Unconfirmed Minutes of the Public Health Wales Knowledge, Research and Information Committee Public Meeting, 16 June 2026 13:00 Held in 3.5 CQ2 and via Microsoft Teams

Present:		
Sian Griffiths	(SG)	Committee Chair and Non-Executive Director (Public Health)
Tamsin Ramasut	(TR)	Non-Executive Director (Equality and Diversity)
In Attendance:		
Alisha Davies	(AD)	Head of Research and Development
Claire Birchall	(CB)	Executive Director of Nursing, Quality and Integrated Governance
Christopher Johnson	(CJo)	Head of VPDP, Deputy Director of Health Protection (for item 3.1)
Danielle Gething	(DG)	Head of Risk Management (for item 2)
Elen de Lacy	(EDL)	Research and Evaluation Strategic Partnership Lead (for item 4.1)
Jenna Goldsworthy	(JG)	Portfolio Lead (Research, Data and Digital Directorate) (for item 4.4)
Jim McManus	(JM)	National Director Health and Wellbeing
Kerry Bailey	(KB)	Consultant in Public Health (for item 4.3)
Liz Blayney	(LB)	Deputy Board Secretary and Deputy Head of the Board Business Unit
Louisa Nolan	(LN)	Head of Data Science (for item 4.2 and 4.4)
Stuart Silcox	(SS)	Assistant Director of Integrated Governance
Sumina Azam	(SA)	National Director of Policy and International Health
Tom Fowler	(TF)	Deputy National Director Health Protection and Screening Services
Apologies		
Catherine Purcell	(CP)	Non-Executive Director (University)
Clare Jenkins	(CJ)	Vice Chair of the Public Health Wales Board and Non-Executive Director
Iain Bell	(IB)	National Director for Public Health Knowledge and Research
Meng Khaw	(MK)	National Director of Health Protection and Screening Services, Executive Medical Director
Paul Veysey	(PV)	Board Secretary and Head of the Board Business Unit

Pippa Britton	(PB)	Chair
Tracey Cooper	(TC)	Chief Executive
Secretariat		
Ffion Lloyd	(FL)	Board Support Officer

The meeting commenced at 13:30

KRIC 1/2026.03.17	**Welcome, Introductions and Apologies**

The Chair opened the meeting and welcomed all present.

The Committee **noted** that the meeting was being recorded to support the accuracy of the minutes, the recording would be deleted once the minutes had been agreed at the following meeting on 15 September 2026.

KRIC 1.1/2026.03.17	**Declarations of Interest**

There were no declarations of interest made, in addition to those already declared on the Declarations of Interest Register.

KRIC 2.5/2026.03.17	**Managing Risk**
KRIC 2.5.1/2026.03.17	**Strategic Risk Register**

DG provided an overview of Strategic Risks 1, 4 and 5, which fell within the remit of the Committee. DG noted that the paper reported the position as of the 1 April 2026, as approved by the Business Executive Team on 20 May 2026. DG highlighted that there had been no change in risk scores since the previous reporting period

Updates were provided to the Strategic Risks under the remit of the Committee:

- **Strategic Risk One** (failure to deliver our role to influence a system shift to prevention, reduce health inequalities and address determinants of health)
- **Strategic Risk Four** (failure to effectively mitigate the public health impacts of climate change on the Welsh population) – SA outlined key developments since the previous Committee meeting:
  - The Climate Response Plan had been submitted to Welsh Government
  - The NHS Wales Adaptation Work Programme qualitative report had been completed with positive progress noted.
  - Work had been undertaken on the Climate Risk Assessment and Response Plan, which included flood risk mapping and assessment of organisational resilience to climate-related risks.
  - Work was ongoing to map resources to strategic priorities, however further analysis was required.
- **Strategic Risk Five** (to fully exploit digital and data fully to improve public health in Wales) – SA and AD highlighted that the risk was being reframed to better reflect the integration of digital and data transformation, and that there was a need for more comprehensive change management approaches across complex, system-wide programmes. It was noted that a revised risk description and supporting action plan are in development and would be presented to the Board.
  - SA expressed ongoing concern regarding data quality and capacity, particularly in relation to primary care data, and noted that this continued to provide limited assurance. While recognising the progress that had been

made, the Chair emphasised a degree of residual discomfort in this area, and requested that this be revisited following further Board-level discussion.
- DG gave assurance that there was a direct read-across between Strategic Risk 5 and Strategic Risk 2, which was overseen by the People and Organisational Development Committee, and confirmed that these interrelated risks were being considered collectively.

