Public Quality Committee

3rd March 2026
14:00pm via MS Teams

Public Agenda

1. **14:00**	**Standing Items**	**Lead**
1.1	Welcome, Introductions & Apologies:	Ceri Phillips
1.2	Declarations of Interest	Ceri Phillips
1.3	Minutes of the Quality Committee Meeting held on 20.01.2026	Ceri Phillips
1.4	Action Log – Following the meeting held on 20.01.2026	Ceri Phillips
1.5	Chair's Actions taken since last meeting - *none*	Ceri Phillips
2 **14:05**	**Items for Review & Assurance**	
2.1 *45 mins*	Audit / Escalation Update (to include ref to Quality & Safety Governance and Structured Assessment 2025)	Matt / Jason / Natasha / David
2.2 *10 mins*	JACIE Report	Jess Castle
3. **15:00**	**Items for Approval / Ratification**	
3.1 *15 mins*	Policies – - *3.1.1 - Healthy Eating Standards for Hospital Restaurant and Retail Outlets* - *3.1.5 - Biological Medicines Value Optimisation Policy* - *3.1.7 - Policy for Commissioning a Review of a Service, Clinical Department, or Clinician*	Claire Beynon / Helen Griffiths David McRae Alex Scott
3.2 *15 mins*	Quality Management System (QMS)	Jason / Natasha / David
3.3 *10 mins*	Annual Quality Report 2024/25	Alex Scott
4. **15:40**	**Items for Noting & Information**	
4.1 -	Minutes from Clinical Board QSE Sub Committees - *standing item* - *PCIC Clinical Board – 18.11.2025* - *CD&T Clinical Board - 18.02.2026* - *Specialist Services Clinical Board – 19.01.2026*	Jason Roberts
4.2 -	Safeguarding Steering Group Minutes – *standing item - there has been no meeting since Sep 2025*	Jason Roberts
4.3 -	IP&C Group Minutes – *standing item*	Jason Roberts
5. **15:50**	**Items to bring to the attention of the Committee**	Ceri Phillips
6.	**Agenda for the Quality Committee Private Meeting:**	
	i. Private Minutes & Actions *ii. Any Urgent / Emerging Themes – Verbal (Confidential Discussion)* *- standing item -10 mins - Execs*	Ceri Phillips
7.	**Any Other Business**	Ceri Phillips
8.	**Review of the Meeting**	Ceri Phillips

	Please would Committee members share their opinions on using Microsoft Teams for meeting papers.	
9.	**Date & Time of Next Meeting:** 14th April 2026 at 2pm via MS Teams	Ceri Phillips

Draft Minutes of the Public Quality Committee

Held on 20th January 2026 via MS Teams

To view the meeting: CAVUHB Public Quality Committee 20.01.2026

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Clive Curtis	CC	Independent Member - Community
Mike Jones	MJ	Independent Member – Trade Union
Judi Rhys	JRH	Independent Member – Third Sector
Rhian Thomas	RT	Committee Vice Chair / Independent Member – Capital & Estates
Kirsty Williams	KW	UHB Chair
In Attendance		
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Natasha Goswell	NG	Deputy Executive Nurse Director
Angela Hughes	AH	Assistant Director of Patient Experience
Matt Phillips	MP	Director of Corporate Governance
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
David Thomas	DT	Director of Digital & Health Intelligence
Catherine Wood	CW	Deputy Chief Operating Officer
Additional Attendees		
Michael Allum	MA	Consultant in Public Health
Timothy Banner	TB	Clinical Director Pharmacy & Medicines Management
Abigail Holmes	AHO	Director of Midwifery and Neonatal Services
Karenza Moulton	KM	Senior Nurse Acute Child Health
Clare Wade	CW	Director of Nursing – Surgery Clinical Board
Robert Warren	RW	Assistant Director of Health, Safety and Fire
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Claire Beynon	CB	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Lauranne Cullen	LC	Regional Director for Llais
David Fluck	DF	Executive Medical Director
Suzanne Rankin	SR	Chief Executive Officer
Stephen Riley	SR	Independent Member – University

QC 2026/01/1.1 Chilcott.Rachel 25/02/2026 16:12:06	**Welcomes, Introductions & Apologies** Ceri Phillips (CP), the Committee Chair, welcomed everyone to the meeting in English & Welsh. Apologies for absence were noted.	ACTION

QC 2026/01/1.2	**Declarations of Interest** No declarations of interest were raised.	
QC 2026/01/1.3	**Minutes of the Committee meeting held on 09.12.2025** The minutes of the Committee meeting held on 09.12.2025 were received. **The Committee resolved that:** a) The minutes of the meeting held on 09.12.2025 were approved as a true and accurate record of the meeting.	
QC 2026/01/1.4	**Action Log following the Meeting held on 09.12.2025** The Action Log following the Meeting held on 09.12.2025 was received and discussed. QC 2025/12/2.1 - UHB Quality Indicators Report – EPMA: - Jason Roberts (JR) informed the Committee that whilst EPMA was referred to in the report for item 2.1, more detail would be included in April's report to provide a more detailed insight on trajectory and emerging themes/trends. QC 2025/12/2.1 - UHB Quality Indicators Report – Improvement Objectives and Trajectories: Kirsty Williams (KW), the UHB Chair, asked whether there would be an opportunity to contribute to conversations around what the future of the Committee would look like. Matt Phillips (MP), the Director of Corporate Governance, explained that he would be considering a new Terms of Reference, which would go to Board for a decision in March 2026. There would need to be a consultation process before then. CP asked for any comments on the Committee meeting to go to Rachel Chilcott (RC), the Corporate Governance Officer. JR explained that the team are in the process of producing consistent templates for Clinical Boards to use in reporting through the Committee. They will be building in the "Rescue KPIs" discussed with the Chief Nursing Officer (CNO) and Chief Medical Officer (CMO) to ensure they are reflected within the reports. **The Committee resolved that:** a) The Action Log from the meeting held on 09.12.2025 was noted.	
QC 2026/01/1.5	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QC 2026/01/2.1	**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 December 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. Topics discussed included, but were not limited to:	

- Patient Safety Incident Reporting
- Infection Prevention and Control (IP&C)
- Deteriorating Patients
- Patient Falls
- Pressure Damage
- Medication Safety
- Mortality
- Audit and Assurance / Internal and External Assurance
- Workforce
- Concerns (themes grouped by UHB-wide and by Clinical Board)
- Patient Experience

KW asked for more detail around timescales to the different programmes of work, and provided the following comments:

- Pressure damage – there was not much indication within the report on progress and when they would expect to see outputs from these workstreams and programmes of work
- NRIs – 73% of cases had been categorised as no/low/moderate harm but asked for a further breakdown of these figures.
- IP&C – more information on timescales was needed, particularly for work around Aseptic Non-Touch Technique (ANTT). She queried how confident they were that all clinicians would participate in the training, and whether they could get a breakdown on the different clinical workforce groups who had/had not completed the training.
- Mortality – KW asked when they would have a higher level of assurance around the mortality figures and the coding issue around stroke would be resolved.

AS responded that further detail on the trajectory of improvement work could be expanded upon in future reports.

KW asked for a note to be circulated, rather than waiting until the following Committee meeting – ACTION.

Rhian Thomas (RT), the Committee Vice Chair, commented that understanding the expected impact of the activity would be valuable.

Regarding equity, access, and coproduction, Clive Curtis (CC), the Independent Member – Community, asked that given the recurring theme of delays, communication, and discharge, what their strategic, system-wide approach was to address these as system-wide inequalities rather than isolated service issues. Additionally, he asked how they would strengthen the role of community voices in shaping quality improvement and service redesign.

AS recognised the need to reflect inequalities across all the quality indicators, but that currently the UHB and national datasets for protected characteristics were limited. They were working with the Public Health team on how to improve.

Judi Rhys (JRH), the Independent Member – Third Sector, highlighted the role of the Third Sector in falls prevention, as there was a lot of expertise and support available which could strengthen the training and awareness work.

CC asked what impact AI was having on the UHB and the concerns team, giving that response times had reduced across Wales, and how were they supporting staff through the transition.

	AH responded that they were seeing an impact. AI had benefits, but how they used it was crucial. AH reminded the team that they needed to check responses for compassion and ensure the response truly answered the person's questions. The new Listening to People guidance also strengthened early personal contact. Mike Jones (MJ), the Independent Member – Trade Union, noted his disappointment to see reports of unprofessional or insensitive behaviour. He asked whether these were large numbers, and where a staff member had been named, how this was handled. AH responded with the following: • Though not a large number, the increase was enough that it should be brought through the Committee. • Any issues raised were followed up immediately. If something needed to go through professional/disciplinary routes, it was escalated to the relevant lead. • They also received compliments and most interactions were positive. But they must get it right every time. KW clarified that they were not currently meeting the Welsh Government (WG) response times target, and asked what steps were being taken to improve response times. AH responded with the following: • They should meet WG targets, but they also needed to ensure responses were high quality • They were doing focused work – CAVUHB's number of longstanding complaints were the lowest in Wales, but still needed to improve • They worked with complainants to agree questions for investigations, looked for themes, encouraged proactive communication, and used the enquiries line to resolve issues quickly. Complaints were reviewed regularly with Clinical Boards. • Volume remained a challenge, but they explored all options and learned from other UHBs. KW explained that it was challenging, and whilst they needed to balance timeliness with quality, they must still meet performance expectations. JR provided assurance that these discussions were ongoing, and the team were working on a focused piece of work around concern responses. They were mindful that some KPIs would change with the new regulations. JRH explained that most people raised concerns because they wanted to see change, not compensation. They needed to show clearly how complaints led to real improvements. JRH noted that whilst patient experience surveys were useful, she had seen in previous roles that often patients gave glowing feedback publicly, whilst sharing serious concerns privately. Many did not want to "rock the boat" during treatment, fearing that it might affect their care. They needed to help people feel safe and confident to speak honestly about their treatment. AH noted that they always included learning in their responses, explaining the actions taken and offered to meet. The new guidance would help, as not everybody needed a formal complaints route and instead needed bereavement support or a safe space to share their story. AH explained that surveys went out three days after discharge and were anonymous unless people chose to provide their details. Asking patients whilst they were still in	

	hospital was harder, as many were reluctant to be critical. They had volunteers who helped gather more independent feedback, and they also relied on input from third-sector partners. **The Committee resolved that:** 1) The assurance provided by the Quality Indicators was noted; 2) The work underway to drive requisite improvements was noted.	
QC 2026/01/2.2	**Children & Women Clinical Board Quality Indicators Report** The Children & Women Clinical Board presented their assurance report and slides to the Committee which detailed the achievements, progress and planned actions within the Children & Women Clinical Board to maintain the priority of QSPE. Topics discussed included, but were not limited to: • NRI and Patient Safety Incident Reporting • IP&C • Quality Audits & Performance • Deteriorating Patient • Patient Falls and Pressure Damage • Medication Safety • Mortality • External Assurance / Clinical Audit and Assurance • Workforce • Patient Experience • Concerns • Equitable Care Regarding neurodiversity, KW observed that demand for assessment and post-diagnosis support was far beyond what the current services could manage, and families still needed help without a formal diagnosis. They needed a joined-up approach with the voluntary sector, education, and social services. KW suggested having a discussion outside of the meeting to understand the work underway. Regarding coroner's cases, KW noted that they had a big impact on staff and public confidence. She asked what role the Committee or Board should have in gaining assurance that all the findings and actions are being addressed. Abigail Holmes (AHO), the Director of Midwifery and Neonatal Services, agreed that for neurodiversity there were long waits, a surge in referrals, and a service not design to meet the scale of the need. They were using year-end funding to reduce the backlog, but they anticipated over 1000 children needing assessments the following year, plus the ongoing support that followed. They also needed more consistency across Wales, as assessment pathways differed widely, and education services played a major role but were not fully linked into the process. AHO explained that for coroner's cases, an action plan alone was not enough, and that they needed to show real, demonstratable learning. This meant being transparent about what happened, what has changed, and how they will ensure it won't recur. They should be reporting measurable outcomes back so that the Committee and Board can gain assurance that improvements were embedded and sustained. **A meeting to be set up between KW, CP, and members from the Children & Women and the Mental Health Clinical Board around neurodiversity demand - ACTION**	

	To improve assurance to the Committee and Board regarding actions and learning from high-profile coroner's cases and inquests, ensuring that outcomes and evidence of change are shared, not just action plans – ACTION. AH explained that they brought PFDs through the Quality Committee to monitor them, but the higher-profile cases needed clearer assurance. They recorded the learning, but they did not always share how it was being acted on. AH noted that the implementation of Badgernet was a major achievement, and the real-time information it provided was already having an impact. AH asked for more detail on AHO explained that Badgernet was the digital maternity system launched in July 2025. They chose a full go-live, which was a big shift for midwives, but was now providing data they had never had before. The real-time dashboards would be hugely valuable. It had long been used in neonatology, but now their systems linked across Wales. **The Committee resolved that:** 1) The contents and assurance provided within the report and the steps being taken to improve quality, safety, and patient experience was noted.	
QC 2026/01/2.3	**WHO Checklist Implementation and Compliance** Clare Wade (CW), the Director of Nursing – Surgery Clinical Board, shared their presentation with the Committee, which summarised the following: • The WHO Collaborative was established following a culture review in main theatres, which aimed to standardise WHO checklist use, improve leadership, and foster a culture where all staff felt empowered to speak up about safety. • Audits revealed that whilst checklist usage was high, multi-signature compliance was inconsistent. The process was revised to require one signature per step, focusing on meaningful engagement rather than administrative compliance. • A new, simplified WHO checklist was being developed, with input from multidisciplinary teams. Standardised team brief whiteboards would be introduced in all theatres to enhance communication and risk awareness. • The new Aqua theatre management system had been launched, with plans to integrate WHO checklist processes in the future, whilst maintaining a focus on safety culture rather than tick-box compliance. CC asked how they were supporting staff who felt responsible for chasing signatures or managing the process. CW responded this was why they stood the sticker initiative down, as they did not want staff chasing signatures. The aim was to move towards open, real-time communication in theatres, where staff feel comfortable raising concerns immediately. They would continue these conversations through the Theatres Together workstream, which was a wider piece about culture and behaviours. CP noted that this work covered a lot of key areas, and getting it right was essential in preventing issues such as NRIs and never events. **The Committee resolved that:** 1) The update was noted.	

QC 2026/01/2.4	**Limited Cyber Security internal audit report - implications for quality & safety** David Thomas (DT), the Director of Digital & Health Intelligence, presented the Internal Audit report on Cyber Security to the Committee, and summarised the following: • The audit identified gaps in cyber risk awareness, risk management, and governance at Clinical Board level. • Actions taken included strengthening clinical board engagement, clarify information asset ownership, and ensure cyber risks were consistently identified and logged via AMAT. • Ongoing assurance included targeted engagement through Operations Delivery Group (ODG), development of standardised information asset registers and training, and a planned cyber resilience exercise. RT explained that for a limited assurance audit, a follow-up was normally done 12 months later. She asked whether they expected to see considerable progress and actions completed by then, or whether substantial work would remain. DT expected the three audit actions linked to clinical board engagement to be completed, as they now understood their roles in tracking information assets and contributing to the Cyber Improvement Plan. The remaining actions were already in progress, so they should have addressed everything identified by the follow-up audit. CP explained that this audit was brought to the Quality Committee because cyber-attacks posed a major risk and attempts to breach NHS systems were constant. DT added that they were being assessed by the Cyber Resilience Unit (CRU) on their readiness. **The Committee resolved that:** a) The update was noted.	
QC 2026/01/2.5	**Bariatric and Medical Cylinders - Patient Safety** Robert Warren (RW), the Assistant Director of Health, Safety and Fire, presented the report and summarised the following: • The first part of the paper covered the need for a clinical pathway for plus-size patients and the importance of its implementation. The issue currently sat on the Health & Safety risk register, but the People & Culture Committee advised that it should be clinically led. He requested to transfer it to an appropriate clinical lead for implementation. • The second part of the paper related to a medical gas incident that occurred during patient transfer. A cylinder placed on a bed slipped off, fracturing a staff member's toe. This had RIDDOR implications and highlighted wider risks, including loss of containment from high-pressure cylinders and potential supply issues for patients. The matter had gone through the Medical Gas Safety Group. • The request was for clinical teams to provide details of how many bed-mounted cylinder brackets may be needed. These bespoke brackets allowed cylinders to be safely secured during transfers. JR explained that he was responsible for oxygen and medical gases in the organisation. He completed the required training alongside around 60 staff, including lead and senior nurses, to strengthen clinical leadership in this area. The training, delivered by BOC,	

	highlighted the legal requirements for safe storage and maintenance of oxygen in clinical areas. JR noted that oxygen training should form part of mandatory training for nurses and other clinical staff handling cylinders but is picking this up with clinical boards to understand current compliance levels and support. KW commented that the issue was not just purchasing the kit, it was ensuring its consistent use. RW responded that this was the role of the Medical Gas Safety Group – training was being reviewed and rolled out, but communication was key. Closing the gap was not just about buying equipment; it must be properly implemented. Timothy Banner (TB), the Clinical Director Pharmacy & Medicines Management, informed the Committee that he chairs the Medical Gas Safety Group, which met monthly with a wide estates and multidisciplinary team (MDT). These points would be picked up in these meetings. RW reiterated that Health & Safety still needed involvement in the plus-size pathway, particularly around fire safety, manual and patient handling. They were not handing over their responsibilities, but they could not act as the clinical lead as they did not have the required expertise. JR explained that in his role as the Executive Lead for oxygen and gases, he had committed to supporting RW and the team. They would introduce regular audits – likely through the Tendable platform – aligned with their usual environmental audits, to provide RW and TB clear oversight across clinical area. **The Committee resolved that:** A) The risk of the plus-size patient pathway as being clinically or patient safety led was accepted; B) The patient risk when transferring with medical gas cylinders was acknowledged, and the drive with suitable communication to determine the magnitude of the issue and to assist in resolving was supported.	
	Items for Approval / Ratification	
QC 2026/01/3.1	**Policies** UHB 484 – Independent and Supplementary Prescribing Governance Framework TB presented the framework which was revised to meet new WG and HIW standards. **The Committee resolved that:** A) The Independent and Supplementary Prescribing Governance Framework was approved.	
	Items for Noting & Information	
QC 2026/01/4.1	**Minutes from the Clinical Board QSE Sub-Committees** **The Committee resolved that:**	

	1) The Clinical Board QSE Sub-Committee minutes were noted.	
QC 2026/01/4.2	**Safeguarding Steering Group (SSG) Minutes** *The previous SSG meeting was cancelled.*	
QC 2026/01/4.3	**IP&C Group Minutes** *The previous IP&C Group meeting was cancelled.*	
QC 2026/01/4.4	**Controlled Drugs Accountable Officer Annual Update** TB presented the Annual Report on controlled drugs management, highlighting incident trends, audit activities, and ongoing work to improve security and oversight. **The Committee resolved that:** A) The progress made during the last 12 months was noted.	
	Agenda for Private Quality Committee Meeting	
QC 2026/01/5.1	*i) Minutes and Action Logs from the Private QSE Committee on 09.12.2025* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*	
	Any Other Business	
QC 2026/01/6.1	CP noted it was MJ's last Quality Committee. He thanked MJ for his commitment and support to the Committee.	
	Date & Time of Next Meeting:	
QC 2026/01/7.1	3rd March 2026 at 2pm via MS Teams	

Title	Minute Reference	Agreed Action	Executive Lead	Action Lead	Date Assigned	Date for Review	Action Status	Action Update
UHB Quality Indicators Report	QC 2026/01/2.1	Circulate further information on the UHB Chair's queries raised around the trajectories and data within the Quality Indicators Report.	Jason Roberts	Alexandra Scott	20/01/2026	03/03/2026	IN PROGRESS	Action to be marked as complete once the information has been circulated.
Children & Women Clinical Board Quality Indicators Report	QC 2026/01/2.2	Arrange a meeting between KW, CP, and members from the Children & Women and the Mental Health Clinical Board around neurodiversity demand	Ceri Phillips	Caroline Andersson	20/01/2026	03/03/2026	COMPLETE	Meeting arranged for 13th March 2026.
Children & Women Clinical Board Quality Indicators Report	QC 2026/01/2.2	Improve assurance to the Committee/Board regarding actions and learning from high-profile coroner's cases and inquests, ensuring that outcomes and evidence of change are shared, not just action plans	Jason Roberts	Angela Hughes	20/01/2026	03/03/2026	COMPLETE	Update from Angela Hughes - 'We will review each case individually to determine the most appropriate forum for discussion. All Prevention of Future Deaths (PFD) reports will be monitored through the Quality Committee until completion, with additional use of Board and Board Development sessions as required. In determining the appropriate forum, we will also take into account any active litigation and the wishes of the family'

Report Title:	Audit Update (Quality & Safety Governance and Structured Assessment 2025)				Agenda Item No:	2.1	
Meeting:	Quality Committee		Public	x	Meeting Date:	03/03/2026	
			Private				
Status	Assurance	x	Approval		Information/Noting		x
Lead Executive:	Jason Roberts - Executive Nurse Director						
Report Author Title:	Natasha Goswell - Deputy Executive Nurse Director						

Main Report
Background and Current Situation:

The purpose of this paper is for Quality Committee to be aware of the content of the advisory audit on the Quality and Safety Governance arrangements within the Health Board and the quality aspects of the Cardiff and Vale University Health Board Structured Assessment 2025 and assured of the actions required.

1. **Advisory audit on the Quality and Safety Governance arrangement**

The **NWSSP Audit & Assurance** conducted an advisory audit on the Quality and Safety Governance arrangements within the Health Board. This audit was commissioned yt he Chair and Chief Executive following the theatres internal review that revealed insufficient governance and oversight within the Surgery Clinical Board. The audit aimed to evaluate the appropriateness and effectiveness of the current governance arrangements and identify areas for improvement. The Audit has primarily focussed on the Medicine and Surgery Clinical Boards, while also reviewing the wider corporate quality and safety governance arrangements within the Health Board.

As this is an advisory audit there is no assurance rating provided.

There were 5 scoping objectives as detailed below

	Objectives	Related Actions
1	Establish and evaluate the current Quality & Safety Governance arrangements operating within the Health Board	1
2	Are the current arrangements clearly documented within relevant policies / procedures and are they readily available / known across the organisation	2, 3, 4
3	Do the arrangements allow for a clear and timely route of reporting, escalation and assurance from ward and service areas up to the Board	5, 6
4	Are the processes within the Clinical Boards operating in accordance with the stated policies / procedures	7, 8
5	Do key management and clinical staff within the Clinical Boards have a good knowledge and understanding of the processes and what they should do if they become aware of an issue	9

Key Findings:

1. **Governance Arrangements**: The Health Board has established Quality and Safety Governance arrangements that are generally in line with other Health Boards in Wales and relevant Welsh Government guidance.
2. **Documentation and Awareness**: There is a Quality, Safety and Experience Framework 2021-26 in place, but it has not been revised since its inception. There is a lack of centralised oversight and detailed guidance for Clinical Boards and Directorates, leading to a general lack of awareness among staff.
3. **Reporting Mechanisms**: The reporting mechanisms are inconsistent, with delays in submitting reports to the Health Board Quality Committee. There is also a lack of clarity and timeliness in the reporting routes from ward and service areas to the Board [3].
4. **Clinical Board Processes**: Both the Medicine and Surgery Clinical Boards have scheduled Quality meetings, but there are inconsistencies in reporting and a lack of standard templates for Quality and Safety Groups [4].
5. **Staff Knowledge and Understanding**: A survey revealed that while staff are generally aware of quality and safety processes, there are concerns about the clarity of escalation processes and the promptness of issue resolution [5].

The following opportunities have been identified that the Health Board may wish to take forward in order to strengthen processes:

- Inclusion of target dates in relation to escalation framework actions.
- Production of a comprehensive structure chart to illustrate the quality and safety governance arrangements within the Health Board.
- Establishing a register of quality and safety groups and compiling a list of quality and safety leads.
- Production of guidance for Clinical Boards and Directorates.
- Ensuring the regularity of reports to the Quality Committee.
- Co-ordination of meeting frequency and scheduling between the tiers of the governance hierarchy.
- Provision of support to Clinical Boards in ensuring all relevant areas are encompassed by the quality and safety governance arrangements.
- Production of Terms of Reference, and implementation of contingency measures to mitigate the impact of shortcomings in administrative support resources.
- Production of supporting guidance for staff.

An action plan has been suggested for completion and oversight and is suggested that this is within AMAT with quality committee oversight and assurance on completion of these. These actions also link with the work of the QMS system and therefore a need to triangulate so that there is no duplication.

2. Quality aspects of the Cardiff and Vale University Health Board Structured Assessment 2025

The **Structured Assessment 2025** evaluates the governance, financial management, and assurance systems of the Cardiff and Vale University Health Board. The assessment focuses on four key areas: the development of strategies and plans, board effectiveness, risk and performance management, and financial management. It also reviews the Health Board's progress in implementing previous recommendations.

Whilst the below provides details on the key findings in regard to the whole structured assurance, the paper will focus on the quality aspects of the structured assessment.

In July 2025, Welsh Government escalated the whole Health Board to Level 4 (Targeted Intervention), due to concerns across all areas in the escalation and intervention framework. The Health Board and Welsh Government are working to agree criteria for de-escalation.

Key Findings:

1. **Governance and Planning**:
    a. The Health Board has made progress in developing its Annual Plan and Clinical Services Plan, aligning them with its long-term strategy.
    b. Strategic portfolios require clearer delivery roadmaps and stronger committee oversight.
    c. The Health Board is at Level 4 (Targeted Intervention) under Welsh Government's escalation framework due to concerns across all areas.
2. **Board Effectiveness and Transparency**:
    a. The Board and committees work well, with a commitment to public transparency and hearing from patients and staff.
    b. Improvements are needed in the sound quality of livestreamed meetings and timely publication of Advisory Group papers.
    c. The Board has experienced significant turnover among Independent Members, with some key positions still vacant.
3. **Risk and Performance Management**:
    a. The Health Board is strengthening its systems of assurance but needs to improve risk and performance management.
    b. The Board Assurance Framework is reviewed regularly, but corporate risk oversight remains unclear.
    c. A new Performance Management Framework is required to clarify roles and accountability for performance improvement.
4. **Quality and Safety Monitoring**:
    a. The Health Board is progressing its Quality Excellence Programme, focusing on areas such as hospital-acquired infections and patient follow-ups.
    b. There is a need to comply with the Duty of Quality and Duty of Candour requirements, including producing an annual quality report.
    c. Clinical audit plans require better monitoring and reporting at the committee level.
5. **Financial Management**:
    a. The Health Board faces significant financial challenges, with a forecast year-end deficit of £56.2 million against a Welsh Government control total of £9.1 million.
    b. It has not met its financial duty to break even and lacks an approved Integrated Medium-Term Plan.
    c. Savings targets are not being met, and there is a gap in recurrent savings identified.

Key Quality Aspects:

1. **Quality Governance**:
    a. The Health Board is developing a Quality Management System and implementing projects to improve hospital-acquired infections, patient follow-ups, and acute deterioration management.
    b. The Quality Committee oversees quality and safety but needs to strengthen reporting on clinical audits and compliance with statutory duties like the Duty of Quality and Duty of Candour.
2. **Patient and Staff Engagement**:
    a. The Health Board has launched initiatives like "Leaders who Listen" and "Speaking Up Safely" to improve patient and staff engagement and address cultural concerns.
    b. Regular patient and staff stories are shared with the Board and committees to inform decision-making.
    c. Since last year, the Health Board has clarified the process and purpose of its patient safety walkarounds. In August 2025, it launched 'Leaders who Listen'. This is wider than Board Members visiting services and includes clinical board leadership walkabouts and learning and feedback mechanisms. While it is too early to comment on its effectiveness, it is a positive step forward. A quarterly report identifying key themes and learning will feed into both the People and Culture, and Quality committees.
3. **Monitoring and Reporting**:
    a. The Health Board is working to develop an integrated dashboard to streamline monitoring of deliverables.
    b. Reports to the Board and committees are generally of good quality but could be improved by adopting an "Alert, Advise, Assure" format to focus on the impact of actions.
4. **Recommendations Tracking**:
    a. The Health Board is using the Audit Management and Tracking (AMaT) system to manage recommendations but needs to improve processes for tracking regulatory audit recommendations and analysing common themes.

In relation to specifics for quality and safety the following was highlighted within the report.
The Quality Committee maintains oversight of the quality and safety of services. It continues to receive assurance through routine reports such as Quality Indicators and Clinical Board Assurance reports, as well as reports on topics such as nationally reportable incidents and internal and external service reviews.

The Health Board is progressing its Shaping our Future Quality Excellence Programme, with high-level updates included in the Quality Indicators Report. The programme has four projects, which focus on:

- Developing a Quality Management System,
- Reducing hospital acquired infections,
- Preventing patients becoming lost to follow-up; and
- Improving management of acute deterioration.

