Confirmed Minutes of the Public Quality Committee

Held on 2nd June 2026 via MS Teams

To view the meeting: https://youtu.be/OAu9zSp2tvE

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Judi Rhys	JRH	Independent Member – Third Sector
Rachna Upadhya	RU	Independent Member - General
Kirsty Williams	KW	UHB Chair
In Attendance		
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
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
Catherine Wood	CW	Deputy Chief Operating Officer
Additional Attendees		
Michael Allum	MA	Consultant in Public Health
Jessica Castle	JC	Director of Operations – Specialist Services Clinical Board
Abigail Holmes	AH	Clinical Board Director for Children & Women
Pamela Johnston	PJ	Independent Advisor – NHS Performance & Improvement
Natalie Vanderlinden	NV	Designated Education Clinical Lead Officer
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Paul Bostock	PB	Chief Operating Officer
Lauranne Cullen	LC	Regional Director for Llais
David Fluck	DF	Executive Medical Director
Suzanne Rankin	SR	Chief Executive Officer
Stephen Riley	SR	Independent Member – University

QC 2026/06/1.1	**Welcomes, Introductions & Apologies** Ceri Phillips (CP), the Committee Chair, welcomed everyone to the meeting in English & Welsh. Apologies for absence were noted.	ACTION
QC 2026/06/1.2	**Declarations of Interest** No declarations of interest were raised.	
QC	**Minutes of the Committee meeting held on 14.04.2026**	

2026/06/1.3	The minutes of the Committee meeting held on 14.04.2026 were received. **The Committee resolved that:** a) The minutes of the meeting held on 14.04.2026 were approved as a true and accurate record of the meeting.	
QC 2026/06/1.4	**Action Log following the Meeting held on 14.04.2026** The Action Log following the Meeting held on 14.04.2026 was received and discussed. **The Committee resolved that:** a) The Action Log from the meeting held on 14.04.2026 was noted.	
QC 2026/06/1.5	**Committee Chair's Actions** No Chair's Actions were raised.	
	Quality Performance Reporting	
QC 2026/06/2.1	**Quality Performance Report** Alexandra Scott (AS), the Assistant Director of Quality and Patient Safety, presented an overview of the development of a new Integrated Performance Report (IPR), replacing the existing quality indicators report. AS summarised the following: • The revised approach would use statistical process control (SPC) charts to better identify trends, variation, and the impact of improvement activity, which supported more robust assurance. • The Standardised IPR would provide a single, consistent source of performance and quality information across the organisation, reduce duplication and improve alignment across Committees. • Phase 1 would focus on statutory and nationally required indicators (including performance, quality & safety, and equity measures), with initial reporting expected by July 2026. • Phase 2 would expand the report to include more detailed and outcome-focused indicators aligned to organisational priorities and the Shaping our Future of Quality Excellence (SOFQE) Programme. • Further work was needed to agree how the report would be used by the Committee. Claire Beynon (CB), the Executive Director of Public Health, noted that the suitability of the proposed methodology depended on the frequency of data collection, and emphasised the importance of applying the approach selectivity and appropriately. Kirsty Williams (KW), the UHB Chair, asked whether they had the capacity, capability and data to deliver this ambition, and what the key risks were. AS responded with the below: • Phase 1 would standardise reporting of existing quality indicators to improve clarity and support more informed discussions • Phase 2 involved wider organisational engagement with colleagues to identify additional indicators that provided stronger assurance and supported improvement, rather than being limited by current data availability.	

