Minutes of the Public Quality Committee
Held on 29th September 2026 via MS Teams

To view the meeting: https://youtu.be/xIF9YChXNtk

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
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
Aled Roberts	AR	Associate Medical Director Patient Safety and Clinical Effectiveness
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		
Jane Brown	JB	Interim Head of Corporate Governance
Sion Lingard	SL	Deputy Director of Public Health / Consultant in Public Health
Abraham Theron	AT	Clinical Board Director – Surgery
Lauranne Cullen	LC	Regional Director – Llais
Secretariat		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies		
Chris Bown	CB	Chief Executive Officer
Judi Rhys	JRH	Independent Member – Third Sector
Stephen Riley	SR	Independent Member – University
Rachna Upadhya	RU	Independent Member - General

QC 26/09/1.1	**Welcomes, Introductions & Apologies** Ceri Phillips (CP), the Committee Chair, welcomed everyone to the meeting in English & Welsh and apologies for absence were noted.	
QC 26/09/1.2	**Declarations of Interest** No declarations of interest were raised.	
QC 26/09/1.3	**Minutes of the Committee meeting held on 28.07.2026** The minutes of the Committee meeting held on 28.07.2026 were received. **The Committee resolved that:** a) The minutes of the meeting held on 28.07.2026 were approved as a true and accurate record of the meeting.	

QC 26/09/1.4	**Action Log** The Action Log following the meeting held on 28.07.2026 was received and discussed. **The Committee resolved that:** a) The Action Log from the meeting held on 28.07.2026 was noted.	
QC 26/09/1.5	**Committee Chair's Actions** No Chair's Actions were raised.	
	Quality Performance Reporting	

QC 26/09/3.1	**Shaping our Future Quality Excellence – Acute Deterioration**
	
	Abraham Theron (AT), Clinical Board Director – Surgery Clinical Board, presented the slides to the Committee and summarised the following:
	• The Acute Deterioration Board covered four main workstreams: Early Warning Scores (EWS), Call 4 Concern, Sepsis, and Treatment escalation plans. Treatment escalation plans were being considered as a separate programme with dedicated governance arrangements.
	• Welsh Government (WG) directed the implementation of four standardised EWS tools across Wales by September 2025. The expectation was for all UHBs to implement despite no additional resource being provided.
	• NEWS 2:
	  ○ NEWS2 score had to be introduced to every adult inpatient in CAVUHB, with different responses required for different areas.
	  ○ Approximately 6,500 staff received training, supported by a Task and Finish Group established to oversee implementation. NEWS2 was introduced in July 2025 to allow additional support ahead of the annual doctor changeover.
	  ○ Escalation pathways were redesigned to ensure implementation remained resource neutral, with greater emphasis on primary clinical teams and support from the Patient at Risk Team (P@RT).
	• Audit data demonstrated improving compliance with the completion of observation charts and escalation processes. Correct chart usage and score calculations were now consistently achieved, with most escalations undertaken appropriately and within expected timescales.
	• Monitoring indicated that implementation had not overwhelmed deterioration or resuscitation services. Referrals and fast-bleep usage remained manageable, and there was evidence of appropriate escalation of deteriorating patients.
	• Early outcome data suggested a reduction in cardiac arrests alongside an increase in peri-arrest interventions, indicating earlier recognition and management of acutely unwell patients.
	• Feedback from resident doctors was broadly positive, with respondents reporting that current escalation arrangements were accessible, proportionate and effective.
	• A Call 4 Concern programme was being implemented following WG direction in January 2026, providing patients, families and carers with a formal mechanism to raise concerns about deterioration. The adult pathway was established, maternity had recently gone live, and implementation was progressing within mental health and community services.
	• Sepsis improvement work continued, including leadership transition arrangements, development of nursing leadership capacity, charity-funded staff training through the UK Sepsis Trust, and a successful sepsis awareness event.
	• Overall assurance was provided that all four EWS had been successfully implemented, compliance was improving, escalation processes were operating effectively, and there was currently no indication of adverse impact on patient outcomes. It was still early days for Call 4 Concern, with further updates in the future to follow. Electronic observations were expected to provide further benefits in the future.
	
	Paul Bostock (PB), the Chief Operating Officer, expressed concern that the Call 4 Concern process may not be widely understood by the public, particularly as the equivalent scheme in England, Martha's Rule, had received greater publicity.	