As part of developing its Quality Management System, the Health Board is reviewing its quality governance arrangements. These are currently detailed in the 2021-26 Quality Safety and Experience (QSE) Framework. In addition, Internal Audit are currently reviewing the Health Board's quality and safety governance arrangements and are due to present their findings to the Audit Committee in February 2026, as described in point 1 of this paper.

The Quality Committee's terms of reference remain framed around the QSE framework, with responsibility for overseeing its implementation and receiving updates from several sub-groups. However, some groups are not reporting as intended. Such as the Learning Committee and the Clinical Safety and Concerns groups.

The Clinical Board Assurance and the Quality Indicators reports remain structured against the six pillars of quality, and the IPR includes some routine reporting on the Duty of Candour. However, there is no evidence that the Health Board has complied with the Duty of Quality requirement to produce an annual quality report for 2024-25. Nor could we see that it has included any commentary on how it is achieving its Duty of Candour within its annual reporting.

Reporting on clinical audit plans is limited. While the Health Board has an up-to-date Clinical Audit Policy requiring clinical boards and corporate audit plans to report to the Quality Committee twice a year, the Clinical Effectiveness Committee7
only reports annually. Additionally, neither the Quality Committee nor the Audit Committee has received the clinical audit plan for review or approval.

In summary the structured assessment identifies that while the Cardiff and Vale University Health Board has made progress in governance, planning, and assurance systems, significant challenges remain in financial management, risk oversight, and quality monitoring. The recommendations aim to address these gaps and enhance the Health Board's ability to deliver high-quality, sustainable healthcare services.

Recommendations:
The report outlines eight recommendations, of which four are pertinent to quality and safety for quality committee to be aware of, these include;

Recommendation 1: The Health Board should improve oversight of the strategic portfolios by:
1.1 Ensuring committees receive routine updates on strategic portfolio development and delivery relevant to their remit.
1.2 Structuring the Integrated Performance Report against the strategic portfolios, rather that the quadruple aims, to make it easier to track progress against Annual Plan and strategy delivery.

Recommendation 4: The Health Board should adopt an 'Alert, Advise, Assure' format for appropriate Board and committee reports, identifying:

- Areas of concern where actions are not delivering impact (Alert),
- Areas where actions are starting to make a difference (Advise), and
- Areas performing effectively (Assure).

Recommendation 7: The Health Board should strengthen monitoring of quality and safety by:
7.1 Ensuring it complies with the Duty of Quality requirement to produce an annual quality report.
7.2 Reporting annually on how it is achieving its Duty of Candour (see paragraph 59). 7.3 Review arrangements for monitoring and agreeing the clinical audit plan at committee level.

Recommendation 8: The Health Board should clarify Board and committee arrangements for reporting on its Quality Improvement and Efficiency Plan.

There was one recommendation from the 2024 structured assessment

Recommendation 3: As part of its review of arrangements for Patient Safety Walkabouts, the Health Board should consider how to ensure learning and resulting actions from walkabouts are reported to the Board. While it is too early to comment on its effectiveness, it is a positive step forward. A quarterly report identifying key themes and learning will feed into both the People and Culture, and Quality committees This was identified as being complete. It is noted that a quarterly report is due to quality committee at the time of writing.

Quality committee are to be reminded of the actions from the last committee which agreed to a review of the quality committee and governance arrangements that report to quality committee. At the time of writing this paper this is currently underway and will be reported at quality committee

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

Quality Committee are asked to note the actions from both internal audit report and structured assessment which include.

Internal audit

The following opportunities have been identified that the Health Board may wish to take forward in order to strengthen processes:

- Inclusion of target dates in relation to escalation framework actions.
- Production of a comprehensive structure chart to illustrate the quality and safety governance arrangements within the Health Board.
- Establishing a register of quality and safety groups and compiling a list of quality and safety leads.
- Production of guidance for Clinical Boards and Directorates.
- Ensuring the regularity of reports to the Quality Committee.
- Co-ordination of meeting frequency and scheduling between the tiers of the governance hierarchy.
- Provision of support to Clinical Boards in ensuring all relevant areas are encompassed by the quality and safety governance arrangements.
- Production of Terms of Reference, and implementation of contingency measures to mitigate the impact of shortcomings in administrative support resources.
- Production of supporting guidance for staff.

Structured Assessment

Recommendation 1: The Health Board should improve oversight of the strategic portfolios by:
1.1 Ensuring committees receive routine updates on strategic portfolio development and delivery relevant to their remit.
1.2 Structuring the Integrated Performance Report against the strategic portfolios, rather that the quadruple aims, to make it easier to track progress against Annual Plan and strategy delivery.

Recommendation 4: The Health Board should adopt an 'Alert, Advise, Assure' format for appropriate Board and committee reports, identifying:

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7.1 Ensuring it complies with the Duty of Quality requirement to produce an annual quality report.
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Recommendation 8: The Health Board should clarify Board and committee arrangements for reporting on its Quality Improvement and Efficiency Plan.

The recommendations from both reports have identified a need for a review of the governance of Quality committee and quality committee members are asked to note the actions to address this and are provided assurance that this will presented at quality committee for endorsement and approval at board to commence in April 2026.

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

1. Advisory audit on the Quality and Safety Governance arrangements within the Health Board Draft
2. Presentation of audit results to management executive meeting 20/10/25
3. Cardiff and Vale University Health Board Structured Assessment 2025 Draft

All appendices can be found in the 'Supporting Documents' folder.

Recommendations:

a) Quality Committee are asked to **note** for **awareness** of the contents within the draft advisory audit on the Quality and Safety Governance arrangements within the Health Board
b) Quality Committee are asked to **note** for **awareness** of the quality aspects of the Draft Cardiff and Vale University Health Board Structured Assessment 2025
c) Quality Committee are asked to have **assurance** of the actions being taken to address the areas identified for improvement.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please place an "x" in the below boxes where relevant – *Click each item for further information.*

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

Five Ways of Working (Sustainable Development Principles) considered:

Prevention		Long Term	x	Integration	x	Collaboration	x	Involvement	x

Quality Impact Assessment Completed?

Yes *(please include the complete QIA document)*	x	No *(please provide reasoning e.g. not required*	x	

Impact Assessment:

Risk: Yes
There is risk to the organisation if actions identified to strengthen quality governance and assurance are not completed
Safety: Yes
There is potential safety to the organisation if actions identified to strengthen quality governance and assurance are not completed
Financial: No
Workforce: No
Legal: No
Reputational: Yes

There is reputational risk due to being in targeted intervention level 4 for quality and no assurance of completion of improvements	
Socio Economic: No	
Equality & Health: No	
Decarbonisation: No	
Welsh Language: No	
Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:
Audit Committee	March 26
Management Executive	20 October 2025

Report Title:	JACIE Inspection Report				Agenda Item No:	2.2
Meeting:	Quality Committee		Public	X	Meeting Date:	03.03.26
			Private			
Status	Assurance	x	Approval		Information/Noting	
Lead Executive:	Catherine Phillips – Executive Director of Finance					
Report Authors:	Jessica Castle (Director of Ops Specialised Services) Katie Innes (Senior Strategic Planning Manager)					

Main Report

Background and Current Situation:

JACIE have issued their formal report (received 12.01.26), following the visit on 18th and 19th September and have deferred reaccreditation of the South Wales Blood and Marrow Transplant Programme.

While clinical outcomes and laboratory practice remain strong, inspectors identified critical deficiencies in adult facilities, workforce capacity, and the absence of a strategic estates' decision for the Processing Facility.

The Health Board must submit a credible, costed, and timelined corrective action plan by 8 July 2026. Failure to do so could lead to loss of accreditation and require NHS Wales to commission services from England.

Immediate Health Board Actions

1. Estates – Adult Transplant Facilities (Critical)

Risk: Inspectors were explicit that the adult estate is *not fit for purpose*. Without a funded plan, accreditation is unlikely.

The Health Board must deliver a signed off capital plan covering: -off capital plan covering: ○ Inpatient Haematology wards (B4/C5) ○ Adult Haematology Day Centre (HDC) ○ Ambulatory Care ○ Outpatients and TCT areas	Clear timescales for: ○ Short-term mitigations -term mitigations ○ Medium-term refurbishment ○ Long-term redevelopment (including new-build options (if required)

2. Processing Facility – Workforce and Safety

Risk: Repeated deficiencies raised by both JACIE and HTA.

CVUHB actions required:

- Update and resubmit the CAR-T Phase 2 business case, addressing:
  - Staffing deficits
  - 24/7 on call LN2 cover-call LN2 cover
- Implement strengthened risk controls following the recent SAE involving lost material

3. Programme Wide Quality Management -Wide Quality Management

- Recruit the Band 4 Quality Officer and temporary Band 7 Quality Manager without delay.
- Complete all procedural updates and document revisions needed to close partial/ non-compliances.

4. Paediatric Programme

- Finalise the paediatric options appraisal, including:
  - Case for excluding paediatrics from the accreditation scope as new patients below JACIE minimum threshold (with impact assessment).
  - Options to maintain competencies for bone marrow harvests and apheresis – consideration of combining with adult service

Programme Wide Actions (SBUHB & CVUHB)

Workforce Alignment Across the Region	

SBUHB must complete:
• Workforce and pathway gap analysis
• Business case to address:
  ○ Medical staffing deficits
  ○ Overreliance on a single specialist nurse
  ○ Introduction of prehabilitation and nurse led elements to ensure parity with CVUHB -led elements to ensure parity with CVUHB
	CVUHB to support and coordinate this work through the Programme Director.

Actions Requiring Escalation to NHS Wales

Processing Facility Long-term Strategy -Term Strategy
A national decision is now required between: 1. Expansion at UHW 2. Move to alternative site 3. A joint venture with Welsh Blood Service
Escalation reason: Option selection has system-wide implications, requires national capital prioritisation, and cannot be resolved by CVUHB alone.
Capital Requirements for Adult Transplant Estate
NHS Wales support is needed for: • Regional prioritisation • Capital allocation • Programme-level oversight
Escalation reason: The scale of required redevelopment is beyond discretionary UHB capital.

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

Estates

A number of capital options have been explored and shared both formally and informally with Welsh Government. Whilst there is recognition from Welsh Government that this is priority capital scheme there is no formal approval for capital funding for this project.

Work is approved and progressing to extend the Haematology Day Unit – this was an approved mitigating action following the inspection to address the risk of nosocomial infection due to the unsuitability of facilities and overcrowding in the unit. The mitigating action for the TCT cohort is that they will be transferred to the new Haem Day Unit once that is available.

There is a recognition by JACIE that a capital solution will not be in place within the 6-month period but there remains an expectation that by July 2026 we must provide concrete plans, with as much detail as possible, regarding how we will address the deficiencies.

Further options are being explored by the Clinical Board and Capital & Estates team, to include previously discounted options given the known constraints around capital available and support for complete new build options and timelines associated with this.

Workforce

There are several workforce issues that will require NWJCC support;

1. Approval of the CAR-T Phase 2 Business Case (previously submitted but placed on hold pending JACIE inspection) *funding from Welsh Government Advanced Therapies resource, not core JCC budget)

2. Uplift of SBUHB workforce to address deficits and fragility
3. Uplift of SBUHB workforce should increased throughput be considered

Governance

- JACIE Action Plan to be added to AMaT for corporate oversight
- Capital discussions to be managed through BMT Project Team and Capital Management Group
- Internal actions and JCC interface to be managed by Clinical Boards (SSCB/CD&T/C&W) and through Tertiary Services Development Group, as required (where needed SBU/CAV interface will be escalated via RSSPPP)

Monthly updates against the Action Plan to be shared at SLT by JC/SSCB as action plan owner.

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

1. Action list in response to the inspection report
2. JACIE Report (Inspection Date: 18/19th September 2025)
3. Risk Assessment (July 2025)

Appendices can be found in the 'Supporting Documents' folder.

Recommendations:

1. Approve governance route and reporting frequency for JACIE Action Plan oversight.
2. Note urgent recruitment underway to essential quality roles.
3. Note letters sent to CEO NHS Wales, NWJCC and key partners/stakeholders to advise on report outcome and escalate as appropriate

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		4. Acting for the Future	x

Five Waves of Working (Sustainable Development Principles) considered:

Prevention		Long Term	x	Integration		Collaboration	x	Involvement	

Quality Impact Assessment Completed?
Please place an "x" in the below boxes where relevant

Yes *(please include the complete QIA document)*		No *(please provide reasoning e.g. not required*	x	Not required at this stage

Impact Assessment

Risk: Yes
Risk Assessment attached
Safety: Yes
Risk Assessment attached
Financial: Yes
Yes there will be both financial and capital implications associated with this report but they are not yet fully assessed.
Workforce: Yes
Yes there are workforce implications which are yet to be full considered.
Legal: Yes/No
Unknown
Reputational: Yes
Loss of accreditation would have significant reputational implications, for the Health Board and NHS Wales
Socio Economic: Yes
Loss of accreditation could result in patients having to travel significant distance for treatment with the potential that this has a disproportionate negative impact on certain patients/patient groups.
Equality & Health: Yes
An EHIA will need to be complete as options are developed to mitigate the risk of losing accreditation. Should the accreditation be lost an EHIA will need to be complete to consider the implications of this.
Decarbonisation: Yes
The outcome of the accreditation, as well as the mitigating actions may have an impact and will need to be fully assessed and considered.
Welsh Language: Yes
Loss of accreditation may mean that this service is no longer available in Wales and therefore in Welsh

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:
Tertiary Services Development Group	30/01/26

Report Title:	Healthy Eating in Hospital Restaurant and Retail Outlets Policy			Agenda Item no.	3.1.1
Meeting:	Quality Committee	Public	x	Meeting Date:	03/03/2026
		Private			
Status:	Assurance	Approval	x	Information	
Lead Executive	Claire Beynon, Executive Director of Public Health				
Report Author:	Senior Public Health Practitioner Public Health Practitioner Consultant in Public Health Medicine				

Main Report

Background

It is often assumed that food choices are entirely a matter of personal preference; however, they are heavily shaped by the environments in which we live and work. The Director of Public Health Report 2025 `What Surrounds Us, Shapes Us' highlights that our surroundings profoundly influence our behaviours, and that settings such as the workplace play a significant role in determining the dietary options we have.

The costs of excess weight to the NHS in the United Kingdom are significant: obesity and overweight costs the NHS around £12.6 billion per year at 2025 costs.[1] One in 10 children aged 4-5 years old are already living with obesity when they start primary school. These children are 5 times more likely to go on to become obese adults.[2] We are now also seeing an increase in the number of children with type 2 diabetes, some as young as 9, being admitted to the Children's Hospital at University Hospital of Wales. Twenty-one percent of adults are living with obesity and are more likely to develop conditions such as type 2 diabetes.[3] People who are overweight or obese are more likely to develop complications when in hospital, requiring additional treatment and bed days.[4] One in 15 people aged over 17 and living in Cardiff and the Vale of Glamorgan have already been diagnosed with type 2 diabetes.[5] If current trends continue, around 1 in 11 adults in Wales will be living with type 2 diabetes by 2035.[6]

Reducing levels of obesity remains one of the top public health priorities for preventing ill health to minimise health inequalities in line with our organisational strategy. *Good Food and Movement* is the local framework for Cardiff and Vale of Glamorgan, taking a whole systems approach to ensure that we create environments, settings and opportunities that enable good food for our population. What surrounds us, shapes us and we need to work together to improve the availability of good food across public sector sites to ensure that our hospital sites present a healthier food environment to staff, patients and visitors through implementing the *Healthy Eating in Hospital Restaurant and Retail Outlets Policy (*see Appendix A).

The Healthy Eating Standards for Hospital Restaurant & Retail Outlets were introduced in 2015. The Standards recommended a 75:25 split in favour of healthy foods. However, progress towards achieving the Standards has at times been hindered by capacity, financial barriers and a lack of enforcement. Focusing on behaviour change interventions has limited impact. The wider influences in our food environment are what shapes us.

Nationally this work has been used as an exemplar for The *Healthy Weight; Healthy Wales* strategy, where hospitals are viewed as a key setting to alter the way our population is exposed to unhealthy food and drink. Cardiff and Vale UHB were leading the way with work to improve the retail environment, however other health boards are now pushing for more stringent policies.

In February 2025, a relaxed version of the criteria (65:35% split) was agreed by Quality Committee for 12 months as a result of the financial deficit faced by the Catering Team. This was with the agreement that there would be a return to the original criteria (75:25) by the end of the calendar year.

It was also agreed that any expression of interest documents informing new tenancies for shops selling food and drink, would contain an expectation that external retail providers adhere to a 60:40 split, in favour of healthy options. This report outlines the need to reinstate the 75:25 split as planned and provides an update on current levels of access to healthy foods across our sites.

Current Situation

All UHB-run restaurant and retail outlets and external vending provision were audited across November and December 2025. The average overall compliance for the UHB-run outlets was 69% (up from 67% last year).

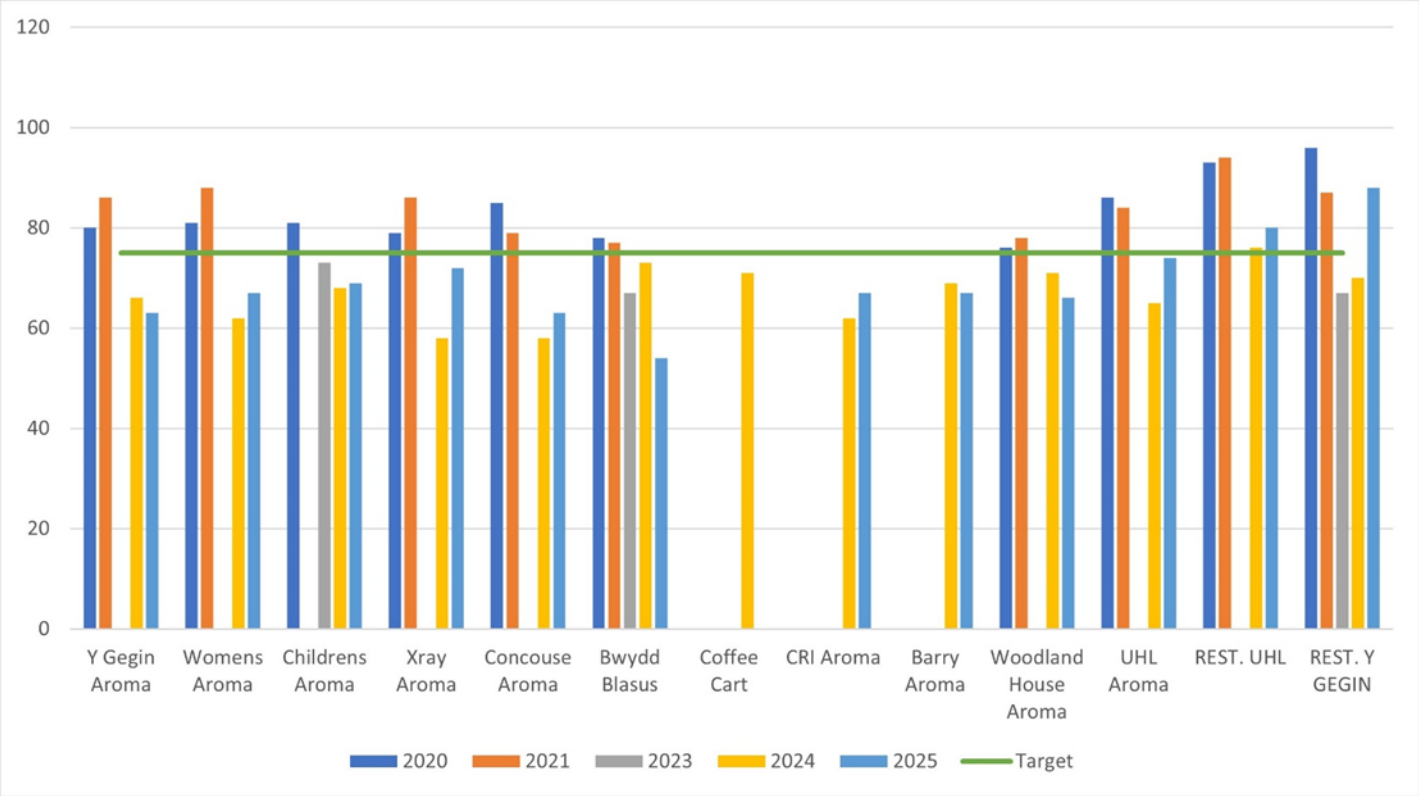

Figure 1: Average percentage of healthy foods available by venue from 2020 to 2025

Figure 1 shows that since 2023 the average volume of products high in fat and sugar has significantly increased, clearly seen by the drop in compliance since this time.

A further breakdown of compliance for each category: hot food 97%, cold food 68%, drinks 80%, and snacks and confectioneries 48%, shown in Figure 2. A Comparison of the data collected from 2020 to 2025 is shown in Figure 2. All of the main café outlets were well below the target on the snacks and confectionery category as shown in Figure 2.

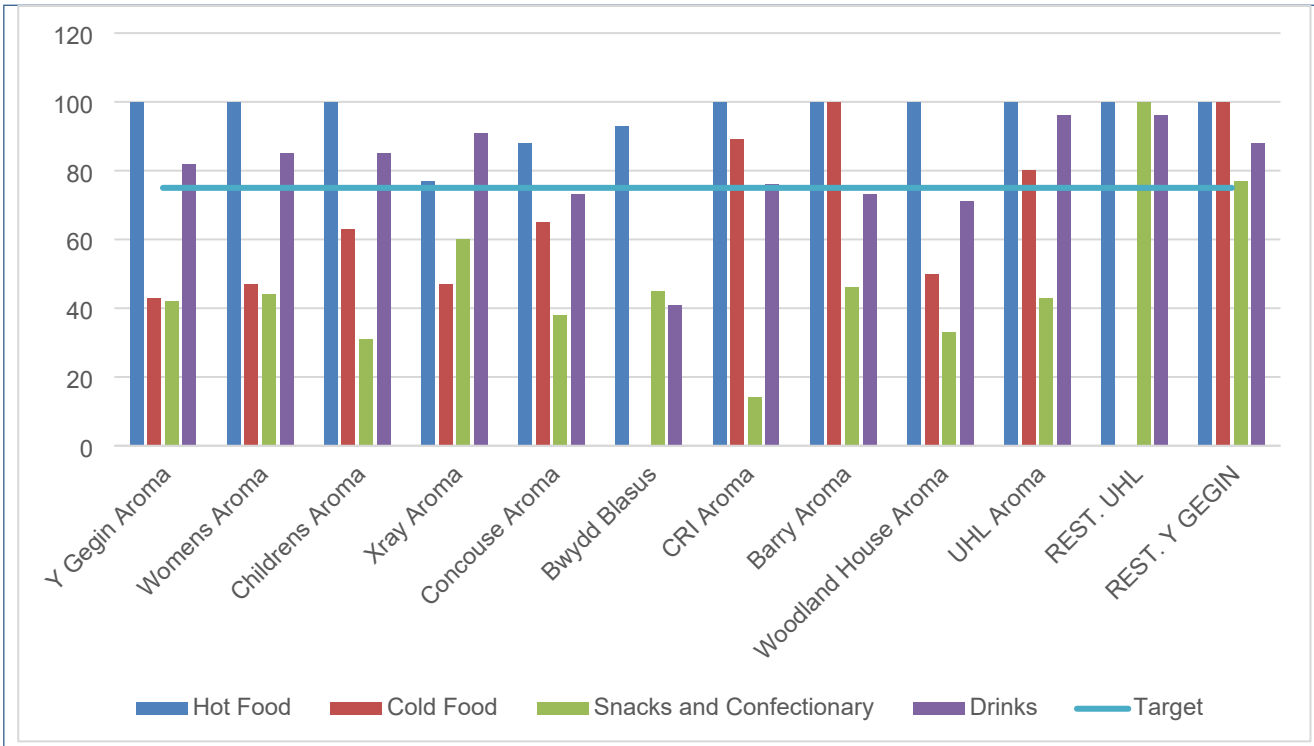

Figure 2: Average compliance from 2025 audits, showing all four category breakdowns.

The Standards require that all categories meet the compliance target. Snacks and confectioneries remain an area of concern, due to the volume of products high in fat and sugar on sale at the outlets.

External provision (Shop retail)
In 2025 audits for Marks and Spencer and WHSmith were completed for the first time. Marks and Spencer was 54% compliant and WHSmith 36% compliant. The criteria are included in the expression of interest form but not as a contractual arrangement. This is an area for improvement identified from the audit.

Vending
The breakdown of the vending machine compliance is shown in Figure 3, comparing this year's results to 2024. Average compliance was 69%, an increase from last year, however very few machines achieved the 75% target. Those with low stock levels scored lower but follow the same product planogram, therefore all offer the range of healthy options we would expect to see. The current provider has worked alongside us to source healthier options and ensure the machines are well stocked. This is an area for improvement identified by the audit.

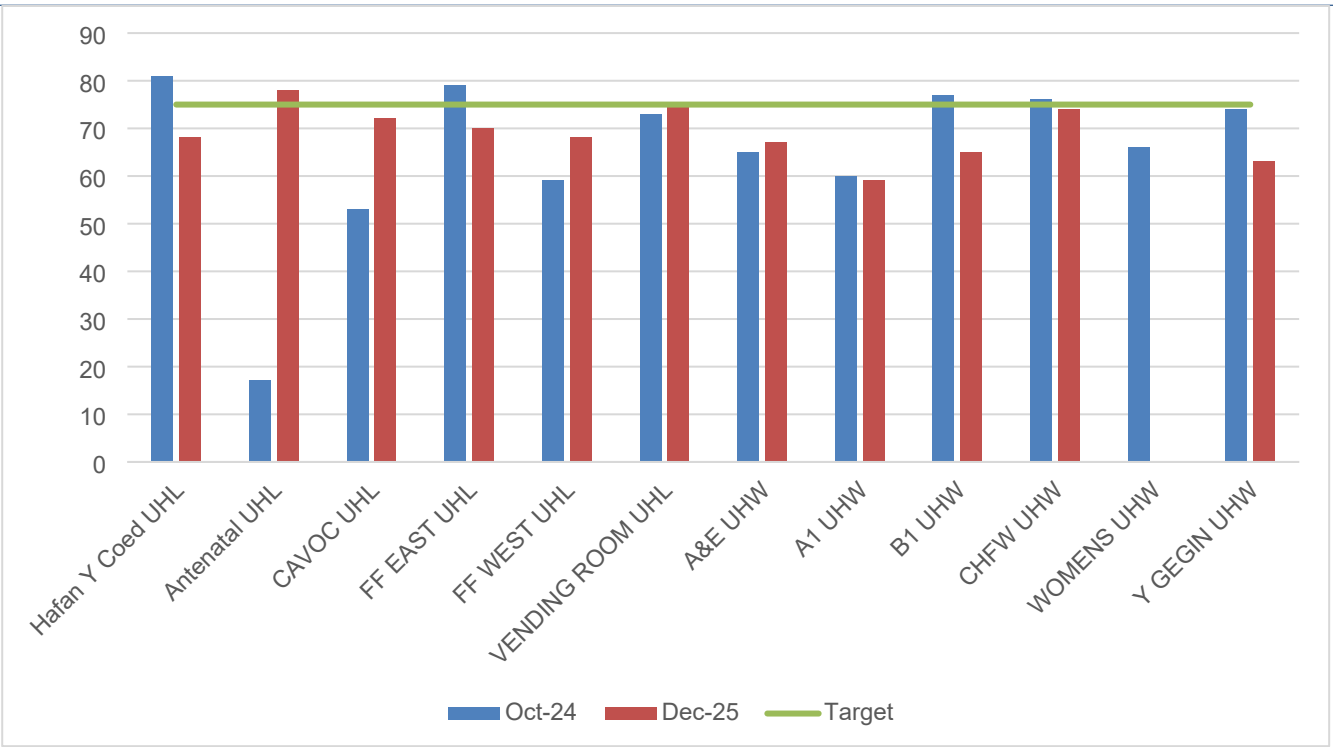

Figure 3: Vending audits comparison October 2024 and December 2025

In the future, audits will continue to be carried out regularly with additional spot checks to ensure compliance and will be reported to the Nutrition and Catering Steering Group for action, and back to this Committee annually.

NB: These standards do not apply to inpatient food provision, which must currently comply with the Welsh Government All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (2011).

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

1. Reducing levels of obesity remains one of the top public health priorities for preventing ill health across Cardiff and the Vale of Glamorgan.
2. Providing a supportive and healthy food environment to visitors, patients and staff at our hospitals is important.
3. This report outlines the need to reinstate the 75:25 split in favour of healthy foods as planned.

Appendices

1. UHB 272 Policy Cover Sheet
2. Appendix A_ Healthy Eating in Hospital Restaurant Retail Outlets Policy
3. Appendix B_EHIA Healthy Eating in Hospital Restaurant and Retail Outlets Policy

Appendices can be found in the 'Supporting Documents' folder.

