PUBLIC Quality Committee

Tue 20 January 2026, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:05
5 min

1. Standing Items

1.1. Welcome, Introductions & Apologies:

Ceri Phillips

1.2. Declarations of Interest

Ceri Phillips

1.3. Minutes of the Quality Committee Meeting held on 09.12.2025

Ceri Phillips

1.3 - Draft Quality Public Minutes 09.12.2025.pdf (9 pages)

1.4. Action Log – Following the meeting held on 09.12.2025

Ceri Phillips

1.4 - Quality Committee actions 20.01.2026.pdf (1 pages)

1.5. Chair's Actions taken since last meeting

Ceri Phillips

None.

14:05 - 15:25
80 min

2. Items for Review & Assurance

2.1. UHB Quality Indicators Report

20 mins *Alex Scott / Angela Hughes*

2.1.1 - Quality Indicators Report (1).pdf (3 pages)
2.1.2 - Quality Indicators January 2026 (5).pdf (24 pages)

2.2. Children & Women Clinical Board Quality Indicators Report

30 mins *C&W Clinical Board*

2.2.1 - CAV Board Committee Covering Report C&W Clinical Board January 2026.pdf (3 pages)
2.2.2 - Final - Clinical Board Quality Assurance slides C&W.pdf (16 pages)

2.3. WHO Checklist Implementation and Compliance

10 mins *Clare Wade / Abraham Theron*

2.3 - WHO collaborative update - January 2026.pdf (13 pages)

2.4. Limited Cyber Security internal audit report - implications for quality & safety

10 mins *David Thomas*

2.4 - CVU-2526-04 Cyber Security Final Report.pdf (12 pages)

2.5. Bariatric and Medical Cylinders - Patient Safety

10 mins *Rob Warren*

2.5 - Bariatric and Medical Cylinders.pdf (3 pages)

15:25 - 15:30
5 min

3. Items for Approval / Ratification

3.1. Policies

5 mins

3.1.1. UHB 484 – Independent and Supplementary Prescribing Governance Framework

Timothy Banner

3.1.1 - UHB 484 Quality Committee Covering Report (1).pdf (5 pages)
3.1.2 - CAVUHB NMP Governance Framework (4).pdf (30 pages)

15:30 - 15:35
5 min

4. Items for Noting & Information

4.1. Minutes from Clinical Board QSE Sub Committees

Jason Roberts

- *Medicine CB – 19.11.2025*
- *PCIC CB – 23.09.2025*
- *Children & Women CB – 28.10.2025*

4.1.1 - 2025.11.19 - Medicine Clinical Board QSE Meeting Minutes.pdf (5 pages)
4.1.2 - 2025.09.23 - PCIC QSE September 2025 Minutes 2025.09.23 - FINAL VERSION (1).pdf (10 pages)
4.1.3 - 2025.10.28 - CW QSPE Minutes 28.10.2025.pdf (7 pages)

4.2. Safeguarding Steering Group Minutes

Jason Roberts

No minutes to share as the previous SSG meeting was cancelled.

4.3. IP&C Group Minutes

Jason Roberts

No minutes to share as the previous IP&C meeting was cancelled.

4.4. Controlled Drugs Accountable Officer Annual Update

5 mins *Timothy Banner*

4.4 - CDAO qs report 2425.pdf (7 pages)

15:35 - 15:35
0 min

5. Items to bring to the attention of the Committee

Ceri Phillips

15:35 - 15:35
0 min

6. Agenda for the Quality Committee Private Meeting

Ceri Phillips

i. *Private Minutes & Actions*

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

15:35 - 15:35
0 min

7. Any Other Business

Ceri Phillips

15:35 - 15:35
0 min

8. Review of the Meeting

Ceri Phillips

15:35 - 15:35
0 min

9. Date & Time of Next Meeting

Ceri Phillips

3rd March 2026 at 2pm via MS Teams

15:35 - 15:35
0 min

10. Declaration

Ceri Phillips

"To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]"

Unconfirmed Minutes of the Public Quality Committee

Held on 9th December 2025 via MS Teams

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

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

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

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

	checks before surgery. Visible tools (e.g. a whiteboard) were being introduced to ensure consistency without adding unnecessary burden, covering key risks like implants, transfusions, and allergies. Regarding EPMA, AS suggested she link with the EPMA team and provide further detail in the following Quality Indicators report - **ACTION**. Regarding the Keeping Me Well website, AS responded that one of their highest reported patient safety incidents was falls - significant work was underway on falls prevention including exercise, medication safety, and home safety. Claire Beynon (CB), the Executive Director of Public Health, commented that the lung cancer screening programme was a positive step for Wales, enabling earlier detection and better outcomes. However, they must maintain focus on tobacco prevention and reducing levels of smoking across the population. Suzanne Rankin (SR), the Chief Executive Officer, noted that whilst the report included extensive data and narrative, most trajectories appeared flat. The focus should shift from activity reporting to clear improvement objectives and outcomes. Jason Roberts (JR), the Executive Nurse Director, commented that EPMA had rolled out in UHW Medicine, Surgery, and EU, with a further rollout planned for UHL. Early feedback showed reduced administration errors but highlighted prescribing issues. More data was expected by the end of December. Provide a report to the Quality and Safety Committee in January 2026 detailing the EPMA programme trajectory, including ward rollout and data on medication errors or emissions from live wards – **ACTION**. JR added that the Executives had been in conversations around how best to demonstrate data and trajectories moving forward. Report the data on WHO safety checklist compliance, including recent audit results, to the Committee at a future meeting – **ACTION**. CP suggested having a conversation outside of the meeting to discuss how best to present tangible results for the Committee's assurance – **ACTION**. **The Committee resolved that:** 1) The assurance provided by the Quality Indicators was noted; 2) The work underway to drive requisite improvements was noted.	
QC 2025/12/2.2 Chilcott.Rachel 03/03/2026 09:12:57	**Mental Health Clinical Board Quality Indicators Report** Susie Boxall (SB), the Strategic Lead for the Lived Experience Team, presented a patient story to the Committee, and summarised the following: • The patient was sectioned and diagnosed with bipolar disorder in his 60s, having also experienced psychosis. • He engaged with the Recovery and Wellbeing College, taking courses on understanding and living well with bipolar, anxiety, depression, and psychosis, which helped him better understand and manage his illness. • The education and peer support from the College reduced his fear of his symptoms, improved his self-identity, and enabled him to redefine himself beyond his diagnosis. • His recovery journey included lifestyle changes, medication, and education, with the College's group setting and peer trainers providing valuable support.	

- He later became a peer trainer himself and piloted a veteran's course.

The Mental Health Clinical Board presented their assurance report and slides to the Committee which detailed the achievements, progress and planned actions within the Mental Health Clinical Board to maintain the priority of QSPE. Topics discussed included, but were not limited to:

- SIRAN Accreditation
- Introduction of the Family Liaison Officer (FLO)
- Patient Safety Reviews and Nationally Reportable Incidents (NRIs)
- Overview of Identified Issues
- Review and Thematic Mapping
- Significance and Next Steps
- Complex Emotional Needs (CEN) Pathway – Overview
- Key Improvements to Provision
- Preparing for Discharge Course – Overview, Outcomes, & Impact
- National Recognition and Expansion
- Recovery College – Service Overview, Accessibility, and Participation
- Out of Area Bed Usage – Overview, Factors Driving the Increase, Addressing the Challenge (Hazel Ward Reopening), and Ongoing Evaluation

JR provided the following comments:

- The out-of-area placements had been driven by operational teams but wished to highlight the quality impact – placing patients in the right area improved experience and outcomes.
- Overdue NRIs had reduced by 50%, which was vital for patients awaiting critical information.
- A protocol regarding lethal substances had been developed to address risks from new and emerging methods, following national concerns.
- He had visited the Recovery College and praised their excellent work.

SR informed the Committee that she and Mike Jones (MJ), the Independent Member – Trade Union, had visited the Beech Ward that morning.

SR suggested the need for better datasets that better reflect mental health care. Current indicators like falls and pressure ulcers were less relevant, but they should consider specific metrics such as medication complications or ECT treatments. Some audits, for example bare below the elbow, may not apply.

SR suggested that the staffing levels and establishments needed clarity, as vacancies and funding changes impacted on quality, and staff on the Beech Ward felt that they were short-staffed.

Regarding bare below the elbow, Tara Robinson (TR), the Director of Nursing – Mental Health Clinical Board, responded that Wales had a uniform policy requiring this, but mental health inpatient areas had historically allowed own clothing for therapeutic reasons. They would review whether uniform requirements remained appropriate.

Regarding safe staffing levels, TR clarified that they were working to professionally agreed safe staffing levels, not budgeted. She wondered whether there was a discrepancy over perceptions on what was professionally agreed.

SR suggested clarifying the narrative of what was considered safe staffing levels.

TR agreed that engagement needed to improve so that the information was cascaded to Band 2 staff and upwards, so the whole team were included in conversations.

	CB informed the Committee that she chaired the Area Planning Board meeting on substance misuse and noted delays in patients accessing UHB treatment. She asked what their plans were around dedicated leadership for addiction services. TR responded that recruitment challenges had affected timely access to addiction services. The Clinical Board was addressing this with the new Director of Operations, but that this remained a priority. Rim Al-Samsam (RAS), the Clinical Board Director – Mental Health, noted that they had approved this re-vacancy the previous week, so hopefully it would improve. JR clarified that all clinical areas required staff to be bare below the elbow, and so it was apparent there had been miscommunication. JR explained that he was facilitating a meeting between TR, the team, and 36 Degrees to review nationally monitored datasets for mental health. **The Committee resolved that:** 1) The assurance provided by the Mental Health Clinical Board in this report and the steps being taken to improve quality, safety and patient experience was noted.	
QC 2025/12/2.3	**Tackling the Planned Care Challenges – risks / incidences of harm** Paul Bostock (PB), the Chief Operating Officer, provided the following summary: • The safest approach was no waiting list, but they had made significant progress: ○ Patients waiting over 2 years had reduced from 9000+ to around 650 by year-end ○ Over 3-year waits had reduced from almost 1000 to 20 • Managing 130,000 patients across multiple pathways was challenging • Initiatives included the Waiting Well Service, with 6000+ patient contacts supporting pain and weight management. It had resulted in some patients not needing intervention. • Balancing resources between Waiting Well and clearing lists remained crucial. AS provided the following summary to the Committee: • Discussions had started on how to develop a more systematic approach to identifying harm for patients on waiting lists. • They proposed 6 potential indicators within the report. • Data collection would take time, but they aimed to start scrutinising their Datix system to analyse the number of incidents and concerns raised by patients on the waiting list, and to scrutinise alongside how long they had been on the waiting list. • They had systems in place using patient reported outcome measures to measure generic health outcomes (e.g. EQ5D in place in Orthopaedics), number of deaths on the waiting lists, referrals from the medical examiner, and number of emergency admissions.	

	SR noted her concern that these reports reflected harm after the event. She asked whether any system did proactive, risk-based monitoring (similar to Ophthalmology prioritising patients at risk of sight loss). AS responded that most indicators identified harm retrospectively, except EQ5D, which could track functionality and health impacts. Operationalising this for prioritisation may be challenging, but they did have protocols for expediting patients based on previous work in Wales and relationships with independent providers, primary care, and neighbouring UHBs. SR asked whether any other region had achieved this. SR also asked whether they provided safety-netting advice to patients on the waiting lists (e.g. guidance on when to return if certain symptoms or thresholds appeared). AS responded that they were good at safety-netting after first contact, but for patients still waiting for an initial assessment, this was less clear. PB responded that waiting lists were far longer than experienced before, which was an uncomfortable position. SR commented that the only way would be safety-netting, which required a cultural shift, so patients owned their own care and were confident to know what to do, which was difficult. PB noted that they had Patient Initiated Follow Up (PIFU) and See on Symptoms (SOS), but engagement had been challenging. These approaches helped to safety-net and create capacity, but with such overwhelming numbers, it was hard. CP noted that a clinically driven target focused on maximising outcomes would allow safety-netting and prioritisation when thresholds were met. Current time-based targets limited this approach. CP asked about the expected timescales for the indicators. AS responded that over the following four months, they aimed to start extracting data from Datix and cross-referencing with BIS, given the large patient numbers. Datix's functionality may require exporting, and they would need discussions with other specialties beyond Orthopaedics to introduce EQ5D. Bring back an update on data extraction and harm indicators for patients on the waiting list to the Committee within four months – **ACTION**. CB highlighted that if left unaddressed, it could worsen inequalities. People in deprivation often delayed coming forward, so they may spend less time on the waiting list but had greater need. JR asked whether someone within Claire's team could help advise.	

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

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

MEETING	Title	Minute Reference	Agreed Action	Executive Lead	Action Lead	Date Assigned	Date for Review	Action Status	Action Update
QUALITY	UHB Quality Indicators Report	QC 2025/10/2.1	Independent Members to receive training and support in interpreting SPC charts and data analysis	Matt Phillips	Matt Phillips	28/10/2025	20/01/2026	ON FORWARD PLAN	On Forward Plan for Board Development in February 2026
QUALITY	UHB Quality Indicators Report	QC 2025/12/2.1	Link with the EPMA team to provide a detailed update on emerging findings and data outputs from the EPMA rollout.	Jason Roberts	Alexandra Scott	09/12/2025	20/01/2026	COMPLETE	Update included within Item 2.1 - UHB Quality Indicators Report.
QUALITY	UHB Quality Indicators Report	QC 2025/12/2.1	Provide a report to a future Quality Committee detailing the EPMA programme trajectory and data.	Paul Bostock	Alexandra Scott	09/12/2025	20/01/2026	ON FORWARD PLAN	On Forward Plan for April 2026 Quality Committee meeting.
QUALITY	UHB Quality Indicators Report	QC 2025/12/2.1	Report the data on WHO safety checklist compliance, including recent audit results	Paul Bostock	Alexandra Scott	09/12/2025	20/01/2026	ON FORWARD PLAN	On Forward Plan for January 2026's Quality Committee meeting.
QUALITY	UHB Quality Indicators Report	QC 2025/12/2.1	Arrange meeting between Ceri, Jason, and Alex around developing and presenting clear improvement objectives and anticipated trajectories for quality indicators.	Jason Roberts	Alexandra Scott	09/12/2025	20/01/2026	COMPLETE	
QUALITY	Tackling the Planned Care Challenges - risks and incidences of harm	QC 2025/12/2.3	Bring back an update on data extraction and harm indicators to the Committee within four months.	Paul Bostock	Alexandra Scott	09/12/2025	20/01/2026	ON FORWARD PLAN	On FP for July 2026 Quality Committee meeting.

Report Title:	Quality Indicators Cover report				Agenda Item No:	2.1	
Meeting:	Quality Committee		Public	x	Meeting Date:	20.01.2026	
			Private				
Status	Assurance	x	Approval		Information/Noting		
Lead Executive:	Executive Nurse Director						
Report Author Title:	Assistant Director of Quality and Patient Safety						

Main Report

Background and Current Situation:

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

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

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

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

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

- The UHB reported 10 Nationally reportable Incidents in December 2025 and a further Never Event was reported at the end of November 2025.
- The UHB has reported 175 Nationally reportable Incidents in 2025. Analysis of all incidents closed between September 2024, and September 2025 demonstrated that 73% had a post investigation harm level of no / low or moderate harm.
- The WHO checklist collaborative are currently scoping theatres in preparation for the installation of team brief whiteboard
- Over 400 staff were trained on standardised outpatient clinic outcomes processes in December 2025 and the training will continue throughout January 2026.
- A review of screening audit data for Carbapenemase Producing Organisms (CPO) and Carbapenemase Resistant Organisms (CRO) on Tendable shows improved compliance compared to 2024.
- The implementation of Marthas law (Call 4 Concern) has commenced in UHW and UHL but will be expanded throughout 2026 to cover A&E, Maternity and mental health Services in HYC. Common themes collated from calls include poor communication of medical management plans to the patient, concerns surrounding discharge, with less than 10% of the calls relating to acute deterioration issues. Communication promoting Call 4 concern to patients has been supported by LLAIS. The introduction of patient wellness scores in the next 6 months, will complete the WHC requirements of Marthas Law for the UHB.
- Falls Action Cards have been developed to improve staff confidence in managing falls in residential care settings and will be piloted with

individual homes during the first half of 2026. During November, a further 13 people completed falls prevention and management training.

- The roll out of ePMA in CAVUHB began in July, with the system going live on early adopter wards in Nephrology and Transplant (B5, A5 North and Cardiff Transplant Unit). The system has also now been rolled out across
- The all-cause mortality rate across the Cardiff and Vale UHB area has remained below the five-year average for the past 2 months and as yet there is no observed seasonal increase in deaths relating to respiratory infections.
- The Clinical Effectiveness Committee held on 28th November 2025 was dedicated to the National Cardiology Audits
- There have been no inspections from HIW however the UHB has shared an update of the IRMER inspection plan with HIW and have developed and improvement plan in relation to the *Review of Significant Accidental or Unintended Exposures (IR(ME)R) Notifications to Healthcare Inspectorate Wales, April 2023–March 2024.* The action plan details how Cardiff and Vale UHB is strengthening radiation-related patient safety by embedding a positive reporting and learning culture, ensuring Significant Accidental Unintended Exposure (SAUE) criteria are clearly understood through accessible IRMER procedures
- Sickness remains a concern across the nursing workforce. Last month, the overall sickness rate was 9.1%, with unregistered staff experiencing a higher rate of 11.1%, compared to 9.2% among registered nurses.
- Concern rates increased over summer, with a small reduction in October. Key issues include delays in diagnostics, discharge planning, monitoring, nutrition, and basic care (Medicine); access and waiting times, postoperative care, clinical decision-making, and staff attitude (Surgery); delays, communication, discharge, assessment, and safeguarding (Children & Women's Services); access, communication, stigma, and continuity (Mental Health); and access, discharge, and transition (Community Care).
- Cross-Cutting Trends from concerns include, delays, cancellations, communication failures, lack of compassion, discharge safety, administrative issues, and calls for learning and accountability are universal concerns. Focused work on discharge has been helpful, and additional clinics have reduced waiting lists in some specialties.
- Over 2,100 enquiries managed since June 2025, with recurring issues around telephone access, waiting times, and ward updates.

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

- Quality Indicators Report January 2026

Recommendations:

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

Link to Strategic Objectives of Shaping our Future Wellbeing:

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

Delivering in the Right Places		Acting for the Future	

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

Quality Impact Assessment Completed?				
Yes		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:

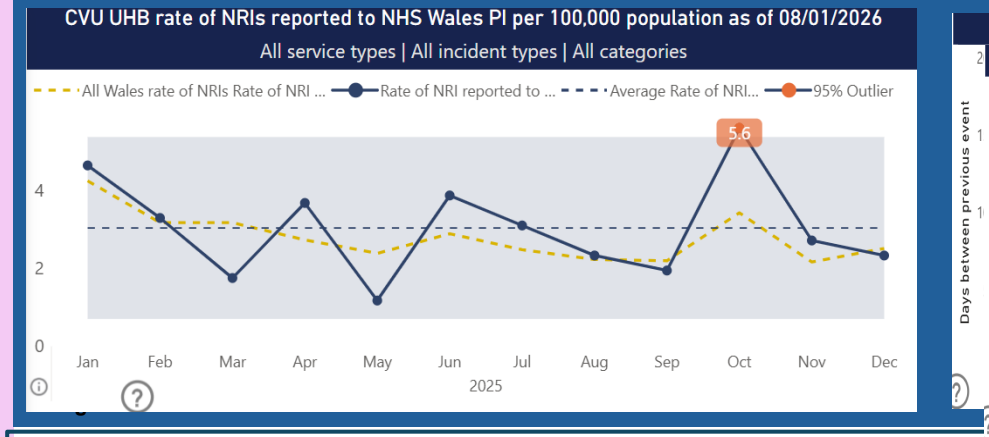
Quality Committee

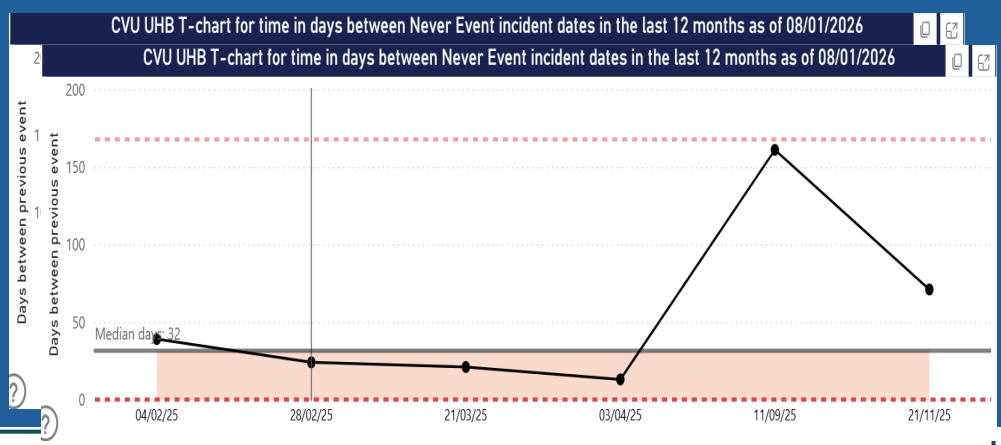
Quality Indicators and Performance Report

January 2026

Safe Care

Patient Safety Incident Reporting





Cardiff and Vale reported an NRI rate of 2.32 per 100,000 population, (All-Wales rate of 2.50 per 100,000). Between 01 January 2025 and 31 December 2025, the UHB has reported **175** Nationally reportable Incidents in 2025 . Analysis of all incidents closed between September 2024 and September 2025 demonstrated that 73% had a post investigation harm level of no / low or moderate harm.

The highest reported category of incidents in 2025 were:
Disruptions to the patient pathway
The Quality Excellence Lost to Follow up Project was implemented in response to recognition that variation in administrative processes had resulted in delays in care or failure to follow up . In response there has been standardisation of clinic follow up processes through the Shaping our Future Wellbeing Quality Excellence Lost to Follow Up project. Training has been delivered to over 400 clinic coordinators and administrative staff and will continue through January and work continues to develop a report of un-cached clinics to support monitoring.

Medication Incidents
The Quality Excellence Medication Safety programme was implemented in response to reported incidents including omissions in administration or prescribing of medication . A Critical time medication task and finish group convened to strengthen education, patient information and prescribing governance and the development of alerts to prescribers and those administering medicine using the ePMA system will provide some safeguards to support the timely administration of medications. Initial data extraction from ePMA will be focused on measuring omissions in medication , with an initial focus on Parkinsons medication.

Perinatal deaths
All will be subject to completion of a Perinatal Mortality Review Tool review and those where there is further scrutiny required will be subject to a full patient safety learning review. The majority of these case are identified as having resulted in no harm as a result of healthcare

Safe Care

Patient Safety Incident Reporting

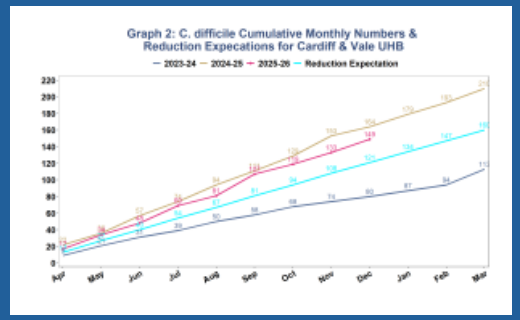
Patient assessment and escalation
The Quality excellence deteriorating patient project was implemented in response to the Welsh Health Circular and patient safety incidents
Delivery of NEWS 2 and associated education programme
Audit of implementation and response
Expansion of the Call 4 Concern

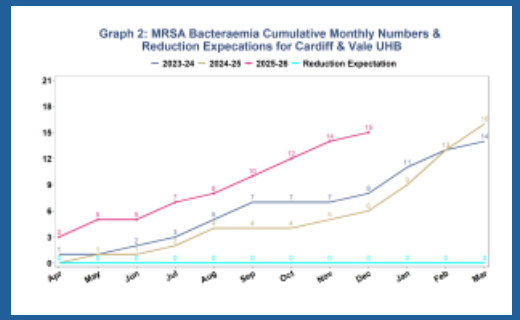
Never Events (6)
The UHB has reported 6 Never Events in the past twelve months
1 retained neck drain following migration of the device/ 4 wrong site local anaesthetic procedures
Theatres together programme and the WHO checklist collaborative were implemented in response to these incidents and the wider theatres concerns

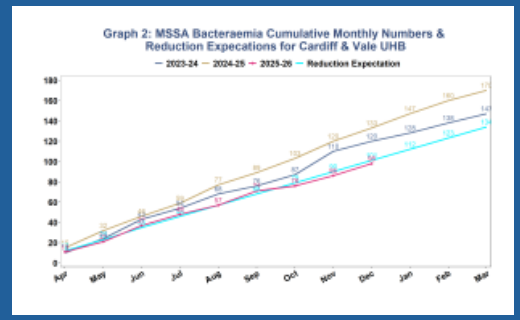
Healthcare associated pressure damage
Pressure damage scrutiny panels have been implemented across the entire UHB and the UHB pressure damage collaborative has been reconvened

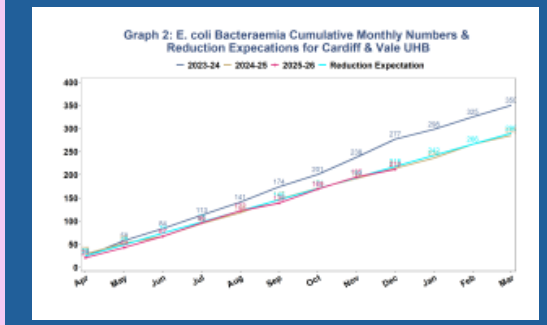
Safe Care

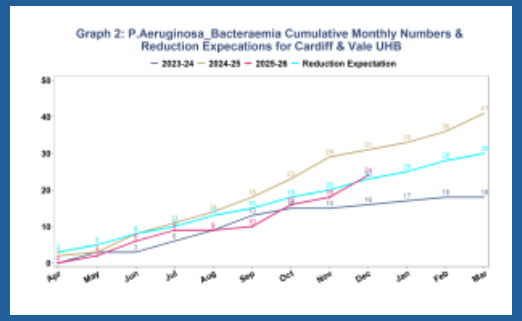
Infection Prevention and Control

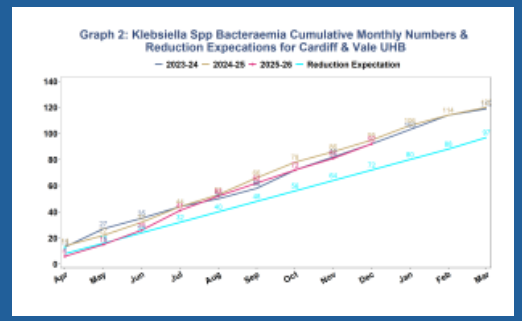












<u>Shaping our Future Quality Excellence HAI Dashboard Development</u>

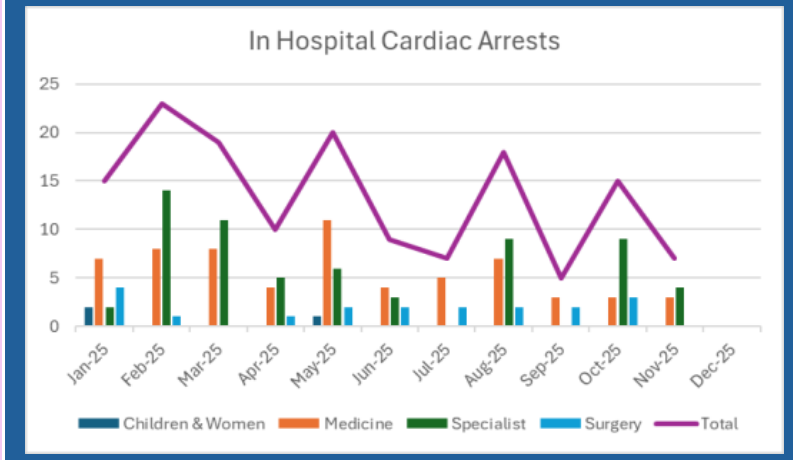
Work to develop the Infection prevention and control surveillance dashboard is continuing with data measures including MRSA by source, Infection screening and response compliance, reason for sample collection by source, response time to positive results and line associated infections.

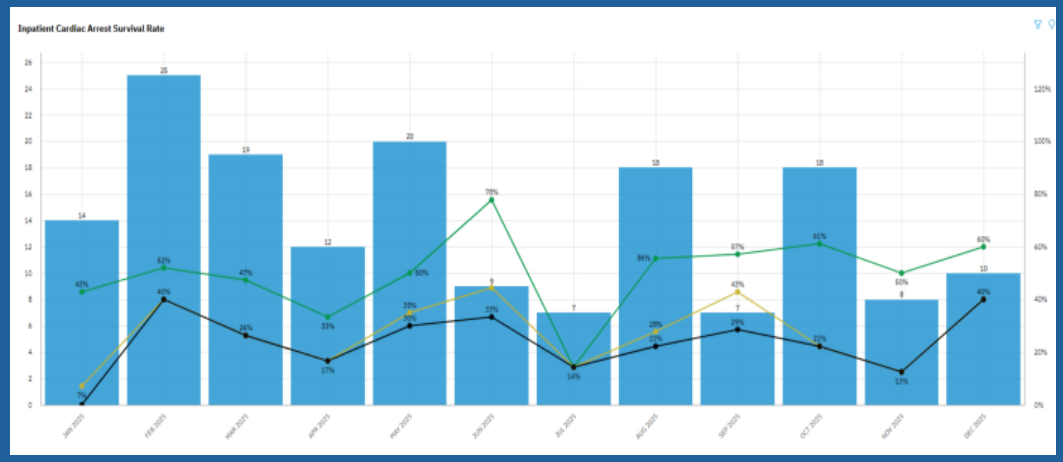
<u>Infection Prevention and Control (IP&C)</u>

Wales health care associated infection CAI surveillance data for December 2025 shows a reduction in Clostridium difficile (C. diff) and Methicillin-Susceptible Staphylococcus aureus (MSSA) cases compared to the same period in 2024. The IPC team continues to issue root cause analysis forms with learning slides to support case reviews and shared learning. MRSA cases have increased throughout the year, prompting a renewed focus on delivering Aseptic Non-Touch Technique (ANTT) training for all clinical staff.
Winter planning is underway to ensure robust IPC support in anticipation of increased respiratory infections. A review of outdated IPC policies and procedures is ongoing, with updates being made accessible via the IPC SharePoint page. A review of screening audit data for Carbapenemase Producing Organisms (CPO) and Carbapenemase Resistant Organisms (CRO) on Tendable shows improved compliance compared to 2024.
Adherence to national cleaning standards remains a priority, particularly the cleaning of bed spaces between patient discharge and admission. Isolation remains a challenge due to limited facilities. Patients with C. diff, CRO, COVID-19, flu or emerging infections require isolation to prevent transmission. Nursing staff complete risk assessments using the Welsh Nursing Care Record to guide safe and timely isolation decisions.

Safe Care

Deteriorating Patients and Resuscitation





Shaping our Future Quality Excellence Acute Deterioration

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

The early warning scores are now fully implemented across secondary care. All areas of Primary care where existing NEWS charts were used went live with NEWS 2 on 15th Dec 2025. All PARIS developments are in place, new paperwork in patient's home and Health Pathways (GP Access) have been updated.

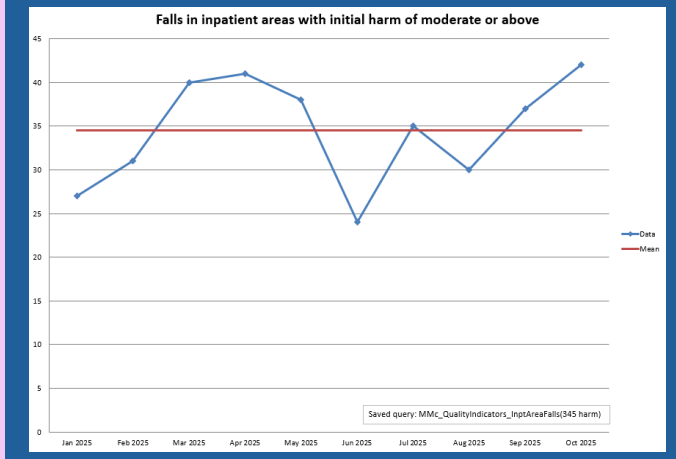
NEWS 2 ESR training compliance across the UHB is at 72% and continues to rise.

The implementation of Marthas law (Call 4 Concern) has commenced in UHW and UHL but will be expanded throughout 2026 to cover A&E, Maternity and mental health Services in HYC. Common themes collated from calls include poor communication of medical management plans to the patient, concerns surrounding discharge, with less than 10% of the calls appropriate acute deterioration issues. Comms promoting Call 4 concern to patients has been supported by LLAIS. The introduction of patient wellness scores in the next 6 months, will complete the WHC requirements of Marthas Law for the UHB.

A quality improvement project following Spread and Scale is in the development stage. It is being run in partnership with the cardiology directorate and aims to support improved team working in a cardiac arrest situation. The project is seeking to improve the efficiency of the initial clinical team response until the resuscitation team have arrived and is being piloted on B1 and the coronary care unit before being rolled out in the Cath Lab. Teams are supported to plan for a resuscitation situation at the beginning of each shift, undertaking checks of the resuscitation trolley, establishing if all staff are trained in Basic Life Support (BLS) and assigning roles in the resuscitation . The aim is to improve the effectiveness of the initial resuscitation response until support has arrived. Once this phase has been completed using PDSA cycles, the project aims to be rolled out to all clinical areas

Safe Care

Patient Falls



Inpatient falls
During November, a further 13 people completed falls prevention and management training. The session continues to be exceptionally well received, with an average staff rating of 4.8 out of 5. Discussions are progressing regarding expansion of this training, as well as adaptation to suit non-inpatient settings, such as clinics or day services.

Community falls
5 care homes in the CAV area have received falls training, provided on behalf of the Health Board by St John Ambulance staff.

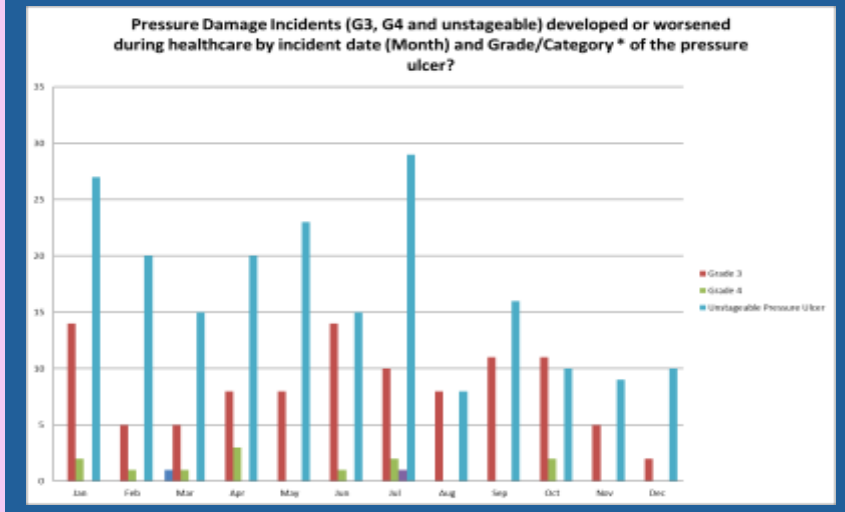
Action cards to improve staff confidence in managing falls in residential care settings have been developed and will be piloted with individual homes during the first half of 2026.

The new self-assessment tool, hosted on the Keeping Me Well website has been released. This guides people to information and classes which are suitable for their needs. Promotional materials have been developed with input from the co-production group and our partner organisations.

