Archwilio Cymru
Audit Wales

# Improving quality governance

## Swansea Bay University Health Board

January 2026

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# Audit snapshot

## What we looked at

1 Our review assessed progress made by Swansea Bay University Health Board (the Health Board) in implementing our 2022 quality governance audit recommendations. It also considered progress made by the Health Board 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 Health Board found that it was committed to improving its quality governance arrangements. But, whilst we found that corporate quality governance arrangements showed strengths, there were significant weaknesses in arrangements both corporately and within operational teams.

4 We made eight recommendations, covering 13 areas for improvement, which focused on:

- risk management;
- clinical audit;
- mortality reviews and learning;
- values and behaviour;
- performance appraisal and development review (PADR);

- Quality and Safety Framework;
- collective ownership of the quality agenda; and
- quality governance resources.

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 Health Board has made strong progress on implementing our 2022 recommendations. Risk management training has improved, and there is stronger scrutiny of corporate risk registers. The Health Board now routinely reports on delivery and outcomes from clinical audit activity, and mortality reviews and learning processes have also improved. The Health Board has also reviewed its quality governance resources, strengthened clinical leadership, and provided more quality training opportunities to staff.

7 However, the Quality and Safety Framework needs to be clearer on operational arrangements, updated to reflect the new organisational structure. Opportunities also remain to strengthen operational scrutiny of risk registers, embed the values and behaviours framework at an operational level and improve arrangements for staff to raise concerns. Clinical attendance at key quality and safety groups needs to be reinforced, and performance appraisal and development review (PADR) compliance rates also need to rise to meet targets.

8 The Health Board has made satisfactory progress on embedding the statutory duties of quality and candour. Strategic planning, leadership commitment, and governance mechanisms are in place. However, monitoring of uptake of staff training on duty of candour needs to improve.

## What we recommend

9 We have made three new recommendations to the Health Board, which focus on:

- updating the quality and safety framework;
- ensuring clinical attendance at key quality and safety groups; and
- improving compliance with duty of candour training.

# Key facts and figures

- Nine out of 13 areas for improvement arising from our 2022 work are addressed, with four remaining in progress.

- 73% compliance with Performance Appraisal and Development Reviews (PADR) in September 2025, compared with 60% in September 2022.

- Quality Dashboard launched in March 2024 which uses live data to provide ward, service and organisational data on quality and safety of care.

- Over 210 staff received quality improvement training during 2024-25.

- Duty of Candour triggered in 188 patient safety incidents in 2024-25, almost 1% of the incidents reported.

- 41 out of 72 Duty of Candour closed cases identified as ‘moderate harm and above’.

# Our findings

## Implementation of previous recommendations

### The Health Board has implemented nine of the 13 areas for improvement from our 2022 review with the remaining areas in progress

#### Risk management

10 Our 2022 review recommended that the Health Board provides training across the operational structure to enable managers to identify risks and update risk registers in line with corporate policy. We have found that the Health Board has made substantial progress in this area.

11 By March 2023, each service group leadership team completed training to identify risks and update the risk registers in line with corporate policy. The Health Board has developed further training as part of the implementation of the new Risk Management Strategy developed in November 2024, which the Risk and Assurance Team are now rolling out.

12 To strengthen oversight of training compliance, the Health Board is planning to integrate compliance tracking into the Electronic Staff Record (ESR) system. In addition, the Risk and Assurance team will issue refreshed guidance by March 2026 to ensure staff have clear, up to date standards.

13 Corporate scrutiny of risk registers has strengthened since our 2022 review. In April 2025, the Health Board refreshed its Risk Management Group to drive improvements in the quality and consistency of service group risk registers. The group conducts systematic reviews and seeks assurance from service group directors on local risk arrangements, resulting in clearer, more accurate registers and consistent scoring.

14 At an operational level, service groups review and update their registers during routine quality and safety meetings, with service group reports feeding into the Health Board Quality and Safety Group (QSG). The QSG validates scoring and escalates significant risks. However, our review found there remains further work to improve the quality of operational risk registers, in terms of mitigating actions and completeness.