	AT responded that the branding and terminology for Call 4 Concern was determined nationally and could not be changed locally, and any changes would require agreement at WG level. AT noted that many calls received related to general concerns rather than acute deterioration, which highlighted the need for greater public understanding of the scheme's purpose. PB asked whether communications could better explain that it was the Welsh equivalent of Martha's Rule. Jason Roberts (JR), the Executive Nurse Director, acknowledged that WG required the scheme to be branded differently from Martha's Rule, including restrictions on referencing the English model. JR agreed that local communications should be refreshed, whilst discussions continued with WG on the potential for greater alignment and public recognition. Angela Hughes (AH), the Assistant Director of Patient Experience, noted that the name "Call 4 Concern" may be confused with the Complaints/Concerns team. AH added that using a three-option wellness score (better, same, worse) may lead respondents to default to the middle option, and consideration should be given to using four response choices to encourage more meaningful feedback. David Fluck (DF), the Executive Medical Director, asked how to move further upstream and whether there were any remaining gaps where earlier intervention could be targeted. f AT responded that cases where deterioration was not recognised and poor outcomes occurred should continue to be reviewed through existing governance processes. Significant resuscitation data was available, including evidence that resuscitation calls were more likely around staff handovers, a pattern also seen nationally. Further analysis of this data may help identify factors contributing to deterioration recognition and opportunities for earlier intervention. Kirsty Williams (KW), the UHB Chair, sought clarification on whether all four tools had been fully implemented as expected and whether the organisation was compliant with national requirements. KW asked about plans to refresh awareness of Martha's Rule among patients and families, benchmarking against other Welsh organisations, and the use of comparative data from England to assess awareness levels and inform discussions on potential improvements to the Welsh approach. AT confirmed that all four EWS tools were implemented on time and fully embedded, with data reporting through the All-Wales implementation network. However, the Call 4 Concern element was less mature, and further benchmarking against comparable organisations in Wales and England would be needed to assess activity levels and identify opportunities for improvement as more comparable data became available. JR acknowledged that work was underway with the Chief Nursing Officer (CNO) to compare performance with England and understand variations in implementation. A refreshed communications strategy was being developed, including renewed publicity, updated materials and digital approaches, to increase awareness of Call 4 Concern. AT added that options being explored included bedside stickers displaying Call 4 Concern contact details and patient information leaflets highlighting how and when to raise concerns. These measures formed part of a wider communications strategy. KW suggested consideration be given to including key information on patient wristbands. AH suggested information also be promoted through volunteer activity trolleys, QR codes, contact details and volunteer uniforms. Aled Roberts (AR), the Associate Medical Director Patient Safety and Clinical Effectiveness, noted that several initiatives were underway to support earlier care planning and prevent deterioration. AR agreed there was a need to bring these strands together to support appropriate escalation decisions and strengthen the preventative approach. **Bring an update on Acute Deterioration / Early Warning Scores and Call 4 Concern back to Quality Committee in spring 2027 - ACTION**	

	The Committee resolved that: a) The Acute Deterioration update was noted.	
QC 26/09/2.1	**Integrated Performance Report (IPR)** AS presented the IPR, and highlighted the following to the Committee: • This was the second iteration of the IPR which highlighted a mixed quality and safety position. • During August 2026, 15 Nationally Reportable Incidents (NRIs) were reported in the month prior. The long-term themes around NRIs continued to show themes around perinatal mortality and pressure damage. Every perinatal mortality case is subject to a multi-professional review that fed into the wider MBRRACE work. The UHB was underway with a Pressure Damage Collaborative to strengthen the governance, oversight, training, awareness and targeted areas of improvement. • Patient experience feedback continued to identify communication, waiting times and care coordination as key areas of concern raised, whilst infection prevention and control (IP&C) performance remained mixed with ongoing challenges related to Klebsiella, C.diff and MRSA. • Positive improvements were noted in the timeliness of incident investigations, with significant reductions in the number of NRIs that remained under review and overdue cases, and patient safety incidents that remained under investigation for a prolonged time, alongside good compliance with the WHO Surgical Safety Checklist and continued quality improvement activity across the organisation. KW sought assurance that Nationally Reportable Incidents (NRIs) were within expected ranges, and that robust organisational learning was being captured and implemented from investigations. AS responded that the UHB had a high reporting rate for NRIs which reflected a strong reporting culture and appropriate review thresholds. Previous reviews of NRIs closed for more than 12 months identified that the recorded level of harm was subsequently downgraded in over 70% of cases. Learning from incidents informed organisation-wide improvement programmes, with examples including work on deteriorating patients, IP&C, continuity of care, and digital solutions to reduce patient identification errors. KW asked how the organisation distinguished between high incident reporting rates driven by a strong reporting culture, and rates that may indicate underlying safety concerns, and whether the downgrading of harm following review was a key measure of this balance. AS responded that the UHB received approximately 24,000 incidents a year through the Datix system, and there were processes in place to ensure there was corporate oversight and discussion at Clinical Board levels and with Executive colleagues to ensure this was proportionate. Whilst NRI reporting rates were higher than many organisations, reviews often identified lower levels of harm than initially anticipated, and findings were used to drive both local and organisation-wide improvement initiatives, with a continued focus on proportionate investigation and learning. JR provided assurance that the UHB's high reporting rates reflected a strong culture of openness and learning. While further work was needed to strengthen how learning and downgraded harm data were reported, ongoing quality and clinical safety governance developments, including the Quality Management System (QMS), were intended to enhance the cycle of reporting, investigation, learning and improvement. AH explained that learning from incidents, claims, redress cases and near misses were essential to preventing recurrence and harm.	

