Archwilio Cymru
Audit Wales

Review of Quality Governance

Betsi Cadwaladr University Health Board

July 2026

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Audit snapshot

What we looked at

1 Our 2022 Quality Governance Review examined how Betsi Cadwaladr University Health Board's (the Health Board) manages service quality. We looked at culture and behaviours, quality strategy, and governance structures. We made 12 recommendations focussing on:

- quality and patient safety priorities;
- risk management;
- clinical audit; mortality reviews and complaint handling;
- sharing learning and good practice;
- values and behaviours; and
- governance and oversight.

2 This follow-on review assesses the extent to which the Health Board's arrangements support high quality and safe services. As part of this, we have assessed progress on our 2022 review recommendations. Our work also looked at the delivery of the Duties of Quality and Candour requirements, and related oversight and scrutiny.

Why this is important

3 Quality should be at the 'heart' of all aspects of healthcare and 'putting quality and safety' above all else is one of the core values underpinning the NHS in Wales. Poor quality care can be costly in terms of waste and unjustifiable variation in services but most importantly it can result in harm and poor outcomes for patients.

4 In February 2023, the Welsh Government escalated the Health Board to Level Five (Special Measures)[1].The Welsh Government set out the actions that it expects the Health Board to achieve, which includes:

- improvement in complaints response times;
- progress on the implementation of and compliance with the Duties of Quality and Candour;
- effective response to external reviews; and
- the use of national clinical audit and Value in Health dashboards to support quality improvement.

What we have found

5 The Health Board is taking steps to strengthen its quality governance arrangements, but there remain weaknesses which it needs to address. It has put in place key parts of a digital Quality Management System (QMS) and updated several governance frameworks. But the Health Board needs to agree clear quality priorities, with strong leadership and accountability across and throughout the organisation to deliver them.

6 Early work to implement the Duties of Quality and Candour is underway, but significant gaps remain in quality leadership, staff training and reporting. The Health Board has a new learning system, but it is not always demonstrating that lessons are learnt. Complaints response timeliness has improved. However, rising complaint volumes is placing pressure on teams. The volume of re-opened cases also suggests the quality of investigations needs strengthening.

[1] NHS Wales escalation and intervention arrangements | GOV.WALES

7 The Health Board could further strengthen quality oversight at Board and committee levels. It has not yet done enough to strengthen its focus and oversight of the quality of commissioned services following concerns raised by the Public Services Ombudsman for Wales. Similarly, despite improvements in national clinical audit reporting, the local clinical audit programme is not risk-based. As a result, there is a missed opportunity to provide the QSE Committee with targeted assurance on areas of concern.

8 The Health Board's progress on the 2022 audit recommendations is mixed. It has taken actions to strengthen arrangements for mortality reviews, culture, and patient feedback, but it has made less progress on other areas.

What we recommend

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

- Establishing clear quality priorities;
- Strengthening assurance and learning systems;
- Improving organisational training and awareness of quality governance systems and process; and
- Enhancing corporate oversight of commissioned care and complaints.

Key facts and figures

3,000	monthly average number of patient safety incidents. This equates to approximately 100 per day.
4,900	open patient safety incidents, with 58.6% overdue for investigation.
291	open complaints with an average of 20 working days to resolve complaints. The Health Board's performance is currently the best in Wales.
41	new contacts with the Public Services Ombudsman for Wales in November 2025, the highest number for a year. The PSOW decided **not** to investigate 29 (71%) of these.
£57,000	in financial penalties for overdue Learning from Events Reports between April 2024 and February 2026, a reduction of 67% compared to the £172,500 penalties received in 2024-25.
9	Number of never events recorded during 2025-26, compared to five in 2024-25.

Source: Integrated Quality Performance Report to the Quality Safety and Experience Committee, January 2026

Our findings

Quality plans and planning

The Health Board's approach to quality improvement planning is not yet sufficiently robust

Quality plans and priorities

10 The Health Board needs to do more set out clear quality priorities and a coordinated programme to deliver them. At the time of our work the Health Board did not have a stand-alone quality plan. It has not updated its previous Quality Strategy (2017-20), with a preference to integrate quality into existing plans including the Integrated Medium-Term Plan (IMTP). This approach does not appear to be driving enough of emphasis on quality improvement. It also leaves some gaps.

11 The Health Board's IMTP 2025-28 is its primary plan for improving quality, supported by the Quality Management System (QMS) and Quality Management Framework. It sets out how the Health Board will deliver its five strategic objectives. The IMTP includes several delivery priorities linked to the objective of 'Improving Quality, Outcomes and Experience'. However, these priorities mainly link to operational targets. Examples include reducing waiting times for planned care and urgent and emergency care. As a result, the IMTP takes a narrow view of quality. It places a greater weight on performance than on other aspects of patient safety, clinical effectiveness, and patient experience.

12 The Health Board's IMTP 2026–29 gives more visibility to quality than the previous IMTP (2025-28). Our review of the IMTP 2025-28 found that the Health Board's quality priorities mainly linked to operational performance targets. The plan also did not have actions for concerns such as infection prevention, sepsis, or pressure damage reduction. Our review of the IMTP 2026-29 found that it includes a wider range of actions to improve patient safety, outcomes and experience.

13 Even with this improvement, the IMTP 2026–29 does not give the Health Board a clear overall plan for how it will manage and improve quality. In particular, the plan does not set out a small number of shared quality priorities, supported by consistent measures and a clear approach to assurance. For example, while the IMTP includes measures such as complaint response times, these are presented as individual actions within specific service areas.

14 There is a risk that the lack of a clear quality plan and priorities affect staff understanding of quality aims. While the Health Board is developing a QMS, it is not yet well implemented. The Quality Management Framework provides structure and processes. However, the Health Board does not translate this into a set of agreed quality priorities, standards, or outcomes for staff and services to work towards.

15 Our work found that staff could consistently identify performance priorities, such as complaints timeliness, emergency department and planned care waits. But they struggled to describe wider quality improvement priorities. This suggests that staff understanding of quality is shaped by what is quantified in performance reports rather than broader quality improvement plans.

16 The Welsh Government has set out in some detail its quality improvement expectations at the Health Board. At present, our view is that the IMTP is not providing a sufficiently robust mechanism to drive the quality improvements needed. There is a clear need for a stand-alone quality plan. This plan should set out quality priorities, the leadership, resources and programme to deliver it. This is particularly important to demonstrate a joined-up response to Welsh Government escalation requirements.