15 At the time of our work, the Health Board was reviewing its arrangements for managing corporate risks. It is intending to introduce a Corporate Risk Register for cross organisational risks and an Operational Risk Register for risks escalated from service groups. These are currently in draft. The Health Board plans to complete this work by April 2026.

## Clinical audit plans and reporting

16 During our 2022 review, we were unable to obtain a copy of the Health Board's most recent clinical audit plan. We have found that the Health Board has since strengthened its clinical audit approach. There is now a clear and agreed clinical audit plan in place.

17 In May 2024, the Audit Committee approved a two-year plan that spans national, corporate, and local audits. The Health Board firmly aligned the plan with operational, corporate, and strategic risk registers, ensuring audits target the areas of greatest impact.

18 We also previously found that oversight of clinical audit and mortality was infrequent. The Health Board has also addressed this. The Quality and Safety Committee now receives bi-monthly updates on clinical audit outcomes and mortality review performance. This is an improvement from the annual reporting found in our 2022 review. However, we note that at the September 2025 Audit Committee meeting, the 2023-24 clinical audit plan was reported as 86% complete and the 2024-26 plan was only 30% complete. The reasons for this were unclear at the time of our work.

19 In addition, the Health Board also has regular updates on outcomes from the clinical audit plan. The Health Board's Clinical Outcomes and Effectiveness Group (COEG) monitors delivery of the clinical audit plan and reports on mortality review performance. As part of the COEG's meeting agenda, there is a clear focus on lessons learned. This group then updates the Quality and Safety Committee (QSC) on a bi-monthly basis.

20 The Health Board has adopted the National Learning from Deaths Framework[1] and the Health Board's Clinical Audit and Effectiveness Annual Report 2024-25 highlights the importance of learning. The Deputy Executive Medical Director leads on mortality reviews and undertakes a weekly mortality review process with a multidisciplinary panel. The Health Board uses a mortality dashboard to identify any outliers and hotspots.

## Values and behaviours

21 Since our 2022 review, the Health Board has worked hard to increase awareness of its values and behaviours framework. We have found that the Health Board has refreshed organisational awareness of the values and behaviours as part of its launch of its ten-year vision, 'One Bay Way'.

22 It also launched a new People Strategy in January 2024. The Health Board promoted the People Strategy through organisation-wide communications, including monthly team brief sessions with the Executive team and weekly mid-week messages. However, it recognises there is more to do to ensure the values are at the forefront of everything staff do within the Health Board, especially within operational teams.

23 Since our original review, the Health Board has undertaken work to understand why some staff felt that it did not encourage reporting of errors, near misses or incidents and did not act in response to concerns. This included listening exercises with staff.

[1] NHS guidance designed to standardise how healthcare providers identify, report, investigate, and learn from patient deaths to improve care and prevent future deaths.

24 This has led to work across the Health Board to increase visibility of the arrangements and support. The Health Board has provided training to managers to support staff in raising concerns and there is information for staff available on the intranet page. HR Business Partners undertake listening exercises and since June 2025 there have been regular quality assurance Board Member visits of clinical areas.

25 The Health Board has invested in a range of tools to support staff including:

- Raising Concerns Hub;
- Speaking Up Safety Framework; and
- Guardian Service.

26 However, a Guardian Service report for 2023-24 found that 37.5% of staff contacted the service as they had raised concerns previously but had not been listened to. In January 2025, an Internal Audit report on the implementation of the Speaking Up Safely (SUS) Framework found limited assurance, with the raising concerns process and the monitoring, reviewing, and analysing concerns particular areas requiring improvement.

27 In response, the Health Board has undertaken focused work to encourage staff to report concerns and build confidence. This includes the creation of a SUS Action Plan, a SUS Working Group, the introduction of a Raising Concerns Hub, a roadshow to promote the Guardian Service and the development of training resources. To improve organisation-wide understanding of incidents, service groups also provide reports detailing themes, trends, actions, and lessons learned to the Workforce and Organisational Development Committee.

## Performance Appraisal and Development reviews

28 Our 2022 review found that compliance with Performance Appraisal and Development reviews (PADR) was low. We recommended that the Health Board needed a clear plan to improve performance and set out a target date for compliance. However, despite improved PADR rates, the Health Board did not agree an overarching plan or set out when it would achieve full compliance.

