MENTAL HEALTH CLINICAL BOARD
Quality, Safety & Experience Meeting Minutes

Thursday 2nd April 2026 at 12:30
Microsoft Teams

Attendees:

- Clare Quinn- Interim Clinical Director for Psychology Psychological Therapies- Chair
- Rim Al- Sam Sam- Clinical Board Director
- Samuel Barrett- Director of Operations.
- Teresa Delaney- Directorate Manager Psychology and Psychological Therapies
- Jodie Carmichael- Dando- Senior Nurse MHSOP inpatient Services
- Gwilym Griffiths- Directorate Manager AMH
- Derek King- IPC Specialist
- Rhiain Lewis- Senior Nurse, Education, Quality, Safety & Patient Experience (MHCB
- Marianne Seabright- Lead Nurse MHSOP
- Clare Quinn- Interim Clinical Director for Psychology Psychological Therapies
- Rachel Dix- Deputy Director of Nursing (Mental Health)
- Jo Wilson- Senior Nurse for Crisis Services
- Victoria Gimson- MH Lead Pharmacist
- Susie Boxall- Lived Experience Team
- Ella Antebi - Mental Capacity Specialist Practitioner (MCA / Safeguarding)
- Gail Evans – Lead Nurse Practitioner, MHSOP
- Radhika Oruganti – Consultant Psychiatrist, Liaison Psychiatry (Older People) & Medical Lead for Audit/QSC
- Simon McDonald – Digital Lead for Mental Health
- Jayne Jennings- Senior Nurse Manager Crisis and Liaison Services
- Morgan Bellamy- Deputy Mental Health Act Manager
- Steve Watkins- Senior Finance Business Partner

Apologies:
Vasileios Stratigakis
Tara Robinson

Part 1 - Preliminaries		
1.1	Welcome and Introductions	Clare welcomed all attendees and confirmed recording arrangements. Full introductions were completed for the record
1.2	Apologies for Absence	Acknowledged above
1.3	Minutes of the meeting held in: 5th February 2026	Minutes of last meeting was reviewed and accepted.

1.4	Action log	A detailed and extended discussion took place regarding progress and risks in the February action log. Key matters: **BLS Compliance & Training Model** • Concerns raised that introducing standalone BLS sessions risks undermining Breakaway/SIMA integrated training. • Requirement for short-term BLS uplift in response to HIW compliance demands acknowledged. • Group agreed the current "tick-box" approach is unsatisfactory and requires a cohesive action plan. • Proposal for a small QI project to redesign mandatory training compliance
1.5	Presentation – Patient Story I dont have to put a mask to go to work	Patient Story **("I Don't Have to Put on a Mask to Go to Work)**– Presented by Susie Boxall Susie presented an abridged version of a story entitled **"I Don't Have to Put on a Mask to Go to Work."** She informed the team that the full version had been circulated but would focus on selected sections due to its length. The individual described within the account had originally been encouraged to consider becoming a peer worker by their psychologist and CPN, although a significant relapse delayed their progress for approximately a year. Despite this setback, persistent encouragement from their clinical team eventually led them to re-engage with the College and attend its informal drop-in sessions. These sessions, Susie explained, had been "invaluable" to the student, giving them confidence to begin structured learning and to assess whether the College environment felt right for them. Over the following term, the student became highly engaged, completing around ten courses. These included modules on understanding anxiety, discovering self-compassion, depression, and recovery and identity. They reported that the self-compassion course reshaped their internal narrative; they had previously believed that being harsh and critical toward themselves was a form of strength but came to realise that this mindset had undermined their wellbeing. The course helped them develop a more compassionate and balanced approach to their own emotional experiences, a shift they described as life-changing. They recounted how their volunteer work had historically required them to adopt a persona—feeling the need to appear assertive, driven and emotionally guarded to meet expectations. Through their involvement with the College,

		they reported that they were increasingly able to act as their "authentic self" and no longer felt compelled to "put on a mask." They described a renewed sense of hope, a greater sense of control over their life, and an improved outlook for the future. The student expressed that the Recovery & Wellbeing College offered a compassionate learning environment where staff blended lived experience with professional expertise. They valued the sense of community that developed during sessions and reflected that they often learned as much from fellow students as from course leaders. The story emphasised how this environment reduced feelings of isolation and helped them process their emotions more effectively. They were surprised by how much they learned in short periods, often revisiting course materials and online resources for further reflection in the days following each session. The Committee heard that the individual had also begun recognising signs of vicarious trauma accumulated from past roles, something they had previously overlooked. They credited their college learning with helping them understand, manage and prevent these responses more effectively. The story concluded with the student expressing enthusiasm about continuing their journey, completing more courses, and even repeating modules to gain new perspectives from different groups. They have since progressed into supporting the College by helping to "tech host" courses—an achievement Susie highlighted as evidence of the student's development and the effectiveness of the College's ecosystem model, where informal engagement evolves into learning, empowerment and active participation.
Part 2 - Governance, Leadership and Accountability		
2.1	UHB QSE Committee	**Presented by Rachel Dix** Rachel provided a concise but informative report. She explained that the UHB QSE Committee had recently received presentations relating to outcomes from HIW concerns and inspections, including those involving Mental Health services. She advised that the organisation is now transitioning into a strengthened process whereby the Mental Health Clinical Board will be **invited to provide regular updates** on progress against HIW-related actions, as well as wider quality and safety learning. This will increase the Board's visibility and accountability at UHB-level governance.