Responding to the Duties of Quality and Candour

The Health Board is taking steps to meet the duties, yet gaps in leadership roles, training oversight and reporting limit assurance over its delivery

Roles and responsibilities

17 The Quality and Engagement Act guidance requires NHS bodies to establish clear lines of accountability for discharging the Duties of Quality and Candour. This includes ensuring that leadership roles are defined at all levels.

18 The Health Board has clearly delegated the strategic lead for both the Duty of Quality and the Duty of Candour to the Executive Director of Nursing and Midwifery. However, wider responsibilities for other executive, operational and clinical leaders are unclear. We understand that this is a result of past and ongoing gaps in management and clinical leadership.

19 Several interviews raised concerns about the visibility and cohesiveness of quality leadership more broadly. This includes clear responsibilities and leadership embedded across quality groups.

20 The Health Board is currently reviewing its organisational structures as part of its Foundations for the Future programme. This work is ongoing and will continue throughout 2026. As it progresses, the Health Board should ensure that it defines clear accountability for discharging both duties.

Training

21 The Health Board has taken steps to brief Board members on the duties of quality and candour. However, it needs to do more to provide assurance that it is sufficiently training operational staff. Executives and Independent Members have had updates on the Duties of Quality and Candour, with a session in 2024 and another planned for spring 2026.

22 There is currently no assurance that operational staff are receiving required training on the duties of quality and candour. Internal Audit's June 2025 review of the Duty of Quality gave a reasonable assurance rating but identified key gaps. This includes the absence of a structured training programme and the inability to verify training uptake. The Health Board completed a training needs analysis in August 2025. Since then, neither the People and Culture Committee nor the QSE Committee has received reports showing progress. The Integrated Concerns Policy also sets clear training requirements for the Duty of Candour, including mandatory training for investigators. However, the Health Board does not report compliance rates.

Quality Management System (QMS)

23 The Health Board's development and implementation of the QMS and Quality Management Framework is not yet well progressed. To help meet the requirements of the Quality and Engagement Act, the Health Board started its journey to develop its QMS with a presentation to the Board in May 2024 which set out high level principles. The more recent Board development session in February 2026 started to explore:

- Board roles and responsibilities for a QMS;
- creating the conditions and organisational enablers for a QMS; and
- using data in the Board as part of a QMS.

24 The QMS should provide a structured, organisation-wide model that supports quality planning, monitoring, assurance and improvement. It should aim to improve learning, transparency, and support data-led decision-making across all services. Yet the QMS approach is not yet well developed nor well-embedded with limited progress in implementing the approach across services. While not the sole reason for delay, there has been a pause while the Foundations for the Future programme is developing.

25 The QMS approach is supported by a high-level Quality Management Framework. This Framework provides limited detail on the implementation of the QMS. It does provide the reader with a summary of the aims of the QMS and how it aligns with the Board's Strategic Objectives. The Quality Management Framework notes further development is needed across all the quality domains and an implementation plan will be developed. This was not completed at the time of our review.

26 The Health Board's Quality Dashboard provides real time service data. The dashboard supports performance monitoring, escalation and incident reporting. It brings together data from both the Datix system[2] and the Audit Monitoring and Tracking system. A November 2025 Internal Audit review of complaints management found no evidence on Datix to show that the Health Board had completed or closed Learning and Improvement Plan actions. The audit also found no routine validation of completed actions.

27 As of March 2026, the Health Board assessed its maturity in responding to the Duty of Candour as 'Yellow/Operationalising'. This shows that it recognises the need to do more before it fully meets the duty. The Health Board is working on an improvement plan to address the remaining gaps during 2026. This includes embedding organisational learning. In June 2025 Internal Audit gave a reasonable assurance opinion on the Duty of Quality. However, it highlighted the need to approve the Quality Regulatory Policy, improve staff training and provide guidance on how to use the QMS.

Monitoring and oversight of response to the duties

28 Statutory guidance for the Quality and Engagement Act sets out explicit expectations for how NHS organisations must implement, evidence, and report on the duties during the year and through annual public reporting.

[2] Datix is a cloud-based software tool within NHS Wales, which has multiple modules, including systems for logging handling patient safety, health and safety and complaint records.

29 The Health Board is improving its reporting approach, but it not yet fully meeting the reporting requirements set out in the Act. The QSE Committee receives a reasonably comprehensive suite of regular quality, safety and experience reports. Routine reporting includes the:

- Integrated Quality Report;
- Integrated Quality & Performance Report;
- regulatory inspection findings; and
- national audit outputs.

30 These reports contain extensive quality performance data and supporting narrative. But they do not explicitly frame this information through the lens of the statutory duties. For example, reports do not describe quality impact consistently in relation to the six quality domains and six enablers set out in statutory guidance nor do they provide information on the number of candour cases and compliance with the candour procedure. These elements are prescribed within the statutory guidance for the duties.

31 We saw similar scope to improve the Health Board's Annual Quality Report. It last published this report in September 2025. The 2024–25 report clearly sets out work to improve patient experience and care outcomes. It highlighted several service-level improvements, such as reduced waiting times through the Planned Care Hub. But it says little about how quality evidence guided big choices, such as changes to the organisation or decisions around financial recovery.

32 The Annual Duty of Candour Report 2024-25 clearly sets out the Duty's requirements and the steps the Health Board is taking. But the report would be stronger if it included more detail on what the Health Board learned from candour cases and what it subsequently improved. In 2024–25, the narrative focuses on arrangements rather than assurance about actions and difference that the Health Board is making.

Learning from service quality feedback

The Health Board is improving how it learns from service quality feedback, though it needs to better demonstrate that learning has been affectively adopted

Listening to staff

33 In 2022, we recommended that the Health Board strengthens how it addresses and learns from staff concerns about bullying, harassment and abuse, which was a theme in the 2022 staff survey. The Health Board has taken several steps to address these concerns, as follows:

- In August 2023, it introduced a culture dashboard, to track organisational culture. The dashboard includes measures such as sickness absence, vacancies, staff turnover and Speaking Up Safely concerns which the Health Board presents in a Culture Synthesis Report.
- In September 2023, the Health Board established a Culture and Leadership Programme, aimed at all levels of leadership across the organisation.
- In September 2024, the Health Board introduced a new ‘Speaking up Safely’ approach. Its aim is to make sure all staff can raise concerns safely and confidently. The approach is supported by a network of Freedom to Speak Up Guardians, an anonymous digital reporting system, and clear guidance and communications material.
- In November 2024, the Health Board approved a new Values and Behaviours Framework. Officers developed the Framework through wide staff engagement and it sets out expectations for how all staff should work, behave, and interact with service users, colleagues and partners.

