Patient Experience
Profiad y Claf

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Putting Things Right

Concerns, Complaints, Compliments Redress and Inquests

Annual Report 2025–26

Contents

Annual Report Overview

This Annual Report provides assurance on Cardiff and Vale University Health Board's arrangements for managing concerns, complaints, redress, and inquests during 2025/26. It describes how the Health Board has met its statutory responsibilities under the **Putting Things Right (PTR)** Regulations during the reporting period, while also preparing for the transition to **Listening to People (LTP)** from April 2026. The report sets out performance, themes, trends, learning and improvement actions arising from feedback, harm, and patient death.

Concerns, complaints, redress, and inquests each provide an important source of information assurance for the Health Board and form part of its wider quality, safety, and governance framework. Complaints and concerns help the organisation understand where patient experience, communication or service delivery have fallen short of expectations. Redress cases provide further insight where harm may have occurred, and legal redress is being considered. Inquests provide an additional opportunity to review the circumstances of a patient's death, respond openly, and identify any wider learning for services and systems.

Taken together, these processes help the Health Board build a more complete picture of risk, patient experience and service reliability. Learning from complaints, redress and inquests is reviewed alongside wider governance information so that recurring themes, emerging risks, and opportunities for improvement can be identified and acted on. This supports a more joined-up approach to assurance and helps ensure that learning is used to improve care, strengthen systems and reduce the risk of similar issues happening again.

Throughout 2025/26, the Health Board has continued to promote openness, early engagement, proportionate investigation, and meaningful learning. This report therefore not only reflects activity and performance during the year but also demonstrates how feedback and lived experience are being used to support safer, kinder, and more effective care across the organisation.

Arrangements for Managing Concerns, Complaints, Redress and Inquests

The Health Board manages concerns and complaints in line with the **Putting Things Right (PTR)** Regulations, supported by established arrangements for acknowledgement, triage, investigation, early resolution, and response. Concerns are reviewed according to seriousness and complexity, which helps determine the most appropriate route for investigation and supports a proportionate, timely and compassionate response.

Complaints, redress, and inquests are managed through linked governance arrangements involving Clinical Boards, Patient Experience, Legal Services, and other relevant teams. This supports oversight of harm, patient experience and legal or Coroner-related processes, while helping the organisation respond openly and consistently where care may have fallen short.

Where concerns indicate possible harm, the Health Board considers whether there may be a qualifying liability and whether redress should be explored. Where a patient death is reported to the Coroner, the Health Board also supports the inquest process through the timely provision of information, statements, and a learning review. In this way, complaints, redress, and inquests are considered as connected sources of assurance rather than as separate processes.

These arrangements help the Health Board identify recurring themes, emerging risks, and opportunities for improvement across services. Learning from concerns, complaints, redress, and inquests is reviewed through established governance routes so that actions can be tracked, assurance strengthened and improvements embedded in practice.

The sections below summarise activity, performance and learning during 2025/26 and show how feedback, harm review and Coroner-related processes are being used to support safer, kinder, and more effective care across the organisation.

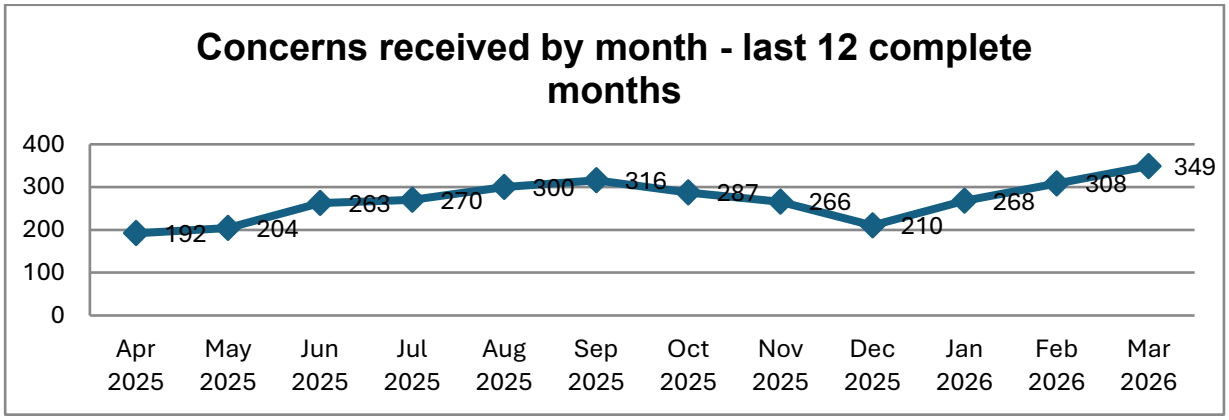
Concerns Statistics

In 2025/26 we received 3,245 concerns. Of these, 430 were managed through early resolution, providing a satisfactory outcome for the person raising the concern within two working days (including the day of receipt).

Overview of 2025-26	**2024/25**	**2025/26**
Concerns	3,471	3,245
Closed under Early Resolution	1,147	430
Enquiries	2189	4206
Compliments	595	761

During 2025/26 we continued to strengthen our ‘listen, respond and learn’ approach so that people receive the right response at the earliest opportunity. We refined how we record and manage initial contacts, with more requests for information, advice and signposting now recorded and managed as **enquiries** rather than being closed under **early resolution**. This provides a clearer picture of demand, improves the consistency of our reporting, and enables early resolution activity to focus on concerns that can genuinely be concluded within two working days.

To support this change and improve people's experience, we reallocated resource from the complaints team to strengthen enquiry handling, helping to provide timely updates, clearer signposting, and earlier reassurance. Alongside this, we maintained robust performance against key timeliness standards for acknowledging concerns and responding within thirty working days, supported by close working relationships with Clinical Boards and a continued focus on early engagement with people raising concerns.



This pattern demonstrates an **overall upward trend in complaints**, in the latter part of the year. As seen across multiple Clinical Boards, the increase was primarily associated with ongoing pressures related to access, waiting times, communication, and service capacity. The trend also reflects increased awareness of complaints processes and confidence among patients and families in raising concerns when care does not meet expectations.

What we are doing

All complaints referenced in this report were managed under the **Putting Things Right (PTR) Regulations**. The Health Board recognises, however, that rising complaint volumes and increasing complexity highlight the importance of strengthening listening, engagement, and learning arrangements consistently across all Clinical Boards.

From **April 2026**, the Health Board has implemented changes in line with the **Listening to People (LTP) Regulations**, establishing an improved, more person-centred approach to concerns and complaints. While responsibility for listening and responding remains embedded within Clinical Boards, this is supported by strengthened **Corporate oversight and assurance arrangements**, ensuring consistency and shared learning at an organisational level.

Key areas of focus include:

- **Greater emphasis on early resolution**, supported by corporate guidance and oversight, enabling concerns to be addressed proportionately and as close as possible to the point of care.
- **Improved use of themes and trends**, with Corporate teams supporting analysis across Clinical Boards to identify system-wide issues and inform organisational priorities.
- **Stronger governance and assurance**, including Corporate monitoring of timeliness, escalation of overdue cases, and support for Clinical Boards managing complex or high-impact complaints.
- **Embedding learning across the organisation**, ensuring that insights from complaints in one service area are shared appropriately and used to support improvement across others.

Through the combined responsibility of Clinical Boards and Corporate teams, the Health Board aims to ensure a consistent, compassionate approach to listening and learning, reduce avoidable

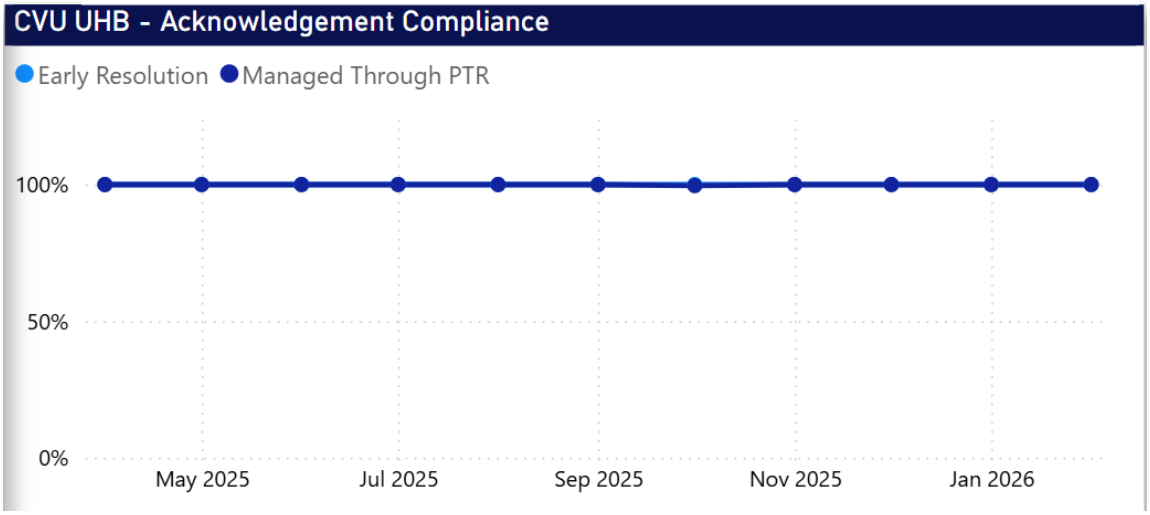
escalation into formal complaints, and strengthen the use of patient and family feedback to drive sustainable improvement during 2026/27 and beyond.

How did we do?

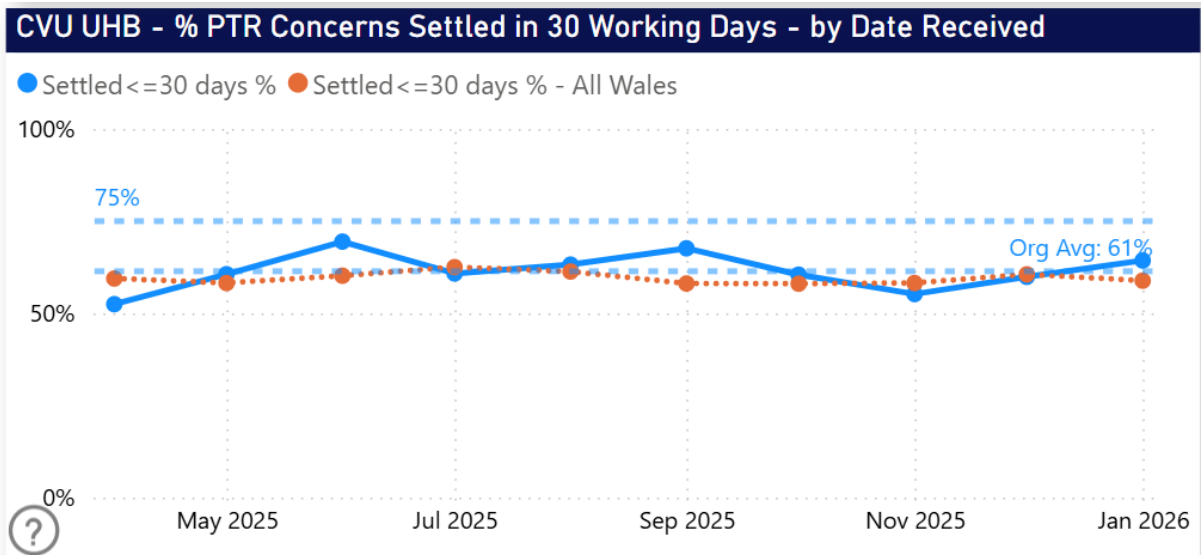
The graphs below summarise our performance in responding to concerns during 2025/26.

Graph 1 shows our timeliness in acknowledging formal concerns (within the required five working days), supporting early engagement and clear agreement of the Terms of Reference at the outset.

Graph 1.



Graph 2 shows the proportion of concerns managed and responded to within thirty working days. Performance remained strong throughout the year, supported by proactive contact where an agreed extension to the response timescale was needed.



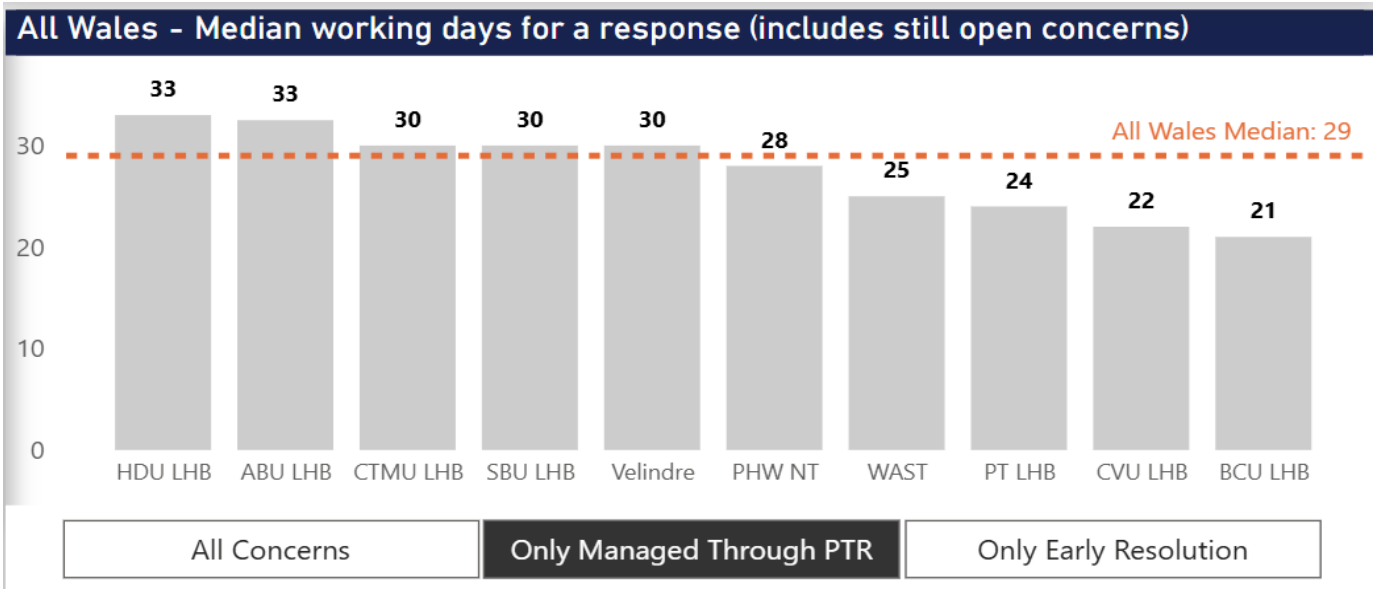
Graph 3 shows the number of concerns overdue at the point of reporting. The all-Wales benchmarking shown in the graph indicates that our overdue numbers remain low in comparison with the position across Wales, supported by close working with Clinical Boards to maintain momentum and oversight.