SG highlighted concerns regarding environmental health capacity and system clarity, particularly in relation to the role of external partners such as the UK Health Security Agency (UKHSA), and noted a lack of clarity regarding responsibilities following changes in support arrangements. SA advised that discussions with UKHSA were ongoing, with a meeting scheduled to clarify roles and responsibilities, and confirmed that an update would be brought back to a future Committee meeting.
Action: SA

TR queried the interpretation of the organisation operating within, but well inside, its stated risk appetite, and suggested that this may indicate an overly risk-averse approach and a potential failure to maximise opportunity. DG acknowledged this, but noted that risk appetite frameworks were intended to support a balance between risk aversion and opportunity-taking, and advised that this would be explored further as part of a planned deep dive on risk assurance at a future meeting.

SG thanked DG for the update, and the Committee took **assurance** on the management of Strategic Risk within the Organisation.

KRIC 2.5.2/2026.03.17	**Corporate Risk Register**

DG provided an update on the Corporate Risk Register, and noted that the Leadership Team had considered the update at its April meeting.

DG confirmed that there are no new risks proposed for inclusion, and no risks proposed for de-escalation on the Corporate Risk Register at this time.

DG highlighted changes to risk scores on the Register:
- Risk 1758 – the risk score had been reduced from 15 to 12.
- Risk 2003 - the risk score had been reduced from 15 to 12, and aligned with the progress updates outlined in the Strategic Risk discussion.

The Committee welcomed the updates and noted that the direction of travel in risk scores was positive.

SG thanked DG for the update, and the Committee took **assurance** that corporate risks were being scrutinised appropriately.

KRIC 3.1/2026.03.17	**Immunisation**

CJo gave a presentation on the Immunisation Programme, with a focus on vaccine equity, system delivery challenges, and emerging risks.

CJo emphasised that Public Health Wales did not directly deliver vaccination services, but instead played a system leadership role, working alongside Health Boards and Welsh Government to provide evidence, surveillance, and support to improve vaccination uptake. CJo highlighted that this created a structural challenge, as Public Health Wales did not hold direct delivery levers, but was nonetheless expected to influence outcomes across the system.

CJo outlined the key areas of progress, which included the continued prioritisation of vaccine equity as a central pillar of the national immunisation approach. This included:

- Development of a Vaccine Equity Network
- Introduction of a vaccine equity toolkit
- Improvements in surveillance capability through individual-level data
- Expanded work on public engagement and vaccine literacy, including delivery of the WHO “immune patrol” educational programme in schools.

CJo also noted that vaccination programmes had increasingly adopted a whole life-course approach, spanning from pregnancy through to older adulthood.

CJo advised that inequalities in this area had widened over recent years, particularly following the COVID-19 pandemic, although early indications suggested a potential improvement in the latest reporting period. He highlighted that inequalities were often driven by access and system factors rather than vaccine hesitancy, and cited examples such as appointment accessibility, service delivery models, and practical barriers faced by families. Specific drivers included school absence, consent challenges in secondary schools, logistical barriers for larger families, and challenges in capturing vaccination records for individuals entering Wales later in childhood.

CJo also outlined that engagement and insight work had been undertaken to better understand barriers to vaccination, noting emerging findings such as the impact of needle anxiety and fear of missing school among teenagers, as well as the importance of co-producing solutions with target populations.

The Committee discussed the following points:

- The number of system-level challenges, particularly the limited ability to translate evidence into consistent changes in delivery models. CJo provided examples where evidence-based interventions—such as delivering childhood flu vaccinations in nursery settings or proactively inviting patients for shingles vaccination had demonstrated improved uptake, but had not been consistently adopted across Health Boards.
- TR raised concerns on accountability and queried the extent of organisational leverage within the system. She also sought clarification on whether improvements in vaccination inequalities had been realised over time. CJo acknowledged these challenges, and confirmed that while there has been some progress, change had been incremental and insufficient, and that broader system levers were required to drive improvement.