		She further outlined a new requirement being implemented at UHB level: a **weekly opportunity to present Rapid Review Tools**, replacing the former fact-finding arrangements. This mechanism is intended to enable the early identification and escalation of potential nationally reportable incidents to the UHB, ensuring timely oversight and system-wide assurance. She indicated that this procedural change would interface closely with future MHCB reporting, improving responsiveness across service areas.
2.2	Risk Register (20+) Corporate Risk Register Template Updated Sept 25.xlsx	Rachel Dix informed the Committee that the risk register displayed during the meeting was not up to date, as all risks had recently been migrated to the AMAT system following the formal transfer deadline of 31 March 2026. Although most high-scoring risks had already been moved, the spreadsheet version being viewed did not fully reflect the current position. She noted that some key risks—such as the shared CAU waiting lists—would not appear on the older template and therefore were not visible during the meeting. To support clarity and assurance, Rachel advised that the updated AMAT-based risk register should be circulated to all attendees. This would ensure members were reviewing the correct and complete risk profile ahead of further scrutiny. Teresa Delaney and Jo Wilson confirmed that this issue was consistent across several directorates: while all significant risks had been migrated, some lower-level or draft entries were still being finalised. Jo added that the migration process had been a helpful opportunity to reassess whether historic risks remained relevant and to ensure alignment with current operational pressures. No new risks were escalated, and the Committee noted the update. Members agreed that the AMAT version of the register would form the basis for review at the **next QSE meeting**
2.3	Exception reports and escalation of any key QSE issues: - Adult Mental Health - MHSOP / Neuro - Psychology - Pharmacy - Mental Health Act - Lived Experience Panel	**Adult Mental Health- Gwillym Griffiths** Gwil provided an overview of key quality, safety and operational issues requiring exception reporting, together with the mitigations currently in place. He reported that the ongoing implementation of **Electronic Prescribing and Medicines Administration (EPMA)** continues to present challenges within Adult Mental Health services, specific risks were noted in relation to patient demographic mismatches within the system and the resolution of EPMA-related issues arising **out of hours**. He advised that arrangements had been established to ensure appropriately trained staff were available to address system issues promptly to mitigate risks to patient safety and continuity of

		care. Further EPMA training and support were ongoing to strengthen staff confidence and system reliability. The team was further informed of recent and forthcoming **capital and estates-related developments**, including service relocations and infrastructure works affecting Adult Mental Health services. Gwil confirmed that these changes were being managed through established governance arrangements, including regular risk management and mitigation meetings and that operational risks associated with the estates programme were under active review and it was emphasised that patient safety considerations remained central to all planning and transition activity. Gwil also highlighted wider system pressures impacting Adult Mental Health services, including capacity challenges and the continued requirement for close monitoring of operational risks. He confirmed that these pressures were reflected within the risk register and subject to routine review through directorate governance structures, with escalation routes in place should risk scores increase or mitigations become insufficient. The team discussed the update and sought assurance that identified risks were being effectively monitored and controlled, It was noted that there were **no new risks requiring escalation** beyond existing governance arrangements at the time of the meeting. The team **noted** the Adult Mental Health exception report and **acknowledged** the ongoing work to manage EPMA-related risks, estates impacts and wider operational pressures through appropriate assurance mechanisms. **MHSOP- Marianne Seabright** Marianne advised the team that **Martha's Law** had now been implemented within MHSOP services. She explained that this provided a clear escalation mechanism for patients and families to raise concerns regarding physical health deterioration. It was noted that consideration is required in Older People's services where issues of mental capacity may affect the ability of patients themselves to escalate concerns, and that reliance on family or carers can therefore be greater which bodes the importance of staff awareness and consistent application of the escalation process was emphasised. An update was provided on **EPMA system resilience**, including a recent system outage. Marianne reported that established contingency arrangements had functioned as intended during the outage, with wards reverting to paper prescribing and medication administration charts. She provided reassurance that staff were familiar with downtime