Recommendation:

The Committee is requested to approve the adoption of this Policy to:

1. *Ensure that all internally and externally provided restaurant, cafe and vending outlets adhere to the 75:25 healthy food criteria.*
2. *Ensure that all internally and externally provided shop retail outlets adhere to the 60:40 healthy food criteria.*
3. *Ensure that all future contract/renewed lease agreements for the sale of food and drink on UHB sites, adhere to the criteria.*

4. *Ensure that all directorates with responsibility for procuring, producing and selling food and drink across the UHB retail outlets adhere to the criteria.*

Link to Strategic Objectives of Shaping our Future Wellbeing:			
1. Putting People First **Click the objective above to view more detail.**	x	2. Providing Outstanding Quality **Click the objective above to view more detail.**	x
3. Delivering in the Right Places **Click the objective above to view more detail.**		4. Acting for the Future **Click the objective above to view more detail.**	x

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

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

Impact Assessment:
Risk: Yes
There is a potential risk of non-compliance, and the number of unhealthy products on sale will increase.
Safety: No
Financial: Yes
There is potential for a financial impact for retail catering from any reduction in sales that occurs with the removal of unhealthy products.
Workforce: No
Legal: No
Reputational: Yes
There is a reputational risk if we do not comply with a 75:25 split, as we are currently the only Health Board in Wales with these measures in place.
Socio Economic: Yes
If prices continue to increase, it becomes more challenging for staff on lower incomes to be able to purchase a healthy and nutritious meal during their shift.
Equality and Health: Yes
If we do not return to a 75:25 split, we will be limiting access to healthy and affordable food for staff during their working day.
Decarbonisation: Yes

Offering healthier choices increases the consumption of fruit and vegetables on site supporting staff, patients and visitors to access healthier choices and pro-actively working to improve diet and prevent ill health in our population. We will continue to source a wider range of plant-based options and sustainable food and drink containers to reduce waste.	
Welsh Language: No	
A literature review revealed no findings on an association between the Welsh language and nutrition or healthy options. Press releases promoting the availability of healthy options are provided bilingually.	
Approval/Scrutiny Route *(please note anywhere else this paper has been before):*	
Committee/Group/Exec	Date:
Nutrition and Catering Steering Group	Circulated for approval February 2026
Quality, Safety & Experience Committee	03 March 2026

[1] Nesta (July 2025) The Economic and Productivity Costs of Obesity and Overweight in the UK Available at: The_economic_and_productivity_costs_of_obesity_and_overweight_in_the_UK_.pdf [Accessed on 4th February 2026]

[2] Cifuentes, R (2026) Children's Commissioner for Wales. Available at: Obesity/ Healthy Weight - Children's Commissioner for Wales [Accessed on 9th February 2026]

[3] Griffith, R. (2023) The costs of obesity Rachel Griffith Institute for Fiscal Studies and University of Manchester. Available at: The Costs of obesity [Accessed on 4th February 2026]

[4] Public Health Wales. 2018. *The case for action on obesity in Wales.* Available at: https://phw.nhs.wales/topics/overweight-and-obesity/the-case-for-action-on-obesity-in-wales/. [Accessed: 4th February 2026].

[5] StatsWales, Disease registers by local health board, cluster and GP practice Disease registers by local health board, cluster and GP practice [Accessed on 4th February 2026]

[6] Public Health Wales (2023) Public Health Wales Observatory. Available at: Diabetes prevalence – trends, risk factors, and 10-year projection - Public Health Wales [Accessed on 9th February 2026]

Reference Number: UHB 272 Version Number: 2	Date of Next Review: Previous Trust/LHB Reference Number:

HEALTHY EATING IN HOSPITAL RESTAURANT AND RETAIL OUTLETS

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure that staff, visitors and patients are encouraged and supported to eat well, with healthy options widely available, and a significant reduction in the quantity of energy-dense, high fat, high sugar and high salt food and drink products.

Policy Commitment

As part of our responsibility under the national obesity strategy, Healthy Weight: Healthy Wales[1], we will implement strict criteria, as outlined in the Healthy Eating in Hospital Restaurant and Retail Outlets Policy [appendix A] that supports people to achieve and maintain a healthy weight.

The UHB is asked to ensure compliance at all food retail outlets on our sites, requiring a 75:25% split in favour of healthy options, along with the eight standards outlined in the Policy.

This Policy also applies to any existing or new contracts for externally operated food retail outlets, including vending machines, restaurants and cafes. Any retail shops will require a 60:40% split in favour of healthy options.

Compliance is monitored through annual audits. Public Health, Retail Catering, Procurement and Dietetics Teams will work together to ensure nutritional information for all products is available, analysed and reported to the Nutrition & Catering Steering Group.

Note: This Policy document was previously referred to as Healthy Eating Standards for Hospital Restaurant and Retail Outlets.

Supporting Procedures and Written Control Documents

The Healthy Eating in Hospital Restaurant and Retail Outlets Policy outlines the criteria for healthy eating standards in food and drink outlets across the UHB.

Other supporting documents are:

1

- *Healthy Weight Healthy Wales Strategy & Delivery Plan*
- *The Food (Promotion and Presentation) (Wales) Regulations 2025*
- *Good Food & Movement Framework and Implementation Plan*
- *Welsh Government Vending Guidance (2012)*
- *Wellbeing of Future Generations Report (2025)*
- *Prevention of Ill Health - Obesity (Senedd Cymru October 2025)*
- *Equality and Health Impact Assessment (updated 2026)* ***[appendix B]***
- *Annual Report of the Director of Public Health*

Scope

This Policy applies to the provision of food and drink sold to our staff, visitors and patients, through UHB-run and externally contracted outlets.

Equality & Health Impact Assessment (EHIA) Part 1 - Equality Impact Assessment (EQIA)	An Equality Impact Assessment (EqIA) has been completed and this found there to be a positive impact. Key actions have been identified and these can be found in the attached Equality Health Impact Assessment (2025).

Equality & Health Impact Assessment (EHIA) Part 2 - Health Impact Assessment (HIA)	*As above.*
Policy Approved by	Quality Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Nutrition & Catering Steering Group
Accountable Executive or Clinical Board Director	Executive Director Public Health
Author	Senior Public Health Practitioner

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Approved by Quality Committee on dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*This is a revised document reflecting the change to a Policy* *Please note: Original Standards were approved by QSE in February 2025.*
2			

REFERENCES

1. Welsh Government. Healthy weight strategy: Healthy Weight Healthy Wales. Available at: https://gov.wales/healthy-weight-strategy-healthy-weight-healthy-wales [accessed 2 February 2026].

Report Title:	**Cardiff and Vale UHB Biological Medicines Value Optimisation Policy**				Agenda Item No:	3.1.5
Meeting:	Quality Committee	Public	X		Meeting Date:	3/3/2026
		Private				
Status	Assurance		Approval	X	Information/Noting	
Lead Executive:	David Fluck - Executive Medical Director					
Report Author:	Senior Pharmacist					

Main Report

Background and Current Situation:

On 6th October 2023, the Welsh Government wrote to Health Board Chief Executives with a set of actions to ensure that the best value brand of a biological medicine – most often a biosimilar - be prescribed for all patients receiving the biological medicine.

Biosimilars are used across all specialties within Cardiff and Vale UHB, with a relatively high utilisation of best value brand proportion compared to other Health Boards in Wales.

Currently, there is no clear policy on whether patients can opt out of brand changeovers from their existing biologic medicine—whether a reference product or a biosimilar—to a more cost-effective biosimilar. This ambiguity has resulted in inconsistent practice: some patients have been allowed to remain on their current treatment based on personal preference (where clinicians have lacked clarity to whether 'patient choice' extends to the brand of biologic medicine they receive), while others have undergone a brand changeover (or switch). Consequently, several biosimilar brand change programmes remain incomplete, with some patients continuing on significantly less cost-effective options. This situation creates inherent inequity and undermines consistency and fairness in prescribing decisions.

The Cardiff and Vale UHB Biological Medicines Value Optimisation Policy has been developed to establish a transparent, equitable, and sustainable approach to the use of biological medicines across the Health Board, while providing absolute clarity on the role of patient choice in brand changeovers. The policy was presented to MIGG prior to consultation in November 2025. MIGG agreed for the consultation to proceed and suggested consultation questions. Following the consultation period and the amendment of the initial draft to incorporate aspects of the feedback received, in January 2026 MIGG agreed for the document to move to the final approval stage at the Quality Committee.

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

Key Risk and Mitigation Summary for Biological Medicines Value Optimisation Policy

a) **Patient Experience and Adherence**

Risks:

Inconsistent or poorly framed communication may heighten patient anxiety, reduce treatment adherence, and amplify the nocebo effect. This risk extends beyond biosimilar switching and is relevant to any change in medicine presentation, formulation, or brand.

Mitigation Measures:

- Implementation of standardised communication materials, including approved patient letters and clinician guidance.

- Systematic identification of patients who may require personalised counselling or additional support.

b) **Operational Capacity**

Risks:
Large-scale switching initiatives can increase pressure on clinics, pharmacy services, and administrative teams, potentially affecting routine service delivery.

Mitigation Measures:

- Accountability placed with Clinical Boards to ensure adequate resourcing and capacity planning.
- Clear escalation pathways established to address operational constraints promptly.

c) **Equity and Compliance**

Risks:
Failure to appropriately adapt communication for individuals with protected characteristics may lead to inequitable access, reduced understanding, or noncompliance with Equality Act requirements.-compliance with Equality Act requirements.

Mitigation Measures:

- Requirements embedded within Section 5.3 of the policy and supported by the Equality and Health Impact Assessment (EHIA).
- Ongoing monitoring to ensure communication and processes remain inclusive and compliant.

d) **Supply Chain and Homecare**

Risks:
Transitions—particularly those involving homecare providers—can introduce risks of supply interruption, delayed deliveries, or inaccurate stock forecasting.

Mitigation Measures:

- Implementation checklist includes coordinated planning with homecare providers, clear stock management processes, and early engagement with pharmacy procurement teams.

e) **Reputational Risk**

Risks:
Patients may perceive a reduction in choice or autonomy, potentially generating complaints or negative feedback that could impact organisational reputation.

Mitigation Measures:

- Transparent communication emphasising the clinical and financial rationale for changes.
- Reinforcement of the organisation's commitment to patient engagement, safety, and equitable care.

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

No appendices included.

Recommendations:

The Committee is requested to:

a) **Approve** the policy.

Link to Strategic Objectives of Shaping our Future Wellbeing:

1. Putting People First		2. Providing Outstanding Quality	X
3. Delivering in the Right Places		4. 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)*	x	No *(please provide reasoning e.g. not required*		

Impact Assessment

Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: Yes
Yes. Reputational risks addressed in Executive Director Opinion section.
Socio Economic: n/a
Equality & Health: Yes
Addressed in the main body of the report
Decarbonisation: No

Welsh Language: Yes
Consideration should be given to potential impact on the Welsh language, including the following key aspects: • ***More than just words**: Yes* • ***Accessibility and compliance**: Yes* • ***Patient understanding and safety**: N/A* • ***Staffing and resources:** No* *Does the subject matter of your paper risk any of the above not being achieved? No*

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:
Medicines Implementation & Governance Group	15/1/2026

Reference Number: *UHB 567* **Version Number:** 1 *unless document for review*	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *New document*

Cardiff and Vale UHB Biological Medicines Value Optimisation Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will:

- Prescribe the best value brand of a biological medicine for all 'new' patients (i.e., those who have not previously received any brand of the specific biological medicine).
- Prescribe the best value brand of a biological medicine for 'existing' patients (those currently receiving a less cost-effective brand of the specific biological medicine) as better value brands become available, and we will not continue to prescribe less cost-effective brands of biological medicines to patients solely for reasons of patient preference.
- Inform patients that the brand of biological medicine they receive may change over time to ensure best value. We will communicate clearly and consistently to support patient understanding and confidence in treatment. We will always inform patients when a brand change is going to take place.
- Avoid prescribing a different brand of a specific biological medicine for a patient within 12 months of their last brand change.
- Not routinely revert to prescribing a less cost-effective brand if a patient experiences loss of disease control or adverse effects following a change of treatment to the best value brand.
- Not change brands of biological medicines at the point of dispensing (known as substitution)
- Always prescribe biological medicines by their brand name.

Policy Commitment

To maximise the value available from biological medicines across the organisation, while maintaining clinical standards and patient-centred care.

Supporting Procedures and Written Control Documents

This Policy describes the following:

- Use of brands of biological medicines

Other supporting documents are:

- UHB 389 Medicines Code

Scope

This policy applies to all of our staff in all locations including those with honorary contracts

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed and this found there to no impact.

Health Impact Assessment	A Health Impact Assessment (HIA) has been and this found there to no impact. *Note: if a HIA has not been completed indicate why*
Policy Approved by	Board/Committee/Sub Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Medicines Implementation and Governance Group
Accountable Executive or Clinical Board Director	Medical Director

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*State if either a new document, revised document (please list main amendments).* *List title and reference number of any documents that may be superseded*
2			
3			

1. Purpose

This policy sets out a transparent and equitable approach to ensure the sustainable use of biological medicines across Cardiff and Vale University Health Board.

2. Scope

This policy applies to:

- All clinical specialties prescribing biological medicines.
- All patients who are receiving or for whom there is a plan to commence treatment with biological medicines.
- All clinicians, multidisciplinary teams (MDTs) and pharmacy team members involved in the prescribing and supply of biological medicines.

3. Definitions

3.1 Biological medicines

Biological medicines offer treatment options for patients with chronic and often disabling conditions such as diabetes, autoimmune disease and cancers.

These medicines contain active substances from a biological source, such as living cells or organisms (human, animals and microorganisms such as bacteria or yeast) and are often produced by cutting-edge technology.

Most biological medicines in current clinical use contain active substances made of proteins. These can differ in size and structural complexity, from simple proteins like insulin or growth hormone to more complex ones such as coagulation factors or monoclonal antibodies.

3.2 Reference product* (or originator product)

A biological medicine reference product (also known as an originator product) is the original biological medicine that was first granted marketing authorisation, serving as the basis for the approval of subsequent biosimilar medicinal products.
*This policy uses the term reference product.

3.3 Biosimilar medicine

A biosimilar medicine is a highly similar copy of its reference product. Since it is not possible to replicate biological medicines exactly, a small degree of variation is expected and accepted so long as the biosimilar has no clinically meaningful differences from its reference product.

3.4 Interchangeability

Once authorised by the Medicines and Healthcare products Regulatory Agency (MHRA), a biosimilar product is considered to be interchangeable with its reference product, which means a prescriber can choose the biosimilar medicine over the reference product (or vice versa) and expect to achieve the same therapeutic effect.

Likewise, a biosimilar product is considered interchangeable with another biosimilar of the same reference product.

As a result of interchangeability, prescribing changeovers from one brand to another brand of a biological medicine (reference product or biosimilar) has become clinical practice. The decision rests with the prescriber in consultation with the patient, in line with the principles of shared decision making; both need to be aware of the brand name of the biological medicine prescribed.

3.5 Substitution

The practice of dispensing one medicine instead of another equivalent medicine at the pharmacy level without consulting the prescriber.

3.6 Nocebo effect

The nocebo effect is the opposite of the placebo effect. It describes a situation where a negative outcome occurs due to a belief that the intervention will cause harm.

For adverse reactions to medicines, nocebo implies that patients are more likely to experience an adverse effect if they expect or are worried about the adverse effect. The adverse effects may be physically experienced by the patient and are often clinically diagnosable. An example of the nocebo effect is the severe adverse effects experienced by patients taking a placebo during a clinical trial.

The nocebo effect in relation to biosimilar medicines is defined as the development of negative, subjective, and non-pharmacological side effects or symptoms caused by a patient's negative expectations or anxieties, rather

than the drug's actual, equivalent pharmacological action. It is a significant clinical challenge during brand changeovers that has the potential to cause treatment discontinuation, often triggered by misinformation or negative perceptions.

4. Responsibilities

Role	Responsible for:
Executive Medical Director	(a) Supporting and championing the use of best value biological medicines within the UHB. (b) Ensuring that all prescribers within the UHB adhere to this policy.
Clinical Board Triumvirate	(a) Providing capacity to implement prescribing of best value biological medicines in clinical teams within their clinical board. (b) Supporting and championing the use of best value biological medicines within their clinical board. (b) Ensuring that all clinicians within their clinical board adhere to this policy.
Director of Pharmacy & Medicines Management	(a) Ensuring the cost-effective use of biosimilar medicines; and the governance framework for the use of these medicines. (b) Ensuring accurate high-cost drug data is supplied to finance for invoicing/cross charging. (c) Ensuring that Pharmacy team members adhere to this policy.

5. Policy Statements

5.1 We will prescribe the best value brand of a biological medicine for all 'new' patients (i.e., those who have not previously received any brand of the specific biological medicine).

In line with the All Wales Medicines Strategy Group document "*Maximising the opportunity presented by biosimilar medicines: A national strategy for Wales*", the best value brand of a biological medicine must be identified for use within a speciality.

The best value brand will be identified by an assessment undertaken by a multidisciplinary group that will include the following as a minimum: Speciality Clinical Lead, Directorate Pharmacist and Medicines Procurement Lead & Homecare Manager.

While acquisition cost will be a major factor in identifying the best value brand, other criteria will be included in the decision-making process:

- Brand product range, presentation (e.g., pre-filled syringe), and stability.
- The robustness of the manufacturer's supply chain.
- Consideration of homecare service provision, if applicable.
- The total cost of treatment, including delivery and administration costs.
- Any negative or positive effects on patient adherence to the medicine (consider patient factors)

There may be more than one best-value brand for a given indication within a specialty. If the lowest-cost brand is not available in all required pharmaceutical presentations, it cannot be considered the best-value option for patients who need a specific presentation to enable administration. For example, if Brand X has the lowest acquisition cost but is not available as a pre-filled pen, it is not the best-value brand for patients who require that presentation.

The availability of new brands and the loss of exclusivity of reference products must be included in horizon scanning activities undertaken by the pharmacy directorate and the prescribing advisory branch of the Primary and Community Integrated Care Board (PCIC). The likely impact of prescribing the best value brand must be factored into financial forecasting where contract prices and timelines for availability in Wales are able to be confirmed by NHS

Wales Shared Services or the Medicines Value Unit (also based in Shared Services).

Existing Health Technology Appraisal advice for the reference products, published by the AWMSG or NICE, automatically apply to biosimilar brands of medicines licensed for the same indication as the reference product.

5.2 We will prescribe the best value brand of a biological medicine for 'existing' patients (those currently receiving a less cost-effective brand of the specific biological medicine) as better value brands become available, and we will not continue to prescribe less cost-effective brands of biological medicines to patients solely for reasons of patient preference.

The responsible prescriber, in consultation with the patient, will decide whether to initiate, continue, or change the brand of a biological medicine, taking into account clinical appropriateness, patient-specific factors, and the organisation's formulary and commissioning arrangements. Biological medicines are prescribed by brand name; brand selection is guided by the organisation's formulary and is not determined by patient preference.

Prescribing changeovers from one biological brand to another brand of the same biological (reference product or biosimilar) is established clinical practice.

There is no scientific rationale to expect different clinical outcomes when changing between brands of the same reference product and this is supported by real-world data. Biological medicines show a small degree of expected variation within their molecular structures. This occurs even between batches of the same product and is due to the variability of biological systems and manufacturing processes. Due to this variation, there is no reason to suspect that prescribing a different brand of a biological medicine would introduce more variability than the natural variation that occurs between batches of a reference product.

To ensure a robust implementation process for brand changeovers is followed in secondary care, the 'Best Value Brand Implementation Checklist' (Appendix II) must be followed. Prescribing brand changeovers originating in primary care must follow the 'Medication Switches Standard Operating Procedure".

No patient will be exempt from a prescribing changeover from a less cost-effective biological brand to the best value brand. In extreme circumstances, a changeover may be delayed by a maximum of 6 months only (12 months for pregnancy related requests) once approval from the CAV Biological Medicines Brand Oversight Group, a sub-group of the Medicines Implementation and Governance Group (MIGG), is provided. To request a

delay to a brand changeover, a 'Request to delay biological brand changeover form" must be completed and sent to:Formulary.Enquiries.cav@wales.nhs.uk.

On expiry of the approved delay (6 months; 12 months for pregnancy-related requests), the prescribing team must implement the brand changeover to the current best-value brand for the next prescription, unless a new clinical contraindication has arisen. No further supplies of less cost-effective brand will be authorised following the expiry of the approved delay.

Where a new reason for a delay arises for the same patient, a new request (with supporting evidence) must be submitted to the CAV Biological Medicines Brand Oversight Group.

5.3 We will inform patients that the brand of biological medicine they receive may change over time to ensure best value. We will communicate clearly and consistently to support patient understanding and confidence in treatment. We will always inform patients when a brand change is going to take place.

From the date of policy implementation, we will provide information to patients:

- At initiation of treatment: All patients starting therapy with a biological medicine must be advised that brand changes are likely to occur during their treatment journey.
- For existing patients: Those already receiving biological medicines should be informed during routine care discussions, such as follow-up appointments or medication reviews.

We will provide key messages to patients:

- We must explain that brand changes are driven by cost-effectiveness and NHS sustainability, not by differences in quality or efficacy.
- We must reassure patients that all biosimilars undergo rigorous regulatory approval and are clinically equivalent to the reference product.
- We must use positive framing: emphasizing that switching supports wider patient access and NHS resource optimization.

Adjustments for Protected Characteristics and Additional Support:

- Communication strategies must be adapted for patients with protected characteristics (e.g., disability, age, language barriers, cognitive impairment) to ensure understanding and reduce anxiety.
- Patients who may need the most support include those with mental health conditions (such as anxiety), learning disabilities, sensory impairments, or limited health literacy. These groups are at higher risk of experiencing the nocebo effect and should receive tailored explanations, accessible materials, and additional reassurance.

Documentation Requirements:

- Confirmation that this information has been provided must be recorded in the patient's clinical record.

All patients must be advised that a brand changeover is taking place and must be made aware of the name of the new brand they are to receive. The method of patient communication selected to inform the patient of the brand changeover will be decided in partnership between the clinical team and the relevant supporting pharmacy team.

Patients must be informed of the brand name they are receiving due to traceability and pharmacovigilance reporting purposes (many biosimilars carry a black triangle▼) if there are any suspected safety issues relating to the reference products or biosimilar medicines.

A record of all communications with the patient about the brand changeovers must be retained within the patient record.

5.4 We will avoid prescribing a different brand of a biological medicine for a patient within 12 months of their last brand change.

To preserve patient stability in their treatment regimen and confidence, we will not look to change brands of specific biological medicines prescribed more frequently than every twelve months.

Where patients have changed brands by a separate health organisation in the prior 12 months prior to their treatment being taken over by a Cardiff and Vale UHB prescriber, they will be prescribed the best value biological medicine upon transition to Cardiff and Vale UHB.

5.5 We will not routinely revert to prescribing a less cost-effective brand of a biological medicine if a patient experiences loss of disease control or adverse effects following a change to the best value brand.

Systematic reviews of brand changeovers, whether from reference products to biosimilars or between biosimilar brands have consistently shown no major loss of efficacy or increase in adverse events. [1-3]

If a patient's disease symptoms worsen, clinicians should include the following factors when assessing the likely cause:

Nocebo effect: Patient expectations or anxiety about changing brands may lead to perceived or real worsening of symptoms.

Natural disease fluctuation: symptom severity of some chronic conditions vary over time, independent of treatment changes.

In extreme circumstances, a clinician can request permission for a patient to revert to a less cost-effective brand of a biological medicine from the CAV Biological Medicines Brand Oversight Group. A 'Request Form To Delay Biological Brand Changeover Or Revert To Less Cost-effective Biological Medicine" must be completed and sent to: Formulary.Enquiries.cav@wales.nhs.uk.

5.6 We will not change brands of biological medicines at the point of dispensing (known as substitution)

Substitution – the practice of dispensing one medicine instead of another equivalent medicine at the pharmacy level without consulting the prescriber – is not permitted for biological medicines, including substitution between biosimilar medicines.

5.7 We will always prescribe biological medicines by their brand name

In line with MHRA guidance all biological medicines (including biosimilar medicines) must be prescribed by brand name.

In the post-authorisation phase as a result of manufacturing, product variability over time within and across products with similar active substances is possible. Therefore, a key requirement for pharmacovigilance of biosimilars is the need to ensure continuous product and batch traceability in clinical use to support detection of any important safety issues that may be product- or batch-specific.

As biosimilar medicines often use the same international non-proprietary name (INN) as their reference product, an important way to ensure substitution does not take place is through brand name prescribing.

Brand name prescribing must be adhered to by all prescribers of biological medicines, including biosimilars, and is in line with recommendations from the MHRA and NICE.

6. Governance

6.1 Complaints/Concerns

Patients wishing to raise a concern about not being able to remain on their favoured brand of a particular biological medicine will be issued a standard response by the UHB Concerns team – Appendix III.

6.2 Medicines Formulary

Formulary requests for biological medicines will follow the Formulary Application Procedure for New Medicines.

6.3 Pharmacovigilance

At market entry, all biosimilar medicines carry a black triangle▼.

The black triangle signifies that there is **less information available** about its long-term safety, so any suspected adverse reactions should be reported, even if they are minor.

Suspected adverse drug reactions (ADRs) must be reported via the Yellow Card Scheme.

6.4 Financial monitoring

The implementation of biosimilar medicines will be monitored via Medicines Implementation and Governance Group (MIGG) and via the NHS Wales Value & Sustainability delivery group.

7. References

1. Barbier L, Ebbers HC, Declerck P, et al. The efficacy, safety, and immunogenicity of switching between reference biopharmaceuticals and biosimilars: a systematic review. Clin Pharmacol Ther. 2020;108:734–755

2. Cohen HP, Blauvelt A, Rifkin RM, et al. Switching reference medicines to biosimilars: a systematic literature review of clinical outcomes. Drugs. 2018;78:463–478.

3. Cohen HP, Hachaichi S, Bodenmueller W, et al. Switching from One Biosimilar to Another Biosimilar of the Same Reference Biological: A Systematic Review of Studies. BioDrugs. 2022 Jul 26;36(5):625–637

Appendix I: Biological Medicines — Exceptional Request to Defer Brand Changeover or Revert to an Alternative (Non–Best-Value) Brand

PART 1: DETAILS OF CLINICIAN SUBMITTING REQUEST

Details of Clinician making request *(must be the responsible prescriber for the biological medicine who is currently prescribing for the patient)*			
Name:			
Job Title:			
NHS Health Board, Trust or GP Practice:			
Correspondence address:			
Tel:			
Email:			
Secretary's Name:		Tel:	
Secretary's Email:			

PART 2: DETAILS OF PATIENT

Details of Patient			
Forename:		Surname:	
Address: *(including postcode)*		Postcode:	
NHS Number:			
Date of Birth: *(dd/mm/yy)*		M or F:	
Registered GP or GDP Name and Practice:			

PART 3: URGENCY

How urgent is the request and why? *(tick as applicable)*	**Urgent:** 24 – 48 hours	**Soon:** within 3 wks	**Non-urgent:** 4 – 6 wks

If the request is **urgent or soon clinical reasons** must be provided. Administrative reasons will not be considered.	
Points to Consider	• Applies to working days only (not weekends or bank holidays). • If application is 'urgent' contact department before submitting application to notify them that an application will be sent in.

PART 4: DIAGNOSIS AND PATIENT'S CURRENT CONDITION RELATED TO REQUEST

Diagnosis:						
Has this been discussed by the MDT?	***YES***		**No**			*If **Yes**, please provide a copy of the minutes to support the discussion*
Relevant Medical History:						
Please summarise the current status of the patient in terms of quality of life, symptoms etc:						

PART 5: BIOLOGICAL MEDICINE AND BRAND DETAILS

Name of biological medicine	
Name of brand currently receiving	
Name of best value brand for this indication	

PART 6: JUSTIFICAITON FOR DELAY OF BRAND CHANGEOVER / OR REQUEST TO REVERT TO LESS COST-EFFECTIVE

Provide a concise summary of the justification for delaying the brand changeover or reverting to less cost-effective brand	

Appendix II: Best Value Biologic Implementation Checklist

Clinical Board: _____ Best Value Biologic Brand: _____

Phase 1: Pre-All Wales Secondary Care Contract Award					
No.	**Task/Action**	**Person/Team Responsible**	**In Progress (Date)**	**Comments/Updates/Decisions**	**Completed (Date)**
1	Identify and appoint a dedicated implementation lead and consultant clinical champion (can be other HCP profession if felt appropriate by team).				
2	Engage and seek input from across all clinical specialties within the board where the originator is currently used.				
3	Identify number of patients currently being treated with the current brand used and how they are supplied (e.g. homecare, hospital pharmacy, OPD, WP10HP).				
4	Identify number of patients initiated on the current brand each month				
5	Review and agree which patients will be eligible for the new biosimilar and which will require completion of "Biological Medicines — Exceptional Request to Defer Brand Changeover or Revert to an Alternative (Non–Best-Value) Brand"				

6	Liaise with homecare providers to understand their processes for managing the prescribing changeover (whether you plan to stay with current provider or move providers).	Pharmacy Procurement Lead & Homecare manager			
7	Consider how patients will be informed about the change in prescribing. Use template letters if available and supporting materials if available (SPS, AWTTC, WMAS). Provision must be made to identify patients who will need additional support and tailored communication as per section 5.3 of policy.				
8	Prepare patient information and agree how this will be distributed.				
9	Manage stock of current brand held in hospital pharmacy				
10	Review SPS guidance and available information (contact NWSSP Medicines Procurement) on biosimilars being launched				
Phase 2: Post- All Wales Secondary Care Contract Award – Pre-Contract Availability Start date					
No.	**Task/Action**	**Person/Team Responsible**	**In Progress (Date)**	**Comments/Updates/Decisions**	**Completed (Date)**
1	Review Contract award documentation to understand prices				

	and presentations offered by each supplier.				
2a	Clinical teams to agree on chosen brand (consider cost, formulation, presentation, QA assessment, supply route)				
2b	Agree whether prescribing changeover will happen at the same time for all indications or specific indications.				
3	For homecare patients, consider whether bundled or unbundled services will be most appropriate and cost effective.				
4	Contact (NWSSP) All Wales procurement to notify them of patient numbers and confirm they have capacity (and can supply from anticipated switch date).				
5a	Inform chosen homecare provider of decision and agree mechanism and timeline for the prescribing changeover ensuring minimal delay based on delivery frequencies (request exit data if moving providers).				