All Wales - Overdue Concerns by working days since due date

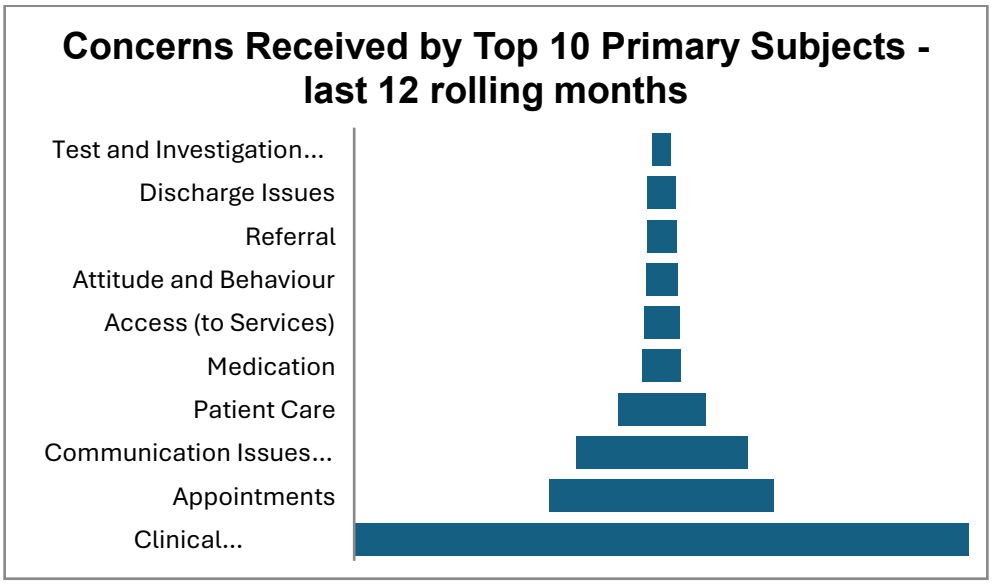
Organisation	<90 Days	90 to 180 Days	180 to 270 Days	270 to 365 Days	Over 365 Days	Total
All Wales	812	267	94	15	4	1192
ABU UHB	187	59	27	6		279
BCU UHB	48	1				49
CVU UHB	83	2				85
CTMU UHB	62	46	5	1	1	115
HDU UHB	203	100	35	5		343
SBU UHB	179	42	14	2	3	240
PT HB	12					12
WAST	35	17	13	1		66
Velindre	1					1
PHW NT	2					2

Graph 4.

Graph 4 shows the median time taken to respond to formal concerns. This is a useful indicator of the typical experience for people who raise a concern, because it is less influenced by a smaller number of complex cases that take longer to conclude. The all-Wales comparator included within the graph indicates that our median response time compares positively with the position across Wales, demonstrating that concerns are typically concluded within a shorter timeframe than the wider benchmark. This has been supported by early contact to agree Terms of Reference, clear ownership of actions, and active oversight with Clinical Boards. Where an extension is required, we continue to prioritise proactive communication so that people understand the reason, the revised timescale, and the next steps.



Top 10 subjects 2025/2026



Public Service Ombudsman

The Health Board continues to manage a significant volume of concerns, with a small proportion progressing to the Public Services Ombudsman for Wales (PSOW).

The majority of cases recorded within the reporting period are categorised as Ombudsman **enquiries rather than full investigations**, with a smaller number progressing to formal investigation or proposal stages. A substantial proportion of cases are closed at an early stage by the Ombudsman with a **decision not to investigate**, indicating that local resolution processes are often accepted as appropriate.

Where cases proceed to full investigation, outcomes include **not upheld, partially upheld and upheld findings**, with associated recommendations focused on learning and service improvement. Evidence within the dataset highlights that **Section 27 compliance actions** and formal responses to Ombudsman reports are routinely progressed and monitored. The Health Board did not receive any public reports in this time period.

Key Themes

The predominant themes arising from Ombudsman referrals include:

- **Clinical treatment and assessment issues**, particularly delays in diagnosis, delays or lack of treatment, and concerns regarding adequacy of care.
- **Communication issues**, including communication with patients, families, and between services or external organisations.
- **Access to services**, including waiting times, appointment delays, and service availability.

- Additional themes include **attitude and behaviour of staff**, **discharge processes**, **record keeping**, and **confidentiality concerns**.

Cases are distributed across all Clinical Boards, with notable representation from:

- **Emergency and Acute Medicine services**
- **Obstetrics and Gynaecology / Women and Children's services**
- **Mental Health services (including community settings)**
- **Surgical and specialist services (including Neurosciences and Haematology)**

Learning and Improvement

Learning identified from Ombudsman cases is consistent with wider organisational themes and focuses on:

- Strengthening **communication and patient engagement**
- Improving **timeliness of assessment, diagnosis, and treatment pathways**
- Enhancing **documentation and record keeping standards**
- Ensuring clear **information provision and consent processes**
- Reinforcing staff awareness of responsibilities through training, audit, and service review

In several cases, **apologies, service reviews, audits, and targeted improvements to patient information** were implemented as part of the response to Ombudsman findings and recommendations.

Current Position

At the point of reporting, the majority of cases are recorded as **'new' or in early-stage Ombudsman processes**, with a smaller number awaiting final outcome or with actions in progress following receipt of final reports. Further detail will be provided in the review of the Ombudsman annual letter which will be shared with Committee

Concerns and Complaints Activity (2025/26)

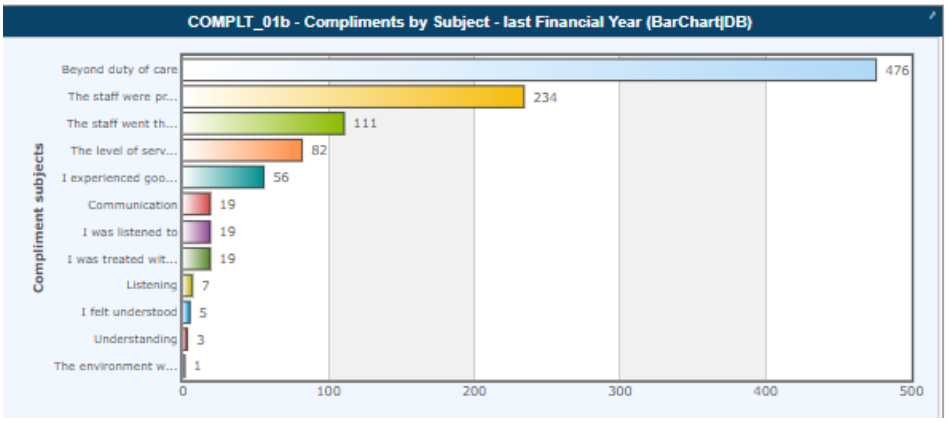
Compliments and positive feedback

Alongside concerns and complaints, the Health Board continues to receive positive feedback that highlights the compassion, professionalism, and commitment of staff across a wide range of services. Compliments received during the year described staff who were calm, reassuring, and attentive during vulnerable moments, including maternity care, surgery, trauma, mental health discharge support, and end-of-life care. Feedback repeatedly emphasised the difference made by clear explanations, emotional reassurance, kindness under pressure and staff going beyond what was expected to make patients and families feel safe, informed, and supported.

Examples of compliments included praise for maternity staff who reduced anxiety and created a calm, supportive experience during labour and induction; surgical and trauma teams who combined efficient treatment with warmth and dignity; staff on acute and end-of-life wards who communicated openly and compassionately with relatives; and individual members of staff who took time to answer questions, explain processes and provide reassurance during difficult

circumstances. These examples provide an important reminder that, even during periods of significant operational pressure, patients and families continue to recognise and value the skill, humanity, and dedication of Health Board staff.

The graph below provides an overview of the compliments received during 2025/26 and illustrates the positive feedback recorded across the year.



The table below summarises compliments by service and shows the main themes reflected in the positive feedback received.

Compliments by Service	Beyond duty of care	Good communication from staff	I felt understood and listened to	I was treated with dignity and respect	Listening	Environment suitable for my needs	The level of service was beyond what I expected	The staff went the extra mile	The staff were professional and caring	Understanding
Children and Women's Services	200	27	17	17	0	0	33	54	157	0
Clinical Diagnostics and Therapeutic Services	20	13	3	0	0	0	6	7	15	0
Executive and Corporate Services	6	22	1	0	5	0	1	3	1	2
Medicine Services	127	5	2	1	1	1	13	18	24	0
Mental Health Services	4	2	0	0	0	0	1	1	0	0
Primary, Community and Intermediate Care	20	4	1	0	1	0	3	4	5	1
Specialist Services	30	1	0	0	0	0	4	4	8	0
Surgical Services	58	1	0	1	0	0	21	20	24	0

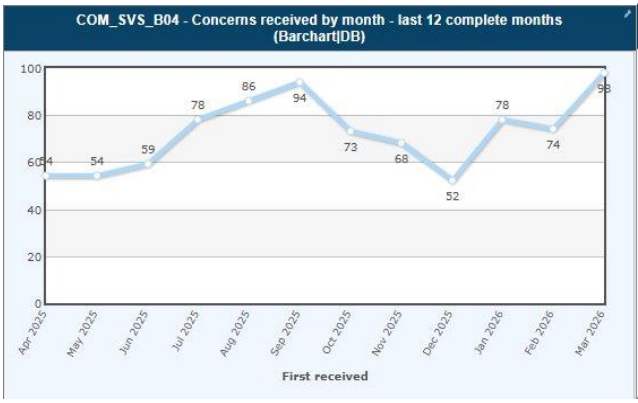
Overall, the above table shows that positive feedback was recorded across all services, with the highest volumes of compliments received in Children and Women, Surgery and Medicine, where feedback most often highlighted professionalism, kindness, reassurance, and staff going the extra mile.

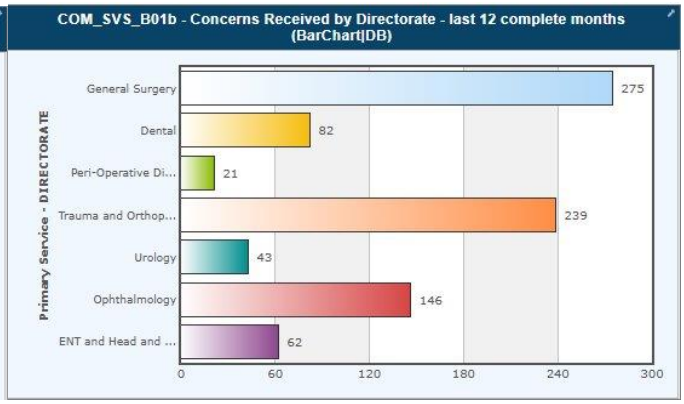
Surgery Clinical Board

During the reporting period, the **Surgery Clinical Board experienced an overall increase in complaints activity**, which was managed in line with the **Putting Things Right (PTR) Regulations**, in force throughout the year.

Over the last twelve complete months, the Surgery Clinical Board received a total of **868 complaints**, equating to an average of **approximately 72 complaints per month**. Monthly volumes were lower at the start of the year before increasing through the summer period, with complaint activity reaching higher levels across **August and September 2025**.

Although complaint volumes reduced during the autumn and early winter months, with the lowest monthly total recorded in **December 2025 (52 complaints)**, activity increased again towards the end of the year. Complaints rose again across **January and February 2026**, before reaching **98 complaints in March 2026**, the highest monthly total recorded during the year. This pattern reflects sustained pressure across Surgery services, particularly in relation to access, waiting times, communication with patients and families, and discharge planning.





Within Surgery, the directorate chart shows variation across services, with some directorates receiving consistently higher volumes of new concerns than others and the highest-pressure areas contributing most to the overall rise seen towards year end.

Overall, this pattern demonstrates a **variable but sustained level of complaints activity across the year**, with higher volumes during the summer and early autumn period and a rise again towards the end of the year. The increase reflects ongoing pressures within Surgery services, particularly in relation to access, waiting times, communication with patients and families, and discharge planning. It also reflects increased awareness of complaints processes and confidence among patients and families in raising concerns when expectations are not met.

What we are doing

All complaints referenced above were managed under the **Putting Things Right (PTR) Regulations**. The Surgery Clinical Board recognises that the increasing volume and complexity of complaints highlights the need to strengthen listening, communication, early resolution, and the use of feedback to support improvement.

In response, the Clinical Board is focusing on:

- **Improved clinical and managerial oversight**, ensuring complaints are reviewed alongside quality, safety, and patient experience data so that common themes, emerging risks, and recurring issues can be identified earlier.

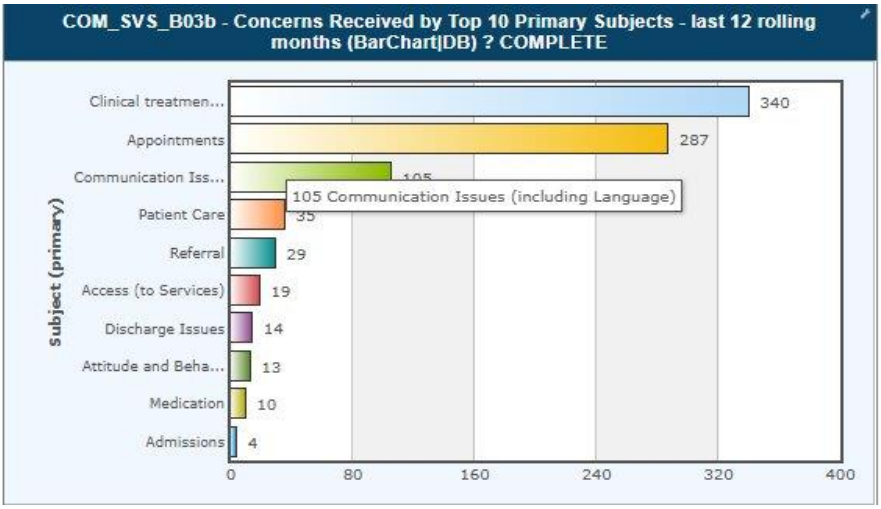
- **Stronger action on communication and discharge planning**, particularly where complaints highlight delays, uncertainty, pathway complexity, or a lack of clear information for patients and families.
- **Earlier resolution where appropriate**, with a focus on responding promptly and proportionately to concerns and reducing avoidable escalation into lengthy formal processes.
- **Use of complaint themes to support improvement**, ensuring learning from complaints informs pathway review, service redesign, and wider quality improvement activity across surgical services.

From **April 2026**, further improvements are being implemented in line with the **Listening to People (LTP) Regulations**, supporting a more person-centred and responsive approach to concerns and complaints. This will help the Surgery Clinical Board improve patient experience, reduce avoidable escalation, and ensure that feedback from patients and families continues to inform meaningful and sustainable service improvement.

Themes and Trends

The top complaint themes mirror those seen across the organisation and relate primarily to:

- **Communication failures** with patients and families,
- **Delays in access, treatment, and follow-up** across surgical pathways,
- **Poorly coordinated discharge and pathway planning**, particularly where patients rely on support from multiple teams and services.