	Vicki Burrell (VB), the Senior Service Improvement Programme Manager, explained that several measures were already within existing SOFQE Programme workstreams, but there were ongoing challenges regarding the availability and reliability of data. KW expressed concern regarding data gaps limiting assurance. KW asked when Phase 1 would end and Phase two would start. AS responded that Phase 1 was expected to be largely complete and operational by July, with Phase 2 indicators to be developed and in use by November/December. JR responded that this was an ongoing process to improve how quality was communicated across the organisation. Positives included a consistent template, improved trend analysis, and integration of equity into the quality agenda. Key concerns related to ensuring data was accurate, consistent, and standardised. Capability to support this would be developed through the Quality Management System (QMS). Judi Rhys (JR-IM), the Independent Member – Third Sector, asked what progress would be expected at upcoming Quality Committees, how this would be monitored for accountability, and how it would ultimately contribute to improving quality. AS responded that Phase 1 would be presented in July's Quality Committee, alongside proposals for developing Phase 2 quality indicators to ensure oversight and alignment with improvement goals. This would remain an ongoing programme, requiring collaboration with individual teams to define meaningful measures. CB explained that their vision in the strategy was for unfair differences in health outcomes to reduce. An internal audit had therefore been commissioned to assess the organisation's ability to collect protected characteristics data, with a subsequent focus on ensuring services used this data to identify and address inequalities. Rachna Upadhya (RU), the Independent Member – General), asked whether they could include an assessment of data quality (such as frequency of collection and confidence levels), so they could better judge accuracy, identify gaps and avoid false assurance. AS agreed the inclusion of confidence levels in the IPR would strengthen the interpretation of indicators. Phase 1 focused on indicators with robust data, whilst acknowledging areas needing improvement, for example clinical coding. Catherine Wood (CW), the Deputy Chief Operating Officer, provided assurance that a robust improvement plan was in place around clinical coding. **The Committee resolved that:** A) The Quality Performance Report was noted for assurance.	
	Strategic Portfolio: <u>Providing Outstanding Quality</u>	
QC 2026/06/3.1	**Board Assurance Framework (BAF)** Matt Phillips (MP), the Director of Corporate Governance, highlighted the following: • The BAF aligned organisational strategic objectives with Board-defined risk themes. • Feedback from the UHB Board meeting at the end of May 2026 had since been incorporated and shared with Executive leads. • Risk summaries had been streamlined from a detailed document into concise statements to improve clarity and usability at Board level. • The key strategic risks for this Quality Committee were:	

	○ i) Quality - there is a risk that workforce, digital, capacity and estate constraints, combined with weak escalation and organisational learning, lead to inconsistent and unsafe care, resulting in avoidable harm, poorer patient outcomes, long waits, reduced patient experience and diminished public trust ○ Health equity - There is a risk that insufficient investment in prevention, worsening socio-economic determinants, inequitable access and poor data limit the Health Board's ability to address inequalities, resulting in widened life expectancy gaps, higher morbidity in deprived populations and increased long-term demand on services • The Committee should use the BAF as an oversight tool and request deep dives on relevant risk areas. Future Board discussions were expected to focus increasingly on mitigations rather than risk identification • Work was underway to align the centralised risk register to strategic risk themes • Further development was planned to link intelligence from Clinical Boards, clinical safety groups and organisational datasets into Committee-level oversight KW noted concern regarding how effectively the BAF demonstrated gap closure and tracked progress over time. Additionally, KW suggested the need to strengthen linkages between the BAF and the corporate risk register. MP emphasised that the BAF should set the strategic context, with its value realised through Committee discussions and the agenda in driving action and assurance. MP supported using strategic risk themes to filter and escalate relevant risks to Committee level, supported by prior scrutiny (e.g. at Clinical Safety Groups). CB suggested reviewing the health equity strategic risk alongside the biannual Equity, Equality, Experience and Patient Safety Framework update, with a focus on gap assurance. CB also suggested periodic deep dives into other BAF risks, particularly quality, linked to relevant agenda items to support focused scrutiny. CP suggested retaining the BAF item on the agenda whilst discussions were ongoing. **The Committee resolved that:** A) The contents of the 2 Quality Committee aligned strategic risks – Quality and Health Equity – were noted; B) How the Committee wished to receive and use the BAF within the architecture of the new Committee format was discussed.	
QC 2026/06/3.2	**Shaping our Population Health and Place-Based Partnerships** 3.2.1 - Update for Women's Health Hubs Michael Allum (MA), a Consultant in Public Health, provided the following summary to the Committee: • The purpose of the report was to provide assurance that the UHB was delivering against the Women's Health Plan from Welsh Government (WG). • The Women's Health Hub was was a primary care cluster-based model established in Cardiff East, and began seeing patients in February 2026, and provided menopause care alongside a wider holistic offer. • The Hub continued in the current financial year due to cluster funding, which enabled evaluation of impact and sustainability	

