

CARDIFF AND VALE UNIVERSITY HEALTH BOARD

PUBLIC Quality Committee

29th September 2026 at 9am via Microsoft Teams

CHAIRS INFORMED AGENDA

09:00	1	Welcome, Introductions & Apologies for absence:	Assurance / Approval or Noting&Information	Presenters
	1.1	Welcomes, Introductions and Apologies for Absence		Ceri Phillips
	1.2	Declarations of Interest		Ceri Phillips
	1.3	Minutes of the last meeting held: 28.07.2026		Ceri Phillips
	1.4	Action Log – following meeting held on: 28.07.2026		Ceri Phillips
09:05	2	Quality Performance Reporting		
15 mins	2.1	Integrated Performance Report (IPR) - <i>IPR document can be found in the 'Supporting Documents' folder</i>	Assurance	Alex Scott
09:20	3	Item for Oversight / Scrutiny		
10 mins	3.1	Shaping our Future Quality Excellence – Acute Deterioration	Assurance	Abraham Theron
30 mins	3.2	Clinical Board Highlight Reports: ○ <i>Medicine Clinical Board</i> ○ <i>Specialist Services Clinical Board</i> ○ <i>PCIC Clinical Board</i> ○ <i>CD&T Clinical Board</i> ○ <i>Children & Women Clinical Board</i> ○ <i>Surgery Clinical Board</i> ○ <i>Mental Health Clinical Board</i> <i>Clinical Board QSE Minutes can be found in the 'Supporting Documents' folder.</i>	Assurance	Execs
10 mins	3.3	Clinical Safety Group (CSG) highlight report	Assurance	Alex Scott
10 mins	3.4	Clinical Effectiveness Committee highlight report	Assurance	Alex Scott
10 mins	3.5	Health Inspectorate Wales (HIW) Inspections Report	Assurance	Alex Scott
10 mins	3.6	Thirlwall Inquiry: Executive Summary, Recommendations and Organisational Assurance	Assurance	Jason Roberts / David Fluck
10:40	4	Strategy: Providing Outstanding Quality		
0 mins	4.1	Board Assurance Framework (BAF) - <i>BAF document can be found in the 'Supporting Documents' folder</i>	Assurance	Matt Phillips

10:40	5	Shaping our Population Health and Place-Based Partnerships:		
10 mins	5.1	Cardiff and Vale UHB Hepatitis B&C Elimination Action Plan 2026-2028+ - <i>the full plan can be found in the 'Supporting Documents' folder</i>	Approval	Sion Lingard
10 mins	5.2	Cardiff and Vale UHB Pandemic Response Plan - <i>the full plan can be found in the 'Supporting Documents' folder</i>	Approval	Sion Lingard
10 mins	5.3	Public Health Wales (PHW) Sexual Health Incident Update	Assurance	Sion Lingard
11:10	6	Shaping our Quality, Value & Sustainability		
		No items.		
11:10	7	Shaping our Future Clinical Services		
0 mins	7.1	No items.		
11:10	8	Policies for Approval		
5 mins	8.1	UHB 588 - CAVUHB Medical Gases Policy - <i>the full policy and EHIA can be found in the 'Supporting Documents' folder</i>	Approval	Natasha Goswell
5 mins	8.2	UHB 132 – CAVUHB Framework for Working with Volunteers - <i>the full policy and EHIA can be found in the 'Supporting Documents' folder</i>	Noting	Angela Hughes
11:20	9	Items for Noting and Information		
0 mins	9.1	Infection Prevention and Control (IPC) Group highlight report	Noting	Jason Roberts
0 mins	9.2	Safeguarding Steering Group (SSG) highlight report	Noting	Jason Roberts
11:20	10	Any Other Business		
	10.1			Ceri Phillips
11:20	11	Review of Meeting		
	11.1	<u>Board and Committee Self-Assessment link</u>		Ceri Phillips
	11.2	Time and date of the next meeting: <i>27th October 2026 at 9am via MS Teams</i>		
	11.3	Declaration before moving into private session: <i>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]</i>		

**Draft Minutes of the Public Quality Committee
Held on 28th July 2026 via MS Teams**

To view the meeting: <https://youtu.be/zd3mJrvVqlg>

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Judi Rhys	JRH	Independent Member – Third Sector
In Attendance		
Claire Beynon	CB	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
David Fluck	DF	Executive Medical Director
Angela Hughes	AH	Assistant Director of Patient Experience
Jason Roberts	JR	Executive Nurse Director
Matt Phillips	MP	Director of Corporate Governance
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Additional Attendees		
Huw Brunt	HW	Consultant in Public Health
Jessica Castle	JC	Director of Operations – Specialist Services Clinical Board
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Natasha Goswell	NG	Deputy Executive Nurse Director
Kirsty Williams	KW	UHB Chair
Suzanne Rankin	SR	Chief Executive Officer
Stephen Riley	SR	Independent Member – University
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness
Rachna Upadhya	RU	Independent Member - General

QC 26/07/1.1	<u>Welcomes, Introductions & Apologies</u> Ceri Phillips (CP), the Committee Chair, welcomed everyone to the meeting in English & Welsh and apologies for absence were noted.	
QC 26/07/1.2	<u>Declarations of Interest</u> No declarations of interest were raised.	
QC 26/07/1.3	<u>Minutes of the Committee meeting held on 30.06.2026</u> The minutes of the Committee meeting held on 30.06.2026 were received. The Committee resolved that: a) The minutes of the meeting held on 30.06.2026 were approved as a true and accurate record of the meeting.	
QC 26/07/1.4	<u>Action Log</u> The Action Log following the meeting held on 30.06.2026 was received and discussed.	

	The Committee resolved that: a) The Action Log from the meeting held on 30.06.2026 was noted.	
QC 26/07/1.5	Committee Chair's Actions No Chair's Actions were raised.	
	Quality Performance Reporting	
QC 26/07/2.1	<i>No items.</i>	
	Items for Oversight / Scrutiny	
QC 26/07/3.1	<u>Clinical Board Highlight Reports</u> Jason Roberts (JR), Executive Nurse Director, advised that the newly piloted AAA reports had been reviewed following publication and, whilst they demonstrated significant improvement in activity across the organisation, they did not provide the level of assurance expected for Public Committee scrutiny. Following discussion with the Chair, it was agreed to withdraw the reports for this cycle to allow further work with Clinical Boards to strengthen the quality and consistency of reporting. CP expressed concern that the reports were not at the standard expected for a Public Committee and did not provide sufficient assurance. The Committee and reporting arrangements remained in a developmental phase, and withdrawing the reports was considered the appropriate course of action. Further work would be undertaken ahead of the next meeting to strengthen assurance and support the Committee's objective of providing proactive oversight of quality issues. The Committee resolved that: A) The update was noted.	
QC 26/07/3.2	Clinical Safety Group Highlight Report Alexandra Scott (AS), the Assistant Director of Quality and Patient Safety, introduced the report and the minutes from April's Clinical Safety Group (CSG) meeting, and summarised the following: • The CSG continued to develop its role in providing oversight of existing and emerging clinical risks and promoting a whole-system approach to risk management across the organisation. • A rolling programme of assurance presentations from Clinical Governance Groups (CGGs) had been established, with the Medicines Safety Group (MSG) providing assurance in the April 2026 meeting. The MSG outlined work aligned to the Quality Management System (QMS), including: ○ Oversight of regulatory requirements and safety standards ○ Quality improvement initiatives relating to opioid safety and the timely administration of critical medicines ○ Assurance processes involving Clinical Board engagement, risk management and reporting arrangements ○ Development of a broader range of medicines safety indicators to enhance organisational intelligence and monitoring • Updates were received on two patient safety solutions underway: ○ A review of clinical systems to address risks associated with incorrect recording of penicillin allergies, including system standardisation and patient record reviews ○ Work to standardise adult breathing systems across the UHB, supported by revised protocols, procurement arrangements and staff training, with compliance expected by the August deadline	

	• Clinical Boards continue to provide updates on emerging risks to facilitate shared learning, discussion and support from relevant CGGs • Challenges regarding Clinical Board engagement with the CSG were noted, and discussions were underway regarding the use of Clinical Board Assurance Reports to strengthen scrutiny and avoid duplication of reporting. Relating to the medicine safety improvement work, David Fluck (DF), the Executive Medical Director, highlighted that the report noted that the introduction of new technologies and systems could introduce other risks, and asked whether this has occurred. DF noted that the ePMA rollout was very successful. AS advised that patient safety incidents associated with ePMA were monitored and reviewed. While a small number of issues relating to user familiarisation and system design have been identified and addressed, the benefits of ePMA have significantly outweighed the risks, with no recurring trends or common incident themes identified. JR emphasised the role of the CSG in providing oversight of clinical risk, quality and assurance. Work was underway to strengthen the group's governance arrangements. The CSG oversaw a number of specialist governance groups responsible for managing significant clinical risks across the organisation. Claire Beynon (CB), the Executive Director of Public Health, suggested bringing the CSG's group structure and Terms of Reference (ToR) through the Senior Leadership Team (SLT). Review and, if appropriate, bring a paper on the Clinical Safety Group's terms of reference and group structure to the Strategic Leadership Team for consideration of gaps and potential new groups – ACTION. Judi Rhys (JR-IM), the Independent Member – Third Sector, asked about the frequency of the CSG meetings. AS responded that a subsequent CSG meeting had taken place and would be reported following formal ratification of the minutes. The meeting received assurance from three CGGs, reviewed the risk register and considered cross-cutting patient safety incidents and HIW findings. A further report would be provided at the following Quality Committee. CP suggested reviewing the schedule of the CSG meetings to align better with the Quality Committee. Consider revising the scheduling of Clinical Safety Group meetings to ensure timely reporting and proactive oversight for the Quality Committee – ACTION. The Committee resolved that: A) The information provided to the CSG and the ongoing actions as well as the development of the agenda to support improved engagement and representation was noted.	
QC 26/07/3.3	<u>Clinical Effectiveness Committee Highlight Report</u> AS introduced the report and provided the following summary to the Committee: • The Clinical Effectiveness Committee (CEC) continued to oversee participation in national clinical audits and the implementation of improvement actions, providing assurance on the quality and safety of services across the organisation. • Positive assurance was received from the National Joint Registry, National Diabetes Foot Care Audit, and the National Audit of Care at the End of Life, with the UHB performing favourably against Welsh and UK benchmarks. • Concerns were identified regarding low participation and data submission rates in some audits, including the Patient Foramen Ovale (PFO) Closure Registry and the	

	National Early Inflammatory Arthritis Audit, limiting the ability to benchmark performance reliably. Actions had since been taken to improve audit participation and data submission. • The Paediatric Diabetes Audit identified the UHB as an outlier for glycaemic control in children with Type 1 diabetes; however, improvement initiatives, including expanded access to insulin pump therapy, had already delivered improved outcomes. Workforce and capacity challenges were highlighted within paediatric diabetes and rheumatology services, although issues affecting insulin pump provision had now been addressed. Recurring patient safety concerns relating to inpatient diabetes care and plans to strengthen education, ePMA functionality and specialist inpatient support were noted. • A key theme across audit findings was the need to strengthen Clinical Board engagement, accountability and oversight of audit participation, data quality and improvement planning. • A revised approach was being developed to require Clinical Boards to review audit findings following publication and present improvement plans to the CEC, with a greater focus on delivery, risk management and assurance. This proposal will be considered by the Executive Team. DF noted that incomplete data submission remained a concern and agreed that future reporting should provide clearer assurance on progress against audit findings, supported by outcome measures and improvement metrics to demonstrate the impact of actions taken. JR-IM sought clarification on why the UHB was not currently participating in the Inpatient Diabetes Audit due to a lack of suitable IT infrastructure. She asked whether this was a local or wider NHS issue. AS confirmed, this was a local CAV-specific issue. The Diabetes and Digital teams were working to identify a solution to improve data collection and enable participation in the audit. Investigate and report back with a timeframe for resolving the lack of suitable IT infrastructure preventing participation in the inpatient diabetes audit – ACTION. The Committee resolved that: A) The information presented to the April and May Clinical Effectiveness Committee and the plans to strengthen the assurance and oversight of improvements presented to the Committee was noted.	
QC 26/07/3.4	Annual Reports 3.4.1 - Annual Quality Report 2025/26 AS noted that the Annual Quality Report, presented to the Private Quality Committee in June 2026, fulfilled the UHB's Duty of Quality requirements by providing an overview of the quality of care delivered, improvement activity underway, and performance across the six quality domains and six quality enablers. The Committee resolved that: a) The Annual Quality Report 2025/26 was noted.	
QC 26/07/3.5	Regulation 28 Prevention of Future Deaths Report –Health Board Response and Assurance Arrangements Angela Hughes (AH), the Assistant Director of Patient Experience, presented the report and summarised the following: • A Coroner's Regulation 28 report issued to CAVUHB, Cwm Taf Morgannwg (CTMUHB), and Welsh Government (WG), highlighted concerns regarding delays in recognising and escalating a suspected bile duct injury for specialist referral to	

	CAVUHB as the tertiary centre. The coroner identified a lack of clear referral and escalation protocols, leading to delays in specialist advice and transfer. • In response, actions had been taken to reinforce consultant-to-consultant escalation processes, remind organisations of existing urgent referral arrangements, and develop a formal regional referral framework with defined triggers, timescales and transfer expectations. • Further work is underway to strengthen assurance, implementation and compliance monitoring, recognising the importance of timely referral in these rare but high-risk cases. Bring a further update back to the Committee in six months, including further information on commissioning status – ACTION. Paul Bostock (PB), the Chief Operating Officer, noted that significant work had been undertaken to strengthen the referral pathway and governance arrangements, with referrals now managed through a formal case-by-case process. Whilst concerns remained regarding the absence of a formally commissioned service, improved oversight, clearer processes and senior clinical leadership involvement had addressed many of the previously identified issues. DF confirmed that a formal referral and approval process was now in place. Whilst opportunities for further improvement remained, assurance was provided that governance arrangements were reasonably robust and that similar arrangements were being developed for other non-commissioned specialist pathways. The Committee resolved that: a) The contents of the Coroner’s Regulation 28 Report and the concerns raised were noted; b) Assurance was received regarding the actions already implemented by the UHB; c) Ongoing governance oversight through appropriate clinical governance structures was endorsed.	
	Strategic Portfolio: <u>Providing Outstanding Quality</u>	
QC 26/07/4.1	<u>Board Assurance Framework (BAF)</u> Matt Phillips (MP), the Director of Corporate Governance, noted that the BAF served as a reference document, with updates aligned to the Board reporting cycle rather than individual Committee meetings. The Committee’s primary focus should be on oversight of strategic portfolio delivery and associated risks, using the BAF to provide context and support assurance discussions where required. The Committee resolved that: A) The BAF was noted for assurance.	
	Shaping our Population Health and Place-Based Partnerships	
QC 26/07/5.1	<u>5.1 - Public Health Work 6 Month Update (including Targeted Intervention Indicators)</u> CB introduced the report and provided the following summary: • The report outlined progress against the UHB’s population health strategy. • Despite a relatively small Public Health workforce (39wte, including 5.5 public health consultants for a population of around 500,000), the team had prioritised three key areas: reducing smoking, increasing vaccination uptake, and tackling obesity. • Performance against WG escalation targets showed improvement in vaccination rates. The gap between CAV and the Welsh average for childhood vaccinations by age five reduced from 4.8% to 2.5%, whilst the gap for HPV uptake by age 15 reduced from 5.2% to 0.6%	

- Smoking cessation activity had increased over the last six quarters, with more referrals generated through strengthened work with primary and secondary care, despite no additional resources. However, achieving the increased WG target for smoking cessation was expected to be challenging.
- The report highlighted a continued focus on reducing health inequalities through targeted preventative programmes, with services increasingly delivered through outreach and community-based models in areas of greatest need.

PB queried whether there was a plan to equip the UHB's 18,000 staff to provide health improvement advice and help mitigate capacity constraints, such as smoking cessation support.

CB responded that limited resource capacity meant only 0.5wte was available to deliver *Making Every Contact Count* training across the UHB and partner organisations. The team promoted online training and monitored uptake within Clinical Boards to encourage wider workforce upskilling. Whilst staff could provide brief health improvement advice and identify teachable moments, specialist services remained important, with evidence showing people were significantly more likely to quit smoking when referred to dedicated support programmes such as *Help Me Quit*.

Huw Brunt (HB), the Consultant in Public Health, noted that Clinical Board reviews helped promote *Making Every Contact Count* by signposting staff to available training resources, including online modules and limited bespoke training support. Awareness had also been raised through primary care clusters and events.

JR-IM noted that whilst the reported 50% increase in smoking cessation was encouraging, concern was expressed that overall numbers remained low and emphasised the need to maximise cross-sector opportunities. JR-IM highlighted the importance of ensuring smoking cessation support was fully embedded within future lung cancer screening programmes.

CB provided assurance that work was underway with primary and secondary care, local authorities and the third sector to increase uptake and maximise community-based opportunities.

CB confirmed that smoking cessation support would be fully integrated into the future lung cancer screening programme, with workforce requirements and anticipated demand already assessed and submitted to Public Health Wales (PHW) for consideration.

HB noted that *Help Me Quit* was delivered through an integrated package of services across public health, community pharmacy, and hospital settings, with partnership working essential to maximising impact despite limited resources. Ongoing work to increase referrals included engagement with primary care, dental and optometry services, Inclusion Health respiratory clinics, the pre-operative assessment clinic, local authorities, and the Fire and Rescue Service.

JR-IM raised concern regarding inequalities in access to sports and physical activity facilities and asked how Public Health worked with sports providers and community organisations.

CB responded that the Good Food and Movement Plan was overseen through established partnership governance arrangements and was delivering tangible progress. A facilities audit

	had been completed to identify gaps in access to physical activity opportunities and would inform future planning by local authorities to address health inequalities. The audit had been recognised as good practice nationally and was being considered for wider adoption across Wales. CP asked to what extent Public Health linked in with the podiatry-led QuickChange initiative. CB responded that QuickChange was a joint initiative, with close collaboration on its delivery. The programme was promoted through Healthy Schools Officers and wider public health networks, supporting obesity prevention, physical activity and wellbeing through a coordinated preventative approach. CP suggested CB link in with the new Public Health Minister in Wales. The Committee resolved that: A) The content of the Cardiff and Vale long-term public health plan, and the current priorities for public health in Cardiff and the Vale was noted; B) Current performance and delivery of public health programmes in our area were noted; C) The first of regular six-monthly updates on the public health programmes was noted.	
QC 26/07/5.2	<u>5.2 - No-smoking and Smoke-Free Environment Policy Compliance at Cardiff & Vale Hospital Site</u> CB introduced the report and highlighted the following: • Despite legislation banning smoking on hospital sites since 2021, smoking remained a persistent issue and a source of complaints. • Assurance was provided that a range of measures had been implemented to improve compliance, including enhanced signage, awareness campaigns and dedicated staff engagement. • As the first UHB in Wales to pursue an enforcement approach, a six-month educational phase had now been completed, with the findings informing the next steps in the programme. HB presented the report and summarised the following: • During the six-month educational phase, over 1300 interactions with smokers were recorded, highlighting ongoing compliance challenges across all groups. • Whilst concerns were noted regarding staff compliance and inconsistent management processes, the initiative also created significant opportunities to provide advice and referrals to smoking cessation services. • Key next steps included strengthening staff compliance processes, improving hospital environments, implementing nicotine dependence pathways, enhancing staff training and communications, and progressing cross-organisational action to improve compliance. JR-IM asked about the effectiveness of the smoking patrols as an intervention. HB responded that the patrols had provided valuable opportunities to monitor compliance, raise awareness and refer smokers to support services. However, successful progression to enforcement would require local authority support, sustainable funding and strengthened UHB policies and procedures to ensure a robust and legally defensible approach.	

	CB commented that the patrols added value by creating over 1300 opportunities to engage with smokers, provide education and promote smoking cessation support. The initiative also highlighted areas requiring further action. Whilst enforcement remained challenging without local authority support and sustainable funding, the six-month pilot provided valuable learning to inform future improvements. MP challenged the advice within the report that enforcement action could be subject to challenge if appropriate systems and controls were not in place. Whilst acknowledging the funding and resource challenges discussed, he suggested the UHB may be able to take a more robust approach should a suitable route to reinstating enforcement be identified and offered to work with colleagues to explore this further. CP asked about what initiatives were proposed to deal with staff smoking on site. HB responded that the team were working with People Services to develop a more formal and standardised procedure for line managers, responding to the recommendations within the Shared Regulatory Services (SRS) report. Discussions were underway with Occupational Health to strengthen smoking cessation support and access to Nicotine Replacement Therapy (NRT) for staff. Additionally, the team was exploring ways to engage staff regularly to understand the barriers to compliance, identify opportunities for improvement, and measure progress over time. MP emphasised the importance of accountability alongside the support being offered to staff, noting that compliance with the law is an implicit expectation of employment. He suggested that any formal guidance should clearly articulate the potential use of disciplinary processes where staff fail to comply. The Committee resolved that: A) The contents of this paper and the accompanying six-month review report was noted; B) The commitment for a UHB-wide group to continue to drive this work forward and receive an update on progress at six months was supported.	
	Shaping our Quality, Value & Sustainability	
QC 26/07/6.1	<i>No items.</i>	
	Shaping our Future Clinical Services	
QC 26/07/7.1	Cardiology Review Update PB presented the update and provided the following summary: • Of the approximately 70 recommendations, 30 had been completed and 32 were in progress, with further work underway to strengthen timescales and accountability. • Positive progress included General Medical Council (GMC) de-escalation of concerns regarding resident doctors, strengthened clinical and operational leadership, improved service resilience, and development of a QMS. • Whilst the service had moved from recovery to stabilisation, it was recognised that embedding the cultural and behavioural changes required would be a longer-term programme. • Priority areas included completing demand and capacity modelling, advancing service redesign, and further embedding quality improvement and collaborative working practices.	

	CP asked why there were 6 recommendations that had not started. PB responded that the number had reduced to 5 recommendations. A stocktake meeting had been scheduled to review the remaining actions and would provide a further update at a future meeting. Provide a brief update at the next meeting on the actions not yet started in the Cardiology Improvement Plan, including reasons and expected start dates – ACTION. Jessica Castle (JC), the Director of Operations – Specialist Services Clinical Board, noted that some actions had been slower to commence because priority had been given to embedding the foundational cultural changes within the Directorate. The Committee resolved that: A) The update was noted.	
QC 26/07/7.2	<u>JACIE Inspection Update</u> JC presented the report and provided the following summary: • The JACIE accreditation review identified 87 areas of non-compliance from over 2300 assessments. Remedial actions had been implemented and submitted to JACIE within the required timeframe, with 336 of 340 actions completed (98.8%). the four remaining actions related to partial compliance and were not considered material, although further work was ongoing. • Good progress had been made in addressing key risks, including workforce planning, estates developments, governance arrangements and quality management process. Enhanced oversight and reporting mechanisms had been established, and plans for the haematology day unit and inpatient facility redevelopment continue to progress. • The organisation awaited JACIE's assessment of the submitted evidence and remained in a period of uncertainty regarding accreditation. Potential mitigations had been discussed with commissioners should accreditation not be maintained, although significant operational, workforce, financial and patient impact challenges remained. The associated risks remained rated as high, pending a formal decision from JACIE, which was expected later in the year. CP asked what their level of confidence was regarding the accreditation outcome. JC responded that it would be a significant step for JACIE to withdraw accreditation outright. A more likely outcome may be a further deferral to allow consideration of the WG business case, workforce investment proposals, and progress with inpatient facility developments. DF noted that even if accreditation was deferred, concerns regarding the suitability of the current facilities would remain. The importance of maintaining visibility of the service's strong clinical outcomes, including infection and success rates, was emphasised, recognising the high-quality care being delivered despite the challenges associated with the existing environment. Present outcome data and benchmarking for the JACIE programme to the Quality Committee in approximately three to four months, hopefully aligning with the expected accreditation decision timeline – ACTION. The Committee resolved that:	

	A) The submission of the SWBMT Programme response to JACIE on 8th July 2026 was noted; B) The significant progress made to address the inspection findings, including completion of all 87 non-compliances and 98.8% of all corrective actions was noted; C) The residual risks pending the final accreditation decision was noted; D) Assurance regarding the governance arrangements and mitigating actions currently in place was noted; E) The ongoing development of contingency arrangements should accreditation not be secured was noted.	
	Policies for Approval	
QC 26/07/8.1	UHB 597 - Accessible Standards and Communication Policy AH provided the following summary: - This policy brought together the All-Wales Accessible Communication and Information Standards, the UHB's Interpretation and Translation Policy, and relevant duties under the Equality Act 2010. - The policy aimed to ensure patients, service users, carers and families could access safe, equitable and person-centred care, regardless of communication needs. - Significant work had been undertaken to develop the supporting framework required for implementation, including a self-assessment tool, a multidisciplinary working group, guidance on interpretation services, and actions to improve the identification and recording of communication needs. - The implementation plan, which included staff guidance, awareness raising, monitoring arrangements and ongoing equality impact assessment work, was noted. The Committee approved the policy. The Committee resolved that: A) The Accessible Information and Communication Policy for implementation across CAVUHB was approved; B) The completed Equality and Health Impact Assessment and the overall positive impact identified was noted; C) The implementation actions relating to recording communication needs, staff access to interpretation and translation guidance, awareness raising, and monitoring through audit/self-assessment was noted.	
	Items for Noting / Information	
QC 26/07/9.1	<i>No items.</i>	
	Items Needing Escalation to Board	
QC 26/07/10.1	<i>No items.</i>	
	Any Other Business	
QC 26/07/11.1	<i>No other business was raised.</i>	
	Review of the Meeting	
QC 26/07/12.1	Committee members were asked to fill out the Committee Self-Effectiveness survey.	
	Date & Time of Next Meeting:	
QC 26/07/13.1	<i>29th September 2026 at 9am via MS Teams</i>	

Title	Minute Reference	Agreed Action	Executive Lead	Action Lead	Date Assigned	Date for Review	Action Status	Action Update
Safeguarding Steering Group (SSG) Highlight Report	QC2 26/06/30/7.2	Arrange for a presentation / report on Mental Capacity Act (MCA) and consent training to be brought to the Quality Committee.	Jason Roberts	Jason Roberts	30/06/2026	29/09/2026	COMPLETE	Standing items from the Mental Health Legislation Committee are scheduled to come through the Quality Committee every quarter. This action will be picked up via the standing items.
Clinical Safety Group Highlight Report	QC 26/07/3.2	Consider revising the scheduling of Clinical Safety Group meetings to ensure timely reporting and proactive oversight for the Quality Committee.	Jason Roberts	Alexandra Scott	27/07/2026	29/09/2026	COMPLETE	CSG meetings have been scheduled for 2 weeks prior to the Quality Committee from August 2026 onwards.
Clinical Effectiveness Committee Highlight Report	QC 26/07/3.3	Investigate and report back with a timeframe for resolving the lack of suitable IT infrastructure preventing participation in the inpatient diabetes audit.	Jason Roberts	Alexandra Scott	27/07/2026	29/09/2026	IN PROGRESS	Action to be marked as 'complete' once an update has been provided.
Regulation 28 Prevention of Future Deaths Report –Health Board Response and Assurance Arrangements	QC 26/07/3.5	Bring a further update back to the Committee in six months, including further information on commissioning status	Jason Roberts	Angela Hughes	27/07/2026	26/01/2027	ON FORWARD PLAN	Item scheduled on the Forward Plan for the 26th January 2027 Quality Committee meeting.
JACIE Inspection Update	QC 26/07/7.2	Present outcome data and benchmarking for the JACIE programme to the Quality Committee in approximately three to four months, hopefully aligning with the expected accreditation decision timeline.	Jessica Castle	Keith Wilson	27/07/2026	01/12/2026	ON FORWARD PLAN	Item added to the Forward Plan for the 1st December 2026 Quality Committee meeting.

Report Title:	Integrated Performance Report		Agenda Item No:		2.1
Meeting:	Quality Committee	Public	x	Meeting Date:	29.09.2026
		Private			
Lead Executive Title:	Executive Nurse Director and Executive Medical Director				
Report Author/s Title:	Assistant Director of Quality and Patient Safety				
Report Focus Summary – AAA Framework: <i>The AAA framework reflects the overall position of the matter being reported. Select one category only and complete the relevant box with a brief summary. A useful guide can be found here: NHS Triple A Guide</i>					
ALERT <i>(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).</i>					
ADVISE <i>(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)</i>					
The UHB reported 15 nationally reportable incidents (NRIs) during August 2026. The most common NRI theme was perinatal mortality cases. These cases are subject to a multi-professional mortality review as part of a national review process and, in the majority of cases, the reviews concluded that the care provided was good and did not impact the outcome. Pressure damage was the second most common category of NRI. The organisation also reported that pressure damage impacts around 9% of inpatients. The main themes arising from patient experience feedback, complaints and concerns continue to relate to communication, including the provision of timely updates, clarity of information and continuity of communication throughout the patient journey. Feedback also highlighted concerns regarding waiting times, access to services and care coordination, particularly where multiple teams are involved in care. Infection prevention and control performance remains mixed. While reductions have been achieved in hospital-onset <i>Pseudomonas aeruginosa</i> bacteraemia, <i>E. coli</i> bacteraemia and MSSA, challenges remain in relation to hospital-onset <i>Klebsiella</i> bacteraemia, <i>C difficile</i> infection and MRSA. The Health Board reported 56 cases of <i>Klebsiella</i> bacteraemia against a midpoint target of 45 cases. MRSA rates have increased compared with the previous year, and the organisation reported the third highest MRSA rate in Wales.					
ASSURE <i>(details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)</i>					
There is improvement in the management of incident investigations. The number of NRIs under review has reduced from 120 in February 2025 to 65 in September 2026, Patient safety incidents under investigation have also reduced from 8,000 in February 2025 to just over 5,000. A WHO Surgical Safety Checklist audit undertaken in August 2026 across four theatre suites reviewed 11 patient episodes and found that Team Brief, Sign In, Time Out, "happy to proceed" checks and Sign Out were completed and documented in all audited cases.					

Learning from patient experience feedback continues to be reviewed through governance arrangements and used to inform quality improvement initiatives. The concerns team remains focused on achieving and sustaining Early Resolution performance above target, while thematic analysis of complaints and patient feedback is being used to identify emerging trends and inform Clinical Board responses.

A range of infection prevention and control improvement actions are in place. These include enhanced auditing of urinary catheter insertion and maintenance, peripheral vascular catheter and central venous catheter care bundles, additional education and training relating to urinary catheter care and ANTT practices, an organisation-wide *C. difficile* improvement plan supported by Clinical Board action plans, and executive-led case review processes for MRSA bacteraemia. The report also notes that targeted interventions in paediatric oncology have been associated with a substantial reduction in *C. difficile* cases.

Board/Committee Response Required

Assurance	X	Approval		Information/Noting	X
-----------	---	----------	--	--------------------	---

Recommendations

The Committee is asked to:

- **NOTE the data and narrative included in the performance report**

Governance Route (*please list all other Committee/Groups this report has been to*)

Where it's been:	Board
When it went:	24.09.2026
What decision was made:	

Main Report

Background & Current Situation

The Integrated performance Report incorporates information relating to digital and health intelligence, finance, people and culture, performance, public health and quality and safety. Quality indicators align to the Wales NHS Performance Framework and the targeted intervention indicators.

The Integrated Performance Report is included in appendix 1 in the Supporting Documents folder.

