Public Quality Committee

14th April 2026
14:00pm via MS Teams

Public Agenda

1. **14:00**	**Standing Items**	**Lead**
1.1	Welcome, Introductions & Apologies:	Ceri Phillips
1.2	Declarations of Interest	Ceri Phillips
1.3	Minutes of the Quality Committee Meeting held on 03.03.2026	Ceri Phillips
1.4	Action Log – Following the meeting held on 03.03.2026	Ceri Phillips
1.5	Chair's Actions taken since last meeting - *none*	Ceri Phillips
2 **14:05**	**Items for Review & Assurance**	
2.1 *10 mins*	EPMA Programme Trajectory and Data	Elaine Lewis / Rhodri Clyburn
2.2 *10 mins*	Prevention of Future Death (PFD) Response	Angela Hughes
2.3 *10 mins*	Royal College of Psychiatry Review Update from the Mental Health Clinical Board (MHCB)	Rachel Dix / Rim Al-Samsam
2.4 *10 mins*	Equity, Equality, Experience and Patient Safety Action Plan - Six Month Update	Claire Beynon
2.5 *10 mins*	JACIE Inspection Report Update	Jess Castle
2.6 *10 mins*	Structured Assessment, Internal Audit, Targeted Intervention De-escalation Criteria Overarching Quality Improvement Plan	Natasha Goswell / Jason Roberts
3. **15:05**	**Items for Approval / Ratification**	
3.1 -	Policies – *no policies for approval*	
3.2 -	Quality Committee Annual Report	Matt Phillips
4. **15:05**	**Items for Noting & Information**	
4.1 -	Minutes from Clinical Board QSE Sub Committees - *standing item*	Jason Roberts
4.2 -	Safeguarding Steering Group Minutes – *standing item*	Jason Roberts
4.3 -	IP&C Group Minutes – *standing item*	Jason Roberts
4.4 *10 mins*	Public Health Wales Sexual Health Incident	Claire Beynon
5. **15:15**	**Items to bring to the attention of the Committee**	Ceri Phillips
6.	**Agenda for the Quality Committee Private Meeting:**	
	i. Private Minutes & Actions *ii. Any Urgent / Emerging Themes – Verbal (Confidential Discussion)* *- standing item -10 mins - Execs*	Ceri Phillips
7.	**Any Other Business**	Ceri Phillips

8.	**Review of the Meeting**	Ceri Phillips
9.	**Date & Time of Next Meeting:** 2nd June 2026 at 9am via MS Teams	Ceri Phillips

Draft Minutes of the Public Quality Committee

Held on 3rd March 2026 via MS Teams

To view the meeting: Cardiff & Vale University Health Board Public Quality Committee Meeting 03.03.2026

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Clive Curtis	CC	Independent Member - Community
Rhian Thomas	RT	Committee Vice Chair / Independent Member – Capital & Estates
Kirsty Williams	KW	UHB Chair
In Attendance		
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Natasha Goswell	NG	Deputy Executive Nurse Director
Angela Hughes	AH	Assistant Director of Patient Experience
Matt Phillips	MP	Director of Corporate Governance
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Claire Beynon	CB	Executive Director of Public Health
Paul Bostock	PB	Chief Operating Officer
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
David Fluck	DF	Executive Medical Director
Additional Attendees		
Lauranne Cullen	LC	Regional Director for Llais
Jessica Castle	JC	Director of Operations – Specialist Services Clinical Board
Helen Griffith	HG	Senior Health Promotion Specialist
David McRae	DM	Lead Pharmacist
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Suzanne Rankin	SR	Chief Executive Officer
Judi Rhys	JRH	Independent Member – Third Sector
Stephen Riley	SR	Independent Member – University

QC 2026/03/1.1	**Welcomes, Introductions & Apologies** Ceri Phillips (CP), the Committee Chair, welcomed everyone to the meeting in English & Welsh. Apologies for absence were noted.	ACTION
QC 2026/03/1.2	**Declarations of Interest** No declarations of interest were raised.	
QC 2026/03/1.3	**Minutes of the Committee meeting held on 20.01.2026** The minutes of the Committee meeting held on 20.01.2026 were received.	

	The Committee resolved that: a) The minutes of the meeting held on 20.01.2026 were approved as a true and accurate record of the meeting.	
QC 2026/03/1.4	**Action Log following the Meeting held on 20.01.2026** The Action Log following the Meeting held on 20.01.2026 was received and discussed. **The Committee resolved that:** a) The Action Log from the meeting held on 20.01.2026 was noted.	
QC 2026/03/1.5	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QC 2026/03/2.1	**Audit / Escalation Update (to include ref to Quality & Safety Governance and Structured Assessment 2025)** Jason Roberts (JR), the Executive Nurse Director, summarised the following: • NHS Wales Shared Services Partnership Audit and Assurance Services were commissioned, initially by the former UHB Chair and supported by the Chief Executive Officer, to review their clinical and quality governance arrangements. This followed the theatre review which highlighted insufficient oversight within the Surgery Clinical Board, particularly around understanding when things went wrong. • Although the audit began with Surgery, the scope was later expanded to include Medicine Clinical Board. • Key objectives included assessing the organisation's current governance structures, whether policies and procedures reflected these structures, the timeliness and clarity of reporting from Clinical Boards to Quality Committee, and staff understanding of governance and escalation responsibilities. • Overall, the established Quality and Safety Governance arrangements broadly aligned with other Welsh UHBs. They had a Quality and Safety Framework (2021-26), though it had not been formally reviewed during this period. The audit found inconsistent and delayed reporting through Clinical Board structures, a lack of standardised reporting templates, and some staff uncertainty around personal escalation duties. • The report identified improvement opportunities, mainly around good housekeeping (e.g. creating clearer organograms), defining governance pathways and roles, and ensuring improvement plans were held on the AMAT system for ongoing monitoring. • Wider UHB governance was also reviewed, influenced by the UHB's increased Targeted Intervention status in Autumn 2025. Recommendations included aligning integrated reports to strategic portfolios, strengthening Duty of Candour and Duty of Quality reporting, and continuing to embed our Quality Management System (QMS). • The internal audit aligned with the timing of their targeted intervention work. The team were working through these findings as part of the deescalation framework, and an improvement plan would be brought to the following Committee. Matt Phillips (MP), the Director of Corporate Governance, added the below: • Both audit reports had been through the Audit & Assurance Committee.	

	• The main question was how they would know the actions were being delivered. There was overlap with the escalation framework, which would sit within a specific quality improvement plan. • All audit actions were logged and tracked through AMAT. Rhian Thomas (RT), the Independent Member – Capital & Estates, asked whether the plans clearly set out who owned each recommendation, along with defined timescales. JR responded that the targeted intervention deescalation plan was structured and would be reported regularly to Welsh Government (WG). The QMS was the organisational thread linking this work and formed part of the *Shaping our Future Quality Excellence* (SOFQE) programme. AMAT enabled assigning responsibilities, tracking progress, and holding people to account. The next step was to pull together a formal improvement plan to bring back and provide assurance. MP noted that the item linked internal and external audit actions with the escalation framework, which they were close to finalising. Once aligned, it would be tracked through the escalation process overseen by the Quality Committee, Finance & Performance Committee, and the UHB Board. Kirsty Williams (KW), the UHB Chair, asked how Independent Members would gain assurance that the plan was being delivered and actions were on track. JR noted some gaps were basic housekeeping, but whether the wider issues stemmed from capacity or capability was not fully clear yet. They needed time to work with Clinical Boards, alongside the ongoing organisational redesign. Clive Curtis (CC), the Independent Member – Community, noted that many actions required stronger admin support, clearer templates, and more consistent scheduling. He asked what the risks were if they did not have the capacity to deliver these improvements quickly. JR responded that they must have the capacity to deliver these actions. Quality, safety and patient experience were as important as any other priority in the organisation, and they were committed to delivering the improvement plan within the agreed timescales. **The Committee resolved that:** A) The contents within the draft advisory audit on the Quality and Safety Governance arrangements within the Health Board was noted; B) The quality aspects of the Draft CAVUHB Structured Assessment 2025 were noted; C) The actions being taken to address the areas identified for improvement were noted for assurance.	
QC 2026/03/2.2 Chilcott.Rachel 08/04/2026 13:36:05	**JACIE Report** Jessica Castle (JC), the Director of Operations – Specialist Services Clinical Board, summarised the following: • The Blood and Marrow Transplant (BMT) programme provided accredited services for South and West Wales and underwent accreditation every 5 years. Following the September 2025 inspection, the latest report (received in January 2026) did not grant automatic reaccreditation, unlike previous cycles. JACIE deferred reaccreditation due to critical deficiencies, although clinical outcomes were noted as strong. • To retain accreditation, they must submit a credible, costed, and timelined corrective action plan to JACIE by 8th July 2026.	

- JACIE assessed over 2000 criteria, identifying 89 areas of non-compliance, mainly relating to:
    - Estates, particularly the adult transplant facilities within the B4 haematology footprint (a recurring issue from previous inspections)
    - Processing facility staffing levels and a lack of formal on-call rotas
    - QMS gaps, including required recruitment and procedure updates
    - Paediatric transplant volumes being very low
    - Workforce deficits from Swansea Bay UHB (SBUHB) elements
- Work was underway in most areas, such as refurbishing the haematology day unit and progressing quality management recruitment.
- However, the major unresolved risk was funding a credible Estates solution for B4 haematology. Previous attempts with WG had shown no viable options within the current footprint.
- Losing JACIE accreditation would have significant consequences, including:
    - Decommissioning of the BMT programme for Cardiff and Swansea Bay (covering ~80% of Wales)
    - Immediate cessation of CAR-T therapy, as manufacturers supply only accredited centres
    - Potential worse patient outcomes if treatment must be sought in England
    - Loss of clinical trial access, reduced recruitment options, and major reputational damage
- Next steps included ongoing work through a Task & Finish Group (T&FG), day unit refurbishment, monthly SLT updates, and a formal meeting with the Joint Commissioning Committee (JCC). A capital solution for the B4 estate was being pursued with WG. The paediatric and SBUHB workforce plans were also in development.

KW noted that the paediatric issues were harder because they stemmed from low patient numbers, which reflected the size of the population. KW asked about the potential consequences for children if this was not resolved.

JC noted that if low activity remained a concern, JACIE would need to decide whether to reaccredit the paediatric component based on the plan the team submits. Any proposal would go through the internal governance process (SLT and likely the Quality Committee) before being sent to JACIE.

Paul Bostock (PB), the Chief Operating Officer, explained there had been ongoing tension between the UHB and JCC around derogations. They had been clear that they would not compromise quality or safety just to secure accreditation. For CAR-T there was no flexibility – without accreditation, they could not provide it.

Regarding paediatrics, PB noted that even if consultants wanted to keep the service and JACIE were willing to relax the standards, they still needed to be confident they could deliver a safe service. In some cases, treatment in England may be the safer option.

JC noted that the threshold was 5 patients a year, and they were below this. Whilst the team was keen to keep paediatrics within the programme, any proposal would need approval from CAVUHB and the JCC.

JC added that they had already discussed whether derogation was appropriate. Paediatrics also fell below JACIE thresholds for bone marrow and apheresis harvest, and they currently had only one nurse able to perform apheresis. They needed a more detailed discussion with the paediatric team about what was feasible.

	RT highlighted that previous inspections had prophesised this outcome. She asked for their reflection on what they should learn from this, and what (whether it be by the UHB or WG) could have done differently to avoid reaching this stage. JC responded that this was a difficult question, but noted the following: • She had been involved since the first inspection in 2012, and the core issue had been aligning what the clinical service needed with a realistic, jointly agreed solution. WG and the UHB had not been on the same page about a deliverable plan. • They had multiple iterations of proposals over the years, similar to wider UHW2 discussions – big long-term plans that subsequently stall. • JACIE had reached the point where they no longer accepted promises without credible, jointly supported, timelined solutions. Understandably this had been frustrating for clinical teams who had repeatedly been told a solution was coming, only for plans to later become unaffordable or misaligned with wider strategies. CC asked that given the risk that losing accreditation could force patients to travel long distances, what assurance could be provided that the action plan would protect equitable access. JC responded that their priority was to retain accreditation and keep BMT and CAR-T services in South Wales. If services did have to move, equitable access would need to be central to JCC's commissioning decisions, with proper patient engagement. Patients already travelled to England for some treatments, but this would require much wider consideration. PB added that this was a commissioned service, and that the JCC must address the questions raised, and CAVUHB would contribute to the solution. KW emphasised that the outcomes of this service were good, despite the limitations. **To escalate the issue of JACIE accreditation to the UHB Board - ACTION** CP asked whether the recruitment issues mentioned in the recommendations related to SBUHB, not CAVUHB. JC responded that two issues were flagged. They were covering a vacancy and upcoming maternity leave in CAVUHB's own quality team, and SBUHB had workforce gaps with reliance on one key individual. A business case was being developed (now included in a letter to JCC) to secure commissioner support for increasing SBUHB's staffing to match CAVUHB. **For an update to come back to April's Quality Committee meeting – ACTION.** **The Committee resolved that:** A) The governance route and reporting frequency for JACIE Action Plan oversight was approved; B) Urgent recruitment underway to essential quality roles was noted; C) Letters sent to CEO NHS Wales, NWJCC and key partners/stakeholders to advise on report outcome and escalate as appropriate was noted.	
	Items for Approval / Ratification	
QC 2026/03/3.1	**Policies** Healthy Eating Standards for Hospital Restaurant and Retail Outlets	

Claire Beynon (CB), the Executive Director for Public Health, summarised the policy which aimed to reduce obesity and health inequalities by mandating that 75% of food sold in internal outlets be classified as healthy, returning from a temporary 65-35 split. The policy excluded inpatient food, which was governed by separate standards. Compliance would be monitored annually and via spot checks.

PB asked what influence they could use for hospital outlets to improve their compliance. Additionally, he asked how they ensured that the healthier options were affordable.

CB responded that they currently included healthy-food wording in the expressions of interest for new tenders, but without a formal policy, they could not require compliance contractually. Adopting the new standards would allow them to build this into future contracts for external outlets.

Regarding affordability, Helen Griffith (HG), the Senior Health Promotion Specialist, noted that they were developing options such as the Wellbeing Wednesday £3.50 staff meal deal, designed with dietetics to be healthy and nutritionally balanced. They were reinforcing that at least one daily meal option must be both the healthiest and the cheapest. Work was ongoing to ensure these options were delivered consistently.

Emma Cooke (EC), the Executive Director of AHPs, Health Scientists and Community Services Development, agreed there was more to be done on affordability. The UHB should offer food that clearly aligned with standards, but there was still some slippage, made more challenging by rising food costs and industry changes.

MP asked for clarification on the scrutiny and governance route.

HG responded that the Healthy Eating Standards Steering Group (with Public Health, procurement, catering, and dietetics) who reviewed progress against the standards and policy and met quarterly. Then members of Public Health, catering, and facilities also attended the Nutrition and Catering Steering Group, where they formally reported progress and sought advice from EC and her team.

EC added that the policy was developed jointly by Public Health and catering teams, but delivery sat with catering. It relied on close collaboration between the groups.

CC asked whether healthy options were also culturally appropriate. He also asked how they would measure if this policy was changing behaviours or improving health outcomes.

CB responded that they could measure success mainly through sales data and compliance with the standards, which is why both were included in the report and brought to this committee annually.

CB noted that measuring the wider health impact was harder. They only had reliable obesity data at age 5, and adult data was self-reported rather than measured. This policy was one part of a broader system, alongside healthier high-street options, limits on unhealthy food advertising, and access to activity and community spaces.

HG added that they were working with wider public-sector partners, but that they needed to demonstrate that they met the standards before influencing others.

Regarding cultural preferences, HG noted the recent health impact assessment recognised there was more to be done. They received frequent requests for halal options, and catering did source halal meat, but they could not advertise it as halal because the

preparation areas were not fully compliant. These issues remained regular agenda items in the Steering groups.

The Committee resolved that:

a) The Policy was approved.

Biological Medicines Value Optimisation Policy

David McRae (DM), the Lead Pharmacist, summarised the policy which mandated prescribing the best-value brand of biological medicines where clinically appropriate, standardised organisational messaging, prohibited pharmacy-level substitution, and established an oversight group and exceptions process.

David Fluck (DF), the Executive Medical Director, noted that they had long used generic prescribing once patents expired, and whilst biosimilars were not identical, they had the same clinical efficacy.

DF asked whether he foresaw further steps that could help accelerate switching, as continued clinician choice could slow progress.

DM responded that further progress depended on the MHRA review, particularly whether they will eventually allow pharmacy-level substitution, which was not permitted. The main factors that slowed switching were drug availability and clinical team capacity. This policy put CAVUHB at the forefront compared with other organisations.

RT commented that she could not gauge the financial scale of the potential savings, as it was not explicit, and suggested strengthening the narrative for patients and clinicians.

DM responded that this had been debated within Pharmacy. These switches did save NHS Wales millions overall, but the amount varied and would not translate into a fixed figure for CAVUHB annually. Therefore, they had chosen to use the broader phrase “millions of pounds”.

DF added that the UHB had saved substantial sums in the past through switching, but this sat against strong lobbying from the pharmaceutical industry to slow the process down. Patients could also react negatively to “cheaper versions”, even though biosimilars were clinically just as effective.

DF explained that they ultimately needed clinician buy-in. When clinicians advocated for the switch, patients trusted the change. Some specialties found switching easier than others. DF was due to meet with the Clinical Director Pharmacy & Medicines Management to discuss this.

The Committee resolved that:

A) The Policy was approved.

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

Alexandra Scott (AS), the Assistant Director of Quality and Patient Safety, summarised the policy which provided a framework for when and how to commission internal or external reviews, ensuring decisions were prudent, consistent, and governed appropriately. The policy was undergoing targeted consultation before wider organisational review.

	KW explained that she could not see a clear step for developing an action plan. AS responded that in developing the policy, they agreed that all reviews would go through the Quality Committee and host their improvement plan on AMAT. This plan would return to the Committee at appropriate intervals until improvements were embedded and could be formally closed. AS explained that she would make this clearer in the Policy. The Committee agreed to note the draft policy and approach, with formal approval deferred until after full organisational consultation and incorporation of feedback.	
QC 2026/03/3.2	**Quality Management System (QMS)** Natasha Goswell (NG), the Deputy Executive Nurse Director, provided the following summary: • The development of the QMS supported the SOFQE programme and aligned with the NHS Wales Performance & Improvement (P&I) QMS framework. • The QMS aimed to provide a consistent, organisation-wide approach to improving quality and safety, supporting the Duty of Quality and Duty of Candour, and strengthening governance and accountability. • A milestone in delivering a QMS required CAVUHB to provide a Position Statement to NHS P&I, along with a Board Development session scheduled for June 2026. There would also be an implementation plan which covered a two-year period. • Progress to date included a Quality Summit in 2023 and a discovery phase throughout 2024. In 2025-26, the project was initiated which established the governance, scope, and branding. A baselining of their current position has been undertaken and will be regularly reported through the Committee. Strong links have been forged with NHS P&I, and they form part of the QMS Learning & Delivery Network. They also had a successful application to become a QMS prototype project within the Cardiology Directorate. • The next steps were noted, including the gap analysis, the development of the implementation plan, a Board Development session, further work to support education, training, and digital integration, and the prototype of a 12–18-month support for Cardiology. Aled Roberts (AR), the Associate Medical Director Patient Safety and Clinical Effectiveness, explained that they were drawing on learning from NHS P&I, the QMS Learning and Leadership Networks, and from organisations both within and outside the health sector. They were also building on strong existing QMS practice within the UHB, including laboratory services and BMT. The Board workshop provided further opportunity to explore this. KW asked for further assurance on how robust the mitigations against the outlined risks were, and how confident they could be in managing those risks where they could not be fully addressed. NG responded that risks and challenges were managed through the SOFQE programme and existing escalation processes. Further clarity would come from the baselining analysis which would help distinguish risks from challenges and identify mitigations. Clinical Boards managed risks through their own risk registers. More detail would be provided as plans developed. CB asked how equity and health inequalities were reflected within the QMS. She suggested to test the integration of equity into the QMS operating model through the Cardiology pilot, using existing equity and equality frameworks and tools.	

	NG responded that the baselining work would provide greater detail across the four QMS domains, including assurance and planning. Equity considerations would be reflected within this framework. JR provided assurance that risks (particularly around digital maturity and capability) had been appropriately escalated through the programme governance, with executive-level decisions underway to identify and release supporting resources. **The Committee resolved that:** A) The progress to date of the QMS was noted for awareness; B) The position statement for QMS ahead of final approval at Board prior to ending to NHS P&I was endorsed for approval.	
QC 2026/03/3.3	**Annual Quality Report 2024/25** AS presented the report and summarised the following: • The UHB was required to publish an Annual Quality Report to demonstrate how the UHB was improving care and outcomes. • The report provided an honest account of challenges and improvement activity, whilst also highlighting successes and innovation. • It was coproduced with patients and the public, structured around the six domains of quality, and included key assurance, safety and improvement programmes. • The report gave oversight of progress around the SOFQE programme, the development of the QMS, the Theatres Together programme, learning from Never Events, and the monitoring of national patient safety alerts and notices. • Designed in an accessible magazine-style format, the report reflected patient perspectives and supported public understanding and engagement. JR explained that the coproduction approach added real value through patient and public involvement. He apologised for the delay in publication due to timing changes and admin issues and assured the Committee that this would not happen in future. CB noted concern that the report presented an overly positive picture and did not sufficiently reflect widening health inequalities or the decline in healthy life expectancy. AS welcomed the feedback and acknowledged that there was scope to strengthen the coverage of population health and inequalities in future reports. CC welcomed the co-produced approach to the report and asked about how patient and community involvement would be further strengthened in future editions. CC also asked for assurance that learning from Never Events and safety alerts was being consistently embedded across all clinical boards, not just those directly affected. AS responded that an update would be provided on work to embed learning from Never Events through the Theatres Together programme, including the WHO Checklist Collaborative, team brief improvements and ongoing audit across multiple services to support organisation-wide learning. Further work on standardising training for interventional procedures was underway, with plans to report back to the Committee. AS confirmed that the coproduction group would continue to shape future reports, with increased use of patient stories to reflect lived experience. **The Committee resolved that:**	

	A) The 2024/25 Annual Quality report was approved.	
	Items for Noting & Information	
QC 2026/03/4.1	**Minutes from the Clinical Board QSE Sub-Committees** JR noted that there had been limited receipt of minutes from Clinical Board Quality and Safety Groups, which was being followed up directly with Clinical Boards. **The Committee resolved that:** A) The Clinical Board QSE Sub-Committee minutes were noted.	
QC 2026/03/4.2	**Safeguarding Steering Group (SSG) Minutes** *The previous SSG meeting was cancelled due to operational pressures and significant sickness.*	
QC 2026/03/4.3	**IP&C Group Minutes** **The Committee resolved that:** A) The IP&C Group minutes were noted.	
	Agenda for Private Quality Committee Meeting	
QC 2026/03/5.1	*i) Minutes and Action Logs from the Private QSE Committee on 20.01.2026* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*	
	Any Other Business	
QC 2026/03/6.1	Prevention of Future Deaths (PFDs) AH provided the following summary of two PFDs received: • The first inquest from February 2026 related to concerns about the reliability of systems used for communicating and acting upon abnormal clinical results. Assurance was given that strong mitigations were in place, with a full response to be brought to April's Quality Committee. • The second was issued on an all-Wales basis, related to a child death from a delay in adrenaline being administered, and highlighted issues with non-standardised resuscitation trolleys. This had been escalated through all-Wales networks to coordinate a response, with a formal response due by June 2026 and would be reported back through the Committee. Microsoft Teams Channels It was noted that Committee papers would now be available via Microsoft Teams, rather than using AdminControl.	
	Date & Time of Next Meeting:	
QC 2026/03/7.1	14th April 2026 at 2pm via MS Teams	

Title	Minute Reference	Agreed Action	Executive Lead	Action Lead	Date Assigned	Date for Review	Action Status	Action Update
JACIE Inspection Report	QC 2026/02/2.2	To escalate the issue of JACIE accreditation to the UHB Board.	Matt Phillips	Jessica Castle, Nathan Saunders	03/03/2026	14/04/2026	ON FORWARD PLAN	Item added to the Forward Plan for the UHB Board meeting being held on the 26th March 2026. Also received by the Strategic Leadership Team on 19.03.2026
JACIE Inspection Report	QC 2026/02/2.2	Update to come back to April's Quality Committee meeting.	Catherine Phillips	Jessica Castle	03/03/2026	14/04/2026	ON FORWARD PLAN	JACIE Inspection Report added to the Forward Plan for the 14.04.2026 Quality Committee meeting.
CD&T Thrombectomy Data	QC 2025/08/2.1	Provide an update to the Committee on the proportion of eligible stroke patients receiving thrombectomy, including benchmarking data, performance data, and trajectory.	David Fluck	Sarah Lloyd	05/08/2025	14/04/2026	COMPLETE	Information circulated via email on the 2nd April 2026 to Quality Committee Members.

Report Title:	EPMA Programme Trajectory and Data				Agenda Item No:	2.1	
Meeting:	Quality Committee		Public	X	Meeting Date:	14.04.2026	
			Private				
Status	Assurance	X	Approval		Information/Noting		x
Lead Executive:	Chief Operating Officer / Executive Medical Director						
Report Author:	Elaine Lewis						

Main Report
Background and Current Situation:

ePMA has now been implemented across over 85% of inpatient settings in CAV UHB. The ePMA team was asked to bring an update to this group to illustrate the trajectory of the programme so far and outline the benefits already being realised across the UHB. The presentation provided illustrates the timeline for implementation so far, highlights the key benefits and achievements and plans for the next 12 months of implementation.

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

- Over 87% of inpatients settings now live
- Over 2 million administrations given
- Over 680,000 prescriptions created
- Plans in place for remaining inpatient settings and then following into outpatients.

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

1. 2.1b - ePMA Go-live Progress April 2026 QSE

Recommendations:

a) To note update provided as requested by previous Quality Committee.

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

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

Five Waves of Working (Sustainable Development Principles) considered:

Prevention		Long Term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?

