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

To view the meeting: https://youtu.be/zd3mJrvVqIg

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

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

	The Action Log following the meeting held on 30.06.2026 was received and discussed. **The Committee resolved that:** a) The Action Log from the meeting held on 30.06.2026 was noted.	
QC 26/07/1.5	**Committee Chair's Actions** No Chair's Actions were raised.	
	Quality Performance Reporting	
QC 26/07/2.1	*No items.*	
	Items for Oversight / Scrutiny	
QC 26/07/3.1	**Clinical Board Highlight Reports** Jason Roberts (JR), Executive Nurse Director, advised that the newly piloted AAA reports had been reviewed following publication and, whilst they demonstrated significant improvement in activity across the organisation, they did not provide the level of assurance expected for Public Committee scrutiny. Following discussion with the Chair, it was agreed to withdraw the reports for this cycle to allow further work with Clinical Boards to strengthen the quality and consistency of reporting. CP expressed concern that the reports were not at the standard expected for a Public Committee and did not provide sufficient assurance. The Committee and reporting arrangements remained in a developmental phase, and withdrawing the reports was considered the appropriate course of action. Further work would be undertaken ahead of the next meeting to strengthen assurance and support the Committee's objective of providing proactive oversight of quality issues. **The Committee resolved that:** A) The update was noted.	

QC 26/07/3.2	**Clinical Safety Group Highlight Report**
	
	Alexandra Scott (AS), the Assistant Director of Quality and Patient Safety, introduced the report and the minutes from April's Clinical Safety Group (CSG) meeting, and summarised the following:
	• The CSG continued to develop its role in providing oversight of existing and emerging clinical risks and promoting a whole-system approach to risk management across the organisation.
	• A rolling programme of assurance presentations from Clinical Governance Groups (CGGs) had been established, with the Medicines Safety Group (MSG) providing assurance in the April 2026 meeting. The MSG outlined work aligned to the Quality Management System (QMS), including:
	  ○ Oversight of regulatory requirements and safety standards
	  ○ Quality improvement initiatives relating to opioid safety and the timely administration of critical medicines
	  ○ Assurance processes involving Clinical Board engagement, risk management and reporting arrangements
	  ○ Development of a broader range of medicines safety indicators to enhance organisational intelligence and monitoring
	• Updates were received on two patient safety solutions underway:
	  ○ A review of clinical systems to address risks associated with incorrect recording of penicillin allergies, including system standardisation and patient record reviews	

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

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

	Angela Hughes (AH), the Assistant Director of Patient Experience, presented the report and summarised the following: • A Coroner's Regulation 28 report issued to CAVUHB, Cwm Taf Morgannwg (CTMUHB), and Welsh Government (WG), highlighted concerns regarding delays in recognising and escalating a suspected bile duct injury for specialist referral to CAVUHB as the tertiary centre. The coroner identified a lack of clear referral and escalation protocols, leading to delays in specialist advice and transfer. • In response, actions had been taken to reinforce consultant-to-consultant escalation processes, remind organisations of existing urgent referral arrangements, and develop a formal regional referral framework with defined triggers, timescales and transfer expectations. • Further work is underway to strengthen assurance, implementation and compliance monitoring, recognising the importance of timely referral in these rare but high-risk cases. **Bring a further update back to the Committee in six months, including further information on commissioning status – ACTION.** Paul Bostock (PB), the Chief Operating Officer, noted that significant work had been undertaken to strengthen the referral pathway and governance arrangements, with referrals now managed through a formal case-by-case process. Whilst concerns remained regarding the absence of a formally commissioned service, improved oversight, clearer processes and senior clinical leadership involvement had addressed many of the previously identified issues. DF confirmed that a formal referral and approval process was now in place. Whilst opportunities for further improvement remained, assurance was provided that governance arrangements were reasonably robust and that similar arrangements were being developed for other non-commissioned specialist pathways. **The Committee resolved that:** a) The contents of the Coroner's Regulation 28 Report and the concerns raised were noted; b) Assurance was received regarding the actions already implemented by the UHB; c) Ongoing governance oversight through appropriate clinical governance structures was endorsed.	
	Strategic Portfolio: Providing Outstanding Quality	
QC 26/07/4.1	**Board Assurance Framework (BAF)** Matt Phillips (MP), the Director of Corporate Governance, noted that the BAF served as a reference document, with updates aligned to the Board reporting cycle rather than individual Committee meetings. The Committee's primary focus should be on oversight of strategic portfolio delivery and associated risks, using the BAF to provide context and support assurance discussions where required. **The Committee resolved that:** A) The BAF was noted for assurance.	
	Shaping our Population Health and Place-Based Partnerships	
QC 26/07/5.1	5.1 - Public Health Work 6 Month Update (including Targeted Intervention Indicators) CB introduced the report and provided the following summary: • The report outlined progress against the UHB's population health strategy.	