29 PADR performance has been on a gradual upward trajectory, with some fluctuations. In September 2025, PADR compliance for the Health Board was 73%, which is an improvement from the 2022 position of 60%. However, the Health Board has not met the PADR target of 85% for several years. There are local variations in performance within the Health Board, with only two out of 18 directorates meeting the 85% target in September 2025.

30 Local improvement plans are in place to improve staff appraisal rates. HR Business Partners are providing added support which is delivering improvements (eg Estates and Support Services directorate improved from 55% in June 2024 to 74% in March 2025 because of business partner support).

31 Despite performance, monitoring arrangements for PADR compliance are strong. Corporately, both the Board and Workforce and Organisational Development Committee receive performance information on PADR compliance. These reports set out short term actions in place to drive improvement. At an operational level, leadership teams are now able to track compliance levels with appraisals through the Workforce Dashboard. This provides leaders with the ability to find hotspots needing attention, enabling targeted interventions.

## Quality and Safety Framework

32 Our 2022 review found that despite developing the Quality and Safety Framework, the Health Board had not implemented it. The framework needed to be relaunched following learning from COVID-19, to provide clarity on the quality expectations and with a strengthened approach to compliance reporting.

33 In May 2024, the Health Board refreshed and relaunched its Quality and Safety Framework. The Health Board framework was updated to reflect the new Duty of Quality and Candour. This framework clearly sets out the quality governance arrangements across the Health Board, but it continues to stop short of describing the operational quality and safety governance arrangements in detail. There is still a lack of clarity in this area. As the Health Board moves into its new organisational structure following its implementation of its 'organising for success' programme, it will need to revisit the framework.[2]

34 Arrangements are in place to monitor the operation of the framework across the Health Board, including through the Quality Strategy Implementation Plan. The Health Board reports progress quarterly to the Quality and Safety Group, which provides highlight reports to the Quality and Safety Committee.

## Collective ownership of the quality agenda

35 Despite our 2022 review reporting collective responsibility for quality and safety amongst the executive team, there was an overreliance on nursing leads to take forward the quality agenda within divisions.

36 We have found there is still a strong collective responsibility for quality and safety amongst the executive team. At an operational level, there is an improved focus within service groups at their quality and safety meetings. The Health Board has recently appointed a clinical lead for quality improvement on a sessional basis. The clinical lead provides expertise and leadership promoting quality improvement across the Health Board, with a key focus upon clinical services.

37 The Health Board's Quality and Safety Group (QSG) is responsible for operating an effective quality management system across the organisation. There is appropriate medical and nursing service group representation within the terms of reference for the group.

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[2] Organising for Success is one of the Health Board's priority programmes that will include a comprehensive review and redesign of organisational structures.

38 However, minutes from the six meetings held by the QSG during 2025 show that on at least three occasions, the group was not quorate, due to a lack of service group Nurse and/or Medical Directors attending. To further strengthen collective clinical responsibility for quality and safety, the Health Board should ensure that attendance from Nurse and Medical Directors is consistent.

## Quality governance resources

39 Since our review in 2022, the Health Board has reviewed its resources to support quality governance. As a result, the Health Board integrated the corporate quality improvement and quality assurance teams into one team responsible for the Health Board's quality management system. This also enabled the creation of a Quality, Safety, and Improvement Hub.

40 The hub aims to improve the triangulation of matters relating to quality and safety, lead the Quality and Safety Framework and provide the Health Board with added capability to identify risks. The Quality Improvement Training Academy also sits within the Hub. The Health Board has been able to improve the amount of Quality Improvement training available to develop and expand these skills across the organisation as a result.

41 To facilitate sharing across the organisation, the Executive Director for Nursing and Patient Experience meets collectively with service group quality and safety leads once a quarter. These meetings focus on quality priorities and opportunities for sharing ideas and learning. The Health Board has also created some opportunities for quality related networking events, including the Quality Improvement Forum and the Patient Safety Congress.

# Responding to the Duties of Quality and Candour

## The Health Board has taken reasonable steps to implement the duties of quality and candour, however, there is scope to improve training compliance and monitoring

42 The Health and Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023. In advance of its introduction, the Health Board assessed its preparedness for complying with the Act against the Welsh Government baseline position.

43 The Health Board articulated a clear approach to the implementation of both statutory duties. There was a clear implementation plan, and arrangements were in place to oversee the implementation by a Task and Finish Group which included regular progress updates to the Patient Safety and Compliance Group, with key milestones tracked. Board members have received development sessions to help them understand their responsibilities under both duties.

44 The Health Board has clearly defined leadership responsibilities for quality and candour. The Executive Director of Nursing and Patient Experience leads on both statutory duties. Service Group leads are also actively involved in operational delivery. There is strong executive sponsorship of organisational culture mechanisms such as Speaking Up Safely, and staff are using the Quality and Safety Framework to shape presentations, performance discussions, and assurance reports.

45 The Health Board has undertaken significant work to raise staff awareness of the two duties. There are clearly defined policies and procedures for meeting Duty of Candour requirements. The Health Board actively identifies and implements actions to reduce the risk of Duty of Candour incidents recurring. Lessons learned and good practice are actively shared.

46 A Duty of Candour staff training package is also available via the Electronic Staff Record (ESR), with completion data monitored. We were unable to assess how many staff have completed this training package. However, the Health Board has acknowledged that it needs to improve uptake.

47 The Health Board launched its strategic vision for quality in its five-year Quality Strategy in March 2023. The Health Board refreshed and relaunched the Quality and Safety Framework in May 2024, to support delivery of the Quality Strategy across the organisation. In doing so, it set out expectations and responsibilities in relation to the duties of quality and candour.

48 The Annual Quality Report 2024-25 and the Annual Duty of Candour Report 2025 provide an analysis of quality and candour information for the year. Routine performance is monitored by the Quality and Safety Committee and the bi-monthly Patient Safety and Compliance Group.

49 At an operational level, divisions feed information into a service group Quality and Safety Group, with a set template covering key quality components, including a concerns item and a Duty of Candour update.

50 The Health Board continues to promote a culture of openness, learning and staff empowerment. However, it recognises there is more work to do. The Health Board is continuing to develop its reporting and has developed real-time reporting tools to provide information to operational teams on quality performance including Duty of Candour.

# Recommendations

51 We have made three new recommendations based on our follow up work.

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

### Quality and Safety Framework

**R1** The Health Board should update its Quality and Safety Framework to reflect its new organisational structure. The framework should identify the arrangements from 'floor to board' to ensure a consistent approach to quality and safety across the organisation.

### Quality and Safety Attendance

**R2** The Health Board should ensure that there is consistent attendance at the Health Board Quality and Safety Group from both Nurse and Medical Directors to strengthen shared responsibility of the quality agenda.

### Duty of Candour e-learning

**R3** The Health Board must routinely monitor and report on completion rates for the Duty of Candour e-learning training module.

# Appendices

# 1 About our work

## Scope of the audit

We have assessed whether:

- the Health Board 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 Health Board strengthened its management of risk at an operational level?
- Does the Health Board have an up-to-date clinical audit plan, which is approved and monitored by the Audit Committee?
- Does the Health Board's Quality and Safety Committee have oversight of the learning from both clinical audit and mortality reviews?
- Does the Health Board actively promote its Values and Behaviours Framework?
- Has the Health Board improved compliance with performance appraisal and development reviews (PADR)?
- Has the Health Board implemented its Quality and Safety Framework to ensure it is functioning as intended and articulates its corporate structures to provide 'floor to Board' assurance?

- Has the Health Board ensured that there is a collective responsibility for Quality and Safety across the clinical executive team?
- Are there sufficient resources to support quality governance, and are operational resources working together effectively?
- Has the Health Board started to take steps to implement the Duty of Quality and Duty of Candour?

## Criteria

In gathering evidence against the above questions, we were looking for the Health Board 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 July and October 2025.

We reviewed the following key documents:

- Quality frameworks;
- Relevant internal audit reports;
- Five Year Quality Strategy;
- Risk Management Strategy;
- People Strategy;
- Policies and procedures, including Putting Things Right and Concerns Management;
- Risk assurance plan, register and reports;

- Clinical audit plan and relevant reports;
- Relevant annual reports, including Clinical Audit and Effectiveness, the Guardian Service and Annual Duty of Candour and Quality reports; and
- Committee reports, including Quality Assurance and Performance reports.

We interviewed the following:

- Executive Director of Nursing and Patient Experience;
- Executive Director of Workforce and Organisational Development;
- Executive Medical Director;
- Deputy Executive Medical Director;
- Executive Director of Therapies and Health Science;
- Director of Corporate Governance and Board Secretary;
- Morriston Service Group Nurse Director;
- Morriston Service Group Director;
- Morriston Service Group Medical Director;
- Singleton and Neath Port Talbot Service Group Nurse Director;
- Singleton and Neath Port Talbot Service Group Director; and
- Singleton and Neath Port Talbot Service Group Medical Director.

We also asked the Health Board to complete and submit a self-assessment, setting out its view of progress against the 2022 recommendations. The Health Board submitted a completed self-assessment on 3 July 2025.

# 2 Previous recommendations

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

**Risk Management**

**R1** The approach taken by operational managers to risk management is inconsistent and risk registers are often incomplete and missing robust mitigating actions. The Health Board should strengthen its management of risks at an operational level by:

a) providing training to managers across the operational structure to enable them to clearly identify the risks for which they are responsible and update risk registers in line with corporate policy (**Complete – paragraph 11**); and

b) ensuring risks registers are receiving sufficient scrutiny at the operational level and the risk management group (**In progress – paragraph 13**).

**Develop a clinical audit plan**

**R2** During our review we were unable to obtain a copy of the Health Board's most recent clinical audit plan. The Health Board should develop a clinical audit plan for 2021-22 which covers both mandated national audits and local audits which are informed by areas of risk. This plan should be approved by the Audit Committee and progress of its delivery monitored routinely (**Complete – paragraph 16**).

### Frequency of reporting of clinical audit and mortality

**R3** The Health Board has set up a Clinical Outcomes and Effectiveness Group which provides assurance on clinical audit and mortality outcomes, but this information is currently fed through the Quality and Safety Governance Group and is only reported in its own right to the Quality and Safety Committee once a year. The Health Board should review this frequency so updates on progress delivering the clinical audit plan, and associated learning from mortality reviews are reported to the Quality and Safety Committee more frequently (**Complete – paragraph 18)**

### Values and behaviours

**R4** The Health Board has a well-established Values and Behaviour Framework which promotes an open and learning culture, but staff are not always aware of the values and behaviours, and some staff do not always recognise a culture that promotes learning from errors. The Health Board should:

a) refresh organisational awareness of the Values and Behaviours Framework, so the values are at the forefront of everything staff do on the Health Board (**In progress – paragraph 21**); and

b) undertake work to understand why some staff feel that the Health Board does not encourage reporting of errors, near misses or incidents, and does not act in response to concerns (**Complete – paragraph 23**).

**Performance Appraisal and Development Reviews (PADR)**

**R5** Our work found that compliance with Performance Appraisal and Development Reviews (PADR) within the operational groups we examined was low. Whilst we recognise the pressures of COVID-19 on the ability of the Health Board to improve performance in this area, these reviews are an important aspect of staff development. The Health Board should put in place a plan to improve performance which sets out when full compliance can be achieved. This plan needs to be monitored at an Executive and committee level (**In progress – paragraph 28**).

**Operational design to support effective governance**

**R6** Despite the development of a Quality and Safety Framework in January 2021 it is yet to be rolled out across the Health Board. The framework sets out the process by which the Health Board assures itself that services are of a high quality and safe for all. The Health Board should:

a) refresh the framework in light of learning from the COVID-19 pandemic (**Complete – paragraph 32**);
b) relaunch the framework and provide clarity on the quality governance arrangements expected within the Health Board (**Complete – paragraph 33)**; and
c) monitor compliance with the implementation of the framework across the organisation (**Complete – paragraph 33**).

**Ensure collective ownership of the quality and safety agenda**

**R7** Our work found that whilst there was collective responsibility for quality and safety amongst the executive team, there was an overreliance on nursing leads to take forward the quality agenda within divisions. The Health Board should look to ensure that other clinical professionals within the operational teams take an active role in quality governance arrangements (**In progress – paragraph 36**).

**Resources to support quality governance**

**R8** There are limited corporate resources to support quality governance and operational resources are working in isolation. The Health Board should:

a) review current resources to support quality improvement at a corporate, service group and divisional level (**Complete – paragraph 39**); and

b) seek to maximise the potential of the operational resources by developing opportunities to bring resources together either through network arrangements or changes in lines of accountability (**Complete – paragraph 39**).

# 3 Key terms in this report

| Term | Description |
|---|---|
| **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. |
| **Clinical Outcomes and Effectiveness Group (COEG)** | A sub-committee of the Quality and Safety Committee which provides assurance that systems for clinical audit and mortality reviews are effective and support safe, high-quality care. |
| **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. |
| **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 |
| **Guardian Service** | An independent, confidential listening service introduced at the Health Board in May 2019. |

| Term | Description |
| --- | --- |
| **Quality and Safety Committee (QSC)** | A committee of the Board which provides assurance and advice to the Board that the Health Board is meeting its responsibilities for the quality and safety of healthcare. |
| **Quality and Safety Group (QSG)** | A key operational governance group responsible for operating an effective quality management system across the organisation. |
| **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. |
| **Raising Concerns Hub** | An online site providing staff with signposted services and support. This includes a raising concerns kit and posters with QR codes. |
| **Risk Management Group (RMG)** | A sub-group of the Management Board responsible for the oversight and improvement of arrangements for the operational management of organisational risk. |
| **Speaking 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. |

# 4 Management Response Form

| Ref | Recommendation | Commentary on planned actions | Completion date for planned actions | Responsible officer (title) |
|---|---|---|---|---|
| **R1** | **Quality and Safety Framework** | | | |
| | The Health Board should update its Quality and Safety Framework to reflect its new organisational structure. The framework should identify the arrangements from “floor to board” to ensure a consistent approach to quality and safety across the organisation. | The Health Board will revise its quality and safety governance Framework to ensure an effective quality management system that reflects the new operational arrangements to be introduced under Organising for Success. Alongside this we will continue our engagement in national work to develop QMS and revision of Quality, Safety and Improvement Framework to reflect the outcome this work. | March 2027 | Executive Director of Nursing and Patient Experience<br><br>Executive Medical Director |

| Ref | Recommendation | Commentary on planned actions | Completion date for planned actions | Responsible officer (title) |
|---|---|---|---|---|
| R2 | **Quality and Safety Attendance**<br><br>The Health Board should ensure that there is consistent attendance at the Health Board Quality and Safety Group from both Nurse and Medical Directors to strengthen shared responsibility of the quality agenda. | The Health Board will strengthen clinical attendance at key quality and safety groups through the following actions:<br><br>1. Review of terms of reference for QSG onwards to reflect the changes introduced under Organising for Success and to ensure responsibility across clinical executives and processes for escalation for non-engagement. | September 2026 | Executive Director of Nursing/ Executive Medical Director/<br><br>Executive Director of Allied Health Professionals and Health Sciences |
| | | 2. Clinical Executives to meet with their professional groups within service groups to remind them of their responsibilities within the Quality and Safety Group terms of reference. | April 2026 | Executive Director of Nursing/ Executive Medical Director/<br><br>Executive Director of Allied Health Professionals and Health Sciences |

| Ref | Recommendation | Commentary on planned actions | Completion date for planned actions | Responsible officer (title) |
|---|---|---|---|---|
| R3 | **Duty of Candour e-learning**<br><br>The Health Board must routinely monitor and report on completion rates for the Duty of Candour e-learning training module. | 1. Quarterly reporting to Patient Safety and Compliance Group of Quality and Safety Group of the total number of staff completing training | October 2026 | Head of Concerns Assurance |

# About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

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