- TR also queried the delivery model, specifically whether health visitors and midwives could play a greater role in vaccination delivery. CJo supported this approach, and noted that multi-professional delivery models were associated with higher uptake. He cited examples where midwife delivered vaccination programmes had achieved improved outcomes.
- TF reflected that Public Health Wales' role may have been necessary but not sufficient in achieving system effectiveness, and emphasised the importance of partnership working and the challenges in influencing system-wide behaviour change. He highlighted that differing views across the wider public health system could also impact the adoption of evidence-based approaches.
- The complexity of the system landscape was noted, which included fragmented delivery arrangements, variable practice across health boards, and missed opportunities for integration across services (e.g. vaccination opportunities during other healthcare contacts). SG highlighted the importance of whole-system thinking, and opportunities to improve vaccination uptake in older populations and through wider public health interactions.
- JM noted the relevance of vaccination within wider school and workforce health initiatives, and suggested that there were opportunities to strengthen integration across programmes and increase emphasis on vaccination as a core component of prevention.
- SA highlighted ongoing work to strengthen health economics evidence, and queried how data could be further used to target prevention of outbreaks, particularly in light of measles risks. CJo confirmed that analytical work had been undertaken to identify areas at higher risk of outbreaks and to inform targeted interventions.
- The significant financial and public health benefits of prevention was noted, which included evidence that the cost of responding to outbreaks substantially exceeded the cost of preventative vaccination programmes. CJo emphasised the ongoing challenge of evidencing outcomes where harms had been avoided, and the importance of strengthening the narrative around prevention impact.

SG thanked CJo for the presentation, and proposed that since the issues of influence and system leadership in this area had been highlighted, that this be reflected back to the Board for further consideration and discussion on how the organisation could maximise its impact on improving vaccination uptake and reducing inequalities.
Action: LB

The Committee took **assurance** from the presentation on the arrangements in place to report and investigate inequalities in vaccine uptake.

KRIC 4/2026.03.17	**Items for Assurance**
KRIC 4.1/2026.03.17	**Research and Evaluation Strategy**

The Committee received an update on the progress of implementation of the organisational Research and Evaluation Strategy.

AD outlined the progress over the previous six months against the Strategy's four key pillars: building a research culture, strengthening research management and delivery, developing strategic partnerships, and enhancing co-production and public involvement.

AD highlighted significant progress across all areas, particularly in strengthening research governance arrangements in response to Welsh Health Circulars, which had included work with Finance colleagues to ensure compliance with new requirements.

AD highlighted key points from the update:

- Reported progress in capacity and capability development within Public Health Wales, which included the success of the research mentorship programme led by EDL which supported staff engagement in research activity, bid development, and alignment with funding opportunities. It was further noted that research activity had increased across key strategic areas, including climate, gambling, health inequalities, and policy modelling.
- A significant achievement in securing approval to host the UK Research and Innovation policy fellows, which marked the first time Public Health Wales would participate in this fully funded scheme. It was noted that grant income and bid development activity was increasing, which demonstrated a positive trajectory in research performance.
- Reported strong progress on a strategic partnership with Cardiff University through the establishment of a Memorandum of Understanding (MoU), and it was confirmed that early discussions are underway with Bangor University to develop a similar arrangement. EDL explained that the MoU approach was intended to focus collaborative effort on key priority areas to enable greater impact while maintaining existing partnerships.
- The current Strategy (due to conclude in 2026) would not be replaced in full, but would instead be extended to 2029, supported by a more focused delivery plan to concentrate effort on priority areas and accelerate progress.

SG thanked AD and EDL for the update, and noted the significant progress made and the development of a strong organisational platform for research. SG also welcomed the success in attracting UKRI fellows and the increase in grant income, and noted these as indicators of external validation and organisational maturity.

SA queried the approach to aligning partnerships with Bangor University within the wider strategic framework and highlighted the importance of evaluation work linked to Welsh Government priorities, particularly the Institute of Health Equity programme. AD confirmed that discussions with Welsh Government were ongoing, with Public Health Wales providing trusted advisory support in the development of approaches to evaluation, although roles and responsibilities for formal evaluation activity were yet to be finalised.

