Confirmed Minutes of the Public Quality Committee
Held on 30th June 2026 via MS Teams

To view the meeting: Cardiff & Vale University Health Board - Public Quality Committee Meeting 30.06.2026 - YouTube

Chair:		
Ceri Phillips	CP	Committee Chair / UHB Vice Chair
Present:		
Judi Rhys	JRH	Independent Member – Third Sector
Rachna Upadhya	RU	Independent Member - General
In Attendance		
Claire Beynon	CB	Executive Director of Public Health
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Jessica Castle	JC	Director of Operations – Specialist
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
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Catherine Wood	CW	Deputy Chief Operating Officer
Frankie Ogden	FO	Head of Corporate Governance
Additional Attendees		
Omar Aldalati	OA	Consultant Cardiologist
David Hanna	DH	Clinical Board Director - Specialist
Helen Luton	HL	Interim Director of Nursing CD&T
Scott Gable	SG	Cellular Pathology Service Manager
Catherine Twamley	CT	Interim Director of Nursing for Specialist Services Clinical Board
Peter O'Callaghan	PO	Consultant Cardiologist and Heart Rhythm Specialist
Lauranne Cullen	LC	Regional Director for Llais
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Kirsty Williams	KW	UHB Chair
Paul Bostock	PB	Chief Operating Officer
Matt Phillips	MP	Director of Corporate Governance
Suzanne Rankin	SR	Chief Executive Officer
Stephen Riley	SR	Independent Member – University

QC2 26/06/30/1.1	**Welcomes, Introductions & Apologies** Ceri Phillips (CP), the Committee Chair, welcomed everyone to the meeting in English & Welsh and apologies for absence were noted.	
QC2 26/06/30/1.2	**Declarations of Interest** No declarations of interest were raised.	

QC2 26/06/30/1.3	**Minutes of the Committee meeting held on 02.06.2026** The minutes of the Committee meeting held on 02.06.2026 were received. **The Committee resolved that:** a) The minutes of the meeting held on 02.06.2026 were approved as a true and accurate record of the meeting.	
QC2 26/06/30/1.4	**Action Log following the Meeting held on 02.06.2026** The Action Log following the Meeting held on 02.06.2026 was received and discussed. **The Committee resolved that:** a) The Action Log from the meeting held on 02.06.2026 was noted.	
QC2 26/06/30/1.5	**Committee Chair's Actions** No Chair's Actions were raised.	
	Quality Performance Reporting	
QC2 26/06/30/2.1	**Quality Performance Report** Alexandra Scott (AS), Assistant Director of Quality and Patient Safety provided the following update on the development of the Integrated Performance Report (IPR): • Work had continued since the previous Committee meeting, with indicators now being populated and Statistical Process Control (SPC) charts being developed. • The report had been presented to a recent Board Development session, where feedback had been received regarding the accompanying narrative content. • Feedback had been incorporated into the development process and that that all leads involved in developing the IPR were undertaking narrative training developed by Making Data Count. • The first iteration of the report would be available for consideration at the next Committee meeting in July 2026. At that point, work would also commence on Phase 2 of the development programme, which would focus on the secondary quality indicators discussed by the Committee at its previous meeting, providing greater depth to quality oversight arrangements. CP noted that he had recently attended a meeting at which the Chief Nursing Officer had provided insight into the national thinking around quality performance measures. He advised that he would discuss this information further with AS outside the meeting. Judi Rhys (JRH), Independent Member Third Sector, welcomed the progress made and acknowledged the significant work undertaken within challenging timescales. It was noted that an iterative approach to development was appropriate. AS agreed that an iterative approach had been beneficial, as it enabled performance data to be shared with the Committee without delaying implementation while further refinements and improvements were being made. **The Committee resolved that:** A) The Quality Performance Report was noted for assurance.	
	Items for Oversight / Scrutiny	
QC2 26/06/30/3.1	**Clinical Board Highlight Reports:**	

