PUBLIC Quality Committee

Tue 09 December 2025, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:05
5 min

1. Standing Items

1.1. Welcome, Introductions & Apologies

Ceri Phillips

1.2. Declarations of Interest

Ceri Phillips

1.3. Minutes of the Quality Committee Meeting held on 28.10.2025

Ceri Phillips

1.3 - Unconfirmed Quality Public Minutes 28.10.2025.pdf (10 pages)

1.4. Action Log – Following the meeting held on 28.10.2025

Ceri Phillips

PUBLIC Central Action Log.pdf (1 pages)

1.5. Chair's Action taken since last meeting

Ceri Phillips

No Chairs Actions since the previous meeting.

14:05 - 15:15
70 min

2. Items for Review & Assurance

2.1. UHB Quality Indicators Report

15 mins *Alexandra Scott / Angela Hughes*

2.1.1 - Quality Indicators Report.pdf (3 pages)
2.1.2 - Quality Indicators December AH 2025.pdf (19 pages)

2.2. Mental Health Clinical Board Quality Indicators Report

30 mins *Mental Health Clinical Board*

2.2.1 - MHCB Quality Committee Submission 9th Dec 2025.pdf (32 pages)
2.2.2- Quality Committee MHCB 9th December 2025 (1).pdf (25 pages)

2.3. Tackling the Planned Care Challenges - risks / incidences of harm

10 mins *Paul Bostock / Jason Roberts / Alex Scott*

2.3 - Tackling the Planned Care Challenges - risks & incidences of harm.pdf (4 pages)

2.4. Care After Death Processes and Learning from Mortality

15 mins *Aled Roberts*

2.4 - Committee_Care After Death_181125.pdf (10 pages)

15:15 - 15:25
10 min

3. Items for Approval / Ratification

3.1. Policies

Ceri Phillips

None for this Committee.

3.2. NHS Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR)

10 mins *Robert Mahoney*

3.2.1 - IPFR Policy Report Board QSE Committee (1).pdf (4 pages)
3.2.2 - Appendix 1 NHS Wales IPFR Policy - Final - July 2025 (1).pdf (30 pages)
3.2.3 - Appendix 2 IPFR EHIA (1).pdf (23 pages)

15:25 - 15:25
0 min

4. Items for Noting & Information

4.1. Minutes from Clinical Board QSE Sub Committees

Jason Roberts

4.1.1 - 2025.07.22 - Minutes PCIC QSE July - 2025.07.22 - FINAL signed off 2025.09.23.pdf (13 pages)
4.1.2 - 2025.09.15 - Specialist Services QSE Minutes 15 September 2025.pdf (5 pages)
4.1.3 - 2025.09.23 - CW QSPE Minutes 23.09.2025.pdf (9 pages)
4.1.4 - 2025.09.22 - CD&T QSE Minutes 22.9.25.pdf (17 pages)
4.1.5 - 2025.10.29 - CD&T - QSE Minutes 29.10.25.pdf (12 pages)

4.2. Safeguarding Steering Group (SSG) Minutes

Jason Roberts

The November SSG meeting was cancelled, so no minutes are attached.

4.3. IP&C Group Minutes

Jason Roberts

4.3 - IPCG minutes 30.06.25.pdf (9 pages)

4.4. Annual Director of Public Health Report 2025

Michael Allum

4.4.1 - DPH report Quality Committee 09.12.25 Covering Report 2025-26 FINAL.pdf (3 pages)
4.4.2 - DPH Report 2025 Obesity and Diabetes Presentation FINAL (1).pdf (6 pages)
4.4.3 - Cardiff and Vale of Glamorgan PH Report v8.pdf (44 pages)

15:25 - 15:25
0 min

5. Items to bring to the attention of the Committee

Ceri Phillips

15:25 - 15:25
0 min

6. Agenda for the Quality Committee Private Meeting

Ceri Phillips

i. *Private Minutes & Actions*

ii. *Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*

15:25 - 15:25 0 min

7. Any Other Business

Ceri Phillips

15:25 - 15:25 0 min

8. Review of the Meeting

Ceri Phillips

15:25 - 15:25 0 min

9. Date & Time of Next Meeting

Ceri Phillips

20th January 2026 at 2pm via MS Teams

Unconfirmed Minutes of the Public Quality Committee

Held on 28th October 2025 via MS Teams

To view the meeting: CAVUHB Quality Committee 28.10.2025

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Rhian Thomas	RT	Committee Vice Chair / Independent Member – Capital & Estates
Mike Jones	MJ	Independent Member – Trade Union
Clive Curtis	CC	Independent Member - Community
Stephen Riley	SR	Independent Member – University
Kirsty Williams	KW	UHB Chair
In Attendance		
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Matt Phillips	MP	Director of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Paul Bostock	PB	Chief Operating Officer
Jason Roberts	JR	Executive Nurse Director
David Fluck	DF	Executive Medical Director
Suzanne Rankin	SR	Chief Executive Officer
Barbara Davies	BD	Interim Director of Nursing PCIC
Lisa Dunsford	LD	Director Of Operations - PCIC
Rachel Thomas	RT	Director of Operations - PCIC
Helen Kemp	HK	Deputy Clinical Board Director - PCIC
Victoria Hayman-Teear	VHT	Senior Nurse - PCIC
Joanne Jefford	JJ	Strategic Lead Dietitian - Dietetics
Joanne Ellis	JE	Senior Catering Team manager (Interim) - Patient Catering Services
Andrew Poole	AP	Head of Estates and Facilities
Michael Allum	MA	Consultant in Public Health
Andy Jones	AJ	Director of Nursing/Midwifery - Children & Women CB
Sarah Martin	SM	Research and Development Manager
Natasha Goswell	NG	Deputy Executive Nurse Director
Sophia Jones	SJ	Value in Health Programme Manager - Operations
Sian Griffin	SG	Consultant Nephrologist - Nephrology Transplant
Observers		
Lauranne Cullen	LC	Regional Director for Llais
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Claire Beynon	CB	Executive Director of Public Health

QC 2025/10/1.1	**Welcomes, Introductions & Apologies**	ACTION

	Ceri Phillips (CP), the Committee Chair, welcomed everyone to the meeting in English & Welsh. Apologies for absence were noted.	
QC 2025/10/1.2	**Declarations of Interest** No declarations of interest were raised.	
QC 2025/10/1.3	**Minutes of the Committee meeting held on 16.09.2025** The minutes of the Committee meeting held on 16.09.2025 were received. **The Committee resolved that:** a) The minutes of the meeting held on 16.09.2025 were approved as a true and accurate record of the meeting.	
QC 2025/10/1.4	**Action Log following the Meeting held on 16.09.2025** The Action Log following the Meeting held on 16.09.2025 was received and discussed. **The Committee resolved that:** a) The Action Log from the meeting held on 16.09.2025 was noted.	
QC 2025/10/1.5	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QC 2025/10/2.1	**UHB Quality Indicators Report** Alexandra Scott (AS), the Assistant Director of Quality and Patient Safety, and Angela Hughes (AH), the Assistant Director of Patient Experience, 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 September 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. Regarding the C.diff spike, Clive Curtis (CC), the Independent Member – Community, asked whether modelling had been undertaken to predict the situation during the winter pressures. He also asked whether consideration had been given to community-based infection prevention to reduce transmission outside of hospitals. Jason Roberts (JR), the Executive Nurse Director, provided the following response: • The UHB was in a much better position on C.diff compared to the previous year, though still not at their reduction target. • A 50% reduction in C.diff had been achieved in surgery, specialist, and medical wards over the past six months, and they saw fewer hospital-acquired cases, with more community-related transmission. • An Infection, Prevention & Control (IP&C) nurse had been appointed to focus on community work and antimicrobial stewardship. • Whilst winter may bring an increase, they hoped that current measures would maintain progress.	

	• CAVUHB formed part of the C.diff Collaborative Group which was All-Wales based to share learning. Rhian Thomas (RT), the Committee Vice Chair, asked how they reconciled the efficacy of falls training with the trend of increased inpatient falls. AS provided the following response: • Wards across the organisation had been recently audited, focusing on those with good uptake of falls training. It demonstrated progress in trained wards but highlighted more work was needed overall. • Training aimed to improve the quality of risk assessments and empower staff to mitigate risks such as high-risk prescribing, poor eyesight, and blood pressure issues. • They were expanding training to a multi-professional approach, as falls prevention was not just a nursing role. • Further work included systematic processes around mitigation for high-risk medications. • The training would be rolled out to other clinical boards and would continue to be monitored and reported back to the committee. Suzanne Rankin (SR), the Chief Executive Officer, highlighted that strengthening data handling and presentation would help provide assurance and identify areas needing deeper review. AS agreed that they should report all data through SPC charts. Many indicators relied on incident reporting on Datix, which had limitations on what could be generated. A new solution moving forward would allow data downloads into their data warehouse and use Power BI for flexible reporting, including incidents by bed days to track seasonal variation. Kirsty Williams (KW), the UHB Chair, noted that they had met the Director General that morning, who emphasised the consistent use of SPCs across all UHBs in Wales, and will be a national expectation. **It was suggested that the Director of Corporate Governance (DCG) look for an opportunity be considered for Independent Members to receive training and support in interpreting SPC charts and data analysis – ACTION**. **The Committee resolved that:** 1) The assurance provided by the quality indicators and the associated work to drive improvements in these areas.	
QC 2025/10/2.2	**PCIC Clinical Board Quality Indicators Report** Victoria Hayman-Teear (VHT), the Senior Nurse – PCIC, presented a patient story on the ANCLE Cafe, an innovative multidisciplinary clinic for leg wound care, which combined clinical treatment, education, digital monitoring, and social support. Plans were underway to expand to additional sites and include more staff groups. The story demonstrated the positive impact of collaborative, innovative community care on patient outcomes and wellbeing. SR asked how equitable would access to this care be across both Cardiff and the Vale. VHT responded that at present there was a site in Cardiff, with further sites planned in the Vale of Glamorgan (VoG) commencing in January 2026.	

	The PCIC Clinical Board presented their assurance report and slides to the Committee which detailed the achievements, progress and planned actions within the PCIC Clinical Board to maintain the priority of QSPE. Topics discussed included, but were not limited to: • PCIC Assurance Mechanisms • Safe Care – including NRI and Patient Safety Incident Reporting, Pressure Damage, IP&C, Medication Safety • Effective Care – Mortality, External Assurance • People Centred – Workforce • Patient Centred Care – Concerns, Patient Experience • Equitable Care • PCIC Top 5 Quality & Safety Risks Steve Riley (SRI), the Independent Member – University, asked whether there was a way of scaling the ANCLE cafe into the community and whether other staff (e.g. district nurses) could learn from this programme. Also, he asked how they would demonstrate whether community health pathways improved care in the future. VHT highlighted the existing plans to scale up with three new sites planned in the VoG. The cafe was currently staffed with district nurses, with a big throughput of staff coming through with many staff being upskilled. In the VoG model, they planned to include practice nurses. Helen Kemp (HK), the Deputy Clinical Board Director – PCIC, responded that demonstrating the value of community healthpathways was challenging as it was multifactorial. However, feedback was positive. They reduced referral variation and improved prescribing consistency, supported by a robust quality assurance process involving primary and secondary care. VHT added that peer support was central. Patients were not discharged after healing; they could keep attending for the social aspect. The cafe was academically led by Cardiff Met, whereas the Leg Clubs were patient-led. SR provided the following comments: • Politicians and the public often asked about access to primary care, but this wasn't mentioned in the report. • How could they better share patient experience and outcomes data from commissioned services? Lisa Dunsford (LD), the Director of Operations – PCIC, noted that in terms of access, all practices complied with national requirements and provided evidence. Patient surveys showed high satisfaction once contact was made, although experience could still improve. Compliance with national contracts remained challenging. SR responded that despite 100% compliance, patients still reported poor access. Public accountability would likely focus on primary care access. Regarding community health pathways, David Fluck (DF), the Executive Medical Director, noted that TriTech published a report on community and hospital pathways, which gained Cabinet minister support for another year, although it still needed UHB funding. The report's conclusions stressed the need to demonstrate benefits and effective use. They were holding interface meetings with primary care to explore refocusing and would need to show tangible impact over the next year to justify continued use.	

	The Committee resolved that: 1) The assurance provided by the PCIC Clinical Board in this report and the steps being taken to improve quality, safety and patient experience was noted.	
QC 2025/10/2.3	**Patient Catering Nutrition Update – Providing Quality Care** Joanne Jefford (JJ), the Strategic Lead Dietitian - Dietetics, and Andrew Poole (AP), the Head of Estates and Facilities, presented the slides and highlighted the following: • The service provided 19 distinct patient menus across 4 hospital sites, serving 1.5million meals annually, including options for therapeutic, religious, allergen-free, and lifestyle-specific diets. • Dietetic support workers assisted with fortified snacks and eating support, aiming to improve patient nutrition, recovery, and experience. • The Nutrition and Catering Steering Group met quarterly. Compliance was maintained with the All-Wales Nutrition and Catering Standards and food safety regulations, supported by a dedicated Food Safety Assurance Manager and regular inspections. • There had been a significant increase in food provision costs (over the past 3-4 years it had totalled around £750k), which contributed to significant budget pressure. Investments in the Central Food Processing Unit (CFPU) had reduced reliance on external providers. • Demand for specialist meals (e.g. halal, kosher, allergen-free) was rising, with a forecast of 37,000 specialist meals this year. AP summarised the following: • The food production pathway involved several complex steps before the meal was served to a patient – procuring, making and storing the product correct and then serving the correct meal to a patient safely • Support was recommended for expanding plant-based meal options and reducing processed meat reliance to promote healthier choices • Financial review may be necessary to ensure a quality product that met the new nutritional standards for now and the future, including menu development proposals for the Children's Hospital for Wales (CHfW). RT highlighted the WG target of less than 5% food waste and asked for the UHB's performance for this target. RT also asked whether the team had engaged with the Youth Board on the specialist children's menu. AP responded that they had significantly reduced food waste from 7-8% to under 5%. A project team had reviewed this in detail, measuring trolley and plate waste across wards and incorporating findings into monthly performance reviews. Benchmarking across other Welsh NHS bodies and national guidance showed they were in a good position. JJ highlighted that plate waste was hard to reduce. Additionally, the UHB had not engaged with the Youth Board on the children's menu but would take this suggestion forward.	

	Mike Jones (MJ), the Independent Member – Trade Union, noted that every ward scored 5 on the food safety scores except ward-based catering and CFPU. He asked if this was due to environmental factors. AP responded that it was a mix of factors, e.g. documentation and environmental. Within Capital, Estates & Facilities (CEF), they reviewed this monthly in a food hygiene meeting. Significant investment had gone into the CFPU over the past 2-3 years to address fabric and mechanical issues. DF asked whether patients enjoyed the food, and whether the food was sourced locally. He suggested the team sample some of the food. AP responded that they aimed to source food locally through shared services and procurement. A menu tasting day was planned soon, and invites could be extended. AH commented that they had created a nutrition and catering survey to capture patient feedback, recognising food as vital for recovery and a key social activity. Data was collected via SMS and volunteers, and they were building a strong dataset to identify themes. She hoped they would be able to share comprehensive insights soon. **The Committee resolved that:** 1) The complexity of the food production pathway and its operational demands as above was acknowledged; 2) The risks associated with ensuring the correct meal reaches the right patient, particularly in relation to allergens, texture modification, and patient safety was recognised; 3) Future opportunities to expand plant-based meal provision and reduce reliance on processed meats, where financially beneficial, was supported; 4) Remain aware of ongoing financial uplifts from external providers and the associated risks, ensuring appropriate investment. 5) Commit to funding the development and implementation of a specialist children's menu. 6) Ensure the implementation and funding of the refreshed Welsh Government food standards scheduled for publication in 2025. 7) Safeguard the quality and provision of food services against increasing financial pressures.	
QC 2025/10/2.4	**Update for Women's Health Hubs** Michael Allum (MA), the Consultant in Public Health, presented the update for Women's Health Hubs, and highlighted the following to the Committee: • The Women's Health Plan was a national plan published at the end of 2024 – it was a 10-year plan that recognised the health inequalities experienced by women across Wales and the need for healthcare to evolve and develop. • A steering group was established led by Claire Beynon and had good representation across the UHB. • The focus for the first year of the plan was the establishment of the Pathfinder Hub. The three priority areas for the Hub were around menstrual health, contraception, and menopause. • Rapid initial scoping identified many good practices already in place in CAVUHB, as well as several challenges. • The hub aimed to improve community access, streamline pathways, and ensure secondary care was reserved for complex cases.	

	• Since the paper's submission, discussions around the Pathfinder Hub focused on the Cardiff East Cluster, which built on a successful menopause pilot, and would offer multidisciplinary support including social prescribing, lifestyle advice, and mental health support. • Work was ongoing to define service capacity, evaluate impact, and expand primary care training in priority areas. SR asked what specific services the Hub would deliver on, or how many women it would see. She asked whether they were clear on addressing both women-specific needs and broader inequalities in outcomes. MA responded that the focus had mainly been on women-specific health issues so far, but addressing wider inequalities was embedded in the health plan. The aim was to complement existing work, not duplicate it. In terms of capacity, MA explained that specific numbers were still being developed due to the pace of progress but would share more information in the future. **It was suggested that a further update be provided to the Committee on the established Women's Health Hub, detailing the services provided and projected capacity/numbers accommodated – ACTION.** **The Committee resolved that:** a) The updates in the Health Board's development of a Women's Health Hub was acknowledged.	
QC 2025/10/2.5	**Looked After Children Assessment Backlogs - Six Month Update** Andy Jones (AJ), the Director of Nursing/Midwifery - Children & Women CB, provided a summary of the report and highlighted the following: • The service provided statutory health assessments for children in care, aiming to improve health outcomes and reduce inequalities. • There had been a significant increase in new referrals, putting pressure on the small team. • Initial health assessments within 28 days remained challenging due to notification delays, but improvements had been made by involving specialist nurses and health visitors. • The backlog of initial health assessments had been more than halved since April 2025, though review assessments for under-fives remained a focus. • Out-of-area placements incurred significant costs and logistical challenges - efforts were underway to reduce these by working with Local Authorities (LAs). • Actions included requesting additional capacity, reviewing skill mix, expanding health visitor involvement, improving information sharing, and streamlining digital reporting. RT commented that the paper noted health visitors struggled with workload complexity, yet one mitigation was the increased use of health visitors. She asked how sustainable this solution was. AJ responded that they were widening involvement from health visitors to share the workload and free up specialist nurses to focus on over-fives, making it more viable. The statutory assessments were just one aspect of the role, they also played a key role in support children and young people, often as trusted adults.	

	It was requested that a further update return to the Committee in six months' time – ACTION. KW noted that the strategic goal must be fewer children entering care, and those who did should be placed locally with timely updates. She asked whether they ensured cross-sector collaboration with social services, education, and voluntary support to address root causes. AJ responded that they did discuss this at Regional Partnership Board (RPB) meetings, but a more focused conversation with LAs and third-sector partners was needed. SR added that executive discussions with LAs were underway to agree priorities for collaborative work. This went beyond the RPB and provided more flexibility with decision-making. **The Committee resolved that:** 1) The content of the paper and the actions taken to mitigate the risks associated child health assessments was noted.	
QC 2025/10/2.6	**Research and Development – Six Month Update** Sarah Martin (SM), the Research and Development Manager, introduced the report which summarised some of the research activity and performance across the UHB. She introduced Sian Griffin (SG), the Consultant Nephrologist - Nephrology Transplant, to provide a presentation on the impact of some of the UHB's research. SG provided a presentation to the Committee and summarised the following: • SGLT2 inhibitors were identified as a major advancement, with CAVUHB participating in key clinical trials and rapidly implementing findings into practice. • Efforts were made to overcome inertia in adopting new treatments, including pharmacist and nurse-led optimisation clinics in secondary care and a primary care project in Caerphilly which screened over 13,000 patients. • Value-based analysis showed significant predicted reductions in end-stage kidney disease, cardiovascular events, and deaths if best practice was implemented. • The work received national recognition and awards, and educational tools were developed for primary care to support early intervention and consistent management. • The specialty formed part of the Wales Commercial Research Delivery Centre, facilitating further research and patient recruitment. CC asked how they ensured public involvement was embedded in the development and delivery of research, especially for studies with community impact. SG responded that education was key. They included links in patient letters, ran low-risk observational studies, and maintained visibility in clinics. They worked with charities like Kidney Wales and Popham Kidney Support to promote research actively in secondary care. Outreach in primary care was harder, but they collaborated on events around organ transplantation and donation to raise awareness where possible. SM explained that public and patient involvement had historically focused on grant development. They worked with patient groups and charities to shape research questions. However, the UHB needed to strengthen involvement in their research portfolio and strategy, which would be reviewed as part of the framework. They needed to improve how public involvement influenced research priorities going forward.	

	The Committee resolved that: 1) The progress made by Research to date was noted; 2) The content of the report and the assurance given by R&D was noted.	
QC 2025/10/2.7	**Ombudsman Annual Letter** AH presented the report and highlighted the following to the Committee: • 149 concerns were referred to the Ombudsman last year out of 3471 total concerns received by the UHB. • Main issues raised included clinical treatment, mental health, and patient risk management, aligning with local concern trends. • Nearly half of the complaints received by the Ombudsman did not meet investigation thresholds – only 5% were upheld, and there were no public interest reports. • Compliance with Ombudsman recommendations had improved to 70%, but further improvement was needed to reach the target of over 90%. • The UHB was focusing on timely completion of recommendations, strengthening complaints handling, and preparing for new guidance on listening meetings and advocacy services from April 2026. **The Committee resolved that:** 1) The contents of this report and actions to be taken was noted.	
	Items for Approval / Ratification	
QC 2025/10/3.1	**Policies** Interventions Not Normally Undertaken (INNU) Policy Update MA and Sophia Jones (SJ), the Value in Health Programme Manager – Operations, summarised the review and update of the INNU policy which aligned with national validation and ensured a live list of interventions. It was clarified that exceptions were possible through the Individual Patient Funding Request (IPFR) process. UHB 556 – Management of Visitors within the Operating Theatre Department Policy JR summarised the new policy for managing visitors in theatre departments, introducing a robust sign-in process. **The Committee resolved that:** 1) The Interventions Not Normally Undertaken (INNU) Policy Update was approved; and 2) The Management of Visitors within the Operating Theatre Department Policy was approved.	
	Items for Noting & Information	
QC 2025/10/4.1	**Minutes from the Clinical Board QSE Sub-Committees** **The Committee resolved that:** 1) The Clinical Board QSE Sub-Committee minutes were noted.	
QC 2025/10/4.2	**Safeguarding Steering Group (SSG) Minutes** **The Committee resolved that:** 1) The minutes were noted.	

	Agenda for Private Quality Committee Meeting	
QC 2025/10/5.1	*i) Minutes and Action Logs from the Private QSE Committee on 16.09.2025* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*	
	Any Other Business	
QC 2025/10/6.1	Matt Phillips (MP), the Director of Corporate Governance, suggested that his team would review how to better gatekeep the Committee's content outside of the meeting.	
	Date & Time of Next Meeting:	
QC 2025/10/7.1	9th December 2025 at 2pm via MS Teams	

PUBLIC QUALITY COMMITTEE

Minute Reference	Agenda Title	Agreed Action	Executive Lead	Action Lead	Date Assigned	Date for Review	Status	Comments
QC 2025/10/2.1	**UHB Quality Indicators Report**	For an opportunity be considered for Independent Members to receive training and support in interpreting SPC charts and data analysis	Matt Phillips	Matt Phillips	28/10/2025		IN PROGRESS	
QC 2025/10/2.4	**Update for Women's Health Hubs**	For a further update be provided to the Committee on the established Women's Health Hub, detailing the services provided and projected capacity/numbers accommodated.	Claire Beynon	Michael Allum	28/10/2025	14/04/2026	COMPLETED	Confirmed with Michael Allum - Added to the Forward Plan for April 2026's Quality Committee.
QC 2025/10/2.5	**Looked After Children Assessment Backlogs - Six Month Update**	For a further update return to the Committee in six months' time.	Jason Roberts	Andy Jones	28/10/2025	26/05/2026	COMPLETED	Confirmed with Andy Jones - Added to the Forward Plan for May 2026's Quality Committee.

Report Title:	Quality Indicators Cover report				Agenda Item No:	2.1	
Meeting:	Quality Committee		Public	x	Meeting Date:	09.12.2025	
			Private				
Status	Assurance	X	Approval		Information/Noting		
Lead Executive Title:	Executive Nurse Director						
Report Author:	Assistant Director of Quality and Patient Safety						

Main Report

Background and Current Situation:

The Quality Indicators report provides assurance in relation to a number of quality, safety and patient experience priorities.

The report provides oversight of data up until the end of October 2025 with details of actions that are being undertaken to drive the requisite improvements.

The quality Indicators report will include exception reporting to bring emerging quality and patient safety issues and themes to the attention of the committee.

The quality indicators are continuing to develop, and further indicators will be included to provide oversight of the timeliness of patient care and equality and equity of care provision and health outcomes.

Executive Director Opinion & Key Issues to bring to the attention of the Committee:

- The UHB reported 29 Nationally reportable Incidents in October 2025 a significant increase form previous month.
- The increase was as a result of retrospective reporting of a number of pressure damage cases following a reconciliation exercise in Specialist Clinical Board.
- The WHO checklist collaborative has progressed the design of the UHB checklist and Team brief tool
- The Standardised Clinic outcomes form was implemented in November 2025
- Early Warning scores have been fully implement in the inpatient setting, however, roll out in Primary Care planned for November 2025 has been delayed due to digital changes to the PARIS system. It is anticipated that the tool should be implemented in December 2025.
- Inpatient falls training continues and falls training is underway in five care homes in Cardiff and the Vale area with additional lifting equipment being provided as required.
- The first meeting of the reconvened pressure damage group took place in November 2025, with five workstreams identified to support a reduction in healthcare associated pressure damage.
- EPMA medication system roll out continues with implementation on medicine wards in November 2025.
- The October 2025 Clinical Effectiveness Committee was focused on the National Cancer audits with presentations around Upper GI Cancer, Lung cancer, prostate cancer and Breast cancer.
- There have been inspections from HIW in October or November 2025, however an update of the St David's Improvement plan has been provided to HIW

- Leadership Listening walk rounds undertaken by the Board in November included B4 Neurology B2 Vascular and Infection prevention and Control
- There has been a slight decline in compliance against the Nurse Staffing Act with 84% of shifts in October 2025 staffed appropriately
- Thematic revies of concerns in all Clinical Board have been undertaken and themes include, delays in treatment and diagnostics, cancellations and delays in ADHD and autism assessments
- 84% of patients completing a Patient Experience Survey were satisfied with the service they received.

Appendices (please list any appendices that will accompany this report. Do **not** embed)

1. Quality Indicators Report December 2025

Recommendations:

a) Note the Assurance provided by the quality indicators
b) Note the work underway to drive requisite improvements

Link to Strategic Objectives of Shaping our Future Wellbeing:

1. Putting People First		2. Providing Outstanding Quality	
3. Delivering in the Right Places		4. Acting for the Future	

Five Ways of Working (Sustainable Development Principles) considered:

Prevention		Long Term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?:

Yes	x	No *(please provide reasoning e.g. not required*		

Impact Assessment

Risk: n/a
Safety: m/a
Financial: n/a
Workforce: n/a
Legal: n/a
Reputational: n/a
Socio Economic: n/a
Equality & Health: n/a
Decarbonisation: n/a
Welsh Language: n/a

Approval/Scrutiny Route ***(please list all other Committees/Groups this report has been to)***

Name of Committee/Group/Exec	Date:

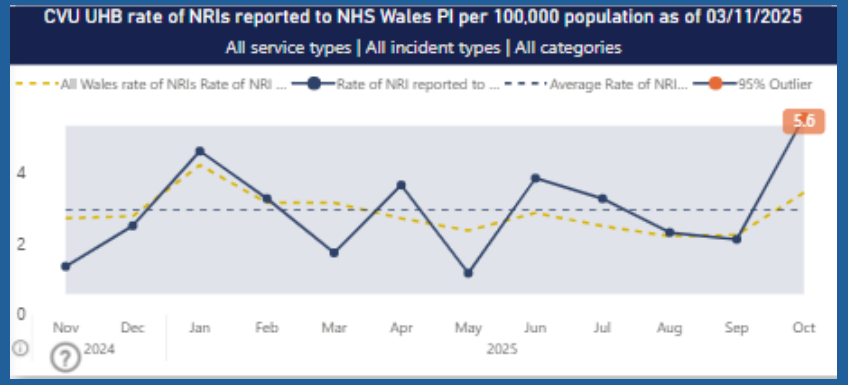
Quality Committee

Quality Indicators and Performance Report

December 2025

Safe Care

Patient Safety Incident Reporting



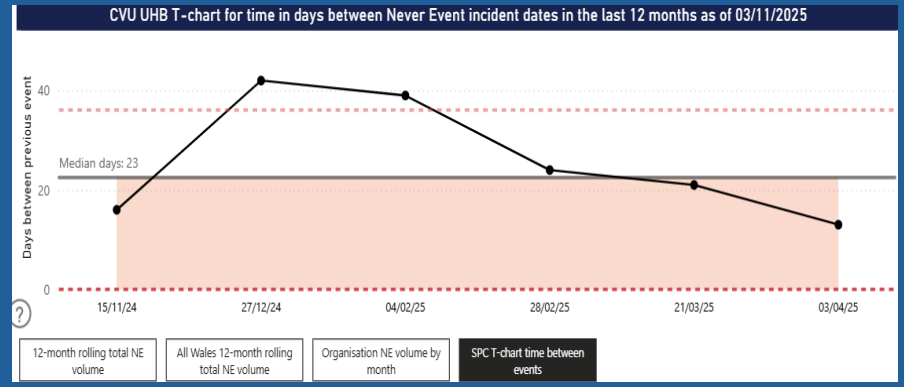


Fig. 1

Cardiff and Vale reported an NRI rate of 5.6 per 100,000, placing us as an outlier on the 95th percentile. This was driven by retrospective pressure damage reports (7 cases) following a reconciliation exercise in specialist clinical board, and increased Intrauterine deaths reported through the Mothers and Babies : Reducing Risk through Audits and Confidential Enquiries (MBRRACE) Process (9 cases), resulting in 29 NRIs last month—more than double the usual monthly average. All MBRRACE cases have been subject to an initial rapid review and no concerns in care have been identified for those cases reported in October 2025 .

Delays in reviewing patient safety incidents remain a risk; however, the situation is improving following outreach support sessions delivered by the Patient Safety Team to incident managers. The number of incidents pending review beyond 30 days has decreased with areas of particular concern targeted for support.

<u>WHO Checklist Collaborative</u>

The WHO collaborative and leadership within theatres work continues with a proposed WHO checklist design produced by the collaborative agreed in October which is being circulated for consultation. Options are being explored to have team brief displayed in the theatre to allow a full team approach to this vital safety discussion, with a view to implement the agreed team brief in April 2026.

Safe Care

Patient Safety Incident Reporting

Shaping our Future Quality Excellence

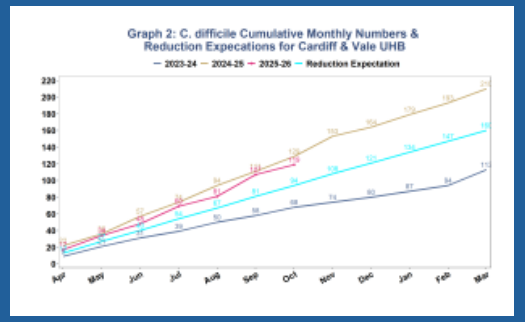
Shaping our Future Quality Excellence is an executive led programme to deliver UHB wide improvement projects addressing quality and patient safety priorities aligned to themes emerging from NRIs and patient safety incidents. Projects reporting into the project board include medicines safety, acute deterioration, infection prevention and control and lost to follow up. Updates on these projects have been provided throughout the quality indicators report. Progress against each of the projects in the programme are included throughout the indicators report.

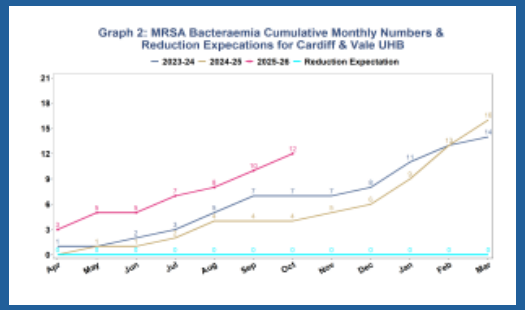
Shaping our Future Quality Excellence – Lost to Follow Up

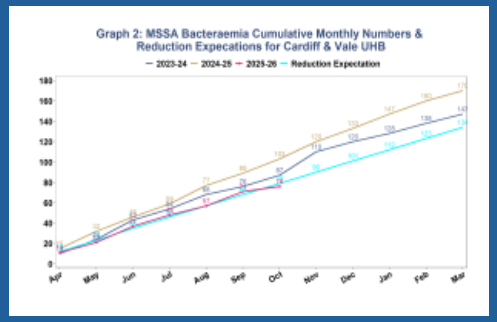
Following the October engagement sessions about the revised and standardised Clinic Outcomes Form (COF), the updated COF was launched on 3 November. Its purpose is to ensure that every patient leaves an outpatient clinic with clear, unambiguous outcomes. Targeted training and support are being provided to areas with a high number of uncashed clinics, while training remains available to all clinic coordinators and administrators. In parallel, work is underway to enhance the current digital system, making it more user-friendly. The redesign has been informed by clinician feedback to ensure it meets practical needs. Additionally, steps are being taken to improve visibility of un-cashed clinic appointments. Weekly reports will highlight these figures, enabling timely action and improved compliance.

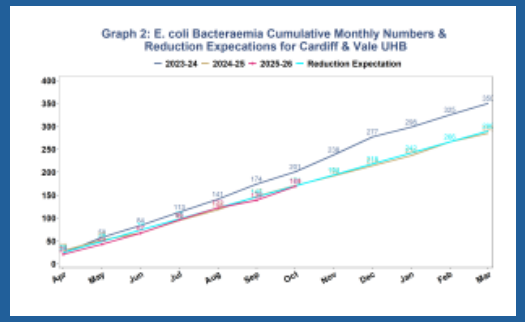
Safe Care

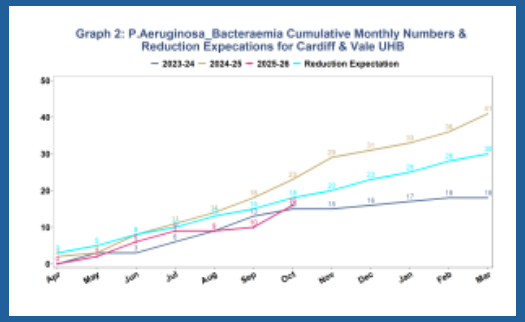
Infection Prevention and Control

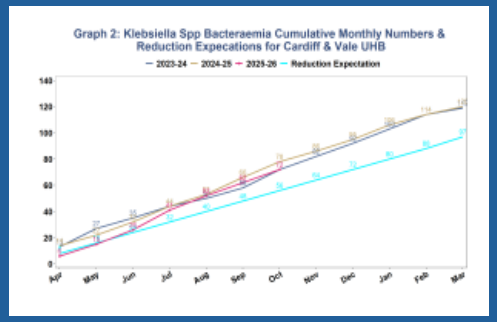












Shaping our Future Quality Excellence HAI Dashboard Development

Work to develop the Infection prevention and control surveillance dashboard is continuing with data measures including MRSA by source, Infection screening and response compliance, reason for sample collection by source, response time to postive results and line associated infections.

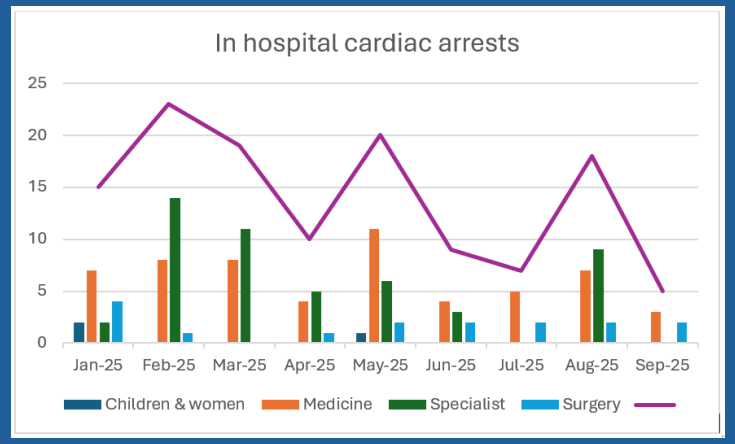
Infection Prevention and Control (IP&C)

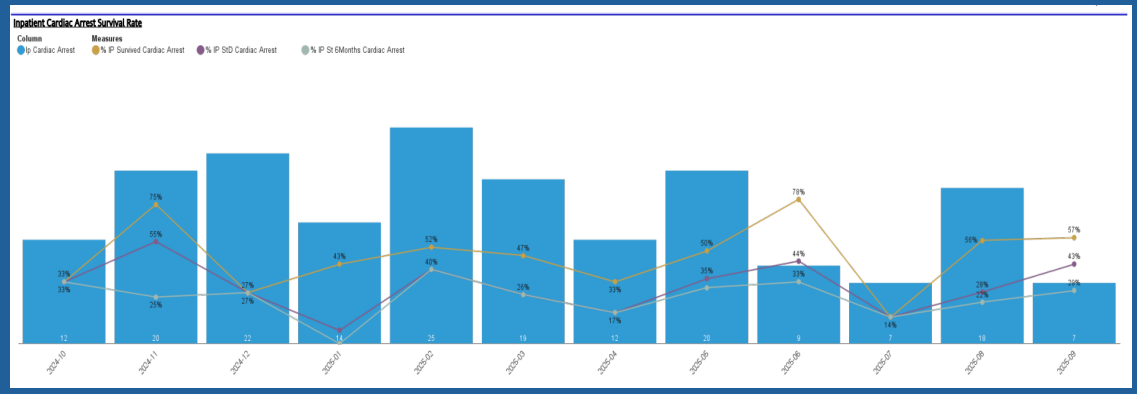
Wales health care associated infection CAI surveillance data for October 2025 shows a reduction in Clostridium difficile (C. diff) and Methicillin-Susceptible Staphylococcus aureus (MSSA) cases compared to the same period in 2024. October had the lowest number of C. diff cases in a single month for the past 24 months. The IPC team continues to issue root cause analysis forms with learning slides to support case reviews and shared learning. MRSA cases have increased, prompting a renewed focus on delivering Aseptic Non-Touch Technique (ANTT) training for all clinical staff.

Winter planning is underway to ensure robust IPC support in anticipation of increased respiratory infections. A review of outdated IPC policies and procedures is ongoing, with updates being made accessible via the IPC SharePoint page. A review of screening audit data for Carbapenemase Producing Organisms (CPO) and Carbapenemase Resistant Organisms (CRO) on Tendable shows improved compliance compared to 2024. Adherence to national cleaning standards remains a priority, particularly the cleaning of bed spaces between patient discharge and admission. Isolation remains a challenge due to limited facilities. Patients with C. diff, CRO, COVID-19, flu or emerging infections require isolation to prevent transmission. Nursing staff complete risk assessments using the Welsh Nursing Care Record to guide safe and timely isolation decisions.

Safe Care

Deteriorating Patients





Shaping our Future Quality Excellence Acute Deterioration
Welsh Government issued the Welsh Health Circular, Standardising the Management of Acute Deterioration in 2024, mandating the adoption of the National Early Warning Score 2 (NEWS 2) for the identification and escalation of acute deterioration of adults, Pediatric Early warning Score (PEWS) for children and young people and Newborn Early Warning Track and Trigger 2 (NEWTT2) for use in the post-natal setting.

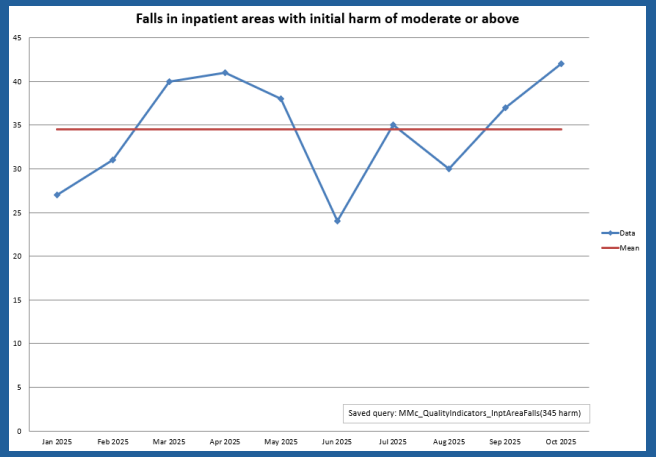
The early warning scores are now fully implemented across secondary care and the implementation of the process is being monitored. Implementation of early warning scores in Primary Care is dependent on digital changes within the PARIS system and the November "go live" date has been delayed until December 2025.

2222/3333 calls in the Outpatient setting
The Resuscitation Service and the Emergency Department on behalf of RADAR have developed a protocol for the escalation of patients that are receiving care outside an inpatient or acute clinical setting. The protocol seeks to to ensure that patient receive timely and effective care and are transferred to a safe clinical setting if they experience clinical deterioration in outpatients etc.

Resuscitation Service
Angela Jones, Senior Nurse, Resuscitation Service recently presented at the RCUK Conference. She has also been appointed to the Executive Committee for the Resuscitation Council (UK). **New Resuscitation Guidelines will be rolled out in the New Year.** Support after cardiac arrest standards have been launched. We are undertaking a gap analysis in the Health Board re this.

Safe Care

Patient Falls



Inpatient falls
During October, a further 21 people have undertaken the falls prevention and management session. The session continues to be exceptionally well received, with an average staff rating of 4.8 out of 5. Over 250 staff have been trained since May 2025.

Community falls
Falls training is underway with 5 care homes in the CAV area, with additional lifting equipment being provided where required. The training is being provided by St John Ambulance.

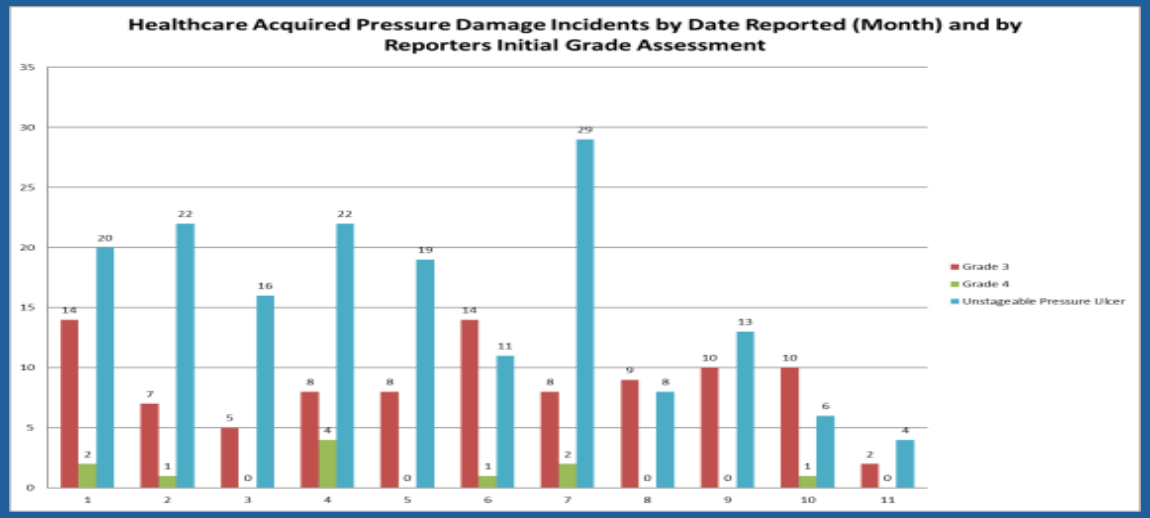
Discussions are underway to improve confidence of care home staff in managing falls through the use of action cards, aligned with the Ambulance Service's iStumble app.

The Keeping Me Well website is being further developed into a one-stop-shop for falls information, with a new self-assessment tool launching in December. This guides people to information and classes which are suitable for their needs. Promotional materials have been developed with input from the co-production group and our partner organisations.

Working collaboratively with Cardiff Telecare and WAST, the Health Board has been developing a pathway for fallers who do not currently receive Telecare to be triaged by the Single Point of Access. An appropriate response can then be deployed by the SPOA, which could be Telecare, the Physician Response Unit, or to continue with an Ambulance. This will reduce the amount of time fallers spend on the floor and allow the most appropriate service to attend to the person's needs.

Safe Care

Pressure Damage



The UHB Pressure Damage Collaborative reconvened in November 2025. Membership has been agreed with involvement from all clinical boards and corporate teams. The purpose of the Pressure Damage collaborative:

The Pressure Damage Collaborative exists to reduce healthcare-acquired pressure damage, improve patient outcomes and experience, and embed a culture of learning and assurance across all care settings. It will provide a multidisciplinary forum to drive improvement, share best practice, and monitor progress against agreed metrics.

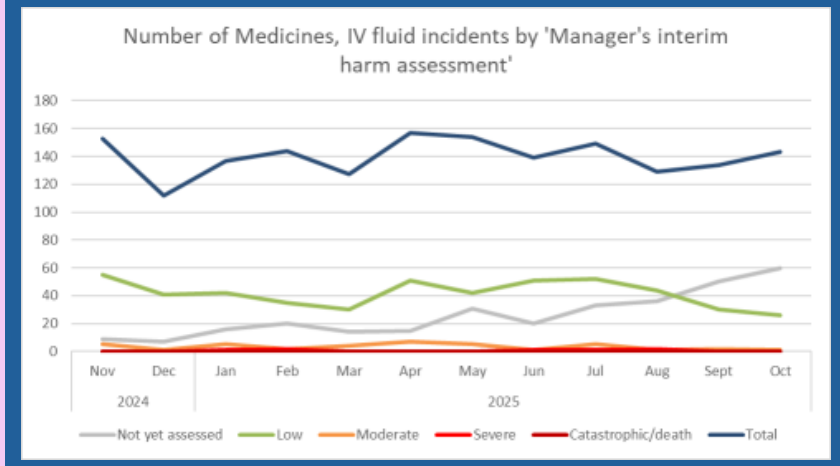
Five key workstreams have been identified:

- Information & Data (including Datix integration and dashboard)
- Education & Shared Learning
- Documentation & Standards
- Equipment
- Scrutiny Panels & Reporting Culture

The next meeting will focus on confirming, the chairs and members for each workstream. Once these roles are agreed, each workstream will collaboratively develop its programme plan and provide regular updates to the wider group. This will help ensure that interdependencies between workstreams are recognised and managed effectively. While the group is being re-established, meetings will be held monthly to maintain coordination and momentum.

Safe Care

Medication Safety



Note: Incidents where the Manager's interim harm assessment is 'none' are not shown on the graph (but are included in the total number of incidents)

Medicines-related incidents reported via Datix Cymru between 1st November 2024 and 31st October 2025
Manager's interim harm assessment:

- **Catastrophic/Death**: 0 incidents
- **Severe**: 7 incidents (0.4% of Meds, IV fluid incidents)
- **Moderate**: 39 incidents (2.3% of Meds, IV fluid incidents)
- **Low**: 499 (29.7% of Meds, IV fluid incidents)
- **No harm**: 832 (49.6% of Meds, IV fluid incidents)
- **Not yet assessed**: 311 (18.5% of Meds, IV fluid incidents)

Launch of Electronic Prescribing Medicines Adminstration (EPMA) system
EPMA is a key part of the digital medicines transformation portfolio which aims to make the prescribing, dispensing and administration of medicines in Wales easier, safer, more efficient and effective for patients and clinicians.
The roll out of ePMA in CAVUHB began in July, with the system going live on early adopter wards in Nephrology and Transplant (B5, A5 North and Cardiff Transplant Unit). The system has also now been rolled out across Neurosciences, Haematology, Cardiology and Medicine at UHW.

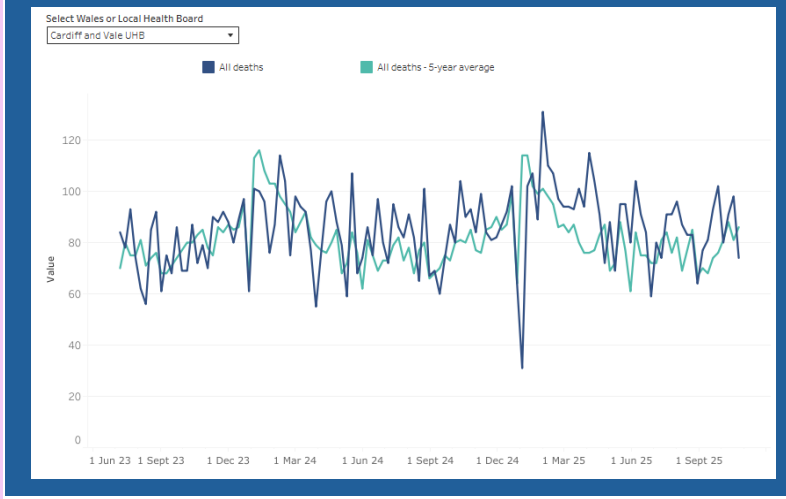
The system is being embedded and initial learning from the first wards are being utilised to improve and optimise further roll-out. Initial data report development and subsequent analysis is being undertaken currently and the ePMA team will soon be able to share initial data related to medicines safety.

Shaping Our Future Quality Excellence (SoFQE) – Medicines Safety
The three workstreams for the project were presented and agreed at Project Board. They are Governance and Assurance, Standards and Operations Processes and Medicines Safety Culture. Leads for each of the workstreams have been identified and met. Outcome measures are being agreed prior to December Project board and Programme board meetings. Cause-and-effect exploration has commenced across the UHB, listening directly to staff to reveal the real reasons why medication errors happen.

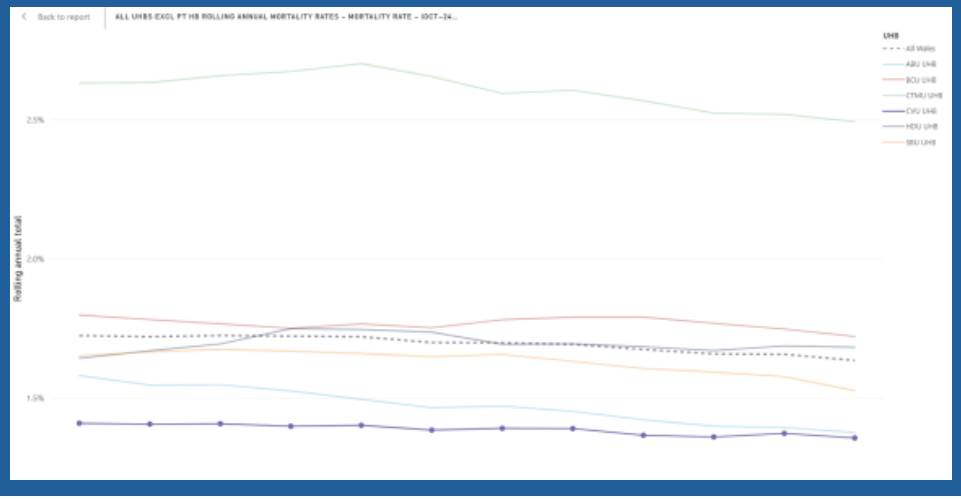
Effective Care

Mortality

All Cause mortality (deaths in all settings)



Crude Inpatient Mortality (Beacon dashboard QOF)



The all-cause mortality rate across the Cardiff and Vale UHB area continues a similar seasonal pattern to the five-year average. Numbers of deaths are similar to the same period in the previous year. Crude inpatient mortality continues under the all-Wales average. Crude inpatient mortality in Sept 2025 was 1.10%, compared with 1.28% in Sept 2024.

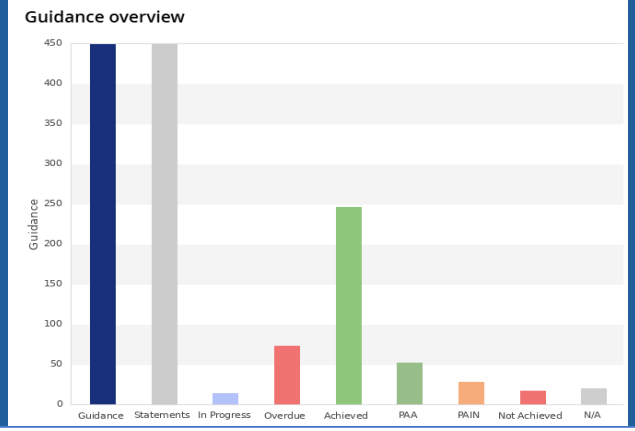
The Medical Examiner scrutiny process continues to be a valuable source of information and learning for the Health Board. During September 2025, in 39 in-hospital deaths the Medical Examiner provided feedback to the Health Board. Feedback themes included delays in treatment and diagnosis, as well as communication.

The national quality outcomes framework has been published and includes a crude measure of inpatient mortality measured against All Wales crude mortality rate. This will supersede the previous UHB crude mortality indicator.

Work is underway in conjunction with CTMUHB and AMaT to improve the mortality module and tailor it for NHS Wales.

Effective Care

Audit and Assurance



Implementation of NICE and Health Technology Wales Guidance

The Clinical Effectiveness Committee held on 22nd October was dedicated to the National Cancer Audits. The following audits were discussed:

Upper GI Cancer (NOGCA)

Cardiff's surgical survival rates and pathology indicators meet or exceed national standards. However, treatment pathways are significantly delayed, averaging 101 days, and national audit data does not accurately reflect local performance due to poor data capture. To improve, it is recommended that the team should streamline diagnostic and treatment pathways, strengthen data entry processes, and provide dedicated administrative support.

Lung Cancer (NLCA)

Cardiff has met surgical resection targets for the first time; 20% of non-small cell lung cancers resected, and overall survival rates are improving.MDT and navigator roles have improved patient flow. Despite this, diagnostic delays remain a major issue, Wales lags behind England, particularly with genomic profiling and variability in CT reporting. The service is not yet prepared for the 2027 rollout of lung cancer screening due to surgical and diagnostic capacity. It was discussed that improvements should focus on accelerating diagnostics, expanding surgical capacity and workforce planning for future screening plans, and validating data accuracy.

Prostate Cancer (NPCA)

The audit shows good compliance for PSA and staging data, and access to radical treatment is strong. However, Cardiff appears as an outlier for metastatic diagnoses, which is likely due to incomplete or inaccurate data. The priority is to validate staging information and review referral pathways to ensure accurate reporting.

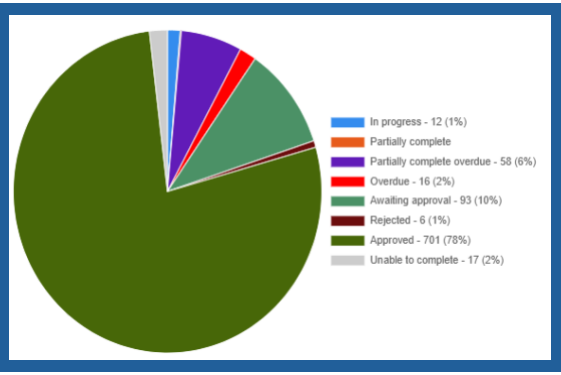
Breast Cancer

Reconstruction rates have improved from 10% to 25% but systemic treatment data remains unreliable and likely under reported. Key challenges include the absence of one-stop clinics since COVID for which Cardiff is an outlier, persistently high re-operation rates, and a lag in published data (audit reflects 2020-2022). The focus should be on reinstating one-stop clinics, reducing re-operation rates through case review, reduce radiology capacity constraints and improving real-time data capture.

Across all audits, the key improvement priorities are to streamline cancer pathways, improve data quality and validation, expand diagnostic and surgical capacity, reinstate timely access to tests and treatments, and move to real-time performance monitoring.

Effective Care

Internal and External Assurance



Progress against HIW inspections

Healthcare Inspectorate Wales

The graph above demonstrates progress against the HIW improvement plans hosted on the UHB quality management System AMaT.

Following the inspection of Elizabeth Ward, St David's Hospital in May, a series of targeted actions have been implemented to address the identified areas for improvement. The following actions have been completed since the inspection:

- **Environment & Infection Control:** Clinical areas have been decluttered to reduce infection risk, and cleaning schedules have been reinforced with documented compliance checks. Weekly audits are now in place to maintain standards.
- **Medication Management:** Daily medication storage checks have been introduced with a clear audit trail, and staff have been reminded of timely documentation requirements.
- **Patient Experience:** Monitoring of nurse call response times has been implemented, with escalation processes for delays. Patient feedback continues to be collected and reviewed monthly to inform improvements.
- **Staff Training & Competency:** A focused drive on mandatory training compliance is underway, supported by progress tracking dashboards. Competency assessments have been scheduled for all clinical staff to ensure skills remain current.
- **Governance & Reporting:** Monthly compliance reports are now shared with ward leadership and governance teams, and electronic prompts for medication recording have been introduced to reduce omissions.

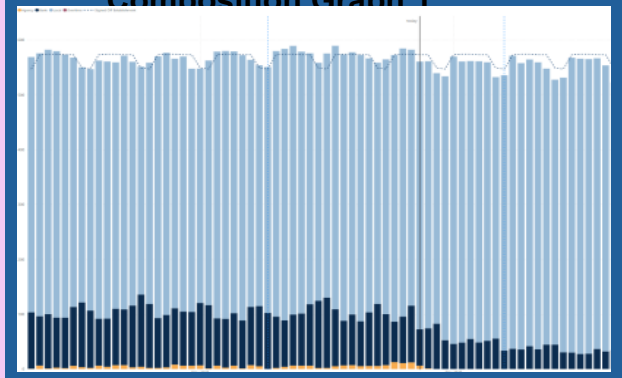
Progress will continue to be monitored through weekly ward huddles and monthly governance reviews.

Leadership Listening walkrounds

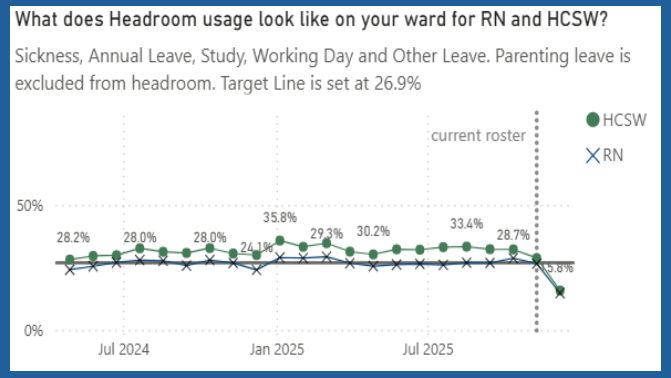
The leadership Listening walkrounds undertaken by the Executive and Independent members of the Board, commenced in August 2025. These walkrounds offer an opportunity for Health Board leaders to meet with clinical teams and support teams across the organsiation, to discuss their successes and challenges. Walkrounds undertaken in November included B4 Neurology B2 Vascular and Infection prevention and Control . The Walkrounds will form part of a wider engagement and internal assurance framework .

Workforce

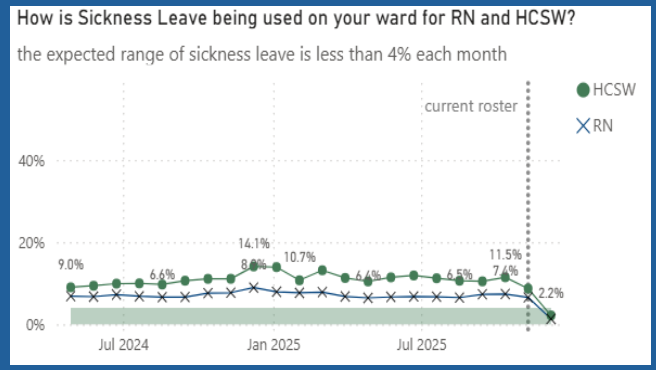
Staffing Composition Graph 1



Headroom trends Graph 2



Sickness Trends Graph 3



Nurse Staffing Levels

- **Staffing Composition Over 24 Hours – 25B Areas (Graph 1):**
  This graph provides an overview of the nurse staffing levels across a 24-hour period for acute adult and paediatric inpatient wards, specifically those designated as 25B areas under the Nurse Staffing Levels (Wales) Act. Substantive staff are shown in light blue, bank staff in dark blue, and agency staff in yellow. A small rise in agency use can be seen towards the end of November, and this is linked to patient care needs. The dotted line demonstrates the signed off establishment and evidence of how nurse staffing rosters are met across the organisation.