5b	Ensure service level agreement with homecare provider is in place.				
6	Engage with patients ahead of the switch by informing them of potential changes to their medication and/or home care services to maintain patient trust. Provide additional support and tailored communication to patients (as per section 5.3 of policy) who have been identified as requiring this.				
7a	Ensure brand is available on the CAV drug formulary				
7b	Ensure brand is available on pharmacy systems (including for homecare and OPDs if required)				
8	Ensure stock and drug files for current brand are managed to run down existing stock				
9	Communicate appropriately with all stakeholders (clinical teams, pharmacy teams, OPDs etc) so that they aware of the change in product and commencement date.				

Phase 3: Post-Contract Availability Start date					
No.	**Task/Action**	**Person/Team Responsible**	**In Progress (Date)**	**Comments/Updates/Decisions**	**Completed (Date)**
1	Order stock of best value brand presentations into hospital pharmacy or outpatient providers if required.				
2	Manage drug files on pharmacy systems to reduce/remove minimum reorder levels if appropriate				
3	Work with homecare providers and clinical teams to progress brand prescribing changeover to agreed mechanism and timelines				
4	Monitor patients for adverse events and ensure regular follow up				
5	Report to clinicians, finance and Pharmacy Director about the ongoing brand changeover progress				

Appendix III: The brand of your medicine is changing

We want to let you know that the brand of your medicine – **[name of biological medicine]** – will be changing to a biosimilar called [name of biosimilar].

What is happening?

- We're letting you know the new brand name on your medicine box. You should not notice any difference. It works the same and is just as safe and effective as your previous brand.
- Your hospital doctor has agreed that you can be prescribed a biosimilar (new brand) of your medicine.
- The new brand will be delivered by a different **homecare service provider** – will be changing from **[former homecare provider]** to **[new homecare provider]**
- You will continue to receive the same care from your doctor, nurse, or pharmacist.

Why is this happening?

- The NHS in Wales needs to reduce spending.
- The Welsh Government has asked Health Boards to save money in ways that do not harm patient care.
- One way to do this is to use biosimilars instead of costly original brands, as they work just as well.

What is a biosimilar medicine?

- Biosimilars are carefully checked by experts before they are used.
- In the UK, the **MHRA** (the medicines regulator) confirms that biosimilars are **just as safe and effective** as the original medicine.
- They work the same way in your body.
- They may look different, but they do the same job.
- They cost less for the NHS.

Why this matters

- Switching to biosimilars saves the NHS in Wales **millions of pounds every year**.
- This helps the NHS spend money on other important care.

We understand

- We know you might feel unsure about this change.
- Please be reassured: your new medicine is still the right one for your condition.
- **Patient safety and good treatment remain our top priorities.**

What will happen next

- **[To be completed by clinic]**
- To include reference to nursing assistance with training on the new device

Have Questions?

If you have questions, please contact us:

- **[Exact name clinic managing care] – Clinic Contact number**

Appendix IV: Your Medicine Has Changed (Concerns team response)

Thank you for contacting the **Concerns Team**.

We want to explain why your medicine has changed to a **biosimilar**.

What is happening?

- Your hospital doctor has agreed to you being prescribed a biosimilar version of your medicine.
- You will still get the same care from your doctor, nurse, or pharmacist. We will make sure the new medicine works well for you.

Why is this happening?

- The NHS in Wales is spending too much money.
- The Welsh Government has asked Health Boards to save money in ways that do not harm patient care.
- One way to save money is to stop using costly brands biologic medicines when a biosimilar is just as good

What is a biosimilar medicine?

- Experts check biosimilar medicines very carefully before anyone uses them. In the UK, the MHRA (a group that makes sure medicines are safe) says biosimilars are just as good as the original ones.
- It works the same way in your body.
- It is safe and effective.
- It may look different, but it does the same job.
- It costs less money for the NHS.

Why this matters

- Changing to biosimilars saves the NHS in Wales millions of pounds every year.
- This helps the NHS spend money on other important care.

We understand

- We know you might feel unsure about this change.
- But we want to reassure you: your new medicine is still the right one for your condition.
- Patient safety and good treatment are still our top priorities.

Thank you

We are sorry if this change has caused any worry.

Thank you for understanding

Equality & Health Impact Assessment for

Cardiff and Vale UHB Biological Medicines Value Optimisation Policy

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Please note:

1. The completed Equality & Health Impact Assessment (EHIA) must be
    1. Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
    2. Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.
2. Formal consultation must be undertaken, as required[1]
3. Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Not applicable
	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Clinical Diagnostics & Therapeutics Directorate: Pharmacy & Medicines Management Lead author: David McRae Contact details: David.mcrae@wales.nhs.uk

[1] http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,73860407,253_73860411&_dad=portal&_schema=PORTAL

	Objectives of strategy/ policy/ plan/ procedure/ service	1. Establish a clear, equitable, and sustainable approach for the use of biological medicines across Cardiff and Vale UHB. 2. Maximise value from biological medicines while maintaining clinical standards and patient-centred care. 3. Ensure cost-effectiveness by prescribing the best value brand for: • New patients (those not previously on a biological medicine). • Existing patients (switching from less cost-effective brands as better value options become available). 4. Promote transparency and consistency in prescribing decisions and implementation. 5. Support shared decision-making by informing patients about potential brand changes and ensuring traceability for pharmacovigilance. 6. Prevent unnecessary variability by: • Avoiding frequent brand changes (minimum 12-month interval). • Prohibiting substitution at the point of dispensing. • Mandating brand name prescribing for all biological medicines. • Align with national strategy (AWMSG guidance) and regulatory requirements (MHRA, NICE).
	Evidence and background information considered. For example 1. population data 2. staff and service users data, as applicable 3. needs assessment 4. engagement and involvement findings 5. research 6. good practice guidelines 7. participant knowledge 8. list of stakeholders and how stakeholders have engaged in the development stages	Good Practice Guidance: Understanding biological and biosimilar medicines – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

	9. comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[2] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[3].	
.	Who will be affected by the policy	This policy applies to all of our staff in all locations including those with honorary contracts. This policy applies to all patients being treated with biological medicines.

[2] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[3] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

11. 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: 1. under 18; 2. between 18 and 65; and 3. over 65	Older adults (>65): Higher rates of frailty, dexterity/vision challenges and polypharmacy may make device changes harder, increase error risk, or heighten anxiety about brand change.	Older adults: large-print materials, and check of dexterity/vision screening before switch; offer home visits or video support for those with mobility issues. Already part of clinic and homecare offerings.	Section 5.3
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	**Sensory loss (hearing/vision):** Risk of inaccessible letters, missed deliveries, or device misuse without adapted training. **Learning disability/neurodiversity:**	Apply All-Wales Accessible Communication Standards: provide BSL, braille, audio, large print, easy-read, and communication passports as needed; record the format in patient record. Additional support and communication required.	Section 5.3

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
	Anxiety and nocebo risk; difficulties understanding switch rationale or device steps. **Mental health:** Heightened switch anxiety; potential adherence drop after changeover.	Simple and reassuring phrasing in all patient conversations/materials required.	
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, 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	No negative or positive impacts identified		

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
6.4 People who are married or who have a civil partner.	No negative or positive impacts identified.		
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	Pregnancy and breastfeeding can heighten anxiety; clinicians may prefer stability during perinatal periods.	Use the exceptional 12-month delay pathway for pregnancy-related requests; set timed review with automatic changeover on expiry unless contraindicated.	Section 5.2: operationalise 12-month delay and timed review.
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	Language barriers can lead to misunderstanding, or non-adherence; travelling communities may need flexible delivery points. Not a risk introduced by policy.	Provide translated letters and telephone interpreting, record language preference in patient record. No mitigation for the need for flexible delivery points.	Section 5.3
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	No negative or positive impacts identified	Provide product excipients/source information where relevant. Standard Clinical Practice	

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
6.8 People who are attracted to other people of: 1. the opposite sex (heterosexual); 2. the same sex (lesbian or gay); 3. both sexes (bisexual)	No negative or positive impacts identified		
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	English-only materials reduce understanding and trust; lack of Active Offer may disadvantage Welsh speakers.	Provide bilingual letters/leaflets and an Active Offer for Welsh; publish easy-read versions in Welsh; audit parity of response times and access.	Section 5.3 Appendix III and switch letters to be bilingual (Welsh).
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	No negative or positive impacts identified		

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
6.11 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	No negative or positive impacts identified		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Low health literacy	Additional communication and reassurance required.	5.3

4. 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	Using best-value biological medicines typically expands access by freeing resources and stabilising supply, while brand-name prescribing and planned switch governance protect safety. The main risks to access (communication barriers, device changes, and provider transitions) are manageable with the actions embedded in the policy.		Section 5.3
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus	No negative or positive impacts identified		

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
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 conditions Well-being Goal – A prosperous Wales	No negative or positive impacts identified		
7.4 People in terms of their use of the physical environment:	No negative or positive impacts identified		

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
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 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	No negative or positive impacts identified		

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
pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	The policy should have a net positive impact on macro-economic, environmental and sustainability factors—by releasing cash for care, strengthening supply resilience, and aligning procurement and delivery with Net Zero and Well-being of Future Generations (Wales) Act duties. The main risks is supply-chain concentration.	Supplier concentration: A “best-value first” model could narrow supplier diversity if not balanced with open frameworks and clear supplier roadmaps. NWSSP are responsible for ensuring supplier diversity, so outside the scope of the policy.	

Please answer question 8.1 following the completion of the EHIA and complete the action plan

1. Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Overall, the net impact is positive if the policy is implemented as written: it should improve value, standardise safe practice, and support equitable access, while recognising and mitigating foreseeable risks around patient experience, device/presentation needs, homecare transitions, and supplier concentration. **Potential positive impacts** • **Better value and service sustainability** Best-value first prescribing for new and existing patients is expected to release savings for care, supported by structured horizon scanning and multi-criteria brand selection (cost, presentations, stability, supply robustness, homecare) to avoid false economies. • **Consistency and safety in practice** Mandating brand-name prescribing, prohibiting dispensing substitution, and keeping a minimum 12-month interval between brand changes reduces unintended variation and supports continuity of care. • **Stronger pharmacovigilance & traceability** Brand-name prescribing, explicit recording of brand changes, and Yellow Card reporting for black-triangle biosimilars enhance batch/brand traceability and safety monitoring. • **Evidence-based brand changes** Cites systematic reviews showing no meaningful loss of efficacy/safety on switching; embeds a governance pathway for planned brand changeovers rather than ad-hoc substitution. • **Clear governance and oversight** Use of an Implementation Checklist (Appendix II), and an Oversight Group

to manage exceptional delays (6 months; 12 months for pregnancy) provide transparent, auditable decision-making.

- **Patient communication & involvement**
  Standard patient letters (Appendix III/IV), shared-decision statements, recorded communications and support for understanding and adherence.
- **Equity and Welsh-language commitments**
  The EHIA builds in actions for accessible formats, support for sensory loss, learning disability, and pregnancy.
- **Alignment with national guidance**
  Aligns with AWMSG/NICE positions on biosimilars and the requirement to prescribe biologics by brand; sets out local formulary processes and financial/benefits monitoring via MIGG and Value & Sustainability.

Potential negative impacts / risks

- **Patient experience & adherence risks**
  Anxiety about switching and nocebo effects may reduce confidence and adherence without careful communication and follow-up. The policy acknowledges and mitigates this but the risk remains.
- **Operational risk during homecare transitions**
  Switching brands and, in some cases, changing homecare provider carry onboarding/delivery risks (missed deliveries, data errors) that could briefly interrupt supply if not closely managed.
- **Equity risks if mitigations lapse**
  Without consistent application of accessible formats and tailored communication and support including: translation/interpreting, device training, for people with sensory loss, limited literacy and health literacy, non-English/Welsh language needs may face barriers.

	• **Supplier concentration** Focusing on a single best-value option could narrow supplier diversity over time; the EHIA flags this as a macro-economic risk requiring NWSSP procurement controls. • **Expectation management** A clear statement that patient preference alone does not determine brand choice may generate complaints if communication is not handled sensitively and consistently. **Built-in mitigations (already in the policy/EHIA)** • **Support for patients most in need**: requirement to support citizens with protected characteristics and those most likely to require additional reassurance and communication. • **Exceptional delay pathway:** up to 6 months (or 12 months in pregnancy), with Oversight Group approval and automatic changeover at expiry unless contraindicated, balancing governance with individual circumstances. • **Horizon scanning & selection criteria:** consider cost, presentation range, supply chain robustness, homecare service provision and total cost of treatment—reducing the chance of picking a brand that undermines usability or supply. • **Monitoring & accountability:** progress and finances monitored via MIGG and Value & Sustainability; communications recorded in the patient record; pharmacovigilance via Yellow Card.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
2. What are the key actions identified as a result of completing the EHIA?	Additional and tailored communication required for patients with certain protected characteristics and those most likely to experience the nocebo effect.	DM	Complete	5.3
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?	No			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
4. What are the next steps? Some suggestions:- 1. Decide whether the strategy, policy, plan, procedure and/or service proposal: 1. continues unchanged as there are no significant negative impacts 2. adjusts to account for the negative impacts 3. continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) 4. stops. 1. Have your strategy, policy, plan, procedure and/or service proposal approved 2. Publish your report of this impact assessment 3. Monitor and review	Policy to proceed unchanged.			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate

Appendix 1

Equality & Health Impact Assessment

Developing strategies, policies, plans and services that reflect our Mission of 'Caring for People, Keeping People Well'

Guidance

The University Health Board's (the UHB's) Strategy 'Shaping Our Future Wellbeing' (2015-2025) outlines how we will meet the health and care needs of our population, working with key partner organisations to deliver services that reflect the UHB's values. Our population has varied and diverse needs with some of our communities and population groups requiring additional consideration and support. With this in mind, when developing or reviewing any strategies, policies, plans, procedures or services it will be required that the following issues are explicitly included and addressed from the outset:-

1. Equitable access to services
2. Service delivery that addresses health inequalities
3. Sustainability and how the UHB is meeting the requirements of the Well-being of Future Generations (Wales) Act (2015)[4]

This explicit consideration of the above will apply to strategies (e.g. Shaping Our Future Strategy, Estates Strategy), policies (e.g. catering policies, procurement policies), plans (e.g. Clinical Board operational plans, Diabetes Delivery Plan), procedures (for example Varicella Zoster - chickenpox/shingles - Infection Control Procedure) and services /activity (e.g. developing new clinical services, setting up a weight management service).

Considering and completing the Equality & Health Impact Assessment (EHIA) in parallel with development stages will ensure that all UHB strategies, policies, plans, procedures or services comply with relevant statutory obligations and responsibilities and at the same time takes forward the UHB's Vision, 'a person's chance of leading a healthy life is the same wherever they live and whoever they are'. This process should be proportionate but still provide helpful and robust information to support decision making. Where a more detailed consideration of an issue is required, the EHIA will identify if there is a need for a full impact assessment.

Some key statutory/mandatory requirements that strategies, policies, plans, procedures and services must reflect include:

[4] http://thewaleswewant.co.uk/about/well-being-future-generations-wales-act-2015

1. All Wales Standards for Communication and Information for People with Sensory Loss (2014)[5]
1. Equality Act 2010[6]
2. Well-being of Future Generations (Wales) Act 2015[7]
3. Social Services and Well-being (Wales) Act 2015[8]
4. Health Impact Assessment (non statutory but good practice)[9]
5. The Human Rights Act 1998[10]
6. United Nations Convention on the Rights of the Child 1989[11]
7. United Nations Convention on Rights of Persons with Disabilities 2009[12]
8. United Nations Principles for Older Persons 1991[13]
9. Welsh Health Circular (2015) NHS Wales Infrastructure Investment Guidance[14]
10. Welsh Government Health & Care Standards 2015[15]
11. Welsh Language (Wales) Measure 2011[16]

This EHIA allows us to meet the requirements of the above as part of an integrated impact assessment method that brings together Equality Impact Assessment (EQIA) and Health Impact Assessment (HIA). A number of statutory /mandatory requirements will need to be included and failure to comply with these requirements, or demonstrate due regard, can expose the UHB to legal challenge or other forms of reproach. This means showing due regard to the need to:

1. eliminate unlawful discrimination, harassment and victimisation;
2. advance equality of opportunity between different groups; and
3. foster good relations between different groups.

EQIAs assess whether a proposed policy, procedure, service change or plan will affect people differently on the basis of their 'protected characteristics' (ie their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation) and if it will affect their human rights. It also takes account of caring responsibilities and Welsh Language issues.

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[5] http://gov.wales/topics/health/publications/health/guidance/standards/?lang=en
[6] https://www.gov.uk/guidance/equality-act-2010-guidance
[7] http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en
[8] http://gov.wales/topics/health/socialcare/act/?lang=en
[9] http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782
[10] https://www.equalityhumanrights.com/en/human-rights/human-rights-act
[11] http://www.unicef.org.uk/UNICEFs-Work/UN-Convention
[12] http://www.un.org/disabilities/convention/conventionfull.shtml
[13] http://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx
[14] http://www.wales.nhs.uk/sites3/Documents/254/WHC-2015-012%20-%20English%20Version.pdf
[15] http://gov.wales/topics/health/publications/health/guidance/care-standards/?lang=en
[16] http://www.legislation.gov.uk/mwa/2011/1/contents/enacted

They provide a systematic way of ensuring that legal obligations are met and are a practical means of examining new and existing policies and practices to determine what impact they may have on equality for those affected by the outcomes.

HIAs assess the potential impact of any change or amendment to a policy, service, plan, procedure or programme on the health of the population and on the distribution of those effects within the population, particularly within vulnerable groups. HIAs help identify how people may be affected differently on the basis of where they live and potential impacts on health inequalities and health equity. HIA increases understanding of potential health impacts on those living in the most deprived communities, improves service delivery to ensure that those with the greatest health needs receive a larger proportion of attention and highlights gaps and barriers in services.

The **EHIA** brings together both impact assessments in to a single tool and helps to assess the impact of the strategy, policy, plan, procedure and/or service. Using the EHIA from the outset and during development stages will help identify those most affected by the proposed revisions or changes and inform plans for engagement and co-production. Engaging with those most affected and co-producing any changes or revisions will result in a set of recommendations to mitigate negative, and enhance positive impacts. Throughout the assessment, 'health' is not restricted to medical conditions but includes the wide range of influences on people's well-being including, but not limited to, experience of discrimination, access to transport, education, housing quality and employment.

Throughout the development of the strategy, policy, plan, procedure or service, in addition to the questions in the EHIA, you are required to remember our values of *care, trust, respect, personal responsibility, integrity and kindness* and to take the Human Rights Act 1998 into account. All NHS organisations have a duty to act compatibly with and to respect, protect and fulfil the rights set out in the Human Rights Act. Further detail on the Act is available in Appendix 2.

Completion of the EHIA should be an iterative process and commenced as soon as you begin to develop a strategy, policy, plan, procedure and/or service proposal and used again as the work progresses to keep informing you of those most affected and to inform mitigating actions. It should be led by the individual responsible for the strategy, policy, plan, procedure and/or service and be completed with relevant others or as part of a facilitated session. Some useful tips are included in Appendix 3.

For further information or if you require support to facilitate a session, please contact Susan Toner, Principal Health Promotion Specialist (susan.toner@wales.nh.uk) or Keithley Wilkinson, Equality Manager (Keithley.wilkinson@wales.nhs.uk)

Based on

1. Cardiff Council (2013) Statutory Screening Tool Guidance
2. NHS Scotland (2011) Health Inequalities Impact Assessment: An approach to fair and effective policy making. Guidance, tools and templates[17]
3. Wales Health Impact Assessment Support Unit (2012) Health Impact Assessment: A Practical Guide[18]

[17] http://www.healthscotland.com/uploads/documents/5563-HIIA%20-%20An%20approach%20to%20fair%20and%20effective%20policy%20making.pdf (accessed 4 January 2016)

[18] http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782 (accessed on 4 January 2016)

Appendix 2 – The Human Rights Act 1998[19]

The Act sets out our human rights in a series of 'Articles'. Each Article deals with a different right. These are all taken from the European Convention on Human Rights and are commonly known as 'the Convention Rights':

1. Article 2 Right to life. NHS examples: the protection and promotion of the safety and welfare of patients and staff
2. Article 3 Freedom from torture and inhuman or degrading treatment. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travelers, issues of patient restraint and control
3. Article 4 Freedom from slavery and forced labour
4. Article 5 Right to liberty and security. NHS examples: issues of patient choice, control, empowerment and independence, issues of patient restraint and control
5. Article 6 Right to a fair trial
6. Article 7 No punishment without law
7. Article 8 Respect for your private and family life, home and correspondence. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travelers, the right of a patient or employee to enjoy their family and/or private life
8. Article 9 Freedom of thought, belief and religion. NHS examples: the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travelers
9. Article 10 Freedom of expression. NHS examples: the right to hold and express opinions and to receive and impart information and ideas to others, procedures around whistle-blowing when informing on improper practices of employers where it is a protected disclosure
10. Article 11 Freedom of assembly and association
11. Article 12 Right to marry and start a family
12. Article 14 Protection from discrimination in respect of these rights and freedoms. NHS examples: refusal of medical treatment to an older person solely because of their age, patients presented with health options without the

[19] https://www.equalityhumanrights.com/en/human-rights/human-rights-act

use of an interpreter to meet need, discrimination against UHB staff on the basis of their caring responsibilities at home

13. Protocol 1, Article 1 Right to peaceful enjoyment of your property
14. Protocol 1, Article 2 Right to education
15. Protocol 1, Article 3 Right to participate in free elections
16. Protocol 13, Article 1 Abolition of the death penalty

Appendix 3

Tips

1. Be clear about the policy or decision's rationale, objectives, delivery method and stakeholders.
2. Work through the Toolkit early in the design and development stages and make use of it as the work progresses to inform you of those most affected and inform mitigating actions
3. Allow adequate time to complete the Equality Health Impact Assessment
4. Identify what data you already have and what are the gaps.
5. Engage with stakeholders and those most affected early. View them as active partners rather than passive recipients of your services.
6. Remember to consider the impact of your decisions on your staff as well as the public.
7. Record which organisations and protected characteristic groups you engaged with, when you engaged with them and how you did so (for example, workshop, public meeting, written submission).
8. Produce a summary table describing the issues affecting each protected group and what the potential mitigations are.
9. Report on positive impacts as well as negative ones.
10. Remember what the Equality Act says – how can this policy or decision help foster good relations between different groups?
11. Do it with other people! Talk to colleagues, bounce ideas, seek views and opinions.

Report Title:	Policy for Commissioning a Review of a Service, a Clinical Department or Clinician				Agenda Item No:	3.1.7
Meeting:	Quality Committee		Public	x	Meeting Date:	3rd March 2026
			Private			
Status	Assurance	X		X	Information/Noting	
Lead Executive Title:	Executive Nurse Director					
Report Author Title:	Assistant Director of Quality and Patient Safety					

Main Report

Background and Current Situation:

Patient safety and quality remain at the forefront of everything the organisation does and this includes ensuring a robust and enquiring approach to understanding quality issues including untoward events.

The UHB has developed an approach to deliver systematic reviews with an associated training programme to ensure a standardised and sustainable approach to scrutinise issues in care and patient safety incidents. Despite this there are occasions when a different approach is required to ensure impartiality, objectivity or specialist expertise. This impartiality and expertise can in some instances be provided by a suitably qualified and experienced individual within the UHB but there are occasions when these criteria can only be met by a reviewer external to the organisation and at this point an external review can be commissioned.

This Policy for Commissioning a Review of a Service, a Clinical Department or a Clinician has been developed for Cardiff and Vale University Health Board (CVUHB) to ensure effective and prudent decision making around the commissioning of a review and to support robust governance in relation to its oversight.

The Policy incudes making the commissioning decision, development of clear scope and terms of reference, legal consideration and interface with regulators and peoples services.

The policy also covers considerations around balancing the public interest with regards to openness and transparency and how to maintain the duty of confidentiality to both patients, public and Health Board employees when deciding on sharing the report.

The Policy has been shared with key individuals across the UHB as part of the early consultation process and is being brough to Quality Committee for further discussion and consideration prior to commencing UHB consultation and then final approval.

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

The Policy describes a framework for standardising the approach to commissioning, delivering and governing service and clinician reviews.

The Policy includes guidance around

- Identifying the reviewer
- Agreeing the scope and terms of reference
- Considering the legal and regulatory aspects
- Agreeing a publication approach
- Developing a communication plan for sharing the outcomes
- Agreeing an approach to delivering in parallel with HR processes
- Oversight of improvement plans

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

1. Policy: Commissioning a Review of a Service, Clinical Department or Clinician

Recommendations:

a) To note the draft policy and the approach to commissioning a review and the governance around the process
b) To approve the policy document in principle, subject to the consultation period

Link to Strategic Objectives of Shaping our Future Wellbeing:

1. Putting People First		2. Providing Outstanding Quality	x
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	x

Quality Impact Assessment Completed?

Yes *(please include the complete QIA document)*	x	No *(please provide reasoning e.g. not required*	x	

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:

Reference Number: *TBA unless document for review* **Version Number:** 1 *unless document for review*	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

Policy for Commissioning a Review of a Service, Clinical Department or Clinician

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensuring a robust and enquiring approach to understanding quality issues including untoward events.

In doing this we recognise that there will be occasions when the decision is made to undertake a review of a service, a clinical department or a clinician. This policy will ensure a standardised approach to developing the scope of each review, delivering a clear, fair and evidence-based report and puts in place the governance to support organisational learning.

Policy Commitment

This Policy has been developed for Cardiff and Vale University Health Board (CVUHB) to ensure effective and prudent decision making around the commissioning of a review and to support robust governance in relation to its oversight.

Supporting Procedures and Written Control Documents

NA

Scope

This policy applies to all staff involved in the decision to commission a review

Equality & Health Impact Assessment (EHIA) Part 1 - Equality Impact Assessment (EQIA)	An Equality Impact Assessment (EqIA) has / has not been completed [delete as necessary] and this found there to be a positive/negative/ no impact [delete as necessary]. Key actions have been identified and these can be found in……./or incorporated within this controlled document. *Note: if an EqIA has not been completed indicate why*

Equality & Health Impact Assessment (EHIA) Part 2 - Health Impact Assessment (HIA)	A Health Impact Assessment (HIA) has / has not been completed [delete as necessary] and this found there to be a positive/negative/ no impact [delete as necessary]. Key actions have been identified and these can be found in……./or incorporated within this controlled document. *Note: if a HIA has not been completed indicate why*

Policy Approved by	Board/Committee/Sub Committee
Group with authority to approve procedures written to explain how this policy will be implemented	For example: Health System Management Board
Accountable Executive or Clinical Board Director	Executive Director of Nursing
Author	Assistant Director of Quality and Patient Safety

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*State if either a new document, revised document (please list main amendments).* *List title and reference number of any documents that may be superseded*
2			

Contents

1 Background

Patient safety and quality remain at the forefront of everything the organisation does and this includes ensuring a robust and enquiring approach to understanding quality issues including untoward events.
The UHB has developed an approach to deliver systematic reviews with an associated training programme to ensure a standardised and sustainable approach to scrutinise issues in care and patient safety incidents.
Despite this there are occasions when a different approach is required to ensure impartiality, objectivity or specialist expertise. This impartiality and expertise can in some instances be provided by a suitably qualified and experienced individual within the UHB but there are occasions when these criteria can only be met by a reviewer external to the organisation and at this point an external review can be commissioned.

