Draft Minutes of the Public Quality Committee

Held on 14th April 2026 via MS Teams

To view the meeting: https://youtu.be/UKNth5j7Wns

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Judi Rhys	JRH	Independent Member – Third Sector
Rachna Upadhya	RU	Independent Member - General
In Attendance		
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Natasha Goswell	NG	Deputy Executive Nurse Director
Angela Hughes	AH	Assistant Director of Patient Experience
Matt Phillips	MP	Director of Corporate Governance
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Claire Beynon	CB	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
David Fluck	DF	Executive Medical Director
Additional Attendees		
Lauranne Cullen	LC	Regional Director for Llais
Jessica Castle	JC	Director of Operations – Specialist Services Clinical Board
Rachel Dix	RD	Interim Deputy Director of Mental Health Nursing - Mental Health Clinical Board
Rim Al-Samsam	RAS	Clinical Board Director - Mental Health
Dalia Alhusseini	DA	Equity and Health Improvement Officer
Elaine Lewis	EL	General Manager - Pharmacy
Rhodri Clyburn	RC	Pharmacist
Em Wilkinson-Brice	EWB	Independent Advisor – NHS Performance & Improvement
Pamela Johnston	PJ	Independent Advisor – NHS Performance & Improvement
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Suzanne Rankin	SR	Chief Executive Officer
Stephen Riley	SR	Independent Member – University
Kirsty Williams	KW	UHB Chair

		ACTION
QC 2026/04/1.1	**Welcomes, Introductions & Apologies** Ceri Phillips (CP), the Committee Chair, welcomed everyone to the meeting in English & Welsh. Apologies for absence were noted.	
QC 2026/04/1.2	**Declarations of Interest**	

	No declarations of interest were raised.	
QC 2026/04/1.3	**Minutes of the Committee meeting held on 03.03.2026** The minutes of the Committee meeting held on 03.03.2026 were received. **The Committee resolved that:** a) The minutes of the meeting held on 03.03.2026 were approved as a true and accurate record of the meeting.	
QC 2026/04/1.4	**Action Log following the Meeting held on 03.03.2026** The Action Log following the Meeting held on 03.03.2026 was received and discussed. **The Committee resolved that:** a) The Action Log from the meeting held on 03.03.2026 was noted.	
QC 2026/04/1.5	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QC 2026/04/2.1	**EPMA Programme Trajectory and Data** Elaine Lewis (EL), the General Manager – Pharmacy, and Rhodri Clyburn (RC), Pharmacist, provided an update on the progress with the Electronic Prescribing and Medicines Administration (ePMA) programme. They summarised the following: • The pilot commenced in July 2025 and had since been rolled out across most inpatient areas, supported by clinical leads and floor-walking teams. • ePMA was now live across the majority of CAVUHB sites, with remaining inpatient areas scheduled to go live by the end of June 2026, including Intensive Treatment Unit (ITU), paediatrics, maternity, Marie Curie hospice, and Neonatal Intensive Care Unit (NICU). They hoped to work on outpatients towards the end of the calendar year. • Key achievements included first-in-Wales implementation in the Emergency Unit (EU), national first use of NerveCentre ePMA in mental health, and significant improvements in discharge advice letter completion (with incomplete letters previously at around 20% to 3%) • The system had been widely adopted, with over 5000 users, more than 2 million medicine administrations completed, and improvements in medicines safety, patient identification, and data visibility. • Future work included completion of inpatient rollout, system optimisation, use of ePMA for home care, and scoping a separate ePMA programme for outpatients, including potential integration with the Electronic Prescription Service (EPS). Paul Bostock (PB), the Chief Operating Officer, asked when evidence would be available to demonstrate the impact of ePMA on medicines safety, including reductions in medication errors and waste, given the scale of system usage to date. RC advised that safety benefits should become clearer within the current calendar year, drawing on incident data and key measures such as VTE compliance and missed doses. The next phase would focus on benefits realisation and system optimisation through refinement of the system, training and data analysis to evidence safety impact.	