Yes *(please include the complete QIA document)*		No *(please provide reasoning e.g. not required*	x	We are presenting a short update on ePMA progress for noting

Impact Assessment

Risk: No
Safety: No
Financial: No
Workforce: No

Legal: No	
Reputational: No	
Socio Economic: No	
Equality & Health: No	
Decarbonisation: No	
Welsh Language: No	
Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:

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

ePMA
ELECTRONIC PRESCRIBING AND MEDICINES ADMINISTRATION

Programme Update April 2026

EPMA across CAV so far

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

July 2025

Nephrology & Transplant Directorate (early adopter sites) ~50 beds

October 2025

Cardiothoracics Directorate – 1 day - ~100 beds

November 29th 2025

Surgery Clinical Board UHW – 1 day ~250 beds

January 24th & 25th 2026

UHL site wide – 2 days ~450 beds

March 14th 2026

Mental Health Clinical Board – 1 day ~240 beds

2026/27

Marie Curie Hospice
NICU
Outpatients

Chilcott,Rachel 08/04/2026 13:36:05

September 2025

Neurosciences & Haematology Directorates ~100 beds

November 8th & 9th 2025

Medicine Clinical Board UHW – 2 days ~350 beds

December 9th 2025

Emergency Department

January 2026

St Davids & Barry Hospitals – Medical wards and Minor Injuries Unit

May 2026

ITU
Paediatrics & Obstetrics

2

Progress

First Emergency Department in Wales to use an ePMA system from the front door

First implementation of Nervecentre ePMA into Mental Health setting

Over **85%** of inpatient settings in CAV live within 5 months

Over 2 million medicines administered using ePMA

100% administrations completed with mobile app

93% of patient wristbands scanned at point of administration

Over **5000 users** of the systems across all staff groups

10,000 discharge letters sent from Nervecentre ePMA

Feedback from staff

"I now have more time to speak to the patient about their medicines" Kate Badman - Pharmacy Technician

"I find it's easy to use and it really makes communication between nurses and doctors, and other staff members, much easier." Gladys - Staff Nurse

"I really wasn't looking forward to this, but I've just realised I will never have to look for a lost drug chart again!" Ward Manager

"Documentation on ePMA has given us a platform to record and communicate information that would have previously be lost amongst the vast amount of paper notes" Andrea Griffiths - Senior Technician for Medicines Information and Patient Safety

"Going live with electronic prescribing is changing the culture within clinical environments, improving patient safety, care and treatment. Clinical staff have worked together and are now working safer not harder." Lesley Hewer - DHCW

"The major benefit of ePMA is the trackability, legibility and accountability of practice, which is transformational for patient safety and staff job satisfaction" Davide Compagnone - Advanced Pharmacist in General Surgery and Pre-operative Assessment Clinic

"ePMA is 100% better than paper charts. It is far more time efficient. I like the medicines configuration of dose sentences and protocol folders, which makes prescribing safer" Gunjan Badwaik - Junior Fellow Doctor Neurosurgery

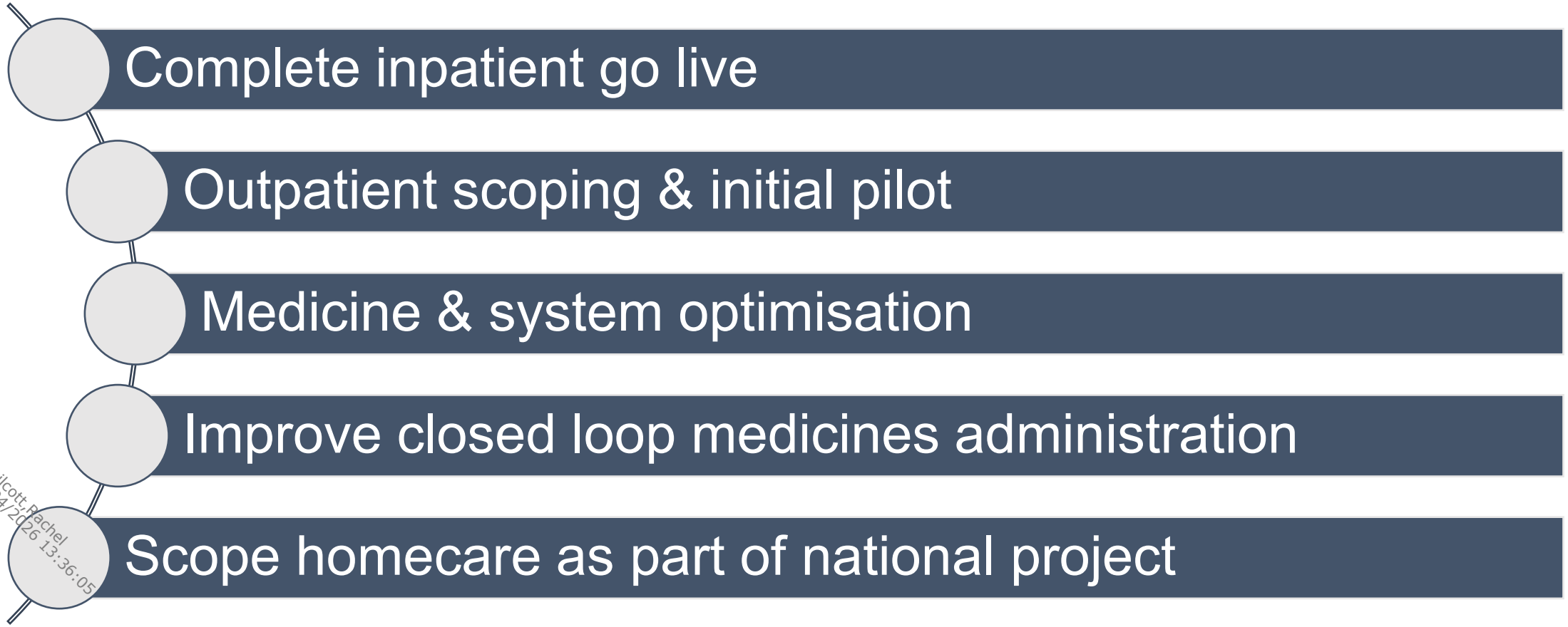
"We can get analgesia prescribed quickly as anaesthetists can prescribe from the theatre and it will instantly appear on the drug chart" Recovery Nurses UHW

"ePMA has modernised medication delivery within our surgical areas, strengthening both safe prescribing and medication identification. It has also improved clarity and accountability, with prescriptions and prescribers now easily identifiable and significantly improving patient safety." Rhian Cottrell – PPDN Surgery

Extra benefits

- Improved compliance with patient identification through wristband use
- Improved oversight and reporting on DAL completion
- ADT tool developed to allow ward staff to accurately record patient movements around the UHB (PMS only)
- VTE risk assessment compliance monitored via Nervecentre
- Temporary account tool developed with plans to broaden use across digital systems

Next 12 months



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Report Title:	Prevention of Future Death (PFD) Response				Agenda Item No:	2.2	
Meeting:	Quality Committee		Public	✓	Meeting Date:	14 April 2026	
			Private				
Status	Assurance	✓	Approval		Information/Noting		✓
Lead Executive:	Executive Nurse Director						
Report Author:	Assistant Director of Patient Experience						

Main Report
Background and Current Situation:

Pleas To inform the Quality, Safety & Experience Committee of the Regulation 28: **Report to Prevent Future Deaths (PFD)** issued by **H.M. Coroner Rachel Knight**, following the inquest into the death of **Mrs Joan Marilyn Read**, and to outline the actions taken and planned by Cardiff and Vale University Health Board in response.

An inquest into the death of **Mrs Joan Marilyn Read**, aged 91, concluded on **3 February 2026**. The medical cause of death included **bronchopneumonia**, **frailty due to B12 deficiency**, and **pernicious anaemia**, with COVID-19 infection and other comorbidities as contributory conditions.

The Coroner identified that a **missed opportunity to communicate a severely deranged Vitamin B12 result** from an admission in **August 2023** meant that treatment was not initiated in hospital or by the community team. When the patient was re-admitted in January 2025, she had significantly deteriorated and sadly died on 18 March 2025.

The Coroner found that the **failure to address the B12 deficiency more than minimally contributed to her death** and issued a Regulation 28 Report on **4 February 2026**, requiring the Health Board to respond by **3 April 2026**.
The PFD focused on two key areas of risk:

1. **Single-consultant model** within the POPS (Perioperative care of Older People undergoing Surgery) service and absence of robust cross-cover.
2. **Risk of missed abnormal/urgent results**, exacerbated by consultant absence and system limitations.

3. CORONER'S MATTERS OF CONCERN
The Coroner highlighted:

- The POPS service is reliant on **one consultant**, with **no cross-cover** during periods of expected or unexpected absence.
- The absence of a **52-week cross-cover rota** increases the risk that deranged or urgent results are not reviewed.
- Despite wider improvements in test result communication, without structural resilience the risk will remain.

4. HEALTH BOARD RESPONSE
The formal response was issued on **13 March 2026** by **Chief Executive Suzanne Rankin**.
The response included condolences to the family and a comprehensive set of **actions already taken** and **actions planned**.

4.1 Immediate Actions / Mitigations (Implemented)
a. Interim POPS Cross-Cover Arrangements

- Abnormal results escalated to the **on-call medical team** where POPS consultant unavailable.
- Urgent findings reviewed by **relevant specialty teams** (e.g., Medicine, Haematology).
- Structured documentation and audit trails now reduce reliance on a single clinician.

b. Strengthened Laboratory SOP for Critically Low B12 Results (<50 ng/L)

- Mandatory **telephone communication** before authorisation.
- Escalation to a **Consultant Haematologist** if clinical team unreachable.
- Comprehensive logging in LIMS.
- Monthly audits from July 2025 show **100% compliance**.

c. Reinforced Use of Welsh Clinical Portal (WCP)

- Senior clinicians must review and acknowledge results.
- POPS Clinical Lead performs **twice-weekly structured checks** of WCP results.

d. Improved Discharge Documentation

- Structured **POPS clinical discharge note** implemented in Oct 2023.
- 100% completion rate recorded in Sept 2025 audit.

5. Planned / Strategic Actions (In Progress)

5.1 POPS Service Expansion

Despite financial constraints, expansion of the POPS consultant workforce remains a strategic priority:

- Development of a **consultant cross-cover rota**.
- Workforce expansion to ensure **52-week continuity**.
- Appointment of a **Clinical Nurse Specialist (CNS)** is underway.
- Strengthening senior decision-making resilience across emergency and surgical pathways.

6. GOVERNANCE, ASSURANCE & MONITORING

- Monthly audit of critically low B12 results continues to show **full compliance**.
- Twice-weekly POPS system checks provide enhanced oversight.
- Workforce planning for POPS expansion is incorporated into IMTP workforce and quality priorities.

A summary action table is available in the response document, showing status and projected completion dates.

7. RISKS

Risk	Current Mitigation	Residual Risk
Delays in reviewing abnormal results	Interim escalation, strengthened SOP, audits	Workforce gap remains until consultant expansion achieved
Over-reliance on single consultant	On-call cover; specialty review; PA/NP support	Sustainable 52-week rota not yet established
Variation in WCP review processes	Twice-weekly checks; strengthened expectations	Reduced but dependent on workforce capacity

CONCLUSION

Significant progress has been made to address the issues raised in the PFD. Immediate risks have been mitigated, system improvements implemented, and monitoring frameworks strengthened. Longer-term resilience relies on the recruitment and establishment of a sustainable POPS workforce model.

The Committee is asked to **note the PFD**, the Health Board's response, and the ongoing work to ensure robust, sustainable cross-cover and safe test result management processes.

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

Response to PFD attached as appendices.

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

1. 2.2b - SWC Regulation 28
2. 2.2c - SR-jb-0326-234 – a copy of the signed response to HMC

Recommendations:

The Quality Committee is asked to:

1. **Note** the Regulation 28 Report and Health Board response.

Link to Strategic Objectives of Shaping our Future Wellbeing:

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

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

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

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

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

GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
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ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Suzanne Rankin, Chief Executive Cardiff & Vale University Health Board**
1	**CORONER** I am **Rachel Knight H M Coroner**, for the coroner area of South Wales Central.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 20 March 2025 I commenced an investigation into the death of Joan Marilyn READ . The

	investigation concluded at the end of the inquest on 03/02/2026 . The conclusion of the inquest was a narrative. The medical cause of death was recorded as follows: **1a Bronchopneumonia** **1b Frailty due to B12 deficiency** **1c Pernicious anaemia** **II COVID 19 infection, hypothryoidism, delirium**
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- Joan Marilyn Read was aged 91 when on 18th March 2025 she died at the University Hospital of Wales, Cardiff. Joan had been an inpatient in August 2023, and was discharged home whilst a blood test result was pending. There was a missed opportunity to communicate a severely deranged B12 result, and as a consequence, it was not treated in hospital, nor in the community. Joan was admitted to the same hospital in January 2025 with a significant deterioration in her physiological reserves, she was frail and had been less compliant with her medication. Sadly, despite all treatment available, Joan did not recover and continued to decline to her death. Joan was treated at the UHW from mid-January until her death on March 18th 2025. It is more likely than not, that the failure to address her B12 deficiency more than minimally contributed to her death. The Inquest focused upon:- - the processes surrounding deranged test results and their onward communication for action
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. (1) Evidence revealed that a single medical consultant is responsible for geriatric perioperative care (POPS). There is no cross-cover during periods of expected and unexpected absence. There is

Coroner's Office, The Old Courthouse, Courthouse Street, Pontypridd, CF37 1JW

Phone/Ffôn (01443) 281100 Fax/Ffacs (01443) 485862

	a risk that deranged test results or other urgent results will be missed when that doctor is absent; (2) Without a robust system for cross-cover 52 weeks per year recognised within another doctor's job plan, this risk will likely continue, despite huge positive strides in communicating test results within the Trust.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 3rd April 2026. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to family and the clinician concerned, who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	4 February 2026

Coroner's Office, The Old Courthouse, Courthouse Street, Pontypridd, CF37 1JW

Phone/Ffôn (01443) 281100 Fax/Ffacs (01443) 485862

SIGNED:

Rachel Knight H M Coroner for South Wales Central Coroner Area

Coroner's Office, The Old Courthouse, Courthouse Street, Pontypridd, CF37 1JW

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Cardiff and Vale University Health Board

Executive Headquarters / Pencadlys Gweithredol

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Eich cyf/Your ref:
Ein cyf/Our ref: SR-jb-0326-234
Welsh Health Telephone Network:
Direct Line/Llinell uniongychol: 029 2183 6010

Suzanne Rankin
Chief Executive

30 March 2026

H.M. Senior Coroner Ms R Knight
South Wales Central
Coroner's Office
The Old Courthouse
Courthouse Street
Pontypridd
CF37 1JW

Dear H.M. Coroner Knight

Response to Regulation 28 Report to Prevent Future Deaths - Death of Mrs Joan Marilyn Read

Thank you for your Regulation 28 Report issued on 4 February 2026 regarding the tragic death of **Mrs Joan Marilyn Read**. We wish to express our sincere condolences to Mrs Read's family. We are grateful for the careful consideration given during the inquest, and we fully acknowledge the concerns you have raised regarding risks associated with:

1. **Single-consultant model within the Perioperative care of Older People undergoing Surgery (POPS) service**, and
2. **Risks of missed abnormal or urgent results due to lack of cross-cover and system limitations**.

Cardiff and Vale University Health Board takes these concerns extremely seriously. We have undertaken a detailed internal Patient Safety Review and enacted several improvements, many of which were outlined in the evidence provided by Dr Nia Humphry (Consultant Geriatrician and POPS Clinical Lead). Further actions are planned to reduce risk and strengthen system resilience.

Below we outline the **actions already taken** and **actions planned**, along with timeframes for full implementation.

Requirement: Improving Cross-Cover and Reducing Dependency on a Single Consultant

Whilst we acknowledge there is one consultant it should be noted that a team is in place;

- Nurse practitioner 18 hours / week
- Physician Associate - 37.5 hours - works over 4 days and non-working day is varied according to service needs
- Clinical Fellow - 0.8 WTE.

In addition we are in the process of recruiting a Clinical Nurse Specialist (CNS).

We acknowledge the coroner's concerns regarding the absence of POPS consultant cross-cover and the associated risk of delays in reviewing results or acting on abnormal findings. If further consultant support is needed out of hours, then the on-call service for hospital cover would be contacted **POPS Consultant Cross-Cover – Interim Mitigation (Implemented).**

While recruitment of additional POPS consultant resource is pursued, the following measures are in place:

- Abnormal results identified by non-medical staff are escalated to the **on-call medical team**.
- Urgent diagnostic findings where the POPS consultant is unavailable are reviewed by the **relevant specialty team** (e.g., general medicine, haematology).
- Use of structured documentation and audit trails reduces reliance on a single individual.

Expansion of the POPS Service – Sustainable Long-Term Plan (In Progress)

Expansion of the POPS service remains a recognised clinical need. Given organisational financial constraints, this is an ongoing strategic objective, but the Health Board is committed to:

- Developing a cross-cover rota for POPS.
- Prioritising consultant workforce expansion to ensure 52-week service continuity.
- Embedding senior decision-making resilience within emergency and surgical pathways.

Enhancing Discharge Documentation and Information Sharing

Learning from this case has led to major improvements in discharge communication:

POPS Clinical Note System (Implemented October 2023)

A structured clinical note authored at discharge ensures:

- Key assessments, investigations, pending results, and follow-ups are documented clearly.
- Notes are uploaded to WCP, automatically notifying primary care.

- Consultant review ensures accuracy and completeness.

Audit of Compliance

A September 2025 audit demonstrated:

- **100% completion** of POPS clinical notes.
- Some variation in upload timing during consultant leave.

We recognise this variation and expect the introduction of cross-cover arrangements to eliminate delays fully.

Requirement: Improving Communication and Management of Abnormal Results

Strengthened Laboratory SOP for Critically Low B12 Results (Implemented)

Following the incident in August 2023, the Haematology Laboratory undertook a full review of its processes and subsequently revised the standard operating procedure for urgent Vitamin B12 results <50 ng/L. The strengthened protocol now requires:

- **Mandatory telephone communication** of critically low B12 results before authorisation.
- **Escalation to a Consultant Haematologist** if the clinical team cannot be reached.
- **Comprehensive electronic documentation** of all attempts to contact the ward or clinical teams.

Monthly Quality Audit – Providing Assurance

A monthly audit process has been established within our quality system to review all results <50 ng/L and confirm that a documented telephone call has been made in every case. The first audit, completed in July 2025, demonstrated **100% compliance**, providing assurance that the revised process is being followed reliably.

Further Strengthening of the Procedure

To enhance safety and clarity, the procedure has been further updated to ensure that:

- Any difficulty in passing on a result triggers **mandatory escalation to the Consultant Haematologist or their deputy**, and
- The telephone log includes more detailed documentation, including the nature of the discussion and the individual to whom the result was communicated.

The revised procedure now states:

"Vitamin B12 <50 µg/L first time. Do not authorise the B12 result until it has been telephoned to the requestor. If unable to contact the requestor, discuss the urgency of the result with the clinical director or deputy. Record all attempts

at telephoning results in the phone log on LIMS. Record outcome even if engaged, no answer or patient not known to location."

Over the past six months, there have been two occasions where difficulty contacting the clinical team was encountered. In both instances, escalation occurred as required, the Consultant Haematologist was involved, and the clinical teams were successfully contacted. This provides additional assurance that escalation processes are effective in practice.

These measures collectively ensure that critically low Vitamin B12 results are communicated promptly and appropriately to the clinical team.

A **monthly audit process** is now in place and early audits show **100% compliance**.

Routine Electronic Communication via Welsh Clinical Portal (WCP) – Reinforced Use

We have strengthened expectations that senior responsible clinicians must:

- Review results within the WCP "Results" tab,
- Acknowledge or comment on findings,
- Ensure timely clinical action.

The POPS Clinical Lead now performs **twice-weekly structured checks** of the WCP system to ensure abnormalities are identified even if not flagged automatically.

Timetable of Actions

Action	Status	Completion Date
Revised B12 SOP & monthly audit	Complete	In place since July 2025
Twice-weekly POPS review of WCP results	Complete	October 2023
POPS clinical discharge note system	Complete	October 2023
POPS expansion workforce plan	In progress	CNS will be appointed

We thank you for bringing these matters to our attention and for the opportunity to outline our response. Should you require any clarification or further assurance, we would be pleased to provide it.

Yours sincerely

Suzanne Rankin
Chief Executive

Report Title:	Royal College of Psychiatry Review Update from the Mental Health Clinical Board (MHCB)				Agenda Item No:	2.3	
Meeting:	Quality Committee		Public	X	Meeting Date:	14.04.2026	
			Private				
Status	Assurance	x	Approval		Information/Noting		
Lead Executive:	Executive Nurse Director						
Report Author:	Interim Deputy Director of Nursing Mental Health						

Main Report

Background:

The Royal College of Psychiatrists' report was commissioned by Cardiff and Vale University Health Board following six suspected inpatient suicides at Hafan y Coed between May 2021 and February 2022. These incidents occurred within a nine-month- period during the second year of the COVID19 pandemic and were considered unprecedented in the recent history of the service. The Health Board sought independent external assurance regarding the standard of care provided to the six individuals, alignment with national inpatient mental health standards, the quality and robustness of internal serious incident investigations, and whether -pandemic related- service changes may have contributed to the deaths. The report was finalised May 2024.

All six individuals were men. Five deaths occurred while individuals were inpatients, and one death occurred within one hour of discharge. All deaths were by violent means. The events took place during a period of significant operational disruption, including ward reconfiguration, increased patient movement, staffing pressures, reduced visiting, and other infection control- measures associated with the COVID-19 response. This report provides an update on the areas of concern identified: risk assessment, care and treatment planning, therapeutic engagement, continuity of care, diagnosis, treatment and Mental Health Act, Observation Practice, SIRAN accreditation and leadership.

Risk Assessment:

Summary of concern: The review identified serious and recurring concerns in the quality and consistency of risk assessment and risk management across all six cases. Risk assessments were frequently static, insufficiently individualised, and poorly informed by information already known within community teams. There was limited evidence that environmental risks on the wards were actively assessed, and attention was often focused on risks to others or self-neglect- rather than risk to self. Indicators of hopelessness, a known critical risk factor for suicide, were not consistently recognised or explored. Most notably, there was no evidence in any case of co-produced safety planning with patients. The review concluded that there was an implicit and unfounded assumption within care processes that admission to hospital reduced suicide risk.

Actions: At the time of the incidents, a risk assessment tool known as *Form 4* was in use. This was a tick box- tool that did not support comprehensive clinical risk formulation. As a result, the Mental Health Clinical Board (MHCB) moved away from Form 4 and adopted WARRN (Welsh Applied Risk Research Network) as the baseline risk formulation tool.

To support this change, the Clinical Risk Assessment and Management Policy was reviewed to reflect current practice. This policy underwent a further review in February 2026, incorporating additional guidance on Person Centred Safety Planning and risk management informed by audit outcomes. Ongoing WARRN audits are in place to provide assurance and support continuous improvement. The MHCB will also continue to work collaboratively with NHS organisations across Wales to support the development of risk management practice and contribute to an emerging All

Wales position. In addition, there is a planned trans-ition of audits to AMaT to further strengthen process assurance.

The MHCB has also committed to Suicide Awareness and Mitigation Training (SAMT) for all clinicians. Safety plans are now routinely offered to all patients identified as being at risk of suicide at the point of assessment. This approach has been fully embedded into practice and is reflected within current policy (ratified Feb 2026)

Care and Treatment Planning:

Summary of concern: Deficiencies were also identified in care planning and formulation. Care plans were often generic and failed to reflect individual needs or identified risk factors. Psychological formulation was largely absent, and care planning rarely drew together biological, psychological, and social factors in a meaningful way. There was limited evidence that patients were provided with copies of their care plans.- Multidisciplinary discussions and ward rounds were inadequately documented, making it difficult to determine the quality of -decision making, patient involvement, or consideration of family perspectives. For individuals with repeated admissions, there was no clear overarching or strategic management plan, with care focused instead on -short-term objectives-.

Actions*:* The ward round template has been reviewed and embedded within a process of ongoing continuous improvement. This review explicitly strengthens the involvement of patients and families in care planning, ensuring that care and treatment decisions are made collaboratively. As part of pre--ward round discussions, *"No Decision About Me Without Me"*- booklets are routinely used to support meaningful patient engagement and shared -decision-making-, with care planning taking full account of individuals' biopsychosocial needs.

A sample selection of Care and Treatment Plans are audited on a quarterly basis, with returns submitted to NHS P&I. This audit programme has also been incorporated into Tendable to support regular assurance checks across key areas, including the use of SMART goals, the development of clear and achievable objectives, and evidence of co-produced care plans.

In addition, a Risk Reference Panel has been commissioned to provide enhanced clinical oversight. This forum enables clinical teams to bring forward cases where management plans and longer-term objectives- require wider consideration than is typically available through routine multidisciplinary team (MDT) discussions.

The MHCB has appointed a CTP lead to deliver an Improvement Project focused on strengthening the quality, safety and legal compliance of Care and Treatment Plans in line with the Mental Health (Wales) Measure 2010. The project responds directly to staff feedback, policy review and audit findings, aiming to improve CTP quality, role clarity, MDT ownership and therapeutic use.

Baseline multi-professional questionnaire evidence showed that while staff value co-production and understand the purpose of CTPs, time pressures, inconsistent MDT involvement, unclear inpatient–community responsibilities and limited training reduce their effectiveness. CTPs not being used as "live" clinical tools was identified as a risk to continuity, safety and service user experience, particularly during transitions of care.

The project delivers an integrated programme of policy, training and governance. A revised CTP Policy clarifies statutory and operational responsibilities and expectations for outcome-focused, co-produced care planning. A new interprofessional training package shifts practice away from

compliance-driven documentation towards therapeutic use, meaningful outcomes, integrated Safety Planning and appropriate family/carer involvement. Implementation is supported through clear governance, audit and feedback mechanisms, reframing CTPs as a core clinical intervention across the MHCB.

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Therapeutic Engagement

Summary of concerns: The review identified serious concerns regarding therapeutic engagement on the wards. There was limited evidence of consistent one-to-one therapeutic interactions, and some patients who were quiet, withdrawn, or perceived as "keeping a low profile" were not reliably identified or engaged proactively. Activity provision was restricted, and opportunities for meaningful interaction were further constrained by pandemic-related measures, including mask wearing, social distancing, and increased procedural demands on staff. In addition, where patients experienced ward transfers, therapeutic relationships were often disrupted and not consistently re-established, increasing the risk of disengagement and unmet need.

Actions: Since the COVID-19 pandemic, the activities team has been re-established, with daily activities now offered to patients on the wards. In addition, Alder, Cedar, and Maple wards each have a dedicated Activities Healthcare Support Worker embedded within their establishment.

Weekly 1:1s are audited with compliance below:

Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
90%	67%	51%	50%	64%	55%	75%	67%	83%	88%	71%	81%

A red flag has been added as an option on Safe Care when therapeutic engagement has been comprised due to staffing levels. Since January 1st, 2026, this has been raised 10 times across MHCB.

Inpatient wards now have professionally signed off establishments which allow for 2 observation levels. Process is in place for out of establishment requests. Review of need twice yearly, and monthly rostering efficiencies meetings.

Continuity of Care

Summary of concerns: Continuity of care was identified as a major systemic weakness. Many patients experienced multiple ward moves due to service reconfiguration during COVID19, including temporary placements and "sleeping out" arrangements. These moves resulted in fragmented responsibility, poor communication between teams, and uncertainty regarding clinical ownership of care. Communication between inpatient and community teams was inconsistent, and the intended continuity offered by -locality linked- ward models was often not realised in practice.

Actions: The former *"sleeping out"* policy has been formally reviewed and replaced with a revised Outliers Policy, which clearly sets out governance arrangements and defines expectations of responsibility and accountability when patients are cared for outside their usual ward area. The revised procedure is currently subject to a further detailed review to ensure it remains robust, clear, and aligned with best practice. This is expected to be completed by August 2026.

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To strengthen oversight and assurance, a red flag- indicator has been implemented on Safe care. Since 1 January 2026, seven red flags have been raised where the requirements of the Outliers Policy were not adhered to, enabling timely escalation and organisational learning.

In addition, a transfer checklist has been developed and embedded into routine practice to support safe, structured, and consistent patient transfers, further mitigating risk and improving continuity of care.

Following the introduction of ePMA, discharge letters are now able to be processed within 24 hours, improving the timeliness and quality of communication with primary and community care partners.

In parallel, the service is adopting the NHS Wales Safe Discharge Standards, with a commitment that all patients receive a 72-hour -post discharge -follow-up- to support continuity of care and reduce risk following discharge. An update on implementation progress is due in late March 2026.

Diagnosis, Treatment and the Mental Health Act

Summary of concerns: The review also identified concerns in relation to diagnosis and treatment. In several cases, longstanding diagnoses were changed without sufficient longitudinal review of clinical records, multidisciplinary discussion, or appropriate involvement of patients and their families. In at least four cases reviewed, medication regimens were significantly adjusted without clear documentation of the clinical rationale, adequate monitoring of impact, or explicit recognition of the heightened risk period associated with changes in diagnosis and treatment.

The review further identified instances of potential non-compliance with the Mental Health Act. In several cases, informal patients were documented as being prevented from leaving the ward or subject to threats of Section 5(2) use without appropriate procedural safeguards. This raised concerns regarding de facto detention and adherence to the Mental Health Act Code of Practice.

Action: Microlearning sessions have been delivered to medical staff groups, alongside the circulation of a formal memo to relevant clinicians, to provide clarity on when consideration should be given to the use of the Mental Health Act (MHA) for informal patients. This work emphasised the importance of timely and appropriate legal frameworks to support patient safety and care.

Further guidance has been shared within the consultant body meeting in relation to circumstances where a long-standing diagnosis is being reconsidered, reinforcing that such decisions must be supported by:

- Multidisciplinary team (MDT) agreement
- A comprehensive review of the patient's full clinical history
- Clear discussion of the implications with the patient and, where appropriate, their family or carers

Learning from the report has been distilled into targeted microlearning and shared with medical staff to influence and strengthen clinical practice. In parallel, the Section 5(2) and Section 5(4) policies have been reviewed to ensure they remain current, clear, and consistent with legislative and best practice- requirements.

To further enhance patient understanding and transparency, an Open/Locked Door Policy has been developed to support improved communication and information for patients. This policy is currently out for consultation prior to formal implementation. It is due to be discussed in our Controlled

Commented [T]3]: @Rachel Dix (Cardiff and Vale UHB - Mental Health Clinical Board is there an audit in place reviewing this please

Commented [T]4]: @Rachel Dix (Cardiff and Vale UHB - Mental Health Clinical Board are we able to state when or how please

Commented [T]5R4]: @Rachel Dix (Cardiff and Vale UHB - Mental Health Clinical Board for both these points please

Commented [T]6]: @Rachel Dix (Cardiff and Vale UHB - Mental Health Clinical Board can we say date it was ratified please

Document Oversight Group 30th March 2026, with further circulation via corporate governance processes on share point.

Observation Practice

Summary of concerns: Observation practice was found to be inconsistent and insufficiently integrated into overall care planning. Observation levels were at times initiated, reduced, or discontinued without clear multidisciplinary discussion or documented clinical justification. There was limited evidence that observation was consistently used as an active therapeutic intervention, rather than being undertaken as a passive task. The review highlighted a lack of recognition that constant observation is the only intervention likely to materially reduce immediate suicide risk, and that any reduction in observation requires explicit, robust, and well-reasoned decision-making.

Actions:- In response to the concerns identified, a supportive observation and engagement practice has been comprehensively reviewed February 2026. A new co-produced procedure has been developed and implemented, supported by targeted training. This revised approach explicitly embeds consideration of suicide risk, reinforces observation as an active therapeutic intervention, and improves consistency, patient safety, and therapeutic engagement across services

Commented [T)7]: @Rachel Dix (Cardiff and Vale UHB - Mental Health Clinical Board can we state the name of the procedure and date it was ratified please

Family Engagement

Summary of concerns: The review identified significant concerns regarding engagement with families and carers, which was inconsistent and often insufficient. In several cases, concerns raised by families were not clearly incorporated into risk assessment or care planning processes. Although COVID-19 restrictions may have contributed to reduced opportunities for contact, there was no evidence of a consistent or proactive approach to mitigating this impact. The review team was unable to meet with families despite repeated attempts, which it regarded as a serious limitation and reflective of wider systemic weaknesses in family and carer involvement.

Action: The Mental Health Clinical Board (MHCB) has commissioned a two-year Family Engagement Project, which is currently underway, aimed at strengthening and embedding consistent, meaningful engagement with families and carers across all MHCB services. In support of this work, a co-produced Information Sharing and Information Gathering Policy has been developed and ratified October 2025, due for review October 2028.This policy provides a clear and supportive framework for appropriately involving families in their loved one's care, promoting transparency, partnership working, and compliance with best practice and legal requirements.

