Draft Minutes of the Public Quality Committee
Held on 27th October 2026 via MS Teams

To view the meeting: https://youtu.be/fP0cuzWM1kE

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Claire Beynon	CB	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
Chris Bown	CB	Chief Executive Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Lauranne Cullen	LC	Regional Director – Llais
David Fluck	DF	Executive Medical Director
Natasha Goswell	NG	Deputy Executive Nurse Director
Angela Hughes	AH	Assistant Director of Patient Experience
Alison James	AJ	Lead Nurse - Children, Young People and Family Health Services
Helen Luton	HL	Director of Nursing and Multi-Professional Teams – Clinical Diagnostics and Therapeutics (CD&T)
Matt Phillips	MP	Director of Corporate Governance
Clare Quinn	CQ	Director of Psychology and Psychological Therapies for the Mental Health Clinical Board
Judi Rhys	JRH	Independent Member – Third Sector
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Rachna Upadhya	RU	Independent Member - General
Kirsty Williams	KW	UHB Chair
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Chloe Evans	CE	Mental Capacity Act (MCA) Project Lead
Stephen Riley	SR	Independent Member – University
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness

QC 26/10/1.1	**Welcomes, Introductions & Apologies** Ceri Phillips (CP), the Committee Chair, welcomed everyone to the meeting in English & Welsh and apologies for absence were noted.	
QC 26/10/1.2	**Declarations of Interest** No declarations of interest were raised.	
QC 26/10/1.3	**Minutes of the Committee meeting held on 29.09.2026** The minutes of the Committee meeting held on 29.09.2026 were received. **The Committee resolved that:** a) The minutes of the meeting held on 29.09.2026 were approved as a true and accurate record of the meeting.	

QC 26/10/1.4	**Action Log** The Action Log following the meeting held on 29.09.2026 was received and discussed. **The Committee resolved that:** a) The Action Log from the meeting held on 29.09.2026 was noted.	
QC 26/10/1.5	**Committee Chair's Actions** No Chair's Actions were raised.	
	Strategy: Providing Outstanding Quality	
QC 26/10/2.1	**Board Assurance Framework** **The Committee resolved that:** A) The BAF was noted.	
	Shaping our Quality, Value & Sustainability	
QC 26/10/3.1	**Discharge Advice Letters (DALs)** Alex Scott (AS), the Assistant Director of Quality and Patient Safety, presented the report and highlighted the following: • Discharge Advice Letters (DALs) were highlighted as a vital mechanism for communicating treatment, diagnoses and prescribing information when patients transfer from secondary to primary/community care • Historically, DALs completion and submission had been poor, with letters remaining in draft and limited data available to monitor compliance • DALs had now been embedded within the Electronic Prescribing and Medicines Administration (EPMA) system, with the draft function removed from 1st September 2026 to ensure letters were clinically signed off and submitted before discharge medication was dispensed • It was confirmed that this change had not adversely affected discharge times and had significantly strengthened compliance for patients discharged with take-home medication • A new DALs dashboard provides Clinical Boards with oversight of compliance and discharge efficiency, including the timing and completion of letters • Further work was required to provide equivalent assurance for patients discharged without take-home medication, although the overall position had significantly improved David Fluck (DF), the Executive Medical Director, noted the revised process represented a significant improvement, with implementation less problematic than initially anticipated. Further work was underway to review the quality and consistency of discharge information, alongside national work to agree the required content of discharge summaries. Judi Rhys (JR-IM), the Independent Member – Third Sector, asked who held responsibility for signing off DALs. JR-IM also asked whether there were any specific area of concern or hotspots. AS confirmed that clinical teams were responsible for signing off DALs. AS responded that although historical data was limited, previous reports indicated that up to 40% of DALs may have remained in draft. The revised process ensured that take-home medication could not be dispensed without a signed DAL. Further work was required to ensure equivalent oversight for patients discharged without medication.	