34 These actions show that the Health Board is committed to responding to concerns about bullying and harassment. We therefore consider our 2022 recommendation to be complete.

35 However, we note that there will be a need to continue to improve against, and closely monitor, metrics related top bullying and harassment in the annual NHS staff survey, which will demonstrate whether the Health Board is implementing the correct actions and learning from staff concerns. The results of the 2025 NHS staff survey were not yet available at the time of our review but are expected to report in Spring 2026.

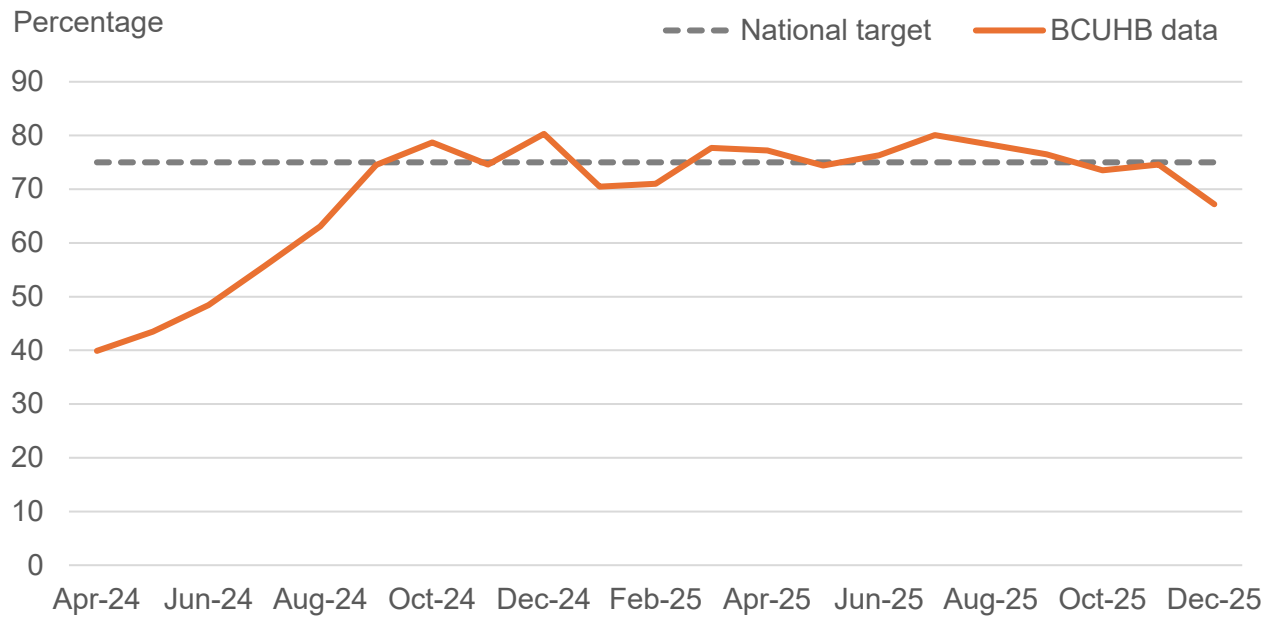
Complaints

36 The Health Board's Integrated Concerns Policy, adopted in September 2024, aligns with the national Putting Things Right Regulations and gives staff clear guidance and procedures for identifying, responding to and learning from complaints, concerns, and mortality reviews. The Patient and Carer Experience Group is the primary operational group for overseeing complaints. It works together with other relevant operational groups to report information on complaints to the Executive Quality Delivery Group. Interviews indicated that this process works well.

37 The QSE Committee provides corporate oversight of complaints. It receives regular updates through the Integrated Quality and Performance Report and considers more detailed analysis in the Integrated Quality Report. This includes the number of new, open, and overdue complaints, along with the main themes. In March 2026, the most common themes still related to long waiting times and poor experiences in emergency departments.

38 Reports demonstrate significant improvements to the timeliness of its responses to complaints in recent months, as shown in **Exhibit 1**. Benchmarking data provided within the Integrated Quality Report also shows how this performance consistently compares well against other Welsh health boards.

Exhibit 1: percentage of complaints closed within 30 days, April 2024 – December 2025



Source: Integrated Quality and Performance Reports between August 2024 and March 2026.

39 Although the Health Board has improved complaint response timeliness, the number of complaints continues to rise at a pace that may become difficult to manage. In 2024-25, it recorded 2,412 complaints, up 17.7% from 2,049 in the previous year. By March 2026, the Health Board was receiving an average of 66 complaints each week and closing 60. To address this growing demand, it plans to focus more on early resolution and on using learning and improvement to reduce the need for people to complain.

40 Alongside a rise in new complaints, the Health Board has also seen a 43% increase in re-opened cases, from 131 in 2023-24 to 229 in 2024-25. This may suggest that some people are not satisfied with the first response. However, cases can be reopened for several reasons. For example, people may ask new questions, share more information, or want further explanation. Currently, QSE Committee does not have clear sight of these issues. It would benefit from receiving the annual Patient Experience & Complaints Review Reports. These reports provide useful insight into longer-term trends and effectiveness of complaints handling.

41 The high number of re-opened complaints also points to gaps in staff training. We first raised this issue in our 2022 review. Since then, there has been little progress, and the Health Board is still not monitoring training completion well enough. For these reasons, we consider that progress against this recommendation remains ongoing.

42 The Welsh Government has introduced a new 'Listening to People[3]' Process which replaces the existing Putting Things Right arrangements from April 2026. The revised framework introduces three key changes:

- a strengthened early resolution stage extended from 2 to 10 working days;
- a mandatory listening conversation with every complainant; and
- an expanded redress threshold with shortened investigation timescales.

43 As a result of these new requirements, the Health Board is anticipating a significant increase the volume of work handled by frontline teams, given the requirement for clinical and operational services to support decisions under the new Process. In response, it is redesigning its concerns-handling model. It plans to replace its Patient Advice and Liaison Service with a new Patient Enquiry, Advice and Resolution Service which will function as a single point of contact, manage enquiries, close lower grade complaints, and facilitate listening conversations. A new People's Experience Team will focus on broader patient-experience work and embedding learning.

[3] Listening to People - Improvements to be made to NHS Wales complaints system

Responding to patient feedback

44 Patient feedback is a valuable source of intelligence on the quality of services. The Health Board uses real-time data and information from the Patient Advice and Liaison Service to collect patient feedback. The Patient and Carer Experience Group reviews this feedback, brings the findings together, and reports to the QSE Committee every two months. However, the Health Board does not track how teams evaluate learning from patient experience feedback or how they use it to improve quality. The Patient Experience and Complaints Review for 2024-25 shows only small improvements in patient experience across all areas.