	• Wider progress had been made across the Women's Health Plan, supporting long-term service development and strong engagement across the UHB • Work was ongoing to expand hub provision geographically and develop additional services in line with WG requirements • A minor report amendment was noted – further development areas also included postnatal health and healthy ageing. JR-IM asked how they were involving the Third Sector. MA responded that the Cardiff Third Sector Council (C3SC) were represented in the Steering Group. Additionally, they used some of the non-recurrent funding to resource and provide engagement and coproduction, with involvement continuing into this year. Angela Hughes (AH), the Assistant Director of Patient Experience, noted this aligned with current complaints themes, particularly around contraception services. AH offered to share complaint data to support further discussions. KW highlighted the ned to view women's health more broadly beyond gynaecology and reproductive care. KW sought clarity on sustainability plans given the reliance on non-recurrent WG funding, and how services would be maintained if the funding ceased. MA responded with the following: • Women's health extended beyond reproductive care, although the initial focus from WG had been on menopause, menstrual health and contraception • The sustainability risk from non-recurrent funding was recognised and was reflected in the risk register. They aimed at building sustainable, system-wide service change rather than short-term, standalone services. For example, a Health Needs Assessment was underway to identify gaps and inform future service design, including sexual health • There was strong engagement with primary care and cluster leads to support delivery within existing resources • The Steering Group was planning based on no ongoing additional funding and aimed to embed changes within current capacity. CB confirmed the programme focused on reducing health inequalities for women, with sustainability supported through lasting elements such as training in primary care, which would continue beyond the initial funding period. JR asked whether future focus was on expanding additional Hubs or embedding the hub model and principles across the whole organisation. JR emphasised the need for a system-wide approach to women's health inequalities beyond isolated services. MA confirmed that the preferred approach was to embed women's health principles across the organisation, with hubs acting as one tool to address inequalities. Further hub expansion was expected, but only where appropriate and sustainable for specific populations. The hubs formed part of a wider suite of interventions. RU asked how the Committee would see the impact of the Hubs on reducing secondary referral rates going forward. MA responded that monitoring of referral impact was being explored locally through analysis of the current Hub, with wider work underway at a national level to develop a women's health data dashboard. MA acknowledged the complexity in attributing	

	changes in referral rates to the Hub alone. It was confirmed that this was a developing area, with plans to provide updates and relevant data in the future. CP asked to what extent did the current data support analysis of equity and related considerations. MA responded that data was collected directly from practice systems, which included key equity characteristics such as age, ethnicity and deprivation. Whilst volumes were currently small, the dataset should support identification of inequalities over time, with ongoing reporting planned as the model developed. **The Committee resolved that:** a) The update in the Health Board's delivery of the Women's Health Plan for Wales over the last 6 months was acknowledged.	
QC 2026/06/3.3	**Shaping our Quality, Value & Sustainability** 3.3.1 - Quality Management System (QMS) Improvement Plan Natasha Goswell (NG), the Deputy Executive Nursing Director, provided the following summary to the Committee: • The QMS position statement was approved by Board in March 2026 and submitted to NHS P&I. • The purpose of the report was to outline the ambition for a single organisation-wide QMS, assess current maturity, and define priorities for the next 12 months. • The aim was to embed a joined-up, consistent approach to manage quality across planning, improvement, assurance and control. • There were four key components: 1. Quality Planning – embedding quality aims and measures into service design 2. Quality Improvement – strengthening capability to identify priorities, test changes and measure impact 3. Quality Assurance – improving triangulated, forward-looking assurance rather than increasing the volume of reporting 4. Quality Control – ensuring standards, audit and learning processes are proportionate and aligned to improvement. • Enablers included leadership, culture, governance, workforce capability and access to good date • Current maturity was assessed as "emerging to developing" maturity, with strengths in commitment but a need for greater consistency and reduced duplication • Key priorities for the next 12 months included establishing a clear QMS framework, strengthen quality planning and improvement capability, enhance assurance and intelligence, and align quality control processes CB asked for assurance that the 'equitable' dimension of quality was clearly embedded within the framework. NG responded that the four components of the QMS were underpinned by their duty of quality. Through indicators and the Clinical Governance framework, it aimed to ensure a "floor-to-board" view, embedding equity in both design and presentation. RU asked whether there was an estimate of quality failures from the past 12-18 months that could have been identified earlier if QMS was fully embedded, to help clarify the improvements expected going forward.	

