

# Patient Quality, Safety & Outcomes Committee

Wed 06 May 2026, 12:30 - 13:30

Conference Centre, Headquarters, St Cadoc's Hospital



## Agenda

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### 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 17th February 2026

Attached          Chair

 PQSOC 20260506 1.4 PQSOC 20260217 Minutes.pdf (18 pages)

### 2. ITEMS FOR DISCUSSION

#### 2.1. Quality Outcomes Report


Attached          Director of Nursing

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 PQSOC 20260506 2.1 Quality Outcomes Click App report.pdf (8 pages)

#### 2.2. Learning from Death Report

Attached          Medical Director

 PQSOC 20260506 2.2 Learning from Death Report.pdf (6 pages)

 PQSOC 20260506 2.2 Learning from Death Report - Appendix 1.pdf (61 pages)

### 3. FOR INFORMATION

No Items for this section

### 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 June 2026**



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

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

<b>DATE OF MEETING</b>	Tuesday 17 <sup>th</sup> February 2026, 13:30am-16:00pm
<b>VENUE</b>	Microsoft Teams

<b>PRESENT</b>	Helen Sweetland, Chair Penny Jones, Vice Chair Philip Robson, ABUHB Vice Chair Paul Deneen, Independent Member Vivek Goel, Independent Member (arrived at 14:10) Helen Cunningham, Independent Member
<b>IN ATTENDANCE</b>	Jennifer Winslade, Director of Nursing Seema Srivastava, Medical Director Peter Carr, Director of Allied Health Professions & Health Science Rani Dash, Director of Corporate Governance Karen Hatch, Assistant Director Allied Professions & Health Science Craig Roberts, Assistant Director of Allied Health Professions & Health Science Rhiannon Price, Senior Quality, Patient, Safety Manager (Item 2.6) Naomi Murtagh, Board Business Manager Fern Woodhead, Committee Secretariat
<b>OBSVERING</b>	Rhian Gard, Internal Audit Thokozani Owino, Aspiring Board Member
<b>APOLOGIES</b>	None

<b>PQSOC 1702/01</b>	<b>Welcome and Introductions</b>  The Chair welcomed everyone to the meeting.
<b>PQSOC 1702/02</b>	<b>Apologies for Absence</b>  The Chair confirmed that there were no apologies for absence.
<b>PQSOC 1702/03</b>	<b>Declarations of Interest</b>  There were no declarations of interest raised relating to items on the agenda.
<b>PQSOC 1702/04</b>	<b>Minutes of the previous meeting</b>

	<p>The minutes of the Patient Quality, Safety and Outcomes Committee held on 2<sup>nd</sup> December 2025 were agreed as a true and accurate record of the meeting.</p> <p>The Committee <b>APPROVED</b> the draft minutes.</p>
<b>PQSOC 1702/05</b>	<p><b>Committee Action Log</b></p> <p>The Committee received the action log and was content with progress made in relation to completed actions and against any outstanding actions.</p> <p>The Committee <b>APPROVED</b> the action log.</p>
<b>PQSOC 1702/06</b>	<p><b>Quality Outcomes Report</b></p> <p>Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Quality Outcomes report for Quarter 3. The report reflected the continued implementation of the Health Board’s Quality Strategy, Patient Experience and Involvement Strategy, and Quality Improvement approach.</p> <p>The Committee was advised that the Quality Outcomes Framework (QOF) had been further refined following feedback from Audit Wales, with clearer alignment to national expectations while remaining rooted in local learning and patient experience. JW advised that this was the second quarterly report using the revised Pillars of Quality, including the addition of Clinical Effectiveness as a distinct pillar.</p> <p>The Committee noted the key updates across the pillars. In relation to patient and staff experience, JW advised that the Health Board continued to perform above the all-Wales benchmark for Civica feedback, with consistently positive comments about staff care and compassion. However, waiting times remained the lowest-scoring theme and continued to require focused improvement, both in planned care and in unscheduled settings. JW highlighted the role of the Patient Advice and Liaison Service (PALS) in supporting early resolution of concerns and reducing pressure on clinical teams.</p> <p>In respect of complaints and concerns, the Committee was advised that there had been a reduction in overdue Putting Things Right cases, although performance remained below the national target. Progress had been made in early resolution, and targeted work was underway in divisions</p>

with the highest complaint volumes, including trauma and orthopaedics and maternity services.

JW outlined performance under the patient safety pillar. The Health Board continued to benchmark positively for mortality, and improvements had been seen in falls performance. Medication safety incidents remained stable overall, with variation between divisions, and several quality improvement projects were ongoing. Pressure ulcer reporting continued to be a challenge, particularly in differentiating between hospital-acquired and community-acquired cases, and further work was underway to improve data quality and focus on preventable harm. JW advised that while there had been no new never events during Quarter 3, a never event had occurred in January 2026 and would be reported in Quarter 4.

Peter Carr (PC), Director of Allied Health Professions & Health Science, provided the Committee with an update on health and safety, highlighting continued focus on violence prevention, reduction of sharps injuries, and statutory training compliance, including fire safety and manual handling. A thematic review of sharps incidents was underway to better understand contributory factors and inform improvement actions.

The Committee was advised that infection prevention and control, had a challenging winter period due to respiratory infections, norovirus and COVID-19. JW highlighted strong joint working between infection prevention teams and operational colleagues, including early adoption of mask-wearing and effective outbreak management. Although performance remained strong against all-Wales benchmarks, challenges persisted in meeting Welsh Government reduction targets for certain infections, including *Clostridium difficile*.

In relation to safeguarding, The Committee was advised that adult duty-to-report referrals had reduced slightly, while children's referrals remained high. JW noted increasing complexity within safeguarding work, including multi-agency demands, and confirmed that workforce capacity continued to be monitored. JW also highlighted work underway in relation to persons in positions of trust and revised safeguarding policies.

During discussion, Philip Robson (PR), ABUHB Vice Chair, welcomed the overall improvement shown in the report and asked how learning and quality improvement extended

into community and domiciliary care settings. JW advised that quality metrics included community services and that close working existed with local authority partners, community nursing teams and care homes, although further joint working opportunities remained.

Paul Deneen (PD), Independent Member, raised questions regarding hospital-acquired thrombosis rates and physical assault data. Seema Srivastava (SS), Medical Director, advised that preventable thrombosis rates remained stable and that further analysis was underway to better understand contributory factors. PC advised that further work would be undertaken to analyse physical assault data, including whether incidents related to repeat individuals or specific wards, and this would be brought back to the Committee. **Action: Director of Allied Health Professions & Health Science**

The Committee was advised of the key areas of ongoing focus, including PTR compliance in divisions of medicine and surgery, antimicrobial stewardship, safeguarding capacity, statutory training compliance, timely isolation of infected patients, and improving the quality and consistency of data reporting through enhanced use of dashboards and statistical process control.

Helen Cunningham (HC) Independent Member, asked about funding for MARAC and JW explained that the safeguarding team were continuing to support the work which was so important.

Seema Srivastava (SS), Medical Director, responded to Helen Cunningham's question about the high antimicrobial prescribing rates in some General Practices. SS explained that there was an antimicrobial working group that was addressing this problem in areas of primary care and working with Neighbourhood Care Networks.

The Committee **NOTED** the report.

**PQSOC 1702/07**

### **Quality Management Group Reporting**

Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Quality Management Group (QMG) Report. JW advised that the QMG continued to receive detailed assurance reports from divisions, alongside consideration of corporate quality and safety themes, and that these matters were reflected appropriately within the report.

Helen Sweetland (HS), Chair, advised the Committee that she had attended the most recent QMG meeting and confirmed that the report provided to the Committee represented a comprehensive and accurate record of the discussions held. HS highlighted that there had been strong engagement from divisions and that the QMG seems to function effectively as a key assurance forum within the Health Board's quality governance structure.

HS drew particular attention to the emerging issues relating to legal services and redress matters referenced within the QMG discussions. HS suggested that this area warranted further consideration by the Committee at a future meeting, given the potential implications for assurance and governance. JW agreed that a more detailed report on redress and the Legal and Financial Exposure Review (LFER) process could be brought back to the Committee for discussion. **Action: Director of Nursing**

The Committee **NOTED** the Quality Management Group Report.

**PQSOC 1702/08**

### **Maternity and Neonatal Report**

Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the annual Maternity and Neonatal Report that gave a forward-looking overview of quality, performance and improvement activity across both services.

The Committee was advised that the complexity of women presenting to maternity services had increased, with a consequential impact on neonatal care. The caesarean section rate had risen to just under 50%, which reflected both increased clinical complexity and a sustained increase in the number of women choosing to give birth at the Grange University Hospital following the closure of a midwifery-led unit after public consultation. The Committee noted that this change in case mix had influenced the proportion of unplanned and emergency caesarean sections.

In relation to workforce, JW advised the Committee that both maternity and neonatal services were in a strong position. Neonatal services were fully recruited, and maternity services were slightly over-recruited, representing a significant improvement from previous years when midwifery vacancies had been a concern. Both services were managing acuity within their existing workforce. JW highlighted the positive role of parent

engagement groups, including the Babby Group in maternity and Dinky Dragons in neonatal services.

The Committee was advised that sickness levels were higher within neonatal services and were subject to review by the Director of Workforce. Maternity sickness levels were reported to be around 6%, reflecting, in part, staff on maternity leave, with appropriate support in place for staff returning to work. JW outlined performance in relation to training and education. Maternity services continued to perform strongly against PROMPT (Practical Obstetric Multi-Professional Training) requirements. Neonatal services were slightly below the national guideline of 70% Qualified in Specialty (QIS) nurses, currently standing at 65%, and this in-house programme was under review.

JW advised the Committee of the ongoing work to improve culture and leadership, including civility training within maternity services, which had been extended to neonatal teams and was positively received. JW highlighted extensive work to improve access and equity, including targeted engagement with Bangladeshi women in Newport, Ukrainian and Hungarian fathers, and Roma communities. The maternity unit had achieved silver cultural competence accreditation, the first maternity service in Wales to do so.

Leadership visibility had been strengthened, particularly in theatres and labour wards, to support staff in high-pressure environments. Neonatal leadership arrangements had also been enhanced to ensure appropriate support for staff caring for critically unwell infants.

During discussion, the Committee queried the increase in unplanned caesarean sections and whether antenatal monitoring and early identification of risk could be strengthened. JW advised that this reflected national trends and increasing population complexity, including women with multiple long-term conditions and variable engagement with antenatal care. JW agreed to review the data further and provide additional information to the Committee. **Action: Director of Nursing**

The Committee also discussed the positive impact of increased visibility of Band 7 staff, improvements in breastfeeding rates, and the development of a tongue-tie pathway. JW confirmed that breastfeeding support remained a priority, with specialist midwives and health visitors providing support across maternity and community settings. The committee noted that medical staff were

infrequently mentioned in the report and hoped that this would be addressed in future reports as it is a multi-professional directorate.

JW reminded the Committee that Maternity and Neonatal teams have to regularly submit data to national audits MBRACE and the National Neonatal Audit Network. No major concerns have been highlighted through this benchmarking.

The Committee was advised that both maternity and neonatal services had established improvement plans, which had been regularly reported through governance structures, and that recent focused improvement work continued to be embedded. The Committee requested a further update on neonatal services at the next meeting, including progress on the 'listening exercise' and the lessons learned activity and the outcome of the recent national review. **Action: Director of Nursing**

The Committee **NOTED** the report.

**PQSOC 1702/09**

### **PALS Scheme and Organisational Change Programme Review Outcomes**

Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the outcomes for the two-year review of the Patient Advice and Liaison Service (PALS) Scheme and its alignment with the Organisational Change Programme.

The Committee was advised that the review had been undertaken to assess whether the original assumptions underpinning the establishment of the PALS service had been achieved. JW confirmed that the majority of objectives had been met and that the service had become a visible and valued point of contact for patients, families and carers. However, 1 key assumption had not been realised, the expectation that PALS would enable a reduction in the resource requirement for the Putting Things Right (PTR) team. While PALS had successfully resolved concerns early, it had largely engaged with a different cohort of individuals, many of whom would otherwise have raised concerns informally with clinical teams rather than entering the formal PTR process.

JW advised the Committee that very few PALS cases had escalated to formal PTR complaints, demonstrating the effectiveness of early resolution. However, due to existing complaint backlogs and the complexity of forthcoming

regulatory changes, it had not been possible to offset investment in PTR through the introduction of PALS.

JW highlighted 2 further areas where progress had been only partially achieved. Firstly, limitations within the Datix system meant that PALS early resolution activity could not be fully recorded within PTR data, reducing visibility of the service's preventative impact. Secondly, while significant work had been undertaken to improve equity of access, particularly for the deaf community, neurodiverse individuals and veterans. JW acknowledged that further improvement was required to fully meet equity objectives.

Despite these challenges, JW emphasised the positive impact and value of the PALS service. The team handled approximately 524 cases per month with 4.69 whole-time equivalent staff, and benchmarking against other Health Boards demonstrated strong value for money. All themes and feedback identified by PALS were shared with divisions to support learning and improvement, and the service fed directly into the Patient Experience and Learning Improvement Forum.

The Committee was advised that the PALS team operated across the Health Board, with a base at the Grange University Hospital, and worked closely with reception and telephony colleagues. The service provided a 24/7 contact line, with out-of-hours messages responded to the next working day. The team also supported digital patient stories and maintained a network of PALS champions. JW described the team as small but highly effective, supporting patients and families through both simple enquiries and complex concerns, and reducing pressure on frontline clinical staff.

JW advised the Committee that the forthcoming Listening to People regulations presented opportunities to further integrate PALS into early resolution pathways and make it clearer regarding their role in 'Listening to People. JW suggested that, once the new arrangements were embedded, there would be value in undertaking a further review to assess whether additional efficiencies and benefits could be realised.

During discussion, Helen Cunningham (HC), Independent Member, noted that the review demonstrated a high-performing service but expressed concern that the anticipated financial release had not been achieved. HC asked whether the new regulatory framework might enable greater efficiencies in future. JW advised that this would

need to be assessed once the new arrangements were operational, but that there was potential for PALS to play a central role in supporting early resolution.

The Committee recognised the strong qualitative benefits of the PALS service, particularly in improving the experience of patients and relatives and providing a consistent, compassionate point of contact for a wide range of queries and concerns, not necessarily related to the PTR process. The Committee acknowledged that it was difficult to quantify the benefits of the work of PALS.

The Committee **NOTED** the report.

**PQSOC 1702/10**

### **Healthcare Inspectorate Wales (HIW) Reports Update**

Jennifer Winslade (JW), Director of Nursing, provided the Committee with an update on the Healthcare Inspectorate Wales (HIW) inspection activity and the Health Board's approach to monitoring and assuring progress against HIW recommendations.

The Committee was advised that HIW inspections generated formal recommendations which required timely and effective action. JW advised that Audit Wales had previously highlighted the need for strengthened assurance and governance arrangements to ensure that actions arising from inspections were consistently monitored, delivered and evidenced. The purpose of the update was therefore to provide assurance to the Committee regarding progress.

JW advised the Committee that following each HIW inspection, divisions were required to develop improvement plans detailing actions to address recommendations. Historically, reporting of progress had been fragmented, making it difficult to assess overall delivery and emerging risks. In response to Audit Wales recommendations, the Health Board had implemented a more robust and transparent approach to monitoring.

The Committee was advised that the Assurance Monitoring and Tracking (AMAT) system was now being used as the central platform for tracking all HIW-related actions. This enabled clearer visibility of progress, supported escalation where actions were overdue, and provided a consistent assurance framework for both divisional and corporate oversight.

JW advised the Committee that there had been good progress in addressing actions arising from recent HIW inspections and that work requested by Welsh Government was progressing as expected. JW confirmed that the majority of actions were either completed or on track, with outstanding actions subject to active monitoring through governance structures.

JW proposed that, to strengthen assurance, the Committee should receive regular scheduled updates, rather than ad hoc reporting. It was suggested that a formal update on HIW actions should be provided to the Committee twice yearly, enabling the Committee to maintain oversight of progress, themes and risks across inspection activity.

**Action: Committee Secretariat**

During discussion, the Committee welcomed the improved visibility provided by AMAT and supported the move towards more structured and routine reporting. The Committee noted the importance of ensuring that learning from HIW inspections was shared across services and embedded into quality improvement activity.

The Committee **NOTED** the HIW Reports Update.

**PQSOC 1702/11**

**Putting Things Right Regulations Update**

Rhiannon Price (RP), Senior Quality and Patient Safety Manager, presented an update on forthcoming changes to the Putting Things Right (PTR) regulations and the introduction of the Listening to People framework, which was scheduled to replace the current statutory PTR guidance from 1<sup>st</sup> April 2026.

The Committee was advised that the changes followed a Welsh Government review and public consultation undertaken in early 2024, which had identified several challenges within the existing PTR system. These included concerns regarding communication, compassion, timeliness, transparency, and an excessive focus on process rather than a person centred approach. The revised framework aimed to create a more open, responsive and learning focused system, placing patients and families at the centre of the concerns process.

RP outlined the key features of the new framework. These included a mandatory "listening conversation" for all concerns, to be undertaken at the outset via telephone, virtual or face-to-face discussion, led by the needs and preferences of the complainant. This was intended to

improve early understanding, identify advocacy or accessibility needs, and promote compassionate engagement from the beginning of the process.

The Committee was advised that there would be an increased emphasis on proportionality and early resolution, with a new target timeframe of 10 working days for resolving concerns at an early stage, where appropriate. RP advised that this represented an expansion of the current early resolution approach and was designed to prevent unnecessary escalation into formal investigation processes.

RP further advised that the financial threshold for redress would increase from £25,000 to £50,000, enabling a greater proportion of cases to be resolved in-house without recourse to protracted litigation. The overall timeframe for managing concerns, including redress, would reduce from 12 months to 120 days, subject to the complexity of the case and agreement with the complainant.

Additional changes highlighted included a stronger focus on supporting bereaved families, the introduction of a People's Experience Survey to capture feedback on how concerns were handled rather than solely on outcomes, and the establishment of a national ministerial target for at least 40% of concerns to be resolved through early resolution. RP confirmed that no further national performance targets had been set at this stage.

RP advised the Committee that the final statutory guidance and detailed operational documentation had not yet been issued by Welsh Government and were not expected until 1<sup>st</sup> April 2026, the date the framework was due to go live. This presented implementation challenges, particularly in relation to policy updates, training, and system configuration. Despite this, preparatory work was already underway both nationally and locally.

The Committee was advised that a National Operational Delivery Group had been established to oversee implementation across Wales. Locally, a Listening to People Readiness Group had been set up, with agreed terms of reference and an action plan aligned to national workstreams. These included education and training, communications and engagement, workforce, assurance and monitoring, learning, process development and

system functionality. Progress would be reported through the Quality Management Group.

RP highlighted several anticipated challenges, including capacity and resource pressures associated with mandatory listening conversations, coordination across multiple agencies, staff training requirements, managing expectations around redress, and limitations of existing digital systems including Datix pending final system enhancements. RP emphasised that Welsh Government had indicated organisations were not expected to have a fully mature system in place on day one, but rather to demonstrate readiness and ongoing improvement.

The Committee raised concerns regarding the absence of additional funding to support implementation, particularly given the increased workload associated with listening meetings, training, redress arrangements, interpretation and translation requirements, and parallel management of legacy PTR cases alongside new Listening to People cases after April 2026. It was confirmed by Jennifer Winslade (JW), Director of Nursing, that no additional Welsh Government funding had been allocated and that no national financial impact assessment had been shared to date.

The Committee discussed the financial and operational risks associated with implementing the new framework without additional resources and noted that difficult internal prioritisation decisions might be required. It was acknowledged that this was consistent with other recent legislative changes and that a risk-based approach to implementation would be necessary.

The Committee also discussed system readiness, including the likelihood that cases received before and after 1<sup>st</sup> April 2026 would need to be managed under 2 parallel frameworks for a period of time. RP confirmed this would be the case and acknowledged the associated complexity, but advised that elements of the new approach had already been embedded into current practice to support transition.

Helen Sweetland (HS), Chair, thanked RP for a comprehensive and clear update and acknowledged the scale of the change and the work already undertaken to prepare the organisation. The Committee recognised that the new framework represented a significant cultural and operational shift and that further learning would emerge following implementation. The Committee requested an

update on progress with these new regulations later in the year. **Action: Director of Nursing**

The Committee **NOTED** the report.