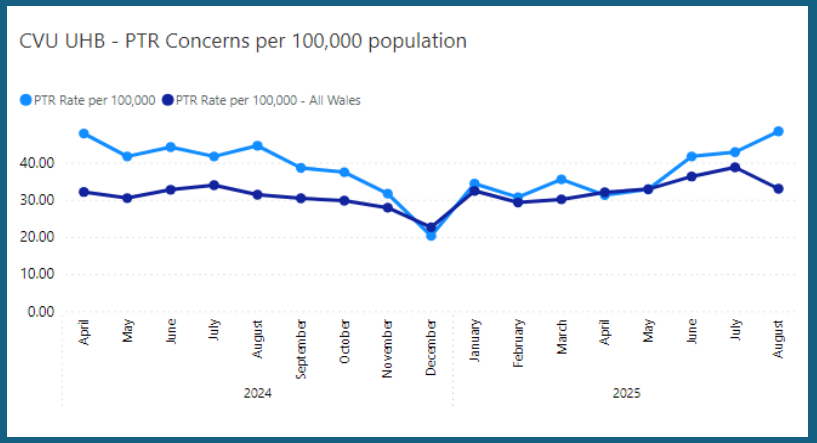
- **Headroom Trends (Graph 2):**
  Average headroom across all areas stands at 30.1%. Unavailability continues to be more pronounced within the Healthcare Support Worker (HCSW) group at 32.2% compared to registered nurses at 28.7%.

- **Sickness Rates (Graph 3):**
  Sickness remains a concern across the nursing workforce. Last month, the overall sickness rate was 9% (previously 8.8% last month), with unregistered staff experiencing a higher rate of 11.5%, compared to 7.4% among registered nurses.

- **Shift Appropriateness – 25B Wards:**
  Staffing levels are assessed for appropriateness on every shift as required as part of the Nurse Staffing Levels (Wales) Act.
  During October 84% of shifts were deemed appropriately staffed- this represents a small decrease on the previous reported 87% of shifts being recorded as appropriate. The total percentages of the planned rosters being met based on their signed off establishment was 70%, again this represent a small decrease. Processes are place to monitor this performance and escalated to the Executive Director of Nursing.

Patient Centred Care

Concerns

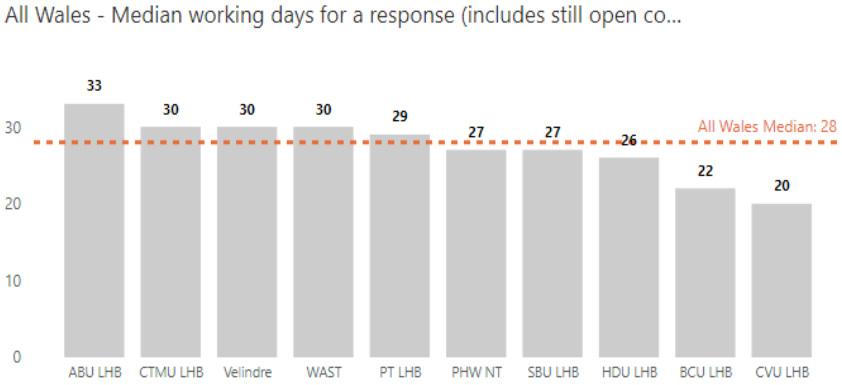


Quality and Patient Experience

Reporting Period: 1 November 2024– 31st October 2025

The data illustrates the monthly volume of concerns received over the past 12 months.

Contrary to historical trends, concern rates increased during the summer months, a period that typically experiences a reduction. We have noted a steady increase since April, however, a small reduction was seen in October.



Performance

The graphs shows the median response time to formal concerns across Wales and Cardiff and Vale UHB's current performance against Welsh Government's 75% target. A decline in response times is recognised across Wales due to the complexity of concerns and the raised awareness of AI tools in generating concerns

Patient Centred Care

Concerns

Themes in concerns across UHB (August to Oct 25 – 920 Concerns)

Thematic reviews of concerns are undertaken to understand challenges in clinical boards and to support improvement.

Medicine Clinical Board

- Delays in Diagnostics are common, particularly in diabetes management and stroke care
- Unsafe or rushed discharges leading to inadequate aftercare , particularly for vulnerable and elderly adults
- Communication failures leading to delays in sharing test results and coordinating care
- Ward cleanliness and infection control improvements required to ensure a safe environment for patients

Surgery Clinical Board

- Patients experienced extensive delays across multiple surgical specialties, causing frustration and anxiety
- Frequent cancellations and poor communication about rescheduling heightened patient dissatisfaction
- Gaps in pain management and rehabilitation support affected recovery and patient trust.

Mental health Clinical Board

- Significant delays in ADHD and autism assessments cause prolonged waiting times of over four years for some patient
- Limited access to psychological therapies and specialist services contributes to prolonged distress and unmet mental health needs.
- Challenges in discharge planning, care continuity, and staff communication impact quality of mental health services.
- Urgent capacity building and process improvements are essential to enhance mental health care delivery.

THEME/ISSUE	FREQUENCY/TREND
Delays in appointments/treatment	Very High
Communication failures	Very High
Unsafe/inadequate discharge	High
Administrative/record errors	High
Staff attitude/behaviour	Moderate-High
Equipment/medication access	Moderate
Hygiene/environmental concerns	Moderate

Patient Centred Care

Concerns

Children and Women Clinical Board

- Delays in paediatric and gynecology appointments affected timely diagnosis and treatment for children and women.
- Lack of clarity and involvement in care planning caused dissatisfaction among families and parents
- Concerns noted in safeguarding referrals, postnatal, maternity, and neonatal care requiring stronger protocols and support.

- **Specialist Clinical Board**
  - Delays in appointments and follow-ups were common complaints across multiple specialties including cardiology and neurology.
  - Patients experienced missed or delayed diagnoses and problems with medication supply and monitoring.
  - Poor communication between teams and with patients worsened service delivery and patient experience.

Patient Centred Care

Concerns

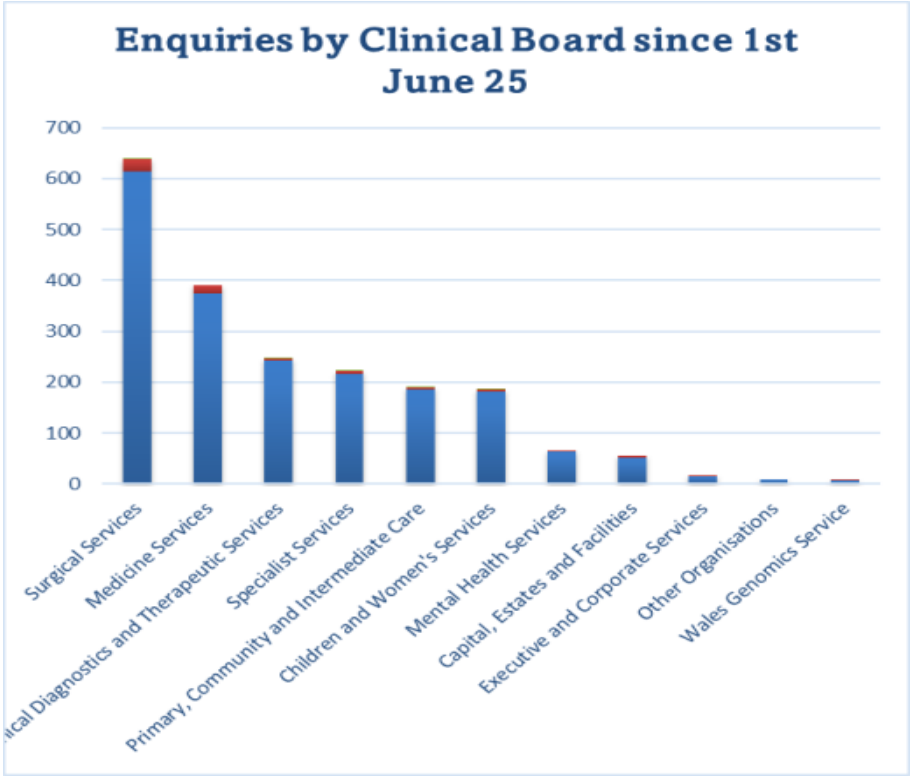
Enquiries line

We Have managed 2027 Enquiries since 1st June 2025. You will note that Surgical Clinical Board continue to receive the majority of enquiries, followed by Medicine Clinical Board.

Emerging Themes:

Recurring issues are regularly collated and shared with relevant teams to support targeted interventions. Current themes include:

- Challenges in booking or modifying outpatient appointments
- Prolonged waiting times
- Requests to fast-track appointments or referrals

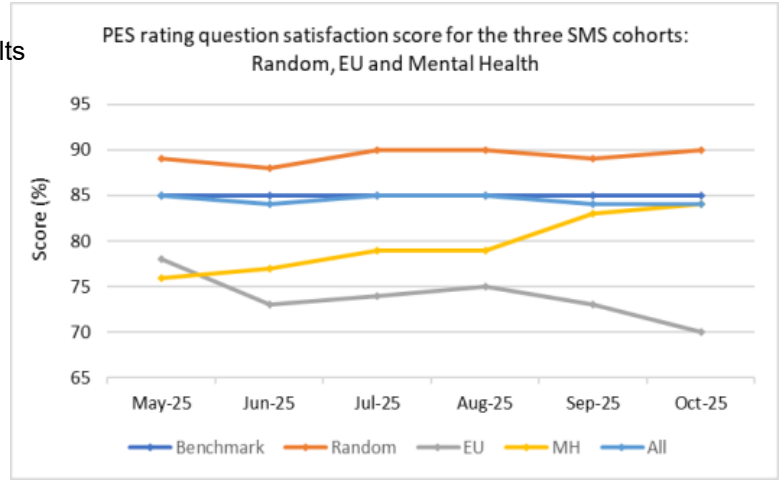


Patient Centred Care

Patient Experience

- The UHB is currently surveying up to 1,000 patients daily via text, 600 chosen randomly from general hospital activity, 200 from EU activity and 200 from Mental Health activity. **Over the past 12 months, we have sent over 183,000 texts** and are seeing a response of 16%.
- In October we sent 17,147 texts and had 2,905 completions (17% response).
- Of those respondents who were discharged during September/October and answered the rating question, 84% were satisfied with our service.
- The information given in the chart opposite, is based on the satisfaction score received for the PES rating question, for each of the SMS cohorts, by month (last 6 months included).

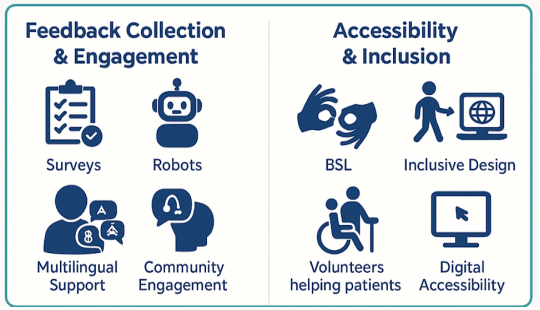
Figure 1 Patient Experience Survey results



We continue to develop and theme our library of patients and relatives' stories

All our surveys are in BSL

and multiple languages



Patient Centred Care

Patient Experience

Feedback

- **Satisfaction scores for core questions in the People's Experience Survey (PES) for Emergency Unit, Mental Health and Random selection**
- **Sample: Based on feedback received from the above areas between: 01/10/2025 – 31/10/2025**

Cohort	Respondents (n)	Staff Caring (%)	Feel Safe (%)	Overall (%)
Emergency Department	736	84	83	70
Mental Health	115	87	88	84
Random Selection	1776	94	96	89

* Staff caring: *Were staff kind and caring?*
Feel safe: *Whilst in our care did you feel safe?*
Overall: *How would you rate your overall experience?*

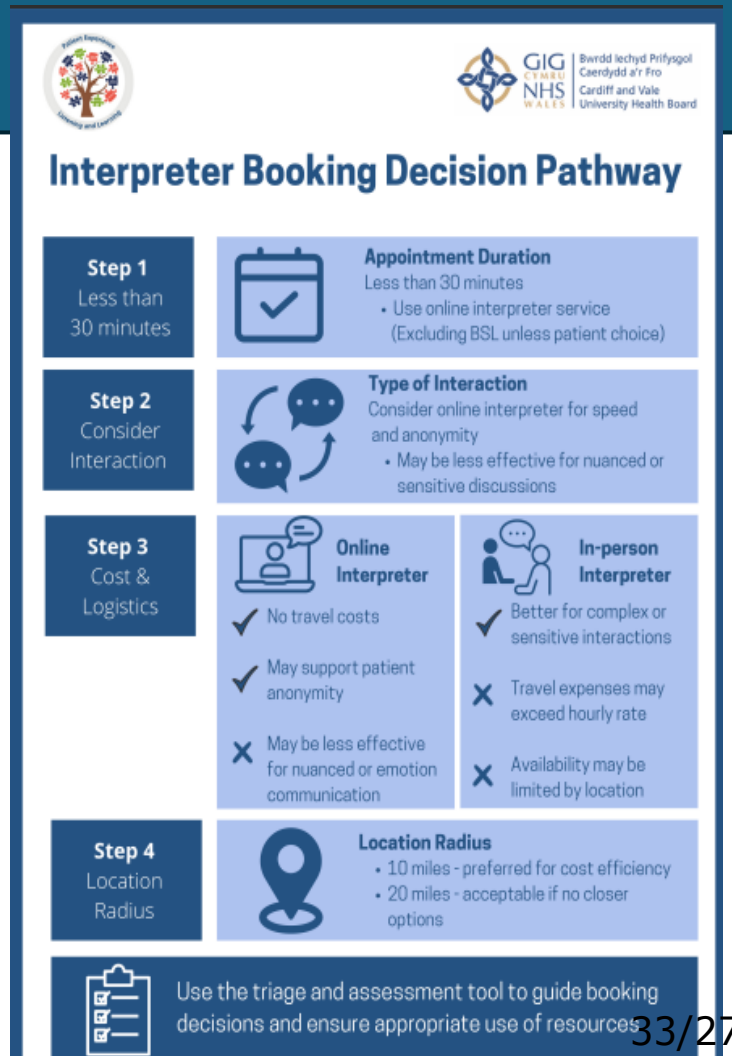
Person Centred Care

Patient Experience

Interpretation & Translation Services including BSL

- Currently exploring the procurement and incorporation of a Video Relay Service (VRS) for deployment across all Cardiff and Vale UHB sites, currently in place in the Children's Hospital
- VRS allows deaf and hard of hearing individuals to communicate with hearing people through a live interpreter over video. This is to ensure effortless and inclusive interactions.

- Following feedback, the PE Team have helped to improve the experiences of those using our translation services from the Deaf Community by raising awareness and reminding staff about booking pathways and processes for interpreters/translators.
- An internal SharePoint microsite has been created for staff, with helpful tips, information and advice on booking interpretation/translation services.
- Over 100 posters have been distributed across hospital sites for use in staff areas as a visual prompt of how to ensure interpretation translation services are booked in a timely and effective way, improving patient experience for the Deaf community and the needs of the wider community.



Report Title:	Mental Health Clinical Board (MHCB) Quality Indicators Report				Agenda Item No:	2.2
Meeting:	Quality Committee		Public	x	Meeting Date:	09.12.2025
			Private			
Status	Assurance	X	Approval		Information/Noting	
Lead Executive:	Jason Roberts - Executive Director of Nursing MHCB					
Report Author Title:	Tara Robison - Interim Director of Nursing MHCB					

Main Report
Background and Current Situation:

This report details the clinical governance arrangements within the Mental Health Clinical Board (MHCB) in relation to Quality, Safety, and Patient Experience (QSPE). It sets out achievements, progress, and planned actions to maintain the priority of QSPE. It is aligned to the UHB's Shaping Our Future Well Being Strategy 2015 – 2025, that underpins the development of our service, and the Quality, Safety and Patient Experience Framework 2021-2026.

Summary of what MHCB covers

MHCB provides a broad range of mental health services throughout Cardiff and the Vale of Glamorgan, supporting people from late teens to older adults. Their services follow an integrated locality care model that connects community, primary care, and inpatient settings, all with a strong focus on recovery and person-centred care.

Core Services

- **Primary Care Services** – The Primary Mental Health Support Service (PMHSS) offers routine assessment, signposting and treatment under part 1 of the MH Measure to people presenting with common mild to moderate mental health difficulties. Other primary care teams offer psychological interventions for people with a range of anxiety disorders, depression and low risk complex emotional needs in the community.
- **Community Mental Health Teams (CMHTs)**: CMHTs are organized across six localities and are responsible for the assessment, treatment, and ongoing care coordination of adults experiencing moderate to severe mental health difficulties. These teams serve as a vital link between individuals and support resources, ensuring that care is tailored to the needs of each patient within their community.
- **Crisis Resolution and Home Treatment Teams (CRHTTs)**: The CRHTTs deliver urgent interventions designed to stabilize individuals in crisis and prevent unnecessary hospital admissions. By providing intensive support within the home environment, these teams help patients manage acute episodes safely while maintaining their connection to family and community.
- **Specialist Services**: A range of specialist programs are available to address specific mental health needs. These include Addictions support (CAVDAS), services for Eating Disorders, Neuropsychiatry, Forensic Mental Health care, the Headroom program for early intervention in psychosis, Autism services, Veterans' Support, and care for Young Onset Dementia. Each service is staffed by professionals with expertise in their respective fields to deliver targeted, evidence-based interventions.
- **Mental Health Services for Older People (MHSOP)**: MHSOP provides comprehensive care for individuals aged 65 and older who are living with dementia or functional mental illness. Multidisciplinary teams offer a continuum of support including inpatient treatment, community outreach, and day services, all aimed at maintaining well-being and quality of life for older adults.

Strategic Priorities

- The Mental Health Clinical Board's strategic direction is closely aligned with the Welsh Government's *Together for Mental Health* strategy, the *Mental Health and Wellbeing Strategy 2025–2035*, and the University Health Board's *Shaping Our Future Wellbeing*

2035 vision. These frameworks guide the Board's work and set the foundation for service development and improvement.

- The Board's primary focus areas include promoting early intervention to address mental health needs promptly, reducing health inequalities across different population groups, collaborating with service users and their families through co-production, and strengthening crisis care pathways to ensure timely support for individuals in distress. We are moving towards the open access/ One at a Time model outlined by Welsh Government.
- The Suicide Prevention and Self-Harm Strategic Plan for 2025–2030 sets out eight key objectives. Among these are delivering compassionate support to those at risk and fostering strong engagement with the community to prevent suicide and self-harm, reflecting the Board's commitment to safety and well-being.

Workforce Information in the MHCB

Current Workforce Pressures and Trends

The Mental Health Clinical Board (MHCB) workforce continues to experience significant pressure due to increasing demand for services, the growing complexity of patient needs, and persistent staffing challenges across both inpatient and community settings. As of January 2025, the total workforce headcount was 1,579, representing a slight decrease from 1,594 reported in August 2023.

While there has been a modest increase in staff numbers for Additional Clinical Services (from 548 to 566) and Add Prof Scientific and Technic roles (from 142 to 148), the number of Registered Nurses has declined from 618 to 592. This reduction in nursing staff is particularly concerning given the rising acuity of patients and increased observation requirements in inpatient environments.

Age and Gender Distribution

Analysis of age distribution data reveals a relatively balanced workforce across age bands. The largest groups of staff are aged 26–35 and 36–45, indicating a strong presence of mid-career professionals. However, there is also a notable proportion of staff aged 56 and above, with over 200 individuals falling into this category. This raises the possibility of future retirement pressures that could further impact workforce stability.

The gender distribution within the MHCB workforce has remained stable, with approximately 75% female and 25% male staff. There has been a slight increase in full-time roles among both genders compared to the previous year, reflecting a shift toward more consistent staffing patterns.

Implications for Workforce Planning and Investment

MHCB is working alongside HEIW and the Strategic Mental Health Workforce Plan for Health and Social Care in Wales focusing efforts on key theme areas such as workforce planning, addressing shortages and building sustainability and actions including data quality improvements.

These workforce trends highlight the urgent need for investment in staffing and training. The current workforce investment case emphasizes the importance of increasing staffing levels, expanding training capacity, and strengthening the Practice Development Team. These measures are essential for supporting staff resilience, promoting retention, and driving quality improvement across MHCB services.

Additionally, the data underscores the necessity for strategic workforce planning initiatives to address future risks, including skill shortages, an ageing workforce, and the long-term sustainability of mental health services. Proactive workforce management will be critical in maintaining high standards of care and meeting the evolving needs of the population served by MHCB.

See the addendum for graphical presentation.

Summary of the Aim of the MHCB

The Mental Health Clinical Board (MHCB) is dedicated to delivering compassionate, recovery-focused mental health care. Central to its mission is the formation of co-productive partnerships, which involve service users, their families, and communities in the design and delivery of care. By working collaboratively, the MHCB seeks to empower individuals and promote dignity throughout their recovery journeys.

MHCB aims to provide comprehensive support to both individuals and communities, ensuring that care is accessible and effective across inpatient and community settings. The emphasis on integrated services reflects the Board's commitment to seamless care coordination, enabling those with mental health needs to live well and thrive within their communities.

In all aspects of care, the MHCB prioritizes dignity, empowerment, and integration of services. These guiding principles shape its approach to fostering well-being, supporting recovery, and building stronger, healthier communities.

Quality, Safety, and Patient Experience (QSPE) Arrangements within the MHCB

Within the Mental Health Clinical Board (MHCB), structured Quality, Safety, and Patient Experience (QSPE) arrangements are in place to support ongoing quality improvement. Bi-monthly QSPE meetings are convened and chaired by the Director of Nursing for Mental Health. These meetings follow the University Health Board (UHB) agenda and provide a dedicated forum to discuss progress and challenges across the six quality enablers.

The discussions and outcomes from these meetings are systematically communicated to bi-monthly directorate QSPE meetings as well as to local team meetings, ensuring that information and learning can be shared at all levels of the organization. This process allows QSPE information to flow in both directions across the various meeting structures, supporting effective feedback loops, and promoting continuous improvement throughout the MHCB.

The report is set out in following the six quality enablers:

1. Safe Care

Patient Safety Incidents

SIRAN Accreditation

The Safety Incident Response Accreditation Network (SIRAN), previously named Serious Incident Review Accreditation Network was established in 2020 to promote quality improvement within and between organisations conducting serious incident investigations.

Audit programme organised by the Royal College of Psychiatrists Centre for Quality Improvement.

Siran is governed by a multidisciplinary group of professionals who represent key interests and areas of expertise in the field of patient safety, as well as carer representation who has lived experience dealing with and affected by serious incidents.

There are currently 16 members across the UK and Cardiff and Vale UHB are the only Welsh member.

We wanted to join SIRAN:

- To reduce compounded harm
- Create a supportive and inclusive review process that involved all
- Learn from and adhere to best practice
- Strengthen and develop stronger networks with safety partners
- Improve our review processes to inform learning

There are 62 standards in total and these cover governance and safety systems, quality of safety incident (SI) reviews, learning responses, engagement and involvement of clinical staff and engagement and involvement of patients and families.

The SIRAN accreditation process involves:

- Self-review assessment (3-month period); included surveys shared with staff, patients and families and SI reviewers, SI reviews, improvements plans, evidence of staff engagement, Sentinels Terms of Reference, incident reporting policy and processes.
- External peer review included meetings with SI reviewers, clinical staff and host team.
- Local report- with the opportunity to comment and provide additional evidence
- Accreditation outcome (Accredited, accreditation deferred, not accredited)
- Round table meetings

Improvements made since joining SIRAN include:

- Development of booklets for patients and families'/reviewers/ staff involved in patient safety incident
- Introduction of a Glossary in reviews
- Improved staff support
- Improved understanding around TORs
- Appointment of a Family Liaison Worker (FLO)
- Opportunity to benchmark (engage in peer reviews)

The Mental Health Clinical Board have been a member of SIRAN since March 2023 and achieved accreditation in March 2024

Introduction of the Family Liaison Officer (FLO)

The Family Liaison Officer (FLO) role was established in June 2024 to strengthen communication and support for patients and families involved in mental health reviews. The FLO plays a crucial part in ensuring that the principles of openness and transparency are upheld throughout the review process.

Key Responsibilities of the FLO

- Ensuring compliance with the Duty of Candour, thereby promoting honesty in all interactions with patients and families.
- Actively contacting all patients or families involved in a Patient Safety Learning Review (PSLR) or a local mental health review to ensure they are informed and included.
- Supporting families to participate fully and meaningfully in the review process, recognising the importance of their perspectives and experiences.
- Providing families with regular updates on the progress of reviews, ensuring they remain informed at every stage.

- Offering guidance and support throughout the inquest process where required, helping families navigate complex procedures.
- Signposting families to relevant support services to address any further needs identified during the review process.

Benefits of the FLO Role

- Ensures all patients and families have equal opportunities to engage in the review process, promoting inclusivity and fairness.
- Enables timely identification and escalation of concerns raised by families, facilitating swift and appropriate action where needed.
- Strengthens transparency and trust between mental health services and families, supporting a culture of learning and continuous improvement.

Patient Safety Reviews

MHCB Fact Finding Form:

Fact-finding forms received by year-end:

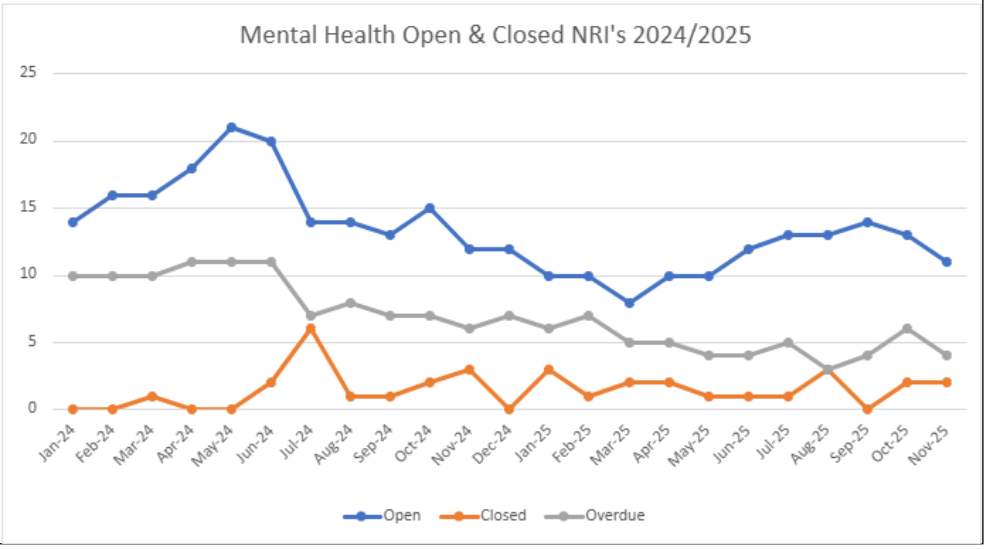
2022	2023	2024	2025 Jan - Oct
201	186	138	89

MH Reviews

Open mental health reviews at year-end:

	2022	2023	2024	2025 (OCT)
Mental Health Review	29	25	33	19

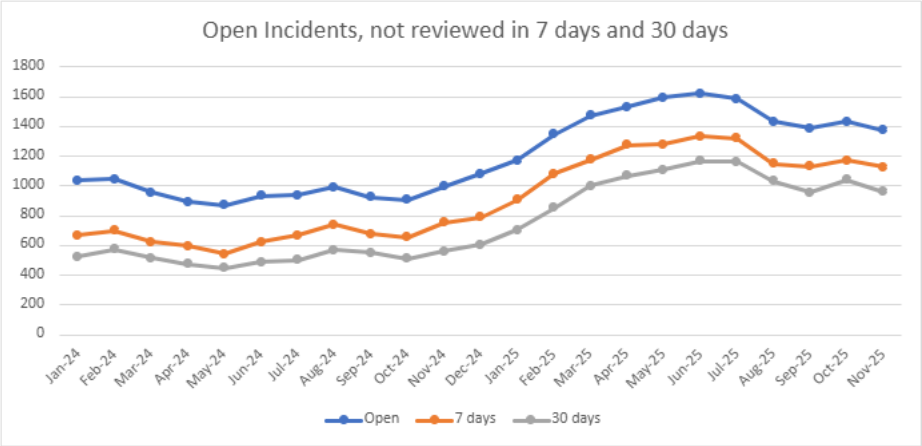
NRIs



NRI's	Open	Closed	Overdue
Jan-24	14	0	10
Feb-24	16	0	10
Mar-24	16	1	10
Apr-24	18	0	11
May-24	21	0	11
Jun-24	20	2	11
Jul-24	14	6	7
Aug-24	14	1	8
Sep-24	13	1	7
Oct-24	15	2	7
Nov-24	12	3	6
Dec-24	12	0	7
Jan-25	10	3	6
Feb-25	10	1	7
Mar-25	8	2	5
Apr-25	10	2	5
May-25	10	1	4
Jun-25	12	1	4
Jul-25	13	1	5
Aug-25	13	3	3
Sep-25	14	0	4
Oct-25	13	2	6
Nov-25	11	2	4

Incidents

Incidents	Open	7 days	30 days
Jan-24	1038	666	522
Feb-24	1046	700	573
Mar-24	954	625	513
Apr-24	894	594	473
May-24	869	544	446
Jun-24	934	621	487
Jul-24	938	666	502
Aug-24	993	741	571
Sep-24	924	677	551
Oct-24	905	654	509
Nov-24	997	755	558
Dec-24	1082	789	605
Jan-25	1170	908	705
Feb-25	1346	1083	854
Mar-25	1472	1177	1000
Apr-25	1534	1274	1068
May-25	1597	1280	1111
Jun-25	1620	1334	1169
Jul-25	1587	1322	1162
Aug-25	1432	1150	1034
Sep-25	1386	1131	956
Oct-25	1432	1171	1041
Nov-25	1376	1128	959



NRI Reporting Dashboard

Matt McCarthy from the Patient Safety Team has created a Dashboard designed to present Incident Data in real time to the Clinical Board, thereby eliminating the need to generate Datix reports manually. The dashboard remains under development, with additional features currently being planned. Directors of Nursing have already been granted access to this tool.

Single Unified Safeguarding Overview (SUSR)

At present, there are two cases being managed under the Single Unified Safeguarding Review (SUSR) process. It should be noted that one of these cases has been temporarily put on hold at the request of South Wales Police (SWP).

Case Review Group (CRG) Involvement

The Quality, Safety and Experience (QSE) team is responsible for referring and presenting cases to the Case Review Group (CRG), which is chaired by the Local Authority. Referral to

the CRG takes place when multi-agency safeguarding concerns are identified during internal review processes.

Regulation 28 (Prevention of Future Deaths) Order

During the past six months, the service has received one Regulation 28 order, also known as a Prevention of Future Deaths order, issued by the coroner. This order specifically identified the need for enhanced processes in the collection and dissemination of information with families.

In response to the coroner's findings, the Health Board has provided a formal reply outlining the steps being taken to address the highlighted concerns. As part of these efforts, new guidance on information sharing and gathering—co-produced in partnership with relevant stakeholders—has been developed. This guidance is currently pending final approval from the Executive Team.

Additionally, a two-year, co-produced family engagement project was launched in August 2025. The aim of this project is to further strengthen collaboration with families and improve communication pathways, ensuring that information sharing is consistent, timely, and supportive of both patients and their families.

Improvement Plans

Overview of Identified Issues

Earlier this year, a comprehensive review of improvement plans within the Mental Health Clinical Board (MHCB) was undertaken. The review highlighted several significant concerns, including the existence of more than 60 separate improvement plans and over 345 actions associated with various recommendations. Additionally, it was observed that historical improvement plans had been lost over time, and the methods in use were not effectively identifying broader organisational themes.

Review and Thematic Mapping

To address these challenges, all improvement plans stored on the S drive, as well as those documented in Word and AMAT from 2022, were systematically reviewed. The learning and recommendations arising from these plans have been mapped into key themes, providing a more structured approach to improvement. As a result, six core themes have been identified:

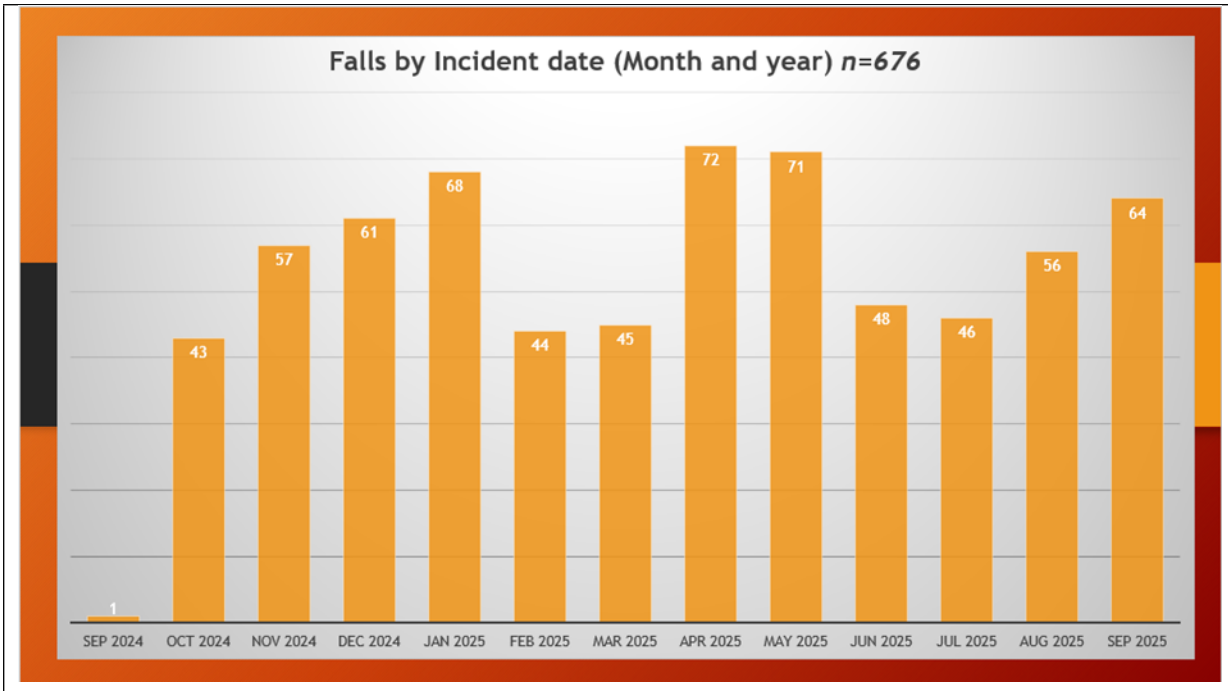
- Engagement and Care Planning
- Safety and Risk Formulation
- Family Engagement and Involvement
- Service Provision
- Safeguarding
- Documentation

Project Leadership and Oversight

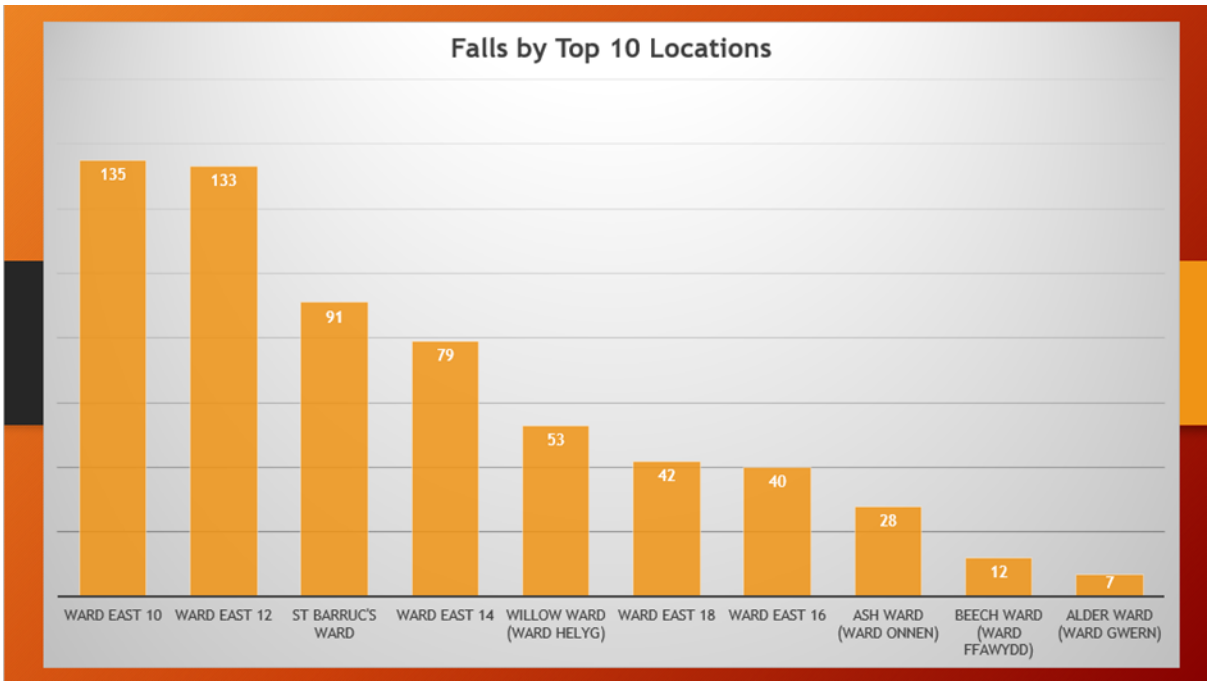
Dedicated project leads have been appointed for the workstreams focusing on safety and risk formulation, as well as family engagement. The remaining four workstreams—covering engagement and care planning, service provision, safeguarding, and documentation—are being overseen by the Deputy Director for Mental Health Nursing.

Falls Overview

Falls occurring within the service have fluctuated over the course of the year, reflecting a pattern of variability rather than consistency. Notably, April 2025 saw the highest incident rate, with a total of 72 falls reported during that month. The accompanying chart provides a visual representation of the monthly fall figures spanning from September 2024 to September 2025. In summary, the total number of falls reported for the year was 676, underscoring the need for ongoing monitoring and review to ensure patient safety and inform future preventative strategies.

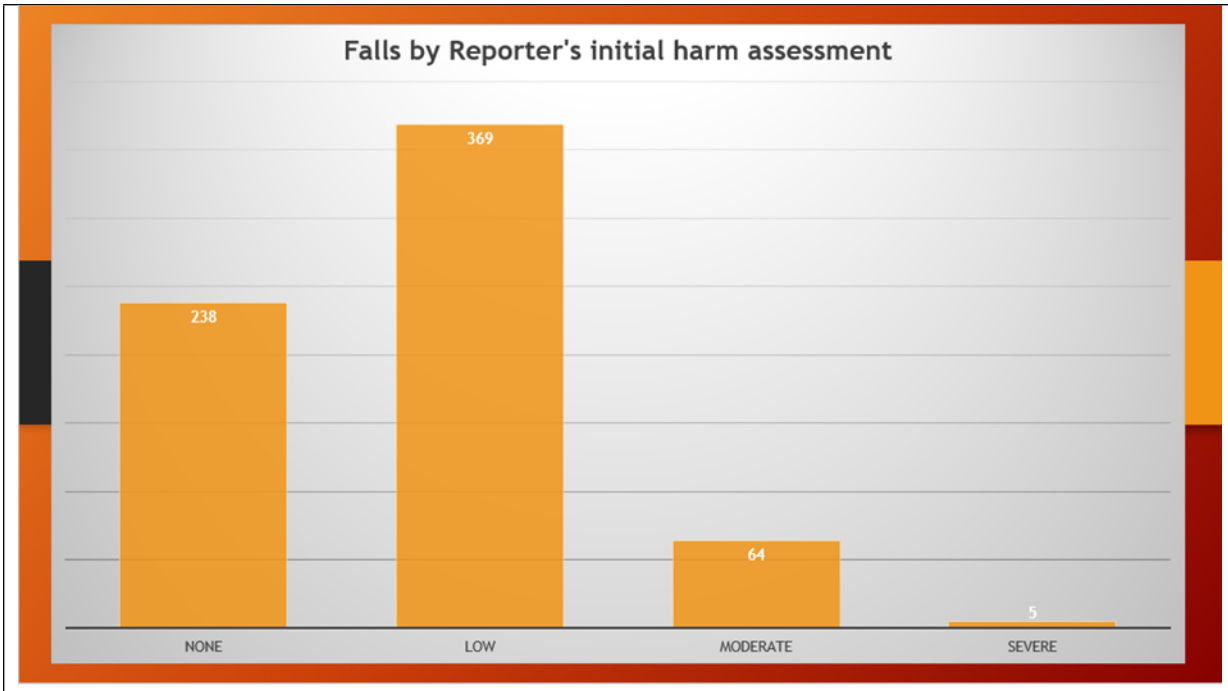


Locations of Falls:

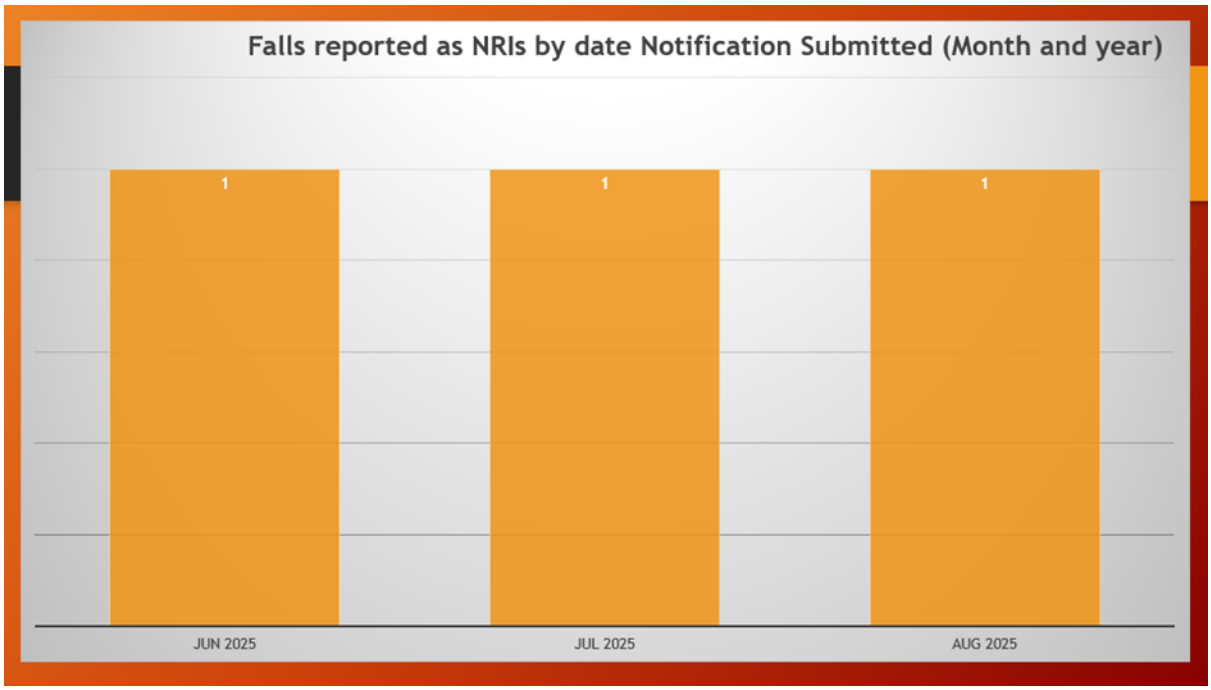


Harm Assessment Following Falls

According to the initial harm assessment reports, the majority of falls resulted in low levels of harm. Specifically, out of the total incidents, 369 falls were categorised as causing low harm. In contrast, a small number of falls—five in total—were associated with severe harm. This distribution highlights that while most falls did not lead to significant injury, there remains a need for continued vigilance and targeted interventions to prevent instances of severe harm within the service.

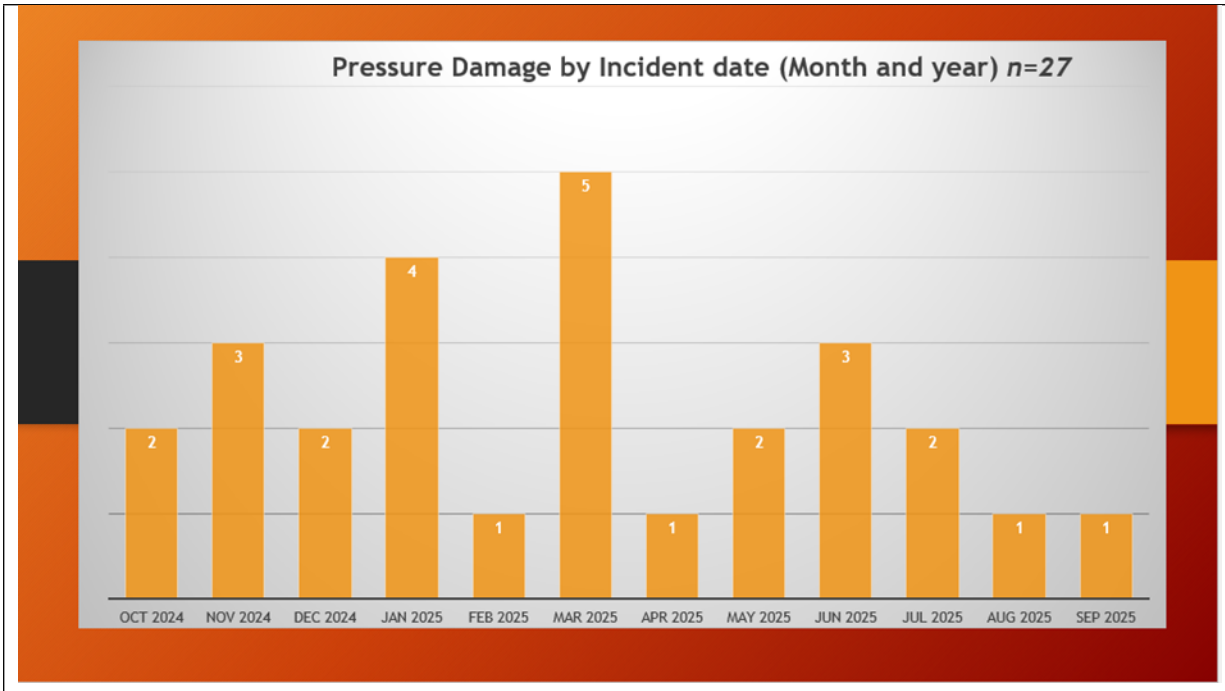


During this period, three falls have been reported as NRIs.



Pressure and Tissue Damage Prevention

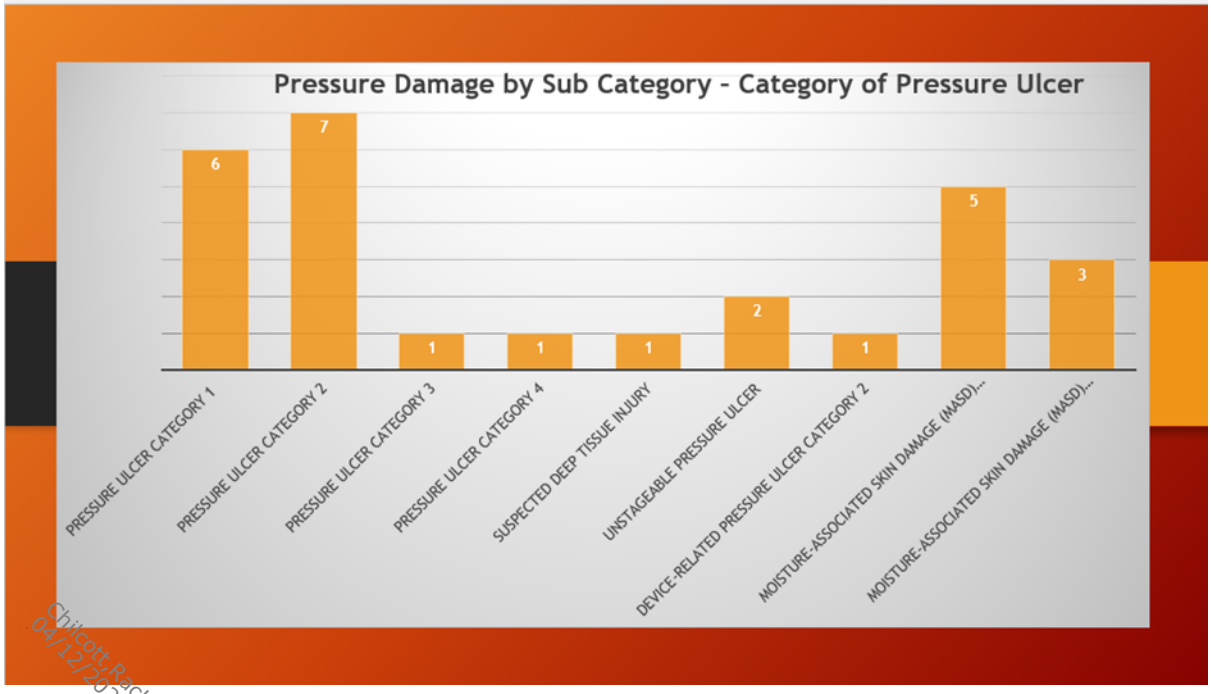
Between October 2024 and September 2025, a total of 27 incidents of pressure damage were reported within the service. The month of March 2025 recorded the highest number of cases, with five incidents noted during that period. These figures highlight the ongoing need for robust preventative measures and regular monitoring to minimise the occurrence of pressure-related injuries among patients.



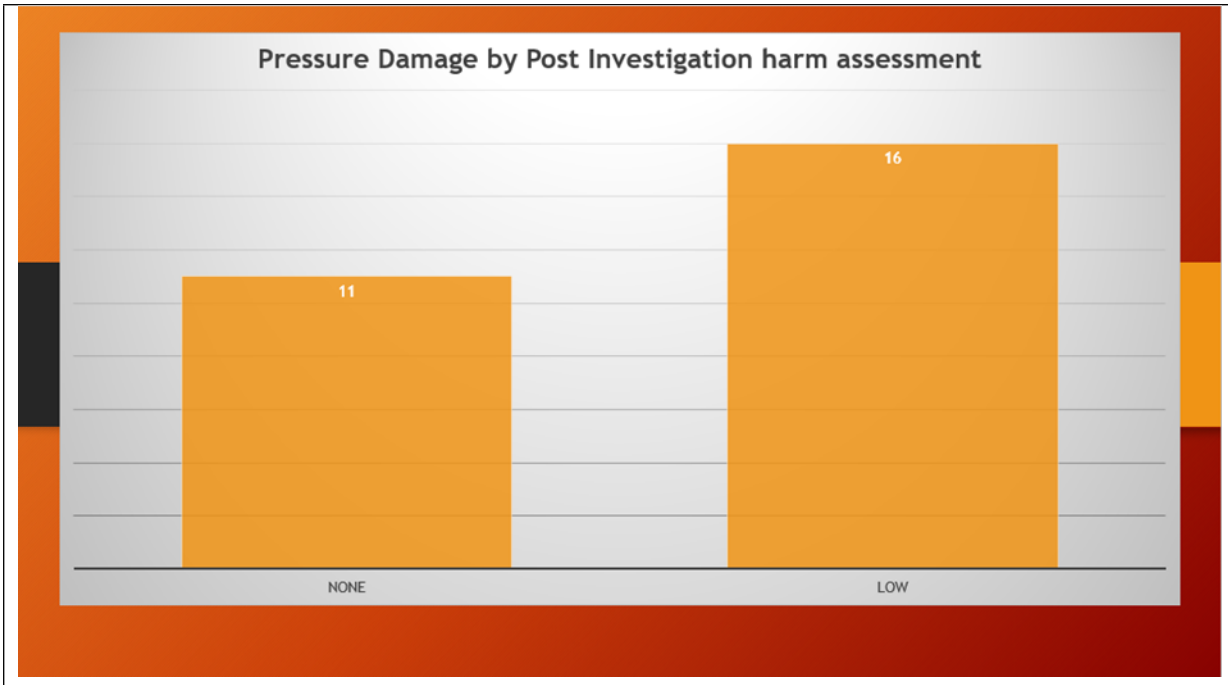
Severity and Classification of Pressure and Tissue Damage

Within the reporting period, incidents of pressure damage were categorised according to severity and type. Notably, there was only one incident each of Stage 3 pressure damage, Stage 4 pressure damage, and suspected deep tissue injury. Additionally, two cases were identified as unstageable pressure ulcers, while one incident was attributed to device-related pressure damage.

Most pressure damage cases reported were classified as grade 1 and grade 2, alongside instances of Moisture-Associated Skin Damage (MASD). This distribution indicates that most patients experienced less severe forms of pressure-related injury, with only a small number of more serious cases observed during the period.



Post investigation harm assessment was as follows:



Infection, Prevention and Control

There were 3 known outbreaks of infection reported from April 2025 within the Mental Health Inpatient Services:

Ward	Outbreak	No. patients/staff affected	Date of Outbreak	Outbreak closed
East 18	COVID-19	4 patients plus 1 low level positive staff	08/06/25	16/06/25
Oak Ward	D&V	6 patients and 6 staff	27/06/25	Not reported
Willow Ward	D&V	2 patients and 1 staff	06/04/25	09/04/25

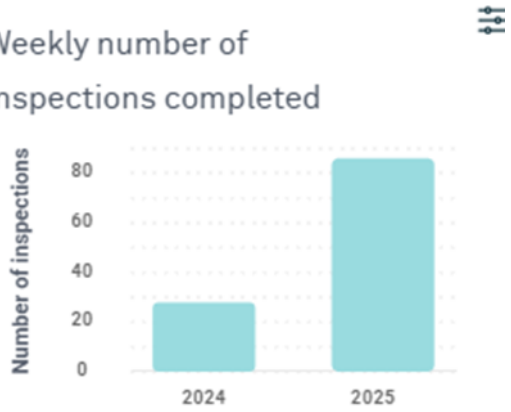
There has only been 1 HCAI (Healthcare Associated Infection) reported during the period April-Sept 2025:

C diff	1 case – July
Ecoli	0
Kleb	0
MRSA	0
MSSA	0
Pseudomonas	0

Tendable audits

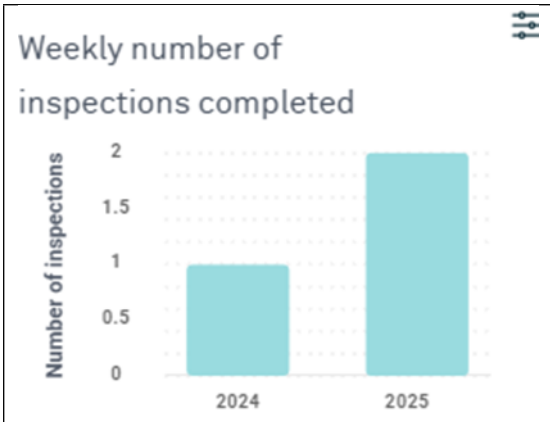
There has been a notable improvement in Tendable audits relating to the Core Standards for Infection Prevention and Control (IPC) during 2025. The data indicates that the frequency of weekly inspections has almost doubled compared to previous periods, reflecting a

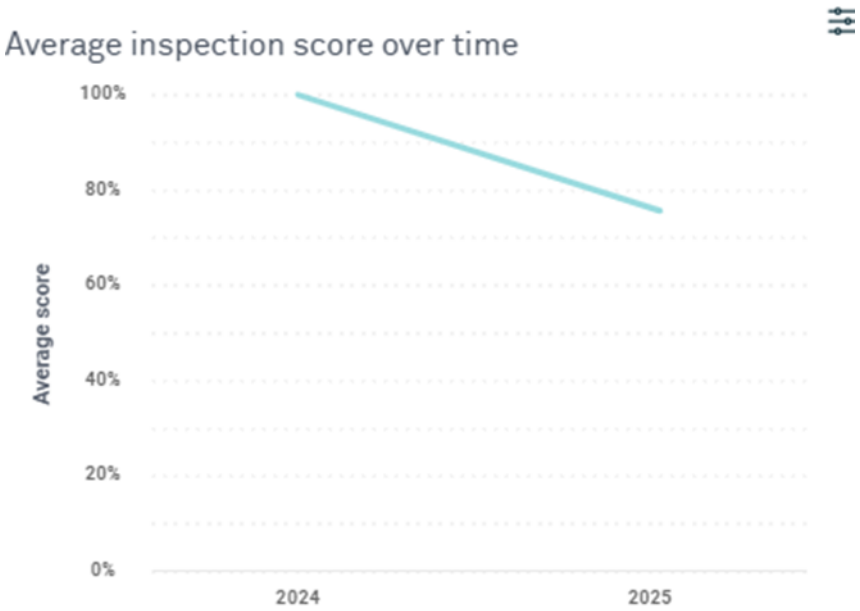
strengthened focus on maintaining high standards of infection control within the service.



BBE (Bare Below Elbow) Nursing Team Audits

The BBE nursing team audits have consistently demonstrated poor performance, both in terms of completion frequency and overall scores. Audit activities are not being conducted regularly, which is directly reflected in the results obtained. This highlights an area in need of focused attention to improve compliance and raise the standards associated with BBE practices within the nursing team.





In the last IPCG meeting in September 2025 we discussed going back to basics and increasing the compliance with the tenable audits.

Ward Rostering Efficiencies

Since August, monthly meetings have been scheduled with all 18 inpatient wards by the Director of Nursing (DoN) and Finance to review ward rostering efficiencies alongside workforce and financial data.

These reviews identified several inefficiencies, including:

- Work Life Balance (WLB) requests not aligned with service needs.
- Manual adjustments to shift times.
- Creation of additional duties that were not required.

As a result, some wards were operating above agreed safe staffing levels, driving unnecessary costs.

Through these meetings and wider clinical board efficiency initiatives, significant improvements have been achieved. While actual bank usage is considerably lower, recent recruitment to vacancies has slightly influenced the overall position. Nevertheless, bank expenditure has reduced substantially, delivering over £200k savings across inpatient wards in September and October compared to the control total.

Looking ahead, these meetings will continue for the remainder of the financial year. From next year, we will transition to a RAG-rated approach, focusing monthly reviews only on wards with high financial risk. With lower risk wards having local directorate level reviews with quarterly and 6-monthly reviews with DoN. This initiative is aligned with the organisation's objective of

maintaining financial sustainability and is supporting the clinical board in reducing its operational overspend.

2. Timely Care

Part 2 Recovery Plan

Overview of Part 2 of the Mental Health Measure

Part 2 of the Mental Health Measure focuses on ensuring that patients have a valid and up-to-date Care and Treatment Plan (CTP). This requirement is designed as a quality standard, aiming to provide individuals with clarity regarding the care they can expect when engaging with Mental Health services.

Current Compliance and Improvement Trajectory

Historically, compliance with Part 2 within Cardiff and Vale has been notably poor. In response, the Clinical Board has collaborated with clinical teams to develop an improvement trajectory. The primary objective of this trajectory is to achieve a compliance rate of 90% by the end of the financial year.

Long-Term Approach and Monitoring

The improvement trajectory has been planned over an extended period to avoid a situation where many CTPs require review within a single month in future years. To facilitate ongoing progress, the Clinical Board has introduced a live dashboard that provides daily performance data at the team level.

Performance Management and Projected Outcomes

In addition to the dashboard, the directorate has established a weekly performance management process with teams to support sustained improvement. As a result of these efforts, the projected compliance position for the end of November is 61.5%, reflecting an improvement of nearly 10% compared to the period prior to the intervention.

Weekly Performance Management Process

To reinforce ongoing compliance improvements, the directorate has implemented a structured weekly performance management process with all teams. This approach is designed to maintain a consistent focus on progress, enabling teams to review performance data, identify challenges, and agree on practical solutions in a timely fashion.

Impact on Compliance Rates

Through the combined use of a live dashboard—providing daily, team-level performance insights—and regular performance management meetings, the directorate has seen measurable progress. The latest projections indicate that, by the end of November, compliance with Part 2 of the Mental Health Measure is expected to reach 61.5%. This represents a significant improvement, amounting to an increase of nearly 10% in compliance compared to the period before these interventions were introduced.

3. Effective Care

Electroconvulsive Therapy Accreditation Service (ECTAS)

In June 2025, the Mental Health Care Board (MHCB) Electroconvulsive Therapy (ECT) clinic achieved full accreditation from the Electroconvulsive Therapy Accreditation Service (ECTAS), valid until June 2028. The clinic was awarded an outstanding score of 100% during the assessment process.