	Jason Roberts (JR), Executive Nurse Director, introduced the Clinical Board Highlight Reports, noting that this was the first occasion on which the new reporting format had been presented to the Committee. JR advised that, whilst each Clinical Board had submitted an individual report, there were several common themes emerging across the organisation, and highlighted the below: • Workforce challenges were reported across a number of Clinical Boards, with vacancies and sickness impacting service delivery, particularly within PCIC, Mental Health, and Community Nursing services. Concerns were noted regarding delays in community care and the impact on patient flow, including prolonged hospital stays for some children awaiting community care packages. • An improving position was reported in relation to incident management, with reductions in overdue high-level Datix incidents and Nationally Reportable Incidents (NRIs), supported through monthly executive oversight and improvement plans. • Patient flow, access and waiting times remained significant concerns across Clinical Boards. Particular concern was noted regarding sustained levels of out-of-area placements within Mental Health services and continued focus on reducing length of stay and associated deconditioning risks. • IP&C remained a key area of focus, with increases in C.difficile and E. coli infections highlighted. Positive progress was reported in some areas, including systematic improvement work within Medicine, although further improvements were required in other services, particularly in relation to MRSA and line-associated infections. David Fluck (DF), Executive Medical Director, informed the Committee that the UHB was focused on articulating its three principal risks to Welsh Government (WG), which included length of stay, patient safety incident management, and lost to follow-up. DF suggested future highlight reports should place greater emphasis on these key quality risks and the areas requiring the most significant improvement. CP welcomed the new reporting format and considered it a significant improvement. JR emphasised that the strengthened reporting arrangements and risk management processes provided a clearer line of sight from Clinical Boards through to Board-level assurance. CP observed that the reports provided an opportunity to inform other UHB Committees of factors affecting quality, including workforce challenges and estate-related concerns. CP highlighted the importance of strengthening this proactive approach to help the UHB recognise and address concerns early, reducing the risk of significant quality failures. JRH expressed concern regarding the increase in hospital-acquired infections and the reported link to the condition of the UHB's estate. JRH asked for evidence supporting this relationship and the actions available to address this. JR acknowledged the significant challenges posed by the ageing estate and its potential impact on infection prevention and control. Whilst it was difficult to directly attribute infection rates to estate conditions due to the many contributing factors involved, the estate remained an important component of the overall IP&C strategy. Ongoing work included peer reviews of clinical environments, investment in maintenance and cleaning standards, and continued collaboration with Estates to ensure clinical areas remain safe and appropriate for patient care. JRH raised concern regarding the risk associated with the liquidation of Richmond Services and the transfer of domiciliary care provision to a new provider and asked for more information.	

	JR advised that the risks associated with Richmond Services entering liquidation had been carefully assessed and managed. Two complex care packages were affected: one concluded naturally, while continuity of care for the other was maintained through the same staff remaining in place under a newly rebranded provider. JR noted that the original concerns related to governance processes rather than direct patient care, and that appropriate risk mitigation measures were implemented while longer-term arrangements were developed. Rachna Upadhya (RU), the Independent Member – General, asked how the UHB assured itself that learning arising from NRIs had been embedded into practice. RU also asked for assurance that improvements in Datix and patient safety incident management reflected genuine quality improvement rather than merely the reduction of administrative backlogs. AS explained that learning from NRIs was embedded through thematic analysis, which informed improvement programmes under the Quality Excellence Programme. Key areas of focus included deteriorating patients, lost to follow-up, IP&C, falls and pressure damage. These were supported by targeted improvement programmes, clinical audits, and ongoing oversight to ensure learning was implemented across the organisation. In relation to Datix incidents, AS acknowledged that assurance was required to demonstrate that improvements reflected meaningful changes in practice and patient safety outcomes, rather than solely reducing backlogs. This would remain a continued area of focus. CP asked how alerts and risks raised through the Clinical Board reports would be tracked over time, including how mitigating actions, progress updates and evidence of risk reduction would be reported to provide assurance that concerns were being effectively addressed. JR noted the reporting process remained under development and that the Committee's focus should be on the assurance provided that risks were being managed appropriately, rather than the detailed operational issues themselves. JR acknowledged that future iterations of the reporting template should strengthen the tracking of issues over time. JR advised that recent reports into maternity services in Nottingham and learning disability services in Muckamore would be reviewed through formal gap analyses by the relevant Clinical Boards. RU expressed concern regarding the increasing complexity of complaints and asked what was driving this. Angela Hughes (AH), the Assistant Director of Patient Experience, advised that complaint volumes had increased significantly, influenced by changes in the political landscape and the introduction of the new complaints process. Increasing complexity was largely driven by communication issues, discharge arrangements and the growing number of patients with health and social care needs spanning multiple services. It was noted that improving communication with patients could help reduce concerns, whilst wider system pressures are also contributing to the trend. JR added that the increased use of technology and AI might be contributing to higher number of concerns raised. RU emphasised that whilst technology might make it easier to submit complaints, the underlying concerns remained valid and should not be discounted.	