**PQSOC 1702/12**

**Maindiff Court Mental Health Inspection report**

Jennifer Winslade (JW), Director of Nursing, provided an overview of the report on recent Healthcare Inspectorate Wales (HIW) inspection of Maindiff Court, focusing on Ty Skirrid Ward, a 15-bed male mental health rehabilitation unit.

The Committee was advised that the inspection was an unannounced visit conducted from 6<sup>th</sup> to 8<sup>th</sup> October 2025, with the final report published on 15<sup>th</sup> January 2026. The inspection had considered patient experience, safe and effective care, and leadership and workforce arrangements.

JW summarised the positive findings from the inspection. HIW reported strong therapeutic relationships between staff and patients, with interactions described as respectful, calm and supportive. Relational security was highlighted as a particular strength, alongside effective multidisciplinary team (MDT) working. The ward benefitted from consistent occupational therapy and psychology input, and care and treatment plans were found to be appropriate and aligned with Mental Health Act requirements. Leadership and governance arrangements were described as effective, with a stable workforce and clear escalation routes within the division.

The Committee was advised of the areas for improvement identified by HIW. These included the need to strengthen documentation, particularly in relation to recording offers of advocacy and ensuring community care and treatment plans were uploaded promptly to the Welsh Clinical Information System. Inspectors also identified environmental limitations associated with the age of the building, including restricted space, the need for additional vision panels to support patient observation and sleep hygiene, and improvements to storage and laundry facilities. Estates related issues were therefore recognised as a constraint to further improvement.

JW advised the Committee that HIW had identified 23 actions across 13 improvement areas, of which 18 actions had already been completed, with the remaining actions in progress and subject to ongoing monitoring. 1 immediate safety issue relating to medication had been addressed at

the time of inspection, with the outdated medication removed promptly.

During discussion, Penny Jones (PJ), Vice Chair, welcomed the largely positive inspection findings and congratulated staff on their performance, particularly given the challenges posed by the ageing environment and the unannounced nature of the inspection. PJ noted that staff morale appeared positive and that patient experience had been described favourably. PJ raised a question regarding the inspection finding relating to night time staffing, where only one registered nurse was routinely on duty, and asked how this concern would be addressed.

JW advised the Committee that staffing models and night time skill mix were being considered as part of wider mental health service reviews and pathway redesign work, and that this issue would continue to be monitored through divisional governance structures.

The Committee **NOTED** the report.

**PQSOC 1702/13**

**Report on recent Health Safety Executive (HSE) intervention at Hafen Deg Ward, including the actions taken and the closure of the investigation**

Peter Carr (PC), Director of Allied Health Professions & Health Science, provided an overview of the Health and Safety Executive (HSE) intervention at Hafen Deg Ward, an older adult mental health inpatient ward at County Hospital, and the actions taken to address the findings.

The Committee was advised that the HSE had undertaken a routine inspection in June 2025, focusing on the management of risks associated with challenging behaviour. The inspection had identified material breaches of health and safety legislation, and a Notification of Contravention was issued to the Health Board in July 2025.

In response, the Health Board had developed a comprehensive improvement action plan, co-produced by the Corporate Health and Safety Team and the Mental Health and Learning Disability Division. PC emphasised that divisional ownership of the action plan had been central to ensuring effective implementation and that the learning from the inspection had been applied beyond Hafen Deg Ward to other older adult mental health units across the Health Board.

PC reported that the HSE had undertaken a follow-up visit in September 2025, during which further

recommendations had been made to strengthen the improvement plan. The key actions taken were summarised under the main themes identified during the inspection.

In relation to absconding risk and environmental security, security checklists had been strengthened to ensure fire escape doors and push bars were fully operational. A new gate and fencing had been installed to ensure that patients exiting via fire escapes remained within a secure external area. Additional environmental risk assessments had been embedded into routine ward safety checks, with particular attention given to climbing risks within the garden area.

Regarding violence and aggression management, the Committee was advised that the number of personal alarms available on the ward had been increased, and routine testing of alarms had been incorporated into the security nurse role to ensure reliability and availability at all times.

PC outlined improvements to observation practice and therapeutic engagement. The mental health observation policy had been revised and ratified in December 2025, with refresher training rolled out across the division. Documentation standards had been improved to ensure observations were recorded at the actual time undertaken, rather than rounded times. Work had also commenced to explore the use of electronic devices to support real time recording and reduce reliance on paper documentation.

In respect of clinical risk documentation, the use of the Wales Applied Risk and Research Network (WARN) risk assessment and associated care and treatment plans had been reviewed. The Audit Management and Tracking system had been used to assess the quality of care plans and environmental standards. As a result of this work, Hafen Deg Ward had achieved bronze accreditation in December 2025, reflecting measurable improvements in quality and safety.

PC advised the Committee on restrictive intervention training, confirming that the curriculum for positive management of violence and aggression had been reviewed to ensure it was appropriate for older adult patients, particularly in relation to frailty. Care plans had been updated accordingly, and training compliance was being monitored through divisional quality and patient safety governance arrangements.

The Committee was advised that, following completion of the improvement actions, the HSE formally wrote to the Health Board on 2nd December 2025, confirming that the identified material breaches had been fully complied with and that the investigation was closed.

During discussion, Penny Jones (PJ), Vice Chair, advised the Committee on the follow up visit undertaken in January 2026, noting that staff reported feeling safer and more supported as a result of the changes implemented. PJ highlighted that minor residual issues, including cleaning of staff facilities, had been identified and were being addressed. The Committee welcomed the positive staff feedback and the improved ward environment and acknowledged the significant work and progress made by the teams.

The Committee **NOTED** the report.

**PQSOC 1702/14**

### **Committee Risk Report**

Rani Dash (RD), Director of Corporate Governance, provided the Committee an overview of the Committee Risk Report, which outlined the current strategic risks delegated to the Patient Quality, Safety and Outcomes Committee for oversight on behalf of the Board. The report confirmed that the risk environment had remained stable since the previous update, apart from a revised risk score for SR005 due to increase likelihood of problems with patient flow.

During discussion, Penny Jones (PJ), Vice Chair, raised a question in relation to the Health and Safety risk, noting that the risk remained rated as high. PJ queried whether the wording and framing of the risk continued to accurately reflect the current position and asked whether the narrative should be revisited in light of ongoing work and recent assurance activity.

RD advised the Committee that the Health and Safety risk had been subject to several discussions at Board level. RD confirmed that, while there had been areas of improvement and strengthened assurance, the Board had previously agreed that the risk should remain rated as high given its breadth, regulatory implications and potential impact. Peter Carr (PC), Director of Allied Health Professions & Health Science, confirmed that although there have been improvements, work was ongoing to improve the engagement of staff with health and safety issues.

	<p>RD clarified that the increased rating for SR 005 relates to an increase in the escalation level for Emergency and Urgent Care.</p> <p>The Chair confirmed that the Committee was assured that the risks delegated to it remained appropriately identified and monitored. It was agreed that, while no change to the risk scores was required at this stage, the wording of the Health and Safety risk should continue to be kept under review to ensure it accurately reflected the evolving assurance position and Board discussions.</p> <p>The Committee <b>NOTED</b> the Committee Risk report.</p>
<p><b>PQSOC 1702/15</b></p>	<p><b>Development of Committee Annual Programme of Business 2026/27</b></p> <p>Rani Dash (RD), Director of Corporate Governance, provided the Committee with an overview of the Committee Forward Work Plan. RD advised that the plan had been developed in line with good governance practice to ensure that the Committee’s statutory responsibilities and core areas of assurance were scheduled across the year. The Programme of Business was intended to support effective agenda planning, enable forward visibility of key items, and ensure alignment with the Committee’s terms of reference.</p> <p>The Committee noted that the Forward Work Plan covered routine assurance reports, thematic deep dives and annual reports required to provide assurance to the Board in respect of patient experience, quality and safety. The Committee discussed the importance of ensuring that the Programme of Business remained sufficiently flexible to accommodate emerging risks, regulatory requirements and matters escalated from other Committees or the Board.</p> <p>During discussion, it was noted that the Pharmacy and Medicines Annual Report should be included within the 2026/27 Forward Work Plan to ensure appropriate Committee oversight of medicines safety and related quality assurance. <b>Action: Committee Secretariat</b></p> <p>The Committee <b>APPROVED</b> the Annual Programme of Business and Forward Work Plan for 2026/27.</p>
<p><b>PQSOC 1702/16</b></p>	<p><b>Review of Committee Programme of Business 2025/26</b></p> <p>Review of Committee Programme of Business 2025/26 was provided to the Committee for information.</p>

<b>PQSOC 1702/17</b>	<p><b>NHS Wales Joint Commissioning Quality Committee Report</b></p> <p>NHS Wales Joint Commissioning Quality Committee Report was provided to the Committee for information.</p>
<b>PQSOC 1702/18</b>	<p><b>Pharmacy and Medicines Annual Report</b></p> <p>Pharmacy and Medicines Annual Report was provided to the Committee for information.</p>
<b>PQSOC 1702/19</b>	<p><b>To confirm any key risks and issues for reporting/escalation to Board and/or other Committees</b></p> <p>The Committee considered which matters from the meeting required escalation or formal notification to the Board and other relevant committees and agreed to escalate the following:</p> <ul style="list-style-type: none"> <li>• The risks associated with the implementation of the Listening to People complaints framework, including the absence of additional funding, potential capacity constraints and the impact on compliance and delivery.</li> <li>• Ongoing Health and Safety risk considerations, to ensure continued Board-level oversight of regulatory and workforce safety issues.</li> </ul>
<b>PQSOC 1702/20</b>	<p><b>Any Other Urgent Business</b></p> <p>There was no urgent business.</p>
<b>PQSOC 1702/21</b>	<p><b>Date of the Next Meeting:</b></p> <p>8<sup>th</sup> April 2026</p>

<b>DYDDIAD Y CYFARFOD:</b>	06 May 2026
<b>CYFARFOD O: MEETING OF:</b>	Patient Quality, Safety and Outcomes Committee
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Update on the development of an analytics platform (Qlik) for Quality and Patient Safety data
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Jennifer Winslade – Executive Director of Nursing
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Kye Smith – Deputy Head of QPS Leeanne Lewis – Assistant Director of QPS Tracey Partridge-Wilson – Deputy Director of Nursing

**Pwrpas yr Adroddiad** (dewiswch fel yn addas)

**Purpose of the Report** (select as appropriate)

Ar Gyfer Trafodaeth/For Discussion

## **ADRODDIAD SCAA SBAR REPORT**

### **Sefyllfa / Situation**

As part of implementation of the Quality Strategy and development of the Quality Outcomes Framework, PQSOC have been explicitly sighted on the intention to use dashboards to improve consistency, reduce duplication, strengthen triangulation and enable more meaningful assurance discussions focused on variation, learning and improvement rather than static data tables.

This paper outlines the current status of implementing an analytics platform (Qlik) to visualise Quality and Patient Safety data. It will explain how it can support consistent, accurate reporting across the Executive Quality Performance Report and the Integrated Performance Report (IPR), Quality Outcomes Framework, and how it strengthens the organisation's ability to understand trends, variation, and areas requiring improvement.

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With the development of the Qlik Sense, most RLDatix data is now accessible directly within Qlik, alongside other key datasets. This creates, for the first time, a single environment where quality, safety, and performance information can be analysed together.

## **Asesiad / Assessment**

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### **Background and Current Position**

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### **Challenges and Risks without an Integrated Analytics Platform**

Without a robust analytical platform, the Health Board was reliant on individuals extracting data (often at different times or apply different definitions), this causes conflicting data, undermining confidence and making it harder for committees to assess the level of assurance provided. The ability to interpret that data to gain statistically significant insight required time, experience and manual analysis.

### **Development of the Qlik Sense Analytics**

As part of the implementation of the Quality Strategy and the annual review of the Quality Outcomes Framework (QOF), the previously labour-intensive approach to producing the QOF highlighted the need to work collaboratively to automate QOF indicators

In November 2024 the Executive Director of Nursing commissioned Informatics Services (now Digital, Data and Technology) to develop a digital dashboard for the Quality Outcomes Framework metrics. Whilst intended to provide corporate oversight of quality metrics an ancillary benefit has been realised that allows enhanced local monitoring.

At the corporate level all reports can now draw from the same data model. This will ensure that figures presented to the Executive Team, Patient Quality, Safety and Outcomes Committee, Quality Management Group and Board are aligned and reliable. With most RL Datix complaints and incident data now available in Qlik, the organisation can:

- Analyse safety and quality issues;
- Identify patterns that would not be visible in isolated systems.
- Strengthen learning from concerns and support targeted improvement work.

Qlik allows users to explore data over time (using trend analysis, SPC Charts and forecasting), across services, and by key characteristics. This supports more informed interpretation and helps distinguish normal fluctuations from areas requiring action.

### **Alignment with Strategic Priorities**

The development and use of the Qlik Sense app is closely aligned with national and local priorities for quality, safety, and performance in Wales.

It supports ministerial priorities for quality and patient safety, including a stronger focus on preventing avoidable harm, improving learning from incidents and complaints, reducing unwarranted variation, and improving patient experience. By making RL Datix data available within Qlik alongside operational and performance information, the organisation is better able to identify patterns, understand the causes of harm, and track the impact of improvement actions over time.

The approach is consistent with the Health and Social Care (Quality and Engagement) (Wales) Act 2020, including the Duty of Quality and the Duty of Candour. A single, transparent data environment strengthens the organisation's ability to demonstrate that it is systematically monitoring quality, acting on concerns, and learning from things that go wrong. It also supports more open and honest reporting to patients, the public, and partners.

The Qlik app underpins delivery of the NHS Wales Quality Framework and national planning expectations, which emphasise:

- A whole-system view of quality, bringing together safety, effectiveness, and patient experience.
- Use of high-quality data and intelligence to inform decision-making and prioritisation.
- Reduction of health inequalities and unwarranted variation through better understanding of outcomes across different groups and areas.
- Stronger assurance and governance, with clear, consistent information for Boards and Committees.

By providing a single, reliable source of data the Qlik app directly supports these aims. It enables clearer sight of trends, variation, and risk, focuses on improvement and more meaningful assurance.

## Benefits Realisation and Adoption

The introduction of Qlik Sense will enhance the organisation's ability to monitor quality, safety, experience and performance through consistent, reliable, and timely data. Key benefits include:

- Better insight and earlier detection of risk: A single, validated data model enables clearer identification of trends, variation, and harm.
- Reduced manual reporting: Automated data flows and aligned definitions decrease duplication and increase efficiency.
- Greater assurance to committees and the Board: Consistent information across QMG, PQSOC, Executive Team and Board improve confidence in decision making.
- Improved adoption and capability: Targeted training will support staff to understand and use dashboards effectively.
- Ongoing refinement: User feedback will shape continuous improvements to dashboards as priorities evolve.

## Next Steps

The next phase of development focuses on expanding the Qlik Sense app to incorporate a broader range of quality and safety data sources.

Work is underway to map the remaining RL Datix modules into Qlik, including the Duty of Candour module. Integrating this information will allow real-time tracking of cases, clearer oversight of statutory timelines, and improved visibility of organisational learning. Bringing these modules into the same analytical environment as incidents and complaints will create a more complete picture of patient safety activity.

Work is underway incorporate the Audit Management and Tracking (AMaT) web-based system into the Qlik app. This provides essential information on clinical audit, quality improvement activity, and compliance with standards. Mapping AMaT data into Qlik will allow audit findings to be viewed alongside incidents, complaints, and performance data. This will help identify where audit results reinforce themes emerging from other sources and where targeted improvement work is required.

The Welsh Nursing Care Record contains rich information about patient assessments, care planning, and nursing documentation. Incorporating WNCR data into Qlik will support a more detailed understanding of care quality at ward and service level. It will also enable triangulation between nursing documentation, patient experience, and safety events, strengthening assurance and supporting earlier identification of concerns.

The long-term ambition is to create a single, integrated intelligence environment where multiple quality, safety, and performance datasets can be viewed together. This will allow the organisation to:

- Triangulate information from different sources to identify early signs of concern that may not be visible within any single dataset.
- Generate more meaningful insight, enabling deeper understanding of the factors that influence quality and safety.
- Support earlier intervention, as patterns and risks can be detected sooner and acted upon more effectively.
- Strengthen organisational learning, by linking incidents, complaints, audit findings, and care records to understand the full context of quality issues.
- Provide clearer assurance, with consistent, transparent information for the Executive Team, Quality Committee, and Board.
- Drive targeted improvement, as services will have access to richer, more connected data to inform their actions.

This integrated approach reflects modern expectations for quality governance and aligns with national priorities for improving patient safety, reducing unwarranted variation, and strengthening the use of data and intelligence across NHS Wales.

## Conclusion

The programme of work to transition the Quality Outcomes Framework from manual compilation to automated, dashboard driven- reporting, delivered in partnership with Digital, Data and Technology, has been successfully completed.

The development of the Qlik Sense app marks a significant step forward in strengthening the organisation's approach to quality, safety, experience and performance.

With most RL Datix data now available within Qlik, the organisation has, for the first time, a single, consistent, and reliable environment in which complaints, incidents, patient safety events, and operational information can be viewed together. This directly addresses long-standing risks associated with fragmented reporting, manual data handling, and limited analytical capability, all of which have historically constrained the organisation's ability to understand variation, identify early signs of concern, and provide meaningful assurance.

The planned integration of additional systems—including the remaining RL Datix modules such as Duty of Candour, AMaT, and the Welsh Nursing Care Record—will further enhance this capability. Over time, these developments will create a unified intelligence system that can triangulate information from multiple sources, generate deeper insight, and support earlier, more targeted action. This aligns strongly with national expectations for quality and patient safety in Wales, including ministerial priorities, the Duty of Quality and Duty of Candour, and the wider NHS Wales Quality Framework.

By adopting Qlik as the central platform for quality and performance reporting, the organisation is laying the foundations for a more transparent, learning-focused, and data-driven culture. This will not only improve the clarity and consistency of reporting to the Executive Team, Quality Committee, and Board, but will also strengthen the organisation's ability to drive improvement, reduce harm, and deliver better outcomes for patients and communities.

## **Argymhelliad / Recommendation**

The Patient, Quality Safety and Outcomes Committee is asked to: -

- **NOTE** the current progress in implementing the Qlik analytics platform and support its continued development to enhance the visualisation and oversight of Quality and Patient Safety data across the organisation.

<b>Amcanion: (rhaid cwblhau)</b> <b>Objectives: (must be completed)</b>	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
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  <a href="#">Link to IMTP</a>	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  <a href="#">Strategic Equality Objectives 2020-24</a>	Choose an item. Choose an item. Choose an item. Choose an item.

<b>Gwybodaeth Ychwanegol:</b> <b>Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	NA
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	NA

<b>Effaith: (rhaid cwblhau)</b> <b>Impact: (must be completed)</b>	
<b>Resource Assessment:</b>	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:
• <b>Workforce</b>	Choose an item.

<ul style="list-style-type: none"> <li>• <b>Service Activity &amp; Performance</b></li> </ul>	<p>Choose an item.</p>
<ul style="list-style-type: none"> <li>• <b>Financial</b></li> </ul>	<p>Choose an item.</p>
<p><b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b></p>	<p>Choose an item.</p> <p>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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a></p>
<p><b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b></p> <p><a href="https://futuregenerations.wales/about-us/future-generations-act/">https://futuregenerations.wales/about-us/future-generations-act/</a></p>	<p>Choose an item.</p> <p>Choose an item.</p>



Bwrdd Iechyd Prifysgol  
Aneurin Bevan  
University Health Board

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

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	06 May 2026
<b>CYFARFOD O: MEETING OF:</b>	Patient Quality, Safety and Outcomes Committee
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Learning from Deaths Report
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Dr Seema Srivastava, Executive Medical Director
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Leeanne Lewis, Assistant Director for Quality & Patient Safety

<b>Pwrpas yr Adroddiad (dewiswch fel yn addas) Purpose of the Report (select as appropriate)</b>
Er Sicrwydd/For Assurance

**ADRODDIAD SCAA  
SBAR REPORT**

**Sefyllfa / Situation**

This paper provides the biannual Learning from Deaths update for April–September 2025 and offers Board-level assurance on mortality outcomes, learning and improvement across Aneurin Bevan University Health Board.