Alongside this remarkable achievement, the clinic received commendations across several key standard domains:

- Monitoring and Follow Up: Recognised for robust procedures ensuring effective patient monitoring and follow-up care.

- Documentation: Commended for maintaining comprehensive and accurate records throughout the treatment process.
- Training and Research: Praised for a strong commitment to ongoing staff training and involvement in research activities.
- Patient and Carer Experience: Acknowledged for providing a positive experience to both patients and their carers, ensuring their voices are heard and their needs are addressed

This accreditation and the accompanying commendations reflect the clinic's dedication to delivering high-quality, safe, and patient-centred care in accordance with national standards.

Pentwyn Community Mental Health Team (CMHT) Carer Friendly Accreditation

In April 2025, the Pentwyn Community Mental Health Team (CMHT) achieved carer friendly accreditation, marking a significant milestone in recognising the team's commitment to supporting carers within the community. This accreditation reflects the dedication of Pentwyn CMHT to fostering a supportive and inclusive environment for carers, ensuring their needs and contributions are acknowledged as an integral part of mental health care provision.

Further recognition of the team's efforts was received in August 2025, when representatives from Tuvida visited Pentwyn to formally present the Carers Accreditation certificate. This event underscored the value of the team's work, which has gained attention beyond the local area. Tuvida has widely shared Pentwyn CMHT's approaches and achievements, positioning them as an exemplar of best practice for other organisations seeking to attain carer friendly accreditation.

Encouragingly, Tuvida indicated that Pentwyn CMHT is well placed to progress towards advanced accreditation in the coming months. This acknowledgement highlights the ongoing commitment of the team to continuous improvement and further development of carer support initiatives, setting a positive example within the sector.

CoLead: Fostering Collaborative and Shared Leadership in Welsh Healthcare

CoLead is a HEIW pilot across two AMH wards (Maple and Beech) to foster team collaboration and a culture of psychological safety utilising a non-hierarchical leadership structure. The CoLead initiative is evidence informed approach, committed to nurturing a culture of collaboration and shared leadership at every level within the healthcare system in Wales. By encouraging active involvement, CoLead aims to empower healthcare professionals to collectively drive progress and improvement across the sector.

Strengthening Leadership Capabilities

Participants have access to innovative development programmes designed to enhance their leadership skills and build confidence. These opportunities focus on equipping individuals with the tools and knowledge necessary for effective leadership in complex healthcare environments.

Driving Meaningful Change

CoLead offers a platform for professionals to play an active role in shaping the future of healthcare leadership. By influencing policy, practice, and organisational culture, participants contribute to meaningful transformation within the sector.

Building Strategic Networks

The initiative fosters connections among peers throughout Wales, encouraging the exchange of insights and sharing of best practices. This collaborative approach supports cross-sector partnerships and strengthens the wider healthcare community.

Improving Patient Outcomes

Through enhanced leadership and teamwork, CoLead aims to empower teams to deliver safer and more effective care. The focus on shared leadership directly supports improved patient outcomes and the delivery of high-quality services.

BPSS Executive Summary

In July 2025, the Buvidal Psychological Support Service (BPSS) received the Executive Summary of its Independent Review, which highlighted several key strengths of the service. The review commended BPSS for delivering high-quality interventions, noting that the treatments provided are both effective and tailored to individual needs. The report also emphasised the service's strong levels of engagement with service users, reflecting a commitment to involving individuals in their care and fostering positive therapeutic relationships.

Additionally, the Independent Review recognised the efficient use of resources within BPSS, illustrating how the service maximises its impact and ensures value for investment. Overall, the findings of the Executive Summary underscore the dedication of BPSS to maintaining high standards in psychological support and delivering measurable benefits to those accessing the service.

2024 Awards and Achievements

RCN Wales Nurse of the Year & Registered Mental Health Nurse Award – Madelaine Watkins

Madelaine Watkins, Clinical Nurse Specialist for Voices and Visions, was honoured with the RCN Wales Nurse of the Year award in 2024 in recognition of her pioneering efforts to improve care for older adults living with psychosis. Observing that only 10% of patients were accessing therapy, Madelaine implemented a trauma-informed, psychosocial approach, shifting care provision away from an exclusively biomedical model. Her work also led to the establishment of the Voices & Visions Champions network and the delivery of psychosis training to over 100 staff members, thereby empowering teams and promoting patient autonomy.

Following her award win, Madelaine has remained at the forefront of service improvement, sharing her expertise at national and international events such as the RCN Congress and the International Council of Nurses Congress in Helsinki. She has also featured in International Nurses Day campaigns. Her ongoing commitment includes embedding trauma-informed principles, expanding staff training, and inspiring future mental health nursing professionals.

Through her leadership, Cardiff and Vale UHB has experienced a cultural shift towards person-centred care, resulting in improved recovery outcomes for patients and their families.

RCN Specialist Nurse Award – Tim Nichols

Tim Nichols, Clinical Nurse Specialist in Dementia Care, received the 2024 RCN Specialist Nurse award, recognising his fifteen years of dedication to mental health nursing and his focus on person-centred dementia care. In his specialist role, Tim has driven evidence-based improvements, including the introduction and delivery of Cognitive Stimulation Therapy (CST) on wards, and the application of the Newcastle Model for holistic psychological formulation. He has also utilised Dementia Care Mapping (DCM) to assess wellbeing and foster positive change in care culture.

Tim's creative engagement initiatives, such as music, dance, and art collaborations, have helped reduce stigma and enhance the patient experience, with outcomes displayed publicly. He is leading an innovative AI project aimed at improving pain detection and management in dementia, which seeks to minimise distress and decrease reliance on antipsychotic and benzodiazepine medication. Tim's work is characterised by compassion, creativity, and a commitment to using technology to enhance the quality of life for people living with dementia.

RCN Improving Individual and Population Health Award – Julia Somerford

Julia Somerford, Senior Nurse for Physical Health, was recognised in 2024 for her exceptional contributions to improving individual and population health within older adult mental health services. As a general nurse, Julia has concentrated on bridging the gap between physical and mental health care by providing training and upskilling mental health nurses in vital physical health competencies. She has established strong partnerships with medical teams to enhance care pathways and ensure patients benefit from integrated, holistic support.

Julia's leadership in falls prevention initiatives has helped to mitigate risks and improve safety for older adults, exemplifying her commitment to high-quality, patient-centred care.

2025 Health and Care Research Wales Impact Award

Recognition of the Perinatal Service

The Perinatal Service was awarded the prestigious 2025 Health and Care Research Wales Impact Award. This accolade was received in acknowledgement of their work in developing an Acceptance and Commitment Therapy (ACT) group.

Development of Acceptance and Commitment Therapy Group

The successful introduction of the ACT group by the Perinatal Service highlights their commitment to innovative therapeutic approaches within perinatal mental health care. The programme was designed to support individuals through evidence-based psychological interventions, promoting acceptance and positive change.

November UHB Health Hero

Julia Stone, high intensity psychological therapist with the Eating Disorder Service (EDSOT) has been named the UHB's November's health hero for her outstanding dedication and care for patients.

Julia has been part of Cardiff and Vale University Health Board since 2002. She originally trained in London as a Mental Health Nurse, starting her career in an Eating Disorders Service.

After moving to Cardiff, Julia worked in various mental health roles before returning four years ago to her passion - the Eating Disorder Service. Today, she manages a caseload of clients, seeing them for between 10 and 40 sessions, and runs compassion-focused therapy groups.

Julia was nominated by a client, who wrote: "Julia has gone above and beyond to support me in my mental health journey. Every move forward has been made with extra care. Julia has been a lifeline! If it were not for Julia, I'm not sure I would even be here.

"She takes her job seriously and it seems she devotes herself to giving the best possible treatment to her patients. I think I would go as far as to say that Julia has helped make my life feel worth living.

“Additionally, Julia has been so understanding of my Autism. She has taken new approaches and made various accommodations to help support me as an autistic individual. I have never felt judged or pressured in my treatment. We have always worked at a pace that is suitable, and Julia is always trying to understand autism more. If anyone deserves an award, it is definitely Julia Stone.”

Responding to the nomination, Julia said: “It was really moving. The fact that even with so much else going on, she still felt that was really important to do. Knowing someone has appreciated the contact you've had with them is quite amazing. “

Julia chose to be photographed as Health Hero with her team. “It's an incredibly compassionate and supportive team, who are always kind. The whole team works so hard to keep doing the best that they can.”

Mental Health Clinical Board Recognition Awards

The Mental Health Clinical Board Staff Recognition Awards are now in their third consecutive year, reflecting a growing culture of appreciation and acknowledgement within the organisation. Each year has seen a progressive increase in the number of nominations, underscoring the enthusiasm and engagement of staff in celebrating excellence across the service.

In the current year, a total of 160 nominations were received, demonstrating widespread participation and recognition of colleagues’ achievements. Nominations were submitted across six distinct categories: Inspiring Leader, Going the Extra Mile, Great Achiever, Putting the Patient First, Team of the Year, and Outstanding Team. Each category serves to highlight unique contributions and exemplary behaviours that support the Board’s values and commitment to quality care.

The awards ceremony, which honours the nominees and recipients, is scheduled to take place on 10/12/2025. This event provides an important opportunity to formally recognise and celebrate the dedication, compassion, and achievements of staff working within the Mental Health Clinical Board.

SafeWards Pilot on Cedar Ward

Cedar Ward was chosen as the NHS Wales Performance and Improvement pilot site for the introduction of the SafeWards model. This structured approach is designed to reduce conflict and the use of containment measures in mental health environments. SafeWards focuses on fostering therapeutic relationships, enhancing communication, and encouraging mutual understanding between staff and patients, all of which help to create a safer, more recovery-focused atmosphere.

Implementation and Progress

Despite the high acuity of the ward, notable progress has been achieved in embedding several key SafeWards interventions. At present, three out of the ten interventions are actively in place:

- Know Each Other: Staff profiles are now displayed in communal spaces, and information about patients is collected either at admission or during the 72-hour care plan review. This approach supports the delivery of personalised care and allows for effective monitoring of the intervention’s impact.
- Mutual Help Meetings: These meetings take place twice a week, offering patients a platform to express concerns and contribute to the daily life of the ward. Documentation and follow-up processes have been established to ensure accountability and that actions are taken in response to feedback.
- Calm Down Methods: Work is ongoing to implement this intervention, with a ‘calm box’ being developed to support emotional regulation and help with de-escalation during challenging situations

Staff engagement is key to the SafeWards pilot's success. Quarterly review meetings with the SafeWards team and implementation group allow for ongoing feedback and collaborative planning.

4. Efficient Care

Innovations in Remote Physical Health Monitoring

Doccla remote physical health monitoring is being introduced for patients living in the community, with a particular focus on developing a Standard Operating Procedure (SOP) for clozapine titrations. This initiative is designed to reduce hospital admissions, optimise nursing time, and provide greater convenience for patients who are suitable for remote monitoring.

Alongside work on clozapine titrations, considerations are currently underway for the development of an SOP tailored to ADHD, reflecting a commitment to expanding remote monitoring practices to support a wider range of patient needs.

Preparing for Discharge Course

The Safe Discharge Standards for Wales (2025) establish clear expectations to ensure that individuals experience a safe, timely, and person-centred transition home. Cardiff and Vale Recovery and Wellbeing College actively applies these principles through its Preparing for Discharge (P4D) programme, a short course designed to help people plan effectively and feel more confident about returning to their everyday lives.

Course Structure and Collaboration

P4D consists of five sessions tailored for inpatients who are nearing discharge. The course was co-produced by patients, mental health practitioners, and peer trainers, reflecting a collaborative and inclusive approach. Delivery is co-facilitated by the Recovery College with contributions from ward teams and partner organisations. Each session is centred around the individual's needs, helping participants develop a personalised plan to support their transition.

Course Outcomes

The primary goal of P4D is to ensure that people leave hospital feeling more prepared, equipped with a clear plan, and strengthened connections to ongoing support. Local data indicates that this approach has a positive impact: readmission rates among P4D graduates are approximately 7.4%, notably lower than the 33% national average. With an estimated cost of £900 per bed per day and a typical three-week inpatient stay, this reduction translates to an indicative saving of roughly £340,000, as validated by Value in Health.

Participant Feedback

Beyond the financial savings, participants report increased confidence in managing medication, greater clarity regarding points of contact, and practical strategies for the initial days at home. As one participant shared, "It reminds me that we're all human and that we're not alone. I think we need to share our thoughts and feelings more."

As part of the work of the National Lived Experience Programme Preparing for discharge is going to be replicated in Cwm Taff and Hywel Dda Health Boards between February and end of March 2026. This course is also included in the safe discharge standards for Wales which have been recently published.

The national interest in this course and the potential benefit it can have across mental health services has resulted in Recovery College strategic Lead and Peer Trainer being invited to speak at the Royal College of Psychiatrists on Friday November 28th. One of the participants who continues to access the ongoing community sessions is attending with his wife and they are both going to share their reflections around the benefits of attending this course and the importance of peer roles and lived experience in mental health services.

Recovery College Attendance Data

Overview of Service

The Recovery and Wellbeing College represents the first co-produced, peer-led service within the NHS in Wales. It operates as part of the Mental Health Clinical Board, embodying an innovative approach to mental health support.

Psychoeducational Courses

The College offers a wide range of psychoeducational courses. These are developed and delivered collaboratively by both practitioners and peers, ensuring that lived experience is valued alongside professional expertise. This co-production and co-facilitation model is central to the College's ethos.

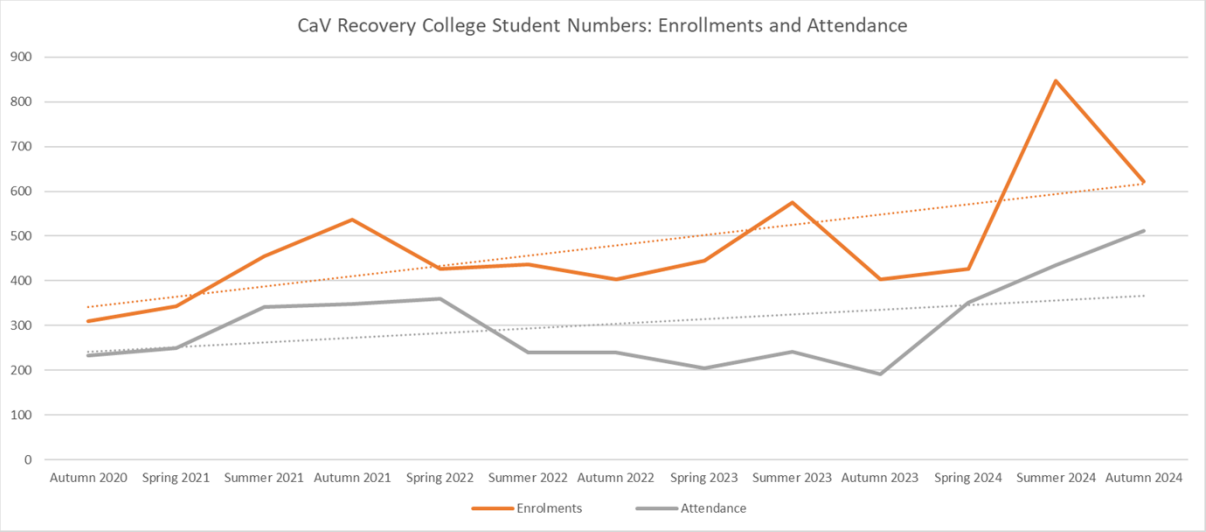
Curriculum and Delivery

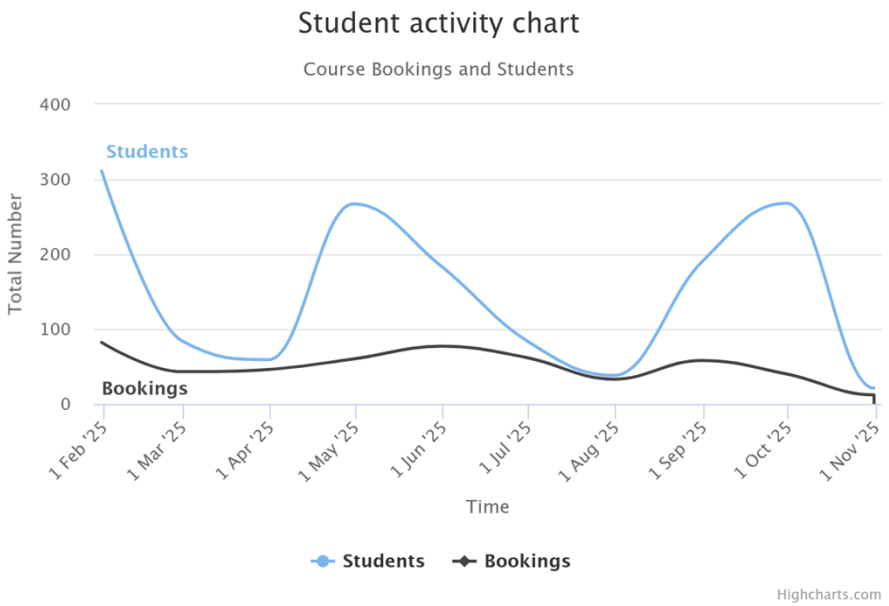
A total of 40 courses are available as part of the community curriculum. These are delivered across three academic terms each year, providing ongoing opportunities for engagement and learning. In addition to the community-based courses, the College also co-facilitates sessions within inpatient wards, including the Preparing for Discharge course held at Hafan – Y – Coed.

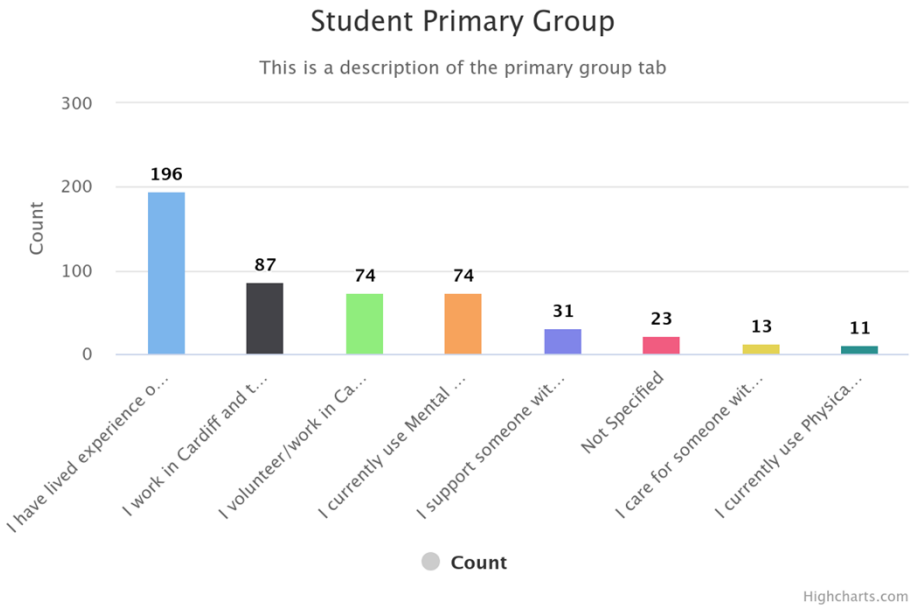
Accessibility and Participation

All courses offered by the Recovery and Wellbeing College are free of charge and open to everyone. The College welcomes a diverse group of students, as illustrated by the attendance data. Staff members from the Mental Health Clinical Board (MHCB) are also encouraged to attend, recognising the positive impact on staff wellbeing.

Link to view the prospectus and register with the Recovery and Wellbeing:
https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fcavuhb.nhs.wales%2Ffiles%2Frecovery-wellbeing-college%2Fautumn-prospectus-2025-eng%2F&data=05%7C02%7CSusie.Boxall%40wales.nhs.uk%7Cd1f03ae063e14f75cd2108de2dcc8e38%7Cbb5628b8e3284082a856433c9edc8fae%7C0%7C0%7C638998553778179107%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=WrQl0cO9%2F5KOzr8MhObx4oFno66tMZElGw7UHsZR35Y%3D&reserved=0







Recovery College Attendance Figures (September 2023 – 2025)

Between September 2023 and 2025, a total of 1,492 students registered with the Recovery and Wellbeing College. This demonstrates ongoing engagement and growing interest in the college's psychoeducational and wellbeing programmes.

- Total Courses Delivered: 61 courses were delivered throughout 2025, offering a variety of sessions tailored to support mental health and wellbeing.
- Total Student Registrations (2025): 427 individuals registered for courses during 2025, highlighting continued uptake and participation.
- Total Session Bookings (2025): There were 2,592 session bookings made, reflecting high levels of engagement across different sessions and topics.
- Total Course Bookings (2025): 160 course bookings were recorded, indicating the number of distinct courses attended by students within the year.

Improvement Review – Initial and Early Findings (Cardiff & Vale Mental Health) with 36 Degrees

Purpose & Objectives:

In partnership the Mental Health Clinical Board, 36 Degrees are actively working to ensure that the identified priorities and actions are fully aligned with the aims of the Mental Health and Wellbeing Strategy 2025–2035, fostering a coordinated and strategic approach to service improvement.

Key Challenges:

- Rising demand for services, workforce shortages, limited funding, and variable quality.
- Data gaps and fragmented service models hinder effective care.
- Lived experience feedback highlights delays, lack of personalised care, and the need for systemic change.

Models of Care:

- The Stepped Care 2.0 model is recommended, emphasising open, same-day access, autonomy, and person-centred pathways.
- This approach has reduced wait times, improved attendance, and increased satisfaction.

Service Profile:

- Cardiff and Vale services support 472,000 residents, with a workforce of 1,400+ and an annual budget of £127.7m.

Review Process:

- Broad engagement identified six priority domains: Safety, Governance, Leadership, Culture, Data/Digital, and Clinical Model of Care.

Emerging Priorities:

Six drivers for improvement: safe care, accountable governance, learning culture, data-driven improvement, empowered clinical leadership, and standardised clinical operating models.

- Six clinical themes: acute flow, primary MH services, discharge/social care, CMHTs, specialist pathways, and neurodevelopmental demand.

Next Steps:

- Consolidate insights, apply evaluation criteria, and build a roadmap for short-, medium-, and long-term improvements.

Leadership & Strategy:

- Strategy focuses on rights-based, person-centred care, timely access, and integrated quality assurance.

People and Culture initiatives

The CAVUHB People and Culture plans sets out a vision for building a motivated, healthy and skilled workforce and MHCB is actively aligning its services and staff development to deliver in these areas. We want to make sure that colleagues feel valued and supported whilst also equipped to deliver high quality care through;

• Seamless Workforce Models – development of a workforce community of practice. Data validation of workforce information to enable proactive, well-informed decisions.
• Engaged, Motivated and Healthy Workforce – Partnership working with staff side, LPF reset. Contribution to Cultural Safety Zone Shape and Scale Academy. Promotion of Staff Survey. CRSS/TIM champions in place. Reflective Practice and Schwartz rounds. Clinical Supervision offered.

• Attract, Recruit, Retain - Secondment opportunities, 16 Student Streamliners, 5 Grow Your Own OU HCSW to Band 5s.
• Leadership and Succession – engagement with HEIW Team Manager development Programme and Mentorship scheme. Bespoke development sessions offered around People, Culture and Finance.
• Building a Digitally Ready Workforce – streamlined, improved sharepoint site, encouragement of data informed decision making. Weekly staffing dashboard.
• Education and Learning – Shared Learning Events, Recovery College initiatives.

The MHCB are currently undertaking work in relation to culture, values and behaviours alongside consideration of avoidable harm initiatives, linking in with 36 degrees in relation to this. The Executive Director of People and OD is leading work around a review of culture in the Health Board and MHCB have offered to pilot work in this space in addition to work already underway.

5. Equitable Care

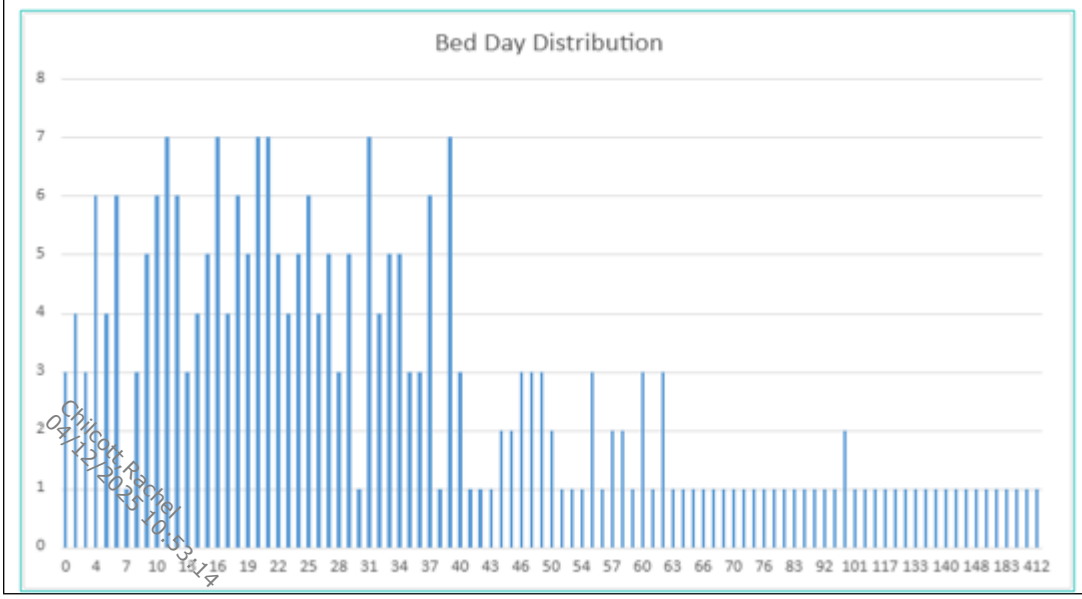
Out of Area Bed Usage and Hazel Ward Reopening

The use of out of area beds has become increasingly common when clinical need requires an inpatient bed but there is no available capacity at Hafan-Y-Coed. Over the past five years, both the number of patients placed out of area and the average length of their stays have grown. Data from April 2021 to November 2025 illustrate this trend.

Rising Demand and Length of Stay

Annual breakdowns reveal a clear upward trajectory in both patient numbers and bed days. In 2021–2022, 37 patients were placed out of area, increasing to 39 in both 2022–2023 and 2023–2024. However, this number rose significantly to 62 in 2024–2025. By 1 November of the current financial year, 82 patients had already been placed out of area. The data also show that bed days are shifting towards longer stays for these patients.

Several factors contribute to this trend, including the closure of Elm Ward, rising social pressures such as the cost of living, and increasing patient acuity and clinical need. Additionally, flow rates through the treatment wards at Hafan-Y-Coed are low. While Cedar (admissions) and Alder (PICU) maintain consistent rates of flow, treatment wards (Oak, Beech, Willow) have slower throughput, causing bottlenecks that affect patient flow throughout the service. At present, 29 patients are on a delayed transfer of care list across adult inpatient environments. Addressing delays in this list would likely facilitate improved patient flow, reducing out of area bed use by freeing up local capacity.



Hazel Ward Reopening

To address the rising number of out of area beds and support care closer to home, the Mental Health Clinical Board, with Executive Team support, has reopened Hazel Ward at Hafan-Y-Coed. This mixed-gender, 10-bed ward is specifically focused on individuals experiencing delayed transfers of care (DTOC). Patients identified as having a delay in transfer are prioritised for transfer to Hazel Ward, where the team collaborates with the individual and their care team to resolve barriers causing delays.

Since reopening on 25 November 2025, Hazel Ward has transferred 10 patients from other wards, which hs enabled the repatriation of 8 people from out of area beds. At the time of reporting, only 3 patients remain out of area, a considerable reduction from 13 nine days earlier. This improvement means that more patients can stay closer to home, benefiting from proximity to their support networks and care teams.

Ongoing Evaluation

The Adult Directorate is partnering with the Lived Experience Team and the Shaping Change Team to develop metrics for reviewing the success of these changes. Key measures will include:

- Patient experience
- Number of inpatients identified as experiencing delayed transfers of care
- Breach days past predicted discharge date (indicating clinical optimisation)
- Average length of stay on Hazel Ward
- Average length of stay for the remaining delayed transfer of care cohort across treatment wards
- Weekly discharge rate
- Number of out of area patients
- Out of area bed days
- Percentage of ‘Green Days’ as an efficiency measure

Changes to ADHD pathway

We have revised our approach to managing ADHD referrals. Previously, referrals were screened out if they lacked sufficient information regarding symptoms or if the details provided did not indicate ADHD as a likely diagnosis.

Key Changes:

- **All ADHD referrals will now be accepted** and placed on the waiting list, regardless of the information contained in the referral letter or accompanying questionnaires.
- Failure to return questionnaires, which was previously a barrier to being placed on the waiting list, will no longer prevent inclusion.

Medication and Assessment Process:

- Any patient referred to a CMHT who is already receiving medication initiated by NHS services (e.g., from a GP in another area, CAMHS, prison services, etc.) will continue to have their medication prescribed by the CMHT without the need for reassessment.
- Private assessments, regardless of quality, will automatically be placed on the waiting list for reassessment to avoid creating a two-tier system.
- Patients currently prescribed medication privately will need to wait for reassessment by the CMHT to confirm diagnosis before the CMHT can take over prescribing.
- Business case for an ADHD service is in development.

Complex Emotional Needs (CEN) pathway

Navigating the complexities of mental health support can be challenging for individuals experiencing distress. The Complex Emotional Needs Pathway aims to provide comprehensive guidance and resources to help individuals find the appropriate support and referrals for their

needs. The pathway will outline the pre-referral support options, referral processes, assessment procedures, and Specialised services available.

The pathway is currently under development by the CVUHB Complex Emotional Needs working group commissioned in September 2025 by the Mental Health Clinical Board, with a wider stakeholder workshop early 2026.

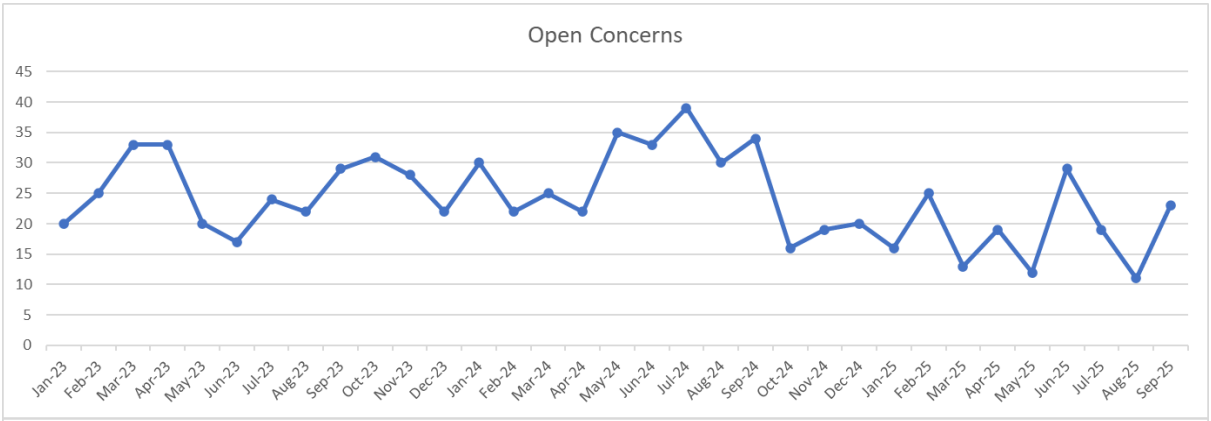
Improvements to current provision to include:

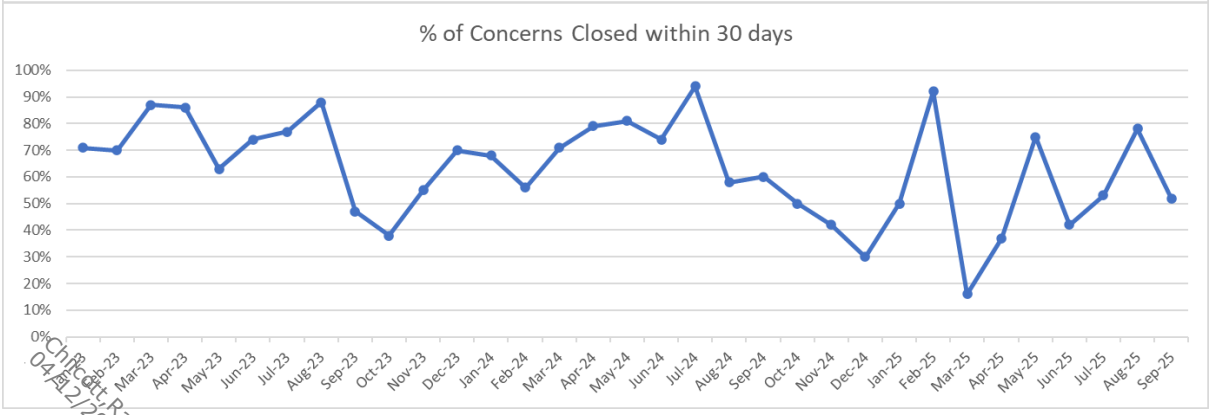
- Stepped approach aligned to the Mental Health and Wellbeing Strategy
- Align service provision to Matrics Cymru and develop action plan to increase therapeutic offer by increasing skills
- Clear roadmap for supporting services to gain support
- If an individual presents in primary care who has repeatedly self-harmed or shows a pattern of persistent risk taking or marked emotional instability, consideration should be given to an onward referral to Community Mental Health services for a more in-depth assessment of needs and risks.
- Ensure diagnosis of borderline personality disorder is not a diagnosis of exclusion.

This work links closely with the development of a multi-agency protocol for managing ultra-lethal substances in the community, in the absence of national guidance. The projected time scale for finalisation of the pathway is April 2026, with a CVUHB pathway for the management of ultra-lethal substances which are often new and emerging methods of suicide. The working group has been supported by waste management, safeguarding, NHS P&I, clinicians, and south Wales police.

6. Person Centred Care

Patient Experience Data





Date	Open	Closed within 30 days
Jan-23	20	71%
Feb-23	25	70%
Mar-23	33	87%
Apr-23	33	86%
May-23	20	63%
Jun-23	17	74%
Jul-23	24	77%
Aug-23	22	88%
Sep-23	29	47%
Oct-23	31	38%
Nov-23	28	55%
Dec-23	22	70%
Jan-24	30	68%
Feb-24	22	56%
Mar-24	25	71%
Apr-24	22	79%
May-24	35	81%
Jun-24	33	74%
Jul-24	39	94%
Aug-24	30	58%
Sep-24	34	60%
Oct-24	16	50%
Nov-24	19	42%
Dec-24	20	30%
Jan-25	16	50%
Feb-25	25	92%
Mar-25	13	16%
Apr-25	19	37%
May-25	12	75%
Jun-25	29	42%
Jul-25	19	53%
Aug-25	11	78%
Sep-25	23	52%

Patient Story

At the Recovery and Wellbeing College, which is part of the Lived Experience team within Cardiff and Vale Mental Health Clinical Board (MHCB), the MSC technique is employed to gather data three times each year. This regular collection of information enables the College to gain a deeper understanding of the significance and impact of participation on students who engage with its programmes. Through this process, the College can capture valuable insights into the experiences of its students, highlighting the difference the College makes in their lives.

Some of the stories collected through this technique, for which consent has been provided, can be accessed via this link (click to view). These stories offer first-hand perspectives on the positive changes experienced by students, illustrating the value and effectiveness of the Recovery and Wellbeing College's approach.

Least Restrictive Practice and Trauma-Informed Care

Overview of Trauma-Informed Care Approach

Trauma-Informed Care represents both an organisational and clinical philosophy that acknowledges the widespread impact of trauma and ensures that this understanding is woven into every facet of service provision. Within the Adult Mental Health directorate, a dedicated working group has been established to explore how trauma-informed approaches can become an enduring and fundamental part of our culture, rather than being treated as a supplementary initiative. This commitment aligns with the objectives set out in the Trauma-Informed Wales Framework for societal transformation.

Development and Delivery of Trauma-Informed Training

Since forming the working group, a comprehensive trauma-informed training programme has been developed. This programme is characterised by its integration of psychologically informed language, relational security, and clear boundaries. Education regarding Adverse Childhood Experiences (ACEs), compassionate leadership, and psychological safety is also embedded. The training is delivered in partnership with the Recovery College, ensuring that the perspectives and experiences of those with lived experience are central to the process.

Key Initiatives and Implementations

- Introduction of trauma-informed reflective practice within inpatient settings.
- Ongoing development of a staff wellbeing room to support mental health and resilience.
- Implementation of a formal staff support procedure.
- Application of a trauma-informed perspective to Controlled Document Oversite Group (CDOG) processes.
- Establishment of Compassionate Response Signposting (CRS) meetings for staff support following incidents.

Pilot Project: Alder Ward, Psychiatric Intensive Care Unit (PICU)

A pilot project is currently underway on Alder Ward, the Psychiatric Intensive Care Unit (PICU), which aims to embed trauma-informed care and reduce restrictive practices. This initiative is designed to support:

- **Staff Experience:** Emphasising psychological safety and promoting reflective practice.
- **Patient Experience:** Upholding dignity and advancing recovery-oriented care.
- **Physical Environment:** Creating spaces that offer safety and therapeutic value.

A central priority is to enhance carer and family engagement, thereby improving communication and collaboration to facilitate continuity of care. All aspects of this work are guided by the principles of compassion, relational security, and co-production, with the goal of nurturing a culture where both staff and service users are respected and supported.

Pilot Site for Trauma-Informed Practice Training

The organisation has been chosen as a pilot site for Trauma-Informed Practice training developed by Traumatic Stress Wales. This marks a significant advancement in the integration of trauma-informed approaches across our services. Two wards, along with the Recovery College, will participate in the pilot, ensuring that both clinical and educational environments gain from enhanced knowledge and skills. Upon completion, staff will be equipped to operate at trauma-skilled and trauma-enhanced levels, consistent with the Welsh Trauma Framework. This will further our ability to deliver compassionate, psychologically safe care that prioritises recovery and resilience for service users, carers, and staff alike.

Executive Director Opinion & Key Issues to bring to the attention of the Committee:

Risk Register: St Barruc Ward

Overview of Identified Risks

Patients admitted to St Barruc ward face a significant risk of harm arising from suboptimal emergency response and inequitable care in comparison to those on other Mental Health Services for Older People (MHSOP) wards at University Hospital Llandough (UHL). Many individuals on the ward present with complex co-morbidities yet experience reduced access to physical health care. Specifically, patients do not have access to the PART team or a SIMA response, nor do they benefit from timely intervention from MEAU. Furthermore, the absence of an on-site pharmacy and the potential discontinuation of portering services—which are essential in emergencies and for oxygen supply—compound these risks. It should be noted that the nursing staff on St Barruc are mental health nurses who are not trained in advanced physical health care. Ambulance response times are often prolonged, owing to the misconception that patients are already in a safe and appropriate care environment.

Safety Incidents and Improvements

Over the past three years, four patient safety incidents have been reported on St Barruc ward. Two of these incidents highlighted the necessity for staff training to improve practice, leading to

the implementation of action plans. These measures have resulted in notable improvements in nursing standards, particularly in the early recognition of unwell patients. Despite these advancements, the two subsequent incidents illustrate that variability in care persists, especially when compared to patients at Llandough.

Environmental and Operational Challenges

St Barruc ward has long been recognised as an isolated unit, but the acuity of patients requiring acute care has increased substantially over the last five years. The current layout, with the ward divided across three separate units, presents considerable difficulties in managing staffing shortages and responding effectively to emergencies. Additionally, the physical environment is inadequate for patient needs, with unsuitable doors and windows and frequent ceiling leaks further compromising safety and wellbeing.

Mitigation Measures Undertaken

A range of actions have been introduced to address these challenges:

- General Practitioner attends the ward twice weekly.
- Senior Nurse support increased to twice weekly, inclusive of a physical health nurse.
- Implementation of NEWS2 to identify deteriorating patients promptly.
- Establishment of clear procedures for accessing emergency services via 999.
- Provision of physical health training sessions for staff.
- Planned training for bladder scanner and ECG use.
- All staff to receive training in Immediate Life Support (ILS).
- All staff to be trained in SIMA response.
- Consideration of transferring physically or acutely unwell patients to UHL.

Despite these interventions, the risks associated with the ward's location and layout remain unresolved.

Appendices (please list all appendices that accompany this report. Do **not** embed)

Mental Health Clinical Board Assurance Slides

Recommendations:

The Committee is requested to:

a) The **note** the assurance provided by the PCIC Clinical Board in this report and the steps being taken to improve quality, safety and patient experience.

Link to Strategic Objectives of Shaping our Future Wellbeing:

1. Putting People First	x	2. Providing Outstanding Quality	x
3. Delivering in the Right Places	x	4. Acting for the Future	x

Five Waves of Working (Sustainable Development Principles) considered:

Prevention		Long Term	x	Integration	x	Collaboration	x	Involvement	x

Chilcott Rachel 04/12/2025 10:53:14

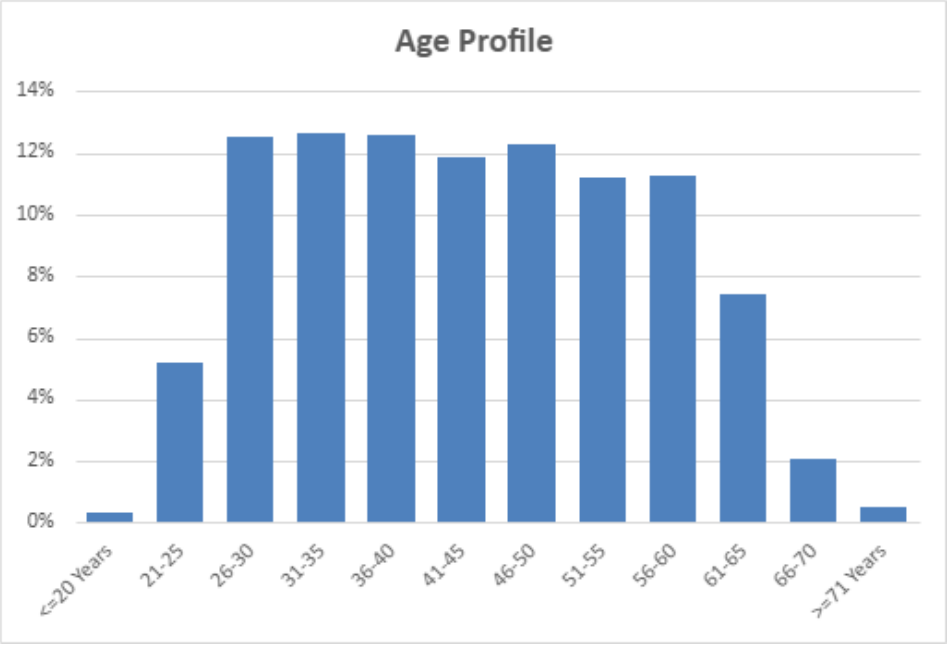
Quality Impact Assessment Completed?

Yes (please include the complete QIA document)		No (please provide reasoning e.g. not required		n/a

Impact Assessment
Risk: Yes/No
Safety: Yes/No
Financial: Yes/No
Workforce: Yes/No
Legal: Yes/No
Reputational: Yes/No
Socio Economic: Yes/No
Equality & Health: Yes/No
Decarbonisation: Yes/No
Welsh Language: Yes/No

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:

Workforce - MHCB



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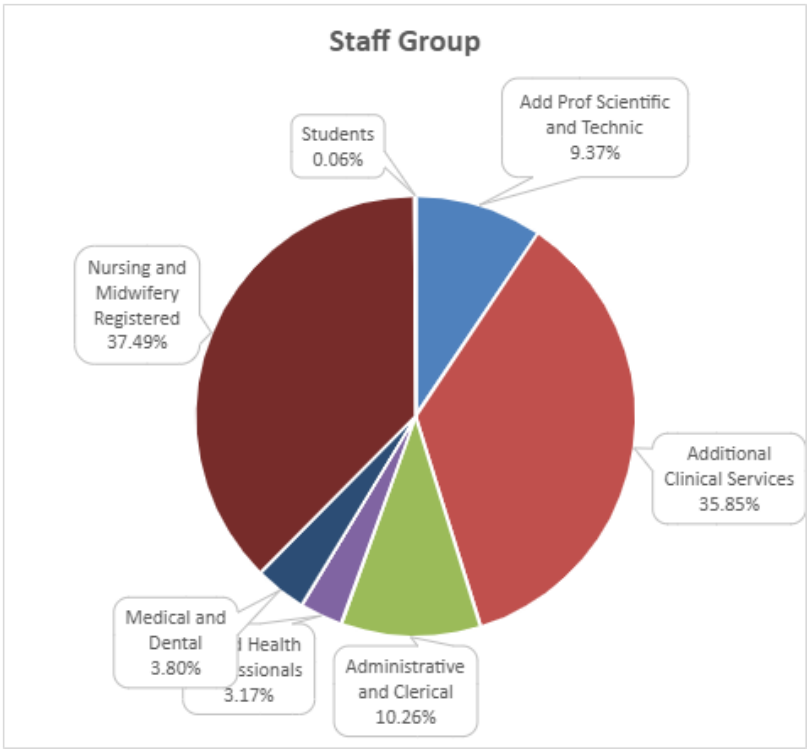

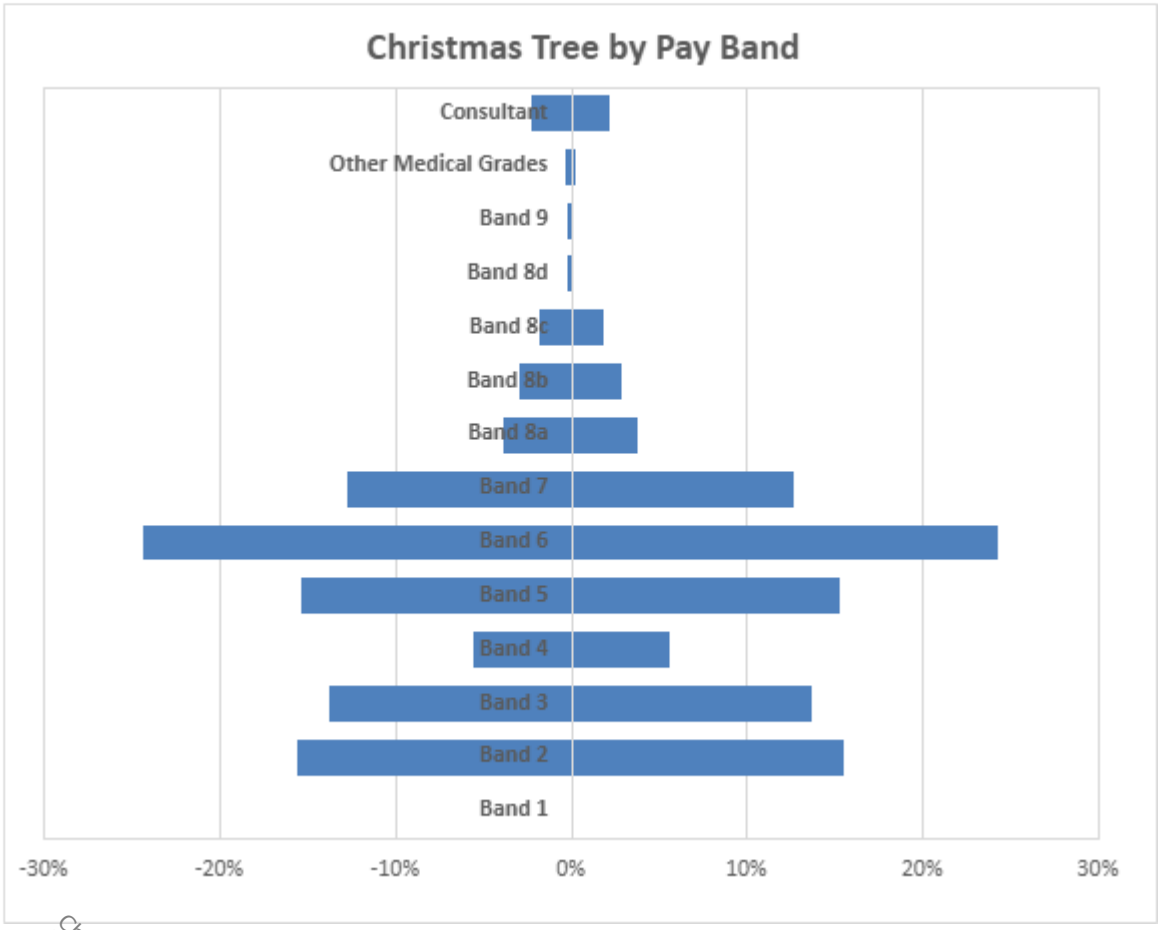

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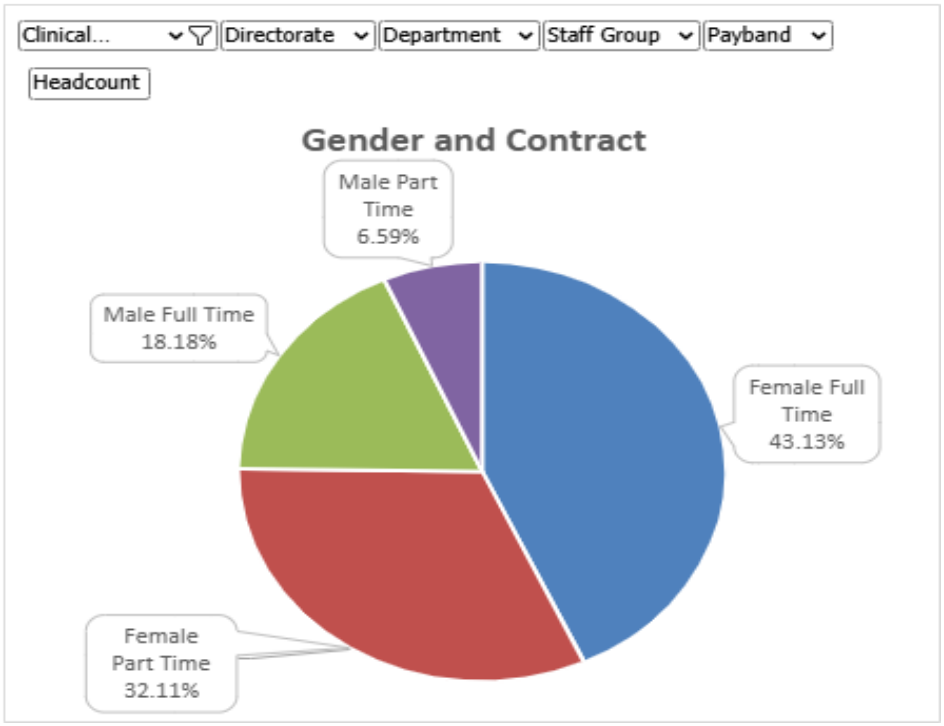


Mental Health Clinical Board
Assurance Report
October 2025

- Tara Robinson - Director of Nursing
- Rachel Dix - Deputy Director of Nursing
- Susie Boxhall - Strategic Lead for Lived Experience Team

Safe Care Patient Safety Incidents and Quality Reporting

- **Siran accreditation**
- **Quality Improvement**
- **Appointment of a Family Liaison Officer**
- **Numbers of NRI**
- **Numbers of PSLR**
- **Numbers of MH reviews**
- **Improvement Plans Overview**
- **Themed Approach**
- **Complex Emotional Needs Pathway**

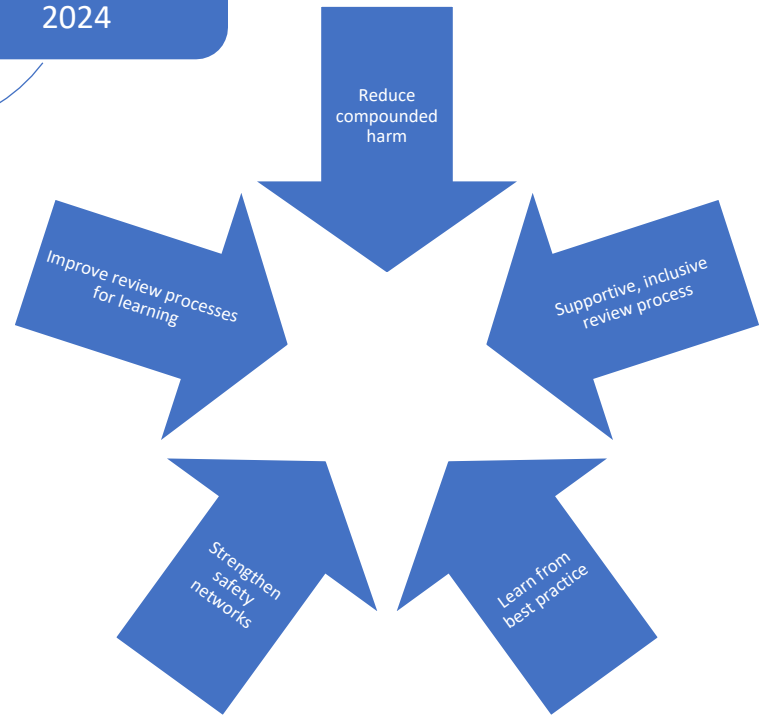
SIRAN Accreditation – Key Points

What is SIRAN?

- Safety Incident Response Accreditation Network, established 2020
- Led by Royal College of Psychiatrists Centre for Quality Improvement
- Promotes quality improvement in serious incident investigations
- Governed by multidisciplinary professionals and carers with lived experience

Why the MHCB joined SIRAN

- Only Welsh member among 16 UK organisations
- Member since March 2023; accredited March 2024



Accreditation Process

- Self-review assessment (3 months): surveys, SI reviews, improvement plans, policies
- External peer review: meetings with staff and reviewers
- Local report and opportunity for feedback
- Accreditation outcome: Accredited / Deferred / Not Accredited
- Round table meetings

Improvements Achieved

Booklets for patients, families, reviewers, staff
Glossary added to reviews
Enhanced staff support and understanding of Terms of Reference. This has been supported by the implementation of round table discussions
Appointment of Family Liaison Officer (FLO)
Benchmarking and peer review opportunities

Introduction of the Family Liaison Officer (FLO)

Introduction of the Family Liaison Officer (FLO)

- **Established:** June 2024
- **Purpose:** To strengthen communication and support for patients and families involved in mental health reviews, ensuring openness and transparency throughout the review process.

Key Responsibilities

- **Duty of Candour:** Promotes honesty in all interactions with patients and families.
- **Active Engagement:** Contacts all patients or families involved in Patient Safety Learning Reviews (PSLR) or local mental health reviews to ensure they are informed and included.
- **Family Participation:** Supports families to participate fully and meaningfully in the review process, recognising the value of their perspectives.
- **Regular Updates:** Provides families with ongoing updates on the progress of reviews.
- **Guidance & Support:** Offers guidance throughout inquest processes and helps families navigate complex procedures.
- **Signposting:** Directs families to relevant support services for any additional needs identified during the review.

Patient Safety Reviews

Number of Fact-finding forms received by year-end:

	2022	2023	2024	2025 (OCT)
Mental Health Review	29	25	33	19

Number of Mental Health Reviews by year-end:

2022	2023	2024	2025 Jan - Oct
201	186	138	89

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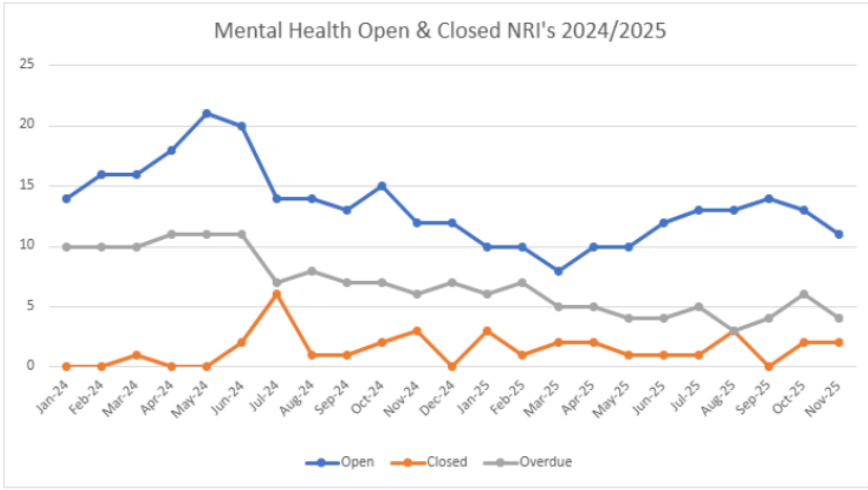
Nationally Reportable Incidents



NRI's	Open	Closed	Overdue
Jan-24	14	0	10
Feb-24	16	0	10
Mar-24	16	1	10
Apr-24	18	0	11
May-24	21	0	11
Jun-24	20	2	11
Jul-24	14	6	7
Aug-24	14	1	8
Sep-24	13	1	7
Oct-24	15	2	7
Nov-24	12	3	6
Dec-24	12	0	7
Jan-25	10	3	6
Feb-25	10	1	7
Mar-25	8	2	5
Apr-25	10	2	5
May-25	10	1	4
Jun-25	12	1	4
Jul-25	13	1	5
Aug-25	13	3	3
Sep-25	14	0	4
Oct-25	13	2	6
Nov-25	11	2	4

Dashboard, SUSR, Regulation 28

NRI Reporting Dashboard

Real-Time Incident Data:

A new dashboard, developed by Matt McCarthy from the Patient Safety Team, provides real-time incident data to the Clinical Board, removing the need for manual Datix reports.

Access and Development:

Directors of Nursing already have access. The dashboard is still being enhanced, with further features planned to improve usability and insight.

Single Unified Safeguarding Overview (SUSR)

Current Cases:

Two cases are currently managed under the SUSR process.

External Factors:

One case is temporarily on hold at the request of South Wales Police (SWP)

Regulation 28 (Prevention of Future Deaths) Order

Recent Order:

In the past six months, the service received one Regulation 28 order from the coroner, highlighting the need for improved information collection and sharing with families.

Response and Actions:

The Health Board has formally responded, outlining steps to address the concerns. New guidance on information sharing and gathering has been co-produced with families, service users, clinicians and UHB consent lead. Awaiting ratification for publication on share point.

Overview of Identified Issues

Earlier this year, MHCB conducted a comprehensive review of its improvement plans. This review surfaced several significant concerns:

Volume and Fragmentation: There were more than 60 separate improvement plans and over 345 associated actions. This volume made it difficult to maintain oversight and ensure strategic alignment.

Loss of Historical Plans: Some historical improvement plans had been lost over time, indicating gaps in record-keeping and continuity.

Lack of Thematic Identification: The existing methods did not effectively identify broader organisational themes, which limited the ability to address systemic issues and drive coordinated improvement across the Board.

Review and Thematic Mapping

To address these challenges, MHCB systematically reviewed all improvement plans stored on the S drive, as well as those documented in Word and AMAT from 2022. The findings and recommendations from these plans were mapped into six key themes, providing a more structured and strategic approach to improvement:

- Six Core Themes Identified
- **Engagement and Care Planning**
  - Focuses on improving how patients and families are involved in care planning, ensuring that care is tailored and collaborative.
- **Safety and Risk Formulation**
  - Addresses the identification, assessment, and management of risks to patient safety, aiming to reduce incidents and improve outcomes.
- **Family Engagement and Involvement**
  - Emphasises the importance of involving families in care and review processes, recognising their perspectives and supporting meaningful participation.
- **Service Provision**
  - Looks at the quality, accessibility, and effectiveness of mental health services, with a view to optimising delivery and meeting diverse needs.
- **Safeguarding**
  - Ensures robust processes are in place to protect vulnerable individuals, including multi-agency collaboration and compliance with safeguarding standards.
- **Documentation**
  - Focuses on improving the accuracy, consistency, and accessibility of records, supporting better communication and continuity of care.

Significance and Next Steps

01

Strategic Alignment: The thematic mapping enables MHCB to align improvement actions with broader strategic priorities, such as those set out in the Mental Health and Wellbeing Strategy and the Quality, Safety and Patient Experience Framework.

02

Project Leadership: Dedicated project leads have been appointed for workstreams focusing on safety/risk formulation and family engagement, while other themes are overseen by the Deputy Director for Mental Health Nursing.

03

Continuous Improvement: This structured approach supports ongoing quality improvement, better oversight, and the ability to address systemic challenges more effectively.