45 Our 2022 review found that less than half of the staff surveyed felt they received regular updates on patient feedback in their work area. We subsequently recommended that the Health Board address this issue. The Health Board has since strengthened its arrangements for sharing patient feedback with staff routinely. For example, feedback is shared with frontline staff by displaying results on ward boards. An October 2025 Internal Audit review of Patient Experience also provided a substantial assurance rating. We therefore consider the Health Board to have completed our 2022 recommendation in this area.

46 The Health Board is planning to further strengthen its arrangements in responding to the new Welsh Government ‘Listening to People’ Process. It plans to improve the sharing of patient feedback to staff to support ward-level learning. However, we note that the delivery of this plan is contingent on finding investment for additional staff.

Learning from mortality reviews

47 In 2013, the Chief Medical Officer for NHS Wales advised that every hospital death should have a mortality review. The Health Board's Integrated Concerns Policy clearly explains the roles of clinicians and committees in this process. A clinician-led Mortality Review Team carries out the reviews and reports the findings to the Strategic Clinical Effectiveness Group. This group includes staff from therapy, pharmacy, and research and development. A Learning from Mortality Forum then looks at the findings, identifies lessons, and shares them across services.

48 In our 2022 review, we recommended that the Health Board set up a system so staff from different professions take part in mortality reviews as a matter of routine. With more structured multidisciplinary oversight now in place, we consider this recommendation complete.

49 Our 2022 review also recommended that the Health Board ensure its QSE Committee receives quarterly mortality review reports that highlight learning. Our recent review found that the QSE Committee now receives regular mortality review updates through the bi-monthly Integrated Quality Report. In early 2024, the Health Board had a large mortality review backlog of around 500 cases. By late 2025, this had reduced, with cases pending scrutiny falling from around 450 in November to about 390 in December, investigations reducing from around 140 to 65, and no significant backlog remaining in the West Integrated Healthcare Community.

50 Themes from mortality reviews continue to centre on concerns about clinical treatment, patient care, and the recording and use of Do Not Attempt CPR decisions. The Health Board has begun a programme to address these recurring issues. The QSE Committee should review the impact of this work to determine whether learning has been implemented as intended.

Embedding learning from internal and external reviews

51 The Health Board has three key groups in place to support organisational learning from internal and external sources:

- the Integrated Concerns Oversight Panel, a weekly executive forum that reviews urgent internal safety issues and escalates concerns through the Health Board's governance structure;
- the Regulatory Assurance Group which meets monthly to oversee how the Health Board responds to external regulatory reports and inspections; and
- the Organisational Learning Forum which meets monthly to share learning and encourage improvement across the organisation.

52 These groups provide oversight of learning from incidents, concerns, external reviews and regulatory findings. Each group reports to the Executive Quality Delivery Group, which then escalates key issues to the QSE Committee through assurance reports. However, the purpose of these groups, and the policies and processes that support them, need strengthening. An Internal Audit review of Learning from Regulatory Reporting in December 2025 gave a limited assurance opinion. The audit highlighted major gaps in the Health Board's regulatory learning processes, including:

- no overarching regulatory assurance policy;
- no central register of regulators or reporting routes;
- the Regulatory Assurance Group reviewing only a small number of regulators and therefore not meeting its remit;
- no formal or consistent process for extracting, sharing or tracking wider learning from regulatory reports; and
- no system to check whether actions are carried out or whether they are effective.

53 In response, the Health Board has introduced a Regulatory Assurance Policy. However, three of the five high-priority actions have long-term deadlines running to March 2027, suggesting greater priority is needed.

54 The Health Board's response to Healthcare Inspectorate Wales (HIW) inspections shows that it acts on regulatory findings to deliver improvement, although the improvements are not always sustained.

55 In June 2023, it improved arrangements including audit and governance in vascular services. This led HIW to remove the "Service Requiring Significant Improvement" status. At Ysbyty Glan Clwyd, the Emergency Department resolved the main patient safety concerns that HIW found in 2022. HIW recognised the improvements and learning and de-escalated the service in 2024. However, some problems continue to appear in HIW reports. This includes concerns about pressure injury checks, falls risk assessments, equipment checks, corridor care and record keeping.

56 Overall, HIW reports show that the Health Board can improve individual services after inspections. But it struggles to embed these changes. This is most clear where change needs strong leadership, clear roles, and shared responsibility beyond the service under review.

57 These challenges in regulatory learning are mirrored in the Health Board's broader approach to organisational learning, including its management of Learning From Events Reports. Learning From Events Reports are mandatory submissions to the Welsh Risk Pool after the Health Board settles clinical negligence, redress or personal injury cases. To receive reimbursement for the costs of redress, the Health Board must show clear learning, identify causes, set out corrective actions and explain how it will prevent the issue from happening again.

58 Over the past two years, performance on LFERs has improved: the number of overdue LFERs reduced from around 105 in September 2024 to 79 by January 2025, and further to 18 by January 2026 following targeted intervention. This improvement has led to a reduction in financial penalties, from 69 penalties (£172,500) in 2024–25 to 23 penalties (£57,500) between April 2025 and February 2026.

59 However, despite the reduction in overdue reports, many cases remain deferred because the Health Board has not yet provided sufficient evidence of learning to close them. This shows that while the backlog has reduced, underlying weaknesses in evidencing learning, assurance processes, and organisational learning systems continue may limit the Health Board's ability to demonstrate timely and robust learning from events.

60 The Health Board also continues to report a high number of never events, with nine recorded in 2025-26. This compares to five which were recorded in 2024-25. Some of these events are very similar in nature. This raises concern about whether the Health Board is effectively learning from serious incidents and using that learning to prevent the same problems happening again. Repeated never events of a similar type suggest that learning is not yet being embedded consistently across services.

61 Our 2022 review raised concerns about the system for supporting staff learning from quality improvement projects. In 2025, the Health Board introduced a new 'Learning Repository' to support the Organisational Learning Forum. The Repository sits within the Quality Management System and brings together learning from incidents, complaints, audits and feedback in one consistent, reliable library.

62 The Pharmacy team is testing the new system, and early results are positive. The Health Board is now expanding the rollout during 2026. If the Health Board delivers the new approach well, the Repository could strengthen thematic learning and help teams share lessons more easily. As this work is still underway, we consider our 2022 recommendation to be in progress.

Quality governance, assurance and oversight

Quality governance arrangements are improving but significant weaknesses remain in oversight of risk, clinical audit and commissioning.