The report consolidates Health Board, Divisional and Directorate-level mortality intelligence, triangulated with Medical Examiner scrutiny, Mortality & Morbidity reviews, complaints, inquests and national benchmarking, to determine whether observed mortality indicators reflect avoidable harm, emerging clinical risk or system-level issues.

**Cefndir / Background**

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.

The Learning from Deaths Framework underpins a structured ward-to-board assurance process, ensuring that deaths are systematically reviewed, learning is identified and actions are tracked through established governance routes.

Mortality intelligence is reviewed through the Quality Management Group (QMG) and escalated to the Patient Quality, Safety and Outcomes Committee (PQSOC) on a six-monthly basis, supporting sustained executive oversight, transparency and regulatory assurance.

### **Asesiad / Assessment**

A learning from death report has been produced for the period March – September 2025. Overall, the report provides strong assurance that mortality outcomes are stable or improving and that identified mortality signals are predominantly explained by case-mix, frailty, palliative complexity, data attribution and system pressures, rather than deficiencies in care or unsafe clinical practice.

At Health Board level, the Risk Adjusted Mortality Index (RAMI 2019) improved to 88.4, representing a significant improvement from the previous reporting period and positioned the Health Board as the third best performing in Wales within its peer group. Crude mortality and deaths per 1,000 occupied bed days demonstrate a sustained downward trend, with seasonal variation consistent with historical patterns. While rebasing to RAMI 2023 increases the headline score (99.4), performance remains better than Welsh peer averages. Data quality remains a known constraint, with approximately 9% of finished consultant episodes uncoded; however, a targeted clinical coding improvement programme is in place to strengthen confidence in mortality interpretation.

Divisional and Directorate-level indicators demonstrate no mortality concerns requiring escalation. Key indicators, including ED admitted mortality, stroke, myocardial infarction, and elective and non-elective surgery mortality, continue to perform better than or in line with peer benchmarks.

To provide assurance at a case-level, a comprehensive programme of targeted mortality reviews and surveillance deep dives was undertaken during this reporting period. A total of 270 structured case-note reviews were completed across Anaesthetics/ITU (45 cases), Gastroenterology (73 cases plus 9 endoscopy cases), and Respiratory Medicine (144 cases). Reviews assessed preventability, quality of

care, escalation and deterioration, advance care planning, documentation, and data attribution.

The overwhelming majority of cases demonstrated good standards of care, with very limited evidence of preventability. Only 7 cases (2.6%) across all reviews showed slight evidence of preventability, and no cases identified unsafe practice or deficiencies judged to have directly altered the outcome of death. Where learning was identified, this was predominantly organisational and system-based, including capacity and flow pressures, ambulance delays, escalation processes, communication, and variation in clinical coding and consultant attribution.

In addition, a one-off consultant-level mortality surveillance exercise, undertaken jointly with Public Health, reviewed 77 anonymised cases for clinicians flagged as potential mortality outliers. This review found no evidence of unsafe or negligent practice, no concerns regarding professional competence, and no patterns of poor clinical decision-making. Apparent outliers were explained by coding inaccuracies (including significant misattribution), case-mix, end-of-life care and team-based models of care, providing strong assurance that individual-level mortality signals did not reflect quality concerns.

Medical Examiner intelligence provides a further layer of independent assurance, with consistent themes relating to delays, communication, discharge processes and DNACPR documentation. Improvements in Datix closure rates and appropriate escalation through governance routes demonstrate increasing maturity of the mortality learning system.

Taken together, the depth, breadth and triangulation of case-level review provide strong assurance that observed mortality variation does not conceal unrecognised clinical risk, and that learning is being appropriately identified and addressed through system-focused governance processes rather than individual performance management.

### **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.

- Continued focus on system learning, particularly in relation to deterioration recognition, discharge quality, communication with families, DNACPR practice and clinical coding accuracy.
- Progress the next phase of development, including:
  - Strengthening Divisional mortality governance and escalation from M&M reviews
  - Accelerating digital integration (CHKS and mortality dashboards) to reduce manual triangulation and improve timeliness of assurance

- 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.
- Receive the next Learning from Deaths report, incorporating full-year trend analysis and the updated RAMI 2023 narrative.

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 ASSURANCE** provided by the Learning from Deaths report that mortality outcomes for April–September 2025 do not indicate unrecognised clinical risk or unsafe care.

<b>Amcanion: (rhaid cwblhau) Objectives: (must be completed)</b>	
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  <a href="#">Link to IMTP</a>	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  <a href="#">Strategic Equality Objectives 2020-24</a>	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.

<b>Gwybodaeth Ychwanegol: Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termiau: 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)**

<b>Impact: (must be completed)</b>	
	<b>Is EIA Required and included with this paper</b>
<b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b>	<p>Choose an item.</p> <p>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 <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a></p>
<b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b>  <a href="https://futuregenerations.wales/about-us/future-generations-act/">https://futuregenerations.wales/about-us/future-generations-act/</a>	<p>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</p> <p>Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives</p>



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Aneurin Bevan  
Aneurin Bevan  
University Health Board

# Learning from Deaths Report

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MORTALITY DATA AND NARRATIVE REPORT  
April 2025 – September 2025

# Introduction

## **Learning from Deaths Report:**

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, enabling a comprehensive and systematic view of mortality trends and associated learning.

## **Framework Implementation and Assurance**

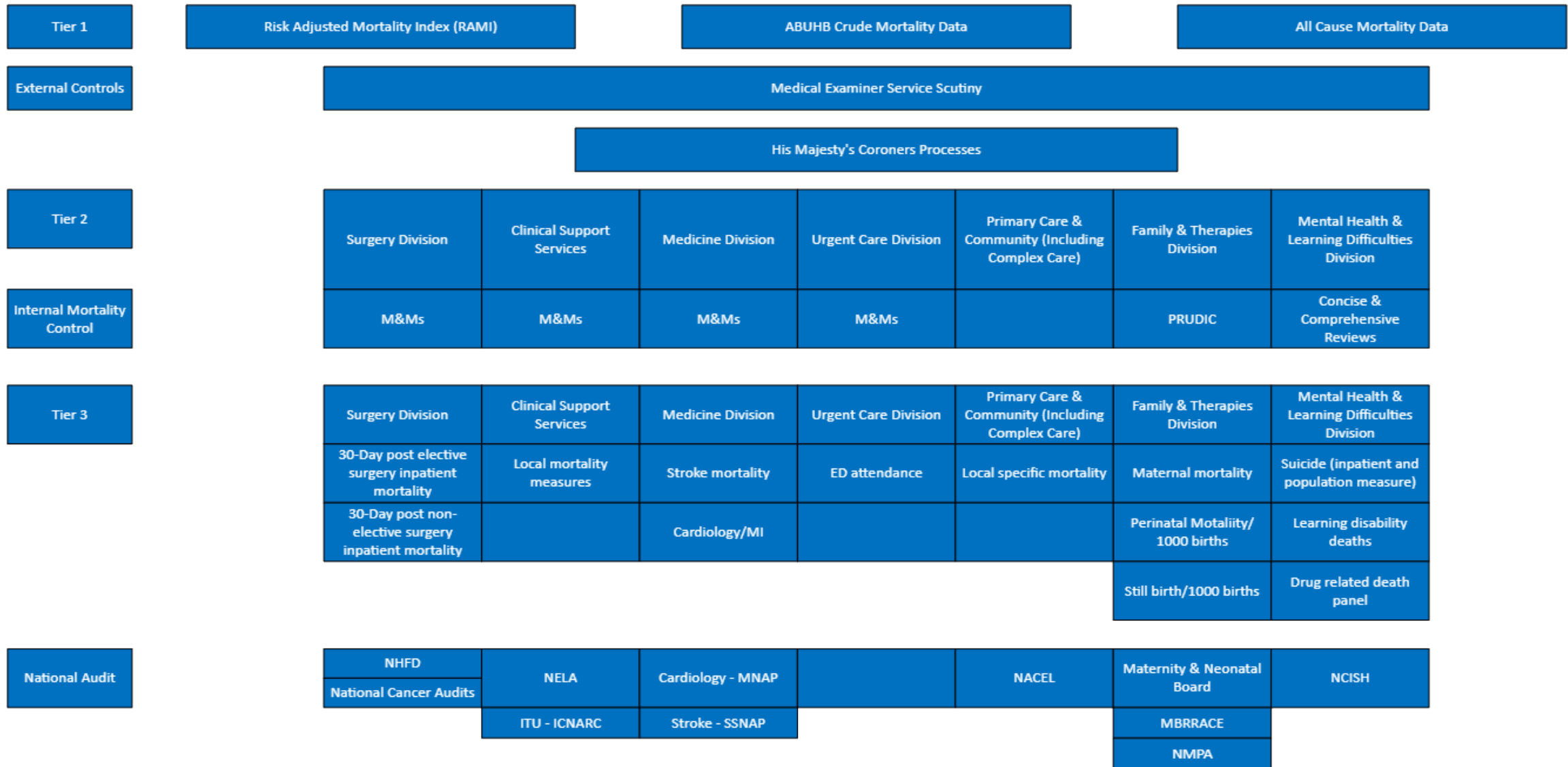
Since the previous reporting period (July 2024 – March 2025), the Learning from Deaths Framework has been disseminated across all Divisions to support consistent engagement in the review of patient deaths. The framework underpins a robust ward-to-board assurance process, enabling structured reporting and executive oversight of mortality data.

The framework supports triangulation of condition-specific mortality trends with insights from the Medical Examiner system, ensuring that learning is evidence-based and aligned with governance and regulatory expectations. This approach strengthens organisational oversight and supports a consistent methodology for identifying and responding to potential areas of concern.

## **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 subsequently to the Patient Quality, Safety and Outcomes Committee (PQSOC) on a six-monthly basis, ensuring sustained executive oversight, transparency, and accountability for actions arising from learning.

# Aneurin Bevan University Health Board Mortality Framework



# Introduction

## **Structured Mortality Reviews**

- The mortality framework reinforces the Health Board's commitment to undertaking structured mortality reviews. These reviews are critical in identifying problems in care, extracting learning, and implementing targeted improvements. This structured approach ensures that learning is not only identified but is translated into measurable actions that enhance patient safety and quality of care.
- This report also demonstrates a surveillance exercise undertaken collaboratively with Public Health, involving clinician-led review of deaths. This exercise confirms that a robust and reproducible methodology exists to support more detailed review where required. It has been agreed that, for the purposes of this reporting period, this one-off deep-dive exercise provides sufficient assurance, as detailed in the accompanying report.
- At present, detailed mortality reviews are primarily undertaken by the corporate team. Due to current coding and data maturity limitations, it is essential that mortality indicators are sufficiently robust before extending detailed case-note reviews across additional clinical specialties. There remains an expectation that mortality review forms part of the Health Board's end-to-end governance processes, including morbidity and mortality review arrangements within clinical services.
- The Health Board continues to work closely with its external software provider (CHKS) to improve understanding of mortality outliers and to strengthen the triggers for deep-dive review. This partnership aims to enhance the timeliness, accuracy, and reliability of mortality intelligence, further strengthening assurance and supporting more targeted review where required.

# Mortality Outliers Review- Surveillance Exercise with Public Health

- This review was undertaken as a one-off surveillance exercise to examine consultant-level mortality and assess whether there was unwarranted variation in outcomes between individual consultants.
- This report provides assurance on consultant-level mortality outliers identified by Public Health Intelligence at Aneurin Bevan University Health Board and sets out actions to strengthen mortality surveillance and governance.
- A structured, case-based review was undertaken by the Medical Director's Quality and Patient Safety (QPS) team for three anonymised clinicians flagged as potential outliers. The review assessed attribution accuracy, preventability of death, quality of care, and triangulated findings with Datix incidents and Medical Examiner (ME) referrals.

## Key Findings

- Total number of notes reviewed was 77 patients. There is no evidence in this review of unsafe practice by any of the clinicians (0%). There were no patterns of unsafe clinical decision-making, no evidence of negligent care and no concerns about professional competence.
- The vast majority of deaths were not preventable, occurring in patients with advanced illness, frailty, or palliative intent.
- Quality of care was consistently rated as good, with only minor organisational issues identified (e.g. communication or transfer delays), none of which altered clinical outcomes.
- Coding and attribution errors were identified, most notably for one clinician where 65% of deaths were incorrectly attributed, materially inflating apparent mortality rates.
- The mortality outlier signals are explained by coding errors, case mix, end of life care, and organisational factors, not by standard of unsafe care, including:
  - Team-based models of care (particularly in acute medicine)
  - Care of the Elderly services incorporating inpatient palliative care beds
  - Potential misclassification of specialty attribution within mortality datasets
- The case-mix reviewed demonstrated that greatest value is gained from focused learning, particularly through detailed review of unexpected deaths, and structured deep dives and case note reviews, rather than routine aggregation of consultant-level mortality data.

# Mortality Outliers Review- Surveillance Exercise with Public Health

## **Assurance from Datix and Medical Examiner Review**

- Triangulation with Datix incident reports, complaints, claims, and ME referrals identified no patterns of concern linked to individual clinician practice. Issues identified were either unrelated to general medical care or had been appropriately managed through existing governance processes.

## **Key Risks Identified**

- Inaccurate consultant and specialty coding risks misleading mortality signals and inappropriate escalation.
- Individual-level mortality metrics may be misaligned with team-based models of care, particularly in acute and palliative settings.

## **Overall Conclusion**

- The review provides strong assurance that the identified mortality outliers reflect systemic and data-related factors, rather than individual performance or unsafe care. Current mortality signals must therefore be interpreted with caution, particularly in services with shared care models and high palliative case-mix.

## **Recommendations**

- The Health Board now has a robust and tested method of assurance for the surveillance of deaths should this type of review be required again. However, it is not considered proportionate or necessary for this to be undertaken as a routine annual exercise.
- To strengthen ongoing assurance and learning, as part of the Learning from Death report, the Health Board will ensure:
  - Targeted mortality outlier reviews, where specific concerns or signals arise, rather than as a standing annual process.
  - Continued linkage with the Coding improvement programme, to strengthen coding accuracy and specialty attribution, ensuring mortality data is interpreted fairly and appropriately.
  - Maintaining focus on existing Learning from Deaths, mortality reviews and governance processes, which provide more meaningful insight into quality of care and opportunities for improvement.

# Learning from Deaths – Focused Mortality Reviews

- The focus of this Learning from Death's report cycle has been to undertake detailed specialty-level deep dives into mortality indicators, rather than high-level thematic reviews. This approach was designed to: interrogate crude mortality data in greater depth, identify learning, variation, and emerging trends, assess whether there are any systemic or underlying quality concerns and provide assurance to the Board and Committees regarding standards of care.
- A total of 270 Deep dives (case notes reviews) were undertaken across Anaesthetics (44 cases) Gastroenterology (73 cases) (including Endoscopy (9 cases)), and Respiratory Medicine (144 cases), covering high-volume and high-mortality cohorts.
- The Medical Director's Quality and Patient Safety team, conducted case-level reviews against mortality indicators that were high. Themes for the notes reviews included: assessing preventability, recurrent clinical or organisational themes, data quality and coding accuracy, consistency in escalation, advance care planning, and documentation and considered the impact of coding and consultant attribution on mortality interpretation to avoid misleading conclusions

## Key Findings and Learning

- The overwhelming majority of deaths demonstrated good standards of care.
- Only 7 cases (2.6%) showed slight evidence of preventability.
- Significant variation in coding and consultant attribution, particularly for ITU patients, was identified as a key factor influencing crude mortality and limiting comparability across organisations.
- Learning identified was predominantly organisational and system-based, including: Bed capacity and patient flow, Ambulance delays, Communication and continuity of care and inconsistent completion of Treatment Escalation Plans and discharge summaries

# Learning from Deaths – Focused Mortality Reviews – Learning and Findings

## SYSTEM-BASED ISSUES IDENTIFIED

### 1. Coding & Data Integrity

Examples include: incorrect specialty coding, inconsistent attribution of patients to: ITU consultant vs parent specialty, Surgeon vs intensivist. Cause of death coding mismatches. CWS was not updated with: correct consultant or correct ward movements. *System impact:* Affects comparability across Wales, inflates or distorts crude mortality and undermines benchmarking and assurance.

### 2. Escalation & Deterioration Systems

NEWS not consistently acted upon. Escalation pathways unclear or inconsistently followed. Decisions taken without clear clinical ownership (e.g. transfer decisions). *System impact:* Failure of early warning systems as a safety net, Reliance on individual vigilance rather than reliable processes

### 3. Interface Failures Between Services

Ambulance delays (8-hour waits), ED → ward → ITU transitions with delays, Inter-hospital transfers with high NEWS, Lack of clarity at handovers between Acute Med / Resp / ITU / COTE. *System impact:* Delays outside the control of individual teams and risk accumulates across interfaces

### 4. End-to-End Pathway Design Gaps

Rare but foreseeable risks (e.g. NJ feeding → bowel ischaemia), risks not embedded in consent processes, post-procedure responsibility unclear (endo vs surgery). *System impact:* Pathways not fully designed around whole-journey risk, learning opportunity rather than unsafe practice.

### 5. Treatment Availability / Process Reliability

Oramorph not available when needed, delays to antivirals (acyclovir) where part of differential diagnosis, no structured prompt when key treatments delayed. *System impact:* Process reliability issue rather than individual error

# Learning from Deaths – Focused Mortality Reviews - Learning and Findings

## ORGANISATIONAL ISSUES IDENTIFIED

### 1. Capacity & Flow

ITU admissions delayed due to lack of high-care beds, patients cared for in the “wrong” hospital, delays in transfer between sites, late or inappropriate moves (e.g. off oxygen → discharge → readmission). *Organisational impact:* Directly affects timeliness and continuity of care.

### 2. Communication & Family Liaison

NOK not informed promptly of death, families not informed of transfers, inconsistent communication standards. *Organisational impact:* Impacts patient and family experience and duty of candour risk.

### 3. Consultant & Team Ownership

Lack of consistent consultant assignment, patients reviewed by multiple teams with no clear lead, decision-making by managers rather than clinicians in isolated cases. *Organisational impact:* diluted accountability and increased risk during deterioration.

### 4. Clinical Documentation & Governance

Discharge summaries frequently not completed. TEPS: Not completed, Completed late, Particularly poor in frail / terminal patients. Variation by consultant and site (notably better in NHH). *Organisational impact:* Missed opportunities for: Anticipatory care, Avoiding inappropriate CPR and Learning from deaths.

### 5. Workforce & Operational Pressures

Nurse staffing concerns, Oxygen supply issues, Delayed medical reviews in ED. *Organisational impact:* Reduces resilience of services under pressure

# Learning from Deaths – Focused Mortality Reviews

Based on the depth and breadth of the reviews undertaken:

- There is no evidence of widespread or systemic quality failures underpinning the identified mortality indicators.
- No concerning trends or patterns were identified that suggest unrecognised clinical risk or unsafe care.
- Mortality variation is more strongly associated with:
  - Case-mix and frailty
  - Organisational pressures
  - Data quality and attribution practices
- The deep-dive approach provides strong assurance that current mortality indicators do not mask underlying quality issues.
- Learning will be feedback to teams.

## Conclusion

- This cycle of Learning from Deaths demonstrates a mature, assurance-focused approach, moving beyond counting deaths to understanding why patients die, where learning can be applied, and where improvement efforts should be targeted. The findings support continued focus on system improvement, data quality, and advance care planning, rather than individual performance concerns.