	Angela Hughes (AH), the Assistant Director of Patient Experience, highlighted the ambition to achieve 100% compliance in providing patients with copies of their discharge information. AH suggested that patient preferences for receiving information electronically or on paper should be captured to support patient involvement, reduce postal costs, and enable improved monitoring of compliance. Kirsty Williams (KW), the UHB Chair, asked for more clarity on ownership, next steps, and timescales for addressing the remaining gaps. AS responded that the new DALs dashboard provided Clinical Boards with improved oversight and scrutiny of performance, with Clinical Board Directors continuing to support delivery. Practical work was underway to enable printed DALs to be provided across wards. **Circulate a note to Committee members providing further assurance on the remaining gaps and next steps, including timescales, responsibilities, provision of DALs to patients discharged without medication – ACTION.** KW commented that DALs seemed dependent on patients discharged with medication. KW asked how Clinical Boards would be held accountable for monitoring and delivering ongoing improvements. CP responded that the existing group would continue to oversee and monitor progress. CP suggested that AH link in with this group regarding her previous suggestions. Paul Bostock (PB), the Chief Operating Officer, commented that the Executive team would hold Clinical Boards to account for performance through the Executive Review meetings. DF added that improvement had been driven through the weekly Clinical Board leadership meetings, with continued senior oversight. Separate work on the quality of discharge summaries remained ongoing. **The Committee resolved that:** a) Recurrent updates on DALs were no longer required, whilst ongoing monitoring of DALs performance and quality would continue.	
QC 26/10/3.2	**Update on Fuller Report Recommendations** Helen Luton (HL), the Director of Nursing and Multi-Professional Teams – CD&T, presented the report to the Committee and highlighted the following: • The local gap analysis against the Fuller recommendations (1-21) continued to be reviewed and updated, with further progress demonstrated. • Established controls remained in place, including CCTV, controlled swipe access, routine audits, quarterly access reviews and incident reporting, with oversight through the Human Tissue Authority (HTA) Compliance Group and Clinical Board governance arrangements. • Further progress had been made on the winter capacity plan to ensure compliance with the recommendations, supported by Capital, Estates & Facilities and Procurement teams. • Outstanding security improvements including an additional contingency lock, CCTV coverage and swipe-out controls, were progressing towards completion by the end of November, following minor delays in sourcing equipment. • An annual report covering regulated activity, including mortuary services and HTA incidents, would be presented to the Committee in February 2027	

	• In relation to safeguarding, an interim staff briefing and memo had been developed pending the national approach to training, with ESR Level 1 and 2 training expected to incorporate the relevant Fuller recommendations. • A further gap analysis had been undertaken against relevant Ockenden recommendations relating to maternal, foetal and perinatal care after death, with work progressing to address this. DF asked when the next HTA inspection would be. HL responded that work on the Fuller recommendations had commenced ahead of the previous HTA inspection, placing the UHB in a positive position. HTA inspections could take place without notice, with inspection readiness maintained through monthly Regularly Compliance Group meetings and ongoing monitoring of regulatory KPIs. Rachna Upadhya (RU), the Independent Member – General, asked about the adequacy of winter mortuary storage capacity, particularly if additional refrigeration was delayed. RU also asked whether the interim safeguarding briefing and memo provided sufficient assurance pending implementation of the All-Wales training arrangements. HL advised that winter capacity arrangements were in the final stages of development, with a suitable location identified and procurement underway. Confidence was expressed that the arrangements would meet the Fuller recommendations. Regarding safeguarding, HL noted that the interim briefing and memo had been reviewed and were considered appropriate pending national guidance. These would be discussed at the Safeguarding Steering Group (SSG), with further consideration given to ensuring effective communication and dissemination across Clinical Boards. RU asked whether existing CCTV arrangements provided adequate security coverage. HL was assured that existing CCTV coverage and security controls were considered adequate, with regular footage audits and quarterly access reviews in place. The additional CCTV covering refrigeration areas would provide a further layer of security in line with the Fuller recommendations. KW endorsed the proposal for an annual report to come to the Committee. **The Committee resolved that:** a) The UK Government update on 15th July 2026 and the national direction for strengthened mortuary security, governance, accountability and safeguarding was noted; b) The evidence of substantial local progress against Fuller recommendations 1-21 was noted; c) The mitigations related to safeguarding arrangements were acknowledged; d) The review of the Ockenden recommendations in relation to maternal, fetal and peri-natal care after death was noted; e) Continued oversight through Quality Committee was supported, with a further update following confirmation of completed works or via annual regulatory compliance report for all regulated activity in CD&T Clinical Bord which would include mortuary activity.	
	Shaping our Population Health and Place-Based Partnerships	
QC 26/10/4.1	**Looked After Children Assessment Backlogs Update** Alison James (AJ), the Lead Nurse - Children, Young People and Family Health Services, presented the report and highlighted the following:	