		procedures and that no harm had been identified as a result of the incident. Marianne highlighted significant **bed pressures** within MHSOP services compounded by limited discharge options and complex patient needs, she stated that these pressures continued to require active risk assessment and close operational management. Ongoing monitoring arrangements were in place to mitigate the impact on patient flow, safety and staff workload. Marianne further provided an update on a recent **unannounced Healthcare Inspectorate Wales (HIW) inspection** of East 14 and East 16 wards. She advised that HIW had identified a number of issues requiring immediate action, particularly in relation to **infection prevention and control**, environmental standards and cleanliness. All immediate actions requested by HIW had been completed promptly and further work was underway to address longer-term improvement requirements. Marianne reported that HIW had expressed appreciation for the level of staff engagement and support during the inspection, and specifically acknowledged the commitment shown by ward teams during a period of significant operational pressure. The team was further advised that the acuity of patients in some older adult wards was comparable to that of psychiatric intensive care environments, reinforcing the need for appropriate staffing, environmental standards and clinical oversight. It was emphasised that learning from the inspection was being incorporated into service improvement planning. The team discussed the update and sought assurance that actions arising from HIW feedback would continue to be tracked through established governance mechanisms. The exception report was noted, agreeing that progress against inspection actions and service pressures would remain under close scrutiny through future QSE meetings. **Pharmacy- Victoria Gimson** Victoria advised that EPMA implementation within Mental Health services was now approximately four weeks into active use. While the system was largely functioning as intended, a number of early-phase issues continued to require active management. These included demographic mismatches within the system and challenges with the completion and reconciliation of **Discharge Advice Letters (DALs)**. She confirmed that Pharmacy teams were closely monitoring incomplete DALs and that exception reporting

		was in place to reduce the risk of medicines-related harm at discharge. Further staff training and system familiarisation were ongoing to improve confidence and compliance. The team was informed of a significant and time-critical service transition relating to **substance misuse prescribing**, following the closure of the **Dafodol** service. Vicky reported that responsibility for the service had transferred to **Canal**, bringing approximately **150 patients**, many of whom were prescribed methadone, into the new pathway. This transition required urgent oversight to ensure the continuity and safety of prescribing arrangements. Vicky explained that interim measures had been put in place, including the use of limited honorary contracts and additional Pharmacy support, to maintain safe prescribing until Canal's Home Office licence was issued. At the time of the meeting, the licence was anticipated to be granted by **1st June 2026,** and the team was advised that risks associated with this interim period were being actively managed. She emphasised that the transition had placed considerable pressure on Pharmacy resources but assured the team that robust controls were in place to safeguard patient care. The team noted the Pharmacy exception report and acknowledged the complexity of managing concurrent system implementation and service transition pressures. **Psychology- Teresa Delaney** Teresa advised that Psychology services were not reporting any exceptions relating to patient safety, clinical quality, workforce, or service delivery that exceeded established risk thresholds or required additional assurance through the QSE governance route. This provided assurance that services were operating within expected parameters and that existing controls remained effective. Teresa further requested clarity on current exception reporting channels and it was agreed that Psychology services would continue to report through standard governance arrangements, with any future exceptions escalated as required. **Lived Experience Susie Boxall** **Susie** presented the exception report on behalf of the Lived Experience Team, her report focused on service activity, opportunities for improvement and areas where additional system support was required.

		Susie advised the team on the continued development and positive impact of the **Recovery & Wellbeing College**, highlighting the team's expanding programme of structured courses and informal engagement opportunities. She reported on the introduction of nature-based sessions at Park Lodge, which are now running weekly and have been positively received by participants. These sessions were described as supporting wellbeing, social connection and recovery outside of traditional clinical environments. She informed the team of the forthcoming launch of a **'Preparing for Discharge' course** targeted at individuals under Community Mental Health Teams (CMHTs). Susie noted however, that referral levels from CMHTs were currently lower than anticipated and she highlighted this as an area requiring further collaborative engagement and emphasised that increased awareness and active referral by CMHTs would enhance access to the course and maximise its impact for service users transitioning from acute care. Susie also provided an update on wider Lived Experience activity, including the development of a new prospectus and the planned rollout of a co-production course aimed at strengthening meaningful involvement and partnership working across services. She advised that individuals with lived experience were increasingly progressing into supportive roles within the College, contributing to peer learning environments and service delivery. The team noted the report and supported further engagement with CMHTs to increase appropriate referrals into Lived Experience-led initiatives, agreeing that this would be kept under review through future QSE meetings. **MHA Office- Presented by Morgan Bellamy** Morgan presented an exception report to the team, she highlighted that the implementation of **EPMA** had shown a number of system gaps in relation to Mental Health Act processes. EPMA does not currently provide automatic prompts or alerts for the completion and monitoring of statutory documentation, including **Consent to Treatment certificates (CO2 and CO3)** and **Section 62** forms. To mitigate this risk, the MHA Office is progressing the introduction of a new alert system and has implemented interim controls, including the use of centralised folders and manual prompts, to ensure legal documentation is completed and monitored appropriately.