Corporate oversight of quality

63 The Quality, Safety and Experience Committee receives clear and structured information. There is a well-established agenda supported by integrated quality and performance reporting. The level of detail and analysis varies between meetings. However, most papers allow the committee to challenge and scrutinise performance effectively. They usually include trend data, benchmarking, and focused deep dives. These deep dives cover key areas of concern, such as patient safety incidents and complaints. But as highlighted elsewhere in this the report there are opportunities for improvement. This includes scrutiny of the quality of commissioned services and target local clinical audit.

64 We found differences in the Health Board's reporting of Nationally Reportable Incidents (NRIs). The numbers given to the QSE Committee during 2025-26 do not match the numbers in the draft annual performance report. For example, the QSE Committee was told there were 14 NRIs in June-July and 26 in August-September, but the performance report says there were two incidents in each of those periods. This makes it harder to trust the data and to get a clear picture of patient safety issues.

65 Our 2022 review raised concerns about how information flowed from operational sub-groups to the quality group responsible for escalating risks to the QSE Committee. At the time, the highlight reports used, known as 'Triple A' reports, varied in quality and detail, and we recommended that the Health Board provide clearer guidance to report authors.

66 Operational groups now submit Quality Highlight and Escalation Reports to the Executive Quality Delivery Group instead of Triple A reports. Although no formal written guidance has been issued, Executive Quality Delivery Group members provide regular verbal feedback to authors on how well their reports have covered the key issues, and our review found that submissions now consistently cover all five key domains with an appropriate level of detail. Based on this, we consider the previous recommendation to be met.

67 However, our review found some duplication in reports sent to the Executive Quality Delivery Group by sub-groups. These included the Patient Safety Group, Regulatory Assurance Group, and Clinical Effectiveness Group. This overlap could lead to mixed or conflicting messages. It also suggests that roles and responsibilities between these groups are not always clear and may overlap in unhelpful ways.

Arrangements for managing quality risks

68 We considered whether services effectively identify and manage quality and patient safety risks. Service teams use local risk registers to record service-level risks. Staff often identify new risks during daily patient safety and incident huddles using information from the Quality Dashboard and Datix reports. Risk escalation processes appear to work well. The weekly Integrated Concerns Oversight Panel provides support and challenge on operational risks and escalates concerns to the Executive Quality Delivery Group when needed.

69 The November 2025 Rapid Quality Review of Emergency Departments found that teams in Emergency Departments were identifying risks and taking action to manage them. However, the review did not provide assurance that officers were managing these risks effectively. It reported that major risks still remained and that the Health Board needs better systems, clearer reporting and improved patient flow. The review also highlighted specific weaknesses that show mitigating actions have had limited impact. Given that the Health Board has other high-risk services, it should consider using this type of review more widely. Currently, the Health Board does not plan to carry out similar reviews in other pressured services.

70 At corporate level, the QSE Committee oversees quality and patient safety risks through the Corporate Risk Register and the Board Assurance Framework, reviewing them in turn each meeting. However, the risks recorded are very high level, with only two quality risks on the Corporate Risk Register and one on the Board Assurance Framework. Given current service pressures, this results in many controls and actions spread across several services and performance areas, making oversight and scrutiny difficult. It also raises questions about how effective corporate risk management is. All three risks remain above tolerance and have not reduced for several months.

71 Our 2022 review found that operational staff needed better risk management training. Internal Audit raised the same concern again in April 2025 during its review of the Board Assurance Framework and risk management. Although Internal Audit gave a reasonable assurance rating, it identified clear gaps. These included limited access to risk management training and a lack of clarity about how many staff were expected to complete it.

72 In response, the Health Board updated its Risk Management Framework, and the Board approved the new version in November 2025. The revised Framework explains roles and responsibilities more clearly and sets out training needs for three levels of staff. The operational Risk Scrutiny Group now checks training rates each month for each group. Current rates are still below target, but the Health Board plans more training and targeted communications to improve uptake. As additional training is still needed we consider our 2022 recommendation to be ongoing.

Clinical audit assurance

73 Local and national clinical audits play an important role in quality assurance. Our 2022 review recommended that the Health Board focus its clinical audit programme on high-risk specialties and patients waiting longest for treatment. Internal Audit raised the same issue in April 2025 and gave a limited assurance rating, partly because the Tier Two[4] audit plan did not reflect the Health Board's key risks. It also identified that 75% of Tier Three audits were not completed on time and lacked updated completion dates, clear ownership, or escalated when progress stalled.

74 In response, the Health Board developed a Clinical Audit Improvement Plan in May 2025. The plan aims to improve action planning, learning, escalation to the Executive Team and reporting across quality groups and committees. While the plan sought to strengthen risk-based clinical audit planning through the Strategic Clinical Effectiveness Group, the updated Clinical Audit Forward Plan still does not show a robust risk-based approach in its Tier Two programme. As a result, we consider our 2022 recommendation to remain ongoing.

75 Our recent review also found a lack of clarity in the approval process for the 2025–26 Clinical Audit Forward Plan. We found no evidence to clearly indicate who had approved the clinical audit plan.

76 Papers to the QSE Committee provide a clear overview of Tier One clinical audit activity, including the number of national audits published in-period and benchmarking results. Reports highlight areas of strong performance which, included clinical audits on bowel cancer and diabetes as well as areas requiring targeted action, such as vascular pathways. Reports provide some assurance that the Health Board is taking action where national audits have highlighted risk or under-performance. In March 2026 for example, a national vascular audit had prompted the Health Board to initiate reviews of specific pathways.

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[4] Tier One refers to National and / or mandatory audits; Tier Two refers to service level audits based on local priorities and risk; Tier Three refers to clinician/team initiated audits

77 The QSE Committee does not receive information on Tier Two or Tier Three audits, and it does not receive a full overview of progress against the wider Clinical Audit Forward Plan. It has no information on how many of these clinical audits the Health Board has completed, overdue or are yet to start, and no assessment of whether the overall programme is on track. As a result, although the Committee has good visibility of national audit outputs, it cannot judge whether the Health Board is delivering its wider clinical audit programme effectively or in line with expectations.

Assurance on commissioned services

78 The Health Board commissions a substantial range of services on behalf of the patients of north Wales across primary, community and secondary care from other NHS providers. The latest Monthly Monitoring Return to Welsh Government indicates that the Health Board is forecasting spend on services from other NHS providers to reach nearly £400 million in 2025-26. Given the volume of treatment and the expenditure involved it is essential that there are effective quality oversight arrangements in place.

