April 2026	Device tender process commenced including minimum expiry of 18 month on receipt and ability to swap out with expiry date greater than 6 months Consignment stock agreements confirmed with Procurement. Company representatives confirmed stock checks: Abbott second Tuesday of each month, Boston third Tuesday, Medtronic 4th Tuesday. Email to be sent to lead physiologist to

			provide evidence of stock checks			Completed Jan 2026 27/05/26	confirm stock levels including expiry dates. Phase 1 of scan for safety completed – assigning to patient Phase 2 training confirmed for the 27/05/2026 (scanning stock/ inventory and waste management)
6. 7.	Adequate stock management systems should be implemented for all implantable medical devices, including unique identifiers for the devices, the purchase price, date of purchase, the date of implantation and end-of-life date. A named individual should be responsible. Implantable cardiac devices should be returned to the manufacturers prior to expiry. Where this is not possible they should be removed from	- Work with the UHB to implement Scan for safety - Work with the UHB to implement Fysicon Data Management system - Monitoring & Compliance: Highlight reports produced by scan for safety to steer further improvement/ development - Designated stock management team - Use first stickers to identify short dated stock	Strong	Directorate Management Team, Cardiothoracic Clinical Director Lead Physiologist Cardiac Device service Dr P O'Callaghan Consultant	Jan 2026 Expected 27/05/ 2026 Working towards w/c 01/06/26	Phase 1 of scan for safety completed – assigning to patient Phase 2 training confirmed for the 27/05/2026 (scanning stock/ inventory and waste management) Regular meetings in place with UHB IT digital team and Fysicon to implement system. Aim to implement in implant w/c 01/06/2026 Two Cardiac Physiologists identified responsible for stock

8. 10. 11.	the stock room and marked unavailable to use at expiry. A system such as Scan-for-Safety should be implemented for Implantable Medical Devices to ensure full traceability between selection of an appropriate device, retrieval of that device from a store by a named team member, and implantation in the patient. Consulant Cardiologists should accept ultimate reponsibility for the implantable device being appropriate and fit-for-purpose. All staff involved with implantable medical devices during training, induction, audit, appraisal and peer-review should be informed that it is never acceptable to implant medical devices in patients past the manufacturer's expiry date.	- Ensure bulk purchases / tenders include the return of stock with greater than six months longevity for replacement - Stock management SOP - Produce a clear flow diagram detailing the Device system selection process - Promote regular team meetings, feedback and VBA's - Device specific induction pack including SOP's and remote monitoring access. - Further development of WHO checklist to clearly include device stock. Consider daily team briefings to discuss the patients listed. - Consignment stock agreements, companies to provide evidence of stock checks		Lead Cardiac devices Cardiac physiology stock team	April 2026 May/ June 2026 Begun May 2026 Expected by Aug 2026 23/06/26	management and 0ne hour protected time for stock check every Monday morning initiated Stock management SOP updated May 2026 to be cascaded in June Q& S. Device tender process commenced including minimum expiry of 18 month on receipt and ability to swap out with expiry date greater than 6 months Band 7/ 8 physiologist to be identified to produce Device service induction pack Cardiac Device implant Teams meeting for all stakeholders arranged for 23/06/2026. This will include discussions around development of WHO checklist and daily team briefings Consignment stock agreements confirmed with Procurement.

		- Dr O'Callaghan to cascade this SOP/ action plan to all device Cardiologists			Completed April 2026 Begun April 2026 TBC	Company representatives confirmed stock checks: Abbott second Tuesday of each month, Boston third Tuesday, Medtronic 4th Tuesday. Email to be sent to lead physiologist to confirm stock levels including expiry dates. Weekly Cardiac physiologist breakfast meeting set up to provide monthly teams meetings and regular training POC to cascade information to device Consultants
3. 12.	Cardiff & Vale UHB should ensure that all services have access to and use an appropriate system to record safe management of their medical devices. An MRI Physics service should be established in the Health Board, in line with comparable organisations. This service should advise Radiology on the suitability of mixed devices for MRI scans,	- Work with the UHB to implement Scan for Safety - Work with the UHB to implement Fysicon Data Management system - Regular stock audits utilising scan for safety highlight reports. Lead cardiac physiologist to feedback to directorate	Strong	Directorate Management Team, Cardiothoracic Clinical Director Lead Physiologist Cardiac Device service	January 2026 Expected 27/05/ 2026	Cath to review with Alex Scott Phase 1 of scan for safety completed – assigning to patient Phase 2 training confirmed for the 27/05/2026 (scanning stock/ inventory and waste management)

	and should input into device procurement decisions.	management team and Cardiac physiologists. - Produce a standard operating procedure of Cardiac device patients requiring MRI procedures. Share the SOP widely across the directorate and ensure it is signed off collaboratively by the Directorate Team, Device Consultants and Cardiac Physiology team - WHO checklist development to include device stock. Consider daily team briefings to discuss the patients listed.		Dr P O'Callaghan Consultant Lead Cardiac devices	Working towards w/c 01/06/26 23/06/26	Regular meetings in place with UHB IT digital team and Fysicon to implement system. Aim to implement in implant w/c 01/06/2026 Cardiac Device implant Teams meeting for all stakeholders arranged for 23/06/2026. This will include discussions around development of WHO checklist and daily team briefings Band 7 Physiologist to be identified to produce MRI SOP.

[Type here]

Report Title:	JACIE Inspection Update		Agenda Item No:		*5.3*
Meeting:	Quality Committee	Public	x	Meeting Date:	30th November 2026
		Private			
Lead Executive Title:	Paul Bostock - Chief Operating Officer				
Report Author/s Title:	Jessica Castle – Director of Operations Specialist Services Katie Innes – Strategic Planning Manager				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

Whilst the Programme has implemented corrective actions in response to the JACIE inspection, a significant strategic risk remains pending the accreditation outcome. Failure to secure accreditation could impact delivery of adult HSCT and CAR-T services in Wales and will require decisions regarding commissioning derogations, alternative provider arrangements and the future sustainability of specialist cellular therapy services. Demand for CAR-T therapies is also expected to increase significantly over the next 12-24 months, creating additional capacity pressures which are not fully addressed through current infrastructure plans. Despite these challenges, the outcomes are comparable with national and international benchmarks.

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

Board/Committee Response Required *(please select only one)*					
Assurance	x	**Approval**		**Information/Noting**	

Recommendations

The Committee is asked to:

- Note the current position regarding JACIE reaccreditation and the residual risk pending the accreditation decision.
- Note the positive outcomes demonstrated by the Programme.
- Note the potential implications for adult HSCT and CAR-T services should accreditation not be secured.
- Endorse continued work with the NHS Wales Joint Commissioning Committee regarding potential commissioning and derogation arrangements should these become necessary.
- Note the emerging strategic risks associated with future cellular therapy demand, infrastructure limitations and workforce sustainability.
- Receive a further report following notification of the JACIE outcome, including recommendations regarding service continuity and future service capacity.

Governance Route *(please list all other Committee/Groups this report has been to)*

***Where** it's been:*	*In various formats – Tertiary Services Development Group, VBRG, SLT, F&P Committee*
***When** it went:*	*F&P – 20/05/26*
***What** decision was made:*	▪ *Oversight and support for delivery of corrective actions.* ▪ *Approval of workforce investment proposal for commissioner consideration.*

	▪ *Ongoing monitoring of accreditation risks and mitigation plans*

Main Report

Background & Current Situation

The South Wales Blood and Marrow Transplant (SWBMT) Programme provides adult and paediatric haematopoietic stem cell transplantation (HSCT) services for patients across South Wales and delivers highly specialised cellular therapies, including CAR-T treatment, on behalf of NHS Wales.

The SWBMT Programme underwent routine reaccreditation assessment by the Joint Accreditation Committee of ISCT and EBMT (JACIE). The inspection identified several areas requiring improvement across governance, quality management systems, documentation, workforce arrangements and infrastructure. A comprehensive improvement programme was subsequently established to address all findings and provide assurance regarding compliance with applicable standards.

Significant progress has been made since the inspection. Actions have been delivered through a structured programme of work involving clinical, operational, workforce, quality and estates colleagues. Evidence has been submitted to JACIE in support of the corrective actions undertaken and the Programme is currently awaiting confirmation of the accreditation outcome.

The work undertaken has strengthened governance arrangements, clarified accountability, improved documentation and quality processes, and supported improvements across both transplant and cellular therapy services. The process has also provided an opportunity to consider longer-term sustainability requirements for these highly specialised services and the infrastructure required to support their future development.

Progress Since Previous Report

Since the last report to Committee, the Programme has continued to implement and embed the actions required in response to the JACIE inspection findings.

Key areas of progress include:

- Completion of the agreed corrective action programme and submission of evidence to JACIE for review.
- Continued monitoring through established programme governance arrangements to provide assurance regarding implementation and sustainability of improvements.
- Ongoing engagement with commissioners, clinical teams and partner organisations regarding future service requirements and accreditation implications.
- Continued work to strengthen governance, quality management systems, workforce resilience and operational oversight across transplant and cellular therapy services.

Service Outcomes and Quality Performance

Whilst the JACIE inspection identified significant concerns relating to infrastructure and accommodation, available outcome data demonstrates that the South Wales Blood and Marrow Transplant (SWBMT) Programme continues to deliver high-quality clinical outcomes which are comparable with national and international benchmarks.

Data presented by the Programme Director indicates that both adult and paediatric transplant services continue to meet agreed performance standards for survival and non-relapse mortality. Adult allogeneic and autologous haematopoietic stem cell transplantation (HSCT) outcomes remain within expected ranges when benchmarked against British Society of Blood and Marrow Transplantation and Cellular Therapy (BSBMTCT) and European Society for Blood and Marrow Transplantation (EBMT) data. All reported Joint Commissioning Committee key performance indicators were achieved.

Similarly, paediatric transplant outcomes compare favourably with national and international benchmarks, with one-year survival and mortality outcomes remaining within expected ranges. Outcome data provides assurance that the quality management system remains effective and that patient outcomes have not been adversely affected by the infrastructure challenges identified during the accreditation process.

The presentation highlighted that accredited status is associated with improved outcomes and remains a prerequisite for commissioning and the provision of CAR-T therapies within the UK. The Programme therefore remains committed to maintaining compliance with JACIE standards whilst continuing to deliver safe and effective care.

Despite the challenges identified through the inspection process, the Programme Director concluded that the quality management system remains effective and fit for purpose, and recognised the significant contribution of clinical, quality, research and operational teams in sustaining high-quality outcomes under increasingly constrained conditions.

Risk Assessment and Residual Concerns
Whilst significant progress has been made in addressing the findings arising from the JACIE inspection, a number of strategic risks remain outstanding.

The final accreditation outcome remains pending and therefore the Health Board continues to operate with a degree of uncertainty regarding future accreditation status. Although substantial work has been undertaken to address identified non-compliances, formal recertification has not yet been confirmed.

The Programme and Clinical Board has continued to consider the potential implications should accreditation be deferred or not granted. Whilst no immediate risks to patient safety have been identified, loss or delay of accreditation would create significant challenges regarding the future delivery and commissioning of haematopoietic stem cell transplantation (HSCT) and associated cellular therapy services in Wales.

Current commissioning arrangements require JACIE accreditation for delivery of HSCT services. Preliminary discussions with commissioners have recognised that, should accreditation not be secured, alternative arrangements may need to be considered, including the potential requirement for commissioning derogations whilst longer-term solutions are developed. Quality Committee members should be aware that these discussions may become necessary depending on the final accreditation outcome.

The Committee should also note that early discussions with commissioners and provider partners have highlighted practical challenges associated with transferring activity outside Wales. These include patient access considerations, continuity of care requirements and concerns regarding provider capacity elsewhere within the system.

In parallel, the Programme has identified longer-term strategic risks relating to service sustainability. CAR-T therapies and other advanced cellular therapies are expected to continue to expand, with national and international developments indicating a likely increase in demand over coming years. This has implications for workforce capacity, infrastructure requirements and future service configuration.

A significant infrastructure risk remains open. The current estate has been identified as a longstanding constraint for the service and has previously been reflected through the organisation's risk management arrangements. Whilst capital proposals have been developed, Welsh Government approval has not yet been secured and therefore a long-term infrastructure solution remains unresolved.

A further outstanding risk relates to recurrent funding. Whilst NHS Wales Joint Commissioning Committee has approved some non-recurrent support during the current financial year, the request for recurrent funding remains under consideration and is expected to be considered through the Joint Commissioning Committee's 2027/28 IMTP process. Until a recurrent funding solution is agreed, uncertainty remains regarding the long-term financial sustainability of the service model.

Taken together, these issues demonstrate that the risks facing the Programme extend beyond the JACIE accreditation process itself. The accreditation outcome remains the immediate priority; however, wider considerations relating to commissioning arrangements, future demand, infrastructure and financial sustainability will require ongoing strategic oversight irrespective of the final accreditation decision.

Service Continuity and Contingency Planning
Appropriate contingency arrangements continue to be maintained whilst the Programme awaits confirmation of the accreditation outcome.

In the event that accreditation is delayed or further action is required, the Health Board would continue to work closely with NHS Wales Joint Commissioning Committee colleagues, partner providers and clinical leaders to ensure continuity of access to transplant and cellular therapy services for patients across Wales. Existing discussions have recognised the complexity associated with any alternative arrangements, including patient access considerations, provider capacity constraints, commissioning requirements and financial implications.

The Health Board's preferred position remains to maintain safe, sustainable and accredited services within Wales wherever possible.

The accreditation process has additionally highlighted the importance of considering longer-term strategic sustainability beyond the immediate accreditation decision. Future planning will therefore continue to focus not only on compliance with JACIE standards but also on workforce resilience, infrastructure requirements, future demand for specialised therapies and the overall sustainability of highly specialised services delivered on behalf of NHS Wales.

Conclusion
Whilst substantial progress has been achieved in response to the JACIE inspection findings, significant strategic risks remain open. These include the pending accreditation outcome, unresolved infrastructure requirements, and recurrent funding requirements.

The Clinical Board continues to oversee these risks and to work with commissioners, Welsh Government and partner organisations to support a sustainable future model for transplant and cellular therapy services in Wales.

A separate presentation will provide further information regarding service outcomes and the potential implications associated with different accreditation scenarios. The Committee is asked to note the current position and the ongoing work to mitigate these risks.

Appendices:

1. Slide deck

Strategic Alignment – Shaping Our Future Wellbeing:

Putting People First	x	Providing Outstanding Quality	x
Delivering in the Right Places		Acting for the Future	x

Impact Asssment

Risk: Yes
Risk Assessment attached

Safety: Yes
Risk Assessment attached

Financial: Yes
Business Case to address revenue requirements to be submitted to JCC for consideration – has been to VBRG, SLT and F&P Committee (20/5/26).
Strategic Outline Case for capital solution submitted to Welsh Government June 2026
Financial risk covered in risk assessment.

Workforce: Yes
Workforce considerations included in revenue case. Implications will not be fully understood until final decision on accreditation made.

Legal: No
None identified at this stage.

Reputational: Yes
Loss of accreditation would have significant reputational implications, for the Health Board and NHS Wales.

Socio Economic: Yes - *https://www.gov.wales/socio-economic-duty-guidance*

Loss of accreditation could result in patients having to travel significant distance for treatment with the potential that this has a disproportionate negative impact on certain patients/patient groups.
Equality & Health: Yes
An EHIA will need to be complete as options are developed to mitigate the risk of losing accreditation. Should the accreditation be lost an EHIA will need to be complete to consider the implications of this.
Decarbonisation: Yes
The outcome of the accreditation, as well as the mitigating actions may have an impact and will need to be fully assessed and considered.
Welsh Language: Yes
Loss of accreditation may mean that this service is no longer available in Wales and therefore in Welsh.

TGMDC | SWBMT
Rhaglen Trawsblannu Gwaed a Mêr De Cymru
South Wales Blood and Marrow Transplant Programme

Midlands-Wales Advanced Therapy Treatment Centre

Advanced Therapies Wales | Therapiau Datblygiedig Cymru

Partneriaeth Ymchwil Canser Caerdydd | Cardiff Cancer Research Partnership

Consortiwm Triniaeth Cellog Cymru
Wales Cellular Therapy Consortium

The SWBMT Programme: Risks associated with JACIE recertification

Dr Keith Wilson
Director, South Wales BMT Programme
Honorary Consultant Haematologist, Cardiff and Vale UHB
Senior Clinical Lecturer in Haematology, Cardiff University School of Medicine

Executive Governance Team Meeting
30 November 2026

Cardiff University | Prifysgol Caerdydd

IMPACT THE UK'S STEM CELL TRANSPLANT CLINICAL TRIALS PARTNERSHIP

ecmc

HTA Human Tissue Authority
Licensed Establishment

ACCREDITED BY: JACIE Joint Accreditation Committee ISCT | EBMT

GIG CYMRU NHS WALES

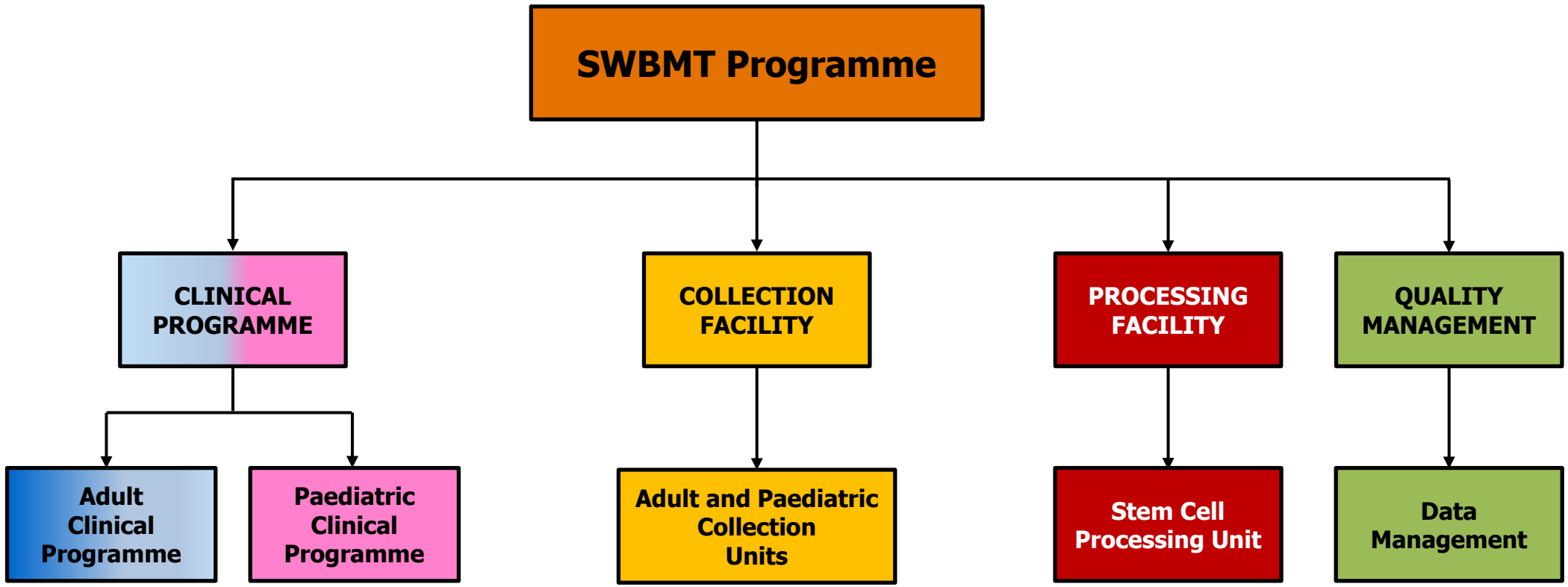
Situation

- **The SWBMT Programme is at risk of losing JACIE recertification**
  - State of the adult premises on CVUHB site major cause for concern
  - **Deficiencies** highlighted in 2013 and 2019 inspections
  - **No evidence** of progress (against promised previously made) in 2025 inspection

- **SWBMT adult activity**
  - **130-140:** Transplants (80-100 at CVUHB, 50 at SBUHB)
  - **100-120:** Autologous and sibling stem cell collections
  - **20-25:** CAR-T infusions

TGMDC | SWBMT
Rhaglen Trawsblannu Gwaed a Mêr De Cymru
South Wales Blood and Marrow Transplant Programme

SWBMT Programme Organogram



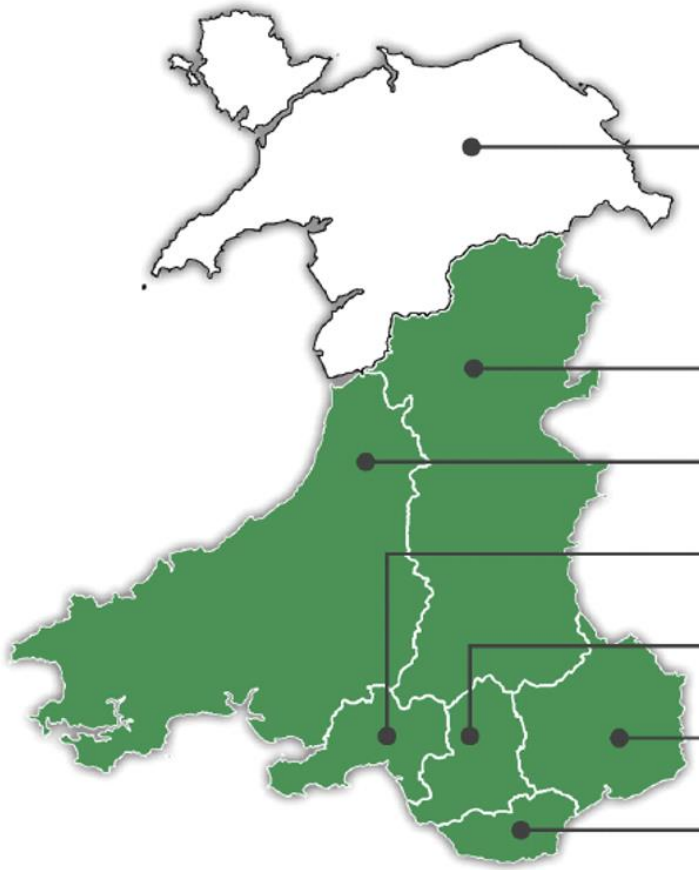
Background

- **JACIE (Joint Accreditation Committee of ISCT and EBMT)**
  - JACIE is the international cellular therapy accreditation standard in Europe
  - Accreditation is a prerequisite for commissioning in the UK and for CAR-T release
  - **Accredited status results in improved outcomes**
- **Stakeholder implications: customer LHBs**
  - **Only 20%** of adult patients treated at CVUHB have a local post code
  - Customer LHBs need to be warned of the implications for their populations
- **Stakeholder implications: patients and families**
  - Patients in Wales are older and more comorbid than their UK and European counterparts
  - Many might opt not to travel to England if offered
  - No guarantee of capacity in or acceptance by NHS England

SWBMT Programme Catchment Area

The SWBMT Programme serves 78% of the population of Wales

Mid-2020 population estimates. Source: Welsh Government, August 2021



North Wales Catchment Area

Population = 0.70×10^6

- Betsi Cadwaladr University Health Board

SWBMT Programme Catchment Area

Population = 2.47×10^6

- Powys Teaching Health Board (0.13×10^6)
- Hywel Dda University Health Board (0.39×10^6)
- Swansea Bay University Health Board (0.39×10^6)
- Cwm Taf Morgannwg University Health Board (0.45×10^6)
- Aneurin Bevan University Health Board (0.60×10^6)
- Cardiff and Vale University Health Board (0.50×10^6)

ACCREDITED BY: JACIE Joint Accreditation Committee ISCT | EBMT

Standard B2: Premises

- **JACIE Standard B2: Clinical Unit**
  - **B2.1:** There **shall** be a designated **inpatient** unit of **appropriate location** and **adequate space and design** that **protects the patient** from transmission of infectious agents and allows for **appropriate patient isolation**, confidential examination and evaluation
  - **B2.2:** There **shall** be a designated **outpatient** care area that **protects the patient** from transmission of infectious agents and allows, as necessary, for **appropriate patient isolation**; confidential examination and evaluation; and administration of intravenous fluids, medications, blood products, or cellular therapy products

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Standard B2: Premises

- **2013 JACIE Report**
  - Facilities **shabby** and **behind the curve** in comparison to other UK centres
- **2019 JACIE Report**
  - The **worst ever seen**…
- **2025 JACIE Report**
  - Inpatient facility poses an **infection control risk**…lack of significant nosocomial infection due to staff diligence rather than adequacy of facilities…
  - **No progress** regarding concerns raised in 2013 and 2019
  - Outpatient unit **old and tired**
  - Day unit facilities **not fit for purpose**
  - Newer ambulatory unit is **cramped**…**compromises** patient confidentiality…**inadequate** privacy…

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Standard B4: Quality Management

- **JACIE Standard B4.7.5: Survival**
  - The Clinical Program should achieve **one-year survival outcome** within or above the expected range when compared to national or international outcome data
  - **B4.7.5.1:** If expected one-year survival outcome is not met, the Clinical Program shall **implement a corrective action plan** that meets FACT or JACIE requirements

- **JACIE Standard B4.7.6: Non-relapse mortality**
  - The Clinical Program should set **benchmarks for non-relapse mortality at one hundred (100) days** after cellular therapy product administration and describe the **rationale** and **process for review** in the Quality Management Plan

Paediatric autologous HSCT KPIs: Survival/Mortality

Source: BSBMTCT 2024 Annual Report (2018-2022)

Parameter	JCC Spec	SWBMT	BSBMTCT	Result	
Day 100 NRM	<5%	0%	2% (1-4)	Within range	KPI met
1-year NRM	<30%	0%	3% (2-5)	Within range	KPI met
1-year OS	N/A	80% (41-95)	84% (80-87)	Within range *P* = 0.71	KPI met

The EBMT does not benchmark paediatric outcomes

Adult autologous HSCT KPIs: Survival/Mortality

Source: BSBMTCT and EBMT 2024 Annual Reports (2018-2022)

Parameter	JCC Spec	SWBMT	BSBMTCT	EBMT	Result	
Day 100 NRM	<5%	2% (1-5)	1% (1-1)	---	Within range	KPI met
1-year NRM	<30%	3% (2-5)	2% (2-3)	---	Within range	KPI met
1-year OS	N/A	94% (91-96)	94% (94-95)	93% (93-94)	Within range $P = 0.55$	KPI met

Adult allogeneic HSCT KPIs: Mortality/Survival

Source: BSBMTCT and EBMT 2025 Annual Reports (2019-2023)

Parameter	JCC Spec	SWBMT	BSBMTCT	EBMT	Result	
Day 100 NRM	<30%	10% (6-15)	6% (5-6)	---	Within range	KPI met
1-year NRM	<30%	16% (12-22)	12% (12-13)	---	Within range	KPI met
1-year OS	N/A	74% (68-80)	77% (76-78)	77% (76-77)	Within range *P* = 0.11	KPI met

Activity forecast, capacity and challenges

- **CAR-T demand is the most important pending challenge**
  - Initial demand for adult indications: **12-15 p.a.**
  - Current demand for adult indications: **20-25 p.a.**
  - Could increase if patients with ALL are repatriated from NHS England
  - **Myeloma CAR-T** will be the game-changer:
    - CAR-T in 4th or later line (up to 5 p.a.)
    - CAR-T in 2nd line (variable modelling: **50-80** *v* **100-150** p.a.)