Complex Emotional Needs (CEN) Pathway – Overview

Purpose:

- To provide comprehensive guidance and resources for individuals experiencing distress, helping them access appropriate support and referrals.

Scope:

- Covers pre-referral support, referral processes, assessment procedures, and access to specialised services.

Development:

- Currently being developed by the CVUHB Complex Emotional Needs working group (commissioned September 2025), with a wider stakeholder workshop planned for early 2026.

Key Improvements to Provision

Stepped Approach:

- Aligned with the Mental Health and Wellbeing Strategy for Wales.

Service Alignment:

- Aligns provision to Matrics Cymru; action plan to increase therapeutic offer by upskilling staff.

Clear Roadmap:

- Structured support for services to access guidance and resources.
- Aligned to removal of new and emerging methods of lethal substances protocol.

Referral Guidance:

- Individuals in primary care with repeated self-harm, persistent risk-taking, or marked emotional instability should be considered for onward referral to Community Mental Health services for in-depth assessment.
- Ensures diagnosis of borderline personality disorder is not a diagnosis of exclusion.

Patient Centred Care Patient Experience

Patient Story

Preparing for Discharge Course – Overview

Overview

Safe Discharge Standards for Wales (2025)

Sets clear expectations for safe, timely, and person-centred transitions home.

Cardiff and Vale Recovery and Wellbeing College applies these standards through the Preparing for Discharge (P4D) programme.

Course Structure & Collaboration

- Five tailored sessions for inpatients nearing discharge.
- Co-produced by patients, mental health practitioners, and peer trainers.
- Delivery: Recovery College, ward teams, and partner organisations.
- Focus: Each session centres on individual needs, supporting personalised discharge plans.

Course Outcomes & Impact

- **Goal:** Ensure people leave hospital prepared, with a clear plan and strong support connections.
- **Impact:**
- Readmission rate for P4D graduates: **7.4%** (vs. 33% national average).
- **Indicative savings:** ~£340,000 per year (Value in Health validation).
- **Participant Feedback:**
- Increased confidence in medication management.
- Clearer points of contact.
- Practical strategies for first days at home.
- “It reminds me that we're all human and that we're not alone. I think we need to share our thoughts and feelings more.”

National Recognition & Expansion

National Lived Experience Programme:

P4D to be replicated in Cwm Taff and Hywel Dda Health Boards (Feb–Mar 2026).

Included in the new Safe Discharge Standards for Wales.

Professional Recognition:

Recovery College Lead and Peer Trainer invited to speak at the Royal College of Psychiatrists.

Ongoing community session participant and family to share reflections on peer roles and lived experience.

Recovery College – Service Overview

First co-produced, peer-led NHS service in Wales.

Operates as part of the Mental Health Clinical Board.

Innovative approach to mental health support.

Psychoeducational Courses & Curriculum

Wide range of courses:

- Developed and delivered collaboratively by practitioners and peers.
- Co-production and co-facilitation central to ethos.

Curriculum:

- 40 courses available in the community curriculum.
- Delivered across three academic terms per year.
- Includes inpatient sessions

Accessibility & Participation

Free and open to all.

Diverse student group, including MHCB staff (supports staff wellbeing).

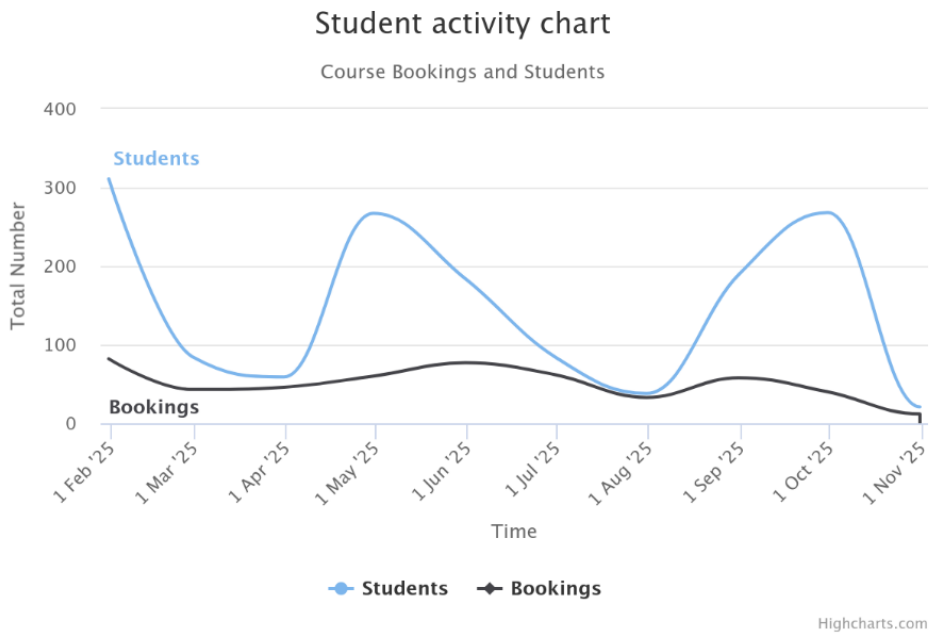
Engagement:

1,492 students registered (Sept 2023–2025).

427 registrations in 2025.

2,592 session bookings in 2025.

160 distinct course bookings in 2025.



Key Takeaways

P4D and Recovery College deliver measurable improvements in patient confidence, outcomes, and financial savings.

Co-production and peer involvement are central to success.

National interest and expansion reflect the value of these initiatives.

Equitable Care

- Capacity
- LOS
- Reopening of Hazel
- Metrics to review pilot of Hazel

Out of Area Bed Usage Overview

Challenge: Increasing use of out of area beds when no capacity is available at Hafan-Y-Coed.

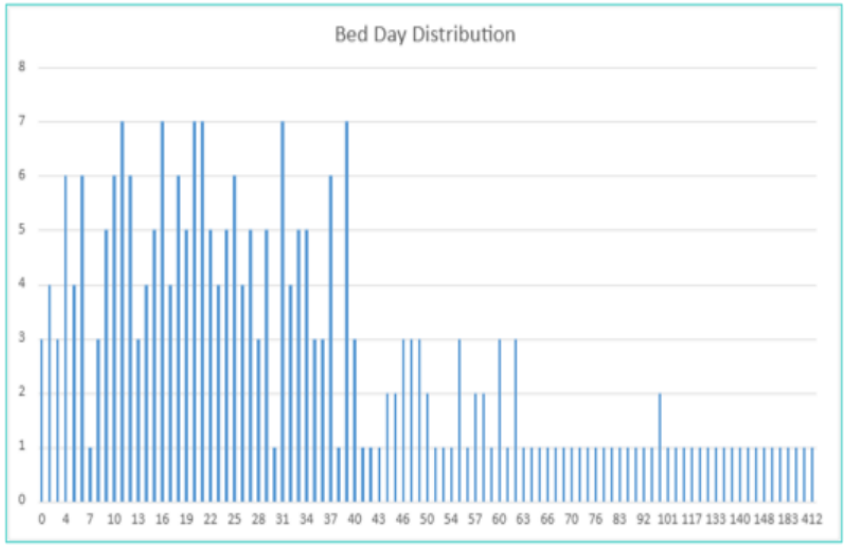
Trend: Both the number of patients placed out of area and the average length of their stays have grown over the past five years.

Data:

- 2021–2022: 37 patients
- 2022–2023: 39 patients
- 2023–2024: 39 patients
- 2024–2025: 62 patients
- By Nov 2025: 82 patients already placed out of area

Factors Driving Increased Out of Area Bed Usage

- **Closure of Elm Ward**
- **Rising social pressures** (e.g., cost of living)
- **Increasing patient acuity and clinical need**
- **Low flow rates** through treatment wards at Hafan-Y-Coed (Oak, Beech, Willow)
- **Delayed transfers of care:** 29 patients currently on the delayed transfer list



Addressing the Challenge -Hazel Ward Reopening

Hazel Ward:

Reopened at Hafan-Y-Coed with Executive Team support

Mixed-gender, 10-bed ward focused on Delayed Transfers of Care (DTOC)

Approach:

Prioritises transfer of patients with delays

Team collaborates with individuals and care teams to resolve barriers

Early Impact of Hazel Ward Reopening

Since 25 Nov 2025:
10 patients transferred from other wards
8 people repatriated from out of area beds
Out of area patients reduced from 13 to 3 in nine days
Benefits:
More patients stay closer to home
Improved access to support networks and care teams

Ongoing Evaluation – Key Metrics

- Qualitative Data- Patient experience
- Number of inpatients with delayed transfers of care
- Breach days past predicted discharge date
- Average length of stay on Hazel Ward
- Average length of stay for delayed transfer cohort
- Weekly discharge rate
- Number of out of area patients
- Out of area bed days
- Percentage of ‘Green Days’ as an efficiency measure

Report Title:	Tackling the Planned Care Challenges - risks / incidences of harm			Agenda Item No:	2.3
Meeting:	Quality Committee	Public	X	Meeting Date:	09.12.2025
		Private			
Status	Assurance	X	Approval		Information/Noting
Lead Executive Title:	Chief Operating Officer / Executive Nurse Director				
Report Author Title:	Assistant Director of Quality and Patient Safety				

Main Report

Background and Current Situation:

In April 2022, the Welsh Government published its Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales. The programme included recurrent funding to support planned care. The programme includes specific targets and Ministerial priorities:

- That no one should wait longer than a year for their first outpatient appointment by the end of 2022 (target date revised to December 2023)
- To eliminate the number of people waiting longer than two years in most specialties by March 2023 (target date revised to March 2024)
- People should receive diagnostic testing and reporting within eight weeks and therapy interventions within 14 weeks by Spring 2024
- To eliminate the number of people waiting longer than one year in most specialities by Spring 2025

Between September 2024 and March 2025, Audit Wales considered the action undertaken by the UHB in tackling the planned care backlog and waiting list performance and considered the barriers to improvement. It was found that despite work to drive operational service improvements, the Health Board's approach until recently did not achieve the desired positive impact on planned care performance. Consequently, the waiting list substantially grew during 2024. The continued growing backlog of people waiting to be treated presents an increasing problem for the Health Board. As of February 2025, there were around 140,000 open treatment pathways as compared to 80,000 immediately prior to the pandemic.

The Outcomes of the Audit Wales review were presented at the UHB Audit Committee on 2nd September 2025 noting that since the publication of the report:

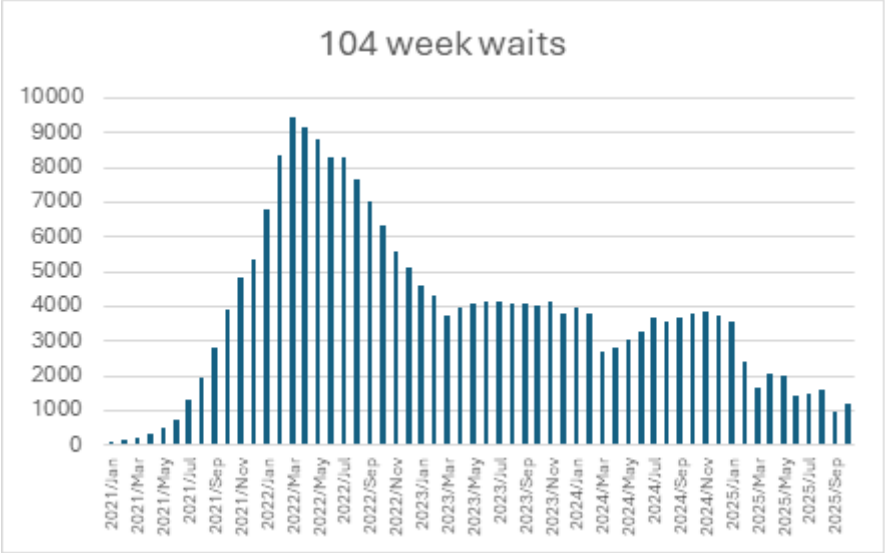
- The waiting list for over 104-week waits had been reduced by a further 50%, with a forecast of 900 patients by the end of Q3
- A dual approach was noted, improving productivity/efficiency (including a new one-year role focused on theatre utilisation in key specialties) and managing the ongoing challenge of recurrent problems with non-recurrent funding
- Progress had been made in Ophthalmology, including meeting the cataract list target through a new facility, and ongoing work to sustain improvements

It was noted that Ophthalmology had an approach to deliver a risk-based review and that this approach should be replicated across other specialities. It was agreed that there should be more specificity in clinical risk analysis emphasising that harm was not just about long waits but about urgency and pathway management.

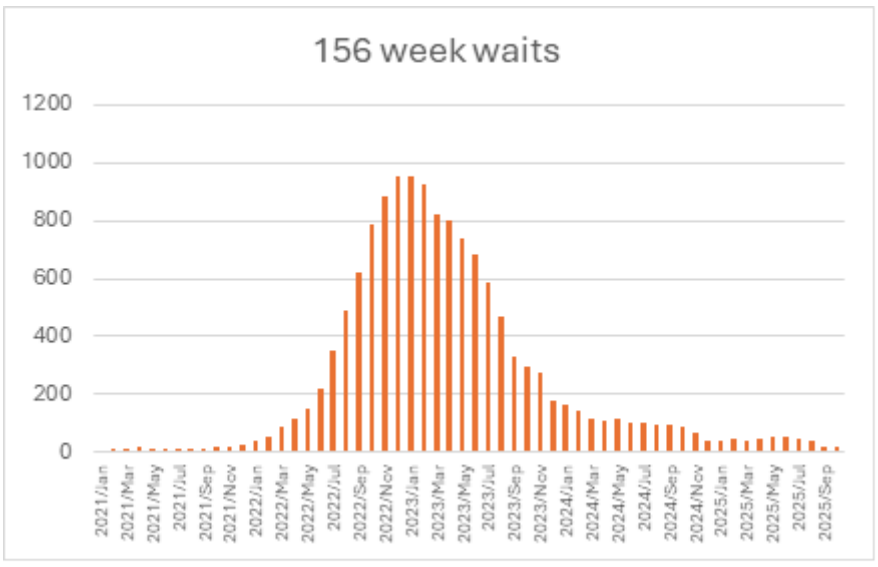
This paper seeks to set out the improvements made in reducing both the volume and shape of the waiting list since the audit was undertaken, the measures we have in place to support our patients whilst they wait, and the systematic approach that will be taken to measure risk moving forward.

Current Waiting List position

The waiting list whilst larger and longer than we would like it to be is now at the smallest volume it has been since pre-pandemic. The graph below shows the volume of patients waiting over 104 weeks, 9500 at its peak, to a trajectory of 630 by the end of December 2025.



Similarly, the number of extreme long waits of 156 weeks has decreased from 955 during the pandemic, to below 20 now as seen below



In addition to a focus on reducing the time people wait, we have many services that support our patients whilst they wait (the full suite is outlines in appendix 1)

The Waiting Well service is available to patients who are preparing for hernia, hip replacement, knee replacement, gall bladder or gynaecology surgery. This is a new service and will be available to people having other types of surgery in the future.

The Waiting Well Service works closely with the Pre-Assessment clinic teams in supporting preparation for surgery. Waiting for surgery can be a frustrating time, especially when living with

pain or trying to manage symptoms. The Waiting Well Service offers support, advice and signposting to services within the Health Board and our community.

A summary of the outcomes of the Waiting Well support offer is seen below

- Over 6,000 total patient contacts
- Themes include issues with pain and weight management
- From follow-up calls held with patients identified with the highest need:
  - ¾ reported increased physical activity
  - 1/5 reported weight loss
  - 40% had made an overall positive change to lifestyle behaviours
  - 1/5 had attended a self-referral healthy lifestyle service

Risk Management System

A systematic approach to measuring risk will be developed to support oversight of individual speciality pathways. It is proposed that five indicators are developed and are reported into the quality committee on a six-monthly basis but are also scrutinised at speciality level.

Measure 1	Patients waiting over 1 year	Numbers of patient safety incidents by harm and numbers of concerns per quarter	Datix / BIS
Measure 2	Patient waiting over 2 years	Numbers of patient safety incidents by harm and numbers of concerns per quarter	Datix/ BIS
Measure 3	Orthopaedics (expand to other specialities)	Patient reported Outcome Measure (EQ5D)	
Measure 4	All patients on planned care waiting list	Deaths of waiting list	BIS
Measure 5	All patients on planned care waiting list	Referrals from ME	Datix / BIS
Measure 6	All patients on planned care waiting list	Emergency admissions	BIS

Executive Director Opinion & Key Issues to bring to the attention of the Committee

Appendices (please list any appendices that will accompany this report. Do **not** embed)

Recommendations:

a) Note the reduction in volume and length of patient waits
b) Note the five indicators suggested to assess risk of protracted waits to patient experience and outcome

Link to Strategic Objectives of Shaping our Future Wellbeing:

1. Putting People First		2. Providing Outstanding Quality	
3.		4.	

Delivering in the Right Places				Acting for the Future					
Five Waves of Working (Sustainable Development Principles) considered:									
Prevention		Long Term		Integration		Collaboration		Involvement	
Quality Impact Assessment Completed?									
Yes *(please include the complete QIA document)*		No *(please provide reasoning e.g. not required*				n/a			
Impact Assessment									
Risk: n/a									
Safety: n/a									
Financial: n/a									
Workforce: n/a									
Legal: n/a									
Reputational: n/a									
Socio Economic: n/a									
Equality & Health: n/a									
Decarbonisation: n/a									
Welsh Language: n/a									
Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*									
Name of Committee/Group/Exec				Date:					

Report Title:	Care After Death Processes and Medical Examiner Update				Agenda Item no.		2.4
Meeting:	Quality Committee		Public	X	Meeting Date:		09.11.2025
			Private				
Status:	Assurance	X	Approval		Information		
Lead Executive:	David Fluck, Medical Director						
Report Author:	Aled Roberts, AMD Patient Safety and Clinical Effectiveness						

Background and current situation:

The Care after death process has been under scrutiny in recent years given the significant waits for the bereaved for death certification – an issue which repeatedly garnered media attention over the last winter. The reasons for this are many – the care after death process is complex requiring a cause of death to be suggested and agreed with the MES or Coroner, scrutiny of the death to be undertaken (in most cases externally by the MES), and the production of a Medical Certificate for the Cause of Death. This is followed by Registration of the Death as well as the need for transfer of the body of the deceased from mortuary to funeral home if the patient has died in the hospital setting.

The importance of learning from deaths attained significance within Health systems stemming from a number of high-profile events within the UK – Harold Shipman (Shipman Enquiry 2003), Gosport Memorial Hospital (The Gosport Independent Panel, 2018), and The Francis Inquiry into the Mid Staffordshire Foundation Trust (Francis Report, 2013) to name 3 examples. In September 2024 the Medical Examiner service (MES) in Wales became a statutory service providing independent scrutiny of all deaths in hospital or in the community not referred to the Coroner. The Cardiff and Vale mortality scrutiny systems have evolved to feed information reliably to the MES and the Coroner, to sieve and sort referrals returning from the MES, and to ensure that any learning from mortality generates learning and improvement in practice across our health systems.
There are 25-60 deaths per week across CAV inpatient hospital sites varying seasonally. There are approximately the same number of deaths per week outside of the acute hospital setting.

This paper highlights current care after death processes within CAV, extra actions to mitigate the risk of reducation in time to the production of an MCCD over the winter and highlight the work ongoing in CAV in relation to learning from the scrutiny of deaths within our system,

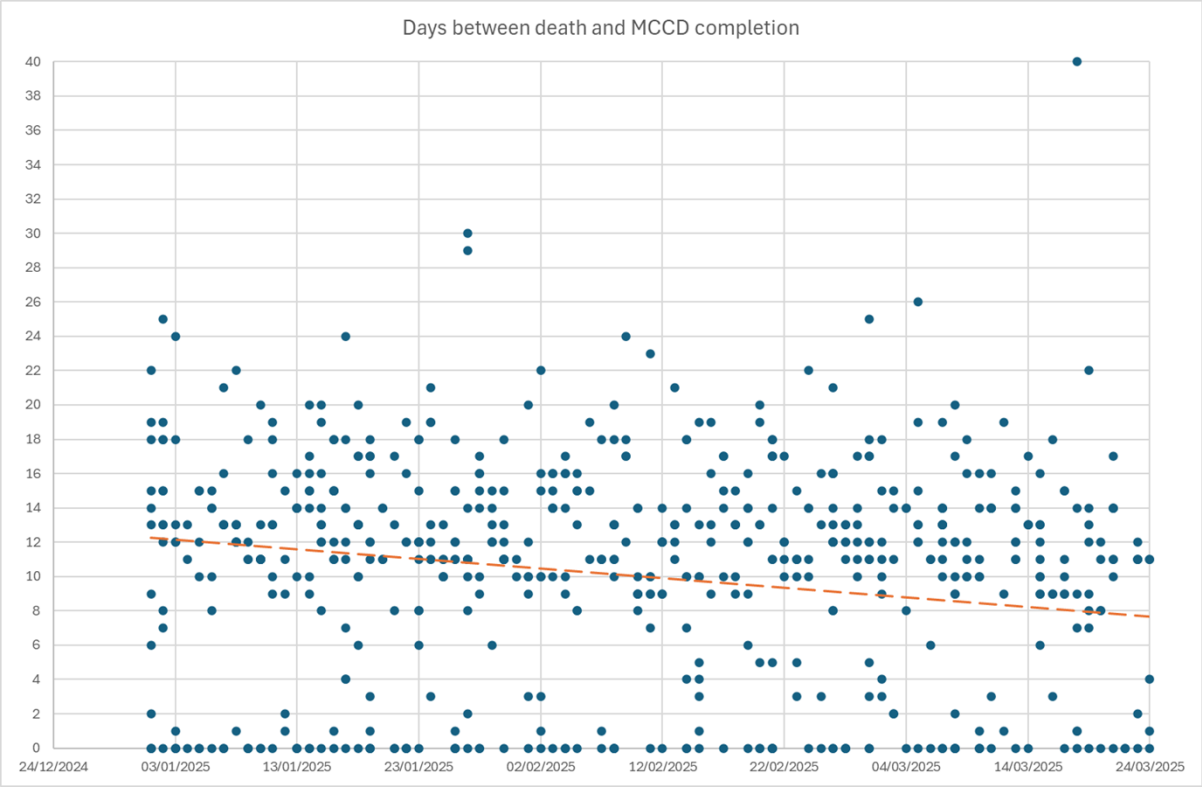
<u>Care after death process</u>

When a patient dies in the hospital setting a Doctor must report the death – to the MES (Medical Examiner Service) or to the Coroner.

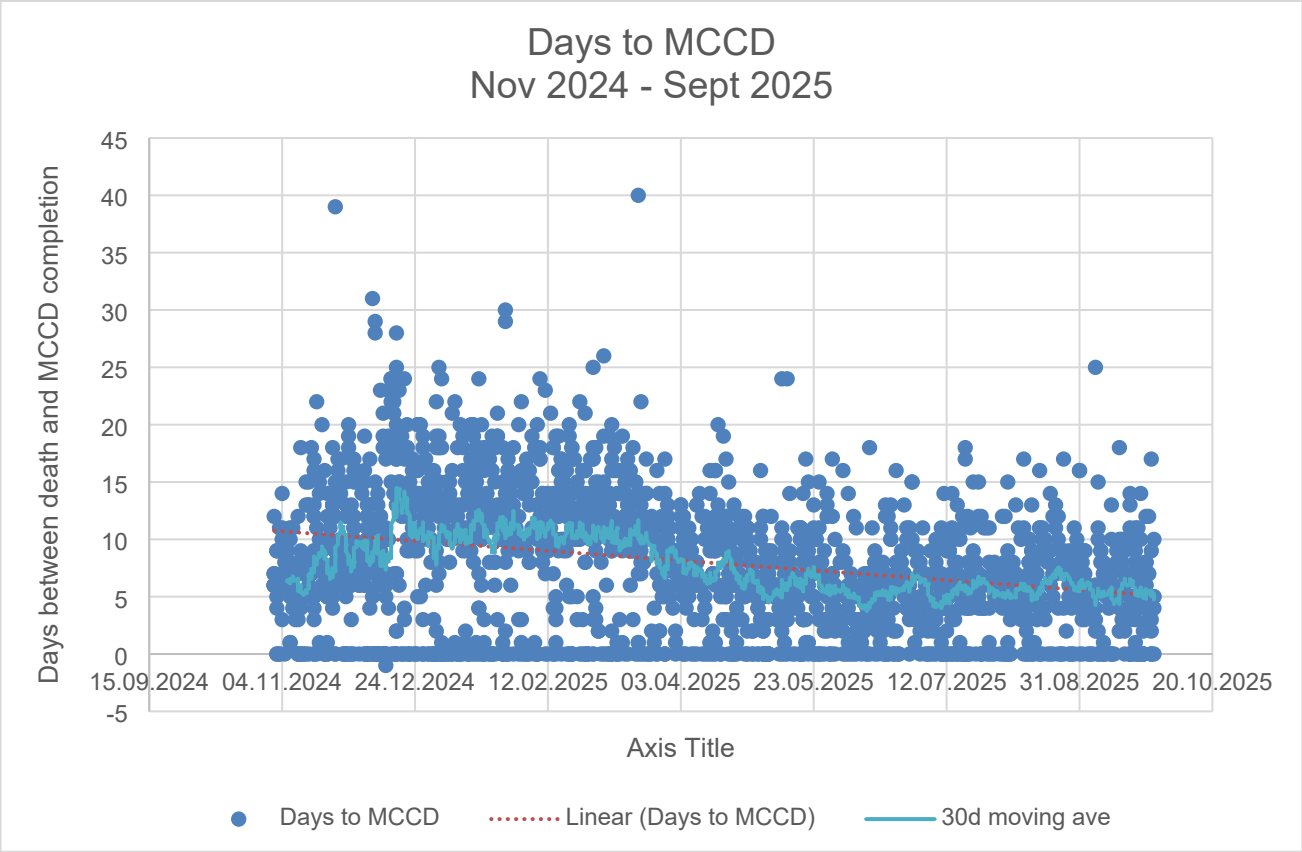
Previously a paper based system, in the summer of 2024 a QR code was introduced by the patient safety team within CAV, which digitalised the recording of a death to the MES. A digitalised copy of the last spell of the hospital (paper based) patient health record is shared with the MES and scrutiny of the death is undertaken by the Medical Examiner (ME). For community deaths, the MES can access GP digital systems to aid the scrutiny process. Following agreement of the cause of death with the MES the Qualified attending practitioner (QAP) will complete the Medical Certificate for the Cause of Death (MCCD). A QAP must be a registered Medical Practitioner (i.e. F2 or above) .
Reporting a death to the Coroner is also now undertaken via a digital form. When a Coroner is content to issue a cause of death we are learning that the organization must recognize

that the MES will not scrutinize the death and that further internal scrutiny may be necessary to highlight learning for our system.

Nationally, there has been significant media attention on the length of time taken to issue death certificates following the introduction of the Medical Examiner Service. The patient safety team meets weekly with bereavement office and medical records teams to monitor and improve the care after death processes within the UHB. The graphs below show the trend in times between deaths and the Medical Team Death Notification (where the clinician provides a proposed cause of death to the Medical Examiner), and between deaths and the MCCD being completed.



Time from Death to completion of MCCD 24/12/24 – 24/03//25



Time from Death to completion of MCCD 24/11/24-31/09/25

The graphs show the improving turnaround times within CAV (red trend line) in the time from a patient's death to the production of an MCCD. There continue to be significant outliers influencing the data. This data is continually being refined and would benefit in the future from one single digital system serving ME referrals and Coroner referrals, and a digital MCCD. However the time from death to completion of MCCD continues to fall in CAV, from around 12 days at commencement of monitoring to 5 days at the end of September 2025.

However, challenges lie ahead of us this winter in maintaining performance within our Care after death processes. The 4 day bank holiday over Christmas, and the New Year bank holiday, thinned down clinical teams due to leave, and the increased volume of deaths in the winter period all pose challenges to timely care after death processes.
Escalation over the Christmas and New Year period in order to avoid New Year backlogs in our Care after Death processes will include:

- There will be Bereavement office resource in UHW on Boxing Day and New Years Day.
- There is now a Digital contact for Bereavement team – the bereaved are able now to contact the Bereavement team digitally to avoid long telephone waits.
- Scanning of notes will be undertaken on every day over the holiday period including weekends (except Christmas Day) at UHW.
- An administrator point of contact will be available in every Clinical Board to escalate and resolve any delay in QR code completion or MCCD completion.
- A nominated clinician has been sought within each clinical Board to minimise delays in the Care after Death process over the holiday period.
- There will be support from the Patient safety team to escalate any delays identified in care after death process.
- There is a scanner in the Emergency Department to scan the MCCD to the MES to register a death and facilitate timely reporting - particularly when considering expedited deaths for Faith reasons.

- There will be ongoing monitoring of response times within care after death process on the dedicated Sharepoint pages.
- Educational comms will be produced to promote documentation of anticipated cause of death to support completion of QR code by all team members (including F1) and timely completion of MCCD by all team members (except F1). Alternatively that a timely digital referral is made to the Coroner should this be necessary.

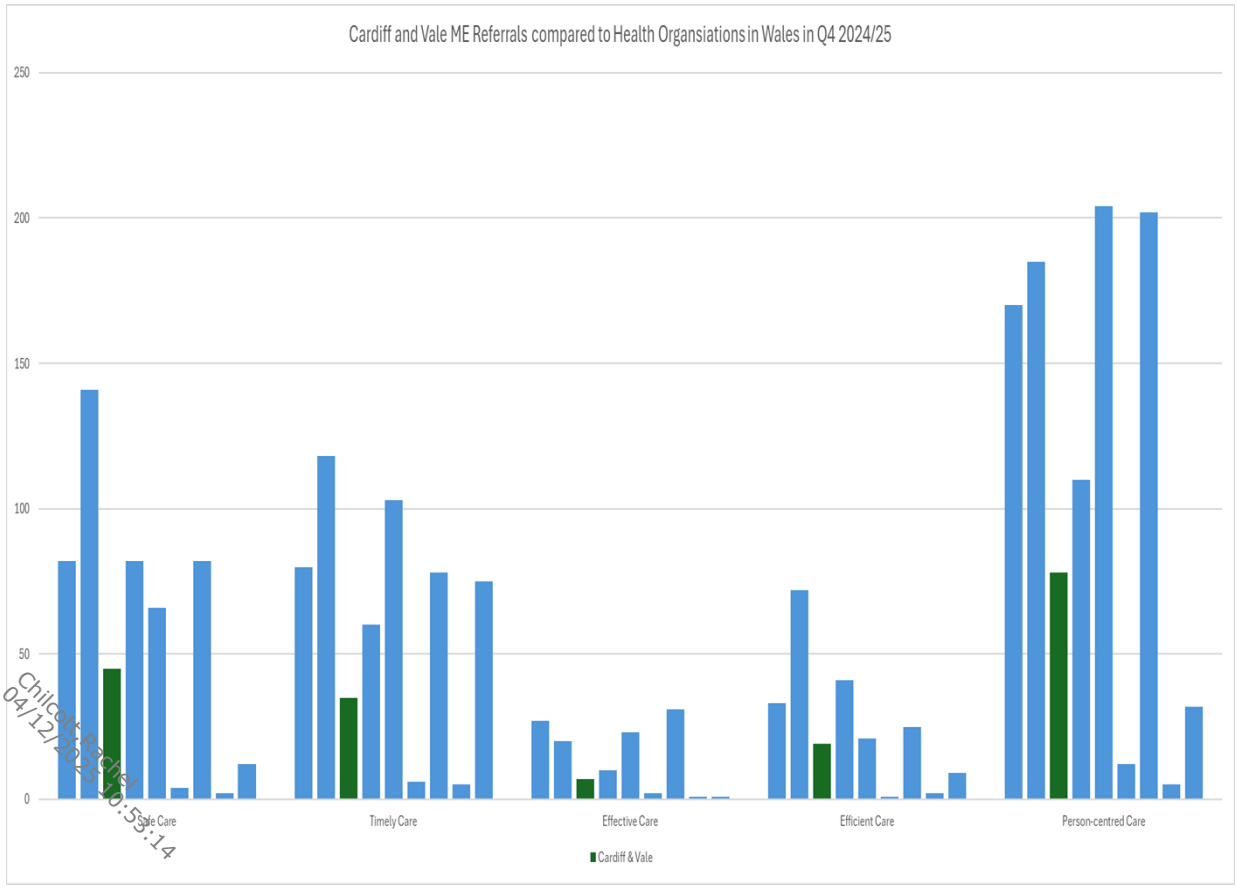
Medical Examiner Referrals- Update

The ME will make a referral of a death to the UHB if any further scrutiny of the death is advised. It is the decision of the UHB as to what level of scrutiny is required upon receipt of the referral into the UHB. The current MES referral rate for deaths in CAV is 19% (MES, Quarter 1 data Apr-Jun 25). Current Coroner referral rates are stable for both UHW and UHL sites -34% of all deaths are reported to the Coroner (National figures, Coroners Statistics 2023, MOJ).

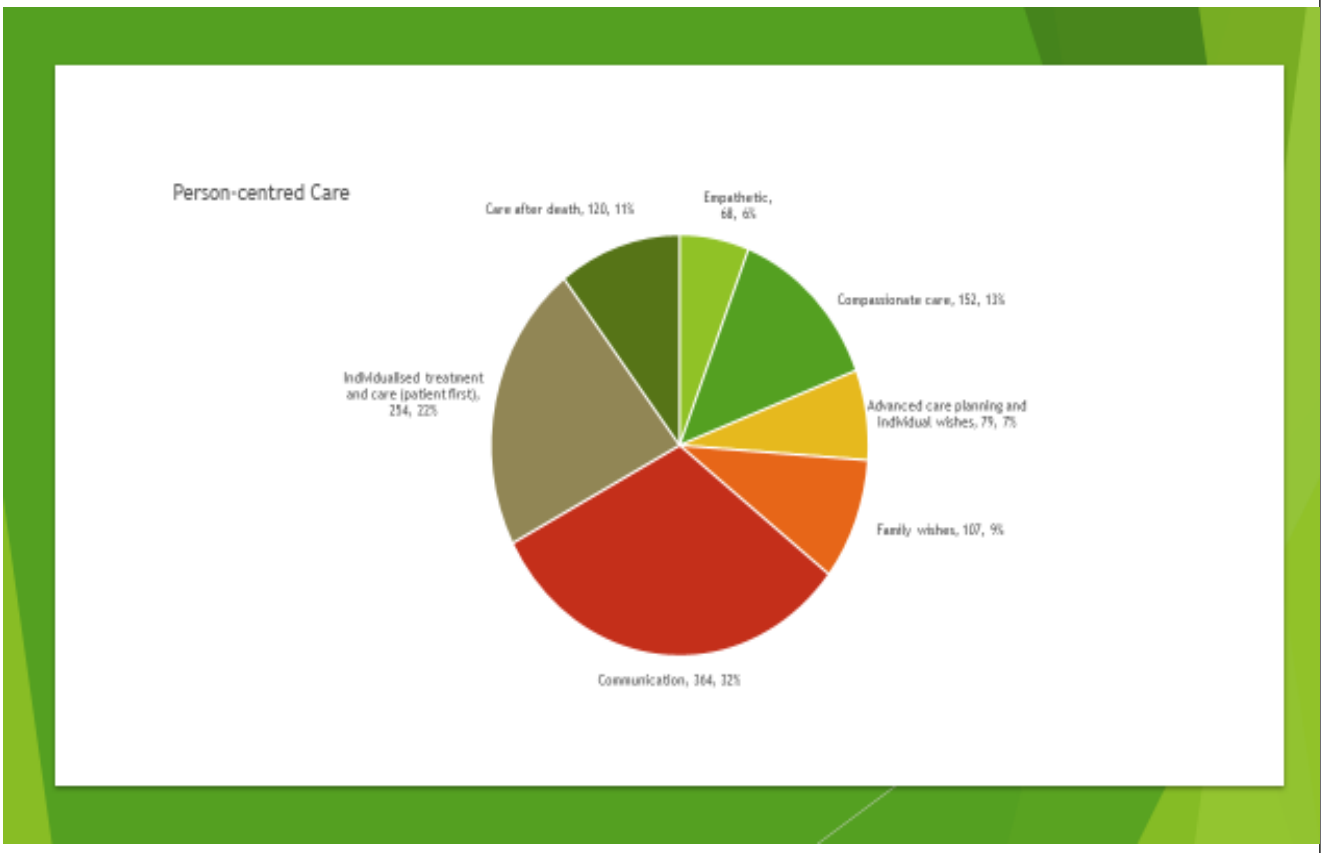
A process of scrutiny of cases reviewed by the Coroner but not taken to inquest is also being worked in to our Mortality scrutiny panels. This is an area which has thus far evaded internal scrutiny for learning purposes.

Since September 2024 all deaths that occur both in inpatient settings and in the community (including Residential and Nursing Homes) receive independent scrutiny from the Medical Examiner unless they are referred to HM Coroner - 19% of all cases are referred back to CAV for further consideration. The rate for CAV acute hospitals is 23.4%. The UHB received less referrals than any other University Health Board in each category, with the exception of Powys UHB.

The Medical Examiner categorises referrals to the health organisations in Wales under the six domains of quality.



Person-centred care was the greatest reason for referral with communication with the patient and their family dominating this category.



Work is ongoing by our Supportive/Palliative care teams to audit the use of SEWS at the end of life which will support learning within CAV in this area. Clinical documentation forms the most common reason for referral under the safe care domain.
The timely completion of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions and the accurate completion of the paperwork including the signature of the consultant consistently features as a common reason for ME referral.

Learning from mortality group

The Learning from Mortality Group is a safety group which meets every 2 months. Clinical Board representatives from every Clinical Board are invited, as well as representatives from Public Health, the Bereavement team, Inquest team and Medical Records and other interested parties. A representative of the MES attends to share feedback and engage with discussion. Themes form the Mortality Scrutiny panel are discussed and the Care after death process monitored. Coroner regulation 28s, both local and National are tracked and shared within the group. Tier 1 mortality trends are considered and Clinical Boards are encouraged to track mortality data and discuss trends and movements in their tier 2/3 mortality data at the meeting. Links have been made with Learning difficulties team (CAV and SBUHB) and Homelessness Service (Dr Ayla Cosh) to ensure learning from mortality reviews are shared with services supporting these high risk groups, and that any feedback from these services on care provision is fed back to CAV service providers. A report from the Learning from Mortality Group is provided to the Clinical Safety Group annually.

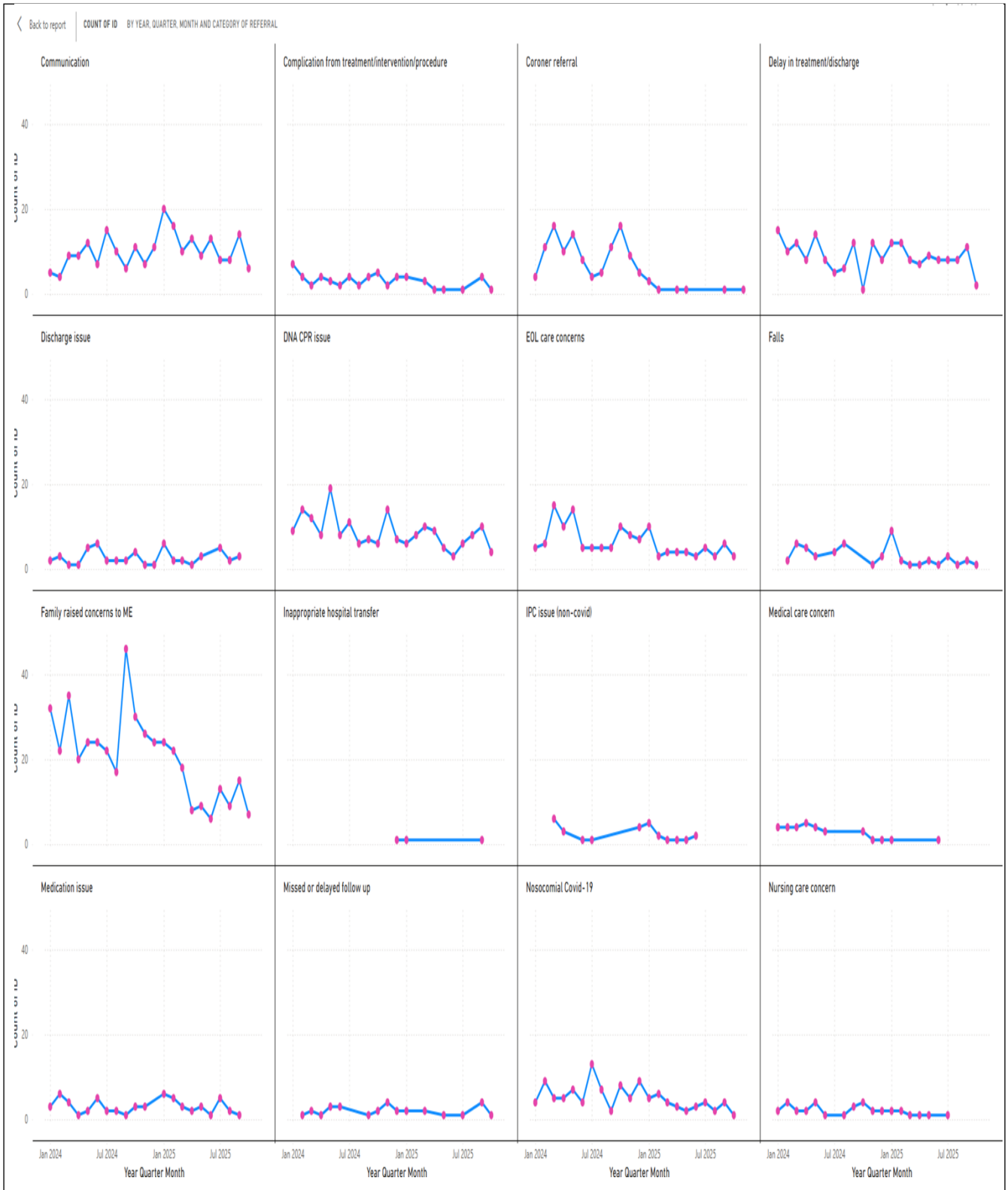
Morbidity and Mortality Review

Morbidity and Mortality reviews occur widely within the UHB though with varying approaches and often little documentation. There is currently heath board wide work ongoing, coordinated from the patient safety team and the learning from mortality group, to standardise M&M process and record outcomes within an AMAT module. This work is

commencing within Vascular and Endoscopy services and will be a vital tool in the organizational work towards Quality Management Systems.

Progress and Learning

Graphical representation of the themes emerging from the initial scrutiny of MES referrals is demonstrated below. Within this data, themes emerging as common from our Mortality Scrutiny include adequate assessment of Capacity, and Mental Capacity Act related concerns, “lost to follow up” associated concerns, the recognition and management of deteriorating patients and the care of patients and decision making at the end of life.



Capacity and MCA

The scrutiny process has identified the documentation of issues relating to capacity assessment and the mental capacity act, consent in the context of a lack of capacity and adherence to Safeguarding policies to be major learning points for our systems. This has led to increased educational efforts, often targeted at areas identified in reviews, on the theme of consent and mental capacity act, aimed at multidisciplinary teams. Also there have been efforts to signpost clinicians to appropriate educational material on ESR and internal educational resources.

The MCA Team have been involved in the Mortality Screening Panel since its second meeting in June 2024. The team's contribution includes scrutinising the SBARs based on ME report findings to identify whether a more detailed record review is required. Findings are then fed back through panel discussion to identify organisational learning, and the team contribute to relevant review processes where MCA practice is a key part of the learning required.

Over this 11 month period, the MCA team have reviewed the records for 42 cases - these record reviews are usually detailed and often lead to further activity through involvement in other review processes, with team statistics indicating that the average case takes 2.2 hours of MCA team time.

As well as contributing to the mortality process' objectives, the MCA team have gained significant benefit from our collaboration, gaining rich information about the broader picture of MCA compliance in the UHB, and directing team priorities for training and resources.

Review themes have identified frequent instances whereby patients are treated as if lacking capacity to make independent decisions during admission but with no reference to the MCA requirements being considered, with varying degrees of harm as a result. This valuable information would otherwise not have been highlighted as both the advisory work of the team & annual audit processes only cover cases where clinicians have identified that the MCA should be applied to their patient's case.

After themes were noted of failure to assess capacity when the threshold was met and poor quality documentation, short-form training with accompanying posters has been developed for 'When to Assess Capacity' and 'Documenting Capacity Assessments'. This has allowed concise and effective feedback through multiple forums to highlight key learning and direct staff to more comprehensive resources and training available.

Emerging themes of failure to recognise and/or act on self-neglect concerns prompted the team to expand our knowledge in this area, and self-neglect now forms a significant portion of both our organisational and regional work. Multiple different Self Neglect and the MCA training resources have been developed and delivered, including multi-agency work, contribution to national guidance and there continues to be considerable resource dedicated to improving practice & staff support in this area.

Management of the Deteriorating Patient

Delays in diagnosis, treatment, referral and transfer or admission featured under the timely care domain and have been used in conjunction with data from patient safety incidents to inform the UHB Shaping Our Future Quality Excellence programmes focusing on ensuring the timely identification and escalation of deteriorating patients and the continuity of patient care provision form referral to discharge. Work is already underway within the organisation to increase advanced care planning in the community, adopt the new All Wales treatment escalation plan (TEP), and regularly review DNACPR decisions in the inpatient setting.
The organisation has recently launched NEWS-2, the latest iteration of the National approach to the identification and escalation of the deteriorating patient and significant efforts have been undertaken to improve and measure the improvement of identification, escalation and management of the deteriorating patient. The target for implementation of NEWS-2 is the end of September 2025.
Both these significant areas of work will impact on the quality of care of the deteriorating patient reducing referrals from the MES in relation to recognition, management and escalation of the deteriorating patient.

Lost to Follow Up

Lost to follow up may include the identification of an abnormal finding which is not acted upon, a patient lost to outpatient or surveillance follow-up, and delayed investigations of concerning symptoms. These all appear as recurrent themes within mortality reviews. Lost to follow up as a theme has also been adopted as a workstream within Shaping our Future Quality Excellence which will improve health systems in providing continuity of care when investigation and surveillance is required.

End of Life Care

The Wales Quality Statement for Palliative and End of Life Care was published in 2022 and sets a standard for how and where people will access safe effective person centred and timely care. To support delivery of these standards, a project is being undertaken to evaluate end of life care provision from the viewpoint of the bereaved. An end-of-life audit tool has been developed to identify areas of poor end-of-life care - for example uncontrolled symptoms, basic human needs unsupported; inequity of access; lack of honest compassionate communication; over-medicalised vs reversible clinical factors not addressed; carer isolation/overwhelm; lack of compassionate care etc that are contrary to the standards set out in the Quality Statement. All referrals from the Medical examiner are being audited to extrapolate themes. The Symptoms Early Warning Score (SEWS) assessment chart, is emerging as an area that requires additional focus. SEWS should be used to assess patients at the end of life to support the recognition of agitation, pain and respiratory symptoms and to standardise the response to ensure optimal symptom control. Educational resources will be developed in response to the findings of the ongoing audit and there are plans to extend the audit to the community over the coming year.

Emerging Themes

Further themes emerging from mortality scrutiny include the lack of advanced care planning (both in the hospital and community), significant numbers of deaths in patients with liver disease, deaths identified in Medical (and other Specialty) patients outlying in non-Medical beds, care of the dying in inpatient long stay beds with associated concerns (e.g. assessment of capacity) and areas where there are a high volume of complex deaths. Awareness of all of these issues are being addressed with relevant safety groups or clinical Boards through the workings of and attendance at the Mortality scrutiny panel, in M&M meetings throughout the organization, and in ad hoc meetings.

Executive Director Opinion and Key Issues to bring to the attention of the Committee:

Recommendation:

The Committee is requested to:

a) Awareness of Care after Death processes in CAV and preparation for Winter.
b) Acknowledge this summary of Mortality Scrutiny being undertaken within CAV UHB
c) Recognise the learning efforts and partnerships in place to embed learning arising from mortality scrutiny and subsequent internal UHB review

Link to Strategic Objectives of Shaping our Future Wellbeing:
https://shapingourfuturewellbeing.com/

Putting People First 1. **Click the objective above to view more detail.**	x	Providing Outstanding Quality 2. **Click the objective above to view more detail.**	x

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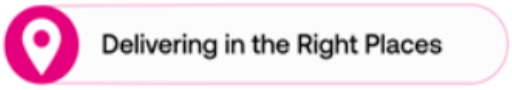
 3. **Click the objective above to view more detail.**		 4. **Click the objective above to view more detail.**	

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term		Integration		Collaboration	x	Involvement	x

Quality Impact Assessment Completed?				
Yes – (***please provide completed QIA document***)		No – ***(Please provide reasoning, e.g. not required)***		Not required

Impact Assessment:
Risk: No
Safety: No
See descriptions of reviews of thematic outputs from mortality scrutiny
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:

Report Title:	NHS Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR)			Agenda Item no.	3.2.1
Meeting:	Quality Committee	Public	x	Meeting Date:	09/12/2025
		Private			
Status *(please tick one only):*	Assurance		Approval x	Information	
Lead Executive:	Catherine Phillips, Executive Director of Finance				
Report Author (Title):	Zoe Rees, Commissioning Officer – IPFR				

Main Report
Background and current situation:

Current Situation:
The extant NHS Wales Policy, Making Decisions on Individual Patient Funding Requests (IPFR) has been in place since June 2017.

Following a Judicial Review in December 2021, in July 2022 the Welsh Government agreed that a specific and limited review of the All-Wales IPFR Policy would be undertaken to clarify how the policy should be interpreted. The changes made to the policy clarify the wording of the policy where the KC felt that there were legal ambiguities following the Judicial Review.

In September 2022, the Joint Committee (JC) approved the proposal for WHSSC to embark on an engagement process with key stakeholders, including the All Wales Therapeutics and Toxicology Centre (AWTTC), the IPFR Quality Assurance Advisory Group (QAG), the Medical Directors and the Board Secretaries of each of the Health Boards (HBs) and Velindre University NHS Trust (VUNT), to update the WHSSC IPFR Panel ToR and on the specific and limited review of the All Wales IPFR Policy.

In July 2025, the final version of the revised Policy was finalised by the Health Boards and the NWJCC. The final version of the Policy is required to be approved and adopted by all Health Boards prior to being implemented operationally and implemented across NHS Wales at an agreed date.

Background:
In 2010, the Director General, Health and Social Services, Chief Executive, NHS Wales requested that Health Boards work together with the Welsh Health Specialised Services Committee (WHSSC) and Public Health Wales (PHW) to develop an All-Wales policy and standard documentation for dealing with individual patient funding requests (IPFR) for treatment. This policy has been in place since September 2011. The policy has been updated on several occasions with the last update previously in 2017.

A comprehensive range of NHS healthcare services are routinely provided locally by primary care services and hospitals across Wales. However, each year, requests are received for healthcare that falls outside this agreed range of services. We refer to these as Individual Patient Funding Requests (IPFR).

The challenge for all Health Boards and the NHS Wales Joint Commissioning Committee (NWJCC) is to strike the right balance between providing services that meet the needs of the majority of the population, whilst having in place arrangements that enable it to accommodate people's individual needs. To manage this aspect of the Health Board and NWJCC's responsibilities, there needs to be a robust process for considering requests for individual patient funding within the overall priority setting framework. Demand for NHS services is always likely to exceed the resources available and, as a result, making decisions on IPFR are some of the most difficult a Health Board or NWJCC will have to make.

NHS Wales introduced the Policy on decision making for IPFR's to ensure an open, transparent, fair, clearly understood and easily accessible process is followed. It describes both the principles underpinning how decisions are made to approve or decline individual patient requests for funding and the process for making them.

The IPFR policy is operated throughout NHS Wales with each Health Board and NWJCC having their own panel.

The IPFR process is supported by the IPFR Policy Implementation Group, whose role is to facilitate the implementation of the Policy, whilst providing and developing assurance systems and guidance to aid the decision-making process. The group membership comprises a senior IPFR member from each HB and NWJCC. Members of the All-Wales Therapeutics and Toxicology Centre (AWTTC) and Health Technology Wales (HTW) are also in attendance. The CAVUHB member of the Policy Implementation Group is the Commissioning Officer for IPFR, Zoe Rees.

The AWTTC also plays a pivotal role in providing a national quality function to assess IPFR cases, ensuring compliance to the IPFR process. In addition, they are responsible for writing the All – Wales IPFR Annual Reports and arranging the annual IPFR training workshop, which are both supported by the IPFR Policy Implementation Group. These arrangements have been in place since 2017.

Feedback and evidence from the national quality assurance group over the years indicates positive improvement in compliance with the policy criteria; improvement in consistency in approach to the IPFR process; and minimal requests for a review of the process followed in making decisions.

In a situation where the Courts consider that there has been a flaw in the decision-making process, the Courts can declare the original decision was invalid and order a Health Board to make the decision again. Such a case was in December 2021, where the NWJCC was subject to a judicial review. The courts supported the request for a judicial review on 5 grounds which included, not using the correct comparator group, not interpreting the NICE interventional procedural guidance properly and not documenting the decision making adequately.

Since that Judicial Review case, representatives of NWJCC have attended meetings with All Wales Board Secretaries, All Wales Medical Directors and the All-Wales IPFR Policy Implementation Group. They sought support to make changes to the IPFR Policy and the Terms of Reference (ToR) to the NWJCC IPFR panel. In July 2022, the Welsh Government also wrote to NWJCC supporting a 'de-minimis' review of the IPFR Policy and associated ToR for the IPFR Panels.

With this support, NWJCC initiated a project to review the IPFR Policy. Following a period of engagement, consultation and development, involving all Health Boards and NWJCC, the final version of the revised Policy was agreed at the NWJCC Joint Committee in September 2025 and is now in the process of being adopted within the Health Boards.

Executive Director Opinion and Key Issues to bring to the attention of the Committee:

The NHS Wales IPFR Policy has been updated collaboratively, following a robust development project. The proposed version is accepted by the IPFR Policy Implementation Group as being fit for purpose.

The main changes to note are:

- Revisions to the section explaining how IPFR decisions are made, with more explanation of the criteria to be considered.
    - Primary criteria relate to whether available guidelines (e.g. from NICE or AWMSG) recommend NOT to use an intervention; or if the intervention has NOT been appraised hence no guidelines are in place.

- Further criteria require the objective assessment of the clinical circumstances of the patient; the potential for significant clinical benefit; and whether the value for money of the intervention is likely to be reasonable.

- The 'decision making guide' has been retained but is now in appendix 1 rather than embedded with the core Policy.
- Updated Terms of Reference for the NWJCC IPFR Panel.
- Inclusion of the Terms of Reference for the IPFR Policy Implementation Group.
- Removal of surplus, convoluted, passages referring to legal challenge.
- Simplification of references to Health Board complaints processes and referrals to Public Services Ombudsman for support.

Appendices

1. NHS Wales Policy for making Decisions on Individual Patient Funding Requests (IPFR)
2. EHIA

Recommendation:

The Committee is requested to:

a) To **note** this report; and
b) To **approve** and **endorse** 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.

Link to Strategic Objectives of Shaping our Future Wellbeing:

1. Putting People First - Shaping our Future Wellbeing Click the objective above to view more detail.	x	2. https://shapingourfuturewellbeing.com/providing-outstanding-quality/ Click the objective above to view more detail.	x
3. Delivering in the Right Places - Shaping our Future Wellbeing Click the objective above to view more detail.	x	4. https://shapingourfuturewellbeing.com/acting-for-the-future/ Click the objective above to view more detail.	

Five Ways of Working (Sustainable Development Principles) considered:

Prevention	x	Long term		Integration		Collaboration		Involvement	

Quality Impact Assessment completed?

Yes – (please provide completed QIA docu	X	No – (Please provide reasoning, e.g. not required)	

Impact Assessment:

Risk: No

Safety: No

Financial: Yes
The IPFR Policy requires the authorisation on the front page of the form from the relevant Clinical Board Director and Clinical Director to confirm that they consent to the requested funding to be from the Clinical Board budget. The only deviation from this is for IPFR requests from Velindre Cancer Centre. To support this, there is a Scheme of Financial Delegation that sits alongside the IPFR Policy.
Workforce: No
Legal: Yes
If the IPFR Policy is not adhered to, the Health Board may be at risk of legal challenge. To mitigate this, the Cardiff and Vale IPFR Team submit randomized cases for independent quarterly audit which is monitored by the Welsh Government and are regularly reviewed by Internal Audit. The IPFR Policy has a Review Procedure to allow for concerns to be addressed prior to any legal action.
Reputational: Yes
Non-adherence to the IPFR Policy may carry a reputational risk.
Socio Economic: No
Equality and Health: Yes
See EHIA
Decarbonisation: No
Not Applicable
Approval/Scrutiny Route:

NHS WALES POLICY
MAKING DECISIONS ON INDIVIDUAL PATIENT FUNDING REQUESTS (IPFR)

Reference Number	Policy Reference (as per individual Health Board)	**Version Number**	FINAL July 2025
Linked Documents	Health Board Policies on Interventions Not Normally Undertaken (INNU)		

Classification of Document: Clinical Policy

Area for Circulation: Health Boards and Primary Care providers across Wales

NHS Wales Joint Commissioning Committee (JCC)
Public Health Wales (PHW)
Public Domain via Internet Sites

Policy Development: All Wales IPFR Policy Implementation Group
NHS Wales Joint Commissioning Committee

Consultation: Legal Advice from Welsh Health Legal & Risk Services
NHS Wales Medical Directors Stakeholder groups

Approved: July 2025

Date of Publication: TBC

Date of Next Review July 2028

Lead Health Board Contact: Contact details as per individual Health Board

Table of Contents

1 INTRODUCTION

1.1 Background

In 2010, the Director General, Health and Social Services, Chief Executive, NHS Wales requested that Health Boards would work together with the Welsh Health Specialised Services Committee (WHSSC) and Public Health Wales (PHW) to develop an All-Wales policy and standard documentation for dealing with individual patient funding requests (IPFR) for treatment. This policy has been in place since September 2011.

1.1.1 In October 2013, The Minister for Health and Social Services announced a review of the IPFR process in Wales. An independent review group was established to explore how the current process could be strengthened.

1.1.2 In April 2014, the "Review of the IPFR process" report was published. The report concluded that the IPFR process in Wales is comprehensive and supports rational, evidence-based decision making for medicine and non-medicine technologies which are not routinely available in Wales. The review group also made a number of recommendations to strengthen the IPFR process.

1.1.3 In September 2016, following the 2014 review and implementation of its recommendations, the Cabinet Secretary for Health, Well-being, and Sport agreed the time was right for a new, independent review of the IPFR process. The panel would be independent of the Welsh Government and encompass a range of expertise and knowledge.

The "Independent Review of the Individual Patient Funding Requests Process in Wales" report was published in January 2017.

1.1.4 Following a Judicial Review in December 2021, the Welsh Government in July 2022 agreed that a specific and limited review would be undertaken to put beyond doubt how the policy should be interpreted. In 2024 the commissioning responsibilities of WHSSC were transferred to the NHS Wales Joint Commissioning Committee (JCC).

1.2 Purpose of this Policy

1.2.1 To ensure an open, transparent, fair, clearly understood and easily accessible process is followed, the NHS in Wales has introduced this Policy on decision making for IPFR's. It describes both the principles underpinning how decisions are made to approve or decline individual patient requests for funding and the process for making them.

1.2.2 Continuing advances in technology, changing populations, better information and increasing public and professional expectations all mean that NHS Health Boards have to agree their service priorities for the application of their financial and human resources. Agreeing these priorities is a complex activity based on sound research evidence where available, sometimes coupled with value judgments. It is therefore important to be open and clear about the availability of healthcare treatments on the NHS and how decisions on what should be funded by the NHS are made.

1.2.3 A comprehensive range of NHS healthcare services are routinely provided

locally by primary care services and hospitals across Wales. In addition, the JCC, working on behalf of all the Health Boards in Wales, commissions a number of more specialist and highly specialist services at a national level. However, each year, requests are received for healthcare that fall outside this agreed range of services. We refer to these as Individual Patient Funding Requests (IPFR).

1.2.4 Each Health Board in Wales has a separate Policy called 'Interventions Not Normally Undertaken' (INNU) setting out a list of healthcare treatments that are not normally available on the NHS in Wales. This is because:

- There is currently insufficient evidence of clinical and/or cost effectiveness; and/or
- The intervention has not been reviewed for the indication under consideration by the National Institute for Health and Care Excellence (NICE) or the All-Wales Medicines Strategy Group (AWMSG); and/or One Wales Medicines process or Health Technology Wales.
- The intervention is considered to be of relatively low priority for NHS resources.