	• Significant progress had been made in reducing the backlog of statutory health assessments for Looked After Children, despite increasing demand. • Medical workforce capacity remained a challenge, although the recruitment of trainee medical staff was expected to improve resilience and assessment capacity. • Delays in notifications from Local Authorities continued to impact compliance with the 28-day assessment requirement, with work ongoing to address this with partners. • Out-of-area placements remained challenging due to reliance on host UHBs to undertake assessments, whilst statutory responsibility remained with the UHB. • Progress had been supported by the transfer of under-five reviews to the Health Visiting Team, with continued improvements in assessment compliance. Claire Beynon (CB), the Executive Director of Public Health, highlighted the positive work being undertaken by the Public Health team in partnership with Cardiff Council, supported by Welsh Government (WG) funding under the Marmot programme. KW expressed concern that statutory requirements were still not being consistently met. KW asked about the extent to which non-compliance was attributable to internal capacity pressures versus delays and challenges involving partner organisations. KW asked about the costs associated with out-of-area assessments and whether reciprocal charging arrangements were in place for children within CAV from other areas. KW also asked whether further partnership working could support more children to remain within their local communities, where safe and appropriate, to improve continuity of care and access to support. AJ responded that retaining Looked After Children within CAV remained a priority, although local placement availability presented challenges requiring further partnership working. A dedicated nurse was in place to monitor the health needs of children placed outside the area. Improvement plans were in place for each stage of the assessment process, alongside partnership working to improve early notification of children entering care. Benchmarking against models across the UK was also underway. JR-IM asked whether sufficient health visiting capacity was available to undertake under-five assessments and whether alternative staff groups could provide support if required. JR-IM also asked what mechanisms were available to improve the timeliness of assessments for children placed outside the area. AJ advised that a previous pilot of a dedicated Health Visiting Team for Looked After Children had proved unsustainable due to workforce pressures. Redistributing assessments across existing Health Visitor caseloads, supported by additional training, was considered a more sustainable approach. AJ explained that improving the timeliness of out-of-area assessments remained challenging, with continued partnership working and accountability arrangements with host UHBs identified as key to improvement. JR provided the following additional comments: • The workforce model had been revised to enable trained Health Visitors to undertake assessments previously carried out by a limited number of doctors. • Further benchmarking was underway to explore alternative workforce models, including the potential role of School Nurses. • Delays in Local Authority notifications continued to impact assessment timeliness. It was agreed that the established partnership group would review opportunities to improve communication and early notification, including digital solutions.	