	NG responded that to was difficult to know, but the main gap was clear “floor-to-board" visibility and assurance. Over the following 12 months, QMS would strengthen this and embed all four components to provide a clearer, more visible “golden thread” to demonstrate improvement and support assurance. RU asked what the greatest risk was to fully embed the QMS over the following 12 months, and what the Committee should be most vigilant about. NG responded that the baseline maturity matrix assessments would show their current position and key gaps to address for full embedding. As work progressed, further updates would come to the Committee to outline developments, identified gaps, and actions being taken. JR emphasised that it must be embedded in everyday practice. Success was defined as staff understanding the QMS and its impact on identifying, monitoring, and reporting risk. KW requested greater detail on the delivery plan and sought clarity on the key implementation risks. KW emphasised the need to demonstrate improved patient outcomes and suggested a potential deep dive to test delivery against the ambition. KW and CP suggested NG attend the Independent Members information session that week to follow up on some of these points. NG responded that a detailed QMS project plan existed but was not presented in full to this Committee. This could be reviewed separately and invited Committee members to attend project meetings for further insight. **The Committee resolved that:** a) The content of the development plan was noted; b) The Quality Management System Organisational Development Plan was approved; c) The approval of the QMS Organisational Development Plan was recommended to Board for approval prior to submission to NHS Performance & Improvement	
QC 2026/06/3.4	**Shaping our Future Clinical Services** 3.4.1 - Theatres Together Programme CW provided the following summary to the Committee: • The report aimed to assure sustained progress across all workstreams under the Theatres Together Programme, moving towards embedded cultural and operational improvements • 34 of the 66 recommendations had been completed, with ongoing progress across remaining areas. • The cultural survey had been undertaken in the perioperative team, and showed improved staff confidence, safety, and pride in theatre environments. Key improvement areas included communication across teams, visible feedback loops, and infrastructure, IT and estates. • In January 2026, the ownership of the Hospital Sterilisation and Decontamination Unit (HSDU) improvement plan had been integrated into the Theatres Together workstream, with 10 recommendations completed, 12 in progress, and 1 descoped.	