2 Principles of a Review

Reviews are commissioned to strengthen services, protect patients and staff, and identify both areas of concern and good practice. They are not a substitute for local management processes, nor are they disciplinary investigations, although findings may inform other formal processes where appropriate.
Reviews commissioned by the UHB will be conducted in accordance with the following principles:

- Patient safety and reduction of avoidable harm
- Proportionality and fairness
- Independence and objectivity
- Transparency and openness
- Learning and system improvement
- Psychological safety and trauma-informed practice
- Clear accountability for action and measurable improvement

External reviews do not encompass inspections from independent and and regulatory bodies

3 Identifying the Need for a Review

3.1 Trigger Events

There are a number of reasons for considering a review and as the organisations quality management system matures, systemising the collection and triangulation of various data sources will improve. Whilst the following is not an exhaustive list, reasons may include:

- Significant clinical incidents that require a degree of independence
- Issues raised through Speaking up Safely, Whistleblowing or
- other formal processes
- Potential systematic failings or repeated incidents
- Signals from noise including staff experience, concerns and patient experience
- Concerns about clinical practice.
- Service wide cultural issues

3.2 Criteria for External Scrutiny

Identifying a reviewer internal to the organisation should be the default position for reviewing quality issues, however, there are a number of criteria that support an independent approach, whether internal or external, and these include:

- A risk of internal bias
- High profile or sensitive nature of the issues
- The need for public transparency
- Conflicts of interest within the organisation.

3.3 Proportionality Test / Pre-Commissioning Safeguard

Before commissioning a review, the Executive Team must consider:

- Whether existing governance, quality or management processes have been appropriately considered
- Whether the issues indicate systemic risk, reputational risk, or potential harm requiring independence
- Whether independence from the organisation would materially improve objectivity, credibility or specialist insight
- Whether the scope is clearly defined and proportionate to the concerns identified

This ensures reviews are commissioned where they add value and are not used as a substitute for local performance management or existing governance mechanisms.

4 Making the Commissioning Decision

4.1 Governance

While potential quality issues could be identified via a number of routes, the decision to commission a review must sit with the Executive Team.
All requests for a review must be through discussion with the Associate Medical Director for Professional Standards, the Associate Medical Director for Patient Safety and Clinical Effectiveness, the Assistant Director of Organisational Development, Wellbeing and Culture and the Assistant Director of Quality and Patient Safety with a clear plan for the resourcing and reporting of the review and the onward governance and oversight of actions undertaken to address recommendations.

Commissioning of consultancy services or external reviewers must comply with the Standing Financial Instructions (SFIs) relating to Procurement. To support this, NWSSP Procurement Services must be contacted at the earliest opportunity to discuss the requirements, ensuring that all procurement and governance obligations are met, prevent delays to the commencement of the service, and avoid any risk of non-compliant expenditure.

4.2 Rationale

In proposing a review, the rational for the requirement for external involvement and the aim of the review and safeguards for fairness must be clearly documented.

5 Scope and Terms of the Review

Establishing a clear term of reference is essential in determining the end product. The terms of reference must be agreed at the outset of the review and outline how key issues will be addressed,
Clear touch points must be identified at the outset of the review to ensure that the report is progressing and delivering its required outcome.

5.1 ToR

The Scope and Terms of reference must include:

- What type of review is required, eg a thematic review, individual case, clinician or departmental review
- Where the report is being commissioned as a result of concerns around patient care or from a whistleblower consider involving these individuals in agreeing the terms of reference.

- The duration of service provision being reviewed
- What methodology should be used. Should the review be limited to medical records or include interviews with staff members, patients or their families.
- Clear timescales for the review that are achievable and realistic
- Whether the report is to be published internally or publicly, this should determine
    - report style
    - language
    - glossary
- Identification of stakeholders. This can include commissioners, Regulators, Welsh Government, Staff Side.
- Final approval or sign off
- Terms of Reference must consider any equality, diversity and inclusion implications, including whether concerns disproportionately affect particular staff or patient groups. Where appropriate, advice should be sought from the Equity, Inclusion and Welsh Language Team.

5.2 Debrief

Consideration should be given to undertaking a debrief of the review process on completion to reflect on its success and learning that could be taken forward for subsequent service reviews.

5.3 Legal Considerations

- Documents generated during a review may be disclosable to HM Coroner or in a future compensation claim. As a result, consideration must be given to how documents are retained for any future disclosure.
- Regulatory engagement must be considered when there is potential for a review to identify professional concerns.
- While GDPR does not require explicit consent from patients or employees for the Health Board to use their information for this purpose, consideration must be given to if and how they will be

informed as to the outcomes of the review. Where interviews are required as part of the review, it must be made clear to these individuals, how the information they provide will be shared

- The requirements of the Duty of Candour must be considered in determining the approach to informing patients if it is established that they have come to harm
- Careful consideration must be given as to how to balance the public interest with regards to openness and transparency and how to maintain the duty of confidentiality to both patients, public and Health Board employees.
- Documents generated as part of the review could be disclosable at future Employment tribunals

5.4 Interface with People Services

Where reviews identify potential individual conduct, capability or performance concerns, existing HR and professional regulatory processes must be followed. Independent reviews do not replace formal disciplinary, capability or performance procedures, but findings may inform those processes where appropriate. People Services must be engaged at an early stage where individual concerns arise.

6 Selection of Reviewers

Ensuring a financially prudent approach to delivering reviews must be the default.

Where possible, a reviewer with the appropriate skills expertise and experience who is internal to the organisation should be identified if they are able to deliver a review without compromising its impartiality or scrutiny. Reciprocal arrangements with neighbouring health organisations could support a cost-effective approach to accessing an expert specialist opinion within the national context.

An external reviewer might offer impartiality and expertise that cannot be facilitated internally.

6.1 Selection of Reviewers

Consideration should be given to the suitability of the reviewer. In identifying an individual or team of reviewers the Executive Team must seek:

- Demonstrable independence
- Professional expertise appropriate for the scope of the review
- No conflict of interest
- Expertise in conducting NHS investigations or reviews
- Understanding of clinical, operational, cultural and professional standards.
- Capacity to deliver the report within a required timescale

7 Engagement with Stakeholders

Early engagement with stakeholders is required to ensure transparent communication, fairness and trust in the review process and to support the availability of information.

7.1 Stakeholders

Consideration must be given to involving the following in the review, its publication or in addressing the recommendations:

- Patients and families
- Staff and Staff Side
- Clinical Board / Directorate management
- Legal services
- Patient Safety and Quality
- Regulators
- Llais
- Ombudsman

Careful consideration must be given to the wellbeing and psychological safety of staff involved in a review. Clear communication regarding purpose, process, confidentiality and support mechanisms must be provided. Staff participating in interviews or evidence gathering should be signposted to available wellbeing support services.

8 Final Report

8.1 Report Design

Where there are specific requirements of the final report, these must be articulated from the outset. These recommendations might include the need for recommendations to be based on a body of evidence eg Royal College, NICE or involvement from People and Culture. While the specifications of each review will differ the requirement of a clear conclusion and achievable recommendations should be stipulated for every report.

8.2 Anonymisation

Where details of the behaviours or practice of individuals is to be included, clear guidance must be given around how these details are to be referenced in the report. Consideration must be given as to how identifiable individuals remain even when their name or role are removed from a report.
Where the behaviours or practice of individuals is likely to lead to subsequent professional scrutiny a sub report should be considered, providing the necessary details when the main report has been anonymised.

8.3 Factual Accuracy

Consideration must be given to sharing the report with key individuals prior to finalisation to allow them the opportunity to make comments with regards to factual accuracy. This process will ensure that the information within the report is complete and correct.

8.4 Publication

The Executive Team will agree the approach to publication and communication for any report, with consideration given to full or partial publication or internal release only.
A communication plan should be developed to support the sharing with patients and families.

Where it has been established that patients have come to harm the UHB must adhere to its requirements under the Duty of Candour
A communication plan should be developed to support sharing the report with staff members.

The UHB communication team must support the publication of any review, with clear planning when there is suggestion of media interest.

8.5 Reporting

All reviews will be reported to the UHB Quality Committee and where required reported to additional sub committees of the Board eg People and Culture

committee. Reporting will include improvements and actions planned to address the recommendations made in the report.

8.6 Debrief

Consideration should be given to undertaking a debrief of the review process on its completion to support subsequent development around the process.

9 Implementation of Recommendations

Every review must include clear and achievable recommendations that support the requisite improvements and align to the UHB quality management system

There must be robust and ongoing oversight of improvements implemented to address the review recommendations, with improvement plans captured on the AMaT clinical governance system.

The Committee will continue to receive updates as a frequency that it determines appropriate, until the improvements are deemed to be" business as usual."

- Each review must have a named Executive Sponsor and an accountable lead responsible for delivery of the action plan.
- Action plans must include clear timescales, measurable outcomes and defined success criteria.
- Closure of review actions will require confirmation that improvements are embedded and demonstrably sustained, as agreed by the relevant Board Committee.

Report Title:	Quality Management System				Agenda Item No:	3.2
Meeting:	Quality Committee		Public	x	Meeting Date:	03/03/2026
			Private			
Status	Assurance	x	Approval	x	Information/Noting	
Lead Executive:	Jason Roberts - Executive Nurse Director					
Report Author Title:	Natasha Goswell - Deputy Executive Nurse Director					

Main Report
Background and Current Situation:

As part of the Duty of Quality under the Health and Social Care (Quality & Engagement) (Wales) Act 2020, every Health Board and Trust in Wales is required to adopt a Quality Management System (QMS). This involves fostering a dynamically interconnected whole organisation quality approach, linking finance, performance and quality in the delivery of care. The goal is that the delivery and assurance of high-quality care is aligned to strategy, underpinned by documented processes, procedures and responsibilities, and fully embedded in organisational culture.

The QMS Framework and position statement outlined in this paper focuses on the design of an organisation management system and how it can enable the delivery of the highest quality care. It provides an approach that can build on work already underway and can be used at local team, directorate, organisational or national level and is applied in all clinical or non-clinical settings. Its implementation will support the organisation to review how effectively it can begin to embed a sustainable operating system to lead and manage for quality

The QMS project reports into a strategic portfolio programme Shaping our Future Quality Excellence Programme (SoFQE). This falls within CAVUHBs Strategic Framework of Priority Portfolios designed to deliver against Shaping our Future Wellbeing, CAVUHB's strategy. The SoFQE is a Health Board-wide Programme to create a system and culture for quality in its broadest sense. The Quality Management System Project mobilised in April 2025 following a UHB-wide Quality Summit in 2023 and an initial discovery and scoping phase throughout 2024.

The QMS was presented at a Senior Leadership Team meeting (2025) to introduce QMS as an approach and to develop this within CAVUHB. The operating system for a quality-driven learning organisation includes the Key Components of QMS

Quality Planning: Establishing clear objectives and strategies to meet the needs of the population served.
Quality Improvement: Implementing initiatives that enhance service delivery and patient outcomes.
Quality Control: Monitoring and evaluating processes to ensure they meet established standards.
Quality Assurance: Ensuring accountability and continuous improvement through governance structures

To deliver a QMS there is a need to understand the organisational enablers, these include

- Leadership
- Workforce and culture

- Learning, improvement and research
- Whole system approach
- Information (aligned to the Duty of Quality Standards)

To provide assurance to the Welsh Government that this is the case we are asking all NHS Wales organisations to provide: An early position statement (by 1 April 2026) This will outline progress to date and the current position with the development and implementation of a QMS. With the important point at this stage is that there is a focus on a quality approach supported by the stewardship of the Board and leadership of the executive team.

The position statement provides detail on the designing and implementing of QMS, providing a shared understanding of organizational processes, integrating existing systems, and offering clarity on governance and progress. The governance structure of the Shaping Our Future Quality Excellence (SoFQE) Programme is detailed, including joint SROs (Deputy Executive Nurse Director & Associate Medical Director Quality & Safety), a multi-professional project board, and monthly reporting to the Programme Board.

Progress to date, includes key milestones from 2023 to 2026, and details the next steps for implementing the QMS, such as gap analysis, implementation planning, and building capability and capacity. The key challenges to the implementation of the QMS, includes variation in community building maturity, digital capacity constraints, capability gaps in quality improvement, data literacy, and workload pressures.
Quality Committee are asked to **endorse the approval** of the position statement, acknowledging progress, supporting organisational readiness workstreams, and noting the forthcoming QMS Implementation Plan due for endorsement and approval in July 2026.

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

Acknowledgment of the progress to date of the QMS as described within the position statement including next steps

The QMS project and position statement highlight the key challenges to the implementation of the QMS, which includes variation in community building maturity, digital capacity constraints, capability gaps in quality improvement, data literacy, and workload pressures.

Endorse for approval at board the position statement to be sent to NHS Wales Performance and Improvement

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

1. Quality Management System Position Statement

Recommendations:

a) Quality Committee are asked to **note** for **awareness** the progress to date of the Quality Management System
b) Quality Committee are asked to **endorse approval** of the position statement for Quality management system ahead of final approval at Board prior to sending to NHS Performance and Improvement

Link to Strategic Objectives of Shaping our Future Wellbeing:

1.		2.	

Putting People First	X	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		Integration		Collaboration	x	Involvement	x

Quality Impact Assessment Completed?				
Yes *(please include the complete QIA document)*		No *(please provide reasoning e.g. not required*	x	

Impact Assessment
Risk: No
Safety: No
As we develop the QMS there maybe elements that provide further insight into the safety elements which will be addressed and form part of the implementation and identification and mitigation of any risks and issues
Financial: No
Workforce: Yes
The workforce across the health board will be part of the development and implementation of the QMS. Clinical board leadership and their teams have been involved in the baselining across the four domains of QMS.
Legal: No
Reputational: Yes
As CAVUHB are in level 4 escalation of which quality is a component, not adhering to NHS Wales and Welsh government requirements for implementing a QMS and not providing a position statement will have detrimental consequences for reputational damage
Socio Economic: No
Equality & Health: No
Not required at this stage, will form part of the implementation plan
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:
Shaping our future excellence programme board	10 Feb 2026

Shaping Our Future

Quality Excellence

Quality Management System

Shaping Our Future
Quality
Excellence

What is a Quality Management System?

(National Definition)

A QMS is a *whole-system approach* that ensures:

- Consistent, high-quality care
- Clear planning, control, assurance, and improvement
- Systematic use of data, learning, and feedback
- Strong leadership and culture supporting quality
- Alignment of all activities to what matters to patients, staff, and the organisation

Source: NHS Wales Performance & Improvement (P&I) QMS Framework

Shaping Our Future
Quality
Excellence

Why QMS for CAVUHB?

- Supports Duty of Quality & Duty of Candour
- Addresses organisational variation in quality systems
- Strengthens governance, transparency, and accountability
- Enables safe, reliable, and value-driven care
- Central to Shaping Our Future Quality Excellence (SoFQE)

Strategic Aim

To establish a consistent, organisation-wide QMS that enables safe, effective, continuously improving care through strong governance, learning and staff engagement.

Position Statement: Purpose

Sets out the HB's approach to designing & implementing QMS

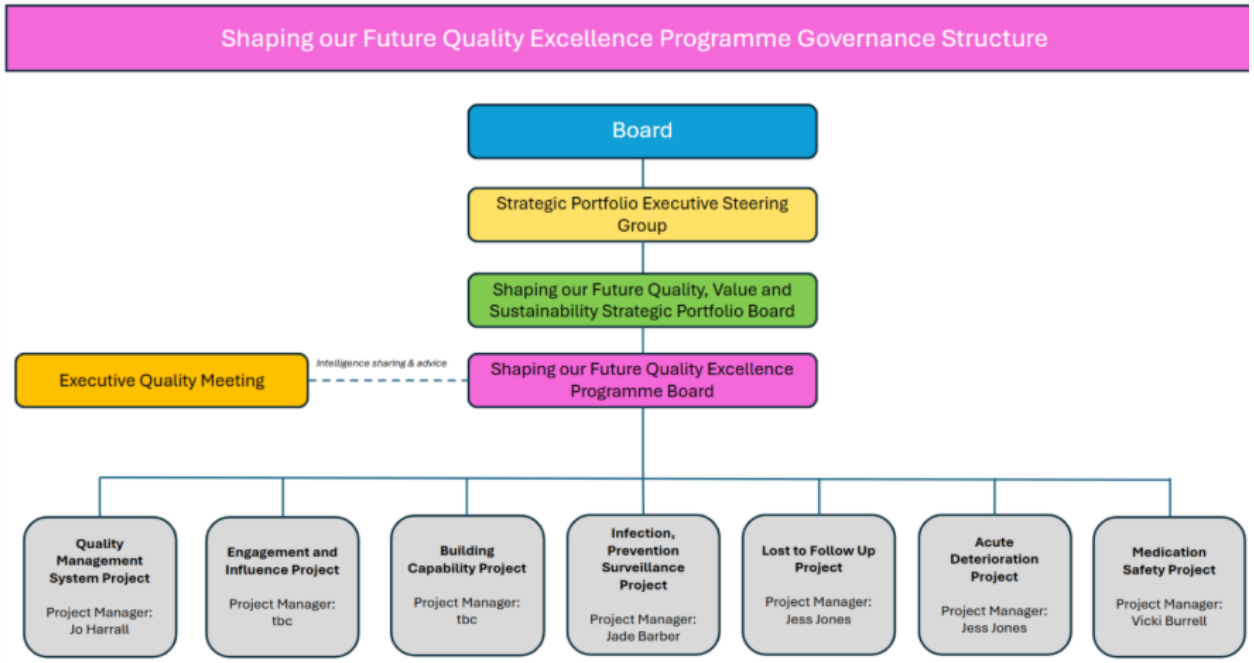
Provides a shared organisational understanding

Integrates existing systems into one coherent framework

Offers clarity on governance, progress and next steps

QMS Governance Structure

- Sits within SoFQE Programme
- Joint SROs: Natasha Goswell & Aled Roberts
- Multi-professional Project Board
- Monthly reporting to Programme Board
- Escalation to Quality Committee & Board



Progress to Date

2023

- Quality Summit

2024

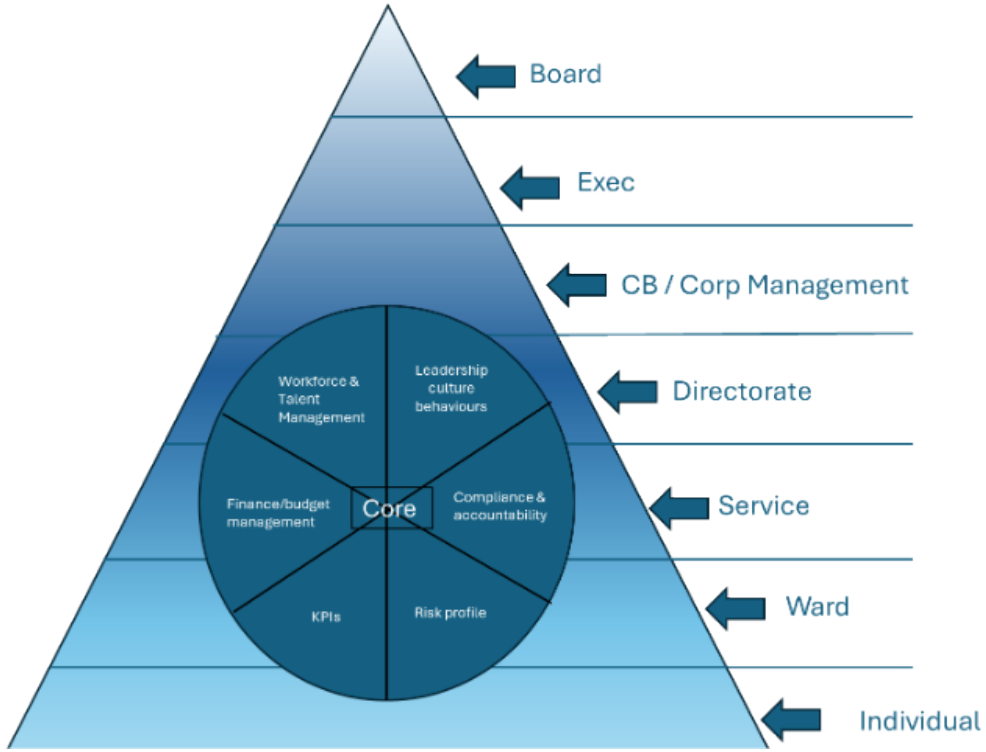
- Discovery Phase

2025/2026 Project Intiation

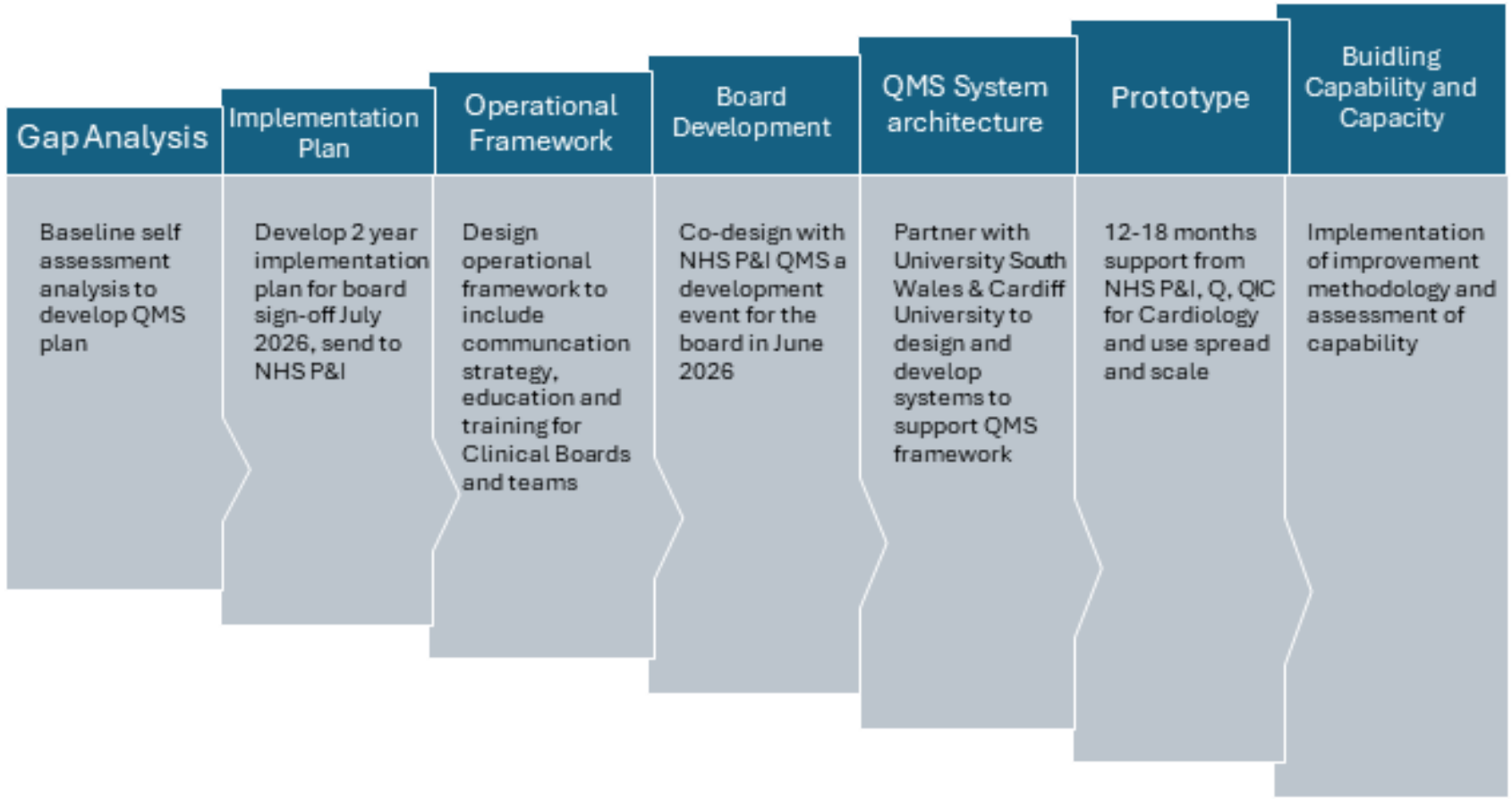
- Governance established.
- Meeting and reporting cadence implemented.
- Scope and project essentials agreed.
- CAV QMS branding designed and agreed
- Baselining our current position - In order to understand our starting point the Project Team designed a questionnaire which was sent out to clinical boards for completion with support from the project team.
- Strong links forges with NHS Wales P&I with attendance at QMS Leadership Events and member of the QMS Learning and Delivery Network
- Successful application to become a QMS Prototype Project (within our Cardiology Directorate)

What QMS Will Look Like

- Core QMS principles applying across all levels
- Increasing granularity for Clinical Boards & specialist areas
- Supports consistent oversight and decision-making
- User-friendly, accessible and relevant



Next Steps



Risks & Challenges

Variation in CB maturity
Digital capacity constraints
Need for organisational communication
Capability gaps in QI and data literacy
Workload/engagement pressures across CBs

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What We Need from Quality Committee

- Endorse direction of travel
- Acknowledge progress to date
- Support for organisational readiness workstreams
- Note forthcoming QMS Implementation Plan (July 2026)

Chilcott,Rachel
25/02/2026 16:12:06

Cardiff and Vale University Health Board
QMS Position Statement

MARCH 2026

1. INTRODUCTION

This Position Statement outlines Cardiff and Vale University Health Board's (CAVUHB) approach to the development and implementation of a quality management system across the whole organisation.

Our objective is to ensure the Quality Management System (QMS) is both accessible, practical and relevant, integrating existing systems into a unified framework. We aim to avoid perceptions of the QMS as theoretical or disconnected from daily operations.

The system will be accessible and applicable at various levels of detail—providing both organisation-wide strategic insights as well as increasingly granular information specific to frontline services, thereby supporting effective quality planning and improvement and demystifying QMS. To achieve this, we propose establishing a set of core principles that apply across all tiers of the operating model, which can be supplemented with additional details to accommodate specialised requirements.

2. QMS GOVERNANCE

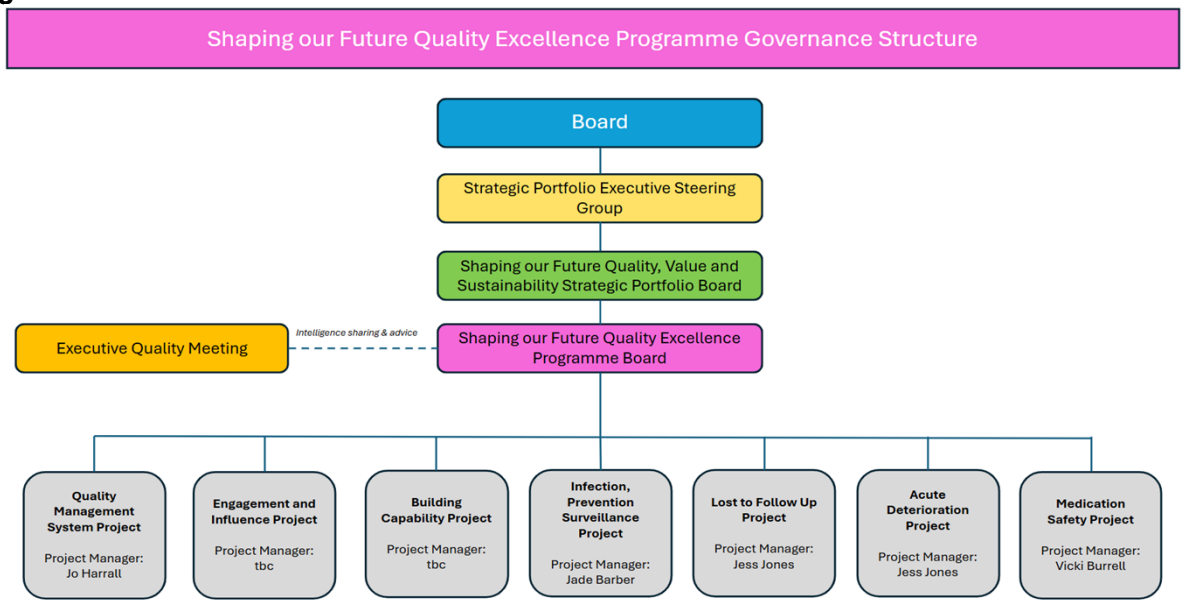
The QMS project reports into the **Shaping our Future Quality Excellence Programme (SoFQE**), a strategic portfolio programme within CAVUHBs Framework of Priority Portfolios designed to deliver against Shaping our Future Wellbeing, CAVUHB's strategy.

SoFQE is a Health Board-wide Programme to create a system and culture for quality in its broadest sense. It is the strategic vehicle by which we deliver the Heath Board's main effort - to eradicate avoidable harm in all its forms.

The Senior Responsible Officer (SRO) for the Shaping our Future Quality Excellence Programme is Jason Roberts, Executive Nurse Director.

The **Quality Management System Project** was mobilised in April 2025 following a UHB-wide Quality Summit in 2023 and an initial discovery and scoping phase throughout 2024. The project is based upon the requirements of the Duty of Quality and the Duty of Candour.