	The Committee resolved that: a) The update on Children Looked After was noted.	
	Shaping our Future Clinical Services	
QC 26/10/5.1	**Eating Disorder Service Review Update** Clare Quinn (CQ), the Director of Psychology and Psychological Therapies for the Mental Health Clinical Board, presented the report and highlighted the following: • The purpose of the report is to highlight progress made over the previous six months and ongoing work to achieve sustainable improvements. • Significant progress had been made in strengthening governance, leadership, multidisciplinary working, workforce recruitment and clinical oversight. • Assurance remained qualified, with continued variation in practice, particularly around physical health monitoring, clinical documentation and alignment of treatment pathways with national guidance. • A further review of 10 cases in September identified previously recognised risks and reinforced the need for continued improvement and consistent implementation of actions. • Work was underway to redesign the clinical model and treatment pathways, including the integration of two services previously operating under separate directorates. Additional specialist expertise had been secured, with a commencement date of 15th December 2026. • Identified risks continued to be monitored through established governance arrangements, the risk register and Improvement Programme. No new complaints or critical incidents had been reported during the previous three months. • Continued senior oversight, repeat audits and evidence of completed patient-level actions would be required before full assurance could be provided. RU acknowledged the improvements made but expressed concern regarding gaps in physical health monitoring, given the potential for rapid patient deterioration. RU asked for more assurance that weekly multidisciplinary reviews and escalation arrangements had addressed identified gaps and that all patients at significant clinical risk were receiving appropriate monitoring. CQ could not provide full assurance yet regarding physical health monitoring, but that dedicated clinical space had been established within one of the Community Mental Health Teams (CMHTs), alongside staff training, to strengthen physical health monitoring and address gaps in care pathways. Further progress and assurance was anticipated at a future meeting. PB reminded the Committee that the service had previously been considered unsafe, with closure deemed to present greater risk. Whilst significant improvements had been made, further work was required to address remaining gaps. Progress continued to be closely monitored, with a clear pathway towards achieving a safe service. KW asked about the remaining barriers and risks to sustaining improvement. CQ confirmed that significant cultural improvements had been made, although challenges remained in bringing together teams from different directorates. Further barriers included the need to modernise the service, align with national recommendations and implement changes. Additional expertise and external benchmarking were expected to support continued improvement and provide greater assurance.	

	PB acknowledged that resistance to adopting alternative models of care and external benchmarking remained a key risk. The importance of supporting the incoming Service Manager to drive cultural change and improvements was emphasised. **Provide a further update to the Committee on progress against the closure of the remaining assurance gaps – ACTION.** **The Committee resolved that:** a) The progress made within the Tier 3 Eating Disorder Service improvement programme was noted, including strengthened governance, leadership, workforce recruitment and multidisciplinary oversight; b) The findings of the September 2026 assurance review and the continuing requirement to strengthen consistency in physical health monitoring, clinical documentation and treatment pathway delivery was noted; c) Assurance was received that identified risks were being actively monitored through the established governance framework, risk register and improvement programme. d) Continued senior oversight, repeated audit activity and evidence of completed patient-level actions will be required before full assurance can be achieved.	
	Quality Performance Reporting	
QC 26/10/6.1	*No items.*	
	Items for Oversight / Scrutiny	
QC 26/10/7.1	**Clinical Board Highlight Reports** JR presented the reports to the Committee and highlighted the following: • Patient Tracking and Lost to Follow Up – significant concerns were identified across Specialist Services, Surgery and CD&T, with patient validation and harm reviews underway. The absence of a comprehensive digital tracking system was recognised. A wider review of existing processes and a coordinated improvement plan would be progressed through the Lost to Follow Up programme. • Mental Health Act Compliance – statutory non-compliance relating to documentation and delays in medication-related professional support was highlighted. Whilst immediate controls had been implemented, further assurance was required. Urgent work was underway to address staffing pressures within the Mental Health Legislation Assurance office. • Urgent and Emergency Care - Sustained operational pressures and deterioration in some performance measures were reported, with business continuity arrangements activated across the organisation and Medicine. • Prison Healthcare - Ongoing concerns regarding service sustainability were highlighted, particularly following notice of the proposed termination of the existing primary care Service Level Agreement. Work was underway to strengthen relationships between Primary Care and Mental Health services, alongside consideration of an external review and benchmarking exercise. • Workforce Pressures - Sustained vacancies, sickness absence and maternity leave across several services were identified as increasing risks to patient safety and service delivery. These risks would need to be considered within Executive reviews of vacancies. • Infection Prevention and Control (IPC) - Outbreaks of scabies, fleas and bed bugs within Mental Health services were being managed alongside IPC and specialist pest control teams. Some bed capacity remained closed, impacting patient flow and resulting in out-of-area placements. • Healthcare Inspectorate Wales (HIW) - Concerns had been raised regarding the sustainability of quality improvements within Meadow and Daffodil, particularly IPC, documentation and statutory training compliance. The services had been escalated to a *Service of Concern*, requiring increased scrutiny and assurance.	

