

## Held on 16th September 2025 via MS Teams

To view the meeting: [CAVUHB Quality Committee 16.09.2025](#)

<b>Chair:</b>		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
<b>Present:</b>		
Rhian Thomas	RT	Committee Vice Chair / Independent Member – Capital & Estates
Mike Jones	MJ	Independent Member – Trade Union
Clive Curtis	CC	Independent Member - Community
<b>In Attendance</b>		
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Matt Phillips	MP	Director of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Claire Beynon	CB	Executive Director of Public Health
Emma Cooke	EC	Executive Director of AHPs, Health Scientists and Community Services Development
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Catherine Wood	CW	Managing Director for Planned Care
Huw Brunt	HB	Consultant in Public Health
Yvonne Hyde	YH	Head of Nursing for Infection Prevention & Control
Vicky Le Grys	VLG	Programme Director, Strategic Clinical Redesign
Natasha Goswell	NG	Deputy Executive Nurse Director
David Fluck	DF	Executive Medical Director
<b>Observers</b>		
Lauranne Cullen	LC	Regional Director for Llais
<b>Secretariat</b>		
Rachel Chilcott	RC	Corporate Governance Officer
<b>Apologies</b>		
Steve Riley	SR	Independent Member – University
Paul Bostock	PB	Chief Operating Officer
Jason Roberts	JR	Executive Nurse Director

QC 2025/09/1.1	<a href="#">Welcomes, Introductions &amp; Apologies</a>  The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh.  Apologies for absence were noted.	ACTION
QC 2025/09/1.2	<a href="#">Declarations of Interest</a>  No declarations of interest were raised.	
QC 2025/09/1.3	<a href="#">Minutes of the Committee meeting held on 05.08.2025</a>  The minutes of the Committee meeting held on 05.08.2025 were received.  <b>The Committee resolved that:</b>	

	a) The minutes of the meeting held on 05.08.2025 were approved as a true and accurate record of the meeting.	
<b>QC</b> <b>2025/09/1.4</b>	<p><a href="#"><u>Action Log following the Meeting held on 05.08.2025</u></a></p> <p>The Action Log following the Meeting held on 05.08.2025 was received.</p> <p><u>QC 25/06/009 - IP&amp;C Position Update</u> – the Assistant Director of Patient Experience (ADPE) informed the Committee that she agreed with the Head of Nursing for Infection Prevention &amp; Control (HN-IPC) to reinstate the COVID-era practice of using volunteers during restricted visiting or outbreaks. Additionally, they would conduct snapshot audits, starting with volunteers, asking inpatients about handwashing before meals considering C.diff concerns. They would report this back to the Committee in the future.</p> <p><b>The Committee resolved that:</b></p> <p>a) The Action Log from the meeting held on 05.08.2025 was noted.</p>	
<b>QC</b> <b>2025/09/1.5</b>	<p><a href="#"><u>Committee Chair's Actions</u></a></p> <p>No Chair's Actions were raised.</p>	
<b>Items for Review &amp; Assurance</b>		
<b>QC</b> <b>2025/09/2.1</b>	<p><a href="#"><u>Quality Indicators Report</u></a></p> <p>The Assistant Director of Quality and Patient Safety (ADQPS) and the ADPE presented the Quality Indicators Report and slides which provided assurance in relation to several quality, safety and patient experience priorities. It provided data through the end of August 2025 where available and detailed ongoing actions to drive necessary improvements. Additionally, it included exception reporting to highlight emerging trends and issues related to quality and patient safety.</p> <p>The Executive Director of Public Health (EDPH) asked the three following questions:</p> <ol style="list-style-type: none"> <li>1) Sepsis Policy Compliance – whether cases where patients did not receive antibiotics within the recommended one-hour timeframe (as per NICE guidance) were recorded as safety incidents, and how such instances were reflected in the data.</li> <li>2) MMBRACE - whether the MMBRACE data was broken down by ethnicity or socio-economic group.</li> <li>3) Equitable Care – whether they could include a slide within the Quality Indicators presentation on equity.</li> </ol> <p>The EDPH noted suggested the ADPE link in with Huw Brunt (the Consultant in Public Health / C-PH) regarding the COPD audit.</p> <p>The ADQPS responded with the following:</p> <ul style="list-style-type: none"> <li>• Sepsis – currently they did not have an electronic system to record observations or patient data, and so non-compliance was reported by exception if patient outcomes were affected and was investigated through Datix. Routine monitoring was not in place yet, but audits were planned following revised guidance.</li> <li>• MMBRACE – they aimed to explore data by ethnicity and deprivation. An annual perinatal mortality report already included some of this, covering factors like comorbidities, mental health and deprivation.</li> <li>• Equity – they currently lacked a system to routinely record protected characteristics like ethnicity across the UHB, though some clinical datasets (e.g. maternity) did collect this. Further work was needed to address this gap.</li> </ul>	

	<p>The ADPE added the following:</p> <ul style="list-style-type: none"> <li>• The National Maternity Services Survey would be coming in, which included data on ethnicity and user experience across different groups. Whilst it did not directly measure outcomes, it offered useful insights.</li> <li>• They also collected data through Civica, and previous slides in the presentation had shown lower satisfaction amongst some groups. Complaints don't always reflect this, so they needed to engage with communities they didn't usually hear from to avoid false assurance.</li> </ul> <p><b>The CC suggested the need for a discussion outside the meeting to explore the potential methodologies and mechanisms for routinely collecting and reporting equity and protected characteristics data – ACTION.</b></p> <p>The Committee Vice Chair (CVC) asked what the plan was for sharing themes, findings, and recommendations from the senior leadership walkarounds.</p> <p>The ADQPS responded that a paper was going to the UHB Board meeting the following week with a proposal. Quarterly reports were planned, and it had been suggested that some findings on staff engagement and psychological safety go through the People &amp; Culture Committee. They were also working with Comms to share outcomes more widely across the organisation. The walkarounds would form part of a broader engagement and assurance framework.</p> <p><b>The Committee resolved that:</b></p> <ol style="list-style-type: none"> <li>1) The assurance provided by the quality indicators and the associated work to drive improvements in these areas.</li> </ol>	
<p><b>QC</b> <b>2025/09/2.2</b></p>	<p><b><u><a href="#">Deep Dive – Infection, Prevention &amp; Control</a></u></b></p> <p>The HN-IPC presented the IP&amp;C Position Update which covered progress against the Welsh Government (WG) reduction goals for antimicrobial resistance and healthcare-associated infections, with a focus on C.difficile, Staphylococcus aureus, E. coli, Klebsiella, and Pseudomonas rates. Additionally, she outlined ongoing audits, education, and collaborative efforts to improve IP&amp;C and patient outcomes.</p> <p>The CC explained that it was great to see the progress and actions delivering improvements.</p> <p><b>The Committee resolved that:</b></p> <ol style="list-style-type: none"> <li>1) The updated was noted.</li> </ol>	
<p><b>QC</b> <b>2025/09/2.3</b></p>	<p><b><u><a href="#">Hepatitis B/C Recovery Plan – Six Month Update</a></u></b></p> <p>The EDPH provided the following summary:</p> <ul style="list-style-type: none"> <li>• Hepatitis B and C were liver infections that could cause serious damage and health problems.</li> <li>• Hepatitis B had no cure, but vaccination (included in the UK's six-in-one vaccine since 2017) and routine screening at birth have kept numbers low.</li> <li>• Hepatitis C was more common in Wales (12,000-14,000 people affected). There was no vaccine, but it was curable with oral treatment that was about 90% effective.</li> </ul>	

	<ul style="list-style-type: none"> <li>• WG aimed to eliminate both by 2030 and issued health circulars in 2017 and 2023 to drive action.</li> <li>• A multi-agency group had been set up to coordinate efforts, including close work with the Hepatitis C Trust, prison and probation services.</li> <li>• The report was structured around prevention, case finding, testing, treatment, reengagement for those who did not complete treatment, and data collection.</li> <li>• Recent progress included successful peer services and ongoing collaboration across agencies.</li> </ul> <p>The CVC asked how well they were reaching hard-to-reach populations on this topic.</p> <p>The EDPH responded that reducing health inequalities was a priority, so they had introduced practical measures like testing in prisons and probation and using a mobile outreach bus. Collaboration with the third sector and peer support had been especially valuable for reaching communities, but there was still more to do.</p> <p>The CC explained that he had visited the HMP Cardiff the previous week, and asked whether they had a testing lead in the prisons yet.</p> <p><b>For the EDPH to confirm the start date of the hepatitis testing lead in HMP Cardiff – ACTION.</b></p> <p><b>For an update to come back to the Committee in six months' time – ACTION.</b></p> <p><b>The Committee resolved that:</b></p> <ol style="list-style-type: none"> <li>a) The progress to date was noted;</li> <li>b) The content and ambition of the Hepatitis B and C Elimination Plan 2025/26 was noted.</li> </ol>	
<p><b>QC</b> <b>2025/09/2.4</b></p>	<p><b><u>No Smoking Enforcement – Six Month Update</u></b></p> <p>The C-PH provided the following summary to the Committee:</p> <ul style="list-style-type: none"> <li>• The UHB has a duty to comply with some-free premises and vehicles legislation, which included hospital sites.</li> <li>• The UHB had implemented various initiatives in the past, but still saw smoking on hospital sites from patients, visitors, and staff. They also received fire reports because of smoking.</li> <li>• The plan was to enhance enforcement with more rigorous patrols and the option to issue fixed penalty notices, which only the Local Authority (LA) could issue.</li> <li>• They were working with the Shared Regulatory Service (SRS) to secure the enforcement resources, however there were delays due to limited capacity and recruitment issues. To avoid delays, the SRS had explored the option to employ an external service provider to deliver enforcement, and procurement was underway.</li> <li>• They were preparing a support package to onboard enforcement officers, which included training and practical arrangements (e.g. parking, data collection, records management, communications).</li> <li>• A six-month educational phase was planned, with signposting to “Help Me Quit” support.</li> <li>• The evaluation framework was being refined to inform future implementation.</li> <li>• The long-term aim would be to bring enforcement in-house within the LA team. The go-live date depended on procurement timelines.</li> <li>• A comprehensive communication strategy was being developed which would announce implementation dates and reinforce legal requirements and support services.</li> </ul>	

	<p><b>It was suggested that the ADPE and C-PH meet to discuss and clarify the approach to vaping and the use of medicinal vaping products on premises, to ensure that a consistent message was agreed and communicated – ACTION.</b></p> <p>The Independent Member – Trade Union (IM-TU) asked whether they were focusing enforcement on the largest UHB sites first. He also asked what their position was on St David’s Hospital, since they had patients there but didn’t own the site.</p> <p>The C-PH responded that the aim was to have patrol officer presence at all five hospital sites, but that there would be more ground to over at the bigger sites.</p> <p>The EDPH noted that she did not know the specifics on St Davids Hospital, but discussions were ongoing with all sites they planned to monitor. In the first six months they would identify smoking hotspots to target their limited resources effectively across all five sites. Other sites could be added over time as needed.</p> <p><b>For the team to clarify the position on St Davids regarding no smoking enforcement – ACTION.</b></p> <p>The EDPH emphasised that nicotine was a really addictive substance, and that it would be about supporting people to make that change.</p> <p>The Director of Corporate Governance (DCG) encouraged staff to challenge people smoking on site.</p> <p>The Executive Medical Director (EMD) noted that he was due to discuss new approaches for managing nicotine dependence in inpatients with a respiratory consultant from Imperial College London and would loop the EDPH in these discussions.</p> <p><b>The Committee resolved that:</b></p> <ol style="list-style-type: none"> <li>1) The content of this update report was noted.</li> </ol>	
<p><b>QC</b> <b>2025/09/2.5</b></p>	<p><b><u><a href="#">Discharge Advice Letters (DALs) - Verbal Update</a></u></b></p> <p>The Associate Medical Director Patient Safety and Clinical Effectiveness (AMD-PSCE) provided the following update:</p> <ul style="list-style-type: none"> <li>• He was continuing to discuss discharge advice communications issues with Clinical Boards and planned to link this work to the hospital discharge policy.</li> <li>• Digital prescribing had highlighted the system issues with DALs – the EPMA delivery group was supporting solutions.</li> <li>• The Task &amp; Finish Group (T&amp;FG) had completed its work – now they had to decide where DALs governance should sit within their structures (digital, safety, or in clinical boards).</li> <li>• This remained a work in progress as they sought a permanent home for this governance.</li> </ul> <p>The ADPE asked the AMD-PSCE to consider sending a copy of DALs to patients as well as GPs, as it was an important safety net. Ideally, all correspondence should be accessible to patients.</p> <p>The AMD-PSCE agreed and noted that this formed part of the T&amp;FG’s discussions. He noted a safeguarding issue with giving a DALs to a patient on a ward, which had paused the practice. The EPMA system could allow for a patient version of a DALs to be generated.</p>	

	<p><b>The CC asked for an update to come back to the Committee in early 2026 – ACTION.</b></p> <p><b>The Committee resolved that:</b></p> <ol style="list-style-type: none"> <li>1) The update was noted.</li> </ol>	
<p><b>QC</b> <b>2025/09/2.5</b></p>	<p><b><u><a href="#">The UHB Clinical Services Plan (CSP)</a></u></b></p> <p>The EMD introduced the item and noted the following:</p> <ul style="list-style-type: none"> <li>• They needed to organise clinical services with a prevention focus, as discussed during the rapid planning event.</li> <li>• The slides outlined the principles and how they shaped their care delivery.</li> <li>• They were developing a narrative for the future of clinical services, supported by other portfolios like workforce, estates, and research.</li> <li>• Public engagement was planned to gather feedback, and they would involve wider organisations.</li> </ul> <p>The Programme Director, Strategic Clinical Redesign (PD-SCR) presented the CSP and highlighted the below:</p> <ul style="list-style-type: none"> <li>• The plan set a 10-year vision (to 2035) for Cardiff and Vale’s clinical services, acting as a high-level blueprint for what care is delivered, how, and where, with detailed service plans to follow.</li> <li>• It prioritised prevention, whole-pathway integration, and secondary prevention, aiming to transform service delivery and align with the organisation’s strategy and WG escalation criteria.</li> <li>• Principles guiding the plan included co-locating high-volume, low-complexity work, ensuring 24/7 delivery of critical interventions, and focusing on equity and access.</li> <li>• The approach featured broad engagement: over 1,000 responses had already been received, with targeted outreach to seldom-heard communities and use of existing co-production groups.</li> <li>• Leadership was provided by key executives, with a structured timeline for engagement, co-design workshops, and plan finalisation before March 2026.</li> <li>• The plan’s engagement process and questions were being refined to ensure transformational, not just incremental, change, with input from public health and community partners.</li> <li>• Insights from engagement would inform not only the clinical services plan but also other strategic portfolios, ensuring a whole-organisation approach.</li> </ul> <p>The Independent Member – Community (IM-C) asked about how the 350-membership coproduction network was coordinated, how it contributed to decision-making, and whether there were governance arrangements supporting its role in shaping the CSP.</p> <p>The PD-SCR responded that instead of coordinating new groups, they used existing coproduction networks to feed into the work. They also analysed feedback from previous public engagement to avoid duplication.</p> <p>The IM-C noted that the paper did not include reference to their key strategic partners – the Third Sector Council and Glamorgan Voluntary Services – who played a major role in community and third sector engagement. He asked whether they would be included going forward.</p> <p>The PD-SCR noted that her team had already been in contact with the Third Sector Council team and would ensure these partners were included in their plan going forward.</p>	

	<p>The EMD explained that moving to an integrated care system meant working closely with the community and third sector. Clusters would likely be the hub for healthcare delivery, but the whole pathway remained important. They needed to define their principles, understand needs, and work differently.</p> <p>The PD-SCR noted that feedback from young adults during Fresher’s Week had been especially insightful, and there was a need to increase health awareness amongst young people. Insights from this engagement would be shared across all strategic portfolios, not just clinical services.</p> <p>The EDPH offered her help in restructuring the questions related to the five chapters, as they encouraged incremental change rather than the transformational shift towards prevention that was needed.</p> <p>The PD-SCR welcomed the EDPH’s input.</p> <p>The Executive Director of AHPs, Health Scientists and Community Services Development (EDAHC) responded that the questions were co-produced with users, reflecting what they wished to be asked. As they engaged further, they may need to tweak the questions, but it would be important to explain any changes to those involved.</p> <p>The CC acknowledged the extensive engagement undertaken for this work.</p> <p><b>The Committee resolved that:</b></p> <ol style="list-style-type: none"> <li>1) The requirement to develop a Clinical Services Plan as a key condition of Welsh Government’s Level 4 Targeted Intervention was noted;</li> <li>2) The timescales for engagement and completion prior to the end of March 2026 when the election period will commence was noted;</li> <li>3) The scope and approach to developing the Clinical Services Plan was noted.</li> </ol>	
<b>Items for Approval / Ratification</b>		
<p><b>QC</b> <b>2025/09/3.1</b></p>	<p><b>Policies</b></p> <p><a href="#"><u>UHB 372 – CAV/UHB Hospital Discharge Policy (integrated with Cardiff and Vale Local Authorities)</u></a></p> <p>The Managing Director for Planned Care (MDPC) provided the following summary:</p> <ul style="list-style-type: none"> <li>• This is the third iteration of the UHB’s discharge policy, which aimed for a whole-systems approach and alignment with the new WG hospital discharge guidance from September 2024.</li> <li>• It had been developed with CAV LA and third sector partners.</li> <li>• The policy focused on equity, timely treatment, and a “home first” approach to reduce readmissions</li> <li>• It brought together all relevant policies, with hyperlinks included for more information.</li> <li>• The policy supported urgent and emergency care goals and whole system working.</li> </ul> <p>The DCG noted that the Senedd LA Housing Committee released a report that day on hospital discharge. It was worth highlighting that the UHB was the only one with a coproduced discharge policy with LAs, which reflected the collaborative work.</p> <p><b>The Committee resolved that:</b></p> <ol style="list-style-type: none"> <li>1) The policy was approved.</li> </ol>	

	<b>Items for Noting &amp; Information</b>	
QC 2025/09/4.1	<a href="#"><u>Minutes from the Safeguarding Steering Group (SSG) held on 22.05.2025 and 24.07.2025</u></a>  <b>The Committee resolved that:</b> 1) The minutes were noted.	
QC 2025/09/4.2	<a href="#"><u>Radiation Protection Group Chair's Report for the meeting held on 22.07.2025</u></a>  <b>The Committee resolved that:</b> 1) The Chairs Report was noted.	
	<a href="#"><u>Agenda for Private Quality Committee Meeting</u></a>	
QC 2025/09/5.1	i) <i>Minutes and Action Logs from the Private QSE Committee on 24.06.2025</i> ii) <i>Any Urgent / Emerging Themes – Verbal (Confidential Discussion)</i> iii) <i>Cardiology Review</i> iv) <i>Cardiff Health Partners (CHP) Prospectus</i>	
	<a href="#"><u>Any Other Business</u></a>	
QC 2025/09/6.1	<i>No items.</i>	
	<a href="#"><u>Date &amp; Time of Next Meeting:</u></a>	
QC 2025/09/7.1	28th October 2025 at 2pm via MS Teams	