	AS added that CAVUHB's NRI rate was 2.89 per 100,000 population, compared with the Wales average of 2.43. Comparisons were affected by reporting methodology and did not fully account for the UHB's tertiary population. **The Committee resolved that:** A) The data and narrative included in the performance report were noted.	
	Items for Oversight / Scrutiny	
QC 26/09/3.2	**Clinical Board Highlight Reports** JR presented the reports to the Committee and highlighted the following: • This was the third iteration of the Clinical Board AAA reports and noted the increased maturity in governance oversight and risk visibility across the organisation. • Recurring themes included workforce fragility, particularly within Mental Health, Maternity and PCIC services, with staffing pressures increasingly impacting patient access, flow and safety. Assurance is dependent on the ongoing recruitment and sustainable service models. • Delays in access to care and waiting list harms remained significant concerns, reflecting ongoing demand and capacity challenges across a number of specialties. • Ongoing work to improve the quality, accuracy and timeliness of discharge communications between secondary and primary care was highlighted, including the use of discharge advice letters and digital systems to strengthen compliance. • The continued impact of the ageing estate infrastructure on patient access, diagnostics and operational performance was noted, with assurance limited pending longer-term funding and sustainable solutions. • Positive progress was reported in a number of areas including WHO Surgical Safety Checklist compliance, the Eating Disorders Transformation Programme, and strengthening Clinical Board governance arrangements. • Significant improvements in incident management were noted, including substantial reductions in Datix backlogs, NRIs under review, and overdue investigations. CP asked Natasha Goswell (NG), the Deputy Executive Nurse Director, for her assessment of where they are with these Clinical Board AAA Highlight reports. NG responded that clinical governance arrangements within the Clinical Boards continued to strengthen, with the AAA reports providing improved visibility of risks and performance. Whilst further development was required, the reports were seen as evidencing a positive trajectory, supported by the ongoing implementation of the QMS. PB suggested that further executive moderation prior to Quality Committee consideration would help ensure risks and issues were presented consistently and proportionately. CP noted variability in how Clinical Boards utilised the AAA reporting framework and agreed that further refinement was required. CP invited comments on the Welsh Gender Service in light of recent scrutiny. DF noted that surgical referrals and intervention within the Welsh Gender Service had been paused by the Joint Commissioning Committee (JCC) in August 2026 following concerns that referral rates for surgical intervention were higher than those seen in England. An independent review of referral processes was being established, whilst the service continued to provide support and regular communication with affected patients and staff, with the aim of resuming referrals as soon as possible.	