1.2.5 The INNU policy should be read together with this policy on making decisions

1.2.6 The challenge for all Health Boards and JCC is to strike the right balance between providing services that meet the needs of the majority of the population in the geographical area for which it is then given responsibility, whilst having in place arrangements that enable it to accommodate people's individual needs. Key to this is having in place a comprehensive range of policies and schedule of services that the Health Board and/or JCC has decided to fund to meet local need within the resource available. To manage this aspect of the Health Board and JCC's responsibilities, there will always need to be in place a robust process for considering requests for individual patient funding within the overall priority setting framework. Demand for NHS services is always likely to exceed the resources available and, as a result, making decisions on IPFR are some of the most difficult a Health Board or JCC will have to make.

1.2.7 In line with the requirements of the Equality Act 2010 and the Welsh Government guidance 'Inclusive Policy Making' issued in May 2010, a detailed equality impact assessment has been completed to assess the relationship between this policy and the duties of the Act.

1.3 Explaining Individual Patient Funding Requests (IPFR)

1.3.1 IPFRs are defined as requests to a Health Board or JCC to fund NHS healthcare for individual patients who fall outside the range of services and treatments that a Health Board or JCC has arranged to routinely provide, or commission. This can include a request for any type of healthcare including a specific service, treatment, medicine, device or piece of equipment.

Such a request will normally be within one of the three following categories.

- a patient and NHS clinician have agreed together that they would like treatment that is either new, novel, developing or unproven and is not within the Health Board's routine schedule of services and treatments for example, a request to use a cancer drug that has yet to be approved by the Health Board for use in that particular condition).

- a patient and NHS clinician have agreed together that they would like treatment that is provided by the Health Board in certain clinical circumstances but is not eligible in accordance with the clinical policy criteria for that treatment (for example, a request for treatment for varicose veins for cosmetic reasons alone).

- a patient has a rare or specialist condition that falls within the service remit of the JCC but is not eligible in accordance with the clinical policy criteria for treatment (for example, a request for plastic surgery where the indication is personal preference rather than medical need).

1.3.2 IPFRs should not be confused with requests for packages of care for patients with complex continuing healthcare needs – these are covered by separate Continuing Healthcare arrangements. Further information can be obtained from the Health Board's Nursing Department.

1.3.3 IPFRs should also not be confused with treatments that have already been provided or administered outside of NHS funded care. Requests **will not** be considered for retrospective funding.

1.3.4 If the clinical circumstances for the specific individual patient have changed, an IPFR application form describing / explaining / justifying:

i. why the patient is likely to gain significant clinical benefit from the proposed intervention; and
ii. demonstrating that the value for money of the intervention for that particular patient is likely to be reasonable,

then a case may be submitted to the Health Board or JCC for consideration for further prospective funding. For example, if a patient funds a treatment themselves and their clinician believes they can demonstrate that the patient has gained significantly more clinical benefit from the intervention than would normally be expected for that treatment, an IPFR can be submitted for consideration.

1.3.5 The three categories of treatment described in 1.3.1 will only potentially be funded in specific clinical circumstances. It is important to note that the NHS in Wales does not operate a blanket ban for any element of NHS healthcare but equally the granting of funding in one case does not mean that funding will be provided for the same treatment for other patients. We will consider each IPFR on its individual merits and in accordance with the arrangements set out in this policy. We will determine if the patient should receive funding based on the significant clinical benefit expected from the treatment and whether the cost of the treatment is in balance with the expected clinical benefits.

1.3.6 In this policy, the words "significantly different to the general population of patients" means that the patient's condition does not have substantially the same characteristics as other members of that population. For a patient to be significantly different, their particular clinical presentation is unlikely to have been considered as being part of the population for which the policy was made.

1.3.7 In practice, it is not always practical to determine the "benefit" of an intervention in numerical terms in the same way, for example as NICE or the AWMSG. In these situations, a description of the benefit should be used to

enable IPFR panels to compare the description of the incremental clinical benefit likely to be obtained.

In general, the clinician should compare the benefits of the intervention being requested with what he or she considers to be the next best alternative, which may in some cases be best supportive care.

1.3.8 Whether an intervention provides "value for money" is assessed conceptually in terms of the incremental cost per incremental quality-adjusted life year (QALY) of benefit. Whilst "reasonable" value for money is to be interpreted in the same way that "cost-effective" is used in the Health Technology Appraisal (HTA) process operated by NICE, AWMSG and HTW.

1.3.9 Recognising that it can never be possible to anticipate all unusual or unexpected circumstances, this policy aims to establish a clear guide to making decisions on IPFRs to determine whether the evidence that the patient is likely to gain a significant clinical benefit, and the value for money of the intervention for that particular patient is likely to be reasonable, has been presented.

Please refer to the decision-making factors in Appendix one. These are factors the panel may consider when looking at the significant clinical benefit expected by the treatment, and whether the cost of the treatment is in balance with the expected benefits.

2 THE LEGAL CONTEXT OF THIS POLICY

2.1 Health Boards exercise functions delegated to them by the Welsh Ministers under various statutes and in particular under the National Health Service (Wales) Act 2006 and under secondary legislation made under that Act.

2.2 In addition to specific statutory obligations, Health Boards are public bodies, which are required to comply with their legal obligations to act in accordance with the rights of individuals under the European Convention of Human Rights as defined in the Human Rights Act 1998 and under common law.

2.3 Health Boards must therefore be able to demonstrate that their decisions are within their powers and comply with their legal obligations. In terms of the exercise of their powers, they must show that they have considered all relevant issues in the decision-making process, giving them appropriate weight and that those decisions are rational, logical, lawful and proportionate.

Careful consideration needs to be given in relation to all decisions; particular care may need to be given in the following circumstances:

- when evidence is not clear or conclusive.
- when the issue is controversial and may not have the support of NICE, AWMSG or HTW.
- when life or death decisions are involved.
- when limiting access to specific services or treatments.
- when setting priorities.
- when other Health Boards or JCC may have used their discretion to make a different decision on a specific topic.

2.4 It is lawful for JCC and Health Boards to adopt policies about which treatments will, and which will not, be routinely funded. It is also lawful for JCC and Health Boards to adopt this policy to define the circumstances in which a decision can be made to fund an intervention for a patient where the patients are lawfully

2.5 denied funding for the same intervention as a result of policies or as a result of an absence of a policy approving funding for that intervention.

2.6 Consistency in policy and approach, together with clarity about clinical criteria for treatment and a consistent approach to dealing with IPFR requests should reduce the need for patients to go through a review or appeal process at any level. This should be the desirable outcome as far as it is possible.

3 PRINICIPLES UNDERPINNING THIS POLICY

The principles underpinning this policy and the decision making of the Health Board are divided into five areas - the NHS Core Values, the Prudent Healthcare Principles, Evidence-based Considerations, Ethical Considerations and Economic Considerations.

3.1 NHS Core Values are set out by the Welsh Government as;

- Putting quality and safety above all else: providing high value evidence-based care for our patients at all times.
- Integrating improvement into everyday work and eliminating harm, variation and waste.
- Focusing on prevention, health improvement and inequality as key to sustainable development, wellness and wellbeing for future generations of the people of Wales.
- Working in true partnerships with partner organisations and with our staff
- Investing in our staff through training and development, enabling them to influence decisions and providing them with tools, systems, and environment to work safely and effectively.

3.2 Prudent Healthcare Principles

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production.
- Care for those with the greatest needs first, making the most effective use of all skills and resources.
- Do only what is needed, no more, no less; and do not harm.
- Reduce inappropriate variation using evidence-based practices consistently and transparently.

3.3 Evidence-Based Considerations

3.3.1 Evidence-based practice is about making decisions using quality information, where possible, and recognising areas where evidence is weak. It involves a systematic approach to searching for and critically appraising that evidence.

3.3.2 The purpose of taking an evidence-based approach is to ensure that the best possible care is available to provide interventions that are sufficiently clinically effective to justify their cost and to reduce inappropriate variation using evidence-based practices consistently and transparently.

NICE issue Technology Appraisals and the All-Wales Medicines Strategy Group and Health Technology Wales issue guidance which Health Boards and JCC are required to follow.

3.3.3 Additionally, a central repository for evidence-based appraisals is available which provides support for clinicians making an application. This is located on the shared database. Users are able to upload and access the information

available which will continue to be developed over time as evidence /new reports are produced.

3.3.4 It is also important to acknowledge that in decision making there is not always an automatic "right" answer that can be scientifically reached. A "reasonable" answer or decision therefore has to be reached, though there may be a range of potentially reasonable decisions. This decision is a compromise based on a balance between different value judgements and scientific (evidence-based) input. Those vested with executive authority have to be able to justify, defend and corporately "live with" such decisions.

3.4 Ethical Considerations

3.4.1 Health Boards and JCC are faced with the ethical challenge of meeting the needs of individuals within the resources available and meeting their responsibility to ensure justice in the allocation of these resources ('distributive justice'). They are expected to respect each individual as a person in his or her own right.

3.4.2 Resources available for healthcare interventions are finite, so there is a limit to what Health Boards and JCC can routinely fund. That limitation is reasonable providing it is fair, and not arbitrary. It must be based on the evidence both about the effectiveness of those interventions and their cost. A cost-effective intervention is one that confers a great enough benefit to justify its cost. That means policies must be based on research, but research is carried out in populations of patients, rather than individual patients. That leaves open the possibility that what is true for patients in general is not true about a specific individual patient. Fairness therefore also requires that there must be a mechanism for recognising when an individual patient will benefit from a particular intervention more than the general population of patients would. Identifying such patients is the purpose of the IPFR process.

3.4.3 Welsh Government communications set out six ethical principles for NHS organisations and these underpin this policy. They are:

- treating populations and particular people with respect.
- minimising the harm that an illness or health condition could cause.
- fairness.
- working together.
- keeping things in proportion; and
- flexibility

3.5 Economic Considerations

3.5.1 It is a matter for Health Boards and JCC to use its discretion to decide how it should best allocate its resources. Such resources are finite and difficult

balancing decisions have to be made. Health Boards and JCC must prioritise the services that can be provided whilst delivering high-quality, cost-effective services that actively avoid ineffective, harmful, or wasteful care that is of limited benefit. The opportunity cost associated with each decision has also to be acknowledged i.e., the alternative uses to which resources could be put.

4 MAKING DECISIONS ON IPFR

4.1 In line with the principles set out earlier in this document, Welsh Government communications set out the key factors for 'good decision making'. These are:

- openness and transparency.
- inclusiveness.
- accountability.
- reasonableness.
- effectiveness and efficiency.
- exercising duty of care.
- lawful decision making; and
- the right to challenge and appeal

This policy aims to ensure that the Health Board and JCC has a clear and open mechanism for making decisions that are fair, open, and transparent. It enables those responsible for decision making to demonstrate that they have followed due process, considered the above factors, and have been both rigorous and fair in arriving at their decisions. It also provides a clear process for challenge and appeal.

4.2 In accordance with Welsh Government communications, NICE definitions, and the criteria set out in this policy, Health Boards and JCC should make decisions on IPFRs based on; the evidence presented to demonstrate the expected significant clinical benefit, and the evidence presented outlining the patient's individual clinical circumstances. Decisions should be undertaken whilst taking into reasonable account the evidence base, and the economic and ethical factors below:

- **evidence-based considerations** – clinical and cost effectiveness; service and policy implications.
- **economic considerations** – opportunity cost; resources available; and
- **ethical considerations** – population and individual impact; values and principles; ethical issues.

Non-clinical factors (such as employment status) will not be considered when making decisions on IPFR.

This Policy does not cover healthcare travel costs. Information on patients' eligibility for healthcare travel costs to receive NHS treatment under the care of a consultant can be found on the Welsh Governments' healthcare costs website.

4.3 The following criteria must be used by all Health Board and JCC IPFR Panels when making IPFR decisions. It is the responsibility of the referring clinician to ensure that sufficient information is placed before the panel to allow the panel to be able to determine whether the criteria are satisfied.

A patient will only be entitled to NHS funding for the requested intervention or drug if the panel conclude that the criteria under **either (a) or (b)** below are satisfied:
(a) If guidelines (e.g. from NICE or AWMSG) recommend NOT using the intervention/drug, or the clinical access criteria of an applicable policy are not met: I. The clinician must demonstrate that the patient's clinical circumstances are significantly different to other patients for whom the recommendation is not to use the intervention. II. The clinician can demonstrate that the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected from patients for whom the recommendation is not to use the intervention, and III. The IPFR panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.
(b) If the intervention has NOT been appraised (e.g. in the case of medicines, by AWMSG or NICE), and there is no applicable policy in place: I. The clinician can demonstrate that the patient is likely to gain significant clinical benefit, and II. The IPFR panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.

4.4 An IPFR panel is required to decide whether the application fulfils Part A or Part B and then consider the application against the relevant criteria. A panel may only approve applications which meet all of the applicable criteria above. It is however the responsibility of the requesting clinician to demonstrate the clinical case for the patient in respect of the criteria outlined.

4.5 Considerations under Part A

4.5.1 Where a recommendation has been made not to use an intervention, the panel is required to consider whether the patients' clinical circumstances are significantly different to other patients for whom the recommendation is made not to use the intervention'. That process will usually require a comparison between the patient for whom treatment is being requested, and other patients with the same medical condition who could have been offered the requested intervention if the relevant guidance and/or applicable policy allowed.

4.5.2 The panel next should consider whether there is a significant difference between the clinical circumstances of the patient for whom funding is being requested, and the comparator group, and whether the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected for patients for whom the recommendation has been made not to use the intervention. If, but only if, both of these criteria are

met on the facts of an individual Part A case, the panel will then consider whether the intervention is deemed value for money as described at paragraph 4.7 below.

4.6 Considerations under Part B

4.6.1 In the absence of any appraisal or applicable policy, the panel need to consider whether the referring clinician has provided sufficient evidence to conclude that the patient is likely to gain significant clinical benefit from the intervention requested. If this criterion is met on the facts of an individual Part B case, the panel will then consider whether the intervention is deemed value for money as described below.

4.7 Value for money

4.7.1 The assessment as to whether the intervention provides "value for money" is a matter of judgement for the panel. The panel should reach a decision exercising its broad discretion to decide whether the value for money of an intervention for a particular patient is likely to be reasonable.

4.7.2 The panel should consider the likely overall costs to the NHS of the requested intervention compared with the next best alternative treatment that is routinely funded on the NHS. The panel should in a similar way consider the overall benefit (effectiveness) of the intervention compared with the next best alternative treatment that is routinely funded on the NHS. If the requested intervention is estimated to be more effective and less costly (than the alternative treatment) then it is likely to represent value for money. If the treatment is less effective and more expensive, then it is unlikely to be deemed value for money. If the treatment is more effective and more costly or less effective and less costly then the panel will need to make a judgement as to whether the treatment is likely to represent value for money. For any scenario, other factors may affect treatment choice, and these should be documented as part of the discussion.

4.7.3 Where presented as part of the evidence, an incremental cost effectiveness ratio ("ICER") and quality- adjusted life year (QALY) may be considered by the panel provided this is relevant to the individual case and there is appropriate expertise by the group to do so. When assessing this evidence, the panel should consider relevant thresholds in relation to NICE and AWMSG when considering if the intervention is a cost-effective option.

4.8 When making decisions, the panel are entitled to have regard to the factors set out at Appendix 1 to this policy, if the panel consider that addressing those issues may assist the panel in coming to decisions on the criteria set out at paragraph 4.3 above. The panel is not obliged to consider all the factors set out Appendix 1 to this policy and may consider that some of the factors are not relevant to the facts of an individual case or do not assist the panel in coming to its decision on those criteria.

5 HOW TO MAKE A REQUEST FOR FUNDING UNDER THIS POLICY

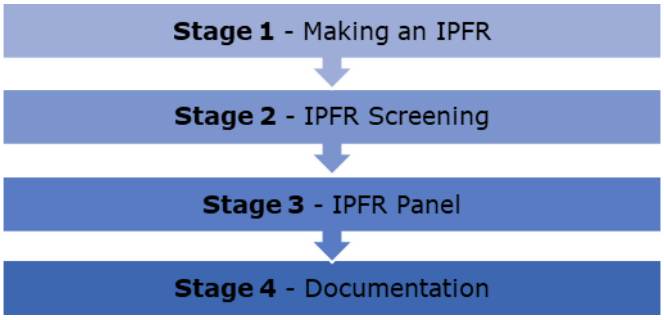
5.1 Information on how to make an IPFR

A patient leaflet is available explaining how an individual patient funding request (IPFR) can be made. These can be downloaded from the Health

Board, JCC or AWTTC website. Further information can be obtained from the IPFR Coordinator.

Copies of this policy and the IPFR application forms can also be obtained via the website, or by contacting the IPFR Coordinator.

5.2 Summary of the IPFR Process



5.3 Stage 1 Making an IPFR

The patient and their NHS clinician (agree together that a request should be made). The IPFR application form is completed by the clinician on the patient's behalf. This will ensure that adequate clinical information is provided to aid the decision-making process.

The requesting clinician must sign the application form to indicate that the patient is aware and agrees with the submission of the request. In doing so, the clinician is providing confirmation that the patient is fully informed of the treatment request and all its associated implications.

Ideally, applications for specialised and tertiary services should be completed by the patient's secondary care clinician, unless extenuating circumstances dictate otherwise. This is to ensure that all pertinent information is included in the form thereby avoiding the delay that will arise from the need to request further information before the application can be processed. All IPFR applications should demonstrate support from the relevant clinical lead, head of department or multi-disciplinary team (MDT). Where relevant, advice may also be sought from the internal clinical team.

It is necessary for clinicians to provide their contact details as there may be times when additional clinical information is required during a panel meeting to aid a decision.

The application form is sent to the IPFR Coordinator electronically or in hard copy so that the authorised consent of the clinician is recorded.

The IPFR application form must be completed in full to enable the IPFR Panel to reach a fully informed decision.

Should the IPFR Coordinator receive an application form which has not been completed sufficiently enough to determine whether or not the request can be screened out or taken to the IPFR Panel, or if the incorrect form is completed, the form should be returned to the requesting clinician **within three working days**.

The requesting clinician is responsible for completing and re-submitting the application form **within ten working days**. Should this time elapse, a chaser letter will be sent providing a **further ten working days** to make a submission.

Where the information has still not been provided in the time set, the case shall be closed, and the requesting clinician notified accordingly.

5.4 Stage 2 Screening of the IPFR

The IPFR application will be considered by the IPFR Senior Officer to determine whether the application needs to be screened out because:

a) The request meets pre-agreed criteria for a service already commissioned/provided and can automatically be funded
b) an alternative and satisfactory clinical solution is found
c) The request represents a service development which needs to be passed to the relevant Division or Directorate for action.

The IPFR Senior Officer should then communicate the outcome of the screening stage to the requesting clinician using a standard letter, **within five working days** of the decision being made. This letter will also include reasons for the decision and information on any further courses of action required.

5.5 Stage 3 Considerations by the IPFR Panel

Requests that are not screened out will be considered at a meeting of the IPFR Panel. The IPFR Coordinator will ensure that the panel has all of the information needed to reach a decision and will ensure that each case is anonymised before each meeting.

Panels will convene at least once per month in order to ensure that applications are dealt with in a timely manner. The volume and urgency of applications may require panels to meet more frequently as and when required.

The panel will consider each IPFR on its own merits, using the criteria set out in paragraph 4.3 of the Policy. Where possible, they should set out their assessment of the likely incremental clinical benefit and their broad estimate of the likely incremental cost so that their judgements on value for money are clear and transparent. The IPFR Coordinator or Senior Officer will complete a record of the panel's discussion on each IPFR, including the decision and a detailed explanation for the reason for that decision.

A standard decision letter should be prepared to communicate the decision to the requesting clinician. Correspondence will also be sent to the patient to inform them that a decision has been made, and their clinician will contact them within 5 working days to discuss. If this has not happened, patients are encouraged to contact their clinician.

These letters will be sent **within five working days** of the panel's decision and will also include information on how to request a review of the process where a decision has been made to decline the request.

5.6 Who will sit on the IPFR Panel?

The Health Board will appoint core members of the IPFR Panel which will comprise:

- Executive Public Health Director (or deputy – Public Health Consultant)
- Executive Medical Director (or deputy - Associate/Assistant Medical Director)
- Executive Director of Nursing (or deputy – Assistant Director of Nursing)
- Director of Therapies & Clinical Science (or deputy - Assistant Director of Therapies)
- Director of Pharmacy and / or Chief Pharmacist or deputy; and
- Two lay representatives.

The Chair of the Panel will be selected from the group of core members and must have a clinical background (with the exception of JCC – see Terms of Reference at Appendix 3).

Each organisation may also wish to appoint up to a further two Panel members at the discretion of the Chair of the Panel, for example a member of the Ethics Committee, Primary Care Director, or Director of Planning.

Please refer to the Terms of Reference at Appendix 2 and 3 for details of the Health Board and JCC IPFR Panel.

5.7 What about clinically urgent cases?

The IPFR Policy and process allows for clinically urgent cases, as deemed by the requesting clinician, to be considered outside of the normal screening and panel processes. In these circumstances, the Chair or Vice Chair of the IPFR panel is authorised to make a decision outside of a full meeting of the panel, within their delegated financial limits. Any such decisions will be made in line with the principles of this policy, considering the clinical urgency of the request outlined in the application form by the clinician. Those marked urgent will be considered within 24-48 hours (working days only) as per the application form.

5.8 Can patients and clinicians attend the IPFR Panel?

Patients are not permitted to attend IPFR Panels. The reasons are that it would make the process less fair because it would draw to the attention of panel members characteristics of the individual patient that should not influence their decision-making. The IPFR process is anonymous therefore allowing patients to attend would jeopardise this level of scrutiny. The IPFR Panel will normally reach its decision on the basis of all of the written evidence provided, including the IPFR application form and other documentary evidence which is provided in support. Patients and clinicians are able to supply any written statements they feel should be considered by the Panel**. Any information provided which relates to non-clinical factors will not be considered.** Local Llais teams are able to support patients in making such statements if required.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on specific issues and/or request independent expert clinical advice for consideration by the panel at a future date. The Chair of the IPFR Panel, may also contact the referring clinician to get more clarification in respect of an individual referral.

The provision of appropriate evidence to the IPFR Panel will be entirely at the Chair of the IPFR Panels discretion.

5.9 Documentation

The IPFR Coordinator will maintain a confidential electronic record of all requests. A separate, confidential hard copy file may also be maintained. This information will be held securely in compliance with Data Protection requirements and with Caldicott Guidance.

The IPFR Administration Team retains a record of the IPFR application and subsequent decision and any outcome data that is provided by the clinician. Data will be retained to help inform future planning requirements by identifying patient cohorts both at a local and national level. Data will also be used for the production of an annual report on IPFR's every year as required by the Welsh Government. This will not include any identifiable data and will use aggregated data.

In addition, a central repository for clinical evidence will be available and will develop over time as and when new evidence reports are produced / become available.

Any information will be held in line with the NHS Information Governance Retention Policy

6 HOW TO REQUEST A REVIEW OF THE PROCESS

If an IPFR is declined by the panel, a patient and their NHS clinician have the right to request information about how the decision was reached. If they are unhappy with the decision the NHS clinician on behalf of the patient can either:

Resubmit an IPFR application, but only if there is either significant new clinical information or a significant change in clinical circumstances, or

If the patient and their NHS clinician feel the process has not been followed in accordance with the IPFR policy, a review hearing can be requested (see below).

The review process for an application for funding under the IPFR policy does not conflict with a patient's ability to make a complaint about the care that has been arranged in relation to a IPFR funding decision. This is best achieved through the Health Boards or JCC's Putting Things Right process which can be found at

https://www.gov.wales/nhs-wales-complaints-and-concerns-putting-things-right (see section 9).

6.1 The 'review period'

There will be a period of **25 working days** from the date of the decision letter during which they may request a review by the review panel ('the review period").

The letter from the Health Board or JCC that accompanies the original

decision will state the deadline for any review request. In calculating the deadline, Saturdays, Sundays, and public holidays in Wales will not be counted.

6.2 Who can request a review?

A review can be requested either (a) by the original requesting clinician on the patient's behalf or (b) by the patient with the original requesting clinician's support. **The review request form must be completed by the clinician**. Both the patient and their clinician must keep each other informed of progress. This ensures the patient is kept informed at all times, that the clinician/patient relationship is maintained, and review requests are clinically supported. Patients are able to access advocacy support at any stage during this process.

6.3 What is the scope of a review?

It does not constitute a review of the merits of the original decision. It has the restricted role of hearing review requests that fall into one or more of three strictly limited grounds. A review request on any other ground will not be considered.

The 3 grounds are:

Ground One: *The Health Board or JCC has failed to act fairly and in accordance with the All Wales Policy on Making Decisions on Individual Patient Funding Requests (IPFR).*

Health Boards and JCC are committed to following a fair and equitable procedure throughout the process. A patient who believes they have not been treated fairly by the Health Board or JCC may request a review on this ground. This ground relates to the procedure followed and not directly to the decision and it should be noted that the decision with which the patient does not agree is not necessarily unfair.

Ground Two: *The Health Board or JCC has prepared a decision which is irrational in the light of the evidence submitted*

The review panel will not normally entertain a review request against the merits of the decision reached by the Health Board or JCC. However, a patient may request a review where the decision is considered to be irrational or so unreasonable that no reasonable Health Board or JCC could have reached that conclusion. A claim that a decision is irrational contends that those making the decision considered irrelevant factors, excluding relevant ones, or gave unreasonable weight to particular factors.

Ground Three: *The Health Board or JCC has not exercised its powers correctly.*

Health Boards and JCC are public bodies which carry out its duties in accordance with the Statutory Instruments under which it was established. A patient may request a review on the grounds that the Health Board or JCC has acted outside its remit or has acted unlawfully in any other way.

6.4 How is a review request lodged?

A review request form should be completed and logged with the IPFR Coordinator of the Health Board or JCC within the review period. The review request form must include the following information:

- The aspect(s) of the decision under challenge and
- The detailed ground(s) of the review request

The review request form should be sent to the IPFR Coordinator so that the signatures of both the patient and their clinician are recorded. A scanned version sent electronically will also be acceptable as long as signatures are present.

If the patient signature cannot be obtained in a timely manner or at all, the requesting clinician can sign to indicate that the patient is aware and agrees with the submission of the request. In doing so, the clinician is providing confirmation that the patient is fully informed of the treatment request and all its associated implications.

6.5 Initial scrutiny by the IPFR Senior Officer

The review documents lodged will be scrutinised by the IPFR Senior Officer who will look to see that they contain the necessary information. If the review request does not contain the necessary information or if the review does not appear to the IPFR Senior officer to fall under any one or more grounds of review, they will contact the referrer (patient or their clinician) to request further information or clarification.

A review will only be referred to the review panel if, after giving the patient and their clinician an opportunity to elaborate or clarify the grounds of the review, the Chair of the review panel is satisfied that it falls under one or more of the grounds upon which the review panel can hear the review.

The Chair of the review panel may refuse to consider a review that does not include all of the above information.

6.6 What is the timescale for a review to be heard?

The review panel will endeavor to hear a review **within 25 working days** of the request being lodged with the Health Board. The date for hearing any review will be confirmed to the patient and their clinician in a letter.

This review process allows for clinically urgent cases, as deemed by the referring/supporting clinician, to be considered outside of the panel process by the Health Board's Chair together with a clinical member of the review panel. Any such decisions will be made in line with the principles of this policy.

6.7 Who will sit on the Review Panel?

The Health Board will appoint members of the review panel. The panel will comprise (see Terms of Reference at Appendix 4 for full details);

- Health Board Independent Board Member – Lay (Chair of the Review Panel)
- Health Board Independent Board Member (with a clinical background)
- Health Board Executive Director, or deputy (with a clinical background)

- Representative from Llais
- Chair of the Local Medical Committee, or deputy
- JCC Representative at Director level (where applicable)

The Health Board will intend to inform the patient and their clinician of the membership of the review panel as soon as possible after a review request has been lodged. None of the members of the review panel will have had any prior involvement in the original submission.

In appointing the members of the review panel, the Health Board will endeavor to ensure that no member has any interest that may give rise to a real danger of bias. Once appointed, the review panel will act impartially and independently.

6.8 Can new data be submitted to the review panel?

No, because should new or additional data become available then the IPFR application should be considered again by the original panel in order to maintain a patient's right to review at a later stage.

6.9 Can patients attend review panel hearings?

At the discretion of the panel, patients and/or their unpaid representative may attend review panel hearings as observers but will not be able to participate. This is because the purpose of a review hearing is to consider the process that has been followed and not to hear new or different evidence.

If new or different evidence becomes available, the case will automatically be scheduled for reconsideration by the IPFR Panel. Patients and/or their unpaid representatives are able to make their written representations to this IPFR Panel in order for their views to be considered.

It is important for all parties to recognise that review panel hearings may have to discuss complex, difficult and sensitive information in detail and this may be distressing for some or all of those present. Patients and/or their unpaid representatives should be aware that they will be asked to retire at the end of the review panel discussion in order for the panel to make their decision.

6.10 The decision of the review panel hearing

The IPFR Senior Officer will complete a record of the review panel's discussion including the decision and a detailed explanation for the reason for the decision. They will also prepare a standard decision letter to communicate the decisions of the panel to the patient and referring/supporting clinician. The review panel can either;

- uphold the grounds of the review and ask the original IPFR Panel to reconsider the request; or
- not uphold the grounds of the review and allow the decision of the original IPFR Panel to stand.

There is no right to further review unless new and relevant circumstances emerge. Should a patient be dissatisfied with the way in which the review panel carried out its functions, they are able to make a complaint to the Public Services Ombudsman for Wales.

6.11 After the review hearing

The Chair of the review panel will notify patients and their clinicians of the review panel's decision in writing. This letter should be sent **within five working days** of the panel and will also include information on how to make a complaint to the Public Services Ombudsman for Wales www.ombudsman-wales.org.uk.

6.12 How will JCC undertake a review?

As the JCC is a collaborative committee arrangement to support all Health Boards in Wales, it will not be able to constitute a review panel. JCC will therefore refer any requests it receives for a review of its decisions to the Health Board in which the patient resides. A JCC representative who was not involved in the original panel will become a member of the review panel on these occasions.

The Health Boards IPFR Senior Officer will be present at these review hearings to advise on proceedings as per their governance role. In the interests of transparency, and not to confuse the applicant, the JCC Senior IPFR Officer will be responsible for circulating the review documentation to review panel members, clerking the hearing, and preparing the standard decision letter to communicate the decision of the review panel to the patient and clinician.

7 QUALITY ASSURANCE

The IPFR Quality Assurance Advisory Group was established in 2017 to monitor and support all IPFR panels to promote quality in decision making and consistency across Wales. The Group meets quarterly to assess anonymised random sample IPFR reports in relation to their completeness, timeliness, and efficiency of communication in line with the NHS Wales IPFR policy process.

8 REVIEW OF THIS POLICY

8.1 This Policy should be reviewed every 3 years or as required to reflect changes in legislation or guidance. The review will be undertaken by the All-Wales IPFR Policy Implementation Group. Any changes made will be undertaken in line with the groups Terms of Reference (see appendix 5) and authorised by the responsible Health Board and JCC Committee. Any delay in conducting a review will not prevent JCC or a Health Board from being able to rely on this policy.

8.2 Any of the following circumstances will trigger an immediate review of the linked INNU Policy:

- an exemption from a treatment policy criterion has been agreed.
- new scientific evidence of effectiveness is published for all patients or sub- groups.
- old scientific evidence has been re-analysed and published suggesting previous opinion on effectiveness is incorrect.
- evidence of increased cost effectiveness is produced.

- NHS treatment would be provided in all (or almost all) other parts of the UK.
- a National Service Framework recommends care.

9 MAKING A COMPLAINT

9.1 Making an IPFR does not conflict with a patient's ability to make a complaint through the Health Boards or JCC's Putting Things Right process, details of which can be found at https://www.gov.wales/nhs-wales-complaints-and-concerns-putting-things-right

9.2 If it is not possible to resolve a concern through local resolution the person raising the concern can refer the matter to the Public Services Ombudsman for

Wales (PSOW). Further information is available on the Ombudsman's website www.ombudsman-wales.org.uk.

Patients are able to access advocacy support at any stage during this process.

APPENDIX 1: DECISION MAKING FACTORS

Panels may find it useful to consider these factors, but they are not required to look at every factor set out in the table. Furthermore, there may be factors in the table that are not relevant to the individual case. The factors in the table are optional and cannot change the meaning of the criteria under paragraph 4.3 of the Policy.

IPFR Panel Decision-Making Factors	**IPFR Panel Evidence for Consideration in Decision-Making**
PART 9A - SIGNIFICANTLY DIFFERENT AND SIGNIFICANT CLINICAL BENEFIT	
Is the clinical presentation of the patient's condition significantly different in characteristics to other members of that population for whom the recommendation is not use the intervention? Does this presentation mean that the patient will derive a greater clinical benefit from the treatment than other patients with the same condition at the same stage and for whom the recommendation is not to use the intervention?	Consider the evidence supplied in the application that describes the specific clinical circumstances of the IPFR: • What is the clinical presentation of this patient? • Is evidence supplied to explain why the clinical presentation of this patient is significantly different to that expected for this disease and this stage of the disease? This is in context of the population for whom the treatment is not recommended. • Is evidence supplied to explain why the clinical presentation means that the patient will gain a significantly greater clinical benefit from the treatment than another patient with the same disease at the same stage? This is in context of the population for whom the treatment is not recommended.
PART 9B - SIGNIFICANT CLINICAL BENEFIT	
Does the presentation of the patient's condition mean they are likely to gain significant clinical benefit from the intervention requested?	Consider the evidence submitted in the application that describes the specific clinical circumstances of the IPFR: • What is the clinical presentation of this patient? • Does the evidence provided explain why this patient is likely to gain a significant clinical benefit when compared to next best alternative for this patient, which may in some cases be best supportive care?
EVIDENCE BASED CONSIDERATIONS	
Does the treatment work? What is the evidence base for clinical and cost effectiveness?	Consider the evidence supplied in the application, and supplementary evidence (where applicable) supplied by professional advisors to the Panel: • What does NICE recommend or advise? • What does the AWMSG recommend or advise? • What does the Scottish Medicines Consortium recommend or advise? • What does Public Health Wales advise? • Is there advice available from the One Wales Medicines process or Health Technology Wales? • Is there peer reviewed clinical journal publications available? • What information does the locally produced evidence summary provide? • Is there evidence from clinical practice or local clinical consensus? • Has the rarity of the disease been considered in terms of the ability for there to be comprehensive evidence base available? • Does the decision indicate a need to consider policy or service change? If so, refer to service change processes.
ECONOMIC CONSIDERATIONS	
Is it a reasonable cost? What is the cost of the **treatment** and is the cost of the treatment likely to be reasonable? Is the cost of the treatment in balance with the expected clinical benefits?	Consider the evidence supplied in the application, and supplementary evidence (where applicable) supplied by professional advisors to the Panel: • What is the specific cost of the treatment for this patient? • What is the cost of this treatment when compared to the alternative treatment they will receive if the IPFR is declined? • Has the concept of proportionality been considered? (Striking a balance between the rights of the individual and the impact on the wider community), in line with Prudent Healthcare Principles. • Is the treatment reasonable value for money?

ETHICAL CONSIDERATIONS	
How has the decision been reached? Is the decision a compromise based on a balance between the evidence-based input and a value judgement?	Having considered the evidence base and the cost of the treatment requested, are there any ethical considerations that have not been raised in the discussions? • Is the evidence base sufficient to support a decision? • Is the evidence and analysis of the cost sufficient to support a decision? • Will the decision be made on the basis of limited evidence and a value judgement? If so, have you considered the values and principles and the ethical framework set out in the policy? • Have non-clinical factors been excluded from the decision? • Has a reasonable answer been reached based on the evidence and a value judgement after considering the values and principles that underpin NHS care?

APPENDIX 2

TERMS OF REFERENCE – INDIVIDUAL PATIENT FUNDING REQUEST PANEL (Health Board)

PURPOSE

The Health Boards IPFR Panel is constituted to act as a Committee of the Health Board and holds delegated Health Board authority to consider and make decisions on requests to fund NHS healthcare for patients who fall outside the range of services and treatments that a Health Board has agreed to routinely provide.

The IPFR Panel will normally reach its decision on the basis of all of the written evidence which is provided to it, including the request form itself and any other documentary evidence which is provided in support of the application.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on any issue or request independent expert clinical advice for consideration by the Panel at a further date. The provision of appropriate evidence to the Panel will be entirely at the Panel Chair's discretion.

SCHEME OF DELEGATION REPORTING	MEMBERSHIP AND ATTENDANCE
The IPFR Panel cannot make policy/commissioning decisions for the Health Board. Any policy proposals arising from the panels considerations and decision will ultimately be reported to the Health Board's Quality & Patient Safety Committee for ratification. Financial authorisation is as follows: - The Panel's authorisation limit will be set at the delegated financial limit as per the individual Health Board structure. - Any decisions resulting in a financial cost in excess of this must be reported to the Health Board Chief Executive for budget authorisation.	• Executive Public Health Director or deputy • Executive Medical Director or deputy • Executive Director of Therapies and Health Science or deputy • Director of Pharmacy and/or Chief Pharmacist or deputy • Executive Director of Nursing or deputy • Two Lay Representatives A further two panel members may be appointed at the discretion of the panel Chair, for example a member of the Ethics Committee, Primary Care Director, or Director of Planning. In Attendance: • IPFR Coordinator • Finance Advisor (if required) • Senior Pharmacist (if required)

PROCEDURAL ARRANGEMENTS

Quorum: Chair or Vice Chair plus 2 panel members with a clinical background.

Meetings: The IPFR Panel will normally be at least once per month, either virtually, face to face or a combination of both.

Urgent Cases: Provision will be made for occasions where decisions may need to be made urgently. In these circumstances, the Chair or Vice Chair

of the IPFR Panel is authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits.

Recording: The IPFR Coordinator will document the meetings to ensure panel discussions and decisions are appropriately recorded.

Training: All Panel members will receive a local induction.

Panel members should have the opportunity to attend a separate annual refresher session to ensure all members maintain the appropriate skills and expertise to function effectively.

Panel Interest: At the start of the meeting members must declare any personal or prejudicial interests relating to the discussions of the panel.

Consensus: IPFR panel members will seek to achieve decisions by consensus where possible. If the panel is equally split the Chair of the Panel will make the final decision

APPENDIX 3

TERMS OF REFERENCE – INDIVIDUAL PATIENT FUNDING REQUEST PANEL (JCC)

PURPOSE

The NHS Wales Joint Commissioning Committee's IPFR Panel is managed by NHS Wales Joint Commissioning Committee and holds delegated authority to consider and make decisions on requests to fund NHS healthcare for patients who fall outside the range of services and treatments that a Health Board has agreed to routinely provide.

The IPFR Panel will act at all times in accordance with the All-Wales IPFR Policy taking into account the appropriate funding policies agreed by JCC.

The IPFR Panel will normally reach its decision on the basis of all of the written evidence which is provided to it, including the request form itself and any other documentary evidence which is provided in support of the application.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on any issue or request independent expert clinical advice for consideration by the Panel at a further date. The provision of appropriate evidence to the Panel will be entirely at the Panel Chair's discretion.

SCHEME OF DELEGATION REPORTING	**MEMBERSHIP AND ATTENDANCE**
The IPFR Panel cannot make policy/commissioning decisions for the Health Boards. Any policy proposals arising from the Panel's considerations and decisions will be reported to the JCC for ratification. Financial authorisation is as follows: **Individual Patient Packages** The JCC scheme of delegation states that financial approval is required for individual NHS patient treatment charges outside of LTS's and SLA's concerning one off treatment costs exceeding £750,000. Therefore, any approved IPFR treatment exceeding £750,000 needs to be reported to the Joint Committee. **Lifetime costs** The JCC scheme of delegation states that financial approval is	• Independent Chair (from open recruitment) • 2 Lay representatives** • Health Board nominated clinician or clinician deputy. • 2 Vice Chairs (appointed from within the panel membership) • JCC Medical Director or nominated deputy. • JCC Director of Nursing or nominated deputy. A further two panel members from the NHS in Wales may be appointed at the discretion of the Chair of the Panel in conjunction with the JCC Medical and/or Director of Nursing, for example a member of an ethics committee. In attendance from JCC • IPFR Coordinator • Finance Advisor (if required) • Governance Advisor (if required) • Other JCC staff as and when required to clarify on policy/commissioning arrangements/evidence evaluation For particularly complex cases the IPFR Panel may invite other individuals with clinical, pharmacy or commissioning expertise and skills, unconnected with the requesting provider to support decision making.

required for individual NHS patient treatment charges outside of LTS's and SLA's for lifetime costs exceeding £100,000,000. Therefore, any approved IPFR exceeding £1,000,000 needs to be reported to the Joint Committee. Any decisions resulting in a financial cost in excess of these limits must be reported to the Chief Commissioner for authorisation and the relevant Health Board for information and if over £1 million to the Joint Committee for approval or ratification (if a Chairs action was undertaken).	

** **Definition: Not registered as a healthcare professional, either lay (not currently healthcare worker) or lay plus (no healthcare experience ever) (Health Research Authority 2014) will be eligible.**

PROCEDURAL ARRANGEMENTS

Quorum: The Panel will be quorate with 4 of the 7 Health Boards representatives, 1 JCC Clinical Director or deputy and the Chair or Vice Chair.

Meetings: The IPFR panel will normally be held as a minimum once per month, either virtually, face to face or a combination of both.

Urgent Cases: Provision will be made for occasions where decisions may need to be made urgently.

Where possible, a virtual panel will be held to consider urgent cases. If this is not possible due to the urgency of the request, or availability of panel members, then the Chief Commissioner with either the Medical Director or Director of Nursing and Quality and the Chair of the JCC Panel (or a vice chair) are authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits, on behalf of the Panel.

	Urgent cases will be reported at the next scheduled IPFR panel. An electronic National IPFR database of all cases will be maintained by AWTTC.
Recording:	The IPFR Coordinator will document the meetings to ensure panel discussions and decisions are appropriately recorded.
Training:	All Panel members will receive a local induction programme. Panel members should have the opportunity to attend a separate annual refresher session to ensure all members maintain the appropriate skills and expertise to function effectively.
Members Interest:	At the start of the meeting members must declare any personal or prejudicial interests relating to the discussions of the panel.
Consensus:	IPFR Panel members will seek to achieve decisions by consensus where possible. If the panel is equally split the Chair of the Panel will make the final decision.
Reporting:	The IPFR Chair shall: Report formally, regularly and on a timely basis to the Collaborative Commissioning Leadership Group (CCLG) on IPFR activities. Bring to the CCLG's attention any significant matters and ensure appropriate escalation arrangements are in place.
Review of the TOR:	The Terms of Reference of the JCC Panel will be reviewed in line with the All-Wales IPFR Policy.

APPENDIX 4

TERMS OF REFERENCE – REVIEW PANEL

PURPOSE

The IPFR Review Panel are constituted to act as a Committee of the Health Board and holds delegated Health Board authority to review (in line with the review process outlined in this policy) the decision-making processes of the Individual Patient Funding Request (IPFR) Panel.

The Review Panel may uphold the decision of the IPFR Panel or, if it identifies an issue with the decision-making process, it will refer the issue back to the IPFR Panel for reconsideration.

The Review Panel will normally reach its decision on the basis of all of the written evidence which is provided to it and will not receive any new information.

SCHEME OF DELEGATION REPORTING	MEMBERSHIP AND ATTENDANCE
The Review Panel has delegated authority from the Board to undertake reviews, limited to the purpose set out above. In exceptional circumstances, the Review Panel may also wish to make a recommendation for action to the Board. The action can only be progressed following its ratification by the Board (or by its Chief Executive in urgent matters).	• Independent Board Member – Lay (Chair of the Review Panel) • Independent Board Member (usually with a clinical background) • Executive Director or deputy (with a clinical background) • Representative from Llais • Chairman, Local Medical Committee, or deputy • JCC representative at Director level (as required) In Attendance: • IPFR Senior Officer (governance advisor) • JCC IPFR Senior Officer (as required)

PROCEDURAL ARRANGEMENTS

Quorum: As a minimum, the Review Panel must comprise 3 members (one of whom must have a clinical background, one must be an Independent Board Member, and one must be a Health Board Officer).

Meetings: As required.

Urgent Cases: It is recognised that provision must be made for occasions where reviews need to be heard urgently and before a full panel can be constituted. In these circumstances, the Health Board's Chair can undertake the review together with a clinical member of the Review Panel. This ensures both proper accountability of decision making and clinical input.

Recording: The IPFR Senior Officer will clerk the meetings to ensure a proper record of the review discussion and outcome is made.

See detail under section 6.12 on how JCC will undertake a review.

APPENDIX 5

NHS Wales Individual Patient Funding Request (IPFR) Policy Implementation Group

Terms of reference

1. Purpose of the Group

The purpose of the NHS Wales IPFR Policy Implementation Group (PIG) is to facilitate the commitment made by Health Boards and the Joint Commissioning Committee (JCC) to adhere to the NHS Wales IPFR Policy, providing and developing assurances systems and guidance to aid the decision making process. This includes areas relating to IPFR's, requests for routine treatment out of area, Interventions Not Normally Undertaken (INNU) and requests for treatment in other parts of the European Economic Area (EEA). The group will:

- Provide strategic leadership for the development and implementation of the IPFR policy and supporting documentation across all Health Boards and the JCC.
- Share good practice across all Health Board areas and promote continuous improvement.
- Review all policies that refer to IPFR to ensure that the policies are up to date, consistent and coherent.
- Provide a forum in which to share advice, support and assistance to ensure deliverance of a consistent process across Wales.
- Explore opportunities to ensure the IPFR process is widely understood by patients and clinicians, providing support on the process and application of IPFR's.
- Use best efforts to ensure the quality of data collection is in line with local and national reporting requirements.
- Monitor identified and emerging risks and advise on their prevention, mitigation and management.
- Work with and support the All Wales Therapeutics and Toxicology Centre on the development of the annual report in relation to IPFR's.
- Utilise the IPFR process to help inform key issues relating to possible future regional and / or national commissioning opportunities.
- Ensure active participation of key stakeholders when and where appropriate.

2. Membership of the Group

The IPFR network group will comprise of;

- A senior IPFR co-ordinator or nominated deputy from each Health Board and JCC.
- A senior member or nominated deputy from the AWTC

Other members may be included in the group as and when required.

3. Chair

The group will be chaired by an appointed member of the group.

The Chair will provide direction on the implementation of all decisions made by the group in relation to the development of the All-Wales policy, related guidance and assurance mechanisms.

All activities carried out under the auspices of the IPFR Policy Implementation Group are to be undertaken with prior agreement from the group members.

4. Frequency of Meetings

The group will meet bi-monthly. However, due to the nature of the work, the group may be required to meet more frequently on occasions, with additional work being done between meetings via email whenever possible.

The Terms of Reference will be reviewed periodically and amended accordingly.

5. Quorum

The quorum will be made up of any 5 members of the IPFR Policy Implementation Group.

Equality & Health Impact Assessment for

NHS WALES POLICY MAKING DECISIONS ON INDIVIDUAL PATIENT FUNDING REQUESTS (IPFR) Policy

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	N/A
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Catherine Phillips, Executive Director for Finance, Catherine.Phillips2@wales.nhs.uk Elinor Mercer, Commissioning Manager – Strategy and Development, Elinor.Mercer@wales.nhs.uk Zoe Rees, Commissioning Officer -IPFR, zoe.rees@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	A comprehensive range of NHS healthcare services are routinely provided locally by primary care services and hospitals across Wales. However, each year, requests are received for healthcare that falls outside this agreed range of services. We refer to the funding requests for such treatments as Individual Patient Funding Requests (IPFR).
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable	The procedure operates within the principles of the: • Cardiff and Vale University Health Board's Shaping Our Future Wellbeing Strategy, • 2010 Equality Act, • Human Rights Act 1998,

	• needs assessment
	• engagement and involvement findings
	• research
	• good practice guidelines
	• participant knowledge
	• list of stakeholders and how stakeholders have engaged in the development stages
	• comments from those involved in the designing and development stages
	
	Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].
		• Welsh Language Act 1993 and Welsh Language (Wales) Measure 2011,
		• Related policies such as Interventions Not Normally Undertaken, Top-Up Policy, the NHS Wales Prior Approval Request Policy and the Healthcare (International Arrangements) (EU Exit) Regulations 2023 (the HIA Regulations)
		• Related UHB policies such as flexible working and Dignity at Work policies.
		• R v North West Lancashire Health Authority Ex Parte A(2000)1WLR 977CA NHS (Wales) Act 2006
		• Colin Ross v West Sussex Primary Care Trust 2008 EWHC 2252 (admin) Health Commission Wales: A Review (2008), Professor Sir Mansel Aylward
		  • R (Condliff) v North Staffordshire Primary Care NHS Trust [2011] EWCA Civ 910, [2012] PTSR 460
		  • The case of Maria Rose Wallpott (MW) – v- (1) WHSSC & (2) Aneurin Bevan UHB (ABUHB)Case No: CO/3775/2021
		• Priority Setting: Managing Individual Funding Requests (2008), NHS Confederation Routledge Report 2009
		• Improving the Availability of Medicines for Patients in Wales: Report of the Routledge Report Implementation Group 2011 R (on the Application of AC) v Berkshire West Primary Care Trust [2011] EWCA Civ 247.
		• Oxfordshire PCT Equality Impact Assessment on Individual Funding Request Policy (March 2011)
		• the National Health Service (Wales) Act 2006 and the Community

		Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010) Following a Judicial Review in December 2021, the Welsh Government in July 2022 agreed that a specific and limited review would be undertaken to put beyond doubt how the policy should be interpreted. It was agreed at an All-Wales Medical Directors Group (AWMDG) meeting, that a de-minimis review with comprehensive stakeholder engagement could be taken forward by the WHSSC team and that this should report into WHSSC's Joint Committee with final approval being sought from the Health Board's. During this review of the IPFR Policy, WHSSC took advice from a King's Counsel (KC) in identifying amendments for the all-Wales IPFR policy following the judgment handed down in the judicial review "Maria Wallpott –v- WHSSC & ABUHB" in December 2021. WHSSC. A stakeholder engagement process took place between the 10th and the 22nd of December 2022. The consultation documentation was issued to a broad range of stakeholders including the WHSSC IPFR panel, the All-Wales Toxicology and Therapeutics Quality Assurance Group (AWTTC QAG), the NHS Wales IPFR Policy Implementation Group (PIG), Medical Directors and Board Secretaries of each of the HBs, Welsh Government (WG) and Velindre University NHS Trust (VUNT). Additionally, a stakeholder engagement workshop was held on the 2nd of December 2022 in Cardiff and a number of engagement briefings were held. During the 2017 review of the IPFR policy views were sought from patients, carers, relatives, patient representatives, health charities, lobbying groups, clinicians, healthcare professionals, IPFR panel

		members in local health boards (LHBs) and the Welsh Health Specialised Services Committee (WHSSC), Assembly Members (drawing from their constituency correspondence), political parties and pharmaceutical industry representatives. The review group held a total of ten face-to-face engagement sessions in Wrexham, Aberystwyth and Cardiff during November 2016. In each location, there was a session specifically for patients, patient organisations, and healthcare professionals, as well as one in Cardiff for the pharmaceutical industry. The review group considered the published documents outlining the approach taken to IPFRs in England, Scotland and Northern Ireland. And looked at statistics on IPFRs in Wales and, where available, the equivalent processes elsewhere.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Clinicians submitting an IPFR request and their patients for whom the request is for, who are residents of the UHB will be affected by the Policy.

EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	The IPFR application form requires patients to disclose their date of birth. This is collected to help: • Establish the legal status of the patient and the need for an appropriate adult (parent or guardian) to act as an advocate on behalf of the patient. • To help locate the patient's hospital or general practice records as appropriate when required. The panel provides clinical	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	based decision making and therefore social factors such as date of birth are redacted prior to review at the IPFR panel. Protected characteristics are not provided to the IPFR Panel for review and consideration therefore, this information is not considered during the decision-making process. The IPFR application form requires patients date of birth only, therefore, age data is not collected and cannot be measured.		
6.2 Persons with a disability as defined in the	The Policy would be made accessible to staff in	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	alternative formats on request or via usual good management practice. The IPFR application form does not routinely require patients to disclose this information. It is at the referrers discretion to disclose this information if it is relevant to the treatment being sought in the IPFR request. Therefore, this data is not routinely collected and cannot be measured.		
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to,	IPFRs referrals from clinicians of any gender and for patients of any gender are dealt with in the same way. All protected patient characteristics, including	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	gender are redacted in the information provided to the IPFR Panel for review and consideration, therefore this information is not considered during the decision-making process. However, where there is evidence that capacity to benefit from a treatment is related to gender, this may affect the decision of the IPFR Panel. The IPFR application form does not routinely require patients to disclose information relating to their gender or gender reassignment. It is at the referrers discretion to disclose this information if it is relevant to the treatment		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	being sought in the IPFR request. It has been noted that NHS England were legally challenged in the case of AC v Berkshire West PCT [2010] EWHC. The challenge itself related to the evidence for 'exceptional significance' for the IPFR commissioning decision rather than the collection or discrimination of the protected characteristic.		
6.4 People who are married or who have a civil partner.	The IPFR application form does not require patients to disclose their marriage or civil partnership status. Therefore, this data is not collected and cannot be measured.	N/A	N/A
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are	The IPFR application form does not routinely require patients to disclose this information. It is at the	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	referrers discretion to disclose this information if it is relevant to the eligibility or treatment being sought in the IPFR request. Therefore, this data is not routinely collected and cannot be measured.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There appears not to be any impact on patients regarding race, nationality, colour, culture or ethnic origin. The IPFR application form does not require patients to disclose this information. Therefore, this data is not collected and cannot be measured.	N/A	N/A
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical	The IPFR application form does not require patients to disclose this information. It is at the referrers discretion to disclose this information if it is	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
belief	relevant to the eligibility or treatment being sought in the IPFR request. Therefore, this data is not collected and cannot be measured.		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	The IPFR application form does not require patients to disclose this information. Therefore, this data is not collected and cannot be measured.	N/A	N/A
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	The All-Wales procedure, website information and patient leaflets will all be made available in Welsh. Clinicians have the discretion to apply through the medium of the Welsh language in line with the UHB's Welsh language policy. Receipt of applications in the Welsh	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	language will be measured accordingly.		
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	The IPFR application form does not require patients to disclose this information. Therefore, this data is not collected and cannot be measured.	N/A	N/A
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	The IPFR application form requests the patient's address on the application form to ensure that the patient is a Cardiff and Vale resident and to allow for communication regarding requests. All protected patient characteristics, including address are redacted in the information provided to the IPFR Panel for review and	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	consideration, therefore this information is not considered during the decision-making process.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	There are no other groups or risk factors to consider regarding this Policy. All patient identifiable information is redacted from the request prior to being presented at the IPFR panel and is therefore not considered.	N/A	N/A

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	The All-Wales IPFR policy enables the decision-making process for patient funding requests and as such this is not applicable to this policy.	N/A	N/A
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking	The All-Wales IPFR policy enables the decision-making process for patient funding requests and as such this is not applicable to this policy.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working	The All-Wales IPFR policy enables the decision-making process for patient funding requests and as such this is not applicable to this policy.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
conditions Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces	The All-Wales IPFR policy enables the decision-making process for patient funding requests and as such this is not applicable to this policy.	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	The All-Wales IPFR policy enables the decision-making process for patient funding requests and as such this is not applicable to this policy.	N/A	N/A
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross	As part of the decision-making process, the IPFR panel consider ethics of funding requests e.g. whether the allocation of funds for high-cost drugs is a fair and	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	equitable allocation of resource for a single patient.		

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Overall, there appears to be very limited impact on the protected characteristics and health inequalities as a result of this All-Wales IPFR Policy.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	All non-clinical information will be redacted from the information provided to the IPFR panel during the decision-making process.	IPFR Commissioning Officer	Ongoing	

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	As there has been potentially very limited impact identified, it it is unnecessary to undertake a more detailed assessment and formal consultation is not required.	N/A	N/A	
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or servi proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or	Minimal changes have been made to the policy. The changes include amendments to the WHSSC IPFR Panel Terms of Reference and revisions to the policy wording based on advice from a King's Counsel (KC) following a judicial review concerning Maria Rose Wallpott	N/A	N/A	

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
missed opportunities to advance equality (set out the justifications for doing so) ○ stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	(MW) – v- (1) WHSSC & (2) Aneurin Bevan UHB (ABUHB). The changes have resulted in no change to the impact of the policy. The updated policy is due to be considered by the QSE Committee. When an IPFR policy is developed or reviewed, this EHIA will form part of that consultation exercise and publication. This EHIA will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required. The UHB			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
	standard is that all policies are reviewed within 3 years (1 year if a statutory requirement).			

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board

PCIC CLINICAL BOARD
MINUTES OF THE QUALITY, SAFETY & EXPERIENCE GROUP
TUESDAY 22nd JULY, 2025 11:00 – 13:00
Venue: MS TEAMS

FINAL MINUTES
Sent to Barbara Davies to review 15.09.25.
Barbara Davies reviewed 16.09.25.
Sent to attendees for comment 17.09.25
Final version signed off during September meeting 23.09.2025.

