

Patient, Quality, Safety Outcomes Committee

Wed 01 October 2025, 09:30 - 13:30

Microsoft Teams



Agenda

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Oral Chair

1.2. Apologies for Absence

Oral Chair

1.3. Declarations of Interest

Oral Chair

1.4. Draft Minutes of the last Meeting held on Tuesday 3rd June 2025

Attached Chair

PQSOC 20251001 1.4 PQSOC 20250603 Draft Minutes.pdf (13 pages)

1.5. Committee Action Log

Attached Chair

PQSOC 20251001 1.5 Committee Action Log.pdf (1 pages)

2. ITEMS FOR DISCUSSION

2.1. Quality Outcomes Reporting

Attached Director of Nursing

PQSOC 20251001 2.1 Quality Outcomes Interim Report - Oct 2025 .pdf (6 pages)

PQSOC 20251001 2.1 Quality Outcomes Report - Appendix 1 Quality Performance Interim Report.pdf (108 pages)

2.2. Quality Annual Report 2024/25

Attached Director of Nursing

PQSOC 20251001 2.2 Annual Quality Report .pdf (5 pages)

PQSOC 20251001 2.2 Quality Annual Report - Appendix 1 .pdf (56 pages)

2.3. Quality Management Group Reporting

Attached Director of Nursing

PQSOC 20251001 2.3 Quality Management Group Report .pdf (3 pages)

2.4. Primary Care Quality Report

Attached Chief Operating Officer

PQSOC 20251001 2.4 Primary Care Quality Report .pdf (5 pages)

-  PQSOC 20251001 2.4 Primary Care Quality Report - Appendix 1.a GDS Contract Reform Variation Offer.pdf (8 pages)
-  PQSOC 20251001 2.4 Primary Care Quality Report -Appendix 1 ANNUAL QUALITY REPORT .pdf (75 pages)

2.5. Putting Things Right Annual Report 2024/25

Attached *Director of Nursing*

-  PQSOC 20251001 2.5 Putting Things Right Annual Report 2024-25 .pdf (10 pages)
-  PQSOC 20251001 2.5 Putting Things Right Annual Report 2024-25 - Appendix 1.pdf (36 pages)

2.6. Safeguarding Annual Report

Attached *Director of Nursing*

-  PQSOC 20251001 2.6 Safeguarding Annual Report 2024-25 .pdf (11 pages)
-  PQSOC 20251001 2.6 Safeguarding Annual Report 24-25 - Appendix 1 .pdf (22 pages)

2.7. Nurse Staffing Levels (Wales) Act 2016: Spring 2025 Recalculations

Attached *Director of Nursing*

-  PQSOC 20251001 2.7 Nurse Staffing Levels (Wales) Act 2016 Spring 2025 Recalculations.pdf (8 pages)

2.8. Health and Safety Compliance Annual Report

Attached *Director of Allied Health Professions & Health Science*

-  PQSOC 20251001 2.8 Health Safety Fire Annual Report 2024-25 .pdf (5 pages)
-  PQSOC 20251001 2.8 Health Safety and Fire Annual Report 2024-25 - Appendix A.pdf (40 pages)

2.9. Learning from Death Report

Attached *Medical Director*

-  PQSOC 20251001 2.9 Learning from Death report.pdf (7 pages)
-  PQSOC 20251001 2.9 Learning from Death Report - Appendix 1.pdf (64 pages)

2.10. Committee Risk Report

Attached *Director of Corporate Governance*

-  PQSOC 20251001 2.10 Committee Risk and Assurance Report.pdf (5 pages)
-  PQSOC 20251001 2.10 Committee Risk and Assurance Report - Appendix A Strategic Risk Dashboard.pdf (45 pages)

3. FOR INFORMATION

3.1. Review of Committee Programme of Business 2025/26

Attached *Director of Corporate Governance*

-  PQSOC 20251001 3.1 Review of Committee Forward Work Plan 2025-26.pdf (3 pages)
-  PQSOC 20251001 3.1 Forward Work Plan 2025-2026 - Appendix 1.pdf (7 pages)

4. OTHER MATTERS

4.1. Items to be Brought to the Attention of the Board and Other Committees

Oral *Chair*

4.2. Any Other Urgent Business

Oral *Chair*

4.3. Date of the Next Meeting: 2nd December 2025



**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	Tuesday 3 rd June 2025, 09:30am-12:30pm
VENUE	Microsoft Teams

PRESENT	Helen Sweetland, Independent Member, Committee Chair Penny Jones, Independent Member, Committee Vice Chair Paul Deneen, Independent Member Philip Robson, ABUHB Vice Chair
IN ATTENDANCE	Jennifer Winslade, Director of Nursing James Calvert, Medical Director Peter Carr, Director of Allied Health Professions & Health Science Leanne Watkins, Chief Operating Officer Rani Dash, Director of Corporate Governance Leeanne Lewis, Assistant Director of Quality & Patient Safety Arvind Kumar, Interim Divisional Director (Clinical Support Services) Tracey Partridge-Wilson, Deputy Director of Nursing Karen Hatch, Assistant Director of Therapies and Health Science Naomi Murtagh, Board Business Manager Moiria Bevan, Head of Service Infection Prevention and Control Nurse Collette Kiernan, Clinical Director of Therapy Services Ann-Marie Matthews, Lead for Clinical Commissioning Thomas Jaynes, Committee Secretariat Gavin Thomas, Committee Secretariat
OBSVERING	Rhian Gard, NWSSP - Audit and Assurance Services Sara Utley, Audit Wales
APOLOGIES	None

PQSOC 0306/01	Welcome and Introductions The Chair welcomed everyone to the meeting.
PQSOC 0306/02	Apologies for Absence The Chair confirmed that there were no apologies for absence.

PQSOC 0306/03	Declarations of Interest There were no declarations of interest raised relating to items on the agenda.
PQSOC 0306/04	Minutes of the previous meeting The minutes of the Patient Quality, Safety and Outcomes Committee held on 31st March 2025 were agreed as a true and accurate record of the meeting. The Committee APPROVED the draft minutes.
PQSOC 0306/05	Committee Action Log The Committee received the action log and was content with progress made in relation to completed actions and against any outstanding actions. The Committee APPROVED the action log.
PQSOC 0306/06	Quality Management Framework Jennifer Winslade (JW), Director of Nursing, presented the report for approval and discussion. It was highlighted that, in line with the Duty of Quality in Wales, there had been a strategic shift towards the development of Quality Systems. The framework was intended to provide assurance regarding the overall Quality Management System. JW advised the Committee that the framework was strategically aligned with the following key national and organisational priorities: • The Health and Social Care (Quality and Engagement) (Wales) Act 2020, including the Duty of Quality and Duty of Candour; • The Health and Care Quality Standards 2023, underpinned by the principles of Safe, Effective, Patient-Centred, Timely, Efficient, and Equitable care; and • The ABUHB Quality Strategy 2023–2026, which sets out the Health Board’s vision for quality improvement. It was noted that the framework would be in place for a three-year period (2025–2028) and would inform the development of the Quality Annual Report to Welsh Government. The Committee noted that the framework was embedded within the Health Board’s overarching Quality Strategy. JW further highlighted that the framework integrated national guidance, including from Improvement Cymru and

Healthcare Inspectorate Wales, and supports the Quadruple Aim through a structured approach encompassing Quality Planning, Control, Improvement, and Assurance. The Committee noted that the framework had received executive oversight, and had been discussed with clinicians and managers.

The Committee noted the Quality Management system principles and noted that the framework would improve quality management and quality outcomes in accordance with the Health and Quality Standards 2023. JW advised that a Clinical Advisory Forum was in place with input from clinical professionals across the Health Board which provided Quality Impact Assessments, as a clinical viewpoint to advise Executives on any proposed changes, which feed into the planning of quality management. The Committee noted that this also provided leadership with a focus on quality, that is embedded throughout the Health Board.

The Committee was advised that there were Quality Control principles embedded across the Health Board connected to daily operational management, to ensure quality and patient safety was monitored in real time. The Committee noted the Health Board's six pillars of quality had been reviewed and that a revised Quality Outcome Framework would come to the Committee for approval for Q2, after testing on Q1 data. It was noted that a new governance framework was being developed on how people report, what and when they report things / incidents.

Rani Dash (RD), Director of Corporate Governance, outlined the three lines of defence model of organisational system assurance which underpinned the risk and assurance framework as part of the assurance framework. The Committee noted this approach was being worked on and would be embedded throughout the Health Board.

Peter Carr (PC), Director of Allied Health Professionals and Health Science, informed the Committee of the work being done by the Health and Safety Committee to strengthen and improve its activities. The Human Tissue Authority, Medical Devices, and Radiation Protection Group were all governed by regulation and their compliance with quality was very important.

The Committee noted all groups in the new framework were reviewing their purpose and their Terms of Reference. The names would be changed from Committees to Groups.

The new Quality Management Group (QMG), would be led by executives and will deal with operational matters. The QMG will receive input from the groups (within each pillar) in the Quality Assurance Framework and the QPS Divisional assurance meetings. The QMG will report to the Executive team.

The Committee was advised that high level reports covering the groups within the pillars, clinical learning and improvement forum, clinical advisory forum and the divisional QPS meetings would now come to PQSO from the QMG for assurance. The Committee noted the new reporting arrangements.

JW reported that reporting arrangements had also been reviewed. A quarterly narrative report will go to Board. Quality metrics would be embedded in an integrated performance report for Board. PQSO will receive a revised QOF and an exception report from QMG.

Helen Sweetland (HS), Chair, welcomed the review and the changes to the new format and structure of reporting and responded to Audit Wales recommendations. HS thanked the team for all the work that had been undertaken.

Paul Deneen (PD), Independent Member, queried how this would link into commissioning of external services and how it would ensure quality standards and reporting were the same as those within services directly provided by the Health Board. The Committee was advised that reporting of commissioning for quality would be monitored through the respective divisions and the Quality Management Group in-line with the Commissioning for Quality Framework.

PD asked how the team would ensure that staff understand these new arrangements and JW explained that this will be done via the Divisional QPS leads.

The Patient Quality Safety and Outcomes Committee **ENDORSED** the implementation of the Quality Management System Framework.

PQSOC 0306/07

Quality Performance and Outcomes Report

Jennifer Winslade (JW), Director of Nursing, introduced the report for assurance and updated the Committee on the work of the QPS team. The Committee noted the team had restructured and operational patient safety resources had been transferred centrally. The Committee was advised that

the QPS team was fully recruited and a revised QOF would be reported to the Committee.

Leeanne Lewis (LL), Assistant Director of Quality & Patient Safety, updated the Committee on the progress of Sepsis work and the Committee was advised that regular updates on sepsis would be included in the Quality Performance report. LL noted work was ongoing for a systematic approach to identify sepsis and the management of patients, by ensuring the use of NICE guidance and the Academy of Medical Royal Colleges guidance.

LL provided an update on a Welsh Health Circular on new early warning scores (NEWS) and standardised scoring systems with an implementation date of December 2025. The Committee was advised that the Health Board was responding via a number of working groups to standardise the audit framework and training for staff. An implementation plan had been developed by the Health Board.

Helen Sweetland (HS), Chair, queried how progress would be reported to ensure the efforts and education programmes were working. The Committee was informed that the sepsis campaign was much wider than previous Sepsis campaigns as this includes engagement with the General Public. It was noted that reporting was being worked through and research was taking place in the Public Health team, based on qualitative research with the public to ensure the Health Board gets further information which provided themes for learning.

James Calvert (JC), Medical Director, highlighted the amount of work that had gone into this programme and thanked Matthew Kevadas, Nursing Lead for sepsis, for his exceptional work.

Paul Deneen (JD) asked whether the teams have engaged with General Practice and Llais about the Sepsis campaigns. LL explained that there have been meetings with Neighbourhood Care Networks and a meeting is planned with Llais.

JW updated the Committee regarding the two divisions that were in escalated measures for quality and informed the Committee of the ongoing work regarding the flow in Urgent and Emergency Care and 'Safe to start' to ensure site safety.

Peter Carr (PC), Director of Allied Health Professionals and Health Science, provided an update to the Committee

regarding the Nutrition and Hydration Group. This update was in response to recent incidents and focused on task-oriented actions to ensure that nutrition and hydration are consistently delivered on wards. The approach emphasised improved risk assessments, early identification of patients' nutrition and hydration needs, and timely escalation where necessary.

The Committee noted an increase in the number of inquests due the work of Assistant Coroners and the impact of this the work on clinical staff, who have to write reports.

Paul Deneen (PD), Independent Member, queried the ongoing delays in the issuing of death certificates. JC explained that the median number of days in Wales was 7 days for completion of a death certificate but could be up to 25 days and noted the distress to affected family members. The Committee noted the process was more complex in Wales than England as Medical Examiners who review all deaths are independent from HBs in Wales and this can delay the issuing of death certificates. The Committee was assured work was ongoing to monitor the situation and improve death certification delays. The committee was also informed of the work of the Care After Death team in ABUHB who support relatives. Their work is being reviewed currently to ensure it is staffed appropriately.

Phil Robson (PR), ABUHB Vice Chair, queried Patient Safety Incidents and how these were triggered. The Committee noted these were usually triggered by staff but if a patient complains this could be triggered by the Health Board on the account provided by the patient via DATIX.

Phil Robson asked how the team ensure that policies such as those related to nutrition and hydration for example are followed on the wards. JW explained that there is ward documentation that should be completed for each patient, which include risk assessments for many areas. The ward manager is accountable for ensuring the ward team appropriately complete these documents

The Committee was **ASSURED** by the ongoing work to deliver the Duty of Quality and Duty of Candour, through implementing the Quality Strategy, Patient Experience & Involvement Strategy and the Quality Improvement Strategy.

	Jennifer Winslade (JW), Director of Nursing, introduced the report for discussion and noted that the Committee had previously approved the approach for the commissioning the assurance framework for quality. The Committee was advised that a working group had been set up and had mapped all of the services the Health Board commissioned. Preliminary findings showed that there were inconsistencies in contract documentation, monitoring mechanisms and escalation procedures. This work was ongoing from a financial, planning and quality perspective. The Committee noted the working group would undertake a pilot and prioritise work on cancer services due to established quality data systems in place, with Velindre NHS Trust. The Committee noted the working group would now be formalised and the Committee was advised that the group would also look at how contracts ensure quality is embedded and how data was pulled on commissioned services. The Committee ACKNOWLEDGED the progress achieved in this workstream to date and endorsed the proposed direction for further development, with a focus on enhancing quality in commissioned services.
PQSOC 0306/09	Infection Prevention and Control & Cleaning Standards Annual Report 2024/25 Moira Bevan (MB), Head of Service for Infection Prevention and Control, introduced the annual report for information. MB highlighted the report had been written by divisions in conjunction with the Infection, Prevention and Control team. The Committee noted a number of awards won by the IPC team. The Committee noted Welsh Government Expectation Reduction targets had been missed apart from one exception. The Committee was informed that this was consistent across Welsh Health Boards. MB outlined actions that had been undertaken to improve infection, prevention and control which included; bespoke training for staff; enhanced cleaning regimes; task and finish groups had been set up on certain types of infections and QI projects on oral hygiene; intranet page had been refreshed as well as new communications for staff and public.

The Committee noted a significant increase in community acquired patients presenting to secondary care which had increased pressure on the Health Board and performance.

The Committee noted an increase in Clostridium Difficile (C.Diff) infection but was assured that the testing of 643 samples had identified 5 clusters which suggests onward transmission in only 9 cases. The Committee noted onward transmission was not spread across all sites.

The Committee noted pressures caused in the Winter by influenza, covid and RSV, but point of care testing (POC) had enabled timely and appropriate placement of patients.

The Committee noted a business case had not yet been developed for the IP&C team as funding had been secured for RIF until March 2027, but this is a potential risk.

Penny Jones (PJ), Independent Member, noted that in the enhanced cleaning paper there was slippage in delivery due to capacity constraints and whether this had been overcome. PJ also asked about non-compliance with Welsh technical memorandum for oral / dental equipment cleaning.

The Committee noted the slippages in the enhanced cleaning programme and that these had not been implemented in YYF and GUH but a new paper had been written to achieve the enhanced cleaning across Health Board sites. The Committee was assured C.Diff had reduced in YYF regardless. The Committee was advised that it has been decided that Ultra Violet light cleaning was going to be implemented rather than Hydrogen Peroxide, which were quicker. The Committee noted a service review for primary care dentists was taking place and there were funding for cleaning of oral stations.

Paul Deneen (PD), Independent Member, queried what was being done to engage with visitors and the general public regarding infectious illnesses. The Committee noted leaflets were provided to hospital visitors to raise awareness of hygiene and infection control.

JC reassured the committee that Health Protection Wales and Public Health teams provide regular updates on unusual infectious diseases and were working on important messaging to the general public regarding disease prevention.

The Committee **NOTED** the Infection Prevention & Control Annual Report 2024-25 and Strategic Plan for 2025/26.

PQSOC 3103/10	Volunteering Annual Report 2024/25 Tanya Strange (TS), Head of Nursing, introduced the report and noted that volunteering across the Health Board continued to grow in scale, impact, and strategic importance. The Committee noted volunteering hours had doubled since the last annual report and five new volunteer roles (experts by experience) had been created. The Committee was informed that volunteers spoke a wide range of languages (40 in total) and twenty volunteers had subsequently become paid employees. The Committee noted the plan for 2025 to try and recruit volunteers who are deaf, LGBTQIA+, neurodiverse and veterans. The Committee noted work had increased with partners across Gwent and working relationships remained strong. The Committee noted challenges of a high case load of volunteers against 3.2wte in the department. The Committee noted 70 volunteers were in recruitment and 500 people, mainly in community, were awaiting to become a volunteer. The Committee was advised that a Charitable Funds bid had been written to request funding for a volunteer coordinator role. Paul Deneen (PD), Independent Member, welcomed volunteer awards as part of the Health Board's Staff awards. The Committee NOTED the Volunteering Annual Report 2024/25; ACKNOWLEDGED the growing scope, diversity, and impact of volunteer activity; NOTED the risks to service sustainability and SUPPORTED the ongoing development of the volunteering programme.
PQSOC 0306/11	Mortuary Incident Action Plan Leanne Watkins (LW), Chief Operating Officer, introduced the report for assurance and noted the report provided formal update on the Pathology Directorate's progress on the transformational agenda, to enhance the safety and efficiency of the mortuary and Care after Death (CAD) services and the vision and objectives for the future of the mortuary and Care after Death services. LW noted the Health Board was highly regulated by the Human Tissues Authority and the service had strict policies and procedures.

	The Committee noted the work ongoing to review the work of the Care after Death (CAD) team; plan to implement a new software system which would track deceased patients rather than it being paper based and WG had requested an independent external review to be undertaken of the division's transformation plans. Arvind Kumar (AK), Interim Divisional Director (Clinical Support Services), assured the Committee that the department was working to achieve internal quality improvement accreditation. The Committee welcomed the action plan and commended the response of the division and thanked all those who have been and are still involved with the transformation programme. Update on the Mortuary Incident action plan to come to the Committee in 6 months Action: Chief Operating Officer The Committee RECEIVED assurance from the report.
PQSOC 0306/12	Clinical Audit: Annual Report on Clinical Audit Activity 2024/25 and Clinical Audit Plan 2025/26 Leeanne Lewis (LL), Assistant Director for Quality & Patient Safety, presented the report for assurance. She highlighted that clinical audit serves as a key tool for evaluating the safety and effectiveness of clinical services. It provides assurance of compliance with clinical standards and helps identify and reduce risks, waste, and variations from guideline-defined care. The Committee was assured that audit findings are actively used to inform and prioritise areas for improvement, with the overarching goal of enhancing patient outcomes. It was noted that there had been considerable work done on reporting mechanisms and the clinical governance of audits by The Clinical Standards and Effectiveness Group (CSEG) and the regular reports to ARA and PQSO Committees. The Committee was informed that there was a framework around the reporting and some of the achievements were outlined to the Committee. The Committee noted the challenges and the impact on audit at times of significant clinical demand; a lack of substantial funding for AMAT and non-participation in some National Audits which have mainly been English only Audits. The Committee was assured these were small audits. The forward work plan was outlined to the Committee.

	The Committee noted the significant progress that had been made on clinical audit activities and the clinical audit plan over the last few years. Rani Dash (RD) highlighted that ARAC still expects there to be a Corporate Local Clinical Audit Plan based on areas of risk that feed into the assurance process. JC advised that a business case would probably be required for additional staffing to be able to support the monitoring of local audits. RD acknowledged that local audits are being done but there is a responsibility for central reporting so there is corporate assurance. JC suggested that there is a hierarchy. All divisions have to complete national audits and will be asked to develop a local audit plan which fits around issues raised through their monitoring of complaints/incidents /risks. The third group of audits will arise from ad-hoc events. JW added that the local audits will then be reported at the divisional QPS meetings. Update on development of local audit plans and funding arrangements in 6 months. Action: Assistant Director for Quality & Patient Safety/ Medical Director The Committee AGREED to the Clinical Audit Plan for 2025-2026 and RECEIVED assurance from the Audit Activity Report for 2024-2025 that the Health Board was meeting its obligation to undertake clinical audit.
PQSOC 0306/13	Committee Risk Report Rani Dash (RD), Director of Corporate Governance, provided the Committee with an overview of the Committee Risk Register for which the Board had delegated responsibility to the Committee. The Committee was advised that the Committee Risk Register included three high-level risks and three sub-risks, covering service delivery, transformation and partnership working, and compliance and safety. The risk environment had remained stable, and there were no changes to the risk scores for the monitored risks. The Committee NOTED the delegated strategic risks and NOTED the work being undertaken to ensure the Committee is sighted on all risks that have the potential to impact patient quality and safety.
PQSOC 0306/14	Development of Committee Annual Programme of Business 2025/26

	Rani Dash (RD), Director of Corporate Governance, updated the Committee on the Committee's Annual Programme of Business and noted it now included regular updates from the Quality Management Group and Quality Outcomes report. RD advised that some annual reports had been removed as assurance will now be provided via the routine Quality Management Group reports. The Committee APPROVED the proposed Committee workplan for 2025/26 and NOTED that it will be brought forward to each future Committee meeting for oversight.
PQSOC 0306/15	NHS Wales Joint Commissioning Committee's Quality Report NHS Wales Joint Commissioning Committee's Quality Report was provided to the Committee for information.
PQSOC 0306/16	Listening & Learning Forum Assurance Report Listening & Learning Forum Assurance Report was provided to the Committee for information.
PQSOC 0306/17	Clinical Advisory Group Assurance Report Clinical Advisory Group Assurance Report was provided to the Committee for information.
PQSOC 0306/18	Committee Annual Report 2024/25 Committee Annual Report 2024/25 was provided to the Committee for information.
PQSOC 0306/19	To confirm any key risks and issues for reporting/escalation to Board and/or other Committees There were no key risks or issues for reporting or escalation to the Board or other Committees.
PQSOC 0306/20	Any Other Urgent Business There was no urgent business.
PQSOC 0306/21	Date of the Next Meeting: 29th July 2025

DRAFT

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		No current outstanding actions.			

All actions in this log are currently active and are either part of the Committee's forward work programme or require more immediate attention, such as an update on the action or confirmation that the item scheduled for the next Committee meeting will be ready.

Once the Committee is assured that an action is complete, it will be removed. This will be agreed at each Committee meeting.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	01 October 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Quality Performance – Interim Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis – Assistant Director for Quality and Patient Safety Tracey Partridge-Wilson - Deputy Director of Nursing

**Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

As an NHS Wales organisation, there are clear expectations set out for the quality standards we must maintain. These are set out through the:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020;
- A Healthier Wales;

The Health Board is continuing to develop our Quality Management System to routinely set meaningful targets, monitor, measure and report performance. This ensures we provide excellent standards of care and set quality goals to continuously improve the services we provide.

Cefndir / Background

Following the launch of the Quality Strategy, Patient Experience & Involvement Strategy and the Quality Improvement Strategy, we continue to develop and report quality metrics. This has been an iterative process and under constant development. The measures allow the Health Board to report and capture what is important for our patients, their families and the Public.

The is an interim performance report for July 2025, providing an overview of quality and safety metrics, aligned to Ministerial priorities and the Health Board's strategic objectives. The report highlights improvements in patient experience, safety, and clinical effectiveness, while also identifying ongoing risks and areas requiring further action.

The Health Board's Quality Management System Framework 2025–2028 is now final, supporting a structured approach to safe, effective, and equitable care. Governance has been strengthened through the establishment of a Quality Management Group, with oversight via PQSOC and alignment to national directives. Key priorities include: Sepsis and Early Warning Systems (EWS) rollout, nutrition and hydration improvements, enhanced patient and staff feedback mechanisms, and robust incident and complaint management.

Asesiad / Assessment

The Health and Care Quality Standards provide a clear framework to help the planning, delivery and monitoring of healthcare services in Aneurin Bevan University Health Board. These continue to be developed to enable delivery of our services around the six domains of quality and the six quality enablers. These outcomes and indicators collaboratively establish a set of quality indicators that align with the Health Board's priorities and strategic goals. The indicators cover all aspects of care, clinical outcomes, patient safety, patient experience, and efficiency.

Here is a summary of data themes as mapped against the Pillars of quality. These 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains. Providing data across these Pillars of Quality will enable us to review our performance. The pillars are our Quality Markers in our quality management system. Strengthening our quality management system helps us make sure our decision-making focuses on improving the quality of health services.

Pillar 1: Patient and Staff Experience

- Patient and staff feedback is at its highest ever, with most people reporting positive experiences, especially around compassion and support.
- In July 2025, the Health Board received a record 2,556 feedback responses through CIVICA, with an overall satisfaction rate of 87%. The main positives were compassion (297 comments), emotional/physical support (223), and friendliness (215). However, waiting times scored 73 ("red") and remain the top negative theme. Staff engagement is strong, and patient stories continue to highlight the value of compassionate, timely support.
- The main area for improvement is waiting times, which continue to be a concern.
- Staff engagement and learning from patient stories are helping to drive improvements.



Pillar 2: Incident Reporting

- The crude mortality rate for July 2025 was the lowest in four years (3.89 per 1,000 bed days). There were no “Never Events” in July, and the number of open patient safety incidents is falling. 99% of reported falls resulted in no or low harm, and July saw the lowest number of falls since April 2024 (230 incidents). Patient identification errors (e.g., WBIT) remain a risk, but digital solutions are being developed.
- Fewer serious incidents and deaths are being reported, and the number of open safety cases is going down.
- There are still some risks around patient identification and documentation, but new digital solutions and training are being put in place.
- Falls and pressure ulcers are reducing, and most incidents result in little or no harm.

Pillar 3: Complaints, Concerns and Compliments

- 5,896 PALS cases were managed in the year, with only 0.28% escalated to formal complaints. 87% of people were satisfied with complaint handling. Communication issues accounted for 57% of PALS enquiries and 26% of early resolution complaints. Compliance with 30-day response targets has dipped, but overdue cases are being actively managed.
- Complaints are being managed more quickly, with a strong focus on early resolution and open communication.
- Most complaints relate to communication issues.
- The team is working hard to close old cases and improve response times.

Pillar 4: Health, Safety and Security

- Training compliance is improving: Health & Safety (87%), Fire Safety (82%), Violence Prevention (86%), but Manual Handling has dropped slightly to 69%. In July, 8 RIDDOR incidents were reported, with 75% reported within legal timeframes (a decrease from previous months).
- Training in health and safety is improving, and there’s a strong focus on reducing staff injuries and incidents.
- Some delays in reporting incidents to regulators need to be addressed.
- Regular reviews and audits are helping to keep staff and patients safe.

Pillar 5: Infection Prevention and Control

- 77 cases of C. difficile were reported from April–July 2025, but a surgical ward achieved over 130 days without a new case. Staph aureus and E. coli bloodstream infections are closely monitored, with care bundle compliance above 86%. Antimicrobial stewardship is improving, but primary care antibiotic use remains above the all-Wales average.
- Infection rates, especially for C. difficile, are coming down thanks to targeted improvement work.
- There is strong monitoring of infection risks and regular audits.



- Antimicrobial stewardship is improving, but primary care antibiotic use is still higher than average.

Pillar 6: Safeguarding

- Adult Safeguarding Level 3 training compliance is 20%; Children's Level 3 is 35% (target: 85% by March 2028). There's been a significant increase in safeguarding referrals, partly due to better reporting. The domestic abuse service in general practice has been decommissioned, with interim pathways in place.
- Safeguarding processes are robust, but more staff need to complete advanced training.
- There's been an increase in safeguarding referrals, partly due to better awareness and reporting.
- The team is reviewing capacity and processes to keep up with rising demand.

Strengths and Achievements

- **Patient Experience:** CIVICA feedback platform shows record engagement, with 2,556 responses in July and an overall satisfaction score of 87%. Compassion, support, and friendliness are the top positive themes, though waiting times remain a concern.
- **Learning & Improvement:** The Learning and Improvement Forum has driven action on patient identification, nutrition, hydration, and infection control. Notable progress includes a 130+ day period without healthcare-acquired C. difficile on a surgical ward, and improved compliance with fluid balance documentation.
- **Incident Reporting:** Crude mortality rates have declined, with July 2025 the lowest in four years. No "Never Events" were recorded in July. The number of open patient safety incidents is reducing, and overdue Nationally Reportable Incidents (NRIs) have halved.
- **Ward Accreditation:** 16 wards achieved Bronze, and 4 progressed to Silver, with accreditation linked to reductions in reported falls.
- **Sepsis & Deterioration:** National Early Warning Scores (NEWS2, PEWS, NEWTT2) are being implemented to meet the Welsh Health Circular 2024/035 mandate. Sepsis awareness campaigns have reached over two million views.

Risks and Concerns

There are a number of issues, risks and concerns which are discussed in the report and reflect areas requiring improvement in terms of quality outcomes. The report details the analysis, actions and assurance. The areas are summarised below.

- **Mental Health & LD:** Increase in self-harm and restrictive practice incidents, with documentation and staff competency highlighted as improvement areas.
- **Complaints & Safeguarding:** Compliance with 30-day complaint response targets has dipped, partly due to historic case closures and staff absences. Safeguarding Level 3 training compliance remains below target.
- **Infection Control:** Healthcare-associated infections, particularly C. difficile, remain a focus, with ongoing quality improvement and audit cycles.



- This report demonstrates the hard work and commitment from the Health Board to develop the quality strategy and our reporting obligation under the Duty of Quality. The report demonstrates how the Health Board is striving to better understand our systems of care and continues to mature our Quality Management System to enable us to set meaningful targets to monitor, measure and report our performance.

As part of this work, we are continuing to strengthen our governance structures through Ward-to-Board connections that promote cross directorate and multi-professional working. We have initiated work to ensure that the implementation, measurement and monitoring of our strategy is hardwired through our governance and integrated performance reporting.

This report is to provide **ASSURANCE** to the Patient Quality, Safety and Outcomes Committee on the ongoing work to deliver the Duty of Quality and Duty of Candour, through implementing the Quality Strategy, Patient Experience & Involvement Strategy and the Quality Improvement Strategy.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable currently
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 5. Timely Care 6.3 Listening and Learning from Feedback Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item.



Strategic Equality Objectives 2020-24	Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	The Health and Social Care (Quality and Engagement) Wales Act (2020)). Duty of Quality.
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper Choose an item.
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

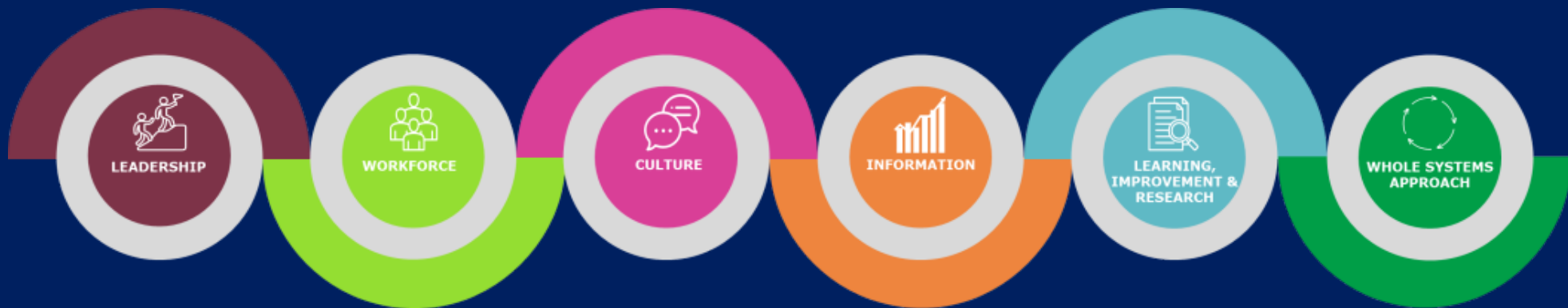




Patient Quality, Safety and Outcomes Committee

July 2025 Data - Interim Performance Report

October 2025





This is an interim Patient, Quality and Safety performance report for July 2025. This provides the Board with an overview of the Health Board’s quality and safety metrics and summary of performance. It is aligned to the Ministerial priorities and key challenges, which are:

QPS updates

Good Practice

Escalated Risks and Concerns

Quality and Safety Pillars

- Patient Experience and Staff Feedback
- Incident reporting
- Complaints and concerns
- Health, Safety and Security
- Infection Prevention and Control
- Safeguarding

Information

Clinical Effectiveness





- Quality Management System Framework 2025–2028 Final outlines the Health Board's structured approach to delivering safe, effective, and equitable care. It promotes continuous improvement and patient-centred services.
- Quality Management group established which reinforces governance oversight via the PQSOC, ensuring strategic alignment with national directives.
- Sepsis & Early Warning Systems (EWS): A comprehensive strategy and rollout improved early recognition and management of deteriorating patients, including the planned switch over to NEWS2.
- Nutrition & Hydration: Governance structures and pilot protocols were introduced to address fluid balance and nutritional needs. Learning has been shared at the Learning and Improvement Forum. See Good Practice for more information.





- CIVICA feedback showed high satisfaction rates. New surveys and reporting tools enhanced visibility of patient voice.
- Data Capture: Refined data capture processes to emphasise insights and actionable outcomes, supported by streamlined dashboards. Roles redefined to support data and performance.
- Dashboards: Dashboards produced, working closely with Divisions and Heads of Service.
- Learning Events: Co-created with individuals who raised concerns.
- Engagement: Regular engagement with Divisional Triumvirate and leads, building stronger networks across the teams.
- Workforce development: Enhanced team-building initiatives with comprehensive induction plans and mentorship programs to align staff with organisational goals.
- Review of OCP through a structured questionnaire - closing date end of June 25.



Patient Quality and Safety Learning and Improvement Forum Highlights

The Patient Quality, Safety Learning and Improvement Forum held on 18th June focused on various aspects of patient experience, safety, and quality improvement within the Aneurin Bevan University Health Board. Some highlights include:

Patient Story: Patient Advice and Liaison Service (PALS)

A recent patient experience shared by a neurodivergent individual, provided valuable insight into the challenges faced by patients with additional needs in the Emergency Department (ED). The powerful video's testimony highlighted several key issues during her visit, including: the absence of a designated quiet space, limited staff awareness and support during episodes of sensory overload and a missed opportunity to involve the Patient Advice and Liaison Service (PALS) at an earlier stage. Posters and communication boards have been introduced, including visual symbols to indicate the availability of quiet spaces and support for patients with additional needs.

Collaboration between PALS and urgent care teams has been strengthened to improve accessibility and responsiveness.

Organisational Learning and Improvement:

- **Patient Identification Issues:** One of the Divisions outlined serious incidents linked to patient misidentification, including wrong blood in tube (WBIT) events. These incidents have resulted in significant clinical risks, such as incorrect blood transfusions, medication errors, and neonatal misidentification. It was noted that the Health Board's Patient Identification Policy has recently been updated. However, discussions revealed recurring issues across clinical areas, including inconsistent patient ID checks, labelling errors, and poor compliance with bedside labelling protocols. These themes appear to be widespread and not isolated to a single department.
- In response, it was agreed that these issues should be collated and escalated to the Quality Management Group for further consideration. Recommendations included reinforcing training and monitoring compliance, as well as exploring digital solutions such as GS1 wristbands and Scan4Safety technologies to reduce manual error. A proposal was also made to establish a task and finish group to address the systemic nature of these challenges and drive sustainable improvements.
- **Body-Worn Cameras Pilot:** A pilot initiative is currently being introduced in the Minor Injuries Unit at the Royal Gwent Hospital and the Emergency Department at The Grange University Hospital to trial the use of body-worn cameras for staff safety.

Patient Quality and Safety Learning and Improvement Forum Highlights

Organisational Learning and Improvement:

Nutrition & Hydration improvements: Two key workstreams are currently underway to enhance nutrition and hydration practices across the Health Board. The first focuses on nutrition escalation, where a 7-minute briefing and an action card have been developed to support the timely identification and response to malnutrition. These tools aim to improve staff awareness and consistency in recognising and acting on nutritional concerns. The second workstream addresses fluid balance, where a pilot ward has demonstrated significant improvements in both documentation and staff awareness. This success has been supported by a combination of audit activity, targeted education, and the introduction of a fluid balance action card. As a result of these efforts, compliance with fluid balance documentation has improved, and the work has contributed valuable evidence in support of a Regulation 28 response. The initiative is now being rolled out more widely across divisions, with ongoing audit and feedback mechanisms in place.

Ward Accreditation Progress: The latest round of ward accreditation has seen strong engagement and encouraging progress. A total of 16 wards achieved Bronze accreditation, with four of these progressing to Silver, reflecting a commitment to continuous improvement and high standards of care. The accreditation process identified some common areas for development, particularly around documentation practices, including care planning and discharge planning, as well as compliance with hand hygiene and uniform policies. These themes will inform targeted support and future training.

C. difficile Reduction Initiative: A focused Quality Improvement (QI) project has been successfully implemented on a surgical ward to reduce healthcare-acquired *Clostridioides difficile* (C. difficile) infections. The initiative was driven by a multidisciplinary approach, with a strong emphasis on environmental improvements, staff education, and fostering a sense of ownership among the team. A task and finish group was established to coordinate efforts, and practical tools such as grab bags and checklists were introduced to support consistent infection prevention practices. These measures have led to a significant outcome—over 130 days without a new case of healthcare-acquired C. difficile on the ward.

Good Practice

Section 1

Nutrition and Hydration Progress Report



Overview:

The Nutrition and Hydration Task & Finish Group was formed under the ABUHB Nutrition and Hydration Strategic Group to address key concerns raised through complaints, Regulation 28 notices, and audit findings. Two priority workstreams were established: Nutrition Escalation and Fluid Balance Monitoring. These were later amalgamated into a single group to streamline efforts and share learning

Nutrition Escalation - Key Drivers:

- Concerns and complaints, including Regulation 28 notices, highlighted inconsistent escalation of nutritional needs.
- Gaps in awareness and timely action for patients with complex needs (e.g. learning disabilities, swallowing difficulties, tube feeding).

Actions Taken:

- Developed a **7-minute briefing** and **Action Card** to support staff in identifying and escalating nutritional concerns.
- Emphasised use of the **WAASP tool** for risk screening within 24 hours of admission or extended ED stay.
- Provided clear guidance for:
 - Patients unable to participate in assessments
 - Swallowing difficulties (SLT referral pathways)
 - Cultural, religious, or therapeutic dietary needs
 - Tube feeding and out-of-hours feeding protocols
 - Missed meals or extended ED stays

Assurance Measures:

- Dissemination of materials across divisions
- Audit and feedback mechanisms to assess implementation
- Ongoing development of training and escalation procedures



Nutrition Escalation: 7 minute briefing



7-minute Briefing

Nutrition & Hydration Escalation

Use this reference document to guide educational awareness to your team.

Each step is intended should take only 1 minute to deliver

7

Key Points

- ***ALWAYS** contact appropriate specialist teams for support as needed
- ***ALWAYS** escalate concerns
- ***ALWAYS** be mindful of patients on Enhanced Care or with any additional needs and requirements who may require assistance and encouragement with nutrition and hydration +/- family/NOK support

****See Action Card for relevant contact details, additional information and further action steps**

1

When should a nutrition risk assessment be completed?

- *Within **24hrs of admission** to any ward/unit/department
- *If in Emergency Department for **more than 24hrs**
- *If pt has #NOF initiate #NOF Nutrition Pathway within 24hrs of admission
- *Reassess weekly, or sooner if condition/triggers change

2

How is a nutrition risk assessment (WAASP) carried out?

WAASP

Step 1

- *Record weight and height
- *Establish if any unintentional weight loss or lack of appetite

Step 2

- *Select highest score in each section of WAASP tool

Step 3

- *Add up scores from each section
- *Record in total box

Step 4

- *Take actions based on total risk score

3

Patient unable to participate in assessment or has additional needs

- *Consider contacting relatives/carers for further information
- *Contact appropriate specialist teams e.g. SLT, LD, Dementia Care Teams
- *If known LD – liaise with LD liaison team **immediately**
- *Refer to Hospital Passport if appropriate

4

Patient has swallowing difficulties

- *Check CWS – is pt known to SLT?
- *If pt known to SLT, and there are concerns about current management plan, email SLT shared inbox
- *If pt not known to SLT – refer **as soon as difficulty is identified**
- *Last entry will detail Eating, Drinking, Swallowing recommendations

5

Tube Feeding

Existing Use of Tube Feeding

- *Refer to dietetics **as soon as need identified**
- *Obtain details of feeding regimen from pt/carers
- *Follow 'Community Pts with Tube Feeding' Pathway

Home TPN

- *Contact UHW Dietetics if ABUHB Dietetics unavailable

Starting Feeding 'Out of Hours'

- *Follow 'Out of Hours' guidance
- *Refer to dietetics **as soon as need identified**

6

Catering Requests

Missed Meal/Extended Stay in ED

- *Contact Catering Dept for your site **as soon as need identified**

Pt has therapeutic, religious, cultural or lifestyle dietary needs

- *Inform Catering of the dietary need **immediately**
- *Refer pt to dietetics if additional support required

Nutrition and Hydration Progress Report



Fluid Balance Monitoring - Key Drivers:

- Regulation 28 concerns around poor fluid balance documentation and associated patient harm.
- Audit findings revealed over half of staff had not received training on completing fluid balance charts.

Actions Taken:

- Developed a **7-minute briefing** and **Action Card** to standardise practice.
- Clarified roles and responsibilities across the MDT (nurses, AHPs, doctors, patients).
- Defined when fluid balance charts are required (e.g. sepsis, AKI, IV fluids, enteral/parenteral nutrition).
- Provided detailed guidance on: Accurate input/output recording, recognising signs of dehydration, measurement standards and receptacle volumes and poor outcomes linked to hydration imbalance.

Assurance Measures:

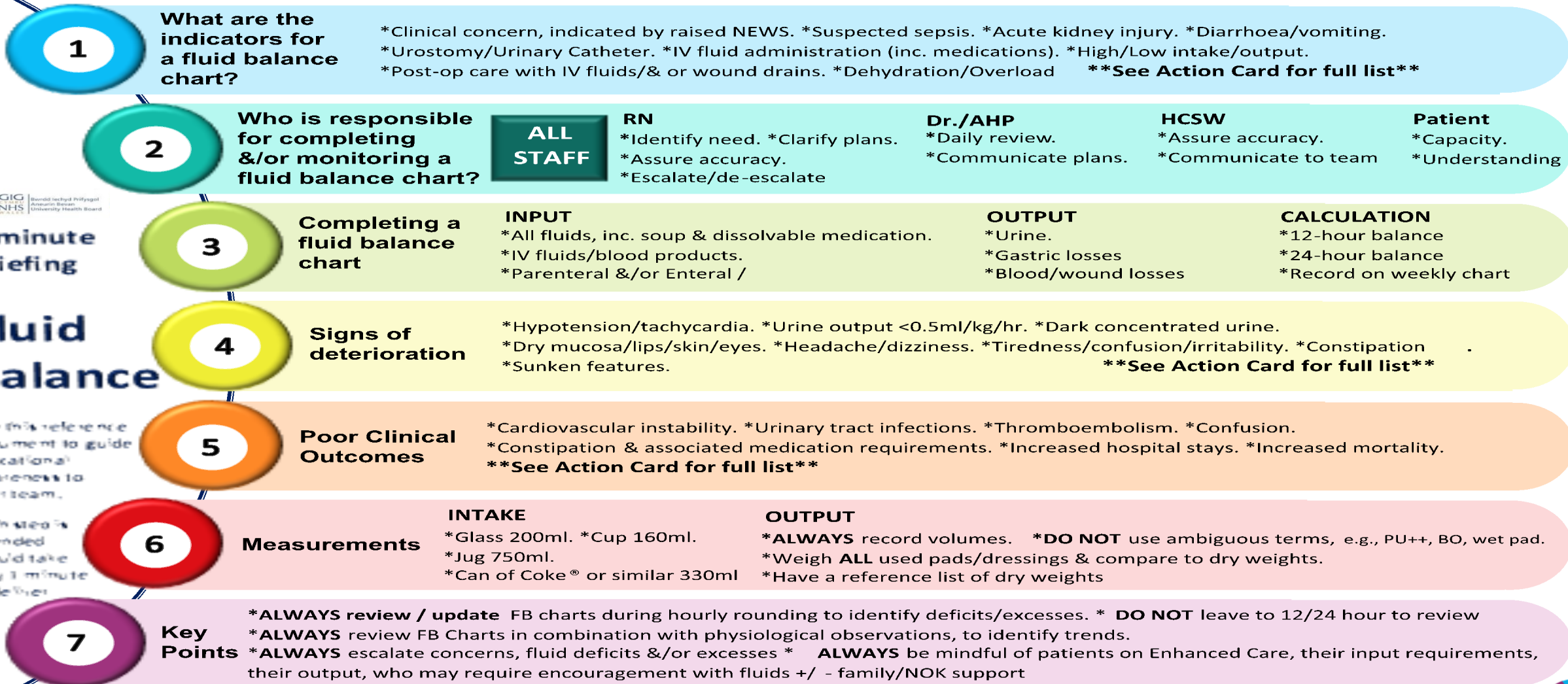
- Pilot audits showed improved practices (e.g. midday calculations, alternate-day weighing)
- PDSA cycles used to refine approach
- SOP and guidelines under review by Clinical Policy Group

Forward Planning:

- Continued audit and improvement cycles for both workstreams
- Development of a **Nutrition and Hydration intranet resource hub**
- Annual action plan in development
- Ongoing membership expansion of the Clinical Sub-Group



Fluid Balance: 7 minute briefing



Nursing Directorate FB Version 1: Mar 2025



Escalation

Section 2

QPS Overview- DSH and Observations

- **Most reported DATIX incidents:** Self-harm and restrictive practice.
- **Increase in reporting** aligns with expected rise in actual incidents.
- **Risk management:** Proportionate use of restrictive interventions (mainly PMVA techniques) in response to deliberate self-harm.
- **April 2025 thematic review** of DSH incidents led to a focused action plan for service improvement.
- **Additional case reviews** identified further learning and broader improvement opportunities.
- **Top emerging themes:**
 - Staff training and competency (substantive and temporary), especially in risk recognition and response.
 - Quality of clinical documentation (WARRN, DATIX, patient records).
- **Key needs:** Targeted staff development and improved documentation to support risk management and continuity of care.

QPS- HSE Hafan Deg

Inspection Overview

- **Date of Inspection:** 19 June 2025
- **Notification Letter Issued:** 9 July 2025 (Health & Safety contraventions)

Areas of Concern

- **Violence & Aggression:** Personal and affray alarms
- **Abducting Risk:** External door access; garden furniture
- **Self-Harm:** Quality of WARRN and CTP
- **Restrictive Intervention:** Training adaptations for 65+ age group

Actions Taken

- Fortnightly meetings with Health & Safety and OAMH senior leadership
- Action plan developed to address recommendations
- Immediate safety measures implemented (alarm testing, personal alarm availability)
- Divisional audit of personal alarms requested (7 Aug); report due 18 Aug
- Bespoke WARRN/CTP training session planned for Hafan Deg
- Ongoing meetings to monitor progress
- Response to HSE due by 30 Sept – must evidence actions taken

Next Step

- Share and implement inspection learnings and action plan across MH/LD division



Policy

- Therapeutic Observation & Engagement policy under review by multi-professional steering groups
- Planned launch: **October 2025**
- Focused training events to support safe and effective rollout

Training & Competency

- Interim checklist and awareness assessment in place for temporary staff
- Therapeutic Observation & Engagement, Ligature, and WARRN training added to ESR
- Training available and bookable through **March 2026** for substantive staff
- Remote training package (ESR/pre-recorded) for temporary staff launching **October 2025**
- Therapeutic Observation & Engagement added to HealthRoster as a skill requirement

Quality of Clinical Recording

- Divisional audit of CTP and WARRN completed
- SOP developed to define standards for managing DSH incidents (**August 2025**)
- Daily 'touch point' meetings to review DATIX reports and ensure appropriate follow-up

Engagement in National Strategy

- Participation in National Patient Safety Programme for MHLD
- Suicide and self-harm prevention initiatives
- Involvement in physical intervention reduction network

Governance & Monitoring

- Oversight via Divisional and Directorate QPS
- Bi-monthly Divisional action plan meetings
- Implementation of professional standards action plan

Next Steps

- Benchmark DSH incidents and use of restrictive practices across Welsh Health Boards





- **Complaint Case Management and Overdue Cases:** The Division has eliminated cases open over 12 months and reduced cases overdue between 6-12 and 9-12 months despite staffing shortages. Regular meetings and deep dives support complaint response completion. In July, 10 cases were received across various mental health teams, with 18 outstanding complaints overdue ranging from less than 30 days to over 6 months.
- **Compliance with Complaint Response Targets:** Compliance with the 30-day formal complaint response target slightly decreased in June, partly due to closing historic cases, while early resolution compliance declined due to MH&LD QPS team absences. The Health Board aims for 75% compliance in both areas, supported by new template forms to aid timely closures.
- **Patient Experience Survey Insights:** A new Wales-wide survey launched in May highlights concerns about waiting times, involvement in decision-making, and family support, with the lowest scores on wait times. Ongoing national discussions focus on question weighting and specificity, with monitoring continuing as only three months of data are available.
- **Patient Safety Incidents and Datix Reporting:** Datix incident reports over 13 months show one expected and one unexpected death requiring investigation. Ligature incidents are highest at Belle Vue and Hafan Deg, with notable self-harm and restrictive practice cases. July saw a dip in overall incidents. A thematic review is underway to understand self-harm incident variations.
- **Nationally Reportable Incidents and Investigations:** No new NRIs were reported in July, with overdue incidents reduced from 8 to 4. Increased inquests by the coroner require faster, comprehensive reviews. Delays in investigations may prolong formal processes, but ongoing work supports divisions in managing these cases. Patient safety incidents and never events were nil in July.
- **Safeguarding Processes and Training Compliance:** The Corporate Safeguarding Team ensures timely referrals and risk management, with no escalations due to process failures last month. Inpatient safeguarding incidents show active action plans and learning. MHLD leadership commits to regular safeguarding supervision, with Level 3 training compliance at 45% and significant progress made since its April 2025 mandate.



Urgent and Emergency Care Update



Aneurin Bevan UHB has made clear progress in operational transformation, focusing on patient flow, workforce resilience, and implementing new ways of working to achieve 45-minute ambulance handovers

Progress:

- **6 new ED consultant appointments** in place September
- All Wales **immediate release** and **regional escalation protocol** implemented.
- **Transfer Lounge** – operational 7 days a week, helping to streamline patient discharge and free up inpatient beds.
- **Safe to Start (S2S)** – fully embedded and across all eLGHS
- **SPA – phase 1 – advanced WAST practitioner** in place
- **First Floor Step Down protocol** in place
- Ensure **operational preparedness** for upcoming Emergency Department changes while maintaining core standards.

Actions & Focus for September 2025:

Sprint Delivery

Launch a dedicated sprint to achieve **15-minute patient handover targets**, supporting the mandated **45-minute standard**.

Model Implementation

Deliver the **continuous flow model**, with emphasis on readiness for the **hard launch on 8th September 2025**.

Engagement & Events

Conduct key sessions and events leading up to the launch, including the **Accelerated Local Event held on 29th August** to engage staff and set expectations.

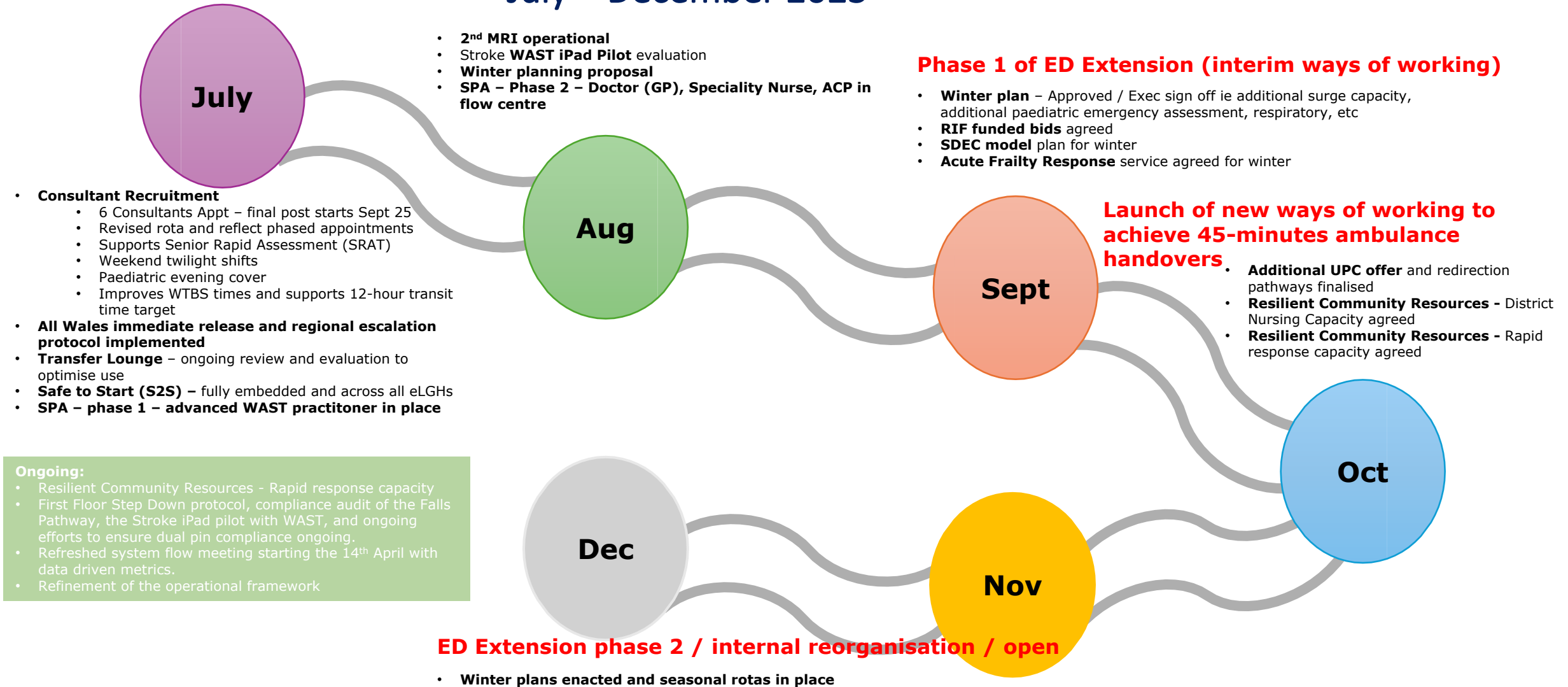
Operational Planning

Finalise **logistical arrangements**, define **daily discharge targets** and establish **governance** arrangements.



U&EC Enhanced Monitoring Plan

July – December 2025



For Discussion

Section 3

Sepsis Progress Report – Update



National Drivers for Deteriorating Patient Recognition

- The Welsh Health Circular (WHC) 2024/035 mandates the standardised use of Early Warning Scores (EWS) to support the early identification and management of acutely deteriorating patients. This initiative aims to enhance patient safety and improve clinical outcomes. Health Boards are expected to implement the recommendations by 30th September 2025. The work is being driven nationally through the Safer Care Partnership, led by NHS Executive and Improvement Cymru, and included the rollout of Martha's rule (Call for Concern) as a key component.

Go live dates for EWS Implementation

- Adults: NEWS2 – **9th September 2025** (community & MH&LD launch 29th September)
- Paediatrics: PEWS – **25nd September 2025**
- Neonates: NEWTT2 – **28th July 2025**
- Maternity: MEWS – **Delayed launch due to digital template restriction**

Local Implementation

- NEWTT2 is planned for the end of July. NEWS2 for the beginning of September. For adult secondary care settings, NEWS2 will involve switching over the electronic observation (EWS) system on Careflow. This is a whole system change that has to happen for the whole Health Board on the same day. To support this, paper charts will be used whilst the electronic observation system is upgraded and will take around 12 hours.

Training and Support

- Staff education has been a priority, with ESR modules funded by the NHS Executive and tailored packages developed by ABUHB to compliment national training resources. These resources are designed to ensure all staff are confident and competent in applying the new EWS tools in practice.
- To support the delivery of education, 54 “Train the Trainer” sessions were delivered to support ward managers, deputy ward managers and practice educators to cascade their training.



Sepsis Progress Report – Update



The Health Board continues to advance its commitment to improving the recognition, response, and management of sepsis, aligned with national mandates and internal quality priorities. Sepsis is a designated workstream within the Quality Strategy, with oversight embedded in the Deteriorating Patient and Acute Deterioration workstreams. The Health Board is actively implementing the updated NICE NG51 guideline and the Academy of Medical Royal Colleges (AoMRC) recommendations, ensuring evidence-based practice across all clinical areas.

A dedicated Sepsis Working Group, is leading assurance activities including: Development of divisional sepsis expertise, setting performance targets and supporting improvement initiatives through structured scoping and stakeholder engagement. This group has temporarily disbanded to support NEWS2 implementation and will reconvene post launch.

Implementation and Compliance Monitoring

The UK Sepsis Trust screening tool will be launched in September, alongside NEWS2 in adult secondary care. Quality improvement methods, will be used to test and refine the new screening tool before reviewing the tools suitability before launching across paediatrics, maternity, neonatal, and community settings. Compliance and effectiveness will be reviewed post-implementation to ensure measurable improvements in patient outcomes. This includes: monitoring uptake and fidelity of screening tools, evaluating escalation protocols and clinical decision support systems and aligning digital systems (e.g., CareFlow, BadgerNet) with national EWS timelines.

Engagement and Cultural Change

- Preparations are underway for the “Big Conversation” event to engage staff and the public in shaping future sepsis care. This will be complemented by a staff-focused event to capture frontline insights and inform strategy development. The event will be held in the Parkway Cwmbran on 18th September 2025.
- The Health Board’s sepsis awareness campaign launched internally in November 2024, and to the public in April 2025, achieving over two million views to date and has being shared nationally to support wider adoption. The All Wales Sepsis group are reviewing the assets created for the sepsis campaign, including safety netting information and exploring a national approach to raising awareness of signs and symptoms of sepsis.

National Collaboration and Assurance

ABUHB continues to contribute to national sepsis forums and the development of a standardised education and communications strategy across Wales. This includes reviewing eLearning materials and supporting the adoption of the UK Sepsis Trust screening tool across all health boards.



Action	What is needed?	How will this be achieved?	Who	When
Implementation of the WHC (2024/035), national Early Warning Scores & UK Sepsis Trust Screening tool	ABUHB continues to work towards implementing the Welsh Health Circular (WHC) 2024/035 early warning scores, aimed at supporting the national goal of standardising acute deterioration. Alongside the EWS, ABUHB will be launching the UK Sepsis Screening across adult acute divisions, with the aim of conducting PDSA cycles in targeted areas, measuring and auditing the impact. Other health boards in Wales are also looking towards implementation of UK Sepsis Trust Screening tool with an aim of standardising sepsis management throughout NHS Wales.	Implementation focus groups are working towards implementing x4 EWS across ABUHB clinical areas. This includes: - NEWS2 – 9th September 2025 - PEWS – 25th September 2025 - NEWTT2 – 28th July 2025 - MEWS – TBC The focus groups and exploring opportunities, resources and actioning barriers to ensure safe and effective implementation the tools. Each group is reviewing key information around Implementation, policy and education. Once delivered, the Deteriorating patient/sepsis group will continue to measure the effectiveness and impact of the EWS tools.	Assistant Quality & Patient Safety Assurance Lead	To be completed by Sept 2025
Standardise Sepsis education	To deliver high-standard sepsis care and comply with NICE guidelines, it's crucial to provide consistent education to all Health Board members. Reviewing and implementing standardised sepsis education will enhance monitoring and impact assessment, enabling opportunities for improvement.	Following the implementation of the WHC and EWS, a standardised education resource will be developed utilising the Sepsis Working group forum and in collaboration with key services, such as critical care, outreach and resuscitation services. The education package with require input from clinical experts within ABUHB, as well as oversight from the Deteriorating patient/ sepsis group and the Wales sepsis group.	Assistant Quality & Patient Safety Assurance Lead	To be completed by Dec 2025
Building on Standardised Sepsis Education	Ensuring the same message around expectation, management and process surrounding sepsis management is crucial.	An Education Task and Finish group will be established in Q4 to develop a robust training strategy for the workforce ahead of implementing Early Warning Scores and NICE Guidance. Representation at the national group will allow for reviewing and contributing to eLearning education materials. Through working closely with divisions and practice educators, utilising the standardised education package and initiatives from national groups, review and development of training programmes will be undertaken. This will include reviewing, amending and developing the sepsis content for programmes such as the JOE preceptorship, ALERT, BLS, PROMPT. Utilising the Deteriorating patient/ Sepsis group, oversight, feedback and progress will be maintained.	Assistant Quality & Patient Safety Assurance Lead	To be completed by End of December 2025
21/108				41/543

Action	What is needed?	How will this be achieved?	Who	When
Public Awareness Campaign for Sepsis	Phase 1 has been launched internally, during January 2025 phase 2 launch to the public April 2025. We continue to review the effectiveness of the campaign and assets, whilst ensuring accessibility for patients is maintained. Additionally, we aim to influence nationally to ensure other health boards and services support and continue to share the message around signs, symptoms of sepsis and when the seek urgent medical attention is shared across NHS Wales.	The Health Board maintains communication with the UK Sepsis Trust and uses evidence-based resources. The Comms team and QPS are collaborating on building and updating sepsis assets and sharing where possible. This includes presenting to and supporting the Wales Sepsis group with shared information, assets and encouraging others to continue raising awareness and standardise assets, such as “spotting the unwell child leaflet”. internal sepsis pulse page has been created as well as a public facing sepsis page. This, alongside the social media campaign allows a mechanism to provide update to date information and a platform for information for the public.	QPS and Comms	Ongoing
Working in Collaboration	Maintaining a collaborative approach in sepsis management is crucial for upholding best practices and mitigating risks. The Sepsis Working Group provides a forum for the multidisciplinary team (MDT) to discuss ongoing issues, identify areas for improvement, and share Health Board and national updates.	Maintaining the Sepsis Working Group will ensure a multidisciplinary approach to discussing and implementing solutions. The Assistant Quality and Patient Safety Assurance Lead will collaborate closely with Directorates, linking services, sharing best practices, and supporting quality improvement initiatives. Working directly with each area/specialty will provide a deeper understanding of the needs for improving sepsis recognition, diagnosis, and treatment. The “Big Conversation” will be hosted on the 18th September 2025 to allow a forum for public feedback and allow the QPS team to focus on direct areas of concerns, as highlighted and shared within the event. A mechanism to feedback information around actions generated will be developed.	Divisions and QPS	Ongoing September 2025
Continue working with UK Sepsis Trust, national forums and other health boards/trust	Founded in 2012, the UK Sepsis Trust is a valuable resource for NHS England and NHS Wales. It facilitates collaborative practices among Health Boards and Trusts across both countries. The charity offers a range of evidence-based resources, including Sepsis UK screening tools, educational materials, and signs and symptoms awareness posters/leaflets.	Representatives from the UK Sepsis Trust have previously supported the Health Board with the initial NEWS implementation and remain valuable contacts. Maintaining regular communication between ABUHB and UK Sepsis Trust allows for the continued sharing of evidence-based resources to enhance clinical practice. ABUHB continues to represent nationally within Acute Deterioration groups, All Wales Sepsis group, NHS executive forums and recently as part of the “Safe Care Partnership- Deteriorating patient” group. This include exploring escalation processes and a new way to capture response to deterioration.	Divisions and QPS	Ongoing
Develop Audit Strategy for Sepsis and ensure learning from incidents	It's essential to establish a consistent method for capturing sepsis data across the Health Board. Currently, varied monitoring approaches hinder the collection of reliable data needed for improvement. Standardising data capture methods will enhance the ability to support clinical practice and drive better outcomes.	Collaboration: Work closely with national groups, divisions and the deteriorating patient working group, to identify universal data requirements and agree on standardised methods for capturing patients with Sepsis. Efficiency: Use AMaT to develop a proforma, ensuring the audit process is efficient and the workforce can input data effectively. Learning System: Develop a system to learn from incidents where Sepsis was missed, including thematic reviews of Datix incidents.	Sepsis Working Group	December 2025 42/543

Sepsis Annual Workplan 2024/25



Quarter One	Quarter Two	Quarter Three	Quarter Four
- Continue hosting Task and Finish group to ensure readiness for EWS launch - Review opportunities to capture missed opportunities around deterioration and escalation - Continue work with UK Sepsis Trust and awareness campaign	- Implement Early Warning Scores (EWS) by 30 Sept; approve and roll out updated policy with revised escalation thresholds and NICE-aligned sepsis guidance; launch audit strategy post launch, to monitor EWS and UK Sepsis Screening Tool. - Standardise education packages. - Launch Big Conversation for Sepsis.	- Evaluate EWS effectiveness; initiate NHS Executive QSI projects to improve escalation; relaunch Sepsis Group post-EWS implementation. - Work collaboratively with Divisional to drive quality improvement. - Work with practice educators on sepsis training.	Standardise improvement initiatives using QSI findings; continue divisional engagement and thematic reviews; optimise escalation documentation and processes.



Patient Safety Leadership Visits



Overview

Areas Visited (10 Total)

Grange University Hospital (GUH)

- Decontamination Unit, Medical Assessment Unit (AMU), Transfer Lounge, Ward A/0

Ysbyty Ystrad Fawr (YYF)

- Ty Cyfannol

Ysbyty Aneurin Bevan (YAB)

- Ebbw Ward, Sirhowy Ward, Tyleri Ward

Other Sites

- Bevan Health & Wellbeing Centre (Tredegar), Vaccination Centre (Cwmbran)

Cancelled Visits: 2

1. **Anwylfan, YYF (02/06/25)** – No management team present due to leave and illness
2. **Breast Unit, YYF (22/07/25)** – Cancelled by Executive due to Board commitments; unable to reassign in time

Positive Findings

- New areas are bright, clean, and spacious with enthusiastic staff
- Acute wards show strong commitment to patient care despite corridor equipment
- Mental Health & Community Wards at YAB offer strong meaningful patient activities
- Staff across sites are proactive in resolving issues and escalating concerns
- Individual staff members have been instrumental in driving improvements
- Previous concerns around storage have not re-emerged during this round



Site-Specific Issues

- **AMU, GUH:** GP referrals increased by 40 patients month-on-month, limited triage space after 17:00, staffing issues when chair patients exceed 10 (they are often 20-30)
- **Bevan Centre:** Low chairs without arms, booking-in system faulty, winter pathway safety concerns, drainage smell causing offensive smell, no Centre-wide Operational Policy
- **HSDU:** Manual tracking of instruments in theatres; poor compliance with checklists
- **Transfer Lounge, GUH:** Entrance system poses manual handling risk, no hot food due to hygiene rules (resolved after visit)
- **Ty Cyfannol:** Limited physiotherapy, motion sensor delays, night staffing concerns
- **Vaccination Centre:** Inconsistent availability across GP practices
- **Ward A/0:** Difficulty weighing spinal patients; upper arm circumference tool recommended
- **YAB:** Patients can be boarded in day rooms without call bells, orthopaedic review delays due to transport cancellations



Visit Outcomes and Observations

Key Themes Identified

- **Discharge Delays** due to late Social Care assessments
- **Inappropriate Transfers** to step-down sites
- **Incomplete Information** provided to step-down wards
- **Out-of-Hours Transfers** still occurring

Actions and Follow-Up

- Actions shared with Executives and clinical area management teams
- Some local actions completed
- Awaiting feedback from Executives despite follow-up
- Meeting scheduled in October to discuss YAB actions

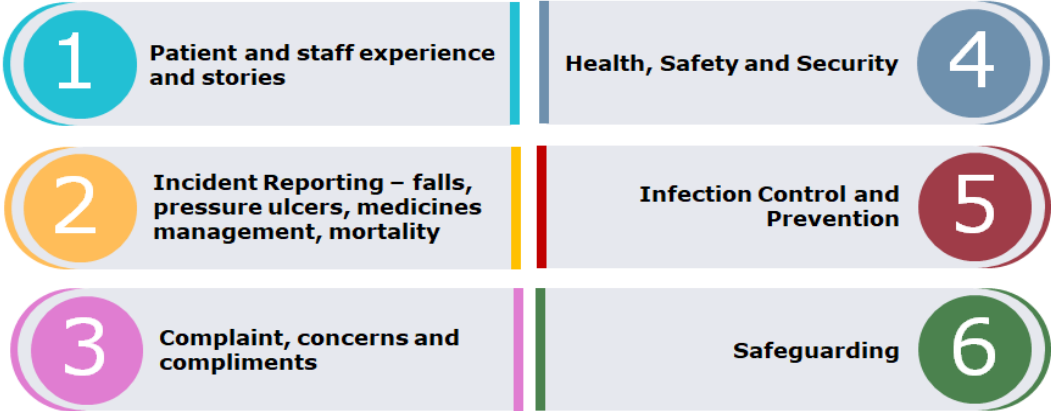


6 Pillars of Quality



Section 4

Pillars of Quality



These 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains. Providing data in these Pillars of Quality will review our performance.

We must put the quality and safety of our health services above everything else. This strategy signals our intention to progress these six pillars of quality to establish our level of performance. The pillars will be our Quality Markers in our Quality management system. Strengthening our quality management system helps us make sure our decision-making focuses on improving the quality of health services.

These measures of quality will allow standardised agendas for Divisions to report on quality measures.

PATIENT AND STAFF EXPERIENCE AND STORIES

Through the introduction of CIVICA – an electronic Citizen Feedback platform that will help people who are using our services to tell us what they think about their care. Providing feedback on our services will help us learn, make changes where we need to and celebrate what we do well. Staff will also be able to feedback on a regular basis, helping them to make improvements in their areas.

Analysis of patient experience data including complaints and compliments will provide a comprehensive picture of areas of positive performance and areas for improvement.

COMPLAINTS, CONCERNS AND COMPLIMENTS

Our commitment to patients is, wherever possible, to respond to their complaints timely and provide the information requested in an open and transparent way. Where it is not possible to provide immediate resolution, we commit to agree an appropriate investigation and to carry out that investigation to a high standard and on time. To ensure that all complainants have access to an investigating officer and are contact regularly.

INFECTION PREVENTION AND CONTROL

The Health Board is committed to zero tolerance of preventable Healthcare Associated Infections (HCAIs). Welsh Government sets reduction expectations for healthcare acquired infections which are achieved via collaboration from experts across healthcare. The Health Board are committed to providing clear programmes of work and evidence-based Policies which sets the expectation on the organisation. Our workforce will be skilled and trained to deliver against national, local and organisational objectives. We will monitor outcomes and reporting compliance/ learning through the Reducing Nosocomial Transmission Group (RNTG), Patient Safety Operational Group and Committee.

INCIDENT REPORTING

Through our 'Pillars of Quality' Programme, we will continue to focus on incident reporting as a key enabler of organisational learning and improvement. We will co-ordinate a comprehensive rolling Programme of quality improvement initiatives which strive to reduce avoidable harm with a focus on falls, pressure ulcers, deteriorating patients, mortality, end of life care, medicines management, discharge and safe transfers of care.

Our commitment to staff is to have a **just** culture, where staff feel safe to report concerns, incidents and near misses, knowing this will result in a timely, fair, comprehensive investigation. Our incident reporting system 'Datix' is a key component in providing insights to data gathering and learning actions.

HEALTH, SAFETY AND SECURITY

We are committed to ensuring that the fundamental standards of health, safety and security are continuously improved. We have a committed workforce of operational leaders who we will educate to ensure they have the advanced skills to deliver safe services. We will support the development of local policies and practices through our Health, Safety and Security Practitioners. We will conduct reviews of all sites and an annual snapshot of health and safety. Our focus for the duration of this strategy will be to reduce staff harm from lifting and handling, violence and aggression and slips, trips and falls.

SAFEGUARDING

Safeguarding is everybody's responsibility. We will demonstrate reasonable steps to ensure the safety of children and adults at risk. The Health Board's Strategy and Policy sets the expectation of accessing services. The workforce will be skilled and trained to deliver national, local and organisational objectives. The Health Board will support and enable operationalisation through provision of tools and direct support from the corporate safeguarding team, as the workforce undertakes its duties in relation to safeguarding. We will monitor outcomes and report effectiveness through effective audit and clear governance processes.

PILLAR 1

Patient and staff experience and stories

Civica	Bereavement Collaboratives	Patient Stories	IPAC Dashboards	Volunteer to Career	Chaplaincy	Volunteering
Patient Advice and Liaison Service (PALS)	Leadership, Accountability and Culture	Deprivation of Liberty Safeguards/ Mental Capacity Act	Cultural Competence Accreditation Scheme	Dementia Standards	Listening Meetings	



- Feedback numbers continue to increase with July 2025 the highest month to date with total feedback responses of 2556. SMS responses 1539 and 1017 responses from QR code/paper, which is also the highest number.
- Work continues on the All Wales Maternity and Neonate Surveys which will be sent via CIVIC SMS. Currently working on a live date of the 1st September 2025.
- There has been very little movement in top themes this month (only 1 change) compared to last quarter.

	2024							2025						
Satisfaction Score by Month	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	
Overall – All Surveys	91	92	90	89	88	87	93	93	85	86	**86	**86	87	
PCC/PES Surveys	92	92	93	91	92	90	92	92	90	90	*85	*86	87	
ED Survey	72	79	77	61	60	67	77	65	67	70	75	n/a	n/a	

**Previously both reported as 85 (Overall score)

*Previously both reported as 84 (PCC/PES) – see later slide for info on scoring change



Civica – Patient feedback



CIVICA Patient Experience Feedback
Number of Responses & Satisfaction
Scores July 2024 – July 2025

All Surveys

16134
responses

87%
satisfaction

Person Centred Care (PCC) & People’s Experience (PES)

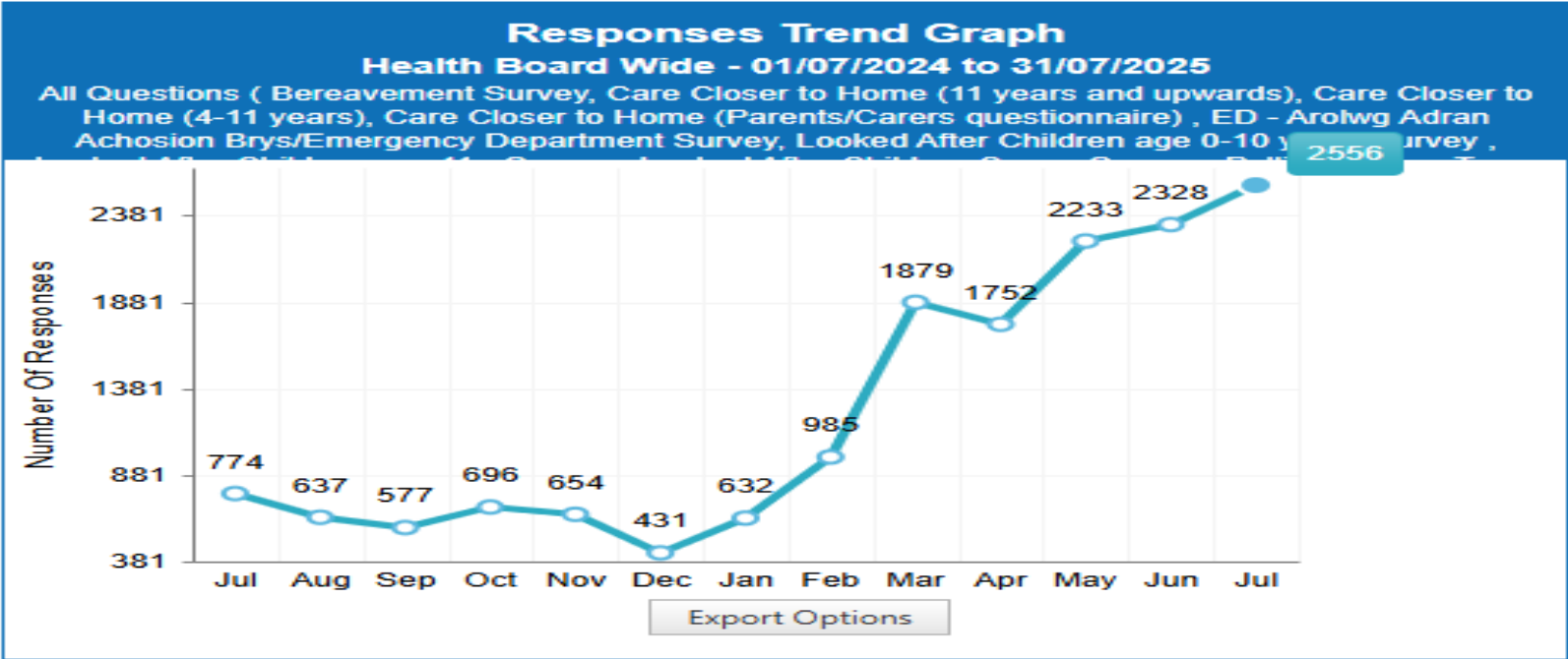
14023
Responses

88%
Satisfaction

Emergency Department Survey

1306
Responses

68%
satisfaction

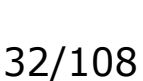


Themes & Emotions for July 2025 All data correct at date of pulling data (07/08/25)

Overall Emotions

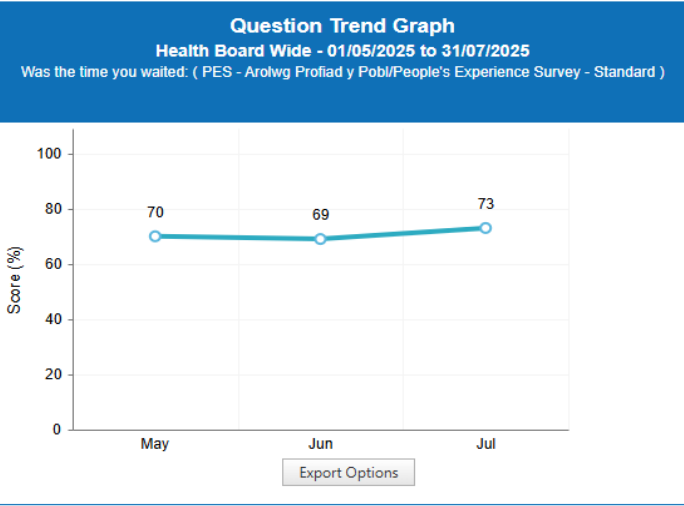
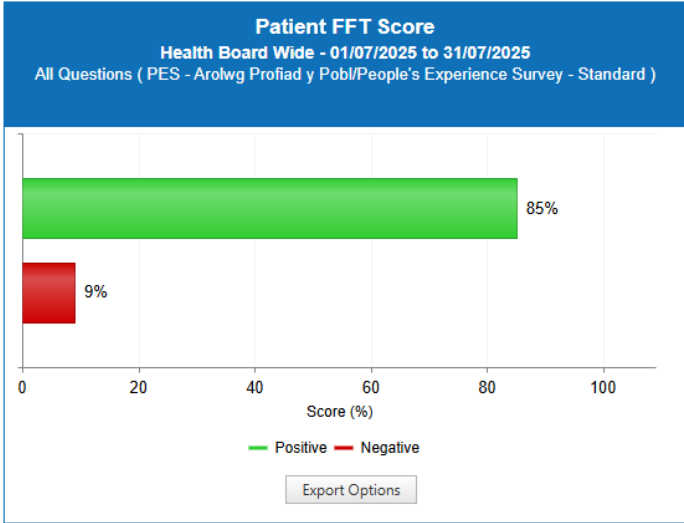


A word cloud titled "Overall Emotions" in a large, bold, dark blue font. The words are arranged in a circular pattern, with larger words in the center and smaller words towards the edges. The words are in various colors, including green, red, and blue. The most prominent words are "excellent", "amazing", "brilliant", "outstanding", "wonderful", "fantastic", "lovely", "happy", "friendly", "supportive", "kindness", "cheerful", "pleasant", "compassionate", "empathy", "well done", "exceptional", "comfortable", "reassuring", "anxiety", "delay", "at ease", "fab", "dismissive", "anxious", "worry", "nervous", "delays", "ridiculous", "unpleasant", "surprise", "surprised", "impressed", "eventually", "terrible", "pleased", "appreciate", "welcoming", "enjoyed", "disappointing", "frustrating", "boring", "tiring", "stressful", "rude", "inadequate", "waited 9 hours", "failed to", "my concerns", "a shambles", "would like to", "amazing", "brilliant", "outstanding", "wonderful", "fantastic", "lovely", "happy", "friendly", "supportive", "kindness", "cheerful", "pleasant", "compassionate", "empathy", "well done", "exceptional", "comfortable", "reassuring", "anxiety", "delay", "at ease", "fab", "dismissive", "anxious", "worry", "nervous", "delays", "ridiculous", "unpleasant", "surprise", "surprised", "impressed", "eventually", "terrible", "pleased", "appreciate", "welcoming", "enjoyed", "disappointing", "frustrating", "boring", "tiring", "stressful", "rude", "inadequate", "waited 9 hours", "failed to", "my concerns", "a shambles", "would like to".



Patient Experience Feedback July 2025

- Feedback numbers continue to increase with July 2025 the highest month to date with total feedback responses of 2556. SMS responses 1539 and 1017 responses from QR code/paper, which is also the highest number.
- Following launch of People's Experience Survey (PES) in May 2025 the 5 core questions will be copied to other ABUHB surveys. This has been done for the Bereavement survey and will be added to the Endoscopy survey shortly. The five core questions are the 2 questions on language, the 2 open questions on 'what was good' and 'what was bad', and question regarding overall experience.
- FFT scoring for question 'How would you rate your overall experience?' for July has a scoring of 85% positive responses versus 9% negative, those that scored neither good nor bad are excluded.
- Bespoke report created for responses to new language questions and shared with Welsh Language Unit.
- Scoring around the question 'Was the time you waited' has been updated across Wales and change noted on scoring, however for July this question remains overall 'red' at 73. The change in scoring has retrospectively changed figures previously reported. This question scores low against most Divisions and the only question overall that is red. Other questions for July flagged below the benchmark/amber (by Division) are - 'Did you feel well cared for?' = Score 84. 'Did you feel physically comfortable?' = 81 and 'How would you rate your overall experience?' = 83.
- There has been very little movement in top themes this month (only 1 change) compared to last quarter.
- Work continues on the All Wales Maternity and Neonate Surveys which will be sent via CIVIC SMS. Currently working on a live date of the 1st September 2025.



PILLAR 2

Incident Reporting

Falls

Pressure Ulcers

Medicines Management

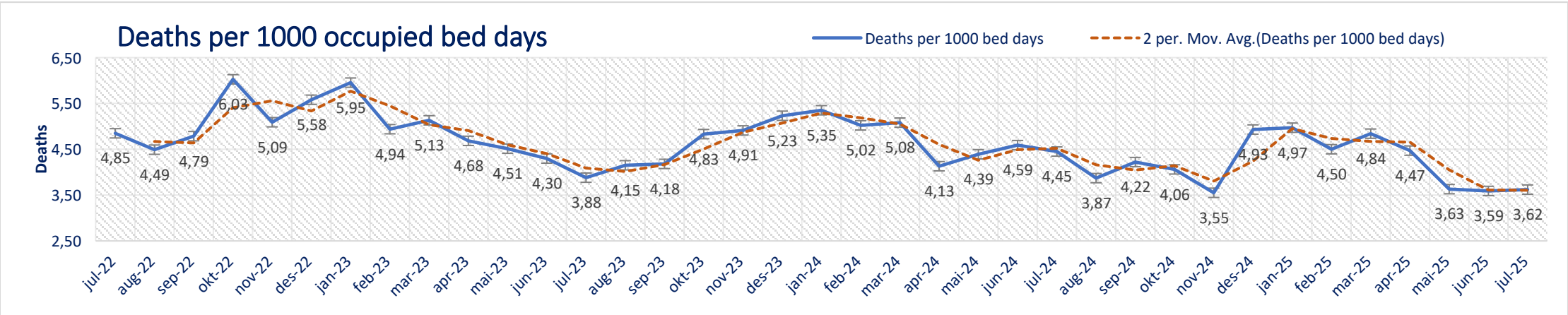
Mortality

Leadership, Accountability and Culture	Never Events	Deteriorating Patient	Patient Safety Incident process	QPSE Dashboards
Pressure Ulcers / Medicines Management	Staff Training	Datix (validation)	Falls Panel	Duty of Candour
Learning, Monitoring & Assurance	Just Culture/ Psychological Safety	Mortality	Risk Registers	Human Factors

Crude Mortality in Hospital



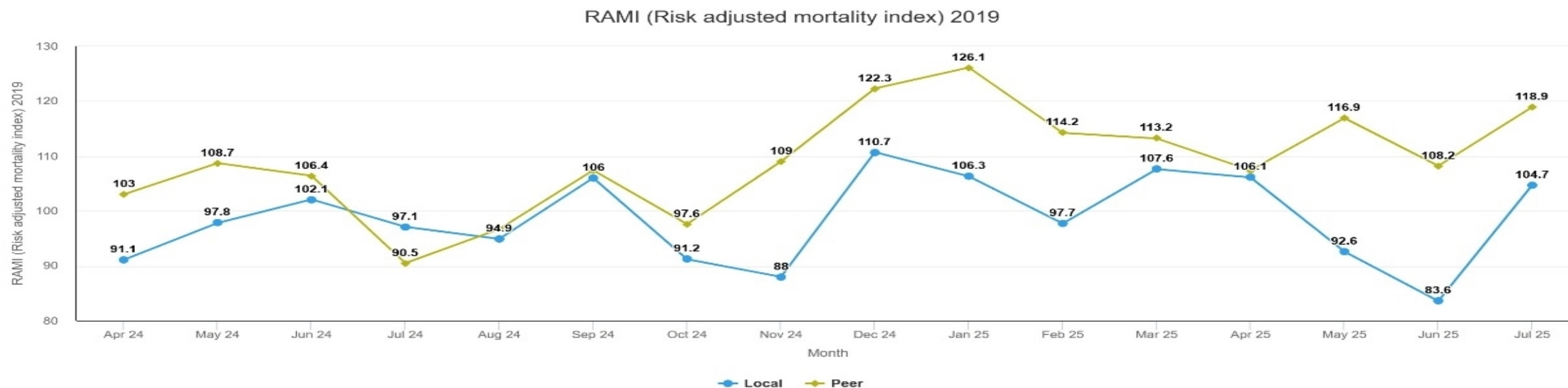
June and July have seen a decline, below the level seen in the previous year. July has been the lowest in the calendar year 2025 so far



After a notable rise in Q4 2024/25, Q1 2025/26 saw a sharp decline of 18.45%, bringing the rate down to 3.89. This is the lowest recorded rate in the five-quarter span from Q1 2024/25 to Q1 2025/26. July 25 was the lowest July average of the previous 4 years



RAMI - (Risk Adjusted Mortality Index)



RAMI accounts for individual patient risk factors and comorbidities, enabling comparisons across different organisations. A RAMI less than 100 indicates the observed mortality is lower than the expected mortality rate for the population. Suggesting it is performing better than expected in terms of outcomes. The accuracy of RAMI relies heavily on the completeness and precision of clinical coding.

Coding takes at least 8 weeks which typically results in the RAMI figure decreasing as the information becomes more accurate. It should be noted that the June's data is likely to be revised down as coding occurs.

RAMI for Q1-Q4 2024/25 was 104.63, Both lines show a decline in RAMI during mid-year (summer months), followed by a consistent rise through autumn and winter.

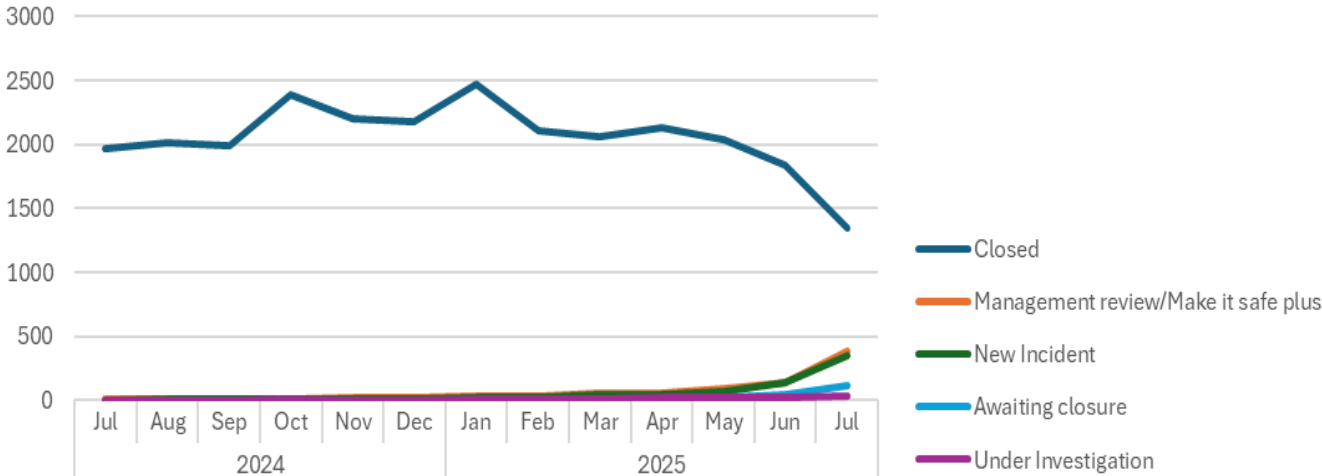
The sharpest increases occur from October to Jan, which may reflect seasonal pressures such as winter illnesses or increased hospital admissions. RAMI for Q1 is 105.90, which is an increase. July RAMI is high and will decrease following the coding lag.

However still performing better than the All Wales Peer Average





Patient/Service User Incidents per Month
Status of Incidents



Closed	1966	2010	1988	2389	2199	2178	2470	2102	2066	2130	2032	1842	1349
Management review/Make it safe plus	9	12	12	10	17	17	32	36	59	54	89	134	391
New Incident	3	6	5	10	6	7	24	18	40	43	66	143	349
Awaiting closure		1			2	3	1	10	3	9	25	45	117
Under Investigation	2	2	3	5	4	4	10	8	14	17	19	17	35

- The table above shows the status of all Patient/Service User incidents reported since July 2024. The number of open incidents increased significantly in June (339) and July (892) as these are likely to be still under investigation.
- A decline in open incidents from 2024 can be seen, in part due to F&T working to ensure their longest open incidents are closed.

Stage No	Status	Definition
1	New Incident	First stage of any incident, prior to management review.
2	Management review / Make is safe	Record awaiting review and "make safe" actions
3	Under Investigation	Has undergone management review and initial make safe actions which has indicated further investigation is required.
4	Awaiting closure	All appropriate actions have been taken and is awaiting final review
5	Closed	All actions complete and record is closed.

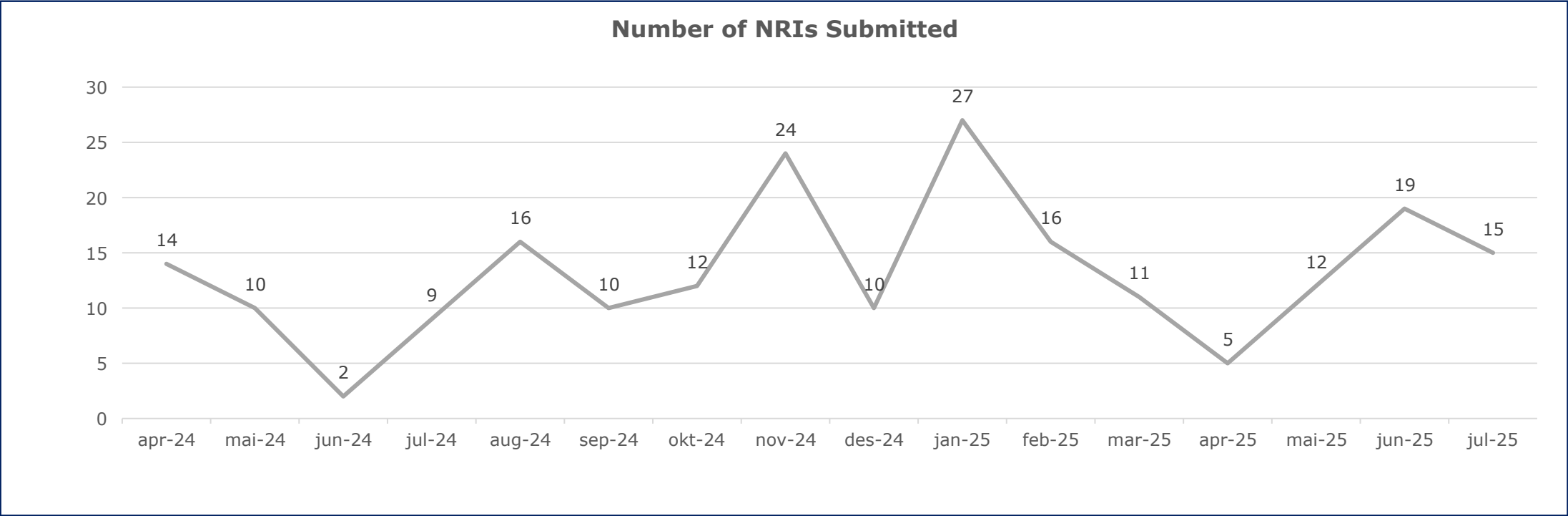
Datix Incident Top 10 Themes - Moderate and above harm (post investigation assessment)



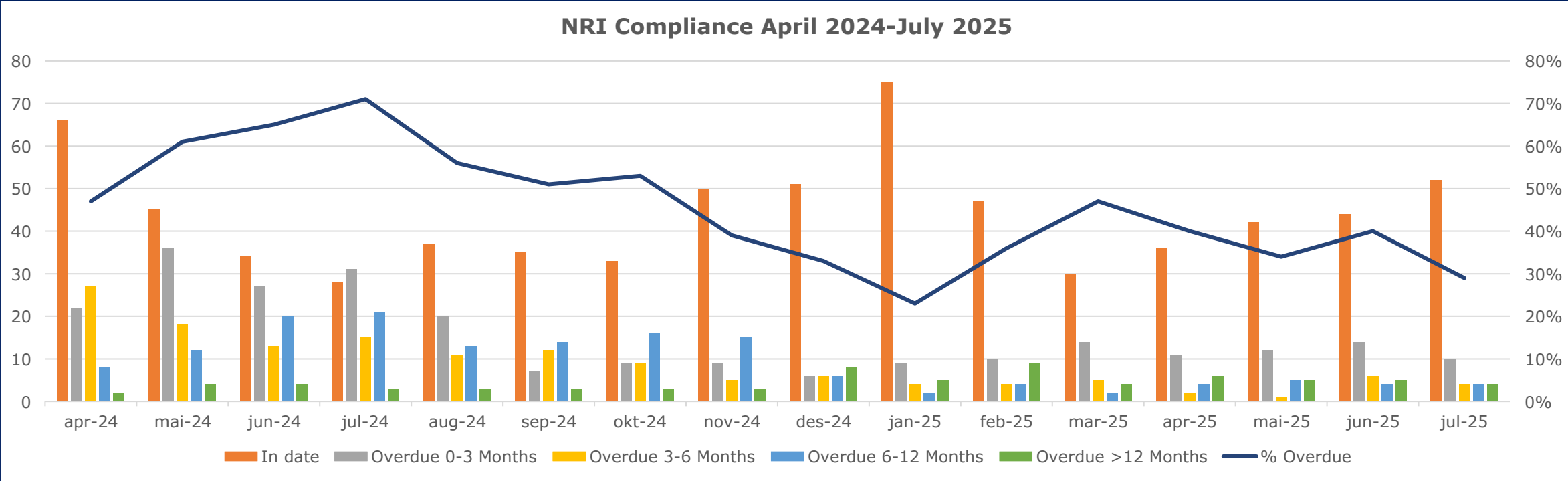
	Expected death	Unexpected death	Pressure ulcer developed or worsened during care in this clinical care area/caseload	Pressure ulcer present before admission to this clinical care area/caseload	Slip, trip or fall	Treatment or procedure issues	Medication supply errors	Clinical assessment, clinical diagnosis	Patient injury	Safeguarding - Adult	Self-harm / self-injurious behaviour
2024											
Jul	4	2	2	3	3	2	1				
Aug	1	4	2	5	1		1	1		1	
Sep	8	1	1	1	1	1	3		1	1	
Oct	4	8	3	3	3	3		1	1		1
Nov	5	2	1	1	2		1				
Dec	9	4	4		1	1	2				
2025											
Jan	7	5	1	3		2		1		1	2
Feb	5	6	1		2	1			1		1
Mar	1	5	2	2	1						
Apr	1		3		1	1		1	1	1	
May	3	3									
Jun				2							
Jul	1		3	2	2						
Grand Total	49	40	23	22	17	11	8	4	4	4	4

- The table above shows the 10 most common themes for incidents graded as moderate harm or above since July 2024. Noting that more recent incidents are likely to not have harm assessments completed.
- Since the last report work has been initiated to ensure the correct harm assessment levels are being used for “expected death” and “unexpected death”. Datix harm should be based on the level of harm attributed to Healthcare, rather than the harm (in these cases, death) that the patient sadly experienced. Unfortunately, this can cause confusion in scenarios where the individual passed away as the category “Death” appears the most applicable.
- For “Expected deaths” these Datix reports are predominately OAMH (47) the final two were Primary Care patients in a nursing home and a hospice.

National Reported Incidents



Definition	Analysis	Implications
A Nationally Reportable Incident (NRI) is a patient safety incident that meets specific criteria for reporting to the NHS Wales Performance and Improvement, typically due to the level of harm or service impact.	A total of 15 National Reported Incidents (NRIs) were reported in July 2025. Reporting categories this month: • 4x delayed diagnosis • 1x Deteriorating patient • 6x HCAI associated Deaths • 2x HCAI outbreaks • 2x IUD There are no unusual trends this month.	Following the identification of patient safety incidents around missed radiological findings, there is currently work ongoing coordinated by the Corporate Putting Things Right Team with ED, Radiology and acute medicine to close the potential gaps in radiology findings/reports governance and accountability.



Definition	Analysis	Implications
The graph above shows: The % of open cases that are within the compliance window. The number of open cases are split by in-date and overdue.	In July we have a total of 73 open cases, with 52 number of cases within the compliance window. The number of cases overdue by: 12 months is 4 6-12 months is 4 3-6 months is 4 0-3 months is 10 The trends show an improvement in the number of open overdue cases.	The Corporate patient safety team are currently running workshops to review the PSI investigation process and measures that may be put in place to streamline and optimise progression of incident investigation, and thus improve not only NRI compliance, but improve patient/family/staff experiences of the PSI process and outcomes.

Achievements / Escalations	Update	Next Steps
PSI process development workshops	The Corporate PSI team continued with the planned PSI process development work in a July workshop. From this, one of the team has undertaken a scoping exercise with Health Boards across England and Wales focusing upon Family Liaison Officer requirements and any training available.	To clarify expectations of the FLO role and formulate an FLO toolkit.
Standardisation of tracking and monitoring across divisions	Through improvement workshops with the divisional QPS teams a standardised method for tracking PSIs is being developed with an agreement in principle made at the beginning of August. The aim is to be able to provide cross cover between divisions, simplify processes, provide corporate oversight and improvement monitoring and reporting.	Roll-out the new process and retrospectively move open cases to the new system. Utilise data capture tool to provide real time monitoring and analysis through Qlik.

Early Warning Notifications



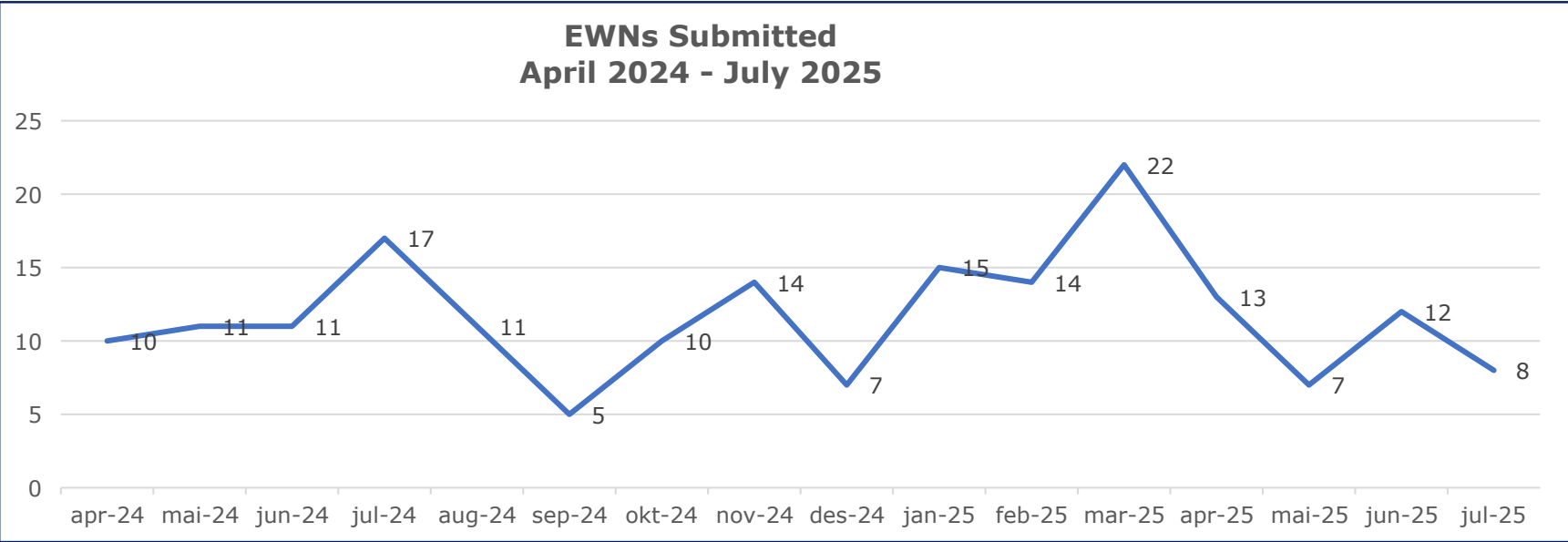
Definition	Analysis	Implications
These are immediate notifications reported to WG that, in some cases, incidents may not result in direct harm to a patient(s) but may impact on service provision or organisational reputation including adverse media coverage.	A total of 8 Early Warning Notifications (EWNs) were reported to Welsh Government in July. Themes: 2x Criminal Offences - Patient is the Suspect 2x Violent Incidents on Patients by Staff 1x update regarding Alleged assault on patient by staff 2x Safeguarding issues 1x Derogatory post on social media by staff member	There are no clear themes in the EWNs reported in July, and whilst 8 submissions represents the lower end of EWN submissions, it is impossible to compare unequivocally against other months.

Never Events

No “Never Events” were recorded in July.

Duty of Candour (DoC)

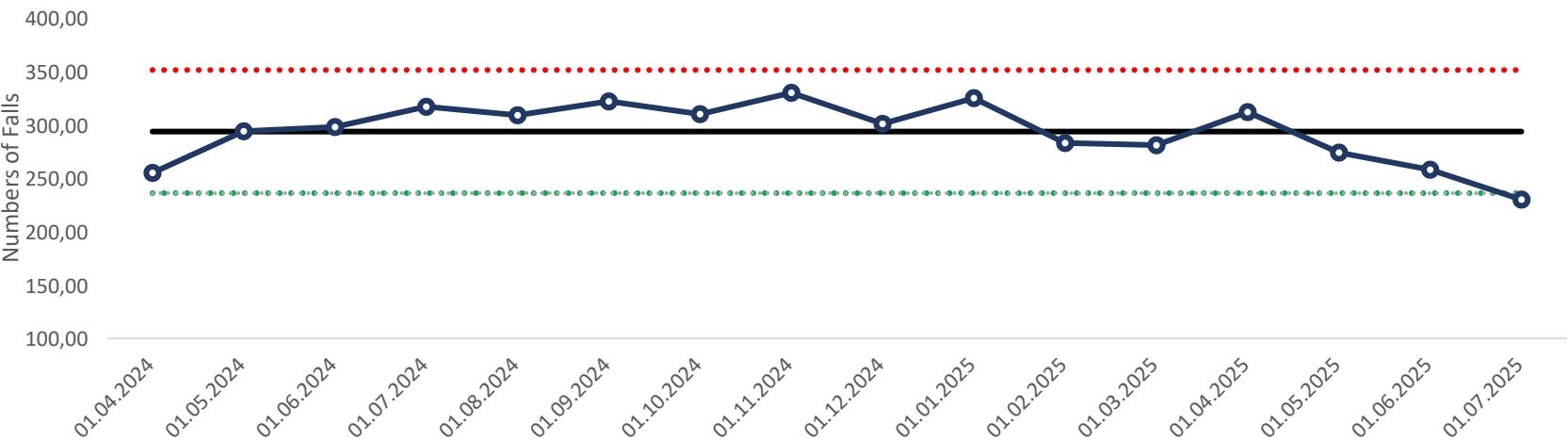
In July a total of **4** DoC events were triggered where ‘was healthcare provided a factor?’, compared to **2** number in the previous month. Division of Surgery triggered 1 incident and Medicine triggered 3 times. There were 3 delay in treatment and incomplete risks assessments completed for a fall.



Health Board Wide Inpatient Falls – Total Incidents



Total Numbers of Inpatient Falls April 2024- July 2025



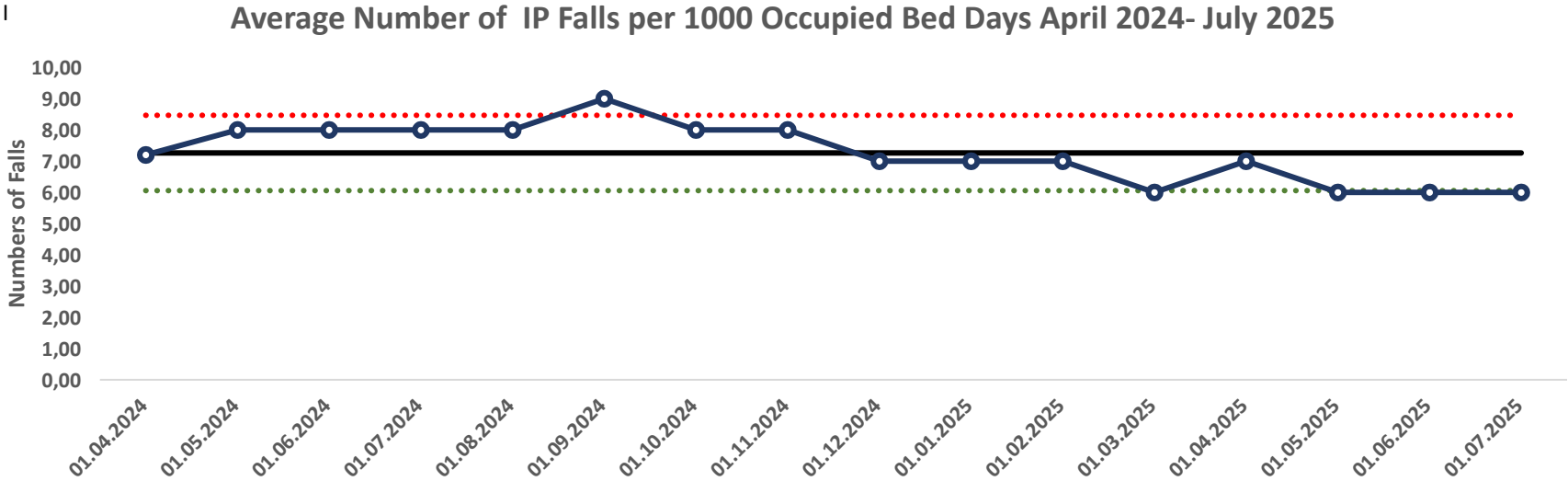
August 2025 - Context

The data used in this chart has been retrieved from RL Datix and refers to the total numbers of reported falls incidents for the period April 2024-July 2025

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RL Datix as the information source.	- For the given period of analysis, the mean average of fall incidents is 293 which is a decrease since the last report (300). - The rise in April has been following by a continuation of the downward trajectory for the months May to July. The numbers of incidents for July is the lowest recorded value for the period of analyse at 230.	The value for Q1 into Q2 represent a continued decrease in reported falls incidents The July value for reported incidents is marginally below the designated control limit.



Health Board Wide Inpatient Falls per Occupied Bed Days (OBD)



August 2025 - Context

The data used in this chart has been retrieved from RL Datix and refers to the total numbers of reported falls incidents for the period April 2024-July 2025.

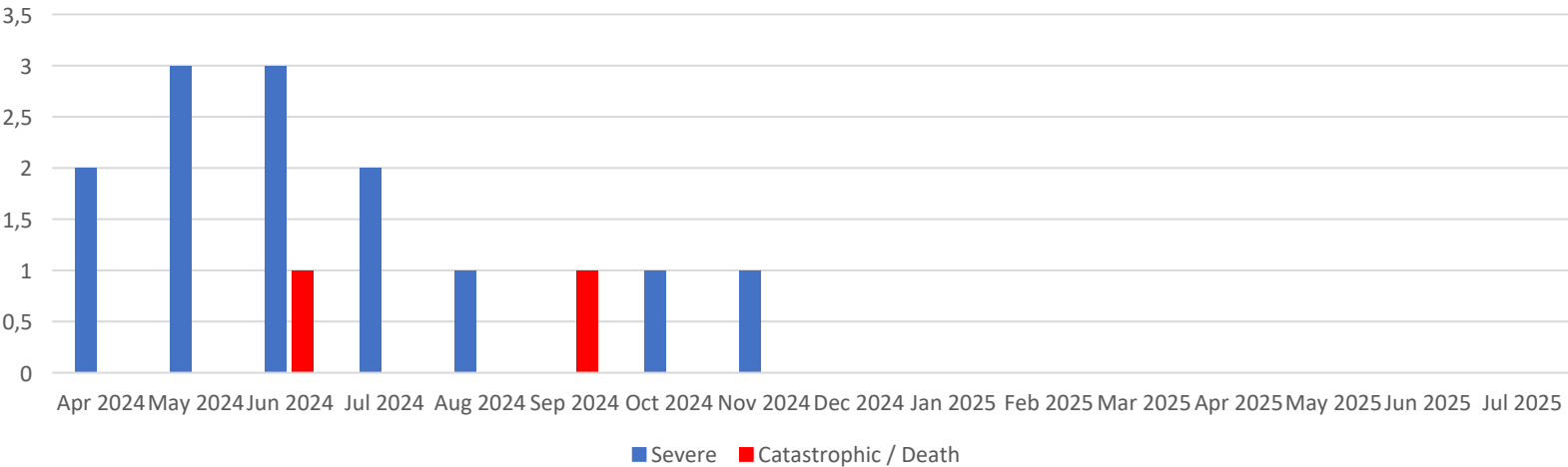
The figures are rounded for the purposes of the chart presentation.

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RL Datix as the information source.	The value aligned to per 1000 Occupied Bed Days (ODD) has been below the mean average value for the period of analysis for 8 consecutive months.. May to July for OBD’s represents values that remain below the National average (6.6). The values for these months together with March are the lowest for the period of analysis.	Positive variation for Q1 into Q2 for the period of analysis and as compared to the same period in 2024.



Health Board Wide Inpatient Falls Severity of Harm

Numbers of Inpatient Falls – Severe and Catastrophic Levels of Harm Only



August 2025- Context

The data represents the collective information for ABUHB and refers to the severity of harm for reported falls incidents for the period April 2024 to July 2025

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	The total numbers of falls incidents reported for which the severity of harm is categorised for the given period is 4699. For April and July 2025, the following details the severity of harm: • 99% - No or low harm • 1% - Moderate harm • 0% Severe harm • 0% Catastrophic	For the period of analysis there have been no reported incidents of falls resulting in a catastrophic outcome since September 2024 with no instances of severe harm since January 2025.

Caring for those at risk

Governance & Monitoring

- Quarterly Falls and Bone Health Strategic Group Meetings.
- Establishment of the Falls and Bone Health Strategic Oversight Panel (FSOP) **July 2025**
- Weekly data review of all IP Falls
- Oversight of Falls with Fractures review at weekly Executive Huddle
- Divisional QPS monthly reports.

Engagement in National Strategy:

- Participation in development of the National Head Injuries (HI) Pathway – Awaiting ratification.
- Engagement in National falls prevention initiatives.
- Participation in the National forum in support of Fracture Liaison Services and the promotion of improvements in bone health

Actions and Learning:

Falls Policy for Hospital Adult Inpatients:

- Updated and ratified -Multi-professional engagement and oversight by Falls and Bone Health Strategic Group
- Planned launch of Policy during 'Falls Awareness Week' **September 2025.**

Real Time Data:

- Development of a fall's incidents dashboard representing real-time activity

Falls with Fractures:

- Transition to the adoption of a concise review methodology – Identification of themes and trends with local and system wide learning.

FSOP:

- Approach supporting improvements in RIDDOR Compliance for falls related incidents.

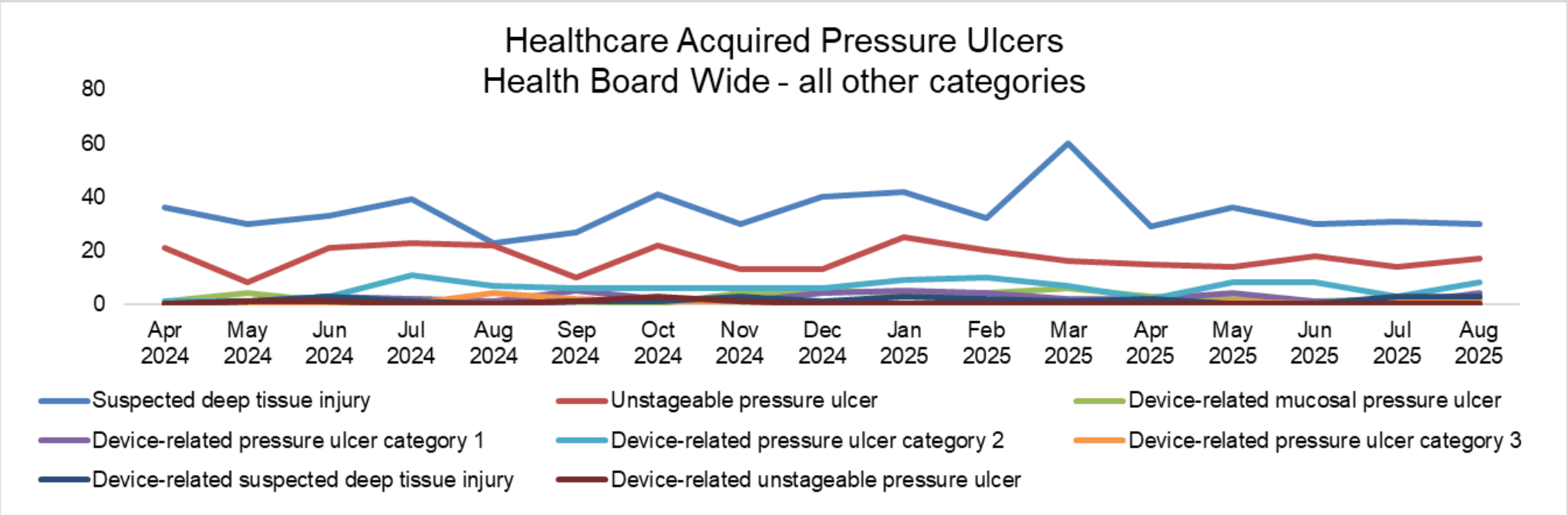
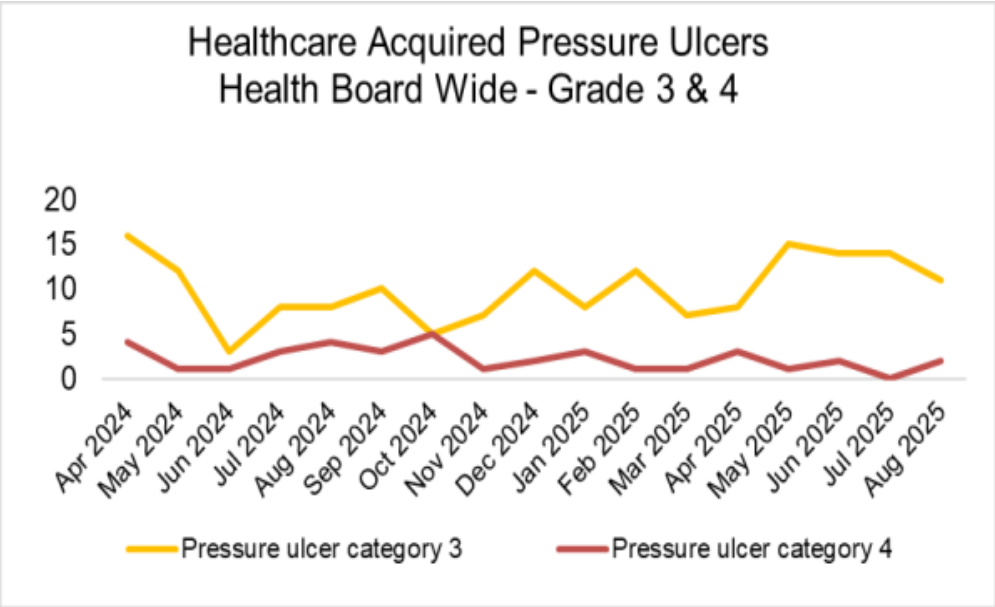
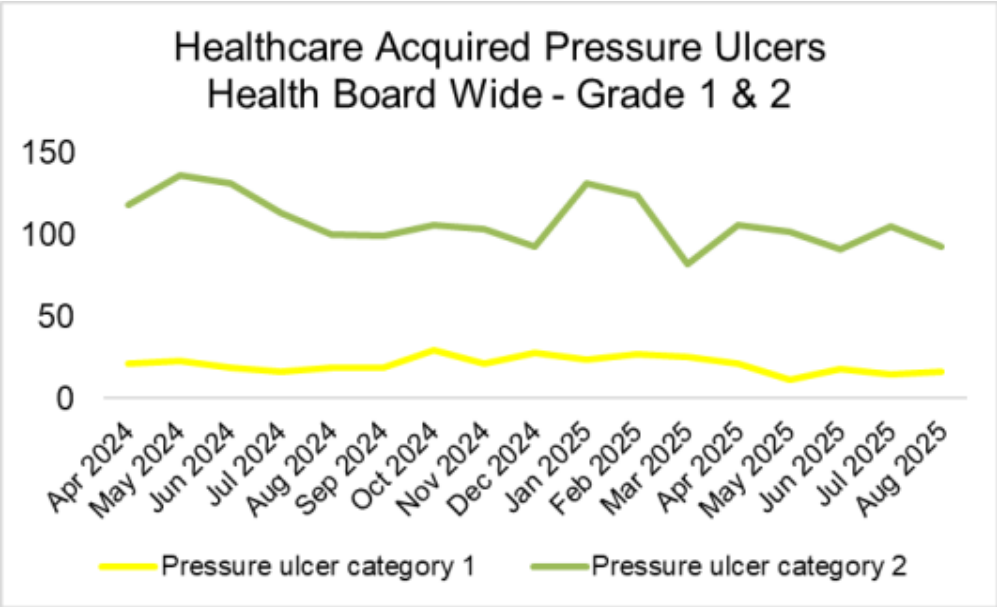
Thematic Analysis Falls with Catastrophic Outcome:

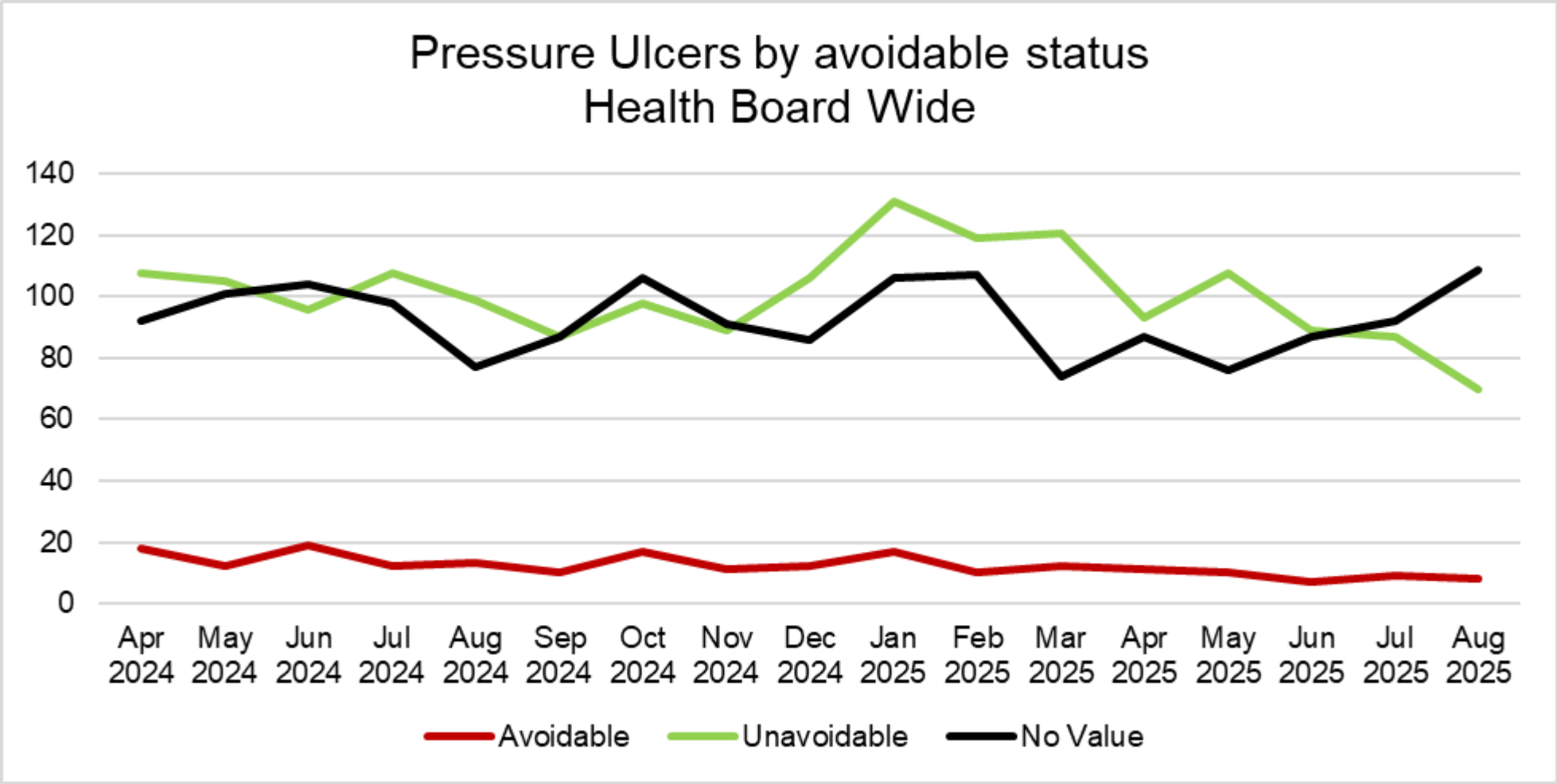
- Informed the establishment of a risk specific register of further recommendations.

Flat Lifting Equipment :

- Equipment procurement to support and improve safe lifting and post falls management.

Hospital Acquired Pressure Ulcers





High occurrence of “No Value” incidents.

No Value incidents pertain to incidents that have not been assessed through a Datix Focus Review to ascertain whether the damage is Avoidable or Unavoidable. Consequently, a key objective of the steering group is to assist divisions in thoroughly reviewing any outstanding cases (No Value) to enhance the validation process.



❖ Re-established Steering Group – Divisional Representation

❖ Agreed Terms of Reference

- The aim of the group is to eradicate the incidences of avoidable hospital acquired pressure ulcer damage and moisture lesions.
- Develop a reliable validation process to ensure accurate reporting
- The 6 pillars of quality will underpin the work of the group, which will embrace a whole-systems approach. Measuring and assessing quality is essential for monitoring progress and identifying areas for improvement.

❖ Primary Focus

- **Improve Datix reporting**
 - **Reducing No Value entries**
 - **Timely review of outstanding cases awaiting closure**
- **Scrutiny panels**

❖ Updates:

The focus at the last forum 5th September was addressing No Value incidents. Below are some of the key issues discussed:

- ❖ Linked records
- ❖ Incidents involving Care/Residential Homes
- ❖ Focus Reviews
- ❖ Wound Classification

All divisions have been asked to focus on reviewing outstanding no value cases from April 2025, this is to be completed by end of October 2025 with an aim to see immediate improvements following the training session.





Issue	Action	Learning and Improvement	Who	When (RAG)
Quality of Datix Reporting – correct grading, duplication, adding a value (Avoidable or Unavoidable), Focus Reviews & closure	Through the Steering Group. work with divisions to develop achievable processes to improve the validation of incidents	Grading guides & resources available on the Tissue Viability webpage to support improvement.	All Divisions	Ongoing
Access to air mattresses Mattresses arriving in clean packaging – damaged or contaminated	Ensure staff are aware of how to access mattresses via Drive Report incidents of damaged or contaminated mattresses to Drive immediately	Posters & booklets available to support mattress choice. Education programme in place at YYF. Plan to roll out to other sites. Review process for mattress purchase and hire across all divisions.	All divisions	ongoing
Timely investigation & share learning	Establish regular scrutiny panels Complete investigations & Yorkshire contributory factors on Datix	Identify themes & actions to improve. Share via QPS forums & HAPU steering group	All divisions	ongoing
Validation for Grade 2 pressure ulcers	Senior Nurse review and sign off for all grade 2 pressure ulcers. Provide information for clinical teams on reporting , roles and responsibilities and the focussed review process.	All divisions to present current flow charts and processes, these are to be reviewed and develop standardised information and guidance. DATIX flow chart shared with all divisions.	Heads of Nursing – All Divisions	October 2025

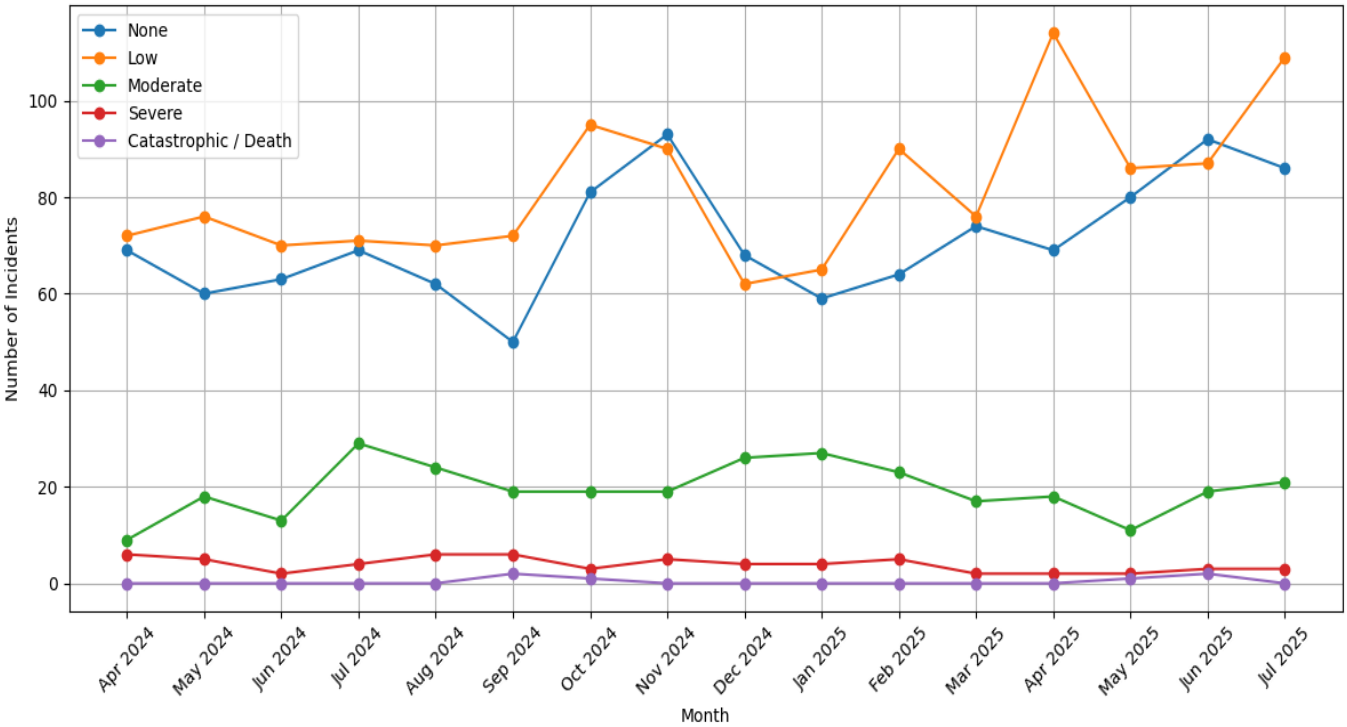


Trends in Medication Incidents



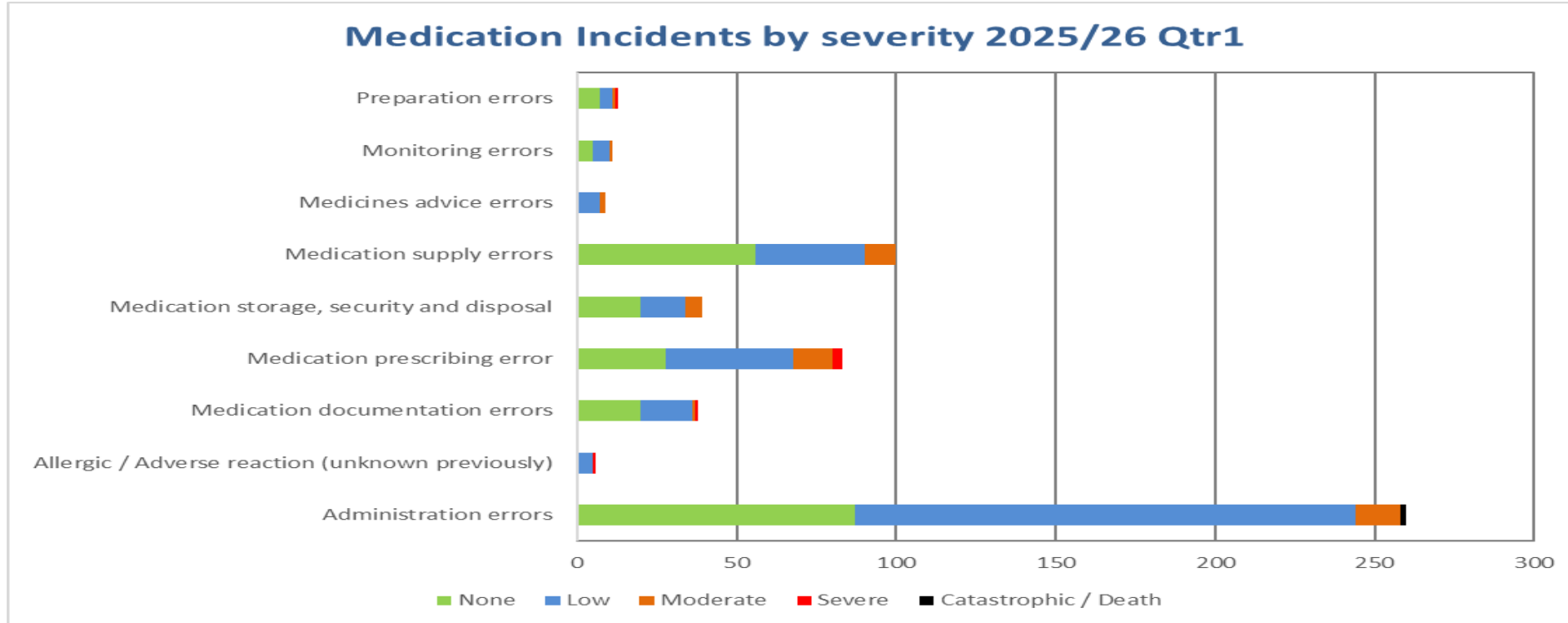
Medication Incidents	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Total
None	69	60	63	69	62	50	81	93	68	59	64	74	69	80	92	86	1,139
Low	72	76	70	71	70	72	95	90	62	65	90	76	114	86	87	109	1,305
Moderate	9	18	13	29	24	19	19	19	26	27	23	17	18	11	19	21	312
Severe	6	5	2	4	6	6	3	5	4	4	5	2	2	2	3	3	62
Catastrophic / Death	0	0	0	0	0	2	1	0	0	0	0	0	0	1	2	0	6
Total	156	159	148	173	162	149	199	207	160	155	182	169	203	180	203	219	2,824

Trends in Medication Incidents by Severity (Apr 2024 - Jul 2025)



- **Low severity incidents** consistently represent the highest category, with a noticeable increase in April–July 2025.
- **No harm incidents** also show a general upward trend, peaking in October and November 2024, and again in June 2025.
- **Moderate incidents** fluctuate but remain relatively stable, with a spike in July 2024 and again in July 2025.
- **Severe incidents** are low and stable, with no significant spikes.
- **Catastrophic/Death incidents** are rare, with isolated occurrences in September 2024, October 2024, May 2025, and June 2025.





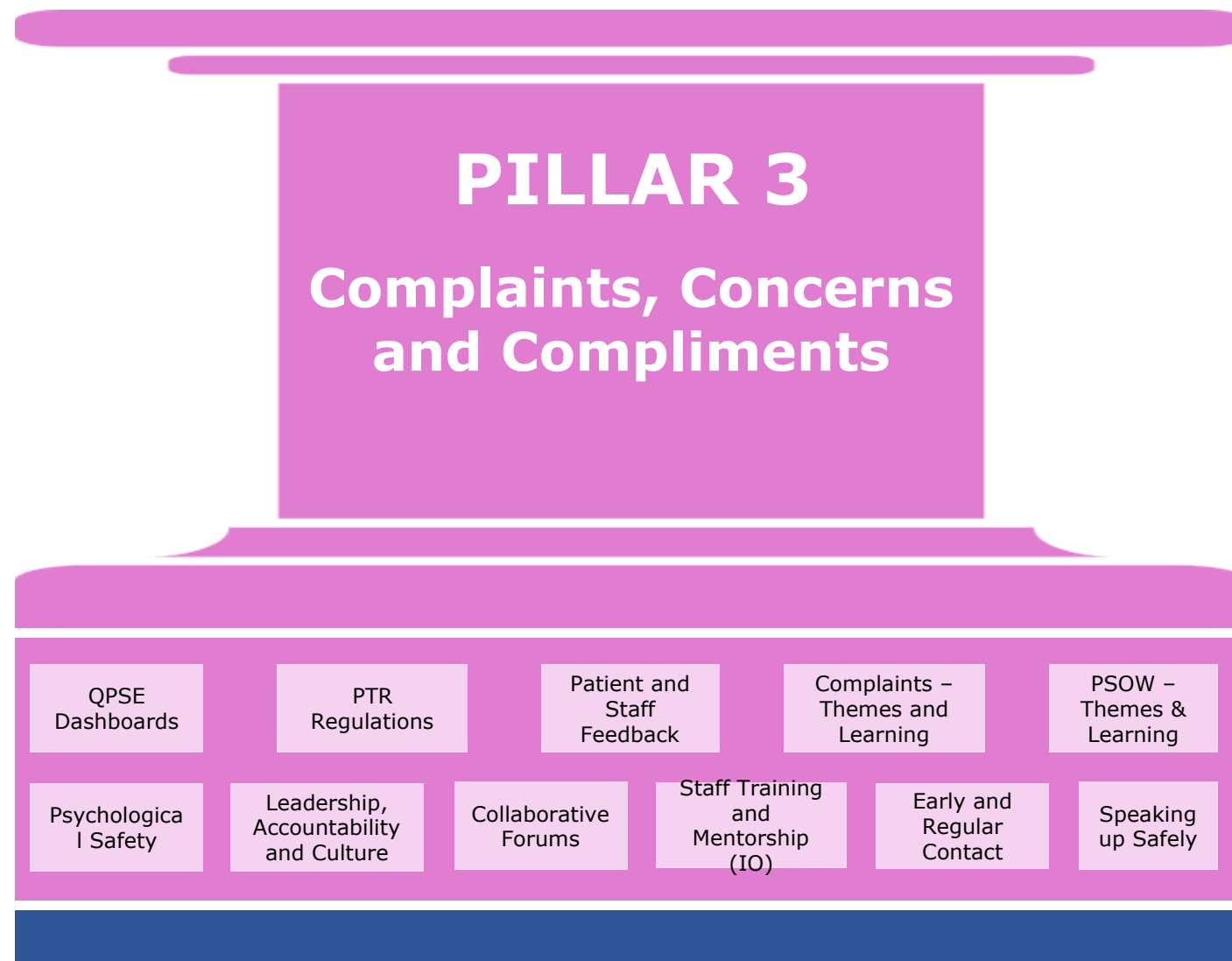
Administration errors are the most frequent, with the highest number of incidents.
Medication prescribing errors are the second most common.
Other notable categories include: Medication documentation errors, Monitoring errors and preparation errors
Medicine consistently reports the highest number of incidents across all three months.
Most divisions show fluctuations across the three months, but no single month stands out as universally higher or lower across all divisions.

Medication Safety Group 2025/26



Item	Action	Learning and Improvement Progress	Who	When
Meeting the HEIW Standards for Quality Assurance for all Non Medical (NMP) and Supplementary Prescribers (SP)	Action plan for N&M complete. MDT group representing IPs and SPs met and action plan for all disciplines will be managed. Declaration of Scope of Practice – well embedded Royal Pharmaceutical Society – competencies converted to self-assessment document Demonstrating competence – Portfolio document developed and awaiting ratification by the group.	Standardisation process is now being embedded by N&M leads MDT leads engaging and aligning within individual regulatory bodies and HEIW requirements. Meeting held June 2025 with professional representatives and HB action Plans populated for nursing, pharmacy and allied health care professionals	Karla Hobbs, member of the short life working group Includes Karen Hatch (HCPC), Hana Thabrees (pharmacy)	6 – 12 Ongoing work with updates provided to quarterly Med safety group.
High Risk Medication - Categorise and report incidents related to high-risk medications at MSG.	Priority 1 – Anticoagulation incidents. Task and finish group will meet and identify; a. The processes in place for prescribing and administering anticoagulation b. The risks and barriers to target change Priority 2 – Time critical Medicines Priority 3 - Insulin	ERASE poster and Staff bulletin –MDT and organisational approach required to manage incidents. A deep dive required for anticoagulant action plan and review processes and protocols. T & F group met June 2025 New Dashboard in development to capture and analyse anticoagulant and time critical medicines incidents	Task and Finish group. Divisional leads/ KH/Pharmacy lead CB/JT/JH Dashboard Support from Lynne Davies	
Medicines Governance Audits	Develop a comprehensive medicines audit governance tool. .	Current tool taken from the DECI includes medicines audit requirements Separate tool from AMaT is required. Work with divisions to identify all medicines storage areas	KH/JH /AG Met May 2025 Support from Grace Hargreaves	
Controlled Drug SOPs	Complete the SOPs for all CD SOP recommended by CQC.	8 CD SOPs to include the journey from ordering to storing within the clinical area are ready for review. This is support the recent ERASE poster CD SOP for use in community under review	Karla Hobbs – In progress working with pharmacy and QPS leads	

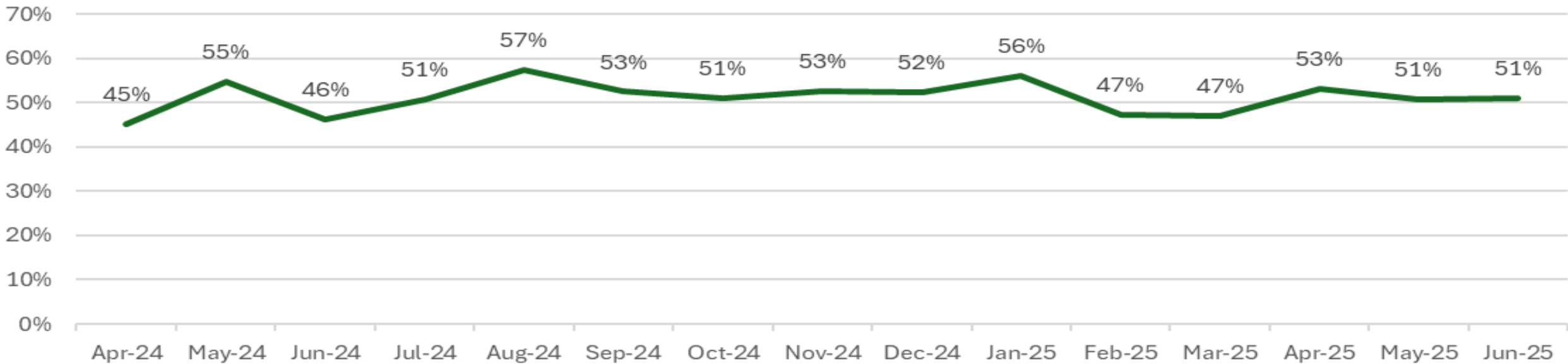
BESS – Document review in progress, meeting with leads from Primary and Community care for feedback related to BESS. BESS – Document review in progress, meeting with leads from Primary and Community care for feedback related to BESS. Education and Revalidation review for N&M –Divisional N&M Practice educators met March 2025. Ongoing key stakeholder engagement to progress the policy. Final draft policy due by Sept 2025.