	• Workforce indicators were improving, which included reduced turnover, stable staffing, increased appraisals and training • Regarding Nationally Reportable Incidents (NRIs), some variability remained in incident reporting intervals, but trends suggested improvement • Data indicated more focus was needed on areas such as post-operative wound infection and complications of anaesthesia • The plan was to bring data to all relevant Committees to include clearer trajectory data and use of statistical process control to demonstrate sustained improvement. **For an update on progress against the Theatres Together Improvement Plan to return to a future Quality Committee – ACTION**. CB asked for more detail on the action which was descoped. **For further detail on the descoped action within the Theatres Together Improvement Plan to be circulated outside of the Committee – ACTION.** KW noted that they had not received theatre performance data since January 2026 which limited visibility on utilisation, timeliness and cancellations. KW asked when this data issue would be resolved. **Confirm timeline for restoring theatre performance data reporting – ACTION.** **The Committee resolved that:** a) The updates on the Theatre Together Programme were noted. 3.4.2 - Pathway to Safer Beginnings (Wales): Gap Analysis and Proposed Three-Year Improvement Programme Abigail Holmes (AH), the Clinical Board Director for Children & Women, highlighted the following to the Committee: • The language around maternity services had changed – the National MatNeo Safety Support Programme had disbanded, which had aligned to England. During the end of 2025, an independent assessment was commissioned by WG, and the outcome was the Pathway to Safer Beginnings for Perinatal Services across Wales. The paper aimed to provide a credible and aligned response to the Safer Pathways. • A three-year national programme of work would start soon, with recruitment ongoing. CAVUHB would develop their own three-year programme to align with the national work. • The assessment against the recommendations showed strong assurance in most of the eight areas, but not yet fully compliant. This required ongoing review rather than one-off reporting. • The five key gap themes included workforce capacity and sustainability, theatres and neonatal resilience, perinatal mental health provision, incident response and family involvement, and data inequalities. • Governance arrangements were strong but were still developing, particularly within the new perinatal structure. There was a need for a single, integrated dashboard which aligned clinical and patient-reported outcomes • There was a variability in the quality of care (e.g. birth reflections) and a requirement to maintain UNICEF Baby Friendly accreditation • Major risks included workforce skill mix, rising sickness, estates challenges, and gaps in mental health provision.	

	• Positive practice included bereavement and support services and strong family engagement. The model was to be scaled nationally. • There needed to be a national reconfiguration of the cots whereby CAVUHB would need to increase to 37 cots. However, this was dependent on other organisations taking down their cop base and had to led by the Joint Commissioning Committee (JCC). Until they could reconfigure their services, they would still encounter babies born in the wrong facility. • They needed to strengthen family involvement in investigations and service design • The Safe Beginnings Programme Board were to oversee delivery, with regular monitoring and a biannual gap analysis. JR noted that the recommendations were largely expected, and this was the first baseline gap analysis. AH would lead implementation, supported by existing governance within the Clinical Board. Progress would be held to account through Executive oversight and future updates could be brought through the Committee. RU requested timelines for completing the mapping of perinatal mental health services, and for further detail on impact (e.g. waiting times, staff training). AH responded that the mapping was expected to be completed within 1-2 months. The baseline understanding was already in place and gaps identified (e.g. a wellbeing midwife). The plan was to train all community midwives in trauma-informed care, with the Elan team (who look after more vulnerable women in the community) to be trained in the more advanced care. AH suggested the work feed into the Safer Beginnings Board, with quarterly updates then submitted to this Committee. CB asked whether the feedback-to-improvement pipeline was inclusive and captured diverse voices, rather than a single feedback loop. AH confirmed multiple feedback access points would be used. This included engagement through the Elan team and midwives supporting vulnerable women, alongside multilingual birth discussion groups to ensure inclusion of non-English speaking families. JR-IM asked whether third sector partners were engaged in supporting this work. AH confirmed there was strong engagement with the third sector, led by the consultant midwife for public health and vulnerable women, who had lots of close links with the third sector. KW asked how the UHB's senior leadership could influence national discussions and issues, and better support operational delivery. AH responded that the current Birthrate Plus workforce tool was not fit for purpose but remained mandated by WG. This failed to reflect the growing complexity and acuity in maternity and neonatal care. There was a need for a multidisciplinary workforce model to cover all roles, not just midwives. The ask of the Executive team was for them to help influence discussions to adopt or develop a better system (e.g. the Scottish model). JR confirmed that Birthrate Plus was being escalated via Executive Directors of Nursing (EDONs) to the Chief Nursing Officer. Work was underway to develop a more realistic approach to assess maternity workforce acuity in Wales.	

The Committee resolved that:

a) The work towards full implementation of the Pathways to Safer Beginnings Priorities was noted.

