Confirmed Minutes of the Public Quality Committee

Held on 3rd March 2026 via MS Teams

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

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

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

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

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

	• JACIE assessed over 2000 criteria, identifying 89 areas of non-compliance, mainly relating to:
	  ○ Estates, particularly the adult transplant facilities within the B4 haematology footprint (a recurring issue from previous inspections)
	  ○ Processing facility staffing levels and a lack of formal on-call rotas
	  ○ QMS gaps, including required recruitment and procedure updates
	  ○ Paediatric transplant volumes being very low
	  ○ Workforce deficits from Swansea Bay UHB (SBUHB) elements
	• Work was underway in most areas, such as refurbishing the haematology day unit and progressing quality management recruitment.
	• However, the major unresolved risk was funding a credible Estates solution for B4 haematology. Previous attempts with WG had shown no viable options within the current footprint.
	• Losing JACIE accreditation would have significant consequences, including:
	  ○ Decommissioning of the BMT programme for Cardiff and Swansea Bay (covering ~80% of Wales)
	  ○ Immediate cessation of CAR-T therapy, as manufacturers supply only accredited centres
	  ○ Potential worse patient outcomes if treatment must be sought in England
	  ○ Loss of clinical trial access, reduced recruitment options, and major reputational damage
	• Next steps included ongoing work through a Task & Finish Group (T&FG), day unit refurbishment, monthly SLT updates, and a formal meeting with the Joint Commissioning Committee (JCC). A capital solution for the B4 estate was being pursued with WG. The paediatric and SBUHB workforce plans were also in development.
	
	KW noted that the paediatric issues were harder because they stemmed from low patient numbers, which reflected the size of the population. KW asked about the potential consequences for children if this was not resolved.
	
	JC noted that if low activity remained a concern, JACIE would need to decide whether to reaccredit the paediatric component based on the plan the team submits. Any proposal would go through the internal governance process (SLT and likely the Quality Committee) before being sent to JACIE.
	
	Paul Bostock (PB), the Chief Operating Officer, explained there had been ongoing tension between the UHB and JCC around derogations. They had been clear that they would not compromise quality or safety just to secure accreditation. For CAR-T there was no flexibility – without accreditation, they could not provide it.
	
	Regarding paediatrics, PB noted that even if consultants wanted to keep the service and JACIE were willing to relax the standards, they still needed to be confident they could deliver a safe service. In some cases, treatment in England may be the safer option.
	
	JC noted that the threshold was 5 patients a year, and they were below this. Whilst the team was keen to keep paediatrics within the programme, any proposal would need approval from CAVUHB and the JCC.
	
	JC added that they had already discussed whether derogation was appropriate. Paediatrics also fell below JACIE thresholds for bone marrow and apheresis harvest, and they currently had only one nurse able to perform apheresis. They needed a more detailed discussion with the paediatric team about what was feasible.	

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

	Claire Beynon (CB), the Executive Director for Public Health, summarised the policy which aimed to reduce obesity and health inequalities by mandating that 75% of food sold in internal outlets be classified as healthy, returning from a temporary 65-35 split. The policy excluded inpatient food, which was governed by separate standards. Compliance would be monitored annually and via spot checks. PB asked what influence they could use for hospital outlets to improve their compliance. Additionally, he asked how they ensured that the healthier options were affordable. CB responded that they currently included healthy-food wording in the expressions of interest for new tenders, but without a formal policy, they could not require compliance contractually. Adopting the new standards would allow them to build this into future contracts for external outlets. Regarding affordability, Helen Griffith (HG), the Senior Health Promotion Specialist, noted that they were developing options such as the Wellbeing Wednesday £3.50 staff meal deal, designed with dietetics to be healthy and nutritionally balanced. They were reinforcing that at least one daily meal option must be both the healthiest and the cheapest. Work was ongoing to ensure these options were delivered consistently. Emma Cooke (EC), the Executive Director of AHPs, Health Scientists and Community Services Development, agreed there was more to be done on affordability. The UHB should offer food that clearly aligned with standards, but there was still some slippage, made more challenging by rising food costs and industry changes. MP asked for clarification on the scrutiny and governance route. HG responded that the Healthy Eating Standards Steering Group (with Public Health, procurement, catering, and dietetics) who reviewed progress against the standards and policy and met quarterly. Then members of Public Health, catering, and facilities also attended the Nutrition and Catering Steering Group, where they formally reported progress and sought advice from EC and her team. EC added that the policy was developed jointly by Public Health and catering teams, but delivery sat with catering. It relied on close collaboration between the groups. CC asked whether healthy options were also culturally appropriate. He also asked how they would measure if this policy was changing behaviours or improving health outcomes. CB responded that they could measure success mainly through sales data and compliance with the standards, which is why both were included in the report and brought to this committee annually. CB noted that measuring the wider health impact was harder. They only had reliable obesity data at age 5, and adult data was self-reported rather than measured. This policy was one part of a broader system, alongside healthier high-street options, limits on unhealthy food advertising, and access to activity and community spaces. HG added that they were working with wider public-sector partners, but that they needed to demonstrate that they met the standards before influencing others. Regarding cultural preferences, HG noted the recent health impact assessment recognised there was more to be done. They received frequent requests for halal options, and catering did source halal meat, but they could not advertise it as halal because the	

	preparation areas were not fully compliant. These issues remained regular agenda items in the Steering groups. **The Committee resolved that:** a) The Policy was approved. Biological Medicines Value Optimisation Policy David McRae (DM), the Lead Pharmacist, summarised the policy which mandated prescribing the best-value brand of biological medicines where clinically appropriate, standardised organisational messaging, prohibited pharmacy-level substitution, and established an oversight group and exceptions process. David Fluck (DF), the Executive Medical Director, noted that they had long used generic prescribing once patents expired, and whilst biosimilars were not identical, they had the same clinical efficacy. DF asked whether he foresaw further steps that could help accelerate switching, as continued clinician choice could slow progress. DM responded that further progress depended on the MHRA review, particularly whether they will eventually allow pharmacy-level substitution, which was not permitted. The main factors that slowed switching were drug availability and clinical team capacity. This policy put CAVUHB at the forefront compared with other organisations. RT commented that she could not gauge the financial scale of the potential savings, as it was not explicit, and suggested strengthening the narrative for patients and clinicians. DM responded that this had been debated within Pharmacy. These switches did save NHS Wales millions overall, but the amount varied and would not translate into a fixed figure for CAVUHB annually. Therefore, they had chosen to use the broader phrase “millions of pounds”. DF added that the UHB had saved substantial sums in the past through switching, but this sat against strong lobbying from the pharmaceutical industry to slow the process down. Patients could also react negatively to “cheaper versions”, even though biosimilars were clinically just as effective. DF explained that they ultimately needed clinician buy-in. When clinicians advocated for the switch, patients trusted the change. Some specialties found switching easier than others. DF was due to meet with the Clinical Director Pharmacy & Medicines Management to discuss this. **The Committee resolved that:** A) The Policy was approved. Policy for Commissioning a Review of a Service, Clinical Department, or Clinician Alexandra Scott (AS), the Assistant Director of Quality and Patient Safety, summarised the policy which provided a framework for when and how to commission internal or external reviews, ensuring decisions were prudent, consistent, and governed appropriately. The policy was undergoing targeted consultation before wider organisational review.	

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

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

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