Putting Things Right – 30 day performance



PTR % Compliance
(30 working days)

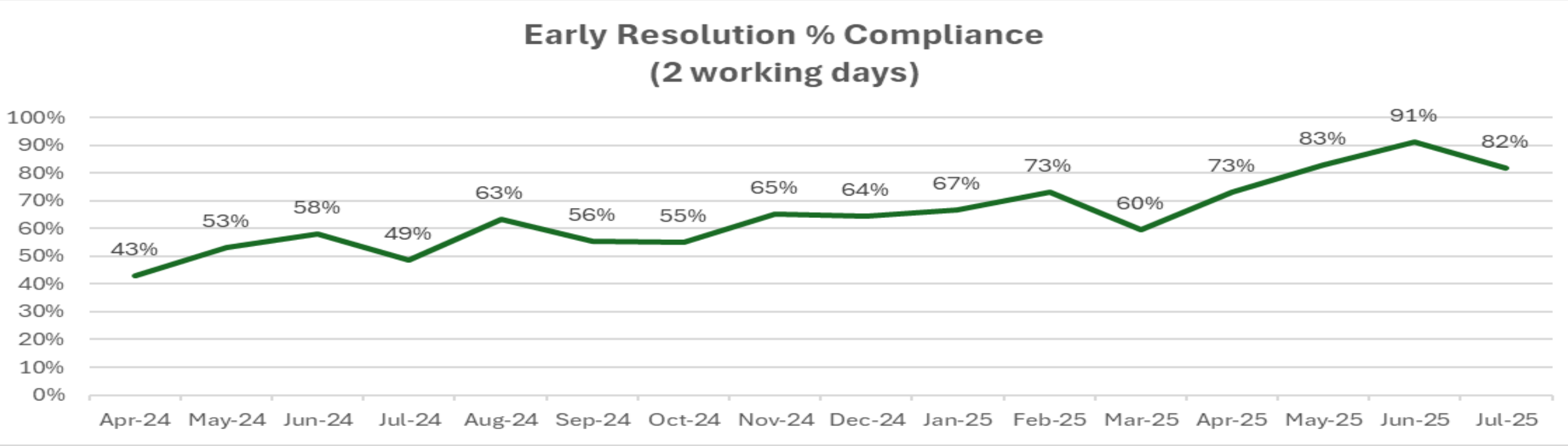


Definition	Analysis	Implications
The above represents the organisation’s rolling position for compliance with the WG target of responding to concerns managed under PTR (formal). Reporting is now aligned with NHS Executive Beacon Dashboard, therefore % Compliance is being reported against the month received. This data is obtained from the Once 4 Wales RL datix system, which is populated by the Health Board’s corporate PTR team. The data is live and is an ever-evolving picture as matters are opened and closed by several members of the team during the course of the mandated timescales for recording concerns 9-5, Mon-Fri.	The data is reported up to June to align with the Beacon dashboard and to ensure that inaccurate data is not recorded, noting 6.82% of cases received in June are still open within the compliance timescales and being expedited. The trend for those matters closed under PTR has been relatively consistent across the reporting period, this has been achieved through continued targeted work by PTR and the QPS SMT. It is intended that benchmarking will be provided in the future, to offer a more meaningful comparison of performance and measurement on a National scale.	The QPS SMT have given considerable time to the validation work. This is being supported by dedicated sessions to assess and close concerns on a regular basis Further dedicated time has been allotted to continue work with Divisional colleagues to decrease aged cases. Closure of any case which is >30-working days will negatively impact cases that are being closed within compliant timeframes. Focused weekly sessions have been instigated by the SMT to monitor and escalate where required cases approaching compliance deadline to ensure those which can be achieved within timescale are being driven by the co-ordinators.

Putting Things Right – Early Resolution Performance

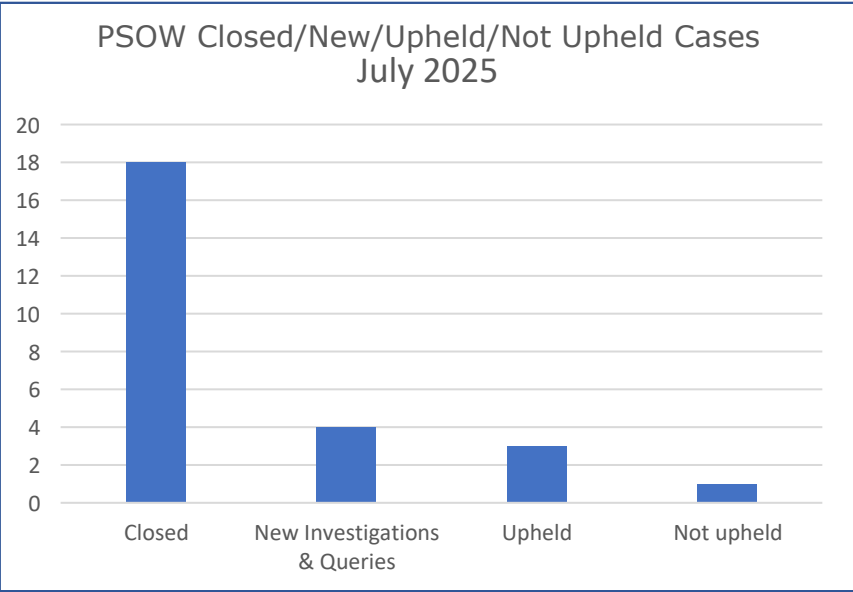
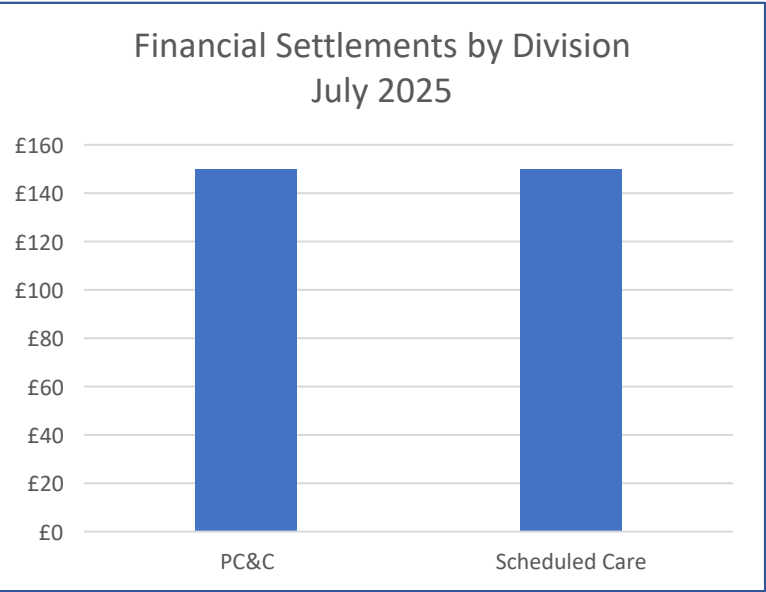
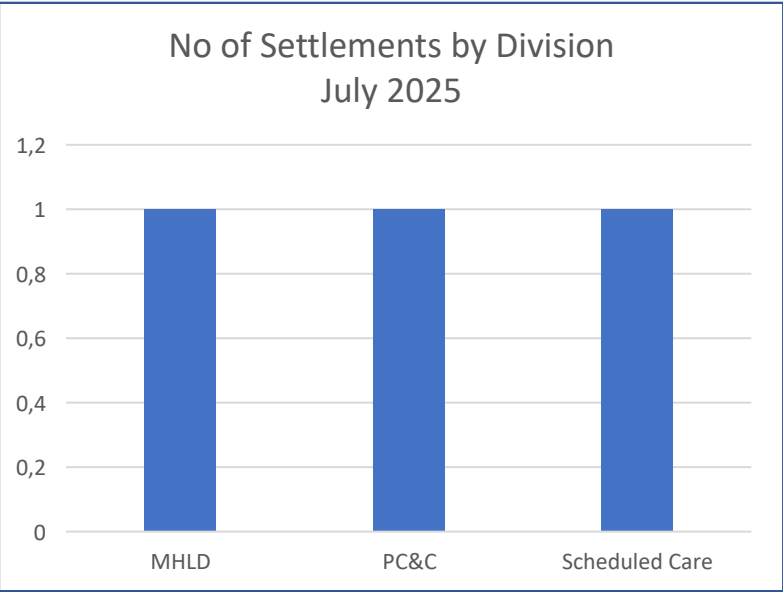


	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
	2024							2025						
Early Resolution	133	117	133	126	149	150	118	180	126	171	85	77	48	71
Managed Through PTR	154	143	132	158	106	116	102	134	90	134	142	144	149	114
Reopened	3	5	4	3	2	4	3	1	2	2	2		2	0



Definition	Analysis	Implications
The trend in the type of concerns being received has seen a positive shift towards more matters being considered via Early Resolution since December. The trend has been maintained throughout Q4 25/26 and into Q1 25/26.	Completion of Early Resolutions proformas to ensure robust information has been rolled out across all Divisions. Coupled with Triumvirate engagement sessions to highlight the importance of sharing information with the PTR team who can help in contacting complainants to support them with Early Resolution.	Early Resolution response times are considerably faster than formal processes and resolve the issues raised by individuals through a more person-centred approach. Current timeframes do result in a number of matters being escalated formally. Which will impact the numbers able to be managed as Early Resolution pending adjustment to the Regulations in Spring 2026. A position and monitoring dashboard is now being shared with the Division and Directorate teams to allow greater visibility and oversight for maintaining compliance.

Ombudsman (PSOW) & Regulation 28



Issue	Action Taken Position/ Learning & Improvement
Delays in the issuing of complaints responses	Complainants are now being acknowledged within the required timeframes, their expectations are being managed in terms of expected contact timeframes and work remains ongoing via dedicated sessions to decrease the numbers of historic concerns, available to PSOW for delayed responses.

Learning and Completed Recommendations

Issue: Documentation and Communication: Notes were not taken during a meeting with a family and an agreed update regarding medication was not provided. medication, as agreed in the meeting.

Learning & Actions: An apology will be issued, and updates on the Health Board’s Serious Incident Investigation recommendations will be provided.

Issue: Investigation Delays: There was a delay in concluding the investigation and communicating the outcome. Improvements have since been made to receipt and acknowledgment processes.

Learning & Actions: As part of the resolution, a formal response will be issued and compensation of £150 will be paid for the delay.

Issue: GP Practice Complaint Response Delays: The complaint response was delayed due to the E-Harley system transition.

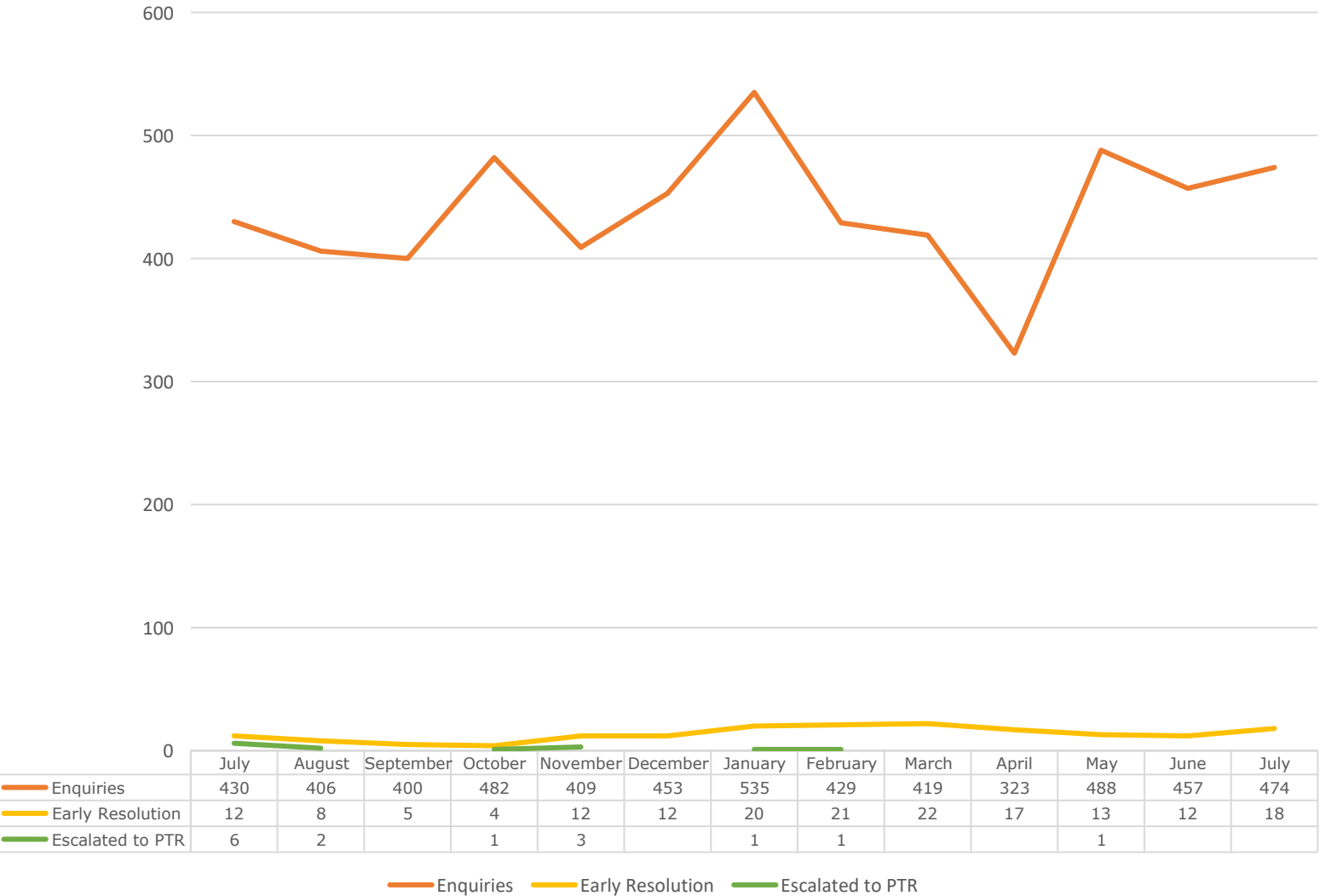
Learning & Actions: A formal response will be issued and compensation of £150 will be paid for the delay.

Reg 28: Prevention of Future Deaths Report

The Coroner issued 2 Regulation 28 reports during July.
One report related to a delay in offloading an ambulance at GUH.
The second related to difficulties in sharing of information between Primary Care Go and Secondary Care Mental Health & LD services. Comprehensive responses are in the process of being compiled for both reports and will be subject to Executive scrutiny.



Total Contacts Received by PALS
Enquiries/Early Resolution/Escalated to PTR

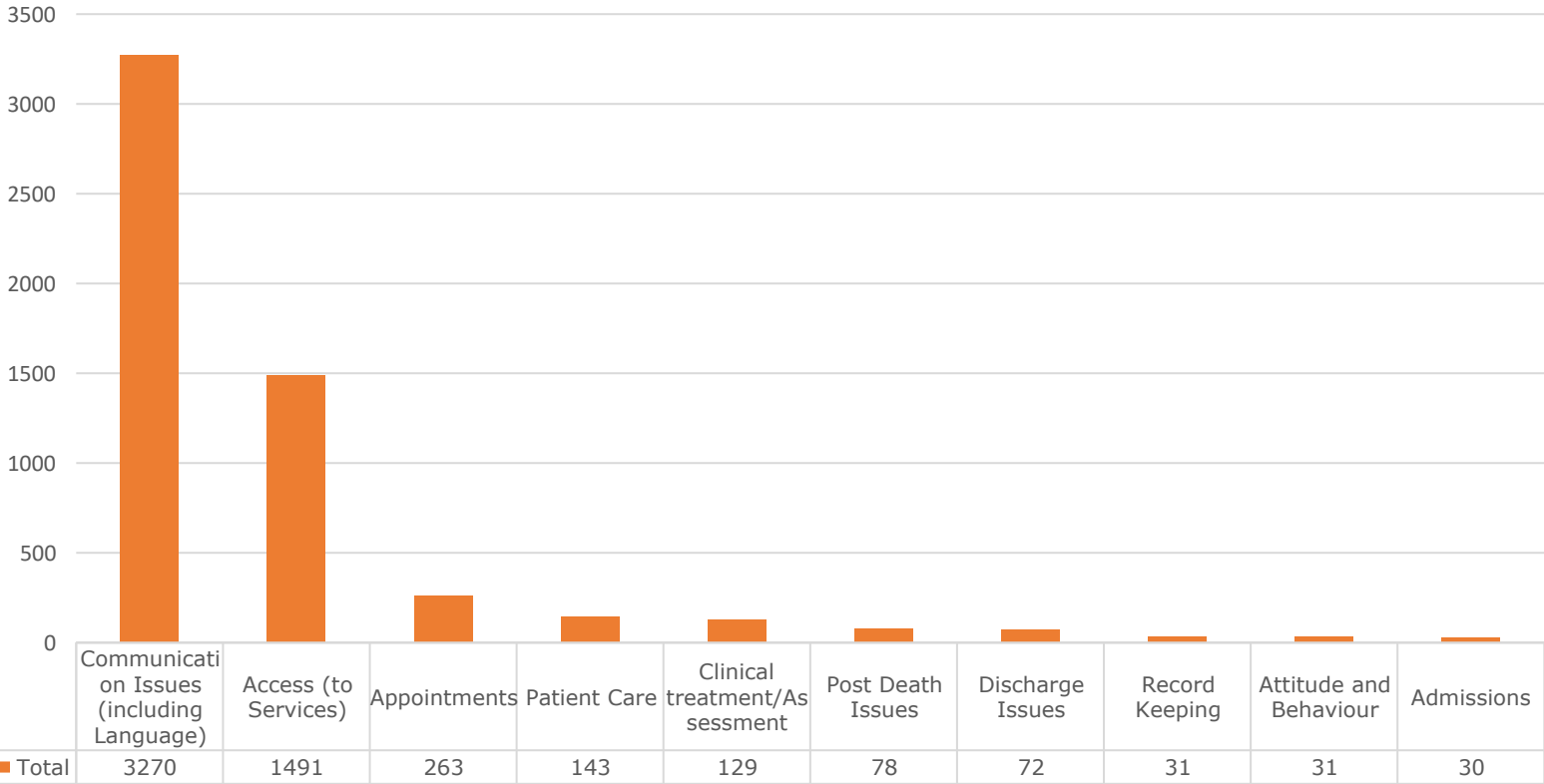


July 2024-July 2025

- **5896 cases managed by PALS**
- **17 Escalated to PTR = 0.28%**
- **Early Resolution primarily applies to concerns sent from PTR to PALS.**
- **While many concerns handled by PALS could be classified as Early Resolution, they are managed as Enquiries due to the complexity and nature of the cases.**



Top 10 Enquiry Themes
July 2024 - July 2025



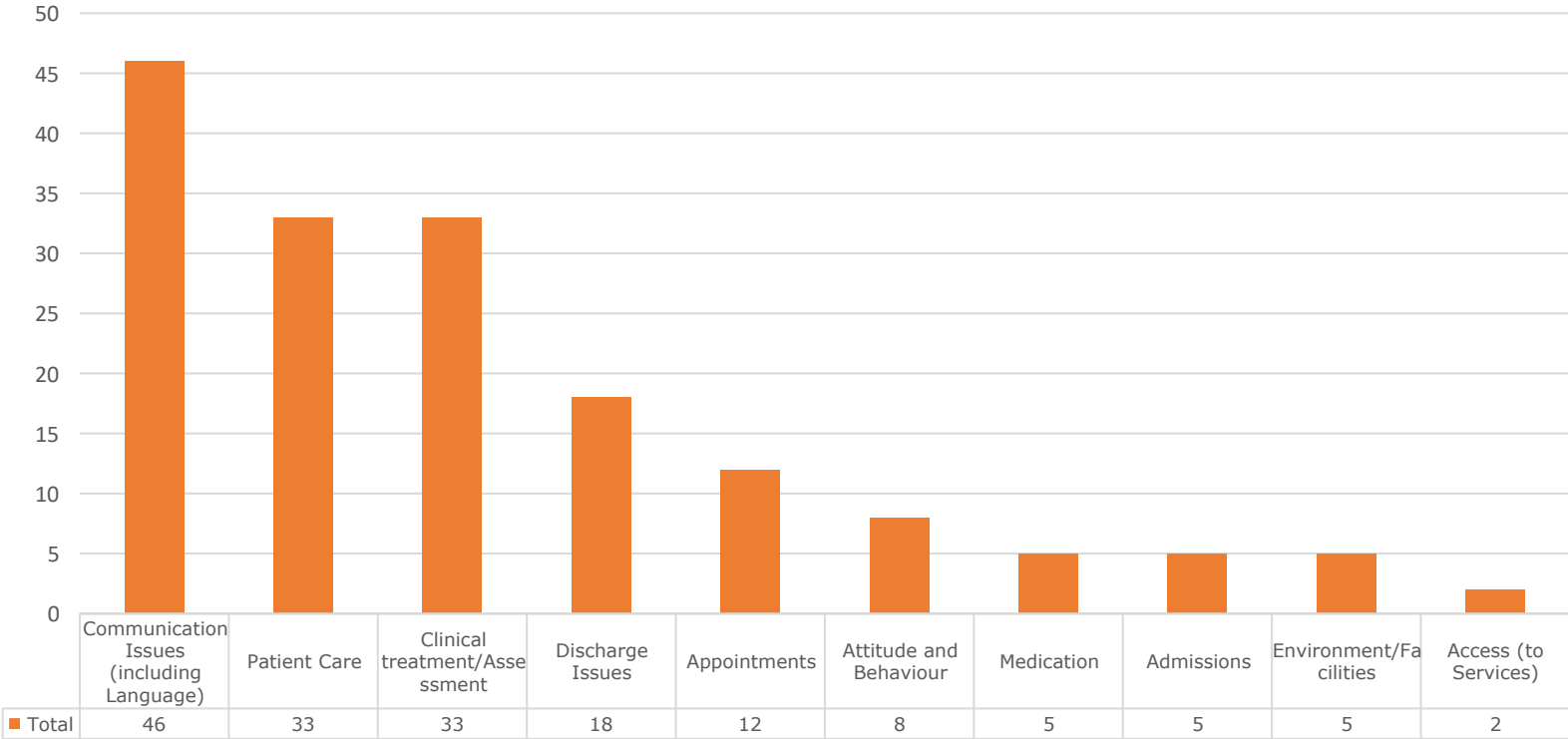
Themes	Count
Communication Issues	3270
Access (to Services)	1491
Appointments	263
Patient Care	143
Clinical treatment/ Assessment	129
Post Death Issues	78
Discharge Issues	72
Record Keeping	31
Attitude and Behaviour	31
Admissions	30

Of 5719 Enquires the overall Theme is Communication Issues, with 3270 Enquiries related to Communication - 57%.





Early Resolution Top 10 Themes
July 2024 - July 2025



Themes	Count
Communication Issues (including Language)	46
Patient Care	33
Clinical treatment/Assessment	33
Discharge Issues	18
Appointments	12
Attitude and Behaviour	8
Medication	5
Admissions	5
Environment/Facilities	5
Access (to Services)	2

176 Early Resolution Complaints

46 concern Communication Issues - **26%**.

Patient Advice & Liaison Service – Case Study

Case Study 1:

A patient with a laryngectomy tube was transferred from one hospital site (Site A) to another (Site B) within the health board. Upon arrival at Site B, the patient was turned away due to the site’s inability to meet the patient’s complex care needs, and was subsequently returned to Site A.

The patient and their family experienced distress and disappointment due to the manner in which the situation was handled. They were particularly concerned about the lack of clear communication regarding why Site B could not accommodate the patient. The patient’s spouse, who had been actively involved in daily laryngectomy care, sought clarification on the underlying issue. A family meeting was arranged with the support of the PALS team. During the meeting, the concerns were discussed openly. It was acknowledged that the situation presented an opportunity for learning, particularly around communication and coordination of care.

The family was reassured that the team at Site A is trained and capable of managing the patient’s laryngectomy care, even in the absence of daily family support. The meeting helped rebuild trust and confidence in the care team. It was agreed that lessons from this incident would be used to improve future service delivery and communication practices.

This case highlights the importance of clear and compassionate communication during inter-hospital transfers, especially for patients with complex needs. It also demonstrates the value of involving families in care discussions and the role of PALS in facilitating resolution and reassurance.

Case Study 2:

A family contacted the Putting Things Right team to raise concerns about the care their relative was receiving on a hospital ward. The PALS team was copied into the correspondence and promptly reached out to offer support.

The family requested a short-notice meeting on the ward to discuss their concerns directly with the healthcare team. They were seeking reassurance and clarity around the patient’s care. A PALS officer adjusted their schedule to attend the meeting without impacting service delivery. The meeting included the family, ward staff, and other healthcare professionals. PALS supported the family, kept the discussion focused, and helped identify practical solutions to potential care obstacles.

The family felt heard and supported. As a result of the constructive engagement facilitated by PALS, the formal complaint was withdrawn. A positive relationship was established, with PALS continuing to support through bed management to ensure the patient remains in hospital until all arrangements are in place for transfer to a care facility.

This case highlights the value of timely, compassionate support from PALS in resolving concerns and strengthening trust. It shows how proactive engagement can turn a complaint into a collaborative partnership.

Case Study 3:

A patient recently contacted the PALS team requesting support at an upcoming outpatient appointment. They shared that during a previous visit, they felt unheard and left without a clear plan, which made them feel lost within the system.

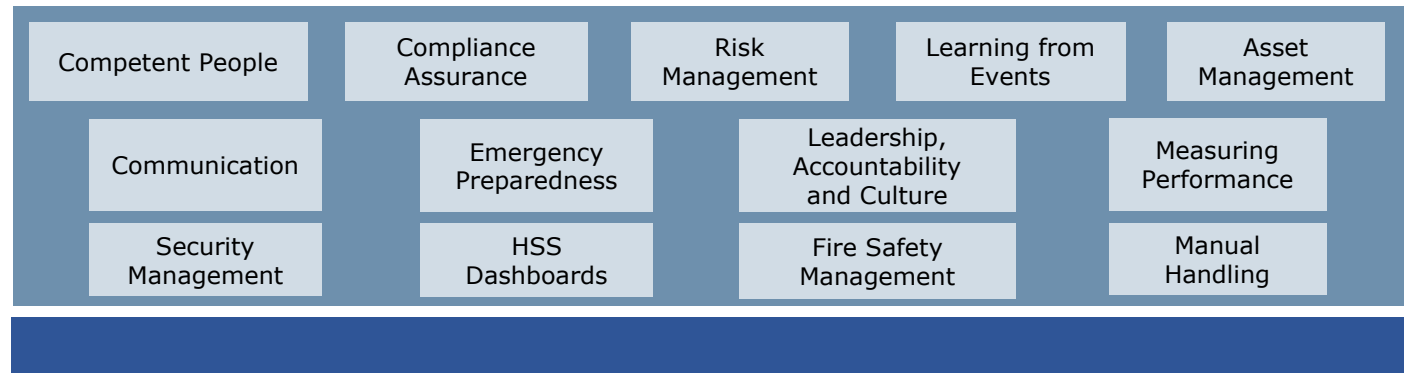
A member of the PALS team attended the appointment to offer support. While they did not speak on the patient’s behalf, their presence helped the patient feel confident enough to clearly express their concerns to the clinician.

Following the appointment, a scan was arranged for further investigation and a follow-up was scheduled. The patient expressed sincere gratitude for the support and has since requested PALS involvement at their next appointment.

This case demonstrates how a supportive presence can empower patients to advocate for themselves, leading to improved care outcomes.

PILLAR 4

Health, Safety and Security

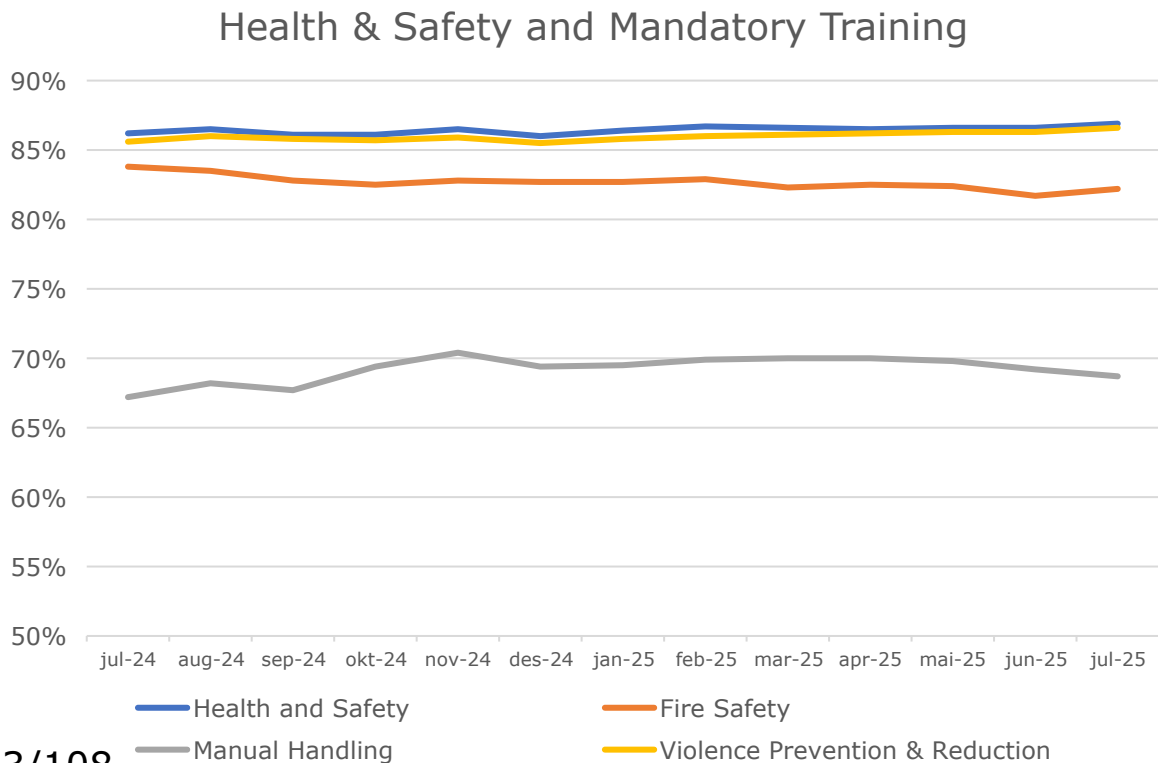




Health and Safety Statutory and Mandatory Training

At end of July 2025 training compliance for the Health Board was reported as below.

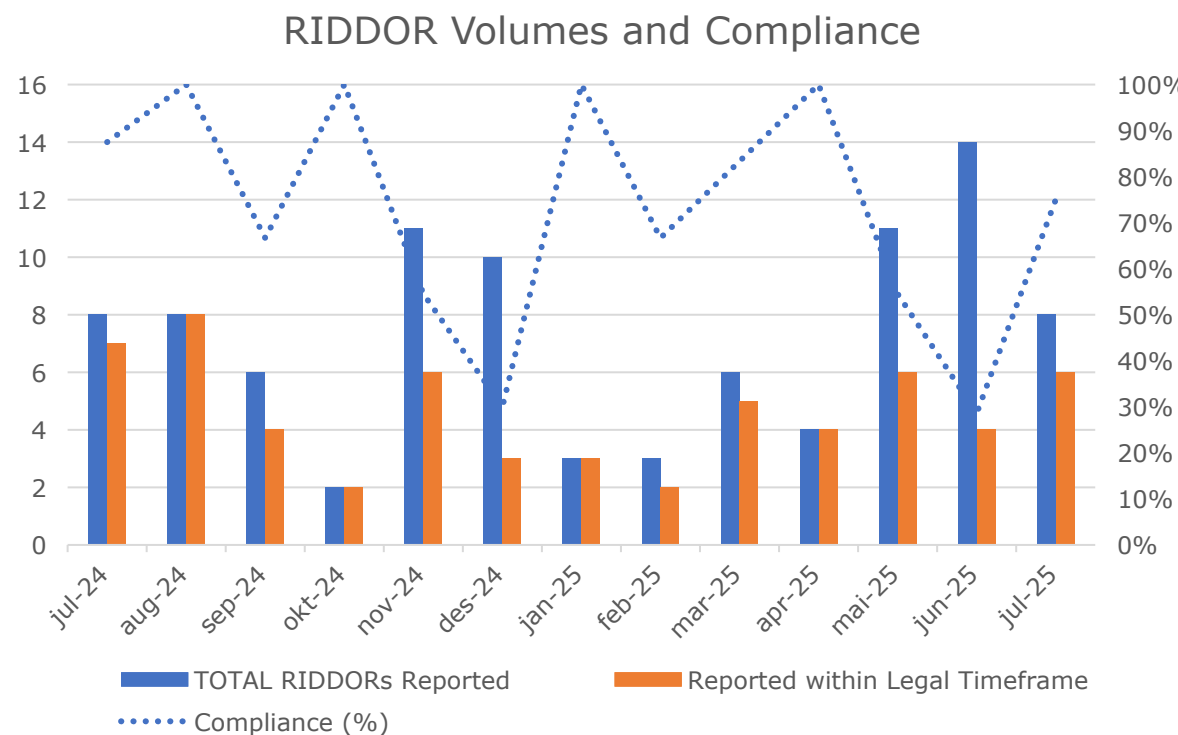
There has been a small increase in training compliance for Health & Safety, fire safety and Violence Prevention & Reduction, however, compliance against manual handling has reduced slightly.



Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

During July 2025 the Health Board have reported **8 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

75% of these cases were reported within the legal timeframes within the legislation. This is a decrease on the previous month. The majority of incidents were reported outside the legal timeframes due to late notification to Corporate Health and Safety.

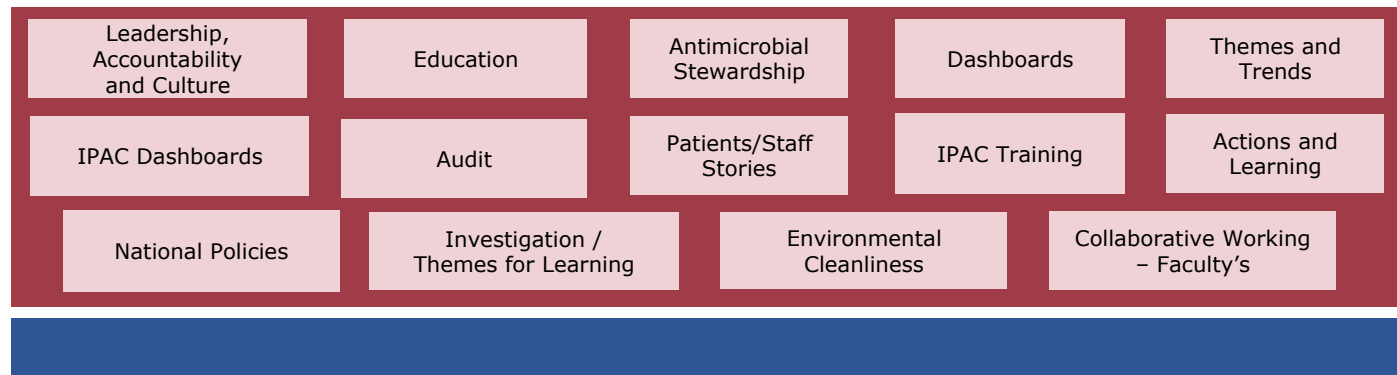


Learning and Improvement

- Review of Training Framework: Competency and Delivery - A review of the training framework is being undertaken to evaluate both the competency requirements and the methods of delivery. This review will adopt a risk-based approach, ensuring that training remains relevant and proportionate to individual job profiles. For example, manual handling training will be tailored to reflect the specific risks associated with different roles—such as patient handling for clinical staff versus office-based duties. This approach ensures that the level of training provided is appropriately aligned with the nature and risk level of the activities performed within each role.
- RIDDOR Awareness and Training Proposal - RIDDOR awareness sessions are being developed to enhance understanding of reporting requirements and responsibilities under the Regulations. To support this, a proposal is being taken through the Core Learning Committee to mandate RIDDOR training for all managers. This training will equip managers with the knowledge and skills needed to recognise and respond appropriately to RIDDOR-reportable incidents, fostering a culture of safety, accountability, and continuous improvement across the organisation.
- Health and Safety Management Audits are being integrated into the Audit Tracking and Management System (AMaT) to support the development of a performance dashboard. This will enhance visibility of areas of non-compliance and focus, enabling the identification of learning opportunities and the creation of targeted action plans for improvement.
- A programme of workplace inspections is planned for the remainder of the year. These inspections will be carried out in collaboration with trade union representatives, fostering shared learning and strengthening engagement in health and safety practices.
- The Health Board remains committed to strengthening its safety culture through education, governance, and continuous monitoring. Efforts are underway to improve timely incident reporting, enhance training compliance, and respond effectively to regulatory inspections.

PILLAR 5

Infection Control and Prevention



Infection Prevention and Control



All Wales – Current FY rate per 100,000 population

Healthcare Associated Infections

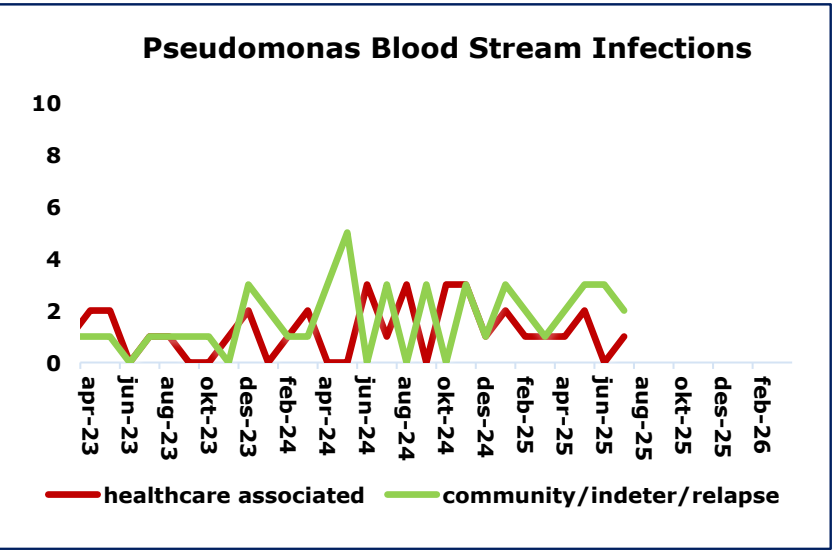
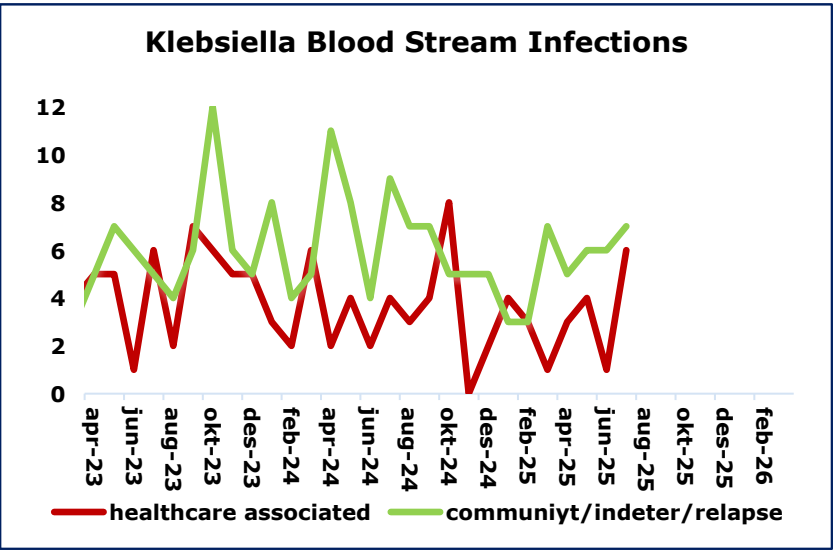
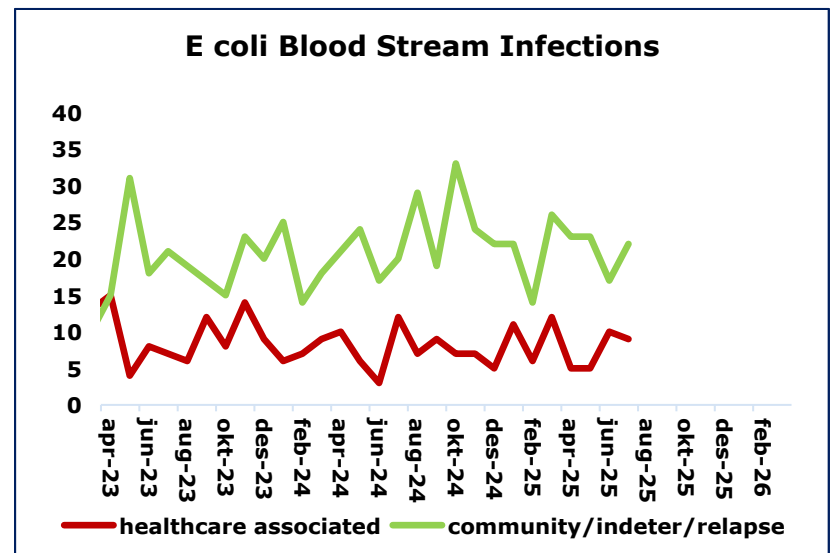
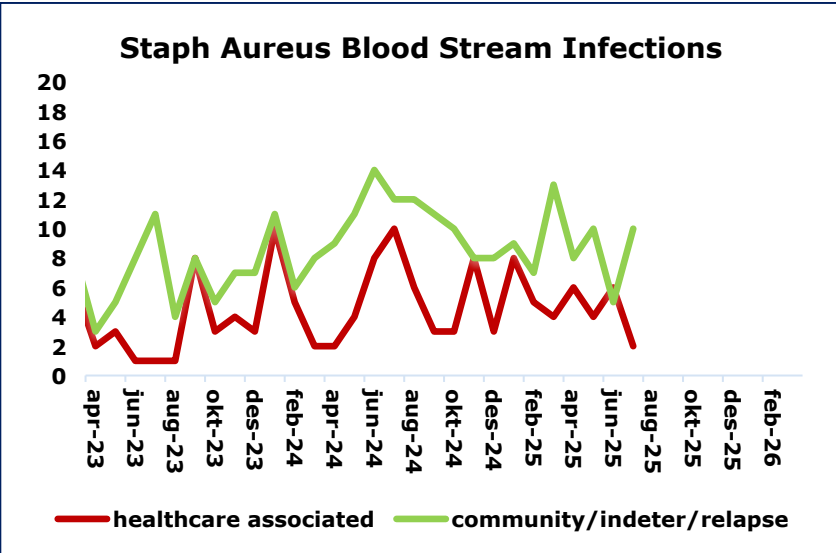
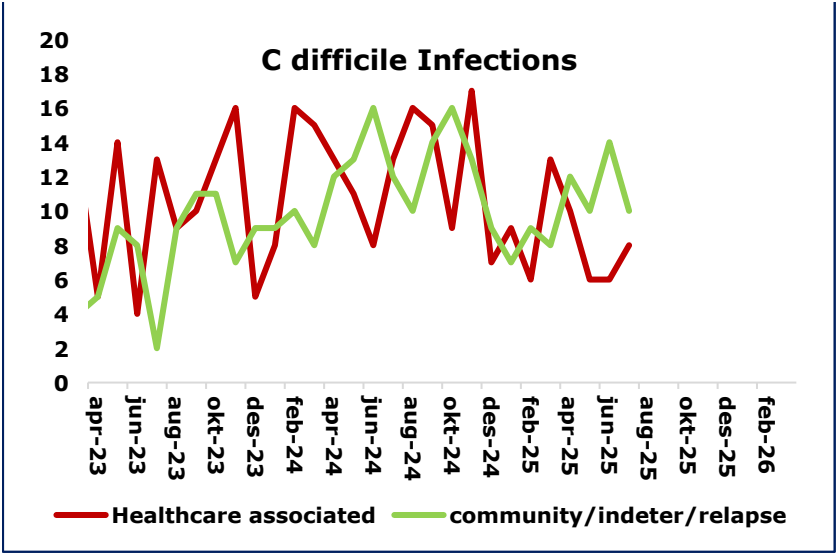
	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	38.69	1.51	24.12	57.28	19.6	7.03
Betsi Cadwaladr UHB	42.8	2.16	28.1	72.63	20.32	3.89
Cardiff and Vale UHB	39.83	3.46	27.71	55.42	23.67	5.2
Cwm Taf Morgannwg UHB	33.5	0.67	24.12	86.43	29.48	2.01
Hywel Dda UHB	46.25	3.08	30.83	94.04	30.06	5.4
Powys THB	17.8	0	2.23	0	0	0
Swansea Bay UHB	59.89	3.07	29.95	71.41	32.25	7.68
Velindre NHST						
Wales	41.69	2.17	26.28	68.73	23.83	4.92

All Wales – Current FY count of specimens

■ < than same period last FY
■ = same period last FY
■ > than same period last FY

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	77	3	48	114	39	14
Betsi Cadwaladr UHB	99	5	65	168	47	9
Cardiff and Vale UHB	69	6	48	96	41	9
Cwm Taf Morgannwg UHB	50	1	36	129	44	3
Hywel Dda UHB	60	4	40	122	39	7
Powys THB	8	0	1	0	0	0
Swansea Bay UHB	78	4	39	93	42	10
Velindre NHST	0	0	1	5	0	0
Wales	441	23	278	727	252	52

Infection Prevention and Control

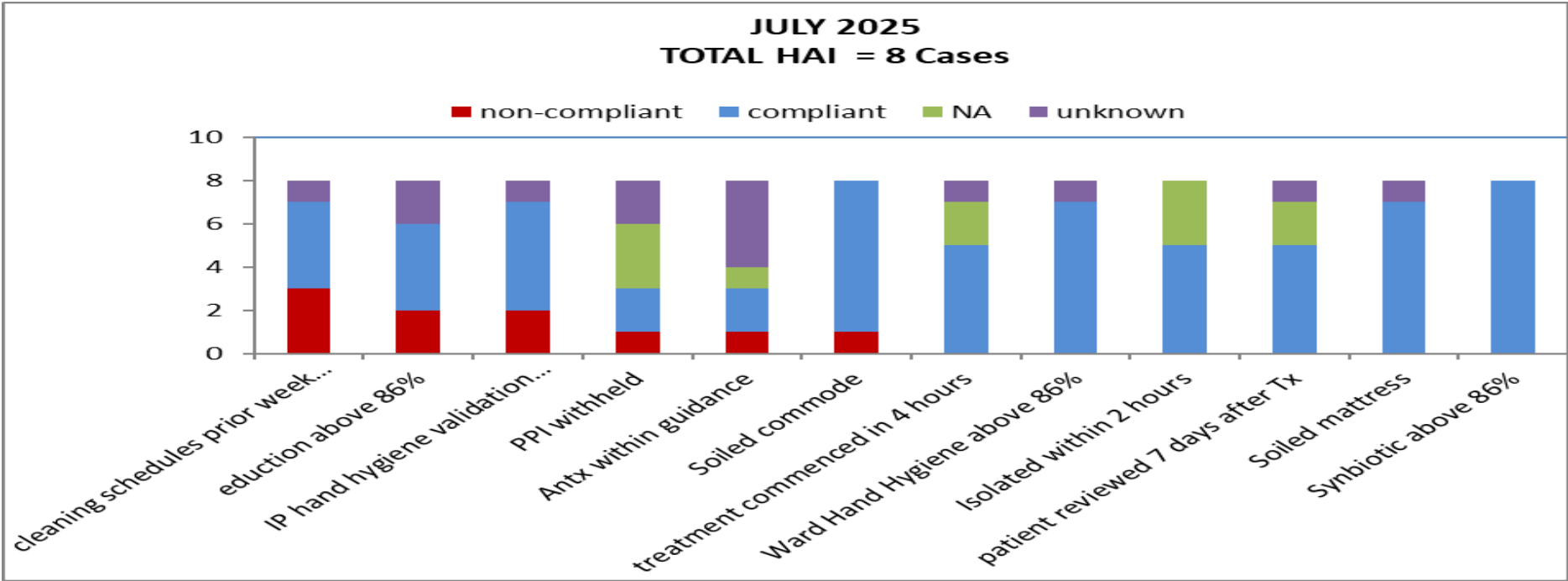


Explanation of Data:

The data provided is a combination of local surveillance obtained from ICNET and validated against Public Health Wales data on or around the 9th of each month. It is accurate at the point of being submitted.

Fundamental IP Measures

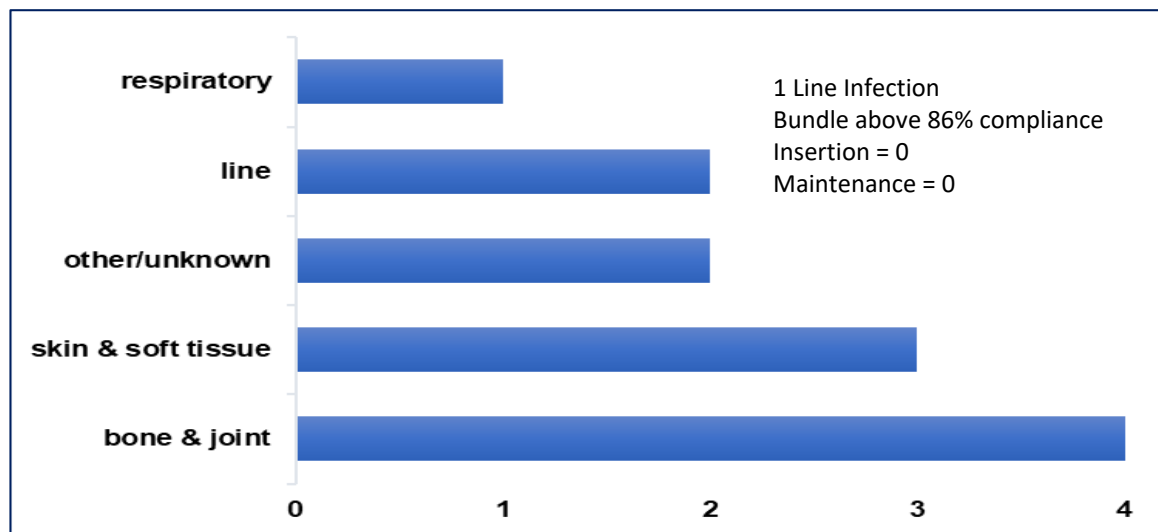
Compliance from RCA for healthcare associated C difficile cases



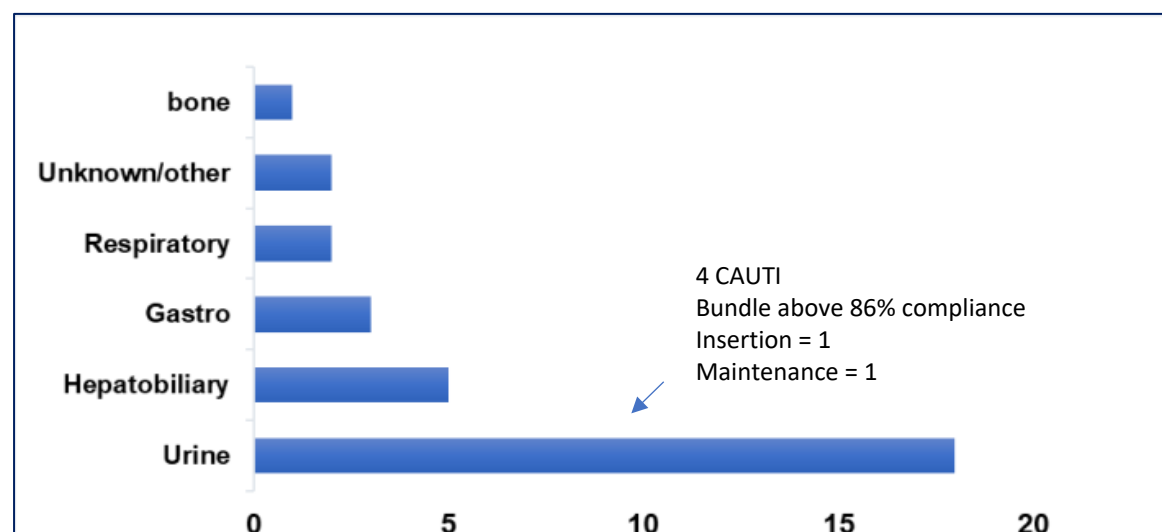
Issue	Action	Learning and Improvement
C difficile infection Apr 2025 – July 2025 = 77 cases 30 = Healthcare associated 28 = Community acquired 5 = Indeterminate 12 = Relapse	RCA undertaken Proactive ward HPV clean commenced at NHH Ongoing promotion of fundamental infection prevention Reviewed AMAT questions to provide consistency Updated level 1 infection prevention training Ongoing Quality improvement work	Isolation reviewed at safe to start Reviewed cleaning schedules and focus on training Uniform policy and hand hygiene promoted

Source of Infection – July Cases

Staph Aureus blood stream infections



E coli blood stream infections



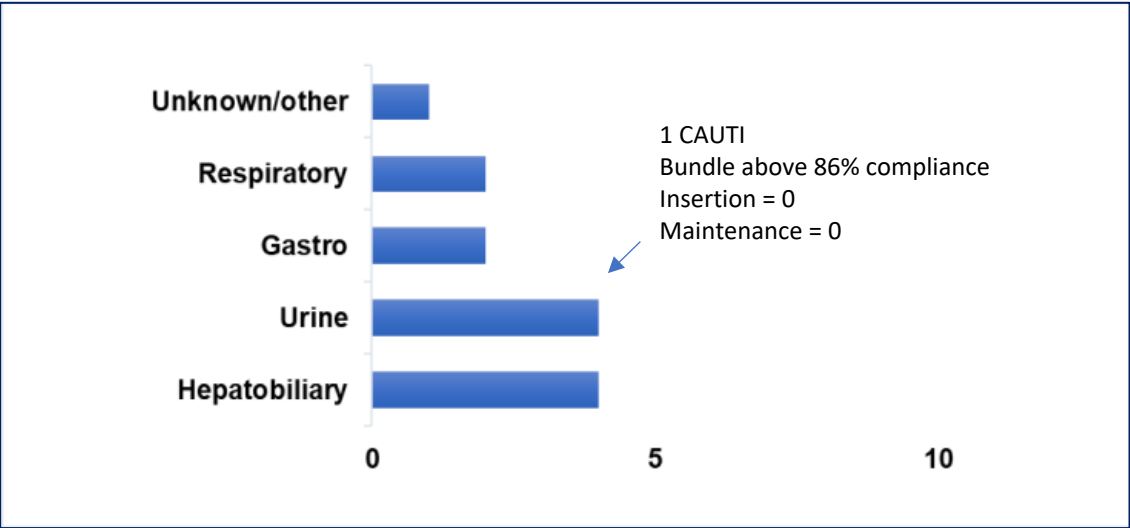
Issue	Action	Learning and Improvement
Staph Aureus BSI Apr 2025 – July 2025 = 51 cases 19 = Healthcare associated 28 = Community acquired 1 = Indeterminate 0 = Relapse 3 = Other Health Board	Reviewed documentation of IV line care Linked with medical team re potential contaminant for blood culture	Developed an IDECEIDE tool for discussion at IPAS 19.08.25 with the aim to increase nursing ownership Promotion of ANTT Dr education session 29.07.25 using a case example

Issue	Action	Learning and Improvement
E coli BSI Apr 2025 – July 2025 = 114 30 = Healthcare associated 80 = Community acquired 3 = Indeterminate 0 = Relapse 1 = Other Health Board	RCA for blood stream infection linked to CAUTI continues. Update at Infection Prevention and Antimicrobial Stewardship group re the AMR in urinary coliforms and blood culture report. Reviewed the cleaning of incubators on NICU.	Promotion of HOUNDINI bundle. Linked with digital re some elements of the bundle not being displayed on WNCR. Promotion of "what pot" circulated. NICU incubator audit developed and available on AMAT.



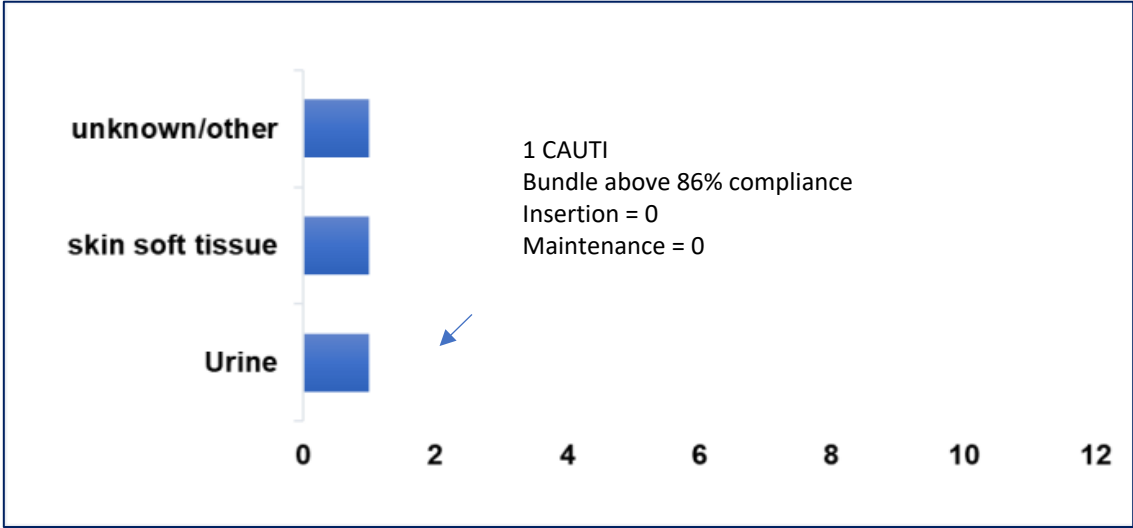
Source of Infection – July Cases

Klebsiella blood stream infections



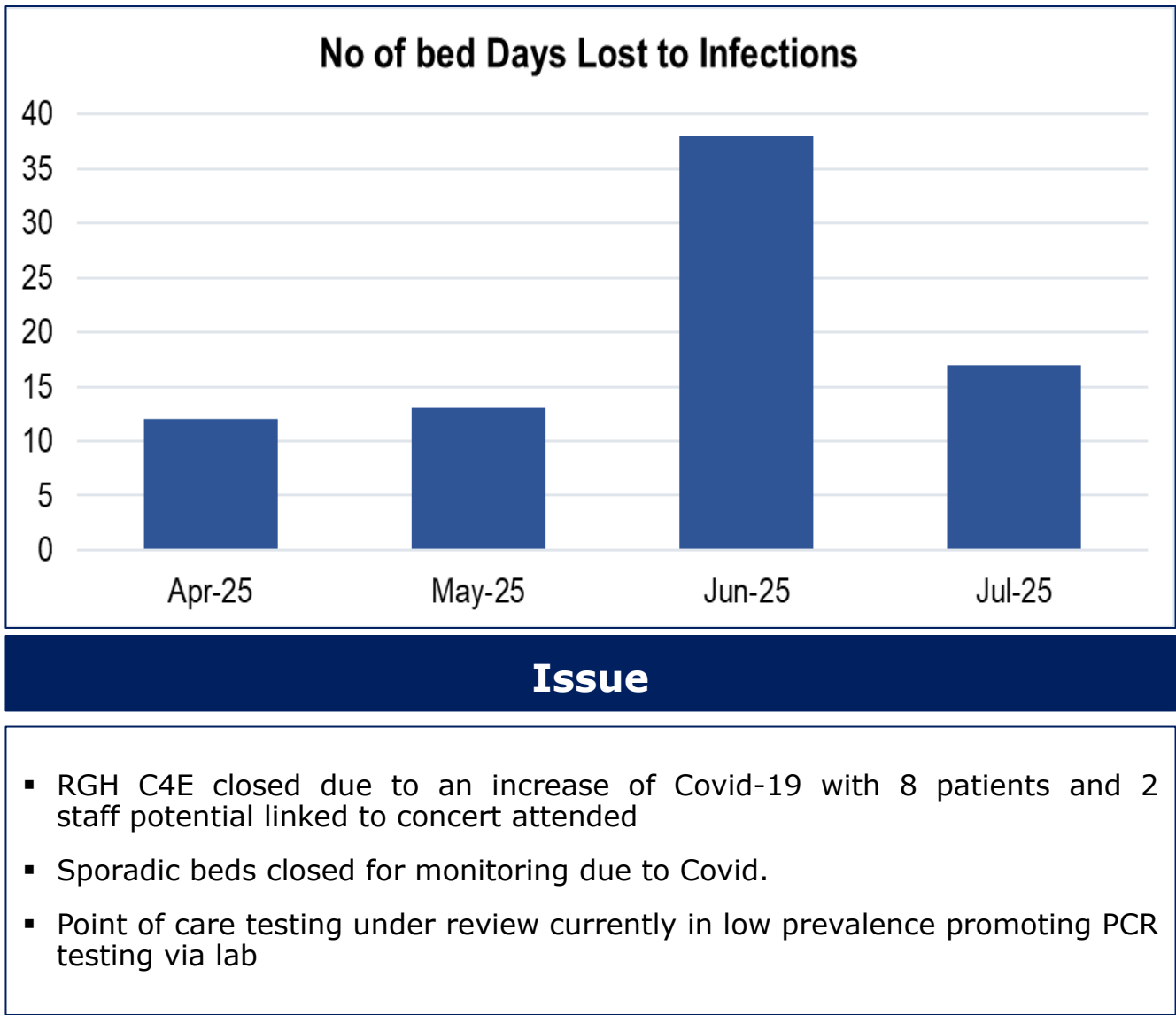
Issue	Action	Learning and Improvement
Klebsiella BSI Apr 2025 – July 2025 = 38 14 = Healthcare associated 23 = Community acquired 0 = Indeterminate 0 = Relapse 1 = Other Health Board	Training package for facilities staff under review	Promotion of best practice, standard operating procedures developed for cleaning

Pseudomonas blood stream infections



Issue	Action	Learning and Improvement
Pseudomonas BSI Apr 2025 – July 2025 = 14 4 = Healthcare associated 6 = Community acquired 2 = Indeterminate 0 = Relapse 2 = Other Health Board	Continue to promote ANTT	

Infection Prevention: Bed Days Lost



Infection Prevention: Learning & Improvement

Issue	Action	Learning and Improvement	Who	When
Patient seen in CEAU & a swab from localised rash tested positive for VzV	Patient was isolated Staff immunity checked – none of concern	Patient was isolated promptly Promotion of staff known immunity	Ward staff O/H and ITP	28.07.25
Patient attended GUH AMU at RGH D1W. Diagnosed with facial shingles.	Patient isolated Contact tracing undertaken	No swabs for VZV PCR sent and no clinical photography to certify diagnosis	Clinical team and IPT	Completed 01.08.25
Known CPE patient discharged from NHH AMU to Care Home. Home not informed of diagnosis on discharge	Medical alert added to other residents Advice given to care home for CPE management	Communication on discharge IPT reminded of the requirements Reviewed CPO GP letter	IPT ward staff	24.07.25
Patient screened on transfer from GUH A4 to UHW and found to have an unusual antibiotic-resistant pathogen.	Ongoing monitoring of ward for any other cases	Patient did not meet the criteria for screening during their ABUHB admission and the patient was isolated during their stay on A4 and ITU. Concerns with HPV cleaning process	IPT Ward staff	Meeting 07.07.25 with 3 months
2 incidences of AFB positive patients affecting GUH ED, RGH MAU and RGH MDCU	Screen families Collect patient lists Reassess the outcomes to determine if further screening is needed	Improve communication to clinical and respiratory/TB nursing team Importance of treating patients as infectious until TB can be ruled out	Clinical teams and IPT	05.08.25 with continued 3 months monitoring

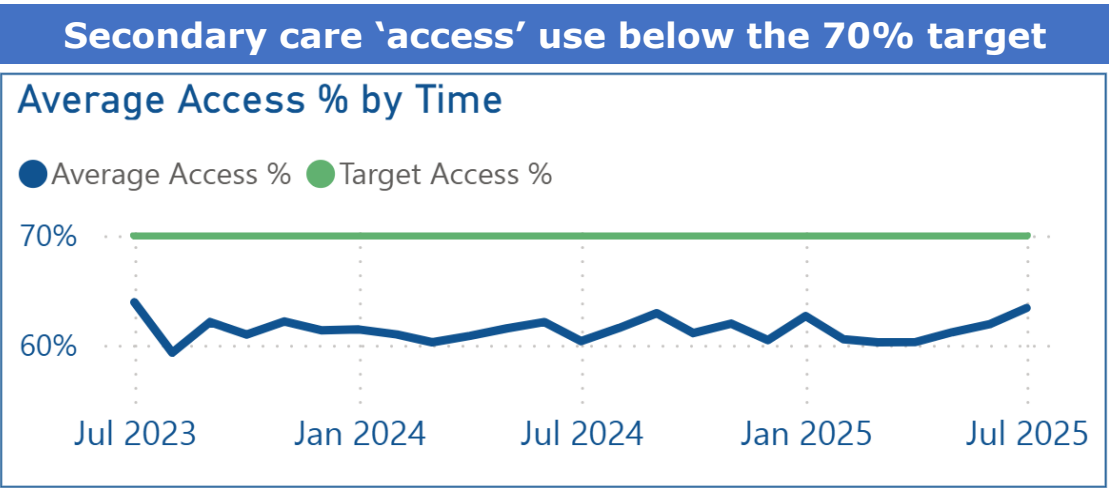
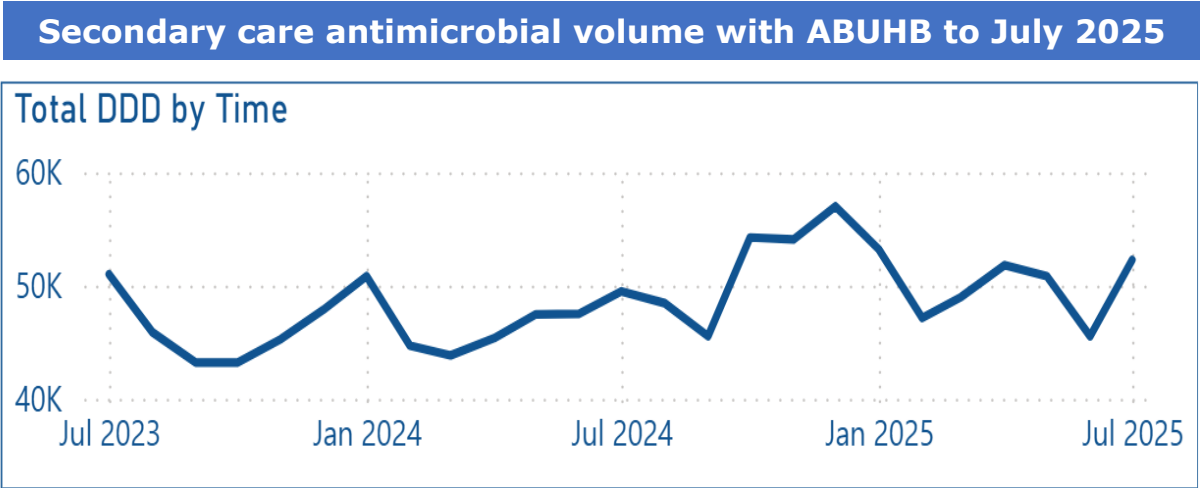
Infection Prevention: Decontamination

Issue	Cause	Remedial Action	Who	When
Holes in wraps linked to orthopaedic sets from theatres note the majority of the holes are being found on the inside of the sets and not visible from the outside	Weight and storage and handling of sets	Reviewed alternative drapes available carry out an audit of STW and complete an audit, of the journey of the tray set and the touch points	HSDU Rep IPT	07.08.25
The RGH endoscopy unit does not have Bowel Screening Wales (BSW) status due to the decontamination provision not meeting BSW capacity coping expectation.	The interim unit is working at full capacity to continue endoscopy service provision to ABUHB patients. BSW deemed the unit a risk of non provision for BSW patients.	Action plan was produced to address issues raised. New build RGH centralised scope decontamination unit which is BSW approved not likely completed until Q1 25/26 Q1 26/27.	HSDU Lead HSDU / Director of Estates & Facilities	Ongoing March / April 26
Authorised Person (Decontamination) AP(D) role not fully functioning from a governance aspect.	AP(D) and works decontamination team are included in the works	Appointment of another AP(D) albeit from within Works & Estates base. Recommendation of joint AP(D) & decon manager report review.	Operational Manager of Works & Estates / Director of Estates & Facilities	September 2025
Risk of losing automated decontamination process for US probes.	Trophon 1s HPV probe disinfectors are obsolete and some removed. Introduction of UV.	Introduction and review of new methods of decon process.	Ultrasound Lead	September 2025
Poor decon process for US probes within Critical care (CC), ED & NICU.	Decon compliance issue within Critical care, ED & NICU	ED, NICU & CC strive to address the training aspects and acceptance within Directorates	ED, NICU & CC leads	September 2025



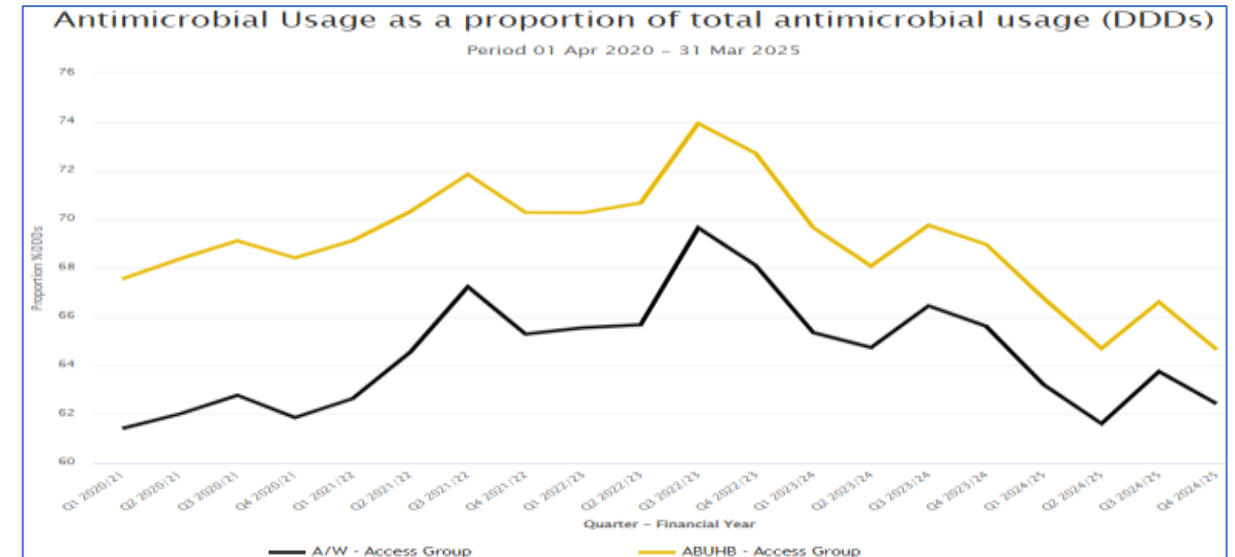
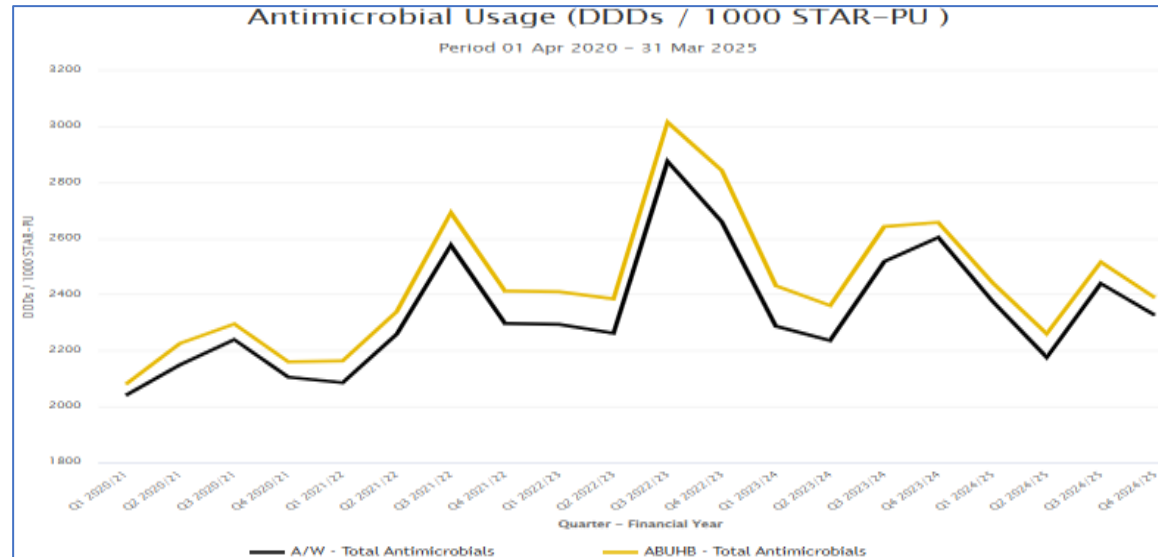
WG Antimicrobial Performance: Secondary Care

- 🌈 No new data are available from PHW. Local data shows no real change in antimicrobial volume up until July 2025 and remains up year-on-year. There has been a slight improvement in the proportion of 'access' antibiotics in July, although still significantly below the 70% target.
- 🌈 Business as usual antimicrobial ward rounds have continued due to improved Medical Microbiology & Antimicrobial Pharmacist staffing. Work is starting to introduce antimicrobial rounds to medical wards at GUH in autumn 2025.
- 🌈 Work continues to embed good antimicrobial stewardship (AMS) principles into the new electronic-prescribing system, with roll-out commencing in 26/27 FY.



WG Antimicrobial Performance: Primary Care

- Data to 24/25 FYE demonstrate a reduction in volume but still tracking above the all-Wales average. This reduction has been assisted by the move from 7-day to 5-day prescriptions for 3 antibiotics commonly used for respiratory infections, with ABUHB achieving the best performance in Wales for this metric.
- The reduction in volume continues to have a negative impact on attainment of the 'access' category target, with ABUHB moving away from the target of 70% prescribing of lower-risk 'access' antibiotics, but above the all-Wales average.
- The AMS team have met with the AB Public Health Team who will be building a dashboard to map antibiotic usage against key demographic & admissions metrics, in the hope that it will provide actionable insights.
- The AMS team have expanded teaching to GP trainees in Q1, and fed back current performance to NCN leads.

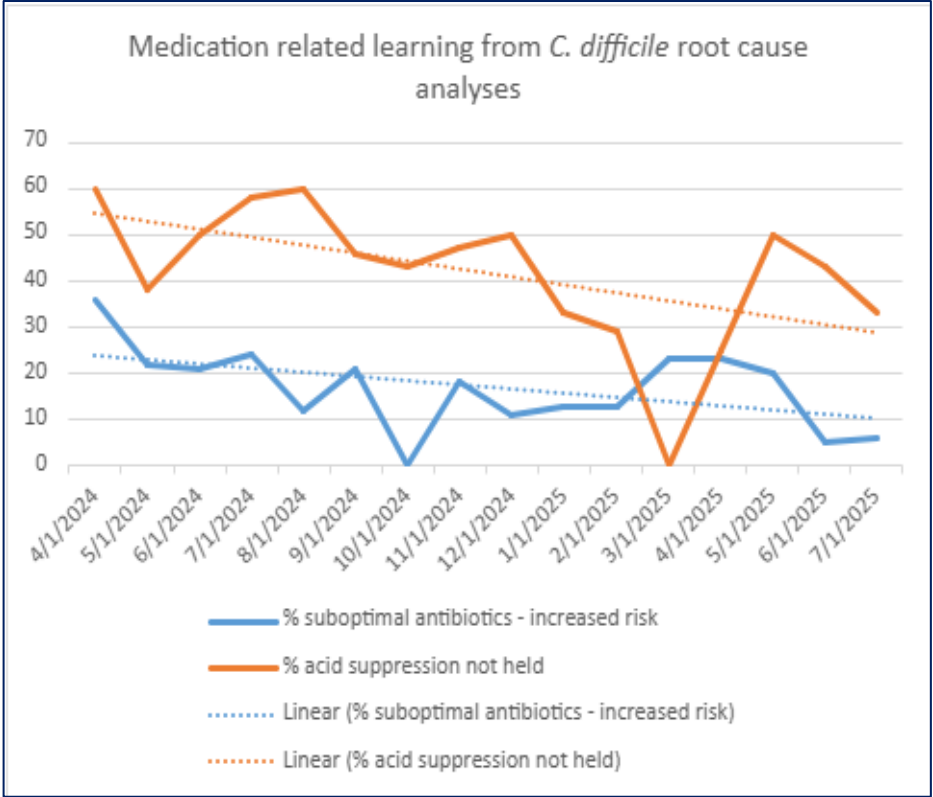


WG Antimicrobial Performance: Overarching Actions

Issue	Action	Learning and Improvement	Who	When
Primary care in-hours GP antimicrobial usage increasing, in spite of audit & feedback cycles with high-prescribing practices	Attended Primary Care Clinical Directors meeting to discuss. Hybrid strategy agreed: thematic work at scale (e.g. syndrome-based education) plus continue 1:1 work for high prescribing practices with a lighter touch approach.	Met with Assistant Primary Care Divisional Director for Partnerships Jan 25 & agreed approach for high prescribing localities. Agreed by 2 of 3 localities to date. Added to Divisional Annual Plan for 25/26, and presented at NCN leads May 2025	Consultant Antimicrobial Pharmacist	2025/26 FY
Antimicrobial staffing: 33% vacancies/maternity leave from February 2025 (baseline 4.33 WTE AMS time)	Explored options for maternity leave cover with secondary care pharmacy team. Plan for replacing project support role discussed. Alternative of technician time explored but limited interest.	Fixed term pharmacist point recruited on second round & commenced in post June 2025	Lead Antimicrobial Pharmacist for Secondary Care	April 2025
Use of order sets (standard prescriptions) in electronic prescribing (ePMA) key to improving antimicrobial use in secondary care. Need to be embedded from go-live to ensure behaviour change	- Discuss with ePMA lead pharmacist once in post - Collaborate with other health boards using the Better system to share workload - AMS team to prioritise developing order sets in 25/26	AMS agreed as a priority area for ePMA development with ePMA lead pharmacist. Weekly meetings commenced April 2025 to review requirements and progress. ABUHB chairing all-Wales group to assist with standardisation & facilitate collaboration with other HBs using the same system	Consultant Antimicrobial Pharmacist	2025/26 FY
Improve divisional engagement with antimicrobial metrics	Working with Assistant Director for Quality and Patient Safety to embed antibiotic indicators into divisional assurance	Secondary care dashboard finalised Dec 24. Met March 2025 and agreed exception template for divisions, pilot pending wider QPS work around pillars.	Lead Antimicrobial Pharmacist for Secondary Care	2025/26 FY
Attempt to model primary care antimicrobial usage data against more demographic parameters to better understand drivers of use	Meeting planned with ABUHB Public Health Team to discuss data collaboration	Met April 25 and discussed available data streams & desired outputs. Further meeting June 25 where Public Health Team offered to develop dashboard.	Primary Care Antimicrobial Pharmacist	October 2025

C. difficile Antibiotic Themes

August 2024 to July 2025						
Antibiotic Finding		HCAI	CAI	Relapse	Indeterminate	Total
No antibiotics received	0	5	4	12	2	23
No suboptimal antibiotics	1	64	13	11	5	94
Possible suboptimal use – no increased risk	0	23	11	6	2	42
Possible suboptimal use – increased risk of C. diff	1	32	8	1	2	44
Awaiting GP response	0	0	37	5	2	44
RCA pending	0	1	1	0	1	3
Total	2	125	74	35	14	250
Please Note: Table excludes entries with "Blank" for Antibiotic Finding						



Learning: July 2025

- **1 patient received suboptimal antimicrobials outside of guidelines:**
 - 4 days of antibiotics for likely viral gastroenteritis
 - 6 day course of piperacillin tazobactam for HAP – antibiotics not de-escalated once source identified
- **6 patients had their acid suppression continued inappropriately**

PILLAR 6

Safeguarding

Policy/SOP

Leadership,
Accountability and
Culture

Level 1, 2 and 3
Training

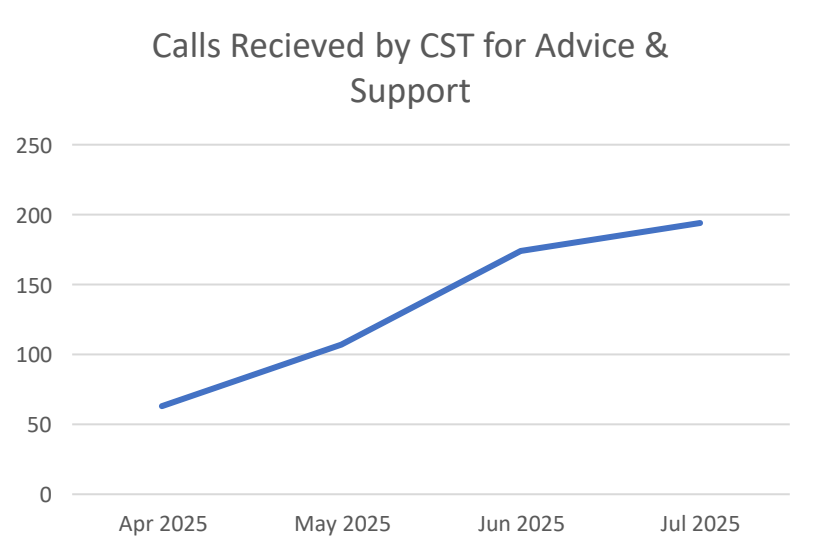
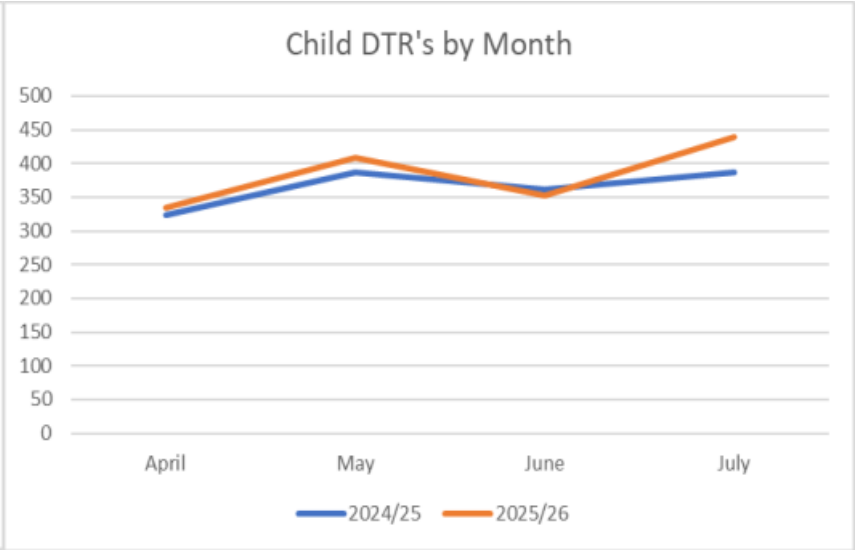
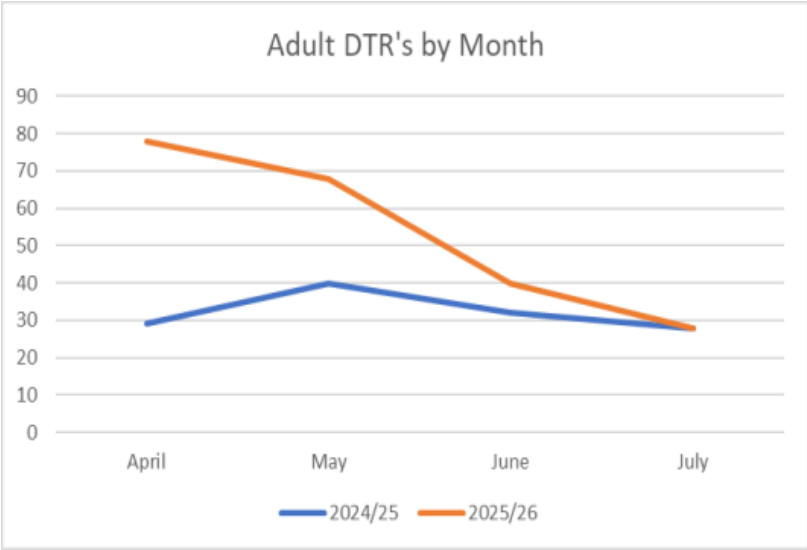
Safeguarding
Supervision

Practitioner
Concerns

Partnership
Working

Domestic Abuse
and Sexual Safety

Statutory Reviews



- All CST data is now being collated in RL Datix which is providing more accurate reporting figures.
- Adult DTR's initially increased in 2025/26 compared to 2024/25 and have now decreased. However, a further rise would be expected after Summer from previous data collection.
- The number of calls to CST are continually rising. A proportion of this could be attributed to an improvement in reporting since the implementation of RL Datix.

Training Module	Current Compliance %	Compliance Q1 2024/24	Training module	Current Compliance %	Compliance Q1 2024/24
Adult Safeguarding Level 1	82%	87%	Children's Safeguarding Level 1	82%	86%
Adult Safeguarding Level 2	85%	89%	Children's Safeguarding Level 2	83%	88%
Adult Safeguarding Level 3	20%	Not measured	Children's Safeguarding Level 3	35%	Not measured

- Improvements in compliance have been noted in the last month, however further increases are required to reach the target of 85%.
- Level 3 Children and Adults Training is now mandated via ESR to relevant staff. Efforts are underway to develop a phased training implementation plan, setting revised quarterly targets with the goal to reaching 85% compliance by March 2028.

Safeguarding Actions



Issue	Action	Learning and Improvement	Who	When
Safeguarding Level 3 Training Non-Compliance Delays in being mandated via ESR	Extensive work has been completed by Corporate Safeguarding and the ESR Team which should result in mandate showing on staff records from the beginning of 2025/26 financial year.	Upon completion of this action it will be simple for managers at all levels of organisation to monitor compliance and identify areas for improvement.	ESR Team	Q4 2025
Decommissioning of Specialist Domestic Abuse Service in General Practice Funding is not sustainable for 2024/25 to enable the continuation of the IRIS Programme	A number of presentations are being delivered to the NCNs to outline what services are available to support survivors of Domestic Abuse and an interim pathway for management of a disclosure has been provided to practices.	System leaders in primary care will have received bespoke training and support to enable them to embed pathways within their practices. This training has now been completed for three of the five boroughs	Corporate Safeguarding	Q4 2025
Significant increase in safeguarding referrals and strategy meetings for vulnerable children and adults It is unclear if there is any singular cause for this increase in activity, though improved staff awareness will be a contributory factor.	As activity continues to rise, a formal review of the scope and responsibilities of the safeguarding team is being undertaken to determine priorities and to look at strategies to mitigate risk	Increases in safeguarding activity are difficult to predict, so developing more robust methods of monitoring increased activity will facilitate early escalation. The Datix Safeguarding Module will be in place from 1st April 2025, which should provide a better quality of data.	Corporate Safeguarding	Q4 2025



Additional Information

Section 5



Health Inspectorate Wales - Inspections

Nil to report

Health Inspectorate Wales - National Reviews

Nil to report

Health Inspectorate Wales – Submitted Improvement Plans

03838 – Adferiad & Pillmawr Wards
Inspection: 19 – May 2025
Draft Inspection Report Received: 25/06/25
Improvement plan Submitted: 09/07/25
No. of Improvements Identified: 33
No. of Health Board Actions Identified: 64
No. of Health Board Actions Complete: 17

Royal College Nursing or Professional Reviews of other Regulatory Reports

RCN – Nil to report

Health Inspectorate Wales – Immediate Assurance Letters

HIW Ref: 14013

Concerns at Rhymney Ward, Ysbyty Ystrad Fawr and the alleged bullying felt by staff and the failure to address concerns of this nature when raised.

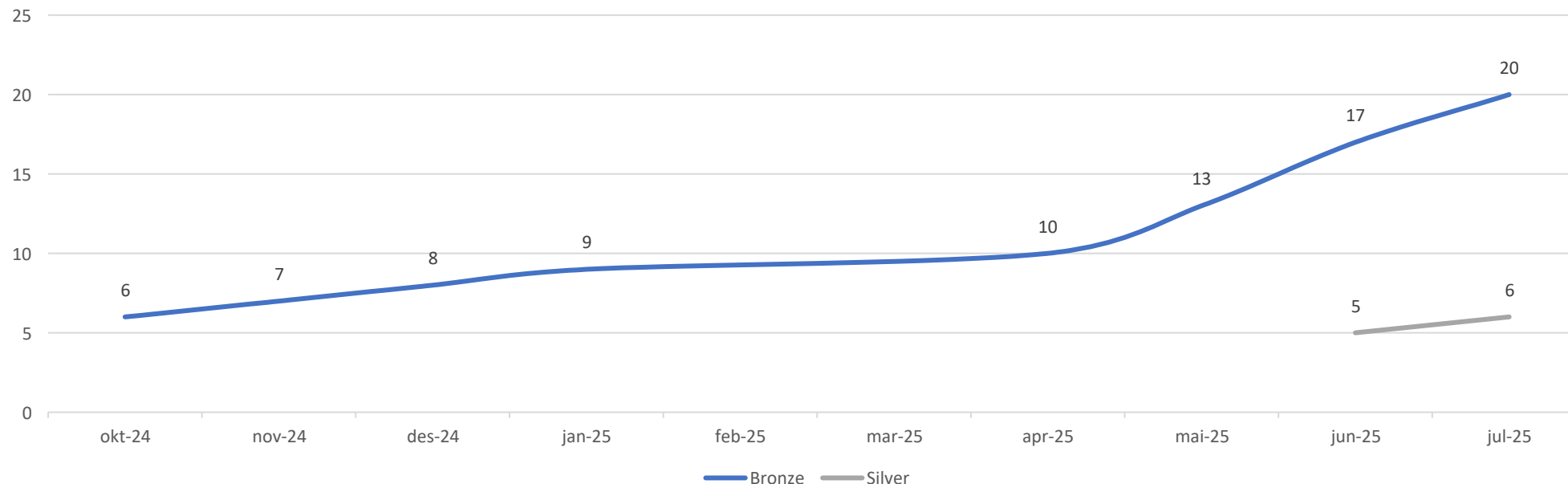
Response provided to HIW 10/07/25.



Ward Accreditation



Ward Accreditation July



Silver awards are cumulative: participants must first achieve Bronze (3 months) and then additional 5-month totalling 8 month compliance criteria. In this month, 5 areas awarded Bronze became eligible for Silver review under this criteria, and were successful in gaining Silver Award

AWARDS

Total to date:

20 Bronze

6 Silver



ROLL OUT:

Currently rolling out to:
78 outpatient clinics

Endoscopy

Interventional radiology

NICU

Cardiac cath lab

Discharge lounges

Updates:

- 4 Areas pending Silver Panel.
- Data from the past year shows correlation between accreditation and a reduction in reported falls.
- Dementia audit questions updated to reflect 3 year Dementia action plan.

Ambition	Action	Learning and Improvement	Who	When
Improve efficiency of independent reviews (IDR).	- Accreditation Lead to support Senior Nurses with deferred IDRs. - Explore potential for Divisional support with IDRs - Scoping exercise to establish process in other HBs; Engage in an All Wales working group (in creation at WG).	- Reduce workload for senior nurses. - Quicker review process for deferred areas. - Standardisation and share best practice - Improve utilisation of current resource	Accreditation Lead Data Analyst and Service Improvement Manager	December 2025
Align accreditation with organisational/ divisional strategies	- Meet specialist teams to review current audits. (Dementia / IPAC / nutrition & hydration / MHLDD). - Attend Workforce and Professional strategic meetings as required to share data.	- Assurance to align with organisational action plans / reg 28 actions - Demonstrate any correlation between accreditation and service improvement	Accreditation Lead	Ongoing

Nurse Staffing Levels Wales Act 2016



Issue	Action	Learning and Improvement	Who	When
4 DATIX without focussed review. - Small number of HAPU closed without senior Nurse Validation	- Senior nurses to validate all HAPU reported on DATIX - NSA lead contacts senior nurses to cleanse and validate datix (focussed review to be undertaken to determine if HAPU avoidable or unavoidable)	- Agenda HAPU on monthly QPS meetings and one to one meetings with senior nurses and ward managers. - HAPU validation and DATIX cleansing to be discussed in PU collaborative. - Positively, most HAPU are being investigated timely.	Divisional leads Senior nurse Ward managers NSA lead	- Monthly QPS meetings. - Monthly one to one discussions with senior nurse and ward managers - PU collaborative
Some falls in DATIX are closed prematurely as no injury sustained, however following a CT / MRI, in some incidents a fracture or head injury is discovered	NSA lead to attend senior nurse and ward manager meetings to explain issues of inaccurate detail in DATIX fields.	Further training on DOC and assessing level of harm required.	Divisional Nurses Senior Nurses NSA Lead QPS Leads	- Monthly Divisional QPS meetings - Divisional senior nurse meetings
Complaints are often complex and multifactorial and can involve nursing, medical and OHP's. Therefore, complaints managed through PTR are rarely closed within the same reporting period.	The All-Wales Nurse Staffing reporting Group are presenting an SBAR to EDON's to propose health Boards only report on complaints that have been fully investigated and closed within the annual reporting period. This is the only way to report accurately on nursing complaints and whether staffing levels contributed.	- NSA lead to continue to work with divisions to inform of any agreed changes nationally. - NSA lead to liaise with senior nurses and complaint hubs to ensure the NSA questions are completed timely and accurately in the datix fields in complaints.	NSA Lead Senior Nurses Complaints Hubs	- Monthly QPS meetings. - Meetings / discussions with senior nurses

Welsh Nursing Care Record



Update of risk assessment compliance – comparing 2024/2025 to June 2025

Parameter	2024 -2025	June 2025	Status
Overall % of On admission Risk Assessments being completed	67.4%	64.1%	Down by 3.3% 
Overall % of Ongoing Risk Assessments being completed	65.2%	60.8%	Down by 4.4% 
Overall % of Ongoing Risk Assessments being completed on time	7.4%	10.3%	Up by 2.9% 



Welsh Nursing Care Record



Issue	Action	Learning and Improvement	Who	When
Not currently providing quantitative data to wards to support service improvement due to lack of resources within information team. % of Ongoing Risk Assessments being completed on time	WNCR dashboard being developed and data validated	Dashboard under local development. Already had parameters for number and percentage of risk assessment which have been completed on time at admission for those patients who are still admitted. Now looking to develop and validate parameters around patient not seen in the last 48 hours and records not closed for patient that have been discharged. Dashboard will enable divisional oversight to target areas of poor compliance	Information Services (within Digital, Data & Technology)	Some elements n UAT, aiming to have active for ward users by the end of Q1
Upcoming new form releases – catheter care bundle due for release on 1st July 2025	Testing to be undertaken by DDaT with comms to staff prior to release as well as training materials	Significant changes to the WNCR team within DDaT. Plan to use this release to map out a new process for future releases.	Digital, Data & Technology - WNCR team	To be completed after catheter form release and before the end of Q2





<u>Alert</u>	<u>Compliance Deadline</u>	<u>Action to achieve compliance</u>	<u>Status</u>
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients	Sep-23	An SBAR has been updated to highlight the work that has been progressed as part of this PSN and actions that remain outstanding.	In-progress OVERDUE



PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified

Situation:

- ABUHB remains non-compliant with PSN066

Background:

- This PSN was first released in February 2023.
- This PSN concerns providing a unique identity to each unknown patient. This is to ensure safe and prompt diagnostic testing and treatment, especially in the effort to prevent incorrect blood test results being allocated to the wrong patient with the potential to cause a fatal incompatible blood transfusion.
- Work has been on-going in the intervening time to work towards compliance, and has kindly been led by Peggy Edwards.

Assessment:

Updated current barriers for declaring compliance with this PSN are;

1. Merging patients in WPAS. There is a long standing issue where DHCW have changed the way the system works which has damaged the merging process. The DHCW are unable to resolve this issue, so it will need to be resolved in-house. There remains no clear time-line for this at present.
2. The age of the code which underpins and supports the admission, transfer and discharge process in CWS means we are unable to merge in-patient records until after discharge as the care episode is technically broken (therefore affecting information available to the clinician on viewing the record) – fix is within the development of CWS2 anticipated 2025. We have met with the technical team to establish how we can do this and it is to be included in the backlog of working. This should be completed for Q3.
3. Inability to link records within Masterlab for Blood transfusion purposes. Once WinPath is implemented in Sep '25 this will be achieved.

Recommendations:

The Health Board acknowledge the delay in implementation of all the requirements and the support the ongoing activity to ensure a 'robust' merger process is in place for all down stream systems requiring an appropriate patient identification.

Oxygen cylinders: regulation 28 report and patient safety notice 041 reminder (WHC/2024/036)

Declaration of Compliance and Completion of Actions:

Following the death of a patient in NHS Wales, a Regulation 28 'Prevention of Future Deaths' coroner's report was issued concerning the incorrect use of Oxygen CD cylinders manufactured by BOC. This incident prompted a review aligned with the guidance set out in **PSN041 – Risk of Death and Severe Harm from Failure to Obtain and Continue Flow from Oxygen Cylinders** (2018).

In response, the Health Board has undertaken a comprehensive review in collaboration with the **Medical Gases Group** and the **Medicines Safety Group**, ensuring alignment with the broader workplan for medical device training.

✓ Actions Completed:

• Education and Awareness:

- Dissemination of posters and a training video across the Health Board.
- Visual instructions and video guidance on the safe use and initiation of oxygen therapy from cylinders.
- Reinforcement of the importance of incident reporting via **Datix** and reference to **MHRA Yellow Card** criteria.

• Training Compliance:

- A dedicated **ESR training module** has been published and communicated across Aneurin Bevan UHB.
- Staff have been encouraged to complete the module, which is now considered **fully compliant**.
- No further action is required at this time.

This declaration reflects the Health Board's commitment to patient safety and its proactive approach to implementing national guidance.



Training video for BOC
O2 cylinders

Quality Improvement



Workforce QI Skills Development Framework

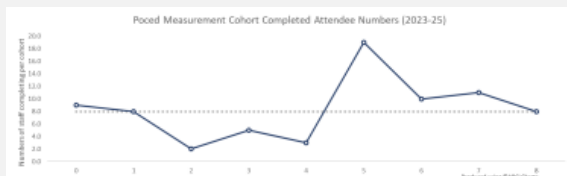
PocEd QI Training (virtual) – 2 half days - QI method/tools

- 375 Staff undertaken training in total



PocEd Measurement Training (virtual) – 1 half day - Time Series Data, includes Runcharts and SPC

- 75 staff trained in total over 9 cohorts



Quality Improvement Advisor Cymru Programme

Year long advanced QI Skills development programme run by QSI Academy

- 3 members of ABUHB staff graduated QIAC
- 2 members of ABUHB staff accepted next cohort

Coleg Gwent Lean Six Sigma

- 2 members of ABCi team gained Black Belt

NHS Elect – Quality Coach Train the Trainer Prg

- Member of ABCi team gained free place

Quality Improvement Coaches embedded

Quality Improvement Coach Programme (face to face) – 4 days total, interactive, experiential prg. Coaches sign up to undertake half day coaching each month. Aim to develop 300 coaches in 4 years

- Cohort 2 complete, Cohort 3 cancelled due to service pressures
- 43 coaches in total have completed the programme (inc. 3 external candidates).
- Cohort 4 fully booked

Aim ‘unleash a million minutes of QI Coaching over next four years’ 19,980/1000,000 minutes of QI Coaching delivered

Next steps: Divisions to support QI Coach protected time.

Agree methods to prioritise QI work and coach allocation.

QI Coaches attached to upcoming national Safe Care Partnership streams of work.

QI Coach Video

First edit of QI Coaching video complete

Systems to Share Learning

NHS Wales Awards 2025 - applications

- 35 applications from ABUHB across all 12 categories.
- ABCi supported the applications this year or for those not ready, support to develop applications in readiness for next year

QI Delivery

ABUHB Accreditation

- QI maturity matrix mapped to each dimension of the ABUHB Accreditation process: Bronze, Silver, Gold and Platinum. The maturity matrix is structured to develop the following in each area:
 - QI Training
 - QI Practice
 - QI Readiness

QI Programmes

- Theatre Safety Programme – 5 Never Events avoided. Days between events increased from 90 to 518
- Head and Neck Cancer – number of days from suspicion to treatment halved reaching 28 days. Compliance with pathway doubled to 62%

Safe Care Partnership – next slide

April – June 2025

Prepared by ABCi team



Safe Care Partnership - update



The Safe Care Partnership (SCP) is a collaboration between NHS Wales Health Boards, Trusts, Improvement Cymru within HS&I (NHS Executive). The aim of the SCP is to provide nationally coordinated, locally delivered support for safe, reliable and effective care supporting national collaboration and cross boundary learning.

The Safe Care Partnership (SCP) – Next Steps Deconditioning workstream

Three projects from ABUHB accepted to take part in the Deconditioning workstream:

- Contenance promotion – Oak, Rowan, SAU, D4E wards
- Education and Training around deconditioning – C4E
- 'Shred the Bed' – C4E

Additional run across Wales led by CTM Pharmacy

- Self administration of Medication

Also YYF included in research pilot of CEDAR deconditioning tool Learning sessions due in July and final in November 2025

HCAI – Clostridium Difficile workstream

- Co-design virtual event on 24th June 2025
- Aim to drive C.Diff improvement
- Survey/interviews to gather healthboard expertise/thoughts
- Call for projects July/August
- Learning Sessions – 30th Sept, Feb 2026, June 2026

Acute Deterioration Workstream

The initial phase of this work will be implementation by all health boards and trusts of standardised early warning scores across all ages, supported by the Acute Physical Deterioration Implementation Network (APDIN).

- SCP Acute Deterioration Workstream in person event in July 2025
- Initial focus on implementing early warning score tools ie. NEWS2, MEWS, PEWS, NEWTT2 by 30th Sept 2025
- Focus is on escalation
- Improvement arm of the work to start in the autumn following the implementation phase

Duty of Quality Leaders Workstream

This workstream supports the delivery of effective quality management systems at organisational level, with a QMS learning network being convened and a national resource hub in development to support this.

- Initial co-design workshop took place in April
- Quality Assurance, Quality Improvement, Planning and Data/Information representatives from each health board invited to attend

New – Leading Quality and Safety Improvement Programme

Designed for all professions and grades involved in leading improvement across the SCP workstreams, the programme uses the IHI SREC Framework as its foundation. Applications closing on 11th July, programme to start in September 2025 to May 2026





- Target cancer services as a starting point for reviewing and documenting commissioning arrangements.
- Log of commissioned services is being reviewed by all Divisions to ensure consistent and up to date information is provided.
- New Service Level Agreement (SLA) proforma has been drafted with emphasis on quality.
- Guidance/advice sought from Welsh Health Legal & Risk Services on drafted SLA proforma.
- Establish a commissioning group with the aim of building knowledge of commissioning across the Health Board.



Quality Assurance for Commissioned Services



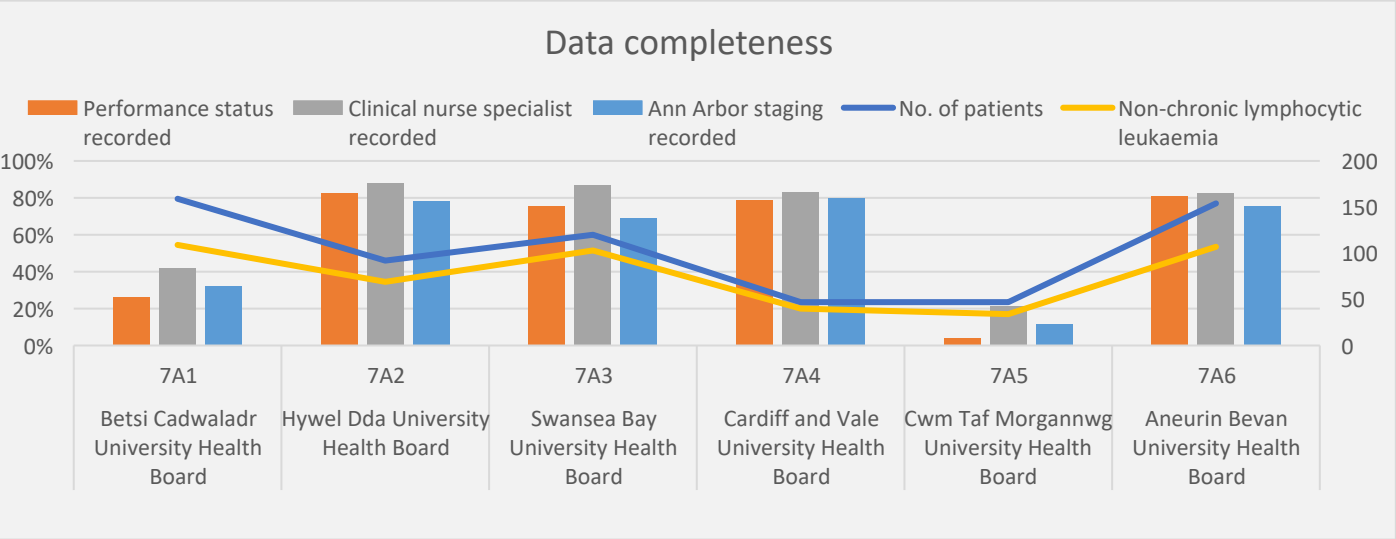
Issue	Action	Learning and Improvement	Who	When
Need to ensure the Health Board is commissioning high quality, sustainable services, including the ability to recognise any early action and systematic deterioration in care within a provider organisation.	Small working group has been created to review existing commissioning arrangement across Divisions	Inconsistencies identified in the information held by divisions regarding contracts, monitoring, and escalation processes. Need to tailor work to divisions and build knowledge around commissioning.	Tracey Partridge-Wilson Ann-Marie Matthews Philip Meredith	Ongoing
Information held in relation to agreements with providers across the Health Board are inconsistent and contain outdated information.	All divisions have been instructed to update a newly established log, ensuring information is standardised to support consistent reporting and facilitate easier analysis.	Need to understand the scale of commissioning arrangements in place across all divisions and agreed a realistic target to make meaningful improvements.	Philip Meredith	October 2025
The current Service Level Agreement (SLA) template is not fit for purpose, as it lacks sufficient detail regarding the quality assurance mechanisms for commissioned services.	Develop a new SLA proforma to ensure a consistent approach across commissioned services, with a strengthened emphasis on quality assurance. Advice and guidance should be sought from Welsh Health Legal and Risk Services to support its development.	Collaborate across multiple divisions to identify and address undocumented commissioning arrangements, with the overarching goal of driving quality improvement in service delivery.	Tracey Partridge-Wilson Ann-Marie Matthews Philip Meredith Christopher Dawson-Morris	May 2025 – ongoing
Limited engagement and understanding of commissioning related issues has been identified across relevant teams impacting consistency and effectiveness in service planning and delivery.	Establish a commissioning group tasked with identifying areas where additional support is needed to strengthen broader aspects of the commissioning process.	Development of best practice guides. Inclusion in the group will develop a pool of 'experts' through the building of knowledge as the work progresses	Ann-Marie Matthews / Philip Meredith	July 2025 – ongoing
Commissioning processes across the Health Board lack consistency, clarity, and robust quality assurance. This has led to fragmented practices and limited oversight of service standards.	Cancer services will be prioritised as the initial focus area for enhancing commissioning processes across the Health Board, serving as a model for broader system-wide improvements.	Prioritising cancer services has highlighted the need for a consistent, quality-focused commissioning approach. This initiative will strengthen collaboration, improve staff understanding, and create a scalable framework for wider service improvement.	Tracey Partridge-Wilson Ann-Marie Matthews Philip Meredith Christopher Dawson-Morris	October 2025 – ongoing

Clinical Effectiveness

Section 6

National Non-Hodgkin Lymphoma Audit (NNHLA)- State of the Nation Report 2024 - An audit of care received by people diagnosed with non-Hodgkin lymphoma in England (2020-2021) and Wales (2022)				
Clinical Lead: Dr Rachel Trickey – Consultant Haematologist				
Objectives: e:	NNHLA aims to assess care patterns and outcomes for patients with non-Hodgkin lymphoma in England and Wales , helping services enhance the quality of care. It is part of the National Cancer Audit Collaborating Centre (NATCAN), which oversees ten national cancer audits and works to improve cancer services by evaluating diagnosis, treatment processes, and patient outcomes across various cancer types.			
	- Performance Indicator: - Tumour Characteristics: - Data Quality:	- Aim: to provide a national picture and highlight regional variation in the patterns of non-Hodgkin lymphoma care across England and Wales. - Aim: to provide context for interpretation of performance indicators - Aim: to shine a spotlight on areas where improvements in data completeness are needed.		
Report Successes:		Assurance level	Description	
1	New patients with NHL always see a CNS	Significant	The project has mostly achieved the standards or criteria being audited against	
2	One-year overall survival for both low and high grade NHL comparable with rest of UK	Risk level	Description	
Report Concerns:		Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved	
1	Data suggests less than 50% of patients receive chemotherapy within 62 days of referral for high grade NHL-data not in keeping with clinical experience	Has this audit been placed on a Risk Register (N/A if above risk is None)		NO
2		If not on a risk register, why not: This is a new audit with incomplete data, the current data is not likely to be representative but will continue to be collected and improved on in the future		
Clinical Leads Local Recommendations:		S.M.A.R.T Actions:		Responsible:
1	Commenced a new MDT proforma for all haematology MDT discussions, to try and improve recording of staging	This has already been initiated within Haematology for all patients and our aim is for 100% of patients with NHL have staging and PS accurately recorded at the time of MDT		Victoria Williams (Haem MDT lead) Sarah Hine (Cancer services)
96/108				116/543

Data Completeness:



Key Message:

NHS trusts and MDTs should ensure key data items are submitted to cancer registries for all people diagnosed with NHL. Particular attention should be given to documentation of staging/prognostic indices, MDT records and CNS involvement in both England and Wales

Key Message:

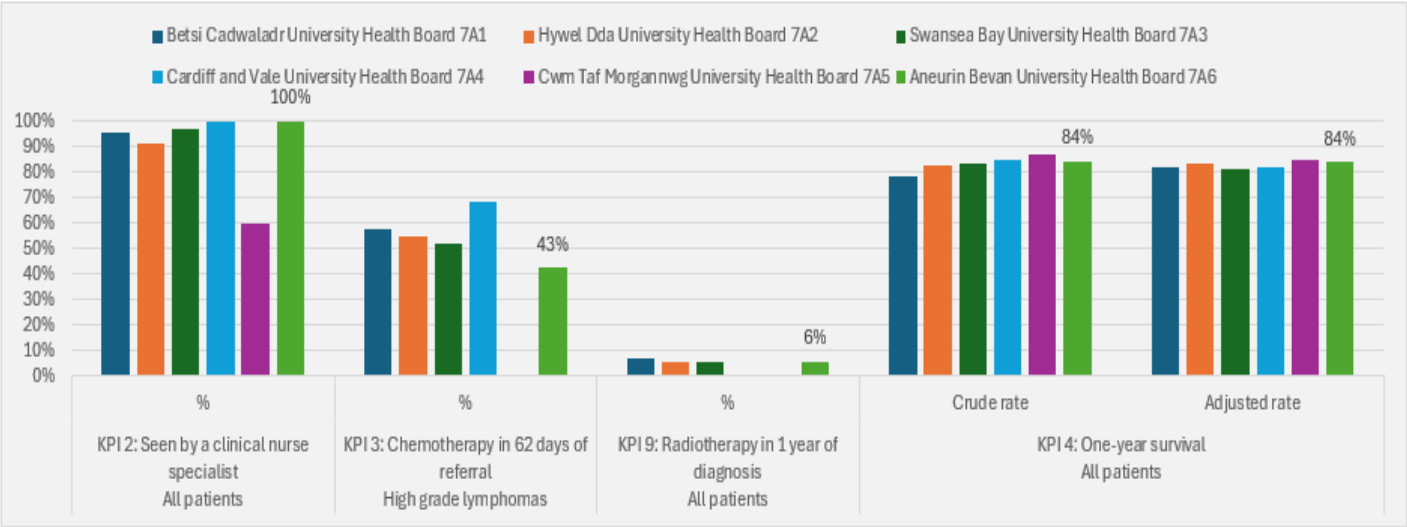
Less than 67% of people with high-grade NHL in England and 50% of people with high-grade NHL in Wales receive chemotherapy within 62 days of referral.

Key message:

High 1 year survival of around 90% for people with low-grade lymphoma, and around 70% for people with high-grade lymphoma, with similar results reported for England and Wales.

RGH is performing better than the Wales and England for Performance Status and Clinical Nurse Specialist and better than Wales, however slightly reduced on the England result for Staging (Ann Arbor), whilst NNH is performing better than Wales and England in all 3 areas – *Binet staging is only recorded in one HB in Wales.*

Key Message: Less than 44% of people with high-grade lymphoma start their radiotherapy within 8 weeks of the end of first line chemotherapy and there is wide variation between trusts. Radiotherapy not often given unless specific indications



Due to current difficulties in radiotherapy capture with existing databases in Wales, only limited conclusions can be drawn from the current data provided for Wales; this may explain lower proportions of radiotherapy delivery in Wales compared to England.

Report Recommendations:		S.M.A.R.T Actions:Responsible:Due Date:Progress:
1	Identify and address factors delaying people with NHL being discussed at a haematology or lymphoma MDT including referral pathways, staging investigations and record keeping.	Wales 2022: Not available
2	Identify pathway factors contributing to delays in people with high-grade NHL starting chemotherapy within 62 days of referral to develop strategies for process improvement <i>Wales 2022: 51.2%, ABUHB 43%</i>	Unlikely the data that has been collected is representative
3	Identify patient and hospital factors contributing to delays in radiotherapy delivery since last administered dose of Chemotherapy	Wales 2022: Not available
4	Ensure adequate resource allocation for data provision. They should support hospitals/trusts/health boards in England and Wales with coding, data entry, and quality assurance to improve quality and completeness of data submitted. Data items of focus include: • Cancer staging (Ann Arbor and Binet) • Prognostic indices for NHL <i>Ann Arbor Wales 60.0%, ABUHB 76%</i>	Binet Staging only relates to two Health Boards in Wales, SBUHB – Singleton Hospital and CTMUHB – Royal Glamorgan Hospital.
5	Deliver more comprehensive cancer data in Wales, with particular focus on: • Chemotherapy regimens and delivery • Radiotherapy regimes and delivery This is in the process of being developed with introduction of National Data Resource (NDR) as part of the newly established Digital Health and Care Wales (DHCW) as part of the “Digital Strategy for Wales”	Detailed chemotherapy and radiotherapy information is not currently available for Wales

It should be noted that these provider-specific results are affected by varying levels of data completeness and quality and random variation (i.e., the “role of chance”). At this stage, the audit has not implemented HQIP’s formal “outlier process” (i.e., a formal process to assess the performance of healthcare providers with results that are outside the expected range). This is because, although there is sufficient confidence to report the results publicly, it is the first time that provider-specific results are being provided with untested data completeness and quality, and risk adjustment methods are in development. Instead, where results highlight a potential cause for clinical concern, we will contact the providers within one month following publication of the State of the Nation Report, and work with them to explore factors that may explain their results, according to HQIP’s formal guidance. This process is with a view to being able to adopt the formal outlier process in 2025.

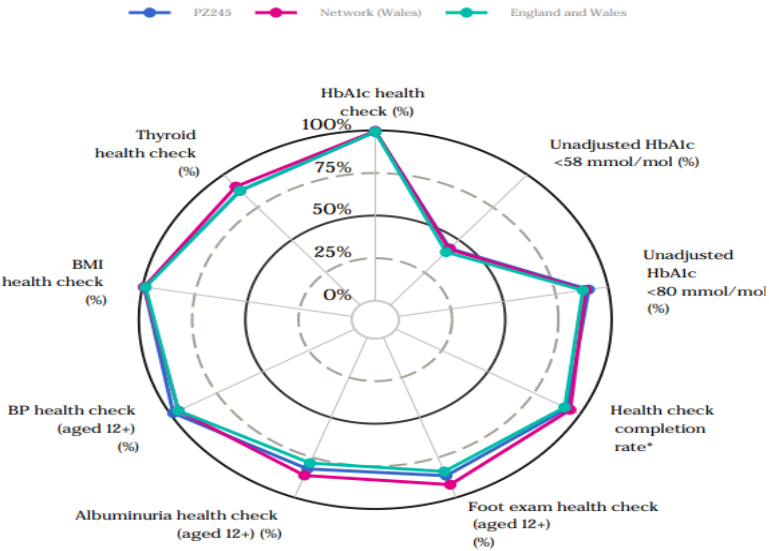
National Paediatric Diabetes Audit (NPDA) 2025 Report on Care and Outcomes 2023/24
Clinical Lead: Dr Davida Hawkes – Consultant Paediatrician

NICE: NG18 & NICE 2015
TA943 (Technology Appraisal)

No quality statements, recommendations only

Rationale: The NPDA has been reporting for 20 years. Data is submitted by healthcare professionals in Paediatric Diabetes Units (PDUs) in England and Wales about the care received by the children and young people with diabetes using their service.

Objectives: The effectiveness of diabetes care is measured against NICE guidelines (NG18, NICE 2015) and includes treatment targets, health checks, patient education, psychological wellbeing, and assessment of diabetes-related complications including acute hospital admissions, all of which are vital for monitoring and improving the long-term health and wellbeing of children and young people with diabetes.



Above shows GUH Health Checks compared to national rates, below right, shows 2023/24 versus 2022/23 ABUHB and below left ABUHB additional Health Checks

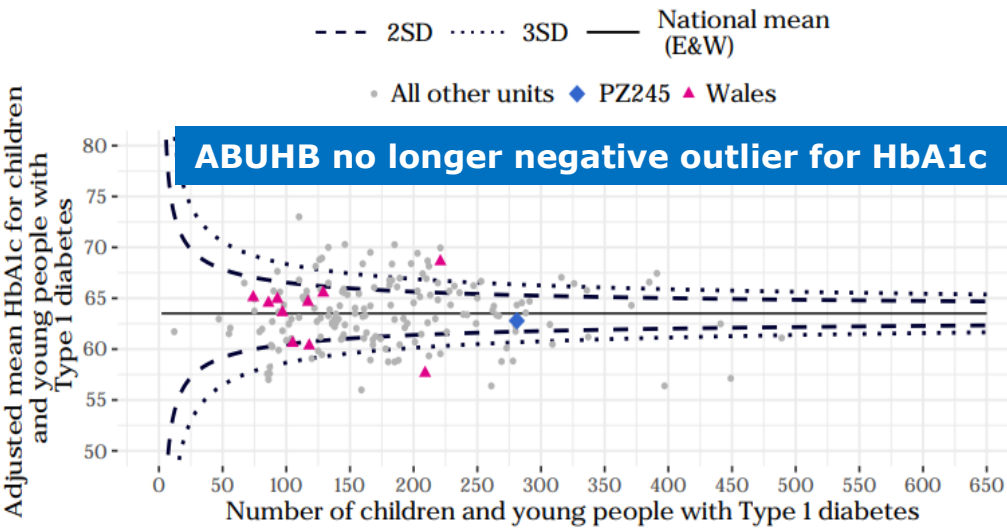
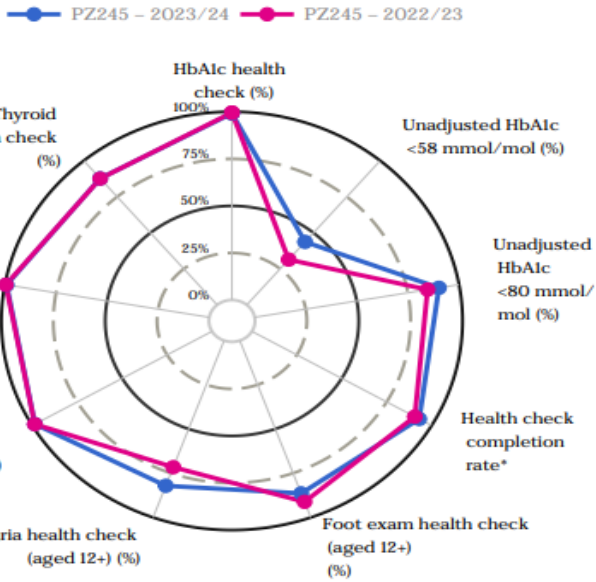
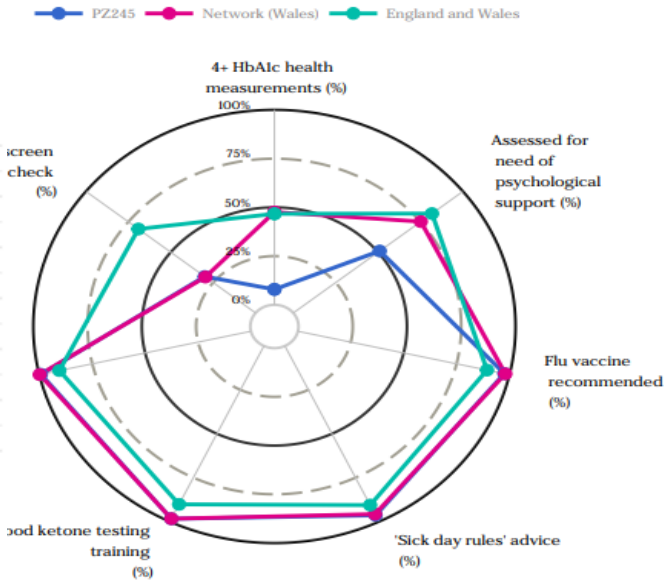
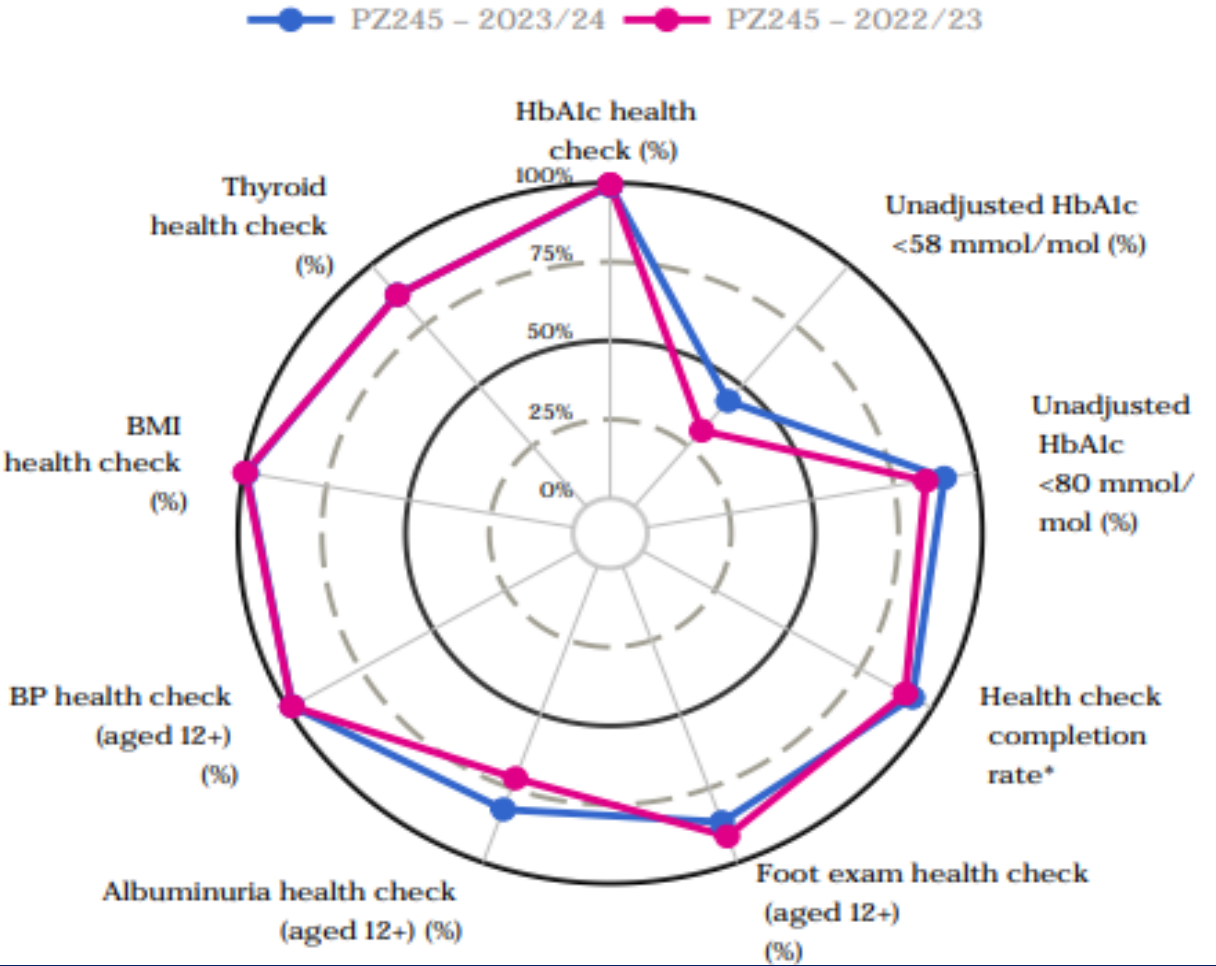
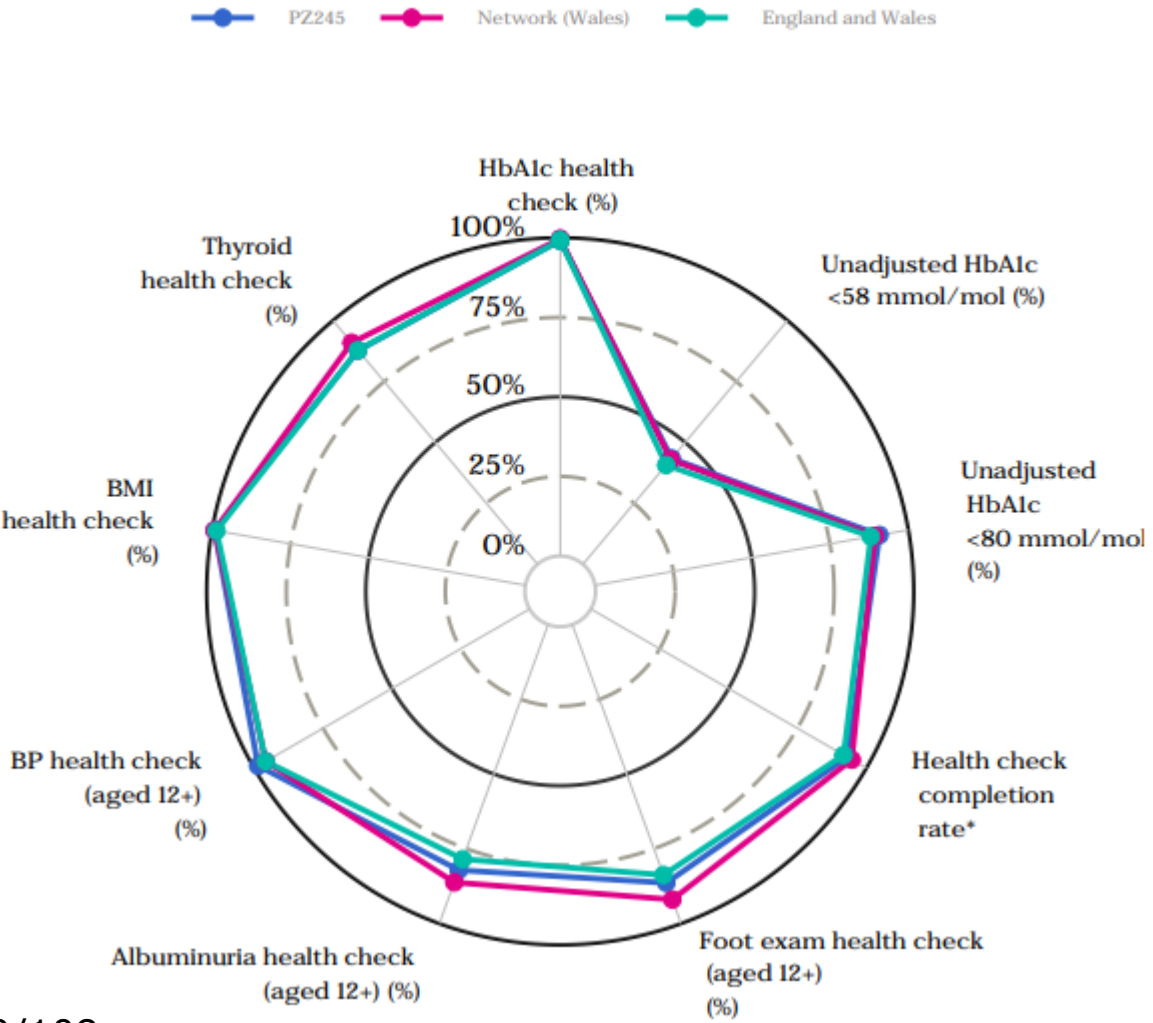


Figure 21: Adjusted mean HbA1c



DIABETES HEALTH CHECKS COMPLETION RATES

The chart below demonstrates that the Health Board is performing similarly to the rest of the Welsh Health Boards and compared to the overall national rates.



The Health Board has improved in relation to Unadjusted HbA1c <58mmol/mol & <80mmol/mol in 2023/24 compared to 2022/23 and has Albuminuria (aged 12+) with a slight reduction in foot examination (aged 12+)

Assurance level		Description		Risk level	Description		
Significant		The project has mostly achieved the standards or criteria being audited against		Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon		
Report Successes:					Report Concerns:		
1	Reduction I median HbA1c	3	Improvement in numbers completing health care checks				
2	No longer negative outlier for HbA1c	4	Increased numbers of CYP on Hybrid closed loop pumps				
Report Recommendations:				S.M.A.R.T Actions:		Responsible :	Due Date: Progress:
1	PDU workforce numbers should be mapped against the guidelines published by the National Children’s and Young People’s Diabetes Network in 2024 (NCYPDN), taking into account the 16% increase in children and young people with diabetes in their care.			Refer back to business case for pumps-request for increased staffing is being met – not yet requested additional staff for increased incidence		Diabetes leads	Dec 2025
2	The variation in outcomes by geography should be investigated and addressed to ensure that children and young people with diabetes have equitable access and care for diabetes. Commissioners should use NPDA data (three monthly and annual PDU level reports), alongside other trusted data sources and peer review programmes, to assess equity of care within and between their regions.			All CYP in ABUHB have access to same care by MDT and same access to Technology		MDT	
3	Studies should be funded to understand the progression from childhood signs of micro- and macro-vascular disease to the development of future diabetes complications, and to inform preventative interventions.			Action by: Research funding bodies and diabetes charities such as Diabetes UK and Breakthrough T1D.			
4	Diabetes services should offer holistic multidisciplinary support, including dietetic input, to children and young people with diabetes who are overweight or obese.			All CYP have access to specialist nurses specialise dietitians and specialist psychologists		MDT	Dec 2025
5	Children and young people with Type 1 diabetes, regardless of ethnicity and social deprivation, should have equitable access to diabetes-related technologies. This could include engagement with families that may experience inequalities (such as those within the Core20PLUS5 framework) and healthcare professionals to better understand the barriers to equitable access.			All cyp in abuhb have access to diabetes tech regardless of ethnicity or deprivation		MDT	Dec 2025
6	Hybrid Closed Loop (HCL) systems should be offered to all eligible children in England and Wales in line with NICE Technology Appraisal guidance (TA943) and the implementation plans in England and Wales.			All CYP with type 1 DM in abuhb are offered HCL pumps as per nice tech appraisal still a waiting list of over 6 months but much reduced		MDT	Dec 2025

101/108

121/543

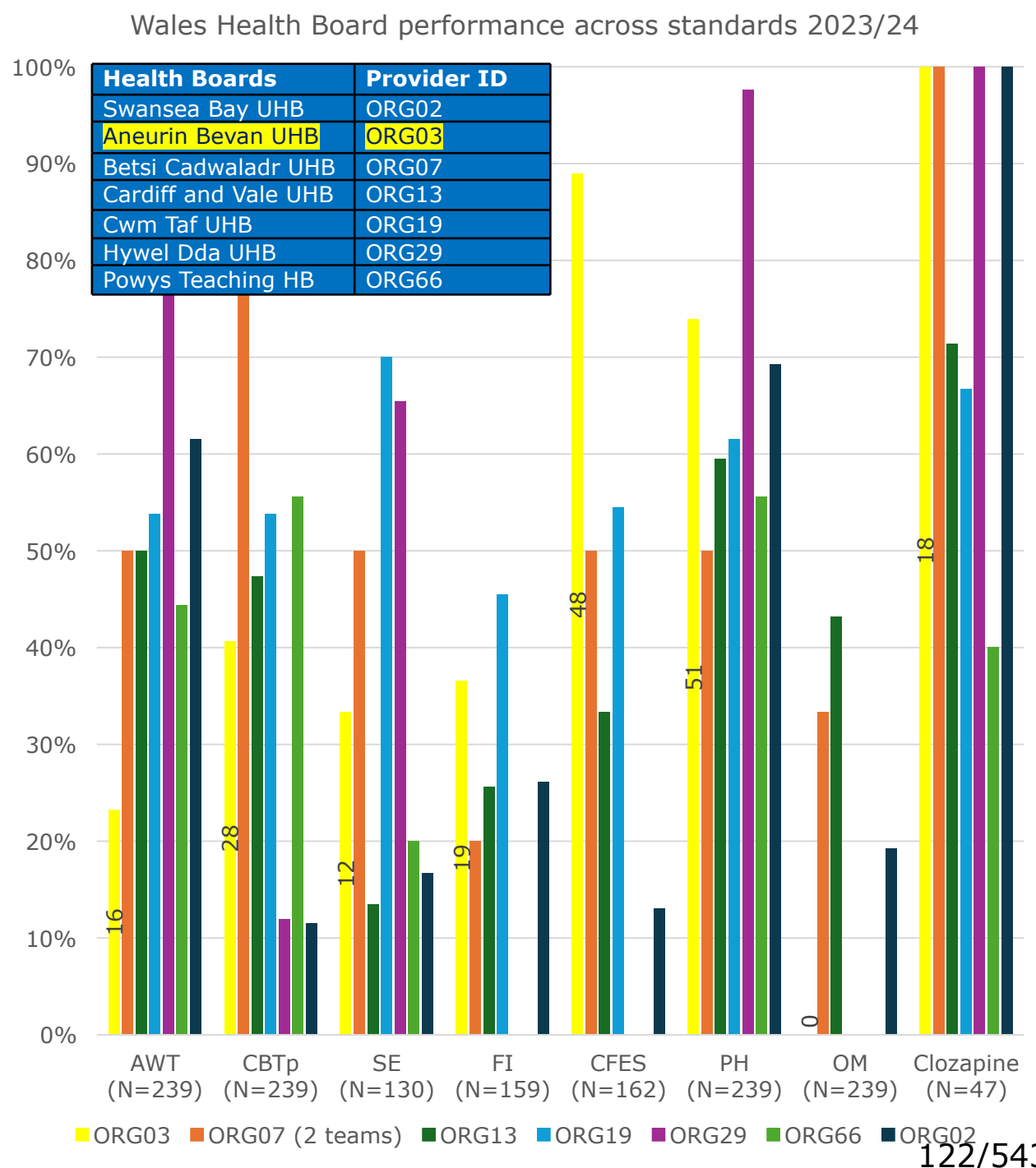
State of the Nation Report 2024 - Audit of Early Intervention in Psychosis (EIP) Provision in England and Wales in 2022/23 and 2023/24. Clinical Lead: Dr Gemma Williams, Consultant Psychiatrist, EIP.

NICE QS 80 – See slide 9

NICE QS 102 – see slide 9

Rationale:	EIP services support individuals experiencing psychosis or at-risk mental states (ARMS) by delivering care aligned with NICE guidance. The National Clinical Audit of Psychosis (NCAP), led by the Royal College of Psychiatrists, evaluates EIP services in England and Wales against standards including: Waiting times, Cognitive Behavioural Therapy for psychosis (CBTp), Education and employment support, Family and carer interventions, Clozapine use Outcome measures and Physical health screening and interventions NCAP has audited EIP services since 2018, providing feedback at team, trust, regional, and national levels to inform and improve local service delivery.
Objectives:	This approach involves tracking changes over time through repeated data collection to monitor progress against care standards. It includes: Comparing performance across teams, Trusts/Health Boards, and regions. Analysing variation by health inequalities such as age, gender, and ethnicity. Identifying opportunities to reduce inequalities. Providing Quality Improvement (QI) guidance to support initiatives aimed at enhancing care in areas measured by the audit.

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against
Risk level	Description
Minor 102/108	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved



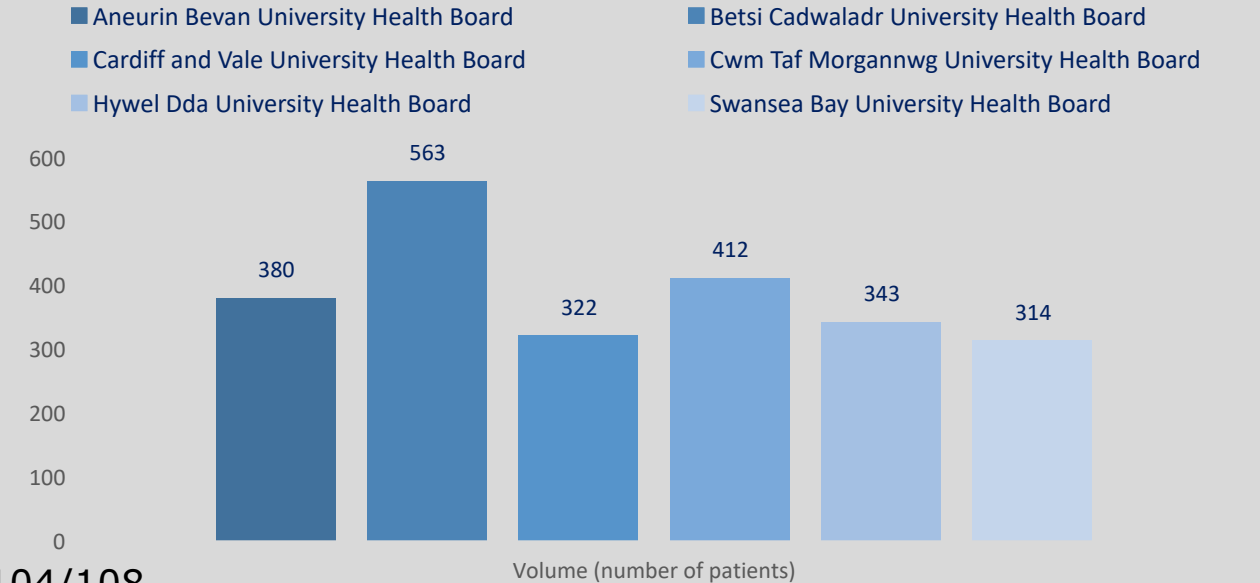
Report Successes:			Report Concerns:		
1	Physical health monitoring and interventions (74%)		1	Access and Waiting Time (23%)	
2	Carer focussed education and support (89%)		2	Outcome Measures (0%)	
3	Supported Education and Employment (33% taken up)		3	Provision for Children and Young People (BUT error with reporting)	
Report Recommendations:			S.M.A.R.T Actions:Responsible:DueDate:		Progress:
1	Focus on sustaining performance; notably around timely access and addressing factors affecting delivery of NICE concordant EIP and ARMS provision across all age groups, particularly Family Intervention (FI) in England, Cognitive Behavioural Therapy for psychosis (CBTp) in Wales and CBT for ARMS in England and Wales.		CBTp: new psychologists (trained or training in CBTp) in post should improve provision.		Ongoing
2	Improve lipid measurement screening in England and referral for blood pressure treatment by an appropriate clinician in response to elevated cardiovascular risk when completing physical health checks in both England and Wales.		Physical health monitoring and intervention workstream in Wales.		Ongoing
3	Routinely use standard nationally agreed outcome measures (DIALOG and ReQoL for Wales; DIALOG, ReQoL and GBO for England) and use of outcome measures data to evaluate EIP outcomes in England and Wales.		Routine collection following OPAs. NCAP routine data collection.		Ongoing
4	Continue to record and monitor which interventions get offered to whom. Actively seek to address health inequalities both in offer and take-up related to regional and health board variation, gender, ethnicity or age in both England and Wales.		Routine NCAP data collection is allowing us to be more proactive in addressing this. Ongoing discussions around how to improve awareness and referrals into the service.		Ongoing
5	Ensure the National Institute for Health and Care Excellence (NICE) recommended specialist EIP and ARMS interventions and care are available to Children and Young People (CYP) with First Episode Psychosis (FEP) and ARMS (England and Wales).		We offer joint working with CAMHS. No ARMS provision at present but we will continue to discuss how this can be offered within our current resource.		Partially complete
Clinical Leads Local Recommendations:		S.M.A.R.T Actions:		Responsible:Due Date:Progress:	
1	Access and waiting time needs to be improved in line with target of 60% being seen within 14 days of referral.	QI project completed to improve awareness of target within the team and change process of screening and allocating referrals		Achieved. (Data from last 6 months show 64% allocated within 2 weeks and 85% within 4 weeks.)	
2	Completion of two outcome measures to be done as standard	Care coordinators are already more aware of the need to complete these. Discuss again within MDT and check outcomes via NCAP monthly audit data		Ongoing	

103/108

123/543

National Lung Cancer Audit (NLCA) - State of the Nation 2025
An audit of care received by people diagnosed with lung cancer in England and Wales during 2023
Clinical Lead: Dr Mat Jones – Medical Consultant
NICE:NG122, QS17

Rationale:	The aim of the NLCA is to evaluate the patterns of care and outcomes for people with lung cancer in England and Wales, and to support NHS services to improve the quality of care for these individuals.
Objectives:	The National Lung Cancer Audit (NLCA) assesses how well current lung cancer care aligns with national guidelines. These include: NICE Quality Standard QS17, National commissioning guidance from the Lung Cancer Clinical Expert Group and the National Optimal Lung Cancer Pathway. Using these standards, the NLCA has developed quality improvement goals and indicators, shaped through consultation with its clinical reference group and Patient and Public Involvement (PPI) forum. These are detailed in the NLCA Quality Improvement Plan.



It is important to note that data is not comparable to the English data as data is derived from different dataset collection systems.