# Areas to highlight

## **Tier 1: Health Board-Level Mortality Data and Assurance**

- This report still presents mortality data across the Health Board.
- Tier one provides assurance at the Health Board level, highlighting performance, trends, and actions taken to strengthen mortality surveillance and learning.
- For the period April 2025 to September 2025, the Health Board's Risk Adjusted Mortality Index (RAMI) 2019 stands at 88.4, showing a positive improvement from 100.3 from the previous Learning from Death report. This positions the Health Board as the 3<sup>rd</sup> 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 April and September 2024, 9.3% of consultant episodes remained with an uncoded Primary diagnoses, 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 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 0.8%, down from 2.6% last year, indicating improved clinical outcomes and timely interventions.
- **30-Day Inpatient Mortality – Stroke:** Currently at 7.2%, a slight improvement from 8.%. This remains lower than the All-Wales peer value of 11.7%, reaffirming the Health Board's position as the lowest in Wales for this indicator.
- **Elective Surgery Mortality (within 30 days):** Currently a rate of 0.01%, compared to 0.0%. There have been 2 recorded deaths for this reporting period.
- **Non-Elective Surgery Mortality (within 30 days):** Improved to 1.1%, down from 1.2% last year, and remains below the All-Wales peer value of 1.5%, 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 – Medical Examiner Reviews

- The Medical Examiner (ME) Service provides independent scrutiny of all deaths not referred to the Coroner, offering a critical layer of external assurance for Aneurin Bevan University Health Board. Medical Examiners are employed by NHS Wales Shared Services Partnership and are independent.
- This structural separation ensures independence from local clinical teams and reduces the risk of bias in the scrutiny of deaths. Each death is reviewed to:
  - Confirm the accuracy of the medical cause of death
  - Assess the circumstances surrounding the death
  - Identify any potential concerns about care or treatment
  - Capture and consider the views and concerns of bereaved families
  - This independent review functions as an external check on the quality and safety of care provided.
- Since full implementation in 2024, including community deaths, all deaths now undergo initial Level 1 screening, ensuring no case is excluded from review. While only a proportion of cases progress to panel or formal investigation, every referral is reviewed to determine the appropriate pathway and avoid duplication.
- Where concerns are identified, cases are proportionately escalated through structured governance routes, including Mortality Review Panels, Serious Incident processes, and specialty reviews. Analysis of ME referrals shows that the majority of deaths reflect good standards of care, with learning largely focused on system and organisational issues rather than unsafe clinical practice.
- Overall, the ME process provides strong assurance that all deaths are independently scrutinised, family concerns are heard, and any identified risks or learning are appropriately managed through robust governance arrangements.

# Areas to highlight – Medical Examiner Reviews

Analysis of ME referrals demonstrates that:

- The majority of cases show good standards of care, with very limited evidence of preventability
- Common themes relate primarily to system and organisational issues (e.g. delays, communication, discharge processes, DNACPR documentation), rather than unsafe clinical practice
- Where concerns are identified, they are appropriately routed into governance processes and tracked through to resolution [Positive feedback from bereaved families is also routinely captured, providing additional assurance around compassion, dignity, and quality of care at end of life.

Taken together, the Medical Examiner process provides strong assurance that all deaths within ABUHB are independently scrutinised, family concerns are heard, and any potential issues are identified and managed through established governance arrangements. The combination of universal ME review, proportionate escalation, triangulation with Datix, complaints, audits and mortality deep dives demonstrates a mature, transparent, and independent system of mortality assurance, supporting both patient safety and organisational learning

# Progress update

Action from previous report	Progress
Work with Directorates to establish mortality indicators	Work with Clinical Directors to strengthen end to end governance processes for mortality review. The Medical Director's team is reviewing directorate- specific mortality indicators to improve insight to intelligence, supporting meaningful learning from death. These indicators will be used to inform directorate-level review and targeted deep dives with further indicators developed as data quality and feasibility allow.
Increase engagement with clinicians regarding mortality processes	Deliver a structured mortality learning programme in 2026/27, led jointly with the Medical Director, to strengthen clinical engagement in mortality deep dives, case note reviews and M&M processes. This programme will focus on clarifying clinical roles and expectations, improving the consistency and quality of directorate-level mortality review, and strengthening clinical ownership of learning from deaths. Outputs will provide improved, evidence-based assurance through Directorate governance routes and onward escalation to corporate committees as part of the Learning from Deaths reporting framework.
Develop governance route for Mortality Review and assurance	The Quality Management Group (QMG) is now fully established and can provide regular oversight and scrutiny of mortality data, deep dives, and learning. This delivers the assurance function originally instead of a Mortality Review Committee, with clearer executive oversight and escalation routes.
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 strengthened divisional governance, particularly for unexpected deaths. Mapping and validation of M&M meeting coverage is underway, providing increasing assurance that mortality learning is reviewed locally and escalated appropriately where needed.
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	A structured, condition-specific deep-dive review process has been implemented and applied during this reporting period (e.g. Anaesthetics/ITU, Gastroenterology, Respiratory Medicine). This has enabled case-level scrutiny, triangulation with ME referrals and Datix, and clearer identification of system-level learning.

Establish the mortality outlier model in CHKS to create alerts

The CHKS mortality alerts module is now live and actively used to support surveillance and targeted review. While currently reliant on manual extraction, work is progressing with CHKS.

# Areas of development

## 1. Governance and Assurance Framework

- The mortality governance framework is in place but not yet fully embedded or standardised across Divisions.
- Assurance from M&M reviews is not consistently escalated, tracked, or monitored at Divisional and Board level.

Next steps - Finalise and embed the structured mortality governance framework. Agree a standard escalation and assurance route from M&M reviews into Divisional QPS meetings and QMG. Ensure actions arising from mortality reviews are tracked, monitored and closed, not just identified by Q1 2026/27.

## 2. Divisional Ownership and Reporting

- Divisional-level mortality reporting is developing, but variation remains in consistency, depth and learning.
- Local ownership of trends and learning needs to be strengthened.

Next steps - Next steps (Q1–Q2 2026/27): Establish routine Divisional mortality reporting through Divisional QPS meetings, with agreed standards for reporting trends, learning and actions. Embed consistent review and escalation processes, ensuring Divisions demonstrate learning and action taken, with clear and timely feedback loops to the centre to support corporate oversight and assurance.

## 3. Directorate Ownership

- Develop directorate- specific mortality to improve insight to intelligence, supporting meaningful learning from death.
- Use indicators to inform directorate-level review and targeted deep dives

Next steps: Establish and deliver a structured mortality learning programme with the Medical Director to strengthen clinical engagement in mortality deep dives, case note reviews and M&M discussions. The programme will clarify expectations for directorate-level mortality review and improve the quality and consistency of assurance through Directorate and corporate governance routes into Q3 and Q4 2026/27.

## 4. Targeted Reviews and Thematic Learning

- Condition/procedure-specific mortality reviews are not yet triggered consistently when indicators fall outside expected parameters.
- Learning from deep dives is not always systematically fed into assurance reporting.

Next steps - Finalise and implement a formal trigger process for condition/procedure-specific mortality reviews. Use learning from deep dives process and consider how thematic findings are continued in the next reporting cycle to demonstrate learning and impact. Target Q3 2026/27.

# Areas of development

## 5. Digital Integration and Data Maturity

- Delays in CHKS development and poor system interoperability limit triangulation between mortality data, Medical Examiner reviews, M&M outcomes and inquest findings.
- Heavy reliance on manual data trawling undermines timeliness and consistency of assurance.

Next steps - Accelerate development of the mortality dashboard to reduce manual processes. Improve interoperability between CHKS, ME reviews and clinical systems to support automated triangulation and thematic analysis.

## 6. Clinical Coding Quality

- Variability in coding depth and accuracy limits confidence in RAMI and mortality interpretation.
- Resource constraints affect coding review in high-risk specialties.

Next steps - Continue the clinical coding improvement programme, focusing on depth and accuracy.

## 7. Embedding Learning and Culture Change

- Mortality learning is not yet consistently disseminated or embedded across the organisation.
- Opportunities exist to strengthen learning culture beyond formal reports.

Next steps - Strengthen learning dissemination via mortality newsletters, audit cycles and Divisional QPS meetings. Ensure mortality learning is visible, shared and linked to improvement activity.

## 8. Equity, Inclusion and Bereavement

- Further work is needed to ensure equitable access to end-of-life and bereavement care, particularly for under-represented groups.

Next steps Strengthen links with bereavement and EoL programmes to address inequity. Continue engagement with community stakeholders (e.g. faith leaders) to ensure culturally appropriate bereavement support.

# Conclusion

- This Learning from Deaths report provides clear and credible assurance that the Health Board continues to review deaths in a structured, proportionate and meaningful way, with a strong focus on learning and improvement rather than counting deaths alone.
- With a surveillance deep dive in partnership with Public Health and a focus on Tier Three reviews, the vast majority of deaths demonstrated good standards of care, with very limited evidence of preventability and no findings to suggest systemic quality failures or unsafe practice. Where opportunities for improvement were identified, these were predominantly organisational and system-based, including escalation, communication, advance care planning, discharge processes and wider operational pressures. Importantly, no issues were identified that were judged to have directly altered the outcome of death.
- The targeted deep-dive approach undertaken during this reporting period provides strong assurance that observed mortality indicators do not conceal unrecognised clinical risk. Variation in mortality is more strongly associated with case-mix, frailty, palliative complexity, data quality and specialty attribution practices than with deficiencies in care. This reinforces the importance of careful interpretation of crude and risk-adjusted mortality measures, supported by structured case note review and clinical judgement.
- The continued expansion of the Medical Examiner Service strengthens independent scrutiny, transparency and triangulation with M&M reviews, Datix, complaints and inquests. While increasing referral volumes reflect improved awareness and vigilance, they also highlight the need to address capacity, digital interoperability and sustainability to support timely and consistent assurance.
- Overall, this reporting cycle demonstrates a maturing mortality assurance framework, with improving governance, clinical engagement and analytical capability. The Health Board is appropriately focused on system improvement, data quality and learning, rather than individual performance, providing robust assurance to the Board and Committees that deaths are reviewed, learning is identified, and improvement actions are being progressed.

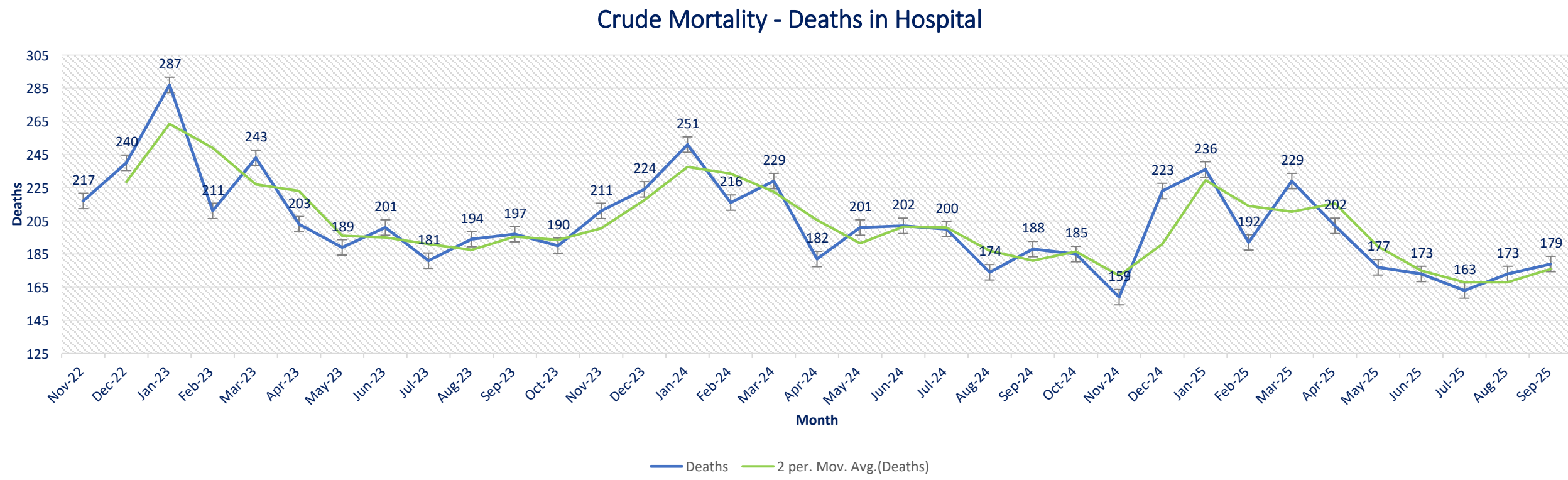
# For Information

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Mortality Indicators

Learning and improvement provided as part of the Health Board mortality framework

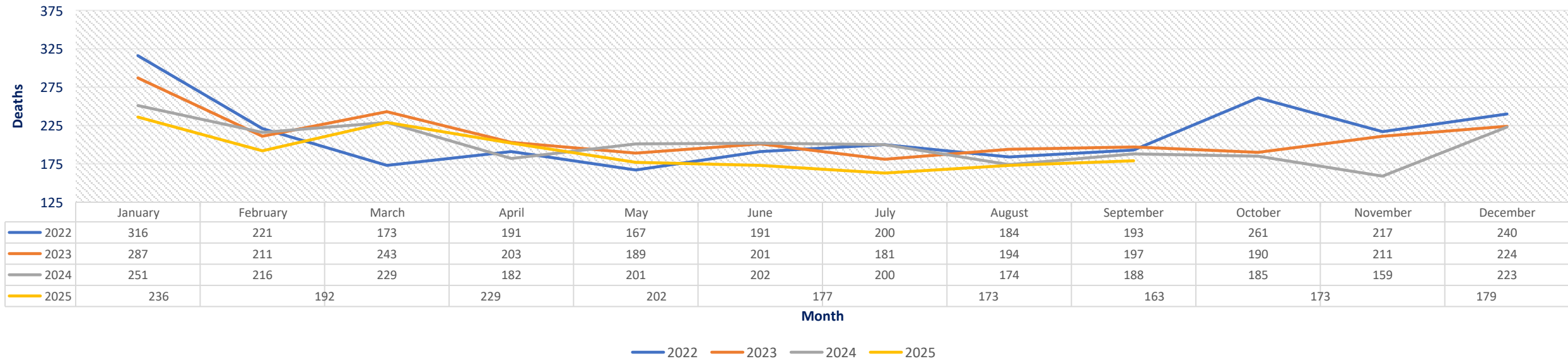
# Tier One Mortality Indicators – Crude Mortality



**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.)

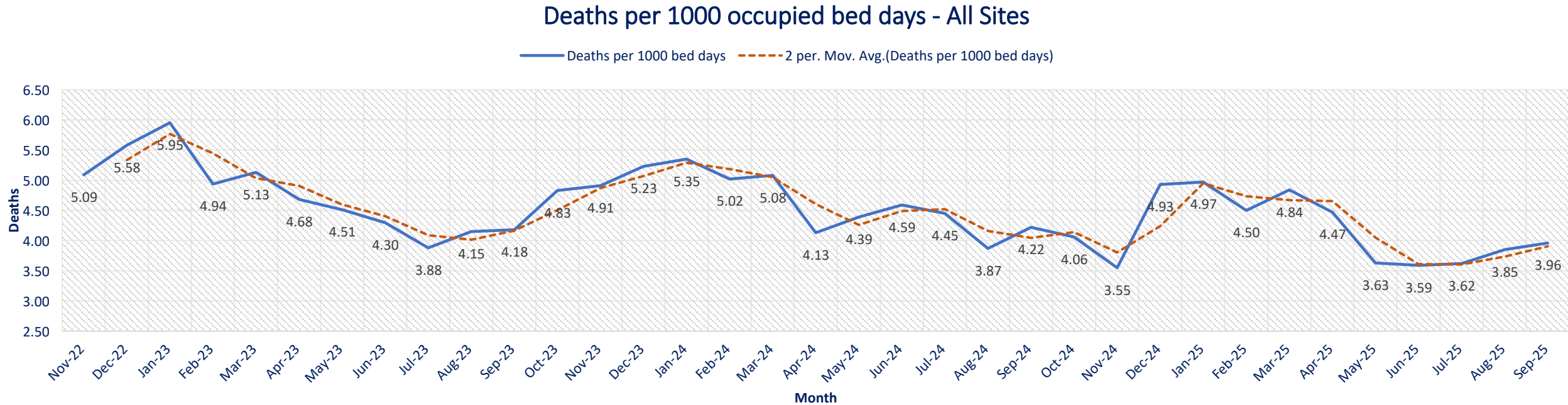
## Crude Mortality - Deaths in Hospital



The chart shows monthly hospital deaths from 2022 to 2025, revealing a clear seasonal pattern with higher mortality in winter months (January, October, December) and lower in summer (May–August). Overall, there is a downward trend in mortality over the years: January deaths dropped from 316 in 2022 to 236 in 2025, and 2025 consistently records the lowest figures across most months. 2022 stands out as the year with the highest peaks, while 2024 and 2025 show improvement, particularly with notable lows in July and November.

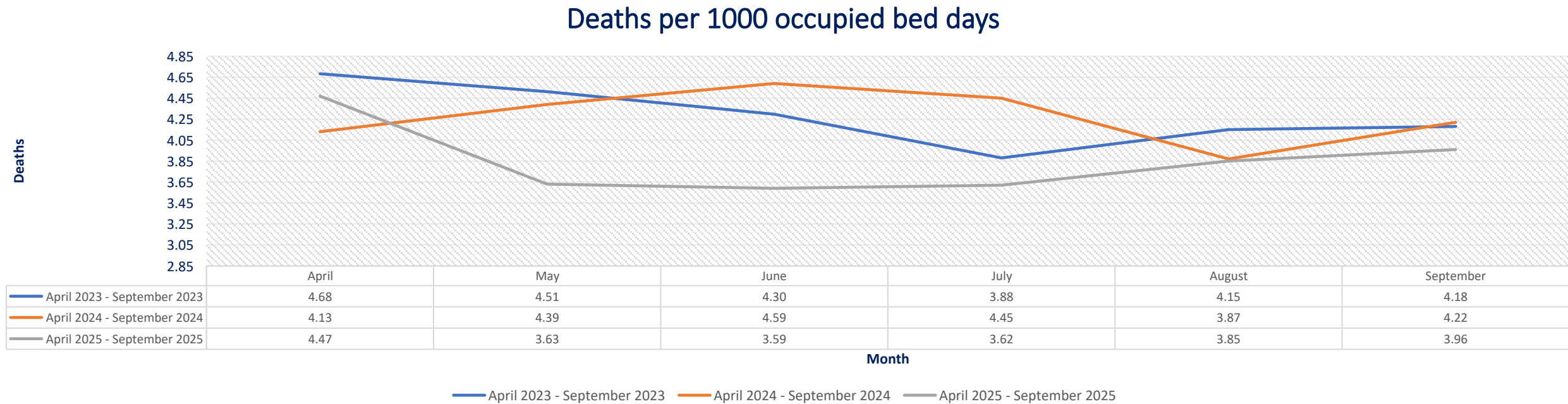
# Tier One Mortality Indicators – All-cause Mortality

**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.



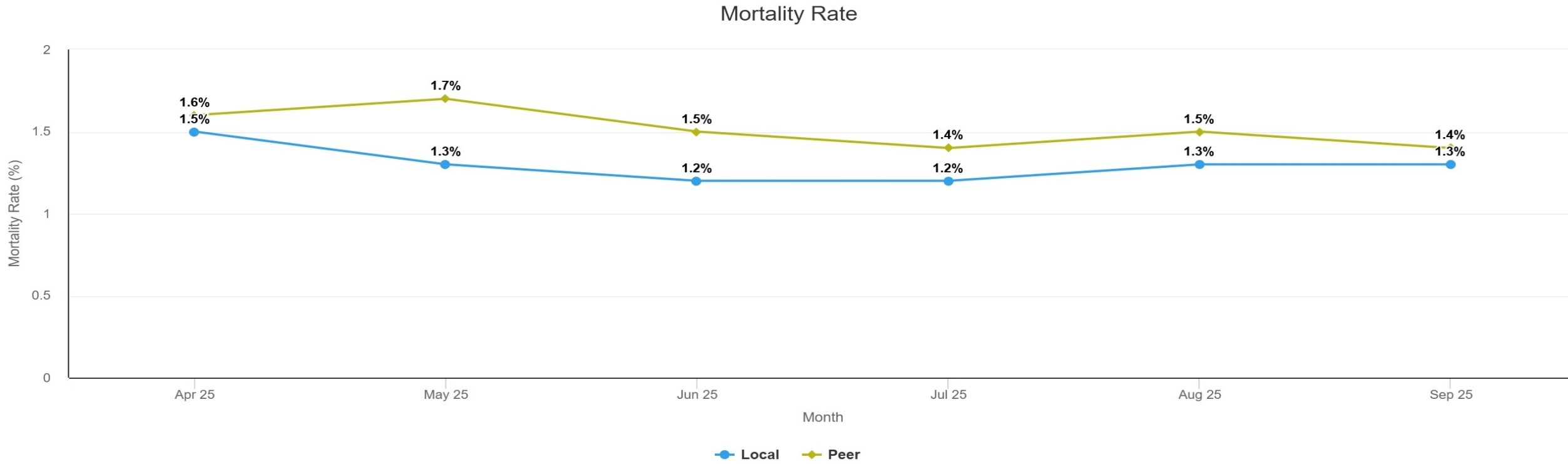
- Deaths per 1000 occupied bed days – a steady decline is observed from January 23 to July 23 before a noticeable and trending increase until April 24. Since then, there has been a prolonged period of fluctuation until May 2025 where it stabilises