You said / We did

You said: Patients and families experienced long waits and inconsistent communication for complex cases needing dental theatre procedures.
We did: We introduced a new approach so complex cases are routinely discussed at the weekly theatre meeting, giving earlier senior oversight, better planning and more proactive management of cancellation and delay risks.
You said: There were concerns about how urgent MDT outcomes were communicated and how follow-up care was arranged.
We did: We reviewed and strengthened processes for urgent MDT decisions and follow-up, and increased the use of face-to-face appointments where patients need timely specialist input.

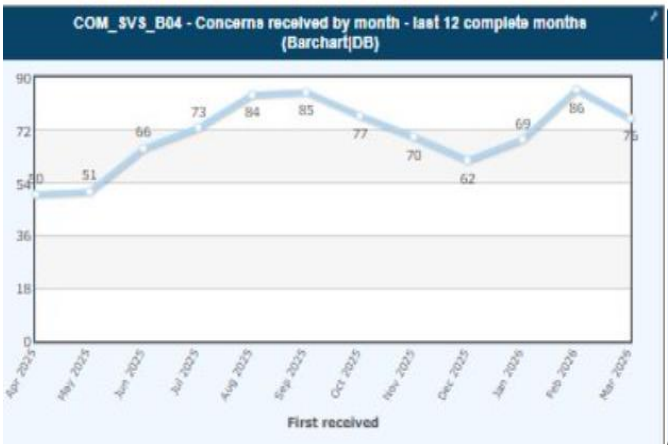
Medicine Clinical Board

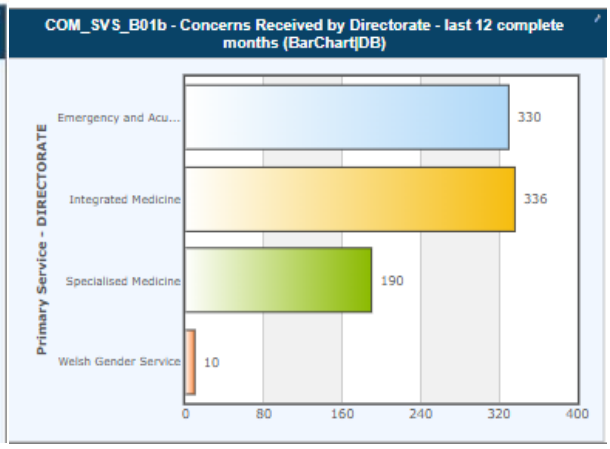
Medicine Clinical Board – complaints activity (last 12 months)

During the reporting period, the **Medicine Clinical Board experienced an overall increase in complaints activity**, which was managed in line with the **Putting Things Right (PTR) Regulations**, in force throughout the year.

Over the last twelve complete months, the Medicine Clinical Board received a total of **852 complaints**, equating to an average of **approximately 71 complaints per month**. Monthly volumes increased during the first half of the year, rising from **54 complaints in April** and **51 in May** to a sustained peak over the summer period, reaching **84 complaints in August** and **85 complaints in September**.

Although complaint volumes reduced during the autumn and early winter months, with the lowest monthly total recorded in **December 2025 (62 complaints)**, activity increased again towards the end of the year. Complaints rose to **69 in January**, peaked at **86 in February**, and remained higher than earlier months in **March 2026 (75 complaints)**. This pattern reflects sustained pressure across Medicine services, particularly in relation to access, communication with patients and families, and discharge planning for frail and complex patients.





Within Medicine, the graph shows clear variation between directorates, with some service areas receiving a consistently higher share of new concerns and driving the overall increase seen across the year.

Overall, this pattern demonstrates a **variable but sustained level of complaints activity across the year**, with higher volumes during the summer and early autumn period and a rise again towards the end of the year. The increase reflects ongoing pressures within Medicine services, particularly in relation to access, communication with patients and families, and discharge planning for frail and complex patients. It also reflects increased awareness of complaints processes and confidence among patients and families in raising concerns when expectations are not met.

What we are doing

All complaints referenced above were managed under the **Putting Things Right (PTR) Regulations**. The Medicine Clinical Board recognises that the increasing volume and complexity of complaints highlights the need to strengthen listening, communication, continuity, early resolution, and the use of feedback to support improvement.

In response, the Clinical Board is focusing on:

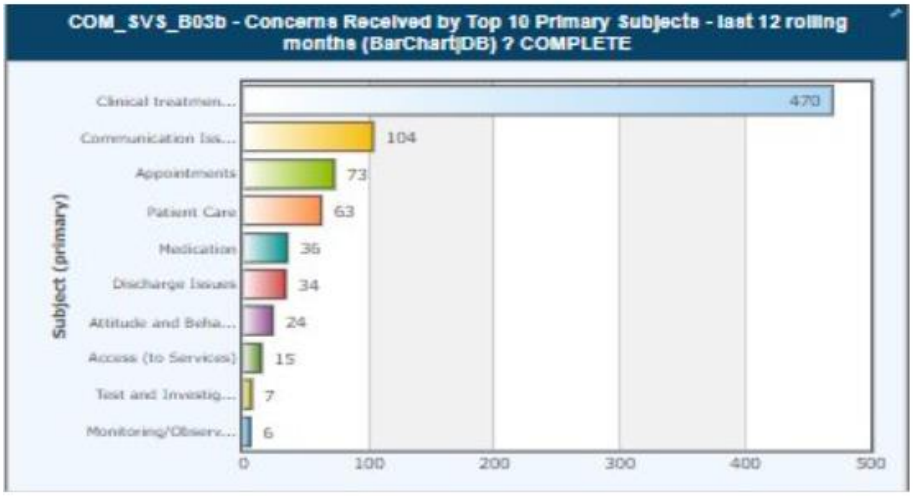
- **Improved clinical and managerial oversight**, ensuring complaints are reviewed alongside incidents, mortality, and quality data to identify common themes and risks.
- **Focused action on communication and discharge planning**, particularly for frail and vulnerable patients, where complaints most frequently arise.
- **Greater emphasis on early resolution**, seeking to resolve concerns promptly and proportionately where appropriate, and reduce escalation into lengthy formal processes.
- **Earlier coordination of complex complaints**, using multiprofessional meetings where concerns span several services, so that investigating officers, responsibilities and lines of enquiry are agreed at an early stage.
- **Practical support for investigating officers**, including coordinator support to help develop clear, timely and high-quality responses.
- **Stronger oversight of active cases**, reinforcing expectations for weekly tracker meetings, timely progress, and clear ownership by investigating officers.

From **April 2026**, further improvements are being implemented in line with the **Listening to People (LTP) Regulations**, supporting a more person-centred and responsive approach to concerns and complaints. This will help the Medicine Clinical Board improve patient experience, reduce avoidable escalation, and ensure that feedback from patients and families continues to inform meaningful and sustainable service improvement.

Themes and Trends

The top complaint themes mirror those seen across the organisation and relate primarily to:

- **Communication failures** with patients and families,
- **Unsafe or poorly coordinated discharge**, particularly for frail and vulnerable patients,
- **Delays in assessment, escalation, diagnostics and treatment** across emergency, integrated and specialist medicine pathways.



You said / We did

You said: Patients and families did not always know who to speak to on the ward when they had a concern.
We did: We produced a leaflet for acute medicine wards to explain how the ward works and who to speak to first, including the ward sister.

You said: It was not always clear where patients should go or how to find information in the Emergency Department.
We did: We improved redirection pathways in triage and added QR codes so that information is easier to access.
You said: Some staff communication and record keeping did not meet the expected standard.
We did: We reminded staff about professional standards, respectful communication, and the importance of clear documentation.
You said: Staff were not always clear about how to raise or escalate concerns.
We did: We shared clearer information with staff about how to escalate concerns using P@ART.
You said: There were concerns about recognising sepsis and escalating care quickly.
We did: We provided staff education on sepsis care and when to escalate concerns.
You said: People needed quicker direction to the right service when they first arrived.
We did: We are testing a front-door redirection nurse role to help guide people to the right service and reduce triage waiting times.
You said: The public needed clearer advice about how to use emergency services.
We did: We ran social media campaigns to help people choose the right emergency service for their needs.

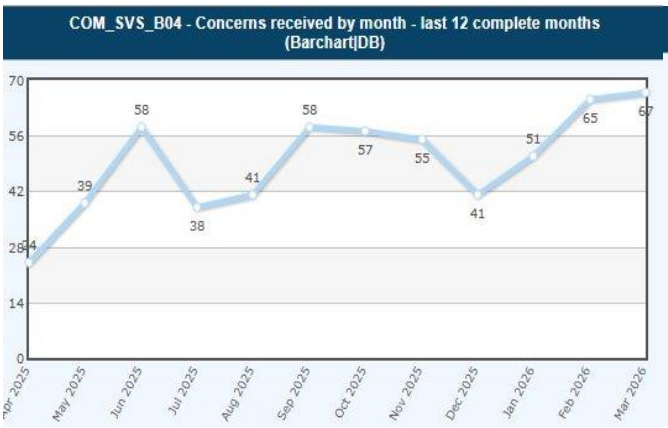
Children and Women Clinical Board

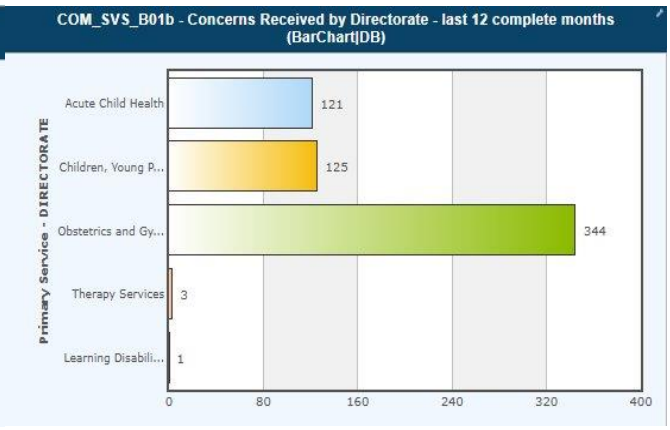
Children and Women Clinical Board – complaints activity (last 12 months)

During the reporting period, the **Children and Women Clinical Board experienced an overall increase in complaints activity**, which was managed in line with the **Putting Things Right (PTR) Regulations**, in force throughout the year.

Over the last twelve complete months, the Children and Women Clinical Board received a total of **364 complaints**, equating to an average of **approximately 30 complaints per month**. Monthly volumes were lower at the start of the year before increasing through the summer period, with complaint activity reaching higher levels across **August, September, and October 2025**.

Although complaint volumes reduced during the winter months, with lower activity recorded in **December 2025 and January 2026**, volumes increased again towards the end of the year. Complaints rose again across **February and March 2026**, indicating renewed pressure across Children and Women services, particularly in relation to access, waiting times, communication with families and coordination across pathways.





Within Children and Women, the directorate graph shows an uneven distribution of new concerns, with higher activity concentrated in some service areas while others remained lower and more stable across the year.

Overall, this pattern demonstrates a **variable but sustained level of complaints activity across the year**, with higher volumes during the summer and early autumn period and a rise again towards the end of the year. The increase reflects ongoing pressures within Children and Women services, particularly in relation to access, demand, communication with patients and families, and coordination across pathways. It also reflects increased awareness of complaints processes and confidence among patients and families in raising concerns when expectations are not met.

What we are doing

All complaints referenced above were managed under the **Putting Things Right (PTR) Regulations**. The Children and Women Clinical Board recognises that the volume and complexity of complaints highlight the need to strengthen listening, communication, family experience, early resolution, and the use of feedback to support improvement.

In response, the Clinical Board is focusing on:

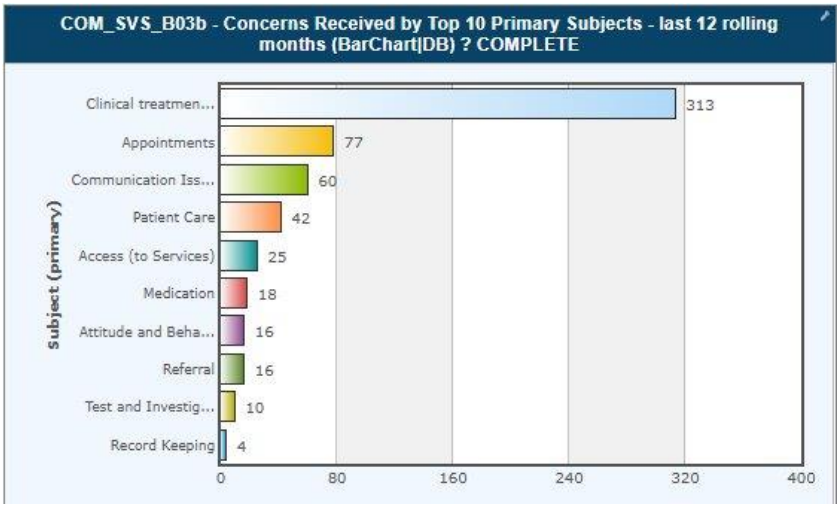
- **Improved clinical and managerial oversight**, ensuring complaints are reviewed alongside quality, safety, and experience data to identify common themes and risks.
- **Focused action on communication and family experience**, particularly where delays, uncertainty and pathway complexity are most frequently raised.
- **Greater emphasis on early resolution**, seeking to resolve concerns promptly and proportionately where appropriate, and reduce escalation into lengthy formal processes.
- **Use of themes and trends to inform improvement**, ensuring learning from complaints is embedded into service review, pathway redesign, and quality improvement activity across maternity, gynaecology, paediatric and family-centred services.
- **Stronger weekly case tracking**, with revised tracker arrangements to support clearer ownership and more timely responses.
- **Clearer accountability for response times**, including active follow-up with investigating officers to reinforce expected timescales and progress.

From **April 2026**, further improvements are being implemented in line with the **Listening to People (LTP) Regulations**, supporting a more person-centred and responsive approach to concerns and complaints. This will help the Children and Women Clinical Board improve patient and family experience, reduce avoidable escalation, and ensure that feedback continues to inform meaningful and sustainable service improvement.

Themes and Trends

The top complaint themes mirror those seen across the organisation and relate primarily to:

- **Communication failures** with patients and families,
- **Delays in access, assessment, and follow-up** across maternity, gynaecology and paediatric pathways,
- **Poorly coordinated care across pathways**, particularly where families rely on support from multiple teams and services.



You said / We did

You said: Families wanted better communication and more compassionate conversations in obstetrics and gynaecology.
We did: The directorate invited Dr Chris Turner, UK lead for Civility Saves Lives, to support improvement in communication and compassionate conversations.
You said: Parents needed clearer communication and an easier referral pathway in neurodevelopment services.
We did: Concerns helped us improve proactive communication with parents and streamline the pathway for accepting referrals.