TR questioned how the organisation defined and demonstrated system leadership, which included how impact is measured and evidenced. JM supported this point, and noted the need for greater clarity and precision in the use of terminology, particularly in defining what is meant by “system leadership” and “system support”. SG acknowledged this and proposed that further work be undertaken to clarify the organisation’s role and impact as a system leader. It was agreed that this would be explored further outside the meeting and brought back to the Committee at the December meeting for a more detailed discussion.

Action: AD/EDL

The Committee took **assurance** on progress on the implementation of the organisational Research and Evaluation Strategy.

KRIC 4.2/2026.03.17	Outcomes Framework

LN provided an overview of the work to develop and embed the Outcomes Framework system across the organisation.

LN highlighted key updates from the report:

- Work undertaken on modelling and evaluation plans, which included work to assess the cost of mental health, and to build on previous work in relation to obesity. LN advised that this work was intended to strengthen the organisation's ability to articulate impact and value, particularly in supporting wider system discussions.
- Work on Healthy Life Expectancy continued to be of significant interest both within Public Health Wales and externally, which included Welsh Government engagement and ongoing collaboration with the Chief Medical Officer.
- Plans had been outlined to review performance indicators to ensure that indicators provided the right information at the right time. She emphasised that individual indicators should be viewed as signals rather than complete measures of performance, and that there was a need to develop a more contextual and integrated approach to bring together multiple indicators with modelling and evidence, in order to support deeper understanding of organisational priorities.
- The development of a horizon scanning group aligned to the wider determinants Strategic Priority. LN explained that this group would integrate data, analysis, research and evidence to inform recommendations for organisational priorities, and support reporting to governance groups such as Committees and the Board. LN noted that this approach aimed to maximise value from existing analytical resources, and could be expanded further subject to capacity.

SG thanked LN for the update.

The Committee discussed the following points:

- SG sought assurance that inequalities are embedded within the Outcomes Framework. LN confirmed that inequalities were currently reported separately, but acknowledged that there was opportunity to better integrate inequalities analysis, in particular through the horizon scanning work, but noted that progress in this area was partly dependent on improved data availability.
- JM reflected on a recent session on impact indicators with their extended leadership team, and noted that the approach to the Outcomes Framework emphasised co-production, whereby programme teams were actively involved in developing impact measures rather than relying solely on central analytics. JM noted that this strengthened ownership and ensured relevance to operational delivery. LN agreed with this approach and emphasised that the next phase of development would focus on ensuring that outcomes thinking was embedded within programme delivery, rather than as a separate analytical exercise.

- AD noted that the Outcomes Framework incorporated both quantitative and qualitative evaluation, and would include targeted engagement with groups that were less likely to participate to better understand inequalities and variations in outcomes.
- TR queried how learning from evaluation activity, specifically the example of the prehabilitation and rehabilitation programme in Cardiff and Vale, is translated into wider system improvement. LN acknowledged that while evaluation findings have supported local funding and sustainability, there was an opportunity to improve the proactive sharing and scaling of best practice across health boards.
- JMs supported this point, noting that Public Health Wales had a role in identifying and disseminating effective interventions, and emphasised the importance of applying consistent evidence across the system while adapting delivery to local contexts.

The Committee:

- Took **assurance** on the implementation and use of the PHW measurement system.
- Took **assurance** that work was underway to further embed the measurement system into IMTP and performance reporting.

KRIC 2.4/2026.03.17	**Primary Care (Focus on Inequalities)**

ZW and KB provided a presentation to the Committee on the Primary Care programme to reduce health inequalities.

ZW noted that the programme aimed to improve health equity through Primary Care, and recognised that while wider determinants of health sit outside healthcare, the NHS still has a significant role in addressing inequalities. ZW highlighted that primary care accounts for the majority of patient contacts, which made it a critical setting for prevention and early intervention.

The presentation outlined the development of the Teg i Bawb (Fair for All) Programme, which included the evidence base, co-production approach, and system-wide action plan. KB noted that the programme was developed in response to gaps in existing frameworks and limitations in available data, which required the team to undertake new analysis to identify persistent inequalities and the impact of the inverse care law. KB emphasised that the programme was underpinned by evidence, data, and lived experience, and was supported by a range of tools which included dashboards, planning guidance, and an equity checklist for service planning.