Working collaboratively with Cardiff Telecare and WAST, the Health Board has developed a pathway for fallers who do not currently receive Telecare to be triaged by the Single Point of Access. An appropriate response can then be deployed by the SPOA, which could be Telecare, the Physician Response Unit, or to continue with an Ambulance. This will reduce the amount of time fallers spend on the floor and allow the most appropriate service to attend to the person's needs. The pilot of this service goes live on Monday 12th January and runs until the end of March. The effectiveness of the service will be evaluated and this will feed into plans for 2026/27.

Safe Care

Pressure Damage



The UHB Pressure Damage Collaborative reconvened in November 2025 and monthly meetings are being held. Five key workstreams have been identified:

Information & Data (including Datix integration and dashboard)
The UHB hold data relating to pressure damage in a number of different system, including Welsh Nursing Care record, Datix, Paris and the community wound care app. This workstream will scope the data availability and reporting function of each system to understand the data and reporting functions of each platform and develop a health board approach that allows triangulation and learning.

Scrutiny Panels & Reporting Culture
A review of all Health Board scrutiny processes will be undertaken to standardise the approach to review all grade three, four and unstageable pressure ulcers across the organisation to support learning and to establish causative factors

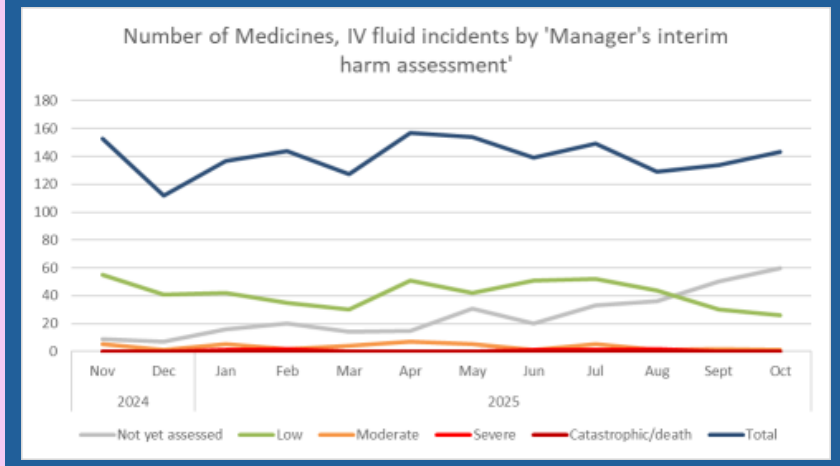
Documentation & Standards
This workstream will review the pressure damage standards and the risk assessment and documents that are used across the organisation as well as measurements of quality and compliance.

Education and Shared Learning
This workstream will be supported by Education, Culture and Organisational Development

Equipment
The workstream will address equipment issues highlighted by scrutiny panels, including selection and requesting equipment and will support the procurement of the UHB bed contract.

Safe Care

Medication Safety



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

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

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

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

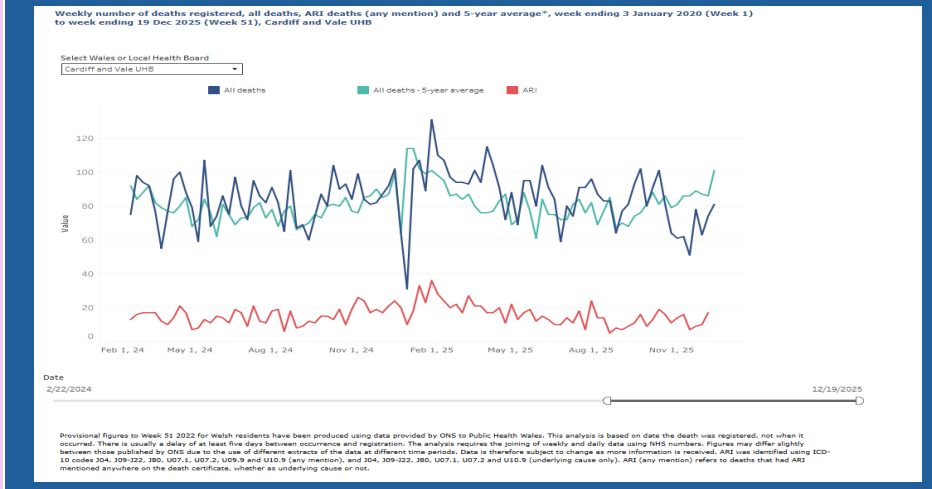
The system is being embedded and initial learning from the first wards are being utilised to improve and optimise further roll-out. Initial data report development and subsequent analysis is being undertaken currently and the ePMA team will soon be able to share initial data related to medicines safety.

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

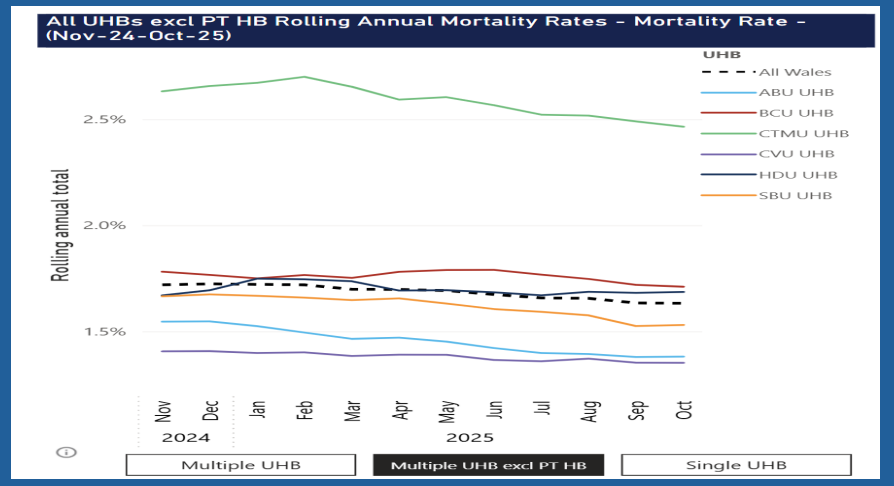
Effective Care

Mortality

All Cause mortality (deaths in all settings)



Crude Inpatient Mortality (Beacon dashboard QOF Nov 2024 – Oct 2025)



The all-cause mortality rate across the Cardiff and Vale UHB area has remained below the five year average for the past 2 months and as yet there is no observed seasonal increase in deaths relating to respiratory infections. Crude inpatient mortality was 1.32% in November 2025 below under the all-Wales average and the lowest of all Health Boards in Wales. However, the UHB measurement of Risk Adjusted Mortality Index (RAMI) remains high, but it is likely that delays in clinical coding are impacting the reliability of this data. Work is underway to explore greater collaboration between coding and clinical teams in Stroke services to improve coding and opportunities to further expand this approach into orthopaedics.

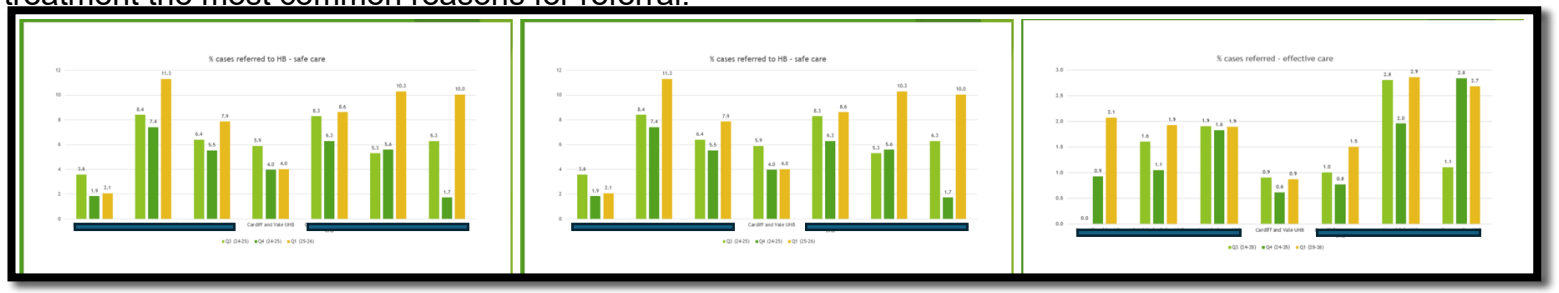
The Medical Examiner provides oversight of all deaths in the community and as an inpatient. In the first quarter of 2025/26 the ME referred 19.2% of cases that they reviewed back to the UHB for further consideration.

0.9% of cases reviewed were referred for consideration around effective care, with care at the end of life being the most common theme.

4.7 of cases reviewed were referred for consideration around the timeliness of care with delays in intervention, diagnosis, treatment and escalation observed equally

4.0% of cases reviewed were referred for consideration around safe care with clinical documentation the predominant theme

13.2% of cases reviewed were referred for consideration around person centred care with communication and individualised treatment the most common reasons for referral.

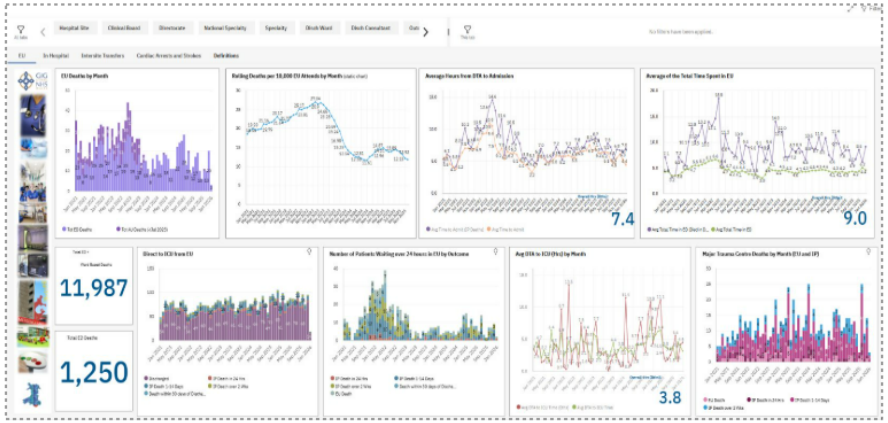


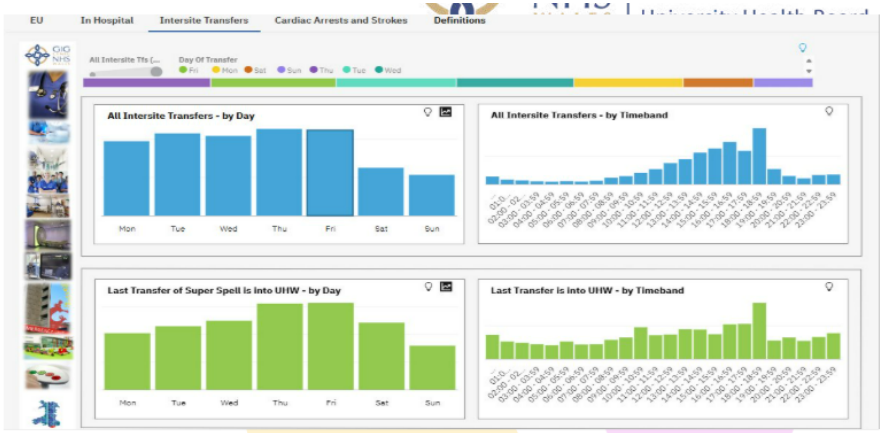
Effective Care

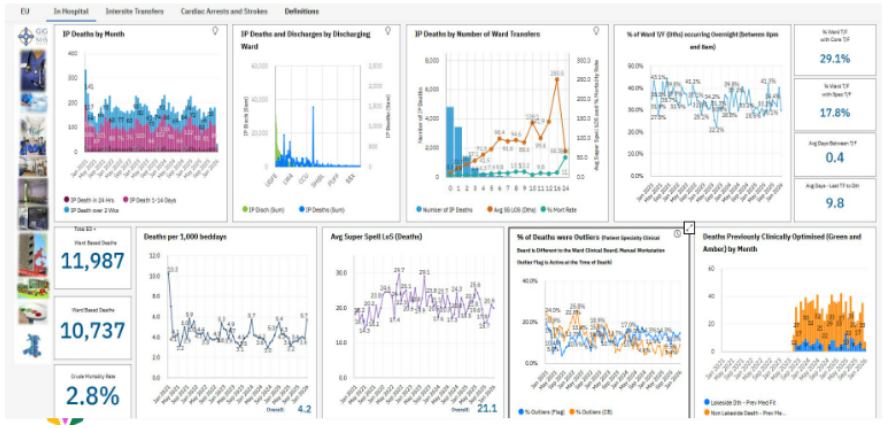
Mortality

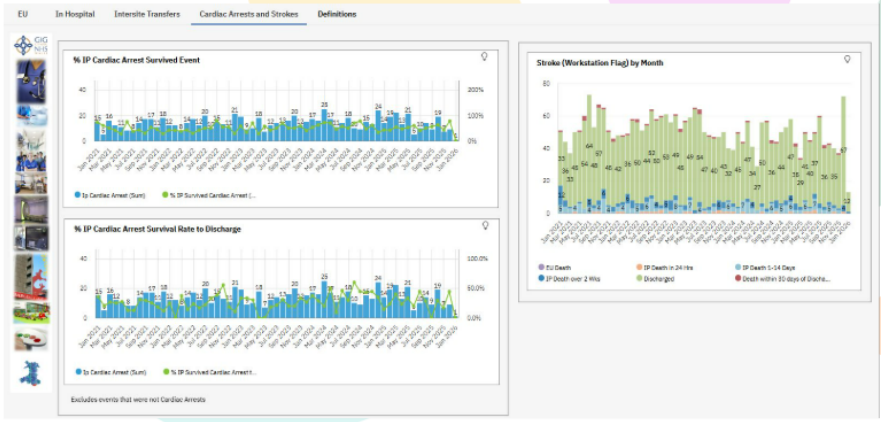
Mortality Governance

The development of a mortality dashboard allows the correlation of a number of care variables, including length of time to admission from ED, attendance at ED , ward transfers and length of stay. Work is underway to extend this dataset to include post operative inpatient and 30-day mortality and mortality associated with unplanned returns to theatre. Development of the database will also support access to patient level information which along with the roll out of a digital mortality and morbidity review module will support scrutiny of mortality associated with inpatient care.



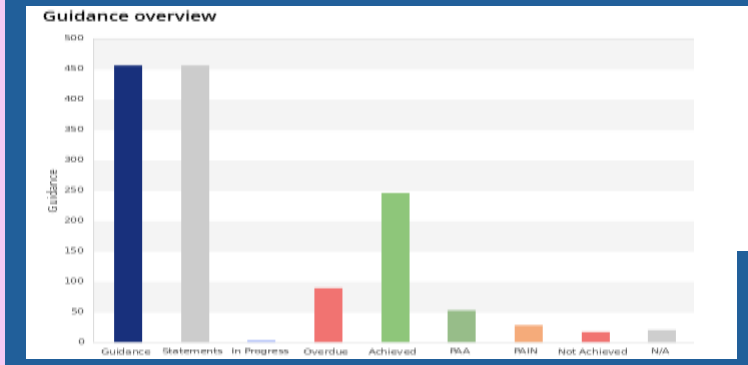






Effective Care

Audit and Assurance



- **Guidance (455)** - total number of guidance (that may contain one or more statements)
- **Statements (455)** - total of 'In Progress', 'Achieved', 'Partially Achieved', and 'Not Achieved' bars
- **In Progress (3)** - number of the trust's Guidance Statement entries that do not currently have a status
- **Overdue (89)** - number of the trust's Guidance Statement entries that are overdue
- **Achieved (246)** - number of the trust's Guidance Statement entries that have this status value
- **PAA (52)** - number of the trust's Guidance Statement entries that have 'Partially Achieved - Acceptable' status value
- **PAIN (28)** - number of the trust's Guidance Statement entries that have 'Partially Achieved - Improvement Needed' status value
- **Not Achieved (17)** - number of the trust's Guidance Statement entries that have 'Not Achieved' status value
- **Not Applicable (20)** - number of the trust's Guidance Statement entries that have 'Not Applicable' value

Implementation of NICE and Health Technology Wales Guidance

The Clinical Effectiveness Committee held on 28th November 2025 was dedicated to the National Cardiology Audits. The following audits were discussed:

Ablation audit

57 centres in the UK that provide ablation, in terms of size, UHW ranks 39th with 157 ablations performed in 2023/2024. C&V has one of the lowest AF ablation rates per million in the UK but a low rate of re-intervention. C&V provides high quality ablations with low rates of re-intervention but perform relatively few. Challenges: development of the service is hampered by lack of access to GA and insufficient Ablationists in post.

Devices Audit

There is incomplete NICOR data making it difficult to make any meaningful recommendations. There are clinical risks around box changes, depleted battery, outdated devices being implanted and the use of a paper-based monitoring system for >10,000 patients without admin support. Challenges: need for an urgent overhaul of device service to implement robust electronic tracking with dedicated admin support.

National Heart Failure Audit

In-patient mortality had increased, although 30 day and 1 year mortality rate has decreased. The increase in-patient mortality maybe due to improved data quality. The 1 yr survival rate has been found to be higher for patients discharged from a cardiology ward. Target 60% for HF patients to be cared for on a cardiology ward, UHW and UHL are below target. Target for specialist review is 90%: UHW 76%, UHL 78%. Discharge medication (4 pillars) and echocardiography uptake disappointing. In-patient pathway is in development. Challenges: workforce numbers, engagement from medical teams, training and education.

BCIS NICOR PCI Audit

C&V rank 20th in terms of total PCIs/year (~1500/yr). UHW PCI operators perform higher volumes than national average, staffing is a challenge around provision for rest days for current consultants. Approx 30% PCIs are emergency which is similar to regional partners (Morriston and Bristol). Call to balloon time not so good, national guidelines <150 mins, C&V rate 40% - often due to issues outside C&V control e.g. transfer delays. Above average use of intravascular imaging. Challenges: Data completion is a challenge and needs improvement, requirement for a dedicated data manager.

National Congenital Audit

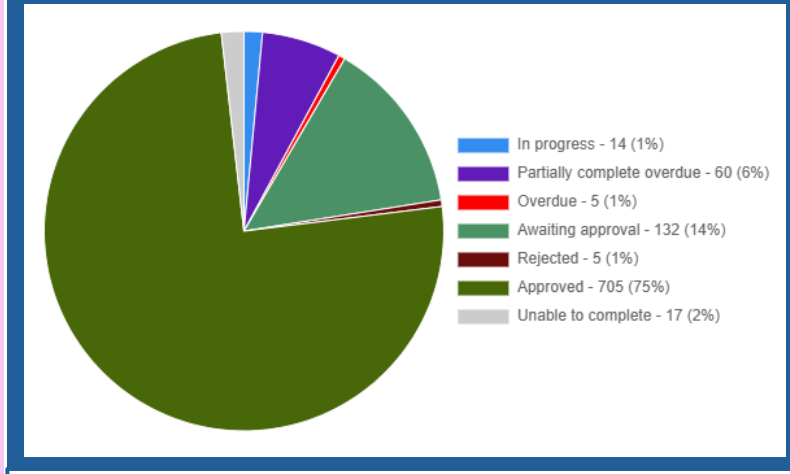
High-quality service with excellent outcomes and strong patient trust, transition service considered a national exemplar, RTT improvements: new patient waits reduced from 26 weeks (2018) to 13 weeks (2025), Innovation: physiology-led echo clinics, expanded outreach OPD, and nurse-led medication challenges. Challenges: Workforce shortages, fetal cardiology delays, communication between centres, reliance on charity funded equipment, space constraints, outpatient backlog.

Summary

Issues identified across the teams: data collection, data quality, need for dedicated admin support, workforce constraints (capacity and people), need to modernise device service with electronic systems and dedicated support.

Effective Care

Internal and External Assurance



UHB wide progress against HIW inspections

Healthcare Inspectorate Wales

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

There have been no new inspections since July.

Following the HIW inspection undertaken in July 2026, UHL Radiology developed a comprehensive improvement plan to address 20 identified issues across governance, patient safety, workforce, documentation, and regulatory compliance. As of December 2025, 18 of these actions have been completed, with the remaining two progressing toward completion. This reflects sustained and timely progress, demonstrating a robust commitment to strengthening safety, regulatory adherence, and staff engagement. UHL Radiology is now well positioned to achieve full compliance and provide enhanced assurance to both HIW and the wider organisation.

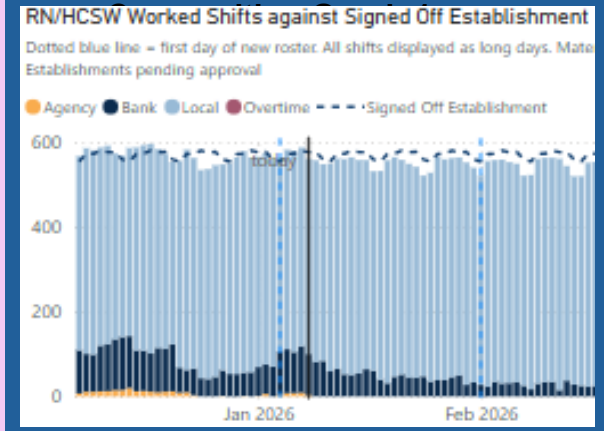
An action plan has been developed in response to the *Review of Significant Accidental or Unintended Exposures (IR(ME)R) Notifications to Healthcare Inspectorate Wales, April 2023–March 2024.* The action plan details how Cardiff and Vale UHB is strengthening radiation-related patient safety by embedding a positive reporting and learning culture, ensuring Significant Accidental Unintended Exposure (SAUE) criteria are clearly understood through accessible IRMER procedures and Medical Physics Expert support, maintaining efficient and timely incident reporting via robust policies, Datix training and HIW-notification monitoring, and continually reviewing and adjusting corrective actions at both directorate and UHB level to address contributory factors and ensure sustained improvements in patient safety.

Leadership Listening walkrounds

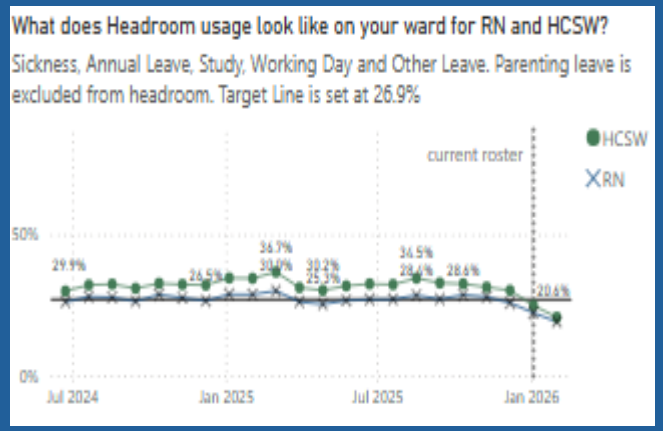
There have been seven leadership Listening walkrounds undertaken by the Executive and Independent members of the Board in the past quarter, with teams from Infection prevention and control, Biochemistry and immunology, adult mental health , vascular and neurology wards and CaV 24/7 Out of Hours visited. While the Board members discussion are supporting collation of themes including the fast turn around of patients on wards, estates challenges, the value of adopting a research first environment , feedback from the hosting areas has also demonstrated the value of these visits with one colleague stating " I felt quite emotional afterwards" and another stating "I enjoyed listening to the perspective of the Board and it was uplifting to hear how important they felt our work was."

Workforce

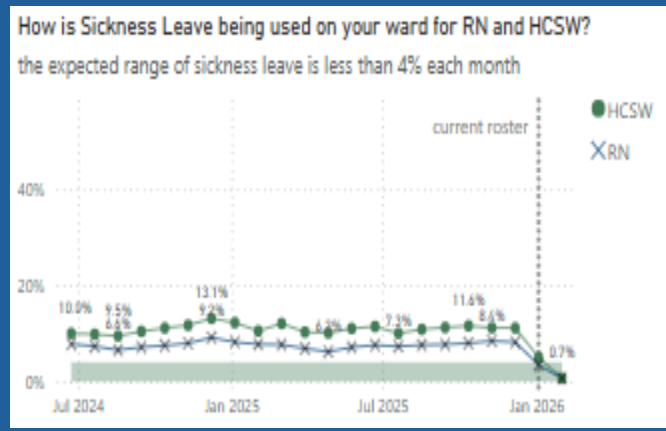
Staffing



Headroom trends Graph 2



Sickness Trends Graph 3



Nurse Staffing Levels

- **Staffing Composition Over 24 Hours – 25B Areas (Graph 1):**
  This graph provides an overview of the nurse staffing levels across a 24-hour period for acute adult and paediatric inpatient wards, specifically those designated as 25B areas under the Nurse Staffing Levels (Wales) Act. Substantive staff are shown in light blue, bank staff in dark blue, and agency staff in yellow. A reduction below the establishment line can be seen during the week commencing 21/12/2025. The dotted line demonstrates the signed off establishment and evidence of how nurse staffing rosters are met across the organisation.

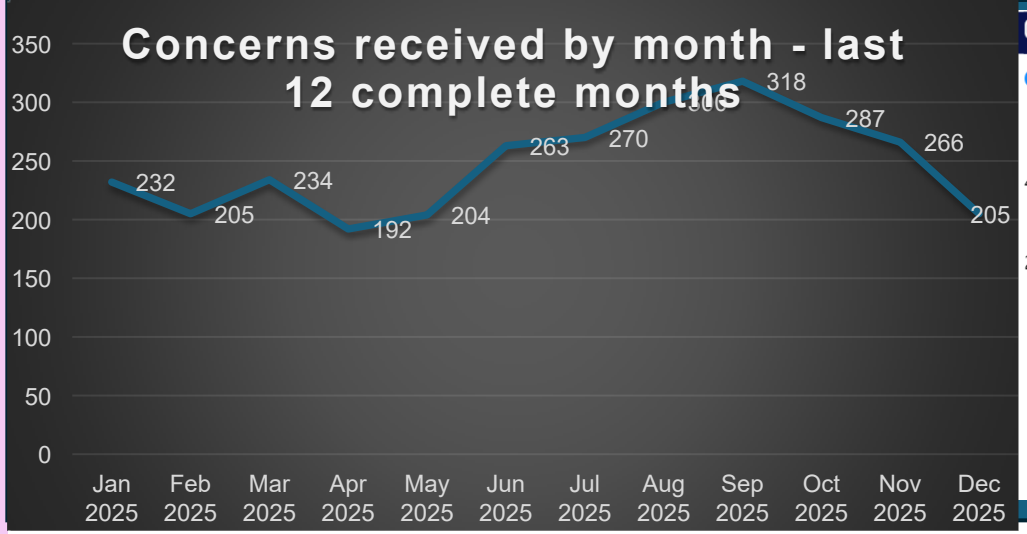
- **Uplift Trends (Graph 2):**
  Average Uplift across all areas stands at 27.2%. Unavailability continues to be more pronounced within the Healthcare Support Worker (HCSW) group at 30.2% compared to registered nurses at 25.8%.

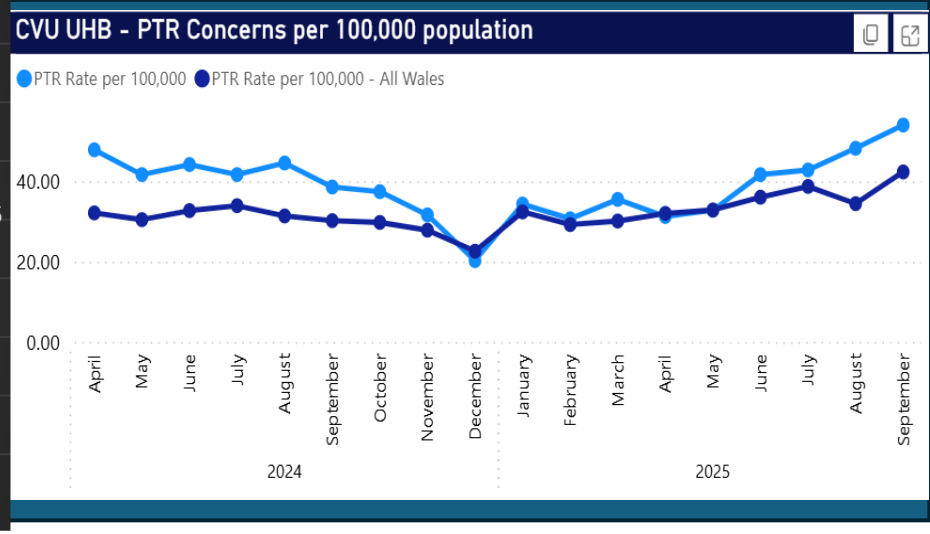
- **Sickness Rates (Graph 3):**
  Sickness remains a concern across the nursing workforce. Last month, the overall sickness rate was 9.1%, with unregistered staff experiencing a higher rate of 11.1%, compared to 9.2% among registered nurses.

- **Shift Appropriateness – 25B Wards:**
  Staffing levels are assessed for appropriateness on every shift as required as part of the Nurse Staffing Levels (Wales) Act.
  During December 88% of shifts were deemed appropriately staffed- this represents an increase on the previous reported 84% of shifts being recorded as appropriate. The total percentages of the planned rosters being met based on their signed off establishment was 68%, again this represent a small decrease but recognising the reduction against establishment week commencing 21/12/2025. Processes are place to monitor this performance and escalated to the Executive Director of Nursing.

Patient Centred Care

Concerns



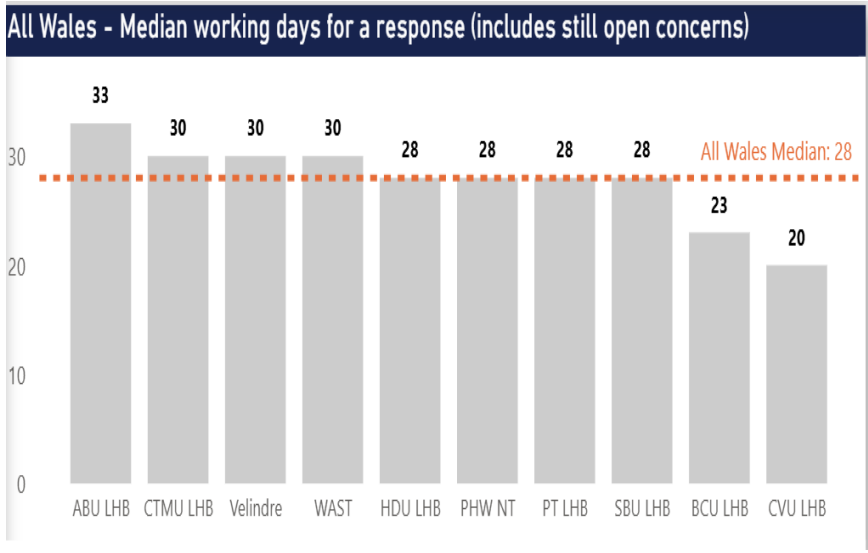


Quality and Patient Experience

Reporting Period: 1st January 25 – 31st December 2025

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

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



Performance

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

Patient Centred Care

Concerns

Themes in concerns across UHB (Oct 25 to Dec 31st 25)

Medicine Services

Key Themes:

Delays in Diagnostics and Results: Long waits for diagnostic tests (radiology, endoscopy, bloods), delayed communication of results, and missed opportunities for early intervention

Discharge Planning and Coordination: Alleged unsafe or premature discharges, lack of multidisciplinary input, and poor coordination with community services, leading to readmissions or deterioration at home.

Monitoring and Observation: Failures in monitoring patients, resulting in missed deterioration, falls, or inadequate symptom control.

Nutrition, Hydration, and Basic Care: Concerns re meeting basic care needs, such as assistance with meals, hydration, hygiene, and pressure sore prevention

Patient Centred Care

Concerns

Themes in concerns across UHB (Oct 25 to Dec 31st 25) Surgery

Surgical Services

Key Themes:

Access and Waiting Times: Significant delays for elective and urgent surgeries (orthopaedics, general surgery, ophthalmology, dental). Repeated cancellations and lack of clear communication about rescheduling are common.

Postoperative Care and Follow-up: Concerns about inadequate post-op monitoring, lack of follow-up appointments, and insufficient pain management or rehabilitation support.

Clinical Decision-Making: Questions about the appropriateness of clinical decisions, including prioritisation for surgery, management of complications, and escalation of care for deteriorating patients.

Attitude and Behaviour: Reports of unprofessional or insensitive behaviour by clinicians, especially during stressful or complex procedures, and lack of patient-centred communication.

Patient Centred Care

Concerns

Themes in concerns across UHB (Oct 25 to Dec 31st 25)

Children and Women's Services

Key Themes:

•**Delays in Appointments and Treatment:** Persistent delays in paediatric, gynaecology, and obstetric appointments, including repeated cancellations and long waits for surgery or specialist assessments (e.g., autism, ADHD, fertility, endometriosis).

•**Communication and Compassion:** Multiple concerns about poor communication, lack of empathy, and dismissive attitudes from staff, especially in maternity and paediatric settings. Parents and patients often felt uninformed or unsupported during critical moments.

•**Discharge and Aftercare:** Unsafe or poorly planned discharges, lack of aftercare instructions, and inadequate support for vulnerable patients (e.g., neonates, children with complex needs, postnatal mothers).

•**Clinical Assessment and Diagnosis:** Missed or delayed diagnoses (e.g endometriosis, congenital conditions), inconsistent application of clinical guidelines, and lack of holistic or multidisciplinary review for complex cases.

•**Safeguarding and Consent:** Issues with safeguarding referrals, consent for procedures, and involvement of families in care planning, particularly for children and those with additional needs.

Patient Centred Care

Concerns

Themes in concerns across UHB (Oct 25 to Dec 31st 25)

Mental Health Services
Key Themes:
Access to Services: Extended waiting times for assessments (ADHD, autism, eating disorders), difficulties accessing crisis support, and lack of follow-up after discharge from inpatient or community teams.

Communication and Care Planning: Poor communication between teams, patients, and families; lack of involvement in care planning; and inconsistent application of risk management protocols.

Attitude and Stigma: Reports of dismissive, judgmental, or unempathetic attitudes from staff, particularly towards patients with complex or long-standing mental health needs.

Continuity and Coordination: Fragmented care, frequent changes in clinicians, and lack of clear points of contact, leading to patients feeling abandoned or unsupported.

Patient Centred Care

Concerns

Themes in concerns across UHB (Oct 25 to Dec 31st 25)

Primary, Community, and Intermediate Care
Key Themes:
Access to Community Services: Delays in community-based therapies (physiotherapy, occupational therapy, district nursing), difficulties with equipment provision (wheelchairs, splints), and lack of support for home-based care.
Discharge and Transition: Poor communication and planning during transitions from hospital to home or care facilities, leading to gaps in care and increased risk for vulnerable patients.

Specialist Services (e.g., Cardiology, Neurosciences, Haematology)
Key Themes:
- **Delays and Access Issues:** Delays in specialist appointments, diagnostics, and interventions (e.g., insulin pumps, cardiac procedures, neurosurgery).
- **Communication and Information:** Inadequate explanation of diagnoses, procedures, and follow-up plans; lack of timely updates to patients and families.
- **Complex Case Management:** Challenges in coordinating care for patients with rare, complex, or multi-system conditions, often resulting in missed opportunities for early intervention or holistic support.

Patient Centred Care

Concerns

Themes in concerns across UHB (Oct 25 to Dec 31st 25)

Cross-Cutting Trends

Delays and Cancellations: Across all Clinical Boards, delays in access to care, repeated appointment cancellations, and long waiting times are the most prominent and distressing issues for patients and families.

Communication Failures: Poor communication—between staff, with patients/families, and across services—emerges as a universal theme, contributing to confusion, anxiety, and dissatisfaction.

Compassion and Attitude: Many complaints cite a lack of empathy, compassion, or respect from staff, with patients feeling dismissed, judged, or not listened to.

Discharge Safety: Unsafe or poorly coordinated discharges, especially for elderly, frail, or complex patients, are a recurring concern.

Administrative and Systemic Issues: Lost referrals, missing records, administrative errors, and lack of clarity around processes (e.g., waiting list management, eligibility criteria) are frequently cited as barriers to effective care.

Learning and Accountability: Many complainants request assurance that their experiences will lead to learning, service improvement, and accountability for staff or systemic failures.