		Morgan highlighted that **staffing shortages within the MHA Office** continue to present a challenge with capacity pressures impacting the ability to support statutory processes consistently. Morgan reported that these shortages had led (in some cases) to **delays and postponements of Mental Health Review Tribunals**, as well as an increase in missed or delayed delivery of Section 132 rights. Recruitment activity remains ongoing, with the intention of stabilising capacity and reducing reliance on escalation responses. Morgan also provided an update on the review of the **Rights Policy**, noting that the frequency of rights delivery had been reassessed. A revised approach was being developed to reduce administrative burden while remaining compliant with legal requirements. This work was being taken forward to ensure consistency in practice and clarity for clinical teams. The team noted the MHA Office exception report and acknowledged the mitigating actions underway. Members recognised the ongoing pressures within the service and agreed that workforce capacity, EPMA system development and rights delivery would remain areas of focus for continued assurance at future QSE meetings.
2.4	Duty of Candour/Quality (Documents Presented) MHCB Duty of Candour Update - A	**Presentation delivered by Andrea Sullivan**. Andrea advised that a **Duty of Candour overview document** was shared with members for information. She confirmed that the document sets out current statutory requirements, responsibilities and expectations relating to openness, transparency and engagement with patients and families following incidents resulting in harm. The update was intended to support continued awareness and consistency of practice across Mental Health services rather than to highlight any specific breaches or concerns at this time. As part of the quality update, Andrea drew the team's attention to the **Patient Safety Review Bulletin**, which had been circulated for learning. She highlighted that the bulletin brings together themes emerging from recent reviews, including recurring issues relating to mental capacity, risk formulation and self-harm. Andrea emphasised the importance of using this information to support learning and service improvement at team and directorate level. Andrea also referenced the introduction of the **new Rapid Review Form**, which replaces the former fact-finding process. She acknowledged that the revised approach

		represents a shift in practice particularly for Mental Health services but reiterated that it is intended to support earlier identification of risk, improved escalation and stronger organisational learning. Guidance and support were being made available to teams to ensure the tool is used appropriately and consistently.
Part 3 - Safe Care		
3.1	Patient Safety Review Meeting Bulletin Update	**Presented by Andrea Sullivan** Andrea advised that the PSRM Bulletin had been circulated to members and brought together key themes emerging from completed reviews across Mental Health services. She highlighted that recurring themes continued to include **mental capacity and consent**, **risk formulation**, and the **management of self-harm risk**, particularly where complexity and co-morbidities were present. The Bulletin was described as an important mechanism for sharing learning consistently and transparently across teams and directorates. The team was informed that the Bulletin also summarised activity in relation to **nationally reportable incidents (NRIs)** and closed reviews. Andrea advised that, at the time of reporting, there were **11 open NRIs**, with one closed during March and several exceeding recommended timescales. An improvement plan was being developed to address delays in review completion and to strengthen oversight and timeliness within Adult Mental Health services. Andrea further highlighted that supporting resources linked to the Bulletin, including guidance documents and learning materials, are being made available via a dedicated **SharePoint site**. This is intended to ensure staff have access to consistent information and to support local dissemination of learning through ward and team meetings. Members were reminded of the forthcoming **Shared Learning Event scheduled for 8 May 2026**, which will focus on **safety and risk formulation**. The team was advised that this event would provide an opportunity to build on the themes identified through PSRM reviews and to promote reflective practice across services.
3.2	Learning From Events  Learning From Events.pdf	**Presented by Andrea Sullivan** The team received a detailed **Learning from Events** update presented by **Andrea.** The purpose of the item was to provide assurance that learning from serious incidents and historical events continues to be identified, embedded and monitored across Mental Health services.

		Andrea presented learning arising from a **historic incident dating back to 2017**, which had recently been reviewed. The incident involved a patient detained under **Section 2 of the Mental Health Act** who absconded from care and subsequently sustained significant harm. Andrea confirmed that the review identified a **breach of duty**, relating primarily to failures in observation practice, handover and the management of leave arrangements. The team was advised that contributing factors included insufficient clarity in observation levels, inadequate communication during patient transfers, and weaknesses in the supervision and recording of **Section 17 leave**. These issues were compounded by inconsistent documentation and a lack of shared understanding of the patient's risk profile at the point of transition between services. Andrea outlined the **actions implemented as a result of the review**, which included strengthening requirements for clear and comprehensive **handover documentation** when patients move between wards or services. Updates had been made to expectations around the recording and supervision of Section 17 leave, including clearer guidance on authorisation, risk assessment and return arrangements. Improvements had also been introduced to **signing-out and location-tracking processes** on wards to support oversight of patient movements. The team was further informed that **observation practices** had been reviewed to ensure that observation levels are clearly defined, consistently applied and explicitly linked to the patient's current risk assessment. Care plans have been updated to ensure that leave arrangements and observation decisions are reviewed regularly and adjusted in response to changes in clinical presentation. Andrea confirmed that learning from this event has been disseminated through appropriate governance and learning routes, including safety forums and clinical governance meetings. Ongoing monitoring arrangements are in place to ensure that changes remain embedded in practice and that similar risks are identified early. The team discussed the update and acknowledged the importance of continuing to review learning from historic incidents, particularly where themes remain relevant to current service pressures. Members emphasised the need for sustained assurance that improvements in handover,

