BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD

MINUTES OF THE PATIENT QUALITY SAFETY AND OUTCOMES COMMITTEE MEETING

DATE OF MEETING	Tuesday 2nd June 2026, 13:30PM – 16:00PM
VENUE	Microsoft Teams

PRESENT	Helen Sweetland, Chair
	Penny Jones, Vice Chair
	William Smart, ABUHB Vice Chair
	Paul Deneen, Independent Member
	Vivek Goel, Independent Member
IN ATTENDANCE	Jennifer Winslade, Director of Nursing
	Peter Carr, Director of Allied Health Professionals and Health Science
	Seema Srivastava, Medical Director
	Naomi Murtagh, Board Business Manager
	Leeanne Lewis, Assistant Director for Quality and Patient Safety (Item 3.3)
	Megan Detheridge, Committee Secretariat
	Fern Woodhead, Governance Support Officer
OBSERVER	
APOLOGIES	Rani Dash, Director of Corporate Governance

PQSOC/0206/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
PQSOC/0206/02	**Apologies for Absence** The Chair noted the apologies for absence.
PQSOC/0206/03	**Declarations of Interest**

	There were no declarations of interest raised relating to items on the agenda.
PQSOC/0206/04	**Minutes of the previous meeting** The minutes of the Patient Quality, Safety and Outcomes Committee held on 6th May 2026 were agreed as a true and accurate record of the meeting. The Committee **APPROVED** the draft minutes.
PQSOC/0206/05	**Committee Action Log** The Committee discussed action **PQSOC 1702/06** relating to physical assault data. Helen Sweetland (HS), Chair, queried whether the action was complete, noting that the data within the QOF report did not provide sufficient information. The Committee requested that the action was marked as in progress until further assurance was provided. **Action: Committee Secretariat** The Committee raised concern regarding the potential under-reporting of physical assaults, highlighting that this may affect the reliability of the data. The Committee emphasised the importance of ensuring that all incidents were reported and that appropriate action, including prosecutions where possible, was being pursued to strengthen accountability and reporting culture. The Committee noted feedback suggesting that reporting could be hindered by the complexity and time required to complete the current reporting process. The Committee highlighted that this may act as a barrier to reporting and discussed whether a more streamlined or informal approach could support staff and improve reporting levels.

	The Committee was advised that work was ongoing to improve awareness and encourage staff to report incidents through the Datix system. It was noted that specialist case managers for violence prevention and reduction were in place to support departments, and that there was continued focus on encouraging the reporting of all types of aggression, regardless of severity. The Committee requested that Peter Carr (PC), Director of Allied Health Professionals and Health Science, raise the matter at the next Health and Safety Committee meeting, to provide more detailed data on incidents, violence prevention, and seek assurance on whether current reporting levels were adequate and then report back to PQSO Committee. **Action: Director of Allied Health Professionals**. The Committee **APPROVED** the action log with the discussed changes.
PQSOC/0206/06	**Consent Agenda** The Committee was content with the papers listed within the consent agenda and did not want further discussion of them.
PQSOC/0206/07	**Quality Outcomes Reporting** Jennifer Winslade (JW), Director of Nursing, provided a detailed overview of the report and outlined that the Quality Outcomes Report had evolved into a more comprehensive and dynamic reporting framework. The Committee noted that the framework now aligned explicitly with the revised Pillars of Quality, supported divisional and corporate clinical governance pathways, and strengthened

	the ability to provide transparent assurance to the Committee, Quality Management Group and the Board. The Committee noted that Quarter 4 had witnessed sustained system pressure following winter demand, which had continued to impact patient flow, workforce capacity and operational resilience. Emerging risks were highlighted, including increasing complexity in safeguarding demand, ongoing pressures on timely care pathways, and challenges relating to workforce training compliance and system capacity. The Committee noted that a new Quality Strategy was being developed and would be presented to the Board in January 2027. The Committee was advised of an increase in complaints during Q4. Performance against the 30-day response target remained below the 70% benchmark at approximately 60%, although this remained slightly above the national average. The Committee noted that there was a continued focus on early resolution with patients and families. JW advised that early Q1 reporting via Listening to People indicated a modest improvement of around 0.5%, although work remained at an early stage. It was confirmed that a formal review of 'Listening to People', would be undertaken after three months to collate and assess data. **Action: Director of Nursing** The Committee emphasised the importance of learning from complaints and raised concern about the potential normalisation of waiting and patient discomfort within hospital settings. JW advised that this would form part of planned care work and highlighted initiatives such as

	pastoral support within the Emergency Department. It was noted that reporting on waiting times remained complex due to variation across pathways. JW agreed to bring further information on waiting times in EC and pain-related complaints to a future meeting. **Action: Director of Nursing** The Committee sought assurance on how quality and performance oversight was managed across multiple sites. JW advised that this was monitored through divisional assurance meetings, with strategic oversight provided at Committee level. The Committee further sought assurance in relation to infection prevention and control, including how action plans were being managed and monitored, and queried the data presented under Pillar 2, noting an increase. Clarification was requested to support understanding of this position. **Action: Director of Nursing** The Committee noted that three Never Events had been reported in Quarter 4 and requested follow-up assurance. **Action: Director of Nursing** JW mentioned the slide on quality assurance of commissioned services. This is a complex area and JW reported that work had not progressed as anticipated. A focused piece of work on children and young people services had started. The Committee agreed that a further report on Quality assurance and the framework for commissioned services should come to the committee in six months. **Action: Director of Nursing**

	The committee asked for further information on Datix reporting, decreasing number of pressure ulcers, and the increasing number of inquests. JW and SS provided information on these areas. The Committee **NOTED** the report for **ASSURANCE**.
PQSOC/0206/08	**Quality Management Group Report** Jennifer Winslade (JW), Director of Nursing, presented the report. The Committee noted that the QMG had considered a comprehensive range of intelligence and received overall assurance that arrangements to monitor, manage and improve quality and patient safety across the Health Board remained in place and were functioning effectively. It was noted that services continued to engage with quality improvement activity and maintained appropriate oversight of core safety risks. The Committee noted that several cross-cutting issues had been identified which required continued focus at Executive and Committee level. These included limitations in the alignment between local and national measures, which continued to restrict benchmarking and comparative analysis. An assurance gap was also identified in relation to mandatory training compliance, especially for medicines administration training which had not been recorded on ESR as it had delivered face to face. The Committee acknowledged progress in response to the Fuller Inquiry, particularly in strengthening mortuary governance, infrastructure and access controls. However, strengthened assurance was required in relation to the

	patient pathway between death on the ward and transfer to the mortuary. JW highlighted the need to improve the service and care that was provided for deaf patients and the use of professional translation / interpreter services in clinical settings. The Committee noted the Research and Development Annual Report as a positive area and noted that this aligned with the Committee's terms of reference. It was agreed that this should be brought forward as a future agenda item via the Committee's workplan. **Action: Committee Secretariat/Medical Director** The Committee discussed system pressures, including patient flow and boarding, and noted the need for further focus on how these issues would be addressed. The Committee also discussed suicide prevention and sought clarity on the level of structural support in place, recognising the need for further development in this area. Sepsis and antimicrobial considerations were also raised as areas requiring continued attention. The Committee highlighted that once Electronic Prescribing and Medicines Administration (EPMA) has been piloted in the Health Board, there would be a need for ongoing audit and feedback to Clinical Executives on the impact of it, particularly regarding antibiotic prescribing. The Committee discussed mandatory training compliance and noted that current approaches may not be fully effective. It was suggested that group-based sessions could support improved compliance. The Committee was

	advised that a piece of work was underway to review training requirements across different roles, with the aim of tailoring delivery. The Committee emphasised that a single, standardised approach was unlikely to be effective and that more creative and flexible solutions would be required. The committee supported the work that was being done to review the terms of reference for all of the subgroups of QMG to improve the governance. The Committee **NOTED** the report.
PQSOC/0206/09	**National Clinical Audit: Activity Report 2025/2026 and Annual National Clinical Audit Plan 2026/27** Seema Srivastava (SS), Medical Director, presented the National Clinical Audit Report to the Committee with support from, Leeanne Lewis (LL), Assistant Director for Quality and Patient Safety. The Committee noted the refreshed National Clinical Audit Activity Report and Forward Plan for 2026–27, which aimed to strengthen focus on assurance, learning and improvement rather than activity alone. The Committee noted the improvements including standardised reporting templates, further development of the Audit Management and Tracking system (AMaT), and stronger divisional engagement and governance arrangements. It was noted that audit was now better embedded within existing Committee structures to support scrutiny and Board-level assurance. The Committee recognised the significant progress made over recent years but raised concerns regarding audit actions not completed due to resource constraints. It was agreed that clearer tracking and alignment with the risk

	register was required, supported by a review of historic decisions and risk appetite. The Committee noted that national audit data was often historic and highlighted the need to strengthen local clinical audit activity to provide more timely insights. Embedding audit into routine practice across directorates was seen as a key priority, although resource pressures remain a challenge. The Committee discussed communication of audit findings and noted that current methods were not fully effective. Embedding audit outcomes within wider pillar reports and clarifying local responsibilities was supported to improve visibility and impact, to ensure that the relevant staff are aware of the outcomes of national audits and what improvements need to be made. The committee was informed that there is now a corporate clinical audit plan (presented to ARAC Jan 26) and local clinical audits. The committee noted that it would be important to know the plan and the outcomes of these audits too in an annual report. **Action: Medical Director** The Committee **NOTED** the report for **ASSURANCE** and **APPROVED** the National Clinical Audit Plan for 26/27.
PQSOC/0206/10	**Healthcare Inspectorate Wales (HIW) Reports Update** Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the HIW inspection reports, highlighting these were centrally coordinated through a strengthened governance process. All reports were reviewed, and action plans were quality assured prior to submission. A comprehensive log of recommendations and

	actions was maintained, and progress was routinely chased to minimise the risk of delays or non-compliance. JW advised the Committee that the Health Board had received several HIW recommendations, with multiple actions often linked to a single recommendation. These were being tracked through a structured process to ensure visibility and accountability. The Audit Management and Tracking (AMaT) system would be used as the central platform for monitoring delivery of all HIW-related actions, in response to Audit Wales' expectation for strengthened assurance arrangements. The Committee noted that HIW operated an escalation framework; however, there were no direct financial penalties associated with delayed actions. JW clarified that where actions were delayed, there was a risk of re-inspection rather than financial sanction, provided the Health Board continued to engage and supply regular updates. Paul Deneen (PD), Independent Member, sought clarification regarding expected timescales for responding to HIW reports and submitting action plans. JW advised that timescales were not fixed and were determined by the judgement of the Health Board, taking account of the complexity of findings and available resources. Immediate actions were prioritised with defined deadlines, while other actions were scheduled appropriately. JW further confirmed that once an HIW report was formally published, it would be presented to the

	Committee at the earliest opportunity to ensure oversight and transparency. The Committee discussed the importance of maintaining clear visibility of progress against all HIW improvement plans to demonstrate compliance and accountability. It was emphasised that consistent reporting to the Committee was required to provide assurance that actions were being delivered as intended. The Committee **NOTED** the report.
PQSOC/0206/11	**Update on neonatal services, including progress on listening and lessons learned activity and the forthcoming national review** Jennifer Winslade (JW), Director of Nursing, reported that an improvement plan had been developed to strengthen assurance that neonatal services provided safe care, a positive experience for parents, families and babies, and a supportive and psychologically safe working environment for staff. The Committee noted that over 70% of the identified improvement actions had been completed, with remaining actions in progress to sustain and embed improvements. JW highlighted to the Committee the key areas of focus within the plan, which included reducing medication errors, strengthening infection prevention measures, improving governance processes, and addressing cultural development within the service. These areas aligned with the themes identified through engagement with staff and earlier reviews of the service.

	JW reported that there was a new senior manager for midwifery and neonates who had been leading the improvement work and working with staff to improve training and culture within the department. There has been a decrease in sickness levels within the team and the committee saw this as a positive sign. The Committee discussed staff training and development. Penny Jones (PJ), Vice Chair, queried whether any additional feedback had been received regarding requests for further bedside or cot-side training. JW advised that a further update would be brought to the Committee once this information was available. **Action: Director of Nursing** The Committee also sought assurance regarding workforce visibility, specifically the presence of Band 6 and Band 7 staff. It was confirmed that reduced visibility was not a Health Board-wide concern and targeted actions were in place to address this locally. The Committee noted the significant improvements that had been made in the last 12 months and that executive monitoring of some areas was continuing. The Committee **NOTED** the report.
PQSOC/0206/12	**WRP Penalties and Learning Compliance: Update on Health Board Improvement** Jennifer Winslade (JW), Director of Nursing, reported that the Health Board had been identified as the highest recipient of Welsh Risk Pool (WRP) penalties for delays in completing Learning from Events reports (LFER). There were 55 penalties issued between April and December

	2025. The Committee noted that this represented a deterioration in performance compared to the previous year, where 34 penalties had been recorded. JW advised the Committee that Welsh Risk Pool Committee guidance recommended that financial penalties be passed to the individual divisional budget holders responsible for the delays, rather than a central budget. It was confirmed that this approach had now been implemented within the Health Board, with penalties attributed directly to the responsible Divisions to strengthen accountability. The Committee noted that January data identified a continued backlog of outstanding LFERs across several Divisions, indicating that further work was required to bring reporting within required timescales. JW reported that the work falls on a small number of people in a few divisions and it is often difficult to retrieve the information / notes needed as it was a long time since the initial event. JW advised the Committee that Legal and Divisional teams were working closely and at pace to improve compliance. A range of improvement actions had been initiated, including strengthened tracking processes, clearer escalation routes, and increased oversight to support timely completion of reports. These actions were intended to recover performance and reduce future penalties. JW noted that there had been recent improvement. The Committee **NOTED** the report and the decisions made by the Executive.
PQSOC/0206/13	**Committee Risk Report**

	Naomi Murtagh (NM), Board Business Manager, provided the Committee with an overview of the Committee Risk report, advising that there had been no changes to the risk profile since the previous meeting, and no new risks had been added or escalated. Existing risks remained under review, with controls and mitigating actions continuing to be monitored through established governance processes. NM advised the Committee that further work was being undertaken to strengthen assurance against current risks, with a more detailed update to be provided at the next Committee meeting. The Committee **NOTED** the report.
PQSOC/0206/14	**Review of Committee Programme of Business 2026/27** The report was received for Information.
PQSOC/0206/15	**HIW Operational Plan 2026-2027** The report was received for Information.
PQSOC/0206/16	**Items to be Brought to the Attention of the Board and Other Committees** The Committee considered which matters from the meeting required escalation or formal notification to the Board and other relevant committees and agreed to escalate the following: • Health and Safety report on Violence and Aggression to be reported to People and Culture committee too. • Mandatory Training to be raised with the People & Culture Committee.
PQSOC/0206/17	**Any Other Urgent Business**

	The committee requested updates at a future committee on the outcomes of the investigations into two recent incidents that been the subject of significant publicity: the sterilisation unit and the lumbar puncture case. **Action: Director of Nursing and Medical Director**
PQSOC/0206/18	**Date of the Next Meeting:** • 28th July 2026