	• Despite a relatively small Public Health workforce (39wte, including 5.5 public health consultants for a population of around 500,000), the team had prioritised three key areas: reducing smoking, increasing vaccination uptake, and tackling obesity. • Performance against WG escalation targets showed improvement in vaccination rates. The gap between CAV and the Welsh average for childhood vaccinations by age five reduced from 4.8% to 2.5%, whilst the gap for HPV uptake by age 15 reduced from 5.2% to 0.6% • Smoking cessation activity had increased over the last six quarters, with more referrals generated through strengthened work with primary and secondary care, despite no additional resources. However, achieving the increased WG target for smoking cessation was expected to be challenging. • The report highlighted a continued focus on reducing health inequalities through targeted preventative programmes, with services increasingly delivered through outreach and community-based models in areas of greatest need. PB queried whether there was a plan to equip the UHB's 18,000 staff to provide health improvement advice and help mitigate capacity constraints, such as smoking cessation support. CB responded that limited resource capacity meant only 0.5wte was available to deliver *Making Every Contact Count* training across the UHB and partner organisations. The team promoted online training and monitored uptake within Clinical Boards to encourage wider workforce upskilling. Whilst staff could provide brief health improvement advice and identify teachable moments, specialist services remained important, with evidence showing people were significantly more likely to quit smoking when referred to dedicated support programmes such as *Help Me Quit*. Huw Brunt (HB), the Consultant in Public Health, noted that Clinical Board reviews helped promote *Making Every Contact Count* by signposting staff to available training resources, including online modules and limited bespoke training support. Awareness had also been raised through primary care clusters and events. JR-IM noted that whilst the reported 50% increase in smoking cessation was encouraging, concern was expressed that overall numbers remained low and emphasised the need to maximise cross-sector opportunities. JR-IM highlighted the importance of ensuring smoking cessation support was fully embedded within future lung cancer screening programmes. CB provided assurance that work was underway with primary and secondary care, local authorities and the third sector to increase uptake and maximise community-based opportunities. CB confirmed that smoking cessation support would be fully integrated into the future lung cancer screening programme, with workforce requirements and anticipated demand already assessed and submitted to Public Health Wales (PHW) for consideration. HB noted that *Help Me Quit* was delivered through an integrated package of services across public health, community pharmacy, and hospital settings, with partnership working essential to maximising impact despite limited resources. Ongoing work to increase referrals included engagement with primary care, dental and optometry services, Inclusion Health respiratory	

