Archwilio Cymru
Audit Wales

Improving quality governance

Public Health Wales NHS Trust

August 2025

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We have prepared and published this under section 61 of the Public Audit Wales Act 2004.

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Audit snapshot

What we looked at

1 Our review assessed progress made by Public Health Wales NHS Trust (the Trust) in implementing our 2022 quality governance audit recommendations. It also considered progress made by the Trust to review and implement corporate arrangements to meet the new Duties of Quality and Candour requirements, and related oversight and scrutiny.

Why this is important

2 Quality should be at the 'heart' of all aspects of healthcare and 'putting quality and safety' before anything else is one of the core values underpinning the NHS in Wales. Poor quality healthcare can be costly in terms of harm, waste, and variation.

3 During 2021-22, the Auditor General reviewed quality governance arrangements across all health boards and trusts in Wales. Our 2022 Review of Quality Governance at the Trust found that it was committed to improving its quality governance arrangements. But, whilst we found that arrangements were effective at the time, the Trust could have coordinated them better to ensure consistency and sharing of learning.

4 We made seven recommendations, covering 23 areas for improvement, which focused on:

- equality impact assessments,
- operational risk management,
- clinical audit monitoring,
- staff appraisals and training,
- policies and procedures,

- service user and staff feedback, and
- the subgroups of the Quality, Safety, and Improvement Committee.

5 In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act) became law. The Act has strengthened the duty to secure system-wide quality improvements. It also placed a Duty of Candour on NHS bodies, requiring them to be open and honest with service users when things go wrong and apply lessons learned.

What we have found

6 The Trust has implemented the majority of our 2022 audit recommendations, with significant progress made in improving arrangements for risk management and clinical audit. The Trust now has a strong approach to equality impact assessments in place, and its compliance rates with staff appraisals and training have improved. The Trust provides greater oversight of committee subgroups and its approach to gathering service user and staff feedback has improved.

7 While the Trust has strengthened its approach to updating and sharing policies, there are opportunities to assess staff policy awareness and compliance more proactively. The Trust could also be more explicit in reporting the actions it is taking in response to service user feedback.

8 The Trust has made substantive progress in preparing for, and embedding, the statutory Duties of Quality and Candour. Strategic planning, leadership commitment, and governance mechanisms are in place, and the Trust has made visible efforts to raise awareness and align its improvement frameworks accordingly. The Trust needs to improve the uptake of staff training relating to the duties, but it has plans in place to address this.

What we recommend

9 We have made two new recommendations, which replace the outstanding 2022 recommendations. The new recommendations are about:

- testing awareness of, and compliance, with quality governance policies, and
- being more explicit and transparent around reporting changes made in response to service user feedback.

Key facts and figures

- 19 out of the 23 recommendations arising from our 2022 work are complete, and four recommendations are partially complete.

- 90.2% compliance with statutory and mandatory training in June 2025, compared with 87% in October 2021.

- 83.2% compliance with staff appraisals in June 2025, compared with 61% in October 2021.

- Two ‘moderate harm and above’[1] incidents have needed the application of the Duty of Candour procedure during 2024-25, out of a total of 66 incidents.

[1] Moderate harm within the context of the Duty of Candour is defined as a patient safety incident that results in a moderate increase in treatment and significant, but not permanent, harm.

Our findings

Implementation of previous recommendations

The Trust has implemented 19 of the 23 2022 recommendations but needs to better assess staff awareness and compliance with quality policies and improve reporting on changes arising from service user feedback

Equality impact assessments

10 The Trust has made significant progress in strengthening its approach to Equality Impact Assessments (EIAs).

11 The Trust has set up a central Governance Hub as part of a pilot which aims to ensure that all relevant proposals undergo EIAs, and all other required governance needs (such as compliance with legislation, information governance compliance and financial implications), before reaching the Executive or Board. This approach ensures that the necessary assessments are complete before presenting information on which to make key decisions, minimising delays in decision making. The approach has also enabled the Trust to proactively embed EIAs into planning stages and decision making across the organisation. The pilot phase of the Governance Hub has concluded and is currently being reviewed by the Trust, with the intention of permanent implementation for 2026-27.

12 The Trust has agreed quality standards for EIAs, which it keeps under regular review. Each Executive Director provides oversight of the quality of completed EIAs within their respective remits, which are then scrutinised as part of the decision-making process. This ensures they follow agreed standards and that their authors address any gaps in coverage or mitigation to avoid adverse impacts.