Attendees:

- Andrea Rich, **AR**, Lead Nurse for Palliative Care, PCIC
- Anna Mogie, **AM**, Deputy Director of Nursing, PCIC
- Barbara Davies, **BD**, Interim Director of Nursing, PCIC (Chair)
- Carol Preece, Lead Nurse for Community Specialist Services, PCIC
- Clare Clement, **CC**, Lead Pharmacist, PCIC
- Eleri Thomas, **ET**, Quality and Safety Officer, PCIC (minute-taker)
- Ellen Davies, **ED**, Infection, Prevention and Control Clinical Nurse, PCIC
- Dr Helen Cordy, **HC**, Consultant in Chemical Pathology with Metabolic Medicine, Point of Care Clinical Lead
- Helen Donovan, **HD**, Locality Lead Nurse for Cardiff, PCIC
- Janice Aspinall, **JA**, Lead Representative for Health and Safety for Staffside
- Katy Wells **KW**, Emergency Dental Service Manager for CAV24/7
- Lauranne Cullen, **LC**, Regional Director for LLAIS, Cardiff and Vale
- Lloyd Waygood, **LIW**, Deputy Head of Operations, Cardiff Locality, PCIC
- Neil Morgan, **NM**, Vale Locality Manager, PCIC)
- Rachel Armitage, **RA**, Quality and Safety Manager, PCIC
- Rebecca Stringer, **RS**, Acting Lead Nurse for Community Specialist Services, PCIC
- Ruth Cann **RC**, Consultant Nurse Older Vulnerable Adults, PCIC
- Sarah Griffiths, **SaG**, Interim Assistant Director of Primary Care, PCIC
- Sian Flower, **SF**, Deputy Operational Manager, CAV 24/7, PCIC
- Sian Pennel, **SP**, Community Nurse, Spott
- Victoria Whitchurch, **VW**, Head of Operations for Community Specialist Services, PCIC [Note: Joined the meeting intermittently]

Apologies:

- Bethan Watkins, **BW**, Safeguarding Nurse Advisor, Corporate Safeguarding Team
- Danielle James, **DJ**, Senior Operational Manager, CAV 24/7
- Dr Gneeta Joshi, **GJ**, Community Director of Governance, PCIC
- Hayley Pugh, **HP**, Interim Head of Primary Care, PCIC
- Helen Britton, **HB**, Head of Planning and Performance (Interim)
- Helen Earland, **HE**, Clinic and Operational Lead for Urgent Primary Care, PCIC
- Dr Helen Kemp, **HK**, Clinical Director for Governance, Quality and Safety and Deputy Board Clinical Director (GP), PCIC
- Kate Roberts, **KR**, Senior Nurse Vale Locality, PCIC

PCIC QSE 22nd JULY 2025

- Lisa Waters, **LiW**, Senior Nurse, Quality, Safety and Education, PCIC
- Rebecca Lewis, **RL**, Principal Public Health Practitioner

Chair: Barbara Davies, **BD**, Interim Director of Nursing, PCIC

Minutes: Eleri Thomas **ET**, Quality and Safety Officer, PCIC

July Meeting Agenda: 00 PCIC QSE Agenda - 2025.07.22.docx

July Action Log: 05.1 - Action Log PCIC QSE July 2025.docx

ITEM NO.	TITLE	ACTION
Part 1	**ITEMS FOR DISCUSSION**	
25/07/01	**Welcome & Introductions** *Chair **BD** welcomed attendees and introduced herself as the Interim Director of Nursing for PCIC.* *Introductions were noted as listed above.*	
25/07/02	**Apologies for absence** ***BD** noted apologies as listed above.*	
25/07/03	**Declarations of interest** *There were no declarations of interest to note.*	
25/07/04	**Minutes and Matters Arising** *The previous PCIC QSE May 2025 minutes were reviewed and accepted as accurate. Please see full minutes here: Item 04.1*	
25/07/05	**PCIC Quality & Safety Action Log** *The PCIC QSE May 2025 action log was reviewed and updated – Item 05.1* *Regarding palliative care, **AM** raised that recent Medical Examiner reports had flagged that families are struggling to identify pharmacies where they can get end of life drugs. The drug in question was glycopyrronium. **CC** said that the details would need to be reviewed, as the items now fall under the Urgent Medicine Service. The current stock list has been developed in collaboration with the palliative care team. If any amendments are required, these can be made accordingly.* ***AR** added that in the End-of-Life Quality and Safety meeting, the access to out h hours medicine standard operating procedure was present. This will be reviewed and updated and contains a list of which drugs are in which pharmacies. This will help staff tell relatives which pharmacies to visit to obtain the drugs.* ***CC** added that if there are issues with pharmacies stocking the drug, to flag with the Medicines Management team, including any updates to mentioned standard operating procedure so it can be signed off an updated on the Medicine Management website. Any further conversations around these issues can be had outside of this meeting.* *The new action log for July 2025 can be found here - 05.1 - Action Log PCIC QSE July 2025.docx*	
25/07/06	**Patient Story**	

	KW *presented a story on behalf of the Out of Hours service, regarding a case raised by a triage dental nurse following a patient's second contact with CAV24/7. The story highlighted the need for bariatric provision in emergency dental patients and the care pathways.* ***KW*** *referenced the possible lack of understanding regarding patient pathways and services within Cardiff and Vale Health Board, and* ***KW*** *believes that the need for a full review of dental services in Cardiff and Vale is due, if not overdue.* *The case was initially brought to attention following a second contact by the patient with CAV 24/7, as directed by the Maxillofacial team at University Hospital of Wales (UHW) after an unplanned out-of-hours A&E visit. Concerns were raised by the triage dental nurse regarding the initial triage outcome, particularly why the patient had not been directed to A&E despite reporting significant oral swelling. A review of the patient's pathway and clinical notes identified that during the first contact, appropriate triage questions were asked, including weight, which is a critical factor in determining treatment location due to dental chair safety limits. The patient, who exceeded the standard weight threshold, was advised accordingly and given safety advice and red flag information.* *On the second contact, however, the triage clinician did not ask the patient's weight and booked them into an appointment at St David's Hospital, which was not suitable due to equipment limitations. When the patient attended, they disclosed a weight above the chair's safety limit but declined to be weighed. As a result, treatment could not be safely provided, and the patient was rebooked for the next available appointment at University Dental Hospital (UDH).* *The investigation into this case highlighted a longstanding need for improved bariatric provision within primary dental care services. This issue has been raised repeatedly by both Community Dental Services and the Emergency Dental Service (EDS), with ongoing discussions around how to better support patients requiring bariatric care in emergency settings. The case also underscored the importance of consistent training and mentoring for triage staff, particularly given the limited substantive dental triage workforce and the reliance on bank and medical staff to cover out-of-hours shifts. These staffing pressures, combined with high call volumes, may contribute to occasional errors in booking and documentation. Additionally, it became evident that some healthcare professionals across the Health Board may lack awareness of the scope and limitations of the CAV 24/7 and EDS services, potentially leading to misdirection of patients.* *In terms of service improvement, new intermediate-weight dental chairs (165kg capacity) have been installed and are operational at St David's Hospital, increasing access to emergency dental care for a broader patient group and reducing pressure on UDH and A&E. Patients exceeding this weight limit will continue to be booked into UDH, with clear communication around the potential for delayed active treatment. The case also prompted a review of communications materials, with updates underway to improve clarity for patients, including the addition of QR codes linking to online information about services, payments, and oral health. These developments, while not direct outcomes of the case, align with the learning identified and support ongoing efforts to enhance patient safety and service accessibility.*	

	***BD** acknowledged the difficulty of resources being spread across different sites within the primary care setting.* *AM asked if a higher weight specification (25 stone plus) could be put in place in St David's Hospital? KW acknowledged that a chair with these specifications could be used but not in St David's Hospital due to structural concerns.* ***AM** noted that the concerns received regarding the emergency dental service often related to a patient paying for treatment they were not having to pay for. Due to this, explicit comms that **KW** had previously mentioned would be welcomed. **KW** added that this patient story had highlighted that a service review would be beneficial.*	
25/07/07	**Risk Register Update** *The live risk register is located on the PCIC Clinical Board HUB Site and each Business Unit is managing their own risks. Link to live risk register is here - Item 07.1* ***ET** noted that a 'how-to' guide will be shared in draft form with the service leads. Once reviewed and comments fed back to ET, this can be updated and shared with all teams who update the risk register.* ***ACTION: Eleri Thomas to share with Service Leads a draft 'how to' guide regarding the risk register. For review and comments. (Actioned 01/08/25, with deadline for comments 15/08/25)*** ***ET** explained that teams should select 'Open in browser' when editing the risk register.* ***ET** added that the Governance, Quality and Safety team has access to previous versions of the risk register. It is saved in an archive folder but only this team has access to the folder. **ET** asked teams not to make their own back-up copies but to contact the Governance, Quality and Safety Team should they require any information from a previous version of the risk register.* ***BD** highlighted the ongoing work at corporate level regarding risk management and **BD** will bring any updates regarding the AMaT (Audit Management and Tracking) system to future PCIC QSE meetings. **RA** is representing PCIC in the AMaT transfer group. **AM** understands that the system is intended to allow linking of common risks across Clinical Boards or business units to avoid duplication on separate risk registers.*	
25/07/08	**PCIC Quality Report** *Please see full report here, shared in LiW's absence – Item 08.1* *It was noted that there are multiple sources of investigation ongoing with the NRI relating to the prisoner death, which includes Health Inspectorate Wales (HIW) involvement and the Prisons & Probation Ombudsman (PPO). AM added that the inquest is scheduled to take place in the near future.* *RA highlighted from the report that most of the concerns raised where a death has occurred in the community relate to secondary care.* ***ACTION: Barbara Davies and Anna Mogie to discuss with Mike Mullan the possible removal of Estates and Ancillary team from the PCIC Clinical***	

	Board Statutory and Mandatory Training figures. Reviewed – appears to be staff in OOH who are under PCIC	
25/07/09	**NRI feedback** *NRI updates can be found in the PCIC Quality Report above.* *General feedback noted in LiW's absence:* • *General NRIs - Nil closures.* • *Pressure Damage – to be fed back at next QSE meeting.* ***AM** added that there has been 1 avoidable pressure damage was identified in the past two weeks, attributed in part to delays in assessment and equipment provision, and will be reported next month.*	
25/07/10	***Infection Prevention and Control*** *Please see report in full – Item 10.1* ***ED** explained that revised reduction expectations have been implemented for this year, aligned with last year's figures. While C. difficile and other organisms remain within target, MRSA bacteraemia has exceeded its zero-tolerance threshold with three reported cases. The RCA (Root Cause Analysis) return rate is strong, with Cardiff and Vale at 87% and Cardiff alone at 93%, thanks to continued efforts from the Quality and Safety team. Insights from RCAs are being shared with secondary care and the IPCG, particularly around antibiotic prescribing and discharge communication. Staffing challenges within the IPC team, including vacancies and long-term absences, have led to a temporary pause in the audit plan, with a review planned for next month. **AM** added that this will provide some relief for our Estates colleagues.* ***ED** noted that RCAs are not currently completed for MRSA, but **ED**'s own deep dive shows that two cases are endocarditis related and the third was gastrointestinal in source. Discussion showed there were not any clear themes to be fed back at the next Executive performance review.* ***RA** noted that the Band 4 Nursing Team Coordinator post has been removed from PCIC following **Glenys Jenkins**' departure. **Sarah Whittaker** (Nursing Team Coordinator, PCIC) has been supporting fit testing coordination but is also transitioning out of her role. Despite a temporary delay due to a shortage of fit testing solution, the programme has progressed well and is now able to resume. **Sarah Whittaker** has maintained a central database of all fit-tested staff and cascade trainers within the Clinical Board, which remains available for reference. Coordination of access to fit testing machines and cascade training continues, and staff are advised to contact either **ED** or Health and Safety for support if cascade trainers leave or if new staff require training.* ***ED** highlighted in the report that there has been an outbreak of Haemophilus influenza at Adam's Court. The Health Protection team is aware, and support and advice have been provided to the District Nursing team who visit Adam's Court.* ***ED** explained that training on Carbapenemase Producing Organisms (CPO) is being arranged for district nursing teams, with additional Teams sessions available for other interested teams; this follows increased community*	

	identification due to improved secondary care screening and lab testing, and work is ongoing to implement patient flagging in both Welsh Clinical Portal and the PARIS. Group conversation noted that education would be needed to remind staff to check PARIS alerts if this process came into place. ***ED** added that she will be circulating a report regarding C.diff themes following the meeting.* ***BD** queried any updates regarding practice nurse training that was previously offered twice per year but is currently unavailable. **ED** explained she had been advised that she is not contracted to provide support to care homes or the GP practices.* ***ACTION: Barbara Davies and Ellen Louise Davies to discuss arrangements for future practice nurse training. Meeting scheduled 16/9/2025*** ***BD** informed attendees that consideration is being given to whether a separate IP&C meeting will be necessary for PCIC from a governance standpoint, or if the current segment within the PCIC QSE meeting is adequate. Further updates will be communicated in due course.*	
25/07/11	**Safeguarding Metrics** *The following report was shared on **LiW's** behalf for attendees to read and review - Item 11.1* ***RA** reassured attendees that not all of professional performance concerns cases listed were safeguarding concerns, only six are purely safeguarding cases.*	
25/07/12	***MCA Presentation by Sian Pennell (10 minutes)*** *A patient case was presented for discussion by **Sian Pennell**, Team Leader for Splott District Nurses, previously discussed at a recent steering committee. The process initially commenced at the scrutiny panel. It was noted that, following this review, there were concerns across the Health Board regarding the potential for organisational failure in meeting patient needs. At the time, the self-neglect tool was a relatively new resource. **Pippa Johnson**, representing the mental capacity aspect of safeguarding, subsequently became involved in the case. The team undertook a detailed examination of the safeguarding tool to determine how best to protect and support the patient in question.* *For full details, please see presentation here - **Sian Pennell**, Team Leader for Splott District Nurses, presented the following item - Item 12.1* ***BD** thanked **Sian Pennell** for her presentation and the team's efforts and the positive outcomes achieved for both the patient and the staff involved were commended. **BD** noted that self-neglect has emerged as a significant and evolving theme.* *The effectiveness and positive outcomes of collaborative working in the discussed case were highlighted by **RA** with a clear contrast drawn to the challenges and negative impacts seen in situations where silo working persists.*	

	*It was noted by **RC** that there are multiple third sector advocacy services within the region that are currently underutilised. **RC** is working to map these services and distinguish their roles from those of link workers supporting individuals with dementia. The importance of advocacy was emphasised, particularly in enabling people to have their voices heard and providing support that may be better received than clinical intervention alone. The contribution of advocates in understanding and communicating service users' reasons for refusing services was highlighted, with recognition that such input can lead to positive outcomes.* ***AM** noted that the introduction of the toolkit has facilitated a more effective multi-agency response, improving engagement with various services. Although managing these cases is highly time-consuming for all involved, the established framework enables staff to address and transform complex individual needs. While the workload is intensive in the short term, it is anticipated to result in better long-term outcomes and reduced ongoing work for teams, particularly senior and lead nurses, who continue to provide significant support.* *Recognition was given **Sian Pennell** and her team by **HD** for their significant efforts and hard work, particularly in managing increasingly complex patient cases in the city centre, with appreciation expressed for the positive outcomes achieved.*	
25/07/13	***Adult Practice Review Report*** *The following report was shared for noting and discussion -* • *Item 13.1 - English* • *Item 13.2 - Welsh* *The report refers to case from 2020 and relates to the self-neglect discussions surround previous items on the agenda. **BD** highlighted the level of self-neglect and the opportunity after hospital discharge to assess mental capacity. **BD** referenced the learning points surrounding self-neglect, mental capacity and the ability to assess, the pandemic, and safeguarding processes. The case involved a district nursing team, who were essentially the only team accessing the home for a significant amount of time. **BD** noted that the report mentioned instances where professional curiosity was lacking and missed opportunities, some influenced by the COVID pandemic. **BD** urged attendees to read the report and reflect on the presentation by Sian Pennell in Item 12.* ***RA** reflected on the challenges highlighted within the report, noting that recurring issues for these reports include limited inter-agency communication, incompatible IT systems, and silo working, all compounded by the effects of the COVID-19 pandemic. It was questioned whether the drive to expedite hospital discharges in April 2020 may have influenced tolerance towards self-care, and whether the pandemic impacted the decision-making of the individual, such as their refusal of a face-to-face GP visit during a subsequent lockdown. **RA** also observed how COVID-19 may have reinforced the individual's desire for privacy and control, with safeguarding teams being familiar with such circumstances. Concern was raised regarding the lack of GP awareness of family dynamics and care arrangements, indicating a breakdown in communication. Additionally, it was noted that poor mental health highlighted in the case may have been exacerbated by home conditions and the combined pressures of the pandemic and other adverse circumstances.*	

	***AM** also urged attendees to read the report, highlighting that limited questioning and professional curiosity significantly influenced the outcome.*	
25/07/14	***Support Matters 2025*** *The following items were noted -* • *Item 14.1* • *Item 14.2*	
25/07/15	***Child Sexual Abuse 2023/24: Trends in Official Data*** *The following items were noted -* • *Item 15.1* • *Item 15.2* • *Full report can be accessed on website here*	
25/07/16	**Report – Review of Deaths of people with a Learning Disability known to SBUHB 2024** *The following item was noted, with AM explaining it is common pracice for a mortality review to take place for the any death of a person who has a learning disability -* • Item 16.1 ***BD** noted a significant increase in the number of cases this year, approaching 50%. **AM** confirmed this rise and suggested it may partly reflect a post-COVID 'bounce back' in investigations, as seen in other areas such as palliative care. It was observed that there has been a notable upward trend over the past couple of years.*	
25/07/17	**Neurodiversity Training** *The following items were noted -* • Item 17.1	
25/07/18	**Cardiff & Vale Local Public Health Team Newsletter** *The following items were noted -* • Item 18.1 • Item 18.2	
25/07/19	***Compliments*** ***BD** directed attendees to the following item to read the positive comments received for PCIC teams - Item 19.1*	
25/07/20	**Concerns** ***Need to send copy of this to Roz Meah re. Ombudsman by 19.09.25***	

Commented [E(1]: Need to send copy of this to Roz Meah re. Ombudsman by 19.09.25

Commented [E(2R1]: Action completed - Sent minutes to Roz Meah on 16.09.25 prior to 19.09.25 deadline

	BD *noted the following complaint made to the Ombudsman (Case: 202405374) in relation to catheter care. Please see Summary and Final Report – Item 20.1 and Item 20.2.* ***AM*** *explained that the case involved a patient who had a catheterisation in the community and ended up going into hospital and suffered from sepsis. This was first raised via the concerns process as the patient felt his catheterisation was traumatic and was not done appropriately. When the patient visited the Emergency Unit, the patient was told the catheter was not inserted correctly. PCIC investigated this as a complaint, including review documentation, records and meeting with the patient. The involved nurse was confident that the catheterisation was performed correctly and was left draining appropriately. PCIC's response to the concern included this statement, indicating that we were unable to provide an explanation for the incorrect positioning of the catheter during the patient's visit to the Emergency Unit.* *Despite efforts to address the matter,* ***AM*** *explained that the individual remained dissatisfied and referred the case to the Ombudsman. The Ombudsman, with input from an independent advisor, reviewed the case and highlighted that the available documentation did not provide sufficient assurance that the catheterisation was carried out appropriately.* *From a learning perspective,* ***AM*** *recognised that the principal lesson from this incident was the need to improve documentation standards to better demonstrate the quality of care provided, and that this learning has been shared with the individual involved.* ***AM*** *noted that the Ombudsman recommendation has not been challenged, and learning has been identified surrounding documentation, ensuring staff training is up to date, and performing audits. The report has been issued on the back of accepting the recommendations. An apology has been issued to the patient, the individual concerned has reflected on the report, and the report will be shared at relevant Quality and Safety meetings. This will include meetings where a wider range of district nurses are present, and consideration will be taken to ensure how effective audit processes are undertaken regarding training compliance around catheterisation and refreshing.*	
25/07/21	**Death Certification in Wales update** *The following items were noted -* • Item 21.1 • Item 21.2 • Item 21.3 • Item 21.4 • Item 21.5	
25/07/22	**Individual care** *There were no specific items to note under this heading.*	
25/07/23	**Home Fire Safety Check** ***BD*** *highlighted the below video and information regarding home fire safety checks for patients in the community.*	

	Vale PSB recently and South Wales Fire and Rescue gave a presentation highlighting the increase in number of house fires, some of which have very sadly been associated with fatalities. They were very keen to promote the free Home Fire Safety Check they offer and asked PSB members to circulate to their staff. *The link below is for the video that explains what a Home Fire Safety Check is, risk groups, risk factors and how to refer to the Fire Service.* *https://youtu.be/MinNl-qhxE4*	
25/07/24	**OOH Business Report** *Please see Business Unit report here - Item 24.1* *The following information was presented by exception by SF:* • *Non-clinical staffing remains a risk on the risk register due to struggle to obtain approval to recruit. As a temporary workaround, approval has been received to increase the bank staffing position.* ***SF*** *reported that interviews held the previous week enabled the hiring of additional bank staff for all non-clinical groups, who were in the process of completing pre-employment checks. The committee also noted they were awaiting approval to permanently fill vacancies, which was expected in the coming weeks.* • *111 press 2 workforce is another current risk. Band 5 Wellbeing Practitioners have been recruited, which will bring the team to full establishment upon completion of pre-employment checks and confirmation of start dates.* • *Ongoing challenges with senior workforce. Although a further two senior mental health clinicians have been recruited, long term sickness and pre-booked annual leave at the end of the summer period has exacerbated the situation.* • *GP worker status is unchanged; awaiting an update after the meeting on 30 July 2025.* • ***SF*** *noted a recent RIDDOR incident involving a staff member who fell from a table at work has been formally closed. Health and safety officials reviewed and approved both the procedures in place prior to the incident and our subsequent response. The incident will be incorporated into future health and safety training materials.* ***RA*** *noted the report showed two information governance breaches in out of hours. Once the investigation was completed, RA requested the findings are presented at a future PCIC QSE meeting, as information governance is also covered by the quality and safety group for the clinical board.* ***SF*** *noted this and will pass the information on to the team.*	
25/07/25	**Cardiff Community Business Unit** *Please see Business Unit report here presented by* ***HD*** *- Item 25.1* *The following information was presented by exception:* • ***HD*** *highlighted gaps in teams during the summer period but this is currently being managed. Noted weekend staffing for Safe@Home has been challenging with sometimes the need to close to new admissions. Gaps also noted for weekend cover for GP and ANP cover.* • *Increase in parking fines for staff and appeals being rejected. Localities following this up with Cardiff Council. This has caused stress for staff.*	

Commented [E(3]: Please can I check this is correct, Barbara?

	• *Concerns regarding traffic restrictions implemented for City Centre events have been communicated to the Council, as these measures have created challenges for teams attempting to visit patients.* • *North Cardiff District Nursing team have been invited to the Mansion House by the Lord Mayor.* ***BD** acknowledged the News2 work ongoing with community teams and invited **HD** to provide an update at a future meeting.*	
25/07/26	**Vale Locality Business Report** *Please see Business Unit report here presented by **NM** -* • *Item 26.1* • *Item 26.2 - Includes IP&C report* *The following information was presented by exception:* • *Temporary solution in place regarding staff safety in Broad Street. Looking to find a long-term solution.* • *Bladder and Bowel service have issued the letters to patients regarding the phased removal of some level one products. AM queried whether these letters had been issued as the report says they are planned to be sent in August, as it had been raised to the Communications team that some patients may contact the Concerns team.* • *Continued review of VBA and mandatory training compliance.* *Praise was noted from **BD** regarding the Ancle Cafe which has been shortlisted for an NHS award. **NM** praised the Ancle Cafe after recently visiting the group and encouraged attendees to visit the Ancle Cafe themselves.*	
25/07/27	**Cardiff Specialist Business Unit** *Please see Business Unit report here by **CP** - Item 27.1* *The following information was presented by exception:* • *Slow progress is being made regarding accessing accommodation for the mass vaccination centre at St David's.* • *Conversations under way with the Vale regarding HIV injectables, with guidelines, referral pathways and standard operating procedures being adapted. Aiming for 1st September 2025.* • ***RS** raised that staffing levels is the biggest risk for HMP. Noted that there was a recent assault on a nursing staff member. The staff member is not currently off work but has been referred to Occupational Health. The incident has been logged on DATIX, reported through 101 and via the Police. Team linking in with Health and Safety. **BD** offered any support if needed.* • ***RS** added that the completed clinical review relating to a death of a patient in HMP Cardiff (undergoing NRI process) has been received with the team required to provide an action plan following the recommendations in the report by 18th August 2025.* ***BD** and **CP** highlighted that the DoSH team have been involved in being part of the first in the UK to administer a gonorrhoea vaccination.*	
25/07/28	**Medicines Management & Community Pharmacy**	

	*Please see Business Unit report here by **CC** - Item 28.1* *The following information was presented by exception:* • ***CC** highlighted workforce as the primary risk, noting that current vacancies are beginning to affect team deliverables.* • *Recruitment is under way for lead pharmacists in frailty and community roles, which will support ICCS work and enhance governance around medicines use. Approval has been granted to progress recruitment for an additional vacancy, pending corporate scrutiny.* • *It was also noted that a safeguarding concern referenced in the report does not relate to pharmacy teams but pertains to a member of the public who has been reported to the police via community pharmacies; the Health Board is supporting affected contractors.* *Regarding the final point above, **RA** asked if the incident had been entered on DATIX so any themes and mitigations can be put in place relating to the individual to link any concerns from community settings with secondary care. **CC** confirmed that the pharmacies have been advised to submit a DATIX. **CC** added that it seems to be an ad hoc opportunity that has being taken, whereas in other places in the UHB appointments would need to be made in advance. It is the accessibility of community pharmacy that is the downfall in this situation.*	
25/07/29	**Palliative Care** Please see Business Unit report here by **AR** - Item 29.1 *The following information was presented by exception:* • *Bank staff have been recruited to Marie Curie Hospice which will help keep beds open. Additionally, **Viv Cooper** has been recruited to Head of Nursing and Quality.* • *All Wales Syringe Driver Chart is progressing. It has been added to Oracle and progressing at both Health Board and All Wales level. Awaiting final sign off.* • *Hospital palliative care team struggling due to being a small team and trying to cover maternity cover and assisting discharge liaison team. VBA compliance is struggling due to this.* • *Finance strategy has been signed off, so team are recruiting into first phase of palliative care posts.* *Regarding the HEIW consultation around framework for palliative care competencies around education, **AR** noted this is out for consultation. It will then be returned on a national level to build on accessible resources.*	
25/07/30	**Primary Care** *Please see Business Unit report here by **SG** - Item 30.1* *The following information was presented by exception:* • *Partner for Corporation Road has provided notice for their contract and the practice will be closing on 29th August 2025.* • *GMS escalation levels – noted four practices operating at Level 4. Level 5 is when a practice must close. The team have a programme in place to visit the practices to support as necessary.*	

	• *New dental risk has arisen regarding the dental contract reform 2026. The team had been asked to contribute, alongside other stakeholders, to a Welsh Government proposal to radically reform the General Dental Services contract. It was noted that this was expected to have a significant impact on patients, the Health Board, and the wider system. The associated risk had been rated at 20 on the risk register. The team anticipated that, as a result of the reforms, contracts would be returned, which would affect patient access to general dentistry. Patients would no longer have ongoing relationships with practices, and those deemed low risk would be unable to access a dentist for less than three years. Instead, patients would be required to use the centralised Dental Access Portal and be allocated to any available dentist in the area. The Committee agreed to continue monitoring the situation as further information was released by Welsh Government.* • *The team is experiencing significant workforce pressures due to the relinquishment of four posts as part of cost-saving measures, compounded by unplanned vacancies and long-term sickness absence. As a small team, these factors are impacting the ability to deliver on priorities. A request was made by **SG** for current vacancies to be approved by the scrutiny panel, noting that two posts remain blocked and urging for progress on these positions.* ***AM** noted that Whitchurch Road had recently been in the press regarding GP capacity issues, of which **SG** was already aware.*	
25/07/31	**Any other business to be discussed** ***Health and Wellbeing Newsletter July 2025*** • *Item was noted and for onward sharing, please see Item 31.1* ***Welsh Nursing Care Record - Information and Update*** • *Item was noted, please see Item 31.2* *Post meeting note -* ***POCT*** • *Following the meeting, **Dr HC** submitted the following POCT update – Item 31.3* • *Attendees can contact **Dr HC** with any questions.* ***ACTION – Governance team to link in with Helen Cordy to find out more information about audit (Update – Audit information has been included as a post-meeting note in the July PCIC QSE minutes).***	
PART 2	PART 2: Items to be recorded as Received and Noted for Information by the sub-Committee	
25/03/32	All items below have been previously circulated as appropriate. PCIC Central Register – Comms & Alerts	

Date and time of next meeting: Tuesday, 23rd September 2025 at 11.00 am.

Minutes of the Specialist Services Clinical Board
Quality, Safety & Experience Committee
Monday 15 September 2025
Via Teams

M I N U T E S

Chair:		
Cath Twamley	CT	Interim Director of Nursing, Specialist Services
Mat Davies	MD	QSE Lead for Specialist Services
Present:		
Andrew Partridge	AP	Corporate Archivist & Records Management Manager
Ceri Phillips	CP	Lead Nurse, Cardiothoracics
Colin Gibson	CG	Consultant Clinical Scientist
Gareth Jenkins	GJ	Directorate Manager, Haematology
Hayley Valentine	HV	Q&S Lead, Critical Care
Jane Morris	JM	Senior Nurse, P@RT
Joanne Bagshaw	JB	Senior Nurse, Haematology
Jo Clements	JCl	Lead Nurse, Critical Care
Kirsty Britton	KB	Senior Nurse, Nephrology & Transplant
Leanne Handly	LHa	Assistant Service Manager, Cardiothoracics
Lazlo Sabu	LS	Consultant Transplant Surgeon
Lisa Simm	LSi	Service Manager, Neurosciences
Maria Bassett-Davies	MBD	Major Trauma Practitioner
Matthew Creed	MC	Consultant in Anaesthetics
Mathew King	MK	Head of Service, Podiatry
Nicholas Denny	ND	Quality & Safety Improvement
Priya Chankria	PC	Assistant Service Manager, Neurosciences
Rachel Long	RL	Directorate Manager, Nephrology & Transplant
Sian Williams	SW	Senior Nurse, Cardiothoracics
Thomas Holmes	TH	Consultant, Critical Care
Tracey Vine	TV	QSE Facilitator for Specialist Services
Secretariat		
Kim Abberley	KA	Administrator
Apologies:		
Angela Jones	AJ	Senior Nurse, Resuscitation
Bethan Ingram	BI	Lead Nurse, Haematology
Helen Thomas	HT	Lead Pharmacist for Specialist Services Clinical Board
Ryan Paxford	RP	Senior Fire Safety Officer
Siwan Jones	SJ	Clinical Nurse Specialist, IP&C

Item No	Agenda Item	Action
Part 1: Preliminaries		
1.1	**Welcome & Introduction** MD welcomed everyone to the meeting	
1.2	**Apologies for Absence** Apologies for absence had been received from Angela Jones, Bethan Ingram, Helen Thomas, Ryan Paxford and Siwan Jones	
1.3	**Review the minutes of the previous meeting and matters arising** The minutes from the previous meeting held on 17 July 2025 had been circulated. No amendments were required to the minutes, and they were, therefore, accepted. **Actions from last meeting:** KN to circulated communication regarding the issue of the damaged floor on B3 and the high risk when transporting patients. Completed: Works are planned for this weekend to replace the floor on B3. CT to send a reminder email to all Directorates asking for information on M&M. Completed: Most areas have now provided the information required on M&M. HT to look into the ME Service having access to ePMA. Completed: HT has raised this issue with the ePMA team and they have taken this on. There is facility for read only access which would enable retrospective review of the ePMA drug chart, including details on when drugs were prescribed and administered, and the names of individuals undertaking these activities. However, as the medical examiners are not CAVUHB employees, this may not be possible currently, so the ePMA team are looking into how this can be overcome.	
1.4	**Exception Reports and escalation of key QSE issues from directorates** **Neurosciences** There is a further leak on West 8 which has been raised with Estates. Two beds have been closed. **Cardiac Services** No specific new risks but there are a number of risks that are being worked through. Issues with staff vacancies, especially in admin. Ongoing concerns and significant risks with the device incidents. **Haematology** Haematology's JC inspection will take place on 18th/19th September. Also have issues with workforce vacancies. The main issue is the vacancy in the lead chemotherapy post. Interviews are taking place today and hopefully this post will be filled.	

	Critical care The main issue is with the UPS on B3N. High risk patients have had to be moved as there is no backup power. Estates hope to have the replacement part available today. CT and MD will meet outside the meeting to discuss how to best report and escalate these ongoing issues. **Nephrology** There was nothing significant to raise from a nursing point of view. There are challenges around sickness within the medical workforce and this is having an effect on planning and filling the rotas. This issue has been added to the risk register. There is now a tight timeline around the procurement for unit haemodialysis. An internal Cardiff & Vale group needs to be set up to understand what governance Cardiff & Vale will be looking for around this matter. **ALAS** There have been issues with the Orthotic service to such an extent that the service was unable to be delivered. However, this is now a little more stable but there are still issues, and prioritisation continues on the basis of risk. In the long term this is something that will need addressing as the service is too fragile, relying on a small number of staff. CT informed the group that a scrutiny panel for Clinical Board is scheduled this week but there is nowhere to progress vacancies currently. An urgent meeting has, therefore, been requested with Jason Gough to discuss how and where to progress these vacancies. MD said that some of these vacancies are funded externally so how to escalate these vacancies needs to be considered.	
Part 2: Safe Care		
2.1	**Nationally Reportable Incidents** **Feedback re Never Event ID 71171:** Michele Ball was unable to attend meeting to present this NRI. This NRI will be discussed at the next meeting on Thursday 9th October.	
2.2	**Vaccinations** Vaccination clinics have now commenced and the roaming team are visiting wards to carry out vaccinations. Ten clinics are now fully staffed. CT thanked KB for all her hard work on this undertaking.	
2.3	**Alerts/Patient Safety Notices** **Specialist HCAI report** The safety memo on the shortage of medicines used for tuberculosis (TB) treatment has been uploaded on to Teams. There has been a notice which CT had shared in regard to the Ranger blood warming kit. There is going to be disruption in stock in the near future. An email	PDF Safety Memo - TB Medicines shortage.

	will be sent to the relevant areas - haematology lipids unit critical care and cath labs.	
2.4	**Healthcare Associated Infections** **Specialist HCAI report** SJ had sent her apologies but had submitted her report (see attached). MD said that there had been an increase across the clinical board relating to Klebsiella. SJ has done a thorough analysis of this issue (see attached) and it concluded that all infections related to instrumentation of the urinary tract in patients, ie catheterisation, nephrostomies etc. The lesson to be learnt, therefore is to reinforce the fact that serious infections can occur and these procedures need to be managed with proper sterile techniques to try to minimise the amount of bacteraemia occurring.	
2.5	**Specialist Services Medical Devices** **Safety Officer Update** The MHRA had recently visited the Health Board on a fact-finding mission to find out more about in-house design and manufacture of medical devices. The UK government is going through a consultation process around rewriting the medical devices regulations for the UK. The MHRA will be looking at a range of services in dental, clinical engineering and ALAS. CG was away at the time of the visit but it appears that the MHRA were fairly happy and found the visit useful.	
2.6	**Resuscitation Clinical Board Monthly Report** AJ had sent her apologies. There were no changes in trends in the areas previously discussed.	Resus Monthly Summary - Specialist
2.7	**Safeguarding** Ellis McDonough is the new link for safeguarding. She will be attending the meeting on 20th November to introduce herself and to present an update on safeguarding. CT asked that everyone copy EMcD into emails regarding safeguarding.	
2.8	**Risk Register update** CT introduced Andrew Partridge who had joined the meeting to provide an update on risk registers. There is a key change in the way the risk registers are going to be stored, and a change in the way the information is captured and presented going forward. AP shared his screen and presented his update on risk registers. Risk registers will now be captured/stored in AMaT for all specialties. AP said his team are happy to assist all specialties with the new way of storing risk registers. The target for risk registers to be uploaded is the end of October 2025. MD asked that all Directorates put their 20+ scores into the system by the end of October. CT said there will be a phased approach to moving over to the new system. CT asked that all DMTs reach out to AP and ask him to attend one of their meetings to discuss the change in capturing risk registers.	

	Action: All directorates to arrange for AP to attend one of their meetings to discuss the change in capturing risk registers.	
Part 3: Governance, Leadership and Accountability		
3.1	**Health & Safety OHSG update** JD was not in attendance. JD will be asked to update at the next meeting on 9th October.	
3.2	**Mortality and Morbidity** A reminder email from CT asking all areas for information regarding M&M had not been circulated as there had been a lot of competing priorities. M&M will be discussed at a future meeting**.**	
Part 4: Items to be recorded as received and noted for information by the committee		
4.1		
Part 5: Any other business		
5.1	**Haematology prescribing update** See attached notice on Adult Haematology Systemic Anti-Cancer Therapy (SACT) Prescribing Procedure. Any queries or comments should be directed to Angharad Atkinson or Helen Thomas.	 CAVUHB adult haematology prescri
Part 6: Action log		
6.1	**2.8** All directorates to arrange for Andrew Partridge to attend one of their meetings to discuss the change in capturing risk registers.	
Part 7: Date of next meeting		
7.1	The next meeting will be held on Thursday 09 October; 09.30-11.00; via Teams	

Minutes of the Children & Women's Clinical Board QSE (CWQSE) Committee
Held on Tuesday 23rd September 2025 at 8.30am
Via Microsoft Teams

Present:		**Title**
Andy Jones	AJONES	Director of Nursing, C&W Clinical Board
Emma Bramley	EB	Quality & Safety Lead, CHFW Directorate
Louise Platt	LP	General Manager, CHFW Directorate
Becci Ingram	BI	General Manager, CYPFHS Directorate
Alison Davies	AL	Lead Nurse, CYPFHS Directorate
Samuel Barrett	SB	Deputy Director of Operations, C&W Clinical Board
Karenza Moulton	KM	Lead Nurse, CHFW Directorate
Natalie Vanderlinden	NV	Designated Education Clinical Lead Officer (DECLO)
Ceri Phillips	CP	Deputy General Manager, CHFW Directorate
Angharad Grimwood	AG	Governance Midwife, O&G Directorate
Alison Lewis	AL	Patient Safety Facilitator
Alan Pateman	AP	Clinical Director, CHFW Directorate
Elizabeth Sheppard	ES	Governance Midwife, O&G Directorate
Elizabeth Smith	ES	Clinical Governance & Risk Lead Nurse, Neonatal Services
Hannah McLoughlin	HM	Clinical Governance & Risk Lead Midwife, O&G Directorate
Tirion Pryce	TP	Health & Safety Advisor
Rhodri John	RJ	Directorate Manager, O&G Directorate
Paula Davies	PD	Clinical Governance & Risk Lead Nurse, CYPFHS Directorate
Sara Wright	SW	Clinical Nurse Specialist, Infection Prevention & Control
In Attendance		
Tracey Cooper	TC	SARC Manager, O&G Directorate
Apologies		
Kirsty Hook	KH	Risk, Governance & Patient Experience Facilitator, C&W Clinical Board
Abigail Holmes	AH	Director of Midwifery & Neonatal Services, C&W Clinical Board
Lois Mortimer	LM	Head of Midwifery, O&G Directorate
Angela Jones	AJ	Senior Nurse, Resuscitation Service

Item No	**Agenda Item**	**Action**
CWQSE/ 2025/148	**Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2025/149	**Apologies for Absence** **The CWQSE resolved:** a) The apologies were noted	
CWQSE/ 2025/150	**Minutes of the previous Q&S Meeting held on 26th August 2025** The minutes of the meeting held on 26th August 2025 were agreed to be an accurate record.	

	The CWQSE resolved: a) The minutes were noted and agreed	
CWQSE/ 2025/151	**1.4 To note and update the latest action log (from AMaT System)** The action log is now available via AMAT for live updates to be provided. Outstanding actions will be followed up outside of the meeting for completeness. Requests were made for the action log to be updated via the AMaT system following the meeting. **The CWQSE resolved:** a) Further update to be provided on any outstanding actions at the next meeting.	**ALL**
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
CWQSE/ 2025/152	**Health & Care Standards Directorate QSE Exception Reporting** The Directorates were asked to provide updates on specific areas of escalation and noting. **CYPFHS Directorate Report** • Fluenz campaign commenced on 15th September. New All Wales requirement for input onto WIZ2 System at the point of vaccination, however the new system is currently not fit for purpose due to functionality issues which is impacting on live input. A risk assessment has been completed to outline the challenges; however, this is resulting in a backlog and staffing vacancies are also impacting this. This will continue to be monitored and options to address the backlog are being explored. Requests were made for consideration of approval of the use of bank to support fulfilment of the delivery plans. It was agreed that further information and discussions would take place outside of the meeting on the way forward. • ICCNS staffing risks continue with increased vacancies and increased packages within the service. 10 packages awaiting support. There are also delayed transfers of care from the Children's Hospital also. Requests have also been received for external agency training which is having additional pressures on the team and the service. • Implementation of the Healthy Child Wales Programme risks regarding delivery and compliance with phase 2. Further resource paper has been developed for Welsh Government. Detailed review of activity and compliance against the model has been completed, and support has been requested from the shape and change team to explore and support the changes being considered. It was agreed that the paper would be shared outside of the meeting for further discussion. • Admin capacity continues to cause significant pressures across a number of teams. Request was made to discuss further at vacancy panel to consider the business-critical teams specifically complex needs, community paediatrics and neurodevelopment service. Agree to discuss outside of the meeting. • New NRI reported relating to a 19yr old care leaver which is progressing. • X1 RIDDOR reported relating to staff injury of ICCNS nurse. H&S have been informed, and support is being provided with regard to updating the moving and handling plans. • Significant vacancies within the Crisis Team in EWMH Service. Twilight offer has been stepped down as this is currently not required. Gaps in forensic psychiatry. • VBA rates are being impacted relating to vacancies gaps across Band 6/7 and admin staff.	

	• Power outage in St David's Hospital which had a direct impact on the PARIS use and clinic/admin teams' activity. AD to escalate to Capital Estates and Facilities for support/resolution. • Increase in number of concerns being received, specifically in relation to Neurodevelopment, which is having an impact on the team and ability to manage them. • Compliment received from Eating Disorders Service in relation to the recent implementation of the Phlebotomy Service. • Adult Mental Health Teams are accepting transitioning patients who are on the ADHD pathway and are honouring the waiting time from when they joined the list, however the integrated autism service will not accept any children in transition and are only accepting children who get referred when they are 17 ½ yrs old. Currently there are 28 children on the pathway who will be 18 and this will increase to 90 by the end of March and only a handful have waited over three years. Further conversations are needed with regards to the way forward. BI agreed to contact Adult Mental Health for further discussions. • Endow Service run by Cardiff University and possibility of being able to refer to them for outsourcing of patients for Neurodevelopment. This is being explored further from a governance perspective. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded. b) Contact to be made with Adult Mental Health regarding Transition c) Power Outage at St David's Hospital to be escalated to Capital Estates and Facilities for support d) SBAR re: HCW 2 programme risks to be shared with the Clinical Board	**BI** **AD** **AD**
CWQSE/ 2025/153	**CHFW Directorate Report** • X2 open NRI's within NICU which are being progressed. 5 open LRI's which are progressing from a learning perspective. • Datix drive is being progressed for all incidents. • X10 open formal concerns, x1 of which is over 100 days and is awaiting an external review report which is almost complete. • X1 risk of 16 on the risk register relating to endoscopy waits due to lack of theatre capacity to meet current demand. JCC will undertake a review of the baseline contract in Quarter 2. Further discussions are ongoing with the Perioperative Directorate regarding additional theatre capacity. • 32 medication Datix reported over a 2month period. 15 of which were related to prescribing errors, 14 relating to admin errors and the remaining incidents relating to supply, storage and advice errors. All are being reviewed. • New beds and cots relating to the MHRA Guidance are being trailed across the ward areas in CHFW. Feedback received to date has been positive and progress being made regarding final decisions for ordering. Discussions are ongoing with Procurement regarding funding for replacements. • X1 pressure area reported since July 2025 which related to suspected deep tissue injury from a Kendrick splint applied within another Health Board for an MTC patient. From initial assessment this will need to be reviewed by the transferring health board and information has been shared for review. Focused review will also be concluded by the team for completeness of the Datix investigation. • Three P's Pump Product Patient in July 2025. Update will be provided at the next meeting with regards to the work undertaken to date. • Positive feedback received through patient experience Civica System. • Pathway for YP under 18 being detained on a 136-communication escalation	

	pathway and the new Mental Health Act Papers and bed booking pathway have been shared widely. It was agreed that the pathway for admission into the Children's Hospital would be shared at the next meeting for noting. • VBA compliance is currently at 61.7% and mandatory compliance Safeguarding level 1 is at 79% and level 2 at 63%. Overall sickness rate is 4.31% • PEWS has gone live across the CHFW on 22nd September • JC accreditation for Oncology Services, discussion is ongoing, and feedback is awaited. This is an organisational risk for adult and paediatric services. **Timely Access** • Biggest performance pressures relate to Paediatric Endoscopy and Paediatric Respiratory Waiting Times. Hitting three years waits for Sleep Studies and work continues to reduce these waiting times. • **The CWQSE resolved:** a) Update noted. b) Three P's Pump Product Patient Update to be provided at the next meeting	**EB**
CWQSE/ 2025/154	**O&G Directorate Report** • In August 110 new Datix incidents reported, 90 closed in month. Work continues to improve the closure rate going forward. • 14 LRI investigations (6 BIT), x3 NRI's for Obstetrics all of which are progressing. 4 open LRI's and 4 NRI's for Gynaecology. • 5 new concerns in August, 14 in total open for Obstetrics and these are progressing. • 7 high scoring risks on the risk register. Work has taken place in line with the updated risk register guidance and register updated accordingly. • X4 medicines management incidents reported in August. No themes identified and all reported as low or no harm. • IP&C audit in MLU completed in August and actions have been implemented. • Health Promotion - Two midwife training in subdermal implants to support contraception within the unit prior to discharge and there is a new best practice guidance for post pregnancy contraception which has been realised by the College of sexual and reproductive health and there was work ongoing with public health teams around good food and movement that can be promoted in pregnancy. • Fetal surveillance training – Consultant Obstetricians 95%, Resident Dr 90%, Midwifery 88% IFS and 81% IIA • Prompt - 98% Community prompt and 87% with hospital prompt. • VBA rate 67.92%, sickness rate at 5%. **Timely Access Update** • 6085 patients on the outpatients waiting list with the longest waiting patient being 101 weeks. Work continues regarding insourcing with a view to bringing down the wait to 26 weeks by the end of March 2026. Concerns were raised regarding the number of gynaecology clinical teams from the insourcing company has not yet materialized which will impact on the targets being met. • Urgent and USC patients are being seen within timeframes. • Vetting remains a pressure and work is ongoing to ensure that referrals are reviewed as quickly as possible. Thanks were expressed to all Directorates for the ongoing support in focus on staff sickness absence, and it was noted that there has been an improvement in	

	bringing down the sickness percentage across the Clinical Board. Monthly sickness panels are continuing in the hope of further reduction in the rates and enable staff to stay at work or return to work as quickly as possible. All were asked to continue to support increases/improvements across statutory and mandatory training. Discussion ensued with regards to entitled persons and asylum seekers coming into the UK and whether there has been any impact across the services/Directorates. All were asked to feedback any issues so that this can be reported accordingly. **The CWQSE resolved:** a) The update was noted for information and key highlights recorded.	
CWQSE/ 2025/155	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** Detail noted as part of the Directorate report updates. Roll out of risk registers to the AMAT system is progressing. Requests were made for key representatives from each Directorate to be shared for inclusion in the Task & Finish Group **The CWQSE resolved:** a) The update was noted for information b) Directorate representatives to be identified for inclusion in Risk Register T&F Group c) Clinical Board/Directorates to progress AMAT Risk Module	
SAFE CARE		
CWQSE/ 2025/156	NRI's/PSLR's for **noting/exception reporting** • **Final PSLR and Improvement Plan – MB – Datix 76056 (NRI)** Final improvement plan shared and noted for information. • **SBAR, PSLR and Improvement Plan – RA-P – 72719 (LRI)** Unexpected Neonatal Unit Admission – HIE A 17-year-old primigravida experienced an emergency caesarean section following misinterpreted CTG and failed analgesia. Baby required neonatal admission. Issues included equipment failure, delayed decision-making, and analgesia management. • **SBAR, PSLR and Improvement Plan – JK – Datix 83591 (LRI)** Return to theatre, intra-abdominal bleeding. Post-caesarean intra-abdominal bleeding led to delayed diagnosis and return to theatre. The patient developed AKI, ileus, and infection. Missed opportunities for earlier intervention were identified. • **SBAR, Birth Injury Tool and Improvement Plan - JL – Datix 87458** Birth Injury – Erb's Palsy Forceps-assisted vaginal birth resulted in Erb's palsy and facial palsy. Although care was deemed appropriate, documentation gaps and lack of MSU follow-up for GBS were noted. Baby referred to Morriston for nerve assessment.	

	• **SBAR, PSLR and Improvement Plan – EB – Datix 87734 (LRI)** Cardiac arrest, ITU admission, requirement for ongoing renal replacement therapy. A medically complex patient suffered cardiac arrest during caesarean section and developed AKI requiring long-term dialysis. TXA dosing and escalation protocols were scrutinised. • **SBAR, PSLR and Improvement Plan – KB – Datix 71631 (LRI)** Postnatal Readmission with pyelonephritis Postpartum voiding dysfunction led to pyelonephritis and readmission. Documentation gaps, inappropriate TWOC timing, and missed infection screening were identified. Language barriers impacted care. It was agreed that it would be useful for the bladder care improvement plan to be shared with the group for information sharing. • **SBAR, Birth Injury Tool– Baby T – Datix 89040** Birth Trauma – Fractured clavicle Shoulder dystocia managed appropriately. Clavicle fracture identified days later. Documentation lacked clarity, and neonatal team were not informed of shoulder dystocia. • **SBAR, Birth Injury Tool– Baby R – Datix 92168** Birth trauma: Midshaft right clavicular fracture Shoulder dystocia managed well, but fracture discovered post-discharge. No direct learning identified, but importance of neonatal awareness reinforced. The above cases have been discussed in detail as part of the NRI/LRI Governance Subgroup Meeting and were shared for information. Full detail was shared as part of the supporting SBAR's. There were no specific issues to highlight for this meeting. All improvement plans have been completed and are progressing to closure. **The CWQSE resolved:** a) Updates noted b) Bladder Care improvement plan (case of KB Datix 71631) to be shared for information	**HM**
CWQSE/ 2025/157	**Infection Prevention Control Update Report** The report was shared for information. X2 C Diff bacteremia's over August and x1 reported for September 2025. Work is ongoing with First Floor Maternity to complete audits in conjunction with Housekeeping and Estates. Reminder provided to all with regards to PPE readiness for the Winter. X2 outstanding RCAs for Rainbow and Owl Wards. **The CWQSE resolved:**	

	a) Update noted.	
CWQSE/ 2025/158	**Safeguarding/Mental Capacity Act (MCA)** No specific issues for noting at this meeting. AJONES advised that members of the Safeguarding team will join on a six-monthly basis and representatives for the Clinical Board are Fionn Lloyd, Natasha Volenic and Chloe Laws.	
CWQSE/ 2025/159	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • Safety Memo – Bactroban Shortage All alerts have been circulated for onward sharing and action as necessary. There were no specific exceptions to note. **The CWQSE resolved:** a) Alerts noted.	
CWQSE/ 2025/160	**Clinical Audit** The group were asked to review and provide updates to the Clinical Audit Team. No specific issues to note for this meeting. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2025/161	**Medicines Safety Executive Update** No update to note for this meeting.	
CWQSE/ 2025/162	**SARC Update (9.45am)** Tracey Cooper, SARC Manager was welcomed to the meeting. An overview was provided on data from January – July 2025 which illustrates the increase in referrals into the service. There were 214 referrals received, and 172 forensic examinations that were undertaken. Compared to the same period last year there is a significant increase in the number of forensic examinations undertaken. It was noted that there are pressures within the crisis worker workforce and it was acknowledged that the accreditation is having a significant impact on the type and length of training required before a crisis worker is able to work independently. Funding has been secured for the counselling service until the end of March 2026 and a review of the service is anticipated for next year. A pathway has been established between SARC and Sexual Health for historic sexual abuse and those patients who don't wish to report to the police. Working in partnership with the universities to be able to provide student counselling. Self-referrals are also being accepted. Links with Cardiff Council for young people under 18yrs old. Waiting list is currently between 5-6weeks. Service is now working as a Regional Hub and all forensic suites are in line with forensic accreditation. A quality management is now in place allowing all crisis workers to access SOP's and documentation and ongoing discussions with the quality management team ensuring accountability across the service. A training matrix has also been implemented.	

	It was noted that there are currently x2 SOP's awaiting approval at Directorate level one relating to Telephone Enquiries and SARC Self Referral Procedure. Once approved these will then be submitted to Board for final ratification. Update provided on recent incidents, concerns and compliments reported within SARC (detail included within the supporting presentation). Thanks were expressed to TC for the update, and it was agreed that a future invitation will be extended for an update to be provided regarding the accreditation work being undertaken and ISO standards. Discussion ensued with regards to the figures included, and it was confirmed that this relates to adults and children. BI noted that a regional paediatric rota has now been implemented, and it was agreed that a further update can be provided regarding the Swansea Paediatric Hub. TC agreed to provide a further breakdown for the next update. **The CWQSE resolved:** a) Update noted.	
TIMELY CARE		
CWQSE/ 2025/163	**Directorate concerns & assurance update** Discussed as part of the directorate reports. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2025/164	**Patient Feedback** The Latest CIVICA Summary Report Children and Women's report was shared for information. **The CWQSE resolved:** a) Update noted.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2025/165	**Patient Safety Day** The World Patient Safety Day Blog was shared for information. World Patient Safety Day Blog **The CWQSE resolved:** a) Update noted.	
ANY OTHER BUSINESS		
CWQSE/ 2025/166	**Patient Use of Mobile Phones in Hospital Setting** Deferred to the next meeting.	
CWQSE/ 2025/167	**ANTT Compliance Update** Teams were asked to submit this information ahead of each meeting so that this can be noted and shared as part of executive performance reviews. It was noted that this will remain a standing agenda item going forward.	

	The CWQSE resolved: a) Update noted.	
CWQSE/ 2025/168	**Future of Community Nursing** AD updated regarding invitation received from HEIW regarding the future of community nursing project. There will be ongoing work reviewing the sustainability of the workforce, models etc. Requests have been made from the group to receive questions regarding workforce sustainability. All were asked to feedback any questions they wish to have raised through the forum. Further updates will be provided as the work progresses. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2025/168	**Date and Time of Next Meeting** Tuesday 28th October 2025, 8.30am, Microsoft Teams.	**ALL to note**

Minutes of the Clinical Diagnostics and Therapeutics Clinical Board
Quality, Safety and Patient Experience Sub-Committee

Held on 22nd September 2025

Present:		
Helen Luton (Chair)	HL	Director of Nursing/Multi Professional Teams
Becca Jos	BJ	Deputy Director of Operations
Keeley Baker	KBa	Head of Health Records
Karen Holmes	KH	Assistant Manager, Health Records
Ruth Lang	RL	Office Manager, AWTTC
Melissa Melling	MM	Head of Medical Illustration
Stephanie Ashmore	SA	Safeguarding Lead
Suzanne Rees	SR	Lead Nurse for CD&T
Adam Sotero	AS	Quality Lead, Cellular Pathology
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Jonathan Davies	JDa	Health and Safety Adviser
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Rhys Morris	RM	CD&T R&D Lead/Director of MPCE
Jo Fleming	JF	Quality Lead, Radiology
Alana Adams	AA	Principal Pharmacist, Welsh Medicines Information and Advice Service
Julia Dinley	JD	Head of Speech and Language Therapy
Sue Lawless	SL	Laboratory Service Manager, Haematology
Sian Jones	SJ	Directorate Manager, Laboratory Services
Tracy Wooster	TW	Sister, Outpatients
Secretariat:		
Helen Jenkins	HJ	Business Support Manager
Apologies:		
Adam Christian	ACh	Clinical Board Director
Kim Atkinson	KA	Clinical Director of Allied Health Professions
Sarah Lloyd	SL	Director of Operations
Alison Lewis	AL	Patient Safety Coordinator
Seetal Sall	SS	Point of Care Testing Manager
Jamie Williams	JW	Senior Nurse, Radiology
Paul Williams	PW	Quality and Safety Lead, Medical Physics
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Bill Salter	BS	Lead Staff Representative
Sandra Watts	SW	Senior Nurse for EPMA, Pharmacy
Elaine Lewis	EL	General Manager, Pharmacy
Yvonne Hyde	YH	IP&C Team Representative
Timothy Banner	TB	Clinical Director, Pharmacy
Susan Beer	SB	Public Health Wales Representative
Kate Blower	KB	Shaping Change Team
Debra Woolf	DB	Sister, Outpatients
Edward Chapman	EC	Head of Clinical Engineering/ Medical Devices Officer/Assistant Director of Therapies and Health Sciences

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 25/222	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 25/223	**Apologies for Absence** Apologies for absence were noted.	
CDTQSE 25/224	**Minutes of the previous meeting** **The Group resolved that:** a) The minutes of the previous meeting were accepted as an accurate record.	
CDTQSE 25/225	**Matters Arising/Action Log** An update was provided on the outstanding actions from the previous meeting. *CDTQSE 25/172 Use of Personal Devices in the Clinical Setting* JF raised an issue at the last meeting on staff using their own personal devices in a clinical setting for the purpose of E-referrals and whether mitigation is in place should the device become damaged. SO will make enquiries on whether the bring your own device policy is being updated. HL asked SW, Senior Nurse for EPMA whether this issue has been considered as part of the implementation of EPMA and she will follow up on a response. *CDTQSE 25/207 UHB Approved Messaging App for Staff* SO has made enquiries and was advised that the most appropriate messaging app for staff to use is Microsoft Teams. **The group resolved that:** a) The updates to the outstanding actions were noted.	**SO** **HL**
6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 25/226	**Concerns and Compliments Report** In August 2025, the Clinical Board received 56 concerns: 4 formal and 52 early resolution concerns. There were 0 breaches in response times and 1 compliment was received. The key themes of concerns received in August were:	

	• Difficulties in cancelling/arranging appointments • Waiting times The key themes of concerns received year to date: • Difficulties cancelling/arranging appointments • Waiting times • Waiting times for test results/scan report The key theme of compliments received year to date are: • Excellent clinical treatment • Efficient service HL noted that there are forthcoming changes to the response times for early resolution concerns and enquiries. **Update from the Bereavement Team Following Changes to the Medical Examiner Process** KBa and KH presented the changes to the Medical Examiner Process. A bereavement service that sits within the Health Records department is available at both the UHW and UHL sites. The key purpose is to provide administrative support to doctors and the Medical Examiner to enable the timely completion of the MCCD (Medical Certificate and Cause of Death) forms for the relatives. Prior to Covid, the process involved relatives having to collect the MCCD from the Bereavement service. During Covid, to reduce footfall, the process was changed to a digital approach whereby the MCCD was written by what was then, Junior Doctors and the MCCD was then scanned to the registrars who registered the death. Relatives then collected the MCCD from the registrars' offices. On 9th September 2024, it became law that every death was to be scrutinised by the Medical Examiners' Service with the exception of Coroner referrals. This process involves a QR code that is completed by the doctors that automatically provides the Medical Examiner with the provisional cause of death and demographic information. The scrutiny of the medical records by the Medical Examiner is now an added step in the process that has put a delay in the relatives receiving the MCCDs, however when the death is registered by the Registrars the information is accurate. In terms of the health records process, the medical records are left with the ward for up to 48 hours, for the doctor to complete the QR code. When this is completed the notes are collected and then scanned to be sent to the Medical Examiner's Office for the Medical Examiner to review them. These are accessed through Cardiff Clinical Portal. When the Medical Examiner has completed their review, they will then send the MCCD digitally to the Registry Offices for relatives to collect.	

	The Medical Examiner Service is a 7-day service and the expectation is that the Health Records service follows suit. Whilst the scanning function is now 7 days a week, the Bereavement Service is not covered 7 days a week and during Bank Holidays there can be up to 4 days where there is no cover. A Care after Death SharePoint site has been set up to provide guidance for staff. Between January and May 2025 there has been an improvement of the time between death and completion of the QR code to 1.5 days. The issue is for doctors finding time to attend the Bereavement Office to complete the MCCD and the Bereavement team are having challenges with contacting and reminding doctors to visit the department. Weekly meetings are being held with the patient safety team to look at improving the escalation process and improve engagement with the bereaved. One improvement would be the introduction of digital MCCDs, whereby doctors could complete them on the wards, but this has been put on hold. **The Group resolved that:** a) HL will invite the concerns team to a future meeting to discuss the changes to the concerns process and the new timeframes for responding to enquiries and early resolution concerns. b) HL acknowledged the hard work of the bereavement team and commended the professional and sympathetic behaviours they show to relatives, particularly when they are having difficult conversations relating to delays in the process.	**HL**
CDTQSE 25/227	**National Reportable Incidents** The NRI Report was **RECEIVED.** A key focus of today's meeting was to share learning from NRIs that have taken place across a number of departments within the Clinical Board. **Learning from Incidents Relating to Pathology Delays** AS presented four incidents between June and July 2024 that met the threshold for NRI reporting. These all related to delays in pathology reporting which was due to similar themes and challenges within the Cellular Pathology laboratory. Incident 65285 The patient had GI biopsies collected on 16th April 2024, evaluated for Iron Deficiency Anaemia. The incident was not marked as a USC (Urgent Suspected Cancer) and therefore on 22nd May 2024 the slides were sent to an outsourcing	

	company, Diagnexia for external reporting. The report was available from 28th May, however there was a delay with the report being typed into the Laboratory Information Management System and the diagnosis was of an adenocarcinoma. This was a delay of 42 days from receipt to the report being available. A significant microtomy backlog contributed to a 30-day delay in this timeframe. At this time, there were around 4000 blocks in the backlog which equated to around 1500 patients. The outsourcing company, Diagnexia was being used to support reporting as there was a reporting deficit in the department. This was compounded by annual leave, sickness and Royal College of Pathologist guidelines, that sets a restricted number that can be reported by a pathologist safely in a given day. There was also an admin staffing shortage at the time where the typing was being undertaken by one person instead of four. A new Laboratory Information System was also being introduced so usage of the system was not as effective and efficient at that time. Incident 64066 Gastro biopsies were taken in UHL on 26th March 2024. The clinical history was described as IDA (Iron Deficiency Anaemia). The priority of USC was identified on the request form. An incidental diagnosis of diffuse gastric cancer was reported on 24th June 2024, 90 days from receipt to reporting. Again, there were similar issues relating to the microtomy backlog. In this instance, the case was reported inhouse, as cases marked as USC tend to be reported in-house rather than sent off for external reporting. However, the size of the reporting backlog at the time, and the need for extra work requests that were required, whereby immunohistochemistry was also requested for further definitive diagnosis, resulted in a 37-day delay in reporting. Incident 66528 The patient attended Endoscopy on 17th March 2025 and the results were not available until 18th July 2024. There were delays within Cellular Pathology of 4 months. The diagnosis was a Grade 1 neuroendocrine tumour and took 123 days from receipt to reporting. There was a 13 day delay due to a delay in the case being booked onto the LIMS system, which is less than one month following the go live date of the new system. There was a 61-day delay linked to the microtomy backlog and when the case was taken for reporting, extra work was required as there was no indication on the request form to identify the case as urgent or USC so it was placed in the routine stream.	

	Each of the above cases were affected by the similar factors described. Confirmation was received from the clinicians involved in each patient's care that the outcome for each of these patients would have been the same regardless of the delays. However, the psychological impact the patients would have experienced due to these delays was likely to have been significant and distressing. Measures were taken to review processes and improve the turnaround times and a number of recommendations were made: Cellular Pathology should continue monitoring KPIs for the microtomy backlog. At the lowest point there was a backlog of around 4500 and at February this year this reduced to 101, which is no longer a backlog and represents a half day's work. Ensure minimum staffing levels for Consultant Pathologists are met to prevent delay in diagnosis. If this cannot be achieved due to recruitment difficulties, then utilisation of reporting scientists should support service delivery. Ensure the functionality to perform outstanding worklists on LIMS is explored and implemented to allow for better oversight of any outstanding cases. Cellular Pathology should be involved with the planning of increased workflows through Endoscopy and Surgery. Streamline processes within the laboratory to ensure there is no backlog of cases. Improve compliance with staff training and competence to ensure that staff working in the most efficient and effective way. Process changes have been implemented and include: Daily microtomy KPIs are shared with the Clinical Board for assurance and oversight. The Cellular Pathology Management team attend a weekly cancer performance meeting with the Clinical Board for a deeper dive of USC patients, ensuring that any outstanding cases are identified and escalated as necessary. Reporting capacity has been augmented with outsourcing and the use of commercial capacity. A capacity plan has been undertaken recognising the deficit in reporting of approximately 1 wte consultant. The department signed up to the All-Wales Collaborative to support shared learning and ensure the principles of Lean Management became a fundamental aspect of the service. This involved links and training with Toyota Lean Management	

	Centre, who supported streamlining processes and removing waste from the system. Workforce plans have been assessed as per the demand of services. The department has employed a full-time cancer tracker to aid with the identification and escalation of patients on either the PTL or SCP. 1 reporting scientist is already in post, a second post is in the process of being recruited to. BJ acknowledged the huge amount of work undertaken in the Cellpath department to improve the position and noted that as well as a better patient experience the department is a much-improved working environment and has improved the mental wellbeing of staff. SO referred to the training undertaken with Toyota and if this has spread wider than the team. SG noted that WG spread this across all Health Boards in Wales and there have been opportunities for shared learning across Health Boards. SO asked if there will be a review of the learning process. It was noted that this will be undertaken as part of the collaborative process. **NRI 43651** SR shared a case review involving a patient fall on Glan Ely Ward in 2023 at the time when this was part of this Clinical Board. An 87-year-old with an advanced medical history was admitted to the ward for rehabilitation. On 11th October 2023, he was meant to be having one to one supervision on the ward, and due to issues occurring on the ward, he was left unsupervised and sustained a fall. He was found at the side of the bed area at night during the night shift and had a bump to the head and bruising. As per protocol, he was transferred to UHW but his condition deteriorated and he passed away on 14th October 2023. The incident was RIDDOR reportable and an NRI. A focused falls review was undertaken and a review of the enhanced supervision took place. The lessons learned identified poor use of the enhanced supervision framework. Also, there was a lack of adherence to the falls risk protocols. Recommendations were made to reinforce enhanced supervision procedures. Improve training on falls management. Ensure proper escalation for high-risk patients. The case was presented at Coroner's Court and a Regulation 28 was issued. The Coroner raised concerns around enhanced supervision practices, risk assessment protocols and the need for systematic improvements in patient safety and supervision.	

	An action plan was put in place to address staff training on falls management. Review and reinforce supervision protocols and implement audit mechanisms for compliance. Improvements had also already been put in place across the Health Board on falls management and the UHB were able to evidence this to the Coroner's Court. Whilst this incident occurred on Glan Ely Ward, it could easily have taken place elsewhere. Enhanced supervision is challenging to manage and on a busy ward, particularly where human instinct is to respond to another patient if they call out. **NRI 57482** This case involved a 70-year-old patient referred by their GP on 26 January 2023 for a suspected upper gastrointestinal malignancy. Due to an issue with the Health Board's digital referral system, the referral was not processed correctly and remained undiscovered until a second referral of expedition was submitted by the GP practice 6 weeks later. The patient did not receive an OGD until March 2023, resulting in a total delay of 50 days between the original USC referral and the investigations in Endoscopy. The patient sadly passed away in March 2024. This was an incident involving multiple Clinical Boards and departments. An NRI process commenced and the case was investigated, following a review of the case by the Medical Examiner, who submitted a number of questions to the Health Board. The review identified that the referral was made correctly via the Welsh Patient Referral Service but due to a technical glitch in the system, whilst the referral was processed correctly, the glitch prevented the referral from being sent to the onward part of the Welsh Clinical Portal, where clinicians review and triage and make decision around results. BJ asked if there is assurance that there have been no further incidents. SO noted that a new version of the system has been launched which rectified the glitch and there have been no further incidences of this issue. The Health Records Team have also been instructed to escalate any unusual activity linked to processing. A key recommendation from the investigation was that all Clinical Boards should implement a robust process to ensure that they monitor their zero status referrals reports. The UHB Planned Care Board will be implementing this as a KPI. **Radiology NRIs** 71935/ 81055 (reporting errors)	

	71935 related to a patient who received a CT scan in 2021. This was reported as normal but unfortunately there was an abnormality present, whereby a right lower lobe nodule should have been reported. This resulted in a delayed diagnosis of lung cancer of 3 years. The patient subsequently had an increase in their staging from 1A to 1B. The investigation was unable to identify the cause of the error as there were no external factors leading to the error. In 2021. the breast MDT was only covered by one Radiologist. This led to increased pressure and often resulted in only the report being reviewed in MDT and not the images. There are now 2 Radiologists for every breast MDT. 81055 This incident was in relation to a patient who attended A&E and had a CTC Spine performed in August 2024. The A&E attendance was following a fall and the CT was performed in the context of Trauma. There was a neck mass which was present on the CTC Spine which was not reported on at the time. This resulted in a 6-month delayed diagnosis of lymphoma. The patient subsequently presented for an MRI scan via her GP that was performed in February 2025 and it was at this point that they were diagnosed with lymphoma. The CTC Spine scan was reported by an external company, who undertook a review. There was no identifiable cause for the reporting error and no external factors were identified that could have contributed to the error. With regards to recommendations and learning, errors of perception are one of the most common errors within Radiology. Where there are no external factors identified that could have led to an error, the actions that can be put in place are limited. These cases are therefore discussed at Radiology events and learning meetings to increase awareness and education. NRI 72489 The third case related to a delayed chest x-ray report. The patient presented as an emergency admission and went on to have an Inguinal hernia repair during their admission. The discharge advice letter indicated that the chest x-ray had no abnormality detected and this was undertaken by a member of the surgical team. The chest x-ray was formally reported on 12th August and raised suspicion of malignancy and recommended CT, which was performed a few days later. This confirmed a diagnosis of lung cancer. Plain films are reviewed by doctors on the ward for inpatients and this abnormality was not identified by the surgical team who reviewed the chest x-ray. They will have a limited understanding and appreciation for image interpretation and is	

	the reason why a formal Radiology report is issued for all imaging. A key issue in this case is that it took 136 days to issue the report due to reporting capacity and demand at that time. Recommendations and actions taken following this investigation was that the case was to be discussed at Surgery and Perioperative Quality and Safety meetings, highlighting the requirement to document review of tests. Improvements to be made to plain film reporting capacity, including the prioritisation of inpatient plain films. Radiology to explore whether there is suitable Artificial Intelligence Software to support flagging/prioritisation of plain films for priority reporting. **The Group resolved that:** a) The incidents were noted for shared learning and the presentation slides will be shared with the Group.	
CDTQSE 25/228	**Duty of Candour Cases/Claims/LFERs** **The Group resolved that:** a) All of the incidents presented at today's meeting have been subject to the Duty of Candour process.	
CDTQSE 25/229	**Risk Register Updates** It was noted that departments have been informed to transfer their risk registers onto the AMAT system. BJ reported that the National LIMS Programme has been delayed, with Cardiff and Vale go live date delayed until December. This will result in the LIMS system in Laboratory Medicine and the RISP system in Radiology both going live within a short space of each other. JD reported that Podiatry couches are reaching end of life and there is cost related to their replacement. The Podiatry team based at Denbigh House are concerned that no alternative accommodation has been identified, despite notice of the closure of Denbigh House. JD also noted that discussions are being held with Mental Health Clinical Board in relation to the withdrawal of Speech Therapy services from Hafan-Y-Coed. JF referred to the PET centre ceasing production of radiopharmaceuticals. Whilst this relates to Cardiff University, this impacts on Radiology workforce and the department is in the process of producing a risk assessment.	

	The Group resolved that: a) The risk register updates were noted.	
CDTQSE 25/230	**Patient Safety Alerts** **The Group resolved that:** a) No new alerts have been received.	
CDTQSE 25/231	**Medical Device/Equipment Risks** **The Group resolved that:** a) There were no issues to report.	
CDTQSE 25/232	**Point of Care Testing** **The Group resolved that:** a) There were no updates to report.	
CDTQSE 25/233	**IP&C/ Decontamination Issues** The UHB IP&C Group was held last week and there was a focus on ANTT. SR is linking in with relevant departments within the Clinical Board around improving compliance. Flu clinics are now running across sites for staff to obtain the flu vaccination. Flu Champions are also undertaking walk rounds across sites. SR noted that the Water Safety group is being held this week. **The Group resolved that:** a) The feedback relating to IPC was noted.	
CDTQSE 25/234	**Safeguarding Update** SA, Safeguarding Lead was in attendance. She noted that following the retirement of LH-J, Fiona Bullock is the Interim Acting Head of Safeguarding. She provided an update on the members of the team and the contact details for the service. In terms of safeguarding training, Level 1 and 2 are mandatory on ESR. Under Agenda for Change, Level 3 training is mandatory for any clinical staff Band 6 and above or equivalent and F1 medical staff, regardless of whether their role is patient facing. Only 1 session needs to be completed e.g. either adults or children in order to be compliant. The training requirement is every 3 years.	

	In terms of training compliance, this Clinical Board is reporting 82.21% compliance against Level 1 violence against women, domestic abuse and sexual violence. 88.75% compliance for Level 2 Safeguarding Adults module. Level 3 compliance across the UHB needs significant improvement. The latest compliance figures will be shared. There were issues with staff having access to Level 3 training but this is now available via Teams. National Safeguarding Week is running10-14th November and the regional theme is Child Sexual Abuse. A regional conference is being held on 14th November. The current safeguarding topic of focus is Prevent. This is part of the UK's counterterrorism Strategy Framework. Prevent is the UK's current level of the framework which is to stop people becoming or supporting terrorism. There has been a rise in individuals participating and supporting terrorism rather than large extremist groups. This increase has risen from social media and internet activity. Anyone is susceptible to extremism and if staff are concerned about an individual to contact the safeguarding team and a referral can be made to Prevent. The counterterrorism team review each referral to ensure there is no immediate security risk and check if there is a risk of radicalisation. The Safeguarding team sit on a panel to decide if a person is at risk and the individual is invited to join a support programme. This is voluntary and if the individual refuses to participate, they may be offered support instead. **The Group resolved that:** a) SA will share the presentation slides, particularly for the contact details slide that can be cascaded across teams. b) Suggestions for future topics to present at this group were self-neglect, domestic abuse and lasting power of attorney. SA will create a list. c) The Clinical Board is presenting its AS1 and MARF referral audit to the next Safeguarding Group and this will be shared at a forthcoming meeting of this group.	**HL**
CDTQSE 25/235	**Consent issues** **The Group resolved that:** a) It was agreed that this item will be discussed under the safeguarding agenda item for future meetings.	
CDTQSE 25/236	**Health and Safety/Staff Wellbeing**	

	The Group resolved that: a) There were no issues to report.	
CDTQSE 25/237	**Regulatory Compliance** HL reported that the HTA have undertaken recent inspections in the Stem Cell Processing Unit and Cellular Pathology. The inspectors commented on the welcoming approach from staff and their knowledge and experience. A JACIE inspection was also held in the Stem Cell Processing Unit last week. **The Group resolved that:** a) Good feedback was received from all the inspections.	
TIMELY		
CDTQSE 25/238	**Waiting Times Performance** BJ reported that Radiology performance deteriorated in month by nearly 900 patients following 2 months of good improvement in their position. This was compounded by workforce issues and scanner downtime. The 8-week breach position at the end of August was 8790. Performance in all services in Therapies also deteriorated, linked to the recruitment issues. Whilst the Weight Management Service performance figures are not reportable, a risk assessment is being produced in regard to the level of referrals being received linked to injectables. Injectables can only be prescribed by the level 3 weight management service and the demand for this service is now beyond control. A strategy group has been set up in Cardiff and Vale as the level of resources available will never be able to meet the level of demand. The increase in concerns being received from patients who are requesting the service is challenging for the team and this issue will be discussed at a future meeting. JD will follow up with the Head of Dietetics for an update on progress in producing the risk assessment. **The Group resolved that:** a) Waiting times performance is monitored and discussed in detail in the directorate performance review meetings.	**JD**
EFFECTIVE		
CDTQSE 25/239	**Feedback from UHB QSE Committee 5th August** HL reported that the Clinical Board's Annual Report was presented on 5th August and this was well received. The report will be circulated to the group for information.	

	A patient story was presented on one of the first patients who accessed the Thrombectomy Service that had recently gone live in Cardiff and Vale. The story demonstrated the positive impact, benefits and good outcomes for patients who will receive this service. **The group resolved that:** a) The minutes from the meeting held on 5th August 2025 were circulated and the key issues noted.	
CDTQSE 25/240	**Research and Development** RM asked if deputies could attend the R&D Group when their leads are unable to attend. Therapies are unable to appoint to a funded research post given the current enhanced scrutiny on recruitment. RM is seeking volunteers for speakers for the R&D Forum. HL encouraged colleagues undertaking academic study to be involved in the R&D Forum. **The Group resolved that:** a) The minutes from the R&D Group meeting held in July were circulated.	
CDTQSE 25/241	**Service Improvement Initiatives** SO will ask KB to provide a highlight report for this group for an update on the initiatives that are in progress within this Clinical Board. JD noted that Therapies are undertaking a lot of work with the Value in Health Team. **The Group resolved that:** a) There were no initiatives to report.	**SO/KB**
CDTQSE 25/242	**Information Governance/Data Quality** SO stressed the importance of staff being mindful of phishing attempts and for staff to undertake the mandatory training module for information governance. He noted that the Clinical Coding are undertaking collaborative work with the Stroke team around the quality of data. SO is also linking in with the Discharge of Letters Group around the quality of information in discharge letters.	

	The Group resolved that: a) The data quality work currently being undertaken was noted. b)	
CDTQSE 250/243	**HIW/Llais Reports and Improvement Plans** **The Group resolved that:** a) No reports or improvement plans have been received.	
CDTQSE 25/244	**Policies, Procedures and Guidance (including NICE Guidance)** **The Group resolved that:** a) There were no new local policies or procedures to be reviewed.	
EFFICIENT		
CDTQSE 25/245	**Feedback from Directorate QSE Meetings** Dietetics have submitted a Datix relating to a security issue in their department. This will be discussed in the Health and Safety Group. AHP Week is due to be held next month. JF noted that guidelines have been produced to support CT. This will be included in hospital pathways. **The Group resolved that:** a) HL requested for departments to submit their action notes, minutes or summaries from their QSE Groups.	
CDTQSE 25/246	**Clinical/Internal Audits** **The Group resolved that:** a) There were no audits to report.	
CDTQSE 25/247	**Sustainability** HJ advised that the UHB Green Group has been reinstated. The EU team presented an infographic on the steps required to achieve EU accreditation and it was requested that this is shared with the Green Group. **The Group resolved that:** a) The update on sustainability was noted.	

EQUITABLE		
CDTQSE 25/248	**Feedback from Clinical Board Inclusion Ambassadors Group** The Race Equality Standards have recently been updated. **The Group resolved that:** a) HL will ask the Equality Adviser to present on the updated Race Equality Standards at a future meeting. b)	**HL**
CDTQSE 25/249	**Equality and Diversity Issues** This item will be incorporated with the Inclusion Ambassador agenda item at future meetings. **The Group resolved that:** a) There were no further issues to report.	
PERSON CENTRED		
CDTQSE 25/250	**Patient Story – Medical Illustration** MM presented a patient story involving a compliment that was received from bereaved parents in the maternity service expressing their gratitude to the clinical photographer that attended the maternity unit to take photographs for them to take home. Clinical Photography regularly receive requests for this service whereby the bereaved family will have a set or prints taken by the photographer with a card and they are also offered the opportunity to have the digital copies. Families are currently provided with the prints and card in a standard white envelope and the team are exploring the option of inserting the prints and card into a higher quality envelope that will be more meaningful for the family as a keepsake as opposed to a standard envelope. MM will share an update at a future meeting on how this progresses. **The Group resolved that:** a) The patient story highlighted that this is one of the services provided by the Medical Illustration team which is often unknown across the UHB. b) Occupational Therapy are due to present their patient story at the next meeting.	
CDTQSE 25/251	**Patient Experience Feedback** **The Group resolved that:**	

	a) HL will circulate Civica reports when they are received.	
CDTQSE 25/252	**Internal/External Awards** Medical Illustration were successful in achieving a number of awards at the Annual Medical Illustration Awards. The Dietetics Liver Project was awarded at the BAPEM Conference. **The Group resolved that:** a) The successes within the Clinical Board were noted.	
CDTQSE 25/253	**Good News Stories** **The Group resolved that:** a) There were no further good news stories to be shared.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 25/254	Regulatory Compliance Group Minutes 11.9.25 Health and Safety Group Minutes 4.8.25	
ANY OTHER BUSINESS		
CDTQSE 25/255	Nothing further to report.	
CDTQSE 25/256	**Date & time of next Meeting** The next meeting will be held on 23rd October 2025 at 10am via Teams.	

Minutes of the Clinical Diagnostics and Therapeutics Clinical Board
Quality, Safety and Patient Experience Sub-Committee

Held on 29th October 2025

Present:		
Helen Luton (Chair)	HL	Director of Nursing/Multi Professional Teams
Becca Jos	BJ	Deputy Director of Operations
Sarah Lloyd	SL	Director of Operations
Melissa Melling	MM	Head of Medical Illustration
Rhys Morris	RM	CD&T R&D Lead/Director of MPCE
Edward Chapman	EC	Head of Clinical Engineering/ Medical Devices Officer/Assistant Director of Therapies and Health Sciences
Kim Atkinson	KA	Clinical Director of Allied Health Professions
Susan Beer	SB	Public Health Wales Representative
Kate Blower	KB	Shaping Change Team
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry
Elaine Lewis	EL	General Manager, Pharmacy
Jonathan Davies	JDa	Health and Safety Adviser
Sian Jones	SJ	Directorate Manager, Laboratory Services
Jo Fleming	JF	Quality Lead, Radiology
Alison Lewis	AL	Patient Safety Coordinator
Secretariat:		
Helen Jenkins	HJ	Business Support Manager
Apologies:		
Adam Christian	ACh	Clinical Board Director
Emma Holmes	EH	Head of Nutrition and Dietetics
Keeley Baker	KBa	Head of Health Records
Ruth Lang	RL	Office Manager, AWTTC
Suzanne Rees	SR	Lead Nurse for CD&T
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Seetal Sall	SS	Point of Care Testing Manager
Jamie Williams	JW	Senior Nurse, Radiology
Paul Williams	PW	Quality and Safety Lead, Medical Physics
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Bill Salter	BS	Lead Staff Representative
Sandra Watts	SW	Senior Nurse for EPMA, Pharmacy
Alana Adams	AA	Principal Pharmacist, Welsh Medicines Information and Advice Service
Yvonne Hyde	YH	IP&C Team Representative
Timothy Banner	TB	Clinical Director, Pharmacy
Julia Dinley	JD	Head of Speech and Language Therapy
Sue Lawless	SL	Laboratory Service Manager, Haematology
Debra Woolf	DB	Sister, Outpatients
Tracy Wooster	TW	Sister, Outpatients

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 25/257	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 25/258	**Apologies for Absence** Apologies for absence were noted.	
CDTQSE 25/259	**Minutes of the previous meeting** **The Group resolved that:** a) The minutes of the previous meeting were accepted as an accurate record.	
CDTQSE 25/260	**Matters Arising/Action Log** An update was provided on the outstanding actions from the previous meeting. *CDTQSE 25/172 Use of Personal Devices* Medics had requested exploring for the possibility of EPMA for them to use on their personal devices. Discussions have been held with the digital team but it was noted that EPMA does not have an app that can be downloaded onto personal devices. *CDTQSE 25/226 Process for Dealing with Concerns* The new process in terms of 'Putting Things Right' has yet to be finalised, therefore HL will invite the Concerns Team to attend a future meeting when the new process is officially ratified. *CDTQSE 25/238 Risk Assessment for Level 3 Weight Management Service* EH to confirm that a risk assessment has been produced. *CDTQSE 25/241 Service Improvement Report* KB to provide a high-level report showing the service improvement projects that the Shaping Change team are supporting for this Clinical Board. *CDTQSE 25/248 Welsh Race Equality Standards* HL has requested for the UHB Equality Adviser to attend a meeting in the New Year. **The group resolved that:** a) The updates to the outstanding actions were noted.	**HL** **EH** **KB**

6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 25/261	**Concerns and Compliments Report** In September 2025, the Clinical Board received 53 concerns: 4 formal and 49 to be resolved through early resolution. There were 2 breaches in response times. 1 compliment was received. The main themes of the concerns received in September related to difficulties cancelling and arranging appointments and the waiting time for test results or scan reports. The key themes of the total concerns received this year are difficulties cancelling/arranging appointments, waiting times and the waiting time for test results/scan reports. The key theme of compliments received this year are excellent clinical treatment and efficient service. **The Group resolved that:** a) The 2 breaches in response times were complex concerns involving responses needed from multiple Clinical Boards.	
CDTQSE 25/262	**National Reportable Incidents** Incident 44284 relates to a local learning review within Cellular Pathology that can be closed. Incident 86176 relates to an adult ENT patient in Outpatients that can be closed this week. Incident 89726 relates to a DXA scanning incident in Medical Physics that is also due to close this week. Incident 89392 relates to the issue within the Biochemistry laboratory related to the PSA reagent. The investigation is awaiting finalising information from Urology prior to completion. **The Group resolved that:** a) Both the Biochemistry and DXA incidents have been particularly complicated and very technical. Producing a report that is written in such a way that it is understandable to the patients, whilst providing the appropriate level of technical information has been challenging. Significant efforts are being made by those involved in the investigation to meet the timeframes for submission given these were complex incidents involving multiple patients.	
CDTQSE 25/263	**Duty of Candour Cases/Claims/LFERs** **The Group resolved that:**	

	a) All of the incidents presented at today's meeting have been subject to the Duty of Candour process.	
CDTQSE 25/264	**Risk Register Updates** HL thanked HJ for supporting both the Clinical Board and directorates in transitioning their risks to the AMAT system. The level of vacancies across the Clinical Board is a key risk and directorate are encouraged to complete impact assessments. **The Group resolved that:** a) The updates relating to risks were noted.	
CDTQSE 25/265	**Patient Safety Alerts** **Safety Memo – Laboratory Results on CAV Clinical Portal** It has been identified that some test results for Biochemistry, Immunology, Toxicology and Haematology are not being displayed in CAV clinical portal, however all test results are available in the Welsh Clinical Portal. **PAS019 Harm from delayed administration of rasburicase for tumour lysis syndrome** The alert was shared for information. **The Group resolved that:** a) The alerts were noted.	
CDTQSE 25/266	**Medical Device/Equipment Risks** **The Group resolved that:** a) There were no issues to report.	
CDTQSE 25/267	**Point of Care Testing** **The Group resolved that:** a) There were no updates to report.	
CDTQSE 25/268	**IP&C/ Decontamination Issues** There is a prevalence of influenza and norovirus cases within the Health Board and the community. The IPC team have issued a reminder to staff on their responsibilities if they experience symptoms.	

	The Group resolved that: a) All staff are encouraged to receive the flu vaccination.	
CDTQSE 25/269	**Safeguarding /Consent Issues** A template was circulated from the Mental Capacity Act Group for Clinical Board to highlight where they have had any MCA or DoLs cases. **AS1 and MARFs audit** Clinical Boards were tasked to audit their referrals into safeguarding services. with a view to improving the quality of the referrals. The majority of referrals from this Clinical Board related to child safeguarding referrals. 18 referrals were reviewed by 2 sets of reviewers. There were 16 MARFs and 2 AS1s. The results identified that: • 15 of the 18 referrals had appropriate information gathered. • 4 of the 18 were repeat referrals. • Consent boxes were completed in 100% of the referrals. • For the AS1's, capacity was recorded. Recommendations for areas of improvement included: • Ethnicity was only recorded in 50% of cases. • In 4 of the 18 cases the concern and nature of the abuse was not classified well. • Evidence of discussion or engagement with other Health Professions involved in the child's care was not documented in all the referrals. • Explore further around the family history and family circumstances. • 100% of consent was received but consent issues could have been explored more fully. • Voice of the child was not considered in the majority of referrals. • It was not always clear in the referral whether reasons for not attending had been explored including steps taken to contact the family prior to a referral. • The Was Not Brought Policy needs to be reviewed in line with Public Health Wales guidance. **The Group resolved that:** a) The audit results were noted.	
CDTQSE 25/270	**Health and Safety/Staff Wellbeing** JD noted that there are significant numbers of actions from fire risk assessments that are not being closed.	

	The Group resolved that: a) Directorates to close down any actions that are showing as open on the dashboard.	**Dirs**
CDTQSE 25/271	**Regulatory Compliance** **The Group resolved that:** a) The minutes of the previous Regulatory Compliance group were circulated for information.	
TIMELY		
CDTQSE 25/272	**Waiting Times Performance** **The Group resolved that:** a) Waiting times performance is monitored and discussed in detail in the directorate performance review meetings.	
EFFECTIVE		
CDTQSE 25/273	**Feedback from UHB QSE Committee** **The group resolved that:** a) The minutes from the meeting held on 16th September 2025 were not yet available.	
CDTQSE 25/274	**Research and Development** RM reported that R&D Leads have submitted summaries of their current activity to the UHB Joint Research and Governance Group. AWTTC have 2 projects ongoing. Radiology highlighted their key involvement in the successful Huntingdon's disease trial that was featured in the media, where the scans were undertaken at UHW and is the only centre in the UK that participated in this trial. Therapies reported encouraging results from a TRICEPS trial. **The Group resolved that:** a) The R&D update was noted.	
CDTQSE 25/275	**Service Improvement Initiatives** Mr David Scott Coombes, Assistant Medical Director, was welcomed to the meeting. He has been collaborating with Cath Wood, Managing Director of Planned Care and Jessica Jones, Project Manager, Shaping Change Team as part of a drive to improve productivity and performance in Outpatients.	

	As of early this month, 76,000 patients were waiting for a first appointment, with 13,000 of those waiting over a year. This is a cross Clinical Board issue. A major contributing factor is the failure to record consultation outcomes, leading to 2,800 unrecorded cases in September and 19,000 since January. This lack of documentation creates risk to patients and is essentially a failure between the clinician, and the coordinator to record on the system the outcome for the patient. The primary reason for this is the clinical outcomes form. This was introduced over decade ago following a Welsh Government initiative**.** The form is complex and filled with obscure codes and terminology. To improve clarity and efficiency, meetings were held with clinicians and coordinators from across all Clinical Boards who have a PMS background and understand patient flow. Collaboratively, the top half of the form has been redesigned to simplify the number of options. At the same time there is a drive for See on Symptoms (SOS) and Patient Initiated Follow Up (PIFU) as two preferred outcomes to a routine follow-up to support the carve out of more capacity, with the aim for 20% of patients to be managed this way. The new form uses plain English and includes options for virtual follow-ups and diagnostics. Despite the desire for a digital solution, resource constraints mean the system will currently remain paper-based, except for those using COM 2, which already supports outcome recording. Many clinicians prefer the Welsh Clinical Portal for its imaging and test request capabilities, making a full transition to COM 2 impractical. However, there is a commitment to eventually digitise the process across platforms. The lower half of the form remains specialty-specific and unchanged, as it supports tracking investigations and subsequent actions. The updated form is set to launch on Monday 3rd November and feedback is encouraged. Jenny Pinkerton, Clinical Lead Occupational Therapist, Medicine Team and Ella Short, Team Lead for the Medicine Team were welcomed to present a service improvement initiative within the Medicine's Occupational Therapy service, which then led to their patient story. The service improvement highlighted a shift towards a more efficient and patient-centred model of care. Previously, each ward had one dedicated occupational therapist who received referrals during board rounds, but a service review revealed significant challenges including limited capacity due to staffing shortages, and an imbalanced skill mix. Operational pressures further strained the team's capacity. A deep dive into caseloads	

	revealed that 66% of time was spent on tasks that detracted from core Occupational Therapy assessments, such as administrative duties and coordination efforts such as house clearance arrangements. Duplication in multidisciplinary assessments and poor communication also disrupted workflow, with OTs often assuming discharge coordinator roles. In response, the OT Medicine team adopted value-based healthcare principles, focusing on the unique contributions of occupational therapy and encouraging practitioners to work at the top of their capabilities. The team identified that tasks exclusive to occupational therapists provided the highest value to patients and the organisation. A staff wellbeing analysis showed a sharp decline from July to August, due to reduced staffing hours and inconsistent ward coverage. To address these issues, the team introduced an Occupational Therapy Outreach Service, centralising referrals through a duty desk and enabling therapists to prioritise and cover all Medicine wards. New tools, including a prioritisation framework and Microsoft Lists, were implemented to support caseload management. The change has allowed for increased staff training and support, with positive feedback from nursing teams and successful implementation at St David's Hospital. The model promotes individualised assessments focusing on cognition and functional ability, improving discharge planning. Clear expectations have been set for assessments, and digital tools are used to enhance support. Ten days after implementation, 50% of OT caseloads now consist of tasks only OTs can perform, marking a 16% increase. An audit of 20 patients showed a dramatic improvement in response time to referrals, dropping from 3.85 days to 0.25 days, and a reduction in referral-to-discharge time from 16.4 days to 4.2 days. Staff wellbeing among OTs has improved since August, though OT Technicians' wellbeing has declined since June, prompting further investigation. Staff feedback on the changes has been positive, with 92% of comments expressing support and engagement. It has been acknowledged that the MDT have been less positive to the service change, however the changes will place the OT team in a stronger position as the pressures of winter approaches. The patient story shared during the meeting reflects many patients' experiences and health journeys encountered by the medicine team. **The Group resolved that:**	

	a) SO and the Patient Administration team including clinic coordinators have been fully briefed and involved in the improvement to the Clinical Outcomes Form. b) HL asked JF if the sleep team in Paediatric Radiology could present at a future meeting. JF noted it has also been requested for their work to be presented to a future Ask Suzanne session.	
CDTQSE 25/276	**Information Governance/Data Quality** **The Group resolved that:** a) There were no issues to report.	
CDTQSE 250/277	**HIW/Llais Reports and Improvement Plans** **The Group resolved that:** a) No reports or improvement plans have been received.	
CDTQSE 25/278	**Policies, Procedures and Guidance (including NICE Guidance)** A Radiology SOP for communication of alerts and significant findings has been ratified. The process is currently manual and there will be further changes to the procedure when the new radiology system is implemented. **The Group resolved that:** a) There were no other local policies or procedures to be reviewed.	
EFFICIENT		
CDTQSE 25/279	**Feedback from Directorate QSE Meetings** Therapies QSE Minutes were submitted. Radiology has noted an increase in incidents relating to requests being submitted for the wrong patients that were not detected prior to their imaging, which has resulted in a number of reportable incidents to HIW under IRMER. To help address this issue, a safety memo is being developed to increase awareness and this will be distributed through the Patient Safety Team. **The Group resolved that:** a) HL requested for departments to submit their action notes, minutes or summaries from their QSE Groups.	

CDTQSE 25/280	**Clinical/Internal Audits** SJ reported that Laboratory Medicine have contacted the IPC team to request for IPC audits to be undertaken across the directorate. **The Group resolved that:** a) It would be useful for any departments involved in national audits to present them to this group where other directorates could benefit from any shared learning.	
CDTQSE 25/281	**Sustainability** **The Group resolved that:** a) There were no updates on sustainability to report.	
EQUITABLE		
CDTQSE 25/282	**Equality, Diversity and Inclusion Issues/ Inclusion Ambassadors Update** **The Group resolved that:** a) There were no issues to report.	
PERSON CENTRED		
CDTQSE 25/283	**Patient Story – Occupational Therapy** Mrs. Jones was admitted to hospital following an unwitnessed fall at home, which led to confusion and a noticeable decline in her confidence. Prior to admission, she lived independently with her husband and whilst both were quite elderly they managed all activities of daily living (ADLs) without external care support. On the ward, however, she required assistance with washing and dressing, used a bedside commode instead of walking to the toilet, and needed supervision for transfers and mobility, including verbal prompts to use an A-frame safely. Occupational therapy assessed her using a person-centred model, identifying her strong desire to return home despite increased anxiety and cognitive deterioration. Her home environment posed challenges: the bathroom was upstairs, there was no downstairs toilet or community alarm, and no equipment had been in place before her admission. Although her family was supportive with helping with shopping, appointments, and domestic tasks, they had growing concerns about her cognition and medication adherence. A personal care assessment confirmed she needed assistance, and a physiotherapy stair assessment led to a	

	referral to the Community Resource Team (CRT) for continued support at home. Plans were made for 1 care visit per day, but her discharge was postponed due to a decline in her health on the ward. This delay increased the risk of further deconditioning. The family continued to raise concerns about Mrs Jones' cognitive impairment and Occupational Therapist completed an Allen's Cognitive Disability Model assessment to better understand her cognitive level and guide safe discharge planning. Her equipment needs were evaluated in relation to her cognitive function to ensure safe use at home. To enable Mrs Jones to remain as independent as possible, the visual and verbal cues that she would need to support her safety were also identified. A referral was made for CRT to provide continuing care and assessment post-discharge. The outcome for Mrs Jones was that she could return home with her husband as she wished and would be supported to be as independent as possible, whilst reducing the risk of falls at home. **The Group resolved that:** a) The patient story highlighted how a service change implemented to address a deteriorating situation has had a positive impact on patients. b) There is a plan for the next PDSA cycle to focus on the medical outliers not on the medical wards, to understand the service they are receiving and identify if there is equity. c) HL suggested that following the next PDSA cycle, this work is shared with the wider Medicine Clinical Board. Also with the OPAT team, to demonstrate how the service change has impacted positively on flow.	
CDTQSE 25/284	**Patient Experience Feedback** **The Group resolved that:** a) HL will circulate Civica reports when they are received.	
CDTQSE 25/285	**Internal/External Awards** **The Group resolved that:** a) There were no success stories to share.	
CDTQSE 25/286	**Good News Stories** There has been good engagement from directorates in with the Senior Management Team's Roadshow Sessions to encourage uptake of the Staff Survey.	

	The Clinical Board is current reporting an uptake rate of 17% and is also reporting the highest uptake of the Clinical Boards. **The Group resolved that:** a) Departments are asked to continue to promote the survey to their staff.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 25/289	Regulatory Compliance Group Minutes 7.10.25 Health and Safety Group Minutes 2.10.25	
ANY OTHER BUSINESS		
CDTQSE 25/290	Nothing further to report.	
CDTQSE 25/291	**Date & time of next Meeting** The next meeting will be held on 24th November 2025 at 10am via Teams	

INFECTION PREVENTION AND CONTROL GROUP

Monday 30th June 2025
Via TEAMs
MINUTES

Present:	
Jason Roberts (chair)	Executive director of Nursing
Abigail Holmes	Director of Midwifery and Neonatal Services Obstetrics & Gynaecology
Anna Mogie	Deputy Director of nursing PCIC CB
Andy Jones	Director of Nursing WCH CB
Andrew Poole	Capital Planning, Estates and Facilities
Catherine Twamley	Director of Nursing Specialist CB
Clare Wade	Director of Nursing Surgery CB
Ceri Richards-Taylor	Lead nurse integrated medicine
Gareth Simpson	Estates Manager
Helen Bonello	Senior Nurse Professional Standards Nursing
James Hughes	Health protection
Jo Clements	Lead Nurse Critical Care Directorate
Mark Campbell	Head of Decontamination
Marianne Seabright	Lead Nurse MHSOP and Neuropsychiatry
Rachael Daniel	Health and Safety
Rishi Dhillon	Consultant microbiologist, IPC doctor
Suzanne Rees	Lead Nurse CD&T
Yvonne Hyde	Head of Nursing IPC
Tea Racic (notes)	IPC Admin
Apologies:	
Barbara Davies	Director of nursing PCIC CB
Clare Main	
Dino Motti	
Gavin Forbes	Consultant microbiologist, IPC doctor
Rhian Lewis	
Sue Mably	

PART 1: PRELIMINARIES *(Chair)*		
1.1	Apologies for Absence As noted above.	**JR**
1.2	Minutes of last meeting held on Tuesday 18h March 2025 Minutes of the last meeting were accepted as a true record.	**JR**
1.3	Matters Arising and Action Points from 18th March 2025 IPC team to do outbreak report- completed IPC team to do a breakdown of RCA's- deferred to the next meeting CB to include ANTT data for both medical and nursing staff- deferred to the next meeting JR to contact PCIC and MH clinical boards- completed ECOD colleague needs to be included into ANTT conversations- completed Add HESG minutes under 6.1 section-deferred to the next meeting	**JR**
1.4.1 1.4.2	General Acute Respiratory Illness Update There are no updates on general acute respiratory illness. There are no affected areas with any incident or outbreak. Some flu and Covid are present. No community cases either. General MPox update There is no update regarding Mpox. Last meeting was cancelled. Staff in unscheduled care continue with PPE training and are prepared if a patient should attend with suspected HCID.	**YH/JR**
PART 2: STRATEGIC AND OPERATIONAL DELIVERY OF THE IPC AGENDA		
2.1	1. ICD Reports (UHW + UHL) RD presented ICD report. VRE Outbreak B4 Haematology. Nine patients affected in total, six of them are linked by typing. Meeting was held a few weeks ago. Another meeting is scheduled for tomorrow. 2. IP&C Position Report Welsh circular has not been received until September lats year. Which meant delaying outlining targets for this financial year. IPC team is holding few	**GF/RD** **YH**

	vacancies. TR is leaving the IPC team. There will be another vacancy soon. IPC team attended All Wales C. Diff Collaborative meeting organised by NHS Executives and Public Health Wales. Most of the policies are up to date. CJD policy is brough here for ratification. IPC team continues to support with incident and outbreak management. In year 24/25 for Covid there was 872 bed day lost, compared to 454 year before. Interestingly there was less staff affected in 24/225 compared to the year before. For flu there was 438 beds day lost compared to the year before when it was 254 beds day lost. Norovirus had 66 beds day lost and only 14 staff affected, and 110 patients affected. IPC team continues to do audits. Focus is on MRSA and CRO screening because the audits scores are very low. Average MRSA score is 65%, CRO is 33%, Bed and Mattress average score is 58%. Continue to deliver formal education. In the last financial year there was 1769 attendees over 103 sessions and 152.5 hours. IPC team also supports cadets and spoke placements. Last year there were 3 Link Practitioner Study Days in April, July, and November attended by 123 staff across 7 clinical boards. YH thanked clinical boards releasing time for colleagues to attend. Unfortunately, 19 planned education session had to be cancelled or abandoned due to clinical staff being pulled into clinical duties. This year focus will be in ANTT, admission screening and cleaning. Continue to work in partnership with local authority in the Council. Public Health Wales, the Health Protection team, the NHS exec as well. 3. HARP HCAI Performance Report This presentation shows graph for the final position financial year 2024/2025. CAVUHB did not meet the reduction expectation target of 160 cases. An increase was seen national with all health boards affected and none achieving the targets. CAVUHB did not meet targets for MRSA, MSSA, and Pseudomonas. CAVUHB met the reduction expectation. Klebsiella numbers are as same as the last year. Current position states that CAVUHB is performing well on C. Diff, MSSA, E. Coli, Klebsiella, and Pseudomonas. The only organism that has exceeded the reduction expectation is MRSA. Please find attached presentation. 2.1.3 HCAI Update IPCG June 2025.ppt› 4. Internal Audit Report The only item outstanding on the internal audit report is IPC annual programme.	**PB/YH** **YH**

2.2	New Guidance/application in the Health Board New guidance has come out for Candida Aureus, on admission screening for it. YH has met with GF, and RD. they will meet again to decide regarding screening.	**YH**
2.3	Clinical Board Reports 2.3.1 Medicine The success is for the medical clinical board, are the joint working with infection with IP and C. It has been acknowledged that with the reduction goals, we have got significant challenges. Clinical Board reported on average 98% compliance with at and ANTT course standard. IP and C and PVC audits for the same time with about 88%. C diff has been really challenging picture especially during the winter. There were 60 cases of C diff across MCB during 2024 to 2025 and that represented a 42% increase. With help of IPC a dip dive into RCA has been done. In total 35 RCA were sent and 27 came back. Findings noted: 80% of patients had previously received antibiotics, 8% received antibiotics within Primary Care and 58% within Secondary Care, Medical input into C. difficile tool has improved from previous years,72% of stool charts completed, 35% of patients were prescribed Tazocin. Three cases of C. difficile were reported in May and 5 in April 2026. Themes from investigations undertaken reflect recurrent CDI in some cases, with antibiotics being the main precursor. The Clinical Board reported 1 case of MRSA in April 2025, 2 cases of MSSA, 3 cases of E. Coli. A recent IP&C audit for Endoscopy UHW noted 100% compliance for commode, hand hygiene, BBE, equipment and Decon audit. Environmental 97.5% compliance.  2.3.1 a Medicine Clinical Board NPG J 2.3.2 Surgery/Dental Surgery clinical board has seen an increase of C. diff cases. In total 38 cases for 24/25 financial year. Deep dive findings for C-diff cases 2024/ 2025 have shown: patients over the age of 65 (5 of which were over > 90 years), multiple admissions over 6 months, patients developed symptoms at home, GI surgery, excessive alcohol intake, use of tazocin. Target for was met for MRSA, MSSA. Not achieved target E. coli, Klebsiella and Pseudomonas. Summary of the audit results for the Surgery Clinical Board from June 2024 to June 2025: Aseptic Non-Touch Technique: 100%. Bare Below the Elbow: 93.3% to 99.4%. Cleanliness: 57.1% to 100%. Environmental Audit: Scores fluctuated between 86.0% and 98.1%. (sluice	

Equipment Audit: 84.0% to 97.8%. (green indicator tape not being used)
Hand Hygiene Audit: 81.7% and 100%.
Linen Audit: 100%.
Peripheral Vascular 79.6% to 94.5% (Various – no PVC sticker/ VIP score not documented)

HSDU shut down due to insertion of new Air Handing Unit currently on going and likely to be extended by 2 weeks. Bespoke work being undertaken in theatres following the Culture review. IPC team have supported with a suite of audits under the last 2 months.

2.3.3 Specialist Services

Echoing other clinical boards, specialist services have seen increase in C. diff cases. No cases of MRSA this year, 4 cases of MSSA, 2 cases of E. coli, 1 case of Pseudomonas.

CPO OXA- 48 E. coli Outbreak on B5

This has been reported as an NRI, directorate management team currently completing review. Through the outbreak meeting it has been identified that the communal areas (toilets and wash facilities) were a key feature in the potential transmission of OXA-48. The ward was also attempting to manage a patient who was colonised with OXA-48 who was mobile and independent who declined to adhere to isolation requirements.

There is currently an open NRI (ID 45048) in Haematology for Cryptococcal Meningitis.

B4 Haem – VRE Outbreak

5 cases were identified in April 2025, 3 in blood cultures and 2 in urine samples with a further 3 cases in May 2025. Noted an influx of new staff preceding the outbreak. Challenging medical staff around BBE. Being highlighted at directorate QSE.

Ongoing issues with poor compliance with CRO screening. Audit by IP&C demonstrates good compliance with screening of patients transferred to CB from other hospitals. There is poorer compliance when screening patients who are admitted from home and identifying any admission history over the 12 months preceding admission.

Significant sewage leak in Cardiology procedure suite/recovery area. The burst pipe in the ceiling was caused by a build-up of inappropriate items in the system, predominantly wipes. The area has been HPV cleaned 3 times and deep cleaned 5 times. The area has reopened but there is still a significant smell from the ceiling in the recovery room, this has been escalated to estates. Also awaiting the pipe to be replaced.

	Colleagues in critical care have launched the Gloves Off campaign with huge success. They have already seen significant savings and improvements and posters that they have developed are to be used by PHW throughout the country, amazing work! 2.3.4 CD&T CD&T are making really good progress with ANTT compliance. More assessors are being trained. Coming on board with Tendable as well clinical areas they use are included in the DMT audit as well. SR asked CB to feedback to areas that you know that cleaning of equipment is important. 2.3.5 PCIC PCIC had a reduction in the number of cases for MRSA bacteraemia, E. coli bacteraemia compared with the same period in 23/24. No hotspots have been identified. Cryptosporidium outbreak in Vale which was linked to a petting farm. There were about 89 confirmed cases, the public health team are managing that incident. 2.3.6 Children and Women Limited improvements in in a couple of areas the biggest challenge is C. diff. This year there has been 6 cases. Of the 18 cases it was only 13 patients. There were few recurrences. So, this focus is almost entirely around paediatric oncology. The majority of the cases are on rainbow. Improvements on hand hygiene, and ultraviolet decontamination. Sixty two percent of the patients are immunosuppressed, 46% are on Ng feeds and 54% on PP is 77% on laxatives and 100% have had recent antibiotic use. Reduction in MRSA cases compared to last year. No cases of E. coli, Pseudomonas, and Klebsiella this year. NICU MRSA outbreak meeting has been closed. ANTT 85% medical compliance, and 75 % for nursing staff. 2.3.7 Maternity and Neonatal 2.3.8 Mental Health There is one incidents of C diff in November 2024 on E 10 and one M SSA on E 16 in February 2025.The key things are really in relation to ash ward. a patient with CPO was transferred to Ash ward. A risk assessment was produced. In terms of ANTT, 240 staff have now completed the training online. Number of numbers of face-to-face training by producing by implementing regular physical health days alongside mandatory training. There was an audit for antibiotics that were produced quite a positive result. Tendable audits evidence that mental health remains quite poor in relation to bell below the bear below the elbow.	
2.4	ANTT Update Nothing further to update.	**Verbal YH**

2.5	HCAI Delivery Board update YH will give update at the next meeting.	**YH**
2.6	Antimicrobial stewardship RMac gave her apologies. Please see antimicrobial minutes for reading and noting only. 6.2 AMG DRAFT minutes May 2025 v	**RMac**
2.7	Tendable update Please find attached Tendable presentation. 2.8 Tendable IPCG Quarterly Report Ma	**HB**
PART 3: CORPORATE ASSURANCE SUPPORT AND PERFORMANCE FRAMEWORK (REDUCTION EXPECTATIONS 2021/22)		
3.1	Caesarean Section Surgical Site Infection Surveillance 3.1 CSSSI 2024 Q4 - CAV UHW V1.pdf All Wales Caesarean group has been reinstated. Public health data shows that there has been a reduction in infection rate.	**AH**
PART 4: DECONTAMINATION AND INFRASTRUCTURE		
4.1	Decontamination Report All decontamination service departments maintain their accreditation to ISO 13485 in the medical device regulations. Any non-conformances that were open from previous audits have all been closed. The biggest piece of work has been planning for the HDSU closure. There is a new ceiling going up in HSD department. New flooring and the new air Handling Unit is currently running. There was an issue of what they call the dampeners, and the dampeners control the pressure in the clean room so when the doors open the dirty air blows out of the room. But for assurance the contingency plan is working. Surgical activity does not appear to have been affected. Lots of projects going on in decontamination department. The endoscopy user group continues. these are the subgroups from the decontamination group and last meeting was on 25th of June. Nothing majorly to note from that meeting.	**MC**

4.2	Legionella in Water UHL – SBAR - General Update on Facilities/Estates/Capital Planning There has been an increase in Legionella detection. Paul Morgan from our water safety team provided a presentation at the Link Practitioner Seminar a couple of weeks ago, which was a benefit. Focus is on the Barry hospital. Water temperature improved slightly. There was an increase in HPV request. No problem with linen. Cost for theatre cleaning has been received. Backlog for maintenance request is big. Future Capital schemes: C1 Refurbishment, HSDU Mechanical Works, Electrical Substation 2A Replacement – Affecting different areas at various times. Please find attached Estate presentation.  4.2 and 4.3 Estates IPCG June 2025 Pape	**AP**
PART 5: INFECTION CONTROL POLICIES AND PROCEDURES		
5.1	5.1.1 Update on Current Position regarding Procedures for Noting 5.1.2 Procedures and Protocols for Comment 5.1.3 Procedures and Protocols for Ratification CJD procedure has been agreed.	**YH**
PART 6: REPORTS FROM OTHER COMMITTEES/GROUPS (For information only not, discussion)		
6.1	Minutes of the Decontamination Group Meeting Minutes for information only.	**MC**
6.2	Antimicrobial Group Minutes Minutes for information only.	**RM**
6.3	Staff Flu Vaccination Update	**DM**
6.4	Water Safety Group minutes Minutes for information only.	**YH**

6.5	Public health Update	**AA**
6.6	HESG Update	**YH**

PART 7: GENERAL UPDATES/ISSUES

7.1

There are no general updates/issues.

DETAILS OF FUTURE MEETINGS

IPCG Meeting Date	Meeting times	Papers to be received by:	Papers for the meeting will be sent out by:
18/09/25	**09:00-11:30**	**08/09/25**	**12/09/25**

Action log
IPC team to do a breakdown of RCA's
CB to include ANTT data for both medical and nursing staff
CB to have representation at the ANTT meeting
JR, YH, Medstrom and Procurement to have a meeting regarding bed cleaning
TR to send ANTT list to CT
Add HESG minutes under 6.1 section
YH to send data to AM

Report Title:	Annual Director of Public Health Report 2025			Agenda Item no.	4.4	
Meeting:	Quality Committee	Public Meeting	x	Meeting Date:	09/12/2025	
		Private Meeting				
Status:	Assurance		Approval		Information	X
Lead Executive:	Claire Beynon, Executive Director of Public Health					
Report Author:	Dr. Michael Allum, Consultant in Public Health					

Background and current situation:

The Director of Public Health (DPH) has a duty to provide an annual independent report on the health of the local population. This year's DPH report is entitled '**What Surrounds us, Shapes us: A Whole System Approach to Preventing Obesity and Type 2 Diabetes'.**

Executive Director Opinion and Key Issues to bring to the attention of the Committee:

In Cardiff and the Vale of Glamorgan, more people are living with obesity and type 2 diabetes. This means that more people are living in poor health, needing long term treatment and care. As preventable health conditions, we can, and we must work together and work differently to prevent obesity and type 2 diabetes.

We know that whilst individual level interventions (including weight management support and/or medication) are important in supporting some individuals, they have limited reach. Focusing on these alone to treat obesity and type 2 diabetes leaves the wider influences around people unchanged. Unless these broader influences are addressed obesity and type 2 diabetes will continue to rise, and the costs to local people and the NHS are unsustainable. A whole-system approach is the evidence based solution to preventing obesity and diabetes.

A whole system approach means:

- **Big picture thinking:** so that we consider all the influences, how they affect each other, who has a role to play and what they can do.
- **Common purpose**: so that we all pull in the same direction towards our shared goals
- **Collaboration**: so that we create solutions together and connect people so that ideas and resource can be shared
- **Shared leadership**: so that we spread leadership across communities, teams and organisations to enable everyone to play their role and take action to make change
- **Flexibility:** so that we embed a culture of learning, sharing and reflection to enable us to adapt what we do and how we do it.

This report sets out how society has changed over the last 2 decades and what impact this has had on obesity and type 2 diabetes. It also shares what we are currently doing together to prevent these health conditions through the Good Food and Movement Framework (2024-2030) which aims to enable good food and movement for everyone in Cardiff and the Vale of Glamorgan. By 'Good Food' we mean, food that is nourishing, healthy and culturally appropriate and by 'Movement' we mean, all kinds of movement such as physical activity, taking the stairs, sport, play, housework, or active travel.

The report makes three calls to action which will accelerate our collaborative efforts:

1. **Make prevention the focus**

- Public sector budgets need to prioritise and refocus spend towards to the earliest stage prevention of obesity and type 2 diabetes
- Put the prevention of obesity and type 2 diabetes at the centre of decision-making

2. **Create supportive spaces and places**
   - Plan, design and build the spaces and places around where we live with a focus on movement and to ensure access to healthy affordable food
   - Design, build and operate the places where we spend our time to support and enable good food and movement
   - Use our strong local voice to influence and advocate for wider policy change

3. **Put communities at the heart**
   - Come together and build a picture of community health development; what is going well and where, to identify what more we can do together to support and enable good food and movement

These will create the change needed to have population level impact and reduce the number of people living with obesity and type 2 diabetes in Cardiff and the Vale of Glamorgan.

Appendices

1. Director of Public Health Report 2025

Recommendation:

The Committee is requested to:

a) To note the Director of Public Health Report 2025.

Link to Strategic Objectives of Shaping our Future Wellbeing:

https://shapingourfuturewellbeing.com/

1. Putting People First **Click the objective above to view more detail.**	Y	2. Providing Outstanding Quality **Click the objective above to view more detail.**	Y
3. Delivering in the Right Places **Click the objective above to view more detail.**	Y	4. Acting for the Future **Click the objective above to view more detail.**	Y

Five Ways of Working (Sustainable Development Principles) considered:

Prevention	Y	Long term	Y	Integration	Y	Collaboration	Y	Involvement	Y

Quality Impact Assessment Completed?

Yes – (***please provide completed***		No – ***(Please provide reasoning, e.g. not required)***		N/A	

QIA document)				

Impact Assessment:
Risk: No
N/A
Safety: No
N/A
Financial: No
Not directly
Workforce: No
Not directly
Legal: No
Reputational: No
The DPH report is an annual independent report required to be completed by the Director of Public Health
Socio Economic: No
The report does not contain specific strategic decisions, such the development of services. It is supportive of addressing and reducing inequalities.
Equality and Health: No
Not required
Decarbonisation: No
Welsh Language: No
The report will be translated in to Welsh ahead of publication, and made available in English and Welsh.

Approval/Scrutiny Route (***please note anywhere else this paper has been before***):	
Committee/Group/Exec	Date:
Senior Leadership Team	13th November 2025
The Board	27th November 2025
[External] Vale of Glamorgan Public Services Board	2nd December 2025
Quality Committee	9th December 2025
[External] Regional Partnership Board	13th January 2026
[External] Cardiff Public Services Board	20th January 2026

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Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

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Tim Iechyd Cyhoeddus
Cardiff and Vale University Health Board
Public Health Team

What Surrounds us, Shapes us: A Whole System Approach to Preventing Obesity and Type Diabetes

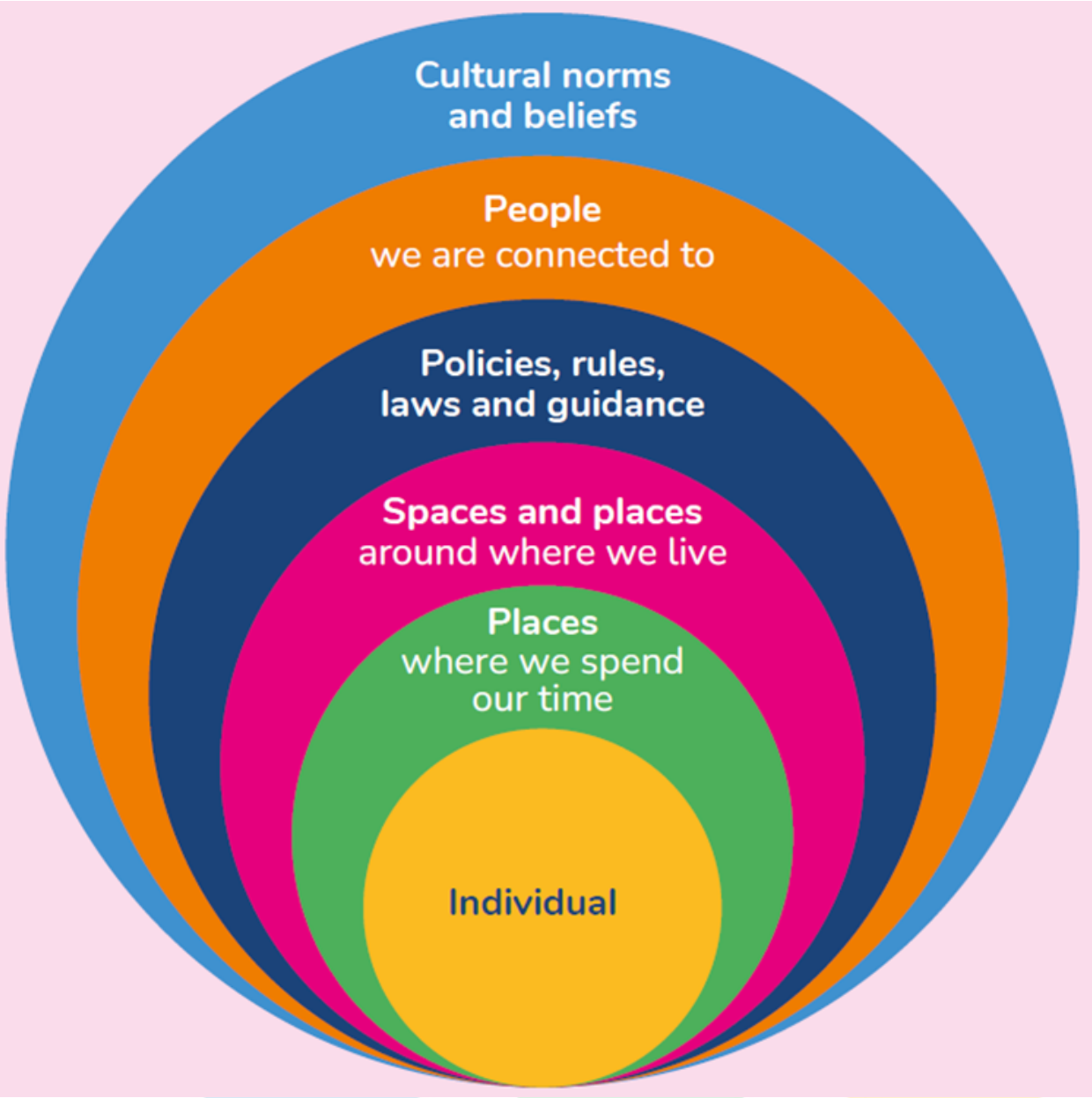
Director of Public Health Report 2025

Claire Beynon
Executive Director of Public Health

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Tim Iechyd Cyhoeddus
Cardiff and Vale University Health Board
Public Health Team

Introduction

- Director of Public Health Report 2025 – independent and objective review by the Executive Director of Public Health
- This year's report looks at the prevention of both obesity and type 2 diabetes
- It looks at what influences how we live and how the world has changed over time
- It is a complex issue that needs an evidence-based solution
- It outlines what we are already doing to combat this
- Finally, there are three calls to action that we can all work on together



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What surrounds us, shapes us: what has changed over time?

- Places where we spend our time, such as schools and workplaces has evolved
- Places and spaces where we live, such as roads, transportation and food environment have changed hugely
- Policies, rules, laws and guidance have had some positive influence; however, keeping pace with societal changes and industry lobbying is a challenge
- Cultural norms and beliefs about how we usually behave has changed over time, and shapes how we live

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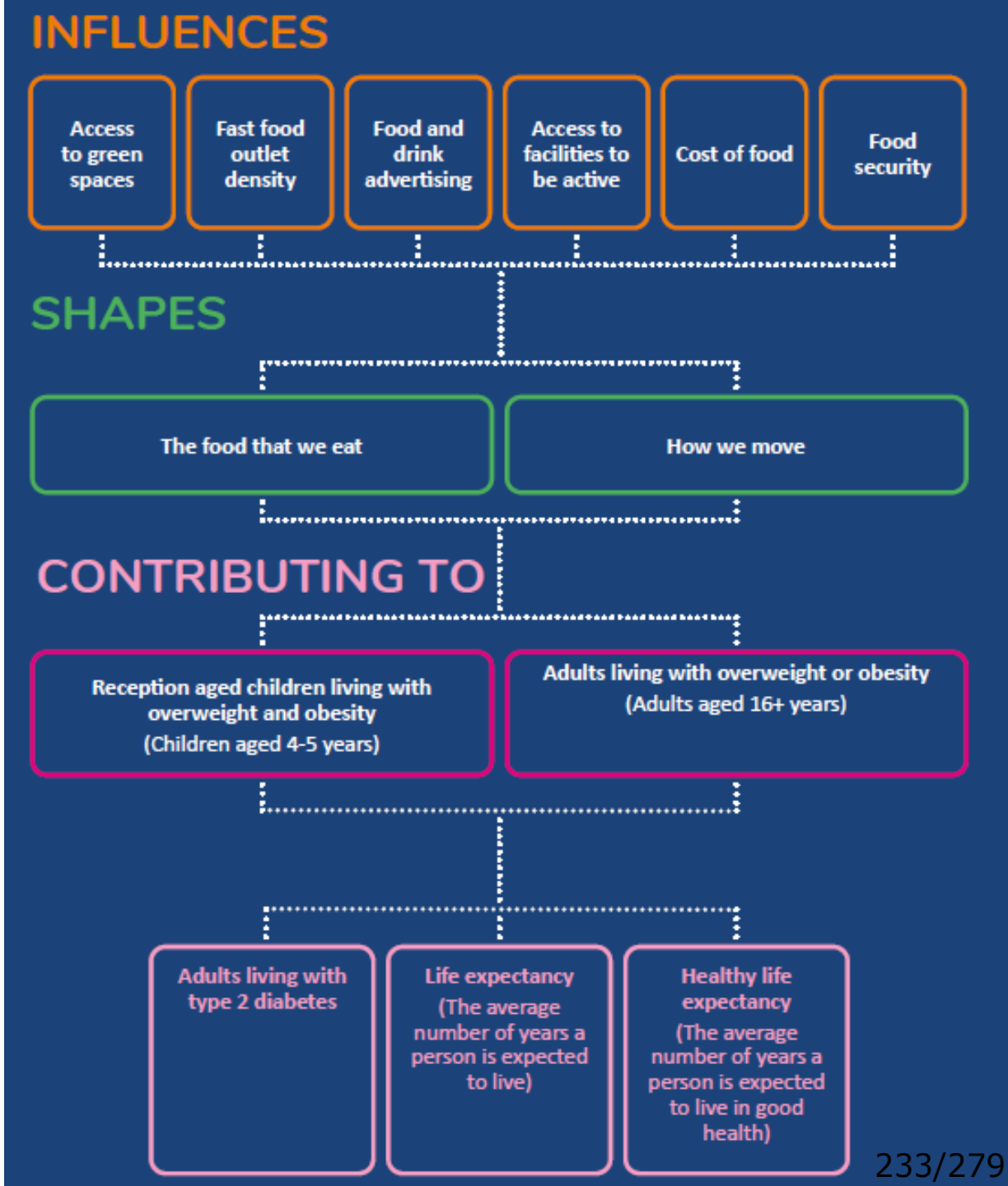
The data story

- 1 in 10 children starting school in Cardiff and Vale of Glamorgan are obese
- Children and young people living with obesity are 5 times more likely to be living with obesity as adults
- Obesity leads to many health problems, including type 2 diabetes and cardiovascular disease and this can affect life expectancy and healthy life expectancy
- 1 in 15 people aged 17 and over in Cardiff and Vale of Glamorgan are already diagnosed with type 2 diabetes – this is set to increase to 1 in 11 adults (in Wales) by 2035.
- Importantly this is preventable



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Public Health Team

What are we doing already?

- Healthier advertising and sponsorship policies developed by Vale of Glamorgan Council and Cardiff Council
- Significant progress in transforming active travel infrastructure
- Active soles campaign implemented across Cardiff and Vale UHB, Cardiff Council, Vale of Glamorgan Council and Cardiff Metropolitan University
- Food Cardiff have rolled out the Planet Card, supporting low-income families to access healthy food
- Food Vale have developed the Llantwit Major Food Access Partnership Project, tackling food insecurity in the area

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Tim Iechyd Cyhoeddus
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Public Health Team

Call to action: Make Prevention the Focus

1. Public sector budgets need to prioritise and refocus spend towards to the earliest stage prevention of obesity and type 2 diabetes
2. Put the prevention of obesity and type 2 diabetes at the centre of all our decision-making

Three calls to Action:

Call to action: Create supportive spaces and places

1. Plan, design, build and enhance the spaces and places around where we live with a focus on movement and to ensure access to healthy affordable food
2. Design, build and operate the places where we spend our time to support and enable good food and movement
3. Use our strong local voice to influence and advocate for wider policy change

Call to action: Put communities at the heart

1. Come together and build a picture of community health development; what is going well and where, to identify what more we can do together to support and enable good food and movement

Director of Public Health Report 2025

What Surrounds us, Shapes us: A Whole System Approach to Preventing Obesity and Type 2 Diabetes

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Tim Iechyd Cyhoeddus
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Public Health Team

Acknowledgements

With thanks to Cardiff and Vale Public Health Team and all those who contributed to writing, editing and producing this report including Suzanne Wood, Michael Allum, Rebecca Stewart, Lauren Idowu, Alex Wood and Helen Griffith.

Thanks also to all our colleagues who contributed their time and expertise to having conversations with us, providing case studies and photos, to Miacis Media for the design work and to Matthew Horwood for photos.

I'd like to also acknowledge everyone who is already contributing and committed to working towards the vision for Good Food and Movement.

Together, change is possible.

Foreword

In Cardiff and the Vale of Glamorgan, more people are living with obesity and type 2 diabetes. As Executive Director of Public Health for Cardiff and Vale University Health Board, I have chosen to focus my second report on obesity and type 2 diabetes; two closely linked health conditions that are both largely preventable.

What surrounds us, shapes us. It is easy to think that what we eat and how we move is entirely personal choice however we are constantly being influenced by what is around us. It is these wide range of influences that make preventing obesity and type 2 diabetes a complex challenge. To address the broader influences, we must shift from traditional approaches which have focused on individual behaviours, to a whole system approach so that we zoom out to look at the big picture and tackle the full range of influences, for lasting change rather than short-term fixes.

We are already taking a whole system approach in Cardiff and the Vale of Glamorgan through our Good Food and Movement Framework (2024-2030) and making some great progress. However, we need to do more, we need to go further and act faster.

My report makes three calls to action that I believe will accelerate our collaborative effort towards Good Food and Movement and create change so that together we can have the population level impact that is needed to reduce the number of people living with obesity and type 2 diabetes in Cardiff and the Vale of Glamorgan.

I am committed to taking a collaborative, whole system approach and I look forward to discussing how we can all play our part in driving forward my calls to action.

Claire Beynon
Executive Director of Public Health
Cardiff and Vale University Health Board

Contents

Introduction

My Director of Public Health report this year brings together obesity and type 2 diabetes as health conditions that are both highly preventable.

In Cardiff and the Vale of Glamorgan, more people are living with obesity and type 2 diabetes. This means that more people are living in poor health, needing long term treatment and care. As preventable health conditions, we can, and we must work together and work differently to prevent obesity and type 2 diabetes.

This report sets out what influences how we live, how society has changed and what impact this has had on obesity and type 2 diabetes. It also shares what we are currently doing together to prevent these health conditions through the Good Food and Movement Framework (2024-2030) which aims to enable good food and movement for everyone in Cardiff and the Vale of Glamorgan. By 'Good Food' we mean, food that is nourishing, healthy and culturally appropriate and by 'Movement' we mean, all kinds of movement such as physical activity, taking the stairs, sport, play, housework, or active travel.

I make three calls to action which will accelerate our collaborative efforts. These will create the change needed to have population level impact and reduce the number of people living with obesity and type 2 diabetes.

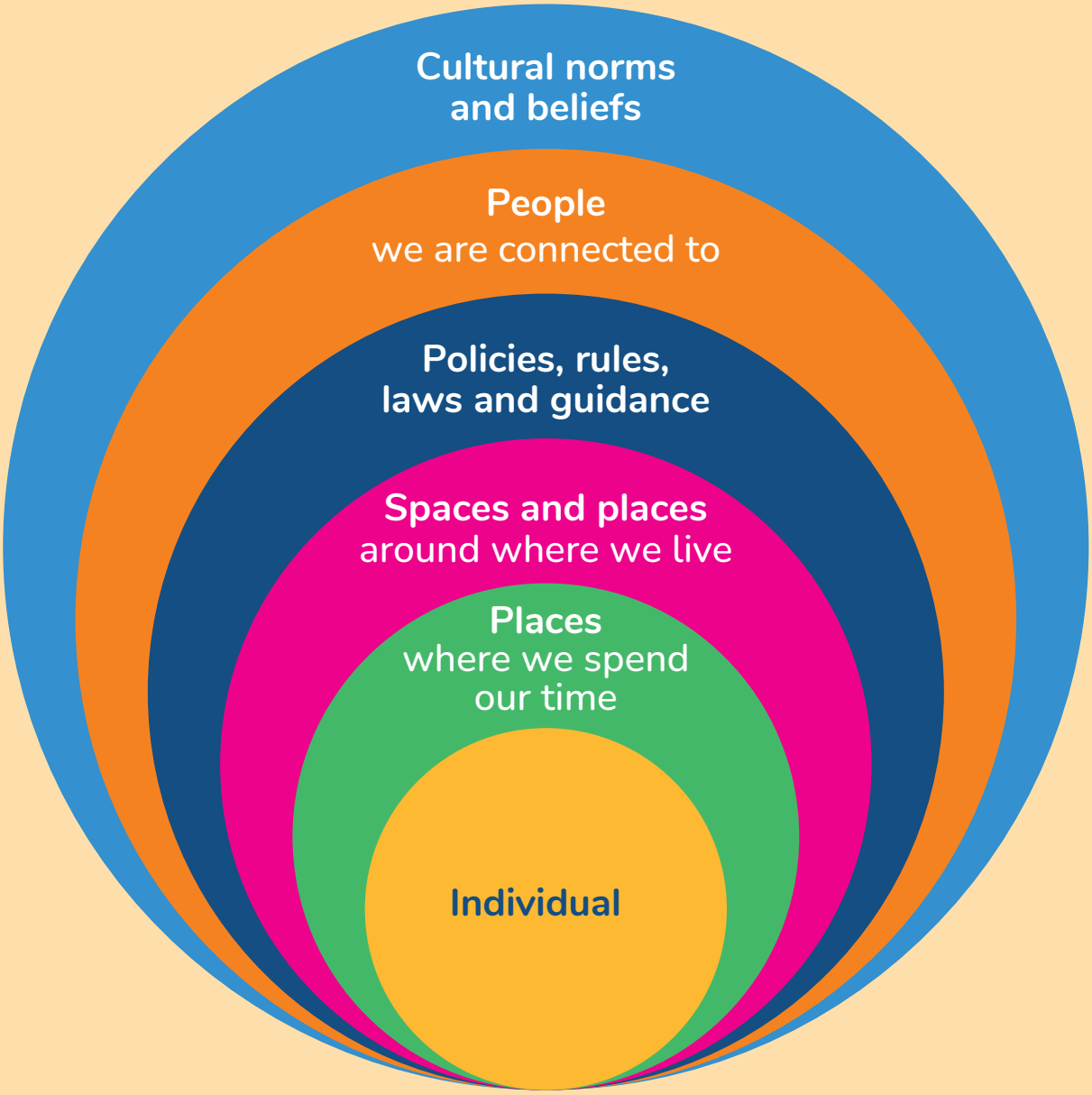
1. What influences how we live?

What surrounds us, shapes us. It is easy to think that what we eat and how we move is entirely personal choice however we are constantly being influenced by what is around us.[1]

We can think about all these different influences as layers[2] around us that continuously interact and affect how we live, including the food we eat and how we move. The layers are described below.

- The **places where we spend our time.** These influence how we access and experience food and movement through how they are designed, built and how they operate. Places could include our schools, workplaces, hospitals, health centres, sports clubs, community centres as well as places of worship.
- Around the places where we spend our time are the **spaces and places around where we live** like our neighbourhoods, high streets, parks, fields, sports pitches, playgrounds, roads, and public transport routes. These affect how we access food and experience movement through how they are designed.
- Next are the **policies, rules, laws and guidance** that shape our places and spaces. These affect what food is available, affordable and promoted, as well as what opportunities to move are made possible.
- Then we have, the **people we are connected to like family, friends, colleagues and neighbours.** They affect how we think, feel and act about food and movement. Our connections to other social support networks, either in person or virtually are often around common interests or at life stages and these can also shape what we think, feel and how we act.
- **Cultural norms and beliefs** are the shared ideas and unwritten rules that shape how people live, what they value, how they think and what they prioritise.
- Finally, a **person's own knowledge, attitudes and behaviours towards food and movement** includes things like what they know about healthy food and movement, their belief in their own abilities, their preferences and relationship with food and movement, the resources available to them, as well as how motivated and confident they are. A person's knowledge, attitudes and behaviours are shaped by their life experience, and through the influences described above that continuously interact around them. These influences can act to support and positively reinforce health behaviours around good food and movement; they can also hinder.

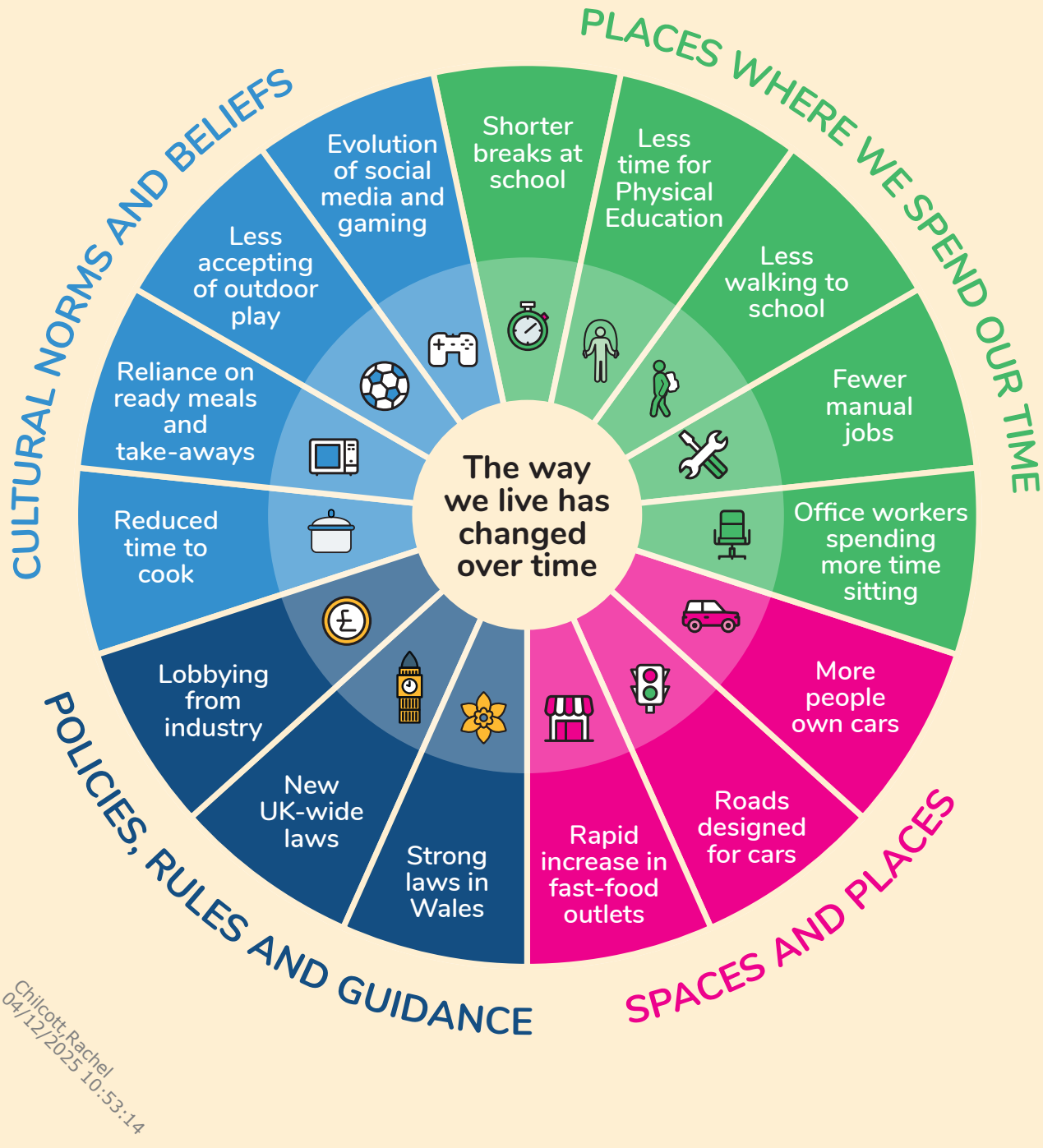
Figure 1: Layers of influence



2. How has the world changed?

In recent generations, the way we live has changed. Figure 2 shows how some of the influences that surround us have changed over time.

Figure 2: Influences over time



The places where we spend our time, such as schools and workplaces, have evolved.

- Adjustments to the school day has seen lunchbreaks become shorter and afternoon breaks nearly disappearing in many schools; meaning less time for play and movement.[3]
- There has been a small but gradual decline in time allocated for Physical Education in both primary and secondary schools.[4]
- How we get to school has changed; in the 1970's, most children in the UK (63%) walked to school, but by 2023 this had dropped to less than half (44%).[5]
- Manual jobs have declined, and office-based working has risen dramatically.[6]
- Office workers now spend most of the working day (82%) sitting down.[7]

The places and spaces around where we live, such as our roads and transport, and the make-up of our food environment have seen major changes.

- Until the 1950s, most people got around on foot or by public transport. Since then, car ownership has risen rapidly, and we have seen a huge increase in car use (27% of journeys were made by car in 1952 compared to 83% in 2016).[8]
- Our road network is often designed for cars, rather than pedestrians or cyclists.[9]
- Accessing food is easier than ever before through the rise in online home delivery services, smaller convenience stores, and a rapid increase in fast-food outlets. This has altered how we buy food and what we eat.[10] Many convenience stores rely on sales of less healthy products[11] and take-away food is often high in fat, sugar and salt.[12]

The policies, rules, laws and guidance that shape our places and spaces have led to positive change, but keeping pace with changes in society is a challenge

- We have strong laws in Wales which support and improve health and wellbeing such as the Well-being of Future Generations Act,[13] and the Active Travel Act.[14]
- UK-wide laws are also driving positive change, such as the advertising watershed. This will ban TV adverts for unhealthy food and drink before 9pm, ban online paid adverts altogether and will come into effect in 2026.[15]
- However, laws and guidance can face challenges such as heavy lobbying from industry leading to delays and/or modifications and putting the laws into practice at a local level can be limited by capacity, short term funding and lack of enforcement.[16]

Cultural norms and beliefs about how people usually behave change over time and shape how we live.

- The rise in families where both parents work[17] has reduced time for cooking, making convenient solutions like ready meals and takeaways often a necessity rather than an option.[18]
- The introduction of freezers and microwaves has contributed to the rise of ready meals, and reliance on these instead of home cooked meals. Ready meals are often high in salt, high fat, and low in fibre.[19]
- Three quarters of parents agree that society is less accepting of children playing outside than it was when they were growing up, with confidence, perception of safety and traffic, recognised as key factors.[20]
- Evolution of social media, online gaming and use of smart phones has changed how we interact with huge impacts on sedentary and sitting time for children, young people and adults.[21]

3. What are the consequences?

The changes described have shaped the way we all live, and this is affecting our health.

3.1 Living with obesity

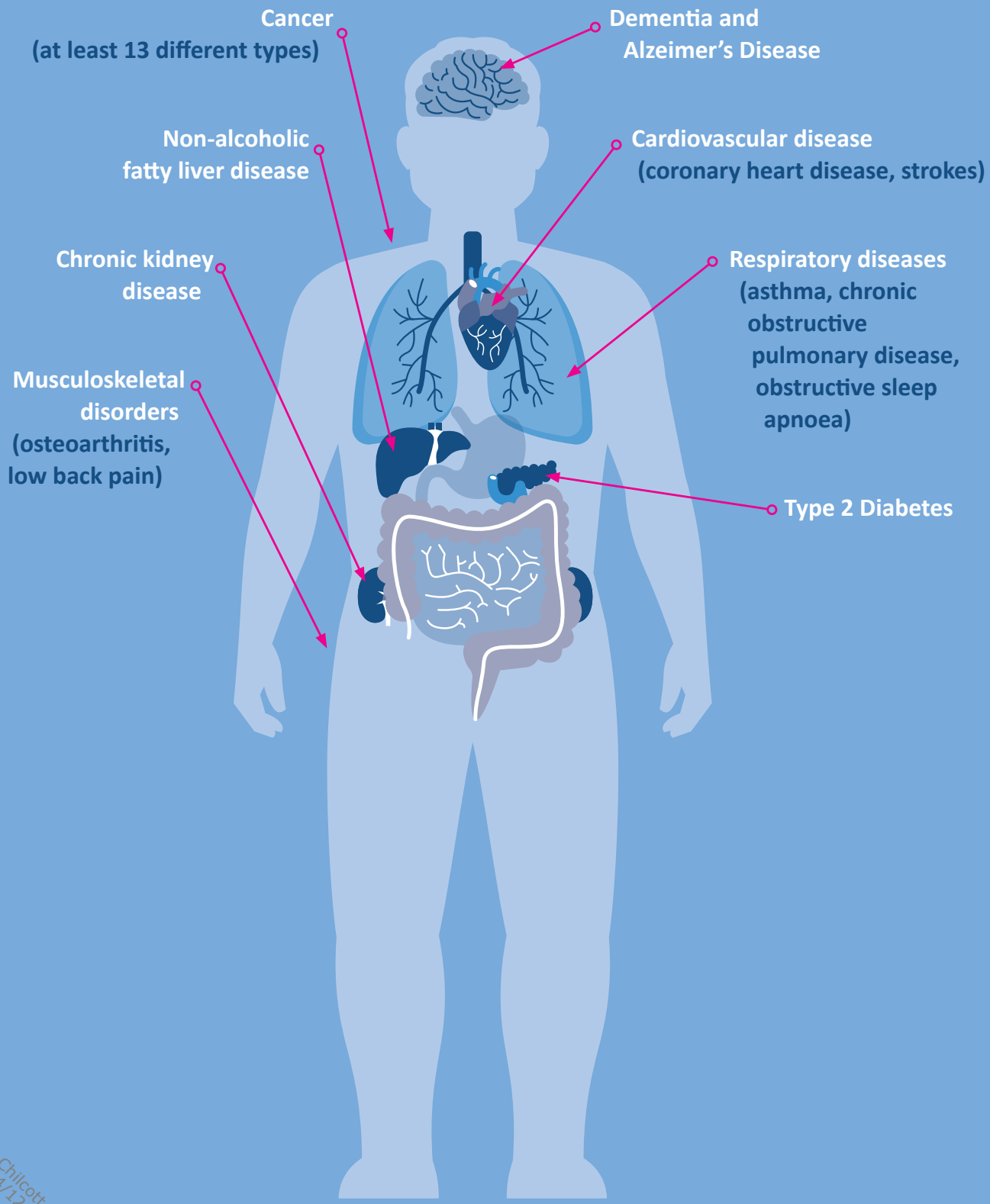
Every year, the Child Measurement Programme for Wales measures the height and weight of children in Reception class (aged 4–5). It's a simple check that helps us see how young children are growing.

The most recent results for Cardiff and the Vale of Glamorgan found that 1 in 10 children aged 4-5 years old are already living with obesity when they start primary school[22]. There are also more young children living in our most disadvantaged communities living with obesity.

Obesity in early childhood often continues into later childhood[23], through adolescence and into adult life, and children and young people living with obesity are five times more likely to be living with obesity when they become adults[24].

More than 1 in 5 adults (21%) in Cardiff and the Vale of Glamorgan are living with obesity[25]. People living with obesity are more likely to develop a range of medical conditions and illnesses as shown in Figure 3[26]. These include type 2 diabetes, as well stroke, cancer, dementia, and heart disease. These conditions can shorten lives. Across Cardiff and the Vale of Glamorgan we are also seeing more adults living with obesity in our most disadvantaged communities.

Figure 3: How living with obesity affects the body



3.2 Living with type 2 diabetes

Wales has more than 200,000 people (8% of adults) living with the condition[27]. Type 2 diabetes is a serious condition that can affect your heart, kidneys, eyes and nerves.

Many people are also living with pre-diabetes meaning their blood sugar levels are high but not yet in the diabetes range. It is estimated that 65,500 people are living with undiagnosed type 2 diabetes in Wales[28]. Young adults are more likely to be living with undiagnosed type 2 diabetes, and type 2 diabetes in younger people often develops faster and causes problems earlier[29].

Adults from Black and Asian ethnic backgrounds[30] are also more likely than twice as likely to be living with pre-diabetes or undiagnosed type 2 diabetes compared to adults from White, Mixed and Other ethnic backgrounds. People who don't know they have diabetes miss out on treatment and support and are at a much higher risk of health problems that could have been prevented.

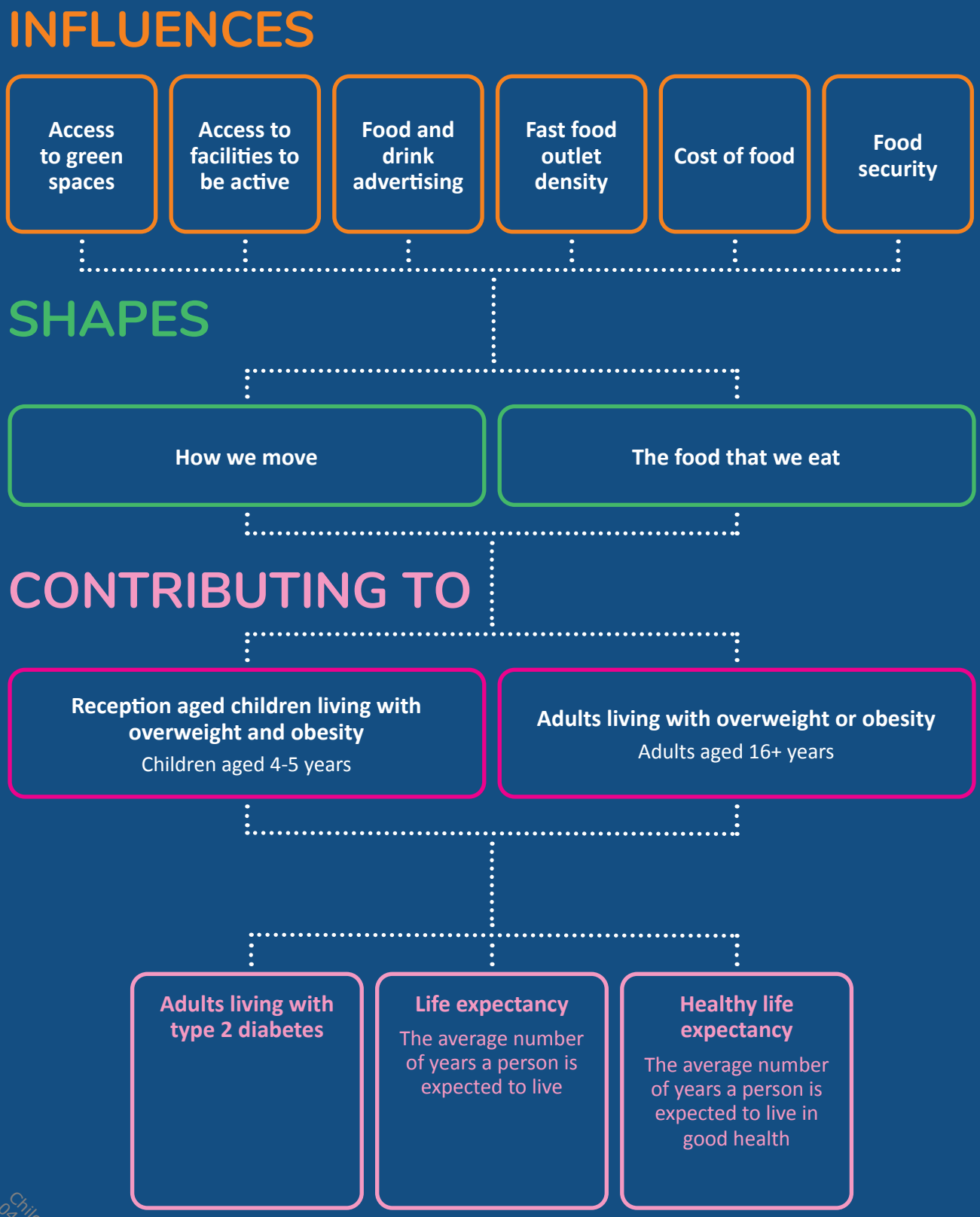
3.3 How are obesity and type 2 diabetes connected?

Obesity and type 2 diabetes are closely linked. When someone is living with obesity, it can change how the body uses insulin. Insulin is a hormone that helps move sugar (glucose) from the bloodstream into cells, where it is used for energy. Living with obesity, especially when fat is stored around the abdomen can lead to insulin resistance. This means that although the body still produces insulin, it's doesn't work as well, and sugar starts building up in the bloodstream instead of being used for energy. Over time, this can lead to type 2 diabetes[31].

3.4 The data story

Figure 4 presents key local and national data which shows the link between some of the influences around us, that shapes what we eat and how we move and contribute to obesity and type 2 diabetes. It also shines a light on some of the unfair differences that we are seeing across our communities in Cardiff and the Vale of Glamorgan.

Figure 4: The data story



INFLUENCES

Access and use of green space

Green spaces include parks, gardens, playground, fields, sports pitches, community gardens and nature reserves

Young children living in the **most disadvantaged communities** across Cardiff and the Vale of Glamorgan have **less access** to **green spaces** where they can play.[32]

People living in the **most disadvantaged communities** of Cardiff are almost **twice as likely** as people living in least disadvantaged communities to report that they **do not regularly spend time in nature/ green spaces**.[33]

Access to facilities to be active

Facilities can include for example, sports halls, swimming pools, leisure centres

The **closer** adults **live to sports facilities,** the **more active** they are.[34]

Food and drink advertising

Including bus stops and billboards

An average of **1 in 4 adverts on display*** across Council assets were for foods and drinks **high in fat, sugar and or salt**.[35]

*Mapped across 4 time points between Nov 2022 – July 2024

Fast food outlet density

Food outlets that serve energy dense savoury food eaten outside of the home

There are almost **twice the number of fast-food outlets** in our **most disadvantaged communities** compared to our least disadvantaged communities.[36]

Cost of food

What people pay for their food

Prices of food and non-alcoholic beverages rose around 25% between January 2022 and January 2024.[37]

Around **33% of adults** in the Vale of Glamorgan say that **high food prices** are the **main difficulty in getting food**, followed by how far they must travel to buy it.[38]

Food Security

People have enough safe and healthy food to meet their dietary needs and keep them healthy

Around **10%** of households in Cardiff have **worries about food security**, have skipped or reduced meals or sought external help.[39]

People living in the **most disadvantaged communities** of Cardiff are more likely to report **not being able to afford food**.[40]

SHAPES

The food that we eat

Around **61%** of adults living in Cardiff and the Vale of Glamorgan report that they did **not eat** the recommended **five portions of fruit or vegetables** on the previous day.[41]

45% of young people in Cardiff and the Vale of Glamorgan report **eating under one portion of fruit or vegetables a day**.[42]

How we move

33% of adults living in Cardiff and the Vale of Glamorgan report they **did not meet** the recommended guidelines of **150 minutes of physical activity** in the previous week.[43]

80% of young people **aren't meeting recommended guidelines** of **60 minutes of physical activity every day**.[44]

In a **class of 30 young people** in Cardiff and the Vale of Glamorgan, **nearly 5 (15%) now sit for 7 or more hours on a weekday**—up from 3 (10%) in 2017.[45]

CONTRIBUTING TO

Reception aged children living with overweight and obesity

Children aged 4-5 years

Around **25%** of reception aged children are **living with overweight or obesity**.[46]

Almost **three times the number** of reception aged children are **living with obesity** in our **most disadvantaged communities** (**14.5%**) compared to our least disadvantaged communities (**5.4%**).[47]

Adults living with overweight or obesity

16+ years

58% of adults in Cardiff and the Vale of Glamorgan are **living with overweight or obesity**.[48]

21% of adults in Cardiff and the Vale of Glamorgan are **living with obesity**.[49]

Adults living with type 2 diabetes

1 in 15 people aged 17 and over living in Cardiff and the Vale of Glamorgan have already been **diagnosed with type 2 diabetes**.[50]

Type 2 diabetes is a growing problem. If current trends continue, around **1 in 11 adults** in Wales could be **living with diabetes by 2035**.[51]

Life expectancy

The average number of years a person is expected to live

There are **major differences in life expectancy** between our **most disadvantaged** and **least disadvantaged communities** across Cardiff and the Vale of Glamorgan. For **men**, life expectancy is **9.6 years shorter**, and for **women** life expectancy is **7.6 years shorter**.[52]

Healthy life expectancy

The average number of years a person is expected to live in good health

People living in our **most disadvantaged communities** can expect to have between **14 -18 fewer years of healthy life** than people living in our least disadvantaged communities.[53]

4. What are we already doing about this?

4.1 A complex challenge: why we need a different approach

As described, we are constantly being influenced by what surrounds us. These wide range of influences make preventing obesity and type 2 diabetes a complex challenge and our approach must reflect this. It requires a shift from traditional approaches which have focused on individual behaviours, to approaches that recognise and address the broader influences that shape the food we eat and how we move.

We know that whilst behaviour change interventions are important in supporting some individuals, they have limited reach. Focusing on these alone to prevent obesity and type 2 diabetes leaves the wider influences around people unchanged. Unless these broader influences are addressed, they will continue to impact on health behaviours. We also know weight-loss medicines can help some people reduce health risks, but they are not a population-level solution because the wider causes of obesity remain[54]. Ultimately, behaviour change interventions, and medication alone won't lead to population-level impact and may increase inequalities.

A whole-system approach is required, so that we zoom out to look at the big picture and tackle the full range of influences, for lasting change rather than short-term fixes.

A whole system approach means:

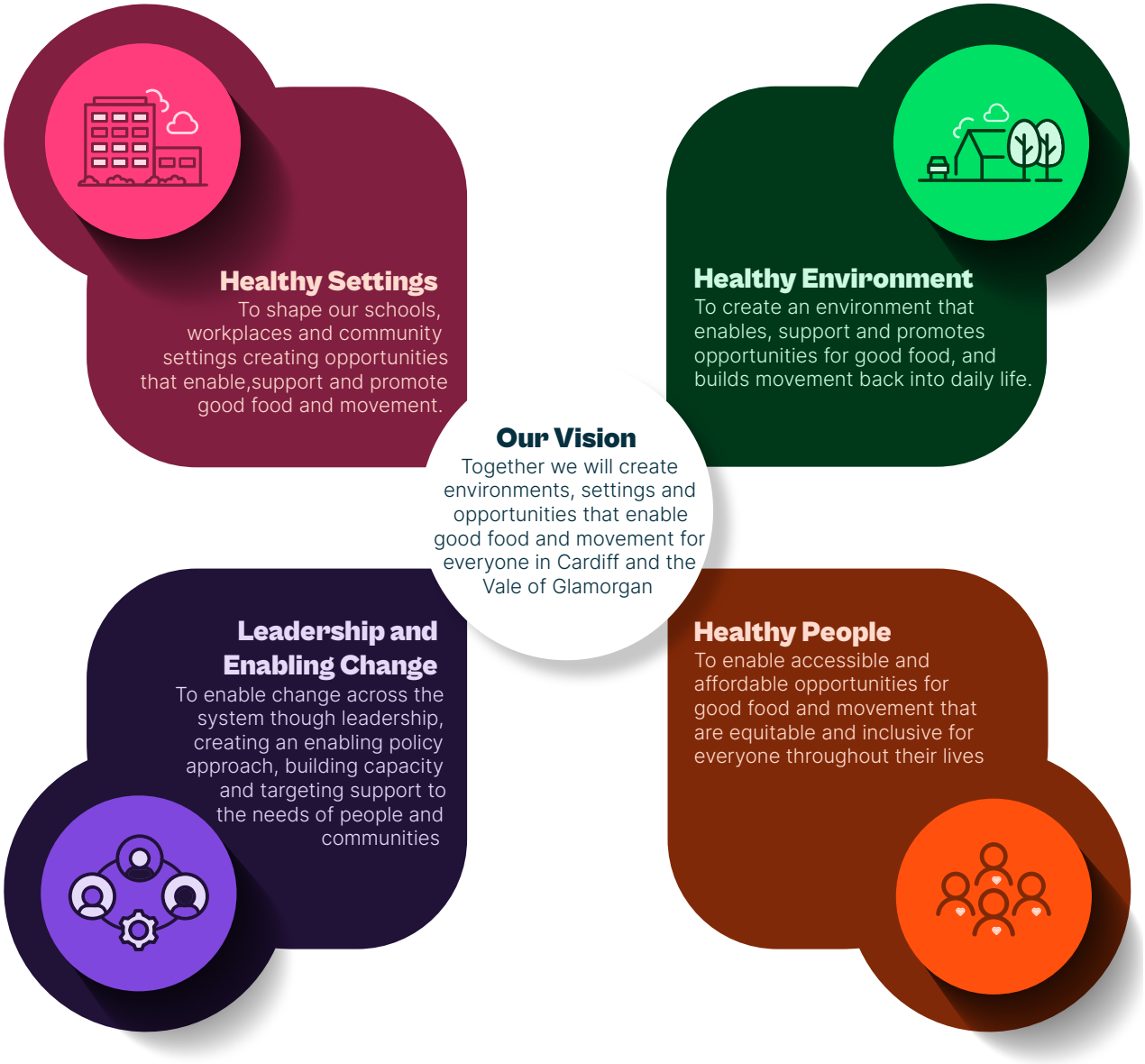
- **Big picture thinking:** so that we consider all the influences, how they affect each other, who has a role to play and what they can do.
- **Common purpose:** so that we all pull in the same direction towards our shared goals.
- **Collaboration:** so that we create solutions together and connect people so that ideas and resource can be shared.
- **Shared leadership:** so that we spread leadership across communities, teams and organisations to enable everyone to play their role and take action to make change.
- **Flexibility:** so that we embed a culture of learning, sharing and reflection to enable us to adapt what we do and how we do it.

4.2 Good Food and Movement Framework (2024-2030) and Implementation Plan

We are already taking a whole system approach in Cardiff and the Vale of Glamorgan through our Good Food and Movement Framework (2024-2030)[55]. Shaped by a wide range of ideas, perspectives and voices, it describes our shared vision, approach, where we prioritise our collective efforts, and how we work together to create change over the six-year period.

The Framework brings together a number of partnership groups, strategies and programmes of work focused on key areas such as sport, physical activity, movement, and good food to progress action against four key themes; Healthy Environment, Healthy Settings, Healthy People, and Leadership and Enabling Change.

Figure 5: Good Food and Movement Framework (2024-2030) Vision and Goals



Two-year Implementation Plans outline the actions we will take together, with different teams, and organisations working collaboratively to change the influences that affect how we live. Our local work also aligns to Welsh Government's Healthy Weight: Healthy Wales Strategy[56], their 10-year plan to prevent and reduce obesity.

4.3 Progress so far

We are already making a lot of great progress. Figure 5 highlights a few examples from across the themes: Healthy Environment, Healthy Settings and Healthy People. We are also making progress in the Leadership and Enabling Change theme including strengthening strategic leadership, developing an evaluation framework and delivering training.

Healthy Environment

- Healthier Advertising and Sponsorship policies developed by the Vale of Glamorgan Council and Cardiff Council that will restrict high fat, salt and sugar food and drink advertising across their owned/managed assets.
- Growing number of Public Sector organisations signed up to the Healthy Travel Charter.
- Significant progress in transforming active travel infrastructure across Cardiff and the Vale of Glamorgan.
- Health and wellbeing embedded into Cardiff and the Vale of Glamorgan Replacement Local Development Plans.
- Audit of all the facilities that enable people to be active in Cardiff complete and the Vale of Glamorgan audit underway.
- Increased focus on inclusive play equipment through changes to the Vale of Glamorgan Council's Fixed Play Areas inspection process.
- Pilot project progressed with parcels of land identified and being used by community groups for food growing as part of the development of a community growing plan for Cardiff.
- Community food growing projects in the Vale of Glamorgan mapped and key barriers to participation and access explored.

Spotlight on Inclusive Parks and Planning Cardiff Council/ Child Friendly Cardiff

Cardiff is embedding a child-rights approach to planning inclusive parks, playgrounds and community spaces.

Cross sector collaboration between planning, parks, health, housing, youth services, and academia has been critical to this work. Progress includes:

- HerParks research at Cardiff University explored how teenage girls and young women experience local parks and play areas, finding that many feel excluded by design, safety concerns and lack of voice.
- Cardiff Council collaborated with AtkinsRealis to test a new framework for child-centred design, identifying improvements to independent routes, visibility, playful features and safe routes of movement.
- The inclusion of a dedicated Play Policy and Supplementary Planning Guidance (SPG) in the Replacement Local Development Plan 2021-2036 seeks to embed and enhance inclusive play opportunities and greenspace access across the city.

By designing and building public spaces that are genuinely inclusive, welcoming, and designed with children's voices at the heart, we can create healthier spaces that children and teenage girls feel safe and empowered to use. This will make a meaningful difference in how children grow, move and thrive.

Healthy Settings

- Brought a wide range of partners together to consider the influences, how they affect each other, who has a role to play and what they can do in supporting schools to embed whole school approaches to food and physical activity.
- Early Years partners explored what influences how these settings access, use, and embed food and movement training and resources, and how they create opportunities for 'healthy conversations' with families.

Spotlight on Active Soles

Active Soles aims to change the culture of workplaces by giving employees permission to wear comfortable shoes. What we wear changes the way we think and behave. Wearing comfortable shoes at work makes it easier to build movement into the day, such as taking extra steps, taking the stairs instead of the lift, standing at desks instead of sitting, or walking meetings.

Cardiff and Vale University Health Board, Cardiff Metropolitan University, Cardiff Council, and Vale of Glamorgan Council have all adopted Active Soles, and the feedback has been overwhelmingly positive. Senior leaders are role-modelling active soles, and colleagues are swapping traditional footwear for more active alternatives. There have been reports of improvements in physical health, mental health too, as well as boosts to team morale and productivity.

Ruth Jordan, Assistant Director for Improvement, Implementation and Spread at Cardiff and Vale University Health Board, said wearing trainers to work has made a "massive difference" to her wellbeing. "I'm a physiotherapist by background, so I was used to being on my feet all day, everyday walking thousands of steps. Then I got another job which meant I was desk-bound," she explained. "I felt grumpy, lethargic and put on too much weight. It was terrible. But being given permission to wear trainers to work has made such a difference to getting up and about – and my step count has gone up no end." Ruth said seeing senior leaders also wearing comfortable shoes around the office has given others the confidence to do the same. "We're now having walking meetings, and a lot of our one-to-ones are on the go. It's actually improved the working environment."

Active Soles continues to grow and expand, with more organisations joining in. Visit the website to find out more: **https://makeyourmove.org.uk/activesoles**

Healthy People

- Food-related benefits training package updated, improving the links to community food initiatives like Food Pantries and providing resources, posters, and videos to share with communities.
- Activity finder being developed to support communities to access local physical activity opportunities in Cardiff.
- Families living in more disadvantaged communities supported and connected to local opportunities for play, physical activity, nutrition and food activities.
- Research undertaken with parents to better understand barriers and enablers to breastfeeding to influence policy development.
- Roll out of the Planet Card by Food Cardiff Partnership which aims to support low-income households to access healthy food.

Spotlight on Food Vale Partnership work through the Llantwit Major Food Access Partnership Project

Food Vale is the local food partnership for the Vale of Glamorgan and is driving Good Food and Movement action. Over recent years, in response to increasing levels of deprivation caused by the cost of living crisis there has been a groundswell of community-led projects. These seek to improve access to affordable food by providing no or low-cost food, often redirecting surplus food from supermarkets.

Whilst this is often deemed as a win-win in terms of reducing food poverty and preventing food waste, there can also be distinct risks[57]. By simply providing free or low-cost food to the individual, we risk failing to address the root causes of household food insecurity.

To address this, Food Vale has been working with partners to improving access to food in the Vale of Glamorgan, using the 'Food Ladders Toolkit'[58] to understand some of the root or 'systemic' causes of food insecurity and identify resources and opportunities to reduce vulnerability and improve community resilience.

This was first trialled in the award-winning, Llantwit Major Food Access Partnership Project. So far this has seen; two food pantries being supported in the rural Western Vale, the establishment of a community drop-in hub to provide face-to-face community support around food-adjacent issues, investment in local community growing spaces and practical cooking and nutrition skill building opportunities. Importantly, community engagement has been an integral part of this work, ensuring that it is being led by those with lived experience.

Funding secured from both Welsh Government and The National Lottery Community Fund, will see a roll-out of this approach across the whole of the Vale of Glamorgan from 2026.

To find out more visit: **https://foodvale.org/llantwit/**

5. What more can we do?

As described, we are already making some great progress towards preventing obesity and type 2 diabetes. However, we need to go further and act faster to reduce the number of people living with and experiencing the consequences of obesity and type 2 diabetes.

This report is my call to action. I have identified three key areas that if we all commit to doing well, will move us forward and accelerate our efforts. These are:

1. Make prevention the focus

2. Create supportive spaces and places

3. Put communities at the heart

5.1 Call to action 1: Make prevention the focus.

Why this call to action?

We can't treat our way out of the current situation. With over a quarter of reception aged children and over half of adults living with overweight and obesity in Cardiff and the Vale of Glamorgan the only real solution is prevention to keep people healthy and well and stop the development of these preventable health conditions.

Public sector organisations have a duty to focus efforts and resource on prevention as a core goal of the Wellbeing of Future Generations Act[59] with the principle of 'acting to prevent problems occurring or getting worse as well'.

Obesity and type 2 diabetes are both mainly preventable. Currently our resources and budgets are directed towards treatment and managing the complications of these conditions. This reactive approach is unsustainable. There needs to be a shift in resource and budget to ensure we can make prevention the focus, enabling our whole system approach to progress at the pace and scale needed to have population level impact.

What do we mean by prevention?

Prevention can often mean different things to different people[60]. Broadly, prevention is any action that keeps people healthy and prevents or avoids the risk of ill health or death. Prevention can be grouped by the stage at which action is taken, as well as focus on whole populations or particularly high-risk groups/individuals.

Figure 6: Types of prevention

TYPE	DEFINITION	EXAMPLE
Earliest stage prevention	Acting early to stop the influences that lead to obesity and type 2 diabetes from occurring	• Designing our places and spaces so that they support and enable access to good food and movement • Restricting food and drink advertising • Protecting and building new green spaces and places to play, be active, take part in sport
Primary prevention	Acting to reduce or manage the known harmful influences that are leading to obesity and type 2 diabetes	• School programmes that actively support healthy eating and active lifestyles • Community initiatives supporting active lifestyles and healthy eating
Secondary prevention	Acting to detect and manage obesity and type 2 diabetes early to stop them getting worse	• Diabetes risk assessment in primary care • Community weight management programmes
Tertiary prevention	Acting after obesity and type 2 diabetes have developed helping people to live well with their health condition preventing complications and improving quality of life	• Specialist weight management services • Diabetic Eye Screening • Diabetes annual check ups

What we need to do

As an underpinning call to action, we need to make earliest stage prevention the focus by:

- Building more capacity for our whole-system approach for Good Food and Movement so that we can take stronger action at pace, scale and at the 'earliest stage' to stop the influences that lead to obesity and type 2 diabetes from occurring. This will require public sector organisations to prioritise prevention and refocus spend.
- Putting earliest stage prevention of obesity and type 2 diabetes at the centre of all our decision-making, as part of our duty to prevent problems rather than react to them. By doing this, we can activate every opportunity available to us to change the influences.

Call to action: Make Prevention the Focus

1. **Public sector budgets need to prioritise and refocus spend towards to the earliest stage prevention of obesity and type 2 diabetes**
2. **Put the prevention of obesity and type 2 diabetes at the centre of all our decision-making**

5.2 Call to action 2: Create supportive spaces and places.

Why this call to action and what do we need to do?

We know what surrounds us shapes us. The spaces and places where we live, work, learn and play make all the difference. We are already making progress towards creating supportive spaces and places but need to go further:

- Plan, design, build and enhance the spaces and places around where we live (e.g. our neighbourhoods, high streets, parks, playgrounds, roads, and public transport routes) so that movement is designed into everyday life and access to healthy food is easy and affordable.
- Design, build and operate the places where we spend our time (e.g. our schools, workplaces, hospitals, community centres) to support and enable good food and movement.

Some of this we can continue to progress locally as there are lots of opportunities. For example, through; the Replacement Local Development Plans (RLDPs) for Cardiff and the Vale of Glamorgan alongside Supplementary Planning Guidance (SPG) development, regeneration and placemaking, and through the roll out of the new Curriculum for Wales[61] and School Improvement.

To enable us to take local action, we may also need wider policy change at a national level (e.g. changing the use class of hot food takeaways through national Planning Policy Wales). Working together, we can identify where wider policy change is needed and use our strong local voice to advocate for national change.

Call to action: Create supportive spaces and places

1. **Plan, design, build and enhance the spaces and places around where we live with a focus on movement and to ensure access to healthy affordable food**
2. **Design, build and operate the places where we spend our time to support and enable good food and movement**
3. **Use our strong local voice to influence and advocate for wider policy change**

5.3 Call to action 3: Put communities at the heart.

Why this call to action and what do we need to do?

As already described, there are unfair differences across our communities. We know that people living in our most disadvantaged areas don't always have access to the same opportunities for good food and movement.

Many community groups, third sector and public sector organisations are already doing fantastic work using a range of approaches and working with many communities across Cardiff and the Vale of Glamorgan to create change. This brings diversity, creativity and strong local connections.

To build on this we need to:

- Continue to focus our collective community health development resource and efforts in the communities that need it most.
- Work with our communities to develop solutions together that reflect communities' unique needs, priorities and ideas.
- Consider how we co-ordinate our efforts so that we all pull in the same direction towards our shared goals.

By coming together to share our learning, develop a picture of what is going well and where, we can agree what more we need to do together.

Call to action: Put communities at the heart

1 **Come together and build a picture of community health development; what is going well and where, to identify what more we can do together to support and enable good food and movement**

6. What will be the impact?

If we respond to my calls to action, we will build the capacity that we need to accelerate action at pace and scale and stop the influences that lead to obesity and type 2 diabetes.

The impact of this is described in Figure 7.

Figure 7: Examples of how creating change will lead to impact

Create supportive spaces and places

	1	2	3	4	5
IF WE	Restrict the advertising of foods and drinks high in fat, sugar and or salt (HFSS)	Ensure everyone has equitable access to local facilities that enable them to be active	Improve the availability of spaces for community food growing	Build safe connected routes for walking and cycling	Design and develop inclusive and safe parks and playgrounds
THIS LEADS TO	Healthier foods and drinks on display Reduced persuasive messaging for HFSS foods and drinks Less advertising driven purchasing of HFSS foods and drinks A shift in purchasing towards healthier food	Well located facilities Decisions about building new or upgrading facilities being informed by need Reduced barriers to accessing facilities Improved access	More spaces for food growing (e.g. allotments, school gardens, community plots) More families and community groups growing fruit, vegetables and herbs Improved skills, knowledge and confidence to grow food	More separate cycle lanes, wider pavements, safe road crossings, secure bike parking and well-lit routes Routes becoming more direct and easier to navigate People feeling safer when walking or cycling	Parks and playgrounds being co-designed with children and young people with safety built in (e.g. soft surfaces and lighting) Children of all ages, abilities, backgrounds and identities feeling safe and comfortable to join in More families visiting and using parks and playgrounds
RESULTING IN	People eating less HFSS foods and drinks and more healthy foods	More people being more active more often	People eating what they grow and sharing surplus produce with their community	More people walking and cycling	More children and young people playing and being active

Create supportive spaces and places

IF WE
Improve the availability of healthy food in our workplaces

THIS LEADS TO
- Healthier food and drink options in canteens, vending machines and at catered meetings
- Healthy food being more accessible and visible

RESULTING IN
More healthy food being eaten in the workplace

IF WE
Embed strong policy guidance in workplaces to enable physical activity

THIS LEADS TO
- Visible organisational commitment and a supportive culture for movement in the workplace
- Facilities such as bike storage, changing rooms, standing desks, staff incentives to be active and comfortable footwear
- More opportunities and fewer barriers to being active in the workplace

RESULTING IN
Staff being more active in the workplace

IF WE
Build physical activity into all parts of the school day

THIS LEADS TO
- Movement becoming a routine part of the day and not something extra
- Active breaktimes, active lessons, changes to the physical environment, active travel, prioritised PE, sport and extra-curricular activity
- Children and young people developing confidence, skills and enjoying being active

RESULTING IN
More children and young people being active every day

IF WE
Prioritise healthy food across all parts of the school day

THIS LEADS TO
- More opportunities for children and young people to access, experience and learn about healthy food
- Healthy food becoming part of daily school life through lessons, food provision, school culture, policies, role modelling and staff training

RESULTING IN
More children and young people eating, enjoying and learning about healthy food

IF WE
Ensure early years settings value and promote active play and support positive relationships with food

THIS LEADS TO
- Physical spaces being redesigned to encourage movement and play
- Daily routines integrating movement, play and learning about food
- Staff being confident to support and engage children in active play/ promote good food
- Families being aware and supported to enable play
- Nutritious menus

RESULTING IN
More young children being active and enjoying healthy food everyday

Put communities at the heart

IF WE
Better understand our current approach to community health development

THIS LEADS TO
- A more co-ordinated strategic approach to community health development
- Reduced gaps, duplication, and strengthening of community assets
- Improved use of funding
- Changes being made with communities so solutions meet their needs
- Better flow between communities and strategic decision making

RESULTING IN
Communities with greatest needs being supported and enabled to live well

IF WE
Take a place-based approach to good food and movement

THIS LEADS TO
- Local needs being identified and addressed
- Communities and key partners working together to co-design solutions
- Supported and enabled communities

RESULTING IN
Reduced barriers to good food and movement

IF WE
Ensure support for families is targeted to those most in need

THIS LEADS TO
- Areas of greatest need being identified and supported
- Tailored support to meet needs
- Engaged families
- Improved knowledge, skills and confidence

RESULTING IN
More families are supported to engage in active play and access good food

IF WE
Take action to support communities experiencing food poverty

THIS LEADS TO
- Food poverty and its root causes being addressed
- Policies and programmes developed to support communities experiencing food poverty through emergency food aid and community food initiatives
- People accessing food related benefits
- People receiving emergency food where needed

RESULTING IN
Improved access to good food

IF WE
Connect people to opportunities to be active

THIS LEADS TO
- More supportive conversations with people about physical activity to find suitable physical activity opportunities that are right for them
- An activity finder tool that helps to connect people to physical activity opportunities tailored to their needs (e.g. when, where, cost, type, level)
- Increased awareness of local physical activity opportunities

RESULTING IN
More people accessing local physical activity opportunities

7. Conclusion

My report has shared what influences how we live, how society has changed and what impact this has had on obesity and type 2 diabetes in Cardiff and the Vale of Glamorgan. The wide range of influences described make preventing obesity and type 2 diabetes a complex challenge and our approach must reflect this. We need to shift from traditional approaches which have focused on individual behaviours to approaches that recognise and address the broader influences that shape the food we eat and how we move.

We are already making some great progress. However, we need to go further and act faster if we are to reduce the number of people living with and experiencing the consequences of these health conditions.

My calls to action will accelerate our collaborative effort and create change so that together we can have the population level impact that is needed to reduce the number of people living with obesity and type 2 diabetes in Cardiff and the Vale of Glamorgan.

Change is possible. Together we can prevent obesity and type 2 diabetes.

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Appendix 1

DPH Report 2024: Prioritising the Early Years – Investing for the Future

Progress update

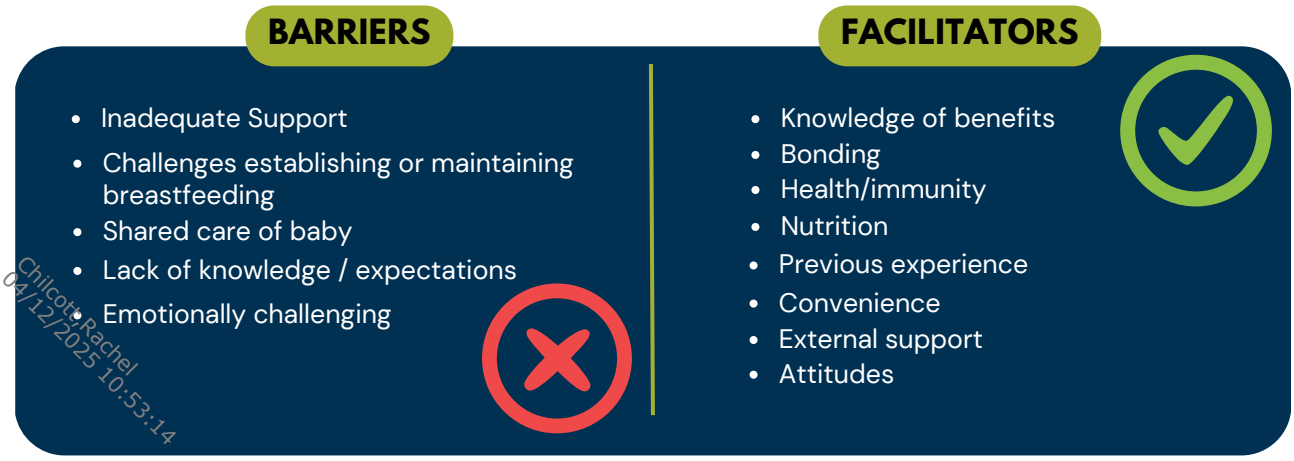
Following publication of the 2024 DPH Report `Prioritising the Early Years – Investing for the Future', much progress has been made in addressing the recommendations contained in the report.

A launch event was held in April 2025, which brought together colleagues from across the early years space, to share the findings and add their expertise and knowledge in taking the recommendations forward together. Speakers on the day included colleagues from Play Wales, Cardiff and Vale UHB and its Youth Board, Vale of Glamorgan Council, Cardiff Council and the Royal College of Paediatrics and Child Health.

Following on from this success, Claire Beynon will lead the Starting Well Partnership which will have a distinct focus on the early years.

Notable successes to date include:

- Completion of an early years Health Needs Assessment
  Key findings include –
  - School readiness: data last published in 2019 suggested significant inequalities between social and gender groups. The population group with the highest percentage of children assessed as ready for school were boys of White British ethnicity. The population group with the lowest percentage of children assessed as ready for school in this period were girls from traveller backgrounds.
  - Childcare Supply: Childcare place provision in Cardiff in 2023-24 was 189.07 per 1000 children. Provision in the Vale of Glamorgan in 2023-24 was 254.53 per 1000 children.
  - Health Visiting: 60220 children did not receive their health visiting appointments during the 2020-2023 (including COVID-19 pandemic) period. 43895 children in Cardiff and 16325 in the Vale of Glamorgan did not receive their full health visiting appointments during the COVID pandemic period 2020-2023. There have been improvements in more recent data with the service.
- An updated Childhood Immunisations Strategy, which will include a detailed delivery plan focussing on key areas:
  - Improving access
  - Communications and engagement
  - Data and intelligence
  - Measles Prevention
  - The strategy is supported through a series of annual delivery plans.
- Further breastfeeding research undertaken and completed to help understand the barriers and facilitators to improving breastfeeding rates across Cardiff and the Vale
  A number of recommendations were made from this research which are being advanced through the Infant Feeding Strategic Group within the Health Board.



- Comprehensive mapping of the key early years actions identified in 'Good Food and Movement' is underway. Partners from across the early years workforce have been invited to workshops and meetings to input their knowledge and expertise. This will develop into several actions around how early years settings can support babies and young children through healthy eating and keeping active.

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