# 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

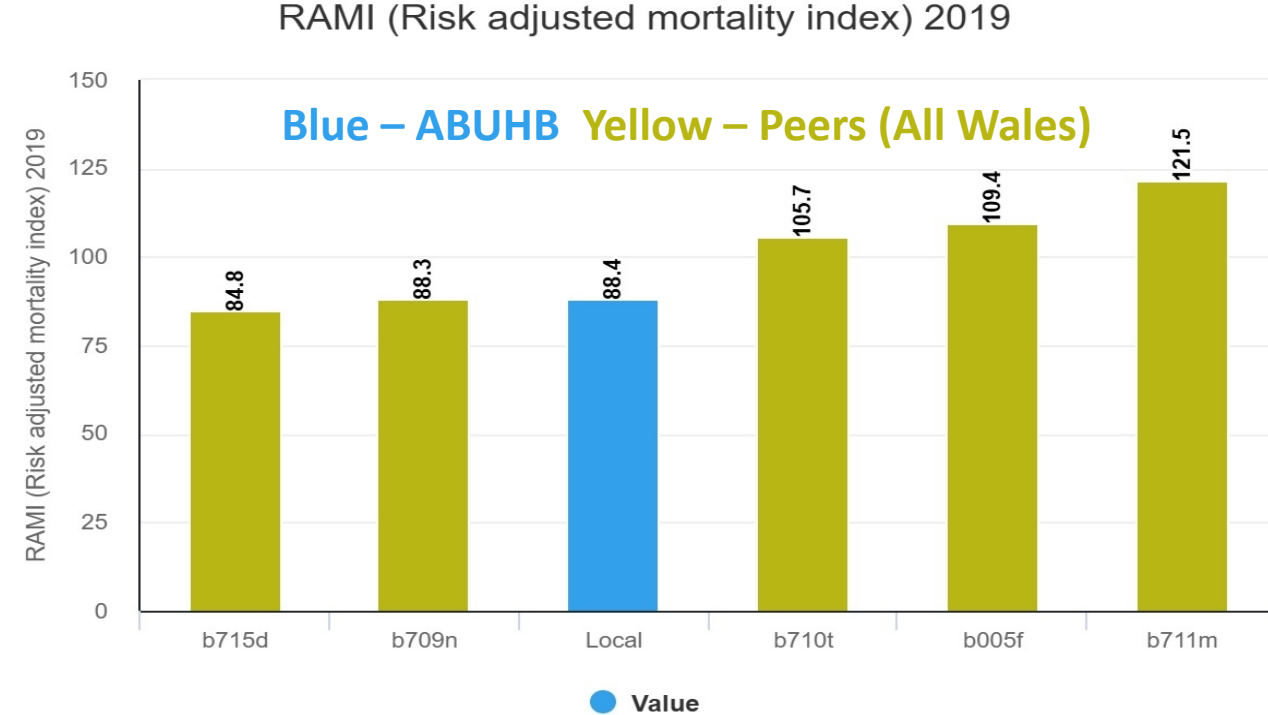


The Health Board's mortality rate has remained stable, showing a flat trend. Actual in-hospital deaths decreased during Q1 2025/26 before a slight increase in Q2.

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) 2019

- 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)

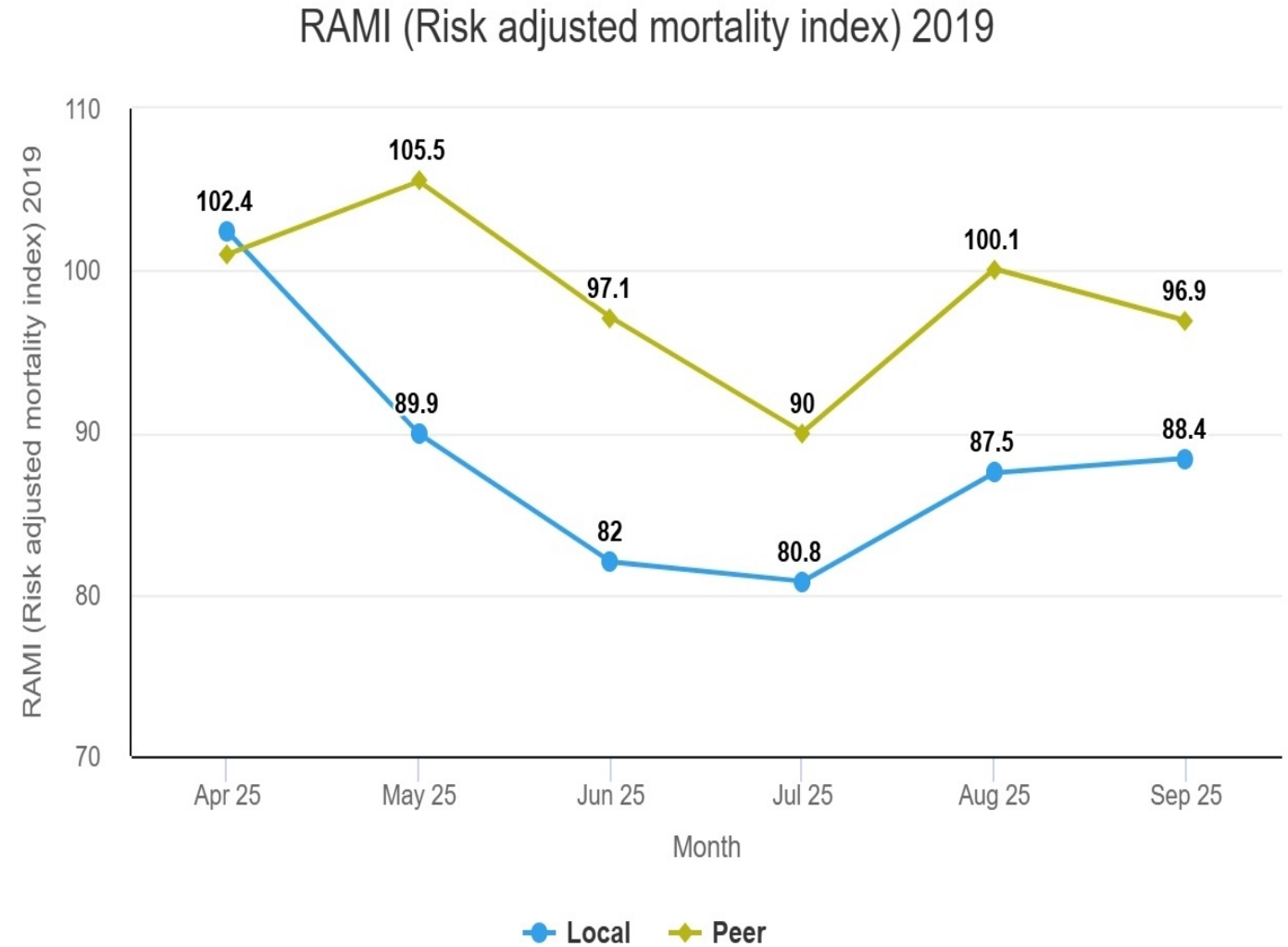


April 2025 – September 2025

The Health Board is the 3rd best performing Health Board within the All Wales Peer Group.

# Tier One Mortality Indicators – Risk Adjusted Mortality Index (RAMI) 2019

- 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 April 2025 and September 2025, 9.4% 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 April 2025.

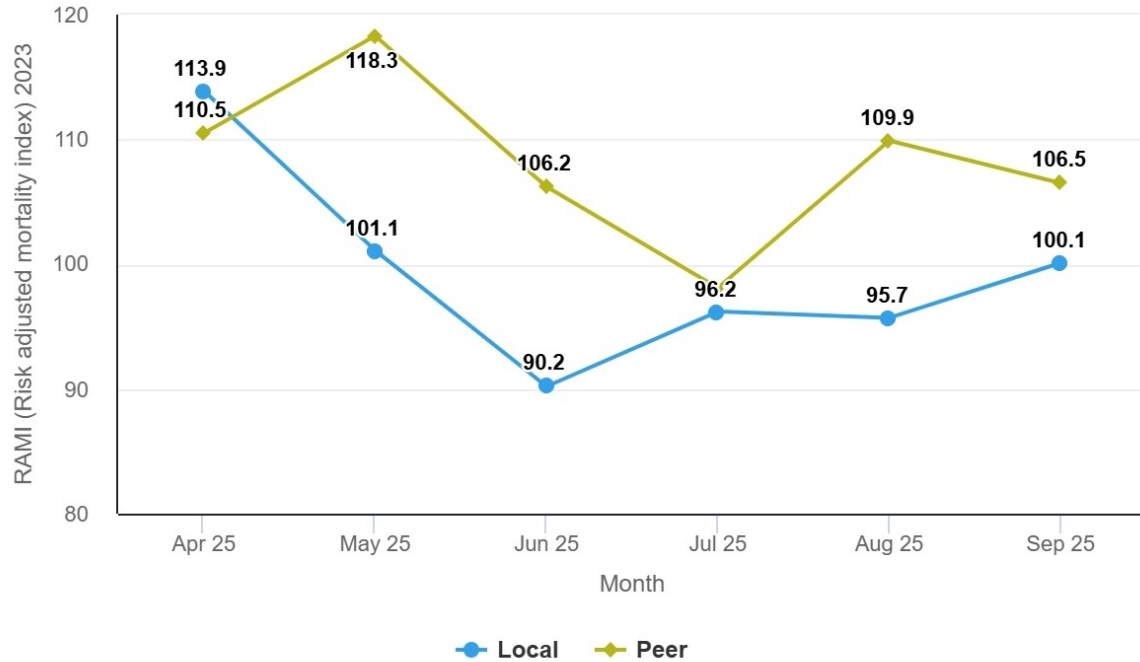


# Tier One Mortality Indicators – Risk Adjusted Mortality Index (RAMI)

- The rebasing of the Risk-Adjusted Mortality Index (RAMI) from the 2019 model to a 2023 baseline reflects CHKS's standard process of recalibrating the index using more recent national hospital activity data so that the benchmark returns to a norm of 100 and stays aligned with current clinical practice. RAMI models are rebased by reconstructing the expected-mortality norms from updated datasets, ensuring that shifts in case-mix, coding practices, service delivery, and clinical outcomes are accurately represented. The 2019 model is derived entirely from pre-COVID patterns and excludes COVID-related deaths from its baseline, meaning expected-mortality estimates were anchored to an environment that no longer reflects today's post-pandemic activity, coding behaviour, and treatment pathways. By rebasing to a 2023 dataset, the RAMI model incorporates contemporary mortality risks, updated palliative-care coding practice, and changes in admission behaviour and patient acuity.
- On average RAMI 2019 is 9 points lower than RAMI 2023, but this is an artefact of the time difference in setting each of the standards rather than an actual difference in risk adjusted mortality.

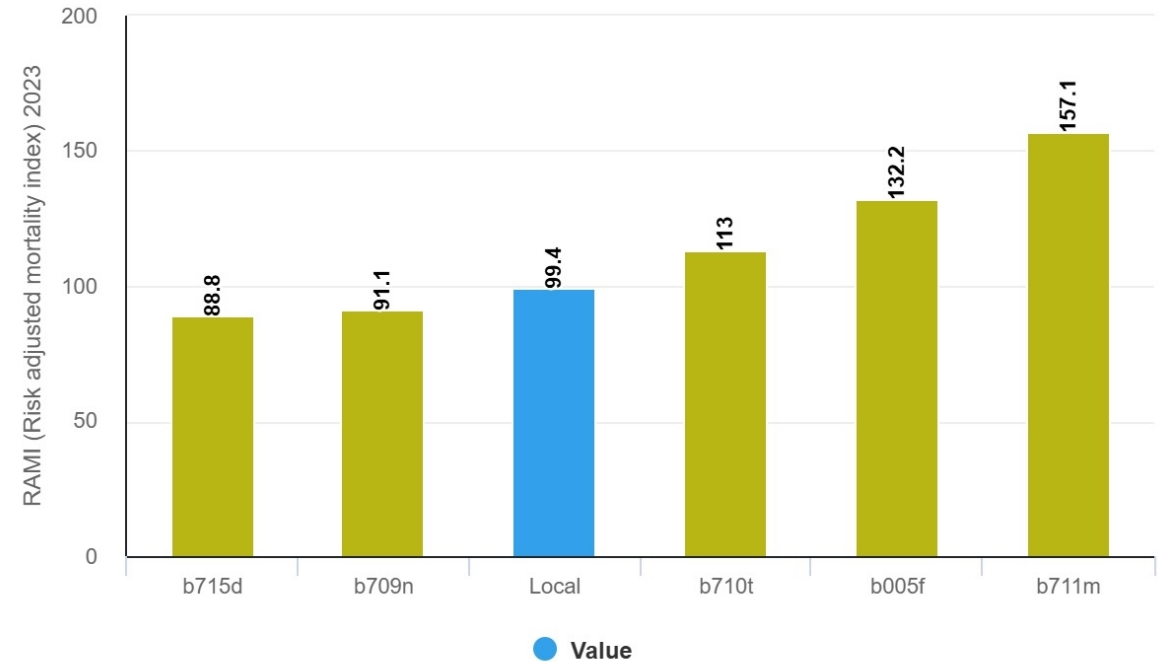
# Tier One Mortality Indicators – Risk Adjusted Mortality Index (RAMI)

RAMI (Risk adjusted mortality index) 2023



- 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 April 2023.

RAMI (Risk adjusted mortality index) 2023

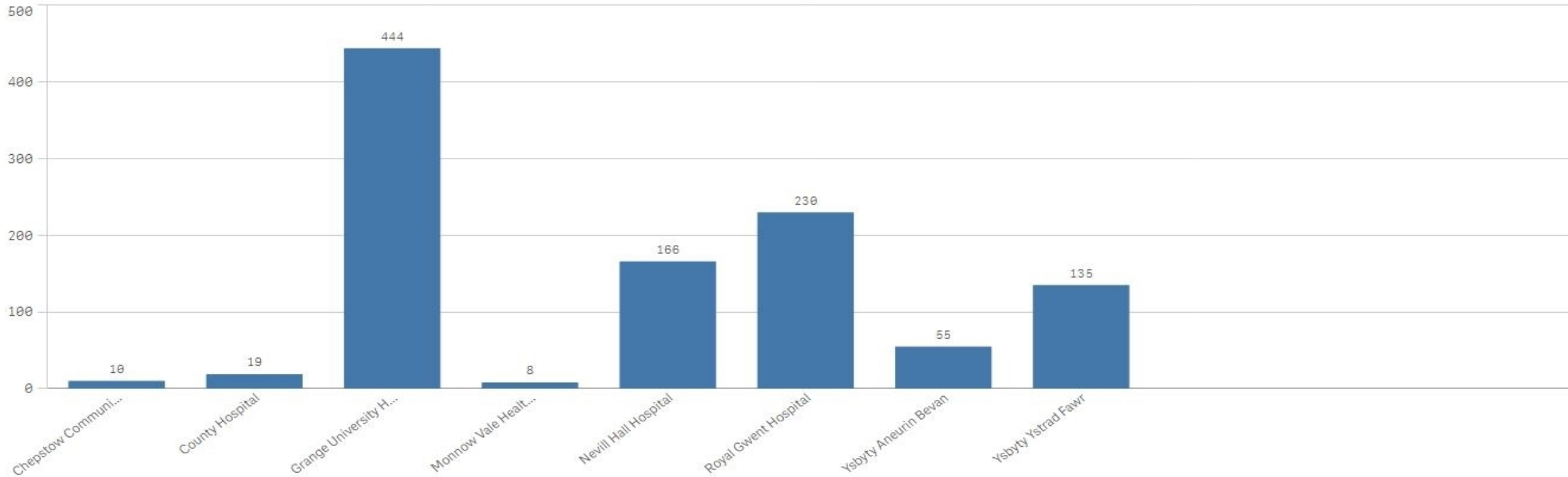


- The Health Board is currently the 3<sup>rd</sup> best performing Health Board within the Welsh Peer Value group.
- RAMI 2023 has been re-based as a score of 99.4 compared to 88.4 based on RAMI 2019

# Tier One Mortality Indicators – All-cause Mortality per site

April 2025 – September 2025

Deaths by Hospital



- The Grange University Hospital has the highest number of recorded deaths, followed by the ELGH sites

# Tier One Mortality Indicators – All-cause Mortality in Hospital

April 2025 – September 2025

Deaths per Month (excluding current)



- Downward trend in the amount of Deaths within Hospital from April – July 2025 in line with seasonal trends seen in previous years

# 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.
- The Health Board's coding completeness levels have improved to 90% which is a positive development, however, the ongoing increase in activity continues to limit the coding performance.
- 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.

## 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.

*Depth of coding describes the number of additional risk factors captured by our coders, e.g. diabetes, hypertension. Availability of this data significantly affects accuracy of RAMI. The extent to which we code co-morbidities is we code all relevant co-morbidities documented within the patient record. Best practice for depth of coding is code main condition treated, all relevant procedures/interventions and all relevant co-morbidities within the patient record. Improving the depth of coding and standardising our depth of coding will improve our accuracy of mortality data*

Code Type	Percentage Correct
Primary Diagnosis	93.50%
Secondary Diagnosis	94.85%
Primary Procedure	88.34%
Secondary Procedure	81.17%

# Tier Two Mortality Indicators

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 Three Mortality Indicators

- The current phase of work has deliberately focused Tier 3 on structured deep-dive reviews within Directorates demonstrating the highest RAMI values and greatest number of deaths, as set out in this report. This targeted approach is intended to strengthen learning, provide focused support, and enhance assurance where the mortality signal is greatest.
- During this reporting period, Tier 3 activity has centred on structured, case-based mortality reviews, enabling a deeper understanding of variation, contributory factors and opportunities for improvement. This work is underpinned by RAMI-aligned benchmarking and CHKS analytical measures, ensuring consistency, robustness and comparability.
- The next phase will further strengthen assurance through triangulation of mortality outcomes using national clinical audit data alongside local intelligence.
- This work will continue to focus on building a robust governance framework aligned to the Learning from Deaths Framework, including structured reporting through Directorate Quality and Patient Safety meetings, triangulation with Medical Examiner, M&M and Coroner intelligence, formal escalation arising from M&M reviews, and exception-based assurance reporting.
- Overall, the Tier 3 approach ensures that mortality data is actively used to drive learning, support Directorates, and provide assurance that identified risks are understood and addressed, rather than solely monitored.

# Tier Three Mortality Indicators – Crude Mortality - Specialty

Description	Local Numerator	Local Denominator	Apr 25 - Sep 25	Jul 24 - Mar 25	Peer Value	Performance
<a href="#">Mortality Rate</a>	1181	92715	1.3%	1.5%	1.5%	
192 - Intensive Care Medicine	45	162	27.8%	28.6%	38.1%	
430 - Geriatric Medicine	408	4677	8.7%	10.9%	9.4%	
314 - Rehabilitation Medicine	101	1353	7.5%	9.2%	7.7%	

This report presents RAMI-aligned mortality performance for selected specialties within the Health Board. To ensure statistical robustness, only specialties with cohorts of 25 patients or more have been included. Overall mortality performance remains favourable, with a crude mortality rate of 1.3%, compared to a peer average of 1.5%. This provides assurance that outcomes at a Health Board level continue to compare well against peers. At specialty level, variation remains, with Intensive Care Medicine having the highest local mortality rate at 27.8%. While this remains lower than the peer average of 38.1%, it represents the area of greatest relative mortality risk and continues to require focused assurance.

In the previous report, the Health Board committed to undertaking a series of actions to strengthen assurance and learning from mortality data. These commitments and the intended approach are set out below:

- Acknowledge and sustain good performance - Continue to monitor and maintain the positive overall mortality position, ensuring ongoing oversight and early identification of any emerging adverse trends.
- Targeted review of Geriatric and Rehabilitation Medicine - Undertake a focused deep dive into recent cases within these specialties to review case notes, understand causes of death, and identify potential learning. This will include engagement with clinical leads to explore the impact of patient complexity, discharge delays, and wider system factors on outcomes.
- Maintain a RAMI-aligned benchmarking approach Ensure ongoing analysis remains focused on RAMI-aligned specialties with sufficient patient volumes to preserve statistical validity and meaningful peer comparison.
- Escalate and deepen scrutiny where required - Where variation or risk is identified, ensure appropriate escalation, deeper review, and follow-up action to provide assurance that learning is identified and acted upon.