13 Staff now see EIAs as integral to service redesign and the development of policies and strategies, and not just a procedural step. The Trust has incorporated EIAs into its broader governance framework through the Governance Hub pilot, treating equality considerations with the same strategic importance as other governance requirements.

14 The Trust now stores and tracks EIAs in a new central repository within the Governance Hub, which will be accessible across the organisation following the review of the pilot. This repository supports visibility and consistency. It also helps ensure that the organisation is learning from earlier assessments and applying learning to future decisions. The centralisation also improves transparency in the governance process, making it easier to track the impact of EIAs on decision-making.

15 The Trust has plans to also develop a mitigation tracking tool embedded into the EHIA database which is currently in a pilot phase. The tool aims to allow the Trust to seek progress updates from leads on the implementation of mitigating actions included in EIAs, ensuring the completion of actions on time. The reporting arrangements around this will be determined once implemented for 2026-27.

Risk management

16 The Trust has made substantial progress in strengthening its risk management arrangements.

17 The Trust has made significant strides in implementing its 2022 Risk Management Development Plan (RMDP). The Trust has completed a thorough review of both strategic and operational risks, leading to the identification and clear mapping of risks to the business priorities included in its 2025-28 Integrated Medium-Term Plan (IMTP). There is now a well-defined escalation pathway for risks from directorates to corporate and executive levels, ensuring transparency and accountability.

18 The Trust has reviewed and enhanced its risk management resources, appointing a Head of Risk Management in early 2024 to provide strategic oversight of the RMDP. This role has been instrumental in driving the implementation of risk management improvements and ensuring that there is active discussion of strategic risks by the Executive Team and Board.

19 The Trust has realigned its strategic risks to focus on areas which it can directly control or influence, such as leadership, culture, and operational delivery. The Trust has made good progress in developing its arrangements to assure the quality of controls in the Strategic Risk Register (SRR)[2]. The SRR includes improved narratives on risks and their controls, and there is clear alignment to operational aims. The Trust has implemented a revised risk appetite framework, which further strengthens risk scoring and the understanding of residual risks. The progress made supports more rigorous scrutiny. However, we continue to highlight through our structured assessment work that levels of assurance provided by the Trust are largely operational, and there are some gaps in second and third levels of assurance[3]. The Board, Executive Team and relevant committees regularly receive and review operational and strategic risk registers.

[2] The Trust's Strategic Risk Register is what we would consider to be a Board Assurance Framework, a document used to record and report an organisation's key strategic objectives, risks, controls, and assurances to the Board.

[3] The three lines of defence model enables sources of assurance to be categorised, with increasing independence and objectivity of assurance at the second and third levels.

20 A more robust risk management culture is developing within the Trust, with increased directorate involvement and a greater emphasis on ensuring controls are effective. The introduction of operational risk dashboards and composite reporting tools is improving the visibility and effectiveness of risk assurance processes. But the Trust has identified that some areas of the organisation need greater focus to further mature operational risk management. Operational teams are increasingly embedding risk management into their daily routines. But the Trust faces a challenge in ensuring there is sufficient time and resources dedicated to support risk management across all levels of the organisation.

21 The Trust uses Datix Cymru as its primary risk management software. While the system has been adapted to better support the Trust's risk management framework, including customisation for risk appetite and categorisation, it still has functional limitations. The Trust is actively reviewing options for a more effective and scalable risk management solution, and an Executive decision is pending on whether to move away from the Datix Cymru risk module.

22 In the interim, Digital Health and Care Wales is enhancing Datix Cymru with more features, and the Trust is developing more Power BI risk dashboards to strengthen real-time monitoring. The dashboards will offer a more integrated view of risks and support triangulation with other assurance data.

Clinical audit

23 The Trust has made significant progress in ensuring a more structured, integrated and risk-informed approach to clinical audit across the organisation.

24 The Trust has made progress to ensure that the Clinical Audit Plan links to operational, corporate, and strategic risk registers. The Trust now requires all audit proposals to highlight whether the activity is associated with a specific risk. This process ensures alignment between audits and key risks and helps effectively prioritise audits in high-risk areas. The focus on risk-based prioritisation is clear, with the Trust beginning with clinical audits in high-risk areas such as infection prevention and control.

