Confirmed Minutes of the Public Quality Committee

Held on 9th December 2025 via MS Teams

To view the meeting: https://youtu.be/LPEM6Wmhkug

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Mike Jones	MJ	Independent Member – Trade Union
Rhian Thomas	RT	Committee Vice Chair / Independent Member – Capital & Estates
In Attendance		
Claire Beynon	CB	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Natasha Goswell	NG	Deputy Executive Nurse Director
Angela Hughes	AH	Assistant Director of Patient Experience
Matt Phillips	MP	Director of Corporate Governance
Suzanne Rankin	SR	Chief Executive Officer
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
Additional Attendees		
Michael Allum	MA	Consultant in Public Health
Rim Al Samsam	RAS	Clinical Board Director – Mental Health
Susie Boxall	SB	Strategic Lead for the Lived Experience Team
Rachel Dix	RD	Interim Deputy Director of Mental Health Nursing
Robert Mahoney	RM	Deputy Director of Finance (Operational)
Tara Robinson	TR	Director of Nursing – Mental Health Clinical Board
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Lauranne Cullen	LC	Regional Director for Llais
Clive Curtis	CC	Independent Member - Community
David Fluck	DF	Executive Medical Director
Angela Hughes	AH	Assistant Director of Patient Experience
Stephen Riley	SR	Independent Member – University

		ACTION
QC 2025/12/1.1	**Welcomes, Introductions & Apologies** Ceri Phillips (CP), the Committee Chair, welcomed everyone to the meeting in English & Welsh. Apologies for absence were noted.	
QC 2025/12/1.2	**Declarations of Interest** No declarations of interest were raised.	

QC 2025/12/1.3	**Minutes of the Committee meeting held on 28.10.2025** The minutes of the Committee meeting held on 28.10.2025 were received. **The Committee resolved that:** a) The minutes of the meeting held on 28.10.2025 were approved as a true and accurate record of the meeting.	
QC 2025/12/1.4	**Action Log following the Meeting held on 28.10.2025** The Action Log following the Meeting held on 28.10.2025 was received and discussed. **QC 2025/10/2.1 - UHB Quality Indicators Report** - Matt Phillips (MP), the Director of Corporate Governance, explained that there was overlap between the SPC training request and work with the Welsh Government (WG) Quality Framework. There was a plan for this to be discussed at a future Board Development meeting. **The Committee resolved that:** a) The Action Log from the meeting held on 28.10.2025 was noted.	
QC 2025/12/1.5	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QC 2025/12/2.1	**UHB Quality Indicators Report** Alexandra Scott (AS), the Assistant Director of Quality and Patient Safety, presented the Quality Indicators Report and slides which provided assurance in relation to several quality, safety and patient experience priorities. It provided data through the end of October 2025 where available and detailed ongoing actions to drive necessary improvements. Additionally, it included exception reporting to highlight emerging trends and issues related to quality and patient safety. Rhian Thomas (RT), the Committee Vice Chair, asked why the target implementation date for the WHO checklist implementation was for April 2026, and whether extensive consultation and stakeholder engagement was necessary for successful implementation versus expediting. RT asked what the initial findings were since the rollout of EPMA in July. RT suggested discussing Keeping Me Well at a future Committee to consider its scope and impact on services. Paul Bostock (PB), the Chief Operating Officer, explained that the WHO checklist had already been overhauled with five steps being adhered to. Compliance was being audited, and findings were shared with the Senior Leadership Team the previous week. Processes had been tightened since the theatre review in May and clarified that they were not waiting until April 2026 to act. The paper referred to broader work around improving safety culture. AS added that the WHO collaborative co-designed principles for the national checklist, supported by executive-led engagement across surgical teams. Assurance work followed on the uptake of those principles, leading to a standardised team brief for safety	