SG thanked KB and ZW for the presentation, and welcomed the structured and practical nature of the approach.

The Committee discussed the following points:

- SG sought clarification on how the programme translated into frontline delivery. KB provided an example of cluster-level working in Cardiff, where practices collaborated to deliver immunisation and wider health interventions within community settings. KB explained that this approach had improved uptake and

identified unmet need (including undiagnosed diabetes), but noted that delivery required local leadership, collaboration, and overcoming governance barriers, particularly around sharing resources and patient cohorts across practices. KB highlighted that Public Health Wales' role was to facilitate, support, and share best practice, which included development of tools, dissemination of evidence, and partnership working with Health Boards, Welsh Government, and frontline services.

- TR welcomed the increased focus on inequalities but raised concerns that inequalities may not yet be embedded as a core priority across the system. She also cautioned against the use of equality checklists, and highlighted the risk that equality considerations may become a compliance exercise rather than a cultural shift. KB acknowledged the complexity of achieving culture change, and noted that the programme focused on supporting and enabling early adopters, building momentum across the system, and tailoring approaches for different audiences.
- TR queried the impact of including inequalities within the GP contract and whether this would drive behaviour change. KB confirmed that inclusion health requirements have been introduced into the GP contract, with an initial focus on developing registers and building awareness, with further development expected over time.
- SG queried how the programme engaged with practices that were less advanced in this area. KB advised that work was ongoing to support those willing to adopt this work, but recognised that progress remained variable and that even among early adopters there was further development required, particularly in relation to data use and measurement.
- SA noted the upcoming Primary Care Summit, and queried what aspects of this work should be highlighted at the summit. ZW responded that this work would be linked into areas of a shift to a prevention strategy and population health management, but noted that the key message would be that current limitations, such as access primary care data and linked datasets, constrained the ability to target interventions and evaluate impact. ZW also highlighted that KB would be taking forward a national task and finish group to look into the approach to population health management in Wales.
- KB noted that while improved data infrastructure was important, there was also a need to make better use of existing data and intelligence, which included publicly available datasets and local knowledge. SA highlighted the importance of ensuring that data was effectively shared with primary care to support understanding of local population needs.
- In relation to the importance of system wide collaboration, JM emphasised the need for Public Health Wales to consistently consider inequalities across all programmes and partnerships, and to strengthen integration across organisational activities.
- TR raised questions regarding measurement of impact and resource allocation, and whether sufficient resources were directed towards areas of greatest need. Kerry acknowledged this and noted that more deprived practices often faced higher demand with fewer resources, which limited their capacity to undertake proactive population health work.

The Committee noted that while progress had been made in this area, there remained a significant system-wide challenge in embedding equity, improving data use, and ensuring consistent adoption of best practice across Wales.

The Committee took **assurance** that a comprehensive, evidence-based approach to system wide development of primary care was in place and noted progress in delivery.

	Digital and Data Strategy and Portfolio

JG provided an update on the Digital and Data Strategy and associated portfolio.

JG noted that the overall portfolio remained significant in scale, and that an associated delivery risk identified. JG confirmed that mitigations were currently being explored to ensure delivery remained on track and to manage capacity constraints.

JG provided an overview of key programmes within the portfolio:

- The **Digital Health Protection** programme remained on track for Phase 1 completion, with full delivery anticipated by January 2028.
- Progress on **the Lung Screening Programme** had been impacted by a pause and review of the National Data Resource (NDR) programme led by Digital Health and Care Wales (DHCW). JG confirmed that discussions were ongoing with DHCW to identify mitigations, with a proposed solution expected to be considered in July. JG clarified that while there was a dependency risk, there was no immediate delay to delivery at this stage, as the impact was expected later in the programme timeline.
- Elements of the **Data, Analysis, Registers and Cloud Programme** had been affected by the DHCW National Data Resource Programme pause, resource constraints caused by the pause, and staff turnover. JG confirmed that recruitment was underway in the affected areas and was expected to be completed shortly, which would help to stabilise delivery.
- JG noted that the first regular output produced via the National Data and Analysis Platform (NDAP) has now been implemented for real-time suspected suicide surveillance data, with further outputs expected in July.
- The risk associated with the Audit+ system remained open, with a decision pending from the GP Council in July about progression. JG also confirmed that the previous issue relating to survey response rates had now been resolved, with actions completed and the risk closed.