Data quality indicators

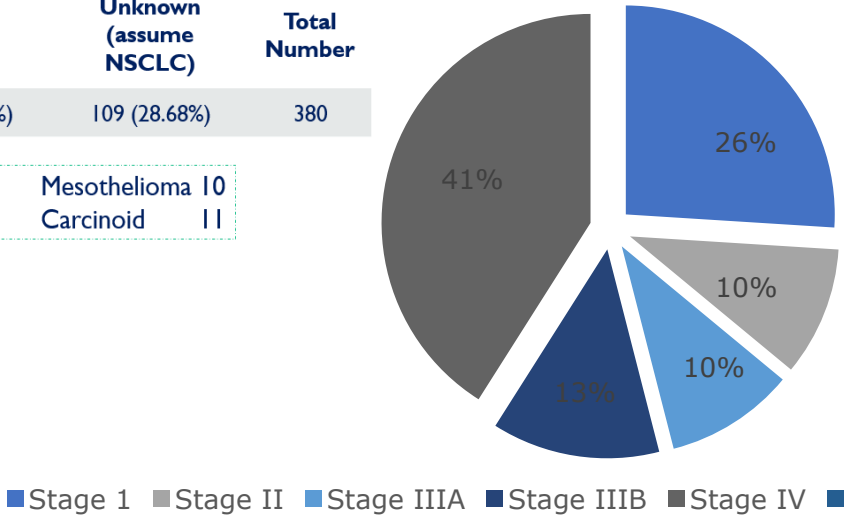
WALES	ABUHB
2,334 patients diagnosed with lung cancer in Wales in 2023. Completeness of key data items in the Welsh data was excellent. Completeness for the 2,334 patients analysed were: 100% for basis of diagnosis, 69% for tumour morphology (100% with tissue), 99% for disease stage, and 100% for performance status. 98% of records had data on whether a lung cancer nurse specialist was present at diagnosis. - Data was not provided for the ethnicity or smoking status data items.	380 patients diagnosed with lung cancer in Wales in 2022. The completeness of the key data items in the Welsh data was excellent. The levels of completeness for the 380 patients analysed were: 100% for basis of diagnosis, 71.3% for tumour morphology (100% with tissue), 99.74% for TNM stage, and 100% for performance status. 95.26% for IMD (deprivation) – 2nd in Wales 100% of records had data on whether a lung cancer nurse specialist was present at diagnosis. - Data was not provided for the ethnicity or smoking status data items.

NLCA Audit 2023

ABUHB Patient Cohort

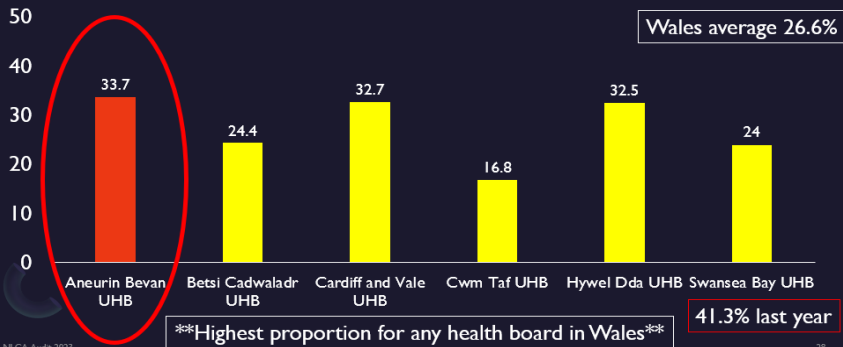
Small Cell Cancer	NSCLC	Unknown (assume NSCLC)	Total Number
32 (8.42%)	239 (62.89%)	109 (28.68%)	380

Others: Mesothelioma 10
Carcinoid 11



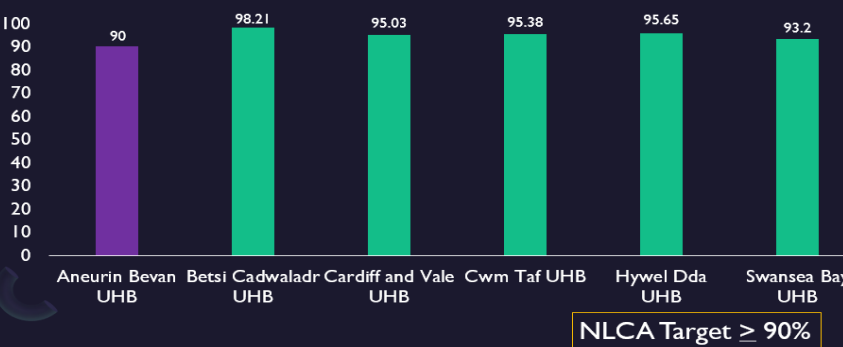
Diagnosis after emergency presentation (%)

Welsh health board comparison



Seen by LCNS (%)

Welsh health board comparison



Waiting times in NSCLC (Wales)



One year and median survival (%)

Wales as a whole

Median survival	One year survival
301 days	46%
262 days in 2022	43% in 2022
222 days in 2021	39% in 2021
224 days in 2020	40% in 2020

Assurance level

Description

Significant

The project has mostly achieved the standards or criteria being audited against

Risk level

Description

None

Standards met and findings demonstrate no risk to patient safety

Report Successes:

1	NSCLC patients with stage I/II and good performance status (0-2) curative treatment rates 81.2% - higher than Wales mean
2	NSCLC patients with stage IIIA and good performance status (0-2) curative treatment rates 78.2% - higher than Wales mean
3	Surgical resection rate for patients with NSCLC 17.47% - higher than Wales mean
4	Use of systemic anti-cancer therapy for stage IIIB/IV NSCLC patients (PS 0-1) 72.2%- higher than Wales mean
5	Patients with Stage I/II with PS 0-1 confirmed pathological staging 95.1% - higher than Wales mean

Report Concerns:

1	Proportion of SCLC patients having chemotherapy 56.2% - lower than Wales mean
2	Proportion of patients seen by a Lung Cancer Nurse Specialist - lower than Wales mean but above audit standard
3	Proportion of patients with lung cancer diagnosed after an emergency presentation 33.7% - highest in Wales cohort
4	Proportion of patients in Quintile 5 (most deprived) IMT 31.5% - highest in Wales (England 15.11%)

Performance indicator values

- Velindre treatment data no longer input into Canisc as in previous years
- No national functioning radiotherapy or SACT dataset (Wales)
- Each cancer site database managed by different team and obtain information differently
- Manual systems to treatment data into audit spreadsheet for submission - not a robust solution
- This year - we were unable to review the data prior to submission
- We had gone through the data, highlighting treatments prior to submission - validation

Concerns concerns over this in November 2024 - no reply

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Ensure services maximise the uptake of lung cancer screening for people aged 55 to 74 who are at high risk of lung cancer. <i>The percentage of people with lung cancer diagnosed with stage 1/2 disease in Wales was 33.9% in 2023.</i> Goal 1: Improve early diagnosis of lung cancer	Lung Health Check Operational Pilot complete HB conducted scoping exercises – part of nationwide ongoing endeavours Evaluation 2 submitted and PHW report and recommendations awaited	PHW Welsh Government Individual Health Boards	Decision pending from WG on next steps	Initial response to recommendations from screening committee submitted. Ongoing engagement with central stakeholders
2	Ensure providers have sufficient thoracic surgery capacity to accommodate the larger number of people with Non-Small Cell Lung Cancer (NSCLC) who are candidates for curative surgery. <i>In Wales, 364 people had surgery in 2023, up from 276 in 2022.</i> Goal 2: Increase the proportion of patients who have treatment with curative intent	Surgical resection rate above NLCA target Ongoing increase in patients undergoing surgery Continued early diagnosis and prioritisation of patients requiring surgical intervention No issues with access – but waiting times >4 weeks	CAVUHB/WG MDT members	Ongoing Report recommendations complete	Complete – continued growth going forward
3	Identify opportunities for increasing the proportion of people with NSCLC stage 3B-4 (PS 0-1) to have Systemic Anti-Cancer Therapy (SACT) as per NICE guidance, such as help people maintain their fitness for SACT throughout the care pathway. <i>In Wales during 2023, the proportion was 55.2%, a fall from 2022 (=60.1%)</i> Goal 3: Increase the proportion of people receiving SACT and reduce variation in access	Improved pathological services – PD-L1 in-house, QuicDNA ctDNA project pioneers and imminently to be provided as part of the National Test Directory Oncology delays – recent resignation of oncologist – replacement pending and some delays related to external tissue processing	Velindre University NHS Trust ABUHB pathology service All Wales Medical Genomics Service	ctDNA with NGS panel to be added to the National Test Directory imminently Ongoing liaison with Velindre NHS trust – replacement appointment anticipated this year	Above audit standard achieved Ongoing refinement of pathways according to threats

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
4	Ensure NHS hospitals have the necessary resources and capacity to meet the timelines for patients to start primary treatment. <i>In England and Wales, among key subgroups, most people diagnosed in 2023 did not start treatment within the recommended timeframes</i> Goal 4: Improve the quality of the patient pathway	All facets of the pathway to be assessed on an ongoing basis to ensure efficiency – breach reports, tracker meetings, engagement from wider MDT. Ensure timely review and treatment from Oncology and Surgical services	CAVUHB/WG MDT members Velindre University NHS Trust AWMGS	This is an ongoing, prospective endeavour	Continued service development with ongoing improvement in active treatment rates and achievement of NLCA standards – however, ongoing vigilance, refinement and improvement is core to our MDT working
5	Ensure NHS hospitals have the necessary resources and capacity so that biomarker test results are delivered within 14 calendar days of the test being performed, as defined in the National Optimal Lung Cancer Pathway. <i>England: Between 2017 and 2021, approx. 25% of people with stage 4 (PS 0-1) had genomic testing.</i> Goal 4: Improve the quality of the patient pathway	This remains a challenge and is unachievable with current structures Turnaround time for AWMGS is 14 days from receipt of sample – therefore attainment impossible Ongoing review of timeliness ABUHB pathology service processing of samples	AWMGS ABUHB pathology services	This is a prospective endeavour – ongoing liaison with AWMGS no current plans to change service centrally	With the advent of ctDNA, this may speed up one aspect of the pathway and allow a T.A.T of 14 days No current opportunity to achieve T.A.T of 14 days for tissue samples
Clinical Leads Local Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Proportion of patients seen by a Lung Cancer Nurse Specialist Target $\geq$ 90%: ABUHB proportion = 90% Target achieved but below All Wales average	To review feasibility of inpatient review of patients given route of entry	Lung CNS team ABUHB	Prospective – feasibility to be assessed and planned	Discussed at MDT operational meeting 21/5/25 and planning ongoing
2	Proportion of patients with SCLC receiving chemotherapy Target $\geq$ 70% ABUHB proportion = 56.2%	Audit conducted Appropriate decisions made	MDT members Oncology services Velindre NHS Trust	Ongoing	Patient prioritisation for oncology review under ongoing review
107/108		127/543			

Questions





GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	01 October 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Quality Annual Report 2024/25
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade, Executive Director of Nursing Peter Carr, Executive Director of Therapies & Health Science Andy Bagwell, Acting Executive Medical Director Tracy Daszkiewicz, Executive Director of Public Health
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis, Assistant Director for Quality & Patient Safety Tracey Partridge-Wilson, Deputy Director of Nursing

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board's Annual Quality Report for 2024/25 presents a comprehensive account of the Health Board's commitment to delivering safe, effective, and compassionate care. This report is not only a statutory requirement under the Duty of Quality and Duty of Candour, but also a reflection of the Health Board's values and culture. It captures the collective efforts of staff across all services to improve outcomes, enhance patient experience, and embed quality into every aspect of care. The report is structured around the Health Board's Pillars of Quality and the STEEEP domains—Safe, Timely, Effective, Efficient, Equitable, and Person-centred—and provides assurance that quality is being actively managed and continuously improved.

Aneurin Bevan University Health Board presents its Annual Quality Report for 2024/25, aligned with the reporting requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2020. This legislation places quality, transparency, and engagement at the heart of healthcare through the Duty of Quality, Duty of Candour, and the Citizen’s Voice body, Llais.

The report narrates our quality journey over the past year, reflecting on previous objectives and setting new priorities to improve patient and staff safety, outcomes, and experiences. A strong focus was placed on developing our quality management system to support this work. As we move into 2025/26, we carry forward these achievements with a renewed commitment to continuous quality improvement.

The Health and Care Quality Standards continue to provide a clear framework for planning, delivering, and monitoring healthcare services, and the outcomes and indicators reported here align with the Health Board’s strategic goals—covering clinical outcomes, patient safety, and experience. This Annual Quality Report offers a comprehensive account of our commitment to delivering safe, effective, and compassionate care.

Cefndir / Background

Over the past year, the Health Board has made significant strides in strengthening its quality infrastructure. The implementation of the Quality Strategy and the Patient Experience and Involvement Strategy has provided a clear framework for improvement, while the development of the Quality Management Group and Framework has enhanced governance and oversight. The Ward Accreditation Programme has expanded to cover more clinical areas, and the launch of the Quality Improvement Capability Strategy for 2025–2028 has embedded a culture of continuous improvement across the organisation. These developments have been supported by robust data systems, inclusive engagement mechanisms, and a commitment to learning from lived experience, incidents, and feedback.

Asesiad / Assessment

The Annual Quality Report provides information on our progress to deliver the Duty of Quality and review our reporting and assurance framework. The Health Board adopted a reporting structure which mapped progress on quality and patient safety as mapped against the Pillars of quality:

- Patient and staff experience and stories
- Incident reporting – falls, pressure ulcers, medicines management and mortality
- Complaints, concerns and compliments
- Health, safety and security
- Infection Control and Prevention

- Safeguarding

The report demonstrates measurable progress across all domains of quality.

In terms of safety, there has been a reduction in inpatient falls and pressure ulcers, improved infection prevention and control, and the establishment of a Sepsis Working Group. Safeguarding referrals have increased, and staff training compliance has improved, reflecting a proactive approach to keeping people safe.

Timeliness has been enhanced through early resolution of complaints, rapid response to infection outbreaks, and strengthened escalation protocols.

Effectiveness has been evidenced by participation in national clinical audits, the implementation of the Learning from Deaths Framework, and the use of PDSA cycles and real-time dashboards to drive improvement.

Efficiency has been improved through centralised complaints handling, better antibiotic stewardship in GP surgeries, and streamlined resolution of Public Services Ombudsman for Wales cases.

Equity has been promoted through inclusive bereavement support, engagement with diverse communities, and the use of accessible feedback platforms.

Person-centred care remains a cornerstone, with high satisfaction rates, active patient panels, and real-time feedback mechanisms shaping service delivery.

The Health Board has also demonstrated strong leadership and workforce development, with the QI Coach Programme and the Human Factors Programme improving safety culture in high-risk areas. Digital tools such as CIVICA and AMaT have supported data-driven decision-making, while collaborative learning events and patient stories have helped embed a culture of openness and improvement.

Looking ahead to 2025/26, the Health Board should continue to embed the Quality Management System and Pillars of Quality into everyday practice. This includes rolling out the new Quality Improvement Strategy, expanding coaching and training programmes, and strengthening data systems for real-time assurance. Engagement with patients, families, and communities should be deepened, with a focus on inclusive service design and feedback mechanisms. Strategic oversight should be maintained through governance forums such as the Clinical Advisory Forum and the Quality Management Group, ensuring that quality remains the golden thread running through all aspects of care.

By sustaining momentum, investing in staff capability, and fostering a culture of learning and collaboration, the Health Board will be well positioned to deliver on its statutory duties and continue improving outcomes and experiences for the communities it serves.

Argymhelliad / Recommendation

The Committee is asked to NOTE the progress of work over the past 12 months as reflected in the Annual Quality Report and to take assurance from this report.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:

Ar sail tystiolaeth: Evidence Base:	
Rhestr Termiau: Glossary of Terms:	

Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives



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Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Quality Annual Report 2024/25

Chief Executive's Introduction to the Annual Quality Report

I am pleased to present our organisation's Annual Quality Report, which reflects our ongoing commitment to the highest standards of health care, as enshrined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020. This report is both a record of our achievements and a transparent assessment of areas where we must continue to improve, as we strive to consistently meet exceptional standards of care for those we serve across Gwent.

The success of our quality improvement journey is underpinned by the dedication and expertise of our workforce. Over the past year, our teams have worked tirelessly against unprecedented challenges. The ongoing impact of the COVID-19 pandemic, alongside increased demand and workforce pressures, has continued to test the resilience of services and individuals alike. Despite these difficulties, I am proud to report that our staff have continued to uphold the core values of NHS Wales – putting people at the heart of everything we do.

As we look to the future, our priorities remain clear. We will continue to focus on:

- Enhancing patient and service user experience through person-centred care and genuine co-production
- Strengthening data-driven quality improvement and sharing best practice across services
- Addressing health inequalities and improving accessibility for all groups
- Investing in workforce wellbeing, development, and leadership
- Embedding a culture of openness, candour, and accountability at all levels of the organisation.

In partnership with our communities, staff, and stakeholders, we will continue our journey toward excellence — never losing sight of our duty to deliver safe, compassionate, and effective health care.

I would like to extend my deepest gratitude to all our staff, volunteers, partners, and the individuals and families who put their trust in us. Your commitment, courage, and resilience inspire everything we do. Together, we are shaping a health and social care system that is truly worthy of the people of Gwent.

Thank you.

Nicola Prygodzicz



Executive Summary: A Message from the Clinical Executives

We are proud to present the 2024/25 Annual Quality Report on behalf of Aneurin Bevan University Health Board.

This report is more than a statutory requirement, it is a heartfelt reflection of the care, compassion, and commitment shown by our staff every single day. It tells the story of a Health Board that is learning, listening, and improving together. A Health Board where quality is not just a word, it is a shared value, a lived experience and the golden thread that runs through everything we do.

We would like to begin by sincerely thanking our teams across all services. Their dedication, resilience, and humanity have been extraordinary. Whether at the bedside, behind the scenes, or in leadership roles, they have kept the patient at the centre of every decision. Our staff have spoken up, shared learning and supported one another through challenges and change. This report is a tribute to their efforts.

Over the past year, we have strengthened how we report on quality, not just to meet our duties under the Duty of Quality and Duty of Candour, but to make assurance meaningful. Through our Pillars of Quality programme, we have created a structure that allows us to report with clarity, consistency, and compassion. We have worked hard to ensure that this report is not only comprehensive, but also accessible, so that everyone, from frontline staff to patients and families, can see what quality means in practice and how it connects to their own experiences.

Aligned with the STEEP domains: Safe, Timely, Effective, Efficient, Equitable and Person-centred, this report highlights the progress we've made, the lessons we've learned, and the areas where we must continue to grow. It reflects a culture where improvement is not a project, it is a way of being.

As we move ahead to 2025/26, we remain committed to nurturing a culture of openness, inclusion, and continuous learning. To ensure we will keep building a system that is caring, more responsive and more collaborative for everyone.



Jennifer Winslade
Executive Director of Nursing



Dr James Calvert
Executive Medical
Director



Peter Carr
Executive Director of
Therapies and Health
Science



Tracy Daszkiewicz
Executive Director of Public
Health and Strategic
Partnerships

Introduction

As a Health Board within NHS Wales, it is our moral and legal duty to demonstrate how we are delivering high quality and safe care. This Annual Quality Report serves as a vital assurance tool—in demonstrating our openness and transparency in our quality reporting through this report, an easy-to-understand story of our progress, challenges, and commitment to quality, keeping people safe, learning and improving.

It enables us to show how we are meeting the expectations set out in:

- The Health and Social Care (Quality and Engagement) (Wales) Act 2020
- A Healthier Wales
- The Core Commissioning Requirements

These structures place quality and safety at the heart of everything we do. The 2020 Act strengthens this focus by introducing a Duty of Quality and a Duty of Candour, and by establishing Llais, the independent Citizen Voice body.

The Annual Quality Report is not just a statutory requirement, it is a vital opportunity to reflect on our progress, share our achievements and be transparent about the challenges we face. It helps build trust with the public, demonstrate accountability, and continuously improve the care we

Key Achievements

The Health Board has made considerable progress in delivering both Strategies, guided by a strong focus on insight, involvement, and improvement. This supports our wider ambition: to deliver high-quality, safe, and compassionate care every day.

Insight

We have deepened our understanding of keeping people safe by drawing intelligence from a range of sources, including incident reports, medical examiner reviews, and patient feedback. This comprehensive, system-wide approach enables more informed decision-making and the development of targeted interventions to improve care.

The use of data analytics has further enhanced our ability to monitor performance and drive improvement. In particular, the development and refinement of our Quality Outcomes Framework (QOF) allows us to systematically measure, report, and raise standards of care across all services.

Improvement

We have launched several quality improvement programmes, including our participation in the Safe Care Collaborative a National quality programme which focuses on key safety priorities. These programmes provide structured support for teams to test, implement, and embed changes that lead to lasting improvements in care.

Alongside this, we are investing in staff development through targeted training, direct coaching, and support for frontline improvement initiatives, ensuring our workforce has the skills and confidence to lead important areas of change.

By fostering a whole-system approach to quality, we are strengthening collaboration across departments and services. This integrated way of working ensures that improvement efforts are not only effective, but also

Involvement

The introduction of the CIVICA Citizen Feedback System has significantly increased the volume and richness of feedback from both patients and staff. These insights are actively shaping service delivery and informing ongoing improvements.

Our commitment to person-centred care is evident in how people are included in planning and decision-making processes, which involve patients, families, carers, and system partners. This has contributed to an overall satisfaction score of 88% within Civica, exceeding the benchmark of 85%.

We continue to promote a culture of openness and helping people to feel safe to speak up and encouraging staff to report incidents and raise concerns without fear of blame. This supports continuous learning and shared accountability across the organisation.

A Whole System Commitment to Quality and Safety

Together, these efforts reflect our wider commitment to become a true team that learns and improves, where every member of staff is empowered to contribute to the delivery of safe, effective, and person-centred care.

The work we are doing through insight, involvement, and improvement is helping us to better understand our systems of care, build collective capability through an ‘all teach, all learn’ approach, and foster a culture of curiosity and innovation.

Our improvement efforts are continuously shaped by the voices of patients, families, carers, staff, and communities. We are committed to learning from mistakes and to creating an environment where people feel safe, supported, and encouraged to speak up.

Quality is not just a principle, it is embedded in our systems, behaviours, and outcomes. Above all, we believe that important and sustainable change happens with our patients and communities—not just for them but their involvement is central to our vision. Together, we are building a safer, more responsive, and more compassionate health system.

Quality Strategy

This three-year strategy sets out a clear and ambitious blueprint for delivering safe, effective, and person-centred care.



It places quality and safety at the heart of everything we do, recognising that risks and challenges evolve over time. The strategy commits us to:

- A culture that values quality and ensuring we improve.
- A flexible and responsive approach to emerging safety and quality issues.
- Clearly defined improvement plans to address themes from feedback and supporting structures to drive measurable progress.

By embedding quality into our planning delivery, and evaluation processes, we are actively fulfilling our statutory Duty of Quality.

Together, these strategies provide clear evidence of how the Health Board is delivering on its statutory responsibilities under both the Duty of Quality and the Duty of Candour. They establish a robust and integrated structure for assurance, demonstrating how we improve with clear accountability through ensuring that the care delivered is as good as it can be, that people are kept safe, and how people feel about care remains central to everything we do.

Both articulate our goals to enhance outcomes and experiences, whilst ensuring that everything we do has a culture of engagement. They reflect our commitment to listening to feedback, learning from it, and using that

Patient Experience and Involvement Strategy

Developed in direct response to feedback from patients, families, carers and staff, this strategy ensures that lived experience shapes the way we design and deliver services. It reflects our belief that:

- Learning from experience must be central to our improvement efforts.
- Staff are passionate about improving the experience of those who use our services.
- Engagement must ensure that, everyone is included and that this is an ongoing process.



Milestones Achieved to Date

The Health Board has made considerable progress in embedding principles and processes for quality and embedding these in everything we do, in order to make sure we do a good job and are honest, with a whole-system approach that is grounded in evidence, shaped by lived experience, and driven by a culture of openness, learning, and collaboration.



Strategic Implementation and Governance

- Successfully implemented the Quality and Engagement (Wales) Act
- Developed a comprehensive Reporting Framework and Quality Outcomes Framework (QOF) aligned to the Health Board's Six Pillars of Quality and the Health and Care Quality Standards.
- Reviewed and strengthened Quality, Safety and Patient Experience (QPS) structures within divisions and directorates, formalising lines of responsibility, accountability, escalation, and assurance.
- Restructured the QPS function under the Executive Director of Nursing, including redefining the Deputy Head of QPS role to focus on data and performance analysis, ensuring alignment with the Quality Strategy, Patient Experience and Involvement Strategy, and Quality Improvement approach.
- Implemented an escalation process to support divisional teams in managing Public Services Ombudsman for Wales (PSOW) cases and other critical issues, ensuring timely resolution and accountability.
- Established regular meetings with Divisional Triumvirates to facilitate communication, set work plans, and address divisional priorities.
- Designed a Quality Improvement Approach and a commissioning model that places quality at the centre of service planning and delivery.

Embedding a System to Check and Improve Care

- Refined the Quality Outcomes Framework (QOF) to systematically measure, monitor, and enhance healthcare quality, supporting benchmarking and evidence-based practice.
- ensuring robust systems to monitor and drive the QPSE agenda.
- Dashboards are being developed to enable real-time monitoring of escalated cases and action plans.

Quality Management Group and Framework

To further strengthen governance and assurance across the Health Board, a dedicated Quality Management Group has been established in 2025/26. This group provides strategic oversight of quality performance, escalation, and improvement across all domains of care. It serves as a central forum for reviewing real-time data, monitoring trends, and ensuring that divisional and corporate priorities are aligned with the Health Board's statutory Duty of Quality.

The Quality Management Group is underpinned by a robust Quality Management Framework, which defines the Health Board's approach to quality planning, control, improvement, and assurance. This framework supports the delivery of safe, effective, person-centred, timely, efficient, and equitable care by:

- Embedding performance monitoring and escalation processes.
- Aligning reporting structures with strategic priorities.
- Supporting evidence-based decision-making through dashboards and data triangulation.
- Ensuring consistent compliance with Health and Care Quality Standards.
- Promoting a culture of accountability and continuous improvement.

Together, the Group and Framework will enhance transparency, responsiveness and assurance, ensuring that quality is not only measured but actively managed across all services.

Patient Experience, Engagement and Support

- Rolled out the 'Big Conversation' Engagement Strategy across all boroughs, enabling important community, staff and patient involvement in end-of-life care planning.
- Introduced single points of access for key services including PALS, Dementia, GRACE (end-of-life and bereavement), and enhanced the deployment of Volunteers and Companions.
- Implemented the Immediate Support Pathway for sudden and unexpected deaths in children and young people up to age 25, ensuring timely and compassionate support for families.
- Delivered the National Bereavement Pathway for Wales and implemented the Health Board's Bereavement Model by August 2024, standardising care and support for those who are bereaved.

Learning, Insight and Improvement

- Launched a 'Listening and Learning Framework' and established a Learning and Improvement Forum, learning from and sharing themes and trends, putting rapid learning cycles into everything we do and improving care and services.
- Improved early resolution of complaints and strengthened learning and communication around Health and Safety.
- Developed a Learning from Death Framework and a Mortality Report, triangulating data from the Medical Examiner Service to inform learning and assurance.
- Increased the number of safeguarding referrals and improved training uptake, enhancing protection for vulnerable individuals.
- Embedded organisational learning through monthly Learning from Events Reports (LFERs) and drop-in sessions to support interpretation and action.
- Supported the launch of new psychological support programmes, improvements in patient waiting areas, falls assessment tools, and enhanced pain management following HIW inspections.

Clinical Effectiveness and Assurance

- Developed and implemented an Annual Clinical Audit Plan, an Annual Audit Activity Report, and launched a web-based Audit Management and Tracking System to improve oversight and accountability.
- Established a Clinical Advisory Forum to provide strategic oversight and drive quality improvement across clinical services.
- Strengthened evidence-based Infection Prevention practices and introduced process improvements in Infection Prevention and Control, including targeted action plans in response to escalated issues such as C. difficile outbreaks, norovirus, and Covid-19, coordinated through a Silver Command Group.

Clinical Effectiveness will become one of the Pillars of Quality for 2025/26, as part of our review and refinement. These milestones reflect a Health Board that is not only meeting its statutory duties—but actively delivering visible, patient focused and measurable improvements in care with what matters to people at the centre. They demonstrate a culture of learning

Ongoing work for 2024/25 was outlined in our ambitions for our Year Two Quality Strategy.

Workplans were developed for:



Infection Prevention and Control

The Health Board has taken a proactive and system-wide approach to infection prevention and control this year. A strategic leadership group and organisational action plan were established to address rising healthcare-associated infections, particularly C. difficile and Staph aureus. Outbreaks were managed swiftly with enhanced cleaning, rapid isolation, and targeted staff education. Quality improvement projects focused on hand hygiene, environmental cleanliness, and compliance with care bundles. Monitoring and assurance were strengthened through dashboards, regular check-ups, and leadership surveys. Despite a rise in some infection rates, the Health Board responded with updated policies, investment in cleaning resources, and piloting new decontamination technologies. Learning from root cause analyses was widely shared, and careful use of antibiotics remains a continuous focus. These actions have reinforced IPC as a cornerstone of keeping people safe and high-quality care.

As part of the Infection Prevention and Control (IPC) pillar of our Quality Strategy, the Health Board is strengthening its focus on careful use of antibiotics and the safe use of antibiotics. Routine reporting of infection rates continues, and a dedicated workstream has been established to improve prescribing practices and to reduce healthcare-associated infections (HCAIs).



Enhanced Cleaning Programme

A robust cleaning strategy has been implemented to reduce HCAIs. This approach balances keeping people safe with operational pressures such as bed availability and ward reconfiguration, using a more targeted and risk-



Patient Flow and Infection Prevention

Daily participation in Patient Flow Meetings ensures infection prevention is embedded in patient placement decisions, supporting safe and timely care.



Reporting and Root Cause Analysis

Datix is used to report and analyse HCAIs, with virtual root cause analysis meetings reinstated to identify themes, share learning, and drive improvement.



Supporting Divisions

IPC teams continue to work closely with clinical divisions to promote best practice and provide expert guidance on infection



Antimicrobial Prescribing, Stewardship and Resistance

In collaboration with clinical teams, the Health Board is reinforcing the Start Smart - Then Focus principles, ensuring antibiotics are prescribed appropriately,

This workstream reflects our commitment to the Duty of Quality, ensuring that infection prevention and careful use of antibiotics are embedded across all services, supported by data, education, and improvement.

Refining the Reporting Structure

During 2024-2025, the Health Board has made progress in refining its reporting structure to provide greater assurance, transparency, and responsiveness in quality and keeping people safe. The Quality Outcomes Framework (QOF) was systematically reviewed and enhanced to highlight trends, enabling more timely and actionable insights. The development of the system to check and improve care framework and the establishment of a dedicated Quality Management Group in the last 12 months has ensured that reporting is not only standardised but also aligned with strategic priorities and the Duty of Quality.

Regular meetings with Divisional Triumvirates, the implementation of dashboards for real-time monitoring, and ensuring escalation processes for safeguarding, incidents, and regulatory concerns are part of everyday practice have further strengthened quality assurance. These developments mean that the Board and operational leaders now have access to robust, information from a number of sources with stories and peoples experience, supporting evidence-based decision-making and how we improve across all domains of quality.

To ensure the Health and Care Quality Standards are consistently met, we have:

1

Refined and strengthened the Health Board Clinical Audit Plan to ensure that all priority areas are systematically reviewed and that check-up activity is aligned with national standards and local priorities.

2

Produced regular, comprehensive annual reports that track compliance, highlight areas of good practice, and identify themes and therefore opportunities for improvement, enabling targeted action and transparent Board-level assurance.

3

Enhanced corporate support and streamlined decision-making, ensuring that Divisions have access to expert guidance and that escalation routes for quality and safety issues are clear and effective.

4

Embedded robust assurance mechanisms by consistently monitoring performance against quality and safety standards, using real-time dashboards, information from different places, and regular review meetings.

5

Leveraged existing tools, staff expertise, and digital technology to drive improvement, support learning, and enable timely, data-driven decision-making.

6

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Human Factors Programme

Over the past year, the Health Board has made huge strides in putting human factors principles into clinical practice and quality improvement. The Human Factors Programme has focused on the building of capability and safety culture, particularly in high-risk areas such as theatres. Theatres have benefited from the introduction of Human Factors simulation sessions, safety culture surveys, and the roll-out of the updated WHO checklist and the "Pause for the Gauze" initiative, all designed to reduce serious mistakes that should not happen in a theatre environment and improve team communication.

The Quality Improvement Coach Programme has also incorporated human factors training, with 31 coaches trained to date and a target of one million minutes of QI coaching over four years. Human factors principles are now routinely included in QI projects, safety briefings, and incident reviews, supporting a just culture and ensuring that staff feel safe to speak up. These efforts have contributed to a sustained period without serious mistakes that should not happen in theatres with improved staff engagement, and a demonstrable shift towards proactive risk identification and system-based learning across the organisation.

In 2025, the programme expanded beyond Theatres to include Cardiology and Obstetrics & Gynaecology, with

Key Components:

- Regular introductory and advanced training sessions delivered by the Human Factors Lead, tailored to clinical context and team needs.
- Embedding Human Factors principles into everyday practice to foster psychologically safe, open, and high-performing environments, ensures department integration.
- Undertaking cultural transformation by empowering staff at all levels to speak up, challenge unsafe practice, and contribute to continuous learning and improvement.

This workstream is a critical enabler of the Health Board's commitment to the Duty of Quality, driving safer care through behavioural insight, systems thinking, and team-based learning.

Sepsis

As part of our ongoing commitment to keeping people safe and the Duty of Quality, the Health Board is actively implementing the updated NICE Sepsis Guideline (NG51). This work addresses systemic challenges in recognising and managing deteriorating patients, with a strong focus on early identification, timely intervention, and effective escalation of care.

Over the past year, we have prioritised:

- Early recognition of sepsis through the planned rollout of updated Early Warning Scores for adults, paediatrics, maternity and neonates. across all divisions. This has been planned for implementation throughout 2025/26.
- A comprehensive approach encompassing digital tools, education, implementation, escalation pathways, and check-up.
- A standardised education package has been developed and will be delivered throughout 2025.

A dedicated Sepsis Working Group has been established. There has been a scoping exercise to review current practice and align with updated NICE and Academy of Medical Royal Colleges guidance. In November 2024, the Health Board launched an internal sepsis awareness campaign, with a public-facing campaign planned for April 2025. This will include a new website, staff Pulse page, and awareness materials to support wider engagement.

We are also applying quality improvement methods, such as PDSA cycles, to test and implement the UK Sepsis Trust tool within acute settings. Compliance and effectiveness are being continuously reviewed through a developing check and assurance structure.

The Health Board continues to contribute to national sepsis forums and the development of eLearning resources, ensuring alignment with national standards and shared learning.

The sepsis workstream is structured around the following:

- Initial Treatment – Timely prescribing and administration of antibiotics
- Source Identification – Prompt identification of infection source
- Early Monitoring – Rapid clinical assessment and review
- Escalation of Care – Strengthened protocols including Call for Concern and Martha's Rule
- Information and Support – Accessible sepsis information for patients and families
- Training and Education – Building staff confidence and capability
- Audit and Assurance – Monitoring compliance and driving improvement

Our collaboration with the UK Sepsis Trust continues to embed best practice and strengthen our contribution to national efforts to improve sepsis recognition, response, and outcomes.

6 Pillars of Quality



Pillar One: Patient and Staff Experience and Stories

Key Achievements and Successes

Embedding Patient Experience and Involvement

Feedback Platform

The roll-out of the CIVICA electronic feedback system, has enabled real-time collection of opinions and thoughts from patients. Over 8,900 answers were received in 2024/25. with an overall satisfaction rate of 89% and 91% for Person Centred Care (PCC) questionnaires.

Positive Emotional Trends

86-91% of answers reflected positive emotions, with compassion, emotional/physical support and friendliness consistently the top positive themes.

Patient Participation Panels

Ongoing involvement through patient panels, Patient Advice and Liaison Service (PALS), loss of a loved one (bereavement) services, and volunteer programmes has strengthened care that focuses on the person and provided direct input into service improvement. Funding has also been secured for a dedicated Patient and Family Involvement Lead to take forward a community of practice.

Award Recognition

The Patient Experience and Involvement Team and Maternity Services achieved the silver distinction award as part of the Diverse Cymru Black. Asian and Minority Ethnic Cultural Competence Certification Scheme. The Fracture Liaison Service won the MediWales Innovation Award.

Volunteer and Peer

Support

Volunteering Service

Volunteers have played a key role in supporting patient experience, especially for those whose first language is not English, and in collecting opinions and thoughts. Over 20,000 volunteer hours were provided.

Cancer Cafés and Support Groups

Initiatives such as cancer cafés and help for feelings (psychological) support groups have been launched in response to patient feedback, enhancing help with improving the support for people receiving care and people who help others.

Pillar One: Patient and Staff Experience and Stories

Results

Quantitative

CIVICA Survey Responses: 8,985 total answers (2024/25), with 7,472 PCC questionnaire answers and 918 Emergency Department questionnaire answers. 595 other surveys received (e.g. endoscopy, children)

Compliments and Positive Feedback: Compliments logged via CIVICA and Datix increased, with “beyond duty of care,” communication, and listening as frequent themes

Patient Advice and Liaison Service (PALS) Activity: PALS managed an average of 476 enquiries per month, with communication issues and access to services as the most common themes



Qualitative



Patient Stories: Patient stories and case studies (e.g. Patient Advice and Liaison Service interventions, cancer patient panels. end of life care) have been used to drive service improvements and inform training.

Learning Forums: Regular Learning and Improvement Forums have facilitated cross-divisional sharing of best practice and learning from incidents.

Cultural Competence Initiatives: The Diverse Cymru accreditation process has led to tangible changes in staff training. Recruitment, and patient engagement practices.

Challenges

Sustaining High Engagement and Data Quality

While response rates are high, some locations still have limited feedback, and there are ongoing efforts to increase involvement in underrepresented areas. This improved coverage and reduces survey fatigue.

A recent CIVICA system upgrade led to queries about the accuracy of “waiting” as a negative theme, highlighting the need for ongoing data validation.

Addressing Negative Themes

“Waiting,” “food & beverages,” and “facilities” remain the top negative themes in patient feedback, indicating persistent issues with timeliness and the care environment. Bespoke reports are sent to the Facilities team and other areas each month capturing comments and themes.

The theme of communication issues is broad, including language barriers and continues to be the most common theme raised through PALS enquiries and early resolution complaints. Because this feedback is received in real time, it allows for quicker identification of concerns where possible. The Health Board is now working to explore defining the specific issues related to communication by expanding the categorisation options. This will support more meaningful data integration and help clarify what is meant by “communication” in different contexts.

Equity and Inclusion

While progress has been made on culture competence, there is a need to further embed cultural competence and address health inequalities. particularly for minority ethnic groups and those with additional needs.

Pillar One: Patient and Staff Experience and Stories

Priorities for 2025/26

Establish People Participation Panels

- To bring together those with different backgrounds (protected characteristics) and seldom-heard voices, including condition-specific groups, to ensure their experiences shape services and improvements.

Establish a Community of Practice

- To provide a safe space for patients, carers and staff to share opinions and thoughts and speak up, strengthening trust and driving meaningful service improvement.



Expand CIVICA and All-Wales Surveys

- Continue to increase coverage and response rates, including the launch of the All-Wales People's Experience Survey and targeted questionnaires for maternity and looked-after children.

Enhance Real-Time Feedback

- Further develop real-time opinions and thought mechanisms and ensure a rapid response to emerging themes.

Pillar One: Patient and Staff Experience and Stories

Bereavement Summary

The Health Board has made significant progress in developing a compassionate, inclusive and responsive loss of a loved one (Bereavement) support system. The approach is based on a principle of working together involving both staff and bereaved people and is underpinned by robust opinions and thought mechanisms and a commitment to improvement. Priorities for the coming year include; further involvement with diverse communities, enhancing staff support, developing and delivering staff training and ensuring that 'loss of a loved one' services are easy to use and meet the needs of all who experience loss.

Collaborative Approach and Engagement

- In September 2024, the Bereavement Collaborative event brought together 94 people (staff and bereaved members of the public), with 42 attending in person. Priorities included pregnancy loss, child loss, and loss from traumatic experiences. Over the last 12 months, 400 people have been involved in the collaboratives.
- 12 bereavement subgroups have been identified, some led by bereaved people themselves, ensuring lived experience is at the heart of improvement work.
- A dedicated event for workers (Staff Bereavement Collaborative) was arranged for December 2024 to coincide with National Grief Awareness Week, focusing on psychological support, workforce and staff needs.

Survey and Feedback

- A new Bereavement Survey questionnaire was tested and amended, now built into the CIVICA platform and including a National Core Question. The questionnaire is easy to use in audio and British Sign Language (BSL) formats, supporting changes to help people and inclusivity.
- The questionnaire captured a range of experiences, including place of death (home, hospital, care home, hospice, pregnancy, elsewhere,) relationship to the deceased, and satisfaction with 'loss of a loved one' support (ratings from "very poor" to "very good"). It also asked whether the death was expected or unexpected, and if support needs were met.

Key Priorities and Actions

- There is a focused plan for Engagement with People with Protected Characteristics to engage bereaved people with different backgrounds and needs through face-to-face and webinar events.
- Engagement events have been agreed for staff, people living with dementia, people with sensory loss, people whose first language is not English, and those affected by baby loss.
- The questionnaire on Reasonable Adjustments and involvement activities are designed to be easy to use, with adjustments for audio and BSL users.

Learning and Improvement

- There has been collaboration when prioritising pregnancy loss, child loss, sensory loss, and traumatic loss, recognising the unique needs of these groups.
- Staff Support: Recognising support for staff is needed when dealing with the loss of colleagues and loved ones and developing resources and events to address this.
- End of Life Care Senior Nurse and Patient and Family Support Officer roles commenced in October 2024 to strengthen bereavement support and end-of-life care.

Snapshot of Survey Findings

(baseline findings prior to implementing the loss of a loved one model)

- Place of Death: Most common were at home and in hospital, but also included care homes, hospices, during pregnancy, etc.
- Relationship to Deceased: Responses included parents, spouses/partners, children, siblings, and extended family.
- Satisfaction: Responses ranged from "very poor" to "very good," with a spread across all categories, highlighting variability in experiences.
- Most respondents indicated their support needs were not fully met.
- Expected vs Unexpected Death: Both expected and unexpected deaths were represented, with a slight majority being expected.

Pillar Two: Patient Safety/Incidents

Key Achievements and Successes

Number of Incidents Reported

It has been encouraging to see a high number of incidents being reported on Datix Cymru, with a clearly defined process for those that go onto Patient Safety Incidents (PSIs) investigations. The Health Board maintained a strong learning culture, with regular thematic reviews and divisional dashboards. Staff reported **26,661 incidents** using the Datix Cymru system. This shows people are speaking up to help make care safer.

Serious Incidents Investigated

Out of all the reports, 528 were serious and looked at more closely to ensure that we learn and improve.

Being Honest When Things Go Wrong

84 cases triggered the Duty of Candour, which means we told patients and families when something went wrong and shared what we learned. Duty of Candour triggers have a robust divisional monitoring and an improvement programme.

Fewer Late Reports

The number of overdue serious incidents (called NRIs) dropped from 71% to 51%, which means we are getting better at closing them on time.

Never Events

Two very serious mistakes happened. They were fully investigated and downgraded from never events and lessons were shared to stop them from happening again. No Never Events happened between January and March 2025.

Learning Together

Staff joined monthly learning sessions and drop-ins to talk about what happened, themes, what went well, and what could be better.

Early Warnings

142 Early Warning Notifications (EWNs) were sent to the Welsh Government. These helped us act quickly on issues like violence, safeguarding, and patients going missing.

Pillar Two: Patient Safety/Incidents

Results

What Was Reported:

Total Incidents	Serious Incidents (PSIs)	Duty of Candour Cases	National Reportable Incidents (NRIs)	Early Warning Notifications (EWNs)
26,661	528	84	948	142

Never Events

2 serious mistakes were investigated and shared, and declassified as never events

Closing Cases

Serious cases are being closed faster, but some still take time, between 76 and 299 days, depending on how serious they are.

Learning and Sharing

Monthly reports and sessions help staff learn from real events. Improvements were made in areas like blood clot prevention, baby monitoring, and follow-up care regular learning forums, thematic reviews, and monthly divisional reporting.

Challenges

- Some serious cases still take too long to finish, especially when they are complicated and involve multiple agencies.
- Some incidents are hard cases to investigate as involve many teams or outside groups, which makes them harder to sort out.
- It's important to get the details right and write down what happened clearly and correctly, especially for things like pressure sores and falls.
- There are high numbers of incidents and not always enough people to investigate them quickly.
- It can be hard to keep staff focused on reporting and learning when they're busy with other work.

Pillar Two: Patient Safety/Incidents

Priorities for 2025/26

1

Keep using the Duty of Candour to be open and honest with patients and families and learn from what happened.

3

Make sure all reports are written clearly and correctly, with good training and checks.

5

Make sure safety teams feel supported and have enough people and time to do their work well.



Keep working to close serious incidents more quickly and improve how we investigate them.

2

Focus on preventing Never Events and sharing lessons, to help further occurrence when they do happen.

4

Keep using Early Warning Notifications to act fast and learn from serious issues.

6

Themes and Learning

01

Learning from Events held as monthly learning sessions and reports help teams understand what happened and how to improve and how themes can be identified to support others.

02

The Duty of Candour process encourages being open and honest and helps staff spot when healthcare caused harm, so we can be honest and learn from it.

03

Families are now more involved in investigations, and their questions are included in reports.

04

For complicated incidents, teams meet early and work together to make sure everything is done properly. Early contact with internal and external stakeholders and strategy meetings for complex cases have improved the coordination and quality of investigations.

05

Reviews have already helped improve care in areas like blood clots, baby monitoring and follow-up appointments.

Pillar Two: Falls

Key Achievements and Successes	Results
• The number of inpatient falls showed a downward trend in the final quarter, with March 2025 recording the lowest monthly figure (281) since April 2024. • Most falls resulted in no or low harm (96.5%), with severe/catastrophic harm being rare. • Falls with severe or greater harm, Q1 and Q2, a total of one PER quarter, and zero for Q3 and Q4. • Regular falls panels and executive huddles reviewed all falls with fractures, supporting learning and prevention.	• 3,625 inpatient falls were reported in 2024/25, with detailed severity analysis and monthly reporting. For 2023/24 this was 3,480 inpatient falls reported annually. • Falls prevention strategies included daily huddles, targeted audits, and sharing of learning through QPS forums. • Trauma service reviews and ring-fencing beds to reduce A&E delays.
Challenges	
• Variation between divisions in falls rates and harm severity. • Some falls closed without full senior nurse validation or focused review. • Delays in transfer to orthopaedic wards and in surgery for hip fractures.	

Pillar Two: Falls

Priorities for 2025/26

1

Further analysis of themes and trends with a focus on high-risk areas.

3

Embed the newly established methodology to review all falls with fractures and falls with associated head injuries by means of a concise review as aligned to recommendations of the National Audit of inpatients Falls.

5

Ensure all incidents receive Senior Nurse validation and that a focused review is completed for all incidents of falls.



Embed and monitor the requirements of the updated 'Falls Policy for Hospital Adult Inpatients'.

2

Increase the implementation of evidenced bases practice and methodologies to reduce the incidents of falls e.g. Swarms.

4

Expand daily huddles and use of digital tools for early identification and prevention.

6

Themes and Learning

01

Most falls resulted in no or low harm (96.5%). Severe or catastrophic harm related to 1 fall in Q1, 1 Fall in Q2 and no falls in Q3, and there were no severe/catastrophic falls in the final quarter (number of falls with severe or greater harm per Quarter were Q1=1, Q2=1 and Q3 and Q4 were zero).

02

Falls with fractures are reviewed weekly at Executive huddles, and all data is available at ward level for review and discussion. This enables rapid identification of trends, learning and targeted interventions.

03

Some falls were closed without full Senior Nurse validation or focused review, highlighting the need for improved documentation and validation processes. Inconsistencies in completion of the Multifactorial Risk Assessment (MFRA) in terms of quality of information to support current patient status.

04

The National Hip Fracture Database audit highlighted the importance of prompt orthogeriatric assessment, timely surgery, and early mobilisation. These are being reinforced through regular governance meetings and action planning.

05

Delays in transfer to orthopaedic wards and in surgery for hip fractures were identified as areas for improvement. Trauma service reviews and ring-fencing beds are being used to address these issues.

Pillar Two: Pressure Ulcers (PU)

Key Achievements and Successes

- There was a notable reduction in pressure ulcers in March 2025, reflecting the impact of early identification, daily huddles, and improved documentation.
- Most divisions reported fewer hospital-acquired pressure incidences, and grades 1, 2, and 3 pressure damage over time.
- A professional forum group was established to enhance assurance and validation of Datix reporting.

Results

- This year, 8,963 pressure ulcers were recorded, with breakdown by category and avoidability reported. For 2023.24, 8429 were reported. These are high level figures and do not relate to harm. This is a 6% increase.
- There has been a steady volume of pressure ulcers with Grade 2 being reported and a slight increase in Grade 3 ulcers in December and February.
- Monthly audits, daily huddles, and a professional forum group for validation and learning.
- Implementation of symbols on PSAG boards and use of the PANDO app for wound imaging.
- PDSA cycles are being used to test and refine improvements.

Challenges

- Ensuring accurate grading, documentation, and validation of pressure ulcers.
- Some cases closed without full senior nurse validation or focused review.
- Variation in performance between divisions.

Pillar Two: Pressure Ulcers

Priorities for 2025/26

1

Continue to promote early identification and response strategies.

3

2

Strengthen validation processes and ensure all cases are reviewed by senior nurses.

Share successful practices.

Themes and Learning

01

A professional forum group is being established to enhance assurance and validation of Datix reporting. This will include monthly meetings to review dashboards and validate incidents.

02

Early identification and response strategies, such as daily huddles and the use of symbols on PSAG boards, have contributed to the reduction in pressure ulcers.

03

Improved documentation, staff training in tissue viability, and the use of the PANDO app for wound imaging are supporting better prevention and management.

04

Scrutiny and oversight panels and focused reviews, with Senior Nurse sign-off have been key to PU management

05

Most divisions reported fewer hospital-acquired pressure incidences demonstrating learning from data.

06

Scrutiny panels and focussed reviews with Senior Nurse sign off have been key to PU management.

Pillar Three: Complaints, Concerns and Compliments

Key Achievements and Successes

Sustained High Performance in Early Resolution

Early Resolution of concerns was maintained at an average of 67-71% throughout the year, with some divisions consistently above 80%.

Fewer Late Complaints

Focused efforts, such as weekly meetings and daily huddles, led to a reduction in the number of overdue and long-standing complaints.

One Place to Handle Complaints

Complaints are managed centrally ensuring staff respond to calls efficiently and the process is more streamlined. This approach enhances consistency, eliminates duplication, and provides more robust oversight.

Learning from Complaints

Teams worked together to find better ways to fix problems and make things easier by encouraging open communication and sharing ideas.

More Thank You Messages

Staff received more compliments from patients during the reporting period. October saw the largest surge in compliments as teams are proactively recording the compliments received.

Better use of PALS

The PALS team implemented a new system to record compliments, helping everyone see the good work being done.

Pillar Three: Complaints, Concerns and Compliments

Priorities for 2025/26



Training staff to produce better information and write down complaints clearly and correctly. Give staff training and keep patients informed during the complaints process.



Keep writing down compliments to celebrate good work and use the system to show what's going well.



Make communication better with clearer messages and language support.



Continue to focus on improved timeliness and closure rates, reducing overdue complaints and increasing compliance with 30-day closure targets, especially for PTR-managed concerns.



Use reviews and action plans to share learning and help all teams learn from complaints.



Build better dashboards and tools to help manage complaints in real time.



Pillar Three: Complaints, Concerns and Compliments

Learning and Improvement

1

Holding monthly learning sessions has enabled teams to discuss themes and how to address issues.

2

Every team includes members dedicated to addressing issues promptly.

3

Teams employ intelligent methods to identify the root causes of problems and implement improvements.

4

Reports now include questions from patients and families to make sure their voices are heard and illustrate we are listening.

5

A dashboard assists in identifying issues and improving staff training on the system's use.

6

A strategy meeting helped the Medicine team decrease complaints by 13%

7

The legal and complaints teams have shown their commitment to collaborating on complaints by meeting monthly to resolve issues promptly.

8

Making sure that every team member is present to take calls and properly trained to address complaints effectively.

Pillar Three: Patient Advice & Liaison Service (PALS)

Key Achievements and Successes

Helping People

PALS helped with about 476 questions every month. They gave advice and support to patients and families who needed help or had concerns.

Fixing Problems Early

PALS helped solve about 18 complaints each month before they became bigger issues. Most were about treatment, but they also helped with communication, appointments, leaving hospital, and patient care.

Recording Good Feedback

Since January 2025, PALS started using a new system called CIVICA to write down compliments. This helps everyone see what's going well.

Supporting Patients and Families

PALS helped patients and families in many ways—like helping them talk to hospital staff, supporting people with autism or communication needs, and helping with discharge plans.

Results

- About 476 contacts are received each month, mostly about communication and getting services. 18 complaints solved early each month, mostly about treatment.
- Over 500 compliments were written down. People said staff went “above and beyond,” listened well, and were kind.
- PALS helped create real-life stories in tough situations, like supporting people with serious illnesses, setting up video calls for lonely patients, and helping those with communication or memory problems.
- Learning and Feedback has been pivotal as the PALS team shared what they learned in monthly reports so the whole organisation could improve.

Challenges

- There is a high volume of work as PALS had many questions and complex problems to deal with, which made it hard to keep up.
- New rules and systems meant staff needed training to make sure everything was written down properly and to help keep good records.
- At times there are not enough staff, when staff were off duty, some calls went to voicemail, and fewer questions were recorded.
- Some problems were challenging cases and involved many teams, which made them harder to fix quickly.

Pillar Three: Patient Advice & Liaison Service (PALS)

Priorities for 2025/26

1

Make sure there are enough staff to answer questions quickly, even when someone is off duty.

3

Help more patients and families, especially those who find it hard to ask for help, so our outward reach increases.

5

2

Keep using CIVICA to record compliments and make sure all PALS work is written down clearly.

Train PALS staff to keep solving problems swiftly and share good ideas/practice with other teams.

4

Learn from Good and Bad Feedback, by using both compliments and complaints to learn and improve across the organisation.

Learning and Improvement

01

PALS share real life cases and stories (without names) in reports and meetings to show what went well and what could be better to enhance learning.

02

PALS feedback to hospital teams what they have heard from patients so services can improve.

03

The new CIVICA system and changes to complaint rules helped PALS improve processes in how they record and follow up on cases.

04

PALS staff get regular training on how to talk with people, solve problems, and manage information.

Pillar Three: Legal Services / Public Service Ombudsman for Wales/ Regulation 28

Key Achievements and Successes

Better Oversight and Clear Rules

Reports were shared regularly with the Board to demonstrate the legal and risk workload. New rules were put into place for big cases (over £1 million) and inquests to help things run smoothly and fairly.

Fewer Serious Reports from the Coroner

Only 3 reports were sent by the Coroner to help prevent future deaths. That's fewer than last year, showing we're learning and improving.

Managing Inquests Well

349 new inquests came in this year. 291 were completed —67 had staff speak in person, and 224 were undertaken with written answers. This saved time and helped staff.

Clearing Old Cases

A special project helped close old redress cases faster, reducing risks and delays.

Improved Legal Team Structure

The legal team changed how they work. Now they focus on different areas of work i.e claims or inquests , which helps them respond faster and be more expert in their work.

Results

- 349 new inquests came in; 291 were finished (67 in person, 224 in writing), 3 serious reports from the Coroner were received, 34 redress cases were looked at; 14 were settled, saving about £30,000 each compared to bigger legal claims, 123 new clinical negligence cases were received; 419 were still open at the end of the year and 37 new personal injury cases came in; 82 were still open at the end of the year.
- Reports were shared every few months. New rules were made for significant cases and inquests, The Board and leaders were kept updated.
- In 2024/25, the Health Board received 3,190 complaints. Of these, 178 were escalated to PSOW, which is equivalent to 0.30 per 1,000 residents. The number of interventions decreased by 30%, from 37% in 2023/24 to 28% in 2024/25, reflecting a reduction in the number of full investigations conducted. 6 reports were issued, with 3.3% of referred cases to the Health Board upheld in 2024/25, compared to 25 cases upheld in 2023/24.
- Lessons from Ombudsman cases were shared through posters and updates, contributing to improvements in areas such as discharge advice and patient information.

Challenges

- Some cases take a long time, especially when they involve outside groups or large sums of money
- There are lots of cases, which makes it hard for the team to finish them quickly.
- It's sometimes hard to keep all the paperwork and details correct and on time.
- Legal cases and inquests can be stressful. Staff need support to manage the emotional and work pressure.

Pillar Three: Legal Services / Ombudsman / Regulation

28

Priorities for 2025/26

1

Make sure lessons from legal cases and Ombudsman reports are shared and lead to real improvements.

3

Give staff training, feedback, and emotional support when they're involved in legal cases.

5

2

Keep working to close inquests and legal cases more quickly.

Improve how we track and report legal and risk work.

4

Keep improving rules, reports, and Board updates to make sure everything is well managed.

Learning and Improvement

01

Every serious report is reviewed. Action plans are made and shared to help everyone learn. For example, advice after leaving hospital was improved to include tips on drinking water, leg important, lessons are shared using posters and bulletins so staff know what happened and how to improve.

02

03

The legal team now works in smaller groups focused on different topics. This helps them respond faster and learn more.

04

Legal and risk lessons are included in monthly reports and reviewed in meetings.

Pillar Four: Health, Safety and Security

Key Achievements and Successes

Most staff completed important safety training:

A new training for manual handling started in April 2025. The goal is to reach 85% in high-risk areas by December.

Reporting of serious incidents, there were 12 were reported to the Health and Safety group in the last part of the year. Most (83.3%) were reported on time, which is an improvement.

No new warnings or actions were needed from the Fire Service. Some changes were requested to help fire alarms work better.

The team helped with 1,120 incidents where staff faced violence or aggression at work. This shows how important Health and Safety is in keeping people safe.

Results

- Training and Safety Checks are:
Health & Safety training: 86.5%
Fire Safety: 82.3%
Violence & Aggression: 86%
Manual Handling: 70%
- Of the serious incidents were reported in the last part of the year. Most were reported on time. Two cases about patient falls are still being reviewed.
- Health and safety updates were shared often with the Board and top managers.

Challenges

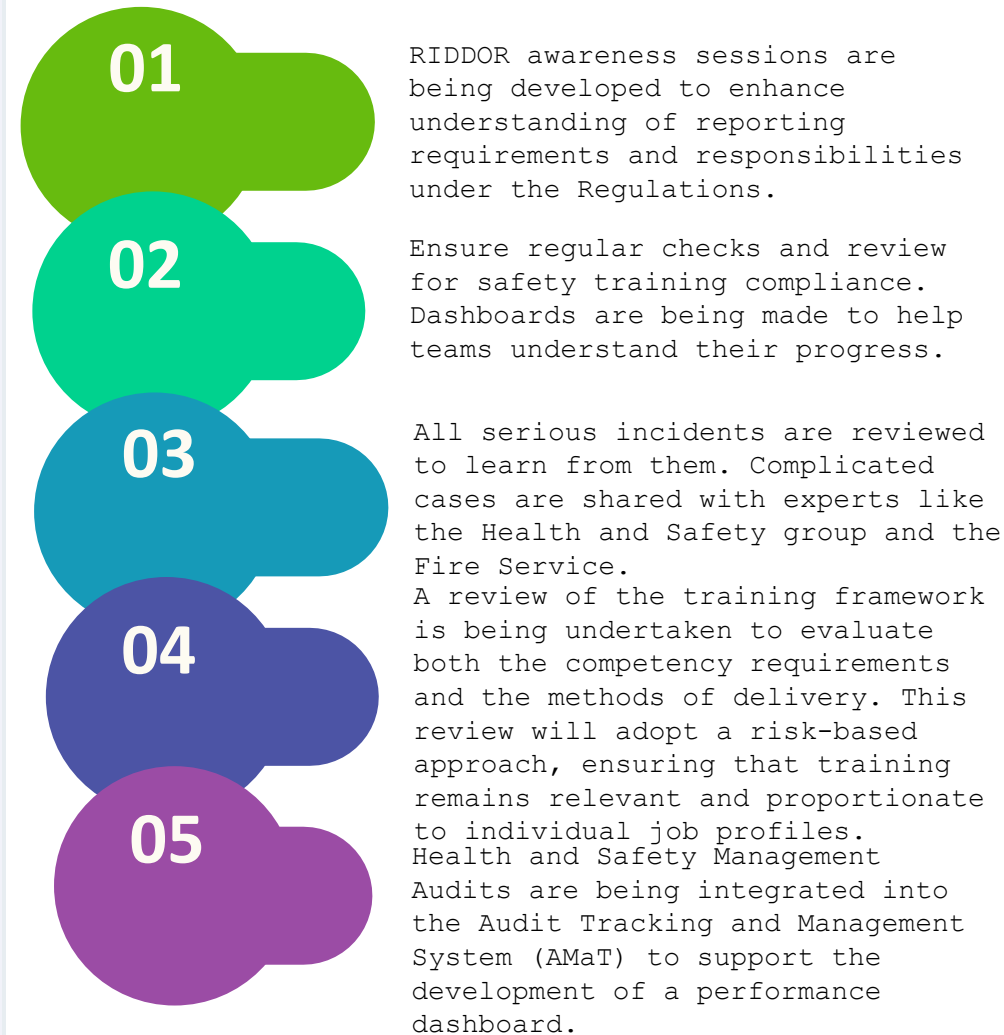
- More staff need to complete Manual Handling Training, the new programme will help.
- The Health Board is waiting for advice from the Fire Service about alarm changes in old buildings. Work is still going on to make older buildings safer.
- Some problems, like burns or serious falls, take longer to understand and fix as they are complicated incidents. Outside experts are helping.

Pillar Four: Health, Safety and Security

Priorities for 2025/26



Learning and Improvement



Pillar Five: Infection Prevention and Control (inc. Antimicrobial

Key Achievements and Successes

The team worked hard to stop infections like C. difficile, norovirus, COVID-19, and others. They instigated cleaning more often, checked wards regularly, and acted quickly when problems appeared.

Special projects helped wards improve infection control. These included work on C. difficile and oral hygiene. Infection control was also added to leadership training.

The team met their goals for using fewer antibiotics in GP surgeries. In hospitals, they worked on improving how antibiotics are prescribed using digital systems. They also taught staff and checked how antibiotics were used.

When infections spread, the team held quick meetings, instigated cleaning, grouped patients safely, and managed visiting to stop further spread.

Results

Infection Numbers - 275 cases of C. difficile (20% more than last year), 189 Staph Aureus infections (47% more), 376 E. coli infections (8% more), 115 Klebsiella infections (15% less), 42 Pseudomonas infections (68% more)

Ward Closures - 21 closed for C. difficile, 30 for norovirus, 25 for COVID-19, 3 for flu - over the 12 months.

Checks and Training - Regular infection checks and staff training, Webinars on topics like C. difficile and winter viruses, Surveys to check how well staff understand infection control

Antibiotic Use - GP surgeries met their goal for using fewer antibiotics but didn't reach the target for using the safest types, Hospitals created dashboards and held meetings to track antibiotic use. GP surgeries received

Challenges

- Some infections increased, partly due to shared spaces, poor airflow, and busy wards.
- GP surgeries didn't meet the target for using the safest antibiotics. Hospitals had staff shortages and delays in using new digital systems.
- There were delays in getting clean mops and replacing old ones which created cleaning delays .
- Some infection and antibiotic records weren't complete, making it harder to track and learn.
- It was hard to keep staff focused on infection control with so many other things going on.

Pillar Five: Infection Prevention and Control (inc. Antimicrobial

Priorities for 2025/26

1

Reach the goal for using safer antibiotics in GP surgeries, use digital systems in hospitals to track and improve antibiotic use, providing GP surgeries with more that need support

3

Plan for Resources, by making sure there are enough cleaning supplies and staff to keep up with infection control.

5

2

Focus on reducing infection rates like C. difficile, Staph Aureus, E. coli, and Pseudomonas with better cleaning and fast action.

4

Make sure infection and antibiotic records are complete and accurate. Use dashboards to help wards see and improve their results.

Keep teaching staff about infection control and include it in leadership training.

Learning and Improvement

01

Special projects helped wards take charge of infection control. These were supported by regular checks and leadership involvement. Quick meetings were held during outbreaks. Lessons learned were shared to help prevent future problems.

02

03

Infection checks and staff training helped teams learn and improve. Results were shared to keep everyone informed.

04

Staff were trained regularly on infection control, how to use antibiotics safely, and how to manage data.

Pillar Six: Safeguarding

Key Achievements and Successes

There were more reports made to help keep adults and children safe. Adult reports went up by 31%, and children's reports went up by 14%.

Strong Safeguarding Groups were formed, the team worked with leaders to set up regular meetings about keeping people safe. Smaller groups were also created to focus on adults, children, and staff concerns.

Most staff completed their safeguarding training. If any areas fell behind, plans were made to help them catch up.

Timely referral ensured staff could engage early with patients, families and their representatives to develop safety plans. The statutory safeguarding processes enabled us to work closely with multiple services within our own organisation, as well as with statutory partners and third sector organisations, to ensure the correct support is in place from the correct

Results

Reports Made: 506 reports to help adults, 4,290 reports to help children

Training:

- Level 1 Adult Safeguarding: 81% completed
- Level 1 Children's Safeguarding: 82% completed
- Level 2 Adult Safeguarding: 82% completed
- Level 2 Children's Safeguarding: 83% completed
- Level 3 training is now required and will be tracked from early next year

Managing Cases: A new digital system has commenced to help track safeguarding concerns and actions. Cases open longer than three months were reviewed to make sure they were dealt with quickly

Challenges

- The number of safeguarding concerns has gone up and there are more complex issues resulting in increased demand on the safeguarding team.
- Some teams didn't reach the 85% training goal, extra help and support has been provided.
- The new Datix system to track safety concerns is being rolled out, which has presented challenges.
- There are different arrangements in different areas within the five local authorities, which has made things confusing at times, work is underway with partners to make the systems clearer.
- Some cases have taken an extended time to complete, especially when external partners were involved. This has at times affected staff wellbeing and made workloads more challenging.

Pillar Six – Safeguarding

Priorities for 2025/26

1

Finalise the configuration of the Datix digital system to effectively monitor and report safety issues.

3

Continue collaborating with partners to regularly review cases that remain open for long durations, enabling prompt learning and timely action.

5

2

Reach Training Goals by ensuring 85% of staff complete their safety training, especially those in leadership roles.

Work with local authorities and Police to ensure that procedures and policies are consistently applied.

4

Provide staff with consistent feedback and ensure they feel supported while handling challenging safeguarding cases to promote their wellbeing.

Learning and Improvement

01

Regularly examining cases that remain open for extended periods allows teams to gain insights and expedite closure. This practice has become a routine and has received positive feedback from both staff and partners.

02

Collaborate with Local Authorities and the Safeguarding Board to clarify procedures and guidance, minimising confusion about what needs to be reported.

03

A new Safeguarding Datix Module is currently being developed for release, awaiting the completion of the All-Wales multi-agency referral form.

04

Awareness raising around the importance of initiating early communication with patients, their families, and representatives to collaboratively create safety plans at an early stage.

Ward Accreditation: Annual Review

The Ward Accreditation Programme developed in 2024-25. More areas have achieved accreditation and staff are motivated to improve and achieve accreditation, and quality improvement is now part of everyday work. In 2025-26, the focus will be on finishing the rollout, improving data and audits, and keeping staff supported and engaged.

Key Achievements and Successes

The Ward Accreditation Programme now covers 78 areas, including adult wards, mental health, learning disabilities, and children's wards.

Programme Growth is evident - Phase 1 is finished. Phase 2 (including theatres and critical care) has started, and Phase 3 (maternity and district nursing) will begin in

Independent Checks are carried out - 14 reviews were completed. 8 wards earned bronze awards, and 2 were ready for Silver.

Staff morale was improved and staff were more aware and involved thanks to updates, online tools, and news posts.

Quality improvement (QI) is now part of daily work, not just a special project.

Results

- Monthly checks are now normal, which look at patient care, staff feedback, and team improvements. "One Patient One Day" audits help show how care is improving. New folders help teams plan and track their progress. A data expert started in May 2025 to help with reporting. Staff can use Padlet (an online tool) to find audit information and resources.
- Feedback forms help teams share what they need. Senior nurses help keep audits on track. Guides and tools are being updated to help staff understand the process.

Challenges

- Staff said some audits were repeated too often, which slowed down awards.
- Data issues can be a hindrance, with challenges in pulling useful information from the audit system. A data analyst is starting in post in May 2025.
- Some wards didn't meet the 6-hour goal for risk assessments or had delays due to staff shortages.
- Keeping Up Momentum and maintaining audits was a concern. Staff have needed clear guidance and regular support.

Ward Accreditation

What Should We Be Focussing on in 2025-26



Learning and Improvement



Nutrition and Hydration Progress Overview

In response to concerns raised through complaints, Regulation 28 notices, and audit findings, the Nutrition and Hydration Task & Finish Group was established under the Aneurin Bevan University Health Board (ABUHB) Nutrition and Hydration Strategic Group. The group initially focused on two priority workstreams—Nutrition Escalation and Fluid Balance Monitoring, which were later amalgamated to streamline efforts and enhance shared learning.

Nutrition Escalation

Key drivers included inconsistent escalation of nutritional needs and gaps in staff awareness and timely action for patients with complex requirements, such as those with learning disabilities, swallowing difficulties, or requiring tube feeding. In response, the group developed a 7-minute briefing and an Action Card to support staff in identifying and escalating nutritional concerns. The WAASP tool was promoted for risk screening within 24 hours of admission or extended ED stays. Clear guidance was provided for patients unable to participate in assessments, those with swallowing difficulties (including SLT referral pathways), and those with cultural, religious, or therapeutic dietary needs. Protocols were also established for tube feeding and missed meals.

Assurance measures included dissemination of materials across divisions, audit and feedback mechanisms, and ongoing development of training and escalation procedures.

Fluid Balance Monitoring

This workstream was driven by Regulation 28 concerns regarding poor documentation and associated patient harm. Audits revealed that over half of staff had not received training on completing fluid balance charts. To address this, a 7-minute briefing and Action Card were developed to standardise practice. Roles and responsibilities were clarified across the multidisciplinary team, and criteria were defined for when fluid balance charts are required (e.g. sepsis, AKI, IV fluids, enteral/parenteral nutrition). Detailed guidance was provided on accurate input/output recording, recognising signs of dehydration, and understanding measurement standards and receptacle volumes.

Assurance measures included pilot audits showing improved practices, such as midday calculations and alternate-day weighing. PDSA cycles were used to refine the approach, and SOPs and guidelines are currently under review by the Clinical Policy Group.

Forward Planning

Future plans include continued audit and improvement cycles for both workstreams, the development of a Nutrition and Hydration intranet resource hub, an annual action plan, and expansion of the Clinical Sub-Group’s membership.

Embedding a Culture of Listening, Learning and Improvement

The Health Board's commitment to becoming a true team that learns and improves is clearly demonstrated through the implementation of our Listening and Learning Framework. This provides a structured and consistent approach to capturing, analysing, and acting on learning from incidents, feedback, and lived experience. It ensures that learning is not only identified but also embedded into practice—supporting safer, more effective, and more compassionate care.

A key enabler of this work is our web-based learning repository, which allows us to track how learning is identified, triangulated, shared, and implemented across the organisation. This supports a culture of appreciative enquiry and improvement, while also enhancing the experience of our workforce.

We are committed to becoming a team that learns and improves—one that improves keeping people safe, people's experience of care responding to insights and feedback in order to continuously improve. Our plans and priorities are continuously adapted to ensure we are doing the right things, in the right way, at the right time.

Collaborative Learning, Education and Improvement

The Health Board has taken a strategic and system-wide approach to learning and education as core enablers of quality, safety, and patient experience. Key achievements include:

- Identifying key quality issues and keeping people safe priorities through using multiple sources of intelligence, shaped by the voices of service users, to inform a responsive learning plan.
- Strengthening partnerships between corporate and educational teams to support the development of health professionals around core quality and safety themes.
- Facilitating cross-disciplinary education that aligns with organisational priorities and promotes shared understanding across teams and services.
- Ensuring learning and education are embedded in key quality and keeping people safe groups across the organisation, supporting alignment between clinical and corporate priorities.
- Supporting divisions and directorates to develop annual improvement plans based on insights from complaints, incidents, surveys, and reviews—ensuring a standardised, consistent and evidence-informed approach.
- Building capacity within teams to co-produce digital patient stories that support important listening, reflection, and learning.
- Standardising training, education, and competency records to reduce unwarranted variation and strengthen assurance.
- Establishing Collaborative Learning Events, multi-agency, public, and staff collaboratives, including learning events attended by patients, families, and carers to ensure a collective and inclusive approach to improvement.

This integrated approach reflects the Health Board's commitment to learning and improvement where education, insight, and collaboration drive improvement in care quality and patient and staff experience.

Delivering Assurance Through the Quality Management System (QMS)

The Health Board is committed to delivering safe, high-quality, and equitable care through the development and implementation of a comprehensive QMS.

This system will define the Assurance Framework that underpins our approach to quality planning, control, improvement, and assurance—ensuring that care is consistently safe, effective, patient-centred, timely, efficient, and equitable.

The QMS will support the Health Board in embedding a culture of improvement and accountability, with a clear focus on the following objectives:

- Implementing proactive plans to minimise risk, reduce avoidable harm and keep people safe.
- Ensuring clinical care is evidence-based and grounded and consistently delivers optimal outcomes.
- Fostering a culture for Person-Centred Care that prioritises the needs, preferences, and experiences of patients and their families.
- Optimising the use of available resources to deliver high-quality care in a sustainable and cost-effective manner.
- Addressing disparities in healthcare access, equity and outcomes to ensure all patients receive the same high standard of care.
- Measuring and understanding the quality and safety implications of timely access to care.
- Setting clear performance metrics and monitoring systems for each pillar of quality to ensure comprehensive oversight and improvement.
- Evaluating changes to service access and delivery to ensure they enhance safety, effectiveness, and experience—while preventing health inequalities and promoting improvement.

By aligning these objectives with the principles of Quality Planning, Quality Control, and Quality Improvement, the QMS will provide a structured and transparent approach to delivering assurance. It will enable the Health Board to demonstrate how quality is being embedded at every level of the organisation, supporting our statutory duties under the Duty of Quality and ensuring that patients receive the highest standard of care, every time.

Clinical Advisory Forum

To strengthen clinical oversight and embed assurance into our quality governance arrangements, the Health Board established a dedicated Clinical Advisory Forum during 2024-25. This strategic group was created to provide expert guidance, challenge, and support across all clinical services, ensuring that decisions about care are informed by evidence, lived experience, and best practice.

The Forum brings together senior clinical leaders and subject matter experts to review performance, share learning, and drive improvement aligned with our Quality Strategy and the statutory Duty of Quality.

As part of its strategic oversight function, the Clinical Advisory Forum has taken on a pivotal role in reviewing and assuring Quality Impact Assessments (QIAs) across the Health Board. This ensures that any proposed changes to services, pathways, or models of care are rigorously evaluated for their potential impact on patient safety, clinical effectiveness, and experience.

The Forum provides a structured, multi-disciplinary space where QIAs are scrutinised through a clinical lens, balancing innovation and transformation with the statutory Duty of Quality. By embedding QIA review into its core business, the Forum supports evidence-based decision-making, promotes consistency in quality assurance, and ensures that risks are identified, mitigated, and transparently addressed before implementation. This approach strengthens governance and reinforces the Health Board's commitment to delivering safe, effective, and equitable care.

Quality Improvement

Over the past year, Aneurin Bevan UHB has made significant strides in embedding a culture of quality improvement (QI) across the organisation. The development and launch of the new Quality Improvement Framework approach for 2025–2028 has been a cornerstone achievement, setting a clear vision for QI as a core organisational value and daily practice. This strategy was shaped through broad engagement, including staff at all levels, QI leaders, and external experts, and is aligned with the Health Board's Quality Management System.

A key feature of the QI culture is the empowerment of staff to lead and participate in improvement activities. The ABUHB QI Knowledge and Skills Programme is building internal capacity for QI and is contributing to a network of QI Coaches and Practitioners who support colleagues, facilitate change, and drive improvement from the ground up. The expansion of the Ward/Team Accreditation Programme to include QI is reinforcing local accountability and continuous improvement at the frontline.

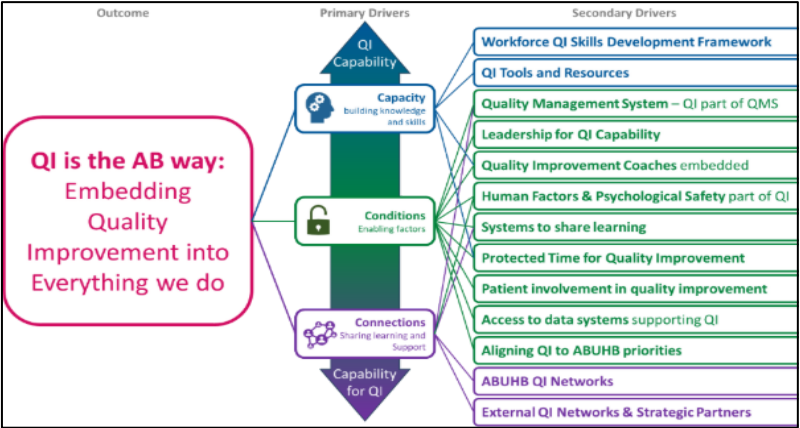
The Health Board's approach to QI is characterised by openness, collaboration, and a willingness to learn from both success and challenge. Staff are encouraged to undertake improvement locally, celebrate achievements and share best practice. As a result, QI is increasingly seen not as a separate initiative, but as an integral part of everyone's role. The culture is one where improvement is continuous, learning is valued, and staff at all levels are empowered to make a difference for patients, families, and colleagues. This cultural shift is laying the foundation for even greater achievements in the coming year, as the Health Board continues to implement its QI Capability Strategy and build on the successes of 2024/25.

Quality Improvement

Key Achievements and Successes

Number of Incidents Reported

The Health Board developed and launched a new Quality Improvement (QI) approach for 2025–2028, with broad engagement from staff, QI leaders, and external experts. The strategy sets out a vision for embedding QI into every aspect of organisational practice as part of a wider Quality Management System. It aims to develop the Health Board as a learning organisation where clinical & non-clinical staff share ownership over the services they provide, have the agency to improve them, and an environment that enables them to do so. It will do this by building QI capacity, creating enabling conditions, and fostering connections for shared learning and improvement. This has helped to create a more open, proactive, and collaborative culture for QI, where improvement is seen as everyone’s responsibility and is part of daily work. The Driver Diagram below outlines key areas of work to achieve this



QI Coach Programme

Spread and Scale of QI Coaching capacity is key to enabling teams to improve quality locally. The QI Coach Programme was launched in 2024. The ultimate aim is to “unleash a million minutes of QI Coaching over the next four years,” with 17,355 minutes delivered so far. This is about embedding improvement capability and empowered staff at all levels to lead and support change.

Continuous Improvement Culture

Through the implementation of the QI Capability Strategy the Health Board embedding a culture of continuous improvement. Regularly engaging with health board teams, sharing learning, using QI principles and tools, staff are being encouraged to celebrate success and address ongoing challenges. .

QI Programmes

NHS Wales – Safe Care Collaborative ended in May 2024:

- Increase from 40 to 490 days between cardiac arrests on Ward C0 – 17 cardiac arrests avoided with potential savings of over £290k
- Positive outcomes also achieved by the Monmouth Integrated Team and the OT Early Intervention Memory Service

Theatre Safety Programme – reduction in Never Events

- Increase from 90 to 518 days between Never Events in theatres – 5 Never Events avoided up to March 2025 with a potential saving of over £330k

Q Lab – Head and Neck Cancer

- Duration between initial suspicion of cancer to decision to treat halved to 31 days, with 7 potential deaths avoided. Compliance with suspected cancer pathway doubled to over 61%. Estimated health benefit value between £2-3 million annually

Quality Improvement

Outputs

Quality Improvement Knowledge and Skills Framework: This has been developed to 'dose' appropriate knowledge and skills training around QI principles and methodology targeted at staff at different levels. Training is delivered through the following programmes:

- **QI Coach Programme** - 31 coaches trained by the end of 2024. Programme is set up to train 75 QI Coaches across 3 cohorts per year to create 300 QI Coaches integrated into services by the end of 2028.
- **PocEd QI virtual training** - 349 staff undertook virtual QI method/tools training (a 32% increase, with 102 trained in 2024)
- **PocEd Measurement virtual training** - 67 staff completed measurement training focused on run charts and SPC. This has improved the organisation's ability to use data for improvement and to measure the impact of changes.

QI Networks/Partnerships

- Positive links with external QI Bodies such as the national Quality Safety and Improvement, Q Community, Q Lab, Q Lab Cymru, NHS Elect.

QI Resources:

- QI Padlets including Problems to Solutions tool

Challenges

Improvement

Sustaining Momentum: Keeping up the pace of QI work and ensuring protected time for QI coaches and staff, especially as the programme scales up.

Corporate and divisional leadership - structures to support quality improvement as part of a wider Quality Management System

Priorities for 2025/26



**Clinical Effectiveness:
Ensuring Quality and Patient
Safety**

Delivering consistently safe, effective, and evidence-based care is central to the Health Board’s vision and our statutory Duty of Quality. Over the past 12 months, we have strengthened our focus on how well care works to support improved outcomes and keeping people safe across all services.

**National Clinical
Audit Programme**

The Health Board actively participates in the National Clinical Audit Programme, using its findings to benchmark the quality of care and identify areas for improvement. Our Annual Clinical Audit Plan outlines the timeline of national check-up publications and ensures alignment with local priorities. Insights from these check-ups are reviewed by the Clinical Standards and Effectiveness Group and reported to the Patient Quality, Safety, and Outcomes Committee, ensuring robust oversight and accountability. These

Learning from Deaths Framework

We have strengthened our approach to deaths review through the implementation of a comprehensive Learning from Deaths Framework, supported by a detailed report capturing key deaths metrics and insights. This work is triangulated with data from the Medical Examiner Service, which now reviews all deaths within the Health Board. Emerging themes are shared through newsletters and briefings, ensuring learning is disseminated and embedded into practice.

By putting continuous improvement into our governance, audit, and learning systems, we are ensuring that quality and keeping people safe remain at the heart of everything we do—delivering the highest standards of care to the communities we serve.

Clinical effectiveness will be embedded as a core component of the Health Board’s Quality Pillars for 2025/26, enhancing our ability to monitor, measure, and report on the delivery of safe, evidence-based care with greater consistency and transparency.

**Structured Audit
Participation**

We have implemented a standardised approach to clinical audit through the development of a Clinical Audit Strategy, Annual Clinical Audit Plan, and Annual Audit Report. This ensures purposeful participation in both national and local audits. Local actions and recommendations are captured and tracked through our Audit Management and Tracking (AMaT) system, enabling teams to refine practice, raise standards, and improve patient outcomes.

**Continuous Improvement and
Collaboration**

Our commitment to how continuous improvement is supported through collaboration with other NHS Wales Boards, Trusts, and the NHS Wales Executive via the Safer Care Partnership. This national initiative supports local teams in delivering safe, reliable, and high-quality care, and ensures that improvement is informed by shared learning and best practice.

Conclusion

The 2024/25 Annual Quality Report reflects Aneurin Bevan University Health Board's unwavering commitment to delivering care that is safe, timely, effective, efficient, equitable, and person-centred, aligned with the STEEP domains of quality. These principles are not just aspirational; they are embedded in our systems, behaviours, and outcomes, guiding every aspect of our work.

Our Pillars of Quality programme has provided a robust framework for assurance, enabling us to monitor performance, escalate concerns, and celebrate achievements across all domains of care. It ensures that our statutory Duty of Quality and Duty of Candour are actively upheld, and that quality remains the golden thread running through everything we do.

We would like to extend our heartfelt thanks to all our staff and teams across the Health Board. Their dedication, compassion, and relentless focus on putting the patient at the centre of everything we do is the foundation of our success. It is through their hard work and commitment to learning and improvement that we continue to deliver safe, effective, and compassionate care.

As we look ahead to 2025/26, we remain focused on listening, learning, and improving-together. With our Quality Management System and Pillars of Quality guiding the way, we are building a health system that is safer, more responsive, and more inclusive for all.

Appendices

To strengthen our assurance and demonstrate meaningful progress under the Duty of Quality, the following table outlines key achievements from 2024-25 mapped against the STEEEP domains of quality – Safe, Timely, Effective, Efficient, Equitable, and Person-centred and the core quality enablers that underpin our improvement efforts. These examples reflect how the Health Board has embedded quality into its systems, behaviours, and outcomes, supported by robust governance, data-driven decision-making, and inclusive engagement. Together, they provide clear evidence of how we are delivering safe, effective, and compassionate care, while continuously learning and improving across all services.

STEEEP Domains Summary

The Health Board’s Quality Management System (QMS) aligns with the **STEEEP** domains, ensuring care is:

- **Safe:** Through incident reporting, infection control, safeguarding, and sepsis management.
- **Timely:** Via improved patient flow, early identification of issues, and rapid response mechanisms.
- **Effective:** Through evidence-based practice, clinical audits, and structured learning from deaths.
- **Efficient:** By optimising resources, refining reporting structures, and reducing delays in investigations.

Domains of Quality (STEEEP): Achievements with Assurance Focus

Domain	2024–25 Achievements	Assurance Mechanisms
Safe	▪ Reduction in inpatient falls and pressure ulcers ▪ Sepsis Working Group and updated NICE guideline implementation ▪ Infection control response to outbreaks (C. difficile, norovirus, COVID-19)	• Executive huddles and scrutiny panels for falls and pressure ulcers • Real-time dashboards and Datix reporting • Root cause analysis and thematic reviews
Timely	▪ Early resolution of complaints via PALS ▪ Rapid response to infection outbreaks ▪ Escalation processes for safeguarding and regulatory concerns	• Monthly divisional reviews and escalation protocols • Dashboards for incident tracking and patient flow
Effective	▪ Participation in National Clinical Audit Programme ▪ Launch of AMaT audit system ▪ PDSA cycles as part of Quality Improvement	• Annual Audit Plan and Clinical Advisory Forum • Mortality Report triangulated with Medical Examiner data
Efficient	▪ Centralised complaints handling ▪ Improved antibiotic stewardship in GP surgeries ▪ Escalation and resolution of PSOW cases	• Quality Outcomes Framework (QOF) and reporting structure refinement • CIVICA system for feedback and compliments
Equitable	▪ Engagement with diverse communities in bereavement support ▪ CIVICA feedback in BSL and audio formats ▪ Diverse Cymru accreditation	• Protected characteristic panels and inclusive survey design • Community of Practice and targeted webinars
Person-centred	▪ 89% satisfaction rate from CIVICA feedback ▪ Patient panels and volunteer programmes ▪ Bereavement collaborative and support roles	• Patient Experience and Involvement Strategy • Real-time feedback and monthly learning forums

Quality Enablers Summary

The report identifies several **quality enablers** that support the Duty of Quality and STEEEEP domains:

Leadership: Strategic oversight and governance through divisional structures and executive engagement.

Information: Dashboards, CIVICA feedback platform, AMaT audit system, and real-time monitoring tools.

Learning, Improvement and Research: Listening and Learning Framework, Learning from Events Reports, and collaborative forums.

Workforce: Training programmes, QI coaching (aiming for one million minutes over four years), and human factors integration.

Culture: Patient panels, bereavement collaboratives, and multi-agency learning events.

Whole Systems Approach: Quality Outcomes Framework (QOF), Clinical Audit Plan, and structured reporting.

Quality Enablers: Achievements with Assurance Focus

Enabler	2024–25 Achievements	Assurance Mechanisms
Leadership	• Strategic oversight via Divisional Triumvirates • Executive huddles for falls and infection control	• Governance structures and escalation pathways • Quality Management Group planned for 2025/26
Information	• CIVICA feedback platform • Real-time dashboards for QOF and infection rates • AMaT audit tracking system	• System to check and improve care Framework • Data triangulation and reporting tools
Learning, Improvement and Research	• Listening and Learning Framework • Monthly Learning from Events Reports (LFERs) • Drop-in sessions for staff reflection	• Learning and Improvement Forum • Embedded learning from incidents and deaths
Workforce	• Human Factors Programme and simulation training • QI Coach Programme (1 million minutes target) • Training in sepsis, safeguarding, and infection control	• Standardised education and competency records • Strategic representation in quality groups
Culture	• Bereavement collaboratives and subgroup leadership by bereaved individuals • Multi-agency learning events • Patient and Family Support Officer roles	• Inclusive engagement strategies and feedback loops • Community involvement in service design
Whole System Approach	• Quality Outcomes Framework (QOF) • Structured audit plans and reporting • Escalation and accountability frameworks	• Clinical Audit Strategy and AMaT system • Monthly governance meetings and performance monitoring

QMG ASSURANCE REPORT

Meeting Date:	04/09/2025
Chair:	Jennifer Winslade (Executive Director of Nursing)

KEY ESCALATION AND DISCUSSION POINTS			
ALERT			
Alert	Action	By whom	Target Date

ADVISE
• Divisional Highlight Report – Medicine – COTE Silver Ward Accreditation. • Quality Annual Report 2024/25 - Highlighted work on Sepsis, human factors, Infection control improvement and work on reporting structures. • HIW - IR(ME)R Inspection – March 2025 – Overall positive but some immediate actions as a result of the inspection which have all been completed. • HIW Adferiad/Pillmawr Inspection – May 2025 – Inspection noted the responsive, respectful and compassionate management of patients in a high-pressured environment. However, key areas of concern were noted (risks section below).

ASSURE
• QI Coaching – A Million Minutes – 43 coaches trained (Health Board aim is 750 coaches based on the size of the organisation). With 75 more coaches anticipated next year. Highlighted significant projects in reducing cardiac arrests in C0, head and neck projects, never events in surgery and others. • PTR Annual Report 2024/25 – 11,000 patient interactions in the last financial year with 0.027 interactions resulting in a PTR complaint. Improved complaints management process with enhanced contact (>90% compliance with acknowledgements). A 200% increase in the number of compliments captured. Reduction in financial penalties and investigations from PSOW • Review of Ligature Incidents – Training/competency issue identified – remote training through ESR developed and implemented and train the trainer course. Therapeutic observation policy under review with multi-professional steering group, aim for finalization and launch in October. Discussions had on how to spread around the scale of the work across the organisation. • Maternity/Neonatal Update – Recruitment progress with both areas filling all vacancies, midwifery will be over establishment from October. Improvement work on training in midwifery has yielded positive results in training compliance, with neonatal life support, basic life support and fetal surveillance training over 90%.

Neonatal unit have bespoke action plan for top 5 patient safety risks forming part of the overarching 150 point action plan.

- **HTA Annual Report 2024/25** –HTA reportable incidents noted in the year with action plans around training, procedures and traceability, considerable work taken place since serious incidents in the previous reporting year. All 72 HTA standards have be examined and audited to ensure full compliance.

RISKS DISCUSSED OR IDENTIFIED:

- **Divisional Highlight Report** – Medication incidents were highlighted in a number of divisional reports, urgent care have recently improved medication training which has resulted in a significant reduction in incidents. Falls training highlighted as a cross divisional risk with many divisions recording it on local risk registers. Disparity between PTR backlog noted (medicine, surgery and F&T represent >80% of backlog) whilst compliance is relatively consistent across divisions. Civica feedback was noted as inconsistent between wards, hospitals and divisions. In response to medication management incidents surgery have delivered bitesize training in conjunction with pharmacy, reviewed the “do not disturb” whilst giving out medication, this has seen a decrease in those areas. NNU has a bespoke action plan for medication errors. Urgent care have also created in house medication administration training which has seen a reduction in errors.
- **QI Coaching – A Million Minutes** – Critical the trained coaches are given time to deliver quality improvement to ensure we embed quality improvement methodology.
- **PTR Annual Report 2024/25** – Duty of Candour awareness and compliance remains a concern, relaunch planned with more training.
- **Review of Ligature Incidents** – Two themes identified training / competence particularly in temporary staff (lack of therapeutic observation training and quality of clinical record keeping).
- **HIW Adferiad/Pillmawr Inspection – May 2025** – Areas of concern: Environment and safety, workforce, training and governance. Action plan in place to work through these recommendations but risks remain whilst incomplete. The biggest challenge around the environment.
- **Maternity/Neonatal Update – Maternity** – High number of NRIs due to national reporting requirements (this year (2025) 2 late fetal loss, 13 stillbirths and 5 neonatal deaths) assurance provided on the review process around these baby losses occur including a 72-hour review. MBBRACE 2024 report is still not published, but 2023 shows neonatal deaths where there is a congenital abnormality had increases.

MATTER FOR THE BOARD OR OTHER COMMITTEES:

MEETING AGENDA ITEMS

- Quality Annual Report 2024/25
- QI Coaching – A Million Minutes
- PTR Annual Report 2024/25
- Review of Ligature Incidents
- QPS Divisional Assurance Reports * 7
- HIW - IR(ME)R Inspection – March 2025
- HIW Adferiad/Pillmawr Inspection – May 2025
- Maternity/Neonatal Update
- HTA Annual Report 2024/25

ATTENDEES

Jenny Winslade (Chair)	Executive Director of Nursing
Amanda Hale	Divisional Nurse – Surgery and Clinical Support Services
Rachel Manley	Business Manager
Joanne Lane	Divisional Nurse – Primary Care and Community
Robert Holcombe	Director of Finance
Natalie Skyrme	Divisional Nurse - Medicine
Jo Hook	Senior Nurse – Patient Experience and Involvement
Leeanne Lewis	Assistant Director – Quality and Safety
Craig Roberts	Assistant Director of Allied Health Professions & Health Science
Kye Smith	Deputy Head of Quality and Patient Safety
Rani Dash	Director of Corporate Governance
Gemma Couch	Head of Quality and Patient Safety
Peter Carr	Executive Director of Allied Health Professions & Health Science
Nadine Gould	Divisional Nurse Mental Health
Howard Stanley	Head of Safeguarding
Chris Morgan	Divisional Nurse – Urgent Care
Moiria Bevan	Head of Nursing – Infection Prevention & Control
Tracey Partridge-Wilson	Deputy Director of Nursing
Stephen Edwards	Deputy Executive Medical Director
Deb Jackson	Divisional Nurse – Family & Therapies
Jayne Beasley	Head of Midwifery
Garvin Jones	Head of Legal Services
Scott Taylor	Head of Health, Safety & Fire
Jayne Beasley	Head of Midwifery
Christopher Dawson-Morris	Deputy Director Strategy Planning and Partnerships
Christopher Morgan	Divisional Nurse – Urgent Care

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	01 October 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Annual Quality Report; Primary Care Contracting, Primary and Community Care Academy and Quality and Patient Safety.
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Lloyd Hambridge, Divisional Director of Primary Care, Community Services and Complex and Long Term Care

**Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

This report introduces the 2024/25 Annual Quality Report in respect of Primary Care Contracting, Primary and Community Care Academy and Quality and Patient Safety.

The full report is included as appendix 1.

Cefndir / Background

The 2024/25 Annual Quality Report provides the detail and assurance in respect of commissioning arrangements between Aneurin Bevan University Health Board and its Independent Contractors across General Dental Services, Welsh General Optometry Services, General Medical Services and Community Pharmacy.

Additionally, included in the report is the role of the Primary and Community Care Academy in the development of the multi-professional team within Primary Care and a brief overview in respect of Quality and Patient Safety in the Primary Care context.

Asesiad / Assessment

The 2024/25 Annual Quality Report (AQR) confirms the Health Boards commissioning arrangements and the management and monitoring processes in place, in accordance with the relevant Regulations, in respect of the following;

General Dental Services

The Health Board commissions General Dental Services (GDS) throughout Aneurin Bevan University Health Board from independent contractors, through The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006.

76 General Dental Contracts were commissioned in 2024/25, with 52 practices opting into Contract Reform focusing on prevention and needs-based care, while the rest continued under traditional Units of Dental Activity (UDA) metrics. Activity data is provided in the report demonstrating the level of routine access across the Health Board.

Urgent dental access was prioritised with 279 Emergency Dental Service appointments commissioned weekly. The report notes that demand for EDS appointments has decreased whilst access to routine general dental care has increased.

The Dental Access Portal (DAP), which was developed during 2024/25, is a national centralised platform for individuals to register to access routine dental care in a consistent manner. The DAP was implemented within Aneurin Bevan in February 2025 and at 31 March 2025, 1307 Health Board patients had added their details.

The AQR also outlines the specialist dental services commissioned within the Health Board and confirms current activity levels and wait times.

Full details are included in respect of the end of year management process and governance arrangements.

General Ophthalmic Services

In accordance with the National Health Service (Ophthalmic Services) (Wales) 2023 Regulations 2024/25, 54 optometry practices provided NHS Welsh General Ophthalmic Services (WGOS) including urgent and essential appointments. All practices are required to provide WGOS 1 and WGOS 2, additionally, 35 practices provide low vision services through WGOS 3. The Health Board implemented WGOS 4 and 5, the activity data is included in the AQR and the impact on the wider system is starting to be seen.

In line with the Health Board implementation plans, the five commissioned Ophthalmic Diagnostic Treatment Centre's transitioned to the delivery of WGOS 4.

General Medical Services

It is widely acknowledged that approximately 90% of all NHS patient interventions take place in the primary care through GP practice engagement. During 2024/25,

through The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023, the Health Board commissioned 68 General Practices, with 3 being directly managed by the Health Board. Access and sustainability were key focus areas and the AQR provides an overview of the management of these elements.

In order to demonstrate the required assurance in respect of contract management, the AQR provides an overview of the Access Standards and Quality Improvement Framework and their achievement and enhanced monitoring arrangements in place. Also detailed is the annual contract review process via the national Contract Assurance Framework and the outcome for the 2024/25 period.

Community Pharmacy Services

125 community pharmacies provided pharmaceutical services during 2024/25 in accordance with the terms of service laid out in the National Health Service (Pharmaceutical Services) (Wales) Regulations 2020. Alongside dispensing services, the pharmacies provide a range of additional clinical services commissioned using provisions in the Pharmaceutical Services (Clinical Services) (Wales) Directions 2022.

The AQR provides an overview of the activity through the Clinical Community Pharmacy Service, the Discharge Medication Review Service and the Independent Prescriber alongside locally commissioned additional services.

Outlined is the Health Board process for performance related sanctions, including the issuing of breach notices in respect of one contractor, across two sites, as a result of the pharmacies failing to meet the essential terms of service under the Regulations.

Primary and Community Care Academy

An overview of the education programmes and courses developed by the academy is provided, demonstrating the Health Boards commitment to the ongoing development of the multi-professional workforce in primary care supporting the sustainability of services.

Quality and Patient Safety

Full governance and reporting arrangements are included for each contracting area. The report also includes a specific section on Quality and Patient Safety in respect of Primary and Community Care. Specifically addressing the requirements of Duty of Candour in relation to independent contractors and the support available to practice staff to ensure compliance.

Horizon scanning is included for each area, of particular note is the anticipated implementation of a new General Dental Services Contract from April 2026, following the recent Welsh Government consultation. Also highlighted are the regulatory changes in respect of procurement processes, implemented in February 2025, through The Health Services (Provider Selection Regime) (Wales) Regulations 2025.

The Annual Quality Report for 2024/25 from the Primary Care, Community Services, Complex and Long Term Care Division outlines the robust mechanisms in place for monitoring contract delivery across all independent contractors and goes some way to demonstrate the depth and breadth of work involved in relation to contractual review, enhanced monitoring, Post-Payment Verification processes, and engagement with Health Inspectorate Wales.

Appendix 1 -Annual Quality Report

Argymhelliad / Recommendation

The Committee is requested to note the detail provided in the 2024/25 Annual Quality Report and endorse the submission to the October Patient, Quality, Safety & Outcomes Committee.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1. Staying Healthy 3. Effective Care 5. Timely Care Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the access, experience and outcomes of those who require mental health and learning disability services Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers

**Gwybodaeth Ychwanegol:
Further Information:**

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	
• Workforce	Not Applicable
• Service Activity & Performance	Not Applicable
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs



Directors of Primary Care – all Health Boards
NHS Shared Services Partnership – for distribution to all NHS dental providers
British Dental Association Wales

21 December 2023

Dear Colleagues,

NHS DENTISTRY: CONFIRMATION OF CONTRACT REFORM OFFER FOR 2024-25

We'd like to take this opportunity to set out the proposal for practices wishing to participate in contract reform in 2024/25. We had hoped to issue this offer last month however, with agreement of the British Dental Association, we delayed slightly to prioritise reaching an agreement on the annual pay uplift for 2023/24.

We had also hoped that the current year would be our last under temporary arrangements however with negotiations for a substantive new dental contract only starting in September, it is unlikely we will conclude these and make the required legislative changes in time. We also recognise that practices need certainty about the immediate future.

You will be aware that we have held several engagement events throughout the year, and we speak with health boards and the British Dental Association regularly to get feedback on how the current reform offer is working. We have used that feedback to make some changes for next year. These changes relate to the new and historic patient requirements and recognise that we cannot continue to ask practices to take on new patients in the volumes they did last year and to a lesser extent this year. Since the re-start of reform in April 2022 over a quarter of a million new patients had gained access to NHS dental care. Whilst we still want to support practices to take on new patients where capacity is available, we also want to provide practices and the health boards with some flexibility to target activity in line with local needs. The revised metrics are set out in Annex 1.

Practices also retain the choice of either being part of the reform programme delivering the activity metrics set out in Annex 1 or returning to their contractual arrangements based wholly on delivery of Units of Dental Activity (UDA). The expected UDA target for these practices will return to 100% for 2024-25. Orthodontic practices will also return to 100% UOA activity.



This letter also provides updated guidance for health boards in managing end of year reconciliation. We are committed to the principle of mitigation for those practices that see a disproportionate number of high needs patients. Again, we have listened to feedback and made amendments that trust reflects the feedback received. The revised guidance for 2023/24 is attached at Annex 2. We can also confirm that we intend to take a similar approach in 2024/25 recognising that some amendment will be required to reflect the 2024/25 metrics.

We will now begin work with our legal advisers to produce the Contract Variation Notice for next year and we are aiming to have that issued to contract holders early in the New Year.

Yours sincerely,

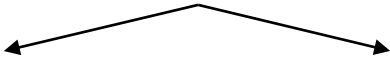
	
Paul Casey Diprwy Cyfarwyddwr o Gofal Sylfaenol ac Iechyd Meddwl Deputy Director of Primary and Community Care	Julie Denley Deputy Chief Operating Officer, Primary Care, Community & Mental Health Cwm Taf University Health Board On Behalf of NHS Wales

CONTRACT REFORM VOLUME METRICS 2024-25

Worked example of a “standard” contract variation for 2024-25

The following example is illustrative and based on a notional GDS contract that currently has a contract value (ACV) of £186,533 and UDA target of 6,000 at £31.09 per UDA.

As in 2023-24 the Health Board and contractor will need to agree that for the 2024-25 financial year, the UDA target and the contract value allocated to UDA performance are both materially reduced in return for performance against the revised metrics for 2024-25. The example contract would, through an agreed variation, be varied so that:

Maximum contract value (MCV) remains the same £186,533			
			
UDA element (ACV)	25% / £46,633 allocated to existing metrics (UDAs) (this value would be the ACV for the purposes of the SFEs) 1,500 UDAs	75% / £139,900 allocated to new metrics (details below): Fluoride varnish (10%) New/Urgent patient target (20%) Supply of mandatory General Dental Services to (and completion of ACORNs for) existing patients (45%)	New metrics

Metrics for 2024-25

Whilst the ACV will be reduced to the 25% of the MCV, the contractor will be able to receive the balance of the MCV (£139,900) if they achieve all of the following metrics in full. The metrics purely determine whether there is an entitlement to the related payments. Failure to achieve a metric will therefore reduce the entitlement to full payment for that particular metric.

Fluoride varnish (no changes)

10% of the maximum contract value (£18,653) earned if fluoride is applied to 75% or more of all of the patient groups below. No payment will be made if there is a failure to reach that level.

In order to be entitled to the payment for this metric:

- At least 80%* of all Adult FP17Ws that indicate a caries risk of red or amber support the application of fluoride varnish as part of the treatment provided; and
- At least 80%* of all FP17Ws for Child patients aged 3 and over as well as for Child patients aged under the age of 3 with a risk of caries (caries risk of red or amber) support the application of fluoride varnish as part of the treatment provided

*A 5% tolerance is allowed i.e. the target is 75%.

New/Urgent patient target

20% of the maximum contract value (£37,307) earned if target met/exceeded. Pro-rata payment if the target is not met. **The percentage of contract value associated with the metric has been reduced to reflect the reduction in activity and transferred to the historic patient metric.**

In order to be entitled to full payment for this metric, the contractor must:

- accept (undertake an ACORN for and, where appropriate, provide appropriate mandatory services / a banded course of treatment for) at least 52 new patients per year (1 New Patient per week); **and**
- provide at least 104 urgent new patient appointments per year (2 appointments per week)

It would be proportionately higher/lower for higher/lower contract values.

A "New Patient" is someone in relation to whom the contractor has not submitted an FP17W with a completed COT in the four financial years preceding the appointment.

Health Boards and Practices can, if both parties want to, agree in advance the types of new patients who can be referred and the pathway of referral. Doing this in advance will ensure that there is clarity and what will be considered as part of year end reconciliation.

A new urgent patient will need to have an assessment, but no ACORN, and receive definitive urgent treatment to count towards the new urgent patient metric.

A 5% tolerance is allowed.

Supply of services to existing patients

45% of the maximum contract value (£83,940) earned if target met/exceeded. Pro-rata payment if target is not met. **The percentage of contract value associate with this metric has been increased to reflect the additional activity transferred from the new patient metric.**

Patients seen in the 2024-25 financial year for whom the contractor has submitted an FP17W in the previous four financial years will be considered Historic Patients. Historic Patients must be subject to an ACORN (either as part of the current course of treatment or where ACORN is recorded as being completed less than 12 months before the current course of treatment is completed) and, where appropriate, receive the appropriate mandatory services / Course(s) of Treatment (CoT) in the financial year.

In order to be entitled to full payment for this metric It is expected that a practice of the size used in this example would need to see a **1,510** Historic Patients.

A 5% tolerance is allowed.

Transferability of Historic, New and New Urgent Patient Metrics

The metrics set out above are the standard offer. For 2023/24 we introduced the concept that any over delivery on new patients that could be netted off the historic patient metric at a rate of 2.5 historic patients for 1 new patient. We would like to take this flexibility further this year and enable full transferability across all three categories of patient.

Practices should agree their intentions with the health board before the start of the year however this isn't mandatory and can instead be dealt with through the year end reconciliation process.

Whether a practice is dependent on their health board for a supply of new and new urgent patients will also play a part in whether a conversation is needed before the start of the year.

We propose continuing the 2.5:1 ratio for new/historic patients and a worked example is provided below:

Historic Patient (HP)	New Patient (NP)	New Urgent Patient (NUP)	Comments
1,510	52	104	Standard offer
1,570	40	92	60 additional HP results in 12 fewer NP and 12 fewer NUP
1435	76	110	24 additional NP and 6 NUP results in 75 less HP

We recognise that this additional flexibility makes monitoring ongoing delivery more complex as there are essentially no fixed targets. Practices may wish to use the formula below which creates a control total for the total number of patients needing to be seen factoring in the weighting for new and new urgent patients:

$$2.5 \times (NP+NUP) + HP = 1900$$

Other requirements continuing from 2023-24

- NHS Number – the NHSBSA is currently engaged in a project that we hope will auto-populate around 70% of historic patient NHS numbers and provide a digital solution for that to be uploaded into dental practice software via suppliers. For next year we are asking practices to continue where possible to collect NHS numbers for the remaining 30%. There is no metric assigned to this but we hope practices will support the collection as there will be many benefits in the long term.
- Did not Attend (DNA) – We are aware that DNAs are placing pressure on practices. We would remind practices that the Attend Anywhere platform is available for use. We have seen examples, particularly with new patients, where a pre-appointment call has reduced their DNA rate significantly. This is an area we want to continue to explore so we would ask practices to maintain good records with regards to DNAs and document the things you have tried to reduce your DNA rate.
- The contractual requirements in relation to providing urgent treatment will apply to all Historic Patients.

These will be contractual obligations (so failure would give rise to the usual rights/remedies for breach) but there will be no additional payment attached to them (although failure to comply with the ACORN requirement may also adversely impact on the level of payment available for new and historic patient metrics).

ACORN and FP17W data will continue to be collected and analysed during the year to allow refinement, identify issues and any unintended consequences as a result of this new way of working. Practices remaining on UDA arrangements are also encouraged to use ACORN and record outcomes.

To be clear this is not the new dental contract but a step on our journey to shaping a future contract that is fair and sustainable for all parties.

End of Year review and performance management of practices participating in the GDS Reform Programme: All-Wales approach – arrangement for 2023/24

Background:

Mitigation guidance was issued for 2022/23 end of year management to support practices that had seen a higher-than-average number of patients with high dental need. This revised guidance note sets the arrangement for 2023/24 and reflects lessons learned and feedback from stakeholders.

The substantive changes to the 2022/23 version of the guidance are as follows:

- Section 2 – amended to reflect the 2.5:1 NP:HP ratio
- New section 3 – additional flexibilities were offered to health boards around carryover of under performance after the mitigation guidance was issued last year. This section confirms arrangements for this and next year.
- Additional Notes section – the requirement to meet the health board/Wales average for laboratory-based work has been removed. Changes to the foundation dentist section to reflect the introduction of the new urgent patient metric.
- Changes to the foundation dentist section to reflect the introduction of the new urgent patient metric.

For clarity we would restate that any decision on financial sanction rests with the commissioning Health Board and this guidance does not seek to remove or interfere with their autonomy or decision-making responsibilities. Before any consideration is given to financial sanctions it is imperative that the practice and health board have an open conversation, as per the regulations to understand the reasons why the volume metrics have not been achieved.

Fundamentally, this guidance seeks to ensure that a practice is not disadvantaged for seeing a disproportionate or above the health board average of red ACORN patients. While the following guidance is designed to ensure that such practices are supported and not disadvantaged, there will be scenarios where a financial sanction is appropriate in order to ensure the proper stewardship of public funds. This guidance cannot cover all possible scenarios.

The guidance is intended for contract variation practices only. The guidance will assume that the fluoride metric has been achieved. Failure to meet this element of the contract variation has been clearly defined when setting out the contract variation offer in March 2023.

This guidance will be revised again to reflect changes for the 2024/25 contract reform variation.

1. Historic Patients (HP), New Patients (NP) and New Urgent Patients (NUP)

The target of 1280 HP, 104 NP and 156 NUP per £177.65K ACV are interchangeable **providing the NP metric has been met**. Each additional NP seen will result in a 2.5 reduction in the HP metric. For example, if a practice has seen 110 NP (additional 6), 156 NUP and 1255 HP (a reduction of $6 \times 2.5 = 15$) then the practice can be assumed to have achieved the metrics.

2. Mitigation Formula

For every 1% increase above the Health Board **median** average for red ACORN with 4 or more interventions, the annual HP, NP and NUP targets can be decreased by 2%.

For example: If the Health Board median average for Red ACORN with 4 or more interventions is 50% and a contract's mean average for Red ACORN with 4 or more interventions is 51%, the annual number of patients to be seen by the practice can be reduced by 31 patients for every 177.65k ACV (2% of 1540 total for every 177.65k ACV).

The 5% tolerance should be applied before any mitigation is applied.

3. Carryover of Underperformance

For 2022/23 Health Boards were offered additional flexibilities that permitted underperformance of up to 20% of an annual contract value to be carried forward into 2023/24. This provided practices the opportunity to earn back any underperformance in a defined timeframe.

Mid-year performance data suggests that at an all-Wales level the variation metrics are on course for delivery this year. These additional flexibilities are therefore withdrawn for the 2023/24 year-end process and carryover should be managed as per the regulations which provide for a 5% carryover.

Additional Notes

The definition of a high needs red ACORN patient is currently assumed to be 4 interventions and above. This is calculated by adding 1 to the average of 2.8 (the average number of interventions per patient that required an intervention in 2022/23) and then rounding up. Interventions for the purpose of this guidance are defined as the following items:

- endodontic_treatment_-_number_of_teeth
- permanent_fillings_&_sealant_restorations_-_number_of_teeth
- extractions_(general)_-_number_of_teeth
- crowns/onlays_provided_-_number_of_teeth
- upper_denture_(acrylic)_-_number_of_teeth
- lower_denture_(acrylic)_-_number_of_teeth
- upper_denture_(metal)_-_number_of_teeth
- lower_denture_(metal)_-_number_of_teeth
- veneers_applied_-_number_of_teeth
- bridges_fitted_-_number_of_teeth
- advanced_perio_rsd_-_number_of_sextants
- onlay_with_cusp_-_number_of_teeth
- pre_formed_crowns_-_number_of_crowns
- upper_and_or_lower_metal_denture_-_number_of_dentures
- prevention_and_stabilisation_-_number_of_teeth
- non-surgical_extraction_-_number_of_teeth
- surgical_removal_-_number_of_teeth

The NHSBSA eDen dashboard will, at year end, display the health board average Red ACORN high needs patient data (4 plus interventions) and the contract holder's Red ACORN high needs patient data (4 plus interventions) making it easier for contracting teams to apply mitigation if required. We have also asked NHSBSA to make this information available on a live basis. When this becomes available contract holders will receive an update via NHSBSA on how to access the information in eDen.

Foundation Dentists Activity and Contract Year-End Management

April-August – new patient target is 21 with up to 13 of those patients requiring an urgent course of treatment only

September-April – new patient target is 47 with up to 28 of those patients requiring an urgent course of treatment only

Any delivery above the new patient targets can be added to the practice's metrics at year end.



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ANNUAL QUALITY REPORT 2024/25

**Primary Care Contracting, Primary and Community
Care Academy and Quality and Patient Safety**

Primary Care, Community Services, Complex and Long Term Care Division

2024/25 Annual Quality Report

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Introduction

This report provides the detail in respect of commissioning arrangements between Aneurin Bevan University Health Board and its Independent Contractors across General Dental Services, Welsh General Optometry Services, General Medical Services and Community Pharmacy.

The Health Board strives to provide patient centred, timely, quality health care through local commissioning with robust governance arrangements in place.

Additionally, included in the report is the role of the Primary and Community Care Academy in the development of the multi-professional team within Primary Care and a brief overview in respect of Quality and Patient Safety in the Primary Care context.

DRAFT

1. General/Personal Dental Services

The Health Board commissions General Dental Services (GDS) throughout Aneurin Bevan University Health Board from independent contractors, through The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006.

In 2024/25 there were 76 General Dental Contracts that were responsible for providing general dental care to patients. Since the inception of the NHS General Dental Services contract in 2006, patients are not registered with dental practices. It is the patient's responsibility to ensure regular attendance at a dental practice to receive ongoing dental care.

Since April 2022, all NHS dental practices have had the opportunity to opt into Contract Reform (CR) or remain on the substantive Units of Dental Activity (UDA) contract. Those practices that have opted into CR, are required to deliver against a set of metrics derived by Welsh Government with a focus on prevention and needs based care. Whilst the core metrics remain unchanged, their specific application is subject to annual review by WG. In 2024/25, 52 NHS GDS practices opted-in to deliver dental services via Contract Reform.

Practices that opted into Contract Reform in 2024/25, were required to deliver the following:

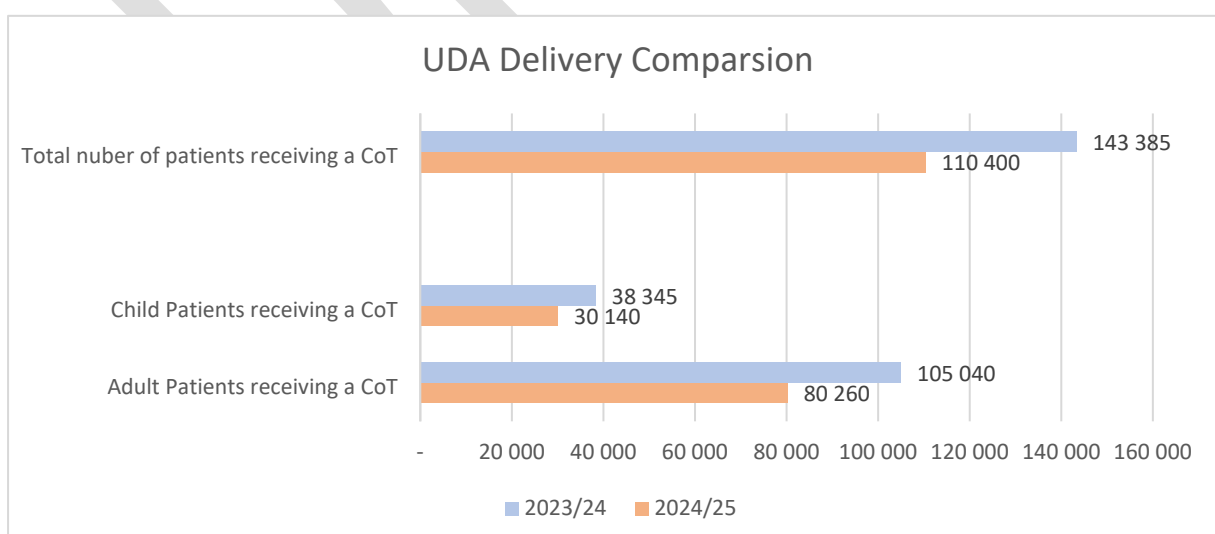
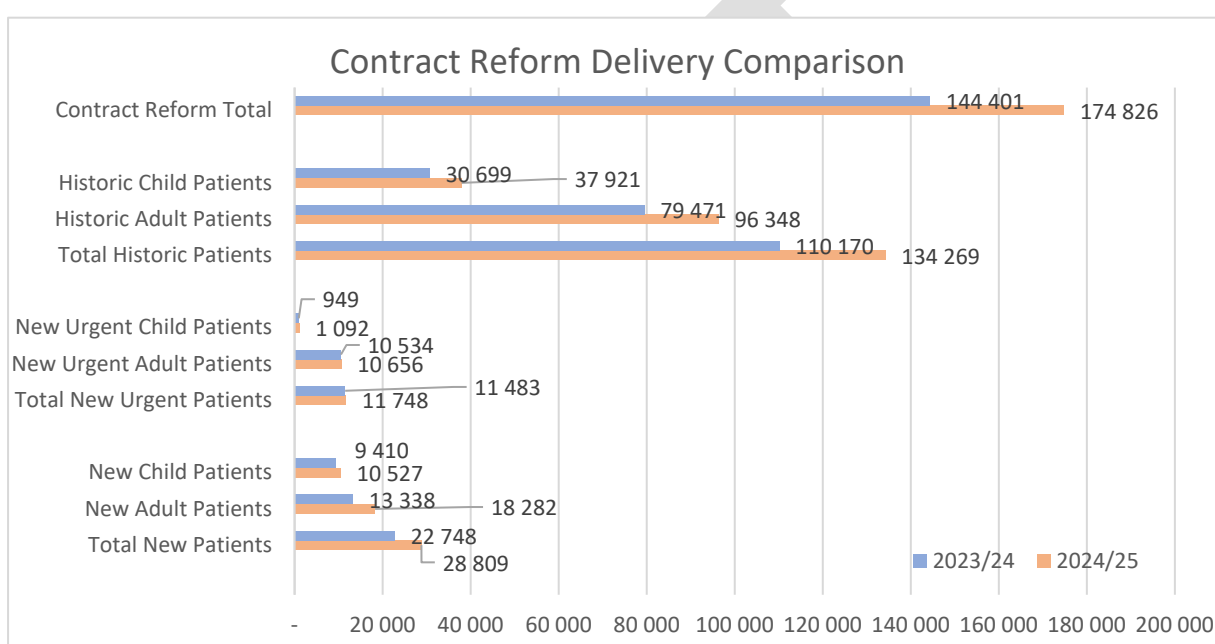
- Complete and report **ACORN** (Assessment of Clinical Oral Risk and Needs assessment) findings,
- Accept at least 52 **New patients** and 104 **New Urgent patients** per £186,533 of Annual Contract Value (ACV) (per year)
- See a minimum of 1,510 **Historical patients** per £186,533 ACV. A historical patient is defined as someone who a dentist has submitted a claim for in the previous four financial years,
- Apply Fluoride Varnish (FV) to at least 80% of all adult patients with risk of (amber), or active decay (red) and at least 80% of all child patients aged 3 and over as well as for child patients aged under 3 with a risk of caries (red or amber) and
- Deliver 25% of their contracted UDAs.
- Quality Improvement activities.

Contract Reform is implemented as a contract variation to the existing substantive NHS GDS Contract in accordance with the 2006 Regulations. For those practices that remained with UDAs, they continued to provide dental services in accordance with The NHS (GDS Contracts) (Wales) Regulations 2006.

Below is a summary of the number of practices within each borough that opted into Contract Reform or delivered activity against UDAs.

Borough	2023/24		2024/25	
	Contract Reform (CR)	UDA	Contract Reform (CR)	UDA
Blaenau Gwent	7	3	9	2
Caerphilly	13	16	13	12
Monmouth	5	8	9	3
Newport	9	6	10	4
Torfaen	7	6	11	3
Totals	41	39	52	24

The following table details the total number of patients seen during 2024/25:



The reduction in UDA activity in 24/25 is reflective of the shift of practices to CR delivery.

1.1 Urgent Access

Urgent Access remains a key priority for the Health Board. From 1 April 2024, the Health Board commissioned 96 core Emergency Dental Service (EDS) appointments per week with an additional 183 EDS appointments commissioned per week as a result of the Contract Reform requirements for 2024/25, across 41 practices.

Below is a summary of the number of EDS appointments available per week:

Borough	2023/24			2024/25		
	Contract Reform EDS appts per week	Core appts week	EDS per	Contract Reform EDS appts per week	Core appts week	EDS per
Blaenau Gwent	34	21		34	21	
Caerphilly	52	6		47	6	
Monmouth	16	12		14	9	
Newport	64	51		56	51	
Torfaen	44	9		32	9	
Totals	210	99		183	96	

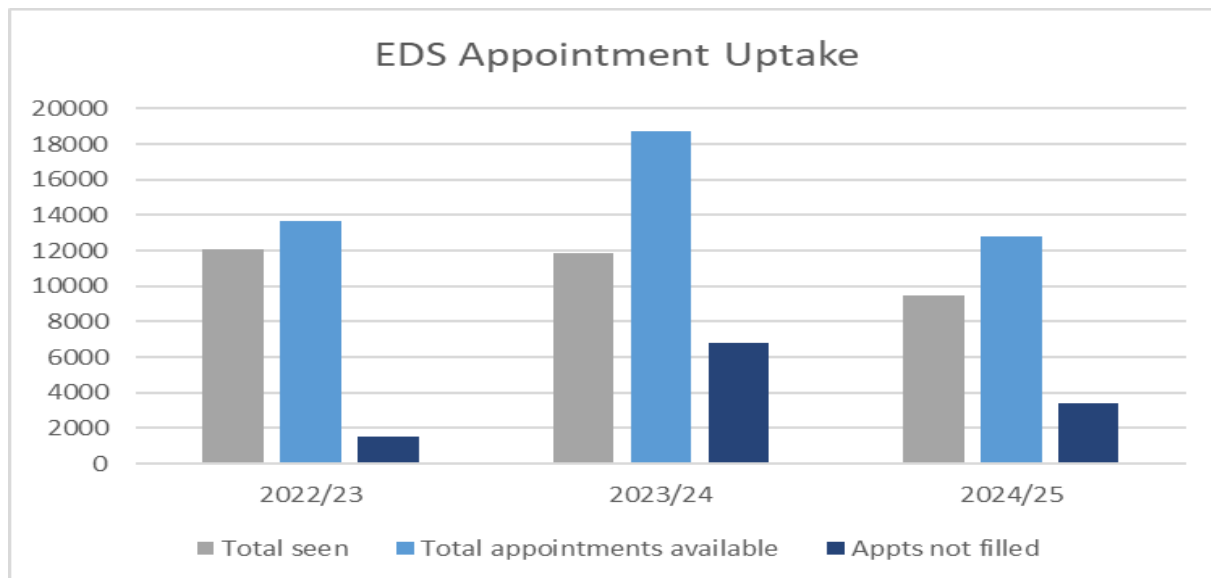
The Health Board has maximised the use of these appointments by introducing a pathway between Gwent Urgent Primary Care (OOH) and in hours EDS appointments via the Dental Helpline. A number of appointments have been ring fenced to enable patients that contact Urgent Primary Care the opportunity of an EDS appointment.

The following table details the number of patients seen for EDS care during 2024/25:

Number of patients seen 2024-25

Month	Number of pts seen 2023-24	Number of pts seen 2024-25
April	1104	1105
May	1126	1081
June	1141	1048
July	1200	1028
August	1225	890
September	1118	889
October	1097	945
November	988	830
December	870	886
January	777	870
February	638	841
March	599	802
Total	11,883	11,220

The following graph details the number of appointments available each year and the number of patients seen for EDS care during from 2022/23-2024/25:



The Primary Care Contracting Team monitor EDS demand and capacity throughout the year. From August 2024 onwards there was a reduction in the number of patients seeking urgent dental care via the Health Boards Dental Helpline resulting in lower demand for urgent dental appointments. On closer analysis of the data available the reduction in urgent dental demand is in direct correlation with an increase in general access to dental practices with more New Patients accessing dental practices within this timeframe.

Information has also been issued to all GP Practices and Community Pharmacies to ensure any patients experiencing dental pain are directed to this service. Public communication has also been shared via social media.

1.2 Dental Access Portal

In response to the Welsh Parliament Health & Social Care Committee's recommendations in February 2023, the Dental Access Portal (DAP) was developed to centralise and streamline the dental waiting list system in Wales. Designed and built by Digital Health and Care Wales (DHCW), the DAP is a digital platform that allows individuals across Wales to register their interest in accessing routine NHS dental treatment. This centralised system enables all Health Boards to manage and allocate available places at NHS dental practices more effectively and equitably, based on local capacity.

The Primary Care Contracting Team collaborated with all key stakeholders in preparation for the launch, including Llais. Local communication was developed for the profession, wider primary care services, service users, and the public to raise awareness of the DAP while managing expectations.

Historically, the Health Board has not held a centralised waiting list. The Dental Access Portal was launched within Aneurin Bevan University Health Board in February 2024. It is the responsibility of patients to add their details to the DAP if they wish to access routine NHS dental care and have not done so in the previous four years. It is important to recognise that joining the DAP does not facilitate earlier access to routine NHS dental care; rather, it allows for more equitable management of access and supports demand and capacity reporting and analysis.

Within Aneurin Bevan University Health Board, the Primary Care Contracting Team, coordinates and manages the centralised access portal for dental practices and patients. This includes overseeing the patient list, managing waiting times, and addressing expectations regarding access to both routine and urgent care.

Between February and March 2025, 1,307 patients applied to join the DAP within Aneurin Bevan.

The necessary processes are in place and have been tested and refined, including the development of a standard operating procedure (SOP) and Data Protection Impact Assessment (DPIA) to support patients, practices, and the wider primary care team in managing the portal and related communication. However, it is anticipated that the forthcoming new General Dental Services (GDS) Contract, due for implementation in April 2026, will place additional demand on the DAP and its management.

"Under the new dental contract, the DAP will become the only mechanism through which new patients can access routine care."

As communicated in the Welsh Government Reform of NHS general dental services equality impact statement, provided as part of the Welsh Government Reform of NHS General Dental services consultation:

<https://www.gov.wales/sites/default/files/publications/2025-03/reform-nhs-general-dental-services-equality-impact-assessment.pdf>

https://www.gov.wales/sites/default/files/consultations/2025-04/consultation-reform-nhs-general-dental-services-wales_0.pdf

Please refer to section 1.14 for further detail.

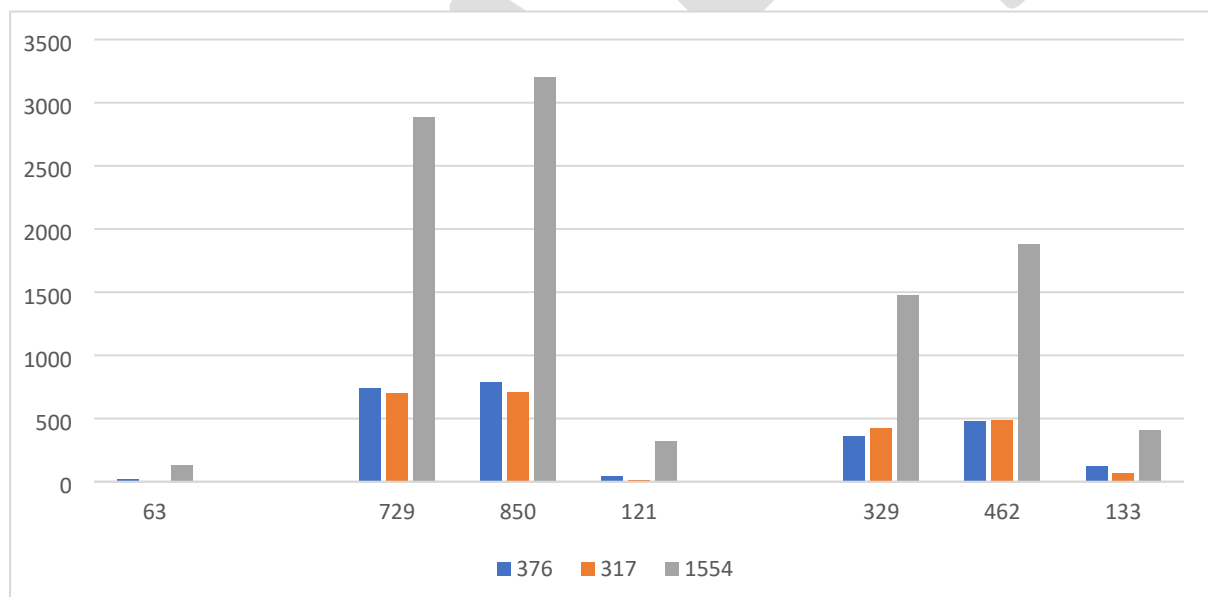
1.3 Backlog/Waiting Times

Since 2022, General Dental Services and Specialist Dental Services have seen a significant growth in patient demand and/or referral rates, resulting

in an increase in patient wait times. However, during 2024 referral rates have generally stabilised.

The table and graph below details the referral rates across services since 2022:

Speciality	Number of Referrals 2022	Number of referrals 2023	Number of referrals 2024
Max Fax	800	916	1057
Minor Oral Surgery	4658	4837	4362
Oral Medicine	683	837	829
Orthodontics	4659	4989	4726
Paediatrics	2184	2452	2350
Restorative	466	537	551
Sedation	542	457	508
Special Care	407	439	401
Urgent Cancer Referral	380	501	526



1.4 Orthodontics

The Health Board commissioned Orthodontic services from 8 providers across the region during 2024/25.

Historically, Orthodontic services have always managed a waiting list from referral to assessment and then from assessment to treatment. However, with the prioritisation of treatment changing in 2020, waiting times have increased.

The criteria for orthodontic referral is that patients that score a 3.6 as part of the Index of Treatment Need (IOTN) assessment can be referred for NHS orthodontic treatment however, following the pandemic, Welsh Government advised that patients with an IOTN of 4 or 5 should be prioritised for treatment.

The Health Board regularly collates wait times and waiting list numbers from Orthodontic practices and as of March 2025, Orthodontic practices reported approximately 7,500 patients waiting for either an assessment or treatment appointment within Primary Care.

Prior to the pandemic, the longest wait time from referral to assessment was 30 months, with the shortest wait being 1 month. For assessment to treatment the longest wait time was 2 years, and the shortest wait time was 6 weeks. At the end of 2024/25, patients were typically waiting up to 3 years for an assessment appointment with the shortest wait time being 18 months. The wait time for assessment to treatment was up to 1 year, with 6 weeks being the shortest.

There is no guidance for Orthodontic practices to follow with regards to the management of waiting lists. Some practices will have a longer wait time for an assessment appointment and shorter wait time for a treatment appointment and vice versa.

Orthodontic provision across ABUHB is detailed below by borough.

Borough	Number of Orthodontic Practices
Blaenau Gwent	1*
Caerphilly	2*
Monmouth	1
Newport	3*
Torfaen	1*
Totals	8

*1 orthodontic practice in BG, Caerphilly, Newport and Torfaen closed their list in 2024/25 in order to manage waiting lists/times.

In order to support both patients and Orthodontic practices, the Health Board has developed an Orthodontic list closure process which supports the consideration and management of orthodontic provider requests to temporarily close their list to new referrals. Orthodontic providers continue to manage their waiting lists to full capacity within their attributed funding. By the Health Board agreeing temporary list closures this enables orthodontic providers to appropriately manage their waiting lists and ensures patients are not waiting longer at one provider when an alternative provider has a shorter waiting time.

In addition, to support General Dental Practices and patients when referring patients for orthodontic services, the Primary Care Contracting team collate and share wait times quarterly across all orthodontic providers to encourage General Dental Practices to refer to those orthodontic providers with the shortest waiting list.

The Primary Care Contracting Team monitor each orthodontic contract via its activity delivery and an annual independent Peer Assessment Review (PAR) outcome audit. For 2024/25, orthodontic performers were asked to PAR score 20 completed patient treatments. Where a performer has less than 20 completed patient treatments, they are asked to PAR all. This review process for 2024/25 remains in progress and practices have until September 2025 to respond.

The Primary Care Contracting Team also manages patient transfer requests, typically for patients who are receiving active orthodontic care initiated outside of the area and are relocating within Aneurin Bevan University Health Board. In 2024/25, the team managed 8 transfer requests, supporting all 8.

The Health Board received 1 patient concern in 2024/25 relating to wait times in Orthodontic services.

The Health Board acknowledges that wait times have increased partly due to the backlog of referrals being made during the recovery period from the pandemic since 2021/22 when services began to resume in full, along with recruitment and retention difficulties faced by practices. Historically, the Health Board has invested additional non-recurrent funding into Orthodontic services, during 24/25, the Health Board was able to secure additional funding enabling 91 additional patients to be treated during this period. This is something the Health Board will consider again in 2025/26. However, it is important to recognise that this is reliant on the capacity and appetite of existing providers to be able to increase their provision.

Additionally, the Health Board also sought Expressions of Interest from the providers of Oral Surgery contracts with one provider being able to demonstrate additional capacity and as such the Health Board commissioned the below non-recurrently to reduce waiting times within the speciality.

Borough	Provider	Total Additional Funding	Number of patients treated
Caerphilly	Blackwood Dental Centre	£42,983.52	149

1.5 Oral Surgery (Sedation)

1.5.1 Oral Surgery

The Health Board commissions a referral based Primary Care Oral Surgery Service via 2 practices:

- Blackwood Dental Centre – Caerphilly; and
- Kensington Court – Newport.

In March 2025, the wait time across both sites, from referral to assessment was between 2-14 weeks with approximately 715 patients waiting for an assessment and the wait time from assessment to treatment was between 14-38 weeks with approximately 326 patients awaiting treatment. During 2024/25 the Health Board invested non recurrently into the service to support with waiting times, enabling an additional 149 patients to be seen. Blackwood Dental Centre came forward with capacity to see the additional patients.

Every 6 months the Health Board's Dental Practice Advisor(s) reviews a sample of patient referrals to ensure clinical appropriateness.

During 2024/25 approximately 10 referrals were returned to the referring General Dental Practice due to inappropriateness.

1.5.2 Oral Surgery with Sedation

The Health Board has historically commissioned an Oral Surgery with Sedation service, however, from 1 April 2023 the service was suspended due to the existing provider terminating their agreement. During 2023/24 the Primary Care Contracting Team successfully procured the Oral Surgery with Sedation contract from an alternative provider, which was effective from 1 July 2024.

Following the previous provider terminating their agreement there was a cohort of patients that had been either referred for Oral Surgery with Sedation or were part way through their treatment. By successfully procuring a new contract for the service in 2024, this enabled those patients referred, prior to the termination of the previous agreement, to receive treatment. The current contract agreement is therefore time limited until 31 March 2026, when it is anticipated that the waiting list will be cleared

1.6 Sedation

Gateway Dental Surgery, Monmouthshire, is commissioned to provide an inhalation sedation service to adults, via an NHS Personal Dental Service (PDS) contract. As of April 2025, the practice reported a wait time of approximately 12 months, with approx. 636 patients waiting to receive treatment. This is an increase from 2023/24, when the wait time for an appointment was approximately 11 months.

Bettws Dental Surgery, Newport, is commissioned to provide an IV sedation service to adults via the practices existing NHS GDS contract. The practice does not receive additional funding for this element, but should an NHS patient attend the practice that requires IV sedation, they have the ability to offer this service as part of their routine GDS contract therefore, there is no specific target that the sedation element of the contract needs to deliver against, and as such the contract is monitored against usual GDS metrics.

1.7 Domiciliary Services

A Health Board wide domiciliary service is commissioned via Blackwood Dental Centre.

The purpose of the domiciliary dental care service is to deliver safe and effective oral health care to people whose circumstances make it impossible, unreasonable or otherwise impractical for them to receive care in a dental surgery.

The range of dental care that can be provided safely at a person's home/residence is limited.

The following services are usually available to domiciliary patients. However, this list is not definitive, and clinicians will assess and provide the best and most appropriate dental care possible under the circumstances presented to them:

- Oral health risk assessment (ACORN) and clinical examination;
- Oral health prevention, oral hygiene instruction and dietary advice;
- Prescription of higher strength fluoride varnish, toothpaste and mouthwashes;
- Denture repair and construction;
- Temporary dental fillings (restorations) or smoothing of sharp teeth;
- Sealing of root remnants, where appropriate;
- Sub and supra gingival debridement (Scaling); and
- Simple extractions that do not require radiographic examination.

Blackwood Dental Centre is supported by an Oral Health Improvement Practitioner (OHIP), which domiciliary patients access following referral by the dentist. The OHIP, employed by Community Dental Services (CDS), provides support to patients, including those in residential homes, as well as providing preventative care.

In addition to this practice, there were 3 practices, Trefynwy Dental Practice, Monmouthshire, Teeth for Life, Magor and Usk Dental Practice, Usk within the Monmouthshire borough have historical contracting

arrangements in place to provide domiciliary care to their own practice patients in 2024/25.

Requests for domiciliary visits are managed via the Dental Helpline with the Community Dental Service triaging those referrals to ensure the patient is seen in the most appropriate setting i.e. CDS or Primary Care.

In 2024/25 677 referrals were received in total with 198 of those referrals directed to Blackwood Dental Centre.

1.8 Governance and Reporting

Robust mechanisms are in place to monitor all contract delivery and activity on a monthly basis, with a formal meeting on a quarterly basis to undertake a more in-depth analysis of contract activity. Members of the quarterly meeting include Health Board Primary Care Contracting Managers, Dental Practice Advisor(s) and NHS Business Service Authority (BSA) colleagues.

Whilst Health Board monitoring of the contract activity occurs monthly, the NHS BSA also undertake independent reviews of contract activity in the form of, Immediate Assurance reports, Peer Assessment Report (PAR), and Provider Assurance Dental (PAD) ACORN support.

Immediate Assurance reports are high level contract reports provided monthly to the Health Boards. The contract data is presented in a way which is benchmarked against the Health Board and Welsh averages to help identify outliers in service provision. If outliers are identified the Health Board can request NHS BSA to undertake a Peer Assessment Report (PAR) audit. This provides the Health Board with an in-depth review of practices claiming data. The process is a supportive mechanism for practices, ensuring inconsistencies are highlighted at the earliest opportunity for practices to make amendments to their claiming processes.

In addition, NHS BSA offer support to Dental Contractors with the completion of an ACORN, via PAD Acorn assessment review. The primary focus of these reviews is around education regarding Oral Health Assessments.

In 2024/25:

- 11 PAR reports were prepared and shared with practices. All of which will receive a further review in 12 months.
- 3 data reports were compiled with the Dental Practice Advisors meeting with the practices to discuss the findings. The practices now offal under normal review processes.

Primary Care Contracting Team ensures that risk is managed appropriately and through prompt identification and assessment, reported into Divisional

Quality and Patient Safety (QPS) forum. This ensures that where possible, the organisation is informed of the risks that are present and how they are managed or mitigated.

The GDS risk register is reviewed regularly and describes risks in sufficient detail so that they are clearly understood. All risks identified are assessed for severity and likelihood of the risk along with necessary actions to treat, remove or minimise the risk.

In addition, the Primary Care Contracting Team monitor mid-year and end of year contract activity as per the NHS General/Personal Dental Services Contract (Wales) 2006.

1.8.1 Mid-Year

The NHS G/PDS contract stipulates a threshold of 30% achievement at mid-year. In 24/25, of the 24 UDA contracts, 2 contracts achieved less than 30% as of 30 September 2024.

Of the 53 Contract Reform contracts, 12 contracts achieved less than 30% as at September 2024 against the New Patient (NP), New Urgent Patient (NUP), Historic Patient (HP) metric or any of the combination.

To understand the reasons for under achievement, the Primary Care Contracting Team met with practices to discuss the issues affecting contract delivery. All practices identified similar challenges which were attributed to their low performance as detailed below:

- New Urgent Patient (NUP) metric difficult to achieve due to low demand;
- Due to practices being able to offset NUP with New Patients (NP) to aggregate the total, practices have identified that NP's have a higher level of dental care required;
- High level of DNA's and late cancellations;
- Software claiming issues; and
- Workforce, recruitment and retention issues of dental associates and therapists.

Whilst the above were acknowledged as challenges impacting contract delivery at that time, all providers were able to provide the Health Board with assurances that they had instigated processes to remedy the low performance, with the aim for full year contract delivery at year-end. The Primary Care Contracting Team agreed with all providers to continue to monitor delivery and maintain dialogue through the second part of the year.

As part of the Mid-Year process any practice can request a meeting with the Health Board to discuss their performance. The Health Board received

no requests from providers who had achieved over the required 30% threshold.

1.8.2 End of Year

All NHS GDS practices within the Health Board are monitored and managed in accordance with the 2006 Regulations, including mid-year reviews and the management of end-of-year (EOY) based on performance and delivery of activity against either the UDA target or CR metrics. Following the application of any agreed mitigation, financial recoveries are instigated in all instances where there is an underperformance identified.

During 2024/25, 24 NHS GDS practices opted to deliver the substantive Units of Dental Activity (UDA) contract, and 52 practices opted to deliver against the Contract Reform metrics. (Appendix a).

Practices delivering against the contract reform metrics are managed in accordance with the Welsh Government End of Year Performance management guidance issued 22 January 2025.

Whilst UDA practices are managed in accordance with the NHS GDS/PDS Regulations 2006.

<https://www.legislation.gov.uk/wsi/2006/490/contents/made>.