25 Clinical audit activity is currently stored and shared via internal webpages and document management systems. While the systems are currently functional, the Trust has identified the need for a more centralised and robust system to support the management of clinical audits. The Trust procured AMaT (Audit Management Tool) in 2024-25, and it is currently rolling the tool out.

26 While the Trust is rolling out AMaT, it has made interim improvements to tracking clinical audit actions via Microsoft (MS) Planner. This provides a basic but effective way to check the progress of actions at divisional level and provide six-monthly updates to the Executive Team and Quality, Safety, and Improvement Committee (QSIC), via the Quality Oversight Group (QUOG). Although MS Planner is not as comprehensive as AMaT, it shows the Trust's commitment to ensuring continuous visibility and tracking of audits until the new system is fully operational.

27 AMaT will centralise audit recommendations, actions, and progress, providing automated notifications to responsible officers when actions are overdue or require attention. This will not only ensure that the Trust meets audit requirements but also drive greater accountability and oversight. Real-time reporting via AMaT will provide dashboards to show the progress of audits and track their completion, offering a higher level of transparency for leadership teams. Additionally, the integration of audit results with other sources of assurance (for example, incident reports) via AMaT will foster a more integrated approach to quality improvement and operational planning.

28 The Trust is currently implementing AMaT which is due to be fully functional by 31 March 2026. The Trust is planning to provide AMaT training workshops for staff across clinical teams and divisions to ensure they can use the system effectively to access and manage audit information.

29 The Trust reviews and collates themes arising from its clinical audit activity. The QUOG has plans to develop a process in 2026 for reviewing learning themes from audits and follow-up actions before escalating them to the QSIC for strategic oversight through quarterly Quality Governance and Performance Reports. The Trust has committed to further improvements to strengthen the tracking of implemented learning, supported by functionality in AMaT. The Trust also plans to ensure future audit plans provide assurance that it is effectively investigating and addressing audit themes.

Staff appraisals and training

30 The Trust has improved staff appraisal rates, and compliance with statutory and mandatory training is now well above target levels.

31 For the twelve-month period July 2024 - June 2025, the Trust's compliance with statutory and mandatory training has been over 90% compared to a target rate of 85%. Compliance has been above the target across all the Trust's directorates.

32 For the twelve-month period, staff appraisal rates across the Trust have fluctuated between 81.3% and 85.6%, against a target of 85%. The Trust has not met the staff appraisal target in ten of the twelve months, although performance is much improved when compared to 61% in October 2021. Staff appraisal rates vary by directorate, with six of the Trust's eight directorates meeting the target. Appraisal rates in the Health and Wellbeing, and Health Protection and Screening Services Directorates fall short of the target at 80% and 81%, respectively. This compares to 54% in the Health Protection and Screening Services Directorate in October 2021[4].

[4] We do not have data for appraisal rates achieved by the Health and Well-being Directorate in October 2021.

33 Leadership teams are now able to track compliance levels with appraisals and statutory and mandatory training through monthly detailed dashboards. This offers leadership teams with real-time insights and has helped highlight areas needing attention, enabling targeted interventions. The Trust has also provided enhanced support for staff and line managers by offering clearer guidance, regular drop-in sessions, and dedicated resources, all aimed at improving both the quality and consistency of appraisals.

34 Local improvement plans are in place to improve staff appraisal rates in directorates that are not meeting the target. The Trust is actively managing these plans through quarterly workforce reviews, supported by routine monitoring of compliance rates. Additionally, the development of tailored training plans for different roles, alongside clearer communication on training completion deadlines, has helped increase statutory and mandatory training compliance.

35 The Trust plans to review of the staff appraisal system between October and December 2025. The Trust expects the review to further refine processes and improve the Trust's compliance rates. The overall culture surrounding appraisals and training has shifted positively, with staff expressing increased confidence in the process, supported by a stronger sense of purpose and engagement.

Policies and procedures

36 The Trust has made significant progress in updating and sharing new and revised policies and procedures. Although, it could do more to assess awareness and compliance more proactively.

37 The Trust has set up robust processes for updating and sharing policies across directorates. The Board approved an updated Policy for Policies in July 2022. The Board Business Unit co-ordinate the process, with each directorate supported by Business and Planning Leads. New policies undergo formal consultation, and leadership and committee level approval. The Trust's intranet has a strengthened policy page to highlight policies currently under review.

38 The Trust's Integrated Performance Report provides an update on the status of corporate policies at each Board meeting, with bi-annual reports provided to each committee. In June 2025, the Trust reported to QSIC that it had two out of date quality and safety policies, out of a total of thirty policies. Approval of one policy is due in August. The remaining policy was pending a review on an all-Wales basis.