	KW welcomed the greater visibility of risks and challenges within the AAA reports. Whilst reporting maturity was improving, concerns were raised regarding variation in reporting approaches, the need for greater standardisation and moderation, and ensuring that identified risks resulted in clear organisational action, accountability and improvement. KW asked what the Quality Committee did with these reports as a result. CP asked for further information around the issues in the prison service. PB suggested discussing the prison service in the private Quality Committee session. PB agreed that the AAA reports should be used to identify areas that require deeper scrutiny and assurance by the Committee and inform future agenda items and discussions. JR emphasised the importance of balancing transparency and openness about risks with providing assurance on actions and improvements. Further work was required to strengthen moderation, consistency and communication of the actions being taken in response to identified risks. **The Committee resolved that:** A) The Clinical Board Highlight Reports were noted for assurance.	
QC 26/09/3.3	**Clinical Safety Group (CSG) Highlight Report** AS presented the report and summarised the following: • The CSG reviewed key quality and safety risks across the UHB in August 2026, including outsourced endoscopy follow up processes, service capacity pressures in diabetes, dermatology and ADHD services, district nursing workforce challenges, and risks associated with digital implementation. • Common themes identified from incidents, inspections and mortality reviews included communication, documentation, escalation of deterioration and compliance with policies and training requirements. • Positive progress was noted in IP&C, theatre audit assurance, mortality governance and oversight, and the establishment of the Pressure Damage Collaborative to address pressure damage rates. • The CSG reviewed its scope and arrangements to strengthen oversight of risk and assurance across the clinical effectiveness framework. AR noted plans to strengthen the role of the CSG, including improving engagement with Clinical Boards, enhancing the escalation of risks and assurance, and refining how quality and safety information is reported to the Quality Committee. **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 26/09/3.4	**Clinical Effectiveness Committee (CEC) Highlight Report** AS introduced the report and provided the following summary to the Committee: • The CEC in September 2026 received assurance regarding performance and improvement activities across the National Respiratory Audit Programme, paediatric asthma, and the delivery of the Welsh Respiratory Quality Statement. • Significant improvements were noted in audit participation, data quality and compliance with national standards, alongside strong performance in areas such as tobacco dependency interventions, oxygen prescribing, and invasive ventilation. • Ongoing challenges remained in relation to prolonged waiting times for pulmonary rehabilitation, respiratory diagnostics and interstitial lung disease waiting times,	

	although service redesign, workforce investment and pathway improvements were beginning to demonstrate benefits, including early reductions in respiratory-related emergency attendances and admissions. AR welcomed the joined-up approach taken by the Respiratory Service, which combined national audit findings with quality, waiting list and service improvement work to support quality planning and service development. While challenges remained, particularly in pulmonary rehabilitation, assurance was provided that services are using audit findings constructively to drive improvement and prevention-focused care. DF noted that the Clinical Board were reviewing their services across respiratory and looking to move resources to fill this gap in pulmonary rehabilitation. CP highlighted the opportunity to align pathway changes with the Clinical Services Plan (CSP) and sought assurance on the extent to which this was had been progressed. AR noted the importance of pulmonary rehabilitation and community-based support in preventing admissions and supporting a shift towards preventative care. Assurance was provided that these priorities were recognised by the Clinical Board and were being progressed through service improvement and escalation processes. Emma Cooke (EC), the Executive Director of AHPs, Health Scientists and Community Services Development, highlighted the importance of strengthening preventative and community-based respiratory care, with a focus on improving support for people with existing long-term conditions whilst also shifting further upstream to prevent ill-health and reduce future demand on services. Claire Beynon (CB), the Executive Director of Public Health, noted ongoing public health and respiratory improvement work focused on smoking prevention and cessation, including school-based education programmes, the development of smoke-free ambassadors, and closer integration between respiratory services and stop smoking support. The importance of expanding preventative interventions and reaching people earlier to reduce the burden of respiratory disease was highlighted. **The Committee resolved that:** A) The assurance provided by the clinical performance reported in the national audits and the improvement work that was underway to address requisite improvement was noted.	
QC 26/09/3.5	**Health Inspectorate Wales (HIW) Inspections Report** AS presented the report and highlighted the following: • Positive findings from recent HIW inspections across primary and secondary care were noted, including compassionate care, positive patient experiences, effective multidisciplinary working and committed staff teams. • Inspections also highlighted recurring improvement themes relating to estate and environmental issues, including maintaining dignified care environments, medication storage, records management and equipment storage to support IP&C. • Assurance was provided that improvement plans were actively monitored, with regular progress updates submitted to HIW and ongoing oversight of actions that remained outstanding. • In primary care, independent contractors were responsible for implementing required improvements, supported by follow-up assurance processes to ensure actions were embedded and sustained. CP sought assurance that learning from HIW inspections were shared across the organisation.	