PB provided the following additional comments:

- A contract had been awarded to 36 Degrees to undertake an independent review of the prison healthcare model, including service delivery, culture and working relationships. The review was expected to commence shortly and take 8–12 weeks.
- Significant concerns were highlighted regarding outpatient management, with 1.1 million follow-up appointments undertaken in the previous year, 69,000 patient's overdue follow-up appointments and 58,000 patients on Patient Initiated Follow-Up (PIFU)/SOS pathways.
- Approximately 2,000 outpatient appointments remained without recorded outcomes at any given time, presenting potential patient safety risks. Weekly monitoring had commenced to identify outcomes and ensure patients requiring follow-up were appropriately tracked.
- Approximately 2,000–2,500 appointments had been cancelled monthly across Ophthalmology and Orthopaedics, contributing to patient confusion, missed appointments and potential loss to follow-up.
- The need for a comprehensive outpatient transformation programme was emphasised, including reviewing the clinical necessity of follow-up appointments, improving pathway management and reducing unnecessary activity. A comprehensive improvement plan would be developed and presented to the Committee in early January.

Develop an organisation-wide plan to address outpatient follow-up, uncashed appointments and patients lost to follow-up, including how follow-up activity can be transformed and reduced where appropriate – ACTION.

CP welcomed the proposed outpatient transformation plan and emphasised the need to review the necessity of follow-up appointments and explore alternative approaches, including virtual consultations and telephone support.

KW asked how outpatient transformation would align with WG requirements and address performance gaps against other organisations.

KW highlighted the importance of strengthening links with the People & Culture (P&C) Committee, particularly regarding the impact of sickness absence on patient safety and workforce pressures.

JR-IM requested that reports include clearer explanations of acronyms and abbreviations.

JR-IM highlighted concerns regarding the potential loss of accreditation for the Endometriosis Service beyond December 2026 and the associated risks to patients.

JR-IM highlighted the continued reporting of incomplete DALs as a significant risk, despite improvements and assurance earlier in the meeting.

Chris Bown (CB-CEO), the Interim Chief Executive Officer, provided assurance that the necessary actions to secure endometriosis accreditation had been identified and would be implemented, alongside wider opportunities to strengthen regional service provision.

CB-CEO emphasised the need for outpatient transformation, including greater use of digital solutions, reducing unnecessary follow ups and redirecting resources towards care that delivered greater patient benefit.

KW highlighted the need for clearer, more specific actions in the Clinical Board AAA highlight reports, including defined timescales and accountable leads.

	DF explained that progress had been made in discharge summary completion, with improved visibility and monitoring through timestamping, although further work was required. CB raised concern regarding sepsis management and the number of NRIs and suggested a future audit against NICE guidelines to provide further assurance. **Review the existing sepsis audit arrangements and bring the findings back to Committee to provide further assurance on compliance with sepsis guidelines and identify any areas for improvement – ACTION.** **The Committee resolved that:** A) The Clinical Board Highlight Reports were noted for assurance.	
QC 26/10/7.2	**Clinical Effectiveness Committee (CEC) Highlight Report** AS introduced the report from September's CEC meeting and highlighted the following: • Presentations were received in relation to the National Audit of Metastatic Breast Cancer and the National Primary Breast Cancer Audit, highlighting data collection and reporting challenges following the transition to the Welsh Clinical Portal (WCP). • The transition meant for the metastatic cancer audit, there was only data available for 4 of the 10 KPIs, whilst in primary breast cancer all 10 were available. Additionally, the audits related to data from 2021-23, which meant some information was outdated. • Adjuvant therapies data was collected and submitted by Velindre on behalf of organisations across Wales but provided an inaccurate oversight of the proportion of CAVUHB patients who had access to these therapies. This was being addressed with Velindre and would be corrected moving forward. • Strong performance was reported in Clinical Nurse Specialist involvement, multidisciplinary team working and three-year survival rates, which were above or in line with national averages. • Performance below national averages were identified in breast-conserving surgery, offers of immediate reconstruction surgery and reoperation rates. • Work was ongoing with plastic surgery to put in place a flat perforation pathway to offer women great choice following mastectomy, for breast conserving surgery and offering lumpectomy to a greater proportion of women. • Local audit demonstrated improvements in immediate reconstruction rates from 15% to 25%. Further scrutiny of reoperations and consideration of enhanced imaging was underway to improve surgical outcomes. CP asked for further clarification around Wales being limited to receiving the annual report with data relating to care provision three years prior. AS responded that this was not unusual for their national audits, with more national audits moving towards being able to report data with a relatively small time lag. The wider cancer audits were moving to this approach, however the Welsh transition to WCP restricted this and was a national issue. From early 2027, they would receive quarterly reports. KW highlighted the need for the UHB to challenge national audit data limitations but recognised strong clinical outcomes and opportunities to improve patient experience and quality. KW sought further assurance regarding reoperation rates, and emphasised the need for clear, definitive improvement actions rather than proposals under consideration, to demonstrate measurable progress against national benchmarks.	