39 The Trust makes its staff aware of new or revised policies through a monthly email bulletin. The Trust also communicates to staff through other internal mechanisms, including the staff intranet, leadership meetings, and directorate-level updates. The Trust actively checks staff awareness of new or updated policies through corporate structures, such as strategic HR partners and Business and Planning Leads, who support staff during change processes. However, the Trust's formal testing of staff awareness is limited.

40 The Trust reviews compliance with new or updated policies in a reactive manner through breaches of policies, for example, incident reporting and complaints. The Executive Nurse Team leads on monitoring compliance and reports findings to the QSIC. The Trust uses performance dashboards and exception reports to flag areas of concern, prompting remedial action.

41 Specific policies, such as Speak up Safely and Putting Things Right, have received particular attention to track their implementation. Despite this, there is still scope for the Trust to introduce a systematic, Trust-wide approach for proactively testing policy compliance, including awareness. This would be particularly useful for policies for less often used policies.

Service user and staff feedback

42 The Trust has made strong progress in enhancing its approach to gathering and acting on feedback from service users, staff, stakeholders, and partner organisations. But the Trust should improve the visibility of service changes resulting from service user feedback.

43 Seven staff equality networks, each with an executive sponsor, provide a structured way for staff voices to feed directly into Board-level discussions. Regular staff surveys, appraisal reviews, and the emerging Speak Up Safely culture all support a psychologically safe and transparent environment to encourage staff feedback.

44 The Trust has implemented the CIVICA system across all screening programmes, supporting a consistent and visible approach to capturing service user feedback. This includes bespoke digital surveys hosted on programme webpages, links on printed materials promoting feedback, and a growing use of iPads and feedback kiosks across screening clinics. Surveys capture protected characteristics, enabling an equity-focused analysis. The investment in digital platforms, combined with a clear focus on user accessibility, has enhanced the reach and the number of responses, and supports quicker receipt of feedback.

45 The Trust has embedded routine triangulation of service user feedback with other information. The Quality Team now regularly review CIVICA service user feedback alongside complaints data, incident trends, risk data and workforce feedback. This enables themes to be identified, for example, where service user concerns align with operational or safety risks. This provides a more comprehensive picture of service quality and promotes a whole-system view. Integrated Governance and Leadership Team meetings consider the insights and related escalation and improvement plans. Reports to the QSIC provide evidence of triangulation of feedback, with thematic insights from service users analysed alongside staff feedback and performance and risk data.

46 The Trust has trialled agile improvements resulting from more timely feedback in areas such as screening uptake and digital access to the Trust's public information. These initiatives show the Trust's growing capability to turn feedback quickly into actions with measurable impact, such as increased screening appointments in evenings and new locations.

47 The Trust is making progress to close the feedback loop. It is piloting the receipt of text / SMS-based feedback to increase transparency and improve public confidence in the responsiveness to feedback. A follow-up message thanks respondents and outlines next steps. Demonstrating how service user feedback has shaped screening services has also featured in Quality Reports and, to a limited extent, in deep dives to QSIC.

48 The Trust should, however, more explicitly report the changes it has made in response to service user feedback to improve transparency. This should include reporting to QSIC and highlighting service changes resulting from service user feedback on its website. The 'You Said, We Did' framework should be implemented to provide the necessary transparency.

49 The Trust has implemented wide-ranging and maturing mechanisms to capture and act on service user, community, and stakeholder feedback. During 2024 and 2025, the Trust has undertaken an organisational baseline engagement review using the EDGE tool to assess the following across the organisation:

- Current engagement resources and activity.
- The quality of engagement.
- Understanding of the full spectrum of engagement activity.

50 The aim of the work is to set up a comprehensive centralised framework to capture, triangulate, and act on feedback from its service users, including those working in other organisations (including health boards, local authorities, and wider partner organisations). The Trust is also improving its knowledge of, and ability to engage with, its service users through the ongoing development of a central Customer Relationship Management (CRM) system. The Trust plans to create a central engagement function linked to existing engagement functions within divisions. The aim being to develop a common approach and method for engagement, supported with a guiding framework and toolkit.

51 The Trust's newly created People's Experience Learning Group will develop the Trust's plan to implement the NHS Wales National People's Experience Framework. The group also provides a platform for cross organisational learning from engagement and provides associated feedback of associated improvement to the Trust's Quality Oversight Group and the Board.