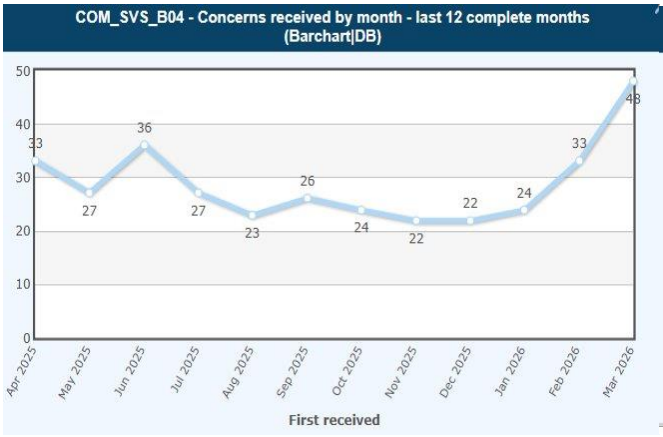
Specialist Services Clinical Board

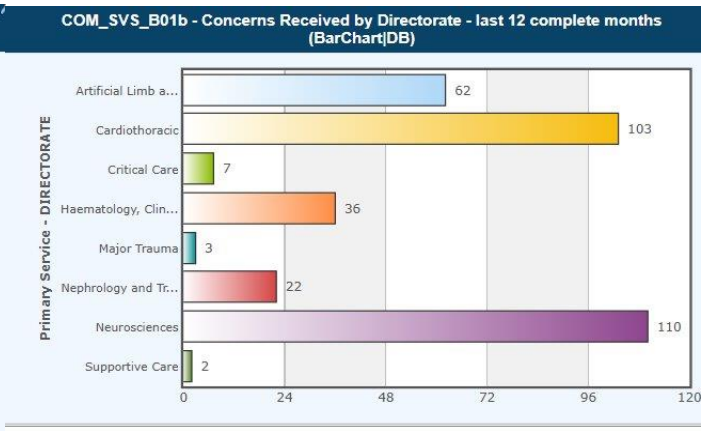
Specialist Services Clinical Board – complaints activity (last 12 months)

During the reporting period, the **Specialist Services Clinical Board experienced a variable but sustained level of complaints activity**, which was managed in line with the **Putting Things Right (PTR) Regulations**, in force throughout the year.

Over the last twelve complete months, the Specialist Services Clinical Board received a total of **238 complaints**, equating to an average of **approximately 20 complaints per month**. Monthly volumes were lower at the start of the year before increasing through the summer and early autumn period, with higher activity sustained across the middle months of the year.

Although complaint volumes reduced slightly after the summer and autumn peak, activity increased again towards the end of the year. This pattern indicates a variable but sustained level of complaints across Specialist Services, particularly in relation to access, communication, pathway coordination, and the experience of care within specialist services, where patients often require timely intervention, clear information, and input from highly specialised teams.





Within Specialist Services, the chart suggests that new concerns were spread across a smaller number of directorates, with some specialist areas showing more fluctuation while others remained comparatively steady.

Overall, this pattern demonstrates a **variable but sustained level of complaints activity across the year**, with higher volumes during the summer and early autumn period and a rise again towards the end of the year. The trend reflects the complexity of specialist pathways and the importance of timely access, coordinated care and clear communication for patients receiving specialist assessment, treatment, and follow-up.

What we are doing

All complaints referenced above were managed under the **Putting Things Right (PTR) Regulations**. The Specialist Services Clinical Board recognises that, although complaint volumes are lower than in some larger Clinical Boards, the complexity of cases highlights the need to strengthen listening, communication, early resolution, and the use of feedback to support improvement.

In response, the Clinical Board is focusing on:

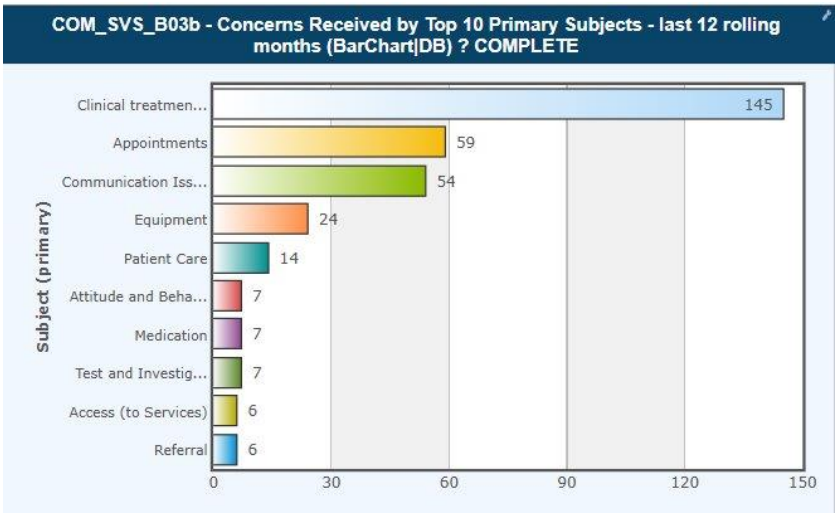
- **Improved clinical and managerial oversight**, ensuring complaints are considered alongside quality, safety, and patient experience information so that themes, risks, and service pressures can be identified more effectively.
- **Focused action on access, communication, and pathway coordination**, particularly where patients rely on timely specialist review, treatment, diagnostics, or follow-up across complex pathways.
- **Earlier and more proportionate resolution of concerns**, reducing unnecessary escalation and supporting a more responsive experience for patients and families.
- **Using complaint themes and trends to support service improvement**, ensuring learning from complaints informs pathway review, service redesign, and quality improvement activity across specialist services.

From **April 2026**, further improvements are being implemented in line with the **Listening to People (LTP) Regulations**, supporting a more person-centred and responsive approach to concerns and complaints. This will help the Specialist Services Clinical Board improve patient experience, reduce avoidable escalation, and ensure that feedback from patients and families continues to inform meaningful and sustainable service improvement.

Themes and Trends

The top complaint themes mirror those seen across the organisation and relate primarily to:

- **Communication failures** with patients and families,
- **Delays in access, treatment, or follow-up** within specialist pathways,
- **Poorly coordinated care across pathways** where patients rely on input from multiple teams and services.



You said / We did

In Specialist Services, learning from concerns during 2025/26 has largely been addressed through reflective conversations, local case review, and targeted support or training with staff. Although this has not always resulted in formal action plans or clearly documented improvement outputs, it has supported immediate learning and practice improvement at service level. A priority for 2026/27 will be to strengthen how this learning is recorded and evidenced so that service improvements can be demonstrated more clearly in future reports.

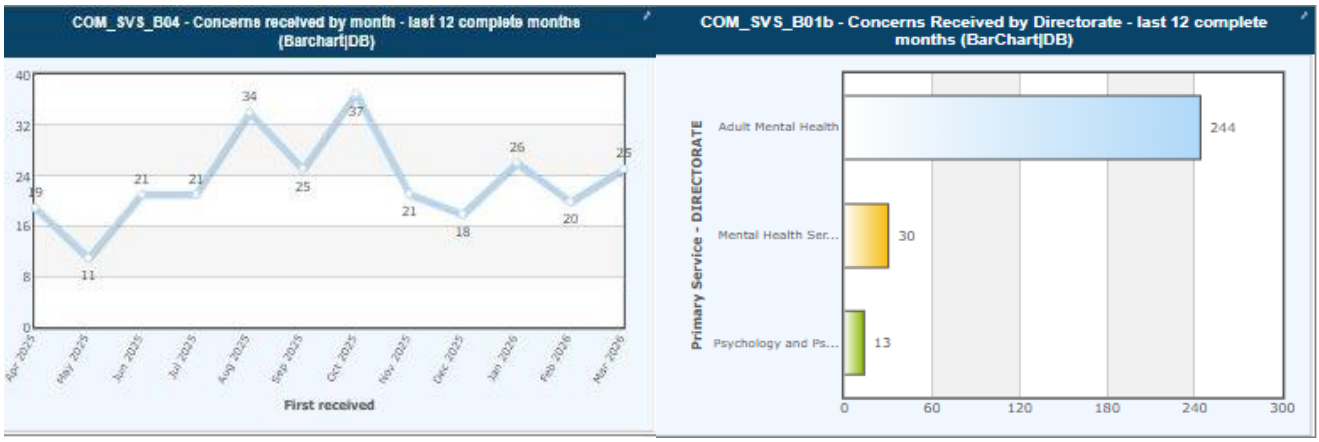
Mental Health Clinical Board

Mental Health Clinical Board – complaints activity (last 12 months)

During the reporting period, the **Mental Health Clinical Board experienced a variable but sustained level of complaints activity**, which was managed in line with the **Putting Things Right (PTR) Regulations**, in force throughout the year.

Over the last twelve complete months, the Mental Health Clinical Board received a total of **278 complaints**, equating to an average of **approximately 23 complaints per month**. Monthly volumes fluctuated across the year, rising from **19 complaints in April 2025** to **21 in June and July 2025**, before increasing further during the late summer period to **34 complaints in August 2025**.

Complaint volumes reduced slightly to **25 in September 2025** before rising to a peak of **37 complaints in October 2025**. Activity then reduced during the winter months, with lower totals recorded in **December 2025 and February 2026**, before increasing again in **January and March 2026**. This pattern indicates variable but sustained pressure across Mental Health services, particularly in relation to access, communication, continuity of care and the experience of support across community, inpatient, and specialist pathways.



Within Mental Health, the directorate graph shows that some service areas experienced more pronounced peaks than others, indicating that pressure was not evenly distributed across the Clinical Board.

Overall, this pattern demonstrates a **variable but sustained level of complaints activity across the year**, with higher volumes during the summer and early autumn period and a rise again towards the end of the year. The trend reflects the importance of timely access, coordinated care, clear communication and compassionate support for people using Mental Health services, many of whom may be particularly vulnerable at the point concerns are raised.

What we are doing

All complaints referenced above were managed under the **Putting Things Right (PTR) Regulations**. The Mental Health Clinical Board recognises that the volume and nature of complaints highlight the need to strengthen listening, communication, continuity, early resolution, and the use of feedback to support improvement.

In response, the Clinical Board is focusing on:

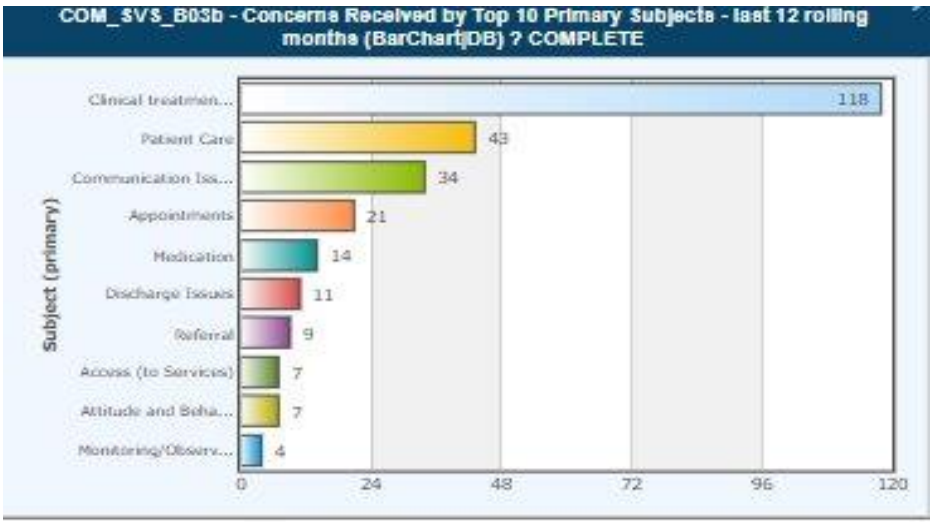
- **Improved clinical and managerial oversight**, ensuring complaints are reviewed alongside quality, safety, and patient experience information to identify recurring themes, risks, and opportunities for improvement.
- **Focused action on communication and continuity of care**, particularly where concerns arise during transitions between teams, community services, inpatient care, or specialist pathways.
- **Earlier and more compassionate resolution of concerns**, supporting timely responses where appropriate and reducing avoidable escalation into lengthy formal complaints.
- **Use of themes and trends to inform service development**, ensuring learning from complaints is used in pathway review, service redesign, and improvement activity across Mental Health services.

From **April 2026**, further improvements are being implemented in line with the **Listening to People (LTP) Regulations**, supporting a more person-centred and responsive approach to concerns and complaints. This will help the Mental Health Clinical Board improve patient and carer experience, reduce avoidable escalation, and ensure that feedback continues to inform meaningful and sustainable service improvement.

Themes and Trends

The top complaint themes mirror those seen across the organisation and relate primarily to:

- **Communication failures** with patients, carers, and families,
- **Delays in access, review, or follow-up** across Mental Health pathways,
- **Poor continuity or coordination of care**, particularly where people move between teams, settings, or levels of support.



You said / We did

You said: People waiting for ADHD and ASD assessments needed clearer information about waiting times and available support.
We did: We introduced a standard letter to explain expected waiting times and the support available while people are on the waiting list.
You said: People wanted more understanding and support around neurodiversity while waiting for help.
We did: We increased promotion of the Recovery College neurodiversity programme, “Under the Mask.”
You said: Access to community mental health support needed to improve, including waiting times.
We did: We continued delivery of the 36 Degrees Pillars, with a focus on culture and Community Mental Health Team waiting lists.

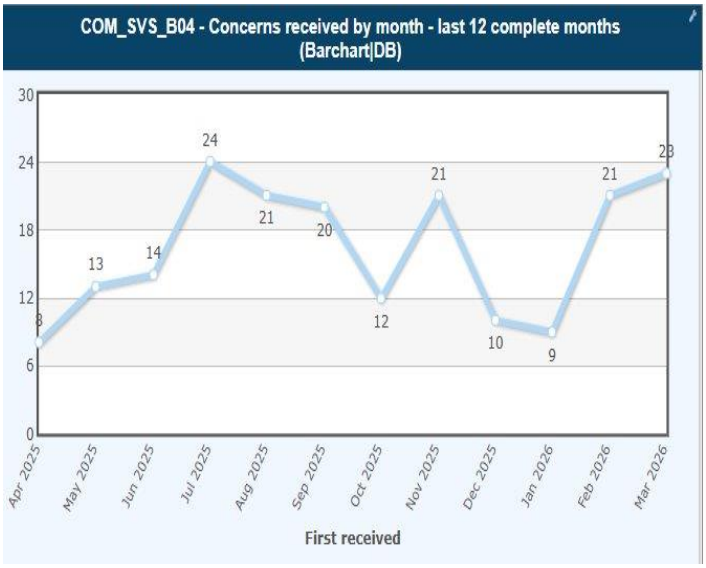
CD&T Clinical Board

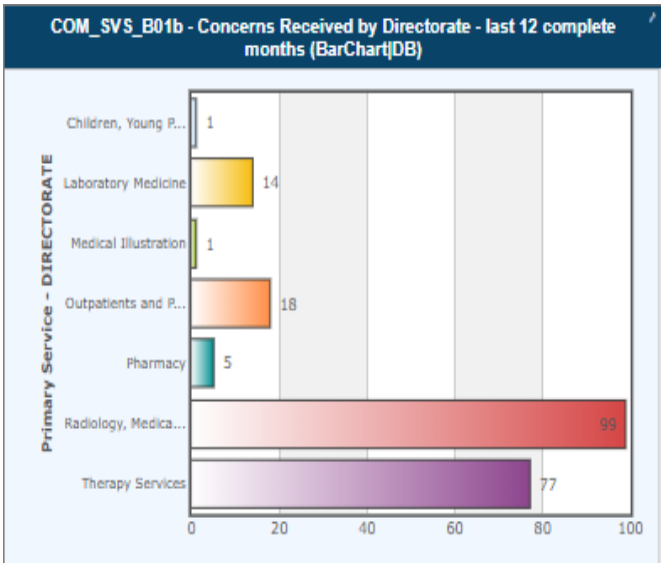
CD&T Clinical Board - Complaints activity (last 12 months)

During the reporting period, the **CD&T Clinical Board experienced a variable but sustained level of complaints activity**, which was managed in line with the **Putting Things Right (PTR) Regulations**, in force throughout the year.