# Tier Three Mortality Indicators – RAMI - Specialty

Description	Local Numerator	Local Denominator	Apr 25 - Sep 25	Jul 24 - Mar 25	Peer Value	Performance	Alert
RAMI (Risk adjusted mortality index) 2023	1181	1188.2	99.4	116.9	108.1		
430 - Geriatric Medicine	408	386.1	105.7	128.1	85.1		
340 - Respiratory Medicine	154	77.2	199.5	239.1	114.3		▲
300 - General Internal Medicine	130	201.5	64.5	75.7	118.2		
100 - General Surgery	104	116.7	89.1	86.8	107.3		
314 - Rehabilitation Medicine	101	78.4	128.8	125.8	73.1		▲
301 - Gastroenterology	54	40	134.9	167.1	113.6		

For this reporting period, RAMI for selected specialties within the Health Board has been reproduced. With a focus on specialties with a minimum sample size of 25 patients, ensuring statistical robustness and meaningful peer comparison. ABUHB performance is benchmarked against Welsh peer values, with areas of concern highlighted using red alert indicators. Key insights from the data are as follows:

- General Internal Medicine demonstrates the lowest RAMI score.
- Intensive Care Medicine shows the highest RAMI score, indicating a higher observed mortality rate compared to peers. A comprehensive mortality review for Intensive Care has been undertaken and is presented on the following slide.
- Respiratory Medicine and Rehabilitation have RAMI scores that are significantly higher than Welsh peer averages and are therefore flagged with alerts.

### Actions and further assurance:

- Mortality reviews have been completed to explore potential patterns, contributory factors, and systemic issues within the alerted specialties.



**Respiratory Medicine – coding consideration:** ABUHB appears to use a generic Respiratory Medicine code more frequently than other health boards. This coding practice may be influencing RAMI calculations and limiting the validity of peer comparisons. The Coding Team is currently investigating this issue, and a detailed deep dive has now been completed to understand the impact and inform corrective action.

# Tier Three Mortality Indicators – RAMI - Anaesthetic / ITU Review

Description	Local Numerator	Local Denominator	Jul 24 - Mar 25	Jul 24 - Mar 25	Peer Value	Performance	Alert
RAMI (Risk adjusted mortality index) 2019	72	16.8	428.8	428.8	588.3		
192 - Intensive Care Medicine	72	16.8	428.8	428.8	588.3		

- A structured review was undertaken of anaesthetic cases involving patients admitted to Intensive Therapy Unit (ITU).
- All cases reviewed related to ITU admissions; no surgical patients were included, as these patients typically remain under the care of the operating surgeon, are often elective, or have low NELA scores. Including surgical cases would risk artificially inflating crude mortality figures.
- A total of 45 cases were reviewed.
- No concerns were identified in relation to care delivered on ITU.
- Where concerns were raised by the Medical Examiner, these related to care provided prior to ITU admission, rather than ITU management itself.
- Review of primary cause-of-death coding identified cases where coding inaccuracies were present.
- In most instances, the coding reflected an alternative diagnosis listed on the death certificate or a closely related condition, for example confusion between *Haemophilus influenzae* and *Influenza A*. These findings highlight the impact of coding practices on reported mortality data.

# Tier Three Mortality Indicators – RAMI - Anaesthetic / ITU Review

Description	Local Numerator	Local Denominator	Jul 24 - Mar 25	Jul 24 - Mar 25	Peer Value	Performance	Alert
? RAMI (Risk adjusted mortality index) 2019	72	16.8	428.8	428.8	588.3		
192 - Intensive Care Medicine	72	16.8	428.8	428.8	588.3		

Three cases were assessed as having a slight degree of preventability:

- One case involved a delay in the initiation of antibiotics prior to ITU admission.
- One postoperative death occurred in a patient with COPD, where an alternative anaesthetic approach may have altered the outcome; however, there was no pre-operative indication to suggest this, and the approach taken was considered reasonable.
- In the third case, clinical decision-making was appropriate based on the information available at the time.
- Several cases highlighted organisational factors where care processes could potentially be strengthened. These predominantly related to ITU admissions occurring due to reduced capacity in respiratory high-care units, with one case identifying a delay in medical review in the Emergency Department.
- The review also identified system-level variation across Wales in how ITU patients are attributed to consultant specialty. Differences in whether patients are coded to intensivists or specialty teams limits the comparability of crude mortality data between organisations.
- Overall, the review did not identify significant concerns relating to ITU care delivery.
- Key learning from the review is that specialty attribution and coding practices materially influence crude mortality measures and must be carefully considered when interpreting mortality data and benchmarking performance.

# Tier Three Mortality Indicators – RAMI - Gastroenterology Review

Description	Local Numerator	Local Denominator	Jul 24 - Mar 25	Jul 24 - Mar 25	Peer Value	Performance	Alert
RAMI (Risk adjusted mortality index) 2019	106	68.5	154.8	154.8	115.2		
301 - Gastroenterology	106	68.5	154.8	154.8	115.2		

**Total cases reviewed:** 73 gastroenterology cases. **Additional endoscopy cases:** 9 (reported separately below)

Similar coding issues were identified to those noted in Anaesthetics.





- Consultant attribution inconsistencies: 10 patients should have been reassigned to an ITU consultant. 1 patient should have been attributed to a surgical consultant. 1 patient should have been attributed to Cardiology. These inaccuracies were reflected in the Clinical Workstation System (CWS).
- Ward admission data was often incomplete, with multiple patient moves recorded, reducing clarity of clinical responsibility.
- Units where all critical care patients are assigned to intensivists may demonstrate lower apparent crude mortality, limiting cross-unit comparability.

Quality of Care Assessment (73 patients)

- Good standard of care: 60 cases
- Room for improvement – organisational (11 cases): Primarily related to bed availability, including: Lack of beds, Patients being in the wrong hospital, Delays in inter-hospital transfer and Communication issues and lack of continuity of the clinical team.
- Room for improvement – clinical and organisational:
  - Severely frail patients without Treatment Escalation Plans (TEPs) or DNACPR decisions, resulting in CPR attempts. Lack of timely access to symptom control medication (e.g. Oramorph). NEWS scores of 6 not escalated or acted upon.
  - **None of these issues were considered to have impacted the outcome or contributed to death.**

Advance Care Planning - **TEPs completed in 67% of cases**, highlighting an opportunity for improvement, particularly in frail and high-risk patients.

# Tier Three Mortality Indicators – RAMI – Endoscopy Review





Description	Local Numerator	Local Denominator	Jul 24 - Mar 25	Jul 24 - Mar 25	Peer Value	Performance	Alert
RAMI (Risk adjusted mortality index) 2019	106	68.5	154.8	154.8	115.2		
301 - Gastroenterology	106	68.5	154.8	154.8	115.2		

**Total procedures reviewed:** 9 endoscopic cases

## Key Findings

- **Only one death was linked to endoscopy:**
  - Patient receiving nasojejunal (NJ) feeding died from small bowel ischaemia.
  - No concerns identified with the endoscopic procedure itself.
  - The rare risk of this complication was not included in the consent process.
  - Case ranked as slight evidence of preventability.
- One case should have been re-coded to a General Surgical consultant (post-operative death following oesophageal perforation more than one month after endoscopy).
- One case identified as not meeting good standards of care:
  - High NEWS score not acted upon.
  - Patient had clear treatment limitations in place, and escalation was very unlikely to have altered the outcome due to a high risk of re-bleeding.
- No systemic concerns were identified regarding endoscopy practice.
- All cases involved **high-mortality patient groups** (e.g. frailty, end-stage liver disease).

# Tier Three Mortality Indicators – RAMI - Respiratory Review

Description	Local Numerator	Local Denominator	Jul 24 - Mar 25	Jul 24 - Mar 25	Peer Value	Performance	Alert
RAMI (Risk adjusted mortality index) 2019	244	108.3	225.3	225.3	121.6		
340 - Respiratory Medicine	244	108.3	225.3	225.3	121.6		

## Total cases reviewed: 144

- 8 cases coded to incorrect specialty due to CWS errors: 2 Critical Care, 3 Acute Medicine, 2 Care of the Elderly (COTE) and 1 General Surgery
- 4 cases where recorded cause of death did not align with review findings, including one where cause of death was unknown.
- 1 healthcare-related death identified (chemotherapy-related lung disease) with no care concerns.

## Preventability Assessment

- 2 cases of slight evidence of preventability: High NEWS recorded with no escalation before death verification; unlikely to have altered outcome. Failure to act on NEWS and escalation despite new oxygen requirement; unlikely to have altered outcome.
- 1 case classified as “possible but not likely” (<50/50) relating to delayed Acyclovir initiation (4 days) and ambulance delays.

## Room for Improvement – Clinical (8 cases)

Includes preventability cases above, plus: Medication dosing error (identified and corrected). Missed odontoid peg fracture (no impact on outcome). Late ITU admission (no impact on outcome; specialty attribution inappropriate). Early discharge following oxygen cessation with subsequent readmission. Misclassification of overdose (benzodiazepine vs opioid), with inappropriate suggestion of Flumazenil. No documented medical review following a fall.

## Room for Improvement – Clinical and Organisational (2 cases)

- Prolonged ambulance delay (8 hours). Transfer decision made by managerial staff rather than a clinician despite high NEWS.

## Room for Improvement – Organisational (4 cases)

- Delays in ambulance offload. Next of kin communication issues. Family not informed of hospital transfer. Issues with oxygen supply and nursing staffing levels.

The Respiratory mortality review demonstrated a high standard of care overall, with very low levels of preventability identified across a large cohort. Where learning was identified, this primarily related to system and organisational factors rather than individual clinical practice, providing reassurance that deaths were appropriately scrutinised and managed in line with Learning from Deaths principles.

# Tier Three Mortality Indicators

## Cross-Cutting and System-Wide Learning

### Documentation and Communication

- Discharge summaries frequently incomplete or absent, particularly in Gastroenterology and Respiratory Medicine. This has previously been proposed as a corporate audit and can be revisited.
- Marked variation between consultants, with better compliance observed at Nevill Hall Hospital (NHH).
- Treatment Escalation Plans often not completed or completed late, including in frail or terminal patients.
- Consultants with missing discharge summaries frequently also had poor TEP completion.

### Data Quality and Comparability

- Inconsistent consultant attribution for ITU patients across Wales limits comparability of mortality data between organisations and specialties.
- CWS ward admission and consultant fields are frequently incomplete or inaccurate.
- Multiple consultant changes during admission further complicate attribution, though inaccuracies remain evident even when this is considered.

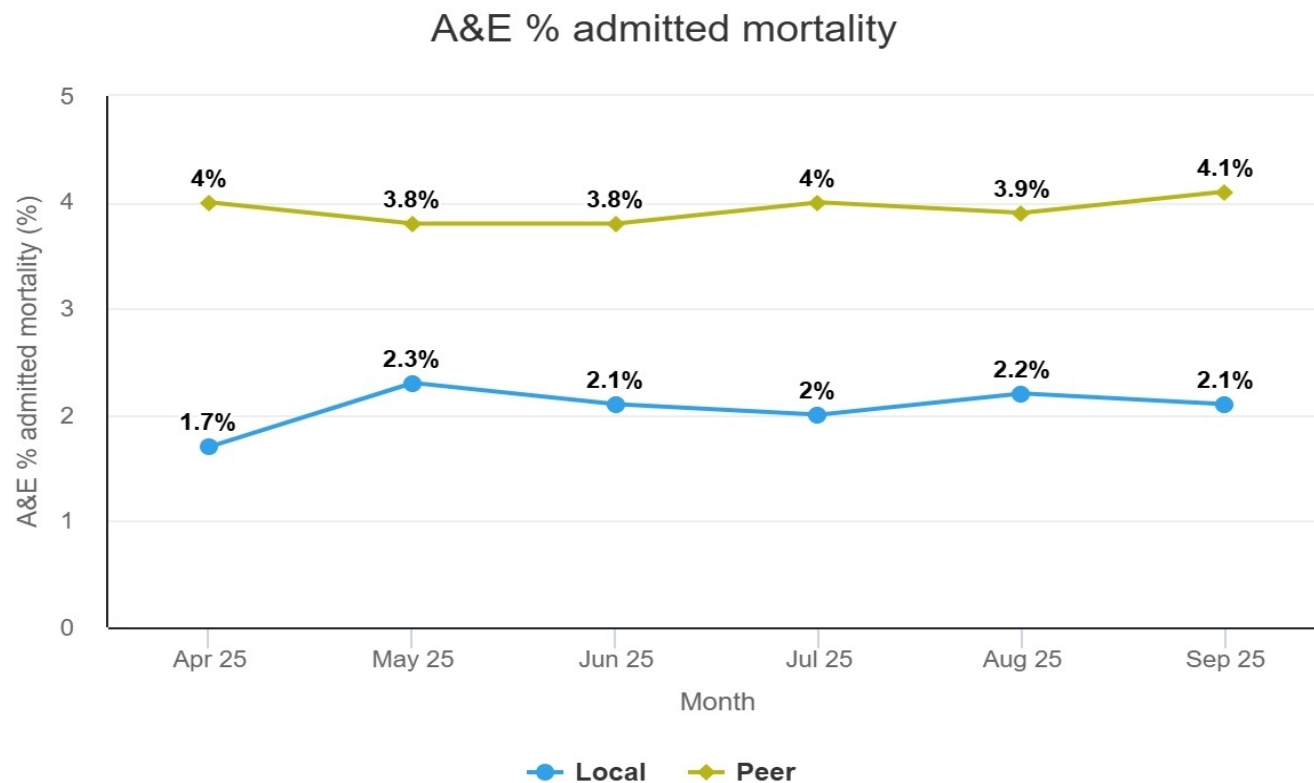
### Key Learning

Overall, the majority of cases across all specialties demonstrated good standards of care, with very limited evidence of preventability and no cases where identified issues were judged to have directly altered the outcome of death. The predominant themes for learning relate to:

- Data quality and coding accuracy
- Advance care planning and escalation
- Organisational pressures, particularly bed capacity, ambulance delays, and communication

These findings support continued focus on system improvement rather than individual performance.

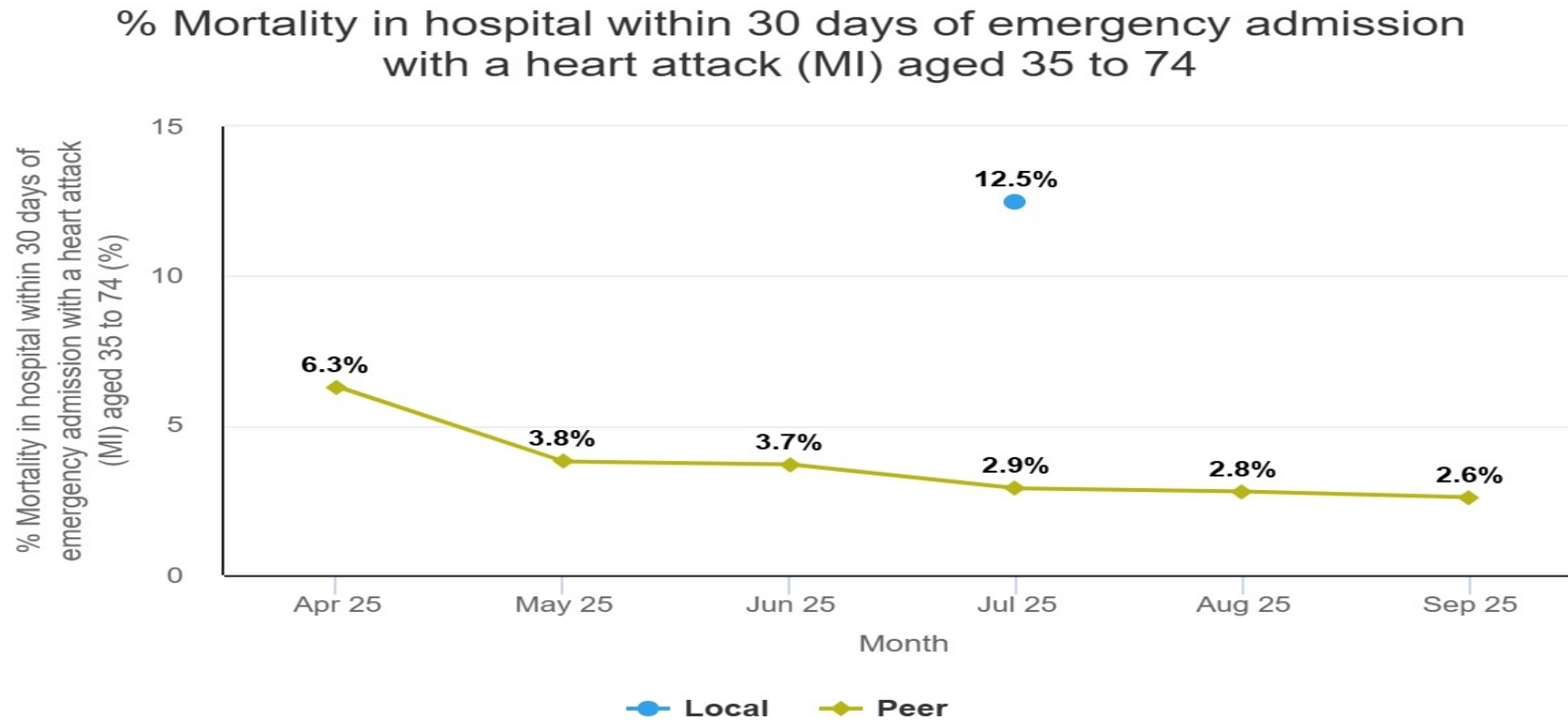
# Tier Three Mortality Indicators – ED admitted Mortality



## 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

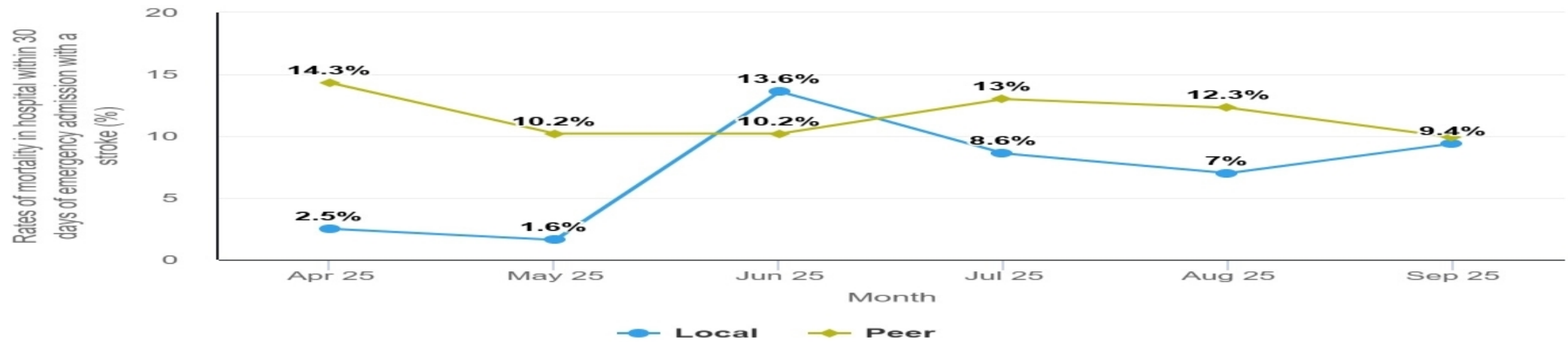
# Tier Three Mortality Indicators – Condition Specific Mortality - MI



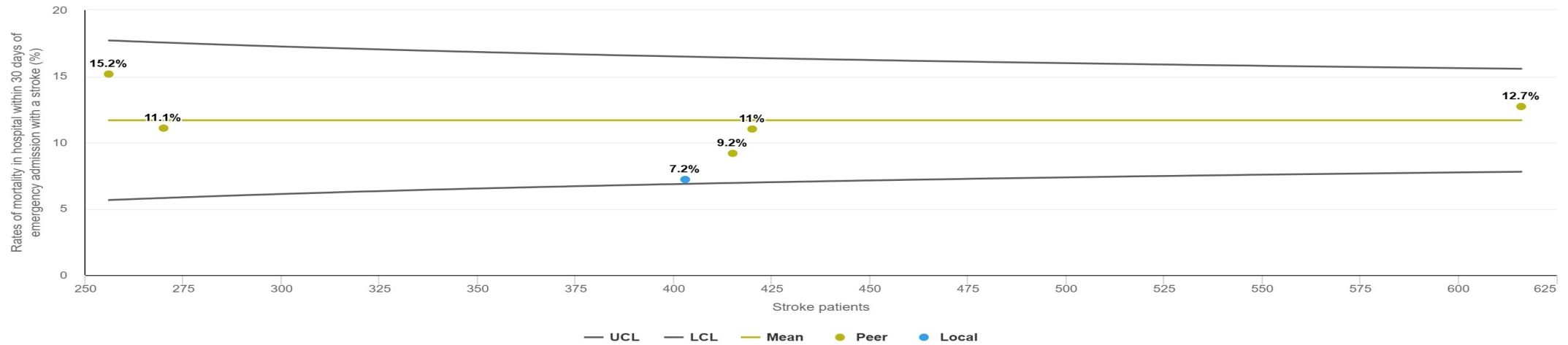
- 1 deaths between April 2025 – September 2025
- Period mortality – ABUHB 0.8% Peers (All Wales) 3.6%
- Patients with remediable issues are transferred to Cardiff for intervention

# Tier Three Mortality Indicators – Condition Specific Mortality - Stroke

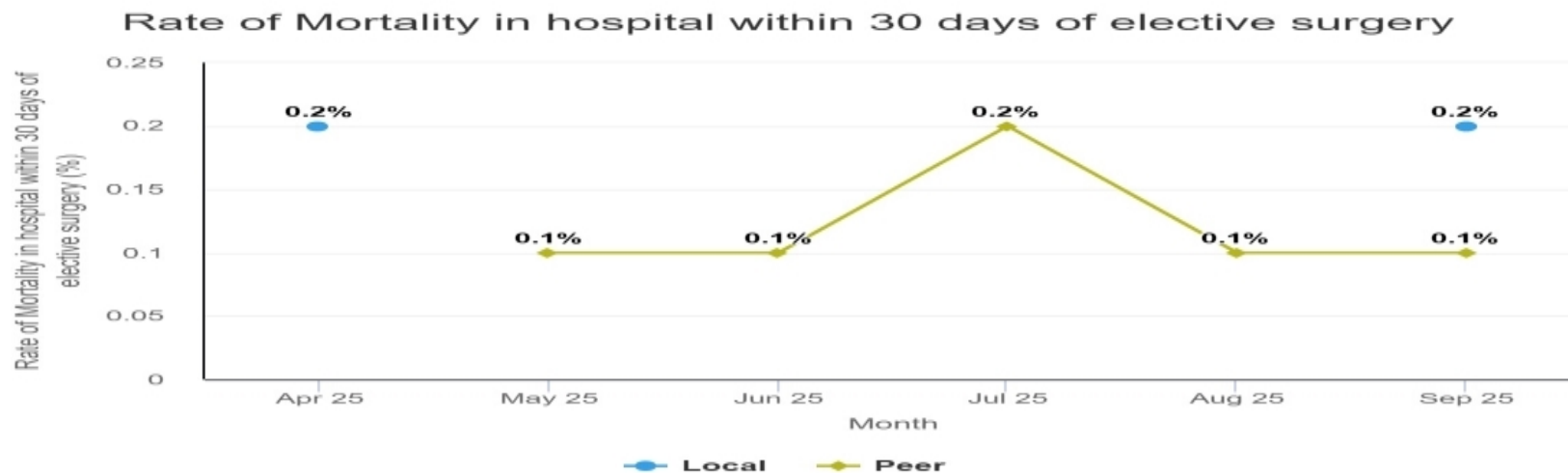
Rates of mortality in hospital within 30 days of emergency admission with a stroke



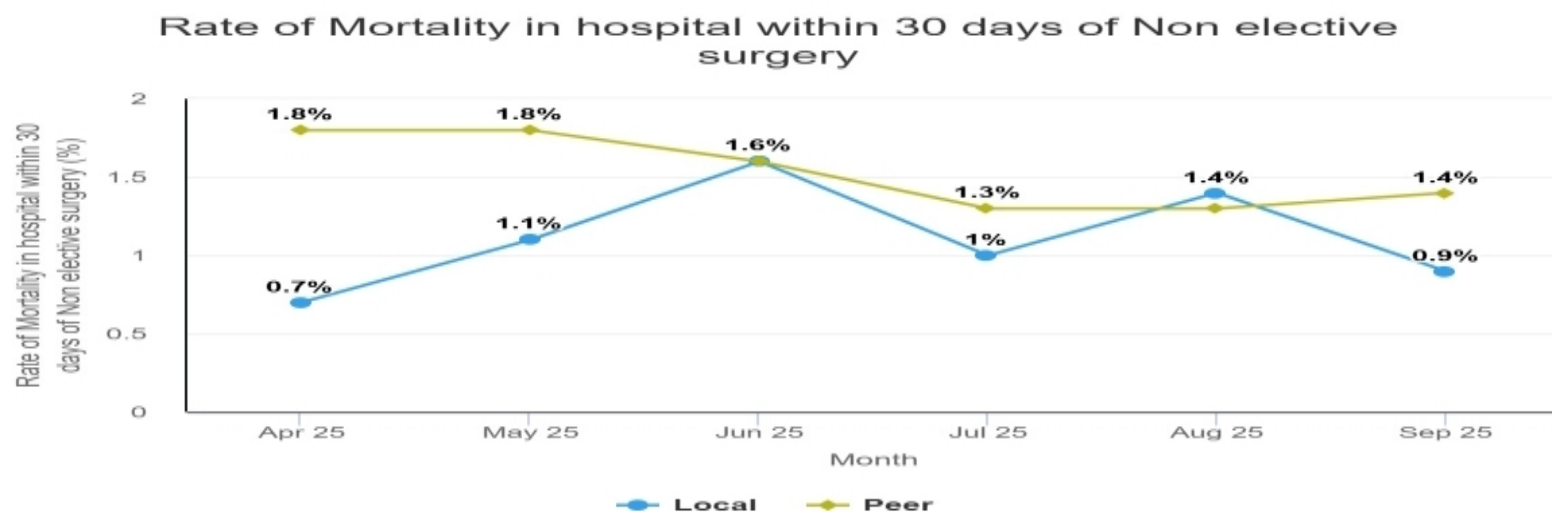
Rates of mortality in hospital within 30 days of emergency admission with a stroke



# Tier Three Mortality Indicators – Surgery Mortality



During the reporting period of April 25 – September 25. There were 2 recorded deaths in Hospital within 30 days of elective surgery. Both ABUHB and the All Wales peer group reported a mortality rate of 0.1% for this period.



The rate of mortality in hospital within 30 days of non-elective surgery has decreased to 1.1% from 1.2% in the previous Learning from Deaths report. This remains lower than the all Wales peer group mortality rate of 1.5%

# Tier Three Mortality Indicators – Surgery Mortality

Description	Local Numerator	Local Denominator	Apr 25 - Sep 25	Jul 24 - Mar 25	Peer Value	Performance	Alert
Rate of Mortality in hospital within 30 days of Non elective surgery	53	4695	1.1%	1.2%	1.5%		
100 - General Surgery	15	1023	1.5%	1.6%	1.4%		
110 - Trauma & Orthopaedics	14	961	1.5%	1.5%	1.3%		
301 - Gastroenterology	6	62	9.7%	9.9%	7.4%		
320 - Cardiology	6	261	2.3%	0.8%	3.3%		
192 - Intensive Care Medicine	2	8	25%	33.3%	48%		
300 - General Internal Medicine	2	31	6.5%	7.3%	10.9%		
328 - Stroke Medicine	2	8	25%	16.7%	-	No data to display	
340 - Respiratory Medicine	2	33	6.1%	10.4%	12.6%		
422 - Neonatology	2	4	50%	50%	-	No data to display	
420 - Paediatrics	1	31	3.2%	-	1.1%		
430 - Geriatric Medicine	1	23	4.3%	3.2%	10.7%		

- 53 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 9.7% for the period April 2025 – September 2025. A deep dive is underway in this area as this was also highlighted in the previous edition of the Learning From Death Report.

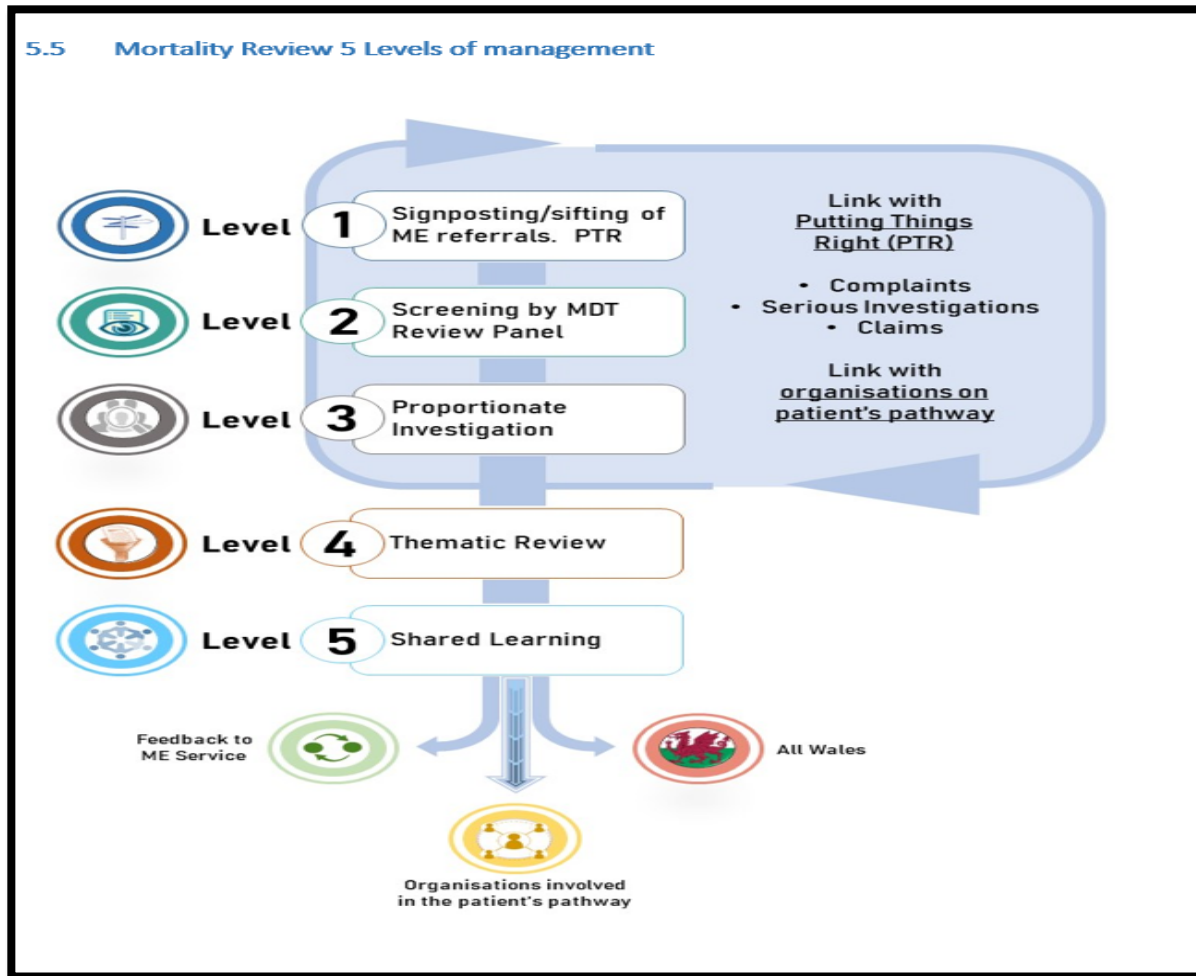
# The Medical Examiner Service

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 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 necessary), 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 are not 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](#).

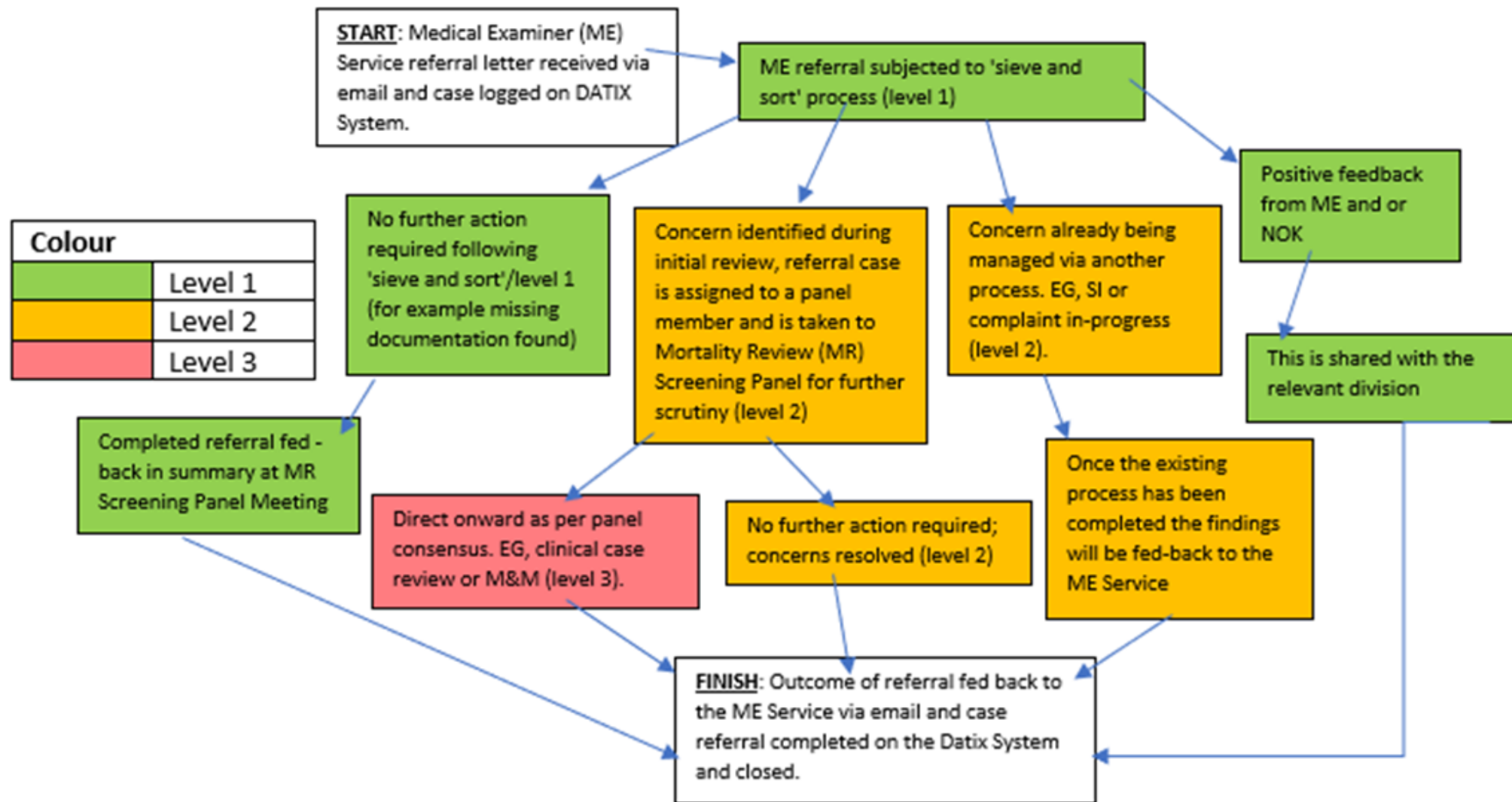
The ME Service system provides external, independent scrutiny of the treatment and care delivery and reports back cases for concern to the Health Board for further review.

# Aneurin Bevan University Health Board Mortality Review Process

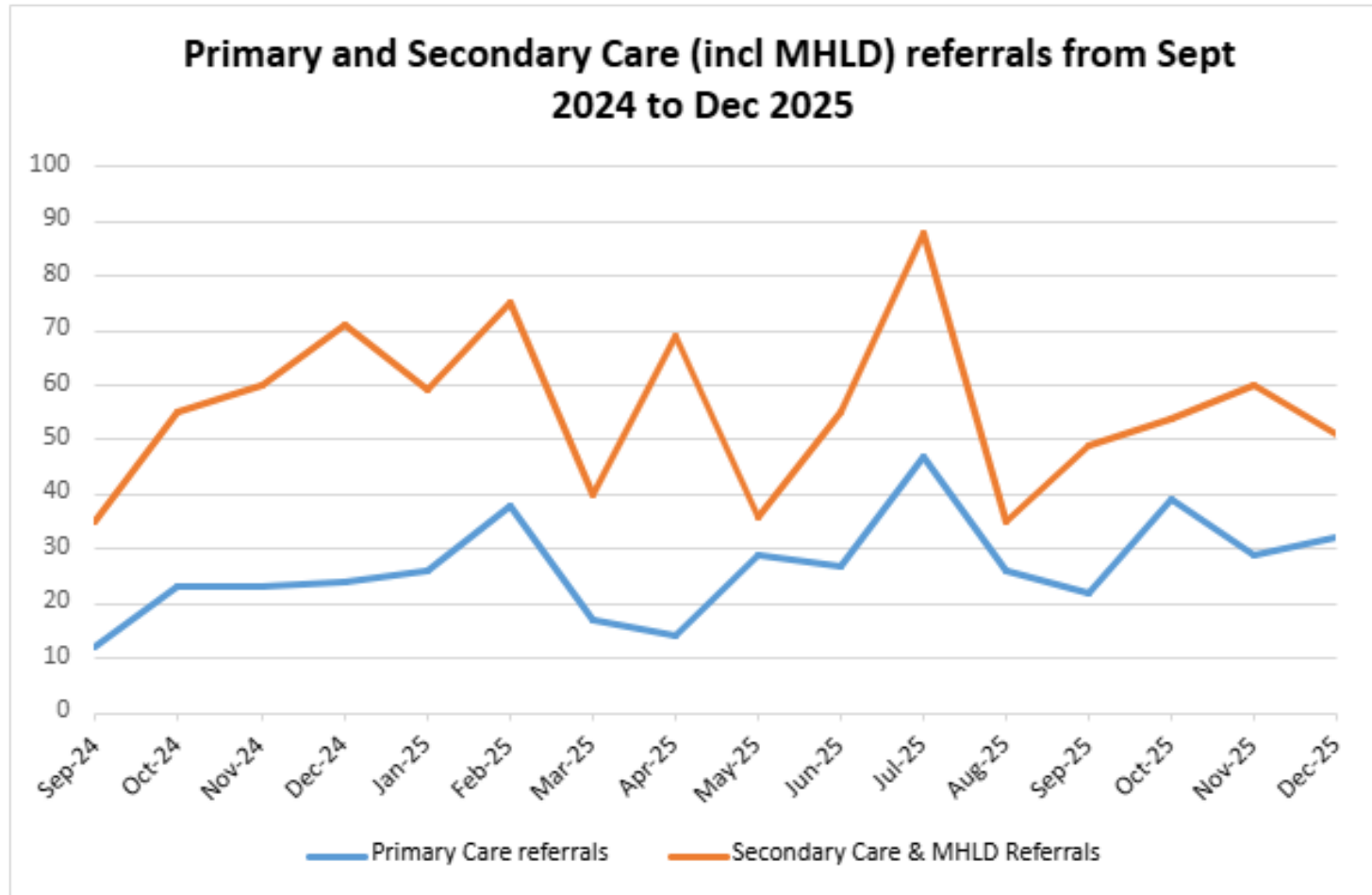


- All mortality cases referred to the Health Board by the ME Service undergo an initial review (level 1) to determine if further action is needed and to avoid duplication of work from existing processes.
- If further investigation is required, the case moves to a level 2 review. There it is discussed 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. Only 1 paediatric and no maternity death referrals have been received at ABUHB from the ME Service yet.

# Aneurin Bevan University Health Board Mortality Review Screening Process



# Medical Examiner Referrals Acute Compared to Primary Care & Community



The graph compares referral volumes from primary care with those from secondary care.

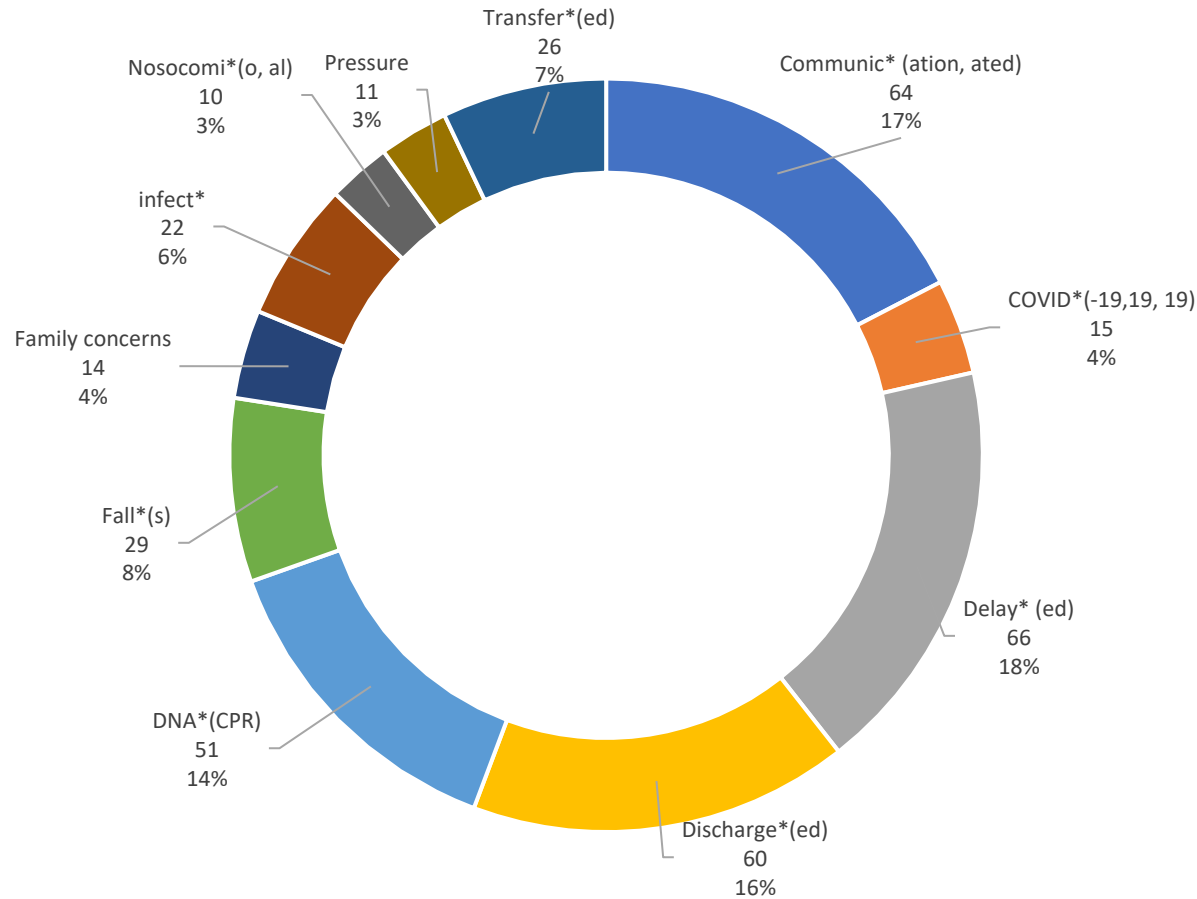
The dataset begins in autumn 2024, reflecting the point at which primary care coverage by the Medical Examiner (ME) Service across ABUHB was considered complete.

Overall, referrals originating from secondary care are consistently higher than those from primary care. Secondary care referral volumes also show greater month-to-month variation, whereas primary care referrals remain comparatively stable over time

# Medical Examiner Referral Themes

## Number of Times Words Appear in 'Reason for Referral' in ME

### Referral Letter



**Thematic Analysis of Referrals to the Medical Examiner Service** illustrates the common reasons for referral to ABUHB from the ME Service.

### **Delays**

Delays remains the most common theme, accounting for 66 referrals (18%) in the current dataset. These relate to:

- Perceived delays in treatment or investigations raised by next of kin (NOK)
- Ambulance off-load delays
- Delays in treatment or investigations identified by the ME
- Delays in verification paperwork

### **Communication Issues**

Communication continues to be a consistent theme, encompassing interactions with families, clinicians, between clinical teams, and with the Care After Death (CAD) Team.

- Referrals due to communication issues are static with 64 referrals (17%) in the current data and 17% in the previous data set.

### **Discharge Issues**

Discharge-related concerns are more prominent in this dataset, accounting for 60 referrals (16%), an increase from 9% previously.

- Issues primarily relate to failed or premature discharges and concerns raised by the NOK.

### **DNACPR (Do Not Attempt Cardiopulmonary Resuscitation)**

- 51 referrals (14%), consistent with the previous dataset.
- Common issues include DNACPR forms not being correctly co-signed by the Senior Responsible Clinician, or concerns about missed opportunities or delays in considering resuscitation status.

# Medical Examiner Referrals

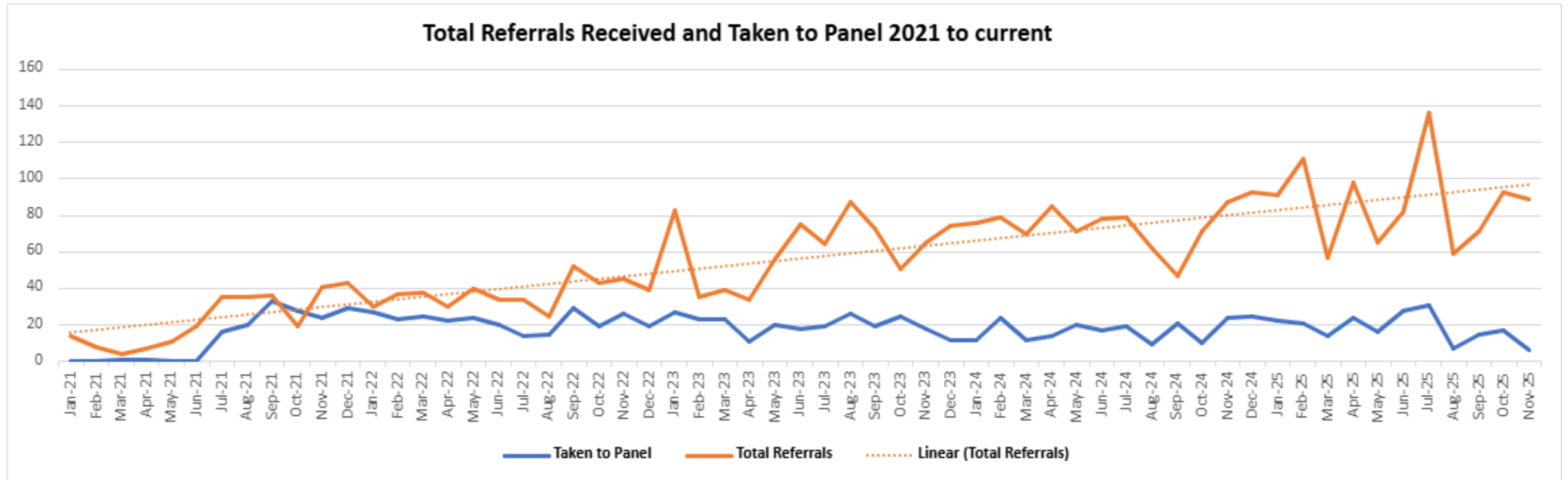
	Data set 1 (01/10/2023- 01/12/2023)	Data Set 2 (01/12/2023- 31/10/2024)	Data Set 3 (01/07/2024- 31/03/2025)	Data Set 4 01/04/2025- 30/09/2025
Number of days	426	335	273	182
Total ME Referrals	797	783	715	492
No further action	405 (51%)	164 (21%)	120 (17%)	89 (18%)
IP&C	70 (9%)	33 (4%)	12 (12%)	7 (1%)
Resus/Cardiac arrest audit	11 (1%)	8 (1%)	8 (1%)	1 (less than 1%)
Shared for awareness	88 (11%)	39 (5%)	74 (10%)	77 (16%)
Positive feedback	27 (3%)	15 (2%)	4 (1%)	13 (3%)
M&M	51 (6%)	13 (2%)	6 (1%)	3 (1%)
SI	47 (6%)	20 (3%)	9 (1%)	18 (4%)
Clinical Review	73 (9%)	22 (3%)	15 (2%)	7 (1%)
Cases which were referred to HMC	153 (19%)	150 (19%)	162 (23%)	110 (22%)
Closed on Datix	6 (1%)	140 (19%)	222 (31%)	209 (42%)

## ME Referral Destination

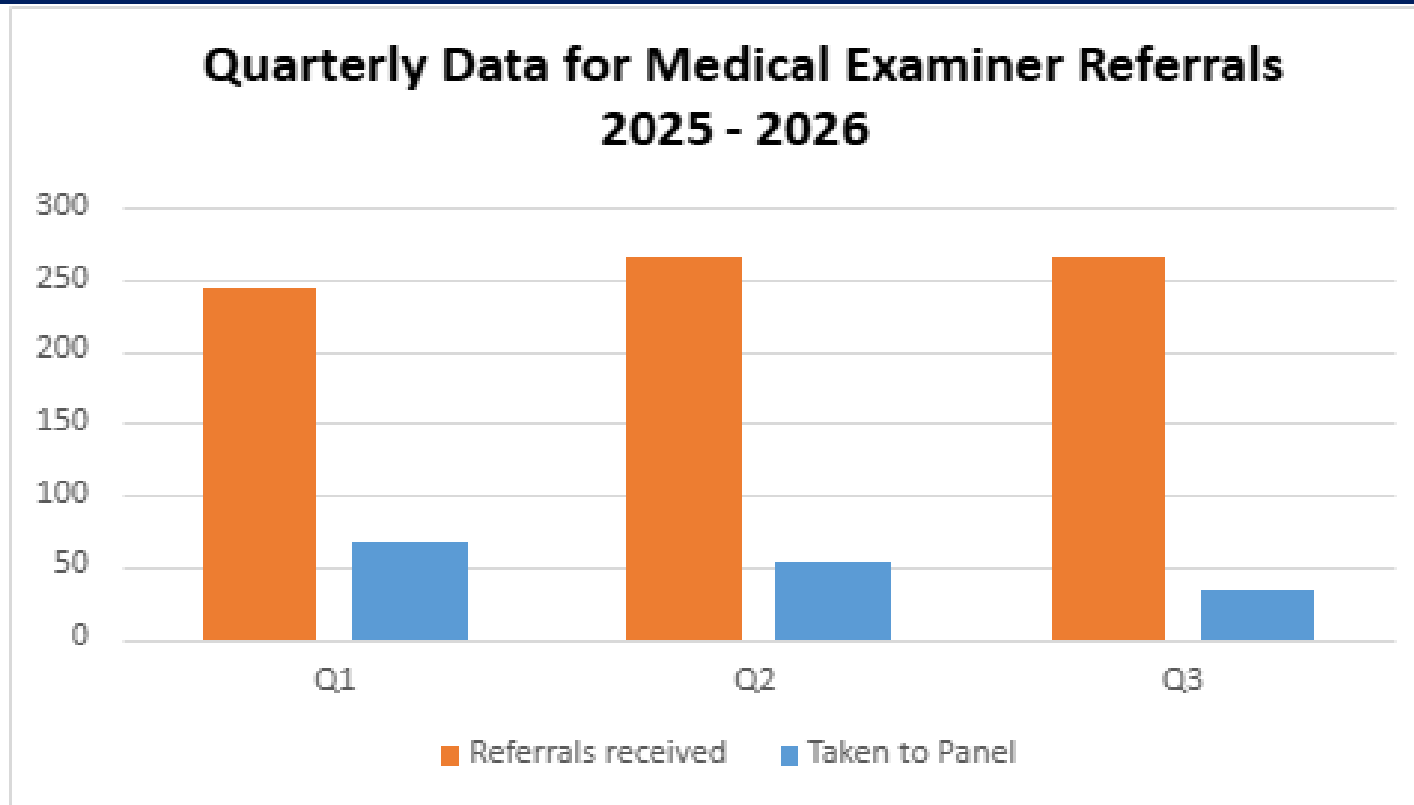
- **No Further Action:** Referrals needing no further action at level 1 are static in percentage from the previous data set. Referrals for 'no further action' refer to cases where no review beyond level 1 is required.
- **IP&C Referrals:** These continue to decrease, matching the drop in COVID-19 cases.
- **SI Referrals:** Serious Incident (SI) referrals have increased since the previous data set. This might 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 HMC is quite static in percentage from the previous data set.
- **Closed on Datix:** Whilst there is still ample improvement we can make here, our closure rate has improved a lot. This was one of our aims for the second half of 2025.
- **Positive Feedback:** This has increased from the previous data set which is brilliant.

# Aneurin Bevan University Health Board Mortality Review Service Growth

- **Growth of Mortality Review** - Since the introduction of the ME Service in 2021, the ABUHB Mortality Review (MR) Screening Process has expanded significantly, particularly in 2024 following extension into community settings.
- **Case Progression Gap** - There remains a gap between the number of cases received and those progressing to panel review. This reflects cases closed at Level 1 and those already subject to investigation through existing processes.
- **Resource Impact** - The ME service was implemented without additional resource or investment, placing sustained pressure on the Medical Directors' Team and reducing capacity for clinical audit activity. This pressure has intensified following expansion into community services.

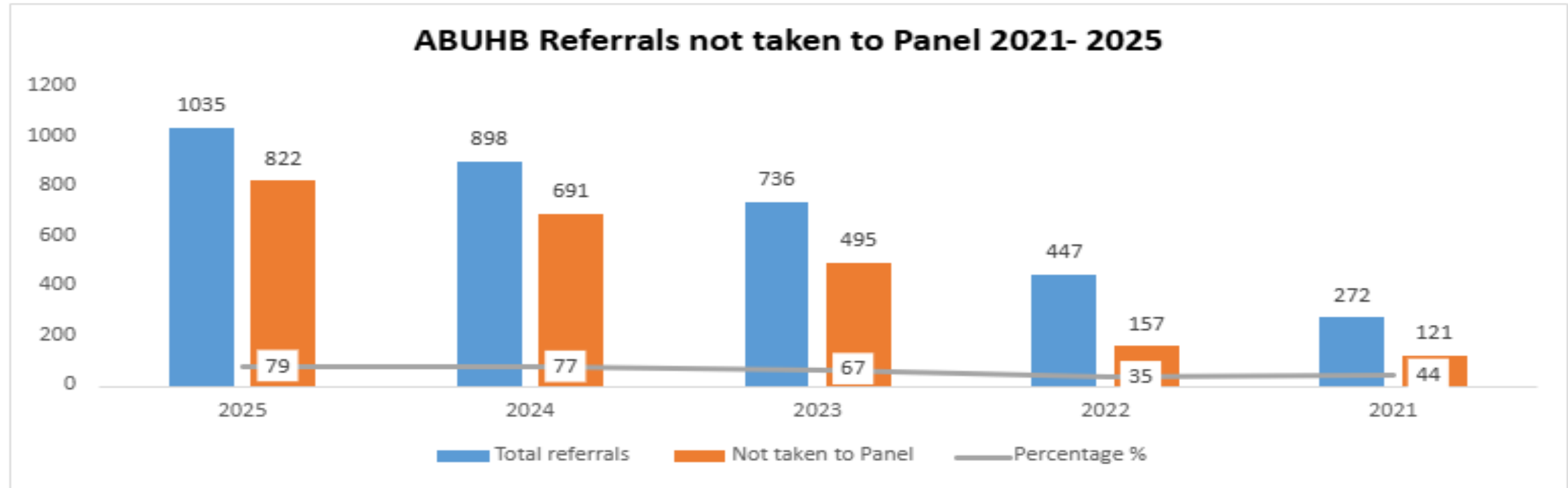


# Medical Examiner Referrals by Quarter



- This graph further highlights the sustained disparity between the total number of cases received and the number progressing to panel review each quarter. While only a proportion of cases proceed to panel, every referral still requires detailed level-one screening, including review, and professional discussion to determine the appropriate route and rationale for closure.
- This level-one process is time-intensive, requiring the team to assess each case individually to establish whether it can be closed at level 1, is already subject to another investigative process, or warrants escalation to panel review (level 2 or 3). As referral volumes increase, the cumulative time required to review and discuss cases at level one represents a significant workload for the team, regardless of whether cases ultimately proceed to panel. As such, the volume of Level 1 activity represents a substantial and ongoing time commitment for the team, irrespective of onward escalation.

# Aneurin Bevan University Health Board Mortality Review Service Growth



- This graph, again, illustrates the disparity between the number of cases progressing to panel review (Level 2 or 3) and those closed at Level 1 or managed through existing governance routes and processes.
- The trend shown provides assurance that the Health Board is actively and proportionately triaging cases, ensuring that only those requiring enhanced scrutiny are taken forward to panel review. At the same time, it reinforces the sustained increase in referrals received, reflecting improved reporting, awareness, and vigilance across services, with corresponding implications for capacity and sustainability.
- As demonstrated on the previous slides, this pattern has been consistent since June 2023 and, given current referral volumes, is unlikely to change significantly.

# Positive Patient Feedback (from discussions with the bereaved undertaken by the Medical Examiner Officers)

He was very complimentary of the ward staff and advised her dignity was maintained at all times and was given the best of care

He had only praise for the care his father received "from the cleaners to the doctors"

"We thought the care she received was outstanding... everyone was absolutely amazing."

"He had absolutely wonderful medical care, they went out of their way to keep him alive (obviously within reason), and to make sure he had the best medical care".

She gave effusive praise for all staff and said "if I ever needed to know anything there was always a doctor or nurse to help".

"...Cannot fault the GP's or the nurses looking after her, they were outstanding".

"They were so kind and supportive to us".

"...At the hospital they were absolutely fantastic..."

# Bereavement and End of Life – Learning and Actions

## Overview

Between March and September 2025, the Health Board delivered a structured programme of Bereavement Collaborative activity, aligned to national bereavement standards and the Health Board's Quality Strategy (Pillar One: Patient and Staff Experience). The programme embedded lived experience, inclusion and co-production as core principles and progressed from engagement to demonstrable service learning and system improvement.

## Key Areas of Delivery

### 1. Public Bereavement Collaboratives

- Delivered a Bereavement Collaborative for people affected by pregnancy and baby loss (March 2025), providing a safe forum for bereaved families to share experiences and identify priorities for improvement. Learning focused on compassionate care at the point of loss, communication, environment and ongoing support, directly informing service development.

### 2. Inclusion and Health Inequalities

- Delivered a dedicated Bereavement Collaborative for Deaf BSL users, deafened and hard-of-hearing people (April–May 2025), co-designed with Deaf-led organisations. Identified clear barriers to access, resulting in prioritisation of BSL and Easy Read patient information, and improvements to accessibility of bereavement and end-of-life resources. This work demonstrated tangible progress in addressing inequity in bereavement care.

### 3. Staff Bereavement and Workforce Support

- Continued development of a Staff Bereavement Collaborative, enabling staff to share experiences of loss, identify support needs and inform organisational responses. Learning contributed to improved signposting, manager guidance and alignment with wellbeing and occupational health support.

# Bereavement and End of Life – Learning and Actions

## Impact and Learning

- Bereavement improvement work moved beyond isolated events to a systematic, collaborative model.
- Lived experience directly informed:
  - Review of bereavement information and communication
  - Accessibility standards (BSL, Easy Read)
  - Clarity of referral and support pathways
- Bereavement was treated as a cross-cutting quality priority, influencing patient experience, staff wellbeing and equity.
- Learning and progress from the Bereavement Collaborative programme were formally captured within Pillar One: Patient and Staff Experience and Stories as part of the 2024/25 Quality narrative.
- Bereavement improvement activity was included in the Quality Annual Report 2024/25, providing Board-level visibility and assurance.
- The programme aligns with national bereavement frameworks and contributes to the Health Board's wider quality and experience assurance arrangements.

Between March and September 2025, the Health Board delivered a credible, inclusive and well-governed Bereavement Collaborative programme, with clear evidence of engagement, learning and impact. Bereavement improvement has been embedded within corporate quality reporting and is positioned to continue as a priority area of work.

# Glossary

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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.

- **Stroke-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.