	clinics, the pre-operative assessment clinic, local authorities, and the Fire and Rescue Service. JR-IM raised concern regarding inequalities in access to sports and physical activity facilities and asked how Public Health worked with sports providers and community organisations. CB responded that the Good Food and Movement Plan was overseen through established partnership governance arrangements and was delivering tangible progress. A facilities audit had been completed to identify gaps in access to physical activity opportunities and would inform future planning by local authorities to address health inequalities. The audit had been recognised as good practice nationally and was being considered for wider adoption across Wales. CP asked to what extent Public Health linked in with the podiatry-led QuickChange initiative. CB responded that QuickChange was a joint initiative, with close collaboration on its delivery. The programme was promoted through Healthy Schools Officers and wider public health networks, supporting obesity prevention, physical activity and wellbeing through a coordinated preventative approach. CP suggested CB link in with the new Public Health Minister in Wales. **The Committee resolved that:** A) The content of the Cardiff and Vale long-term public health plan, and the current priorities for public health in Cardiff and the Vale was noted; B) Current performance and delivery of public health programmes in our area were noted; C) The first of regular six-monthly updates on the public health programmes was noted.	
QC 26/07/5.2	5.2 - No-smoking and Smoke-Free Environment Policy Compliance at Cardiff & Vale Hospital Site CB introduced the report and highlighted the following: • Despite legislation banning smoking on hospital sites since 2021, smoking remained a persistent issue and a source of complaints. • Assurance was provided that a range of measures had been implemented to improve compliance, including enhanced signage, awareness campaigns and dedicated staff engagement. • As the first UHB in Wales to pursue an enforcement approach, a six-month educational phase had now been completed, with the findings informing the next steps in the programme. HB presented the report and summarised the following: • During the six-month educational phase, over 1300 interactions with smokers were recorded, highlighting ongoing compliance challenges across all groups. • Whilst concerns were noted regarding staff compliance and inconsistent management processes, the initiative also created significant opportunities to provide advice and referrals to smoking cessation services. • Key next steps included strengthening staff compliance processes, improving hospital environments, implementing nicotine dependence pathways, enhancing	

	staff training and communications, and progressing cross-organisational action to improve compliance. JR-IM asked about the effectiveness of the smoking patrols as an intervention. HB responded that the patrols had provided valuable opportunities to monitor compliance, raise awareness and refer smokers to support services. However, successful progression to enforcement would require local authority support, sustainable funding and strengthened UHB policies and procedures to ensure a robust and legally defensible approach. CB commented that the patrols added value by creating over 1300 opportunities to engage with smokers, provide education and promote smoking cessation support. The initiative also highlighted areas requiring further action. Whilst enforcement remained challenging without local authority support and sustainable funding, the six-month pilot provided valuable learning to inform future improvements. MP challenged the advice within the report that enforcement action could be subject to challenge if appropriate systems and controls were not in place. Whilst acknowledging the funding and resource challenges discussed, he suggested the UHB may be able to take a more robust approach should a suitable route to reinstating enforcement be identified and offered to work with colleagues to explore this further. CP asked about what initiatives were proposed to deal with staff smoking on site. HB responded that the team were working with People Services to develop a more formal and standardised procedure for line managers, responding to the recommendations within the Shared Regulatory Services (SRS) report. Discussions were underway with Occupational Health to strengthen smoking cessation support and access to Nicotine Replacement Therapy (NRT) for staff. Additionally, the team was exploring ways to engage staff regularly to understand the barriers to compliance, identify opportunities for improvement, and measure progress over time. MP emphasised the importance of accountability alongside the support being offered to staff, noting that compliance with the law is an implicit expectation of employment. He suggested that any formal guidance should clearly articulate the potential use of disciplinary processes where staff fail to comply. **The Committee resolved that:** A) The contents of this paper and the accompanying six-month review report was noted; B) The commitment for a UHB-wide group to continue to drive this work forward and receive an update on progress at six months was supported.	
	Shaping our Quality, Value & Sustainability	
QC 26/07/6.1	*No items.*	
	Shaping our Future Clinical Services	
QC 26/07/7.1	Cardiology Review Update PB presented the update and provided the following summary:	

	• Of the approximately 70 recommendations, 30 had been completed and 32 were in progress, with further work underway to strengthen timescales and accountability. • Positive progress included General Medical Council (GMC) de-escalation of concerns regarding resident doctors, strengthened clinical and operational leadership, improved service resilience, and development of a QMS. • Whilst the service had moved from recovery to stabilisation, it was recognised that embedding the cultural and behavioural changes required would be a longer-term programme. • Priority areas included completing demand and capacity modelling, advancing service redesign, and further embedding quality improvement and collaborative working practices. CP asked why there were 6 recommendations that had not started. PB responded that the number had reduced to 5 recommendations. A stocktake meeting had been scheduled to review the remaining actions and would provide a further update at a future meeting. **Provide a brief update at the next meeting on the actions not yet started in the Cardiology Improvement Plan, including reasons and expected start dates – ACTION.** Jessica Castle (JC), the Director of Operations – Specialist Services Clinical Board, noted that some actions had been slower to commence because priority had been given to embedding the foundational cultural changes within the Directorate. **The Committee resolved that:** A) The update was noted.	
QC 26/07/7.2	JACIE Inspection Update JC presented the report and provided the following summary: • The JACIE accreditation review identified 87 areas of non-compliance from over 2300 assessments. Remedial actions had been implemented and submitted to JACIE within the required timeframe, with 336 of 340 actions completed (98.8%). the four remaining actions related to partial compliance and were not considered material, although further work was ongoing. • Good progress had been made in addressing key risks, including workforce planning, estates developments, governance arrangements and quality management process. Enhanced oversight and reporting mechanisms had been established, and plans for the haematology day unit and inpatient facility redevelopment continue to progress. • The organisation awaited JACIE's assessment of the submitted evidence and remained in a period of uncertainty regarding accreditation. Potential mitigations had been discussed with commissioners should accreditation not be maintained, although significant operational, workforce, financial and patient impact challenges remained. The associated risks remained rated as high, pending a formal decision from JACIE, which was expected later in the year. CP asked what their level of confidence was regarding the accreditation outcome. JC responded that it would be a significant step for JACIE to withdraw accreditation outright. A more likely outcome may be a further deferral to allow consideration of the WG business case, workforce investment proposals, and progress with inpatient facility developments.	

	DF noted that even if accreditation was deferred, concerns regarding the suitability of the current facilities would remain. The importance of maintaining visibility of the service's strong clinical outcomes, including infection and success rates, was emphasised, recognising the high-quality care being delivered despite the challenges associated with the existing environment. **Present outcome data and benchmarking for the JACIE programme to the Quality Committee in approximately three to four months, hopefully aligning with the expected accreditation decision timeline – ACTION.** **The Committee resolved that:** A) The submission of the SWBMT Programme response to JACIE on 8th July 2026 was noted; B) The significant progress made to address the inspection findings, including completion of all 87 non-compliances and 98.8% of all corrective actions was noted; C) The residual risks pending the final accreditation decision was noted; D) Assurance regarding the governance arrangements and mitigating actions currently in place was noted; E) The ongoing development of contingency arrangements should accreditation not be secured was noted.	
	Policies for Approval	
QC 26/07/8.1	UHB 597 - Accessible Standards and Communication Policy AH provided the following summary: • This policy brought together the All-Wales Accessible Communication and Information Standards, the UHB's Interpretation and Translation Policy, and relevant duties under the Equality Act 2010. • The policy aimed to ensure patients, service users, carers and families could access safe, equitable and person-centred care, regardless of communication needs. • Significant work had been undertaken to develop the supporting framework required for implementation, including a self-assessment tool, a multidisciplinary working group, guidance on interpretation services, and actions to improve the identification and recording of communication needs. • The implementation plan, which included staff guidance, awareness raising, monitoring arrangements and ongoing equality impact assessment work, was noted. The Committee approved the policy. **The Committee resolved that:** A) The Accessible Information and Communication Policy for implementation across CAVUHB was approved; B) The completed Equality and Health Impact Assessment and the overall positive impact identified was noted; C) The implementation actions relating to recording communication needs, staff access to interpretation and translation guidance, awareness raising, and monitoring through audit/self-assessment was noted.	
	Items for Noting / Information	
QC 26/07/9.1	*No items.*	
	Items Needing Escalation to Board	

QC 26/07/10.1	*No items.*	
	Any Other Business	
QC 26/07/11.1	*No other business was raised.*	
	Review of the Meeting	
QC 26/07/12.1	Committee members were asked to fill out the Committee Self-Effectiveness survey.	
	Date & Time of Next Meeting:	
QC 26/07/13.1	*29th September 2026 at 9am via MS Teams*	