Over the last twelve complete months, the CD&T Clinical Board received a total of **211 complaints**, equating to an average of **approximately 18 complaints per month**. Monthly volumes increased from **8 complaints in April 2025** to **14 in June 2025**, before rising further to **24 complaints in July 2025**.

Although complaint volumes reduced during the autumn period, activity increased again towards the end of the calendar year, with the highest monthly total recorded in **December 2025 (25 complaints)**. Following a reduction in **January 2026**, volumes rose again across **February and March 2026**. This pattern reflects variable but sustained pressure across CD&T services, particularly in relation to access, communication, coordination, and the experience of care across diagnostic and therapy pathways.





Within CD&T, the directorate chart shows differing levels of demand across services, with some pathways generating a higher volume of new concerns and contributing more strongly to the peaks seen during the year.

Overall, this pattern demonstrates a **variable but sustained level of complaints activity across the year**, with higher volumes during the summer and early autumn period and a rise again towards the end of the year. The trend reflects the importance of timely access, clear communication and coordinated care for patients using diagnostic and therapy services.

What we are doing

All complaints referenced above were managed under the **Putting Things Right (PTR) Regulations**. The CD&T Clinical Board recognises that the volume and nature of complaints highlight the need to strengthen listening, communication, early resolution, and the use of feedback to support improvement.

In response, the Clinical Board is focusing on:

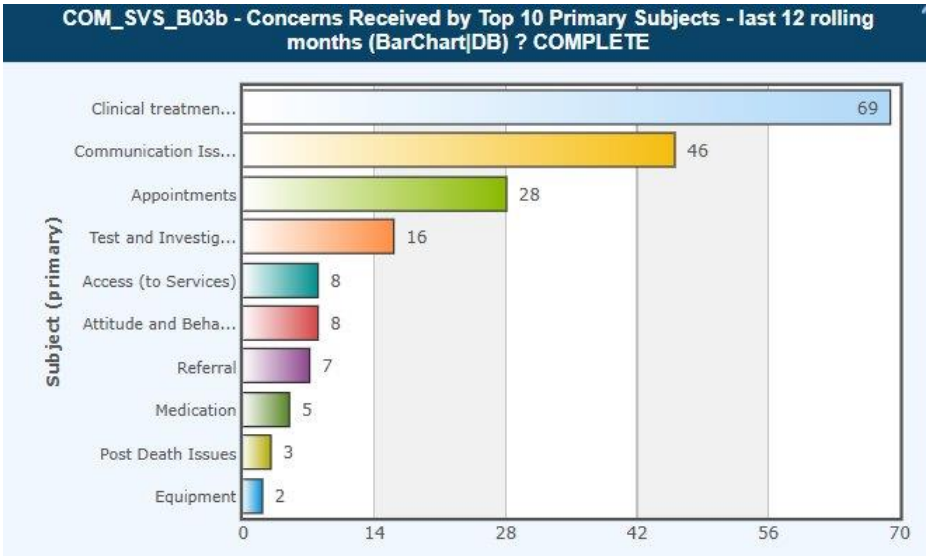
- **Improved clinical and managerial oversight**, ensuring complaints are reviewed alongside quality, safety, and patient experience information so that patterns, pressure points, and recurring issues can be identified earlier.
- **Focused action on access, communication, and coordination**, particularly where concerns relate to diagnostics, appointments, communication of results, therapy pathways, or follow-up arrangements.
- **Earlier resolution of concerns where appropriate**, helping to provide a quicker and more proportionate response and reduce avoidable escalation.
- **Using complaint themes to drive improvement**, ensuring learning from complaints informs pathway review, service redesign, and quality improvement activity across diagnostic and therapy services.

From **April 2026**, further improvements are being implemented in line with the **Listening to People (LTP) Regulations**, supporting a more person-centred and responsive approach to concerns and complaints. This will help the CD&T Clinical Board improve patient experience, reduce avoidable escalation, and ensure that feedback from patients and families continues to inform meaningful and sustainable service improvement.

Themes and Trends

The top complaint themes mirror those seen across the organisation and relate primarily to:

- **Communication failures** with patients and families,
- **Delays in access, diagnostics, appointments, or therapy follow-up** across CD&T pathways,
- **Poorly coordinated care across services** where patients rely on multiple diagnostic or therapy teams.



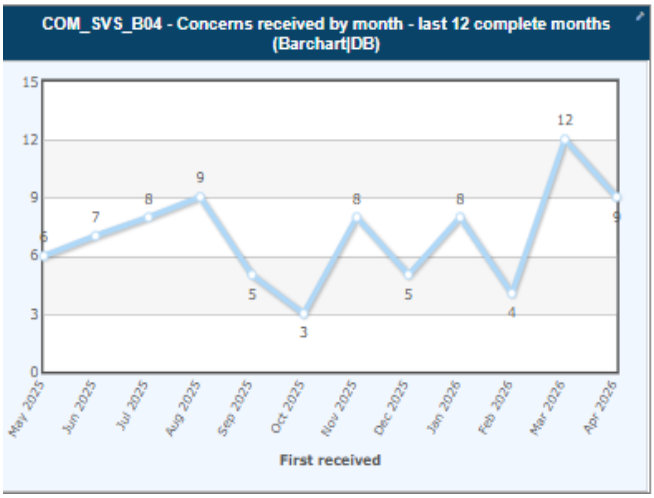
You said: Deaf patients wanted more choice and control over interpreter arrangements, including the ability to request an interpreter directly and state their preferences.
We did: Health Records, WITS and Patient Experience developed a new process to support patient choice. While technical changes delayed full implementation, interim arrangements have been agreed and, with support from the British Deaf Association, a patient trial will evaluate booking scenarios, gather feedback, and shape longer-term improvements. Patients who prefer interpreters to be booked on their behalf will still be able to choose this option.
You said: Appointment information and communication options were not always consistent or accessible for patients with hearing loss.
We did: The Health Board is introducing a Video Relay Service (VRS) to improve communication between deaf patients and hearing services through a qualified sign language interpreter by video link. Development of the NHS Wales App is also being used to improve access to appointment information and support more consistent communication and contact options across services.
You said: Patients were frustrated when they could not get through by telephone to arrange phlebotomy appointments.
We did: Booking Lab, an online booking system for phlebotomy appointments, was introduced in GP surgeries within the Barry Hospital hub to give patients an additional booking option. This has reduced pressure on telephone lines, improved access for patients who are comfortable using digital systems and contributed to a fall in concerns about being unable to contact the department. Wider use across the Clinical Board is now being explored.
You said: Patients in the MSK outpatient setting were not always clear why imaging was not requested earlier in their rehabilitation pathway.
We did: MSK physiotherapy colleagues have made this an improvement priority and are reviewing how clinicians explain imaging decisions within rehabilitation pathways. This work will continue over the next 12 months to support clearer communication and improve patient understanding.
You said: A patient with sight loss described how difficult it was to navigate to a podiatry outpatient appointment at Cardiff Royal Infirmary.
We did: The podiatry team invited the complainant to share her lived experience with the service. With her agreement, her story was recorded and is now being used as a learning resource to help staff better understand accessibility challenges for patients with sight loss.

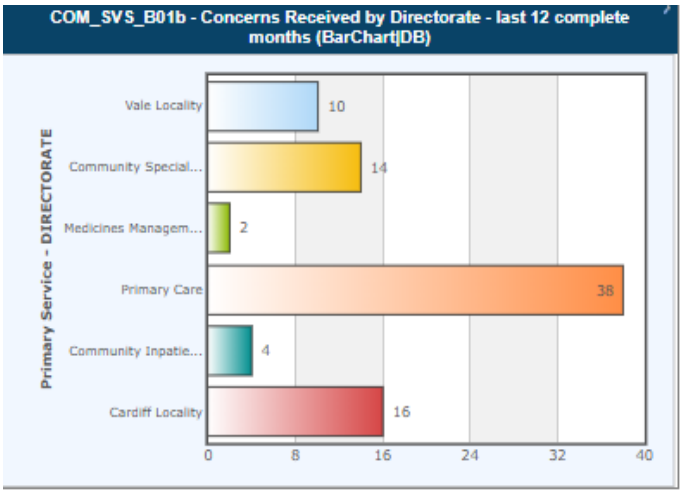
PCIC Clinical Board

PCIC Clinical Board – complaints activity (last 12 months)

During the reporting period, the **PCIC Clinical Board experienced a variable but sustained level of complaints activity**, which was managed in line with the **Putting Things Right (PTR) Regulations**, in force throughout the year.

Over the last twelve complete months, the PCIC Clinical Board received a total of **79 complaints**, equating to an average of **approximately 7 complaints per month**. Monthly volumes increased from **3 complaints in April 2025** to **7 in June 2025**, before rising further to **8 in July** and **9 in August 2025**.





Although complaint volumes reduced during **September and October 2025**, activity increased again towards the end of the year. Complaints rose across **January, February, and March 2026**, with the highest monthly total recorded in **March 2026 (11 complaints)**. This pattern reflects variable but sustained pressure across primary, community and intermediate care services, particularly in relation to access, communication, care coordination, and continuity across pathways.

Within PCIC, the graph shows variation between service areas, with a small number of directorates accounting for a greater share of new concerns while others remained low-volume throughout much of the year.

Overall, this pattern demonstrates a **variable but sustained level of complaints activity across the year**, with higher volumes during the summer period and a rise again towards the end of the year. The trend reflects the importance of timely access, clear communication and coordinated care for patients receiving primary, community, and intermediate care services.

What we are doing

All complaints referenced above were managed under the **Putting Things Right (PTR) Regulations**. The PCIC Clinical Board recognises that the volume and nature of complaints highlight the need to strengthen listening, communication, continuity, early resolution, and the use of feedback to support improvement.

In response, the Clinical Board is focusing on:

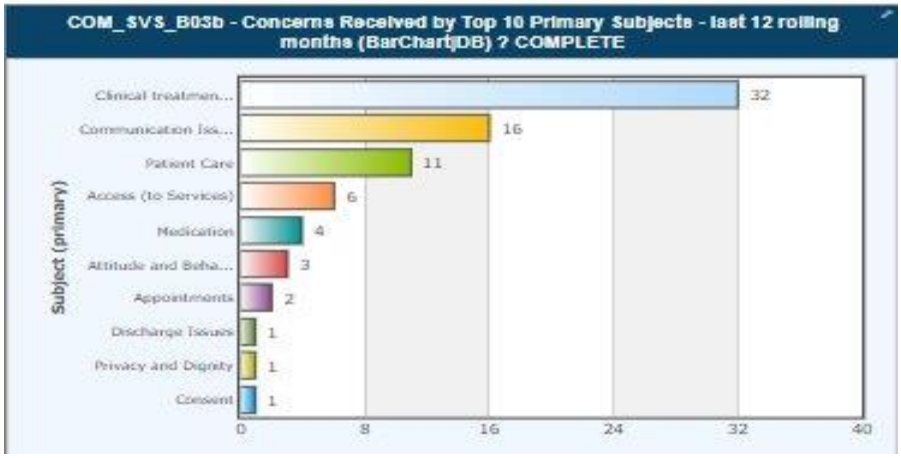
- **Improved clinical and managerial oversight**, ensuring complaints are reviewed alongside quality, safety, and patient experience information to identify common themes, risks, and opportunities for improvement.
- **Focused action on access, communication, and coordination**, particularly where concerns arise around community appointments, follow-up arrangements, discharge, wound care, equipment, and transitions between services.
- **Earlier and more proportionate resolution of concerns**, helping services respond more quickly where appropriate and reduce avoidable escalation into lengthy formal complaints.
- **Use of complaint themes and trends to support service improvement**, ensuring learning informs pathway review, service redesign, and improvement activity across primary, community and intermediate care services.

From **April 2026**, further improvements are being implemented in line with the **Listening to People (LTP) Regulations**, supporting a more person-centred and responsive approach to concerns and complaints. This will help the PCIC Clinical Board improve patient experience, reduce avoidable escalation, and ensure that feedback from patients and families continues to inform meaningful and sustainable service improvement.

Themes and Trends

The top complaint themes mirror those seen across the organisation and relate primarily to:

- **Communication failures** with patients and families,
- **Delays in access, appointments, or follow-up** across PCIC pathways,
- **Poorly coordinated care across services** where patients rely on support from multiple community and intermediate care teams.



You said / We did.

You said: Concerns were raised about wound care, equipment availability, and communication between teams.
We did: We reviewed the care provided, reinforced expectations for clear discharge information and wound assessment, and improved access to appropriate equipment.

Learning from Concerns

All concerns, complaints and wider patient feedback provide opportunities to improve services and patient experience. The examples below describe actions taken in response to issues raised during the year, presented using a “You said / We did” approach to demonstrate learning and improvement.

Lessons Learned from Complaints and Concerns

This infographic shows what we have learned from complaints and concerns in 2025/26, and how we are using that feedback to improve care for patients and families.

Executive summary

During 2025/26, Cardiff and Vale University Health Board continued to learn from concerns and complaints managed under the *Putting Things Right* framework, while preparing for the transition to *Listening to People* from April 2026. Review of closed cases shows that complaints remain a valuable source of insight into patient experience, communication, clinical processes, and service reliability across the organisation.

Although many concerns were not upheld, they still highlighted opportunities to improve how care is explained, coordinated, documented, and delivered. Across Clinical Boards, learning has been used to support reflection, strengthen local practice and guide improvement activity in areas that matter most to patients and families.

Overall, the learning profile for the year shows a consistent focus on person-centred care, better communication, safer decision-making, and stronger organisational learning. The section below presents the main themes in a clearer annual-report format, with a summary view of what feedback told us and where improvement effort has been directed.