Patient Centred Care

Concerns

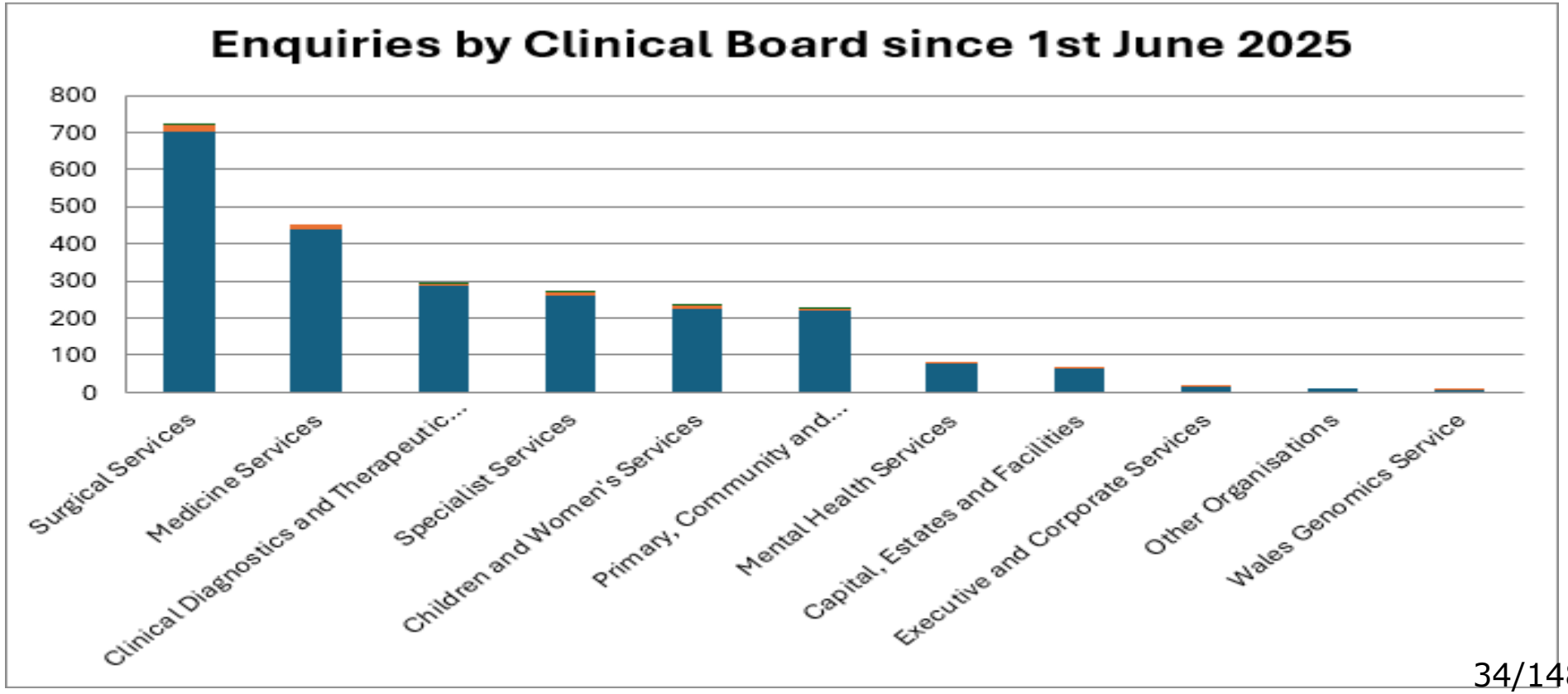
Enquiries Line

We have managed 2,114 enquiries since 1st June 2025. You will note that Surgical Clinical Board continue to receive the majority of enquiries, followed by Medicine Clinical Board.

Emerging themes

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

- Difficulty getting through to departments by telephone
- Prolonged waiting times
- Contacting ward staff for updates

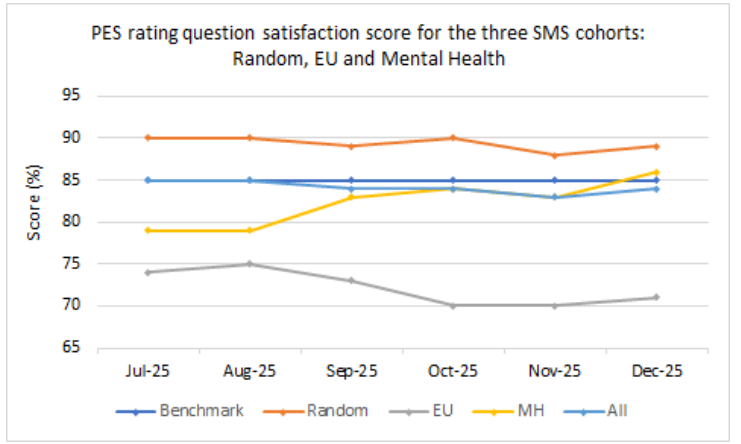


Patient Centred Care

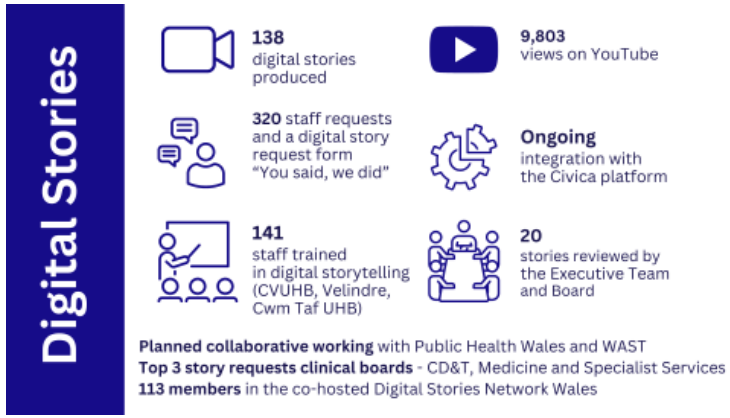
Patient Experience

- The UHB is currently surveying up to 1,000 patients daily via text, 600 chosen randomly from general hospital activity, 200 from EU activity and 200 from Mental Health activity. **Over the past 12 months, we have sent over 185,000 texts** and are seeing a response of 16%. (figures based on the People's Experience Survey)
- In December we sent 14,785 texts and had 2,423 completions (16% response).
- Of those respondents who were discharged during November/December and answered the rating question, 83% were satisfied with our service.
- The information given in the chart below, is based on the satisfaction score received for the PES rating question, for each of the SMS cohorts, by month (last 6 months included)

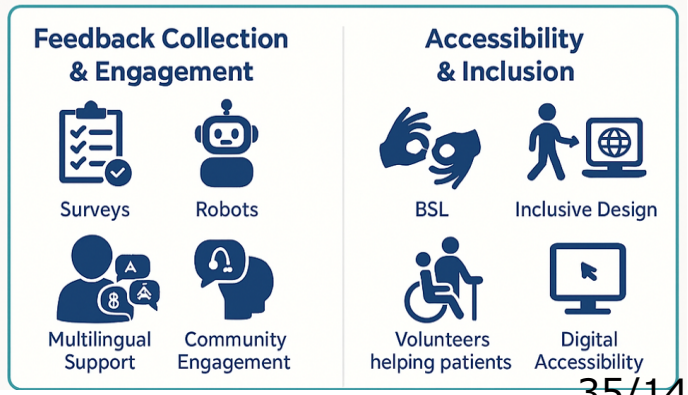
Figure 1. Patient Experience Survey results



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



All our surveys are in BSL and multiple languages



Patient Centred Care

Patient Experience

Feedback

- Satisfaction scores for core questions in the People's Experience Survey (PES) for the Emergency Unit, Mental Health and Random cohorts.
- **Sample:** Based on feedback received from the above areas between: 01/12/2025 – 31/12/2025

Cohort	Respondents (n)	Staff caring (%)	Feel safe (%)	Overall (%)
Emergency Unit	692	84	84	71
Mental Health	63	93	90	86
Random	1571	94	95	89

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

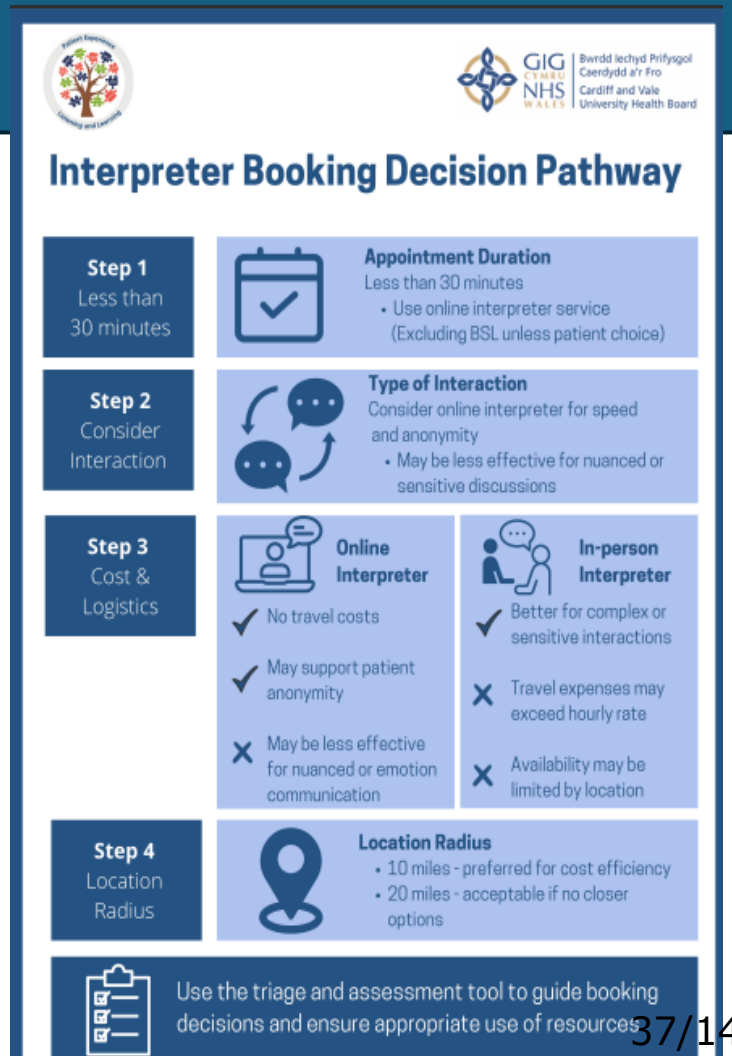
Person Centred Care

Patient Experience

Interpretation & Translation Services including BSL

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

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



Report Title:	Children & Women's Clinical Board QSE Quality Assurance Report				Agenda Item No:	2.2
Meeting:	Quality Committee		Public	X	Meeting Date:	20/01/2026
			Private			
Status	Assurance	X	Approval		Information/Noting	
Lead Executive :	Jason Roberts, Executive Director of Nursing					
Report Author Title:	Abigail Holmes, Director of Midwifery & Neonatal Nursing / Interim Director of Operations Andy Jones, Director of Nursing					

Main Report

Background and Current Situation:

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

The report provides an oversight of achievements, risks and improvements across Children & Women's Clinical Board for the period of January – December 2025. The report outlines the robust governance structures in place, including QSPE meetings and incident management groups, including updates relating to audit, learning and assurance through internal and external reviews and benchmarking, with a commitment to continuous improvement in quality, safety and experience

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

- **Governance & Assurance**
  - Robust governance via QSPE Committee (meets every 4 weeks), sub-groups for incident review, and AMaT system for audits and learning.
  - Regular review of risk registers and migration to AMaT system for improved tracking.
- **Incident Management**
  - 41 open National Reportable Incidents (NRIs), mostly MBBRACE cases.
  - Strong reporting culture; most incidents are low/no harm, with ongoing work to refine harm assessment.
  - Falls and pressure damage incidents have decreased; scrutiny panels and targeted interventions in place.
- **Safeguarding**
  - Appropriate and consistent volumes of safeguarding referrals being due to the nature of the population we deliver service to.
  - Safeguarding is a regular agenda item on QSE, with good links to support teams.
- **Infection Prevention & Control**
  - Notable increase in C. difficile, MRSA, and E. coli cases compared to previous year; reduction targets not met.
  - Outbreaks managed with targeted actions (cleaning, audits, SOPs); no ongoing outbreaks at report time.
- **Patient Experience**
  - CIVICA platform used for feedback; overall satisfaction scores at 85%+.
  - Surveys tailored for different age groups and needs; ongoing work to improve response rates and feedback mechanisms.
  - 316 formal compliments received; 510 concerns logged, with hotspots in Neuro Development and Gynaecology waiting times.

- **Redress, Claims & RIDDOR**
  - 9 active redress cases; learning shared and improvements made (e.g., bladder care guidance).
  - 2 active personal injury claims; example of successful defence saving £21,000.
  - 4 RIDDOR incidents reported, showing a downward trend.
- **Clinical Negligence**
  - 110 open cases; 16 Learning from Events triggered.
- **Quality Improvement Initiatives**
  - Early warning scores and Call4Concern rolled out.
  - Antimicrobial stewardship and electronic prescribing (ePMA) progressing.
  - Tendable app used for live quality audits; high compliance across areas.
- **Research & Development**
  - Active research portfolio in paediatrics, obstetrics, and gynaecology, including national and international studies.
- **Workforce & Wellbeing**
  - Focus on recruitment, retention, and wellbeing (champions, packs, psychology support, recognition awards).
  - Seeing a reduction in overall sickness and turnover
  - Staff engagement initiatives (newsletters, walkarounds, feedback apps).
- **Risks**
  - Significant reduction in high-rated risks; ongoing review and migration to AMaT.
  - Key risks: diagnostic waiting times, sleep study capacity, ND waiting times, psychiatric cover, demand/capacity in Gynaecology, estates issues, psychology funding, out-of-guidance home births.
- **Directorate Highlights**
  - Acute Child Health: full staffing, reduced sickness, improved access, risks in endoscopy and sleep studies.
  - CYPFHS: ND pathway redesign, safeguarding integration, high HV performance.
  - Obstetrics & Gynaecology: demand/capacity issues, estates challenges, QI achievements (Badgernet, MEWS/NEWTT2).
- **Assurance & External Review**
  - Regular performance management, independent audits, benchmarking, and patient experience monitoring.

Issues & Areas for Attention

- **Infection rates above targets** (C. diff, MRSA, E. coli) – need for ongoing prevention and control measures.
- **Waiting times and capacity** in diagnostic endoscopy, ND and Gynaecology – risk to timely care and outcomes.
- **Staff wellbeing and sickness absence** – stress/anxiety remains a focus; further support being developed through co-production with staff.
- **Safeguarding training compliance** – access to training dates and delivery methods require improvement. Level 3 training being prioritised
- **Patient feedback response rates** – ongoing work to increase engagement and capture children and young people's voices via expansion of CIVICA.
- **Risk register migration** – ensure full transfer to AMaT and robust review processes.
- **Funding for key services** – Need to secure sustainable funding for services currently provided via short term funding or grants.

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

- Children & Women's Clinical Board Assurance Report (Slide Deck)

Recommendations:

The Committee is asked to:

1. **NOTE** the contents and assurance provided within the report and the steps being taken to improve quality, safety and patient experience.

Link to Strategic Objectives of Shaping our Future Wellbeing:			
1. Putting People First		2. Providing Outstanding Quality	
3. Delivering in the Right Places		4. Acting for the Future	

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

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

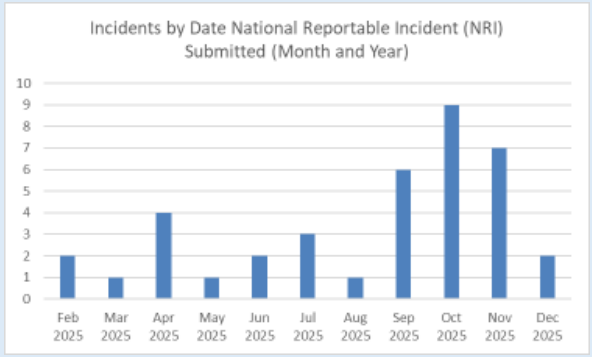
Impact Assessment
Risk: n/a
Safety: n/a
Financial: n/a
Workforce: n/a
Legal: n/a
Reputational: n/a
Socio Economic: n/a
Equality & Health: n/a
Decarbonisation: n/a
Welsh Language: n/a

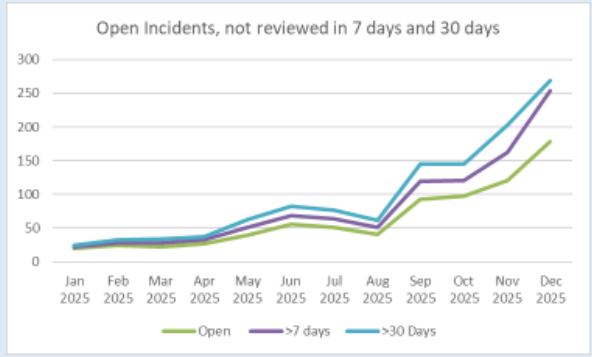
Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:

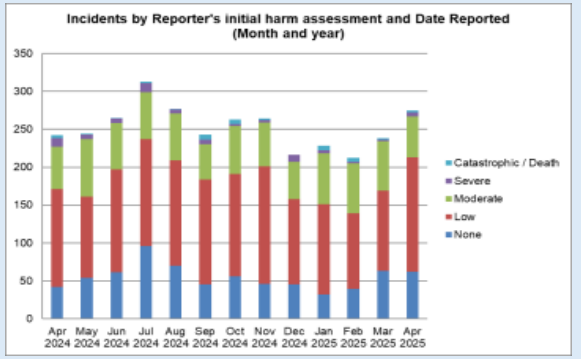
Children & Women's Clinical Board Assurance Report (January 2026)

Safe Care

NRI and Patient Safety Incident Reporting







NRI (National Reportable Incident) Management
The Clinical Board has a robust review of all NRI's through initial fact-finding meetings, with subsequent progress meetings, followed by a closure and action planning meeting. The Clinical Board is in the process of establishing post closure meetings at regular intervals to ensure actions are completed and embedded in clinical practice to provide further reassurance. Each report is also presented through Clinical Board QSPE meetings and shared more widely as appropriate.

The criteria of investigation for reported NRI's (excluding MBBRACE Criteria) included:
Potential Lost to Follow Up – 3 incidents
Medication, IV Fluids – 2 incidents
Treatment, Procedure – 1 incident
Assessment, Investigation, Diagnosis – 1 incident
Patient/Service User Death – 4 incidents

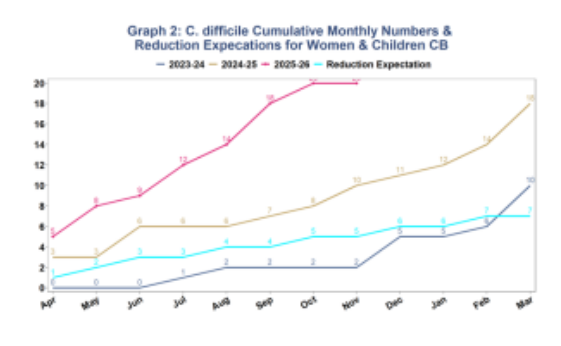
There has been a rise in the number of Nationally Reportable Incidents (NRI's) within the Clinical Board since November 2023 because of a change in reporting for incidents that meet MBBRACE Criteria, however no initial care concerns have been identified. These incidents are reviewed and reported in line with the Perinatal Mortality Review Process and Child Death Review process.

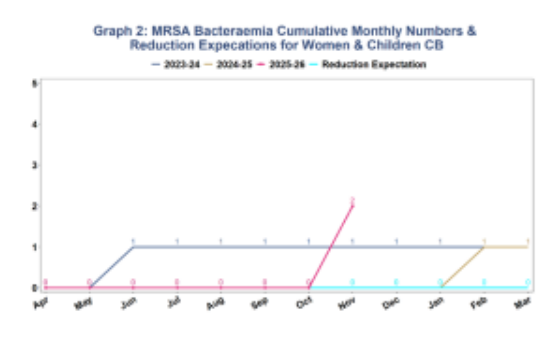
Datix/Patient Safety Incident Management
The substantial incident reporting observed within the Clinical Board reflects our dedication to fostering an open, transparent, and psychologically safe culture—essential conditions for delivering safe, high-quality patient care and experience.

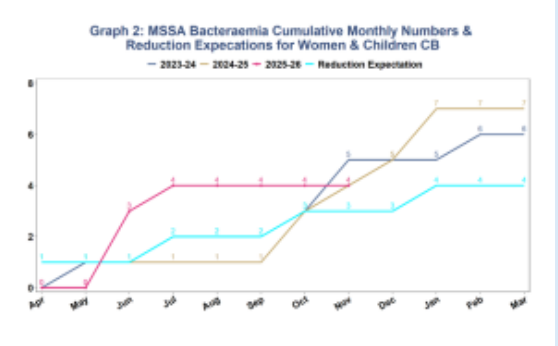
The Charts show: The line chart show the numbers of incidents that were not reviewed in 7 days and not reviewed in 30 days in each month between January – December 2025. The bar chart illustrates that, although a considerable number of incidents were reported during this period, the majority involved low or no harm. Upon review of incidents initially classified as severe or catastrophic, several did not meet this criteria. Ongoing efforts are focused on refining harm assessment standards and knowledge to improve the accuracy of incident reporting. These efforts are supported by the Patient Safety Team in collaboration with clinical staff to enhance their knowledge

Safe Care

Infection prevention and Control







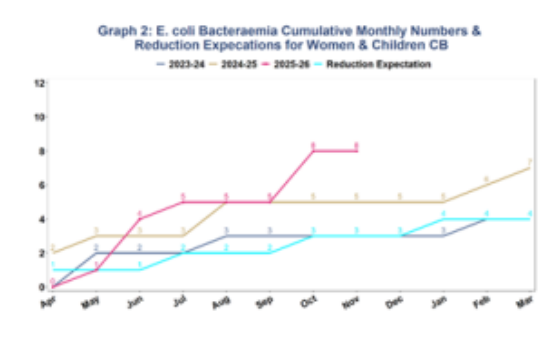
C. Difficile
Cases: 20 cases so far, this financial year (Apr–Nov 2025), double the number from the same period in 2024/25.
Target: The reduction expectation was 5 cases, so the board is 15 cases over target.
Location: Most of the increase is at UHW (+10 cases), with Child Health (+9) and Obstetrics & Gynaecology (+1) also seeing rises.
Trend: Significant increase, well above reduction targets, indicating a need for urgent review and action.

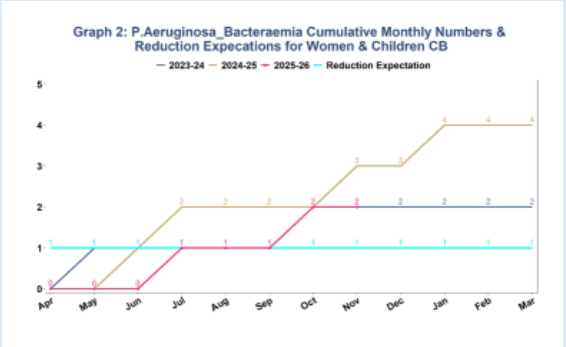
MRSA Bacteraemia
Cases: 2 cases this year (Apr–Nov 2025), both at UHW and in Child Health.
Target: The expectation was zero cases, so the board is 2 over target.
Trend: Any MRSA bacteraemia is a concern for patient safety, especially as the target is zero.

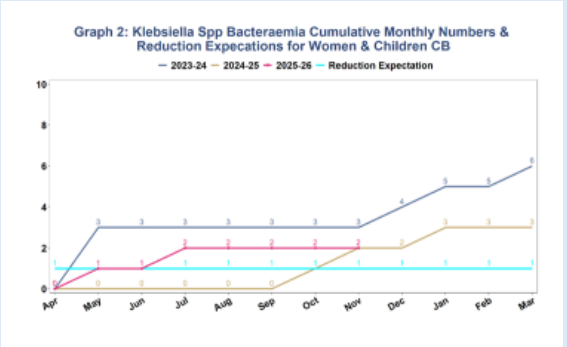
MSSA Bacteraemia
Cases: 4 cases, unchanged from last year.
Target: 1 case over the reduction expectation (target was 3).
Trend: No improvement but not worsening either.

Safe Care

Infection prevention and Control







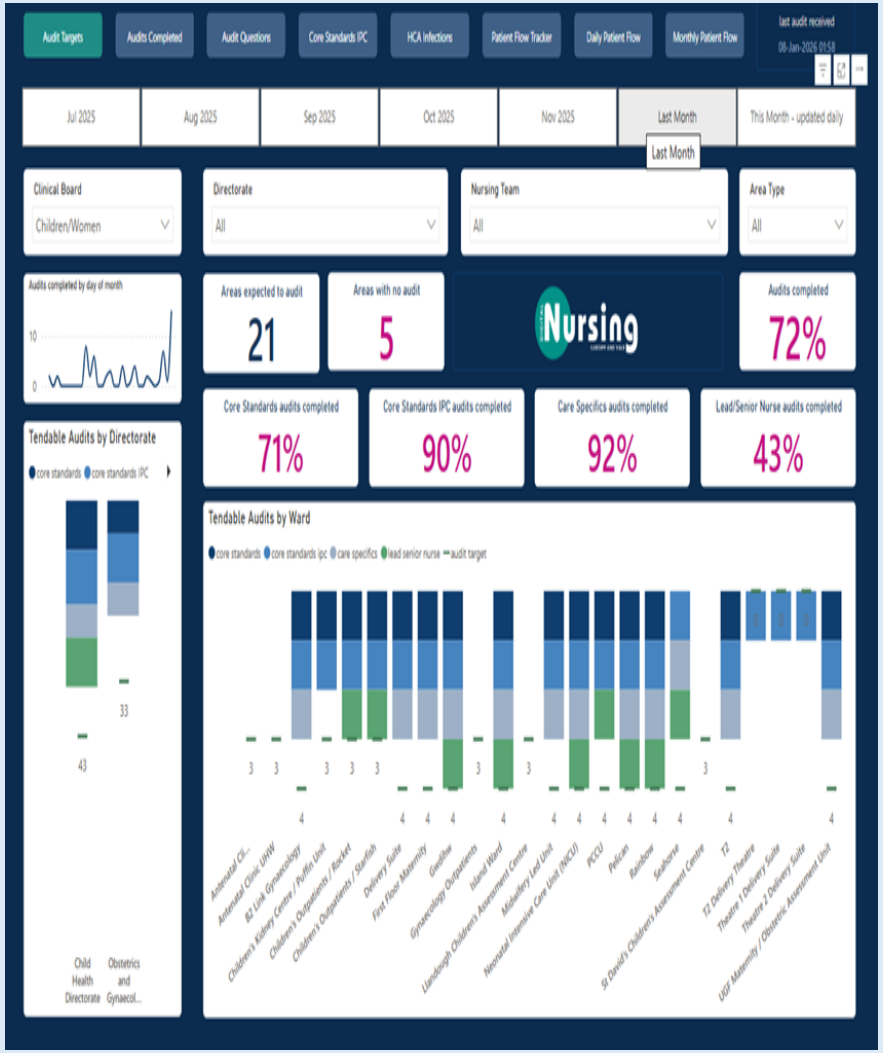
E. coli Bacteraemia
Cases: 8 cases, up 60% from last year.
Target: 5 cases over the reduction expectation (target was 3).
Location: Increase mainly in UHW (+3) and Child Health (+5), but a decrease in Obstetrics & Gynaecology (–2).
Trend: Rising trend, especially in Child Health.

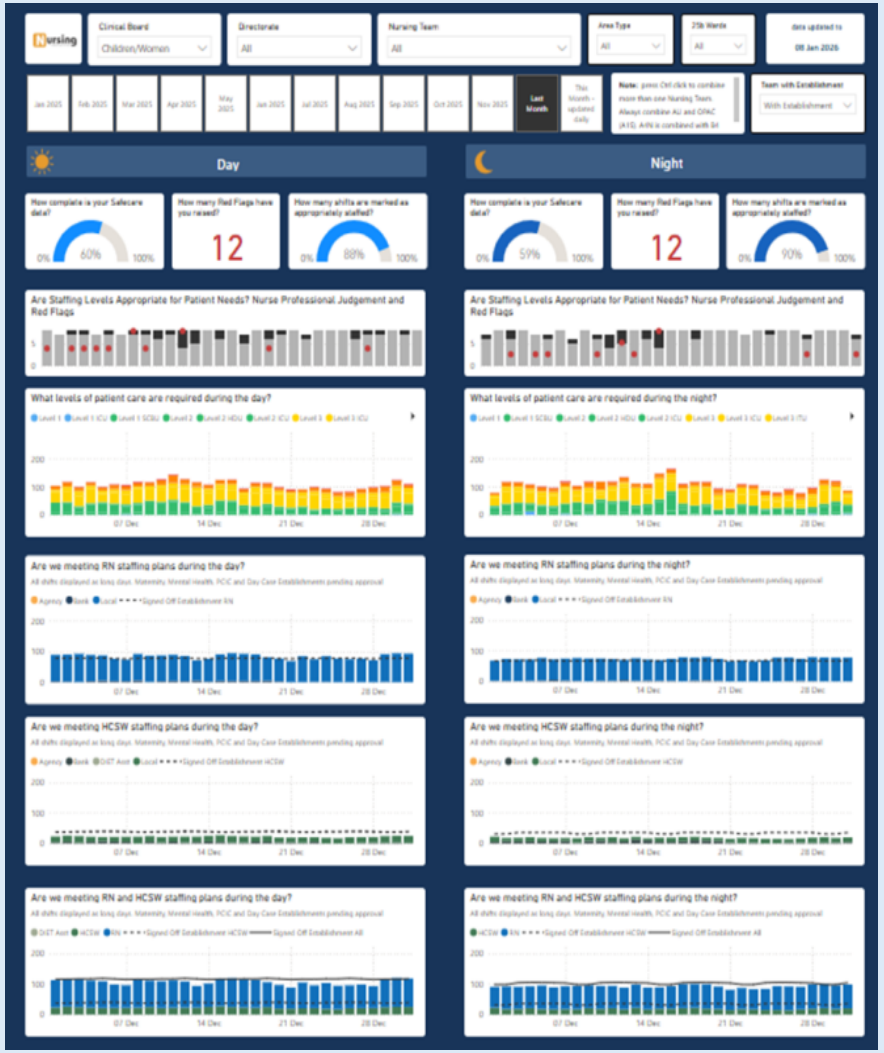
Pseudomonas aeruginosa Bacteraemia
Cases: 2 cases, down 33% from last year.
Target: 1 case over the reduction expectation (target was 1).
Trend: Some improvement, but still above target.

Klebsiella sp Bacteraemia
Cases: 2 cases, same as last year.
Target: 1 case over the reduction expectation (target was 1).
Trend: Stable but not meeting reduction goals.

Periods of Increased Incidence/Outbreaks
There are currently no ongoing outbreaks in the Women & Children Clinical Board.
MRSA screening (April 2024–January 2026) showed most cases were independent acquisitions (14), with smaller numbers linked to previous clusters or other MRSA types. Only 2 patients developed bacteraemia. No new cases have been identified since March 2025, and the last outbreak strain was seen in January 2025.
The MRSA outbreak on NICU was managed with deep cleaning, increased screening, improved hand hygiene, and equipment cleaning protocols. The outbreak was officially closed in April 2025. Alongside MRSA, there was a brief increase in MSSA on NICU, with three positive blood cultures and two positive eye swabs. Genomic analysis suggested some transmission, but no further actions were required. Also, an increase in C Diff, predominantly in Oncology which is being monitored.

Safe Care
Quality Audits & Performance





Tendable
Tendable is used across Children's and Women's Services to capture real-time data on quality, patient and staff experience, and the care environment. All inpatient, outpatient, and delivery areas use it for regular audits, supporting high compliance and continuous improvement. Teams complete monthly audits, and child health areas also gather monthly satisfaction feedback to resolve issues quickly.

Safe Care

Deteriorating Patient

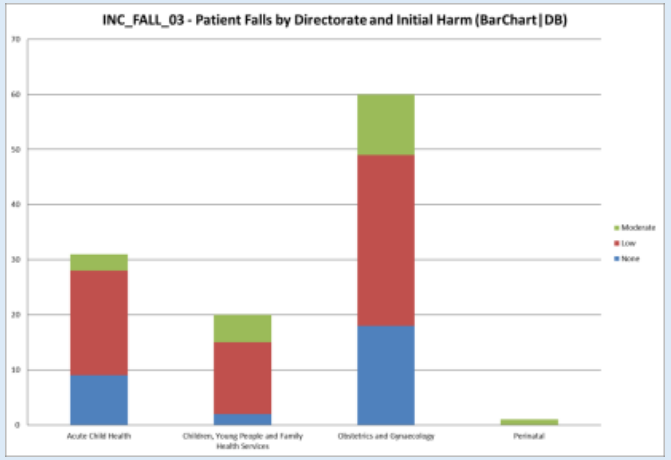
Acute Deterioration and Call4Concern

Over the last 12 months the clinical board has successfully implemented a number of early warning scores, Paediatric Early Warning Score in CHFW, NEWS 2, MEWS and NEWTT2 in Neonates. In addition to this Call4Concern has been rolled out in all areas to ensure patients or families are able to call for immediate help and advice if they are worried about deteriorating health.

Clinical Board representation on the UHB Acute Deterioration Project Group and a representation on the All-Wales Acute Deterioration Improvement Board.

Safe Care

Patient Falls
&
Pressure Damage



Falls

The graphs above demonstrates the number of falls reported for the period January 2024 – December 2025 and patient falls by initial harm.

There has been a decrease in the number of falls being reported in 2025 compared to that of 2024. There have been no incidents deemed to have caused severe harm, and no falls reported have been NRI reportable during this period.

Pressure and Tissue Damage, Reduction and Prevention

Extensive work has been conducted across the C&W Clinical Board, particularly within Acute Child Health Directorate, to strengthen the management of scrutiny of pressure damage. These efforts aim to reduce preventable pressure injuries and ensure that shared learning is effectively communicated.

The Acute Child Health Directorate, in partnership with the Tissue Viability Nurse, has established a Pressure Damage Scrutiny Panel to systemically review and assess all reported incidents. The panel evaluates whether each case was avoidable or unavoidable and determines appropriate follow up actions as necessary. This process is integrated with the Datix system to facilitate prompt review and action throughout the Directorate. Since its implementation, the scrutiny panel has contributed to a notable reduction in the number of reported pressure damage incidents.

	Pressure from medical device developed or worsened during care in this clinical care area/caseload	Pressure from medical device present before admission to this clinical care area/caseload	Pressure ulcer developed or worsened during care in this clinical care area/caseload	Pressure ulcer present before admission to this clinical care area/caseload	Total
Acute Child Health	23	6	56	13	98
Children, Young People and Family Health Services	1	1	10	8	20
Obstetrics and Gynaecology	2	1	29	12	44
Therapy Services	0	0	4	0	4
Total	26	8	99	33	166

Safe Care
Medication Safety

Medicines Management

Antimicrobial Stewardship
The CAV UHB antimicrobial stewardship (AMS) pharmacists have continued to provide quarterly reports to C&WCB, which have been discussed at the QSE committee meetings. These reports detail how antimicrobial agents are prescribed and used across the Clinical Board. They are based on the results of regular AMS audits completed by ward pharmacists, assessing compliance with good prescribing practices—such as documenting the indication for all antimicrobial prescriptions and prescribing in line with guidance or microbiology advice.

The most recent C&WCB report highlighted areas for improvement, particularly around documenting the intended duration of treatment and ensuring all antimicrobial prescriptions are reviewed after 72 hours of treatment.

There has been a successful antimicrobial weekly ward round piloted on Owl ward in the CHfW which has continued due to improvement. This is lead by an Antimicrobial Consultant and supported by the ward pharmacist.