In addition, the MHCB is progressing work towards achieving Carers Accreditation, demonstrating a formal organisational commitment to recognising, supporting, and valuing carers as key partners in th delivery of mental health care.

SIRAN Accreditation

Summary of concerns: The review identified substantial concerns regarding the quality and consistency of internal serious incident investigations. There was marked variation in investigative approach and depth, with no consistently applied methodology and variable levels of investigator expertise and training. MDT involvement was inconsistent, and some investigations lacked appropriate medical or psychiatric input. Root cause analysis was not always clearly evidence-based, with some issues framed as patient-related rather than addressing systemic

contributors. Recommendations were often poorly defined, insufficiently linked to findings, and not framed as SMART actions. Evidence of family involvement in investigations was limited

Action: The Mental Health Clinical Board (MHCB) has worked in partnership with the Royal College of Psychiatrists to meet the standards of the Serious Incident Investigation Accreditation Network (SIRAN) and has successfully achieved accreditation. This accreditation was reviewed in January 2026 and, following an interim review, the MHCB has retained its accredited status for a further 18 months, with the next formal review scheduled thereafter.

To strengthen support for families throughout investigation processes, a Family Liaison Officer has been appointed, providing a consistent point of contact and improving communication, transparency, and compassionate engagement with families.

In addition, the MHCB has introduced structured roundtable discussions to enhance multidisciplinary learning and reflection following incidents. The existing 'Sentinels' process has also been reviewed, with its scope and function formalised through updated terms of reference for the Patient Safety Review Meeting, ensuring clearer governance, greater consistency, and a strengthened focus on organisational learning and continuous improvement.

Leadership and Supervision

Summary of Concerns: The report highlighted the importance of strengthening and sustaining a skilled MDT, with clear supervision and leadership arrangements in place to support safe decision-making, professional development, and high-quality care delivery.

Actions:
The report identified the need to further develop and sustain a skilled and confident multidisciplinary team (MDT), underpinned by clear, robust leadership, effective supervision, and role clarity. These factors were recognised as critical to the delivery of safe, effective, and compassionate inpatient care, as well as to workforce sustainability.

In response, a range of actions have been implemented to strengthen MDT capability, skill mix, and leadership arrangements. These include the appointment of an inpatient psychology consultant, the introduction of activities-focused Healthcare Support Worker (HCSW) roles, and the inclusion of a ward-based Recovery College trainer, all of which enhance therapeutic engagement and support recovery-focused care. Professionally agreed nursing establishments have also been implemented to improve staffing stability, and inpatient social worker roles have been advertised to further strengthen multidisciplinary working and holistic care delivery.

Alongside these structural changes, the Clinical Board has expanded access to leadership, supervision, and workforce development opportunities. Several secondment opportunities have been created through changes to the Clinical Board, supporting leadership development and talent progression. Thirteen staff have completed the HEIW Mental Health Team Manager Development Programme (PG Cert), strengthening operational leadership capability, while 42 interprofessional staff are actively participating in the HEIW Mental Health Mentorship Programme, enhancing supervisory capacity and professional support across services.

Further strengthening this approach, the Clinical Board is supporting the 'co-lead' programme, a HEIW pilot, across two Adult Mental Health inpatient wards. This programme focuses on fostering team collaboration and psychological safety through a non-hierarchical leadership model. In addition, a new Band 7 Practice, Professional Development Nurse (PPDN) secondment has been

established within Adult Mental Health inpatient services. This role has a specific focus on leadership, mentoring, and clinical supervision, directly addressing identified workforce and leadership challenges and supporting the delivery of safe, sustainable, and compassionate care.

Further work remains ongoing in partnership with 36 Degrees as part of a wider model-of-care transformation programme. This programme continues to strengthen skill-mix planning, clarify roles and supervision arrangements, and ensure MDTs are appropriately configured to meet patient need. Leadership development is a core component of the commissioned 36 Degrees work and provides additional assurance regarding the development of sustainable leadership capacity across inpatient services.

Executive Director Opinion & Key Issues to bring to the attention of the Committee:
Not applicable
Appendices (please list any appendices that will accompany this report. Do **not** embed)
1. The PowerPoint slides which support the report
Recommendations:
a) To note the update provided to the Committee.

Link to Strategic Objectives of Shaping our Future Wellbeing:

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

Five Waves of Working (Sustainable Development Principles) considered:

Prevention		Long Term		Integration		Collaboration		Involvement	

Quality Impact Assessment Completed?

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

Impact Assessment

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

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

Name of Committee/Group/Exec	Date:

Chilcott Rachel 08/04/2026 13:36:05

Mental Health Clinical Board

Cardiff and Vale Recovery & Wellbeing College

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Public Quality Committee
April 2026
Mental Health Clinical Board

Royal College of Psychiatry Review

Site Visit 25th-26th October 2023 Report May 2024

Update from Presentation in May 2025

The Health Board commissioned the Royal College of Psychiatrists to examine:

- The **care and treatment** provided to six individuals who died by suspected suicide.
- Whether care aligned with **national standards**.
- The **quality and robustness** of internal serious incident investigations.
- System and service factors, particularly during the **COVID-19 pandemic**

Areas that needed addressing:

- ✓ Risk Assessment
- ✓ Care Planning and Formulation
- ✓ Therapeutic Engagement and Observation
- ✓ Continuity of Care
- ✓ Diagnosis, Treatment and MHA
- ✓ Family Engagement
- ✓ SIRAN standards

Risk Assessment

VISION To deliver consistently high-quality, formulation-driven risk assessment and co-produced safety planning, founded on the principle that suicide risk requires active, ongoing therapeutic engagement—not assumptions about the protective effect of hospital admission

Our Mission Patients to have high quality Risk Assessments and Safety Plans

Area of Need	The right Risk Assessment Form	Development of Safety Planning Skills	Ensure be-spoke support	Assurance of SAMT and WARRN Practice	Policy Development
Action	Move From Form 4 to WARRN	Suicide Awareness and Mitigation Training (SAMT) for all clinicians	Development of be-spoke formulation sessions for teams	Ongoing WARRN audits	Develop a policy which reflects current practice
Progress Chilcott,Rachel 08/04/2026 13:36:05	WARRN has been embedded as the baseline risk assessment	SAMT has been rolled out across all areas	Embedded into practice on request and when an audit has identified need	Risk Management and formulation remains an area of need with dedicated working group WARRN audits are embedded into practice but development and audit to ensure SAMT quality and completion	Reviewed with introduction of SAMT, enhanced guidance on risk management plans.

Mental Health Clinical Board

Cardiff and Vale Recovery & Wellbeing College

Care and Treatment Planning

GIG CYMRU NHS WALES

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Cardiff and Vale University Health Board

VISION To achieve compliance and quality in Care and Treatment Planning through robust assessment, clear documentation, and collaborative practice that ensures every plan reflects best standards of care and supports safe, effective recovery

Our Mission For every relevant patient to have a meaningful Care and Treatment Plan (CTP)

Area of Need	For care and treatment discussions to occur in every ward round	Embed CTP audits into practice	Development of CTP training	Policy Development
Action	Review the ward round template	Quarterly CTP audits to be submitted to NHS P&I	Development of co-produced CTP training	Develop a policy which reflects current practice
Progress	The ward round template has been reviewed, however will continually be reviewed and audited to ensure meeting the needs of our service users.	Audits embedded into usual practice	The recovery college have supported development of co-produced training. A further identified need has been identified for clinician specific training which is being developed on an all Wales Basis.	Draft policy has been developed; however further work is needed to define relevant patient in CVUIHB. Aim to be completed within 3 months.

Mental Health Clinical Board

Cardiff and Vale Recovery & Wellbeing College

Therapeutic Engagement and Observation

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Cardiff and Vale University Health Board

VISION To embed therapeutic engagement as a fundamental part of care, ensuring regular, meaningful 1:1 interactions that deepen understanding, enhance safety, and improve outcomes.

Our Mission For patients to have minimum of weekly 1:1s and experience therapeutic engagement

Area of Need	Alignment to NCISH observation guidance	Weekly 1:1s	Escalation when staffing levels have impacted therapeutic engagement	Staffing levels to allow for therapeutic engagement
Action	Review the reassurance and observation procedure used within MHCB	Weekly 1:1s set as a minimum across inpatient areas	Add a red flag to SafeCare when therapeutic engagement has been comprised due to staffing levels	Review staffing levels to allow for therapeutic engagement
Progress	Policy has been co-produced with individuals with lived experience and clinicians across disciplines.	Audits ongoing: December 2025 audit showed: Cedar 100% Alder 83% Beech 80% Willow 70% Oak 80% Maple 81% Daffodil 100% Meadow 80% Phoenix 80%	Red flag has been set up on SafeCare	Inpatient wards now have professionally signed off establishments which allow for 2 observation levels. Process is in place for out of establishment requests. Review of need twice yearly, and monthly rostering efficiencies meetings.

Mental Health Clinical Board

Cardiff and Vale Recovery & Wellbeing College

Continuity of Care

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

VISION To deliver compassionate, safe and person-centred mental health care where every individual receives seamless support, built on strong therapeutic relationships, high-quality clinical practice, and a commitment to *ensuring continuity of care and robust communication during transfers and discharges*.

Our Mission Ensure continuity of care and robust communication during transfers and discharges

Area of Need	Patient Transfer	Patient outlying to another ward	Discharge Letters	72-hour follow up
Action	Develop a transfer checklist to ensure a transfer across wards is carefully considered and key information handed over	Develop an outlying policy which promotes consideration of risks and patient need.	For discharge letters to be sent to GP with 24 hours.	Embed 72 hour follow up for all patients
Progress	Transfer checklist embedded into practice	The outlying policy had been reviewed post RCPsych report, however, is now up for review with a team working on this. Due to be complete within 3 months.	Progress has been made, but still not consistently within 24 hours. DALS now in place and ePMA in March 2026 which will support process in keeping with 24-hour letters.	All patients from treatment wards receive 72 hour follow up, however aligned to new All Wales Discharge Standards plans in place to pilot for Cedar where some patients would be discharged to GP. Review of progress due March 2026

Mental Health Clinical Board

Cardiff and Vale Recovery & Wellbeing College

Diagnosis, Treatment and MHA

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

VISION To ensure full compliance with the MHA Code of Practice for all informal patients, and to deliver safe, accountable and informed diagnostic decision-making supported by comprehensive history, multidisciplinary input and meaningful patient involvement.

Our Mission Protect rights. Strengthen diagnostic clarity. Deliver care aligned with the MHA Code of Practice.

Area of Need	Alignment to MHA Code of Practice to avoid de facto detention	Change of diagnosis consideration	Policy review
Action	For defacto detention language not to be used in medical notes.	• When changing a longstanding diagnosis to consider • MDT agreement • Full history review • Discussing implications with patient/family	Review policies in relation to Section 5(2) and 5(4) of the MHA
Progress	Microlearning presented to medical groups and memo sent to relevant staff in relation to when to consider using the MHA for informal patients.	Microlearning from the report shared with medical staff for learning of the report to influence practice.	Section 5(2) and 5(4) policies have been reviewed
	Ongoing audit needed to ensure consistent language is used (new medical intakes every 6 months). Working with the MHA office to support this review		To support the rights of information patients a open door policy has been developed currently out for consultation

Family Engagement

VISION To build a culture where families are fully engaged as partners in care, with clear communication, meaningful involvement and support at every stage of the patient journey.

Our Mission For family engagement to be embedded across an admission and discharge

Area of Need	Family engagement project	Policy review
Action	To develop a family engagement project	Develop a co-produced information sharing and gathering policy which supports family engagement in their loved one's care
Progress	SBAR for family engagement project completed and presented to the MHCB with SRO allocated	Guidance developed in 2025
	Family engagement project commenced – this is a 2-year project aimed at improving family engagement across all of MHCB	

Leadership and Supervision

VISION To build a skilled, confident and well-supported workforce through regular skill-mix reviews, high-quality supervision, underpinned by strong, visible clinical leadership at every level.

Our Mission To develop and sustain a skilled MDT

Area of Need	Complete skill mix-review	Supervision arrangements	Transformation work with 36 degrees
Action	Adopt a standardised approach aligned with SIRAN standards	Develop a clinical supervision procedure	
Progress	Nursing establishments have been reviewed and professionally signed off	Procedure has been completed, but further work as CNO recommendation for twice year clinical supervision not considered sufficient for managing complex mental health.	Models of Care and Leadership form part of the pillars in 36 degrees which will strengthen this area further. Essential for MDT skill mix to be completed within 36 the workstreams.
	MDT skills mix review still required		
	Cardiff Local Authority have advertised for inpatient social workers to enhance inpatient MDT		

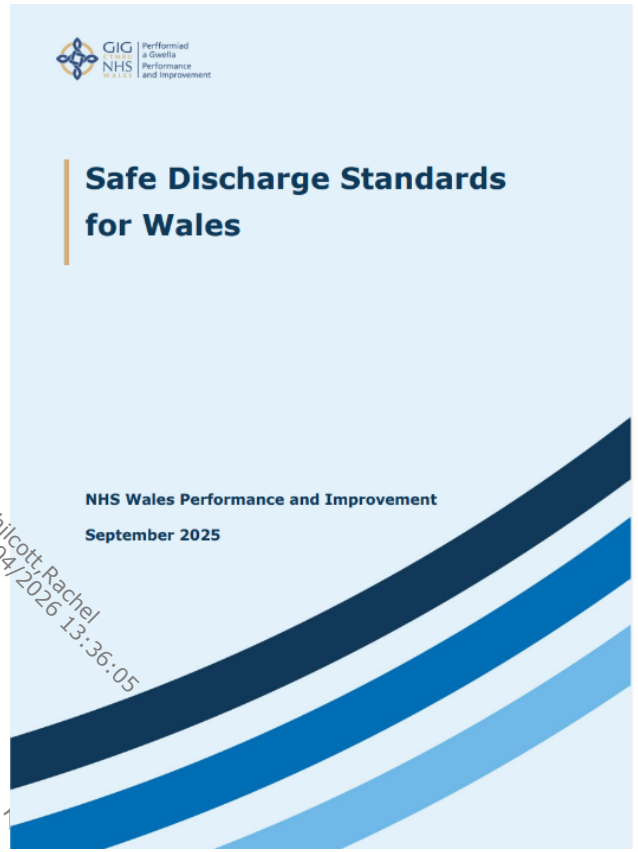
SIRAN Standards

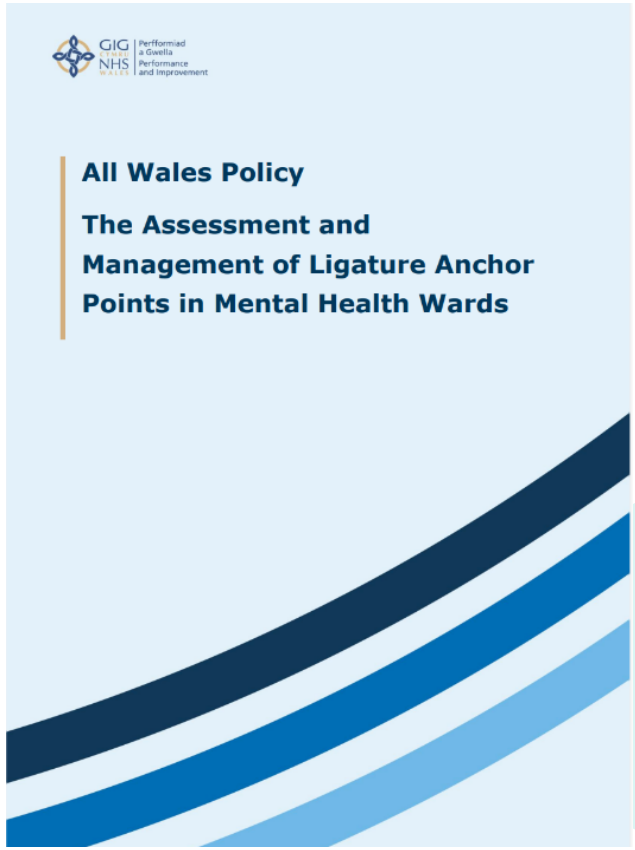
VISION To ensure all serious incidents are reviewed in line with national Serious Incident Response Accreditation Network (SIRAN) standards, promoting transparent, compassionate processes that meaningfully involve and support both families and staff

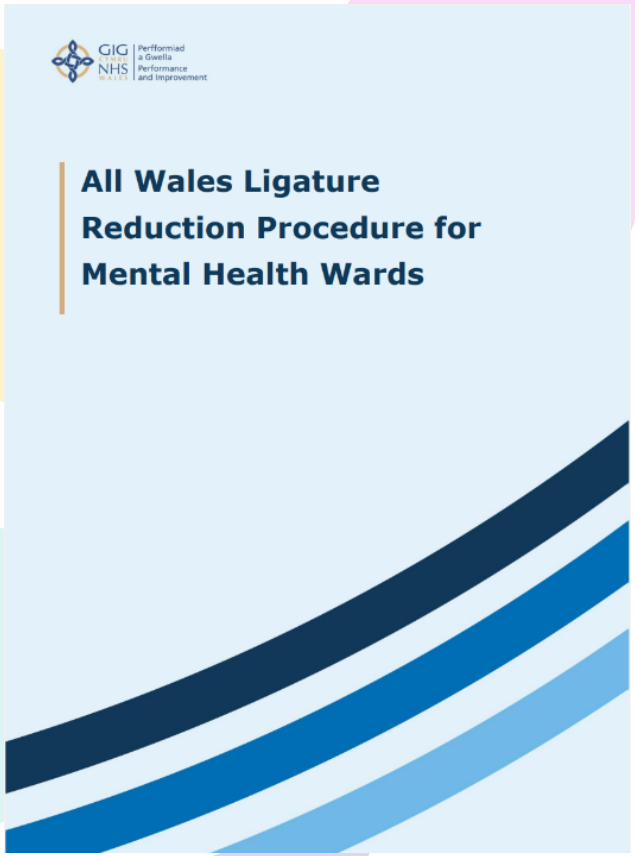
Our Mission To gain accreditation with SIRAN

Area of Need	Alignment to standards	Family Involvement	Staff Involvement	Review internal patient safety review processes
Action	Adopt a standardised approach aligned with SIRAN standards	Develop a Family Liaison Role (FLO) to support Serious Incident Review engagement	Develop terms of reference following a round table discussion	Review 'sentinels' process
Progress	Accreditation gained – with interim review of evidence submitted Jan 2026 and reviewed by the committee on the 12th of February and accreditation sustained.	FLO has been appointed	Embedded into practice where applicable	New terms of reference developed, and sentinels replaced with monthly 'Patient Safety Review Meeting'

OTHER RELATED WORK







To summarise,
Several actions have been embedded into practice, with a few remaining with ongoing work. They are:

- Risk Working Group ongoing
- All Wales CTP Training
- CTP policy completion
- Ongoing audits for defacto detention and Weekly 1:1s
- 24-hour discharge letters and all patients receiving a 72 hour follow up March 2026
- Ongoing family engagement project
- Work with 36 degrees for transformation pillars (to include flow, OOA, clinical operating model and leadership)

Some areas have been superseded by development of All Wales Work, and we are committed to working aligned to National all Wales Standards

Any questions?

Report Title:	*Equity, Equality, Experience and Patient Safety Action Plan Update*			Agenda Item no.	*2.4*
Meeting:	Quality	Public	X	Meeting Date:	14/04/2026
		Private			
Status *(please tick one only):*	Assurance X	Approval		Information	
Lead Executive:	Claire Beynon – Executive Director of Public Health				
Report Author:	Specialty Registrar in Public Health				

Main Report

Background

Health inequities and inequalities are preventable, unfair and unjust differences in health between groups, populations or individuals.

The aim of this work is to deliver equitable and excellent preventative and clinical services in Cardiff and Vale University Health Board (UHB). As a provider of prevention, primary and community care, secondary and tertiary health services, we have a duty under the Equalities Act (2010) to look for and address inequalities in the access to, experience and outcomes from our services.

In 2023, a three-step process – the 3i Framework – was developed to help staff think through how their services could make a difference to reducing health inequalities. The framework together with a Support Pack was developed to assist staff with applying the framework in practice. The Health Board identified a number of initial actions that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. These 24 projects were described in the first action plan. The actions needed are organisation wide: Planned Care, Equitable Employee Experience, Unscheduled Care, Maternity Care, Prevention, Analytics, Primary Care, Representation, Mental Health and Patient Safety.

Current Situation

The Equity, Equality, Experience and Patient Safety action plan sets out the initial action areas, providing updates approximately six months on from their previous update, along with target completion dates. We will provide further updates in six months' time on progress and aim to reassess actions within the plan and explore new actions to be added.

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

We need to deliver equitable and excellent preventative and clinical services for the population of Cardiff and the Vale of Glamorgan.

This action plan provides six-month updates on progress across the Health Board on current projects of strategic importance to equity, equality, experience and patient safety.

Recommendation:

The Committee is requested to:

a) Support and advocate the actions under way in the action plan to address health inequities in Cardiff and the Vale of Glamorgan.
b) Acknowledge the six-month progress that has been made against the actions, including the challenges around health inequality data availability.
c) Agree to receiving further updates in another six months.

Link to Strategic Objectives of Shaping our Future Wellbeing:

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

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

Impact Assessment:
Risk: Yes
Inaction in these action areas poses a risk of widening health inequalities in Cardiff and the Vale of Glamorgan.
Safety: Yes
Patient safety actions within the action plan seek to reduce variation in patient safety and quality of reporting incidents.
Financial: No
Workforce: Yes
Implementation of the actions in the action plan will improve the experience and health of employees in the Health Board.
Legal: Yes
Achieving the actions in this report will facilitate the Health Board complying with the Socio-economic Duty Equality Act 2010.
Reputational: Yes
Achieving the actions in this report will facilitate the Health Board complying with the Socio-economic Duty, Equality Act 2010, and the More Equal Wales aspect of the seven well-being goals set out in the Wellbeing of Future Generations (Wales) Act 2015.
Socio Economic: Yes
Achieving the actions in this report will facilitate the Health Board complying with the Socio-economic Duty Equality Act 2010.
Equality and Health: Yes
The majority of the actions in this action plan will address health inequalities.
Decarbonisation: Yes
Reducing health inequalities in access to services will reduce demand for high value services in secondary care. Prevention is the best form of decarbonisation.

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Chilcott Rachel
08/04/2026 13:36:05

Quality Committee

Feb 2026

Equity, Equality, Experience and Patient Safety Action Plan

Sally Percy, Specialty Registrar in Public Health

The 3I Framework

Beynon, Scott, Whiles, Hughes, Jones, and Roberts, 2023

Identify:
Acknowledge and understand the differential experience, access to health services, health inequity and inequality for local people and our employees

Output- summary of equity and excellence priorities

Intelligence for action:
Use community engagement and qualitative insights to understand lived experience and improve quantitative data collection on equity and use both sources to co-produce service improvements that deliver equity and excellence

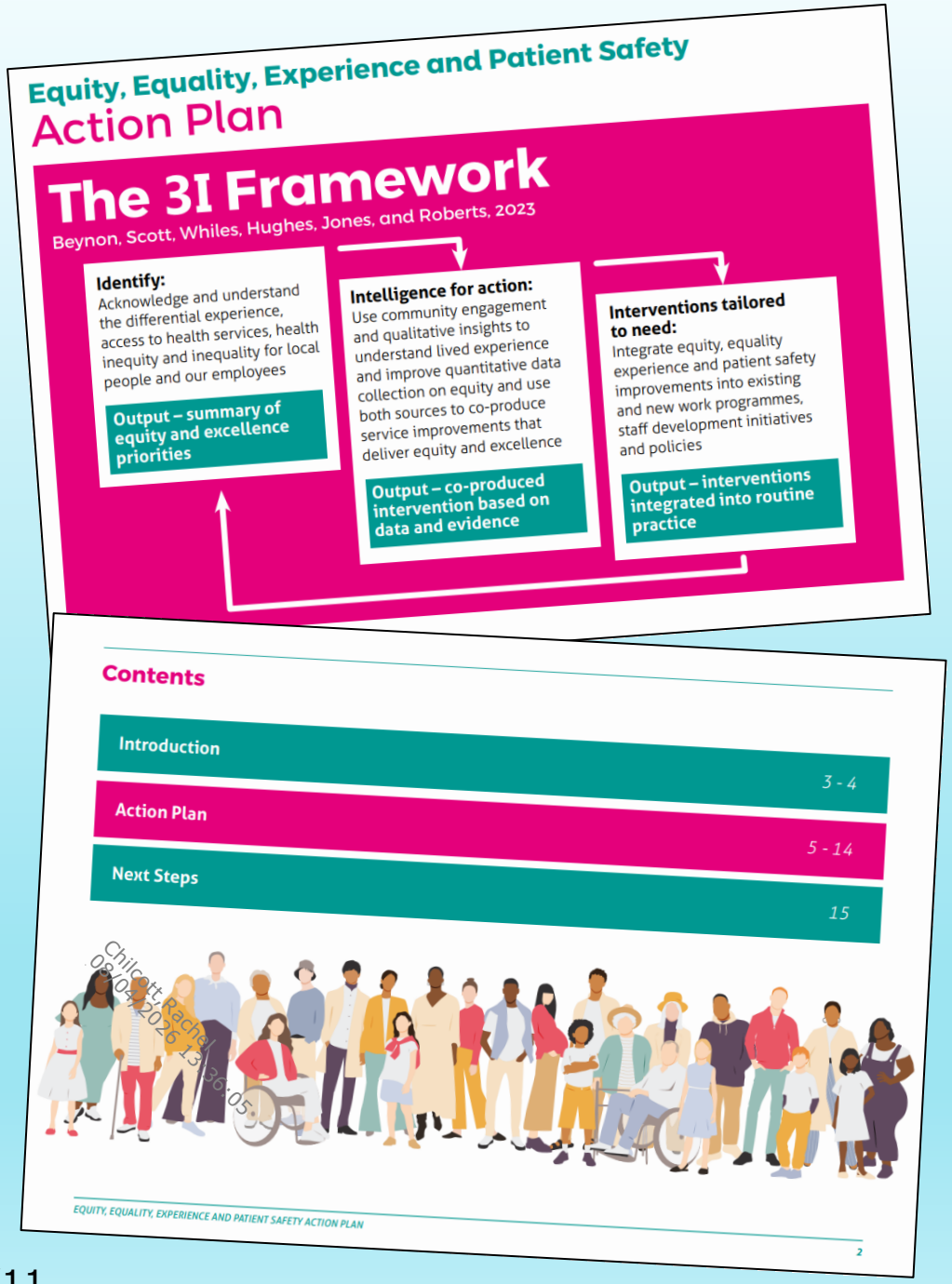
Output- co-produced interventions based on data and evidence

Interventions tailored to need:
Integrate equity, equality experience and patient safety improvements into existing and new work programmes, staff development initiatives and policies

Output- interventions integrated into routine practice

Aim
To deliver equitable and excellent preventative and clinical services/ approaches.

The framework sets out actions each Clinical Board or Team could take on their journey to delivering equity and excellence as part of a quality approach



Action Plan

Equity, Equality, Experience and Patient Safety

Purpose:

The action plan sets out the initial action areas agreed in 2023, providing six month updates, along with target completion dates.

Action areas

- Prevention
- Unscheduled Care
- Planned Care
- Mental Health
- Maternity Care
- Patient Safety
- Analytics
- Representation
- Primary Care
- Equitable Employee Experience

Recent Successes

Maternity Care

- Badgernet informatics system is facilitating development of a dashboard and datasets to evaluate work programmes including the All Wales Obesity Prevention CoP and Healthy Weight Healthy Wales workstreams.

Chilcott,Rachel 08/04/2026 13:36:05

Representation

- Targeted initiatives to promote CAVUHB as an employer with key groups are being rolled out including people with disabilities, experiencing homelessness, living in areas of deprivation, with mental health challenges, minority ethnic groups and young adults bought up in care.

Planned Care

- Examining waiting lists by postcode (Welsh Index of Multiple Deprivation – WIMD) to aid prioritization
- No evidence of inequalities of waiting, except for 104+ week waiters where .

Equitable Employee Experience

- The most recent WRES report was published in December 2025 and with recommendations on tackling inequalities included.
- Anti racism is now included as part of the Equity and Inclusion session in the First Steps to Leadership and Management programme.

Primary Care

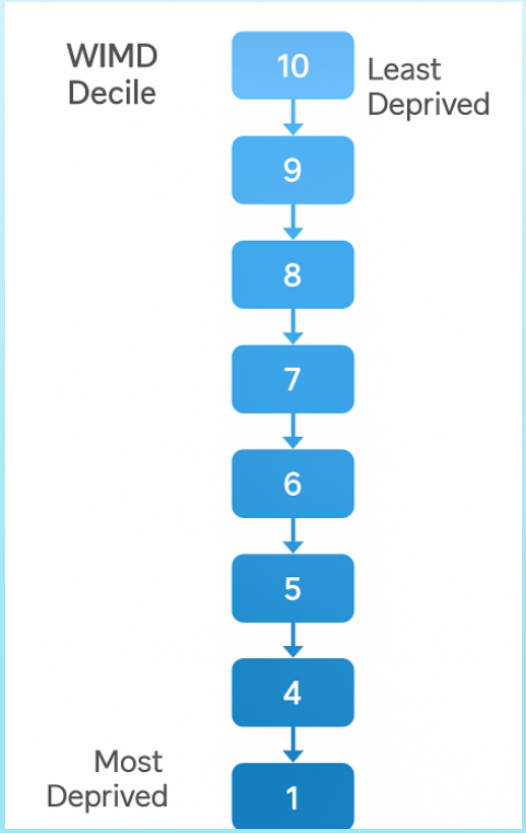
- The two new actions identified at the last review have been progressed and demonstrate potential to embed equality in planning in primary care clusters.
- The team are engaging with PHW on the local implementation guidance for the ABCD+ programme.