	PB asked whether given the volume of activity to date, there was early evidence of improvement. RC responded that it was still too early to draw firm conclusions on safety impact, though early feedback from the first Clinical Board to go live suggested a reduction in reported drug errors, which was viewed as a positive early indicator. **CP suggested that data demonstrating the impact of ePMA on patient safety and quality be made available – ACTION**. EL responded that they had agreed to go to the Senior Leadership Team (SLT) within the next 4-5 months with this data, so can share with the Quality Committee also. Jason Roberts (JR), the Executive Nurse Director, asked whether the implementation of ePMA had introduced any new or different patient safety risks. RC provided the following response: • The risks associated with ePMA largely related to human interaction with digital systems rather than the technology itself • Identified risks included drop-down selection errors, alert fatigue from clinical decision support warnings, and users bypassing safety features such as alerts and barcode scanning • Some incidents had arisen where alerts were overridden or scanning processes were not followed, reducing the effectiveness of built-in safety controls • The importance of understanding user behaviour was emphasised, alongside the need for mitigations through system design, training, and awareness to minimise avoidable risks and improve safe use of the system. EL added that alert overrides and alert fatigue were well-recognised risks within ePMA, with national evidence showing alerts can be frequently overwritten if not well designed. EL acknowledged that an increase in reported drug incidents was anticipated due to improved visibility compared to paper systems and historic under-reporting. RC explained that the UHB would join the national ePRaSE programme from September, providing six-monthly assessments of local ePMA configuration against clinical scenarios to support continuous system optimisation and improvement. Judi Rhys (JR-IM), the Independent Member – Third Sector, asked about confidence levels in delivering the remaining ePMA activity to the agreed timeline, and asked about opportunities to share learning and good practice from the programme. EL responded that the programme was ambitious but was on track, with confidence expressed in completing the inpatient rollout, whilst NICU presented specific clinical challenges still being addressed. Outpatient implementation would proceed regardless of EPS readiness. EL added that learning from the programme was being actively shared across the organisation, including with Shaping Change and the digital foundations teams. Alex Scott (AS), the Assistant Director of Quality and Patient Safety, explained that the Shaping our Future Quality Excellence (SOFQE) Programme included a medicines safety workstream focused on reporting culture and quality indicators, with robust audit data available in some areas, which could be used to assess quality and wider patient safety impact despite limitations in baseline data. **The Committee resolved that:**	

	A) The update provided as requested by the previous Quality Committee was noted.	
QC 2026/04/2.2	**Prevention of Future Death (PFD) Response** Angela Hughes (AH), the Assistant Director of Patient Experience, presented an overview of a Regulation 28 report to PFDs issued by the coroner following a missed critically abnormal vitamin B12 result, which was found to have contributed to a patient death. AH provided the following summary: • Key risks identified included reliance on a single consultant within the Perioperative Care of Older People Undergoing Surgery (POPS) service without formal cross-cover, and the potential of abnormal results being missed. • The UHB submitted a timely response and implemented immediate mitigations, including interim cross-cover arrangements, revised laboratory procedures with monthly audit assurance showing full compliance, and strengthened oversight via the Welsh Clinical Portal. • Additional actions included improvements to how results were displayed to clinicians by Digital Health and Care Wales (DHCW), increased staffing within the POPS team, and enhanced consultant review processes • Residual risk remained due to growing service demand, and the Clinical Board was considering longer-term sustainable service models to maintain patient safety and system resilience. Lauranne Cullen (LC), the Regional Director for Llais, asked whether there was a defined deadline for completion of the workforce expansion plan, and what contingency arrangements were in place should recruitment be unsuccessful. AH confirmed that team cover was in place, with recruitment to the specialist nurse post underway. AH would provide confirmation and feedback to LC outside of the meeting. JR emphasised that whilst this case related to vitamin B12, the learning must be applied more widely across the organisation to strengthen the management and follow-up of blood results and medicines safety processes overall. AH noted that emerging work by DHCW to present results in a single, clearly prioritised view, including time-critical actions, should significantly improve the management of abnormal results, with learning applicable beyond B12 to other medicines requiring timely follow up. Claire Beynon (CB), the Executive Director of Public Health, asked how frequently urgent action blood results occurred and whether laboratory staffing was sufficient to ensure timely action and escalation. AH responded that although such incidents were rare due to multiple existing fail-safes, this case highlighted how failures at several points could align, particularly around discharge processes and result follow-up. The true frequency was difficult to quantify due to reliance on reporting and reinforced the need for improved systems. Aled Roberts (AR), the Associate Medical Director Patient Safety and Clinical Effectiveness, explained that clear protocols were in place for “panic” results requiring action within 15 minutes, supported by a developing communication plan covering both hospital and community settings. The work being undertaken by DHCW was parallel to improve visibility and follow-up of non-urgent but abnormal results through digital enhancements. **The Committee resolved that:**	

	A) The Regulation 28 Report and Health Board response was noted.	
QC 2026/04/2.3	**Royal College of Psychiatry Review Update from the Mental Health Clinical Board (MHCB)** Rachel Dix (RD), the Interim Deputy Director of Mental Health Nursing - Mental Health Clinical Board, presented an update to the Committee of progress against the RCP's report following a cluster of inpatient suicides (2021-2022), including delivery of actions aligned to the 36 Degrees transformation programme. The following was summarised: • Significant progress had been made across key areas including risk assessment (transition to WARRN), care and treatment planning, therapeutic engagement and observation, continuity of care, discharge processes, Mental Health Act (MHA) practice, family engagement, leadership and supervision, and serious incident review standards. • <u>Risk Assessments</u> – risk assessments had transitioned from Form 4 to WARRN, now embedded but with ongoing challenges. Further work was needed to strengthen risk management and consistency, aligned to an All-Wales approach. Plans were in place to introduce WARRN as a Tier 2 audit using AMAT for better data use and oversight. A risk management policy had been reviewed and was currently out for consultation. • <u>Care and Treatment Planning</u> – co-produced care and treatment planning training was in place and linked to discharge preparation. An All-Wales training approach was being developed with ESR. A new care and treatment planning procedure to support the continuity of care was out for consultation. • <u>Therapeutic Engagement and Observation</u> – a co-produced therapeutic observation approach had been implemented, focusing on relational care and supported by training. Weekly 1:1 compliance was monitored (target was 100%), with some gaps being addressed. A SafeCare red flag system highlighted risks on the ability to undertake 1:1 observations in real time. • <u>Continuity of Care</u> – they had embedded the transfer checklist, with a policy under review. The transition and recovery ward had reduced out-of-speciality placements. Discharge letters had improved (closer to the 24-hr target) following ePMA, with work ongoing to enhance the quality. 72-hr follow-up for all discharges was being piloted in line with All Wales standards. • <u>Diagnosis, Treatment, and MHA</u> – the use of language was being addressed through training, ongoing audit, and external support from the MHA office. Key policies relating to Section 5(2) and 5(4) had been reviewed to ensure clarity and consistency. A new open and locked door policy was out for consultation to improve transparency for staff and patients. • <u>Family Engagement</u> – co-produced family engagement guidance had been developed to support information sharing and handling sensitive conversations. A two-year family engagement project was underway (mid-point) which aimed to strengthen family and carer involvement across the MHCB. • <u>Leadership and Supervision</u> – progress was being made on nursing establishments and MDT review, linked to the 36 Degrees transformation programme. Recruitment of dedicated inpatient social workers was expected to improve care. Clinical supervision had been strengthened with a new procedure, but monitoring was limited due to the lack of ESR recording. Further work was needed to define the optimal MDT model and improve supervision oversight. • <u>SIRAN Standards</u> – SIRAN accreditation had been maintained, which demonstrated compliance with the Royal College standards for incident reviews and family and staff engagement. The service had been recognised as a good practice exemplar, particularly for family involvement, terms of reference, and the use of AMAT for improvement tracking.	

	• Work was progressing on NHS Wales discharge standards, supported by co-produced discharge and admission materials and an All-Wales ligature risk assessment. Some areas remained outstanding and linked to the 36 Degrees programme. These would be strengthened through Tier 2 audits to improve monitoring and alignment with All-Wales requirements. PB asked for clearer visibility of any remaining gaps following the RCP report, including proposed timescales for addressing them, and suggested that the 36 Degrees programme could provide independent validation of progress to give additional assurance. JR agreed that independent validation through the 36 Degrees programme could provide additional assurance. JR asked whether the implementation of the WARRN risk assessment introduced new risks and how staff confidence and cultural transition were being supported. RD responded with the below: • There was an ongoing effort to shift the culture around WARRN away from a tick-box approach towards a more psychologically informed, formulation-based assessment of risk, led with support from psychology colleagues. • Whilst WARRN served a purpose, it was not consistently embedded in clinical practice and there was all-Wales resistance to it as a tool, which prompted discussions about alternatives. • Suicide awareness and mitigation training, alongside safety planning, had been more effective in changing practice, with targeted and team-based training, additional guidance, and a new risk management policy supporting this work. • This formed a key and evolving workstream within the safety pillar's risk project plan. JR provided assurance to the Committee that this would be scrutinised through Executive Reviews. AS explained that a paper on Clinical Board's audit forward plans would be brought to the following Committee to provide ongoing assurance and feeding into the Clinical Board and UHB risk registers where risks were identified. **The Committee resolved that:** A) The update provided to the Committee was noted.	
QC 2026/04/2.4	**Equity, Equality, Experience and Patient Safety Action Plan** CB presented the six-monthly update on the Equity, Equality, Experience and Patient Safety Action Plan, and highlighted the below: • Under the Equality Act 2010, the UHB had a duty to identify and address inequities in access, experience and outcomes, which aligned with the vision for 2035 to reduce unfair health differences. • To support this, a 3i Framework and implementation toolkit was developed in 2023, with progress against the action plan reported to the Quality Committee every six months. AH explained that work was underway on accessible standards, with gaps in adherence which contributed to communication-related inequities. A new translation and accessible standards policy was being drafted, and there was a clear need to link with this work	

	with related equality initiatives. AH suggested linking with CB's team outside of the meeting. JR-IM asked about the reported increase in the ethnic minority workforce and sought clarity on whether this reflected local recruitment or international recruitment. She also queried why this data was not readily available and whether the source of recruitment mattered. CB responded that if the information was not readily available, it was likely because ESR data did not distinguish between local and international recruitment. In response to whether it mattered, CB responded that she did not think so. **For a further update to come back to the Committee in six months – ACTION.** **The Committee resolved that:** A) The actions underway in the action plan to address health inequalities in Cardiff and the Vale of Glamorgan were supported and advocated; B) The six-month progress that had been made against the actions, including the challenges around health inequality data availability, were acknowledged; C) To receive further updates in another six months was agreed.	
QC 2026/04/2.5	**JACIE Inspection Report Update** Jessica Castle (JC), the Director of Operations – Specialist Services Clinical Board, provided the Committee with the following update: • The JACIE inspection was undertaken in September 2025, with reaccreditation currently deferred pending submission of a credible corrective action plan by 8th July 2026. • Whilst the majority of standards were compliant, areas of non-compliance and partial compliance were being tracked through a dedicated Task & Finish Group (T&FG) which reported regularly through governance structures. • Adult Premises (CAVUHB) - good progress was being made on the Haematology Day Centre, although groundworks issues had delayed completion by a few months. A revised timeline would be included in the response to JACIE. The main risk remained the wider capital scheme for the inpatient ward, which was still in the planning stages. The UHB hoped to have a completed internal business case, sought a support letter, and developed a high-level project plan by the JACIE deadline. • Paediatrics (Clinical) - concerns focussed on low patient volumes in the paediatric programme, below expected standards. Mitigation included closer working between adult and paediatric teams to maintain competencies. A robust organisational decision was required on the future of the autologous transplant programme. An options paper was being developed which would go through the Clinical Board and the Strategic Leadership Team (SLT) in May. The outcome would inform the formal response to the JACIE. • Swansea Bay UHB (SBUHB) Personnel – JACIE had identified issues at SBUHB including medical staffing gaps, over-reliance on a single specialist nurse, and gaps in prehabilitation and nurse-led services compared to CAVUHB. SBUHB had produced a paper outlining the requirements to achieve parity with CAVUHB, which would be presented to SLT. • Stem Cell Unit Personnel – the unit was identified as a key concern due to staffing gaps, insufficient on-call cover, and weaknesses in risk controls following a recent adverse event. A paper was being developed for SLT to agree next steps. Any proposals requiring additional resources would need approval through JCC as the service commissioner.	