	CP sought assurance that learning and good practice identified within Clinical Board reports was being shared and embedded across the organisation, ensuring opportunities for improvement are translated into practice and adopted more widely where appropriate. AH emphasised the importance of learning from all complaints. Robust processes were in place to identify and implement learning from incidents, but further focus was needed on embedding lessons, demonstrating improvement, sharing learning with complainants, and identifying emerging concerns before harm occurs. CP highlighted the opportunity for the Committee to promote organisational learning by identifying and sharing good practice across Clinical Boards. **The Committee resolved that:** A) The Clinical Board Highlight Reports were reviewed for assurance.	
QC2 26/06/30/3.2	**Annual Reports** <u>3.2.1 - Complaints, Redress and Inquests</u> AH presented the Annual Report on Complaints, Redress and Inquests, and highlighted the following: • This was the final report prepared under the former Putting Things Right arrangements, following the introduction of the Listening to People framework from April 2026. • Complaints, redress cases and inquests remained important sources of organisational intelligence, providing insight into patient experience, safety, service reliability and organisational risk. • The UHB received 3,245 complaints during the reporting year together with 1,173 enquiries, with recurring themes relating to access, waiting times, communication and service capacity. Complaint volumes had continued to increase, with over 1,000 complaints received during the first quarter of 2026/27, representing a 57% increase compared to the same period in the previous year. • The introduction of an enquiries service and an early resolution approach had resulted in approximately 55% of concerns now being managed through early resolution processes. This represented a significant increase compared to previous years and reflected a more proportionate and person-centred approach to complaint handling. • Performance against statutory standards had remained strong and that robust governance arrangements were in place, supported by regular oversight meetings with Clinical Boards. • Common learning themes continued to include communication, clinical assessment and decision-making, documentation, discharge planning, care coordination, compassionate care and system reliability. • 212 inquests had been recorded during the reporting period, most of which had been categorised as low risk and managed through established arrangements. • The organisation had received four Prevention of Future Deaths (PFDs) reports during the year, relating to estates issues, medication management, patient follow-up arrangements and risk information sharing. Learning arising from inquests was focused on improving evidence gathering, family communication, clinical decision-making and organisational learning. • The UHB had developed a new Complaints Management System (CMS) to complement the Datix system and that the new system would provide greater visibility of demand, complaint themes, timeliness and pressure points and would enable more detailed thematic analysis to support organisational learning and improvement.	