	checks before surgery. Visible tools (e.g. a whiteboard) were being introduced to ensure consistency without adding unnecessary burden, covering key risks like implants, transfusions, and allergies. Regarding EPMA, AS suggested she link with the EPMA team and provide further detail in the following Quality Indicators report - **ACTION**. Regarding the Keeping Me Well website, AS responded that one of their highest reported patient safety incidents was falls - significant work was underway on falls prevention including exercise, medication safety, and home safety. Claire Beynon (CB), the Executive Director of Public Health, commented that the lung cancer screening programme was a positive step for Wales, enabling earlier detection and better outcomes. However, they must maintain focus on tobacco prevention and reducing levels of smoking across the population. Suzanne Rankin (SR), the Chief Executive Officer, noted that whilst the report included extensive data and narrative, most trajectories appeared flat. The focus should shift from activity reporting to clear improvement objectives and outcomes. Jason Roberts (JR), the Executive Nurse Director, commented that EPMA had rolled out in UHW Medicine, Surgery, and EU, with a further rollout planned for UHL. Early feedback showed reduced administration errors but highlighted prescribing issues. More data was expected by the end of December. Provide a report to the Quality and Safety Committee in January 2026 detailing the EPMA programme trajectory, including ward rollout and data on medication errors or emissions from live wards – **ACTION**. JR added that the Executives had been in conversations around how best to demonstrate data and trajectories moving forward. Report the data on WHO safety checklist compliance, including recent audit results, to the Committee at a future meeting – **ACTION**. CP suggested having a conversation outside of the meeting to discuss how best to present tangible results for the Committee's assurance – **ACTION**. **The Committee resolved that:** 1) The assurance provided by the Quality Indicators was noted; 2) The work underway to drive requisite improvements was noted.	
QC 2025/12/2.2	**Mental Health Clinical Board Quality Indicators Report** Susie Boxall (SB), the Strategic Lead for the Lived Experience Team, presented a patient story to the Committee, and summarised the following: • The patient was sectioned and diagnosed with bipolar disorder in his 60s, having also experienced psychosis. • He engaged with the Recovery and Wellbeing College, taking courses on understanding and living well with bipolar, anxiety, depression, and psychosis, which helped him better understand and manage his illness. • The education and peer support from the College reduced his fear of his symptoms, improved his self-identity, and enabled him to redefine himself beyond his diagnosis. • His recovery journey included lifestyle changes, medication, and education, with the College's group setting and peer trainers providing valuable support.	

	• He later became a peer trainer himself and piloted a veteran's course. The Mental Health Clinical Board presented their assurance report and slides to the Committee which detailed the achievements, progress and planned actions within the Mental Health Clinical Board to maintain the priority of QSPE. Topics discussed included, but were not limited to: • SIRAN Accreditation • Introduction of the Family Liaison Officer (FLO) • Patient Safety Reviews and Nationally Reportable Incidents (NRIs) • Overview of Identified Issues • Review and Thematic Mapping • Significance and Next Steps • Complex Emotional Needs (CEN) Pathway – Overview • Key Improvements to Provision • Preparing for Discharge Course – Overview, Outcomes, & Impact • National Recognition and Expansion • Recovery College – Service Overview, Accessibility, and Participation • Out of Area Bed Usage – Overview, Factors Driving the Increase, Addressing the Challenge (Hazel Ward Reopening), and Ongoing Evaluation JR provided the following comments: • The out-of-area placements had been driven by operational teams but wished to highlight the quality impact – placing patients in the right area improved experience and outcomes. • Overdue NRIs had reduced by 50%, which was vital for patients awaiting critical information. • A protocol regarding lethal substances had been developed to address risks from new and emerging methods, following national concerns. • He had visited the Recovery College and praised their excellent work. SR informed the Committee that she and Mike Jones (MJ), the Independent Member – Trade Union, had visited the Beech Ward that morning. SR suggested the need for better datasets that better reflect mental health care. Current indicators like falls and pressure ulcers were less relevant, but they should consider specific metrics such as medication complications or ECT treatments. Some audits, for example bare below the elbow, may not apply. SR suggested that the staffing levels and establishments needed clarity, as vacancies and funding changes impacted on quality, and staff on the Beech Ward felt that they were short-staffed. Regarding bare below the elbow, Tara Robinson (TR), the Director of Nursing – Mental Health Clinical Board, responded that Wales had a uniform policy requiring this, but mental health inpatient areas had historically allowed own clothing for therapeutic reasons. They would review whether uniform requirements remained appropriate. Regarding safe staffing levels, TR clarified that they were working to professionally agreed safe staffing levels, not budgeted. She wondered whether there was a discrepancy over perceptions on what was professionally agreed. SR suggested clarifying the narrative of what was considered safe staffing levels. TR agreed that engagement needed to improve so that the information was cascaded to Band 2 staff and upwards, so the whole team were included in conversations.	

