PATIENT EXPERIENCE, QUALITY AND SAFETY COMMITTEE

CONFIRMED MINUTES OF THE MEETING HELD ON 30 APRIL 2026 at 09:30 VIA MICROSOFT TEAMS

MEMBERS		
Rhiannon Beaumont Wood	RBW	PTHB Vice-Chair (Chair)
Mick Giannasi	MG	Independent Member (General)
Jennifer Owen Adams	JOA	Independent Member (Third Sector) (from 09.45)
Ian Thomas	IA	Independent Member (General) (09.45)
Simon Wright	SW	Independent Member
IN ATTENDANCE		
Mererid Bowley	MB	Executive Director Public Health
Helen Bushell	HB	Director of Corporate Governance / Board Secretary
Carl Cooper	CC	Chair of PTHB Board (observing)
Hayley Hughes	HH	Corporate Business Manager (observing)
Matthew King	MK	Deputy Director Therapies and Health Sciences (observing)
Elaine Lorton	EL	Executive Director of Primary Care, Community and Mental Health
Claire Madsen	CM	Executive Director of Allied Health Professionals, Health Sciences and Digital
Chris Moss	CMo	Assistant Director Performance and Commissioning (10.05 – 10.35)
Paul Hooton	PHo	Executive Director of Nursing, Quality, Women and Family Health
Liz Patterson	LP	Head of Corporate Governance
Aime Symes	AS	Director of Midwifery, Women and Family Health
Hayley Thomas	HT	Chief Executive
Kate Wright	KW	Executive Medical Director
APOLOGIES FOR ABSENCE:		
Nicola Johnson	NJ	Executive Director Planning, Performance and Commissioning
Chris Walsh	CW	Independent Member (Local Authority)

1. PRELIMINARY MATTERS

1.1 WELCOME AND APOLOGIES (PEQS/26/01)

The Chair welcomed everyone to the meeting. Apologies for absence were received as recorded above. Thanks were expressed to SW for chairing the Committee between PTHB Vice-Chair appointments

1.2 DECLARATIONS OF INTEREST (PEQS/26/02)

No declarations of interests were received in addition to those already recorded on the register.

2. CONSENT AGENDA BUSINESS

RBW asked Members if they wished to bring forward any items from the Consent agenda to the main agenda.

No items were requested to be brought forward from the Consent to the main agenda.

3. ITEMS FOR APPROVAL / DECISION / RATIFICATION

3.1 MINUTES OF PREVIOUS MEETING (PEQS/26/03)

The minutes of the meeting held on 05 February 2026 were **CONFIRMED** as an accurate record.

3.2 COMMITTEE ACTION LOG (PEQS/26/04)

HB presented the action log noting the following updates:

- PEQS/25/88 (a trajectory of improvement relating to incident closure be provided in the Integrated Quality Report) – a date change request to the August 2026 meeting was proposed
- Three actions were not due
- Ten actions were proposed as complete and recommended for closure
- One action had been transferred for monitoring under the Board escalation arrangements

Independent Members asked the following questions for assurance:
The action log and some of the responses to the actions were circulated only two days before the meeting, and in the case of the provision of the Patient Experience Framework implementation plan, this was provided as a background paper rather than brought to the meeting. Does the action log that is presented have sufficient controls to ensure that the actions marked as complete have addressed the original action?
HB advised that this action log had an unusually large number of actions and collating responses had coincided with staffing pressures in some areas and annual leave. The team would reflect on the comments and consider how best to ensure the response correctly addresses the action set out.

PH confirmed there had been staffing pressures within the Quality & Safety Team, however, the area was now in recovery and was making good progress. Some actions related to items later on the agenda for example the Patient Experience Framework Implementation Plan and perhaps consideration of closure of an action would be more appropriately timed to when an individual matter had been considered.

Should the change of date noted for PEQS/25/85 be more accurately recorded as a request for a date change rather than 'on track'?
HB concurred that this should be shown as RAG status red with a requested date change to October 2026.

In relation to PEQS/25/63 (reporting arrangements for dental services) the response details that the matter would be considered at the Chair's Forum. A recent Chair's Forum did not consider this matter.

HB advised that the Chair's Forum had considered and looked across all the Committee work programmes which had included dental services, and therefore this action had been viewed as complete. However, reporting arrangements for dental services will be clarified in the next iteration of the action log (PEQS/25/63 to remain open).

The Committee:

- **APPROVED** the date change request for PEQS/25/88 and PEQS/25/85, and
- **REOPENED** PEQS/25/66 dental services for a more detailed response to be included in the next action log.
- **CLOSED** the following actions: PEQS/25/62b, PEQS/25/63, PEQS/25/65a, PEQS/25/65b, PEQS/25/86, PEQS/25/87a, PEQS/25/87b and PEQS/25/94, and
- **TRANSFERRED** the following action PEQS/25/90 to the Board escalation process.

3.3 COMMITTEE ANNUAL WORK PROGRAMME 2026/27 (PEQS/26/05)

HB presented the draft work programme explaining it was informed by the terms of reference, risk register and profiles and considered by the Chair and Lead Executive Member before being brought to the Committee for approval. It is a plan for the year which remains flexible if in year changes are needed to respond to relevant or urgent matters.

Independent Members asked the following questions for assurance:
Is there sufficient capacity to deliver the programme and how is it prioritised?
HB advised that capacity remains challenging and is closely monitored across the Executive team. The programme is designed to be proportionate while meeting statutory and regulatory assurance requirements. Prioritisation is based on professional judgement, informed by risk, urgency, external factors, audit and regulatory requirements, and consultation with committee and Board Chairs. Items may be moved, deferred, escalated, or redirected to remain agile.

Should commissioned services have greater visibility within the work programme?
PH confirmed commissioned services require clearer visibility which may be achieved through a standalone focus or clearer identification within existing reports. Work is underway to strengthen quality, safety, and patient experience oversight for commissioned services, including development of a dedicated dashboard, to support assurance through the integrated quality report.

How will assurance be provided on 'listening to people' and the new complaints process?
HB advised this would be provided within the revised Integrated Quality Report.

May an item on Mortality Reviews be added to the work programme?
KW confirmed that whilst mortality reviews are briefly referenced within the Integrated Quality Report it would be appropriate to have an annual report on this item.

The Committee **APPROVED** and **RECOMMENDED** the PEQS Annual Work Programme 2026/27 to Board.

3.4 COMMITTEE ANNUAL REPORT 2025/26 (PEQS/26/06)

HB presented the Patient Experience, Quality and Safety Committee Annual Report for 2025/26 which outlined the roles and responsibilities of the Committee, membership and attendance along with activity during the period.

Committee Members observed the report would benefit from inclusion of key areas of focus, impact and added value, and change it to a more reflective document that identified where challenge had been applied and what changes had resulted.

HB noted the benefit of extending the annual report in this way and wished to reflect on the capacity of the team to produce such a document across all Health Board Committees.

The Committee :

- **CONSIDERED** the Patient Experience, Quality and Safety Committee Annual Report for 2025/26 summarising the key areas of business activity undertaken;
- **RECOMMENDED** the report to the Board for the 20 May 2026 meeting.

4. ESCALATED ITEMS

4.1 CHILDREN'S NEURODIVERSITY SERVICES (PEQS/26/07)

CMo joined 10.00

CMo presented the report and drew attention to the following matters:

- The Executive Oversight Group had reviewed updated Integrated Quality and Performance (IQP) and Conditions for Sustainability assessments.
- For safe and effective care, an amber/green maturity rating was accepted; the service were asked to provide actions and timescales to achieve full green status.
- For patient and family experience, green (results) and amber (maturity) were accepted; with further actions and timelines requested to secure full maturity.
- For leadership and management, insufficient evidence was provided; further detail was requested before a maturity rating could be agreed.
- The updated Conditions for Sustainability assessment recognised significant work but required additional information before formal acceptance.
- Latest performance shows 807 patients waiting for first appointment (as at 24 April 2026), an improvement, with no waits over 104 weeks.
- Referrals are increasing (73 in February rising to 105 in March), with acceptance rates above planned levels, impacting recovery trajectory (now extending to 28–29 weeks).
- Open pathway numbers are rising (528 patients), with issues identified in the under-5 pathway and proposals to move some cases to community paediatrics "watch and wait".
- Service reviewing capacity and workforce requirements, including increased MDT panels and potential clinical psychology input; overall demand continues to rise (c.1,336 in April, with ~40% open caseload).

Independent Members asked the following questions for assurance:
What assurance could be provided regarding rising referral rates and the extended recovery timeline?

Referral rates were recently higher than expected and were under review to determine whether this was a sustained trend or temporary variation. Analysis was underway, with partnership discussions ongoing to support demand management.

What was the position regarding the diagnostic psychology role and mitigation?
Diagnosis currently relied on paediatricians due to limited psychology input. Work was progressing to explore alternative roles and a business case to improve capacity and efficiency.

What did 'substantive workforce structure alignment' mean and how was partnership working progressing?
Changes within the local authority were supporting new partnership arrangements via the Regional Partnership Board (RPB), strengthening collaboration with education partners to improve early support, referral pathways and ongoing care, with expected benefits for demand management.

Does the maturity matrix accurately reflect the position of the service, particularly given ongoing staffing gaps, pathway pressures, and increasing demand, and can assurance be provided on the rigour of the assessment and sustainability of improvement?
The service is close to meeting the Integrated Quality (IQ) Path criteria for maturity against the original escalation triggers, reflecting strong progress. However, it is not yet meeting the criteria for sustainability. Current assessments highlight concerns regarding the service's ability to sustain improvements, particularly given workforce gaps and demand pressures. Further work is underway to strengthen the sustainability assessment and provide assurance that improvements can be maintained over time.

Are increasing referral numbers and demand pressures unique to the service?
The rise in referrals and associated demand is being observed at a national level. Further mapping and analysis of these trends is ongoing to support future planning and understanding of demand.

How confident is the team that the actions identified to address capacity issues will enable the service to achieve a 'green' position?
Assurance cannot yet be provided. Further work is required through the IQ Path and sustainability assessment to test whether the identified and additional actions will sufficiently address capacity and sustainability concerns. An updated assessment will be brought to the next meeting for committee scrutiny and assurance.

Would presenting Statistical Process Control (SPC) type data support better understanding of variation in demand, such as increases in referrals?
Yes. Incorporating SPC-style data is being explored, with work underway between performance and information teams to develop this and present it through escalation oversight and future committee reporting to aid interpretation of variation.

PH advised that progress had been recognised, but assurance on sustainability depends on strengthening workforce capacity and developing a robust sustainability plan to be brought back for committee scrutiny.

HT noted that the report provides assurance against the original escalation triggers through a moderated self-assessment approach; however, further reflection is required on the purpose, scope and positioning of the maturity matrix within the wider assurance framework, particularly to avoid conflating escalation criteria with broader service sustainability in the context of inherently fragile services.

The Committee:

1. Took **ASSURANCE** that the implementation of the IQPF Escalation Oversight mechanism is providing robust oversight of the quality improvement and risk mitigation work being undertaken within Neurodevelopmental Services.
2. Took **ASSURANCE** from the ongoing monitoring and evaluation mechanisms in place as part of IQPF.

CMo left 10.40

4.2 PEOPLE'S EXPERIENCE FRAMEWORK UPDATE (PEQS/26/08)

PH introduced the report which provided an update on the implementation of the Peoples Experience Framework (PEF) including work completed to date, ongoing activity and the associated action plan aiming for delivery by September. The report also addressed the previously escalated Civica issue outlining the assurance provided and seeking agreement to de-escalate this issue.

Independent Members asked the following questions for assurance:
Can the framework, strategy and action plan be clarified?
AS advised that two frameworks operate: the statutory Listening to People framework (complaints) and a non-statutory patient experience framework (feedback and learning), with this paper relating to the latter. The strategy sets out local delivery, and the action plan details implementation.

Is Civica being used effectively, and how is data being strengthened (including by triangulation)?
AS advised system capacity and access are increasing, though limitations remain (e.g. cross-border and anonymised data). Triangulation with external intelligence (including Llais) will be developed through integrated quality reporting, this is currently at an early stage.

Does the self-assessment provide a whole-system view, including primary care, commissioned services and partners?
The current position largely reflects internal services. Primary care data is reported separately but is being aligned; commissioned services and partner contributions are not yet fully reflected and require further development and confirmation.

How will assurance and a comprehensive patient experience view be strengthened across commissioned services?
Assurance will be progressed through commissioning arrangements, including use of self-assessments from other providers and further work with English partners. Integration of additional data sources is planned to provide a more complete system-wide view.

What was the original reason for escalating the Civica issue and has it been addressed?

The escalation related primarily to a lack of capacity to implement Civica. This has been addressed through investment in staffing, and the original issue is now considered actioned.

The Committee observed that whilst progress had been made on capacity and structures, assurance on system effectiveness and impact remains a developing matter, with ongoing concerns about functionality and maturity. Civica would remain within routine committee business, with regular updates on effectiveness and impact requested, and the ability to re-escalate through established governance mechanisms if concerns arose.

The Committee:

- **RECEIVED** the report and took **ASSURANCE** that People's Experience is appropriately monitored and reported and that continued actions are in place to further develop People's Experience implementation, monitoring, and reporting.
- **APPROVED** the recommendation to de-escalate CIVICA from Board within Patient Experience, Quality and Safety Committee.

5.ITEMS FOR ASSURANCE

5.1 INTEGRATED QUALITY REPORT (PEQS/26/09)

PH advised that the Integrated Quality Report had been refreshed following Audit Wales recommendations, with a stronger focus on data triangulation, thematic analysis, and action planning. This first iteration provided assurance and highlighted key issues, while inviting ongoing feedback, with further work planned to strengthen analysis and develop actions in future reports. AS provided an overview of the report.

Independent Members welcomed the refreshed report observing a more thoughtful analysis with an aim to further improve the report. A move to dashboard reporting would further strengthen the current narrative focussed style, along with a greater focus on commissioned services.

Independent Members asked the following questions for assurance:
Why are a significant proportion of incidents not fully harm graded, and when will this be resolved?
AS advised, this related to the Datix system and internal processes. Harm grading is completed at initial entry but was not always updated at the conclusion of investigations. Improvements are underway, with incremental progress expected monthly and more noticeable improvement anticipated by the next quarterly report. This has been prioritised for resolution.

How will dashboard reporting be developed and what will it include?
AS advised that further work was required to determine the key metrics and focus areas. National guidance had recently been published to support metric development, which will inform local implementation.

Independent Members requested that the purpose and role of patient stories as a mechanism for capturing lived experience at Board and this Committee be discussed at Board Development.
Action: Executive Director of Nursing, Quality, Women and Family Health

The Committee:

- **NOTED** the introduction of a revised Integrated Quality Report structure and provide feedback to support further refinement and development over the coming period.
- **RECEIVED** the report and took **ASSURANCE** that Quality and Safety is appropriately monitored and reported and that continued actions are in place to further develop quality and safety monitoring and reporting.

5.2 NATIONAL ASSURANCE ASSESSMENT OF MATERNITY AND NEONATAL SERVICES IN WALES (PEQS/26/10)

PH introduced the report and AS drew attention to the following areas:

- The assessment confirmed that Powys Maternity Services are operating without immediate safety concerns.
- A structured Improvement Programme is in place, focusing on key domains including safety, escalation (including commissioning), and clinical governance.
- Further strengthening of escalation processes is required, particularly with cross-border partners in England.
- Ongoing development of clinical governance dashboards and alignment with national work, avoiding duplication through shared approaches across Wales is taking place.
- Progress is underway to improve workforce capability, including safe integration of newly qualified midwives.
- There have been significant achievements in data and digital systems (notably BadgerNet implementation) which is supported by multi-team collaboration.
- There has been a focus on strengthening care pathway assurance, particularly managing risks at service interfaces between organisations.
- There is a recognition of the complexity of the Powys midwifery model, with cross-boundary pathways presenting inherent risks.
- Work is in progress to improve consistency, coordination, and cultural capability within maternity services.

Independent Members asked the following questions for assurance:
What issues led to the strengthening of escalation arrangements, and how are escalation processes being improved?
Observations identified that the maternity manager on-call arrangements were not as robust as they could be, primarily due to variability in practice and the absence of a clear, standardised step-by-step process. The escalation policy required further development, and the rota included more junior roles than is typical in comparable services. Processes have been standardised through the introduction of clear operating procedures, revision of escalation tiers to include more senior oversight, and strengthened communication and contingency planning. In addition, improvements to data capture and incident reporting are being implemented to enhance oversight, learning, and staff confidence. These actions were undertaken as proactive improvements rather than in response to identified harm.

How are cross-border governance arrangements working, and what improvements are being made?

Cross-border relationships were described as positive, with established networks and strong engagement from partner organisations. However, opportunities for improvement were identified in the consistency and standardisation of information shared. Work is underway to strengthen governance arrangements by agreeing more consistent reporting requirements, enabling better comparability of data, improving the identification of safety indicators and early warning signals, and supporting more effective oversight across partner organisations.

What assurance is available regarding the experience, safety and quality of care for Powys women receiving services outside the Health Board, and when will a complete picture be available?
AS acknowledged a gap in assurance, however, cross-border arrangements (particularly with England) provide some quality information. National work in Wales is ongoing to strengthen data and assurance systems, with local mechanisms in place for intelligence sharing and contract levers available. Further development of standardised cross-border processes is underway, with a fully mature assurance position anticipated in approximately 12 months.

PH added that maternity services provide strong commissioning practices that can be applied more widely, with work underway to strengthen integrated commissioning, improve engagement, and secure better data to support assurance on care quality and safety.

What assurance can be provided on support for inexperienced midwives to build competence and confidence despite limited opportunities for experience?
AS advised that robust preceptorship, supervision and workforce planning arrangements were in place, including pairing with experienced staff. It was acknowledged that there is constrained exposure to some skills but a cautious approach to workforce mix, meant that services remained safe and effective while competencies were developed.

The Committee:

- **RECEIVED** the All-Wales Maternity and Neonatal Assurance Assessment (February 2026) and the Health Board's response, confirming maternity services are safe and effective, with a structured improvement plan in place.
- Took **ASSURANCE** that a relevant Action Plan (Appendix 1) in place, including priority areas for improvement, progress to date, delivery timelines, and alignment with national expectations.

5.3 BOARD OUT AND ABOUT PROGRAMME (PEQS/26/11)

This item was deferred due to time pressures.

5.4 ANNUAL CLINICAL AUDIT PROGRAMME 2026/27 (PEQS/26/12)

KW presented the report noting that the clinical audit plan continued to be strengthened, focusing on areas of concern, incident learning, key actions, and evaluation of new services. Service groups provided annual plans, which remained lengthy despite efforts to streamline them. Some elements were identified as potentially more suitable for future dashboards, although they currently required inclusion within the plan, which remained under ongoing review.

Independent Members asked the following questions for assurance:

Does the organisation have sufficient capacity to complete the programme, particularly given there are a number of nationally driven reviews?
KW advised that the national audit plans tend to be relatively stable year-on-year. These are reviewed annually, with initial scrutiny undertaken by the Quality Improvement Manager, noting that not all audits are applicable to Powys and many are filtered out as not relevant.

Is the organisation consistent and effective at stopping repeat audits where the risk is low and learning has been demonstrated?
KW confirmed that this challenge had been raised with service groups. While many audits remained in place, the position was that continued scrutiny was necessary to ensure resources were being used appropriately and to test whether repeat audits were still justified.

How are audit outcomes fed into the Board and sub-committee structure, and how is learning shared across audits?
HB advised that clinical audit reports were rarely presented in full to committees; instead, learning was embedded operationally within service and improvement plans. Assurance was provided through forward plans and consolidated summary reports outlining key themes and learning, rather than individual audit reports.

Is there sufficient assurance that clinical audit coverage is appropriate across service areas, and that there is capacity to support and develop effective audit activity?
KW advised assurance was provided through Director-led ownership of audit plans, with organisational oversight to identify gaps. While no dedicated central resource existed, capacity and support were available through senior clinical leadership and the Quality Improvement function.

CM added Clinical Directors collectively reviewed and contributed to audit plans, using intelligence from complaints and incidents to shape activity. Each Director took ownership of approval within their service area, with coordination provided centrally, reflecting a shared, team-based approach.

The Committee **APPROVED** the 2026-27 Clinical Audit Programme.

5.5 MONITORING REPORT OF MENTAL HEALTH SERVICE POST ESCALATION (PEQS/26/13)

This item was deferred due to time pressures.

5.6 QUALITY STATEMENT INFECTION PREVENTION AND CONTROL (IPC) (PEQS/26/14)

GT joined 12.02

PH introduced the report and GT drew attention to the following areas:

- Mapping against the 52 IPC quality attributes confirmed a strong organisational baseline, with clear strengths, risks and improvement actions identified.
- Assurance was provided through recent audits (2024–2025) and a two-year improvement plan aligned to Welsh Government standards.
- Key strengths included robust governance, effective surveillance (38% reduction in C. diff), established operational groups, a comprehensive audit programme, and high training compliance.

- Reporting arrangements have been strengthened to improve board-to-ward assurance.
- Ongoing work includes national collaboration, including embedding patient experience in IPC.
- Overall, the Health Board is well aligned with the Welsh Government IPC quality statement, supported by a structured improvement programme.

Independent Members asked the following questions for assurance:
How is the organisation engaging with primary care to ensure confidence in IPC, particularly regarding equipment and arrangements?
GT advised work was ongoing with primary care as part of an improvement project, including engagement with GP virtual ward rounds to embed IPC. A primary care lead was in place, links with GP practices were strengthening, practices were increasingly seeking advice on decontamination and IPC, and work with the commissioning team was underway to strengthen processes.

What arrangements are in place to ensure resilience and succession planning within the IPC function?
GT confirmed a strong and robust team was in place, including an antimicrobial stewardship pharmacist as part of the improvement plan. The team was well connected across the Health Board, supporting resilience and sustainability.

The Committee:

1. **NOTED** the Welsh Government IPC Quality Statement, its expectations for NHS organisations and the key findings of the Health Boards initial analysis
2. **NOTED** the strengthened governance and reporting structure, whereby operational groups provide assurance reporting into the IPC Quality domains of Safe, Effective, Timely, Workforce, Quality and Experience.
3. Took **ASSURANCE** of the Health Boards compliance with the required standards **NOTING** the planned next steps including further data analysis.

GT left 12.12
MB joined 12.12

5.7 PUBLIC HEALTH WALES TEST AND POST SEXUAL HEALTH SERVICE INCIDENT (PEQS/26/15)

MB advised that the Public Health Wales had identified issues within the Test and Post Sexual Health Service which were being dealt with by the organisation as an enhanced incident. A report is included in the Patient Experience, Quality and Safety In-Committee meeting.

5.6 COMMITTEE RISK REGISTER (PEQS/26/16)

HB presented the report noting a review of strategic risks was underway following approval of the Board supported Annual Plan and therefore future iterations of the register may change.

Independent Members asked the following questions for assurance:
Should escalated issues held at Directorate level be included on the corporate risk register?
HB was confirmed that escalated issues would sit on the organisational (corporate) risk register. Further work is underway, informed by Audit Wales feedback, to clarify whether risks reported to committees should be strategic, operational, or both, as part of the updated Risk Management Framework.

The Committee

- **RECEIVED** the corporate risks within the committee's remit;
- **DISCUSSED** any relevant issues; and
- took **ASSURANCE** that risks are being managed in line with the Risk Management Framework.

6. ITEMS FOR DISCUSSION

There were no items for discussion

7. CONSENT AGENDA (PEQS/26/17)

The below reports were taken under the Consent Agenda and recommendations supported:

- **FOR INFORMATION:** Internal Audit Reports on:
  - Clinical Supervision (Reasonable Assurance)
  - Deprivation of Liberty Standards follow-up audit (all actions implemented)
- **FOR ASSURANCE:** Joint Commissioning Committee highlight report from the Quality, Safety and Outcomes Sub-Committee 15 December 2025

8. OTHER MATTERS

8.1 ANY OTHER URGENT BUSINESS (PEQS/26/18)

There were no items of any other business.

8.2 ITEMS TO BE BROUGHT TO THE ATTENTION OF THE BOARD AND/OR OTHER COMMITTEES (PEQS/26/19)

It was noted that the Chair would provide updates on those items escalated to Board, together with the actions taken to address the backlog in incident closure.

In particular, Board would be advised that the Civica matter would now be de-escalated from Board and monitored as business as usual.

8.3 COMMITTEE REFLECTION (PEQS/26/20)

The following summary of business and reflections were provided by members:

- RBW noted it had been a full agenda and challenging to balance sufficient time for discussion
- SW commended the Chair for handling the demanding agenda and recognising the flexibility of deferring items where necessary
- JOA praised the quality of papers and reflected that whilst assurance had been provided there had been lesser time to scrutinise any underlying implications. (HB confirmed a scrutiny and assurance training session was scheduled for Board Development in May)
- MG highlighted effective chairing, flexibility and an improved balance between succinct officer presentations enabling more time for discussion, which had worked better than in previous meetings.

8.4 DATE OF NEXT MEETING (PEQS/26/21)

The date of the next meeting is scheduled on 04 August 2026 via Microsoft Teams.

Meeting closed 12.20.

8.5. CONFIDENTIAL MATTERS

The following motion was passed:

"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"