	• Under the Listening to People framework there would be an increased emphasis on addressing concerns as close as possible to the point of care, promoting early engagement with patients and families, reducing duplication and ensuring complaints were used as a mechanism for learning and improvement rather than simply a process for case closure. JRH commented that an increase in complaints should not necessarily be viewed negatively, as it could indicate that people felt able to raise concerns and access appropriate channels. Drawing on a personal experience, JRH welcomed the move towards more personalised responses under the Listening to People arrangements. AH welcomed improvements introduced through the Listening to People process, noting that complaint responses were now more person-centred and proportionate. She emphasised that complaints should be viewed as valuable learning opportunities and highlighted the importance of engaging with communities who may not raise concerns, sharing learning from feedback, and capturing positive as well as negative patient experiences to support service improvement. RU asked how the new CMS would enhance governance arrangements and support the identification of themes and organisational intelligence. AH explained that whilst Datix would remain the Health Board's central repository for complaints data, the CMS would allow for more detailed categorisation and analysis of concerns. She advised that this would enable the UHB to identify more granular themes, strengthen learning and support service improvement activity. **The Committee resolved that:** a) The content of the Putting Things Right Annual Report 2025/26 was noted; b) Assurance was taken that governance, oversight and operational arrangements were in place to manage concerns, complaints, redress and inquests in line with statutory requirements and support transition to the Listening to People Framework; c) The visibility of organisational themes, trends, risks and emerging issues, and the arrangements in place to support escalation, learning and service improvement across Clinical Boards was noted; d) The continued development of the CMS and associated governance processes to strengthen oversight, reporting, compliance and organisational learning was supported; e) The clear forward plan for implementation of Listening to People was noted, supporting a more consistent and person-centred approach to engagement, resolution and learning.	
QC2 26/06/30/3.3	**Quality & Operational Risks (scoring 20-25)** Frankie Ogden (FO), the Head of Corporate Governance, presented the report on Quality and Operational Risks, and highlighted the following: • The purpose of the paper was to demonstrate the approach being implemented to improve the visibility and oversight of high-scoring risks across the organisation. • 93 risks had been identified as quality and operational risks, forming a significant proportion of the approximately 190 risks scoring 20 or above currently recorded on the organisation's risk register on AMAT and noted that around 1,500 risks were recorded in total across the UHB. • The proposed approach would align risks to relevant Committees, ensuring each receives oversight of risks within its remit, including quality, operational, workforce, reputational, digital and cyber risks. • The UHB was now in a much stronger position following the implementation of a single risk management system, enabling risks to be viewed, scrutinised and monitored consistently across the organisation.	

	• This provided greater opportunity to identify risks driving quality concerns and would help inform organisational decision making. Further work remained ongoing to review and moderate risks, particularly within Clinical Boards, to ensure consistency in risk scoring and descriptions. JR commented that the focus now was on embedding risk management as a live, ongoing process across the organisation, ensuring risks were consistently identified, reviewed and escalated. RU asked how the Committee would be able to track movement in risks over time and identify where risks had improved, deteriorated or remained unchanged between meetings. FO explained that the information would become a standing feature of Committee reporting and would be discussed regularly throughout the year. She advised that the reports generated from AMAT provided significantly more detail than had previously been available and that there was ongoing work to integrate risk management with the Quality Management System (QMS) and wider performance management arrangements. **The Committee resolved that:** a) The approach being implemented to align high-scoring (20+) organisational risks to Committee structures, improving visibility and governance oversight across all remits was noted; b) The development of a consistent, organisation-wide approach to risk reporting and discussion within Committees, including integration into forward plans and routine agenda items, was supported.	
	Strategic Portfolio: <u>Providing Outstanding Quality</u>	
QC2 26/06/30/4.1	**Board Assurance Framework (BAF)** FO introduced the Board Assurance Framework (BAF) which was presented for initial awareness, with future items focusing on specific areas within the BAF for more detailed scrutiny. These would be incorporated into the Forward Plan for ongoing oversight throughout the year. CP asked whether trend reporting could be standardised, including the potential use of SPC charts, to improve the clarity and consistency of data presentation and interpretation. FO responded that these conversations were ongoing to try and present the information in a clearer and more consistent format. CP raised concern that several actions showed overdue completion dates without providing a current status update. FO explained that tracked versions of the BAF usually included status updates and confirmed that future reports would provide greater visibility regarding progress and completion status. **The Committee resolved that:** A) The BAF was noted for assurance.	
QC2 26/06/30/5	**Shaping our Population Health and Place-Based Partnerships** *No items.*	
QC2 26/06/30/6.1	**Shaping our Quality, Value & Sustainability** <u>6.1.1 - Update on Fuller Report recommendations</u>	

	Helen Luton (HL), the Interim Director of Nursing CD&T, presented an update on progress against the recommendations arising from the Fuller Inquiry, and highlighted the following: • The paper focused on the 21 recommendations relevant to NHS mortuary services and outlined the work undertaken locally to assess compliance and implement the necessary improvements. • A detailed gap analysis had been completed against the recommendations and that seven of the 21 recommendations had been fully implemented, with the remaining actions largely on track. • Some outstanding actions were dependent upon capital investment and support from Estates and Facilities colleagues, whilst others required national changes to All-Wales procedures. • The UHB had recently undergone a Human Tissue Authority (HTA) inspection and had achieved compliance with all required standards. • Key updates were provided in relation to the mortuary estate and security and access arrangements. CCTV systems, access controls and monitoring arrangements had been strengthened following previous refurbishment works of the UHB mortuary, with routine audits now undertaken to ensure access permissions remained appropriate. Further improvements were required to fully meet recommendations relating to access controls and CCTV coverage but were working closely with Estates colleagues. • The UHB's temporary body store at University Hospital Llandough (UHL) had been decommissioned following publication of the recommendations, as it did not fully meet the revised requirements. Additional mortuary capacity had been created elsewhere within the UHB, and further work was underway to ensure sufficient compliant capacity was available to support winter pressures. • In relation to safeguarding, full compliance with recommendation 19 would require amendments to All-Wales safeguarding procedures and training materials. However, discussions were already underway with safeguarding colleagues to identify interim arrangements that could strengthen compliance locally. • Requirements around governance and reporting were highlighted, as recommendations reflated to board reporting arrangements for mortuary services as a regulated area. Locally they had a HTA Compliance Group which reported into CD&T Quality & Safety meetings. CP sought assurance regarding the interim arrangements in place whilst the temporary body store in UHL was out of use. HL responded that the temporary UHL body store was taken out of use following recommendations received. Additional mortuary capacity was created within the UHB and proved sufficient over the winter, but further contingency capacity was being explored to manage potential seasonal pressures whilst ensuring compliance with security and CCTV requirements. **Provide a formal report to the Committee on mortuary activities – ACTION.** **The Committee resolved that:** a) The evidence of substantial progress against the 21 Fuller recommendations was noted; b) The residual risks relating to body storage capacity, capital-dependent security controls and safeguarding training was acknowledged; c) Arrangements for future reporting into appropriate Board / Committee was confirmed; d) A further update once capital estimates, winter capacity plans were confirmed was supported.	

QC2 26/06/30/7.1	**Shaping our Future Clinical Services** 7.1.1 - Cardiac Implant Update David Hanna (DH), the Clinical Board Director – Specialist Services, presented an update on the Cardiac Devices Service, and highlighted the below: • The service was a high-volume, safety-critical service, supporting approximately 10,000 patients under routine follow-up and around 800 new implants each year • Concerns had first been raised during 2024 through staff feedback, Datix reporting and a wider review of Adult Cardiology services. • Initial concerns related to eight patients receiving devices beyond their expiry date and a separate cohort of patients who had reached battery depletion before device replacement. Whilst investigations found minimal or no harm in the former group, both issues highlighted weaknesses in administrative processes, scheduling arrangements and service capacity. A multidisciplinary working group had subsequently been established to oversee investigations, validation work and service improvements. • As further reviews were undertaken, additional risks were identified, including capacity constraints, reliance on manual Excel-based tracking systems, inappropriate removal of patients from follow-up lists following non-attendance, weaknesses in remote monitoring arrangements, disconnected home monitoring systems affecting approximately 600 patients, and incorrect alert settings affecting around 800 patients. • A Coroner's Regulation 28 case and an NRI investigation relating to concerns about whether missed opportunities for clinical intervention had contributed to patient harm were highlighted. • Actions underway over the past 12 months included validating patients removed from follow-up after a DNA, with high-risk cohorts completed and lower-risk cohorts ongoing. Work continued to validate missed alerts, while all patients affected by unconfigured alerts have been notified, with only 22 of 800 still awaiting device reconfiguration. Clinical governance had been strengthened through improved Datix reporting, patient safety learning processes, and a response to the coroner's Regulation 28 request. Service improvements included new SOPs, a more clinically led outpatient booking process to reduce loss to follow-up, enhanced stock control through Scan for Safety, and implementation of the Fysicon patient management system to improve oversight and data quality. • Investment and service development work was underway to improve leadership, governance and workforce capacity. This included recruitment to a senior Cardiac Physiology Professional Lead role, development of a dedicated remote monitoring function, ring-fenced education and training time for physiologists, enhanced quality management arrangements and development of KPI dashboards and governance reporting processes. Claire Beynon (CB), the Executive Director of Public Health, sought assurance regarding whether the identified issues could recur in the future. DH responded that whilst risk could never be completely eliminated within such a complex service, substantial progress had been made, and the service was considerably safer than it had been previously. Peter O'Callaghan (POC), the Consultant Cardiologist and Heart Rhythm Specialist, noted that although the service had improved significantly, further work remained necessary to ensure it reached the required standard. He highlighted the need for continued attention to administrative support, workforce resilience, leadership and capacity. Jessica Castle (JC), the Director of Operations – Specialist Services, commented that one of the most significant improvements had been the positive change in organisational	

	culture within the service. Staff were now more willing to raise concerns openly, report risks and engage in governance processes, which contributed significantly to service improvement. JC also highlighted the importance of protected time for quality, safety, education and professional development. RU asked how physiological findings and clinical symptoms would be integrated to ensure a holistic, patient-centred approach, avoiding siloed care and ensuring all aspects of treatment and monitoring worked cohesively. DH responded the service was shifting towards a more holistic model of care, with staff encouraged to identify and respond to wider patient needs. New SOPs, clinical assessments at device review appointments, and strengthened governance, monitoring and quality management arrangements were intended to support a more integrated, patient-centred and resilient service. POC noted physiologists were highly trained and supported by named cardiologists for each patient. Following lessons from the coroner's case, communication was moving from email to an e-advice system within the Welsh Clinical Portal (WCP), improving integration, record-keeping and access to specialist cardiology support when required. Emma Cooke (EC), the Executive Director of AHPs, Health Scientists and Community Services Development, noted that the new service lead would focus on workforce development, increasing advanced training and HCPC registration to strengthen workforce capability and resilience. RU asked how the new e-advice system would support documentation and learning within clinical records, and whether multidisciplinary case reviews or grand rounds were being used to share learning and promote collaborative practice across cardiology services. POC responded that learning from cases was routinely discussed through Quality & Safety forums. Regarding e-advice, a pilot was being developed to record communications between psychologists and cardiologists within the WCP, improving documentation and information sharing. DH added that there was always a cardiology registrar and consultant on call, ensuring physiologists could access timely specialist advice and support whenever clinical concerns arose. JRH asked about the timescales for the remaining improvements, whether additional support or investment would be required and how the Committee would continue to monitor progress. DH responded that as risks were investigated, further issues emerged, requiring prioritisation of the highest-risk patients and actions. Immediate patient safety concerns had largely been addressed, with current efforts focused on embedding sustainable improvements. Further investment in leadership, skills and capacity may be required to achieve the desired standard of care, supported by robust service planning and governance arrangements. JR asked whether the cardiology service was able to reliably identify risks moving forward. DH responded that significant improvements had been made to the cardiac devices service through strengthened risk management, use of AMAT and development of a multidisciplinary QMS. While the service was in a much stronger position than previously, further work was required to address remaining risks and continue service improvement.	

	JR reflected that many of the themes identified within the review including governance, workforce sustainability, capacity, follow-up arrangements and risk management, were relevant across a number of clinical services. He suggested that the learning arising from this work should be considered more broadly across the organisation. DH added that learning from this work highlighted that relying solely on nationally reported metrics could leave important risks unidentified. In response, the service was developing a QMS with locally defined quality measures to strengthen oversight and risk identification at service level. **Return to the Committee in six months with an update on progress and assurance regarding the cardiac devices service improvements – ACTION.** **The Committee resolved that:** a) The progress made in reviewing the service and addressing patient safety risks was noted; b) Ongoing system risks across workforce, governance and digitisation and current mitigations in place were acknowledged; c) Continued transformation programme delivery was supported; d) Progress with reviewing workforce models of delivery and demand/capacity review, digital transformation and administrative capacity, systems and processes were noted.	
QC2 26/06/30/7.2	<u>7.1.2 - Ophthalmology review update</u> Catherine Wood (CW), the Deputy Chief Operating Officer, presented an update on the Ophthalmology Improvement Programme, and highlighted the below: • Ophthalmology services, particularly the Age-Related Macular Degeneration (AMD) pathway, had been subject to scrutiny over the previous two years due to concerns regarding service sustainability, waiting times and patient safety. • Intensive improvement work had been undertaken over the last 18 months, supported by strong clinical leadership and oversight from the Chief Operating Officer and Executive Team. • Substantial progress had been made within the AMD pathway. The previous backlog of approximately 2,600 patients had been eliminated, the pathway had been stabilised, and a sustainable service model had been established. Harm reviews had been completed for patients within the lost-to-follow-up cohort, and a dedicated fail-safe officer had been appointed to strengthen compliance with Royal College guidance. • Changes to the treatment pathway and the introduction of alternative medication regimens had enabled patients to be treated more efficiently whilst increasing capacity and improving the sustainability of the service. • In relation to glaucoma services, a bespoke Glaucoma Diagnostic Unit had been established at UHL. Alongside this, they implemented the Welsh General Ophthalmic Services pathways for monitoring patients in the community and has meant 56% of their patients are now receiving care outside of a hospital setting. • CAVUHB led Wales in delivering high-volume cataract surgery at UHL, meeting GIRFT and ministerial requirements. Routine lists now delivered 7-8 cases per session, supported by a clear expansion plan that had significantly reduced long waits for cataract treatment across the UHB and region. • A range of digital improvements had been made, including the full implementation of the OpenEyes electronic patient record system and the introduction of an electronic referral process in June 2026. These developments had strengthened governance arrangements, improved patient tracking and reduced the risk of patients being lost within pathways. • Workforce and succession planning arrangements had been strengthened through new appointments and recruitment activity across several specialist areas. Focus	

	had been given to roles supporting patient safety, governance and pathway management. • Outpatient waiting lists had reduced significantly, with the number of patients waiting over 104 weeks falling by approximately 90%. • The service had moved from a position of significant fragility to one which was considerably more sustainable and better equipped to manage future demand. David Fluck (DF), the Executive Medical Director, noted that whilst further work was needed to embed the use of the electronic systems across all teams, significant process had been made. **Provide a further update to the Committee in six months on further progress in Ophthalmology service transformation and electronic system engagement – ACTION.** CP suggested that the cataract service and wider surgical hub development be promoted more widely, including consideration of a ministerial visit. **The Committee resolved that:** A) The update was noted.	
	Policies for Approval	
QC2 26/06/30/8	*No policies for approval.*	
	Items for Noting / Information	
QC2 26/06/30/7.2	**Safeguarding Steering Group (SSG) Highlight Report** The Safeguarding Steering Group (SSG) Highlight Report was received. **Arrange for a presentation / report on Mental Capacity Act (MCA) and consent training to be brought to the Quality Committee – ACTION.** **The Committee resolved that:** a) The Safeguarding Steering Group (SSG) Highlight Report was noted.	
QC2 26/06/30/9.1	**Infection Prevention & Control (IPC) Group Highlight Report** The Infection Prevention & Control (IPC) Group Highlight Report was received. **The Committee resolved that:** A) The Infection Prevention & Control (IPC) Group Highlight Report was noted.	
	Items Needing Escalation to Board	
QC2 26/06/30/9.2	CB asked if the Cardiac devices item needed to be received by the Board. CP advised that it would feature in the Quality Committee Chairs Report at the next Board meeting in July 2026.	
	Any Other Business	
QC2 26/06/30/12	*No other business was raised.*	
	Review of the Meeting	
QC2 26/06/30/13	*Committee members were asked to fill out the Committee Self-Effectiveness survey.*	
	Date & Time of Next Meeting:	

QC2 **26/06/30/14**	*28th July 2026 at 9am via MS Teams*	