	AS responded that delivery of triple diagnostic clinics was below the national average, which reflected challenges in delivering mammograms alongside other diagnostic assessments. Wider radiography improvements, including 3D mammography and service standardisation, were underway. **Circulate a note providing greater clarity on the specific improvement actions to improve benchmarking nationally, particularly in relation to breast surgery/re-operation rates – ACTION.** KW highlighted the significant impact of reoperations on patient experience and surgical capacity. CB emphasised the importance of breast cancer prevention, particularly modifiable risk factors including obesity, smoking, physical inactivity and alcohol consumption. CB asked how long it would be before the 10 indicators become available, and whether they had a plan for improvement on data quality. AS responded that progress towards all 10 national indicators remained dependent on the national Cancer Informatics Programme, led by NHS Performance & Improvement (P&I), but the UHB continued to support this work. JR-IM raised concern regarding the prolonged transition to the new WCP, which continued to hamper data reporting and service improvement. **The Committee resolved that:** A) The assurance provided by the clinical performance reported in the national audits and the improvement work that was underway to address requisite improvement was noted.	
QC 26/10/7.3	**Summary of Recent Healthcare Inspectorate Wales (HIW) Inspection Reports** AS presented the report and highlighted the following: • No secondary care HIW inspections had taken place since the previous meeting. One dental clinic inspection was reported, with positive findings and minor recommendations relating to policies and environmental improvements. • Primary Care follow-up arrangements were in place to oversee improvement plans and provide assurance on actions arising from inspections. • Ongoing oversight of secondary care HIW improvement plans continued through Clinical Board scrutiny and Executive Performance reviews. • Recurring Mental Health inspection themes included environmental concerns, documentation, risk assessments and mandatory training compliance. Work was underway to strengthen the accountability framework across wards and provide sustained assurance. **The Committee resolved that:** A) The actions taken in response to recent HIW inspection findings across primary care services were received for assurance. B) The progress of associated improvement plans was noted. C) The continued organisational learning arising from inspection activity was endorsed.	
QC 26/10/7.4	**Public Services Ombudsman for Wales Annual Letter 2025-26** AH presented the report and highlighted the following: • Across NHS Wales, complaints to the Ombudsman increased by 42%, with hospital clinical treatment remaining the most common reason for complaints.	

	• CAVUHB received 230 complaints, with 216 closed and 38 interventions, representing an 18% intervention rate, compared with the Welsh average of 22%. No public reports were issued. • Clinical treatment accounted for 52% of complaints, with other themes including appointments, mental health, patient lists and referral to treatment. • The Ombudsman made 86 recommendations, with 71% of recommendations due during the reporting period completed within agreed timescales, slightly above the Welsh average of 69%. Improving compliance remained a priority. • A newly appointed Ombudsman Lead would support training across Clinical Boards, strengthening understanding of recommendations, evidence requirements and compliance monitoring. • The importance of robust, objective investigations, openness, transparency and compliance with the statutory Duty of Candour was emphasised. • Arrangements were in place to monitor compliance and share learning across Clinical Boards, including lessons from Ombudsman reports relating to other organisations. • The annual letter provided reasonable assurance, although further improvement was required in the timely completion and evidencing of recommendations. KW sought further assurance on the specific actions planned to improve compliance with Ombudsman recommendations and demonstrate measurable improvement in the next annual letter. AH responded that work was underway to strengthen compliance with Ombudsman recommendations, including earlier engagement with Clinical Boards, clearer evidence requirements, regular monitoring and improved data tracking. Greater emphasis was placed on raising awareness of mandatory compliance, with early improvements already evident. CB asked what 'premature complaints' meant in Appendix D. CB asked about the proportion of complaints relating to staff attitude and behaviour. AH clarified that premature complaints referred to cases submitted to the Ombudsman before the UHB had an opportunity to investigate, which were subsequently referred back. AH responded that complaints related to staff attitude and behaviour were monitored, with a listening campaign being developed to strengthen communication and support difficult conversations. Unacceptable behaviour would be addressed through appropriate professional processes. **The Committee resolved that:** a) The Health Board's compliant, intervention and recommendation-compliance performance was noted; b) Continued monitoring of outstanding and future Ombudsman recommendations through established governance arrangements was supported.	
QC 26/10/7.5	**Annual Reports** Duty of Candour Annual Report 2025/26: Application of the Process, Themes, Trends and Staff Survey Findings AH presented the report and highlighted the following: • The Duty of Candour Report provided partial assurance - whilst processes were established, further work was required to demonstrate compliance, transparency and organisational learning.	

	• Of the 216 Duty of Candour records reviewed, 178 (82%) had been closed, with the remainder under investigation or awaiting review or closure. • Key themes included delays in referrals and follow-ups, diagnostic failures, surgical care, patient deterioration, pressure damage, medication incidents and falls. • Concerns were identified around handover arrangements, accountability and communication between teams, highlighting the need for improved patient tracking and escalation processes. • Gaps in recording and evidencing compliance with statutory requirements were identified, particularly around patient communication, written notifications and sharing investigation outcomes. • A staff survey identified that 80% of respondents were aware of the Duty of Candour, although only 54% felt confident undertaking conversations, highlighting the need for further training and support. • Improvement priorities included timely incident reviews and harm assessments, strengthened documentation, staff training and improved communication with patients and families. • Further work was required to move beyond procedural compliance and demonstrate meaningful learning, openness and improvements in patient experience. JR highlighted concerns regarding Duty of Candour compliance, including inconsistent interpretation of requirements, gaps in documented evidence and incident backlogs potentially delaying the identification of patient harm. JR noted that a dedicated improvement group and framework would be established, with Clinical Boards held accountable for strengthening compliance and demonstrating sustained improvement. CB noted concern that 20% of the staff survey respondents did not know what the Duty of Candour was and 52% had not received the training. CB asked whether the Duty of Candour training was mandatory and whether specific staff groups should be prioritised. AH clarified that the Duty of Candour survey included non-clinical staff, with plans to repeat and better target the survey to improve representation. Targeted training was underway across professional groups, including nursing, medical and therapy staff, with further priorities to be identified across Clinical Boards. The mandatory status of training would be confirmed, with continued emphasis on practical, case-based training to strengthen staff confidence and compliance. KW emphasised the need for a cultural shift in Duty of Candour, moving beyond procedural compliance towards meaningful learning, improved practice and patient outcomes. KW sought assurance that the improvement plan would focus on measurable impact, with clear Clinical Board accountability and future reporting to demonstrate sustained progress. **The Committee resolved that:** a) The report was received for assurance; b) The recommendations to improve the process and assurance were endorsed.	
	Mental Health Legislation	
QC 26/10/8.1	**Consent** Natasha Goswell (NG), the Deputy Executive Nurse Director, presented the report and highlighted the following: • The Welsh Risk Pool (WRP) National Review of Decision Making and Consent provided reasonable assurance, with full compliance in policy management and	

	consent forms, partial compliance in procedure specific patient information and training, and non-compliance in monitoring and review. • Gaps were identified in the absence of a consistent UHB-wide audit and peer review programme. • Overall training compliance exceeded the 85% standard, although medical and dental staff compliance remained below the required level. • An electronic consent pilot was being developed within General Surgery to strengthen monitoring and assurance. • A Consent Assurance Programme was planned for March 2027, supported by quarterly reporting to the Committee. Progress against the improvement action plan would be overseen by the Consent Lead and Consent Group. CB asked about progress towards adopting the All-Wales peer review tool and methodology for consent monitoring, as referenced in the report. NG responded that the All-Wales consent peer review programme was scheduled for rollout from March 2027. CP asked about the actions being taken to address low consent training compliance amongst medical and dental staff. NG responded work was underway to improve medical and dental consent compliance and representation within the Consent Group, with Clinical Boards being asked to nominate representatives. JR highlighted that medical training compliance reporting was affected by a national issue with incompatible ESR and Shared Services systems, potentially understating actual compliance. Work was ongoing locally and nationally to resolve this. **The Committee resolved that:** a) The WRP's overall Reasonable Assurance rating was received for assurance, whilst noting the areas of patrial and non-compliance identified in the review; b) The action plan developed in response to the recommendations was noted, including the priority actions relating to Procedure Specific Patient Information Leaflets (PSPIL) governance, training compliance and the establishment of a UHB-wide consent audit and peer-review programme; c) The continuing assurance gap arising from non-compliance in monitoring and review was noted, and the need for sustained executive and Clinical Board oversight; d) Quarterly progress reports would be received setting out delivery against the action plan, training compliance by staff group, audit findings, outstanding risks, escalations and evidence that improvements have been completed and sustained.	
QC 26/10/8.2	**Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS)** NG presented the report and highlighted the following: • The Q2 Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) report highlighted improvements following the June 2026 Supreme Court judgement, with DoLS referrals reducing from 522 to 337 and waiting lists from 59 to 11. • Average waiting times for best interest allocation reduced from 13 to 4 days, reflecting strengthened referral processes, communication and training. • Declining mandatory MCA training compliance remained a key concern, with Clinical Board improvement plans in place and regular monitoring arrangements established. • Independent Mental Capacity Advocate (IMCA) referrals reduced by 50% compared with the previous year, and reduced Section 39D activity reflected fewer DoLS	

	authorisation. The reason for fewer long-term accommodation referrals remained unclear and would continue to be monitored. • The MCA team would operate at reduced capacity until April 2027, with prioritisation arrangements in place to manage demand. • Implementation of the All-Wales Advocacy Contract had been deferred until April 2027. CP suggested that mandatory training compliance be referred to the P&C Committee for further review. **Confirm why the number of MCA advice/support requests attributed to Corporate/Executive areas was comparatively high – ACTION.** **Raise the recurring issues regarding training compliance with the P&C Committee, including consideration of barriers to compliance and the distinction between statutory, mandatory and other training requirements – ACTION.** AS suggested that the high number of Corporate and Executive MCA referrals may reflect the team's involvement in patient safety incidents and mortality reviews. JR-IM noted that the volume of statutory and mandatory training was recognised as a potential barrier to completion and highlighted the need for more engaging approaches. AH added that low mandatory training compliance was highlighted as a risk to the WRP reimbursement, with compliance below 80% requiring an improvement trajectory before Learning from Events reports could be approved. CB-CEO recognised the significant volume of mandatory training was a barrier and highlighted the need to review and clearly distinguish between statutory, mandatory and optional training requirements to ensure expectations were realistic and manageable. **The Committee resolved that:** a) The Q2 position for MCA and DoLS activity was noted, including the impact of the AGNI judgement, the reduction in referrals and waiting times, and the continued monitoring of IMCA referral trends; b) The decline in mandatory MCA training compliance was noted; c) A further update on the impact of Clinical Board action plans would be received, including areas of continuing non-compliance, at the next reporting cycle; d) The mitigations in place for reduced MCA Teams capacity and the revised implementation date of 1st April 2027 for the All-Wales Advocacy Contract were noted.	
	Policies for Approval	
QC 26/10/9.1	*No policies for approval.*	
	Items for Noting / Information	
QC 26/10/10.1	*No items for noting / information.*	
	Any Other Business	
QC 26/10/11.1	**To bring an update on EPMA back to a future Committee (either Quality Committee or the Finance and Performance Committee) – ACTION.**	
	Review of the Meeting	

QC 26/10/12.1	Committee members were asked to fill out the Committee Self-Effectiveness survey.	
	Date & Time of Next Meeting:	
QC 26/10/13.1	*30th November at 9am via MS Teams*	