At a glance	What complaints highlighted	Improvement response
Communication	Unclear information, inconsistent updates and limited involvement of patients and families.	Reinforced active listening, role clarity, compassionate conversations, and clearer explanations at key points of care.
Clinical safety	Concerns about escalation, assessment, risk recognition, and timely referral.	Reinforced clinical pathways, reflective discussion and education through governance and quality forums.
Documentation	Incomplete records and limited recording of discussions and rationale.	Strengthened expectations for accurate, timely documentation and alignment with audit and governance processes.
Care coordination	Discharge delays, weak coordination and uncertainty across teams and services.	Promoted earlier multidisciplinary planning and stronger links with community and partner services.
Compassionate care	Need for dignity, empathy, and personalised support, especially for vulnerable people.	Promoted values-based practice, reasonable adjustments, and more person-centred approaches.
Systems improvement	Issues in referral routes, appointments, results communication, and service processes.	Reviewed local pathways, improved administrative processes, and supported digital improvement.

Key themes of learning

1. Communication and patient experience

Communication remained the clearest and most recurrent learning theme in 2025/26. Complaints showed that patients and families most often wanted timely information, clearer explanations, consistent updates, and more empathetic conversations, particularly during distressing or uncertain periods of care.

What this tells us: The quality of communication strongly shapes how care is experienced, even where clinical care itself is not in dispute.

2. Clinical assessment, decision-making, and safety

Complaints also identified learning about clinical assessment, escalation, and decision-making. Cases pointed to delays in recognising deterioration, variability in symptom or risk assessment, and delays in investigations, diagnosis, or onward referral.

What this tells us: Reliable clinical decision-making depends on timely escalation, adherence to established pathways and reflective discussion where care falls short of expected standards.

3. Documentation and record keeping

Documentation continued to be a recurring area of learning. Complaints highlighted incomplete or inconsistent records, insufficient recording of discussions with patients and families, and limited explanation of the rationale behind key decisions.

Why it matters: Good documentation supports patient safety, continuity of care and organisational transparency. In response, services have reinforced expectations for accurate, timely and comprehensive records and linked documentation standards more clearly to audit and governance oversight.

4. Discharge planning and care coordination

Discharge and care coordination remained a frequent source of concern. Complaints described weak coordination between hospital and community services, delays or omissions in onward referrals, and limited patient or family involvement in discharge planning.

Improvement focus: Learning has reinforced the need for earlier multidisciplinary planning, clearer communication across organisational boundaries, and more consistent involvement of patients and families in safe and timely discharge arrangements.

5. Patient-centred and compassionate care

Across multiple services, complaints reinforced the importance of dignity, compassion, and personalised care. Patients highlighted the need to feel respected, understood and supported as individuals, particularly where they were vulnerable or experiencing anxiety, distress, or complex needs.

Improvement focus: Services have used this learning to reinforce person-centred practice, reasonable adjustments, values-based care, and the importance of compassionate communication in everyday interactions.

6. System and process improvement

Complaints also highlighted opportunities to improve the systems that underpin care, including referral routes, appointment processes, communication of results, administrative pathways, and coordination between departments.

Improvement focus: In response, services have reviewed local processes, strengthened operational pathways, and supported digital improvements intended to reduce delays, improve flow, and create a more reliable patient experience.

7. Learning culture and continuous improvement

The Health Board continues to promote complaints as a source of reflection, assurance, and service improvement. Learning has been shared through governance meetings, team discussion, and training, with evidence of local reflection and action across a range of services.

Opportunity for 2026/27: Analysis also shows variation in how clearly learning is captured and evidenced. As the organisation moves into the *Listening to People* framework, the next step is to strengthen consistency, show measurable impact and demonstrate more clearly how feedback leads to service change.

Conclusion and next steps

The 2025/26 complaints analysis shows that feedback continues to provide important insight into both patient experience and service delivery. The strongest themes this year were communication, clinical safety, documentation, discharge coordination, compassionate care, and system reliability.

Looking ahead, the priority is not only to share learning but to evidence improvement. Under *Listening to People*, the Health Board has an opportunity to strengthen how actions are captured, monitored, and reported so that patients, families, staff, and the Board can see more clearly how feedback drives safer, kinder, and more effective care.

Aims for 2026/27

From 1 April 2026, the Health Board will implement the **Listening and Learning from Feedback and Putting Things Right (LTP) Regulations**. Priorities for 2026/27 will focus on embedding the new framework, strengthening learning and assurance, and supporting a more integrated, person-centred approach to concerns, complaints, and redress.

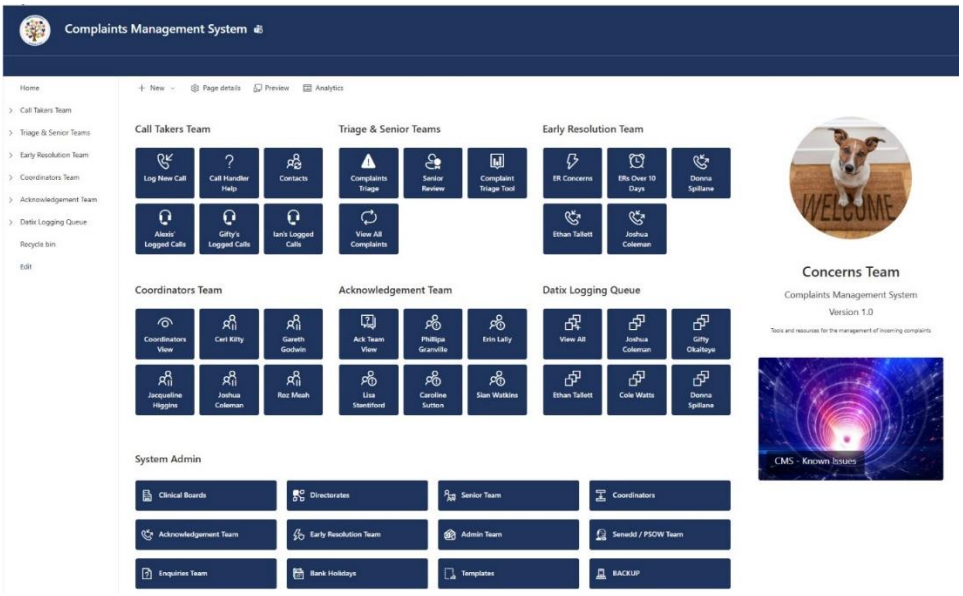
- Update local policies, procedures, templates, and standard operating guidance to align with the new **LTP** framework.
- Provide training and briefings for Investigating Officers and services on revised requirements, communication expectations, and timescales.
- Strengthen how learning and actions are captured, tracked, and reported through governance routes, including improving the quality of **LFERs** submitted to the **Welsh Risk Pool (WRP)** through effective use of the **LFER Scrutiny Panel**.
- Improve information for people raising concerns, including what to expect and how to access advocacy and support.
- Support a single, integrated approach to managing concerns and complaints alongside relevant patient safety processes, based on the principle of **'investigate once, investigate well.'**
- Promote early engagement, proportionate investigation, and clear responses, with a continued focus on learning, improvement, and feedback to services.

Key Achievements

Complaints Management System

Modernising how we manage concerns at Cardiff and Vale UHB

In late 2025 and early 2026, the Concerns Department at Cardiff and Vale University Health Board led a significant programme of work to develop and implement a bespoke digital Complaints Management System (CMS). Built using the Health Board's existing Microsoft 365 infrastructure and software licences, the system was delivered without additional cost. CMS went live on 23 April 2026 and represents a major step forward in how the Health Board receives, acknowledges, and manages incoming complaints.



Why we developed it

Before the introduction of CMS, complaints management relied heavily on manual processes, spreadsheet-based tracking, and paper correspondence. This created challenges in maintaining consistent oversight, supporting staff, ensuring timely acknowledgement of complaints, and enabling prompt progression to Clinical Boards for investigation and response.

As complaint volume and complexity increased, the need for a more structured and digitally enabled approach became clear. The new system is intended both to strengthen oversight and efficiency and to better support staff managing concerns on behalf of patients and families.

The CMS was developed from the ground up by the Concerns Department. The system provides a single-entry point for all incoming complaints, with structured fields to capture key information at the point of receipt, automated workflows to support a meticulous triage process by our senior team and mitigate any delays to our acknowledgement and coordinator teams.

The system also includes real-time reporting through a dedicated Power BI dashboard, enabling senior managers to monitor demand, identify pressure points and provide timely operational support.

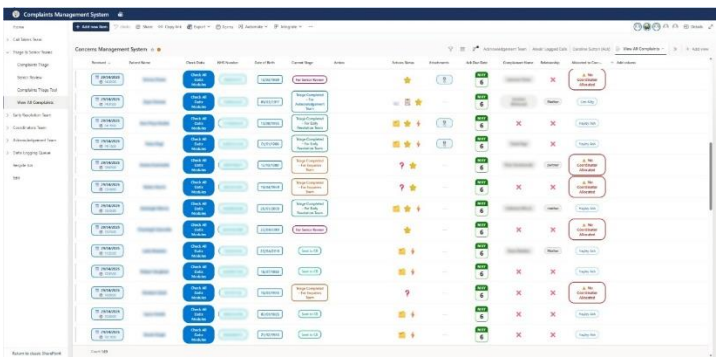
Correspondence, attachments, and team communications are all held within a single system of record, removing the need for parallel manual tracking and significantly reducing administrative burden on the team.

Supporting the transition to Listening to People (LTP)

The timing of the CMS launch is directly aligned with the introduction of *Listening to People*, the most significant reform of NHS Wales complaints handling in almost fifteen years, which came into force on 1 April 2026.

The CMS has been designed with these principles at its centre. The system's triage architecture enables the team to assess the complexity and nature of each concern at an early stage, supporting the mandatory offer of a listening discussion and ensuring that concerns are directed to the right pathway without delay. Structured data capture improves the quality of information available for investigation, and integrated reporting means that senior leaders can access timely, accurate oversight of complaint activity across the organisation.

The CMS therefore provides Cardiff and Vale UHB with the operational foundation needed to meet its obligations under the new regulations and to embed the cultural shift towards openness, learning and compassionate resolution that *Listening to People* demand.



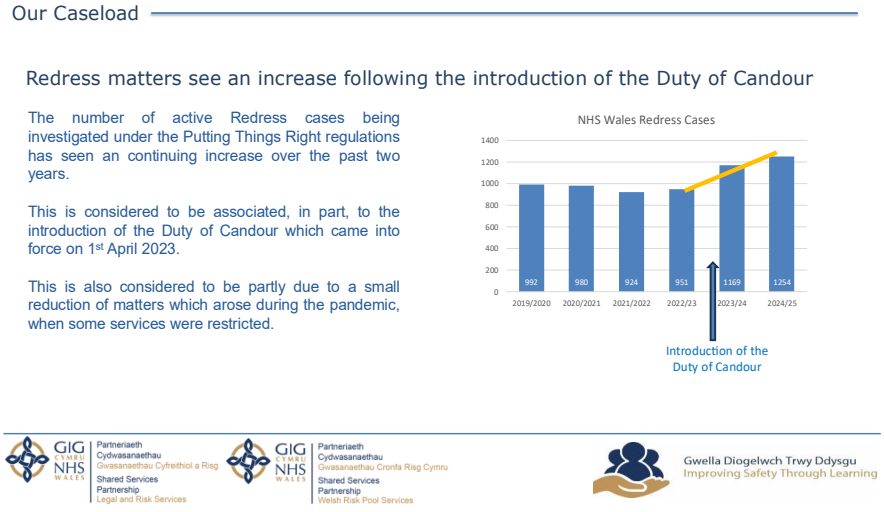
Looking ahead: ACT

Building on the CMS launch, the next phase of development will see the introduction of the Active Complaints Tracker (ACT), which is planned for rollout in 2026. ACT is a complementary system designed for use by Clinical Boards and Complaints Coordinators to manage and track complaints once they have been formally assigned following triage. It will give clinical boards real-time visibility of their active caseload, clearer accountability for response timelines, and a structured record of actions taken at board level.

Together, CMS and ACT will provide an end-to-end digital pathway for complaint management across the Health Board, from first receipt through to investigation, response, and closure, supporting our commitment to transparency, continuous learning, and meaningful improvement in the experience of everyone who raises a concern with us.

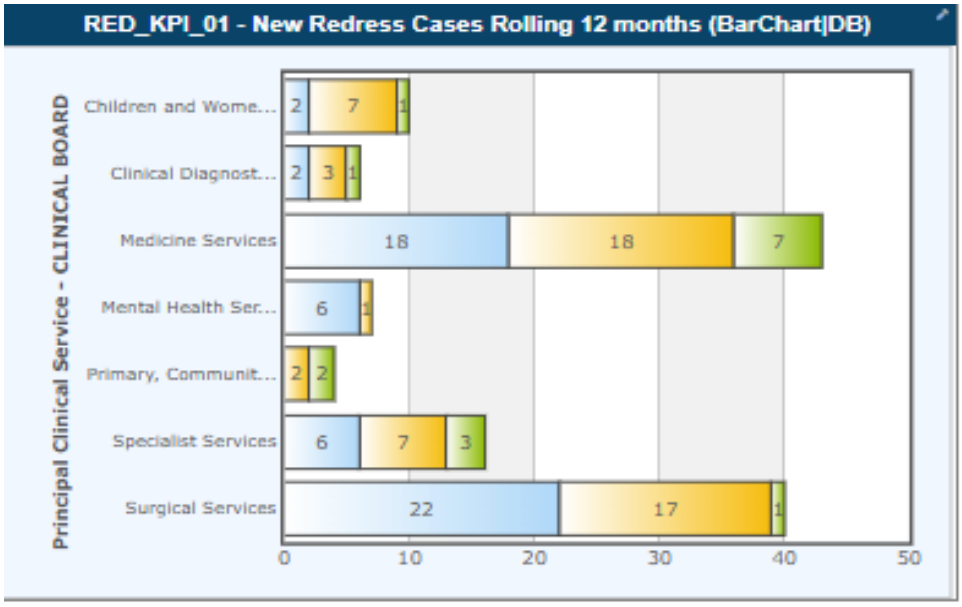
Redress (Putting Things Right)

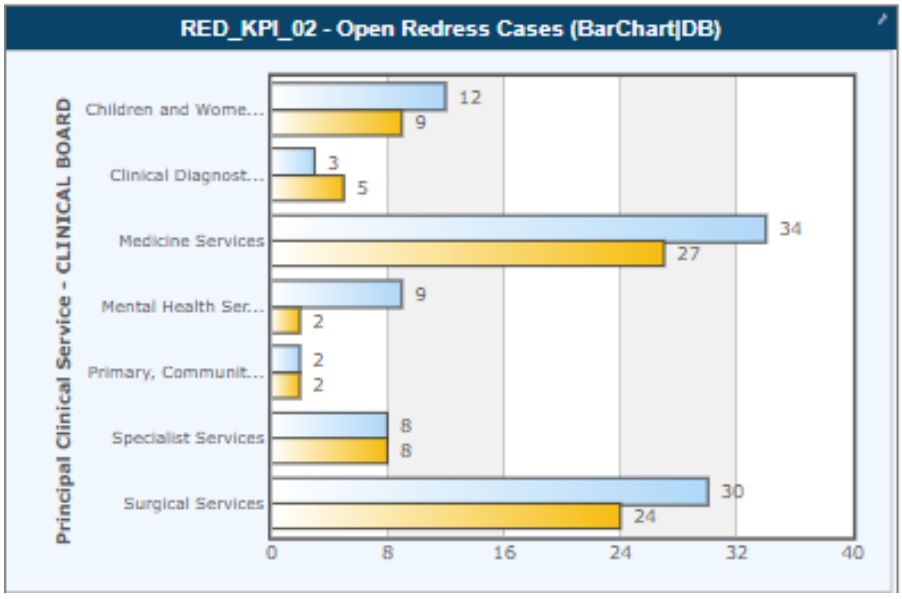
Redress remains an important part of the Putting Things Right arrangements, ensuring that where care may have caused harm, cases are considered fairly, openly and in line with the Regulations. This includes situations where there may be a qualifying liability, meaning a possible breach of duty of care resulting in harm, or where further investigation is needed to determine whether harm occurred.