	• <u>Next Steps</u> – a T&FG oversaw delivery of action and provided regular assurance to SLT, the JCC had been briefed and WG discussions on capital plans were ongoing, the paediatrics options appraisal and the SBUHB workforce business case had been completed and were progressing through governance, and the Quality Team were addressing the remaining areas of non-compliance. JR-IM asked how ongoing discussions with WG, including the impact of the election period, was affecting progress and contributing to delays. JC responded that work on the business justification case (BJC) was still ongoing, so the election period was not currently causing delay. The main challenge was uncertainty linked to potential changes in government, meaning approval could not be confirmed. The focus remained on finalising the BJC, progressing internal govern ance, and preparing supporting documentation. Final ministerial approval was outside of local control. **For an update to come back to the following Quality Committee – ACTION.** **The Committee resolved that:** A) The progress and risks were noted.	
QC 2026/04/2.6	**Structured Assessment, Internal Audit, Targeted Intervention De-escalation Criteria Overarching Quality Improvement Plan** Natasha Goswell (NG), the Deputy Executive Nurse Director, presented the overarching Quality Improvement Plan for assurance, and highlighted the following: • The improvement plan consolidated actions from the internal audit on Quality and Safety Governance, the Structured Assessment 2025, and targeted intervention de-escalation criteria • The plan provided a single line of site on 22 requirements, clearly setting out actions, owners, evidence and reporting routes, and aligned to the organisational strategy. • Delivery would be overseen through weekly executive quality meetings using AMAT, with formal reporting to the Quality Committee monthly initially, moving to quarterly, and included assessment of risks and safety impacts should improvements not be delivered. JR noted that the plan brought together the integrated Quality Improvement Framework into a single, coherent approach, supporting future development of the Quality Committee. It would also be embedded within the Quality Management System (QMS) to make quality improvement everybody's business. CB emphasised the need to ensure equity was included as one of the quality elements. **The Committee resolved that:** A) The contents of the overarching Quality Improvement Plan were noted for awareness; B) The actions being taken to address the areas identified for improvement and the governance arrangements for oversight of the reporting and monitoring of the improvement plan were noted for assurance.	
	Items for Approval / Ratification	
QC 2026/04/3.1	**Policies** *No policies for approval.*	

QC 2026/04/3.2	**Quality Committee Annual Report 2025/26** Matt Phillips (MP), the Director of Corporate Governance, explained to the Committee that the Annual Report formed part of the annual end-of-year reporting cycle. It provided a high-level summary of the year, complementing existing minutes, reports, and Chairs updates. **The Committee resolved that:** A) The Quality Committee Annual Report was endorsed for approval at Board.	
	Items for Noting & Information	
QC 2026/04/4.1	**Minutes from the Clinical Board QSE Sub-Committees** **The Committee resolved that:** A) The Clinical Board QSE Sub-Committee minutes were noted.	
QC 2026/04/4.2	**Safeguarding Steering Group (SSG) Minutes** JR assured the Committee that the absence of minutes reflected timing only. The Group had met in March, and their papers would be brought to the next Committee following ratification.	
QC 2026/04/4.3	**IP&C Group Minutes** JR assured the Committee that the absence of minutes reflected timing only. The Group had met in March, and their papers would be brought to the next Committee following ratification.	
QC 2026/04/4.4	**Public Health Wales Sexual Health Incident** CB provided the following summary to the Committee: • This incident involved Public Health Wales's (PHW) sexual health test-and-post service, which was used by some CAVUHB patients. • Whilst the service remained safe and operational, issues were identified relating to ineffective safeguarding and data handling processes. • PHW had taken appropriate action, issued an apology, and published supporting information and FAQs online. • PHW had advised that they all affected individuals had been contacted, corrective actions were in place, and follow-up support, including a helpline, remained available. JR provided assurance to the Committee that the CAVUHB Safeguarding Team had reviewed the patient cohort and confirmed there were no safeguarding concerns from a UHB perspective. **The Committee resolved that:** A) The contents of the report were noted; B) The actions undertaken by CAVUHB in response to the incident were noted.	
	Agenda for Private Quality Committee Meeting	
QC 2026/04/5.1	*i) Minutes and Action Logs from the Private QSE Committee on 03.03.2026* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*	

	iii) Eating Disorder Service Review Update *iv) Health Inspectorate Wales - SSSU* *v) Inquest Outcome, Organisational Learning and Assurance* *vi) Public Health Wales Hepatitis C Incident*	
	Any Other Business	
QC 2026/04/6.1		
	Date & Time of Next Meeting:	
QC 2026/03/7.1	2nd June 2026 at 2pm via MS Teams	