79 The Health Board does not currently have a Commissioning Assurance Framework. A draft Commissioning Assurance Framework was developed in July 2024, but this Framework has not progressed to a final, agreed version as of the time of writing. In its absence, there are significant gaps in governance for these services. Our review found that the Quality Management Framework and Integrated Concerns Policy do not set out expectations for commissioned services. The Health Board's arrangements also lack clarity on how it will meet its responsibilities under the Duties of Quality and Candour in relation to outsourced patient care.

80 Our 2022 review recommended that the Health Board develop quality measures to reflect commissioned services across primary, community and secondary care. Similarly, Public Service Ombudsman for Wales (the Ombudsman) reviews[5] and Internal Audit Reviews highlight the absence of effective quality assurance arrangements for commissioned services. This included a 'No Assurance' rated Internal Audit review of Contracted Patient Service in 2022. When Internal Audit followed up progress in May 2025, none of the four high priority recommendations had been implemented resulting in a repeated 'No Assurance' rating. Those recommendations related to significant weaknesses in contracting of patient services, including:

- absence of a robust Commissioning Assurance Framework, policy or relevant Standard Operating Procedure, with lines of escalation, roles, responsibilities and requirements for oversight unclear;
- absence of controls and oversight to ensure commissioned providers are adhering to contractual agreements;
- weaknesses in contractual quality measures, and in escalation procedures for quality issues; and
- weaknesses in review and scrutiny of NHS provider quality, supported by performance data.

81 The Ombudsman raised concerns that the Health Board's contract monitoring of commissioned care placed financial reporting ahead of patient safety and service quality. As a result, the Ombudsman recommended that the Health Board complete and implement a Commissioning Assurance Framework within six months. The Health Board first committed to doing this by 30 September 2025. It later extended the deadline to January 2026. At the time of our fieldwork, the Health Board was seeking another extension because work on the Framework was still ongoing.

[5] The Investigation of a Complaint against Betsi Cadwaladr University Health Board: A Report by the Public Services Ombudsman for Wales, Case 202301141, April 2025 and An Own Initiative Investigation issued under s23 of the Public Services Ombudsman (Wales) Act 2019, August 2021

82 Due to limited progress on a clear Commissioning Assurance Framework, the Health Board's routine performance reports to the QSE Committee still lack quality metrics for externally commissioned services or wider assurances on the quality or safety of care delivered through commissioned services. We noted an isolated improvement in March 2026, when the QSE Committee received a paper on the national insourcing programme. However, we understand that this is an exception rather than a systematic approach.

Recommendations

83 Based on the findings of our follow-up review, we have issued nine new recommendations.

Develop and monitor standalone quality plan

R1 The Health Board should develop and implement a standalone, multi-year Quality Plan that clearly sets out its quality priorities, intended outcomes, leadership accountability, and the resources required to deliver sustained improvement **(paragraphs 10-16)**.

R2 The Health Board should ensure that the quality priorities, metrics, and expected benefits of its quality plan are regularly monitored through Executive Quality Delivery Group and QSE Committee, with progress routinely reported using meaningful indicators **(paragraphs 10-16)**.

Training Oversight for Risk Management

R3 The Health Board should monitor and report workforce training for each risk-management level on a regular (e.g. quarterly basis) and take action where training rates remain below targets. **(paragraphs 68-72)**.

Demonstrating lessons are learnt and shared

R4 The Health Board should ensure that quality and performance reports include clear evidence of learning, improvements achieved, and measurable change over time particularly:

- outcomes of mortality-related improvement work;
- actions from complaints, incidents, and thematic reviews; and evidence of learning from external regulatory intelligence **(paragraphs 47-61).**

Improve the reliability of NRI reporting

R5 The Health Board should investigate and reconcile the discrepancies between Nationally Reportable Incidents contained within its committee reports and annual report for 2025-26 and strengthen arrangements to ensure that future reporting is reliable **(paragraph 64).**

Strengthen quality oversight of commissioned services

R6 The Health Board should implement a commissioning oversight framework to fully address the Public Services Ombudsman for Wales' recommendation **(paragraphs 78-82)**.

R7 Develop clear and routine assurance reporting to the QSE Committee on the quality of commissioned services includes quality metrics, patient experience information, and risk assessments for care delivered through commissioned and outsourced services **(paragraphs 78-82)**.

Improve staff understanding and engagement with quality systems

R8 Building on the Culture & Leadership programme, the Health Board should provide progress and evaluation reporting on the implementation of the QMS to the Executive Quality Delivery Group **(paragraphs 23-27)**.

Strengthen complaints oversight and escalation

R9 The Health Board should enhance QSE Committee reporting on complaints by:

- regularly highlighting re-opened complaints as an emerging risk;
- providing analysis of root causes and quality of investigations; and
- monitoring compliance with complaint-handling training requirements **(paragraphs 36-43).**

Appendices

1 About our work

Scope of the audit

We have assessed whether:

- the Health Board's quality governance arrangements support high quality, safe and effective services;
- 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:

- Does the Health Board have clear and well-understood plans and priorities relating to quality?
- Are roles and responsibilities relating to quality clearly set out and understood?
- Does the Health Board have effective arrangements to support the Duties of Quality and Candour?
- Does the Health Board consistently and effectively demonstrate learning from internal and external assurance sources, including mortality reviews, patient and staff feedback and external regulators?

- Does the Health Board have a strong approach to risk management in relation to quality and patient safety?
- Does the Health Board have an up-to-date and risk-based clinical audit plan, which is approved and monitored by the Audit Committee?
- Does the Health Board have good oversight over the quality of its commissioned services?
- Is there regular and well-informed oversight for quality and patient safety at operational and corporate levels?

Criteria

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

- Had effective governance arrangements support high quality, safe and effective services, specifically in relation to risk, complaints, staff culture and learning;
- 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 September 2025 and January 2026.

We reviewed the following documents:

- The Integrated Quality Management Framework
- The Integrated Concerns Policy
- Relevant Internal Audit reports
- Public Services Ombudsman for Wales Public Interest Reports

- Committee and operational group reports, including Quality, Safety and Experience Committee papers, Executive Quality Delivery Group reports
- Relevant annual reports, including Clinical Audit Plan, Duty of Quality, Duty of Candour and Putting Things Right Reports
- Corporate and Service Risk Registers

We interviewed the following:

- Executive Medical Director
- Interim Executive Medical Director
- Executive Director of Nursing & Midwifery
- Chair of the Quality, Safety & Experience Committee
- Executive Director of Allied Health Professionals & Health Science
- Executive Director of Finance
- Deputy Director for Legal Services
- Head of Quality
- Head of Risk Management
- Directors of Integrated Health Communities
- Head of Patient Experience
- Head of Patient Safety
- Director of Women's Services
- Head of Midwifery and Gynaecology
- Director of Operations Mental Health & Learning Disabilities
- Interim Executive Director of People's Services and organisational Development
- Associate Director, Diagnostic and Specialist Clinical Support

2 Previous recommendations

We made the following recommendations in 2022 following our review of the Health Board's quality governance arrangements. The Health Board has demonstrated partial progress in implementing previous audit recommendations. We have highlighted the status of these recommendations based on our follow up review.