Appendices:

1. Appendix 1 Integrated Performance Report (in the Supporting Documents folder)

Strategic Alignment – Shaping Our Future Wellbeing:

 Putting People First	 Providing Outstanding Quality	X
 Delivering in the Right Places	 Acting for the Future	

Impact Assessment

Risk: No

Safety: Yes
<i>The IPR includes data relating to patient safety and quality indicators as well as data around performance including oversight of nationally reportable incidents, Never Events, Infection Prevention and Control and patient experience</i>
Financial: Yes
<i>The IPR includes finance indicators and narrative including the finance deficit</i>
Workforce: Yes
<i>The IPR includes workforce indicators and narrative including workforce turnover, temporary staffing and sickness absence.</i>
Legal: No
Reputational: Yes
The data and information provided in the report is a candid and transparent report of UHB performance
Socio Economic: No - https://www.gov.wales/socio-economic-duty-guidance
Equality & Health: Please select
The IPR includes data and performance relating to public health including smoking cessation, women's health, immunisation and healthy weight
Decarbonisation: No
Welsh Language: No

Acute Deterioration

the story thus far

Abrie Theron

SRO Acute Deterioration

Work Streams

1. Early Warning Scores
2. Call for Concern
3. Sepsis
4. Treatment Escalation Plans

Directive from WG 17/9/24

- All 4 EWS tools introduced by 30 September 2025
- To reduce variation across Wales
- National Implementation Network
- Develop in house deterioration pathways
- Train everyone in HB
- No extra resource

Where we were in April 25

1. NEWTT2
 - already fully implemented
2. PEWS (Rhiannydd Poynter)
 - still working towards consensus in A&E (PED PEWS)
3. MEWS (Lucie Lewis)
 - responses not validated
 - Badgernet - electronic observation
4. NEWS2 (Jane Morris – HB Implementation Lead)

NEWS2 Challenges

- Scale – all adult pts in the HB!
- Different responses for different areas
 - A&E
 - Mental Health
 - Community
- Training 6500 staff recording (ESR) and responses (F2F)
- Summer break – earlier introduction by 28 July 25
- Change over of resident doctors
- Task & Finish Group meeting every Wednesday 8:00

NEWS2 Reponses

- Resource neutral
- Response divided between our current resource
 - **Pt's primary team**, both nursing and medical
 - P@RT (Patient at Risk Team)
 - Resus Team of which the Medical Registrar normally ends up with the pt
- Changes from NEWS to NEWS2
 - NEWS: whole resus team call to >9
 - NEWS2: >7 is most severe category
 - 3333 added as fast bleep for P@RT
 - 2222 cardiac arrest team if concerned / life threatening

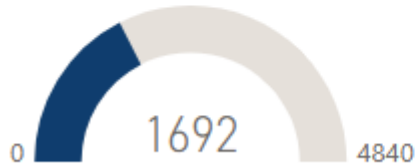
CAVUHB NEWS 2 Response:

News Score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	• If the patient looks or feels unwell increase frequency of observations
1-4	Minimum 4 hourly	• Inform registered nurse who must assess the patient • Registered nurse decides whether increased frequency of monitoring and/or escalation is required
3 in a single parameter	Minimum 1 hourly	• Inform Nurse in charge • Registered nurse to inform parent team caring for the patient • Inform P@RT for review
Total 5 or more URGENT RESPONSE	Minimum 1 hourly	• Immediately inform Nurse in Charge • Inform parent team (min FT2, but escalate up to patient's Consultant if no response from members of the parent team) • Inform P@RT for review • If signs of /or suspicion of infection screen for sepsis
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• Immediately inform Nurse in Charge • DIAL 3333 to fast bleep P@RT to assess patient within 15 minutes • Contact parent team for Specialist Registrar or above for review within 30 minutes • DIAL 3333 to fast bleep Medical or Surgical Registrar, ONLY if the parent team is not available • If no response from any of the above DIAL 2222 to request the Adult Resuscitation Team • For any airway concerns DIAL 2222 to request the Adult Resuscitation Team • If infection is suspected start Sepsis 6
If you feel the patient's condition is immediately life-threatening call 2222 Adult Resuscitation Team		
If the patient is unable to communicate how they feel, please increase minimum frequency of observations for NEWS 0 to 6 hourly		
If the patient is pregnant or < 6 weeks post partum and triggers on NEWS 2 or has a systolic BP > 140 mmhg, please inform Maternity team for additional advice.		

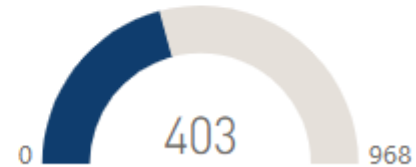
Compliance

Sep 2025 to Jul 2026

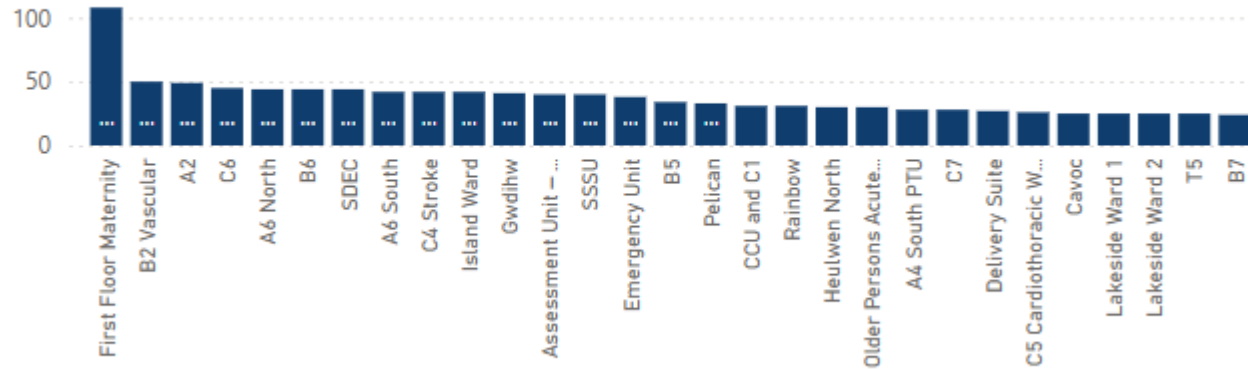
Number of charts reviewed



Number of audits completed



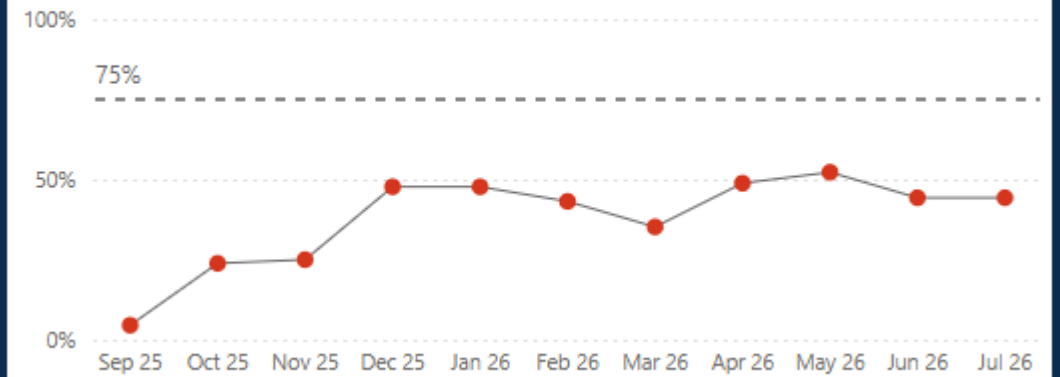
Number of charts reviewed by location



Areas without audits during this time period

Paediatric Emergency Unit
Park Road Houses Recovery & Rehabilitation Unit
Pine
St Barrucs
TACU
Teenage Cancer Unit

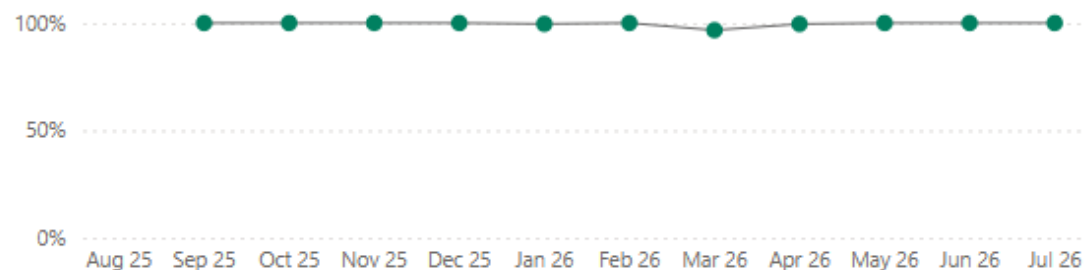
% Audit Compliance Over Time



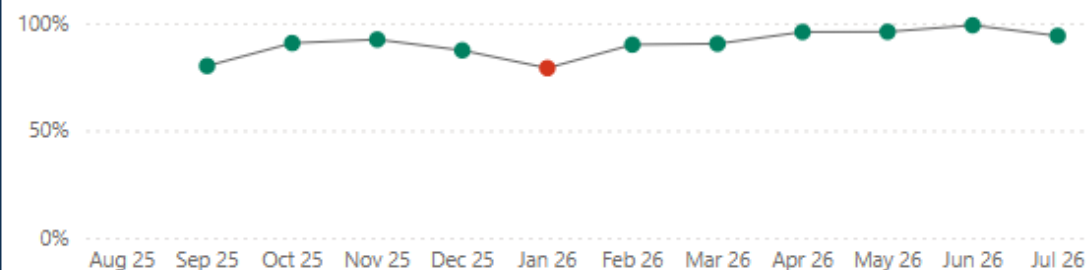
Standards

Sep 2025 to Jul 2026

Are staff using the correct charts?

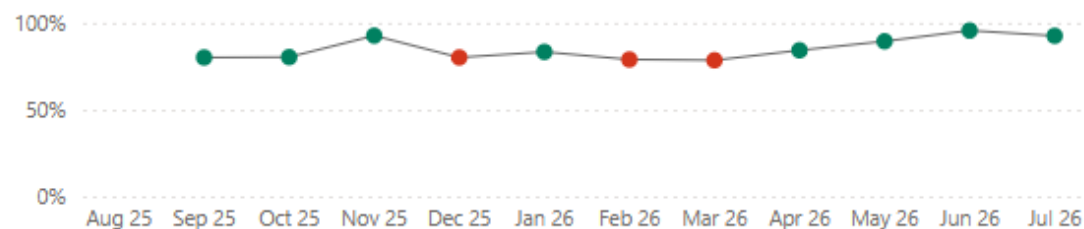


Are staff completing charts in line with the National Standards?



Are all elements of the chart completed?

Patient identification, time of observation, blood pressure etc



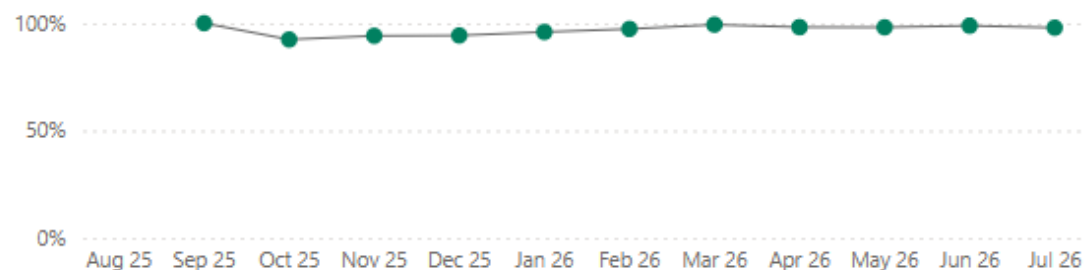
% of charts not completed with justification recorded

16%

% of charts not completed with no justification recorded

84%

Are the scores being calculated correctly?



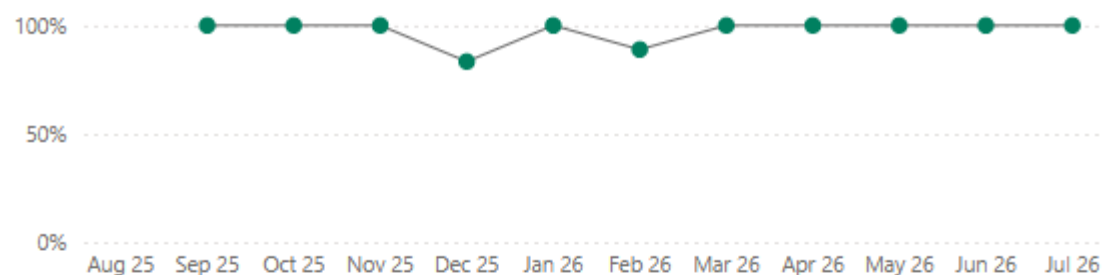
Escalation

Sep 2025 to Jul 2026

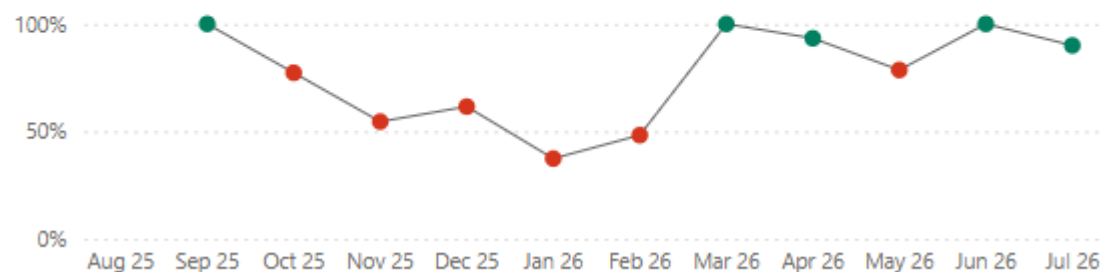
number of patients who met a trigger for escalation

215

Of the patients who were escalated, was there a response?



Was the patient escalated as per local guidance? or had rationale recorded?

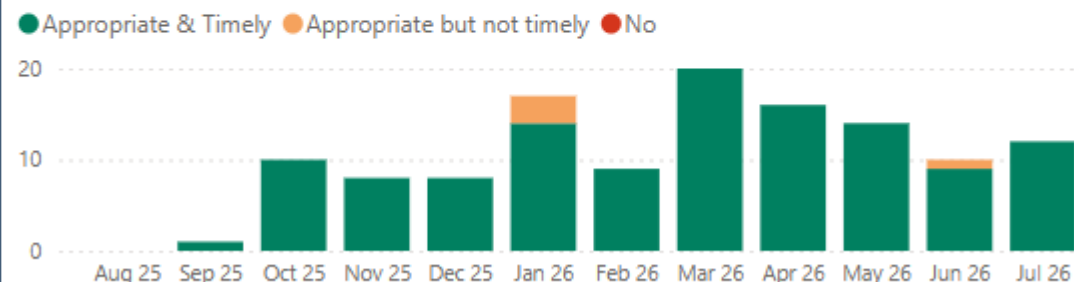


Highest Early Warning Score in last 24hrs of audit

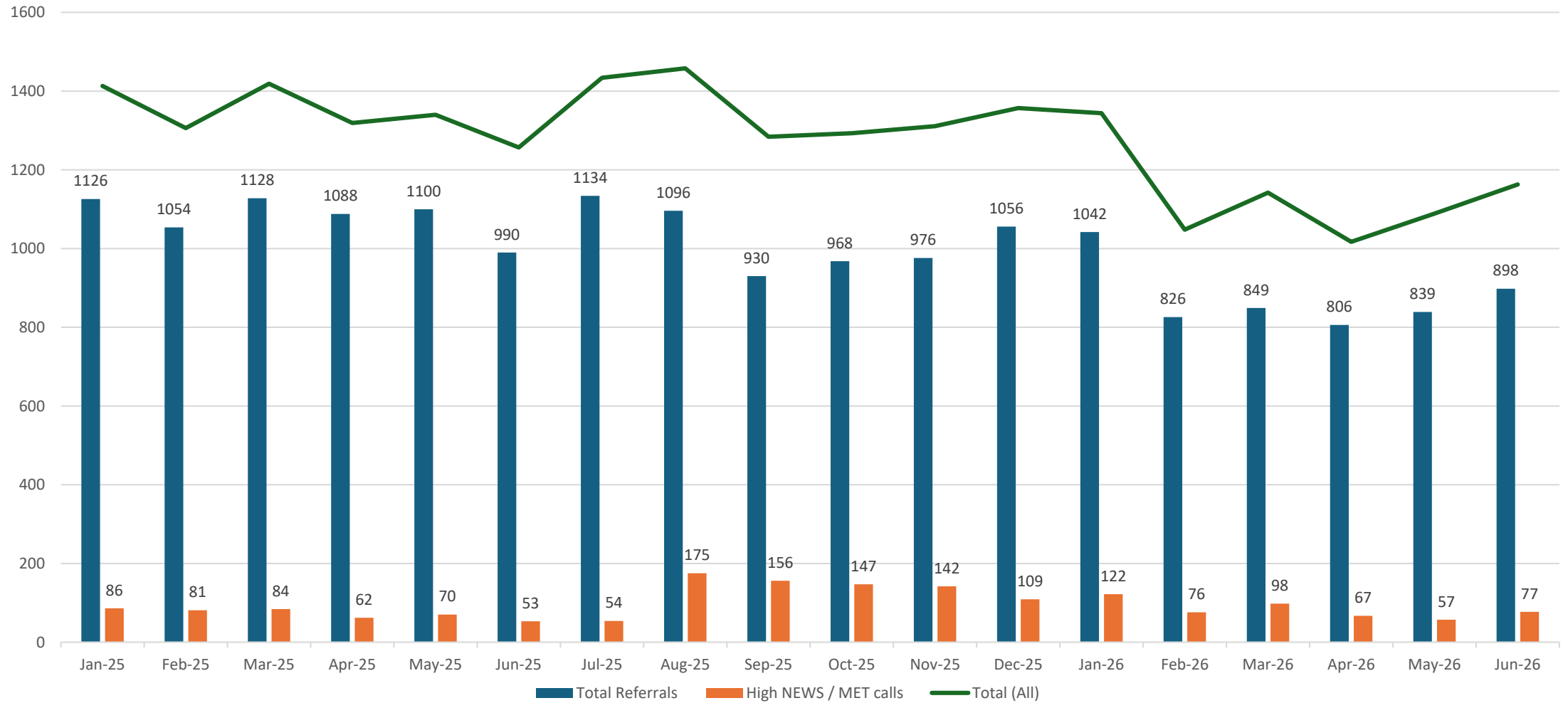
Number of patients

0	661
1	406
2	299
3	128
4	79
5	32
6	21
7	13
8	9
9	6

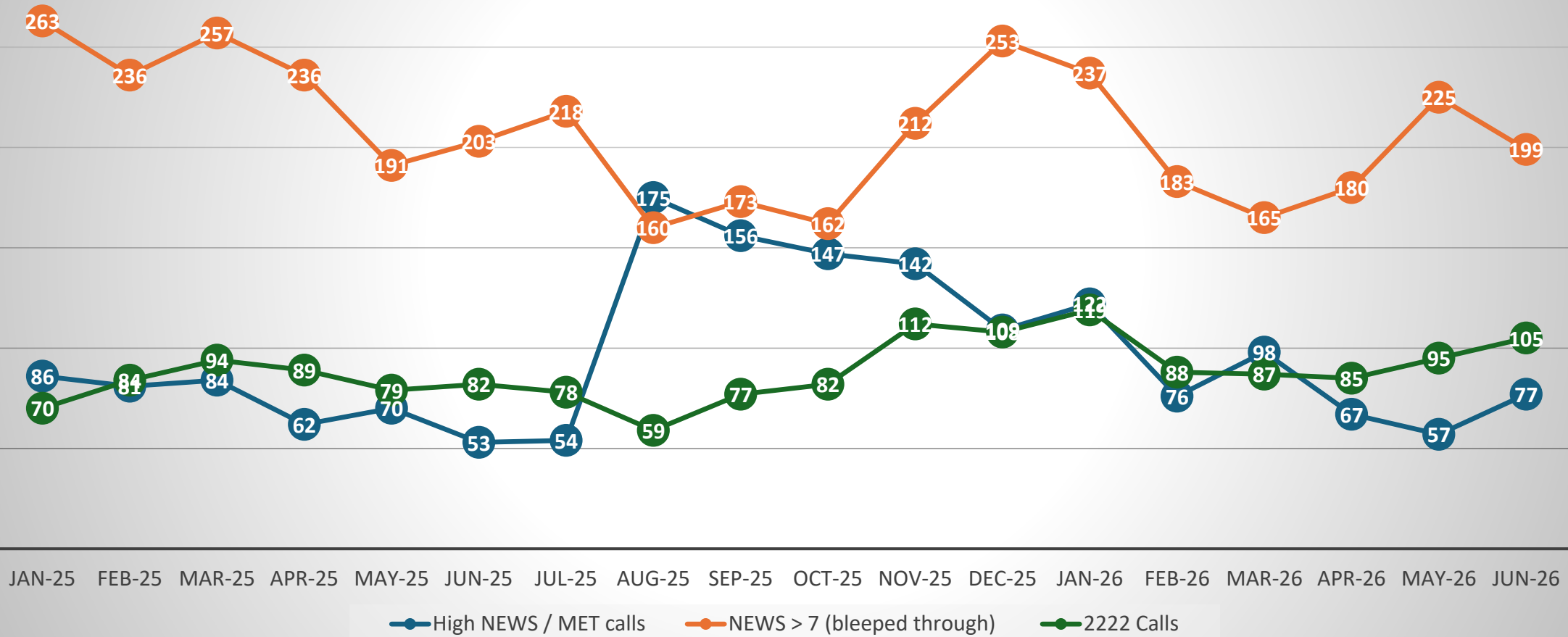
If a response was made, was it timely and appropriate?



Totals per Month



High NEWS / 2222 Trend



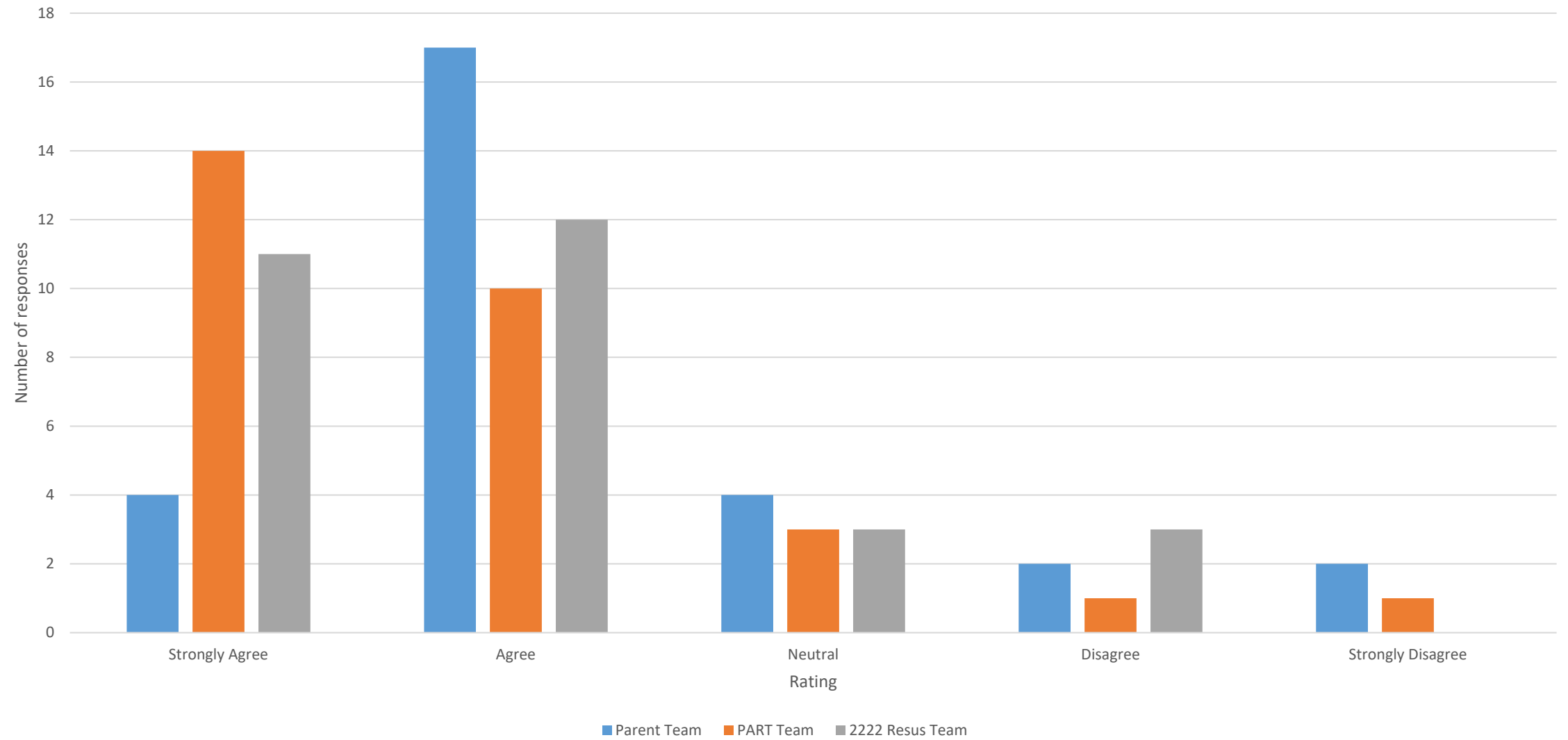
RESUS CUBE Data

RESUS Team Calls / 2222	2024	2025	Jan-July 26	2026
Cardiac Arrest	217	200	97	166
Choking	5	9	3	
Collapse ? Cause	180	138	90	154
Fall	27	32	14	
Mistaken Call	3	1	32	
NEWS high	306	16	8	
Not Defined	15	6	5	
OOH Cardiac Arrest	128	137	65	111
Peri-arrest/acute unwell	565	666	448	768
Respiratory Arrest	11	9	9	
Seizure	239	214	76	
TOTAL	1696	1428	847	1452

3 Questions with free response (n=29)

- Regarding a patient with a NEWS score of 7 or more, please rate the following statement:
 1. The current input and involvement of the **Parent Team** is accessible, proportionate and effective
 2. The current input and involvement of the **PART Team** (Patient at Risk Team) is accessible, proportionate and effective
 3. If needed, the input and involvement of the **2222 Resus Team** is accessible, proportionate and effective

NEWS ≥ 7 response ratings by team



Call for Concern / Martha's Rule

- Directive from WG 8 Jan 2026
- Pt / Family / Carers voice / adjunct to EWS
 - Tier 1 Wellness Scores every 12hrs min – live from July 2026
 - Tier 2 Local Nursing and Medical Team
 - Tier 3 Independent review (P@RT) live since 1 July 2024
 - Review data and learning to make changes (Grand Round)
- A&E
- Maternity
- Mental Health pilot from September

Patient Wellness Scoring

Ask your patient *"How are you feeling compared to the last time we asked you?"*



BETTER



SAME



WORSE

If the patient is unable to answer, please refer to the patient's health care pathway or similar document and/or ask any relatives or carers. If no one available, please document patient unable to answer.

Patient Wellness Score Escalation

Better

- Continue to monitor, BD minimum

Same

- Escalate to nurse in charge of the patient to review the circumstances and escalate to the NIC if indicated.
- Document decisions and actions

Worse

- Registered Nurse to repeat observations.
- Escalate to the NIC .
- Escalate to the medical team for a review when appropriate
- Document decisions and actions.

SEPSIS

- Medical Lead (Paul Morgan) handing over later this year
- Website redesign
- Nurse for Sepsis in P@RT
- Train the Trainers course with UK Sepsis Trust - charity funded
- Cascade training on the wards
- Sepsis Awareness Event / Seminar 9 September 26

Sepsis Seminar - 09/09/2026



Summary

- EWS
 - All 4 Introduced
 - Tenable data incomplete, but majority used and escalated correctly
 - The responses we agreed did not overwhelm teams
 - No indicators that our pts are worse off, there may be improvement
- Call for Concern
 - Early days, further update in 2027
- Sepsis
 - Please join us for the SEPSIS seminar
- Electronic Observation
 - Will change the acute deterioration projects significantly

Thank you

?

Abraham.Theron@wales.nhs.uk

CLINICAL BOARD QUALITY UPDATE REPORT

Governance Group:	Medicine Clinical Board	Date of Meeting:	September 2026
Representative at Clinical Board Governance:		Date of Meeting:	

ITEMS FOR ALERT

Issue / Risk	Actions Taken	Group Responsible
Welsh Gender Service The NHS Wales Joint Commissioning Committee (NWJCC) has placed the Welsh Gender Service into Level 3 escalation following concerns regarding the gender-affirming surgery referral pathway and associated governance arrangements. Referrals for gender-affirming surgery, surgical assessments and scheduled surgery have been paused pending completion of an Independent Clinical Review. A total of 451 patients across the surgical pathway have been identified as potentially affected by the pause. Whilst the wider Welsh Gender Service remains operational, the pause has resulted in delays to surgical care for affected patients and has generated significant public, political and media scrutiny.	Level 3 escalation oversight: Cardiff and Vale UHB continue to work closely with NWJCC in response to the Level 3 escalation and the forthcoming Independent Clinical Review. Escalation meetings arranged with NWJCC and service fortnightly from 17/09/2026 Patient communication completed: All 451 patients identified as potentially affected by the surgical pathway pause have been contacted directly and informed of the changes, available support and routes for raising concerns. Dedicated psychological support via the WGS has been made available to support patients affected as well as working with third party services and local groups to support patients Coordinated communications in place: A communication and engagement plan has been implemented, including patient FAQs, stakeholder updates, public communications and staff briefings to ensure consistent messaging. Concerns and enquiries managed: A single coordinated process is in place to manage patient, public, stakeholder and media enquiries, with escalation arrangements for issues requiring senior review. Clinical and operational oversight maintained: Regular oversight is being maintained between the Welsh Gender Service, Medicine Clinical Board, Executive Team and NWJCC, including review of patient concerns, staff issues, service continuity and emerging risks. Independent Review supported: The Clinical Board will support the Independent Clinical Review and ensure any recommendations are assessed, actioned and reported through established governance routes. Wider service continuity: Non-surgical Welsh Gender Service functions remain operational, including psychological support, endocrine review, hormone therapy, speech and language therapy and fertility services. Residual risk: The key residual risk remains continued delay for patients awaiting surgical care, alongside ongoing public, political and media scrutiny, pending the outcome of the Independent Clinical Review.	Welsh Gender Service and Medicine Clinical Board / Executive Team / NWJCC
ED Overcrowding / Unscheduled Care Performance Following the inquest into the death of Alan Rees in April 2022, HM Coroner issued a Regulation 28 Prevention of Future Deaths report in July 2026 highlighting concerns relating to Emergency Unit overcapacity, workforce pressures during periods of exceptionally high demand, exit block and the impact of patient flow on the delivery of timely care. This risk has been further reinforced by deterioration in unscheduled care performance during August 2026, with ongoing pressure across acute and emergency pathways, persistent Emergency Department waits, capacity constraints and concerns regarding	Health Board-wide programme in place: A coordinated programme of work is in place to improve urgent and emergency care flow and reduce the patient safety risks associated with Emergency Unit overcrowding. Medicine Clinical Board Acute Plan being implemented: The Medicine Clinical Board Acute Plan is being progressed, including acute model redesign, ward realignment, speciality pathway clarification and actions to improve flow through the acute medical system. Same Day Emergency Care being expanded: Medical SDEC pathways are being strengthened to increase ambulatory management of the acute medical take, reduce avoidable admissions and support improved flow from the Emergency Unit. Frailty pathway development: Frailty and Older Persons Acute Medicine pathways are being developed to support earlier assessment, timely senior decision-making, admission avoidance where appropriate and reduced length of stay.	Medicine Clinical Board Triumvirate/ED/AU CD Executive Team

flow through the acute medical system. Performance reviews have identified the need to strengthen same day emergency care, reduce length of stay, improve frailty pathways and optimise bed utilisation in support of the acute care pathway.

The combined position presents a continuing patient safety risk associated with overcrowding, delayed assessment and treatment, ambulance handover delays, exit block and

Datix

Medicine currently has 283 incidents with a status of "New". To support timely review and ensure appropriate oversight, weekly reminder reports are issued to all directorate teams. These reminders prompt Incident Managers to review and progress incidents within Datix, supporting effective governance, risk identification, and management oversight.

Bed utilisation and discharge focus: Bed utilisation, length of stay, discharge planning and timing of discharge are under active review to reduce delays, improve capacity and support safer patient flow.

Workforce realignment underway: Workforce plans are being reviewed and realigned to support the revised acute model, ensuring nursing, medical and multidisciplinary staffing is directed to areas of greatest operational and clinical need.

Executive oversight strengthened: Oversight is provided through the Unscheduled Care Programme, Medicine Clinical Board governance routes and Executive Team review, with escalation of risks and delivery constraints where required.

Performance and safety metrics monitored: Key indicators are being monitored, including Emergency Unit capacity, ambulance handover performance, 12-hour waits, delays to assessment and admission, MSDEC utilisation, bed occupancy, discharge performance, incidents and patient experience.

Regulation 28 response coordinated through governance: The Regulation 28 response has been coordinated through the Health Board governance process and has strengthened the focus on reducing overcrowding, improving patient flow and mitigating harm.

Residual risk recognised: Despite improvement actions underway, residual risk remains due to sustained demand, exit block, workforce pressures and periods of hospital escalation. This will continue to be monitored through Executive and Clinical Board quality and performance governance, with escalation to Board where risks are not sufficiently mitigated

Improvement trajectory set: A focused Datix improvement plan is in place to reduce the number of unopened incidents currently recorded as "New", with the expectation that this position will improve by the end of September.

Weekly incident status reports issued: Weekly reports are circulated to teams, clearly identifying outstanding "New" incidents requiring review and action.

Named accountability in place: Incident Managers are reminded of their responsibility to review and progress incidents in a timely manner, ensuring ownership is clear at service level.

Operational follow-up strengthened: Directorate teams are expected to review outstanding incidents each week, prioritise older incidents and ensure appropriate progression within Datix.

Governance monitoring established: Datix compliance and incident management performance are monitored through routine Medicine Clinical Board governance and quality meetings, providing assurance that progress is being tracked.

Escalation route confirmed: Overdue or non-progressing incidents are escalated through directorate governance routes and to senior Clinical Board leadership where improvement is not being delivered at the required pace.