	AS responded that learning from common HIW inspection findings was applied across the organisation. For example, medication storage issues had been addressed through a UHB-wide review of clinical areas against national standards, with improvement actions monitored through Clinical Boards and the Medication Safety Executive, alongside plans for re-audit and ongoing oversight. A repeat audit was scheduled for early 2027. KW highlighted concerns about the condition of the estate and facilities were consistently raised through HIW reports and Leaders That Listen visits. She asked whether this feedback was collated and shared with the Estates and Executive teams to strengthen the evidence base for business cases and support investment and improvement decisions. AS responded that whilst the Estates team worked closely with services to address issues identified, the approach was often reactive. AS agreed that there was value in collating this feedback and using it more strategically to support business cases and inform wider Executive discussions on estates investment and improvement. JR noted that the discussion highlighted the growing concern about the condition of the UHB's estate and the impact this is having on service delivery. Both Executive colleagues and frontline staff were increasingly concerned about the environments in which care was provided, with estates issues featuring prominently in the Clinical Board AAA reports. JR acknowledged that a more strategic, organisation-wide approach was needed. AH explained that volunteers provided valuable independent perspective, and often highlighted issues that staff may have become accustomed to. PB reported that CAVUHB had an estimated £800m backlog maintenance requirement, including around £50m of critical infrastructure risks such as roofs and electrical systems. Whilst these issues may not visibly improve care environments, they presented significant operational and safety risks. PB suggested that a wider Board discussion may be required to consider the scale of the challenge and the implications for service delivery and patient safety, as some risks may no longer be tolerable without further action. KW suggested that, alongside assessing critical infrastructure risks, the organisation should develop a more holistic understanding of the impact of the estate on service delivery. This should include opportunity costs associated with poor infrastructure, such as reduced capacity, inefficiencies, and impacts on clinical effectiveness, patient safety and performance. The importance of bringing these factors together to provide a comprehensive picture of the risks and consequences of underinvestment in the estate was emphasised. JR noted that the full impact of estate challenges was difficult to quantify, as clinical teams often developed workarounds to maintain services, which could mask underlying risks. While staff remained committed to delivering care, concerns were raised that organisations could become desensitised to substandard environments. PB agreed that the impact of estate challenges should be assessed more comprehensively but recognised that not all issues could be attributed to infrastructure alone and that services must continue to maintain standards and good practice. DF noted that addressing estates challenges must be closely aligned to the CSP and wider service transformation opportunities. The UHB must also consider how existing infrastructure could be used more effectively.	

	Arrange a further strategic discussion, potentially through a Board development session, on the critical estates risks, required investment and the organisation's tolerance of those risks – ACTION. **The Committee resolved that:** A) The actions taken in response to recent HIW inspection findings across secondary and primary care services were received for assurance. B) The progress of associated improvement plans was noted. C) The continued organisational learning arising from inspection activity was endorsed.	
QC 26/09/3.6	**Thirlwall Inquiry: Executive Summary, Recommendations and Organisational Assurance** JR presented the report to the Committee and highlighted the following: • This was recognised as one of the most significant patient safety failures in NHS history, and there were important lessons for healthcare organisations across the UK. • The findings reflected a systemic failure to recognise, connect and escalate safety concerns, with patient protection hindered by fragmented governance arrangements, professional loyalties, employment processes and concerns regarding organisational reputation. • Patient safety depended not only on policies and governance structures, but also on an organisational culture that listened to concerns, responded to signs of harm, and acted decisively when risks were identified. • Key themes highlighted included ensuring patient safety took precedence over organisational considerations, strengthening Board assurance around whether systems were operating effectively in practice, embedding candour and family involvement as core safety interventions, and continuing to enhance mortality surveillance and learning processes. • Assurance was provided that there was no evidence of similar findings within CAVUHB. However, the organisation took the report seriously and were considering the wider implications for clinical and organisational governance. • A formal gap analysis against the 17 recommendations would be undertaken through the Pathways to Safer Beginnings Oversight Board, with a detailed report on findings, assurance and any required actions to be presented at a future Committee meeting. **Undertake a formal gap analysis against the 17 recommendations arising from the Thirlwall Inquiry and bring a detailed report back to Committee in November – ACTION.** **The Committee resolved that:** a) The Inquiry's findings and the direct relevance of its safety lessons beyond England were noted; b) An Executive-led multidisciplinary gap analysis against all 17 recommendations was endorsed; c) The establishment of a single Thirlwall assurance programme, reporting to Quality Committee and Board, was approved; d) Immediate confirmation of controls for deliberate-harm concerns, child and neonatal mortality escalation, insulin security, SUDIC processes, speaking up and duty of candour were required; e) A first comprehensive assurance report within 90 days, with urgent exceptions escalated sooner, was agreed.	
	Strategic Portfolio: Providing Outstanding Quality	
QC 26/09/4.1	**Board Assurance Framework (BAF)** **The Committee resolved that:** A) The BAF was noted for assurance.	
	Shaping our Population Health and Place-Based Partnerships	