3.4.3 - JACIE Inspection Update

Jess Castle (JC), the Director of Operations – Specialist Services Clinical Board, highlighted the following to the Committee:

- JACIE accreditation had been deferred following inspection, with a response due by 8th July 2026 to address the 89 non-compliant areas (from around 2,300 standards)
- Actions were tracked via a Task & Finish Group, with confidence that priorities would be delivered in time despite some delays
- Outcome data was requested after the previous Quality Committee meeting – autologous transplant outcomes benchmarked strongly (five-year survival for entire cohort of autologous patients was 78% vs 73% for the rest of the British Society data, and five-year survival for the multiple myeloma patient cohort was 83% vs 73% for the rest of the Blood and Marrow Transplant programme). Allogeneic transplant outcomes were comparable to benchmarks despite being a more complex patient cohort.
- Key focus areas included estates upgrades to adult's facilities on the University Hospital of Wales (UHW) site, e.g. the extension to the haematology day unit was underway and due to be completed by November, and the business case for the inpatient and ambulatory facilities was being finalised to be submitted to WG. The Children & Women Clinical Board had prepared an options appraisal around the clinical programme for Paediatrics, which was due to be discussed in a Senior Leadership Team (SLT) meeting.
- Workforce challenges, primarily around the Swansea Bay UHB programme and the stem cell processing unit in CAVUHB, were being addressed through a business case submitted for to the JCC
- Next steps included the submissions to the JCC and WG, SLT consideration of paediatrics appraisals, and final accreditation response by 8th July, alongside continued work on outstanding actions.

RU asked for timelines for completing 19 outstanding clinical outcome data actions.

JC responded that the programme team confirmed they were on track to meet the submission deadline. A detailed tracker was in place, with some actions covering multiple requirements.

KW noted this was a risky position if they were not to be reaccredited, and asked what steps were being taken to address this.

JC responded that if reaccreditation failed, CAR-T services would cease immediately, and would require patients to be referred to centres in England. BMT services would likely be decommissioned locally, with alternative provision commissioned in England. This contingency had been under discussion with the JCC for over two years. The organisation had ruled out seeking derogation, which meant external provision would be the only option.

For an update to come back to the following Quality Committee on 30th June 2026 – ACTION.

	KW expressed concern that no clear contingency plans were in place, despite two years of discussion with the JCC. It was noted that reliance on external commissioning was not a quick or simple solution and suggested the need for escalation to the JCC given the risks sat beyond local control. JC highlighted that there had been ongoing engagement with the JCC. A workforce paper was due to be submitted to them shortly, with a further meeting planned pre-submission. JC sought advice needed on requirements for commissioning alternative services, whilst continuing focus on achieving reaccreditation. **The Committee resolved that:** a) The significant risk and ongoing mitigating actions being progressed across the SWBMT Programme, Specialist Services Clinical Board, the wider Health Board and partners, were noted. 3.4.4 - HIW Short Stay Surgical Unit (SSSU) AS provided the following summary to the Committee: - The paper outlined an unannounced Health Inspectorate Wales (HIW) inspection of the SSSU in January 2026, which identified immediate concerns around patient safety, medicines management, environment, governance, and staff experience. Correspondence with HIW following inspection and staff survey results also raised workforce concerns. - Urgent actions were taken by the Clinical Board to address these, including improving medication controls, securing patient records, and deep cleaning. - Many issues were linked to unscheduled weekend openings of SSSU to meet additional demand without adequate support, now addressed through forward planning and risk-based preparation. - Workforce concerns from staff feedback were reviewed which included rostering and workforce practices, opportunities for staff to access training and education, ad support for staff who had periods of absence or leave. An immediate review was undertaken by the health roster team, which did not identify immediate concerns, though further monitoring continued. - All actions within the HIW improvement plan were either complete or on track, with strengthened audits, infection control, governance processes, and patient accessibility improvements in place. - The People & Culture team had helped to support and had undertaken a culture leadership and education programme across the department. The work was in its diagnostic phase, but there had been staff engagement so that everybody could talk about their experiences. VBA compliance had already increased from 70% to 94%, and mandatory training had improved. - A wider organisational response had been initiated, including UHB-wide audits around medication safety and storage, standardised health promotion materials, proactive accessibility assessments, and development of an HIW inspection readiness tool to ensure consistent quality and compliance across services. CB asked how the proposed HIW inspection readiness tool quality assurance tool aligned or linked to the QMS. AS responded that this formed a core element of the QMS, alongside the Clinical Audit Forward Plan. Both were essential components, as the system relied on all measures collectively. CB suggested extending the quality assurance approaches to the community, public health, and other services without established systems.	