		documentation, observation and leave management continue to be applied consistently across services. The team agreed that learning from serious and historic events remains a critical component of the Quality, Safety and Experience governance framework.
3.3	HIW Inspection Readiness	**Presented by Rhiain Lewis** Rhiain provided an update focused on current assurance arrangements, learning from recent inspections, and actions being taken to strengthen organisational preparedness. Rhiain advised that in preparation for HIW visits, **mandatory training compliance data** is now being produced and shared monthly with clinical leadership teams. This had proven effective during recent inspections, enabling timely access to assurance information and demonstrating oversight of compliance with statutory and mandatory training requirements. The team was advised that this approach will continue as part of routine inspection readiness arrangements. Rhiain further highlighted that learning had been drawn from recent HIW activity across Mental Health services, including unannounced inspections. While specific findings were addressed through immediate action plans at service level, Rhiain emphasised that inspection readiness remains a continuous process rather than a one-off exercise. Work is underway to ensure that documentation, audits and governance processes are consistently aligned with HIW expectations. Rhiain reported that the Clinical Board is strengthening its approach to **audit and assurance**, including the use of **Tendable audits** and other quality monitoring tools, to provide clearer and more consistent evidence of compliance. These audits are being reviewed to ensure they are proportionate, meaningful and directly aligned to inspection standards, with the aim of supporting both improvement and assurance. Rhiain highlighted that discussions are taking place with **Elysium Healthcare** to learn from inspection processes used in independent sector services, this work is intended to support shared learning around inspection preparation, real-time assurance and presentation of evidence to inspectors. She highlighted that this comparative learning would help refine local approaches and strengthen confidence across ward and service teams.

		Rhiain further advised that work is ongoing to develop more responsive reporting and oversight systems, enabling the Clinical Board to quickly demonstrate compliance, identify gaps and respond promptly to emerging issues during inspections. This includes improving the visibility of key documentation and evidence required by HIW reviewers. The team discussed the update and emphasised the importance of maintaining staff awareness of inspection processes, particularly during periods of high operational pressure.
3.4	Datix Overview  March NRIs.docx	**Vasileios Stratigakis (Document Provided)** The team noted that a **Datix Overview document had been shared for information** in accordance with the agenda. No separate verbal presentation of the Datix report was delivered during the meeting.
3.5	Welsh Government Closure Form Status	Taken to the Next QSE.
3.6	Annual MCA Audit feedback	**Presented by Ella Antebi** Ella provided feedback on the audit which was undertaken to assess compliance with Mental Capacity Act requirements and to evaluate the quality of capacity assessment, best-interest decision-making and associated documentation across services. Ella advised that the audit reviewed **135 patient records**, encompassing **163 capacity assessments** and **139 best-interest decisions**. Within Mental Health services specifically, **29 records** were reviewed, identifying **36 capacity assessments** and **25 best-interest decisions**. She explained that the audit methodology had been revised this year to extend beyond formal MCA documentation and include records where capacity issues should reasonably have been considered but had not been explicitly documented. The audit findings highlighted a **significant deterioration in the quality of documentation**. The robustness of recorded capacity assessments had reduced from **21% to 7%**, and **66% of cases lacked any documented capacity assessment**. Documentation demonstrating the provision of practical support to enable patients to make decisions was evident in only **6% of records**, representing a notable decline. Ella reported substantial concerns relating to **Deprivation of Liberty Safeguards (DOLS)**. In **41% of audited cases**, a DOLS authorisation should have been considered, yet in **87% of those cases the process had not been followed**.