QC 26/09/5.1	**Cardiff and Vale UHB Hepatitis B&C Elimination Action Plan 2026-2028+** CB and Sion Lingard (SL), the Deputy Director of Public Health / Consultant in Public Health, introduced the report and summarised the following: • The Plan supported the WG ambition to eliminate Hepatitis B and C in Wales by 2030. • Developed in partnership with local authorities, the third sector and other stakeholders, the Plan aligned with national priorities and focused on four key areas: infection prevention, testing and case finding, treatment and engagement, and improved data intelligence. • Key actions included strengthening hepatitis B vaccination programmes and reengaging service users with misuse services and needle exchange programmes, expanding testing and opt-out testing (particularly for higher-risk groups and prison populations), improving access to treatment and peer support, and enhancing surveillance and population health intelligence to better target interventions. • Significant progress had been achieved through the previous action plan, including increased testing capacity, mobile outreach initiatives and enhanced support for substance misuse services. • Delivery of the plan would be overseen through a multi-agency partnership group involving UHB services, Public Health Wales (PHW), local authorities and third-sector organisations. The plan did not currently require additional resources, although future workforce requirements may be identified through separate business planning processes. KW recognised that Hepatitis B and C services often supported some of the most marginalised and vulnerable groups within the population. **The Committee resolved that:** A) The Cardiff and Vale UHB Hepatitis B&C Elimination Action Plan 2026-2028+ was approved.	
QC 26/09/5.2	**Cardiff and Vale UHB Pandemic Response Plan** CB and SL introduced the report and highlighted the following: • The plan had been developed to complement existing major incident and business continuity arrangements, and incorporated learning from the COVID-19 pandemic national exercises and the ongoing UK COVID inquiry. • The plan was designed to be adaptable to different types of pandemics, sustainable over prolonged periods, and focused on practical actions through a series of operational action cards. • Key themes included workforce wellbeing, health inequalities, agile responses to evolving national guidance, and a whole-system approach involving health, local authority, community and third-sector partners. • The plan aligned with regional and national pandemic frameworks and was structured around the recognised phases of a pandemic response: containment, mitigation and recovery. • Extensive engagement had informed the plan, and it would continue to evolve as further learning was identified through exercises and real-world experience.	

	PB sought assurance on how the plan had been tested and validated, noting that pandemic responses differed significantly from major incidents due to their scale and prolonged duration. PB requested clarification on the level of scrutiny and stress-testing undertaken prior to approval. SL responded that the plan had been developed in partnership with Emergency Preparedness, Resilience and Response (EPRR) colleagues and aligned with regional arrangements across South Wales. Whilst it had not yet been formally exercised locally, it reflected learning from national and regional pandemic preparedness work, including exercises undertaken by other UHBs. SL noted that the plan would be tested and refined through future exercises and would continue to evolve as further learning emerged from the COVID inquiry and national pandemic preparedness programmes. PB clarified that this was more around business continuity than a major incident. CB explained that the plan had been developed with extensive input from EPRR colleagues, clinical boards and services across the organisation, ensuring that those identified within the response structure understood their roles and responsibilities. KW sought clarification that the intention was to approve the current framework, undertake exercises to assess its effectiveness in practice, and subsequently update the plan to reflect any lessons identified. CB confirmed this was correct. PB noted concern that it had reached Committee for approval before being considered by the Senior Leadership Team (SLT) or supported by a clear testing and implementation plan. PB suggested an intermediate stage of scrutiny may have been missed. CB responded that the plan had originally been intended for consideration by SLT but was brought directly to Committee following changes to governance arrangements. Assurance was provided that extensive consultation had taken place across the organisation during its development, and no significant concerns were anticipated prior to approval. CP agreed with KW's suggestion of approving the plan on the basis that the document was a working plan to be tested and revised, with further ratification and development as exercises and national learning became available. **The Committee resolved that:** A) The revised Pandemic Response Plan for Cardiff and Vale UHB was approved on the basis that the document was a working plan to be tested and revised, with further ratification and development as exercises and national learning became available.	
QC 26/09/5.3	**Public Health Wales (PHW) Sexual Health Incident Update** CB and SL presented the update and summarised the following:	