Fig 1: Governance Structure



The QMS project exists with joint SROs; Natasha Goswell, Deputy Executive Nurse Director and Aled Roberts, Physician and AMD Patient Safety and Clinical Effectiveness.

A multi-professional project team oversees the thinking, design, testing and development of a QMS for the UHB and includes membership from across the organisation from various disciplines:

Table 1: QMS Project team

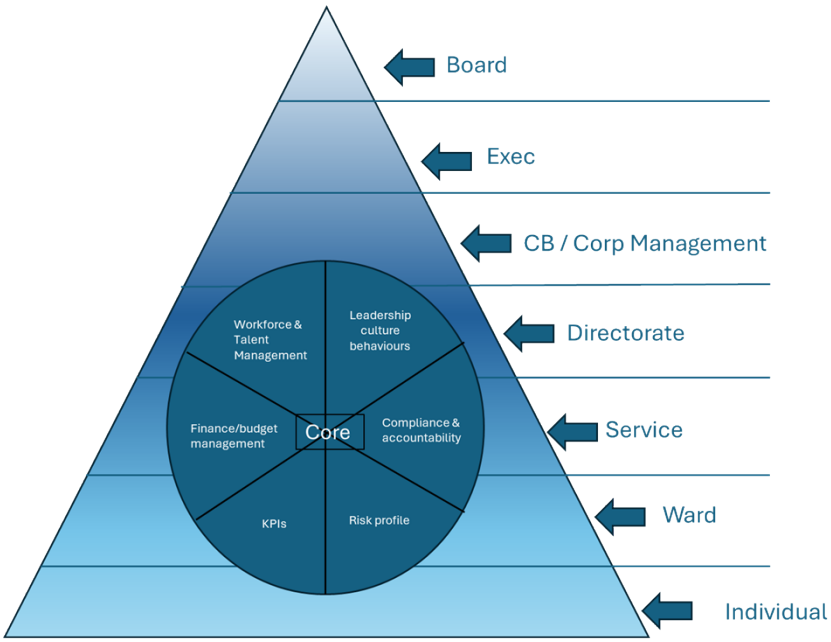
QMS Project Team members
(SRO) Physician and AMD Patient Safety and Clinical Effectiveness
(SRO) Deputy Executive Nurse Director
Head of Strategic Planning
Head of Change Insights and Prioritsation
Director of Medical Physics and Clinical Engineering
Research and Development Manager
Head of Performance
Director of Digital Transformation
Assistant Director of Quality and Patient Safety
Head of Corporate Governance

Value in Health Programme Manager
Director of Nursing and Midwifery, Children and Women's Clinical Board
Head of Change Support
Director of Operational Planning and Performance
Clinical Board Director representative, Specialist Clinical Board
Quality and Safety Manager
Director of Nursing representative, PCIC Clinical Board
Project Manager for QMS

Terms of Reference govern the team and robust Project Management principles are applied using key templates, escalation processes and outcomes evaluation. The QMS Project Board meets monthly and reports to the Shaping our Future Quality Excellence Programme on a monthly basis.

Figure 2 illustrates CAVUHB's goal for a QMS governance framework: quality is delivered by individuals, managed by teams, assured by leaders, owned by executives, and strategically overseen by the Board.

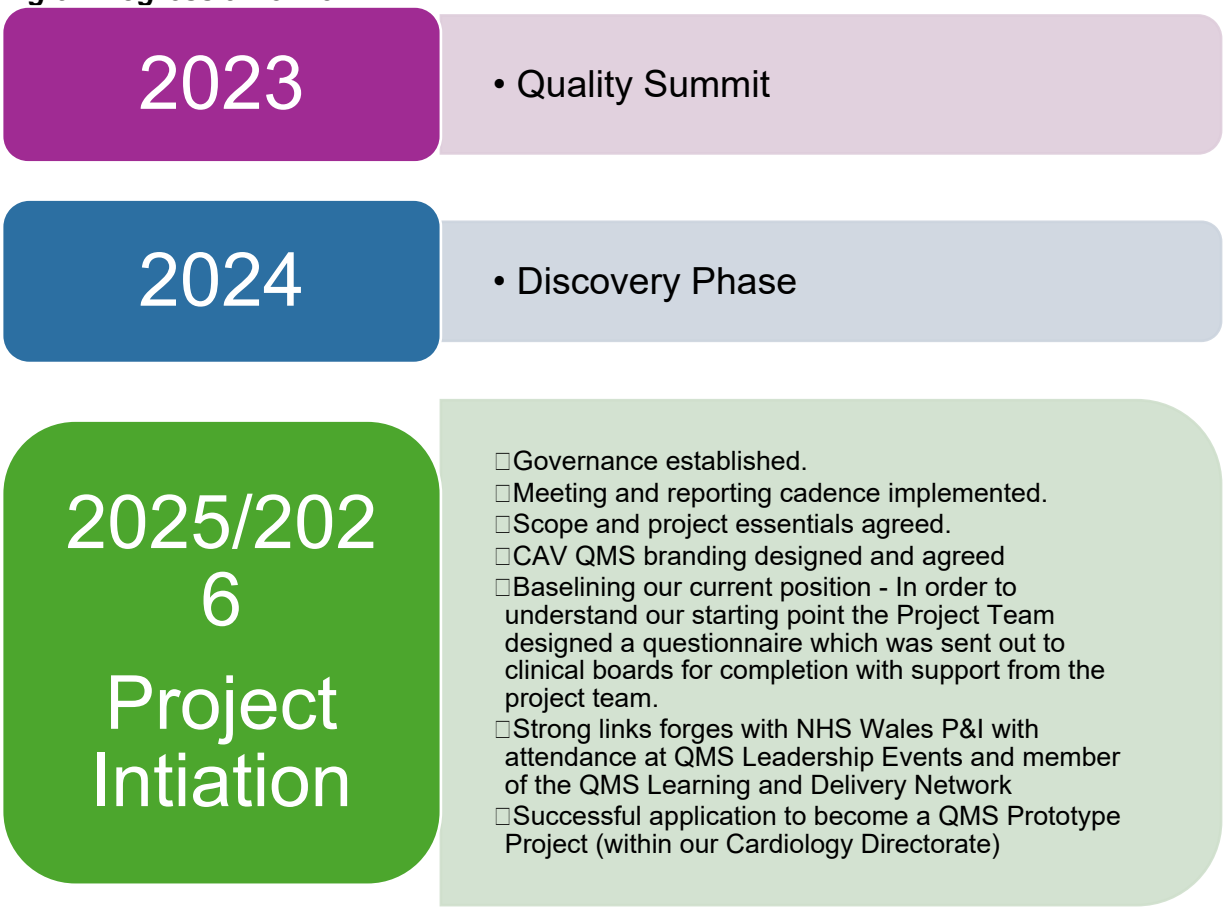
Fig 2: Governance framework



3. PROGRESS TO DATE

The QMS Project Team is clear that the establishment of an effective QMS is a fundamental building block for understanding current position with delivering against priorities and informing future strategic decisions. Utilising the Juran Trilogy concepts (planning, control, improvement) into actions has been a key focus of our consideration. Consequently, initiatives have been launched to commence the formulation of a comprehensive QMS Operating Model, using the NHS Performance & Improvement QMS self-assessment framework.

Fig 3: Progress timeline

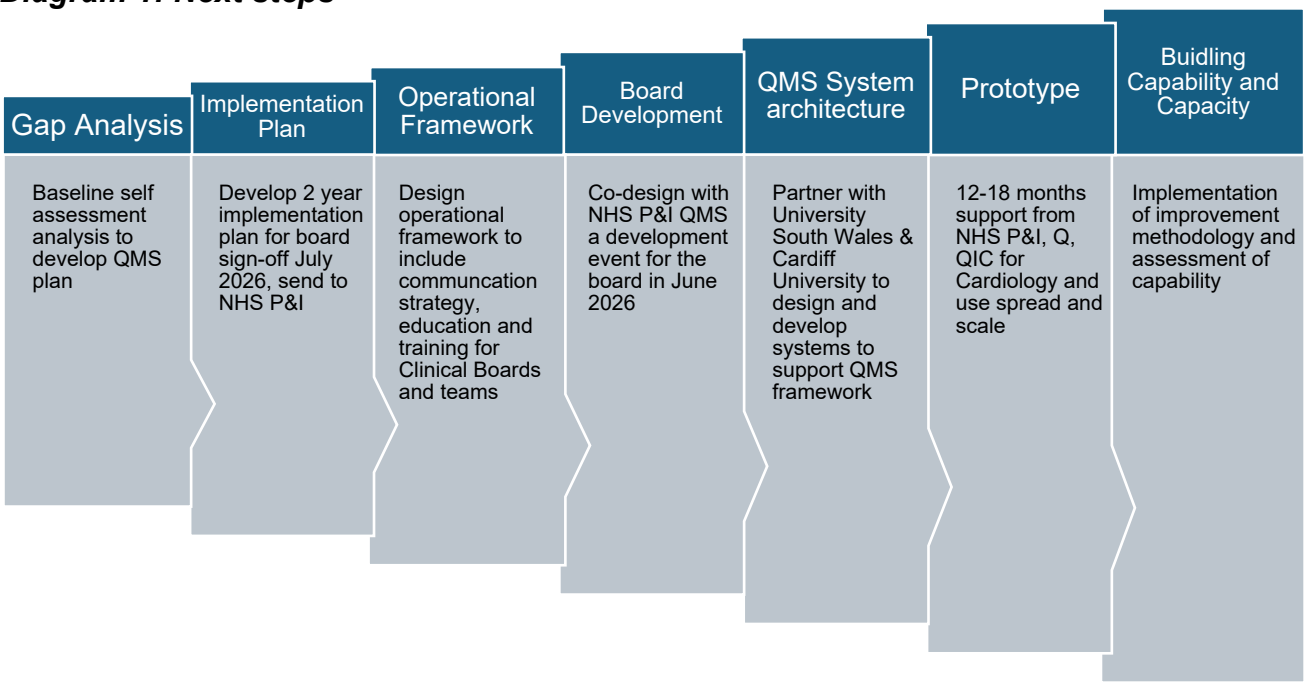


4. Next Steps

To build on this foundation and ensure the Quality Management System moves from concept into meaningful, organisation-wide practice, it is essential to outline the immediate priorities that will shape the next phase of development. The following *Next Steps* set out how we will continue to translate our strategic intent into coordinated action—strengthening our structures, deepening engagement; and to progress the work required to embed a real, relevant and sustainable QMS across Cardiff and Vale University Health Board-wide practice.

The diagram below demonstrates our next steps.

Diagram 1: Next steps



Report Title:	Annual Quality Report 2024/25				Agenda Item No:	3.3
Meeting:	Quality Committee	Public	x		Meeting Date:	03.03.26
		Private				
Status	Assurance		Approval	x	Information/Noting	
Lead Executive:	Executive Nurse Director					
Report Author Title:	Assistant Director of Quality and Patient Safety					

Main Report
Background and Current Situation:

The UHB is required to publish an Annual Quality Report that provides oversight of how the organisation is meeting its aims to improve the quality of healthcare services and to improve the outcomes of people it serves.

The Annual Quality Report has been co-produced with the UHB Co-production group and is set out under the six domains of quality and reflects how the six enabler have supported improvement.

The report provides oversight of how the UHB is working to reduce variation in outcomes, how it implements NICE guidance, the implementation of ePMA and the use of technology and artificial intelligence in clinical practice. The report also includes:

- oversight of HIW and LLais reporting
- The Shaping Our Future Quality Excellence Programme
- Theatres Together Programme
- Never Events
- Monitoring of safety alerts and notices

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

The Annual Quality Report provides an accessible oversight of the UHBs approach to meetings its Duty of Quality. This year the report has been Co produced with the UHB coproduction group

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

1. Annual Quality Report

Appendices found in the 'Supporting Documents' folder.

Recommendations:

The Committee are requested to:

a) Approve the 2024/25 Annual Quality report

Link to Strategic Objectives of Shaping our Future Wellbeing:

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

Delivering in the Right Places		Acting for the Future	x		

Five Waves of Working (Sustainable Development Principles) considered:									
Prevention		Long Term		Integration		Collaboration	x	Involvement	x

Quality Impact Assessment Completed?				
Yes *(please include the complete QIA document)*		No *(please provide reasoning e.g. not required*	x	

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:

FINAL VERSION -
SIGNED OFF JANUARY 2026

PCIC CLINICAL BOARD
MINUTES OF THE QUALITY, SAFETY & EXPERIENCE GROUP
TUESDAY 18th NOVEMBER 2025 11:00 – 13:00
Venue: MS TEAMS

Attendees –

- Barbara Davies, **BD,** Interim Director of Nursing, PCIC (Chair)
- Christopher Martey, **CM**, Multi-Professional Primary and Community Care Education Lead
- Clare Clement **CC**, Lead Pharmacist, PCIC
- Eleri Thomas, **ET**, Quality and Safety Officer, PCIC (minute-taker)
- Gareth Baker, **GB**, Head of People and Culture
- Dr Helen Cordy **HC**, Point of Care Clinical Lead
- Dr Helen Kemp, **HK**, Clinical Director for Quality, Safety and Governance & Deputy Clinical Board Director
- Jayne Gay, **JG**, Clinical Manager CAV 24/7
- Kate Morris, **KM**, Primary Care Pharmacist, Team Lead for Governance PCIC
- Lisa Waters, **LiW**, Senior Nurse for Quality, Safety and Education, PCIC
- Lloyd Waygood, **LlW**, Deputy Head of Operations, Cardiff Locality, PCIC
- Rachel Armitage, **RAr**, Quality and Safety Manager, PCIC
- Rachel Thomas, **RT**, Director of Operations, PCIC
- Rebecca Lewis, **RL**, Principal Public Health Practitioner
- 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

Guest Speakers:

- Craig Walters, **CW**, Interim Senior Nurse, MHSOP
- Marianne Seabright, **MS**, Lead Nurse MHSOP and Neuropsychiatry, MHSOP

Apologies:

- Andrea Rich, **AR**, Lead Nurse for Palliative Care, PCIC
- Anna Mogie, **AM**, Deputy Director of Nursing, PCIC
- Bethan Watkins, **BW**, Safeguarding Nurse Advisor, Corporate Safeguarding Team
- Helen Donovan, **HD**, Locality Lead Nurse for Cardiff, PCIC
- Janice Aspinall, **JA**, Anaesthetics Nurse, Anaesthetics
- Ellen Davies, **ED**, Infection, Prevention and Control Clinical Nurse, PCIC
- Dr Gneeta Joshi, **GJ**, Community Director of Governance, PCIC
- Helen Earland, **HE**, Clinic and Operational Lead for Urgent Primary Care, PCIC
- Dr Huw Brunt, **HB**, Consultant, Public Health
- Kate Roberts **KR**, Senior Nurse Vale Locality, PCIC
- Lauranne Cullen, **LC**, Regional Director for LLAIS, Cardiff and Vale
- Louise Allen, **LA**, Head of Community Pharmacy, PCIC
- Lynne Topham, **LT**, Interim Head of Planning, PCIC
- Neil Morgan, **NM**, Vale Locality Manager, PCIC)
- Nicky Punter, **NP**, People Resourcing Manager, Workforce & Recruitment
- Rhian Smith, **RS**, Macmillan Clinical Nurse Specialist, Palliative Care Team
- Victoria Whitchurch, **VW**, Head of Operations for Community Specialist Services, PCIC

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

PCIC QSE 18TH NOVEMBER 2025

Minutes: Tracey Skyrme, **TS**, Head of Inquests, Patient Experience
Eleri Thomas, **ET**, Quality and Safety Officer, PCIC

November Agenda: 00 PCIC QSE Agenda - 2025.11.18 - FINAL.docx

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

ITEM NO.	TITLE	ACTION
Part 1	**ITEMS FOR DISCUSSION**	
25/11/01	**Welcome & Introductions** Barbara Davies noted the attendees as listed on page one.	
25/11/02	**Apologies for absence** As listed on page one.	
25/11/03	**Declarations of interest** None declared.	
25/11/04	**Minutes and Matters Arising** The PCIC QSE September minutes are linked here – Item 04.1 **ACTION:** All to send to send any final comments to Eleri Thomas by Friday 21st November 2025, otherwise they will be deemed an accurate representation. • Update – action completed and signed off as final version.	**ALL**
25/11/05	**PCIC Quality & Safety Action Log** The action log from the September meeting was reviewed and updated – Item 05.1 The new November action log created from today's meeting has been linked on page one.	
25/11/06	***Patient Story*** *Ruth Cann, Consultant Nurse for Older Vulnerable Adults, presented a case involving a 78-year-old man living alone with poorly managed Type 2 diabetes, resulting in an above-knee amputation. Despite his medical history, the patient maintained that he did not have diabetes. Concerns were raised by his estranged daughter and GP regarding environmental neglect and possible deterioration of his remaining leg, prompting safeguarding referrals and attempted interventions from various agencies, which were hindered by the patient's refusal of entry and his presumed capacity to decline support.* *The Mental Capacity Act (MCA) team escalated the case due to doubts about the patient's ability to make informed decisions about his care, based on a history of self-neglect and unwise choices. After several attempts, Ruth Cann was able to engage the patient, who expressed specific wishes regarding his independence, financial management, and social isolation. Despite ongoing safeguarding concerns and multiple agency involvement, the patient was ultimately assessed as having the mental capacity to make decisions about his diabetes and care, although he continued to refuse most support.* *Tragically, the patient was later found deceased following a house fire caused by unsafe electrics. Key learning points include the challenges in assessing mental capacity when enduring beliefs are present, the importance of not assuming capacity without formal assessment, and the need for improved multi-agency collaboration and engagement strategies for individuals with self-neglect. Ruth Cann noted that the self-neglect toolkit proved useful and was helpful in securing the social work allocation, but earlier intervention and better utilisation of community resources may have impacted the outcome.* *Following a group discussion, it was highlighted that the South Wales Fires and Rescue Service offer free fire safety checks in the home. Please see details here: Free Home Fire Safety Checks.docx*	

	Rachel Armitage commended Ruth Cann for going to the patient's home which started off all the processes being put in place. *Barbara Davies stated it is an ethically challenging situation to be in when capacity has been assessed and a patient is making a decision that might not necessarily fit within the norm.*	
25/11/07	***Risk Register Update*** *Rachel Armitage informed the group that the risk register is in the process of being migrated to AMAT. She confirmed that, as of October 2025, all risks rated 15 and above had been transferred to AMAT; however, any risks of this level added to the register after this date are yet to be migrated.* *The Corporate directive requires all risks are recorded on AMAT by the end of the current financial year. PCIC will be providing training to the Business Units and guidance on this process from the New Year. Rachel Armitage requested that Business Units identify suitable individuals to oversee the transfer of risks to AMAT, emphasising that this is not a routine clerical task. The nominated individuals should be able to make decisions and respond to queries regarding risk ratings and their justifications within AMAT.* *Barbara Davies advised the group to begin identifying appropriate individuals within their teams to participate in the AMAT migration process. With organisational structure changes scheduled to be established in the new year, AMAT training will commence at that time. Efforts are underway to minimise duplication between the risk register hosted on SharePoint and those risks already transferred to AMAT. Further updates regarding these processes will be communicated in due course. All teams are asked to prepare for these forthcoming changes.*	
25/11/08	***PCIC Quality Report*** *Please see full reports here:* • *October Monthly 2025 report (Item 08.1)* • *November Monthly 2025 report (Item 08.2)* *Lisa Waters presented key highlights from the November report.* • *Open NRIs – one open for the PCIC Clinical Board, which includes three services; GP practice, the Emergency Unit, and Radiology. An extension has been granted to the planner closure date of 5th December.* • *Closed NRIs – two closed in October; Lisa Water thanked all those involved for their hard work.* ***ACTION: Lisa Waters to create and share an SBAR for the two NRIs closed in October 2025, for appropriate distribution (including sharing via Primary Care newsletter to GPs). This will be shared in the January 2026 meeting.*** • *Complaints and concerns. Two open cases under Putting Things Right (PTR). PTR. Performance varies, but the Clinical Board gets few cases. Lisa Waters is working with the Concerns team for better KPIs and more accurate monthly data.* • *DATIX management – reduced reporting of pressure damages this month.* • *Inquests – Lisa Waters will follow up with the involved staff in an inquest that was held the previous day.* • *Mandatory and Statutory Training – staff are encouraged to keep their training up to date. Medical staff may have already undertaken their training within other roles, so it is being investigated how this can be captured in ESR.* • *Safeguarding – will be discussed in more detail under Item 13.* • *Operational updates – no further updates to add following details shared in the October report.* *Rachel Armitage reported that she has been undertaking targeted work to close, reject, or move on 16 incidents from the open over 30-day category, and will continue these efforts. Support is available for teams requiring assistance with incident management.*	***Lisa Waters***

	Barbara Davies reiterated this message, encouraging teams to concentrate on addressing incidents within their respective areas and to seek support when necessary.	
25/11/09	**NRI Feedback** *As previously noted, Lisa Waters will share the feedback from two closed NRIs (ID 78736, ID 81925) at the next PCIC QSE meeting in January 2026.* *Lisa Waters presented a summary of three pressure damage incidents in the PCIC District Nursing Teams. Regarding incidents involving avoidable pressure damage, Lisa Waters stated that collaborative efforts are undertaken with the relevant teams to ensure necessary learning and updates are implemented. The resulting information is subsequently communicated to the Welsh Government. Incidents ID72475, ID91238, and ID93058 were noted for closure.* *Key themes included delayed assessment and interventions, equipment issues, documentation gaps, and operational pressures. Lisa Waters noted that due to some instances of gaps in documentation and assessment, it is difficult ascertain whether there was avoidable harm. It is important to support staff and provide appropriate training sessions.* *Please see full report regarding a summary of pressure damage incidents here - Item 09.1* *Barbara Davies explained that pressure damage themes is a common focus area during Corporate Review discussions.*	
25/11/10	***PCIC QSE Terms of Reference*** *Barbara Davies noted that the draft Terms of Reference have been updated with appropriate Business Unit titles and membership changes (including adding representation from the Head of Planning (Lynne Topham) and the PCIC Academy (Christopher Martey). Members were requested to forward any objections or proposed amendments to Eleri Thomas by Friday, 21st November 2025. In the absence of further submissions by this deadline, the Terms of Reference would be considered approved. Any amendments required following structure changes will be added as and when as appropriate.* ***ACTION: All to submit any further changes to Eleri Thomas the Terms of Reference by Friday 21st November 2025.*** • ***Update following meeting – no further changes received. Final version has been saved in the 'Terms of Reference – PCIC QSE' folder, linked here: Terms of Reference - PCIC QSE***	**ALL**
25/11/11	***Information Governance*** *Barbara Davies noted that Information Governance has been added to the agenda as a standing item as it does not currently sit anywhere else within the Clinical Board. This will be reviewed in due course.* *Rachel Armitage requested that any Information Governance incident investigations from Business Units are fed back through the PCIC QSE forum to share learning and be signed off.* *Rebecca Stringer described a recent incident within DOSH (Department of Sexual Health) whereby a patient from CAVHIS (Cardiff and Vale Health Inclusion Service) broke into one of the medical records rooms and slept there overnight. From an operational and clinical perspective, it was believed that all DOSH records were stored electronically, such as on MilliCare, but there were approximately 2,000 records within CRI (Cardiff Royal Infirmary). The incident has been reported to James Webb (Head of Information Governance and Cyber Security), is being investigated, and will be put on the risk register going forward.* *Barbara Davies reiterated, in light of an ongoing investigation, that staff are not permitted to access their own or family members' records. This can lead to a disciplinary*	

	process if proven. Barbara Davies also highlighted an ongoing process relating to staff and the use of NHS e-mail to potentially communicate about other colleagues, which is challenging in terms of culture.	
25/11/12	***Infection Prevention and Control (IP&C)*** *There was no IP&C report submitted this month.* *Barbara Davies noted that C.Diff has become an increasing cause for concern in what appears to be community acquired infection. In September there were 10 cases, reducing to 5 cases in October. There appears to be a switch from secondary care focussed healthcare acquired infection to primary care. The Executive's review is asking why we are seeing an increase within community services. There is a lot of work on antimicrobial stewardship within the community and the initiatives, noting it is antimicrobial week. There is ongoing work on relationships with partners and providers to ensure the RCAs (Root Cause Analysis forms) are returned. IP&C are developing a dashboard to pull out themes from the RCAs. Some of the C.Diff information showed earlier prescribing within secondary care can be a driver, and analysis of the themes may inform where to target. Antimicrobial stewardship is the biggest opportunity and looking at nursing homes to ascertain how to link in with partners to support as well.* *The audit report from Cowbridge Health Centre from September is linked below. The environmental audits scored 71%, previously it was 73%. It was noted that Estates in the community centres are a huge challenge and work is going on to optimise that. (Item 12.1, Item 12.2, Item 12.3 - 2024 audit).* *Clare Clement explained that Pharmacy have noticed through the National Prescribing Indicators that the 4C performance (the prescribing of broad-spectrum antibiotics, which are restricted to certain conditions) has increased, now out of line with the rest of Wales. Pharmacy have done multiple audits around this and when it is studied in comparison to diagnosis, the indication seems appropriate. There are thoughts as to whether the diagnosis is right and whether we are over-diagnosing certain conditions that can lead to prescribing appropriately these antibiotics. There is a bigger piece of multidisciplinary work around diagnosis leading to the antibiotic being prescribed rather than just the choice of antibiotic itself. It will have to ascertained how to address that from an educational and a diagnostic, rather than a prescribing point of view.* ***ACTION: Clare Clement and Christopher Martey to link in to discuss appropriate education and training in an upcoming CPET session regarding diagnosis and prescribing of antibiotics (re. C.diff RCAs).*** ***ACTION: Barbara Davies to meet with Pharmacy Lead for antimicrobial prescribing re. C.diff RCAs.***	*Clare Clement & Chris Martey* *Barbara Davies*
25/11/13	***Safeguarding Metrics*** *Please see full report here - Item 13.1* *Lisa Waters encouraged staff to complete their MCA (Mental Capacity Act) and consent training, as well as sharing with their teams the useful Safeguarding SharePoint links to resources (as on page 3 of the above report).* *Following the Safeguarding team's presentation to the PCIC QSE forum in May 2025, PCIC has undertaken an improvement plan to support the Mental Capacity audit completed by Safeguarding. This is shared in the report. Lisa Waters is linking in with Safeguarding to see if there can be bespoke training for community staff regarding DoLS (Deprivation of Liberty Safeguards).* *Lisa Waters highlighted the Self-Neglect 7 Minute Briefing on page 5 of the report. The case highlights the important themes of capacity and professional curiosity across multiple services involved with the patient.*	

	Ruth Cann reflected on if a 'no wrong door' approach can be utilised across the services when a referral is made. Even if the referral comes to the wrong team, is there something that can be done to help the patient access the support they need. *Rachel Armitage clarified that not all practitioner performance cases as documented in this report are safeguarding-related; this is the only place where it is feasible for the cases to be reported.* *Christopher Martey highlighted the need to strategically share information and resources, such as the MCA team's GP CPET video, across relevant forums including medicines incentive schemes, CPET forum, and nursing education forums. The aim is to ensure effective dissemination and high uptake of key materials.* ***ACTION: Christopher Martey to share the MCA team's GP CPET video link to relevant forums.*** • ***Update – action completed.*** • ***Here is the link to the CPET video library -*** *CAV PCIC Lunchtime Educational Webinars - YouTube* • ***MCA video can be found here -*** *The Mental Capacity Act in Practice - Learning from Case Reviews Presentation - YouTube* ***ACTION: Lisa Waters and Christopher Martey to coordinate on strategic information sharing and uptake across education forums and newsletters.*** ***ACTION: Christopher Martey to share the Self-Neglect 7 Minute Briefing via the appropriate forum/s.***	*Chris Martey* *Lisa Waters & Chris Martey* *Chris Martey*
25/11/14	***Safeguarding Adult Practice Review Timeline presentation (MHSOP)*** *Craig Walters and Marianne Seabright from MHSOP presented a Patient Safety Learning Review (PSLR). Please see full details in the following presentation - Item 14.1* *This presentation details the case of Mr X, an elderly man with vascular dementia and multiple health issues, who was under the care of various mental health and community services from 2021 until his death in 2024. Despite involvement from several teams—including mental health, speech and language therapy, occupational therapy, and district nursing—there were significant concerns about his living conditions, self-neglect, and the adequacy of care provided by his main carer, who was also his ex-partner. Multiple safeguarding concerns were raised over time, but substantial action was only taken immediately before his death, following a rapid deterioration after hospital admission for delirium and pneumonia.* *The Patient Safety Learning Review identified several issues in the care process, such as gaps in contact from social workers, delays in capacity assessments, and failures in safeguarding procedures. Notably, the Continence Team did not appropriately explore concerns about the carer's obstruction of care to the Safeguarding Team, and there was confusion about the carer's legal authority (Power of Attorney). The phlebotomy service also faced repeated access issues, leading to delays in obtaining blood samples, though this did not directly contribute to the outcome. These lapses highlighted missed opportunities to address ongoing risks and safeguard the patient more effectively.* *Key lessons include the importance of promptly raising safeguarding concerns, verifying the scope of legal authority held by carers, and following local protocols when care is declined or access is repeatedly refused. The presentation also provides information about the Mental Capacity Act Team and the Office of the Public Guardian as resources for staff, emphasising the need for staff training, support, and clear escalation pathways to protect vulnerable adults in similar situations.* *Following the presentation, the group engaged in a discussion that included consideration of whether to make a safeguarding referral concerning the carer. Additional topics addressed were the distinction between community phlebotomy services provided by the district nursing team versus those offered through GP*	

	practices via Clinical Diagnostics and Therapeutics (CD&T), the increased integration of the Mental Capacity Act (MCA) team and its role in fostering collaboration among teams, and the support available from the memory link worker. *Lisa Waters explained that there is a 'patient not at home/DNA procedure' which would be shared following the meeting.* *(Post meeting note: Please see procedure here- Item 14.2.)*	
25/11/15	***Learning from Coroner's Prevention of Future Deaths Reports in Inquests (April 2025)*** *The following report was shared for information - Item 15.1* *Rachel Armitage noted that although this was an England report with a secondary care focus, the themes on 10-15 are relevant. This included concerns related to discharge processes which aligns with the experience PCIC have from Datix reports from GPs. The ambulance service delays are common to this area also. Reassuring that these problems are not only happening in Wales.* *Barbara Davies referenced the quality of documentation and decision making in care planning was particularly striking and that the report contained useful information and themes, for wider learning.*	
25/11/16	**Patient Group Direction (PGD)** *Please see full report here: Item 16.1* *Kate Morris explained the PGD (Patient Group Directive) had been in operation for a while, but this is the updated version, and when it went for sign off, there was pushback in terms of whether a PGD is needed for the administration of vitamin B12. Ideally, it should be given under a PSD (Patient Specific Directive), but the practicalities of this working under a PSD in general practice led to doubt around the governance processes that would be available as there would be additional strain on prescribers. To reassure good governance is followed as an organisation and within Primary Care, as well as consulting with Rebecca Lewis, it was concluded that the use of the PGD remained valid for Primary Care. The PGD needs approval by the group to say approve it can be signed and can be disseminated within Primary Care.* *Discussion noted that this was more appropriate to be discussed in this PCIC QSE meeting than PCIC MMG (Medicines Management Group). Conversation also clarified that this PGD is just for Primary Care GP practices, and that housebound patients are managed by a prescription.* ***ACTION: Helen Kemp and Kate Morris to discuss outside of the meeting whether there can be a PGD and a PSD for the vitamin B12.*** ***ACTION: All to submit any further comments to Eleri Thomas the PGD for vitamin B12 by Friday 21st November 2025.*** • ***Update – action completed and any responses have been shared with Kate Morris.***	Helen Kemp & Kate Morris All
25/11/17	***Duty of Candour (Marie Curie)– Cardiff and Vale UHB Annual Report 2024/25*** *Please see item for information and sharing - Item 17.1* *Barbara Davies acknowledged that there was one incident reported of moderate harm within the high-level summary of hospice care provided by Marie Curie during this period. The Health Board completes an SLA (Service Level Agreement) review with each of the hospice providers.* *Lisa Waters added that this has been shared with the Duty of Candour team within the Health Board.*	
25/11/18	***Compliments***	

	Please see compliments here - Item 18.1	
25/11/19	***Concerns*** *Barbara Davies acknowledged that Lisa Waters had given a high-level summary within her report (please see Item 8).* *Further details will be included in individual Business Unit reports. For example, Ombudsman case outcomes noted in the Primary Care QSE minutes (Item 38.1).*	
25/11/20	***All Wales Learning From Events Report (LFER)*** *Barbara Davies acknowledged that Lotte Ramsden presented a LFER at the September Primary Care QSE meeting regarding to a clinical negligence case relating to events dating back to 2019.* *Please see section 25/09/15 in the Primary Care QSE September minutes for full details (Item 38.1).*	
25/11/21	***POCT Update*** *Please see paper provided by Dr Helen Cordy regarding POCT (Point of Care Testing) - Item 21.1* *Dr Helen Cordy noted that items 4 (Connectivity) and 5 (Funding) are ongoing pieces of work.* *Under Item 1 (POCT CRP), Dr Helen Cordy noted that there that there is no capacity to offer free of charge POCT CRP consumables for the current 40 GP practices and pharmacies in Cardiff and Vale that have expressed interest. Firstly, the team is trying to utilise the free PCT CRP consumables at Barry Hub, and secondly the team is exploring the option of having another device in the Out of Hours service in CRI. Dr Helen Cordy asked to be kept updated of any other interested GP practices and community pharmacies to avoid playing catch-up.* *POCT CRP has been nominated for an NHS Wales Award, working alongside the Supportive Care team, whereby they used a value-based healthcare grant to implement this in the cohort of patients with interstitial lung disease to prevent being unnecessarily admitted to hospital.* *Regarding item 2 (Sharing of devices), Dr. Helen Cordy emphasised the importance of involving the POCT team in any re-distribution of devices. This will ensure that the distribution is handled safely, appropriate training is provided, and cost measures are taken into account.* *For item 3 (POCT glucose HCSW competency), it was discussed that Cardiff and Vale UHB have historically not allowed bank HCSW (Healthcare Support Workers) to undertake blood glucose testing. Dr Helen Cordy noted that the POCT team are working with ECOD (Education, Culture and Organisational Development) to align this across the Health Board. Dr Helen Kemp raised that the HCSW working in GP practices and community pharmacies are employees of the practice, so this would depend on their scope of practice.* *Barbara Davies referenced a recent email trail about INR and an All-Wales piece of work around the device and the consumables. There is more focus as PCIC Clinical Board in terms of the quarterly governance meeting, representation for the POCT agenda and clinical board membership, that Barbara Davies can share with the Directors of Nursing to support the conversation regarding POCT. The focus on increasing urgent care within Primary Care services, such as Safe@Home and UPCCs, is clear. However, it is crucial to ensure that this is done safely and with the proper governance in place.*	

	ACTION: Dr Helen Cordy, Dr Helen Kemp, Barbara Davies (also Sarah Lloyd and Setal Sall) to meet to discuss POCT governance, strategic plans and community implementation. • ***Update: Meeting has been arranged for Thursday 15th January 2026. 12:30 on MS Teams***	**Helen Kemp, Helen Cordy, Barbara Davies**
25/11/22	***Annual Quality Assurance Report*** *Barbara Davies explained that the Annual Quality Assurance Report for PCIC was presented in October with lots of information gathered by Lisa Waters. Upon reflection, it was noted that some areas were not included due to the wide and diverse nature of PCIC. The report was well received by the Executive Board and the Public Assurance Committee.* *Barbara Davies highlighted that over the next set of bimonthly PCIC QSE meetings, there would be a better understanding of the services and the most relevant information to include. Barbara Davies suggested that there might be changes in how the information is presented at the next meeting, such as through the use of presentation slides.* *Here is the report (added following the meeting) - 22.1 - PCIC Board Committee Covering Report Template 2025-26 (v.2 151025).docx*	
25/11/23	***Diabetic Eye Screening Wales (DESW) update*** *Please see September 2025 update here: Item 23.1*	
25/11/24	***All-Wales Community and Primary Care Integrated Musculoskeletal (MSK) Service Specification*** *The follow consultation has previously been circulated to PCIC staff, now closed, but was noted here: Item 24.1*	
25/11/25	***PCIC Academy Courses October and November 2025*** *Christopher Martey noted the following resources:* • *Courses available October and November 2025 – Item 25.1* • *How to sign-up and book onto the courses using Medtribe - Item 25.2* • *Upcoming courses in January – March 2026 for Healthcare Support Workers and non-clinical staff: 2026 E&T training calendar.* *The Academy team operates across a wide spectrum, delivering education and training that spans both primary and community care, with particular emphasis on the four independent contractors. The Academy is currently leading and facilitating the Women's Health Plan, which includes two multi-professional, face-to-face events scheduled for March. Staff interested in the three priority areas of the current plan—contraception, menopause, and menstrual health—are invited to participate in this forum.* *Christopher Martey reported that Dr Helen Kemp and Dr Richard Baxter have contributed to the Academy's governance awareness and have highlighted the significance of education through forums such as CPET. Rachel Armitage has provided valuable input regarding chaperone training and the application of learning from specific cases, which may inform future training initiatives.* *The Academy comprises a small team: Rebecca Hopes (Academy Manager), Kate O'Connell, and Christopher Martey. The team maintains strong links with various teams across PCIC and has played a strategic role in shaping the approach to education and training.* *Barbara Davies welcomed the PCIC Academy team to the PCIC QSE meetings and looked forward to building on relationships.*	

25/11/26	***Consent Newsletter (September 2025)*** *Noted for information - Item 26.1*	
25/11/27	***PCIC Academy Newsletter*** *Noted for information - Item 27.1* *Please note - if the link does not work, click the blue 'Open' box and the Canva newsletter should then open.*	
25/11/28	***Cardiff and Value Public Health Team Newsletters*** *Noted for information -* • *September 2025 newsletters - Item 28.1 and Item 28.2* • *October 2025 newsletters - Item 28.3 and Item 28.4* • *Attitudes towards vaccination in adults aged 55 and over (please see Item 28.5)*	
25/11/29	***CAVUHB Career Progression Survey 2025*** *Noted for information - Item 29.1*	
25/11/30	***Dementia Care Research Conference (Virtual)*** *Noted for information - Item 30.1*	
25/11/31	***Launch of PCIC Viva Engage Community*** *Noted for information - Item 31.1*	
25/11/32	***OOH Business Report*** *Apologies noted for the outstanding report.* *Jayne Gay provided an update regarding 111 press 2 workforce pressures, highlighting that ongoing uncertainty about the commencement of recruitment is impacting service delivery. It was reported that the senior team is significantly understaffed and that high levels of sickness within the team are presenting considerable operational challenges.* *Barbara Davies informed members that there has not yet been an update from EVSP, but an Executive Review is scheduled for the following day, during which recruitment priorities will be set. It was also noted that a request for escalation has previously been submitted. There may be a review this week of the scrutiny process, which continues to present difficulties in determining which priorities to submit to the Executive Scrutiny Panel.* *Jayne Gay further reported that call volumes are increasing given the time of year. A new senior team member has joined this month; however, there is a lack of staff available to provide training. The current situation remains challenging and was formally raised for the group's attention.*	
25/11/33	***Cardiff Community Business Unit*** *Lloyd Waygood presented the following report - Item 33.1* *The discussion focused on workforce risk management, highlighting concerns about current staffing levels due to recruitment challenges and vacancies in the CRT (Community Resource Team) and District Nursing teams, with a particular impact on unregistered staff. These vacancies have resulted in increased stress and higher sickness rates, especially in Rumney. The OCP (Organisational Change Policy) for the District Nursing team has been completed, involving staff reallocation such as the relocation of the Roath team to St Mellons, though this move is still pending final funding approval due to unresolved negotiations regarding ongoing rental costs at a local authority site.* *In terms of statutory compliance, VBA (Values Based Appraisal) rates are currently in the high seventies, while statutory management training compliance stands at around*	

	75–76%. There are ongoing efforts to address the lower compliance rates among individuals who hold multiple contracts, where training completed in one role is not being transferred to others. The past month has seen an increase in concerns, particularly relating to Compass HC and continuing health assessments, which have affected nurse success and lead nurse capacity. Two formal concerns within the District Nursing service have been completed, and positive feedback for District Nursing teams and CRT has also been recorded in the above report. *Initiatives to improve patient experience were discussed, including the introduction of a new QR code system that will allow patients and relatives to provide feedback through a short survey. There is also ongoing work to incorporate feedback into the bereavement booklet. CRT is preparing for the onboarding of the Promptly system, which will support the rollout of the EQ5D-5L patient measure for all service users. Additionally, CCRT has implemented a new SOP (Standard Operating Procedure) enabling physiotherapists and Safe at Home staff to prescribe low-level occupational therapy equipment, which aims to streamline processes and ensure quicker access for patients; initial feedback on this initiative has been positive.* *Audit and compliance activities are ongoing, with IP&C (Infection, Prevention and Control) audits in progress and most remedial works at community sites completed after initial budgetary limitations were resolved. Fire risk assessments are being conducted across community sites, with most outstanding issues addressed and responsibilities clarified between the organisation and landlords. Senior nurses are overseeing uniform audits, and safeguarding cases are being managed with appropriate support and assurance measures in place.* *Barbara Davies acknowledged that VBA compliance is a focus for the Clinical Board currently, and that Romilly Nursing Home had responded well to performance meetings.*	
25/11/34	**Vale Locality Business Report** *No representation present during the meeting.* *Please see Business Unit report here -* Item 34.1	
25/11/35	***Cardiff Specialist Business Unit*** *Please see Business Unit report here - Item 35.1* *Rebecca Stringer addressed several operational matters relating to immunisation services and workforce management. The proposed amendment to the Human Medicines Regulations 2012 was discussed, with specific consideration given to vaccine supply, logistics, administration, and their impact on public health. The Health Board had submitted feedback regarding the inclusion of an age-specific caveat for healthcare support workers involved in childhood vaccination programmes, citing the complexity of delivery in primary care; however, Welsh Government did not support this caveat. The Board's response aligned with other health boards across Wales, and the outcome may influence future directives regarding the deployment of healthcare support workers in vaccine programmes.* *The meeting noted recent issues with TIVc flu vaccine stock levels across Wales, which now appear to be resolved. Nevertheless, the risk associated with potential shortages and their impact on patient safety will be recorded on the corporate risk register.* *An information governance complaint was reported, concerning patient confidentiality at Cowbridge Hall following the removal of confidentiality booths in the transition to a community vaccination model. This matter is being addressed through the appropriate channels.* *Positive feedback from the Independent Monitoring Board (IMB) was acknowledged, recognising improvements in patient safety within prison healthcare despite ongoing nursing workforce challenges. Issues persist regarding emergency and urgent escorts,*	

	as well as handover and discharge processes for patients returning from secondary care to prison, with documentation amendments awaited from the governor. *The meeting also highlighted ongoing nursing vacancies across the service. Workforce models are under review, informed by health needs analyses and values-based healthcare initiatives within clinical settings to establish best practice benchmarks. The Immunisations Team is actively recruiting to fill significant vacancies, with an emphasis on ensuring resilience within the Health Protection business unit, particularly for BPV clinic operations.* *No further action was deemed necessary regarding healthcare support worker consent in immunisation services, as the national protocol in Wales sufficiently covers the consent process for these roles.*	
25/11/36	***Medicines Management*** *Please see full report here - Item 36.1* *Clare Clement discussed ongoing workforce challenges, noting some improvement with the recruitment of two new technicians starting the week following this PCIC QSE meeting and the lead pharmacist for frailty and community joining in the new year. Despite this progress, pharmacy vacancies remain under review, and the team continues to manage sickness and personal absences, limiting capacity for unplanned work. Current pressures, including seasonal flu, have delayed certain medicines management projects. Prioritisation of workloads is ongoing, with efforts to maintain progress on the work plan.* *The group noted the transition from Medicines Management Groups to the Medicines Implementation Governance Group at the corporate level, with an upcoming Medicine Scrutiny Group to oversee medicines governance matters such as policies and procedures. Further clarification is expected regarding the interaction between this new route and existing quality and safety processes. The team also reported on the positive reception of a poster at the UK Royal Pharmaceutical Society conference, summarising community pharmacy work on STI testing kit access. An update was provided on the handling of a complaint regarding electronic transfer prescription nominations, clarifying this falls outside the team's remit and has been referred to the relevant contractors and the Information Commissioner's Office (ICO).*	
25/11/37	**Palliative Care** *No representation present. No paper provided.*	
25/11/38	***Primary Care*** *Please see report provided - Item 38.1* *Sarah Griffiths noted that the minutes provided were from the September 2025 Primary Care QSE meeting and that a November 2025 meeting had occurred since.* *The agenda item focused on current escalation levels within General Medical Services (GMS), with nine practices reporting at Level 4 and thirteen at Level 3. Level 5 indicates practice closure. Discussion centred on reasons for escalation, notably ongoing uncertainty regarding GMS contract negotiations and concerns over inadequate funding for general practice operations and staffing. The introduction of SNOWMED coding, replacing previous Read coding systems, has contributed to operational challenges. Issues relating to the Welsh Immunisation Service (WIS) and flu vaccine stock management were also identified as factors impacting escalation levels.* *The meeting noted the forthcoming General Dental Services contract, scheduled to commence on 01/04/2026, which is expected to significantly affect contractors and patients. Preparatory work is required with contractors to ensure appropriate implementation ahead of the new financial year. The Dental Access Portal, managed*	

	by the Health Board, was cited as a positive development, having allocated nearly 16,000 patients to practices since April, with ongoing efforts to support under eighteens and a continued intake of approximately 50 patients daily. *Key risks highlighted include GMS sustainability and the impact of the new dental contract, both of which are external to the Health Board's direct control. One practice has applied for support under the sustainability framework, a formal process for practices at risk of closure to seek financial or other assistance. The need to review practitioners' access to X-ray facilities at locations such as HMP and MDUs was identified as a risk for inclusion on the register, due to suboptimal equipment and connectivity.* *Staffing challenges continue, with two Band 7 vacancies in the Primary Care and Community Dental Service teams and two Band 6 maternity leave vacancies, one of which is currently being backfilled. The operational manager post in CDS has remained vacant since January, having been declined at executive scrutiny.* *It was confirmed that GMS practice escalations are not directly driving wound care discussions, which tend to fluctuate independently.*	
25/11/39	**Any other business to be discussed** *Barbara Davies gave assurance that in terms of vacancies, there has been risk stratification and conversations regarding the posts which the Clinical Board will discuss at the next Executives Review meeting.* *Lisa Waters encouraged staff to engage with the All-Wales Staff Survey (closing 1st December 2025) and was assured at an engagement session that the survey is anonymous.*	
PART 2	*PART 2: Items to be recorded as Received and Noted for Information by the sub-Committee*	
25/11/40	*All items below have been previously circulated as appropriate.* *PCIC Central Register – Comms & Alerts*	
Date and time of next meeting: Tuesday, 20th January 2026, 11am		

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

Held on 18th February 2026

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

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 26/001	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 26/002	**Apologies for Absence** Apologies for absence were noted.	
CDTQSE 26/003	**Minutes of the previous meeting 22nd December 2025** **The Group resolved that:** a) The minutes of the previous meeting were accepted as an accurate record.	
CDTQSE 26/004	**Matters Arising/Action Log** An update was provided on the outstanding actions from the previous meeting. *CDTQSE 25/226 Changes to Concerns Process* A task and finish group is being set up to consider how to operationalise the new concerns guidance. The new guidance places more emphasis on facilitating meetings. There will also be an increase to the turnaround times required to respond to early resolution concerns. *CDTQSE 25/305 Datix Incidents where Root Cause sits with the Estates team* SR noted that she attends a new Healthcare Environment Steering Group whereby she can escalate any longstanding issues to the Estates team for addressing. *CDTQSE 25/311 Concerns around the Use of AI and Recording of Meetings* HL noted that there is a reference to privacy guidance when recording notification is displayed on screen. There is also guidance on the UHB SharePoint site around retention policies. *CDTQSE 25/320 Clinical Engineering Partnership with BSI* EC shared the details of the 34-year partnership with HL to share with CAV communities. *CDTQSE 25/338 MSK Workstation Assessments* MM has shared the information with HL to follow up with the Occupational Health Team.	

	The group resolved that: a) The updates to the outstanding actions were noted.	
6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 26/005	**Concerns and Compliments Report** In December 2025, the Clinical Board received 47 concerns, 5 formal concerns and 42 to be resolved through early resolution. There were 0 breaches in response times and 3 compliments were received. The top themes of concerns received in December were: • Difficulties cancelling/arranging appointments. • Waiting times The key themes of concerns received this year were: • Difficulties cancelling/arranging appointments • Waiting times • The waiting time for test results/scan reports The key themes of compliments received this year were: • Efficient service • Excellent clinical treatment **The Group resolved that:** a) The concerns report was noted.	
CDTQSE 26/006	**National Reportable Incidents** The NRI report was circulated. A new incident has been reported relating to an external provider being used for the storage of stem cells who experienced a temperature excursion in their liquid nitrogen freezer. An initial meeting was held earlier this week to assess the situation. This will be presented to a future meeting when the incident has been investigated. **Feedback on DXA T-score incident** Rachel Bidder, Head of Nuclear Medical Physics and Amie Roberts, Principal Clinical Scientist and DXA Practitioner were welcomed to the meeting to present the investigation into the NRI and IRMER incident relating to the DXA scanner. This has been a challenging time involving many patients. DXA is the gold standard test for measuring bone mineral density to assess fracture risks and diagnose bone health conditions. A T-score compares a patient's Bone Mineral Density (BMD) value to that of a healthy young adult	

	reference population and is expressed as a standard deviation. The T-score is the output that is then used to diagnose if a patient has normal bone densities or osteoporosis. The reference database used is local department set. The patient can be matched to a reference base, matching gender, age, age and ethnicity or a combination of these. On 26th May, the team were alerted to a discrepancy in T-score results for a patient referred from the Bone Research Unit. The results appeared inconsistent with previously reported values. Dxa scans are reported offline and a Word document is created from the original scan. It compares all previous scans and then recalculates the T-score. A key part of the equipment is that every time point it recalculates the T-score, it not only takes the T-score from the original scant but it recalculates the T-score. The team had to identify why T-scores were changing from year to year and were they accurate at the time. Phantom studies were undertaken and it emerged that on one of the machines, the T-score values were not changing, however on a different machine, the T-score values were changing for those recorded as black ethnicity. This highlighted that there was an issue with the reference database used for the T-score calculations. The reference database used to calculate MT scores were omitted from the Word document and comparisons could not be drawn from the 2019 analysis database or the 2025. A review of the scanner highlighted that the database was not comparing to ethnicity matched, it was only comparing to a white database. Therefore, regardless of ethnicity recorded on the system, it was only comparing to a white database. This introduced an inconsistency in T-score reporting between the 2 DXA scanners at UHW. From this it was identified that the root cause was a configuration change on the scanner. The change had not been documented and had been made without the knowledge of any DXA operator or clinician. An investigation highlighted that were was no access control on the scanners and the system set up could easily have been changed. Work was undertaken to identify the timeframe of when this occurred by comparing all the patients with a recorded ethnicity of black and it was identified that the system change likely occurred between January and March 2020.	

	The key events that occurred during 2020 to 2025 were reviewed and it was noted that there were a lot of engineers on site to convert to upgrade the patient management system during January 2020 and a further engineer visit in March 2020. However, the change could also have occurred during regular day to day use. The team explored why the issue was not detected and the following findings were noted: There was no documentation setting out the required system configuration and no checks had been undertaken to ensure there had been no configuration change. Following the service in March 2020, there were no quality control measurements undertaken. Key information was missing from the offline Word document. Therefore, clinicians reviewing the reports could not identify which database was used and they were taking the T-scores that were reported on it as final. There was a lack of access control on the DXA scanner, with one generic login for the equipment and full permissions were set on that login. This was due to a discounted service contract with the manufacturer as there was an individual onsite who had the skills to undertake frontline maintenance. However, this resulted in all standard operators having access to all the functionalities that could result in a configuration change. A review was also undertaken to understand why the issue took so long to be identified. It was noted that there has been limited clinicians reviewing DXA scans. They had good knowledge how to interpret the results and were not compelled to compare to previous reports as they had undertaken the reporting. Changes have been implemented to address the issues. A major change is moving from offline reporting to online reporting. This provides transparency. It references what database is used, all the scan parameters and allows an overview of what has been reported and a list of previous reports that allows easy comparison. A total of 78 patients with a documented black ethnicity who underwent DXA scans between 2020 and 2025 were potentially affected. With support from the clinicians who referred the patients, the DXA scans were reanalysed and clinicians evaluated changes in the report.	

	13 patients were identified has having a significant change in management. There were difficulties contacting all patients and this work is still underway. As this was not a radiation incident, it was unclear if the incident was reportable to Healthcare Inspectorate Wales (HIW). This was reported Clarification was sought from HIW and due to the number of patients involved it was reported. However, the incident highlighted the lack of guidance in legislation around reporting clinical evaluation errors and software errors. The incident was reported to the MHRA as this was a software issue and also reported as a National Reportable Incident. Key learning from the incident is: Access control audits and audits of both equipment and software is essential. Online reporting provides more transparency and cross reporting and allows clinical review. There is a lack of information around software/clinical evaluation issues within legislation. Communication and multidisciplinary working were key during the incident investigation. Patients are still under review so the harm levels are not yet determined. The patients reviewed to date are reporting no harm. Amie Roberts was thanked for her efforts and hard work in investigating this incident. SS commented that auditing administrators is complex but critical. RM commented that the manufacturer has some responsibility in this incident. It is not acceptable for software to have this level of vulnerability. The technical file should have risk assessments for users errors and failures. There should also be fail safes in place where logins have full permissions. Amie Roberts noted that discussions have been held with the manufacturer but they have taken no action in providing different levels of access control. **The Group resolved that:** a) The NRI report was noted.	

	b) Whilst the DXA incident related to a niche area, there is wider learning in terms of user permissions on equipment and software auditing.	
CDTQSE 26/007	**Duty of Candour Cases/Claims/LFERs** AL reported that Welsh Risk Pool will be auditing patient safety and the duty of candour process is part of this. HL issued a reminder that if incidents are graded as moderate, services need to consider duty of candour and contacting patients. **The Group resolved that:** a) Whilst initial harm is reported as moderate, the harm can be re-evaluated as part of the investigation at a later date.	
CDTQSE 26/008	**Risk Register Updates** There were no new risks to report. **The Group resolved that:** a) Directorate risk registers need to be transitioned to the AMAT system by the end of March.	
CDTQSE 26/009	**Patient Safety Alerts** **Safety Memo: Andexanet Alfa** **The Group resolved that:** a) The alert is applicable to prescribers but was circulated for awareness.	
CDTQSE 26/010	**Medical Device/Equipment Risks** **The Group resolved that:** a) There were no medical device/equipment risks to report.	
26/011	**Point of Care Testing** SS reported that the POCT ream are implementing a new blood gas system and are experiencing multiple problems around connectivity and technical problems. The system must be implemented by the end of the financial year or significant financial penalties will be incurred. An incident has been reported where a clinician reported that they could not view their patient results and upon investigation there was a connectivity issue with the data flows from all the of the blood gas machines. These devices have complex firewalls and one of these firewalls prevented dataflow.	

	The incident has highlighted that it is critically important to have oversight of the systems and the need for robust KPIs need to be built into the contracts with manufacturers to ensure they have a level of accountability. There are other devices from the same manufacturer that are also high risk and these issues have been escalated to the Clinical Safety Group. HL asked whether the new system will resolve connectivity issues. SS responded that it is hoped this will be the case as less firewalls are required. When the new data management system is implemented, in conjunction with an upgrade of the devices in other areas, they should all connect to this one system. This will improve safety and visibility. **The Group resolved that:** a) The Point of Care Testing update was noted.	
CDTQSE 26/012	**IP&C/ Decontamination Issues** There has been an update to PPE guidance whereby the reintroduction of mask wearing in unscheduled care areas has now been stood down. **The Group resolved that:** a) The UHB Decontamination Group and IPC Group will be held at the next week.	
CDTQSE 26/013	**Safeguarding /Consent Issues** **The Group resolved that:** a) There were no updates to report.	
CDTQSE 26/014	**Health and Safety/Staff Wellbeing** JD reported that the Clinical Board is reporting 0 RIDDORs and the number of health and safety incidents have reduced. It was noted that departments are working on producing annual health and safety action plans. **The Group resolved that:** a) The health and safety updates were noted.	
CDTQSE 26/015	**Regulatory Compliance** **The Group resolved that:** a) The minutes were circulated for information.	

TIMELY		
CDTQSE 26/016	**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 26/017	**Feedback from UHB QSE Committee** The minutes of the UHB QSE Committee held on 9th December were received. HL referred to an update on the Care After Death process and learning from mortality. She thanked the colleagues in the Bereavement and Mortuary teams for their involvement in this process. **The group resolved that:** a) The minutes of the UHB QSE Committee were noted.	
CDTQSE 26/018	**Research and Development** RM reported that HIW have 8 funded places for Wales for Healthcare Scientists to participate in their Healthcare Science Innovation Fellowships. The funding will provide peer support and travel expenses. A Therapies Research Seminar will be held on 29th January. Nominations were requested for speakers for the next CD&T R&D Forum. If there is any interest to contact RM. HL suggested that this is an opportunity for any colleagues undertaking extended study to present their dissertation project. **The Group resolved that:** a) The R&D update was noted.	
CDTQSE 26/019	**Service Improvement Initiatives** **The Group resolved that:** a) There were no service improvement initiatives to report.	
CDTQSE 26/020	**Information Governance/Data Quality** The NHS Wales app is now live. This enables patients to view limited details around their new referral outpatient appointments and whether they have been added to a waiting list. There is an intention to expand this over time to include all patient appointments.	

	The Group resolved that: a) Future functionalities could include reviewing test results and booking appointments.	
CDTQSE 26/021	**HIW/Llais Reports and Improvement Plans** The SSSU department within Surgery Clinical Board received an unannounced HIW inspection last week. Any shared learning will be discussed when the report is made available. **The Group resolved that:** a) The importance of departments undertaken work to ensure they are inspection ready was highlighted.	
CDTQSE 26/022	**Policies, Procedures and Guidance (including NICE Guidance)** **The Group resolved that:** a) There were no local policies or procedures to be reviewed.	
EFFICIENT		
CDTQSE 26/023	**Feedback from Directorate QSE Meetings** EH enquired on whether there is any update on the development of a Standard Operating Procedure around the process for patient access to records**.** HL will discuss with SO. Therapies have developed presentation around Equality, Diversity and Inclusion that can be presented at a future QSE meeting. EH to confirm a date with HJ. **The Group resolved that:** a) HL requested for departments to submit their action notes, minutes or summaries from their QSE Groups.	**HL** **EH**
CDTQSE 26/024	**Clinical/Internal Audits** EL reported that Internal Audit are planning an audit of medicines across the wards in February. 4 wards have been identified. This is awaiting sign off from the Medical Director and Director of Nursing. The Counter Fraud team will be linking in with this process with regards to the storage and handling of medicines. AL reported that the Clinical Audit team will be delivering 3 workshops this year for all staff to explain the principles of clinical audit, the aims and objectives and audit tool design. A new member of the clinical audit team will be aligned to the Clinical Diagnostics and Therapeutics Clinical Board. HL	**Dirs**

	requested that directorates send the names of their Clinical Audit Leads to HJ so that initial introductions can be made. **The Group resolved that:** a) The updates relating to internal and clinical audits were noted.	
CDTQSE 26/025	**Sustainability** The UHB is setting up a Clinical Leads Sustainability Group and Clinical Boards have been asked to nominate Clinical Sustainability Leads. Dr Judith White and Megan Dale from the Cedar Service will be representing the Clinical Board. An update has been provided on the walking aids refurbishment project during 2025. A total of 4943 walking aids have been refurbished and put back into use throughout the Health Board. The total cost savings compared to buying new equipment equates to £72.6k. The total Carbon reduction value of reused equipment, compared with potential disposal equates to 192.3kg CO2e. This is an increase on last year's figures by around 10%. Cardiff and Vale is currently leading the way with this project throughout Wales and will work closely with Swansea Bay UHB, Velindre NHS Trust and Betsi Cadwaladr UHB to support them in setting up a similar scheme. **The Group resolved that:** a) The update on sustainability was noted.	
EQUITABLE		
CDTQSE 26/026	**Equality, Diversity and Inclusion Issues/ Inclusion Ambassadors Update** A podcast will be recorded to share the EDI work in Therapies. The Clinical Board is meeting with the UHB Equality Adviser at the end of January and will be discussing the Welsh Race Equality Standards. HL raised an issue with the Director of Digital Health Intelligence in relation to the self-check-in kiosk in Outpatient Physiotherapy asking patients to identify their gender at birth. This is upsetting for some trans patients and the digital team will be looking to address this. **The Group resolved that:** a) The Equality, Diversity and Inclusion updates were noted.	
PERSON CENTRED		

CDTQSE 26/027	**Patient Story – Nutrition and Dietetics: A new way of working to support patients with liver disease using a community-based approach** Amelia Rowlands and Claire Constantinou were welcomed to the meeting. Dietetics and Physiotherapy have been working on supporting patients with liver cirrhosis at home, with a more proactive approach rather than reactive approach to diabetic and physiotherapy support. This involves supporting patients in the community to try and reduce the risk of admission for these patients and keeping them well at home. Liver disease is the only major cause of death that is increasing in the UK, with mortality rates in Wales more than doubling over the past 20 years. It can become particularly challenging to identify because patients often report to medical services quite late and often symptoms do not arise until later stages of the disease progression, so it can be quite difficult to identify these patients and those that are at risk. patients with a liver cirrhosis are at significant risk of nutritional deterioration, sarcopenia and malnutrition which is why Dietetics and Physiotherapy support is particularly important. In the current model of care patients are typically admitted by emergency streams or referred through outpatient clinics. They are admitted to hospital and receive support on the ward. This entails a course of NG feeding. Currently there is no designated physiotherapy support. The project was set up to support patients at home, to identify patients earlier through consultant and nurse led clinics and identify who would be at risk of nutritional deterioration and would benefit from additional nutrition support. The aim was to provide 8-12 weeks of NG feeding and reconditioning at home with a small outreach MDT from the gastroenterology service, including a dietitian, a physiotherapist and a nurse. In total 24 patients were offered the service and 12 patients underwent the intervention, with a range of ages. All patients had cirrhosis. The liver frailty index tool was used to measure how frail patients were in relation to their cirrhosis before and after the intervention. Almost all patients showed an improvement in their liver frailty index over the course of the 12-week intervention, with some patients moving from a frail state to a robust state.	

	The 6-minute walk test was also measured and each patient had a lower tolerance to exercise compared to the end of the intervention, demonstrating they had improved endurance and muscle mass. Perceived quality of life before and after intervention was measured using the EQ5D5L tool. 0 is equivalent to death and 1 is perfect health. The initial average score of the patient cohort was 0.2, which is poor. This raised to 0.7 by the end of the intervention. The financial impact was assessed, comparing the intervention cohort to a previous cohort of patients that received dietetic treatment on the ward. Patients who received their NG feeding on the ward spent 18% of their time in hospital to receive this treatment. This compared to the intervention cohort who had some admission during this time of the intervention, but it was much reduced down to 2.1% of time spent in hospital. The opportunity cost savings for 9 patients equated to £461.7k. If If the project ran full time based on 30 patients a year this would equate to £1.3m. In terms of patient experience, a story was captured for a 35-year-old female who had her first liver transplant aged 3. At the time of assessment, she had graft cirrhosis and progressive liver failure. She was on an active transplant waiting list, under the care of the palliative care team. She had jaundice and encephalopathy. She had pedal oedema and was complaining of severe fatigue and had difficulty engaging with normal day-to-day activities. Her liver frailty index score indicated she was prefrail, which is hard hitting for someone aged 35 years old and she could only walk 476 metres in 6 minutes on the 6-minute walk test. She initially declined to be part of the intervention as she felt that it would impact negatively on her daughter, who was 7 years old, she was worried about how she would feel about seeing her mum with a feeding tube. During a 1:1 session the risks of not engaging with further nutrition support and rehabilitation was discussed including a risk of being declined for transplant should she become frailer and too weak. A meeting was held at her home with her daughter who was shown an NG feeding tube what this would entail. The daughter had no worries and therefore the patient agreed to participate in the intervention. After 12 weeks of feeding and reconditioning, this patient's Liver Feeding Index score improved to 2.68, which is	

	considered robust. She reported an improved fatigue score of 18 from 25 previously. She reports that she is feeling more energetic and able to enjoy her life more, she has an improved appetite and energy to prepare meals and looks after herself better. She was exercising and nutrition has become part of her everyday routine. She was really pleased with her progress with her exercise tolerance, and she was ready and robust for transplant. A few months later she contacted the team to advise that she received a transplant and is feeling very well and with more energy which she attributes to the programme. A second patient story was presented. The patient was waiting for a transplant and initially refused the intervention, however a few weeks later changed her mind and commenced on the programme. The programme improved her wellbeing quite quickly. Whilst she still experiences the symptoms, she acknowledged that this was about being fed and receiving physiotherapy to strengthen her body. She stated that whilst having to wear an NG tube at night, being treated at home is more personal and fits around her life. She is happy to continue with her feed until she receives her surgery so that she will be fit enough to recover. HL asked if the intervention is set at 8-12 weeks or whether people can revisit the programme. It was noted that this is individualise but typically at 12 weeks, patients have regained a lot of their muscle mass and have an improved appetite. There is an option for patients to revisit the programme, however, none of the patients that participated in the project over the last 12 months have additional NG feeding. Alison Lewis asked what is the next step for this service or the barriers that need to be overcome. It was noted that this project was initially funded from a Value in Health bid and was not a funded service. It has recently been advised that funding may be secured to run the service from April permanently. **The Group resolved that:** a) This is a patient-centred intervention that is aligned to the Health Board's strategy of prevention and providing care closer to home.	
CDTQSE 26/028 Chilcott Rachel 25/02/2026 16:12:06	**Patient Experience Feedback** **The Group resolved that:** a) HL will circulate Civica reports when they are received.	

CDTQSE 26/029	**Internal/External Awards** **The Group resolved that:** a) There have been no awards presented to departments or staff this month.	
CDTQSE 26/030	**Good News Stories** **The Group resolved that:** a) There were no specific good news stories to share.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 26/031	CD&T Clinical Board R&D Group Minutes 13.1.26 Regulatory Compliance Group Minutes 12.1.26	
ANY OTHER BUSINESS		
CDTQSE 26/032	Haematology/Blood Transfusion are scheduled to present the patient story next month. Samantha Davies raised issues that the foul smell in Radiology still present. AC and SL visited the department and escalated this issue to Estates with a request for a timeframe around when this will be resolved. PW reported that opposite the entrance to Medical Physics a water catcher is in place that is collecting rainwater due to remedial works on a roof and this is leaking onto the floor. SR noted that this has been escalated at the Healthcare Environment Steering Group. AC agreed to produce a spreadsheet template to capture estates issues and updates from across the Clinical Board. HL suggested that the spreadsheet is placed on Microsoft Teams in the QSE Team in the files section for directorates to complete.	**AC**
CDTQSE 26/033	**Date & Time of Next Meeting** The next meeting will be held on 18th February 2026 at 9am via Teams.	

Minutes of the Specialist Services Clinical Board
Quality, Safety & Experience Committee
Health & Safety Focused
Monday 19 January 2026
Via Teams

M I N U T E S

Item No	Agenda Item	Action
Part 1: Preliminaries		
1.1	**Welcome & Introduction** CT welcomed everyone to the meeting. A few key items were noted at the outset as per minutes. The meeting itself was subsequently stood down because of SPRINT fortnight with most attendees needing to join a 10am meeting, footprint moves and a high volume of apologies. There was therefore not a full quorum with representation for each directorate and service.	
1.2	**Apologies for Absence** Apologies for absence had been received from Colin Gibson, Siwan Jones, Hayley Valentine, Angela Jones, Helen Thomas, Judith Burnett and Tom West.	
1.3	**Review the minutes of the previous meeting and matters arising** The minutes from the previous meeting held on 08 December 2025 had been circulated. No amendments were required to the minutes, and they were, therefore, accepted.	QSE Minutes 08 December 2025.doc
Part 2: Safe Care		
2.1	**Nationally Reportable Incidents**	
2.2	**Vaccinations**	
2.3	**Alerts/Patient Safety Notices** **Specialist HCAI report** Safety notices on Rybelsus and Andexanet alfa have been shared and uploaded to the Teams' channel.	Safety Memo - Rybelsus (semaglutı Safety Memo - Andexanet alfa.pdf
2.4	**Healthcare Associated Infections** **Specialist HCAI report**	

	Siwan Jones had sent her apologies. Her report is attached. This report had been discussed at the Specialist Services IP&C Meeting held on 13.01.26. Noted Specialist group representation at Achieving Behaviour Change (ABC) C diff learning collaborative. Kerry Richards will update at next meeting.	Specialist IPC Report January 2026
2.5	**Specialist Services Medical Devices Safety Officer Update** Colin Gibson referenced Disabled People's Rights' Plan, agreed would bring to Partnership Forum	
2.6	**Resuscitation Clinical Board Monthly Report** Resuscitation guideline update (G 2025) Cath Twamley has individually contacted all areas who have not completed the Microsoft form that confirms that all old guidelines have been removed and replaced with the new versions, and all resuscitation trolleys have updated trolley lists.	Resus Monthly Summary - Medicine
2.7	**Safeguarding**	
2.8	**Risk Register update** **AMaT progress** Directorates to ensure that all risk registers are on AMaT and are up to date.	
Part 3: Governance, Leadership and Accountability		
3.1	**Feedback from UHB Operational H&S Group** JD gave an update from the OHSG meeting held in December. JD had put together slides which cover the OHSG feedback, CB training compliance, CB breakdown of DNA's for H&S courses and COSHH status report. (see attached slides)	Specialist Services Update - 16.01.2026
Part 4: Items to be recorded as received and noted for information by the committee		
4.1		
Part 5: Any other business		
5.1	**Co-codamol 30mg/500mg shortage** Co-codamol 30mg/500mg shortage anticipated to last until at least July. Advice is on admission where there is a need for medication, either step down or switch to paracetamol and codeine.	Safety Memo - Co-codamol shortag
Part 6: Action log		

6.1		
Part 7: Date of next meeting		
7.1	The next meeting will be held on **Thursday 12 February; 09.30-11.00; via Teams**	

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

INFECTION PREVENTION AND CONTROL GROUP

Thursday September 18th 2025
Via TEAMs
MINUTES

Present:	
Abigail Holmes	Director of Midwifery and Neonatal Services Obstetrics & Gynaecology
Anna Mogie	Deputy Director of nursing PCIC CB
Catherine Twamley	Director of Nursing Specialist CB
Ceri Richards-Taylor	Lead nurse integrated medicine
Dino Motti	Consultant in Public Health
Gareth Simpson	Estates Manager
Gavin Forbes (chair)	Consultant microbiologist, IPC doctor
Helen Bonello	Senior Nurse Professional Standards Nursing
Julia Somerford	Senior Nurse Physical Health MHSOP & NeuroPsychiatry
Laura Hodges	Lead Nurse
Natasha Goswell	Deputy Executive Nurse Director
Rachael Daniel	Health & Safety
Rishi Dhillon	Consultant microbiologist, IPC doctor
Yvonne Hyde	Head of Nursing IPC
Helen Luton	Interim Director of Nursing
Teoni M (notes)	Executive Assistant
Apologies:	
Jason Roberts	Executive Nurse Director
Karenza Moulton	Senior Nurse, Child Health
Geoff Walsh	Director Capital, Estates and Facilities
Claire Main	Director of Operations for Medicine and Unplanned Care
Victoria Suter-Jones	Consultant Medicine
Anna Llewellin	PCIC

PART 1: PRELIMINARIES *(Chair)*		
1.1	Apologies for Absence	**GF**

	As noted above.	
1.2	Minutes of last meeting held on June 30th 2025 Minutes of the last meeting were accepted as a true record.	**GF**
1.3	Matters Arising and Action Points from June 30th 2025 IPC team to do outbreak report- one will be ready for December meeting. IPC team to do a breakdown of RCA's- YH uploaded onto team's channel. CB to include ANTT data for both medical and nursing staff- will be discussed as part of the clinical board reports. ECOD colleague needs to be included into ANTT conversations-will be discussed under ANTT update. Add HESG minutes under 6.1 section- Uploaded onto teams channel.	**GF**
1.4.1	General Acute Respiratory Illness Update Flu and COVID-19 are still present, with COVID-19 cases being more prevalent than flu. The previous week saw seven or eight wards affected, but this has reduced to two wards. The Staff Flu vaccine programme has started on September 1st. The campaign started a month earlier than last year to improve winter protection. Vaccines are being delivered through roaming teams visiting wards and static sites with a published calendar. Staff are given 30 minutes of protected time to get vaccinated. There have been data issues due to a transition to a new recording system (Wiz 2.0), so detailed breakdowns by clinical board or staff group are not yet available. As of September 16, 3,764 flu vaccines have been delivered, which is 60% of last year's total and 22% ahead of last year's pace. Efforts are being made to reach harder-to-access staff groups, such as catering and housekeeping, including vaccination at morning huddles. Woodland House will move to an open-door vaccination policy after three weeks of pop-up clinics.	**YH**

1.4.2	General Mpox update Nothing to report.	
PART 2: STRATEGIC AND OPERATIONAL DELIVERY OF THE IPC AGENDA		
2.1	1. ICD Reports (UHW + UHL) UHL, there is nothing exceptional to report since June. Gavin reports no significant issues for UHW, mentioning a potential upcoming C.diff Pii on C7. Gavin notes the closure of a multi-drug resistant gram-negative outbreak on B5, with all actions addressed and expansion of the ward onto A5 with better screening processes. VRE on B4 Haem is closed and all actions address with ongoing surveillance.	**GF/RD**
	2. IP&C Position Report Yvonne provides the IPC position report, highlighting staffing changes: two team members retired and returned (creating a Band 7 vacancy, now filled), a Band 6 vacancy (recently recruited), and another Band 7 on a year's career break (to be covered by a Band 6). There are ongoing recruitment challenges, especially for admin support, which is affecting the team's ability to complete proactive work like audits and education. The team continues to attend policy and procedure meetings, bringing the CJD procedure for ratification and the hand hygiene procedure for comments. Outbreak data from April to August: 103 incidents/outbreaks, 470 patients and 75 staff affected, 737 bed days lost. The December outbreak report will provide more detail on infection sources and themes, including issues with patient handover and respiratory illness outbreaks. Audits and education continue, with 25 education sessions and 315 attendees; 16,000 out of 17,000 staff have completed mandatory IPC training.	**YH**
	3. HARP HCAI Performance Report	**YH**

	Yvonne presents the HCAI performance report, starting with C. diff, UHB had the second lowest rate in Wales by end of August, with a reduction in hospital-onset cases compared to last year, but September cases are rising. For MRSA bacteraemia, performance is poor with seven cases so far, making the board second worst in Wales. MSSA bacteraemia rates have improved, now third lowest in Wales, with fewer cases in September. E. coli bacteraemia rates are stable and remain the best in Wales, with hospital-onset cases mainly linked to high-risk procedures. Klebsiella rates are high (third highest in Wales), with 50% hospital-onset, and Pseudomonas numbers are slightly up but not concentrated in any area. Yvonne summarizes that the board's position is better than previous years, especially for MSSA and Pseudomonas, and stresses the need to continue ANTT rollout and drive down bacteraemia rates. 4. Internal Audit Report There are two outstanding actions: the annual programme (which will be prepared for 2026–27, as it's too late for 2025–26) and IP&C staffing. Yvonne also highlighted the ongoing staffing risks in the IP&C team, stressing the urgency of recruitment to avoid compromising proactive work and outbreak management.	**YH**
2.2	New Guidance/application in the Health Board PHW measles briefing PDF PHW_shortbriefing_Measles_V1.0 (July 25).p Highlighted the importance of staff vigilance for measles symptoms due to recent outbreaks in England. Reminder to staff to use appropriate PPE (FFP3 masks) for suspected or confirmed measles cases and confirms this guidance has been shared with GPs and paediatric teams. A draft report on a local measles incident is being finalized, with some learning identified. Highlighted the need for staff vaccination, as unvaccinated staff exposed to measles may need to isolate for 2–3 weeks, impacting workforce availability.	**YH/DM**

	Dino discusses efforts to engage universities and GPs, including attending freshers' fairs and planning regular meetings to promote MMR vaccination among students. Also highlighted the challenge of many students who are not registered with a local GP, and vaccination records are often incomplete or delayed, especially for those from England. Emphasizes the need for improved student registration processes and opportunistic vaccination but acknowledges logistical difficulties and the lack of a centralized vaccine record system.	
2.3	Clinical Board Reports 2.3.1 Medicine Ceri presents the Medicine Clinical Board report, highlighting strong partnership with infection prevention and control, and welcomes Leanne as the new link nurse. She notes high ANTT compliance (around 96–100%) and hand hygiene compliance (96.8%), but mentions difficulties extracting reliable ANTT data, especially for medical staff, due to system limitations. Ceri discusses recent C. diff outbreaks, particularly on C7, and outlines action plans, including a focus on acute and emergency medicine where closing areas is challenging due to patient flow needs. Reports a reduction in C. diff cases compared to last year, but an increase in MSSA and E. coli bacteraemia's, with detailed improvement plans in place. Ceri describes ongoing educational initiatives, new bed cleaning audits, and issues with CRO patient flagging in the emergency unit, which is being addressed through IT and process reviews. Highlights the move of VIP and PVC risk assessments to WNCR, expecting this to improve compliance and documentation. There are actions to improve audit data, infection control, and communication between teams, and notes the next internal meeting is scheduled for October. 2.3.2 Surgery/Dental Surgery Clinical Board has seen a 50% reduction in C.diff cases compared to last year and no clusters this year. reports a 33% reduction in Klebsiella cases, one MRSA case (none last year), and stable MSSA numbers, with ongoing work to address these.	

E. coli rates are down 40% from last year, attributed to targeted actions and surgeon involvement.
ANTT compliance for nursing staff is reported at 100%, with data managed by PPDNs, and bear below the elbow compliance is also high after addressing one outlier ward.

Environmental and cleanliness audits are lower (70–80%), mainly due to sluice and estate issues; work is ongoing with estates and education teams.

VIP scores remain at 80–90%, with ongoing education and plans to improve, especially as VIPs move to WNCR.

Highlights a major focus on theatre cleanliness, with a workshop planned to review processes and prepare for new all-Wales cleaning guidance and theatre refurbishments.

A full report will be uploaded to the teams channel for further details.

2.3.3 Specialist Services

50% improvement in C. diff but targets are still not met, and an increase in hospital-onset cases.

MRSA cases have increased (three this year, a 200% rise), while MSSA has improved by 56% but remains below reduction targets.

E. coli rates are above target with mixed sources, and Klebsiella has seen a significant 180% increase, especially in critical care and nephrology, mostly linked to urinary sources (catheters, urostomies, nephrostomies).

There is a deep dive into Klebsiella cases, identifying line management, VIP scores, and catheter bundles as key themes, with improvements seen since moving bundles to WNCR.

Highlights the closure of a CPO outbreak on B5, improved screening compliance, and the importance of RCA returns (currently at 52%).

There is a strong antimicrobial stewardship links with pharmacy, ongoing “gloves off” and “masks off” initiatives, and poor bed audit scores due to equipment cleaning challenges.

Full report will be uploaded to Teams for further review.

2.3.4 CD&T

Update on ANTT progress: more staff are being assessed as competent, though there have been challenges training assessors, especially for

physiotherapy and podiatry, which have been addressed with help from PCIC colleagues.
The ANTT compliance figures do not include medical staff, and the Clinical Board is keen to improve compliance in this group.

Pharmacy colleagues are actively involved in antimicrobial stewardship, with no specific issues to report.

Highlights ongoing problems with equipment returned to clinical engineering without proper decontamination, posing cross-infection risks; a project is underway to address this.

The Board is supporting the flu vaccine rollout, though there are challenges releasing some Champions.

Helen mentions an audit in CT/radiology on cannulas after extravasation incidents and offers to bring results to a future meeting.

2.3.5 PCIC

PCIC Clinical Board have reductions in C.diff, MSSA, and E. coli compared to last year, but highlights that community targets differ due to endemic infections.

Reports three MRSA bacteraemia's, with audits showing many had no recent healthcare contact, often linked to IV drug use.

For C. diff RCAs, GP response rates are good, but learning is limited by delays or lack of hospital discharge information; Anna requests that RCAs be sent to consultants when cases are managed in secondary care.

Identifies the poor state of community estate as a key risk, with audits slowed to avoid overwhelming Estates with maintenance requests, though all issues are still logged.

Anna references a recent incident at Barry Hospital requiring urgent relocation of out-of-hours GP services.

ANTT facilitator training and compliance are progressing, but data mainly covers nursing staff, not medical staff.

The Board's antimicrobial work focuses on prescribing incentive schemes, promoting reduced and targeted antibiotic use, and using ScriptSwitch for prescribing prompts.

Plans are underway to establish a dedicated IP&C meeting within the Clinical Board.

	2.3.6 Children and Women To be followed up, no report submitted. 2.3.7 Maternity and Neonatal Report available in teams' channel to view. 2.3.8 Mental Health Only one MRSA and one C. diff case occurred; the C. diff case was contained, but staff hand hygiene was found lacking during the RCA. Successes include improved ANTT training via physical health days and a notable increase in bare below the elbow compliance, attributed to lead nurses auditing each other's areas. COVID outbreaks were minimal, but a review showed only 40% of required audits were completed in the last six months, with some wards not auditing at all. Julia outlines urgent actions: monthly audits by three different people per ward, cross-ward auditing, more senior nurse involvement, and support from the IP&C team. Request put in for a bugometer for hand hygiene education and highlights practical barriers like inaccessible handwashing facilities and empty hand gels. Concerns are raised about flu/COVID vaccination eligibility for mental health inpatients, as many do not meet current criteria, potentially increasing outbreak risk. The plan is a "back to basics" campaign to ensure audit data reflects reality and to improve hand hygiene before winter.	
2.4	ANTT Update The main challenge with ANTT is uploading competence assessments onto ESR; PDNs are conducting assessments where possible. The plan is to meet with ECOD colleagues to explore solutions, such as creating a SharePoint for uploading and sharing ANTT data. Further discussions and actions are pending until Sue return from leave.	**Verbal YH**
2.5	HCAI Delivery Board update Yvonne reports the next HCAI Delivery Board meeting was cancelled; the last approved minutes are from July.	**YH**

	The C. diff collaborative was discussed, with a learning event scheduled due to a 70% increase in C. diff cases in Wales, much higher than the 33% rise in England. UTI management and C. diff focus groups are ongoing, with revised terms of reference and a new code of practice out for comments. The updated code of practice will be shared once finalized.	
2.6	AMG Update – Start Smart Stay Focused Audit findings Deferred to next meeting.	**RMac C**
2.7	Tendable Ongoing issues with Actichlor (bottle) compliance in certain areas, asking clinical boards to address persistent low compliance, especially in Rhydlafar and requests mental health to resolve issues in Alder, Willow, and Maple wards. most areas report high scores, some continue to have problems, and the question about bottles may be removed once resolved. Helen offers to share her paper with the group and summarizes that audit activity has focused on outbreak areas, with a higher number of audits in specialist clinical boards. Mentions water flushing results from Tendable, sharing images and noting that all other areas show 100% compliance.	**HB**
2.8	HCID update	**YH**
PART 3: CORPORATE ASSURANCE SUPPORT AND PERFORMANCE FRAMEWORK (REDUCTION EXPECTATIONS 2021/22)		
3.1	Caesarean Section Surgical Site Infection Surveillance Deferred to next meeting.	**AH**
PART 4: DECONTAMINATION AND INFRASTRUCTURE		
4.1	Decontamination Report Deferred to next meeting.	**MC**
4.2	Legionella in Water UHL / General Update on Facilities/Estates/Capital Planning. Gareth presents on water sampling, noting increased Legionella detections at UHW and previous issues at Llandough, with ongoing monitoring and a new chlorine dioxide system scheduled for installation in early November.	**GS**

	Highlights concerns about lack of flushing in areas, high numbers of maintenance requests, and staffing challenges in keeping up with demand. Housekeeping quality audits and helpdesk job volumes remain steady; HPV and UV cleaning requests are significantly higher than last year. Waste management issues persist, including incorrect disposal of sharps, PPE, and gypsum waste, with new training materials available on the waste management SharePoint page. Joint audits with IP&C continue, and monthly DMT meetings are being coordinated to improve standards. A potential new HPV room is identified, pending capital funding, and the team is preparing for the implementation of the Welsh national standard of cleanliness guidance.	
PART 5: INFECTION CONTROL POLICIES AND PROCEDURES		
5.1	5.1.1 Update on Current Position regarding Procedures for Noting  IPC procedures position.docx 5.1.2 Procedures and Protocols for Comment  Hand Hygiene Infection Control Pr 5.1.3 Procedures and Protocols for Ratification  CJD Procedure final.docx Yvonne has uploaded a document on the teams channel which outlines where we are with all our procedures, what's in date, what's being worked on and what is due for renewal. The hand hygiene procedure is on the team's channel for comments, please pass comments onto Yvonne.	**YH**
PART 6: REPORTS FROM OTHER COMMITTEES/GROUPS (For information only not, discussion)		
6.1	Minutes of the Decontamination Group Meeting Latest Minutes In Teams channel.	**MC**
6.2	HCAI Delivery board minutes Latest Minutes In Teams channel.	**JR**
6.3	Antimicrobial Group Minutes	**RM**

	Latest Minutes In Teams channel.	
6.4	Staff Flu Vaccination Update	**DM**
6.5	Water Safety Group minutes Latest Minutes In Teams channel.	**YH**
6.6	Public health Update	**AA**
6.7	HESG Minutes Latest Minutes In Teams channel.	**YH**
6.8	Public Quality Committee	**YH**

PART 7: GENERAL UPDATES/ISSUES

7.1 Bactroban shortage

Safety Memo - Bactroban Shortage.p

DETAILS OF FUTURE MEETINGS

IPCG Meeting Date	Meeting times	Papers to be received by:	Papers for the meeting will be sent out by:
16/12/25	**09:00-11:30**	**08/12/25**	**12/12/25**

Action log
Mpox to be removed from agenda.
Follow up with the Children and Women report for this meeting.
Julia to distribute Actichlor (bottle) to MH.