		Within Mental Health services, Ella advised that while the need for DOLS had been recognised in all applicable cases, **none had been enacted appropriately**. The audit also identified significant issues relating to **restraint under the MCA**. Restraint had been used in **13% of cases**, of which **94% were assessed as not being lawful**. In **65% of restraint cases**, no accompanying best-interest decision had been recorded. Ella emphasised the seriousness of these findings and the need for urgent action to address both understanding and practice in this area. Despite these concerns, Ella noted some improvement in the **recording of best-interest decisions**, with **58%** demonstrating evidence of a decision-making process. However, consultation with relevant individuals was documented in only **around 50% of cases**, and consideration of alternative options was recorded in just **20%**. Ella outlined a comprehensive programme of **actions and recommendations** arising from the audit, including the development and promotion of new MCA documentation templates and performers, a review of current training provision, and the introduction of enhanced **Level 3 and Level 4 MCA training sessions**. A staff survey is planned to better understand barriers to compliant practice, and additional learning will be offered on areas such as self-neglect, restraint mapping and the interface between the Mental Health Act and Mental Capacity Act. Work is also progressing on a Memorandum of Understanding to clarify this interface. The team discussed the findings at length, recognising the seriousness of the risks identified and the potential legal, ethical and patient-safety implications. Members emphasised the need for sustained leadership oversight and for learning from the audit to be disseminated widely across services.
3.7	Infection Prevention and Control  IPCG Clinical Board MHCB March 2026.d	The team received an update on **Infection Prevention and Control (IPC)** matters as part of the Quality and Safety agenda. The update provided assurance on current outbreak management, wider system pressures and compliance monitoring across Mental Health services. The team was advised that there had been recent **outbreak-related ward closures** affecting Mental Health services. **Meadow Ward** had been closed following an outbreak of **Influenza A**, while **Ash Ward** had experienced a **norovirus outbreak**, involving several patients and staff. It

		was confirmed that appropriate infection control measures had been implemented promptly, including isolation, enhanced cleaning and adherence to local outbreak management protocols. The broader organisational context was noted, with members informed that approximately **120 inpatient beds across the UHB** were closed at the time of the meeting as a result of norovirus activity. This was acknowledged as creating additional system pressure, particularly in relation to patient flow and bed capacity, and reinforcing the importance of strict infection prevention and control adherence across all services. It was highlighted that recent **DMT (Daily Monitoring Tool) scores were consistently high, at approximately 93–94%**, indicating strong compliance with infection prevention standards within Mental Health wards. The importance of fundamental infection control practices, particularly **hand hygiene**, was reiterated. Members recognised that adherence to basic IPC measures remains critical in reducing transmission risk, especially during periods of increased infection prevalence and operational pressure
3.8	Concern Themes	Not Discussed
3.9	BSI standard 30480 - suicide and the workplace Presentation 10.pptx	**Presented by Andrea Sullivan** Andrea advised that BSI Standard 30480 is a recently developed **national guidance framework** designed to support organisations in improving their approach to suicide prevention within the workplace. She emphasised that the standard is **voluntary** rather than regulatory and is intended to provide a structured, evidence-informed approach for employers to recognise, reduce and respond to suicide risk among staff. The presentation highlighted that the standard includes a range of practical resources, including **toolkits for line managers**, guidance for **human resources teams**, and recommendations for supporting staff following a suicide or attempted suicide. Andrea explained that the guidance focuses on creating psychologically safe workplaces, improving awareness, and promoting early intervention through clear organisational processes. Andrea noted that adoption of the standard could support Mental Health services in strengthening existing wellbeing and staff support arrangements. She advised that organisations choosing to align with BSI 30480 may also have the opportunity to be recognised as **early adopters**,

		which could demonstrate organisational commitment to staff wellbeing and suicide prevention at a national level. The team discussed the presentation and acknowledged the relevance of the standard, particularly given the nature of Mental Health services and the pressures faced by the workforce.
3.10	Bare Below the Elbow Discussion  Bare Below Elbow.docx	Discussed at Next QSE
3.11	Staffing Levels Update	**Presented by Rachel Dix** Rachel advised that **staffing shortages continue to present significant challenges**, particularly within **inpatient services**. She reported that weekday staffing levels were of particular concern, with gaps impacting operational resilience and placing additional pressure on existing staff. While bank staff continued to provide short-term cover, the level of reliance on temporary staffing was recognised as unsustainable in the longer term. The Committee was informed of progress in converting **Healthcare Support Workers (HCSWs)** from bank to substantive posts, which was viewed as a positive step toward improving stability within the workforce. However, Rachel highlighted that the recent **Band 3 validation pay award** had created unintended financial pressures, affecting recruitment momentum and limiting the ability to appoint substantively at pace. Rachel reported that targeted **recruitment activity** was ongoing, including a **planned recruitment day within the next two weeks**, aimed at strengthening inpatient staffing capacity. She emphasised that while recruitment remained active, the impact of staffing gaps was continuing to affect service delivery, particularly in relation to patient observation, ward cover and clinical support. The team also noted the impact of staffing shortages on wider statutory functions, including the ability to support **Mental Health Review Tribunal attendance**, where gaps in senior nursing cover had previously contributed to postponements. Rachel advised that a new **senior inpatient nursing role** had been introduced to support tribunal processes and provide additional leadership presence within inpatient settings. The team discussed the update and recognised the ongoing operational and safety risks associated with prolonged staffing pressures.