	• This was a further update on the PHW sexual health testing and postal service incident, which had previously been reported to the Quality Committee in April 2026. • The first incident related to child and adult safeguarding issues where their online tool was not potentially identifying exploitation risks. The second related to patient safety concerns where false results were being reported. The third incident related to information governance issues where patient identifiable information had been sent to the wrong UHB, and incomplete data protection impact assessments had been completed. • Since the previous report, additional issues had been identified, including some HIV-positive service users not being appropriately routed for Hepatitis C testing and instances where test results were communicated by text message despite individuals having opted out of this method. • PHW had established an Incident Management Team, escalated oversight to Chief Executive level, and had since concluded its investigation in August 2026. An independent external review had been commissioned, with work commencing in August 2026. • Safeguarding reviews had been completed across Wales, including within CAVUHB, with appropriate referrals made where required. • PHW had also implemented a number of service improvements to strengthen testing pathways, reduce manual data handling, address information governance risks and resolve the texting issue. • Assurance was provided that the identified issues had been addressed and that ongoing learning would be incorporated into future service improvements. **The Committee resolved that**: a) The improvements made by PHW to their Test and Post service had addressed concerns and risks related to service quality and safety was noted for assurance; b) That CAVUHB Department of Sexual Health and Safeguarding Team responded appropriately and in a timely fashion to PHW's request to review safeguarding referrals incorrectly made by PHW was noted for assurance.	
	Shaping our Quality, Value & Sustainability	
QC 26/09/6.1	*No items.*	
	Shaping our Future Clinical Services	
QC 26/09/7.1	*No items.*	
	Policies for Approval	
QC 26/09/8.1	**UHB 588 - CAVUHB Medical Gases Policy** NG provided the following summary of the Policy: - This was a new UHB-wide policy, developed in response to the Welsh Health Circular 2024 requirement for UHBs to have a robust guidance and training arrangements in place for medical gases, and in line with the NHS Health Technical Memorandum standards for medical gas pipeline systems. - The policy provided a framework for the safe management, storage, transport, prescribing and administration of medical gases. - It clarified staff responsibilities, introduced training and competency requirements, and strengthened governance arrangements through the Medical Gases Safety Group. - The policy aimed to reduce risks related to patient safety, fire, supply disruption and inappropriate storage, whilst ensuring compliance with the relevant legislation and standards. **The Committee resolved that:** A) The Medical Gases 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 training requirements was noted.	
QC 26/09/8.1	**UHB 132 – CAVUHB Framework for Working with Volunteers** AH provided the following summary of the Framework: • This was an updated Volunteering Framework, which focused on recruiting volunteers more strategically to support areas of greatest need and improve representation from diverse communities. • Recent progress had been made in expanding volunteer support within the Emergency Unit. • The Framework ensured that all volunteers were recruited, inducted and supported through robust governance processes. This was recognised as essential to safeguarding patients, staff and volunteers, and ensuring volunteering activity was delivered safely, consistently and effectively across the UHB. **The Committee resolved that:** A) The updated Volunteer Framework and Operational Procedure was noted; B) The findings of the accompanying EHIA 2026-29 Volunteer Framework were noted, which identified no significant adverse equality or health impacts; C) The ongoing development of volunteering opportunities that supported patient experience, community engagement and organisational wellbeing across CAVUHB was noted.	
	Items for Noting / Information	
QC 26/09/9.1	**Infection Prevention and Control (IPC) Group Minutes 16.06.2026** **The Committee resolved that:** A) The IPC Group Minutes were noted for information.	
QC 26/09/9.2	**Safeguarding Steering Group (SSG) highlight report** **The Committee resolved that:** A) The SSG highlight report was noted for information.	
	Any Other Business	
QC 26/09/10.1	*No other business was raised.*	
	Review of the Meeting	
QC 26/09/11.1	Committee members were asked to fill out the Committee Self-Effectiveness survey.	
	Date & Time of Next Meeting:	
QC 26/09/12.1	*27th October 2026 at 9am via MS Teams*	