SG sought clarification on the implications of the NDR pause and review. JG confirmed that this related to national programme-level decisions, and that while it introduced uncertainty mitigations were being actively pursued.

LN outlined the work on Artificial Intelligence (AI) governance within the organisation.

LN explained that AI was now embedded as business as usual rather than a standalone programme, with a focus on achieving an appropriate balance between robust governance and enabling innovation.

LN outlined the current governance arrangements, which included:

- The AI Design Authority (AIDA), which provided oversight and assurance;
- The AI Register, which aimed to capture approved and emerging AI tools;
- An assurance tracking system to monitor wider AI related activity, which would include policy and guidance development.
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LN noted that one new tool (DetectedX) had been added to the register, and was described as a low-risk training tool for breast cancer radiologists, which did not involve the use of organisational data and supported clinical learning.

LN also highlighted ongoing work to strengthen governance:

- The introduction of AI classification within the Datix system to support incident reporting;
- The development of a high-level AI policy to underpin more detailed guidance; and
- Work to address the risks associated with "shadow AI", where staff may use external tools outside organisational control.

LN emphasised that the approach aimed to encourage safe and appropriate use of AI rather than restrict innovation, and was to be supported by staff awareness and training.

SG thanked JG and LN for the update.

TR queried the range of AI tools in use and whether additional platforms had been considered. LN confirmed that the organisation's approved tool is currently Microsoft Co-pilot, due to its integration within the organisational infrastructure and associated data security assurances. Other tools had not been adopted at this stage due to governance and security considerations. TF added that active work was underway to promote adoption of Co-pilot, which would include practical support and training, and highlighted that early insights from pilot work had demonstrated benefits in areas such as administrative tasks and workflow management. TF noted the importance of encouraging staff to use approved tools rather than external platforms.

SG reflected on the importance of maintaining an appropriate balance between innovation and assurance given the pace of change in this area, and the need to ensure organisational oversight remains effective.

The Committee took **assurance** that Public Health Wales was delivering its Digital and Data Strategy through the agreed Route map and had robust governance in place for managing digital and data work.

	Bi-Annual Corporate Policies Update

LB provided an overview of the bi-annual update on Corporate Policies within the Committee's remit.

LB noted that there were no areas of concern to report, and that the overall position reflected effective policy management and review arrangements, with two policies within

scope and in-date. LB highlighted that the Research Misconduct Policy was currently under consultation and was expected to be renewed in due course.

The Committee took **assurance** on the prioritisation and progress being made to review policies, procedures and other written control documents within the remit of the Committee.

KRIC 3/2026.03.17	**Items for Approval**
KRIC 3.1/2026.03.17	**Minutes, Action Log and Matters Arising of meeting (09 December 2025)**

The Committee **approved** the minutes of the 17 March meeting as an accurate record.

LB advised that there were four actions currently in progress, with brief updates provided. LB noted that more substantive updates were expected, and proposed that the target dates for these actions be revised to the September meeting, at which point fuller progress reports will be presented to the Committee:

- **Action 2025/06** (timeline for new IT system)
- **Action 2024/6** (development of the NHS app)
- **Action 2026/02** (Performance and Assurance AI-metrics)
- **Action 2026/04** (alignment with QSIC workplan)

LB highlighted that two actions have been completed and are recommended for closure:

- **Action 2026/01**
- **Action 2026/03**

The Committee **approved** the changes to the action log.

KRIC 5 /2026.03.17	**Items to Note**
KRIC 5.1/2026.03.17	**Audit Recommendations Tracker Update**

The Committee **noted** the Audit Recommendations Tracker for information.

KRIC 7/2026.03.17	**Closing Administration**

Any other business: None.

The Committee were invited to provide feedback from the meeting via e-mail to LB, including any areas that worked well, and any areas for improvement.

Date of Next Meeting: **15 September 2026.**

The meeting closed at 15:47