



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

**MINUTES OF THE PATIENT QUALITY, SAFETY  
AND OUTCOMES COMMITTEE MEETING**

<b>DATE OF MEETING</b>	Tuesday 2nd December 2025, 13:30am-16:30pm
<b>VENUE</b>	Microsoft Teams

<b>PRESENT</b>	Helen Sweetland, Chair Penny Jones, Vice Chair Philip Robson, ABUHB Vice Chair Paul Deneen, Independent Member Vivek Goel, Independent Member (until 15:50)
<b>IN ATTENDANCE</b>	Jennifer Winslade, Director of Nursing Seema Srivastava, Medical Director Peter Carr, Director of Allied Health Professions & Health Science Rani Dash, Director of Corporate Governance Leeanne Lewis, Assistant Director of Quality & Patient Safety Collette Kiernan, Deputy Director of Allied Health Professions and Health Science Arvind Kumar, Interim Divisional Director (Item 2.7 only) Howard Stanley, Head of Safeguarding (Item 2.6 only) Naomi Murtagh, Board Business Manager Gavin Thomas, Committee Secretariat
<b>OBSVERING</b>	Rhian Gard, Internal Audit
<b>APOLOGIES</b>	Leanne Watkins, Chief Operating Officer Fern Woodhead, Committee Secretariat

<b>PQSOC 0212/01</b>	<b>Welcome and Introductions</b>  The Chair welcomed everyone to the meeting.
<b>PQSOC 0212/02</b>	<b>Apologies for Absence</b>  The Chair confirmed that there were no apologies for absence.
<b>PQSOC 0212/03</b>	<b>Declarations of Interest</b>  There were no declarations of interest raised relating to items on the agenda.
<b>PQSOC 0212/04</b>	<b>Minutes of the previous meeting</b>

	<p>The minutes of the Patient Quality, Safety and Outcomes Committee held on 1<sup>st</sup> October 2025 were agreed as a true and accurate record of the meeting subject to the requested changes.<b>Action: Committee Secretariat</b></p> <p>The Committee <b>APPROVED</b> the draft minutes.</p>
<p><b>PQSOC 0212/05</b></p>	<p><b>Committee Action Log</b></p> <p>The Committee received the action log and was content with progress made in relation to completed actions and against any outstanding actions.</p> <p>The Committee noted that the Health and Safety Executive (HSE) report, which had been expected at the meeting, had instead been presented to the Board the previous week (26.11.25). Peter Carr (PC), Director of Allied Health Professions &amp; Health Science, clarified that the action related to HSE activity encompassed all ongoing visits and investigations, and confirmed that summary updates were routinely included in the quality report under the health and safety pillar. PC would prepare a report summarising the recent HSE intervention at Hafan Deg Ward, including the actions taken and the closure of the investigation, for presentation at the next meeting. <b>Action: Director of Allied Health Professions &amp; Health Science</b></p> <p>The Committee also noted that Healthcare Inspectorate Wales (HIW) reports had been completed but were not included on the agenda in time for the meeting. Jennifer Winslade (JW), Director of Nursing, confirmed that these reports would be circulated to Committee members after the meeting and formally noted at the next meeting. <b>Action: Director of Nursing</b></p> <p>The Committee <b>APPROVED</b> the action log.</p>
<p><b>PQSOC 0212/06</b></p>	<p><b>Quality Outcomes Report</b></p> <p>Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Quality Outcomes Report, which highlighted the transition to six revised pillars of quality, that had been developed in response to feedback from divisional staff and the Board. These pillars included patient and staff feedback, patient safety, clinical effectiveness, health and safety, infection prevention and control, and safeguarding. Divisional reporting had been aligned to these pillars, and the introduction of ward accreditation dashboards was noted as a positive development.</p>

JW highlighted the revised format of the report and the work that was being done on a national quality outcomes framework and the development of the national Beacon dashboard. This would enable bench-marking against our peers and work with the local digital team will increase automation.

JW reported to the Committee that the Patient Experience Survey, was a new all-Wales initiative that started in April. An overall satisfaction rate of 87% had been achieved from nearly 20,000 responses across all surveys. Emergency Department satisfaction had improved to 74%, while maternity and neonatal services reported an 86% satisfaction rate since their launch in September. Positive themes included compassion and support, while negative feedback focused on waiting times and facilities. Divisions were working on plans to address these areas for improvement.

The Committee was advised that the Patient Advice and Liaison Service (PALS) continued to support approximately 450 queries per month, ranging from simple communication issues to complex cases. The data and themes from PALS were fed back to divisions to inform service improvements.