The AMS pharmacy team has also led the development of a fluoroquinolone prescribing checklist, implemented across the UHB following the MHRA drug safety alert regarding patient information for these agents. The antimicrobial formulary has been reviewed to ensure fluoroquinolones only appear in guidance where no other effective agents are available. The checklist is accessible to all prescribers to ensure patients receive the appropriate information when these antibiotics are prescribed.

Electronic Prescribing and Medicines Administration (ePMA)
ePMA has been successfully rolled out to Gynaecology. CHfW and Maternity is planned for roll out in March 2026 with outpatients (including CYPF) going live later in the year.

It is anticipated that this will improve documentation for antimicrobial prescribing and significantly enhance data availability. The system will also provide us with much better data around prescribing, high risk medication supply and general trends in prescribing (good and bad). This will allow us to target areas to tackle and use our resource more effectively.

Effective Care

Mortality

Mortality & Morbidity

In the last 12 months we have reviewed and updated the Mortality and Morbidity process for all child deaths within Cardiff and Vale UHB. The new process aims to ensure timely, structured mortality reviews that promote learning, improve patient safety, and support governance. The new mortality and morbidity process sets out responsibilities, meeting structures, and reporting requirements, fostering a culture of transparency and continuous improvement.

The new processes.

- Ensure timely and structured reviews of all child and baby deaths, including rapid reviews within 72 hours.
- Ensures that a standardised MARF and DATIX is completed for all deaths.
- Support learning and improvement in patient care and safety by identifying avoidable deaths and systemic issues.
- Provides a framework for timely Child Health Mortality and Morbidity (M&M) meetings, which aim to review cases, share lessons, and foster a culture of learning rather than blame.
- Define roles and responsibilities of key personnel (e.g., Medical Examiner, Coroner) and outline reporting requirements to national bodies such as MBRRACE-UK.
- Promote standardised review processes through tools like the Perinatal Mortality Review Tool (PMRT) and ensure recommendations are implemented and monitored.

Effective Care

External Assurance

No HIW or LLAIS Inspections during this period

- Clinical Board actively participating in the All-Wales Maternity and Neonatal Assurance Assessment – final reported expected early 2026
- JACIE Inspection Report on Autologous Transplantation – expected Quarter 2 of 2026/27

Effective Care

Clinical Audit and Assurance

The Clinical Board continues to actively participate in a number of National Audit Programmes such as:

Epilepsy 12
RCPCH audit to improve in quality of care for children and young people with seizures and epilepsy in England and Wales.

Cardiff and Vale UHB has successfully completed this audit in full this year, following the appointment of a designated Consultant for Epilepsy Services.

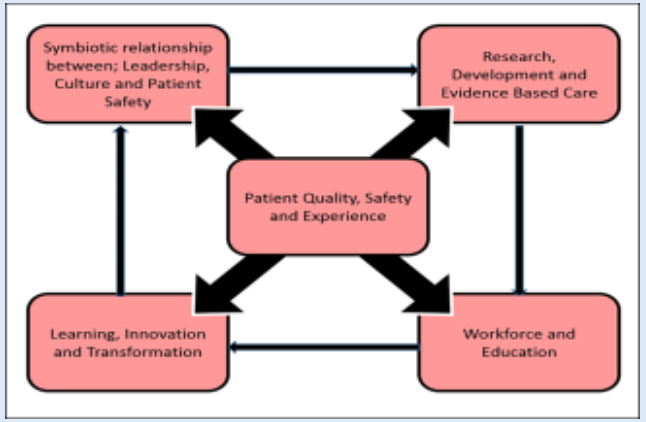
National Diabetes Audit
RCPCH audit which measures health outcomes and experiences, looking at incidence and prevalence, diabetes related outcomes and complications and the use of technologies

National Asthma Audit
RCPCH audit which the quality of care for children and young people (CYP) with asthma in hospital settings across England and Wales

NICU - NNAP, MBRRACE-UK and PMRT

Efficient Care

Workforce



Engaged, Healthy and Motivated Workforce

Whilst the links between Quality, Safety & Experience, and the four quadrants below are often assumed, there has been a significant amount of work undertaken to change the culture across the Clinical Board to make these links explicit. Below is some of the work that has been undertaken and remains ongoing:

Engagement:

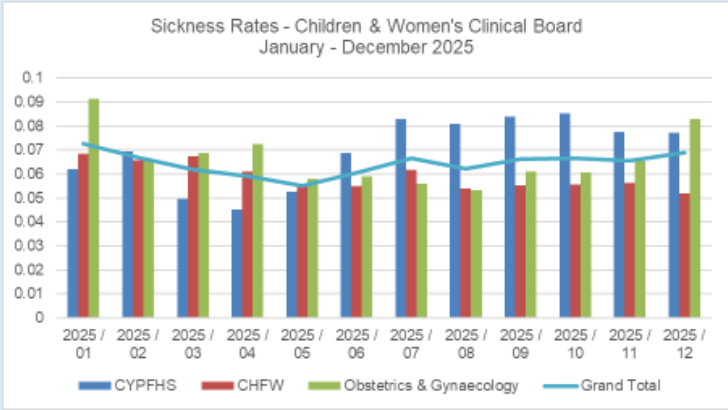
- Staff Newsletters/VLOG
- Establish Managers daily intentional check in rounds
- Inclusion Ambassadors for all 10 protected characteristics
- Workforce and Staff side walkarounds
- Established Internationally Educated Nurses forum
- Introduced Sustaining Resilience at Work Practitioners
- RCM Caring for You Charter Signed

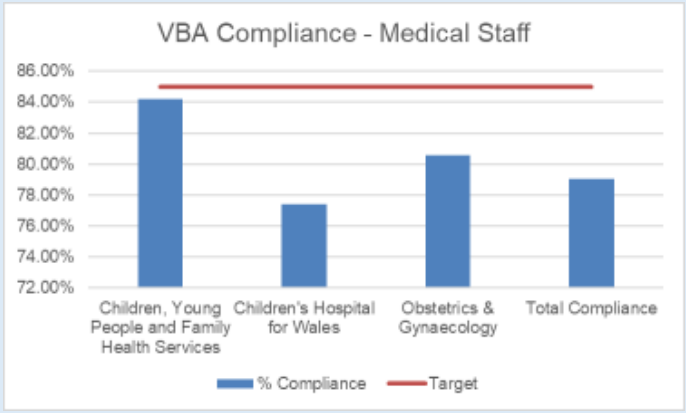
Leadership:

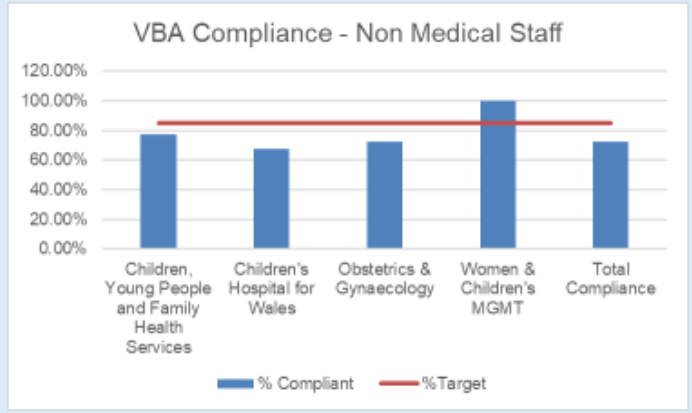
- Meet the Manager Days for new starters
- Senior Responsible Officer (SRO) for the Regional Partnership Board for ND Improvement
- Establish Weekly Listen and Learn Visits
- Senior Clinical Leadership attendance at every handover
- Several UHB Summits to establish organisational support and a base for ICCNS

The Clinical Board recognises that recruitment alone isn't enough to maintain our workforce. Alongside recruitment, efforts focus on improving staff retention and well-being through initiatives like wellbeing champions, psychological support, recognition awards, anonymous feedback via the Staff Voices App, resilience practitioners, newsletters, union collaboration, and tailored staff rotations for career development and relief.

Effective Care
Workforce







Sickness Absence

The Clinical Board, with People Services, has launched sickness scrutiny panels to help managers apply the attendance policy consistently. Key areas with high sickness include CCNS (12.75%), Cardiff Flying Start (11.40%), Child Psychology (9.18%), and Administration (8.38%).

Sickness Actions:

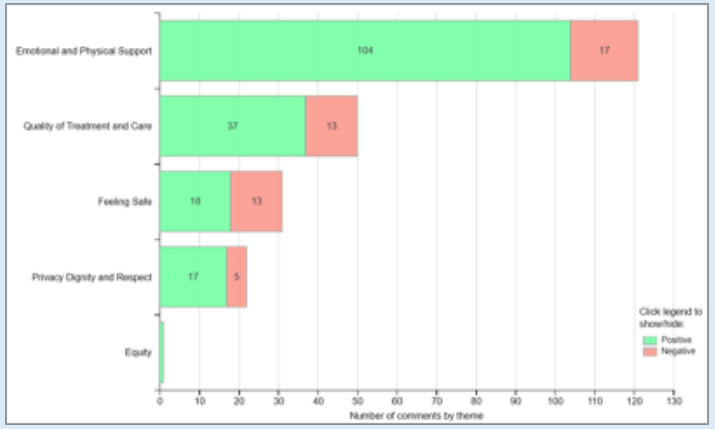
- Focus on hotspots by reviewing HCSW sickness causes, noting 40% relate to stress and anxiety.
- Provide sickness management workshops and enhance Occupational Health support.
- Offer manager training, including Occupational Health referral guidance.
- Engage staff on stress-related absences to improve support.
- Consolidate wellbeing resources into one accessible document.

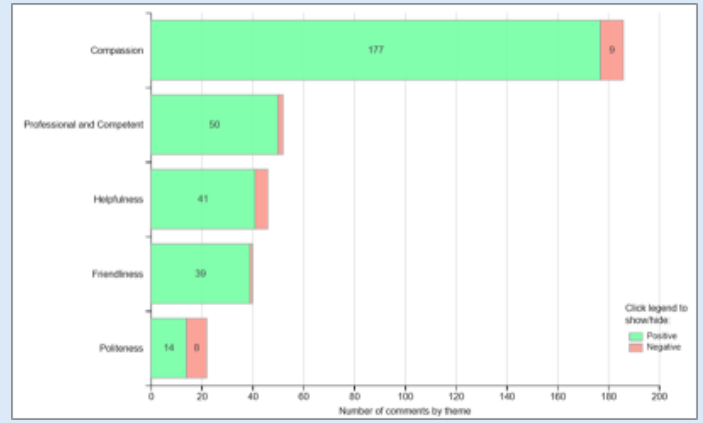
Values Based Appraisals

Congruent with the Clinical Boards belief that the workforce is our most important asset, we have made significant progress in ensuring our Staff have an Annual Value Based Appraisal, progress toward which is described in the graphs above

Patient Centred Care

Patient Experience





The graphs above demonstrate patient feedback from the CIVICA Once for Wales Patient Experience Platform with a focus on the themes of clinical service quality and staff attitude and capability for Maternity and Gynaecology Services. Further work is being taken forward with the Patient Experience Team to look at further options for gathering patient feedback within paediatrics through CIVICA.

Overall satisfaction scores based on those patients who have responded to the surveys under the care of Children and Women's Clinical Board and who were discharged between 1st June - 31st December 2025 is consistently at 85% and above.

Below is general information on number of SMS sent, returns, response and overall satisfaction for those respondents who answered the PES rating question: How would you rate your overall experience? This is based on those patients under the care of Children and Women's Clinical Board and who were discharged between 1st June - 31st December 2025.

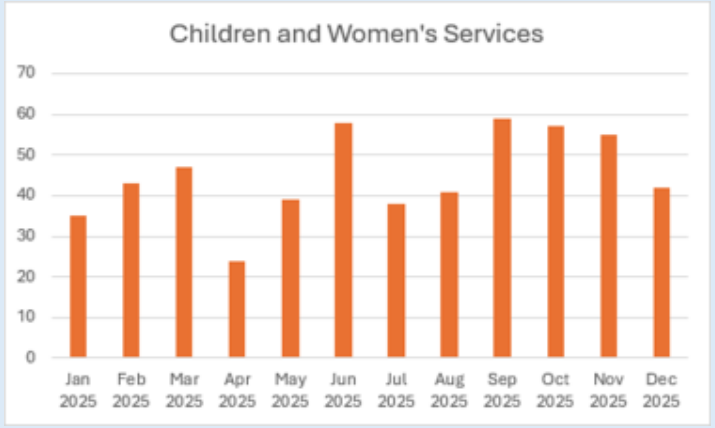
- SMS sent: 8403
- Survey completions (partial/full): 1108
- Response: 13%
- Satisfaction score: 85%

Patient Experience Workstreams

- All maternity and paediatric surveys are ready in the Civica platform, available in English and Welsh, with plans for more languages. Maternity Phase 1 surveying has started, while later phases and neonatal surveys are being developed and will launch once technical work is complete.
- Paediatric surveys (for children and parents) are also ready, with area-specific resources being distributed soon to enable feedback collection.
- Weekly feedback reports will be provided for both workstreams.
- Work is also underway to restart surveys for patients with learning difficulties, using previously developed tools

Patient Centred Care

Concerns



Concerns

The Clinical Board received a total number of 510 concerns over the period of January – December 2025. 442 of these concerns being managed via the formal Putting Things Right Process, and 68 being managed via early resolutions.

The Clinical Board has seen a significant increase in the number of concerns being received overall, with a bigger percentage now being managed through the early resolution process. Some specific hotspot areas being Neuro Development waiting times and Gynaecology Inpatient/Daycase Waiting times.

Equitable Care

Key issues being considered by the Clinical Board:

- Neurodevelopment Redesign
- Starting Well Project Board to address inequalities
- Learning Disability Summits to confirm UHB governance and service delivery framework. Work ongoing to improve annual health checks
- Children Looked After (CLA) Service Redesign
- Reintegration of safeguarding posts into CYPF to improve quality and safety for SCPHN
- Paediatric Endoscopy improvement work
- Free birthing – Women's Choice

THEATRES TOGETHER

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Cardiff and Vale University Health Board

WHO Collaborative

January 2026

Clare Wade and Abrie Theron

Findings

9.2 During the review period, the reviewers were informed of several Nationally Reportable Incidents (NRIs) that occurred in the Main Theatres Upper. Recognising the influence of culture on team collaboration and patient safety, the reviewers requested the patient safety team to summarise the themes from these incidents for consideration as part of the review.

9.2.1 The effectiveness of adhering to the 'WHO Checklist' at all stages and determining who is responsible for its completion was questioned in several incidents.

9.2.2 Reviewers learned from colleagues that application of policies and procedures frequently change, causing confusion and non-compliance. For instance, patients sometimes leave the ward without a signed consent form or a current pregnancy test. During the review, two incidents occurred where patients went to theatre without a signed consent form.

9.2.3 Several NRIs highlighted insufficient challenging of poor practices within the theatre environment. It was noted that a lack of leadership in motivating staff to address suboptimal practices, while not directly contributing to patient incidents, was identified during investigations.

WHO COLLABORATIVE

THEATRES TOGETHER

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Recommendations

8a Audit adherence to policies and procedures for consent and 'WHO Checklist', ensure standardised application across all theatres and provide update training as required.

8k The cultural and leadership work will help to strengthen the team to feel safe and empowered to speak up and challenge where policies and procedures are not followed

WHO COLLABORATIVE

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5 meetings in last 6 months – Great perioperative care and Anaesthetic engagement

In partnership with the perioperative team , anaesthetists and surgeons the WHO have developed a set of principles that must be adhered to, that support a standardised WHO checklist process.

We have developed the required systems and processes to ensure adherence with the WHO checklist and to provide the correct resources to support adherence.

We have verbalised the expectations as widely as possible across the Health Board across as many staff groups as possible

Carried out 2 audits of compliance with required systems and processes with the support of the patient safety team

WHO COLLABORATIVE PRINCIPLES

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On Thursday 1st May 2025 a WHO checklist collaborative comprising clinicians from across the Health Board met to understand the reasons for the deviation from the WHO checklist process and to consider ways of improving compliance. The Health Board's policy clearly sets out the required standard, but several actions that further reinforce the 5 steps of the policy were agreed by the collaborative and are fully endorsed by the Executive Team. These include:

1. Team Brief: The first patient on the list must not be brought into the anaesthetic room, theatre or procedure room until a detailed team brief of all patients for the session has been completed. All members of the team assigned to the list must be present.

2. Sign In: must be undertaken by the anaesthetist and the anaesthetic practitioner together in theatre. In other areas 2 members of the team should be identified to complete sign in. During sign in, valid consent must be confirmed (correct form, correctly completed, signed, dated). Both must sign the checklist.

3. Time Out: must take place before any procedure starts and the scrub practitioner / assistant must not hand a surgical instrument to any member of the operating team until the Time Out is completed

4. Sign Out: must be completed by the whole operating team before any member of the operating team leaves the theatre or procedure room. This should include the question if a debrief is indicated.

5. Debrief: If any member of the operating team has expressed the desire for a debrief to appraise aspects of the list that have gone well or areas that can be improved, a debrief should take place at the end of the session. This must be attended by the whole team. Consideration should be given for the completion of a GREATIX or a DATIX to cascade the learning.

<u>These standards must be implemented with immediate effect in all areas</u>

Simplicity is best

THEATRES TOGETHER

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SIGN IN CONFIRMATION TIME.....
ANAESTHETIST SIGNATURE
.....
ANAESTHETIC PRAC SIGNATURE
.....

TIME OUT CONFIRMATION
NAME OF PERSON CONDUCTING
TIME OUT .....
SIGNATURE.....
TIME

Have all team members confirmed surgery can be commenced? No ☐ Yes ☐

SIGN OUT CONFIRMATION TIME.....
ANAESTHETIST SIGN.....
SCRUB PRAC SIGN.....
SURGEON SIGN.....

Audit of WHO Sticker Compliance X1 - 25 set of notes

- **Audit Results:**
  - **Sign In:** 72% fully compliant (both anaesthetic practitioner and anaesthetist signed)
  - **Time Out:** 100% compliance; all cases had documented stickers.
  - **Sign Out:** 52% fully compliant; missing signatures (mainly anaesthetist and surgeon) in about 1 in 4 cases
- **Themes:**
  - Stickers are being used, but dual/ team signatures are inconsistent, especially at sign out.
  - Time out is consistently documented, usually led by theatre practitioners.
  - Main gaps are surgeon and anaesthetist signatures at sign out, often due to workflow pressures (e.g., surgeons leaving to write notes).

2. Team Feedback

- **General Agreement:**
  - Audit reflects real practice; similar findings in previous audits.
  - Surgeons and anaesthetists are often present but may forget to sign.
  - Responsibility for chasing signatures often falls to anaesthetic practitioners and scrub staff.
  - Are we auditing sticker usage rather than WHO checklist usage
- **Suggestions:**
- one signature per stage, with the signer listing who was present, rather than chasing multiple signatures. Reaudit with larger number of notes

Audit results

Audit 2 of WHO Sticker Compliance X2 -85- sets of notes UHW site (including CHfW)

Audit Results: 2 examples of where WHO was not seen in notes both looked at in more detail – 1 l misfiled / 2nd was a local anaesthetic case not occurred in theatre (but should have had a LOCCSIP)

- **Themes:**
  - Stickers are consistently being used, but dual/ team signatures are inconsistent, especially at sign out.
  - Time out is consistently documented, usually led by scrub practitioners.
  - Main gaps are surgeon and anaesthetist signatures at sign out, often due to workflow pressures (e.g., surgeons leaving to write notes).

2. Team Feedback

- Audit reflects real practice; similar findings in previous audit and has become and of audit of sticker usage rather than practice
- Surgeons and anaesthetists are present but may not sign
- Responsibility for chasing signatures often falls to anaesthetic practitioners and scrub staff.
- Clinical teams feedback that WHO checklist is talking place and all staff feel more supportive

- **Suggestions:**
- One signature per stage, with the signer listing who was present – agreed by WHO Collaborative on 6th November
- Do we do an audit of how staff feel support wise and on staff feedback on the safety culture?

CHECKLIST REDESIGN

THEATRES TOGETHER

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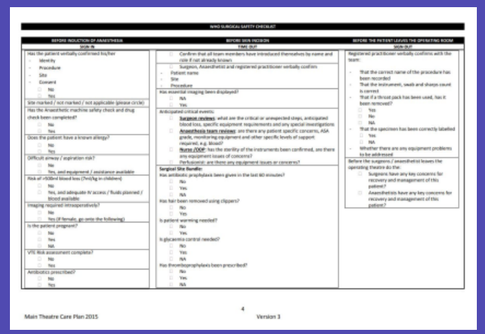
Progress so far

- Interactive in person Workshop held on the 6th November - good attendance from periop team and anaesthetics
- Attendees - split into 3 groups to look at sign in / time out and Sign out
- Each group focused on area most relevant to their expertise
- Plan to simplify the checklist as there have been many add ons over the year – Back to basics approach
- Aim to add any additional extras to the team brief board rather than the checklist



TEAM BRIEF WHITE BOARD DESIGN

THEATRES TOGETHER

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Progress so far

- Draft co- designed in workshop on the 6th November
  - Standardised white board for all theatre suites (based on a successful initiate in Aneurin Bevan)
  - Decision to stick with White boards rather than design Aqua and electronic screens

DATE / / **OPERATING THEATRE TEAM BRIEF** THEATRE

SURGEON		ANAES PRAC		OTHER STAFF PRESENT	
SURGEON		SCRUB PRAC			
SURGEON		SCRUB PRAC			
ANAESTHETIST		SCRUB PRAC			
ANAESTHETIST		CIRCULATING PRAC			
ANAESTHETIST		CIRCULATING PRAC			

THEATRE PREP

ANAES MACHINE CHECK
THEATRE CHECKS
PLANNED BREAKS
EDUCATIONAL OBJECTIVES

PATIENT INITIALS					
Procedure					
Ward / Post-Op Bed Available					
Consent Signed					
Operative Site Marked					
Allergies					
Blood Glucose Monitoring Needed					
Infection Risk					
ASA / Relevant Comorbidities					
Anaesthetic Plan / Equipment					
Surgical Plan / Equipment					
Surgical Positioning					
Local Anaesthetic Dose					
Implants Available					
Imaging Required					
Investigations / Pregnancy Test					
Antibiotics					
Thromboprophylaxis					
Group & Screen					
Cell Salvage / TXA Required					
Comments					

THEATRES TOGETHER

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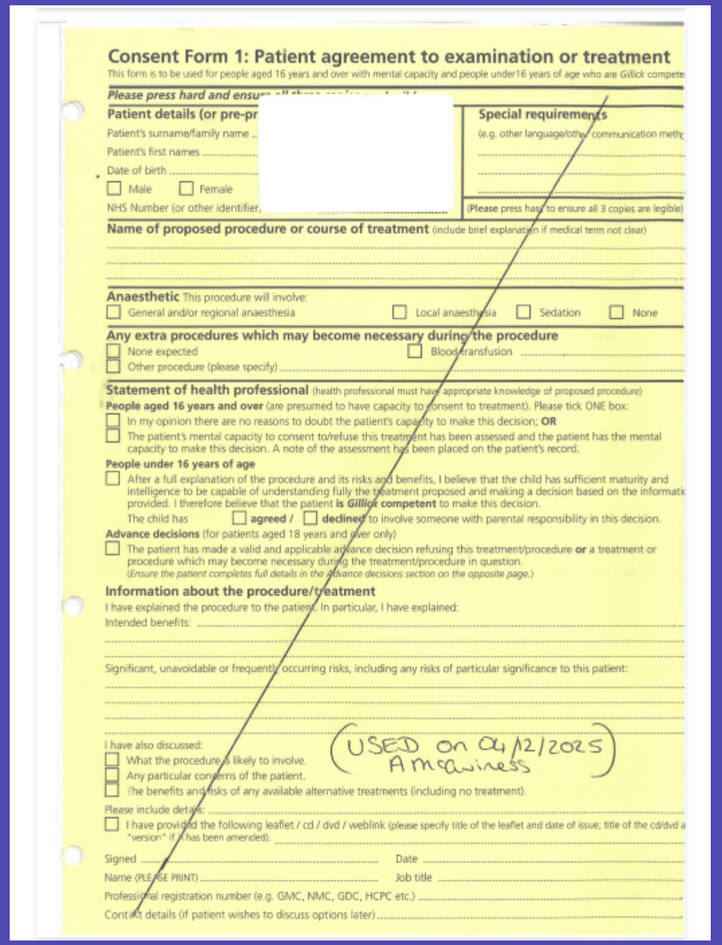
CONSENT

Method for highlighting that a consent form has been used - agreed with legal and risk yesterday - form to be crossed out and dated/ signed with the word **used**



Consent Form 1: Patient agreement to examination or treatment

This form is to be used for people aged 16 years and over with mental capacity and people under16 years of age who are *Gillick* competent

Please press hard and ensure all three copies are legible

Patient details (or pre-printed label)

Patient's surname/family name

Patient's first names

Date of birth

☐ Male ☐ Female

NHS Number (or other identifier, if used)

Special requirements

(e.g. other language/other communication method)

(Please press hard to ensure all 3 copies are legible)

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear)

Anaesthetic This procedure will involve:

☐ General and/or regional anaesthesia ☐ Local anaesthesia ☐ Sedation ☐ None

Any extra procedures which may become necessary during the procedure

☐ None expected ☐ Blood transfusion

☐ Other procedure (please specify)

Statement of health professional (health professional must have appropriate knowledge of proposed procedure)

People aged 16 years and over (are presumed to have capacity to consent to treatment). Please tick ONE box:

☐ In my opinion there are no reasons to doubt the patient's capacity to make this decision; **OR**

☐ The patient's mental capacity to consent to/refuse this treatment has been assessed and the patient has the mental capacity to make this decision. A note of the assessment has been placed on the patient's record.

People under 16 years of age

☐ After a full explanation of the procedure and its risks and benefits, I believe that the child has sufficient maturity and intelligence to be capable of understanding fully the treatment proposed and making a decision based on the information provided. I therefore believe that the patient is ***Gillick* competent** to make this decision.

The child has ☐ **agreed** / ☐ **declined** to involve someone with parental responsibility in this decision.

Advance decisions (for patients aged 18 years and over only)

☐ The patient has made a valid and applicable advance decision refusing this treatment/procedure **or** a treatment or procedure which may become necessary during the treatment/procedure in question.

(Ensure the patient completes full details in the advance decisions section on the opposite page.)

Information about the procedure/treatment

I have explained the procedure to the patient. In particular, I have explained:

Intended benefits:

Significant, unavoidable or frequently occurring risks, including any risks of particular significance to this patient:

I have also discussed:

(USED on 04/12/2025 AM awiness)

☐ What the procedure is likely to involve.

☐ Any particular concerns of the patient.

☐ The benefits and risks of any available alternative treatments (including no treatment).

Please include details:

☐ I have provided the following leaflet / cd / dvd / weblink (please specify title of the leaflet and date of issue; title of the cd/dvd and "version" if it has been amended):

Signed Date

Name (PLEASE PRINT) Job title

Professional registration number (e.g. GMC, NMC, GDC, HCPC etc.)

Contact details (if patient wishes to discuss options later)

Future Workstreams

- **Aqua**

Plan for future functionality of Aqua to integrate WHO

- **Scan for Safety**

Functionality of National joint registry and scan for safety to integrate into Aqua

- **Safety Culture**

How do we expand of safety culture theatres- how do we change to a listening culture ? – based on recent Never Event? How are all voices heard?

External Audit

Objectives of the area under review:

- Effective governance arrangements are in place which ensure the implementation of the Five Steps to Safer Surgery including appropriate procedures;
- Systems and processes are in place at an operational level, on a day-to-day basis which ensure that all stages within the Five Steps to Safer Surgery are being undertaken throughout the Health Board; and
- Monitoring and reporting processes are in place which provide adequate and timely assurance that the Five Steps to Safer Surgery are being utilised effectively and on a consistent basis throughout the Health Board

Approach

- The work to be undertaken as part of this review will include: ·
- Meeting with key personnel within the clinical service areas to obtain an overview of the systems and processes in place; · Ascertaining the level of operational compliance to the checklist via sampling patients records and attending theatre sessions; and ·
- Determining the measures in place to monitor compliance and escalate issues surrounding the five steps to safer surgery checklist

Cyber Security

Final Internal Audit Report

2025/26

Cardiff and Vale University Health Board

Limited Assurance

Contents

Executive Summary **1**

Findings & Agreed Action Plan **4**

Appendix A **11**

Review Reference	CVU-2425-04
Fieldwork	May - July 2025
Executive Sign Off	August 2025
Audit Committee	September 2025
Executive Lead	David Thomas, Director of Digital & Health Intelligence
Audit Team	Ian Virgill, Head of Internal Audit
	Martyn Lewis, IT Audit Manager

GIG CYMRU NHS WALES

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Executive Summary

Purpose

Review how the Health Board is working to improve its cyber security position and the processes in place for monitoring compliance and providing assurance that the risks are appropriately stated in line with the risk appetite.

Overview

We have concluded limited assurance on this area. While cyber risks are formally recognised at the corporate level, key weaknesses in governance, communication, and risk management limit the organisation's ability to manage cyber security effectively. Despite having devolved IT responsibilities across the organisation, there are limited formal communication channels between the cyber team and the asset owners of an estimated 300 critical systems.

Progress in areas such as Security Incident and Event Monitoring (SIEM) implementation, vulnerability scanning and a new secure web gateway is helping to improve cyber security visibility across the organisation. This is particularly important given the scale of the organisation, which employs around 17,000 people and spends approximately £1.4 billion each year. However, the Cyber Security Team currently faces capacity challenges, with two vacancies limiting their ability to complete wider objectives. As a result, their focus remains on business-as-usual operations and maintaining the continuity of critical services.

The significant matters requiring management attention include:

- The cyber security risk register lacks important information and is not regularly updated with actions being taken.
- There is inconsistent cyber security risk awareness across the organisation.
- Although there is devolved responsibility for IM&T within Clinical Boards, there is limited feed in from Clinical Boards into the digital and cyber governance structures. We also note a lack of complete Information Asset Register resulting in a single point of failure in the cyber team.
- The Cyber Improvement does not cover the cyber needs of the whole organisation.

The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

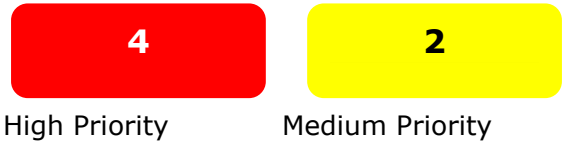
- The Terms of Reference (ToR) for both the Cyber Security Sub-group and the Technical and Cyber Group should be reviewed and refreshed as they both currently say they report into the Cyber Security Sub-group.
- Whilst there is a key finding regarding the cyber risk register included, closed risks with a high residual risk score should be reviewed and reopened on the risk register if appropriate.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	The risks associated with cyber security are appropriately stated, recorded, understood and managed within the organisations risk appetite.	1, 2, 3	**Limited**
2	An appropriate governance process for cyber security across the organisation is in place which enables monitoring, reporting and effective management.	4, 5	**Limited**
3	Identified actions to improve cyber security are progressed appropriately.	6	**Reasonable**

Management Actions



Themes

Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Cyber security questionnaire summary of responses

As part of our fieldwork, we distributed a questionnaire to Board members, Clinical Board Management Teams and a sample of directors. It was sent to 43 staff members in total, and we received a total of 16 responses.

The aim of the questionnaire was to assess the organisation's awareness, understanding, and appetite for cyber security risks.

Below is a summary of the responses to the questions for which we can provide a qualitative analysis.

What is the best description of your current role?	Number of responses
Board Member	3
Clinical Board Director	3
Executive	5
Independent Member	1
Operational Manager	4
Total	**16**

Cyber security updates

Do you regularly receive updates on cyber security risks and incidents during board meetings?
Do you regularly receive updates on cyber security risks and incidents during any other committee meetings?
Do you receive cyber security updates at any other meetings?

- **3/3** Board Members answered 'Yes' to at least one of the questions above.
- **5/5** Executives answered 'Yes' to at least one of the questions above.
- **1/1** Independent Members answered 'Yes' to at least one of the questions above.
- **0/3** Clinical Board Directors answered 'Yes' to at least one of the questions above.
- **1/4** Operational Managers answered 'Yes' to at least one of the questions above.

Cybersecurity risks and actions to mitigate the risks

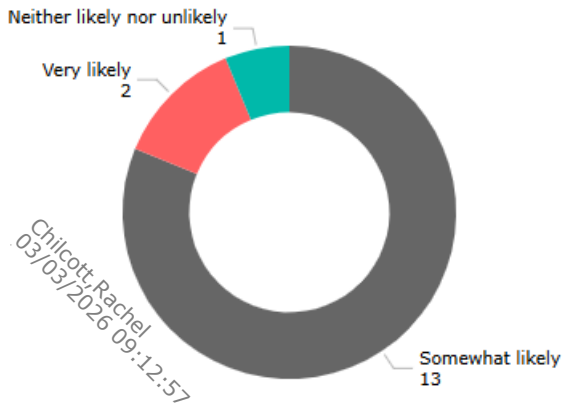
Have you seen cyber security risks on a risk register?
Are you aware of any actions being taken to reduce the current cyber security risk to its target level, or a cyber improvement plan?

- **3/3** Board Members answered 'Yes' to at least one of the questions above.
- **5/5** Executives answered 'Yes' to at least one of the questions above.
- **1/1** Independent Members answered 'Yes' to at least one of the questions above.
- **0/3** Clinical Board Directors answered 'Yes' to at least one of the questions above.
- **1/4** Operational Managers answered 'Yes' to at least one of the questions above.

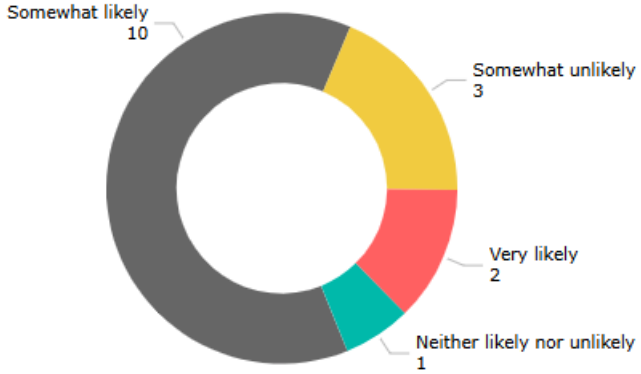
What do you think are the most significant cyber weaknesses for the organisation?

75% of responses to this question highlighted people/ individuals or emails/phishing as the most significant cyber weakness for the organisation.

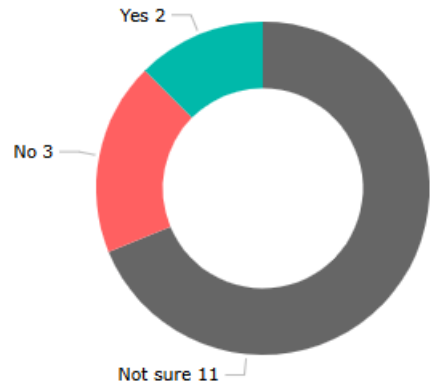
How likely do you think it is that the organisation will suffer a moderate cyber security incident?



How likely do you think it is that the organisation will suffer a serious cyber security incident?



Do you think the current level of cyber risk is acceptable for the organisation?



Findings & Agreed Action Plan

Objective 1: The risks associated with cyber security are appropriately stated, recorded, understood and managed within the organisations risk appetite.	**Limited**

Overview / Summary of Observations

The Cyber Security Team oversees cyber security across the organisation, and is responsible for identifying, assessing, and monitoring cyber security risks. The team maintains a cyber security risk register, which at the time of the audit, contained 85 open risks. The register was maintained in an Excel spreadsheet, with plans to migrate it to AMaT at the early stages of implementation.

We note weaknesses with the cyber risk register, with key information missing such as risk owners, target dates and actions undertaken or planned. During our audit, 58% of the 85 open risks on the register had a risk evaluation of 'Tolerate'. However, there was no narrative recorded for why this decision was made and we were informed that these decisions would be made within the Cyber Security Team and would not be escalated or reported to the Digital and Infrastructure Committee (DIC) for consideration.

Our testing confirmed that the closure of risks were appropriate following completed actions, however we noted one risk with a "High" residual risk was closed and not currently reported or noted as 'Tolerate'.

Cyber security risks are appropriately recognised at the corporate level, with a consolidated risk recorded on both the Corporate Risk Register (CRR) and the Corporate Digital Risk Register (CDRR) which is regularly reported to the Digital and Infrastructure Committee (DIC). However, the minutes for DIC do not show active scrutiny or challenge of the risk register, and there are no meeting notes for the Cyber Security Sub-Group which would demonstrate active review. In addition, although a risk appetite framework exists, its practical application is inconsistent and there is no risk appetite score recorded on any of the risk registers referenced.

As part of our audit, we shared a questionnaire with Board members, Clinical Board Management Teams and a sample of directors (43 staff in total were sent the questionnaire, with 16 responses). Whilst Board members and executive leadership reported receiving regular updates on cyber security, Clinical Board Management Teams reported a lack of visibility of cyber risks, incidents, and mitigation plans in their responses. This gap in awareness presents a risk, given the devolved nature of IT responsibility in the organisation, and it may hinder local risk identification and response in the Clinical Boards. Additionally, we observed limited communication and reporting between the Cyber Security Team and Clinical Boards, as well as minimal Clinical Board representation at the Digital and Infrastructure Committee (as highlighted in Key Finding 4) which further highlighted the disconnect in cyber risk awareness between the central Cyber Security Team and Clinical Boards.

As such, we note a structural weakness in terms of the management of cyber risk management. The Cyber Security Team maintains the central cyber risk register, however this only includes risks of which they are aware. Due to the decentralised management of IT systems- approximately 300 critical systems across the organisation -the Cyber Security Team do not have the resource to be able provide full oversight and management of the cyber risks associated with all these systems. Responses to the questionnaire and follow-up discussions identified that Clinical Boards do not currently record cyber security risks on their local risk registers, despite being responsible for managing their own IT systems. As such cyber risks within Clinical Boards may not be appropriately identified, monitored or reported.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Cyber security risk register** The Cyber Security Risk Register (or Information Systems Security Risk Register as the document is titled) lacks important information such as: • Dates of when the risk was added to the register or target dates for completion • Named responsible individuals • Actions taken or planned to treat the risk • It is not clear when updates on progress to treat risks were added, and some risks don't have this information at all. • There is no narrative for why a risk will be tolerated and the decision process behind this is not recorded or escalated. • Some risk descriptions do not describe what could happen, why it would happen or what the impact could be. Whilst it is recognised that the plan to migrate the risk register to AMaT has now begun, this will not resolve the issues of missing or incomplete information and work will be required to address the gaps highlighted during the migration.	Risks are not being managed appropriately **High Priority**	**Agreed Action:** All high risks have now been migrated onto AMaT which is a specific risk management platform. There are mandatory fields that require information therefore all entries will be fully completed. Medium and low risks and any new risks, will be recorded on AMaT, which will then form the basis of our cyber improvement plan, which will concentrate on those highest risks. **Expected Evidence of Implementation:** Risk register outputs from AMaT. **Officer:** Head of Information Governance & Cyber Security **Target Implementation Date:** 31st October 2025
	Theme: Risk Management	Control Operation	
2	**Inconsistent cyber security risk awareness across the organisation** Responses to our questionnaire showed that there is a disparity in cyber security awareness and oversight between the Board and Clinical Board Management Teams. Whilst Board members and Executive leadership receive regular updates on cyber security risks and incidents, are aware of mitigation actions and have seen the cyber risk on the Corporate Risk Register - Clinical Board Management Teams do not appear to receive the same level of information. This inconsistency suggests a communication gap that may hinder the Clinical Boards' ability to effectively understand and respond to cyber security threats, and with devolved	Limited visibility at the operational level, despite devolved IT responsibilities, increases the risk of unmanaged threats, inconsistent responses, and reduced organisational resilience.	**Agreed Action:** Engagement with the Clinical Boards management will be implemented via the Strategic Leadership Team (SLT) initially, to raise awareness and provide information on what each CB management team should be sharing in identifying and logging any cyber related risks. This is especially important where shadow IT arrangements exist. We will ensure that Cyber have visibility of CB risks, and vice versa for any other relevant risks.

	responsibility for IT in the organisation this poses a risk. It is recognised that the Cyber Security Team have a dedicated SharePoint page that provides advice and updates, however more targeted updates may be required to the Clinical Boards and wider services.		**Expected Evidence of Implementation:** Presentation to SLT jointly with DD&HI and COO to raise awareness and inform of cyber risk management process.
		High Priority	**Officer:** Director of Digital & Health Intelligence/SIRO **Target Implementation Date:** 31st October 2025
	Theme: Communication & Engagement	Control Operation	
3	**Cyber security risk management across the Clinical Boards** Responses to our questionnaire and follow-up communications highlighted a gap in cyber risk management within the Clinical Boards. Although these teams are responsible for their own IT systems, they are not consistently identifying, assessing or managing their own cyber security risks. While there is a centralised cyber security structure within the organisation that is headed up by the Cyber Security Team; there is devolved IT responsibility. So, while the Cyber Security Team manages the cyber security risk register, this will only include risks that they are directly aware of. However, Clinical Boards do not currently record cyber security risks on their local risk registers, despite being responsible for managing their own IT systems. As such cyber risks within Clinical Boards may not be appropriately identified, monitored or reported.	There is the risk that cyber security risks in the Clinical Boards are not being identified, assessed or monitored due to lack of oversight and awareness and communication.	**Agreed Action:** Engagement with Clinical Boards management teams, initially via the SLT to raise awareness and agree a process for identifying and capturing local cyber or IT security risks in a consistent manner and that that CB service leads fully understand and own these risks. These cyber risks will be monitored centrally via AMaT to ensure that they are managed appropriately and owned by the CBs and the SIRO can take assurance that such risks are fully identified and assessed. Cyber risk ownership policy will need to support CBs help understand roles and responsibilities.
			Expected Evidence of Implementation: Clinical Boards' risk registers contain relevant cyber risks and these are shared with the central Cyber team. Guidance and support to be provided Cyber Security Department.
		High Priority	**Officer:** Director of Digital & Health Intelligence/SIRO (with support from Cyber Department) **Target Implementation Date:** 30th November 2025
	Theme: Risk Management	Control Operation	

Objective 2: An appropriate governance process for cyber security across the organisation is in place which enables monitoring, reporting and effective management.	**Limited**

Overview / Summary of Observations

There is a clear governance framework in place, with reporting from the Cyber Security Team to the Digital and Infrastructure Committee and onto the Board. Cyber security governance is centralised under a small, formally structured cyber team of 5 staff (including the Head of Information Governance and Cyber Security), which currently operates with limited capacity due to two vacancies. As a result, the team focuses primarily on business-as-usual and critical service continuity tasks. The team cover cyber security for the whole organisation, which employs around 17,000 people and spends approximately £1.4 billion each year. The Information Governance and Cyber Team's total spend in 2024/25 was 4% of the digital spend for the organisation, and 0.04% of the total organisation spend of £1.4 billion, by month three of 2025/26 the Information Governance and Cyber Team's total spend had decreased to 3% of the digital spend in the same period. Whilst the team cover cyber security for the whole organisation, there is devolved responsibility for IT systems throughout the organisation and with the Senior Information Risk Owner (SIRO) not having managerial responsibility within Clinical Boards, we were informed that the Clinical Boards did not always action requests made by the Cyber Security Team in a timely manner.

We note that there are limited formal communication channels between the cyber team and the asset owners of the approximately 300 critical systems, as such the cyber team cannot be assured that they have oversight of the governance of locally controlled digital systems within the Health Board. This lack of structured engagement is likely to be a contributing factor to low cyber awareness and limited visibility of cyber risks among Clinical Boards and services, which was highlighted in the responses to the questionnaire we shared.

We further note the absence of a complete Information Asset Register (or critical system asset register). This means there is no full visibility of all systems in place, their individual owners and any weaknesses of the systems across the organisation. Consequently, the Cyber Security Team are unable to identify all critical system owners in the organisation and system ownership knowledge is reliant on a single individual, due to their experience and contacts within the organisation, this creates a single point of failure.

Progress in areas such as Security Incident and Event Monitoring (SIEM) implementation, vulnerability scanning and a new secure web gateway is improving cyber security visibility across the organisation, and there is a cyber security intranet page containing guidance, supporting documents, training resources and contact information for the Cyber Security Team. It is also evident from our fieldwork that phishing simulation campaigns are being performed regularly, and cyber training is mandated throughout the organisation (as part of the Information Governance module) - although the completion rate in May 2025 for this training was well below the 85% target, at 70%, being as low as 59% in one Clinical Board and as high as 85% in another.

Cyber security is a standing item at the private session of the DIC, where updates are provided on key areas such as the cyber risk register, cyber improvement plan, cyber security KPIs (that include: updates on legacy systems, end point devices, phishing campaigns and training figures), reported cyber incidents and updates on any completed audits. The chair of the committee also provides regular updates to the Board.

We note however that there is limited representation from Clinical Boards at the DIC. This lack of engagement hinders the flow of information and may reduce the effectiveness of cyber risk oversight across the organisation.

Supporting groups such as the Cyber Security Sub-Group and the Technical and Cyber Group exist, with the sub-group providing assurance to the DIC. The Cyber Security Sub-Group meets monthly and plays a key role in reviewing the cyber risk register and conducting risk assessments for critical systems. However, no formal minutes are taken at these meetings, which limits transparency and weakens governance. This issue was previously raised in a 2022/23 internal audit and remains unresolved.

	Key Findings	Risk & Impact	Agreed Management Action
4	**Cyber security governance gaps and communication challenges** • There are inadequate communication channels between the Cyber Security Team and asset owners within the Clinical Boards. • Representatives from the Clinical Boards do not consistently attend the Digital and Infrastructure Committee meetings, nor do they contribute to the cyber security updates presented to the committee. • The organisation's Information Asset Register (IAR) is incomplete. As a result, the Cyber Security Team lacks full visibility of systems, risks and their respective asset owners. • There is a single point of failure due to there being no communication channels or an IAR, as knowledge of asset ownership is heavily reliant on the personal experience of the Head of Information Governance and Cyber Security.	Incomplete oversight, as the cyber team cannot verify the cyber security risks of all systems. Single point of failure with only one member of staff knowing how to contact system owners if a cyber event occurs.	**Agreed Action:** Presentation to SLT which includes the management teams from each Clinical Board to make them aware of requirements of asset owners in relation to managing cyber risks specifically. Information Asset Registers to be completed and shared centrally. A process to be agreed for ensuring appropriate communication channels with CBs. Process to be developed and shared to ensure that CBs become conversant with procedures should a cyber event occur. SLT to agree to a specific forum where Cyber and the CBs can raise and discuss cyber risks, and critical systems along with their key contacts can be determined and logged.
			Expected Evidence of Implementation: Clinical Boards' cyber risks identified and shared centrally. Regular communication channels established.
		High Priority	**Officer:** Director of Digital & HI (SIRO)/Head of Information Governance & Cyber Security **Target Implementation Date:** April 2026
	Theme: Governance	Control Design	
5	**Lack of minutes for the Cyber Security Sub-group** While risk assessments completed by the Cyber Security Sub-Group record decisions and advice provided, there are no formal minutes or records of the group's meetings. Given the group's role in reviewing the cyber risk register, assessing critical systems and subsequently providing assurance and advice to the SIRO and CCIO to make decisions, as well providing assurance to the Digital and Infrastructure Committee (as outlined in the ToR for the group), the absence of minutes for the meeting limits transparency and weakens governance. Introducing formal minutes or meeting notes would strengthen oversight and ensure a complete audit trail of discussions and decisions.	Without documented evidence of discussions, decisions, and advice provided, there is limited transparency and accountability in the group's oversight of cyber risk management.	**Agreed Action:** Although an Action Log is maintained we will ensure that future meetings are recorded and transcriptions made available so that an accurate record of the meeting is recorded.
			Expected Evidence of Implementation: Meeting minutes.

	(This was a recommendation in the 2022/23 Cyber Security internal audit).	**Medium Priority**	**Officer:** Head of Information Governance & Cyber Security. **Target Implementation Date:** August 2025
	Theme: Governance	Control Operation	

Objective 3: Identified actions to improve cyber security are progressed appropriately. **Reasonable**

Overview / Summary of Observations

There is a Cyber Improvement Plan in place, and this is being managed by the Cyber Security Team with progress reported to the Digital and Infrastructure Committee. The plan is comprised of the high-priority risks (scoring 12+ and with a risk evaluation of 'Treat') on the cyber risk register, these will include recommendations/findings from the Cyber Resilience Unit (CRU) audits and the original CAF assessment of the Patient Management System (PMS). However, the plan's scope is limited due to the absence of CAF assessments from across other services/critical systems throughout the organisation. Despite reported efforts by the cyber lead to initiate broader assessments within the wider services, it was reported that there was resistance to these requests.

Risk identification and assessments for new systems is ad hoc, relying on requests via a shared inbox. A draft NIS assessment was created by the Cyber Security Team for all new critical systems; however, this remains unimplemented. Engagement with Clinical Boards and critical system owners is limited as previously highlighted and these gaps suggest the plan does not fully reflect the organisation's cyber needs, which is inconsistent with NIS Regulations 2018 and CRU guidance.

It is recognised that the plan includes key risks and actions, and most of these objectives are being progressed with updates reported via the cyber security KPI metrics to each Digital and Infrastructure Committee. However, several limitations were identified; these include unclear timescales or actions past their target date, undefined resource requirements, and inconsistent progress reporting to the Digital and Infrastructure Committee or some objectives. For the objectives that are not included within the KPI metrics, progress was confirmed with the cyber lead, however, resource limitations were outlined as an issue for achieving more. We tested one of the three closed objectives on the plan and confirmed and evidenced that the required actions had been completed.

With the cyber risk register now being migrated to AMaT, and with the Cyber Improvement Plan being derived from the high scoring risks on the register, it is hoped that this will ensure regular updates are provided as well as the population of target dates to ensure there can be enhanced scrutiny and accountability of progress.

Key Findings		Risk & Impact	Agreed Management Action
6	**Coverage of the Cyber Improvement Plan** The cyber security improvement plan is based on high-scoring risks (12+) from the cyber risk register and is overseen by the cyber team. While the plan is intended to be implemented organisation-wide, no CAF assessments have been conducted on critical systems—other than the PMS—and there is limited communication, representation, and cyber awareness among critical system owners, services, and Clinical Boards. Additionally, there are known issues with the risk register and the overall approach to cyber risk management, which underpins the plan (see objective 1 and key finding 1). These factors suggest that the plan may be missing key objectives relevant to services and Clinical Boards and therefore may not fully address the organisation's cyber security needs.	The Cyber Improvement Plan does not fully address the organisation's cyber security needs.	**Agreed Action:** Although the basis of the improvement plan should still focus on those highest risks we face, this will be based on the information contained with AMaT and using this platform. Relying upon AMaT will also help factor in those risks that are identified at Clinical Board level. Engagement with all Clinical Boards will be necessary to ensure all cyber risks are captured and that CBs themselves are aware of their obligations (some education and informing will be needed); CBs will be accountable for logging and managing their risks with support from the central Cyber team.
			Expected Evidence of Implementation: AMaT improvement plan extract.
		Medium Priority	**Officer:** Head of Information Governance & Cyber Security **Target Implementation Date:** December 2025
	Theme: Cyber Security	Control Operation	

Appendix A

Assurance Opinion

 **Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Advisory**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]

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Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Report Title:	Patient Safety Risks				Agenda Item no.	*2.5*	
Meeting:	Quality Committee		Public	X	Meeting Date:	20.01.2026	
			Private				
Status:	Assurance	X	Approval		Information		X
Lead Executive:	Executive Director of People and Culture						
Report Author:	Assistant Director of Health, Safety and Fire						

Main Report

Plus Size Patient Pathway

Background

There is currently a UHB risk relating to the management and care of plus size patients.

The Health and Safety Risk Register currently records this risk with a score of 16, reflecting the absence of a comprehensive system, equipment, and protocols to support this patient cohort safely.

The Assistant Director of Health, Safety and Fire has assessed that this risk would be more appropriately managed under clinical governance rather than health and safety, a view that has been endorsed by the People and Culture Committee.
A clinically led, multidisciplinary approach is recommended to ensure comprehensive oversight and sustainable mitigation.

Current Situation

- The risk has been acknowledged and discussed among clinical teams.
- A lead for this workstream is yet to be formally appointed.
- Some processes are in place to manage this patient cohort however; they are disjointed and lack integration across services.
- The risk remains on the Health and Safety Risk Register, pending reassignment to a more appropriate clinical governance framework.

Strategic Implications

Failure to address this risk may result in:

- Compromised patient safety and dignity
- Increased manual handling injuries for staff
- Non-compliance with regulatory standards
- Reputational damage to the Health Board

A coordinated clinical response is essential to ensure appropriate infrastructure, training, and care pathways are in place.

Recommendations

The Committee is asked to:

1. Endorse the transfer of this risk from the Health and Safety Risk Register to the appropriate clinical governance framework through the patient safety Quality, Safety and Experience Committee whereby they can:
2. Request the appointment of a clinical lead to oversee the development of a bariatric patient management strategy.
3. Commission a multidisciplinary task group to produce a comprehensive action plan, including equipment needs, training, and service protocols.
4. Provide a progress update to the People and Culture Committee in Q1 2026.

Transfer of patients and medical gas

Background

An incident occurred during the transfer of a patient where a medical oxygen cylinder was placed unsecured on a slide sheet alongside the patient. During movement of the bed, the cylinder fell and caused a significant injury to a staff member, resulting in a fractured toe and an absence exceeding seven days. The incident has been formally reported to the Health and Safety Executive under RIDDOR and reviewed as a Serious Incident (SIR) by the Clinical Board and Health and Safety. There is currently no clear understanding of how widespread this practice is across the University Health Board (UHB), raising concerns about consistency and safety in patient transfer procedures involving medical gas.

Current Situation

There are several risks associated with a falling gas cylinder, the greatest one being **a failure to supply medical gas to a patient**, other risks posed to patients, staff, and visitors from improper handling of medical gas cylinders during transfers include:

- Loss of containment from a pressurised vessel, potentially resulting in:
  - High-velocity impact from a dislodged cylinder
  - Oxygen enrichment of the surrounding environment
  - Increased risk of ignition
  - Noise of escaping gas at a level greater than 85dB
- Physical injury to staff, particularly from falling cylinders weighing 3.5kg or more

The recommended safe practice is to secure cylinders using a dedicated bracket attached to the bed. However, the extent of bracket usage across UHB sites is currently unknown.

This issue has been escalated to the Medical Gas Safety Group, which is actively reviewing procedures in collaboration with clinical leads. Additionally, the Operational Health and Safety Group has tasked Clinical Boards with identifying areas where cylinder brackets are not in use and reporting back to inform a system-wide response.

Recommendations

The Committee is asked to:

1. Note the incident and associated risks, the greatest one being failure to supply a patient.
2. Endorse a rapid audit of current cylinder bracket usage across all relevant clinical areas.
3. Support the development of a standardised protocol for the safe transfer of patients requiring medical gas.

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

Assurance

Plus Size Pathway

- The risk has been formally recognised and escalated to the appropriate governance level, with endorsement from the People and Culture Committee for clinical oversight.
- Interim measures are in place across some services, and discussions among clinical teams have begun to identify gaps and priorities.
- The planned appointment of a clinical lead and formation of a multidisciplinary task group will provide structured oversight and drive the development of a unified bariatric care pathway.

Transfer of Patients and Medical Gas

- The Medical Gas Safety Group is actively reviewing procedures and has initiated a system-wide audit to assess bracket usage and identify areas of risk.

- Clinical Boards have been tasked with reporting bracket availability, ensuring local accountability and informing the development of a standardised protocol for safe patient transfers involving medical gas.

Recommendation:

The Committee is requested to:

a) Accept the risk of the plus size patient pathway as being clinically or patient safety led.
b) Acknowledge the patient risk when transferring with medical gas cylinders and support the drive with suitable communication to determine the magnitude of the issue and to assist in resolving.

Link to Strategic Objectives of Shaping our Future Wellbeing:			
1. Putting People First **Click the objective above to view more detail.**		2. Providing Outstanding Quality **Click the objective above to view more detail.**	
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.**	

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

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

Impact Assessment:
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: n/a
Equality and Health: n/a
Decarbonisation: n/a
Welsh Language: n/a

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

Chilcott Rachel
03/03/2026 09:12:57

Report Title:	Update & Review of the UHB Non-Medical Prescribing Governance Framework				Agenda Item No:	3.1
Meeting:	Quality Committee	Public	X		Meeting Date:	20th Jan 2026
		Private				
Status	Assurance		Approval	X	Information/Noting	
Lead Executives:	Executive Medical Director, Executive Nurse Director, Executive Director of Therapies					
Report Author Title:	Principal Pharmacist (on behalf of CAVUHB Non-Medical Prescribing Governance Group)					

Main Report

Situation

Non-medical prescribing has significant benefits for patient care; Welsh Government has described how "*investing in and supporting an increasing non-medical prescriber workforce* can be *a key enabler in the planning and delivery of new care models and transforming care*".

CAVUHB has a Non-Medical Prescribing Governance Framework in place which clarifies the UHB's approach to the governance of non-medical prescribing (NMP). The framework was developed to ensure that all NMP practice within Cardiff & Vale UHB is governed by the robust procedures and processes necessary to preserve patient safety and support and safeguard non-medical prescribers (NMPs) working within/for the organisation.

The current version of the UHB NMP Governance Framework was approved in 2021.

A full review and update of the UHB NMP Governance Framework has taken place with input from all professional groups and a wide consultation process involving practicing NMPs. The framework now requires final approval and ratification prior to dissemination and implementation across the UHB. Full implementation is required by March 2026 in order to meet Welsh Government requirements.

Background

As a large healthcare organisation Cardiff & Vale needs to ensure there are clear and robust governance processes in place for non-medical prescribing (NMP). To achieve this purpose there has been a UHB NMP Governance Framework in place since 2021. The framework is a public document which is available on internal (CAVUHB SharePoint link) and external (CAVUHB Internet site link) UHB sites.

In October 2023, HEIW published 'Standards for Competency Assurance of Independent and Supplementary Prescribers in Wales' (link to HEIW standards). These new standards set the minimum requirement for evidencing and review of ongoing competence to prescribe for NMPs and employers of NMPs. Welsh Government (WG) issued a Welsh Health Circular in March 2024 (WHC-2024) which required all health boards to implement these new standards for competency assurance of NMPs within their organisation by 31st March 2026 at the latest. The UHB was required to submit an implementation plan to WG by Sept 2024 which outlined how we would be able to demonstrate achievement of the competency assurance standards. Part of CAVUHB's implementation plan, which was submitted and approved in Sept 2024, included a review of the current

(2021) UHB NMP Governance Framework with updates to be incorporated that would enable the organisation to achieve and demonstrate how it was meeting the new competency assurance standards.

During 2024-2025, the current (2021) UHB NMP Governance Framework was reviewed and revised by a group of stakeholders which included representation from the different NMP professions. In December 2024 an initial draft update of the UHB NMP Governance Framework was circulated for consultation to all NMPs who were on the UHB NMP Register (the UHB is required by WG to hold and maintain such a register, there are currently >400 NMPs on this register) and also to managers and clinicians within different professional groups and to a Staffside representative. After the consultation period ended, further amendments and revisions were made to the framework before a final version was agreed by the stakeholder group, and this was then presented for approval and ratification by CAVUHB Nursing & Midwifery Board and the AHP Network, and then subsequently approved by Senior Leadership Team (SLT) in October 2025.

Assessment
The current (2021) UHB NMP Governance Framework is no longer suitable to provide the level of assurance required by the organisation and WG of the ongoing competence of NMPs working within/for the organisation. The current framework does not allow the organisation to demonstrate to WG how it meets the new HEIW standards for competency assurance of NMPs.

The UHB has a register of all NMPs working within/for the organisation (except for community pharmacy independent prescribers who are governed by separate NHS Wales governance arrangements). The maintenance and administration of the UHB NMP register is managed by Pharmacy. One of the NMP competency assurance standards for Employing Organisations is "*Employers must maintain an accurate electronic record of their prescribers, including an up-to-date scope of practice*" - there is potentially a significant gap with respect to the administrative support in place for ongoing management of this electronic record with respect to demonstrating that WG requirements are being fully achieved whilst also ensuring compliance with GDPR. The information held within the UHB NMP Register has been compared with similar databases held within other Welsh health boards and this has demonstrated a consistent approach across health boards however work is taking place at an All-Wales level to develop a national approach to developing a digital solution which allows WG to monitor employing organisations' compliance with the new NMP competency assurance standards.

HEIW did comparative work which demonstrated that the existing CAVUHB NMP Governance Framework is in line with policies and frameworks in place within other similar organisations. However, as part of the implementation plan submitted to WG in Sept 2024, recommendations were made regarding amendments to the framework which would ensure compliance with the new competency assurance standards and this new updated framework takes these recommendations into account.

Within the WG/HEIW competency assurance standards there is a new requirement for a three-yearly appraisal of prescribing which has been incorporated into the updated UHB NMP Governance Framework; there is CAVUHB representation within an All-Wales HEIW Task & Finish Group exploring the impact of this 3-yearly appraisal on clinical time for NMPs and the

appraisers, and some pilot work has been proposed to test various models for undertaking these appraisals. Involvement in this work will help to support the implementation of the new updated framework within CAVUHB. There are other HEIW T&F Groups exploring aspects of the competency assurance standards which have been identified as being most challenging to implement across Wales and CAVUHB has representation on these T&F groups which will also help to support implementation of the updated framework.

The updated framework has attempted to minimise the impact on time implications for NMPs in order to demonstrate compliance with the competency assurance standards whilst maintaining the required quality standards and ensuring safe and effective care for patients.

Recommendation
It is recommended that the updated UHB NMP Governance Framework is approved for dissemination and implementation.

The UHB NMP Governance Group (which is identified within the updated framework) will oversee the embedding of the framework and implementation across the organisation.

Output and recommendations from HEIW Task & Finish Groups will also support implementation of the updated NMP Governance Framework across the UHB, particularly addressing some of the more challenging aspects of evidencing compliance with the new WG/HEIW competency assurance standards that have been highlighted across Wales. Ongoing UHB input within these HEIW T&F Groups will be maintained as much as possible.

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

Appendices

1. CAVUHB Non-Medical Prescribing (NMP) Governance Framework

Recommendations:

The Committee is requested to:

a) **Approve** the updated Non-Medical Prescribing Governance Framework and the 5 associated documents (appendices), for immediate roll-out and implementation across the UHB.

Link to Strategic Objectives of Shaping our Future Wellbeing:

1. Putting People First		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		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?				
Yes		No *(please provide reasoning e.g. not required*	X	The governance framework has been updated to support compliance with HEIW / WG quality standards

Impact Assessment
Risk: No
Safety: Yes
The UHB Non-Medical Prescribing Governance Framework has been developed to ensure that all independent / supplementary prescribing practice is governed by the robust processes necessary to preserve patient safety.
Financial: Yes
There are potential financial implications from the impact on clinical time from implementing aspects of the revised NMP Governance Framework eg 3-yearly prescribing appraisal. However the inclusion of this appraisal is necessary to meet Welsh Government requirements and the potential impact of this on health boards has been identified at an All-Wales level. There is representation from the UHB in developmental work being done at an All-Wales level to explore options to minimise the impact on clinical time whilst also ensuring that quality standards are met. As the number of NMPs within the organisation increases (eg all newly qualified pharmacists from 2026 will be NMPs at the point of registration, and there are constantly new emerging prescribing roles within all NMP professions) the administrative burden on maintaining an accurate electronic record of all NMPs will increase – the UHB will need to explore options and digital solutions for ongoing management of the NMP Register – again, there is work going on at All-Wales level being led by HEIW and looking into different options.
Workforce: Yes
As above – impact of the new requirement for 3-yearly prescribing appraisals on NMPs and appraisers.
Legal: No
Reputational: Yes
Welsh Government requires all Health Boards to have implemented new standards for competency assurance of non-medical prescribers within their organisation by 31st March 2026. The updated NMP Governance Framework will enable the UHB to achieve WG's requirement by incorporating key changes into the framework which will enable NMPs to demonstrate their ongoing competency as prescribers. There are reputational risks for the UHB if the requirements of WG have not been met by March 2026.
Socio Economic: n/a
Equality & Health: Yes
An Equality and Health Impact Assessment has been undertaken and this found there to be no impact.
Decarbonisation: No
Welsh Language: Yes
The NMP Governance Framework will be translated into Welsh once it has been ratified.

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

The draft revised Governance Framework underwent a full consultation by all non-medical prescribers on the UHB NMP Register and senior managers from prescribing professions	December 2024 to January 2025
CAVUHB Non-Medical Prescribing Governance Group	June 2025
Nursing and Midwifery Board	11th June 2025
AHP Network	Sept 2025
Senior Leadership Team (SLT)	2nd Oct 2025

Reference Number: UHB 484 **Version Number: 3**	**Date of Next Review:** 01.01.2029 **Previous Trust/LHB Reference Number:** UHB 484

Independent and Supplementary Prescribing Governance Framework

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will enable Non-Medical Prescribers (NMPs) to function in line with professional standards, national guidance and legislation and clarify the UHB's governance requirements.

This framework enables NMPs to function in line with professional standards, national guidance and legislation, and clarifies the UHB's governance requirements.

Policy Commitment

The Cardiff and Vale UHB Independent and Supplementary Prescribing Governance Framework has been developed to ensure that all independent / supplementary prescribing practice is governed by the robust processes necessary to both preserve patient safety and support and safeguard Non-Medical Prescribers (NMPs).

Supporting Procedures and Written Control Documents

Other supporting documents are:

Independent and Supplementary Prescribing in Wales: Guidance for employers and practitioners in NHS Wales. Welsh Government (January 2024). Independent and Supplementary Prescribing in Wales (gov.wales)

Standards for Competency Assurance of Independent and Supplementary Prescribers in Wales. Health Education and Improvement Wales (2023). HEIW Standards for Competency Assurance of Independent and Supplementary Prescribers in Wales (nhs.wales)

Nursing and Midwifery Council. The Code. The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council (nmc.org.uk)

HCPC: Standards of Conduct, Performance and Ethics. Standards of conduct, performance and ethics | (hcpc-uk.org)

Nursing and Midwifery Council. Realising Professionalism: Standards for Education and Training. Part 3: Standards for Prescribing Programme. Standards for prescribing programmes - The Nursing and Midwifery Council (nmc.org.uk)

General Pharmaceutical Council. Standards for Pharmacy Professionals. standards_for_pharmacy_professionals_may_2017_0.pdf (pharmacyregulation.org)

General Pharmaceutical Council. Education and training requirements for pharmacist independent prescribers. Standards for the education and training of pharmacist independent prescribers (pharmacyregulation.org)

Competency Framework for all Prescribers Royal Pharmaceutical Society (2021). A Competency Framework for all Prescribers | RPS (rpharms.com)

Competency Framework for Designated Prescribing Practitioners. Royal Pharmaceutical Society (2019). DPP competency framework Dec 2019.pdf (rpharms.com)

Expanding Prescribing Scope of Practice. Royal Pharmaceutical Society (2022). Expanding Prescribing Scope of Practice (rpharms.com)

The Good Prescribing Guide (Cardiff & Vale UHB). Good Prescribing Guide (microguide.global)

All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal. All Wales Medicines Strategy Group (2024). Medicines administration, recording, review, storage and disposal - All Wales Therapeutics and Toxicology Centre (nhs.wales)

Cardiff and Vale UHB Medicines Code. Access via: Medicines Management Resources (sharepoint.com)

NHS Wales Pharmacy Independent Prescribing Service: Governance arrangements. nwssp.nhs.wales/ourservices/primary-care-services/primary-care-services-documents/ccps-documents/pharmacy-ip-services/pips-governance-arrangements/

Scope

The framework applies to:

- All UHB-employed independent and supplementary prescribers working in all care settings within the UHB and their line managers.
- Independent and supplementary prescribers employed by independent contractors / organisations who are commissioned to provide services for the UHB, with the exception of pharmacist independent prescribers in community pharmacy (see below).

The framework does not encompass:

- Non-NHS prescribing by independent contractors e.g. private prescription provided in a private clinic run by a community pharmacist.
- Pharmacists who provide an NHS Pharmacy Independent Prescribing Service in a Community Pharmacy in Wales (although the UHB may monitor their prescribing and provide professional support where appropriate, these community pharmacists will be governed by 'NHS Wales Pharmacy Independent Prescribing Service: Governance Arrangements').
- Other methods of providing medicines to patients such as Patient Group Directives (PGDs); Patient Specific Directives (PSD); or the prescribing of borderline substances in secondary care by dieticians and speech and language therapists.

The framework applies to three categories of prescribers:

Independent Prescribers:
Defined in the British National Formulary (BNF) as "Practitioners responsible and accountable for the assessment of patients with previously undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing".
Independent prescribers must work within their own level of professional competence and expertise and are accountable for their own actions. At the time of writing (check eBNF for most up-to-date information), the following practitioners may train to be registered as independent prescribers:

Nurses	Midwives	Pharmacists
Physiotherapists	Podiatrists	Optometrists
Therapeutic radiographers	Paramedics	

Supplementary Prescribers:
Supplementary Prescribing is defined in the BNF as "a partnership between an independent prescriber (a doctor or a dentist) and a supplementary prescriber to implement an agreed Clinical Management Plan for an individual patient with that patient's agreement".
Supplementary prescribers can only prescribe in partnership with a doctor or dentist. Going forwards, the only disciplines that will train as supplementary prescribers are dietitians and diagnostic radiographers. The following registered practitioners who have previously trained as supplementary prescribers and have up-to-date registration with their regulatory body that reflects this, may continue in this role if they have an up-to-date scope of practice statement and are on the UHB Register of Non-medical Prescribers:

Nurses	Midwives	Pharmacists
Physiotherapists	Podiatrists	Optometrists
Therapeutic/Diagnostic radiographers	Paramedics	Dieticians

Please note: the only way that a dietitian or diagnostic radiographer can train as a supplementary prescriber is by completing the full independent prescribing course. The course leader will provide specific information regarding the role and remit of the supplementary prescriber.

Community Nurse Independent Prescribers:
Registered nurses must complete the v100 or v150 programme to become registered with the Nursing and Midwifery Council (NMC) as Community Nurse Independent Prescribers. A Community Nurse Independent Prescriber will only prescribe from the Nurse Prescribers Formulary (NPF) for Community Practitioners. (See Independent and Supplementary Prescribing in Wales (gov.wales) for more information regarding this category of prescriber).

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 no impact.
Equality & Health Impact Assessment (EHIA)	A Health Impact Assessment (HIA) has been completed and this found there to be no impact.

Part 2 - Health Impact Assessment (HIA)	
Policy Approved by	CAVUHB Strategic Leadership Team (October 2025)

Accountable Executive or Clinical Board Director	**Profession specific Lead Accountable Officers:** Executive Medical Director Executive Nurse Director Executive Director of Therapies With overall accountability delegated to the group listed below: Pharmacy: Director of Pharmacy Nursing and Midwifery: Deputy Executive Director of Nursing Therapies and Health Science: Deputy Executive Director of Therapies & Health Sciences
Author(s)	Non-Medical Prescribing Governance Group
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 of Review Approved	Date Published	Summary of Amendments
3	*--/--/202-*	*TBA*	*Revised document.* *EHIA produced.* *Governance Framework Section 1: The UHB Governance Structure – new section added.* *Governance Framework Section 2:* • *UHB Process has been split into 2.2 The UHB Education Process and 2.3 Management of NMPs following completion of training.* • *More detail added to section 2.3.* • *Section 2.4: Established prescribers joining the UHB – new section added.* • *Section 2.5: Ongoing governance of NMPs and prescribing appraisal – content updated to reflect new HEIW Standards for Competency Assurance (endorsed by WG).* *Appendix 1: Section I – addition of 'demonstration of ongoing competency to prescribe'.* *Appendix 2:*

			• *length of time registered with regulatory body – question amended due to changes to pharmacy regulations.* • *Terminology updated for different roles (DPP etc).* *<u>Appendix 3</u>:* • *Content and title updated so that induction pathway can be applied to newly qualified NMPs and also applicable for qualified NMPs joining the UHB.* • *Amendments made to Step 1, Step 3, Step 7 and Step 8.* *<u>Appendix 4</u>:* • *Completion notes: added 'expanding scope of practice' to criteria for submitting an updated scope of practice statement.* • *Completion notes: added 'wet signatures or verified email trails will be accepted'.* • *Completion notes: added NMPs need 'to provide an annual declaration of continued competence to prescribe and evidence that they have undertaken a prescribing appraisal every 3 years'.* • *Completion notes: added clarification of line manager sign-off for NMPs who are self-employed and providing commissioned services.* • *Prescriber details: added 'verified by Line Manager' to registration as a prescriber with regulatory body.* • *Prescriber details: added 'if applicable' to Directorate and Clinical Board* • *Prescriber details: amended 'department/clinical area' to include more options.* • *Non-medical prescribing qualification: added section for Line Manager to confirm qualification meets UHB requirements.* • *Scope of Practice: Area of practice – added 'in order to accurately and fully describe your prescribing role'.* • *Prescribing for inpatients – clarified this includes 'all forms of electronic prescribing'.* • *Post-qualification supervision – added 'Job Title/Qualification' and 'email trail will be accepted in lieu of wet signature'.* • *Authorisation: added 'where necessary, email trail(s) will be accepted...'.* • *Authorisation: expanded statement of prescriber responsibilities to include ensuring that UHB/WG*

			requirements are met, and that 'an annual declaration of continued competence to prescribe is submitted to Pharmacy and a prescribing appraisal is undertaken every 3 years'. • *Authorisation: Line Manager declaration – amended to add 'prescribing' and replace 'professional' with 'regulatory', and include additional statement of assurance about scope of practice and post-qualification supervision.* • *Admin section removed.* *<u>Appendix 5</u>:* • *Title altered to 'Annual Declaration of Competence to Prescribe'.* • *Format updated into 6 different sections.* • *Introductory paragraph amended to reflect compliance with WG requirements for all NMPs.* • *Section 1 - 'if NMP is UHB-employed' added where appropriate.* • *Section 1 - 'or Clinical Area' added.* • *Section 1 – added requirement to state position/qualification of person who provides post-qualification supervision.* • *Section 1 – amended section confirming scope of practice is up-to-date and added to declaration in Section 5.* • *Section 2 – Review of prescribing practice – content of this section amended.* • *Section 3: Evidence requirements updated to reflect HEIW standards for competency assurance.* • *Section 4: Prescribing Appraisal - new content – section added to reflect HEIW standards for NMP competency assurance.* • *Section 5: Prescriber declaration – content updated to reflect HEIW standards for NMP competency assurance.* • *Section 6: added 'declarations'.* • *Section 6: added clarification for NMPs not employed by the UHB and self-employed NMPs.*

Independent and Supplementary Prescribing Governance Framework

Section 1: The UHB Governance Structure

The following infrastructure has been developed to enable robust governance of non-medical prescribing education and practice.

Profession specific Lead Accountable Officer	
These are the professional leads who hold overarching accountability for ensuring that this Independent and Supplementary Prescribing Governance Framework is implemented across their professions within the scope of the framework, and that processes are in place to enable compliance with the framework.	
Pharmacy	Director of Pharmacy
Nursing and Midwifery	Executive Director of Nursing
Therapies and Health Science	Executive Director of Therapies & Health Sciences
Optometry	Optometric Advisor
Non-Medical Prescribing Governance Group	
This group is responsible and accountable for governance of non-medical prescribing and the development of non-medical prescribers providing services within / to the UHB. The group provides strategic leadership for non-medical prescribing and undertakes a yearly review of this governance framework in conjunction with key stakeholders. Group members: ▪ Director of Pharmacy ▪ Deputy Executive Director of Nursing ▪ Deputy Executive Director of Therapies and Health Sciences or nominated deputy ▪ Optometric Advisor ▪ Principal Pharmacist for Training and Workforce Development ▪ Nurse Advisor for Medicines Management ▪ PCIC representative ▪ Education, Culture and Organisational Development (ECOD) representative(s)	

Senior Accountable Officers
The Senior Accountable Officers are accountable for the governance of NMP within their clinical board/directorate/department. They are required to approve nominations for NMP training and ensure that the governance framework is fully embedded within their areas of operational and professional responsibility. They are: ▪ Directors of Nursing ▪ Heads of therapies ▪ Principal Pharmacist for Training and Workforce Development ▪ Clinical Board Lead Pharmacists
Accountable Officers
These are operational leads who are accountable for the governance of NMP within their service. They will ensure that new NMPs are developed in response to service needs rather than individual development needs. The accountable officers are responsible for ensuring their services comply with the governance framework. ▪ Lead Nurse ▪ Lead Pharmacists or another senior role nominated by the Senior Accountable Officer(s) ▪ Identified clinical lead within therapies nominated by the Senior Accountable Officer
Line Manager/Nominating Officers
Line managers (or clinical leads) of NMPs are accountable for ensuring that this governance framework is embedded in their team and that their staff adhere to the framework. Nominating officers are individuals who provide educational advice for prospective NMP trainees and nominate them via the annual training needs analysis process e.g. Practice Development Nurses/Practice Educators/Therapy line managers. Nominating officers are accountable for ensuring that they are fully conversant with the framework and that all education advice is in line with the requirements within.
Independent and Supplementary Prescribers (NMPs)
NMPs are accountable for ensuring that their NMP practice is in line with this framework and that they comply with the processes and procedures within.

All levels of officer will be required to attend and / or complete non-medical prescribing governance training at a level which is appropriate for their role.

Section 2: The Selection, Training and Management of NMPs

2.1 The Annual IMTP and Educational Commissioning Process within managed sector

Health Education and Improvement Wales (HEIW) undertakes an annual review of the UHB's IMTP and requires the UHB to complete a Workforce Commissioning Proforma at the end of each calendar year.
The commissioning process is co-ordinated by the Workforce Information Team and is aligned to the annual Training Needs Analysis (TNA) process. This process enables the UHB to access HEIW funded NMP places to develop new prescribers. Training nominations must be in line with patient need, service developments and IMTP priorities. The commissioning process is summarised below:

Patient and service need for non-medical prescribing identified (as per UHB IMTP)

↓

Training places commissioned by the Head of Service/Director of Nursing via the HEIW workforce commissioning process (linked with UHB IMTP)

↓

HEIW confirm number of funded training places for the UHB – usually at the start of each financial year, by May at the latest

2.2 The UHB Education Process

This process runs in conjunction with and informs the HEIW commissioning process. Please note that this process ***must*** be followed even if individuals have secured alternative sources of funding e.g. self-funding, educational grants, endowment or directorate funding.

NMP education programmes must be undertaken in a HEI where the UHB has an established relationship which supports adherence to this governance process. Table 2.2.1 below outlines the UHB education process.

It is vital that trainee NMPs receive robust supervision both during the NMP programme and following qualification.

Table 2.2.1: UHB Education Process (does not apply to independent contractor services)

a.	Service need for development of NMPs included in the IMTP.
b.	Nominees for the NMP programme identified via annual training needs analysis (TNA) process. Line manager checks individual meets UHB eligibility criteria (appendix I). Nursing, Midwifery and AHP nominations sent to the Senior Nurse for Nurse Education in Education, Culture and Organisational Development (ECOD) via the annual TNA process. Pharmacy nominations are sent to the Principal Pharmacist for Training and Workforce Development or PCIC Lead Pharmacist.
c.	Nursing, Midwifery and AHP nominees who meet the eligibility criteria are required to complete a nomination form (appendix 2) and are invited to attend a meeting with an NMP Panel in order to review their nomination form and establish their suitability to undertake the Programme. This panel will include the Senior ECOD Manager for Nursing & Midwifery

	Education, the Nurse Advisor for Medicines Management and HEI representation (Independent Prescribing programme lead). Secondary care pharmacy nominations are reviewed by the Principal Pharmacist who will liaise with Pharmacy Directorate Management Team (DMT).
d.	For Nursing, Midwifery and AHPs, a list of suitable applicants is sent to Director of Nursing/Head of Service and Deputy Executive Nurse Director/Executive Director of Therapies/ Director for approval. For Pharmacy, nominations are approved by DMT.
e.	HEIW are informed of approved UHB nominations through completion of the HEIW SharePoint by ECOD team (Nursing, Midwifery and AHPs) or Principal Pharmacist (Pharmacy).
f.	ECOD will inform the Head of Service/Director of Nursing and Lead Nurse/AHP Line Manager of the HEIW funding outcome and provide funding letters and pre-course information to all successful nominees including course application details. The Principal Pharmacist for Training and Workforce Development will manage this process for Pharmacy.
g.	Head of Service/Lead Nurse ensures that NMP trainees are supported and robustly supervised by a Designated Prescribing Practitioner (DPP) throughout the training programme. Trainee NMP takes personal responsibility for ensuring that the necessary study and development is completed. Nurses will be required to have the support of a Practice Assessor (Medic) and Practice Supervisor (Independent prescriber with over 3 years prescribing experience post qualification).

2.3 Management of NMPs following completion of training

a.	Whilst waiting for confirmation of qualification and registration as an NMP with regulatory body, novice NMPs must commence the UHB Induction Pathway for NMPs (appendix 3) and maintain their competence via continued supervised practice with an experienced prescriber (over 3 years prescribing experience). This will support them to maintain their confidence and competence whilst the necessary registration and induction processes are being completed.
b.	Once confirmation of qualification is received from the University, the NMP must complete all steps of the NMP induction pathway (appendix 3) to ensure that the correct registration and induction processes are followed, including registration of Scope of Practice (appendix 4) with UHB Register of NMPs (maintained by Pharmacy on behalf of the UHB).
c.	In order to comply with Welsh Government/HEIW standards, NMPs must ensure that they meet the UHB's annual requirements for evidence of continuing competence to prescribe (see appendix 5). This includes an annual self-assessment and relevant CPD (continuing professional development) activities. For UHB-employed NMPs, Heads of Service/Lead Nurses must ensure that NMPs are supported to enable these CPD activities to happen.
d.	All NMPs must have a suitably qualified individual identified and named on their Scope of Practice (appendix 4) who can undertake a prescribing appraisal every three years. This will be a constructive appraisal of prescribing practice as outlined in HEIW Standards for Competency Assurance of Independent and Supplementary Prescribers in Wales (nhs.wales). It is the line manager's responsibility to ensure that a suitably qualified and experienced individual has been identified, and this could be the line manager (if also an NMP), mentor,

	consultant, GP or DPP. The date of the most recent prescribing appraisal will be included on the annual NMP Declaration form (appendix 5) and this appraisal must always be within the last 3 years.
e.	All NMPs must make an annual declaration of their ongoing competence to prescribe, and a declaration of their scope of prescribing practice (for UHB-employed NMPs this should be part of the UHB annual values-based appraisal (VBA) process). This will involve: • a professional declaration made annually that they have undertaken a self-assessment of their prescribing competence using the RPS Competency Framework for All Prescribers, and that they have evidence of this in line with the requirements set out in Appendix 5 of the UHB NMP Governance Framework • A professional declaration made annually that they have undertaken a prescribing appraisal with a suitably qualified individual within the last 3 years and state the date of the most recent prescribing appraisal. • A professional declaration made annually that an up-to-date copy of their scope of prescribing practice has been submitted to Pharmacy within the last 3 years (minimum) and that this accurately reflects their current role and clinical area of prescribing. • NMPs not submitting an annual declaration will have their status on the UHB NMP Register changed to “not actively prescribing” and they will no longer be covered to prescribe in their current role.
f.	**Scope of Practice:** An updated Scope of Practice (appendix 4) must be submitted to Pharmacy every 3 years. If there are no changes to the content of the Scope a new copy can be printed and re-signed by the NMP and authorised by all the appropriate signatories. In addition, NMPs must submit an updated scope if any element of their scope changes or expands as soon as they have ensured that any educational needs have been met and all sections of the updated scope have been completed and authorised by the appropriate signatories. It is a UHB requirement that all NMPs follow the Royal Pharmaceutical Society (RPS) Professional Guidance: Expanding Prescribing Scope of Practice whenever they are seeking to change / expand their scope of practice: Expanding Prescribing Scope of Practice (rpharms.com). This RPS professional guidance (link above) must also be followed by NMPs who are temporarily redeployed into another area or who are commencing a new prescribing role in/for the UHB either within their usual specialty or for a new patient group / specialist area. A new Scope of Practice must then be submitted once all the identified learning activities have been undertaken, competencies have been met and appropriate signatories have authorised the scope of practice.

2.4 Established prescribers joining the UHB NMP register

Any new members of staff joining the UHB's register who are already qualified NMPs must follow the relevant process below:

2.4.1 Permanent staff who are new to the UHB:

Provide their manager with a copy of their certificate for their prescribing qualification. If they

trained in Wales they will have completed a 40 or 60 credit level 7 NMP programme.
For nurses, midwives and AHPs who have trained outside of Wales, a copy of their certificate must be sent to the Senior ECOD Manager for Nursing & Midwifery Education and the Nurse Advisor for Medicines Management for review. Should they not have a certificate available, they must provide confirmation via their NMC registration that they are trained prescribers to the aforementioned persons for review. If the prescriber completed a 20 or 30 credit module in England or a level 6 programme a transcription of the training content will be required to identify gaps in knowledge. For example: the programme may not have included a calculations assessment or assessment of diagnostic skills. For nurses and midwives, the Senior Nurse for Nurse Education will provide advice re: the additional training to be completed.
If the training meets the required standard, the new member of staff must submit a completed Scope of Practice to Pharmacy to register with the UHB before undertaking prescribing practice. If their new post requires them to prescribe in a new specialty area or for a new patient group, they will need to follow the UHB requirements for an NMP changing / expanding their scope of practice prior to submitting a scope of practice that has been authorised by the appropriate signatories (see 2.3f above) – the NMP will need to be able to demonstrate that they have followed the RPS Professional Guidance in order to develop their new scope of practice.

2.4.2 Locum and temporary staff:

Any registered NMP who does locum/bank/agency shifts in C&V in an appropriate role e.g. pharmacist, nurse practitioner must submit a scope of practice in the usual way as described within Section 2.3 and be able to demonstrate compliance with HEIW Standards for Competency Assurance of Independent Prescribers in Wales.

2.5 Ongoing governance of NMPs and prescribing appraisal (see appendix 5)

Welsh Government requires the UHB to maintain an accurate electronic record / database of all non-medical prescribers. This electronic record must contain the following for each NMP:

- an up-to-date scope of prescribing practice
- an annual declaration of scope of prescribing practice
- an annual declaration of continued competence to prescribe
- date of most recent prescribing appraisal, which must be within the last 3 years

The UHB NMP electronic database is held and maintained by pharmacy.

Entry onto the database for qualified NMPs who are using their prescribing qualification is enabled through the submission of a Scope of Practice form (appendix 4) that has been reviewed and authorised by all of the appropriate signatories. An updated Scope of Practice form must be submitted every three years as a minimum and if there is a change to any of the elements in the scope (see 2.3f above).

If a qualified NMP is not using their prescribing qualification in their current role, their details are recorded on the UHB NMP electronic database as a non-active NMP and they are required to

submit an annual declaration to confirm this (see Appendix 5 (section 2)).

The NMP Annual Declaration Form (appendix 5) provides clear evidence guidance for both prescribers and line managers and it meets the minimum evidence requirements stipulated by Welsh Government and HEIW for NMPs in Wales.

All NMPs who are using their prescribing qualification must have a prescribing appraisal with a suitably qualified individual every 3 years (as per HEIW Standards for Competency Assurance of Independent and Supplementary Prescribers in Wales) - the date of the most recent appraisal must be documented on the NMP annual declaration form* (Appendix 5).

There may be circumstances whereby an NMP would benefit from an additional period of supervised practice with a DPP (or another suitably qualified medic / NMP) e.g.:

- A change in role which requires a significant change in Scope of Practice
- A significant lapse in prescribing activity (eg. ≥ 12 months)
- Concerns regarding prescribing competence
- An established prescriber joining the UHB – to enable effective induction to the UHB's policies, procedures, prescribing practices etc.

The length and form of supervision should be decided through discussions with the DPP (or another suitably qualified medic / NMP), line manager and the individual – these discussions should be based on objective assessments using the RPS Competency Framework for all Prescribers and RPS Professional Guidance: Expanding Scope of Practice. The decisions reached from these discussions should be appropriately documented within the NMP's prescribing portfolio (and Personal File where appropriate) and approved by the Lead Nurse/Department Head/Training Leads.

* *During initial implementation of the new 3-yearly appraisal process (until March 2027), NMPs will be able to complete their 'Annual Declaration of Continued Competence to Prescribe' (Appendix 5) and indicate that a full Prescribing Appraisal has not yet been completed which meets all the requirements of the new HEIW Competency Assurance Standards.*

APPENDIX 1

Cardiff & Vale UHB: Eligibility Criteria for Staff to be Nominated to Undertake a Programme of Study to become a Non-Medical Prescriber

Prospective new non-medical prescribers must meet the following eligibility criteria:

	Please review each statement and tick as appropriate	
a	The practitioner is working in a role in which it is appropriate for them to undertake prescribing practice.	
b	Prescribing is an essential part of the practitioner's role. There is clear service need and patient benefit.	
c	The practitioner will have the opportunity to act as a prescriber upon qualifying.	
d	A Designated Prescribing Practitioner (DPP) has been identified who is a suitably experienced medic/non-medical prescriber and will provide the necessary training, support and practice assessment during the Programme of Study and the post qualification induction period.	
e	The practitioner will be released to attend the required training programme and DPP supervision.	
f	The practitioner will be supported to access continuing professional development opportunities on completion of the course.	
g	The practitioner has evidenced their ability to undertake advanced patient assessment and decision-making – any identified learning needs can be addressed prior to undertaking (or during) the prescribing programme. A formal programme of patient assessment may be required. If applicable, identified learning needs should be recorded in the practitioner's annual appraisal with their line manager.	
h	The practitioner has completed a first degree or equivalent. (If no please seek advice from ECOD regarding the individual's academic qualifications as they may need to undertake further academic study prior to commencing a prescribing programme)	
i	Financial arrangements are in place to meet the cost of prescriptions (as appropriate).	
j	The practitioner is registered with the appropriate regulatory body: • The General Pharmaceutical Council (GPhC) – must also be a practicing pharmacist. • The Health and Care Professions Council (HCPC). • The Nursing & Midwifery Council (NMC) – registered as a first level nurse, midwife and/or specialist community public health nurse.	
k	The practitioner has completed one year of practice as a registered practitioner (immediately preceding application to the programme) in their clinical field. (eg mental health / adult / child health) in which there is the intention to prescribe.	
l	The practitioner is able to demonstrate how they will reflect upon their own performance, take responsibility for their CPD and develop their own interprofessional networks for support, reflection, learning and demonstration of ongoing competency to prescribe.	

APPENDIX 2

Non-Medical (Independent) Prescribing Programme Nomination Form

Must be completed electronically. Handwritten forms will not be accepted

Name	
Role	
Department/Place of Work	
Directorate (*if applicable*)	
Clinical Board	
Do you meet the eligibility criteria set in the UHB Non-Medical Prescribing Governance Framework? Please attach a copy of the eligibility checklist (Appendix 1)	
How long have you been registered with your regulatory body?	
Briefly outline your experience in the area of practice for your proposed prescribing role.	
Name of Lead Nurse, Head of Service, Practice Partner supporting nomination	
Have you completed a BSc or equivalent? **If yes:** please provide title of programme and date completed	
Have you completed any MSc level education? **If yes:** please provide course titles and dates completed	
Have you completed a clinical patient assessment module **If yes:** please provide course titles and dates completed	
Is independent prescribing a new development for your role?	

Is independent prescribing a new development for your department?	
Proposed prescribing role Please ensure you answer the following questions: 1. **Type of service** **This is a vital element of the form so please provide as much detail as possible** 2. **Patient group** **This is a vital element of the form so please provide as much detail as possible** 3. **Patient need** **This is a vital element of the form so please provide as much detail as possible** 4. **Range of medications you wish to prescribe** **Maximum of 2 x groups of medications (eg; Antibiotics, SSRIs, Bronchodilators)**	

Please outline the service need that supports you undertaking a prescribing role	
What are the anticipated benefits for your patients if you become a prescriber?	

What are the potential consequences for your patients or your service if you are not in a prescribing role?	
Have you applied to undertake the independent prescribing programme before? (Y/N) If yes: what was the reason you did not go ahead with the course?	
Have you started an independent prescribing course before? (Y/N) If yes: please provide details re: 1. Where you studied 2. How you were funded 3. The reason for noncompletion of programme	
Are you aware of the extensive time commitment that this course requires?	
Name of Designated Prescribing Practitioner (DPP) and Practice Supervisor (PS) / Practice Assessor (PA) **<u>What is a DPP and PS?</u>** **Note you will require 2 x people, 1 x person cannot fulfil both roles.** **DPP - is an experienced prescriber who supervises and assesses a trainee non-medical prescriber during their practical learning period. Monthly meetings and final sign off. (Minimum of 3 years active prescribing)**	

PS - is a qualified prescriber who supports and guides a trainee's day-to-day learning in clinical practice. (Minimum of 3 years active prescribing)		
Current role of DPP / PS / PA		
Has DPP / PS / PA supervised a student through the independent prescribing programme before?		
Is DPP aware that they will need to attend a session with University course lead to discuss their training and supervisory responsibilities?		
Who will be responsible for clinical supervision for you once you have qualified as an independent prescriber?		
Name of Lead/Senior Nurse or AHP Head of Service/Practice Partner supporting application		
Lead Nurse/ Line Manager signature(s)		Date
Practitioner signature		Date
PS / PA signature(s)		Date
DPP signature		Date

APPENDIX 3
Induction Pathway for Non-Medical Prescribers

This induction pathway is intended for use by all newly qualified Non-Medical Prescribers (NMPs) - the pathway should be commenced as soon as an NMP finishes the prescribing programme. When completed, a copy of this pathway needs to be uploaded to your personal file.
NB This pathway can also be used to support the induction of qualified NMPs joining the UHB as a new / temporary member of staff.

Name of Non-Medical Prescriber (NMP):	Job title:
Profession:	Department (or GP Surgery / other independent contractor):
Directorate (*if applicable*):	Clinical Board:
Date completed NMP programme:	Date received pass result from university:

Step 1: Maintain your competence:
In order to maintain your competence please ensure that you continue to undertake supervised prescribing practice with your Designated Prescribing Practitioner (DPP) (or another suitably qualified medic / NMP) following completion of the programme and continue to maintain your prescribing log in your portfolio whilst doing this. Continue this until you have completed Steps 2 & 3 of this pathway and are able to prescribe autonomously, but then please ensure that you complete Step 7 of the induction pathway in order to maintain a level of supervision in your prescribing practice whilst in the induction period.

Name of DPP / Medic / NMP providing supervision of prescribing practice during post-qualification induction period:

Signature:

Step 2: On receipt of pass result - register as a prescriber with your Regulatory Body:
Complete registration process with regulatory body as per guidance provided by the University.

Date submitted application for annotation on register as a prescriber:
Date confirmation of registration as a prescriber received:

Step 3: Register as a prescriber with the UHB
The Cardiff and Vale UHB Non-Medical Prescriber Register is held and maintained by Pharmacy on behalf of the UHB.
You must be registered with the UHB in order to be able to prescribe within your role; a Non-medical Prescriber will only be covered (in terms of liability) to prescribe if they are on the UHB Non-medical Prescriber Register and if they have submitted an up-to-date Scope of Practice

Statement which accurately reflects their current prescribing role. The current UHB paperwork for the scope of practice statement must always be used (SharePoint NMP Documents)

To register as a prescriber with the UHB please complete the following actions:

1.	Complete all sections of Scope of Practice (SoP) Statement, ensuring that it accurately describes your prescribing role which has been discussed, agreed, and signed off by your line manager (Senior/Lead Nurse or AHP)	Date SoP signed off by line manager:
2.	Ensure that SoP Statement has been signed off by all other required signatories and then a copy retained in your prescribing portfolio and personal file.	Date SoP signed off by all required signatories:
3	Email a scanned copy of your signed SoP Statement to Pharmacy at nmpadminpharmacy.cav@wales.nhs.uk	Date copy of SoP sent to pharmacy:
4	When a confirmation email is received from Pharmacy to confirm that your SoP Statement has been received and your details have been added to the UHB NMP Register – ensure that a copy of this email is retained	Date confirmation received that your details have been added to the UHB NMP Register:

Step 4: Register for access to Welsh Clinical Portal (if access is required and not yet authorised):

You will need a NADEX account to register for access to Welsh Clinical Portal (WCP) – contact your Line Manager if you do not have a NADEX account. Once you have got a NADEX account, complete the Welsh Clinical Portal 'Essential Training' - accessed via the following link: rwmbvsrvwcpweb1.cymru.nhs.uk/captivate_elearning/ostlts/_wcp/wcp_all_in_one_master/index.html	Date registered with Welsh Clinical Portal (*if applicable*):

Step 5: Register for prescribing via COPPS
(ONLY for prescribers who will prescribe in the out-patient setting)

If you are prescribing in the out-patient setting, you will need to register with COPPS via the following link: **Link for registering with COPPS:** Clinical Information System Suite (wales.nhs.uk)	Date registered with COPPS (*if applicable*):

Please make it clear that you are a Non-medical Prescriber when registering with COPPS.	

Step 6: Register with NHS Wales Shared Services Partnership – Primary Care Services
(ONLY for prescribers who will prescribe in primary or community care)

Any non-medical prescriber requiring NHS WP10 prescriptions (for use in primary care) must register with NHS Wales Shared Services Partnership – Primary Care Services. Non-Medical Prescribers - NHS Wales Shared Services Partnership	Date registered with NHS Wales Shared Services Partnership (*if applicable*):

Step 7: Induction period: months 1-3 of independent prescribing practice
During this period the novice Non-Medical Prescriber should:

Attend a monthly supervision meeting with DPP (or another suitably qualified medic / NMP) *Please provide details of person providing supervision if not DPP:*	Dates of meetings:
Complete a prescribing activity log for a minimum of either one month or fifty prescriptions / prescribing decisions. 'Prescribing activity' is a term used to describe the process from Patient Assessment, Diagnostic Reasoning, Shared Decision Making and the use of Therapeutics. The log should be reviewed and signed off by the DPP (or another suitably qualified medic / NMP) *Please provide details of person reviewing log if not DPP:*	Date log reviewed and signed off:
Record any critical incidents and discuss with DPP/Lead Nurse/Line Manager/Head of Dept	Dates of any critical incident discussions:
Attend or take part in a relevant CPD event that is related to prescribing, for example a multi-disciplinary educational meeting or training event, peer review, case-based review etc.	Details of CPD undertaken: Date(s):

Step 8: Pathway sign off – at end of month 3 following prescriber registration:

Three months after you have gained your registration as a prescriber, please complete the following actions:

- Self-assess yourself against the RPS Competency Framework for all Prescribers
- Three months following registration as a prescriber, meet with your Lead Nurse / Line Manager / Manager in order to complete the following:
  - confirm that the induction pathway has been completed
  - ensure that any further development or support needs have been identified

Date of review meeting	
Have all relevant components of the pathway been achieved? **If NO**: Outline an action plan to address any areas not yet completed and include timescales and further progress reviews and arrange further prescribing supervision meetings as appropriate	YES / NO
If YES: Future learning and/or development needs identified, and actions required to address them	
Prescriber signature	
Lead Nurse / Line Manager / Manager signature*	

** For self-employed NMPs, the induction pathway can be signed off by the DPP / Medic / NMP providing supervision of prescribing practice during post-qualification induction period*

Once this induction pathway has been signed off, a copy needs to be uploaded to your personal file (or equivalent).

APPENDIX 4

Non-Medical Prescribing Scope of Practice Statement

Completion notes:

1. To be added to the Cardiff and Vale UHB Non-medical Prescribing Register, non-medical prescribers (NMPs) must submit a signed 'Scope of Practice Statement' to Pharmacy. Therefore a 'Scope of Practice Statement' must be completed by:
    - ♣ Newly qualified NMPs
    - ♣ NMPs who are newly employed by Cardiff & Vale UHB or who are providing a commissioned service for Cardiff & Vale UHB

2. In order to remain on the UHB NMP register prescribers must then:

    - ♣ Submit a reviewed Scope of Practice Statement **once every 3 years** as a minimum. The prescriber must complete a new Scope of Practice Statement, even if it is unchanged, every 3 years.

    And

    - ♣ Submit an updated Scope of Practice Statement immediately whenever **any** aspect of the Scope of Practice Statement changes e.g. expanding scope of practice, changes to clinical area, range of medications, role etc.

3. In order to ensure that you are using the most up-to-date version, the Scope of Practice statement must always be accessed via SharePoint or the C&V UHB Internet site each time it needs to be completed: Sharepoint link: NMP Documents. Please download the Scope of Practice UHB paperwork and complete it as an electronic document.

4. The Scope of Practice Statement **must** be completed by the NMP in conjunction with their line manager. The final version must be signed off by **all** required signatories - either wet signatures or verified email trails (in lieu of signatures) will be accepted. The line manager must retain a copy for the prescriber's personal file and the prescriber must retain a copy for their prescribing portfolio.

5. The prescriber must immediately return the signed statement to: **Pharmacy Department UHW - Nmpadminpharmacy.Cav@wales.nhs.uk** and await email confirmation that the Scope of Practice has been received and the prescriber's details have been added to the UHB NMP register or their entry has been updated.

6. It is the responsibility of the line manager to ensure that Pharmacy are notified immediately, via the email address above, if the prescriber no longer works (or provides commissioned services) for the department or organisation.

7. For NMPs who are self-employed and providing commissioned services, the 'Line Manager' sections can be completed by the person named on this document who provides post-qualification supervision.

NOTE: A Non-medical Prescriber will only be covered (in terms of liability) to prescribe if they are on the UHB Non-medical Prescribing Register and if they have submitted an up-to-date Scope of Practice Statement which accurately reflects their current prescribing role. The Non-medical Prescriber also needs to provide an annual declaration of continued

competence to prescribe and evidence that they have undertaken a prescribing appraisal every 3 years.

Non-Medical Prescribing Scope of Practice Statement

Prescriber details:

Name of Non-Medical Prescriber:	
Email address of Non-Medical Prescriber: (*please use a work email address*)	
Regulatory body:	
Registration / membership number:	
Registered as a prescriber with regulatory body? (*please provide line manager with proof of registration*)	❑ Yes ❑ Verified by Line Manager
Independent or Supplementary prescriber?	
Employee number (if employed by the UHB):	
Job Title:	
Directorate (if applicable):	
Clinical Board (if applicable):	
Department / Clinical Area / Primary Care Cluster (if employed by the UHB) *OR* Independent contractor (if not UHB-employed)	

Non-medical prescribing qualification:

Higher Education Institute (HEI):	
Date of qualification:	
If non-Welsh HEI – Line Manager must confirm qualification meets required number of credits / educational level (*contact Senior Nurse for Nurse Education or Principal Pharmacist T&D for advice*)	Tick as appropriate: ❑ Not applicable ❑ Line manager has confirmed qualification meets UHB requirements

Scope of Practice:

Overarching area of practice: (Please tick)	❑ **Adult**	❑ **Child**
Area of practice summary statement: (max 5 words eg. adult mental health, paediatric surgery, adult rheumatology, adult emergency medicine etc)		
Area of practice: Describe the patients that you care for and will be prescribing for; please provide as much detail as possible in order to accurately and fully describe your prescribing role, including details of clinical conditions, acute v chronic management, etc. *(continue on a separate attached document if necessary)*		
Independent or **Supplementary** prescribing or both?		
Will you be prescribing for inpatients? *(this includes writing discharge prescriptions and all forms of electronic prescribing)*	❑ Yes ❑ No	
Will you prescribe for outpatients? If yes, you will need to register with COPPS via Clinical Information System Suite (wales.nhs.uk) (*please make it clear that you are a Non-medical Prescriber when registering with COPPS*)	❑ Yes ❑ No	
Will you prescribe in primary or community care? If yes, you will need to register with NHS Wales Shared Services Partnership – Primary Care Services	❑ Yes ❑ No	
Have you arranged access to Welsh Clinical Portal (WCP)? If not, please speak to your Line Manager.		

Post-qualification supervision: Details of person who will provide post qualification supervision for you (email trail will be accepted in lieu of wet signature)	Name: Job Title/Qualification: Signature & Date:

Authorisation:
(where necessary, email trail(s) will be accepted in lieu of wet signature(s))

The above details have been discussed and agreed. **NB:** It is understood that it is the responsibility of the **prescriber**, in discussion with the line manager, to ensure that prescribing competencies are maintained and meet UHB / Welsh Government requirements, and that an annual declaration of continued competence to prescribe is submitted to Pharmacy and a prescribing appraisal is undertaken every 3 years.	
Name of prescriber:	
Signature of prescriber:	
Date:	
Line Manager Declaration: I have checked that the post-holder has the necessary prescribing qualification, is registered with their regulatory body as a prescriber, and that there is a service need for their role as a non-medical prescriber in the given clinical area. I confirm that this Scope of Practice provides an adequate description of their prescribing role within the organisation and an appropriate person has agreed to provide post-qualification supervision.	
Name of Line Manager:	
Designation of Line Manager: (*NB for nursing staff this will need to be countersigned by Lead Nurse if Line Manager is not in an equivalent or Lead Nurse role*)	
Signature of Line Manager:	
Signature of Lead Nurse (*if necessary – see above*):	
Date:	

Scope of Practice Statement reviewed by the appropriate signatory (according to professional group) and approved for entry onto UHB Register of Non Medical Prescribers. (*Signatories: Clinical Board Director of Nursing (or Deputy) / Lead Pharmacists for Clinical Boards / Principal Pharmacist / Executive Director of Therapies and Health Sciences (or Deputy) / Medical Director (or Deputy)*)

Reviewed and approved by - name:	
Designation:	
Signature:	
Date:	

Once completed, please send a copy of this paperwork to Nmpadminpharmacy.Cav@wales.nhs.uk

APPENDIX 5

Non-Medical Prescribing (NMP) - Annual Declaration of Continued Competence to Prescribe

To meet UHB and Welsh Government requirements, all non-medical prescribers (NMPs) must complete this declaration annually with their line managers as part of their Values Based Appraisal. For self-employed NMPs, this can be completed with the named person who provides post-qualification supervision (or another suitably qualified and experienced prescriber). A signed copy of an annual declaration of continued competence to prescribe must be submitted to Pharmacy via Nmpadminpharmacy.Cav@wales.nhs.uk.

For UHB-employed staff, if you are a qualified NMP and not using your prescribing qualification in your current role, please complete Sections 1 and 2 annually and return this declaration to Pharmacy via Nmpadminpharmacy.Cav@wales.nhs.uk.

Section 1: Prescriber details:

Name of Non-Medical Prescriber (NMP):	Job title:
Profession:	Department or Clinical Area (*if NMP is UHB-employed*):
Directorate (*if NMP is UHB-employed*):	Clinical Board (*if NMP is UHB-employed*):
GP Surgery or other independent contractor (*if applicable*):	Position / qualification of person named on Scope of Practice who provides post-qualification supervision:

Professional Registration number: ..... Registration as a Prescriber with Regulatory Body confirmed / verified by Line Manager (or *other person signing off NMP Annual Declaration of Competence to Prescribe*): Name (*& position if not Line Manager*): ..... Line Manager signature: …….. Date: ……..	
NMP is included on UHB Register of Non-medical Prescribers – confirmed by: Name (*& position if not Line Manager*): ..... . Line Manager signature: ……..... Date: ……..	Scope of Practice submitted to Pharmacy within last 3 years: ☐ Yes ☐ Not applicable (not an active prescriber) ☐ No (*if >3 years, you will need to urgently submit an updated/revised signed copy of your Scope of Practice statement*)

NB It is the responsibility of the Non-Medical Prescriber to complete a new Scope of Practice statement immediately if any changes occur at any time e.g. change of role or clinical area

Section 2: Review of prescribing practice:

Are you currently using your NMP qualification? Yes / No (*delete as appropriate)*

If yes: please complete Sections 3, 4 & 5 below.

If no: please sign the following declaration and send a copy of this paperwork to Nmpadminpharmacy.Cav@wales.nhs.uk – please update this declaration **annually** if you are not prescribing; no other actions are required unless your prescribing activity status changes.

Declaration: I confirm that I am not currently using my prescribing qualification within my role in the UHB

Signed: .....

Section 3: Evidence of prescribing competency (only complete this section if you are an active prescriber):

Required evidence of competence (all NMPs who are using their prescribing qualification must meet the following standards for competency assurance)	**NMP signature** (*signing below confirms that this evidence exists and is available for review*)
I have a prescribing portfolio which includes **all** of the following records of evidence that demonstrate ongoing competence to prescribe (see below)	

My prescribing portfolio includes evidence that I have undertaken a self-assessment of my prescribing competence within the last 12 months using the RPS Competency Framework for All Prescribers	
My prescribing portfolio contains the following evidence of continuing competence to prescribe: • 1 Peer Review (eg case-based reviews, NMP Peer Groups, Clinical supervision, Discussion of prescribing practice, Random case analysis)	
My prescribing portfolio contains the following evidence of continuing competence to prescribe: • 2 Clinical logs (eg Planned or Unplanned CPD, Case reviews)	
My prescribing portfolio contains the following evidence of continuing competence to prescribe: • 2 records of Continuing Professional Development (eg Planned or Unplanned CPD, Audit, Patient experience / service user feedback)	
The evidence within my prescribing portfolio has all been discussed with the person named on my Scope of Prescribing Practice who provides post-qualification supervision (or another suitably qualified and experienced prescriber)	

Section 4: Prescribing Appraisal (only complete this section if you are an active prescriber):

All NMPs who are using their prescribing qualification must undergo a prescribing appraisal with a suitably qualified individual every 3 years – further guidance about this appraisal can be found in HEIW Standards for Competency Assurance of Independent and Supplementary Prescribers in Wales.

Date of most recent Prescribing Appraisal: .....

During initial implementation of the new 3-yearly appraisal process (until March 2027), NMPs will be able to complete their 'Annual Declaration of Continued Competence to Prescribe' (Appendix 5) and indicate that a full Prescribing Appraisal has not yet been completed which meets all the requirements of the new HEIW Competency Assurance Standards, however all UHB-employed NMPs must have discussed their current prescribing practice during an annual appraisal with their line manager (see 'Section 5: Professional Declarations' below).

Section 5: Professional Declarations (only complete this section if you are an active prescriber):

I confirm that:

1. I am registered with my Regulatory Body, and I have a prescribing annotation included in my entry on the register.

2. My current Scope of Practice Statement accurately and completely describes how I am using my prescribing qualification.
3. I regularly keep up to date with best practice within my scope of practice and have undertaken a self-assessment of my prescribing competence within the last 12 months which I can provide evidence of immediately upon request.
4. I have maintained a prescribing portfolio which contains all the above required evidence of competence to prescribe (in Section 3), and which I can provide evidence of immediately upon request.
5. I have discussed my current prescribing practice during an annual appraisal with my line manager (*applicable to UHB-employed NMPs only*).
6. I have / have not (*delete as applicable*) undertaken a full prescribing appraisal with a suitably qualified individual within the last 3 years which meets the requirements of the HEIW NMP competency assurance standards.
7. I will send a signed copy of this NMP 'Annual Declaration of Continued Competence to Prescribe' to (Nmpadminpharmacy.Cav@wales.nhs.uk) and hold one copy in my prescribing portfolio.

Signature of Non-Medical Prescriber:	Date:

Section 6: Line manager* confirmation:

I confirm that:

1. I have reviewed the professional declarations above which have been signed by the named non-medical prescriber and I support this individual continuing to prescribe in their current role.
2. I have / have not (*delete as applicable*) reviewed their prescribing portfolio.
3. I will place a signed copy of this declaration on the individual's personal file (*applicable to UHB-employed NMPs only*).

Line Manager* Name:	Line Manager* Signature:	Date:

** For independent contractors who are self-employed, this can be signed by the person named on the Scope of Prescribing Practice who provides post-qualification supervision (or another suitably qualified and experienced prescriber)*

Once completed, please send a copy of this paperwork to

Nmpadminpharmacy.Cav@wales.nhs.uk

Minutes of the Medicine Clinical Board
Quality, Safety & Experience Committee Meeting
19 November 2025 14:15 – 15:45, via MS Teams

	Attending	Apologies
MCB Operations/ Nursing Directors & Deputy Directors	Katja Empson (Chair), Jane Murphy, Ceri Richards-Taylor, Claire Main	Mike Bond, Cari Randall
Clinical Directors		Siobhan Lewis, Sharon Jones, Lyndsey MacDonald, Nikola Creasey, Chen Ngua, Aneurin Buttress, Richard Marsh, Tom Pembroke, Neera Agarwal
Patient Safety Team	Rajani Ponnada	
Staff-side		Jonathan Strachan-Taylor
Pharmacy		Manon Owen
People Services		Louise Halliday-Jones
Head of Quality & Clinical Gov.		Sian Rowlands
Quality & Governance Lead		
Consultant Nurse Practitioner, ED	Marianne Jenkins	
General Managers		Dan O'Donnell, Vicci Page
Lead Nurses	Wayne Parsons	Dave Pitchforth, Natasha Whysall, Ceri Martin
Senior Nurses	Beth Jones, Harriet Foley, Sue Eshel Cath Morris	Lisa Green, Sian Brookes, Lowri Warren, Claire O'Keeffe
Senior Nurse, Resuscitation		Angela Jones
Professional & Practice Development Nurses		Sam Hughes, Liz Vaughan
IP&C	Leeanne Provis	
Organisational Learning Facilitator, Mortality Lead		Nick Denny
Service Managers		Niki Turner
Finance		Gareth Jenkins, Kris Prosser
Presentation	Sarah Cornes-Payne	
I&I		Jess Jones
Secretariat	Sheryl Gascoigne	

		Action
1. PRELIMINARY ITEMS		
MCBQSE/ 2025/105	**Welcome and Introductions** – were undertaken. **To receive the minutes of the previous meeting held on 15/10/25** – the minutes were accepted as an accurate account of the meeting. **Action Log** – was updated. **Declarations of Interest** – none declared.	
2. ITEMS FOR REVIEW AND ASSURANCE		
MCBQSE/ 2025/106	**Patient Story, Specialised Medicine** – delivered by Beth Jones An out of area gentleman came to Specialised Medicine in 2021, with complex learning disability needs. Following a procedure, he had a prolonged hospital stay. The patient's family raised a concern regarding the care the patient received, and	

	the concern was dealt with. The patient had to return for a further procedure. A complex MDT took place, including the family and the Metabolic Team and the planning process started 4 months in advance of his procedure. The patient attended for his next procedure and there were no concerns raised by the family. The various meetings held helped to understand the patient's complex needs. **The group resolved**: that the work Specialised Medicine carried out in preparation of the patient's return procedure enabled the patient to have a good outcome. **Action:** to note the above.	
MCBQSE/ 2025/107	**Compliments** - 44 compliments were received in October 2025. **Emergency Unit** – in summary a lady came into the Emergency Department (ED) on 24/10/25 at 7.20pm, suffering with a severe sudden onset headache, rising hypertension, along with coughing and vomiting. The ED was very busy; however, the patient was triaged in 2-3 minutes of arrival. The patient received a thorough examination by Dr Aden who had a calm, professional and reassuring manner. Following tests, Dr Aden explained the results and reassured the patient that there was nothing sinister occurring. The patient left the ED at 11.30am. Dr Aden phoned the patient the next day for a follow up to check on her symptoms. The patient was reassured by Dr Aden's genuinely caring nature advising, UHW should be proud that their doctors, under the stress and pressures of working in A&E, are able to engage with and treat patients in such an exemplary way. **B7** - 'sincere thanks to the staff at UHW and the amazing care our family received at the end of Dad's life. Dad was on Ward B7 for palliative care. All staff were amazing, incredibly professional and compassionate. The 'end of life' sign on the door to my dad's room meant we knew we could ask for support whenever needed but were left to have precious time with Dad as a family and I will cherish this opportunity to say goodbye and comfort him. Dad was given the best palliative care we could hope for, compassion, pain relief, practical care and dignity. As a family we were treated with amazing compassion and care, with every member of staff playing a vital role. We will be forever grateful for the time we were able to spend with him, right up to his final breath and the amazing care he received.' **MCB Concerns** – data available for October 2025 There are 82 open concerns across MCB. On average closing 72% of concerns within a 30-day period. Themes are communication, patient care, staff attitude, clinical treatment, referral and appointment times. **The group resolved/ Action**: to note the above.	
MCBQSE/ 2025/108	**Safeguarding** – October 25 data 41 safeguarding cases are currently open across MCB. 29 safeguarding referrals were received. 119 referrals came from EU. There are 13 professional concerns open and in progress. The Safeguarding Steering Group was stood down for November 25 and the next meeting will take place in January 2026. **The group resolved/ Action:** to note the above.	
MCBQSE/ 2025/109	**Infection Prevention and Control (IP&C)** October 2025 MCB position based on same period 2024-2025: • Reduction - no cases of *Pseudomonas since March* 2025 • 35% reduction with *C. difficile.* • 18% increase with MSSA Bacteraemia's • 0% Change in MRSA Bacteraemia's, same as last year • 27% Increase *with Klebsiella* Bacteraemia's • 14% increase with *E. coli* Bacteraemia's Chilcott Rachel 03/03/2026 09:12:57	

Organism	Total for the month - Oct 25	Total April 2025 – Oct 25
C. difficile	2	25

MSSA	2	13	
MRSA	0	1	
Klebsiella	3	14	
Pseudomonas	0	0	
E. coli	3	24	

Incidents and Outbreaks

There were 20 incidents and outbreaks in October 2025 with a total of 86 patients and 27 staff affected and 70 bed days lost. Majority of Covid outbreaks were at UHL. Lansdowne ward is currently closed due to an outbreak. There are no further cases of C. difficile on C7.

UHL – East 8 and Stroke had prolonged Covid outbreaks. SRC outbreak had more prolonged outbreaks.

Audits – due to staffing constraints, not as many audits were undertaken. When staffing is back to full capacity the team will redevelop the audit plan.

Bed cleaning – it takes 45 minutes to thoroughly clean a bed. Concern was raised that the 45 minutes is not always available to enable bed spaces to be clean before the next patient goes in that bed space. Yvonne Hyde will discuss this further with Bed Management.

Klebsiella – 50% were from urinary tract sources, 21% respiratory, 14% unknown, 14% from an intra-vascular device, however, this referred to one patient who had episodes on A7.

CPO flags in EU – if a flag is put on clinical workstation, it will also show up on EU workstation. It is a red triangle with an exclamation mark, which if you double click on it on EU workstation it will show the patient history.

Water flushing – accurate records need to be kept of this.

Flu – is circulating earlier than in previous years. A new strain of flu is apparent which will impact on patients. The current vaccine offers some protection, however, lower protection for the new strain. All to promote staff get vaccinating. Get the message to patients to get vaccinated. LP will put on Teams the letter from the Chief Medical Officer regarding this new subclade of flu.

RCAs Outstanding April 2025 – September 2025

Organism	Number of RCAs sent	No. of RCAs returned	% Return rate
C. difficile	25	19	76%
MSSA	13	10	77%
MRSA	1	1	100%
Klebsiella	14	8	57%
Pseudomonas	0	-	-
TOTAL	53	38	72%

Actions/ the group resolved: to note the above.

MCBQSE/ 2025/110

The following updates have been carried over to next month's meeting:

Family feedback, Medical Examiners Reports – update from Nick Denny.

Care after Death – update from Nick Denny.

MCB Risk Register AMaT – update from Lyndsey MacDonald

MCBQSE/ 2025/111

Five-year plan for delivery of effective diabetes technology to adults, children and young people to prevent short and long-term complications of diabetes – update from Sarah Cornes-Payne.

Due to the improvements in treatment and improved outcomes NICE has now mandated the use of insulin pumps for therapy for people with type 1 diabetes who meet certain criteria. In C&VUHB there are approximately 2,400 people with type 1 diabetes, of which 240 are children. There are 500 adults on the waiting list for pump therapy with an estimated waiting time of 4.5 years. In the next five years, based on the eligibility criteria there would be over 1,200 adults

	who meet the requirement for HCL. Within current staffing resource, it would take over 17 years to onboard these adults. The adult pump service is currently paused, and a business case is being prepared. SC-P shared slides with patient comments regarding the impact the Insulin Pump Service has had on them; the long waiting time to be issued with a pump; and the patient concerns having. **The group resolved:** this was discussed at today's MCB Executive Review and is being prioritised. **Action**: CM, JM, CR-T and SC-P to have a conversation outside of this meeting to see how best to respond to patient feedback and answering specific patient info. This is a sizeable piece of work, however, this needs to be funded and delivered. **Action**: Katja Empson will discuss this with Neera Agarwal shortly.	Claire Main Jane Murphy Ceri R-Taylor Sarah C-Payne Katja Empson
3 ITEMS FOR APPROVAL/ RATIFICATION		
MCBQSE/ 2025/112	**National Reportable Incidents (NRIs)** – there are 14 open NRI's. 8 are outstanding. Jane Murphy to meet with Rajani Ponnada and Lead Nurses – Sheryl Gascoigne to arrange a meeting to discuss status of NRI's. **Integrated Medicine**: 1 omission of time critical medication **Specialised Medicine**: 9 (2 breached WG closure date aiming to close November/ December) 2 pending new Dermatology NRI's • 5 delayed cancer diagnosis (1 downgrade requested) • 1 metoacidosis from bowel preparation • 3 Dermatology delayed diagnosis **Emergency & Acute Medicine**: 4 (4 breached WG closure date 1 submitted for closure 12/11/25) • 1 never event (wrong side pleural tap) • 2 potential missed diagnosis • 1 IV medication/infusion error **NRI for closure**: **ID 88916, patient KT**- presented by Katja Empson Failure to identify the level of critical illness the patient had when assessed in the ED. The patient was referred to the medical team, however, the referral did not have the appropriate level of escalation, therefore, there was a delay in the medical team reviewing the patient. In the meantime, the patient sadly deteriorated and was admitted to Intensive Care due to not having had the intervention early enough. **Recommendations**: - Regarding news score completion on the ground floor at triage. - Educational training regarding respiratory failure and blood gas analysis for medics in ED. - General awareness for ED team regarding handing over patients and referrals. - This has been discussed at the ED QSE meeting. This NRI can now be closed. **Integrated Medicine: ID77021; ID79017; ID79631** **The group resolved:** the above NRI's will be presented for closure at the next meeting.	Sheryl Gascoigne
MCBQSE/ 2025/113	**Change from first line IV Iron from Cosmofer to Ferrinject**	

	This has advantages to patients as it has a very short infusion rather than quite a prolonged infusion. **The group resolved/ Actions from discussion**: to note the above.	
4 ITEMS FOR NOTING AND INFORMATION		
MCBQSE/ 2025/114	**Patient Safety Alerts/MDAs/ISNs** – to be noted.	
MCBQSE/ 2025/115	**Minutes from Directorate QSE Groups and Chairs Reports/Exceptions:** Acute & Emergency Medicine minutes 9/9/25 and 14/10/25 Integrated Medicine - UHW (await minutes) Integrated Medicine UHL last meeting 21/10/25 EUG last meeting 18/9/25 **The group resolved**: to note the above. **Action from discussion:** none	
MCBQSE/ 2025/116	**Minutes from QSE Sub-groups**: IP&C last meeting 4/6/25. Last meeting 31/10/25. H&S last meeting 1/10/25 Medicines Governance and Access Group minutes 17/10/25 Professional Nursing Board last meeting 10/2/25. Currently stood down	
MCBQSE/ 2025/117	**Feedback from UHB QSE Committee** – no update.	
MCBQSE/ 2025/118	**AOB** **Supporting Smokers in Secondary Care** - ESR training module has been launched. Congratulations to Ward East 8, CF CNS team, Lung Function Team and East 2 who have all been recognised for completing the new ESR training modules and were awarded with healthy food hampers. **ePMA** – rolled out in MCB at UHW on inpatient wards, except for the ED. ED and UHL will go live in 2026. **MCB Staff Celebration event** – 2-4pm on 4/12/25. **Risks regarding Winter Ward** – concern was raised and escalated today. The vacancies of the Ward Manager and Deputy Ward Manager for winter capacity will be discussed at CVSP/EVSP today. **The group resolved**: to note the above. **Action from discussion:** none	
5. ANY OTHER BUSINESS/ DATE AND TIME OF NEXT MEETING		
MCBQSE/ 2025/119	**Date and time of next meeting** – 17/12/25 at 14:15 Teams meeting	

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

PCIC CLINICAL BOARD
MINUTES OF THE QUALITY, SAFETY & EXPERIENCE GROUP
TUESDAY 23rd September 2025 11:00 – 13:00
Venue: MS TEAMS

FINAL VERSION
Signed off following November 2025 meeting

Attendees:

- Andrea Rich, **AR**, Lead Nurse for Palliative Care, PCIC
- Anna Mogie, **AM**, Deputy Director of Nursing, PCIC (Chair)
- Carol Preece, **CP**, Lead Nurse for Community Specialist Services
- Clare Clement **CC**, Lead Pharmacist, PCIC
- Eleri Thomas, **ET**, Quality and Safety Officer, PCIC (minute-taker)
- Ellen Davies, **ED**, Infection, Prevention and Control Clinical Nurse, PCIC
- Emyr Stephens, **ES**, Vale Locality Lead Pharmacist, PCIC
- Hayley Pugh, **HP**, Interim Head of Primary Care, PCIC
- Helen Donovan, **HD**, Locality Lead Nurse for Cardiff, PCIC
- Dr Huw Brunt, **HB**, Consultant, Public Health
- Kate Roberts **KR**, Senior Nurse Vale Locality, PCIC
- Lisa Waters, **LiW**, Senior Nurse for Quality, Safety and Education, PCIC
- Louise Allen, **LA**, Head of Community Pharmacy, PCIC
- Neil Morgan, **NM**, Vale Locality Manager, PCIC)
- Rachel Armitage, **RAr**, Quality and Safety Manager, PCIC
- Rebecca Stringer, **RS**, Acting Lead Nurse for Community Specialist Services, PCIC
- Ruth Cann, **RC**, Consultant Nurse Older Vulnerable Adults, PCIC
- Victoria Whitchurch, **VW**, Head of Operations for Community Specialist Services, PCIC

Guest Speakers:

- Hilary Hyett, **HH**, Team Lead, Cardiff Community Resource Team
- Kathryn Wilcox, **KW**, Physiotherapy Team Lead, Cardiff Community Resource Team
- Stephanie Ashmore, **SA**, Safeguarding Advisor, Corporate Safeguarding Team
- Stephanie Lavelle, **SL**, Occupational Therapist, Cardiff Community Resource Team

Apologies:

- Amy English, **AE**, Deputy Regional Director for LLAIS, Cardiff and Vale
- Barbara Davies, **BD,** Interim Director of Nursing, PCIC
- Bethan Watkins, **BW**, Safeguarding Nurse Advisor, Corporate Safeguarding Team
- Danielle James, **DJ**, Senior Operational Manager, CAV 24/7
- Dr Gneeta Joshi, **GJ**, Community Director of Governance, PCIC
- Dr Helen Cordy **HC**, Point of Care Clinical Lead
- Dr Helen Kemp, **HK**, Clinical Director for Quality, Safety and Governance & Deputy Clinical Board Director
- Helen Earland, **HE**, Clinic and Operational Lead for Urgent Primary Care, PCIC
- Janice Aspinall, **JA**, Anaesthetics Nurse, Anaesthetics
- Josie Collins, **JC**, Senior Nurse, Cardiff and Vale Health Inclusion Service
- Lauranne Cullen, **LC**, Regional Director for LLAIS, Cardiff and Vale
- Lloyd Waygood, **LlW**, Deputy Head of Operations, Cardiff Locality, PCIC
- Nicky Punter, **NP**, People Resourcing Manager, Workforce & Recruitment
- Rebecca Lewis, **RL**, Principal Public Health Practitioner
- Sarah Griffiths, **SaG**, Interim Assistant Director of Primary Care, PCIC

Chair: Anna Mogie **AM**, Deputy Director of Nursing, PCIC

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

September meeting Agenda: 00 PCIC QSE Agenda - 2025.09.23 - FINAL.docx

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

ITEM NO.	TITLE	ACTION
Part 1	**ITEMS FOR DISCUSSION**	
25/09/01	***Welcome & Introductions*** *Anna Mogie noted the attendees as listed on page one.*	
25/09/02	***Apologies for absence*** *As listed on page one.*	
25/09/03	***Declarations of interest*** *None declared.*	
25/09/04	***Minutes and Matters Arising*** *The PCIC QSE July minutes were deemed accurate - Item 04.1*	
25/09/05	***PCIC Quality & Safety Action Log*** *The action log from the July meeting was reviewed and updated - 05.1 - Action Log PCIC QSE July 2025.docx* *The new September action log created from today's meeting has been linked above.*	
25/09/06	***Patient Story*** *Louise Allen presented a case demonstrating collaborative work between the Community Pharmacy Team and the Medicines Management Team. The patient, medically fit for discharge experienced significant discharge delays due to difficulties in securing a community pharmacy willing to provide a new blister pack for his medication. The patient lived alone, with no family support, and relied on carers who could only prompt, not administer, medication.* *The group discussed the significant challenges associated with arranging blister packs for patients being discharged from hospital and the lack of clarity regarding responsibility for arranging blister packs, with hospital staff, social workers etc* *The story underlines the importance of collaborative working across teams and the need to focus on patient-centred solutions, balancing safety, efficiency, and resource allocation. It also points to potential improvements, such as the implementation of MAR (Medication Administration Record) charts and further training for care teams, to streamline the discharge process and reduce unnecessary hospital stays.*	
25/09/07	***Risk Register Update*** *The live risk register can be found here - Item 7.1* *The how-to guide, previously circulated via email, was noted - Item 7.2* *Lisa Waters reported that PCIC is transitioning to a new risk register system on AMaT. The existing system successfully collates higher risks into reports for the Executive Teams, and thanks were expressed for contributions received. A 'how to guide' has been distributed, with feedback noted, and is available on the risk register information section of SharePoint. Monthly reviews continue under the oversight of the Senior Management Team.* *The AMaT risk module is being introduced in the PCIC Clinical Board and will be expected to be used for risk registers at all levels, with an ongoing working group collaborating with Corporate Teams to develop a Clinical Board-wide risk register on AMaT. A comprehensive implementation plan is required, including engagement with business units, due to the significant differences of the AMaT system compared to previous approaches.*	

	Rachel Armitage noted that a PCIC implementation programme for the Clinical Board is underway. The primary challenge lies in the current Executive team's approach to risk management, which differs from practices of the past five years, and further guidance from the Executive Team has been sought. The Quality and Safety team will coordinate the implementation over the coming months, with Corporate Teams aiming for completion by the end of the financial year. Implementation will be carefully managed in light of ongoing operational pressures. *Anna Mogie clarified that while AMaT is used elsewhere across the UK, the risk register module was specifically developed for C&V UHB. The system will generate frequent email notifications to risk owners, helping to keep the register up to date. Training and support will be necessary for widespread use, as responsibility for risk registers is shared among many individuals across the Clinical Board.* *Rachel Armitage is currently adding high-level risks to AMaT, as requested by the Corporate Teams, with lead persons for each risk to be notified by email by end October 2025.*	
25/09/08	***PCIC Quality Report*** *Full report linked here - Item 08.1* *Lisa Waters reported that there had been three open NRIs. Two had been completed and circulated to teams for factual accuracy, with closure anticipated by the end of the month of October 2025. One case related to a patient death at HMP Cardiff in January 2025, while the second involved a medication error contributing to a patient's death. The most recent NRI had commenced, with the reviewer undertaking the PSLR process.* *Lisa Waters explained changes in the Concerns team structure which has now been split into two areas– enquiries team and concerns team. Enquiries will be actioned within 5 working days. Early Resolution will be 2 working days. PTR will be 30 working days as normal.* *Regarding DATIX, Lisa Waters noted that all Datix incidents from 2023 had been closed, with work ongoing on 2024 cases. The Patient Safety Team, operating corporately, had continued to contact staff regularly and had offered drop-in sessions for guidance on Datix incident management and closure. An email regarding these sessions had recently been circulated to all teams by Anna Mogie.* *Relating to Inquests, it was reported that several inquests had taken place with attendance from PCIC staff. The QS&E team had met with staff prior to inquest hearings to provide process guidance and support, ensuring staff were prepared for Coroner's Court. One staff member attended an inquest in September, with another case scheduled for November.* *For Safeguarding Training, level 1 compliance is currently 84.27% and Level 2 is currently 65.28%. Lisa Waters made the request to staff to support our areas in making sure that their mandatory and statutory training is up to date.*	
25/09/09	***NRI feedback*** *NRI - See above* *Pressure Damage NRI - There have been three avoidable pressure damages noted in the last 6 weeks within the Clinical Board. There is work with the teams, learning and what can be done to support in terms of education/training; the cases are due to be discussed at the redress panels.* ***ACTION: Lisa Waters to present themes around pressure damage incidents during November PCIC QSE meeting.***	***Lisa Waters***

	The following NRI was shared for noting - patient safety review ID5067 (please see item 09.1, specifically pages 10-13). This was not led by PCIC, but by Secondary Care, and related to a missed or delayed diagnosis of prostate cancer. PCIC were involved with the patient who was catheterised and had a complicated complex catheter which kept blocking and was being frequently replaced but had not been escalated. Potentially if that had been escalated, this may have led to his diagnosis being earlier than it was. The patient was missed to follow up when a clinic was cancelled. Since this event, PCIC have a standard operating procedure which has been implemented across District Nursing in terms of what, when and how to escalate problematic catheters. Anna Mogie highlighted that staff frequently attend to patients requiring repeated catheterisation, but escalation procedures are not always followed appropriately, particularly when such incidents occur outside of regular working hours, leading to them being overlooked.	
25/09/10	***PCIC QSE Terms of Reference*** *Anna Mogie noted that the Terms of Reference need to be reviewed annually. They include details of members and attendees.* *November 2025 Terms of Reference are linked here - Item 10.1* *All to send any comments about the Terms of Reference to Eleri Thomas within two weeks (by 07/10/25). They will then be signed off as reviewed.*	
25/09/11	***DATIX Support Sessions*** *A message of thanks was shared on behalf of Matt McCarthy, Head of Safety, Quality and Learning, for all staff who have attended recent DATIX Incident Manager Support sessions.* *Details can be found here - Item 11.1* *The sessions are mainly held in UHW and UHL but the Patient Safety Team have agreed to do bespoke sessions for PCIC Community teams. Anna Mogie suggested the Patient Safety Team could be invited to individual Business Unit Quality and Safety meetings to discuss further.*	
25/09/12	***Infection Prevention and Control*** *Ellen Louise Davies presented the following items:* • *General Update – Item 12.1* • *IP&C Audit: Butetown Health Centre 18/08/2025 (Item 12.2 , Item 12.3)* • *IP&C Audit: Broad Street Clinic, Barry 02/09/2025 (Item 12.4, Item 12.5* *Audit results indicate a general reduction in infection rates compared to the previous year, with the exception of MRSA, which saw three cases early in the year. Numerous estates and housekeeping issues, including clutter and toy hygiene, continue to affect audit outcomes, although some improvements have been noted, particularly at Llantwit Major clinic.* *The Cardiff and Vale TB procedure has been updated to require staff to wear FFP3 masks for all suspected or confirmed pulmonary TB cases, with a reminder on the need for fit testing and available support for staff requiring training.* *Training on carbapenem resistant organisms (CPO), increasingly found in the community, is available for staff wishing to attend and covers essential practice requirements for those visiting patients in their homes.* *Staff were reminded of the importance of receiving the flu vaccine this year, given predictions of a severe influenza season and recent experiences in Australia where low vaccination uptake affected outcomes.*	

	Regarding C. diff RCA reporting, Concerns were raised regarding insufficient or missing Discharge Advice Letters (DALs) and incomplete information provided to GPs following hospital admissions, which aligns with recurring DATIX incident reports. The necessity for improved communication and comprehensive discharge information was emphasised, with ongoing escalation and reinforcement across relevant clinical boards and committees.	
25/09/13	***Safeguarding Metrics*** *Please see full report linked here - Item 13.1* *Lisa Waters highlighted that the report contains links to safeguarding training updates, including dates for mandatory domestic abuse training dates. There are documents shared from the Local Authority regarding children and families moving across borders.* *Lisa Waters noted that the training highlighted in red on the final page relating to congenital dermal melanocytosis (birthmark that looks like bruises and can be mistaken for non-accidental injury) is a pre-and post-knowledge check, not a training video.* ***ACTION: Lisa Waters will seek clarification from the Safeguarding team to source the original training video for learning regarding congenital dermal melanocytosis.***	***LISA WATERS***
25/09/14	***Network Communication - Child Protection Medical Information Leaflet*** *Information leaflets outlining what carers of children and young people can expect if a child protection medical referral is made will be distributed to Primary Care. The leaflets are intended for dissemination via the Primary Care newsletter and may also be relevant to certain PCIC services, such as CRI.* • *Item 14.1* • *Item 14.2* • *Item 14.3*	
25/09/15	***Transcribing of Medication by Community Based Nursing Services*** • *Item 15.1 - Standard Operating Procedure* • *Item 15.2 - Insulin Authorisation Sheet* • *Item 15.3 - Implementation Plan* *Anna Mogie provided an update on the implementation of transcribing within the Community District Nursing Services. Anna Mogie reported that a Standard Operating Procedure (SOP) has been developed, based on the All Wales District Nursing SOP, and has been expanded to encompass all community-based nurses working with adults. The SOP, alongside the implementation plan, has received approval from both the Medicines Management Group and the Nursing and Midwifery Board (NMB) and is presented here for noting.* *Anna Mogie confirmed that education and training initiatives have commenced throughout the community nursing services, with an anticipated go-live date at the end of November. Anna Mogie has consulted with the LMC, and the matter is scheduled for discussion on the October agenda. Further, communications will also be initiated at cluster level to ensure GPs and practitioners are informed of the forthcoming changes and what to expect.* *Lisa Waters reported that the first face-to-face training workshop was successful, with positive feedback from attendees. District Nurses were required to complete the e-learning prior to attendance, with the workshop designed to supplement this learning. Thanks were extended to the pharmacy team, Ceri Clatworthy and Helen Jarvis for their support.* *Workshops included preparatory dummy runs to address potential questions and*	

	issues, with further queries raised during the session. The workshop will run every Wednesday from 14:00 to 16:00, and staff can book via ESR. *Kate Roberts highlighted a scheduling conflict for some district nurses due to university commitments on the same day, with Lisa Waters planning to look into if an alternative date can be offered. Anna Mogie confirmed that workshops will operate on a rolling basis, with additional 'mop up' sessions planned to ensure all required staff are trained.* ***ACTION: Lisa Waters to seek alternative dates for training due to conflicts with university commitments for transcribing of medication.***	***LISA WATERS***
25/09/16	***Safeguarding Update (5-10mins)*** *Stephanie Ashmore, Safeguarding Advisor, delivered a six-monthly update covering the Cardiff and Vale Safeguarding Team structure, current operations, training requirements, statistics, and key safeguarding issues.* *Please see full presentation here - Item 16.1* *Team Structure:* *Fiona Bullock is acting Head of Safeguarding following the retirement of Linda Hughes-Jones. The team includes safeguarding nurse and midwife advisors, a training lead (Nicola Johnson), administrative staff, independent domestic abuse advocates based in the hospital, a Violence Prevention Unit located in A&E, and a Mental Capacity Team in Woodland House. The Safeguarding Team operates across three sites including Cardiff Bay Police Station and the Children's hospital's Seahorse Ward. Contact details and working hours (Monday–Friday, 09:00–17:00) were shared.* *Safeguarding Contacts:* • *Safeguarding Team: 02921832001 / safeguarding.referrals@wales.nhs.uk* • *Cardiff Social Services: 02920 536400* • *Vale Social Services: 01446 725202* • *Out-of-hours Social Services: 02920788570* • *Emails: csmash@cardiff.gov.uk, dutymarfs@valeofglamorgan.gov.uk* *Training Update:* *It is mandatory for all staff to complete Level 1 safeguarding training (available on ESR), as well as training on violence against women, domestic abuse, and sexual violence. Level 2 is also available via ESR. The Safeguarding Team provides a three-hour "Ask & Act" session via Teams. Level 3 safeguarding training is required for band 6 clinical staff and above, and F1 medical staff; managers may also enrol band 4 or 5 staff at their discretion. Training topics include 'What happens next', 'Adults at risk', and 'Exploitation Day'.* *Safeguarding Statistics:* *- Level 1 Violence Against Women: 76.97% (target 85%)* *- Level 2 Safeguarding Adults: 84.52%* *- Level 2 Safeguarding Children: 84.83%* *- Level 3 Safeguarding Adults: PCIC is among the better Clinical Boards.* *There remain discrepancies in data recording, particularly for ECOD. The Safeguarding Team is reviewing which Clinical Boards require further support to improve Level 3 training compliance.* *Current Reviews and Forums:* *Three child practice reviews, three adult practice reviews, six multi-agency forums, one offensive weapon homicide review, and four Single Unified Safeguarding Reviews (SUSRS) are ongoing.* *Key Updates and National Safeguarding Week:*	

	National Safeguarding Week will be held 10–14 November 2025, focusing on Child Sexual Abuse. All Clinical Boards will receive promotional materials and information. The current focus is the Prevent strategy, part of the UK's counterterrorism framework, with rising concerns regarding individual radicalisation and domestic terrorism. The framework has four areas: prevent, pursue, protect and prepare. Staff should discuss suspicions of extremism with the Safeguarding Team or report via the All Wales Partners Prevent Referral Form. The Channel Panel meets monthly, supporting affected individuals through multi-agency collaboration.	
25/09/17	***Public Health Wales Briefing: Measles*** *There has been considerable publicity regarding the measles outbreak in England, and, following last year's outbreak in Wales, PCIC services are working to improve MMR vaccine uptake, with guidance issued on protective measures and epidemiological data available from Public Health. FFP3 masks should be used if there is a confirmed or suspected case in PCIC.* *Please see item linked here - Item 17.1*	
25/09/18	***Community Resource Team (CRT) Presentation (10 mins)*** *Please see following presentation for full details – Item 18.1* *Hilary Hyett and Kathryn Willcox from the Cardiff Community Resource Team (CRT) presented the findings of an audit comparing CRT's performance against the All-Wales Community Rehabilitation Best Practice Standards, released by HEIW in September 2023. These standards aim to address inconsistencies in community rehabilitation across Wales and provide a framework for high-quality, person-centred care, focusing on early identification of need, holistic assessment, multidisciplinary working, and equitable access. The audit was conducted using two tools—one for staff and one for service users—adapted with HEIW's approval to suit the local context, ensuring more meaningful responses from both groups.* *15. Key themes from the audits included culture and diversity, agile and flexible working, IT challenges, staffing, and benchmarking/networking. The process highlighted gaps in formal experience and outcome measures, prompting the development of new Patient Reported Experience and Outcome Measures, due to launch in October 2025, to support continuous improvement.* *CRT has implemented several initiatives in response to the findings, including a new digital referral form, an updated data dashboard, improved translation services, and enhanced learning sessions for staff. Ongoing work involves liaising with HEIW for benchmarking and integrating feedback mechanisms, with ambitions for greater alignment with social services and a national approach to measuring outcomes..* *Anna Mogie queried how the Cardiff Community Resource Team (CRT) performed against the All-Wales Community Rehabilitation Best Practice Standards. Kathryn Willcox responded that CRT had identified areas where they were not fully meeting the standards across five key themes but were unable to benchmark their performance against other Health Boards as comparative data from HEIW was not yet available. CRT is awaiting this benchmarking information.* *Anna Mogie suggested the value of sharing good practice and utilising the new CRT dashboard, which now provides live data. Emyr Stephens questioned whether reducing the service user survey from 32 to 9 questions had affected the comprehensiveness of the data collected. Kathryn Willcox explained that the condensed questions were designed to cover the same topics and that many of the original questions were repetitive; the new approach was appropriate for the audit's purpose and aligned with the forthcoming enhanced Patient Experience Measure.* *Anna Mogie also raised the importance of integrating feedback with social services, as service users often do not differentiate between the types of care received. Anna*	

	Mogie advocated for a more integrated, national and local approach to feedback, covering wider aspects such as reablement and personal care. Hilary Hyett agreed, noting that CRT is collaborating with the Strategic Programme for Primary Care and considering the EQ5D as a national tool for outcome measurement, aiming for an integrated All-Wales approach in the future. The community rehabilitation standards have provided a platform for this ongoing development and alignment with national and UHB priorities. *Finally, Anna Mogie enquired whether similar practices were being followed in the Vale. Neil Morgan confirmed that similar approaches were in place and that outcomes would be shared.* ***ACTION: Feedback from a Vale perspective is requested following the recent update on the findings of the Cardiff Community Resource Team audit, which was conducted against the All-Wales Community Rehabilitation Best Practice Standards.***	***NEIL MORGAN & Vale Team***
25/09/19	***Compliments*** *Anna Mogie acknowledged and thanked staff following these compliments across PCIC:* • *Please see attached item for full compliments – Item 19.1* • *ANCLE Café Wins Prestigious National Award – please see Item 19.2*	
25/09/20	***Concerns*** *Eleri Thomas noted that recent Ombudsman responses and decision letters that were discussed during the Primary Care QSE meeting will be noted at the next PCIC QSE meeting.* *Rachel Armitage noted that the Ombudsman's responses are generally balanced and proportionate, with most cases not upheld against GP practices except where procedural errors occur, such PTR process, underscoring the importance of adhering to correct processes and maintaining thorough evidence.*	
25/09/21	***All Wales Learning From Events Report (LFER)*** *Full report - Item 21.1* *The All Wales Learning from Events Report (LFER) was noted, focusing on a missed opportunity in the Community Dental Service for an HMP Cardiff resident. The incident involved delayed X-rays, resulting in undiagnosed dental caries and subsequent tooth extraction, which led to a clinical negligence claim and acceptance of a breach of duty. The Health Board has acknowledged the issue and implemented an action plan, ensuring the learning is considered at relevant forums. The event and associated learning will be reported accordingly.* *Rachel Armitage commended Lottie Ramsden for her considerable efforts in completing the LFER, noting the challenge as the incident occurred six years prior and many involved staff have since moved on.* *Anna Mogie highlighted that clinical negligence claims often arise long after the event, and emphasised the importance of initiating learning as soon as issues are identified, rather than waiting for case resolution. She noted the requirement to demonstrate learning and redress to the Welsh Risk Pool, which can be challenging when significant time has passed and original staff are no longer available for reflection. Anna Mogie also acknowledged Lottie Ramsden's work in this context.*	
25/09/22	***POCT Update*** *Please see update in full from Dr Helen Cordy - Item 22.1*	

	Testing Meters *An audit of INR self-testing meters revealed significant variation in practice across GP surgeries. Approximately half of responding practices reported having at least one or two patients undertaking INR self-testing, but fewer were aware of existing guidance or where to locate it. There were inconsistencies in action limits used for repeat or confirmatory tests, and concern was raised about patients acquiring devices from unofficial sources, such as online marketplaces. The current guidance document is considerably overdue for review, and it was agreed that it should be updated with clinical haematology input to ensure it remains fit for purpose. Recommendations include enrolling all devices on an EQA (External Quality Assurance) scheme, maintaining an up-to-date device log, and ensuring practices have direct access to EQA performance data. Dissemination of updated guidance to all relevant practices was also discussed, alongside the need for ongoing education and clarification of responsibilities between teams, particularly in light of limited central resources.* ***ACTION: Helen Cordy to link in with Primary Care team when INR Self-testing guidance has been updated to look at appropriate education and dissemination of information.*** *HMP Update* *It was reported that some glucose meters in the prison service (HMP) had gone missing after being issued to patients. Corrective actions are underway, and the nursing team is addressing the issue. The situation is attributed in part to staffing challenges and operational churn within the prison, but stabilisation is expected. The team expressed confidence in the current nursing leadership and noted that the matter is being managed appropriately.*	***Helen Cordy***
25/09/23	***Individual Care*** *Nothing noted under this heading.*	
25/09/24	***Medical Devices Involved in Incidents*** *The following paper was noted: Item 24.1*	
25/09/25	***Patient Safety Newsletter Spring 2025*** *The following paper was noted: Item 25.1*	
25/09/26	***Resuscitation Newsletter July 2025*** *The following paper was noted: Item 26.1*	
25/09/27	***Care after Death Newsletter August 2025*** *The following paper was noted: Item 27.1*	
25/09/28	***NHS Wales e-Library for HEIW*** *The following paper was noted: Item 28.1*	
25/09/29	***Greener Primary Care Wales Expert Group*** *The following paper was noted: Item 29.1* *Notification of new interactive map – link here*	
25/09/30	***Neurodivergence Cymru training dates*** *Although the training date had passed, the following was highlighted for awareness: Item 30.1*	
25/09/31	***OOH Business Report*** *The following report was noted in the absence of any team members at this point in the meeting -Item 31.1*	
25/09/32	***Cardiff Community Business Unit*** *Helen Donovan noted that everything was noted in the report for information - Item 32.1*	

25/09/33	***Vale Locality Business Report*** *Kate Roberts and Neil Morgan did not have anything further to add to the report - Item 33.1*	
25/09/34	***Cardiff Specialist Business Unit*** *Carol Preece did not have anything further to add to the report - Item 34.1*	
25/09/35	***Medicines Management*** *The following report was noted in the absence of any team members at this point in the meeting - Item 35.1*	
25/09/36	***Palliative Care*** *Andrea Rich did not have anything further to add to the report - Item 36.1*	
25/09/37	***Primary Care*** *It was noted that the Primary Care QSE meeting in July was cancelled and the September minutes are being written.* *Hayley Pugh noted the closure of Corporation Road Surgery went smoothly and this will be detailed in the Primary Care September minutes.* *Anna Mogie raised that the recent discussions about the dental contract, specifically concerns about not having a dentist and patients seeing whoever is allocated to you at that time, were discussed on BBC Wales News recently.*	
25/09/38	***Any other business to be discussed*** *Rebecca Stringer raised a recent CNO letter has been shared about immunisation, reminding staff about their professional responsibility to promote vaccine uptake to both staff and patients.* *Anna Mogie attended the recent Immunisation Board and noted that staff uptake of the flu vaccine was poor last year and so encouraging staff this year is welcomed.*	
PART 2	*PART 2: Items to be recorded as Received and Noted for Information by the sub-Committee*	
25/09/39	*All items below have been previously circulated as appropriate.* *PCIC Central Register – Comms & Alerts*	

Date and time of next meeting: Tuesday, 18th November 2025 at 11.00 am.

Minutes of the Children & Women's Clinical Board QSE (CWQSE) Committee
Held on Tuesday 28th October 2025 at 8.30am
Via Microsoft Teams

Present:		**Title**
Abigail Holmes	AH	Director of Midwifery & Neonatal Services, C&W Clinical Board
Samuel Barrett	SB	Deputy Director of Operations, C&W Clinical Board
Tirion Pryce	TP	Health & Safety Advisor
Becci Ingram	BI	General Manager, CYPFHS Directorate
Alison James	AJ	Lead Nurse, CYPFHS Directorate
Paula Davies	PD	Clinical Governance & Risk Lead Nurse, CYPFHS Directorate
Hannah McLoughlin	HM	Clinical Governance & Risk Lead Midwife, Obstetrics & Gynaecology Directorate
Genevieve Thueux	GT	Clinical Director, CHFW Directorate
Alison Lewis	ALEWIS	Patient Safety Advisor
Louise Platt	LP	General Manager, CHFW Directorate
Lois Mortimer	LM	Head of Midwifery/Directorate Lead Nurse, Obstetrics & Gynaecology Directorate
Rhodri John	RJ	Directorate Manager, Obstetrics & Gynaecology Directorate
Ceri Phillips	CP	Deputy General Manager, CHFW Directorate
Ryan Paxford	RP	Fire Safety Advisor
Natalie Vanderlinden	NV	Designated Education Clinical Lead Officer (DECLO)
Suzanne Davies	SD	Senior Nurse, CHFW Directorate
Janice Aspinall	JA	Lead H&S Staff Side Representative
Tina Freeman	TF	Senior Nurse, CHFW Directorate
Elizabeth Sheppard	ES	Governance Midwife
Fionn Lloyd	FL	Staff Nurse, Safeguarding Team
Angharad Grimwood	AG	Governance Midwife, Obstetrics & Gynaecology Directorate
In Attendance		
Apologies		
Kirsty Hook	KH	Risk, Governance & Patient Experience Facilitator, C&W Clinical Board
Andy Jones	AJONES	Director of Nursing, C&W Clinical Board
Emma Bramley	EB	Quality & Safety Lead, CHFW Directorate
Karenza Moulton	KM	Lead Nurse, CHFW Directorate
Anthony Lewis	AL	Clinical Board Pharmacist
Kate Leney	KL	Service Manager, Obstetrics & Gynaecology Directorate
Angela Jones	AJ	Senior Nurse, Resuscitation Services

Item No	**Agenda Item**	**Action**
CWQSE/ 2025/169	**Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2025/170	**Apologies for Absence** The apologies for absence were noted **The CWQSE resolved:** a) The apologies were noted	

CWQSE/ 2025/171	**Minutes of the previous Q&S Meeting held on 23rd September 2025** The minutes of the meeting held on 23rd September were agreed to be an accurate record. **The CWQSE resolved:** a) The minutes were noted and agreed	
CWQSE/ 2025/172	**1.4 To note and update the latest action log (from AMaT System)** The action log is now available via AMAT for live updates to be provided. Outstanding actions will be followed up outside of the meeting for completeness. Requests were made for the action log to be updated via the AMaT system following the meeting. Bladder Care Improvement Plan – agreed that this would be shared for information at a future meeting. **The CWQSE resolved:** a) Further update to be provided on any key outstanding actions at the next meeting. b) Action log to be updated via the AMaT system following the meeting. c) Bladder Care Improvement Plan to be shared.	**ALL** **HM**
HEALTH & SAFETY		
CWQSE/ 2025/173	**Update from Operational Health & Safety Representative** Presentation update shared. • Breakdown of the Datix incidents reported from July – October 2025. Aggressive, threatening behaviour remains the highest reported incidents. Slip, trips and falls is also a highly reported incident, and all were asked to review how we can manage areas more effectively to try to minimize the risks and ensure there is learning from the investigations. • COSSH work continues. Visits have been undertaken with a number of ward areas to progress management of COSSH. • Lone worker report was noted. Costs are applied to every device, and it was noted that the lowest usage was reported within Midwifery. Of 33 devices only x1 has been used. It was requested that this would be reviewed to understand the lack of use. • X14 DNA's reported within the last quarter. • Risk assessment regarding door issues within Maternity is being reviewed. • Medstrom have offered bed replacements but are not fit for purpose for T2 and are being reviewed. Further work is underway across other areas including the CHFW. • Training review for modules B&C has been completed • Module C extended and now includes communication and de-escalation • Review of Module C+ continues. • H&S Management audit undertaken on Owl Ward and there were no major findings to report. SARC H&S Management Audit scheduled for 4th November 2025 • RIDDOR target for C&W Clinical Board is 5 • Update provided on further work that has been ongoing across the clinical board. Full detail shared within the presentation.	

	The CWQSE resolved: a) Update noted. b) Lone Worker device usage to be reviewed within Midwifery Services.	**LM**
CWQSE/ 2025/174	**Latest H&S Dashboard – 2025-09 H&S Dashboard - October** The latest H&S dashboard was shared for information and review for any required actions to be taken forward across the Directorate Teams. **The CWQSE resolved:** a) Update noted	
CWQSE/ 2025/175	**Fire Safety Update** Update slides to be shared for information. • For C&W Clinical Board 154 actions raised in total. 109 actions remain unresolved and outstanding. • UHB prosecuted on 4 counts relating to failure to comply with a requirement imposed by an enforcement notice. SWF&RS proposed to drop all 4 counts on the basis of pleading to failure to keep adequate records. No risk of actual harm noted. • Exemptions are in place for Barry, CRI and St David's and are continually being scrutinized by SWF&RS. • UHB fire procedures have been updated • Training compliance for C&W Clinical Board is 74%. Teams training package has been approved and will be available from January 2026. **The CWQSE resolved:** a) Update noted b) All areas to review fire safety unresolved actions and progress to completion c)	**ALL**
CWQSE/ 2025/176	**Feedback from H&S Staff Side** No specific issues to be noted for this meeting. JA confirmed that she is happy to support any workplace inspections and contact to be made by teams for support where required. **The CWQSE resolved:** a) Update noted.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
CWQSE/ 2025/177	**Health & Care Standards Directorate QSE Exception Reporting** The Directorates were asked to provide updates on specific areas of escalation and noting. **CYPFHS Directorate Report** • X2 PSLR's are progressing at present. • Statement request received from coroner on one PSLR which has been drafted. PSLR investigation is ongoing. • X1 RIDDOR reported in month. H&S has supported, manual handling assessment has been updated and more equipment put into place, specific to the needs of the child. • X6 formal open, x1 over 100 days all of which are being progressed. X1 ombudsman concern regarding HV and Safeguarding decision-making process which is being progressed. Themes continue regarding ND waiting times and increase in the number of safeguarding concerns being received.	

	• New risk assessments reviewed for adding to the risk register.
	  o Critical lack of responsible clinician for Crisis Pathway and EWMH Service. Current risk rating 25. Agency doctor has been approved for a period of 4 weeks. The service is very fragile on a day-to-day basis, and there were x3 children who were potentially detainable. X2 children were transferred to Ty Llydiard, and x1 who wasn't detainable, which is a significant risk. This has been escalated with the Executive Team and discussions are ongoing. Agreed that further discussions to take place outside of the meeting with regard to a further agency doctor.
	  o YPDAS Service for CYP with drug and alcohol issues. Currently there is no medical support at present, which is reporting as an unmet need for these young people.
	  o ICCNS Lack of capacity which is impacting on statutory packages of care and vacancies are now at a critical level. Current risk rating 20. There is a waiting list for care, with only x3 families receiving a full care package out of 33.
	• Fluenz delivery impact and ongoing admin capacity due to vacancy continue to be significant risks for the Directorate.
	• Issues regarding WIZ2 system and staffing is challenging which is impacting on the Fluenz delivery.
	• Implementation of Healthy Child Wales Programme 2 cannot be delivered without additional resource. WG have requested that a mapping exercise be undertaken to understand what can be delivered within resources and then consideration of submission of a business case outlining requirement for delivery of the full programme with a phased implementation. Ongoing discussions are taking place regarding this.
	
	Timely access
	• ND waiting times continue to increase. Funding has been received to increase capacity however this will not cover the whole cohort. Current trajectory is estimated to be approx. 500 patients waiting at the end of the financial year. Additional allocation will be outsourced for children with medical titration for ADHD diagnosis.
	• CLA Service initial health assessment backlog is continuing. The longest wait is 6 months. HV returned following the end of the pilot. Medical capacity is the biggest pressure, with 87 under 5yr olds requiring assessment, with the longest waits being between 8-12months. Plan for trainees to support with the initial health assessments.
	
	The CWQSE resolved:
	a) The report provided was noted for information and key highlights recorded.
	b)	

CWQSE/ 2025/178	**CHFW Directorate Report** Report noted. • X2 cases discussed at pressure damage scrutiny meeting, however it was noted that neither case required reporting, and all appropriate actions have been undertaken. **Timely Access** • **The CWQSE resolved:** a) Update noted.	

CWQSE/ 2025/179	**O&G Directorate Report** • 152 new Datix submitted for September with 153 closed. • X12 new concerns with 9 closed. Currently 18 ongoing, which are being progressed. Some themes include poor responsiveness and attitude, incorrect or conflicting information, and lack of senior medical input. • For Obstetrics x9 open LRI's x4 of which are Birth Injury Tools. X3 open NRI's all of which are awaiting closure/sign off. For Gynaecology x4 open LRI's and x4 open NRI's. • X7 high scoring risks and x16 moderate scoring risks on the risk register at present. Further review to take place today, with a view to a reduction in a number of risks/scores. • X5 medicines management incidents reported in month. No specific themes noted. Safety alerts have been shared. • X1 slip, trip and fall reported in month. No RIDDOR incidents reported. X4 V&A incidents reported. All actions are progressing. • No pressure damage reported in month for September 2025. X1 ongoing LFER which includes pressure damage management, and a re-audit is anticipated shortly with a view to closing this LFER. • Safeguarding supervision commenced in April 2025. 42 attendees so far (across hospital and community), so more is needed for compliance with JICPA and Public health Wales recommendations. Staff are being encouraged to attend and the same. • Self-assessment being completed for the National Perinatal Assurance Assessment with reviewers expected in mid-November. • Training update provided. Full detail included within the Directorate report. VBA rate is currently at 69.02% and Mandatory training at 84.42%. Work is progressing to review trajectories for improvement to 85%. **Timely Access Update** • Outpatient operating remains a significant risk, with current wait over 2yrs. Risk assessment has been updated and further discussions required as to what actions can be undertaken to improve this. • Continued significant gaps across demand and capacity for planned care schemes. Demand and capacity work is being completed within Antenatal services and once complete this will be presented to the Clinical Board. • At the end of Quarter 2 there were x9 patients waiting over 104 weeks. End of Quarter 3 numbers anticipated to be the same, however an additional theatre is needed to allow listing of GA cancer cases in a timely manner. • Cancer pathways are being managed tightly, however there is a demand and capacity gap to manage the patients being seen within 14 days which is impacting on benign clinics being taken down in place of cancer clinics. To avoid further cancellations, and balance patient need, there is a plan for patients to be seen within 20 days for a first outpatient appointment which is outside of standards. • **The CWQSE resolved:** a) The update was noted for information and key highlights recorded.	
CWQSE/ 2025/180	**ANTT Compliance Update** Discussion ensued and it was noted there is a requirement for compliance updates to be shared across all staff groups. It was noted that there is mandatory training available for ANTT on ESR and requests were made for all to raise awareness of the requirements. The group were asked to provide an update at the next meeting on plans in place across the Directorate.	

	The CWQSE resolved: a) Update to be provided at the next meeting	**ALL**
CWQSE/ 2025/181	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** Detail noted as part of the Directorate report updates. Roll out of risk registers to the AMAT system is progressing. Requests were made for key representatives from each Directorate to be shared for inclusion in the Task & Finish Group **The CWQSE resolved:** a) The update was noted for information	
SAFE CARE		
CWQSE/ 2025/182	NRI's/PSLR's for **noting/exception reporting** • SBAR, PSLR and Improvement Plan – Datix 57277 – JH • SBAR, Birth Injury Tool and Improvement Plan – Datix 91131 – IW • SBAR, PSLR and Improvement Plan – Datix 20853 – KA • SBAR, PSLR and Improvement Plan – Datix 64819 – NS • SBAR, Birth Injury Tool and Improvement Plan – Datix 83002 - CB The above cases have been discussed in detail as part of the NRI/LRI Governance Subgroup Meeting and were shared for information. Full detail was shared as part of the supporting SBAR's. There were no specific issues to highlight for this meeting. All improvement plans have been completed and are progressing to closure. **The CWQSE resolved:** a) Updates noted	
CWQSE/ 2025/183	**Infection Prevention Control Update Report** The report was shared for information. No specific update to note. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2025/184	**Safeguarding/Mental Capacity Act (MCA)** Number of changes within the Safeguarding service. No specific updates to share for this meeting. **The CWQSE resolved:** **a)** Update noted.	
CWQSE/ 2025/185	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • Patient Safety Alert 019 - Rasburicase All alerts have been circulated for onward sharing and action as necessary. There were no specific exceptions to note. **The CWQSE resolved:** a) Alerts noted.	

CWQSE/ 2025/186	**Clinical Audit** The group were asked to review and provide updates to the Clinical Audit Team. No specific issues to note for this meeting. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2025/187	**Medicines Safety Executive Update** No update to note for this meeting.	
TIMELY CARE		
CWQSE/ 2025/188	**Directorate concerns & assurance update** Discussed as part of the directorate reports. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2025/189	**Patient Feedback** The Latest CIVICA Summary Report Children and Women's report was shared for information. **The CWQSE resolved:** a) Update noted.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2025/190	**Caesarean Birth SSI Annual Report 2024** The CSSI Report was shared for information **The CWQSE resolved:** a) Update noted.	
ANY OTHER BUSINESS		
CWQSE/ 2025/191	**Date and Time of Next Meeting** Tuesday 25th November 2025, 8.30am, Microsoft Teams.	**ALL to note**

Report Title:	*Controlled Drugs Accountable Officer Annual Update April 2024- March 2025*			Agenda Item no.	*4.4*
Meeting:	Quality Committee	Public	✓	Meeting Date:	20.01.2026
		Private			
Status:	Assurance		Approval		Information ✓
Lead Executive:	Executive Medical Director				
Report Author:	Timothy Banner,Clincial Director for Pharmacy and Medicine Management – Controlled Drugs Accountable Officer for CAV				

Main Report

Background and current situation:

Introduction

Controlled Drugs (CDs) are under Home office legislation: The Misuse of Drugs Act 1971. In January 2009, the Controlled Drugs (Supervision of Managment and Use) (Wales) Regulations 2008 came into force. These support the safe management and use of CDs in Wales. Under these regulations designated bodies are required to appoint a Controlled Drugs Accountable Officer (CDAO). For Cardiff and Vale UHB this is held by the Clinical Director of Pharmacy and Medicines Management.

Responsibilities of the CDAO.

The CDAO is responsible for the safe effective use and management of controlled drugs across the Cardiff and Vale UHB locality. The responsibilities cover a broad range of activities in relation to controlled drugs such as ensuring: -

- adequate and up-to-date standard operating procedures (SOPs) are in place
- adequate destruction and disposal arrangements for CDs
- appropriate arrangements for monitoring/auditing the use and management of CDs are in place including
    - Monitoring and analysing NHS and private prescribing of CDs
    - Developing incident reporting systems for untoward incidents involving CD
    - Establishing systems to alert the CDAO of any complaints/concerns involving CDs.
- access to appropriate training to support the safe and secure management of CDs.
- procedures are in place for assessing and investigating concerns and taking appropriate action as necessary
- periodic declarations and self-assessments from General Practitioners, Dentist, Community Pharmacists are requested for assurance purposes

They are also authorised to carry out periodic inspections of premises, not subject to inspection by HIW, CSSIW or GPhC, used in connection with the management or use of CDs

Cardiff and Vale Local Intelligence Network

The regulations require the CDAO to establish a CDLIN for sharing information in relation to the management and use of CDs. This was established in 2010 and is chaired by the CDAO. The LIN network covers Local Health Board, primary care contractors, NHS hospitals, private hospitals, hospices and care homes in Cardiff and the Vale of Glamorgan. As part of this, it has agreed local principles for sharing

controlled drug (CD) intelligence between agencies. It also serves to support the AO in the discharge of their duties.

The membership includes, but is not limited to the following people: -

- Accountable Officer Cardiff and Vale (Chair)
- Controlled Drugs Lead, Primary Care
- Chief Pharmacist (or designated alternative), Secondary care
- Nursing representation
- Clinical Governance representation
- Primary Care representation
- South Wales Police Pharmacy Liaison Officer
- Cardiff and Vale Counter Fraud Officer
- Area Planning Board
- Health Inspectorate Wales
- Care and Social Services Inspectorate Wales
- General Pharmaceutical Council Inspector
- Independent hospitals and hospices representative
- Local Authority Representative
- Shared Services Partnership
- HMP Cardiff Representative
- Welsh Ambulance Services Trust (WAST)

Memberships have the duty to co-operate with other members of the LIN.

The network meets on a quarterly basis.

There is also a bi-annual national CDAO meeting to cover any national CD concerns and to standardise the approach to CDAO responsibilities nationally.

Occurrence reports

Each organisation that is represented at the LIN is required to submit a quarterly occurrence report detailing concerns and incidents relating to CDs that have been raised and investigated appropriately.

Cardiff and Vale has a template for reporting these. In addition to DATIX which is not available to all organisations.

Designated Body	Total Incidents April 2024-March 2025
Cardiff and Vale UHB – secondary care	503
Cardiff and Vale UHB – primary community and intermediate care	77
Cardiff and Vale UHB – HMP Cardiff	26
Kaleidoscope	4
Marie Curie	11
Velindre |NHS Trust	19
WAST	3
Ty Hafan	2
Spire	0

The CD LIN requests assurance that all incidents have been fully investigated, brought to a satisfactory conclusion and that learning has been cascaded appropriately.

The Medicines Code

The UHB medicine Code covers off policies and procedures relating to CDs for the Health Board. [UHB 389 Medicines Code 2023.docx (sharepoint.com)](#) Other organisations are encouraged to have similar policies in place governing CDs. Template standard operating procedures are available for other organisations to modify.

Self-Declarations

Under the Controlled Drugs (Supervision of Managment and Use) (Wales) Regulations 2008 healthcare organisations providing clinical services, and relevant social care organisations, are required to complete a periodic declaration (at least every 2 years) on whether they, or their organisation, keep stocks of controlled drugs and whether there are any special circumstances that might explain any seemingly unusual patterns of prescribing or supply. The CDAO is responsible for asking primary care clinicians, on the health board's Performers List, to complete a CD declaration/self-assessment.

During this year, the self-declaration was sent to the general practitioners (GPs). Return rates were high. However, it was evident that practices were unaware who to contact in relation to issues with CDs, so updated information was sent to all practices. Here were no concerns identified following this exercise.

CD Destructions

The UHB has trained personal that can witness the destruction of controlled drugs. These are known as Authorised Witnesses (AW). They are subject to a code of conduct or a DBS check.

The UHB has SOPs for this process.

Between April 2024 and March 2025 528 controlled drugs have been destroyed in primary care. This ensures unwanted/out of date stock is taken out of circulation, so it doesn't become a target for diversion.

Monitoring

Each quarter the primary care medicine management team monitor CD prescribing in primary care. The aims to pick excessive prescribing and identify outliers. Prescribers are individually challenged and supported where needs arise. Although a key governance task, it is important to note that this alone would not pick up someone who acted like Harold Shipman. This would rely on intelligence from all organisations. This year, the standard operating procedure (SOP) was reviewed and amended to have more meaningful actions. It now includes an in-depth review of syringe driver prescriptions, targeting the top 5 high prescribing practices and reviewing in depth a sample of their prescriptions and looking at non formulary prescribing establishing why these drugs were chosen with a view of using a formulary alternative.

National Prescribing Indicators

The All-Wales National Prescribing Indicators have been produced to show variation in the prescribing of certain medicine across Health Boards.

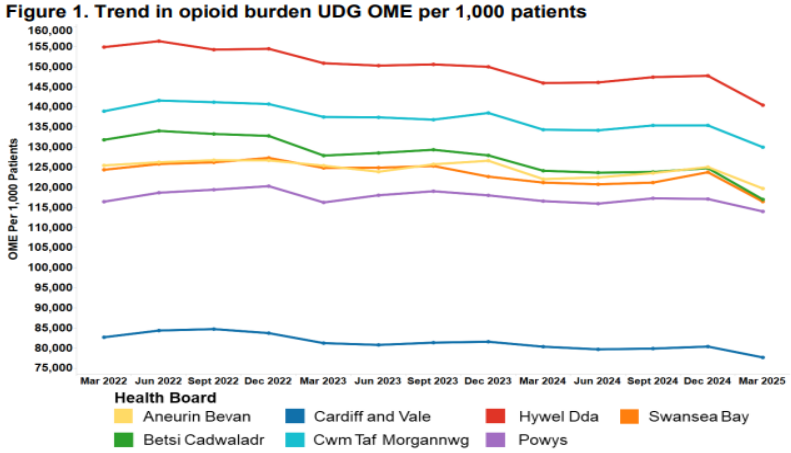
There are three National Performance Indicators (NPIs) monitoring the usage of medicines for pain that are applicable to controlled drugs. GP practices are monitored quarterly on these parameters.

1. Opioid burden
2. Tramadol
3. Gabapentin and pregabalin

Cardiff and Vale perform very well as an organisation on these indicators.

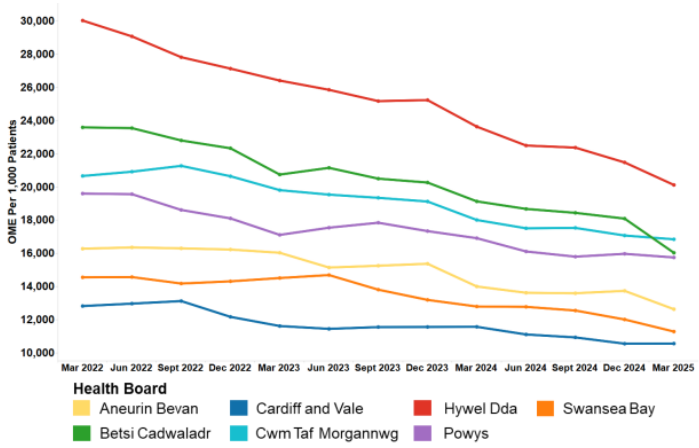
Opioid Burden *- Encourages the appropriate use and review of opioids in primary care, minimising the potential for dependence, diversion, misuse, and adverse drug reactions (ADRs).*

Figure 1. Trend in opioid burden UDG OME per 1,000 patients



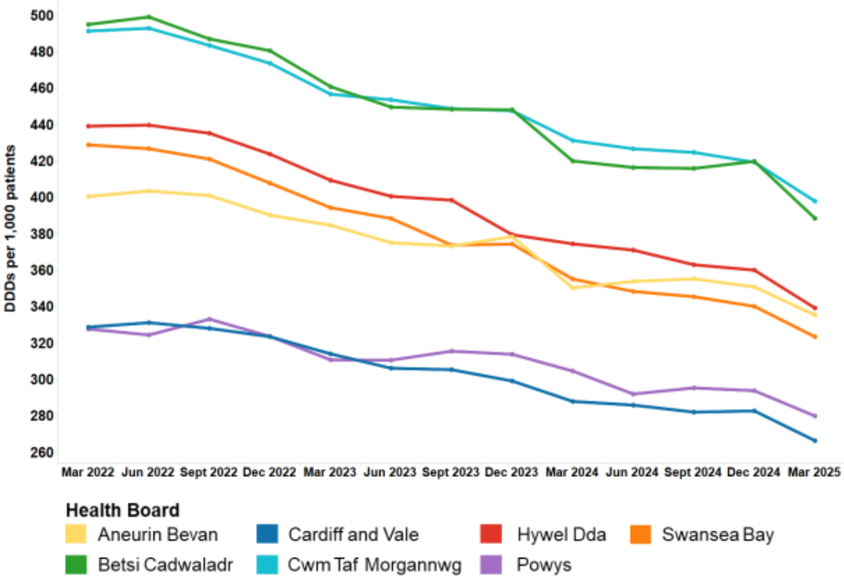
High Strength Opioids

Figure 3. Trend in high strength opioid UDG OME per 1,000 patients



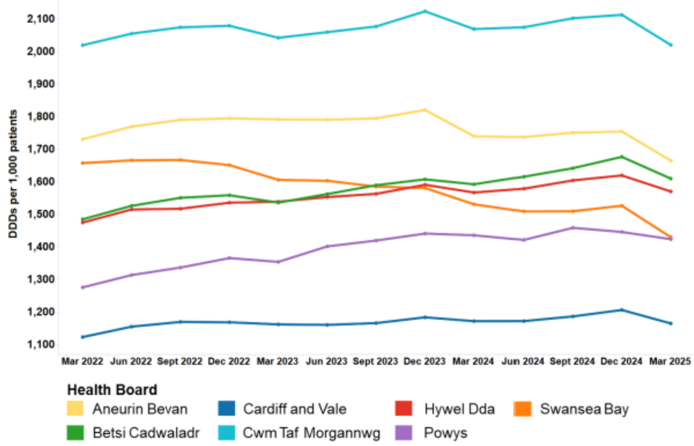
Tramadol *- encourage the appropriate use and review of tramadol in primary care, minimising the potential for dependence, diversion, misuse and ADRs.*

Figure 5. Trend in tramadol prescribing DDDs per 1,000 patients



***Gabapentin and pregabalin** - encourage the appropriate use and review of gabapentin and pregabalin in primary care, minimising the potential for dependence, diversion, misuse and ADRs*

Figure 7. Trend in gabapentin and pregabalin prescribing DDDs per 1,000 patients



Private prescribers

The Health Board receives applications from prescribers wishing to prescribe controlled drugs privately. This year we have seen the number of applications steadily rise with the applications to prescribe drugs for ADHD. This reflects the long waiting times within the NHS clinics.

Licenses

Organisations who store stocks of CDs or who supply stock CDs are required to obtain a license from the Home Office for this activity. There are certain exemptions to these regulations, such as hospitals (under a clear definition) can stock CDs for individual named patient use – within CAV this exemption covers CRI, Barry Hospital and St Davids' Hospital. Clarity in relation to the position of supply of CDs between hospital sites of the same legal entity (i.e., UHL supplying stock to Barry) was sought across Wales and advice received indicted that licenses were required for this

activity. Therefore, supply licenses have been awarded to UHW pharmacy and UHL pharmacy, additionally a CD stock license for Newlands (CDAT Barry) is in the application process as the only other site in CAV which did not meet an exemption criteria.

Security

UHW pharmacy has taken action to increase security of schedule 4 and 5 CDs (do not need enhanced storage). These CDs have been moved from general medication storage areas to either the dispensing robot or to a new CD room which has been established. Additionally, CCTV has been installed in UHW pharmacy to monitor access to these areas in collaboration with the UHW security team, onsite police and counter-fraud teams. Further proactive governance work is planned alongside installing a secure Omnicel cabinet for UHL CDs.

Next steps

Over the next 12 months the CDAO, in collaboration with the CDLIN will build on the achievements made to date to further strengthen the arrangements for the safe and secure management of controlled drugs across the Health Board.

This will include: -

- Strengthen the accountability for Controlled Drugs in each clinical board area by appointing a lead individual to review incidents and develop locally appropriate action plans.
- Use the Medicines Safety Project, which is part of the Shaping our future Excellence Programme as a vehicle for sharing learning around Controlled Drugs
- Greater uptake of the Tendable tool for controlled Drugs audit
- Assist care homes with their understanding of the legislation around controlled drugs
- Support and inform the development of a national CD monitoring dashboard
- Reviewing the Medicines Code as an appropriate method of governing the use of controlled drugs in secondary care and consideration over separate policies.
- Look at developing a training tool to train people to be authorised witnesses.

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

Recommendation:

The Quality Committee is asked to recognise:
• The progress that has been made during the last 12 months.

Link to Strategic Objectives of Shaping our Future Wellbeing:

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

Five Ways of Working (Sustainable Development Principles) considered

Pre	✓	Long term		Integration		Collaboration	✓	Involvement	

vention									

Impact Assessment:
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route: ***Please insert any previous meetings where this paper has been received***	
Committee/Group/Exec	Date: