Confirmed Minutes of the Public Quality Committee

Held on 20th January 2026 via MS Teams

To view the meeting: CAVUHB Public Quality Committee 20.01.2026

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Clive Curtis	CC	Independent Member - Community
Mike Jones	MJ	Independent Member – Trade Union
Judi Rhys	JRH	Independent Member – Third Sector
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
David Thomas	DT	Director of Digital & Health Intelligence
Catherine Wood	CW	Deputy Chief Operating Officer
Additional Attendees		
Michael Allum	MA	Consultant in Public Health
Timothy Banner	TB	Clinical Director Pharmacy & Medicines Management
Abigail Holmes	AHO	Director of Midwifery and Neonatal Services
Karenza Moulton	KM	Senior Nurse Acute Child Health
Clare Wade	CW	Director of Nursing – Surgery Clinical Board
Robert Warren	RW	Assistant Director of Health, Safety and Fire
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
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
Lauranne Cullen	LC	Regional Director for Llais
David Fluck	DF	Executive Medical Director
Suzanne Rankin	SR	Chief Executive Officer
Stephen Riley	SR	Independent Member – University

QC 2026/01/1.1	**Welcomes, Introductions & Apologies** Ceri Phillips (CP), the Committee Chair, welcomed everyone to the meeting in English & Welsh. Apologies for absence were noted.	ACTION

QC 2026/01/1.2	**Declarations of Interest** No declarations of interest were raised.	
QC 2026/01/1.3	**Minutes of the Committee meeting held on 09.12.2025** The minutes of the Committee meeting held on 09.12.2025 were received. **The Committee resolved that:** a) The minutes of the meeting held on 09.12.2025 were approved as a true and accurate record of the meeting.	
QC 2026/01/1.4	**Action Log following the Meeting held on 09.12.2025** The Action Log following the Meeting held on 09.12.2025 was received and discussed. QC 2025/12/2.1 - UHB Quality Indicators Report – EPMA: - Jason Roberts (JR) informed the Committee that whilst EPMA was referred to in the report for item 2.1, more detail would be included in April's report to provide a more detailed insight on trajectory and emerging themes/trends. QC 2025/12/2.1 - UHB Quality Indicators Report – Improvement Objectives and Trajectories: Kirsty Williams (KW), the UHB Chair, asked whether there would be an opportunity to contribute to conversations around what the future of the Committee would look like. Matt Phillips (MP), the Director of Corporate Governance, explained that he would be considering a new Terms of Reference, which would go to Board for a decision in March 2026. There would need to be a consultation process before then. CP asked for any comments on the Committee meeting to go to Rachel Chilcott (RC), the Corporate Governance Officer. JR explained that the team are in the process of producing consistent templates for Clinical Boards to use in reporting through the Committee. They will be building in the "Rescue KPIs" discussed with the Chief Nursing Officer (CNO) and Chief Medical Officer (CMO) to ensure they are reflected within the reports. **The Committee resolved that:** a) The Action Log from the meeting held on 09.12.2025 was noted.	
QC 2026/01/1.5	**Committee Chair's Actions** No Chair's Actions were raised.	
	Items for Review & Assurance	
QC 2026/01/2.1	**UHB Quality Indicators Report** Alexandra Scott (AS), the Assistant Director of Quality and Patient Safety, and Angela Hughes (AH), the Assistant Director of Patient Experience, 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 December 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. Topics discussed included, but were not limited to:	

	• Patient Safety Incident Reporting • Infection Prevention and Control (IP&C) • Deteriorating Patients • Patient Falls • Pressure Damage • Medication Safety • Mortality • Audit and Assurance / Internal and External Assurance • Workforce • Concerns (themes grouped by UHB-wide and by Clinical Board) • Patient Experience KW asked for more detail around timescales to the different programmes of work, and provided the following comments: • Pressure damage – there was not much indication within the report on progress and when they would expect to see outputs from these workstreams and programmes of work • NRIs – 73% of cases had been categorised as no/low/moderate harm but asked for a further breakdown of these figures. • IP&C – more information on timescales was needed, particularly for work around Aseptic Non-Touch Technique (ANTT). She queried how confident they were that all clinicians would participate in the training, and whether they could get a breakdown on the different clinical workforce groups who had/had not completed the training. • Mortality – KW asked when they would have a higher level of assurance around the mortality figures and the coding issue around stroke would be resolved. AS responded that further detail on the trajectory of improvement work could be expanded upon in future reports. **KW asked for a note to be circulated, rather than waiting until the following Committee meeting – ACTION.** Rhian Thomas (RT), the Committee Vice Chair, commented that understanding the expected impact of the activity would be valuable. Regarding equity, access, and coproduction, Clive Curtis (CC), the Independent Member – Community, asked that given the recurring theme of delays, communication, and discharge, what their strategic, system-wide approach was to address these as system-wide inequalities rather than isolated service issues. Additionally, he asked how they would strengthen the role of community voices in shaping quality improvement and service redesign. AS recognised the need to reflect inequalities across all the quality indicators, but that currently the UHB and national datasets for protected characteristics were limited. They were working with the Public Health team on how to improve. Judi Rhys (JRH), the Independent Member – Third Sector, highlighted the role of the Third Sector in falls prevention, as there was a lot of expertise and support available which could strengthen the training and awareness work. CC asked what impact AI was having on the UHB and the concerns team, giving that response times had reduced across Wales, and how were they supporting staff through the transition.	

	AH responded that they were seeing an impact. AI had benefits, but how they used it was crucial. AH reminded the team that they needed to check responses for compassion and ensure the response truly answered the person's questions. The new Listening to People guidance also strengthened early personal contact. Mike Jones (MJ), the Independent Member – Trade Union, noted his disappointment to see reports of unprofessional or insensitive behaviour. He asked whether these were large numbers, and where a staff member had been named, how this was handled. AH responded with the following: • Though not a large number, the increase was enough that it should be brought through the Committee. • Any issues raised were followed up immediately. If something needed to go through professional/disciplinary routes, it was escalated to the relevant lead. • They also received compliments and most interactions were positive. But they must get it right every time. KW clarified that they were not currently meeting the Welsh Government (WG) response times target, and asked what steps were being taken to improve response times. AH responded with the following: • They should meet WG targets, but they also needed to ensure responses were high quality • They were doing focused work – CAVUHB's number of longstanding complaints were the lowest in Wales, but still needed to improve • They worked with complainants to agree questions for investigations, looked for themes, encouraged proactive communication, and used the enquiries line to resolve issues quickly. Complaints were reviewed regularly with Clinical Boards. • Volume remained a challenge, but they explored all options and learned from other UHBs. KW explained that it was challenging, and whilst they needed to balance timeliness with quality, they must still meet performance expectations. JR provided assurance that these discussions were ongoing, and the team were working on a focused piece of work around concern responses. They were mindful that some KPIs would change with the new regulations. JRH explained that most people raised concerns because they wanted to see change, not compensation. They needed to show clearly how complaints led to real improvements. JRH noted that whilst patient experience surveys were useful, she had seen in previous roles that often patients gave glowing feedback publicly, whilst sharing serious concerns privately. Many did not want to "rock the boat" during treatment, fearing that it might affect their care. They needed to help people feel safe and confident to speak honestly about their treatment. AH noted that they always included learning in their responses, explaining the actions taken and offered to meet. The new guidance would help, as not everybody needed a formal complaints route and instead needed bereavement support or a safe space to share their story. AH explained that surveys went out three days after discharge and were anonymous unless people chose to provide their details. Asking patients whilst they were still in	

	hospital was harder, as many were reluctant to be critical. They had volunteers who helped gather more independent feedback, and they also relied on input from third-sector partners. **The Committee resolved that:** 1) The assurance provided by the Quality Indicators was noted; 2) The work underway to drive requisite improvements was noted.	
QC 2026/01/2.2	**Children & Women Clinical Board Quality Indicators Report** The Children & Women Clinical Board presented their assurance report and slides to the Committee which detailed the achievements, progress and planned actions within the Children & Women Clinical Board to maintain the priority of QSPE. Topics discussed included, but were not limited to: • NRI and Patient Safety Incident Reporting • IP&C • Quality Audits & Performance • Deteriorating Patient • Patient Falls and Pressure Damage • Medication Safety • Mortality • External Assurance / Clinical Audit and Assurance • Workforce • Patient Experience • Concerns • Equitable Care Regarding neurodiversity, KW observed that demand for assessment and post-diagnosis support was far beyond what the current services could manage, and families still needed help without a formal diagnosis. They needed a joined-up approach with the voluntary sector, education, and social services. KW suggested having a discussion outside of the meeting to understand the work underway. Regarding coroner's cases, KW noted that they had a big impact on staff and public confidence. She asked what role the Committee or Board should have in gaining assurance that all the findings and actions are being addressed. Abigail Holmes (AHO), the Director of Midwifery and Neonatal Services, agreed that for neurodiversity there were long waits, a surge in referrals, and a service not design to meet the scale of the need. They were using year-end funding to reduce the backlog, but they anticipated over 1000 children needing assessments the following year, plus the ongoing support that followed. They also needed more consistency across Wales, as assessment pathways differed widely, and education services played a major role but were not fully linked into the process. AHO explained that for coroner's cases, an action plan alone was not enough, and that they needed to show real, demonstratable learning. This meant being transparent about what happened, what has changed, and how they will ensure it won't recur. They should be reporting measurable outcomes back so that the Committee and Board can gain assurance that improvements were embedded and sustained. **A meeting to be set up between KW, CP, and members from the Children & Women and the Mental Health Clinical Board around neurodiversity demand - ACTION**	

	To improve assurance to the Committee and Board regarding actions and learning from high-profile coroner's cases and inquests, ensuring that outcomes and evidence of change are shared, not just action plans – ACTION. AH explained that they brought PFDs through the Quality Committee to monitor them, but the higher-profile cases needed clearer assurance. They recorded the learning, but they did not always share how it was being acted on. AH noted that the implementation of Badgernet was a major achievement, and the real-time information it provided was already having an impact. AH asked for more detail on AHO explained that Badgernet was the digital maternity system launched in July 2025. They chose a full go-live, which was a big shift for midwives, but was now providing data they had never had before. The real-time dashboards would be hugely valuable. It had long been used in neonatology, but now their systems linked across Wales. **The Committee resolved that:** 1) The contents and assurance provided within the report and the steps being taken to improve quality, safety, and patient experience was noted.	
QC 2026/01/2.3	**WHO Checklist Implementation and Compliance** Clare Wade (CW), the Director of Nursing – Surgery Clinical Board, shared their presentation with the Committee, which summarised the following: • The WHO Collaborative was established following a culture review in main theatres, which aimed to standardise WHO checklist use, improve leadership, and foster a culture where all staff felt empowered to speak up about safety. • Audits revealed that whilst checklist usage was high, multi-signature compliance was inconsistent. The process was revised to require one signature per step, focusing on meaningful engagement rather than administrative compliance. • A new, simplified WHO checklist was being developed, with input from multidisciplinary teams. Standardised team brief whiteboards would be introduced in all theatres to enhance communication and risk awareness. • The new Aqua theatre management system had been launched, with plans to integrate WHO checklist processes in the future, whilst maintaining a focus on safety culture rather than tick-box compliance. CC asked how they were supporting staff who felt responsible for chasing signatures or managing the process. CW responded this was why they stood the sticker initiative down, as they did not want staff chasing signatures. The aim was to move towards open, real-time communication in theatres, where staff feel comfortable raising concerns immediately. They would continue these conversations through the Theatres Together workstream, which was a wider piece about culture and behaviours. CP noted that this work covered a lot of key areas, and getting it right was essential in preventing issues such as NRIs and never events. **The Committee resolved that:** 1) The update was noted.	

QC 2026/01/2.4	**Limited Cyber Security internal audit report - implications for quality & safety** David Thomas (DT), the Director of Digital & Health Intelligence, presented the Internal Audit report on Cyber Security to the Committee, and summarised the following: • The audit identified gaps in cyber risk awareness, risk management, and governance at Clinical Board level. • Actions taken included strengthening clinical board engagement, clarify information asset ownership, and ensure cyber risks were consistently identified and logged via AMAT. • Ongoing assurance included targeted engagement through Operations Delivery Group (ODG), development of standardised information asset registers and training, and a planned cyber resilience exercise. RT explained that for a limited assurance audit, a follow-up was normally done 12 months later. She asked whether they expected to see considerable progress and actions completed by then, or whether substantial work would remain. DT expected the three audit actions linked to clinical board engagement to be completed, as they now understood their roles in tracking information assets and contributing to the Cyber Improvement Plan. The remaining actions were already in progress, so they should have addressed everything identified by the follow-up audit. CP explained that this audit was brought to the Quality Committee because cyber-attacks posed a major risk and attempts to breach NHS systems were constant. DT added that they were being assessed by the Cyber Resilience Unit (CRU) on their readiness. **The Committee resolved that:** a) The update was noted.	
QC 2026/01/2.5	**Bariatric and Medical Cylinders - Patient Safety** Robert Warren (RW), the Assistant Director of Health, Safety and Fire, presented the report and summarised the following: • The first part of the paper covered the need for a clinical pathway for plus-size patients and the importance of its implementation. The issue currently sat on the Health & Safety risk register, but the People & Culture Committee advised that it should be clinically led. He requested to transfer it to an appropriate clinical lead for implementation. • The second part of the paper related to a medical gas incident that occurred during patient transfer. A cylinder placed on a bed slipped off, fracturing a staff member's toe. This had RIDDOR implications and highlighted wider risks, including loss of containment from high-pressure cylinders and potential supply issues for patients. The matter had gone through the Medical Gas Safety Group. • The request was for clinical teams to provide details of how many bed-mounted cylinder brackets may be needed. These bespoke brackets allowed cylinders to be safely secured during transfers. JR explained that he was responsible for oxygen and medical gases in the organisation. He completed the required training alongside around 60 staff, including lead and senior nurses, to strengthen clinical leadership in this area. The training, delivered by BOC,	

	highlighted the legal requirements for safe storage and maintenance of oxygen in clinical areas. JR noted that oxygen training should form part of mandatory training for nurses and other clinical staff handling cylinders but is picking this up with clinical boards to understand current compliance levels and support. KW commented that the issue was not just purchasing the kit, it was ensuring its consistent use. RW responded that this was the role of the Medical Gas Safety Group – training was being reviewed and rolled out, but communication was key. Closing the gap was not just about buying equipment; it must be properly implemented. Timothy Banner (TB), the Clinical Director Pharmacy & Medicines Management, informed the Committee that he chairs the Medical Gas Safety Group, which met monthly with a wide estates and multidisciplinary team (MDT). These points would be picked up in these meetings. RW reiterated that Health & Safety still needed involvement in the plus-size pathway, particularly around fire safety, manual and patient handling. They were not handing over their responsibilities, but they could not act as the clinical lead as they did not have the required expertise. JR explained that in his role as the Executive Lead for oxygen and gases, he had committed to supporting RW and the team. They would introduce regular audits – likely through the Tendable platform – aligned with their usual environmental audits, to provide RW and TB clear oversight across clinical area. **The Committee resolved that:** A) The risk of the plus-size patient pathway as being clinically or patient safety led was accepted; B) The patient risk when transferring with medical gas cylinders was acknowledged, and the drive with suitable communication to determine the magnitude of the issue and to assist in resolving was supported.	
	Items for Approval / Ratification	
QC 2026/01/3.1	**Policies** UHB 484 – Independent and Supplementary Prescribing Governance Framework TB presented the framework which was revised to meet new WG and HIW standards. **The Committee resolved that:** A) The Independent and Supplementary Prescribing Governance Framework was approved.	
	Items for Noting & Information	
QC 2026/01/4.1	**Minutes from the Clinical Board QSE Sub-Committees** **The Committee resolved that:**	

	1) The Clinical Board QSE Sub-Committee minutes were noted.	
QC 2026/01/4.2	**Safeguarding Steering Group (SSG) Minutes** *The previous SSG meeting was cancelled.*	
QC 2026/01/4.3	**IP&C Group Minutes** *The previous IP&C Group meeting was cancelled.*	
QC 2026/01/4.4	**Controlled Drugs Accountable Officer Annual Update** TB presented the Annual Report on controlled drugs management, highlighting incident trends, audit activities, and ongoing work to improve security and oversight. **The Committee resolved that:** A) The progress made during the last 12 months was noted.	
	Agenda for Private Quality Committee Meeting	
QC 2026/01/5.1	*i) Minutes and Action Logs from the Private QSE Committee on 09.12.2025* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)*	
	Any Other Business	
QC 2026/01/6.1	CP noted it was MJ's last Quality Committee. He thanked MJ for his commitment and support to the Committee.	
	Date & Time of Next Meeting:	
QC 2026/01/7.1	3rd March 2026 at 2pm via MS Teams	