Examining waiting lists by postcode (Welsh Index of Multiple Deprivation – WIMD) to aid prioritisation

The following slide is taken from the D&HI Analytical Team slide deck analysing waiting lists and inequalities.

No inequalities were observed for median waiting time, inpatient/day case or outpatient waits or in anyone waiting less than 52 weeks.

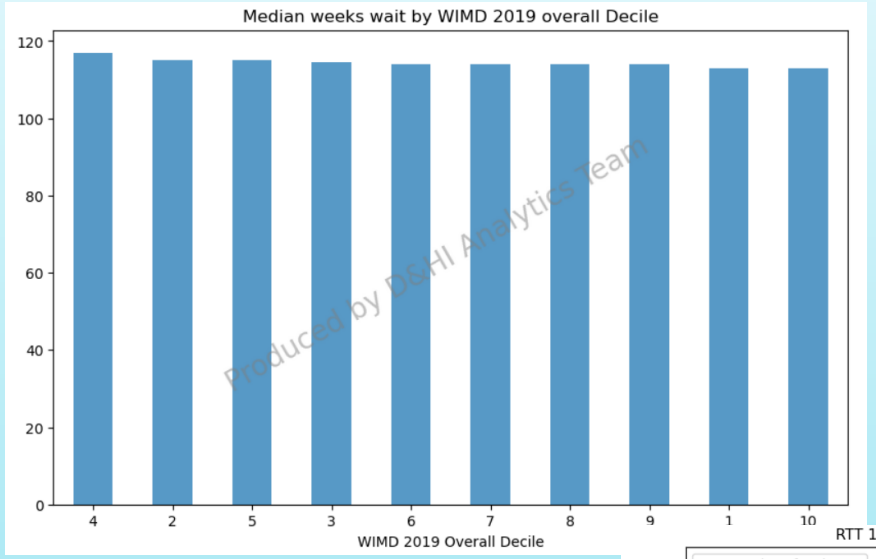
The analysts used postcode to map Welsh Index of Multiple Deprivation (WIMD) deciles to conduct their analysis with 1 representing the most deprived decile.

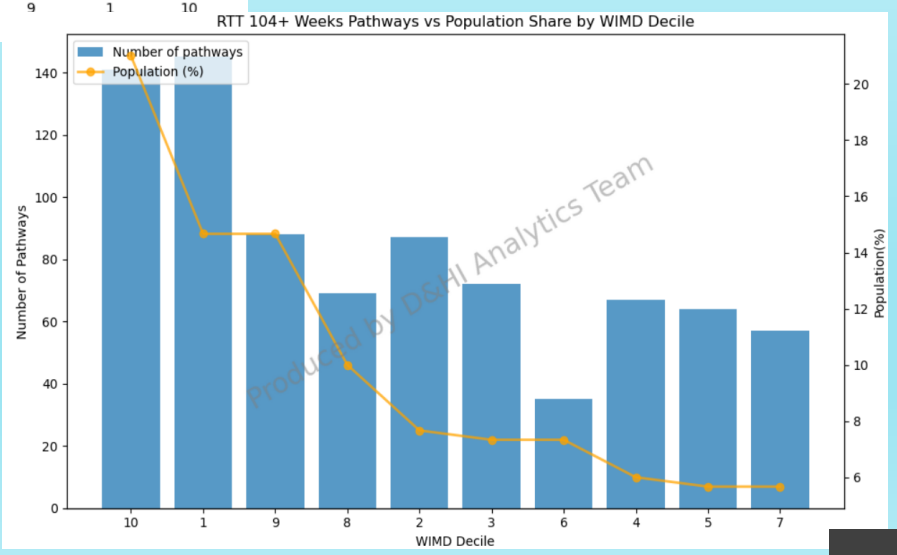


Waiting List Inequality
RTT 104+ Weeks WIMD Analysis

Slide taken from Cardiff and Vale UHB Waiting List Inequality slide deck by the D&HI Analytical Team

- Median waiting vary by decile groups between 0-5 weeks (0-2%)
- A slight skew is observed, with Decile 1 showing higher patient numbers in comparison to Decile 10 despite a small population share; however, this analysis is based on a modest sample (~1,000 patients) and should be interpreted cautiously.





Workforce Race Equality Standard Organisational Report Cardiff and Vale University Health Board 2025 (WRES report)

Key Findings

In the course of engagement with CVUHB, two areas of work were highlighted:

- Supporting ethnic minority staff to progress beyond Band 5, and develop a talent pipeline of staff internally
- Targeting specific regions of Cardiff with higher minoritised populations to provide support for new applicants – some of this involved working with community leaders

The WRES data for this area shows that:

- The bottleneck for progression remains at Band 5, but there is a small early sign of progress with a fractional increase in the percentage of minoritised staff above Band 5 rising from 9.0% in 2024 to 9.8%
- There has been an approximately 10% increase in ethnic minority workforce (from 14.5 to 16.0%) – but it is not clear what proportion of these are from international recruitment compared to coming from Cardiff itself

Changes since July 2025 Snapshot

Equity, Equality, Experience and Patient Safety

Previous reported difficulty with…

Data availability

Data linkage

Data analysis

Progress in some areas is limited/slowed by the current financial and resource climate.

Areas of Future work

- New staff unaware of action plan or principles it is built on- other than sharing the 3i framework and plan is there a way we can ensure people are made aware of the basis of the projects they work on when they take them on.

- Review of actions: to add new actions, review ongoing actions to a defined end point, review stalled actions. Refresh of actions in the plan by triangulating feedback from SLT, joined up reporting and the review of stalled outstanding actions.

- Repeated reporting between the EEEPS action plan and other mandatory equality reporting. Opportunity to streamline reporting into a singular form but would require alignment of reporting timeframes (currently Feb/August for QC and April for WG).

Chilcott,Rachel
08/04/2026 13:36:05

- For actions which have met roadblocks consider:
  - reviewing with framework for alternative interventions to target the inequality observed
  - provide further resource to allow completion if this is the limiting factor
  - decide benefit of keeping on plan if addressing is an impossibility at present.

Next steps

The Committee is requested to:

a) **Support and advocate for the actions** under way in the action plan to address health inequities in Cardiff and the Vale of Glamorgan.

b) **Acknowledge** the six-month progress that has been made against the actions, including the *challenges around health inequality data availability*.

c) **Agree** to receiving further updates in another six months.

Thank you for listening

Any questions or comments?

Equity, Equality, Experience and Patient Safety

Action Plan (update February 2026)

The 3I Framework

Beynon, Scott, Whiles, Hughes, Jones, and Roberts, 2023

Identify:
Acknowledge and understand the differential experience, access to health services, health inequity and inequality for local people and our employees

Output – summary of equity and excellence priorities

Intelligence for action: Use community engagement and qualitative insights to understand lived experience and improve quantitative data collection on equity and use both sources to co-produce service improvements that deliver equity and excellence

Output – co-produced intervention based on data and evidence

Interventions tailored to need:
Integrate equity, equality experience and patient safety improvements into existing and new work programmes, staff development initiatives and policies

Output – interventions integrated into routine practice

Version 5.0 November 2024

Contents

Introduction

People often think that tackling inequities is someone else's business, or think that it is too difficult or that they are doing all they can already.

In 2023 an Equity, Equality, Experience and Patient Safety Framework support pack was produced and released, to support individuals and teams to make a positive difference. The support pack was developed by our staff, for our staff to help tackle issues around equity, equality, experience and patient safety in Cardiff and Vale Health Board.

The aim: To deliver equitable and excellent preventative and clinical services/approaches.

The objectives:

- To reduce variation in health outcomes
- To reduce variation in access to services
- To reduce variation in quality of services
- To have a workforce that is representative of the population, who have an equitable experience of work, career development and personal growth at CAVUHB

Cardiff and Vale University Health Board take seriously our responsibility to our patients, staff, volunteers, and community with regard to equity, equality, experience and patient safety.

Our main responsibilities as a Health Board are two-fold:

- Firstly, we are here to help people live well - from having a healthy start in life through to maintaining health in later years.
- Secondly, we are here to provide excellent care and treatment for people who need healthcare services to keep well or recover to get well.

As a provider of prevention, primary and community care, secondary and tertiary health care services, we can look for and address inequalities in the access to, experience of and outcomes from our services.

Ensuring we collect the data we need to be able to find and address inequalities is fundamental and will be supported by our digital transformation over the coming years.

We can also be a listening organisation and take the time to understand what services our communities need and co-design those services with our communities so that they are fit for purpose and drive a reduction in health inequalities. We can look after and promote the health and wellbeing of our staff in the same way that we look after our patients.

A three-step process – **The 3I Framework** – was developed to help staff think through how their services could make a difference *(see Figure 1 to the right).*

The Health Board identified a number of projects that have strategic importance to delivering on the Equality, Equity, Experience and Patient Safety agenda. This list is not exclusive, but guides the organisation to deliver on strategically important work. If local teams wish to make service improvements this should be supported.

This action plan sets out these initial areas of focus for Cardiff and the Vale University Health Board, providing updates six months on from the previous update.

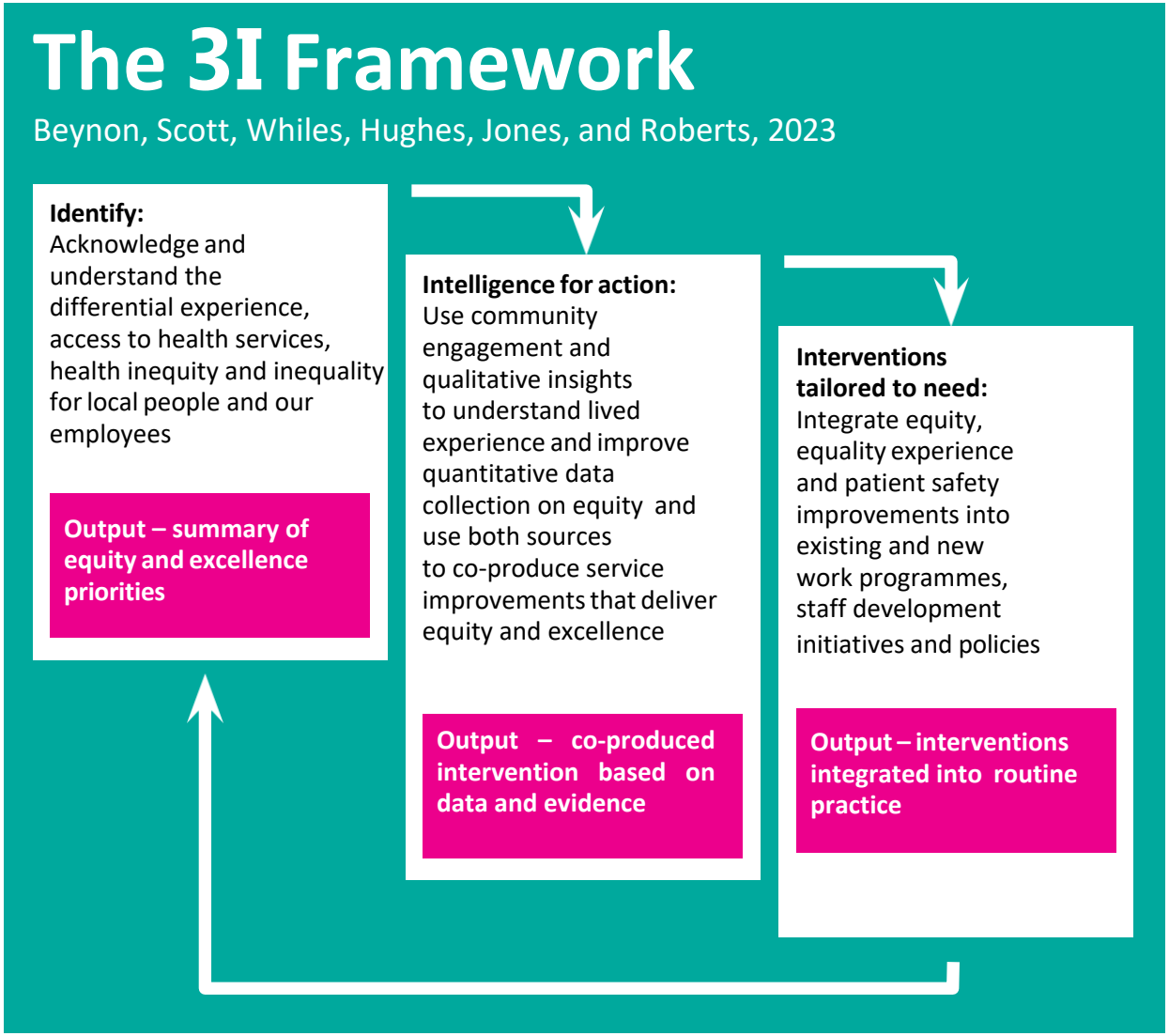


Figure 1: Three I Framework: a three-step tool to support teams in making positive changes to equity, equality, experience and patient safety in Cardiff and Vale University Health Board

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Planned Care	**Adam Wright** *Head of Service Planning (Operations)*	Examining waiting lists by postcode (Welsh Index of Multiple Deprivation – WIMD) to aid prioritisation	Overall, there is no evidence of inequalities of waiting, with the exception of 104+ week waiters. Here the most deprived decile represent more long waiters relative to the proportion in the population but with caveat of small sample size. Requested update on if this is a new result vs 2 previous times exercise performed and if it has influenced how the team are prioritizing waiting lists.	Completed	
	Steven Thomson *PROMS Programme Manager (Digital Health and Intelligence)*	Analysis of PROMs by protected characteristics	Work is being undertaken to link PROMs data to protected characteristics data as this is not routinely collected as part of PROMs. Data is being moved to the Cardiff and Vale Warehouse and checks are in place to establish the data being returned in FHIR (correct) format- currently xls. Work is ongoing as more services come online. Once the format is correct the team are working to have store the PROMS data in the Cardiff and Vale warehouse. Digital exclusion: New system allows collection of PROMs from paper transcription or over the phone. PROMs can also be reported via iPads in waiting room or by friend or relative with digital access.	Integration of data systems- Feb 2026 Store PROMs data in the CAV Warehouse- June 2026	
Planned Care	**Emma Cooke** *Deputy Director of Therapies and Health Sciences*	Supporting Patients Whilst Waiting work	Welsh Government 3Ps Policy explicitly requests that all Health Boards establish a single point of contact for patients waiting for treatment. CAV UHB's single point of contact service (named locally as the Waiting Well Support Service) is now fully operational and current work focuses on bring together existing teams into one to increase the offer to more patients.	March 2026	
Equitable Employee Experience	**Claire Whiles** *Assistant Director (Organisational Development, Wellbeing and Culture)*	Embedding and enaction of the Anti-Racist Action Plan (e.g. policy review)	The WRES Task and Finish Group has been established with organisational agreement to focus on progression and representation. The most recent report was published in December 2025 and with recommendations on taking the action forward. The anti-racism eLearning module has been launched on ESR, and discussions are ongoing about making this mandatory as per instruction from the Welsh Government. Additionally, anti-racism is now included as part of the Equity and Inclusion session in the First Steps to Leadership and Management programme.	Quarter 4 2025/26	

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Equitable Employee Experience	**Claire Whiles** *Assistant Director (Organisational Development, Wellbeing and Culture)*	Establishing and growing Employee Resource Groups (Networks)	A proposal for relaunching staff network is due to be taken ahead in January, this looks at the resource and time afforded to staff networks in addition to the governance framework around them. This proposal aims to enhance employee engagement and support across the organisation.	Quarter 4 2025/26	
Unscheduled Care	**Katja Empson** *Consultant (Emergency Unit)*	Examining EU waits by demographics e.g. ethnicity to support 6 goals of urgent and emergency care	Due to organizational constraints this is not possible at present. Nevertheless, e-triage has been implemented in the department and some data on ethnicity is now being collected. Unable to progress without further operational support.	On Hold	
	Katja Empson *Consultant (Emergency Unit)*	New model for inclusion health based on need	Much progress has been made with respect to the new health inclusion model based on need. There is nurse in place during the hours of 9-5 to provide EU/ward in-reach. There is also a GP in place providing primary care in-reach to inclusion groups working on what sort of support can be provided to the wards (what opportunistic primary preventative care/screening/vaccinations can be provided during admission) but this is a work in progress. The team are in the process of looking at the outcome data.	Ongoing	
Maternity Care	**Judith Cutter** *Consultant Midwife (Maternity)*	Supporting people with obesity in pregnancy	We continue to provide individual support for women with higher body mass index in line with the Healthy Weight, Healthy Wales workstream and strategy group by providing health pregnancy clinics which include a maternal obesity dietician for those with BMI>40. The Guideline has recently been updated to include a pathway for women who conceive whilst using GLP-1 medications which involves early support around diet and lifestyle in pregnancy. Foodwise in pregnancy continues to run and the Foodwise in Pregnancy APP is recommended to all women during pregnancy. Maintain a membership at the All-Wales Obesity Prevention CoP and Health and Wellbeing after pregnancy group hosted by PHW. This will be evaluated and outcomes measured through the development of a dataset within the maternity informatics system. BadgerNet maternity informatics system has recently launched in Cardiff, and a Dashboard is planned to capture outcomes related to BMI.	Evaluation/outcomes to be captured July 2027 February 2026 Ongoing Ongoing	

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Maternity Care	**Judith Cutter** *Consultant Midwiife (Maternity)*	Understanding the needs of ethnic minority people	Maternity Services joined Welsh Government's Diverse Cymru Cultural Competency Scheme and has been provisionally awarded silver accreditation and is awaiting formal accreditation in March 2025. Work continues with the Birth Partner Project to provide face-to-face inclusivity sessions at mandatory training promoting interpretation services and reducing barriers to healthcare. Continued work with Birth Partner Project bi-monthly community sessions for health promotion, learning from birth experiences and building relationships with communities. Face-to-face antenatal education sessions for non-English speaking families continue on a permanent basis. Maternity fast track service has been launched to enable birthing people where English is not the first language to attend the obstetric assessment unit without needing a prior appointment or phone call to reduce language barriers and delays in access for maternity care. A specialist midwife for women seeking sanctuary and survivors of harmful practices who supports women through the asylum process and navigating maternity services and birth has received an MBE for her services in 2025 new years honours.	March 2025 Ongoing Ongoing Ongoing February 2026 January 2026	
Prevention	**Anna Howells** - *Acting up Consultant in Public Health Medicine (Public Health Team)*	Using 'Amplifying Prevention' to increase immunisation	The Vaccine Community Champions model continues to be delivered successfully at and the champions model is being used across multiple settings, including interest from Public Health Wales to create preschool and pregnancy champions. In the health board the momentum from the Champions model is being used to reach the Somali community (through a pilot commissioned from Hayaat Women Trust), and with childhood immunisations through Immune Patrol pilot and pre school champions in Flying Start settings. Workforce champions have been identified and will be able to access a training module known as 'VaxChat' to which is currently being commissioned and will deliver bespoke versions of this training to both volunteer and workforce champions. Engaging with Behavioral Science unit to improve on several opportunities identified by the audit against the Vaccine Literacy standards. Schools remain a key focus and we have developed the appropriate governance to allow for improved information sharing. Three High Schools in Cardiff have been identified to work with us to raise awareness of the risks of measles and the implications of an outbreak and to target unvaccinated teachers and pupils with plans to run school-based clinics in January. The review of the Vaccine Equity Strategy has been completed with recommendations for an updated version to be developed.	Ongoing	

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Prevention	**Suzanne Wood** *(Reduce obesity) Consultant in Public Health Medicine (Public Health Team)*	Using 'Amplifying Prevention' to increase immunisation and reduce obesity	Cardiff Leadership and Enabling Change Group now well established strengthening connections at a senior strategic level. Vale of Glamorgan governance arrangements now agreed, with Vale of Glamorgan Council's Senior Leadership Team undertaking the leadership and enabling change function for Good Food and Movement.	November 2025	
Analytics	**Tom Porter** *Consultant in Public Health Medicine (Public Health Team)* **Kerry Ashmore** *Head of Business Intelligence (Digital and Health Intelligence)* **David Thomas** *Director of Digital and Health Intelligence* **Dave Price** *Head of Architecture and Analytics*	Identification of potential indicators and Development of a dashboard.	Potential equity indicators have been identified and shared with the Business Intelligence team. . A discussion was held with the BI team and due to service pressures this was the agreed course of action- they will give the Public Health Team access to PowerBI licenses to develop dashboards. Initial dashboard to be developed by Tom Porter.		15th Apr 2024
			Digital Service Desk request for development of a Health Equity Indicator dashboard received from the Public Health team on 15/04/24. Due to service pressures this was the agreed course of action- they will give the Public Health Team access to PowerBI licenses to develop dashboards. Initial dashboard to be developed by Tom Porter as per above. Identified indicators will be developed into a dashboard in house. Appropriate access to power BI has now been achieved and development can begin.	Q1 2025/26	

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Primary Care	**Huw Brunt** *Consultant in Public Health Medicine (Public Health Team)* **And Rebecca Lewis** *(Principal Public Health Practitioner, Public Health Team)*	Scope how to identify unmet need e.g. cardiovascular risk	Two actions identified: Action 1: Work with Public Health Wales to consider the implications of implementing the Health Equity Action Framework for Primary Care Action 2: Consider local implications of Prevention Based Health and Care Framework, in particular the ABCD+ Programme in relation to Cardiovascular risk management		Complete
		Action 1: Work with Public Health Wales to consider the implications of implementing the Health Equity Action Framework for Primary Care-	The 'Teg I Bawb / Fair for All' strategic action plan has been launched by PHW, which CAVUHB PHT has engaged in. Work progressing on this (underway or planned action) includes: • Collaborating with Primary Care clusters to embed equity in planning - regular interaction and development of cluster profiles to highlight inequalities concerns and inform planning. • Prioritise research, evaluation and innovation in high-need areas - joint PHT and PCIC project to identify and diagnose long-term conditions and reduce inequalities. • Support CPD training on health inequalities for clinical and non-clinical staff & embed health inequalities training into induction programmes - MECC training is available across CAVUHB and regularly delivered to colleagues by Public Health Team staff; another example is training on Help Me Quit to encourage brief interventions with patients (notably from high prevalence and deprived areas) on smoking cessation. • Identify and utilise alternative community-based settings for care delivery in collaboration with local partners and voluntary sector - engaging with partners to broaden the location of Help Me Quit clinics to ensure equitable access in areas where smoking prevalence remains high.	Q4 2025/26	

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Primary Care	**Huw Brunt** *Consultant in Public Health Medicine (Public Health Team)* **And Rebecca Lewis** *(Principal Public Health Practitioner, Public Health Team)*	Action 2: Consider local implications of Prevention Based Health and Care Framework, in particular the ABCD+ Programme in relation to Cardiovascular risk management	• Awaiting guidance from PHW on local implementation of CVD Prevention and ABCD+ Programme; CAVPHT are part of the national CVD Prevention Steering group and national Primary Care Interest Group (PHW-led) to ensure we are engaged in this work. • Quality improvement projects underway by local GP Practices with national and local webinars held to support local delivery. • Use of national Primary Care One dashboard to develop cluster profile summaries to inform population health need. • MECC training available, and regularly provided to clinical and non-clinical staff. • The Blood Pressure (BP) monitor loan scheme through libraries and hubs in Cardiff (and soon to launch in the Vale of Glamorgan, January 2026) removes the barrier of purchasing their own machine for residents who are encouraged to monitor their blood pressure. The information booklet advises the action to take for individuals with high readings, helping to detect those at risk of untreated high blood pressure. CAVPHT have attended the PHW Cancer Screening equity workshop to input to the next Cancer Screening Equity Strategy.	Q4 2025/26	
	Emma Holmes *Head of Nutrition and Dietetics* ***Catherine Washbrook-Davies*** *Strategic Lead for Community Dietetics*	Consider diabetes prevention programme expansion	• Six of the nine primary care clusters have been actively involved in the All Wales Diabetes Prevention Programme (AWDPP). • The remaining clusters have not committed any funding, although there had been expressions of interest. • There have been challenges in recruiting staff due to delays in funding confirmation, the recruitment freeze and staff movement. • The team currently has 4 HCSWs in post, providing limited activity across the 6 funded clusters. • National AWDPP outcome data has been published indicating it is a successful model. • Funding from Welsh Government, due to end on 31st March 2026 has been extended. Exact details to be confirmed. • In discussion with PCIC re Strategic Programme for Primary Care (SPPC) & Cluster future funding A business case was submitted to SLT & VBRG in Dec 26	Ongoing	

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Representation	**Claire Whiles** *Assistant Director (Organisational Development, Wellbeing and Culture)*	Understanding current workforce demographics (Workforce Race Equality Standard)	The WRES Task and Finish Group has been established with organisational agreement to focus on progression and representation. Analysis of the data was published in the WRES organisational report in December, this highlights several areas of work that are required including bottle necks in progression. There is a call to action and recommendations to establish a task and finish group and co ordinating with the equality plans- there is a need to understand if there are further actions which can be taken forward using the framework for this action plan	Q4 2025/26	
	Jonathan Pritchard *Assistant Director (People Resourcing)*	Proactive community outreach to promote UHB as an employer	1. Progress continues with a number of initiatives to promote employment within UHB. 2. Targeted groups for initiatives include: individuals with disabilities, experiencing homelessness, living in areas of deprivation, with mental health challenges, minority ethnic groups and young adults bought up in care. Examples: • 5th Year of Project Search for people with learning disabilities and/or autism. Delivering meaningful, supported work placements for individuals with disabilities through Project Search, support approximately nine individuals per year with autism or learning disabilities, helping them move into employment or further education. • We have undertaken targeted work with local homeless charities such as Llamau to promote NHS roles and pathways to individuals experiencing housing insecurity, and are raising awareness of the range of opportunities available and offering practical employability advice whilst strengthening partnerships with organisations eg Huggard. • Work experience for people living in areas of deprivation: supported 15 ad hoc work experience placements and ran a Pharmacy taster session on 25th November with 12 attendees • Delivered the **Summer Jobs Programme in partnership with Youth Cymru**, offering paid work placements to two to young people aged 16–20 who are at risk of violence or face significant barriers to employment. Other work: • as anchor institution • summer job work experience • engagement with schools and colleges.	Ongoing	

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Mental Health	**Dan Crossland** *Director of Operations (Mental Health Clinical Board)*	Development of a local strategy and framework for peer workers.	The peer toolkit has been co - produced service users, carers and staff and outlines how to integrate peers into teams within mental health services. Peers are recruited into teams they will receive 6 weekly supervision from our peer or deputy peer lead. They also facilitate monthly co - reflection sessions for peers working across services	2025	
Patient Safety	**Alexandra Scott** *Assistant Director of Quality and Safety (Patient Safety team)*	Understand variation in quality and patient safety reporting	The development of reporting from Datix had not progressed due to vacancies held but has now been appointed. This work will sit with them, although it is unlikely that it will be started within the next 9 months due to a backlog of work as the position has been held for a year.	2026 onwards	
		Scope a pilot of variation in Medical Examiner Referrals by postcode	Discussed with medical examiner but they are not unable to progress. To consider potential to progress within the UHB once power BI analysis of Datix information is enabled. Until an alternative approach can be resourced, this action is on hold indefinitely.	On hold	

Action Plan

Actions Recorded as Completed at July 2025 Update

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Equitable Employee Experience	**Claire Whiles** *Assistant Director (Organisational Development, Wellbeing and Culture)*	Benchmarking and progress monitoring e.g. Employers Network for Equality and Inclusion (ENEI)	Financial challenges have made taking work forward with ENEI or other external organisations difficult; however, new KPIs included in the annual plan report around equity, inclusion, and the Welsh language will mean that the Health Board can monitor progress more effectively. This will ensure that we are on track and can address any issues promptly.		Quarter 4 2024/2025
Unscheduled care	**Katja Empson** *Consultant (Emergency Unit)*	Analysis of frequent users by postcode (WIMD)	The Business Intelligence Department hold a Frequent Attendees report that collates by post code, which can be refreshed, but it's not currently scrutinised. This information is available for us by the frequent attenders team who work to put in place management plans for the more complex and/or high frequency attenders.		10/04/24
Prevention	**Suzanne Wood** *Consultant in Public Health Medicine (Public Health Team)*	Using 'Amplifying Prevention' to increase immunisation and reduce obesity	• Progress report for the Good Food and Movement Implementation Plan shows that the majority of actions were in train during 2024/25. • Consultation on the Cardiff Replacement Local Development Plan was held. Cardiff and Vale UHB submitted a response to include the priorities and commitments of the Good Food and Movement Framework. • Research completed by the PHIRST INSIGHT Team enabling insight around unhealthy food advertising from young people, residents and stakeholders (key to system change) to be gathered. Unhealthy food advertising on University Hospital of Wales site bus stops restricted. In Vale of Glamorgan schools, 425 extra-curricular physical activity / sport sessions were facilitated during 2024/25, resulting in 7930 attendances/participations. The offer was based on consultation with young people.		April 2025 April 2025 March 2025 March 2025
Primary Care	**Huw Brunt** *Consultant in Public Health Medicine* **And Rebecca Lewis** *(Principal Public Health Practitioner)*	Scope how to identify unmet need e.g. cardiovascular risk	l data items are being regularly added to PHW's Primary Care Clusters Dashboard, nefit clusters in identifying unmet need. ased Planning pilot has been completed, led by regional planning and PCIC. Lessons re being considered and will inform future cluster planning.		Complete Complete

Action Plan

Action area	Lead	Actions	Update	Target completion by (date)	Completed on (date)
Representation	**Claire Whiles** *Assistant Director (Organisational Development, Wellbeing and Culture)*	Listening to understand barriers, challenges and views	The 2024 Staff Survey results have been received, and the Equity & Inclusion team has been given access to the raw data to better understand our workforce's experiences. With the improved dashboard functionality, the survey results can now be broken down by various characteristics, providing more detailed insights.	Complete	Quarter 4 2024/2025
Mental Health	**Dan Crossland** *Director of Operations (Mental Health Clinical Board)*	Training and self-certification commissioned from Diverse Cymru	There are 20 service areas in the Mental Health Clinical Board undertaking training and self-certification at various stages. As of December 2023, 2 Clinical Board level trainings were completed. We were aiming for submission of the remaining service areas to Diverse Cymru for review by Q1 of 2024-25. This is now complete. We had confirmation recently that the MHCB has won a Bronze Award with Distinction! We also had a silver award for Psychology and Psychological Therapies Directorate and a Bronze 'foundation' for our Headroom 1st Episode Psychosis service.	Complete	2024
Mental Health	**Dan Crossland** *Director of Operations (Mental Health Clinical Board)*	Work with Police and Crisis Care Concordat to improve and understand shared ethnicity recording.	We have requested a report to cover Welsh Language compliance (would they prefer to speak in Welsh), preferred language and Ethnicity report by team. Our data set does match the police one now in terms of detail.	Complete	2024
Patient Safety	**Alexandra Scott** *Assistant Director of Quality and Safety (Patient Safety team)*	Undertake a baseline assessment of National audit data set to identify measures of inequity.	The work around measures of inequity in national audit is complete, however it is limited to only a few indicators relating to long term conditions. While useful, these don't provide a systems wide approach beyond these conditions.		2025

Next Steps

Ensure colleagues who are new to actions within the plan are aware of the 3i Framework and action plan to ensure equity and underlying aims of the actions are seeded throughout the work.