Where a practice was projecting under-performance in March 2025, the Primary Care Contracting Team made contact with those practices to encourage commencement of recoveries early, with the Health Board reconciling at final year-end (June).

Practices were given the option for financial clawback to be recovered via COMPASS in instalments or in a lump sum. In addition, practices had the option to pay via a one-off Bacs payment. Where a practice had under-performed recoveries are required to be paid in full by 31st October 2025.

To confirm the position of all contract types at end of year:

Contract Reform

Breakdown	Practices Affected
Financial Recovery	21
Carry Forward of underperformance activity 95%-100%	5 – (77 NP, 37 NUP & 657 HP)
Carry Forward of 5% underperformance activity where a practice achieved < 95%	2 – (27 NP, 13 NUP & 231 HP)
Overperformance	2 – (11 NP, 5 NUP & 91 HP)

UDA

Breakdown	Practices Affected
Financial Recovery	18
Carry Forward of underperformance activity 95%-100%	7 (6 UDA practices & 1 CR practice)
Carry Forward of 5% underperformance activity where a practice achieved < 95%	3 (1 UDA practice & 1 CR practice)
Financial Recovery excl carry forward	11
Overperformance	6 (5 UDA practices. 1 CR practice)

Orthodontics

Orthodontic contracts are managed to 100% of their contract, in line with the afore mentioned NHS GDS/PDS Regulations 2006.

Breakdown	Practices Affected
Financial Recovery	2
Carry Forward of underperformance activity 95%-100%	1
Carry Forward of 5% underperformance activity where a practice achieved < 95%	0 – Practice opted for no carry forward
Financial Recovery excl carry forward	1
Overperformance	6 (617 UOAs)

Specialist

All specialist contracts are managed to 100% of their contract, in line with the afore mentioned NHS GDS/PDS Regulations 2006.

Breakdown	Practices Affected
Financial Recovery	3
Carry Forward of underperformance activity 95%-100%	1 (57 UDAs)
Carry Forward of 5% underperformance activity where a practice achieved < 95%	1 (47.5 UDAs)
Financial Recovery excl carry forward	1
Overperformance	2 (47.5 UDAs)

In line with the Regulations, the Primary Care Contracting Team issue contract breach notices to those practices who under-performed greater than 5%, in accordance with the relevant sections as detailed in the respective contracts under the UDA, Orthodontic and Specialist contracts.

The following is a breakdown of the contract breach notices issued:

Speciality	Number of Breach Notices Issued for 2024/2025	Borough of UDA Practice Breach	1st year to receive breach notice	Second consecutive year to receive breach notice
UDA	10	Caerphilly x 4 Newport x 3 Torfaen x 2 Monmouth x 1	3	7
Orthodontics	0	NA	0	0
Specialist	0	NA	0	0
Totals	10	10	3	7

1.8.3 Quality Assurance System

Hosted and co-ordinated by the Dental Public Health Team, the QAS is an online annual self-assessment toolkit that supports GDS/PDS providers to identify areas for Quality and Safety improvement in their practice.

Since December 2023, QAS has been accessed via an up-dated web-based platform, known as Caforb, which satisfies the strengthened requirements for data security.

One of the benefits of Caforb is that it will remain live and accessible throughout the year, other than a brief period when Dental Practice Advisors will take a snapshot of the data the practice has entered to analyse and prepare a report for Welsh Government. After this, practices can log in again as many times as they wish to amend any information, so the record will always be up to date which will mean the process will not be arduous year on year. Over time the platform will evolve to introduce new features such as reminders being sent to practices to inform them if audit expiry dates are approaching and anything else which might be useful.

All completed QAS returns are reviewed and RAG rated by the Health Boards Dental Practice Advisor(s) who prepare a report and provide advice to the Primary Care Contracting Team in respect of any Quality and Safety concerns arising from the practices' self-assessments. The team liaise with practices regarding any additional information required to satisfy the requirements of the QAS.

The Dental Public Health team produce an annual QAS report based on the summary reports provided by the DPAs across the seven health boards.

The following table highlights the 'red' categorisation of submissions, significantly reduced compared to 23/24:

Health Board	Issues that resulted in practices categorised as 'Red'
ABUHB	• Inconsistent autoclave/compressor inspection/certification • PPE availability (Heavy duty gloves in case instrument manual cleaning needed) • Waste disposal protocols/procedures inconsistencies • Corporates' submission not verified by Provider

Other common issues highlighted included:

Health Board	Other common issues identified from the QAS submission
ABUHB	• Latex policy, despite latex-free alternatives being available • General reluctance to take the time to answer the sections fully • Display of Welsh language literature.

Feedback received from practices stated that the Primary Care Contracting Team are approachable and supportive. It was noted that the contractual arrangements practices are required to work within are challenging but practices recognise that these are nationally agreed contracts.

The Primary Care Contracting Team provide regular report updates to the Senior Management Team (SMT), Divisional Senior Leadership Team (SLT), Divisional Quality and Patient Safety Group (DQPS) and wider external groups either on an All-Wales basis or regional basis via the Managed Clinical Network (MCNs), All Wales QPS meeting, Welsh Government.

1.8.4 Annual Uplift for 2024/25

In January 2025, Welsh Government issued communication to all Health Boards and NHS Dental Contract Holders regarding the NHS Dentistry – Annual Pay Uplift for 2024/25. It was confirmed that a 6% contract uplift would be invested subject to the following conditions:

- Every dental contract holder, excluding orthodontic contracts, required to repeat the antimicrobial audit undertaken in 2023/24, compare with previous findings and hold a discussion with practice staff to identify any actions required to improve antibiotic prescribing by 30 June 2025.
- All dental contract holders required to fully participate in the Wales National Workforce Reporting System (WNWRS), reporting quarterly as a minimum.

- All contract holders expected to record patient NHS numbers on form submitted to NHS BSA. As a minimum patients must be asked for their NHS number and any appointment text/email/letter should remind patients to have their NHS number available.
- All practice held waiting lists, excluding orthodontic contracts, to be transferred to the Dental Access Portal (DAP) by 30 June 2025.

Subsequent communication was issued by the Primary Care Contracting Team in February 2025 to practices, advising practices that the HEIW Antimicrobial Improvement Toolkit could be utilised and shared guidance regarding accessing WNWRS.

NHS BSA provided support to practices regarding the recording of patient NHS numbers.

The Primary Care Contracting Team developed a self-declaration form, via an MS Form, for practices to confirm their agreement and acceptance of meeting the annual pay uplift 2024/25 requirements. 100% practice returns were received by 31 March 2025 and the uplift was applied and backdated to April 2024.

1.8.5 Health Inspectorate Wales (HIW)

HIW inspect all NHS dental practices for clinical and managerial/administrative compliance, providing a report of each inspection to the practice and the Health Board identifying any areas for improvement. During 2024/25, 8HIW inspections were undertaken, 8 of which received improvement plans with 4 having immediate improvement plans and 2 were issued non-compliance notices.

In summary, practices were reminded to ensure:

- Regular audits are carried out and the findings shared and discussed, also identifying any lessons learnt;
- Staff training is kept up to date;
- Practice policies are kept up to date and easily accessed for staff members;
- Public facing information to be translated to Welsh;
- Equipment is stored securely with cleaning and testing labels attached; and
- Decontamination and WHTM01-05 (Welsh Health Technical Memorandum) Compliance.

Practices engage directly with HIW, but the Health Board offers support and guidance to a practice before and after inspections have occurred, via the Health Board Dental Practice Advisors, and continues to share learning with practices.

1.9 Contract Variations and Terminations

There continues to be many challenges facing NHS dentistry across Wales, and Aneurin Bevan have received numerous contract variations and terminations

The Health Board is not obliged to source alternative dental practice provision for patients affected by contract variations/terminations, however, without the re-provision of services, overall access will reduce and wait times will inevitably increase. The Health Board is committed to maintaining access to NHS GDS and as such has developed a Variation and Termination Policy, reflective of the NHS GDS Regulations 2006, which is implemented upon receipt of such a notification with the aim being to secure alternative NHS dental care for those patients affected by the change.

The Health Board received the following contract variations and terminations during 2024/25:

24/25	Apr-24	Contract Termination	Bridges Dental, Caldicot
	Apr-24	Contract Termination	Oakdale Dental Centre, Caerphilly
	Apr-24	Contract Termination	Trefynwy Dental, Monmouth
	Aug-24	Contract Termination	Thrive Dental, Magor
	Aug-24	Contract Termination	Beaufort Park Dental, Chepstow

Approximately, 16,700 NHS patients were affected by the contract variations/terminations. The Primary Care Contracting Team procured for new service provision via alternative NHS dental practices and all patients affected were assigned to a new NHS dental practice within the Health Board area.

To provide an overview:

- Bridges Dental, Caldicot – 1,574 patients affected and directed to Severn Dental, Chepstow
- Oakdale Dental Centre – 710 patients affected and directed to Smart Smiles, Caerphilly
- Trefynwy Dental – 5,504 patients affected and directed to Severn Dental, Chepstow
- Thrive Dental, Magor – 536 patients affected and directed to Severn Dental, Chepstow
- Beaufort Park Dental, Chepstow – 8,403 patients affected and directed to, Severn Dental, Chepstow, 168 Dental Practice, Newport and St Julians Dental Surgery, Newport

1.10 Prison Services

The Health Board commissions Time for Teeth Ltd to provide General Dental Practitioner/Therapist sessions to the population of HMP Usk and HMP Prescoed to ensure equitable access to NHS Dental Care. The delivery of the service is monitored by the Primary Care Contracting Team and quarterly meetings take place with the service provider.

Regular updates are provided to the Prison Delivery Group and Prison Partnership Board.

Time for Teeth are commissioned to provide 5 sessions per week, the below details a breakdown provided across both sites.

- Tuesday AM – Usk and PM – Prescoed – Dentist
- Wednesday AM/PM - Usk – Therapist
- Wednesday AM/PM - Prescoed – Dentist Assessment Clinic
- Friday AM – Usk and PM – Prescoed – Dentist

1.11 Occupational Health

Occupational Health services are commissioned by the Health Board for dental teams working within the Aneurin Bevan area. Services include:

- Pre-placement health assessment and further re-assessment as required
- Long term health/sickness absence consultation
- Blood tests and screening (*e.g. screening for hepatitis B / HIV / hepatitis C/ T.B.*)
- Vaccination for work related preventable disease (*e.g. hepatitis B, MMR, T.B, chickenpox etc.*)
- Flu vaccination (details will be circulated annually, some staff may qualify to receive flu vaccination from their GPs)
- Advice on sharps / body fluid incidents including post-exposure prophylaxis if required
- Advice on possible contact with or symptoms of communicable diseases

315 dental staff accessed the service during 2024/25.

1.12 Concerns/FOI

In respect of GDS, during 2024/25 the Primary Care Contracting Team managed and responded to:

- 5 – PTR Concerns
- 11 – MS/MP Requests
- 4 – FOIs

Through the management and investigation of these concerns, the Health Board addresses any specific contractual issues with the relevant provider ensuring any learning points are taken forward.

1.13 Looking Ahead

The Primary Care Contracting Team continues to work closely with all key stakeholders to ensure access to NHS dental services is maintained and enhanced.

The Primary Care Contracting team have recently re-established the Dental QPS group with the first meeting held in May 2025. The group will meet every 4 months going forward.

In addition, the Primary Care Contracting Team are currently working to re-establish the Integrated Oral Health Group.

Where possible, any contract variations/terminations will be considered for reinvestment along with awarding additional monies to enhance current service provision.

Acknowledging the current financial challenges, as a Marmot region, the Health Board remains committed to improve access to NHS services, especially in areas of high need and deprivation. This opportunity has been taken forward with additional investment from 2023/24 with a new dental practice, Ty Dant opening within the new Tredegar Health & Wellbeing Centre in April 2024 and a further investment as part of the Newport East Development, 19 Hills Health & Wellbeing Centre, whereby a local General Dental Practice, Ringland Dental Centre relocated into the centre, opening in early June 2025.

Any future commissioning of new GDS services must comply with the Provider Selection Regime (PSR) in NHS Wales. Introduced through the Health Services (Provider Selection Regime) (Wales) Regulations 2025, which came into effect on 24 February 2025, the PSR modernises health service procurement by moving away from routine competitive tendering. It enables more flexible, collaborative approaches that support improved patient outcomes and reduce unnecessary bureaucracy.

The statutory guidance outlines three procurement routes available to relevant authorities (e.g. local health boards)

- Direct Award Process 1, where only one provider can deliver the service.
- Direct Award Process 2, where the incumbent provider continues to meet service standards and the contract terms remain largely unchanged.
- Most Suitable Provider Process, where a provider can be identified without competition.
- Competitive Process used when other routes are not appropriate.

Authorities must act transparently, fairly, and proportionately when selecting providers, including those from the independent and voluntary sectors. These principles underpin the successful application of the PSR and support the broader aims of the Health Service Procurement (Wales) Act 2024.

<https://www.legislation.gov.uk/ukdsi/2023/9780348252613/contents/data.pdf>

1.14 Reform of NHS GDS 2026- Welsh Government Public Consultation

The consultation forms part of a broader effort to improve access to, and the quality of, NHS dental services in Wales. The proposed reforms aim to address existing issues within the current system, including the complexity of the remuneration process and a potential over-reliance on routine examinations.

The consultation outlines the Welsh Government's proposals to reform the GDS contract, and the potential impacts these changes may have on both patients and dental professionals. The key proposed changes include:

- Creating a single route of entry for patients to access NHS dental services
- Introducing a new, fairer and more transparent remuneration system
- Disincentivising unnecessary routine examinations
- Adjusting patient charges in line with the new remuneration approach and changing how these charges are collected
- Amending contract terms and conditions, such as provisions for parental leave

The consultation highlights how these contractual changes are intended to reshape NHS dental service provision across Wales. However, it also notes that not all aspects of existing laws and regulations will require amendment to implement the proposed reforms. This consultation document was prepared by the Welsh Government and applies specifically to Wales.

The consultation has now concluded, and responses are currently being reviewed by the Welsh Government. The outcome of the consultation and final proposals regarding the 2026 GDS contract are expected to be published in September 2025. In the meantime, the Health Board is actively reviewing the existing proposals to assess their implications for both service users and contractors.

https://www.gov.wales/sites/default/files/consultations/2025-04/consultation-reform-nhs-general-dental-services-wales_0.pdf

2. General Ophthalmic Services

The new National Health Service (Ophthalmic Services) (Wales) 2023 Regulations, which govern Wales General Ophthalmic Services - WGOS 1 and WGOS 2, came into force on 20 October 2023. The new regulations and legislative directions replace all previous General Ophthalmic Service instructions for optometry services including all Wales Eye Care Service instructions for example, Eye Health Examinations Wales (EHEW) and Low Vision Services Wales.

As part of the Contract Reform Clinical Framework, services have been categorised as follows:

- WGOS 1 (Core Mandatory Clinical service) – Eye examination with Holistic Health element;
- WGOS 2 (Core Mandatory Clinical Service) – Previously Eye Health Examinations Wales (EHEW), includes examinations for urgent eye problems;
- WGOS 3 – Low Vision Services Wales (LVSW) and Certificate of Visual Impairment Wales (CVIW) and SPECS;
- WGOS 4 – Referral Refinement/Monitoring (including, Glaucoma, Medical Retina and Hydroxychloroquine); and
- WGOS 5 – Independent Prescribing (IPOS).

In 2024/25 there were 54 Optometry practices providing WGOS 1 and WGOS 2, all of which were open for urgent and essential appointments and could also provide routine sight tests to patients. Practices continue to prioritise and schedule patient appointments based on clinical need and presenting symptoms relative to the risk of sight loss and harm.

Of the 54 practices across the Health Board in 2024/25, 11 practices provide mobile services, 35 practices provide WGOS 3 services, and 23 practitioners/23 practices were eligible to provide the WGOS 5 service.

The WGOS 4 service was launched within the Health Board on 1 November 2024. In 2024/25, 22 practices provided a Medical Retina Service, 11 practices provided a Glaucoma service, and 2 practices were commissioned to provide Hydroxychloroquine monitoring.

The Health Board also commissioned 5 Ophthalmic Diagnostic Treatment Centre's (ODTCs) which provided care for patients with Glaucoma that were suitable to be treated within Primary Care. Referrals were made and reviewed by Secondary Care. One of the ODTCs in Newport also provides a Wet AMD service. However, in line with the WGOS 4 implementation plan, the ODTC/Wet AMD service ceased on 31 March 2025, with all providers transitioning to provide WGOS 4 services.

Financial allocations were shared with each Health Board for 2024/25, and services were commissioned through a Primary Care Contracted Services (PCCS) framework. Some services are non-cash limited, and, as a minimum, providers must ensure they are accredited to provide WGOS Levels 1 and 2 as core service provision. All WGOS services are available to all providers that meet the requirements, and Health Boards are expected to commission on that basis.

2.1 Current Position

2.1.1 WGOS 1 and 2 - Fully Implemented

WGOS 1	A sight test as defined by the Opticians Act as well as the inclusion of prevention and wellbeing provision as part of a Patient Management Plan
WGOS 2 Band 1	Examinations for Urgent Eye Problems This examination is for patients who have eye problems of an acute nature. It can also be used to accept referrals from another healthcare provider
WGOS 2 Band 2	Further investigation/examinations These examinations enable patients to have additional investigations following a WGOS 1 or Private sight test only. They can only be used to further inform or prevent onward referral to the hospital eye service
WGOS 2 Band 3	Follow-up examinations This examination enables a patient to be followed up after they have had an initial appointment for a WGOS 2, Band 1 or for a post-operative cataract check

From 20 October 2023, WGOS 1 and 2 became mandatory services for all Ophthalmic practices on the Ophthalmic list and all Optometrists on the Ophthalmic and Supplementary list. All practitioners performing a WGOS service must have completed mandatory compliance training, which consists of four training modules:

- WGOS;
- Make Every Contact Count (MECC);
- Infection Prevention Control and Sharps Safety; and
- Improving Quality Together-Improvement Foundations Training.

In addition, should Practitioners wish to provide a WGOS 1 and 2 mobile service, they are required to submit a Mobile Service Agreement. Mobile services are for patients who are unable to leave their home unaccompanied.

2.1.2 WGOS 3 – Fully Implemented

Low Vision Service Wales (LVSU)	A low vision assessment is for patients who reach the criteria for the service. This assessment helps a patient make the best use of their remaining sight. When a patient first enters the service, they will receive an initial examination, and they are entitled to a follow up examination every year
Certificate of Vision Impairment Wales (CVIW)	Certification is the pre-requisite to being registered with a vision impairment. Practitioners accredited to provide the Low Vision Assessments are now able to certify eligible people with sight loss

WGOS 3 is an opt in service. Practitioners must undergo additional training to provide LVSU and have a LV qualification. In order to undertake the training practitioners must practice in Wales, be WGOS compliant and be an Optometrist or Ophthalmic Medical Practitioner registered with the General Optical Council (GOC), or Dispensing Optician registered with the GOC.

In respect of the CVI element of WGOS 3, the WHC (<https://www.gov.wales/certification-vision-impairment-primary-and-community-care-whc2024029.html>) was issued in 2023 and updated in June 2024 and allows Optometrists to be able to sign a Certification of Visual Impairment (CVI) for patients who meet the following criteria;

- The patient must be aged 16 or over; and
- The cause of Vision Impairment must be permanent; and
- The patient must not be currently undergoing treatment which may result in vision returning to non-certification levels.

The All-Wales patient pathway was introduced to support Optometrists who are also low vision accredited to certify eligible patients with sight loss in the community, which historically, could only be signed by Consultant Ophthalmologists.

The Health Board awaits the final manual in respect of School Pupil Eye Care Service (SPECS).

2.1.3 WGOS 4 – Partially Implemented

WGOS 4 sees patients who would previously have been referred to/or managed in the Hospital Eye Service (HES) instead remain in primary care for further enhanced assessment as part of an agreed referral refinement or monitoring pathway for patients:

- with or with suspected medical retina conditions
- with or with suspected glaucoma or ocular hypertension; and

- who are at risk of retinopathy due to taking hydroxychloroquine or chloroquine.

In April 24, Health Boards were required to submit WGOS 4 implementation plans to Welsh Government for each service. Aneurin Bevan University Health Board's plan outlined how Primary and Secondary Care, through integration and collaboration, would launch the Referral/Filtering and Monitoring aspects of the pathway. In addition, the plans detailed how the existing ODT services (Glaucoma and Wet AMD) would transition to the WGOS 4 pathway.

The WGOS 4 Referral Filtering service was implemented on the 1 of November 2025 as per the agreed implementation plans. During the transition period, the ODT service, which was launched in 2016, continued to run alongside WGOS 4 services until it ceased on 31 March 2025. The 5 practices providing this service in Gwent all transitioned into WGOS 4. The Health Board worked closely with the providers throughout the year to ensure a smooth transition of service delivery.

In order to support the implementation of WGOS 4 monitoring services the Health Board have recruited three higher qualified Optometrists through transformation funding. The optometrists will review existing Hospital Eye Service (HES) referrals and assess their eligibility to be seen in Primary Care. Administrative staff have also been appointed, alongside the Optometrists, to undertake all administrative duties relating to the discharge of patients. WGOS 4 Monitoring services will be launched by the 31 of August 2025.

As WGOS 4 is an 'opt in' service it is anticipated that the number of practices providing each service will continue to grow during 2025/26 and beyond.

2.1.4 WGOS 5 – Fully Implemented

IPOS – Urgent	Practitioners with an independent prescribing qualification can manage certain acute conditions in primary care for their own patients or following a referral from another WGOS practitioner.
IPOS - Discharge	Practitioners with an independent prescribing qualification will monitor conditions initially seen in hospital eye casualty

The WGOS 5 IPOS Urgent Service has been delivered in the Health Board since November 2023. The service is provided on a rota basis and all Independent Prescriber's (IP) working within Aneurin Bevan, with a WP10, are expected to provide the service. The Primary Care Contracting Team manage the IP rota and circulate to all practices monthly, also publishing on Optometry Wales's secure professional webpage. Non-IP practitioners

can refer patients to an IP practitioner but retain responsibility for the patient until they have been accepted by the IP practitioner. Please refer to section 2.2.4 for an activity breakdown.

This service is subject to Post Payment Verification (PPV). In addition, prescribing data continues to be reviewed and monitored by the Health Boards Optometric Advisor and Medicines Management team on a quarterly basis to identify trends and any outliers.

2.1.5 Mobile Services

With the implementation of the WGOS Regulations in October 2023, there was a requirement for Optometrists to reapply to the All-Wales Ophthalmic list and for Contractors to have a Mobile Service Agreement in place with the Health Board, aligned to the location where the service is to be delivered with a predetermined list of equipment required at every domiciliary appointment.

The following practices have a Mobile Services Agreement with the Health Board:

Borough	Practice/Provider
BG West	Gwynn's Optician, 90 Queen Victoria St, Tredegar, NP22 3PY
BG East	Williams & Parry, 50 Church St, Abertillery. NP13 1DB
Caerphilly North	Leighton Rowland (Gwynn's Opticians) 39 Hanbury Rd, Bargoed. CF81 8QU
Monmouth South	Darlington, 2a The Cross, Church Rd, Caldicot, NP26 4HY
Newport East	RW Cole, 58/59 Commercial Rd, Newport. NP20 2PF
Torfaen South	RJD Jenkins Optician, 13 New St, Pontnewydd, Cwmbran, NP44 1EF
Dom	Bristol 1 Domiciliary Specsavers Ltd Specsavers Healthcall Pure Offices Kestrel Court Waterwells Drive Quedgeley Gloucestershire GL2 2AT
Dom	Gwent Domiciliary Specsavers Limited Specsavers Home Visits Gwent Specsavers Britannia House Caerphilly Business Park Caerphilly CF83 3GG
Dom	The Outside Clinic, The Outside Clinic Stirling House, 10 Viscount Way, Swindon, SN3 4TN
Dom	Opticall Healthcare, Temple Court, Cathedral Road, Cardiff, CF11 9HA
Dom	CATVOG, SS home visits
Dom **LV SW Only	South Wales Low Vision Clinic t/a Russell Ham 24 Yeo Close, Newport, NP20 7RS

2.2 Reporting

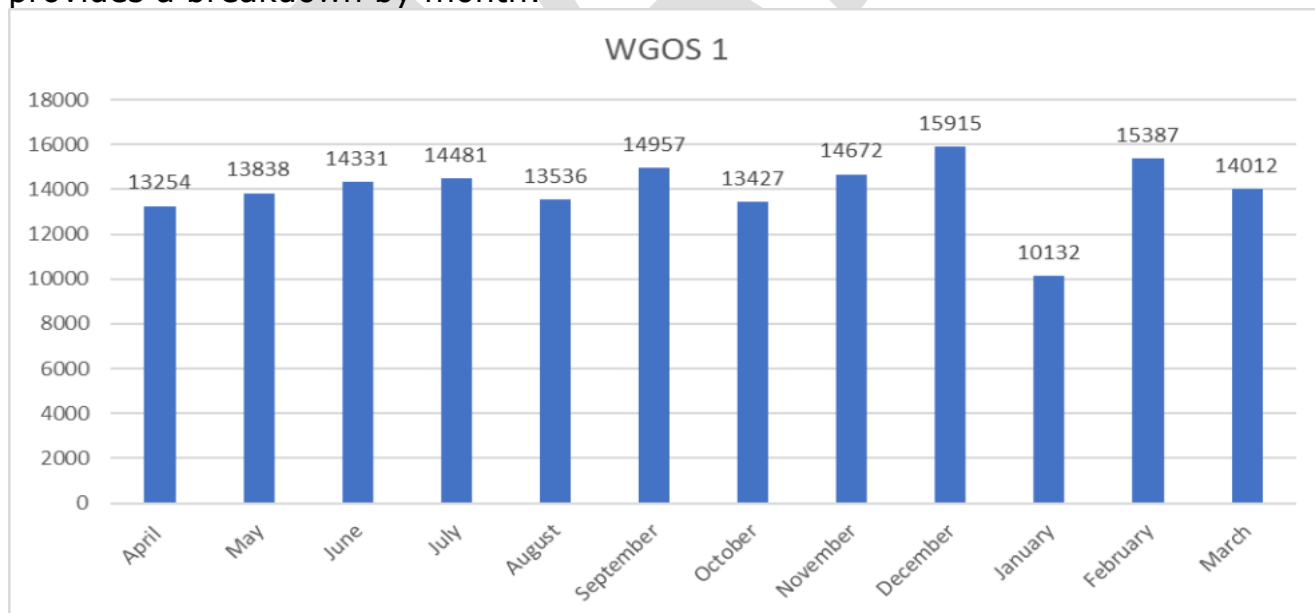
The following table shows the number of practices, by Neighbourhood Care Network (NCN) as of 31 March 2025 providing each WGOS service

	WGOS 1 & 2	WGOS 3	WGOS 4- Medical Retina	WGOS 4- Glaucoma	WGOS 4- HCQ	WGOS 5
Blaenau Gwent East	2	2	2	1	-	2
Blaenau Gwent West	4	3	2	-	-	3
Caerphilly East	9	7	3	2	-	2
Caerphilly North	3	3	3	1	-	2
Caerphilly South	5	4	3	2	-	2
Monmouthshire North	8	5	2	2	-	2
Monmouthshire South	3	1	1	-	1	1
Newport East	5	2	2	-	-	2
Newport West	8	4	4	2	1	5
Torfaen North	3	2	2	1	-	1
Torfaen South	4	1	-	-	-	
Domiciliary	5	1	-	-	-	1

2.2.1 GOS/WGOS 1 and 2

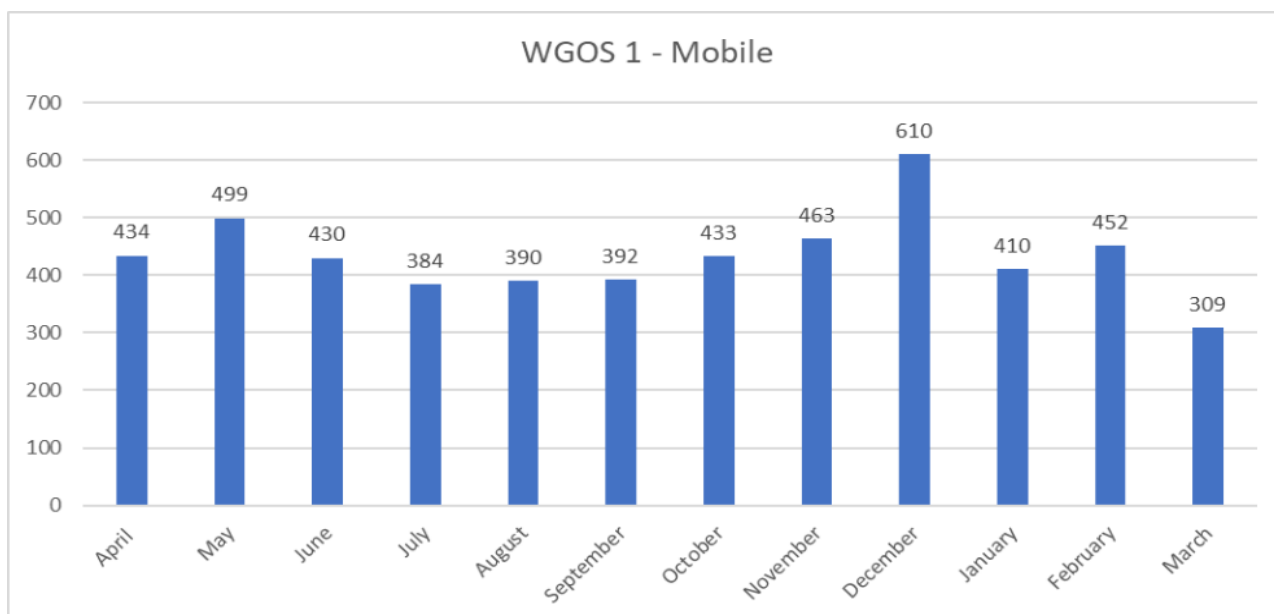
54 high street practices and 5 domiciliary practices provide WGOS 1 and 2 services in Aneurin Bevan University Health Board. The WGOS 1 Sight Test fee for 2024/25 was £44.00.

In 2024/25, 173,148 WGOS sight tests were claimed. The graph below provides a breakdown by month:



Mobile Sight Tests

The graph below details the number of mobile sight tests claimed since April 2024:



2.2.2 EHEW/WGOS 2

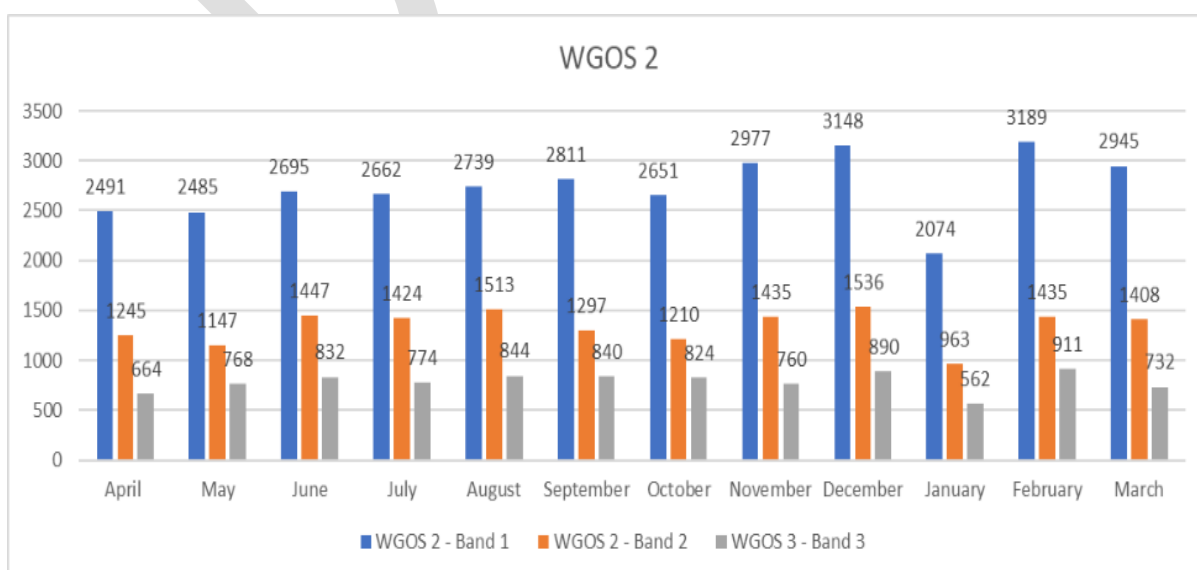
The WGOS 2 fees for 2024/25 are detailed below:

- WGOS 2 B1 £71.63
- WGOS 2 B2 £54.23
- WGOS 2 B3 £26.61

In 2024/25, 58,568 WGOS 2 claims were made.

- WGOS 2 B1 – 33,021
- WGOS 2 B2 – 16,118
- WGOS 2 B3 – 9,429

The graph below provides a breakdown by month:

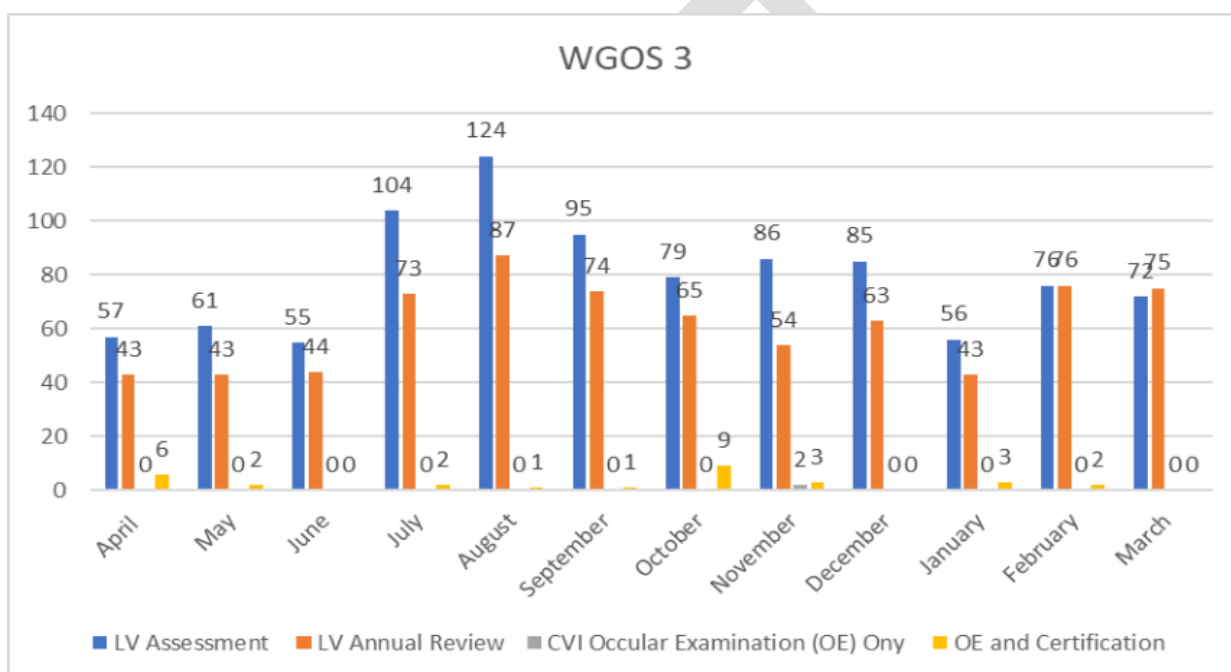


2.2.3 Low Vision Service Wales and CVI

This serviced is managed by the NHS Wales Shared Services Partnership (NWSSP). 35 practices provide the service in Aneurin Bevan University Health Board.

The WGOS 3 fees for 2024/25 are detailed below:

- LVSW Initial Assessment £97.20
- LVSW Annual Review/Follow £57.24
- WGOS 3 CVI in primary care £76.00
- WGOS 3 CVI - Ocular examination claim only £71.63
- WGOS 3 Ocular examination and low vision certification £147.63



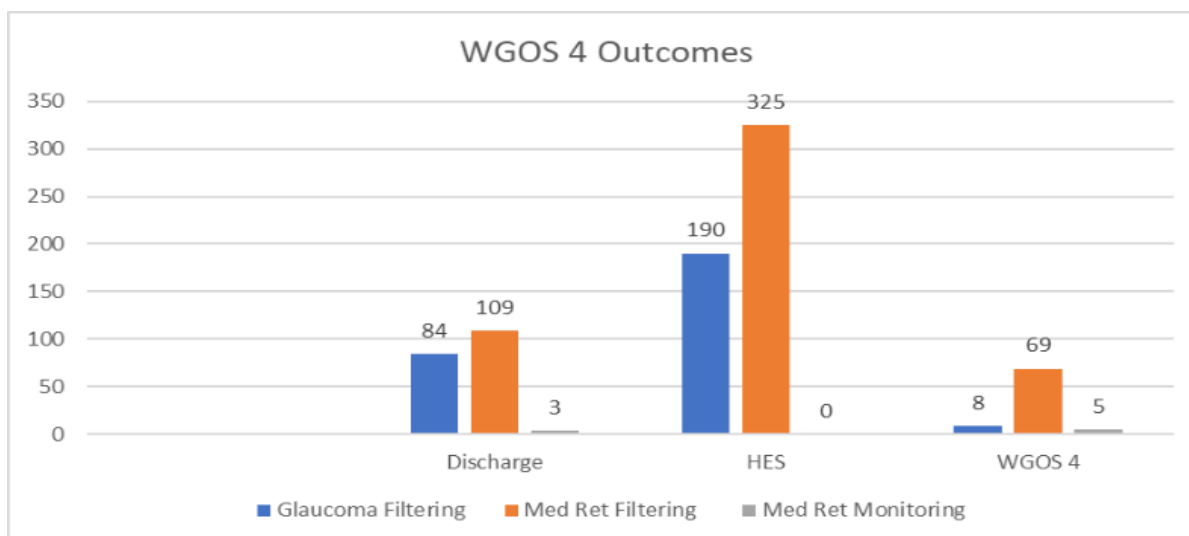
2.2.4 WGOS 4 Services

WGOS 4 Referral/Filtering services went live on 1 November 2024. In 2024/25, 22 practices provided a Medical Retina Service, 11 practices provided a Glaucoma service, and 2 practices were commissioned to provide Hydroxychloroquine monitoring.

The WGOS 4 fees for 2024/25 are detailed below:

- WGOS 4 Medical Retina Referral/Filtering and/or monitoring £98.28
- WGOS 4 Glaucoma Referral/Filtering and/or monitoring £110.00

Since November 2024, 793 WGOS 4 claims were made. The graph below provides a breakdown by month:



From November 2024 to March 2025, WGOS 4 prevented a total 278 referrals being made into Secondary Care. During 2024/25, the Health Board audited a sample of Hospital Eye Service referrals and have since reviewed all WGOS 4 Medical Retina referrals to ensure patients are accessing services via the appropriate pathways.

2.2.5 ODTc; Glaucoma and Wet AMD

Glaucoma

The Glaucoma ODTc service commenced on 1 April 2016 and was designed to allow patients to receive both New and Follow Up Glaucoma reviews within the community. As part of WGOS transition arrangements, it was agreed that the service would cease on 31 March 2025. All providers transitioned to provide services under WGOS 4. During the transition period it was agreed that practices could claim under a WGOS 2, Band 1 per patient episode.

A 'core' referral rate for each ODTc was agreed in 2022-23. During 2024/25, referrals were capped at practices agreed core as part of implementation planning for WGOS 4.

In 2024/25, 3,023 glaucoma claims were processed.

The table below provides a claim breakdown for 2024/25:

Payment month	Glaucoma ODTc Claims
Apr-24	321
May-24	266
Jun-24	204
Jul-24	193
Aug-24	202
Sep-24	233

Oct-24	89
Nov-24	99
Dec-24	0
Jan-25	3
Feb-25	0
Mar-25	0
	1610 (-54.44% from 23/24)

As detailed above, it was agreed that any ODT claims from the 1 September 2024 could be claimed under WGOS 2 Band 1 which reflect the claim data detailed in the table.

Wet AMD

The Wet AMD ODT service commenced on 1 April 2016 and was hosted by Specsavers Austin Friars, Newport and was a referral refinement service for patients with suspected Wet AMD. As part of WGOS transition arrangements, it was agreed that the service would cease on 31 March 2025 and all providers transitioned to deliver services under WGOS 4.

The table below, provides a breakdown of the number of referrals seen in Primary Care (to undertake initial assessment) and the number of patients then seen in the Hospital Eye Service as a total.

Payment Month	Wet AMD Claims
Apr-24	106
May-24	109
Jun-24	140
Jul-24	120
Aug-24	119
Sep-24	129
Oct-24	125
Nov-24	121
Dec-24	81
Jan-25	30
Feb-25	15
Mar-25	2
	1097

Where possible, the practice was advised to move patients to a WGOS 4 Referral Filtering appointment during the transition period whilst still recognising the Wet AMD Service was active. This accounts for the reduction in claims from November 2024.

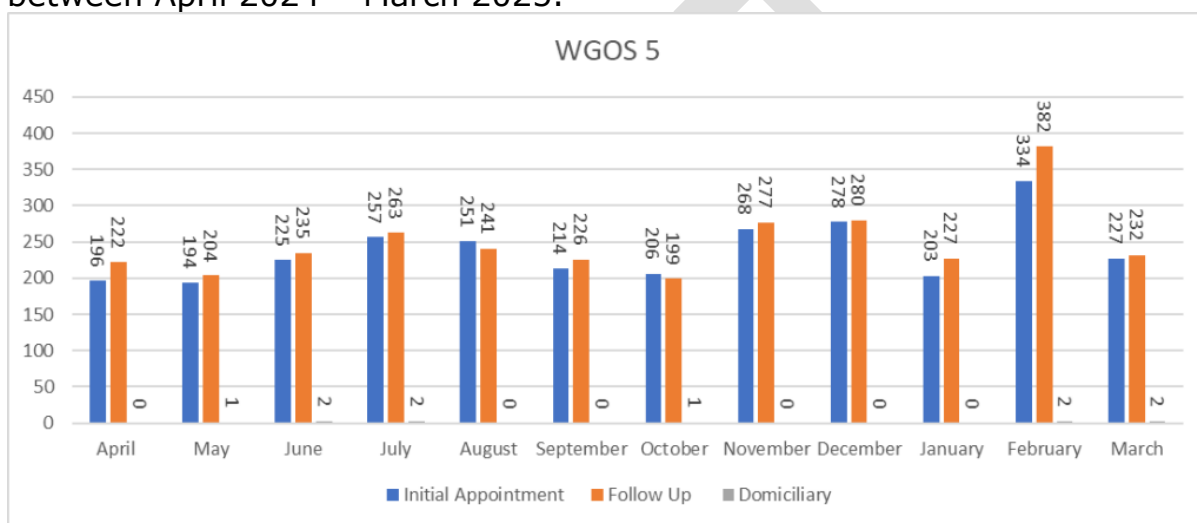
2.2.6 WGOS 5 Services

WGOS 5 Urgent services have been delivered within the Health Board since November 2023. The WGOS 5 clinical manual was updated in 2024, to include the Hospital Eye Service discharge element of the service, this part of the service was launched on 6 February 2025.

The WGOS 5 fees for 2024/25 are detailed below:

- Initial Assessment £135.00
- Follow up £66.96

The graph below details the number of patients seen under WGOS 5 between April 2024 – March 2025.



The Health Board conducted practice visits to all WGOS 5 providers during 2024/25 as part of its ongoing monitoring process. The service has been well received by the profession and secondary care colleagues who have noted a reduction in attendance in the Emergency Eye Clinic which has been supported by the documented figures below:

Total Attendances by Hospital - Where Presenting complaint was Eye problem/ Injury/Pain in or around eye;

2023/24 - 4451

2024/25 - 3403 (-1048 = **23% reduction**)

2.3 Backlog/Wait Times

Optometry services continue to see a significant growth in patient demand and/or referral rates, resulting in an increase in patient wait times.

The following table details the wait times as at the end of 2024/25:

SPECIALTY	URGENTS REQUESTED UP TO 7 WKS	ROUTINE	
	TOTAL NUMBER OF PATIENTS WAITING	TOTAL NUMBER OF PATIENTS WAITING	WAIT TIME (WEEKS)
CATARACT	252	8358	96
CORNEA	65	688	101
DIABETIC RETINA - Diabetic nurse appointments	192	1023	93
GENERAL	188	1265	107
GLAUCOMA	25	787	99
LASER	467	1529	96
MINOR OPS	3	114	80
ADULT OCULAR MOTILITY	0	189	116
ORTHOPTIST Adults	9	87	25
ORTHOPTIST Paeds	21	502	25
OCCULOPLASTIC	200	968	121
PAEDIATRIC	4	916	91
RETINA	528	1662	108
Grand Total	1954	18088	

Since the implementation of WGOS 4 and 5 services, the number of patients discharged from secondary care to primary care has been monitored closely and reported through the Eye Care Wales Committee and the Eye Care Collaborative Board. The HES have noted a reduction in the number of attendances at HES, as detailed above and the number of patients referred directly to HES has reduced due to WGOS 4 Referral Filtering service, all of which will go some way to address the backlog detailed above.

In addition, and as part of a Regional Ophthalmology Project, additional funding was received from Welsh Government which has supported additional staff, theatres and outsourcing meaning 13,048 patients received Cataract surgery in 2024/25. As of 31 March 2025, there were no patients waiting more the 104 weeks for Cataract surgery. Further funding has been secured for 2025/26.

2.4 Governance and Monitoring

Robust monitoring processes are in place whereby claiming and prescribing data available to the Health Board is reviewed on a monthly and quarterly basis to identify trends and understand claiming and prescribing patterns. During 2024/25, as part of the process practice visits were undertaken initially with WGOS 5 providers. The monitoring of claim activity continues to inform financial reporting and planning.

WGOS services are also subject to Post Payment Verification (PPV) which is undertaken by NWSSP on behalf of the Health Board. Once the PPV team has undertaken their visit and the report has been finalised, this report is shared with the Health Board. The Health Board reviews each report received and for an error rate of 10% or more, or a recovery value of £1000 or more, a practice visit is scheduled, for an error rate of 5%- 9% an initial letter is issued to practices. Anything less than 5% results in no further action.

In addition to the Primary Care Contracting Team's monitoring process, the team continues to engage with the PPV team, the Eye Care Collaborative Board, Welsh Government and the National Eyecare Wales Committee. A Regional South East Wales Regional Optometric Committee (SEWROC) group has also been established to support regional working. A number of processes have been agreed through the group and implemented on a regional basis

As part of Contract Reform, a Quality in Optometry package was agreed. As part of the package contractors are required to ensure employees involved in the provision of NHS WGOS will have completed the Optometry Improving Quality Together Foundations e-learning package as part of their mandatory WGOS training. Contractors are also required to make a return of the Quality for Optometry (QO) template at least once every six months. Other requirement of the package includes, completion of workforce toolkit, completion of a quality improvement project and annual audits.

Regular updates are provided to the profession by way of local communication.

The Primary Care Contracting Team ensures that any risk is managed appropriately and through prompt identification and assessment.

The GOS risk register is reviewed regularly.

2.5 Training

The Health Board continues to work with HEIW in respect of training and supported the following practitioners to undertake the following training in 24/25:

- Professional Certificate Glaucoma- 4
- Higher Certificate Glaucoma-3
- Professional Certificate Medical Retina-13
- Higher Certificate in Medical Retina-2
- Independent Prescribing-5
- Low Vision-4

During 2024/25, practices were required to submit their workforce data, including details of those practitioners with higher qualifications, using a excel spreadsheet. A Primary Care Workforce Intelligence System (PCWIS) has recently been launched, and it is a contractual requirement that Contractors use this platform to update their workforce information monthly. The Primary Care Contracting Team will monitor compliance and will use the data to inform future training opportunities.

2.6 Honorary Contracts

During 2024/25 the Primary Care Contracting Team facilitated the process to award 9 Honorary Contracts for Ophthalmology placements in the Royal Gwent Hospital:

- 3 Higher Qualification, Post Graduate Placements; and
- 6 IP Placements.

2.7 Practice Closures/Relocation

To reflect the WGOS regulatory changes, a robust process is currently being developed across Wales regarding the notification and management of practice changes.

In April 24, Lawrence and Harries Opticians closed their branch in Ystrad Mynach. Patients were notified by letter, and posters were displayed in the practice. Patient records transferred to the practice's other branch in Caerphilly. In December 2024, The Optic Shop in Newport moved to a larger premise on the same street.

2.8 Accelerated Cluster Development (ACD)

As part of the Optometry Contract Reform, Welsh Government requested a Primary Care Collaborative Lead (PCCL) from each Optometry practice to be identified, who will engage and support the Collaborative Optometric Lead (COL) for each of the cluster/NCN areas across the Health Board. The PCCL and the COL are remunerated for their engagement. The National Health Service (Ophthalmic Services) (Wales) Regulations 2023 state that a contractor must attend at least 4 meetings per financial year.

To ensure compliance in line with the regulation, the Primary Care Contracting Team have developed a process, which has been agreed through the Regional South East Wales Region Optical Committee (RSEWROC) meeting which was established in 2024/25.

Participation at cluster level continues to support the identification of Quality and Safety improvements within the borough footprint. There is an expectation that pathways will be developed and tested, that optometry priorities will be aligned to the Health Boards overarching NCN plans, provide support and leadership for the profession and contribute to the Health Board's Neighbourhood Care Network IMTP plan continue.

During 2024/25 the professional collaboratives successfully rolled out a project across Gwent that set to make smoking cessation discussions and the offer of a referral to support services a routine element of the eye examination.

There is currently no PCCL in Torfaen and Caerphilly South, the NCN team continue to link with practices and SEWROC to ensure a lead is identified in order to take forward the NCN plans in this area.

2.9 Prison Services

Across Wales, Health Board Prison SLAs are inclusive of the WGOS services provided in community Optometry, ensuring equitable services for all. Following a robust procurement exercise in 2023/24, the prison Optometry contract was re-awarded to 'The Prison Opticians Ltd' from April 2024.

Four sessions are provided a month, two at Usk and two at Prescoed. The Primary Care Contracting Team undertake routine monitoring of the service, in line with the wider processes.

2.10 Occupational Health Service

In accordance with the Regulations, the Health Board commissioned the following via Occupational Health from April 2024:

- Needlestick/sharps injury service, including access to any relevant BBV screening including any related blood tests and any onward monitoring related to risk of infection.
- Annual influenza vaccines.
- Pre-placement health check using a standardised questionnaire for new starters, plus the provision of any necessary and essential vaccines and/or immunisations.
- Baseline assessment of the vaccination status of current staff, with the offer of any necessary and essential vaccines and/or immunisations to be undertaken within the first year of the service being established.
- Sickness absence assessment on request to assist with the management of sickness absence (both short and long term); including plans for supporting a return to work following long term absences.

The service is available to Optometrists, Dispensing Opticians and Contact Lens Opticians. The service does include those in pre-registration training (student optometrists) and trainee opticians. It is noted that the inclusion of student optometrists will be reviewed in 2024/25 in line with the changes to the undergraduate programme to an integrated MSc.

In 2024/25, there was minimal activity through the Occupational Health Service. The Health Board have commissioned the service in 2025/26 and will continue to promote through SEWROC, Optometry Wales and direct communication.

2.11 Eye Health Needs Assessment

As part of the NHS Legislative Directives each Health Board must prepare and publish an Eye Health Needs Assessment (EHNA) for its area. The first publication was required by March 2025 and every 3 years thereafter.

Primary Care Commissioning were commissioned to facilitate the completion of the EHNA on behalf of the Health Board and several steering group meetings were set up to support. The steering group included representation from several stakeholders including NWSSP, Secondary Care, Llais and the Health Board Communications Team. The EHNA was approved by the Health Boards Eye Care Collaborative Board (ECCB) and has been published on the Health Boards internet.
<https://abuhb.nhs.wales/hospitals/gps-dentists-opticians-ncns/optician/>

2.12 Annual Report

In addition to the Eye Health Needs Assessment and as part of the NHS Legislative Directives each Health Board was required to prepare and publish an annual report for the purpose of monitoring the provision of WGOS 1-5.

The Annual Report has been published on the Health Boards internet
<https://abuhb.nhs.wales/hospitals/gps-dentists-opticians-ncns/optician/>

2.13 Engagement

In collaboration with Secondary Care colleagues, a number of engagement events took place during 2024/25:

- 19.09.24 – WGOS 4 Implementation Event
- 24.10.24 – WGOS 4 'Opt In' Events
- 16.01.25 – WGOS 4 Glaucoma Event- Led by Glaucoma Consultant and Principal Optometrist at Royal Gwent Hospital
- 30.01.25 – Non WGOS 4 Provider Event
- 06.03.25 – WGOS 5 Provider Event
- 20.03.25 – WGOS 4 Medical Retina Event – Led by Medical Retina Consultants at the Royal Gwent Hospital

In addition, Aneurin Bevan University Health Board, in conjunction with Cwm Taf Morgannwg University Health Board and Cardiff and Vale University Health Board, hosted a regional optometry event in March 2025. The event was led by WG with presentations from HEIW, Health Board Optometric Advisors and National Clinical Leads. Two events took place across the SE Wales region, both were well attended by the profession.

Following the regional optometry event, WG met with Health Board colleagues regarding progress of the implementation of WGOS. The

meeting was very positive and an action plan was agreed and taken forward. These meetings will take place annually.

Key Health Board colleagues attended an Eye Care Workshop in May 2024 where barriers to implementation were discussed and priorities were set for the year ahead. The workshop will become an annual event with the 2025/26 workshop scheduled in June 2025.

2.14 Concerns/FOI

In respect of Optometry services, during 2024/25 the Primary Care Contracting Team received nil concerns.

2.15 Looking Ahead

Through collaboration and integration, the Primary Care Contracting Team will implement WGOS 4 monitoring services by 31 August 2025. The implementation of the service will be supported by the WGOS Referral Team, who have been appointed through Transformation Funding. The team will also undertake a review of secondary care services during 2025/26.

As part of the ongoing review of secondary care services, the team will support where any services, typically provided in secondary care can be transferred to primary care. The team will engage with the profession, secondary care Ophthalmology colleagues, the Third Sector and SEWROC to ensure services are patient focused, taking ideas/plans forward via the Eye Care Collaborative Working Group and Board.

During 2025/26, the team will continue to support with the deflection of patients suitable for WGOS 4 and the School Vision Screening Programme which has recently been implemented and sees those patients who failed the school vision screening, historically seen in secondary care, be redirected to primary care for tests in the first instance.

Digitalisation teams will be supported in implementing an electronic patient record and electronic referral system that is fit for purpose. Health Boards have been mandated to implement Open Eyes by the end of March 2026. In the meantime, the team are supporting the implementation of interim solution for electronic referrals, by use of an MS Form. It is anticipated that the MS Form will be in use by October 2025.

Using the recently published EHNA, the Primary Care Contracting Team will create an action plan to enhance service provision in both the Health Board area and across the SE Wales Region, including the advancement of Advanced Training Practices.

Regional working will be supported with the continuation of Regional SEWROC meetings planned for 2025/26. The team will also contribute into

the National clinical Strategy for Ophthalmology and the Regional Ophthalmology Project with consideration to regional training and how we can support this going forward, working collaboratively with other Health Boards on possible services that could be delivered on a regional basis aligned to the National Clinical Strategy.

The Primary Care Contracting Team will continue to engage fully with the profession, with a number of engagement events already planned in 2025/26. The team will also support engagement events for the wider profession, which will be led by WG and will continue to provide regular updates to WG by way of reporting and face to face engagement.

3. General Medical Services

The Health Board is responsible for providing General Medical Services (GMS) to residents throughout Aneurin Bevan University Health Board and commissions services from independent contractors through The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023.

Approximately 90% of all NHS patient interventions take place in the Primary Care setting.

During 24/25 there were 68 General Practices responsible for providing care to patients between 08:00 and 18:30 Monday to Friday. Outside of these "core hours", access to medical care is provided by the Health Board's Out of Hours Service, which operates between 18:30 and 08:00 each weekday evening and throughout weekends and Bank Holidays.

Outside of the period the Urgent Primary Care Service provides clinical assessment including remote and face to face consultations in urgent care centres in Newport, Abergavenny and Ystrad Mynach and also home visits where patient is medically unfit to attend one of the centres. Patients are initially assessed by the 111 Wales service which is provided by the Welsh Ambulance Service Trust. More recently the Health Board has established an in-hours urgent care service in Newport and Abergavenny for those who have been diverted by the 111 service, the Emergency Department in the Grange University hospital or the Minor Injury Units in Abergavenny, Newport, Ebbw Vale and Ystrad Mynach.

3.1 Access

The Health Board has a well-established Access Group in place to review, sustain and develop primary care access within General Medical Services to ensure it is sufficient to meet the needs of the patient population and remains sustainable for the future.

Access Group considers any applications received from practices in relation to:

- Branch Surgery Closures/reduction in service provision
- Boundary Changes: monitor, review and consider applications
- Plan and prepare for contract terminations/variations
- List closure requests o Premise relocation

The group also review GMS Access achievement and provides a mechanism for quality assurance for access

During 24/25 Access Group considered:

3.1.1 Branch Surgery Closure/Reduction

The Health Boards Access Group considered one application in Monmouth South to permanently reduce service provision from a branch surgery. All steps detailed in the Health Boards Change in Service Provision Process were followed and the application was supported with no reduction in overall service provision as the practice consolidated their resources onto their main site.

3.1.2 Boundary Changes

Three practices submitted requests to redefine their practice boundaries in 24/25, one in Monmouth North, one in Newport West and one in Blaenau Gwent West.

One application in Monmouth North was not supported by the Access Group as it was deemed that there was sufficient existing GMS provision covering the proposed areas and there were a number of concerns raised from neighbouring practices and Health Boards regarding the potential destabilisation of those practices should the request be supported.

Applications from Blaenau Gwent West and Newport West were supported by the Access Group. Neither of the practices were seeking to reassign patients that resided outside of their re-defined practice boundary and both requests were considered in line with the criteria set in the Health Boards process.

3.1.3 Contract Resignations

General practice continues to face significant challenges including recruitment and retention of workforce, financial constraints and managing patient expectations and demand. In line with the Welsh Health Circular (2006) 063 General Medical Services Practice Vacancies – A Guide to Good Practice, the Health Board has a robust process in place to consider all GMS contract resignations, and upon receipt of a contract resignation the Vacant Practice Policy is implemented.

Each Vacant Practice is considered on its individual merit, in line with the Health Boards strategic plan and the local population health needs. When a Practice becomes vacant, the Health Board seeks to determine the most

appropriate, sustainable option for the delivery of services to the registered population.

Following acknowledgement and early engagement, in confidence, with interested parties including neighbouring practices and local elected members, a Vacant Practice Panel is convened with representatives from Health Board officials, Llais Cymru and the Local Medical Committee (LMC).

At the Vacant Practice Panel meeting, the options for the future of the practice where a vacancy is declared are discussed and a recommendation reached. The options are listed below (options 1-6 do not have to be considered in sequential order, and/or each one implemented before considering the next option. Option 1,2 and 3 may be considered together):

- Option 1: Aim to fill vacancy through local interest under a GMS Contract, (the practice could be passed completely over to another practice in the borough under GMS Contract arrangements (through inviting local expressions of interest))*
- Option 2: Aim to fill vacancy through national interest under a GMS Contract, (the whole practice would be advertised nationally as a vacancy under current GMS Contract arrangements)*
- Option 3: Managed list dispersal with existing neighbouring practices (through inviting local expressions of interest). Practices to consider taking on a proportion of the list*
- Option 4: If vacancy not filled, the LHB take on the management and delivery of GMS services, in accordance with GMS Regulations*
- Option 5: Dispersal of practice list (the LHB decide to disperse the practice list)*
- Option 6: Fill the vacancy through interest from existing/remaining partners (where clauses 525-529 of the GMS contract do not apply (existing partners agree to the transfer of the existing contract to one or more of the existing partners following dissolution)) aim to fill the vacancy through interest from existing partners*

The Health Board will be required to undertake a procurement exercise in relation to options 1-3. Practices may be required to attend for interview at a later stage.

*** Options 1, 2, 4 and 6 maybe subject to Policy for the Reassignment of Patients whose Address is outside the Catchment Area of their Registered GP & Application Process.*

The panel recommendation is presented to the Health Boards Executive Team for consideration and ratification.

In February 2025, Internal Audit undertook a review of the Health Boards application of the Vacant Practice Policy and reported reasonable and substantial assurance.

Reflecting on some of the learning and the implementation of procurement changes through The Health Services (Provider Selection Regime) (Wales) Regulations 2025, the Health Board will update the VPP and incorporate into a Standard Operating Procedure for the management of vacant GMS practices.

During 24/25 the GP partnership of Dr Allinson & Dr Ahmed resigned their GMS contracts for five previously directly managed practices. The Health Board has assumed direct management for all 5 practices for an initial stabilisation period; three from 1 March 2025 and two from 1 April. There has been a Divisional response to the contract resignations and an Operational Support group has been established to provide day to day support for all 5 practices.

3.1.4 Practice Mergers

The Health Board first offered a discretionary payment scheme in 2015 to support practices that are considering merging and it was re-launched in 2023/24 and again in 2024/25. The scheme seeks to support working at scale with wider skill mix, achieving economies of scale with a larger critical mass of patients and thus improving quality of care for patients.

The scheme is backed by significant financial incentive payments. Any practice in Aneurin Bevan University Health Board area can apply, regardless of its current sustainability situation, however prior consideration may be given to those considered more vulnerable depending on their sustainability risk matrix scoring. This scheme applies only to practices in Aneurin Bevan University Health Board area. A typical merger between two practices may attract payments of approximately £30,000.

During 24/25 the Health Board received one expression of interest to merge from two practices in Newport East, however this application was not progressed following practice decision not to pursue.

The table below shows the contractual changes for 2024/25:

24/25	Apr-24	Managed Practice Contract awarded	Aberbeeg Medical Practice, Brynmawr Medical Practice, Bryntirion Surgery & Blaenavon Medical Practice
	Jul-24	Branch Surgery Service Reduction	Magor Surgery, Branch of Caldicot
	Nov-24	Boundary Change	Bryngwyn Surgery, Newport
	Nov-24	Boundary Change	Glan Rhyd Surgery, Blaenau Gwent
	Jan-25	Boundary Change	NHS Gloucestershire practice, potential impact on ABUHB bordering practices being assessed.
	Jan-25	Contract Resignation	Brynmawr Medical Practice
	Feb-25	Contract Resignation	Aberbeeg Medical Practice
	Feb-25	Contract Resignation	Blaenavon Medical Practice
	Feb-25	Contract Resignation	Bryntirion Surgery
	Feb-25	Contract Resignation	Tredegear Medical Practice

3.2 Sustainability Assessment Framework

There is a national framework in place that provides a consistent approach to the assessment of the sustainability of practices and enables practices to request support. In lieu of physical resource, Aneurin Bevan University Health Board has a mechanism in place to determine a level of financial support available to practices, under this framework.

The ‘financial calculator’ applies a consistent formula to enable partial reimbursement for locum sessions for those practices that have a shortfall in their core clinical sessions against the local benchmark of 1 clinical session per 200 registered patients. This ensures the sustainable delivery of services whilst the practice seeks to recruit permanent staff, whilst mitigating some of the financial risk associated with locum engagement.

During 2024/25 5 practices received a financial support package under the framework; two in Blaenau Gwent East (both ceased June 2024); one in Caerphilly North; and two in Torfaen North.

With all sustainability applications, financial support is subject to regular review and ongoing monitoring, and the Health Board reserves the right to adjust for any significant changes in circumstances. Practices are required to demonstrate that they are undergoing active recruitment campaigns.

3.3 General Practice Escalation

GMS practices are contractually required to accurately report their escalation level monthly and/or when it changes. The contracting team and respective borough teams continue to support the practices in escalation in line with the agreed process, with additional on the day support from Urgent Primary Care if required, for practices reporting level 3 and above. Gwent Local Medical Committee (LMC) continue to promote accurate escalation.

ABUHB Practice Reported Escalation Status 2024/25				
Escalation Level	1	2	3	4
Qtr 1	36	25	6	1
Qtr 2	38	21	9	0
Qtr 3	31	24	8	5
Qtr 4	33	26	7	2
ABUHB Practice Reported Escalation Status 2023/24				

Escalation Level	1	2	3	4
Qtr 1	59	10	1	0
Qtr 2	52	15	1	1
Qtr 3	37	21	9	1
Qtr 4	35	20	11	2

Demand on General Medical Services (GMS) remained high throughout 2024/25 particularly during Winter months as highlighted in the table above.

3.4 Enhanced/Supplementary Services

The Enhanced Services Operational Group (ESOG) is established to develop and monitor primary care enhanced/supplementary services, ensuring a consistent approach is applied to the delivery and management of the services.

Enhanced/ Supplementary Services are, in essence, an element of core provision delivered to a higher specification, outside of the normal scope of primary medical services which are designed around the needs of the local population and provide the Health Board with the opportunity to develop more local and integrated services across primary and secondary care.

Enhanced/Supplementary Services are optional for practices to deliver and are commissioned by the Health Board from those practices who can meet the requirements within the service specification.

In order to deliver effective and efficient Supplementary Services in primary care it is crucial that there are:

- Appropriate facilities in local communities as referred to above. Contractors must ensure they meet required health and safety standards for primary care premises.
- Staff with appropriate skills, knowledge and attitude to meet the needs of the local population.
- Practices with systems to ensure effective communication in place, between all primary care professionals and patients, to support the delivery of high-quality primary care.

During 2024/25 the following services were commissioned;

Directed Supplementary Services - all Health Boards must commission or provide

Service	% Practices Commissioned
Pneumococcal	100%
Childhood Imms	100%

Asylum Seeker	40%
Learning Disability	91%
Violent Patients (Alternative Treatment Scheme)	1 practice commissioned via SLA
Minor surgery - Fee A & B	75%
Minor surgery - Fee B Only	90%
Diabetes Gateway DES	90%
Care Home	72%
Anti-coagulation Level A & B	85%
Anti-coagulation Level B Only	12%
Homeless	13%
Gender Identity for Registered Patients or on behalf of the NCN	50% registered and 10% for NCN
Complex Multi-Morbidity and Frailty	68%

National Supplementary Services- all Health Boards should commission or provide however not mandatory

Service	% Practices Commissioned
GLP1 Monitoring	47%
Flu Immunisation	100%
Unscheduled Immunisations	100%
Non-Routine Imms	90%
Substance Misuse	16%
Shingles	100%
Rota virus	99%
Meningitis	100%
Catch Up Programme Vaccination of Children Who Have Outstanding Immunisations	72%
People Fleeing War and Persecution in Ukraine	35%

Local Supplementary Services - optional commissioning of services based on local need

Service	% Practices Commissioned
Minor Surgery Non-Registered patients	9%
DOAC Initiation & Monitoring	84%
DOAC Monitoring Only	18%
Depo-Provera	99%
Depo/Sayana Press	25%
Contraceptive Implants (Nexplanon) for Registered and Non-Registered Patients	53% registered/ 4% non-registered
Depression/Lithium	50%
IUCD Registered and Non-Registered Patients	54% registered/ 27% non-registered
Near Patient Testing	97%
Denusomab	94%
Pertussis	100%
Gonadorelin/Zoladex	100%
Extended Minor Skin Surgery	13%

A Schedule 7 is prepared annually as part of the GMS contract and shared with each practice detailing each Supplementary Service the contractor is commissioned to provide.

3.4.1 Alternative Treatment Scheme

Welsh Government issued WHC 2002 (082) "Stopping Violence against Staff Working in the NHS: Tackling Violence Against those in Primary Care". This guidance stated that professionals and staff working in the health service would not tolerate aggression, violence and threatening behavior by the public. The report recommends that Health Boards adopt a "zero tolerance" approach to patients, relatives and members of the public who use violence and aggression towards NHS staff.

The ATS was introduced as a Directed Enhanced Service in 2004 with the aim of providing a secure environment in which patients who have been violent or aggressive in their GP practice can receive General Medical Services.

The right of individuals to receive mainstream primary care services remains a fundamental principle of the NHS and patients who have been subject to immediate removal from a practice list will not be excluded from receiving primary care services.

The ATS is designed to provide General Medical Services to patients who meet the criteria for inclusion into the Scheme and allows Health Boards to balance the rights of patients to receive services from GPs whilst ensuring that GPs, practice staff and bystanders are able to deliver a service without threats or occurrences of unacceptable behavior.

Any immediate removal of the patient from the practice list and referral into the Scheme, whether it is as a result of unacceptable actions, threats or inappropriate behavior must be in accordance with the GMS Contract Regulations 2023.

During 2024/25 31 referrals were received for the scheme of which, 24 were accepted and 7 rejected as they did not meet the threshold.

St Julians Medical Centre in Newport, is commissioned via an SLA to provide this service across the Health Board area.

3.4.2 Welsh Government Additional Capacity Funding

Welsh Government introduced this scheme in 2021/22, to fund additional staff resources (GPs, practice nurses, administration staff, etc) above what is already in place within GMS practices to support recovery from the pandemic.

For 2024-2025, the Health Board was allocated £763,630 to enable the reimbursement of up to 50% of the total cost (salary / sessional fee & on-costs) of either additional posts upon appointment (including those in post from December 2021 under the 2021-22 scheme) or additional hours worked by existing post holders. Individual practice allocation is based on patient list size.

Four practices confirmed that they would not be utilising their allocation and this was distributed between the remaining practices in order to maximise uptake and benefit. Reimbursement is made on the submission of verified claims and the total amount of funding utilised in 24/25 totalled £740,833.07. The following table shows the additional hours, by staff role, facilitated through this scheme.

Welsh Government Additional Capacity Utilisation in Hours

Role	2024/25**	2023/24**	2022/23**	2021/22
GP	8,415.44	5,522.20	9,054.47	801.3
Nurse	8,080.62	11,213.91	4,842.84	808.5
Other Healthcare	8,075.51	7,744.69	4,312.08	149
Admin	51,992.85	49,016.17	27,041.96	4,832.90
Total	76,564.42	73,496.97	45,251.35	6,591.70

**** number of hours is the 100% figure stated on the claim form but funded for 50%**

This funding is time limited and will be available up to 31 March 2026.

3.4.3 Child Health

The Healthy Child Wales Programme (HCWP) sets out what planned contacts children and their families can expect from their Health Boards; from maternity service handover to the first years of schooling. These universal contacts cover three areas of intervention: screening, immunisation and monitoring and supporting child development.

The 6–8-week baby examination is delivered by Health Boards and undertaken by General Practitioners as part of the GMS contract. A Health Board assurance process, developed in collaboration with the Child Health Department has been implemented for the monitoring of the uptake of the 6 to 8-week baby checks in General Practice. This seeks to provide assurance that GP practices are undertaking 6 to 8-week baby checks in line with the Unified Services element of the GMS Contract and the Healthy Child Wales Programme.

The childhood immunisation programme is delivered by Health Boards and undertaken by General Practitioners as a direct enhanced/supplementary service. The Health Board actively monitors immunisation queues in General Practice in order to gain assurance that GP practices are undertaking childhood immunisations in line with the service specification and the Healthy Child Wales Programme. The process has been developed collaboratively with the Health Board immunisation team.

3.5 Access Commitment

The standards listed in this section were previously referred to as Phase 2 Access Standards and are now referred to only as Access Standards for 2024/25. Participation in the GMS Access Commitment is not mandatory for practices but carries up to 100 Quality and Improvement Framework points for achievement. Health Boards are responsible for verifying

achievement and providing assurance to Welsh Government on progress with delivery of the Access Commitment.

Practices are required to achieve all 6 measures, detailed below, in order to receive 40 points for the Standards section of the commitment and 60 points for the Reflective Report.

Standard	Standard Requirement
1	All existing patient facing staff who did not undertake the national care navigation training package provided by HEIW in the financial year 2022/23 are required to undertake this training, as well as all new patient facing staff completing this training within 3 months beginning with their start date. Practices will supply names of new starters and date of training undertaken.
2	All patients telephoning the practice are to have their calls received by a standard recorded message, and subsequently calls are answered with appointments made available for advanced booking each day with declaration confirming that every patient contact is supported throughout the day. Patients will be offered an appropriate consultation, whether urgently or through advanced booking consistent with the patient's assessed clinical need, without 4 the need for the patients to contact the practice again. Where clinically appropriate, patients may be signposted to another appropriate service.
3	To maintain a planned and forward-looking approach to consultations, practices to undertake a regular assessment of their scheduling appointment system to ensure a mix of remote, face to face, urgent, on the day and pre-bookable. A more planned and forward-looking approach should be taken to the scheduling of appointments throughout the day, or for future dates, meaning it is no longer acceptable for all appointments for that day to be released at 8.00am.
Standard	Standard Requirement
4	Practices must confirm each quarter that they regularly maintain an automated and standardised public facing dashboard and make this available via a range of communication methods to meet the needs of their patients. (an Infographic is available via the PCIP for practices to use)
5	Practices are required to undertake the national patient experience survey which should include 25 completed questionnaires per 1000 registered patients from a range of practice population and captured through a range of methods.
Standard	Standard Requirement
6	Practices are required to undertake care navigation on digital requests in a similar and equitable fashion to telephone requests

Practices are required to produce a reflective report to include; Equality Impact Assessment, Patient Engagement, National Patient Experience Survey, Patient Survey Action plan, Digital Request and Telephone System Intelligence.

The Primary Care Contracting Team reviewed all evidence submitted by practices via the Primary Care Information Portal (PCIP) and provided support to those facing challenges in uploading the relevant documentation. 100% of practices reported 100% achievement in 2024/25, this was verified via the PCIP.

3.6 Quality Improvement Framework

This year's QI cycle ran from 1 April 2024 until 31 March 2025 and the completion of two QI projects was mandatory for practices participating in the QI process.

With the allocation of points as set out below:

1. Supporting Healthy Behaviours project (continuation of 2023-24 Unhealthy Behaviours project) 100 points
2. Prescribing Safety project 70 points

Project specifications were provided to practices with an overview of the objectives and requirements to demonstrate achievement. These specifications would facilitate practices to undertake QI activity. Reporting templates were also issued to practices and all resources to support the completion of the QI projects were available on the <https://primarycareone.nhs.wales/tools/gms-quality-improvement-projects-20242025/>

Practices were required to submit evidence demonstrating completion of each of the QI projects for verification using the national templates. The Primary Care Contracting Team reviewed all submissions to validate evidence of achievement.

Supporting Healthy Behaviours: Initial assessment by the Health Board verified 30/68 practices had completed the projects to meet all objectives and 38 required further information to be included within the reports.

Prescribing Safety: Initial assessment by the Health Board verified 43/68 practices against the agreed indicators and 25 required further information within the reports.

The Primary Care Contracting Team liaised with practices regarding additional information required to evidence achievement with a deadline of 6 May 2025 for submission via PCIP, in line with nationally agreed timescales.

68 out of 68 practices within the Health Board met all requirements set out in Welsh Government guidance against both mandatory projects, including the requirement to engage in Neighbourhood Care Network (NCN) discussions in respect of the QI projects.

3.7 Prison

Primary Care General Medical Services (GMS) services are being provided at both HMP Usk and HMP Prescoed via a Service Specification in accordance with the requirements of the General Medical Services contract and in accordance with the NHS (GMS) Contracts Regulations 2023. This includes but is not limited to the provision of Unified Services described in the GMS contract and Supplementary Services as agreed between provider and commissioner.

In December 2024 a procurement process for the provision of GMS across both sites, with a combined population of 485, was undertaken due to the existing contract due to end in March 2025, with a view to commission an NHS General Medical Prison Service from 1 April 2025.

The contract was awarded to Malpas Brook Health Centre.

Malpas Brook Health Centre provide general medical services for 5 sessions a week across both HMP Usk and HMP Prescoed.

3.8 Governance

The Primary Care Contracting Team have robust mechanisms in place to monitor all contract delivery on a monthly basis, and additional processes in place for reviewing claiming data in respect of locum reimbursement payments and Enhanced/Supplementary services to ensure timeliness of submissions. The Enhanced/Supplementary services monitoring also enables the team to identify any gaps or anomalies in claims which may highlight staffing or training issues at practice level. Appropriate support is provided to practices to ensure practice cash flow is maintained and training issues are addressed. It also allows for the contracting team to identify where practices may be commissioned but not delivering a service and allow for appropriate steps to be taken.

Primary Care Contracting ensures that risk is managed appropriately and through prompt identification and assessment, reported into Divisional QPS. This ensures that where possible, the Health Board is informed of the risks that are present and how they are managed or minimised.

The GMS risk register is reviewed regularly and describes risks in sufficient detail so that they can be clearly understood. All risks identified are assessed for severity and likelihood of the risk along with necessary actions to treat, remove or minimise the risk.

The Post-Payment Verification (PPV) service is delivered by NWSSP on behalf of Health Boards providing assurance to Health Boards that claims made by GP Practices are appropriate and in line with the regulations set and guidance documents issued.

The PPV programme runs on a three-year cycle, monitoring a third of the contractors each year. A random sample of claims are reviewed and verified against the patient's clinical record.

Once the PPV team has undertaken their visit and the report has been finalised, this report is shared with the Health Board.

The Health Board reviews each report received and for an error rate of 10% or more OR a recovery value of £1000 or more, then a practice visit is scheduled, for an error rate of 5%- 9% an initial letter is issued to practices. Anything less than 5% results in no further action.

During 2024/25 the Health Board received 20 reports for GP practices, 12 of which required primary care action. In total £18,882.63 was recovered due to claims errors.

HIW inspect all GMS practices for clinical and managerial/administrative compliance, providing a report of each inspection to the practice and the Health Board identifying any areas for improvement. A total of six HIW inspections were carried out in 2024/25.

Of the GP practices inspected in 2024/25, two practices were issued a non-compliance notice and received an immediate improvement plan. All practices submitted acceptable improvement plans agreed by HIW.

Practices engage directly with Health Inspectorate Wales and the Health Board offers support and guidance to a practice before and after inspections have occurred.

3.8.1 Annual Contract Review

The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023, requires general practice contractors to comply with all relevant legislation and submit an annual return relating to the contract to the relevant Health Board. The same categories of information will be requested from all persons who hold GMS contracts with the Health Board. Failure to comply could result in the Health Board activating remedial notice procedures.

Unified Contract Assurance Framework 2024/2025

The Unified Contract Assurance Framework (CAF) has been developed via tripartite task and finish group taking in account the context of the New Health and Care Quality Standards for Wales (2023). It is used across NHS Wales and by General Medical Services contractors to provide assurance of the delivery of the GMS Unified Contract.

It was agreed that the Unified Contract Assurance Process should:

- Be open and transparent in process;
- Be proportionate and not bureaucratic in execution;
- Make use of existing sources of data;
- Include data analysed at national level and provided to practices and Health Boards;
- Use national standards and measures;
- Be consistently applied across Wales;
- Set out processes that are formative and supportive where possible; and
- Provide a clearly articulated stepped approach to escalation if concerns exist.

The Assurance Framework indicators have been mapped to the 6 domains of quality and 6 enablers as set out in the Health Care Quality Standards.

6 Domains

1. Safe
2. Timely
3. Effective
4. Efficient
5. Equitable
6. Person-centred

6 Enablers

1. Leadership
2. Workforce
3. Culture
4. Information
5. Learning, improvement and research
6. Whole-systems perspective

Assurance Framework Process

There are five key stages to the CAF process, ensuring a consistent approach across Wales.

Stage one – Nationally agreed data set for quality, safety, governance and contract management.

A desk top review of practice assurance using the nationally agreed set of indicators including Assurance Indicators, CGPSAT, IG Toolkit and Annual Contract Returns was carried out for all 68 GP practices within ABUHB.

Stage two – Prioritisation by Health Boards

The desk top reviews were utilised to determine the level of assurance and then prioritise the depth of assessment required for each practice. Information submitted by the practices on the Annual Contract Return was validated by the Primary Care Contracting Team with the weighted scores automatically assigned on PCIP, manually adjusted to reflect the outcome.

The desk top reviews enabled the categorisation of practices based on the following assurance levels;

- Substantial Assurance – few matters require attention, low risk. Action Plan drafted for practices to complete and return, no visit required.
- Reasonable Assurance – some matters require attention with a low to moderate risk until resolved.
- Limited Assurance – more significant matters require management attention with a moderate risk until resolved.
- No Assurance – action required to address the whole framework with a high risk until resolved.

As a result of the desktop reviews, 37 practices were provided with an action plan consisting of low to moderate risks that required attention within a given timeframe.

Stage three – Process for assessing compliance against contractual requirements

A schedule of practice visits was agreed based on the outcomes of the desktop reviews, Annual Contract Return, National Prescribing Indicators, National Safety Indicators, Contractual Issues, Governance and local intelligence. As a result, 23 practices (34%) were highlighted to receive a Contract Assurance Visit during 2024/25 for the review period 1 April 2023 to 31 March 2024.

Visits are led by the Primary Care Contracting team, alongside a Primary Care Clinical Director. Practices are prioritised for a practice visit, based on their submissions, with all practices offered an opportunity to meet each year should they wish.

Stage four – Output of visit

Visits took place between January and March 2025, with a multidisciplinary focused approach in collaboration with the Medicines Management Team where appropriate.

Following each practice visit an action plan was provided to the practice, where applicable, with associated timeframes and also included any actions identified from the desktop reviews. A summary report of the visit was also provided to the practice for information.

Number of Practices:						
No actions	1 action	2 actions	3 actions	4 actions	5 actions	6 > actions
6	13	15	11	11	5	7

Number of practices:				
Immediate actions	Actions within 1 month	Actions within 3 Months	Actions In 3-6 Months	Ongoing Improvement
2 (5 Actions)	16 (42 Actions)	31 (87 Actions)	3 (8 Actions)	15 (54 Actions)

Stage five- nationally agreed escalation ladder

The Health Board approaches the CAF process in a supportive manner in order to ensure practices are able to meet the requirements and work through any action plans to achieve substantial or reasonable assurance. Should any practice not engage with the process or have limited or no assurance then the escalation ladder supports the management of those scenarios, which ultimately could lead to the Health Board issuing a Remedial or Breach notice.

Stages of the escalation ladder include:

1. Practice contract and governance framework response plan
2. Sustainability Framework
3. Unified and Supplementary service review
4. Remedial/Breach notice issued

All actions identified during the 2024/25 visit cycle have been satisfactorily completed in line with practice response plans, therefore the escalation ladder has not been invoked.

3.8.2 Enhanced Monitoring Arrangements

The Partners who resigned the contracts for the 5 practices have retained GMS contracts for a further 3 practices in Aneurin Bevan. The Health Board has requested that the partnership provides a detailed plan for each of their remaining GMS contracts that describes when and how they expect to enter a period of greater stability, independent of the Health Board. The Health Board continues to work with the partnership to support the development of their plans and arrange a sequential approach to reviewing each GMS contract. During this time contractual management and compliance monitoring will remain to ensure the needs of the registered population are met, with the primary focus being patient safety and access to service provision.

3.9 Concerns/FOI

In relation to GMS, in 2024/25, the team investigated and responded to a total of:

- 18 FOI requests;
- 17 PTR concerns; and
- 100 MS MP concerns.

Through the management and investigation of these concerns, the Health Board addresses any specific contractual issues with the relevant provider ensuring any learning points are taken forward. Common themes include access to GP appointments, difficulties in contacting practices and access to vaccines and immunisation.

3.10 Looking Ahead

The following information is based on local knowledge and at this stage there is no indication that any of these practices propose a change to their current service.

As of 1 April 2025:

Blaenau Gwent

Currently no single-handed contractors.

Managed practices:

Practice	Location	List Size
Aberbeeg Medical Centre	Blaenau Gwent East	4,713
Brynmaur Medical Practice	Blaenau Gwent East	10,874
Tredegar Health Centre	Blaenau Gwent West	6,829

Caerphilly

Single Handed Contractors:

Practice	Location	List Size
Sunnybank Health Centre	Caerphilly East	5,605
South Street Surgery	Caerphilly North	3,330
Bryntirion Surgery	Caerphilly North	10,619

Monmouthshire

Single Handed Contractors:

Practice	Location	List Size
Wye Dean Practice (Tintern)	Monmouth South	1,933

Newport:

Single Handed Contractors:

Practice	Location	List Size
St Paul's Clinic	Newport West	6,570

Torfaen:

There are no single-handed contractors.

Managed practices:

Practice	Location	List Size
Blaenavon Medical Practice	Torfaen North	6,576

The Health Services (Provider Selection Regime) (Wales) Regulations 2025 came into force on 24 February 2025. Aneurin Bevan Health Board will continue to apply the Regulations to the procurement of relevant health services in Wales. The Primary Care Contracting Team will continue to review and update all local procurement policies and procedures to ensure alignment with National Regulations.

The Health Board's well established Access Group will continue to be scheduled on a Quarterly basis and the Enhanced (Supplementary) Services Operational Group (ESOG) will continue to be scheduled Bi-annually. The Primary Care Contracting Team continue to work closely with all key stakeholders and liaise with Llais and Local Medical Committee (LMC) will all policy changes and application.

3.11 Directly Managed Practices

The Health Board assumed direct management for 5 practices for an initial stabilisation period; 3 from 1 March 2025 and 2 from 1 April. There has

been a Divisional response to the contract resignations and, in addition to the robust contractual process which were implemented, the Division also established an operational oversight team comprised of Clinical Directors, Nursing Colleagues and management support. This dedicated team is aligned to the practices to support them during this time.

Following an initial stabilisation period, there will be a sequential review of the practices to determine the longer- term arrangements for the ongoing delivery of GMS for each practice.

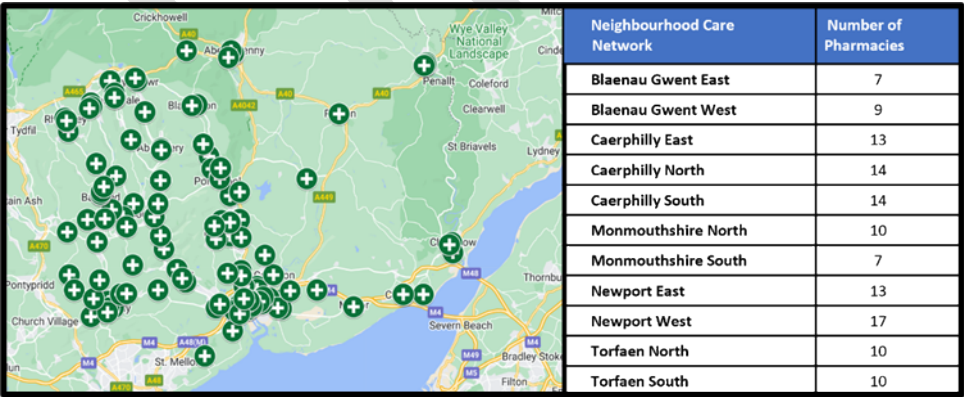
As the Health Board cannot enter a contractual arrangement with a directly managed practice, Managed practices are monitored in accordance with the Practice Statement which mirrors the requirements of the GMS Regulations.

4. **Pharmaceutical Services (Community Pharmacy)**

One hundred and twenty-five community pharmacies provide NHS pharmaceutical services to the citizens of the Health Board in accordance with the terms of service laid out in the National Health Service (Pharmaceutical Services) (Wales) Regulations 2020. Alongside dispensing services, the pharmacies provide a range of additional clinical services commissioned using provisions in the Pharmaceutical Services (Clinical Services) (Wales) Directions 2022. As independent contractors, community pharmacies also provide private services outside the remit of the NHS terms of service. These private services include delivery, provision of compliance aids and clinical services such as travel vaccinations and weight management.

This report focusses on the NHS pharmaceutical services provided by Community Pharmacies.

4.1 Distribution of services and opening hours



The 125 community pharmacies are distributed across the Health Board area according to population need based on historical arrangements for control of entry.

Community pharmacies must open for 40 “core” hours to provide NHS pharmaceutical services. They may also open for additional “supplementary” hours. The Health Board must be notified of all changes to opening hours but only core hours need Health Board’s consent for change.

Opening hours range from 8am to 8pm Monday to Saturday with some pharmacies open between 10am and 4pm on Sundays. Most pharmacies are open between 9am and 6pm Monday to Friday and just over half open for at least part of the day on Saturday. Eight pharmacies open on Sundays.

In 2024-25 eleven pharmacies reduced their opening hours including stopping to open on Saturdays. Nine of these involved a change to core hours. This continues an ongoing trend to reduce total opening hours to maintain viability.

All contractors reducing Saturday hours cited a lack of footfall, recruitment and retention challenges, and operating costs as reasons for the change. Sunday opening has remained consistent.

The Health Board managed all applications to change core hours with a formal process and scrutiny by the Change of Core Hours Review Panel. Applications are usually subject a four-week patient consultation period and are examined by the pharmacy team before being presented alongside an options paper to the Panel. Panel decisions are ratified by the Primary Care and Community division’s Senior Leadership Team. Decisions made consider the existing Pharmaceutical Needs Assessment. To date, the panel has not identified a need for a new pharmacy or a new service provision.

To ensure citizens have access to medicines during the out of hours period, a pharmacy rota service is commissioned as an additional service outside of the core and supplementary hours requirements.

4.2 Pharmaceutical Needs Assessment

The NHS Wales Act 2006 requires Health Boards to produce a statement of their needs for pharmaceutical services, this statement is termed the Pharmaceutical Needs Assessment (PNA) and must be published every five years. The Health Board’s first PNA was published on 1 October 2021 and is used when considering whether to grant applications to join its pharmaceutical list or dispensing doctor list under the 2020 regulations.

The PNA does not identify any existing additional pharmaceutical needs for Aneurin Bevan University Health Board.

Planned housebuilding and the creation of new communities has identified a future need for pharmaceutical services in Newport East and Torfaen North. The needs are contingent upon defined house completion levels within each of the identified areas and this is monitored by periodic contact with the site developers. Current building rates suggest that the need is not likely to be realised during the lifetime of the 2021 PNA.

The next PNA is due to be published in October 2026.

4.3 Contract Monitoring

To ensure pharmacies provide their NHS services in line with their NHS terms of service, two health board officers visit each of the one hundred and twenty-five pharmacies at least once every three years. The visits are conducted according to the formal community pharmacy contract monitoring process.

In 2024/25, fifty-five pharmacies received contract monitoring visits. Fifty-one were fully compliant with their terms of service at the point of monitoring or at the end of a one-month local resolution period. Four pharmacies did not meet the local resolution deadline and were issued with a Remedial Notice in line with the 2020 regulations. The notices have now been satisfactorily closed as the pharmacies are fully compliant with their terms of service.

4.4 Accelerated Cluster Development

The Community Pharmacy Contractual Framework (CPCF) provides funding for collaborative working within Neighbourhood Care Networks (NCNs). This includes a collaborative lead for each NCN who is selected by the pharmacies in the NCN. During 2024-25 four NCNs were without a community pharmacy collaborative lead (Blaenau Gwent East, Caerphilly North and South and Monmouthshire South). The community pharmacy team have worked with Community Pharmacy Wales to try and increase awareness and interest in the role without success. In March 2025 the community pharmacy team provided a collaborative event for the unrepresented clusters to garner interest for the role. The governance around the role is managed locally within the community pharmacy team by including listings enabling payment and receipting meeting reports.

The CPCF also provides funding for individual pharmacies to participate in up to six collaborative meetings each year. The meeting may be those organised by the NCN pharmacy collaborative lead or meetings agreed between the pharmacy and other healthcare professionals within the relevant cluster do discuss prescribed areas of mutual interest including, implementing periods of treatment review, the Electronic Prescription Service and clinical services.

Financial governance surrounding the collaborative working arrangements are managed by NWSSP Post Payment Verification in line with the requirements of the drug tariff.

4.5 Dispensing Activity

The community pharmacies included on the Health Board's Pharmaceutical List are operated by different contractors ranging from single handed independent pharmacies, through small chains to large national chains with multiple pharmacies. During 2024-25 the pharmacies dispensed a total of 16,597,551 prescription items, an increase of 1.3% compared with 2023-24 and an average of 319,000 items each week.

Depending on the geographical location and the communities the pharmacies serve, the dispensing activity ranges from 800 to 6500 prescriptions a week.

4.6 Additional Service Activity

4.6.1 Clinical Community Pharmacy Service

Alongside dispensing prescriptions, all community pharmacies in Aneurin Bevan University Health Board offer the NHS Clinical Community Pharmacy Service (CCPS). A nationally directed service within the community pharmacy contractual framework.

The CCPS comprises the following components:

- The provision of emergency, bridging and quick-start contraception
- The supply of previously prescribed medicines in an emergency
- The provision of the national common ailments service

The CCPS was changed during 2024-25 to combine the provision of bridging and quick-start contraception with emergency contraception to form a mandatory contraception service.

During 2024-25 community pharmacies provided over 113,000 patient consultations through the services.

Flu was also removed from the core CCPS to reflect differences in provision and sat as a separate, optional service for the 2024-25 season with 124 pharmacies opting into service provision.

Service name	Activity
Contraception	4,602 consultations
Emergency Supply	23,256 consultations (40,458 medicines)
Common Ailments including: Sore Throat Test and Treat UTI	70,637 consultations 5,817 consultations 1,849 consultations
Seasonal Influenza	14,553 vaccinations

The other nationally directed community pharmacy services available within the Health Board are the Discharge Medication Service and the Pharmacy Independent Prescriber service.

4.6.2 The Discharge Medication Review Service

The service offers an additional safety assurance by reconciling a patient's medicines after being discharged from hospital. Because if the transfer of care, there may be differences in the medicines compared with those the patient used before admission.

All pharmacies in the Health Board are commissioned to provide the directed service but not all actively provide it on a regular basis. During 2024-25, ninety-seven pharmacies (78%) provided 2,495 Discharge Medication Reviews (DMRs) between them.

The clinical record system used in the Gwent hospitals is incompatible with the national system developed for the DMR service and our patients are at a disadvantage compared to those discharged from other hospitals. Our information transfer is reliant on paper records and self-referral compared with automated electronic notification in other areas. Our Health Board has the second lowest uptake of DMRs per unit of pharmacy activity of all seven Health Boards in Wales. The IT compatibility issue has been raised directed with Digital health and Care Wales and the Executive team in ABUHB, but the programme to update our Clinical Work Station (CWS) has chosen to omit the inclusion of communication with the Choose Pharmacy, continuing to disadvantage citizens of ABUHB compared with other Health Boards.

4.6.3 The Pharmacist Independent Prescriber Service

Pharmacy: Delivering a Healthier Wales, the pharmacy profession's vision for the development of pharmacy to meet the Welsh Government's long-term vision for health and social care, identified a goal to have a Pharmacist Independent Prescriber in every community pharmacy in Wales by 2030.

The Health Board has been involved in this journey since its inception, developing local pilot services and collaborating on a national approach. From tentative first steps with seven community pharmacists qualifying in 2019, the Health Board now has fifty-seven community pharmacies (46%) commissioned to provide the service in line with the national service specification.

During 2024-25, ABUHB pharmacies provided 24,671 consultations via the service. Growth is again expected in future years with approximately thirty pharmacists entering training each year.

4.6.4 Local Additional Services

Alongside the directed services detailed above, the Health Board commissions additional clinical services locally. The services include:

Service name	Number of pharmacy providers
Blood Borne Virus	8
Care Home Support	4
Covid vaccination service	6

Directly Observed Therapy	commissioned on demand
Inhaler use review	46
Medicines Administration Record Supply	85
Needle Exchange	23
Naloxone	3
Out of hours rota	63
Palliative Care Out of Hours	9
Prison supply service	1
Smoking cessation level 2	123
Smoking Cessation level 3	93
Supervised Consumption	114
Tuberculosis Compliance Support	2
Urgent Medicines Supply	23
Waste Reduction Intervention	107

The Health Board commissions these services via 764 individual service level agreements stipulating provision in line with agreed national or local service specifications. The commissioning arrangements are dependent upon local and overall need and geographical location. For example, the nine pharmacies commissioned for the out of hours palliative care service work with the ABUHB OOH and provide for the entire Gwent region. Smoking cessation is commissioned much more widely to ensure good local access. Given the range and nature of services available, activity information can be provided separately on request.

4.7 Governance

Governance regarding the NHS Terms of Service for community pharmacy is managed through the Contract Monitoring Process identified earlier in this document. Annual reporting of clinical and information governance feed into the monitoring process and issues of suspected non-compliance are managed through the performance related sanctions described in the 2020 regulations.

The community pharmacy team also provide local scrutiny of additional clinical service provision. For the Pharmacy Independent Prescriber service, prescribing trends are monitored to identify potential variance from the service specification. Services where supplies are enabled by Patient Group Directions (PGD) undergo the same scrutiny with a focus on service specifications and PGD requirements.

Potential discrepancies are firstly discussed with pharmacy superintendents for local resolution with continued monitoring evaluating compliance. Sanctions are limited to suspending or removing a service, but as these

impact upon patients' access to NHS care, support and guidance is the usual route to resolution.

Claims for service activity are monitored against commissioning information and account schedules paid by NHS Wales Shared Services Partnership. Monitoring of dispensing is managed as part of medicines management overseen by the wider pharmacy team.

4.7.1 Information Governance

With community pharmacists and technicians having access to the NHS Wales "Choose Pharmacy" platform, related information governance around access is also managed by the community pharmacy team. A formal process is in place utilising the National Intelligent Integrated Audit Solution (NIIAS) to monitor access. In common with the service scrutiny above, reports are sent to superintendent pharmacists for local resolution. The ultimate sanction is removal of access rights. During 2024-25 twenty-eight potential breaches were identified, documented and communicated to superintendent pharmacists for investigation and appropriate action.

4.7.2 DATIX Reporting

Community pharmacies in Wales are obligated to submit reports of patient safety incidents via the Once for Wales Primary Care Wales National Incident Reporting tool, DATIX Cymru. Each submission comes to the Health Board to be closed. Whilst it's important to note that it's the pharmacy that is responsible for investigating and managing incidents, acknowledging receipt and closing the reports is an additional function of the community pharmacy lead with support from a medicines management technician. During 2024-25 four hundred and six incidents were receipted and closed. For context, over sixteen million prescription items and one hundred thousand patient consultations were completed during the same period. Awareness of the contractual need to report is raised through contract monitoring visits. There is no national feedback mechanism for these incidents to allow learning at scale and this may be responsible for the low increase in reporting compared with 2023-24.

4.8 Performance Related Sanctions

The 2020 Pharmaceutical Services Regulations introduced the ability for Health Boards to manage non-compliance with the community pharmacy Terms of Service with a series of remedial and breach notices, the opportunity to withhold monies associated with non-compliance and provided the ultimate sanction of removal from the pharmaceutical list.

To ensure consistent application of the sanctions the Health Board utilises the formal "Procedure for Managing Breaches of the NHS Terms of Service for Community Pharmacy Contractors". Initially the process was used to manage potential breaches of the terms of service relating to pharmacy opening hours. With contract monitoring becoming fully operational post

covid in 2022-23 the process is also used to manage any non-compliance identified during the visits.

Broadly speaking the process has several stages, progressing from local resolution through remedial notices and finally breach notices. The process is managed via a sub group that gathers evidence and presents a recommendation, and a main contractual breach group that formally decides the action to be taken. The community pharmacy development manager compiles, issues and manages the remedial and breach notices. During 2024-25, one hundred and one potential breaches were investigated with four breach notices issued.

The four breach notices were issued to Jhoots Pharmacy across its two branches within the Health Board area. These breaches were due to the pharmacies failing to meet the essential terms of service under the NHS (Pharmaceutical Services) (Wales) Regulations 2020. Ongoing challenges remain regarding opening hours and stock availability and supply. The Health Board is actively liaising with the provider and continuing to apply appropriate sanctions whilst seeking a longer-term resolution.

4.9 Consistency of Action

To ensure that the Health Boards' interests are fully represented when national services and policies are being developed that for community pharmacy the community pharmacy team have roles in a variety of relevant national boards and working groups. They also work closely with equivalents in other Health Boards and liaise with Llais, Welsh Government and Community Pharmacy Wales to ensure monitoring and development arrangements are equitable and proportional for all Health Boards and pharmacy contractors in Wales.

5. Primary and Community Care Academy

Development of the multi-professional workforce remains the priority for the Primary and Community Care Academy (PCCA) in line with the vision of the Primary Care Model for Wales (PCMW).

Established through HEIW and Aneurin Bevan University Health Board funding, the PCCA continues to deliver and develop training and education for a broad range of professionals working in primary and community care to ensure the multi-professional workforce has access to the necessary training and education and associated support to deliver a wider range of services and interventions within these settings.

The PCCA aims to provide positive educational experiences for trainees to allow them to develop skills and confidence to work at the top of their licence and provide excellent healthcare. Courses and programmes delivered by the PCCA are outlined in this section.

5.1 Healthcare Support Worker Programme

Healthcare Support Worker (HCSW) Programme to support primary and community care HCSWs through effective induction and training to allow them to deliver safe, effective healthcare. In 2025, 13 HCSWs have completed the training course with a further 6 from County Hospital beginning the programme in September 2025.

5.2 Nursing Foundation Programmes

The General Practice Nurse (GPN) Programme supports qualified nurses who are new to primary care. This comprehensive programme of training events is delivered in collaboration with Swansea University over 9 months. Learners receive a Post Graduate Certificate in Primary Care Practice at the end of the programme. Three cohorts of GPN trainees have completed the programme over recent years; 22 trainees in total, with another cohort of 10 trainees starting the programme in September 2025.

The Journey of Excellence is a preceptorship programme to support newly qualified nurses in community, to enable a smooth transition from a newly registered nurse into a confident practitioner. The JOE programme remains the flagship recruitment programme for community care settings within Aneurin Bevan University Health Board. 2024 -2025 has seen the Academy train 3 cohorts of nurses:

- JOE Cohort 4 – 14 completed training In March 2025
- JOE Cohort 5 – 10 due to complete training in September 2025
- JOE Cohort 6 – 14 starting the programme in September 2025

Commencing in March 2026, the Academy JOE programme will align with the corporate JOE offer for nurses.

5.3 Advanced Practice Training

The PCCA delivered a Managing Same Day Presentations Advanced Practice module via Swansea University to develop the primary care skills of existing Advanced Practitioners. Eight Advanced Practitioners, including ANPs and Pharmacists, completed the training. Work is continuing to deliver further PCCA Advanced Practice Training in 2025 / 2026.

5.4 Pharmacists

The Academy Post registration foundation Pharmacist programme has been remodelled in order to address sustainability needs across Community Pharmacy and GMS. The Academy has recruited 1 pharmacist to the training programme on a 2-year fixed term contract from January 2025. The programme includes rotations between General Practice and Community Pharmacy. A memorandum of understanding and Service Level Agreement has been developed to provide an agreement framework

between the three parties A mentor and a competency handbook is in place to support the learner.

At the end of the programme the pharmacist will achieve 80 level 7 credits, the independent prescribing qualification and the RPS post-registration foundation credential award – this provides assurance that they are working at the required level and enables progression into advanced practice.

5.5 Pharmacy Technicians

The aim of introducing a Pharmacy Technician programme through the academy is to showcase the work that pharmacy technicians can complete within primary care and consequently evidence the more effective use of pharmacist time on more complex clinical tasks. The PCCA has now introduced the Pharmacy Technician Programme, with 1 pharmacy technician currently placed in 19 Hills Practice in Newport. This is a revolutionary new transition pathway for pharmacy technicians new to primary care in Wales and aims to showcase the role within GP Practices. Many GP practices are still unaware of the roles and responsibilities that a pharmacy technician can undertake and therefore pharmacists are still routinely completing some of these roles and therefore this is not a prudent use of their time.

5.6 Clinical Skills Programme

The Clinical Skills Programme offers a range of courses to Healthcare Professionals (HCPs) across primary, community and care home settings to allow them to develop or refresh their clinical skills. This includes ANTT, BLS, Bowel Management, Catheterisation, Wound Care HICC&PICC lines, Recognising the Deteriorating Patient, NEWS and Sepsis.

5.7 Continuing Professional Development (CPD) sessions

A range of CPD sessions including lunchtime learning events covering a range of subjects for HCPs have been delivered again in 2025 and the 2026 programme is currently being developed. These are either pre-planned or in response to requests to address specific training needs. The PCCA has also delivered Protected Learning Time (PLT) events for GMS practices which focussed on Diabetes and Mental Health. Further PLT sessions for 2025 / 2026 are currently being planned around the themes of CKD & Health Pathways and Frailty.

5.8 Internationally Educated Nurse Programme

The Internationally Educated Nurse (IEN) programme is designed to support internationally educated nurses in developing the knowledge, skills, and confidence to work effectively within UK primary and community healthcare settings. 16 Nurses are currently booked on to this Academy training programme

5.9 National (HEIW) Workstreams

The PCCA continues to work with HEIW and the Wider Academies Network in Wales to develop national training programmes. Programmes include Practice Manager Development, Non-Clinical Workforce Development, Advanced Practice Framework Digitisation, Support for Non-Clinical Prescribers, Training Needs Analysis development and Evaluation / Benefits Realisation development.

5.10 Schools and Colleges

Engagement with schools and colleges is essential to promote careers in primary and community care to students who are our potential future workforce. The PCCA has attended a number of engagement events at schools and colleges through the Gwent Schools Programme. These events have been very well received and given PCCA staff an opportunity to explain the range of career opportunities and career pathways in Primary and Community Care.

6. Primary Care & Community Quality and Patient Safety

6.1 Duty of Candour/Duty of Quality

The Duty of Candour (DoC) requirements in relation to health care providers have been in place since 1 April 2023, with the aim of being open and honest with patients receiving care and treatment.

Divisional representation at the national Welsh Risk Pool DoC and learning network with specific responsibility for promoting raising of awareness for independent contractors, sharing tools, templates algorithms and direct support when DoC is triggered.

The Primary Care and Community Quality and Patient Safety (QPS) team continue to review all incidents reported by the Division to establish and support with any cases that could potentially trigger the Duty. The more information included within the initial Datix report and management review sections, the easier it is to establish whether the duty has been triggered. The number of incidents triggering DoC have reduced, as processes for review and validation have been embedded.

For independent contractors, the DoC and decision-making sits with the contractor although the QPS team are available to provide support or guidance. Once the duty has been triggered, initial contact (in person notification) is made with the patient/next of kin by the clinically responsible person. This is followed up with a written notification sent to

patient or next of kin by day 5 (suggested template provided by QPS to ensure all required information to comply with the DoC is captured). The investigation can then commence and the outcome can be shared with the patient/relative if agreed.

Rapid review of incidents by managers is important and the QPS Team currently review all divisional incidents to establish potential cases whilst processes are being embedded.

6.2 Monitoring and assurance

Robust mechanisms are in place for the screening of all incidents and concerns and timely escalation within the Division and to the corporate team where indicated.

Weekly focussed reviews are undertaken of all DATIX reports and liaison with clinical teams as appropriate.

There is continued engagement with GPs via the Local Medical Committee to further explore the implementation of the All-Wales strategic review, awareness raising, promotion of primary care drop-in clinics and additional training and support for practice staff.

The Health Board is engaging with the national Welsh Risk Pool DoC and learning network to develop a State of the Nation self-assessment to demonstrate to Welsh Government its maturity and progress made for implementation. The Division has contributed case studies to inform the All-Wales DoC casebook to share and promulgate learning identified.

Independent contractors are required to complete an annual submission confirming all incidents which triggered DoC during the year, the Health Board then submits a report to Welsh Government identifying the themes in relation to DoC triggers across primary care. The Welsh Government report for 2024/25 is due to be submitted in November 2025 and the data is currently being collated to inform this report.

7. Conclusion

This Primary Care Annual Quality Report for 2024/25 from the Primary Care, Community Services, Complex and Long Term Care Division has outlined the robust mechanisms in place for monitoring contract delivery across all independent contractors and goes some way to demonstrate the depth and breadth of work involved in relation to contractual review, enhanced monitoring, Post-Payment Verification processes, and engagement with Health Inspectorate Wales.

Also included is an overview of the Primary and Community Care Academy education programmes supporting the ongoing sustainability of services and a brief review of the Duty of Candour reporting requirements through the Quality and Patient Safety team.

Appendices

Appendix A – GDS Contract Reform Variation Offer



2024-25 - Variation
offer - letter to prac

DRAFT

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	01 October 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Putting Things Right Annual Report 2024-2025
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Tracey Partridge-Wilson - Deputy Director of Nursing Gemma Couch - Head of QPS, Learning and Improvement

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The Putting Things Right (PTR) Annual Report has been prepared in accordance with the PTR Regulations. The annual report demonstrates our ongoing commitment to the population of the Health Board, which covers Blaenau Gwent, Torfaen, Monmouthshire, Caerphilly, and Newport. This equates to around 600,000 children, young people and adults. It will provide an overview of the 2024/2025 position in terms of how Aneurin Bevan University Health Board (ABUHB) has managed concerns, Redress cases, Claims, Patient Safety Incidents, Duty of Candour and Public Services Ombudsman for Wales (PSOW) cases during this reporting period. It will provide information on progress, performance as well as an overview of emerging themes and trends, including lessons learnt and emphasises the Health Board's dedication to openness, honesty, and patient-centred care and the subsequent vision for 2025/2026.

Cefndir / Background

The Report focuses on and describes the successes and challenges related to 'Putting Things Right' during the reporting period. It encompasses, Complaints, Compliments, Redress, Patient Safety Incidents, and PSOW cases and Duty of Candour all of which are underpinned by the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

The Health Board values feedback and concerns from service users and families, recognising their vital role in improving services and patient safety. The introduction of the Health and Social Care Quality and Engagement (Wales) Act and NHS Duty of Candour on 1 April 2023 further strengthens our organisational responsibility to communicate openly, learn from concerns, and integrate these principles into everyday practice.

The report also details the organisational structure and governance of the Putting Things Right/Quality Patient Safety (QPS)/Putting Things Right (PTR) teams, which have been aligned with the Nursing Directorate since February 2024.

Asesiad / Assessment

The period 2024/25 has brought both opportunities and challenges.

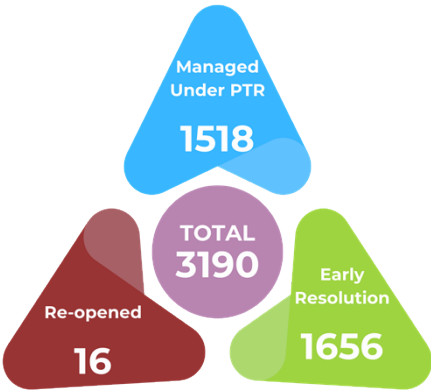
At the heart of the "Putting Things Right" (PTR) and Duty of Candour arrangements is the requirement to be open and honest when dealing with concerns. Most importantly to play a significant role in improving patient safety; endorse a person-centred approach to concerns management and reinforce a culture of organisational learning and quality. This is underpinned by the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) 2011.

The Health Board is committed to making it easy for people to raise concerns, feel that they are being listened to, and that their concerns are being taken seriously.

The Organisational Change Process, which integrated the Divisional and Nursing Directorate resources for Quality and Patient Safety, was completed in February 2024, with the Quality Improvement team from ABCi joining in May 2024. This new model is now in place, ensuring that Quality Patient Safety (QPS), Putting Things Right (PTR) and Quality Improvement (QI) services are coordinated and aligned to deliver the vision set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020, 'A Healthier Wales' (Welsh Government, 2018), and the more recent 'NHS Quality & Safety Framework', Duty of Quality and Duty of Candour. The effectiveness of this organisational change will be subject to evaluation to ensure it achieves the intended outcomes.

As a Health Board we aim to echo the NHS core values by putting Quality and Patient Safety first by always providing high value evidence-based care for our communities and delivering that via a Person-Centred approach.

The Health Board position for the delivery of the PTR regulations in 2024/25 is as follows: -



Patient Experience: Complimentary to the PTR process the Patient Experience and Involvement team have supported clinical teams in meeting with patients or patients' relatives who would like to share their experiences following either incidents and or complaints.

Dedicated members of the Patient Experience and Involvement team meet with the person who has agreed to talk about their experiences to support listening and learning. The person agrees to the format of their 'story' and consents to their story being used either internally, externally or both. The person is not interviewed, rather, they speak from the heart about an episode of care that has had the most significant impact on them, either positive or negative. The person is shown the film once it has been edited for their approval. The whole process gives them an opportunity to talk about what has happened and to put structure to it in the format of a 'patient story', which can then be shared for learning and quality improvement.

Some patients or carers who have shared their experiences are also invited to participate in involvement events such as the Bereavement Collaborative, People Participation Panels and the Dementia In-Patient Working Group. The involvement of patients and carers is increasing through listening and ongoing collaboration.

Formal complaints: During the reporting period, the Health Board has taken receipt of 1518 concerns which have been managed under the Putting Things Right regulations, meaning that a formal investigation has been undertaken, the findings of which have been collated into a letter of response which is reviewed and signed by the CEO.

Early Resolution: In addition to concerns Managed Under the Putting Things Right guidelines, the Health Board can attempt to address concerns within 48 hours, and these are considered as Early Resolution. This aims to bring concerns that are appropriate to a swift resolution for people without needing to await a formal investigation and response.

Patient Safety Incidents and Never Events: During the reporting period 161 patient safety incidents met national reporting criteria, reflecting a decrease from 187 in the previous year. Never Events, which are serious and preventable incidents, continued to decline, with only two reported this period—one historic case and one wrong-site surgery. This downward trend demonstrates the effectiveness of ongoing safety measures and quality improvement.

Redress Panel: Of the Redress Panels convened by the Health Board, 40 cases were prepared, heard and deliberated upon. Redress panels assess and determine concerns where potential failings and resulting patient harm have occurred. This is a high-level panel with quorate membership.

Inquests: Over the last 3 years, the Health Board has seen a year-on-year growth in the number of new Inquest matters with 299 inquests concluded in year

PSOW Cases: The Public Service's Ombudsman for Wales (PSOW) referred 178 cases to the Health Board for consideration during the reporting period. These encompass matters which are enquiries only, full investigations, anonymous queries and in some cases where a full investigation is undertaken by the PSOW service.

The Ombudsman conveyed highly positive feedback regarding the Health Board's achievements over the past year.

Review of Priorities 2024/25

Priority 1: PTR Regulations and Health Board Concerns Management

1.1. The Putting Things Right Regulations are currently under consultation. The Health Board will ensure we are fully prepared and equipped ahead of any revised guidance being issued, to support our staff in the implementation and effective delivery for our communities.

- We have ensured readiness for revised Putting Things Right regulations through collaboration with external partners and internal teams.

1.2. Early Resolution – Person-centred approach: The Health Board is working to ensure that compliance with the Welsh Government 30-working day target is achieved where possible. Collaborative focus days will be planned to review complex concerns and assist with finalisation and conclusion of high-quality investigations.

Internal streamlining of quality assurance processes. This aims to provide a more consistent approach to the investigating and subsequent responses to concerns.

- Streamlined quality assurance processes for earlier resolution and a more person-centred approach.

1.3. Meaningful Engagement: An Acknowledgement Team will be introduced, to understand early on what people raising concerns are seeking and what matters most to them and how we can resolve concerns in a timely and meaningful way so that patients and their families know that they are being listened to and that their concern is being taken seriously.

- Improved documentation, response, and investigation of concerns, with enhanced engagement and accessibility for service users.

1.4. We will develop Communication Standards to ensure consistency across all our teams. We will be clear in setting out resolution proposals, actions and agreements and dates for contact and updates.

- Introduced Communication Standards and established a dedicated acknowledgment team to deliver consistent and timely updates to individuals raising concerns.

Priority 2: Improving Quality Patient Safety Experience, Learning and Improving

2.1 Embed the centralised QPS/PTR/QI teams and revised ways of working.

- We have established central QPS/PTR/QI teams to improve operations and drive patient safety and quality initiatives.

2.2 A suite of training is being developed which is specific to complaints/ incident investigation. The Health Board also intends to work collaboratively with Welsh Risk Pool colleagues to devise more readily available and accessible video training in the future. The Public Service Ombudsman for Wales (PSOW) will also be supporting bespoke training.

- Delivered targeted training (including Once for Wales sessions), workshops, learning events, and newsletters to enhance staff expertise.

2.3 Patient Safety Incidents (PSI):

- Patient safety incident bespoke 1-2-1 Investigating Officer (IO) training to work with new IO's that have been allocated an investigation.
- Complete a toolkit for IO's, Panel Chairs and staff involved in PSI's in no matter the context.
- Roll-out amended PSI template to align to DoC.
- Revised induction and education and training for PSI chairs.

- Enhanced support for Patient Safety Incidents (PSI) through specialised training, a dedicated toolkit, and updated templates to meet Duty of Candour requirements.

2.4 The ABCi QI Unit have been working to support the development of Quality Improvement Capability across ABUHB.

In particular, the QI Unit are working with divisional staff to develop Quality Improvement Coaches embedded into clinical teams. To this end, a new Quality Improvement Coach programme has been adapted and tested in ABUHB in conjunction with Improvement Cymru.

The programme will run from Autumn 2024, with 3 cohorts planned each year. Potentially 75 QI Coaches will be trained annually, who can support clinical teams in their improvement priorities.

- Launched the Quality Improvement Coach programme in Autumn 2024 to foster improvement skills within the organisation.

2.5 Development of the Listening and Learning Framework & Learning Repository: The framework will demonstrate how learning will be identified, stored, triangulated, shared, disseminated and implemented in practice to facilitate and embed a culture of appreciative enquiry and continuous improvement in health care services.

- Introduced a new Listening and Learning Framework and set up robust forums—including a central repository and the Patient Quality and Safety Learning and Improvement Forum—for shared learning and continuous improvement.

Priority 3: Partnership Engagement & Collaborative working

3.1 To work closely with external partners such as the Public Services Ombudsman for Wales, Llais, Audit Wales, Health Inspectorate Wales through which we will demonstrate an open culture and always seek out opportunities to learn and improve for our ongoing commitment to the population of the Health Board.

- We have strengthened collaboration with key external partners, ensuring community voices shaped our work and fostering ongoing improvement in service delivery.

3.2 Work with the Medical Examiner's Office to implement the Death Certification Reform.

- Worked closely with the Medical Examiner's Office to embed Death Certification Reform, improving transparency and accuracy in the certification process.

3.3 Work with the National Bereavement Leads to implement the GRACE bereavement model.

- Implemented the GRACE bereavement model across services, providing compassionate and consistent support for bereaved families, with comprehensive staff training to maintain high standards of care.

3.4 Continue to meet with and support patients and carers who have raised concerns, either directly or through third parties, such as Llais and the Ombudsman, to improve listening and learning.

- PTR team meet with Llais and Ombudsman regular

3.5 Introduce People Participation Panels for sepsis and dementia.

- Introduced people Participation panel.

3.6 Scope existing End of Life Care services and develop an inclusive End of Life Care Pathway in collaboration with people, staff and partners.

- Developed an inclusive End of Life Care model through wide consultation with people, staff, and partners, ensuring the model reflected collective experiences and needs.

3.7 Hold a Big Conversation around Future Care Planning to raise public awareness.

- Hosted the "Big Conversation" event to raise awareness and encourage participation in Future Care Planning, gathering valuable community feedback.

3.8 Divisions to promote the use of the CIVICA system for timely patient feedback

- Leveraged the CIVICA system to capture timely patient feedback and enable divisional teams to act quickly on insights for continuous service improvement.

The 2024/25 reporting year has been both challenging and rewarding for the Corporate Putting Things Right (PTR) Team. The Health Board has continued to evolve its approach to complaint management, building on earlier improvements and introducing new initiatives to enhance patient experience and service quality.

Significant progress has been made in centralising processes, embedding a culture of early engagement, and strengthening the infrastructure for timely, person-centred resolution. Despite operational pressures, the team has focused on improving communication, compliance, and learning from experience to drive system-wide improvement. The Health Board's commitment to quality, safety, and listening to patient voices remains at the heart of everything we do.

The Health Board will build on its achievements in 2024/2025, maintaining a commitment to continuous learning and improvement. This process will incorporate feedback from service users as well as insights gained through internal evaluations to identify opportunities for quality improvement.

The Health Board has identified three key priorities that will frame the PTR Annual Work Programme 2025/2026: -

Priority 1: PTR Regulations and Health Board Concerns Management

1.1. The Health Board is committed to ensuring comprehensive preparedness and robust support for staff in the implementation and effective delivery of the revised PTR Regulations. This includes streamlining quality assurance processes, improving documentation standards, and enhancing the person-centred approach to early resolution and meaningful engagement with service users.

1.2. We will continue to drive compliance with PTR timeframes and statutory requirements, through monitoring and governance oversight to identify and address areas of non-compliance.

1.3. We will focus on addressing historic cases eradicating any concerns over 6 months, with clear trajectories for resolution and reporting, ensuring equitable and timely outcomes for patients and families.

Priority 2: Improving Quality Patient Safety Experience, Learning and Improving

2.1 As part of the ongoing commitment to quality and safety, we will formally review the effectiveness of this organisational change to ensure that the intended outcomes are being achieved, and to identify any areas requiring further refinement or improvement.

2.2	We will continue to focus on learning and improvement from patient safety incidents, fostering a culture of continuous learning and improvement, implementing changes based on lessons learned, and encouraging the use of dashboards.
2.3	We will focus on improving Nationally Reportable Incident (NRI) compliance through strengthened processes for recognition, reporting, investigation, and closure, supported by enhanced oversight and accountability mechanisms.
2.4	We plan to relaunch Duty of Candour (DoC) training on ESR for staff who have not undertaken this training. DoC training will become mandatory for all patient-facing staff within the Health Board.
2.5	The Medical Director's Quality and Patient Safety team is developing a two-year sepsis strategy to enhance patient safety and improve outcomes. This includes enhancing sepsis recognition and management, strengthening initial treatment, implementing new Early Warning Scores, standardising staff education and training, and developing an audit strategy.
2.6	We will work with divisions to embed Quality Improvement (QI) Coaches to support their QI priorities. Additionally, developing an organisational QI Faculty will focus on building conditions for quality improvement.
2.7	We plan to enhance Human Factors training across the organisation to strengthen safe systems and reduce variation in practice.
2.8	Strengthen Data Quality and Reporting: Enhance documentation, tracking, and reporting of legal management activities.
2.9	Maintain and Develop Governance Structures: Continue to refine SOPs, portfolio reporting, and Board engagement to ensure robust oversight and accountability.

Priority 3: Partnership Engagement & Collaborative working

3.1	We will continue to enhance collaborations with external partners to further reinforce oversight and promote ongoing improvement in quality and safety initiatives. Continued engagement with organisations including the Public Services Ombudsman for Wales, Llais, Audit Wales, and Health Inspectorate Wales will be prioritised, enabling greater transparency and fostering the adoption of best practices through these strategic partnerships.
3.2	We will build on recent progress; efforts will focus on fully embedding the Death Certification Reform in partnership with the Medical Examiner's Office and ensuring the GRACE bereavement model is consistently applied to support bereaved families.

3.3 Further engagement with patients and carers will be prioritised to gather valuable insights, which will inform ongoing improvements in patient care and organisational learning. These steps aim to reinforce a responsive, learning-focused environment and ensure the Health Board remains committed to delivering safe, compassionate, and high-quality care.

3.4 We are committed to foster a culture of openness, compassion and learning, with a strong emphasis on listening to patient and staff voice and embedding that insight into the way we deliver care.

Argymhelliad / Recommendation

The Committee is asked to: -

- **RECEIVE** the Putting Things Right Annual Report 2024/2025.
- **NOTE** the three key priorities for the PTR Annual Work Programme.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	CRR002
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 3.1 Safe and Clinically Effective Care 6.3 Listening and Learning from Feedback 3.2 Communicating Effectively
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau:	NA

Glossary of Terms:	
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	NA

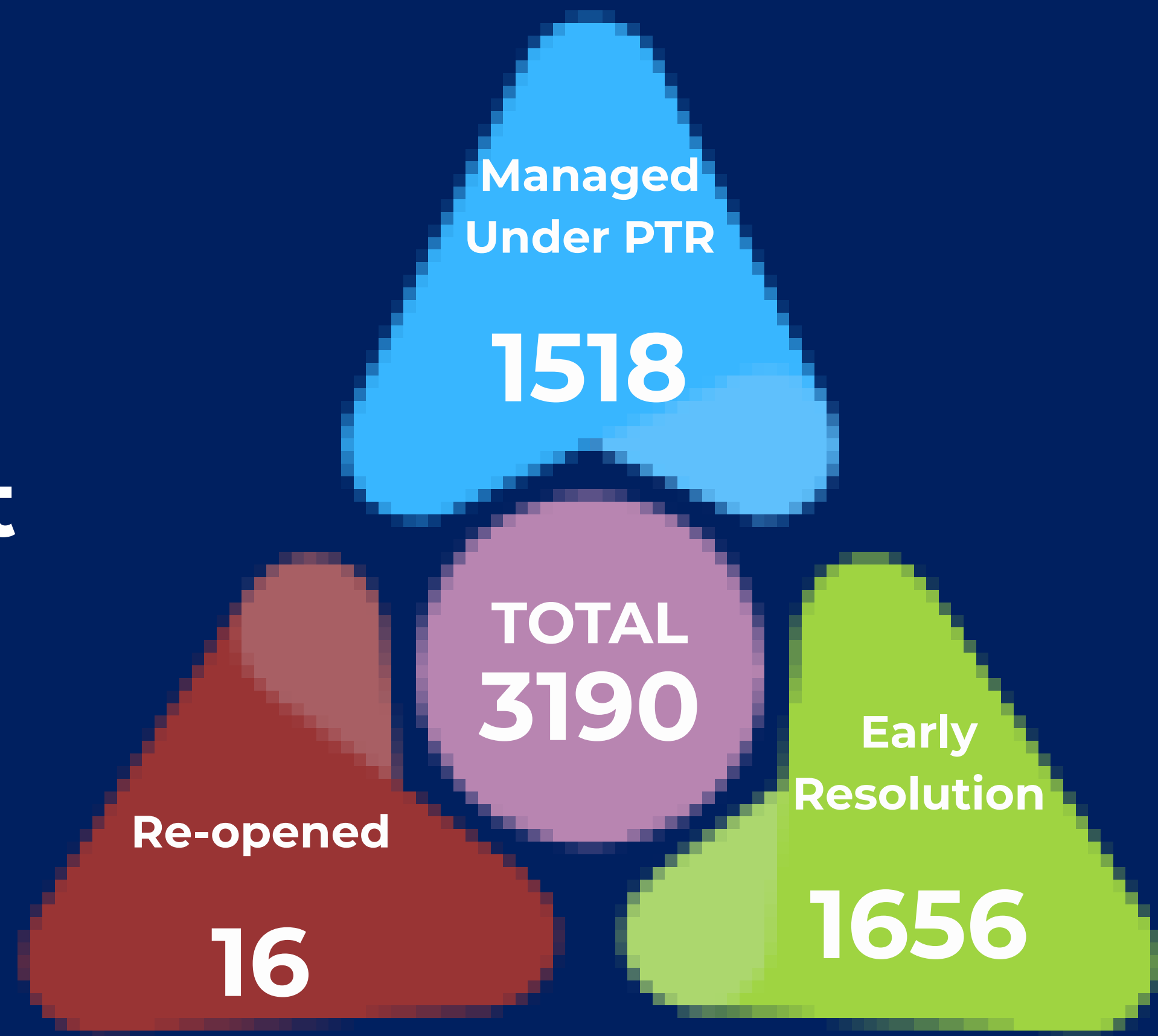
Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Choose an item.
• Service Activity & Performance	Choose an item.
• Financial	Choose an item.
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Putting Things Right ANNUAL REPORT 2024-2025



Introduction

This Annual Putting Things Right Report covers April 2024 to March 2025, reflecting Aneurin Bevan University Health Board's commitment to over 600,000 residents across Blaenau Gwent, Torfaen, Monmouthshire, Caerphilly, and Newport.

At the core of PTR and Duty of Candour arrangements is a commitment to openness, honesty, and person-centred concern management, supporting patient safety and organisational learning. This approach is guided by the NHS (Concerns, Complaints and Redress Arrangements) (Wales) 2011.

The Health Board values feedback and concerns from service users and families, recognising their vital role in improving services and patient safety. The introduction of the Health and Social Care Quality and Engagement (Wales) Act and NHS Duty of Candour on 1 April 2023 further strengthens our organisational responsibility to communicate openly, learn from concerns, and integrate these principles into everyday practice.

If you require a printed version of the Annual Report or in alternative formats/languages, please contact us using the details below:

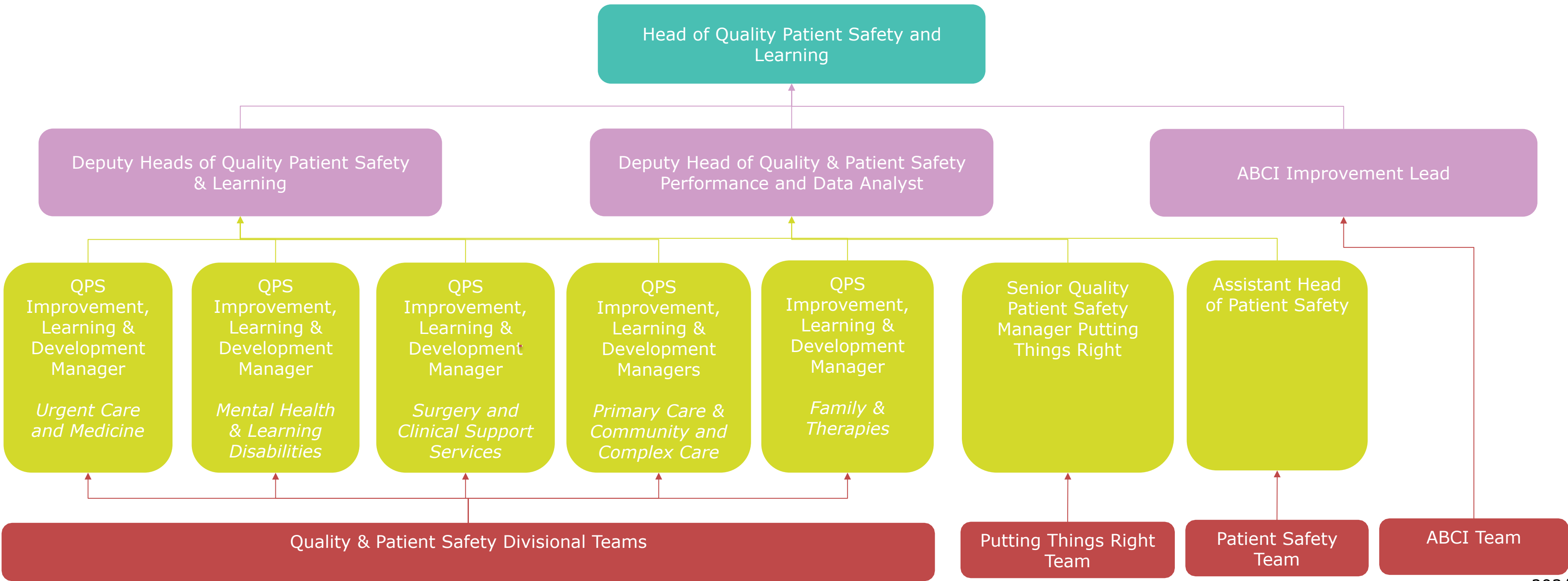
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NP18 3XQ

Staffing and Governance

There is a structure underpinning PTR, with executive leadership delegated to the Executive Director of Nursing (EDoN). Since the end of February 2024, the central Divisional Quality Patient Safety (QPS)/PTR teams have been aligned to the Nursing Directorate. Assurance is provided by reporting to the Quality Management Group, Patient Quality and Safety Learning and Improvement Forum, which in turn reports to the Executive Committee and the Patient Quality and Safety Outcomes Committee.

This committee sets out the Health Board’s strategy and objectives to encourage continuous improvement, as well as compliance with national and local policies. It is further tasked with responsibility to develop and implement systems for quality monitoring that are robust, auditable and effective, as well as raising the awareness of the PTR and QPS agenda.

The current Putting Things Right/QPS Team structure is illustrated below:



Summary of Achievements

In last years annual report, we set our priorities for 2023-204. How did we do?

Priority
1

PTR Regulations and Health Board Concerns Management

- Ensured readiness for revised Putting Things Right regulations through collaboration with external partners and internal teams.
- Streamlined quality assurance processes for earlier resolution and a more person-centred approach.
- Improved documentation, response, and investigation of concerns, with enhanced engagement and accessibility for service users.
- Introduced Communication Standards and established a dedicated acknowledgment team to deliver consistent and timely updates to individuals raising concerns.

Priority
2

Improving Quality Patient Safety Experience, Learning and Improving

- Established central QPS/PTR/QI teams to improve operations and drive patient safety and quality initiatives.
- Delivered targeted training (including Once for Wales sessions), workshops, learning events, and newsletters to enhance staff expertise.
- Enhanced support for Patient Safety Incidents (PSI) through specialised training, a dedicated toolkit, and updated templates to meet Duty of Candour requirements.
- Launched the Quality Improvement Coach programme in Autumn 2024 to foster improvement skills within the organisation.
- Introduced a new Listening and Learning Framework and set up robust forums, including a central repository and the Patient Quality and Safety Learning and Improvement Forum for shared learning and continuous improvement.

Priority
3

Strengthened collaboration with key external partners, ensuring community voices shaped our work and fostering ongoing improvement in service delivery.

- Collaborated closely with the Medical Examiner’s Office to implement Death Certification Reform, enhancing transparency, improving accuracy in the certification process and ensuring timely communication for bereaved families.
- Implemented the GRACE bereavement model across services, providing compassionate and consistent support for bereaved families, with comprehensive staff training to maintain high standards of care.
- Developed an inclusive End of Life Care model through wide consultation with people, staff, and partners, ensuring the model reflected collective experiences and needs.
- Hosted the “Big Conversation” event to raise awareness and encourage participation in Future Care Planning, gathering valuable community feedback.
- Leveraged the CIVICA system to capture timely patient feedback and enable divisional teams to act quickly on insights for continuous service improvement.

Arrangements for the Management of Concerns

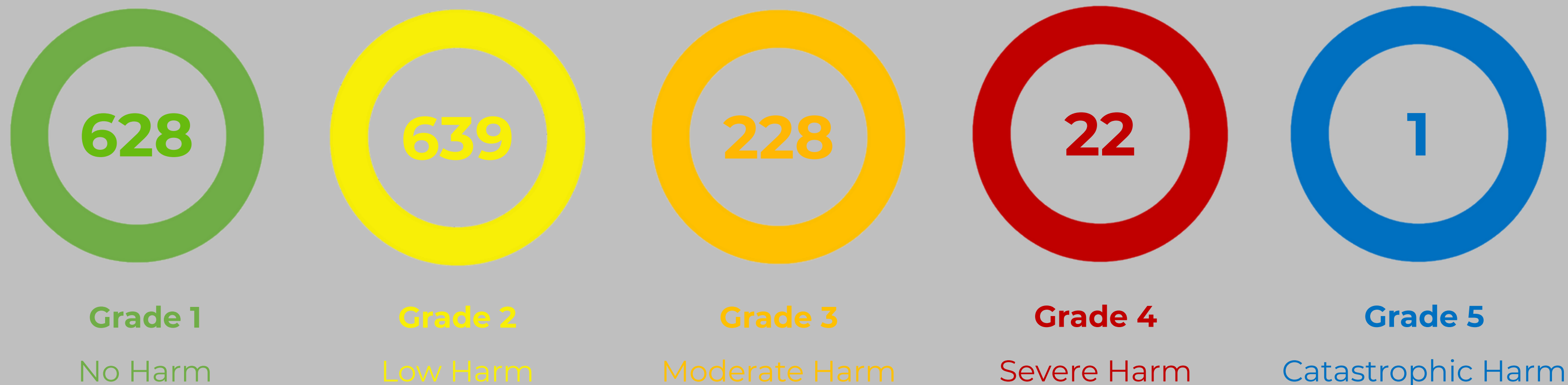
To support the effective management of complaints and patient safety incidents the Health Board has implemented the Putting Things Right Policy for the Management of concerns (complaints) policy along with the Patient Safety Incident Reporting & Management Policy. These should be read in conjunction with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and Putting Things Right Guidance (2013).

Complaints are submitted through various channels, including direct submissions from patients, families, staff, partner organisations, and feedback systems such as CIVICA. The primary method for contacting the Health Board is email, which represents 57.1% of complaints received; 25.7% are submitted by phone.

Feedback reporting channels include:



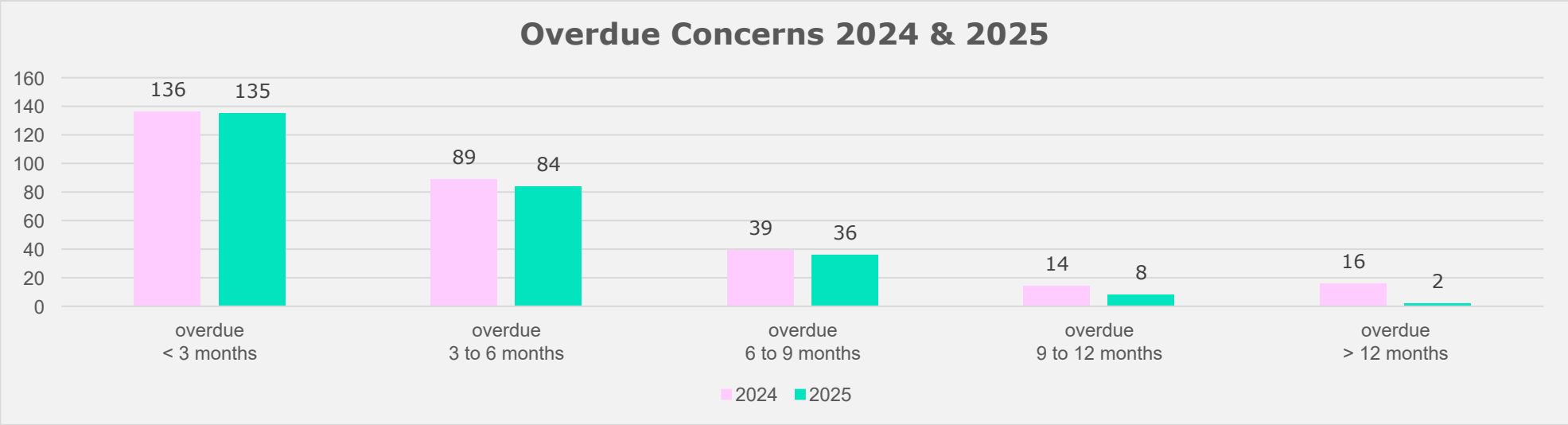
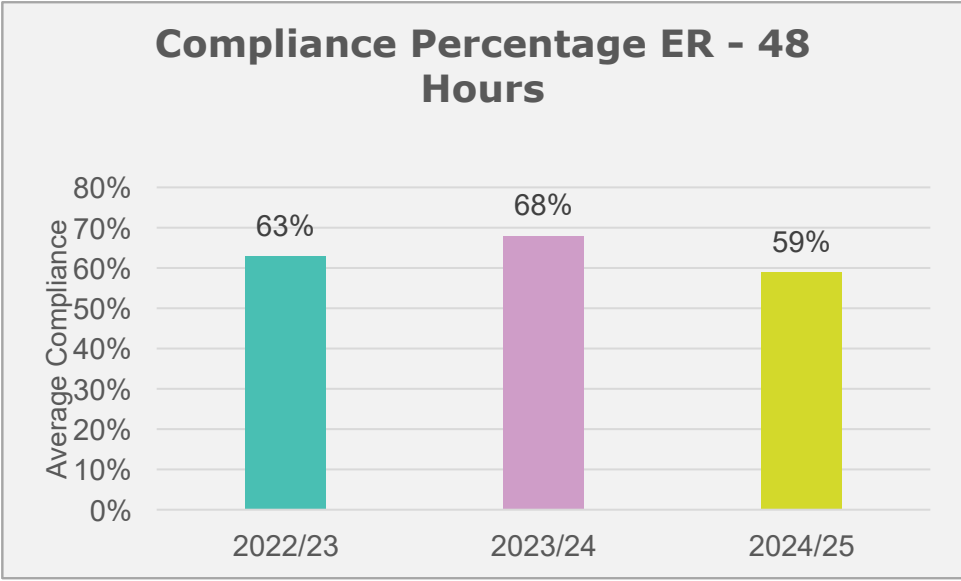
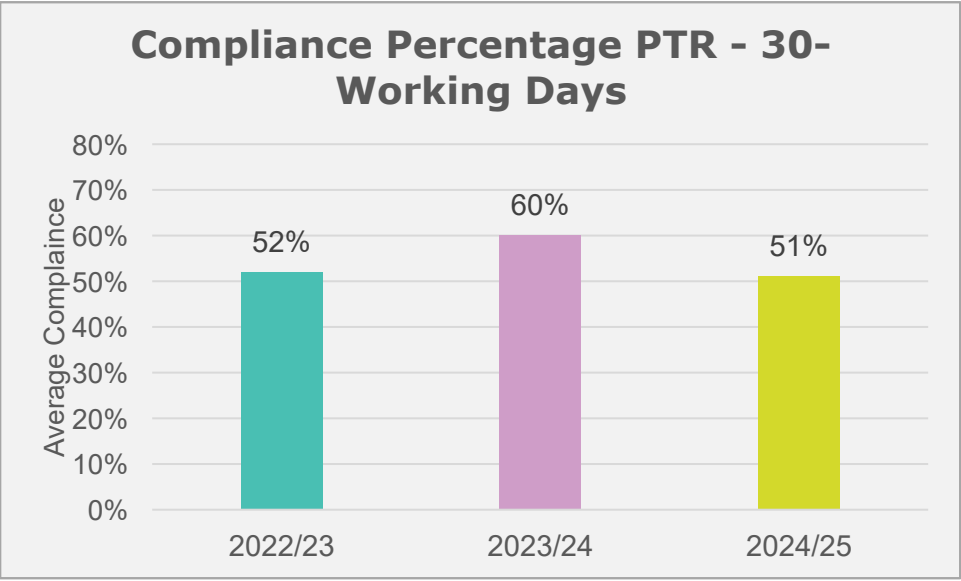
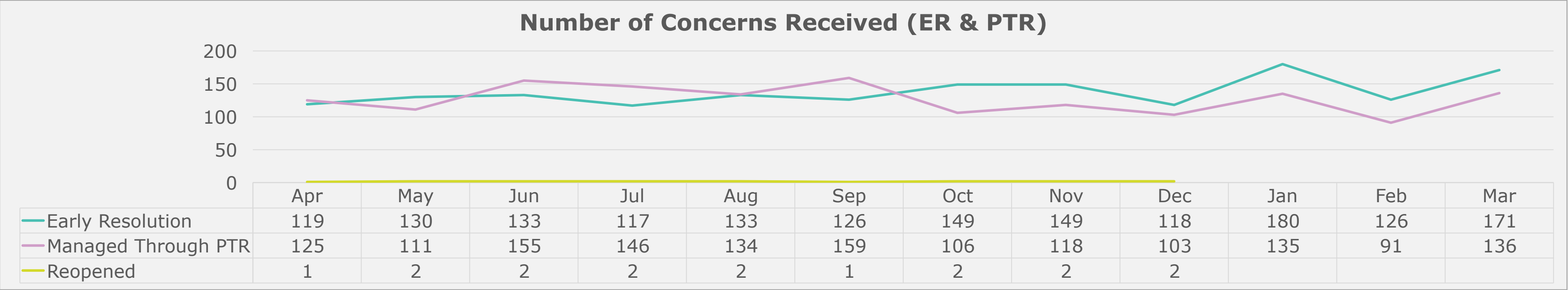
Grading of Managed under PTR Complaints upon Receipt 2024/25



All complaints are graded and triaged upon receipt, from 1 (No Harm) to 5 (catastrophic Harm) in accordance with the All-Wales Grading Framework. This will determine the level of investigation required in dealing with concerns raised. All complaints undergo an assessment of harm to determine the grading and whether there is a possibility that the Health Board may have breached its duty of care, to ensure that the appropriate level of investigation is commissioned. This structured approach facilitates timely investigation, resolution, and learning from each case, helping to drive ongoing improvements in service quality and patient safety.