Recommendation	Audit Wales Assessment of progress
Recommendation 1 We found that the Health Board did not formally review its quality improvement priorities in light of the consequences of COVID-19. The Health Board should ensure its new Quality Improvement Strategy sets out how the Health Board will manage and mitigate the potential harms associated with the COVID-19 pandemic. **Original target completion date**: September 2022	**Superseded**

Recommendation	Audit Wales Assessment of progress
Recommendation 2 We found that not all operational staff are trained to record clinical and nonclinical risks and compile risk registers. The Health Board should ensure staff have adequate levels of risk management training so that they can confidently contribute to the risk identification and escalation process. **Original target completion date**: Completed	**In Progress** **(see paragraph 71)**
Recommendation 3 The Health Board's Quality Improvement Hub (BCUQI) has developed a quality improvement database to allow staff to share, adopt and learn from existing quality improvement projects. However, we found that the database is not well used. The Health Board should promote and encourage routine use of the database by setting targets for participation, by keeping the level of engagement under regular review and by taking action if engagement is too low. **Original target completion date**: Completed	**In Progress** **(see paragraph 62)**

Recommendation	Audit Wales Assessment of progress
Recommendation 4 The Health Board has restarted clinical audits after most activity was paused during the pandemic. The Health Board should look to use its programme of clinical audit work to focus on the risk of harm as a result of the pandemic. For example, to better understand the consequences of long waits or exacerbation of chronic conditions. The audits could be targeted at high-risk specialities. **Original target completion date**: June 2022	**In Progress** **(see paragraphs 73 - 74)**
Recommendation 5 We found that mortality reviews are not reported to the QSE Committee in a timely manner. The Health Board should ensure the QSE committee receives a quarterly mortality review report, which highlights learning and what action has been taken. **Original target completion date**: July 2022	**Complete** **(see paragraph 48)**

Recommendation	Audit Wales Assessment of progress
Recommendation 6 We found that, generally, mortality reviews are medically led, but there is an appetite for multidisciplinary mortality reviews. The Health Board should look to establish a system where a multidisciplinary mix of staff are routinely involved in mortality reviews. **Original target completion date**: October 2022	**Complete** **(see paragraph 49)**
Recommendation 7 The Health Board recognises that it does not yet have a process to systematically share learning across the organisation. The Health Board should use the new integrated governance framework and the Quality Improvement Hub (BCUQI) as tools to support organisational learning and sharing good practice across the organisation. **Original target completion date**: October 2022	**In progress** **(see paragraph 61)**

Recommendation	Audit Wales Assessment of progress
Recommendation 8 Only 37.9% of Health Board staff responding to the NHS staff survey agreed or strongly agreed that the organisation takes effective action when bullying harassment or abuse occurred. The Health Board should review its systems for managing, addressing, and learning from the concerns of staff in relation to bullying, harassment, or abuse. **Original target completion date**: Completed	**Complete** **(see paragraphs 33-35)**
Recommendation 9 We found that operational teams did not know what proportion of staff had been trained to investigate complaints, incidents, and root cause analysis. The Health Board should review levels of complaints handling training across the organisation. If this shows shortfalls, the programme of training should be expanded. **Original target completion date**: Completed	**In progress** **(see paragraphs 40-42)** **(see paragraph 41)**

Recommendation	Audit Wales Assessment of progress
Recommendation 10 Less than half (42%) of respondents responding to our survey agreed or strongly agreed that they receive regular updates on patient feedback for their work area. Whilst patient feedback is shared with wards monthly, the Health Board needs to ensure all ward staff are aware of this feedback and that it is easily accessible to staff. **Original target completion date**: October 2022	**Complete** **(see paragraphs 44-45)**
Recommendation 11 The Health Board introduced a new reporting format (triple A) to improve the flow of quality assurance. But we found some variation in the levels of detail provided in the reports. To reduce the risk of quality and safety issues being missed or not correctly escalated the Health Board should provide staff with guidance on using the new template, especially setting out how much detail is expected and how to agree which issues are escalated. **Original target completion date**: July 2022	**Complete** **(see paragraphs 64-65)**

Recommendation	Audit Wales Assessment of progress
Recommendation 12 We found that whilst the measures in the integrated performance report aligns with the NHS delivery framework, there are no locally agreed quality measures or wider measures such as for community services. Through the new Quality Improvement Strategy, the Health Board should review current quality measures with a view to developing measures that reflects the services it provides and commissions across primary, community and secondary care. **Original target completion date**: October 2022	**No Progress** **(see paragraphs 78-82)**

3 Key terms in this report

Term	Description
Clinical Audit	The process that looks to improve patient care and outcomes through systemic review of care against explicit criteria and the implementation of change
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
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
Executive Quality Delivery Group	A senior executive group responsible for overseeing the delivery of quality, safety and clinical governance priorities
Foundations for the Future	A major organisational change programme at aimed at aligning the Health Board's structures, systems, processes, culture, and strategy to support long-term improvement and sustainability as part of its special-measures recovery.
Integrated Concerns Policy	The formal policy for managing complaints, claims and patient safety incidents under the Putting Things Right regulations.

Term	Description
Learning From Events Reports	Formal reports submitted to the Welsh Risk Pool that describe the learning and improvement actions taken by NHS Wales bodies following clinical negligence, redress, or personal injury cases. They are scrutinised by the Learning Advisory Panel, which ensures that learning has been implemented to prevent recurrence before the Welsh Risk Pool reimburses claim costs.
Listening to People	The new NHS Wales complaints system that replaces Putting Things Right. It focuses on compassionate, clear, and timely handling of concerns, using listening discussions, early resolution, and a two-stage process with potential redress up to £50,000. Its aim is to ensure people feel heard and that the NHS learns from complaints.
Never Events	Serious Incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers.
Organisational Learning Forum	The Health Board forum where leaders and staff share learning and improvement insights.
Patient & Carer Experience Group	A sub-group to support the work of the Executive Quality Delivery Group and to raise the profile and visibility of patient and carer experience and to provide assurance that the Health Board is listening and learning from patient and carer feedback.

Term	Description
Patient Safety Group	A sub-group of the Executive Quality Delivery Group responsible for co-ordinating and overseeing patient safety activity.
Public Services Ombudsman for Wales	An independent body that investigates public complaints about maladministration, service failures, and injustice by Welsh public services, including NHS bodies and local authorities.
Putting Things Right	A statutory NHS Wales process for handling concerns, complaints, patient safety incidents, and redress, ensuring issues are investigated fairly, openly, and in a timely manner under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. It provides a clear route for raising concerns and requires NHS bodies to learn from mistakes and take corrective action.
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.
Quality Management Framework	A framework document which is intended to explain how health boards will adopt their Quality Management System.
Quality Management System	The organisation-wide framework that NHS Wales bodies are required to implement to ensure they continuously, reliably, and sustainably meet the needs of the population, in line with the Duty of Quality under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

Term	Description
Speaking Up Safely	The NHS Wales framework that ensures all staff can raise concerns safely, confidentially, and without fear of victimisation, and that organisations listen, respond, and learn from those concerns to improve the quality and safety of care
Strategic Clinical Effectiveness Group	A senior clinical governance group that oversees and promotes clinical effectiveness, ensuring care is aligned with the Health Board's quality improvement and strategic priorities. It supports wider organisational efforts to improve clinical outcomes, quality, and patient experience.
Welsh Risk Pool	The Welsh Risk Pool is part of the NHS Shared Service Partnership Legal and Risk service. It provides the means by which all Trusts and Health Authorities in Wales are able to indemnify against risk. The role of the Welsh Risk Pool is to have an integrated approach towards risk assessment, claims management, reimbursement and learning to improve.

4 Management Response Form

Recommendation	Commentary on planned actions	Completion date	Responsible officer
Develop and monitor standalone quality plan			
R1 The Health Board should develop and implement a standalone, multi-year Quality Plan that clearly sets out its quality priorities, intended outcomes, leadership accountability, and the resources required to deliver sustained improvement **(paragraphs 10-16).**	The Health Board will develop and agree a clearly defined set of organisation-wide quality priorities document which will be reported, aligned to the Duty of Quality and IMTP, with measurable outcomes, named executive and clinical leads, and defined governance oversight through Executive Quality Delivery Group and QSE Committee.	September 2026	Clinical Directors

Recommendation		Commentary on planned actions	Completion date	Responsible officer
R2	The Health Board should ensure that the quality priorities, metrics, and expected benefits of its quality plan are regularly monitored through Executive Quality Delivery Group and QSE Committee, with progress routinely reported using meaningful indicators **(paragraphs 10-16).**	Progress will be monitored through the Executive Quality Delivery Group and reported six monthly to the QSE Committee, supported by an enhanced suite of quality indicators and assurance metrics.	March 2027	Clinical Directors
Training Oversight for risk management				
R3	The Health Board should monitor and report workforce training for each risk-management level on a regular (e.g. quarterly basis) and take action where training rates remain below targets **(paragraphs 68-72).**	Arrangements will be strengthened to include defined compliance targets, routine reporting, and escalation where performance falls below agreed levels, providing improved assurance to the Board on workforce capability in risk management.	December 2026	Director of Corporate Governance

Recommendation	Commentary on planned actions	Completion date	Responsible officer
Demonstrating lessons are learnt and shared **R4** The Health Board should ensure that quality and performance reports include clear evidence of learning, improvements achieved, and measurable change over time particularly: • outcomes of mortality-related improvement work; • actions from complaints, incidents, and thematic reviews; and • evidence of learning from external regulatory intelligence **(paragraphs 47-61).**	Work is underway to strengthen how learning is captured, evidenced, and reported. This will include: • Embedding the Learning Repository within the Quality Management System in addition to exploring and implementing effective mechanism of spreading learning within all layers of the organisation; • Enhancing reporting to demonstrate clear links between incidents, complaints, and subsequent improvements; and • Introducing measures to evidence impact over time, including outcome-based indicators. Future reports to the QSE Committee will place greater emphasis on demonstrable change and assurance that learning has been embedded.	December 2026	Clinical Directors

Recommendation	Commentary on planned actions	Completion date	Responsible officer
Improve the reliability of NRI reporting			
R5 The Health Board should investigate and reconcile the discrepancies between Nationally Reportable Incidents contained within its committee reports and annual report for 2025-26 and strengthen arrangements to ensure that future reporting is reliable **(paragraph 64).**	An immediate review will be undertaken to reconcile discrepancies in NRI reporting across Board and committee reports.	June 2026	Executive Director of Finance and Executive Director of Nursing and Midwifery
Strengthen quality oversight of commissioned services			
R6 The Health Board should implement a commissioning oversight framework to fully address the Public Services Ombudsman for Wales' recommendation **(paragraphs 78-82)**.	Completion and implementation of a Commissioning Assurance Framework will be prioritised, addressing previous audit and Ombudsman findings.	September 2026	Executive Director of Finance

Recommendation		Commentary on planned actions	Completion date	Responsible officer
R7	Develop clear and routine assurance reporting to the QSE Committee on the quality of commissioned services includes quality metrics, patient experience information, and risk assessments for care delivered through commissioned and outsourced services **(paragraphs 78-82).**	Routine reporting to the QSE Committee will be enhanced to include quality, safety, and patient experience information relating to commissioned services.	September 2026	Executive Medical Director
Improve staff understanding and engagement with quality systems				
R8	Building on the Culture & Leadership programme, the Health Board should provide progress and evaluation reporting on the implementation of the QMS to the Executive Quality Delivery Group **(paragraphs 23-27).**	The implementation of the QMS will be accelerated as a key component of the Foundations for the Future programme. This will include: • Clear governance and accountability for QMS delivery; • Phased implementation across services; and	September 2026	Executive Director of Nursing and Midwifery

Recommendation	Commentary on planned actions	Completion date	Responsible officer
	• Regular progress and evaluation reporting to Executive Quality Delivery Group.		
Strengthen complaints oversight and escalation			
R9 The Health Board should enhance QSE Committee reporting on complaints by: • regularly highlighting re-opened complaints as an emerging risk; • providing analysis of root causes and quality of investigations; and • monitoring compliance with complaint-handling training requirements **(paragraphs 36-43).**	Arrangements for complaints oversight will be strengthened through: • Enhanced reporting of trends, including reopened complaints as a specific risk indicator; • Improved analysis of root causes and quality of investigations; and • Monitoring and reporting of training compliance for staff undertaking investigations.	December 2026	Executive Director of Nursing

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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Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.

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