CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

MINUTES OF THE PATIENT QUALITY, SAFETY AND OUTCOMES COMMITTEE MEETING

DATE OF MEETING	Wednesday 6th May 2026, 12:30PM-13:30PM
VENUE	Conference Centre, St Cadoc's HQ/ Microsoft Teams

PRESENT	Penny Jones, Vice Chair William Smart, ABUHB Vice Chair Philip Robson, Special Advisor Paul Deneen, Independent Member Vivek Goel, Independent Member
IN ATTENDANCE	Jennifer Winslade, Director of Nursing Seema Srivastava, Medical Director Peter Carr, Director of Allied Health Professions & Health Science Kye Smith, Deputy Head of Quality and Patient Safety (item 2.1) Leeanne Lewis, Assistant Director for Quality and Patient Safety (Item 2.2) Bryony Codd, Head of Corporate Governance Fern Woodhead, Committee Secretariat
OBSVERING	None
APOLOGIES	Rani Dash, Director of Corporate Governance Helen Sweetland, Chair Naomi Murtagh, Board Business Manager

PQSOC 0605/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
PQSOC 0605/02	**Apologies for Absence** The Chair noted the apologies for absence.
PQSOC 0605/03	**Declarations of Interest** There were no declarations of interest raised relating to items on the agenda.
PQSOC 0605/04	**Minutes of the previous meeting** The minutes of the Patient Quality, Safety and Outcomes Committee held on 17th February 2026 were agreed as a true and accurate record of the meeting.

	The Committee **APPROVED** the draft minutes.
PQSOC 0605/05	**Quality Outcomes Report – Qlik App** Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the report, setting out the development of the Qlik analytics platform as part of the Health Board's wider Quality Strategy and Quality Management System. JW advised that the work represented a key step in moving from traditional data reporting towards more meaningful intelligence, enabling improved focus on areas requiring action, variation in performance, and opportunities for improvement. It was emphasised that whilst data and intelligence were critical, triangulation with staff and patient experience remained essential to provide a comprehensive view of quality and safety. The Committee was advised that the Qlik platform would support the evaluation of the current Quality Management System and inform the development of a refreshed Quality Strategy, due to be presented to the Board in January 2027. Kye Smith (KS), Deputy Head of Quality and Patient Safety, provided the Committee with a detailed overview of the Qlik system and its implementation. KS advised that the platform had been commissioned in November 2024 in collaboration with the Informatics Service and brought together data from multiple systems into a single environment, including incident reporting, complaints, and patient feedback. KS highlighted to the Committee that the system enabled advanced analytics, including trend analysis, forecasting, and the use of Statistical Process Control (SPC) charts, supporting the differentiation between normal variation and statistically significant change. The Committee was advised that the first phase, including integration of Datix data, had been completed, and that further datasets, such as Welsh Nursing Care Record and CareFlow, would be incorporated over time. The Committee received a live demonstration of the system, which illustrated how data could be interrogated across organisational, divisional, and ward levels. KS provided examples of how the tool could be used to explore incident trends, including falls and medication-

	related incidents, and to support targeted quality improvement interventions. The Committee noted the significant benefits of the platform in improving consistency and reducing the reliance on manual data compilation. It was recognised that the system would enable both corporate oversight and local ownership of data, with ward teams able to directly access and monitor their performance. The Committee discussed the importance of training and capability development to support effective use of the platform, particularly in relation to interpreting SPC charts. KS outlined that training programmes were being developed and delivered across staff groups, with a phased rollout to divisional teams, senior nurses, and ward managers. The Committee also considered how the platform would be used at Board level, including whether it would replace or supplement existing static reports. It was confirmed that a corporate dashboard was under development for Committee and Board use, though further work was required to validate data and refine calculations before full implementation. The Committee was advised that the system remained in development, with user acceptance testing ongoing. It was agreed that a timeline for full implementation and rollout would be presented to a future meeting. **Action: Director of Nursing.** The Committee welcomed the progress made to date, recognising the platform as a significant enabler for improving quality intelligence, strengthening triangulation of data, and supporting a culture of continuous improvement across the organisation. The Committee **NOTED** the current progress in implementing the Qlik analytics platform.
PQSOC 0605/06	**Learning from Death Report** Seema Srivastava (SS), Medical Director, provided the Committee with an overview of the report, advising that it was the biannual Learning from Deaths report which sought to provide assurance in relation to mortality outcomes, learning, and improvement across the Health Board. SS outlined that the report triangulated intelligence from multiple sources, including Medical Examiner

	scrutiny, Mortality and Morbidity reviews, complaints, inquests, and benchmarking data, to establish whether any deaths reflected avoidable harm, emerging clinical risks, or wider system issues. Leeanne Lewis (LL), Assistant Director for Quality and Patient Safety, provided a summary of the key findings. LL advised that this was the fourth Learning from Deaths report, with a particular focus on strengthening organisational learning through structured case note reviews and targeted deep dive exercises. The Committee was advised that a programme of structured case note reviews had been undertaken in specialties with higher than expected mortality, alongside a surveillance exercise in collaboration with Public Health. A total of 77 case notes had been reviewed as part of the Public Health exercise, with no patterns of unsafe clinical decision-making identified. The majority of deaths were associated with frailty, advanced illness, or palliative care needs, and the quality of care had been assessed as consistently good, with only minor issues identified that did not impact clinical outcomes. Further structured reviews, totalling 270 cases across key specialties, had also been undertaken. LL advised that these had identified a high standard of care overall, with no evidence of unsafe or negligent practice. A small number of cases had identified opportunities for learning, which had been fed back to directorates to support continuous improvement. LL highlighted to the Committee that mortality indicators provided strong assurance, with the Risk Adjusted Mortality Index (RAMI) reported at 88.4 for the period, indicating performance better than expected and ranking the Health Board among the strongest performers in Wales. It was noted that a transition to RAMI 2023 would result in a slight increase in the reported figure but remained in line with national peers. The Committee noted that crude mortality remained stable with a downward trend and that key condition-specific indicators were performing in line with or better than peers. Importantly, there were no mortality indicators requiring escalation and no evidence of hidden clinical risk or avoidable harm. LL drew attention to key learning themes identified through the review process, including improvements

	required in data quality and clinical coding, communication and care planning particularly in relation to end-of-life care, and the management of deteriorating patients. These themes would be integrated into existing governance structures and work programmes to support ongoing improvement. The Committee discussed the report in detail and welcomed the triangulated approach to mortality intelligence, recognising the added value this provided in complementing time-based performance metrics and strengthening assurance. The importance of accurate clinical coding and data quality was highlighted, particularly in relation to the correct attribution of cases to clinicians, with LL confirming that improvement work was underway and regularly monitored. Th Committee discussed the level of reporting, with clarification provided that mortality was monitored at organisational and divisional levels, and that site-level analysis was available where required but had not added additional assurance in routine reporting. In relation to patient experience, The Committee explored the impact of Medical Examiner processes on bereavement timelines. LL advised that the Health Board was operating within required performance standards and continued to work collaboratively to improve timeliness and the overall experience for bereaved families. The Committee further noted an identified issue regarding delays in completion of discharge death notifications. LL advised that a corporate audit had been proposed to further explore this issue and inform improvement actions. Overall, The Committee expressed strong support for the report, recognising it as providing a high level of assurance and demonstrating a maturing approach to mortality governance and organisational learning. The Committee **NOTED** the Learning from Deaths report.
PQSOC 0605/07	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** There were no matters from the meeting that required escalation or formal notification to the Board and other relevant committees.
PQSOC 0605/08	**Any Other Urgent Business**

	There was no urgent business.
PQSOC 0605/09	**Date of the Next Meeting:** 2nd June 2026