Additionally, this will empower others to use the framework and advocate when they witness inequalities in their work.

Creating a joined-up reporting system for inequalities work across the health board by collaborating with the Board Assurance Framework and Equality and Inclusion colleagues reporting to Welsh Government. The aim will be to ensure maximum capacity is put into reducing inequalities and reduce duplication of efforts in reporting ongoing work.

The opportunity to streamline reporting into a singular form but would require alignment of both reporting time frames.

Need to review actions which have met roadblocks and to make decisions on how to proceed.

Options include:

1. to review with framework for alternative interventions to target the inequality observed
2. provide further resource to allow completion if this is the limiting factor
3. remove from framework if meeting the action is not feasible.

To follow up on other work and opportunities within the health board which can feed into the action plan.

To decide if a follow up plan for completed actions.

Next Steps

Work to be undertaken to complete the actions outlined above

University Health Board to be updated of progress in six months time

Next Steps

Report Title:	JACIE Inspection Report – Action Plan Progress Update				Agenda Item No:	2.5
Meeting:	Quality Committee		Public	X	Meeting Date:	14/04/26
			Private			
Status:	Assurance	x	Approval		Information/Noting	
Lead Executive Title:	Catherine Phillips / Paul Bostock					
Report Author Title:	Jessica Castle (Director of Operations Specialist Services) Katie Innes (Senior Strategic Planning Manager)					

Main Report

Background and Current Situation:

Further to the report shared at the March Committee, this report provides an update on progress to address the deficits raised in the recent JACIE inspection.

Background

Following the accreditation visit on 18th and 19th September 2025, the decision was taken by JACIE to defer reaccreditation of the South Wales Blood and Marrow Transplant Programme (formal report received 12th January 2026), pending confirmation of remedial and corrective actions. We are required to respond to JACIE by 8th July 2026 when a further decision on accreditation will be made.

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

Many of the areas of non-compliance and partial compliance identified are within the remit of the programme to correct, however there are several areas that lie outside of the gift of the Directorate, requiring support and/or input variously from JCC, SBUHB, Capital Estates & Facilities, other Clinical Boards and Welsh Government:

Governance & Progress Against Actions

The SWBMT Quality Team has a comprehensive database of all 2330 standards and is systematically working through the areas of non-compliance (as a priority) and partial compliance. Each standard has an agreed action, action owner and target completion date.

A Task & Finish Group has been established, meeting 3 weekly, to monitor progress against the database and to focus on the significant, system wide actions that require input from other organisations and Clinical Boards to progress. This action plan is included as appendix 1. The next meeting is planned for 10th April 2026.

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

Key system wide actions:

1. Adult - Premises (CVUHB)
   Good progress is being made with the expansion of the Haematology Day Centre which will address a number of deficits raised by JACIE. The timeline for completion of the works is September 2026, therefore we will be able to demonstrate significant progress by the July response date.

   The timelines associated with the broader capital scheme to address the inpatient ward, ambulatory care and outpatient facility deficits remain challenging. There are

several meetings planned in the coming weeks to move discussions forward. By the JACIE deadline we aim to have:

a. A completed BJC that has been through CAVUHB internal governance and had approval
b. A letter of support from Ian Gunney (Deputy Director, Capital Estates & Facilities, Welsh Government) for the scheme
c. A project plan to include likely timescales to tender and to work commencement (appreciating this will be influenced by ministerial sign off timescales)

2. Paediatrics – Clinical

The paediatric programme treats fewer patients annually than required by JACIE to meet their standards. There are plans in place to support the collections by closer working between adult and paediatric teams to ensure competencies are maintained , however a decision is required for the autologous transplants. Children & Women's Clinical Board have prepared an options paper in response to the JACIE findings, and the aim is for this to be discussed at SLT mid-April for a decision and next steps to be agreed. Options may include:

a. Cessation of the transplant activity and commissioning of service from NHSE
b. Collaboration with another unit to increase patient numbers accessing services from CHfW
c. Continuation of service outside of JACIE accreditation

3. SBUHB - Personnel

A Business Case has been developed by SBUHB colleagues to address the staffing gaps identified by JACIE. As lead provider, CAVUHB will review and scrutinise the case in the context of the wider programme and report into SLT (7th May) for agreement of next steps. Any request for additional resource will be subject to commissioner approval from NWJCC.

4. Stem Cell Processing Unit – Personnel

A gap analysis has been undertaken by CD&T Clinical Board to address the deficits noted by JACIE. As per the above, the programme will review the case and report into SLT (7th May) for agreement of next steps.

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

1. Updated Action Plan

Recommendations:

Note progress and risks.

Link to Strategic Objectives of Shaping our Future Wellbeing:

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

Five Ways of Working (Sustainable Development Principles) considered:

Prevention		Long Term	x	Integration		Collaboration	x	Involvement	

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

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

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

Appendix 1	Issue	Action	Lead	Update 13/03/26	Risk of Action Completion by Deadline
Paediatrics - clinical	The number of autologous HSCT procedures is below JACIE requirements.	Develop options paper for decision on paediatrics programme, options could include: - Derogation (from JACIE and/or against JCC Service Spec) - Service to be commissioned from NHSE - CAV Service to treat patients from a wider geographical area so as to meet the JACIE threshold	Cathy Morley-Jacob	Options paper drafted with Clinical Board for review. Aiming for TSDG 16th April and then SLT.	
Paediatrics - collection	Number of bone marrow harvests below JACIE threshold	JACIE has suggested introducing simulation procedures or ceasing activity	Cathy Morley-Jacob; Jim Murray	Cross cover arrangements and closer links between paeds and adults has been proposed as a solution; detail and governance still to be worked through	
	Number of apheresis harvests insufficient to maintain competencies	Option to maintain apheresis competency by doing adult procedures			
Paediatrics - personnel	Single nurse capable of performing apheresis procedures (succession planning needed)	Consider paediatric nurses maintaining competencies on adult patients or alternatively adult nurses performing procedures on paediatric patients to improve robustness of cover			
Processing facility - personnel	Staffing levels in the processing facility are inadequate	CD&T to undertake gap analysis to address the deficits raised by JACIE	Sian Jones; Sarah Phillips; Keith Wilson; JCC	CAR-T Phase 2 Business Case placed on hold pending JACIE outcome - includes additional staffing which would mitigate this risk. Being progressed by JCC, for discussion at Specialised Services Commissioning Group 19/03/26. Further gap analysis to be shared with JCC to address residual deficits	
	Unable to provide on-call cover for LN2 storage tanks (also noted by HTA as a deficiency)				

CVUHB Adult - premises	Inadequacy of adult facilities, specifically: Haem Day Centre (adults) Day Centre (TCT)	Upgrade of HDC Adults in progress TCT-aged patients to use upgraded adult facilities until upgrade of TCT facilities	Estates; Clinical team	HDC Capital scheme in progress - target completion September 2026	
	Inpatient facility on B4/C5 Haem Ambulatory Care Outpatients	Capital scheme		Ongoing discussions with WG around capital scheme to replace inpatient facility and incorporate ambulatory and outpatient facilities.	
SBUHB - premises	The Autologous Transplant Service needs to expand in both space and workforce to manage current demand.	SBUHB developing a Business Case to address deficits	SBUHB finance; Ann Benton; Keith Wilson	Paper going to SBUHB TSOG 19/3. Decision needed as to how paper is taken through CAVUHB governance as we host the Programme	
SBUHB - personnel	The Autologous Transplant Programme requires a robust succession plan for potential Programme Directors and BMT Nursing Coordinators.				
	The programme is heavily dependent on single CNS for smooth operation, highlighting the need for increased resilience.				
	Expansion of nursing roles at Singleton is needed, in line with the role expansion at Cardiff				
	The Nurse Educator role needs to be restructured to enable the post holder to deliver more effective transplant training to the nursing team.				
	The pharmacist requires dedicated time for transplant related Continuing Professional Development (CPD).				
	Notable differences exist between the two transplant programmes; Singleton patients do not have access to prehab or rehab				

	services, leading to inequities in patient care.				
QA	Remaining non-compliant/partially compliant actions to be addressed by team	Quality team working through full standards spreadsheet, action owners assigned to each non or partially compliant standard	Nicola Davis (QA Manager) Nick Gidman (GM)		
		Vacant posts in the Quality Team to be fast tracked for recruitment			

There are a total of 2330 standards included as part of the inspection process; for the vast majority of these the programme was deemed compliant.
The number of non-compliant and partially compliant standards are noted below:

Actions	Total Non-Compliant	Total Partially Compliant	Completed	Overdue
Clinical (UHW)	24	23	0	0
Clinical (SB)	9	16	0	0
Paediatrics (CHW)	6	57	0	0
Collection (CM)	25	74	2	0
Processing	15	60	0	0
Quality	9	25	0	0
Total	88	255	2	0

Report Title:	Structured Assessment, Internal Audit, Targeted Intervention De-escalation Criteria Overarching Quality Improvement Plan					Agenda Item No:	2.6	
Meeting:	Quality Committee		Public	x		Meeting Date:	14/04/26	
			Private					
Status	Assurance	x	Approval			Information/Noting	x	
Lead Executive:	Jason Roberts - Executive Nurse Director							
Report Author:	Natasha Goswell - Deputy Executive Nurse Director							

Main Report
Background and Current Situation:

The purpose of the overarching quality improvement plan paper is for Quality Committee **to be assured** that the findings and recommendations from the following reports are being implemented, monitored and reported on.

- NWSSP Audit & Assurance advisory audit on the Quality and Safety Governance arrangement
- Quality aspects of the Cardiff and Vale University Health Board Structured Assessment 2025
- Targeted Intervention Quality De-escalation Criteria

These reports were presented at March 2026 Quality Committee.

The mechanism for the reporting and monitoring will be on a monthly basis; this will be through the weekly executive led quality meetings and presented at Quality Committee. The presentation at Quality Committee will be for awareness, assurance, and alerting to any areas that are not on track and provide understanding of the necessary mitigations or further actions to ensure that alignment to completion and remaining on track is presented.

For those areas that are on track we will report on the implementation and sustainability aspects as they progress and evolve

In total there are 22 standard requirements to be implemented (8 related to the structured assessment, 5 in relation to the NWSSP internal audit and 9 related to the quality targeted intervention de-escalation criteria). Within the improvement plan each of the standard requirements have identified improvements to be implemented and monitored, these are also linked with evidence that aligns to the annual plan and organisational strategy, with specific alignment to the strategic quality portfolio's, alongside identification of the governance arrangements that the standard requirements would be reported and monitoring of the improvements.

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

Quality Committees are asked to note and be **assured** the content, implementation, reporting and monitoring arrangements of the overarching improvement plan (attached) which covers standard requirement actions from NWSSP Audit & Assurance advisory audit on the Quality and Safety Governance arrangement, Quality aspects of the Cardiff and Vale University Health Board Structured Assessment 2025, Targeted Intervention Quality De-escalation criteria.

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

1. Structured Assessment, Internal audit and Targeted Intervention de-escalation criteria overarching quality improvement plan

Recommendations:

a) Quality Committee are asked to **note** for **awareness** the contents of the overarching quality improvement plan.
b) Quality Committee are asked to be **assured** of the actions being taken to address the areas identified for improvement and the governance arrangements for oversight of the reporting and monitoring of the improvement plan.

Link to Strategic Objectives of Shaping our Future Wellbeing:

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

Five Ways of Working (Sustainable Development Principles) considered:

Prevention		Long Term	x	Integration	x	Collaboration	x	Involvement	x

Quality Impact Assessment Completed?

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

Impact Assessment

Risk: Yes
There is risk to the organisation if actions identified to strengthen quality governance and assurance are not completed
Safety: Yes
There is potential safety to the organisation if actions identified to strengthen quality governance and assurance are not completed
Financial: No
Workforce: No
Legal: No
Reputational: Yes
There is reputational risk due to being in targeted intervention level 4 for quality and no assurance of completion of improvements
Socio-Economic: No
Equality & Health: No
Decarbonisation: No
Welsh Language: No

Approval/Scrutiny Route *(please list all other Committees/Groups this report has been to)*	
Name of Committee/Group/Exec	Date:
Audit Committee	03 March 26
Weekly Quality Meeting	18 March 26

Quality Escalation Audit and Structured Assessment Improvement Plan

Exec Lead: Jason Roberts/David Fluck

SRO: Natasha Goswell

CAVUHB Structured Assessment Plan

					25/26	2026/2027			
Standard	**Standard requirements**	**Actions**	**Evidence link**	**Action Owner**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
1.The Health Board should Improve oversight of the strategic portfolio's	Ensure committees received routine updates on strategic portfolio developments and delivery relevant to their remit	• Standing agenda item for strategic portfolio updates at relevant committees.	•Structured assessment 2025 Internal audit governance arrangements	Director Corporate Governance					
		• Quarterly standardised report aligned to committee remit and Annual Plan priorities.	•Annual Plan •Shaping our Future Quality Excellence	Director Corporate Governance					
		• Committee minutes record challenge, assurance and actions	•Corporate Governance pages	Director Corporate Governance					
	Structuring the Integrated Performance Report against the strategic portfolios, rather that the quadruple aims, to make it easier to track progress against Annual Plan and strategy delivery	• Redesign Integrated Performance Report structured by strategic portfolio.	•Board and committee papers	Director Corporate Governance					
		• Clear mapping to Annual Plan objectives and delivery milestones.	•Integrated Performance Report	Director Corporate Governance					
		Revised format approved through appropriate committee.	•Quality Committee	Director Corporate Governance					
2. The Health Board should ensure information on its website is up to date by:	Ensuring Board and Committee forward workplans on the website are current	• Quarterly review of forward workplans.	• Corporate Governance Pages	Director Corporate Governance					
		• Named governance lead responsible for updates	•Director Corporate Governance	Director Corporate Governance					
		• Published versions checked against statutory and Annual Plan requirements.	•Board Sub committees	Director Corporate Governance					
3. The Health Board should adopt an 'Alert, Advise, Assure' format for appropriate Board and committee reports, identifying	• Areas of concern where actions are not delivering impact (Alert), • Areas where actions are starting to make a difference (Advise), and • Areas performing effectively (Assure).	• Consistent definitions applied across all reports. • Explicit categorisation in performance and quality reports. • Clear actions, owners and timescales for Alert and Advise items.	• Board sub committees • Templates on Corporate governance teams site	Director Corporate Governance					
4. The Health Board should strengthen monitoring of quality and safety by:	Ensuring it complies with the Duty of Quality requirement to produce an annual quality report	• Annual timetable agreed for production and approval. • Report demonstrates quality planning, assurance and improvement. • Board approval and publication achieved.	• Quality Committee	Director Corporate Governance					
	Reporting annually on how it is achieving its Duty of Candour	• Annual Duty of Candour report produced and scrutinised. • Learning and improvement actions clearly articulated. • Board approval and publication completed.	• Quality Committee	Director Corporate Governance					
	Review arrangements for monitoring and agreeing the clinical audit plan at committee level	• Committee responsibility for clinical audit oversight confirmed. • Annual audit plan approved and monitored. • Delivery and impact reported regularly.	•Quality Committee • Audit Committee • Integrated Performance Report	Director Corporate Governance					
5. The Health Board should clarify Board and committee arrangements for reporting on its Quality Improvement and Efficiency Plan	Review arrangements for reporting and monitoring and agreeing the quality improvement and efficiency plan	• Committee ownership for quality improvement and efficiency plan agreed. • Routine progress and impact reporting received. • Risks escalated through governance processes.	• Quality Committee	Director Corporate Governance					

CAVUHB Quality and Safety Governance Internal Audit

Exec Lead: Jason Roberts/David Fluck

SRO: Natasha Goswell

					25/26	2026/2027			
Standard	**Standard requirements**	**Actions**		**Action Owner**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**

1. Establish and evaluate the current Quality & Safety Governance arrangements operating within the Health Board	Clearly defined Quality & Safety Governance structures are in place, formally agreed, documented and routinely reviewed for effectiveness.	Map existing governance structures; review terms of reference; evaluate effectiveness; identify and address gaps.	• Templates on Corproate Governance Pages • Quality weekly committee	Deputy Executive Nurse Director					
2. Are the current arrangements clearly documented within relevant policies / procedures and are they readily available / known across the organisation	Governance arrangements are documented in approved policies and procedures and are accessible and understood by staff.	Review and update policies; ensure central accessibility; communicate and embed via induction and training.	• Corporate Governance Pages • Audit of policies	Director Corporate Governance					
3. Do the arrangements allow for a clear and timely route of reporting, escalation and assurance from ward and service areas up to the Board	Clear, timely reporting and escalation routes exist from ward/service level to Board, supported by assurance mechanisms.	Review escalation pathways; clarify thresholds; test routes using examples; strengthen Board assurance reporting.	• Clinical Governance Framework •Monthly Executive Review meetings	Director Corporate Governance					
4. Are the processes within the Clinical Boards operating in accordance with the stated policies / procedures	Clinical Boards consistently apply governance processes in line with agreed policies, with oversight and monitoring.	Undertake compliance reviews; identify variation; agree corrective actions; share good practice.	•Monthly Executive Review Meetings •Audit of clinical governance framework	Deputy Executive Nurse Director					
5. Do key management and clinical staff within the Clinical Boards have a good knowledge and understanding of the processes and what they should do if they become aware of an issue	Key staff have appropriate knowledge of governance, reporting and escalation responsibilities.	Assess knowledge; deliver targeted training; reinforce responsibilities through appraisal and leadership forums.	• Clincal Boards Training needs assessment •Training records •Improvement trajoectories on key performance indicators •Attendance records and minutes of meetings and action logs	Deputy Executive Nurse Director					

CAVUHB detailed action plan against the NHS Wales Escalation framework

Exec Lead: Jason Roberts/David Fluck

SRO: Natasha Goswell

					25/26	2026/2027			
Standard	**Standard requirements**	**Actions**	**Evidence link**	**Action Owner**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
1. Evidence (via submitted documentation) of quality and safety, quality governance and quality improvement progress through an agreed bi-annual self assessment		• Agree bi-annual self-assessment template & schedule • Collect evidence (quality & safety, governance, QI) • Maintain single evidence repository with version control • Produce summary dashboard & narrative • Exec sign-off and submit to NHS Wales • Log feedback and track actions to closure		Associate Director Patient Safety/Associate Medical Director Patient Safety					
2. IPC - to be in lines with All-Wales average over 2 succesive quarters	Number of cumulative C.Difficile cases	• Maintain real-time CDI surveillance and reporting • Complete RCA for every case and implement learning • Strengthen antimicrobial stewardship & prescribing review • Weekly IPC ward rounds + cleaning/hand hygiene audits • Check isolation compliance and cohorting • Report vs All-Wales average; escalate if >2 consecutive quarters • UHB attendance at All Wales C.Diff collaboarative • Case review through Executive Oversight group • Monthly tracking through Executive performance review	• Harp data • Integrated Perfromance Report • Beacon Dashboard • Shaping our Future Quality Excellence - IPC Surveillience • IPCG • Executive Review Meeting Monthly	Head of IPC Clinical Board Directors of Nursing					
	Number of Hospital onset E.Coli BSI	• Maintain real-time HO E.coli BSI surveillance • Complete RCA and share learning for each case • Review catheter/line necessity daily; reinforce bundle compliance • Aseptic technique refresh training for relevant staff • Monthly device care audits and cluster review • Publish run charts vs benchmark and implement targeted actions • Monthly tracking through Executive performance review	• Harp data • Integrated Perfromance Report • Beacon Dashboard • Shaping our Future Quality Excellence - IPC Surveillience • IPCG • Executive Review Meeting Monthly	Head of IPC Clinical Board Directors of Nursing					
	Number of MRSA BSI cases	• Maintain MRSA BSI surveillance and timely reporting • Ensure screening + decolonisation compliance • Complete RCA for each case and implement learning • Reinforce hand hygiene & environmental cleaning programme • Care bundle audits (lines/wounds) with feedback to teams • Quality Committee monthly reporting; demonstrate improvement over 2 quarters • Case review through Executive Oversight group • Monthly tracking through Executive performance review	• Harp data • Integrated Perfromance Report • Beacon Dashboard • Shaping our Future Quality Excellence - IPC Surveillience • IPCG • Executive Review Meeting Monthly	Head of IPC Clinical Board Directors of Nursing					

3. Complaints	65% of complaints to be closed within 30 working days (by date received) over two successive quarters 40% of complaints to be closed at early resolution (from April 2026 under listening to people regulations due for publication)	• Map complaints process and remove bottlenecks • Daily triage and allocation with clear due dates • Tracking system (received date → response deadline) • Weekly backlog review with escalation for overdue cases • Staff training + response templates • Monitor KPI (≥65% closed within 30 working days) and report quarterly	• Integrated Performance Report • Annual Plan • Beacon Dashboard • Monthly Executive Reviews	Associate Director of Patient Experience					
4. Never Events	Sustained reduction in never events (by incident date) to be demonstrated over two successive quarters	• Review never event policy vs national guidance • Implement preventative checklists and STOP-the-line culture • Implementation of NatSipps and LocSipps organisational wide group • Rapid RCA + learning within agreed timescales • Monthly audits of high-risk processes with feedback • Mandatory training/competency checks for relevant staff • Board reporting; evidence sustained reduction over 2 successive quarters	• Annual Plan • Integrated Performance Report • Executive Review Monthly Meeting • weekly quality meeting • Structured Assessment	Associate Director of Patient Safety					
5. NHS Staff Survey - raising concerns	Health board reported improvement over two quarters in the raising concerns sub-score on NHS Staff Survey	• Strengthen Freedom to Speak Up/Guardian arrangements • Awareness campaign and simple reporting routes • Leadership training on psychological safety • Timely feedback loop to staff who raise concerns • Track themes/actions monthly and remove repeat issues • Quarterly pulse checks to evidence improvement over 2 quarters	• Pulse Checks • Staff survey results • Integrated Performance Report • Annual PLan • People and Culture Committee • Shaping our Future People First	Executive Director of People and Culture Director of Corporate Governance					
6. Hospital Mortality	Analysis and deep dive when the rate of hospital mortality within 30 days following emergency admission for hip fracture in patients aged over 64 deviate from the All-Wales average	• Monitor hip fracture mortality/outcomes monthly against benchmark • Define trigger thresholds for deviation from All-Wales average • Case-note review and thematic deep-dive when triggered oversight by Medical Director • Review pathway (time-to-surgery, peri-op care, rehab) • Agree actions with Trauma/Orthogeriatrics MDT • Track delivery and re-measure improvement	• Mortality Dasboard • Beacon Dashboard • Annual Plan • Integrated Perfromance Report • Learning from Deaths group • Monthly Executive Review Meeting	Associate Medical Director Patient Safety					
	Analysis and deep dive when the rate of hospital mortality within 30 days following emergency admission for stroke patients deviate form the All-Wales average	• Monitor stroke mortality/outcomes monthly against national benchmark • Define trigger thresholds for deviation from All-Wales average • Case-note review and thematic deep-dive when triggered, oversight by Medical Director • Review pathway (door-to-needle, complications, access to thrombectomy) • Agree actions with Stroke MDT • Track delivery and re-measure improvement	• Mortality Dasboard • Beacon Dashboard • Annual Plan • Integrated Perfromance Report • Learning from Deaths group • Monthly Executive Review Meeting	Associate Medical Director Patient Safety					

Annual Report of the Quality Committee 2025/26

1.0 INTRODUCTION

In accordance with best practice and good governance, the Quality Committee ("the Committee") produces an Annual Report to the Board setting out how it has met its Terms of Reference during the financial year.

2.0 MEMBERSHIP

The Committee met nine times during the period 1 April 2025 to 31 March 2026. This is in line with its Terms of Reference. The table below demonstrates the attendance of the Committee Members through 2025/26 noting that greyed out areas show when a particular member was not in post.

Attendance	01/04/2025	13/05/2025	24/06/2025	05/08/2025	16/09/2025	28/10/2025	09/12/2025	20/01/2026	03/03/2026	Graph	Percentage
Ceri Phillips	☑	☑	☑	☑	☑	☑	☑	☑	☑		100.00%
Rhian Thomas	☑	☑	☑	☑	☑	☑	☑	☑	☑		100.00%
Steve Riley	☐	☐	☐	☐	☐	☑	☐	☐	☐		11.11%
Mike Jones	☑	☑	☐	☑	☑	☑	☑	☑			87.50%
Clive Curtis				☑	☑	☑	☐	☑	☑		83.33%
Judi Rhys								☑	☐		50.00%
Jason Roberts	☑	☑	☑	☑	☐	☑	☑	☑	☑		88.89%
Paul Bostock	☑	☑	☐	☑	☐	☑	☑	☐	☑		66.67%
David Fluck	☑	☑	☑	☑	☐	☑	☐	☐	☑		66.67%
Emma Cooke	☑	☑	☑	☑	☑	☑	☑	☐	☑		88.89%
Claire Beynon	☑	☑	☑	☑	☑	☐	☑	☐	☑		77.78%
Matt Phillips	☑	☑	☑	☑	☑	☑	☑	☑	☑		100.00%

**If an Executive was unable to attend a Committee meeting, a Deputy would be sent.*

The Committee achieved an attendance rate of 76.74% (80% is considered to be an acceptable attendance rate) during the period 1st April 2025 to 31st March 2026.

3.0 TERMS OF REFERENCE

A shared General Terms of Reference which applies to every Committee was reviewed and approved by the Board on the 28 November 2024.

4.0 WORK UNDERTAKEN

The purpose of the Committee is to provide advice and assurance to the Board with regards to the discharge of its functions and responsibilities around the quality, safety and experience (QSE) of health services within the Health Board. During the financial year 2024/25, the Committee considered the following:

- **Clinical Board Assurance Reports**

The Committee received and discussed Clinical Board Assurance reports and Patient Stories from each of the Clinical Boards. These reports provided details of the clinical governance arrangements within the Clinical Board. The reports identified the achievements, issues, progress and planned actions to maintain the priority of QSE which had arisen during the previous 12 months.

  - Surgical Clinical Board – 01.04.2025
  - Specialist Services Clinical Board - 13.05.2025
  - Clinical, Diagnostic & Therapies (CD&T) Clinical Board – 05.08.2025
  - Primary, Community and Intermediate Care (PCIC) Clinical Board – 28.10.2025
  - Mental Health Clinical Board – 09.12.2025
  - Children & Women Clinical Board – 20.01.2026

- **Quality Indicators Report**

The Committee received an overview of the Health Board's current performance against a range of agreed quality indicators which included Patient Safety Incident Reporting, Infection Prevention and Control, Deteriorating Patients and Resuscitation, Patient Falls, Pressure Damage, Medication Safety, Mortality, Audit and Assurance, Internal and External Assurance, Workforce, Concerns, and Patient Experience.

In addition, the Committee were frequently presented with Deep Dives on the following topics:

- The Deteriorating Patient – 01.04.2025
- Nationally Reportable Incidents (NRIs) - 24.06.2025
- Infection, Prevention & Control (IP&C) - 16.09.2025
- Care After Death Processes and Learning from Mortality – 09.12.2025

- **Policies for Approval**

A number of policies were discussed & approved at the Committee as follows:

1. UHB 529 - Policy for the Management of Suspected and Proven Neutropenic Sepsis in Adults
2. UHB 372 – CAVUHB Hospital Discharge Policy (integrated with Cardiff and Vale Local Authorities)
3. UHB 009 - Intervention Not Normally Undertaken (INNU) Policy
4. UHB 556 - Management of visitors within the Operating Theatre Department Policy
5. UHB 484 – Independent and Supplementary Prescribing Governance Framework
6. UHB 272 - Healthy Eating Standards for Hospital Restaurant and Retail Outlets
7. UHB 567 - Biological Medicines Value Optimisation Policy
8. UHB 333 – NHS Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR)

- **Minutes from Clinical Board QSE Sub-Committee Minutes**

A number of minutes from Clinical Board QSE Sub-Committee minutes were noted at the Committee meetings, which included:

- Children & Women's Clinical Board
- Medicine Clinical Board
- Primary, Community and Intermediate Care (PCIC) Clinical Board
- Clinical, Diagnostic & Therapies (CD&T) Clinical Board
- Specialist Services Clinical Board

Additional minutes noted by the Committee included:
- Safeguarding Steering Group (SSG) Minutes
- Infection Prevention and Control Group (IPCG) Minutes

- **Other matters of business discussed during the year, included**: -

- Children Looked After Assessment Backlogs Update
- Research and Development Update
- Baby Friendly Breastfeeding Accreditation
- Medical Records Tracking Update
- Cancer Services – Audit Wales report
- Smoking Cessation Internal Audit report
- Joint Commissioning Committee (JCC) Quality, Safety and Outcomes Highlight report
- Learning from Mortality
- Royal College of Psychiatrists (RCP) Progress Update
- Quality Excellence Framework Board
- Discharge Advice Letters (DALs)
- Board Assurance Framework (BAF)
- Suicide and Self-Harm Prevention Strategy
- Primary Care Eye Needs Health Assessment
- Prevention of Future Deaths (PFDs) Update
- IP&C Position Update
- Clinical Effectiveness Committee Report
- Regional Health Protection Partnership
- Vale Food Strategy
- Follow-Up Health Roster System Internal Audit report
- Invited Service Review (IRS) of CAVUHB Mental Health Services
- Equity, Equality, Experience and Patient Safety Action Plan Update
- Theatres Review
- Hepatitis B/C Recovery Plan Update
- No Smoking Enforcement Update
- UHB Clinical Services Plan (CSP)
- Patient Catering Nutrition Update – Providing Quality Care
- Update for Women's Health Hubs
- Ombudsman Annual Letter
- Tackling the Planned Care Challenges – risks / incidences of harm
- Annual Director of Public Health Report 2025
- WHO Checklist Implementation and Compliance
- Limited Cyber Security internal audit report – implications for quality and safety
- Bariatric and Medical Cylinders – Patient Safety
- Controlled Drugs Accountable Officer Annual Update
- Audit / Escalation Update
- JACIE Report
- Quality Management System (QMS)
- Annual Quality Report 2024/25

All items discussed were reported to the Board via the formally agreed minutes and Chairs Reports.

Papers for the above items, are all available on the Cardiff and Vale University Health Board website, linked here.

5.0 REPORTING RESPONSIBILITIES

The Committee reported to the Board following each of its meetings by presenting a summary report of the key discussion items at the Committee. The report is presented by the Chair of the Committee.

6.0 OPINION

The Committee is of the opinion that the Quality Committee Report 2025/26 is consistent with its role as set out within the Terms of Reference and that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Through Q1 of 2026/27, a review of the Quality Committee's work and function is being undertaken. This review will encompass the below:

- The sub-Committee structure, and how issues are being appropriately escalated to Quality Committee and Board
- Alignment of the Quality Committee focus to the organisation's strategic portfolios
- Clinical Board presentations
- Cover report templates to follow a AAA format (Assure, Alert, Advise), as recommended in the Structured Assessment
-

Changes to the Quality Committee are anticipated to commence in June 2026.

Ceri Phillips

Committee Chair

Minutes of the Children & Women's Clinical Board QSE (CWQSE) Committee
Held on Tuesday 27th January 2026 at 8.30am
Via Microsoft Teams

Present:		**Title**
Karenza Moulton	KM	Deputy Director of Nursing, C&W Clinical Board (CHAIR)
Emma Bramley	EB	Quality & Safety Lead, CHFW Directorate
Georgina Mather	GM	Operational Services Manager
Paula Davies	PD	Clinical Governance & Risk Lead Nurse, CYPFHS Directorate
Tina Freeman	TF	Interim Lead Nurse, CHFW Directorate
Alison Lewis	AL	Patient Safety Facilitator
Elizabeth Smith	ES	Clinical Governance & Risk Lead Nurse, Neonatal Services
Angharad Grimwood	AG	Governance Midwife, O&G Directorate
Rhodri John	RJ	Directorate Manager, O&G Directorate
Mallinath Chakraborty	MC	Clinical Director, Neonatal Services
Lois Mortimer	LM	Head of Midwifery/Directorate Lead Nurse, O&G Directorate
Tiron Pryce	TP	Health & Safety Advisor
Becci Ingram	BI	General Manager, CYPFHS Directorate
Genevieve Thueux	GT	Clinical Director, CHFW Directorate
Debbie Engstrom	DE	Interim Service Manager, CHFW Directorate
Alison James	AJ	Lead Nurse, CYPFHS Directorate
Gareth Simpson	GS	Interim Head of Estates
In Attendance		
Kirsty Hook	KH	Risk, Governance & Patient Experience Facilitator, C&W Clinical Board
Apologies		
Andy Jones	AJONES	Director of Nursing, C&W Clinical Board
Anthony Lewis	ALEWIS	Clinical Board Pharmacist
Fionn Lloyd	FL	Safeguarding Nurse Advisor
Janice Aspinall	JA	Lead Health & Safety Staff Side Representative
Louise Platt	LP	General Manager, CHFW Directorate

Item No	Agenda Item	Action
CWQSE/ 2026/001	**Welcome & Introduction** The chair welcomed everyone to the meeting.	
CWQSE/ 2026/002	**Apologies for Absence** The apologies for absence were noted **The CWQSE resolved:** a) The apologies were noted	
CWQSE/ 2026/003	**Minutes of the previous Q&S Meeting held on 23rd December 2025** The minutes of the meeting held on 23rd December 2025 were agreed to be an accurate record. **The CWQSE resolved:** a) The minutes were noted and agreed	

CWQSE/ 2026/004	**1.4 To note and update the latest action log (from AMaT System)** The action log is now available via AMAT for live updates to be provided. It was noted that there are a few outstanding action from 2025 that require update. KH agreed to follow up outside of the meeting and update the action plan accordingly. **The CWQSE resolved:** a) Action log to be updated via the AMaT system following the meeting. b) Any outstanding updates to be reviewed and actioned following the meeting.	**KH**
HEALTH & SAFETY		
CWQSE/ 2026/005	**Update from Operational Health & Safety Representative** **Needle-stick and Sharps Incidents** Increase in avoidable sharps injuries, including needles left on surfaces and incorrect disposal causing bin-bag punctures. Teams asked to revisit safe sharps practice and ensure investigations occur promptly. **Slips, Trips and Falls** Rise noted, partly linked to wet weather and environmental housekeeping. Staff are reminded to follow spillage procedures and contact housekeeping promptly. **Lone Worker Devices** Low compliance in several areas (notably CAMHS and Midwifery). Teams were asked to: • Review risk assessments before returning unused devices • Ensure monthly or quarterly device testing • Engage with H&S if staff are reluctant to use devices • Review duplicate team listings (e.g., Health Visiting/Flying Start) to be checked. **COSHH System and Supplier Change** Provider has switched to a per-assessment charging model. One-year grace period granted for system cleansing. Services urged to: • Review and archive obsolete assessments • Engage with cost leads to ensure full visibility **Manual Handling and Bed Safety** Ongoing delays in Medstrom bed contract approval. New Solo-Lux bed training underway; rollout to follow once staff trained. **Estates Concerns** • Recurrent leaks across sites remain a significant operational risk. • Estates are undertaking a large MR system reset; some jobs will appear "closed" as part of backlog clearance. Teams advised to re-raise still-outstanding issues.	

	The CWQSE resolved: a) Update noted. b) Teams asked to revisit safe sharps practice and ensure investigations occur promptly. c) Teams to review low compliance of Lone Worker Devices and ensure a review of risk assessments before returning unused devices d) Teams to review COSHH assessments e) Teams advised to re-raise still-outstanding estates issues.	
CWQSE/ 2026/006	**Latest H&S Dashboard** – 2026-01 H&S Dashboard - January The latest H&S Dashboard was shared for information and onward dissemination. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2026/007	**Fire Safety Update** • Fire safety training will now be delivered via MS Teams. Cameras must remain on for attendance validation. • **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2026/008	**Feedback from H&S Staff Side** JA provided apologies for the meeting, however asked for the following to be noted: **Estates Issues** There are ongoing estates concerns across the Clinical Board that are impacting on the safety and wellbeing of both staff and patients/clients. This includes frequent leaks within the hospital and across community bases, which continue to cause significant disruption and risk. **Violence & Aggression (V&A) Incidents** There appears to be an increase in V&A incidents across the UHB. Staff have fed back that verbal abuse is becoming normalised, and as a result, these incidents may not be consistently reported. This is an area that requires attention to ensure staff feel supported and safe. **Use of Lone Worker Devices** From a Trade Union perspective, we would like to encourage staff to make full use of lone worker devices where available, as part of promoting staff safety, particularly in community and lone-working environments **The CWQSE resolved:** a) Update noted.	
GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY		
CWQSE/ 2026/009	**Health & Care Standards Directorate QSE Exception Reporting** The Directorates were asked to provide updates on specific areas of escalation and noting. **CYPFHS Directorate Report** • Breach of Duty of Confidence has been declared, with learning from recent concern raised around lack of clear consent. This will be shared through Q&S processes and Health Visiting professional forum as part of lessons	

	learnt. • Open NRI is almost complete, and one LRI which is progressing. • Cluster of V&A incidents specifically within the EWMH Service. Meeting being arranged to review incidents, and link with H&S to review controls and mitigations of risks. • X6 open formal concerns, themes continue. • Transfer of adult Learning Disability Service into the CYPFHS Directorate. Concerns noted regarding a lack of governance arrangements which will be reviewed, and a risk assessment is being developed to outline the risks and mitigation following the transfer from PCIC Clinical Board. • ICCNS service remains a significant risk, with the inability to implement new care packages and fully deliver current care packages. Recruitment is ongoing, which is hoped will improve the position. • CYFUNO Service continues to be a pressure due to vacancy of Band 8b lead. Support being provided by the CALDS service to cover the triage process and management of risks. • Administrative vacancies which are significant and running at 30-40% vacancy rate. Recruitment processes continue. • No open RIDDOR incidents. • Outstanding Fire Risk Assessments from UHL Children's Centre which are being reviewed for action and closure. • Ongoing discussions with regards to safeguarding supervision for a number of services and how this can be better utilised and supported across services. • Successful completion of the fluenz programme, with increased uptake and delivery of 35,000 immunisations. Challenges included new vaccines types and central changes, however the team managed to improve the coverage. • Work ongoing for HCWP 2 regarding the timescales and gaps in **Timely access** • ND waiting list continues to be an ongoing significant pressure. Work is ongoing with regards to outsourcing for first assessment; however, it was noted that this will have a significant impact on an already pressured service with regards to ongoing assessment. **The CWQSE resolved:** a) The report provided was noted for information and key highlights recorded.	
CWQSE/ 2026/010	**CHFW Directorate Report** • Standardised consent for Upper GI procedures was shared and ratified at Directorate Q&S which will ensure that consent comprehensively standardize the benefits and complications of the procedures. • No NRI's within ACH, x3 open LRI's are progressing. • Continuing Datix drive to action and close as many Datix incidents • X15 open formal concerns which are progressing • PICU has been under pressure with periods of overcapacity over the month of December. Risks have been mitigated through two daily huddles. • Risk Register – x3 risks over 16 which include the endoscopy service with children waiting in excess of 52 weeks for diagnostic endoscopy due to lack of theatre capacity. As a mitigation JCC are aware of the challenges and a service review will be undertaken. Sleep service is also a pressure due to demand and capacity gaps. A sleep technician has been seconded to support the service. Funding for PICU Psychologist is ceasing from Noah's Ark Charity. A further bid has been submitted, and the risk has also been raised with JCC. • 18 medicines management incidents reported, all of which reported as low	

	or no harm. Theme identified was missed administration of medications. • No open RIDDORS • Mandatory training 79.6% for level 1, and 62% for level 2. • Awaiting delivery of Solo Lux Beds and training is ongoing. • X7 pressure damage incidents reported. X1 will be progressed through scrutiny panel, initial review has noted that this is an unavoidable incident • IP&C Tendable scores noted at 80%, main area of improvement was noted to be environment. • Positive feedback has been received through Tendable and CIVICA platforms with scores being reported above 85% • Concern raised regarding a MARF submission. Noted that this was an appropriate submission and advice/support has been sought from both safeguarding and Information Governance • Deputy Days are being reintroduced to support the wellbeing of senior teams on the wards. Ward Sister PNF's will continue this year. • Recruitment is ongoing across a number of areas. **Neonatal Services** • X1 open NRI which is progressing to closure. X6 open LRI's which are progressing, with x2 progressing to closure this week. • Datix drive is continuing and progress has been positive. • X5 medication error incidents reported in month. No specific theme to note, however there has been a downward trend of reported incidents since last year, which is a positive position. • ANTT compliance (Nursing) 78% • NICU admission to discharge pathway and welcome to NICU booklet shared at the Directorate Q&S which will be implemented to inform how consent is managed within NICU. • NICU Insulin Pathway was shared • **Timely Access** • Inpatient Surgery – Level 2, 29 on waiting list, Level 3, 193 waiting. Longest wait is 60 weeks, with a TCI date. • Significant reduction in the inpatient waiting list. • No children waiting over 52 weeks for outpatient appointment within Paediatric Surgery. • General Paeds and sub specialties – no children waiting over 52 weeks for an outpatient appointment, with 51 children waiting over 36weeks. Longest wait is 39 weeks with dates being set. • Continuing to work with services to ensure clinic utilization always remains at 95%. DMT are reviewing DNA rates and improvements are being seen. • Paediatric Cardiology – longest wait is 24 weeks • Paediatric Endoscopy – 149 patients waiting, 138 are over 8 week target date. Longest wait is currently 84 weeks. **The CWQSE resolved:** b) Update noted.	
CWQSE/ 2026/011	**O&G Directorate Report** • 139 new incidents reported, with xx closed in month. Need to raise awareness with regards to the reporting of incidents under perinatal instead of reporting under obstetrics or neonatal • Number of new concerns received in December with themes including racial bias, breastfeeding on postnatal wards etc. • As of December 4 NRI's, 14 LRI's and 4 BIT for Obstetrics, x2 NRI's are	

	currently progressing to completion, and anticipated both will be closed within timescales. • No new risks reported in month for the risk register. • X4 medicines incident reported in month, all reported as low/no harm with no specific issues to note. • X2 pressure damage incidents reported in month. X1 is closed and x1 is being reviewed, however on initial investigation following reporting this does not look to be moderate harm. Further updates will be provided. • A thematic review of bladder care cases is underway, with an updated guideline pending ratification. Plans include education, spotlight sessions, and involvement of staff in quality improvement. • X10 staff voices reported in December, themes identified, and feedback provided. • Ongoing reviews are taking place with regard to the transfer to the Badgernet system, and the assurance that information is being transferred across from the E3 system • Civility Saves Lives day has been offered to staff which is a collaboration with ECOD. • New student streamlines commenced in September. Turnover rate is low is circa 5%. **Timely Access Update** • Cancer compliance – treatment compliance was 67% for October, 41% for November. December reported at 80% with the standard being 75%. • Demand & capacity start of pathway needs rightsizing and work is progressing to look at support for this within the new financial year. • Cystoscopies and Urodynamics – work is progressing with zero patients waiting over 8 weeks by the end of March being anticipated. • Weekly clinical oversight regarding antenatal clinic pressures continues. • Anticipated that there will be zero patients waiting over 104 weeks, which has been primarily due to planned care funding to allow backfill of theatres • Outpatient operating waiting times are significant pressure, with a number of patients waiting over 2 years, and it is anticipated that this wait is likely to increase due to a conversion of several daycases over to outpatient operating. • Fetal Medicine continues to breach due to demand and capacity. Consultant recruitment is progressing and once this is arranged, this should have a positive impact. Update provided that discussions are underway with potential changes within the Obstetrics & Gynaecology and Neonatal Services to create a Perinatal and Gynaecology Directorate. Work is progressing and further updates will be provided as this progresses. Communication has been shared with all teams on the workstreams, and updates will continue. **The CWQSE resolved:** a) The update was noted for information and key highlights recorded.	
CWQSE/ 2026/012	**Exception Reporting / New Risks to be considered for the Clinical Board Risk Register** Details noted as part of the Directorate report updates. **The CWQSE resolved:** a) The update was noted for information	

SAFE CARE		
CWQSE/ 2026/013	**Acute Patient Deterioration** Welsh Government Patient Safety Notice for a requirement for acute areas to have implementation an acute patient deterioration programme. Audit process requires improvement with regards to compliance against the new early warning scores. This is part of the lead and senior nurse tendable audit and current compliance is 83%. Work is required to ensure that audits are being completed appropriately, specifically within Obstetrics & Gynaecology. All were asked to ensure that the audits are being completed. **The CWQSE resolved:** a) The update was noted for information b) Ensure completion of audits as part of the lead and senior nurse tendable audits.	
CWQSE/ 2026/014	**NRI's/PSLR's for noting/exception reporting** • SBAR, PSLR and Improvement Plan – Datix 63610 – CM • SBAR, Birth Injury Tool and Improvement Plan – Datix 98222 – SG • SBAR, Birth Injury Tool and Improvement Plan – Datix 98865 – EHH The above cases have been discussed in detail as part of the NRI/LRI Governance Subgroup Meeting and were shared for information. Full detail was shared as part of the supporting SBAR's. There were no specific issues to highlight for this meeting. All improvement plans have been completed and are progressing to closure. **The CWQSE resolved:** a) Updates noted	
CWQSE/ 2026/015	Learning from Events for **noting/exception reporting** • Learning from Events (LFE) – CLM • Learning from Events (LFE) – HR • Learning from Events (LFE) – ET The above cases have been discussed in detail as part of the NRI/LRI Governance Subgroup Meeting and were shared for information. Full detail was shared as part of the supporting SBAR's. There were no specific issues to highlight for this meeting. **The CWQSE resolved:** a) Updates noted	
CWQSE/ 2026/016	Learning from Events for **discussion** **Learning from Events (LFE) 2795 – SAC** The draft LFE was shared for information. This was a historic neonatal case from 2013 brought for formal discussion. The evidence from the original review could not be located, so the case was revisited to ensure learning is captured and assurance is documented. **Overview of the Event** Term baby discharged home before a newborn examination (NIPE). Readmitted the following day with bilateral pneumothoraces.	

	RCA at the time found: • Rare severe respiratory deterioration • Possible delay in diagnosis • No symptoms evident at discharge **Key Issues Identified** A. Missed Identification of Abnormalities Prior to Collapse Baby had no documented concerns at 8–9 hours pre-collapse. Historically staffing and process differences meant not all newborns received early examinations. Improvement since: • Implementation of NEWTT2 across hospital and community (Dec 2024 and July 2025). • Clear assessment requirements for newborns within first hour of life. B. Discharge Without NIPE Examination NIPE expected between 3–24 hours. Current guidance emphasises examination before transfer home. Updated neonatal pathways now support earlier identification of emerging concerns. C. Failure to Record a Telephone Call (Documentation Gaps) The midwife's postnatal telephone advice call was not recorded in 2013. Improvement since: • Introduction of BadgerNet, requiring digital documentation of all contacts. • Quick guides and process instructions support safe use. D. Potential Delay in Suspecting Pneumothorax No specific local guidance existed in 2013. Current practice: Parents receive clear discharge information on red-flag symptoms. Updated neonatal care pathways outline escalation for respiratory concerns. • **The CWQSE resolved:** a) Updates noted	
CWQSE/ 2026/017	**Infection Prevention Control Update Report** No specific update to note for this meeting. **The CWQSE resolved:** a) Updates noted b) Update to be requested from IP&C	
CWQSE/ 2026/018	**Safeguarding/Mental Capacity Act (MCA)** • Promoting Decision Making and Consent in Wales – Training **The CWQSE resolved:** **a)** Update noted.	
CWQSE/ 2026/019	**Patient Safety Alerts (internal/external)/Welsh Health Circulars** • Safety Memo – Andexanet Alfa • Safety Memo – Rybelsus (semaglutide) • MHRA Safety Roundup	

	• NPSA/2010/RRR013 – Safe Administration of Insulin – Use of Insulin Syringes • Safety Memo – Co-codamol shortage This alert has been circulated for onward sharing and action as necessary. There were no specific exceptions to note. **The CWQSE resolved:** a) Alerts noted.	
CWQSE/ 2026/020	**Clinical Audit** **Overdue Guidance Summary Update** The update was noted. The group were asked to review all outstanding guidance and provide update to the Clinical Audit team on position against compliance. **The CWQSE resolved:** a) Update noted.	
CWQSE/ 2026/021	**Medicines Safety Executive Update** No specific update to note for this meeting.	
TIMELY CARE		
CWQSE/ 2026/022	**Directorate concerns & assurance update** Discussed as part of the directorate reports. New PTR process is coming in from April 2026, with a specific focus on early resolutions with the implementation of a listening discussion. With more complex concerns there will be new timeframes for completion. It was noted that there will also be changes to the redress process. Angela Hughes will attend a further meeting to provide an update on the changes. **The CWQSE resolved:** a) Update noted. b) Invite to be sent to AH to attend future meeting	**KH**
CWQSE/ 2026/023	**Patient Feedback** The Latest CIVICA Summary Report Children and Women's report was shared for information. **The CWQSE resolved:** a) Update noted.	
ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE		
CWQSE/ 2026/024	**Resus Monthly Summary C&W** The summary report was noted and shared for information. **The CWQSE resolved:** a) Update noted.	

CWQSE/ 2026/025	**ANTT Compliance** Compliance to be included on your exception reports for every month. All were asked to ensure this is included going forward. This should include both nursing and consultant workforce where possible. **The CWQSE resolved:** a) Update noted. b) ANTT Compliance to be included on exception report updates	**ALL**
ANY OTHER BUSINESS		
CWQSE/ 2026/025	**Date and Time of Next Meeting** Tuesday 24th February 2026, 8.30am, Microsoft Teams.	**ALL to note**

Minutes of the Medicine Clinical Board
Quality, Safety & Experience Committee Meeting
18 February 2026 14:15 – 15:45, via MS Teams

	Attending	Apologies
MCB Operations/ Nursing Directors & Deputy Directors	Jane Murphy (Chair)	Katja Empson, Cari Randall, Claire Main, Emma Davies
Clinical Directors		Siobhan Lewis, Sharon Jones, Nikola Creasey, Chen Ngua, Aneurin Buttress, Richard Marsh, Tom Pembroke, Neera Agarwal, Lyndsey MacDonald
Patient Safety Team		Rajani Ponnada
Staff-side		Jonathan Strachan-Taylor
Pharmacy		Manon Owen
People Services		Louise Halliday-Jones
Quality & Governance Lead		Zara Jenkins
Consultant Nurse Practitioner, ED		Marianne Jenkins
General/ Deputies Managers	Emma Keen	Vicci Page
Lead Nurses	Wayne Parsons, Natasha Whysall	Ceri Martin
Senior Nurses	Lisa Green, Beth Jones, Rachael Maiden	Harriet Foley, Sue Eshel, Sian Brookes, Lowri Warren, Claire O'Keeffe, Cath Morris
Senior Nurse, Resuscitation		Angela Jones
Professional & Practice Development Nurses		Sam Hughes, Liz Vaughan
IP&C CNSs	Leeanne Provis, Hannah Pulis	
Organisational Learning Facilitator, Mortality Lead	Nick Denny	
Ward Clerk, C4	Dionne Wood	
Endocrine Registrars	Frederick Keen, Shah Rukh Malik	
I&I		Jess Jones
Secretariat		Sheryl Gascoigne

		Action
1. PRELIMINARY ITEMS		
MCBQSE/ 2026/1	**Welcome and Introductions** – were undertaken. **To receive the minutes of the previous meeting held on 17/12/25** – the minutes were accepted as an accurate account of the meeting. **Action Log** – was updated. **Declarations of Interest** – none declared.	
2. ITEMS FOR REVIEW AND ASSURANCE		
MCBQSE/ 2026/2	**Patient Story** – delivered by Dionne Wood (DW) Cardiff Stroke Social Club was set up over 15 years ago by Dr Shetty, Stroke Consultant and DW is a volunteer and Chair at this group. Over the past four years, the club has expanded and now runs three monthly sessions: Lunch Club; Evening Social; Stroke of Harmony Choir. The therapeutic value of music was recognised, and 12 months of funding was secured from Cardiff & Vale Health Charity to launch the choir. The first choir taster session attracted around 25 participants, including stroke survivors, families, staff, and hospital colleagues.	

	DW co-leads the choir alongside a young stroke survivor and musician. The choir is already demonstrating strong emotional and therapeutic benefits, especially for participants with aphasia and recently bereaved individuals. DW is in discussions with the Waterloo Foundation for extended funding. Feedback has been overwhelmingly positive. The choir has been invited to perform at the launch of the new Charity Hub in the Concourse. Further information on the choir is available on social media on X, Facebook and Instagram. **Action**: JM will contact Dionne Wood to discuss the work carried out with the choir which is positively impacting patients and their families. **Action**: WP and DW will meet to discuss further and sharing this information with SRC. **The group resolved: i**t would be appreciated if staff could promote the choir and social sessions through hospital networks and stroke pathway teams.	JM WP/DW
MCBQSE/ 2026/3	**MCB Concerns, January 2026** - there are 74 open concerns across MCB as below: Concerns over 75 days throughout C&VUHB are being reviewed. MCB are to close 5 of these concerns by 31/3/26. There are currently 11 concerns which have been open for over 75 days. Areas of focus are AU and EU. **Action:** JM will share the information with colleagues. **Compliments** **A&E** 'a very heartfelt thank you to A&E staff. I was seen quickly and the receptionist helped me check-in. She was so calming and supportive. I was soon checked by another woman who took me into an examination room and explained what she was going to do so that I understood the next steps which included stitches and quickly gave me painkilling gas. The doctor was very kind. His professionalism and sense of humour helped me bear the stitches and feel lucky that the cut had not injured any tendons. I was in and out of A&E in 1.5 hours if not less. Each member of the team was professional, courteous and informative which helped me physically and emotionally as they helped me remain calm and confident that I would be fine and that my hand would be fine. Many thanks to everyone involved in treating my hand and to the whole A&E team. The wound is healing well!' **A&E** 'I wanted to thank the team who treated me in A&E last night. I was seen promptly and felt listened to and taken seriously at what was a very stressful time for me. The assessment was thorough, the plan was clearly explained, and I was reassured throughout. I'm very grateful for the professionalism and kindness shown by everyone involved. Please pass on my thanks to the doctors and nurses who were on duty'. **Bowel Screening Wales/Endoscopy** 'my immense gratitude for the Bowel Screening Team at Llandough Hospital. The Staff Nurse was very engaging, professional and reassured me. I was allocated a very prompt appointment (within three weeks of the call), which I attended at 9am 08/01/2026. From the moment I arrived in the department I was put at ease by the friendly professionalism of all the staff from the unit receptionist to the Bowel Team completing the examination. The whole process of booking me in and getting prepped was quick and efficient I really felt like I was in the care of professionals, who are at the top of their game, where nothing was too much trouble. Throughout the procedure Dr took the time to explain to me what was happening and what he had found, answering any questions	JM

Compliments	Formal Concern	Early resolution Concern	Enquiries	
Emergency Medicine	4	26	2	8
Integrated Medicine	0	25	3	23
Specialised Medicine	2	12	3	29

	I had. The whole process took two hours, I feel it is important to recognise exceptional service when it is offered. I feel fortunate to have been treated so well by the whole of this'. **The group resolved/ Action**: to share these compliments with teams. **Family feedback** – ND will liaise with ZJ regarding feedback. Themes are hydration, nutrition, communication and end of life care.	
MCBQSE/ 2026/4	**Infection Prevention and Control (IP&C)** January 2026 MCB position based on same period 2024-2025: • Reduction - no cases of *Pseudomonas* since March 2025 • 35% reduction with *C. difficile.* • 21% increase with MSSA Bacteraemia's • 67% reduction in MRSA Bacteraemia's • 25% Increase *with Klebsiella* Bacteraemia's • 12% increase with *E. coli* Bacteraemia's	

Organism	Total for the month – Jan 26	Total April 2025 – Jan 26
C. difficile	4	35
MSSA	2	17
MRSA	0	1
Klebsiella	3	20
Pseudomonas	0	0
E. coli	2	28

Incidents and Outbreaks

	Total number of outbreaks In January 2026	Total patients affected	Total staff affected	Total number of bed days lost
Total MCB	13	20	1	21
Total UHW	10	16	0	21
Total UHL	3	4	1	0

Current Incidents and Outbreaks
C7 - whole ward closure, 20 patients affected, 8 confirmed as Norovirus and 8 staff.
A7 – 9 bedder closed with 3 patients affected by Norovirus.
East 2 – 8 patients affected and 1 confirmed with Norovirus.
East 6 – 14 patients and 1 staff member affected by Covid-19, 9 patients confirmed.

Audits – all results are shared in the monthly report.
3 wards have had 0% compliance for clean commodes.
PVC audits have highlighted poor compliance with VIP scoring. Insertion documentation also remains an area of poor compliance. BBE good compliance across UHW wards.
Joint environment audits with IP&C, Housekeeping and Estates have been arranged.

RCAs Outstanding – up to 31/1/26

Organism	No. of RCAs sent	No. of RCAs returned	No. of RCAs outstanding	% Return rate
C. difficile	35	29	6	83%
MSSA	17	15	2	88%
MRSA	1	1	0	100%
Klebsiella	20	16	4	80%
Pseudomonas	0	-	0	-
TOTAL	73	61	12	84%

Other News
- Mandatory mask wearing in unscheduled care was stood down on 20/1/26.

	• Increase in Norovirus cases. • Link Practitioner Study Days scheduled for 3/3/26, 1/7/26 and 2/10/26. • IP&C education sessions are planned for C7 training days in March and April 2026. • New decontamination room on 2nd floor corridor will enable equipment and beds to be HPV cleaned following PII and outbreaks. **Actions/ the group resolved:** to note the above and an overarching action plan will be prepared for MCB.	
MCBQSE/ 2026/5	**Death Certification Update** - in January 2026, from patient death to QR code being completed has significantly improved overall in C&VUHB.	
3 ITEMS FOR APPROVAL/ RATIFICATION		
MCBQSE/ 2026/6	**National Reportable Incidents (NRIs)** as at 10/2/26 There are currently 24 open NRI's. Key focus will be on the overdue NRIs. • **Integrated Medicine (IM)**: 3 open- 1 expected for closure in February, however likely to be delayed and 1 to be downgraded. • **Specialised Medicine (SM)**: 11 open- 5 overdue. (1 in final draft, 1 awaiting improvement plan likely close end of February 1 in first draft, 1 at information gathering stage, 1 awaiting sign off PSQ). • **Emergency & Acute Medicine (A&E)**: 4 open- 3 overdue (2 awaiting sign off PSQ, 1 in first draft). • **IR(ME)R-** 6 open (5 at factual accuracy- aiming for closure end February 2026, 1 at information gathering) **New NRI's Reported**: 4 Reported - 1 Assault RIP, 1 unstable hypoglycaemia (to be downgraded) and 2 pressure damage. **Closures**: 2 pressure damage - combined forms shared. **NRI's for closure**: Integrated Medicine: ID77021; ID79017; ID79631 **IM, ID91995** – on West 2 on 5/7/25 an elderly patient with lots of co-morbidities was discovered to have a grade 3 pressure ulcer was discovered. The patient was on the correct mattress, however, had been lying on the catheter. This was reportable. **Learning/ Actions:** • Reinforcing training for staff on device related pressure area care. • Regular audits of WNCR documentation. • It was documented that the patient was reluctant to move their position in bed. The patient was deemed to have capacity. • There was no evidence of a Stat-Lock fixation device being in place. Catheter bundles are now on the Welsh Nursing Care Record (WNCR) and staff have been reminded to ensure that the fixation device is observed and ticked within WNCR daily. **A&E, ID99404** – on 7/10/26 a patient was admitted with a category 2 pressure ulcer. During routine skin checks staff observed deterioration of the ulcer which appeared to have progressed to a suspected deep tissue injury. A referral was made to the Tissue Viability Nurse (TVN). An appropriate pressure-relieving mattress (Area Pro) was authorised and the patient received regular repositioning and pressure relief measures. **Learning:** • Documentation was brief regarding if the patient was being moved and turned in the bed regularly at night. • Staff have had further training on suspected deep tissue injuries and what to do. • Ensured current mattress selection information is available to the team and there are posters displayed. • Regular audits are taking place. • TVNs have given training to staff. **The group resolved:** to note the above.	

4	ITEMS FOR NOTING AND INFORMATION	
MCBQSE/ 2026/7	**Changes to the MCB 2018 Enhanced Supervision Booklet** – presented by Wayne Parsons. Relating to an LFE from an incident on East 7 regarding a member of staff providing 1:1 enhanced care to a patient who was deemed to have aggressive behaviour. The staff member reported that the patient was getting out of bed and was going to fall. The staff member caught the patient and hurt their wrist. The staff member had a soft tissue injury, and the outcome was pain and suffering. The staff member was not up to date with their training for falls and for manual handling. There was evidence of trying to engage the staff member with training who was allocated study time to undertake training. The staff member did not attend their required training. The staff member was injured, was not up to date with their training and the liability ultimately sits with the Health Board. Statutory and mandatory training compliance for East 7 was poor. A supportive action plan was prepared for the ward and training compliance has improved. If staff do not attend their allocated study days, then managers will enact a capability policy. Following the LFE, senior managers engaged with Ruth Cann. David Stimpson acts on behalf of C&VUHB regarding what should be sent to Welsh Risk Pool. The falls booklet was not fit for purpose. As part of learning and validation for the Welsh Risk Pool this is being presented at MCB QSE. This has been discussed at the Falls Group. **The group resolved:** to note the above.	
MCBQSE/ 2026/8	**4.2 Patient Safety Alerts/MDAs/ISNs** – to be noted.	
MCBQSE/ 2026/9	**4.4 Diabetic Ketoacidosis and New CAVUHB Charts** – presented by Frederick Keen, ST6-Endocrinology/DM Current charts are paper charts printed from the intranet. The DKA charts which have been rolled out in Aneurin Bevan UHB have been updated for use at C&VUHB and will be available, along with education, in the next few months. This chart will be presented at various medical meetings. The proposed updates to the DKA charts were discussed. **Hyperosmolar Hyperglycemic State (HHS) Charts** - presented by Shah Rukh Malik, ST6-Endocrinology/DM HHS usually affects those with pre-existing type 2 diabetes Mellitus and in those aged over 45 years old. The charts were discussed and are nationally acknowledged and followed.	
MCBQSE/ 2026/10	**Minutes from Directorate QSE Groups and Chairs Reports/Exceptions:** • Acute & Emergency Medicine • Integrated Medicine UHW • Integrated Medicine UHL • EUG last meeting **The group resolved**: to note the above. **Action from discussion:** none	
MCBQSE/ 2026/11	**Minutes from QSE Sub-groups**: • IP&C last meeting Feb 2026 • H&S last meeting (7th Jan 26) – JM will advise who will be the Chair. • Medicines Governance and Access Group minutes 17/12/25 - now stood down. • Professional Nursing Board - currently stood down.	
MCBQSE/ 2026/12	**Feedback from UHB QSE Committee** – no update.	
MCBQSE/ 2026/13	**AOB** **The following items will be carried over to next month's meeting.** **MCB Risk Register AMaT** – the top 5 risks on the overall MCB risk register will be discussed. Each directorate to discuss their top 5 risks and how they are managed. 20-minute time slot required for this.	

	Safeguarding – JM will invite a Safeguarding colleague to attend next month's meeting and give an update. **Roll out of the PRISMA Vent40 NIV machine. Starting Dec 2025. Respiratory CNS team have distributed posters/quick guides & most of B7 staff have had 'on the spot' training. P@rt team training has commenced and a roll out date for EU/AU is expected early Jan/Feb 2026**	
5. ANY OTHER BUSINESS/ DATE AND TIME OF NEXT MEETING		
MCBQSE/ 2026/14	**Date and time of next meeting** – 18/3/26 at 14:15 Teams meeting	

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

Held on 18th February 2026

Present:		
Helen Luton (Chair)	HL	Director of Nursing/Multi Professional Teams
Adam Christian	ACh	Clinical Board Director
Sarah Lloyd	SL	Director of Operations
Alicia Christopher	AC	General Manager, Radiology & Medical Physics/ Clinical Engineering
Edward Chapman	EC	Head of Clinical Engineering/ Medical Devices Officer/Assistant Director of Therapies and Health Sciences
Alison Lewis	AL	Patient Safety Coordinator
Suzanne Rees	SR	Lead Nurse for CD&T
Julia Dinley	JD	Head of Speech and Language Therapy
Jonathan Davies	JDa	Health and Safety Adviser
Vanessa Goulding	VG	Interim Head of Podiatry
Seetal Sall	SS	Point of Care Testing Manager
Carly Issit	CI	Assistant Practitioner, Radiology
Scott Gable	SG	Laboratory Service Manager, Cellular Pathology
Elaine Lewis	EL	General Manager, Pharmacy
Samantha Davies	SD	Radiographer, Radiology Department
Rhys Morris	RM	CD&T R&D Lead/Director of MPCE
Jo Fleming	JF	Quality Lead, Radiology
In Attendance:		
Gemma Taylor	GT	Nurse Advisor for Medicines Management
Kate Blower	KBl	Shaping Change Partner, Shaping Change Team
Angela Hughes	AH	Assistant Director of Patient Experience
Secretariat:		
Helen Jenkins	HJ	Business Support Manager
Apologies:		
Becca Jos	BJ	Deputy Director of Operations
Sion O'Keefe	SO	Head of Business Development/ Directorate Manager of Outpatients/Patient Administration
Melissa Melling	MM	Head of Medical Illustration
Kim Atkinson	KA	Clinical Director of Allied Health Professions
Debra Woolf	DB	Sister, Outpatients
Keeley Baker	KBa	Head of Health Records
Ruth Lang	RL	Office Manager, AWTTC
Jamie Williams	JW	Senior Nurse, Radiology
Emma Holmes	EH	Head of Nutrition and Dietetics
Bill Salter	BS	Lead Staff Representative
Sandra Watts	SW	Senior Nurse for EPMA, Pharmacy
Yvonne Hyde	YH	IP&C Team Representative
Timothy Banner	TB	Clinical Director, Pharmacy
Sue Lawless	SL	Laboratory Service Manager, Haematology
Tracy Wooster	TW	Sister, Outpatients
Nigel Roberts	NR	Laboratory Service Manager, Biochemistry

Tracy Wooster	TW	Sister, Outpatients
Sian Jones	SJ	Directorate Manager, Laboratory Services
Paul Williams	PW	Quality and Safety Lead, Medical Physics
Susan Beer	SB	Public Health Wales Representative

Item No	Agenda Item	Action
PRELIMINARIES		
CDTQSE 26/034	**Welcome & Introductions** HL welcomed everyone to the meeting.	
CDTQSE 26/035	**Apologies for Absence** Apologies for absence were noted.	
CDTQSE 26/036	**Minutes of the previous meeting 22nd January 2026** **The Group resolved that:** a) The minutes of the previous meeting were accepted as an accurate record.	
CDTQSE 26/037	**Matters Arising/Action Log** An update was provided on the outstanding actions from the previous meeting. *CDTQSE 26/023 SOP for Access to Records* Helen Luton to ask Sion O'Keefe if there is an update on an SOP being developed around the access to patient records process. *CDTQSE 26/023 Therapies Equality Work* JD to ask Sarah Clements if she can present the Equality and Inclusion work being undertaken in Therapies to a future meeting. *CDTQSE 26/024 Clinical Audit Leads* Directorates that have not yet submitted the name of their Clinical Audit Lead were reminded to send the names to HJ. *CDTQSE 26/032 Collating CD&T Estates Issues* AC asked for thoughts on whether an MS form or spreadsheet would be preferable for collating estates issues. It was noted that Therapies have already set up a spreadsheet and JD will send a copy to AC.	**HL** **JD** **Dirs** **All** **JD**

	The group resolved that: a) The updates to the outstanding actions were noted.	
6 DOMAINS OF QUALITY		
SAFE		
CDTQSE 26/038	**Concerns and Compliments Report** In January 2026, the Clinical Board received 55 concerns, 3 formal concerns and 52 to be resolved through early resolution. There were 2 breaches in response times and 1 compliment was received. The top themes of concerns received in January were: • Communication issues • Difficulties cancelling/arranging appointments The compliment received related to a positive patient experience within Medical Illustration. **New Listening to People Process** Angela Hughes was welcomed to the meeting to provide an update on the new Listening to People Process, that will be replacing the Putting Things Right process and comes into effect on 1st April 2026. This will impact on how the organisation manages what is currently known as concerns. Although this terminology will still be in the regulations, the UHB will be using the terms complaints, incidents, nationally reportable incidents, duty of candour, redress case which are much clearer and are preferred by patients and service users. The beginning of the Listening to People process involves a listening discussion. This could be an in-person meeting, a telephone conversation or a virtual meeting to ensure that the issues being raised by the patient and what they actually want investigated are understood. This will continue to be facilitated by the Coordinators. For complex complaints, a meeting may be required and a member from the clinical team will be requested to attend. A positive change is that any complaint where there is no allegation of harm can go through a Stage 1 process of early resolution, where a regulatory response is not required to be provided. Departments will have up to 5 days to offer a listening discussion and then 10 days from that point in which to respond. It is therefore likely that a greater number of concerns will be addressed through this route such as issues raised around waiting list enquiries, or where people are unable to contact departments to book appointments. Formal complaints will need to be responded to within 30 working days. There is an option for extremely complex concerns to be responded to within 6 months but robust	

	justification will be required for example, where complaints involve multiple Health Boards. At the beginning of the process, consideration will need to be given as to whether cases will require an external expert. This decision will need to be justified but there will be some cases where a local response will not be accepted. Expert reviews are costly and therefore careful consideration should be given to this. If a case becomes a redress case or a claim, the UHB will be able to reclaim the expert fee from Welsh Risk Pool. However, if it is identified that there was no breach and no harm, then the cost would need to be funded by the Clinical Board. The other major change is the redress threshold will be changing from £25k to £50k. This will allow for more cases to be managed under the redress process. The timeframes for completion of redress have reduced from 6 months to 5.3 months (120 working days). When triaging cases, it needs to be clearly determined whether the value of the case would exceed £50k. In these cases, no comments are to be made on breach of duty or causation, only a factual response will be provided. A further improvement in the new process is that all the legal elements of the regulatory response when referring to breach of duty and causation, will be provided as an appendix to the main letter. There is still discussion around the grading framework for harm. The duty of candour framework would be a suitable option but a decision is required from Welsh Government. Guidance will not be available on the new regulations until 1st April and the public communication will also be available on 1st April and these have not yet been shared with the Health Board. JF asked will there be any guidance produced by the UHB for staff dealing with concerns in advance of 1st April. It was noted that SharePoint pages have been developed to support staff managing concerns and guidance highlighting the key changes will also be circulated to the Clinical Boards. It was noted that there will be double running of 2 systems in early April for concerns received prior to 1st April. There will be changes to the coordinators allocated to Clinical Boards but the plan is to ensure a smooth transition. **The Group resolved that:** a) The concerns report was noted. b) Any queries on the new Listening to People Process to contact Angela Hughes.	

CDTQSE 26/039	**National Reportable Incidents** The open NRI report was circulated to the group. ID 44284 has been downgraded as an LRI and this incident will be finalised for closure. ID 75230 related to an incident in a creche session is now closed. ID 90068 relates to a pressure damage incident. The investigation has been completed and is being shared with the patient. ID 99980 relates to a SHOT report in Blood Transfusion. The harm was downgraded on review and is awaiting closure. ID 105327 relates to a temperature excursion in an external facility used to store stem cells. A meeting was held last week to set the terms of reference and consider the learning in terms of the procurement contract. The patients affected are Haematology patients and these will be reviewed by Specialist Clinical Board. **The Group resolved that:** a) The NRI report was noted.	
CDTQSE 26/040	**Duty of Candour Cases/Claims/LFERs** **Claims** Early notification has been received of a number of possible claims and HL has linked in with directly with the directorates involved. **LFERs** Nothing to report. **Duty of Candour Cases** AL explained that when the statutory Duty of Candour was first introduced, the Concerns Team initially took responsibility for managing cases involving moderate harm. This responsibility now sits with Clinical Boards, and as a result, the Patient Safety team has recognised that there is a need to support them in how they handle moderate-harm cases. Moderate harm is frequently reported, but many of these cases are later downgraded. For those that remain moderate, the Duty of Candour is triggered, which raises questions about who within each directorate should take ownership of contacting the patient or family, having the initial conversation, and then issuing the follow-up letter. There is also the question of who	

	should sign these letters, whether it should be the directorate leads or whether the Clinical Board should continue to sign them, as they do for severe and catastrophic harms. Each Clinical Board and directorates need to agree the process that works best for their areas. The Patient Safety team has suggested attending directorate meetings to offer guidance. Many staff report incidents as moderate harm simply because they are unsure which category to choose, and sometimes incidents are closed as moderate even when no actual harm occurred. The harm should be assessed based on what the Health Board caused, not solely on the patient's eventual outcome. Clarity on the definitions of harm will help reduce confusion and improve consistency across the organisation. JF reported that from a Radiology perspective, the process can feel particularly challenging because patients are often informed about an issue by a clinician before the Radiology team have been involved, particularly for reporting errors. The team then have to link in with other clinicians to identify what was discussed with the patient and follow this up in writing and try to determine the level of harm. If a blinded review has to be undertaken this takes more time and having an understanding the facts before discussions are held with patients would be more appropriate. HL noted that she reviews cases recorded as moderate harm that are open on Datix and downgrades them where appropriate. There are a number of historic cases on Datix that require closure and she will produce a report of these and circulate it to the relevant departments to review, prioritising those of moderate harm. **The Group resolved that:** a) It was suggested that Podiatry contact the Patient Safety team for guidance relating to pressure damage cases of moderate harm.	**HL**
CDTQSE 26/041	**Risk Register Updates** HJ reported that Pharmacy and Haematology/Blood Transfusion Laboratory are the only departments that have yet to have their risk registers transitioned across to the AMAT system. A meeting has been arranged with Pharmacy in March to complete this by the deadline of 31st March. Haematology/Blood Transfusion Laboratory has been highlighted as an exception by the Clinical Board due to current operational pressures and workforce issues and this has been escalated at the UHB Risk Management Task and Finish Group. It was noted that the department has a risk register in place which is currently held on the Q-Pulse system.	

	JF raised a risk relating to access to global imaging, whereby as other Health Boards go live with the new RISP system, there will be challenges to Cardiff and Vale viewing their images. Cardiff and Vale will be reliant on Health Boards that are live on the new system, having processes in place for the manual transfer of images to Cardiff and Vale. This will be a particular issue for out of hours working. Out of hours staff in other Health Boards have been trained on a method to transfer images in the interim, however this is dependent on the current supplier of the old system not withdrawing this functionality. An overarching risk relating to the RISP Programme has been uploaded on AMAT and a separate risk log is kept locally that records all the individual risks. Given this is a high risk, HL will discuss with BJ whether it needs to be added to AMAT as a separate risk. AC stated that this is a critical risk that should be escalated. JF raised a short-term risk in Radiology whereby a CT outpatient scanner is being replaced and estates work is needed resulting in no access to the second scanner in the main department. Therefore, only the scanner in Emergency Unit will be available this weekend. The team are exploring business continuity arrangements should the EU scanner fail. The team will provide comms /information on the imaging options available/ approach to be taken in the event of a failure for the Site team and the pathways that may be affected, including external pathways. JD raised a risk in Speech and Language Therapy relating to their feed system. The endoscopic scope She has been damaged whilst in the decontamination process and cannot be repaired. The procurement of new scopes has been explored however new scopes are incompatible with the stack system in the service which is now obsolete. The purchase of a new stack system will involve significant costs and the less expensive option is to purchase the same system as current, however given this has failed and is obsolete would be a poor decision. EC suggested that the service take time to make an informed decision on their preferred way forward and submit a capital bid for the allocation in April. **The Group resolved that:** a) The updates relating to risks were noted.	**HL**
CDTQSE 26/042 Chilcott Rachel 08/04/2026 13:36:05	**Patient Safety Alerts** EC advised that an alert has been received relating to a risk associated with adult breathing circuits lacking a patent exhalation route. The UHB is setting up a group to develop recommendations and guidelines around the use of NIV, particularly outside of the intensive care setting. **The Group resolved that:**	

	a) EC shared the alert for information.	
CDTQSE 26/043	**Medical Device/Equipment Risks** EC noted that 2 Field Safety Notices have been received from Philips and the recommended actions are being undertaken. He also reported that the UHB is looking at introducing a more robust reporting structure for patient safety and medical device alerts and a group is being set up to look at implementing a module on AMAT. **The Group resolved that:** a) The medical device and equipment updates were noted.	
26/044	**Point of Care Testing** SS reported that the Point of Care Testing team are progressing with the blood gas implementation. The team have also been liaising with Clinical Boards to identify POCT devices that need to be removed from service or need to be replaced. These devices need to be taken out of service as they are either at end of life or were purchased outside of the remit of POCT governance. Had the business cases been submitted to the POCT Governance Group, a more suitable product would have been identified. **The Group resolved that:** a) The Point of Care Testing update was noted.	
CDTQSE 26/045	**IP&C/ Decontamination Issues** SR reported that an IP&C walkround was held in the Vascular Theatres. Actions were raised relating to the cleaning standards of the theatres. Issues were also raised around the foul smells in Radiology and Estates work is needed to rectify this. Air purifiers have been loaned to the department as an interim measure. EC asked the department to check that the air purifiers being used are not IQ Air models as the HEPA filters have not been changed since Covid and could result in an IPC risk to staff. The IPC and Capital teams are of the view that these are no longer in circulation in the UHB as they are not fit for purpose, however JF will check the models. The UHB Decontamination Group was held in January. The terms of reference and membership are being reviewed. The next Water Safety Group meeting will be held in March. SR also reported that IPC audits were held in Speech and Language Therapy in Barry and Phlebotomy. Estates issues were highlighted that are outside of the department's ability to	**JF**

	resolve and are likely not a priority for the Estates team given their volume of work. However, the departments are asked to rectify any issues that are within their control. **The Group resolved that:** a) The IPC and decontamination updates were noted.	
CDTQSE 26/046	**Safeguarding /Consent Issues** There are no updates to report from the UHB Safeguarding and Consent Groups. HL reported that there has been an instruction issued for all Clinical Boards to ensure they have representation on all the Clinical Safety Groups such as Medical Devices, POCT Governance Group, Radiation Protection Group etc. **The Group resolved that:** a) HL will circulate a list of the groups to check whether there is already representation from this Clinical Board and where there are gaps, she will ask relevant members of this group to represent the Clinical Board.	**HL**
CDTQSE 26/047	**Health and Safety/Staff Wellbeing** JD reported that the Health and Safety team are training fit testers and are still providing fit testing. He also advised that the system used for contractor management has been changed. Any contractors coming onto site that are not already utilised by Capital Estates and Facilities will need to be added to the system. Directorates to inform JD of any contractors that they are bringing directly onto site and he will upload their details onto the system and ensure that procedures and processes are being followed. **The Group resolved that:** a) The health and safety updates were noted.	
CDTQSE 26/048	**Regulatory Compliance** HL reported that at the last Regulatory Compliance Group meeting, air handling unit maintenance issues were raised relating to SMPU and the Stem Cell Processing Unit and HL has escalated these issues to Estates. EL will check if the issue in SMPU has been addressed. **The Group resolved that:** a) The minutes were circulated for information.	**EL**

TIMELY		
CDTQSE 26/049	**Waiting Times Performance** **The Group resolved that:** a) Waiting times performance is monitored and discussed in detail in the directorate performance review meetings.	
EFFECTIVE		
CDTQSE 26/050	**Feedback from UHB QSE Committee** HL reported that there will be required changes to the format of reports submitted to the UHB Quality Committee going forward with a greater focus needed on actions being taken or needed to address issues raised. There will also be low tolerance on NRIs and concerns exceeding response timeframes. **The group resolved that:** a) The minutes of the UHB QSE Committee held on 20th January 2026 are not yet available.	
CDTQSE 26/051	**Research and Development** RM reported that R&D Leads have been asked for contributions to be made to the Health Board's annual capital priorities plan for the next financial year. The deadline for responses is Friday to submit any requests for capital and estates development, equipment or digital requirements that will facilitate or are related to research. SL has collated a list of discretionary capital requests and will be reviewing the list for submission on Friday. If there is any overlap with research she will liaise with RM. **The Group resolved that:** a) Any research related contributions are to be submitted to RM. b)	
CDTQSE 26/052	**Service Improvement Initiatives** **Initiatives being Supported by Shaping Change Team** Kate Blower, Change Partner for CD&T in the Shaping Change team was welcomed to the meeting. The UHB has commissioned priority pieces of work and the majority of resources in the Shaping Change Team are aligned to supporting these priorities. The Scan to Code Programme, is a commissioned programme linked to this Clinical Board.	

	The programme supports digitisation of patient notes through scanning paper notes in order to support workforce retention challenges within the Clinical Coding team. The Shaping Change team are supporting the Scanning Bureau team with implementing the scanning of Trauma Ambulatory Care Unit (TACU) notes. This commenced in December. The team are also supporting the team with team building exercises, looking at efficiencies that can be made to their processes, reducing waste and workplace environment challenges. Support is also being provided to the Podiatry Service to look at improving their Booking system with the aim of moving to a system that lessens the administrative burden. A workshop is being held next month to explore this further. Kate Blower is also supporting mentoring and support with Safer Eating work and has been subject to discussions around the Diagnostic Stewardship work being led by ACh. She referred to the Improvement Practitioner course that is available to staff that are interested in developing improvement skills. Mentoring is available to staff that participate in this course. **Oxygen E-Learning** Gemma Taylor, Nurse Advisor in Medicines Management was welcomed to the meeting. A Regulation 28 from a 2024 Welsh Health Circular, stated a requirement for all Health Boards to ensure that medical gases training is mandatory for any staff who transport, handle, or administer medical gases**.** Although the training exists as an ESR module, it cannot currently be added to the core set of 13 mandatory modules as it is not applicable to all staff. As a result, even though the training is technically mandated, compliance levels are not being met as ESR does not flag when the training is required in the same way as it alerts staff's compliance levels for other mandatory training modules. Communication is being circulated to encourage the relevant staff to complete the module. The request is for teams to escalate this message to staff to improve the UHB's compliance. **Non-Medical Prescribing** Gemma Taylor also provided an update on non-medical prescribing. The details of Non-Medical Prescribers are held on a register within Pharmacy. A UHB Governance Framework has been in place since 2021 that clarifies the UHB's approach to the governance of non-medical prescribing. In 2023, HEIW published new standards for competency	

	assurance and Welsh Government circulated a WHC in 2024 advising that all Health Board were required to implement these new standards by 31st March 2026. A Governance Framework Group has been updating the framework to incorporate all the new standards and provide clarity on the responsibilities at each level. A key difference in the changes to the framework is that a 3 yearly Non-Medical Prescriber appraisal must now be undertaken. Any individual not compliant with the new framework may not be covered with indemnity insurance. A review of the register identified 61% of NMPs were not compliant against existing regulations. An email has been circulated that all staff not compliant to advise that action must be taken by end of February. To avoid registers becoming out of date in the future, the aim is for all non-medical prescribers to be listed on ESR and they will be alerted when an annual declaration is due and when their 3 yearly appraisal is approaching. This will prevent the risk of a register becoming out of date in the future. From this Clinical Board's perspective, current compliance is positive with only one Non-Medical Prescriber out of date and 3 that are due to be out of date in March. **The Group resolved that:** a) JF asked for the details of the Medical Gas ESR modules. GT will send her the details.	
CDTQSE 26/053	**Information Governance/Data Quality** **The Group resolved that:** a) Nothing to report.	
CDTQSE 26/054	**HIW/Llais Reports and Improvement Plans** **The Group resolved that:** a) Nothing to report.	
CDTQSE 26/055	**Policies, Procedures and Guidance (including NICE Guidance)** **The Group resolved that:** a) There were no local policies or procedures to be reviewed.	
EFFICIENT		
CDTQSE 26/056	**Feedback from Directorate QSE Meetings** Dietitians have escalated concerns that there is possible asbestos in the debris falling from the ceiling in their third-floor	

	accommodation in Denbigh House. BJ has been informed and action will be taken quickly if asbestos is confirmed. Procurement concerns were also raised from Dietetics that their enteral feed contract continues to roll over. HL will discuss with EH. **The Group resolved that:** a) HL requested for departments to submit their action notes, minutes or summaries from their QSE Groups. b)	**HL**
CDTQSE 26/057	**Clinical/Internal Audits** HL will produce a report of the current audits that are open on AMAT for this Clinical Board for the April meeting. Gemma Taylor reported that a Medicines Management internal audit is taking place across 3 wards at UHW and 2 Wards at UHL. One of the wards will be a non-EPMA ward to highlight if there are any differences in practice. **The Group resolved that:** a) The updates relating to internal and clinical audits were noted.	**HL**
CDTQSE 26/058	**Sustainability** **The Group resolved that:** a) There were no updates to report.	
EQUITABLE		
CDTQSE 26/059	**Equality, Diversity and Inclusion Issues/ Inclusion Ambassadors Update** HL reminded the Group that it is now mandatory for all staff to record their level of Welsh language skills on ESR. The Clinical Board is currently 78.9% compliant. **The Group resolved that:** a) The Equality, Diversity and Inclusion updates were noted.	
PERSON CENTRED		
CDTQSE 26/060	**Patient Story – Haematology** **The Group resolved that:** a) EL will arrange for a team to present at a forthcoming meeting.	**EL**

CDTQSE 26/061	**Patient Experience Feedback** JF reported that the paediatric radiology surveys are ready for rollout and feedback will be presented at a future meeting. **The Group resolved that:** a) HL will circulate Civica reports when they are received.	
CDTQSE 26/062	**Internal/External Awards** The deadline for nominations for the Nursing and Midwifery Awards has been extended. **The Group resolved that:** a) SR shared the details on the Teams channel.	
CDTQSE 26/063	**Good News Stories** **The Group resolved that:** a) There were no specific good news stories to share.	
ITEMS TO RECEIVE/NOTE FOR INFORMATION		
CDTQSE 26/064	Regulatory Compliance Group Minutes 4.2.26	
ANY OTHER BUSINESS		
CDTQSE 26/065	The Biochemistry team are scheduled to present the patient story next month. SR provided feedback on the Speaking Up Safely system. Over the last few months there has been a reduction in the number of concerns raised and Connectors have been asked to promote the system to staff. A discussion will be held around ways to raise awareness in the Partnership Forum. SR also noted that she participated in a CD&Talks Podcast on the SUS system which is available on the CD&T SharePoint site. JF asked if anyone has a contact that can provide support in completing an Equality Impact Assessment. It was suggested she contacts Mitchell Jones, UHB Equality Adviser.	
CDTQSE 26/066	**Date & Time of Next Meeting** The next meeting will be held on 23rd March 2026 at 10am via Teams.	

FINAL VERSION – APPROVED 24.03.26

PCIC CLINICAL BOARD
MINUTES OF THE QUALITY, SAFETY & EXPERIENCE GROUP
TUESDAY 20TH JANUARY 2026 11:00 – 13:00
Venue: MS TEAMS

Attendees –

- Amy Worrell, **AW**, Senior Nurse, District Nursing
- Barbara Davies, **BD,** Interim Director of Nursing, PCIC (Chair)
- Christopher Martey, **CM**, Multi-Professional Primary and Community Care Education Lead
- Clare Clement **CC**, Lead Pharmacist, PCIC
- Eleri Thomas, **ET**, Quality and Safety Officer, PCIC (minute-taker)
- Ellen Davies, **ED**, Infection, Prevention and Control Clinical Nurse, PCIC
- Gareth Baker, **GB**, Head of People and Culture
- Helen Earland, **HE**, Clinic and Operational Lead for Urgent Primary Care, PCIC
- Dr Helen Kemp, **HK**, Clinical Director for Quality, Safety and Governance & Deputy Clinical Board Director
- Dr Huw Brunt, **HB**, Consultant, Public Health
- Katie Rawson, **KR,** Lead Pharmacist Frailty, Care Homes and Community Care
- Matt Williams, **MW,** Senior Nurse, CAV 24/7
- Rachel Thomas, **RT**, Director of Operations, PCIC
- Rhian Smith, **RS**, Macmillan Clinical Nurse Specialist, Palliative Care Team
- Rhys Davies, **RD**, Head of Operations, Cardiff Locality
- Ruth Cann, **RC**, Consultant Nurse Older Vulnerable Adults, PCIC
- Sarah Griffiths, **SaG**, Interim Assistant Director of Primary Care, PCIC
- Tracy Valade, **TW**, Senior Nurse, District Nursing
- Victoria Whitchurch, **VW**, Head of Operations for Community Specialist Services, PCIC
- Lisa Dunsford, **LD**, Director of Operations, PCIC

Guest Speakers:

- Dr Firdaus Adenwalla, **FA**, Consultant Physician, Medicine Clinical Board
- Sian Pennel, **SP**, Community Nurse, PCIC

Apologies:

- Amy English, **AE**, Deputy Regional Director for LLAIS, Cardiff and Vale Region
- Andrea Rich, **AR**, Lead Nurse for Palliative Care, PCIC
- Bethan Watkins, **BW**, Safeguarding Nurse Advisor, Corporate Safeguarding Team
- Diane Walker, **DW**, Head of Integrated Discharge Service
- Dr Rachel Lee, **RL**, Clinical Board Director, PCIC
- Eleri Crudgington, **EC**, Operations Manager, HMP Cardiff, PCIC
- Frances Woodyatt, **FW**, Senior Nurse, Integrated Discharge Service
- Dr Helen Cordy **HC**, Point of Care Clinical Lead
- Helen Donovan, **HD**, Locality Lead Nurse for Cardiff, PCIC
- Janice Aspinall, **JA**, Anaesthetics Nurse, Anaesthetics
- Dr Karen Pardy, **KP**, Deputy Clinical Board Director, PCIC
- Kate Roberts **KR**, Deputy Director of Nursing, PCIC
- Lauranne Cullen, **LC**, Regional Director for LLAIS, Cardiff and Vale Region
- Lisa Waters, **LiW**, Senior Nurse for Quality, Safety and Education, PCIC
- Lloyd Waygood, **LlW**, Deputy Head of Operations, Cardiff Locality, PCIC
- Lorna McCourt, **LM**, Staff Side Lead Rep role for PCIC
- Louise Allen, **LA**, Head of Community Pharmacy, PCIC

PCIC QSE 20TH JANUARY 2026

- Lynne Topham, **LT**, Interim Head of Planning, PCIC
- Natallie Webb, **NW,** Interim Senior Nurse Immunisation and Health Protection Team, PCIC
- Neil Morgan, **NM**, Vale Locality Manager, PCIC)
- Rachel Armitage, **RAr**, Quality and Safety Manager, PCIC
- Rebecca Gill, **RG**, Senior Nurse Primary Care, Primary Care
- Rebecca Hopes, **RH**, PCIC Academy Manager
- Rebecca Lewis, **RL**, Principal Public Health Practitioner
- Rebecca Stringer, **RS**, Acting Lead Nurse for Community Specialist Services, PCIC (partial attendance)
- Sarah Congreve, **SG**, Assistant Vale Locality Manager, PCIC
- Susan Eshel, **SE**, Senior Nurse, Community Hospitals, PCIC
- Victoria Hayman-Teear, **VHT**, Senior Nurse, PCIC
- Yvonne Hyde, **YH**, Head of Nursing for Infection Prevention & Control

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

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

January Agenda: **00 PCIC QSE Agenda - 2026.01.20 - FINAL.docx**

January Action Log: **05.1 - Action Log PCIC QSE January 2026.docx**

ITEM NO.	TITLE	ACTION
Part 1	**ITEMS FOR DISCUSSION**	
2026/01/1	***Welcome & Introductions*** *Barbara Davies noted the attendees as listed on page one.*	
2026/01/2	***Apologies for absence*** *As listed on pages one and two.*	
2026/01/3	**Declarations of interest** None declared.	
2026/01/4	***Minutes and Matters Arising*** *The November 2025 minutes were deemed accurate and received final-sign off-* *04.1 - PCIC QSE November 2025 Minutes 2025.11.18 - FINAL.docx*	
2026/01/5	***PCIC Quality & Safety Action Log*** *The November 2025 action log was reviewed and updated -* *05.1 - Action Log PCIC QSE November 2025.docx* *The January 2026 action log has been created and can be found here: 05.1 - Action Log PCIC QSE January 2026.docx*	
2026/01/6	***Patient Story*** *Amy Worrell introduced Sian Pennell (Team Leader, City Central, District Nursing Team) to present a patient story regarding collaborative work to safeguard a vulnerable patient.* *The case concerned a 40-year-old patient with learning and physical disabilities, lacking mental capacity, who was living on a caravan site with her family. She was initially referred for a pressure damage assessment in December 2024, presenting with severe grade 4 pressure damage to her right malleolus and multiple other wounds. The family environment was challenging, with the mother as the primary carer suffering from a palliative condition and passing away in July 2025. The patient's care was further complicated by unsuitable living conditions, resistance from the family to hospital admission, and limited space for essential equipment. Safeguarding concerns arose due to the patient's vulnerability and lack of advocacy, prompting urgent interventions to address her complex needs and ensure her safety.*	

	Collaborative working was central to the patient's care, involving district nurses, tissue viability nurses, podiatry, physiotherapy, the Safe@Home team, social workers, day centre staff, and consultants. The multidisciplinary team (MDT) undertook daily strategic meetings, legal consultations, and coordinated wound care, equipment provision, and assessments. Despite challenging relationships with the patient's father, the teams maintained a patient-centred approach, adapting communication and care strategies to ensure continued involvement. Through persistent effort and teamwork, the patient was safely transferred to a nursing home, subsequently moved to hospital for further care, and ultimately returned home with a comprehensive package of support and specialised equipment, enabling her to spend Christmas with her family. *Key lessons learnt included the importance of flexibility and persistence in managing complex family dynamics, cultural sensitivities, and safeguarding vulnerable adults. The MDT approach, thorough documentation, and collaborative planning were vital in overcoming obstacles, maintaining professional standards, and ensuring continuity of care. Effective communication, patient-centred care, and engagement with community and extended family resources were crucial in achieving positive outcomes, demonstrating the value of coordinated teamwork and adaptability in safeguarding and supporting individuals with complex needs.* *The group praised the hard work of both Sian Pennell and the team to maintain a respectful and collaborative environment for the patient's care, with Barbara Davies acknowledging the complexity of the safeguarding and court of protection work involved in the case.* *The upcoming Patient Story rota can be found here - 06.1 - Patient story schedule 2025-28.docx*	
2026/01/7	***Risk Register Update*** *The link to the live risk register can be found here: Item 7.1*	
2026/01/8	***AMAT Update*** *All risks within the Health Board will soon be managed on the AMaT system, instead of the current Excel spreadsheet (see Item 7.1). Conversations with heads of departments and looking at identifying those within the business units who will support that transfer of the risks. Rachel Armitage has previous transferred the higher rate risks, as at October 2025, so these will need managing and updating by the appropriate Business Units. Barbara Davies acknowledged other services that may not be sat directly under a Business Unit will be included in this process, such as Palliative Care.* *Eleri Thomas explained that there are upcoming training sessions planned for February, with a recent email communication to Heads of Service containing a form to be filled in to register for a session and appropriate pre-training materials.* ***ACTION: Eleri Thomas to circulate AMaT training sessions (February 2026) email to PCIC QSE distributions list.*** *Barbara Davies acknowledged the task to complete the original transfer and then maintain the risks on AMaT, but this will allow a greater oversite across the organisation for risk management.*	**ET**
2026/01/9	***PCIC Quality Report*** *Please see report for information: Item 09.1* *Barbara Davies highlighted the following elements:*	

	• *A second NRI has been noted for the Clinical Board since the report has been written.* • *There has been a slight decrease in open DATIX incidents, but all are asked to review any open incidents for closure.* • *There are regular scrutiny panels in place to review pressure damage incidents. The Vale and Cardiff have merged scrutiny panels and initial feedback, reiterated by Amy Worrell, shows that this merger is beneficial.* • *Updates were added to the Mortality Reviews section post-meeting, following an update from Nicholas Deny, Organisational Learning Facilitator – Mortality Review).*	
2026/01/10	***NRI Feedback*** ***Barbara Davies discussed the following reports*** • *NRI ID 78736 - Item 10.1* • *NRI 81925 - Item 10.2* *NRI 78736 concerned the death of a prison inmate by self-harm. Although the mechanism was not overdose, there had been previous incidents of, or suggestion that, the individual may overdose and there were issues around paracetamol. The investigation highlighted significant communication failures between healthcare and prison staff, leading to missed opportunities for mental health referrals, inadequate medication follow-up, and insufficient documentation. The mental health team did not attend ACCT reviews, limiting continuity of care, while risk assessments and escalation of concerns were lacking. Night shift restrictions, staff shortages, and reliance on prison officers further impeded effective healthcare delivery. The incident underscored non-compliance or misinterpretation of national policies and a limited safety culture within both clinical and custodial settings. Lessons learned include the necessity for improved communication, robust risk assessments, adherence to documentation standards, and enhanced staff training and competence. Significant progress has since been made, including the development of systems and procedures for custodial healthcare, with the NRI now closed with Welsh Government.* *NRI 81925 involved an investigation following the omission of levothyroxine from a multi-dose blister pack over several months, whereby the patient sadly later died. The investigation highlighted ambiguity regarding the medication's role in the patient's outcome, with differing clinical opinions. Key lessons identified include significant communication failures between the GP practice and pharmacy, lack of formal documentation of dose changes, and an absence of robust policies for managing mid-batch prescription amendments. Systemic issues such as inadequate staff training, over-reliance on informal communication, unsynchronised batch prescribing processes, and insufficient safety prompts were also noted. The need for clear procedures, improved staff education, and enhanced communication protocols between care teams and pharmacies was emphasised to prevent recurrence.* *Dr Helen Kemp, who was involved in the NRI 81925 discussions, raised with the group if future EPS (Electronic Prescribing Systems) may present the same risks as this case which involved repeat dispensing. Clare Clement suggested that while EPS may not necessarily increase risks, their adoption could streamline processes and* reduce reliance on complex repeat dispensing as digital healthcare evolves.	
2026/01/11	***Information Governance*** *The following information regarding Freedom of Information (FOI) requests was noted, with PCIC being 95.% compliant in the previous reporting period (1st January – 18th December 2025) - Item 11.1.*	
2026/01/12	***Infection Prevention and Control (IP&C)*** *Ellen Davies noted that the following updates:* • *There has been a 26% increase in incidences of Clostridium difficile (C.diff) compared to the same period last year.*	

	• *The Welsh Government has a zero tolerance for MRSA bacteraemia, meaning the Health Board should have 0 cases. PCIC has had 6 cases to date, which is a 500% increase compared to the previous year.* • *PCIC has a 30% reduction in MSSA bacteria, compared with same period last year.* • *There is an 8% reduction in E Coli bacteraemia compared to the same period last year.* • *There is an 12% reduction in Pseudomonas bacteraemia compared to the same period last year.* • *There is an 40% reduction in Klebsiella bacteraemia compared to the same period last year.* *An upcoming report on C diff, staph aureus and an E Coli bacteraemia from April 2025 to January 2026 will outline the data and incidence.* *Ellen Davies' last working day is 12th March 2026.* *Barbara Davies noted that root causes analyses are a critical part of the Executive review and presented a visual dashboard which shared some themes coming out of these reviews. It was noted that the Public Health team are supporting IP&C with developing the dashboard.*	
2026/01/13	***Safeguarding Metrics*** *Deferred to future meeting, as no representation present.*	
2026/01/14	***Draft SOP from Safe@Home Team*** *Dr Firdaus Adenwalla gave an overview of a draft Standard Operating Procedure (SOP) for the provision of acute home oxygen (Safe@Home team). Please see below documents for full details:* • *Item 14.1* • *Item 14.2* • *Item 14.3 (please open in app)* • *Item 14.4* *Dr Firdaus Adenwalla explained that the Safe@Home service delivers hospital-level interventions in the community to improve care for frail, acutely unwell older patients and reduce unnecessary hospital admissions through early assessment and access to treatments.* *The SOP outlines short-term, community-based low-flow oxygen provision for acutely unwell, hypoxic patients, detailing supply logistics (from company Baywater), patient selection, and collaboration with the COPD team for appropriate care pathways.* *Staff will receive background training, including guidance on accessing Baywater for oxygen supply. A risk assessment process is in place for home oxygen provision and prescribing. Point of care testing (POCT) for capillary blood gas analysis will be accessible, with the COPD team utilising blood gas testing in select cases. The intervention is already established and widely used in hospital at home services across England and Scotland, demonstrating its validity and effectiveness within the community setting.* *Dr Helen Kemp thanked Dr Firdaus Adenwalla for the work involved in this SOP, noting that both oxygen and prescribing colleagues had been involved in developing this SOP Dr Firdaus Adenwalla has linked in with Dr Helen Cordy from a POCT point of view, noting it may be beneficial for both services to consider teaming up to put a bid in for appropriate POCT kit. Rhys Davies echoed the sentiment that kit, if located centrally in St David's Hospital, could be utilised by multiple teams.*	

	Barbara Davies noted that the PCIC QSE endorsed this SOP to progress to next appropriate stages, subject to the local endorsement (i.e. own QSE group) and the POCT elements being resolved.	
2026/01/15	***Effective Care*** *No items noted under this heading.*	
2026/01/16	***Compliments*** *Please see full details here - Item 16.1*	
2026/01/17	***Concerns*** *Details are included in the January 2026 PCIC Quality Report here – (noted previously as Item 09.1). Details include: 9 concerns in the PTR (Putting Things Right) process. General themes include: quality of care provided, funding under the CHC packages, continence products and access to the Dental Access Portal, and waiting times through that system.* *In addition, please see November PC QSE minutes, section 25/11/15, for Ombudsman case outcome discussions - Item 17.1*	
2026/01/18	***POCT Update*** *Full details noted in this report, in Dr Helen Cordy's absence - Item 18.1* *Details including the INR Policy which is still out of date but has been raised with CD&T, and recurring theme such as connectivity and funding.*	
2026/01/19	***Individual Care*** *No items noted under this heading.*	
2026/01/20	***PCIC Academy Updates*** *Christopher Martey noted the upcoming launch of the PCIC Padlet, the Academy's one-stop place to find out about the education updates - Item 20.1* *Details were shared regarding the Women's Health Funded Education & Training Programme, highlighting the in-person events planned for March 2026 in collaboration with PCIC colleagues and other specialists- Item 20.2* *The following training calendar for the non-clinical workforce is linked here - Item 20.3* *Christopher Martey encouraged sharing of these resources, explaining there is a communication strategy in place to ensure dissemination through the relevant channels. This includes an email strategy, the upcoming Padlet resource, and appropriate working groups. Dr Helen Kemp referenced CAV GP may be an appropriate channel of communication also.*	
2026/01/21	***Public Health Newsletter*** *The below November and December 2025 Public Health newsletters were noted for information:* • *Item 21.1* • *Item 21.2* • *Item 21.3*	
2026/01/22	***Fraud Alert*** *The fraud alert, was shared via PCIC Admin - Item 22.1 .* *An attempt to obtain payment through invoice fraud in Aneurin Bevan UHB, so noting for awareness and vigilance.*	
2026/01/23	***Sub Group Reports*** *The below updates were shared verbally by exception due to recent OCP (Organisational Change Process.* ***CAV 24/7 and GP OOH***	

- *Reports shared for information - Item 23.1 and Item 23.2*
- *Helen Earland highlighted the 111 press 2 capacity. Performance is only at 43% due to sickness and vacancies. This is causing major issues regarding the staffing rota and covering the service 24 hours a day. There are interviews this week for band 6 posts and band 5 posts shortly. It has been ascertained on shortlisting, that external advertising is required to re advertise the posts because insufficient staff have applied internally. The staffing deficit will be submitted to SMT for review.*

Primary Care

- *Sarah Griffiths outlined that a general dental provider is handing back their contract, potentially leaving 1,000 city centre patients without a regular dentist, and prompting analysis and consideration of retendering to address capacity and continuity of care. It was noted there has been dissatisfaction with a major contract change from 1st April within the profession.*
- *The GMS negotiation have been agreed this year. The general practices will have received quite significant uplift in terms of their funding, and the Primary Care team will see what that means in terms of escalation.*
- *Workforce risks – hoping to replace vacant positions; including CDS Operational Manager (position vacant for over a year), a Band 7 Primary Care Contracts and Development Manager and cover for Band 6 Primary Care Support Manager.*

Barbara Davies raised that there has been a significant impact for district nursing regarding the wound care hand backs from practices. There is a working group in place looking into this ongoing, evolving situation, with District Nursing Senior Nurses involved in discussions to access spaces and mitigate risks to patients.

Medicines Management

Clare Clement shared the following updates:

- *Katie Rawson has begun her role as Lead Pharmacist for Frailty, Community Care, and Care Homes, supporting community services and team expansion with a focus on medicines, governance, and pharmacy involvement.*
- *There are two vacancies for 8a Pharmacists, with one retirement at the end of March. Both positions are being repurposed to recruit two Band 7 pharmacists, as part of workforce reshaping, with recruitment underway.*
- *Continued support is being provided to two staff members on medium to long term sickness absence.*
- *Clinically facing staff have been added to the mandatory training list for violence against women, but obtaining timely training slots remains challenging, which will affect training statistics.*
- *The process for the currently closed Fairwater pharmacy is ongoing, with notification of removal from the list being issued but then a change of ownership application was received, though regulatory delays persist.*
- *Significant changes are underway in Community Pharmacy and Medicines Management, including an incentive scheme, altered provision of gluten free foods, and changes in medicines access within the health board.*
- *An independent review is being conducted into pharmacy professionals working in general practice and Clusters, with pharmacy teams contributing to high-profile health board projects on medicines access.*
- *The Medicines Implementation Group (MIG) and Medicines Scrutiny group are influencing PCIC internal processes related to medicines, access, strategy, and governance.*
- *Ongoing discussions aim to develop a plan for better oversight and engagement within the Clinical Board, with pharmacy work on this to be finalised in the next month.*

Palliative Care

	Rhian Smith noted there was nothing to be noted by exception. Barbara Davies explained that the Palliative Care and End of Life strategy is progressing and a presentation will be made at a future PCIC QSE meeting. ***Community Specialist Services*** *Victoria Whitchurch noted the following updates:* • *Escalations continue with emergency escorts at HMP, with delays in transferring high-risk patients over the weekend causing pressure on bed watch and affecting this week's escorts.* • *HMP capacity is stretched across the region, as Swansea and Bristol are full, leading to increased transfers to HMP Cardiff, including 40 receptions late at night requiring extra staff cover.* • *Ongoing capacity issues at HMP are being investigated, with three months' data analysis underway and findings set to be discussed with the new Governor, which may impact staffing in the coming weeks.* • *Accommodation challenges persist for the Immunisations team at Riverside, as plans to move fridges from Rookwood were halted due to unreliable electricity supply, posing risks to vaccine cold chain management.* • *Staff concerns remain about working at Riverside, with calls to relocate due to continued issues, and progress on moving to Saint David's is stalled, while CRI and Woodland House are considered as alternatives.* ***Cardiff Locality*** *Tracy Valade provided the following updates:* • *Four District Nursing teams remain at escalation level 4, presenting ongoing pressure across the service. Neighbouring teams are providing support where possible.* • *Phlebotomy continues to face challenges, primarily due to staff members on long-term sickness absence.* • *Healthcare Support Workers within the District Nursing Teams are covering some phlebotomy duties.* • *There has been a slight improvement, with some staff on phased return from sickness in the Vale area, although coverage remains difficult.* *Rhys Davies provided the following updates:* • *Rhys Davies has recently assumed responsibility for the Vale area and is beginning to review operations there.* • *The Vale Local Authority is planning to relocate staff from Ty Jenner, with Rhys Davies exploring the possibility of accommodating the Nurse Assessor Team and other services within Barry Hospital.* • *The current sprint fortnight is underway, with ongoing pressures related to the Community Resource Team (CRT) and local authority care capacity; despite these challenges, planned discharges continue to be supported.* • *Board rounds have started at Saint David's Hospital, revealing issues that will be addressed moving forward.* • *The Standard Operating Procedure (SOP) for Safe@Home regarding home oxygen has been shared, with further SOPs to follow concerning Care Home initiatives.* • *Data Protection Impact Assessments (DPIAs) for information governance aspects are in progress and will be submitted to the next panel.* ***ACTION: Rhys Davies to submit DPIAs and Information Governance updates at next PCIC QSE meeting.***	***RD***
2026/01/24	**Any other business to be discussed** *Barbara Davies noted that Community Hospitals formally transferred to PCIC on 03/01/2026. The transition period is ongoing in collaboration with the Medicine Clinical Board. Community Hospitals will need representation and contribute to this forum in the future, particularly regarding Quality and Safety reporting due to the bed-based nature of the service. The integration of Community Hospitals is expected to introduce*	

	a different dynamic to reporting and forum participation; this will be addressed as the transition progresses. *Barbara Davies acknowledged that he meeting proceeded with some absences from the Governance Team. Appreciation was expressed for continued support and participation, emphasising the importance of maintaining focus on Quality and Safety.*	
PART 2	*PART 2: Items to be recorded as Received and Noted for Information by the sub-Committee*	
2026/01/25	*All items below have been previously circulated as appropriate.* *PCIC Central Register – Comms & Alerts*	
Date and time of next meeting: Tuesday, 24th March 2026, 11am		

Report Title:	Public Health Wales Sexual Health Incident				Agenda Item No:	4.4	
Meeting:	Quality		Public	x	Meeting Date:	14.04.2026	
			Private				
Status	Assurance		Approval		Information/Noting		x
Lead Executive Title:	Jason Roberts, Executive Director of Nursing Claire Beynon, Executive Director of Public Health David Thomas, Director of Digital						
Report Author Title:	Jason Roberts, Executive Director of Nursing Claire Beynon, Executive Director of Public Health David Thomas, Director of Digital & Health Intelligence						

Main Report

Background

Public Heath Wales Sexual Health Incident

The Sexual Health Test and Post Service enables people in Wales to request sexual health tests and receive advice about sexually transmitted infections. The service began as a pilot in the Hywel Dda area in 2018 and expanded to cover the whole of Wales in May 2020. It is run by Public Health Wales (PHW) and processes nearly 100,000 test requests each year.

Following a review, PHW has identified some operational issues in their Sexual Health Test and Post Service. These include:

- Safeguarding processes for people using the online and community test-and-post sexual health service which were not effective and did not meet required legislative standards. This meant that Public Health Wales reported safeguarding information to health boards, rather than to local authorities as PHW should have.
- Some data handling processes, involving personal data, which were not effective and did not meet required standards.

PHW have advised us that as soon as they became aware of these issues in November and December 2025, PHW took immediate steps to resolve them. PHW undertook a risk assessment to ensure the service was safe to continue. PHW also changed their internal safeguarding processes for people who contact their Sexual Health Test and Post Service to ensure that the correct safeguarding processes and procedures are followed.

PHW are in the process of reviewing cases of people who contacted their Sexual Health Test and Post Service and who may have not been safeguarded appropriately. Where needed, PHW are directing these cases to the relevant local authority for the appropriate management and support. PHW also advise us that they are also conducting a thorough review of their test-and-post sexual health service to improve processes, quality and assurance. This includes reviewing the online platform. PHW have implemented a new online process to ensure that young people are appropriately safeguarded when using the platform. PHW are also conducting a lookback exercise to ensure any historical safeguarding information is shared with local authorities.

PHW have advised that the data handling concerns identified were mainly internal administrative issues. However, there were occasions when test results were sent to the wrong Health Board. PHW advise that they have made changes to their data handling

procedures to protect against this happening again. PHW have reported the data incidents to the Information Commissioners' Office.

PHW also identified a small number of people who received incorrect results and received delayed test results and referrals. Where they identified an incorrect result, PHW corrected it straight away and informed the person involved. PHW also offered them the appropriate follow-up care where needed. Where PHW have identified delayed test results and referrals, PHW responded promptly to ensure they were sent out as quickly as possible.

Public Health Wales have issued an apology, "*I would like to sincerely apologise to anyone who has been affected by these issues. Please be assured that as soon as these issues were identified, PHW acted immediately to put things right. Our services remain here for you whether you need a confidential sexual health test sent to your home, access to condoms, or advice on any sexual health concerns – our teams are here to support you. PHW will be commissioning a full independent external review into these issues. PHW are committed to learning from this experience and understanding exactly what went wrong, so PHW can improve the quality of the service.*" PHW have established a helpline for support: 0800 0352 877. It will be open 8am-8pm Monday to Friday and 9am to 4pm on weekends.

Current Situation

Cardiff and Vale University Health Board Actions
Safeguarding
Safeguarding services are working closely with sexual health services, PHW and National Safeguarding Services to review the first cohort of children to confirm if notifications were received, and to identify the safeguarding actions taken in each case. This initial review shows a mixed picture. Where notifications were received, there are examples of appropriate and timely responses; however, there are also cases where no action was taken.

These findings will be shared with National Safeguarding Service and with PHW as part of the assurance process. We are also reviewing our internal processes, and this will be reported through the appropriate governance arrangements of the executive led safeguarding steering group.

Sexual Health Services

Data and Information Governance

The team at PHW have confirmed that they have been in contact with the Information Commissioners' Office (ICO) as they are the data controller and responsible for managing this incident. They will keep us informed of progress but there is nothing further required by the CAV UHB team at this stage.

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

Public Health Wales have briefed all Health Boards across Wales two issues with the Test and Post Sexual Health Service:

- Safeguarding processes for people using the online and community test-and-post sexual health service which were not effective and did not meet required

legislative standards. This meant that Public Health Wales reported safeguarding information to health boards, rather than to local authorities as PHW should have.
- Some data handling processes, involving personal data, which were not effective and did not meet required standards.

This paper outlines the issues raised and the subsequent actions that PHW and C&VUHB have taken. Further actions will be required to manage the ongoing issues as they arise.

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

Frequently Asked Questions to this incident from PHW are available here: STATEMENT: Sexual Health Test and Post Service - Public Health Wales

Recommendations:

a) Note the contents of this report.
b) Note the actions undertaken by C&VUHB in response to the incident.

Link to Strategic Objectives of Shaping our Future Wellbeing:

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

Five Waves of Working (Sustainable Development Principles) considered:

Prevention	x	Long Term	x	Integration	x	Collaboration	x	Involvement	x

Quality Impact Assessment Completed?

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

Impact Assessment

Risk: n/a
Safety: Yes
Public Health Wales advise that they have completed a Risk Assessment this has not been shared with C&VUHB.
Financial: No
Workforce: No
Legal: No

Unknown at the moment.
Reputational: Yes
There is a risk that the incident reduces trust in the service and that people use it less. If people use the service less this may have an impact on their health and well-being and that of their partners, or it may increase demand for face to face services.
Socio Economic: No
Equality & Health: Yes
There is a risk that the incident reduces trust in some groups and that this negatively impacts health outcomes in some groups.
Decarbonisation: Yes
There is a risk that the incident reduces trust in some groups that more face to face services will be needed to manage demand and this will increase carbon used.
Welsh Language: No

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