Activity forecast, capacity and challenges

- **Capacity on the CVUHB site (adults)**
  - Unable to accommodate **existing** commissioned **HSCT** indications
    - Autologous HSCT for multiple sclerosis
  - Unable to accommodate **existing** commissioned **CAR-T** indications
    - Autologous CAR-T for adult/adolescent acute lymphoblastic leukaemia
  - Unable to accommodate **new** commissioned CAR-T indications
  - Unable to accommodate **clinical trial** CAR-T outside of Haematology/BMT

Programme Director's Statement

- **Quality Management System remains effective and fit-for-purpose**
  - High through-put of clinical, research and clinical trial and quality activity despite very challenging conditions of work
  - Staff are to be commended for commitment to producing a very high standard of work despite constraints
  - SWBMT Programme is in a **partially validated state**
  - State of **adult premises on CVUHB site** is **main risk** regarding JACIE re-certification

Recommendations

- **Need an urgent decision from WG regarding new build BC**

  - Patients in Wales would be put in a difficult decision regarding treatment option
  - Patients denied a transplant have inferior outcomes compared to those who do

  - Existing commissioned activity will continue to go unfilled in Wales
  - New commissioned activity will not be adopted unless patients travel to England

  - WG has asked for the BC to address current needs with no horizon scanning

  - Income from transplant and CAR-T trials which have the potential to attract millions in inward investment (gross) will no longer be possible in Wales

Report Title:	Integrated Performance Report		Agenda Item No:		6.1
Meeting:	Quality Committee	Public	x	Meeting Date:	30.11.2026
		Private			
Lead Executive Title:	Executive Nurse Director and Executive Medical Director				
Report Author/s Title:	Assistant Director of Quality and Patient Safety				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

A multidisciplinary collaborative has developed and implemented a revised WHO Surgical Safety Checklist, supported by dedicated Team Brief whiteboards have been ordered and will be placed in every theatre to standardise communication, situational awareness and teamwork before procedures. Compliance and effectiveness are being monitored through ongoing audit and supplementary instructional resources are being developed to support consistent application of best practice. In addition, scrub practitioner training is being reviewed following learning from a Never Event, with a pilot programme in Oral and Maxillofacial Surgery introducing enhanced mentoring by surgeons and exposure to outpatient clinics to strengthen understanding of procedural requirements, professional interdependencies and safe theatre practice.

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

The UHB continues to demonstrate improvement in several key quality and safety indicators. Overdue nationally reportable incidents have reduced by 62% compared with October 2025, with no Never Events reported since July 2026. Crude mortality has remained below both the historical UHB mean and the All-Wales rate for eight consecutive months, with continued improvement in Risk Adjusted Mortality Index, stroke mortality and hip fracture mortality measures. Patient experience intelligence is available through the Quality Management System dashboard, supported by implementation of the Patient Experience Toolkit. Infection prevention and control performance remains mixed, with reductions in Klebsiella, MSSA bacteraemia and Clostridioides difficile infections, whilst increases in E. coli, Pseudomonas and MRSA bacteraemia have identified ongoing priorities relating to urinary catheter care, invasive device management, screening compliance and environmental standards. Improvement actions are underway through strengthened governance, audit, education, standardised safety processes and targeted quality improvement programmes.

Board/Committee Response Required *(please select only one)*					
Assurance		**Approval**		**Information/Noting**	x

Recommendations

The Committee is asked to:

1. **NOTE** the data and narrative included in the performance report

Governance Route *(please list all other Committee/Groups this report has been to)*

***Where** it's been:*	
***When** it went:*	
***What** decision was made:*	

Main Report
Background & Current Situation

The Integrated Performance Report incorporates information relating to digital and health intelligence, finance, people and culture, performance, public health and quality and safety. Quality indicators align to the Wales NHS Performance Framework and the targeted intervention indicators.

The Integrated Performance Report is included in appendix 1.

Appendices:

- Appendix 1 - Integrated Performance Report

Strategic Alignment – Shaping Our Future Wellbeing:

Putting People First		Providing Outstanding Quality	**x**
Delivering in the Right Places		Acting for the Future	

Impact Assessment
Risk: No
Safety: Yes
The IPR includes data relating to patient safety and quality indicators as well as data around performance including oversight of nationally reportable incidents, Never Events, Infection Prevention and Control and patient experience
Financial: Yes
The IPR includes finance indicators and narrative including the finance deficit
Workforce: Yes
The IPR includes workforce indicators and narrative including workforce turnover, temporary staffing and sickness absence.
Legal: No
Reputational: Yes
The data and information provided in the report is a candid and transparent report of UHB performance
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: Please select
The IPR includes data and performance relating to public health including smoking cessation, womens health, immunisation and healthy weight
Decarbonisation: No
Welsh Language: No

CLINICAL BOARD QUALITY UPDATE REPORT			
Governance Group:	Medicine	**Date of Meeting:**	November 2026
Representative at Clinical Board Governance:		**Date of Meeting:**	

ITEMS FOR ALERT		
Issue / Risk	Action taken	Group responsible
Deteriorating Urgent and Emergency Care performance and associated patient-safety risk: Significant and sustained operational pressure continues across UEC. Emergency Unit overcrowding, ambulance handover and constrained flow through assessment and inpatient pathways. These pressures create ongoing risks of delayed clinical assessment and escalation, deterioration while waiting, poorer patient experience and increased pressure on staff.	The W45/EU improvement and assurance plan provides the framework for recovery, with local and system oversight of waiting-to-be-seen performance, ambulance handover, capacity, flow and escalation. Residual risk remains until sustained improvement in these measures is demonstrated. The Health Board has commenced a cross-organisational programme of urgent clinical and operational improvement in response to sustained urgent and emergency care pressures and the recent GIRFT review. MCB is actively contributing to the organisation-wide programme and aligning its existing acute-model and UEC improvement work with the Call to Action. This includes work on the Acute Referral Policy and operational standards, direct access to SDEC/assessment pathways, frailty streaming, weekend senior decision-making and discharge/flow arrangements. Delivery is being coordinated with the wider Health Board programme rather than progressed as a Medicine-only intervention. To support this work, in-depth reviews are underway for clinically optimised patients to better understand the actions required to support discharge and where opportunities exist to reduce delay. Discussions are also underway with colleagues in PCIC Clinical Board to support this work, including consideration of timely social worker allocation and assessment.	Emergency and Acute Directorate MCB C&V / COO & Medical Director's Office / all relevant Clinical Boards, with Medicine Clinical Board responsible for delivery of its component actions.

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Removal of Home Ventilation Drive Through Facility in UHL with no discussion or mitigation plans made The Home Ventilation Team look over 400 patients who are on ventilators at home. These patients need regular reviews, and expedited reviews when they are unwell, to address their health needs with the aim to keep them healthy and stable in the community and prevent admission. The drive through tent had a number of benefits: • reduced clinic needs in the outpatient department • improved patient experience through (PREMs carried out): • reduction in patient stress, through not needing to park • reduction in patient exertion, through not needing to mobilise (which is hard for many of our patients due to their reduced mobility due to respiratory complications) • better access to healthcare (many of our patients would not be able to come if they had to exit their vehicle to attend) • more time efficient and reduce the number of home visits that the HVT need to carry out, and therefore reduce strain on HVT due to increasing numbers in their patient population	MCB is asking for an urgent meeting with the estates team as we have patients booked in on a weekly basis with currently no mitigation to provide the service in an appropriate location. MCB have asked for support from estates colleagues since 2022 to provide a more permanent solution for the home ventilation team as they are currently based in a portacabin aligned to the tent that has now been removed. It is recognised that the tent is not an ideal solution as it is a temporary structure and therefore subject to risks with adverse weather, is not a confidential clinical space and not an appropriate work environment for staff overall. This service could be managed in a community setting and the most important consideration is co-location for the team in a space that is easily accessible for patients with very limited mobility due to breathlessness.	MCB/ HVT/ Estates and accommodation teams

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group Responsible**
As of 11 November 2026, there are 17 open NRIs across the Medicine Clinical Board, of which 5 are currently overdue. This position reflects a continued focus on improving the timeliness of NRI reviews and closures across all divisions. Significant effort is being made to ensure that overdue investigations are actively progressed, with regular follow-up undertaken with reviewers and additional support provided where required to assist with completion, approval and closure of cases.	To support effective oversight and timely progression of investigations, the Clinical Board holds weekly NRI review meetings involving the Director/Deputy Director of Nursing, Quality and Safety Lead (MCB) and the Patient Safety Facilitator for Medicine. These meetings provide an opportunity to review each open NRI in detail, monitor progress against agreed timescales, discuss any barriers to completion, and identify where additional support may be required to facilitate closure. The meetings also	QSE Lead MCB/Director & Deputy Director of Nursing MCB

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The current position comprises 6 open NRIs within Integrated Medicine (3 overdue), 5 open NRIs within Specialised Medicine (1 overdue) and 6 open NRIs within Emergency and Acute Medicine (1 overdue). There are currently no open IR(ME)R investigations.	provide a forum to escalate concerns, consider emerging risks, and discuss any newly identified potential NRIs that may require rapid review and early investigation. While further work is required to reduce the number of overdue cases, the overall position represents an improvement compared to previous months. Focused work has been undertaken to address the backlog of longstanding investigations, resulting in the closure of a number of significantly overdue NRIs. As a result, the total number of open NRIs has reduced to 17, compared with previous periods when the Clinical Board had in excess of 22 open investigations. This demonstrates positive progress in strengthening review oversight, supporting reviewers through the investigation process, and improving the timely completion and closure of NRIs across the Clinical Board. Continued scrutiny through weekly review meetings, combined with targeted support for investigators, will help sustain this improvement and further reduce the number of overdue investigations.	
Diabetes & Endocrinology urgent referral pathway A new risk has been identified relating to a digital system issue affecting the management of urgent D&E referrals. The potential consequence is that an urgent referral is not appropriately identified or progressed.	The Digital Development team has identified the system issue and is progressing a permanent fix as a matter of urgency, with the Digital reference recorded within the AMaT mitigation plan. As an interim control, Medical Records are manually vetting referrals to identify urgent cases and minimise the risk of harm. The Clinical Board/Directorate is maintaining oversight and seeking assurance on delivery of the permanent digital solution, recognising that continued	D&E Directorate MCB

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	reliance on a manual process is not a sustainable long-term control.	
Resilience of access to Lakeside Wing The recent temporary closure of the connecting tunnel between UHW and Lakeside Wing has been resolved following investigation and remedial works. However, the incident highlighted the vulnerability created by reliance on a single internal access route for patient movement between Lakeside Wing and the main hospital. Loss of this route necessitated external transfer arrangements for patients requiring investigation, escalation or return to the main hospital, with associated clinical, operational, patient dignity and flow risks. Concerns remain with respect to the environment of the tunnel access and the patient experience when transferring between LSW and the main UHW site.	During the closure, individual patient risk assessment, alternative transfer arrangements, emergency escalation processes and additional transport provision were implemented. The tunnel subsequently reopened following testing and remediation. The incident has highlighted the need for a more resilient contingency arrangement for access to and from Lakeside Wing, particularly for deteriorating or time-critical patients and where internal access is unexpectedly unavailable. Planned work to improve the environment of the tunnels will require further planning to ensure patient access to LSW remains safe.	C&V / Capital, Estates & Facilities / with Medicine Clinical Board and other relevant Clinical Boards contributing to clinical contingency arrangements

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Medicine Clinical Board (MCB) currently has a total of 137 new incidents requiring review across its services. Of these, Integrated Medicine accounts for 65 incidents, Emergency and Acute Medicine has reported 70 incidents, and Specialised Medicine has reported 2 incidents. This is a marked difference from when tracking of this information commenced in August 2026 when the clinical board had over 400 New incidents for review.	To support the effective management of incidents, the Clinical Board distributes a weekly Datix overview report to all directorates. This report provides visibility of outstanding incidents across each service area, highlighting the number of newly reported incidents awaiting review and enabling directorates to monitor progress against timescales. In addition, the report identifies the top 50 incident managers with the highest number of Datix records awaiting review or action, helping to ensure that overdue work is recognised and prioritised appropriately.	MCB Directors and QSE Lead.

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	Recognising the pressures faced by operational and clinical teams, the Clinical Board also ensures that incident managers are aware that support sessions can be arranged to support with managing datix appropriately. This support includes guidance on incident management processes, advice on completing reviews and investigations, help with action planning, and assistance in progressing cases towards closure. The aim is not only to improve compliance with reporting requirements but also to ensure that the valuable learning arising from incidents is captured, shared, and translated into meaningful improvements that reduce the risk of recurrence. Support sessions can be via the Patient Safety Team or Clinical Board QSE Lead.	

RECENT LEARNING OPPORTUNITY			
Source:	Patient Safety Learning Reviews / sepsis NRIs / Medicine Clinical Board QSE	**Reference (if applicable):**	
What happened / what was the problem?			
Review of recent patient-safety incidents has identified a recurring theme of delayed recognition and/or escalation of deteriorating patients, including patients with sepsis. Contributory factors have included competing clinical priorities, high workload, communication difficulties and delays in obtaining timely senior medical review.			
What was learned and how was this shared?			
The reviews reinforce the importance of clear ownership of deteriorating patients, reliable communication between nursing and medical teams and timely escalation when the expected clinical response is not available. Learning from five sepsis-related NRIs has been shared through Medicine Clinical Board governance and at the Cardiff and Vale Sepsis Day, with further thematic review planned to identify recurring factors and assess whether previous actions have been embedded.			
What action has been taken or planned? What was the impact of this?			
Actions include strengthened morning handover of unwell patients, mid-morning safety/prioritisation huddles, clearer escalation to the Patient at Risk Team where medical review cannot be obtained, and reinforcement that suspected sepsis requires timely senior medical review or appropriate delegation. A wider thematic review of historical sepsis incidents is planned to test whether learning and agreed actions have been consistently implemented across Medicine.			

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

Positive patient experience: Patient-experience measures for Medicine remained consistently above benchmark between June and October 2026. In October, approximately 94% of respondents reported feeling safe in our care, around nine percentage points above benchmark, while approximately 90% reported a positive overall experience, around five percentage points above benchmark. This reflects the sustained commitment of teams to safe, compassionate and patient-centred care despite significant operational pressures.

Improvement in Discharge Advice Letter completion: Medicine Clinical Board has achieved substantial and sustained improvement in the completion of Discharge Advice Letters following the introduction of the revised ePMA workflow, improved performance reporting and focused clinical leadership. Incomplete DALS associated with monthly discharges reduced from 239 in June to 85 in September 2026, a reduction of 64.4%. September was also the first month since ePMA implementation in which the overall historical backlog reduced, falling from 879 to 802, with incomplete DALS representing 1.8% of completed activity.

Targeted improvement has also been demonstrated in MEAU, previously identified as an area of concern. A detailed review led by Margaret Egan (Cardiff and Vale UHB - Acute Medicine) cleared the majority of outstanding cases, identified issues arising from the transition between WCP and ePMA, and reduced the remaining historic backlog to 12 cases awaiting notes. The unit was otherwise reported as up to date and no longer appeared on the DALS league table. Ongoing consultant ownership, daily reinforcement with resident doctors and close monitoring are in place to sustain the improvement.

This improvement reflects effective collaboration between clinical teams, Pharmacy, operational colleagues and the ePMA programme, supported by clearer accountability and improved visibility through the DALS dashboard.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non Delivery	Risk (RAG)

NEW / CLOSED / AMENDED RISKS

None to report.

CLINICAL BOARD QUALITY UPDATE REPORT			
Governance Group	UHB Quality Committee	**Date of Meeting:**	November 30th 2026
Representative at Clinical Board Governance:	Mat Davies (CB QPSE Consultant Lead)	**Date of Meeting:** ***[NB*** *22.10.26 – Cx, no chair* *13.11.26 – Cx due to Microsoft outage]*	28.9.26

ITEMS FOR ALERT		
Issue / Risk	**Actions Taken**	**Group Responsible**
Mortality outlier notification from the UK Kidney Association (UKKA) The Health Board has been identified as an outlier for case mix adjusted one-year survival of adult patients prevalent to dialysis on 31 December 2023. The reported one-year survival rate for the Health Board was 84.9%. This compares with a survival rate of 90.9% in the four-year 90-day incident Kidney Replacement Therapy (KRT) survival cohort and 87.9% in the cohort measuring one-year survival following the first 90 days of incident KRT.	Chief Medical Officer & Chief Nursing Officer notified. Welsh Kidney Network and NHS Wales Joint Commissioning Committee notified. Review of patient level data to validate – completed. In progress: • Agree the review scope, patient cohort, standardised approach and target completion date. The review will focus on factors relating to vascular access, line infections, socioeconomics and the provision and delivery of supportive care for patients with advanced kidney disease • Confirm a named clinical lead, working-group membership and reporting responsibilities. • Complete individual case reviews and thematic analysis, distinguishing confirmed findings from potential contributory factors	Assistant Director of Quality and safety Nephrology and Transplant (N&T) Directorate Management Team (DMT) Nephrology and Transplant (N&T) Directorate Management Team (DMT)

	• Assess any immediate safety concerns requiring interim mitigation or escalation • Assess risk-register requirements and agree an owner, rating, controls and review date where appropriate • Agree dates for interim and final reports to Directorate and Clinical Board governance, with feedback to WKN and UKKA as appropriate • Develop an improvement plan from agreed findings, with named owners, measures of effectiveness and arrangements for sharing learning and monitoring sustained improvement	
Difficulty in patients with epilepsy obtaining levetiracetam from community pharmacies An emerging patient-safety concern has been identified regarding community pharmacies refusing to dispense levetiracetam despite valid prescriptions. Electronic prescribing further limits patients' ability to transfer prescriptions to alternative pharmacies. Interruption to essential anti-epileptic medication creates a risk of breakthrough seizures, injury and avoidable hospital admission, alongside significant distress for patients and families and increased pressure on the Epilepsy Nursing Team who are receiving an increased volume of calls re. this. Currently four active incidents under investigation	Escalation to Primary care on 03/11/2026 Update received 05/11/2026 - Louise Allen, Head of Community Pharmacy. A patient safety letter was issued to all Cardiff and Vale community pharmacies in October regarding concerns about antiepileptic medications, and the issue has been escalated to senior UHB pharmacy leadership and Welsh Government. Continued oversight until reliable access to medication and a sustainable Primary Care/Community Pharmacy response are confirmed. Staff are encouraged to report concerns via Datix, including details of the patient, pharmacy, medication, date of refusal, and any harm caused, as this supports direct follow-up with the pharmacy involved.	Neurosciences DMT and Epilepsy Team Primary Care and Community Pharmacy Teams All
Potential case of lost to neurosurgical follow up resulting in an adverse outcome – Datix ID 126641	Cross clinical board NRI meeting scheduled for 17.11.26, to be chaired by Patient Safety Team	Neuroscience Directorate Management Team

In the process of addressing a concern, a neurosurgical senior nurse noted that patient, known to have Von Hippel Lindau syndrome, was lost to follow up. Patient had been under the longstanding care of neurosurgeons and should have had regular reviews and scans every 12-18 months. Patient was last reviewed by a neurosurgeon in early 2020, he did not attend an appointment for an MRI head/spine in November 2020. There is no further evidence that the patient was followed up by neurosurgery until March 2025. The patient passed away at home on the 12th of September 2026.		Interventional Radiology
Significant delay in the investigation, diagnosis and management of cardiac disease – Datix ID 125243 A functional cardiac investigation requested in May 2023 cannot be confirmed as having been received, processed or completed because the paper-based requesting system had no auditable tracking mechanism. This was compounded by prolonged cardiology outpatient waits and inadequate safety-netting for patients with outstanding investigations.	NRI meeting 3.11.26 Immediate tracking of outstanding diagnostic requests and exploration of an electronic, auditable request/ referral system to strengthen oversight and waiting list monitoring.	Cardiothoracic Directorate Management Team

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Cardiff and Vale UHB are the only health board in Wales that lacks a commissioned Hospital Acquired Thrombosis (HAT) surveillance service and dedicated practitioner resource. Venous thromboembolism is the leading cause of preventable morbidity and mortality in hospitalised patients Escalation to executive level has been actioned and this risk is also captured on the UHB risk register. This is a recognised gap creating a patient-safety and governance risk relating to systematic identification and review of hospital-acquired thrombosis, audit, learning, education and assurance of VTE prevention. The operational and governance activities required to support effective thrombosis prevention and HAT surveillance cannot be delivered consistently, comprehensively or sustainably without dedicated specialist nursing or practitioner support.	Mitigation work continues through the Thromboembolism Prevention Group, including VTE risk assessment/ePMA optimisation, audit, education and quality improvement. UHB-wide proposal understood to be in process of being developed to establish a sustainable approach, requiring collective Clinical Board resource.	UHB Patient Safety All Clinical Boards Thromboembolism Prevention Group

Assurance re. operational responsibility, accountability and UHB wide action requested by Thromboembolism Prevention Group and Haematology Consultant Group		
HIW IR(ME)R visit: **(Retained item from last report)** Announced HIW IR(ME)R inspection of UHW Cardiology 10–11 November 2026 supported by self-assessment and supporting evidence.	Inspection completed with positive attendance. Awaiting report. No immediate action notice but assurance requested re. mandatory training compliance amongst medical and physiology staff which has been actioned.	Cardiothoracic and Interventional Radiology Teams
The All-Wales Anaerobe reference lab has identified isolates from three B5 patients that are very closely related and may represent a Clostridioides Difficile transmission event that could be healthcare related. Upon further investigation x3 cases were identified as being epidemiologically linked to ward B5, during September/October 2026. Audits 4/11/26 indicate improved hand hygiene, bare below the elbow. B5 C.diff SBAR.docx	▪Continued enhanced IPC surveillance ▪Housekeeping informed of cluster, twice daily cleaning requested by IPC team ▪Focus on commode and bed cleaning ▪Weekly IPC audits ▪Antimicrobial Stewardship ▪Education sessions ▪All equipment on North side to receive Actichlor plus clean and IPC team requested HPV clean of acute bay overnight with equipment to be left inside ▪Cube 7 requested to be deep cleaned and to have repeat HPV clean ▪Outbreak meeting to be scheduled	CB, DMT and wider stakeholders to include network Infection, Prevention and Control Team IPCG and CB IP&C groups

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Outbreak of Resistant Acinetobacter baumannii on T4 Neuro pending closure. NRI ID 118203	Outbreak meeting planned for 4th December – case likely to be closed. Excellent and improved audit results and compliance with screening noted since repatriation to T4 last month.	CB, DMTs and all wider stakeholders to include relevant Networks IPCG and CB IP&C groups
Review of ABO-incompatible (ABOi) blood protocol following NRI ID 86938	Protocol formally reviewed by transplant team in recent protocol meeting- awaiting formal publication	Clinical Director and Transplant Team

RECENT LEARNING OPPORTUNITY			
Source:	Datix reported as Nationally Reported Incidents (NRIs)	**Reference (if applicable):**	ID85431 ID98374

What happened / what was the problem?

Patients deceased on cardiac surgery waiting list

What was learned and how was this shared?

Key learning from Investigation into both incidents highlighted a significant discrepancy between waiting times on each surgeons waiting list with an absence of a pooled option for operations not requiring individual specialist skills.

What action has been taken or planned? What was the impact of this?

Strengthening of **cardiac surgery referral pathways, waiting-list governance, clinical oversight and accountability**

- **Single referral and triage pathway:** Introduce one digital point of referral, initially supported by a generic mailbox, with a defined minimum referral dataset. Referrals will ordinarily be pooled, with allocation according to waiting time unless specific surgical expertise is required. A Consultant of the Day model will provide clinical triage.
- **Formalise and assure the pathway:** Working group/consultant leadership established. In process of developing an SOP, communicate the agreed pathway across cardiology and neighbouring Health Boards, and use regular audit through the Cardiothoracic Quality & Safety Forum to monitor compliance.
- **Strengthen waiting-list governance:** Introduction of monthly multidisciplinary waiting-list management meetings, led by the Directorate Manager with Clinical Director oversight, with explicit challenge around clinical acuity, long waits and listing decisions. Consultant peer review will be considered if improvement is insufficient.
- **Improve monitoring and documentation:** Development of a digital patient database with visibility of key indicators; reinforce RTT requirements; establish consistent review of patients on waiting lists and a clear escalation process where clinical condition deteriorates.
- **Demand and capacity:** The cardiac surgery service specification self-assessment and demand/capacity forecast were completed and submitted to the Joint Commissioning Committee on 17 July 2026.
- **Regional engagement:** Re-engage cardiologists within Cardiff and Vale and neighbouring Health Boards so referrals consistently meet the agreed minimum dataset and new referral requirements.
- **Training governance:** Ensure equitable allocation of cardiac surgical trainees to recognised consultant trainers, with ongoing oversight through the Faculty Education Group four times per year and HEIW review every six months.

Overall assurance: The plan has moved beyond immediate mitigation, with an interim referral log and generic email route already established and the demand/capacity work completed. The principal outstanding actions concern full implementation of the digital referral/triage model, strengthened waiting-list governance and monitoring, with remaining milestones extending to March 2027.

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

Thoracic Surgery team celebrates 50th robotic-assisted procedure

Led by Consultant Thoracic Surgeon Mr Tom Combellack, the team began using the da Vinci Xi surgical system in April to operate on patients with known or suspected lung cancer. Its use for thoracic surgery is a first for Wales.

The expansion of robotic-assisted surgery into thoracic procedures is helping to improve equity of access to the technology and enabling patients to receive specialist care closer to home.

Evidence shows that patients undergoing da Vinci robotic-assisted surgery can experience shorter hospital stays, fewer post-operative complications, lower mortality and fewer blood transfusions compared with open or thoracoscopic surgery. The technology also gives surgeons enhanced visualisation, dexterity and precision, helping them to perform complex procedures through smaller incisions.

Mr Combellack said: “Operations on the chest are usually one of the most painful procedures to have. The robot not only maximises the chances of performing this operation through small incisions, it also reduces the pressure on surrounding tissues, in particular the nerves between the ribs. Consequently, we are seeing patients recover far quicker and with far fewer complications than we would normally see. The length of stay in hospital is also far less than surgery performed non-robotically.”

Lung cancer is the leading cause of cancer deaths in Wales and is often diagnosed at a late stage, when mortality rates are higher. Tom said: “By offering patients minimal access surgery with the lowest rate of bleeding and chance of other complications, we are providing the best chance of surviving lung cancer."



Critical Care had the opportunity to meet with Mabon ap Gwynfor MS, Cabinet Minister for Health and Care, and Jeremy Griffith, Welsh Government Director of Operations, as part of their recent visit to UHB to see how teams are improving urgent and emergency care.

The Critical care Team explained how they support some of the most seriously ill patients and discussions covered demand for the service, the constraints of an ageing clinical environment and future workforce, equipment and building requirements.

Building on Improvement While Recognising the Challenges

These conversations also explored wider pressures affecting patients and colleagues.

Increasing demand, longer hospital stays and delays in arranging the next stage of care can leave beds unavailable when other patients need them. Across the hospital, the age and condition of buildings also affect service delivery and development.

Addressing these issues requires coordinated work across hospital services, primary and community care, local authorities and other partners.



Compliment received in Stroke Services:

"I have been given your address by the Stroke Support team, and would ask if our gratitude for the wonderful service we have received from the NHS when Brabara suffered a stroke, could be sent to all departments involved.
From our first consultation with our GP at Stanwell Road Surgery in Penarth, through to; Heath Hospital A&E, the Stroke Team at the hospital, the doctors and nurses on ward C4, and after discharge the ESD Team. They have all given, Barbara myself and family, excellent caring support and advice, which I can best describe as, above and beyond expectations.

They can all be extremely proud of the support given, and I'm sure we are not an exception.

Thank you

Mr & Mrs xxxxx "

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS				
Case No	**Action**	**Due Date**	**Reason for Non Delivery**	**Risk (RAG)**
	Nil new for this reporting period			

NEW / CLOSED / AMENDED RISKS
N/A for reporting period

CLINICAL BOARD QUALITY UPDATE REPORT			
Governance Group:	Quality Committee	**Date of Meeting:**	30th November
Representative at Clinical Board Governance:	PCIC Clinical Board Quality, Safety & Experience Group	**Date of Meeting:**	17th November 2026

ITEMS FOR ALERT		
Issue / Risk	Actions Taken	Group Responsible
Risk ID: Primary, Community & Intermediate Care/2026-27/02 HMP Cardiff Healthcare Service Capacity and Sustainability **RR 20** There is a risk that safe, sustainable and continuous primary healthcare provision at HMP Cardiff cannot be maintained following notice given by the Clinical Director and the GP practice to terminate the current Service Level Agreement. Without a timely and viable replacement service model, this may result in reduced clinical leadership and GP capacity, disruption to continuity of care, delays in assessment, diagnosis and treatment, unmet physical and mental health needs, and regulatory non-compliance. In addition, limited or delayed access to secondary and acute mental health services may compromise the timely assessment and management of individuals with complex mental health needs, increasing the risk of clinical deterioration, self-harm, suicide, safeguarding concerns, emergency hospital admissions and avoidable harm within a highly vulnerable custodial population. National Reportable Incidents and near-miss incidents reported at HMP Cardiff in recent months, predominantly relating to mental health provision, are being investigated through the standard Patient Safety Learning review process. Emerging themes are being reviewed to identify contributory factors, inform service improvements and strengthen patient safety arrangements. These findings will also inform ongoing workforce, service and mental health provision reviews.	Although the HMP risk remains high at **20**, there is evidence of strengthened oversight: an interim senior mental health nurse has been appointed and historic NRI, PPO and HEIW learning is being consolidated into an improvement approach. A joint improvement plan is being implemented across both Clinical Boards, supported by regular oversight and monitoring. Learning from Patient Safety Learning Reviews are being used to inform service improvement actions, workforce planning and the ongoing review of healthcare and mental health provision within the prison. Further recommendations will be incorporated into governance and quality improvement plans as reviews are concluded.	PCIC & Mental Health Clinical Board
Risk ID: Integrated Community Care Services (ICCS)/2026-27/03 District Nursing Workforce Capacity Deficit Resulting from Registered Nurse Vacancies **RR 20** There is a risk that District Nursing cannot deliver	The service remains at high escalation/risk **20** because demand exceeds capacity, but recruitment/onboarding is progressing and PCIC Nursing is meeting **twice**	PCIC CB & UHB/Corporate Nursing for Nurse Recruitment Strategy

timely, preventative community care due to 23% registered nurse vacancies and sickness absence, resulting in delayed care, increased deterioration, avoidable hospital admission and patient harm.	**weekly** to support operational management. Positive patient/family feedback on end-of-life care provides additional qualitative assurance despite pressures.	

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Backlog of Continuing Health Care (CHC) case reviews within the adult and Older Persons Mental Health (OPMH) cohort. This includes, CHC and Funded Nursing Care (FNC) follow up reviews and the CHC. From a 1500+ caseload, 45% breached assessment review date in September. Appeals and Retrospective Claims Position is also backlogged with 48 cases activated awaiting review with a further 22 received = 70 pending. **Turnaround actions:** Prioritise CHC backlog reviews to ensure packages are appropriate, provide quality and safety of care and represents value for money.	Onboarding from recruitment to vacant posts is actively progressing to strengthen capacity and support a sustainable reduction in the review backlog. Two locality teams have been co-located to improve operational resilience, facilitate flexible deployment and maintain service cover. **Top 50 High Cost Adult CHC** A UHB-wide, clinically led programme has been established through the CHC Working Group, reporting into the CHC Programme Board. **Of the 15 Adult/Older Persons MH in top 50;** Reviewed since June 2026 = 7 Review date Planned in November = 2 Reviews not completed in the past year and Pending Review date = 6 A Project Initiation Document (PID) has been developed through turnaround actions for resourcing and structuring for a future All Age Complex Care provision in CAV.	Turnaround Board Optimising Complex Care Programme

Proposed community bed changes at St David's Hospital present a system risk. Expected flow improvements from the optimising flow programme have not to date been achieved; length of stay remains high and capacity constrained. **Turnaround actions:** The bed closures as part of the optimising flow programme is designed to financially support delivery of integrated end of life care strategy in the form of a social contract the UHB has with MacMillan.	Formal Staff Consultation under the All Wales Organisational Change policy will close on 18th November. A period of Public Consultation in line with the Clinical services Plan is being progressed through the planning team. Equality Impact Assessments, with identified risks and mitigations monitored. A Project Initiation Document (PID) has been developed through turnaround actions for all bed closures requiring sign off at turnaround board, given system risks to flow and capacity until system improvements are implemented and embedded.	PCIC Clinical Board with Medicine Clinical Board Turnaround Board
The Primary Care Prescribing Team reports patients attending UHW after being unable to obtain medicines from community pharmacies, with particular safety risks from delays to time-critical anti-epileptics. Difficulties appear linked to shortages and purchase costs exceeding reimbursement rates. The Prescribing Team have highlighted the need for a coordinated UK-wide response rather than individual pharmacy or prescription-level solutions.	The team is gathering patient and pharmacy details, encouraging Datix reporting and following up individual cases through the breach process. Engagement with Community Pharmacy Wales supports a coordinated, proportionate response that recognises and addresses the patient safety implications.	Primary Care Prescribing Team

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Rapid Assessments tools completed for		
AVT - Planned roll out of ambient voice technology in District Nursing and other Community Nursing teams to support contemporaneous record keeping and maximising staff time to care.	Use of Neighbourhood District Nursing funds to develop	Integrated Community Care Business Unit & PCIC
Summary Care Viewer - The Summary Care Viewer is a read-only, real-time view of key health and social care information sourced from Cardiff and Vale	PCIC involvement in pilot and roll out with Regional Partnership Board	Regional Partnership Board

systems and both local authorities. Records are joined using the NHS number, are not retained except for audit purposes, and currently have approximately 350 users. Live services include safeguarding, integrated discharge, community resource services, learning disability liaison, Safe@Home, and CAV 24/7; mental health, older people's services, health inclusion, and GP data are in development.	Workshop on 18th November 2026.	
Safety Alerts -	Internal Cardiff and Vale safety notices are now logged and monitored through **AMaT**, providing a central audit trail and oversight of compliance.	PCIC Clinical Board
Community Hospitals Tendable & Audit	Staff across grades have received relevant training, with ward-level audit activity increasing and good practice spreading between wards.	PCIC Clinical Board
2026/27 Flu vaccination – Uptake 50% and aligns broadly to last 25/26 uptake position	Winter campaign is progressing to protect staff, patients and services. There are walk-in clinics with dates and locations across CAVUHB. Further support being offered for bespoke delivery to hard-to-reach places i.e. Community teams.	Health Protection and Immunisation Business Unit and PCIC CB with PHW support

RECENT LEARNING OPPORTUNITY

Source:	Staff Story - Individualised Vaccination Plan	**Reference (if applicable):**	

What happened / what was the problem?

Stephen, a biochemistry staff member who had never previously received a staff flu vaccination because of severe needle phobia, was supported through a tailored approach.

What was learned and how was this shared?

Hannah used listening, topical anaesthetic cream, and a virtual-reality headset showing calming environments; Stephen planned to return and repeat the approach.

What action has been taken or planned? What was the impact of this?

Stephen is returning for the second year for his Flu vaccination and is promoting Flu vaccination for all staff through a video to support patient and staff safety.

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

PCIC has two RCN Nurse of the year finalists which will be on Thursday 19th November;

- Rhian Smith, Senior Nurse Palliative Care
- Josie Collins, Senior Nurse CAVHIS

Work with CTM is progressing towards agreed cross-boundary District Nursing principles. Weekly liaison and clearer coordination have already been established, particularly supporting end-of-life patients.

Compliments received across VCRS, Community Dental, Immunisation and particularly District Nursing provide qualitative assurance of positive patient experience, complementing quantitative safety measures.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non Delivery	Risk (RAG)
ID113015	Support for IO from patient safety team and Senior clinical Board Deputy director of Nursing. Final NRI meeting 30th November	28.10.2026	Delayed closure while report is finalised. IO capacity and complexity of case across a range of services.	

NEW / CLOSED / AMENDED RISKS

Regular senior review and deep dives of risks rated **16+** are taking place across business units. Reviews are challenging risk scores, ensuring risks remain current and identifying opportunities to reduce risk.

CLINICAL BOARD QUALITY UPDATE REPORT			
Governance Group:	CD&T Quality Committee	**Date of Meeting:**	
Representative at Clinical Board Governance:	Director of Nursing/Multi-Professional Teams	**Date of Meeting:**	

ITEMS FOR ALERT		
Issue / Risk	**Actions Taken**	**Group Responsible**
Radiology Information system (RISP) **Stable ops still not signed off since go live 1st June** • **Report transmission/messaging failures remain a key risk.** Manual monitoring and retransmission arrangements continue pending implementation and assurance of the permanent solution. • A number of **workflow and integration issues remain unresolved**, including GP/Primary Care referrer identification, which remains dependent on interface investigation and testing between Philips and Soliton. • **Critical results alerting, addendum and associated national reporting functionality remains incomplete**, with elements dependent on national as well as local/supplier resolution. • Duplicate patient record/global imaging issues remain under review, with wider dependencies on national demographic standardisation and NHS number data quality. • Outstanding technical issues and delivery timescales remain dependent on **Philips, Soliton, national programme/DHCW and internal PACS/IT capacity**, with delays impacting progression to Stable Operations. • Continued **administrative, clerical, clinical and PACS support remains an important patient-safety and operational mitigation**, particularly for manual checking, retransmission and workflows where anticipated digital integration benefits have not yet been realised.	• **Stable Operations sign-off remains deferred** pending deployment and testing of the permanent solution for report transmission failures and assurance that system stability has been demonstrated. • The **Philips reporting service pack remains pending deployment**. Release and testing by Philips is awaited before a production installation date can be confirmed. • Historical image migration is nearing completion, with final validation and assurance continuing ahead of cessation of the Fuji contract. • Data extraction and validation activity continues. • Local escalation and supplier engagement arrangements remain in place to maintain oversight of outstanding operational, technical and patient-safety issues	RISP programme board

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Laboratory Information Management System implementation (LIMS) Laboratory Medicine identified significant outstanding issues ahead of the planned Blood Sciences LIMS go-live on 16	System updates are being designed and implemented, and the risks continue to be managed through Laboratory Medicine and LIMS programme governance. Go live pushed back to	LIMS Programme Board / Laboratory Medicine / Regulatory compliance group

November 2026. These include aliquoting, electronic test requesting and the potential effect of delays on other health boards.	January/ February 2027 Implementation is expected to take place through a phased five-week rollout, but the precise start date remain subject to confirmation. Cellular pathology went live in January with microbiology (PHW) go live in September, both teams are still reporting difficulties with the system and a number of manual processes remain	
IR(ME)R incident	Reviews commenced for unintended cardiac CT exposure (ID124949) and two unnecessary infant pelvic X-rays (ID124898). Harm was assessed as low/negligible. Review scopes include referral and cancellation processes, delayed imaging, re-justification, previous-image checks, cross-specialty communication and capacity pressures.	Radiology QSE
Concerns and communication themes 99 complaints received and 93 closed between 1 August and 30 October 2026. Of those closed, 74 (79.6%) received a response on time. The leading complaint subjects were clinical treatment or assessment (34), appointments (19), and tests or results (17).	Individual cases continue to be investigated through the Listening to People process. Radiology and Therapies directorate have the largest volume of concerns. Booking teams are reviewing processes to improve timeliness of communications with patients about appointments, including options of healthcare comms as a tool to support this. A date for roll out is to be agreed The decline in response timeliness requires attention but driven by associated increase in volume and operational pressures. Performance monitored via directorate performance review	QSE Sub-Committee Directorate performance review

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Blood Transfusion workforce resilience action plan	A draft action plan in response to the All-Wales Transfusion Laboratory Workforce Capacity and Resilience Review has been completed. Priority risks and required investment are being translated into the annual planning process, with a risk assessment required for the Blood Health National Oversight Group by 30 November.	Laboratory Medicine / Blood Transfusion Quality Group / Executive Review
National Reportable Incident closure 3 NRI's remain under investigation, with closure dates in November and	IO's working with patient safety colleagues to progress learning reviews.	QSE Sub-Committee

December. 2 NRI's sat with radiology and should close within time. Due to complexity of one investigation, involving dietetics and a number of other services outside of the clinical board we may not meet the deadline for closure in November.	Point of contact are informing patients/ relatives if there are any delays in completing investigations	

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

Sustained positive patient experience. The Civica reports demonstrate patient ratings for feeling safe and overall experience remained above the 85% benchmark in every reported month from June to October 2026. In October, approximately 96% reported feeling safe in care and approximately 90% rated their overall experience positively. These scores are rounded in the source presentation.

Nuclear Medicine Physics and Radiology: national commendation for transforming patient experience. Team highly commended in Excellence in Diagnostics at the Advancing Healthcare Awards Cymru. Colleagues across clinical science, technology, radiography, administration and healthcare support contributed to a redesigned bile acid malabsorption testing service. Waiting times fell from around two years to less than two months, with scans now taking around five minutes in a more open environment.

Dietetic colleagues recognised at the Advancing Healthcare Awards Cymru 2026. "Care closer to home: transforming liver disease rehabilitation through home-based nasogastric feeding and reconditioning" in the New Ways of Working category.
"Virtual delivery and smartphone application for Foodwise for Life: an all-Wales community weight management programme" in Digital and Technology Innovation.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non Delivery	Risk (RAG)
47616	Develop a defined pathway for follow-up and surveillance of patients with ERCP stents with Radiology and referring specialties.	Jan 2025	Multi-stakeholder agreement on the final SOP has taken longer than planned. An electronic tracking system, such as scan for safety has not got the functionality required to prevent a similar incident, so a local solution involving microsoft forms and automated e-mail reminders is being deveoped. Will still require oversight by individual(s) to ensure patients are followed up Evidence to be submitted to WRP by 20th November	Amber

NEW / CLOSED / AMENDED RISKS

CLINICAL BOARD QUALITY UPDATE REPORT			
Governance Group:	C&W CB QS&PE meeting	**Date of Meeting:**	
Representative at Clinical Board Governance:	Clinical Board, Obstetrics & Gynaecology, Acute Child Health (ACH), Children Young People & Family Health Service(CYPFHS)	**Date of Meeting:**	

ITEMS FOR ALERT		
Issue / Risk	**Actions Taken**	**Group Responsible**
Richmond support services (domiciliary support) arm of Richmond Nursing Agency disbanded. On afternoon of Tuesday 26th May, informed that the whole of Richmond agency had gone into liquidation with immediate effect.	Currently 2 Adult Learning Disabilities packages of care supported by Beelong. Both cases being transferred over to registered nursing agency provision. Work ongoing with other agencies and the families to move over to care agencies on Care Inspectorate Wales (CIW) framework.	Children Young People & Family Health Service Directorate Management Team
Neurodevelopment Waiting Times Welsh Government allocation will not be sufficient to clear the three year waits, posing a reputational risk to the Health Board and continued risk of delay to children and young people awaiting assessment, diagnosis and treatment Significant number of concerns being received from families.	Insourcing and outsourcing have been completed. Additional hours agreed for existing team members to support the backlog. Remains on the risk register as a risk score of 15. Plan for Neurodevelopment delivery has gone to UHB Finance Group for ratification which has been agreed, however further funding gap of £200k identified.	Children Young People & Family Health Service Directorate Management Team / Clinical Board Senior Team
Total Bed Management Contract. There is a risk that compliance against the MHRA alert will not be met due to newly procured beds and cots are unable to accommodate the Dolphin and Aria Pro Mattresses.	Risk assessments completed and ongoing work with Procurement to identify appropriate options. Remains on the risk register as part of ongoing monitoring and mitigation of risks	Acute Child Health Directorate Management Team / Clinical Board senior team
Additional Learning Needs (ALN) Provision Expansion. Cardiff Education planning to commence increase in ALN provision over the next 18months by 300-600 places. Risk that this will not be limited to cohorting existing learners but will also include repatriation of out of area educational placements which will significantly increase the demand on	Regular meetings being undertaken to understand extent of plans, timing of delivery and cohort of learners included	Director of Nursing/ Children Young People & Family Health Service Directorate Management Team/Designated Education Clinical Lead Officer (DECLO)/Local Education

current Health Visiting, Special School services.		

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group responsible**
Ongoing Health Visiting (HV) Job Description review Risk that Industrial Action currently being undertaken in Cwm Taf Morgannwg (CTM) UHB Health Visiting Service may spread which will result in significant disruption to the service and affect child protection/safeguarding. Possibility of financial risk dependent upon decisions made.	Move via UNITE to move HV's in C&V to a collective Grievance stage. CTM UHB have settled on a decision. Further update is awaited.	Executive Director for People & Culture overseeing an all-Wales draft HV JD suite has been out to CYPFHS for comment but no further update received to date.
Requests from outside care providers for specific training in relation to long term care of tracheostomies and other related devices. Risk relates to legal position on confirming competence of non C&V UHB staff.	Production of a governance document which will be shared with the Corporate Governance Team and ECOD for advice. SBAR has been written and linking with ECOD to finalise before going to Nursing & Midwifery Board (NMB) for approval	Children Young People & Family Health Service Directorate Management Team – Standard Operating Procedure (SOP) being finalised and will need ratification Director of Nursing / ECOD
Potential of 3 children from Gaza to be sent to Children's Hospital for Wales (CHFW) in October for treatment.	X2 children confirmed in the first cohort (9yr old boy and 11yr old girl with immunodeficiencies). Multidisciplinary Team (MDT) meeting held with Welsh Government and arrival is imminent. X1 child with scoliosis – further update is awaited.	Acute Child Health Directorate Management Team/Clinical Board
Learning Disabilities Service Packages of Care / Continuing Health Care (CHC) Risk is that the care packages are not being regularly reviewed and monitored by Swansea Bay UHB due to capacity which may result in unnecessary financial impact for CAVUHB and potential clinical risk to patients.	£39M transferred over and increased our control over spend by £5.3M. Line of sight to 1.5M saving if package of care (POC) reviewed. Quality Impact Assessment (QIA) completed. SBAR to support additional resource for review of existing packages to go to Value Based Resource Group (VBRG) for approval. Exec to Exec conversations with Swansea Bay UHB ongoing regarding responsibility and resource. Following discussions with Price Waterhouse Coopers, work ongoing across the UHB to release Continuing Health Care assessing staff and registered Learning Disabilities	Children & Women (C&W) Learning Disabilities team are reviewing the top 40 cases. Need workforce to undertake the reviews and reduced packages. Discussed at turnaround meetings.

	nurses working within the UHB to support focused review of cases.	
Adult Learning Disability (CHC) Governance Arrangements There is a risk that the absence of formal governance and oversight arrangements for adult learning disability services limits the Health Board's assurance over the quality and safety of care. Reliance on information from Swansea Bay UHB for specialist inpatient and community services restricts visibility of emerging harm and assurance that patient safety standards are met.	Concerns regarding off-framework placements. Inability to obtain assurance around safety, quality and value of care provided due to main service responsibility sitting with Swansea Bay UHB. Regional Integration Fund (RIF) Funding slippage money to be used this financial year on procurement of Tricordent support, with expectation of a governance and oversight framework delivery. Work with Tricordent is progressing, regular update meetings are in place.	Director of Nursing & Children Young People & Family Health Service Directorate working through list of adult LD packages of care and seeking reviews. Continuing to link with Joint Commissioning Committee (JCC) where placements are via Commissioning Care Assurance and Performance (CCAP) framework. Will ensure part of the UHB's new complex care board.

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group responsible**
Datix Management	Targeted approach being undertaken across all Directorates to ensure that all incidents are being reviewed in a timely manner and that none are over a year old.	Clinical Board & Directorate Management Teams – weekly Clinical Board Datix review meeting established
Electronic Prescribing and Medicines Administration (ePMA) Rollout and Discharge Advice Letters (DALs)	Successful rollout across Gynaecology and Children's Hospital. Incomplete DALs issues being managed at ward level. Prep and comms regarding implementation of the requirement for DALs to be fully completed and signed off prior to discharge underway.	ePMA team producing comms plan and supporting materials which will be shared.
C Difficile/MRSA Performance Previous year significantly exceeded expectation targets in these areas	C. difficile performance had improved considerably, with 3 cases reported compared with 18 during the equivalent period the previous year. There had also been no MRSA bacteraemia's, consistent with the previous year.	Clinical Board and Corporate Infection Prevention & Control

RECENT LEARNING OPPORTUNITY			
Source:		**Reference (if applicable):**	
What happened / what was the problem?			
What was learned and how was this shared?			
What action has been taken or planned? What was the impact of this?			

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

Working Together to Make Change Happen Improvement Forum developed within the Clinical Board to engage with staff in improvement ideas and co-produce/co-deliver improvements that make a difference.

Walkabouts for NHS Staff Survey and promotion of staff flu vaccinations being undertaken to promote uptake of both.

Regular meetings with Heads of Education in Cardiff and Vale of Glamorgan in relation to Additional Learning Needs (ALN) Expansion

Imminent introduction of Penthrox analgesia to enable maximum utilisation of outpatient gynaecological procedures and avoidance of theatre requirements and general anaesthesia risks.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

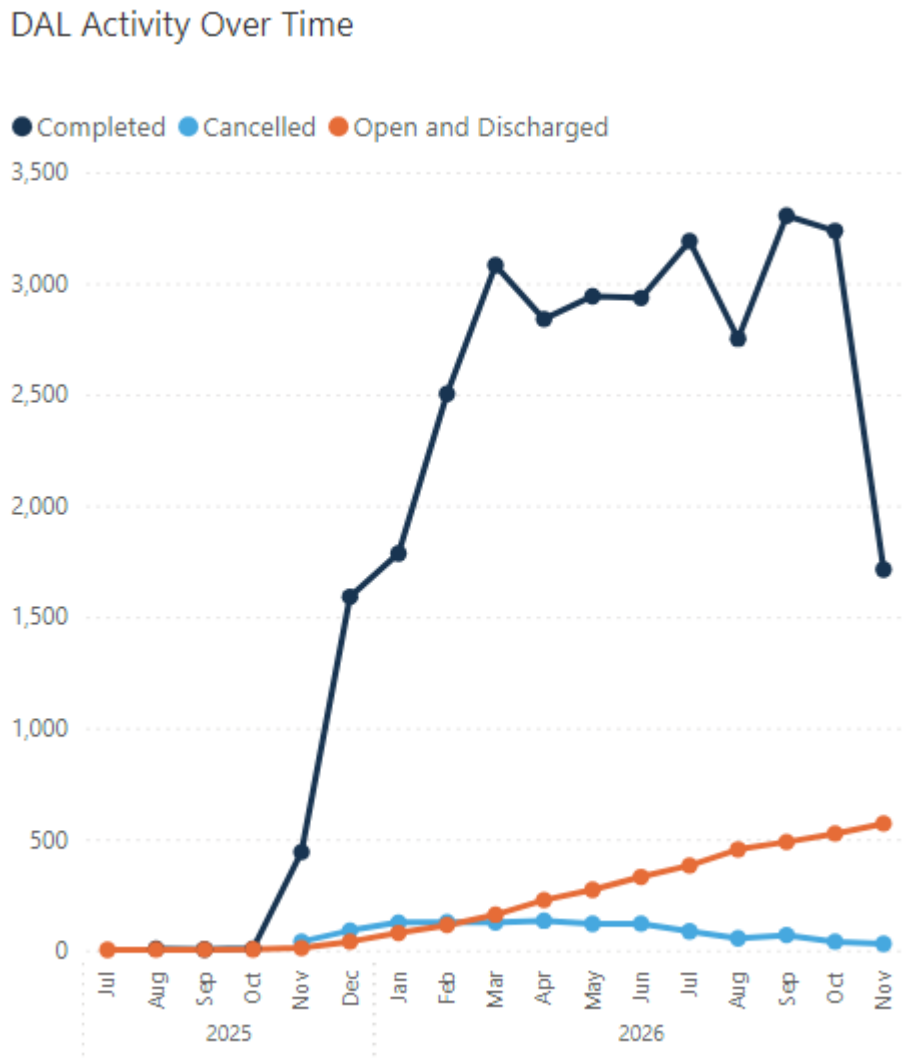
Case No	Action	Due Date	Reason for Non Delivery	Risk (RAG)
	X3 overdue NRI's:			
116341	Patient Safety Learning Review (PSLR) almost complete. Aim for December closure.	October 2026	Delay in completion of Patient Safety Learning Review (PSLR) due to impact of clinical work for Investigating Officer, and inability to contact staff member involved (bank) at present.	
116052	Final Draft of Patient Safety Learning Review (PSLR) with Patient Safety Team for review prior to sharing for factual accuracy. Closure meeting set for 23/11/2026. Aim for November closure	October 2026	Delay in allocation of investigating officer and impact of operational pressures for Investigating Officer.	
116363	Final Draft of Patient Safety Learning Review (PSLR) requires further amendment following closure meeting. Aim for December closure	October 2026	Further comments received following closure meeting from Patient Safety Team require review.	

NEW / CLOSED / AMENDED RISKS

No change since last meeting.

Governance Group:	Clinical Board QSE	**Date of Meeting:**	Executive Quality and Safety Committee
Representative at Clinical Board Governance:	Director of Nursing	**Date of Meeting:**	November 2026

ITEMS FOR ALERT

Issue / Risk	Actions Taken	Group Responsible
Incomplete ePMA Discharge Advice Letters	**Current position and action taken** The November recorded 320 incomplete discharge advice letters (DALs) across the Surgery Clinical Board as of 17th November 2026.  **Review and oversight** A dedicated member of staff has reviewed the DALs identified as outstanding across the Surgical Clinical Board during the past four weeks, and this review is nearing completion. This provides a clearer understanding of the backlog and supports targeted follow-up by the relevant directorates. **Additional assurance identified** Approximately 50% of patients with an outstanding DAL have a clinic	Surgery Clinical Board; Surgical Directorates; ward and specialty teams

ITEMS FOR ALERT		
Issue / Risk	**Actions Taken**	**Group Responsible**
	attendance letter on file recording the relevant admission dates, diagnosis, and follow-up plan. Although this does not remove the requirement to address incomplete DALs, it provides evidence that key clinical information has been communicated for a substantial proportion of affected patients. **For Dals not completed pre-September 1st 2026** Within Nerve centre ePMA, there is an option to cancel a Discharge Advice Letter (DAL). For patients who have already received a follow-up letter that adequately documents the reason for admission, clinical outcome, and ongoing management plan, a standardised comment could be recorded when cancelling the DAL. This comment should clearly state that the decision has been discussed and agreed at Clinical Board level and that the approach has been approved for all historical DALs outstanding prior to 1st September 2026. The comment should also acknowledge the associated risk that any medication changes made during the admission may not have been communicated to the patient's GP through the usual discharge process. Giving a consistent and clear audit trail of the decision-making process. **Actions to strengthen assurance for DALS not completed post 1st September** • Complete the review of outstanding DALs and provide directorates with targeted recovery information. • Continue directorate recovery action for every DAL that has not completed the mandated complete-and-send process. • Identify clinic attendance letters separately within performance reporting to show where key clinical information has already been communicated.	
Breast Validation	**Current situation** Patient tracking at the breast centre relied largely on manual, paper-based systems for mammography surveillance and referrals upgraded from urgent or routine to urgent suspected cancer (USC). These processes depended heavily on individual staff, leaving them vulnerable to staff absence. Long-term sickness absence involving two staff members exposed this dependency. These were escalated after new member of staff joined the team to support Five rapid patient reviews were completed. The reviews identified missed or delayed follow-up and gaps that could leave patients outside the intended surveillance pathway or review pathway **Actions under way**	SCB Triumvirate team and QSE structure

ITEMS FOR ALERT		
Issue / Risk	**Actions Taken**	**Group Responsible**
	Complete clinical harm reviews, pathway validation, and incident assessments, including consideration of duty of candour and redress. Maintain multidisciplinary team oversight and reconcile historic records with the new surveillance database. Validate urgent and routine lists, supported by tracking, referral-to-treatment oversight, and standard controls. Arrange an independent multidisciplinary fact-finding review – Deputy Director of Nursing will be completing the Patient Safety learning Review Complete the formal governance review, preserve relevant records, and investigate digital interfaces. Assess capacity requirements and develop a contingency recovery plan alongside validation activity **Validation update: position as of the 17th November 2026** The three validation streams are outlined above. Validation is expected to accelerate with two redeployed members of staff now supporting the work. **0 missed patients have been identified in the validation completed so far.** **1. Mammography surveillance: 3,200 patients** • 1300 patients have been reviewed; no missed patients have been identified. • The total cohort requiring validation is 3,200 patients. **2. USC upgrades (routine to USC)** • Of the 318 patients requiring review, 225 have been reviewed, with no issues identified. • Of the three original patients, two experienced no harm and have been discharged from the breast centre, initial indications show that 3rd patient has been discharged from Velindre and needs no further treatment however this needs to be confirmed via a formal harm panel **3. Uncashed clinics** • Ten patients identified who had not been listed have now been added to the waiting list, with no disadvantage to them. • Of the 600 patients in uncashed clinics, 100 have now been cashed, with no harm identified.	

ITEMS TO ADVISE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Complaint demand is concentrated in treatment, assessment, and appointments Recurring access, cancellation recovery and communication themes	**Assurance from complaints-resolution activity** Surgical Services maintained complaints-resolution activity during 1 August–30 October 2026, closing 263 complaints. This provides evidence of continued progress in bringing concerns to a conclusion during a period in which 330 complaints were received. Of the 263 complaints closed, 180 received an on-time response, representing 68.4%; therefore, more than two-thirds of completed complaints were responded to within the required timescale. A further 83 complaints were closed outside the response timescale. Although these responses were late, the cases have been completed: the 83 cases do not represent an outstanding backlog. September recorded the highest number of closures, demonstrating continued resolution activity. Early resolution remained in use, with 126 complaints managed through this route and 38 converted to the formal process. The conversion rate was **23.2%**, calculated against the relevant pool of 164 complaints, rather than all 330 complaints received. Approximately three-quarters of that pool therefore remained within early resolution at the reporting point. This provides assurance of continued use of early resolution, but does not establish that all non-converted cases had been resolved. Complaints analysis provides a clear focus for targeted improvement across Surgical Services. During **1 August–30 October 2026**, three subjects accounted for **281 of 330 complaints (85.2%)**: clinical treatment or assessment, 173 (52.4%), appointments, 73 (22.1%), and communication, 35 (10.6%). Clinical treatment and assessment therefore represent the largest opportunity for focused review and learning.	Surgery Clinical Board; Surgical Directorates; Patient Experience and Concerns teams
Risk-register oversight	The Executive Review reported 239 risks, with moderation required for two directorates. Weekly risk meetings were in the diary for emerging risks and QSE issues.	Surgery Clinical Board; Directorate QSE groups
National audit data gap	The Executive Review reported that the Health Board was not collecting pelvic-fracture data, and that identification of patients requires a Health Board-wide approach because only a proportion attend through trauma.	Surgery Clinical Board; relevant Clinical Boards; Clinical Effectiveness

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
Patient experience	Patient experience remains consistently positive, with confidence in safety a particular strength. Between June and October 2026, both reported	Surgery Clinical Board; Patient Experience

ITEMS FOR ASSURANCE		
Issue / Risk	**Actions Taken**	**Group Responsible**
remains above benchmark	safety and overall experience scores remained above the 85% benchmark. In October, approximately 95% of respondents felt safe in the service's care, while 89% reported a positive overall experience, around 10 and four percentage points above benchmark respectively. Feedback about staff highlights compassion and professional competence. Staff attitude and capability attracted 987 positive mentions, including 360 recognising compassion and 263 recognising professionalism and competence. Patients also praised friendliness, helpfulness and politeness. Communication with patients received a further 95 positive mentions, demonstrating strengths on which services can build. The feedback identifies specific opportunities to improve consistency. There were 35 negative communication mentions, covering listening and involving patients, communication with patients, information provision and communication between staff. The improvement focus is therefore to sustain compassionate, competent care while strengthening listening, patient involvement and the clarity of information provided. Together, the findings present a positive picture of patient experience with clear priorities for further improvement.	
Positive IPC performance in several standards	Tendable data was described as generally positive across nursing teams, with robust performance in ANTT, linen management and several equipment and environmental standards. Targeted work continues for cleanliness, hand hygiene, Bare Below the Elbow and peripheral vascular cannula compliance, with repeat and peer audit planned.	Ward Sisters and Charge Nurses; IPC; Surgery Clinical Board

NOT APPLICABLE			
Source:	Concern	**Reference (if applicable):**	
What happened			
Established a community erectile dysfunction service for men without urological cancer, addressing a service gap of over 10 years. By 16 November, 118 appointments had taken place. 1 Reduced the waiting list by approximately 25%, from 426 to 319. At current activity rates, the service projects clearing the backlog within 18 months.			
What was learned and how was this shared			
Telephone appointments support most follow-up care, accounting for 85% of follow-ups. Most patients leave the service after their first follow-up, with virtually all expected to do so after their second.			
What action has been taken or is planned, and what impact has this had?			
There is an opportunity to extend access through greater primary care awareness, promotion of the community HealthPathway and closer working with Endocrinology for patients with ED and low testosterone.			

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

• Tendable demonstrated positive IPC compliance, particularly in ANTT, linen management and several equipment and environmental standards.

University Hospital of Wales has achieved Gold status in the National Joint Registry (NJR) Quality Data Provider Scheme for 2026.

Position: Gold is the highest level within the NJR's three-tier Gold, Silver and Bronze award scheme.
Significance: The award recognises excellence in the quality, completeness and compliance of data submitted to the NJR, supporting robust monitoring of joint replacement outcomes and patient safety.

Standard: Hospitals must achieve a minimum **95% baseline compliance**, alongside stringent data quality audit requirements, to qualify for an award.

External recognition: UHW's Gold status will be displayed on its NJR Surgeon and Hospital Profile, with the achievement also included within the NJR's published Quality Data Provider award information.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for non-delivery	Risk (RAG)
ID 82094 ID 91732 ID 82952	Development of a Health Board SOP for referrals and follow up, including defined documentation standards, tracking, escalation timeframes, and role clarity. Transition to digital clinic outcome recording, eliminating paper COFs and improving auditability of follow-up decisions.	No confirmed completion date	Digital support and pathway redesign are underway as part of the Health Board's Lost to Follow Up programme to reduce harm led by the deputy COO from patients lost to follow-up. Progress is ongoing but, due to resource and capacity limits, a completion date cannot yet be confirmed. Interim assurance is provided through continued programme oversight, recognition of the residual risk and prioritisation of safer documentation, tracking,	Amber

			escalation timeframes and role clarity. The action remains Amber because delivery is dependent on digital capacity and pathway redesign; continued scrutiny is required until a confirmed implementation date and measurable milestones are agreed.	

Top 5 risks		
Ageing estates impacting patient care	Clinical areas may not receive urgent estates work quickly enough, affecting safety/functionality and care quality.	1) Agree and publish a prioritised programme of urgent works for high-risk areas 2) Continue joint estates/IPC/clinical inspections and update risk registers 3) Progress capital bids/rolling refurbishment programme (e.g., theatres) 4) Put contingency plans in place to minimise disruption to services.
No resident doctor cover for spinal service (OOH)	Spinal patients may face delayed assessment/treatment out of hours; unsafe and unsustainable reliance on trauma registrar and consultants.	1) Develop a business case for a resident SHO rota 2) Review and redesign OOH cover model to ensure protected spinal cover 3) Implement clear response-time standards and escalation pathways 4) Improve data collection/reporting on delays and outcomes.
No spinal navigation technology	Lack of image guided navigation increases risk of instrumentation error and serious harm; limits service capability and creates reputational/financial exposure.	1) Finalise and progress capital business case 2) Seek capital approval to procure navigation 3) Plan implementation to embed navigation into routine practice once approved.
Harm to patients on long waiting lists	Patients waiting extended periods may deteriorate without timely review; risk of harm, emergency	1) Implement a standardised harm review at defined waiting time thresholds 2) Strengthen risk stratification/prioritisation models

	presentations, and regulatory scrutiny.	3) Increase frequency of waiting list validation and review 4) Escalate capacity gaps through recovery/productivity planning with clear specialty accountability.
Incomplete Discharge Advice Letters (DAL) on ePMA	Discharge information not reliably sent to WCP/GPs; continuity and medication safety risks; potential complaints/scrutiny.	1) Require services to clear backlogs identified in reports 2) Mandate routine use of ePMA dashboards at ward/specialty level 3) Introduce regular governance reporting and escalation for overdue DALs 4) Clarify roles/responsibilities and provide targeted education/support for prescribers. 5) New process will be switched on 1/9/2026 that does not allow EPMA to produce a TTO without a DAL.

CLINICAL BOARD QUALITY UPDATE REPORT			
Governance Group:	Mental Health Clinical Board (MHCB) Quality, Safety and Experience (QSE)	**Date of Meeting:**	12 November 2026
Representative at Clinical Board Governance:	Mental Health Clinical Board	**Date of Next Meeting:**	10 December 2026

SUMMARY OF KEY ASSURANCE POINTS

Key alerts: Adult Inpatient Nationally Reportable Incident (NRI); Mental Health Act recording and capacity; Care and Treatment Plan (CTP) quality; medicines safety; Interpersonal Psychotherapy Training (IPT) recruitment; and Mental Health Services for Older People (MHSOP) Vale Community Mental Health Team (CMHT) nursing shortages.

- Refurbishment-related environmental and staffing risks remain under review.
- Oversight strengthened through the improvement plan, fortnightly Executive review, expanded efficiency meetings, walkarounds, audit and draft assurance framework.
- Reset Week targets Healthcare Inspectorate Wales (HIW), Datix, patient-safety, estates and training actions; outcomes remain to be confirmed.

Reported progress: Out of Area (OOA) beds at 2 on 10 November versus 10 on 12 October

ITEMS FOR ALERT

Issue / Risk	Actions Taken	Group responsible
HIW service-of-concern : Mental Health inpatient services have been considered through HIW's service-of-concern process. HIW's letter of 12 October 2026 confirmed that no formal escalation designation was being applied at that stage, pending evidence-backed organisational assurance. Recurring concerns relate to environmental safety and estates, Infection Prevention and Control (IPC), workforce competence and mandatory training, audit reliability, governance follow-through and organisational learning.	• **Improvement and assurance plan:** The MHCB has developed a consolidated HIW improvement and assurance plan addressing recurring inspection themes, with identified workstreams, accountable leads, milestones and evidence requirements. • **Executive oversight:** Strengthened governance through weekly clinical board oversight meetings, fortnightly Executive reviews, monthly HIW assurance reporting and routine monitoring within Directorate performance and assurance meetings. • **Estates and environmental safety:**	MHCB Management Team and Directorate leads, with Executive oversight and Corporate Nursing, Estates, IPC and Workforce support.

	Established coordinated oversight of estates concerns, including capital works, ligature risks, maintenance and ward environments. Introduced requirements for ward-level verification before actions are closed. • **Mandatory training:** Developed a training compliance tracker and commenced ward-level recovery planning for SIMA, basic life support and other safety-critical training. Additional training capacity and revised delivery arrangements are being progressed. • **Audit and assurance:** Strengthened independent ward walkabouts, IPC scrutiny and validation of local audit findings. Findings are being incorporated into Clinical Board quality and safety oversight, with audit schedule for themes developed for implementation December 2026. • **Leadership and accountability:** Increased visible senior leadership activity and commenced development of an accountability framework clarifying ward, Directorate and Clinical Board responsibilities. • **Action monitoring:** Strengthened AMaT monitoring of outstanding HIW and patient-safety	

	actions. Between the reporting extracts of 16 November, outstanding HIW actions reduced from 48 to 45, with patient-safety actions reducing from 150 to 144. • **Organisational learning:** Initiated arrangements to share inspection themes and learning across services in mental health, including HIW seven-minute briefings and a review of recurring findings.	
Adult Mental Health have reported an NRI following a severe inpatient incident following absence without leave (AWOL) and ingestion of a caustic substance.	A rapid review has been completed. The Rapid Review identifies the need for further investigation of cumulative risk, leave management, escalation following self-harm and multidisciplinary team (MDT) decision-making which has formed the terms of reference. The incident has been reported as a Nationally Reportable Incident, and reviewer has been allocated to support this, with regular follow up meetings booked in.	Adult Mental Health and QSE Senior Nurse
Mental Health Act statutory and information risks remain an alert. Patients detained to Emergency Assessment Suite (EAS) without an available bed state cannot always be recorded correctly on the PARIS system, creating inaccurate monitoring and a risk that staff may not have timely visibility of detention or leave status.	A meeting has been held with Adult Mental Health and Digital Services to explore system solutions. As PARIS is due to be replaced, further system development is not being progressed. Existing recording workarounds will continue until the replacement system is introduced, although these do not fully mitigate the identified risks.	Mental Health Act Office, MHCB, Adult Services, Digital
Adult Mental Health reports concern that the CTP compliance improvement process may weaken quality and co-production, including clinical ownership, patient involvement,	A structured CTP quality improvement programme has been established, including the development of co-produced training, therapeutic 1:1 guidance, carer information and	Adult Mental Health and QSE Senior Nurse

recording of agreement and administrative role boundaries.	revised CTP policy. Two quality audit reviews involving 25 and 35 records have been undertaken, identifying priorities relating to co-production, patient and carer involvement, clinical ownership, meaningful reviews and personalised safety planning. Three introductory All-Wales training modules have been drafted with HEIW support. Monthly CTP and therapeutic 1:1 audits are being introduced through AMaT from December 2026. Development of a Copilot-supported quality assurance tool is also progressing, with a pilot planned for December, subject to validation and governance approval. Further work is required to demonstrate sustained improvements in CTP quality alongside achievement of the 90% completion threshold.	
Medicines safety remains an alert. Pharmacy reports ePMA/DAL mismatches and use of paper charts, particularly in admission wards, with variable uptake of PMS system training. This creates transcription, duplication and medicines-authorisation risks.	Pharmacy-led controls have been strengthened to address ePMA/DAL discrepancies and associated medicines-safety risks. Incomplete DALs are challenged before dispensing, with outstanding documentation identified through the Incomplete Discharge Report and returned to prescribers for completion. Mandatory ePMA fields have been introduced, alongside agreed guidance and posters addressing duplication between electronic prescribing and Crisis Team paper medication charts. PMS training resources have been circulated to clinical teams. Pharmacy continues to monitor incomplete DALs, with six outstanding from 887 created (0.7%) in the November executive review. Further ward-level assurance, audit and incident	Medical, Nursing, Administrative staff and Pharmacy

	monitoring are required to demonstrate sustained effectiveness.	
MHSOP community capacity remains under pressure, with critical staffing shortages within Vale CMHT. By 11 December 2026, the Vale part of CMHT is expected to have no nursing staff available because vacancies will rise to 4.32 WTE across the wider CMHT and Vale is also affected by long-term sickness.	A Quality Impact Assessment has been completed by the MHSOP Lead Nurse, supported by a workforce and patient-safety SBAR developed by the Community Senior Nurse, to evidence the impact of reduced community nursing capacity. Risks have been escalated through Clinical Board governance. Two Band 6 CPN vacancies have been through vacancy panel, with a further 2 pending. A review of 40 patients requiring reallocation identified 10 suitable for transfer to social work colleagues, leaving 30 requiring alternative care-coordination arrangements. Concerns raised by the Local Authority regarding workforce pressures and the sustainability of integrated working have been highlighted. Urgent recruitment decisions and interim workforce mitigations remain necessary to reduce risks of delayed intervention and have been actioned with temporary redeployment to support the community patients.	MHSOP Directorate Nursing Teams
ITEMS TO ADVISE		
Issue / Risk	**Group responsible**	
Clozapine myocarditis screening	Pharmacy has introduced a Clozapine myocarditis screening tool and new guidance is now live and shared with teams. This strengthens the framework for monitoring patients commencing clozapine and supports early identification and escalation of potential myocarditis.	Medical, Nursing and Pharmacy teams
Service for High-Risk Eating Disorders (SHED) Update	A comprehensive SHED improvement programme has been implemented following	Adult Mental Health (AMH) Directorate, MHCB

	identified concerns regarding clinical safety, governance, workforce capacity and service sustainability. Actions undertaken include retrospective reviews of clinical caseloads, discharges, incidents and complaints; establishment of enhanced weekly assurance arrangements; strengthened clinical supervision and risk escalation; and implementation of interim leadership arrangements. Recruitment and workforce stabilisation measures have progressed alongside staff wellbeing support. An external review has been completed, with recommendations informing the development of an integrated Tier 2/Tier 3 eating disorder pathway and revised operating procedures with Cwm Taf Morgannwg UHB. Funding has been agreed for external transformation support through Royal College of Psychiatry. Enhanced Clinical Board oversight continues while we await 8c Project Leads to start January 2027.	
MHSOP and Neuropsychiatry report amended environmental and operational risks during refurbishment of the East Wards. Completion due February 2027.	A Quality Impact Assessment has been undertaken and identified the requirement for one additional HCSW on long-day and night shifts to mitigate increased risks associated with temporary ward relocations. Daily staffing reviews incorporate SafeCare, patient acuity, enhanced observations and professional judgement. Structured relocation plans have been introduced, incorporating environmental safety assessments, ligature and falls risk controls, fire safety, equipment readiness and ward-level safety checks. A further five-	MHSOP Directorate

	ward ligature review is planned for February 2027 following completion of the refurbishment programme.	
ITEMS FOR ASSURANCE		
Issue / Risk	**Group responsible**	
EPMA and Crisis Teams	Pharmacy reports that guidance has been agreed and posters disseminated to address ePMA and Crisis Team paper medicines-chart interface problems and duplication.	Ward doctors, Crisis Team and Pharmacy
The reported out-of-area (OOA) bed position has improved to 2 as at 10 November 2026. This is lower than the 10 reported on 12 October 2026.	A programme of improvement has been undertaken to reduce reliance on out-of-area placements. This has included enhanced consultant-led clinical oversight, strengthened multidisciplinary OOA board rounds, direct engagement with external providers and proactive review of discharge and repatriation opportunities. A four-week pilot of dedicated consultant sessions demonstrated improvements in clinical decision-making, earlier identification of discharge barriers and increased use of community alternatives, including Crisis Services and Cynnwys. Executive authorisation arrangements have been introduced to strengthen scrutiny of new OOA placements and ensure local alternatives are fully explored. A Directorate improvement plan has also been developed to strengthen inpatient flow, reduce length of stay, improve discharge planning and address delayed transfers of care. These combined measures have been accompanied by a reduction in OOA placements from **10 in October to 2 in November 2026 (80%)**. Continued monitoring is	Adult Mental Health Directorate Management Team, with MHCB Nursing and Operations oversight

	required to demonstrate that this improvement is sustained.	
Datix position: A structured recovery programme has been developed to address the historic open-incident backlog while maintaining investigation quality, organisational learning, Duty of Candour and safe closure standards.	A structured Datix recovery programme has been implemented across the Mental Health Clinical Board, supported by dedicated Datix closure days and a focus on reset week, targeted incident-management training and enhanced senior nursing and operational oversight. Actions have included validation of historic incidents, review of incident ownership and harm grading, prioritisation of severe and catastrophic incidents, and focused closure workshops with Patient Safety colleagues. Weekly monitoring and Directorate escalation arrangements have been strengthened, alongside Executive scrutiny of recovery trajectories. A dedicated Reset Week has further accelerated incident reviews and the progression of outstanding patient-safety actions. These measures have contributed to a sustained reduction in the historic backlog, with open incidents reducing from 1,489 to 803 by September 2026, representing a 46.1% reduction. During November Reset Week, a further reduction from 738 to 558 was reported.	Directorate Management and Senior Nursing Teams, supported by Patient Safety colleagues and MHCB QSE oversight.

RECENT LEARNING OPPORTUNITY			
Source:	HIW escalation response and ward walkaround programme	Assurance walk round feedback and 7 minute briefing.	Assurance walk round feedback and 7 minute briefing.
What happened / what was the problem?			
The senior ward walkaround on 30 October 2026 recognised good patient care and positive patient feedback, but also found recurring environmental, IPC and assurance concerns consistent with HIW themes. These included damaged curtains, damp, cleanliness and waste issues, unsecured equipment and medicines, fire-safety and blocked-exit concerns on East 4, missed fridge checks, expired food and incomplete environmental checklists. Variable policy awareness, unclear			

responsibilities and limited training availability were also noted; training compliance levels were not assessed. Patient-experience themes included meaningful activity, food choice, privacy, handovers and ward rounds. This was a high-level walkaround, not a full inspection, and not all records were reviewed.

What was learned and how was this shared?

Checks and audit records must reflect observed practice, and completing a form or requesting a repair does not demonstrate that a concern has been resolved. Every action needs clear ownership, escalation, support and a recheck to establish lasting improvement. The 7 Minute Briefing is intended for sharing with all staff, reinforced through team huddles and handovers. Good practice identified for wider sharing included Maple's food labelling, Daffodil's date and temperature checklist and mandatory-training clinics, MHSOP fridge checks and Tendable peer audits, and Cedar's patient information and ward organisation.

What action has been taken or planned? What was the impact of this?

Findings will be collated in a tracker with owners, timescales and evidence of resolution. Visiting senior teams will provide local feedback and support, with Senior Nurses and ward managers verifying completion before immediate actions are closed. Follow-up includes addressing Maple's expired oxygen cylinders and replacing the patient kitchen door handle; the company has been contacted and replacement is under way. The same senior teams will be providing individual feedback to ward managers. Tendable peer audits are planned across all areas, alongside huddles that agree priorities, owners, support and how effectiveness will be checked. The visits identified good practice and immediate follow-up needs; sustained resolution remains to be verified.

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

Rhiain Lewis Senior Nurse for QSE has developed and shared mandatory-training compliance analysis to support targeted improvement across Adult and MHSOP inpatient areas. A new share point is being developed for each area. Ward Managers on Meadow and Dafodil have developed 'mandatory training clinica' on a Monday and Tuesday morning which has supported increase in compliance. This approach has been shared across the inpatient areas.

Inpatient Ward Mandatory Training Progress - All Staff Level 1

September to October 2026 | Weighted required-versus-achieved compliance | Target 85%

Wards improved	At/above 85% in October	Comparable wards	Absent October wards	
	13	9	17	0

Like-for-like basis: all-staff Level 1. The final October extract includes all 17 wards; Level 2/3 is reported separately in Inpatient Compliance.

Service	Inpatient area	September Level 1	October Level 1	Change (pp)	October RAG	Direction	October data coverage
Adult	Alder Ward	95.6%	95.3%	-0.4 pp	Green	Declined	Complete
Adult	Daffodil (Llanfair Unit)	94.5%	97.8%	3.2 pp	Green	Improved	Complete

Adult	Maple Ward	87.5%	87.5%	0.0 pp	Green	No material change	Complete
Adult	Meadow Ward	87.7%	89.1%	1.4 pp	Green	Improved	Complete
Adult	Hazel Ward	79.3%	76.7%	-2.6 pp	Amber	Declined	Complete
Adult	Cedar Ward	81.8%	85.0%	3.2 pp	Amber	Improved	Complete
Adult	Beech Ward	73.5%	71.9%	-1.6 pp	Red	Declined	Complete
Adult	Willow Ward	66.5%	68.6%	2.1 pp	Red	Improved	Complete
Adult	Pine Ward	67.2%	70.3%	3.1 pp	Red	Improved	Complete
Adult	Oak Ward	68.6%	73.3%	4.7 pp	Red	Improved	Complete
MHSOP	Ash Ward	87.0%	92.0%	5.0 pp	Green	Improved	Complete
MHSOP	Llandough East 12	87.1%	91.7%	4.6 pp	Green	Improved	Complete
MHSOP	Llandough East 16	85.5%	91.2%	5.7 pp	Green	Improved	Complete
MHSOP	Llandough East 10	77.1%	80.8%	3.6 pp	Amber	Improved	Complete
MHSOP	Llandough East 18	76.4%	83.8%	7.4 pp	Amber	Improved	Complete
MHSOP	ST Barrucs	70.4%	89.6%	19.2 pp	Green	Improved	Complete
MHSOP	Llandough East 14	72.1%	91.5%	19.4 pp	Green	Improved	Complete

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non-Delivery	Risk (RAG)
	Protocol for harmful substances	Originally due September 2026; final ratification remains outstanding.	Presentations due at the PCIC and C&W clinical board QSE, and then will return to medicines safety for final ratification	Amber
	Complex Emotional Needs Pathway	Revised completion: December 2026.	Psychological-interventions and next steps to be agreed with Head of Speciality and Clinical Board Director following meeting with psychology 16th November 2026.	Red

NEW / CLOSED / AMENDED RISKS

Environmental safety, estates and infection prevention and control remain key risk areas, including unresolved maintenance, ligature, equipment and cleanliness concerns, and the risk that local audits do not accurately reflect ward conditions. The Estates Improvement Plan sets out a consistent approach across Adult Mental Health and MHSOP to recording, tracking, escalating, verifying and closing estates work, supported by a master register and monthly oversight meeting. The HIW assurance plan also requires documented interim controls for unresolved risks, separate identification of capital-dependent actions and verification that completed work has addressed the underlying concern.

Workforce competence and safety-critical training remain areas requiring assurance, particularly the risk of staff undertaking restrictive interventions or other safety-critical activities without the required training and competence. The HIW assurance meeting on 6 November recorded the requirement for ward-level Strategies and Interventions for Minimising Aggression (SIMA) improvement trajectories across Adult Mental Health and MHSOP, alongside work to increase training capacity and consider future delivery options.

The risk of false assurance from audits and compliance reporting is explicitly recognised in HIW's concerns. The improvement approach therefore requires environmental and IPC audits to be validated against observed ward conditions, with reinspection and re-audit used to establish whether actions have resolved the underlying issues rather than relying on documentary completion alone.

Governance and action delivery remain risk areas where actions are overdue, repeatedly re-dated or recorded as complete without evidence of reduced risk. The improvement plan requires named accountability, target dates, identification of residual risks and explicit interim controls for overdue actions. The draft Accountability and Assurance Framework reinforces the distinction between completing an action and demonstrating that the resulting improvement is effective and sustainable.

Report Title:	Summary of Recent Healthcare Inspectorate Wales (HIW) Inspection Reports		Agenda Item No:		7.2
Meeting:	Quality Committee	Public	X	Meeting Date:	30/11/2026
		Private			
Lead Executive Title:	Executive Nurse Director				
Report Author/s Title:	Deputy Head of Quality, Safety and Organisational Learning/Assistant Director of Quality and Patient Safety				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

The UHB has received correspondence from HIW raising concerns around recurrent themes in Mental Health services around environmental safety and estates maintenance, infection prevention and control, completion of mandatory training and the reliability of local audits. A comprehensive overarching improvement plan was developed and shared with HIW and will be subject to ongoing monitoring by both the UHB and HIW.

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

HIW provide oversight of independent healthcare contractors across Wales undertaking a programme of regular inspections.

No requirements for immediate improvements were issued following any of the inspections.

The inspections highlighted strengths in governance arrangements, safeguarding processes, patient experience and service leadership. Whilst opportunities for improvement were identified, these primarily related to environmental maintenance, infection prevention and control processes, workforce documentation, patient information, Welsh language provision and medicines management arrangements rather than concerns regarding the quality of clinical care delivered. Issues identified in relation to emergency medicines and stock control were addressed promptly by practices during inspection activity.

Improvement plans have been developed in response to all findings and arrangements are in place to monitor implementation through established Primary Care governance processes, providing assurance that identified learning and improvement actions are being progressed.

Board/Committee Response Required ***(please select only one)***					
Assurance		**Approval**		**Information/Noting**	x

Recommendations

The Committee is asked to:

1. **NOTE** the recent inspection activity undertaken by HIW and the processes in place to assure the ongoing progress with the improvement plans.

2. **NOTE** the recent correspondence from HIW around the recurrent themes from Mental Health Inspections and the UHB processes in place to progress the required improvement work and to ensure sustained improvements.

Governance Route *(please list all other Committee/Groups this report has been to)*

***Where** it's been:*	
***When** it went:*	
***What** decision was made:*	

Main Report
Background & Current Situation

Mental Health Services
On 12 October 2026, the UHB received correspondence from Healthcare Inspectorate Wales (HIW) pointing out repeated patterns of findings arising from HIW inspection activity across Cardiff and Vale UHB Mental Health Services. The letter explained that these inspections had noted many positive findings including compassionate and respectful care, positive staff patient interactions and person-centred care planning. However, there were recurrent themes around environmental safety and estates maintenance, infection prevention and control, completion of mandatory training and the reliability of local audits.

The UHB response highlighted the programme of ward refurbishments that was currently underway within Mental Health Services for Older People and Adult Mental Health. The ward environment on wards East 18,12, 16, 10 and 14, and the rolling programme of ward refurbishment underway in Adult Mental Health, with Maple Ward currently undergoing refurbishment. The extensive review and recruitment to the multidisciplinary team continued with most posts appointed to, other than a psychology post. There is a plan to review existing team structures to release funding to appoint to psychology posts.

In response to the concerns raised by Healthcare Inspectorate Wales, the Mental Health Clinical Board has implemented a programme of actions to strengthen governance, oversight and assurance across inpatient services. An accountability framework has been established, setting clear expectations and responsibilities for Senior Nurses, Lead Nurses and Directorate teams in relation to environmental safety, ward assurance and escalation processes. All inpatient wards have completed the All-Wales Ligature Risk Assessments, with remaining actions due for completion by the end of November 2026. Environmental walkrounds and assurance processes are being standardised across Mental Health services, supported by regular estates reviews, strengthened risk monitoring arrangements, enhanced oversight of mandatory training compliance and the development of recovery plans for areas below required compliance levels. It was noted that there was a programme of capital refurbishment underway in Mental Health Services for Older People to improve the environment of wards

The Clinical Board has also introduced strengthened quality assurance and organisational learning arrangements. A comprehensive audit programme has been developed covering Care and Treatment Plans, WARRN, Nursing Intervention and Reassurance Observation Systems audits, with these incorporated into a Clinical Board audit forward plan and governance reporting structure from December 2026. Peer review processes and enhanced validation of ward inspections have been introduced to improve the reliability of assurance information. In parallel, a thematic review of recommendations arising from Patient Safety Learning Reviews and HIW improvement plans is underway, alongside the development of a single overarching Mental Health Improvement Plan to coordinate improvement activity. Workforce measures have included enhanced staffing oversight through the Mental Health Staffing Hub, fortnightly workforce review meetings, expansion of multidisciplinary team provision, and ongoing Executive-level oversight of improvement delivery and progress reporting through the Quality Committee.

A meeting took place between HIW and the UHB on 5th November 2026 where the improvement work was noted. It was agreed that the UHB would share progress with the overarching improvement plan monthly and a further meeting would take place in early 2027 to review.

The overarching improvement plan has been shared in appendix 1.

Primary Care
Healthcare Inspectorate Wales (HIW) undertakes a programme of inspections across General Medical Services (GMS) and General Dental Services (GDS) to assess compliance with the Quality Standards 2023 and relevant regulatory requirements. Following receipt of inspection reports, the UHB Primary Care Team reviews findings, monitors delivery of improvement actions, follows up any immediate assurance requirements and seeks assurance that recommendations have been appropriately addressed through practice improvement plans and governance arrangements. During the reporting period, HIW published inspection reports relating to Rhoose Dental Practice, East Street Dental Surgery, Restore Dental Group and Whitchurch Road Surgery.

Rhoose Dental Practice (GDS)
HIW undertook an inspection of Rhoose Dental Practice in July 2026. The inspection identified a number of positive findings, including positive patient experiences, effective governance arrangements, strong safeguarding processes and effective infection prevention and control measures. Patients provided positive feedback regarding the care and treatment they received, and inspectors identified a culture focused on quality and continuous improvement. No areas requiring improvement were identified. The report provides assurance regarding the quality and safety of services delivered by the practice.

You can read the full report and improvement plan at: 20260721RhooseDentalEN.pdf

East Street Dental Surgery (GDS)
HIW undertook an inspection of East Street Dental Surgery in July 2026. HIW identified positive patient experiences, effective governance arrangements and appropriate safeguarding processes. No immediate improvements were required. Recommendations focused on strengthening infection prevention and control arrangements, workforce documentation and aspects of governance and record keeping. An issue relating to the availability of the correct paediatric emergency medicine formulation was identified during the inspection and addressed immediately by the practice. An improvement plan has been developed, and implementation continues to be monitored through Primary Care governance arrangements.

You can read the full report and improvement plan at: 20260728EastStreetDentalEN.pdf

Restore Dental Group (GDS)
HIW undertook an inspection of Restore Dental Group in July 2026. The inspection identified positive patient feedback, effective leadership and appropriate clinical governance arrangements. No immediate improvements were required. Recommendations focused on environmental maintenance, patient information, Welsh language provision and aspects of governance and documentation processes. The practice has developed an improvement plan in response to the findings and progress continues to be monitored through established governance arrangements.

You can read the full report and improvement plan at: RestoreDentalGroupEN.pdf

Whitchurch Road Surgery (GMS)
HIW undertook an inspection of Whitchurch Road Surgery in July 2026. HIW identified a number of positive findings, including effective leadership and governance arrangements, positive patient experiences, multidisciplinary team working and arrangements to support

patient access to services. During the inspection a number of expired items were found within store cupboards, including skin cleansing wipes, syringes, diagnostic tests, dressings and oxygen administration tubing, this issue was resolved immediately. Further recommendations focused on medicines and stock management processes, workforce documentation, patient information and Welsh language provision. Expired stock items identified during the inspection were removed immediately and appropriate actions were implemented by the practice. Progress against the improvement plan continues to be monitored through established Primary Care governance arrangements.

You can read the full report and improvement plan at:
20260729WhitchurchRdSurgeryEN.pdf

Overall, the inspections demonstrated that services were providing safe, effective and person-centred care, with positive patient experiences reported across all inspected practices. No immediate non-compliance notices were issued and one practice, Rhoose Dental Practice, required no improvement actions. Common themes arising from the inspections included infection prevention and control arrangements, workforce documentation, medicines and stock management, premises and environmental standards, patient information and Welsh language provision. Improvement plans have been developed in response to all inspection findings and continue to be monitored by the UHB Primary Care Team through established governance arrangements. The Committee can take assurance that appropriate action has been taken in response to the inspection findings and that arrangements are in place to monitor delivery of outstanding actions and embed learning arising from the inspections.

Organisational Learning
Common themes arising from primary care inspections included governance and assurance arrangements, workforce documentation, infection prevention and control, medicines and stock management, patient information, environmental standards and Welsh language provision. Learning will continue to be shared through Primary Care governance structures to support quality improvement, strengthen assurance processes and promote the consistent application of good practice across primary care services.

Appendices:

- 7.2b - Mental Health Improvement Plan 20261116

Strategic Alignment – Shaping Our Future Wellbeing:

Putting People First	x	Providing Outstanding Quality	x
Delivering in the Right Places	x	Acting for the Future	

Impact Assessment
Risk*:* Yes
inspection findings identified risks requiring monitoring and action plans.
Safety*:* Yes
inspection findings relate directly to quality and patient safety.
Financial*:* No
Workforce*: Yes*
Actions include training, staffing, leadership, and culture improvements.
Legal*:* No
Reputational: Yes
HIW inspection reports are published in the public domain.
Socio Economic*:* No - *https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health*:* No
Decarbonisation*:* No

Welsh Language*:* No

Mental Health Improvement Plan November 2026

Root Cause/Recommendation	Recommended Action	Designation of Person Responsible for the Action	Timeframe for Completion of the Action:	Evidence of Progress and Completion	
Strategies and Interventions for the Management of Aggression (SIMA)	Decision around the delivery of an accredited Violence and Aggression Training course	**Director of Operations**	**January 2027**	Development of an options appraisal to explore the benefits of commissioning an external accredited course or continuing with UHB model and progressing accreditation- Complete Work underway to explore the logistics of accrediting the UHB programme – December 2026	
	Review of training compliance on each ward and delivery against improvement trajectory	**Director of Nursing**	**March 2027**	Complete with plan to achieve 85% by March 2027	

	Ensure training team capacity to increase SIMA training capacity.	**Director of Operations**	**December 2026**	Discussion with executive team to support secondment of fixed term training post to support enhanced delivery – complete Agreed and posts are advertised	
	Develop and deliver a SIMA refresher training course for those who have previously undertaken the full training	**Director of Operations**	**February 2027**	Discussions with ABUHB to review their refresher model	

Capital Estates Improvement programme	Capital refurbishment of MHSOP wards to ensure a dementia therapeutic environment	**Director of Operations**	**February 2027**	Work ongoing • **East 18**: Complete by 9 November 2026 with new flooring, handrails and decoration to footfall areas and bedrooms. complete • **East 12**: Complete by 7 December 2026 with new flooring, handrails and decoration to footfall areas and bedrooms. In progress • **East 16**: Complete by 4 January 2027 with new flooring and handrails. • **East 10**: Complete by 25 January 2027 with new flooring, handrails and decoration to footfall areas and bedrooms. • **East 14**: Complete by 19 February 2027 with new flooring and handrails.	

	Capital refurbishment programme in Adult Mental Health • Cedar ward flooring replacement and refurbishment • Elm Ward – refurbishment of ward • Alder Ward – redecoration and development of a seclusion suit • Maple ward refurbishment – underway • Explore inclusion of Oak Ward bathrooms and redecoration if feasible within financial year.		**February 2027**	Cedar ward – complete January 2025 Elm Ward refurbishment – complete January 2026 Alder ward –Complete August 2026 Maple Ward – ongoing Feb 2027 To be discussed with Estates team and added to tracker. Bathroom refurbishments need to be progressed Ash Ward - plan to commence in feb 2027	
Estates Maintenance	MHCB Estates tracker to be developed and reviewed monthly by Director of Operations, Director of Nursing and Capital Estates and Facilities	**Director of Operations**	**December 2026**	In progress	

	Annual ligature assessment completion	**Director of Nursing**	**November 2026**	Assessment complete as of October 2026 • All wards assessed with three workbooks remain in progress	
	Balcony maintenance MHSOP Cleaning of balcony areas underway to include cleaning of guttering Integrity of roof checked and cleaning and repair of guttering, balconies and pathway		**November 2026**	Work underway	
	Oversight of all estates issues at Efficiency and Assurance meeting fortnightly		**November 2026**	Commenced 2nd November 2026	
Training competence	Development of a mandatory Training competence tracker to provide oversight of compliance levels on every ward	**Director of Nursing**		Complete and updated	
	Ward trajectories in place to support compliance to 85% • Oversight to be included in the Efficiency and Assurance meeting agenda		**March 2027**	Complete Add link to live tracker Commenced 2nd November 2026	

Environmental and Infection and Prevention and Control Improvements	Development of Accountability Framework to provide explicit requirements for Ward Managers, Senior and Lead Nurse and Directorate Manager. The framework will include accountability for a therapeutic, clean and safe environment	**Director of Nursing**	**January 2027**	Draft document complete to share with Senior Team and Staff Side as part of consultation Comments received and then sharing with staff side	
	Immediate MDT Walkround of all inpatient areas in MHSOP and Adult Mental Health to capture environmental issues.		**13th November 2026**	All ward walk rounds complete except for Ash and Meadow Ward and Park Road and Pheonix which are scheduled in the next two weeks. Complete and revisit all areas during 23/11 and high level briefing shared with all staff	
	Senior Nurses to undertake a monthly Tendable validation inspection in addition to twice weekly ward walkrounds.		**November 2026**	Ongoing 68% of ward have been done and otheres scheduled	
	Twice Monthly Lead Nurse walkrounds			Ongoing	
	Schedule of Clinical Board walkrounds to be undertaken in partnership with Estates		**19th November 2026**	Schedule of walkrounds agreed. Three wards undertaken in November and a further walkround in December add in schedule	
Mental Health Transformation Programme	Delivery of the Mental Health and Wellbeing Strategy 2025-2035 and the Open Access Models.	**Executive Medical Director**		Delivery Group will be held monthly and Transformation Board bi-monthly with Executive oversight to track progress manage constraints	

Clinical Board Governance	Development of Accountability Framework to include the Clinical Board Governance Structure	**CB management team**	**January 2027**	Draft document complete to share with Staff Side as part of consultation	
	Submission of monthly Alert, Advise and Assure report to Quality Committee to support assurance and escalation			Ongoing	
	Clinical Board Risk Register migrated to AMaT			Complete Review underway and led by sam	
	Clinical Board Forward Audit Plan updated to include cumulative audits All audits will be undertaken on a set schedule with results reported into the Clinical Board governance structure.			Complete Audits to commence in December 2026	
	Tendable IP&C core standards audit will be undertaken weekly and hand hygiene and bare below the elbows undertaken fortnightly by ward managers and all will be reported into Efficiency and Assurance meeting fortnightly.		**November 2026**	Underway Ongoing and results overseen in efficiency and assurance meetings	

Legal Safeguards and Documentation	Clinical Board Forward Audit Plan updated to include cumulative audits: • Reassurance and Observation Audits • Care and Treatment Plan Audits • WARRN Audits • Restrictive Care Audit • Section 17 Leave Audit • Environmental and Ligature Audit • Training to Roster Safety Assurance Audit	**Director of Nursing** **Director of Nursing**	**November 2026** **November 2026**	Complete. Audits to commence in December 2026	

	Delivery of Board Rounds	**Deputy Director of Nursing**		**Ongoing and in place-** **Weekly board round schedule** Monday – 09:30 – LINKS Tuesday – 13:30 – Pendine Wednesday – 09:00 – Vale Wednesday – 09:30 – Pentwyn Thursday – 09:30 – Gabalfa Friday – 10:00 – Hamadryad Cedar ward – Monday at 11:00. Elm ward – Tuesday at 11:30. OOA board round – Monday at 13:30. **Attendees** • CMHT Team Manager or representative • Ward Manager or representative • Patient Flow • Consultant Psychiatry • Home Treatment Team Co-Ordinators **Red and Green Days** Red and Green Days have commenced on all treatment wards and PICU. **Daily Schedule** Beech – 10:30 Oak – 10:45 Willow – 11:00 Alder – 11:30 **Attendees** • Inpatient Clinical Senior Nurse • Ward Manager or representative • Patient Flow Manager • Inpatient Senior Nurse	

	Delivery of a Clinical Board wide Mental Capacity Act Improvement Plan to improve standards. • Delivery of professional and shared learning events on MCA • Twice yearly audits • Improvement in MCA training compliance • Increasing awareness of MCA team			• Professional and shared learning event took place on July 2026 • Twice years audits to occur in August 2026 and next due in February 2027 • MCA training compliance is 73.85% as of September 2026. Need an up on compliance	
	Delivery of quality improvement project to improve compliance with Mental Health Act Rights. To include: • Education • Audits • A review of how Rights data is shared with clinical teams			Yet to commence	

Workforce and multi-disciplinary effectiveness	Complete a review of the MDT model against the AQWA standards	**Clinical Board Management Team**	**May 2027**	Commenced in 2024. • Occupational Therapists now aligned to all wards with exception of Alder which refer to central OT service to mitigate vacancies • Speech and Language Therapist appointed to Adult Mental Health to commence in January 2027. Posts already in place within MHSOP. • LA Social Workers and Social Worker Assistants appointed to patient flow team to due to start in July 2026. • Dual Diagnosis team are now aligned to Cedar Ward to support the complexity of the patient group • Senior Peer Trainer appointed to deliver Preparing for Discharge and ward-based Recovery College courses. • Activities HCSW aligned Cedar Ward. • Appointment of a Director of Psychology and Psychological Therapies to commence in January 2027. • Psychology vacancies remain. A review of existing posts is underway to make funding available. The vacancies are being mitigated by utilising community psychology until the post is filled	

Nursing Workforce	Deliver Nurse staffing aligned to professionally agreed establishment. Delivery of a Health Care Support Worker Forum to provide support and professional development	**Director of Nursing**	**Complete and Ongoing**	Twice yearly Executive sign off of Professional Nursing Establishments – October 2026 Delivery of Mental Health Nursing Hub Monday to Friday to oversee staffing levels and good roster practices as well as redeployment of staff and to agree temporary staffing. - Complete and Ongoing Delivery of fortnightly Efficiency and Assurance meeting to review rosters to ensure alignment with establishments – Complete and Ongoing Delivery of monthly sickness panels Chaired by Director of Nursing or Deputy. - Complete and Ongoing Forum running bi-monthly commenced in October 2026, next schedule November 2026.	

Report Title: *(needs to match agenda)*	Director of Public Health annual report 2026 – *Let's Stop Cancer Before It Starts*.		Agenda Item No:		7.3
Meeting:	Quality Committee	Public	X	Meeting Date:	30/11/2026
		Private			
Lead Executive Title:	Executive Director of Public Health				
Report Author/s Title:	Consultant in Public Health				

Report Focus Summary – **AAA Framework:**

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

This paper introduces the 2026 annual report of the Executive Director of Public Health, Cardiff and Vale University Health Board.

There is a statutory duty on the Director of Public Health to produce an annual report on the health of the local population. This should offer an independent professional view of a local public health issue and is provided as a steer for local action.

The 2026 Director of Public Health annual report focuses on cancer prevention.

A communications plan is being developed in parallel to support and facilitate effective dissemination of key messages to system stakeholders.

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

Board/Committee Response Required *(please select only one)*					
Assurance		**Approval**		**Information/Noting**	X

Recommendations

The Quality Committee is asked to:

A. Receive and note the annual report.

Governance Route *(please list other Committee/Groups this report has been to)*

***Where** it's been:*	No other groups
***When** it went:*	N/A
***What** decision was made:*	N/A

Main Report

Background & Current Situation

The 2026 Director of Public Health report focuses on cancer prevention. Cancer remains the lead cause of death in Cardiff and the Vale of Glamorgan (and Wales) and one of the most significant contributors to premature mortality, long-term ill-health and loss of healthy life.

The report argues that although cancer incidence and prevalence are projected to continue to rise, this trend is not inevitable. A significant proportion of cancer cases are preventable. In Cardiff and the Vale of Glamorgan alone, at least 2,500 new cancer cases every year could be avoided if prevention efforts are prioritised to stop cancer before it starts.

Prevention must be central to response. Indeed, this is recognised in the Health Board's *Shaping Our Future Wellbeing Strategy*, as well as the Welsh Government's *A Healthier*

Wales policy and health outcomes framework and key legislation such as the *Wellbeing of Future Generations Act*. It is also an ambition of the forthcoming Wales Cancer Strategy.

The following recommendations, as set out in the report, form a call to action:

- Reduce smoking prevalence through uptake prevention, smoking cessation, creating smoke-free places, and influencing national policy and legislation.
- Reduce alcohol intake and harm through screening and brief intervention, evidence-based population measures and policy advocacy.
- Promote healthy food and physical activity through the whole-system Good Food and Movement Plan, creating healthier environments and enabling healthier choices.
- Prevent infection through equitable vaccination, targeted action to improve uptake, effective communication, and community engagement.
- Promote breastfeeding through a whole-system approach that removes barriers, strengthens support, and advances Baby Friendly accreditation.
- Reduce harms from environmental factors through active travel, sustainable transport initiatives, public awareness campaigns, and policy action to reduce harmful exposures.
- Increase participation in cancer screening through equitable screening provision, tailored communications, community engagement and continuous service improvement.

These recommended areas of focus for public health investment and action recognise the importance of adopting an 'invest to save' approach to improve health and wellbeing outcomes *and* reduce future demands on health and care services. Investment should be prioritised in evidence-based prevention interventions proven to reduce exposure to cancer risk factors, increase early detection, and improve outcomes for those affected by cancer.

Importantly, the report recognises that actions taken to prevent cancer will also help reduce impacts and burdens from other major conditions, including cardiovascular disease, respiratory disease and diabetes, all of which share many of the same risk factors.

The Health Board's Public Health Team are fully committed to reducing inequalities and improving health and wellbeing and never has this commitment been more important. However, the report notes the need for collective action to maximise impacts and achieve lasting change; everyone can and should play a role in embedding prevention into everyday decisions, into service planning and delivery, and into the lives we lead.

To support and accelerate progress with taking forward recommended actions, the report also highlights a suite of principles which can underpin efforts. These include making prevention everyone's business, strengthening public health leadership and capacity to provide system-wide advice and support, reducing inequalities through equitable, person-centred approaches, and embedding evaluation, learning and research into actions.

The challenge is significant, but the opportunity is too important to miss. Cancer prevention has the potential to deliver substantial improvements in health, reduce inequalities, and reduce growing demands on health and care services. The evidence is unequivocal, the benefits are substantial, and the need for action is urgent. By acting now and working together across organisations and sectors, thousands of cancer cases can be avoided.

The report seeks to inform, inspire, and motivate readers to support the preventative action needed to build a healthier, fairer and more sustainable future for the people of Cardiff and the Vale of Glamorgan.

Appendices:

- 2026 Director of Public Health annual report.

Strategic Alignment – Shaping Our Future Wellbeing:

Putting People First	X	Providing Outstanding Quality	X

Delivering in the Right Places	X	Acting for the Future	X

Impact Assessment
Risk: No
No governance or risk issues for the Health Board have been identified in relation to the Director of Public Health annual report. It is an independent, statutory report.
Safety: No
Financial: No
No direct financial implications of this report.
Workforce: No
No direct workforce implications of this report.
Legal: No
The Director of Public Health annual report is an independent, statutory report.
Reputational: No
Socio Economic: Yes
The recommended areas of focus for investment and action can inform decision-making and help improve health and wellbeing outcomes for all; targeting action can also help reduce inequalities.
Equality & Health: No
Decarbonisation: No
Welsh Language: No
No implications for the Welsh language. The annual report will be published in Welsh.

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Tim Iechyd Cyhoeddus
Cardiff and Vale University Health Board
Public Health Team

Llunio ein Llesiant i'r Dyfodol
Shaping Our Future Wellbeing

Director of Public Health Annual Report 2026

Let's Stop Cancer Before It Starts



Dr Claire Beynon
Executive Director of Public Health

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Tim Iechyd Cyhoeddus
Cardiff and Vale University Health Board
Public Health Team

Llunio ein Llesiant i'r Dyfodol
Shaping Our Future Wellbeing

Introduction

- Director of Public Health Annual Report – statutory duty on the health of the population
- This year's focus is on cancer prevention
- Cancer is lead cause of death and major contributor to premature mortality, long-term ill-health and loss of healthy life
- **More than 2,500 new cancer cases could be avoided each year if prevention efforts are prioritised to stop cancer before it starts**
- Call to action – areas for investment and action



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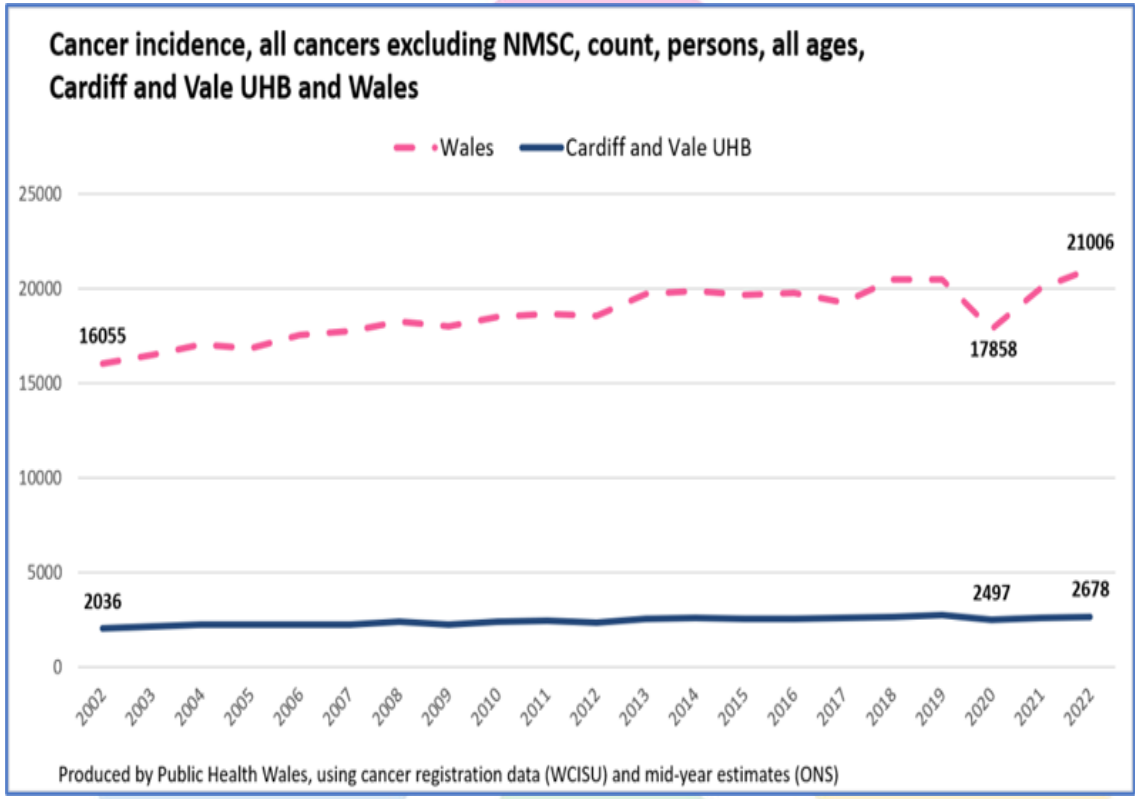
Shaping Our Future Wellbeing

Context

- Locally, 283 per 100,000 population aged 30-70 years die prematurely, but 1 in 5 deaths avoidable
- Cancer incidence and prevalence projected to continue to rise, but trend is not inevitable
- Prevention efforts must focus on conditions responsible for greatest burden – cancer
- Most common cancer types: lung, bowel, prostate, female breast and skin cancer
- Policy drivers – prevention shift (*A Healthier Wales, WBFGA, incoming Wales cancer strategy*)



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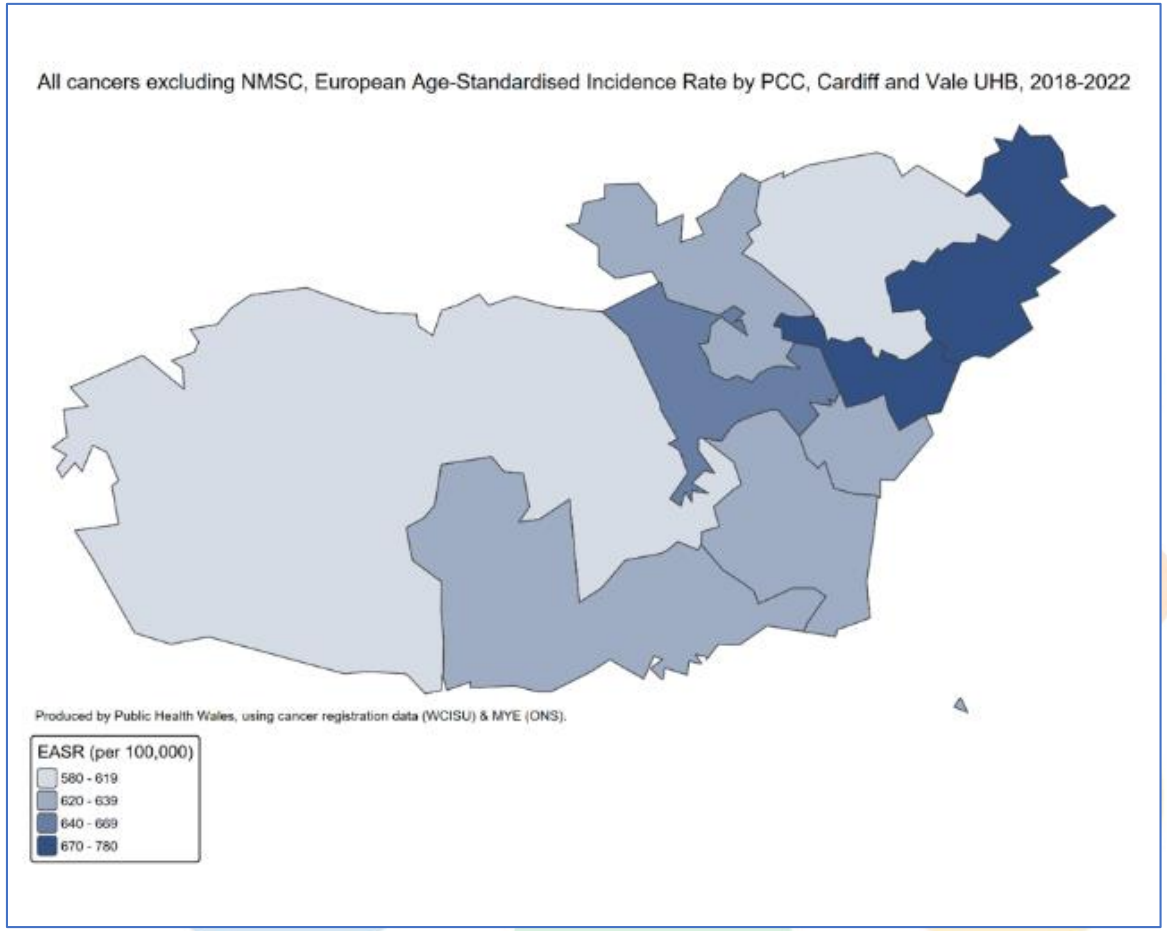
Public Health Team

Llunio ein Llesiant i'r Dyfodol
Shaping Our Future Wellbeing

Cancer inequalities

- Cancer incidence rate in most deprived areas of Wales is 20% higher than in least deprived



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Tim Iechyd Cyhoeddus
Cardiff and Vale University Health Board
Public Health Team

Prevention opportunities

- 4 in 10 cancer cases (excluding NMSC), and most cases of skin cancer, are avoidable
- Effective actions to modify risk factors – smoking, alcohol, diet, physical activity, infection, breastfeeding, environmental exposures
- Actions also help reduce other chronic conditions, (e.g. cardiovascular and respiratory diseases and diabetes), which share many of same risk factors



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Cardiff and Vale University Health Board
Public Health Team

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Shaping Our Future Wellbeing

Recommended areas for investment and action

1. **Reduce smoking prevalence** through preventing uptake, smoking cessation, creating smoke-free places, and influencing national policy and legislation
2. **Reduce alcohol intake and harm** through screening and brief intervention, evidence-based population measures and policy advocacy
3. **Promote healthy food and physical activity** through the whole-system Good Food and Movement Plan, creating healthier environments and enabling healthier choices
4. **Prevent infection** through equitable vaccination, targeted action to improve uptake, effective communication, and community engagement
5. **Promote breastfeeding** through a whole-system approach that removes barriers, strengthens support, and advances Baby Friendly accreditation
6. **Reduce harms from environmental factors** through active travel, sustainable transport initiatives, awareness campaigns, and policy action to reduce exposures/harm
7. **Increase participation in cancer screening** through equitable screening provision, tailored communications, community engagement and continuous service improvement

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Tim Iechyd Cyhoeddus
Cardiff and Vale University Health Board
Public Health Team

Llunio ein Llesiant i'r Dyfodol
Shaping Our Future Wellbeing

Call to action

"The challenge is significant, but the opportunity is too important to miss.

Cancer prevention has the potential to deliver substantial improvements in health, reduce inequalities, and reduce growing demands on health and care services.

The evidence is unequivocal, the benefits are substantial, and the need for action is urgent.

By acting now and working together across organisations and sectors, thousands of cancer cases can be avoided."

"I want my report to inform, inspire and motivate readers to support the preventative action needed to build a healthier, fairer and more sustainable future for the people of Cardiff and the Vale of Glamorgan."

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Tim Iechyd Cyhoeddus
Cardiff and Vale University Health Board
Public Health Team

Llunio ein Llesiant i'r Dyfodol
Shaping Our Future Wellbeing

Director of Public Health Annual Report 2025

Stopping Cancer Before It Starts



Dr Claire Beynon
Executive Director of Public Health

Report Title:	Mental Health Act Exception Report		Agenda Item No:		8.1
Meeting:	Quality Committee	Public	X	Meeting Date:	30.11.2026
		Private			
Lead Executive Title:	Chief Operating Officer				
Report Author/s Title:	Mental Health Act Manager				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

The Mental Health inpatient legal status between being detained and informal has steadily grown since the end of 2024. There were no fundamentally defective applications, although three defective 5(2) reports were identified and managed appropriately.

A key exception is the notable rise in Section 136 use, from 160 to 217 cases, with 80.7% of individuals not subsequently admitted to hospital and 48.4% discharged to community services; two Section 136 periods lapsed without assessment because the individuals were not medically fit. For under-18s, Section 136 assessments increased from 8 to 12, although one young person accounted for six repeat presentations, and 83% were assessed and discharged to community services.

The MHA Office continues to provide staff training on various different topics and development, with generally positive feedback, alongside ongoing audits of wards and CMHTs, with identified compliance issues followed up and re-audited within 4–6 weeks.

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

Board/Committee Response Required *(please select only one)*					
Assurance	X	**Approval**		**Information/Noting**	

Recommendations

The Committee is asked to:

1. **NOTE** the approach taken by the Mental Health Clinical Board to ensure compliance with the appropriate Mental Health legislation, as set out in the report.

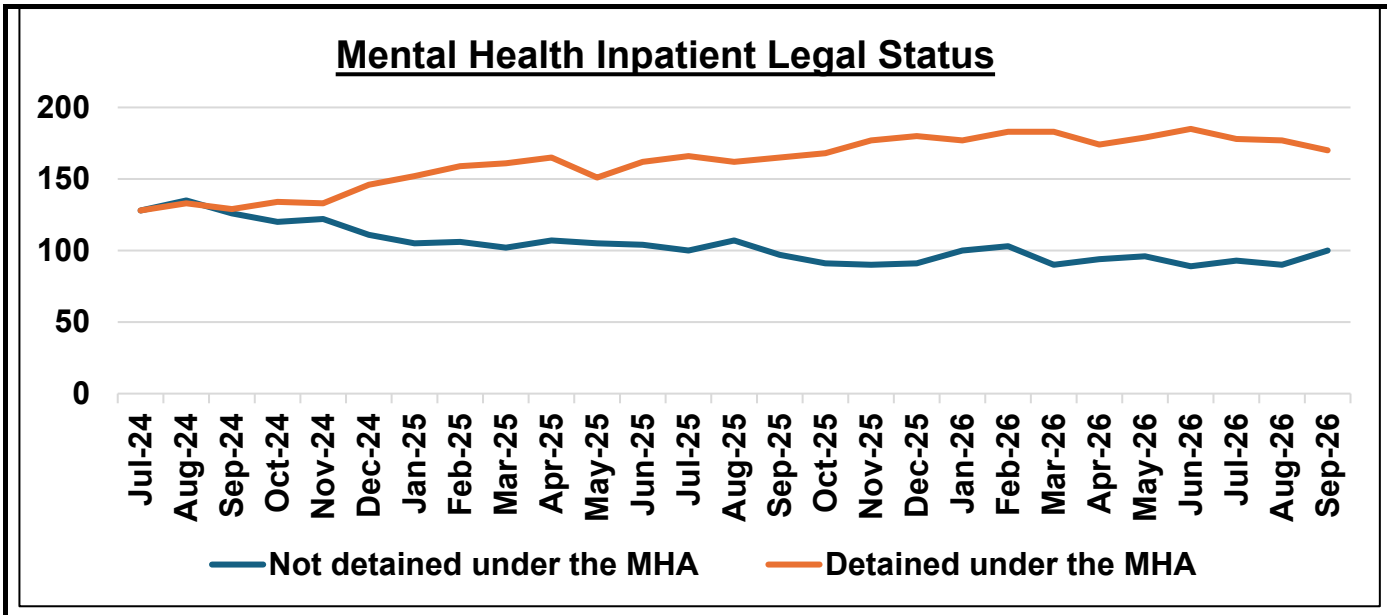
Governance Route *(please list all other Committee/Groups this report has been to)*

***Where** it's been:*	*Mental Health Legislation and Governance Group*
***When** it went:*	*15th October 2026*
***What** decision was made:*	*Recommended to Board Committee for assurance*

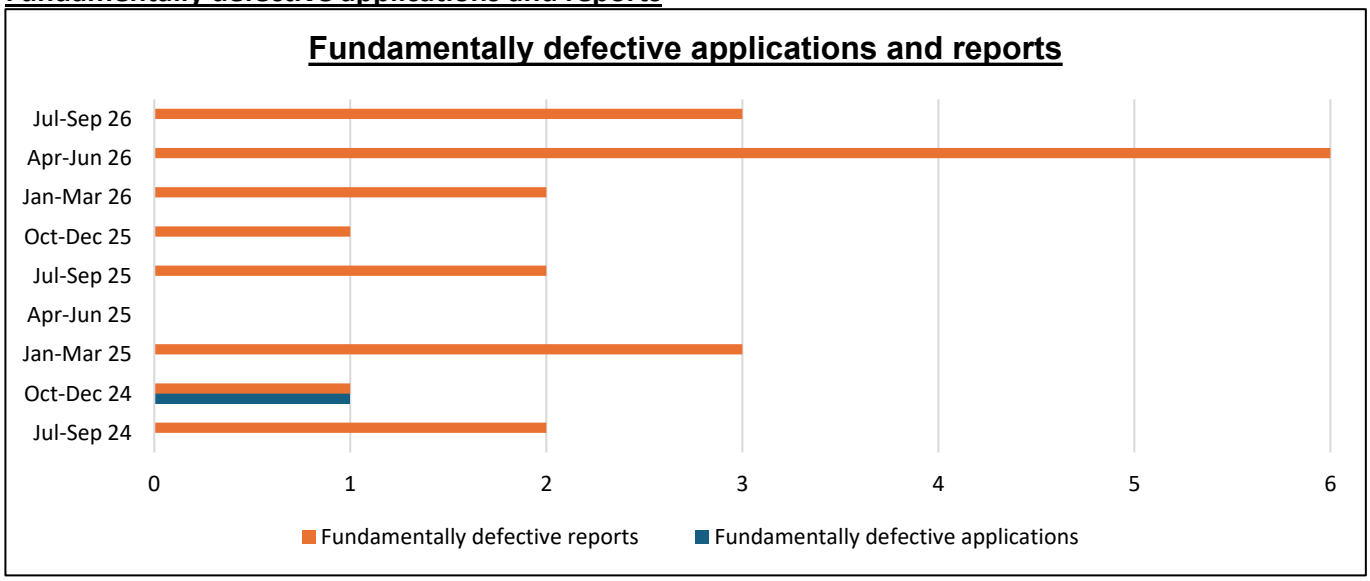
Main Report

Background & Current Situation

Use of the MHA



Fundamentally defective applications and reports



During the quarter there were no fundamentally defective applications

During the quarter there were three fundamentally defective reports

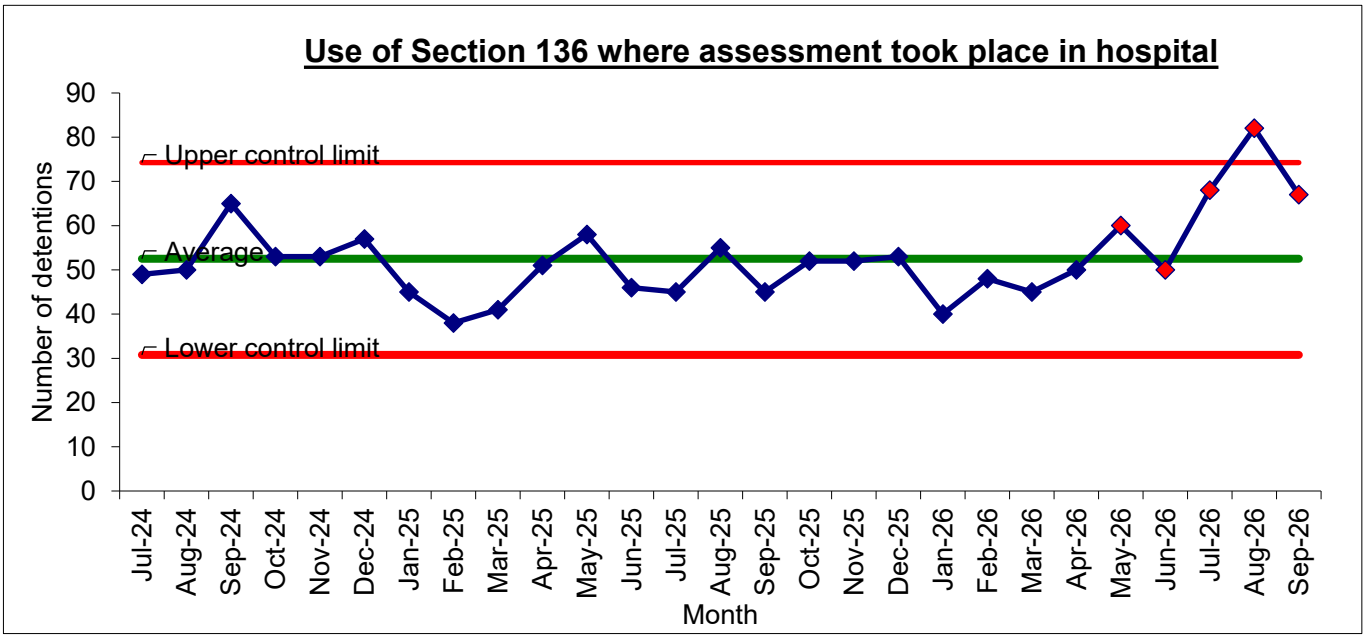
- The doctor was grade F1 x 1 – presentation improved and an assessment wasn't needed.
- Not furnished to the Hospital Managers x 1 – patient had a MHA assessment before the MHAO was aware of the 5(2) – detained under section 3.
- Wasn't completed by the AC/Nominated Deputy x 1 -5(2) completed again and further detention under section 2.

Section 136

During the period, the use of section 136 has increased from 160 in the previous quarter to 217 this quarter. Two 136's lapsed with no assessment taking place due to not being medically fit.

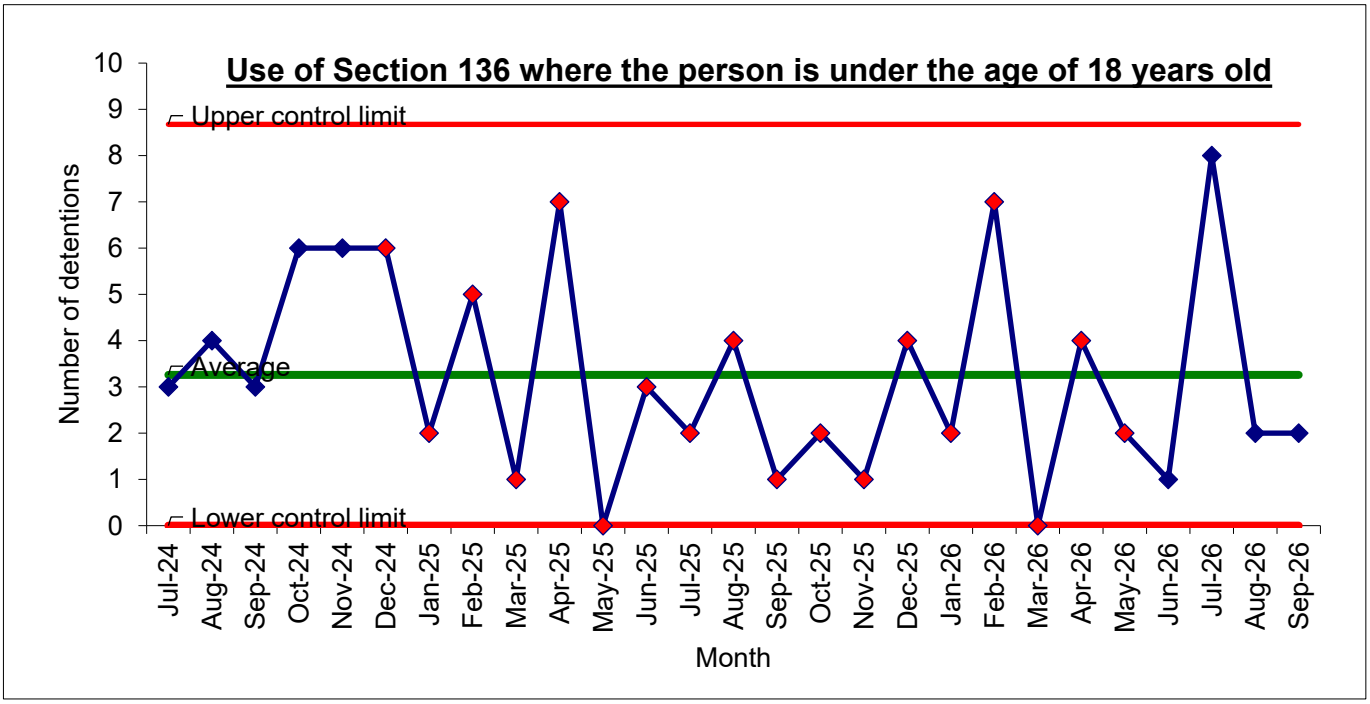
Period	% not admitted to hospital	% admitted to hospital	% discharge to community services	% discharge with no follow up
July – September 2026	80.7%	18.5%	48.4%	32.3%
April – June 2026	75.6%	23.1%	47.5%	28.1%
January – March 2026	76.7%	23.4%	42.1%	34.6%

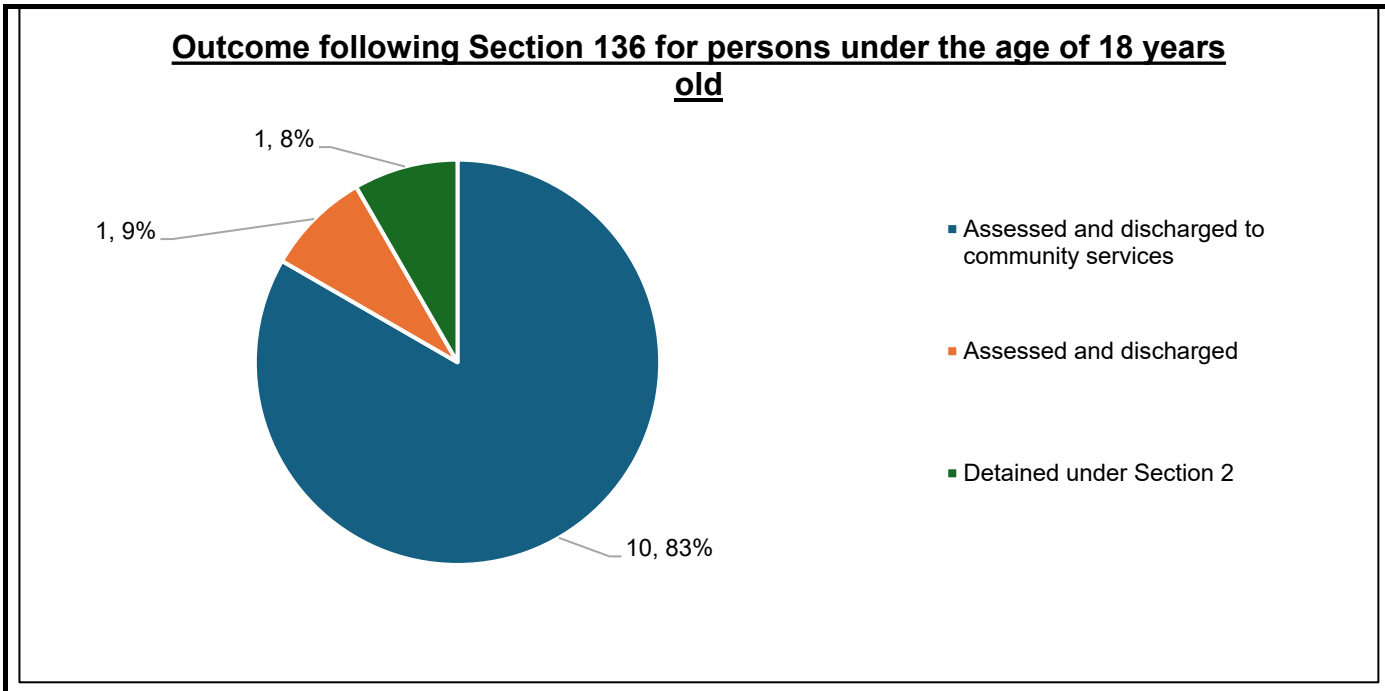
October – December 2025	77.7%	20.4%	43.9%	33.8%
July – September 2025	82.8%	17.3%	46.9%	35.9%



Section 136 - CAMHS

The number of those under 18 assessed under section 136 has increased from eight in the previous quarter to twelve in this quarter. One service user had six repeat presentations.





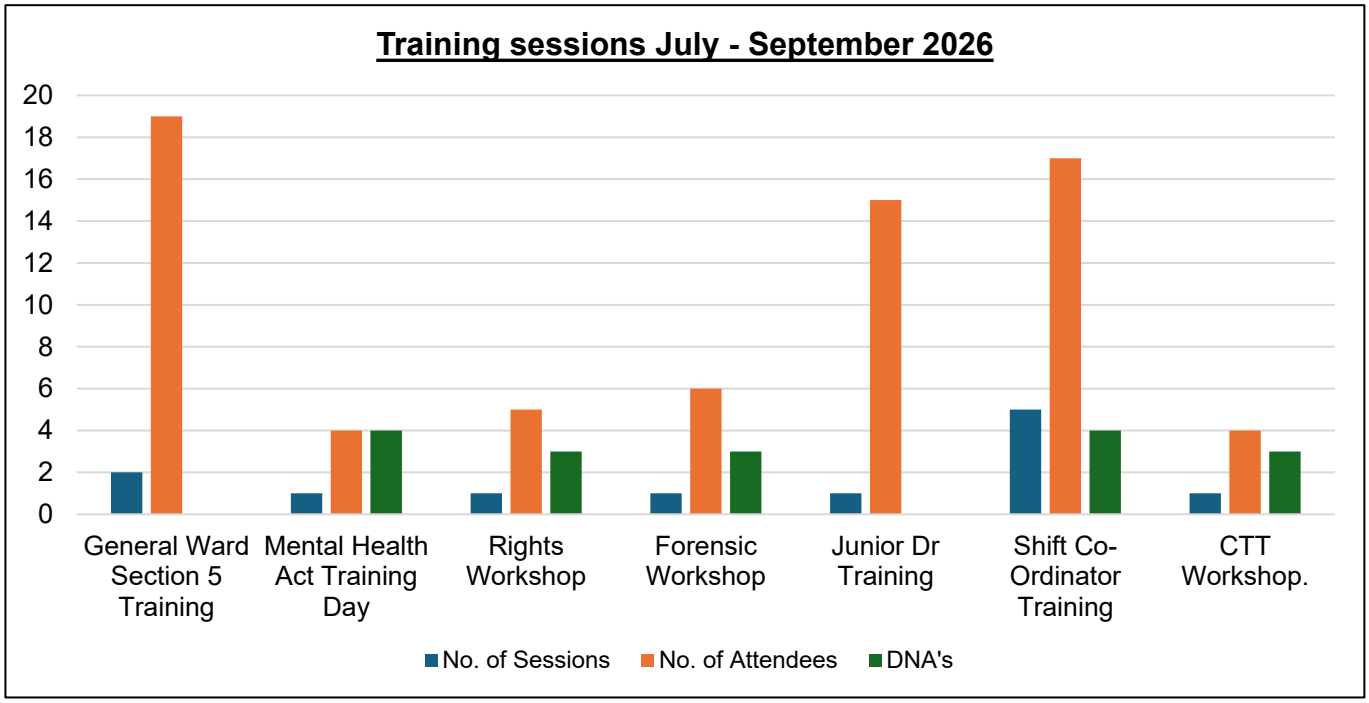
Development Sessions

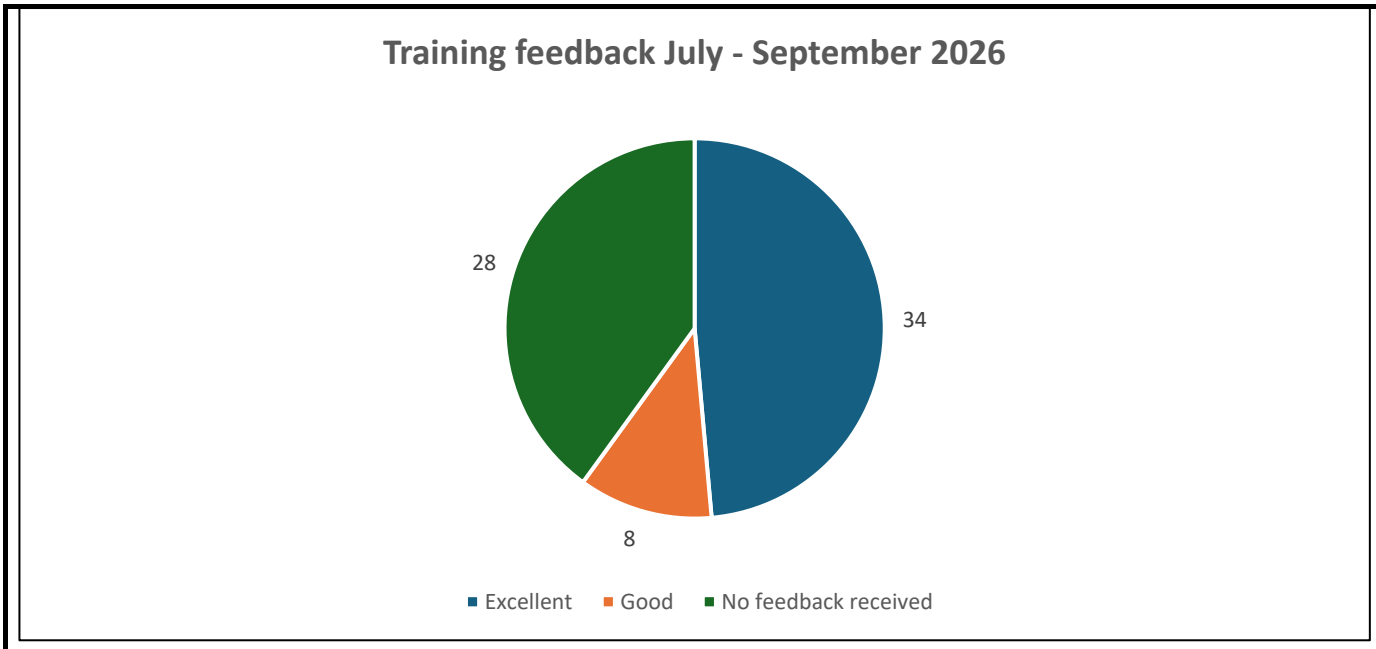
The MHA office continues to run the below awareness sessions available to all staff within the Health Board:

- Bi monthly MHA training day
- Yearly refresher receipt and scrutiny training for all shift coordinators

We also continue to support the below training programmes as and when required:

- Nurse foundation/Preceptorship programme
- Junior Doctor's MHA inductions
- AMHP programme





Audits

The MHA office continue to audit all the wards and CMHT's within the UHB. This is to ensure compliance with the MHA and best practices are maintained. If any issues are found during the audit, we will follow up with an e-mail to the ward manager and/or responsible clinician confirming what is needed to rectify the issue and re-audit within 4-6 weeks.

Appendices:			
Strategic Alignment – Shaping Our Future Wellbeing:			
Putting People First	X	Providing Outstanding Quality	X
Delivering in the Right Places	X	Acting for the Future	X

Impact Assessment
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No - *https://www.gov.wales/socio-economic-duty-guidance*
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Report Title:	**Mental Health Measure Monitoring Report including Care and Treatment Planning Update**		Agenda Item No:		8.2
Meeting:	Quality Committee	Public	X	Meeting Date:	30.11.2026
		Private			
Lead Executive Title:	Chief Operating Officer				
Report Author/s Title:	Interim Director of Operations, Mental Health Clinical Board				

Report Focus Summary – **AAA Framework:**

*The AAA framework reflects the **overall position of the matter being reported**. **Select one category only** and complete the **relevant box** with a brief summary. A useful guide can be found here:* NHS Triple A Guide

ALERT *(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).*

ADVISE *(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)*

Performance against Parts 1 and 2 of the Mental Health (Wales) Measure remains strong for assessment and intervention timeliness, but significant improvement remains necessary in valid Care and Treatment Plan compliance and Part 3 outcome timeliness.

In September 2026, 99% of adult Part 1 assessments and 100% of interventions were completed within 28 days, substantially above the 80% standards. CAMHS also maintained strong performance: in October 2026, 100% of Part 1a assessments and Part 1b interventions were completed within 28 days. The NHS Performance and Improvement dashboard reports adult Part 2 compliance at 76.9%, but this dataset is subject to a reporting lag. The current adult operational position is 83.2%, which is 3.2 percentage points above the Welsh Government de-escalation measure of 80%, although it remains below the 90% national standard. CAMHS CTP compliance was 93.1% in October, above the national standard. Adult Part 3 outcome letters issued within 10 working days were 71.4% against the 100% standard.

The position requires continued committee oversight because rising demand, care-planning quality and the timeliness of Part 3 outcomes create legal, quality, patient-experience and workforce risks. Recovery actions and quality audit arrangements are in place.

ASSURE *(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)*

Board/Committee Response Required ***(please select only one)***

Assurance	X	**Approval**		**Information/Noting**	

Recommendations

The Committee is asked to:

- **Note** the September 2026 position and the continued strong performance for Part 1;
- **Receive assurance** that current Part 2 compliance is 83.2%, three percentage points above the Welsh Government de-escalation measure, while noting that the lagged NHS Performance and Improvement dashboard reports 76.9% and the current position remains below the 90% national standard;
- **Support** continued recovery action, including a quality audit of Care and Treatment Plans, directorate-level performance management and targeted action for teams below trajectory;
- **Note** the deterioration in Part 3 timeliness and request a focused review of process, ownership and capacity, with a recovery trajectory reported at the next meeting; and

- Continue to **monitor** referral growth and the impact on capacity, waiting lists, patient experience and workforce sustainability.

Governance Route *(please list all other Committee/Groups this report has been to)*	
***Where** it's been:*	Mental Health Clinical Board performance arrangements, directorate performance reviews and NHS Wales Performance and Improvement monitoring
***When** it went:*	Ongoing monthly and fortnightly monitoring during 2026
***What** decision was made:*	Continue recovery oversight, complete CTP quality assurance and develop focused action to improve Part 3 outcome timeliness.

Main Report

Background & Current Situation

1. Purpose and statutory context

The report provides the Committee with the latest position for Parts 1 to 3 of the Mental Health (Wales) Measure 2010. The Measure establishes statutory requirements for access to local primary mental health support services, coordinated secondary mental health care and treatment planning, and reassessment of eligible former users of secondary mental health services.

2. Part 1: Local Primary Mental Health Support Services

Demand remains high and is increasing over the longer term. There were 1,904 referrals in September 2026, compared with 1,614 in August and 1,950 in October 2025. Of the September referrals, 822 were assessed. The workforce position remained stable at 29 WTE practitioners across the 12-month period.

Timeliness remains strong. In September, 99% of assessments were completed within 28 days and 100% of interventions commenced within 28 days, against standards of 80%. The adult trajectory indicates performance is being sustained, although the assessment waiting list remains materially above the planned trajectory and the intervention waiting list increased sharply in the latest month. This requires active capacity and flow management rather than reliance on the compliance percentage alone.

CAMHS Part 1. CAMHS performance is also strong. Part 1a assessment timeliness was 100% in October 2026 and remained at or above 96.8% in every reported month. Part 1b interventions were completed within 28 days in 100% of cases throughout the period. Demand remains high, with 329 referrals and 76 assessments completed in October. The service continues to monitor capacity, vacancies and expected seasonal demand.

3. Part 2: Care coordination and treatment planning

The NHS Performance and Improvement dashboard reports September 2026 compliance at 76.9% against the 90% standard. The dashboard position is subject to a reporting lag and does not reflect the latest operational data. Current local compliance is 83.2%, which is three percentage points above the Welsh Government de-escalation measure of 80%. This is a material improvement from 62% in October 2025 and demonstrates that the recovery programme is delivering. However, the current position remains seven percentage points below the 90% national standard, so sustained delivery and quality assurance remain necessary.

The recovery approach includes team-level trajectories, directorate performance review, clarification of care-coordinator accountability and targeted work with professional groups. The immediate next phase should move beyond document completion to quality and co-production. A structured audit led through the Clinical Board will test whether plans are current, outcomes-focused, holistic, co-produced and translated into care delivery.

CAMHS Part 2. CAMHS valid CTP compliance was 93.1% in October 2026, remaining 3.1 percentage points above the 90% national standard, although this had reduced from 96.7% in September. Compliance has been maintained above 90% since November 2025. The position provides assurance on delivery, but the service reports that engagement can be more difficult because the statutory process and paperwork are adult-focused. This issue has been escalated to the NHS Executive through the national CAMHS development workplan.

4. Part 3: Assessment of former users

There were 29 requests in September 2026. Thirteen people were assessed and seven were accepted into services. Fourteen outcomes were due, of which 10 were issued within 10 working days. Performance was therefore 71.4% against the 100% standard, following 70% in August. This deterioration requires a focused review of administrative process, clinical sign-off, capacity and clear ownership of outcome communication.

5. Overall assessment

The position is mixed but improving. Adult Part 1 demonstrates reliable delivery against the national standards despite high demand. CAMHS Part 1 performance is also strong, with 100% assessment and intervention timeliness in October 2026. Current adult Part 2 compliance has reached 83.2%, above the Welsh Government de-escalation measure of 80%, although it remains below the 90% national standard and the published NHS Performance and Improvement dashboard continues to show the lagged 76.9% position. CAMHS Part 2 compliance was 93.1% in October and remained above the national standard. Adult Part 3 requires corrective action. The overall ADVISE rating reflects evidence of improvement and established controls, alongside residual statutory, quality and patient-experience risks that need continued Committee oversight.

Appendices:

- Appendix 1: NHS Wales Performance and Improvement Mental Health Measure dashboard, information reported to September 2026.

Strategic Alignment – Shaping Our Future Wellbeing:

Putting People First	X	Providing Outstanding Quality	
Delivering in the Right Places		Acting for the Future	

Impact Assessment

Risk: Yes

The principal risks are failure to sustain the current 83.2% adult Part 2 position and progress towards the 90% national standard, deterioration in adult Part 3 timeliness and demand growth outstripping capacity. The current adult Part 2 position is above the 80% Welsh Government de-escalation measure, but quality and sustainability must still be demonstrated. CAMHS Part 1 and Part 2 performance provides assurance, although demand, capacity and the suitability of adult-focused statutory paperwork for children and young people require continued monitoring. Mitigations include team trajectories, directorate review, quality audit, targeted recovery plans and escalation through Clinical Board governance.

Safety: Yes

People without a current, high-quality and co-produced CTP may experience fragmented care, unclear accountability and weaker risk management. Delayed Part 3 outcomes may also prolong uncertainty and delay access to appropriate support. Recovery and audit actions are described in the main report.

Financial: Yes

Maintaining Part 1 performance during higher demand may require temporary or bank assessment capacity. No new recurrent investment is requested through this paper. Any additional resource requirement should be quantified and considered through established vacancy, workforce and financial-control processes.

Workforce: Yes

Sustained demand places pressure on primary mental health practitioners, care coordinators, clinical reviewers and administrative teams. Clear ownership, protected review time, multidisciplinary allocation of care coordination and targeted support for teams below trajectory are required.

Legal: Yes

The Mental Health (Wales) Measure 2010 creates statutory duties covering access, care coordination, treatment planning and reassessment. Continued below-standard Part 2 and Part 3 performance increases legal and regulatory risk. The report's recovery and assurance arrangements are intended to support compliance.

Reputational: Yes

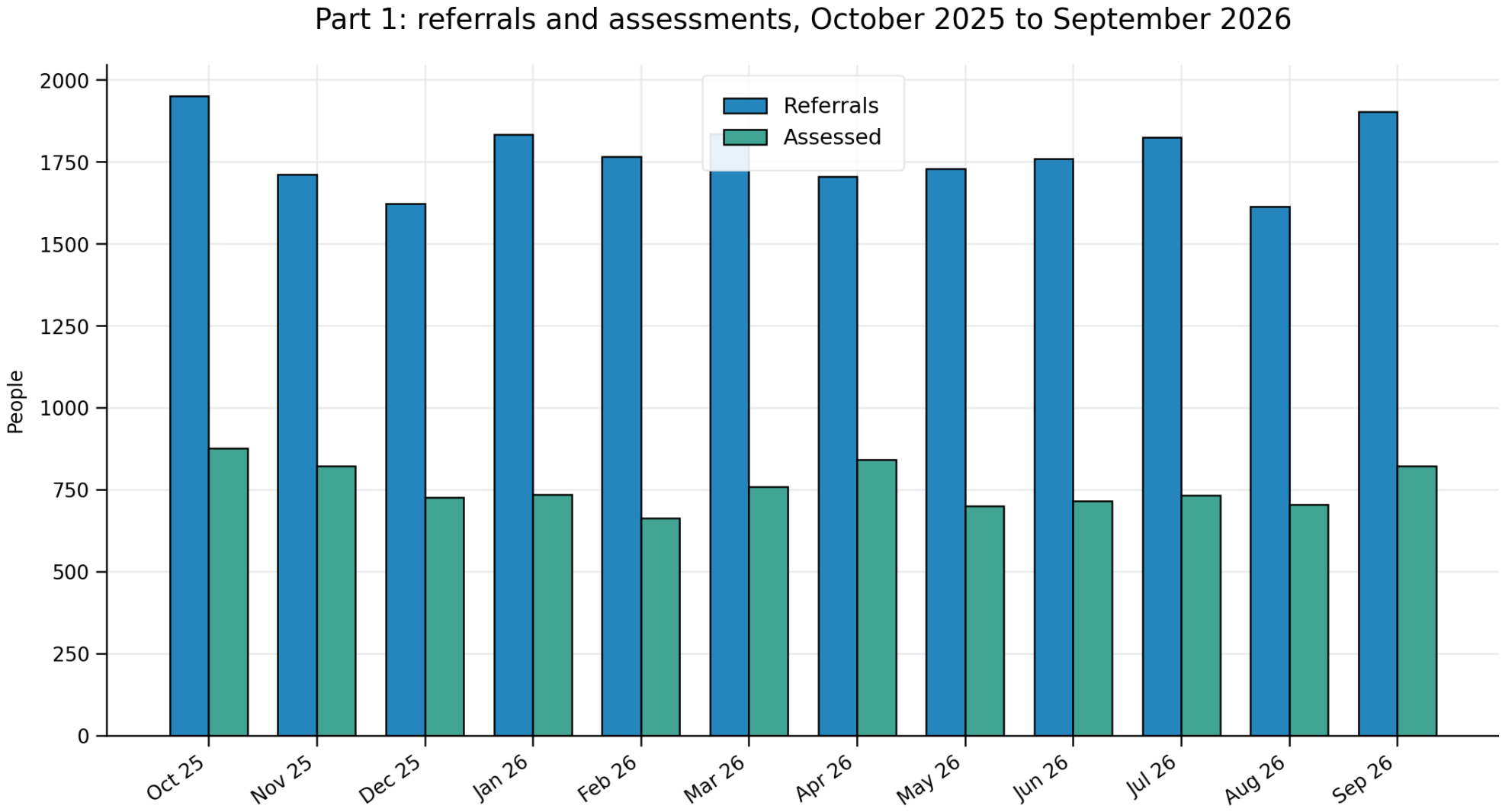
Failure to achieve statutory and national standards may reduce confidence among patients, carers, partners, regulators and Welsh Government. Transparent reporting, clear trajectories and demonstrable quality improvement are the main mitigations.

Socio Economic: No

Not applicable. This is a monitoring and assurance report and does not propose a new strategic decision. The service should continue to monitor equitable access and outcomes by population group.
Equality & Health: No
Not applicable. No service change is proposed through this report. Ongoing monitoring should identify variation by age, protected characteristic, geography and service area where data permits.
Decarbonisation: No
Not applicable. The report does not propose operational changes expected to adversely affect the Health Board's decarbonisation objectives.
Welsh Language: No
Not applicable. Existing Welsh Language Standards and More Than Just Words requirements continue to apply, including access to care and information in a person's preferred language.

Appendix 1: Mental Health Measure Part 1

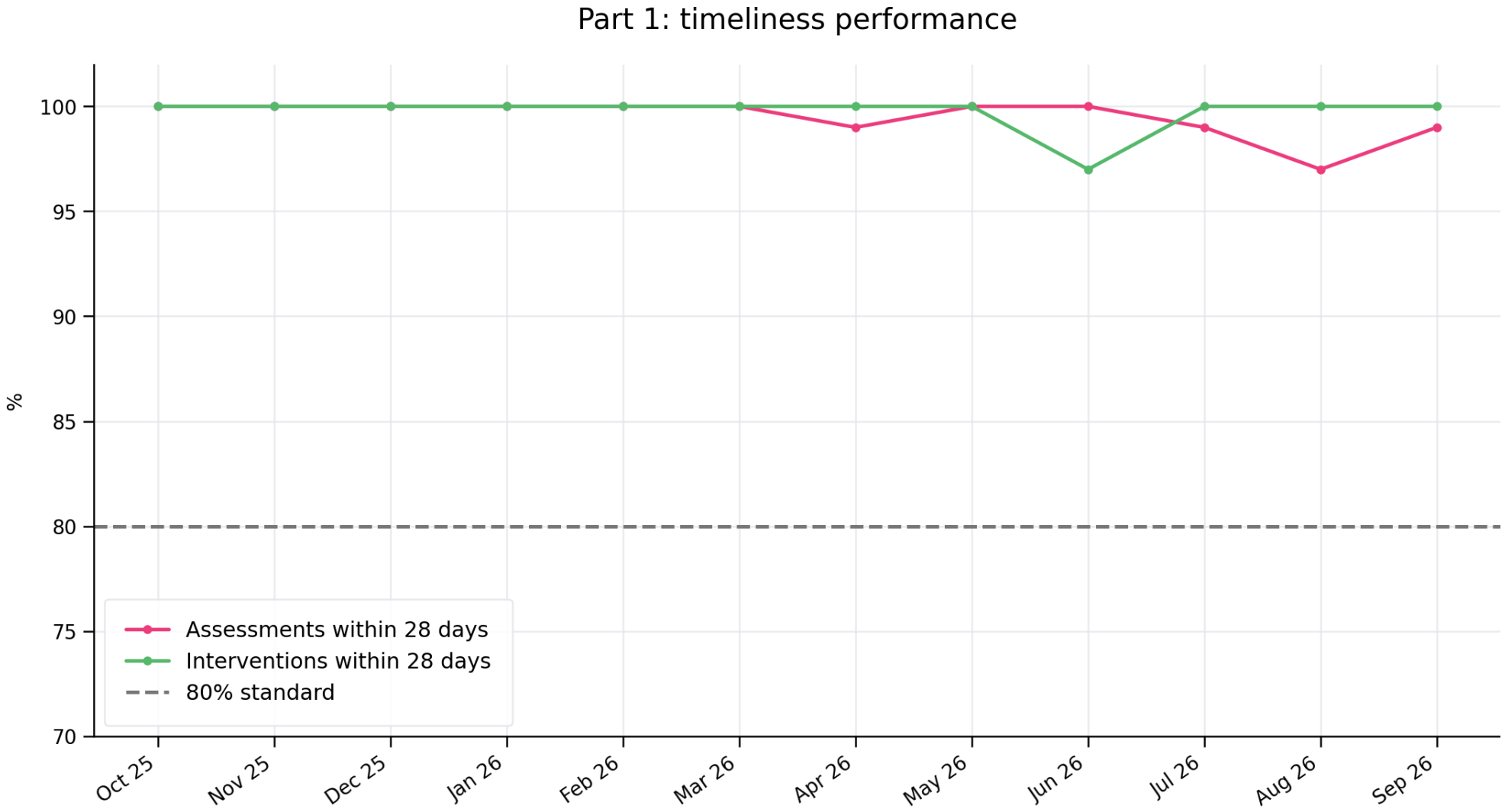
Local Primary Mental Health Support Services, data to September 2026



September 2026: 1,904 referrals; 822 assessed (43.2%). Referral volumes remain high and the longer-term direction is upward.

Appendix 2: Mental Health Measure Part 1

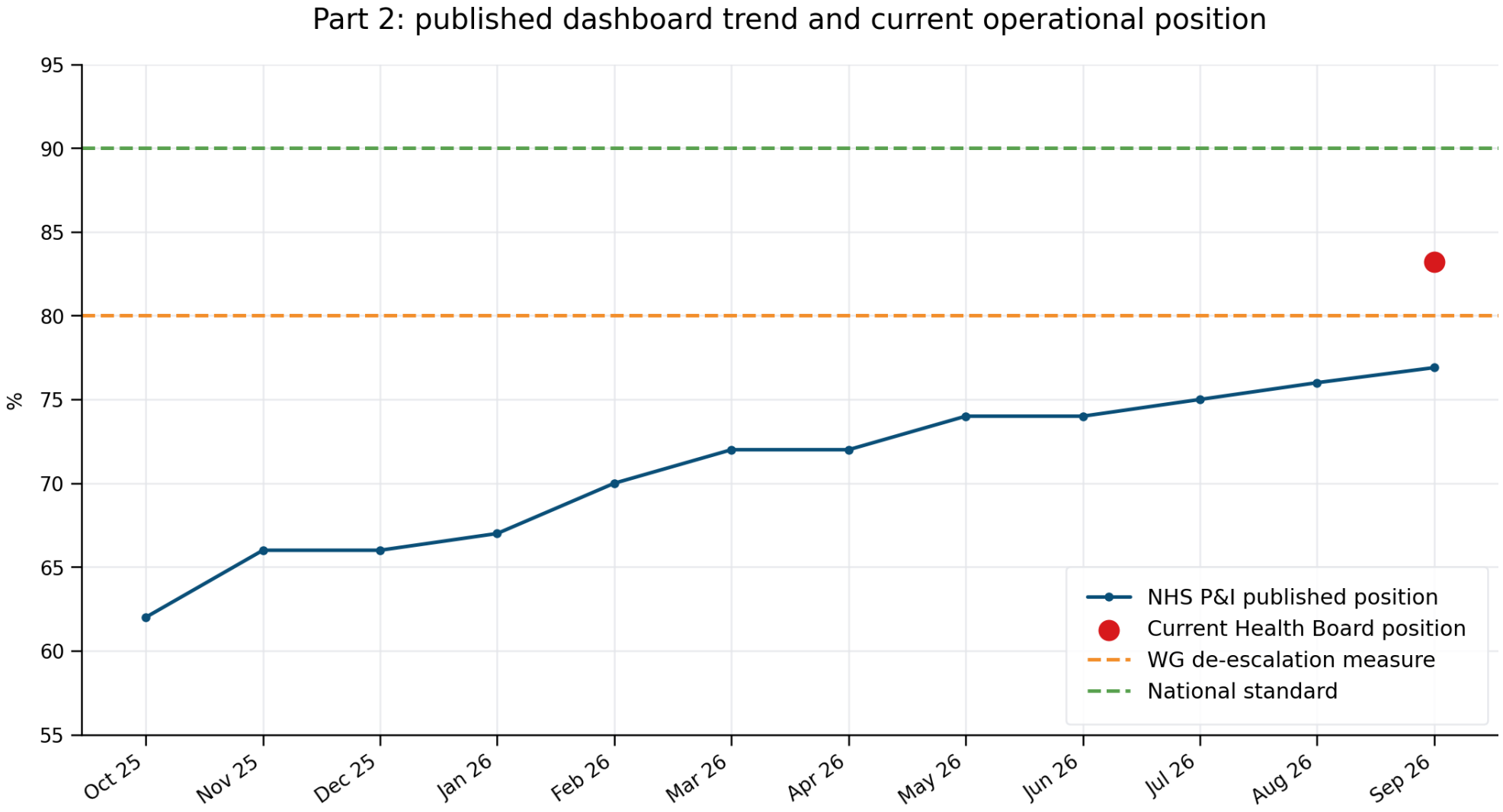
Assessment and intervention timeliness, data to September 2026



September 2026: 99% of assessments and 100% of interventions completed within 28 days, above the 80% standards.

Appendix 3: Mental Health Measure Part 2

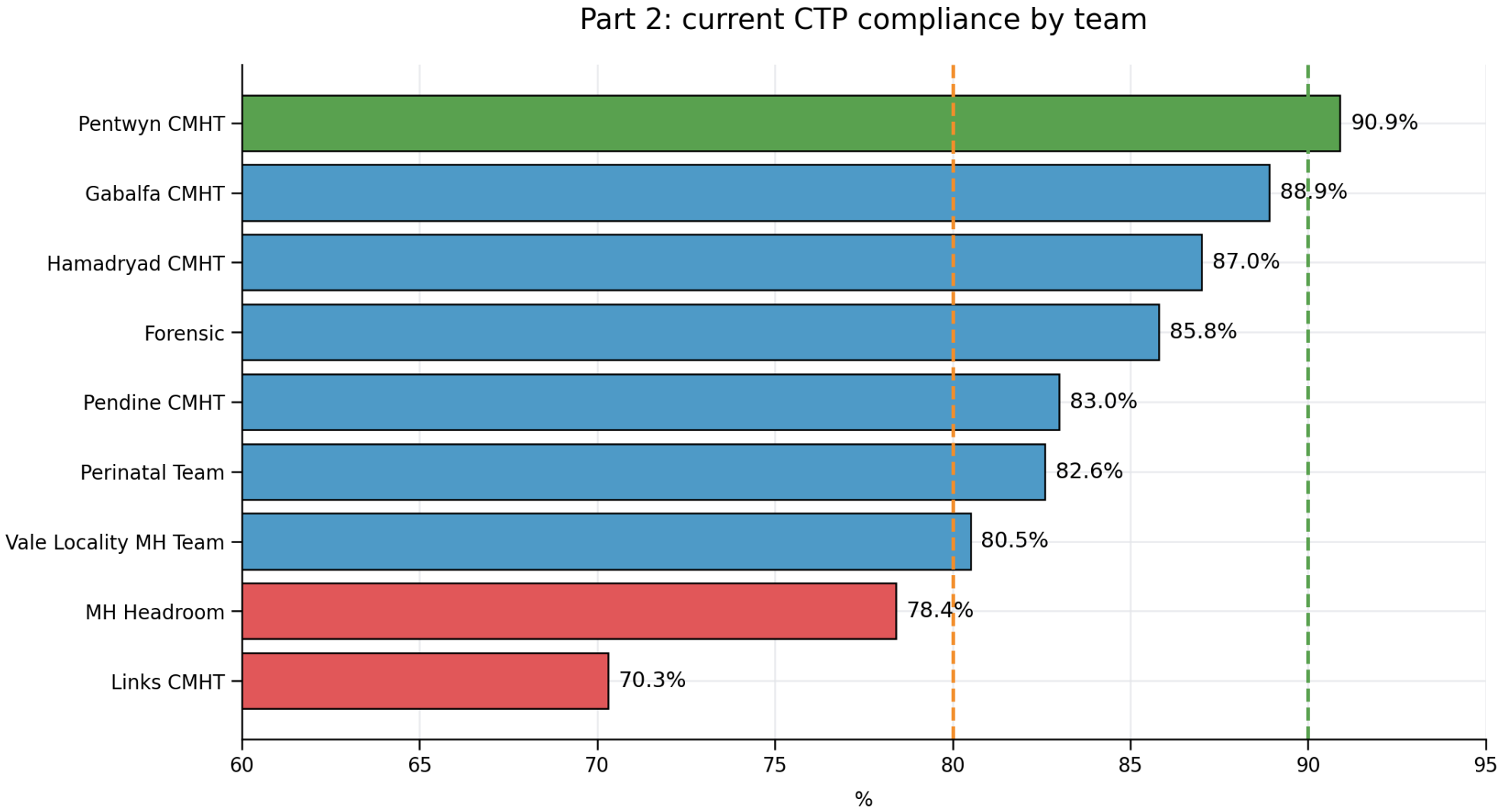
Reconciliation of published and current Care and Treatment Plan compliance



The NHS Performance and Improvement dashboard reports a lagged September position of 76.9%. The current Health Board position is 83.2%, 3.2 percentage points above the Welsh Government 80% de-escalation measure and 6.8 percentage points below the 90% national standard.

Appendix 4: Mental Health Measure Part 2

Current Health Board CTP compliance by team



Current overall compliance is 83.2%: 2,864 in-date CTPs from an estimated caseload of 3,443. The month-end target is 3,099 in-date CTPs, leaving a gap of 235.

Appendix 5: Mental Health Measure Part 3

Assessment of people who have previously used specialist mental health services

16/11/2026

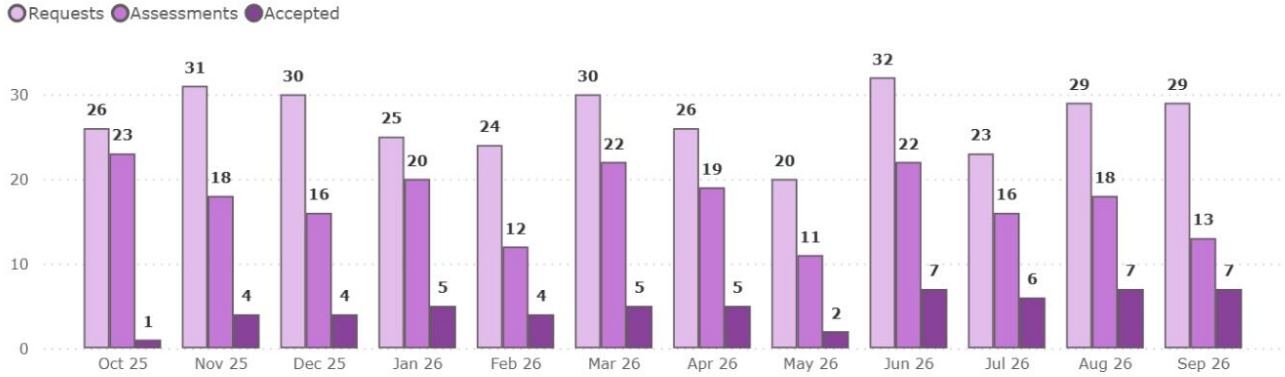
MHM Part 3

Assessment of people who have used specialist mental health services before

GIG CYMRU NHS WALES | Perfformiad a Gwella Performance and Improvement

Healthboard: CAVUHB | Age: All | Service: All

MHM Part 3 - Requests, Assessments and Accepted Adult Services

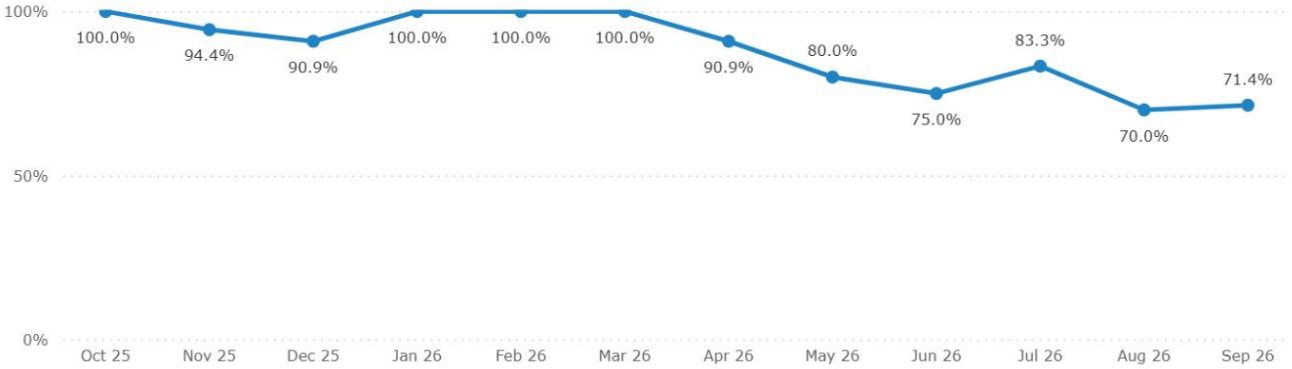


In Sep 2026, there were 29 requests from patients who have used specialist mental health services before.

Of these, 13 (44.8 %) were assessed and 7 (24.1 %) were accepted.

MHM Part 3 - Percent of Outcomes Sent within 10 Days

Target: 100% of outcomes sent within 10 days



In Sep 2026, there were 14 MHM P3 outcomes.

10 (71.4 %) were sent within 10 days. This is **below** target (100%).

September 2026: 29 requests, 13 assessments and 7 accepted into services. Ten of 14 outcomes were issued within 10 working days, giving 71.4% compliance against the 100% standard.

Supplementary section: CAMHS Mental Health Measure performance

CAMHS position. CAMHS performance is strong across the measures shown in the 2026–27 dataset. Part 1a assessment timeliness was 100% in October 2026 and was at or above 96.8% in each reported month. Part 1b interventions were completed within 28 days in 100% of cases throughout the period. Referral demand remains high: 329 referrals were recorded in October 2026, compared with 316 in September, while 76 assessments were completed in October.

Care and Treatment Plans. Valid CTP compliance rose from 88.3% in October 2025 to 94.6% in November 2025 and then remained above the 90% national standard, reaching a peak of 98.8% in January and February 2026. Compliance was 93.1% in October 2026, a reduction from 96.7% in September but still 3.1 percentage points above the national standard. The service reports that compliance has been achieved and maintained, while engagement can be more difficult because the statutory process and paperwork are adult-focused. This issue has been escalated to the NHS Executive through the national CAMHS development workplan.

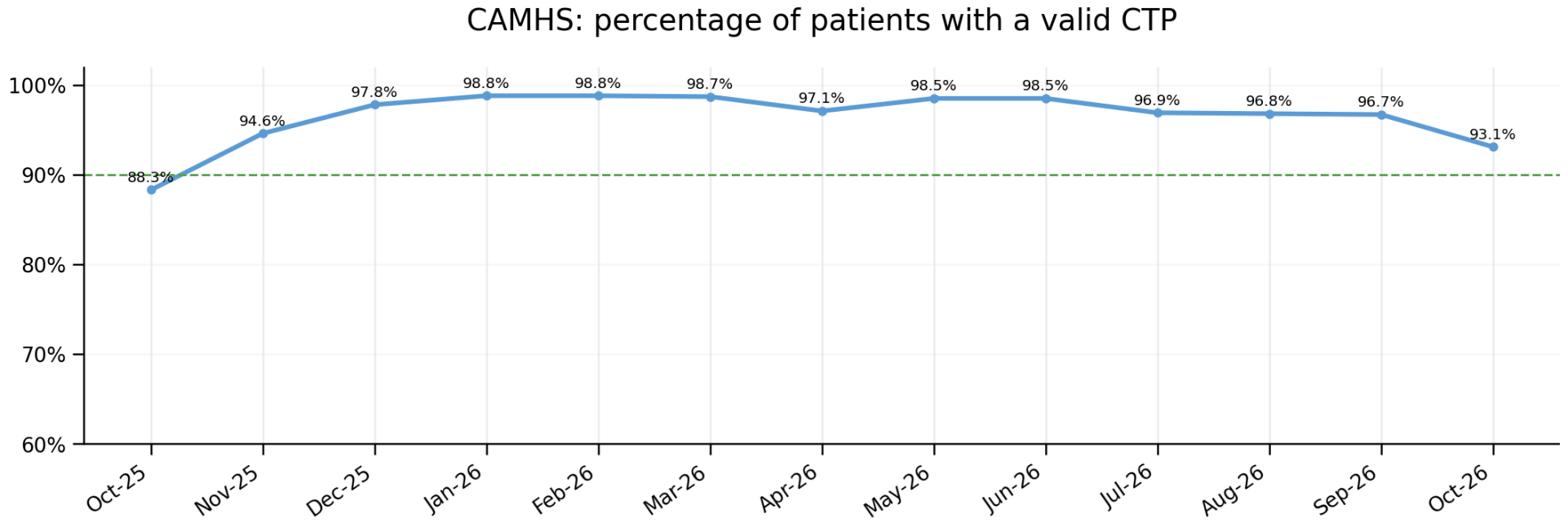


Table: CAMHS performance from worksheet 26-27

Indicator	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
Part 1a completed within 28 days	100%	98.8%	100%	100%	100%	96.8%	100%	100%	100%	100%	100%	100%	100%
Part 1b completed within 28 days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Referrals	316	325	267	345	311	321	275	271	260	270	208	316	329
Assessed in month	83	88	83	82	78	95	101	85	84	56	61	70	76
Patients with a valid CTP	88.3%	94.6%	97.8%	98.8%	98.8%	98.7%	97.1%	98.5%	98.5%	96.9%	96.8%	96.7%	93.1%

Source: MHM Data.xlsx, worksheet 26-27 and Graphs. CAMHS is presented as Early and Wider Mental Health (EWMH) in the source workbook.

ALERT, ADVISE, ASSURE (AAAs) HIGHLIGHT REPORT	
Committee/Group	**Infection Prevention and Control Group (IPCG)**
Meeting Date	16 June 2026 and 8 September 2026
Lead	Executive Nurse Director
Report by	Deputy Executive Nurse Director

Infection Prevention and Control — June and September 2026

Highlights for Quality Committee from IPCG meetings on 16 June and 8 September 2026, reported separately below. Entries describe each meeting's position, not subsequent completion of actions.

Overall position: Outbreaks, bacteraemia, competency and environmental risks remained alongside evidence of improved infection performance, audit and local practice. Priorities were Clinical Board improvement delivery, consistent reporting, antimicrobial governance, preparedness and infrastructure follow-up. No formal overall assurance rating is assigned.

Data caveat: June HARP figures use 2024–25/2025–26 labels; September places 186 C. difficile cases at March 2026. Confirm reporting periods before comparing meetings; no combined trend is inferred.

ALERT

(Alert the Committee to areas of non-compliance or matters that need addressing urgently)

16 June 2026

Outbreak and infection risks: West 8 had 11 MRSA-positive patients since January 2025 and two typed clusters. Repeated poor practice/cleanliness audits, a four-month monitoring gap and limited audit warning weakened assurance; enhanced screening, weekly audits and an outbreak plan were in place. MRSA and Klebsiella exceeded targets; Specialist Services reported excess MSSA/E. coli, line-related infections, isolation shortages and RCA compliance of 60–70%. Medicine reported rising E. coli and unreliable/tardy data access.

Practice and resources: ANTT reporting was inconsistent: Medicine compliance was approximately 57%; CD&T practical assessment 68% versus 92.9% e-learning. Surgical SDEC audits, instrument-tray defects and a hip-fracture surgical-site infection cluster required action. IPC staffing and assessment-support gaps persisted.

Infrastructure and assurance gaps: Recurring Legionella-positive samples in UHL Glaucoma required remediation/surveillance; the completed UHW HPV unit awaited operating arrangements. PCIC, Children and Women, Maternity/Neonatal and Mental Health gave no Board update because representatives were absent; Caesarean surveillance and AMG updates were also unavailable. Policy review/annual programme audit matters remained open; MDRO policy awaited national clarification.

8 September 2026

Outbreaks and HCAI: B3 North/T4 reopening depended on remedial works and negative surveillance. Four NICU babies had acquired closely related MRSA; transmission remained unresolved. Influenza/COVID-19 caused temporary closures. E. coli reached 133 cases (approximately 40 healthcare onset); seven MRSA bacteraemias included four hospital onset. Specialist Services reported ten E. coli cases, four above expectation, and approximately 56% RCA returns.

Standards and workforce: Sixteen of 54 Quality Statement standards required

improvement. C. difficile recognition, isolation, sampling, diagnostics, medical engagement and cleaning remained priorities; Tendable identified chlorine storage, commode and local variation concerns. Mandatory IPC training was approximately 84–85%; ANTT competency/capacity gaps persisted, particularly outside nursing and in Mental Health. Housekeeping had approximately 30 WTE vacancies.

Estate and assurance: Poor flushing, restricted outlet access and cold-water temperatures above 20°C required action. Old HQ kitchen flies/mould and reported staff health concerns remained unresolved; ageing decontamination equipment and estate defects needed follow-up. Procedures were overdue, Caesarean surveillance was absent and AMG membership, objectives and meeting frequency remained unclear.

ADVISE

(Detail here any areas of on-going monitoring where an update has been provided to the subcommittee AND any new developments that will need to be communicated or included in operational delivery)

16 June 2026

Improvement delivery: Finalise/circulate the Quality Statement gap analysis to inform September's Annual Programme. Yvonne Hyde to share C. difficile Collaborative/campaign learning through Board IPC meetings; local paediatric resources were in development. Medicine's lead-nurse workstreams covered devices, catheters, commodes, hand hygiene and ANTT, supported by its IPC Panel/peer review. Surgery was addressing cleaning, environments and instrument defects; Specialist Services planned line-infection review. Consistent ANTT reporting required review.

Governance and pathways: Review AMG membership/Board representation for the next IPCG and improve EPMA stewardship-data access. Finalise Paediatric/Maternity HCID pathways and develop urgent-surgery pathways. Review Measles contact-tracing arrangements; Emma Davies/Yvonne Hyde to revise Safe to Move/respiratory pathways, considering a simpler risk tool.

Infrastructure and policies: Agree UHW HPV access, transport, capacity and operating arrangements with wards/Shaping Change; explore UHL provision. Continue water remediation/sampling. Viral Gastroenteritis comments were due 10 July before ratification; revised Code of Practice/national MDRO guidance remained awaited.

8 September 2026

Delivery and reporting: Boards to embed C. difficile/MRSA/MSSA frameworks in local plans, including isolation, diagnostics, stewardship, cleaning, surveillance and learning; strengthen local testing and Collaborative participation. Yvonne Hyde/Natasha Goswell to finalise the reporting template. Link audit trends/learning to plans, develop ESR ANTT assessment and cross-professional assurance; Medicine to present improvement work next meeting.

Governance and preparedness: Yvonne Hyde to clarify AMG membership, frequency and objectives. Disseminate updated transmission-based precautions for education/winter preparedness; review plans when the revised Code arrives. Yvonne Hyde/HCID Team to report preparedness gaps next meeting; PPE training continued.

Follow-up: Relevant leads to return All-Wales Caesarean/decontamination-leadership updates; reinstate surveillance reporting when available. Yvonne Hyde/Gareth Simpson to revisit Old HQ. T4 handback was provisionally around 1 October, unconfirmed. Annual-report comments were due 28 September; final annual/internal

audit reports and further procedures were anticipated in December. PCIC's IPC Forum was planned from October; next IPCG: 8 December 2026. These were plans, not confirmed outcomes.

ASSURE

(Detail here any areas of assurance that the committee has received)

16 June 2026

Oversight and improvement: March minutes/actions were accepted/completed. Executive MRSA reviews occurred every 4–6 weeks. HARP reported C. difficile down from 210 to 186 and MSSA/E. coli/Pseudomonas targets achieved (reporting-year caveat above). Medicine ANTT improved from approximately 30% to 57%; peer review supported ownership/engagement. Specialist Services CRO audit compliance reached 96% in May; Tendable generally showed positive results across approximately 280 areas, with local exceptions.

Controls in place: Adult HCID pathways and trained staff on every ED shift supported preparedness, with wider PPE training; respiratory activity was very low. Scope-room leaks were resolved, HSDU operational and Theatres 3/4 refurbished. Chlorine dioxide treatment operated at UHW/UHL with sampling, flushing and remediation; impact was not yet established. HPV funding was extended one year. C. difficile Procedure 2026 was ratified unchanged; most IPC documents were current. West 8, isolation/competency gaps and outstanding policy/programme work limited assurance.

8 September 2026

Performance and oversight: June minutes were accepted and Board attendance improved. MSSA performance improved; C. difficile was two cases below the previous year's equivalent point despite national increases. Children and Women reported C. difficile improvement following Collaborative participation.

Education and local evidence: Over 700 staff received education across over 50 sessions in the previous year; audit activity more than doubled, supported by joint audits. Admission screening improved but required further work. Mental Health achieved 100% catheter-audit compliance after improvement work/electronic passport introduction. Satellite dialysis positive blood cultures fell from 26 to 14 between prior reporting years. A four-suite theatre-cleaning pilot awaited evaluation.

Policy and limits: Viral Gastroenteritis Procedure 2026 was ratified with a Health Protection notification/outbreak-meeting amendment. T4 learning reinforced multidisciplinary working, joint audits and environmental controls. Active management was evident, but outbreak investigations, practice/workforce gaps and awaited reports prevented confirmation of risk closure.

ALERT, ADVISE, ASSURE (AAAs) HIGHLIGHT REPORT	
Committee/Group	**Safeguarding**
Meeting Date	15/09/2026
Lead	Executive Nurse Director
Report by	Deputy Executive Nurse Director

This report summarises the Safeguarding Steering Group meeting of 15 September 2026 for Quality Committee. Clinical Board updates covered July–August 2026.

Alert: Low training compliance, unreliable ESR data and safeguarding referral quality remain key risks.
Advise: November follow-up covers training recovery, data correction, MCA action plans and revised reporting. Datix referrals, routine enquiry and Section 5 changes are progressing.
Assure: A completed MARF audit, targeted learning and local scrutiny provide evidence of oversight, but not sustained improvement.

Previous minutes were approved and the earlier action log completed. New actions are due in November; the next SSG is on 24 November 2026.

Overall assessment: partial assurance. Audit and improvement actions are evident, but sustained training improvement, reliable data and action completion remain unproven. This is the report's assessment; the minutes record no formal rating.

ALERT

(Alert the Committee to areas of non-compliance or matters that need addressing urgently)

Training and data: Mental Health VAWDASV Group 2 attendance was 17.9%; Medicine Level 3 compliance was 15.99%. Medical workforce attendance affected Medicine and Specialist Services; Surgery reported MCA training challenges and CD&T a decline. Inaccurate ESR competency allocations and job profiles undermine assurance data; figures require caution pending correction.

Activity and open cases: Mental Health reported nine acute out-of-area placements and falling MARF/AS1 referrals. Medicine reported fewer health referrals but more local authority-led cases. CD&T's rising child referrals may reflect complexity or duplication. Surgery and Safeguarding will review open adult health cases for closure.

Thresholds and capacity: Cardiff Adult Services reported annual referrals rising from 1,600 to over 3,000, with many screened out because adult-at-risk criteria were not met or understood. Premature Section 5 referrals and gaps with employment processes create tribunal risk; early HR involvement and evidenced decisions are needed.

Referral quality and pressure damage: The 60-MARF audit identified gaps in professional judgement, risk/impact analysis, relevant child information and the child's voice. Cardiff Adult Services reported missing referrals for multiple Stage 2 pressure injuries, with some concerns only emerging after catastrophic or fatal incidents.

Reporting gaps: PCIC did not attend; Children and Women were unavailable for the Clinical Board reporting item.

ADVISE

(Detail here any areas of on-going monitoring where an update has been provided to the subcommittee AND any new developments that will need to be communicated or included in operational delivery)

November actions: Clinical Boards: bring training recovery plans, send MCA audit action plans to Chloe Evans and submit 3As reports before the next SSG. Rachel Dix: report the October Mental Health AS1 audit. Natalie and Jane: investigate falling Medicine AS1 referrals. Fiona Bullock and Carla Blackshaw: issue reporting guidance and update on training data correction.

Data and MCA improvement: Safeguarding administration will work with Patient Safety to correct ESR allocations by Clinical Board. A standardised MCA training framework and staff survey on compliance barriers are being developed.

Referral and enquiry changes: Datix integrated referrals will replace adult and child forms, with CAMHS and OPMH targeted as pilots; no launch date is confirmed. Chloe Laws will coordinate routine enquiry expansion to EU, DOSH and Mental Health, including training, documentation and audit.

Section 5: Review policy and risk assessment following July changes, ensuring consistent thresholds, early HR input, evidenced suitability and transferable-risk decisions, and staff support.

Wider developments: Cardiff Adult Services raised uncertainty over VAWDASV grant administration and under-reporting of abuse in older adults. The National Safeguarding Service called for collaborative planning on mortuary safeguarding governance. No outcome was recorded for Ask and Act or Task and Finish Groups.

ASSURE

(Detail here any areas of assurance that the committee has received)

Audit and learning: The completed 60-MARF audit found good administrative and factual recording, with CAMHS strong on the child's voice. Bite-size learning and referral guidance address gaps; re-audit is planned in six months.

Oversight and support: The new 3As template structures reporting of training, referral quality, activity and risks, with review at the next SSG. Specialist Services holds fortnightly pressure damage scrutiny panels, now including the redress team. Weekly DoLS updates were offered in September–October, alongside a seven-minute briefing. These measures support improvement but do not yet demonstrate sustained compliance or reduced risk.