A large proportion of concerns 83.5% were categorised as Grade 1 and 2 (low or having caused no harm (upon receipt, with Grade 3's (moderate) representing 15%, and with Grades 4 and 5 (severe and catastrophic) accounting for 1.5% of the total received. The grading of complaints is dynamic and should be kept under review throughout the investigation.

Overall Health Board Compliance



Compliance with the Welsh Government 30-working day target averaged 51% across the reporting period.

Extensive collaborative work, involving the Deputy Director of Nursing, the Head of Quality Patient Safety, Deputy Heads of Quality Patient Safety, and the dedicated PTR and divisional teams, has taken place alongside the Once for Wales data team and Divisional leadership teams to prioritise and finalise concerns investigations.

The PTR & QPS teams have made progress in managing and resolving aged concerns more efficiently, resulting in an 87.5% decrease in the number of cases open longer than 365 days.

Trends in Compliance Data - ER/PTR

In 2024/25, the Health Board received 1,518 formal complaints and addressed 1,656 concerns through early resolution. This suggests that recent enhancements to complaint management processes have had a positive impact, with more issues being resolved via Early Resolution approaches in a person-centred way, thereby reducing the need for formal investigations.

The Health Board aspires to resolve 75% of concerns as Early Resolution, as well as attaining a 75% compliance with Managed through PTR.

The main themes relate to: Clinical treatment/assessment; Appointments and Communication issues across 2024/25. The Health Board has been undertaking significant work across these areas which aims to support and improve patient experience.

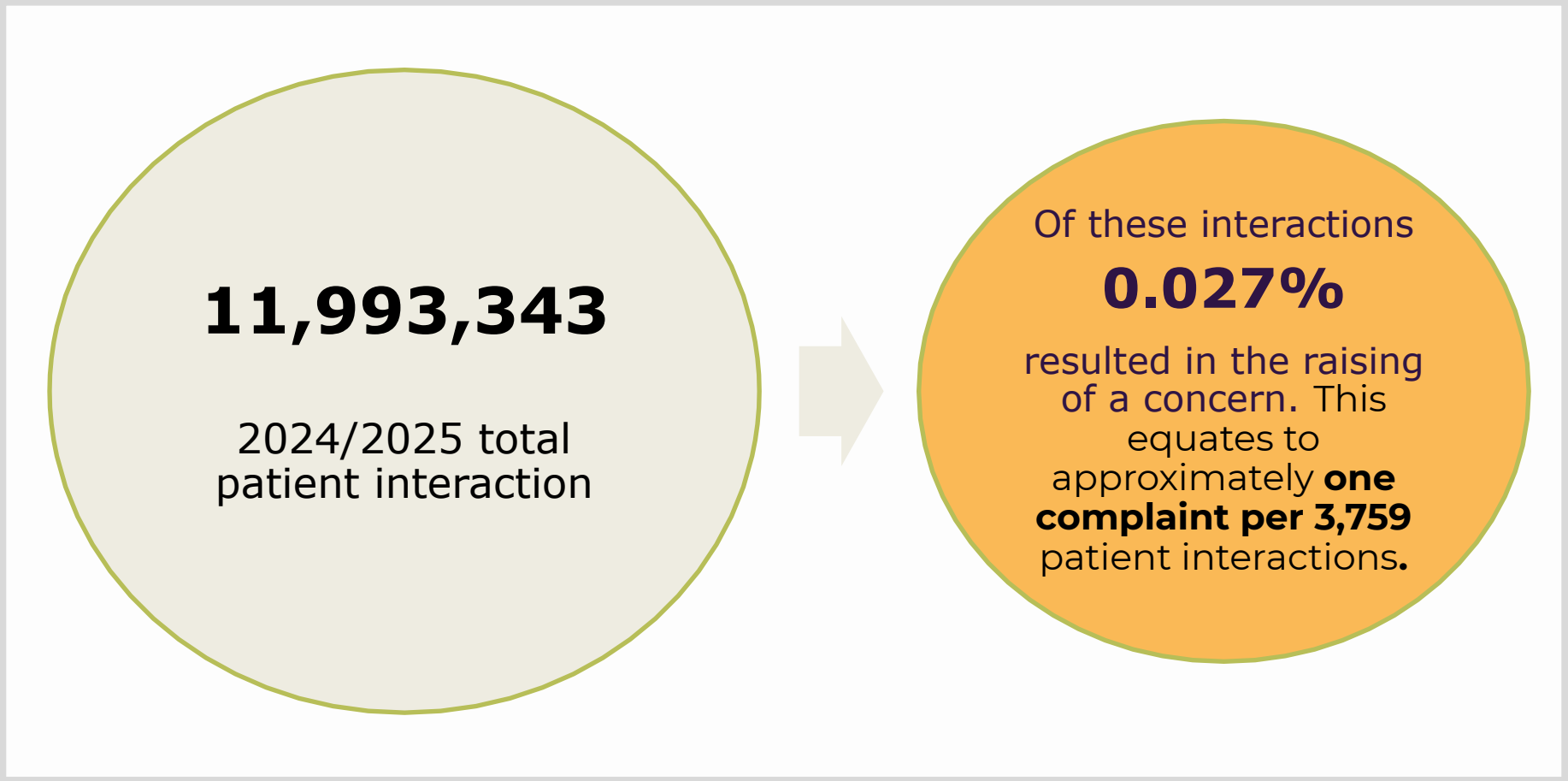
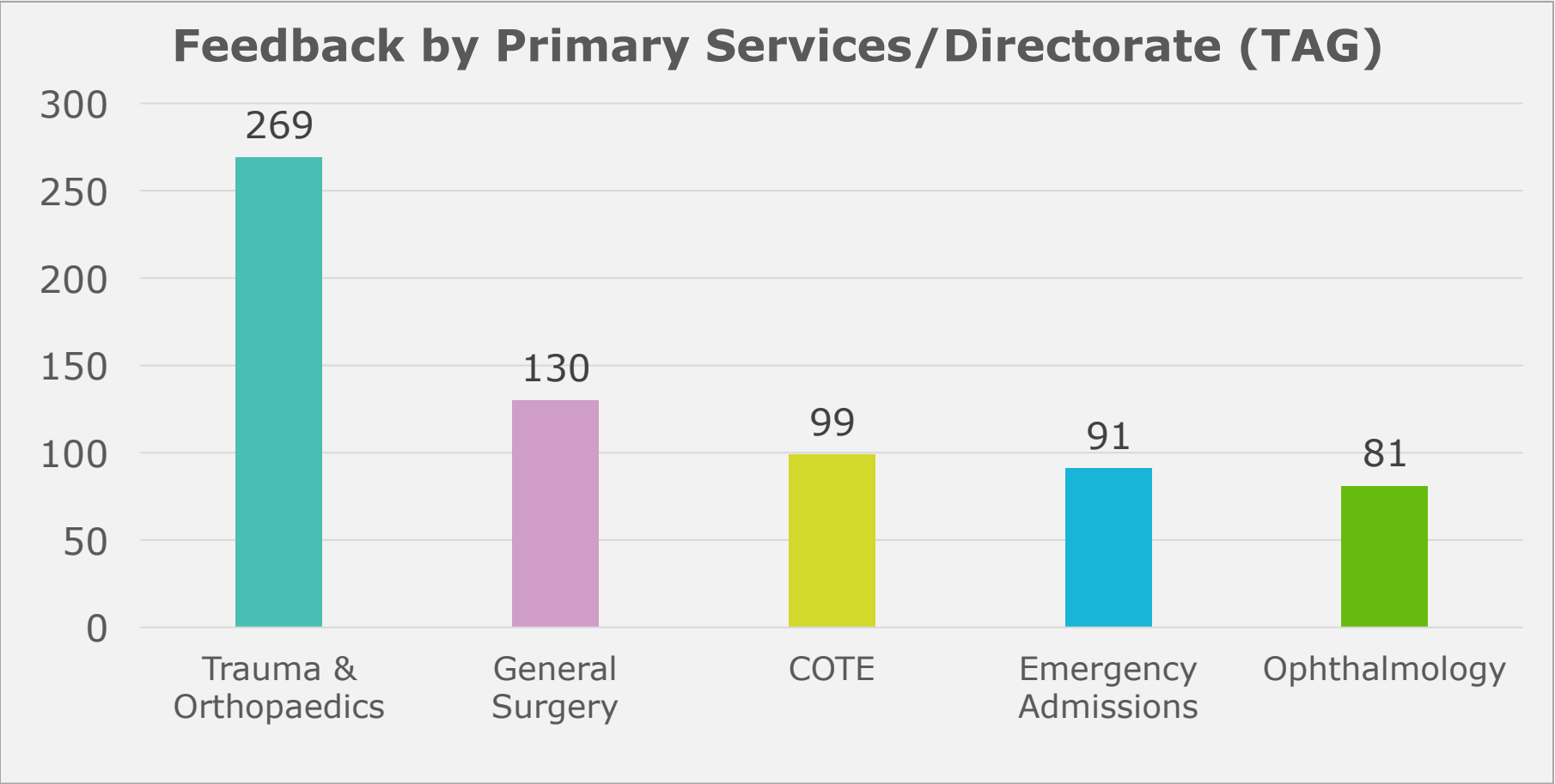
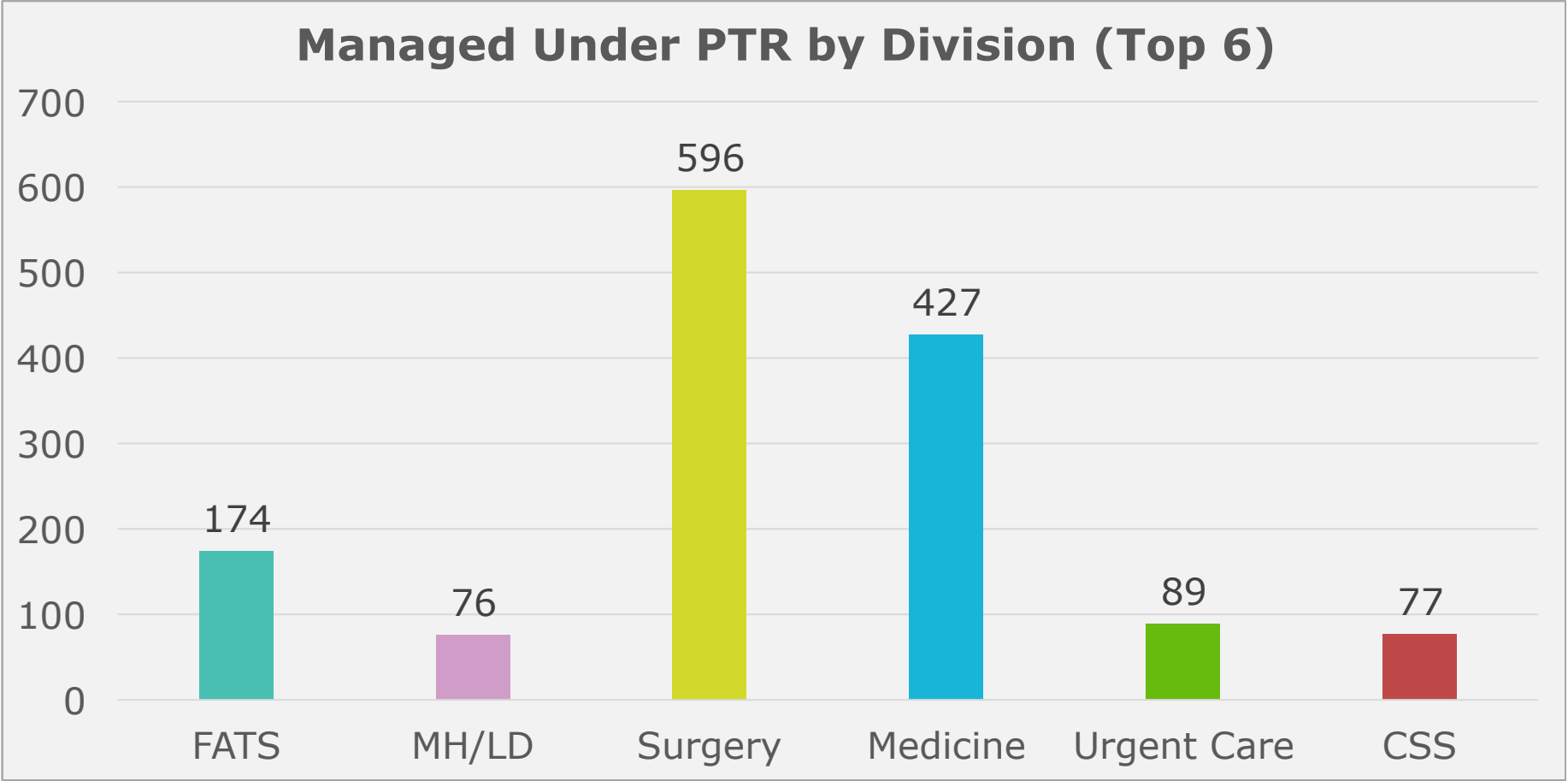
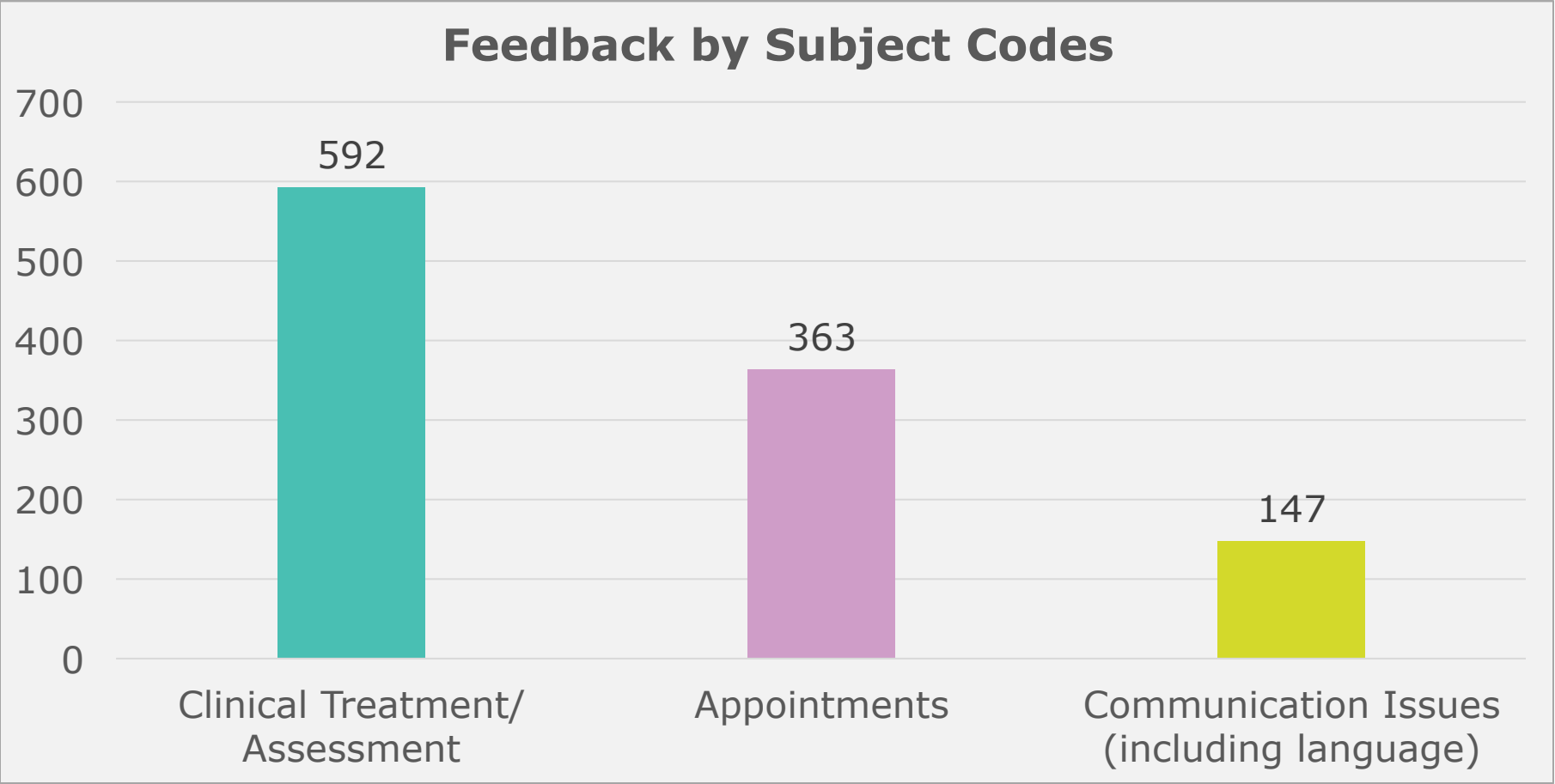
The Health Board achieved significant progress in 2024/25 across key priorities, notably reducing long referral to treatment waits and making advances in cancer and diagnostics performance. Targeted funding enabled substantial decreases in patients waiting over 104 weeks for treatment, especially in ENT, Ophthalmology, and Trauma & Orthopaedics, with some specialties reporting zero patients above this threshold. Waits exceeding 156 weeks were eliminated, and nearly 3,000 fewer patients waited over 52 weeks for outpatient appointments.

Collaborative work with the Welsh Ambulance Services Trust improved system flow and while system reconfiguration and service redesigns, such as the extension of Community Resource Teams and the establishment of an Acute Frailty Response Team, enhanced care for older people. The Same Day Emergency Care model expanded its reach, serving increasing numbers at Grange University Hospital and Ysbyty Ystrad Fawr. Efforts to facilitate early discharge, including the 50-day challenge and the Hospital 2 Home initiative, further improved patient transitions and partnership working with local authorities.

The Health Board also focused on communication improvements, adopting a more person-centred approach to managing concerns and complaints. These initiatives, recognised positively by the Public Services Ombudsman for Wales and Llais, have led to earlier engagement and more effective resolutions for patients and families.

The Health Board reports and monitors concerns received by all divisions. This allows identification and active engagement in collaboration with services that are receiving concerns to understand areas of good practice or where targeted improvement and action may be required. This supports the Health Board in its aim to be a proactive learning organisation.

Concerns Data



Learning From Concerns

Over the past year, the Health Board has continued to evolve its approach to complaint management, building on earlier improvements and introducing new initiatives to enhance patient experience and service quality. The key learning points are as follows:

The Health Board has prioritised transparency and open communication, valuing all feedback as opportunities for learning and improvement.

Communication Standards have been developed to standardise interactions with patients and families, focusing on timeliness, clarity, and empathy.

The centralisation of the QPS and Complaints Team has matured improving consistency, collaboration, and knowledge-sharing across divisions, allowing for better integration of learning from complaints and incident reviews.

There has been significant progress in reducing complaints breaching the 30-day response target, due to targeted action plans and real-time monitoring.

A formalised acknowledgement process, launched in mid-2024, reinforces prompt, personalised initial contact with complainants, leading to earlier engagement and more tailored resolutions.

Regular meetings with external bodies (PSOW and Llais) and direct engagement with patients support a culture of openness, leading to deeper insights into community concerns and stronger accountability.

Weekly cross-team meetings, with expanded participation facilitate rapid sharing of learning and escalation of challenges across departments.

Patient stories and learning events are widely shared across the organisation, ensuring real-life experiences inform continuous improvement and foster a culture of empathy.

Learning From Concerns: PALS Performance/Impact

5940 calls were received over the 12-month period to the PALS Team.
The total number of complaints escalated to the Putting Things Right (PTR) over the past 12 months = 20 (0.34%).

The positive impacts PALS has had on patient experience is significant and includes:

✓

Single point of contact.

✓

Early intervention and resolution to patient and family queries.

✓

Helping patients and families to keep in touch.

✓

Supporting patients and families in clinical meetings.

✓

Supporting face-to-face listening meetings

✓

Positive assurance for families who are unable to visit/live away

POSITIVE

IMPACTS

Facilitated ward moves closer to home

✓

Recommended reasonable adjustments for people with protected characteristics

✓

Secured volunteer visits for people who are lonely or isolated

✓

Signposting to support services for example, bereavement support

✓

Reduced escalation to PTR

✓

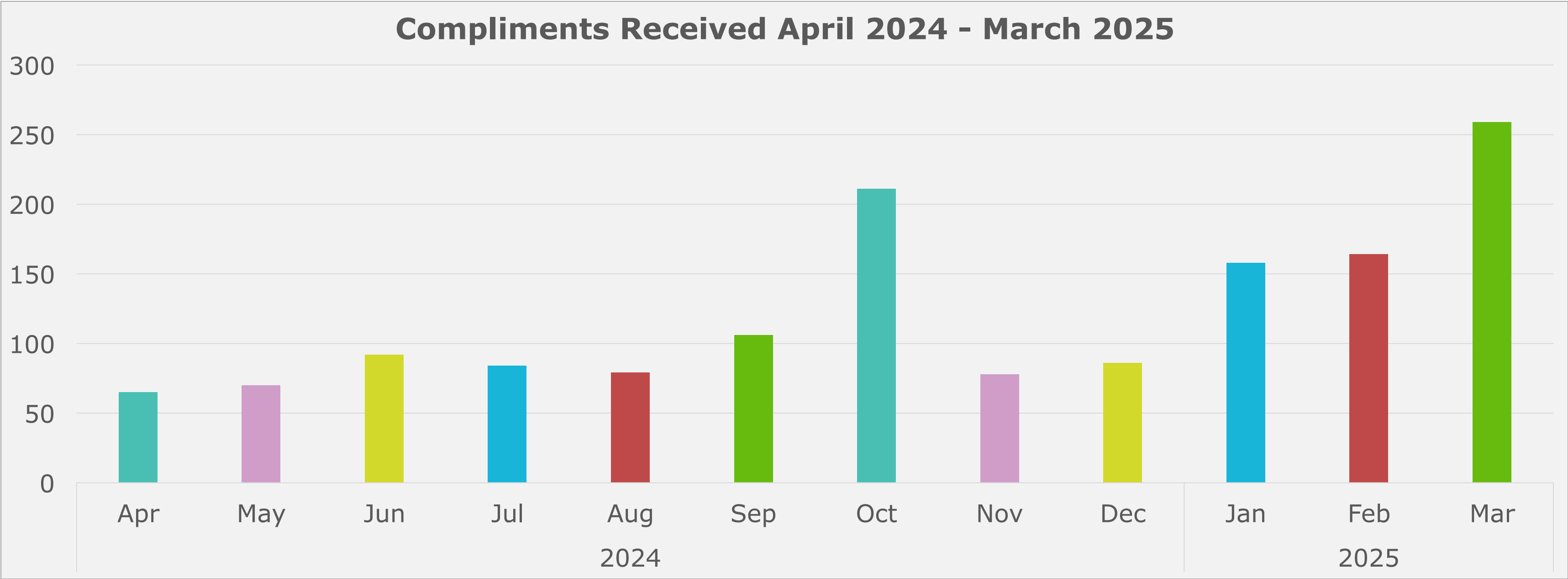
Development and near future deployment of a sticker with PALS contact details on every bedside locker

✓

Compliments

The Health Board receives compliments through various channels, such as letters, emails, telephone calls, cards, conversations, and social media. Compliments provide valuable feedback, highlight positive practices, support staff morale, and help measure patient satisfaction and drive improvement. Complainants often include a compliment within a complaint; areas are encouraged to share these with staff.

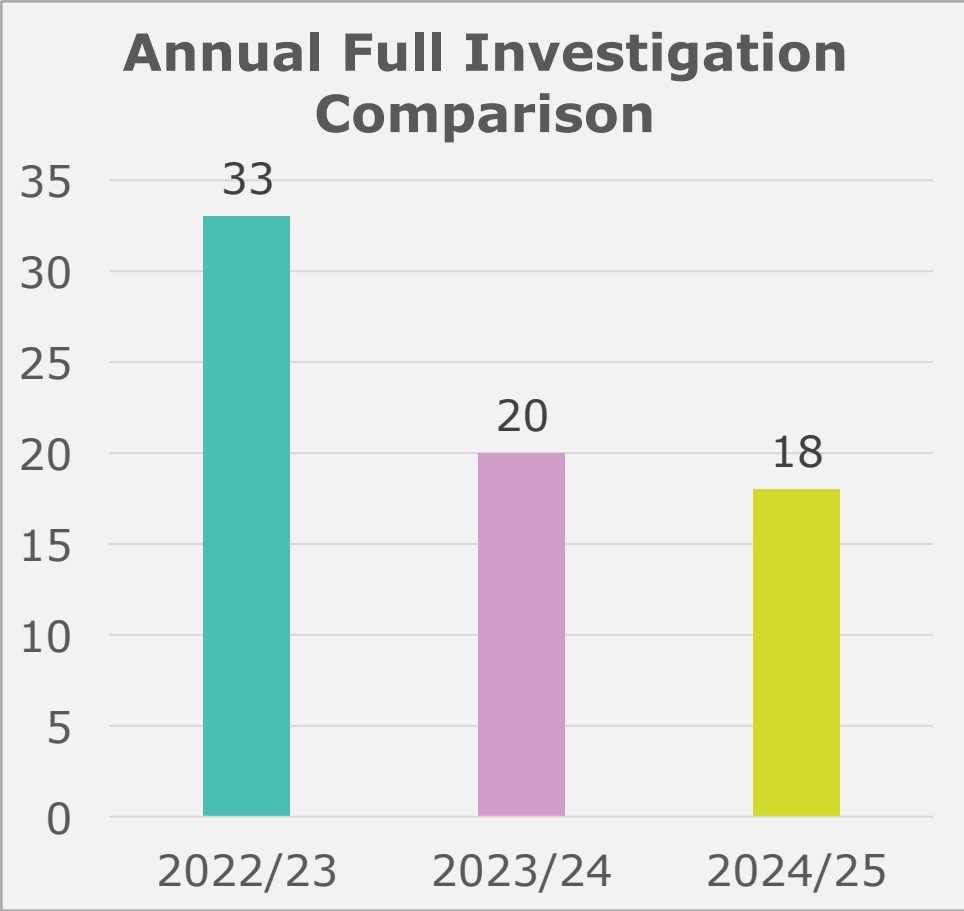
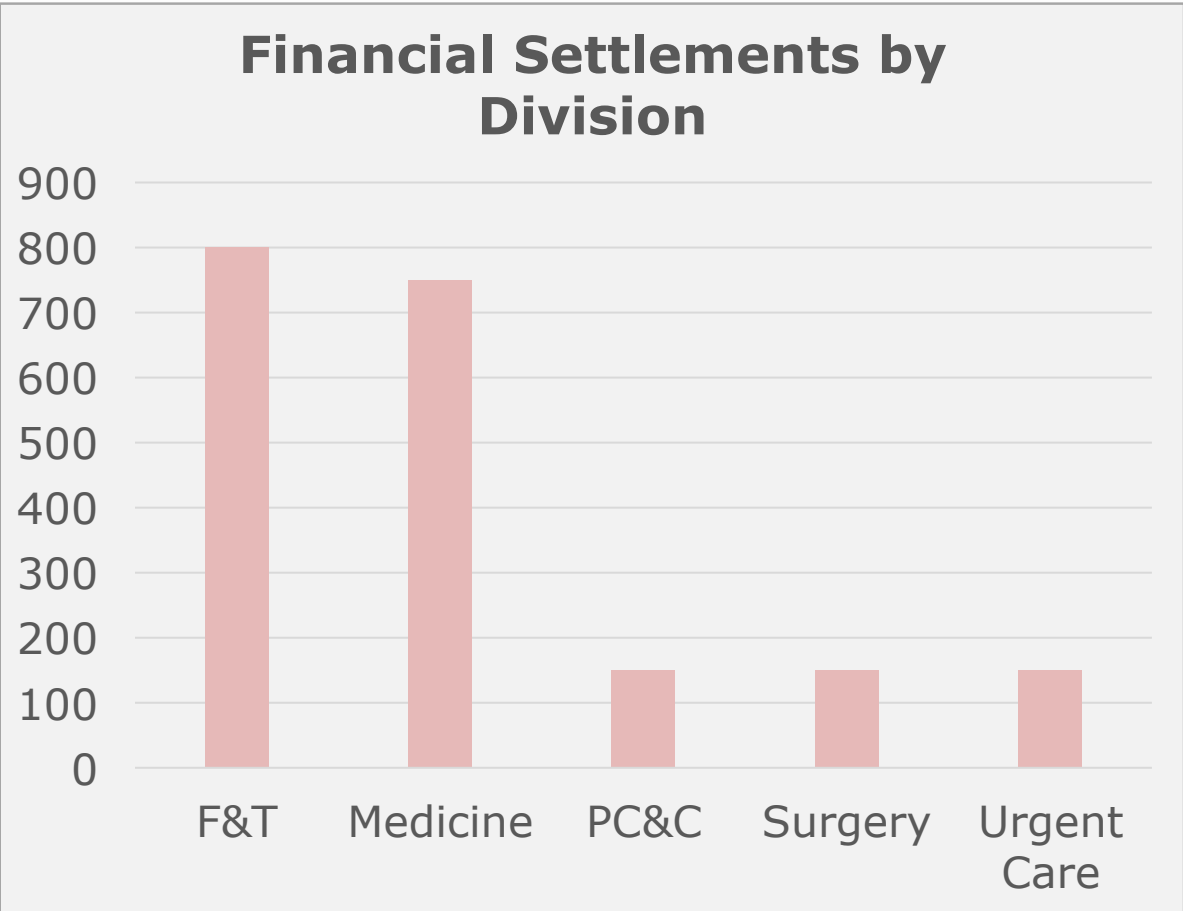
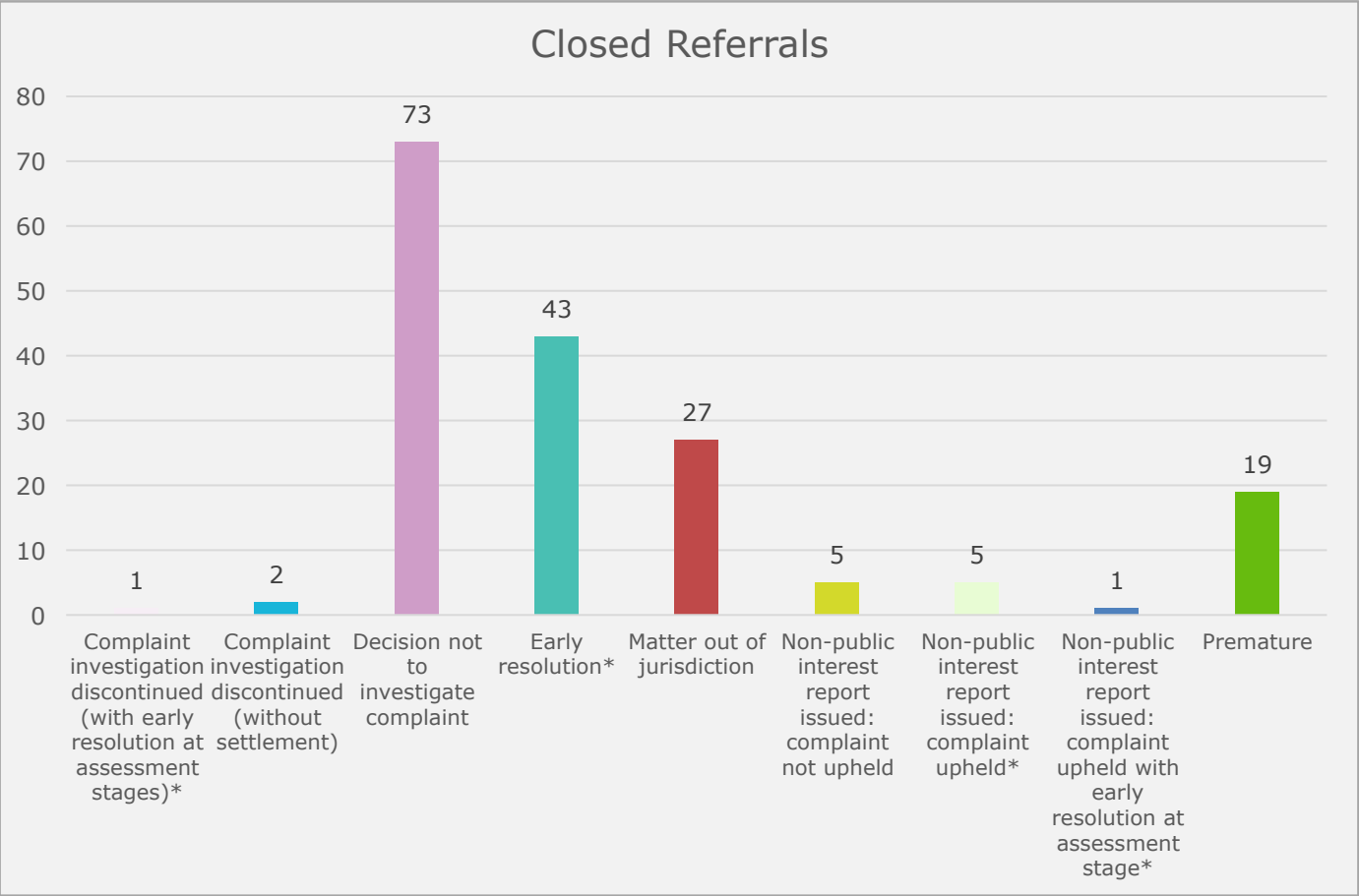
1452 compliments were captured on the RL Datix system during 2024/25 which is a 219% increase on the compliments recorded in the reporting period 2023/24. Further work is ongoing to have a more systematic approach to capturing compliments.



Public Services Ombudsman for Wales (PSOW)

In 2024/25, the Health Board held quarterly meetings with the PSOW Improvement Officer and Head of Complaints Standards, along with relevant managers, to address concerns and complaints. If a complainant is not satisfied with the Health Board's response, they may refer their case to the Public Ombudsman for Wales (PSOW), who provides independent and impartial support for issues involving public services and NHS organisations.

The PSOW ensures impartial delivery of public services, has the authority to uphold concerns, and can make recommendations for improvement. Despite efforts to resolve complaints, some cases may still be referred to the PSOW. The Health Board values collaboration with the PSOW to achieve positive outcomes for complainants and maintains agreed processes to meet deadlines whenever possible.



In 2024/25, the PSOW received 178 new referrals and closed 176 cases – including some carried over from the previous year. Of these, 1 complaint investigation was discontinued with early resolution at assessment stage*; 2 complaint investigations were discontinued without settlement; PSOW decided not to investigate 73 complaints; The Health Board settled 43 matters through Early resolution* and 27 matters were considered out of jurisdiction. There were 6 instances where non-public interest reports were issued, meaning 3.3% of the cases referred to the Health Board being upheld in 2024/25 compared to 25 cases being upheld in 2023/24.

The number of PSOW interventions decreased by 30%, from 37% in 2023/24 to 28% in 2024/25, reflecting a reduction in the number of full investigations conducted.

There has been a reduction in financial compensation awarded for the year 2024/25, representing a positive reflection of settlements ordered. In 2023/24 it equated to £3000.00, which was approximately 33.3% more than 2024/25 which was £2000.00. The Ombudsman has conveyed highly positive feedback regarding the Health Board’s achievements over the past year.

* Denotes intervention

Feedback from the Ombudsman including Learning and Actions Implemented

Of the six cases upheld by the PSOW, the main themes identified throughout the period relate to complaint handling. Specifically, the Health Board either did not adhere to PTR guidance appropriately or delayed sharing the findings of the investigation.

1

ACCOUNTABILITY AND GOVERNANCE

Systems and processes have been introduced to improve accountability and focus roles and responsibilities across the wider PTR team. This will ensure appropriate levels of escalation and monitoring oversight regarding concerns management.

2

CLINICAL DOCUMENTATION AND COMMUNICATION

Emphasis on documenting clear clinical rationale and management plans when deviating from BNF guidance. This has been cascaded to all relevant staff and included in trainee inductions.

3

COMMUNITY NURSING AND DOCUMENTATION MANAGEMENT

Community nursing teams are currently evaluating and enhancing documentation procedures in anticipation of transitioning to electronic records, with the goal of achieving greater integration through the All-Wales community nursing initiatives.

4

FLUID MANAGEMENT AND HYDRATION

Fluid management and hydration have been recurring themes in cases where PSOW has intervened. An Educating and Recommendations After Significant Events (ERASE) poster has been shared to highlight the Ombudsman's findings and ensure learning is shared.

5

LEARNING FROM ACCIDENTS AND INCIDENTS

The ABUHB Physiotherapy service has emphasised the importance of assessing patients who display unexpected mobility changes or lack of progress, and to request X-rays if necessary, considering joints above and below the site of pain.

6

CLEAR DISCHARGE GUIDANCE

Obstetrics, Gynaecology, and related services have implemented discharge information sheets advising on worsening symptoms, contact details, and fluid intake to prevent dehydration.

Legal Services: Claims

ABUHB Legal Services oversee the management of clinical negligence claims, personal injury claims, concerns progressed under the PTR Redress Scheme, and Coroner inquests.

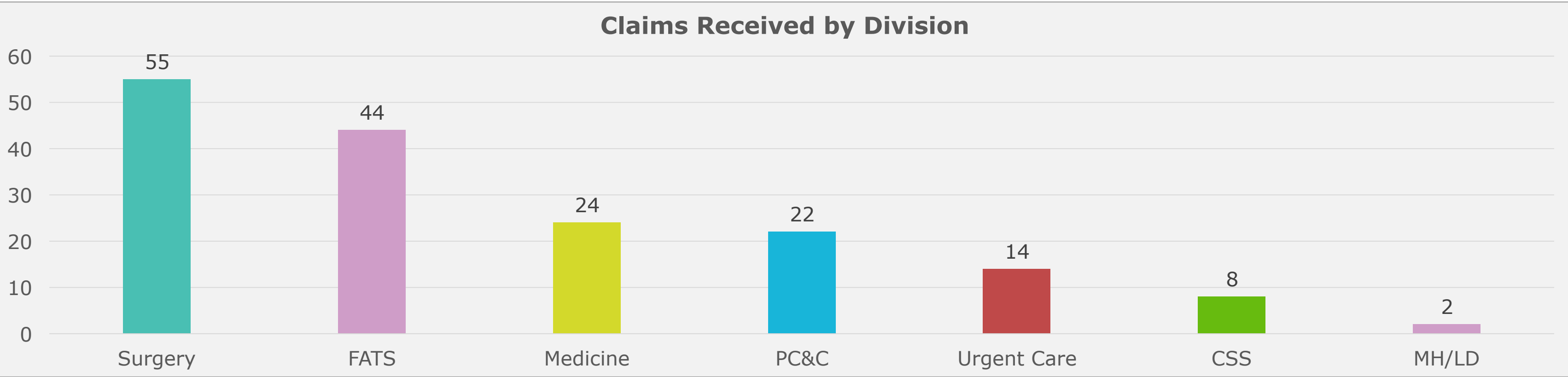
Quarterly Reports with data, analysis and learning are formally reported to Board by way of assurance and governance (2024-2025).

Clinical Negligence and Personal Injury are indemnified activities under the Welsh Risk Pool all-Wales indemnity scheme.

As at 31 March 2025 the Health Board had a combined 505 live claims under management.

Clinical negligence live claim numbers have increased to 422 with the preceding year at 368.

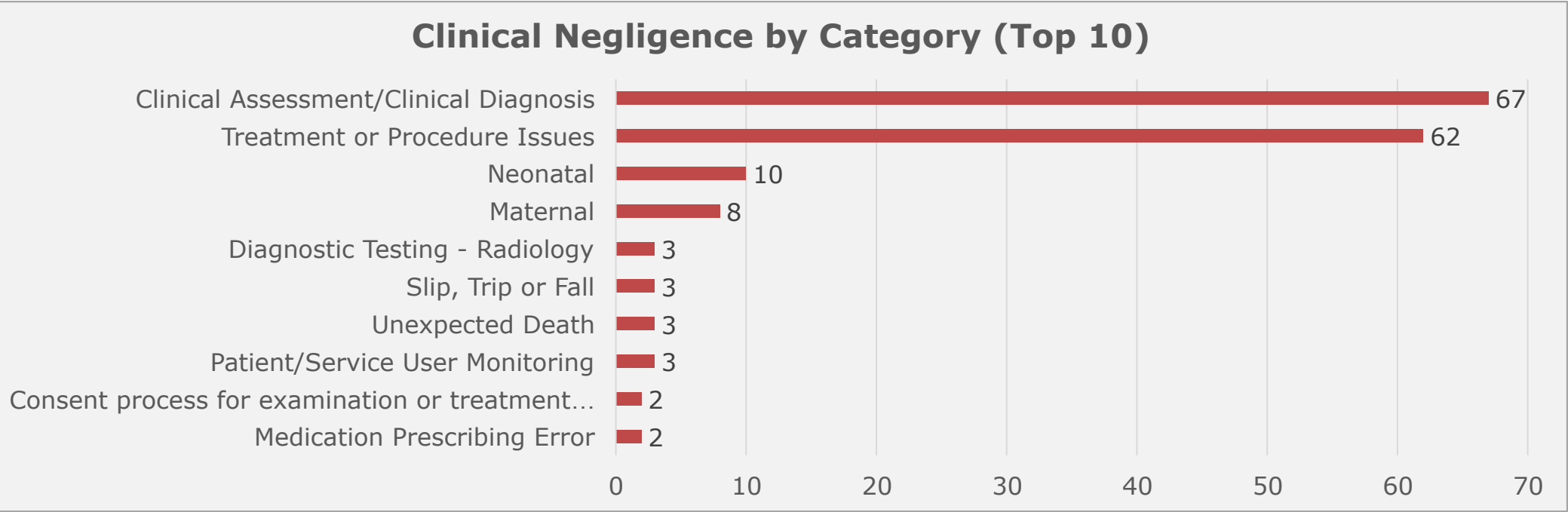
Personal injury claims continue a year-on-year 16-year downward trend with 83 live claims.



Clinical Negligence

The Health Board aims to provide its patients with the best level of healthcare and treatment possible. Most people do not experience any difficulties, but occasionally things can go wrong, and this may result in adverse outcomes for patients. This may then lead to people seeking out independent legal advice in relation to the care they received from the organisation.

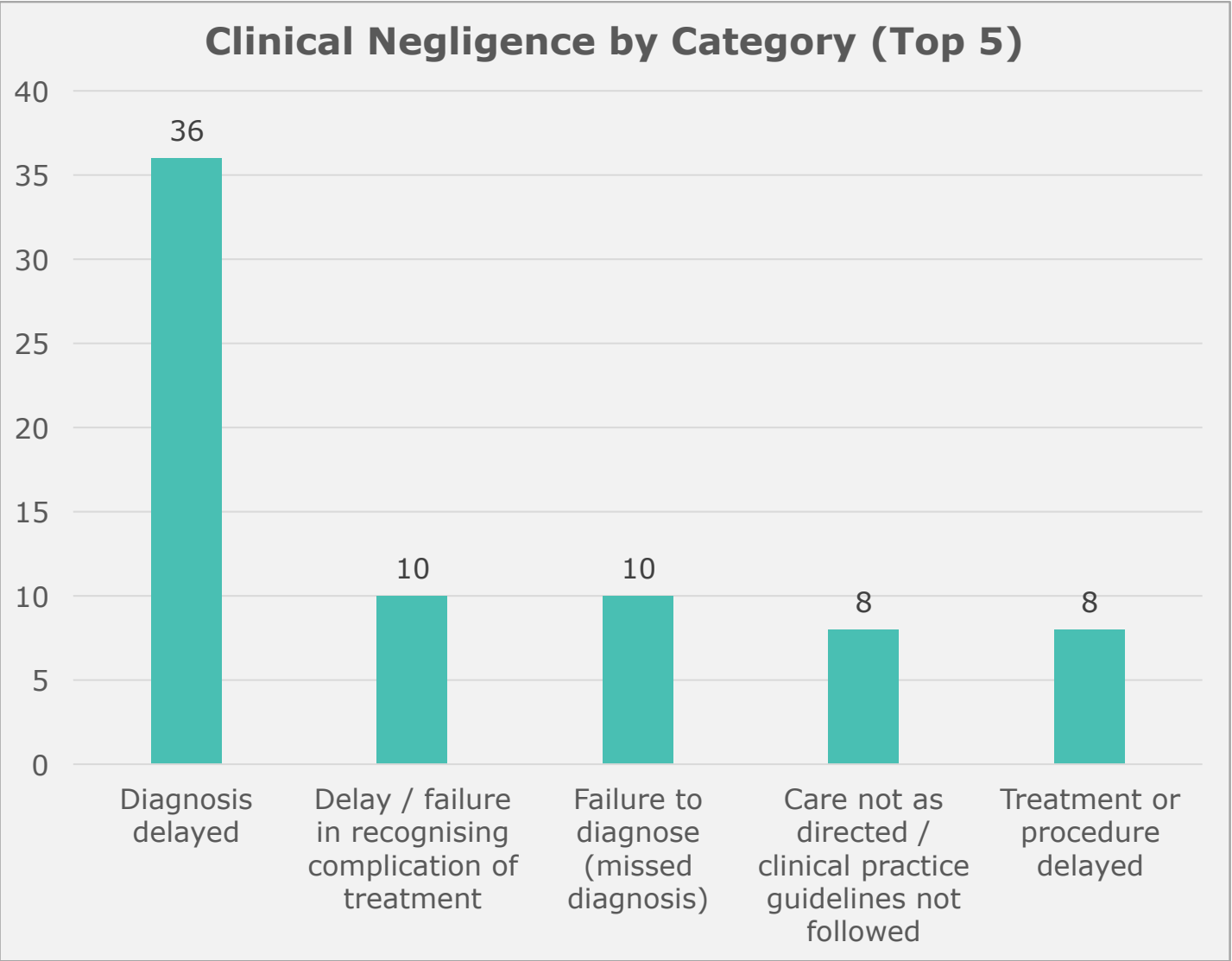
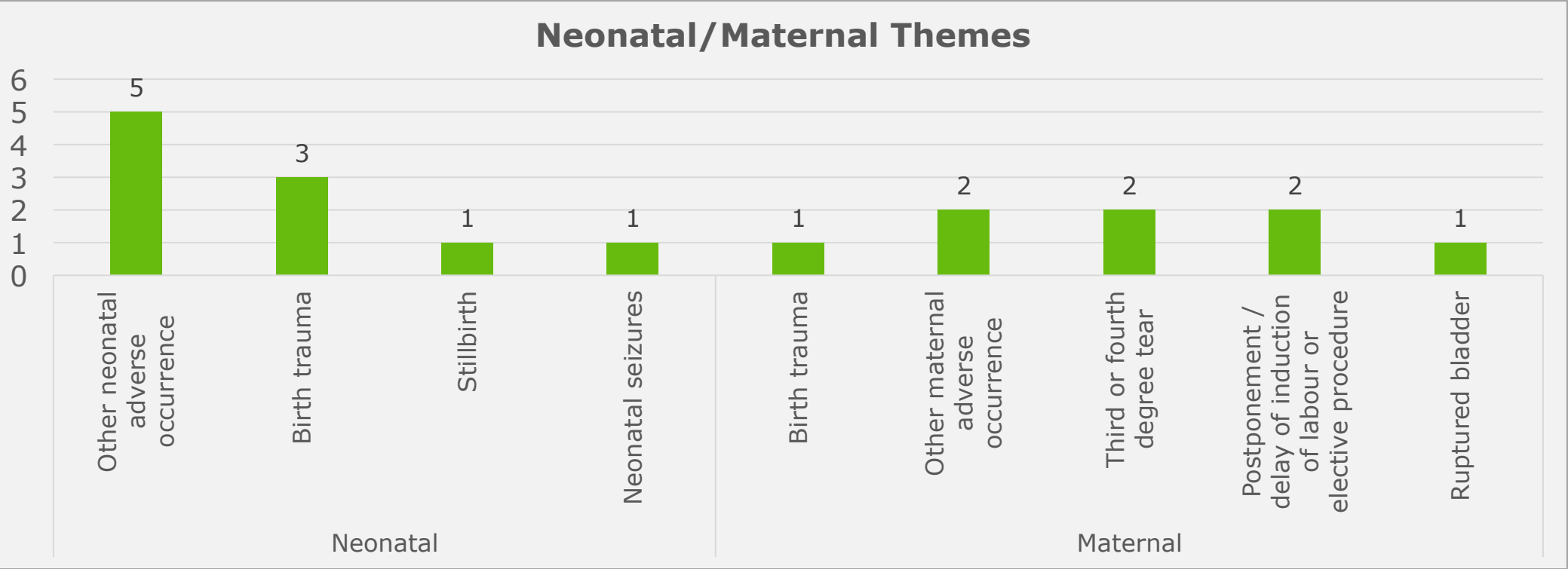
169 new clinical negligence claims were received during 2024-2025.



Claims are spread across Divisions and Directorates. Numbers are higher as expected in higher risk areas, including surgery, trauma & orthopaedics, urgent care, midwifery and obstetrics.

There continues to be a mixed picture in the detail of the cases, spread over multiple Divisions/Directorates, sites and timescales, with key themes:

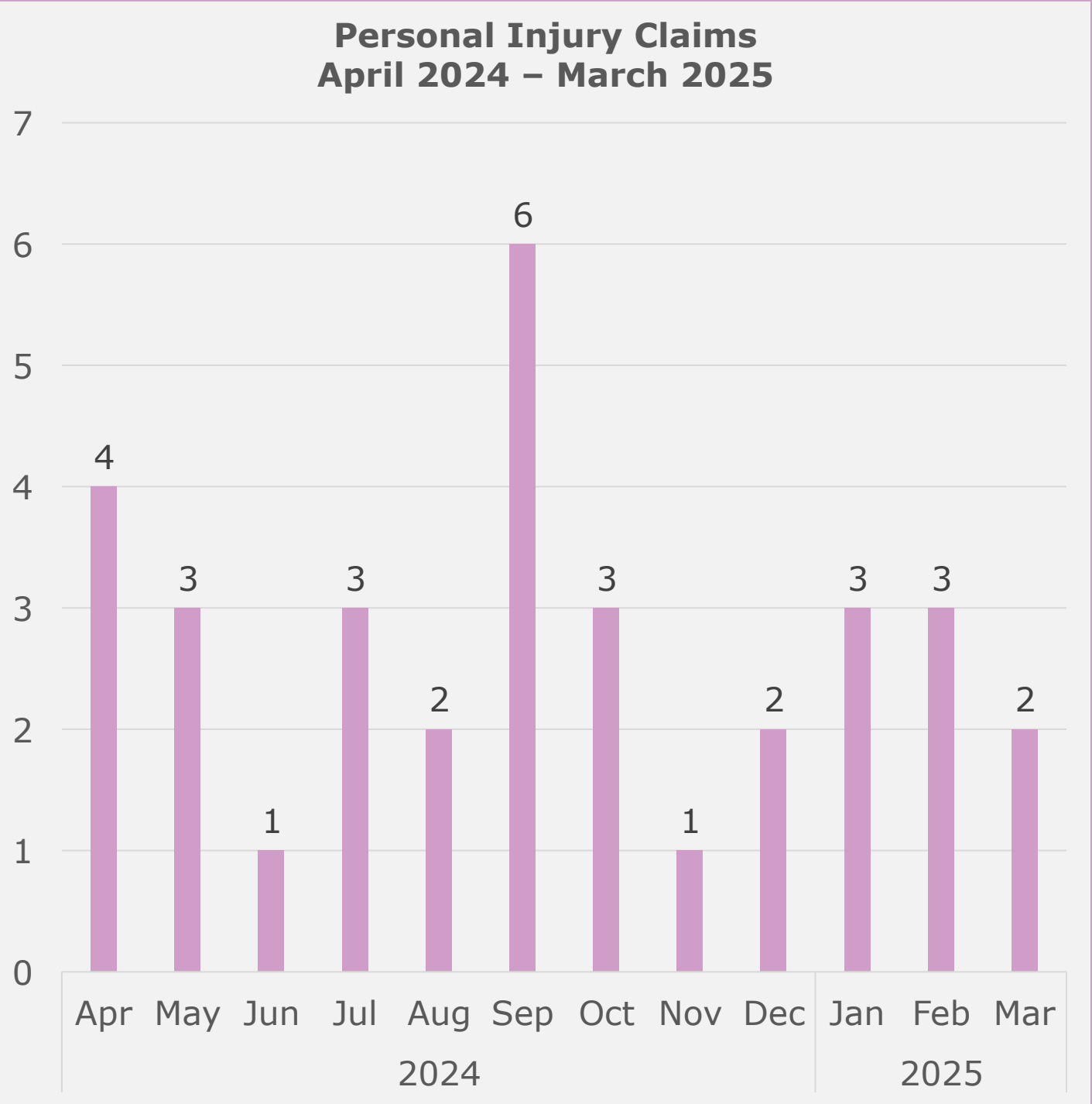
Further context on the Neonatal and Maternal categories:



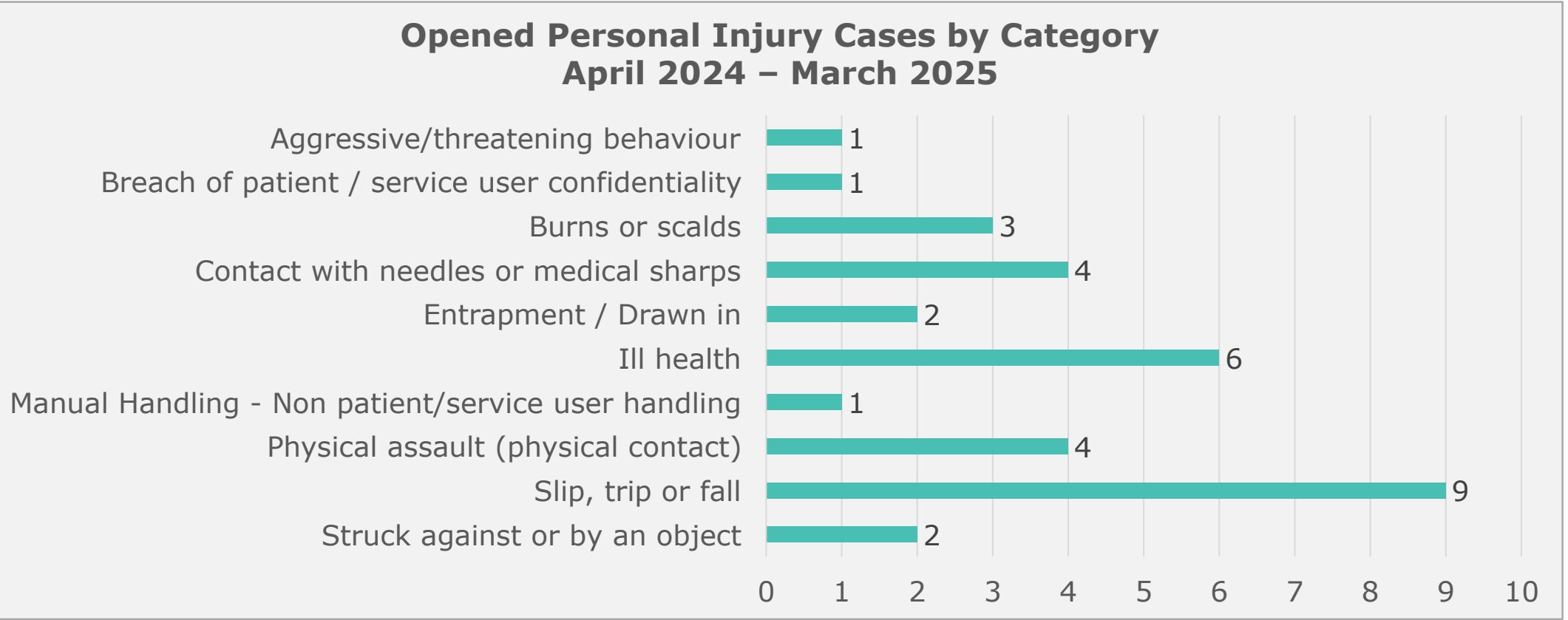
Personal Injury

Personal injury claims are a mixture of employer liability claims (injury sustained by employees within the course of their employment with the Health Board) and public liability claims (injury sustained by members of the public whilst on Health Board owned or managed premises).

From 1 April 2024 – 31 March 2025 the Health Board received 33 new personal injury claims. By way of comparison, over the same period in 2023-24, the Health Board received 38 new claims – this is a 13% decrease in new claims.



Personal injury claims have declined steadily over 16 years, with current live cases down to 83 from over 160. Of the 33 new claims this year, 85% were from employees. This sustained reduction reflects strong preventative efforts across the Health Board, with Legal Services managing all active cases.



Over the last 12 months, we have seen an increase in sharps cases and injuries involving burns/scalds. Please see exemplar learning in response to this.

Learning From Claims: Key Lessons and Improvements Implemented

- ✓ Staff are reminded to promptly report hazards and defects, such as unsafe infrastructure, to ensure timely repairs and prevent repeat incidents. Clear guidance has been issued to all community premises on their responsibilities.
- ✓ New guidelines and mandatory training for managers and supervisors have been introduced to strengthen local risk assessment skills, particularly in high-risk environments like showers and cleaning areas, preventing slips and workplace accidents.
- ✓ Reviews led to adjustments in equipment placements, such as relocating or deactivating hand dryers and switching to hand towels, to reduce slip hazards in bathrooms.
- ✓ Regular inspections, clear marking, and removal of faulty clinical waste bins are now policy. Contracts with external contractors are being updated to ensure robust procedures for checking and repairing critical equipment.
- ✓ Enhanced risk assessments, safety alerts, and staff reminders around sharps disposal and equipment checks have been implemented. There is now increased collaboration between Health and Safety and Estates/Facilities to reduce injuries from sharps and burns.



Governance and Assurance: All learning from claims is captured in Learning from Events Reports, scrutinised by the Welsh Risk Pool and Learning Advisory Panel, ensuring actions are robust, improvements are made, and learning is shared Health Board-wide.

Clinical Practice Improvements:

- ✓ Neonatology: Guidelines, training, and induction processes have been strengthened to improve management of neonatal hypoglycaemia. All staff have easy access to policies and participate in regular training.
- ✓ Surgery and Orthopaedics: Dedicated teaching sessions and audit meetings are used to address previous diagnostic oversights and share learning on fracture assessment.
- ✓ Emergency and Paediatrics: Clear rules now require all children with repeat visits to be reviewed by a senior doctor, improving early identification of serious conditions.
- ✓ Primary Care: GPs are encouraged to use standard assessment tools, such as the NICE 7-point checklist, to improve cancer detection and referral practices. Learning is shared across teams.
- ✓ Maternity: Updated guidelines, training, and patient information materials now support better post-natal bladder care, with learning shared widely among midwives.
- ✓ Radiology and Emergency Department: Cross-divisional sharing of learning stresses the importance of correct imaging procedures and documentation, with training updated accordingly.

Redress

Redress is a range of actions that can be taken to resolve a concern.

- An apology and explanation of what happened;
- and/or an offer of treatment/rehabilitation to help relieve the problem;
- and/or financial compensation. In these cases there has to be consideration of Breach of duty and Causation.

The Health Board manage a redress portfolio in accordance with the PTR regulations. This involves assessing concerns/investigations where a breach of duty of care has been identified causing moderate harm or above. Redress cases are currently capped at £25,000.

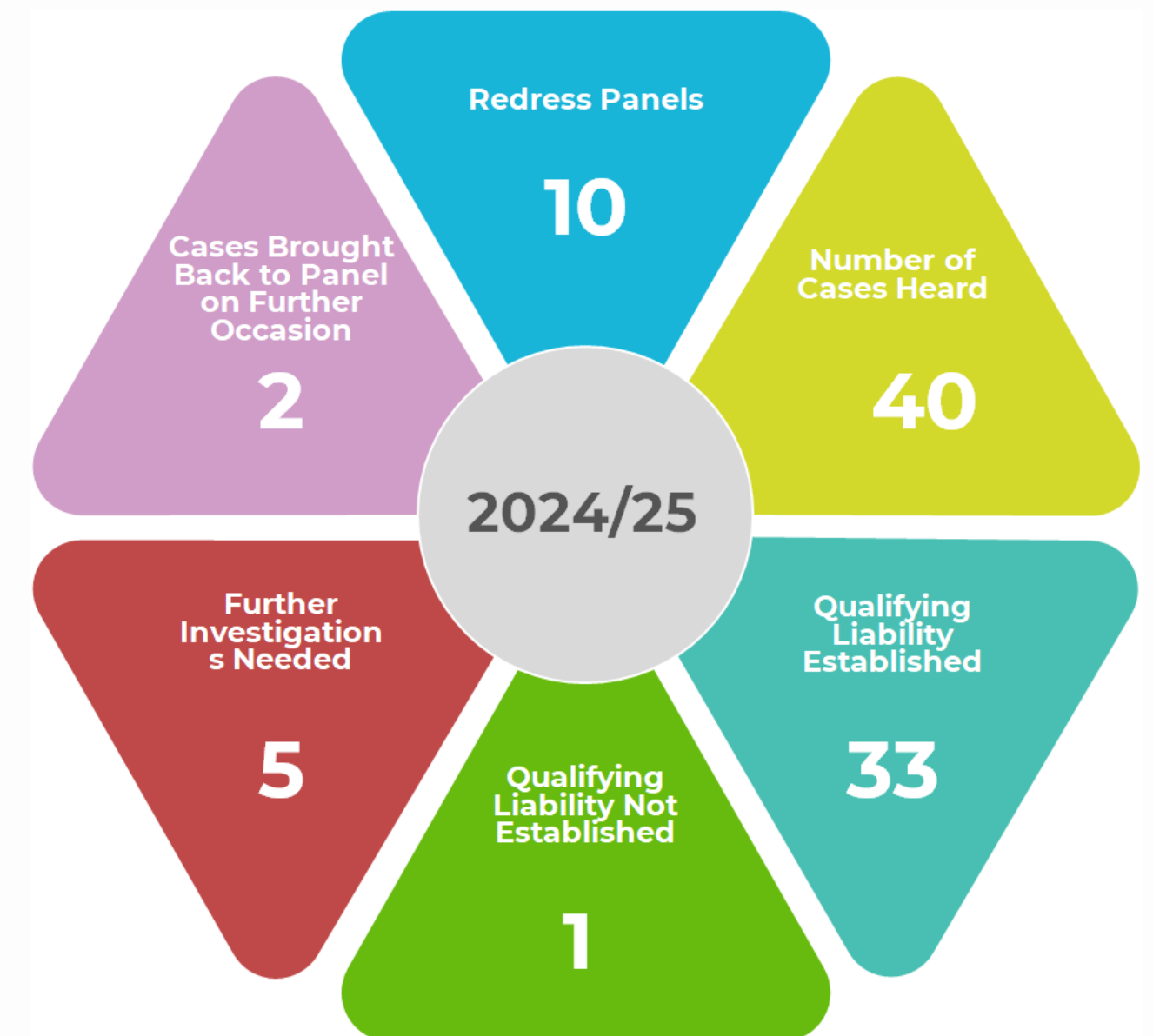
There are significant benefits to the redress scheme. Often the alternative route available to patients/families is the option of pursuing a clinical negligence claim.

Redress allows the Health Board to make an early admission of liability. This early dialogue is often appreciated by patients/families who find it beneficial during distressing times.

Data for 2024-25 is consistent with the previous year, with a similar number of cases of qualifying liability determined both years. The data demonstrates higher referrals to redress from the emergency department and obstetrics, this is unsurprising given these are “high risk areas” from a claims/litigation perspective. In addition, these are departments which proactively refer matters under the redress scheme..

The majority of cases concerned issues of delayed diagnosis and failure to diagnose. The previous year, the category of “clinical treatment including delayed diagnosis” was the highest category. As such, there appears to be little change in the trend on themes. Pressure ulcer cases have reduced in numbers in comparison with the previous year.

Whilst again the largest class of cases, there continues to be a very mixed picture in the detail of the cases, spread over multiple Divisions/Directorates, sites and timescales, with no evident area of concern or outlier identified.



Learning From Redress

Every case presented to the Redress Panel is the subject of consideration of any immediate actions or follow up actions to prevent future patient harm or improvement in services, including the assurance of personal learning and reflections where appropriate.

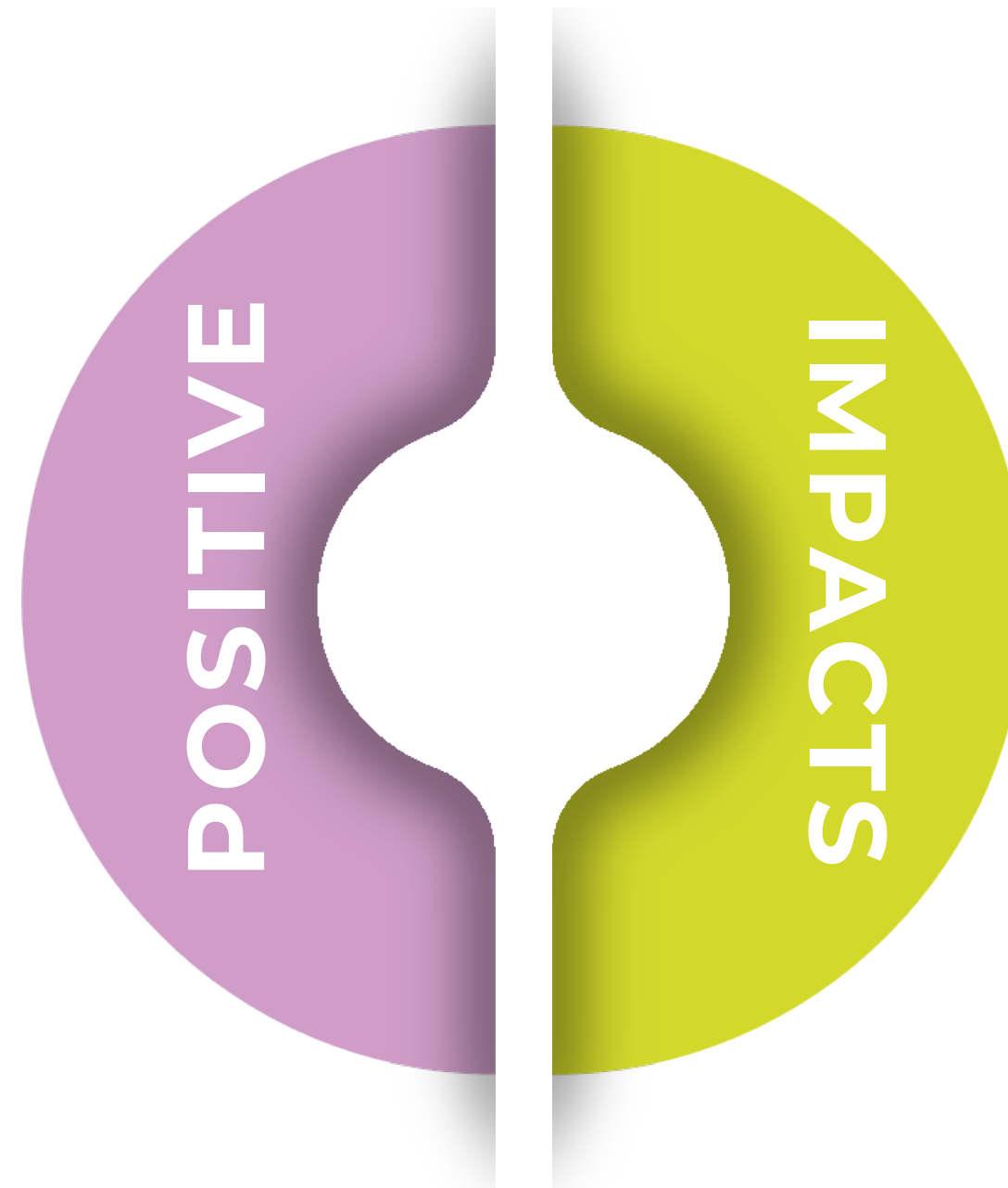
A Divisional Learning from Events Report (LFER) is produced for each case, setting out the key 'issues' identified from the investigation and the resulting 'actions' by way of learning/improvement/assurance of all actions taken and to be taken to prevent future harm. Where a qualifying liability is identified every LFER will then undergo several stages of vigorous scrutiny and assessment by the Welsh Risk Pool, including clinical and peer review via a 'Learning Advisory Panel' (LAP) to provide robust assurance and approval of the Health Board's actions taken, improvements and learning.



Improvements in stroke care have been implemented following a case involving delayed thrombolysis, including increased specialist nurse staffing and enhanced training for ward nurses in stroke management and administration of thrombolysis.



Maternity practices have been updated to reduce the risk of retained swabs, with induction programmes and induction packs now reinforcing swab counting procedures during births.



Mandatory 'Gap training' for all staff is being closely monitored, with compliance and audit evidence provided to ensure continued improvement in clinical practice.



Guidance on the induction of labour for patients with gestational diabetes is under review and clarification, prompted by a redress case, to ensure clear and safe planning for timing of birth.



Inquests

Inquest Data 2024/25 Financial Year	
Inquests opened in year:	349
Total Open live inquests (31/3/25):	241

Concluded Inquests	
Inquests in Writing 231	• Inquests where the Coroner feels assured by the witness statements and reports • Without the need for Health Board staff to attend • Savings on clinical time and resource • 77% of concluded inquests
Inquests in Person 68	• High profile/complex cases • High numbers of staff attending • Over several days in length • 23% of concluded cases

Increasing volume	
Q1-3 (April-Dec 2024/25):	226 new Inquests (= 25 pm)
Q4 (Jan-March 2025):	123 new Inquests (= 41 pm)
% increase per month in Q4:	Monthly increase of 64 %

Over the last 3 years, the Health Board has seen a year-on-year growth in the number of new Inquest matters.

Regulation 28 Prevention of Future Death Reports	
Inquests concluded in year:	299
Regulation 28 Reports issued:	3
Reports issued to Inquests heard as %:	1%
Decrease for 2024-25:	5 reports for 2023-24
Themes / Trends:	There were no connecting themes or trends

Standard Operating Pathway (SOP) – Inquest Management
This year the Legal Team have developed a SOP with regards to the management of Health Board Inquest files. The intention is to drive improvement in consistency and timeliness of management of the Health Board’s Coronial matters

Inquests

The Health Board has strengthened its approach to inquest management, developing clear procedures and prioritising consistency and timeliness. Emphasis has been placed on learning from inquests, with the sharing of reports, action plans, and lesson learning statements to improve practice and promote organisational learning. Enhanced collaboration with the Coroner's Office—including meetings, staff sessions, and relationship building—has further supported this work and contributed to a reduction in Prevention of Future Deaths reports. Feedback and debrief sessions post-inquest have been positively received, reinforcing a culture of openness, improvement, and support for staff and families.

Health Board staff are supported throughout their inquest journey at every stage, from initial notification, to statement, to preparing for and attendance at inquest, and post inquest de-briefs, working with Divisional peer support colleagues.

Positive feedback received from staff this year has included -

Staff Feedback

Thank you for all your help, it made the experience much easier than I had worried it would be.

Your guidance on the inquest procedure, help to secure relevant statement bundles, and your presence on the day itself was invaluable. It really made a difference to have such thorough support throughout the process.

You have been completely accessible throughout this whole process, offering expert advice, support and reassurance, and I for one am very grateful for that.

I was really nervous going in but thank you for all your support and advice it made it much easier.

Can I just thank you once again for all your help in the preparation of my statements - all your help has been very much appreciated.

I really appreciated your support, and the support of legal services for the duration of the process. A big thank you from me, and please do extend this to the wider team.

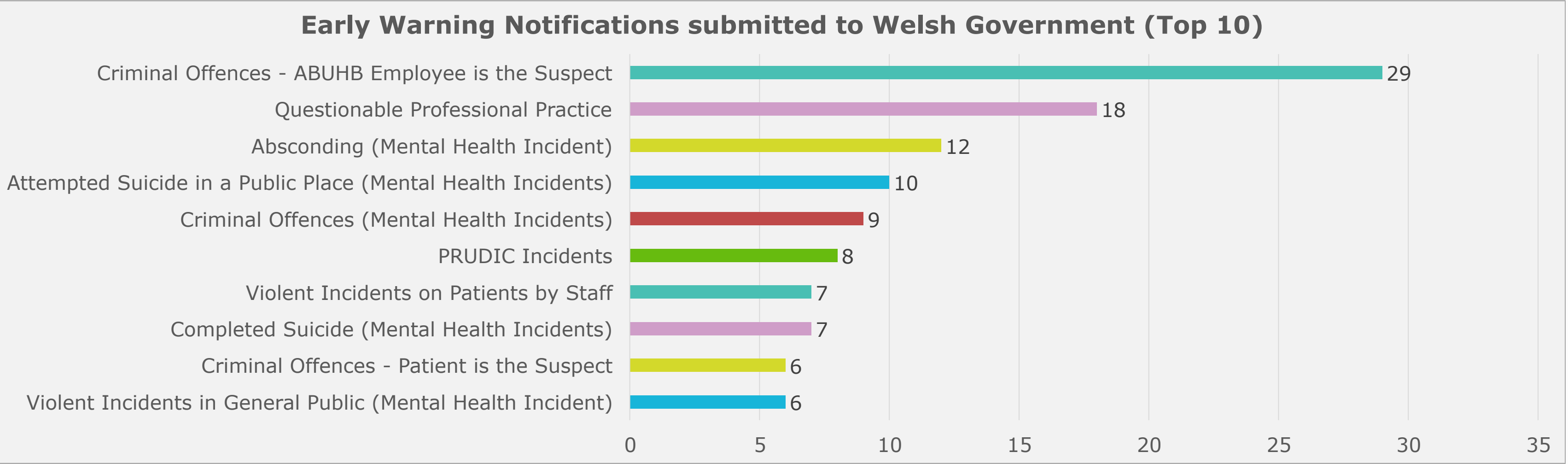
Early Warning Notifications (EWN's)

An Early Warning Notification (EWN) is a formal communication mechanism used to rapidly alert Welsh Government to issues that may or may not involve patient safety incidents but could impact:

- Service provision
- Organisational reputation
- Media coverage
- Political sensitivity
- Public interest (e.g., Regulation 28 inquests or PSOW reports)
- Positive developments worth highlighting

They are distinct from Nationally Reportable Incidents (NRIs), though both processes must be followed if an incident qualifies for both.

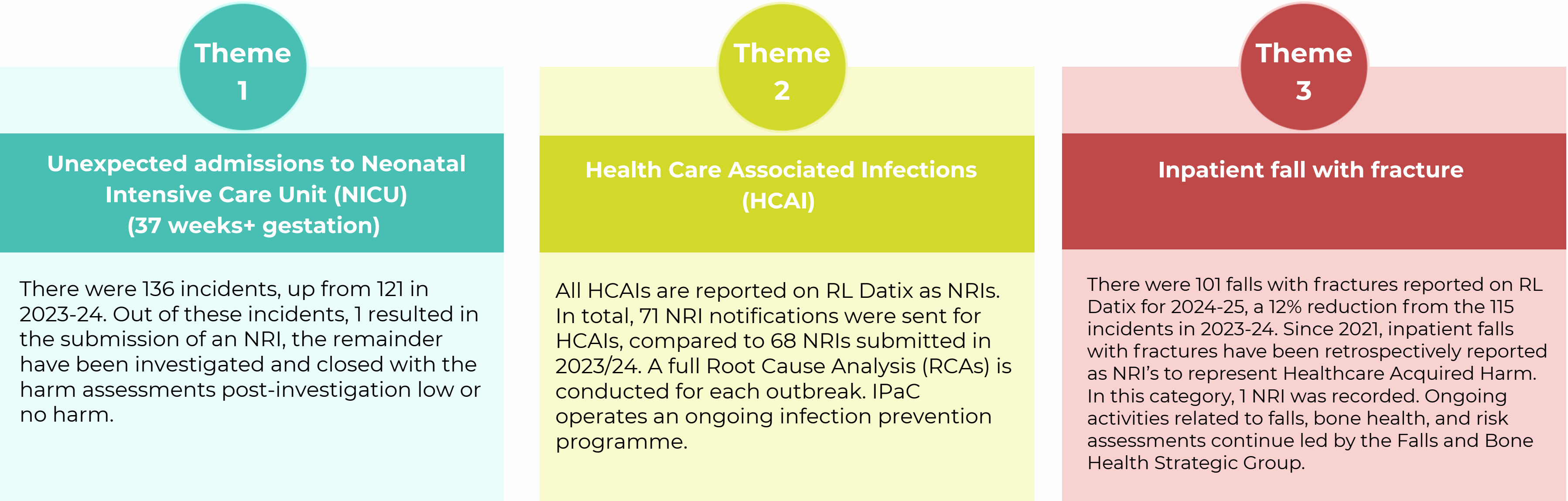
During the reporting period, 142 Early Warning Notifications were processed, compared to 127 in the previous year. The top 10 themes were:



Patient Safety Incidents

From 1 April 2024 to 31 March 2025, a total of **25944** patient safety incidents were reported via RL DATIX across all ABUHB sites, representing a 3.95% increase from 2023-24. Following investigation, 25,617 (98.74%) incidents were categorised as resulting in no or low harm. During the reporting period 161 patient safety incidents met national reporting criteria, reflecting a decrease from 187 in the previous year. Never Events, which are serious and preventable incidents, continued to decline, with only two reported this period—one historic case and one wrong-site surgery. This downward trend demonstrates the effectiveness of ongoing safety measures and quality improvement. This increase is representative of the Health Boards safety culture, and staff willingness to report to enhance organisational learning.

Top Three Patient Safety Incident Themes

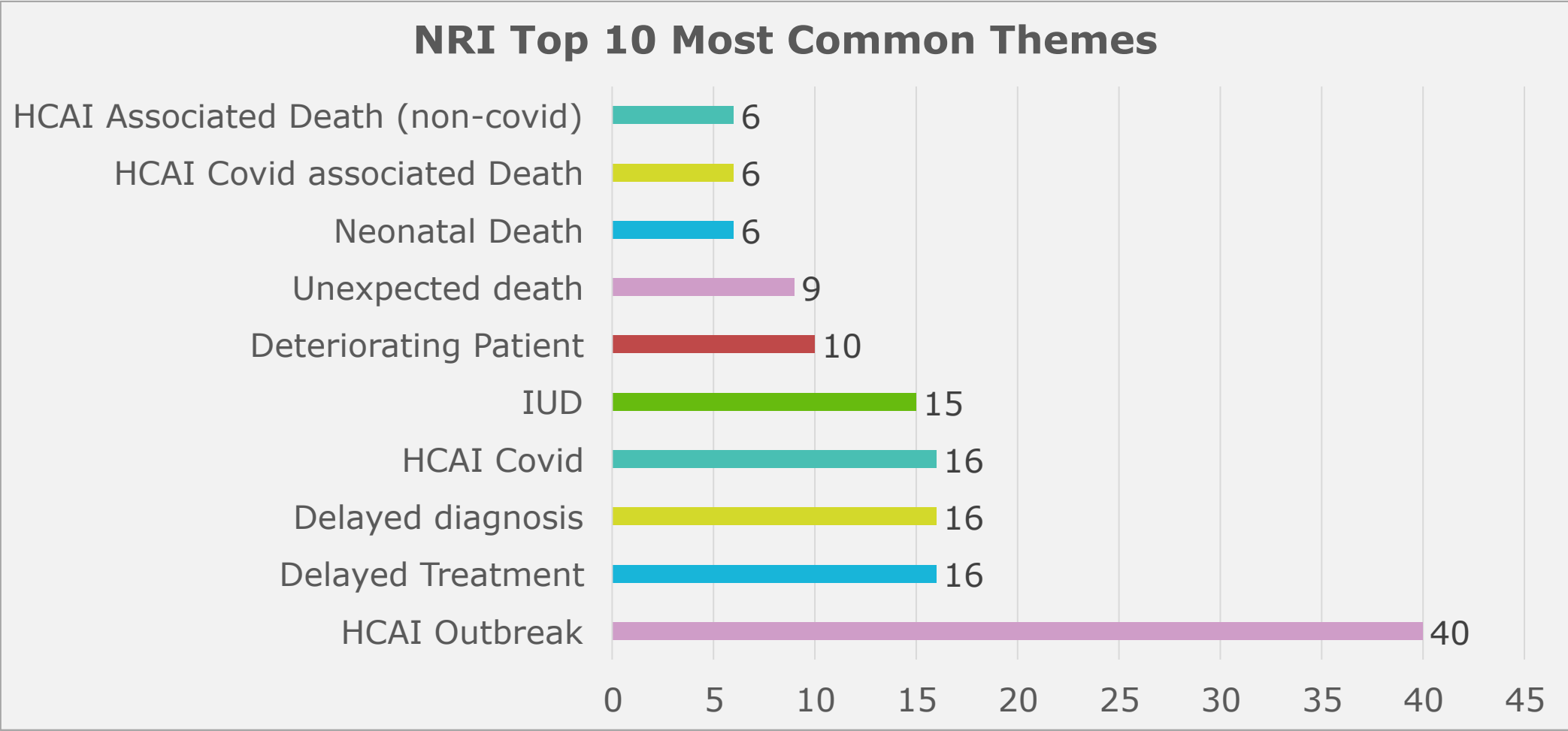


Patient Safety Incidents (PSI) resulting in Moderate harm and above including Never Events in the reporting period undergo scrutiny by the Clinical Executives on a weekly basis to determine level of investigation required.

Nationally Reportable Incidents

A Nationally Reportable Incident (NRI) is a patient safety incident that has caused or contributed to the unexpected or avoidable death or severe harm of one or more patients, staff, or members of the public during NHS-funded healthcare. Patient Safety Incidents that meet the reporting criteria of the National Reporting Framework are reported to the NHS Executive as NRI's.

From 1 April 2024 to 31 March 2025, 161 incidents were identified as meeting the reporting criteria of the National Reporting Framework. This demonstrates a decrease in reported incidents in comparison, to the reporting period of 1 April 2023 - 31 March 2024 187 PSIs were reported which could be reflective of the criteria for Duty of Candour (moderate and above).



Never Events

Never Events are one of the categories of Patient Safety Incidents that are always nationally reportable, even where no harm has occurred. These are defined as:

“Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers”.

Reduction in Never Events

During the reporting period, two Never Events were captured. These included: -

- 1) A historic case from 2010 relating to a retained guidewire after a vascular procedure
- 1) Wrong site surgery (wrong site dermatology biopsy).

The Health Board has observed a consistent decline in Never Events, decreasing from 10 in 2021-22 to 7 in 2022-23, and further down to 5 in 2023-24.

Duty of Candour

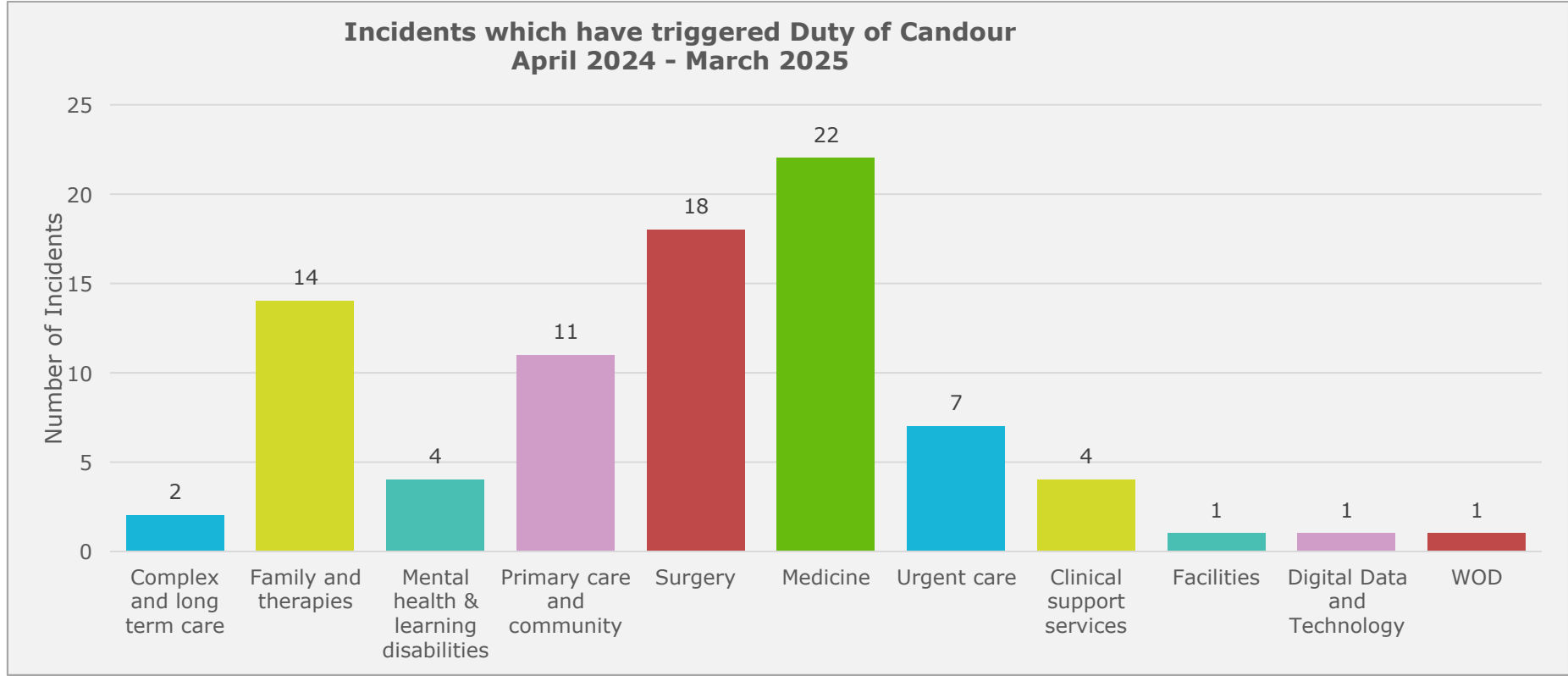
The Duty of Candour came into effect on 1 April 2023 with statutory provisions set through the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

The organisational duty on all NHS bodies requires incident reporting, management and investigation into the circumstances of a notifiable adverse patient safety event to be undertaken in an open and timely manner, including any actions to be taken under the Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011.

The Duty of Candour is triggered when a review of an adverse patient safety event identifies that the service user experienced, or could experience, unexpected or unintended harm that is more than minimal (moderate, severe, death), whilst in receipt of NHS funded care and where the provision of health care was or could have been a factor in that harm occurring.

In preparation for this transition the Health Board reviewed its management of incidents, systems and processes to align to the requirements of the Duty of Candour to minimise disruption to service user experience.

Following the DoC triggered by management review of incidents, there were 85 incidents that were found to be healthcare related harm.



Over the past year there has become a better understanding amongst staff of the definitions of the Duty of Candour and the difference between actual harm and healthcare associated harm as defined by the Law. The focus of the organisation going forward must be to improve compliance with the requirements of fulfilling notification and outcome correspondence following the investigation.

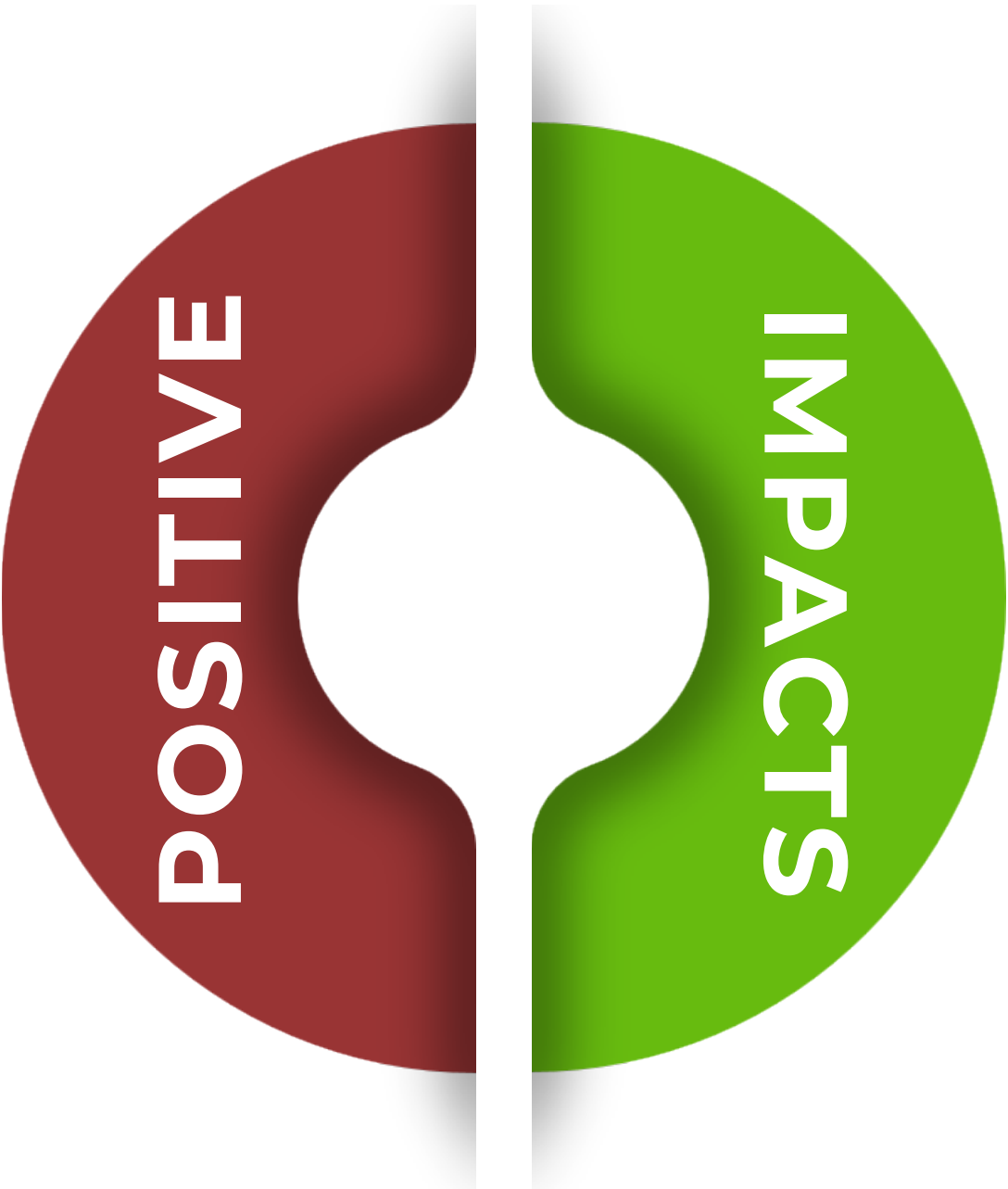
Next Steps for 2025/26

- Relaunch Duty of Candour (DoC) training on ESR for staff who have not undertaken this. DOC training to become mandatory to all patient facing staff with the Health Board.
- The Assistant Head of Quality Patient Safety will oversee organisational efforts to improve compliance with, and understanding of, statutory requirements.
- Encourage Divisional use of DoC dashboards to provide visual cues of requirements.
- Implement changes and improvements based on lessons learned.
- Foster a culture of continuous learning and improvement.
- To produce quarterly data for divisional review at the QPS, Learning and Improving meetings.
- Learning and Improvement to be discussed at Patient Quality and Safety Learning and Improvement Forum.

Patient Safety: Learning and Improvement Initiatives

The organisation has embedded a multi-layered approach to capturing and applying learning, including:

- ✓ Divisional accountability for implementing actions and sharing learning through reports and presentations
- ✓ Integration of incident, complaint, audit, and patient feedback data
- ✓ Quality Outcomes Framework to monitor progress and drive decision-making
- ✓ Support for a positive, learning-focused safety culture aligned with national standards
- ✓ Acute Medical Unit (AMU): Staffing adjustments and improved handover processes were implemented following incidents related to patient deterioration and escalation, enhancing capacity management and medical follow-up.



- ✓ Nutrition & Hydration: Investigations identified the need for board-wide protocols and multidisciplinary coordination, especially for vulnerable patients. An Executive-led task and finish group was established to improve nutritional assessment, monitoring, and referral processes.
- ✓ Bell's Palsy: Delayed diagnoses led to a health board ALERT and a standardized referral pathway to ENT, in line with NICE guidance, to raise awareness across primary care and emergency settings.
- ✓ Avoidable In-patient Falls: There has been a reduction in avoidable, injurious falls classified as Serious Incidents, reflecting ongoing safety improvements.
- ✓ Nosocomial Measles Outbreak: Lessons learned prompted new measures, including a Pre-Triage Screening Questionnaire to better identify and isolate potential cases.

These initiatives demonstrate a commitment to learning, continuous improvement, and enhanced patient safety across the organisation.

Patient Safety Team

The corporate Patient Safety Incident (PSI) Team oversee the investigation and management of Patient Safety Incidents where patient harm is moderate, severe or catastrophic.

Key Achievements for 2024-2025 include:



ABUHB Patient Safety Incident Reporting & Management Policy further updated and refreshed to map to current best practice, patient and family feedback.



Embedding of revised PSI Reporting template incorporating current best practice in Human Factors methodologies.



Patient safety incidents information leaflet updated to align to Duty of Candour.



Reduced NHS Executive historical case closures and improved NRI closure compliance.



Recruitment to vacancies within the team.

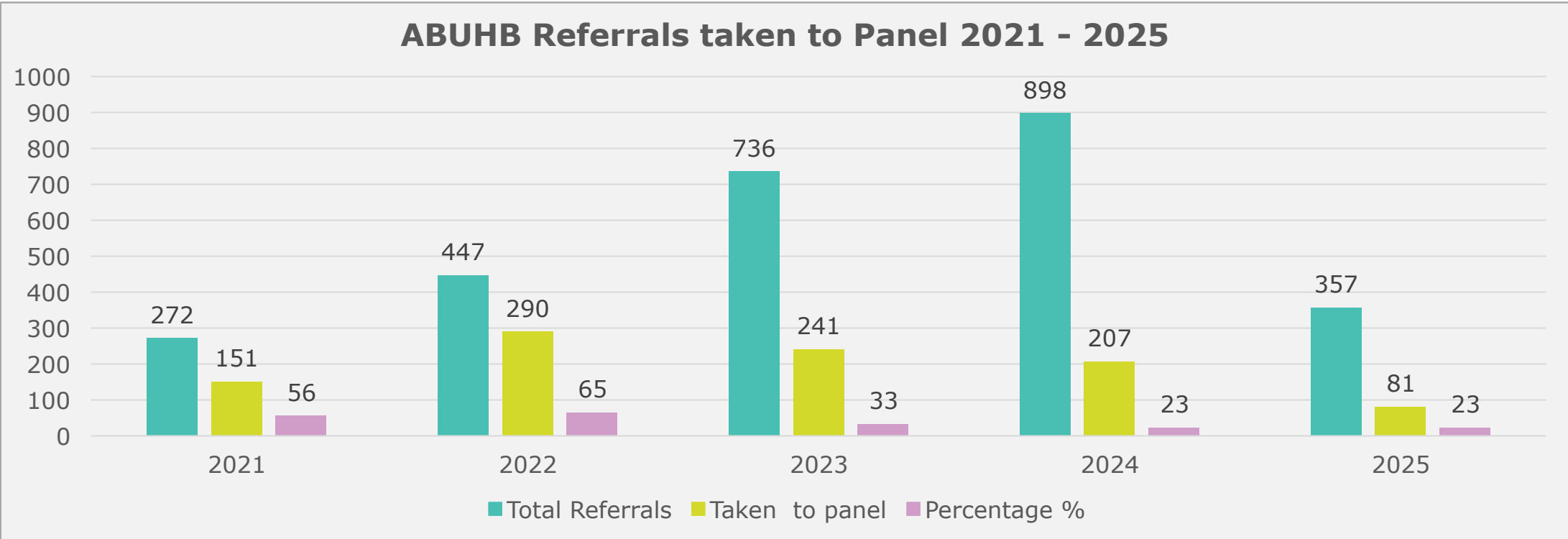


Providing individual support for Investigating Officers

Medical Examiner Service and Mortality Review Screening Panel

The Medical Examiner Service (MES) in Wales, hosted by NHS Wales Shared Services Partnership (NWSSP), provides independent scrutiny of deaths not referred to the coroner. Experienced Medical Examiners (MEs) ensure the accuracy of death certification, identify concerns for further review, and take into account the views of the bereaved families. To maintain impartiality, MEs are employed by NWSSP and avoid reviewing deaths from their own work areas. The service offers external oversight and refers concerns back to Health Boards. MES was introduced in January 2021 and achieved full coverage across hospital, primary care and community settings by the end of 2024. MES findings are shared with care providers to support system-wide learning. This included identifying patterns in causes of death and enabling Health Boards to reflect on and respond to concerns. It provides families with a transparent way to raise issues, aligning with the goals of Putting Things Right. Referrals MEs that require a case review are assigned to a member of the Health Board’s Mortality Review (MR) Screening Panel. This is a multidisciplinary group with cross divisional representation that meets weekly. An assigned panel member reviews and presents the case to the group, which then determines whether further investigation is warranted. Recommended actions are clarified and communicated to the relevant team or clinician for completion. To reinform learning, a biannual newsletter is produced that shares key themes and insights from MES referrals and reviews. All ME-referred deaths undergo a structured three-level review process:

Level 1:	Initial review to determine if further investigation is needed.
Level 2:	Cases requiring escalation are reviewed by the multidisciplinary Mortality Review Screening Panel, which meets weekly to assign actions.
Level 3:	Actions may include clinical reviews at Mortality and Morbidity (M&M) meetings, investigations under the Putting Things Right (PTR) process, or specialist panel reviews (e.g. Falls Review Panel).



Over a 12-month period, a total of 843 ME referrals were received in 23/24, this constituted 30% of the total deaths at ABUHB during that period. 715 cases between 2024/25, representing approximately 37% of all ABUHB deaths during that time.

The Health Board produced a twice-yearly report on Learning from Deaths, which includes a Framework on mortality rates, MES data, trends, learning and improvement. The Mortality Screening Panel publishes a twice-yearly newsletter, sharing learning and raising awareness, highlighting themes and insights from MES referrals

Learning Overview and Trends:

No Further Action: These referrals have decreased, likely due to improved referral quality and increased local sharing by the Health Board's Mortality s MR Screening Panel. Many involve concerns already under review via other processes (e.g. Datix).

Infection Prevention & Control Referrals: Declined in line with reduced nosocomial COVID-19 cases.

Serious Incident (SI) Referrals: Continued to fall, possibly due to earlier proactive management of incidents.

HMC Referrals: Increased compared to previous periods—trend to monitor.

Closed on Datix: Closure rates have improved significantly, though further progress is still needed.

Thematic Analysis of MES Referrals:

Acute Setting

Delays: The most frequent theme, covering perceived delays in treatment, ambulance handover, diagnostics, and access to urgent care beds.

DNACPR: Concerns about incomplete documentation, particularly missing senior clinician signatures in Part 6. Frequency is gradually decreasing.

Communication: Ongoing issues in interactions between clinicians, services, patients, and families.

COVID-19: Referrals related to hospital- or community-acquired cases have declined.

Pressure Damage: Referrals have reduced from 5% to 3%.

Primary Care and Community Setting

Concerns from bereaved families regarding GP care.

Issues related to care delivery in residential and nursing homes.

Delays in the Medical Certificate of Cause of Death (MCCD) process.

I honestly can't fault them at all, they gave 100%. She said (The staff) were very attentive, very respectful and mindful.

The care (her husband) received was excellent on both wards that he was on during his last admission. She said the nursing team were brilliant and she couldn't thank them enough.

She said the care (her mother) received was excellent and she could have not wished for better care.

She said the actual nurses were amazing, they looked after the family as well as (her husband)/ She said 'they were absolutely lovely'.

'At every point (the staff) were all amazing. Communication was excellent - we knew everything they were doing and why. They really looked after my and my mum too. I really can't thank them enough.'

In the hospital (the staff) were second to none, absolutely brilliant. The ward staff were brilliant, and the ward manager was superb.

Future Goals:

Aims for the remainder of 2025 include: -

- 1. Maintain the biannual newsletter** to support shared learning by highlighting key themes and insights from MES referrals.
- 2. Share positive feedback** from MES referral letters, which often include valuable comments from bereaved families about the care received—this qualitative data will continue to be collected and shared.
- 3. Improve referral closure rates** on the Mortality Module in Datix to enhance data quality and support organisational learning.
- 4. Develop a Health Board-wide approach:** Collaborate with the Care After Death Team and the Patient Engagement and Involvement Team to ensure that the voices of bereaved families, along with feedback from the MES, inform and shape our learning and improvement efforts.

Sepsis

Following a serious incident and the resulting action plan, the Health Board has prioritised sepsis as a key focus within one of the workstreams of the Quality Strategy. This commitment has been further strengthened by the drive to standardise electronic Early Warning Scores, supporting timely recognition and response to deteriorating patients.

Sepsis is a syndrome defined as life-threatening organ dysfunction due to a dysregulated host response to infection (NICE, 2024). The UK Sepsis Trust estimates that in the UK, sepsis affects 245,00 per year, results in 48,000 deaths per year and 5 deaths per hour.

Over the past 12 months, the Medical Director’s Quality and Patient Safety team have been collaboratively developing a two-year sepsis strategy. The primary aim is to enhance patient safety and improve outcomes by addressing systemic challenges in the identification and management of sepsis. This includes ensuring compliance with the latest National Institute Care Excellence (NICE) NR51 guidance and adopting best practice from the Academy of Medical Royal Colleges (AoMMRC) guidance.

Strategic Goals include:

Improve sepsis recognition and management Enhance the timely identification, treatment and management of sepsis across ABUHB	Strengthening initial treatment Review current resources and update sepsis related policies and clinical materials	Implement and enhance sepsis tools Roll out Early Warning Scores (EWS) across all divisions to support clinical decision-making	Standardise staff education and training Promote consistency and raise awareness to improve the effectiveness of sepsis response and management
Audit and Assurance Framework Develop a robust audit strategy to monitor compliance and provide assurance on sepsis management	Quality Improvement Support Provide a mechanism for direct support to Divisions using QI methodology to deliver sustainable high-quality care	Service User Engagement Gather feedback from patients and the public to identify missed opportunities and areas for improvement	National Collaboration Continue working with UK Sepsis Trust and NHS Wales Health Boards to maintain up-to-date guidance and explore innovative practices

Progress Report

National Drivers for Deteriorating Patient: The Welsh Health Circular (WHC) 2024/035 mandates the standardised use of Early Warning Scores (EWS) to identify and manage acute deterioration. The Health Board is actively working to meet the implementation deadline of 30th September 2025. This initiative is supported by the Safer Care Partnership, led by NHS Executive and Improvement Cymru, is focusing on this initiative, including the rollout of Martha's rule (Call for Concern).

Local Implementation: The Health Board's Deteriorating Patient Working Group has formed dedicated task groups to implement NEWS2, focusing on digital enablement, education, escalation protocols, and audit. Planning for Paediatric EWS is underway, with a target launch in September 2025. For Maternity and Neonatal EWS, workshops and follow-up meetings have established groups with digital templates scheduled for release.

These efforts aim to improve sepsis awareness, treatment, and outcomes across the Health Board.

Quality Improvement and Learning



Human Factors Training for All Staff:

We have introduced comprehensive Human Factors Training focusing on communication, decision-making, and teamwork. By embedding this programme into induction and ongoing education, staff across the Health Board are now better equipped to communicate clearly, make sound decisions, and collaborate effectively—even in high-pressure situations.



Empowering Teams through Quality Improvement Coaching:

We have expanded the role of QI (Quality Improvement) coaches, who are now working alongside clinical teams to systematically address patient safety incidents and complaints. By introducing structured improvement methods and supporting staff to use their own expertise, we have fostered a culture where solutions come from within our teams, not just from top-down directives.



Embedding Learning into Everyday Practice:

Our commitment to continuous learning means that staff are encouraged to reflect on complaints and safety events, identify root causes, and implement changes to prevent recurrence. Through the development of QI Coaches and our “million minutes of QI coaching” initiative, we have increased our organisation’s capacity for quality improvement, ensuring safer and higher-quality care for all.



Building a Culture of Openness and Early Engagement:

By integrating best practices and learning from incidents into staff education, we have reduced the likelihood of issues escalating to formal complaints. This proactive approach supports a culture of openness, learning, and continuous improvement, leading to faster, more empathetic resolutions for our patients and their families.



Enhancing Patient Experience and Outcomes:

By strengthening communication and teamwork, our initiatives have created a safer, more responsive environment for those we care for. This not only improves outcomes but also aligns with our broader strategy of early engagement and person-centred resolution.

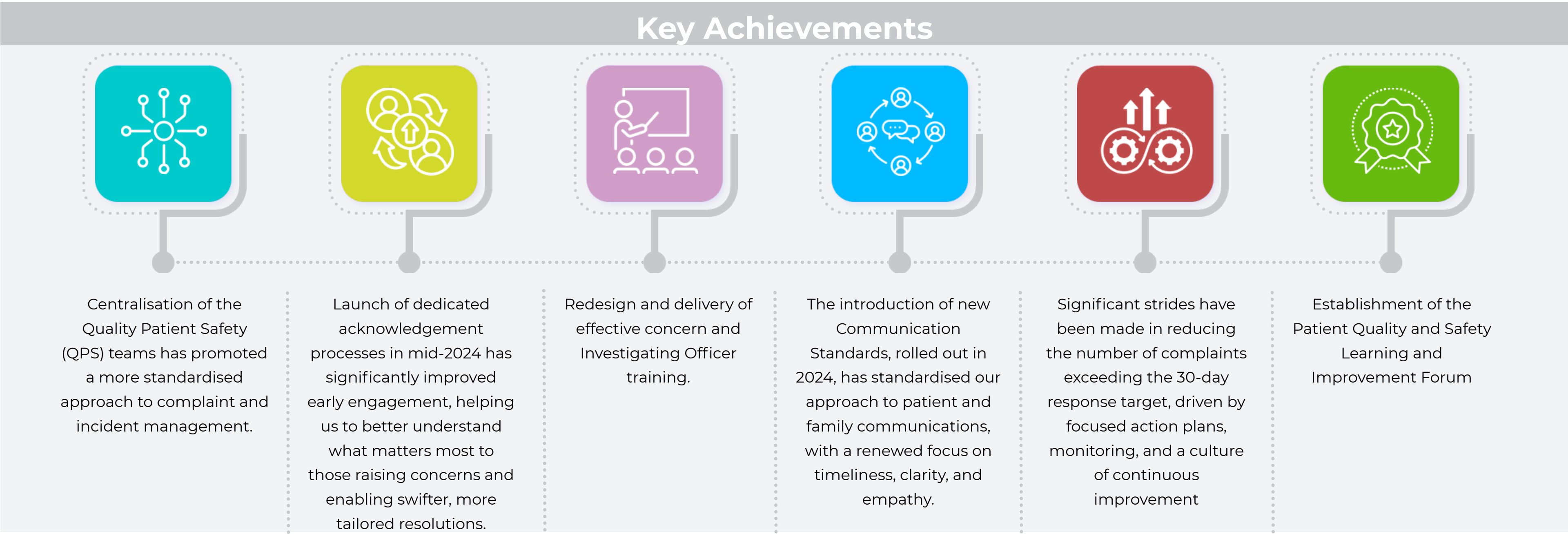


Collectively, these improvements demonstrate our ongoing commitment to learning, collaboration, and delivering the highest quality of care across the Health Board.

Conclusion

The 2024/25 reporting year has been both challenging and rewarding for the Corporate Putting Things Right (PTR) Team. The Health Board has continued to evolve its approach to complaint management, building on earlier improvements and introducing new initiatives to enhance patient experience and service quality.

Significant progress has been made in centralising processes, embedding a culture of early engagement, and strengthening the infrastructure for timely, person-centred resolution. Despite operational pressures, the team has focused on improving communication, compliance, and learning from experience to drive system-wide improvement. The Health Board’s commitment to quality, safety, and listening to patient voices remains at the heart of everything we do.



Continued Commitment: Throughout 2024/25, the Health Board has remained committed to timely and effective management of concerns, with a sustained focus on quality, safety, and putting people at the centre. This ongoing commitment was reinforced through collaborative efforts with staff, communities, and partners.

Next Steps: As the year concludes, the emphasis shifts to reviewing the effectiveness of recent organisational changes, assessing outcomes, and identifying further opportunities for refinement and improvement for 2025/26.

Priorities for 2025/26

The Health Board will build on its achievements in 2024/2025, maintaining a commitment to continuous learning and improvement. This process will incorporate feedback from service users as well as insights gained through internal evaluations to identify opportunities for quality improvement.

Priority 1

PTR Regulations and Health Board Concerns Management

1. The Health Board is committed to ensuring comprehensive preparedness and robust support for staff in the implementation and effective delivery of the revised PTR Regulations. This includes streamlining quality assurance processes, improving documentation standards, and enhancing the person-centred approach to early resolution and meaningful engagement with service users.
2. We will continue to drive compliance with PTR timeframes and statutory requirements, through monitoring and governance oversight to identify and address areas of non-compliance.
3. We will focus on addressing historic cases eradicating any concerns over 6 months, with clear trajectories for resolution and reporting, ensuring equitable and timely outcomes for patients and families.

Priority 2

Partnership Engagement & Collaborative Working

- 4) We will continue to enhance collaborations with external partners to further reinforce oversight and promote ongoing improvement in quality and safety initiatives. Continued engagement with organisations including the Public Services Ombudsman for Wales, Llais, Audit Wales, and Health Inspectorate Wales will be prioritised, enabling greater transparency and fostering the adoption of best practices through these strategic partnerships.
- 5) We will build on recent progress; efforts will focus on fully embedding the Death Certification Reform in partnership with the Medical Examiner’s Office and ensuring the GRACE bereavement model is consistently applied to support bereaved families.
- 6) Further engagement with patients and carers will be prioritised to gather valuable insights, which will inform ongoing improvements in patient care and organisational learning. These steps aim to reinforce a responsive, learning-focused environment and ensure the Health Board remains committed to delivering safe, compassionate, and high-quality care.
- 7) We are committed to foster a culture of openness, compassion and learning, with a strong emphasis on listening to patient and staff voice and embedding that insight into the way we deliver care.

Priorities for 2025/26

Priority 3 Improving Quality Patient Safety Experience, Learning and Improving

- 8) As part of the ongoing commitment to quality and safety, we will formally review the effectiveness of this organisational change to ensure that the intended outcomes are being achieved, and to identify any areas requiring further refinement or improvement.
- 9) We will continue to focus on learning and improvement from patient safety incidents, fostering a culture of continuous learning and improvement, implementing changes based on lessons learned, and encouraging the use of dashboards.
- 10) We will focus on improving Nationally Reportable Incident (NRI) compliance through strengthened processes for recognition, reporting, investigation, and closure, supported by enhanced oversight and accountability mechanisms.
- 11) We plan to relaunch Duty of Candour (DoC) training on ESR for staff who have not undertaken this training. DoC training will become mandatory for all patient-facing staff within the Health Board.
- 12) The Medical Director's Quality and Patient Safety team is currently developing a comprehensive two-year sepsis strategy aimed at enhancing patient safety and improving clinical outcomes. This work builds on the ongoing Deteriorating Patient programme and aligns with national efforts to standardise early warning systems across healthcare settings. The strategy will focus on several key areas: improving the early recognition and management of sepsis, strengthening the delivery of initial treatment, and implementing updated Early Warning Scores. It also includes standardising staff education and training to ensure consistency in practice, and establishing a robust audit framework to monitor progress and drive continuous improvement.
- 13) We will work with divisions to embed Quality Improvement (QI) Coaches to support their QI priorities. Additionally, developing an organisational QI Faculty will focus on building conditions for quality improvement.
- 14) We plan to enhance Human Factors training across the organisation to strengthen safe systems and reduce variation in practice.
- 15) Strengthen Data Quality and Reporting: Enhance documentation, tracking, and reporting of legal management activities.
- 16) Maintain and Develop Governance Structures: Continue to refine SOPs, portfolio reporting, and Board engagement to ensure robust oversight and accountability.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	01 October 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Safeguarding Annual Report 2024-2025
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade – Executive of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Kelly Downes – Deputy Director of Nursing Eleanor Edwards – Deputy Head of Safeguarding

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The Aneurin Bevan University Health Board has experienced a notable rise in safeguarding referrals this year. The Safeguarding Annual Report 2024/25 outlines key progress, ongoing challenges, and strategic priorities, highlighting the board's commitment to protecting vulnerable individuals.

Cefndir / Background

The Health Board recognises its statutory responsibility to ensure robust safeguarding measures are in place, supported by key legislative frameworks such as the Health and Care Standards for Safeguarding Children and Adults at Risk, the Social Services and Well-being (Wales) Act, and the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Act.

The Safeguarding Team is actively involved in multi-agency partnerships, including the Gwent Joint Children and Adult Safeguarding Board and the Gwent VAWDASV Partnership Board.



Staffing and Governance

The health board maintains a robust safeguarding governance structure. The Chief Executive holds overall accountability, with executive leadership delegated to the Executive Director of Nursing, supported by the Deputy Director of Nursing. The Head of Safeguarding, along with a Deputy, oversees safeguarding systems, policies, training, and operational practices, ensuring compliance and quality monitoring.

Since 2022/23, there has been a significant rise in Duty to Report (DTR) referrals, with Adult Safeguarding referrals increasing by 94% and Children's Safeguarding referrals by 132%. In response, the team structure was revised in September 2024 to support the growing complexity of cases and increased workload. This continues to be kept under review.

The Safeguarding Strategic Group, reporting to the Quality Management Group and Patient Quality and Safety Outcomes Committee, oversees safeguarding practices for Adults, Children, and Young People. This group sets the Health Board's Safeguarding Strategy and defines objectives for continuous improvement. It is supported by three sub-groups focusing on safeguarding adults, children and young people, and persons in a position of trust (PIPOT), which provide quarterly feedback and drive quality improvement.

Single Unified Safeguarding Reviews (SUSR)

Launched in Wales in October 2024, the Single Unified Safeguarding Review (SUSR) merges different review processes into one coordinated approach for serious safeguarding incidents. SUSR lessens family stress, fosters interagency learning, and improves service understanding. The process examines what occurred and why, promoting collaborative improvement and resulting in actionable plans to strengthen future safeguarding of vulnerable individuals across agencies.

Safeguarding Adults

The Adult Safeguarding team assesses Duty to Report submissions, coordinating with Divisions and multi-agency partners for adults at risk. In 2024/25, DTR submissions rose sharply to 510—an increase of 41% from 362 in 2023/24—reflecting the team's expanding workload and responsibilities.

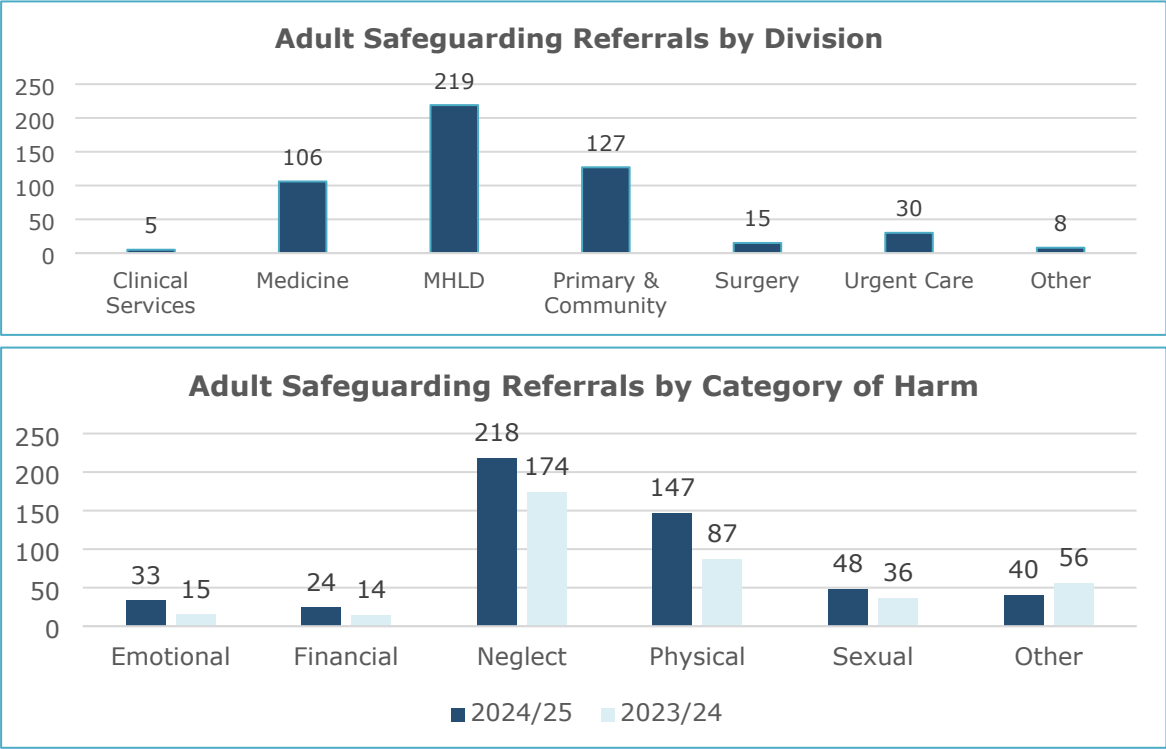
When examining the data by type of harm, it is evident that Neglect is the most frequently reported category. This includes allegations of neglect with sub-themes such as poor discharge practices, pressure ulcers, and medication errors.

A review of incidents involving physical harm reveals that most cases are patient-on-patient assaults. Investigations have shown that these incidents are largely unavoidable.



A particularly concerning area is the number of reports related to sexual assault, which was also highlighted in the Annual Reports for 2022/23 and 2023/24. While the volume of incidents remains troubling, they do not meet the criteria for serious sexual harm. Notably, the proportion of sexual abuse cases relative to the total number of DTRs has decreased this year.

The tables below present referrals by division and category of harm:



Collaboration with the Mental Health and Learning Disabilities Division has enhanced DTR quality, with ongoing support from the Safeguarding Team. This engagement and Safeguarding Supervision will continue into the next financial year.

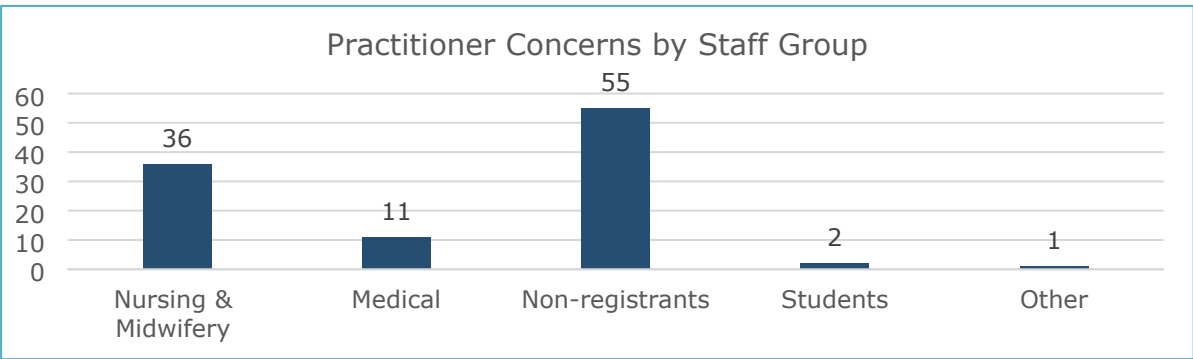
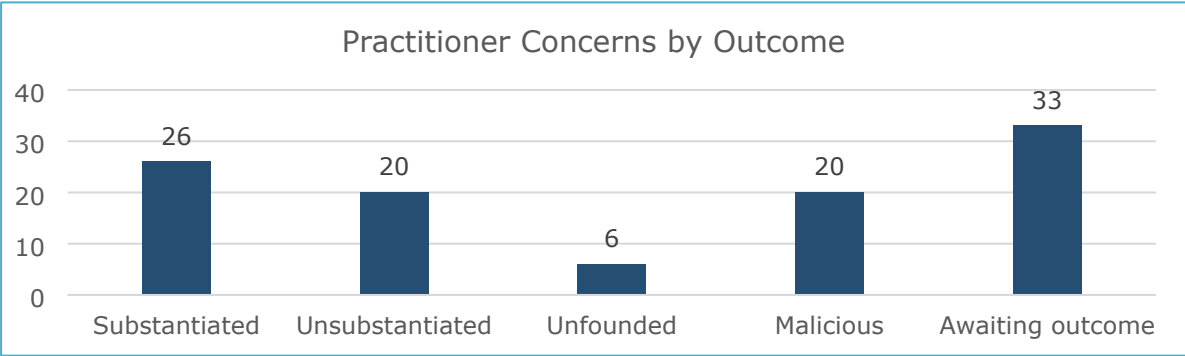
It should be noted that often referrals reported by the Division are unrelated to the care and treatment they directly deliver.

Safeguarding Allegations/Concerns

In 2024/25, 105 safeguarding allegations or concerns were raised involving staff working within the health board, with 26 substantiated cases and 29 progressing to criminal investigation. This marks a significant increase compared to the previous year, which saw 10 substantiated cases, all of which were referred for police investigation.

Of the 105 allegations, 41 were related to incidents within the workplace and 64 incidents occurred outside the workplace. Not all cases involved directly employed health board staff; some concerned independent contractors, staff bank and agency staff.

The tables below present the practitioner concerns by outcome and staff group:

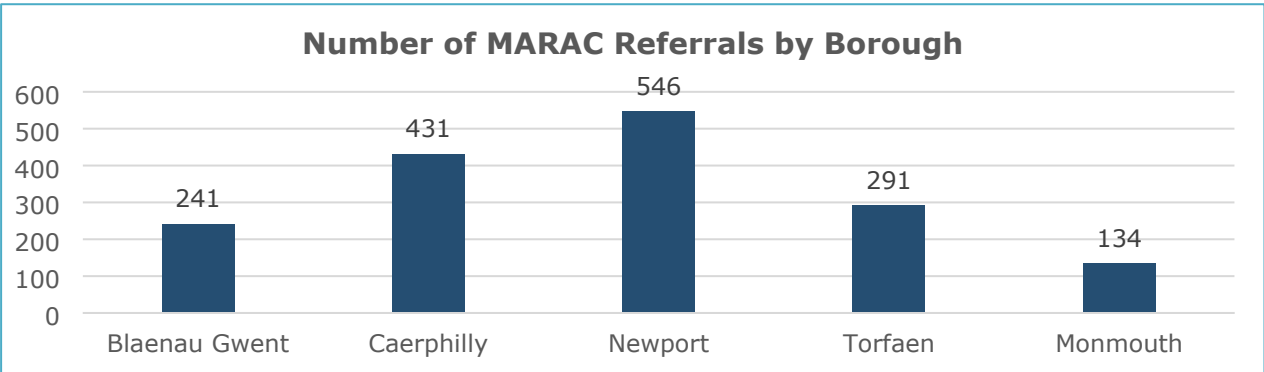


A working group now examines incidents closely, clarifies referral thresholds, and tracks trends. Regular meetings with Police have started to ensure investigations are timely and that emerging issues are addressed.

Domestic Abuse

The Safeguarding Team supports high-risk domestic abuse victims by engaging in fortnightly MARAC meetings for each Gwent Local Authority. As a statutory agency, their attendance is mandatory. Recently, referrals discussed at MARAC have increased across all Local Authorities compared to 2023/24, highlighting the growing need for coordinated safeguarding efforts.

The table below presents the number of MARAC referrals:



The increase highlights a rise in medium and high-risk domestic abuse cases, assessed via a national tool. Additionally, many individuals classified as standard

risk continue to seek support, with those cases generally handled by single agencies or independent contractors.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

Whilst MCA & DoLS function does not fall directly under the portfolio of the Corporate Safeguarding Team, it is closely aligned, and strong professional relationships exist between the two teams.

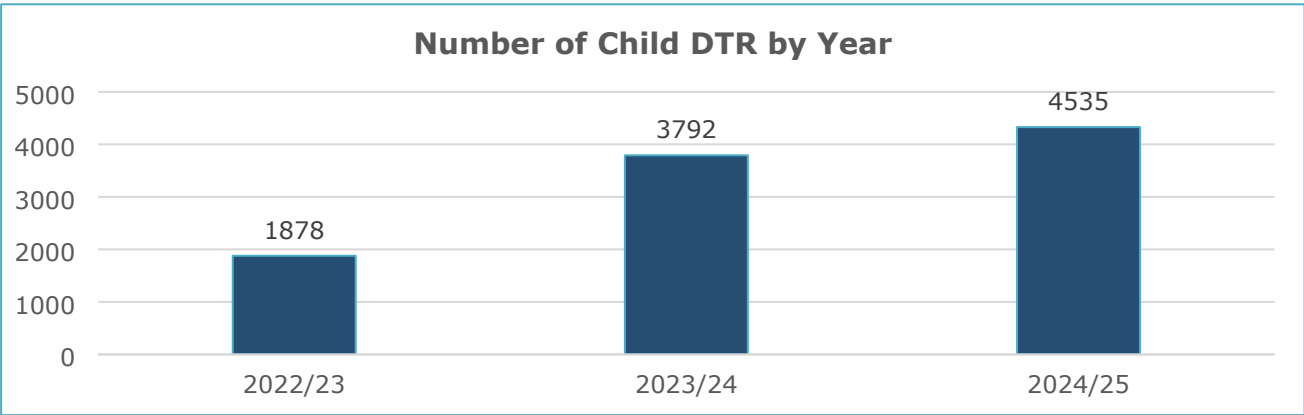
MCA training has now been made mandatory across the health board and is in the process of being aligned with ESR for accurate recording and compliance monitoring.

Throughout 2024/25 at total of 2763 DoLS referrals were received with 1452 assessments completed. Ongoing work is underway to address delays.

Safeguarding Children

During 2024/25, the Health Board made 4,535 Duty to Report referrals regarding suspected child abuse or neglect—an increase of 17% from last year. Case complexity has also risen, with 49% of referrals advancing to strategy meetings, resulting in 2,119 such meetings attended, marking a 33% increase. While improved resourcing and greater safeguarding awareness have contributed, they do not fully explain the surge. The Safeguarding Team collaborates extensively with partners to identify emerging themes, taking a multi-agency approach to provide early intervention and coordinated support for children, young people, and families at risk.

The tables below illustrate the volume of DTRs processed by the Safeguarding Team and the emerging themes (the notably high number of referrals categorised as "other" is attributed to previously inadequate reporting systems and the dual classification of harm types):



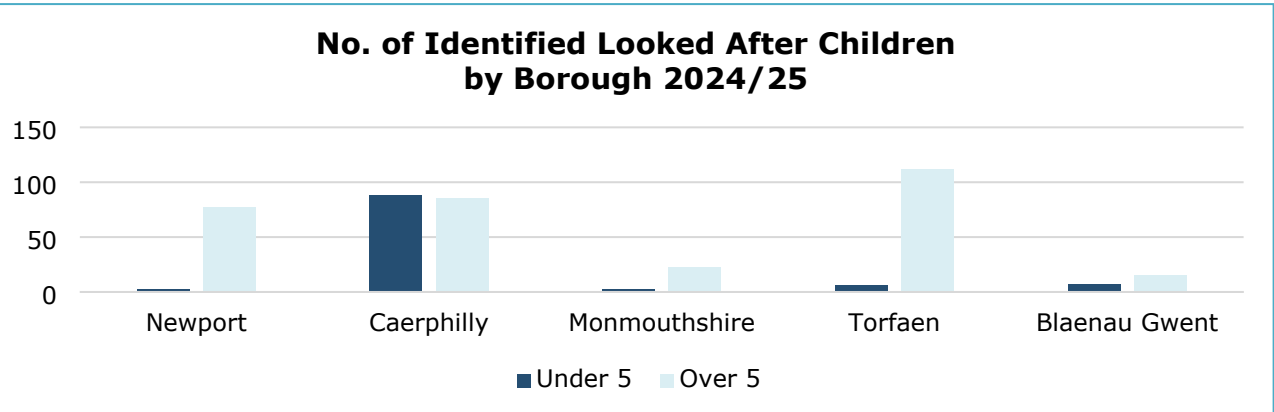
Category of Abuse for DTR's	No.
Neglect	198
Emotional Abuse	80

Sexual Abuse	75
Physical Abuse	275
Financial Abuse	0
Other	3907

Looked after Children (LAC)

Looked After Children (LAC) are cared for by the Local Authority due to unsafe home environments. The Health Board ensures their holistic health needs are met through assessments and services. Although LAC aren’t part of the Safeguarding Team, both teams collaborate closely to support these vulnerable children and young people.

The table below presents the number of children who were identified as looked after at the end of the financial year 2024/25:

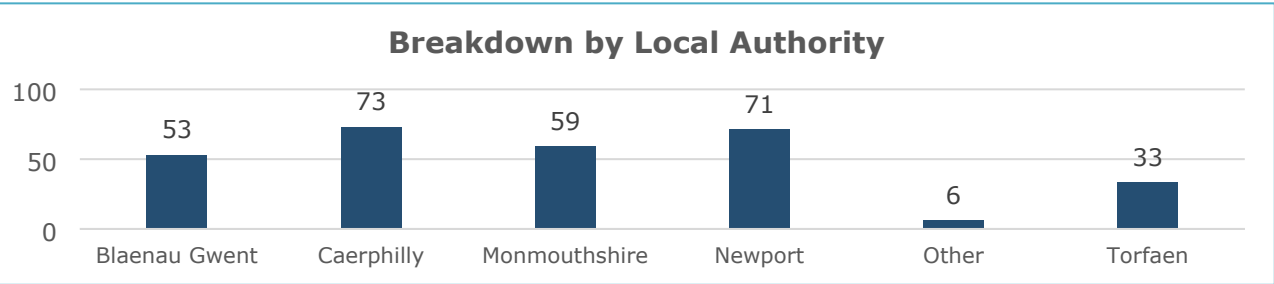


Child Protection Medical Assessments (CPMA)

Child Protection Medicals are assessments carried out to identify any signs of abuse or neglect in children and young people.

In 2024/2025, a total of 295 Child Protection Medicals were conducted—matching the number from 2023/2024.

The table below presents a breakdown by borough:



In line with policy, all Child Protection Medicals were completed within 24 hours of the request being accepted. Each case undergoes monthly peer review by medical staff to maintain service quality and encourage professional challenge.

Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

PRUDiC ensures a coordinated, safe, and compassionate approach through effective communication, joint action, and information sharing. In 2024/2025, 8 child deaths in the health board area met the PRUDiC criteria. This reflects a continued decline since 2020. All PRUDiC cases are reported to the Welsh Government in line with *Putting Things Right* guidance. This enables monitoring of patterns and trends—none of which were identified in 2024/2025.

Safeguarding Supervision

Safeguarding supervision plays a vital role in supporting staff with their safeguarding responsibilities. The Safeguarding Team ensures staff are equipped with essential knowledge and skills through reflective, restorative supervision. This takes place via phone support, post-incident debriefs, one-to-one, and group sessions. The process, aligned with All Wales Safeguarding Supervision Guidance (2024), helps staff develop resilience, well-being, and professional growth, while allowing the Safeguarding Team to identify trends and challenges within the health board.

Training

Safeguarding training is mandatory across the Health Board and is expected to align with the Welsh Government's national target of 85% compliance. During 2024/2025, overall compliance with safeguarding training has shown a positive upward trend, with improved engagement from divisions.

Level 1 Safeguarding Training: Online module for all staff, compliance is 81% for adults and 83% for children as of March 2025.

Level 2 Safeguarding Training: Mandatory for all staff with direct patient contact. Compliance for adults and children are 84% and 81%, respectively.

Level 3 Safeguarding Training: Mandatory for all staff engaging with patient safeguarding concerns. As of March 2025, compliance was 25% for children's and 15% for adults' training, both below the 85% target. Efforts include in-person and virtual sessions, with improvement plans underway to meet compliance standards.

Ask and Act Training: Ask and Act training empowers staff to support individuals facing gender-based violence, domestic abuse, and sexual violence. In 2024/25, 75% of eligible staff completed Group 1 training. Group 2 compliance remains challenging to track, so it will be prioritised in the 2025/26 Training Needs Analysis.



National Contribution

The Safeguarding Team supports the national agenda by participating in working groups such as the National Safeguarding Network and contributing to projects like the Once for Wales Safeguarding Module. A national safeguarding data set is being developed to enable benchmarking and learning across Welsh Health Boards.

Progress on Priorities 2024/2025

The table below presents the priorities that were set for 2024/25 with progress RAG rated (Green completed, Amber ongoing):

Priority	Progress
Primary Care Training	Delivered training and resources for safeguarding compliance, including domestic violence awareness.
Safeguarding Adult Supervision	Piloted group supervision; expansion planned for 2025/26.
Sexual Safety Policies	Developed and published guidance on sexual safety and historical abuse.
Level 3 Safeguarding Training	Made mandatory on ESR with revised delivery and monitoring.
DATIX Module	Launched to enhance safeguarding case management.
Section 5/Practitioner Concerns Guidance	Guidance under revision to align with referral thresholds; work to continue in 2025/26.
Assurance Measures	Integrated within Ward Accreditation to reinforce safeguarding accountability.
Operational Subgroups	Formed to embed learning from reviews and drive improvement, with regular assurance reporting.

Priorities noted as Amber have been carried forward for completion for 2025/26.

Priorities for 2025/26

- Expand Safeguarding Supervision: Extend the adult safeguarding supervision pilot to more teams.
- Revise Guidance: Continue updating and implementing key guidance documents, such as the ABUHB Section 5/Practitioner Concerns Guidance.
- Enhance Training Compliance: Improve safeguarding training uptake and monitoring at all levels, with particular focus on Level 3.
- Strengthen Multi-Agency Collaboration: Deepen joint working with partners to improve outcomes for vulnerable people.
- Deliver Strategic Priorities: Drive forward new initiatives, including the DATIX Safeguarding Module, for 2025/26.



Summary

The year 2024/25 presented significant challenges for the Safeguarding Team, driven by a notable rise in safeguarding activity alongside the team’s ongoing statutory responsibilities.

Despite these pressures, key achievements were realised in the following areas:

- Delivery of Safeguarding Training.
- Mandating Level 3 Safeguarding compliance via the ESR platform.
- Proactive management of an increased and more complex caseload.
- Expansion of safeguarding supervision across wider areas.
- Strengthening the IDVA role within urgent care settings.
- Establishment of a well-attended and effective Strategic Safeguarding Group, supported by dedicated sub-groups.
- Successful planning and preparation for the implementation of the Datix Safeguarding module.

The health board remains firmly committed to prioritising the safeguarding of both children and adults. This commitment will continue into 2025/26, with a focus on addressing both existing and emerging challenges.

Ongoing collaboration with the community and partner organisations will be essential to support continued development and adaptation.

The health board remains dedicated to safeguarding children and adults, with continued focus on current and future challenges. Collaboration with partners will support ongoing improvement and adaptation.

Argymhelliad / Recommendation

The Patient Quality Safety and Outcomes Committee is asked to **NOTE** the Safeguarding Report for 2024-2025

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.7 Safeguarding Children and Safeguarding Adults at Risk 3.1 Safe and Clinically Effective Care 2.1 Managing Risk and Promoting Health and Safety 6.2 Peoples Rights



Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Quality Management Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.



<https://futuregenerations.wales/about-us/future-generations-act/>





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Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Safeguarding Annual Report 2024/25

Introduction

Aneurin Bevan University Health Board recognises its statutory responsibility to ensure robust safeguarding measures are in place to protect individuals at risk. This duty is underpinned by key legislative frameworks including:

- **Health and Care Standards for Safeguarding Children and Adults at Risk** (Welsh Government and NHS Wales, 2015)
- **Social Services and Well-being (Wales) Act** (Welsh Government, 2014)
- **Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Act** (Welsh Government, 2015)

This Safeguarding Annual Report outlines the Health Board's compliance with these legislative requirements and provides a comprehensive overview of safeguarding activities undertaken between April 2024 and March 2025. The report aims to:

- Provide assurance to the Board that statutory safeguarding obligations are being met effectively.
- Demonstrate to external partners and regulatory bodies that proactive measures are in place to prevent abuse and mitigate harm to vulnerable individuals.
- Inform the Board, staff, partners, and stakeholders about the roles, responsibilities, and achievements of the Safeguarding & Vulnerabilities Team.
- Highlight the governance and assurance structures that support safeguarding practices within ABUHB.
- Identify key risks addressed during the reporting period and outline current risks along with their mitigation strategies.
- Summarise significant safeguarding initiatives and contributions at both local and national levels.
- Outline strategic priorities and areas for improvement in safeguarding for implementation in the 2024/2025 period.

Multi-Agency Partnership Working

The ABUHB Safeguarding Team continues to fulfil its statutory responsibilities through active membership of the Gwent Joint Children and Adult Safeguarding Board and the Gwent VAWDASV (Violence Against Women, Domestic Abuse and Sexual Violence) Partnership Board. In addition to these core roles, the team contributes to a wide range of sub-groups and committees that support the delivery of strategic safeguarding priorities across the region.

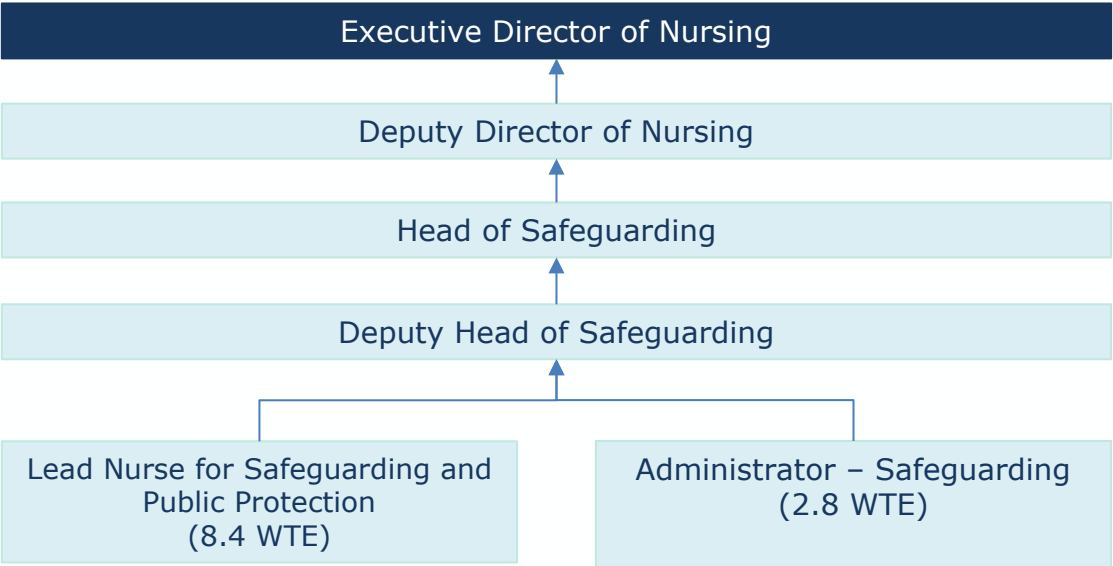
The Gwent Joint Children and Adult Safeguarding Board is a multi-agency partnership committed to embedding safeguarding at the heart of all services across Gwent. Its work is underpinned by a number of sub-groups that oversee both core business functions and targeted thematic workstreams aligned to annual strategic objectives.

The Gwent VAWDASV Partnership Board brings together agencies across the region to prevent violence against women, domestic abuse and sexual violence. Its focus is on improving outcomes for individuals at risk or affected by such harm, as well as for their families and support networks, through coordinated and collaborative action.

Aneurin Bevan University Health Board maintains a clear and robust safeguarding governance structure to ensure that its responsibilities are met effectively across all services. The Chief Executive holds overall accountability for safeguarding, with executive leadership delegated to the Executive Director of Nursing. This role is supported operationally by the Deputy Director of Nursing.

Strategic oversight is provided by the Head of Safeguarding, who is supported by a Deputy. Together, they offer assurance on safeguarding arrangements and represent the Health Board on regional partnership boards.

As the strategic lead, the Head of Safeguarding is responsible for the development and implementation of safeguarding systems and policies. This includes oversight of training provision and compliance, support for operational safeguarding practice, and the establishment of mechanisms to monitor the quality and effectiveness of safeguarding activity across the organisation.



	22/23	23/24	24/25	22/23 – 24/25 Comparison
Adult DTR's	263	382	511	+94%
Children DTR's	1878	3737	4356	+132%

Since 2022/23, there has been a substantial rise in Duty to Report referrals submitted to the Local Authority and processed by the ABUHB Safeguarding Team. Adult Safeguarding has seen a 94% increase, while Children’s Safeguarding referrals have surged to 132% over the two financial years. This upward trend is evident across the entire service.

In response, the team structure was revised in September 2024. Additional hours were allocated to both the adult and children’s safeguarding teams by converting Band 8a full-time equivalent (FTE) hours into Band 7 FTE hours. This adjustment created the equivalent of six Band 7 days, which were then distributed between the two teams.

Despite these changes, referral activity continues to rise and is expected to increase further as safeguarding training compliance improves. The complexity of cases is also growing, demanding more intensive involvement. As a result, the team currently lacks the capacity to absorb additional responsibilities.

The Safeguarding Strategic Group is an established entity within the Health Board's governance framework. It reports to the Patient Quality and Safety Outcomes Committee through the Quality Management Group and holds delegated authority to oversee and monitor safeguarding practices for Adults, Children, and Young People.



This group is responsible for setting the Health Board's Safeguarding Strategy, defining objectives that promote continuous improvement and ensure compliance with both national and local safeguarding policies.