Quality, Safety, and Improvement Committee subgroups

52 The Trust has taken clear and proactive steps to strengthen oversight of its QSIC subgroups.

53 The Trust has reviewed and updated the Terms of Reference for QSIC and its subgroups, including the Infection Prevention and Control Group and Safeguarding Group. These revisions explicitly define reporting responsibilities, escalation pathways, and meeting frequencies. This ensures greater clarity on the remit of each subgroup and their role in contributing to system-wide quality assurance.

54 The formation of QUOG in 2023–24 marked a significant development in terms of quality oversight. A governance mapping exercise, which assessed interdependencies between quality groups and the flow of intelligence, informed the establishment of the group. QUOG functions as a critical interface, translating operational learning into strategic discussion and reporting to QSIC. This group has improved the visibility of cross-cutting risks, emerging trends, and learning from incidents and complaints.

55 The QSIC receives the Quality Governance Report, which includes items for escalation arising from subgroup outputs. This includes thematic reports, deep dives, and quarterly dashboards (for example, for infection prevention and control, safeguarding, Duty of Candour, and clinical audit). The structure of the Quality Governance Report is based on recognised quality domains. It routinely features key issues, progress updates, and required actions, supporting a more mature assurance environment.

56 The QSIC has adapted its own agenda and presentation style, ensuring it gives sufficient time for learning and critical reflection. For example, recent meetings have included deep dives into service-user experience and workforce culture, based on findings raised by the QUOG and subgroups. The committee also has a standing forward work programme to ensure alignment with strategic priorities and governance expectations.

Responding to the Duties of Quality and Candour

The Trust has made demonstrable progress in implementing its statutory duties around quality and candour

57 The Trust has well developed corporate arrangements to support the implementation of the two duties. It has completed the national self-assessment for both duties and reported the findings to the Board and relevant committees.

58 Governance reporting regularly includes updates on implementation, with the Duty of Quality now reflected in the Corporate Risk Register. The IMTP and other strategic documents also now explicitly reflect the quality domains of the Duty of Quality.

59 Board members have received development sessions, supported by the national Delivery Unit, to help them understand their responsibilities under both duties. The Trust has provided staff training via the Electronic Staff Record (ESR), with uptake monitored, although Duty of Candour training is not currently mandatory.

60 Senior leaders, such as the Executive Director of Nursing and divisional leads, have received training and are acting as champions within their respective areas. However, at the time of our fieldwork, awareness of the duties and uptake of training at the operational level was variable. The Trust is addressing this through continued awareness-raising, divisional updates, and leadership engagement.

61 The Trust has clearly defined leadership responsibilities for quality. The Executive Director of Nursing leads on both statutory duties, with senior divisional leads actively involved in operational delivery. There is strong executive sponsorship of organisational culture mechanisms such as Speak Up Safely, and staff are using the quality framework to shape presentations, performance discussions, and assurance reports.

62 There is no evidence of capacity or capability gaps at a divisional level. Engagement with QSIC and Board development sessions has strengthened collective understanding of what assurance on these duties should look like.

63 Monitoring arrangements are in place and maturing. The quarterly Quality Governance and Performance Report provides a progress update to both QSIC and the Executive Team. Annual reporting cycles are also in place to support ongoing oversight.

64 While Duty of Candour cases are infrequent due to the nature of services provided by the Trust, each case is carefully managed, and the Trust is reviewing reporting processes to ensure proportionality and effectiveness. In 2024-25, the Trust reported two ‘moderate harm and above’ incidents needing the application of the Duty of Candour procedure, out of a total of 66 incidents. The Trust is also working to triangulate risk, quality, and incident data more effectively, using tools such as Power BI dashboards to provide real-time insights and operational visibility.

65 The Trust continues to promote a culture of openness, learning, and staff empowerment. Speak Up Safely has led to an increase in reporting, with leadership teams actively promoting psychological safety and reflective practice. Staff networks, trade union partnerships, and training on difficult conversations have supported a positive shift in culture.

66 A Cultural Action Plan is in place, and screening services have aligned their quality improvement activity with the duties, using the Duty of Quality as a central framework for performance and learning.

Recommendations

67 We have made two new recommendations based on our follow up work. These recommendations replace four recommendations from our 2022 work which we have identified as partly complete (Recommendations 5.2, 5.3, 6.3 and 6.4).

68 The status of the 2022 recommendations is set out in **Appendix 2**.

R1 The Trust should introduce a systematic, Trust-wide approach for proactively testing awareness of, and compliance with quality governance policies. (**see paragraph 41**).

R2 The Trust should more explicitly and transparently report the changes it has made in response to service user feedback. This should include reports to QSIC, and more explicit use of “You Said, We Did” to support reporting on its website of service changes stemming from service user feedback. (**see paragraph 48**).

Appendices

1 About our work

Scope of the audit

We have assessed whether:

- the Trust has implemented previous audit recommendations arising from our 2022 review of its quality governance arrangements and is realising the intended outcomes and benefits of those recommendations; and
- there is a sound corporate approach to oversee and scrutinise the quality and safety of services in line with the Duty of Quality and Duty of Candour requirements.

Audit questions and criteria

Questions

Our audit addressed the following questions:

- Has the Trust strengthened its approach to equality impact assessments (EIAs)?
- Has the Trust strengthened its risk management arrangements?
- Has the Trust strengthened its clinical audit arrangements?
- Has the Trust improved compliance with staff appraisal and statutory and mandatory training targets?
- Has the Trust strengthened its approach to user and staff feedback?
- Has the Trust strengthened its approach to seeking feedback from its wider stakeholders and partner organisations?
- Has the Trust strengthened its oversight of the sub-groups of the Quality, Safety, and Improvement Committee?

- Has the Trust taken steps to implement arrangements to deliver both the Duty of Quality and Duty of Candour?

Criteria

In gathering evidence against the above questions, we were looking for the Trust to demonstrate that it:

- Had made the expected progress in implementing our 2022 audit recommendations (set out in **Appendix 2)** to address the issues and concerns identified in the original audit; and
- Was implementing the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act) in respect of the duties of quality and candour.

Methods

We undertook our audit work between March and July 2025.

We reviewed the following key documents:

- Quality frameworks,
- Relevant internal audit reports,
- Patient experience and involvement strategy,
- Staff feedback and engagement,
- Policies and procedures,
- Risk assurance plan, register and reports,
- Clinical audit plan and relevant reports,
- Relevant annual reports, including Putting Things Right, and Duty of Quality reports, and
- Committee reports, including Quality Assurance and Performance reports.

We interviewed the following:

- Executive Director of Nursing, Quality, and Integrated Governance,
- Executive Director of People and Organisational Development,
- National Director of Health Protection and Screening Services, and Executive Medical Director,
- Director – Screening Division,
- Quality, Safety, and Improvement Committee Chair,
- Head of Risk Management, and
- Board Secretary and Head of Board Business Unit.

We also asked the Trust to complete and submit a self-assessment, setting out its view of progress against the 2022 recommendations. The Trust submitted a completed self-assessment on 27 May 2025.

2 Previous recommendations

We made the following recommendations in 2022 following our review of the Trust's quality governance arrangements. We have highlighted the status of these recommendations based on our follow up review.

R1 The Trust should strengthen its approach to equality impact assessments by:

1.1. Ensuring EIAs are completed where necessary (**complete**).

1.2. Agreeing quality standards and a process to assess EIAs, ensuring they are meaningful assessments with appropriate actions to mitigate adverse impacts (**complete**).

1.3. Developing a central repository to store and share EIAs across the organisation (**complete**).

1.4. Developing a process to monitor implementation of mitigating actions (**complete**).

R2 The Trust should strengthen its risk management arrangements by:

2.1. Prioritising the implementation of its Risk Development Plan (**complete**).

2.2. Continuing to develop systems to assure the quality of controls in the strategic risk register and consider the best forum to share the information (**complete**).

2.3. Ensuring consistent software is used to manage risk across the business (**complete**).

2.4. Review resources for risk management including the breadth of the Chief Risk Officer's portfolio of work, and whether operational staff have protected time for risk management (**complete**).

R3 The Trust should strengthen its clinical audit arrangements by:

3.1. Creating a central repository to store and share all clinical audits, either in the quality hub or elsewhere (**complete**).

3.2. Developing a system to track and report progress implementing the recommendations of clinical audit to the Business Executive Team and Quality, Safety, and Improvement Committee (**complete**).

3.3. Developing a process to link the clinical audit plan more clearly to operational, corporate, and strategic risk registers to demonstrate that audits are mapped to key quality and safety risks (**complete**).

3.4. Collating themes arising from the clinical audit programme and sharing with the Business Executive Team and Quality, Safety, and Improvement Committee. Future clinical audit plans should provide assurance that themes are being investigated (**complete**).

R4 The Trust should ensure compliance with staff appraisals and statutory and mandatory training meets the national target within the next 12 months (**complete**).

R5 The Trust should strengthen its management of policies, procedures, and written control documents by:

5.1. Developing a process to update and share policies and procedures at directorate level with staff (**complete**).

5.2. Monitoring staff awareness of new or updated policies and procedures (**partly complete**).

5.3. Testing compliance with new or updated policies and procedures including the Putting Things Right Procedure and All Wales Concerns policy (**partly complete**).

5.4. Providing assurance to the Quality, Safety, and Improvement Committee that staff are using new and updated policies and procedures (**complete**).

R6 The Trust should strengthen its approach to user and staff feedback by:

6.1. Developing and implementing the CIVICA system and a consistent approach to capture information on the protected characteristics of service users and respondents to research surveys (**complete**).

6.2. Developing an approach to combine feedback from staff, service users, complaints, incidents, and compliments to create a more robust picture of the quality and safety of services (**complete**).

6.3. Developing mechanisms to inform service users about the impact their feedback has had on service improvement (**partly complete**).

6.4. Including service user feedback in deep dives for the Quality, Safety, and Improvement Committee (**partly complete**).

6.5. Developing an approach to sharing learning from engagement with staff and users either through the implementation of the Quality as a Business Strategy and progressing agile methods which have been initiated (**complete**).

R7 The Trust should revise its terms of reference of the Quality, Safety, and Improvement Committee to include its sub-groups and reporting mechanisms. In doing so, it should ensure that the Committee has oversight of the breadth of material covered by the sub-groups and key themes or issues arising from discussions (**complete**).

3 Key terms in this report

Term	Description
Board Business Unit	The function supporting the Trust's Board Secretary.
CIVICA	An electronic system for capturing and measuring patient and employee feedback.
Clinical audit	The process that looks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.
Datix Cymru	The official Once for Wales Concerns Management System, a secure, cloud-based digital platform used by all NHS Wales staff to report incidents, risks, and safety concerns under the Duty of Candour.
Deep dive	An in-depth examination or analysis of a topic received by the Board or one of its committees for information and/or assurance.
Duty of Candour	The Duty of Candour is a legal requirement for Welsh NHS organisations to be open and honest with service users when harm occurs during their care. This includes communicating with the patient, investigating the incident, and learning from it to prevent future occurrences.

Term	Description
Duty of Quality	The Duty of Quality is a legal obligation on Welsh NHS organisations to continually improve the quality of healthcare services and outcomes for the people of Wales. The Duty requires a focus on quality in all strategic decisions and ongoing monitoring of progress in quality improvement
EDGE Tool	Embryonic, Developing, Gripping, Embedded – the EDGE tool, developed by the National Co-ordinating Centre for Public Engagement, is a self-assessment framework used by organisations to evaluate and improve their support for public engagement.
Equality Impact Assessments	The process used to systematically examine the potential effects of a policy, project, or service on different groups of people, particularly those with protected characteristics under equality legislation.
Governance Hub	A single point of contact for staff on all aspects of governance.
Improvement & Innovation Hub	A corporate function to support staff drive quality, improvement, and innovation, to achieve strategic aims.
Integrated Medium-Term Plan	An Integrated Medium-Term Plan is a three-year plan that sets out how the organisation will deliver its services, manage its workforce, and meet its financial duties to break even. The organisation

Term	Description
	submits its plan to Welsh Government for approval.
Power BI	Computer software used to analyse and view data to help support understanding of data.
Putting Things Right	The formal process for raising concerns and complaints about the NHS in Wales and its services.
Quality governance	The combination of structures, processes, and behaviours used by an organisation, particularly its board, to lead on and ensure high-quality performance, including safety, effectiveness, and patient experience.
Risk Management Development Plan	A plan developed following a gap analysis undertaken in 2022, setting out actions needed to improve the Trust's risk management arrangements over a three-year timeframe.
SharePoint	A web-based collaboration and document management platform.
Speak Up Safely	A cultural framework that aims to create an environment where individuals feel secure and confident to raise concerns about issues such as patient safety, quality of care, and workplace bullying without fear of victimisation or detrimental treatment.

About us

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We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.