JW discussed compliance with the Putting Things Right (PTR) process, noting ongoing challenges in meeting the 30-working-day target for complaint responses. Although the timeliness of responses remained a concern, the quality of responses had improved, and early resolution rates had reached 92.98%. There was a plan in place to address the delays in responding to complaints. New PTR regulations were expected to extend the early resolution timeframe to ten days, which would further support improvements.

JW provided an update to the Committee on Ombudsman interventions, reporting a reduction in complaints and improved quality of responses. The Committee was assured that regular reporting on actions and learning points would continue.

The Committee reviewed data on patient safety, including mortality rates, incident reporting through Datix, and hospital falls. Peter Carr (PC), Director of Allied Health Professions & Health Science, reported a downward trend in hospital falls and highlighted the impact of ward accreditation and targeted training. The Committee noted that 99.7% of hospital falls resulted in no or low harm, and

that weekly reviews of moderate, severe, and catastrophic falls were conducted by the Executive team.

Further updates were provided on healthcare-acquired pressure ulcers, hospital-acquired thrombosis, medicines management, and duty of candour compliance. JW advised that improvements in reporting incidents and compliance had been achieved over the last year, and that the Health Board was not a national outlier for reportable incidents. PC reported on the steps being taken on staff training to improve RIDDOR reporting.

The committee received an update on the Sepsis campaign and the introduction of NEWS-2 scoring systems. The Committee was pleased to hear how the team is reaching schools, young people and GP surgeries with important messages.

The Committee discussed infection prevention and control, noting strong performance below the all-Wales average for most infections, except for Pseudomonas and a recent increase in Clostridium difficile. Ongoing work with pharmacy and estates colleagues was highlighted as essential to address these challenges.

JW advised the Committee that a significant rise in child duty to report incidents for safeguarding. The reason for this may be due to increased staff training and awareness but this needs to be analysed further. Multi-agency meetings and partnership working with local authorities and police continued to be a priority.

The Committee acknowledged the comprehensive nature of the report and the improvements made in data presentation and automation. The Committee expressed appreciation for the clarity of the new format and the inclusion of patient safety leadership visit findings. The Committee agreed that ongoing monitoring and targeted improvement actions were essential to maintain and further enhance the quality of care across the organisation.

The Committee **NOTED** the report.

**PQSOC 0212/07**

**Quality Management Group Reporting**

Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Quality Management Group (QMG) report. JW informed that the report was concise and covered several areas already discussed earlier in the meeting. JW confirmed that the QMG

received regular reports from divisions for each of the six pillars of quality, ensuring a comprehensive overview of quality management across the organisation.

JW advised the Committee that the QMG had recently reviewed revisions to the Patient Safety Incident Policy and noted that the policy, which was due to be presented to the Board, included important amendments based on organisational learning, particularly regarding the management of complex investigations and challenging family circumstances. The policy had been strengthened to improve training and to clarify the role of the Family Liaison Officer, recognising the specialist skills required to support families through difficult events.

The Committee was updated on the outcome of a recent patient safety visit to 19 Hills. JW advised that the visit identified the need for a standard operating procedure (SOP) to guide staff responses when individuals arrived unwell at the facility, which does not have a designated reception or building owner. A SOP for management of unwell patients in a community setting had been approved. The Committee noted that this alert would be disseminated to 19 Hills and other relevant settings.

The Committee was advised that the QMG had received inspection reports from Health Inspectorate Wales (HIW) for the Royal Gwent Hospital Minor Injuries Unit (MIU) and Ysbyty Ystrad Fawr (YYF) Birth Centre, which would be circulated to members after the meeting. The Committee also received the Pharmacy and Medicines Management Annual Report, which was commended for its thoroughness and quality and would be included for information at the next Committee meeting. **Action: Director of Nursing.**

Risks and highlights identified by the QMG were consistent with those previously discussed, with particular attention given to urgent care flow and future care planning. JW noted that future care planning, including advanced care planning and Treatment Escalation Plans (TEPs), remained an area for further development. The need to embed future care planning across both primary and secondary care was emphasised and it was reported that a lead and programme of work were in place to address this.

The Committee accepted the Quality Management Group report, noting that quality assurance processes and governance arrangements were robust and that

improvements were being actively progressed. The Committee agreed that ongoing monitoring and reporting would be essential to sustain progress and maintain high standards of care across the organisation.

The Committee **NOTED** the report.

## **PQSOC 0212/08**

### **Update on Neonatal Service Improvements**

Jennifer Winslade (JW), Director of Nursing, provided the Committee with an update on the Neonatal Intensive Care Unit (NICU) service improvements. The report outlined the structured approach taken to address persistent challenges within the NICU, focusing on four priority areas: infection prevention and control, medicines management, workforce, and culture.

JW reported that a proactive risk management strategy had been established, with weekly oversight meetings chaired by the Director of Nursing. These meetings ensured close monitoring of progress and provided support to maintain momentum. The Executive Team received formal briefings each week, reflecting the organisation's commitment to resolving ongoing issues and safeguarding patient outcomes.

The Committee was advised that Infection prevention and control improvements were triggered by benchmarking data and internal inspections, which identified areas for enhancement. The division implemented enhanced cleaning schedules, targeted environmental improvements, and daily audits, achieving compliance rates above the benchmark. Laundry arrangements were reviewed, and a pilot with an external service was introduced to strengthen infection control. Reporting and procedures for venepuncture were also reviewed, with the aim of de-escalating the infection prevention risk.

Seema Srivastava (SS), Medical Director, provided further detail on medicines management, describing the collaborative approach involving senior medical, nursing, and pharmacy staff. Immediate actions included the development of standard operating procedures for high-risk processes, improved medication storage and double-checking, and updated guidance for thrombosis management. The team had addressed themes identified in incident reviews, such as gentamicin prescribing practices, and implemented spot audits, medication safety huddles, and updates to the neonatal prescribing handbook. Plans were being made to increase pharmacy

input and introduce regular audits and micro-teaching for clinical staff.

JW advised the Committee that Workforce actions focused on maintaining safe staffing levels, particularly in nursing, where recruitment pressures had eased but sickness absence remained high. Twice-daily situation reports were received from the unit, and visibility of senior staff was increased. Plans were in place to review skill mix and staffing structures, and medical staffing escalation was being addressed. The Committee was assured that the unit had remained safe, with further work ongoing to optimise workforce arrangements.

The Committee was advised of the cultural improvement efforts, including an eight-week listening exercise open to all staff groups. The report from this exercise was in final draft and would be shared with the Executive team and division before wider dissemination. This report and further updates to be shared with the Committee at a later date.

**Action: Director of Nursing.**

Civility training and human factors approaches had been introduced to support a positive culture, and regular HR support and visibility on the unit continued.

JW advised the Committee that weekly monitoring and oversight of the improvement plan would continue until risks were de-escalated to an acceptable level. Once achieved, a wider NICU improvement plan would be developed, aligned with the successful maternity services improvement plan. External assurance visits were expected to further inform targeted improvements.

The Committee raised questions regarding pharmacy support and the early adoption of the electronic prescribing system (EPMA), which SS clarified would be phased in across the Health Board to ensure safety and appropriate capacity.

The Committee **NOTED** significant progress in all four priority areas and expressed support for the ongoing improvement efforts.

The Committee received the report for **ASSURANCE**.

**PQSOC 0212/09**

**Year 3 Quality Strategy Implementation Plan**

Leeanne Lewis (LL), Assistant Director of Quality & Patient Safety, provided the Committee with an overview of the Year 3 Quality Strategy Implementation Plan, which outlined the plan that had been developed to align with

statutory duties for reporting the Duty of Quality and Duty of Candour, and aimed to embed a culture of continuous improvement throughout the organisation.

LL highlighted to the Committee that the implementation plan was built on previous years' work and set out clear priorities for 2025/26. The plan focused on strengthening assurance and governance, improving the quality management system, and automating reporting dashboards to provide divisional and directorate-level insights. The Committee was advised that the six pillars of quality remained central to the strategy, with clinical effectiveness now included as Pillar 3.

The Committee was advised on how the plan incorporated quarterly milestones, which had been mapped from April onwards to ensure progress could be tracked and reported in the annual quality report. The Committee noted that the plan emphasised cultural engagement, psychological safety, visible leadership, and the spread of learning and improvement through dedicated forums.

Jennifer Winslade (JW), Director of Nursing, advised the Committee that an underpinning piece of work on safety culture was planned for the coming year, which would align with national initiatives and further strengthen the organisation's approach to quality and safety.

The Committee discussed the importance of joined-up reporting and the clarity provided by the six pillars and associated metrics. The Committee agreed that the new framework should make it easier to hold the organisation to account and to conduct deeper dives into key issues.

Vivek Goel (VG), Independent Member, asked whether data from sources such as Freedom to Speak Up Guardians was included in the safety framework. LL confirmed that work was underway to integrate multiple data streams from different sources and areas of the Health Board such as workforce, into a central data warehouse, enabling more effective triangulation and reporting within the Quality Outcomes Framework.

The Committee clarified that quarterly milestones had been maintained from the previous year and that progress against these would be tracked and reported in future annual quality reports.

The Committee agreed that the plan provided a clear structure for embedding quality and safety at every level

of the organisation, with measurable outcomes and a commitment to continuous improvement.

The Committee **NOTED** the report and received **ASSURANCE** on the ongoing work to deliver the Duty of Quality and Duty of Candour.

**PQSOC 0212/10**

**Update on Safeguarding Level 3 Training**

Howard Stanley (HS), Head of Safeguarding, provided the Committee with an update on Safeguarding Level 3 Training. The Committee was advised that both child and adult Level 3 safeguarding training were mandated for all regulated professionals, following recent revisions to national intercollegiate guidance. The scope of required training had expanded significantly, resulting in a substantial increase in the number of staff needing face-to-face, interactive training.

HS reported that the initial estimates suggested around 4,000 staff would require Level 3 training, but updated workforce data revealed that the actual figure was closer to 6,500. The Committee noted the challenges faced in delivering training at this scale, including limited resources, operational pressures, and attendance issues the training sessions were regularly overbooked to maximise attendance, but capacity constraints remained.

HS confirmed that the organisation had adopted a phased implementation plan, aiming to reach 85% compliance over three years and then maintain that level. It was advised that, following additional funding and increased session capacity, compliance for adult Level 3 training had reached 31% by the end of November. The Committee was assured that high compliance rates for Level 1 and 2 online training continued to mitigate patient safety risks, and that staff were actively reporting safeguarding concerns.

The Committee discussed the reputational risks associated with low compliance and noted that Aneurin Bevan University Health Board was one of only two health boards fully adhering to the guidance.

Paul Deneen (PD), Independent Member, raised concerns regarding the lack of national resources to support delivery and the prescriptive nature of the training requirements. HS confirmed that feedback had been provided to national

working groups, but changes to the guidance were unlikely in the short term.

HS clarified that the training was designed to equip staff with the skills to manage complex safeguarding cases and that the organisation was prioritising high-risk staff Groups, such as health visitors, school nurses, and midwives. The Committee discussed the feasibility of alternative delivery models, but HS confirmed that the current guidance required face-to-face, interactive sessions led by appropriately skilled trainers. HS confirmed that the HB team is working hard to optimise attendance at all the sessions that can be delivered.

The Committee **NOTED** the report and the actions being taken to increase training uptake.

## **PQSOC 0212/11**

### **Mortuary Incident Action Plan**

Arvind Kumar (AK), Interim Divisional Director, provided the Committee with an update on the Mortuary Incident Action Plan. The report summarised the progress made since the last report to the Committee, focusing on outstanding actions and new developments within the Pathology Directorate and Care After Death (CAD) services.

AK advised the Committee that the implementation of the Eden software had been completed, with user acceptance testing finalised and a go-live date scheduled for mid-December. Integration with the LIMS 2.0 system was pending, and the team was awaiting its launch to ensure full functionality. Improvements to community admissions out of hours had been agreed, with training for relevant staff nearing completion. The team had also worked with police colleagues to improve IT processes for community cases, achieving reasonable compliance.

The Committee was advised that electronic audit processes had been successfully implemented in collaboration with nursing colleagues, and the review of the CAD team service Group had concluded that the team should continue in its current form, supporting the Medical Examiner and death certification pathway. The Pathology Academy was developing a career pathway programme for Anatomical Pathology Technologists (APTs), which remained ongoing.

AK highlighted to the Committee the new developments, including the completion of a gap analysis following the release of the Fuller Phase Two recommendations, which had been reviewed by the HTA Governance Committee. The closure of the YAB body store was noted as a risk that had been swiftly addressed with Executive support. An NHS P&I colleague had conducted a review, and a formal response letter had been drafted.

The Committee was updated on the inclusion of YAB in the CAD team portfolio, which had been recommended to the Executive Team and was scheduled for further work. Delays in body release due to Medical Examiner (ME) and death certification processes had been addressed through a new paper proposing the use of the Medical Certificate of Cause of Death (MCCD) document for body release, in line with neighbouring Health Boards and NHS England. This change was expected to reduce unnecessary waiting times for bereaved families by up to seven days.

AK confirmed that no Human Tissue Authority (HTA) reportable incidents had occurred since the last meeting, and that the most recent incident had been identified through the audit process, demonstrating the effectiveness of the new systems. A recent HTA inspection had taken place, and formal feedback was awaited.

Helen Sweetland (Chair) asked about the wellbeing and morale of the team now. AK reported that there was a new manager in place and there was ongoing work to support and develop staff and improve their working arrangements.

The Committee was assured that quarterly HTA Governance Committee meetings were now fully embedded, with dual representation from relevant colleagues and a standard process for assurance reporting to the Executive team, Board and Quality Management Group. Work was ongoing to develop a peer support network with neighbouring Health Boards, pending the implementation of LIMS 2.2.

The Committee **NOTED** the report and acknowledged the progress made in delivering improvements.

Naomi Murtagh (NM), Board Business Manager, provided the Committee with an overview of the Committee Risk Report, the Committee was advised that there had been no significant changes to the risk profile since the previous meeting.

Peter Carr (PC), Director of Allied Health Professions & Health Science, provided an update regarding health and safety risks, confirming that the appointment of a Deputy Head of Health and Safety and additional support for the Datix team had been completed. PC advised that these appointments had contributed to the mitigation of health and safety risks, although further work was required to reach the target risk level.

The Committee accepted the Committee Risk Report, noting that the risk environment remained stable and that mitigation actions were progressing as planned. The Committee was assured that appropriate staffing and governance measures were in place to manage strategic risks and agreed to continue monitoring progress at future meetings.

The Committee **NOTED** the report.

## **PQSOC 0212/13**

### **Ophthalmology Audit Wales Report**

Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Ophthalmology Audit Wales Report. The Committee was advised that the Audit Wales report was about the delivery of Ophthalmology services but had highlighted significant risks of harm associated with long waiting lists for ophthalmology appointments.

JW summarised the main findings of the report, noting that the Health Board continued to face workforce shortages, with three consultant vacancies and physical space constraints impacting service delivery. It was advised that new appointments had been made for cornea, paediatric, and glaucoma specialists, with further recruitment underway. The Committee noted that non-medical roles, such as optometrists and nurse practitioners, had been expanded to help address capacity issues.

The Committee discussed the processes in place for managing incidents and mitigating harm. JW confirmed

	<p>that all incidents were reviewed by a senior nurse practitioner and, where necessary, referred for consultant harm review. The Committee was advised that between 2023 and 2025, 26 nationally reportable incidents had occurred, with 15 relating to glaucoma patients lost to follow-up. These cases had been fully investigated, and learning from the thematic review had been shared across the organisation. Themes included: delays in triaging referrals from opticians, cancelled clinics, delays in rebooking appointments, equipment failure and lack of diagnostic capacity.</p> <p>JW highlighted to the Committee the improvements made in response to the report, including the introduction of a red flag protocol for urgent referrals, the development of subspecialty pathways, and the implementation of electronic systems for patient records and referrals. JW noted that additional diagnostic capacity had been created, and that ongoing validation of waiting lists was being carried out to ensure high-risk patients were prioritised.</p> <p>The Committee discussed the impact of delays on patient safety and the importance of compliance with the Duty of Candour. JW confirmed that cases of severe harm were managed through the serious incident process and reported in accordance with statutory requirements.</p> <p>The Committee acknowledged the risks identified in the Audit Wales report and noted the actions taken to mitigate patient harm and improve service delivery for ophthalmology patients.</p> <p>JW acknowledged that lessons learnt from thematic reviews of other areas of should be presented to the committee on a regular basis. <b>Action: Director of Nursing</b></p> <p>The Committee <b>NOTED</b> the report and the actions taken.</p>
<p><b>PQSOC 0212/14</b></p>	<p><b>Review of Committee Programme of Business 2025/26</b></p> <p>Review of Committee Programme of Business 2025/26 was provided to the Committee for information.</p>
<p><b>PQSOC 0212/15</b></p>	<p><b>To confirm any key risks and issues for reporting/escalation to Board and/or other Committees</b></p>

	<p>The Committee considered which matters from the meeting required escalation or formal notification to the Board and other relevant committees.</p> <p>Members discussed several key issues that had emerged during the meeting. The Committee agreed that the ongoing challenges and resource implications associated with Safeguarding Level 3 Training, particularly the requirement for nearly half the workforce to complete face-to-face training without additional national resources, should be highlighted to the Board. The Committee recognised this as a significant operational and reputational risk.</p> <p>The Committee agreed that the progress and assurance provided by the Mortuary Incident Action Plan, including improvements in digital systems, audit processes, and governance arrangements, warranted formal notification to the Board to demonstrate effective risk management and service improvement.</p>
<b>PQSOC 0212/16</b>	<p><b>Any Other Urgent Business</b></p> <p>There was no urgent business.</p>
<b>PQSOC 0212/17</b>	<p><b>Date of the Next Meeting:</b></p> <p>17<sup>th</sup> February 2026</p>