	CB informed the Committee that she chaired the Area Planning Board meeting on substance misuse and noted delays in patients accessing UHB treatment. She asked what their plans were around dedicated leadership for addiction services. TR responded that recruitment challenges had affected timely access to addiction services. The Clinical Board was addressing this with the new Director of Operations, but that this remained a priority. Rim Al-Samsam (RAS), the Clinical Board Director – Mental Health, noted that they had approved this re-vacancy the previous week, so hopefully it would improve. JR clarified that all clinical areas required staff to be bare below the elbow, and so it was apparent there had been miscommunication. JR explained that he was facilitating a meeting between TR, the team, and 36 Degrees to review nationally monitored datasets for mental health. **The Committee resolved that:** 1) The assurance provided by the Mental Health Clinical Board in this report and the steps being taken to improve quality, safety and patient experience was noted.	

QC 2025/12/2.3	**Tackling the Planned Care Challenges – risks / incidences of harm**
	
	Paul Bostock (PB), the Chief Operating Officer, provided the following summary:
	• The safest approach was no waiting list, but they had made significant progress:
	  o Patients waiting over 2 years had reduced from 9000+ to around 650 by year-end
	  o Over 3-year waits had reduced from almost 1000 to 20
	• Managing 130,000 patients across multiple pathways was challenging
	• Initiatives included the Waiting Well Service, with 6000+ patient contacts supporting pain and weight management. It had resulted in some patients not needing intervention.
	• Balancing resources between Waiting Well and clearing lists remained crucial.
	
	AS provided the following summary to the Committee:
	• Discussions had started on how to develop a more systematic approach to identifying harm for patients on waiting lists.
	• They proposed 6 potential indicators within the report.
	• Data collection would take time, but they aimed to start scrutinising their Datix system to analyse the number of incidents and concerns raised by patients on the waiting list, and to scrutinise alongside how long they had been on the waiting list.
	• They had systems in place using patient reported outcome measures to measure generic health outcomes (e.g. EQ5D in place in Orthopaedics), number of deaths on the waiting lists, referrals from the medical examiner, and number of emergency admissions.	

SR noted her concern that these reports reflected harm after the event. She asked whether any system did proactive, risk-based monitoring (similar to Ophthalmology prioritising patients at risk of sight loss).

AS responded that most indicators identified harm retrospectively, except EQ5D, which could track functionality and health impacts. Operationalising this for prioritisation may be challenging, but they did have protocols for expediting patients based on previous work in Wales and relationships with independent providers, primary care, and neighbouring UHBs.

SR asked whether any other region had achieved this. SR also asked whether they provided safety-netting advice to patients on the waiting lists (e.g. guidance on when to return if certain symptoms or thresholds appeared).

AS responded that they were good at safety-netting after first contact, but for patients still waiting for an initial assessment, this was less clear.

PB responded that waiting lists were far longer than experienced before, which was an uncomfortable position.

SR commented that the only way would be safety-netting, which required a cultural shift, so patients owned their own care and were confident to know what to do, which was difficult.

PB noted that they had Patient Initiated Follow Up (PIFU) and See on Symptoms (SOS), but engagement had been challenging. These approaches helped to safety-net and create capacity, but with such overwhelming numbers, it was hard.

CP noted that a clinically driven target focused on maximising outcomes would allow safety-netting and prioritisation when thresholds were met. Current time-based targets limited this approach.

CP asked about the expected timescales for the indicators.

AS responded that over the following four months, they aimed to start extracting data from Datix and cross-referencing with BIS, given the large patient numbers. Datix's functionality may require exporting, and they would need discussions with other specialties beyond Orthopaedics to introduce EQ5D.

Bring back an update on data extraction and harm indicators for patients on the waiting list to the Committee within four months – **ACTION**.

CB highlighted that if left unaddressed, it could worsen inequalities. People in deprivation often delayed coming forward, so they may spend less time on the waiting list but had greater need.

JR asked whether someone within Claire's team could help advise.

	For EQ5D, CP suggested using the five-level measure rather than the three-level for better specify. **The Committee resolved that:** 1) The reduction in volume and length of patient waits was noted; 2) The six indicators suggested to assess risk of protracted waits to patient experience and outcomes was noted.	
QC 2025/12/2.4	**Care After Death Processes and Learning from Mortality** Aled Roberts (AR), the Associate Medical Director Patient Safety and Clinical Effectiveness, provided the following summary: • Care After Death was a key issue under increased scrutiny following delays producing Medical Certificate of Cause of Death (MCCDs) last winter and related press coverage. • Wales differed from England, with more external scrutiny via the Medical Examiner Service. • They had moved from paper to a QR code digital system, both in reporting to the Medical Examiner Service and to the coroner, improving turnaround times for MCCDs from 15 days last winter to about 5 days (although flu season may challenge this). • The measures being implemented for the winter were detailed within the report. • They also scrutinised all deaths returned by the Medical Examiner and now reviewed coroner cases not going to inquest to extract learning. These fed into mortality scrutiny processes for appropriate review. • An early flu season would test these improvements. Robert Mahoney (RM), the Deputy Director of Finance (Operational), added that his own experience highlighted that the main issue lay with the Local Authorities (LAs) and funeral director processes, not with the medical examiner. AR noted that WGs work had involved LAs and funeral directors. Sadly, not everybody received an MCCD within 3 days. Moving bodies from mortuaries to funeral homes remained a challenge. It was a complex system with many steps, but significant work and scrutiny was now in place. CP highlighted that one emerging theme noted significant deaths among patients with liver disease and asked whether there was a reason. AR responded that this was a common theme in a lot of cases over the past few months – usually alcohol related liver disease was a significant factor. **The Committee resolved that:** a) The Care After Death processes in CAV and preparation for winter was noted; b) This summary of Mortality Scrutiny being undertaken within CAVUHB was acknowledged; c) The learning efforts and partnerships in place to embed learning arising from mortality scrutiny and subsequent internal UHB review was recognised.	
	Items for Approval / Ratification	
QC 2025/12/3.1	**Policies** *No policies for approval.*	

QC 2025/12/3.2	**NHS Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR)** RM provided the following summary to the Committee: • IPFR needed a review as it was a sensitive and highly scrutinised area, often subject to legal challenge. • The policy had not been updated for some time, and a recent NHS Wales Joint Commissioning Committee (JCC) case prompted changes. These were minor but important, ensuring consistent application across Wales. • The key update was that where something was not recommended for use, but an application was made to access this treatment, that appropriate consideration of the potential benefit to the patient and value for money was considered. • The paper outlined these changes, which required governance approval and Board ratification. **The Committee resolved that:** A) The report was noted; B) The implementation of the updated NHS Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR) for operational use in CAVUHB as part of the All-Wales rollout was approved and endorsed.	
	Items for Noting & Information	
QC 2025/12/4.1	**Minutes from the Clinical Board QSE Sub-Committees** **The Committee resolved that:** 1) The Clinical Board QSE Sub-Committee minutes were noted.	
QC 2025/12/4.2	**Safeguarding Steering Group (SSG) Minutes** *The November SSG meeting was cancelled.*	
QC 2025/12/4.3	**IP&C Group Minutes** **The Committee resolved that:** A) The minutes were noted.	
QC 2025/12/4.4	**Annual Director of Public Health Report 2025** **The Committee resolved that:** A) The minutes were noted.	
	Agenda for Private Quality Committee Meeting	
QC 2025/12/5.1	*i) Minutes and Action Logs from the Private QSE Committee on 28.10.2025* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*	
	Any Other Business	
QC 2025/12/6.1		
	Date & Time of Next Meeting:	
QC 2025/12/7.1	20th January 2026 at 2pm via MS Teams	