	AS responded the QMS approach was being embedded across all levels, including clinical boards and specialties, though coverage in community services remained variable. Early work was underway to strengthen this. A QMS would not reveal unknown issues but would enable a whole-system view (e.g. linking NICE compliance to outcomes, understanding impact, and targeting improvement). **The Committee resolved that:** a) Assurance was taken from the actions completed to address immediate patient safety risks and the progress made against the HIW improvement plan, noting that all actions are either completed or on track within agreed timescales; b) The ongoing People & Culture review was noted.	
	Items for Oversight / Scrutiny	
QC 2026/06/4.1	**Clinical Audit Highlight Report** 4.1.1 - Additional Learning Needs (ALN) Internal Audit report update Natalie Vanderlinden (NV), the Designated Education Clinical Lead Officer, provided the following summary to the Committee: • The report provided assurance on progress following the internal audit in December 2025 on the implementation and progress made against the ALN reforms. • The ALN reform, introduced in 2021, represented a major change to how children and young people with ALN were identified, assessed and supported, with statutory responsibilities for the UHB, particularly through legally binding Individual Development Plans (IDPs). • The audit gave a reasonable assurance but identified required improvements, including an ALN governance policy development, workforce training, multi-agency working, and statutory compliance monitoring. • Progress had been made across all objectives, with many actions completed and others underway, particularly those dependent on finalising the ALN Governance Policy. • Key improvements included strengthened partnerships, emerging systems for managing referrals and data, and development of national KPIs and dashboards. KW noted concern that some actions had been marked as ‘complete’ despite still being in progress (e.g. policies are still out for consultation) which risked false assurance. KW sought clarity on when the UHB would achieve full legal compliance. NV responded that statutory ALN KPIs (under the ALNET Act) would begin All-Wales reporting from September 2026, with the first dashboard (based on August’s data) providing an initial view of compliance and statutory duties. VB highlighted that actions should demonstrate measurable impact, not just activity, with clear evidence that improvements were meaningful and effective. Emma Cooke (EC), the Executive Director of AHPs, Health Scientists and Community Services Development, acknowledged that ALN implementation was complex, and involved legal duties and partnership working. The audit helped to identify assurance gaps and focus improvement. Whilst progress was strong, emphasis was on ongoing assurance rather than “tick-box” completion. The introduction of All-Wales KPIs would support benchmarking.	

	For progress made against the ALN KPIs and legislation to return to the Committee in early 2027 – ACTION. **The Committee resolved that:** a) Progression to finalisation and implementation of the ALN Governance Policy was supported; b) Strengthened training and workforce oversight arrangements was endorsed; c) Continued development of multi-agency working arrangements was supported; d) Statutory compliance monitoring was strengthened; e) Governance effectiveness and engagement was monitored. 4.1.2 - Clinical Audit Forward Plan 2026/27 AS provided the following summary to the Committee: • The Clinical Audit Forward Plan formed part of the QMS to provide assurance against evidence-based standards and drive improvement. • It outlined a comprehensive but dynamic audit programme, with risks noted around resourcing national (Tier 1) audits due to reliance on clinicians, which could affect data quality. Tier 2 audits focused on quality and safety priorities. • Oversight sat with the Clinical Effectiveness Committee (CEC), with delivery supported by Clinical Boards. • Multiple systems (e.g. AMAT, Q-Pulse, Tendable) were used to manage audits. KW asked what actions would be taken to address the 'alert' findings in the cover report and mitigate the associated risks. AS responded that resourcing of national audits was under review with Clinical Boards and the Executive Medical Director, as current models varied and could impact data quality and delivery. A hybrid approach (combining dedicated audit staff with clinical engagement e.g. SSNAP model) was seen as best practice, with Clinical Boards expected to set timelines to achieve this. **For information to be circulated to Committee members on the actions being taken to address the 'Alert' from the report - ACTION** **The Committee resolved that:** a) The breadth of the Clinical Audit Forward Plan and participation in the national clinical audit and outcome review plan was noted.	
QC 2026/06/4.2	**Clinical Board Quality highlight reports** CP noted the highlight reports were a welcome improvement which replaced the previous Clinical Board reporting and attendance. JR highlighted that a new reporting format which used the Triple-A framework to strengthen assurance by clearly identifying and managing Clinical Board risks, rather than showcase achievements. It highlighted the key risk themes, aimed to improve visibility for Independent Members, and supported deeper scrutiny or follow-up where required. KW explained that it would be helpful to track whether risks were reducing, stable, or escalating to help identify emerging issues and themes across Clinical Boards. **The Committee resolved that:**	

	A) The Clinical Board highlight reports were noted for assurance.	
QC 2026/06/4.3	**Annual Reports** 4.3.1 - Claims Annual Report 2025/26 AH provided the following summary to the Committee: • Claims activity was increasing (in line with Wales) which reflected systemic risks rather than isolated issues, particularly delays in care, decision-making, communication, and estates. • Whilst processes for managing claims were robust, challenges remained in embedding system-wide learning. Current programmes aimed to strengthen consistent, system-led improvements, supported by future changes (e.g. Duty of Candour). **The Committee resolved that:** a) The increase in claims activity and associated system risks was noted; b) The escalation of key risks relating to the below were recognised: o System reliability and pathway delays o Gap between learning and assurance o Estates and environmental risks c) Assurance was sought on the below: o Strengthening of escalation and diagnostic pathways o Evidence of measurable and sustained learning o Reduction in reliance on individual compliance vs system controls d) Escalation of key risks to the organisational risk register where required was supported. 4.3.2 - Patient Experience Annual Report 2025/26 AH summarised the report which provided assurance on a mature patient experience system aligned to the People Experience Framework and the Health and Social Care Quality and Engagement Act, supported by significant volunteer contribution and a wide service offer. It highlighted strong activity and impact with a clear focus on accessibility and improvement. A maturity matrix had informed priorities and objectives for the coming year. **The Committee resolved that:** a) The Patient Experience Annual Report 2025-26 was received for assurance on the effectiveness of systems for capturing, responding to, and learning from patient experience; b) Assurance was received from the evidence of high levels of patient satisfaction and the impact of experience-led improvements; c) The priorities for 2026-27 were noted; d) Continued organisational focus on embedding patient experience as a core driver of quality, safety and service improvement was supported.	
	Policies for Approval	
QC 2026/06/5.1	*No policies for approval.*	
	Items for Noting / Information	
QC 2026/06/6.1	Safeguarding Steering Group (SSG) Highlight Report – 11.03.2026 **The Committee resolved that:**	

	a) The minutes from the SSG meeting on the 11.03.2026 were received for noting.	
	Items Needing Escalation to Board	
QC 2026/06/7.1		
	Any Other Business	
QC 2026/06/8.1	*No other business was raised.*	
	Review of the Meeting	
QC 2026/06/9.1	*Committee members were asked to fill out the Committee Self-Effectiveness survey.*	
	Date & Time of Next Meeting:	
QC 2026/06/10.1	*30th June 2026 at 9am via MS Teams*	