Wider NHS Wales data also shows that active Redress matters investigated under the *Putting Things Right* framework have increased over the last two years. This is understood to be associated in part with the introduction of the Duty of Candour in April 2023 and reinforces the importance of maintaining effective local Redress arrangements, timely review, and strong organisational learning. Increased use of the Redress pathway may also reduce the number of matters that proceed to litigation.

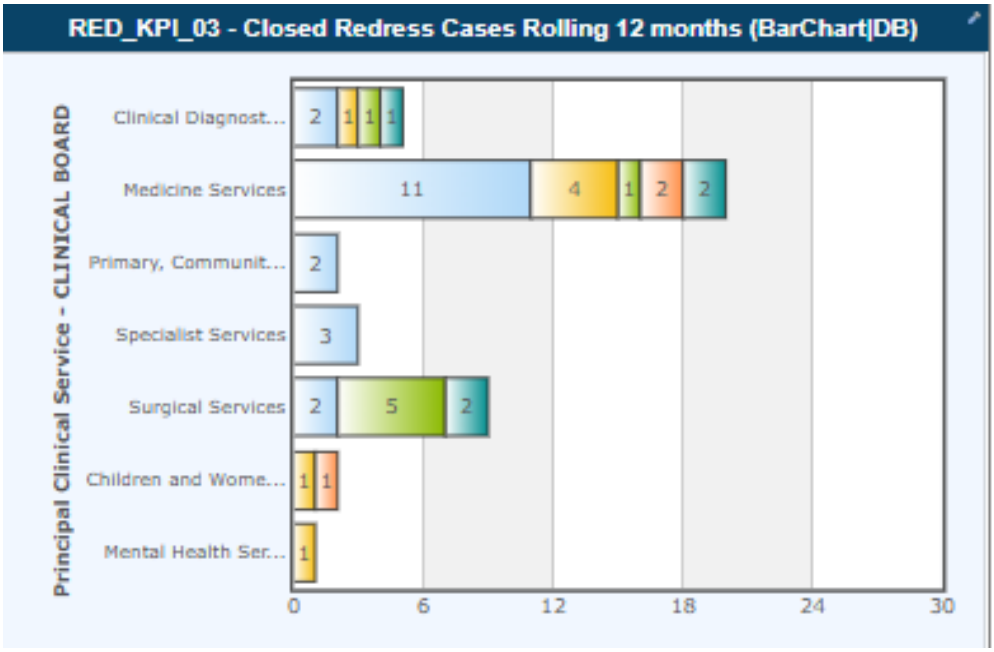
During 2025/26, the Health Board continued to manage redress cases through established governance arrangements, with oversight provided through the Putting Things Right Redress Panel. This process supports timely consideration of cases, helps determine whether redress applies, and ensures that learning from harm is identified, acted on, and shared appropriately.





The first graph shows **new Redress cases opened in the last 12 months by position**. It illustrates where new case activity has arisen across the Health Board and provides an overview of which Clinical Boards are contributing most strongly to new Redress demand. Consistent with the wider Redress profile, the highest volumes are seen in **Medicine** and **Specialist Services**, while **CD&T** and **PCIC** contribute the lowest overall volumes.

The second graph shows **all current open Redress cases** and supports oversight of cases that remain active across the organisation. This provides a current view of where open-case pressure sits and where continued scrutiny is needed to support timely progression. Consistent with the wider Redress profile, the greatest concentration of active cases is within **Medicine** and **Specialist Services**, with lower numbers in **PCIC** and **CD&T**.



The third graph shows **Redress cases closed in the last 12 months**. This helps demonstrate how cases are being concluded and provides an indication of throughput across Clinical Boards. The pattern again suggests that the highest volumes of concluded cases are associated with **Medicine** and **Specialist Services**, reflecting their larger overall case numbers, while **CD&T** and **PCIC** account for the smallest share of closed cases.

Redress is not limited to financial compensation. It may also include a clear explanation, a written apology, or remedial treatment, reflecting the Health Board's commitment to openness, compassion and learning when care has fallen below the standard expected. Alongside addressing individual cases, the redress process provides an important source of organisational learning, helping to strengthen patient safety, improve practice and reduce the risk of similar incidents happening again.

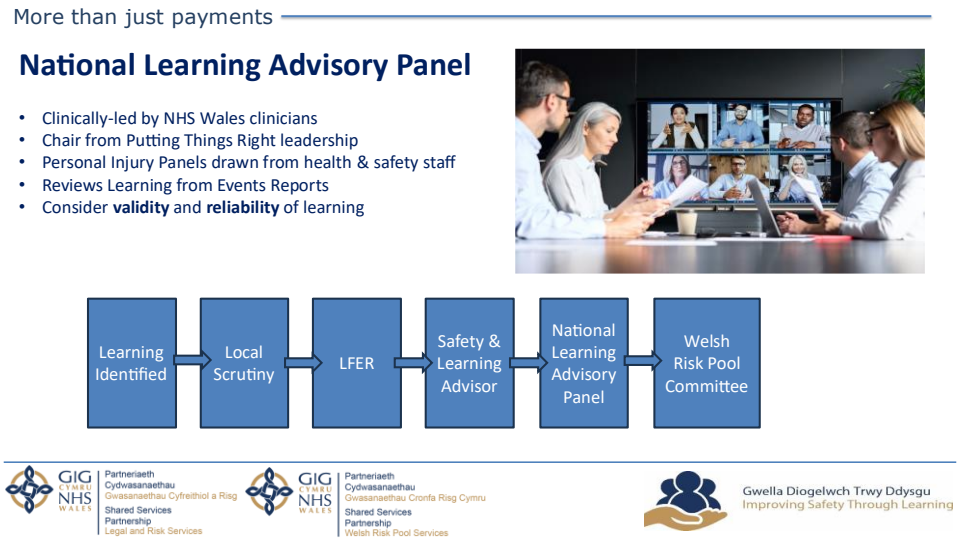
Effective Redress case management can also provide significant financial benefit by resolving appropriate cases earlier and avoiding some of the additional costs associated with litigation. National data indicates that cases with damages up to £25,000 are associated with average claimant cost savings of £23,764.73 per case, rising to £40,173.21 for cases between £25,000 and £50,000. This reinforces the value of Redress as both a patient-centred and proportionate route to resolution.

Redress decision-making and oversight

The **Putting Things Right Redress Panel** provides oversight of cases where there may be a qualifying liability and harm arising from care provided by the Health Board. The Panel considers evidence from investigations, determines whether redress applies, and helps ensure a fair, timely and consistent approach in line with the Regulations.

Membership includes the Assistant Director of Patient Experience (Chair), Assistant Medical Director, Head of Concerns, Redress Manager and Redress Leads. The Panel also supports

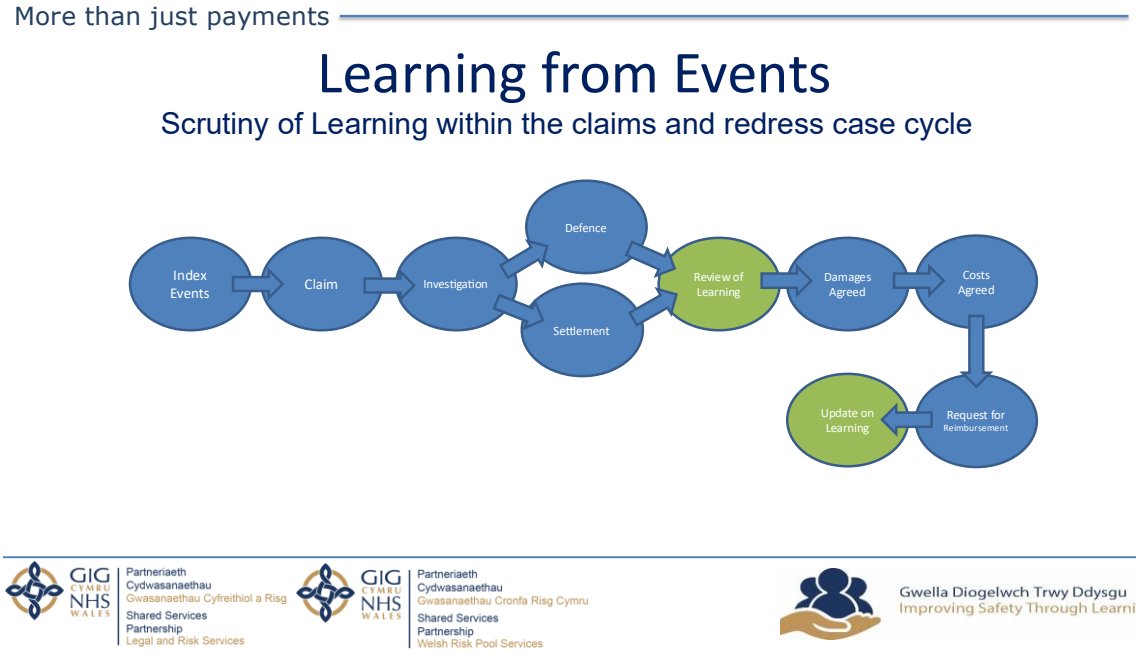
shared learning through a weekly drop-in clinic, where staff can discuss cases, seek advice and consider appropriate next steps.



Learning from redress

Overview

Learning from redress cases provides an important complement to learning from complaints and concerns. While complaints often highlight issues in communication, experience and service delivery, redress cases provide additional insight into patient harm, clinical risk and the reliability of the systems that support safe care. Learning arising from Redress is also subject to wider scrutiny through the National Learning Advisory Panel, which reviews Learning from Events Reports and considers the validity and reliability of learning identified. This strengthens assurance that actions arising from harm are not only recorded, but are sufficiently robust, evidence-based, and capable of supporting improvement in practice.



Learning in Redress is not confined to the end of a case. It sits throughout the case cycle, from investigation and defence through to settlement, reimbursement and review of actions taken. This reinforces the principle that Redress should support both fair case resolution and continuous organisational learning.

During 2025/26, review of redress cases showed strong alignment with themes identified through complaints, particularly in relation to follow-up, communication, documentation, and adherence to safety-critical processes. Taken together, these sources of intelligence provide a broader picture of where improvement is needed and where stronger assurance is required.

A consistent finding from redress reviews was that harm often arose from weaknesses in systems and processes rather than isolated individual error. This reinforces the importance of reliable follow-up arrangements, consistent safety checks, effective documentation, and measurable evidence that learning has led to change.

This infographic summarises the main lessons identified through redress cases in 2025/26, and how this learning is helping us strengthen safety, reliability, and accountability across services.

Key learning themes

1. Results management and follow-up

Redress cases highlighted weaknesses in the review, tracking and escalation of test results and follow-up actions. Learning included results not being reviewed or acted upon, follow-up investigations not being arranged, and unclear ownership of monitoring responsibilities.

Improvement focus: These cases show the need for stronger systems to track outstanding results, clearer clinical ownership of follow-up and more reliable safety-netting arrangements so that delays in diagnosis and treatment are reduced.

2. Reliability of safety-critical processes

Cases also identified inconsistent application of established safety procedures, including incomplete surgical safety checks, weak patient identification processes, and failures to complete two-person verification where required.

Improvement focus: The learning reinforces the importance of consistent compliance in practice, stronger real-time oversight, and a shared team responsibility for safety-critical checks to reduce avoidable incidents.

3. Documentation and care planning

Redress reviews identified gaps in documentation and care planning, including incomplete risk assessments, missing records of care interventions and patient concerns that were not consistently recorded or explored.

Improvement focus: These cases reinforce that documentation is a safety-critical activity. The response needed is stronger audit and feedback, clearer care planning standards and more consistent recording and escalation of patient concerns.

Cross-cutting learning and system improvement

4. System and process design

Some cases highlighted design weaknesses in the systems that support care, including digital systems that did not flag critical results, limited mechanisms to track pending investigations and a continued reliance on manual processes without sufficient safeguards.

Improvement focus: The learning points to the need for stronger digital alerts, better process safeguards, and greater standardisation so that safety depends less on individual vigilance and more on reliable system design.

5. Workforce pressures and clinical oversight

Redress cases also showed how workload pressures, absence and limited cross-cover arrangements can affect the timely review of results and continuity of follow-up, creating additional risk in already pressured services.

Improvement focus: This learning supports the need for stronger team-based accountability, clearer cross-cover arrangements and workforce planning that is more closely aligned to safety-critical activity.

6. From learning to measurable improvement

A further message from panel review was the need to demonstrate impact more clearly. Recording learning and delivering training are important, but the stronger expectation is that services can also evidence implementation, improved compliance, and sustained change over time.

Assurance gap: Evidence of sustained improvement and routine monitoring remains variable across some cases, with further work needed to show consistent impact from redress learning.

Conclusion

Learning from redress cases reinforces the themes seen in complaints and concerns, particularly around communication, follow-up, documentation, and safety processes. Together, these sources show that safer care depends on reliable systems, clear accountability, and stronger evidence that improvement actions are working in practice.

Looking ahead, the priority is to strengthen system reliability, improve compliance with safety-critical processes and embed more robust monitoring of actions arising from redress. This will support the Health Board's continued transition to safer, more dependable and more person-centred care under both *Putting Things Right* and *Listening to People*.

Key achievements for 2025/26

- Recorded a training session for use across the Health Board to support implementation of the new **Listening to People (LTP) Regulations** and promote consistent understanding of the changes required in practice.
- Through regular peer review and scrutiny of **LFERs**, reduced the number of **Red Deferred** cases considered by the **Welsh Risk Pool (WRP) Learning Advisory Panel**, strengthening the quality and consistency of submissions.

Learning Assurance

Learning from Events CVUHB

- CVUHB has a very robust timeliness for submission
- A greater proportion of CVUHB LFERs are not red deferred by panel at first review than the all-Wales position
- 2025/26 data shows a continually improving position

Health Body	Total number of cases reviewed by LAP	Number Approved at Initial Panel	% Approved	Number Deferred until Info Received	%Deferred until Info Received	Number Deferred at Initial Panel	% Deferred	Proportion NOT Red Deferred
ALL WALES	866	235	27%	520	60%	111	13%	87%
Cardiff & Vale University Health Board	115	21	18%	87	76%	7	6%	94%

This reflects a positive local position, with CVUHB demonstrating robust timeliness of submission and a greater proportion of LFERs not being Red Deferred at first review than the all-Wales position. Presentation data for 2025/26 also indicates a continually improving trajectory.

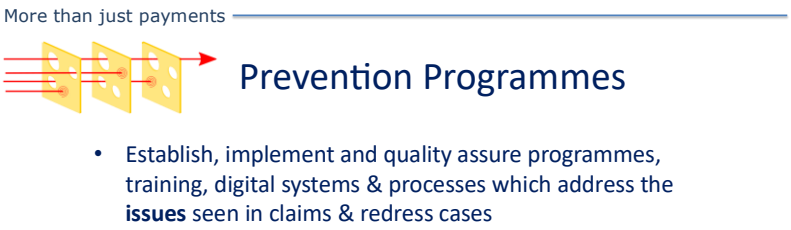
Redress priorities for 2026/27

Priorities for 2026/27 will focus on strengthening Redress arrangements, embedding the transition to *Listening to People*, and improving the quality, consistency and assurance of learning arising from Redress cases.

Key changes under Listening to People

The changes most relevant to Redress under *Listening to People* are:

- Clearer expectations for **accessible, compassionate communication**, including explanation of clinical and legal terms, support options, and reasonable adjustments.
- Stronger emphasis on **openness when harm occurs**, including prompt explanation, apology, and clarity about next steps.
- An increased **redress threshold of £50,000**, allowing more cases to be resolved without court action.
- Stronger expectations for **leadership accountability, organisational learning, and assurance**, so Redress leads more clearly to measurable improvement.
- Embed the transition from **Putting Things Right (PTR)** to **Listening to People (LTP)** through updated practice, governance, documentation, staff guidance, and use of the recorded training session across the Health Board.
- Improve the quality of **LFERs** and strengthen evidence of learning through regular peer review, scrutiny panel oversight, and continued reduction in **Red Deferred** outcomes at the **WRP Learning Advisory Panel**.
- Strengthen alignment between the **Redress** and **Inquest** teams to improve shared learning, consistency, use of internal legal expertise and organisational readiness, including more coordinated use of the Health Board's **three in-house solicitors**.



Nationally, the timeliness of LFER submission has deteriorated and the number of cases deferred at first review by the National Learning Advisory Panel increased during 2024/25. This reinforces the importance of continued local scrutiny and quality assurance so that learning submissions are timely, robust, and more likely to achieve approval at first review.

Inquests

Inquest oversight, family engagement, and shared learning

During 2025/26, inquests continued to provide an important source of assurance, organisational insight, and family engagement for the Health Board. Most cases progressed appropriately through established arrangements with Clinical Boards, Legal Services, and governance teams, while ongoing review of evidence, family concerns and case themes helped identify opportunities to strengthen communication, improve timeliness, and align findings more closely with patient safety and Redress processes. The receipt of four Prevention of Future Deaths reports during the year further reinforced the value of inquests in supporting organisational improvement.

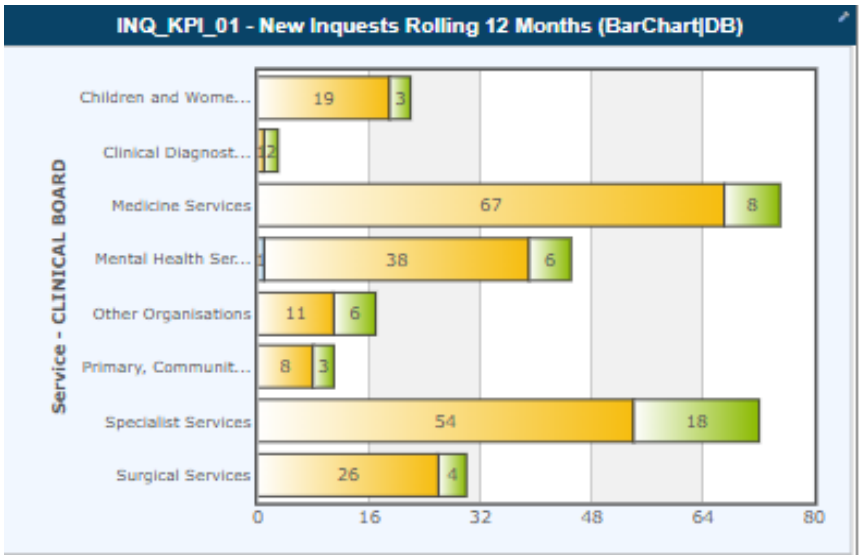
An inquest is a legal process led by the Coroner following certain reported deaths. It establishes who has died, and when, where, and how the death occurred. For the Health Board, inquests also provide an important opportunity to support openness, respond to family questions, and identify learning that may help improve care.

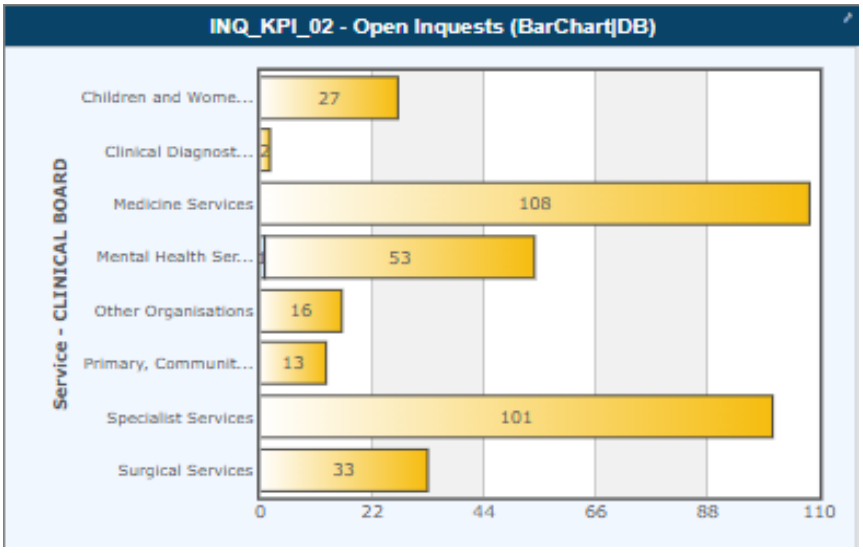
What happens in the inquest process?

- Cases are reported to the Coroner where the circumstances of death require formal consideration under the Coroner's remit.
- The Coroner determines whether an inquest is required and what information is needed to support that process.
- The Health Board coordinates records, statements, investigation reports, and any other relevant evidence.
- The Coroner reviews the evidence and may hold a pre-inquest hearing or inquest hearing where required.
- The inquest establishes the facts of the death, including when, where and how the person died.

- Any learning arising is reviewed through Health Board governance arrangements to support improvement in care and systems.

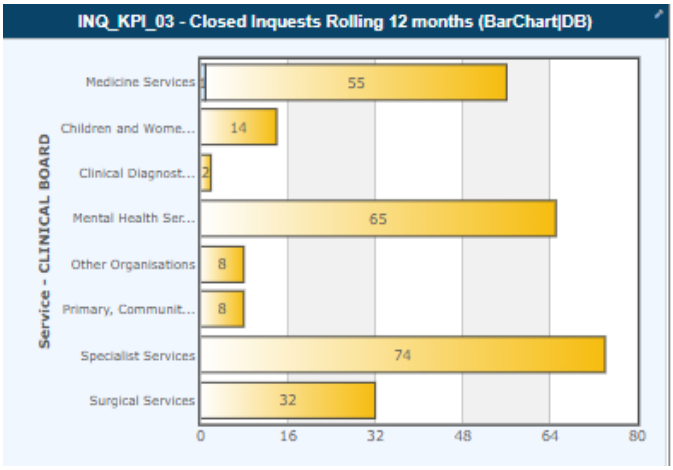
During 2025/26, the Health Board continued to support the inquest process through close working with Clinical Boards, Legal Services, Patient Experience, and other relevant teams. This helps ensure that information is provided in a timely and respectful way, families are appropriately supported throughout the process, and learning is identified, shared, and acted upon.





The first graph shows **new inquests opened in the last 12 months**. This provides an overview of new inquest activity across the reporting period and helps show where the highest levels of new case activity have arisen. Consistent with the wider inquest profile, the greatest number of newly opened cases is associated with **Medicine Services** and **Specialist Services**, while **Clinical Diagnostics & Therapeutics**, **PCIC** and **Other Organisations** account for the smallest volumes.

The second graph shows **all open inquests**. This provides a current view of active inquest cases across the organisation and helps show where the highest levels of open-case pressure sit. Consistent with the wider inquest profile, the greatest number of open cases is associated with **Medicine Services** and **Specialist Services**, while **Clinical Diagnostics & Therapeutics**, **PCIC** and **Other Organisations** account for the smallest volumes.



The third graph shows **all inquests closed in the last 12 months**. This provides an overview of completed inquest activity across the reporting period and helps show where the highest levels of closure activity have taken place. Consistent with the wider inquest profile, the greatest number of closed cases is associated with **Medicine Services** and **Specialist Services**, while **Clinical Diagnostics & Therapeutics**, **PCIC** and **Other Organisations** account for the smallest volumes.

Inquests Overview (March 2025 – April 2026)
A total of **212 inquests** were recorded across Cardiff and Vale UHB services during the reporting period.

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1. Breakdown by Clinical Board

Clinical Board	Number of Inquests	% of Total
Medicine Services	**60**	**28.3%**
Specialist Services	**53**	**25.0%**
Mental Health Services	**35**	**16.5%**
Surgical Services	**27**	**12.7%**
Children & Women's Services	**19**	**9.0%**
Other Organisations	**9**	**4.2%**
Primary, Community & Intermediate Care	**8**	**3.8%**
Clinical Diagnostics & Therapeutics	**1**	**0.5%**

2. Current Status of Inquests

Stage	Number	%
All evidence submitted – date awaited	162	76%
Waiting for statements/documents	20	9%
Waiting for investigation report	15	7%
Inquest date set	13	6%
Pre-Inquest Hearing listed	1	<1%

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3. Risk Profile (RAG Rating)

RAG Status	Number	%
Green	152	72%
Amber	52	25%
Red	7	3%

The risk profile graph shows that most inquest cases were assessed as **Green**, with **152 cases (72%)** classed as low risk. A further **52 cases (25%)** were rated **Amber,** and **7 cases (3%)** were rated **Red**, meaning that just over a quarter of all inquests required closer oversight because of family concerns, ongoing investigations, or potential care-related issues.

Learning from inquests

Review of inquest cases during the year highlighted several recurring operational and governance themes. These centred on the timeliness of evidence gathering, completion of investigation reports, communication with families and the management of cases involving wider safety or system concerns.

1. Timeliness of evidence and investigation

Operational review shows that the main pressure point remains the timely completion of statements, supporting documents and investigation reports. While most cases had progressed to the Coroner with evidence submitted, a smaller cohort remained in evidence-gathering stages, indicating where further attention is needed to reduce avoidable delay.

2. Family engagement and communication

A smaller number of cases involved explicit family concerns, but these remain important because they highlight the need for early engagement, sensitive communication, and clear explanations throughout the inquest process. This aligns closely with the wider principles of openness and person-centred communication under *Listening to People*.

3. Governance and patient safety links

Some inquest cases were linked to wider patient safety issues, including Nationally Reportable Incidents, transfers of care, delays in treatment and clinical decision-making concerns. This demonstrates the importance of aligning inquest learning with patient safety, Redress, and governance processes so that improvement activity is joined up across the organisation.

4. Learning value of lower-frequency cases

Although less frequent, cases involving falls, documentation issues and complex pathways across multiple services can provide significant learning value. These cases often reveal how system interfaces, handovers and coordination arrangements affect patient experience and organisational assurance.

Prevention of Future Deaths reports

During 2025/26, the Health Board received **four Prevention of Future Deaths (PFD) reports** arising from inquests and responded to **all four** within the required timescale. Although no single recurring theme was identified, each report highlighted important learning and prompted action to strengthen communication, clinical processes, infrastructure, and the management of safety-critical information. All PFD'S are shared in the public Quality Committee and the responses with embedded actions monitored to completion through the Inquest team.

Actions arising from the PFDs included strengthened guidance for Mental Health staff on the appropriate sharing of information with families; infrastructure changes to support safer patient placement, including arrangements to maintain a minimum of two level 3 staffed admitting beds in ICU, prioritisation of the most acutely unwell patients for CCU, and use of PACU for lower-risk patients where appropriate; improvements to clinical escalation and decision-making through a revised referral-to-cardiologist protocol for cardiac physiologists, a new standard operating procedure for *Managing the Unwell Patient*, and a revised history sheet to better support safe practice; and more robust arrangements for the management of abnormal blood results, including recruitment of a Clinical Nurse Specialist for the POPS team and strengthened escalation to specialist on-call teams.

Key achievements for the Inquests team

During 2025/26, the Inquests team strengthened organisational oversight, staff preparedness, and operational support for inquest activity across the Health Board. Key achievements included the introduction of Clinical Board trackers to improve case visibility, oversight and timely progression; the development of targeted training to better prepare staff attending inquests; enhanced practical support for staff before and during hearings; and the establishment of dedicated points of contact for each Clinical Board to improve communication, continuity and accountability in case management.

Inquest priorities for 2026/27

Priorities for 2026/27 will include strengthening local inquest arrangements, aligning more closely with **Redress** where priorities overlap, and making better use of shared legal expertise, learning, and governance support across both processes. This will help improve consistency, support organisational readiness, and strengthen how learning is captured, shared, and acted upon.

- Consider and prepare for the proposed **Hillsborough Law** changes and their implications for inquest practice, including expectations around candour, openness, and assistance to bereaved families.
- Review the potential impact of increased legal scrutiny and representation at inquest hearings, including the effect on case preparation, evidence quality, and hearing management.

- Strengthen support arrangements for families, recognising that any change in the legal framework may increase expectations around communication, involvement, and practical assistance.
- Prepare for increased administrative and resource pressures, including statement preparation, disclosure, document management and coordination across Legal Services, Clinical Boards, Patient Experience, and governance teams.
- Make best use of **internal legal expertise** through a more coordinated approach with **Redress**, including effective use of the Health Board's **three in-house solicitors** and closer shared working between **Redress** and **Inquest leads** to improve consistency, strengthen shared learning and reduce legal cost.

Overall, the 2025/26 inquest profile indicates that most cases were assessed as low risk and progressed appropriately through established arrangements. Continued focus is, however, required on timely evidence gathering, family communication and the effective coordination of learning across patient safety, Redress, and governance processes.

During 2026/27, the Health Board will continue to strengthen inquest oversight, support timely case progression, and improve how lessons are captured, shared, and acted upon. This will include a continued focus on clear communication with families, closer alignment between inquest, patient safety and Redress processes, and more coordinated use of internal legal expertise across Redress and Inquests to support readiness for emerging legal and policy changes.