Part 4 – Effective Care		
4.1	Audits Presentation (Tier 1, 2 and 3)	**Presented by Radhika Oruganti** Radhika outlined the **tiered audit structure**, explaining that Tier 1 audits focus on fundamental assurance requirements, Tier 2 audits support service-level quality improvement, and Tier 3 audits relate primarily to national audit programmes and externally mandated reviews. She advised that this approach enables proportional oversight and supports alignment with regulatory and national expectations. She highlighted ongoing participation in **national audit programmes**, including **NCAPOP** and the **Royal College audits**, with Cardiff and Vale actively engaged in audits relating to dementia and psychosis. Radhika confirmed that Mental Health services remain subscribed to the **National Clinical Audit of Psychosis** and the **Prescribing Observatory**, supporting benchmarking and comparative analysis at national level. She also highlighted work aligned to **NCISH-related themes**, focusing on suicide and self-harm prevention, with review activity structured around identified safety priorities. Radhika reported on **outcome measures**, noting Welsh Government requirements for the routine use of **patient-reported outcome measures (PROMs)**, including EQ-10 and EQ-20, at the start and end of clinical interventions or at defined review points. She advised that while implementation is progressing, challenges remain for specific cohorts, including dementia services, where validated norms are not yet available at national level. This issue is being considered by the National Dementia Group Wales, and local services will continue to engage in the interim. An update was provided on **Tendable audits**, which have been expanded following recent HIW inspection activity. Radhika explained that the audit approach is being refined to include **peer review**, with broader multidisciplinary involvement, including Allied Health Professionals and Healthcare Support Workers. She advised that feedback indicated some duplication and burden within audit tools, and a meeting was scheduled for **14 April** to streamline audit questions and ensure focus on key assurance requirements. The team was further advised that work is underway to strengthen the **responsiveness and usefulness of audit findings**, ensuring results are clearly linked to action planning and improvement activity at ward and service level. This includes ensuring that audit outcomes are fed into

		governance forums and aligned with inspection readiness and patient safety priorities.
4.2	NCISH Suitability	**Presented by Radhika Oruganti** Radhika outlined the relevance of NCISH findings to Mental Health services and advised that the current work programme aligns closely with the priority safety areas identified through national NCISH recommendations. She confirmed that review activity has been structured around key risk domains, including suicide prevention, self-harm management, risk formulation, and continuity of care. Radhika informed the team that a set of **ten identified safety focus areas**—derived from NCISH learning—are being used to guide local review and improvement activity. These areas are intended to strengthen clinical practice, reduce risk and ensure that services remain aligned with national learning on suicide prevention and patient safety. Radhika advised that NCISH suitability work is being embedded within existing governance arrangements, including audit activity, service reviews and quality oversight processes. This approach enables national learning to be translated into local action without duplication and supports triangulation with findings from Patient Safety Reviews, Datix reporting and HIW inspection feedback.
4.3	Tendable Audit Feedback (MHSOP)	**Presented by Marianne Seabright** Marianne gave a feedback on Tendable audits within Mental Health Services for Older People (MHSOP), she advised that the use of Tendable audits had been expanded significantly in response to recent HIW inspection activity. This expansion was intended to strengthen assurance and provide clearer, real-time insight into ward-level standards, particularly in areas scrutinised by regulators. She confirmed that the increased audit activity had enabled services to identify gaps more quickly and respond to issues in a timely manner. She highlighted the audit approach had evolved to include **peer review**, widening participation beyond senior staff to involve a broader multidisciplinary workforce, including **Allied Health Professionals** and **Healthcare Support Workers**. This was described as a positive development, supporting collective ownership of quality and improving staff understanding of standards and expectations. Marianne reiterated that while the increased audit coverage had been valuable, feedback indicated that some **audit questions were duplicative or overly burdensome**, potentially detracting from meaningful engagement and

		improvement activity. In response, work was underway to review and refine the Tendable question sets to ensure audits remain proportionate, focused and aligned with regulatory and service priorities. It was confirmed that a **meeting scheduled for 14 April 2026** would bring together relevant stakeholders to streamline audit questions and improve consistency across MHSOP services. The aim of this work is to ensure that Tendable audits provide clear assurance against standards while supporting continuous improvement rather than compliance alone.
Part 5 – Equitable Care		
5.1	CEN Pathway Development Update	To be taken to the next QSE.
5.2	CMHT Pillars and 36 degrees Update	**Presented by Clare Quinn** The team were advised that work continues across CMHT services to implement the agreed **pillar framework**, which is intended to support consistent delivery, assurance and service improvement across community mental health provision. The pillars were described as a structured means of focusing effort on core priority areas, improving clarity of roles and strengthening governance at team level. An update was also provided on the **36 Degrees approach**, with emphasis on its alignment to safety planning and quality improvement. It was noted that the principles of 36 Degrees are reflected within current workstreams aimed at reducing risk, improving continuity of care and supporting holistic, person-centred practice within community services. The team was advised that pillar-related activity and 36 Degrees work are being progressed through identified CMHT leads with tasks and updates shared through established communication and governance mechanisms. The approach was described as supporting greater consistency across teams, whilst allowing flexibility to respond to local needs and operational pressures.
5.3	Benchmarking Data Update (In-Patient)	**Presented by Sam Barrett** Sam advised that benchmarking continues to be used to compare in-patient Mental Health performance against relevant peers and national datasets, with a focus on identifying variation, emerging risks and opportunities for improvement. The data supports understanding of performance in the context of system pressures, including bed occupancy, flow, acuity and workforce challenges. It was acknowledged that benchmarking information complements other sources of assurance presented to the

		team, including audit activity, patient safety reviews and inspection feedback. Sam emphasised that benchmarking is intended to support informed decision-making and prioritisation rather than to be viewed in isolation. The team noted the importance of continuing to triangulate benchmarking data with qualitative intelligence and local context, particularly given the current operational pressures affecting in-patient services
5.4	SHED Update	**Presented by Dr Rim Al Sam Sam** Rim updated that SHED continues to support discharge planning and pathway development, with work aligned to a wider **discharge review exercise** currently underway across services. This review represents a substantial assurance task, with returns required by the end of April, and involves engagement with Community Mental Health Teams and Perinatal services to ensure consistency and oversight of discharge arrangements. She highlighted that discussions are ongoing regarding how SHED should best integrate with other service models, including **EDSOTT**, to support effective transitions and continuity of care. At the time of the meeting, no final decision had been made regarding the preferred configuration, and further consideration was required at directorate and Clinical Board level before progressing. Rim highlighted that the focus remains on ensuring that discharge processes are safe, coordinated and aligned with quality and patient experience priorities. She confirmed that learning from the discharge review and wider assurance work would inform future decisions regarding SHED development and integration. The team discussed the update and acknowledged the complexity of discharge pathways and the importance of maintaining oversight during periods of system pressure
Part 6 -Person Centred Care		
6.1	Documentation Group Update MHCB Paperwork Amnesty - Early Find	**Presented by Rhiah Lewis** Rhiain highlighted that the Documentation Group has been reviewing current expectations around the completion and updating of core clinical documents, with particular attention to the **WARRN and Care and Treatment Plan (CTP)**. She reported that a proposal had been developed to amend existing practice so that these documents would require updating **only where there is a clinical change**, rather than automatically following every ward move or transfer.

		The rationale for the proposed change was outlined, with Rhiain explaining that current documentation requirements were contributing to unnecessary administrative burden for clinical staff, without always adding meaningful clinical value. The revised approach is intended to support **proportionate, clinically relevant documentation**, while maintaining appropriate standards of safety, continuity of care and regulatory compliance. The team noted that this proposal aims to improve the quality of recorded information by allowing staff to focus on significant clinical developments, risk changes and care planning decisions, rather than routine repetition. It was emphasised that this would also support more meaningful engagement between staff and patients, reducing time spent on non-value-added documentation tasks. The team discussed the proposal and expressed support in principle, recognising the potential benefits for staff efficiency and documentation quality. It was acknowledged that clear guidance and communication would be required to ensure consistent understanding of when updates are necessary and to maintain assurance for inspection and governance purposes.
Part 7- AOB		
7.1	Healthcare Support Worker Forum Discussion	Members were advised that work is underway to establish dedicated **forums for Healthcare Support Workers**, intended to provide a structured and psychologically safe space for staff to raise concerns, share experiences and contribute to service improvement. The forums are being developed with **trade union support** and will sit within wider workforce engagement arrangements across Mental Health services. It was acknowledged that Healthcare Support Workers play a critical role in service delivery, particularly within inpatient and community settings, and that providing an appropriate mechanism for engagement is important in supporting staff wellbeing, retention and quality of care. The discussion emphasised that these forums would complement, rather than replace, existing escalation and reporting routes.
7.2	RMN Forum Discussion	Noted. Not Discussed.
7.3	Internal Safety Notice 2026 001 - Burkholderia stabilis infections from non-sterile wipes ISN 2026 001 - Burkholderia stabilis infections from non-sterile wipes	Noted. Not Discussed
Part 8 – Future Meeting Dates		
8.1	**Next QSE Meeting**: 4th June 2026 12:30 **Next Lessons Learned Meeting:**	