Residual risk recognised: The level of "New" incidents remains a live governance risk until the backlog is reduced and sustained compliance is demonstrated. Continued monitoring will remain in place, with escalation to Executive and Board routes where required.

DoN Speciality
Managers/Lead
Nurses/General
Managers

ITEMS TO ADVISE

Issue / Risk	Actions Taken	Group Responsible
NRI's The current NRI position has improved compared with previous months, with 15 open	Sustained improvement demonstrated: The current NRI position has improved, with 15 open NRIs compared with 21 in July, demonstrating a positive reduction in the overall backlog.	Director of Nursing/MCB QSE Leads

NRIs, down from 21 in July. Although five incidents remain overdue, there is evidence of continued progress, with three of these cases nearing completion. Ongoing oversight and support are being provided to reviewers to facilitate timely progression of investigations, with regular monitoring through established governance processes to ensure appropriate management and closure of outstanding cases.

Traffic light tracking system implemented: A traffic light tracker is being used to monitor each open NRI, clearly identifying progress, overdue cases, cases nearing completion and those requiring additional support or escalation.

Weekly Director of Nursing oversight: Weekly oversight meetings are in place with the Director of Nursing to review the NRI position, track progress against each case and agree any required escalation or support.

Direct engagement with reviewers: Reviewers are being contacted directly to support timely progression, address barriers to completion and ensure investigations are finalised within expected timescales.

Overdue cases actively managed: The five overdue NRIs remain under active review, with three cases nearing completion in 4/5 weeks and further follow-up in place for those requiring additional action.

Governance monitoring established: The NRI position is monitored through established Clinical Board quality and governance processes, providing routine oversight of open, overdue and closing cases.

Escalation arrangements confirmed: Cases that are not progressing at the required pace are escalated through Clinical Board governance routes and to senior leadership where additional intervention is required.

Quality and learning focus maintained: Continued focus is being placed on timely investigation, identification of contributory factors, delivery of learning actions and closure of cases to strengthen patient safety and reduce recurrence.

Residual risk recognised: Residual risk remains while five NRIs are overdue and until sustained compliance with investigation timescales is demonstrated. This will continue to be monitored through Clinical Board and Executive quality governance, with escalation to Board where required.

Gastro Update

An ongoing patient safety risk remains under review relating to endoscopy and pathology results management. A review identified a cohort of unreported endoscopy reports and outstanding pathology results, creating a risk that patients may not receive results or appropriate follow-up in accordance with national guidance. Concerns have also been raised regarding continuity of clinical oversight where investigations were requested by temporary clinicians. An Executive Warning Notice and Nationally Reportable Incident process are in progress.

Review process: A dedicated consultant-led review process has been established to assess all outstanding endoscopy and pathology results and ensure appropriate clinical follow-up.

Multidisciplinary harm review panel: has been convened to review affected patients, assess potential harm, and oversee any required actions.

Robust governance and reporting arrangements have been strengthened to provide oversight of review progress, risk management and completion of follow-up actions.

Learning: Learning from the investigation is being embedded through strengthened results-management processes, improved clinical oversight arrangements and enhanced governance controls to reduce the risk of recurrence.

Governance and oversight: Progress, actions and outcomes are subject to ongoing monitoring through the NRI process, Executive oversight arrangements and the MDT Harm Panel.

Governance and Oversight: A thematic review has been completed, and a formal improvement plan is being delivered.

Regular pathway review meetings are in place to monitor progress, risks and actions.

Cancer Tracking and Escalation: Cancer tracking arrangements have been strengthened to improve patient visibility and reduce the risk of delays.

Medicine Clinical
Board Triumvirate
Specialised
Medicine CD's/Lead
& Senior
Nurses/Service
Managers

Medicine Clinical
Board Triumvirate
Specialised
Medicine CD's/Lead
& Senior
Nurses/Service
Managers

Dermatology skin cancer pathways continue to experience increasing demand and capacity pressures across outpatient assessment, surgery and diagnostic processes. Recent Nationally Reportable Incidents and thematic reviews have identified recurrent pathway failures including delays in diagnosis, referral

management, biopsy, pathology reporting, communication of results and definitive treatment. Concerns have also been identified regarding patient tracking, escalation processes and pathway ownership, creating a risk of delayed cancer diagnosis and treatment.

Standardised escalation processes and exception reporting have been introduced to support early identification and management of pathway concerns.

Pathway Management: Improvements to results management processes are being implemented to strengthen timely review, communication and follow-up of diagnostic results.

Pathway ownership and accountability have been clarified to support consistent oversight of patients throughout the pathway.

Service Improvement: Workforce and service redesign initiatives continue to address capacity pressures across the pathway. Tele-dermatology and wider skin cancer pathway transformation work are underway to improve pathway resilience, efficiency and access to care.

Expected Outcomes: Improved patient tracking and pathway oversight.

Earlier identification and escalation of delays.

Reduced risk of delayed diagnosis and treatment.

Strengthened results management and pathway governance.

Greater assurance that patients progress safely and timely through the skin cancer pathway.

ITEMS FOR ASSURANCE

Issue / Risk	Actions Taken	Group Responsible
A revised discharge process has been implemented requiring completion of the discharge advice letter before patient discharge and release of discharge medication. This has improved the quality and timeliness of communication with GPs and community teams, supporting safer transitions of care and reducing the risk of information being unavailable after discharge. Monitoring to date has not demonstrated any significant impact on discharge timeliness or patient flow.	Clinical Board has communicated to wider teams of expectations in relation to completion of DALs Review of compliance data and feedback provided to wards/CDS	Medicine Clinical Board Triumvirate
Closure of West 2 Ward, UHL – implementation and transition risk Closure of West 2 at University Hospital Llandough forms part of the Medicine Clinical Board acute medicine redesign and workforce realignment programme. The proposal is intended to strengthen Acute Medicine, improve patient flow, support earlier senior decision-making, reduce avoidable delays and harm, and deploy staff to areas of greatest patient need. The quality impact is assessed as positive overall; however, implementation carries recognised transitional risks relating to continuity of specialist respiratory pathways, cystic fibrosis inpatient care, elective respiratory procedures, staff redeployment, workforce morale, during the change period.	Formal consultation and engagement: Staff consultation has been undertaken in line with the All-Wales Organisational Change Policy, supported by updated consultation documentation, QIA, FAQs and EHIA. The consultation period was extended by four weeks to allow staff and Trade Unions further opportunity to provide feedback, seek clarity and influence the final implementation plan. Workforce redeployment controls: Workforce mapping is being completed for nursing, HCSW, medical, therapies/AHP, pharmacy and related services. One-to-one meetings, redeployment preferences, support for staff on authorised absence and receiving-area induction/competency plans are being progressed to support safe transition. Clinical pathway mitigation: Respiratory admissions, intra-hospital transfers, cystic fibrosis provision and elective respiratory procedures require clear pathway mapping before implementation to ensure continuity of specialist care and equitable access. Governance oversight: Clinical Board and triumvirate oversight is in place through transition planning, a live risk log, decision tracking and escalation of unresolved clinical, operational or workforce issues. Staff and Trade Union feedback is being reviewed and reflected in updated documentation throughout the consultation period. Quality monitoring: Post-implementation monitoring will include incidents, complaints/concerns, patient moves, discharge delays, length of stay, staffing fill rates and patient experience to ensure risks are identified early and mitigations remain effective.	Medicine Clinical Board Triumvirate People & Culture / Staff-side representatives

ITEMS FOR ASSURANCE

Issue / Risk	Actions Taken	Group Responsible
	Residual risk: Residual risk remains during transition until pathway arrangements, redeployment plans and quality monitoring demonstrate sustained safe implementation.	

RECENT LEARNING OPPORTUNITY

Source:		Reference (if applicable):	
What happened / what was the problem?			
Recent Bare Below the Elbows (BBE) audit results identified inconsistent compliance across Medicine Clinical Board, with some areas failing to maintain the expected high standards. Walkround audits and Infection Prevention and Control (IPC) observations highlighted examples of non-compliance, including the continued wearing of jewellery and artificial nails despite staff being asked to remove them. Variability in understanding of BBE requirements was identified, alongside reluctance by some individuals to comply with established standards.			
What was learned and how was this shared?			
Review of the findings identified underlying cultural issues contributing to poor compliance. There was evidence that some staff did not fully understand the importance of BBE requirements, while others appeared to believe non-compliance would not be challenged. The findings highlighted the need for stronger leadership visibility, more consistent challenge of non-compliance, and a renewed focus on promoting a positive culture of personal accountability for infection prevention and patient safety.			
What action has been taken or planned? What was the impact of this?			
- Lead Nurses and Senior Nurses reviewed the audit findings and identified the need for a focused Medicine Clinical Board-wide improvement programme aimed at all staff, to strengthen compliance with Bare Below the Elbows (BBE) standards. - A dedicated "High Five" campaign has been launched across the Clinical Board, encouraging staff to visibly demonstrate BBE compliance during safety briefs, huddles and ward rounds. - A targeted poster campaign has been introduced across clinical areas to reinforce key BBE messages, increase awareness and remind staff of expected standards. - A communications and media campaign has been developed using staff briefings, team meetings and internal communication channels to promote the patient safety importance of BBE compliance and encourage personal accountability. - Senior nursing leaders are providing increased visibility within clinical areas, reinforcing expectations and challenging non-compliance where identified. - BBE compliance continues to be monitored through routine audits, IPC walkrounds and observational reviews, with feedback provided to ward and departmental teams. - Audit performance will be reviewed over the coming months to assess the impact of the campaign and identify any further actions required to improve compliance and sustain behavioural change.			

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

A compliment was recently received from a complainant who acknowledged the Health Board's detailed and transparent investigation, including the recognition that aspects of care fell below the expected standard. Positive feedback was received regarding the openness and professionalism demonstrated throughout the review process, the provision of an apology, and the clear communication of findings. The complainant welcomed the organisation's commitment to learning and improvement, particularly the actions implemented to strengthen medicines management, discharge processes and medication safety. The response was viewed as evidence of a patient-centred approach, with a focus on organisational learning and reducing the risk of recurrence.

In this case good practice was evidenced by the timely investigation of concerns, transparent communication with the family, acknowledgement of care delivery issues, and implementation of learning actions aimed at reducing the risk of recurrence and improving patient safety.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non Delivery	Risk (RAG)

NEW / CLOSED / AMENDED RISKS

--

CLINICAL BOARD QUALITY UPDATE REPORT

Governance Group:	UHB Quality Committee	Date of Meeting:	28.08.26
Representative at Clinical Board Governance:	Cath Twamley (DON)	Date of Meeting:	

ITEMS FOR ALERT

Issue / Risk	Actions Taken	Group Responsible
Boston Scientific Cybersecurity Incident  DCMO Letter - Boston Scientific Cyl - There has been a safety alert issued by the Welsh Government related to a cyber security breach at Boston Scientific. - The alert states there is no implication of safety of the advice but there is significant risk to new implants being set up on Remote Monitoring. - Those already set up remain unaffected - Programmer interrogation remains unaffected - Supply chain - Boston's supply chain has been affected, specific stock list - Need to assess any immediate risk - Remain vigilant to any communication from Boston or purporting to be from Boston Scientific The safety alert states: Health Boards should review any recent or planned implants for which remote monitoring has not yet been activated and ensure appropriate interim follow-up arrangements are in place. Existing patients should not be advised that their implanted device has been compromised on the basis of the information currently available.	Cardiac Devices Cardiff and Vale had received its outstanding and subsequent cardiac-device orders, experienced no disruption to existing remote monitoring or new-patient enrolment, and have resumed normal use of Boston Scientific devices after a short precautionary shift towards other suppliers. Cardiac Device Orders: Outstanding order for Boston Scientific pacemakers and CRTs had been received, followed by a subsequent order placed towards the end of the previous week that arrived on the day of the meeting. Remote Monitoring: Cardiff and Vale's physiology service saw no impact on existing patients enrolled in remote monitoring; red flags and patient downloads continued as normal. The service also experienced no disruption when enrolling patients implanted during the incident period. Local Mitigation: Cardiff and Vale initially slowed implantation of Boston Scientific devices and favoured Medtronic and Abbott while the incident was being clarified. The service subsequently	Cardiac Services DMT & Physiology Team The Department of Health and Social Care's Four Nations NSDR group Boston Scientific. NHS Wales (NHS P&I, Shared Services and Welsh Government colleagues)

	returned to normal practice.	
Unplanned Power Outage September 3rd 2026, circa 45 mins. Datix 122471 Central monitoring and telemetry capability lost on C1 despite understanding UPS back up installed. DTU (David Thomas Dialysis Unit) lost all power and water with emergency lights only. All dialysis machines ceased to function once battery provision lost.	Patients moved to bedside wall monitors. Datix raised and will be linked to ID 122471 Ryan Thomas (Head of Tech. Services/ Deputy head of Clinical Engineering following up. All patients disconnected safely and clinically reviewed to schedule treatment. Datix 122575 (Linked to ID24710.	Head of Operations/ Estates Cardiac Services Nephrology and Transplant/ Estates
Closure of uncommissioned Major Trauma Centre (MTC) Plastic Dressing Clinic currently operating in CAV UHB from 10th September with impact on experience of patients who will now receive appointments for Swansea Bay UHB (SBUHB)	Joint correspondence from South Wales Trauma Network (SWTN), CAVUHB and SBUHB to JCC to consider this matter as an urgent service risk and work with both organisations to identify a sustainable commissioning solution.	Specialist Services CB MTC directorate SWTN SBUHB JCC
Urgent Safety Notice re. GE Healthcare PACS system to advise: <i>Under Certain Conditions historical imaging data migrated from a legacy system may become incorrectly associated with a different patient. This issue may occur in certain historical data migration scenarios.</i> <i>and</i> <i>Do not perform any new inbound data migration project.</i>	Shared with Cardiac Catheter Labs team who use GE PACS. Confirmation received no known plans to migrate historical data to the system.	Cardiac Catheter Labs team

ITEMS TO ADVISE		
Issue / Risk	Actions Taken	Group Responsible
Outbreak of Resistant <i>Acinetobacter baumannii</i> on T4 Neuro and Critical Care. ID 118203 (NB previous ALERT item) Five patients have been identified with pan-resistant <i>Acinetobacter baumannii</i> carrying identical OXA-23 and	As per SBAR and Improvement plan:	CB, DMTs and all wider stakeholders to include relevant Networks IPCG and CB IP&C groups

NDM carbapenemase genes across T4 Neuro and B3 North Critical Care. - Cases one and two have an epidemiological link on T4 Neuro. Case one has since been transferred to Nevill Hall Hospital. - Case two was isolated on B3 North and has subsequently died. - Case three was later identified on B3 North Critical Care and has an epidemiological link to case two. - Case four identified on B3N following the implementation of enhanced screening and has an epidemiological link to cases two and three, having been accommodated in the same bay area. - Case five was subsequently identified on T4 Neuro and has an epidemiological link to case one. The first Outbreak Control Team (OCT) meeting was held on 08/07/2026, with weekly meetings continuing. Last positive case August 5th	 T4N CCD A.baumannii Outbre  T4N CCD A.baumannii Outbre	
--	--	--

ITEMS FOR ASSURANCE		
Issue / Risk	Actions Taken	Group Responsible
 8.-Wales-2026.pdf Looking after staff to achieve quality outcomes.	British Junior Cardiologists Association survey results for 2026 reflect the hard work and dedication of the team and reinforce the GMCs decision to cease enhance monitoring. UHW achieved an overall rating of 8.7 with only 10 centres across the UK achieving equivalent or a higher score.	Abbas Zaidi (Cardiology Consultant) and the team
■ePMA Missed \medications Audits: Missed medications are shown on ePMA as an orange cell with "Missed?" displayed. Medications which were "Not given" and the reason why were also reviewed. The latest results show that the percentage of missed doses has significantly reduced since the last audit from 21% to 13%.	Prior to implementation the ePMA nursing team carried out missed medication audits that have been repeated post go live,	Specialist Services nursing teams

The data also shows that common medications not given include Paracetamol, Senna, Docusate and Lactulose. Many of these are refused by patients. All audits are available on Tendable to view.		
Incomplete DALs progress: Currently 64 incomplete DALs for patients which is a significant improvement. The starting position was 120 incomplete DALs.	Project DAL being led by SSCB. Regular review and touchpoint meetings with all teams. Those open currently being validated with on a case by case basis with end of sept. deadline. Practice now embedded as part of daily ward round.	SSCB, Clinical Directors, pharmacists and Lead Nurses
Stroke Mortality data: Apparent coding mismatch with stroke activity indicating we are not an outlier for mortality in SSNAP with a higher than national average mortality rate for the health board. This suggests that more patient deaths are being coded as 'stroke' than we are auditing in SSNAP.	Review of Beacon data to establish which patients are being coded as stroke without an admission to C4 and therefore are not stroke patients Ongoing engagement between Stroke Services and coding team	Stroke services Patient Safety Team

RECENT LEARNING OPPORTUNITY			
Source:	Helen Thomas (Specialist services CB Lead Pharmacist)	Reference (if applicable):	Datix (? April 2026)
What happened / what was the problem?			
An incident was reported via Datix involving an inadvertent overdose of sodium oxybate due to patient confusion between pharmacy labelling and the manufacturer supplied dosing syringe. The patient's consultant has confirmed that they did not come to any harm as a result of the overdose, however this incident has highlighted an ongoing risk for patients receiving this medication.			
What was learned and how was this shared?			
Sodium oxybate is a sedative drug used to consolidate sleep in adults and children experiencing narcolepsy with cataplexy. It is not currently on the CAVUHB formulary; however, is used for a cohort of patients (c 10 adult patients) where there is no appropriate alternative on the formulary. Sodium oxybate is prescribed as two nightly doses, one given on retiring and the second given 2.5 to 4 hours later. The normal total daily dose is between 4.5g and 9g.			

The patient was prescribed as 2.25g on retiring and 2.25g 2.5-4 hours later and presented to the UHW pharmacy for dispensing. This was clinically checked and labelled correctly in accordance with Cardiff and Vale University Health Board's dispensing standards, with the dose expressed in millilitres (2.25g dose = 4.5 mL of 500mg/ml oral solution).

However, the dosing syringe supplied by the manufacturer is graduated in grams rather than millilitres, which led the patient to take a dose of 4.5g for several days. Review of stock confirms that this applies to both brands currently held in CAVUHB pharmacy (Ascend® and Kalcex®), as well as other available brands whose patient information leaflets have been accessed via the electronic Medicines Compendium.



The manufacturer's patient information leaflet ([GUK S 500 4.cdr](#)) describes an involved dose preparation process, relying on the supplied syringe, bung, and two dosing cups provided in the pack.

The mismatch between standard pharmacy labelling units (millilitres) and the units displayed on the manufacturer supplied syringe (grams) presents a clear risk of patient misinterpretation and dosing error. Removal or substitution of the syringe and PIL was considered but is not recommended, as this would conflict with manufacturer instructions and may increase risk given the complexity of the dose preparation process.

The incident is therefore attributed to system level inconsistency rather than a dispensing or checking error. Learning as per actions and QSE channels.

What action has been taken or planned? What was the impact of this?

Recommendations to mitigate ongoing risk:

- A dispensing flag has been added to the All Wales pharmacy system to alert the dispenser that **sodium oxybate should be labelled with the dose expressed in grams**, in line with the manufacturer supplied syringe. (National impact)
- A standardised label (similar to warning labels) has been introduced to reinforce this requirement at dispensing
- A warning has been added to ePMA to inform nurses of the syringe and dose preparation to support safe in-patient administration
- A letter is sent to all patients currently prescribed sodium oxybate alerting them to the syringe and dose preparation
- Mandatory patient counselling is provided at supply to ensure correct use of the syringe and dose preparation

- A safety communication has been circulated and the issue highlighted at dispensary meetings to raise awareness.

These actions align pharmacy labelling with manufacturer instructions and aim to reduce the risk of future dosing errors

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

- Ellie Jones, a Staff Nurse on the Acute Stroke Unit at University Hospital of Wales, has been named August's Health Hero after being nominated by a patient's wife for the care and support she provided following her husband's stroke, aged just 38.

Ellie joined Cardiff and Vale University Health Board almost two years ago as a newly qualified nurse. After completing a student placement on the Acute Stroke Unit, she enjoyed it so much that she decided to stay after qualifying.

Ellie looks after patients in the early stages of stroke, providing specialist care, monitoring and treatment, often within hours of them arriving at hospital.

Ellie was nominated by a patient's wife, who wanted to recognise the difference she made during her husband's stay on the ward. She said:

"This nurse in particular was caring for my husband when he came through A&E after having a stroke. He was admitted to C4 Stroke Ward, where he was looked after by Ellie. My husband is only 38 years of age and he's never experienced being ill or being in hospital before, so he was scared and couldn't understand what was happening to him.

"She took time out to explain to him what was happening and what treatments he needed and why, even though she was busy. And with the endless questions my husband had, she took time to sit and explain everything to him, which made him feel so much more at ease.

"She was extremely knowledgeable and even did little things like changing his blood pressure cuff to a different size to make him more comfortable. She was kind and funny and honestly helped him feel more relaxed during his stay on the ward.

"Nothing was too much trouble, and she even took the time to get to know him. She made him feel less embarrassed about being so young on a stroke ward. I work for the Health Board myself and am surrounded by good nurses, and I have to say she stood out for me when I came to visit because of how good she was at her job.



- On **19 August**, the dedicated team from the Neurorehabilitation Centre at University Hospital Llandough will aim to cover the distance from North to South Wales in 8 hours to raise funds for patients living with an acquired brain

injury. From 9am to 5pm, staff, patients and supporters will be taking on the challenge to raise vital funds that help Cardiff & Vale Health Charity improve hospital environments and fund projects that go above and beyond NHS care.

Why put themselves through such a demanding challenge?

Because they are passionate about improving the lives and rehabilitation journey of the patients they support every day. The team sees first-hand the difference that charitable funding can make and is committed to providing opportunities that go beyond what NHS funding alone can deliver.

Funds raised will help support a range of therapeutic activities, including:

- Weekly music therapy sessions
- Dance and movement sessions delivered by Rubicon Dance
- Pedal Power cycling sessions
- Other rehabilitation and wellbeing activities that support recovery and independence

These valuable opportunities are only possible thanks to the generosity of our supporters. Every donation helps provide experiences that motivate, inspire and support patients as they rebuild their lives following an acquired brain injury.

Please show your support and help the team reach their fundraising goal. Together, we can make a real difference.




SPINATHON
TOGETHER, LET'S GO THE EXTRA MILE!

**WEDNESDAY
19 AUGUST 2026**

**LLANDOUGH HOSPITAL
PLAZA - GALLERY SPACE**

9:00AM - 5:00PM

Improve hospital environments

Help fund projects that go above and beyond NHS care

SCAN TO DONATE

Can't stay? You can still support us by scanning the QR code and making a donation today.

Cardiff & Vale Health Charity
Join us throughout the day as staff, patients and supporters come together for a special fundraising Spinathon.

WHY YOUR SUPPORT MATTERS

- Support patients and families
- Every donation makes a difference

▪ The Thoracic Surgery team at the University Hospital of Wales has been recognised nationally after receiving the “Best Department for Trust Doctor Support” award at the 2026 Society for Cardiothoracic Surgery (SCTS) Annual Meeting in Belfast.

The award is particularly meaningful as it is voted for directly by Trust Doctors working within cardiothoracic departments across the UK and Ireland. It recognises departments that go above and beyond to support doctors through training, mentorship and career development.

For the Cardiff Thoracic Surgery team, the recognition reflects years of work focused on creating a supportive and inclusive culture where all doctors are given equal opportunities to grow, regardless of their training pathway.

Within the NHS, Trust Doctors play a vital role in delivering patient care and supporting services, but nationally they can sometimes face fewer opportunities for structured training and career progression compared to doctors on traditional Deanery training programmes.

The Cardiff team has worked to challenge that perception by building what they describe as a “training first” culture, ensuring Trust Doctors are fully integrated into the department and supported to develop their clinical, academic and surgical skills.

The consultant team, Miss Malgorzata Kornaszewska, Mr Ainis Pirtnieks, Mr Vasileios Valtzoglou and Mr Tom Combella have focused on creating an environment where educational opportunities are based on ambition and ability rather than job title or training route.

This includes providing meaningful operating theatre exposure, regular teaching opportunities, mentorship and involvement in research projects, helping doctors build both confidence and experience within the specialty.

A major area of support has been for doctors pursuing the Portfolio Pathway (formerly CESR), an alternative route that enables experienced doctors to work towards specialist registration outside of traditional national training schemes.

For many doctors, the Portfolio Pathway can be a complex and demanding process, requiring extensive evidence of competencies, operative experience and professional development. The Cardiff Thoracic Surgery team has developed a structured approach to supporting doctors through this pathway, offering tailored mentorship, guidance on evidence collection, research opportunities and progressive clinical responsibility.

The department believes this approach not only benefits individual doctors, but also strengthens the future workforce within the NHS by helping retain talented clinicians and providing clearer routes for career progression.

Speaking about the award, members of the team said they were incredibly proud to see the department recognised by the doctors themselves, describing it as a reflection of the supportive culture that has been built within the service.

The recognition also highlights the wider importance of investing in staff development and wellbeing at a time when healthcare services across the UK continue to face significant workforce pressures.

Alongside its work in education and training, Cardiff Thoracic Surgery has continued to gain recognition nationally for innovation and patient care. The department has also recently been shortlisted in the 2026 Moondance Cancer Awards in the “Improving Patient Experience” category.

The SCTS award reinforces Cardiff’s growing reputation as a centre of excellence for thoracic surgical training and support, while highlighting the important contribution Trust Doctors make across the NHS every day.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non Delivery	Risk (RAG)
---------	--------	----------	-------------------------	------------

ID 98374 ID 85431	X2 NRIs related to death on waiting lists in Cardiac Services. NB Notified by Patient Safety Team a previous theme of historic NRIS associated with death pending	Feb 2026 Aug 2026	Immediate make safe actions completed. Improved plan drafted. Held for completion of second NRI to make sure all necessary actions included. Improvement plan now agreed with DMT and consultants, will be shared at next CB Exec. R/V (21/9/26). Actions in process of being progressed.	Amber
------------------------------	---	------------------------------	--	---------------------

NEW / CLOSED / AMENDED RISKS

CLINICAL BOARD QUALITY UPDATE REPORT

Governance Group:	Quality Committee	Date of Meeting:	29 th September
Representative at Clinical Board Governance:	PCIC Clinical Board Quality, Safety & Experience Group	Date of Meeting:	21 st July 2026

ITEMS FOR ALERT

Issue / Risk	Actions Taken	Group Responsible
Risk ID: Primary, Community & Intermediate Care/2026-27/02 HMP Cardiff Healthcare Service Capacity and Sustainability RR 20 There is a risk that safe, sustainable and continuous primary healthcare provision at HMP Cardiff cannot be maintained following notice given by the Clinical Director and the GP practice to terminate the current Service Level Agreement. Without a timely and viable replacement service model, this may result in reduced clinical leadership and GP capacity, disruption to continuity of care, delays in assessment, diagnosis and treatment, unmet physical and mental health needs, and regulatory non-compliance. In addition, limited or delayed access to secondary and acute mental health services may compromise the timely assessment and management of individuals with complex mental health needs, increasing the risk of clinical deterioration, self-harm, suicide, safeguarding concerns, emergency hospital admissions and avoidable harm within a highly vulnerable custodial population. National Reportable Incidents and near-miss incidents reported at HMP Cardiff during the last month, predominantly relating to mental health provision, are being investigated through the standard Patient Safety Learning review process. Emerging themes are being reviewed to identify contributory factors, inform service improvements and strengthen patient safety arrangements. These findings will also inform ongoing workforce, service and mental health provision reviews.	Following notice of termination of the current SLA for healthcare provision at HMP Cardiff, the risk has been formally assessed and escalated through Executive governance arrangements. The key risks relate to the sustainability of primary and mental health services, continuity of care, clinical leadership, and timely access to healthcare for a vulnerable custodial population. Executive oversight is in place, alongside engagement with the current provider, collaboration with Mental Health Services, and contingency planning to maintain service continuity. Work is underway to identify sustainable future service, workforce, governance and contractual arrangements. An Interim Senior Nurse for Mental Health in HMP has been appointed, with a confirmed start date of 21 September. Patient Safety Learning Reviews are underway for recent National Reportable Incidents and near-miss events at HMP	PCIC & Mental Health Clinical Board

	Cardiff. Early findings indicate recurring themes relating to mental health assessment, escalation pathways, continuity of care and access to specialist support. Joint letter, from PCIC and Mental Health, to all staff within HMP reinforcing expectations around governance and escalation of concerns. Learning is being used to inform service improvement actions, workforce planning and the ongoing review of healthcare and mental health provision within the prison. Further recommendations will be incorporated into governance and quality improvement plans as reviews are concluded.	
Risk ID: Integrated Community Care Services (ICCS)/2026-27/03 District Nursing Workforce Capacity Deficit Resulting from Registered Nurse Vacancies RR 20 There is a risk that District Nursing cannot deliver timely, preventative community care due to 22 WTE registered nurse vacancies and sickness absence, resulting in delayed care, increased deterioration, avoidable hospital admission and patient harm.	Daily call prioritisation and cross-team staff redeployment continue to mitigate operational risks and maintain patient safety. Monitoring of key quality indicators is in place. Recruitment has been strengthened through the student streamlining programme, with approval secured from the Executive Director of Nursing and Director of Strategic Nursing to increase Phase 2 student streamliner numbers, which will in due course support workforce resilience and service sustainability. A live advert is now in place for internal recruitment to Community Nurse posts.	PCIC CB & UHB/Corporate Nursing for Nurse Recruitment Strategy
Risk ID: Primary, Community & Intermediate Care/2026-27/03 Risk of delayed and incomplete communication between primary and secondary care following patient discharge (DALs)	PCIC is represented on the UHB Discharge Advice Letter (DAL) Improvement Group,	DAL Group

RR 15

Datix reporting continues to identify concerns relating to discharge documentation and prescribing quality. Of the 67 incidents reported in the first six months of 2026, 80% related to discharge prescription errors, including medication omissions and incorrect prescribing. The impact of delayed or incomplete DALs has also been discussed through NRI governance arrangements. These issues present ongoing risks to medication safety, continuity of care and patient outcomes, and are being monitored through patient safety and quality governance processes.

chaired by the Associate Medical Director for Patient Safety. The group is overseeing actions to improve the timeliness, quality and accuracy of discharge information and prescribing, with learning from Datix reports, NRIs and primary care feedback informing ongoing improvement work across the Health Board. Work to improve discharge letters within Haematology is planned to be presented at spread and scale in October. From 1 September, the draft functionality on the ePMA DAL is no longer be available; discharges left in draft have previously been a barrier for nursing teams to complete and send the DAL at the point of discharge. This change provides an opportunity to strengthen timely nurse checking and completion of DALs prior to discharge.

ITEMS TO ADVISE

Issue / Risk	Actions Taken	Group Responsible
The PPO report following a death after release from HMP Cardiff has highlighted concerns regarding compliance with national guidance requiring a healthcare review prior to release. Current arrangements prioritise individuals with complex health and social care needs, creating a gap between recommended and available provision. The findings, alongside recommendations from the HMP Cardiff Health Needs Assessment, reinforce the need for additional workforce capacity to strengthen pre-release healthcare planning, improve adherence to national standards, support harm reduction, and mitigate risks to this vulnerable population. (Links to Risk ID: Primary, Community & Intermediate Care/2026-27/02 HMP Cardiff Healthcare Service Capacity and Sustainability	Workforce review in HMP and review of opportunities for workforce reshaping Cross Clinical Board working and collaboration around Mental Health Provision Establishment/Funding review	PCIC Clinical Board

RR 20		
Changes to the Human Medicines Regulations now mean that Healthcare Support Workers can no longer administer vaccinations (except COVID-19) or undertake consent, significantly reducing workforce capacity and flexibility in current immunisation team workforce model with need to revert to a predominantly Registered Nursing workforce model. (Links to Risk ID: Primary Comm & Intermediate Care/2019-2001 PCIC Workforce) RR 16	A workforce review is underway to identify opportunities for workforce redesign and optimise skill mix. Targeted recruitment support for existing Band 5 Registered Nurse vacancies is being implemented to improve staffing resilience, support safe service delivery and strengthen workforce sustainability. Further recruitment through phase 2 student streamlining has progressed to reshape workforce resulting from changes to the regulations.	PCIC Clinical Board
Primary, Community & Intermediate Care/2026-27/04 Complex Care Placement Failure (Patient ..) RR 20 There is a significant risk to the Health Board's ability to discharge its statutory responsibilities as Commissioner of Care for an individual following the breakdown of a highly complex community placement. The placement has served notice to terminate the current placement due to the intensity of care required, staff burnout, and ongoing safeguarding and clinical concerns.	Executive oversight is in place, with a multi-agency approach being coordinated to explore all available options, mitigate immediate risks and identify a safe and sustainable long-term solution. The situation remains high risk and requires ongoing executive monitoring and support.	PCIC Clinical Board &
DOSH/2025-2604 Loss of automated results management RR 20 Ongoing absence of automated results management in the Department of Sexual Health following the liquidation of Millcare EPR in 2025. Agreement secured to integrate LIMS2 with Lillie Healthcare as a long-term solution, but UHB are reliant on DHCW to prioritise and deliver a replacement system interface.	Ongoing engagement with UHB Digital and Digital Health and Care Wales (DHCW) is in place to establish a timeline for resolution and implementation of required actions. Progress is being monitored through established governance arrangements to minimise operational impact and support risk mitigation.	CAV Digital & Health Intelligence & PCIC CB

ITEMS FOR ASSURANCE		
Issue / Risk	Actions Taken	Group Responsible
Rapid Assessments tools completed for		
Audit plans; Integrated Discharge Service – Audit of UHB Discharge Procedure	Work with AMAT team and digital team to automate data entry	Primary Care Quality & Safety
Follow up Mental Capacity Act audit within PCIC as part of MCA audit action plan	Work with Consultant Nurse for Older Vulnerable adults	PCIC QSE
Ongoing use of CIVICA scheduling and PARIS (Digital patient record) to work up capacity and demand in District Nursing	Scheduling and demand Dashboard development and daily use of CIVICA to prioritise the circa 1100 calls a day undertaken by DN's	Integrated Community Care Business Unit & PCIC
Primary & Community Wound care review is ongoing. A revised Local Supplementary Service to GP practices is being progressed and will support clearer service boundaries, safer patient transitions, and improved operational planning. However, the quality assurance focus should remain on monitoring demand transfer, District Nursing capacity, pathway compliance, patient access, and any unintended consequences following implementation.	Revised LSS being issued through Primary Care Team with phased transition to implementation to manage demand on District Nursing	PCIC Wound Steering group
2026/27 Flu vaccination	Winter campaign has commenced to protect staff, patients and services. There are walk-in clinics with dates and locations across CAVUHB.	Health Protection and Immunisation Business Unit and PCIC CB with PHW support

RECENT LEARNING OPPORTUNITY		
Source:	Improvement Story - Implementing a new Falls Strategy in Community Hospitals	Reference (if applicable):
What happened / what was the problem?		
Prior to June 2024 patients who had a fall in community hospitals were regularly being transferred to UHW / UHL for post falls checks and treatment.		
What was learned and how was this shared?		
- Unnecessary conveyance to ED when there is no obvious injury or acute medical concern. - Risk-averse decision-making, particularly out of hours. - Long ambulance turnaround times transporting patients who could potentially remain in their current setting. - ED overcrowding caused by patients requiring assessment only rather than treatment. - Patient distress and discomfort from lengthy transfers and waits. - Increased risk of delirium and deconditioning in older adults. - Reduced ambulance availability for higher-acuity emergencies. - Increased healthcare costs associated with avoidable hospital attendance. - Difficulty returning patients to community settings after assessment despite no intervention being required.		

- Regular Datix / emails about inappropriate transfers / poor relationship with Emergency Unit colleagues.

What action has been taken or planned? What was the impact of this?

- **Intervention:** A six-month programme introduced six falls action cards, standardised post-fall documentation, scenario-based staff training, Consultant Connect clinical advice and new lifting equipment
- **Clinical pathway:** Staff assess consciousness, injury and head-trauma risk; escalate major concerns; manage minor injuries locally where safe; and complete observations, documentation and follow-up actions.
- **Implementation:** Collaboration and responsive, site-specific training worked well. Challenges included building staff confidence, Consultant Connect reliability and reaching 80% training compliance.
- **Benefits:** Faster evidence-based assessment, fewer unnecessary transfers, improved patient experience, reduced hospital-related harm and better integration across services.
- **Continuous improvement:** Recorded calls exposed process gaps and informed an **SBAR handover prompt**, strengthening communication and governance.

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

Patient stories used in PCIC forums

Use of AAA reporting template within Business Units to escalate to Clinical Board by exception

Weekly pressure damage scrutiny panels in place with focused work with Local Authorities to hold scrutiny panels to review incidents of Pressure damage in Care homes

Proactive monitoring of Section 5 and Safeguarding referrals

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non Delivery	Risk (RAG)
104362	NRI - Overdue	23 rd June 2026	DON has signed off, pending final closure.	
108678	NRI - Overdue	14 th July 2026	Factual accuracy checks in progress	

NEW / CLOSED / AMENDED RISKS

PCIC SMT has completed an AMaT Risk Register deep dive to review moderate and high risks, confirm risk ratings, and agree appropriate treat, tolerate or escalate actions, strengthening risk oversight and management.

Now progressing risk register deep dives with Business Units

CLINICAL BOARD QUALITY UPDATE REPORT

Governance Group:	CD&T QSE Sub-Committee	Date of Meeting:	21 st September 2026
Representative at Clinical Board Governance:	Director of Nursing/Multi-Professional Teams	Date of Meeting:	14.9.2026

ITEMS FOR ALERT

Issue / Risk	Actions Taken	Group Responsible
Water ingress into emergency department CT scanner, leading to 3 days downtime, causing delays to patients in ED transferring to main CT department and cancellations of outpatient activity booked into main CT scanner	Worked with estates and engineer to get CT back on line, demonstrates impact only having one CT for emergency department has on performance. Outpatient activity displaced to accommodate emergency patient in main CT scanner	QSE sub- committee
Lift in LSW used to gain access to physiotherapy outpatients on 1 st floor has been out of use for 6 months. The alternate route for patients is much longer and require outpatients to walk through inpatient areas. Concerns from team as Winter approaches risk of patients falling walking further to gain access or if IPC concerns restrict access through in patient area. Staff where possible identify patients with mobility issues prior to appointments and re-direct to CRI	Issue raised with estates, lift parts not easily available, possible mitigations being worked up. Monthly meetings to report on progress in place with all stakeholders. May need to review whether service can continue if mitigations aren't forthcoming. Need a decision regarding feasibility and timescales for either internal stair lift or external temporary lift options or department may need to find an alternative location	QSE sub committee
Radiology electronic results notification remains a current risk. Recent Datix feedback describes delayed identification of a reported study that was visible in PACS but not available through downstream clinical systems, with harm not yet known pending clinical review. This aligns with ongoing QSE discussion that intermittent report transmission issues continue despite a deployed fix and stable operations have not yet been signed off. Risk that images are not available in WCP for referrers to view which may cause delays to patients treatments/ diagnosis	Issue remains under active investigation through Radiology/Phillips via RISP programme board. Dependence on manual mitigations	Radiology / RISP Project Board / QSE Sub-Committee
LIMS remains a high-risk transition with unresolved reporting and interoperability concerns. Unreliable postal reporting, loss of electronic reporting to England, potential impact on income and reputation, and dependency on linked external go-live timetables. A fix has been identified with associated costs	Risks remain escalated through LIMS programme governance and DHCW. No timescales for when fix can be implemented	LIMS Project Board / Laboratory Medicine / QSE Sub-Committee

ITEMS TO ADVISE

Issue / Risk	Actions Taken	Group Responsible
--------------	---------------	-------------------

HTA regulatory update requires declaration from the designated individual to review incident records from 1 st April 2015 to 30 th June 2026 and confirm whether all HTARI's have been reported to the HTA, any previously unreported incidents must be subsequently reported through the portal. Review to be completed by 18 th September	Review completed, 142 incidents recorded on Datix 16 were reported as HTARI's and identified 1 that may have been reported but wasn't. This has been reported to HTA via portal and related to ventilation failure reported, pre-dates mortuary refurbishment. No harm or impact to service delivery resulted- near miss	HTA compliance group.
4 open NRI's within CD&T CB, all within time. 3 are in radiology with 2 relating to a delay in imaging due to capacity/ demand mismatch and one a reporting error. The 4 th reportable incident is with dietetics relating to rapid weight loss and possible missed opportunities in medicine, surgery and community dietetics	IO's identified and working through investigations. One due to close this month, closure meeting held and with EDON for sign off. Demand/ capacity issues within radiology (backlog in diagnostics on risk register) are known and department working through improvement plans to meet the WG target of 8 week wait for diagnostics.	QSE sub-committee
Speech and Language Therapy workforce resilience is an emerging risk. Identified workforce gaps affecting inpatient SLT capacity,	Mitigations worked through, staff deployed, support from CRT and vacancies in process.	Therapies / QSE Sub-Committee

ITEMS FOR ASSURANCE		
Issue / Risk	Actions Taken	Group Responsible
Ockendan recommendations in relation to mortuary and foetal pathology services	Recommendations reviewed and changes have begun to be implemented to align the FPU suite to mortuary practices in regard to audit etc. Access to FPU has also been restricted to only FPU staff. Can provide an update alongside Fuller recommendations if required	HTA compliance group
HTARI reported by mortuary service in relation to fridge failure during the heatwave, upper limit exceeded for 3-4 hours.	Not taken forward as reportable incident by HTA as temperature monitoring triggered as it should	HTA compliance group, CD&T QSE sub committee
Datix queues, remain a focus for CB.	Met with directorates and incident managers, focus on oldest open incidents and those graded moderate	Directorate performance review and QSE sub-committee

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

MSK physiotherapy team have collected patient experience feedback



OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non Delivery	Risk (RAG)
47616	A defined pathway for follow up and surveillance of patients with ERCP stents should be developed with Radiology and referring specialities	January 2025	Work has progressed but due to number of stakeholders involved agreement with final version of SOP has taken time. Further meeting planned with stakeholders to move forward	Amber

NEW / CLOSED / AMENDED RISKS

Current risk movement and emerging risks noted

- Planned maintenance risk is being reworked to describe the future potential impact of inadequate maintenance rather than an existing operational backlog.

CLINICAL BOARD QUALITY UPDATE REPORT

Governance Group:	C&W CB QS&PE meeting	Date of Meeting:	No August Mtg
Representative at Clinical Board Governance:	CB, O&G, ACH, CYPFHS	Date of Meeting:	

ITEMS FOR ALERT

Issue / Risk	Actions Taken	Group Responsible
transfer of budget for CHC –LD from PCIC to C&W Risk is that the care packages are not being regularly reviewed and monitored by Swansea Bay UHB due to capacity which may result in unnecessary financial impact for CAVUHB and potential clinical risk to patients.	£39M transferred over and increased our control over spend by £5.3M. Line of sight to 1.5M saving if POC reviewed. QIA completed. SBAR to support additional resource for review of existing packages to go to VBSG for approval. Exec to Exec conversations with Swansea Bay UHB ongoing regarding responsibility and resource.	C&W LD team are reviewing the top 40 cases. Need workforce to undertake the reviews and reduced packages
Richmond support services (domiciliary support) arm of Richmond Nursing Agency disbanded. On afternoon of Tuesday 26th May, informed that the whole of Richmond agency had gone into liquidation with immediate effect.	Currently 2 Adult LD packages of care supported by Richmond. 1 was under the Richmond support services (domiciliary support) arm for non term-time domiciliary support when person is on leave from collage. Care for immediate period was to be undertaken via continuing Richmond Nursing Agency and its governance and assurance frameworks, however 12 hours into the arrangement alternative action was needed. Staff from Richmond were moved into a new agency called Beelong, which we believe is unregistered at present and uncertain governance framework, however following discussion with Executive Director of Nursing and Corporate Governance it was felt this was the only option for the immediate period. Work ongoing to identify alternative framework and approved providers of care.	CYPFHS Directorate Management Team - Continued support of use of Beelong Agency for the immediate period. Alternative approved governance agency options scoped and in final stages of move across to new on framework CIW approved provider with switch over expected in July/August. CIW have been informed of the interim arrangement.
Adult Learning Disability (CHC) Governance Arrangements	Concerns regarding off-framework placements. Inability to obtain assurance around safety, quality and value of care provided due to main service responsibility sitting with Swansea Bay UHB. RIF Funding slippage money to be used this financial year on procurement of Tricordent support, with expectation of a governance and oversight framework delivery.	Director of Nursing & CYPFHS Directorate working through list of adult LD packages of care and seeking reviews. Continuing to link with JCC where placements are via CCAPs framework. Will ensure part of the UHB's new complex care board.

RIF Funding Uncertainty	Concerns regarding impact of major service sustainability risk if funding ceases, with potential loss of services such as Goleudy & ENFYS. Staff uncertainty also leading to workforce retention concerns.	Clinical Board Senior Management Team working with RPB, and services. RPB have coordinated an impact assessment doc and we have done a risk assessment. Awaiting WG decision on future funding
Potential loss of BSGE Accreditation (Endometriosis Service). This will result in increased waiting times for women with DIE (deep infiltrating Endometriosis) neighbouring accredited services are unable to absorb these women so likely referrals to England will be required. The service will cease without accreditation The harm to women is prolonged experiences of debilitating pain which is life limiting	Accreditation ends in December 2026. Options discussed with Executive Team at Executive Performance Review and Turnaround Meetings. Gynaecology Service Summit taking place to work on mitigation actions and to further explore regional joint working opportunities.	Executive Team to take to next UHB Board for decision on continuing without accreditation C&W Clinical Board Senior Team/Gynae Senior Team & Execs

ITEMS TO ADVISE		
Issue / Risk	Actions Taken	Group responsible
Outcome of current BR+ assessment received. Service is currently not compliant with Band 7 workforce.	Consideration of assessment and risk being reviewed.	O&G DMT/Clinical Board
Ongoing HV JD review	Move via UNITE to move HV's in C&V to a collective Grievance stage	Executive Director for People & Culture overseeing an all-Wales draft HV JD suite has been out to CYPFHS for comment but no further update received to date.
Plan for ND delivery plan has gone to UHB Finance Group for ratification	Approval from COO w/c 31/8 to progress with hybrid outsourcing & agency psych capacity plan to reduce 3 year waits to end of year.	Directorate to enact.
Requests from outside care providers for specific training in relation to long term care of tracheostomies and other related devices.	Production of a governance document which will be shared with the Corporate Governance Team and ECOD for advice. SBAR has been written and linking with ECOD to finalise before going to NMB for approval	CYPFHS Directorate Management Team - SOP being finalised and will need ratification Director of Nursing / ECOD

Potential of 3 children from Gaza to be sent to CHFV in October for treatment. Details unknown at this time.	Awaiting further information	CHFV DMT/Clinical Board
Ministry of Justice undertaking inspections of both Cardiff and the Vale Youth Justice Services in September	Health is required to meet with inspectors and share information on Youth Justice management board participation and service delivery to C&YP involved in criminal justice process	Director of Nursing / General Manager CYPFHS

ITEMS FOR ASSURANCE		
Issue / Risk	Actions Taken	Group responsible
Datix Management	Targeted approach being undertaken across all Directorates to ensure that all incidents are being reviewed in a timely manner and that none are over a year old.	Clinical Board & Directorate Management Teams – weekly CB Datix review meeting established
ePMA Rollout and DALs	Successful rollout across Gynaecology and Children's Hospital. Incomplete DALs issues being managed at ward level. Prep and comms regarding implementation of the requirement for DALs to be fully completed and signed off prior to discharge underway.	ePMA team producing comms plan and supporting materials which will be shared.

RECENT LEARNING OPPORTUNITY			
Source:	NRI – Retained Product	Reference (if applicable):	IN105653
What happened / what was the problem?			
On 29/12/2025 a patient presented to Emergency Gynaecology Assessment Unit (EGAU) with PV discharge and advised that she had passed a foreign object vaginally. Upon investigation, it appeared that the foreign body was the distal part of a thread lever used during her previous gynaecological surgery in University Hospital of Llandough on 19/11/2025.			
What was learned and how was this shared?			
The main learning is that systems for checking, tracking and escalating risks around disposable devices used during invasive procedures need to be strengthened, so staff can identify problems earlier and reduce the risk of retained foreign objects.			
The review was shared widely across the Gynaecology Directorate and Clinical Board and also highlighted across Peri-Operative Directorate to aid learning and reflection.			
What action has been taken or planned? What was the impact of this?			
• Refresher training/ education for scrub practitioners and theatre assistants on checking the integrity of all items used during surgery, and what to do if problems are noted. • Operating surgeon to check the integrity of all instruments after use • Reminder to all surgeons to audibly inform scrub practitioner when device is being used internally.			
The incident has been highlighted to the manufacturer and also a yellow card report submitted.			
Discussions taken place to review and clarify which single use items should be incorporated into checking and reconciliation processes and consider policy amendments where necessary.			

As this item was deemed to be a “one-off” request it was ordered as a “non-stock special order”. This is the appropriate method of ordering items that are not intended to be regular stock. It has only ever been requested once, and no further requests to replace have been made.

These actions should strengthen theatre safety processes by improving checks and reconciliation of items used internally, including disposable devices. They will support clearer communication between surgeons and scrub practitioners, promote earlier identification of issues, and share learning across Peri-Operative and Gynaecology teams. Overall, the actions aim to reduce the risk of a similar retained foreign object incident and provide assurance that learning has been acted on.

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

Continue to hold regular Babies, Children and Young People’s strategic plan implementation sessions with a workshop being held 08/09/2026 with wider partners.

Paediatric Call for Concern initiative has been strengthened with new Children & Young People appropriate communication.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non Delivery	Risk (RAG)
	X3 Overdue NRI’s:			
IN103121 (DD)	PSLR required further review following comments received from Patient Safety Team. PSLR now completed Closure meeting arranged for 22/09/2026 for Clinical Board Sign off of PSLR.	June 2026	IO currently on sick leave. Comments being reviewed for necessary action in IO absence.	
IN103706 (JT)	Final Improvement Plan agreed	June 2026	Improvement Plan now submitted to Executive Team for closure of NRI	
IN108161 (EF)	PSLR required further review. PSLR now completed. Closure meeting arranged for 22/09/2026 for Clinical Board Sign off of PSLR.	August 2026	Further questions raised as part of patient debrief that needed to be explored prior to finalisation of PSLR.	

NEW / CLOSED / AMENDED RISKS

Two high scoring risk (20) reduced. One reduced to 12 through discussion with AMH and further mitigations implemented, one reduced to 15 following review of mitigating actions.

15 September 2026

Governance Group:	Surgery Clinical Board QSE	Date of Meeting:	15 September 2026
Representative at Clinical Board Governance:	Director of Nursing	Date of Meeting:	

ITEMS FOR ALERT

Issue / Risk	Actions Taken	Group Responsible
Theatre heat, humidity and estates resilience	Perioperative areas reported leaks and continuing theatre humidity issues, including at UHL. An interim SOP is being developed to support safe operational decision-making while longer-term estates solutions are progressed. External support has been requested to identify a sustainable solution, with approval sought from senior leaders. Assurance can be provided through interim controls and escalation routes; however, the residual risk remains until a sustainable estates solution is agreed and implemented. The interim SOP that is being developed reduces the risk of harm and cancellations to patients in the meantime. Cancellations of patients occurred during the heatwave in July where the HB declared BCI and numbers were reported to Welsh Government	Perioperative Care; Estates; Health and Safety; Clinical Board SMT
Incomplete discharge letters and communication to GPs	The Clinical Board reported 291 surgical discharge letters that had not been completed and sent to GPs, with the highest volumes in SSSU and SACU, creating a patient-safety risk because the outstanding clinical information has not been reviewed and communicated. A revised process introduced on 31 August prevents take-home medication from being issued until the discharge letter is complete. Directorates have been asked to review consultant-level lists, close completed drafts as quick wins, and track clearance over the next six weeks with support from our Clinical Lead for Quality and Safety. Assurance is provided by the new prospective control and active recovery work; however, the backlog remains an Alert until all 291 letters are reviewed, completed and sent, with any impact on take-home medicines or patient flow monitored and escalated.	All Surgical Directorates; SSSU and SACU leadership; Clinical teams; Clinical Board SMT
NHFD data Quarter 1 2026	The National Hip Fracture Database (NHFD) has written to University Health Board advising that its casemix-adjusted 30-day mortality rate for patients with hip fracture was above the 95% (2SD) control limit for the year up to and including the most recent quarter. This is a statistical alert rather than a formal outlier designation. The NHFD specifically highlights that, given the number of participating hospitals nationally, some organisations will exceed the 2SD threshold due to normal statistical variation and many return within expected limits in subsequent quarters.	Trauma and Orthopaedic Directorate and Clinical Board Triumvirate



The Surgery Clinical Board acknowledges receipt of the NHFD mortality flagging letter and notes that the organisation has exceeded the 95% (2SD) control limit for casemix-adjusted 30-day mortality. This represents a statistical alert rather than a formal outlier designation.

A multidisciplinary review has already been initiated to validate data quality, examine mortality cases and assess compliance with key hip fracture standards. Existing governance arrangements will oversee the review, with findings used to inform a targeted improvement plan where required.

At present, no evidence has been identified to suggest a systemic patient-safety concern. However, a thorough assessment is being undertaken to confirm that ASA grading is being captured correctly and that patients who experienced inpatient falls resulting in mortality are being reviewed. This will allow the Clinical Board to gain assurance regarding the quality of care delivered and to identify any opportunities for further improvement.

ITEMS TO ADVISE

Issue / Risk	Actions Taken	Group Responsible
UHL escalation and treat-and-transfer procedure	A combined procedure has been developed for critical-care transfers and patients needing higher-level medical or surgical input. Further assurance will be sought through wider engagement with Resuscitation, Patient at Risk, Critical Care, Medical and Surgical teams before Health Board governance review and corporate circulation. UHB QSE is asked to note the developing control and the need for system-wide ownership before final approval.	Perioperative Care; Resuscitation Service; Corporate Governance
Complex airway guideline and specialist pathway	A guideline and referral pathway were developed following a patient safety learning review. A weekly specialist complex-airway POAC session began in July. The pathway includes structured assessment, MDT planning, documentation, imaging and consideration of 3D reconstruction or modelling. The guideline will be formatted and logged as a local procedure and publicised across surgical specialties.	Anaesthetics; Perioperative Assessment; Surgical specialties
Pressure-damage investigation requirements	The Health Board is moving to the All-Wales approach for investigation of grade 2 pressure damage and deep-tissue injury. Further communication is expected. Teams will need to distinguish damage arising or deteriorating during Cardiff and Vale care from damage attributable to another Health Board.	Patient Safety Team; Nursing leads; Clinical areas
Patient safety alerts and medicines shortages	Four Health Board alerts were highlighted: inappropriate use of the ePMA duration field; shortage of adrenaline 1 mg in 1 ml pre-filled syringes, expected until at least January 2027; reduced-quality imaging from Philips View Motion default settings; and a ChloraPrep applicator recall. Directorates must evidence dissemination and action through local Q&S or audit meetings.	Directorate Q&S groups; Pharmacy; Radiology; Clinical teams

ITEMS FOR ASSURANCE

Issue / Risk	Actions Taken	Group Responsible
Significant incident management	Seven NRIs were open. Three were overdue and expected to close during the month. The Clinical Board continued to report comparatively low numbers of open NRIs, supported by the Patient Safety Team. Managers can seek direct support to close outstanding Datix records. Assurance can be taken that incident-management oversight is in place, with further assurance to be confirmed through closure of the three overdue cases and continued monitoring of Datix timeliness.	Patient Safety Team; Incident managers; Directorate teams
Clinical Board risk register	Following focused review, only four risks remained scored 20 or above, with remaining review work concentrated in General Surgery. Directorates are expected to review risks routinely through DMTs. A protected weekly Clinical Board SMT slot is in place to review emerging risks before Executive discussion. This provides assurance that high-scoring and emerging risks are visible, governed and escalated through established Clinical Board routes.	Clinical Board SMT; Directorate Management Teams; Governance/Risk Team
Five Steps to Safer Surgery, WHO checklist and theatre white boards	The Clinical Board can give assurance that the Five Steps to Safer Surgery remain subject to active Clinical Board oversight. A recent internal audit which was carried out in January 2026 concluded reasonable assurance, confirming that WHO safety checks are being completed, with improvement required in consistency of signature recording within theatre care plans. Local controls include continued reinforcement of zero tolerance for non-compliance with the WHO safety checklist, use of theatre white boards to support visible list planning, team briefing, role clarity and real-time safety communication, and ongoing review through perioperative governance routes. Further assurance will be strengthened through continued observational audit, documentation review and feedback to theatre teams where variation is identified. Update - September 2026 In August 2026, a total of 11 audits were completed across Main Theatre Upper UHW, Children's Hospital for Wales Theatres UHW, Main Theatre Lower UHW and UHL Theatre Suite as part of the Perioperative Care Tendable audit schedule. Compliance was strong, with team brief, sign in, time out and sign out processes documented as completed across all audited cases. The audit provides positive assurance that core WHO Surgical Safety Checklist processes are embedded and being consistently applied across the directorate. Additional assurance is provided by the formal sign-off of the new theatre white-board design and revised WHO Surgical Safety Checklist, supporting a standardised approach to team briefing, sign-in, time-out and sign-out across theatre areas. Both will be launched on World Patient Safety Day, 16	Perioperative Care; Theatre teams; Anaesthetics; Surgical specialties; Clinical Board QSE

	September, aligning the local rollout with national patient-safety priorities and increasing visibility of the work across perioperative teams. Educational videos are being filmed with support from Media Resources to provide consistent training material, reinforce expected practice and support staff engagement. Ongoing assurance will be obtained through local implementation monitoring, feedback from theatre teams, targeted review of checklist documentation, observation of white-board use during theatre lists and escalation through perioperative governance where variation or non-compliance is identified. The Surgery Clinical Board will close the WHO Collaborative and re-establish the work as a Perioperative Care Safety Collaborative, with a broader focus on safety systems and alignment with NatSSIPs 2.	
HIW improvement activity in SSSU	All actions from the SSSU HIW report were reported closed. Culture work has progressed with staff feedback and support from People and Culture.	SSSU leadership; Patient Safety Team; People and Culture
Specialist learning and pathway improvement	The complex-airway pathway, weekly specialist clinic and access to advanced imaging/model review demonstrate implementation of learning following a serious clinical event. The work has been approved within Anaesthetics and will be formalised and shared more widely. This provides positive assurance that learning has been translated into a sustainable pathway with defined referral, assessment, MDT planning, and documentation arrangements.	Anaesthetics; Perioperative Care; Clinical Board QSE

NOT APPLICABLE

Source:	Pharmacy audit	Reference (if applicable):	
What happened			
Pharmacy identified medicines stored in bedside medicine lockers that were damaged or could not be locked. This created a risk of insecure access to medicines.			
What was learned and how was this shared			
Previous audit work had focused mainly on treatment rooms and had not included bedside lockers. The discussion reinforced that medication-security assurance must cover the full storage pathway, and that staff should escalate damaged equipment promptly.			
What action has been taken or is planned, and what impact has this had?			
All clinical areas are to inspect bedside medicine lockers, submit maintenance requests or replace defective units, and report assurance to the next SCB QSE meeting. PPDNs will undertake ad hoc ward audits. Any barriers to replacement arising from financial controls are to be escalated immediately as a patient-safety matter.			

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

- The South Wales Auditory Implant Service achieved the 52-week RTT target in 2025/2026 after adult waits had reached 114 weeks and paediatric waits 94 weeks; patient stories demonstrated substantial benefits for communication, independence, and family life.
- The General Surgery SDEC abscess pathway reduced the proportion of patients requiring theatre from 23% to 14% after introducing Pentrox-supported local anaesthetic procedures; seven patients were treated successfully without repeat admission or repeat procedure.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non-Delivery	Risk (RAG)
ID 82094 ID 91732 ID 82952	Development of a Health Board SOP for referrals and follow up, including defined documentation standards, tracking, escalation timeframes, and role clarity. Transition to digital clinic outcome recording, eliminating paper COFs and improving auditability of follow-up decisions.	No confirmed completion date	Digital support and pathway redesign are underway as part of the Health Board's Lost to Follow Up programme to reduce harm from patients lost to follow-up. Progress is ongoing but, due to resource and capacity limits, a completion date cannot yet be confirmed. Interim assurance is provided through continued programme oversight, recognition of the residual risk and prioritisation of safer documentation, tracking, escalation timeframes and role clarity. The action remains Amber because delivery is dependent on digital capacity and pathway redesign; continued scrutiny is required until a confirmed implementation date and measurable milestones are agreed.	Amber

Top 5 risks

Ageing estates impacting patient care	Clinical areas may not receive urgent estates work quickly enough, affecting safety/functionality and care quality.	1) Agree and publish a prioritised programme of urgent works for high-risk areas 2) Continue joint estates/IPC/clinical inspections and update risk registers 3) Progress capital bids/rolling refurbishment programme (e.g., theatres) 4) Put contingency plans in place to minimise disruption to services.
No resident doctor cover for spinal service (OOH)	Spinal patients may face delayed assessment/treatment out of hours; unsafe and unsustainable reliance on trauma registrar and consultants.	1) Develop a business case for a resident SHO rota 2) Review and redesign OOH cover model to ensure protected spinal cover 3) Implement clear response-time standards and escalation pathways 4) Improve data collection/reporting on delays and outcomes.
No spinal navigation technology	Lack of image guided navigation increases risk of instrumentation	1) Finalise and progress capital business case 2) Seek capital

	error and serious harm; limits service capability and creates reputational/financial exposure.	approval to procure navigation 3) Plan implementation to embed navigation into routine practice once approved.
Harm to patients on long waiting lists	Patients waiting extended periods may deteriorate without timely review; risk of harm, emergency presentations, and regulatory scrutiny.	1) Implement a standardised harm review at defined waiting time thresholds 2) Strengthen risk stratification/prioritisation models 3) Increase frequency of waiting list validation and review 4) Escalate capacity gaps through recovery/productivity planning with clear specialty accountability.
Incomplete Discharge Advice Letters (DAL) on ePMA	Discharge information not reliably sent to WCP/GPs; continuity and medication safety risks; potential complaints/scrutiny.	1) Require services to clear backlogs identified in reports 2) Mandate routine use of ePMA dashboards at ward/specialty level 3) Introduce regular governance reporting and escalation for overdue DALs 4) Clarify roles/responsibilities and provide targeted education/support for prescribers. 5) New process will be switched on 1/9/2026 that does not allow EPMA to produce a TTO without a DAL.

CLINICAL BOARD QUALITY UPDATE REPORT

Governance Group:	Discussed in MHCB Formal Meeting	Date of Meeting:	11 September 2026
Representative at Clinical Board Governance:	Mental Health Clinical Board	Date of Meeting:	Next QSE meeting: 16 October 2026

SUMMARY OF KEY ASSURANCE POINTS

- The 11 September Mental Health Clinical Board (MHCB) Quality, Safety and Experience (QSE) meeting identified several matters requiring continued senior oversight. The Datix position shows a clear improvement in open incidents and review timeliness, with the headline position summarised in the table below. Key residual risks remain in severe and above graded incidents, nationally reportable incidents (NRIs) and Duty of Candour compliance.

Datix assurance measure	September 2025 position	August 2026 position	Current position	Movement
Total open incidents	1,386	1,219	883	From September 2025: -503 (-36.3%) From August 2026: -336 (-27.6%)
Severe and above graded incidents	Not available	136 severe and above incidents	38 severe and above graded incidents	From August 2026: -98 (-72.1%)
Nationally reportable incidents (NRIs)	Not available	10	9	From August 2026: -1 (-10%)

- Assurance was received that risks are being actively managed through strengthened Alert, Advise, Assure (AAA) reporting, incident oversight, improvement plans in development, reinforced Mental Health Act controls, Infection Prevention and Control audit follow-up, Eating Disorders improvement delivery, and structured monitoring of out-of-area improvement and prison in-reach stabilisation.
- Recent learning has been acted on following Healthcare Inspectorate Wales (HIW) feedback for Meadow and Daffodil Wards, including immediate oxygen-cylinder safety learning, competency evidence requirements and Safeguarding Group C / Level 3 recovery actions. The Mental Capacity Act (MCA) audit confirmed completion of MCA proformas, but identified a need to improve assessment quality, decision-specific recording, person-centred rationale and documentation of legal safeguards.
- Good practice was highlighted in Recovery College prison-course delivery, particularly the 5 Steps to Wellbeing course, lived-experience engagement and prospectus launch, co-produced Care and Treatment Planning resources accepted for All-Wales development, and positive student-placement feedback.
- Key residual risks remain in workforce resilience, statutory compliance, patient flow, environmental safety, medicines management, neurodevelopmental waiting times and pathway gaps for people with Complex Emotional Needs. No risks are proposed for closure at this stage; continued review is required to ensure risk scores, controls and escalation routes remain current.
- Before the next QSE meeting on 16 October 2026, focused follow-up is required on incident closure, Duty of Candour data completeness, prison in-reach governance, Mental Health Act assurance, Mental Health Services for Older People (MHSOP) flow, Complex Emotional Needs pathway delivery, Newlands mobilisation, Community Mental Health Team (CMHT) treatment-room risk, Infection Prevention and Control actions, Eating Disorders improvement actions, Audit

Management and Tracking (AMAT) actions and overdue significant-incident actions.

ITEMS FOR ALERT

Issue / Risk	Actions taken	Group responsible
Datix remains an alert due to the residual risk associated with 883 open incidents, including 38 incidents graded severe and above and 9 nationally reportable incidents (NRIs). The overall open incident position has reduced from 1,386 in September 2025 and 1,219 in August 2026 to 883 currently, and severe and above graded incidents have reduced from 136 in August 2026 to 38 currently. Continued senior oversight is required to support incident closure, timely review, learning, data quality and completion of the historic case review by December 2026. Duty of Candour performance also remains an area of concern, with 17% of acknowledgements completed on time, 29% completed late and 13 records with missing data.	Continued oversight of Datix and nationally reportable incidents remains in place, with a focus on closure, factual accuracy, learning and timely review. A targeted recovery plan will review all historic cases and ensure appropriate action is taken by the end of December 2026. The next phase of the Datix recovery plan will focus specifically on the timeliness of incident review, alongside continued monitoring of incident closure and data quality. A Patient Safety Team representative will be asked to provide practical Duty of Candour guidance at a future QSE meeting to support improved compliance, data completeness and assurance. A generic Duty of Candour initial acknowledgement letter will now be used with immediate effect for incidents identified as moderate harm or above, and this will be reviewed through the weekly tracker meeting chaired by the DON/DDON.	Interim Director of Nursing Interim Deputy Director of Nursing
Prison mental health in-reach services remain an alert due to current service pressures, workforce fragility and governance gaps, with potential impact on delivery of safe, consistent and sustainable mental health provision within the prison setting.	The Mental Health In-Reach Team is managed by Primary Care and Intermediate Care (PCIC), but improvement and assurance are a shared key responsibility across PCIC and the Mental Health Clinical Board (MHCB). A joint improvement plan and Project Initiation Document (PID) are	PCIC and MHCB

	being developed to stabilise the service, clarify governance, confirm priorities and track actions. Board-to-Board oversight, fortnightly PCIC and MHCB meetings, and monthly operational meetings will support shared ownership, timely escalation and strengthened connection with wider mental health services.	
Phoenix Community House is included as an alert following concerns raised at QSE about community activity directed towards residents. This presents a safeguarding, resident safety and community interface risk, requiring continued oversight and assurance.	Safeguarding and police liaison have taken place, a fire-risk assessment is planned, and Welsh Government involvement is being explored. An update is required at the next QSE meeting to confirm progress, any further safeguarding actions, risk controls and learning.	MHCB Adult Mental Health Directorate
Patient flow within Mental Health Services for Older People is a significant risk. Only one discharge liaison nurse is currently in post, and delayed transfers of care have increased from 19 in April to 27, impacting length of stay, bed availability, discharge coordination and patient outcomes.	Vacancy-specific discussion will continue outside the meeting, with continued senior oversight of discharge coordination, delayed transfers of care and patient flow. The discharge liaison role has been reviewed by the Directorate and agreed to be taken forward as a priority for consideration at the MHCB Scrutiny meeting on Wednesday 23 September.	Lead Nurse MHSOP Directorate Manager MHSOP
There is a statutory compliance risk relating to Mental Health Act processes, specifically C02/C03 consent-to-treatment assurance, invalid Section 5(2) use on non-mental health wards, and reduced Mental Health Act Office capacity. A recent C02/C03 incident exposed a governance control gap, although no patient harm or further expired certificates were identified. Section	Controls are being strengthened through C02/C03 ward-round checks, confirmation that Responsible Clinicians and Medical Secretaries receive and review daily Mental Health Act (MHA) reports, spot-check audits, and confirmation of patient notification and Duty of Candour requirements. Section 5(2) incidents will be analysed and	MHCB Adult Mental Health Directorate Management Team Mental Health Act Office Responsible Clinicians

5(2) errors and reliance on manual checks increase the risk of invalid detention, missed statutory deadlines and limited Health Board assurance.	escalated through Quality and Safety and medical governance. A Mental Health Act Office risk assessment and Situation, Background, Assessment, Recommendation (SBAR) will set out workforce, statutory compliance and support requirements, including administrative support and circulation of the Section 5(2) guide.	
--	---	--

ITEMS TO ADVISE

Issue / Risk	Actions taken	Group responsible
Neurodevelopmental services remain a high-risk area due to increasing ADHD and autism demand, long waiting times and disputed diagnostic outcomes. In August 2025 there were 2,031 patients awaiting an assessment, with 876 of those patients waiting over 52 weeks. In August 2026 this number had increased to 3,406, with 1,726 patients waiting over 52 weeks. Complaint and concern themes continue to focus on ADHD assessments and clinical reasoning, creating risks to patient experience, consistency of decision-making and assurance on clinical pathways. Primary Mental Health Support Services also remain under pressure, with sickness reported at 9%, affecting capacity and resilience.	Demand, capacity, waiting lists, complaints and triage activity remain under directorate and Clinical Board oversight. Concerns colleagues are supporting development of an ADHD Frequently Asked Questions resource for GP services. The Clinical Board is also exploring alternative providers who may be able to screen and manage ADHD referrals, with an initial meeting with one potential provider having taken place in August 2026. Primary Mental Health Services will receive targeted support from People Services for sickness management.	Adult Mental Health Directorate Psychology and Psychological Therapies MHCB
There is a risk of inconsistent access and repeated crisis presentation for people with Complex Emotional Needs, particularly those with mild to moderate self-harm who may not	Scoping has been completed across disciplines, service areas and lived experience. A further session with psychology is planned for October 2026, as the	Interim Deputy Director of Nursing

meet CMHT thresholds. Current provision remains variable across the pathway, creating gaps in preventative support and escalation options.	psychological interventions element of the pathway requires further work. A pilot for a new way of supporting frequent attenders with Complex Emotional Needs (CEN) will start in October in conjunction with the Frequent Attenders Lead for the University Health Board (UHB). The project plan has been developed into a RAID format, with a risk, action, issue and decision log. To strengthen governance and ensure barriers are overcome, the CEN pathway will feed into the urgent pathway project within the Mental Health transformation programme.	
A delay in obtaining the required Home Office Licence for the Newlands development presents an operational risk, with potential impact on mobilisation, controlled drug management and pressure on existing pharmacy and addictions services.	The Home Office Controlled Drugs Licence application has been submitted and expedited, but approval is unlikely before mobilisation. Contingency arrangements are therefore being progressed with Pharmacy, Addictions, CAU, Commissioning, Adult Mental Health and governance colleagues. A temporary CAVUHB hosting model has been developed, supported by a Service Level Agreement (SLA), honorary contracts, controlled drug Standard Operating Procedures (SOPs) and CDAO/CDLIN oversight. This provides lawful controlled drug governance while clinical responsibility remains with Dr PA/G4S and commissioning accountability remains with OPCC/HMPPS. Further work is	Adult Mental Health Directorate Management Team Pharmacy and Addictions Services MHCB Quality and Safety governance arrangements

	focused on Barry Hospital treatment-room access, controlled drug storage, Buvidal clinic provision and transfer of affected activity from Barry Police Station following HIW concerns.	
High temperatures in CMHT treatment rooms present a seasonal medicines management risk. Sustained temperatures above 25°C, and periods above 30°C, may affect safe medicines storage and the reliability of PocHi blood analysis results, particularly for clozapine monitoring. Oil-based depot injections may also be affected by prolonged heat exposure. The risk is likely to return during future summer periods, particularly from early May to mid-September 2027.	Guidance has been issued and the high-temperature CMHT treatment room risk will be added to the MHCB risk register by Kate Southern and Chris Frayne. A business continuity plan for adverse heat will be developed to maintain safe treatment-room operation during sustained high temperatures. Refrigeration is not an appropriate mitigation for oil-based depot injections. Air conditioning remains the preferred sustainable control to support safe medicines storage, reliable PocHi testing and a suitable treatment-room environment. Directorates are considering priority areas for UHB-sourced air-conditioning units; however, CMHTs have not been identified as a priority area at this stage. Further work will therefore be undertaken before the next summer period to identify an appropriate solution. Pharmacy and governance routes will continue to monitor the risk.	Pharmacy Services Medicines Management Governance Director of Operations

ITEMS FOR ASSURANCE

Issue / Risk	Actions taken	Group responsible
The AAA reporting framework is providing a clearer Clinical Board-level method for escalating risks, monitoring progress and providing assurance to the Executive Team	Directorates are expected to present issues as Alert, Advise or Assure, identify escalation routes, describe actions and provide evidence of impact. AAA reports	MHCB Quality and Safety governance arrangements Directorate Management Teams

and Board Committees. This reduces duplication across directorate updates and supports a more consistent view of key quality, safety, experience, workforce and operational issues.	are now discussed monthly at QSE alongside review of the relevant risk assessment, ensuring that risks, mitigations and assurance are considered together.	
The Eating Disorders Service improvement programme continues to show progress, with 7 actions rated green, 6 rated amber and no actions rated red. The main remaining risks relate to workforce stability, the time required to confirm the start date for the independent expert, integration between tier 2 and tier 3 provision, governance and partnership improvements, and the longer-term transformation programme. Staff have also raised concerns that integration of the two teams may be contributing to longer waiting lists for tier 2 patients, and that some staff do not yet feel sufficiently trained or experienced to deliver interventions for patients with more complex presentations.	Since the last update, the service has continued to embed weekly multidisciplinary team (MDT) caseload reviews, risk discussions and escalation processes. Medical cover across Cardiff and Vale and Cwm Taf Morgannwg has been secured. Work on the merged MDT model has commenced, with project management support established to coordinate initial transformation activity. Recruitment to Occupational Therapy, dietetics and Clinical Psychology posts has been successful. Cultural compass work has started, and development of the joint Standard Operating Procedure has continued.	Director of Psychology and Psychological Therapies
Infection Prevention and Control audit findings provide assurance on progress, but ongoing environmental risks require active management. Alder Ward achieved a 92% environmental audit score and 100% Bare Below the Elbows compliance, with 18 previously identified issues resolved. Remaining risks include a ripped sofa that cannot be cleaned to IPC standards, seven repeat actions relating mainly to storage,	Actions are focused on removing immediate IPC risks and strengthening routine environmental oversight. The ripped sofa has been escalated for urgent removal or replacement, with removal from Alder Ward being arranged next week and the Waste Department contacted by the ward manager. The seven repeat actions will remain on the local action plan and be tracked through Tendable and directorate	Infection Prevention and Control Team Interim Director of Nursing Interim Deputy Director of Nursing Directorate Management Teams

environmental cleanliness and equipment in clinical areas, and the need for continued oversight of ward environments to prevent recurrence.	quality governance until completed. Monthly walkarounds will be undertaken by the Director of Nursing with Facilities and Directorate leads to identify environmental issues early, agree ownership and ensure actions are completed.	
---	---	--

RECENT LEARNING OPPORTUNITY

Source:	HIW visit to Meadow and Daffodil Wards	Reference (if applicable):	HIW immediate assurance feedback; CD Integral Valve Oxygen Cylinder video; Safeguarding Children and Adults Group C / Level 3 training update.
----------------	--	-----------------------------------	--

What happened / what was the problem?

Recent Healthcare Inspectorate Wales (HIW) feedback for Meadow and Daffodil identified gaps in safety-critical training and staff awareness, particularly safe use of portable oxygen cylinders and Safeguarding Level 3 compliance. HIW highlighted that staff were not consistently aware of Patient Safety Notice / Regulation 28 learning relating to portable oxygen cylinders and that staff who may use them require competency-based training. The visit also reinforced the need to recover Safeguarding Group C / Level 3 compliance across the relevant workforce.

What was learned and how was this shared?

Learning was shared immediately following the HIW feedback. The CD Integral Valve Oxygen Cylinder Operation video was cascaded for relevant staff to view, with local records retained as evidence of completion. Additional safeguarding learning was shared following confirmation that Agenda for Change Band 6 qualified staff and above, and F1 medics and above, are required to complete Group C / Level 3 Safeguarding Children and Adults training every three years.

What action has been taken or planned? What was the impact of this?

Oxygen cylinder learning has been cascaded to ward and senior nursing teams, with staff asked to complete the video and local completion records retained. This provides immediate mitigation while competency-based training and wider assurance arrangements are strengthened.

Safeguarding Level 3 recovery is tracked through the HIW improvement plan and weekly oversight arrangements. Staff are being booked onto available training sessions, attendance is reviewed, and non-attendance or exceptions are escalated. One member of staff on Meadow Ward remains outside Level 3 training compliance and is booked to attend in September 2026. One member of staff on Daffodil Ward is awaiting confirmation of a training date, to be completed by December 2026.

The impact is improved awareness of oxygen cylinder safety requirements, with 100% training compliance for Daffodil Ward and 76.9% compliance for Meadow Ward, clearer accountability for evidencing

completion, and strengthened assurance that safeguarding competence requirements are understood and being acted upon across the relevant workforce. A recovery plan to achieve 100% compliance across all inpatient areas has been requested by the Senior Nurse for Quality, Safety and Patient Experience by December 2026.

MCA Audit – what happened

As part of the MCA improvement plan, the Clinical Board identified the need for additional reviews outside the annual MCA team audit. The Lead Nurses, Deputy Director of Nursing and UHB MCA Lead completed an audit in August 2026 across Adult Mental Health Services (AMHS) and Mental Health Services for Older People (MHSOP), reviewing 10 assessments completed between November 2025 and April 2026. While all audited records contained a completed MCA assessment proforma, the quality and specificity of assessments varied. The most significant concern was that only 50% of assessments clearly defined the specific decision being assessed. This area is covered in MCA training, which currently stands at 73.85%, with a target of 85% compliance by December 2026 and a re-audit planned for early 2027. Some assessments also lacked sufficient person-specific rationale, evidence of practicable support offered to maximise capacity, and clear documentation of legal safeguards such as Independent Mental Capacity Advocates (IMCA) and Lasting Power of Attorney (LPA).

MCA Audit – learning

The audit identified high completion of MCA documentation but highlighted the need to improve documentation quality. Key learning focused on clearly identifying the specific decision, evidencing practicable steps to support decision-making, individualising assessments and recording legal safeguards. Findings and learning have been shared through the MCA annual audit report and at the September 2026 Quality, Safety and Experience meeting.

MCA Audit – action and impact

The PARIS team has been asked to amend the electronic MCA proforma to include prompts relating to legal safeguards. A targeted re-audit is planned within six months, with a wider range of disciplines undertaking the audit to measure improvement and provide service-level feedback. MCA training compliance will be monitored through performance meetings and the Safeguarding Steering Group, with a target of 85% compliance by December 2026. The expected impact is improved decision-specific recording, stronger person-centred rationale, clearer evidence of practicable support to maximise capacity, improved documentation of legal safeguards, and strengthened assurance on MCA practice across Adult Mental Health Services and Mental Health Services for Older People.

HIGHLIGHTS OF GOOD PRACTICE TO SHARE

Good practice and improvement were noted across several areas: Recovery College courses in the prison are progressing well with positive engagement and feedback; the Lived Experience celebration event and new prospectus launch were positively received; the co-produced Care and Treatment Planning programme, companion guide and training are close to launch and have been accepted for development as an All-Wales training resource; and positive student-placement feedback was received.

In relation to the 5 Steps to Wellbeing course run in the prison with the Recovery College since September 2025, the programme was initially delivered on the B1 therapeutic landing and has evolved following improvements in prison support arrangements. It is now delivered within the library, widening access to prisoners across the establishment. The current model provides two 1.5-hour sessions in a calmer and more suitable learning environment. Since implementation, the course has been delivered approximately every two months, with an average attendance of six participants per cohort. Feedback has been consistently positive, indicating high levels of engagement and perceived benefit. Participants reported attending to improve their mental health, manage anxiety, PTSD and ADHD symptoms, gain coping strategies, learn from others, and support their personal recovery and wellbeing.

Feedback highlights the value of the course as a safe, interactive space where individuals can discuss mental health openly, learn from peers and develop practical wellbeing skills. Participants particularly valued the group discussions, supportive atmosphere, opportunity to hear others' experiences and the practical content delivered. Comments described the programme as an "eye opener on human behaviour" and praised the openness, non-judgemental environment and quality of facilitation. A key strength was the involvement of a peer support worker who fostered participation. Feedback has requested longer sessions, which is being considered for future delivery.

OVERDUE ACTIONS FROM SIGNIFICANT INCIDENTS

Case No	Action	Due Date	Reason for Non-Delivery	Risk (RAG)
	Protocol for harmful substances	Medicines Safety Group: 25 September 2026 Quality Committee date TBC.	The protocol was ratified through the Mental Health Clinical Board (MHCB) Controlled Documents Oversight Group (CDOG) in August 2026, subject to minor amendments. It now requires presentation to the University Health Board (UHB) Medicines Group before final ratification through the Quality Committee. The request has been sent to the Medicines Safety Group Chair and is due to be presented on Friday 25 September 2026. If supported, it will then progress to the Quality Committee.	Amber
	Complex Emotional Needs Pathway	Originally due September 2026; revised completion	Further work is required following the lived experience workshop, as described above in Items to Advise. The completion date was extended to September 2026; however, the	Red

		December 2026.	pathway cannot be finalised until key stakeholders in psychology meet in October 2026 to complete the psychological interventions section. To strengthen governance of the pathway development, the work will now sit under the urgent pathway project within the Mental Health Clinical Board transformation programme.	
--	--	----------------	--	--

NEW / CLOSED / AMENDED RISKS

No risks scoring 15 or above have been identified since the previous report. The Mental Health In-Reach Team does not sit under the Mental Health Clinical Board (MHCB) risk register, as the team is managed by Primary Care and Intermediate Care (PCIC). However, this is noted as a joint priority for both PCIC and MHCB, with improvement and assurance being a shared key responsibility across both Clinical Boards. Current service pressures, workforce fragility and governance gaps may affect the delivery of safe, consistent and sustainable prison mental health provision. A Mental Health In-Reach improvement plan and Project Initiation Document (PID) are being developed to support transformation and stabilisation of the service, clarify governance, confirm priorities and track delivery of agreed actions. Board-to-Board oversight, fortnightly PCIC and MHCB meetings, and monthly meetings to strengthen connection with mental health services will provide additional governance, support and assurance.

Out of Area bed use remains a significant financial, operational and patient experience risk, although the improvement approach is now more structured through weekly review, repatriation planning, executive escalation and the wider transformation programme. SHED staffing challenges have reduced from 25 to 15, reflecting progress through the improvement plan, but residual workforce, specialist clinical cover and sustainability risks remain. St Barruc's Ward isolation has reduced from 20 to 15; however, the underlying estates, isolation and emergency response risks remain unresolved pending options appraisal and relocation planning.

Security at Hafan y Coed Main Reception remains under active review. Meetings have taken place with the C&V Head of Security, and different options are now being explored to increase security presence and strengthen the current control environment. A further meeting is scheduled with the private provider for CAVIS to identify whether there are opportunities to support additional security capacity, improve responsiveness and reduce residual risk for patients, staff and visitors.

No risks are proposed for closure at this stage. The focus is on ensuring existing risks are accurately scored, linked to current controls, and amended where the risk position has changed. High-scoring risks will continue to be reviewed through directorate governance, QSE, Clinical Board and executive escalation routes, with particular focus on patient safety, statutory compliance, workforce resilience, operational delivery, financial impact and patient and staff experience.

Report Title:	Update report from Clinical Safety Group	Agenda Item No:	3.3		
Meeting:	Quality Committee	Public	X	Meeting Date:	29 th September
		Private			
Lead Executive Title:	Executive Nurse Director				
Report Author/s Title:	Assistant Director of Quality and Patient Safety				
Report Focus Summary – AAA Framework: The AAA framework reflects the overall position of the matter being reported . Select one category only and complete the relevant box with a brief summary . A useful guide can be found here: NHS Triple A Guide					
ALERT (Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).					
ADVISE (Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)					
There remain a number of organisational constraints that have continued oversight. The most prominent include the ongoing review of outsourced endoscopy activity, where a large number of historical cases continue to undergo clinical review oh delayed histology reporting with formal harm assessment in place. No patient harm has been identified to date. Pressures within diabetes services associated with implementation of national hybrid closed-loop insulin pump requirements are affecting waiting times and service capacity. Other areas of concern include delays within DEXA reporting, dermatology waiting times, Mental Health out-of-area placements, increasing demand for ADHD assessments, workforce pressures within district nursing services and uncertainty regarding the future provision of primary care services within HMP Cardiff. Risks relating to implementation of major digital systems within Radiology and Pathology also remain, with delays and technical issues presenting potential service resilience concerns. Organisational learning from incidents, inspections and mortality reviews continues to identify recurring themes relating to communication, documentation, recognition and escalation of deterioration, training compliance and adherence to established policies. Clinical Boards should maintain focused oversight of areas where sustained operational and workforce pressures have the potential to impact patient safety and quality of care. Particular attention should be given to completion of the outsourced endoscopy review, delivery of sustainable workforce solutions for diabetes, mental health and community services, and strengthening governance arrangements around training compliance and documentation standards. Continued emphasis should be placed on improving communication, handover processes and compliance with DNACPR requirements, as these themes recur consistently across National Reportable Incidents, Healthcare Inspectorate Wales findings and Medical Examiner feedback. The organisation should also continue to support implementation of major digital programmes and ensure that learning from incidents, mortality reviews and external scrutiny is translated into measurable service improvements across all Clinical Boards.					

There is evidence of robust improvement activity and strengthened governance arrangements being implemented across the Health Board. Clinical Boards reported positive progress in managing infection prevention risks.

ASSURE (details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)

Surgery Clinical Board reported positive progress in improving theatre governance through the Theatres Together programme, de-escalating cardiology services following successful improvement actions and embedding the AAA framework within Mental Health governance processes.

The Learning from Mortality Group has strengthened mortality governance, developed improved mortality intelligence and supported implementation of the Medical Examiner Service, contributing to improved organisational oversight and learning.

The Pressure Damage Collaborative has enhanced reporting, scrutiny and prevention arrangements, while organisational learning processes continue to promote Duty of Candour compliance and the dissemination of learning from incidents, inspections and mortality reviews.

A review of all clinical Safety groups that report into the Clinical Safety Group is underway as part of wider work to agree the agenda and membership of the group.

Board/Committee Response Required (please select only one)

Assurance	X	Approval		Information/Noting	x
------------------	---	-----------------	--	---------------------------	---

Recommendations

The Committee is asked to:

- Note the information provided to the Clinical Safety Group and the ongoing actions as well as the development of the agenda to support improved engagement and representation.

Governance Route (please list all other Committee/Groups this report has been to)

Where it's been:

When it went:

What decision was made:

Main Report

Background & Current Situation

The Clinical Safety Group met on 12th August 2026. Presentations included Clinical Board Assurance reports and annual assurance reports from the Learning from Mortality Group and The Pressure Damage Collaborative Group

The minutes of the meeting are included in Appendix 1.

Appendices:

- Appendix Minutes August Clinical Safety group

Strategic Alignment – Shaping Our Future Wellbeing:

 Putting People First	 Providing Outstanding Quality	X
 Delivering in the Right Places	 Acting for the Future	

Impact Assessment
Risk: Yes
<i>Clinical Boards raised risks associated with delays in care provision and IP&C</i>
Safety: Yes
Details relating to Nationally Reportable Patient Safety incidents were reported through the group
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No - https://www.gov.wales/socio-economic-duty-guidance
Equality & Health: No
Decarbonisation: No
Welsh Language: Yes
<i>Findings from HIW inspections include Welsh Language and Active Offer</i>

Wednesday 12th August 2026

14:30-16:00

Attendance list		
Name	Role	Initials
Jason Roberts	Executive Nurse Director	JR
Alex Scott	Assistant Director of Quality and Patient Safety	AS
Suzie Cheesman	Deputy Head of Safety, Quality and Organisational Learning	SC
Cath Evans	Deputy Head of Patient Safety	CE
Natasha Goswell	Deputy Executive Nurse Director	NG
Jane Murphy	Director of Nursing Medicine Clinical Board	JM
Clare Wade	Director of Nursing Surgery Clinical Board	CW
Cath Twamley	Director of Nursing Specialist Clinical Board	CT
Helen Luton	Director of Nursing and Multi-Professional Teams CD&T Clinical Board	HL
Tara Robinson	Director of Nursing Mental Health Clinical Board	TR
Barbara Davies	Director of Nursing PCIC Clinical Board	BD
Emma Davies	Deputy Director of Nursing Medicine Clinical Board	ED
Jane Morris	Senior Nurse Patient at Risk Team and RADAR representative	JM
Nick Denny	Learning from Mortality Facilitator	ND
Marilyn Rees	Hospital Acquired Thrombosis Group Representative	MR
Seetal Sall	Point of Care Manager	SS
Claire Quinn	Director of Psychology and Psychological Therapies Mental Health Clinical Board	CQ

Item	Detail
	Welcome and actions
1.1	JS welcomed members to the meeting. Apologies were received and noted for Abi Harris, Mike Stephens, Ed Chapman, Rim Al-Samsam and Thomas Holmes. The Group reviewed progress against outstanding actions.

	Work continues to review the effectiveness and future role of the Clinical Safety Group, with discussions scheduled regarding future arrangements and alignment with organisational governance requirements. In relation to governance of hazardous materials, members were advised that concerns regarding the delivery and handling of radioactive materials had been escalated through Health and Safety governance arrangements. Further clarification is required regarding whether oversight should sit within Health and Safety or Ionising Radiation governance structures and the action will remain open pending resolution. Terms of Reference for the Advanced Therapies Research Oversight Committee remain awaited from Research and Development and will be circulated when available. The Group reviewed progress regarding inpatient hip fracture data validation. Members noted that Cardiff and Vale remain an outlier in relation to inpatient hip fracture reporting, however no increase in reported falls has been identified. Concerns remain regarding the accuracy of some National Hip Fracture Database records, with initial review identifying patients admitted with fractures who may have been incorrectly classified as inpatient fractures. It was agreed that further review of individual cases should continue through the Falls Delivery Group and the action would transfer to falls governance arrangements. Members received an update regarding development of revised falls governance arrangements. Work is underway to establish a dedicated inpatient falls group feeding into the strategic Falls Delivery Group, with revised governance structures and Terms of Reference to be brought back to a future meeting. A review of dementia governance arrangements remains ongoing following discussions at the previous Clinical Safety Group meeting. Significant progress was reported in relation to the Ward Manager Quality Information Hub. A SharePoint-based quality resource portal and accompanying quality handbook are being developed, providing ward leaders with access to quality, safety and improvement resources. The resource will be presented to the Senior Nurse Forum in September. Progress was also noted regarding development of an organisational HIW Inspection Readiness Tool. A draft single assurance tool has been developed by consolidating multiple existing HIW assurance resources. Wider engagement and feedback will now be undertaken prior to implementation. Clinical Safety Group Action Log.xlsx
	Alert Advise and Assurance Clinical Board Reports
2.1	<u>Medicine Clinical Board</u> Alert: The Group was alerted to a number of significant risks. The review of a very significant number of outsourced endoscopy records continues following concerns relating to delayed results, surveillance, follow-up and onward

2.2	management. Whilst no patient harm has been identified to date, the review remains ongoing and additional capacity has been secured to complete the work within six weeks. Members were advised of significant pressures within the Hybrid Closed Loop insulin pump service, where demand substantially exceeds available capacity. There are currently 382 patients awaiting treatment, with demand increasing by approximately 30 patients per month against service capacity of 12 starts per month. Without additional capacity, waiting times are projected to increase from 32 months to approximately 50 months. Further concerns were raised regarding increasing DEXA scan reporting backlogs. Approximately 800 GP-referred scans are awaiting interpretation, with service capacity significantly below demand and backlog growth continuing. Members noted the associated risks relating to delayed diagnosis and treatment of osteoporosis. The Clinical Board highlighted risks associated with prolonged hospital stays, delayed discharges and ongoing service pressures within Dermatology, where delayed follow-up appointments have contributed to a number of National Reportable Incidents. Advise: The Clinical Board advised that strengthened standard operating procedures and workload allocation arrangements had been implemented within Endoscopy. A business case for a sustainable insulin pump service has been submitted and a wider review of diabetes services is underway. Work continues with PCIC, Clinical Diagnostics and Therapeutics, Medical Physics and Primary Care colleagues to redesign the DEXA pathway. Dermatology services are progressing pathway redesign work including teledermatology models, risk-based follow-up arrangements and strengthened post-operative tracking processes. Assure: The Group was assured that all identified risks are subject to executive oversight, are included on the Clinical Board risk register and continue to be actively monitored through established governance arrangements. <u>Surgery Clinical Board</u> Alert: The Group received assurance regarding actions implemented in response to environmental concerns previously identified across surgical wards. Increased environmental audits have been introduced and ward-based environmental walkabouts involving Estates, Infection Prevention and Control and ward teams are now established. Members noted that these arrangements had contributed to timely management of a recent <i>Clostridioides difficile</i> outbreak. The Group was also alerted to a recent Never Event involving implantation of a wrong-sided femoral implant. Immediate actions included communications to
-----	--

2.3	staff, reminder posters relating to implant checking procedures and direct engagement with theatre teams while the investigation remains ongoing. Advise: Members received details of a newly developed peri-operative ketone monitoring pathway for patients prescribed SGLT2 inhibitors. Concerns were raised regarding the absence of a central repository for clinical pathways following closure of HealthPathways. Updates were also provided regarding implementation of a paediatric thromboprophylaxis risk assessment process, hypoglycaemia improvement work and progress through the Theatres Together programme. Learning from the inquest into the death of Mr Donald Goff was shared, with the Coroner recognising improvements already implemented by the organisation and therefore not issuing a Regulation 28 report. Members also noted progress within Same Day Emergency Care where a new abscess pathway had enabled seven patients to be treated without requiring theatre intervention or anaesthesia. Assure: The Group was assured that robust governance arrangements remain in place for the Theatres Together programme and that improvements continue across culture, infection prevention and theatre efficiency workstreams. Learning arising from communication failures affecting patients awaiting treatment was also shared, with actions implemented to improve communication regarding waiting times and follow-up arrangements. Action A10: Natasha Goswell to progress discussions regarding a central repository and governance arrangements for clinical pathways, protocols and guidance. <u>Specialist Services Clinical Board</u> Alert: The Group was alerted to an Acinetobacter outbreak on T4. Ongoing outbreak management arrangements remain in place, including enhanced screening, hand hygiene measures and Infection Prevention and Control oversight. Waiting time pressures within the Electronic Assistive Device Service have also resulted in Level 1 escalation through JCC processes. Advise: Updates were received regarding escalation of Cardiac Surgery through JCC processes due to concerns regarding clinical audit data quality, case ascertainment and completeness. Members also noted de-escalation of Cardiology following completion of actions associated with prior HIW recommendations. The Clinical Board reported ongoing work relating to implantation of an expired pacing device, recurrent heparin-related incidents, changes to Deprivation of Liberty Safeguards and the management of incomplete discharge summaries (DALs). Significant improvement work within Haematology has led to the development of a DALs pathway.
-----	---

2.4	Members were also advised of forthcoming media coverage relating to the Infected Blood Inquiry and engagement with Communications teams in preparation. Assure: The Group was assured that all escalation, audit and safety concerns remain subject to active governance oversight and improvement plans. Action A11: Specialist Services Clinical Board to share learning relating to the DALs improvement programme across the organisation. <u>Mental Health Clinical Board</u> Alert: The Group was advised that out-of-area placements remain the most significant risk within the Clinical Board, although progress continues against reduction trajectories. Security concerns at Hafan y Coed were also highlighted following several challenging incidents involving visitors, including occasions where visitors were found carrying knives. Workforce pressures remain significant across services. Advise: Significant progress has been made in reducing overdue Datix investigations, with only 45 remaining open. Updates were provided regarding implementation of the HIW Improvement Plan for Meadow and Daffodil wards, where mandatory training gaps had been identified and improvement plans implemented. Members heard that ADHD waiting lists continue to increase and that work is underway to explore both external and internal capacity solutions. Development of the Complex Emotional Needs pathway remains ongoing, with a first draft expected for stakeholder engagement in September. Assure: The Group was assured that AAA reporting has now been embedded within Mental Health governance arrangements and continues to strengthen oversight of quality and safety risks.
2.5	<u>Clinical Diagnostics and Therapeutics</u> Alert: The Group was alerted to continuing risks associated with implementation of the new Radiology Information System, including issues relating to report transfers, web-based imaging quality and patient record integration. Delays affecting the Laboratory Information Management System programme were also highlighted, with potential implications for diagnostic services, service resilience and future sustainability. Advise: Members received updates regarding retrospective review requirements issued by the Human Tissue Authority, four open National Reportable Incidents, internal audit of Clinical Board governance arrangements, mortuary refrigeration failure during the recent heatwave and learning arising from wrong blood in tube incidents.

2.6	The Group also noted local review of recommendations arising from the Ockenden Report in relation to paediatric pathology services. Assure: The Group was assured that all programme, governance and incident management issues remained under active oversight, with mitigation plans and improvement actions in place. <u>PCIC Clinical Board</u> Alert: The Group was alerted to significant risks associated with healthcare provision within HMP Cardiff, including withdrawal of the current GP contract and associated Clinical Director provision from March 2027. Three National Reportable Incidents and one near miss relating to prison healthcare are currently under investigation. District nursing workforce pressures remain significant, with large numbers of patient visits reallocated daily to manage demand. Ongoing delays in DALS completion continue to impact continuity of care and have contributed to incidents and near misses within community services. Advise: Updates were provided regarding implementation of recommendations arising from the Prison and Probation Ombudsman report, workforce modelling, changes to Human Medicines Regulations affecting vaccination delivery, complex care placements and automated results management risks associated with System One functionality. Members also received updates regarding wound care service review work and implementation of the MenB vaccination programme. Assure: The Group was assured that identified risks continue to be monitored through Clinical Board and SMT governance arrangements, supported by a recent comprehensive risk register review. AAA reporting and the use of patient stories have also been embedded within PCIC quality governance processes.
	Clinical safety Group Annual Assurance
3.1	Learning From Mortality Group The Group received the annual assurance report from the Learning from Mortality Group and noted the significant progress made during 2025/26 in strengthening mortality governance arrangements. Members heard that improvements had been made to mortality review processes, death certification arrangements, mortality intelligence and organisational reporting. The implementation of the Medical Examiner Service, development of mortality dashboards and improvements in clinical coding had contributed to a reduction in the organisation's RAMI score from 132 to 114.

3.2	The Group noted that 3,673 deaths had occurred across the Health Board during the reporting period and that Medical Examiner referrals continued to provide valuable insight into themes relating to safe care, patient-centred care and timely care. Communication remained the most frequently identified theme through Medical Examiner referrals and mortality review activity. Members discussed variation in Morbidity and Mortality review processes across Clinical Boards and noted that further work was required to standardise arrangements and improve organisational visibility of learning. The Group also noted ongoing review work regarding increased mortality observed during the June heatwave period. The Group received assurance that appropriate mortality governance arrangements remain in place and supported continued implementation of the AMaT system and standardised mortality review processes across Clinical Boards. <u>CSG Safety Group report - Learning from Mortality.pptx</u> Pressure Damage Collaborative Members received the annual assurance report from the Pressure Damage Collaborative. Progress was noted following relaunch of the Collaborative in November 2025, including establishment of five workstreams, development of a central quality dashboard, standardisation of scrutiny arrangements and development of education programmes. Despite these developments, pressure damage rates remain largely unchanged. Members discussed the need to strengthen prevention strategies, improve data quality and implement focused reviews of grade 2 pressure damage to inform earlier intervention and reduce progression to category 3 and 4 harm. Clinical Safety Group Exception Reports None received
3.3	
	Organisational Learning
4.1	<u>NRI, Mortality and HIW</u> The Group received an update on organisational learning arising from recently closed National Reportable Incidents (NRIs), Healthcare Inspectorate Wales (HIW) activity and feedback from the Medical Examiner Service. Members noted that recurring themes identified through NRI investigations included communication and handover failures, poor documentation and record keeping, failure to recognise and escalate deteriorating patients, staffing and workload

4.2	pressures, training gaps, inconsistent application of policies and guidance, and loss of situational awareness. The Group also noted positive themes relating to evidence of Duty of Candour processes, communication with patients and families and positive bereavement care within maternity services. Learning from recent HIW inspections identified recurring concerns relating to mandatory training compliance, data quality within ESR, governance and assurance arrangements for monitoring compliance, and implementation of Patient Safety Notices. Particular attention was drawn to compliance with the requirements of PSN041 relating to training for staff using portable oxygen cylinders. Members noted the importance of accurate training compliance reporting and effective escalation processes where compliance concerns are identified. The Group also received an update from the Medical Examiner Service. During July 2026, 20.2% of deaths reviewed by the Medical Examiner Service were returned to the Health Board with feedback. Recurring themes included DNACPR documentation, communication with patients and families, delays in treatment and late notification to the Medical Examiner Service. Members noted that DNACPR documentation remains a recurring theme across secondary care, with common issues relating to missing dates and counter-signatures. Communication concerns also featured prominently within family feedback, including concerns regarding communication during the patient's final days of life The Group discussed the importance of ensuring that learning from incidents, mortality reviews and regulatory inspections is disseminated consistently across Clinical Boards and considered within existing quality and safety improvement programmes. Members agreed that further assurance should be sought regarding organisational compliance with mandatory training requirements, implementation of PSN041 and actions to improve ESR data quality. <u>HIW, Mortality and NRI update for CSG.pptx</u> Action A12: Develop proposals to strengthen dissemination of organisational learning arising from Patient Safety Learning Reviews, mortality reviews and inspections. Action A13: Seek assurance from the RADAR Group regarding recurring DNACPR documentation themes identified through Medical Examiner referrals. <u>Alert and Notices</u> Nothing to note
-----	--

	Any Other Business
5.1	Members discussed whether exception reporting remained necessary alongside implementation of AAA reporting arrangements and agreed that further discussion would be required regarding future reporting arrangements.
	Next meeting
	The next meeting will be held on 15 September 2026 via Microsoft Teams.

Report Title:	Clinical Effectiveness Committee Update		Agenda Item No:	3.4	
Meeting:	Quality Committee	Public	x	Meeting Date:	29.09.26
		Private			
Lead Executive Title:	Executive Medical Director				
Report Author/s Title:	Assistant Director of Quality and Patient Safety				
Report Focus Summary – AAA Framework: <i>The AAA framework reflects the overall position of the matter being reported. Select one category only and complete the relevant box with a brief summary. A useful guide can be found here: NHS Triple A Guide</i>					
ALERT <i>(Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).</i>					
Prolonged waiting times for pulmonary rehabilitation, respiratory diagnostics, interstitial lung disease services and access to specialist respiratory review for patients admitted with asthma and COPD have the potential to adversely affect patient outcomes through delayed diagnosis, progression of respiratory disease and missed opportunities for evidence-based interventions known to reduce exacerbations and hospital admissions.					
ADVISE <i>(Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)</i>					
Waiting list validation across respiratory medicine has resulted in 50% of long waiting patients being removed from the outpatients waiting list either through virtual reviews or diagnostic testing or the provision of specialist advice. Waits for interstitial lung disease exceed 52 weeks, but a business case has secured additional medical and speciality nursing capacity to address these long waits. redesign work within bronchiectasis and asthma services is supporting more effective multidisciplinary models of care. Improvements in community spirometry pathways have demonstrated early evidence of reduced respiratory-related emergency attendances, reduced hospital admissions and improved clinical decision-making within urgent care settings, providing assurance that investment in earlier diagnosis and integrated pathways is contributing to better outcomes for patients.					
Work continues to reduce spirometry waiting times and to ensure that these results are captured in primary care clinical systems and Welsh Clinical Portal to inform individual clinical approach to care delivery.					
Developments to paediatric asthma nursing documentation will ensure inhaler technique assessment, education and discharge advice and constantly recorded, all areas that the 2026 audit identified as requiring improvement.					
Work to strengthen the completion and implementation of the discharge bundle continues for patients admitted with exacerbations of COPD.					
Ongoing work to strengthen audit participation, improve coding and enhance identification of patients managed outside traditional inpatient pathways has resulted in improvements in case ascertainment and this work continues. The Committee further advised that service redesign,					

workforce investment and multidisciplinary models of care should continue to be progressed to address capacity constraints and improve compliance with national standards. Significant improvements had been made in the past 12 months in ensure effective data capture.

ASSURE (*details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements*)

Significant improvements have been achieved across respiratory services, audit participation and service improvement initiatives. Performance within the adult asthma audit has improved substantially over recent years, with Cardiff and Vale now achieving the national target for case ascertainment and delivering high levels of compliance in the assessment and documentation of asthma severity at admission. Progress has been demonstrated in delivering tobacco dependence interventions with UHW and UHL now in the top quartile for performance. Improvements in completion of the asthma discharge bundle and in the prescribing of inhaled cortico-steroids have been observed.

Assurance was also provided through evidence of strong performance within Chronic Obstructive Pulmonary Disease (COPD) services. Compliance with spirometry documentation, oxygen prescribing and tobacco dependency interventions remains above national averages, while the introduction of electronic prescribing has strengthened the reliability and safety of oxygen management. Performance relating to non-invasive ventilation continues to compare favourably with national standards, providing confidence that patients with acute hypercapnic respiratory failure are receiving timely evidence-based treatment.

National pulmonary rehabilitation audit results demonstrated that patients who access the service continue to achieve meaningful improvements in exercise capacity and quality of life despite increasing levels of frailty and complexity amongst the patient population. In paediatric services, re-engagement with the national asthma audit has already driven quality improvement actions, including the development of enhanced nursing documentation, structured asthma discharge documentation and strengthened specialist follow-up arrangements through the paediatric asthma nursing team. These interventions are expected to improve documentation quality, compliance with national standards and the consistency of discharge processes.

Board/Committee Response Required (please select only one)

Assurance	☒	Approval	☐	Information/Noting	☐
------------------	-------------------------------------	-----------------	--------------------------	---------------------------	--------------------------

Recommendations

The Committee should:

- **NOTE the assurance provided by the clinical performance reported in the National audits and the improvement work that is underway to address requisite improvement**

Governance Route (please list all other Committee/Groups this report has been to)

Where it's been:	
When it went:	
What decision was made:	<i>e.g. Recommended to Board for approval</i>

Main Report

Background & Current Situation

The Clinical Effectiveness Committee met on 11th September 2026 to hear presentations and assurance relating to associated improvement plans for National Respiratory Audit Programme, including oversight of Inpatient Asthma, Inpatient Chronic Obstructive Pulmonary Disease (COPD), Pulmonary Rehabilitation, Paediatric Asthma, primary Care COPD and progress against the Wales Respiratory Quality Statement.

The minutes of the meeting are included in appendix 1

Appendices:

(List any appendices that will accompany this report).

- **Minutes of Clinical Effectiveness Committee 11 the September 2026**

Strategic Alignment – Shaping Our Future Wellbeing:

 Putting People First	 Providing Outstanding Quality	
 Delivering in the Right Places	 Acting for the Future	

Impact Assessment

Risk: Yes

Waits for pulmonary rehabilitation continue to extend well beyond national limits. Continued challenges around case ascertainment continue although considerable progress has been made. Coding inaccuracies result in inefficiencies in identifying appropriate cases

Safety: Please select

Financial: No

Workforce: Yes

Cardiff and Vale UHB employ one respiratory consultant for 58 000 population compared with a Welsh average of 1: 40 000 and English average of 1: 35 000

Legal: No

Reputational: No

Socio Economic: Yes - <https://www.gov.wales/socio-economic-duty-guidance>

Respiratory disease disproportionately impact some communities more than others and therefore delays in care will lead to inequalities in outcome

Equality & Health: Yes

Respiratory disease disproportionately impact some communities more than others and therefore delays in care will lead to inequalities in outcome

Decarbonisation: No

Welsh Language: No

Minutes of Clinical Effectiveness Committee

11th September 2026

Attendance list		
Name	Role	Initials
Aled Roberts	Chair and AMD Quality and Safety	AR
Alex Scott	Assistant Director of Quality and Patient Safety	AS
Aneurin Buttress	Consultant Respiratory Physician and Clinical Director Acute Medicine	AB
Daniel Rigler	Consultant Child Health and Paediatric Asthma Audit Lead	DR
Katie Pink	Consultant Respiratory Physician and Adult Asthma Audit Lead	KP
Jane Murphy		JM
Ramsey Sabit	Consultant Respiratory Physician and COPD Audit Lead	RS
Richard Baxter	Community Director PCIC- Quality Improvement	RB
Tara Cardew	Head of Patient Safety	TC
Tom Lines	Physiotherapist and Pulmonary Rehabilitation Audit Lead	TL

	Welcome and introductions
1.1	Aled Roberts (AR) the committee Chair welcomed everyone to the Clinical Effectiveness Committee meeting with a focus of Respiratory Medicine. Apologies' were noted
2	Room to Breath – Clinical Audit 2026
2.1	KP presented the 2026 National Respiratory Audit Programme (NRAP) asthma audit relating to care provided in 2024/25, reporting a marked improvement in performance across several clinical indicators when compared with previous years. The audit demonstrated that Cardiff and Vale is now achieving the national target for case ascertainment, with just over 50% of expected asthma admissions being captured for audit review, a substantial improvement from previous years.

	• The strongest area of performance was observed in the assessment and documentation of asthma severity on admission. Compliance at both sites was exceptionally high, achieving approximately 97-98%, placing both University Hospital of Wales and University Hospital Llandough within the highest-performing quartile nationally. • Significant improvements were also seen in discharge care. Compliance with discharge bundle elements improved across all measures and Cardiff and Vale now performs within the upper national quartile for several indicators. • The most notable improvement concerned prescribing of inhaled corticosteroid-containing therapy at discharge. Historically, approximately 30% of patients had been discharged without optimal preventative asthma treatment following an exacerbation, creating a significant patient safety concern. • Current performance demonstrates a substantial improvement following implementation of updated All Wales Asthma Guidelines and widespread education across Emergency Department and Acute Medicine services. This was described as one of the most important improvements from a patient safety perspective because it is anticipated to reduce future exacerbations, readmissions and avoidable asthma-related harm. • Performance relating to tobacco dependency interventions also showed sustained improvement. Both acute hospital sites are now achieving top quartile performance for tobacco dependency documentation and referral. This improvement was attributed to improved documentation processes as well as initiatives within Acute Medicine that have actively encouraged referral to smoking cessation services. • Documentation of inhaler technique assessment, medication review and broader discharge education also improved considerably. • The national standard requires patients admitted with asthma to receive specialist respiratory review within 24 hours. Performance at both sites remains below the national average and substantially below the target of 90%. Data presented demonstrated a worsening trend over recent years, despite the introduction of respiratory retrieval services. The principal reason identified was that the majority of asthma patients are managed on acute medical wards rather than respiratory wards, limiting opportunities for specialist respiratory input. Only around one in five asthma patients admitted to University Hospital of Wales and approximately one in four patients admitted to Llandough are cared for on respiratory wards. • Performance relating to corticosteroid administration within the first hour of admission also remains below expected standards. While local performance is broadly comparable with national results and showed some signs of improvement, only around one-third of asthma admissions received steroids within the first hour, compared with an audit expectation of approximately 95%. Although this remains nationally challenging, it continues to represent an important opportunity for improvement given the clinical importance of timely steroid administration during acute exacerbations.
--	--

	Action 1: To undertake further work in partnership with the clinical audit team and Emergency department informatics and the coding team to improve identification and capture of asthma cases managed outside traditional inpatient pathways
2.2	RS presented the 2026 Inpatient COPD audit results relating to care provided in 2024/25 The audit demonstrated strong performance in diagnostic standards, oxygen prescribing and tobacco dependency assessment, but ongoing challenges in achieving timely respiratory specialist review and discharge bundle completion. The audit demonstrated high compliance with documentation of spirometry across both sites, providing assurance that patients diagnosed with COPD have objective evidence of airflow limitation and reflects the success of the respiratory clerking proforma in supporting good diagnostic practice. • Oxygen prescribing remained consistently strong and above national averages. The introduction of electronic prescribing has improved reliability and ensured oxygen is prescribed appropriately with documented target saturations. • Tobacco dependency documentation and referral have also improved steadily and now compare favourably with national performance. • Performance relating to non-invasive ventilation (NIV) was generally positive. Most patients requiring NIV for acute hypercapnic respiratory failure received treatment within expected timescales, although occasional delays continued to occur due to patient flow and access to specialist respiratory beds. Overall, this remains one of the stronger-performing clinical indicators within the audit. • The national standard is 90% of patient should receive specialist respiratory review within 24 hours of admission, however neither University Hospital of Wales nor University Hospital Llandough is currently achieving this target. Whilst performance is better at UHW due to the respiratory retrieval service, compliance remains below expected standards across both sites. • The respiratory team highlighted that many patients admitted with COPD are managed on acute medical or outlying wards rather than respiratory wards. As a result, patients often receive treatment for the acute exacerbation but do not consistently benefit from specialist respiratory review, optimisation of long-term management or assessment for interventions such as pulmonary rehabilitation. • Discharge bundle compliance remains the weakest area of performance. Although some improvement initiatives are underway, completion rates continue to fall below national expectations. This is clinically important because the discharge bundle includes interventions proven to reduce future exacerbations and readmissions, including inhaler review, smoking

	cessation support, pulmonary rehabilitation referral and follow-up arrangement. ACTION : The respiratory consultant group agreed to continue reviewing retrieval criteria and patient flow arrangements to maximise specialist input for patients most likely to benefit. Work will continue to strengthen discharge bundle implementation and improve capture of audit data.
2.3	TL presented the Pulmonary Rehabilitation Audit findings, reporting that case ascertainment and data quality has improved significantly following changes to the audit methodology. • Approximately 70% of patients completing rehabilitation achieved a clinically meaningful improvement in exercise capacity, a figure that has remained stable over time despite patients entering programmes with increasing levels of frailty and deconditioning due to prolonged waits. Similarly, patient-reported outcome measures, including COPD Assessment Test (CAT) scores, showed performance above national averages, reflecting meaningful improvements in symptoms and quality of life amongst those able to access the service. • Performance was strong in relation to completion of discharge assessments, with the majority of patients attending rehabilitation programmes successfully completing outcome measures at programme completion. Although national audit measures report poor performance for provision of written exercise plans, the service highlighted that over 85% of patients completing rehabilitation are referred into formal exercise referral schemes or community exercise programmes. As this activity is not recognised within the national audit methodology, local performance is likely to be better than the reported audit results suggests. • National standards require patients to commence pulmonary rehabilitation within 90 days of referral and those referred following an acute COPD exacerbation should begin rehabilitation within 30 days. The service is currently unable to achieve either standard. Audit data demonstrated average waits of more than 600 days from referral to treatment, with some waits continuing to increase. Members heard that waiting times had reached approximately 628 days and were continuing to rise • Service capacity remains the principal constraint. Although referrals continue to increase, resources have not increased proportionately, resulting in a growing waiting list. The committee heard that many patients deteriorate while awaiting rehabilitation, with some developing additional long-term conditions, becoming too frail to participate or dying before treatment can be offered. Nevertheless, the service continues to demonstrate meaningful clinical benefit amongst patients ultimately accessing rehabilitation.

3	National Paediatric Asthma Audit
3.1	DR presented the latest paediatric asthma audit findings and outlined progress since Cardiff and Vale re-engaged with the national audit programme. Whilst case ascertainment is below the level required and overall patient numbers are smaller than within the adult audit, the data has provided valuable assurance regarding both acute management and discharge processes. • The audit identified 315 potentially eligible cases through the initial case-finding process. Following review, only approximately 40 cases met inclusion criteria. This highlighted significant inefficiencies within current coding and note retrieval processes, with a large number of records requiring review despite not representing true asthma admissions. • 100% of paediatric admission received a specialist review by clinicians who met the audit definition of an asthma specialist with recognised expertise in asthma management. • Steroid administration performance was generally good and almost all children admitted with asthma ultimately received corticosteroid treatment during their admission, although compliance with the standard of administration within the first hour of arrival was lower and demonstrated monthly variation. • The audit identified several months where performance fell below expected levels, although these fluctuations were largely influenced by small patient numbers and the inclusion of younger children with diagnostic uncertainty between asthma and preschool wheeze. Overall, the majority of children received appropriate steroid treatment during admission, but performance against the first-hour treatment standard remains an area for improvement. • There was good performance in relation to inhaled corticosteroid prescribing at discharge amongst children aged over five years with a confirmed asthma diagnosis, comparing favourably with national performance. • Lower performance was observed in younger children as a result of complexities in diagnosing younger children. • Discharge documentation fell below the required standard. Compliance with documentation of medication adherence assessments and maintenance treatment reviews was particularly poor. Recording of smoking exposure and second-hand smoke exposure also showed considerable variation over time and often fell below national benchmark levels. Recommendations for follow-up in primary care within two days of discharge were inconsistently documented, despite being a national requirement. The audit further demonstrated low recorded compliance with provision of asthma action plans and documentation of inhaler technique assessment. Review of individual case notes suggested that many interventions were being undertaken but not reliably recorded within the patient record and therefore captured in the audit. • The service has strengthened follow-up arrangements through the paediatric asthma specialist nursing team, currently comprising four nurses

	with approximately 2.5 whole-time equivalent capacity. These nurses are providing outpatient follow-up for children admitted with asthma and are increasingly identifying frequent attenders who may not reach inpatient wards but would benefit from specialist review. Additional support from nurse practitioner-led clinics is also being developed to improve compliance with the requirement for review within four weeks of discharge. Action Participation in the audit has already driven several quality improvement initiatives. New asthma-specific nursing documentation has been developed to ensure assessment of inhaler technique, education and discharge advice are consistently recorded. A standardised paediatric asthma discharge document is being introduced to provide clinicians with a structured checklist covering all discharge bundle requirements.
4	Respiratory Quality Statement
4.1	AB presented an overview of respiratory service performance, highlighting both significant improvement work and ongoing capacity pressures across the specialty. • A major achievement during the year was completion of a consultant-led waiting list validation exercise, which resulted in approximately 50% of long-waiting patients being removed from respiratory outpatient waiting lists through virtual review, diagnostic testing, provision of specialist advice or discharge back to primary care where ongoing respiratory follow-up was no longer required. This has improved the accuracy of waiting lists and ensured outpatient capacity is focused on patients with genuine specialist respiratory needs. • There is significant variation in performance across respiratory subspecialties. The greatest concern remains Interstitial Lung Disease (ILD), where waiting times continue to exceed the directorate target of 52 weeks. This presents a significant clinical risk because patients may experience irreversible progression of pulmonary fibrosis whilst awaiting assessment and treatment. In response, a successful business case has secured additional medical and specialist nursing capacity to support the service. • Bronchiectasis services also continue to experience long waits, although service redesign and additional consultant support are being implemented to develop a more integrated multidisciplinary model and improve access to specialist review. • Performance within asthma services has improved during the year, supported by additional specialist nurse capacity and improvements identified through the national asthma audit. However, increasing demand associated with severe asthma and biologic therapies continues to place pressure on outpatient services and specialist nursing teams. The recent extension of biologic therapies into COPD management is expected to further increase demand. • Pulmonary rehabilitation remains the most significant service challenge. Members heard that patients often experience prolonged waits for respiratory assessment followed by a second wait for pulmonary

	rehabilitation, resulting in a total delay that can extend over several years. Given the established evidence that pulmonary rehabilitation improves quality of life and reduces healthcare utilisation, this was highlighted as a major clinical concern. • The review highlighted ongoing workforce constraints across the specialty. Cardiff and Vale currently has approximately one respiratory consultant per 58,000 population compared with a Welsh average of around one consultant per 40,000 population and an English average of around one consultant per 35,000 population. This creates limited resilience and reduces the service's ability to absorb increasing demand or staff absence. Diagnostic capacity remains another area of pressure, with respiratory diagnostic tests and lung function investigations experiencing waits of between 26 and 50 weeks. Although community spirometry services are supporting diagnostic pathways, capacity remains insufficient to meet current levels of demand. • Significant improvements have been achieved through waiting list validation, improved community spirometry pathways and the development of alternative models of care. Additional investment has been secured for ILD services, and asthma services have demonstrated measurable improvement in national audit performance. The respiratory team has also continued to develop more efficient multidisciplinary and physiologist-led pathways to maximise available capacity.
5	Primary Care COPD Audit RB presented data from the primary care COPD dashboard and the Community Spirometry Service, demonstrating the developing impact that improved diagnostics and integrated respiratory pathways are having on clinical outcomes across Cardiff and Vale. The data presented was derived from routine primary care information and was aligned, where possible, with National Respiratory Audit Programme (NRAP) measures • Encouraging trends in COPD disease control have been observed across the Health Board population. Around 60% of patients with COPD had experienced no exacerbations during the preceding year, which compared favourably with available English comparator data. Patients experiencing one or two exacerbations annually were broadly comparable with national benchmarks. However, approximately 12% of patients continued to experience three or more exacerbations each year, identifying a significant cohort of high-risk patients who are likely to have greater healthcare utilisation, poorer quality of life and increased risk of admission. Members noted that future improvement work should focus particularly on this group. • The data suggested a positive shift in exacerbation patterns across the population. While the proportion of patients experiencing a single exacerbation had increased slightly, there had been a reduction in the numbers experiencing two or more exacerbations. This was interpreted

as evidence that some patients were moving into lower-risk categories, potentially reflecting improvements in disease management, earlier diagnosis and optimisation of treatment through integrated respiratory pathways.

- Particular attention was given to emerging outcome data following community spirometry assessment. Analysis of more than 5,000 patients demonstrated a reduction in respiratory-related Emergency Unit attendances following spirometry testing. Respiratory attendances reduced by approximately 8% overall and remained reduced by around 5% even when patients acted as their own controls through comparison of equivalent time periods before and after spirometry assessment. The reduction was considered clinically significant because COPD is a progressive disease, and therefore healthcare utilisation would normally be expected to increase over time rather than decrease. Furthermore, the reduction appeared greatest amongst patients with higher levels of healthcare utilisation, suggesting that improved diagnostic certainty may have the greatest benefit in more complex patients.
- The committee also noted evidence that the average time spent within Emergency Units before a patient reached a clinical disposition, whether discharge or admission, had reduced substantially following spirometry assessment. This suggested that access to objective respiratory diagnostic information may be enabling more rapid clinical decision-making and helping clinicians to determine appropriate treatment pathways sooner. Members felt this represented an important patient flow and quality improvement benefit which warranted further investigation.
- Further analysis demonstrated reductions in overall hospital admissions following spirometry assessment at both University Hospital of Wales and University Hospital Llandough. Whilst interpretation of some hospital data remained complex because of changes in patient pathways and ward allocation, the overall trend suggested fewer admissions following access to community respiratory diagnostics. This provided further evidence that timely and accurate diagnosis may be contributing to improved disease management and reducing avoidable healthcare utilisation.
- The presentation also considered the wider economic impact of improved COPD control. Using published healthcare utilisation modelling, reductions in exacerbation frequency were estimated to be associated with substantial reductions in healthcare costs across Cardiff and Vale. Members recognised that the greatest financial benefit arose from reducing the number of patients experiencing frequent exacerbations, reinforcing the importance of identifying and managing this high-risk population effectively.
- Despite these positive clinical indicators, significant operational challenges remain. The Community Spirometry Service experienced considerable disruption due to workforce shortages and recruitment

difficulties. Demand has continued to increase throughout this period, resulting in a substantial waiting list. Although recent recruitment has enabled the service to recover capacity and begin reducing waiting times, delays to diagnostic testing continue to affect timely diagnosis and treatment initiation for some patients. The committee was advised that waiting list performance had improved considerably from its peak position and was now moving in a positive direction.

- Diagnostic coding was identified as a further area requiring improvement. Current data demonstrated that only a minority of patients had appropriate post-bronchodilator spirometry ratios accurately coded within primary care records. Members heard that spirometry results are not currently transferred directly into GP systems and therefore rely on manual coding processes, creating opportunities for omissions and inaccurate recording. The committee recognised that this affects not only audit performance but also broader understanding of COPD prevalence and disease severity across the population. Work is therefore underway to support direct electronic transfer of spirometry data into general practice systems and improve accessibility of results through clinical information platforms.
- Cardiff and Vale performs favourably against available English comparator data for patients experiencing no COPD exacerbations,
- There is evidence of a reduction in the number of patients experiencing multiple exacerbations, suggesting improved disease control across the population.
- Community spirometry is associated with reductions in respiratory-related Emergency Unit attendances and hospital admissions.
- Time to clinical decision within Emergency Units appears significantly improved following access to spirometry results.
- The principal area of ongoing concern remains the cohort of patients experiencing three or more annual exacerbations, who continue to generate a disproportionate burden of morbidity and healthcare utilisation.

Action The committee supported continued work to reduce spirometry waiting times, improve digital integration of results into GP systems and Welsh Clinical Portal, strengthen coding compliance and develop targeted interventions for patients experiencing three or more COPD exacerbations annually. Further evaluation of the impact of community spirometry on emergency care utilisation and patient outcomes will continue as the service matures

Report Title:	Summary of Recent Healthcare Inspectorate Wales (HIW) Inspection Reports		Agenda Item No:	3.5	
Meeting:	Quality Committee	Public	X	Meeting Date:	29.09.2026
		Private			
Lead Executive Title:	Executive Nurse Director				
Report Author/s Title:	Deputy Head of Quality and Patient Safety				
Report Focus Summary – AAA Framework: <i>The AAA framework reflects the overall position of the matter being reported. Select one category only and complete the relevant box with a brief summary. A useful guide can be found here: NHS Triple A Guide</i>					
ALERT (Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).					
There are no issues requiring escalation to the Committee through the Alert category at this reporting period. Immediate Assurance requirements arising from recent HIW inspections have been addressed and are subject to ongoing monitoring through established governance arrangements. The report is therefore presented to support organisational learning, oversight of improvement activity and assurance regarding the implementation of inspection recommendations.					
ADVISE (Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)					
HIW inspections undertaken across secondary and primary care services identified many areas of positive practice, including compassionate and person-centred care, positive patient experiences, committed staff teams, effective multidisciplinary working and supportive leadership arrangements. Across secondary care services, common themes for improvement included governance and assurance arrangements, environmental and estates oversight, infection prevention and control, medicines management, workforce compliance, documentation standards, patient information, organisational learning and leadership visibility. Improvement plans have been developed in response to inspections of Ward B2 (University Hospital of Wales), Barry Minor Injuries Unit, Mental Health Services for Older People (Wards East 10, 14 and 16) and the Llanfair Unit (Meadow and Daffodil Wards). Immediate Assurance requirements identified during the Mental Health Services for Older People and Llanfair Unit inspections have been addressed, with ongoing monitoring arrangements in place to ensure improvements are embedded and sustained. Across primary care services, inspections of The City Surgery, Cathedral Orthodontics, Bupa Dental Care Pentwyn and PD Care Limited identified positive patient experiences and generally effective clinical care, alongside opportunities to strengthen governance arrangements, clinical audit, workforce records, safeguarding processes, infection prevention and control arrangements, medicines management and clinical documentation. The UHB Primary Care Team reviews all HIW inspection reports, monitors progress against improvement plans, follows up regulatory requirements where applicable, and provides oversight and support through established Primary Care governance arrangements. Key organisational learning themes emerging across both primary and secondary care services include the importance of robust governance and assurance processes, environmental safety, workforce compliance, infection prevention and control, medicines management, effective record keeping, strong audit arrangements and the systematic use of patient feedback, incidents and complaints to support continuous improvement.					

ASSURE (details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)

Improvement plans have been developed in response to all inspection findings and subject to ongoing monitoring. Secondary care improvement plans are monitored through directorate and clinical board governance structures and logged on AMaT and progress against these are discussed at the Executive Performance Reviews and an update is provided to HIW three months after the publication of each report. Primary care improvement plans are overseen through established Primary Care governance arrangements.

Significant progress has been made in implementing recommendations arising from both secondary and primary care inspections. The majority of actions identified within improvement plans have been completed, with remaining actions largely relating to longer-term environmental improvements, recruitment processes, workforce compliance targets and the ongoing embedding of governance and quality assurance arrangements. Where actions remain outstanding, they have agreed completion timescales and continue to be actively monitored.

The Committee can take assurance that appropriate action has been taken in response to inspection findings, appropriate mitigating actions have been implemented and remaining risks continue to be monitored through established governance arrangements, robust governance arrangements are in place to oversee the completion of outstanding actions, and learning arising from HIW inspections is being embedded to support continuous improvement in the quality, safety and experience of care across Cardiff and Vale University Health Board.

Board/Committee Response Required (please select only one)

Assurance	Approval	Information/Noting
☒	☐	☐

Recommendations

The Quality Committee is asked to:

- Receive assurance regarding the actions taken in response to recent HIW inspection findings across secondary and primary care services, note the progress of associated improvement plans, and endorse the continued organisational learning arising from inspection activity.

Governance Route (please list all other Committee/Groups this report has been to)

Where it's been:

When it went:

What decision was made: e.g. Recommended to Board for approval

Main Report

Background & Current Situation

Healthcare Inspectorate Wales (HIW) has published a number of reports since February 2026 relating to secondary care and primary care services across Cardiff and Vale University Health Board. These include inspections of:

Secondary Care

- Ward B2 (Gynaecology and Oncology), University Hospital of Wales.
- Barry Minor Injuries Unit, Barry Hospital.
- Mental Health Services for Older People, Wards 10, 14 and 16, Llandough Hospital.
- Meadow and Daffodil Wards, Llanfair Unit, Llandough Hospital.

Primary Care

- City Surgery (General Medical Services).
- Cathedral Orthodontics (General Dental Services).
- Bupa Dental Care Pentwyn (General Dental Services).
- PD Care Limited (General Dental Services)

The purpose of this report is to provide the Quality Committee with an overview of the key findings, actions taken and organisational learning arising from these inspections.

Ward B2, University Hospital of Wales

HIW undertook an unannounced inspection of Ward B2 in February 2026. HIW identified several positive findings, including compassionate and respectful care, positive patient feedback, and a supportive ward environment. Recommendations focused on enhancing patient information and health promotion resources, improving support for people with communication and sensory needs, strengthening infection prevention and control arrangements, improving documentation and record keeping, increasing visibility of audit outcomes, and further strengthening governance and incident reporting processes. In response, actions were undertaken to improve patient information and accessibility resources, enhance health promotion materials, strengthen infection prevention and control arrangements, address environmental issues identified during the inspection, and reinforce governance, audit and patient safety processes. The improvement plan is largely complete, with the remaining action relating to the replacement of ward clocks. Progress continues to be monitored through established directorate governance arrangements.

You can read the full report and improvement plan at: [20260521UHWGYNAEEN.pdf](#)

Barry Minor Injuries Unit

HIW undertook an unannounced inspection of Barry Minor Injuries Unit in March 2026. HIW identified a number of positive findings, including positive patient experiences, a caring and supportive environment, and a committed multidisciplinary team. Recommendations focused on strengthening governance and leadership arrangements, enhancing staff and patient safety processes, addressing environmental and estate-related issues, and further developing medicines management, documentation and assurance processes. In response, a range of actions have been implemented, including strengthened escalation and governance arrangements, environmental improvements, enhancements to medicines management processes, and increased leadership capacity within the service. The majority of actions within the improvement plan have been completed. Remaining actions relate to the completion of a review of security arrangements and the appointment of additional management capacity through a Band 7 Emergency Unit management post, which has been approved and is currently being recruited to. Progress against these actions continues to be monitored through established governance arrangements.

You can read the full report and improvement plan at: [20260612 - Barry Hospital EN.pdf](#)

Mental Health Services for Older People, Llandough Hospital

HIW undertook an unannounced inspection of Wards East 10, 14 and 16 in April 2026. While HIW identified a number of positive findings, including compassionate care, positive interactions between staff and patients, and a committed multidisciplinary team, there were a significant number of issues identified around the cleanliness of the care environment and the oversight and scrutiny of this standard. Recommendations focused on improving environmental cleanliness and maintenance, strengthening governance and organisational learning processes, enhancing medicines management and patient safety arrangements, improving management of patient property, strengthening patient

and carer feedback processes, and increasing compliance with mandatory training requirements. Immediate actions were implemented in response to the inspection findings, including enhanced environmental monitoring, strengthened housekeeping and audit arrangements, improvements to medicines governance, revised night staffing arrangements, enhanced oversight of patient property processes, and strengthened governance and escalation mechanisms. A three-month improvement plan update has been provided to HIW demonstrating significant progress has been made across the improvement plan, with the majority of actions completed. Outstanding actions relate to completion of planned guttering and balcony improvement works within the ward environment, finalisation of revised patient property information resources, and achieving the target level of mandatory training compliance across all wards, with a revised completion date of October 2026. Ongoing monitoring arrangements have been embedded for environmental standards, patient property management, medicines safety, governance processes and workforce compliance.

You can read the full report and improvement plan at: [4603 - Llandough Ward 10,14 & 16.pdf](#)

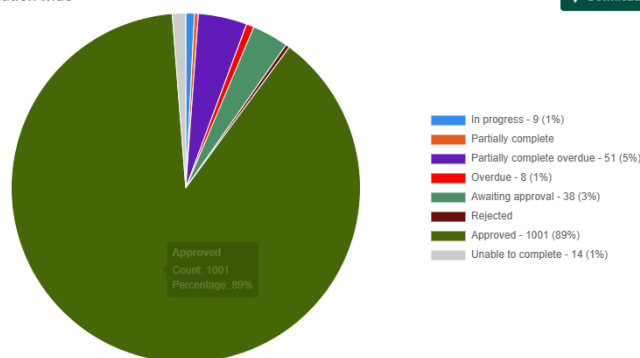
Meadow and Daffodil Wards, Llanfair Unit, Llandough Hospital

HIW undertook an unannounced inspection of Meadow and Daffodil Wards at the Llanfair Unit in June 2026. HIW found that patients were treated with kindness, dignity and respect and highlighted positive multidisciplinary working, therapeutic activity provision and support for rehabilitation and discharge planning. Recommendations focused on environmental and estates issues, governance and organisational learning arrangements, workforce compliance, patient information, leadership visibility and patient engagement. Immediate actions were implemented in response to concerns regarding safety-critical training compliance and restraint governance, alongside measures to strengthen workforce assurance, incident review and governance oversight. Significant progress has been made, with immediate risks addressed and a number of improvement actions completed. Remaining actions relate primarily to environmental improvement works, enhancing patient information resources, strengthening patient engagement arrangements and embedding governance and organisational learning improvements. Progress continues to be monitored through Mental Health Clinical Board governance arrangements and the AMaT process, and a three-month update is currently being developed to provide assurance of the progress in relation to the improvement plan.

You can read the full report and improvement plan at: [20260617LlanfairUnitEN.pdf](#)

Organisational learning from secondary care inspections

Secondary care HIW inspections are subject to ongoing oversight by the Clinical Boards with scrutiny from the Executive Directors through structured performance reviews. Monitoring of progress against HIW improvement is undertaken through the AMaT clinical governance system, and the chart below shows progress against secondary care improvements as of mid-September.



There are a number of recurring themes across secondary inspections, which include environmental safety and maintenance, governance and assurance arrangements, workforce compliance and mandatory training, medicines management, infection prevention and control, clinical documentation, patient information, and the effective use of audit, incident reviews and patient feedback to drive improvement.

The patient safety team is working with colleagues to embed improvements at organisational level include wider reviews of environmental standards, medication storage standards, documentation quality, training compliance and patient information provision. Findings and learning have been shared through quality and governance structures to support consistency of practice across the Health Board. A digital quality handbook is being developed to ensure that learning from HIW inspections are available for all clinical areas to embed.

Primary Care Inspections

Healthcare Inspectorate Wales (HIW) undertakes a rolling programme of inspections of General Medical Services (GMS) and General Dental Services (GDS) to assess compliance with the Quality Standards 2023 and other relevant professional and regulatory requirements. Following receipt of inspection reports, the UHB Primary Care Team reviews all findings, monitors delivery of improvement actions, follows up any immediate assurance requirements, provides support to practices where required and seeks assurance that recommendations have been appropriately addressed. Where responses do not provide sufficient assurance, matters are subject to further regulatory scrutiny and ongoing oversight through established Primary Care governance arrangements. During the reporting period, HIW completed inspections of one GP practice and three dental practices within Cardiff and Vale University Health Board. One Immediate Assurance notification was issued and progress against all identified actions continues to be monitored through the Primary Care Quality and Safety governance framework.

The City Surgery (GMS)

HIW undertook an inspection of City Surgery in April 2026. HIW found that the practice provided a positive, patient-centred service with high levels of patient satisfaction, strong teamwork and safe clinical systems. Recommendations focused on strengthening governance and audit arrangements, infection prevention and control processes, safeguarding arrangements, workforce records and policy management. In response, the practice developed an improvement plan to strengthen governance oversight, improve organisational learning and action tracking processes, review safeguarding arrangements, update policies and procedures, introduce a workforce training matrix and workforce plan, and further enhance patient feedback and quality improvement mechanisms. No immediate patient safety concerns were identified. Progress continues to be monitored through Primary Care governance arrangements.

You can read the full report and improvement plan at: [20260421 - The City Surgery.pdf](#)

Cathedral Orthodontics (GDS)

HIW undertook an announced inspection of Cathedral Orthodontics in April 2026. HIW identified a number of positive findings, including excellent patient feedback, compassionate care, effective infection prevention and control arrangements, safe medicines management, and strong leadership and governance processes. No immediate patient safety concerns were identified. Recommendations focused on strengthening clinical record keeping, workforce governance, training compliance and aspects of premises management. In response, the practice implemented actions to strengthen workforce and training monitoring arrangements, review clinical documentation standards, address environmental issues identified during the inspection and provide additional assurance regarding radiation safety arrangements. Progress against the improvement plan continues to be monitored through established Primary Care governance arrangements, with oversight provided by the UHB Primary Care Team.

You can read the full report and improvement plan at: [260709 - Cathedral Orthodontics.pdf](#)

Bupa Dental Care Pentwyn (GDS)

HIW undertook an announced inspection of Bupa Dental Care Pentwyn in April 2026. HIW identified a number of positive findings, including positive patient feedback, person-centred care, effective infection prevention and control arrangements, robust safeguarding processes and strong governance systems. No immediate patient safety concerns were identified. Recommendations focused on strengthening premises maintenance, medicines management, radiography governance, clinical record keeping and workforce compliance arrangements. In response, the practice implemented actions to address environmental and equipment issues, strengthen medicines management processes, improve clinical documentation standards and enhance governance and training arrangements. Progress against the improvement plan continues to be monitored through established Primary Care governance arrangements, with oversight provided by the UHB Primary Care Team.

You can read the full report and improvement plan at: [27042026 - BUPADentalCarePentwyn, EN.pdf](#)

PD Care Limited (GDS)

HIW undertook an inspection of PD Care Limited during the reporting period. Whilst patients reported positive experiences of care, HIW identified concerns relating to infection prevention and control and procedural safety arrangements, resulting in the issue of an Immediate Assurance notification. Recommendations focused on strengthening infection prevention and control arrangements, completing overdue decontamination and infection prevention audits, implementing actions from previous inspections, strengthening governance and audit processes, and ensuring the consistent use of Local Safety Standards for Invasive Procedures (LocSSIPs). In response, the practice implemented immediate corrective actions, completed outstanding audit activity and provided evidence of actions taken to address identified risks. The UHB Primary Care Team followed up with a visit to the practice to gain assurance that the actions identified had been implemented. Progress continues to be monitored through established Primary Care governance arrangements and ongoing regulatory oversight, with oversight provided by the UHB Primary Care Team.

You can read the full report and improvement plan at: [20240229PDCareLtdFull.pdf](#)

Primary Care Assurance

Improvement plans have been developed in response to all primary care inspection findings and are monitored through established Primary Care governance arrangements, with oversight provided by the UHB Primary Care Team. Remaining actions primarily relate to the embedding of governance and audit arrangements, workforce compliance and training records, clinical documentation standards, premises and equipment improvements, radiography governance, infection prevention and control assurance, and the ongoing monitoring of procedural safety arrangements. The UHB Primary Care Team continues to review provider responses, monitor progress against improvement plans and seek assurance that identified improvements have been implemented and sustained. The Committee can take assurance that appropriate action has been taken in response to all primary care inspection findings, that immediate concerns have been addressed where identified, and that robust arrangements are in place to monitor delivery of outstanding actions and support continuous improvement in the quality and safety of primary care services.

Organisational learning from primary care inspections

Common themes arising from primary care inspections included governance and assurance arrangements, clinical audit, workforce records, safeguarding processes, infection prevention and control, medicines management and clinical documentation. Learning has been shared through Primary Care governance structures and is being used to support quality improvement, strengthen assurance processes and promote the consistent application of good practice across primary care services.

Conclusion

Recent HIW inspections identified many examples of compassionate care, positive patient experiences and committed staff across Cardiff and Vale University Health Board services. Where areas for improvement were identified, improvement plans have been developed and immediate actions completed where required. The majority of actions are now complete, with remaining actions progressing within agreed timescales and subject to ongoing monitoring through established governance arrangements. The Health Board continues to use findings from inspections to support organisational learning and drive continuous improvement in the quality, safety and experience of care.

Appendices:

Strategic Alignment – Shaping Our Future Wellbeing:

 Putting People First	X	 Providing Outstanding Quality	X
 Delivering in the Right Places	X	 Acting for the Future	

Impact Assessment

Risk: Yes

inspection findings identified risks requiring monitoring and action plans.

Safety: Yes

inspection findings relate directly to quality and patient safety.

Financial: No

Workforce: Yes

Actions include training, staffing, leadership, and culture improvements.

Legal: No
Reputational: Yes
<i>HIW inspection reports are published in the public domain.</i>
Socio Economic: No - https://www.gov.wales/socio-economic-duty-guidance
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Report Title:	Thirlwall Inquiry: Executive Summary, Recommendations and Organisational Assurance			Agenda Item No:	3.6
Meeting:	Quality Committee	Public	x	Meeting Date:	29 Sept 26
		Private			
Lead Executive Title:	Executive Nurse Director				
Report Author/s Title:	Deputy Executive Nurse Director				
Report Focus Summary – AAA Framework: The AAA framework reflects the overall position of the matter being reported . Select one category only and complete the relevant box with a brief summary . A useful guide can be found here: NHS Triple A Guide					
ALERT (Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).					
The Thirlwall Inquiry identifies profound failures to recognise, connect and escalate repeated safety signals, including suspected deliberate harm, mortality signals, speaking up, medicines security and Board oversight. Patient protection was delayed by fragmented governance, professional loyalties, employment processes and concern for organisational reputation. We are committed to ensure that the recommendations are reviewed and so a structured gap analysis and testing of critical controls with a proposed assurance programme is undertaken to maintain oversight of urgent actions and residual risks. The Quality Committee are asked to note the contents and endorse the gap analysis and proposed assurance programme.					
ADVISE (Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)					
ASSURE (details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)					

Board/Committee Response Required (please select only one)					
Assurance	x	Approval		Information/Noting	
Recommendations					
Quality Committee is asked to: - note the Inquiry's findings and the direct relevance of its safety lessons beyond England - endorse an Executive-led multidisciplinary gap analysis against all 17 recommendations - approve establishment of a single Thirlwall assurance programme, reporting to Quality Committee and Board - require immediate confirmation of controls for deliberate-harm concerns, child and neonatal mortality escalation, insulin security, SUDIC processes, speaking up and duty of candour - receive a first comprehensive assurance report within 90 days, with urgent exceptions escalated sooner.					
Governance Route (please list all other Committee/Groups this report has been to)					

Where <i>it's been:</i>	
When <i>it went:</i>	
What <i>decision was made:</i>	
Main Report <i>Background & Current Situation</i>	

1.0 Executive summary

Chaired by the Rt Hon Lady Justice Thirlwall DBE, the statutory Inquiry examined the experiences of the babies and families; the response of clinicians, managers, the Board and external bodies; and wider NHS arrangements for patient safety, safeguarding, speaking up, regulation, mortality surveillance and accountability. Evidence hearings began in September 2024, with 134 witnesses giving oral evidence. The final report was presented to Parliament on 15 September 2026.

The report is organised in three volumes. Volume I examines the hospital's governance and the events through June 2016; Volume II follows the managerial response, external reviews, employment processes and eventual police referral; Volume III addresses systemic NHS issues and contains the recommendations.

The Inquiry examined how a marked rise in neonatal deaths and a series of sudden, unexpected and clinically unexplained collapses at the Countess of Chester Hospital between June 2015 and June 2016 were recognised, investigated and escalated. Against a historical baseline of one to three neonatal deaths a year, the unit recorded eight deaths in 2015 and a further five by the end of June 2016. Many babies had appeared stable before deteriorating rapidly; several displayed unusual discolouration or failed to respond to resuscitation in the expected way. The Inquiry concluded that this pattern warranted urgent collective investigation, but deaths and non-fatal collapses were repeatedly reviewed as isolated clinical episodes rather than as a connected signal of possible harm.

Clinical concern developed incrementally. Rotas, timing, unusual clinical features and unexplained outcomes increasingly pointed to a recurring staff association. The March 2016 Thematic Review identified a substantial mortality increase, repeated sudden deterioration, a concentration of arrests between midnight and 04:00, and a common staffing association. These warning signs were not stated or escalated with sufficient clarity. By May 2016, consultants had raised the possibility of deliberate harm in good faith, yet the response remained "monitor and alert". After the deaths of two triplet brothers on 23 and 24 June 2016, consultants sought removal of the staff member from clinical duties and police involvement. Executives instead pursued internal and external clinical reviews, and the police were not contacted until May 2017.

The Inquiry's central conclusion is that this was not a single-process failure but a system-wide breakdown in safeguarding, leadership, professional challenge, incident management, mortality surveillance, candour and accountability. Credible concerns were treated as matters of capability, grievance and employment law rather than child protection. Professional loyalty, fear of being unfair, reputational anxiety and an uncritical application of "no blame" thinking displaced the first duty to protect patients. The Board received incomplete and overly reassuring information, external organisations accepted partial accounts, and reviews not designed to investigate criminal or deliberate harm were used as substitutes for immediate safeguarding action.

Families experienced the consequences of these failures directly. Important information about collapses, unusual clinical signs, insulin results, staff associations and internal concerns was not consistently disclosed. Parents were not routinely involved in reviews, some complaints were dismissed or minimised, and bereavement support was inconsistent and at times insensitive. Several families learned of material concerns only through the police investigation, criminal proceedings or the Inquiry. The report therefore places family voice, honest communication, meaningful involvement and compassionate bereavement care at the centre of organisational safety rather than treating them as ancillary services. The recommendations translate these findings into a national safety programme: livestreaming in-cot cameras; secure and auditable insulin controls; mandatory laboratory escalation; national bereavement standards; safeguarding training and contractual duties; interoperable neonatal data; Board-level child-death surveillance; named weekly data leadership; explicit application of SUDIC to babies who have never left hospital; a concise

Suspicion of Deliberate Harm Protocol; access to independent expert panels; strengthened medical examiner and pathology capacity; regulation and candour duties for managers; more searching inspection; stronger oversight of speaking up; and independent audit of implementation. For NHS Wales, not every named recipient or deadline applies directly, but the underlying safety outcomes require formal local assessment and evidence-based assurance

2.0 Principal findings and lessons for Board assurance

2.1 Failure to connect and act on safety signals

Recognising the pattern. Individual deaths and incidents were repeatedly considered in isolation. The rise from the unit's historically low mortality to eight deaths in 2015 was a signal warranting investigation, but incident and risk systems did not reliably aggregate deaths, non-fatal collapses, unusual clinical features and staffing associations.

Leadership and governance. Senior managers did not respond with a consistently patient-first approach. The Board was not given a complete, timely and unvarnished account. Internal reviews were used despite not being designed to determine deliberate harm. Risk to reputation was given greater prominence than the real risk of unexplained neonatal mortality.

Safeguarding and deliberate harm. Concerns that a staff member might be harming patients were treated principally as clinical, HR or performance matters rather than as safeguarding concerns. The Inquiry concluded that patient protection should have been the first response and that police engagement should not have been delayed while the organisation sought certainty.

Culture and professional loyalty. An uncritical "no blame" mindset, tribalism and loyalty to professional groups inhibited objective consideration of evidence. A just culture must support learning while preserving individual accountability and acting immediately where deliberate, reckless or seriously negligent harm may have occurred.

Speaking up and employment processes. Concerns raised in good faith were not consistently protected. Grievance, disciplinary and legal considerations became disconnected from patient safety. The report's lesson is that employment action to restrict duties pending investigation is neutral and proportionate where patient safety may be at risk.

2.2 Families, candour and bereavement

Parents held important information about their babies' condition, changes and care but were not always listened to, involved in reviews or informed before public announcements. The Inquiry calls for earlier, more truthful and compassionate communication, meaningful involvement in investigations, and bereavement pathways that offer practical and psychological support without placing decision-making burdens on families at moments of acute distress.

2.3 Data, mortality review and medicines governance

The report supports continuous monitoring of neonatal and maternity outcomes, named accountability for timely data entry and interpretation, predetermined escalation routes and direct Board visibility. It also identifies practical controls around insulin access and abnormal insulin/C-peptide results, stronger medical examiner processes, and in-cot monitoring for neonatal units.

3.0 The 17 recommendations in full summary

No.	Recommendation	Detailed requirement and assurance significance
1	CCTV and neonatal monitoring	Fit every neonatal cot and incubator with a baby monitor providing livestreaming video for parental access. Funding

		should be centrally managed and ring-fenced, with an NHS England implementation roadmap by 31 March 2027.
2	Insulin security and laboratory escalation	Use digital access controls that restrict and record access to insulin; meet GIRFT safe-insulin requirements by 31 March 2027; use CCTV directed at insulin storage until biometric access is implemented, retaining footage for at least 28 days; and make national insulin/C-peptide testing and reporting guidance mandatory.
3	Bereavement care	Implement the National Bereavement Care Pathway for neonatal death nationally and in every Trust by 31 August 2027, providing consistent, compassionate and practical support to families.
4	Safeguarding training and employment contracts	Provide role-appropriate safeguarding training to all staff and Board members, including Non-Executive Directors, covering suspected deliberate harm by staff. By March 2027, contracts for substantive, agency and bank staff should require compliance with safeguarding guidance and the deliberate-harm protocol.
5	Interoperable operating systems	Set a timed national route by 31 March 2027 to harmonise NHS systems by December 2028, supported by mandatory information standards so neonatal data can be entered once, reviewed promptly and monitored continuously.
6	Board monitoring of deaths	By 31 March 2027, every Trust should have effective Board-level monitoring of all deaths of babies and children and a predetermined route for escalating concerning patterns or trends to senior management.
7	Named neonatal data lead	Every hospital with a neonatal unit should appoint a trained lead reporter to enter and review MBRRACE neonatal and maternity data at least weekly. Urgent alerts must be reported immediately to the Medical Director and Board; otherwise, the Board should receive at least six-monthly reports on alerts, investigations and action plans.
8	SUDIC application and guidance	Explicitly apply the Sudden Unexpected Death in Infancy and Childhood process to babies who die suddenly and unexpectedly without ever leaving hospital; notify relevant staff and Boards promptly; revise national guidance by 31 March 2027; and simplify forms to focus on essential information.
9	Suspicion of Deliberate Harm Protocol	Introduce by 31 March 2027 a one-page protocol, supported by concise guidance, requiring immediate action on good-faith concerns regardless of whether the recipient believes them. Neutral movement away from patient contact should usually be the first protective step, safeguarding procedures must be followed and police involvement must result. Guidance should address bias, loyalty, communication and consequences of non-compliance.
10	Independent expert panel	Give serious consideration to a national multidisciplinary panel able to deploy a swift, technically expert and independent team when concerns arise about an

		individual and patient harm. Each review should include relevant clinicians, safeguarding consideration and police contact where required.
11	Medical examiner arrangements	Issue a one-page neonatal death checklist by 31 March 2027; embed revised SUDIC guidance; require direct safeguarding questions and same-day recording of all clinicians who cared for the baby; create a funded pool of neonatology expertise; and review the medical examiner system and funding in 2027.
12	Paediatric and perinatal pathology workforce	Ensure that 37 doctors are in paediatric and perinatal pathology training posts by June 2033 and maintain funded incentives until that workforce level is achieved.
13	Management accountability and regulation	Establish a barring system for clinical and non-clinical managers by September 2027, review it in 2030 and move towards statutory regulation by September 2032. Strengthen fit-and-proper-person checks for manager moves, create an individual duty of candour and put patient safety first in the leadership code and competency framework.
14	CQC inspection reform	Use unannounced departmental inspections with at least two current practising specialists, investigate operational reality rather than accept assurances at face value, and train inspectors to test whether systems actually keep patients safe rather than merely checking that processes exist.
15	External assessment of CQC	Require rigorous and consistent scrutiny of CQC performance by the Health and Social Care Committee annually at first and, once confidence is established, at least every three years or at another interval set by the Committee.
16	Independent oversight of speaking up	Transfer the functions of the National Guardian's Office to the Parliamentary and Health Service Ombudsman in England and expand its powers to investigate inadequate handling of whistleblowing, refer concerns to appropriate NHS bodies and oversee the response.
17	Independent audit of implementation	Give the National Audit Office responsibility and additional resources to audit implementation of recommendations from statutory inquiries into NHS bodies, commencing by September 2027.

3.1 Cross-cutting themes arising from the recommendations

- **Protection before proof:** credible concern triggers immediate safeguarding action; conclusive evidence is not a prerequisite.
- **Independent scrutiny:** mortality review, technical investigation, inspection, speaking-up oversight and implementation assurance require sufficient externality and expertise.
- **Data converted into action:** real-time, interoperable information must be interpreted by named people, linked across events and escalated through predetermined routes.
- **Personal accountability:** Board members and managers must understand their individual responsibilities for candour, safeguarding and putting patients first.

- **Family partnership:** transparent communication, access to information and consistent bereavement support are essential components of safety and accountability.
- **Implementation evidence:** organisations must show that controls work in practice through audit, simulation, case tracing and independent validation, not rely on policy approval alone.

4.0 Implications for Cardiff and Vale UHB

Although several recommendations are addressed to bodies in England, the report's central safeguards are directly relevant to NHS Wales. The Health Board should distinguish between formal national dependencies and actions within its own control. Immediate local priorities include Board-level surveillance of all child and neonatal deaths; explicit escalation thresholds; a staff-harm safeguarding pathway; auditable insulin controls; reliable abnormal-result escalation; independent and protected speaking-up arrangements; clear separation of patient-safety decisions from employment processes; family involvement; and evidence that the medical examiner, SUDIC and safeguarding interfaces work together. Welsh Government or NHS Wales decisions may be required for national digital architecture, contractual provisions, specialist pathology capacity, oversight arrangements and capital investment, but these dependencies should not delay our protective controls.

Assurance domain	Key question for the Committee	Indicative position
Escalation of suspected deliberate harm	Is there one clear multi-agency pathway that overrides ordinary incident and HR processes and includes immediate restriction from patient contact?	Amber pending evidence
Neonatal and child mortality surveillance	Are deaths and unexpected collapses reviewed collectively and continuously, with explicit triggers for executive and Board escalation?	Amber pending evidence
Medical examiner and SUDIC interface	Are specialist advice, safeguarding questions, family voice and staff-contact records consistently built into neonatal and child death review?	Amber pending evidence
Insulin safety	Is access identifiable and auditable, and is high insulin/low C-peptide managed through an immediate escalation protocol?	Amber pending evidence
Speaking up	Can staff raise concerns independently; are concerns logged, investigated and tracked; and are reporters protected from detriment?	Amber pending evidence
Candour and family involvement	Do families receive timely, honest information and meaningful involvement in reviews and improvement?	Amber pending evidence
Executive and Board oversight	Does the Board receive unfiltered narrative, data signals and dissenting clinical views, with actions, owners and due dates?	Amber pending evidence
Governance of quality recommendations	Is there a single repository tracking decisions, delivery, evidence of impact and overdue action from inquiries and reviews?	Amber pending evidence

5.0 Proposed assurance framework

Workstream	Executive lead	Key evidence	Committee measure
Safeguarding and deliberate harm	Executive Nurse Director / Medical Director	Approved pathway, simulation results, case audits, police and safeguarding liaison arrangements	Compliance and timeliness; exceptions; learning closed
Mortality and quality intelligence	Medical Director	Weekly review logs, statistical process control, case triangulation, Board reports	Signal-to-action time; overdue reviews; unexplained events
People, speaking up and culture	Director of People and Culture	Speaking-up data, detriment reviews, grievance/disciplinary interface audit, staff survey	Responsiveness, protection and staff confidence
Medicines and laboratory safety	Medical Director / Director of Pharmacy	Insulin audit, access logs, laboratory protocols, drills	Control compliance and escalation performance
Families, candour and bereavement	Executive Nurse Director	Family feedback, involvement audit, bereavement pathway, duty-of-candour records	Timeliness, experience and action completion
Digital and monitoring infrastructure	Director of Digital / Estates	Options appraisal, privacy impact assessment, implementation plan	Delivery against milestones and risk reduction
Programme governance	Chief Executive	Master action log, independent validation, overdue-action escalation	RAG trajectory and residual risk

6.0. Risks and dependencies

- **Jurisdictional variation:** implementation responsibilities differ between England and Wales; local action should focus on equivalent safety outcomes while national directions are clarified.
- **Financial and infrastructure impact:** camera systems, secure drug storage, interoperability and specialist medical examiner capacity may require business cases and national support.
- **Privacy and workforce implications:** monitoring must be co-designed with families and staff, with robust information-governance safeguards.
- **False assurance:** completion of policy revisions is not evidence that practice has changed; testing, case tracing and independent validation are essential.
- **Fragmentation:** multiple parallel programmes may dilute accountability; one consolidated executive programme and action log are recommended.

7.0 Conclusion

The Thirlwall Inquiry describes a prolonged failure to translate clinical concern, family experience, mortality data and professional judgement into timely protection of babies. Its

enduring message is that patient safety must override disbelief, hierarchy, professional loyalty, organisational reputation and procedural comfort. A credible concern about deliberate harm must be treated as a safeguarding emergency: protect patients, preserve evidence, involve independent expertise and police through safeguarding routes, communicate honestly and investigate without delay. For the Health Board, assurance should therefore be based on tested pathways, traceable decision-making, direct Board visibility, independent challenge and demonstrable change in practice. The proposed programme should report both completion and impact, with unresolved risks, delays and exceptions escalated transparently to the Quality Committee and Board.

Appendices:

(List any appendices that will accompany this report).

Strategic Alignment – Shaping Our Future Wellbeing:

 Putting People First	x	 Providing Outstanding Quality	x
 Delivering in the Right Places		 Acting for the Future	x

Impact Assessment

Risk: Yes

The report identifies material patient-safety, governance, workforce, financial, legal, information-governance and reputational risks. Principal risks and dependencies are set out in section 6.0, with further assurance gaps described in sections 4.0 and 5.0. All domains are provisionally rated amber pending evidence. Mitigation is through an Executive-led multidisciplinary gap analysis against all 17 recommendations, a consolidated action log, named executive ownership, testing of critical controls, independent validation and transparent escalation of overdue actions, exceptions and residual risks to the Quality Committee and Board.

Safety: Yes

The report has direct patient- and staff-safety implications. Patient risks include delayed recognition and escalation of mortality or deterioration signals, suspected deliberate harm, insecure insulin controls, failures in SUDIC and medical-examiner interfaces, incomplete candour and fragmented Board oversight. Staff implications include psychological safety, protection for those speaking up, fair restriction from duties where required, safeguarding competence and separation of safety decisions from employment processes. Mitigation is addressed in sections 4.0–6.0 through immediate confirmation and testing of controls, a deliberate-harm pathway, mortality surveillance, medicines and laboratory audits, speaking-up safeguards, family involvement and Executive and Board assurance.

Financial: Yes

Potential costs may arise from neonatal monitoring and camera infrastructure, secure and auditable insulin storage, digital interoperability, specialist pathology and medical-examiner capacity, staff training, independent review and programme administration. The financial impact is not yet quantified. Relevant workstreams should complete costed options appraisals and business cases, identify national dependencies and funding routes, and prioritise immediate low-cost protective controls pending capital decisions. Any unfunded pressure or material variance should be escalated through established financial governance.

Workforce: Yes

Implementation will require protected multidisciplinary capacity, named workstream leads, role-appropriate safeguarding and deliberate-harm training, strengthened speaking-up arrangements, weekly mortality-data review and possible additional digital, pharmacy, pathology and medical-examiner expertise. There may also be employee-relations

implications where precautionary restriction from patient contact is required. Mitigation should include a workforce capacity and skills assessment, training and communication plans, staff-side engagement, occupational-health and wellbeing support, and fair, timely processes that maintain patient protection without presuming culpability.

Legal: Yes

Legal considerations include safeguarding duties, duty of candour, employment law and fair process, data protection and privacy for video monitoring and access logs, record retention, information sharing, police referral, contractual requirements and professional regulation. No specific legal advice is recorded in this paper. Legal, safeguarding, information-governance and People advice should be obtained during the gap analysis and before material policy, monitoring, contractual or employment-process changes are implemented, with advice and decisions documented in the programme assurance record.

Reputational: Yes

There is significant reputational risk if the Health Board cannot demonstrate that the Inquiry's lessons have been understood, translated into local action and independently tested, particularly in relation to patient protection, speaking up, candour and Board oversight. There is also risk from overstating assurance before evidence is available. Mitigation is through transparent reporting of the amber position, clear ownership and timescales, early escalation of exceptions, meaningful engagement with families and staff, and publication or communication of evidenced progress through established governance and communications routes.

Socio-Economic: Yes

The report initiates strategic decisions that may affect access to family information, bereavement support, digital monitoring and routes for raising concerns. People experiencing socio-economic disadvantage may face greater barriers to digital access, travel, advocacy, health literacy and participation in reviews. The gap analysis and subsequent service changes should therefore assess differential impact, involve affected families and communities, provide accessible non-digital alternatives, avoid transferring costs to families, and monitor uptake and outcomes by relevant population characteristics and deprivation where lawful and available.

Equality & Health: Yes

An Equality and Health Impact Assessment will be required as individual recommendations are translated into policies, pathways, digital solutions, workforce processes and family-facing services. Particular consideration should be given to disability, communication needs, language, race and ethnicity, religion or belief, sex, pregnancy and maternity, age, digital exclusion and health inequalities. The programme should complete proportionate assessments at workstream or business-case stage, involve patients, families, staff and representative groups, provide reasonable adjustments and accessible information, and monitor whether implementation creates unequal access, experience or outcomes.

Decarbonisation: Yes

Potential environmental impacts may arise from new camera and digital infrastructure, secure storage equipment, data retention, specialist travel and additional procurement; however, improved digital information sharing and remote assurance may reduce duplication, paper use and avoidable travel. Options appraisals and business cases should include whole-life carbon, energy use, sustainable procurement, equipment reuse and disposal, and opportunities for remote participation, while ensuring that carbon considerations do not delay essential patient-safety controls.

Welsh Language: Yes

Implementation may affect Welsh-speaking patients, families and staff through revised safeguarding pathways, bereavement information, consent and monitoring communications, speaking-up routes and training materials. All public-facing information and key staff resources should be available bilingually, the Active Offer should be embedded, interpretation and Welsh-speaking support needs should be considered, and any digital solution should provide equivalent Welsh-language access. Compliance should be assessed through the gap analysis and monitored through programme governance.

Report Title:	Cardiff and Vale UHB Hepatitis B&C Elimination Action Plan 2026-2028+	Agenda Item No:	5.1
Meeting:	Quality Committee	Public	X
		Private	
Lead Executive Title:	Executive Director of Public Health		
Report Author/s Title:	Deputy Director of Public Health		
Report Focus Summary – AAA Framework: The AAA framework reflects the overall position of the matter being reported . Select one category only and complete the relevant box with a brief summary . A useful guide can be found here: NHS Triple A Guide			
ALERT (Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).			
ADVISE (Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)			
ASSURE (details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)			
This report presents the draft Cardiff and Vale Hepatitis B&C Elimination Action Plan 2026-2028+ for approval. The Plan presents evidence of extensive coordination and collaboration between services from CAVUHB, local authorities and the third sector. The Welsh Government have committed to following the World Health Organisation's (WHO) ambition of eliminating hepatitis B&C as a public health threat by 2030 and require all health boards to have Action Plans to meet this ambition.			

Board/Committee Response Required (please select only one)			
Assurance		Approval	X
		Information/Noting	
Recommendations			
The Committee is asked to:			
Approve the Cardiff and Vale UHB Hepatitis B&C Elimination Action Plan 2026-2028+			
Governance Route (please list all other Committee/Groups this report has been to)			
Where it's been:	N/A		
When it went:			
What decision was made:			
Main Report			
<i>Background & Current Situation</i>			
This Action Plan has been developed to coordinate resources and activity in the CAVUHB area to support the elimination of hepatitis B and C as a public health threat by 2030, in line with Welsh Government and WHO ambitions. The Action Plan follows on from previous iterations that have sought to maintain progress to preventing infection through advice and harm reduction and vaccination, case finding for hepatitis B and C, and treatment of hepatitis C. The Plan has been drafted through extensive engagement with health board, local authority and third sector services who are members of a Cardiff and Vale			

Hepatitis B&C Elimination Oversight Group, chaired by the Deputy Director of Public Health.

Priority Topics identified for action are:

1. Infection Prevention

The plan identifies several prevention challenges:

- Hepatitis B childhood vaccine uptake remains below the desired 95% level in Cardiff and Vale.
- The need to improve the identification and vaccination of household contacts and families affected by hepatitis B.
- Reduced engagement with Needle and Syringe Programmes (NSPs) since COVID-19 requires investigation and service redesign.
- The need for sustainable hepatitis B vaccination pathways for both high-risk populations and staff.

2. Case-Finding and Testing

Key issues include:

- A limited understanding amongst services of some high-risk populations and where they can be reached.
- Testing uptake remains below desired levels in some substance misuse services and healthcare settings.
- The need to ensure positive antibody tests and followed up with confirmatory testing.
- A lack of testing in community pharmacies.
- The need to embed opt-out testing consistently across relevant services.
- A need to improve prison testing and continuity of care after release.

3. Treatment and Engagement

The plan recognises that:

- Vulnerable populations can be difficult to locate and retain in care.
- Delays occur between testing and treatment because of laboratory turnaround times.
- Treatment completion and adherence remain a challenge.
- Peer support programmes are important for maintaining engagement and preventing loss to follow-up.

4. Data and Intelligence

There is a need to:

- Improve surveillance and outcome reporting.
- Better understand the location and characteristics of high-risk populations.
- Strengthen performance monitoring and assurance processes.
- Improve completeness and accessibility of testing, treatment and vaccination data.

In summary, key action areas contained in the Plan are:

Action Area 1: Infection Prevention

1. Review the effectiveness and coverage of outreach services.
2. Re-establish the Peer-to-Peer Harm Reduction Programme and ensure sustainable succession planning.
3. Implement recommendations from the national review of pharmacy and specialist NSP services.
4. Use immunisation barrier analysis to increase hepatitis B vaccine uptake.
5. Develop a sustainable hepatitis B vaccination pathway for staff through Occupational Health and immunisation services.

Action Area 2: Case-Finding and Testing

1. Produce a comprehensive assessment of high-risk populations across Cardiff and Vale, including prevalence and access routes.
2. Explore earlier identification of pregnancies where the father has hepatitis B and improve household contact vaccination.
3. Deliver annual public and professional awareness campaigns.
4. Increase the number of active community pharmacy testing sites.
5. Expand community testing using point-of-care technology.
6. Ensure BBV opt-out screening is fully implemented across all substance misuse services.
7. Establish a sustainable point-of-care testing model in HMP Cardiff.
8. Develop robust pathways to ensure individuals released from prison continue treatment, vaccination and screening in the community.
9. Expand opt-out testing in hostels and homelessness services.
10. Explore further opportunistic point-of-care testing approaches.
11. Complete and evaluate the Emergency Department opt-out BBV testing pilot at UHW.
12. Develop targeted testing and prevention activity priority groups.

Action Area 3: Treatment

1. Secure future commissioning and funding arrangements for the Hepatitis C Trust Follow Me Peer Programme beyond 2026/27, informed by service evaluation findings.

Appendices:

- Cardiff and Vale University Health Board Hepatitis B & C Elimination Action Plan 2026-2028+

Strategic Alignment – Shaping Our Future Wellbeing:

 Putting People First	X	 Providing Outstanding Quality	X
 Delivering in the Right Places	X	 Acting for the Future	X

Impact Assessment

Risk: No

Safety: Yes

The Action Plan includes details for service coordination and improvement within existing quality and safety governance arrangements.

Financial: No

The Plan includes suggested service development needs, however there is no request for additional funding through this process. Any need to service development and managing financial implications will follow the usual approval processes for the relevant organisation.

Workforce: No

Legal: No

Reputational: No

Socio Economic: No - <https://www.gov.wales/socio-economic-duty-guidance>

Equality & Health: Yes

Addressing health inequalities was a core consideration during the development of this Action Plan. The issues and activity detailed in the Plan aim to reduce inequity and provide services to those at greatest need.

Decarbonisation: No

Welsh Language: No

Report Title:	Cardiff and Vale UHB Pandemic Response Plan	Agenda Item No:	5.2
Meeting:	Quality Committee	Public	X
		Private	
Lead Executive Title:	Executive Director of Public Health		
Report Author/s Title:	Deputy Director of Public Health		
Report Focus Summary – AAA Framework: The AAA framework reflects the overall position of the matter being reported . Select one category only and complete the relevant box with a brief summary . A useful guide can be found here: NHS Triple A Guide			
ALERT (Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).			
ADVISE (Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)			
ASSURE (details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)			
This Plan complements existing CAVUHB Plans developed to support the management of business continuity and major incidents. It builds on established structures and provides a framework for mobilising a resilient and proportional response to the next pandemic. Priority areas for consideration in the different phases of a pandemic are outlined and action cards are provided for those leading key groups.			

Board/Committee Response Required (please select only one)				
Assurance		Approval	X	Information/Noting
Recommendations				
The Committee is asked to:				
Approve the revised Pandemic Response Plan for Cardiff and Vale UHB.				
Governance Route (please list all other Committee/Groups this report has been to)				
Where it's been:	N/A			
When it went:				
What decision was made:				
Main Report				
<i>Background & Current Situation</i>				
The development of a Cardiff and Vale UHB Pandemic Response Plan is necessary to set out a framework for the response to a future pandemic that is adaptable, resilient and uses structures familiar to staff from other emergency plans and policies to aid its appropriate activation. The Plan incorporates learning identified during the COVID-19 pandemic, published reports from the COVID-19 Public Inquiry and Exercises carried out at an all Wales and UK level. The revision has been informed through engagement with health board services, local authorities and representatives of the third sector locally. The importance of involving the third sector in reaching and supporting under-served communities was critical during the COVID-19 pandemic response and that is reflected in the revision.				

The COVID-19 Public Inquiry has published the reports from 5 modules so far:

1. Resilience and preparedness
2. Core decision making and political governance
3. The impact on healthcare systems
4. Vaccines and therapeutics
5. Procurement

As additional Inquiry reports, or findings from the UK wide Exercise Pegasus, are published there may be a need to further review this Plan.

Incorporated in this revision are important learning points taken from the published COVID-19 Inquiry reports:

- Preparedness must be a whole system responsibility
- Processes to support healthcare capacity must be activated promptly
- The importance of workforce wellbeing
- National infection prevention and control advice must be agile
- Data, intelligence and risk assessment elements need improvement
- Inequalities must be central to emergence planning
- Care planning needs stronger safeguards

The Plan follows the principles of established CAVUHB EPRR documents – such as the Business Continuity Plan and Major Incident Plan – to ensure staff are familiar with the framework provided. The usual command and control escalation process is followed – Bronze (operational); Silver (tactical); and Gold (strategic).

It is likely that escalation to a pandemic response will evolve over a number of weeks. Welsh Government / Office of the CMO, with support from Public Health Wales, will liaise with other UK Nations on appropriate response levels. CAVUHB will be supported in its decision making by National Guidance / Direction.

A number of Task and Finish Groups are described at Bronze (operational) level. These are based on experience during the COVID-19 pandemic and cover core activity areas essential to a resilient response that can be sustained for the required period of time. Each Group has an associated Action Card to describe appropriate responsibilities. These can then be adapted should the need arise due to an evolving situation / novel pathogen being encountered.

The Plan will be reviewed on a 3 year cycle, as is usual for EPRR documentation, to ensure it remains fit for purpose.

Appendices:

- **Pandemic Response Plan for Cardiff and Vale UHB v1.0 final**

Strategic Alignment – Shaping Our Future Wellbeing:

 Putting People First	X	 Providing Outstanding Quality	X
 Delivering in the Right Places	X	 Acting for the Future	X

Impact Assessment

Risk: No

Safety: Yes

The response to a future pandemic would require the health board to adapt to changing demands and service constraints. The Plan sets out a framework for enabling patient safety to be appropriately managed using available, established, processes.

Financial: No
Workforce: No
The contents of this Plan align with existing Plans, such as the Major Incident Plan. Any implications for the CAVUHB workforce is managed within the arrangements outlined, or through normal workforce training and deployment arrangements.
Legal: No
Reputational: Yes
CAVUHB will be required to respond to a future pandemic based on the learning identified from the COVID-19 response and subsequent civil contingency planning and Exercises carried out in Wales and across the UK. This revised Plan included lessons identified from Exercises and available reports from the COVID-19 Public Inquiry.
Socio Economic: No - https://www.gov.wales/socio-economic-duty-guidance
Equality & Health: No
The Plan recognises the need to address inequality references health impact assessment. However, the Plan itself provides a framework for a pandemic response, rather than specific actions or developments that are needed to meet individual or community needs.
Decarbonisation: No
Welsh Language: No
The Plan provides for the convening of a Communications and Engagement Task and Finish Group that would consider how to communicate / engage with our communities and provide information in Welsh.

Report Title:	Public Health Wales Sexual Health Incident - Update	Agenda Item No:	5.3
Meeting:	Quality Committee	Public	X
		Private	
Lead Executive Title:	Executive Director of Public Health		
Report Author/s Title:	Deputy Director of Public Health		
Report Focus Summary – AAA Framework: The AAA framework reflects the overall position of the matter being reported . Select one category only and complete the relevant box with a brief summary . A useful guide can be found here: NHS Triple A Guide			
ALERT (Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).			
ADVISE (Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)			
Public Health Wales (PHW) deliver a number of national sexual health services. These include the Test and Post sexual health testing service. Since November 2025 PHW have been investigating a number of issues relating to the service and have briefed health boards on a confidential basis on the matters identified. This report provides an update to Committee on the matters released by PHW to date and actions taken as they affect residents of Cardiff and Vale and the services that CAVUHB provides.			
ASSURE (details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)			

Board/Committee Response Required (please select only one)					
Assurance		Approval		Information/Noting	X
Recommendations:					
The Committee is asked to be assured that: 1. Improvements made by PHW to their Test and Post service has addressed concerns and risks relating to service quality and safety. 2. Cardiff and Vale UHB Department of Sexual Health and Safeguarding Team responded appropriately and in a timely fashion to PHWs request to review safeguarding referrals incorrectly initially made by PHW.					
Governance Route (please list all other Committee/Groups this report has been to)					
Where it's been:	Quality Committee				
When it went:	14 April 2026				
What decision was made:	For noting				
Main Report					
Background & Current Situation					
An initial paper on this matter was presented to the Quality Committee on the 14 April 2026. This update provides further information and a summary of issues					

identified and measures taken to rectify them, based on updates from Public Health Wales (PHW).

As reported to Committee on 14 April PHW notified partners, including health boards on an initial incident relating to their “Test and Post” sexual health testing service.

This first incident (Incident 1) reported three issues:

1. Child and Adult Safeguarding

- Safeguarding concerns were incorrectly sent to Health Boards rather than Local Authorities, breaching statutory duties.
- The screening tool for 16–17-year-olds was not validated for online use and may not have effectively identified exploitation or abuse risks.
- Users could bypass safeguarding checks by self-declaring themselves over 18 without verification.
- The service had no process to identify adults at risk, meaning risks to vulnerable adults may have been missed.

2. Patient Safety Concerns

- Instances of false positive results occurred when positive notifications were sent after earlier negative laboratory results.
- The testing and result-processing pathway relied heavily on manual processes, increasing the likelihood of error at multiple stages.

3. Information Governance Issues

- Personal identifiable information (PII) was emailed to the wrong Health Boards.
- Referral documentation contained incorrect or mixed patient details, including data for more than one patient.
- Incomplete and insufficient data protection impact assessment (DPIA) has resulted in significant risks not being identified or mitigated.

A second update and briefing (Incident 2) was subsequently issued by PHW, providing details on another identified concern:

4. Omission of Hepatitis C testing for self-declared HIV individuals

- Between the launch of the Sexual Health Test and Post service in May 2020 and 25 February 2026, it was identified that service users who declared themselves HIV-positive and requested a blood test did not receive Hepatitis C (HCV) testing, despite the testing portal implying that HCV testing was included.
- The omission affected 258 individuals in Wales, with 136 having unknown HCV status requiring urgent recall. 114 have subsequently tested negative for hepatitis C and so pose no infection risk. 8 are hepatitis C antibody positive.
- The misleading “all tests negative” text result generated a risk of misinterpretation, false reassurance, and potential ongoing transmission risk.
- The issue stemmed from long standing use of the WA21 blood test code, in place since 2020, which excluded HCV despite service documentation implying the test was included.

In addition, the review found that:

5. Texts messages sent incorrectly

- Text messages with results were incorrectly sent to those who requested that text messages not be received.

PHW convened an Incident Management Team (IMT) in December 2025 to manage the initial safeguarding, patient safety and information governance issues. An additional Look-Back Group was convened by PHW in February 2026 to manage the HCV risks. PHW escalated the matter to an Enhanced Incident in March 2026 and established a Strategic Response Group chaired by their Chief Executive. An external review and expert advisory support has been commissioned to strengthen governance, improve systems and redesign unsafe processes.

PHW has acknowledged that identified weaknesses reflect historical non-compliance, insufficiently detailed DPIAs and system design flaws. PHW recommended that the Test and Post service remain operational, on the basis that suspension would pose greater risk to vulnerable service users who rely on online access for safe and confidential testing.

PHW has issued proactive media releases in response to Incident 1 and 2. No details of the numbers of individuals affected has been included in any public accessed update.

On the 19 August 2026 PHW issued a final briefing, reporting that the Incidents had been closed as on 11 August 2026.

In summary:

- Health Boards in Wales have reviewed all records identified to them by PHW to determine if retrospective Duty to Report referrals needed to be made.
- Data handling and information governance concerns had been addressed through a review of processes and the implementation of significant improvements.
- The failure to test for hepatitis C in those living with HIV. A review by PHW found that these tests had been requested on 540 occasions by 258 individuals across Wales. All those whose hepatitis C status was unknown were contacted by PHW and offered tests via Test and Post or their local health board.
- The text messaging issue was resolved once it had been identified.
- A Chair and panel have been appointed by PHW for the External Review Group and work commenced in August 2026.

Appendices:

(List any appendices that will accompany this report).

n/a

Strategic Alignment – Shaping Our Future Wellbeing:

 Putting People First	X	 Providing Outstanding Quality	X
 Delivering in the Right Places	X	 Acting for the Future	X

Impact Assessment

Risk: Yes

All relevant records relating to the safeguarding element of incident 1 were reviewed by Department of Sexual Health and Safeguarding Team members. Where appropriate referrals were made to the relevant local authority.

Safety: Yes

PHW has reported incorrect or delayed STI including HCV test results which may have caused delays in treatment and misdirected follow up.

With respect to Incident 2, there are 136 service users in Wales, who have been told their results are negative (but for what test is not specified). This cohort and the 8 known positive HCV cases are being contacted by PHW from 30 March 2026 offering an apology and an offer of a new HCV test either using the test and post service or via Health Board blood borne virus team.

Financial: Yes

The work that was requested by PHW of Health Boards created a financial pressure, as the workload associated with clinical review, administration, and safeguarding activity is unfunded and falls outside planned service capacity.

Workforce: Yes

The unplanned demands generated by the PHW Test and Post incident placed pressure on the Department of Sexual Health workforce and operational capacity. Staff were diverted temporarily from core service delivery to undertake retrospective safeguarding reviews, additional clinical assessments and follow-up linked to the identified service failures.

Legal: No

Not for Cardiff and Vale UHB.

Reputational: No

PHW issued media statements relating to these incidents, health board services were not implicated.

Socio Economic: No - <https://www.gov.wales/socio-economic-duty-guidance>

Equality & Health: Yes

Test and Post uptake is highest in more deprived communities, with 23.5% of users in the most deprived quintile. Failures in safeguarding, testing accuracy and follow-up disproportionately impact groups with existing vulnerabilities.

There is a potential widening of health inequalities if high risk or deprived populations experience delayed or incorrect results and a risk of reduced public confidence in digital sexual health services, decreasing engagement among groups most likely to rely on home testing routes.

Decarbonisation: No

Welsh Language: No

Report Title:	Medical Gases Policy		Agenda Item No:		8.1
Meeting:	Quality Committee	Public	X	Meeting Date:	29.09.2026
		Private			
Lead Executive Title:	Executive Director of Nursing				
Report Author/s Title:	CAVUHB Medical Gases Safety Group				

Report Focus Summary – **AAA Framework:**

The AAA framework reflects the **overall position of the matter being reported**. Select one category only and complete the **relevant box** with a **brief summary**. A useful guide can be found here: [NHS Triple A Guide](#)

ALERT (Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).

ADVISE (Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)

ASSURE (details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)

The policy promotes the safe management and delivery of medical gases across CAVUHB.

The completed Equality and Health Impact Assessment identifies an overall positive impact, with the main implementation risks relating to an increase in training requirements for staff with a small financial cost to the UHB

- The policy provides assurance that CAVUHB will comply with NHS Health Technical Memorandum (HTM) 02-01
- It confirms the Medical Gases Safety Group will monitor training compliance and manage concerns in a timely manner
- This policy adheres to the WHC 2024 stipulating that Health Boards must have guidance and training for staff handling and administering medical gases.
- The policy clearly outlines staff roles and responsibilities relating to medical gases.
- It reduces the risk of patient harm when receiving medical gas treatments
- Successful implementation will depend on staff awareness of the policy and new training requirements and competencies to manage medical gases.

Board/Committee Response Required (please select only one)

Assurance		Approval	☒	Information/Noting	
------------------	--	-----------------	-------------------------------------	---------------------------	--

Recommendations

- APPROVE the Medical Gases Policy for implementation across Cardiff and Vale University Health Board.
- NOTE the completed Equality and Health Impact Assessment and the overall positive impact identified.
- NOTE the implementation actions relating to training requirements

Governance Route (please list all other Committee/Groups this report has been to)

Where it's been:	Nursing and Midwifery Board, Consultation period, Capital, Estates and Facilities Safety Group
When it went:	2025/2026
What decision was made:	Approved

Main Report

Background & Current Situation

Following a Welsh Health Circular (2024), all UHB's were required to produce a policy for medical gases focusing on safe management, sustainable procurement, and decarbonisation, particularly reducing nitrous oxide use.

This report seeks Quality Committee approval of the Medical Gases Policy that aims to support staff in the safe handling, storage and administration of medical gases in addition to meeting the WHC requirements

It enables the UHB to adhere to HTM 02-01 for Medical Gas Pipeline Systems.

The policy applies to all UHB employees that transport, store, prescribe and administer medical gases.

Appendices:

- Appendix 1: CAVUHB Medical Gases Policy.
- Appendix 2: Equality and Health Impact Assessment.

Strategic Alignment – Shaping Our Future Wellbeing:

 Putting People First	☒	 Providing Outstanding Quality	☒
 Delivering in the Right Places	☒	 Acting for the Future	☒

Impact Assessment

Risk: No

Safety: Yes

The policy is intended to reduce safety risks linked to storage, handling and administration of medical gases, providing clear guidelines on education requirements, roles and responsibilities, improving both staff and patient safety.

Financial: No

Minimal financial requirements covered in the EHIA

Workforce: Yes

Minimal related to training requirements and awareness. This is covered in the EHIA

Legal: No

Information regarding HTM 02-01 in EHIA

Reputational: Yes

Approval and implementation of the policy provides assurance that the UHB has a clear approach to managing medical gas products.

Socio Economic: No - <https://www.gov.wales/socio-economic-duty-guidance>

This policy does not cause any negative barriers to individuals

Equality & Health: Yes

EHIA completed. It identifies an overall positive impact on patient care, and staff safety when handling medical gases

Decarbonisation: No

This policy enables sustainable procurement, and decarbonisation, particularly reducing nitrous oxide use

Welsh Language: No

Information within EHIA

Report Title:	Volunteering Framework and Operational Procedure 2026-2029	Agenda Item No:	8.2
Meeting:	Quality Committee	Public	X
		Private	
Lead Executive Title:	Executive Nurse Director		
Report Author/s Title:	Assistant Director of Patient Experience		
Report Focus Summary – AAA Framework: The AAA framework reflects the overall position of the matter being reported . Select one category only and complete the relevant box with a brief summary . A useful guide can be found here: NHS Triple A Guide			
ALERT (Highlights areas of significant concern, such as non-compliance, urgent risks, or major issues that require immediate action or that the Board/Committee must be immediately aware of).			
ADVISE (Any areas of ongoing monitoring where an update has been provided to a sub-Committee/Group AND any new developments that will need to be communicated or included in operational delivery)			
ASSURE (details areas where the Board/Committee will receive evidence of effective control, high-quality performance, or improvements)			
The updated 2026-2029 Volunteer Framework and Operational Procedure provides assurance that Cardiff and Vale University Health Board has a comprehensive framework for the recruitment, placement, support, governance and development of volunteers from 2026-2029. The framework aligns volunteering activity with the People's Experience Framework, organisational strategy and national volunteering policy, whilst maintaining robust governance arrangements including role descriptions, risk assessment processes, DBS checks, training, supervision and safeguarding requirements. An accompanying Equality and Health Impact Assessment has identified no significant adverse impacts and confirms that the framework promotes equitable, accessible and inclusive volunteering opportunities.			

Board/Committee Response Required (please select only one)					
Assurance		Approval		Information/Noting	X
Recommendations:					
Committee Members are asked to: 1. Note the updated Volunteer Framework and Operational Procedure. 2. Note the findings of the accompanying EHIA 2026-2029 Volunteer Framework, which identifies no significant adverse equality or health impacts. 3. Note the ongoing development of volunteering opportunities that support patient experience, community engagement and organisational wellbeing across Cardiff and Vale University Health Board					
Governance Route (please list all other Committee/Groups this report has been to)					
Where it's been:	Patient Experience Directorate Management Team and Staff Side				
When it went:	September 2026				
What decision was made:	Endorsed for information to the Quality Committee.				

Main Report

Background & Current Situation

The Health Board recognises volunteers as an integral component of patient experience and values the significant contribution they make in enhancing services provided to patients, families, carers and staff. The updated Volunteering Framework and Operational Procedure 2026-2029 replaces the previous 2020-2025 framework and sets out the strategic direction, governance arrangements and operational requirements for volunteering activities across Cardiff and Vale University Health Board.

The framework is aligned with the Health Board's strategic priorities, the People Experience Framework, Welsh Government Volunteering Policy and the Well-being of Future Generations (Wales) Act.

It establishes clear responsibilities for the Assistant Director of Patient Experience, Head of Patient Experience, Voluntary Services Manager, managers hosting volunteers and volunteers themselves. It also reinforces the principle that volunteer roles complement, rather than replace, the paid workforce.

Key priorities within the framework include:

- Ongoing recruitment and retention of volunteers.
- Expansion and diversification of volunteer opportunities.
- Development of youth volunteering initiatives.
- Strengthening partnerships with third sector organisations, schools, colleges and universities.
- Increasing access and inclusion for underrepresented communities.
- Ensuring robust governance, training, supervision and safeguarding arrangements.
- Enhancing recognition and visibility of volunteer contributions. The framework confirms that all volunteers are recruited through a structured process including application, interview, references, occupational health clearance, DBS checks where appropriate, induction and mandatory training. Clear arrangements are also established for support, supervision, confidentiality, health and safety and reimbursement of expenses. An Equality and Health Impact Assessment has been completed alongside the framework. The assessment concludes that the framework will have an overall positive impact on equality, health and wellbeing, whilst improving access to volunteering opportunities and reducing barriers to participation through the provision of reasonable adjustments, flexible opportunities and reimbursement of expenses where required. No significant negative impacts were identified and no further assessment is required

Appendices:

(List any appendices that will accompany this report).

- **Volunteer Framework and EHIA**

Strategic Alignment – Shaping Our Future Wellbeing:

 Putting People First	X	 Providing Outstanding Quality	X
 Delivering in the Right Places		 Acting for the Future	X

Impact Assessment

Risk: Yes

The framework includes comprehensive governance arrangements including role descriptions, risk assessments, DBS requirements, safeguarding processes, supervision arrangements and management oversight to mitigate risks associated with volunteering activities
Safety: Yes
The framework strengthens patient and staff safety through mandatory recruitment checks, occupational health clearance, training, area induction, safeguarding requirements and health and safety procedures.
Financial: No
The framework formalises existing arrangements. Volunteer expenses continue to be reimbursed in accordance with established Health Board processes and budgets.
Workforce: Yes
The framework supports staff by providing governance for volunteer involvement and confirms that volunteer roles complement rather than replace substantive staff roles. Staff side engagement is embedded in role development processes.
Legal: Yes
<i>The framework supports compliance with the Equality Act 2010, Human Rights Act 1998, Welsh Government Volunteering Policy, Data Protection requirements and safeguarding obligations. Appropriate liability and indemnity arrangements are detailed within the framework.</i>
Reputational: Yes
Effective volunteer governance and positive volunteer experiences contribute to enhanced patient experience and organisational reputation. Robust controls are included to mitigate reputational risks.
Socio Economic: Yes - https://www.gov.wales/socio-economic-duty-guidance
<i>The framework promotes equitable access to volunteering opportunities and seeks to reduce barriers through inclusive recruitment processes and reimbursement of out-of-pocket expenses</i>
Equality & Health: Yes
A full Equality and Health Impact Assessment has been completed. No significant adverse impacts were identified. The assessment concludes that the framework supports equality of opportunity, inclusion and improved wellbeing.
Decarbonisation: No
The framework is not expected to adversely affect decarbonisation objectives. It supports community-based volunteering and sustainable engagement activity.
Welsh Language: Yes
<i>The framework supports the Welsh Language Standards and encourages Welsh-speaking volunteers to use their language skills when supporting patients and service users. Volunteers are able to identify themselves as Welsh speakers and access Welsh language development opportunities</i>

ALERT, ADVISE, ASSURE (AAAs) HIGHLIGHT REPORT

Committee/Group	Safeguarding
Meeting Date	14/07/2026
Lead	Executive Nurse Director
Report by	Deputy Executive Nurse Director

This summary highlights matters arising from the Safeguarding Steering Group held on 15 September 2026 to Quality Committee under the headings of Alert, Awareness and Assurance.

Alert: Safeguarding training compliance and data reliability remain the most significant organisational risks, alongside increasing safeguarding complexity and DOLS pressures.

Awareness: Major changes are underway nationally and locally, including Datix safeguarding referrals, routine enquiry standards, Section 5 arrangements and future external safeguarding funding structures.

Assurance: The Health Board has strengthened governance arrangements, completed quality audits, re-established safeguarding oversight within Clinical Boards and has a clear improvement programme underway to address identified risks

The Safeguarding Steering group minutes of meeting held on 14 July 2026 have been approved and are for noting to Quality Committee. The summary below provides detail of the content for Quality Committee.

The Safeguarding Steering Group provides **partial assurance** that the identified safeguarding risks are recognised and being actively managed through case reviews, targeted audits, revised training arrangements, Clinical Board action planning and strengthened governance oversight. However, full assurance cannot yet be provided until there is clearer evidence of accountable ownership, delivery against timescales, sustained improvement and demonstrable impact. Safeguarding Steering Group will monitor this.

ALERT

(Alert the Committee to areas of non-compliance or matters that need addressing urgently)

Safeguarding activity and open cases: Several Clinical Boards reported increasing or sustained referral activity. Medicine's MARF referrals increased in May/June, with **nine open Section 5 cases**; Children and Women recorded **160 referrals in May and 180 in June**; and CD&T increased from **12 child referrals in May to 20 in June**.

Historic cases requiring closure: Surgery and PCIC identified long-standing adult safeguarding cases that require review and, where appropriate, formal closure.

Training compliance: Medical workforce attendance is adversely affecting safeguarding compliance in Surgery and Medicine. Medicine reported Level 3 compliance at **15.96%**; Children and Women reported Level 3 adult and child compliance at **50%**, and VAWDASV Group 2 attendance at **40%**. MCA compliance in PCIC reduced from **74% to 70%**, with a slight decline also reported in CD&T.

Data quality: Concerns remain that ESR may not be accurately recording

safeguarding training, potentially weakening the reliability of assurance data.

Learning from serious cases: Reviews of two high-profile Prevent cases identified failures in mental healthcare, information sharing and understanding of risk. The RH case also identified missed opportunities relating to repeated non-attendance, severe obesity, self-neglect, safeguarding escalation, carers' needs and capacity/autonomy assessments.

Representation: Mental Health was not represented at the meeting, and the Steering Group membership/invite list requires review.

ADVISE

(Detail here any areas of on-going monitoring where an update has been provided to the subcommittee AND any new developments that will need to be communicated or included in operational delivery)

Clinical Board actions: Boards are expected to review historic open cases, develop MCA and consent action plans, identify barriers to training and assessment completion, and submit updated membership nominations for the Steering Group.

Prevent follow-up: Safeguarding support is required to translate the recommendations from the two Prevent reviews into allocated organisational actions.

Training oversight: The safeguarding team is addressing ESR data concerns, monitoring monthly Level 3 capacity and developing targeted bespoke training informed by audit findings.

Steering Group development: The agenda will be redesigned around organisational risk, cross-cutting themes, statutory compliance, escalation and assurance; Cardiff Inclusion Service will be invited.

National developments: Priorities include executive-level VAWDASV training, stronger primary care links, updated PRUDiC arrangements, implementation of the All-Wales safeguarding performance framework, an October Datix module launch and new guidance concerning pregnancy in children under 13.

Forward plan: Task and Finish Groups are due to commence in September and report to the Steering Group in November. The Cardiff Adult Services update was deferred, and a new Consent Lead is due to start on 3 August 2026.

ASSURE

(Detail here any areas of assurance that the committee has received)

Governance: The meeting was quorate, previous minutes were approved, and the earlier action log was reported as complete.

Training improvements: Safeguarding compliance improved across most areas; the new combined full-day Level 3 adult and child programme has received positive feedback and should improve accessibility. Monthly sessions are now in place and demand is being monitored.

Local improvements: Specialist Services reported increased compliance across all training. Children and Women reported Level 2 compliance of **84% for children** and **81% for adults**, with attendance improving following tighter mandatory training controls.

Patient safety: A full review of the RH case has been agreed, supported by internal reviews across all involved departments to identify missed opportunities and learning.

Referral quality: The AMAT audit has commenced, reviewing five randomly selected MARFs from each Clinical Board. Early findings from Children and Women, including CAMHS referrals, were positive and showed strong capture of the child's voice.

Pressure damage: PCIC reported 115 incidents, with none identified as healthcare

acquired or avoidable.

Resources and communication: Prevent is included in Level 3 safeguarding training, supervision briefings and newsletters. A seven-minute DoLS briefing has also been circulated and made available on SharePoint