To support its work, the Strategic Group is backed by three dedicated sub-groups that focus on developing and implementing robust, auditable, and effective quality monitoring systems. These sub-groups also play a key role in raising awareness of safeguarding issues and provide quarterly feedback to the Strategic Group.

The sub-groups are:

- Safeguarding Adults Sub-group
- Safeguarding Children and Young People Sub-group
- Persons In a Position of Trust (PIPOT) Sub-group

Single Unified Safeguarding Reviews

The Single Unified Safeguarding Review (SUSR), introduced in Wales from 1 October 2024, streamlines the safeguarding review process by combining multiple review types into a single, coordinated approach. This ensures that families affected by serious incidents experience a more efficient and compassionate process, reducing the emotional burden of participating in several separate reviews.

To qualify for an SUSR, the incident must meet the criteria for one of the following:

- Adult Practice Review
- Child Practice Review
- Domestic Homicide Review
- Mental Health Homicide Review
- Offensive Weapons Homicide Review

The SUSR creates a safe and collaborative learning environment for agencies and individuals involved in the incident. Its aims include:

- Gaining a deeper understanding of what occurred and the reasons behind it
- Evaluating how organisational actions influenced the outcome
- Considering whether alternative actions could have led to different results for the child or adult at risk
- Identifying opportunities for learning and improvement
- Developing a clear and actionable plan to enhance future service delivery

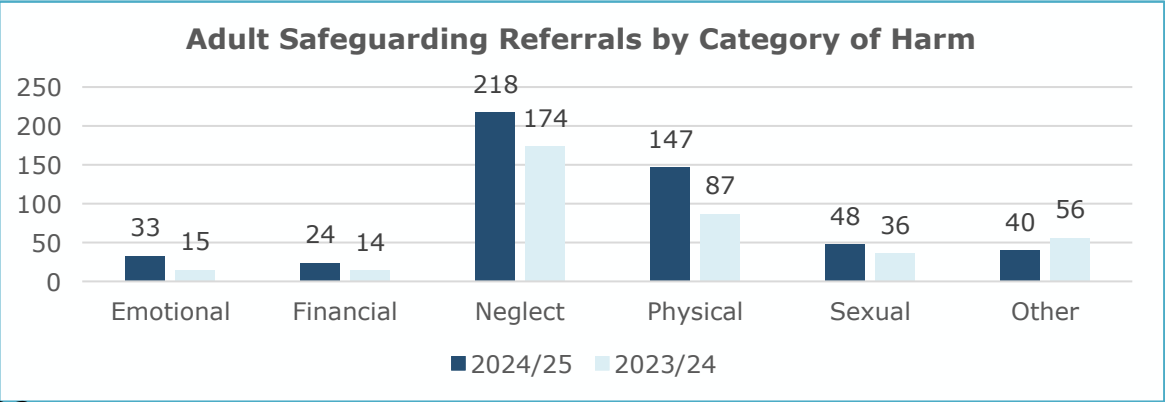
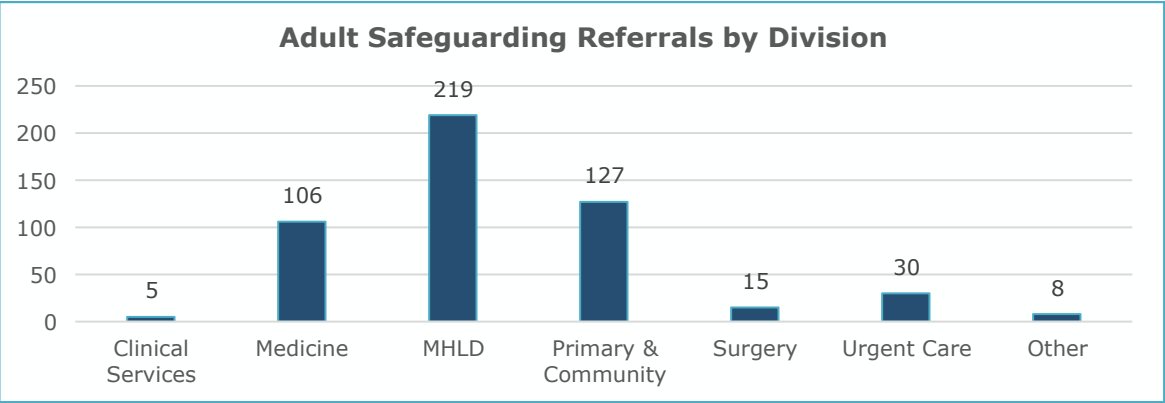
Safeguarding Adults

The Adult Safeguarding function within the Corporate Safeguarding Team receives Duty to Report submissions from Local Authority and then subsequent enquiries are made with Divisions. These reports enable the assessment of concerns and, where appropriate, referral to multi-agency partners for adults at risk.

These cases include instances where safeguarding concerns may involve the Health Board as a contributing factor, as well as those where external individuals or organisations are implicated.

In 2024/25, the Safeguarding Team received 510 Duty to Report submissions, an increase of 41% compared to the 362 received in 2023/24. This represents a significant rise in demand on the service.

The following illustrate the referrals by Division and Category of Harm.



The data provided by the Division is shared for informational purposes only and should not be interpreted as comparative. Often, the concerns reported by the Division are unrelated to the care and treatment they directly deliver.

When examining the data by type of harm, it is evident that Neglect is the most frequently reported category. This includes allegations of neglect with sub-themes such as poor discharge practices, pressure ulcers, and medication errors.

A more detailed review of incidents involving physical harm reveals that most cases are patient-on-patient assaults. Investigations have shown that these incidents are largely unavoidable.

A particularly concerning area is the number of reports related to sexual assault, which was also highlighted in the Annual Reports for 2022/23 and 2023/24. While the volume of incidents remains troubling, they do not meet the criteria for serious sexual harm. Notably, the proportion of sexual abuse cases relative to the total number of DTRs has decreased this year.

Targeted collaboration with the Mental Health and Learning Disabilities Division has continued throughout 2024/25. The quality of most DTRs has improved, and the Division maintains strong engagement with the Safeguarding Team. This work is expected to continue into the new financial year, with Safeguarding Supervision being offered as part of ongoing support.

Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust

In 2024/25, a total of 105 safeguarding allegations or concerns were raised involving ABUHB staff — the lowest figure recorded since data collection began. However, cases where practitioners were subject to allegations - but a multi-agency discussion concluded that no further action was required have not yet been formally documented.

Of the 105 referrals that entered the safeguarding process:

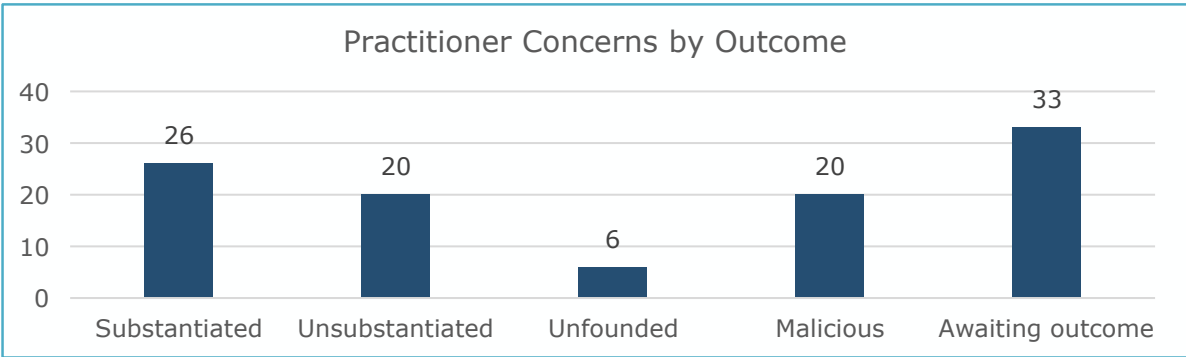
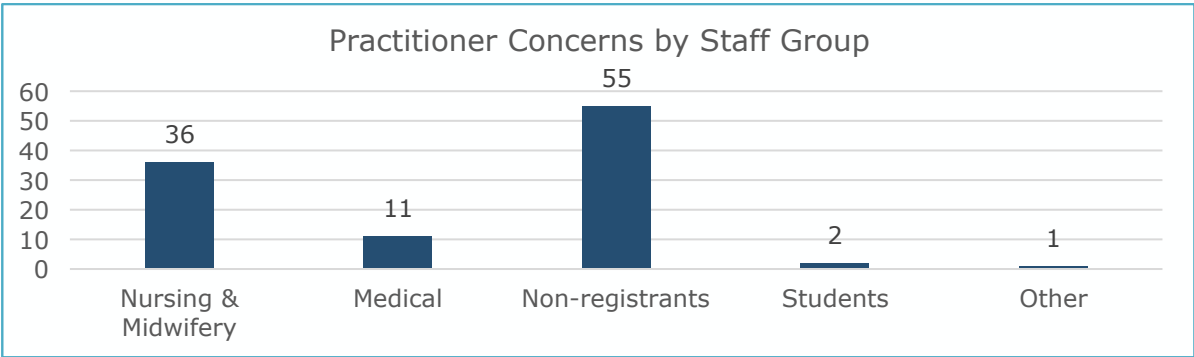
- 26 were substantiated, and
- 29 progressed to criminal investigation.

This marks a significant increase compared to the previous year, which saw only 10 substantiated cases, all of which were referred for police investigation. All other referrals noted in the initial figure did not meet threshold for the process.

To provide further context:

- 41 allegations related to incidents within the workplace.
- 64 incidents occurred outside of work.
- Not all cases involved directly employed ABUHB staff; some concerned independent contractors, Nurse Bank personnel and agency staff.

A working group has been established to examine these incidents in greater detail. Their focus includes clarifying referral thresholds and identifying emerging themes and trends. In addition, regular meetings with Police have been established to ensure that investigations progress in a timely manner.



Adult Practice Reviews

Domestic Abuse

Domestic abuse is defined by the Welsh Government (2015) as “any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.”

In Wales, the health sector holds a crucial position in tackling domestic abuse, serving as a primary point of contact for recognising and supporting those affected. Health professionals are expected to play an active role in identifying signs of abuse and responding appropriately, with an emphasis on early intervention and connecting individuals to specialist services. The Welsh Government promotes a public health model, embedding domestic abuse awareness into healthcare delivery and ensuring victims and survivors receive holistic support.

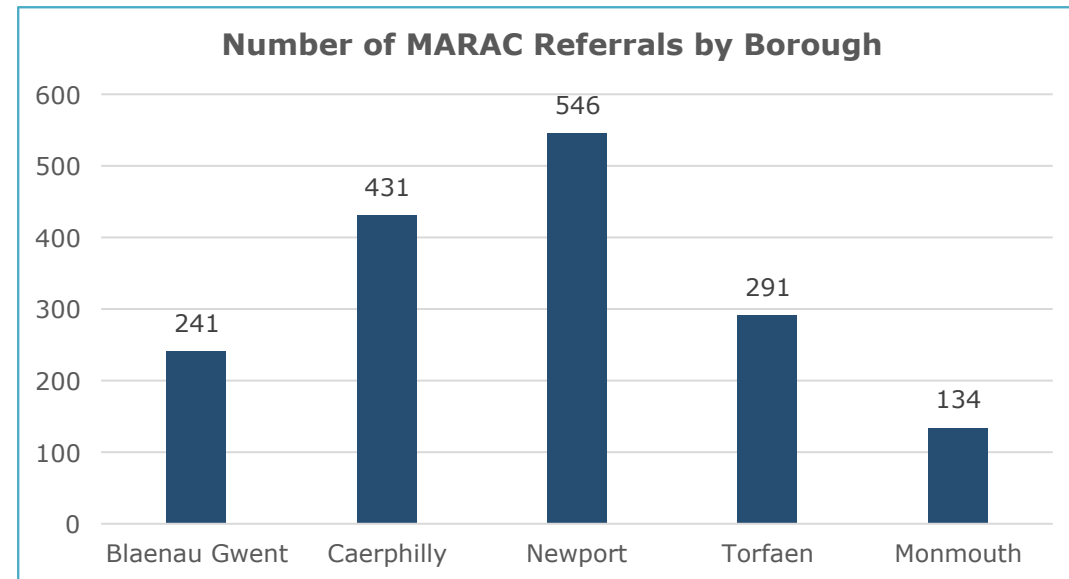
The responsibilities of the health sector include:

- Identifying and referring individuals at risk
- Delivering support and clinical care
- Focusing on prevention and early action
- Working collaboratively with partners and agencies
- Engaging with perpetrators to address harmful behaviours
- Implementing relevant legislation and policy frameworks

Multi Agency Risk Assessment Conference (MARAC)

The Safeguarding Team plays a vital role in supporting victims of domestic abuse who are at high risk, through active participation in Multi-Agency Risk Assessment Conferences (MARAC). These multidisciplinary meetings focus on individuals assessed as being at high risk of serious harm or homicide, with the aim of coordinating safeguarding actions across agencies.

Each Local Authority within the Gwent area currently convenes a MARAC panel on a fortnightly basis. As a statutory agency, the Safeguarding Team is committed to attending all of these meetings. Notably, the number of referrals discussed at MARAC has seen a slight increase across all Local Authorities compared to 2023/24.



This rise reflects the growing number of individuals experiencing domestic abuse who are assessed as medium or high risk using a nationally accredited risk assessment tool. In addition to this significant group, there remains a high volume of individuals accessing our services who are assessed as standard risk. These cases are typically managed by a single agency, often our own teams or independent contractors.

Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS)

Within the health board, MCA & DoLS function does not fall directly under the portfolio of the Corporate Safeguarding Team. However, it is closely aligned, and strong professional relationships exist between the two teams. The health board continues to fulfil its statutory responsibilities regarding DoLS and the broader requirements of MCA. Additionally, the health board actively participates in the All Wales MCA/DoLS Network.

MCA training has now been made mandatory across the health board and is in the process of being aligned with ESR for accurate recording and compliance monitoring. Training, clinical support, and an audit cycle have been embedded into MCA practice. MCA/DoLS training is offered at three levels, culminating in skills workshops designed to help staff develop clinical competencies. MCA practitioners remain available to support and advise clinical teams with MCA assessments and Best Interest (BI) meetings.

Number of referrals received: The chart below details the number of referrals received by month throughout 2024/25.

April	May	June	July	August	September	October	November	December	January	February	March	TOTAL
251	197	225	248	203	272	272	232	214	246	207	196	2763

Number of assessments completed: The chart below details the number of completed assessments by month throughout 2024/25.

April	May	June	July	August	September	October	November	December	January	February	March	TOTAL
160	140	128	147	114	91	137	114	83	99	104	135	1452

Domestic Homicide Reviews

In 2024/25, the Safeguarding Team contributed to three Domestic Homicide Reviews (DHRs), all of which are awaiting publication. Two of these reviews were initiated in the previous year, with one originating in 2020.

Initial findings show that patient support was delivered to a high standard. Nonetheless, opportunities for improvement were identified—particularly in how domestic abuse and associated vulnerabilities are documented in patient records. Enhancing the visibility of such concerns would support better information sharing among professionals involved in the patient's care. Compared to earlier DHRs, there is clear progress in professional curiosity and good practice, especially in ensuring patients are offered the chance to be seen alone.

Traditionally, the Health Board has represented all health agencies during the DHR process. However, in the three most recent reviews, General Practice has taken a more active role, enriching multi-agency discussions and leading to clearer, more actionable recommendations.

Learning from these reviews is being embedded through the SUSR process and will inform future practice. This will strengthen the Health Board's ability to identify not only victims of domestic abuse but also those offering them support.

Independent Domestic Violence Advisers

The Independent Domestic Violence Advisor (IDVA) service operates across Gwent and is currently hosted by Newport City Council. It is jointly funded by the five Gwent Local Authorities, Aneurin Bevan University Health Board and the Office of the Police and Crime Commissioner (OPCC). The role is designed to improve awareness, assessment, signposting, and referral pathways for patients affected by domestic abuse—including coercive control—who engage with Health Board services.

Following the successful integration of the IDVA role within ABUHB, a second position was introduced to address the growing demand and workload identified by staff. In addition to delivering training and raising awareness, the IDVA provides direct support to patients, including conducting risk assessments, creating safety plans, assisting with Police disclosures, and facilitating access to housing and specialist support services.

During the 2024/25 reporting period, the health-focused IDVA service was based at the Grange University Hospital, while continuing to support patients and staff across ABUHB's inpatient and urgent care settings. A total of 261 direct referrals were received—22 involving male victims and 239 involving female victims. Although male referrals remain comparatively low, this data underscores the importance of ongoing efforts to identify and support male victims of domestic abuse.

Safeguarding Children: Activity Summary 2024/25

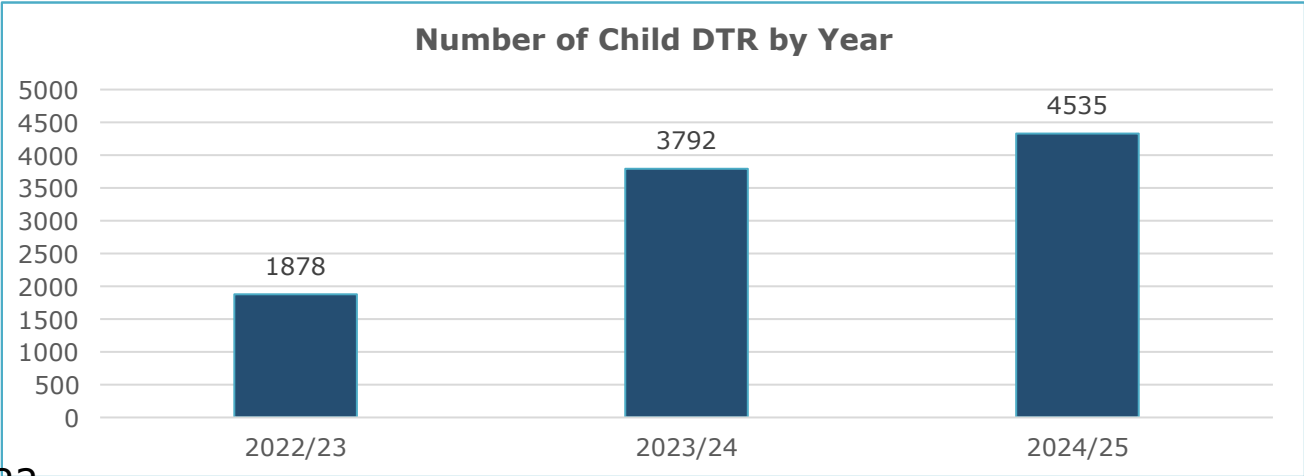
During 2024/25, the Health Board made 4,535 Duty to Report referrals concerning suspected child abuse or neglect across the five boroughs. This represents a 17% increase compared to the 3,736 referrals made in the previous year. In addition to the rise in volume, the complexity of cases has also grown, with 49% progressing to strategy meetings. This equates to 2,119 strategy meetings attended this year, a 33% increase from the previous year.

While some of this increase can be attributed to improved resourcing within Local Authority Safeguarding Teams and enhanced training and awareness around safeguarding, these factors alone do not fully account for the significant rise in activity.

Throughout 2024/25, the Corporate Safeguarding Team has continued to collaborate with partner agencies, both reactively on individual cases and proactively through the Safeguarding Board—to better understand the drivers behind this trend.

The Safeguarding Hub has played a key role in early intervention and safety planning for children at risk. In addition to this, 4535 strategy meetings have been attended to form a multi-agency approach as specified in the Social Services and Wellbeing (Wales) Act (2014). Its multi-agency approach enables staff to provide more effective support to children, young people, and their families at an earlier stage.

The graphs illustrate the volume of DTRs processed by the Corporate Safeguarding Team and the thematic areas emerging from them. The notably high number of referrals categorised as "other" is attributed to previously inadequate reporting systems and the dual classification of harm types.

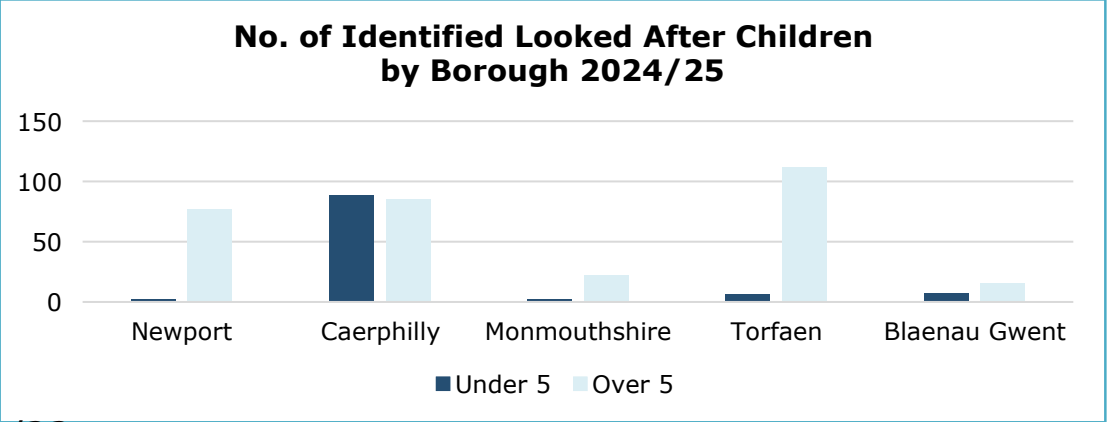


Category of Abuse for DTR's	No.
Neglect	198
Emotional Abuse	80
Sexual Abuse	75
Physical Abuse	275
Financial Abuse	0
Other	3907

Looked After Children (LAC)

Looked After Children (LAC) are those who are in the care of the Local Authority, either temporarily or permanently, because they are unable to safely live with their parents/guardians. The Health Board plays a crucial role in Safeguarding and promoting the health and well-being of these children and young people and are responsible for ensuring that they receive necessary health assessments, services and support their specific health needs in a holistic approach. Each Local Authority holds the responsibility of the children and young people which are LAC. The LAC portfolio is not part of the Safeguarding Team however both teams liaise closely and support where necessary.

By Borough, the numbers below relate to the number of children who were identified as looked after at the end of the financial year 2024/25.



National Contribution

The Safeguarding Team actively contributes to the National Safeguarding agenda. The National Safeguarding Service operates within Public Health Wales as a team of experts who provide a strategic focus and professional lead to improve safeguarding across the NHS in Wales. A data set to encapsulate safeguarding data from all Health Boards is currently under development to provide assurance and enable Health Boards to benchmark and share learning throughout Wales.

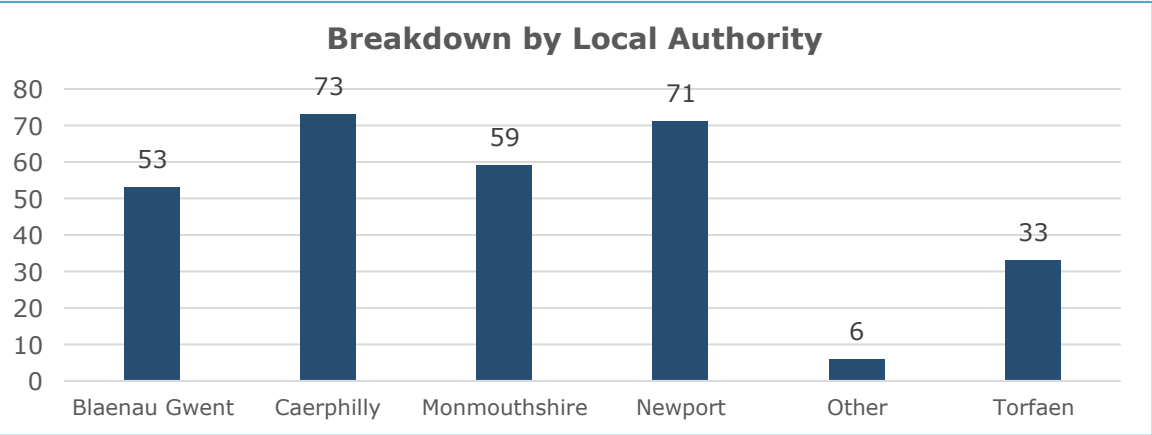
Members of the Safeguarding Team have membership on several national working groups such as:

- National Safeguarding Network
- Safeguarding in Health: Learning Framework
- Learning & Development
- Once for Wales Safeguarding Module
- Restorative Supervision
- Quality Assurance & Accountability Framework

Child Protection Medicals (CPM)

Child Protection Medicals are assessments carried out to identify any signs of abuse or neglect in children and young people.

In 2024/2025, a total of **295** Child Protection Medicals were conducted—matching the number from 2023/2024.



This data provides a local authority breakdown but should not be interpreted in isolation.

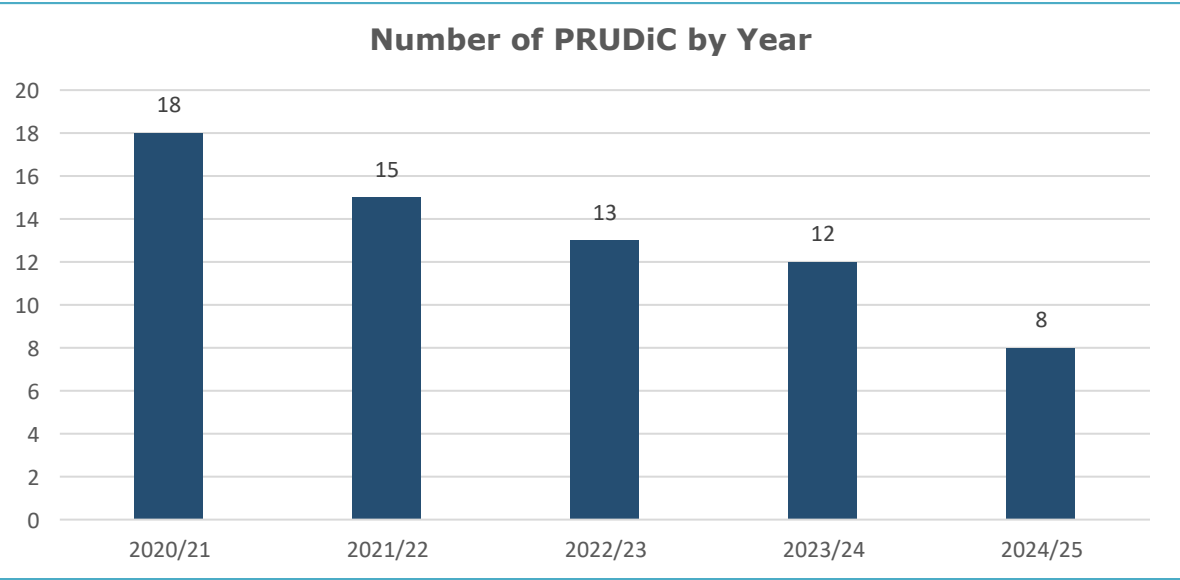
Timeliness and Peer Review:

In line with policy, all Child Protection Medicals were completed within 24 hours of the request being accepted. Each case undergoes monthly peer review by medical staff to maintain service quality and encourage professional challenge.

Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

Prudic outlines the minimum response required following an unexpected child death. It ensures a coordinated, safe, and compassionate approach through effective communication, joint action, and information sharing.

In 2024/2025, **eight** child deaths in the health board area met the PRUDiC criteria. This reflects a continued decline since 2020:



All PRUDiC cases are reported to the Welsh Government in line with *Putting Things Right* guidance. This enables monitoring of patterns and trends—none of which were identified in 2024/2025.

In 2024/25, the Gwent Safeguarding Board published a single Child Practice Review, which was shared through the Strategic Safeguarding Group to support learning and improvement.

The review followed the death of a 15-year-old male in August 2021, referred to as *Child D* at the family's request. Born in 2006 and diagnosed with cerebral palsy, Child D had early contact with social services when a Social Worker from the disability team was assigned at age one. At the time of his death, he was living with his grandparents, where professionals observed signs of neglect and poor living conditions.

While the review did not highlight any specific failings or areas for improvement in services provided or commissioned by the health board, it did identify broader learning opportunities. These included strengthening safeguarding frameworks and enhancing supervision practices for staff managing complex cases—offering valuable insights for internal development and continuous improvement.

Further reviews have been agreed and commenced within the timeframe however are not published at this within 2024/25.

1 Following the death of a 15 year old child (Child D), an extended Child Practice Review was commissioned. Child D was born in January 2006 at 24 weeks gestation. He spent 19 weeks in a neo-natal unit and was diagnosed with cerebral palsy. Child D was first known to Children's Services Disability Team at the age of 1 years old for Occupational Therapy support due to his complex health needs.

In 2008, Child D was placed with his maternal grandparents as a Child Looked After due to his mother feeling unable to meet his needs; this was followed by a Special Guardianship Order being granted to them some months later. Child D's mother and father had moved to a different area and Child D continued to reside with his maternal grandparents. Concerns regarding home conditions first came to light in 2015.

Background



**Diogelu Gwent
Gwent Safeguarding**

7 Child D's educational setting recognised when he was in pain and queried the reasons for this with family.

Professionals recognised that Child D's mother may struggle with his care while grandparents were away and ensured measures were put in place including additional support from extended family, additional school playscheme sessions, and Social Worker home visits.

During the Covid 19 pandemic, school maintained regular contact with the family and Child D was offered and attended a hub placement during school closures.

Local Authority provided support at home to enable grandparents to access virtual core groups during the Covid 19 pandemic.

Good Practice

6 **Recommendation 4 continued:** These could also be used to discuss acceptable standards. A multi-agency approach to a cluttered environment should be considered and agencies such as the fire service to be considered for education regarding risk. **Recommendation 5:** When a child is residing with a parent/carer who no longer holds over-riding parental responsibility, Children Services should complete risk assessments for the parent/carer to prove competence related to the care needs of the individual child. **Recommendation 6:** Risk assessments should be completed by the Local Authority in partnership with other relevant agencies to evidence and therefore enable escalation of poor service from outside companies when waiting times for equipment exceed expected timescales. The impact to the child or young person should be considered within this. **Recommendation 7:** Regular assessments of equipment needed for individuals should be undertaken and equipment removed if appropriate by the Local Authority and partnership agencies. Escalation processes should be clear for all staff across all sectors to enhance the care

Recommendations:

5 **Recommendation 1:** The Safeguarding Board should consider developing practice guidance on the lived experience of children with disabilities to assist practitioner insight, to ensure that the voice of the child is actively heard and to support effective action to safeguard children and young people. **Recommendation 2:** Consideration should be given for the Local Authority to review the strategic responsibility for the Children with Disabilities Team within the directorate of the authority. This consideration could include ensuring consistency across the region. **Recommendation 3:** The Safeguarding Board to explore and consider if information from GP's regarding children who are subject to safeguarding procedures, should be shared with Pharmacists to monitor and share information as appropriate. **Recommendation 4:** The Safeguarding Board to consider the addition of a home conditions threshold to the existing regional neglect guidance. Photographs of home environments should be considered to enable professionals and families to identify and enable change, as appropriate.

Recommendations:

2 Child D's mother returned to the family home in 2016 along with her two children from a different relationship. Whilst residing in another area Children's Services had been involved with Child D due to concerns regarding neglect. Home conditions fluctuated from 2015 up until Child D's death. His health continued to be reviewed with no issues being identified. In 2021 concerns were raised regarding medication management for Child D and later that year his named was placed on the Child Protection Register for Neglect. Throughout the time that Children's Services were involved with child D and his family, they remained as part of the Children's Disability Team within the Local Authority Structure.

Prior to Child D's death his Grandparents went on holiday, extra safeguards were put in place due to mother having caring responsibility for Child D. During this time, it was identified that he was suffering from constipation and a prescription was made by his GP; however, this was not collected. Poor home conditions were noted by paramedics and police attending at the time of Child D's death.

Context

3 **Theme:** Understanding a child's lived experiences is vital for effective safeguarding. Child D was predominantly non-verbal due to his complex needs. Complexities with speech and language should not be a barrier to developing an understanding of a child's lived experience. The Children's Disability Team within the Local Authority currently falls within the Adult Services Structure. Physical needs relating to child D's disability were met with professional input from services such as Occupational Therapy. However, there is a lack of focus on child D's lived experiences as a child with disabilities living within a home where there was cumulative neglect over a number of years.

Recurrent Poor Home Conditions and Neglect: The impact of neglect may be more severe for some children, including those with disabilities such as Child D. The cumulative effect of neglect must be considered by professionals, particularly when children have complex needs.

4 **Theme:** Risk Assessments for Carers Understanding of Child D's Needs: Child D was residing with his grandparents under the requirements of a Special Guardianship Order, however, there were times when his care was the responsibility of his mother, for example when his grandparents were on holiday. Child D had complex care needs and it is unclear the extent to which mother had the ability to meet these needs whilst also caring for Child D's siblings, and what grandparents understanding of this was. **Specialist equipment:** Child D required a range of specialist equipment due to his health needs; these changed over time as Child D grew and it must also be considered that as Child D grew and his grandparents aged, it may have become more challenging for them to meet his needs. Specialist equipment was provided for Child D however some items were not used due to them causing Child D distress. There were significant delays in obtaining other items, influenced by the Covid 19 pandemic. This highlights the importance of ongoing assessment.

Safeguarding Supervision

Safeguarding supervision is a fundamental responsibility of the Safeguarding Team, designed to ensure that staff are well-prepared with the knowledge, skills, and confidence needed to meet their safeguarding duties. It also fosters a supportive environment that promotes reflection and ongoing professional growth.

Supervision provides a restorative and reflective space where staff can explore casework, celebrate successes, and identify areas for development. It also enables the Corporate Safeguarding Team to spot emerging trends and challenges faced across the health board. This approach is consistent with the All Wales Safeguarding Supervision Guidance (2024), which highlights the value of restorative practices in building practitioner resilience and supporting well-being.

Staff across the health board can access safeguarding supervision through a variety of formats, including:

- Immediate telephone support
- Post-incident debriefs
- One-to-one supervision
- Group supervision sessions

Child Safeguarding Supervision

Safeguarding supervision continues to be routinely provided for child-focused specialties, including Health Visitors, School Nurses, CAMHS Practitioners, Community Paediatric Nurses, Children’s Learning Disability Nurses, Sexual Health Outreach teams, Acute Paediatric Nurses, Health Care Support Workers, Neonatal Intensive Care Nurses, the Neonatal Intensive Care Liaison Team, and Midwives.

The Corporate Safeguarding Team acknowledges the importance of ensuring that health board staff have access to subject matter experts for case discussions and incident reviews. In accordance with the Safeguarding Supervision Policy, it is recommended that staff receive supervision at least twice annually.

While operational managers are responsible for monitoring compliance locally, the Corporate Safeguarding Team has facilitated nearly 50 formal supervision sessions over the reporting year. These sessions have been well-attended and have received positive engagement from staff working across children’s services.

Adult Safeguarding Supervision

Unlike the explicit mandate for staff working with children, adult safeguarding supervision is not currently emphasised to the same extent within intercollegiate guidance. This is largely due to a national view that professionals working with adults typically do not maintain formal caseloads and that their interactions with service users are often episodic.

However, within the health board, there is clear evidence that certain teams engage with highly complex and vulnerable individuals over prolonged periods. In recognition of this, a structured model is being developed to support safeguarding supervision within adult services.

To date, the Corporate Safeguarding Team has introduced this supervision model within the Complex Care Team and the High Impact User Service.

Plans are also underway to explore the implementation of more formal supervision arrangements within the Community Mental Health and Learning Disability (MH/LD) Teams.

Safeguarding Training

Safeguarding training remains a fundamental responsibility of the Safeguarding Team and is mandatory across the Health Board. Compliance is expected to align with the Welsh Government’s national target of 85%. Training is delivered through a combination of e-learning and face-to-face sessions.

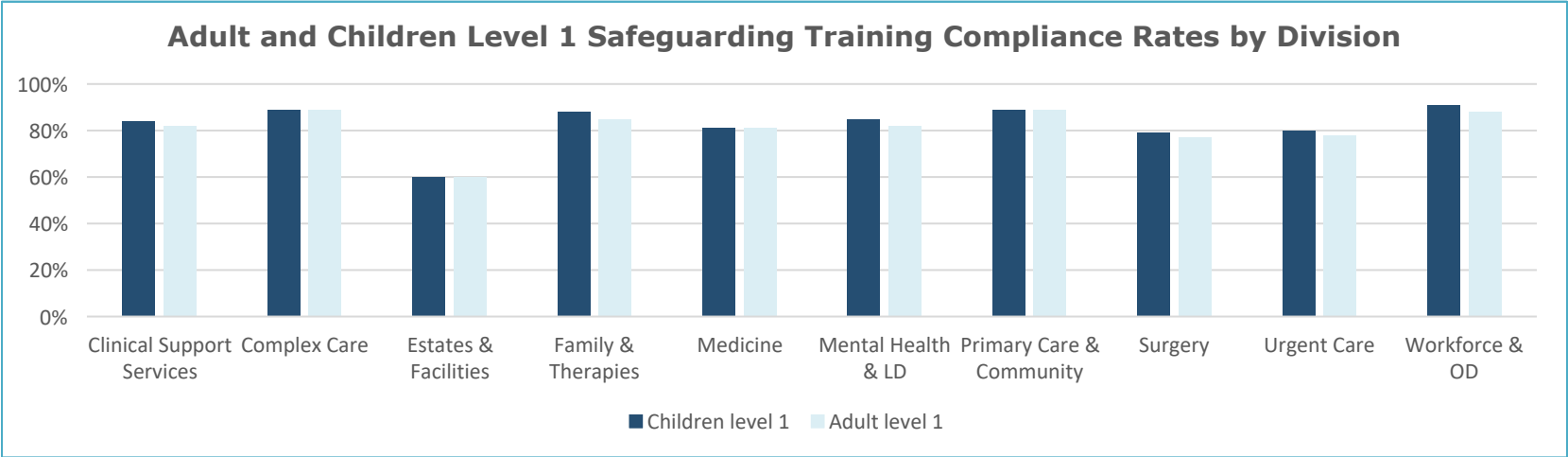
During 2024/2025, overall compliance with safeguarding training has shown a positive upward trend. Notably, there has been a marked improvement in engagement from divisions, which is both recognised and appreciated.

Level 1 Safeguarding Training

Level 1 Safeguarding Training is a mandatory online module for all staff working within ABUHB. It equips professionals with the knowledge and skills to recognise safeguarding concerns involving both adults and children, and to respond appropriately when necessary.

As of 31 March 2025, compliance rates stood at **81% for adults** and **83% for children**. Although ABUHB reached the 85% compliance target at several points during the year, this standard was not consistently upheld. Current figures suggest that only minor improvements are needed to regain the 85% benchmark.

The graph below presents compliance with Level 1 training for both adults and children, broken down by division.



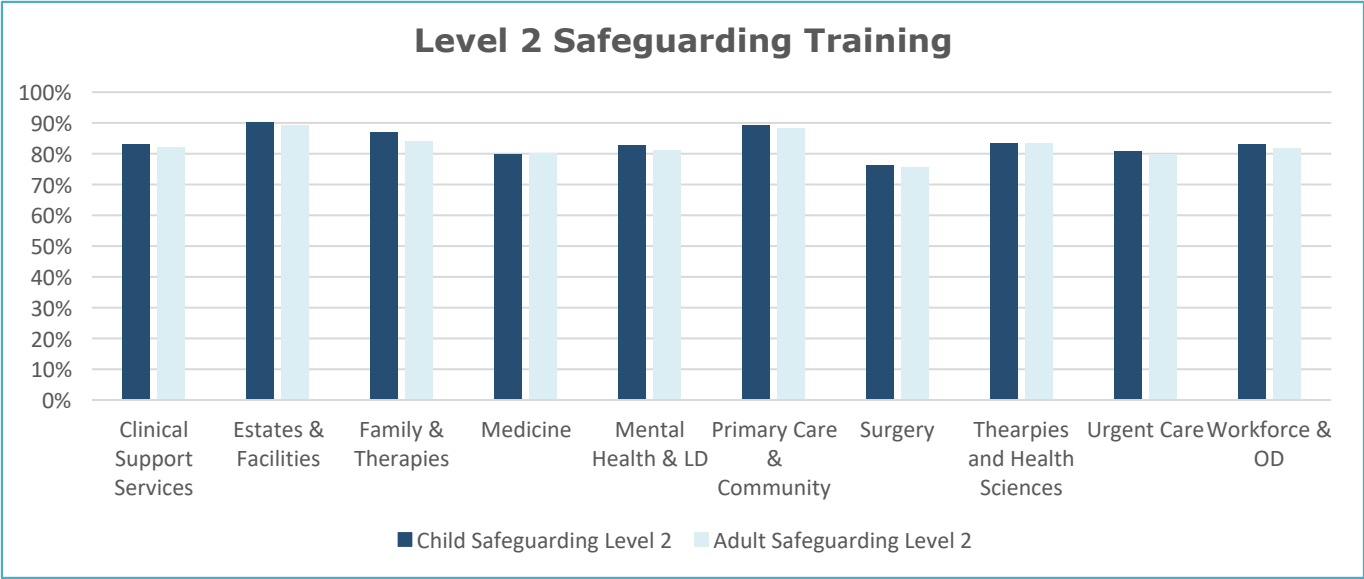
Level 2 Safeguarding Training

Level 2 Safeguarding Training is a mandatory requirement for all ABUHB professionals who have direct patient contact. This training equips staff to recognise safeguarding concerns and respond appropriately, including making referrals and advocating for both adults and children.

As of the current reporting period, compliance rates are 84% for adults and 81% for children, aligning closely with the figures reported in 2022/23.

These results suggest that only minor improvements are needed to reach the 85% compliance target, however this position remains unchanged to the previous year.

The graph below illustrates Level 2 training compliance for both adults and children, broken down by division.



Level 3 Safeguarding Training

Level 3 Safeguarding Training is now a mandatory, interactive module—delivered either face-to-face or virtually—for all registered professionals within the Health Board. In accordance with the Intercollegiate Document (RCN, 2019) and the Wales Safeguarding Training, Learning and Development Standards (2022), staff are required to complete a minimum of eight hours of interactive training every three years.

As of March 2025, this requirement has been formally embedded into the Electronic Staff Record (ESR) system for relevant staff groups.

The training equips professionals with the essential knowledge and skills to effectively assess, plan, intervene, and evaluate the needs of individuals, ensuring the safeguarding of both adults and children at risk.

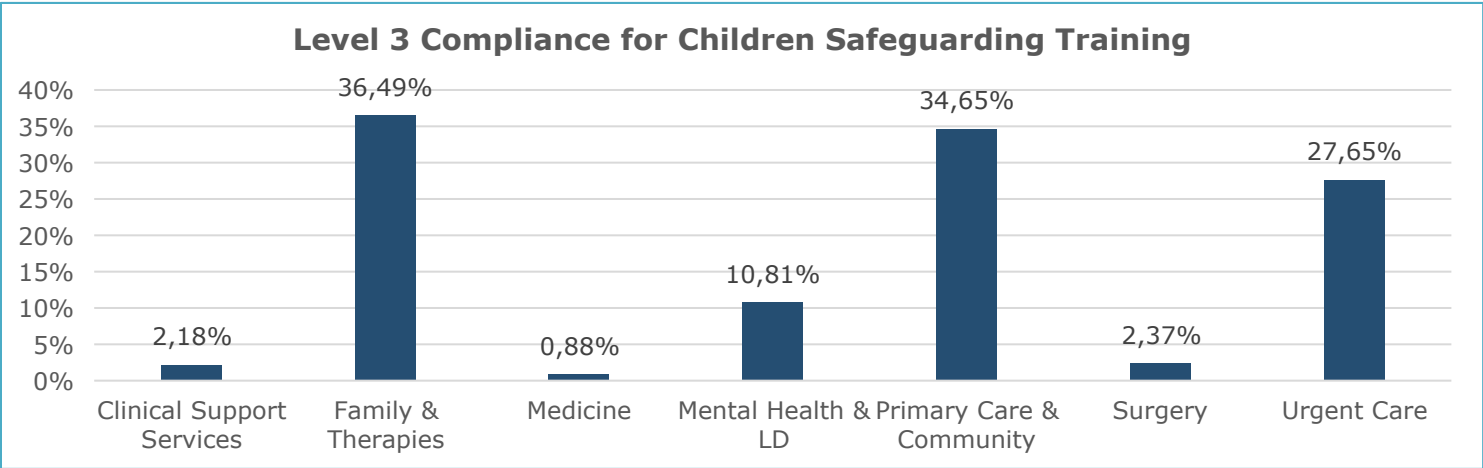
Historically, monitoring compliance with Level 3 training was challenging. However, with ESR now capturing this data, the health board can now track uptake and compliance by staff group and division—bringing it in line with reporting for Levels 1 and 2.

As of March 2025:

- 2,476 staff were identified as requiring Level 3 Safeguarding Children training, with 633 completions, equating to a 25% compliance rate.
- Approximately 6,200 staff were identified as requiring Level 3 Safeguarding Adults training, equating to a starting compliance rate of 15%.

Training is currently delivered as a full-day session—either in person for groups of up to 50 or virtually via Microsoft Teams for up to 30 participants. Despite these efforts, compliance for both adult and children’s Level 3 safeguarding training remains below the Health Board’s target of 85%. Based on current delivery methods, capacity and resources:

- Children’s Level 3 compliance is expected to reach 50% by March 2026, 80% by March 2027, and meet the 85% target by March 2028.
- Adult Level 3 compliance is projected to reach 55% by March 2028, however alternative training methods are being reviewed to achieve greater compliance at around 85% by March 2028.



Domestic Abuse Training

Ask and Act Training Overview

Ask and Act training equips professionals to respond effectively to individuals affected by gender-based violence, domestic abuse, and sexual violence.

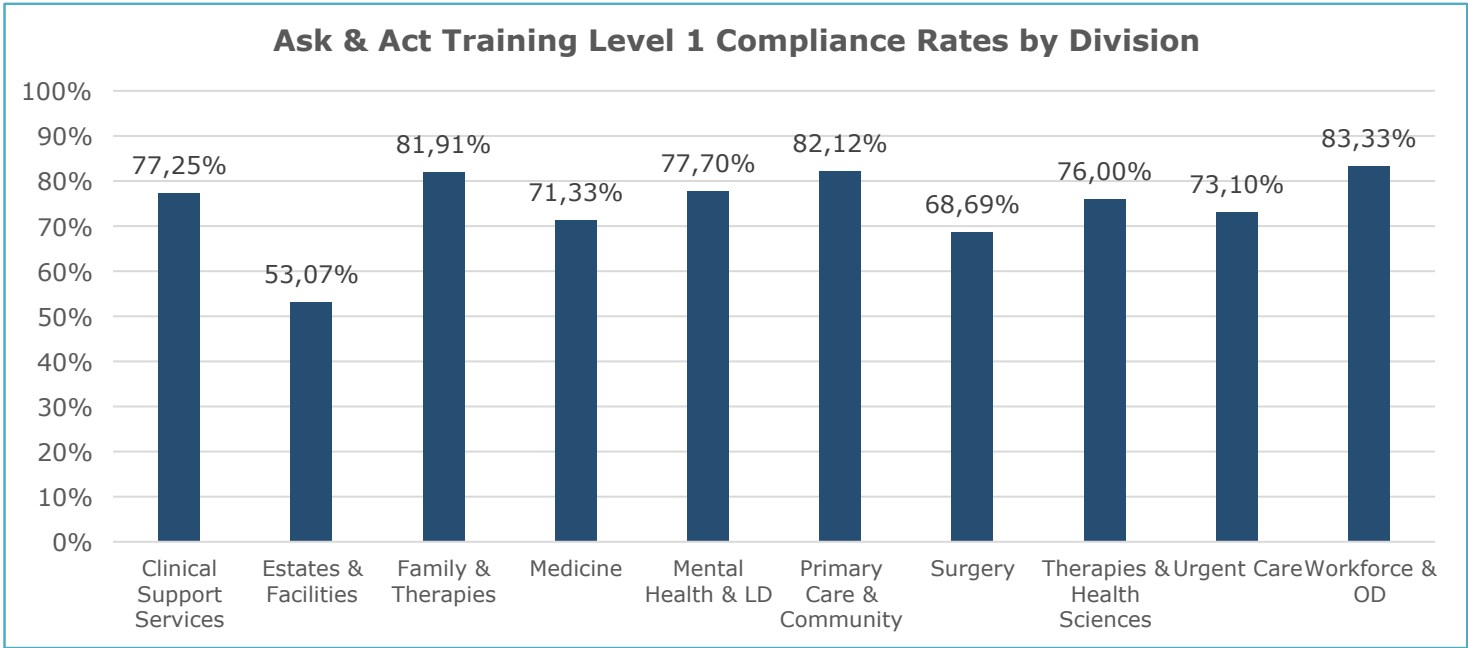
The training is structured similarly to standard safeguarding levels—Groups 1, 2, and 3—based on participants’ responsibilities and learning needs.

- **Group 1** is the foundational training and is mandatory for all ABUHB staff.
- **Group 2** is designed for those who work directly with victims and are responsible for identifying, assessing, and referring cases.

In 2024/25, 75% of eligible ABUHB staff completed Group 1 Ask and Act training, reflecting a slight increase in compliance compared to 2023/24.

Group 2 training continues to present challenges in tracking compliance due to limitations in ESR reporting. As a result, it will remain a focus area in the 2025/26 Training Needs Analysis.

The graph illustrates Group 1 compliance rates by division



Review of Priorities for 2024/25

1	To work with Senior Leadership Team in Primary Care to ensure that those working within primary care have the training and resources to ensure compliance with the Wales Safeguarding Procedures.		The Safeguarding Management Team has now completed this work, having delivered presentations across all Boroughs to outline the available training offer on recognising domestic violence. They have also proactively extended ongoing supervision and support to designated safeguarding leads within practices managing such cases.
2	To ensure delivery of appropriate Safeguarding Adult Supervision to teams within the Mental health and Learning Disability Division who are holding caseloads.		Group supervision, initially piloted in selected areas, will be expanded to additional teams throughout 2025/26.
3	To develop and launch a suite of documents in relation to sexual safety, including a Chaperone Policy, a standard operating procedure for referral to SARC and guidelines on internal reporting.		Work on policies addressing sexual safety and historical sexual abuse has commenced, with guidance documents now developed, shared and published on the Safeguarding intranet page.
4	To revise the model for delivery and monitoring of Level 3 Safeguarding training.		Safeguarding Level 3 training is now a mandatory requirement on the ESR platform, enabling accurate tracking of compliance and ensuring Divisions are accountable for meeting their training obligations.
5	Launch of the DATIX Safeguarding Module to facilitate better case management of cases open to the safeguarding processes.		The implementation of the Once for Wales Datix system was backed by the ABUHB Executive Team and the National Safeguarding Service. Following a period of planning, the Safeguarding module officially went live on 1 April 2025.
6	To rewrite the ABUHB Section 5/Practitioner Concerns Guidance to reflect internal processes and to strengthen local application of the national threshold for referral.		A dedicated sub-group of the Strategic Safeguarding Group has been established to support this model of working within ABUHB, with efforts continuing into 2025/26 to deliver on this priority. Awaiting revision of National section 5 policy.
7	To develop a set of internal assurance measures, which can contribute to ward accreditation, in regard of Safeguarding and Domestic Abuse.		Safeguarding has been established as one of the Six Pillars of Quality within ABUHB and is included in ward accreditation audits. This approach reinforces accountability and promotes the understanding that safeguarding is a shared responsibility across all areas.
8	To establish operational subgroups of the safeguarding committee with a focus on embedding learning from statutory reviews and driving quality improvement.		The three sub-groups are now operational and provide assurance through reporting to the Strategic Safeguarding Group. These groups facilitate early learning from reviews and incidents, enabling the delivery of work through a multidisciplinary perspective.

Conclusion

The year 2024/25 presented significant challenges for the Corporate Safeguarding Team, driven by a notable rise in safeguarding activity alongside the team’s ongoing statutory responsibilities.

Despite these pressures, key achievements were realised in the following areas:

- Delivery of Level 3 Safeguarding Training.
- Mandating Level 3 Safeguarding compliance via the ESR platform.
- Proactive management of an increased and more complex caseload.
- Expansion of safeguarding supervision across wider areas.
- Strengthening the Independent Domestic Violence Advocate (IDVA) role within urgent care settings.
- Establishment of a well-attended and effective Strategic Safeguarding Group, supported by dedicated sub-groups.
- Successful planning and preparation for the implementation of the Datix Safeguarding module.

ABUHB remains firmly committed to prioritising the safeguarding of both children and adults. This commitment will continue into 2025/26, with a focus on addressing both existing and emerging challenges.

Ongoing collaboration with the community and partner organisations will be essential to support continued development and adaptation.

Priorities for 2025/26

The health board recognises that further progress is needed to strengthen safeguarding for children and adults at risk. As a Health Board, it is essential that we continue to evolve and enhance our services to meet the needs of a modern and changing society.

The priorities for the health board in 2025/26 include:

Priority 1:
To finalise the framework for delivering and monitoring Level 3 Safeguarding training.

Priority 2:
To ensure the provision of appropriate Safeguarding Adult Supervision for teams within the Mental health and Learning Disability Division who are managing active caseloads.

Priority 3:
To develop and launch a suite of Safeguarding Policies (to also include sexual safety and a SOP for SARC referrals) that staff can easily access and apply, supporting the effective safeguarding of individuals and staff across ABUHB.

Priority 4:
To implement functionality within the ESR platform that enable accurate monitoring and Divisional reporting of Ask & Act Group 2 training compliance.

Priority 5:
To launch the DATIX Safeguarding Module to enhance the management and oversight of cases within safeguarding processes.

Priority 6:
To continue developing internal assurance measures relating to Safeguarding and Domestic Abuse, which will contribute towards ward accreditation processes.

Priority 7:
To work collaboratively with Local Authority and Police partners to reduce the duration cases remain open and to establish processes that support early learning.

Priority 8:
To collaborate with Police and Local Authority partners to ensure the consistent and equitable application of nationally revised Section 5 processes.



Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	01 October 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Nurse Staffing Levels (Wales) Act 2016: Spring 2025 Recalculations
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Kelly Downes - Deputy Director of Nursing Laura Thomson – Nurse Staffing Act Lead

Pwrpas yr Adroddiad (dewiswch fel yn addas) Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

This report presents the outcomes of the Spring 2025 recalculations conducted across all 25B wards, providing assurance regarding the Health Board's compliance with the Nurse Staffing Levels (Wales) Act 2016 (NSLWA).

Sefyllfa / Situation

In accordance with the NSLWA, Health Boards and Trusts have a duty to use the triangulated approach to calculate the nurse staffing levels in adult acute medical and surgical wards, and paediatric wards bi-annually. There is also a requirement to report compliance in maintaining the nurse staffing levels as a means of providing assurance to the public, the Board and Welsh Government.

Consequently, the All-Wales Nurse Staffing Group agreed a Once-for-Wales approach to provide consistency in reporting across all Health Boards. A clear governance process is required to inform the Board, or delegated committee, of any changes following the Bi-annual recalculations.

The Spring 2025 recalculations will be presented to the Executive Team for assurance and noting.



Cefndir / Background

The NSLWA became law in 2016 and requires Health Boards to have regard for the provision of appropriate nurse staffing levels to ensure nurses have time to care for patients sensitively.

The NSLWA statutory guidance states that health boards should undertake a recalculation every six months for all wards that come under Section 25B of the Act. In previous years data taken from January and June acuity audits based on the Welsh Levels of care has been used to inform the calculation process. The successful rollout of Safecare to all 25B wards, has enabled ward staff to have access to 6 months of acuity data for the recalculation meetings as opposed to a 1-month snapshot.

The Executive Team were appraised of the changes made to 25B Wards following the Autumn 2024 recalculations.

Asesiad / Assessment

In accordance with the NSLWA - a systematic triangulated approach to review and recalculate the nurse staffing levels on all 25B wards (Adult and Paediatric) has been applied as stipulated in legislation.

The Spring recalculation/deep dive meetings take place throughout the months of March and April with representation from the Divisional Lead/Head of Nursing, Senior Nurse, Ward Manager, Nurse Staffing Act Lead, e-rostering and finance teams.

The divisions use a well-established term of reference to conduct the recalculation meetings. Discussions include the type of ward, bed base, funded establishment, e-roster housekeeping and Safecare compliance. The acuity levels over the previous 6 months are scrutinised along with the staffing levels deployed, including bank and agency usage and variable pay. Quality indicators from the previous 6 months are examined, these include incidences of hospital acquired pressure ulcers, patient falls with harm, medication errors, infection rates and complaints involving nursing care. Learning taken from incidents is discussed and ward managers are given the opportunity to share good practice. Ward accreditation progress, PADR and mandatory training compliance is also scrutinised.

Following the discussions and review of the data, collaborative professional judgement is used to determine if the staffing levels are appropriate to provide sensitive care to the patients. An agreed template for each 25B ward is



subsequently completed by the Divisional Nurse and presented to the Executive Director of Nursing and Deputy Director of Nursing in the form of a challenge and support meeting.

In total 33 wards were included under the reporting requirement of The Act for the Spring 2025 recalculations:

Acute Medical:	19 Wards
Surgical:	12 Wards
Gynaecology:	1 Ward
Paediatrics:	1 Ward (50 beds)

Surgical, Gynae & Paediatric wards

In the Divisions of Surgery and Family & Therapies planned rosters and funded establishments were deemed appropriate to meet the needs of patients. Therefore, there were no changes required to roster templates following the Spring recalculations.

Medicine

The sustainability of the Core Care Model was a strong theme throughout the COTE wards in Medicine, with many ward managers expressing the need for 4 Registered Nurses by day. However, following discussions with the lead Nurses it was concluded that a full review of the Core Care Model is required, taking into consideration the work being undertaken across Wales on the team around the patient and the imminent introduction of the Registered Nurse Associate Role.

The division of medicine identified 5 wards requiring amendments to previously agreed rosters which will align them to other similar wards in the Division, ensuring equity across services.

The proposed changes have been presented to the Divisional Management Team.

The Executive Committee is asked to note the following proposed recalculation changes:

Medicine

Ward 4.4, Nevill Hall Hospital (30 Bedded Care of the Elderly Ward)

This ward was repurposed from a semi acute respiratory ward to a COTE ward following the respiratory and general medicine reconfiguration in the Autumn of last year. It is a 30 bedded ward with the capacity to board 1 patient.



Due to consistent variable pay usage to support enhanced care and to bring them in line with other COTE wards on the Nevill Hall site, the request is to increase Band 2 HCSW to 4, 7 days a week (2.8 WTE), this will be at a cost of £103, 499 per annum, this will support some off setting of variable pay.

Previous roster: Day 4 RN / 3 HCSW - Night 2 RN / 4 HCSW
Proposed Roster: Day 4 RN / 4 HCSW - Night 2 RN / 4 HCSW

Presented to and approved by DMT in 6th May 2025

Total Cost: £103,499 per annum.

Bargoed Ward, Ysbyty Ystrad Fawr (27 Bedded Stroke Rehabilitation, capacity to board 2 patients)

The unit is a stroke rehabilitation ward with high acuity and dependency; due to the centralisation of stroke services the patients are being transferred from GUH earlier in their stroke pathway. The patients are acutely unwell, with many patients requiring Peg feeding which results in prolonged time for medication administration by a registered Nurse (RN).

There is requirement to increase this ward to 4 RNs 7 days a week, this equates to an increase of 2.84 WTE at a cost of £163,752.

The proposed change will align Bargoed ward with Oakdale ward. The model will include reviewing the Band 4 assistant practitioners to work across Bargoed ward and Oakdale ward ensuring an equitable service and the same staffing levels across the 2 Stroke Rehabilitation Wards in YYF.

Previous roster: Day 3 RN / 6 HCSW - Night 2 RN / 4 HCSW
Proposed Roster: Day 4 RN / 6 HCSW - Night 2 RN / 4 HCSW

Presented to and approved by DMT 6th May 2025

Total Cost: £ 163,75 per annum.

Oakdale Ward YYF (28 bedded Stroke rehabilitation ward, no Surge Capacity)

The unit is a stroke rehabilitation ward with high acuity and dependency; due to the centralisation of stroke services the patients are being transferred from GUH earlier in their stroke pathway. The patients are acutely unwell, with many patients requiring Peg feeding which results in prolonged time for medication administration by a registered Nurse (RN).

The establishment for this ward includes 4 RNs by day to support the prolonged medication rounds, however, because of the high dependency of the patients there is a need to increase the HCSW to 5 by day, 7 days per week, at a cost of £103, 499 per annum. A review of the data revealed that this ward is continually creating



additional HCSW shifts to cope with the dependency of the patients. This change would mean both Stroke Rehabilitation wards will be aligned.

Previous Roster: Day 4 RN / 4 HCSW - Night 2 RN / 4 HCSW
Proposed Roster: Day 4 RN / 5 HCSW - Night 2 RN / 4 HCSW

Presented to and approved by DMT by 6th May 2025

Total Cost: £ 103,499 per annum

C6E Royal Gwent Hospital (30 bedded General Medical Ward, no Surge capacity)

Patient dependency is high on this ward, concerns were raised around the Core Care Model, with staff expressing the need for 4 RNs by day. However, this will be revisited following a full review of the Core Care Model and how it fits with the future Registered Nurse Associate role. It was recognised however, that the variable pay for this ward is high. Additional HCSW shifts are consistently created by night to support high dependency and increased enhanced care needs of the patients.

Therefore, to offset variable pay and ensure continuity of care, there is a need to increase the establishment by 1 HCSW by night, 7 days a week at a cost of £124,000 per annum to offset variable pay.

Previous roster: Day 3 RN / 5 HCSW - Night 2 RN / 3 HCSW
Proposed Roster: Day 3 RN / 5 HCSW - Night 2 RN / 4 HCSW

Presented to and approved by DMT 6th May 2025

Total cost £124,000 per annum

C6W Royal Gwent Hospital (28 bedded Endocrinology ward with some General Medicine Beds)

The Ward Manager highlighted that the existing planned roster does not suit the needs of the ward. The ward manager proposed the ward would run more smoothly with an additional RN during the day shift to manage the workload. In addition, an extra HCSW by night is consistently needed to support patient acuity and enhanced care, driving up variable pay.

Following professional discussions, it was agreed to make a cost neutral change to the planned roster. The new proposed roster will swap the RN by night with the HCSW by day

The change to the planned roster will be cost neutral.

Previous Roster: Day 3 RN / 5 HCSW - Night 3 RN / 3 HCSW
Proposed Roster: Day 4 RN / 4 HCSW - Night 2 RN / 4 HCSW



Cost neutral

This paper was discussed at the Executive Committee on the 18th of September, it was agreed that the Division of Medicine would implement the cost neutral change on C6W.

In terms of the requests regarding 4/4 at Nevill Hall Hospital, Oakdale Ward & Bargoed Ward at Ysbyty Ystrad Fawr and C6E at the Royal Gwent Hospital in order to meet the requirements of the Act the existing arrangement of utilising variable pay spend to staff these wards as set out in the spring calculation has been supported. A further review through workforce, finance and nursing was agreed to be undertaken as part of the autumn calculation process prior to any permanent funding arrangements being agreed or roster changes

The continuance of variable pay would maintain bed stability as we head into the winter months, support health board compliance with the mandated 45-minute Ward handover and continuous flow model, and ensure staffing levels are equitable across the medical wards.

Appendix 1: provides a summary of the required establishment for all 25B wards following the Spring 2025 recalculations.

Appendix 2: provides detail for the 5 wards identified following the Spring recalculations as requiring alterations to their agreed templates.

Argymhelliad / Recommendation

The Health Board has a duty to implement the statutory guidance and ensure compliance with the requirement of the Nurse Staffing Levels (Wales) Act.

The Patient Quality Safety Outcomes Committee is asked to: -

- Acknowledge the Health Board is meeting its statutory requirement to calculate the nurse staffing levels for all wards that fall under Section 25B of the NSLWA.



- Agree to option 1, the alterations of ward establishments and planned rosters for the 5 wards in the Division of Medicine.
- Note that the financial cost of increasing ward establishments should be weighed against the advantages in terms of safe care delivery.

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 7. Staff and Resources 2. Safe Care Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:

Ar sail tystiolaeth: Evidence Base:	- Nurse Staffing Levels (Wales) Act 2016 - Health and Social Care (Quality and Engagement) (Wales) Act 2020.
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	



Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	01 October 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Health, Safety & Fire Annual Report 2024/25
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Peter Carr, Executive Director of AHPs & Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Peter Carr, Executive Director of AHPs & Health Science

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The purpose of this report is to present the Committee the Health, Safety & Fire Annual Report for 2024/25.

The report identifies both the opportunities and challenges for the Health Board in ensuring and sustaining compliance with Health and Safety legislation, including specific compliance improvement action delivered in this period.

The Committee are asked to approve the annual report and note the actions being taken to achieve compliance.

Cefndir / Background

The purpose of the annual report (Appendix A) is to provide the Health Board with a summary of principal activity and outcomes relating to the management of health and safety within Aneurin Bevan University Health Board during 2024/25. The report also highlights key priorities for the Health and Safety Committee and its subgroups for the financial year 2025/26.

The report summarises the prevailing legislative framework within which health and safety concerns are managed and addressed and outlines the local governance arrangements that underpin health and safety arrangements within the Health Board. Additionally, the report provides information relating to key activities

undertaken by the Health and Safety Committee and reporting subgroups with respect to:

- Fire Safety
- Health and Safety Training Provision
- Manual Handling
- Risk Management
- Violence and Aggression

The Executive Chair of the Health and Safety Committee, and director with the delegated responsibility for Health and Safety within the Health Board, continues with the Executive Director of AHPs & Health Science.

Asesiad / Assessment

The progress against the Health, Safety & Fire Improvement Plan in 2023/24 has provided a focus resulting in a reduction in key risk areas of concern.

The following points highlight and support the increase in compliance and reduction in risk following implementation of the improvement plan:

- **RIDDOR Reporting Compliance:** increase from 67.7% (2023/24) to 69.8% (2024/25)
- **Health and Safety Statutory & Mandatory Training Compliance:** increase in 2024/25 compared with 2023/24. This includes Manual Handling and Violence Prevention & Reduction.
- **Health and Safety Monitoring:** a programme of health, safety and environment workplace inspections was completed for wards and departments in the Acute Hospitals, Community Hospitals and Mental Health & Learning Disabilities sites. These assessments yielded an average Health Board compliance score of 89.63%.
- **Health and Safety Risk Assessments:** an additional 226 employees trained in Health & Safety Risk Assessment.
- **Fire Risk Assessments:** 100% completed/reviewed against of the planned areas in 2024/25. This is an increase of 4% compared with 2023/24.
- **Fire Alarm Systems:** work has been completed on upgrading the fire alarm system at St Cadocs Hospital and a programme has commenced on replacing the fire alarm system at Royal Gwent Hospital. Fire alarm systems across the Health Board have been analysed and a planned replacement programme has been developed.
- **Fire Barriers (Compartmentation):** the condition of fire barriers has been analysed across Hospital sites which has identified improvements required at Nevill Hall Hospital and Royal Gwent Hospital. Funding has been secured to repair the fire resisting barriers on these sites.

In addition to the progress made within the reported period, the Health and Safety Committee has recommended a series of risk areas for focus for 2025/26.

The Strategic Health and Safety Action Plan, aligned to the Health and Safety Strategy 2025-2028, outlines 8 key objectives to enhance a health and safety culture within the Health Board.

Health and safety leadership

The lack of knowledge and understanding of health and safety responsibilities for Managers and Supervisors presents a significant risk to the Health Board.

Health and safety assistance

The resource allocated to the Corporate Health and Safety Department presents a risk to the Health Board to meet the requirements of health, safety and fire legislation.

Health and safety policies & procedures

Health and safety policy compliance is currently poor and presents a risk to the Health Board. Outdated policies and procedures may be unclear, contradictory, or inconsistent with other organisational documents. This can lead to confusion among employees, resulting in misunderstandings, errors, and conflicts.

Manual handling training

The level of compliance with manual handling training presents a concern to the Health Board and a lack of staff competence to undertake manual handling techniques safely increases the risk of injury to staff and patients.

Fire safety training

Compliance with requirements of fire safety training guidance (HTM 05-03 part A: Operational provisions – Training) presents a risk to the Health Board. The organisation is currently dependant of staff completing their training and gaining competence by attending eLearning training.

Violence in the Workplace

The level of violence Health Board staff are exposed to is a significant risk and needs to be reviewed with prevention and reduction strategies implemented.

Compliance with the legal timeframes of reporting outlined within the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013

Failure to comply with RIDDOR leaves the Health Board at risk of enforcement action from the relevant enforcing authority.

Health and safety monitoring

The lack of a formal and structured health and safety monitoring system presents a risk to the Health Board.

Health and safety risk assessments

The poor quality and standard of risk assessments increases the risk to the Health Board. The risk is based on the likelihood of accidents and incidents occurring resulting in harm and the increased chance of enforcement action.

Recognising the Health Board challenges in compliance, a health and safety strategic risk (SRR 010) was developed in 2023/24. The risk is monitored regularly and reported via the Audit, Risk and Assurance Committee. The risk level has been reduced following the implementation of plans to improve controls, however, the risk level remains outside of target level and outside appetite threshold (minimal risk appetite level which should be managed to a Score of 8 or below). The risk areas of focus, listed above and set out in the annual report, will be the basis of the ongoing compliance improvement plan for Health & Safety, with routine progress reported to the Executive Committee.

Argymhelliad / Recommendation

The Committee is asked to:

- approve the annual report and note improvement in compliance during the reporting period, and the actions being taken to achieve ongoing compliance improvement.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	Draft Health, Safety & Fire Annual Report 2024/25
Rhestr Termiau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Health Board Health and Safety Committee Health Board Executive Committee

Effaith: (rhaid cwblhau)

Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Choose an item.
• Service Activity & Performance	Choose an item.
• Financial	Choose an item.
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.



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Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Health, Safety and Fire Annual Report 2024/25



Our Values and Behaviours

People First

**Personal
Responsibility**

**Passion for
Improvement**

**Pride in What
We Do**

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1 EXECUTIVE SUMMARY

The purpose of the report is to provide the Health Board with a summary of principal activity and outcomes relating to the management of health and safety within Aneurin Bevan University Health Board during 2024/25. The report also highlights key priorities for the Health and Safety Committee and its subgroups for the financial year 2025/26.

The report summarises the prevailing legislative framework within which health and safety concerns are managed and addressed and outlines the local governance arrangements that underpin health and safety arrangements within the Health Board. Additionally, the report provides information relating to key activities undertaken by the Health and Safety Committee and reporting subgroups with respect to:

- Fire Safety
- Health and Safety Training Provision
- Manual Handling
- Risk Management
- Violence Prevention & Reduction

The Executive Chair of the Health and Safety Committee, and director with the delegated responsibility for Health and Safety within the Health Board, continues with the Executive Director of Allied Health Professions & Health Science.

The progress against the Health, Safety & Fire Improvement Plan in 2023/24 has provided a focus resulting in a reduction in key risk areas of concern.

The following points highlight and support the increase in compliance and reduction in risk following implementation of the improvement plan:

- **RIDDOR Reporting Compliance:** increase from 67.7% (2023/24) to 69.8% (2024/25)
- **Health and Safety Statutory & Mandatory Training Compliance:** increase in 2024/25 compared with 2023/24. This includes Manual Handling and Violence Prevention & Reduction.
- **Health and Safety Monitoring:** a programme of health, safety and environment workplace inspections was completed for wards and departments in the Acute Hospitals, Community Hospitals and Mental Health & Learning Disabilities sites. These assessments yielded an average Health Board compliance score of 89.63%.
- **Health and Safety Risk Assessments:** an additional 226 employees trained in Health & Safety Risk Assessment.
- **Fire Risk Assessments:** 100% completed/reviewed against of the planned areas in 2024/25. This is an increase of 4% compared with 2024/24.
- **Fire Alarm Systems:** capital investment was secured to enhance the fire alarm systems. Work programmes commenced on replacing the fire alarm systems at Royal Gwent Hospital and St Cadocs Hospital. Fire alarm systems across the Health Board have been analysed and a planned replacement programme has been developed.
- **Fire Barriers (Compartmentation):** condition of fire barriers analysed across Hospital sites, identifying improvements required at Nevill Hall Hospital and Royal Gwent Hospital.

In addition to the progress made within the reported period, the Health and Safety Committee has recommended a series of risk areas for focus for 2025/26.

1.1 Risk Areas for Focus in 2025/26

Health and safety leadership

The lack of knowledge and understanding of health and safety responsibilities for Managers and Supervisors presents a significant risk to the Health Board.

Health and safety assistance

The resource allocated to the Corporate Health and Safety Department presents a risk to the Health Board to meet the requirements of health, safety and fire legislation.

Health and safety policies & procedures

Health and safety policy compliance is currently poor and presents a risk to the Health Board. Outdated policies and procedures may be unclear, contradictory, or inconsistent with other organisational documents. This can lead to confusion among employees, resulting in misunderstandings, errors, and conflicts.

Manual handling training

The level of compliance with manual handling training presents a concern to the Health Board and a lack of staff competence to undertake manual handling techniques safely increases the risk of injury to staff and patients.

Fire safety training

Compliance with requirements of fire safety training guidance (HTM 05-03 part A: Operational provisions – Training) presents a risk to the Health Board. The organisation's Compliance data is currently based on staff completing eLearning training. The standard requires face to face training.

Violence in the Workplace

The level of violence that Health Board staff are exposed to is a risk and needs to be reviewed with prevention and reduction strategies implemented.

Compliance with the legal timeframes of reporting outlined within the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013

Failure to comply with RIDDOR leaves the Health Board at risk of enforcement action from the relevant enforcing authority.

Health and safety monitoring

The lack of a formal and structured health and safety monitoring system presents a risk to the Health Board.

Health and safety risk assessments

The poor quality and standard of risk assessments increases the risk to the Health Board. The risk is based on the likelihood of accidents and incidents occurring resulting in harm and the increased chance of enforcement action.

2 INTRODUCTION

This report provides analysis of the level of health and safety performance throughout the Health Board for 2024/25.

The Health and Safety at Work (etc.) Act 1974 provides a legislative framework to promote, stimulate and encourage high standards of health and safety at work.

In particular, the Act requires an organisation to provide and maintain:

- A Health and Safety Policy;
- A system to manage and control risks in connection with the use, handling, storage and transport of articles and substances;
- A safe and secure working environment, including provision and maintenance of access to and egress from premises;
- Safe and suitable plant, work equipment and systems of work that are without risks;
- Information, instruction, training and supervision as necessary;
- Adequate welfare facilities;

As an NHS Wales organisation, there are clear expectations set out for the quality standards we must maintain. These are set out through the:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020;
- A Healthier Wales;
- Core Commissioning Requirements.

Health, Safety and Security is an identified quality pillar within the Health Board Quality Strategy. The 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains.

The Health Board operates a Health and Safety Management System, utilising the Health and Safety Executive (HSE) '*Managing for health and safety*' (HSG65) model.

The model is structured into the Plan, Do, Check, Act approach (see diagram 1).

Plan, Do, Check, Act helps achieve a balance between the systems and behavioural aspects of management. It also treats health and safety management as an integral part of good management generally, rather than as a stand-alone system.



Diagram 1: PDCA Health and Safety Management Model

3 HEALTH, SAFETY AND FIRE GOVERNANCE STRUCTURE

3.1 Accountability

The Chief Executive Officer (CEO) is accountable for Health and Safety with responsibility for executive leadership delegated to the Executive Director of Allied Health Professions & Health Science.

3.2 Health and Safety Leadership

Effective health and safety performance is led by the senior responsible officers of the Health Board. Members of the Board have both collective and individual responsibility for health and safety. Directors and boards need to examine their own behaviours, both individually and collectively, against the guidance given and, where they see that they fall short of the standards it sets them, to change what they do to become more effective leaders in health and safety.

Why directors and board members need to act:

- Protecting the health and safety of employees or members of the public who may be affected by your activities is an essential part of risk management and must be led by the board.
- Failure to include health and safety as a key business risk in board decisions can have catastrophic results. Many high-profile safety cases over the years have been rooted in failures of leadership.
- Health and safety law places duties on organisations and employers, and directors can be personally liable when these duties are breached: members of the board have both collective and individual responsibility for health and safety.

Business leaders have responsibility for determining and implementing effective health and safety management and monitoring its success, so it's essential that they understand how to implement a risk management strategy.

To support Board Members and Executive Directors to deploy their health and safety responsibilities, training was planned and delivered in 2024/25.

Regulation 7 of The Management of Health and Safety at Work Regulations 1999 states that *"Every employer shall, subject to paragraphs (6) and (7), appoint one or more Competent Persons to assist him in undertaking the measures he needs to take to comply with the requirements and prohibitions imposed upon him by or under the relevant statutory provisions"*.

The legislation states that a person shall be regarded as 'competent' if they have sufficient training, experience, or knowledge and 'other qualities'.

The Corporate Health and Safety Department employs specialist safety professionals to advise and support the Health Board to deliver and maintain health and safety standards.

The department structure (as of end of March 2025) is illustrated in diagram 2.

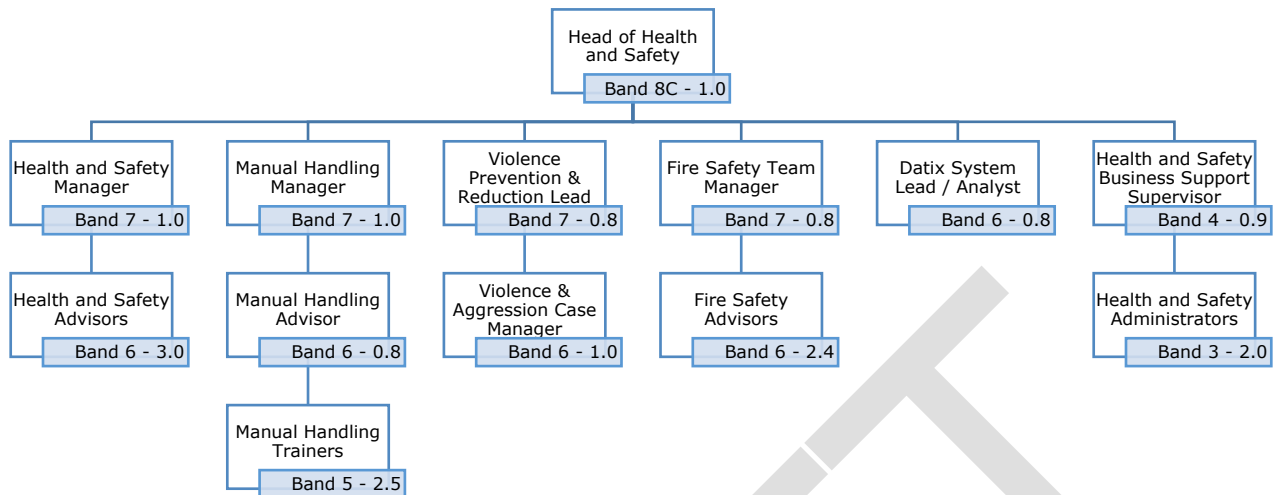


Diagram 2: Corporate Health and Safety Department Structure

Approval has been obtained in 2024/25 to recruit two new positions within the department; Deputy Head of Health, Safety & Fire (Band 8A) and Datix Systems Support Officer (Band 5). Plans are in place to recruit to these posts in 2025/26.

The Corporate Health and Safety Department is structured within specific functions i.e. health & safety, fire safety, manual handling and violence prevention & reduction.

The individuals within the functions are allocated areas of responsibility across the Health Board to support the development of effective relationships with key stakeholders. (See diagram 3)



Diagram 3: Map of Gwent Hospitals

During 2024/25 the Corporate Health and Safety Department has effectively integrated into the Health Board leadership structures and regularly engage via Divisional Quality and Patient Safety meetings and specific Health Board forums.

To ensure the Health Board can effectively meet its legal duties under Health and Safety legislation there is a need to consider the current resource available to the Corporate Health & Safety Department.

A review of the Corporate Health and Safety Department was completed in 2023/24. The review identified additional positions as key to enhancing the current establishment.

3.3 Health and Safety Reporting Arrangements

The Health and Safety Committee has been established to plan, manage and monitor Health Board compliance with statutory health and safety requirements and specific NHS duties.

The Executive Director of Allied Health Professions & Health Science is the Chair of the Health and Safety Committee, being the Director with delegated responsibility for health and safety within Aneurin Bevan University Health Board. The Health and Safety Committee is accountable to the Executive Committee and provides assurance to the Patient Quality and Safety Outcomes Committee.

The Health and Safety Committee receives reports from the subgroups and ratifies policies. The reporting arrangements are illustrated in diagram 4.



Diagram 4: Health and safety reporting arrangements

The Health and Safety Committee met three times in 2024/25. In June, September and December 2024.

The Committee Terms of Reference was agreed in September 2024 with agreed membership comprising of Executive Team members.

3.4 Health and Safety Committee Subgroups

Each subgroup is responsible for the production and updating of their own policies and terms of reference. These documents are submitted to the Health and Safety Committee for ratification.

During 2024/25 the subgroups did not meet. A plan of meeting dates for the subgroups will be implemented in 2025/26.

In addition to the corporate reporting arrangements, health and safety is a regular agenda item at the Divisional Quality and Patient Safety forums and Assurance meetings providing an opportunity to monitor health and safety performance.

3.5 Health and Safety Policies & Procedures

Health and safety policies and procedures have been developed within the Health Board to outline the organisations plans to achieve compliance with the relevant health and safety legislation and/or standards.

An objective for 2025/26 is to ensure all policies are reviewed and updated as appropriate.

Enforcement action taken by the Fire & Rescue Service against NHS Wales organisations relating to the control and management of ignition sources in healthcare has highlighted the requirement to develop a 'Search Policy'. This development is currently being led by the Corporate Health and Safety Department with engagement from key individuals across the Health Board.

A 'Vibration at Work Policy' is also in development to ensure the Health Board complies with the Control of Vibration at Work Regulations 2025. This policy is due to be finalise in 2025/26.

3.6 Audit and Assurance

There has been an Internal Audit on health and safety conducted during 2024/25. The outcome of the Internal Audit will be available in quarter 1 of 2025/26.

The Health and Safety Legislative Assurance Framework identifies the compliance with health and safety statutory instruments. The document is subject to an assessment by the Corporate Health and Safety Department in 2025/26.

4 HEALTH, SAFETY AND FIRE ENFORCEMENT ACTIVITY

During 2024/25, no prosecutions or enforcement actions have been issued by the Health and Safety Executive (HSE), however, South Wales Fire & Rescue Service (SWFRS) issued the Health Board with enforcement notices in February 2024 and April 2024 with respects to the fire safety arrangements at the staff accommodation buildings (Gerylyn and Bron Haul) at Nevill Hall Hospital.

The following matters highlight the non-compliance with the provisions of the Regulatory Reform (Fire Safety) Order 2005 for the buildings.

- Fire doors are being held open inappropriately
- Intumescent strip seals missing, damaged or defective
- The fire safety measures evaluated in the fire risk assessment have not been implemented
- The fire detection system is inadequate for the type and use of the premises
- The existing provision of manual firefighting equipment is inadequate
- Emergency routes and exits could not be used as quickly and as safely as possible
- The standard of fire separation is not adequate
- Fire resisting doors are not adequately maintained

A working group was formed to address the recommendations. Capital investment was secured to enhance the fire precautions in both building and the notices were complied with and subsequently lifted by South Wales Fire and Rescue Service in December 2024.

Although the HSE didn't issue any enforcement against the Health Board, they did issue a notification of contravention in relation to a fatal patient fall. The HSE investigation of this incident is still ongoing.

During 2024/25 there have been HSE intervention costs of approximately £1,250.00. These costs relate specifically to HSE investigations into a patient fall incident. (The Health and Safety (Fees) Regulations 2012 places a duty on HSE to recover its costs for carrying out its regulatory functions, from those found to be in material breach of health and safety law.)

5 RISK MANAGEMENT AND RISK REPORTING

A health and safety strategic risk (SRR 010) was developed in 2023/24. The risk is monitored regularly at Health and Safety Committee meetings and reported via the Audit, Risk and Assurance Committee.

The risk level has been reduced following the implementation of plans to improve controls, however, the risk level is outside of target level and outside appetite threshold.

In addition to the health and safety strategic risk, directorate health and safety risks have been completed and are under regular review.

The completion of risks assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999. To support the risk assessment programme, the Corporate Health and Safety Department deliver risk assessment training, promoting best practice in the completion of a risk assessment and the principals of effective Risk Management within departments and in the wider organisation.

The Health and Safety Professionals within the Corporate Health and Safety Department continue to provide advice and guidance on the implementation of statutory risk assessments through the various subgroups. Specialist risk assessments being completed by the Health and Safety Professional upon request.

Most of the health and safety risks are reported via the risk module on the DatixWeb system. The Health Board also subscribe to CoSHH management software for the risk assessments relating to substances hazardous to health. All fire safety risk assessments are recorded via the NWSSP fire auditing and reporting system. New software for recording and monitoring fire risk assessments is now available and will be introduced in 2025/26.

The Health and Safety Committee receives reports on health and safety risks for consideration, action and assurance.

As part of the monitoring arrangements, the Corporate Health and Safety Department continually engage with Risk Leads to review the risks recorded as Extreme High and High with the view to provide further advice and support and ensure that appropriate mitigation is applied as a means to manage the risks at a level that is so far is reasonably practicable.

6 HEALTH, SAFETY AND FIRE TRAINING

Suitable and sufficient training is a requirement of The Health and Safety at Work Act 1974 and The Management of Health and Safety at Work Regulations 1999.

The Management of Health and Safety at Work Regulations state “every employer shall ensure that his employees are provided with adequate health and safety training”.

The health and safety statutory and mandatory training compliance as of 31 March 2025 was as follows:

Training Course	2024/25 Compliance %	2023/24 Compliance %
Health and Safety	86.6%	86.7%
Fire Safety	82.3%	82.9%
Manual Handling	70.0%	55.3%
Violence Prevention & Reduction	86.1%	85.1%

During 2024/25 training compliance for health and safety, fire safety and violence prevention & reduction have been maintained compared with 2023/24.

With the exception of manual handling training, the delivery of the health and safety statutory and mandatory training programme in 2024/25 continues to be delivered by eLearning with access via the electronic staff record (ESR) self-service portal for ease to individuals. Line managers can view their team’s compliance and are also notified when staff are nearing non-compliance. Positive changes are being progressed in relation to the requirements for manual handling training dependent on role. This will result in staff deemed low risk only required to conduct eLearning manual handling training every three years.

Manual handling training continues to prove a challenge for the Health Board with compliance levels well below the required standard of 85%. The manual handling training strategy has been reviewed in 2024/25 to ensure the Health Board has a sustainable programme of manual handling education, particularly for high-risk areas.

Manual Handling training within NHS Wales is delivered to the scope of the All-Wales Manual Handling Passport. This ensures a consistent and standard approach to training.

During 2024/25, the Manual Handling Team have continued to deliver manual handling training to Health Board staff.

The table below provides details of the manual handling training delivered and the attendance.

Manual Handling Course Title	No. of Sessions	No. of Attendees	No. of DNA's
People Handlers Foundation Training	74	718	163
People Handlers Update Training	48	259	76
Object Handlers Foundation Training	7	41	14
Object Handlers Update Training	0	0	0
People Handlers Trainers Foundation Training	3	12	6
People Handlers Trainers Update Training	9	50	16
Object Handlers Trainers Foundation Training	2	18	2
Object Handlers Trainers Update Training	3	16	2

Staff attendance on manual handling training and specifically those who do not attend remains a challenge.

Violence prevention and reduction training is aligned to the All-Wales NHS Violence & Aggression Passport Scheme. The passport scheme is broken down into four areas:

Module A – Induction and Awareness Training: Introduction to the basic concepts of violence and aggression prevention, including organisational policies and employee responsibilities.

Module B – Theory of Personal Safety and De-escalation: In-depth theoretical training on personal safety techniques and strategies for de-escalating potentially violent situations.

Module C – Breakaway Techniques: Practical training on breakaway techniques to safely disengage from physical confrontations.

Module D – Restrictive Physical Intervention: Training on the appropriate and safe use of restrictive physical interventions when necessary.

All Health Board staff are mandated to complete modules A & B, whilst module C & D is based on risk assessment. Selected members of the Corporate Health and Safety Department have attended accredited training to enable them to teach module C and D.

Building on the work started in 2023/24, the Violence Prevention & Reduction Team continued delivering targeted training into the 2024/25. Specifically, three remaining training sessions were scheduled and delivered at Nevill Hall Hospital to complete the programme.

These sessions focused on the specific risks of violence and aggression posed by elderly patients in Care of the Elderly Wards. Recognising the difficulties faced by staff in these settings, bespoke training was developed to strengthen staff capability in managing such behaviours particularly where they intersect with dementia, mental health conditions, and environmental factors. Key areas covered included environmental safety and de-escalation techniques.

Feedback from attendees has been positive. Staff reported gaining a stronger understanding of the unique complexities involved in these scenarios and appreciated the practical nature of the techniques shared. Many noted increased confidence in managing challenging behaviours and a noticeable reduction in incidents requiring physical intervention.

6.1 Health and Safety Training for Executives and Senior Managers

In December 2024 and February 2025 seven members of the Executive Team, including the Chief Executive Officer attended the IOSH Safety for Executives and Directors. Plans are in place for the remaining members of the Executive Team to attend in 2025/26.

A Health and Safety for Managers Training package is currently being developed nationally. This work is being led by Cwm Taf Morgannwg University Health Board and will be agreed at the All-Wales Health and Safety Management Group.

Once the course is approved it will be implemented within the Health Board to provide Managers with an awareness of their role in health and safety management and implementation. The course will cover vital information such as the legal requirements, safety management systems, safety culture, risk assessment & hazard control and incident investigation.

6.2 Safety Guidance

Safety guidance have been implemented as a method to provide further information, instruction & training to Health Board employees in relation to health and safety matters.

The safety guidance provides safety reminders, brief refreshers and quick lessons on safety topics. The safety guidance is developed by the Corporate Health and Safety Department.

The use of safety guidance has provided greater opportunity to discuss recent incidents, near misses and everyday tasks.

6.3 Manual Handling Cascade Trainers Training

To support the delivery of the manual handling training strategy, cascade trainers are nominated in areas across the Health Board. The cascade trainers i.e. Transfer Specialists, Safer Handling Coaches etc. attend foundation training and are required to attend an update every two years to maintain their competency.

The register of cascade manual handling trainers was reviewed, cleansed and a programme of updates was delivered in 2024/25.

Trainer type	Number in organisation	Number currently out of date (over 2 years)
Transfer Specialist	234	53
Assistant Trainer	49	7
Safer Handling Coaches	224	93

6.4 Risk Assessment Training

The completion of risk assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999. To support the Health Board to maintain its legislative requirement and ensuring the provision of competent risk assessors, the Risk Assessor Training course has been revitalised for 2024/2025, 26 courses have been delivered and 226 Health Board Employees trained in Health & Safety Risk Assessment.

The aim of the course is to ensure all participants have an understanding on the concept of risk assessment, when a risk assessment is required within the workplace and how to conduct a suitable and sufficient risk assessment.

6.6 Fire Safety Training

The compliance data for fire safety training appears acceptable, however, these results are derived from compliance with eLearning modules alone. Staff with the responsibility to evacuate immobile patients require additional, practical evacuation training, delivered by Fire Safety Advisors. This requirement is highlighted in the fire safety guidance contained in Welsh Health Technical Memorandum (WHTM) 05:01.

This additional level of training is delivered to all Theatres, Critical Care and similar departments caring for high dependency patients. Efforts by the Fire Safety Team to expand face to face training to all inpatient wards in 2024/25 have been partially successful but problems securing release of staff persist.

A programme of fire evacuation training for staff on inpatient wards has been drawn up for 2025/26. However, delivery of the programme will be challenging at current Fire Safety Advisor resource levels.

6.7 Fire Warden Training

Fire wardens at Health Board premises perform a vital function in maintaining safe environments. Their role during fire emergencies is as a *critical friend* to department and ward managers who are responsible for initiating and managing evacuations.

Key functions of fire wardens include the continual monitoring and completion of monthly safety checks of their areas to identify fire safety concerns. They provide the valuable service of liaison with the Fire Safety Advisors to provide early warning and resolution of potential safety issues.

The Fire Safety Team continue to promote the role via the fire risk assessment process with the goal that every work area in the Health Board has at least one fire warden assigned.

An additional 73 fire wardens were identified and attended training in 2024/25.

Recruitment and retention of Fire Wardens is challenging. There are currently 349 wardens registered with 171 departments regularly submitting monthly fire safety checklist returns.

6.8 Fire Drills & Exercises

The Fire Safety Team conduct an annual programme of fire drills and exercises across the Health Board. The purpose of these is to confirm the fire evacuation strategies for the areas are robust.

In 2024/25, the Fire Safety Team carried out fire exercises in 12 departments across the Health Board. Exercises are conducted at high-risk departments, such as Theatres and Critical Care Units annually on multiple occasions to ensure staff compliance.

The annual programme of fire evacuation exercises continues to target 12 departments per year.

7 RIDDOR REPORTING

Under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013), certain workplace accidents, incidents, ill health and certain near miss events must be recorded. Depending on the severity and nature of the injury, and indeed the party affected, the Health Board has a legal duty to report this data to the Health and Safety Executive (HSE).

The reporting process to the HSE is undertaken by the Corporate Health and Safety Department.

During the period of April 2024 to March 2025 the Health Board reported a total of 73 incidents to the Health & Safety Executive which met the criteria of being reportable under RIDDOR. This is a 18.8% decrease on the number of incidents reported in 2023/24. (See figure 1)

30.2% of these incidents were reported outside of the legal reporting timeframes.

Non-compliance with RIDDOR duties can have consequences, both in terms of Health & Safety and legal ramifications for the Health Board.

To ensure the Health Board meets the legal requirements under RIDDOR the Corporate Health and Safety Department continues to deliver RIDDOR Awareness Training Sessions. This training is designed to provide all managers with a clear understanding of their duties under RIDDOR, ensuring that they can fulfil their responsibilities effectively. During 2024/25 44 staff attended the RIDDOR Awareness Training.

A RIDDOR Compliance Dashboard have been established within the Datix Cymru system to enable Divisions to proactively monitor their RIDDOR compliance and identify areas of good practice, but also areas of further improvement. Compliance with RIDDOR is a health and safety performance indicator which has been imbedded into the Divisional Assurance Reviews.

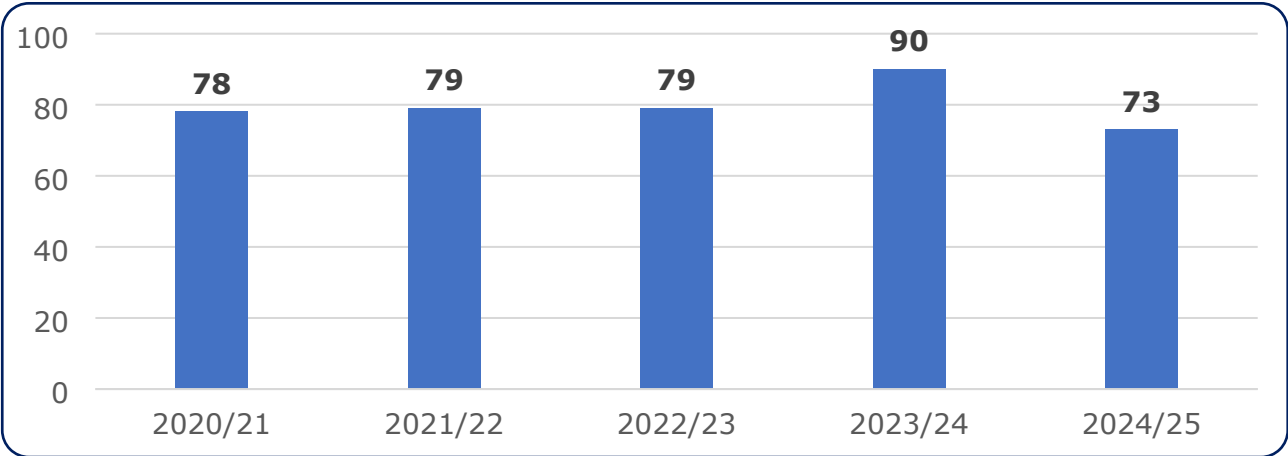


Figure 1: Total number of RIDDOR reportable incidents reported to the HSE for the past five financial years

In 2024/25 there has been three fatal incidents reported, all relating to patient falls. This is an increase from the one fatal incident reported in 2023/24. Over-seven-day incapacitation of a worker are the highest reported classification in 2024/25 with 48 incidents reported, a decrease of 9 incidents compared with 2023/24. The number of specified injuries has reduced from 26 incidents reported in 2023/24 to 11 in 2024/25. (See figure 2)

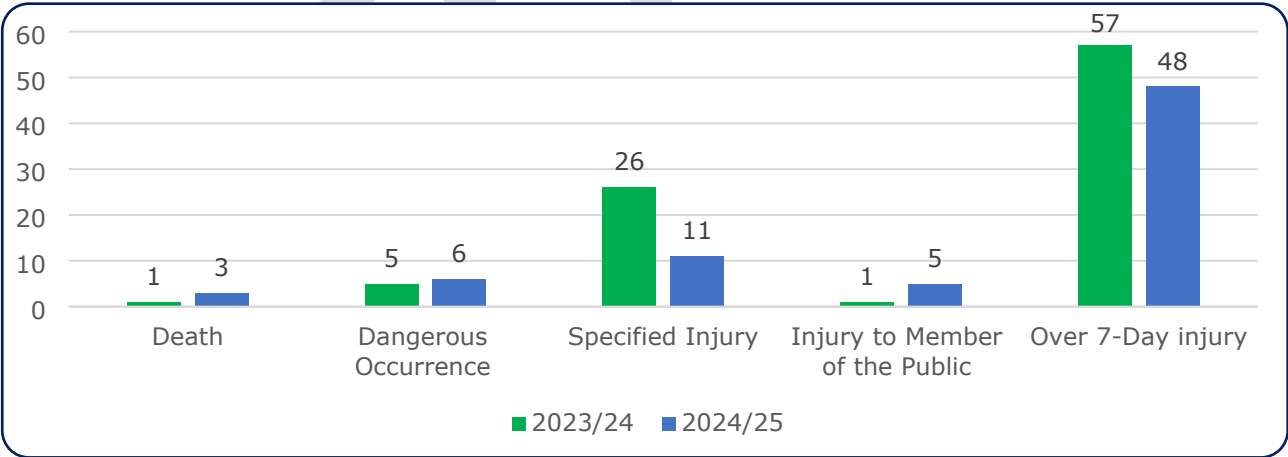


Figure 2: RIDDOR reportable incidents by classification reported to the HSE for 2024/25

Slips, trips and falls continue to be the highest type of RIDDOR reportable incident reported to the HSE, with 32 slips, trips and falls reported in 2024/25. However, this was a reduction on the 39 reported in the previous financial year (2023/24). There was a significant reduction in the number of abuse to staff RIDDOR reportable incidents reported to the HSE in 2024/25 (12) compared with 2023/24 (23).

Manual handling RIDDOR reportable incidents have increased slightly in 2024/25, with 13 being reported to the HSE. This is compared with 12 incidents in 2023/24. (See figure 3)

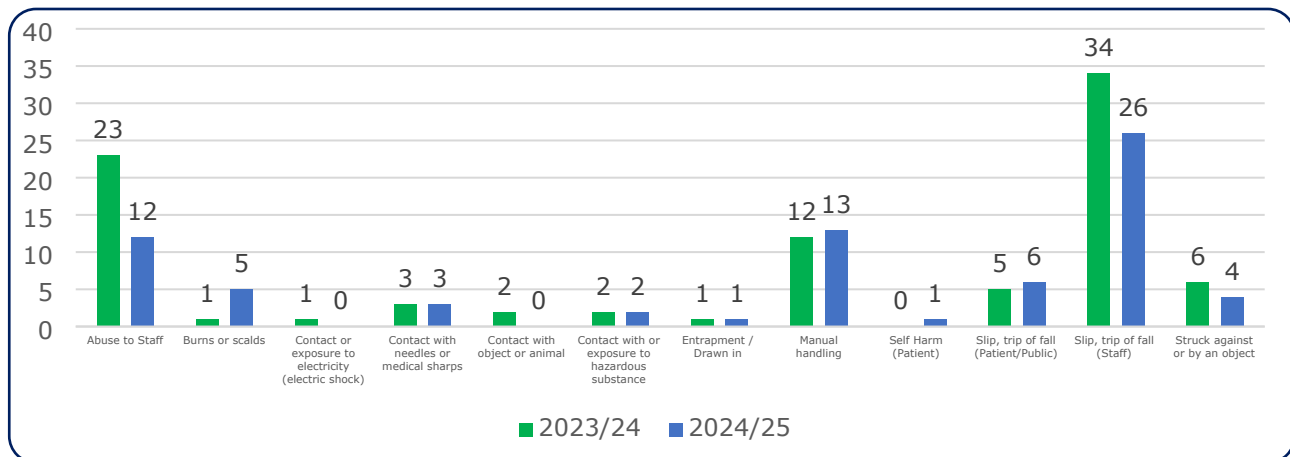


Figure 3: Type of RIDDOR Reportable incidents reported to the HSE for 2024/25

RIDDOR reporting compliance for 2024/25 was 69.8% a 2.1% improvement on the compliance reported in 2023/24 (67.7%).

8 LEARNING FROM EVENTS

The Corporate Health and Safety Department has implemented various communication methods to support learning from incidents across the Health Board.

As part of these methods, information is cascaded through Health and Safety performance reports, post investigation meeting de-briefs, amendment to relevant health and safety training packages and organisational alerts.

During 2024/25 health and safety information sheets have been issued which relate to the following:

- HSI-2024-004 - Seizure of Prohibited Articles
- HSI-2024-005 - Storage and Handling of Medical Gas Cylinders
- HSI-2024-006 - Management of Portable Electrical Appliances (Toasters)
- HSI-2024-007 - Safe Use of Temporary Portable Heating Appliances
- HSI-2025-001 - Suitability of chair castors used on flooring
- HSI-2025-002 - Management and storage of sharp objects

The Corporate Health & Safety Department has provided support to Legal Services in relation to Personal Injuries Claims by assisting in the investigation process, supplying necessary documentation, and facilitating the identification and communication of key learnings from events to prevent future occurrences.

During 2024/25, the Health Board received 9 personal injury cases involving slips, trips and falls, 6 cases of ill health (to include 4 covid cases), 5 violence and aggression cases, 4 cases involving sharps, 3 burns/scalds, 2 cases of individuals being struck against or by an object, 2 cases of entrapment (being injured in lift doors, doors falling on individuals), 1 data breach and 1 incident involving a manual handling task.

Over the last 12 months, there has been an increase in sharps cases and injuries involving burns/scalds.

Personal injury claims continue a year-on-year 16-year downward trend.

9 HEALTH AND SAFETY

9.1 Health and Safety Monitoring

The Corporate Health & Safety Department initiated a programme of workplace health, safety, and environment inspections spanning from October 2024 to March 2025.

These inspections align with the Workplace (Health, Safety and Welfare) Regulations 1992, which encompass fundamental health, safety, and welfare concerns applicable to the Health Board.

The inspection criteria have been developed based on the stipulations outlined in the Regulations, as well as consideration of other pertinent workplace hazards.

The inspection criteria included:

- Lighting
- Noise
- Prevention of Slips, Trips, & Falls (including falls from height and falling objects)
- Temperature & Ventilation
- Workstations, Seating, Furniture, and Fittings
- Welfare Facilities
- Cleanliness, Waste Management, & Sharp Safety
- Access and Egress
- Electrical Equipment
- Handling of Chemicals & Hazardous Substances
- Prevention of Violence & Aggression
- Alert Systems & Communications
- Provision of First Aid

A goal was established to complete health, safety, and environment workplace inspections for the wards and departments in the Acute Hospitals, Community Hospitals and Mental Health & Learning Disabilities sites by the end of March 2025. This objective has been successfully met, with a total of 64 inspections carried out.

These assessments yielded an average Health Board compliance score of 89.63%. The table (right) offers a detailed breakdown of the number of inspections completed per site and the corresponding site compliance score (average).

The inspections revealed both areas of compliance and areas requiring attention to ensure a safe working environment. While an average Health Board compliance score of 89.63 indicates overall adherence to

Site	Total Number of Inspections Scheduled	Total Number of Inspections Completed	Site Compliance (Average)
Chepstow Community Hospital	1	1	83.10%
County Hospital	5	5	84.30%
Grange University Hospital	9	9	96.10%
Maindiff Court Hospital	2	2	92.40%
Monnow Vale Hospital	1	1	89.70%
Nevill Hall Hospital	7	7	89.20%
Other Premises (Health Centres, Clinics)	8	8	91.40%
Royal Gwent Hospital	12	12	84.30%
St Cadocs Hospital	4	4	86.90%
St Woolos Hospital	2	2	91.50%
Ysbyty Aneurin Bevan	7	7	87.90%
Ysbyty Tri Chwm	1	1	89.80%
Ysbyty Ystrad Fawr	5	5	96.90%

regulations, specific areas of concern were identified of which further attention is required.

The main findings of the health, safety and environment workplace inspections are as follows:

Control of Substances Hazardous to Health (COSHH)

- Most areas lacked COSHH Inventories and Assessments.
- Workers lacked clarity on accessing COSHH Assessments and understanding precautionary measures for substance use.
- Cleaning substances, such as Actichlor solution, were frequently left unattended without proper storage and security measures.

Electrical Equipment Checks

- While user checks on electrical equipment were noted, there was insufficient evidence to confirm regular checks.

Tripping and Entrapment Hazards

- Cables supplying air mattresses and electric profiling beds were often positioned in ways that posed tripping and entrapment risks.

Unauthorised Access

- Various areas within ward environments were frequently left open, allowing unauthorised access.

Signage for Anti-Violence Measures

- Absence of signage regarding NHS Wales Anti-Violence Posters was noted.
- Seating for DSE Use
- In some clinical areas, ergonomic office chairs were utilised but often had castors unsuitable for the flooring type.

Use of medical gases

- In some clinical areas, Medical Gas Cylinders were not correctly stored.

Water safety

- In some premises, infrequently used outlets are not routinely flushed and flushing regime is not recorded. Ensure infrequently used outlets are routinely flushed and flushing regime is recorded.

First aid

- In some premises, there aren't appointed first aiders. Conduct a First Aid Needs Assessment to identify specific requirements.

General Condition of Premises

- Flooring was generally in good condition with no significant defects or obstructions affecting safety.
- Lighting levels were found to be adequate for activities within the areas.
- Window restrictors limiting window opening were robust and tamper-proof.
- No workplace noise issues were identified, and employees did not raise concerns.
- No defects such as exposed wiring or damaged casing were identified.
- Workplace temperature was considered reasonable, and concerns regarding thermal comfort were limited.

Provision and Access to Welfare Facilities

- Welfare facilities such as break rooms and W/Cs were routinely available.
- Facilities for heating food/drinks and storing personal items were provided.

Employee Awareness and Reporting

- Employees demonstrated substantial awareness of how to raise health and safety concerns and report accidents, incidents, and near misses.

These findings highlight areas requiring attention to ensure compliance and maintain a safe working environment for all staff, patients and visitors.

The completion of these inspections resulted in the assignment of 594 actions which have been assigned to local ward/department managers and recorded on the Audit Management and Tracking (AMaT) platform.

Among these actions:

- 421 have been successfully marked as fully complete by the assigned responsible person (70.8%).
- 56 have been marked as partially complete by the assigned responsible person (9.5%).
- 117 actions are overdue and have not been completed within the assigned timeframe (19.7%)

Where actions in relation to non-compliance have been identified, these areas must be addressed in order to reduce the likelihood of accident and ill health and to close any gaps in compliance. The responsible person must ensure that sufficient progress notes are recorded within the assigned action point detailing the action(s) taken to address and remedy the identified non-compliance.

The Corporate Health & Safety Department continue to monitor the completion of these actions and provide updates on inspection findings and action completion during Divisional and Directorate Quality & Patient Safety meetings.

The conclusion of the health, safety, and environment workplace inspections emphasises the importance of ongoing monitoring of workplaces to uphold necessary standards and identify potential hazards. To facilitate this, the Corporate Health & Safety Department has devised local workplace inspection tools to assist areas in conducting regular monitoring. Divisions must ensure that appropriate systems are established to facilitate these inspections and promptly address any areas found to be non-compliant by implementing corrective measures.

The Health & Safety Work Plan for 2025/26 outlines key actions to ensure regular monitoring of workplaces across the Health Board. These include:

- Develop a health and safety management audit 3-year plan
Year 1 (Inpatient Areas), Year 2 (Out Patient Areas), Year 3 (All Other Areas)
- Develop a workplace health and safety inspection proforma for inclusion in the ward accreditation programme in 2025/26
- Develop a manual handling management audit programme
- Conduct health and safety workplace inspections for community premises i.e. health centres and clinics

9.2 Health and Safety National Meetings

The All-Wales Health and Safety Management Steering Group represents Health & Safety professionals working in NHS Wales in all areas of health and safety management, providing a forum to network, share best practice and work collaboratively to develop improvements in health and safety.

The group represent all NHS organisations, recognising the importance of providing informative and stimulating meetings, workshops, and seminars for the continued professional development of all members.

The purpose of the All-Wales Health and Safety Management Steering Group is to:

- Discuss all areas of health and safety management to ensure compliance with the legislative and regulatory frameworks in place for managing health and safety effectively.
- Share lessons learned and best practice identified for effective health and safety management.
- Encourage strong leadership in health and safety and championing the importance of a common-sense approach to motivate focus on core aims distinguishing between real and trivial issues.
- Where appropriate, advise the Health Boards and Trusts on where and how, its health and safety management may be strengthened and developed further.

The aims of the group are to:

- Support members to develop the health and safety management arrangements within healthcare organisations.
- Provide a forum in which health and safety risk and issues can be debated, to ensure effective communication of ideas, sharing of experiences and areas of best practice.

Subgroups and workstreams have been established to review current health and safety practice in specific areas and develop minimum standards for implementation across NHS Wales.

During 2024/25 an All-Wales Health & Safety Workstream has been revitalised in relation to Health & Safety Incident Codes recorded within Datix Cymru. The purpose of this workstream is to standardise the Health & Safety Incident Codes for all NHS organisations in Wales in order to reduce barriers to incident reporting and to improve the quality of incident data which will further support in identifying learning from incident themes and trends.

9.3 Reinforced Autoclaved Aerated Concrete (RAAC)

The Corporate Health & Safety Department has conducted comprehensive Risk Assessments in areas of Nevill Hall Hospital (NHH) where Reinforced Autoclaved Aerated Concrete (RAAC) has been identified during structural surveys.

To ensure safety, Acrow props have been installed in these areas. The Risk Assessments focus specifically on evaluating the hazards and potential risks associated with the introduction of Acrow props into the working environment.

The assessment aims to mitigate any risks posed by the structural supports, ensuring that the hospital environment remains safe for both staff and patients. The Risk

Assessments have been recorded within the Datix Risk Module and local Department risk leads have been assigned to enable ongoing management of the risk.

As part of the governance arrangements in relation to the management of RAAC, the Corporate Health & Safety Department attend the RAAC Fortnightly Governance Group of which the group focus is on the actions that have been taken and the ongoing management of the challenges enabling wider discussions of service implications and also remediation plans.

9.4 Health and Safety Incident Reporting

The following data provides a detailed breakdown of the type of health and safety related incidents that have been reported in 2024/25. *This excludes violence and aggression and fire incidents as these are reported in the relevant sections of this report.*

Figure 4 indicates an increase of 8.5% in the number of reported incidents affecting staff and contractors compared with last two financial years.

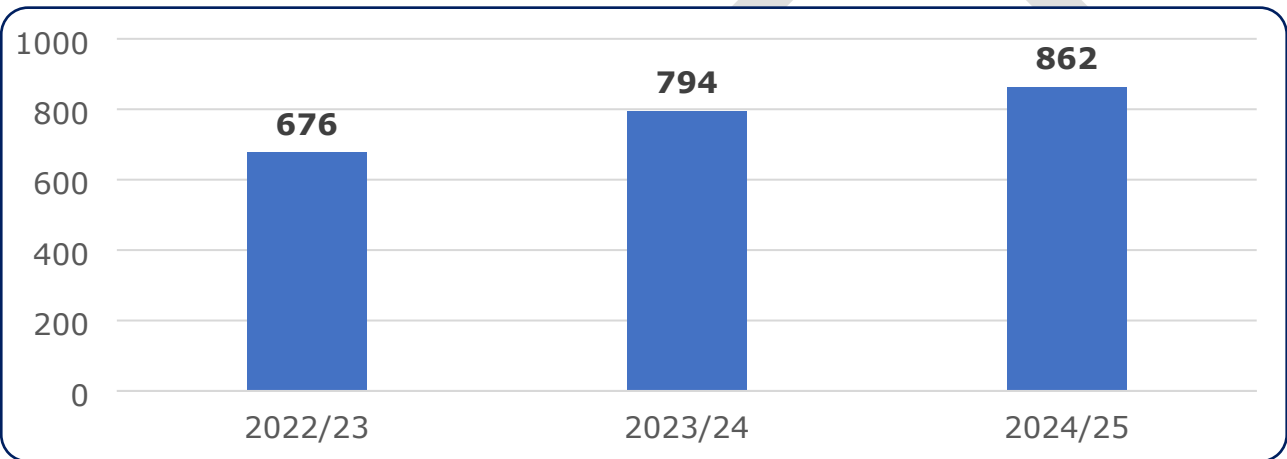


Figure 4: Number of reported incidents affecting staff and contractors for the past three financial years

Contact with needles or medical sharps is the most reported health and safety incident category affecting staff or contractors (215 incidents), this is an increase of 13.1% on the previous year. (See figure 5)

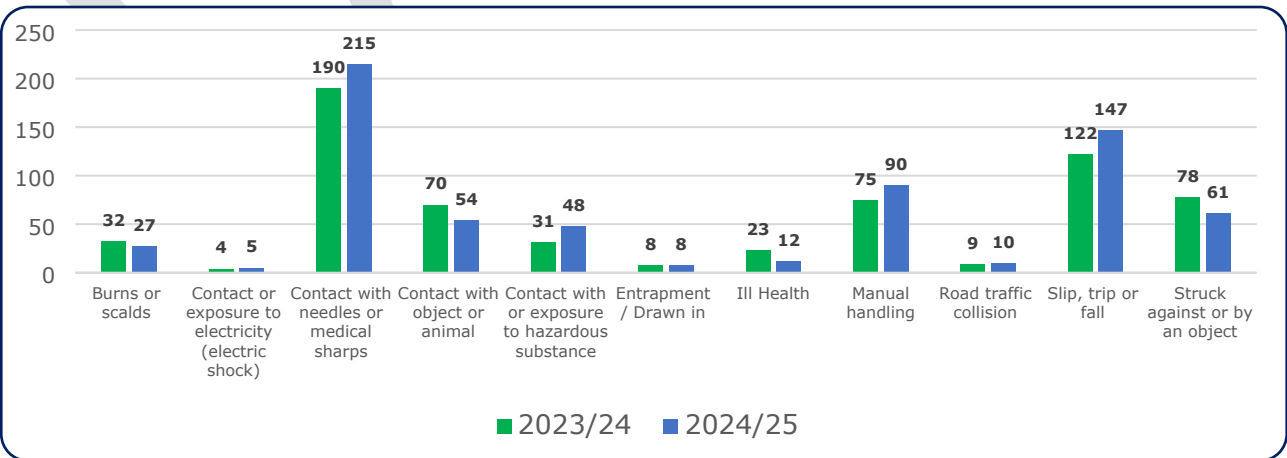


Figure 5: Type of incidents affecting staff and contractors for 2024/25

The number of contact with needles or medical sharps incidents reported in 2024/25 has increased by 13.1% from the previous financial year (215 reports). The incidents from contaminated / used sharps devices have increased by 21.1% in 2024/25. (See figure 6)

It is difficult to obtain data on the number of tasks or procedures carried out across the Health Board using needles or medical sharps. However, based on the incidents reported and the significant number of tasks and procedures the incident rate would be very low.

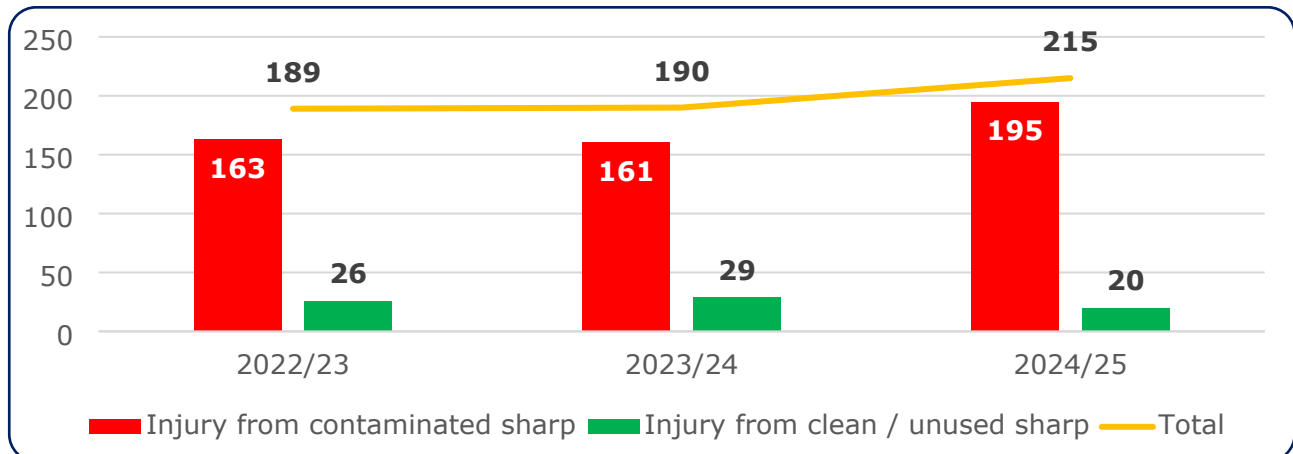


Figure 6: Total number of sharps incidents by type for 2024/25

To identify learning outcomes from sharps incidents and demonstrate continuous improvement a standard will be set via the Health and Safety Committee that all incidents will require an investigation which is recorded on the focused review in the Datix Cymru system.

The revitalisation of the health and safety monitoring programme included an assessment of clinical area's adherence to best practices for the safe use of sharps. This assessment was designed to ensure that areas comply with the standards set out within the Health Boards Sharps Policy, and the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

As part of the inspection process, wards were specifically monitored for their procedures regarding sharps use and disposal of sharps. This includes the availability of safety engineered devices, the availability and correct use of sharps trays and sharps containers and adherence to protocols designed to reduce the likelihood of needlestick injuries and other sharps related incidents.

Throughout the inspections, instances of good practice were routinely identified. These practices provide assurances of compliance with best practice guidelines and legislative requirements. The findings of these inspections have also supported the development of training information such as Tool Box Safety Talk on the Safe Use of Sharps in order to further reinforce best practices.

The outcomes of the monitoring are reported to the Health and Safety Committee.

Slip, trip or falls is the second highest reported health and safety incident category affecting staff or contractors.

The number of slips, trips and falls incidents to staff, contractors or visitors reported in 2024/25 has increased by 15.4% from the previous financial year (142 reports). (See figure 7) These types of incidents continue to be the highest reported to the HSE in accordance with RIDDOR and those resulting in personal injury claims.

The highest categories of slips, trips or falls in 2024/25 were 'Fall on a slippery or wet surface' (56 incidents) and 'Trip or fall over an object or obstacle' (26). This is a significant increase reduction from the previous year's reporting.

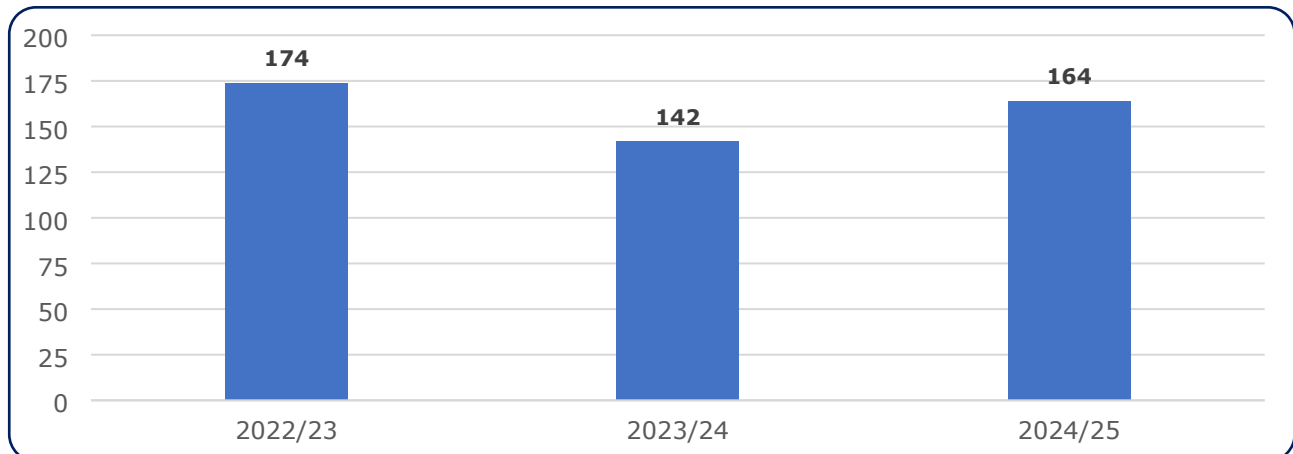


Figure 7: Number of reported slips, trips and falls incidents affecting staff, visitors and contractors for the past three financial years

9.5 Face Fit Testing

Where personal protective equipment and respiratory protective equipment is used, it must be able to provide adequate protection for individual wearers.

Face Fit testing ensures that the equipment selected is suitable for the wearer. Face fit testing is a mandatory requirement as prescribed by Health & Safety Executive Control of Substances Hazardous to Health Regulations Approved Code of Practice (ACoP) L5 and associated guidance documents that support the relevant statutory provisions.

The delivery of Face Fit Testing continues to remain a key tasking for the Corporate Health and Safety Department with weekly Face Fit Testing sessions being offered across the Health Board.

To enable the Health Board to maintain compliance with Face Fit Testing requirements a review of the Health Boards Face Fit Testing Strategy and Face Fit Testing resource allocation will be undertaken in 2025/26.

10 FIRE SAFETY

Fire safety is an umbrella term covering fire prevention and fire precautions. The principal requirements of fire safety legislation are:

- To reduce the probability and severity of a fire occurring within a building.
- To ensure that persons are kept safe or can safely evacuate a premises if a fire occurs.

Fire has the potential to cause widescale damage and disruption of NHS services that could have a serious consequence for service users. Therefore, in addition to life safety, property protection and business continuity are key aims of the Health Board fire safety policy.

The Regulatory Reform (Fire Safety) Order 2005 (FSO) is the main piece of legislation governing fire safety in buildings in England and Wales. The FSO applies the concept of the responsible person to ensure general fire precautions are in place to protect persons who work at, stay or visit premises in England and Wales.

The legislation imposes liability on managers proportionate with their levels of control. The principle responsible persons in the Health Board are the executive, directorate and departmental leaders.

The Executive Director of Allied Health Professions & Health Science is the Executive Director with delegated responsibility to ensure compliance with current fire safety legislation and responsibility for ensuring that fire safety issues are highlighted at Board level. In particular they will ensure, by delegation to The Fire Safety Manager that the fire safety policy is promulgated, and that Fire Risk Assessments are completed to record the general fire precautions required for all areas.

Individual divisional directors and divisional leadership groups as a collective are responsible for ensuring compliance with the Health Board Fire Safety Policy and that the general fire precautions are applied within their departments.

10.1 Provision of Officers with Specific Fire Safety Responsibilities

Health Boards are required to provide a structure of Fire Safety Management within their organisations aligned with WHTM 05:01.

The structure is based on delegated responsibility of fire safety functions to functional roles within the organisation. The nominated offers are accountable for fire safety functions assigned to them.

Fire Safety Protocol 031 Roles and Responsibilities for Implementation details the roles and delegated responsibilities for fire safety within the Health Board.

Key roles covered in the document (in addition to Executive Director with delegated responsibility and The Fire Safety Manager) are the Director of Estates and Facilities Division who bears key responsibilities for maintenance of systems and fire response, and Ward/Department managers who act as frontline fire safety managers.

Regardless of the roles designated, it should be understood that although accountability can be designated and shared, it cannot be legally transferred. All senior managers are legally accountable for adherence to the fire policy in any areas that are under their control or influence.

10.2 Fire Safety Risk Management

The Health Board are legally required to carry out and record fire risk assessments at all sites. The legislation requires that assessments are completed for all new buildings when staff first take occupancy and are reviewed on a regular basis.

Additional reviews are required if there are significant changes to staffing or working arrangements in departments and wards.

The Health Board fire safety team review fire risk assessments at a frequency based on risk as shown in the table below.

Type of Area to be Assessed	Frequency of Assessment
Buildings or parts of buildings that provide sleeping or inpatient accommodation	12 months
Other than above but areas provided for public access such as outpatient facilities	24 months
Other than above. Areas not provided for public access such as offices, plantrooms etc.	36 months

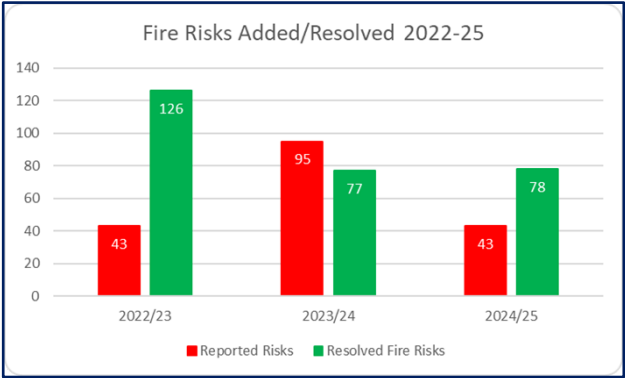
During the period April 2024 to March 2025 the Fire Safety Team completed 254 programmed fire safety risk assessment reviews. This represents 100% of the programmed assessments. The figures for major sites are displayed in the table below.

Hospital	Annual Assessments	Bi-annual Assessments	Tri-Annual Assessments
County Hospital	5	7	12
Grange University Hospital	26	1	16
Nevill Hall Hospital	20	9	22
Royal Gwent Hospital	32	6	12
St Cadocs Hospital	7	0	0
St Woolos Hospital	6	12	2
Ysbyty Aneurin Bevan	5	5	0
Ysbyty Ystrad Fawr	11	6	1

In addition to the above the Fire Safety Team completed fire risk assessments to:

- Support various moves of departments at the Royal Gwent, St Woolos and Nevill Hall Hospitals.
- Assess and record hazards associated with RAAC at Nevill Hall Hospital.
- Support the opening of 19 Hills Heath and Welling Centre and the new Satellite Radiology Unit at Nevill Hall Hospital.

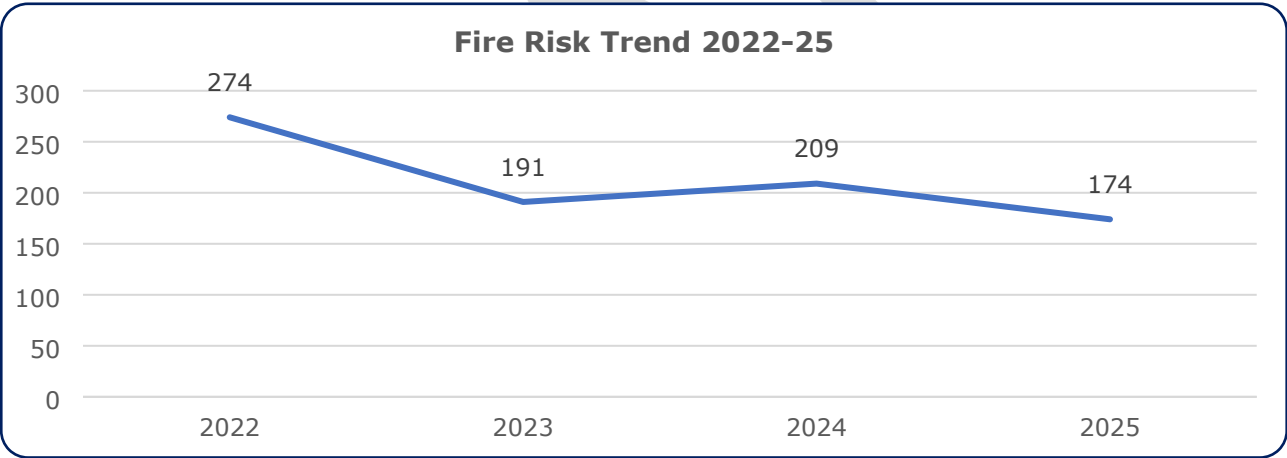
A register of the risks identified during the assessment process is handled by the Fire Safety Team and recorded on the DatixWeb system. The table (right) highlights the risks that have been added to the risk register following risk assessments and removed from the risk register after being rectified over the three-year period April 2022 to April 2025.



The decision taken by the Health Board to provide sprinkler protection at new hospitals has produced massive benefits for the management of fire safety and the safety of persons at the relevant premises. The hospitals are relatively risk free with no significant fire safety issues.

The major fire safety risks held on the system are legacy fire risks at older building stock including Royal Gwent and Nevill Hall Hospitals. These premises remain a priority for resolution and are likely to dominate the Fire Safety Discretionary Capital spend for the foreseeable future.

The risk trend for April 2022 to April 2025 is shown below.



10.3 Planning and Implementing Fire Safety Improvement Works

The duties of the Fire Safety Manager include planning and implementing a programme of improvement works to remove or mitigate fire risks carried by the organisation.

During 2024/25 improvements have been made in the following areas to ensure the Health Board meets minimum safety standards and fulfils its legal requirements.

Site	Area	Improvement
Nevill Hall Hospital	Third & Fourth Floors including inpatient wards	End of Life Replacement of Fire detection and sounders. The system in this area is now fully compliant.
Nevill Hall Hospital	Ward 4/1	Repairs to fire resisting barriers
Nevill Hall Hospital	Bron Haul & Gerylyn Staff Residencies	End of Life Replacement of Fire detection and Fire doors. These buildings are now fully compliant.
Royal Gwent Hospital	Ward D7 West, Blocks 3, 6 (Staff Residences) & 7, Level 2, Level 8 (Plantrooms)	Installation of new fire detectors connected to the new <i>Gent</i> panel system. The system in these areas is now fully compliant.
St Cadoc's Hospital	Whole Site	Replacement Fire Alarm System
Ebbw Vale Clinic	Whole Building	Replacement Fire Alarm System

In addition to the above there has been a continued incremental improvement across all building stock.

10.4 Key Fire Risks

The key residual fire risks carried by the Health Board are related to management of the aging infrastructure and degradation of fire protection at older acute hospitals, namely the Royal Gwent and Nevill Hall Hospitals.

The safety of large numbers of inpatients at these hospitals relies on the capability of the alarm systems to give early warning of fire and the capability of fire walls and fire doors to stop the spread of fire through the buildings.

Fire Alarm Systems: The fire alarm system at Nevill Hall Hospital has benefitted from a major replacement programme in 2024/25.

The detectors in all inpatient areas have been replaced and the system covering these areas is now full compliant with current standards. The fire control panel that monitors the staff residencies has also been replaced along with the detection in Bron Haul and Gerylyn. The detection in all other staff residencies is planned for replacement in 2025/26.

3 panels on site covering the works and estates offices, plantrooms and the undercroft are approaching their planned replacement date. It is important that these panels and the associated detection are replaced in the near future. On completion of this works the system will be fully compliant.

Although some progress has been made at the Royal Gwent Hospital, the situation is more severe. Improvements have been delivered to migrate some of the system over to a new replacement system. Eight of the blocks on site, including E Block and Block 6 Staff Residencies are now covered by the new system along with some areas in C&D Block.

However, the vast majority of C&D Blocks are still reliant a system which is obsolete and for which spare parts are no longer being manufactured. The system is functional but not reliable due to aging components that may be vulnerable to sudden failure.

Funding has been allocated to provide for the new system to be expanded into most of the inpatient wards by March 2027 but this will not be achievable without some disruption. It is estimated that a minimum of 40 weeks of single ward decants will be required to facilitate the works.

Attempts to carry out this work in a live ward environment were aborted in 2024/25 due to safety concerns.

Fire Walls and Fire Doors: The safety of inpatients at the Royal Gwent and Nevill Hall Hospitals relies on the ability of the structure of the buildings to withstand fire and stop fire spread between wards.

The Fire Safety Team have worked collaboratively with Facilities to introduce measures to ensure that fire barriers are effectively managed and protected. Work is now required to rectify existing breaches in the fire resisting partitions at both sites.

Surveys conducted at both hospitals has identified extensive works that is required to fix damage to the fire walls that protect the inpatient wards.

Funding has been secured to carry out remedial works at both sites. The feasibility of repairing the breaches on live wards is currently being considered, it is also possible to complete this works in tandem with the fire alarm replacement at The Royal Gwent Hospital if the decant wards are made available.

10.5 Emerging Risks

Capital investment is required to mitigate fire safety risks in the following areas.

- Replacement of end-of-life fire detectors at Ysbyty Aneurin Bevan.
- Replacement of the fire alarm system in the old hospital buildings at St Woolos Hospital (the system is not acceptable to modern standards, however clarity on the future use of the buildings is required before a commitment to spend circa £300k on a replacement system can be made).
- Enhanced Fixed electrical testing and of aging electrical infrastructure on older sites.
- Risks associated with aging ventilation infrastructure (Fire Dampers) for inpatient areas on older sites.

- The majority of fire doors at St Cadocs and St Woolos Hospital buildings are functional to older standards but are increasingly difficult to maintain. Replacement schemes are likely to be required within the next five years.

10.6 Planned Improvements

The following improvement schemes are planned to be completed in 2025/26.

- Partial replacement of the fire alarm system at Royal Gwent Hospital Site including fitting new detection and transition of levels 7, 6 & 5 of C & D Block to the new fire alarm system.
- End of Life replacement of detectors at Ysbyty Aneurin Bevan.
- Repairs to fire partitions on inpatient Wards at Nevill Hall Hospital.
- Replacement of 30-minute fire doors with 60-minute fire doors on inpatient wards at Nevill Hall Hospital.
- End of Life replacement of detectors at Ysbyty Ystrad Fawr.

10.7 Future Challenges and Priorities for the Fire Safety Team

The strategic goals for the Fire Safety Team are to improve fire strategies at older hospitals while replacing older, complex and costly alarm systems with modern systems incorporating graphics information displays that are easier to manage and economical to maintain.

A lack of available information on safety systems at these buildings continue to pose challenges in the production of detailed, site specific fire safety building strategies. Continued improvement will rely on acquisition of reliable documents such as:

- Fire Zone Plans
- Fire Alarm Cause and Effect Matrices
- As Fitted Fire Alarm System Device Drawings
- Fire Damper Plans

10.8 Fire Safety Advice and Support for Internal and External Partners

The Fire Safety Team provides advice and support to both internal and external partners across a variety of issues affecting fire safety.

Internal queries include advice and assessment of risk posed by shutting off areas to allow building work and application of building regulations for the repurposing of individual areas within a hospital.

External queries range from assessment of the suitability of fire safety building materials, design of cause and effect for fire alarm systems to active consultation with project managers on fire safety building regulations and fire strategies during the planning phase of new builds.

On completion of projects the Fire Safety Team provide training, risk assessment and updated fire safety strategies for new or repurposed areas and buildings.

The Fire Safety Team has been involved in the following projects currently being progressed or completed within the last financial year:

- Adoption of Chepstow Community Hospital from PFI
- Extension to Emergency Department (ED) at the Grange University Hospital

- Satellite Radiology Unit at Nevill Hall Hospital
- 19 Hills Health and Wellbeing Centre
- Upgrade to Pharmacy at Royal Gwent Hospital
- Decontamination Suite at Royal Gwent Hospital
- Crisis Hub at St Cadocs Hospital
- Replacement Roof Glen Usk Suite at St Cadocs Hospital
- The Bevan Health and Wellbeing Centre

10.9 Fire Safety National Groups

In addition to their duties for the Health Board the Fire Safety Team are actively engaged as members of The National Association of Healthcare Fire Officers (NAHFO). Fire advisors attend regular meetings of the Wales Branch of NAHFO where they receive updates on fire safety building regulations and legislation and discuss common issues and best practice with colleagues from the other health boards in Wales and Shared Services fire advisors.

The Fire Safety Team are also involved in the All-Wales Fire Safety Managers Group. The group is engaged in the development of a number of All Wales Fire Safety protocols, the Health Board currently chair the working group on Control of Ignition Sources and contribute to groups working on Fire Safety Training and Fire Safety Considerations for Bariatric Patients on Healthcare Premises.

10.10 Fire Safety Incident Reporting

The Health Board has suffered no serious fire incidents in the financial year 2024/25 . The most notable of the five minor incidents reported are:

- A spate of three repeated incidents of rough sleepers starting fires in the grounds of Pontllanfraith Health Centre between October 2024 and January 2025. As a consequence, fire safety advice was given around waste management and security at the site.
- Waste materials inside a dishwasher at Chepstow Community Hospital that came into contact with the heating element and caused smoke but without fire. Following which, fire safety advice was given regarding safe use of the appliance.

The number of unwanted fire signals (UwFS) reported in 2024/25 has seen an 8.5% reduction compared with 2023/24 (See figure 8).

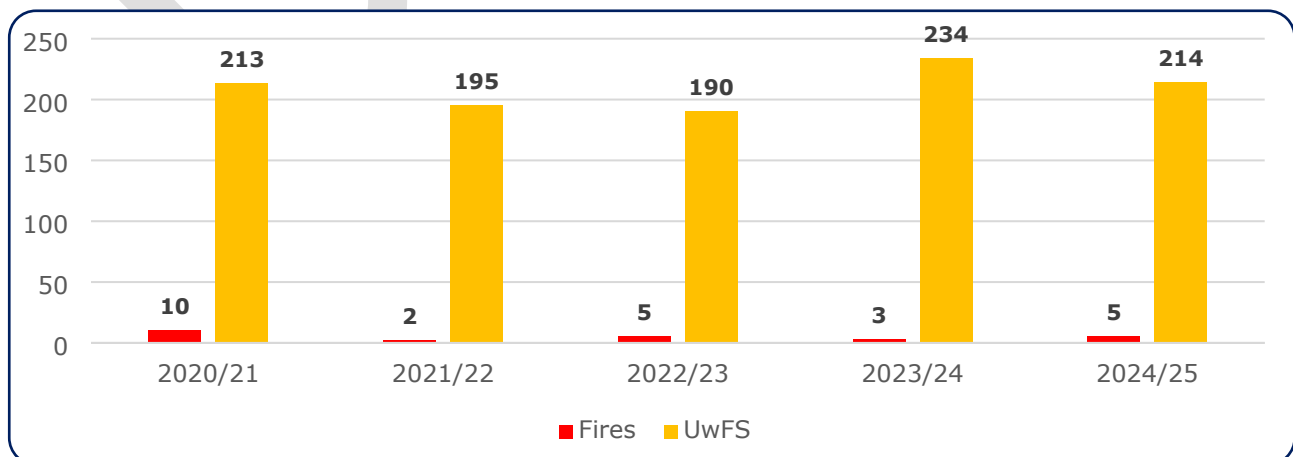


Figure 8: Number of reported fire safety incidents for the past five financial years

The overall trend in unwanted fire signals is flat and although improvements can be seen in the number of activations at County Hospital those at the Royal Gwent Hospital show a year-on-year increase.

Figure 9 provides a comparison on the number of unwanted fire signals by hospital by financial year.

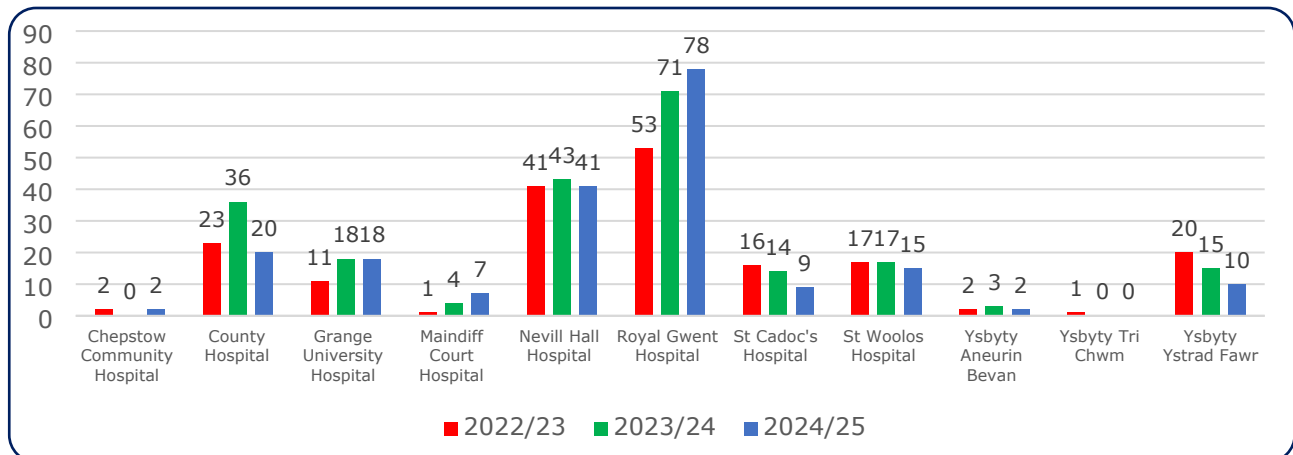


Figure 9: Number of reported unwanted fire signals by Hospital

A significant proportion of the false alarms at the Royal Gwent Hospital are directly attributable to malfunctions of the obsolete panels.

Performance grading of fire alarm systems for the generation of unwanted fire signals takes account of the size of the systems as well as the number of unwanted signals.

Using this metric, the trend is either stable or positive for all fire alarm systems at major sites (See figure 10). Notwithstanding, the continued objective of the team is to achieve an A grading for all systems.

Hospital	False alarms including UwFS	Actuation devices	2023/24 Grade	Current Grade
Chepstow Community Hospital	2	504	no incidents	A - performance should be maintained
County Hospital	20	1018	C	B - 10% reduction in UwFS
Grange University Hospital	18	2978	A	A - performance should be maintained
Llanfrehfa Grange	3	400	B	A - performance should be maintained
Maindiff Court Hospital	7	388	B	B - 10% reduction in UwFS
Monnow Vale Health & Social Care Facility	0	169	no incidents	A - performance should be maintained
Nevill Hall Hospital	41	2850	B	B - 10% reduction in UwFS
Royal Gwent Hospital	78	4560	B	B - 10% reduction in UwFS
St Cadoc's Hospital	9	1225	B	A - performance should be maintained
St Woolos Hospital	15	953	B	B - 10% reduction in UwFS
Ysbyty Aneurin Bevan	2	1150	A	A - performance should be maintained
Ysbyty Tri Chwm	0	130	no incidents	A - performance should be maintained
Ysbyty Ystrad Fawr	10	2267	A	A - performance should be maintained

Figure 10: Unwanted fire signals performance indicators by Hospital for 2024/25

The Fire Safety Team investigate all fires, unwanted fire signals and incidents that are related to fire or any report or incident that may affect fire response.

The purpose of the investigations is to provide data to facilitate a reduction in false alarms and a reduction in the number and severity of fire incidents.

11 MANUAL HANDLING & ERGONOMICS

The Manual Handling Team continue to provide mandatory training to support the education strategy, including providing expert advice as required i.e. selection of key equipment.

Based on current demands the Team’s activity is primarily focused on training and improvements in compliance.

11.1 Manual Handling National Meetings

Manual Handling subject matter experts across NHS Wales meet on a quarterly basis to identify and support each NHS organisation with manual handling learning, best practice and action plan going forward.

11.2 Manual Handling Incident Reporting

The number of manual handling incidents reported in 2024/25 has increased by 20% compared with 2023/24 (See figure 11).

There has been a 51.2% increase in patient handling incidents compared with 2023/24.

To identify learning outcomes from manual handling incidents and demonstrate continuous improvement a standard will be set via the Health and Safety Committee that all incidents will require an investigation which is recorded on the focused review in the Datix Cymru system.

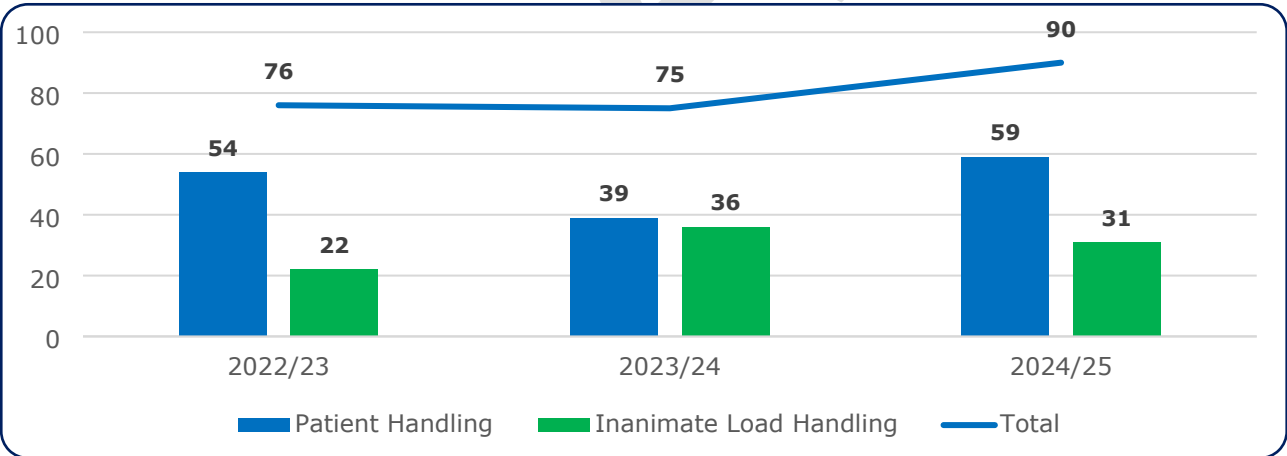


Figure 11: Number of reported manual handling incidents affecting staff for the past three financial years

11.3 Manual Handling Equipment

The Manual Handling Team lead on providing the necessary advice and support to the Health Board in the selection of manual handling equipment to aid in the delivery of care to patients.

All manual handling equipment and its accessories require the necessary testing, inspection or examination to ensure compliance with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) or the Provision and Use of Work Equipment Regulations 1998 (PUWER).

The service and maintenance of the manual handling equipment is contracted to an external provider. The service contract supports the Health Board to meet its legal requirements and identifies the need for investment in new equipment.

'Insight' assessments undertaken by ARJO were completed in December 2024 across all Acute and Community Hospitals. The assessments assess the mobility levels of patients, the type, age and condition of patient handling equipment available and service and routine maintenance information.

The findings have provided the Health Board with the following information:

- Patient handling equipment assessments.
- Identification of aged/obsolete equipment with limited/no service support.
- The need for new equipment to meet patient functional levels and care processes.

There is a requirement to apply for capital investment in the obsolete equipment in 2025/26 and 2026/27.

11.4 Manual Handling Patient Handling Risk Assessments

The Manual Handling Team have contributed to the implementation of the patient handling Welsh Nursing Care Record (WNCR). The manual handling audit programme planned for 2025/26 will review the standard and quality of the patient handling assessments.

11.5 Display Screen Equipment (DSE)

Since the outbreak of Covid-19 more Health Board Staff are working in an agile manner across the Health Board at various sites and from private premises, whilst the increased flexibility of agile working can provide many benefits to both the individual and Health Board, the legal requirement for the Health Board to ensure the health, safety and welfare of its employees continues to apply in agile working situations.

To ensure that the risks associated with agile working are properly identified and managed, a series of guidance documents and policy amendments have been developed as a means to support individuals who are identified as agile workers. This includes amendments to the Health Boards Policy for Workstation Display Screen Equipment (DSE) and Display Screen Equipment Risk Assessment Form.

The Corporate Health and Safety Department in collaboration with the Occupational Health Department have conducted DSE risk assessments for the more complex cases.

12 VIOLENCE PREVENTION & REDUCTION

It is recognised that all NHS staff are among those most likely to face violence and abuse during the course of their employment. These incidents can involve patients, visitors or others acting aggressively towards staff or in a manner that makes staff feel threatened or vulnerable. The impacts of this can be profound on both the individual and the Health Board.

Through 'A healthier Wales' working with the Anti- Violence Collaborative (AVC), we are working towards an agreed approach to prevent violence and aggression towards NHS staff in Wales. We strive to create a culture where our staff feel safe and supported.

Following on from last year 2023/24, we have implemented the 'Obligatory Response to Violence in healthcare' The document sets out the responsibilities of healthcare organisations when dealing with incidents relating to violence or aggression in the NHS.

Its focus is on those incidents that need to be addressed by the criminal justice system that includes:

- Improving the reporting of violent incidents.
- Strengthen the investigation and prosecution process by improving the quality and timeliness of shared information.
- Improve victim and witness care and confidence.
- Raise the issues of violence and aggression against NHS staff as well as the action that will be taken by all parties.

Our team works closely with Gwent Police including monthly meetings to ensure that the objectives are met. The Health Board is committed to the delivery of a safe and secure environment for staff and patients, so that the highest possible standard of care can be delivered.

12.1 Violence & Aggression National Meetings

The Violence and Aggression Case Managers Group was established as a Sub-group of the NHS Wales Health and Safety Management Steering Group. The group plays a crucial role in ensuring the safety of both staff and patients by developing and implementing strategies for violence prevention and reduction. The Violence Prevention & Reduction Team continue to be involved in this group and contribute to the wider all Wales discussion on creating a safe and supported culture for our staff.

The purpose of the group is to:

- To provide a collaborative support to NHS V&A Case Managers.
- Ensuring that National Frameworks and Guidance associated with Violence and Aggression Management is successfully embedded and implemented across organisations. E.g. Obligatory Response to Violence and Aggression in Healthcare (ORV) and associated Welsh Health Circular.
- Establish Task and Finish Groups that will be responsible for the development of National Violence and Aggression Standard Operating Procedures/Guidance that can be adopted by NHS Wales E.g. Violence and Aggression Risk Management/ Assessment.
- The Group is also a forum for partner agencies from the CPS and the four Police Services in Wales, Health and Safety Executive to attend and participate, to foster good relationships and to ensure compliance with the aims of the ORV.
- Develop and agree Datix Cymru Violence and Aggression related codes. Review

- coding and changes to the Datix Cymru system when necessary.
- Support and contribute to the review of the Violence and Aggression Training Passport and Information Scheme. Particularly in relation to risk assessment module.
- In support of the V&A Case Managers professional development, this Group will facilitate information and training opportunities for its members to participate, either as part of normal agenda or occasional separate events.
- To develop a minimum standard Job Description and Specification for a Violence and Aggression Case Manager.
- To inform the Anti-Violence Collaborative (AVC) of any relevant developments and concerns relating to the management of violence and aggression within NHS Wales organisations and seek support from the collaborative in influencing partner agencies in meeting the principles of the ORV.

12.2 Violence & Aggression Incident Reporting

Reported incidents of violence and aggression on staff have increased in 2024/2025 from the previous year by 6.9%. This increase could be explained by the work that has been implemented as part of the ORV as mentioned above to create a positive reporting culture.

Approximately 55% of violence and aggression incidents in 2024/2025 were reported from the Mental Health and Learning Disabilities Division. This is an increase of 2% from the previous year (2023/24).

Physical assaults on staff reported in 2024/25 has increased by 5.3% compared with 2023/24 (see Figure 12). The overall incident rates for 2024/2025 have remained consistent with previous years (2022/2023 and 2023/2024) at 1 in 20 staff experience physical assault.

There has been an 11% reduction in sexual assaults in 2024/25, compared with 2023/24.

To ensure quality data is available the Corporate Health and Safety Department validate all reported incidents of violence and aggression.

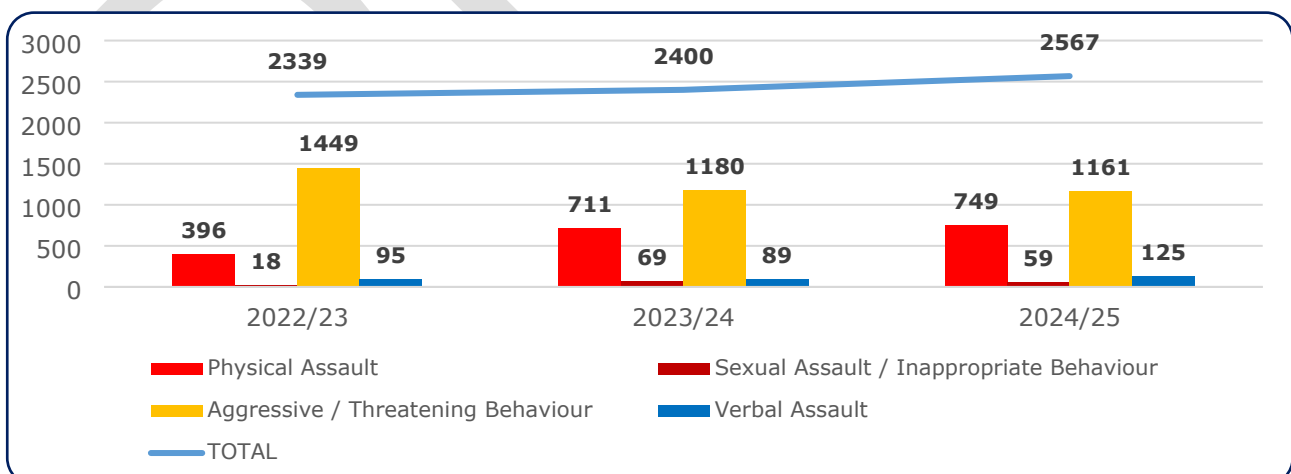


Figure 12: Number of reported violence and aggression incidents for the past three financial years

12.3 Support for NHS Staff Members

The Violence Prevention & Reduction (VPR) Team continue to support staff who have been subjected to incidence of workplace violence & aggression and where matters relating to personal safety are identified.

Where incidents are reported via Datix Cymru, a Violence Prevention & Reduction Advisor (VPR Advisor) is assigned to the incident and will provide advice in relation to the investigation of the incident including; supporting the Line Managers and signposting the person or people affected to relevant support services, internally and externally. A new collaborative approach to supporting victims of crime has been implemented and includes Wellbeing Services, Occupational Health and Connect Gwent to offer specialist and bespoke support to Health Board employees. In 2024/2025 6% of victims accepted a referral to Connect Gwent or CANOPI for additional support.

Between April 2024 and March 2025, the VPR Team has been actively involved in 1,120 incidents, demonstrating their critical role in supporting Health Board Employees who have been subjected to incidents of workplace violence and aggression. (See Figure 13)

Changes to the criteria for incident follow up has seen an increase in follow up in February and March 2025.

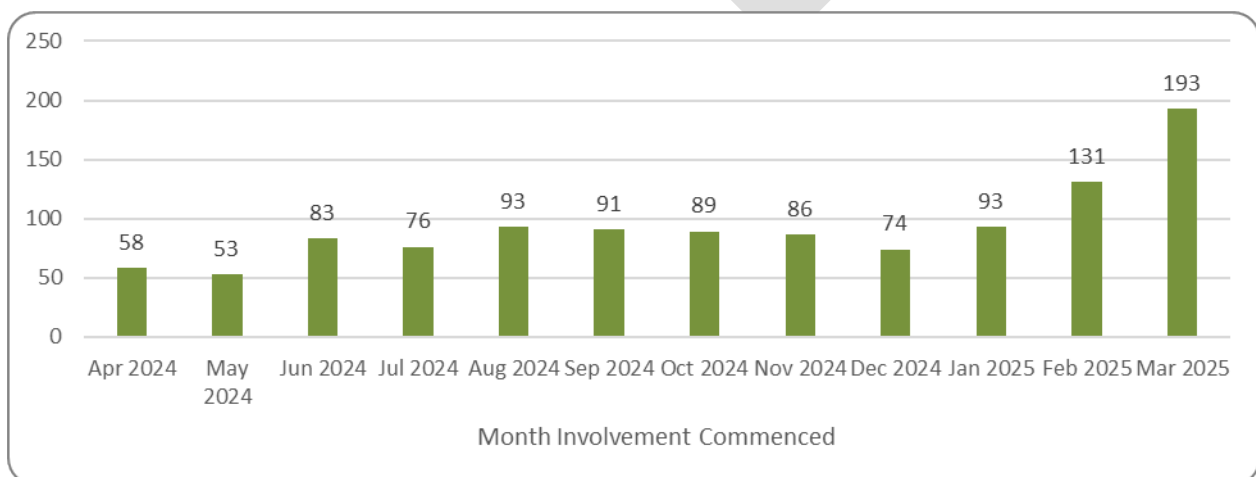


Figure 13: Number of violence and aggression incidents with VPR Advisor involvement

12.4 Engagement with Gwent Police

As mentioned above as part of the AVC and ORV objectives the Health Board has further improved its working relationship with Gwent Police, which has resulted in increased collaboration and wider partnership engagement.

This year in 2024/2025 the Health Board has implemented a Violence and Aggression Incident Review group which brings together key Health Board Employees and Gwent Police colleagues and is chaired by the Violence Prevention & Reduction Lead. The aim of the group is to implement a multi-agency approach to incidents of violence and aggression to reduce risks and attempt to achieve the safest outcome for the person, emergency services workers and members of the public.

12.5 Police Outcomes

Following a review of reported incidents, the Health Board engaged with the NWSSP Once for Wales Programme Team to progress enhancements to Datix Cymru to enable accurate recording of outcomes e.g. civil, criminal sanctions in relation to violence and aggression incidents.

This led to an increase in reporting of Health Board incidents to the Police as seen on Datix Cymru. In 2023/2024 only 1% of violence and aggression incidents against NHS staff were recorded on Datix Cymru as being reported to the Police. This has increased in 2024/2025 to 13% of incidents being reported to the Police.

However, this has only resulted in a total of 2% of violence and aggression incidents being investigated. From this total, 9% of those cases investigated led to an outcome such as a Community Resolution or a Conditional Caution given to the perpetrator. The VPR team will continue to work on creating a positive reporting culture and support investigations with Gwent Police to achieve outcomes that will reduce future risks.

12.6 All Wales Violence Prevention and Reduction Standards

During the period 2024/2025, significant progress has been made on an All-Wales basis to enhance the management and prevention of violence and aggression within NHS Wales.

The Health Board Violence Prevention & Reduction team has worked closely with the Anti-Violence Collaborative and other stakeholders across NHS Wales to create a Draft Version of the All-Wales Violence Prevention and Reduction Standards.

The review process entailed a detailed assessment of the existing standard, with particular attention to its relevance and applicability within the Welsh healthcare context. This has included evaluating current best practices, identifying potential areas for improvement, and ensuring that the standard aligns with the unique operational, cultural, and regulatory environment of NHS Wales. The Standards aim to be introduced and implemented across all NHS Health Boards in Wales in 2025/2026. This will be a key objective of the VPR Team for the next financial year and will feature in the Health Board Violence Prevention and Reduction Strategy.

The adoption of these standards is anticipated to bring several significant benefits to the Health Board, including:

Enhanced Safety for Staff and Patients: By implementing a robust and comprehensive framework for violence prevention and reduction, the updated standard will contribute to a safer working environment for staff and a more secure care environment for patients.

Consistency Across NHS Wales: A standardised approach will ensure that all NHS Wales organisations adhere to the same high standards, reducing variability in practices and enhancing the overall quality of violence prevention and management across NHS Wales.

Improved Reporting and Accountability: The new standard will establish clearer protocols for reporting incidents of violence and aggression, leading to better data collection, analysis, and accountability. This will enable NHS Wales to monitor trends, identify high-risk areas, and allocate resources more effectively.

Increased Staff Support and Training: The standard emphasises the importance of training and supporting staff in recognising, managing, and de-escalating violent situations. This will not only improve staff confidence and competence but also reduce the likelihood of incidents escalating to physical violence.

12.7 ABUHB Violence Prevention & Reduction Strategy

Preventing and reducing violence is a strategic enabler for improving the health and wellbeing of colleagues. Creating cultures where colleagues feel safe and supported can lead to higher retention, lower sickness absence rates, enhanced employee experience, and subsequent improvement to patient experience and outcomes.

In order to achieve change and ensure that we set out clear objectives the VPR Lead will develop and implement a specific Health Board Violence Prevention & Reduction Strategy for 2025/2026.

This Strategy will align our policies to recognise the needs and priorities of our Health Board. This piece of work will involve the VPR Team working collaborative with colleagues across the Health Board and key Stakeholders.

DRAFT

13 CONCLUSION

This report highlights the level of health, safety and fire focussed activity that has been undertaken during 2024/25 to improve the management of health, safety and fire in the Health Board.

The Health and Safety Committee continues to promote the health and safety programme.

The Corporate Health and Safety Department works to actively support the delivery of safe and compliant systems within the context of a health and safety culture. Failure to embed an interdependent and mature health and safety culture presents a risk to the Health Board.

The Health Board has seen a reduction in the number of incidents reported to the HSE in accordance with RIDDOR, however, there has been an increase in the number of incidents reported overall. This is potentially associated with the increase in awareness and a positive reporting culture. The Corporate Health and Safety Department will conduct thematic reviews in 2025/26 for needlestick & sharps injuries and manual handling injuries linked to patient handling.

The internal health and safety monitoring programmes are continuously improving as is the ongoing health and safety training programme.

There are challenges in relation to the current level of resource available within the Corporate Health and Safety Department to support the delivery of the legal requirements of health, safety and fire.

The implementation of the health, safety and fire improvement plan in 2023/24 and 2024/25 provided a focus for the Health Board on key risk areas.

A work plan will be developed for 2025/26 to address the risk areas for focus. Implementation of the actions, outlined in the work plan will support the Health Board to demonstrate continuous improvement and compliance with its legal responsibilities.

An Internal Audit is planned for quarter 4 of 2024/25 to assess the health and safety arrangements within the Health Board.



Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	01 October 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Learning from Deaths Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr James Calvert, Executive Medical Director Dr Stephen Edwards, Deputy Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis, Assistant Director for Quality & Patient Safety

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

The UK Government has enacted legislation requiring the scrutiny of all in-patient hospital and community deaths not referred directly to the Coroner by a Medical Examiner. This marks the implementation of the final recommendation from the Shipman Inquiry.

To ensure the Health Board benefits from this enhanced scrutiny and to enable triangulation with other sources of information relating to patient deaths, a comprehensive **Learning from Deaths Framework** has been developed.

The framework supports the publication of a bi-annual report that captures learning from the deaths of patients under the Health Board's care. It establishes a robust ward-to-board process for reporting and monitoring mortality, using trend analysis and triangulation with multiple data sources—including internal mortality data, national clinical audits, Medical Examiner reviews, Mortality and Morbidity (M&M) reviews, and inquest outcomes.

The framework is structured around three tiers of mortality indicators:

- **Tier One – Health Board Level Indicators**

These include system-wide measures such as the Risk Adjusted Mortality Index (RAMI), crude all-cause mortality, and inpatient mortality. These

indicators are benchmarked against peer organisations to provide assurance on quality and safety.

- **Tier Two – Divisional Mortality Indicators**

These support divisional oversight and include:

- Routine reporting of mortality data at Divisional Quality and Safety meetings.
- Triangulation with Medical Examiner insights, particularly where mortality trends raise concern (e.g. increased stroke deaths).
- Case note reviews triggered by anomalies in Tier One indicators.
- Presentation of emerging themes and trends to the Health Board Mortality Review Group to support organisational learning.

- **Tier Three – Directorate-Level Indicators**

These are tailored to each Directorate and informed by national audits or benchmarking. Where no existing indicators are available, bespoke measures will be developed in collaboration with the Quality and Patient Safety Team using CHKS data. National clinical audit data will also be reviewed to support benchmarking and assurance.

This framework enables the Health Board to ensure services are safe, effective, and subject to rigorous scrutiny, ultimately supporting continuous improvement in patient outcomes.

Cefndir / Background

Thanks to advances in medicine over the past century, people are living longer—and often healthier—lives. Around 1% of the UK population dies each year, with the majority of these deaths occurring in individuals aged 75 and over. Many of these deaths are predictable and occur following a period of care.

Aneurin Bevan University Health Board provides care from birth through to end of life. While most patients receive excellent care in the period leading up to their death, there are occasions where the quality of care does not meet expectations. These instances often involve multiple contributory factors, the identification of which can highlight system-wide issues requiring improvement.

In Wales, all deaths are now subject to independent scrutiny by the Medical Examiner (ME) Service, hosted by NHS Wales Shared Services Partnership. The ME Service reviews all deaths not referred to the Coroner, providing an additional layer of assurance.

Medical Examiners are experienced doctors with specialist training in death certification and the review of the documented circumstances surrounding a death. Their role is to ensure that the cause of death is accurately recorded, to

identify any concerns that may warrant further investigation, and to consider the views of the bereaved.

Through this process, the ME Service offers external, independent scrutiny of the quality of care provided. Where concerns are identified, cases are referred back to the Health Board for further review and learning.

Asesiad / Assessment

A learning from death report has been produced for the period July 2024- March 2025.

Data collated for this report is attached and demonstrates that:

Tier One

- RAMI and crude mortality rates show positive trends.
- Coding completeness remains a challenge (13% uncoded episodes), impacting RAMI accuracy.
- Deaths per 1,000 bed days have decreased, with seasonal fluctuations observed.

Tier Two

- Reporting of stillbirth, neonatal and maternal deaths follows a robust internal process and is reported to Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE) and is case specific.
- The collation of data on unexpected deaths within MHL D has been updated as part of the report over the last 12 months. The database used for this report is continually being updated with new variables to help the Health Board better understand and learn from these tragic events. However, this process involves detailed analysis of patient records, which takes time.
- At present, suicide-related data is not yet available, but the team are actively working to prepare this for inclusion in the next report. The team are ensuring the data is accurate, respectful, and informative.
-

Tier Three

- Stroke and MI mortality rates remain below national averages.
- Elective surgery mortality is 0%; non-elective surgery mortality improved to 1.17%.
- Geriatric and Rehabilitation Medicine flagged for higher-than-peer mortality and RAMI.
- ED mortality remains below peer average; learning from M&M reviews is actively applied.

- Critical Care and General Surgery have implemented targeted improvements based on M&M findings.
- Engagement with Clinical Leads ensures an enhanced understanding of mortality themes and trends. For this report many of the Divisions have shared examples learning and improvement to support the report.
- **Cross-Cutting Themes:**
- Bereavement care, end-of-life planning, and communication require continued focus.
- ME referrals highlight delays, documentation issues, and communication gaps.
- Positive patient feedback reinforces areas of good practice.

Medical Examiner (ME)

- The ME Service provides independent scrutiny of all non-coroner-referred deaths, ensuring accurate cause of death documentation and identifying concerns for further investigation. It also incorporates the views of bereaved families.
- The ME Service has expanded to include community cases and continues to adapt to this broader remit.
- Delays were the most frequently cited concern, appearing in 19% of referrals. These included delays in treatment, investigations, ambulance off-loads, and those identified by MEs.
- DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) issues were noted in 14% of referrals, often due to forms not being co-signed by a senior clinician.
- Communication concerns accounted for 17% of referrals, involving interactions with families, clinicians, and the Care After Death Team. Family concerns were specifically noted in 11% of cases.
- Nosocomial (hospital-acquired) COVID-19 referrals decreased from 9% to 7%.
- Pressure damage referrals dropped from 5% to 3%, indicating improvement in prevention or reporting.
- No Further Action referrals have declined, likely due to improved referral quality and more local sharing by the ME Screening Panel.
- HMC (Health and Mortality Committee) referrals have increased, suggesting a shift in escalation and oversight patterns.
- Datix closures have improved, reflecting better follow-through and resolution.

The attached report provides details for areas for improvement and document learning from clinical areas. The report includes the reported mortality indicators as agreed on the Health Board's mortality framework and is embedded with narrative provided by multiple clinical areas.

Next steps

To strengthen the Health Board's approach to learning from deaths, a series of strategic actions are proposed across governance, digital integration, clinical coding and targeted reviews.

The structured governance framework is being embedded across all levels of the Health Board. This includes ensuring that learning from Mortality and Morbidity (M&M) reviews is consistently escalated to divisional and board-level forums, enabling oversight and accountability.

Digital integration is a key enabler of timely and effective mortality review. The development of the Qlik dashboard should be accelerated to reduce reliance on manual processes. Alongside this, interoperability between CHKS, Medical Examiner reviews, and clinical systems must be improved to support seamless data triangulation and enhance analytical capability.

Clinical coding remains a critical factor in the accuracy of mortality data. The Health Board will continue its coding improvement programme, with a particular focus on addressing resource gaps and standardising the depth of coding. This will ensure that mortality indicators such as RAMI are reliable and reflective of actual patient risk.

Targeted reviews are essential for identifying and addressing areas of concern. Deep dives into Gastroenterology, Geriatric Medicine, and Rehabilitation Medicine are underway, with thematic findings incorporated into the next reporting cycle to inform learning and improvement.

Fostering a culture of learning is vital. This includes promoting the dissemination of insights through newsletters, audit cycles, and divisional Quality and Patient Safety (QPS) meetings.

Argymhelliad / Recommendation

The Committee is requested to note the development of a number of mortality indicators and the development of a Learning from Deaths framework. Comments are invited to support framework development.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	As within the paper
Rhestr Termiau: Glossary of Terms:	As within the paper
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau)

Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives



GIG
CYMRU
NHS
WALES

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University Health Board

Learning from Deaths Report

MORTALITY DATA AND NARRATIVE REPORT
JULY 2024 – MARCH 2025

Introduction

Learning from Deaths Report: July 2024 – March 2025

This report provides assurance that Aneurin Bevan University Health Board continues to strengthen its approach to learning from patient deaths, embedding a culture of continuous improvement, transparency, and accountability. The *Learning from Deaths Report* presents mortality data across three tiers: Health Board, Division, and Directorate.

Framework Implementation and Assurance

Since the previous report (October 2022 – December 2023), the Learning from Deaths Framework has been disseminated across all Divisions to ensure consistent engagement in reviewing and learning from patient deaths. The framework underpins a robust ward-to-board assurance process, enabling systematic reporting and oversight of mortality data. It supports the triangulation of condition-specific mortality trends with insights from the Medical Examiner, ensuring that learning is evidence-based and aligned with governance expectations.

Structured Mortality Reviews

The framework reinforces our commitment to conducting structured mortality reviews. These reviews are essential for identifying problems in care, drawing out learning, and implementing targeted improvements. This structured approach ensures that learning is not only captured but also translated into measurable actions that enhance patient safety and quality of care.

Whilst mortality reviews are being undertaken across the Health Board this is limited at present to the corporate team. The ability to identify mortality outliers is currently restricted by external software (CHKS). The Health Board is actively working in partnership to expedite improvements to this system, which will further strengthen the deep dive process and enhance assurance through more timely and targeted analysis.

Assurance Through Reporting and Governance

The Learning from Deaths Report consolidates all identified learning and provides assurance that the organisation is systematically reviewing deaths, identifying themes, and implementing improvements. The report is submitted to the Quality Management Group and onwards to Patient Quality, Safety and Outcomes Committee (PQSOC) on a six-monthly basis, ensuring executive oversight and accountability for the actions taken.

Areas to highlight

Tier 1: Health Board-Level Mortality Data and Assurance

- The *Learning from Deaths Report* presents mortality data across three tiers: Health Board, Division, and Directorate.
- This section provides assurance at the Health Board level, highlighting performance, trends, and actions taken to strengthen mortality surveillance and learning.
- For the period July 2024 to March 2025, the Health Board's Risk Adjusted Mortality Index (RAMI) stands at 100.3, showing a positive improvement from 106.1 during the same period in 2023/2024. This positions the Health Board as the best-performing Health Board in Wales within its peer group, providing a strong indicator of quality and safety performance.
- While RAMI values fluctuate, crude mortality rates have remained stable, offering further assurance of consistent care delivery. To enhance understanding of areas with higher mortality, the Health Board is developing detailed individual mortality reports. These will support targeted reviews and learning.

RAMI is a key performance indicator that adjusts mortality rates based on patient risk factors. Its reliability is dependent on the quality of clinical coding. Between January and June 2024, 18.3% of consultant episodes remained uncoded, although 100% of deaths were coded. A targeted clinical coding improvement programme is underway to address this and enhance data accuracy.

Areas to highlight

Tier 2: Divisional level data:

- **Perinatal and Maternal Mortality Reporting and Assurance**

The reporting of stillbirths, neonatal, and maternal deaths follows a clearly defined internal governance process and is submitted to the national *Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries* (MBRRACE) audit. This ensures that each case is reviewed individually and contributes to national learning and benchmarking. For the current reporting period:

- Neonatal deaths (deaths occurring in neonatal units) are under active review. A comprehensive paper is being prepared for submission to the Board in September 2025, providing assurance on findings and actions taken.
- Stillbirth data has been included in this report to ensure transparency and completeness.
- There were zero maternal deaths during this period, which provides positive assurance regarding maternal safety.

- **Mental Health and Learning Disabilities (MHLD)**

The collation of data on unexpected deaths within MHLD has been presented, including the causes and circumstances surrounding patients who were in contact with mental health services. At present, suicide-related data is not yet available, but the team are actively working to prepare this for inclusion in the next report. The team are ensuring the data is accurate, respectful, and informative.

- **Expansion of the Medical Examiner Service (MES)**

In September 2024, the Medical Examiner Service expanded its remit to include the scrutiny of all deaths across Paediatrics, Neonates, Maternity, Gynaecology, and Primary Care. This expansion strengthens the Board's assurance framework by ensuring independent, systematic review of all deaths.

To support this, the Medical Director's Quality and Patient Safety team has arranged meetings with MES and has worked collaboratively with Divisions to map out the end-to-end governance process for death reporting in line with national MES protocols. This includes processes for community-based child deaths, such as those reviewed under PRUDiC (Procedural Response to Unexpected Deaths in Childhood), ensuring that all deaths are appropriately scrutinised and reported.

Areas to highlight

Tier 3: Directorate level Data:

All monitored mortality indicators have shown improvement compared to the previous reporting period, and there are no concerns requiring escalation.

- **Emergency Department Admitted Mortality:** Performance remains better than peer comparators, providing assurance of effective acute care pathways.
- **30-Day Inpatient Mortality – Myocardial Infarction (MI):** Reduced to 2.6%, down from 2.8% last year, indicating improved clinical outcomes and timely interventions.
- **30-Day Inpatient Mortality – Stroke:** Currently at 8.0%, a slight improvement from 8.1% last year. This remains lower than the All-Wales peer value of 13.6%, reaffirming the Health Board's position as the lowest in Wales for this indicator.
- **Elective Surgery Mortality (within 30 days):** Maintains a rate of 0%, compared to 0.02% last year. From January 2024 to March 2025, there have been no recorded mortalities, providing strong assurance of surgical safety and pre-operative optimisation.
- **Non-Elective Surgery Mortality (within 30 days):** Improved to 1.2%, down from 1.4% last year, and remains below the All-Wales peer value of 1.8%, reflecting robust perioperative care and risk management.
- **Clinical Engagement and Learning:** Ongoing collaboration with Clinical Leads continues to enhance understanding of mortality themes and trends. Divisions have contributed examples of learning and improvement, which are detailed in the appendices, supporting a culture of continuous improvement.
- **Forward Assurance Planning:** Work is underway with Divisions to establish meaningful metrics for regular review. This includes the implementation of standardised agendas featuring targeted mortality indicators at Directorate level, strengthening governance and assurance mechanisms.

Areas to highlight

Key Themes from Medical Examiner (ME) Referrals

- **DNACPR:** Featured in 14% of recent referrals, down slightly from 15%. Common issues include forms not being co-signed in Part 6 by a senior clinician or consultant.
- **Communication:** Now accounts for 17% of referrals, a decrease from 19%. Issues span interactions with families, clinicians, and the Care After Death Team. The volume reflects increased referrals as ME service coverage expands. *Family concerns* were noted in 11% of cases.
- **Nosocomial (Hospital-Acquired) COVID-19:** Referrals related to hospital-acquired COVID-19 have decreased from 9% to 7%.
- **Pressure Damage:** Down from 5% to 3%, indicating a positive trend in prevention or reporting.
- **Delays:** Now the most frequently cited concern (19%), encompassing delays in treatment, investigations, ambulance off-loads, and those identified by MEs.

Referral Outcomes and Service Development

- **No Further Action:** These referrals have steadily declined, likely due to improved referral quality and increased local sharing by the ME Screening Panel.
- **HMC Referrals:** Cases referred to the Health and Mortality Committee have increased, suggesting a shift in escalation and oversight patterns.
- **Datix Closures:** Closure rates have improved significantly, reflecting better follow-through and case resolution.
- **Service Expansion:** Throughout 2024, the ME Service has evolved to include community cases and continues to adapt to this broader remit.

Areas of development

Governance Framework and Mortality Assurance

The structured governance framework continues to be developed to strengthen assurance around mortality outcomes. This includes:

- **Divisional-Level Reporting:** Mortality data is being tailored for routine reported through Divisional Quality and Patient Safety meetings, ensuring local ownership and visibility of trends and learning.
- **Condition/Procedure-Specific Mortality Reviews:** A formal process is in development to trigger reviews where mortality indicators fall outside expected parameters. This will support targeted learning and assurance at both Directorate and Health Board levels.
- **Escalation and Assurance from M&M Reviews:** Work is underway to define how formal assurance and escalation from Mortality and Morbidity (M&M) reviews will be captured and reported through governance structures. This will ensure that learning is not only identified but acted upon and monitored.
- **System Challenges:** Progress is constrained by delays in CHKS software development. The lack of interoperability between systems currently limits the triangulation of mortality data with Medical Examiner (ME) reviews, M&M reviews, and inquest outcomes. Currently, data capture and thematic analysis rely heavily on manual processes—requiring staff to trawl through records to identify trends and triangulate learning across sources. This limits the ability to generate timely, system-driven insights and undermines the consistency and reliability of assurance reporting

Progress update

Action from previous report	Progress
Work with Directorates to establish mortality indicators Increase engagement with clinicians regarding mortality processes	Directorate-level mortality indicators have been defined in line with the Mortality Framework and are being shared with Clinical Directors. Additional indicators are being identified, with feasibility assessments underway to ensure reliable reporting.
Increase engagement with clinicians regarding mortality processes	Engagement with clinicians is ongoing to embed mortality processes into routine practice, ensuring consistent understanding and ownership across clinical teams.
Develop a Mortality Review Committee	The newly established Quality Management Group will provide oversight and scrutiny of mortality data, fulfilling the assurance function originally intended for the Mortality Review Committee.
Ensure robust and timely governance processes regarding mortality outcomes within the Health Board Establish Mortality and Morbidity (M&M) meetings throughout all Directorates	The expansion of the Medical Examiner (ME) Service has enabled divisional engagement to review processes for unexpected deaths. Assurance is being strengthened through mapping and validation of M&M meeting coverage across clinical areas.
Improve identification of learning from mortality reviews Develop and implement the mortality review process for deep dives into directorates with condition-specific mortality outside control limits	Improve identification of learning from mortality reviews Develop and implement the mortality review process for deep dives into directorates with condition-specific mortality outside control limits
Establish the mortality outlier model in CHKS to create alerts	The CHKS mortality module is now active. While currently reliant on manual data extraction, collaboration with CHKS and the Digital, Data & Technology Division is exploring automation via a Qlik app to enhance real-time assurance.

Learning and Improvement

- Divisions have actively contributed to this report by sharing examples of learning and improvement identified through Mortality and Morbidity (M&M) reviews, reinforcing a culture of reflection and continuous improvement.
- To strengthen analytical capability and assurance:
 - The Health Board now has access to the CHKS Mortality Alerts Module, enabling the development of tailored graphs and charts to meet local needs. This will directly support the creation of a Standard Operating Procedure (SOP) to guide all staff involved in mortality peer reviews. The case note review is being piloted by the cooperate team before engaging with clinicians and looking at implementation.
 - Initial development has begun on an internal QLIK App, designed to replicate and enhance the mortality measures currently provided externally via CHKS. This will allow directorates to access custom dashboards, ensuring that key metrics are monitored efficiently and remain relevant to their specific services.
 - The Mental Health and Learning Disabilities (MHLD) team is reviewing national reports on themes and trends in the deaths of people with learning disabilities, ensuring local learning is aligned with national insights.
 - Perinatal and maternal deaths are also reviewed in line with national systems. Local learning is captured and translated into specific action plans, which are reported to Mat Neo Board and then to the Patient Quality, Safety and Outcomes Committee (PQSOC)—demonstrating a clear line of assurance and accountability.

Conclusion

- The Health Board has demonstrated measurable improvements in mortality outcomes across multiple tiers, with RAMI, crude mortality, and deaths per 1,000 bed days all showing positive trends.
- Structured mortality reviews, enhanced Medical Examiner Service coverage, and divisional engagement continues to strengthen governance and assurance.
- Targeted learning from neonatal, mental health, stroke, and surgical mortality has informed local action plans and national benchmarking.
- The integration of CHKS and Qlik tools is beginning to support more timely, data-driven insights, although system limitations persist.
- Learning from inquests, complaints, and bereavement reviews has reinforced the importance of communication, documentation, and early recognition of deterioration and end-of-life needs.

1. Strengthen Governance and Reporting

- Finalise and embed the structured governance framework for mortality assurance.
- Ensure consistent escalation and feedback loops from M&M reviews to divisional and board-level forums.

2. Advance Digital Integration

- Accelerate development of the Qlik mortality dashboard to reduce reliance on manual processes.
- Improve interoperability between CHKS, ME reviews, and clinical systems.

3. Enhance Clinical Coding

- Continue the clinical coding improvement programme, focusing on depth and accuracy to support RAMI reliability.
- Address resource gaps in coding review for flagged specialties (e.g. Respiratory, Geriatrics).

4. Deep Dives and Thematic Reviews

- Complete and report on deep dives into Gastroenterology, Geriatric Medicine, and Rehabilitation Medicine.
- Include thematic findings in the next report cycle.

5. Embed Learning and Culture Change

- Promote learning dissemination through Mortality newsletters, audit cycles, and divisional QPS meetings.

6. Equity and Inclusion

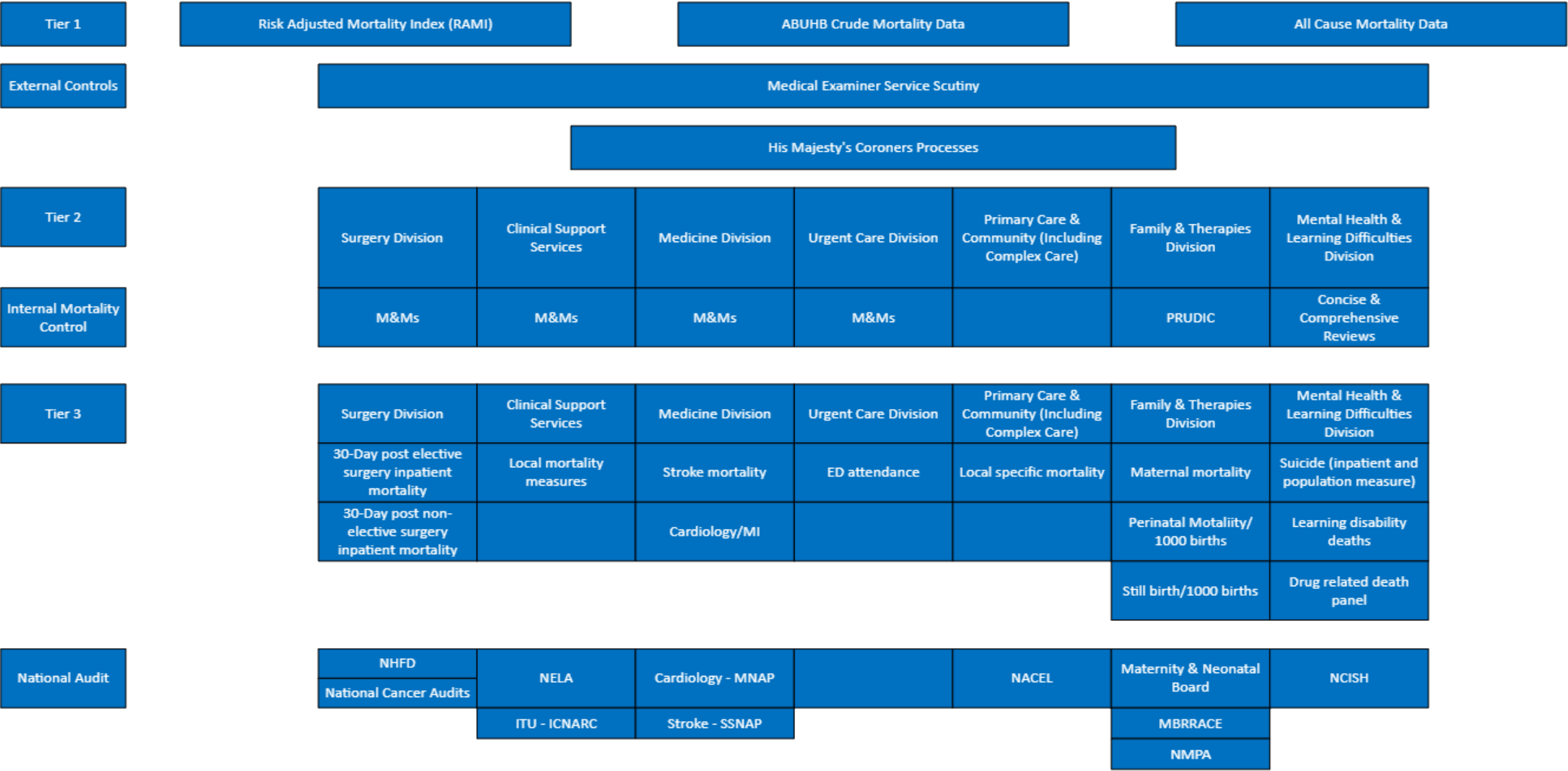
- Link with bereavement work to ensure access to end-of-life care for underrepresented groups.
- Continue engagement with community stakeholders (e.g. Imams) to address cultural needs in bereavement care.

For Information

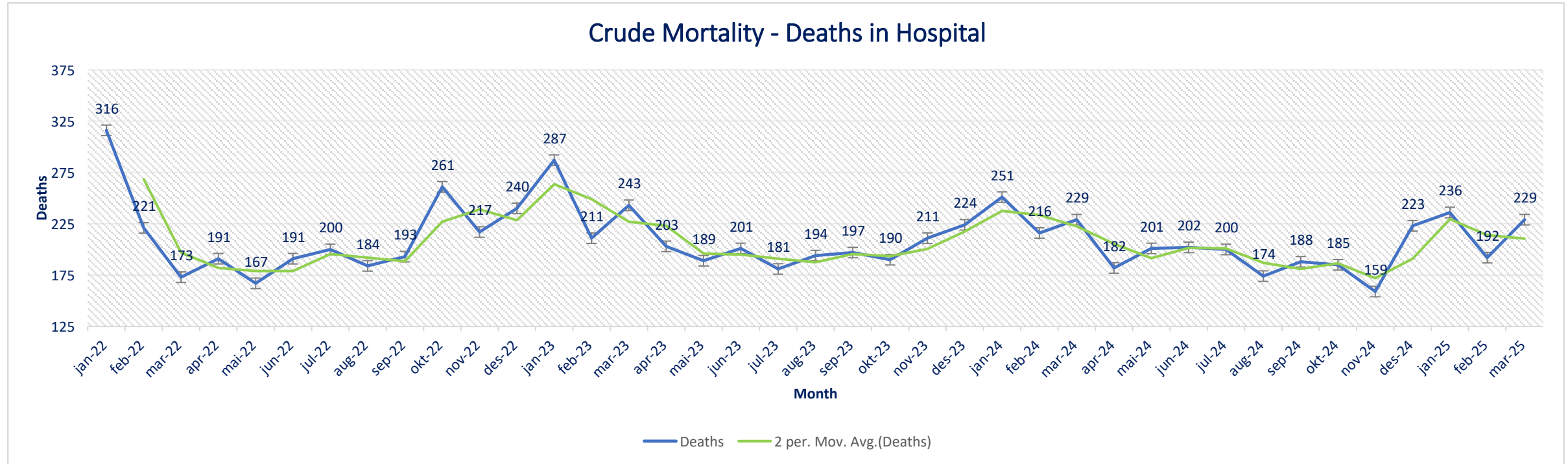
Mortality Indicators

Learning and improvement provided as part of the Health Board
mortality framework

Aneurin Bevan University Health Board Mortality Framework

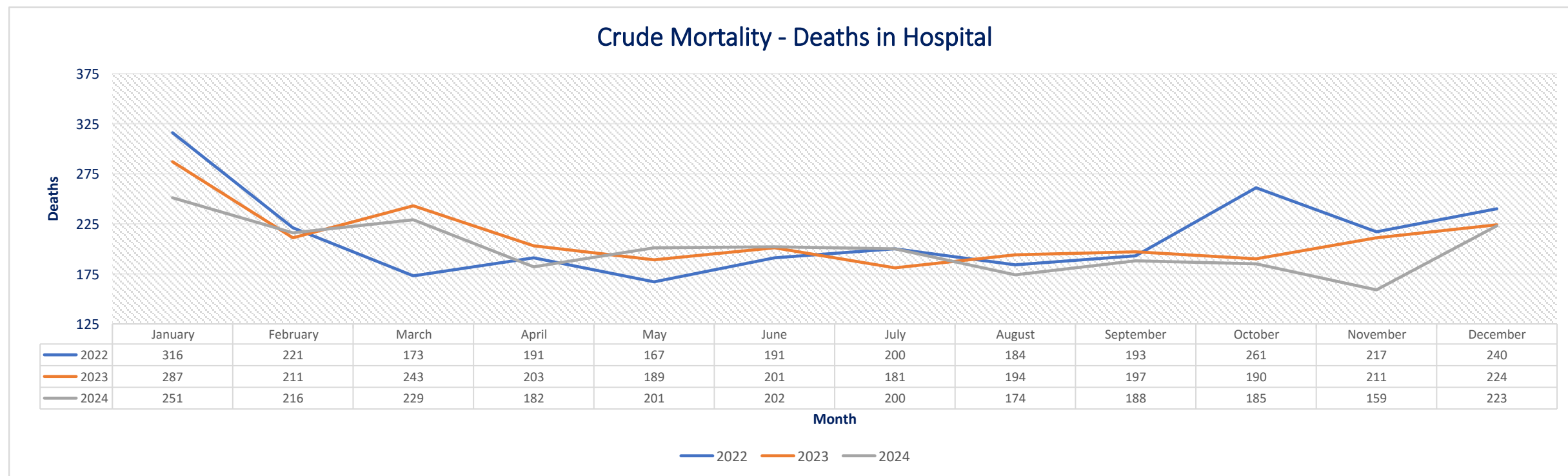


Tier One Mortality Indicators – Crude Mortality



Crude mortality measures the number of deaths in a population over a specific period. It helps understand overall death rates in a community, region, or country by comparing current deaths to the average over the previous four years, identifying trends above or below this average. The data includes all-cause mortality and as seen in the Aneurin Bevan University Health Board. Three years data has been plotted to identify seasonal variation and trends

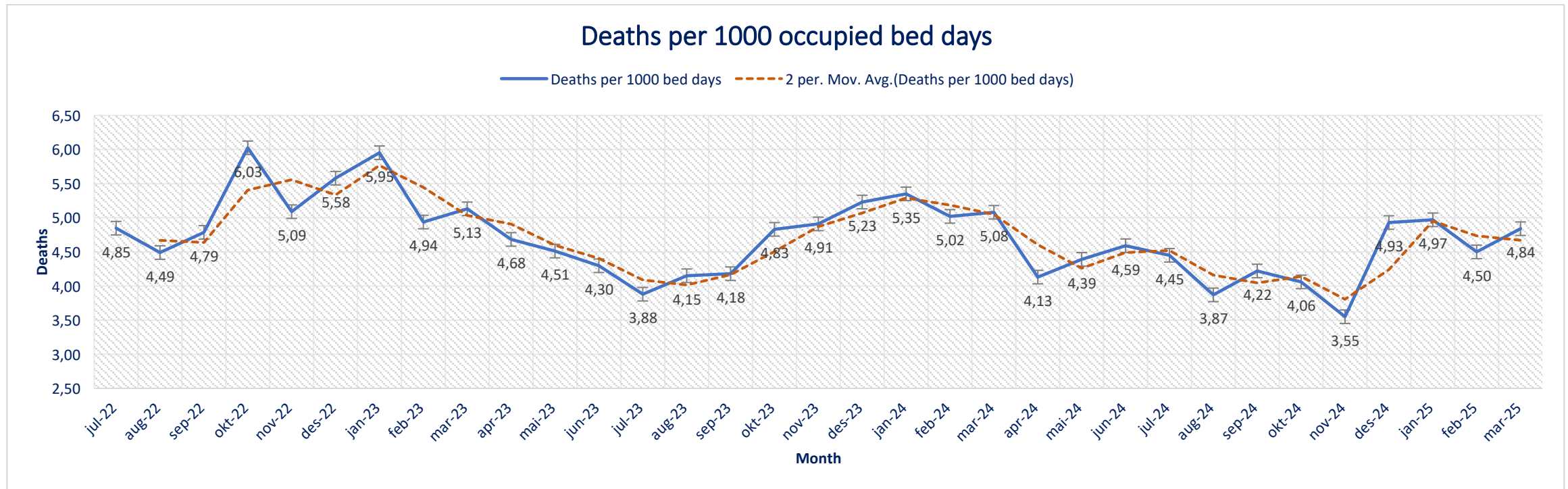
Tier One Mortality Indicators – Crude Mortality (cont.)



- In 2024 there was a notable reduction in hospital deaths compared to both 2022 and 2023, particularly in the early months (January–March). January deaths dropped from 316 (2022) and 287 (2023) to 251 (2024). This downward trend continues through March, suggesting a sustained improvement in early-year outcomes.
- Monthly Patterns (All Years) There is a recurring seasonal pattern across all three years: Decreases in March, May, July, September, and November. Increases in April, June, August, and October.
- This cyclical pattern may reflect seasonal pressures, such as winter surges or summer lulls, and possibly operational or public health interventions.
- The overall downward trend in 2024 suggests improvements in patient safety, care quality, or broader system-level changes. The seasonal fluctuations remain consistent year-on-year, but 2024 shows less volatility, which may indicate better resilience or planning. Anomalies in May and November 2024 warrant further review to understand contributing factors.

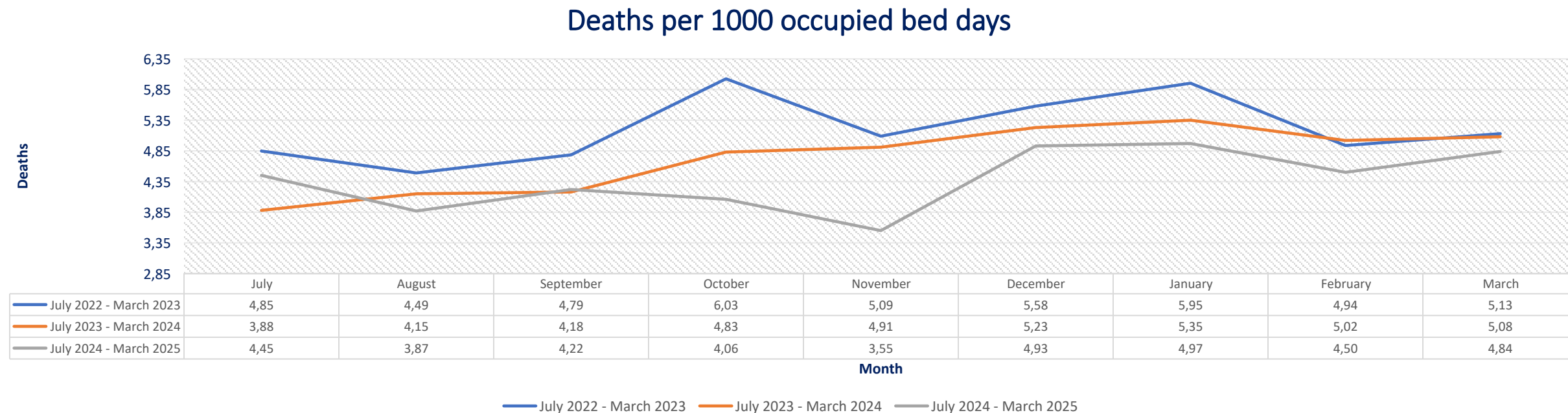
Tier One Mortality Indicators – All-cause Mortality

All-cause mortality measures the total number of deaths from any cause in a population over a specific period. Unlike measures focusing on specific diseases, it counts every death, regardless of the cause. It's usually expressed as the number of deaths per 1,000 people per year.



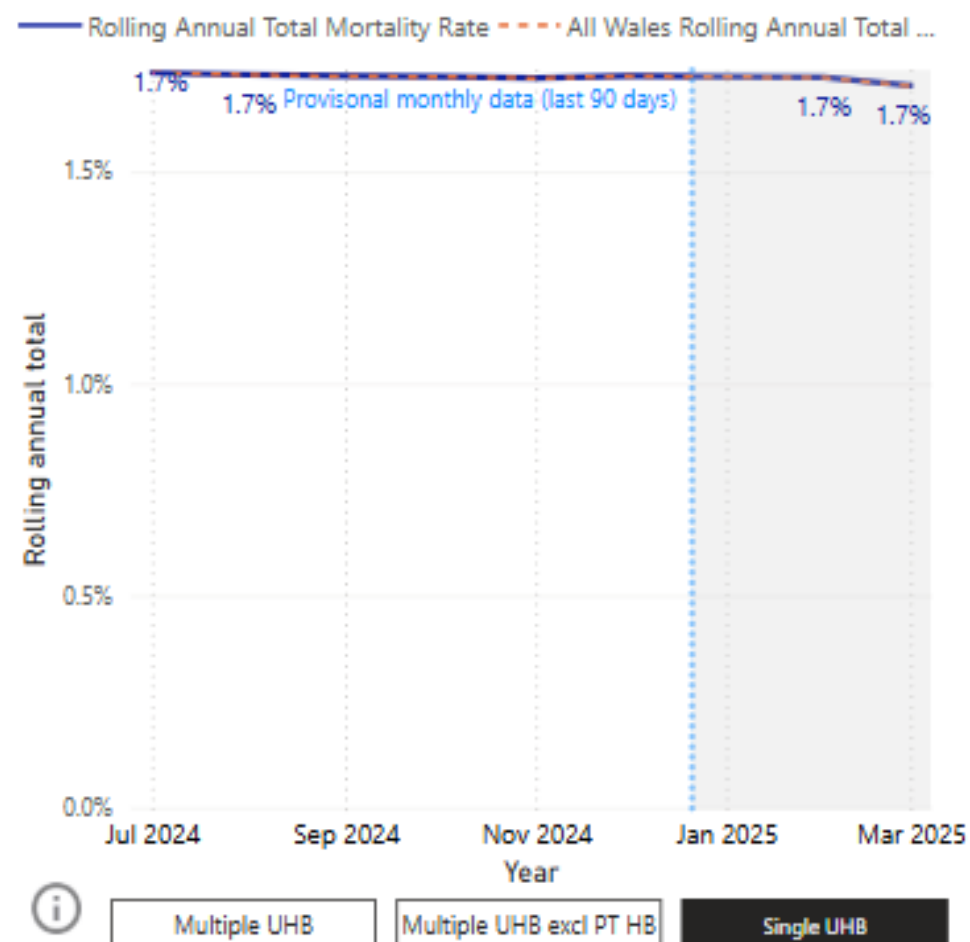
- Deaths per 1000 occupied bed days – a steady decline is observed from January 23 to July 23 before a noticeable and trending increase until April 24. Since then, there has been a prolonged period of fluctuation. However this does include a low point of 3.55 observed in November 24, the lowest since data recording commenced. Year on year November to December increase is consistent with RAMI increases for the same time period.

Tier One Mortality Indicators – All-cause Mortality



- The 2024–2025 period shows a notable reduction in deaths per 1000 occupied bed days compared to the previous two years. The grey line consistently tracks below the blue and orange lines across most months, indicating improved mortality rates relative to bed occupancy.
- December–March: All three years show a rise in mortality rates during winter months, but the 2024–25 values remain lower, suggesting better resilience or interventions during seasonal pressures.
- Notable Improvements The 2023–24 period (orange line) already showed improvement over 2022–23, and the 2024–25 period continues this downward trend, reinforcing a sustained improvement in patient outcomes relative to bed usage.
- This metric—deaths per 1000 occupied bed days—is a key indicator of hospital mortality adjusted for capacity. The downward trend in 2024–25 suggests:
 - Enhanced quality of care and patient safety.
 - Better management of bed utilisation and clinical risk.
 - Potential impact of targeted interventions or service redesigns.

Tier One Mortality Indicators – Rolling Mortality Rate



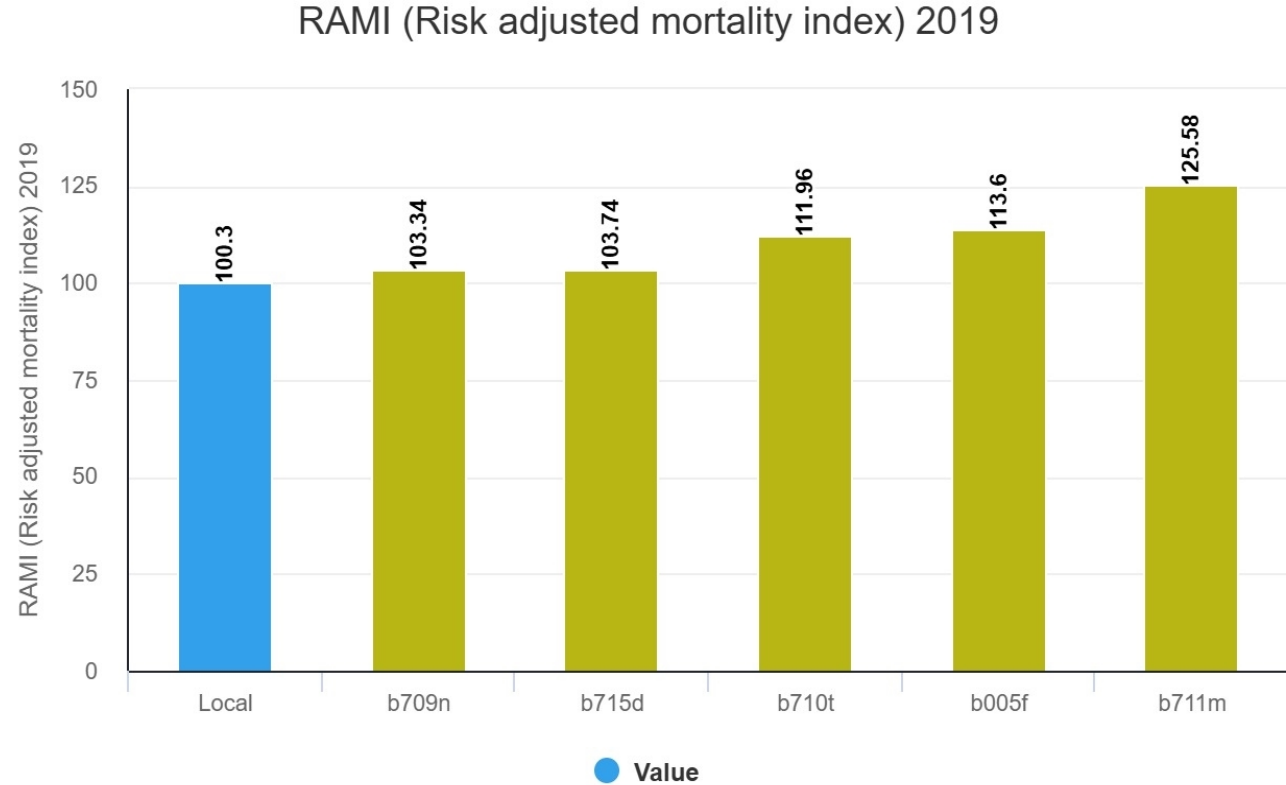
ABUHB	Mortality Rate
Jul-24	1.54%
Aug-24	1.53%
Sep-24	1.63%
Oct-24	1.57%
Nov-24	1.62%
Dec-24	2.11%
Jan-25	2.04%
Feb-25	1.77%
Mar-25	1.67%

The Health Board’s mortality rate has remained stable, showing a flat trend. Actual in-hospital deaths decreased during Q3 2024/25 before an increase in Q4.

The report supports adopting diverse methods to assess performance. This approach ensures quality improvement and assurance around mortality without relying solely on retrospective aggregated data like RAMI. Additional mortality indicators are included for reporting to enhance this process.

Tier One Mortality Indicators – Risk Adjusted Mortality Index (RAMI)

- RAMI is a metric used to measure hospital or treatment-related deaths, considering the initial health status of patients.
- Patient Differences: Patients vary in age, health conditions, and illness severity. Some are at higher risk of dying due to their initial health status.
- Adjustment Process: This metric adjusts the raw death numbers to account for these differences, providing a fairer comparison between hospitals or doctors.
- Fair Comparison: It helps determine if a hospital's death rate is better or worse than expected, given how sick its patients were.
- This way, hospitals treat very sick patients aren't unfairly judged by their higher death rates.
- A RamI of 100 represents the expected mortality rate.
 - Below 100: Fewer deaths than expected (better performance).
 - Above 100: more deaths than expected (potential concern)



July 2024 – March 2025

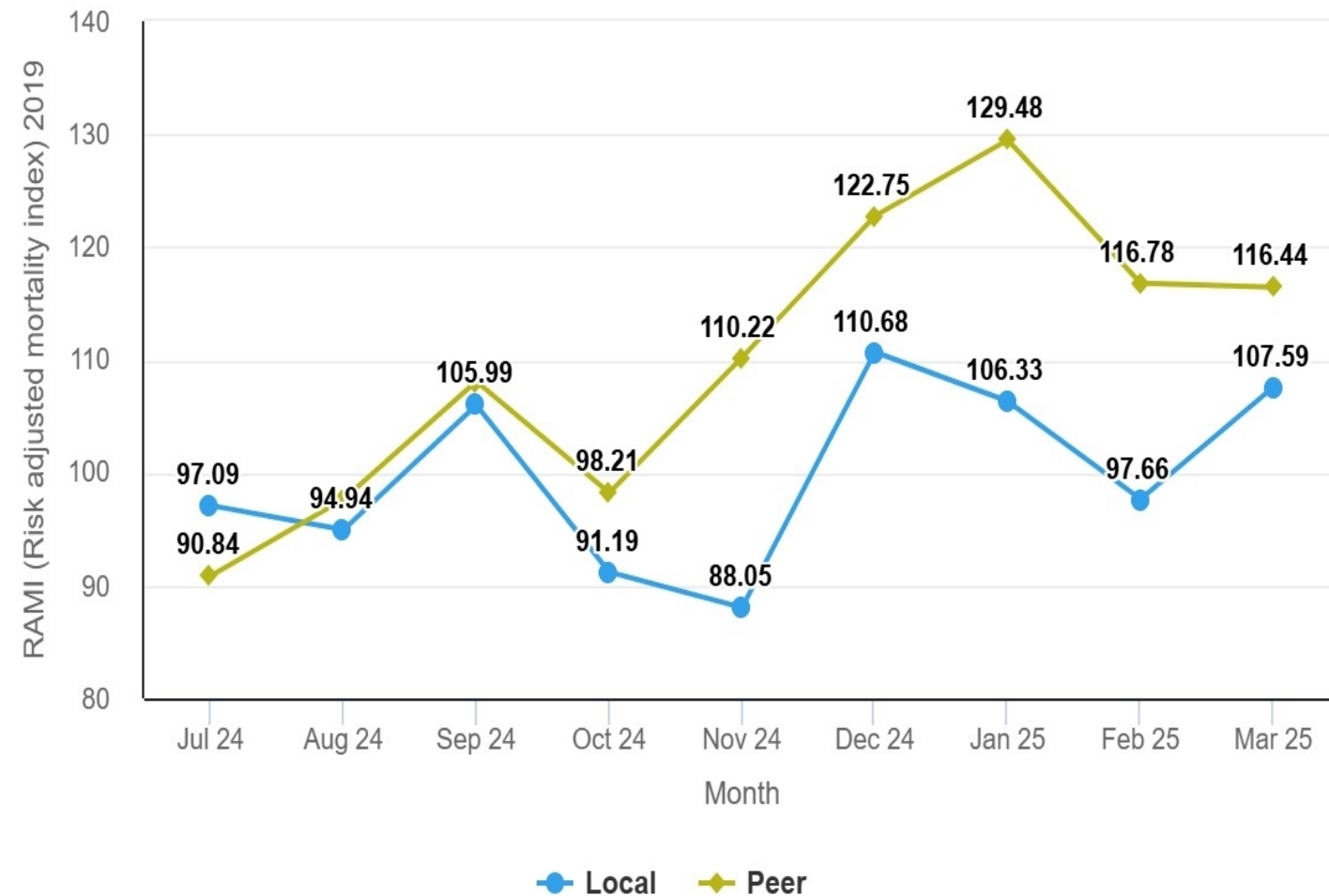
Blue – ABUHB Yellow – Peers (All Wales)

The Health Board is the best performing Health Board within the All Wales Peer Group.

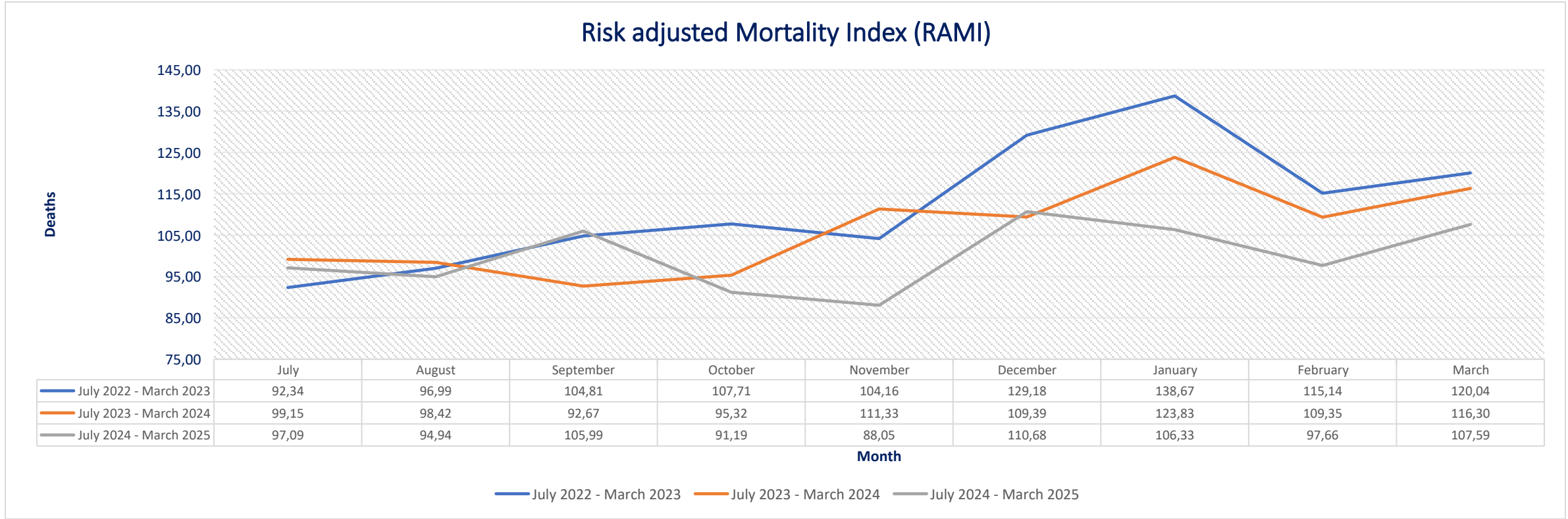
Tier One Mortality Indicators – Risk Adjusted Mortality Index (RAMI)

- The accuracy of RAMI (Risk-Adjusted Mortality Index) relies on the completeness and accuracy of clinical coding. Currently coding is on a lag of 12 weeks. This means our RAMI will improve when the coding is updated.
- Between July 2024 and March 2025, 13% finished consultant episodes at ABUHB were uncoded.
- In 2014, Professor Palmer reviewed RAMI and questioned its validity as a sole measure. He recommended a blended approach using multiple data sources, including mortality reviews, national benchmarking, and national audits, to ensure quality improvement and assurance around mortality.
- The Health Board is currently performing better than the Welsh Peer Value average as an overall value of RAMI.
- Consistent and linear performance against Welsh Peers from August 2024.

RAMI (Risk adjusted mortality index) 2019



Tier One Mortality Indicators – Risk Adjusted Mortality Index (RAMI) (Cont.)

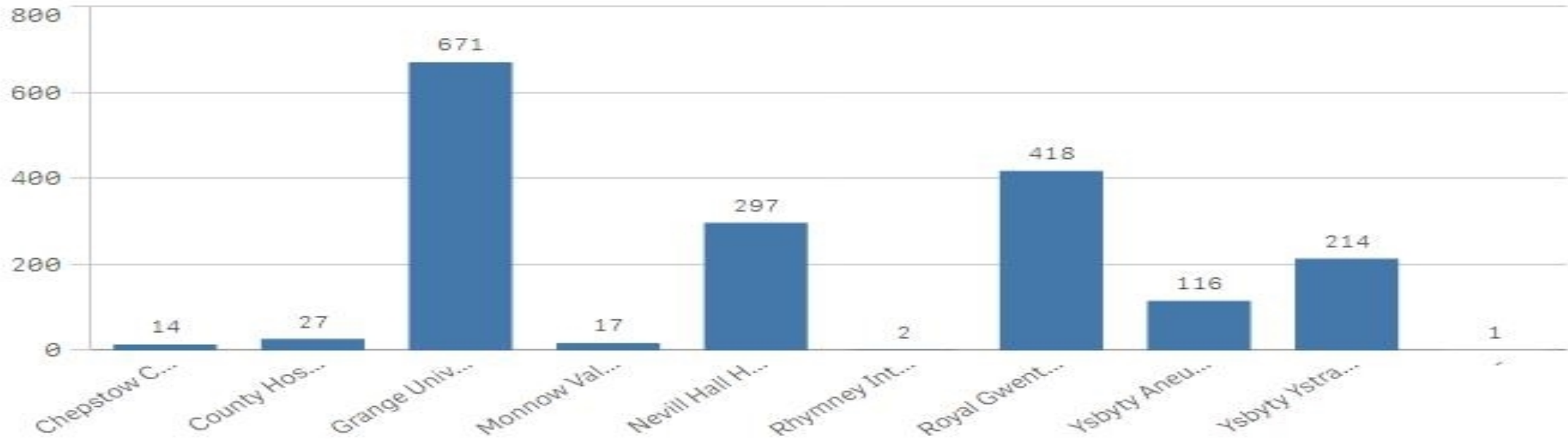


- The 2024–25 RAMI values are consistently lower than in previous years, indicating a positive trend in mortality outcomes after adjusting for case mix.
- The lowest RAMI values appear in October (91.19) and November (88.05) 2024, suggesting particularly strong performance during those months.
- The 2024–25 period shows a marked improvement, especially in the winter months (October–February), where RAMI values are lower than in previous years. This suggests: Better clinical outcomes despite seasonal pressures. Effective risk mitigation strategies. Potential impact of service improvements or targeted interventions.

Tier One Mortality Indicators – All-cause Mortality per site

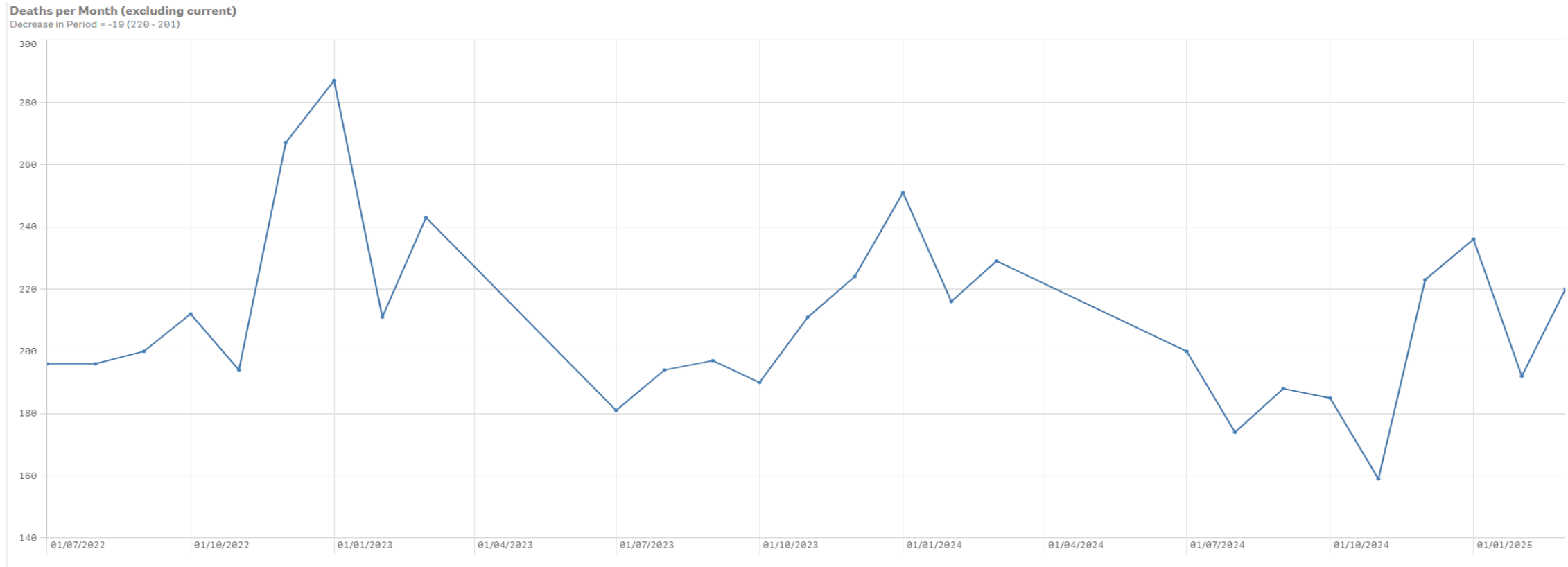
July 2024 – March 2025

Deaths by Hospital



- The Grange University Hospital has the highest number of recorded deaths, followed by the ELGH sites
- Outlier of 1 death with no site attached – Coding issue identified and reported

Tier One Mortality Indicators – All-cause Mortality in Hospital



- The line fluctuates month to month, reflecting seasonal or episodic variations (e.g. winter peaks).
- Despite these fluctuations, the general direction is downward, indicating a positive long-term trend.

Clinical Coding Performance and Improvement Plan

- **Welsh Government Targets:** 95% coding completeness by the end of the following month (e.g. March discharges coded by end of April). 90% of clinical coding errors corrected within 35 days of identification.
- **Current Position:** The Health Board’s coding completeness currently stands at 87%, impacted by increased activity and the onboarding of multiple Trainee Coders.
- **Actions Taken:** A Clinical Coding restructure has been implemented to support national targets and create development opportunities. Ongoing initiatives include:
 - Raising awareness of clinical coding through activities such as *Lunch & Learn* sessions.
 - Developing automation tools to allow coders to focus on more complex cases.

Challenges Identified:

- Increased volume of Finished Consultant Episodes (FCEs).
- Incomplete or unclear patient records.
- Excessive use of abbreviations, which delays coding and limits automation potential.

Performance Against Accuracy Targets:

- The Health Board continues to perform well against Welsh Government accuracy standards.
- The latest DHCW audit (2024/25) shows strong results:
 - 90% target for primary diagnosis and procedure.
 - 80% target for secondary diagnoses.

Code Type	Percentage Correct
Primary Diagnosis	93.50%
Secondary Diagnosis	94.85%
Primary Procedure	88.34%
Secondary Procedure	81.17%

Depth of Coding and RAMI Accuracy:

- Depth of coding refers to the number of additional risk factors (e.g. diabetes, hypertension) captured in the patient record. This significantly influences the accuracy of the Risk Adjusted Mortality Index (RAMI).
- Best practice includes coding: The main condition treated. All relevant procedures/interventions. All documented co-morbidities.

Next Steps:

- Standardising and improving the depth of coding will enhance the accuracy of mortality data and strengthen the reliability of RAMI reporting.

Identifying and embedding **Divisional-level mortality indicators** will significantly enhance the Health Board’s ability to monitor and respond to mortality trends. This approach will:

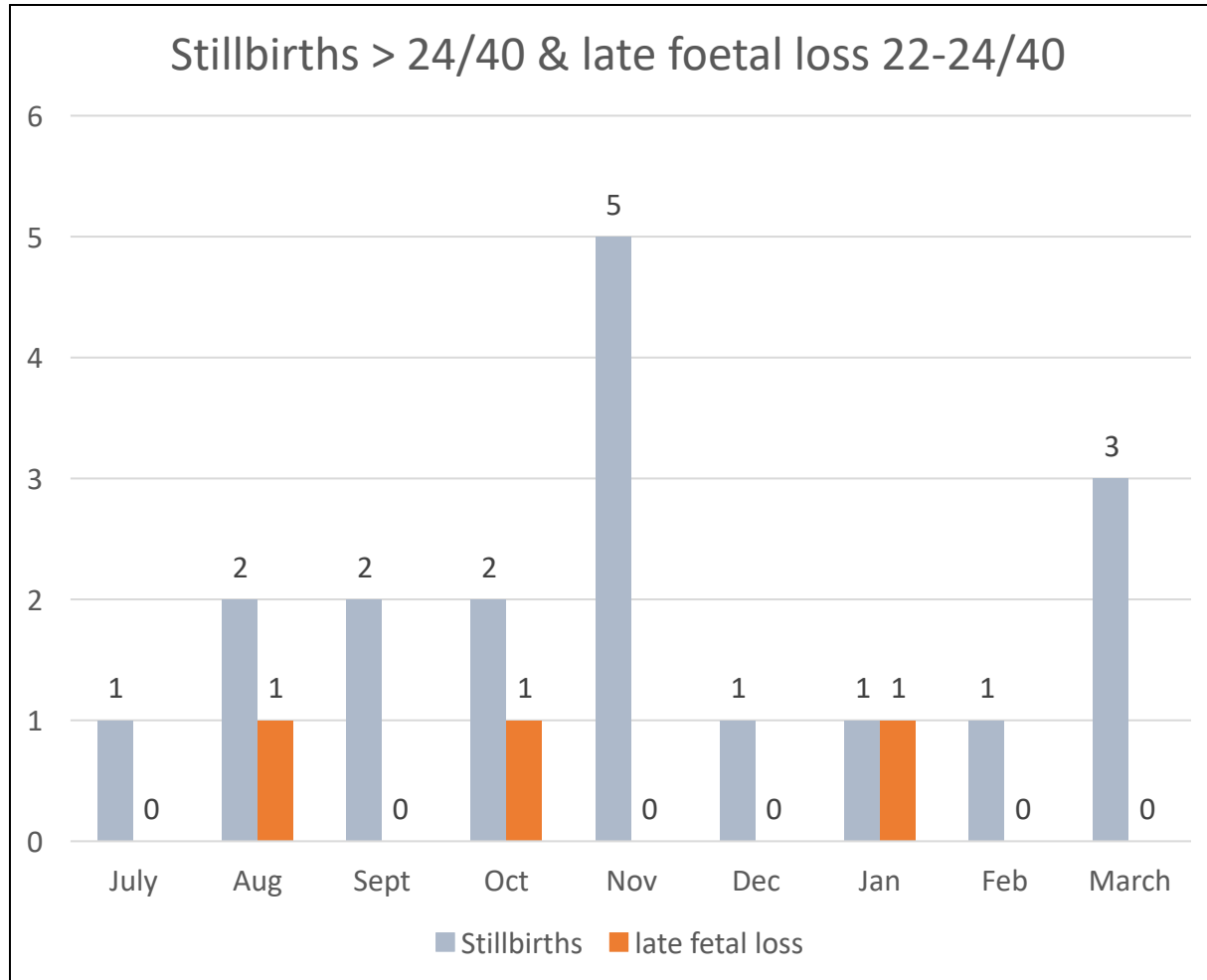
- **Enable systematic reporting** of mortality data at Divisional Quality and Safety meetings, ensuring consistent visibility and accountability.
- **Support triangulation** with Medical Examiner insights, particularly when mortality rates rise—e.g. through thematic reviews of specific patient groups such as stroke patients.
- **Facilitate case note reviews** to provide assurance in the absence of other clinical review mechanisms.
- **Inform organisational learning** by presenting emerging mortality themes and trends to the Health Board Mortality Review Group.

Strengthening Mortality Oversight Through Divisional Indicators

Family and Therapies	Medicine	Urgent Care	Mental Health	PCC	Surgery
Maternal mortality	Stroke Mortality	ED attendance	Suicide (population measure)	Locality specific mortality	30-day post elective surgery inpatient mortality
Perinatal Mortality/ 1,000 births	Cardiology / MI		Learning disability deaths		30 post non-elective surgery inpatient mortality
Still Birth/ 1,000 births					

Table illustrates the proposed mortality indicators identified in collaboration with the Divisions that will allow reporting of Tier 2 mortality data.

Tier Two Mortality Indicators – Stillbirths (Neonatal Mortality)



Outcomes: July 2024 – March 2025

- Zero maternal deaths reported during this period.
- 18 stillbirths at gestation >24 weeks.
- 3 late foetal losses between 22–24 weeks.
- 2 neonatal deaths: babies born at 20 weeks showing signs of life but died on the maternity unit.
- 15 of the babies were born at less than 37 weeks' gestation (preterm).

Clinical Insights

- Placental changes were observed in the majority of cases, suggesting a recurring pathological feature.
- Hydrops fetalis was identified in 1 case.
- Infection was a contributing factor in 2 cases.

Tier Two Mortality Indicators – Neonatal Mortality Learning and actions

Governance and Oversight - A national and local review has been completed, with a full report—incorporating mortality indicators—scheduled for submission to the Board in September.

Neonatal Mortality- All neonatal deaths are now subject to a 72-hour review, ensuring timely scrutiny and learning.

Early Access to Care - The service has introduced a Single Point of Access (SPA) referral system to support early booking, enabling earlier intervention and optimisation of pregnancy outcomes.

Guideline Development A new Antenatal Foetal Surveillance Guideline has been introduced. The Intrapartum Fetal Surveillance Guideline has been updated to reflect current best practice.

Foetal Surveillance Education - A dedicated Foetal Surveillance Midwife is now in post.

Faculty capacity has been increased to support enhanced training delivery.

Monitoring and Equipment - CTG monitors have been installed in every antenatal room to ensure consistent fetal monitoring.

The **Induction of Labour (IOL) guideline** has been updated to support increased monitoring.

Additional trolley space has been created in maternity triage to improve care delivery during high activity.

Sonography Capacity Two midwives successfully completed sonography training in 2025, expanding in-house scanning capability.

Prematurity Care The service has adopted the PERIPrem optimisation tool to improve outcomes for premature babies.

Ongoing audits show improved compliance with optimisation measures.

Bereavement Care - The bereavement pathway has been updated to enhance support for families. Additional training sessions have been delivered by the Bereavement Lead Midwife to improve post-mortem (PM) consent uptake.

Provided by Jayne Beasley - Head of Midwifery & Gynaecology

Tier Two Mortality Indicators – MHLD sudden and unexpected deaths (SUDS)

Summary of Sudden and Unexpected Deaths – Mental Health and Learning Disabilities(MHLD) Division Reporting Period: 1 July 2024 – 30 June 2025

- This report is based on information held by the Mental Health and Learning Disabilities (MH and LD) Division. It includes deaths that were brought to our attention through direct reports (such as from families or carers), emergency services, and the Coroner.
- The database used for this report is continually being updated with new variables to help us better understand and learn from these tragic events. However, this process involves detailed analysis of patient records, which takes time.
- Although the requested reporting period ended on 31 March 2025, this report includes data up to 30 June 2025 to ensure completeness. Of the 92 deaths recorded between 1 July 2024 and 30 June 2025, five occurred between 1 April and 30 June 2025. The remaining 87 deaths happened within the originally requested timeframe.
- All deaths included in this report involve individuals who had any level of contact with MH and LD services within 12 months of their death. This approach ensures we capture learning opportunities and provide appropriate support to families, carers, other patients, and staff.

Tier Two Mortality Indicators – MHLD sudden and unexpected deaths (SUDS)

Figure one – All deaths over time

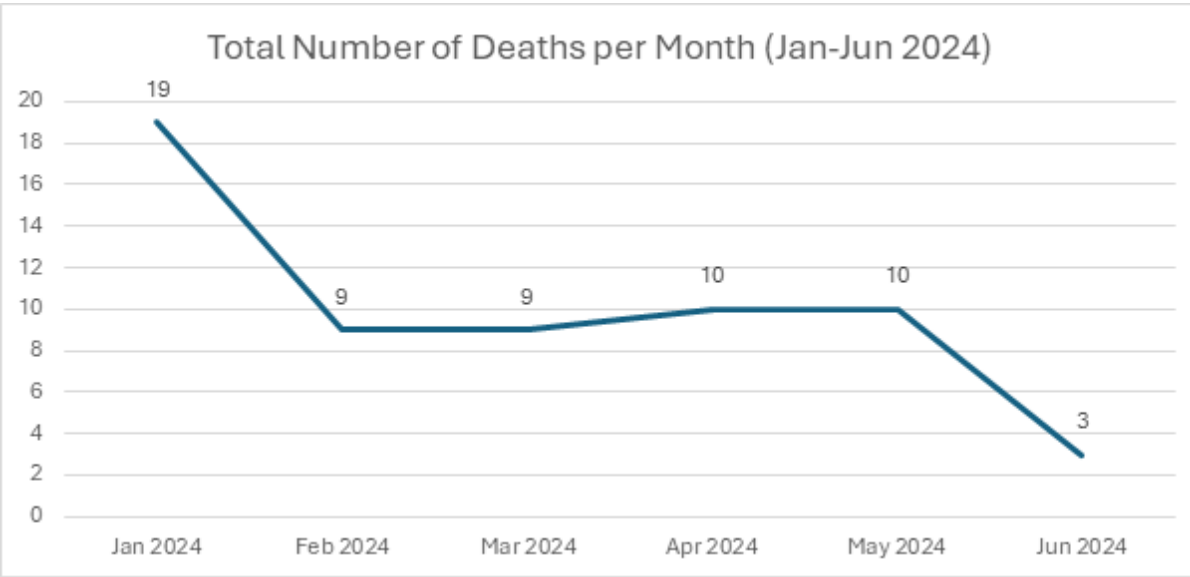


Figure one displays the frequency of deaths by month in the previous study period. The two previous reports (capturing 2021 – 2023 and latterly the first half of 2024) have not revealed any clearly identifiable or reliable trends. Sadly, the incidence of SUDS remains relatively stable albeit on average there is a lower rate of deaths in the current study period (with 92 deaths in a 12-month period ie 7.6 deaths per month compared to 10 per month in Jan – Jun 2024).

Figure two – Sudden unexpected deaths over time

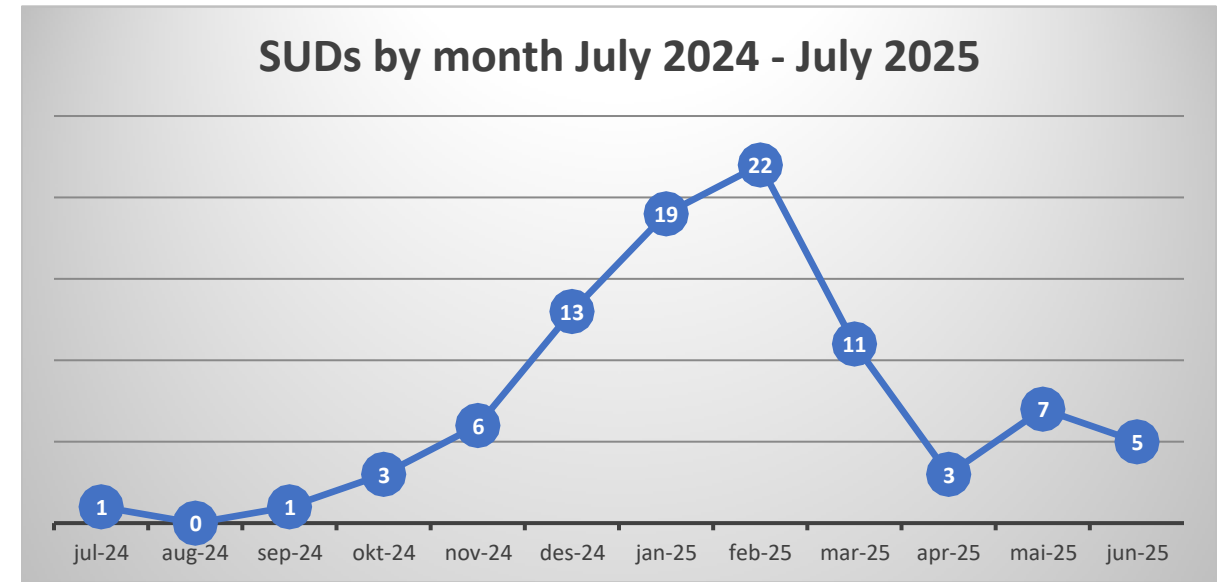
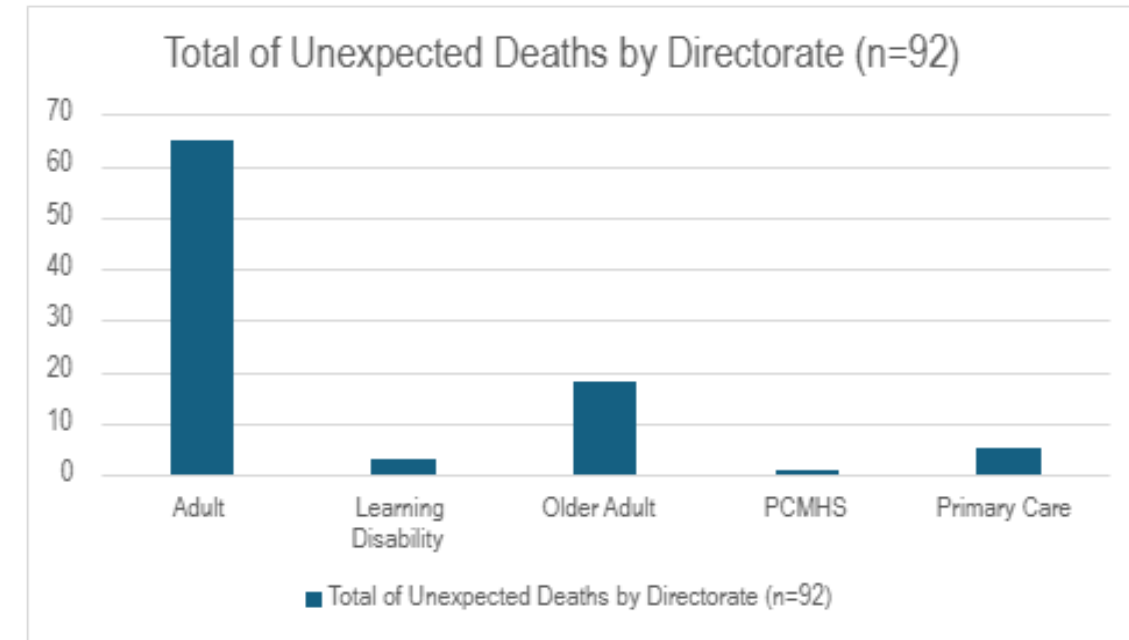


Figure two shows the rate of death per month in the current study period. There does appear to be a seasonal increase in the winter months and given that these deaths have not yet been categorised, it could be that this is a high rate of deaths from physical health causes.

It is recommended that once deaths are categorised, benchmarking is undertaken with national data to consider possibility of outlier status.

Tier Two Mortality Indicators – MHLD sudden and unexpected deaths (SUDS)

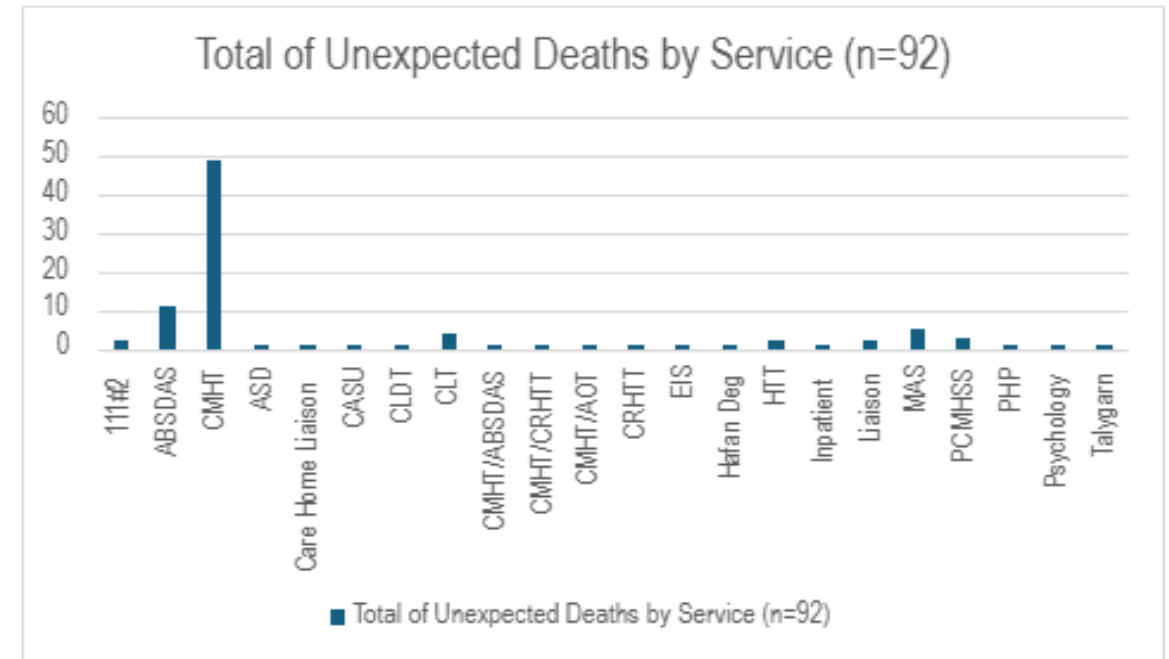
Figure three – All deaths over time by Directorate



Service considerations

Figure three indicates the incidence of death by Directorate and figure four by service area. As previously and unsurprisingly, the highest frequency of deaths occur in the adult directorate (the busiest service serving the highest number of people) and in Community Mental Health Teams

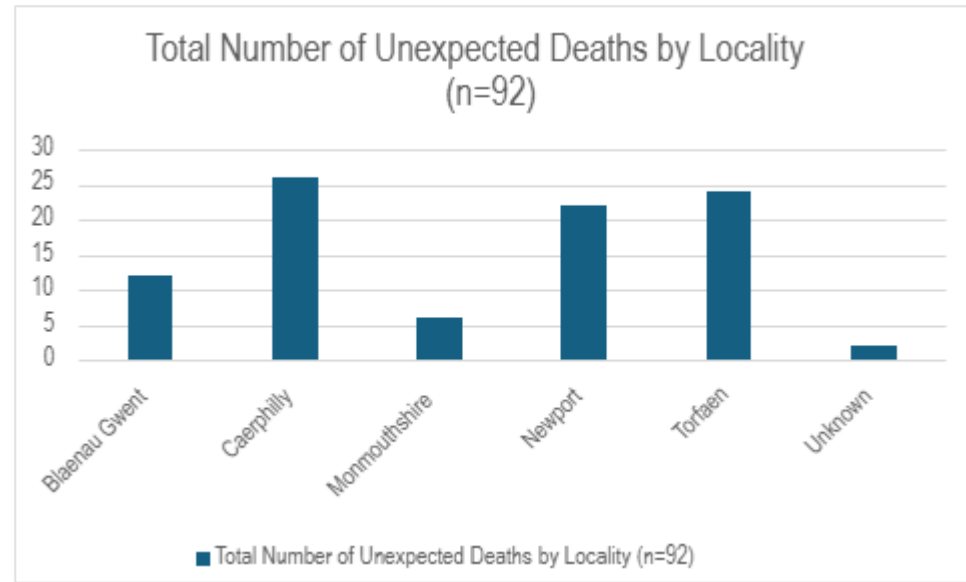
Figure four – Unexpected deaths by service



It would appear that, as previously, there are unexpected deaths amongst those in the care of drug and alcohol services.

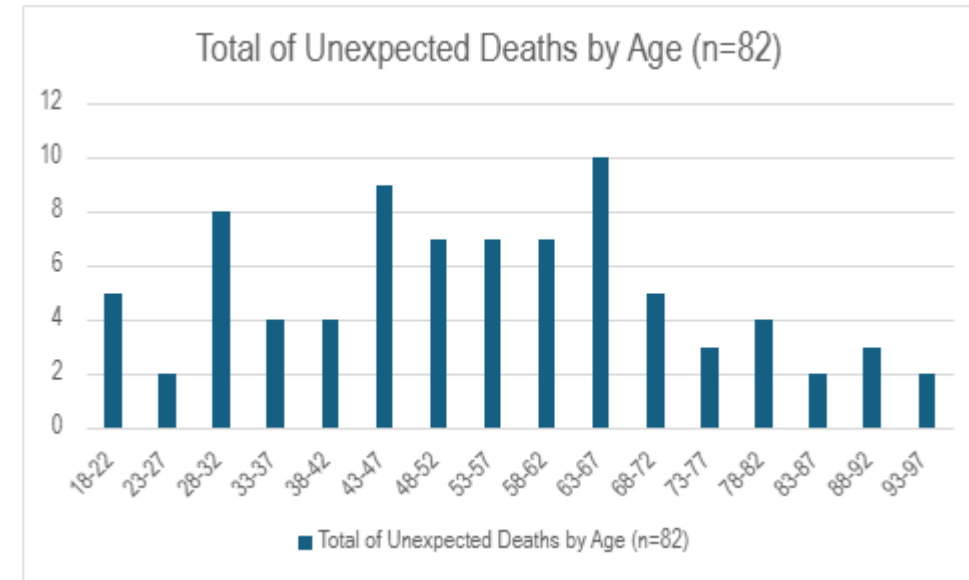
Tier Two Mortality Indicators – MHLD sudden and unexpected deaths (SUDS)

Figure five – Unexpected deaths by Locality



In terms of geographical area, figure five presents the data by local authority area (not currently corrected by population size). When corrected for population served, Torfaen appear to have had a disproportionately high number of deaths. The pastoral needs of the teams serving this area should be considered.

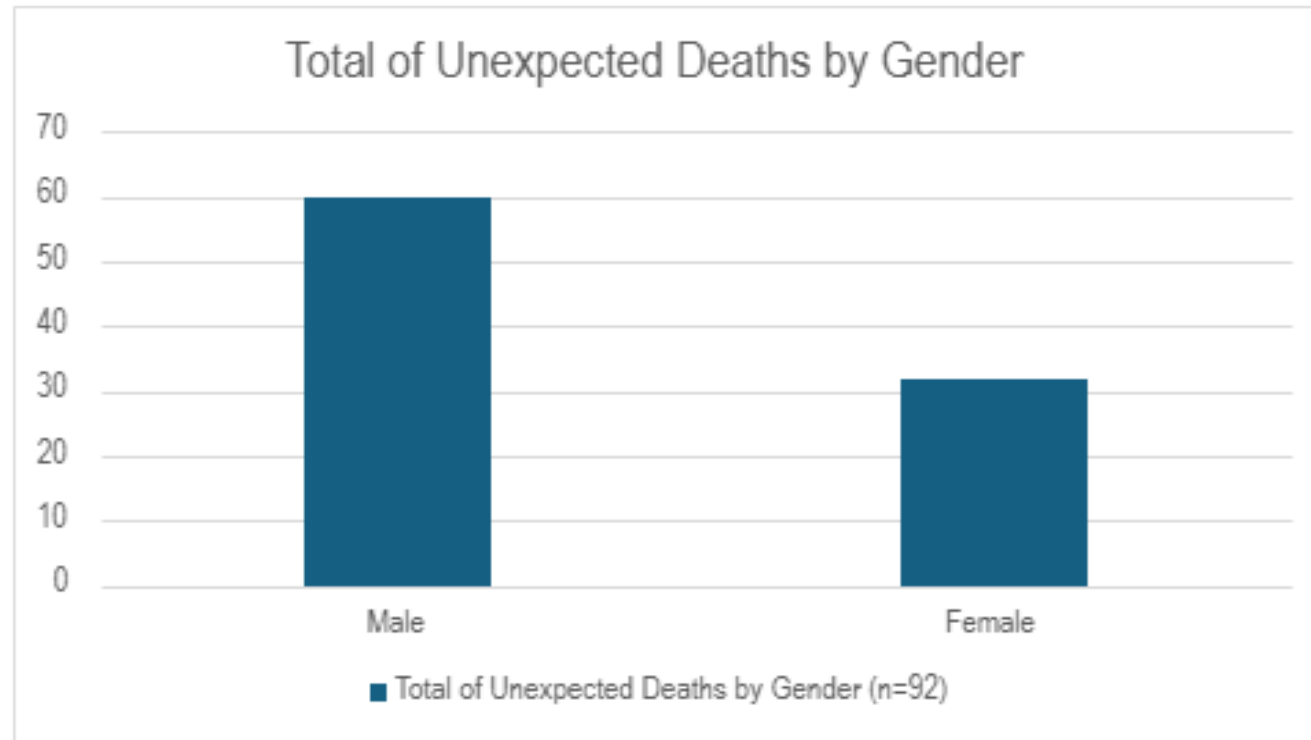
Figure six – Unexpected deaths by age



In terms of demographic features, the preliminary analysis has only been conducted on all deaths considering variables of age and gender and is therefore not especially enlightening. Taken together, this data mirrors findings in two earlier reports in relation to more males dying than females and unexpected deaths occurring in the younger age groups of 28-32 and 43-47. There is some missing data that we need to harvest from patient records.

Tier Two Mortality Indicators – MHLA sudden and unexpected deaths (SUDS)

Figure seven – Unexpected deaths by gender



Tier Three Mortality Indicators

- Once Tier 2 indicators are established, the focus will shift to identifying appropriate, condition-specific indicators within each Directorate. A range of clinical databases—including mortality data—are currently utilised across the organisation to support this work.
- Directorates likely to benefit from this enhanced approach include Emergency Laparotomy Surgery, Cardiology, Neonatal Unit, Intensive Care, Surgery, and Stroke.
- To strengthen assurance, national clinical audit data will be used to triangulate and benchmark mortality outcomes across Directorates. Where no existing mortality indicators are in place, bespoke measures will be co-developed by the Directorate and the Quality and Patient Safety Team, with analytical support from CHKS.
- A robust governance framework will be developed as part of the Learning from Death Framework to ensure a systematic and transparent approach to condition- and procedure-specific mortality. This will include:
 - **Structured reporting** of mortality data through Directorate Quality and Patient Safety meetings.
 - **Triangulation** of mortality data with Medical Examiner reviews, Mortality and Morbidity (M&M) reviews, and Coroner's Inquests.
 - **Formal assurance and escalation** processes arising from M&M reviews.
 - **Exception reporting** and assurance updates to the Quality and Patient Safety meetings.

- Summary of Mortality Review – Anaesthetics Specialty

Follow up from last report						
Description	Local Numerator	Local Denominator	Jan 24 - Jun 24	Peer Value	Performance	Alert
Mortality Rate	1395	84122	1.6583%	1.8056%		
430 - Geriatric Medicine	588	5211	11.284%	10.953%		⚠
190 - Anaesthetics	45	201	22.388%	1.2972%		⚠

- Specialty Selection

The review focused on specialties aligned with those used in the RAMI (Risk-Adjusted Mortality Index) system. To ensure statistical validity, only specialties with a minimum of 25 patients were included in the analysis.

- Observed Mortality Trends

Between January and July, data indicated a higher number of recorded deaths in the Anaesthetics specialty within Aneurin Bevan University Health Board (ABUHB) compared to peer health boards.

- Investigation Findings

A detailed review of anaesthetic-related cases was undertaken using data from Medicus. This analysis confirmed that the RAMI figures in the report do not accurately reflect actual mortality. Most of the cases were ITU-based, and Medicus applies a more sophisticated methodology for calculating the Standardised Mortality Ratio (SMR). SMR compares observed deaths to expected deaths, adjusting for factors such as age, sex, and case mix. In this case, all SMRs were below 1, indicating no cause for concern and suggesting mortality was actually lower than expected.

- Likely Cause of Discrepancy

The discrepancy is most likely due to a change in coding practices during the reporting period—specifically, the reclassification of cases from Anaesthetics to Critical Care. This shift may have skewed the RAMI data, inflating figures for Anaesthetics. At the time of reporting, the coding team was unable to fully analyse the data to confirm its accuracy.

- Next Steps

The Health Board is continuing with a case review to validate this interpretation across the dataset and to provide assurance for the Learning from Deaths report.

Tier Three Mortality Indicators – Crude Mortality - Specialty

Description	Local Numerator	Local Denominator	Jul 24 - Mar 25	Jul 24 - Mar 25	Peer Value	Performance	Alert
Mortality Rate	1964	134063	1.4650%	1.4650%	1.7554%		
430 - Geriatric Medicine	748	6885	10.864%	10.864%	10.599%		⚠
314 - Rehabilitation Medicine	180	1947	9.245%	9.245%	7.749%		⚠

This report presents performance data for selected specialties within Aneurin Bevan University Health Board, focusing on those that align with the RAMI. Only specialties with at least 25 patients have been included to ensure the sample size is meaningful for analysis.

- Mortality Rate: The Health Board’s overall mortality rate is 1.5%, which is better than the peer average of 1.8%. This is a positive indicator and suggests that, overall, mortality outcomes are favourable.
- Geriatric Medicine: The local rate is 10.9%, slightly higher than the peer value of 10.6%. This has triggered a warning alert, indicating a need for closer scrutiny.
- Rehabilitation Medicine: The local rate is 9.2%, which is notably higher than the peer value of 7.7%. This also triggered a warning alert and suggests a more significant variance from expected outcomes.

What We Are Going to Do

1. Acknowledge Good Performance - Maintain and continue monitoring the positive performance in overall mortality rates.
2. Investigate Geriatric and Rehabilitation Medicine – we are conducting a targeted review of recent cases in these specialties to understand contributing factors. This will include engage with clinical leads to explore whether patient complexity, discharge delays, or other systemic issues are influencing outcomes.
3. Use RAMI-Aligned Specialties for Benchmarking - ensure that ongoing analysis continues to focus on RAMI-aligned specialties with sufficient patient volumes to maintain statistical validity.
4. Escalate Where Needed

Tier Three Mortality Indicators – RAMI - Specialty

Description	Local Numerator	Local Denominator	Jul 24 - Mar 25	Jul 24 - Mar 25	Peer Value	Performance	Alert
RAMI (Risk adjusted mortality index) 2019	1845	1839	100.30	100.30	113.01		
430 - Geriatric Medicine	674	608	110.94	110.94	82.58		⚠
340 - Respiratory Medicine	244	108	225.32	225.32	128.04		⚠
314 - Rehabilitation Medicine	169	195	86.80	86.80	64.51		⚠
301 - Gastroenterology	106	68	154.83	154.83	125.74		⚠

This report presents Risk-Adjusted Mortality Index (RAMI) data for selected specialties within Aneurin Bevan University Health Board. It focuses on specialties with a sample size of 25 patients or more, ensuring meaningful comparisons. The data compares ABUHB's local performance against Welsh peer values and highlights areas of concern using red alert icons. Key Insights:

- The lowest RAMI score is seen in Rehabilitation Medicine. However, this score is still higher than the Welsh peer average, indicating potential areas for improvement.
- Highest RAMI: The highest RAMI score is in Geriatric Medicine, suggesting a higher rate of mortality in this specialty compared to peers.

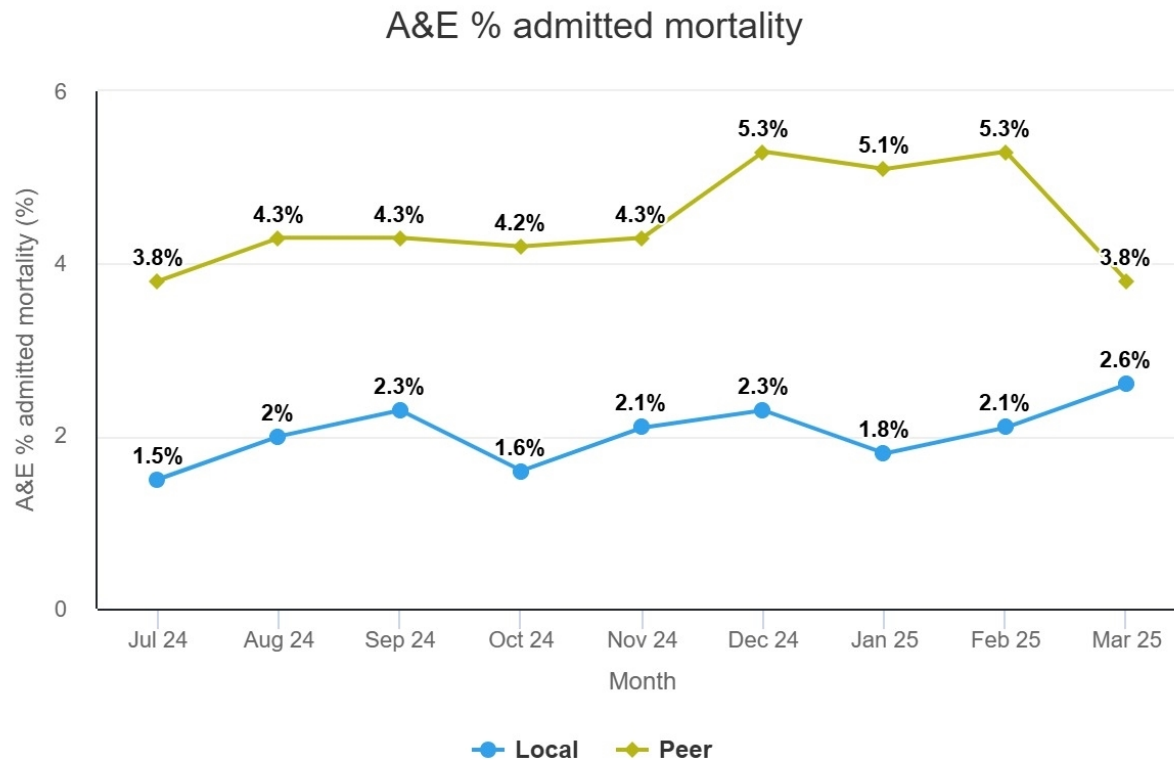
Alerted Specialties: Geriatric Medicine and Respiratory Medicine have significantly higher RAMI scores than peer averages and are flagged with alerts. Immediate Actions to address the concerns in Geriatric Medicine and Respiratory Medicine: The Health Board is conducting mortality reviews to identify patterns or systemic issues. Consider external benchmarking or peer reviews to validate findings and identify best practices.

Additional Considerations: Rehabilitation Medicine and Gastroenterology also show higher RAMI scores than peers, though they are not flagged with alerts. The Health Board will include these specialties in routine quality assurance cycles. Review case mix and coding accuracy to ensure data integrity. Monitor trends over the next quarter to determine if escalation is needed.

Respiratory Medicine – Coding Issue:

ABUHB appears to use a generic Respiratory Medicine code more frequently than other health boards. This coding practice may be skewing RAMI calculations and affecting peer comparisons. The Coding Team is currently investigating this issue.

Tier Three Mortality Indicators – ED admitted Mortality



ED Admitted Mortality Indicator

- **What It Measures:** The percentage of patients who die after being admitted from ED.
- **Purpose:** Assesses the quality of emergency and overall hospital care, highlighting potential issues like delays in treatment or inadequate assessments.
- **Influencing Factors:**
 - **Severity of Cases:** Higher mortality rates in hospitals with more severe cases.
 - **Timeliness of Care:** Delays in diagnosis or treatment can increase mortality rates.
 - **Quality of Care:** Availability of specialist services and adherence to clinical guidelines impact mortality rates.
- **Benchmarking and Improvement:** Used to compare performance with other hospitals and national standards, helping to implement targeted interventions to reduce mortality rates.

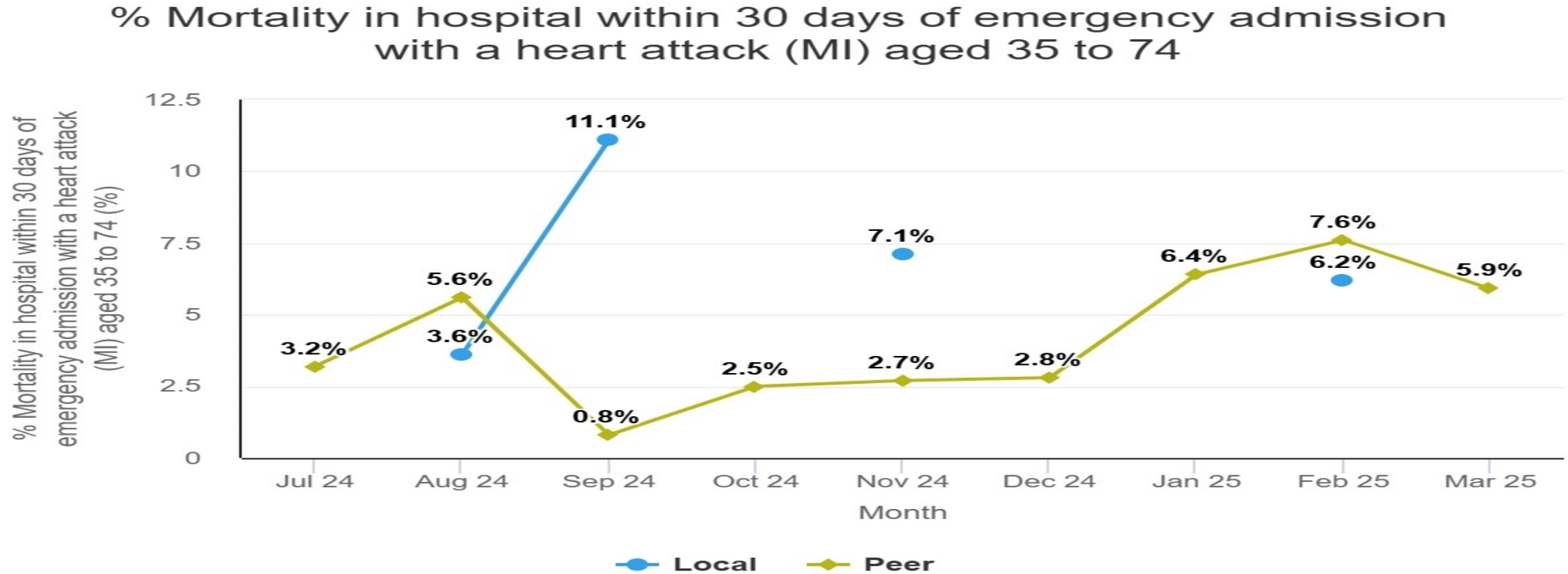
- ABUHB has consistently performed below the Welsh Peer Value for ED admitted Mortality

Tier Three Mortality Indicators – ED admitted Mortality Learning and Actions

The Emergency Department (ED) Mortality and Morbidity (M&M) meetings are held to review specific cases and identify opportunities to improve patient care and outcomes. A range of cases are discussed, covering various medical conditions and patient outcomes, including those involving patient deaths, rare or complex diagnoses, or significant learning points. Here is a summary of key learning from ED M&M reviews, Case of the Day presentations, and Messages of the Week. It highlights examples of good practice, identifies areas for improvement, and outlines actions taken to enhance patient safety and the quality of care provided. Examples include:

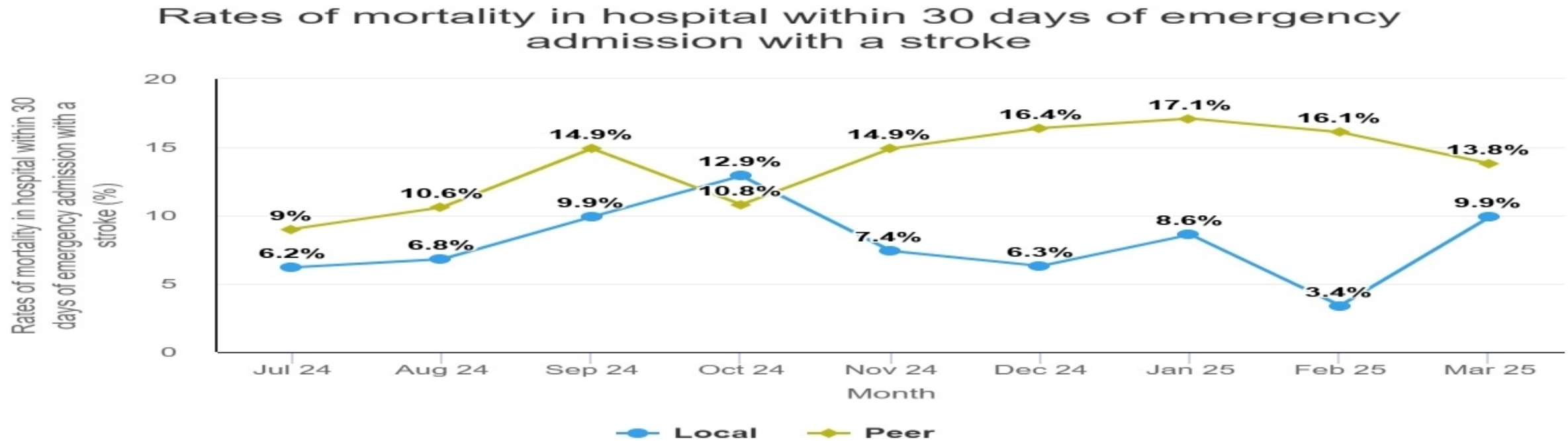
- **Communication:** Poor documentation and unclear escalation pathways. Actions: Structured documentation templates and escalation protocols reinforced.
- **Pain:** Multiple cases highlighted delayed or inadequate pain relief, particularly in confused or vulnerable patients. Pain scores were inconsistently documented and acted upon. Actions: Re-emphasis on validated pain assessment tools at triage, timely administration, and reassessment. Annual audits and patient feedback mechanisms introduced.
- **Neurology:** Missed early signs of TIA, stroke, and spinal cord compression. Actions: Emphasis on red flag recognition, early imaging, and specialist referral. Reinforcement of NICE stroke guidance, aspirin administration, and timely TIA clinic referrals. Updated patient information leaflets.
- **Trauma:** Missed injuries in paediatrics and elderly, under-imaging, and delayed recognition of spinal or internal injuries. Action: Lower threshold for imaging in children, especially when not using the limb normally. Reinforcement of mechanism-based injury assessment.
- **Sepsis:** Delayed recognition and treatment, especially in immunocompromised patients. Actions: Improved documentation, early warning scores, and escalation protocols. Education on managing sepsis in patients on steroids or immunosuppressants. Trauma: Missed injuries in paediatrics and elderly. Actions: Lower imaging thresholds and mechanism-based assessments.
- **Oncology:** Late-stage presentations with vague symptoms. Actions: Education on red flags and streamlined referral pathways.
- **Organ donation:** Missed opportunities due to lack of awareness. Actions: Re-circulation of the Sudden Death Checklist and donation referral process. Training on recognising potential donors.
- **Diagnostic delay:** Delays in diagnosis due to atypical presentations, crowding, or handover gaps. Action: Promote early imaging and escalation for red flag symptoms. Use of structured handover tools.
- **Paediatrics:** Under-imaging and missed diagnoses. Actions: Education on paediatric red flags and imaging thresholds.
- **Policy and Procedure Awareness:** Protocols for major haemorrhage, prescribing and sepsis reinforced via messages of the week and QR codes.

Tier Three Mortality Indicators – Condition Specific Mortality - MI



- 4 deaths between July 2024 – March 2025
- Period mortality – ABUHB 2.59% Peers (All Wales) 4.16%
- Patients with remediable issues are transferred to Cardiff for intervention

Tier Three Mortality Indicators – Condition Specific Mortality - Stroke



Biggest risks and challenges across the Stroke pathway

Key points include:

- **Protecting the urgent intervention pathway:** Ensuring effective front door to HASU (Hyper Acute Stroke Unit).
- **Sustaining rehabilitation:** Addressing medical and therapy cover in a fragile rehabilitation pathway.
- **National Programme uncertainty:** Focus on HASU rather than the entire pathway.
- **Bristol Thrombectomy service:** Operating hours.
- **Public awareness:** FAST campaign and reaching seldom heard groups.

Strengths:

- Good performance in thrombolysis, timely stroke consultant access, and mortality outcomes.
- Community Neuro Rehab Service: Exemplar model for Wales, despite national funding cuts.
- Niwrostriwt Neurological Conditions Recovery College: NHS Wales Awards runner-up.
- In-house 'Living Well After Stroke' service.
- Peer support and volunteer roles in YFF.

Tier Three Mortality Indicators – Acute Medicine – Learning and Actions

Recognition of the Deteriorating Patient

Issues Identified:

- Recurring themes across multiple Datix incidents and Serious Incidents. Inconsistent calculation and escalation of NEWS scores, not always aligned with the Health Board's Deteriorating Patient Policy. Delays or omissions in reviewing and acting on blood gas results.

Actions Taken:

- The Deteriorating Patient Policy has been embedded into practice. Discussions at the Mortality and Morbidity (M&M) reviews. Weekly teaching sessions have been introduced to reinforce best practice. Staff have been reminded of the role and availability of the ICU Outreach Team. The Health Board is transitioning to NEWS2 and standardised Early Warning Systems, which will support earlier recognition and response to patient deterioration.

Improving Safer Discharges for Patients

Issues Identified:

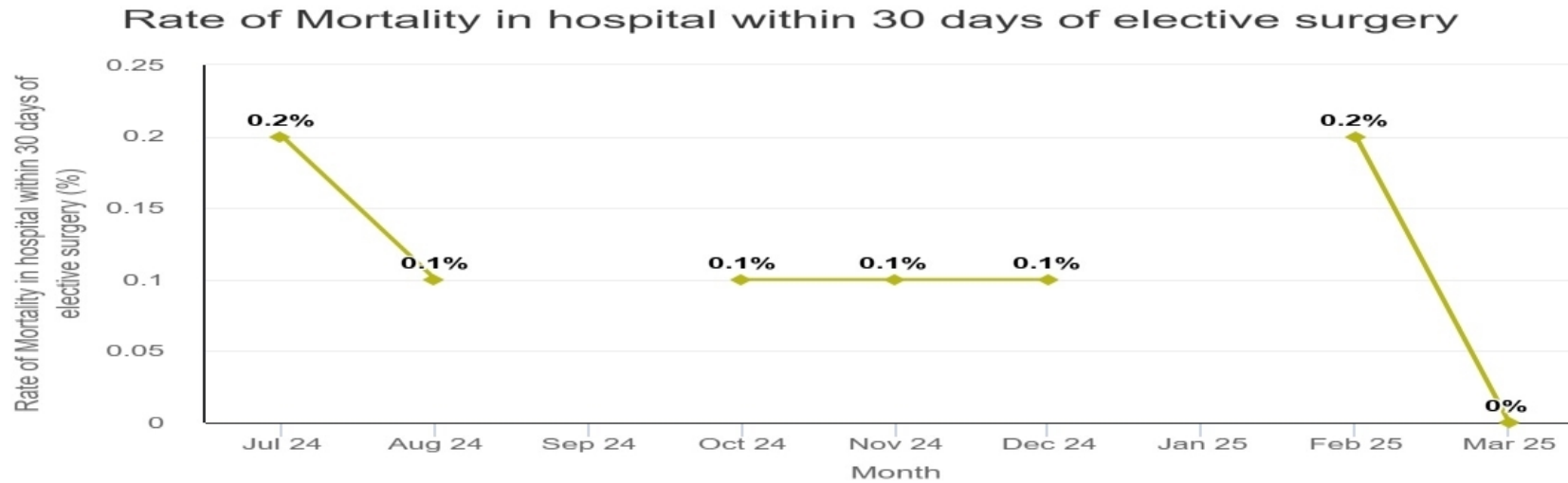
- Patients are sometimes discharged without a discharge letter, leading to communication gaps. Prescriptions are occasionally issued on a WP10, which can result in: Missed information for GPs. Patients leaving hospital without essential medication.

Next Steps:

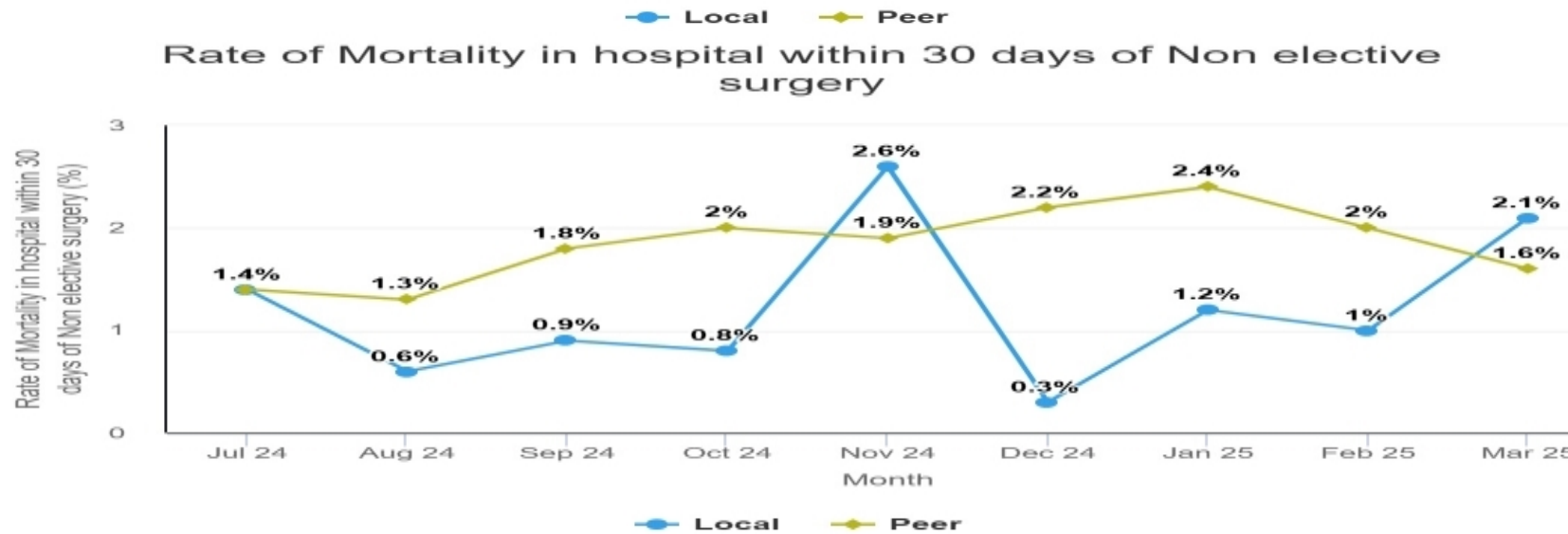
- Strengthen discharge protocols to ensure discharge letters are completed and shared in a timely manner. Review prescribing practices to reduce reliance on WP10s and ensure medication continuity post-discharge.

Provided by Dr Ifor Capel

Tier Three Mortality Indicators – Surgery Mortality



During the reporting period of July 24 – March 25. There were no recorded deaths in Hospital within 30 days of elective surgery. The all Wales peer group reported a mortality rate of 0.09% for this period.



The rate of mortality in hospital within 30 days of non-elective surgery has decreased to 1.17% from 1.5% in the previous Learning from Deaths report. This remains lower than the all Wales peer group mortality rate of 1.86%

Tier Three Mortality Indicators – Surgery Mortality

Description	Local Numerator	Local Denominator	Jul 24 - Mar 25	Jul 24 - Mar 25	Peer Value	Performance	Alert
? Rate of Mortality in hospital within 30 days of Non elective surgery	70	5962	1.2%	1.2%	1.8%		
100 - General Surgery	20	1233	1.6%	1.6%	2%		
110 - Trauma & Orthopaedics	17	1129	1.5%	1.5%	2.2%		
301 - Gastroenterology	9	91	9.9%	9.9%	7.4%		⚠
192 - Intensive Care Medicine	6	18	33.3%	33.3%	56.6%		
340 - Respiratory Medicine	5	48	10.4%	10.4%	9.3%		
300 - General Internal Medicine	3	41	7.3%	7.3%	13.4%		
422 - Neonatology	3	6	50%	50%	-	No data to display	
101 - Urology	2	279	0.7%	0.7%	0.9%		
320 - Cardiology	2	262	0.8%	0.8%	4%		
307 - Diabetic Medicine	1	6	16.7%	16.7%	-	No data to display	
328 - Stroke Medicine	1	6	16.7%	16.7%	-	No data to display	
430 - Geriatric Medicine	1	31	3.2%	3.2%	4.3%		

- 70 Deaths were recorded of patients who have died within 30 days of non-elective surgery
- General Surgery and T&O have the highest mortality level
- Gastroenterology is an outlier for ABUHB as it is higher than the peer average of 7.4% with a mortality rate of 9.9% for the period July 2024 – March 2025. A deep dive is underway in this area.

Tier Three Mortality Indicators – Critical Care Unit – Learning & Improvement

The Critical Care Unit are committed to learning and improving the care delivered to patients. There is a proactive Morbidity and Mortality (M&M) process. The department also include Merit system in these discussions and call it M&M&M. These meetings help the department reflect on patient outcomes and improve the quality of care. Here are some of the changes and improvements the units have made based on these reviews:

- 1. Mortality Trends** - Mortality rates in high-risk groups (e.g. multiorgan failure, severe liver disease) are improving and trending towards expected levels. Collaborative work with specialty groups is contributing to these improvements.
- 2. Themed Morbidity & Mortality (M&M) Sessions** - A new series of themed M&M sessions has commenced. The first session was held jointly with the Bristol ECMO service. Further sessions are being scheduled with GUH inpatient teams to support shared learning.
- 3. Emergency Re-admissions** - Emergency re-admission rates remain low. Any unexpected returns within 48 hours are reviewed by the MDT. A nurse and outreach-led team is actively reviewing discharge practices to ensure ongoing safety.
- 4. Tracheostomy Care** - The tracheostomy care bundle is proving effective. Collaboration with ENT has enabled the upskilling of the Speech and Language Therapy team to perform fiberoptic assessments for airway, cough, and swallow function.
- 5. Patient Acuity & Capacity Pressures** - Data shows an increase in the number of critically ill patients, reflected in higher use of invasive organ support therapies (e.g. mechanical ventilation, renal replacement therapy). Maintaining optimal unit occupancy is challenging due to site pressures. Ongoing collaboration with site teams is focused on improving admission and discharge timeliness.
- 6. Vascular Access Safety** - New work is underway to address complications from invasive vascular access devices. Pathways are being developed to ensure regular monitoring of access sites for signs of concern or injury.

Provided by Dr Hayden Stephenson and Dr Phillipa Jones

Tier Three Mortality Indicators – Primary Care and Community (PCC) Deaths Learning

Prescribing Safety

- **Gastro-protection:** Risks of not prescribing gastro-protective medication alongside drugs that increase GI bleed risk. Action: Shared learning with pharmacy colleagues (referenced in PPI Bulletin).
- **Renal Function Consideration:** Importance of assessing renal function before prescribing and consulting the pain team when uncertain.

Communication & Documentation

- **Death Certification:** Emphasis on timely GP contact post-death and ensuring next-of-kin (NOK) details are shared with Medical Records (MR) services.
- **Follow-up Processes:** Need for safety netting when patients do not respond to follow-up requests, especially for potential cancer investigations (e.g., FIT test).

Bereavement Support

- **Post-Death Contact:** Suggestion to offer bereavement visits soon after death to address family concerns and provide reassurance and signposting to support services.

End-of-Life (EOL) Care in Out-of-Hours (OOH) Settings

- **Medication Access:** Clear documentation on whether families can collect medication or if Emergency Transport Services (ETS) are needed—especially during nights/weekends.
- **Drug Charting:** Avoid prescribing dose ranges; specify exact doses to ensure District Nurses (DNs) can administer.
- **Post-Death Procedures:** Clinicians with experience should remove catheters and syringe drivers when certifying death.

Pathology Handling & Escalation

- **Daily Result Management:** Reinforce the buddy system to ensure pathology results are reviewed daily, even during clinician absences.
- **Urgent Findings:** Immediate communication of critical results (e.g., high potassium) to on-call GPs.
- **DN Communication:** DNs should report findings clearly, especially when Tissue Viability Nurse (TVN) input is needed.
- **Escalation Pathways:** Clarify lab escalation processes to ensure timely flagging of critical results
 - *Provided by PCC Quality and Patient Safety Team*

Tier Three Mortality Indicators – Learning from Inquests

The Health Board approaches each Inquest with a clear commitment to learning and continuous improvement. This learning-led approach is embedded in our governance processes and is a key driver in reducing future risk.

Between 1 July 2024 and March 2025, the Health Board received two Prevention of Future Death (Regulation 28) Reports. Importantly, no Regulation 28 Report was issued for the same issue more than once during this period—demonstrating that learning from previous cases is being embedded effectively.

Recurrent Themes Identified

While no repeated Regulation 28 issues were noted, the following themes have emerged in more than one Inquest:

- Non-compliance with the Deteriorating Patient Policy.
- Inadequate fluid balance monitoring and management.
- Ambulance delays linked to internal organisational pressures.
- Poor documentation by medical and nursing staff.
- Failure to complete risk assessments in a timely manner to mitigate falls.
- Delays in diagnosis or treatment.

Assurance and Actions Taken

- Evidence of learning has been presented to the Coroner during Inquests and documented in Learning from Events Reports, particularly where Inquests have led to clinical negligence claims.
- Following each Inquest, the Legal Services Manager shares learning directly with the relevant Division to ensure local ownership and action.
- All Regulation 28 Reports are escalated to the relevant Executive Leads and cascaded to the teams involved for immediate review and response.
- This structured approach has contributed to the low number of Prevention of Future Death Reports issued to the Health Board, reinforcing confidence in our learning systems.

Provided by Garvin Jones

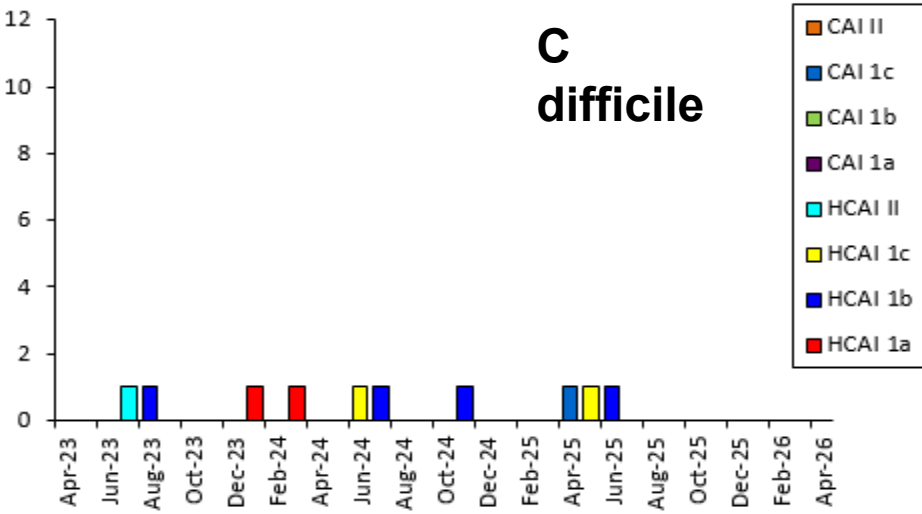
Tier Three Mortality Indicators – Learning from Complaints

- Key Theme Identified: A recurring concern from complaints relates to communication with patients and their loved ones, particularly in cases involving multiple specialties. In efforts to coordinate care and maintain patient comfort, communication with families and patients can sometimes be overlooked.
- Case Learning and Actions – Cross-Board Coordination (PCC and Velindre)
- A notable case involving cross-boundary care between Primary Care Clusters (PCC) and Velindre highlighted several areas for improvement. In response, GSURG implemented a series of actions to strengthen assurance and patient experience:
- Improvements in Care Coordination:
 - GPs and community palliative care teams will now take a more active role in post-discharge care coordination.
 - Hospital teams are expected to directly contact GPs at discharge, providing clear and specific care instructions.
 - This process will be monitored at GP level to ensure consistent implementation.
- Strengthening Multidisciplinary Communication:
 - Community healthcare teams will be invited to participate in planning meetings to better prepare for patient needs.
 - Follow-up check-ins have been introduced for patients on treatment breaks to identify complications early and offer timely support (led by Professor Adams).
- Enhancing Discharge Processes:
 - Discharge letters will be issued promptly to both patients and GPs, including: medication details, dietary guidance and emergency contact information
- For patients with complex needs: a multidisciplinary team will review care plans pre-discharge, dietetic follow-up will occur within one week of discharge and nutritional support (e.g. diet sheets, supplements) will be arranged to prevent gaps in care.

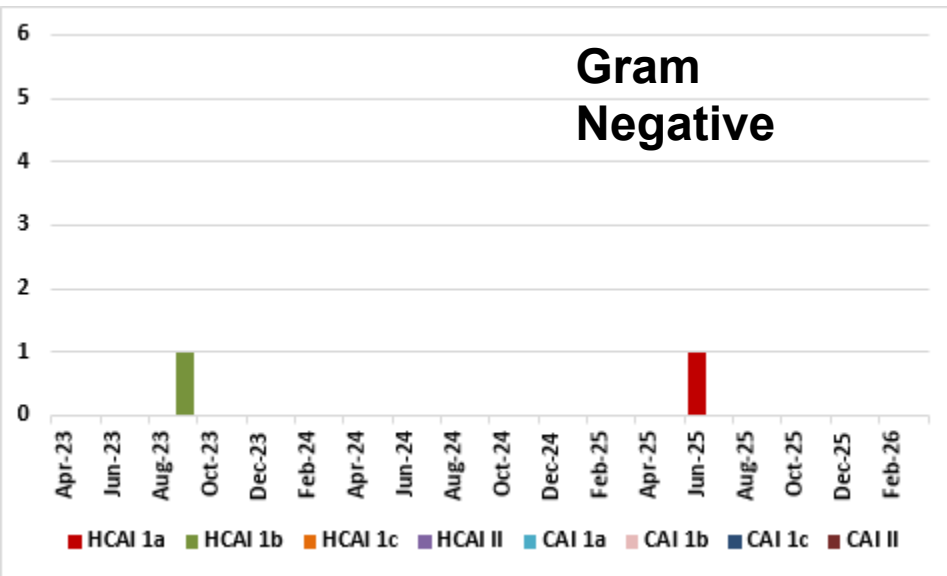
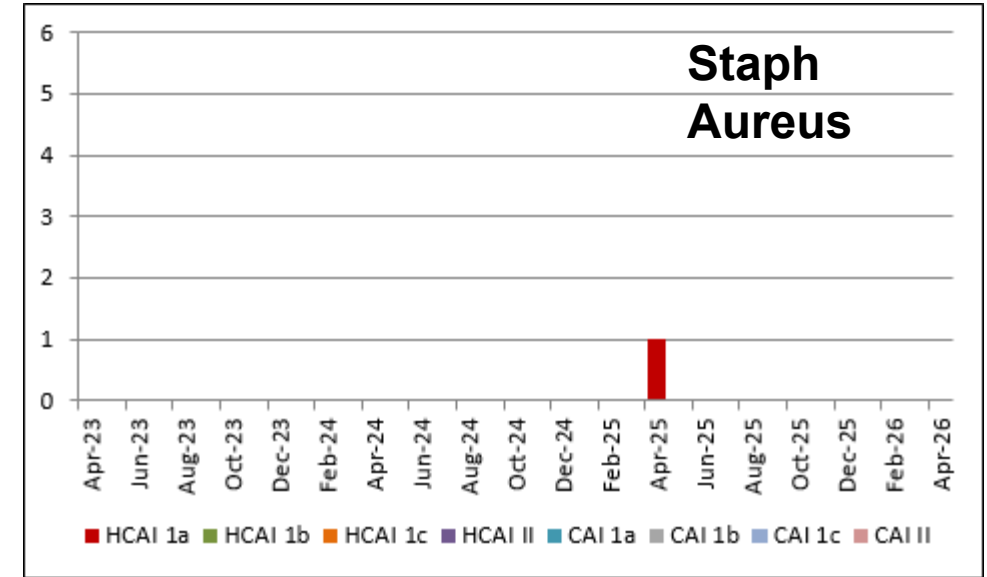
These actions demonstrate a clear commitment to learning from complaints, improving cross-service communication, and ensuring safe, coordinated discharges.

○ *Provided by Rhiannon Price*

Tier Three Mortality Indicators – Infection Prevention & Control



- Charts show the deaths within 28 days where the infection is recorded on the death certificate
- Data is presented in the Divisional monthly updates



- Learning and Improvement**
- Documentation processes for managing care bundles are being reviewed to be clear and consistent
- Sample collection should be carried out effectively to help guide and support antibiotic choices
- Timely review of antimicrobial treatment, with a focus on using narrow spectrum antibiotics where possible
- Special attention is required for patients with complex needs and multiple health conditions

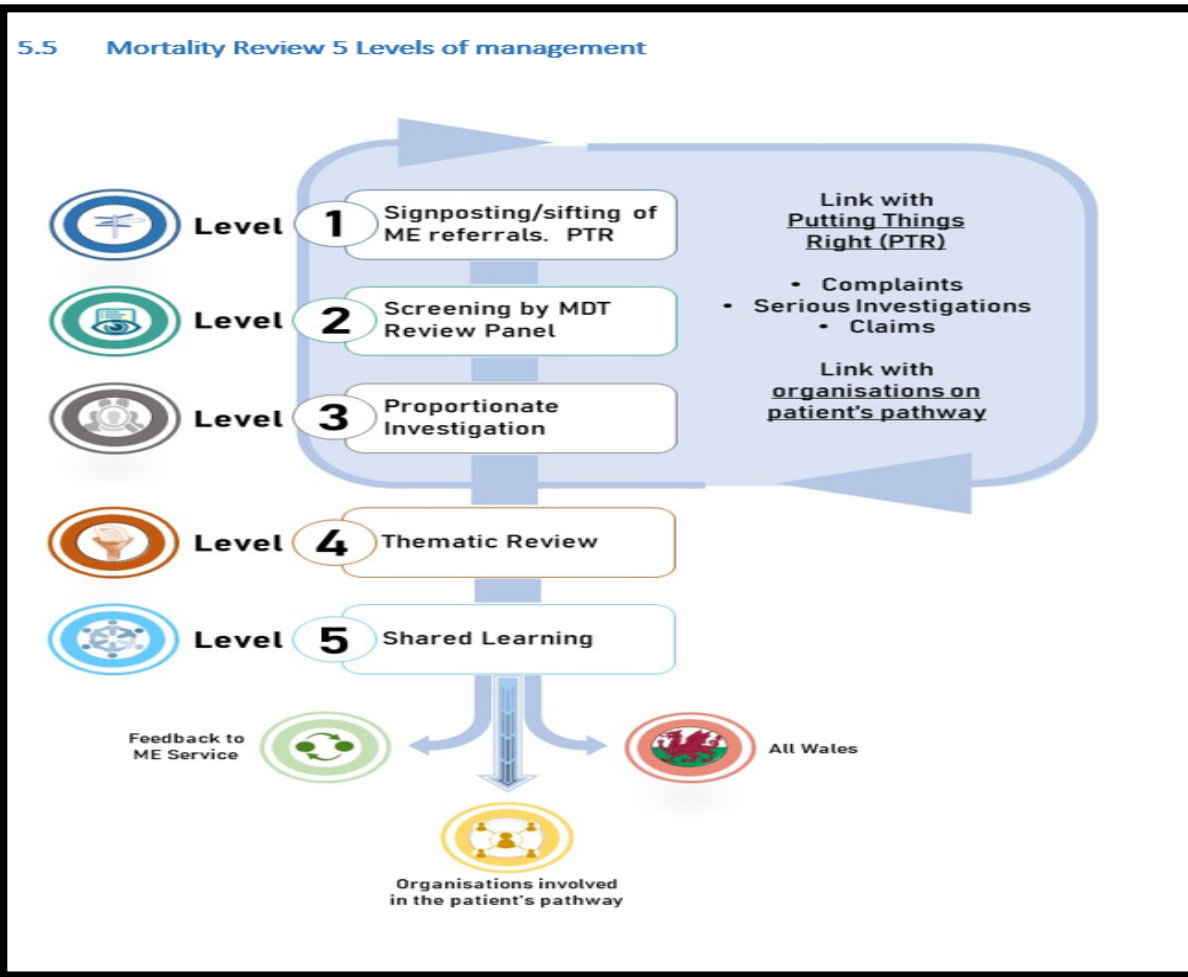
The Medical Examiner Service

The Medical Examiner (ME) Service in Wales is hosted by. NHS Wales Shared Services Partnership (NWSSP). The ME service provides independent scrutiny of all deaths that are not investigated by the coroner (HMC). Scrutiny is undertaken by an ME, who is an experienced doctor with additional training in death certification and the review of documented circumstances of the death. Their job is to ensure that an accurate cause of death is recorded, to identify any concerns surrounding the death itself which can then be further investigated if required, and take the views of the bereaved into consideration.

In order to provide the highest level of independent scrutiny of the cause of, and circumstances surrounding, a death, all MEs and Medical Examiner Officers (MEO) in Wales are directly employed by NWSSP, and Medical Examiners will generally not be involved in the scrutiny of deaths in the area in which they work. Updates can be found at: [Medical Examiner Service - NHS Wales Shared Services Partnership](#).

The ME Service system provides external, independent scrutiny of the treatment and care delivery and reports back cases for concern to the Health Board for further review.

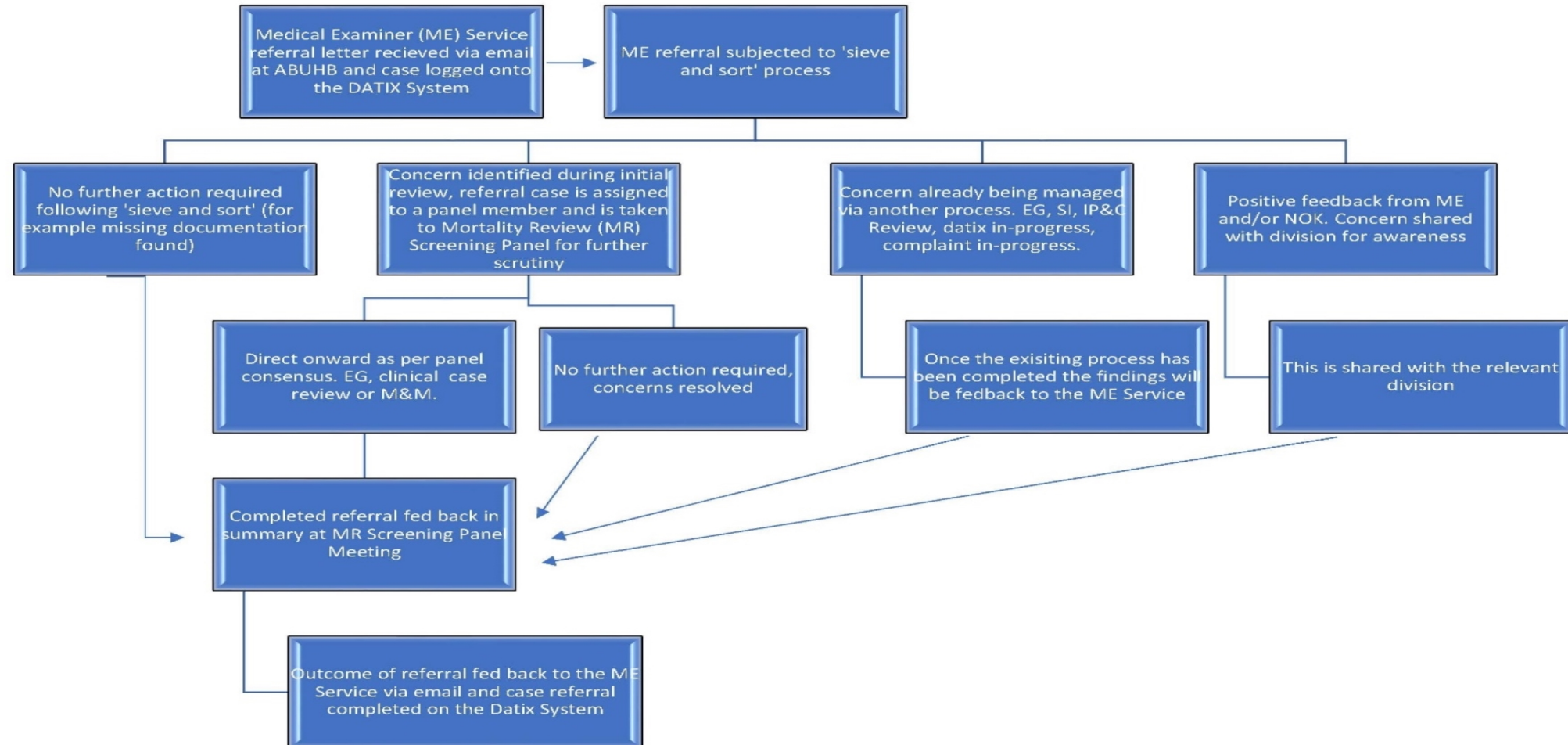
Aneurin Bevan University Health Board Mortality Review Process



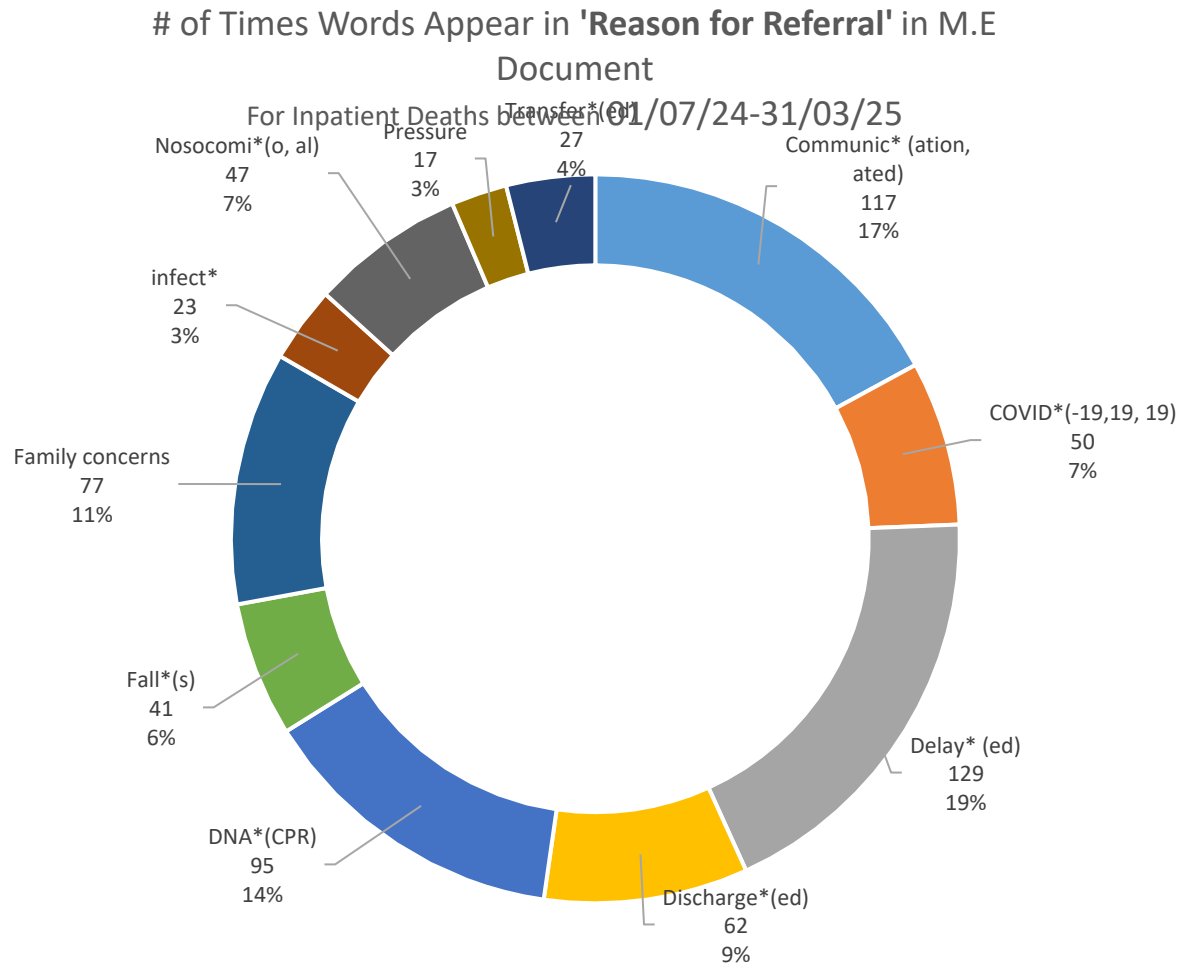
- All mortality cases referred to the Health Board by the Medical Examiner (ME) undergo an initial review (level 1) to determine if further action is needed and avoid duplication.
- If further investigation is required, the case moves to a level 2 review, where it is discussed by the Mortality Review Screening Panel. This multidisciplinary panel meets weekly to review cases and decide on necessary actions, which are then assigned to relevant teams or clinicians.
- Actions may include clinical reviews at mortality and morbidity (M&M) meetings, investigations under PTR processes, or reviews by specific panels such as the Falls Review Panel. This constitutes a level 3 review.
- The ME service was fully implemented by the end of 2024, covering all deaths, including those in Primary Care and Community. No paediatric or maternity death referrals have been received from the ME Service yet.
- As the ME service has been continually increasing – this data set looks at a longer period of time.

Aneurin Bevan University Health Board Mortality Review Screening Process

ABUHB Mortality Review Screening Panel Process



Medical Examiner Documents



This analysis helps us understand the key areas for improvement in patient care, especially around **documentation, communication, and timeliness**. By having a better understanding of these common reasons for referral, we can endeavour to improve patient experience.

Thematic Analysis of Referrals to the Medical Examiner Service identifies common themes in the reasons for referrals to the Medical Examiner (ME) service. The previous data set is from 01/12/23-31/10/24 which is a total of 335 days. The current data set is from 01/07/24-31/03/25 which is 273 days.

Delays

- The term 'delayed' is now the most commonly featured work in the reasons for referral. Constituting 129 (19%) referrals (was previously 128, 17%). This can refer to:
- Concerns from NOK about perceived delays in treatment or investigations.
- Delays related to ambulance off-load.
- Delays in treatment or investigations highlighted by the ME.

DNACPR (Do Not Attempt Cardiopulmonary Resuscitation)

- 95 referrals (14%) in this data related to concerns about DNACPR forms. This has reduced slightly from the previous data set from which 109 referrals (15%) mention DNACPR forms.
- Issues typically involve DNACPR forms not being co-signed correctly in part 6 by the senior clinician or consultant.

Communication Issues

- Communication remains a common theme, covering interactions with families, clinicians, and the Care After Death Team.
- Referrals related to communication have decreased from 19% previously to 117 referrals (17%) in the latest data set.

COVID-19 Related Referrals

- Referrals related to COVID-19 (either caught in hospital or in the community) have reduced from 9% to 7% from the previous data set.

Pressure Damage

- Referrals due to pressure ulcers or injuries have once again decreased from 36 referrals (5%) in the previous set to 17 (3%) in the current data set.

Medical Examiner Documents

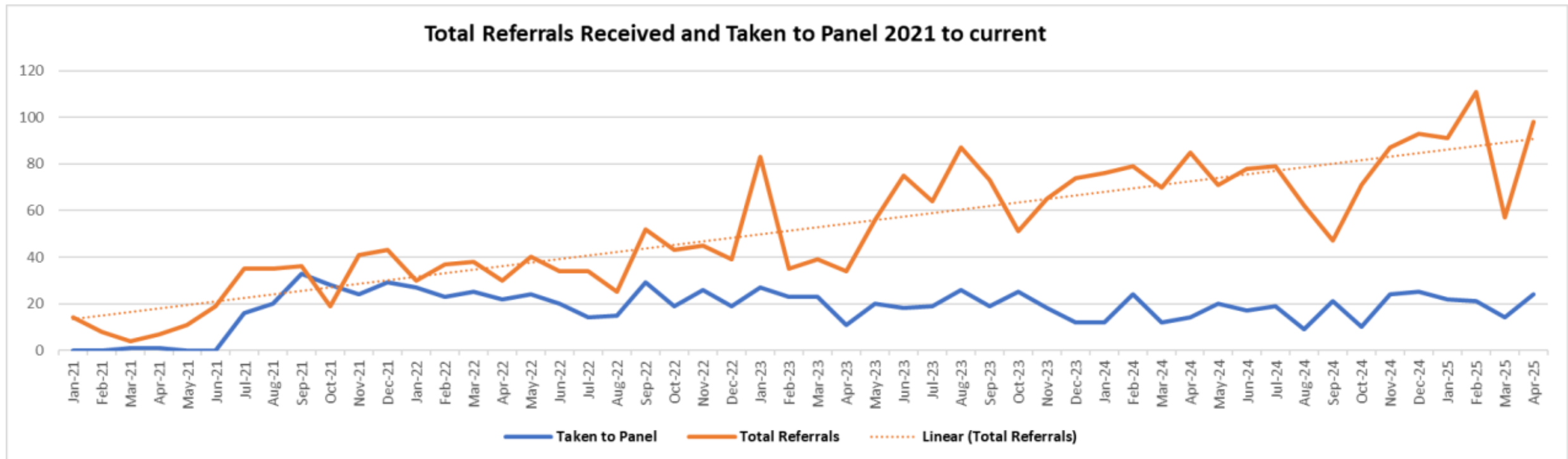
	Data Set 1 (01/10/23-01/12/23)	Data Set 2 (01/12/23-31/10/24)	Data Set 3 (01/07/24-31/03/25)
Number of days	426	335	273
Total ME Referrals	797	783	715
No Further Action	405 (51%)	164 (21%)	120 (17%)
IP&C	70 (9%)	33 (4%)	12 (2%)
Cardiac Arrest Audit	11 (1%)	8 (1%)	8 (1%)
Awareness	88 (11%)	39 (5%)	74 (10%)
Positive Feedback	27 (3%)	15 (2%)	4 (1%)
M&M	51 (6%)	13 (2%)	6 (1%)
SI	47 (6%)	20 (3%)	9 (1%)
Clinical R/V	73 (9%)	22 (3%)	15 (2%)
Referral to HMC	153 (19%)	150 (19%)	162 (23%)
Closed on Datix	6 (1%)	140 (19%)	222 (31%)

ME Referral Destination

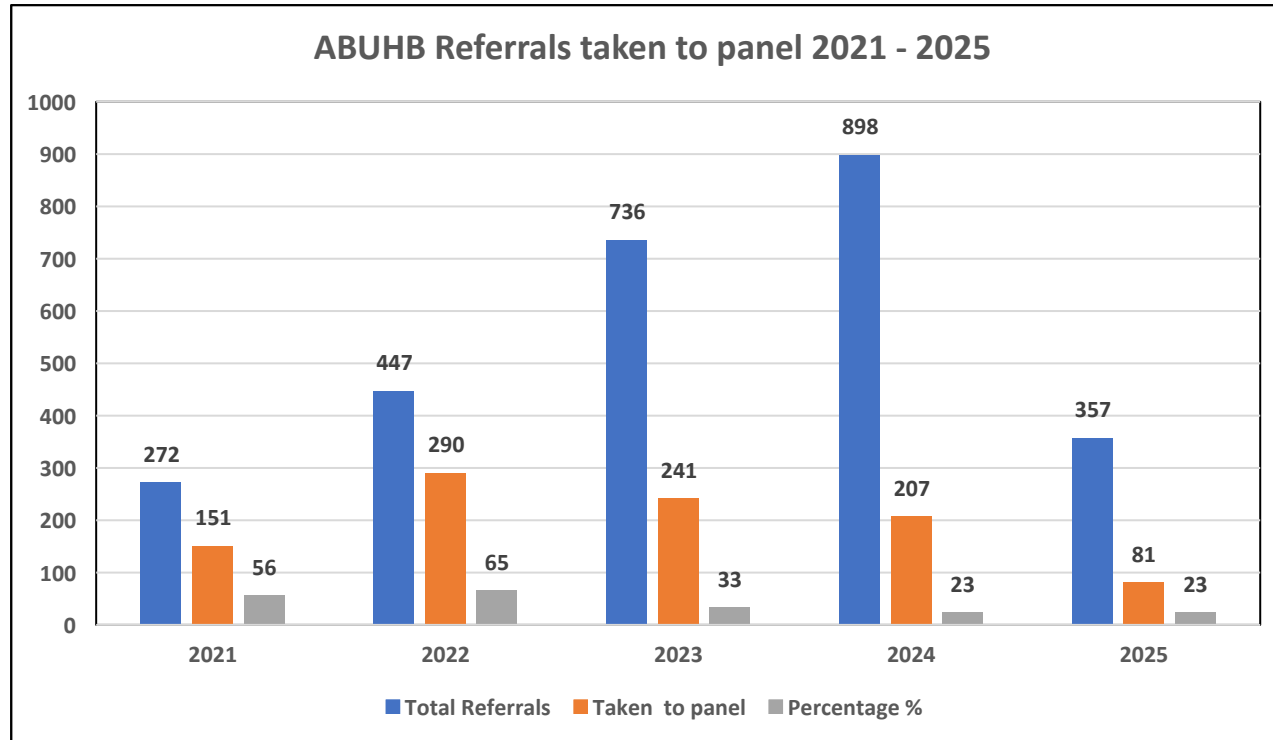
- **No Further Action:** Referrals needing no further action at level 1 have decreased again from the previous data sets. Referrals for 'no further action' includes concerns already being investigated through other processes, like Datix. The decrease might be due to better quality referrals and more referrals being shared locally by the MR Screening panel for awareness.
- **IP&C Referrals:** These have decreased, matching the drop in nosocomial COVID-19 cases.
- **SI Referrals:** Serious Incident (SI) referrals have continued to decrease. This is likely to be because incidents are being managed more proactively so are already in process before coming to panel.
- **HMC Referrals:** The number of cases referred to the Health and Mortality Committee (HMC) has increased from the previous both data sets. It will be interesting to see how this develops for the next data set.
- **Closed on Datix:** Whilst there is still ample improvement we can make here, our closure rate has improved a lot which is really pleasing.

Aneurin Bevan University Health Board Mortality Review Service Growth

- **Growth of Mortality Review:** Since the Medical Examiner (ME) service started in 2021, the ABUHB Mortality Review Screening Process has grown, especially in 2024 when it expanded to cover community settings.
- **Case Gap:** There's still a gap between the number of cases received and those that proceed to panel.
- **Resource Strain:** The ME service was started without extra resources or investment, putting a strain on the Medical Directors' team and reducing resources for clinical audits. This strain has increased since the service expanded to the community.



Aneurin Bevan University Health Board Mortality Review Service Growth



- The graph highlights a disparity between the number of cases that proceed to panel and those that are closed at Level One or managed through existing governance routes—such as ongoing incident investigations, falls panel scrutiny, or Serious Incident (SI) processes.
- This visual trend provides assurance that the Health Board is actively triaging and managing cases through appropriate channels, ensuring that only those requiring panel-level scrutiny are escalated. It also reinforces the increase in referrals received, reflecting improved reporting and vigilance across services.

Positive Patient Feedback - Civica

She said the care (*her mother*) received was excellent and she could not have wished for better care.

She said "I honestly can't fault them at all, they gave 100%". She said (*the staff*) were very attentive, very respectful and mindful.

At every point (*the staff*) were all amazing. Communication was excellent - we knew everything they were doing and why. They really looked after me and my mum too. I really can't thank them enough"

I was very impressed by all the nurses and clinicians who cared for mum. I'm very grateful to them"

The care (*he*) received was marvellous and (*they*) couldn't fault it.

The care (*Dad*) received was fantastic

She said the care was excellent.

The team were absolutely brilliant.

The care (*her husband*) received was excellent on both wards that he was on during his last admission. She said the nursing team were brilliant and she couldn't thank them enough.

She said the actual nurses and HCAs were amazing, they looked after the family as well as (*her husband*). She said "they were absolutely lovely".

In the hospital (*the staff*) were second to none, absolutely brilliant, the ward staff were brilliant and the ward manager superb.

Bereavement and End of Life – Learning and Actions

As part of the Bereavement and End of Life work a Case Note and Serious Incident Review was conducted. This involved a detailed examination of patient records and Serious Incident reports to identify contributory factors and areas for learning.

This also included Stakeholder Engagement- a Collection of insights through interviews and feedback from staff, patients, and bereaved families, ensuring that lived experience informs the analysis.

Finally a framework alignment was undertaken with reference to established local and national frameworks, including:

- NICE NG31 – Care of dying adults in the last days of life
- Ambitions for Palliative and End of Life Care Framework
- Gold Standards Framework (GSF)

1. Key Themes and Learning Points

1.1 Recognition of Dying and End-of-Life Planning

- **Finding:** Delays in recognising the dying phase led to missed opportunities for comfort measures and family involvement.
- **Recommendation:** Strengthen use of tools to support early recognition and timely transition to palliative care.

1.2 Communication with Patients and Families

- **Finding:** Communication about prognosis and care decisions was variable in quality and timing.
- **Recommendation:** Invest in communication training and use structured conversations

Bereavement and End of Life – Learning and Actions (Continued)

1.3 Care Coordination and Continuity

- **Finding:** Some patients experienced fragmented care, especially at transition points.
- **Recommendation:** Improve handover processes and multidisciplinary collaboration across acute and community settings.

1.4 Symptom Control and Comfort

- **Finding:** Inconsistencies noted in symptom management and access to anticipatory medications.
- **Recommendation:** Standardise symptom management protocols and ensure out-of-hours access to palliative care.

1.5 Support for Families and Carers

- **Finding:** Family support before and after death varied, with gaps in bereavement follow-up.
- **Recommendation:** Enhance bereavement pathways and provide clear signposting to support services.

1.6 DNACPR and Future Care Planning

- **Finding:** Some DNACPR forms were poorly completed or lacked accompanying conversations.
- **Recommendation:** Provide clear documentation training and audit use of FCP and DNACPR.

Bereavement and End of Life – Learning and Actions (Continued)

1.7 Training and Staff Support

- **Finding:** Staff expressed the need for more training and emotional support around death and dying.
- **Recommendation:** Expand access to training in end-of-life care and embed reflective practice.

1.8 Equity of Access and Inclusion

- **Finding:** Some patient groups (e.g., non-cancer diagnoses, learning disabilities) had reduced access to tailored EOL care.
- **Recommendation:** Promote inclusive care pathways and monitor equity through data collection.

1.9 Environment of Care

- **Finding:** Lack of privacy or quiet space for families in some settings was noted.
- **Recommendation:** Review ward environments and explore simple adaptations to improve dignity in dying.

1.10 Learning from Feedback and Incidents

- **Finding:** Not all learning from complaints or incidents around death was shared effectively across teams.
- **Recommendation:** Create a feedback loop to share learning widely and implement system-level changes.

Imams in the Community

A meeting was held with a number of imams and members of the Muslim community along with Dr Kas, who is the co-founder of the Muslim Cymru GPs. The feedback from this group was they are still experiencing issues with receiving the death certificates in a timely manner to enable them to bury their loved ones as their faith requires of them. A follow up meeting has been arranged with the ME to discuss their issues.

Glossary

Definitions of terms within the Report

Graph and chart glossary

- **Risk-Adjusted Mortality Index (RAMI)**
 - **What It Shows:** A comparison of hospital mortality rates after adjusting for patient risks like age, health conditions, and severity of illness.
 - **How to Read It:** Compare the Health Boards RAMI score to 100. A score **below 100** means fewer deaths than expected; a score **above 100** indicates more deaths than expected
- **Crude Mortality Rates**
 - **What It Shows:** The number of patients who died in the hospital without adjusting for risk factors.
 - **How to Read It:** A rolling monthly total of mortality within Hospital.
- **Deaths Per 1,000 Occupied Bed Days**
 - **What It Shows:** The number of deaths in relation to the total day's hospital beds were used.
 - **How to Read It:** Look for trends—if the rate is decreasing, it indicates improvement in patient outcomes. Spikes might suggest seasonal factors or specific issues requiring attention.

Graph and chart glossary

- **MI-Related Mortality**

- **What It Shows:** Death rates within 30 days of admission with an MI
- **How to Read It:** Look for comparisons to the peer averages or trends over time. Lower rates reflect better clinical outcomes.

- **Stoke-Related Mortality**

- **What It Shows:** Death rates within 30 days of admission with a Stroke
- **How to Read It:** Look for comparisons to the peer averages or trends over time. Lower rates reflect better clinical outcomes.

- **A&E Admitted Mortality**

- **What It Shows:** Death rates where patients have been admitted via A&E
- **How to Read It:** Look for comparisons to the peer averages or trends over time. Lower rates reflect better clinical outcomes.

All deaths are reported to MMBRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) ensures the quality of neonatal care through:

Systematic Review and Surveillance:

National Surveillance: Collects data on late fetal losses, stillbirths, and neonatal deaths to identify trends.

Perinatal Mortality Review Tool (PMRT): Facilitates thorough, multidisciplinary reviews of neonatal deaths.

Detailed Investigations:

Confidential Enquiries: Conducts in-depth reviews of selected cases.

Root Cause Analysis (RCA): Identifies systemic issues and care delivery problems.

Governance and Accountability:

Annual Reports: Provides insights and recommendations.

Board-Level Oversight: Ensures accountability and compliance through regular reporting.

Quality Improvement Initiatives:

Targeted Actions: Develops interventions like staff training and protocol revisions.

Monitor Impact: Tracks effectiveness of changes.

Learning and Communication:

Multidisciplinary Learning: Organises sessions to address gaps.

Transparency: Engages families and publishes findings.

This approach ensures robust scrutiny, promotes patient safety, and drives quality improvements in maternal and neonatal care.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	01 October 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

**Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)**

Ar Gyfer Trafodaeth/For Discussion

The purpose of this report is to provide a summary of the current strategic risks that have been delegated to the Patient Quality, Safety, and Outcomes Committee (the Committee) for monitoring, on behalf of the Board.

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation & Cefndir / Background

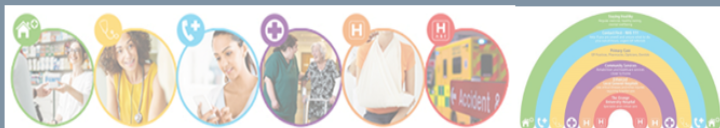
At the last Committee meeting in June 2025, it was reported that the risk environment remained stable, with no changes to the risk scores of the monitored risks. This stability has continued into the current reporting period.

As of the time of writing, the Committee Risk Register includes three high-level risks and three associated sub-risks, spanning the areas of service delivery, transformation and partnership working, and compliance and safety.

Asesiad / Assessment

Committee Strategic Risk Register

Table 1 below provides the current status of the three strategic risks. In accordance with best practice, all risks have been reviewed within the appropriate timeframe for their respective levels of risk.



The review focuses on the control environment, ensuring that the controls remain robust and adequate for managing the identified risks. Additionally, the assurances are tested to verify the robustness of the controls. Detailed information is provided in **Appendix A** (Strategic Risk Dashboard and individual risk assessments).

Table 1

Risk Ref:	Risk Description	Sub-Risk	Risk Level	Within Appetite
SRR 005 Chief Operating Officer Theme Service Delivery Appetite Open Score 17 and below	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	Due to inadequate arrangements to support system-wide patient flow.	High 3 x 4 (12)	Y
SRR 008 Director of Nursing Theme Transformation & Partnership Working Appetite Open Score 17 and below	There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.	Moderate 2 x 4 (8)	Y
SRR 010 Director of Therapies & Health Science Theme Compliance & Safety Appetite Minimal Score 8 and below	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974.	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed, and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	High 3 x 4 (12)	N

Risk Exposure Aligned with Risk Appetite

Risks **SRR 005** and **SRR 008** remain within the Health Board's defined risk appetite, providing assurance that current controls are effective and proportionate. Ongoing engagement with risk owners will help ensure these controls continue to mitigate potential threats appropriately.



The Board maintains a minimal risk appetite for compliance and safety, reflecting its commitment to statutory obligations and the protection of patients, staff, and visitors. In line with this position, any risk with a residual score above eight must be actively managed, reduced, or eliminated where possible. Such risks are subject to targeted interventions and close executive oversight.

SRR 010 remains outside the Board's agreed risk appetite and continues to be closely monitored by the Executive Committee. Since its initial identification, notable progress has been made in reducing both the likelihood and impact of this risk, primarily through the implementation of the Health and Safety Improvement Plan, which has strengthened legislative compliance and supported the sustained delivery of safe and effective services.

To further reduce this risk and bring it within the Board's risk appetite, a new corporate risk has been established, specifically focusing on non-compliance with statutory duties under the Health and Safety at Work etc. Act 1974 and related regulations. This includes key areas such as RIDDOR reporting, fire safety, manual handling, and workplace risk assessments, where deficiencies could present significant operational and reputational risks.

To support this, detailed and targeted risk assessments are being undertaken under the oversight of the Executive Committee. These assessments will provide a clearer understanding of the effectiveness of current controls, identify any gaps, and ensure that robust assurance mechanisms are in place. This will enhance transparency, inform resource allocation, and ensure that attention is directed towards the areas of highest risk and greatest impact.

In addition, a newly established Health and Safety Operational Group, a subgroup of the Health and Safety Committee, will hold its inaugural meeting on 23 October 2025. With attendance from Senior Managers across the Health Board, this group will act as the operational interface for driving the successful delivery of the Health and Safety Improvement Plan. Its remit will include, ensuring continued compliance with the core requirements of the Act, strengthening accountability, and providing a structured forum for sharing and replicating best practice, particularly in areas where performance has stagnated or declined.

By fostering a consistent and proactive approach to health and safety management, the group will play a critical role in reducing the Health Board's overall risk exposure, particularly in relation to regulatory non-compliance, operational failures, and reputational harm. In doing so, it will also directly support the mitigation of SRR 010.

This heightened focus reflects the Board's commitment to a strong safety culture, with executive directors actively supporting the Health and Safety team to strengthen compliance measures and promote individual accountability for maintaining safe and secure environments across the Health Board.



Horizon Scanning

Focused monitoring of individual service areas will remain a priority. Ongoing surveillance, coupled with strengthened control measures, is essential to managing associated risks and ensuring alignment between resources, performance targets, and patient outcomes.

The development of the Corporate Risk Register should provide the Committee with greater assurance that risks to the delivery of safe, effective care, and to the achievement of strategic objectives, are being managed in a more coordinated and comprehensive manner.

Argymhelliad / Recommendation

The Committee is asked to:

- **NOTE** the management of the delegated strategic risks;
- **NOTE** the continued efforts to bring all risks to within the agreed threshold for the risk appetite
- **NOTE** the work being undertaken to ensure that risks with the potential to impact patient quality and safety are systematically identified and incorporated into the forward work plans of key groups and sub-committees of the Health Board.
- **CONSIDER** whether it has sufficient assurance that the strategic risks are being assessed, managed, and reviewed appropriately and effectively, considering the detailed analysis and ongoing mitigation efforts outlined in this report.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The Strategic Risk Register is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.



Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:

Ar sail dystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	The Board and respective Committees of the Board have considered risks contained within the Strategic Risk Register

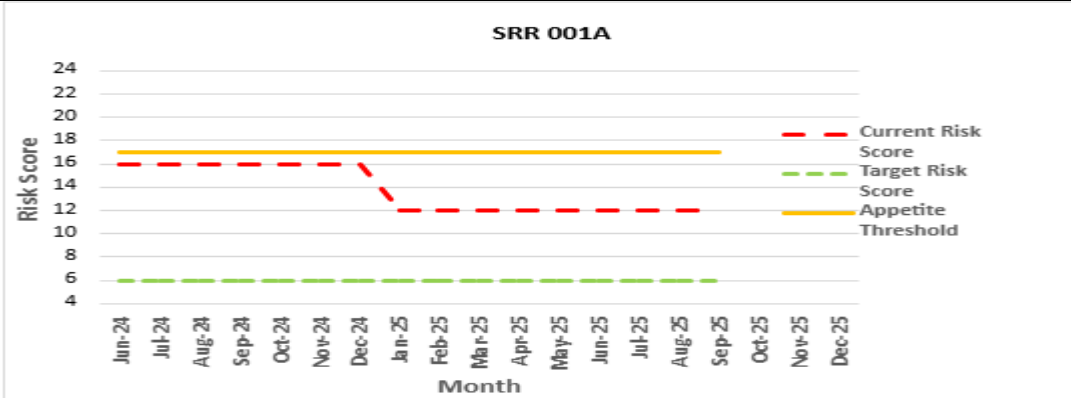
Effaith: (rhaid cwblhau) Impact: (must be completed)

	Is EIA Required and included with this paper
Asesiad Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. N/A



				Risk Score														
Risk ID and Description				IMTP Link	2	3	4	5	6	8	9	10	12	15	16	20	25	
SRR 001	Director of workforce and OD	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a) Due to an inability to recruit and retain staff across all disciplines and specialities.	Workforce & Culture					X				●		◇			
			b) Due to a deterioration in, and a failure to improve, the well-being of our staff							×		●		◇				
			c) Due to insufficient and ineffective leadership levels throughout the organisation.						X			●		◇				
			d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level							X		●		◇				
	Director of Strategy, Planning and Partnerships.		e) Due to inadequate strategic plans which respond to population health and socio-economic needs	System Change					X	●						◇		
			f) Due to unsustainable service models						X			●		◇				
	Director of Finance and Procurement		g) Due to the failure to deliver a sustainable financial position and longer-term financial plan	Finance							X					◇	●	
	Director of Strategy, Planning and Partnerships.		h) Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.	Performance Expectations & Workforce & Culture							X ◇			●				
SRR 002	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board’s estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	Estates	X					◇				●				
			b) Due to significant levels of backlog maintenance						X	◇		●						
SRR 004	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to emergency planning arrangements at both the corporate and operational level not being sufficiently robust to respond to a Major Incident	System Change					X	● ◇								
			b) Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident.						X	◇		●						
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow	System Change							X		●		◇			
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems	Digital, Data & Technology						X					● ◇			
			b) Due to an adverse impact on service delivery in the implementation of new digital systems						X			●		◇				
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future							X		●		◇				
SRR 007	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.	System Change & Regional Plans			X			●					◇			
			b) Due to the impact of fragile services across the regional and supra regional geography				X				●		◇					
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	Quality			X			●					◇			
SRR 010	Director of Allied Health Professions and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	Quality & Workforce & Culture					X	◇			●					
SRR 011	Director of Finance and Procurement	There is a risk that the Health Board will not meet the carbon reduction target set by Welsh Government (16% reduction by 2025 and a 34% reduction by 2030).	a) The effect of a failure to meet this target is on the wider environment due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected	Green Health									X	●	◇			

Key	Current Score	●
	Target Score	×
	Appetite Threshold	◇

RISK THEME	PEOPLE						
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE						
Strategic - SRR 001 A	There is a risk The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.					Publication Status	Public
Threat <i>(As a result of)</i>	Due to an inability to recruit and retain staff across all disciplines and specialties.				Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.		
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> Adverse impacts on delivery of care to patients across acute and non-acute settings	<u>Staff</u> - Non-compliance with safe staffing principles and standards. - Increased Workload	<u>Organisation</u> - Operational Disruptions - Quality of Services - Reputational Damage - Financial strain – use of agency and bank staff		Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.		
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.		
Lead Director	Director of Workforce & Organisational Development		Risk Exposure	Current Level	Target Level		
Monitoring Committee / Group	People & Culture Committee		Likelihood	3 <i>(Possible)</i> x	3 <i>(Possible)</i> x		
Initial Date of Assessment	01 June 2023		Impact	4 <i>(Major)</i>	2 <i>(Minor)</i>		
Last Reviewed	01 July 2025		Risk rating	= 12 <i>(High)</i>	= 6 <i>(Moderate)</i>		
Next Review (Quarterly based on risk score)	01 October 2025						

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- Monitoring Framework to support roll-out of the People Plan. - Workforce Dashboard to track activity – recruitment, turnover, sickness absence. - Supply and demand tracker (Nursing and HCSW). - People Plan tracker to support delivery of actions within the People Plan 2022-25. - Variable Pay Reduction Plan approved June 2022 and supported by the Programme Board. - Management of attendance through All Wales Management Attendance at Work Policy. - Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. - Nurse Staffing Levels (Wales) Act 201625b/25c. - Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. - Workforce planning supported by Compendium of new roles to support innovative workforce models. - Recruitment KPI's. - IMTP (Integrated Medium-Term Plan) Educational Commissioning. - Workforce Establishment controls national working group has been instigated. - Value and Sustainability Board. - Implementation of the Collective Agreement (Non-Pay Deal) 2022/24. - Real Living Wage Employer Recruitment - Engagement with national recruitment campaigns such as BAPIO, M&D Kerela Initiatives, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW (Health Education and Improvement Wales) for Junior Doctor. - Annual programme of Apprentice recruitment - Overseas Nursing (All Wales Recruitment programme)	Recruitment - Approval to overrecruit to newly qualified nurses in September 2025 resulting in zero forecasted RN vacancies in rostered areas. - Consideration of Lateral Move Scheme to provide flexible internal movement of staff. Retention - Development of career pathways (e.g., non-clinical to clinical). - Implementation of Talent Management and succession planning workshops - NHS Wales Nurse Retention Plan quarterly updates being reviewed for submission 09 Sept 2024 ongoing reviews taking place, currently being updated for submission in September 2025 - HCSW retention plan developed in collaboration with Nursing focusing on areas of high turnover being reviewed monthly - Short project completed with an MSc student to develop a retention dashboard, using a regression model to better understand and predict retention. Data analysis currently being undertaken to review findings Variable Pay Reduction - Development of action plan based on WHC to support the reduction in bank and agency usage. E- Systems - Utilise benefits of roll out Safe Care staffing to support effective and efficient staff deployment within adult ward areas. - Roll out of medical rostering to predict junior doctor gaps and look for alternative ways to fill. - Ensure compliance increase in e-job planning to optimise current resources and identify any gaps in provision. - E-Job Planning compliance has increased to 46.7% as of 1st July 2025

- Nursing Workforce Strategy 2023 – 2026 agreed. - Streamlining and improving recruitment timescales through recruitment modernisation programme (started Oct 2022) - Partnerships with employability schemes and FE/HE to widen access. - Actively working with Local Authorities to promote joint recruitment activities via Gwent Workforce Board. - Working with partners to improve visibility and attraction - DBS Policy in place with DBS risk assessment form - Introduced centralised HCSW talent pools from September 2023. - Future Nurse Academy introduced in January 2024. Retention - Retention lead appointed with programme action plan in place for the next two years. - Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR. - Week of events planned to support retention agenda in 2025. This will include a mixed method of online webinars, videos and retention materials. - Internal Retention group has been established with a view to 1) interrogating data from multiple sources to fully understand the issues 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts. - Changes in pension regulation and flexile retirement options from October 2023 and reduced break in service required following retire and return. - Development of HCSW skills matrix and career framework has commenced. - Talent management and succession planning framework and resources now live and available on SharePoint. Framework signed off by Executive Committee. - Career conversations and succession planning resources designed; Talent management succession planning workshop dates available with spaces for 120 people (with monthly training sessions available). Sessions are nearly fully booked with 114/120 places booked. Further workshops planned until the end of the year. - All Wales self-assessment retention tool completed and submitted to HEIW with assessment at organisational level for Nursing and Midwifery to provide a baseline. Variable pay reduction - Plan in place to monitor and review all agency, bank pay incentives supply and demand reporting to Value and Sustainability Board. E- Systems - Effective deployment of current staff - Programme Plan implemented to introduce Workforce Medical E-Systems to support effective deployment of medical staff. E-Locum Bank, E-Job Planning, E-Agency systems are all ‘live’ and rolled out within the Health Board. - E-Rostering is planned to go live shortly following ESR interface testing and following increase in e-job planning compliance, provisionally scheduled for the end of July 2025. Development of Alternative and New Roles - Development of alternative and new roles. - A Gwent Strategic Workforce Action plan has been developed through co-production with our partners across Gwent and now forms the basis of the Gwent Workforce Board programme of work and agenda. The Action plan has been developed around the 7 key principles of A Healthier Wales: Our Workforce Strategy for Health and Social Care. - The NCN (Neighbourhood Care Networks) Workforce Planning programme commenced in Autumn 2023, with all initial workforce planning workshops with all 11 NCN areas completed. The programme is now moving into the next stage of the programme with a comprehensive workforce planning assessment of Blaenau Gwent as an initial project. Programme plan led by WOD developed in conjunction with NCN leads and Divisional Senior Management. Training - The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years. In the HEIW Education Training Plan 22/23 there were increases in - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2025 and beyond which are required to support turnover and existing vacancies in addition to external recruitment and internal training developmental programmes. - The 2024/25 education training plan demonstrated very few increases on previous years for students graduating in 2027 and beyond. The draft 2025/26 education and training plan proposes further increases in Wales training numbers in all branches of Nursing, health care science, medical speciality training junior doctors, pharmacy and continued increase in HCSW investment and increased placements in adult nursing in General Practice. - HEIW have increased Health Care Support Workforce Development funding and there have been further changes for accelerated training pathways in some areas so support entry graduate level qualifications. Improved HCSW funding has enabled clinical induction to be delivered in house from April 2024 to accelerate time to effectiveness and improve employee experience.	- Review and analyse the electronic Bank & Agency data from Patchwork to identify areas with high usage, reasons for use and potentially convert to substantive roles. Development of alternative and new roles - Continued implementation of new roles such as Physician Associates, CAAPs, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP. - Establishment of Mental Health Workforce Planning through HEIW leadership of Mental Strategic Workforce Plan and allocation of workforce planning resources and training programme currently being delivered to Health Boards. - Updating of compendium of new roles and benchmarking is available via workforce planning intranet site and HEIW portal. - Looking to increase Assistant band 4 in Community/Mental Health and areas such as Cardiology Physiology - Continue to extend scope of Advanced Clinical Practitioners to undertake new procedures, reporting etc reducing medical capacity. - Increasing consultant therapy and nurse practitioners. - RCN introduction of Registered Nursing Associate role to help build the capacity of the nursing workforce – students to start from September 2025 with placements from September 2027. - Development of new roles and career pathways to support hard to fill roles in Health Visiting. - Re-design of the Health Board’s work experience programme with 246 applicants since March 2024 and 75 placements confirmed - Development of Medical & Dental Recruitment & Retention Strategy 2025 – 2030 - Looking to further widen access by partnering with DWP to offer 12-week unpaid placements to the unemployed with a view to offering training, support and guaranteed interviews – further promoting ABUHB as an employer of choice at entry level roles. This programme attracts £1000* per candidate and there is a maximum of 50 candidates we can support per year (<i>*as at July 2025</i>) Training - HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce, including Primary Care Academy - Workforce planning training prospectus of local and online training launched May 2025 and HEIW Workforce Planning Hub launched June 2025 - Development opportunity being scoped for Business support staff. - Suite of learning masterclasses launched with 5 topics now available to book, including influencing skills, setting up teams for success, giving feedback, having courageous conversations, having a meaningful PADR. - Recruitment training for managers to streamline campaigns as much as possible to reduce time to hire. - Development of training doctor fill rate dashboard to monitor and improve fill rate or to inform alternative recruitment strategies. - A review and action plan underway to consider how to address instances where nurse streamlining preferences for specific posts exceed the number of vacancies available, to promote recruitment and retention. 31 staff enrolled on workforce planning online training modules level 1. 15 managers enrolled on level 2 training delivered locally March 2025. A capacity and capability workforce planning action plan are being developed to support 25/26 programme of activity.

- RCN Connect Programme has been established in connection with HEIW and higher education providers to support candidates enter registered nursing training (12 supported so far this year, with 3 more to interview) – We don’t get involved with regards to the interview process. - Cadet Nursing programme in place – 16 candidates attended for the 2024 induction and work is ongoing to support all 16 to achieve accreditations. - 16 RCN cadets attending All Wales HCSW Clinical Skills Induction, currently 12 active. - K102 bridging model now being offered to support HCSW pathways into registered nursing. - Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx). Similar program for Directorate Managers (DMx) a 10-month leadership development program to support the capability of this key group commenced 23 April 2024 with cohort 2 launching June 2025. Nursing and Midwifery Academy for senior level nurses and midwives, Leadership Development program (entry level) and Leading People (advanced Level) programmes fully booked. Core Leadership programme currently delivering to 200 staff per year. - Delivery of workforce planning training Vacancy Numbers and establishment control - Quarterly reporting of vacancy numbers to WG as of March 2025 was 629 WTE, an increase of 44 WTE since September 2024. - Development of ESR establishments commenced on a national basis in September 2023. Local delivery action plan has been developed and project workstream established and work commenced. National work programme proposal is also in development to assess digital solutions Staff attendance - Support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. “Hot spot” areas identified and plans in place to support	

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Workforce reports to the Nurse Strategic Workforce Group. - Monthly sickness monitoring reports. - Weekly filled and unfilled shift reports (RN) and reports of agency for HCSW/RN. - Medical Staffing Co-ordinator review of medical rotas. - Cross site operational calls.	- Occupational Health and Wellbeing dashboards report KPIs. - Recruitment KPIs - Medical & Dental and Student Streamlining fill rate reports		
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 - Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. - Workforce and OD (Organisational Development) group established to support delivery and implementation of workforce plans to support Clinical Futures Service transformation. - Measurements of Wellbeing through the ABUHB	(Aneurin Bevan University Health Board) Staff Survey - Routine Reporting against nurse staffing levels. - Variable Pay Programme Board reporting to Value and Sustainability Board	- Governance processes - risk management input (register, risk assessment)	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Internal Audit Reviews 2023 -24 - Long Term Sickness Absence Management (Q4) - Flexible Working (Q4) - External quarterly vacancy reporting to WG - National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges. The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative.	- External reporting on Nursing Staffing Levels - National Acuity Audits (Nursing) - Workforce planning external audit action plan 2024	Latest local survey saw a reduction in staff wellbeing	Internal Audit Staff Culture Q3 2024/25
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> <u>Guidance</u>			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	POSITIVE

RISK THEME	PEOPLE			
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE			
Strategic - SRR 001 B	There is a risk The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status Public
Threat (As a result of)	Due to a deterioration in, and a failure to improve, the well-being of staff.			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact (Consequences of the threat)	<u>Patient</u> Adverse impacts on delivery of care to patients across acute and non-acute settings	<u>Staff</u> - High absence levels, with some sustained long periods - Non-compliance with safe staffing principles and standards	<u>Organisation</u> - Reputational damage to the health board as an employer - Work-related claims - Financial Implications	Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level
Monitoring Committee / Group	People & Culture Committee	Likelihood	3 (Possible) x	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 July 2025	Risk rating	= 12 (High)	= 9 (High)
Next Review (Quarterly based on risk score)	01 October 2025			

SRR 001 B

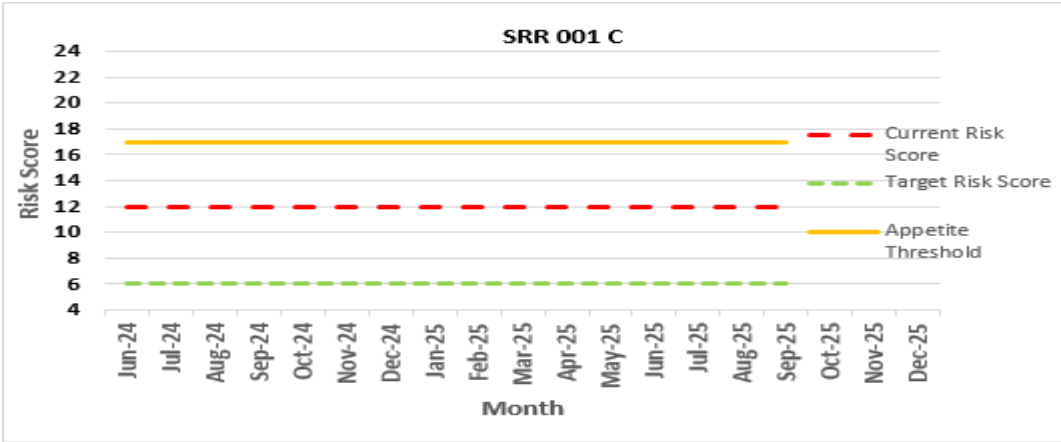
Month	Current Risk Score	Target Risk Score	Appetite Threshold
Jun-24	12	9	17
Jul-24	12	9	17
Aug-24	12	9	17
Sep-24	12	9	17
Oct-24	12	9	17
Nov-24	12	9	17
Dec-24	12	9	17
Jan-25	12	9	17
Feb-25	12	9	17
Mar-25	12	9	17
Apr-25	12	9	17
May-25	12	9	17
Jun-25	12	9	17
Jul-25	12	9	17
Aug-25	12	9	17
Sep-25	12	9	17
Oct-25	12	9	17
Nov-25	12	9	17
Dec-25	12	9	17

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
General - Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard - Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity - Regular meetings with divisions to ensure staff are well supported and staff wellbeing is a priority - Strategic Equality Plan - Rest and Facilities Charter – monitoring and compliance - Staff related policies - National Staff Survey and Health Board Employee Experience Survey - External Employee Assistance Programme - Speaking up Safely Action Plan - Race/LGBT groups - Wellbeing resources - Staff diversity networks - Regular Schwartz rounds arranged across the Health Board - Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own - Close links with the Arts in Health programme - Chaplaincy service for staff - Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being - Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate - Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management.	General - Increase wellbeing initiatives, including long term strategic programmes within large departments (e.g., Maternity) - Identify, training and develop Respect and Resolution advocates (like Mental Health first aiders) - Take a data-based approach to improve our approach to Respect and Resolution processes, and supporting resources - Work with Professional Nurse Advocates (PNA) to explore ways to offer high quality support to nursing colleagues - Trained mediators so there is team and organisational resilience and network - Enhanced our financial well-being offer - Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate - Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management - The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has consistently resulted in a 60-70% reduction in investigations and a wide range of other organisational benefits over 3 years. The programme has now won six awards including two from NHS Wales - Implement, develop and embed the Speaking up Safely process in line with the Welsh Government Framework - We are planning a series of events to celebrate 10 Years of Schwartz Rounds within ABUHB ‘Safe atmospheres’ training has been piloted to support the ongoing psychological safely focused work taking place in theatres and linked to ‘never events’ and team debriefing Occupational Health. - Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted. Current Demand and Capacity review underway with support from planning - Submission of response to All Wales KPI delivery and ongoing data analysis review in place - Support equality and diversity of workforce - Review of staff diversity networks - Review of National Staff survey to understand variations within diverse workforce demographic profile

- The Avoidable Employee Harm Programme, launched on 05 July 2022 initially focusing on HR processes has resulted in a 70% reduction in investigations and a wide range of other organisational benefits - The Avoidable Employee Harm Programme model will be used to underpin our approach to the Speaking up Safely (SUS) initiative within ABUHB - An externally commissioned SUS hotline will be piloted in September 2024 - An external Employee Assistance Programme (Vivup) has been commissioned for a further 12 months to offer additional psychosocial wellbeing support to staff, including a waiting list initiative Occupational Health - Additional occupational health resources secured to reduce waiting times - Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes - Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19 - Support equality and diversity of workforce - A part time Disability Inclusion Officer has been seconded to the EDI Team and made permanent in December 2024 - Band 5 EDI Officer appointed and commenced in post at the end of March 2024 - Inclusive Leadership sessions embedded in the Leading People Programme - Reverse Mentorship Programme launched February 2024 Other - Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC - Reducing fatigue poster developed	- Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms - Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing Staff Survey Action Plan - Findings from the staff survey 24/25 indicate improvements with culture and diversity - An ABUHB action plan is in development to address staff engagement, work related stress and to improve retention of staff - Planning for 2025 staff survey underway to improve compliance and value of outcomes

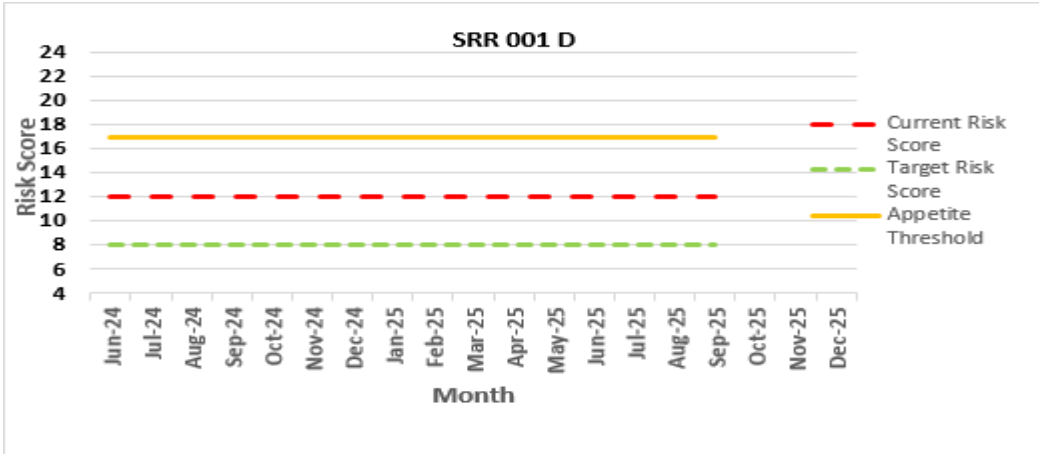
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
• Dashboard reporting • Reporting to monitor the rollout of the People Plan 22-25 • Reporting to monitor of demand on wellbeing services	• Understand if support is reaching all staff	• Meetings with Divisions ongoing to ensure all areas are aware of what’s available.	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
• People and Culture Committee reports (People Plan 22-25) • Local wellbeing surveys • LNC – reporting of compliance of BMA Rest and • Facilities			
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
• National workforce surveys • Monitoring and compliance of BMA Rest and Facilities via NHS Employers • Staff Welfare Charter • Sickness Absence Audit 2023/24 – Outcome: Reasonable Assurance	• Latest local survey saw a reduction in staff wellbeing	• Internal Audit Staff Culture Q3 2024/25	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	POSITIVE

RISK THEME	PEOPLE			
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE			
Strategic - SRR 001 C	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status Public
Threat (As a result of)	Due to insufficient and ineffective leadership levels throughout the organisation			Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.
Impact (Consequences of the threat)	<u>Patient</u> Adverse impacts on delivery of care to patients across acute and non-acute settings;	<u>Staff</u> Adverse impacts on staff recruitment and retention	<u>Organisation</u> - Failure to deliver health board priorities, required improvements and achieve sustainability; - Poor levels of accountability and delivery; - Reputational damage to the health board as an employer;	Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing. SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Director of Workforce & Organisational Development	Risk Exposure	Current Level	Target Level
Monitoring Committee / Group	People & Culture Committee	Likelihood	3 (Possible) x	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)
Last Reviewed	01 July 2025	Risk rating	= 12 (High)	= 6 (Moderate)
Next Review (Quarterly based on risk score)	01 October 2025			



Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- Talent and Succession Planning framework published - Monitoring Framework to support roll out of the People Plan – Focus on Talent and Succession Planning. - Monitoring Frameworks with HEIW - Lead appointed July 2023 on secondment funded by HEIW to create organisational talent management framework to enable to organisation to be deliberate and consistently attract, identify and develop talent for critical roles across ABUHB. - HEIW schemes 1 x HEIW funded graduate management trainee successfully appointed August 2023 following additional recruitment process. - Develop Leadership Capabilities - Leadership journey and programmes mapped, and 1 pager flyer designed and on intranet. Leadership development offer now available for entry level leaders and mangers, clinical directors, directorate managers (DMx), senior nurses and multi-disciplinary teams. - Learning masterclasses have been designed and developed for the organisation addressing ley themes such as giving feedback, developing team and having courageous conversations. - Leading People Programme (starting cohort 9 May 2025) 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire council; our graduate joined the health board in March 2023 and is supporting the decarbonisation agenda.	Talent and Succession Planning - Pilot planned for Finance, Occupational Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy. Development leadership capabilities - Currently exploring leadership funding options with USW to maximise Governmental Grants and utilisation of the apprentice levy. - Continued commitment to NHS graduate schemes. - Continued bespoke development and support for senior management teams in clinical and non-clinical settings focusing on leadership, team dynamics and thriving. - Working with HEIW to inform a national development programme for managers - Engagement with the management competency framework which will be adopted in Wales (following implementation in NHS England). - Review of current leadership journey and training with planning starting to develop a very senior leadership development programme in 2025/26 - Specific leadership and culture work starting in MHLD division with methods being developed to scale across the Health Board in 2026.

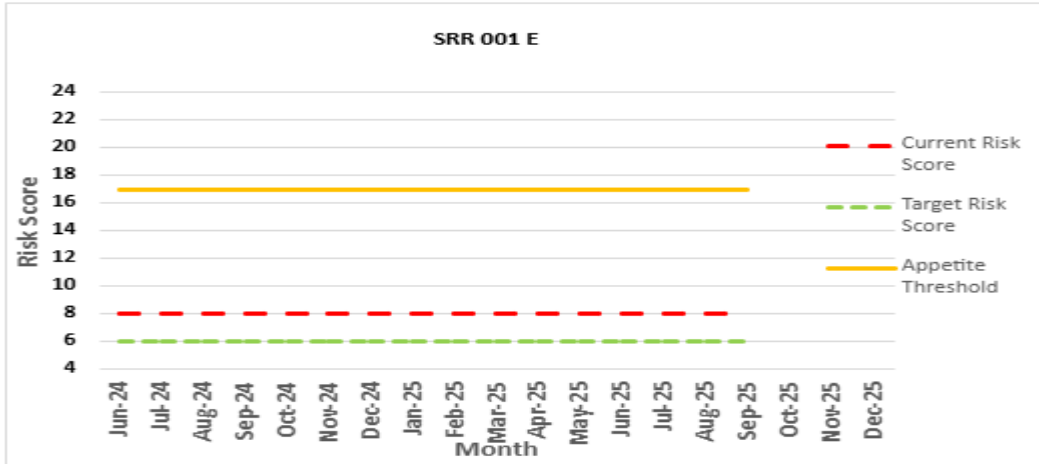
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- WOD Divisional reporting - Evaluation of internal leadership programmes and regular review of our internal offer			
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
Reporting to People and Culture Committee - progress against People Plan 22-25 / 2025 – 2028.			
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Internal Audit Review - Talent and Succession Board			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	POSITIVE

RISK THEME	PEOPLE This risk score will be reviewed following the outcome of the consultative ballots at the end of July 2025.						
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE AND CULTURE						
Strategic - SRR 001 D	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.					Publication Status	Public
Threat <i>(As a result of)</i>	Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level				Risk Appetite Level – Open Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.		
Impact <i>(Consequences of the threat)</i>	<u>Patient</u>	<u>Staff</u>	<u>Organisation</u>		Risk Appetite Threshold - Score 17 and below. Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.		
	• Adverse impacts on delivery of care to patients across acute and non-acute settings	• Non-compliance with safe staffing principles and standards	• Litigation & Financial Penalties • Reputational damage to the health board and loss of public confidence		SUMMARY		
					The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.		
Lead Director	Director of Workforce & Organisational Development		Risk Exposure	Current Level	Target Level		
Monitoring Committee / Group	People & Culture Committee		Likelihood	3 <i>(Possible)</i> x	2 <i>(unlikely)</i> x		
Initial Date of Assessment	01 June 2023		Impact	4 <i>(Major)</i>	4 <i>(Major)</i>		
Last Reviewed	01 July 2025		Risk rating	= 12 <i>(High)</i>	= 8 <i>(Moderate)</i>		
Next Review (Quarterly based on risk score)	01 October 2025						

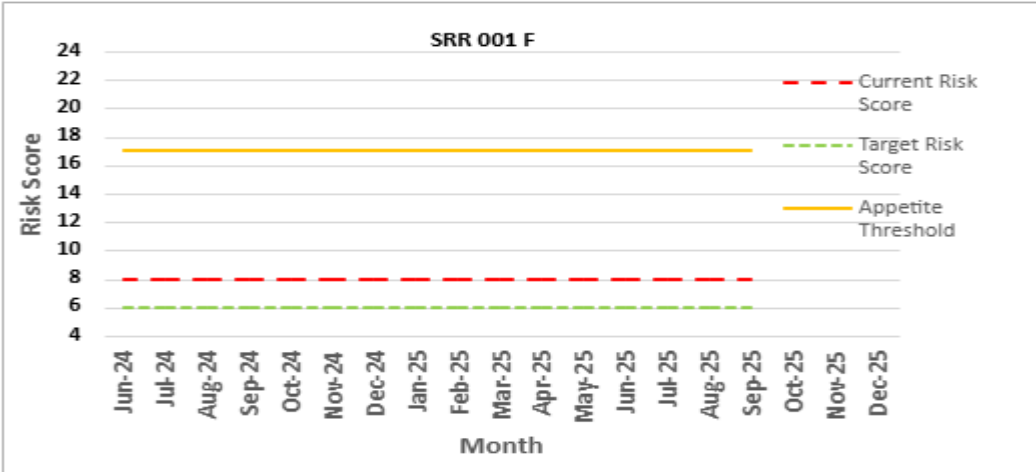
Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- All Wales Industrial Action Planning Group - Local Health Board planning arrangements - Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and - CODE OF PRACTICE Industrial Action Ballots and Notice to Employers - Business Continuity Processes - Redeployment Principles and Risk Assessment agreed. - Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture - Effective derogation processes including Christmas Day cover definition. - Local Negotiating Committee (LNC) - Services Business continuity plans in place. - Terms and conditions agreements in place for medical cover supported by NHS Wales Employer guidance. - Command and control structure and leads established. - Derogation test completed. - Executive and Senior Manager leads established links with national planning cells. - All Wales training sessions provide by legal and risk to support industrial action. - Reducing impact on patients - Support for early supported discharge prior to industrial action. - Picketing guidance supported and agreed. - Workforce Peer Networks – WOD's and DEWOD's.	- Agreement reached in England for Medical & Dental Staff – re-commencement of negotiations in Wales for Medical & Dental Staff. - Issue of WHC AFC non pay elements of collective agreement 2022-24. Response to WG on immediate assurance by end May 2024 - Review of rotas for junior doctor industrial action (minimum staffing levels based on safety assessment). - Communication plans- public, stakeholders and partners - Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer) and pay application. - Consideration of further additional national legal advice - Early notification of consultative ballot outcomes via NHS Employers/WG.

Sources of Assurance (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in Assurance (Insufficient evidence as to the effectiveness of the controls or negative assurance)	Actions to Address Gaps (What further evidence is required to provide the effectiveness of controls)

Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Local Staff re-deployments assessment - Divisional engagement and service planning arrangements in place - Local Negotiating Committee (LNC) - Trade Union Partnership meetings - Established processes and tools used for previous industrial action.			Further industrial action
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Reporting to Executive team - Business Continuity groups - Command and control structure in place to be implemented as required.			
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- All Wales IA group and Welsh Government planning group. - Debriefing session planned to reflect and capture learning for any potential future action			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

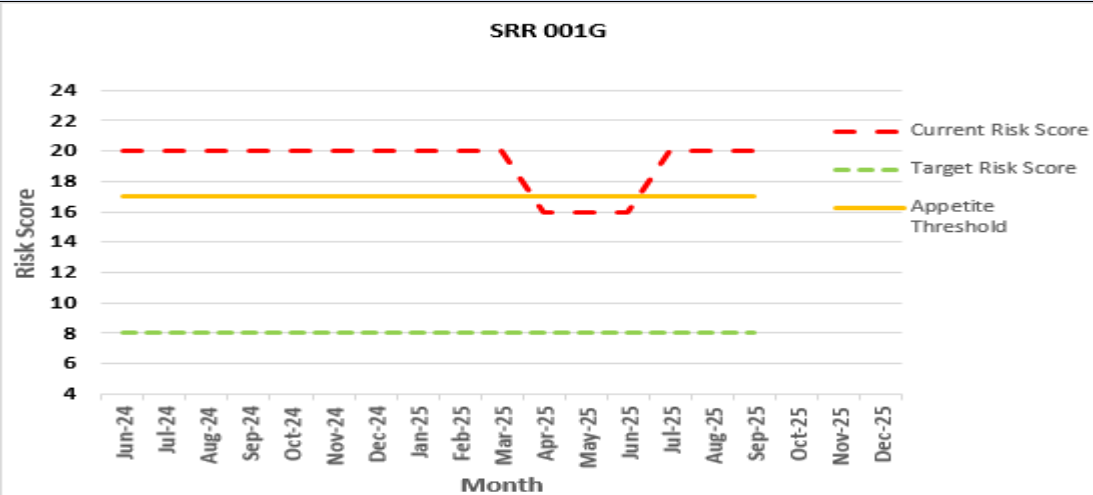
RISK THEME	SERVICE DELIVERY						
LINK TO IMTP	SECTION 3: SYSTEM CHANGE						
Strategic/ Corporate Risk SRR 001 E	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.					Publication Status	Public
Threat <i>(As a result of)</i>	Due to inadequate strategic plans which respond to population health and socio-economic needs.				Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.		
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> - Increased patient acuity levels - Worsening of health inequalities - Worsening of health outcomes	<u>Staff</u>	<u>Organisation</u> - Failure to train teams in multi-morbidity management - Failure to comply with the Wellbeing of Future Generations Act (Wales) - Reputational damage and loss of public confidence - Increased demand		Risk Appetite Threshold – SCORE 17 AND BELOW Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.		
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.		
							
Lead Director	Director of Strategy, Planning and Partnerships		Risk Exposure	Current Level	Target Level		
Monitoring Committee / Group	Partnerships, Public Health and Planning Committee		Likelihood	2 <i>(Unlikely)</i> x	2 <i>(Unlikely)</i> x		
Initial Date of Assessment	01 June 2023		Impact	4 <i>(Major)</i>	3 <i>(Moderate)</i>		
Last Reviewed	01 April 2025		Risk rating	= 8 <i>(Moderate)</i>	= 6 <i>(Moderate)</i>		
Next Review (Six monthly based on risk score)	01 October 2025						

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- QlikSense – performance information - SFN – performance information			Effectiveness of the plans in delivering improvements
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- IMTP Delivery and Outcomes Reporting to Board - Marmot Region Programme - RPB reporting to Board and Population Health, Planning and Partnerships Committee		Regional Planning reporting to Population Health, Planning and Partnerships Committee	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Reviews 2023-24 - IMTP Planning (Q1) Outcome – Reasonable Assurance Internal Audit Reviews 2024-25 - Internal Audit Partnership Arrangements – Limited Assurance			Outcome of the Internal Audit Partnership Arrangements scheduled for Q1 2024/25 Plan
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	SERVICE DELIVERY						
LINK TO IMTP	SECTION 3: SYSTEM CHANGE						
Strategic Risk SRR 001 F	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.					Publication Status	Public
Threat <i>(As a result of)</i>	Due to unsustainable Service Models				Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.		
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> - Increased demand - Increased patient acuity levels - Worsening of health inequalities - Worsening of health outcomes	<u>Staff</u> N/A	<u>Organisation</u> - Failure to train teams in multi-morbidity management - Failure to comply with the Wellbeing of Future Generations Act (Wales) - Reputational damage and loss of public confidence		Risk Appetite Threshold – SCORE 17 AND BELOW Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.		
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.		
							
Lead Director	Director of Strategy, Planning and Partnerships.		<u>Risk Exposure</u>	Current Level	Target Level		
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee		Likelihood	2 (Unlikely) x	2 (Unlikely) x		
Initial Date of Assessment	01 June 2023		Impact	4 (Major)	3 (Moderate)		
Last Reviewed	01 April 2025		Risk rating	= 8 (Moderate)	= 6 (Moderate)		
Next Review (Six monthly based on risk score)	01 October 2025						

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range?</i> <i>(Short, Medium, and Long-Term Plans need to be included)</i>
- The Health Board’s Integrated Medium-Term Plan (IMPT) and associated KPIs - Strategic Programmes in place - Public Health Wales surveillance data – Covid, flu and other communicable diseases. - QlikSense – performance information. - Population needs assessment and area plan development by the RPB. - Southeast Wales Plan for fragile services.	- Area plan is being refreshed through the RPB. - Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. - Review of enhanced local general hospital service models to ensure sustainable quality services. - Development of SEW plan for fragile. - Review of organisational strategy

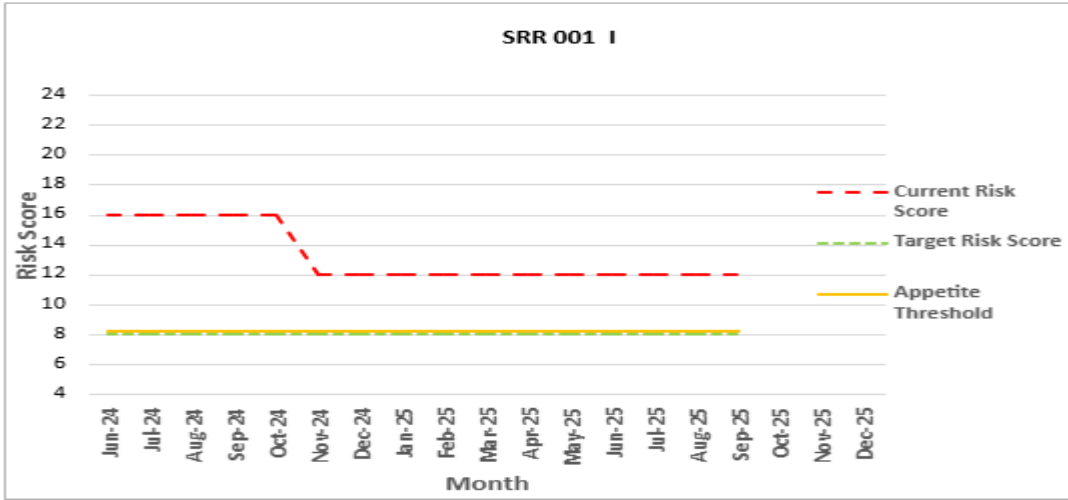
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Public Health Wales surveillance data – COVID, flu and other communicable diseases. - QlikSense – performance information			Evidence of individual arrangements in place to deliver service plans.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- IMTP delivery and outcomes reporting to Board. - RPB reporting to Board and Population Health, Planning and Partnerships Committee. - Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee. - Regional Planning reporting to Population Health, Planning and Partnerships Committee. - Clinical Futures Programme Reporting to Population Health, Planning and Partnerships Committee.			
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Reviews 2023-24 - IMTP planning Q1. Outcome – Reasonable Assurance. Internal Audit Reviews 2024-25 - IMTP – Service Plans (Q2) – Outcome - Reasonable Assurance - Partnership Arrangements. Outcome – Limited Assurance		Recommendations identified in the Limited and Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	Implementation of the management responses to close off recommendations
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	FINANCIAL SUSTAINABILITY				
LINK TO IMTP	SECTION 4: ENABLER - FINANCE				
Strategic - SRR 001 G	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.			Publication Status	Public
Threat <i>(As a result of)</i>	Due to the failure to deliver a sustainable financial position and longer-term financial plan.		Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued and/or establishment of controls; recognising that there could be a high-risk exposure.		
Impact <i>(Consequences of the threat)</i>	<u>Organisation</u> - Breach of statutory duty to breakeven over 3 years. - Instigation of NHS Wales Escalation & Intervention Arrangements. - Non–delivery of Health Board priorities, required improvements, and achieving longer-term sustainability. - Prioritisation and possible disinvestment in service delivery. - Reputational damage and loss of public confidence.		Risk Appetite Threshold – Score 17 and Below Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.		
			SUMMARY The current risk level is OUTSIDE of target and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.		
Lead Director	Director of Finance and Procurement	Risk Exposure	Current Level	Target Level	
Monitoring Committee / Group	Finance and Performance Committee	Likelihood	5 (Almost certain) x	2 (Unlikely) x	
Initial Date of Assessment	June 2023	Impact	4 (Major)	4 (Major)	
Last Reviewed	August 2025	Risk rating	= 20 (Extreme)	= 8 (Moderate)	
Next Review (Monthly based on risk score)	September 2025				
Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>			Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range?</i> <i>(Short, Medium, and Long-Term Plans need to be included)</i>		

• IMTP 25/26-27/28 • IMTP Delivery Framework • Sustainability Route Map revision • Accountability Framework • Performance Framework • 3-year route map to sustainable recovery developed and approved by Board July 24. • Scheme of Delegation • Standing Financial Instructions (SFIs) • Standing Orders (SOs) • Final budget delegation • Financial Control Procedure (FCP) Budgetary control • Financial Budget Intelligence (FBI) • Appropriately trained Finance Team (capacity & capability) • Budget holder training & other business training tools • Cost intervention procedures • 25/26 savings plans & opportunities. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs. • Executive groups and structures established to deliver statutory duties. • Assessment of financial control environment within divisions and corporate teams. • Financial Escalation Meetings • Regular organisational Recovery plan meetings and briefings • Value & Sustainability Board established. • Revised accountability arrangements part of Executive governance. • Budget holder financial recovery deep dive meetings, • Enhanced forecasting and planning processes	• Revised V&SB approach for 2025/26 to help drive financial recovery, separating thematic and divisional scrutiny. • Service Redesign disaggregated as a V&SB theme • Review of programme structures to match V&SB thematic areas • Updated Route Map development • Focus on future opportunity development to deliver 3-year financial plan – through programmes under the VS&B structure.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
• Adherence to SO/SFI/FCPs • Regular AFD meetings to discuss position and performance. • Day 5 comprehensive financial performance review – DoF led. • Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources – part of Chief Operating Officer governance		None	• Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. • Development of detailed 3-year recovery plan.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
• Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Performance escalation meetings established. • Financial assessment and review report to the Board and Finance & Performance Committee	• Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. • Board Briefing sessions on the financial position.	None	• 2025/26 – 27/28 IMTP plans focussed on ‘living within’ budget levels. • 2025/26 savings plan to be delivered. • Detailed delivery plans will be a constant development over next 3 years.
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			

Internal Audit - Annual Report 2024/25 Financial Sustainability – Reasonable Assurance Sept 2025 2025/26 - Audit Reviews External Audit Reports 2024 -25 – Annual Report 2025/26 - Audit Reviews Welsh Government - Financial assessment and review reports to Welsh Government – monthly - Enhanced monitoring T.I. meetings with Welsh Government monthly - IMTP plan to WG end of March 2025		Recommendations from audits	Implement management actions to complete the recommendations from audit reports
Assurance Rating (Overall Assessment of controls and assurances) Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	COMPLIANCE AND SAFETY						
LINK TO IMTP	SECTION 2: DRIVERS – PERFORMANCE EXPECTATIONS				SECTION 4: ENABLERS – WORKFORCE & CULTURE		
Strategic Risk SRR 001 I	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, sustainable services that meet the needs of the population.					Publication Status	Public
Threat <i>(As a result of)</i>	Due to a failure to implement the required performance improvements in some areas of the organisation in line with the Health Board's Performance Management Framework domains of Quality and Safety, Operational Delivery, and Finance.				Risk Appetite Level – MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.		
Impact <i>(Consequences of the threat)</i>	Patient - Unintended Patient Harm. - Negative Public/Patient Experience.		Staff Reduced Staff Morale leading to potential absence from work.		Organisation - Loss of patient/public trust and confidence. - Scrutiny from external organisations. - Adverse publicity. - Punitive Actions. - Financial implications.		Risk Appetite Threshold – SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.
						SUMMARY The current risk level is OUTSIDE of target and the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
							
Lead Director	Director of Strategy, Planning and Partnerships.		Risk Exposure	Current Level	Target Level		
Monitoring Committee	Finance and Performance Committee.		Likelihood	3 (Possible) x	2 (Unlikely) x		
Initial Date of Assessment	19 April 2024.		Impact	4 (Major)	4 (Major)		
Last Reviewed	01 July 2025		Risk rating	= 12 (High)	= 8 (Moderate)		
Next Review (Quarterly based on risk score)	01 October 2025						

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- Performance Management and Assurance Framework - Executive Accountability letters - Divisional Directors Accountability letters - Monthly Assurance meetings with fortnightly meetings for Urgent Care and MH&LD Divisions in place - Escalation processes triggered for Divisions in escalation – including improvement plans and fortnightly oversight (as above) with agendas that focus on priority areas. Reviewed post End of Year and proposed adjustments awaiting sign off - Reporting through to Finance and Performance Committee via Executives - Specific areas of focus are discussed at Value and Sustainability Board - System wide way of working to progress an operational framework, develop winter plans, escalation processes, etc. - External scrutiny via Welsh Government and NHS Executive - Capacity to run the performance framework and reporting requirements has been strengthened with the appointment of the Head of Systems Planning and Performance and analytical team who will fully be in place by January 2025 alongside the Business Partnering Support	6-month review of Performance Management and Assurance - Alignment of internal mechanisms to national escalation - Focussed agendas targeting specific areas of concern and areas for improvement – working with the Business Partners to ensure a joined-up approach. - Standardised Divisional Assurance Templates (pre-populated) - Commission external reviews to support improvements where required. - Appropriate Business Partnering Support and analytical support - Realign capacity and/or redefine roles to provide explicit support

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- DMTs in place for all Divisions - Divisional oversight arrangements – monthly/fortnightly meetings - Divisional plans in place and focussed agendas - Cross Divisional meeting monthly – progress the wider system way of working.	System Leadership Team for awareness and updates	12-month Performance Management Framework review in the Autumn	Outcome if the review will determine if further action is required
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Established reporting to the Executive Committee - Established reporting to the Finance and Performance and Patient, Quality and Safety Committee - Established reporting to the Board - Routine reporting through the IQPD process	None	N/A	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Internal Audit 2024/25 Plan - Directorate Review - Mental Health and Learning Disabilities (Q2) - Divisional Governance Arrangements (Q2) - HIW Inspections - Llais for feedback		- Internal Audit 2024/25 Plan - Findings and recommendations from the Divisional Governance Arrangements (Q2) - Findings and recommendations from the Directorate Review - Mental Health and Learning Disabilities (Q2)	Implementation of the management responses set out in the final Internal Audit Reports
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	COMPLIANCE AND SAFETY										
LINK TO IMTP	SECTION 4: ENABLERS - ESTATES										
Strategic Risk SRR 002 A	There is a risk that there will be significant failure of the Health Boards Estates.								Publication Status		Public
Threat <i>(As a result of)</i>	Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.					Risk Appetite Level – MINIMUM Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.					
Impact <i>(Consequences of the threat)</i>	Patient - Harm or injury to patients - Adverse impacts on delivery of care to patients across acute and non-acute settings		Staff Harm or injury to staff		Organisation - Litigation & Financial Penalties - Loss of estate		Risk Appetite Threshold – Score 8 and below Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.				
						SUMMARY The current risk level is OUTSIDE of the target level and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold					
Lead Director	Chief Operating Officer		Risk Exposure	Current Level		Target Level		SRR 002A			

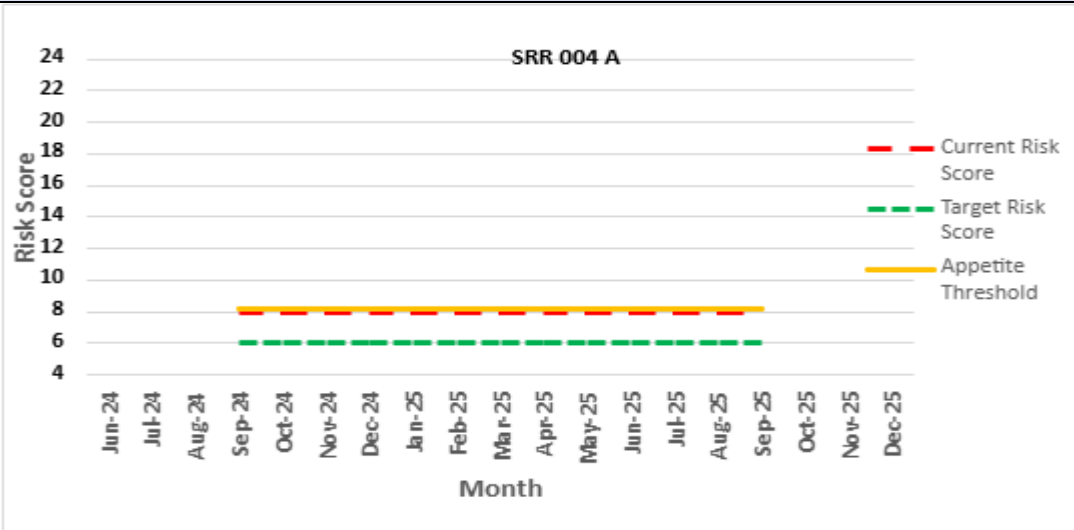
Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range?</i> <i>(Short, Medium, and Long-Term Plans need to be included)</i>
- Work to assess the risk has been undertaken with expert external surveyor advice. Repeat surveys undertaken on 6 monthly intervals (currently ongoing for June and July with report expected in August 2025) - Actions from previous reports including specific actions relating to ‘skylights’ in progress albeit some will require more substantial work -which is being scoped. - Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance - Remediation work to areas of high-risk areas undertaken - Controlled access to roof areas which is being enhanced with proposals around cameras and designated walkways - Implemented toolbox talks for awareness for estate teams and contractors to work in area where RAAC is present. - Ongoing engagement with expert surveyor - Estates and Facilities Divisional Compliance team engaged in supporting the estate's function response to the ongoing management - Risk assessments completed by the Health and Safety function in departments with props to manage any consequences of the presence of props. Note: H&S assessments are around the location of props have been reviewed by H&S team and feedback provided to departments - Links with NHS England and other Health Boards in Wales for shared learning. - Regular dialogue with Welsh Government and Shared Services Estates. - Management Action Plan agreed following Internal Audit including the development of a Management Strategy and submitted to the ABUHB Health and Safety ‘Committee’ in March 2025	- Additional Surveys continue to take place with expert surveyors to inform the next steps relating to further remediation of the issues and monitor existing issues - Management Strategy and the Management Plan are completed and was approved at the Health & Safety Committee in April

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Monthly checks in place for the props albeit fortnightly checks in new prop locations in OPD 2 department - Outcome of surveys continuing, and reinspection of conditions (a regular 6 monthly inspection) - Review of existing arrangements in place supported by external body		Ongoing management of the issues.	N/A
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor - risks and issues associated with any remedial measures implemented. - Outcome of H&S risk assessment in place and reviewed May 2025 - Formal reporting to the Board/Committees in place - Formal update to the PPHPC in July and SOC being developed, led by Planning team		None	N/A
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Internal Audit 2024/25 Plan – report received as Reasonable Assurance (albeit Substantial Assurance on the process relating to surveys. Report submitted to Audit Committee November 2024. - Internal Audit also commented that the risk appetite needs to reflect the current position of monitoring and managing the RAAC pending SOC and FBC hence appetite of 15 should be considered by Board.		Recommendations identified in the Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	- Repeat surveys have been completed and once the latest report from these surveys is received any necessary additional actions will be implements Internal Audit 2024/25 Plan - Implementation of the management responses to close off recommendations been concluded.
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls		Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
REASONABLE			

RISK THEME	COMPLIANCE AND SAFETY						
LINK TO IMTP	SECTION 4: ENABLERS - ESTATES						
Strategic Risk SRR 002 B	There is a risk that there will be significant failure of the Health Boards Estates.					Publication Status	Public
Threat <i>(As a result of)</i>	Due to significant levels of backlog maintenance and structural impairment.				Risk Appetite Level – MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.		
Impact <i>(Consequences of the threat)</i>	Patient - Harm or injury to patients. - Adverse impacts on the delivery of care to patients across acute and non-acute settings.		Staff Harm or injury to staff.		Organisation - Non-compliance with health and safety legislation. - Litigation and financial penalties. - Loss of estate		
					Risk Appetite Threshold – SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications.		
					SUMMARY The current risk level is OUTSIDE of the target level and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.		
Lead Director	Chief Operating Officer		Risk Exposure	Current Level	Target Level	SRR 002B Risk Score Month — Current Risk Score — Target Risk Score — Appetite Threshold	
Monitoring Committee / Group	Partnerships, Health Protection & Planning Committee		Likelihood	3 (Possible) x	3 (Possible) x		
Initial Date of Assessment	01 June 2023		Impact	4 (Major)	2 (Minor)		
Last Reviewed	01 August 2025		Risk rating	= 12 (High)	= 6 (Moderate)		
Next Review (Quarterly based on risk score)	01 November 2025						

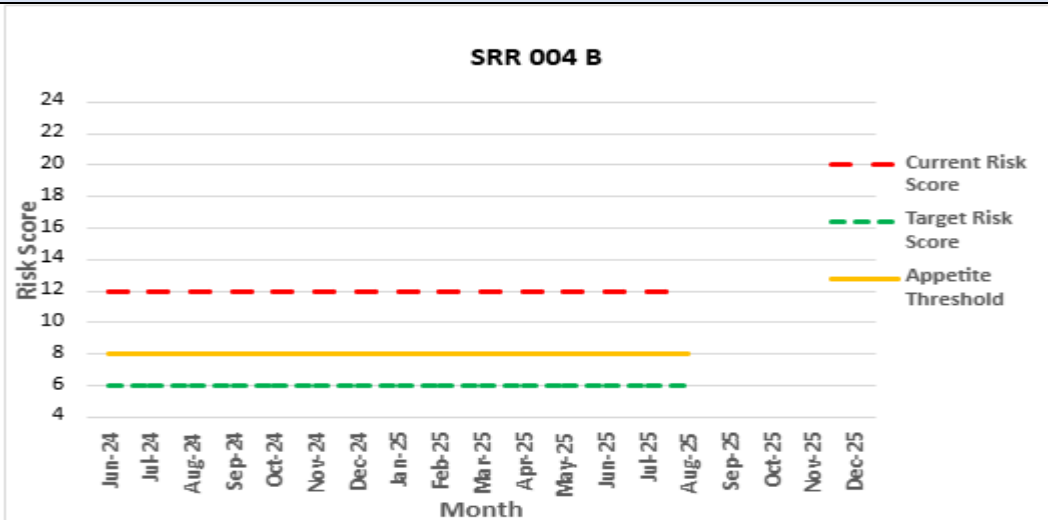
Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range?</i> <i>(Short, Medium, and Long-Term Plans need to be included)</i>
- Health Board Estates Rationalisation Strategy - Health Board Estates Strategy - Health Board policies and procedures related to the maintenance of Health Board estate. 6 Facet survey completed in 2019. - Divisional Risk Register - Multiple policies and SOPs published and communicated to staff. - A robust internal training programme in place covering all aspects of estate management including food hygiene. - Improved statutory compliance processes and forum led by Designated Person - DP (Divisional Director) - Asbestos reinspection programme (over the next 3 years) - Additional capital allocation to Estates and Facilities for backlog maintenance reduction of £500k from discretionary allocation - HB-wide groups on compliance (such as Ventilation and water) are widened in membership to ensure clinical services are active participants - A clear approach to compliance monitoring and escalation of AE reports has been implemented	- Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. - Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. - Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance. - Policies being reviewed and priority given to out-of-date policies, but all policies will be reviewed for effectiveness and compliance with HTM. - Drive clinical service engagement in compliance meetings where engagement is low. - Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible. - Continuation of the additional £500k backlog maintenance allocation by the Board to the Estates and Facilities Division in 2025/26 - Informed by the risk assessment processes of the Estates and Facilities Division, the Health Board has secured significant investment in estate during 2025/26 and 2026/27 from the All Wales Targeted Estates Fund (TEF) - Elements of St Woolos Hospital estate being closed as part of the Board agreement to rationalise the site and remove use of old and poor estate.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Divisional reporting of Statutory and Mandatory training of staff - Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance.		If the revised approach for monitoring and escalation of AE reports is effective in reducing the level of a deterioration.	Performance reporting
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- The divisional risk register is reviewed quarterly by the Senior Management Board this is reported to the Quality & Patient Safety Operational Group - Regular reporting on estate condition to the Executive Committee and Partnerships, Health Protection & Planning Committee		None	N/A
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Reviews 2023- 24 - Estates Assurance - Estate Condition. Audit completed and been shared with Audit Committee and - Finance and Performance Committee Internal Audit Plan 2024-25 - Estates Assurance – Energy Management (Q2) Outcome = Reasonable Assurance. Reported to the - November ARA		Recommendations identified in the Reasonable Assurance Internal Audit Reports from the 2024/25 Audit Plan	Internal Audit 2024/25 Plan Implementation of the management responses to close off recommendations
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	COMPLIANCE AND SAFETY						
LINK TO IMTP	SECTION 3: SYSTEM CHANGE						
Strategic Risk SRR 004 A	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a business continuity incident or critical incident					Publication Status	Public
Threat <i>(As a result of)</i>	Due to emergency planning arrangements at both the corporate and operational levels lacking the necessary robustness to ensure an effective response.				Risk Appetite Level – MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.		
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> - Adverse impacts on delivery of care to patients across acute and non-acute settings - Harm or injury to patients	<u>Staff</u> - Inability to respond to a major incident to meet needs of those affected - Harm or injury to staff	<u>Organisation</u> - Health Board breaches statutory duties under the Civil Contingencies Act 2004 - Litigation & Financial Penalties - Reputational damage and loss of public confidence	Risk Appetite Threshold – SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.			
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.		
Lead Director	Director of Strategy, Planning and Partnerships		Risk Exposure	Current Level	Target Level		
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee		Likelihood	2 (Unlikely) x	2 (Unlikely) x		
Initial Date of Assessment	01 June 2023		Impact	4 <i>(Major)</i>	3 (Moderate)		
Last Reviewed	01 May 2025		Risk rating	= 8 (Moderate)	= 6 (Moderate)		
Next Review (Six-monthly based on risk score)	01 November 2025						

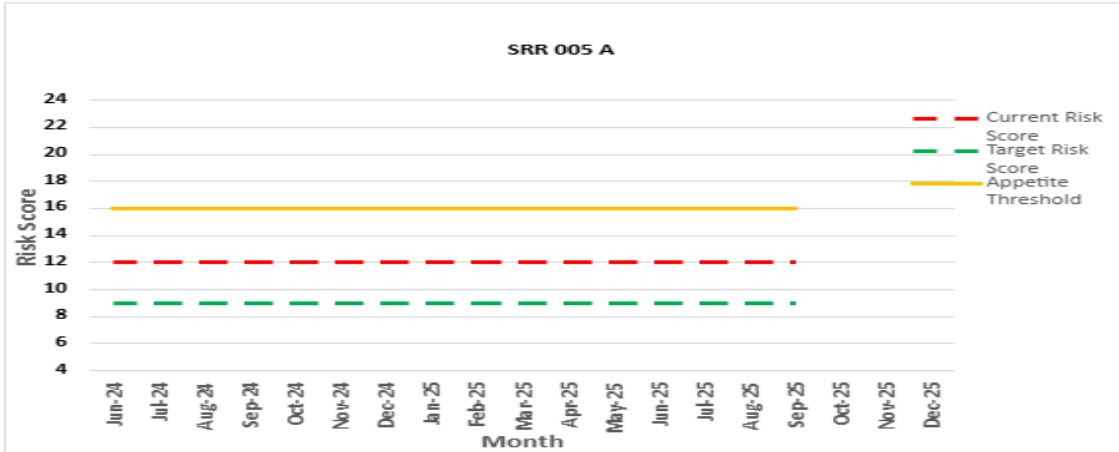
Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- Local/Divisional action cards are in place in key areas - Training undertaken service-specific relating to local response. - Major incident exercise ‘Euclid’ undertaken 20 June 24. Approx. 100 participants and external observers, demonstrated that the Health Board was able to successfully respond to an incident. As a result of the exercise action cards refreshed and renewed with teams to incorporate learning - Internal strategic on call training - Executive Team attending 2-day strategic training. - Loggist training is provided and accessed regularly - New all Wales logbooks are in place for use - Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) - Joint Planning and Training with LRF and across Wales. - Ongoing Participation in exercises UK, Wales, LRF and HB. - Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP) - Continuing to work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner	- Continue to deliver training programmes to support staff preparedness to response to an incident. - Additional ‘local’ team and intra team exercises to take place for areas to practice and embed their response to a major incident together - Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational. - BCPs in place across all services. Work with the Corporate Governance Directorate (Head of Corporate Risk and Assurance) to support improvements in the development of BCP’s across key operational areas. - National pandemic exercise Pegasus Autumn 2025 - Development of a pan plan to support pandemic pathways (HCIDs e.g., MPOX)

LRF Pandemic Solaris undertaken			
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Departmental debrief following an incident to inform learning and enhance controls. - Training records - Plans and action cards in place and up to date - Debrief with key stakeholders following an incident to inform learning and enhance controls.		All key operational departments could actively respond to a BC incident without EP intervention due to the absence of BSPs.	Work with key areas to support development of BCP's and action cards with the support of Corporate Governance Directorate.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Report to the EPRR Group from debrief of incidents - Reports to the PPHP Committee on Emergency Planning Preparedness		EPRR Thematic Risk Register	Develop an EPRR
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Review(s) - Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response - Reasonable Assurance - Outcome and feedback from national exercises		Identification of recommendations to ensure the Health Board is prepared and has the capabilities ato respond effectively.	Implementation of the recommendations and subsequent management responses.
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	COMPLIANCE AND SAFETY					
LINK TO IMTP	SECTION 3: SYSTEM CHANGE					
Strategic Risk SRR 004 B	There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to Business Continuity incidents.				Publication Status	Public
Threat <i>(As a result of)</i>	Due to ineffective and insufficient arrangements across all service areas to respond to a Business Continuity or Critical Incident			Risk Appetite Level – MINIMAL Ultra-safe leading to only minimum risk exposure as far as practicably possible; a negligible/ low likelihood of occurrence of the risk after application controls.		
Impact <i>(Consequences of the threat)</i>	Patient - Harm or injury to patients - Adverse impacts on delivery of care to patients across acute and non-acute settings	Staff - Staff absence (injury, wellbeing) - Harm or injury to staff	Organisation - Operational flow if services fail to prepare BCPs against the 5 key themes - Loss of infrastructure; - Financial implications due to staff absence - Health Board breaches statutory duties under the Civil Contingencies Act 2004; - Litigation & Financial Penalties; - Reputational damage and loss of public confidence		Risk Appetite Threshold – SCORE 8 AND BELOW Risks relating to all aspects of patient safety but also including safeguarding, staff and public security in addition risks relating to compliance and/or legal implications.	
					SUMMARY The current risk level is OUTSIDE of target level but WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
						
Lead Director	Director of Strategy, Planning and Partnerships		Risk Exposure	Current Level	Target Level	
Monitoring Committee / Group	Partnerships, Public Health & Planning Committee		Likelihood	3 (Likely) x	2 (Unlikely) x	
Initial Date of Assessment	01 June 2023		Impact	4 (Major)	3 (Moderate)	
Last Reviewed	01 August 2025		Risk rating	= 12 (High)	= 6 (Moderate)	
Next Review (Quarterly based on risk score)	01 November 2025					
Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>				Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>		
- BC Policy - BC Response Guidance - BC Template & guidance (reviewed and updated April 2025) - Divisional, Directorate & Service BC Plans across a number of key operational areas - BC Exercise - BC debrief learning. - HB and LRF Plans. 3C (Command/Control, Communication) structure in place to respond to incidents. 1-2-1 training with Divisional BC leads and delivering BC workshops for services. - EPRR Group Established. - Repository on intranet for BC plans to be added to by areas for audit, maintenance, and review of interdependencies. - Awareness raising of the requirement for BC across the Health Board through various training programmes - Infectious Diseases plan - Joint plan with PH in response to infectious diseases and public health incidence response overall - Internal strategic on call training - Executive Team attending 2-day strategic training. - Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) - Joint Planning and Training with LRF and across Wales. - Ongoing Participation in exercises UK, Wales, LRF and HB. - Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update				- Ongoing support to develop business continuity plans. - Continued engagement with Divisions, Directorates, and service areas to embed contingency planning into the culture of the organisation, Conduct BIAs, develop plans, train staff, test & exercise, and review plans to mitigate the risks and threats to service delivery. - Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Coordination) structure of strategic, tactical, and Operational. - Continue to engage with the communication team to improve incident cascade during an event to ensure a Health Board wide awareness in a timely manner. - Each Division to identify on their risk register any outstanding business continuity plans against the 5 key themes for their areas and escalate any identified risks to the HB risk group for review. - Development of a business continuity dashboard that enables divisions & directorates to manage, RAG rate and provide assurance of their BC planning arrangements. - Joint working with partners – Exercise Pegasus - Pull together a task and finish group to review and plan for the BC recommendations from the Ex Mighty Oak exercise debrief. - Develop an off the shelf BC exercise for divisions, directorates & services. - Work with the Corporate Governance Directorate (Head of Corporate Risk and Assurance) to support improvements in the development of BCP’s across key operational areas.		

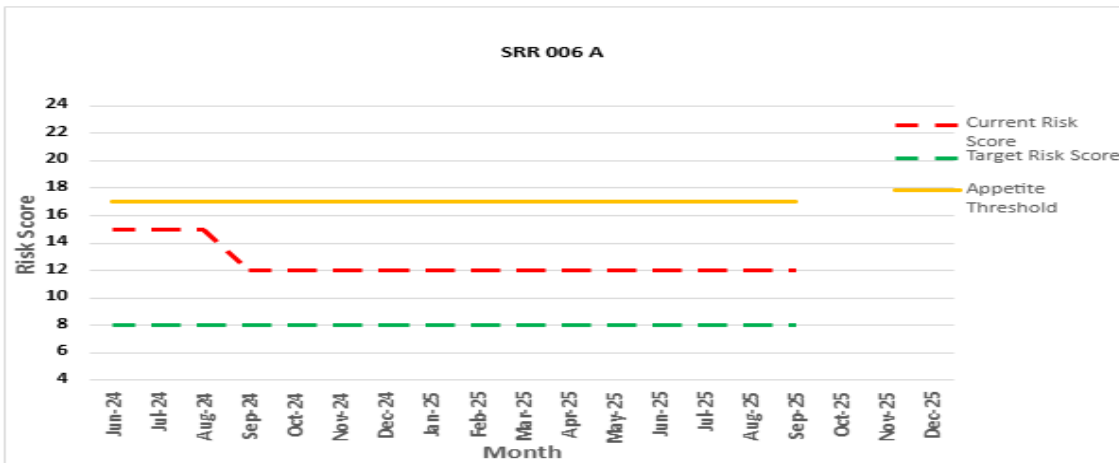
knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP). • Ability to warn & inform the organisation of critical BC incidents via the Health Board communications team. • Health Board service BC supporting plan – to provide a generic response framework if they have no specific plans are in place. • A dedicated business continuity lead for IT applications and networks to reduce the highest key theme risk. • The introduction of a business continuity Incident Response Group in the event that a BC incident that escalates to critical. • Joint working with LRF partners – Exercise Solaris	

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
• Plans and action cards in place and up to date. • Div/Service BC risk registers • Service BC training records • Departmental debrief following an incident to inform learning and enhance controls. • Debrief with key stakeholders following an incident to inform learning and enhance controls.	• All key operational departments could actively respond to a BC incident without EP intervention due to the absence of BSPs.	• Work with key areas to support development of BCP’s and action cards with the support of Corporate Governance Directorate.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
• Report to the EPRR Group from debrief of incidents • Reports to the PPHP Committee on Emergency Planning Preparedness •	• EPRR Thematic Risk Register	• Develop an EPRR
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
Internal Audit Review(s) Business Continuity Planning 2023-24 (Q2) outcome report published – included MI response – Reasonable Assurance • Outcome and feedback from national exercise	• Identification of recommendations to ensure the Health Board is prepared and has the capabilities ato respond effectively.	• Implementation of the recommendations and subsequent management responses.
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance		
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
REASONABLE		

RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	SECTION 3: SYSTEM CHANGE				
Strategic Risk SRR 005 A	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system			Publication Status	Public
Threat <i>(As a result of)</i>	Due to inadequate arrangements to support system-wide patient flow			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> - Avoidable deaths and significant harm. - Delayed discharges from acute and non-acute settings resulting. in deteriorating patients. - Delays in releasing ambulances from hospital sites back into the community.	<u>Staff</u> - Increased workload - Fatigue & burnout	<u>Organisation</u> - Litigation & Financial Penalties - Reputational damage and loss of public confidence	Risk Appetite Threshold – OPEN SCORE 17 AND BELOW Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
					
Lead Director	Chief Operating Officer	<u>Risk Exposure</u>	Current Level	Target Level	
Monitoring Committee / Group	Patient Quality, Safety and Outcomes Committee	Likelihood	3 (Possible) x	3 (Possible) x	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)	
Last Reviewed	01 September 2025	Risk rating	= 12 (High)	= 9 (High)	
Next Review (Quarterly based on risk score)	01 December 2025				

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range?</i> <i>(Short, Medium, and Long-Term Plans need to be included)</i>
- Escalation Policy. - Performance and Accountability Framework - Operational Framework - Major incident Procedures - Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. - Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. - fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. - Enhanced monitoring in place for U&EC - Range of performance measures/metrics in place - Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. - Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. - Planned care recovery meetings with the NHS execs. - Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. - WG – IQPD meetings to review areas of focus	- New developments and pathways coming online into FY25/26 - New expanded transfer lounge o New ED extension and reconfiguration - Additional ED consultants coming onboard - Safety Flow agenda delivering wider developments and improvements

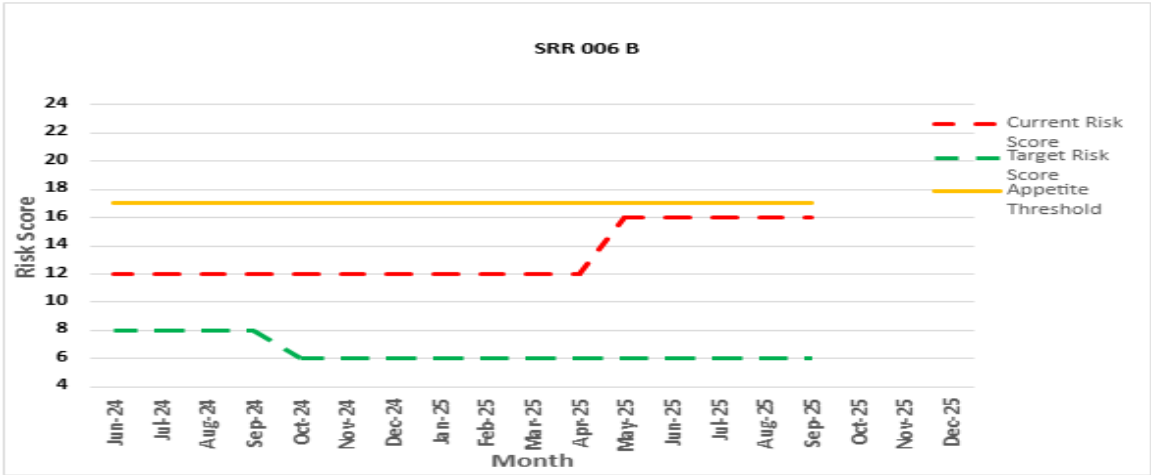
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- The Escalation Framework has been enacted and ineffective in mitigating threats and impact to services. - Performance report against measures/metrics		- Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. - The impact of the Performance and Accountability framework in improving patient flow	Close monitoring and reporting of the frameworks in practice to support learning and improvements.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Divisional Assurance reviews. - Performance against measures/metrics reported to the Executive Committee		Effectiveness of the Operational Framework	The Operational Framework process commenced in November 2024, initiating a series of in-depth reviews across specific services. This is an iterative approach designed to remain active and adaptable, ensuring it continues to meet the evolving needs of the services.
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Reviews - Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024. - External inspections/visits. -		None	N/A
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY				
Strategic Risk SRR 006 A	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.			Publication Status	Public
Threat <i>(As a result of)</i>	Due to the full or partial failure of existing digital infrastructure and systems.			Risk Appetite Level – OPEN Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.	
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> Unintended harm or Injury to Patients.	<u>Staff</u> Unintended harm or injury to staff	<u>Organisation</u> - Data Breaches - Litigation and Financial Penalties. - Reputational damage and loss of public confidence.	Risk Appetite Threshold – Score 17 and Below Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Director of Digital	<u>Risk Exposure</u>	Current Level	Target Level	
Monitoring Committee / Group	Finance and Performance Committee	Likelihood	3 (Possible) x	2 (Unlikely) x	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	4 (Major)	
Last Reviewed	01 July 2025	Risk rating	= 12 (High)	= 8 (Moderate)	
Next Review (Quarterly based on risk score)	01 October 2025				
Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>				Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range?</i> <i>(Short, Medium, and Long-Term Plans need to be included)</i>	

- Remedial Action Plan revised and updated to capture further recommendations against NIS CAF assessment in Jan 2024. This Action Plan has also supported ABUHB risk remediation responses to ABUHB’s NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. - Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO) SIRO trained. - New Information Governance and Cyber Security governance and assurance processes reviewed and implemented. - Governance group terms of reference agreed. Meetings started in November 2023. - Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff - Scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. - Working with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber, and the Teams review compliance levels against policy. Results are captured within the monthly Cyber Report. - Implement the recommendations from Templar report: - Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. - Battle tested OUR cyber incident response, communication cascade and reporting to Cyber Resilience Unit. This will be incorporated into the overall action plan. - Working with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The least important service impacting Version 1 is being managed through ICT Departmental risk management process. · Risk impact reduced as recent loss of power at key sites, incorporating our data Centre allowed is to failover in a seamless fashion from one DC to the other with no service impact. · - Maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails. · - Begun the roll out simulated phishing campaigns. The initial phishing has been tested on the ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff. - Introduced scenario-based incident response exercising using National Cyber Security Centre developed ‘Exercise in a box’ the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023.	- Cyber Resilience Audit (CRU) undertaken in June 2025 showed an overall improvement is assessment. Some key recommendations have been identified which will be progressed and monitored via regular meetings with CRU and reported to Information Governance Group. - Work with Information Governance around implementing the controls required to achieve ISO27001 accreditation. - Updated audit from Cyber Resilience Unit to be undertake in Q2 2025. - Internal Audit review on Shadow IT scheduled for 2025/2026. - Improvements in mandatory training compliance for Information Governance and Cyber Security. - Health Board involvement in national cyber response exercise in September 2025.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- Internal directorate meetings setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. - Single directorate risk registers now in place.	None	N/A
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
- Regular reporting on progress to the Finance & Performance Committee on the cyber security action plan. - Annual Senior Information Risk Owner report.	None	N/A
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
- Cyber security Audit in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems. Internal Audit 2024/25 - Oversight from NHS Wales Cyber Resilience Unit.	None	N/A
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance		
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
REASONABLE		

RISK THEME	SERVICE DELIVERY			
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY			
Strategic Risk SRR 006 B	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.			Publication Status Public
Threat <i>(As a result of)</i>	Due to an adverse impact on service delivery in the implementation of new digital systems.			Risk Appetite Level – OPEN Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.
Impact <i>(Consequences of the threat)</i>	- Unintended harm or Injury to Patients. - Adverse impacts on delivery of care to patients across acute and non-acute settings.	Unintended harm or injury to staff	- Data Breaches - Litigation and Financial Penalties. - Reputational damage and loss of public confidence.	Risk Appetite Threshold – Score 17 and Below Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Director of Digital	Risk Exposure	Current Level	Target Level
Monitoring Committee / Group	Finance and Performance Committee	Likelihood	4 (Major) x	2 (Unlikely) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 September 2025	Risk rating	= 16 (Extreme)	= 6 (Moderate)
Next Review (Monthly based on risk score)	01 October 2025			



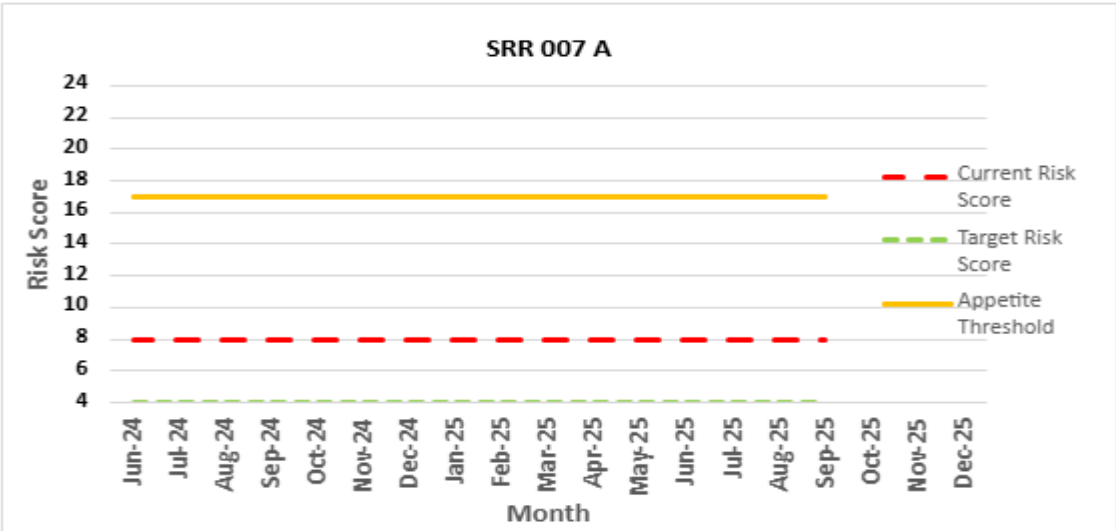
Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services. - Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated. - Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project work packages. - Each clinical project has a clinical lead who would advise and support potential impacts on service delivery caused by the implementation of new digital services. - Business change team in place to support services in improvement of clinical and administrative processes. - Benefits team in place who identify, track, and ensure any benefits are realised which will ultimately improve service delivery. - Projects support backfilling of clinical time where required. - Assurance activities included in project framework including clinical safety, information governance, health records and cyber security. - An overarching Digital Portfolio Progress Group is in place to receive programme updates, manage risk and issue escalations and provide multi-disciplinary assurance over digital projects. - Business change work includes a service readiness impact assessment to enable the project team to develop a realistic plan that incorporates service change requirements. - Aggregated view of risks and issues available to pick up common themes and impact for early intervention or escalation. - Aggregated view of digital Lessons Learned available, and lessons are reviewed during project initiation for best chance of success. - Formal divisional engagement meetings in place monthly to discuss new programmes of work and provide update on critical programmes/projects	- Additional governance being put in place with the Digital, Data and Technology Group which will report to the Finance & Performance Committee. - Terms of reference developed, and meeting will be put in place during Q2 2025. - Digital benefits Board development session planned for 2025. - Digital transformation development programme to be provided to the Board in 2025/2026. - Welsh Government strengthening national governance with the introduction of a DDaT Leadership Board and supporting groups. - Regular reporting now in place to Chief Executive Management Team and Welsh Government DDAT Leadership Board due to concerns over timescales and deliverability to LIMS and RISP. - Local project tolerance levels changed to zero for both RISP and LIMS to ensure immediate escalation processes are enacted for risks or issues impacting delivery / timelines.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
○ Project Boards meet monthly and report into the bi-monthly Digital Portfolio Progress Group (DPPG) ○ Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. ○ Risk management approach and escalation processes in place in line with the Health Board’s Risk Framework		• Escalation of risks and issues done on an Ad hoc basis to Director of Digital and Executive Committee in the absence of DDaT Sub-committee.	• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee • Welsh Government implementing stronger national governance for national project and programmes
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
• Regular Reporting to the Finance & Performance Committee		• None	• Not Applicable
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit 2023/24 • Benefits Management review – Outcome Substantial Assurance • Stakeholder Engagement on IT Projects 2023/24 Q3 – Outcome Substantial Assurance	Internal Audit 2024/25 • Implementation of the Welsh Intensive Care System – future of programme to be decided	• Recommendations identified through audit work	• Recommendations identified through audit work
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	SERVICE DELIVERY						
LINK TO IMTP	SECTION 4: ENABLER – DIGITAL, DATA & TECHNOLOGY						
Strategic Risk SRR 006 C	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.					Publication Status	Public
Threat <i>(As a result of)</i>	Due to failure to develop digital solutions that are sustainable and fir for the future.				Risk Appetite Level – OPEN Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.		
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> - Unintended harm or injury to patients. - Adverse impacts on delivery of care to patients across acute and non-acute settings		<u>Staff</u> Unintended harm or injury to staff.		<u>Organisation</u> - Data breaches - Litigation & Financial Penalties - Reputational damage and loss of public confidence		Risk Appetite Threshold – Score 17 and Below Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.
							SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Director of Digital		Risk Exposure	Current Level	Target Level		
Monitoring Committee / Group	Finance and Performance Committee		Likelihood	3 (Possible) x	2 (Unlikely) x		
Initial Date of Assessment	01 June 2023		Impact	4 (Major)	4 (Major)		
Last Reviewed	01 July 2025		Risk rating	= 12 (High)	= 8 (Moderate)		
Next Review (Quarterly based on risk score)	01 October 2025						

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- New Digital Service Request process in place which provides governance in several key areas: - Automation of request process via ‘Seren’ the ICT Portal - Information Governance – ensuring new services have appropriate controls to keep patient information safe. - Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. - Patient Safety – ensuring services do not introduce any patient safety risks. - Records – ensuring new systems comply with the requirements of records management. - Strong business analysis function in operation which ensures the “as-is” and “to-be” process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. - Business change function which ensures implemented systems are effective and deliver the benefits required. - Formal framework in place for the adoption of new digital services and best practice guidance followed. - Annual planning processes include formal DDAT Annual Operational Plan aligned with service priorities identified in IMTP process - New Digital Request processes include fortnightly senior leadership scrutiny of requests, - New prioritisation framework & tool Monthly/quarterly Operational delivery aligned to ITIL standards - Annual operational plan completed and aligned with IMTP - Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities for Urgent Care, MH & LD, CSS, Division of Surgery & PCCS in place - Software Development uses an agile product management methodology using DevOps software for managing its backlog, delivery plan and sprints.	- Monthly/quarterly Divisional Digital Oversight meetings with senior Digital & Divisional staff to support identification of digital alignment with service priorities to be arranged for Division of Medicine, - Portfolio optimisation to ensure the resources of the service are aligned to key priorities - New Digital Request quarterly reporting to DDAT Group - New governance structures to be put in place further to directorate restructuring - Development of product management approach to delivery of core software applications and extending use of agile processes to ICT - Development of digital strategies including Digital Transformation Strategy linked to ABUHB 2035 – the new Health Board 10 year strategy and associated component strategies and plans including Electronic Health & Care Record and Infrastructure strategy.

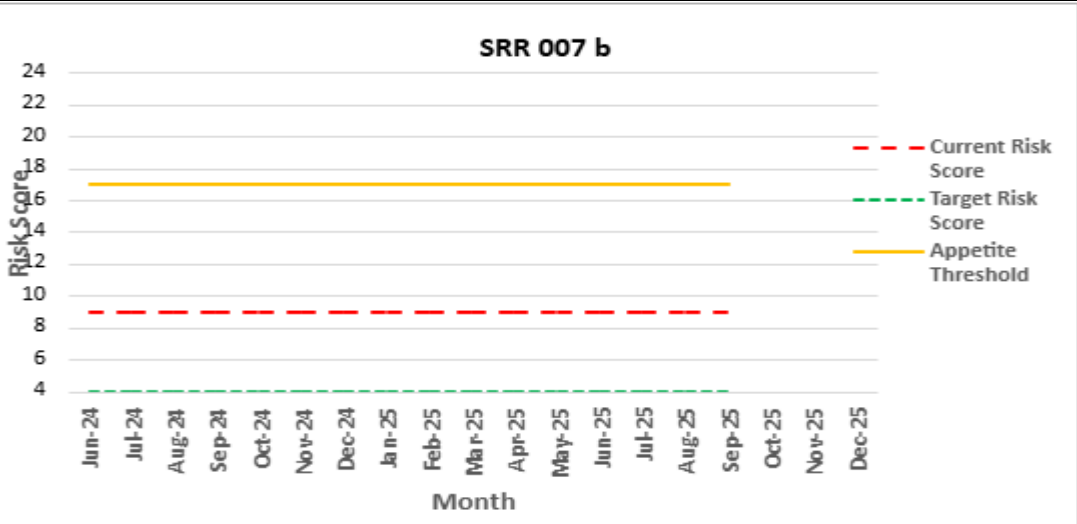
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
Quarterly reporting to DDAT Group		- If the NDSR process delivers anticipated improvements - The outcome of the EDRMS audit	- Monitor the performance of the NDSR process - Audit into the effectiveness and appropriateness of the electronic document and records management solution (EDRMS) in use for the management of digital health records and the provision of scanning services.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
Regular Reporting to the Finance & Performance Committee		None	Not Applicable
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit 2023/24 - LINC Programme– Outcome Reasonable assurance - Network Infrastructure (VPN) - Outcome Reasonable assurance Internal Audit 2024/25 - Electronic document and records management solution - planned for Q4		Recommendations identified through audit work	Regular Reporting to the Finance & Performance Committee
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls		Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
			REASONABLE

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING						
LINK TO IMTP	SECTION 3: SYSTEM CHANGE				SECTION 4: ENABLERS - REGIONAL PLANS		
Strategic Risk: SRR 007A	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.					Publication Status	Public
Threat <i>(As a result of)</i>	Due to the likelihood of further austerity measures impacting effective collaboration with strategic partners across the Health Board footprint.				Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.		
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> Unmet patient need resulting in harm	<u>Staff</u> N/A	<u>Organisation</u> - Ineffective use of combined resource Delayed decision making - Adverse impacts on delivery of care to patients across acute and non-acute settings - Failure to deliver health board priorities, required improvements and achieve longer-term sustainability - Reputational damage and loss of public confidence		Risk Appetite Threshold – SCORE 17 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.		
	SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.						
							
Lead Director	Director of Strategy, Planning, and Partnerships.		<u>Risk Exposure</u>	Current Level	Target Level		
Monitoring Committee	Partnerships, Public Health & Planning Committee		Likelihood	2 (Unlikely) x	2 (Unlikely) x		
Initial Date of Assessment	01 June 2023		Impact	4 (Major)	2 (Minor)		
Last Reviewed	01 April 2025		Risk rating	= 8 (Moderate)	= 4 (Moderate)		
Next Review (Six Months based on risk score)	01 October 2025						

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
The Health Board plays an active role in a range of formal partnership arrangements to enable integrated working for the population including: - The Gwent Public Services Board (Gwent PSB) brings public bodies together to work to improve the economic, social, environmental, and cultural well-being in Gwent. They are responsible, under the Wellbeing of Future Generations (Wales) Act, for overseeing the development of the new Local Wellbeing Plan which is a long-term vision for the area. - The Gwent Regional Partnership Board As set out in the Partnership Arrangements (Wales) Regulations 2015, local authorities and local health boards (RPB) manage and develop services to secure strategic planning and partnership working. RPBs also need to ensure effective services and care, and support is in place to best meet the needs of their respective population. Through these statutory forums formal partnership arrangements take place. - In addition to these statutory forums the Health Board has a range of interfaces with key stakeholder bodies, including regular liaison with local authorities, neighbouring Health Boards, housing associations, and third-sector partners. - Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams	- Governance review of Regional Partnership Board undertaken in August 2023. - Renewed Strategy for strategic partnership Capital in place and revised governance processes. - New Long-Term Strategy for Health Board to focus on Partnership approach.

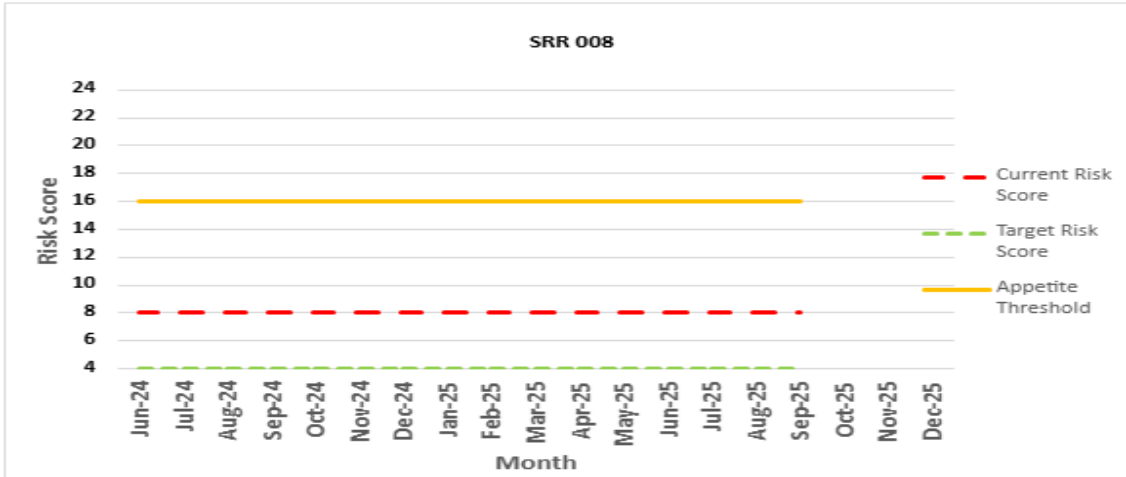
Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- PMO reporting to the Director of Strategy, Planning and Partnerships. - Regional Leadership Group Reporting		- Systematic reporting of outcomes - Systematic evaluation of schemes - Governance of financial control arrangements	- Implementation plan to be developed following RPB governance review. - Health Board strategy development approach to focus on partnership approach
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Assurance reporting to the Population Health, Partnerships, and Planning Committee. - Assurance reporting to the Board.		None	N/A
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Plan 2024/25 - RPB Governance Review (Q4) – Outcome = Limited Assurance. Reported to ARAC September 2024 - Partnership Arrangements Review (Q1) Deferred		Recommendations identified in the Limited Assurance RPB Governance Review	Implementation of the management responses to close off recommendations
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls		Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
REASONABLE			

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
LINK TO IMTP	SECTION 3: SYSTEM CHANGE			SECTION 4: ENABLERS – REGIONAL PLANS	
Strategic/ Corporate Risk SRR 007 B	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.				Publication Status Public
Threat (As a result of)	Due to the impact of fragile services across the regional and supra regional geography			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact (Consequences of the threat)	Patient - Unmet patient need resulting in harm - Adverse impacts on delivery of care to patients across acute and non-acute settings	Staff N/A	Organisation - Failure to deliver health board priorities, required improvements and achieve longer-term sustainability - Reputational damage and loss of public confidence - Ineffective use of combined resources - Delayed decision making	Risk Appetite Threshold – SCORE 17 AND BELOW All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
	Lead Director	Director of Strategy Planning and Partnerships	Risk Exposure	Current Level	Target Level
	Monitoring Committee / Group	Partnerships, Public Health & Planning Committee	Likelihood	3 (Possible) x	2 (Unlikely) x
	Initial Date of Assessment	04 January 2024	Impact	3 (Moderate)	2 (Minor)
Last Reviewed	01 July 2025	Risk rating	= 9 (High)	= 4 (Low)	
Next Review (Quarterly based on risk score)	01 October 2025				



Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- A robust Southeast Wales regional planning infrastructure has been established with clear governance mechanisms in place with attendance from CEO, DoP and COO. - The Regional Portfolio Delivery Board brings the participating health boards together to review all regional service projects, to assess progress against agreed timelines and to agree additional measures / escalations in the event of identified issues and risks. This Board then reports to an Oversight Board with Chief Executive membership. - Four workstreams are established (Orthopaedics, Ophthalmology, Diagnostics and Cancer) and the UHB is well represented and engaged on all. - Where appropriate workstreams are underpinned by a Memorandum of Understanding between the participating health board, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. - The south east Wales health boards agreed revised joint priorities and working arrangements for regional planning in 2024, following a review workshop attended by Chief Executives. Workstreams are underpinned by a Memorandum of Understanding between the participating health boards, setting out their respective commitment to collaborative regional planning where this can enhance service sustainability, quality, and efficiency. - When service issues span regions, arrangements are set up on a bespoke basis, for example the Vascular Project Board and the Interventional Radiology (IR) project. - In addition to these arrangements, the Health Board has a range of informal planning networks and communication channels, with an ongoing commitment to communication, sharing best practice and advising of anticipated service issues and risks.	Additional direction and guidance have been received from Welsh Government, placing greater emphasis on the role of regional planning to achieve sustainable longer-term positions for a range of services where fragilities currently exist. The principal actions are:- - Requirement to develop a portfolio of documents to inform and drive the forthcoming development of a regional diagnostic and treatment centre at Llantrisant Health Park (LHP). These will include a clear outline strategy, comprehensive demand & capacity modelling for proposed LHP services, future development opportunities and programme governance arrangements - Direction for the participating health boards to establish a Joint Regional Committee in quarter 3 of 2025/26, to exercise the facilitation and oversight of regional planning and drive effective collaboration and regional working. The health boards are progressing the above on a collaborative basis. There remains an absolute commitment to delivering on the existing regional programmes of work, and following ‘re-baselining’ work during 2024/25, there is a continued regional consensus on objectives, outcomes, and planning assumptions.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
Service Divisions reporting to the Chief Operational Officer		Alignment and effectiveness of partners to deliver integrated services	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Assurance reporting to the Population Health, Partnerships, and Planning Committee. - Assurance reporting to the Board. - Regular touchpoint meetings of all key players to review progress and issues arising		None	N/A
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	REASONABLE

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
LINK TO IMTP	SECTION 4: ENABLER - QUALITY				
Strategic Risk SRR 008	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public.				Publication Status Public
Threat <i>(As a result of)</i>	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact <i>(Consequences of the threat)</i>	Patient - Unmet patient needs resulting in patient harm. - Ineffective use of combined resources - Delayed decision making - Adverse impacts on delivery of care to patients across acute and non-acute settings - Negative experience of care - Distress and frustration. - Carer stress.	Staff Staff dissatisfaction Frustration Increased absence. Loss of confidence.	Organisation - Failure to deliver health board priorities, required improvements and achieve longer-term sustainability - Reputational damage and loss of public confidence		Risk Appetite Threshold – OPEN SCORE 17 and Below All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.
					SUMMARY The current risk level is OUTSIDE of target but WITHIN the appetite threshold. Target level is WITHIN the set appetite threshold.
					
Lead Director	Director of Nursing	Risk Exposure	Current Level	Target Level	
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)	
Last Reviewed	01 August 2025	Risk rating	= 8 (Moderate)	= 4 (Low)	
Next Review (Six monthly based on risk score)	01 February 2026				

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Corporate Engagement Team - Patient Experience and Involvement Strategy- organisational ownership - Person Centred Care (PCC) Surveys and National surveys via CIVICA - PCC KPI’s (support PCC Quality pillar) ‘You said..... we did’ public facing information for service areas. - PLO service at GUH - Introduction of PALS Service (Oct 23) - Volunteer Patient Experience Feedback - Collaboration to recruit community listeners to support Dementia Awareness - Digital patient stories to support listening and learning. - Patient Experience and Involvement Strategy - DATIX - Oversight of Medical Examiner reports to determine patient experience actions - Public Engagement- Big Conversation Bereavement held 20th March 2024 - People Participation Panel ED in Progress - Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams.	- Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. - PCCT staff training to support Civica data entry and retrieval. - Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. - Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to Quality Management Group - Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. SMS provision to be implemented in Feb 2025 across ED and all MIU’s. 5 National Maternity Surveys to launch via SMS 1st Sept 2025 - National directives around new national surveys that need to be managed additional to internal roll out programme – National People’s Experience Survey live 1st May 2025 and default survey for majority of live areas. - Volunteer feedback to be reviewed to identify themes. - Development of End of Life and Bereavement models in progress and improve bereavement offer to meet Bereavement Standards. Resources being scoped. - Community of Practice for Patient Experience and People Participation Panels now agreed and to be progressed. - Dementia community hubs in each borough of Gwent will enable accessible opportunities for feedback and signposting, plans to increase hubs in more areas of Gwent.

- Dementia Person centred Care team dedicated e mail address. - Dementia Information and signposting through webpages. - Patient feedback on the agenda for each of the dementia workstream meetings. - Dementia - QR code for feedback at each training event and session. - Dementia Thematic review from CIVICA team requested to inform actions and improvements in care. - Dementia - Multi agency partnership workstreams measuring impact of service. - Graces places set up in Newport, Caerphilly and Monmouthshire to support bereaved people	

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Concerns are fed back to divisional teams when identified. - Outcome of the volunteer feedback to drive improvements. - Patient Experience and Involvement Team undertaking Culturally Competent Accreditation, receiving a silver distinction award in Oct 2024 - Immediate feedback and escalation to clinical teams following PALS queries and concerns - Civica patient feedback in in the process of being rolled out across all – all divisional leaders receive reports for their live areas monthly. - Bereavement survey built with CIVICA – Nov 2024 - CIVICA SMS launched 3rd March 2025 across ED and MIU’S	- Currently there is limited SMS provision to increase the number of surveys. - No single point of contact or ‘drop in’ provision for patients/families/staff to raise initial patient experience concerns. - Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards. - CIVICA team have the ability to pull and view feedback that has been left by patients/family. The listening and learning from the feedback to be shared by each department/directorate/division i.e., / ‘you said, we did’ / quality improvement projects.	- SMS provision for patient experience feedback launched in ED and all MIU’s in February 2025. - PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing ‘drop in’ clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Need to have discussions with facilities around rooms. - Patient experience KPI’s and common themes by department/directorate/division need to be identified and pulled from the civica system left on surveys feedback. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation. - Development of a ABUHB bereavement survey has been built within CIVICA and tested. Launch date likely early 2025.	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) - Listening and Learning reported through QPSOG/ Outcomes Committee - Implemented PALS DATIX Module	None	N/A	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Bi-monthly LLais Reports - HIW inspections - Advocacy reports	None	N/A	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
Health and Safety compliance data extracted from ESR and Datix and reported Statutory reporting data reports and dashboards	• Implementation of a health and safety performance report • Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act • Compliance on completion of risk assessments and mitigating actions • Consistent adherence and application of policies	• Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Review the membership and ToRs of the Health and Safety Committee • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
• Established monitoring of H&S at the Executive Committee • Corporate H&S Team report risk and assurance to the Health and Safety Group • Health and Safety Annual Report • Health and Safety Improvement Plan • Established monitoring of H&S at the PQSO Committee	• Thematic Risk Register	• Development of a thematic risk register	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit 2024/25 Plan • Health and Safety Internal Audit – Concluded Limited Assurance • Performance reviews at All Wales Health and Safety Management Steering Group • South Wales Fire & Rescue Service fire safety audit programme. Health and Safety Executive reviews/inspections.	• Recommendations from the 2024/25 Internal Audit	• Implement actions to address the findings and recommendations set out in the Limited Assurance Internal Audit Report	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	SECTION 4: ENABLER – GREEN HEALTH				
Strategic Risk SRR 011	There is a risk that the Health Board will not meet the carbon reduction target set by Welsh Government (16% reduction by 2025 and a 34% reduction by 2030) <i>This is common to all Health Bodies across the country.</i>			Publication Status	Public
Threat <i>(As a result of)</i>	Due to the limitations to change estate and structural operations and available funds to implement strategic changes at scale to fully meet the target expected. <i>(The effect of a failure to meet this target is on the wider environment.)</i>		Risk Appetite Level – OPEN: Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure		
Impact <i>(Consequences of the threat)</i>	Organisation - Failure to meet the target set on Welsh Health bodies for reducing carbon output - Non–delivery of health board priority in this regard, required improvements, and achieving longer-term sustainability for the Health Board and nationally. - Reputational damage and loss of public confidence. - Opportunity cost of reduced energy costs		Risk Appetite Threshold – SCORE 17 AND BELOW. Risk driven by the likelihood of the HB missing this target with some cause for optimism regarding making some progress towards reducing carbon emissions in some areas such as ReFit and changes in clinical practice. The impact locally is relatively small.		
			SUMMARY The current risk level is OUTSIDE of target level and WITHIN the appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.		
			SRR 011		

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Quarterly review of projects and workstreams at the Decarbonisation Programme Board - The project structure has 5 key workstreams each with a Health Board Lead covering clinical, communications, resources, waste and facilities and estates - Regular reporting of financial data available - Significant work already with the ReFit programme and Investment Grade Proposal (IGP) which aims to secure funding for projects of £7.4m, to reduce carbon emissions by 995 tonnes Co2 with a 10-year payback on investment. - Refreshed Decarbonisation Action Plans for 2024-25. The DAPs are integrated with other sustainability plans and were approved at the Decarbonisation Project Board in July 24. - Annual net zero return submitted to Welsh Government - Regular reporting of success stories in this area communicated across the Health Board (e.g., “Gloves R off”) - Decarbonisation Action Plans reported annually Executive lead and publicised on the green health website - SUS Qi training - Met office training - Carbon literacy training HEIW 4 modules on carbon reduction and net zero ESR - Spread & Scale academy training sessions	- Project structure regularly reviewed should action be needed. - Controls will be implemented further as part of the ReFit programme when it progresses following approval of the Investment Grade Proposal.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Regular meetings of the subgroups to discuss position, monitor and new ideas - Bi-annual ISO14001 audit to be undertaken in October 2024. Estates operational meetings	Detailed level metrics and measures are limited due to data capture equipment.	- All opportunities for funding will be optimised - Training opportunities will be maximised.	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Six monthly updates to the Board - Executive Committee (Clinical Futures Board) updates – Quarterly - Six monthly updates to the Finance & Performance Committee Decarbonisation Programme Board – Quarterly reporting	None	- The annual reporting to Welsh Government via the net zero return is the main source of information for carbon output by the Health Board. However, it provides a relatively simplistic picture of output of total tonnes per carbon and so its value is limited. - Funding is the greatest limitation on achieving targets. All opportunities for funding will be optimised - Training opportunities will be maximised.	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Report in July 24. Received “limited assurance” but not because of controls – the issues were largely around funding limitations. External Audit Reports 2023 -24 Periodic reports from Audit Wales – considered by the Audit and Risk Assurance committee	Funding for a comprehensive ABUHB decarbonisation strategy is not available.	As above - REFIT invest to Save capital opportunities being progressed.	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	NEGATIVE

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	01 October 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Patient Quality, Safety and Outcomes Committee – Review of Committee Forward Work Plan 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Governance Support Officer

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Patient, Quality Safety and Outcomes Committee is asked to review the agreed Committee Forward Work Plan appended to this report. The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2025/26 and to enable the Committee to: -

- Fulfil its Terms of Reference;
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- Seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

In line with good governance practice, the Committee has a Forward Work Plan that was developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The Forward Work Plan can therefore

be utilised as a tool for informing and pre-empting Committee business and support the agenda setting process.

To aid the Committee when reviewing its programme of business, the Forward Work Programme captures the timing of when reports are to be submitted, identifies items that have been deferred and captures new requests for reports and enables the Committee to monitor and review its business at each meeting.

During the period the following requests and/or changes to the forward work plan have been included:

Items Deferred on the Forward Work Plan

- Annual Review of Committee Effectiveness 2025/26 was deferred and would be incorporated within the Committee annual report in February 2026 meeting.

These changes have been reflected on the updated Forward Work Programme.

Argymhelliad / Recommendation

The Committee is requested to **NOTE** the updated Committee forward work plan as provided in **Appendix 1**.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Not Applicable
• Service Activity & Performance	Not Applicable
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Annual Programme of Business for 2025-26

Patient, Quality, Safety and Outcomes Committee

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee's self-assessment for 2023/24
- The Board's Strategic Risk Register; and
- Key statutory, national and best practice requirements and reporting arrangements.

Area of Focus as per the Committee's Terms of Reference:
The scope of the Patient Quality, Safety and Outcomes Committee encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on: a. The robustness of the Health Board's Clinical Quality Governance arrangements; b. the experience of patients, citizens and carers ensuring continuous learning; c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services; and d. the effectiveness of arrangements in place to support Improvement and Innovation.

Where required, the Committee will provide accurate, evidence based (where possible) and timely advice to the Board in respect of citizen experience and the quality and safety of directly provided and commissioned services.

MATTERS TO BE CONSIDERED	Lead	Frequency of Report						
			QTR 1		QTR 2	QTR 3		QTR 4
			31 st March	3 rd June	29 th July	1 st Oct	2 nd Dec	17 th Feb
Attendance and Apologies	Chair	SI	✓	✓	✓	✓	✓	✓
Declarations of Interest	All members	SI	✓	✓	✓	✓	✓	✓
Minutes of the Previous Meeting	Chair	SI	✓	✓	✓	✓	✓	✓
Action Log and Matters Arising	Chair	SI	✓	✓	✓	✓	✓	✓
Development of Committee Annual Programme of Business 2025/26	Chair & DoCG	AN	✓				✓	
Review of Committee Programme of Business 2025/26	Chair	SI	✓	✓	✓	✓	✓	✓
Annual Review of Committee Terms of Reference 2024/25	Chair & DoCG	AN	✓				✓	
Annual Review of Committee Effectiveness 2025/26	Chair & DOCG	AN	✓				✓D	✓
Outcome of Annual Review of Committee Effectiveness 2025/26	Chair & DOCG	AN	✓					✓
Committee Annual Report 2025/26	Chair & DOCG	AN	✓					

Committee Annual Report 2025/26	Chair & DOCG	AN						✓
Committee Risk Report	DOCG	SI	✓	✓	✓	✓	✓	✓
NHS Wales Joint Commissioning Quality Committee Report	DOCG	SI	✓	✓	✓	✓	✓	✓
Quality Annual Report 2024/25	DoN	AN				✓		
Quality Management System and Assurance Framework Annual Review	Clinical Executives	AN	✓					✓
Quality Outcomes Reporting	DoN /MD & DOTHS	Quarterly	✓ Interim	✓ Q4	✓ Q1	✓ Interim	✓ Q2	✓ Q3
Primary Care Quality Report	COO	Bi-AN				✓		
Quality Management Group Reporting, including escalation through Quality Management System	DoN	SI	✓	✓	✓	✓	✓	✓
Healthcare Inspectorate Wales Annual Report	DoN	AN	✓					
Healthcare Inspectorate Wales Reviews	DoN	As reported						
Commissioning Assurance Framework Annual Review	Clinical Executives	AN		✓				
Commissioning for Quality Outcomes Report	Clinical Executives	Bi-An	✓			✓		
Putting Things Right Annual Report 2024/25	DoN	AN				✓		
Maternity and Neonatal Report	DoN	Bi-An			✓ D			✓

Learning from Death Report	MD	Bi-AN			✓	✓		✓
Listening and Learning Framework Annual Review	DoN	AN	✓					
Serious Incident Learning Report	DoN	AN					✓	
Health and Safety Compliance Annual Report	DoT&HS	AN			✓D	✓		
Safeguarding Annual Report	DoN	AN			✓	✓		
Ward Accreditation Report	DoN	AN					✓	
Nurse Staffing Levels (Wales) Act 3-year report (3-yearly)	DoN	AN					✓	
Nurse Staffing Levels Wales Act Annual Assurance Report	DoN	AN				✓		
Annual Report on Clinical Audit Activity 2024– 2025	MD	AN		✓				
Mortuary Incident action plan PQSOC 0306/11	COO	Action					✓	
Update on development of local audit plans and funding arrangements PQSOC 0306/12	MD	Action					✓	

Lead Officer	
Key	
CEO	Chief Executive
DoCG	Director of Corporate Governance
DoF&P	Director of Finance & Procurement
DoSP&P	Director of Strategy, Planning & Partnerships
COO	Chief Operating Officer
DPH	Director of Public Health
DoT&HS	Director of Therapies & Health Science
DoW&OD	Director of Workforce & Organisational Development
DoN	Director of Nursing
MD	Medical Director
DOD	Director of Digital
Chair	Chair

Frequency of Inclusion	
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item
An	Annual

1/4ly	Quarterly
BI	1/2 yearly
Schedule of Meetings	
v	Scheduled agenda item in FWP
D	Deferred from this agenda
vD	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee