

Patient, Quality, Safety Outcomes Committee

Tue 03 June 2025, 09:30 - 12:30

Microsoft Teams



Agenda

09:30 - 09:30
0 min

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 Monday 31st March 2025

Attached Chair

📄 PQSOC 20250603 1.4 PQSOC 20250331 Minutes - Approved.pdf (11 pages)

1.5. Committee Action Log

Attached Chair

📄 PQSOC 20250603 1.5 Action Log June - Approved.pdf (2 pages)

09:30 - 09:30
0 min

2. ITEMS FOR DISCUSSION

2.1. Quality Management Framework

Attached Director of Nursing

- 📄 PQSOC 20250603 2.1 Quality Management System Framework Cover Report .pdf (3 pages)
- 📄 PQSOC 20250603 2.1 Appendix 1 Quality Management System Framework 2025-2028 Final_.pdf (20 pages)
- 📄 PQSOC 20250603 2.1 Appendix 2 Quality Outcomes Framework - Potential Metrics - DRAFT May 2025.pdf (12 pages)

2.2. Quality Performance and Outcomes Report

Attached Director of Nursing

- 📄 PQSOC 20250603 2.2 Quality Performance and Outcomes Report .pdf (5 pages)
- 📄 PQSOC 20250603 2.2 Appendix 1 Quality Outcomes Framework - Q1 to Q4 2024-25.pdf (108 pages)

2.3. Development, and Implementation of the Commissioning Assurance Framework

Attached Director of Nursing

- 📄 PQSOC 20250603 2.3 Development, and Implementation of the Commissioning Assurance Framework Report.pdf (6 pages)

2.4. Infection Prevention and Control & Cleaning Standards Annual Report 2024/25

Attached *Director of Nursing*

- 📄 PQSOC 20250603 2.4 Infection Prevention and Control & Cleaning Standards Annual Report 2024-25 .pdf (9 pages)
- 📄 PQSOC 20250603 2.4 Appendix 1 IPAC Annual Report.pdf (56 pages)

2.5. Volunteering Annual Report 2024/25

Attached *Director of Nursing*

- 📄 PQSOC 20250603 2.5 Volunteering Annual Cover Report .pdf (5 pages)
- 📄 PQSOC 20250603 2.5 Appendix 1 Volunteering Annual Report.pdf (21 pages)

2.6. Mortuary Incident Action Plan

Attached *Chief Operating Officer*

- 📄 PQSOC 20250603 2.6 Mortuary Incident Action Plan.pdf (9 pages)
- 📄 PQSOC 20250603 2.6 Appdenix 1 Mortuary Incident Action Plan.pdf (73 pages)

2.7. Clinical Audit

Attached *Medical Director*

- Annual Report on Clinical Audit Activity 2024/25
- Clinical Audit Plan 2025/26

- 📄 PQSOC 20250603 2.7 Clinical Audit Activity Report and Plan Cover Report .pdf (7 pages)
- 📄 PQSOC 20250603 2.7 Appendix 1 Final Clinical Audit Plan 2025.26.pdf (23 pages)
- 📄 PQSOC 20250603 2.7 Appendix 2 Final Anual Audit Activity Report 2024.2025.pdf (135 pages)

2.8. Committee Risk Report

Attached *Director of Corporate Governance*

- 📄 PQSOC 20250603 2.8 PQSO Committee Risk and Assurance Report. June 2025 (1).pdf (5 pages)
- 📄 PQSOC 20250603 2.8 Appendix A_PQSOC Strategic Risk June 2025.pdf (7 pages)

2.9. Development of Committee Annual Programme of Business 2025/26

Attached *Director of Corporate Governance*

- 📄 PQSOC 20250603 2.9 PQSOC Forward Work Plan 2025-26 Cover Report.pdf (3 pages)
- 📄 PQSOC 20250603 2.9 Appendix 1 PQSOC Forward Work Plan 2025-2026.pdf (6 pages)

09:30 - 09:30 **3. For Information**
0 min

3.1. NHS Wales Joint Commissioning Committee's Quality Report

Attached *Director of Corporate Governance*

- 📄 PQSOC 20250603 3.1 QSO Highlight Report March 2025.pdf (8 pages)

3.2. Listening & Learning Forum Assurance Report

Attached *Director of Nursing*

- 📄 PQSOC 20250603 3.2 Listening Learning Assurance Report .pdf (2 pages)

3.3. Clinical Advisory Group Assurance Report

Attached *Director of Nursing*

- 📄 PQSOC 20250603 3.3 CAF Assurance Report.pdf (2 pages)

3.4. Children and Young People's Group Assurance Report

Attached *Director of Nursing*

 PQSOC 20250603 3.4 Notes of Meeting 23 April 2025.pdf (4 pages)

3.5. Committee Annual Report 2024/25

Attached *Director of Corporate Governance*

 PQSOC 20250603 3.5 2024-25 PQSOC Annual Report.docx final.pdf (49 pages)

3.6. Quality Governance Follow up Review

Attached *Director of Corporate Governance*

 PQSOC 20250603 3.6 ABUHB Quality Governance Follow Up .pdf (27 pages)

09:30 - 09:30

0 min

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: Tuesday 29th July 2025



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

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

DATE OF MEETING	Monday 31 st March 2025, 09:30am-12:30pm
VENUE	Microsoft Teams

PRESENT	Helen Sweetland, Independent Member, Committee Chair Paul Deneen, Independent Member Penny Jones, Independent Member
IN ATTENDANCE	Jennifer Winslade, Director of Nursing James Calvert, Medical Director Leeanne Lewis, Assistant Director of Quality & Patient Safety Tracey Partridge-Wilson, Deputy Director of Nursing Karen Hatch, Assistant Director of Therapies and Health Science Kelly Downes, Deputy Director of Nursing Naomi Murtagh, Board Business Manager Collette Kiernan, Clinical Director of Therapy Services Craig Roberts, Assistant Director of Therapies and Health Science Lucy Windsor, Head of Corporate Risk & Assurance Fern Woodhead, Committee Secretariat
OBSVERING	None
APOLOGIES	Peter Carr, Director of Allied Health Professions & Health Science Rani Dash, Director of Corporate Governance

PQSOC 3103/01	Welcome and Introductions The Chair welcomed everyone to the meeting.
PQSOC 3103/02	Apologies for Absence The Chair noted the apologies for absence.
PQSOC 3103/03	Declarations of Interest There were no declarations of interest raised relating to items on the agenda.
PQSOC 3103/04	Minutes of the previous meeting

	The minutes of the Patient Quality, Safety and Outcomes Committee held on 20th January 2025 were agreed as a true and accurate record of the meeting. The Committee APPROVED the minutes based on the change made.
PQSOC 3103/05	Committee Action Log The Committee received the action log and was content with progress made in relation to completed actions and against any outstanding actions. James Calvert (JC), Medical Director, advised that the request for local audit plans would be a challenge due to resources within the team and the fact that members of divisions make their own decisions on audits that will be conducted alongside national audits. Lucy Windsor (LW), Head of Corporate Risk & Assurance, advised she would speak with the Chair of the Audit, Risk and Assurance Committee regarding whether the documents required for ward accreditation can be the assurance mechanism as audits are included. Action: Head of Corporate Risk & Assurance
PQSOC 3103/06	Annual Review of Committee Terms of Reference 2024/25 Lucy Windsor (LW), Head of Corporate Risk & Assurance, provided the Committee of an overview of the annual review of the Committee Terms of Reference, advising that the current Terms of Reference were approved by the Board in March 2022. The Terms of Reference were reviewed, with minor amendments to dates and titles proposed, and circulated to members during January 2025 with no further comments received. Helen Sweetland (HS), Chair, asked that Primary and Community Care was included within the forward work plan of the committee as the Director of Primary and Community Care is part of the role of Director of Operations and not a regular member of the cttee. Paul Deneen (PD), Independent Member, asked how the Terms of Reference fitted in with Mental Health and Learning Disabilities for patient's voice or would this now sit with the new Mental Health Committee. LW advised that she would take the comments to Rani Dash (RD), Director of Corporate Governance, and address these via email outside of the meeting. Action: Head of

	Corporate Risk & Assurance / Director of Corporate Governance. The Committee ENDORSED the revised Terms of Reference for the Patient Quality, Safety and Outcomes Committee for submission to the Board in May, based on the comments being actioned.
PQSOC 3103/07	Committee Annual Report 2024/25 Lucy Windsor (LW), Head of Corporate Risk & Assurance, provided the Committee with an overview of the Committee Annual Report. The document seeks to provide a comprehensive evaluation of the business undertaken by the Committee throughout the 2024-25 financial year including any issues, and gaps in assurance that have required escalation to the Board. The Committee highlighted the following changes to be made to the annual report before submission to the Board:- • Page 40 include the date that Penny Jones (PJ), Independent Member, Became a member of the Committee • Page 12 - spelling mistake from HIEW to HIW. The Committee CONSIDERED and ENDORSED its Annual Report 2024-25 prior to submission to the Board on 21st May 2025.
PQSOC 3103/08	Committee Risk Report Lucy Windsor (LW), Head of Corporate Risk & Assurance, provided the Committee with an overview of the Committee Risk Register for which the Board had delegated responsibility to the Committee. The Committee was advised that the Committee Risk Register included three high-level risks and three sub-risks, covering service delivery, transformation and partnership working, and compliance and safety. The risk environment had remained stable, and there were no changes to the risk scores for the monitored risks. The Committee was advised that there was still one risk above the Health Board's appetite, which was Health and Safety with ongoing work to recruit additional staff members that would support the improvement plan.

	LW advised the Committee that the Health Board was waiting for the outcome of the consultation on nurse training courses at Cardiff University to finish. Once this had happened the Health Board would work with the corporate nursing team to determine whether there was a need for a strategic risk. Paul Deneen (PD), Independent Member, asked if Cardiff University was the main provider for the Health Board's nurses. Jennifer Winslade (JW), Director of Nursing, advised that it provided two thirds of the Health Board's provision with the Health Board not having a nursing school within the footprint. JW confirmed that she would be raising this with HEIW and discussing a Gwent model. The Committee NOTED the delegated strategic risks and the work being undertaken to ensure the Committee is sighted on all risks that have the potential to impact patient quality and safety.
PQSOC 3103/09	Performance Quality Interim Report Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Quality Performance Interim report, advising that the Quality report was mapped across 6 domains of quality and the 6 quality enablers and structured under the Health Board's 6 Pillars of Quality. The Committee was advised that the Health Board has 4 PALS officers who deal with 500 enquires per month. The main theme of the enquiries related to communication which the PALS team had been working to try and improve. The CIVICA text system had gone live in the emergency department and maternity Unit to help improve patient feedback rates. Helen Sweetland (HS), Chair, asked if the Health Board had enough staff in the PALS team. JW advised that they would be undertaking an evaluation of the service in May and would look at how they could increase the team. The Committee was advised that there had been improvement in the compliance on investigation of the patient safety incidents, so now achieving the 70% benchmark. Karen Hatch (KH), Assistant Director of Therapies and Health Science, presented the Falls data from April 2024 to February 2025, advising that there was an average of 304 falls per month across the Health Board, which was above

the national average. It was highlighted that there had been an increase in the number of falls in January and a subsequent decrease in February and this is probably related to the high number of occupied bed days.

JW advised the Committee that there had been 67 incidents that had triggered of duty of candour and no new never events in this reporting period.

Kelly Downes (KD), Deputy Director of Nursing, presented the Pressure Ulcer data from April 2024 to February 2025, advising that work was required to cleanse the data and to ensure the information could be reliably reported.

The Committee was provided with assurance that work was underway with divisions, with a forum being established with the divisional leads to discuss management of data and the support of an improvement coach from ABCi to try and improve the reporting of the pressure ulcer data and to share learning.

Paul Deneen (PD), Independent Member, asked which were the highest level for a pressure ulcer and which wards were reporting the highest level. KD advised grade 1 would be the lowest and grade 5 being the highest. There were no wards reporting higher levels than the others, noting that some patients come into hospital with pressure ulcers.

PD asked what information and advice was being shared with patients and family members regarding pressure ulcers. KD advised the community nurses share the preventative information and patient information leaflets were shared within the community and hospitals.

The Committee was advised that there was 76% compliance for 6-month early resolution of complaints in February 2025. The complaints data showed that the main themes being reported related to clinical treatment / assessment and appointments. The Committee was assured that the Health Board had implemented a new system and were working to improve the complaints performance.

JW advised the Committee that the Welsh Risk Pool (WRP) had assessed the Health Board's Putting Things Right processes in January 2024 (reported Dec 2024) to evaluate their effectiveness and provide recommendations for improvement. An action plan had been developed and shared with WRP to monitor the recommendations. The team would continue to share the plan with the Committee

to demonstrate improvements. Extra member of staff appointed to help review Datix. Further review expected by WRP sometime in 2025.

KH advised the Committee that were 6 incidents under the reporting of injuries, diseases and dangerous occurrences regulations (RIDDOR) reported to Health and Safety Executive (HSE) in Jan / Feb 25 with 83.3% of cases being reported within the legal timeframe.

The Committee was advised that the Health and Safety team were working with the divisions to maintain Health and Safety training compliance, noting that this remained a challenge with a current compliance rate of 69.8% for manual handling.

PD asked if the manual handling training was on ESR. JW advised it was a face-to-face training and there have been struggles due to shortage of trainers and staff having capacity to be released to complete the training. Lucy Windsor (LW), Head of Corporate Risk & Assurance, advised that the Head of Health, Safety & Fire was looking at other initiatives to improve compliance.

The Committee noted that safeguarding training compliance was at 82% with the aim to be at 85%. Level 3 training was now available on ESR with sessions being booked up until October 2025.

JW provided the Committee with an overview of the ongoing work to improve the position of the two areas within escalation:-

The Mental Health and Learning Disabilities division had been working towards the enhanced care framework to focus on patients that require additional support. Continuous improvement was ongoing with an internal learning forum established. The division had 91% compliance on level 1 & 2 safeguarding training with the Health Board providing them with bespoke level 3 training.

The Committee was advised that there was a national improvement programme being led by NHS Executive which would be looking at a fundamental review of mental health services in Wales with a focus of adult inpatients.

Urgent and Emergency Care had now gone live with the Emergency department (ED) transfer lounge at the Grange University Hospital (GUH) and were undertaking a stroke iPad pilot with the Welsh Ambulance Service NHS Trust

	with the aim to improve the flow of patients through the hospital. The Committee was advised that there would be additional consultants starting in ED in April who would be using the new assessment model and the new ED extension would go live in August 2025. JW advised the Committee that there was a 'safe to start' morning meeting in place at GUH to check the safety of the system with the aim to have this rolled out to all hospital sites. The Committee NOTED the Performance Quality Interim Report.
PQSOC 3103/10	Healthcare Inspectorate Wales – Unannounced Inspection of ED, GUH Published Report Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Healthcare Inspectorate Wales report following the unannounced inspection at the Grange University Hospital Emergency Department between 2nd to 4th October 2024. Several areas requiring improvements were identified, necessitating an action plan to address these issues and enhance patient care and safety. The Committee was advised that the inspection revealed significant challenges in patient flow, pain assessment, oversight of waiting areas, risk assessments, and medication management. The Health Board had developed an improvement plan to tackle these issues, with specific actions assigned to responsible officers and timelines for completion. Tracey Partridge-Wilson (TPW), Deputy Director of Nursing, advised the Committee that 95% of the actions were completed with the remaining open actions having an amber status relating to the flow centre. The team were working with the urgent care department to make the improvements. Helen Sweetland (HS), Chair, asked what the role would be for the well-being assistant within the Emergency department waiting room. JW advised the role would be to support with providing refreshments and pastoral support to patients within the waiting room. The Committee NOTED the report and the requirement to focus on monitoring the actions from the improvement plan.

PQSOC 3103/11	Healthcare Inspectorate Wales Annual Report Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Healthcare Inspectorate Wales (HIW) Annual Report 2023-24, highlighting the key findings and areas of concern regarding the quality and safety of healthcare services across Wales. This report included data from inspections, surveys, and reviews conducted during the year. It was crucial for the Health Board to address these findings to ensure the highest standards of patient care and safety. The report underscores the importance of continuous monitoring and improvement to ensure the delivery of safe and effective care to all patients. JW advised the Committee that the Health Board had examined the themes of the report to ensure that our own markers for Quality, Patient, Safety, and Experience and existing improvement plans were in line with HIW priorities. Paul Deneen (PD), Independent Member, asked if the Health Board was an outlier in any areas. JW advised that nationally, further work was required in regard to maternity mandatory training however this was not an issue for the Health Board with compliance being positive. PD asked about DNA CPR decisions in ABUHB and LEEANNE LEWIS reported that a lot of work has been done in this area and JAMES CALVERT reported that there is ongoing work to improve implementation of Treatment Escalation Plans and Advance Care Plans. The Committee NOTED the content of the Annual Report.
PQSOC 3103/12	Medical Devices Annual Report 2023/24 Craig Roberts (CR), Assistant Director of Therapies and Health Science, provided an overview of the medical devices annual report for 2023/24 advising that the report provided assurance to the Committee that the systems and processes were in place and operating effectively to achieve and maintain compliance with current and developing national Regulations, standards and guidance, under the constraints of what were practicable within available resources. The Committee was advised that the Medical Devices Committee was aiming to change to a Strategic Medical Devices Group with a multidisciplinary membership with

the Group governed to work under the medical devices UK regulations.

CR advised the Committee that the Medical Devices Committee met quarterly but there were challenges around attendance and ensuring the meetings were quorate. The team were reviewing the Terms of reference to ensure attendees were aware of their responsibility.

The Committee was advised that the Medical Devices work plans were based on the WG Health and Care standards framework (2015) and had currently moved towards working with the Health and Care quality standards (May 23).

The Committee was advised that a large number of the recommended actions from a long-standing audit in 2017 had been completed throughout 2023/24.

CR advised the Committee that the Health Board were awaiting the release of new medical device regulations for the UK. The new regulations will have more information about AI and software.

The Committee was advised that there had been two moderate and no severe incidents reported in this reporting period with a review of Datix information at each medical devices meeting to identify trends.

CR advised the Committee that the Electrical and Biomedical Engineering team was under resourced, however there had been positive work with PAT testing ensuring that equipment is safe for use. It was also noted that the department has gaps in clinical engineering expertise.

Penny Jones (PJ), Independent Member, asked how challenging the gaps in the Electrical and Biomedical Engineering team were. CR advised their main remit was maintenance of the equipment. The team had capacity to fulfil this role however extra support would be required once AI was introduced.

CR advised the significant progress has been made on several areas of concern in the 23/24 annual report and the committee should see progress in the next annual report for 24/25.

The Committee was advised that there is an informal Executive Committee meeting being held to discuss how to move forward with management and governance of

	medical devices that would inform what support would be required from the Board. The Committee NOTED the contents of the annual report for assurance.
PQSOC 3103/13	Nutrition and Hydration Committee Interim Report Craig Roberts (CR), Assistant Director of Therapies and Health Science, provided an overview of the Nutrition & Hydration Interim report, advising that the report intended to appraise the organisation of the current and future quality, patient safety and governance activity being undertaken across the organisation. The Committee was advised that the intention of the interim report was to provide assurance to the Committee that the systems and processes were now established to achieve a multidisciplinary, timely approach to patient safety and quality within the Nutrition and Hydration agenda. CR advised that the Nutrition and Hydration Steering Group is clinically led and multidisciplinary. It has now been set up with two subgroups that would report into the Steering Group. The subgroups are: Food standards sub-group and Clinical (artificial) nutrition and hydration sub-group. The Committee was advised that that there had been some problems concerning failure to escalate the complex dietary needs of some patients, so they were not being fed in a timely manner. The Committee was assured that a new structure had been put in place with a Task and Finish Group to improve the position. The Committee noted that the Health Board had received a regulation 28 from the coroner which outlined that inadequate fluid balance monitoring had been linked to a patient's death. The Health Board had provided the coroner with an action plan that would improve the fluid balance monitoring across the organisation with a Task and Finish Group to monitor the improvements. CR explained that documents have been introduced to ensure that, if a patient required nutrition this would be highlighted to a doctor or nurse while the patient was in hospital. CR reported on the ongoing work of these two sub-groups and the task and finish groups. Paul Deneen (PD), Independent Member, asked what the Health Board had in place for patient voice. CR advised

	that the Health Board had spoken with Llais to include a patient representative within the Steering Group. Helen Sweetland (HS) thanked the team for the re-establishment of these groups and the renewed emphasis on these important areas. The Committee NOTED the contents of this Interim report for assurance.
PQSOC 3103/14	NHS Wales Joint Commissioning Committee's Quality Report NHS Wales Joint Commissioning Committee's Quality Report was provided to the Committee for information.
PQSOC 3103/15	Listening & Learning Forum Assurance Report Listening & Learning Forum Assurance Report was provided to the Committee for information.
PQSOC 3103/16	To confirm any key risks and issues for reporting/escalation to Board and/or other Committees There were no key risks or issues for reporting or escalation to the Board or other Committees.
PQSOC 3103/17	Any Other Urgent Business There was no urgent business.
PQSOC 3103/18	Date of the Next Meeting: Tuesday 3rd June 2025



Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD PATIENT QUALITY, SAFETY AND OUTCOMES COMMITTEE

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
March 2025	PQSOC 3103/05	Committee Action Log Discuss ward accreditation as the assurance mechanism for the local audit plans with the Chair of ARAC	Head of Corporate Risk & Assurance	April 2025	Complete <u>May update</u> Local Clinical Audit plans being developed as a key source of assurance.
March 2025	PQSOC 3103/06	Annual Review of Committee Terms of Reference 2024/25 Confirm whether the patients voice in relation to Mental Health and Learning Disabilities services should be included in PQSOC ToR or MH&LD Committee.	Head of Corporate Risk & Assurance / Director of Corporate Governance	April 2025	Completed <u>May update</u> The MH&LD Committee has responsibility for oversight of all aspects of MH&LD Services, including quality, safety and patient experience. The PQSO Committee will continue to focus on quality, safety and patient experience from an overall organisational lens.



Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
March 2025	PQSOC 3103/07	Committee Annual Report 2024/25 Requested changes:- - Page 40 - include the date that Penny Jones joined the Committee - Page 12 spelling mistake from HIEW to HIW Director of Corporate Governance, to confirm via email that the changes had been made to the report.	Head of Corporate Risk & Assurance / Director of Corporate Governance	April 2025	Completed <u>May update</u> Updated report presented to the Board in May 2025.

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

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	03 June 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Quality Management System Framework
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Jennifer Winslade, Executive 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

ABUHB has developed a comprehensive Quality Management System Framework (2025–2028) to embed quality as a core principle across all services. This framework is designed to ensure that care is consistently safe, effective, patient-centred, timely, efficient, and equitable, aligning with the Health Board’s strategic ambitions and statutory duties.

Cefndir / Background

The framework is strategically aligned with:

- The Health and Social Care (Quality and Engagement) (Wales) Act 2020, including the Duty of Quality and Duty of Candour.
- The Health and Care Quality Standards 2023, underpinned by the Safe, Effective, Patient-Centred, Timely, Efficient and Equitable (STEEEP) principles.
- The ABUHB Quality Strategy 2023–2026, which sets out the vision for quality improvement.

It integrates national guidance, including Improvement Cymru and Healthcare Inspectorate Wales (HIW), and supports the Quadruple Aim through a structured approach to Quality Planning, Control, Improvement, and Assurance.



Asesiad / Assessment

The framework introduces a robust system of governance and assurance, including:

- A whole-system approach to quality, supported by leadership, culture, and data.
- Clear escalation and reporting structures through the Quality Management Group, Patient Quality Safety Outcomes Committee, and Executive Committee.
- A focus on clinical effectiveness, patient experience, and learning from deaths, supported by the Clinical Advisory Forum and Quality Impact Assessments.
- A commitment to building capacity through the Q Community Quality Improvement Coach Programme, aiming for a million minutes of coaching over four years.
- Integration of patient and public involvement to ensure services reflect what matters most to those we serve.

Argymhelliad / Recommendation

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

1. Endorse the implementation of the Quality Management System Framework as the foundation for all quality assurance and improvement activity.
2. Receive assurance through the established governance structures, using the Quality Outcomes Framework and highlight and exception reporting from the Quality Management Group.

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

Cyfeirnod Cofrestr Risg Datix a
Sgôr Cyfredol:
Datix Risk Register Reference
and Score:

Safon(au) Gofal ac Iechyd:
Health and Care Standard(s):

Blaenoriaethau CTCI
IMTP Priorities

[Link to IMTP](#)

All Health & Care Standards Apply

Choose an item.

Choose an item.

Choose an item.

Choose an item.



Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Experience Quality and Safety Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

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

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





GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

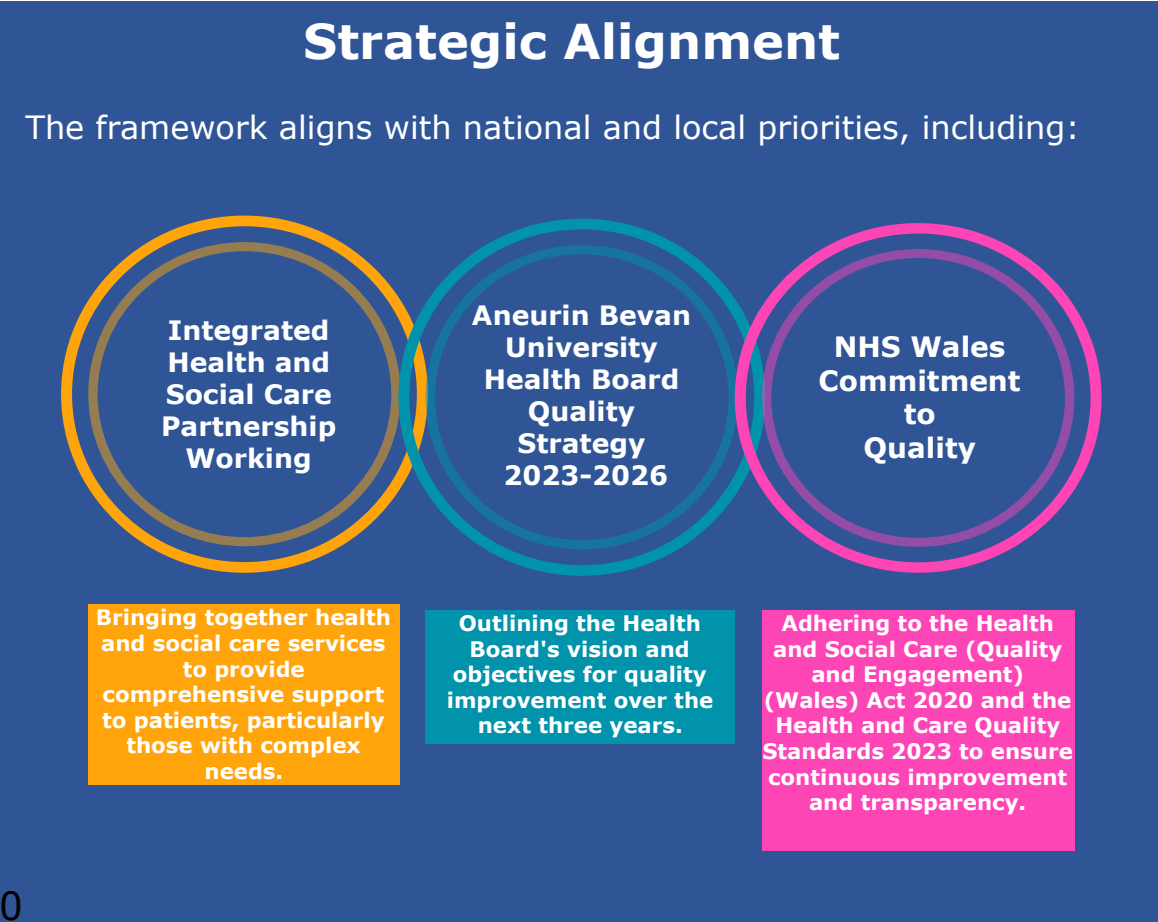
Quality Management System Framework

2025 - 2028



1. Executive Summary

The purpose of the Quality Management System Framework for Aneurin Bevan University Health Board is to establish a structured approach to ensuring the delivery of high-quality health care ensuring that services are truly patient-centred and responsive to the needs and preferences of those receiving care. This framework is designed to guide the Health Board in implementing practices that guarantee patient care is consistently safe, effective, patient-centred, timely, efficient, and equitable. It is a process to ensure that the system is operating effectively and providing quality care in line with standards, guidelines and policy.



Key Components



Expected Outcomes

By following this Quality Management System Framework, ABUHB aims to:



This framework serves as a comprehensive guide to ensure that quality assurance is an integral part of everyday operations through delivery of the Quality Management System, leading to sustained improvements in healthcare delivery.

2. Introduction



Quality assurance in healthcare is essential to ensure that services provided are safe, effective, patient-centred, timely, efficient, and equitable. For Aneurin Bevan University Health Board, this means implementing practices that guarantee patient care is consistently of the highest standard. The Quality Management System will set out the Assurance Framework which will enable the delivery of safe high-quality care. In order to deliver the Quality Management System and Quality Assurance the Framework will link to the following existing documents and standards.



NHS Wales Commitment to Quality

Health and Social Care (Quality and Engagement) (Wales) Act 2020

- **Duty of Quality**: This act places an overarching duty of quality on NHS bodies and Welsh Ministers, requiring them to continuously improve the quality of health services.
- **Duty of Candour**: Establishes a duty of candour on NHS service providers, promoting openness and honesty with patients and service users when things go wrong.
- **Public Engagement**: Replaces Community Health Councils with **Llais**, an all-Wales citizen body for health and social care, to amplify the voices of citizens in the planning and delivery of services.

2.1 Health Board's Quality Strategy 2023-2026

The ABUHB Quality Strategy 2023-2026 outlines the Health Board's vision and ambitions for quality over the next three years. Key elements include:



1

Establishing a clear vision for high-quality care that is safe, effective, and patient-centred. The strategy sets specific objectives to achieve this vision, including improving patient outcomes, enhancing patient experience, and ensuring operational efficiency.



2

Implementing targeted quality improvement initiatives across various areas of care, such as patient safety, clinical effectiveness, and patient engagement



3

Developing robust mechanisms for monitoring and evaluating the impact of quality improvement initiatives, ensuring continuous learning and adaptation

2.2 Quality Management System Principles

The principles for a Quality Management System are designed to ensure Health Board services continuously meet the needs of the population in a reliable and sustainable manner. The key principles are:

Quality Planning: This involves setting objectives and processes required to meet the desired quality standards. It includes identifying the needs of the population and planning how to meet those needs effectively.

Quality Improvement: Continuous efforts to improve the quality of healthcare services. This principle focuses on enhancing processes and outcomes through systematic efforts and innovations.

Quality Control: Monitoring and evaluating the performance of healthcare services to ensure they meet the established standards. This involves regular assessments and adjustments to maintain quality.

Quality Assurance: Ensuring that the healthcare services provided are of high quality and meet the required standards. This principle involves systematic activities and processes to provide confidence in the quality of services.

Leadership and Culture: Strong leadership and a culture that prioritises quality are essential. Leaders at all levels must be committed to quality and foster a culture that supports continuous improvement.

Learning and Research: Encouraging a learning environment where staff can continuously develop their skills and knowledge. Research and evidence-based practices are crucial for informed decision-making and improvement.

Whole System Approach: Integrating quality management across all levels and departments within the Health Board. This ensures a cohesive approach to quality that involves everyone from frontline staff to senior management.

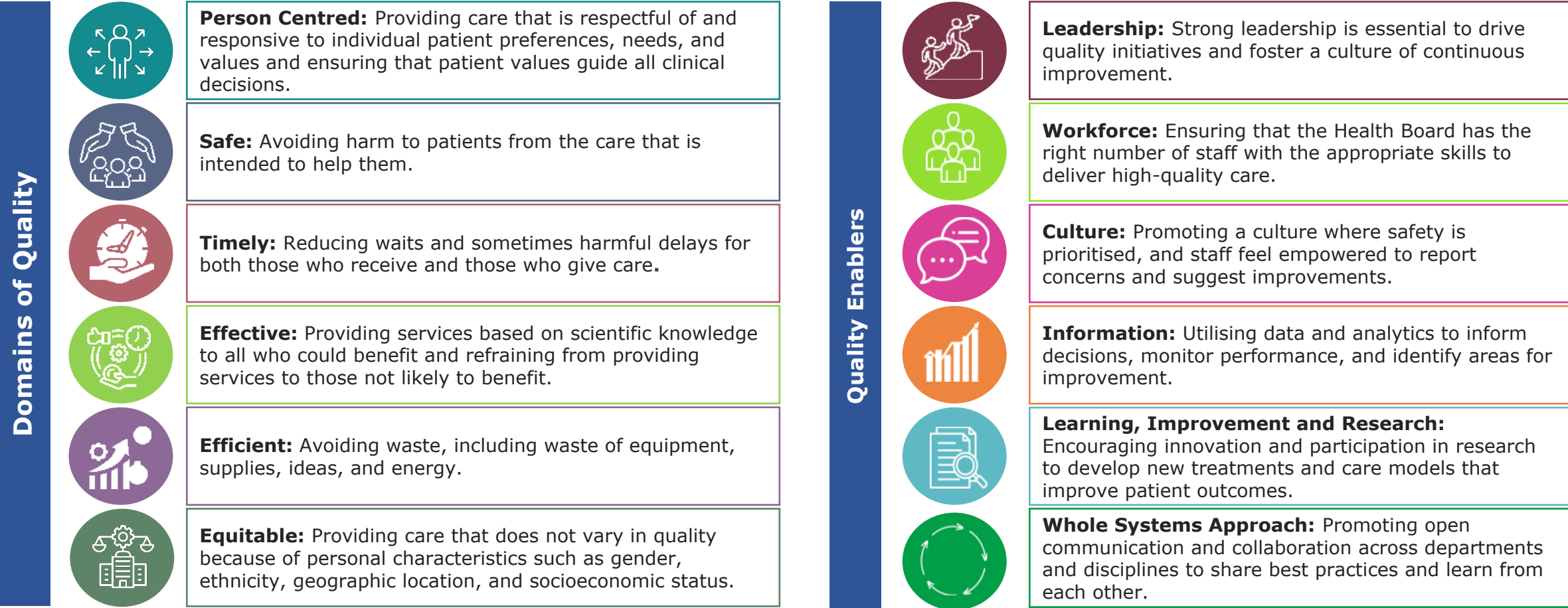
Information and Data: Utilising data and information effectively to monitor, evaluate, and improve quality. Accurate and timely data is essential for making informed decisions and tracking progress.

2.3 Health and Care Quality Standards 2023

The [Health and Care Quality Standards 2023](#) sit within the broader context of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, which places an overarching duty of quality on NHS bodies and Welsh Ministers, requiring continuous improvement in the quality of health services. This ensures that quality assurance is an integral part of everyday operations, leading to sustained improvements in healthcare delivery.

The standards provide a clear framework for planning, delivering, and monitoring healthcare services in Wales. They are based on the STEEP principles (Safe, Timely, Effective, Efficient, and Person-centred care), ensuring a comprehensive approach to quality.

NHS Wales uses the standards to guide quality improvement efforts and ensure that healthcare services meet the highest standards of care.



3. Quality Management System

The NHS Wales Framework for quality assurance illustrated below is designed to achieve the Quadruple Aim. Further to this, the [NHS Wales Quality Management Framework](#) comprises the Juran Trilogy – Quality Planning, Quality Control and Quality Improvement – with Quality Assurance as the overarching process which draws these elements together.



Key Objectives

1 Enhance Patient Safety Implement strategies to minimise risks and prevent harms	2 Improve Clinical Effectiveness Ensure that clinical practices are based on the best available evidence and achieve the best possible outcomes.	3 Promote Patient-Centred Care Foster a culture that prioritises the needs and preferences of patients.	4 Increase Efficiency Optimise resource use to deliver high-quality care efficiently.
5 Ensure Equity Address disparities in healthcare access and outcomes to ensure all patients receive high-quality care.	6 Measure the Impact of Timely Care Ensure that the quality and safety impact of timely care is measured and understood	7 Strengthen the Pillars of Quality Assurance By setting clear performance metrics and monitoring systems for each pillar. This ensures comprehensive, high-quality care that is safe, effective, patient-centred, timely, efficient, and equitable.	8 Quality Impact Assessment Evaluate changes to service access and delivery to ensure patient safety, effectiveness, and experience, while preventing health inequalities and promoting quality improvement.

3.1 Quality Planning

This is the process for leadership to annually plan and prioritise the design and redesign of processes, services and products, allocate resources and identify capacity and capability to meet population needs. The process will be strategically aligned to local and national Value Based Healthcare priorities; it will help to prioritise with a focus on the 4 pillars of value; **Allocative Value:** equitable distribution of resources across all patient groups, **Technical Value:** Achievement of best possible outcomes with available resources, **Personal Value:** Appropriate care to achieve patients' personal goals, **Societal Value:** Contribution of healthcare to social participation and connectedness.

Long-Term Priorities

PATIENT SAFETY

Continuously reducing harm and preventing adverse events through robust safety protocols and a culture of safety.

CLINICAL EFFECTIVENESS

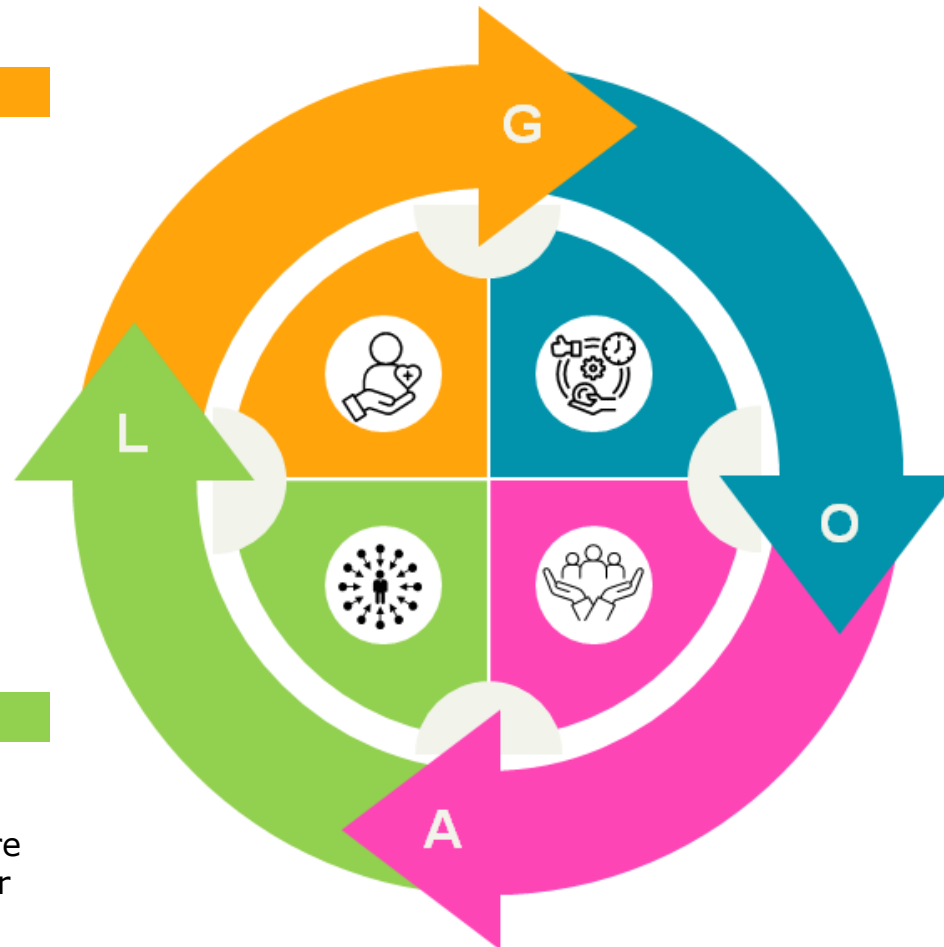
Ensuring that all clinical practices are evidence-based and regularly updated to reflect the latest research and guidelines.

PATIENT-CENTRED CARE

Enhancing patient engagement and satisfaction by involving patients in their care decisions and tailoring services to meet their needs and preferences.

HEALTH EQUITY

Addressing disparities in healthcare access and outcomes to ensure that all patients receive high-quality care regardless of their background or circumstances.



3.2 The Role of the Clinical Advisory Forum/Quality Impact Assessments

The ABUHB Clinical Advisory Forum and Quality Impact Assessments work together to ensure healthcare decisions are both evidence-based and aligned with the highest standards of patient care. The forum provides a space for clinicians to share their expert advice, offering a multidisciplinary perspective on strategic policies and initiatives. This ensures that decisions are informed by frontline experience and clinical expertise.

Quality Impact Assessments compliment this by systematically evaluating the potential effects of these decisions on service quality, patient safety, and overall healthcare outcomes. By identifying risks and benefits, they help ensure that strategies proposed or reviewed by the Clinical Advisory Forum is carefully scrutinised and optimised for delivering safe, effective care.

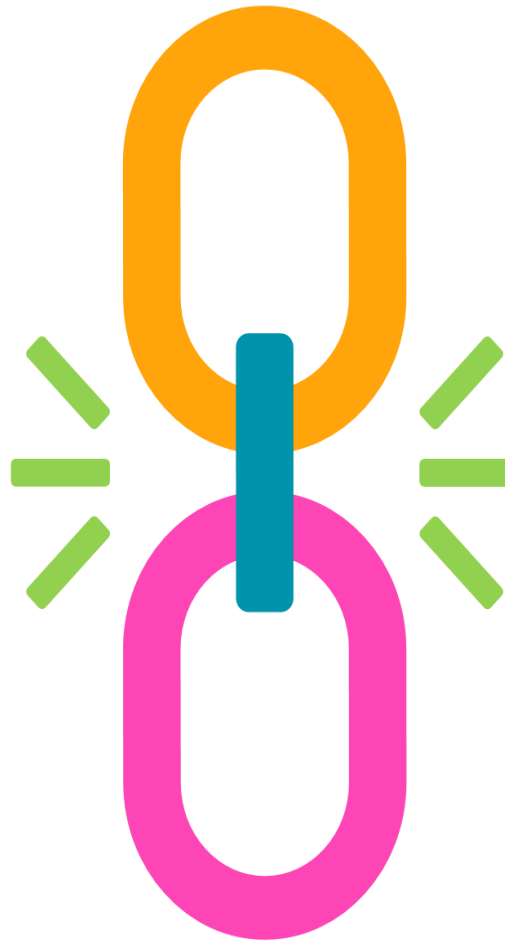
In essence, Clinical Advisory Forum clinically guides the "what" and "why" of clinical policies and processes, while Quality Impact Assessments ensure the "how" remains safe, efficient, and high-quality. Together, they form a robust framework to uphold and improve healthcare standards across ABUHB.



3.3 Creating the Environment for Quality

Creating an environment conducive to quality improvement involves several key elements:

- Strong leadership is essential to drive quality initiatives and foster a culture of continuous improvement. Leaders should visibly support and prioritise quality improvement efforts.
- Engaging healthcare professionals at all levels in quality improvement activities ensures that those closest to patient care are actively involved in identifying and implementing improvements.
- Providing ongoing training and development opportunities for staff to enhance their skills in quality improvement methodologies and tools.
- Utilising data and analytics to inform decisions, monitor performance, and identify areas for improvement.
- Promoting open communication and collaboration across departments and disciplines to share best practices and learn from each other.
- Effective workforce planning is essential to ensure that the Health Board has the right number of staff with the appropriate skills to deliver high-quality care.



3.4 Linked Priorities

Key priorities include:

- Maintaining high standards of clinical care through adherence to evidence-based guidelines and continuous professional development.
- Actively involving patients in their care and ensuring their voices are heard in decision-making processes.
- Encouraging innovation and participation in research to develop new treatments and care models that improve patient outcomes.
- Supporting the wellbeing of healthcare professionals to ensure they can provide the best possible care to patients.
- A process designed to encourage colleagues to raise concerns safely within a culture where no individual will suffer victimisation or detrimental treatment as a result of speaking up. It aims to foster a positive environment where people feel their voice will be heard and their suggestions acted upon.

Innovation, Research, and Improvement System

The Health Board aims to achieve a sustainable, streamlined, efficient, and innovative research infrastructure built on three strategic objectives:

A sustainable and supported research workforce

Investment in staff and infrastructure

A streamlined, efficient and innovative research programme

3.5 Quality Control

Connected daily operational management to monitor and maintain quality, including the use of real-time measures over time.

Arrangements for Monitoring and Reporting:

The Quality Outcomes Framework and the Quality Commissioning Framework provide a detailed structure for monitoring and reporting across various pillars, each with specific performance metrics and quality outcomes.

Pillar 1: Emphasises both patient and staff experiences, incorporating metrics like patient satisfaction trends and staff culture assessments. Includes analysis of complaints, concerns, and compliments, with performance indicators and resolution time benchmarks.

Pillar 2: Strengthens patient safety through incident reporting, tracking metrics like crude mortality rates, incident severity, and compliance with national standards. Implements monitoring systems, audits, and reporting protocols to drive continuous improvement.

Pillar 3: Emphasises clinical effectiveness by focusing on the consistent application of evidence-based practices, robust clinical audit processes, and adherence to clinical standards to improve patient outcomes, reduce variation in care, and ensure continuous quality improvement across services.

Pillar 4: emphasises health, safety, and security, targeting compliance with statutory training and risk assessments.

Pillar 5: focuses on patient and staff experiences, utilising metrics such as patient satisfaction trends and developing metrics for staff culture.

Pillar 6: focuses on safeguarding, with metrics for reporting duties and training compliance.

Providing regular reports to the Board and relevant committees on quality and safety performance, ensuring transparency and accountability.

This structured approach ensures that each area is monitored effectively, promoting continuous improvement and high-quality outcomes.

Measuring and Assessing Quality:

Measuring and assessing quality is essential for monitoring progress and identifying areas for improvement. The Quality Outcomes Framework provides a detailed structure for tracking and reporting performance across multiple areas, each with its own set of metrics and quality benchmarks.

Key approaches include:

- 

Use structure, process, and outcome measures to assess and compare the quality of healthcare services. Structural measures assess the capacity and systems in place, process measures evaluate the actions taken to maintain or improve health, and outcome measures reflect the impact of care on patient health.
- 

Develop and track key performance metrics to monitor progress and identify areas for improvement. This includes clinical outcomes, patient satisfaction, and operational efficiency.
- 

Establish mechanisms for ongoing monitoring and evaluation to ensure that quality improvement initiatives are effective and sustained over time.

By focusing on these areas, the Aneurin Bevan University Health Board can drive significant quality improvements, leading to better patient outcomes, enhanced patient experiences, and more efficient care delivery.

3.6 Quality Improvement

We aim to become a learning organisation by measuring our progress and guiding our actions. We will enhance and refine our Quality Improvement approach to solve complex problems, ensuring a consistent methodology for testing change ideas and informing our decisions.

Developing a structured framework to ensure consistent and integrated quality improvement efforts.

- **Building QI Capacity:** Training staff and providing tools to apply quality improvement principles effectively.
- **Creating QI Conditions:** Establishing an environment that supports and encourages quality improvement activities.
- **Fostering QI Connections:** Promoting collaboration and shared learning among teams and partners to drive collective improvement.
- **A million minutes of quality improvement coaching:** We aim to improve our services over the next 4 years by achieving a million minutes of quality improvement coaching. Through the Q Community Quality Improvement Coach Programme, we will develop 75 Quality Improvement Coaches each year by running 3 cohorts annually. We will select participants based on clear criteria, provide comprehensive training and resources, track progress, offer mentorship, and communicate updates while recognising achievements. This initiative will enhance service quality and build a strong community of skilled coaches. Deployment of coaches will be in line with organisational priorities once trained.
- **Patient Feedback:** Regularly collect and act on patient feedback to inform improvements. This provides valuable insights into patient experiences and areas needing enhancement. This process is underpinned by the ABUHB Patient Experience and Engagement Strategy, which ensures that patient feedback is integrated into a comprehensive approach to enhance patient experience and engagement.



3.7 Patient and Public Involvement



1

Representation

- Patients should broadly represent the relevant population

2

Inclusivity

- The Health Board should allocate sufficient resources to overcome barriers such as access or communication issues.

3

Early and Continuous Improvement

- Patients should be involved as early as possible and throughout the process. Their involvement should span all areas of the Health Board's quality improvement and assurance work.

4

Transparency

- Participants should be able to see and understand how decisions are made, with audit data and outcomes published in clear and understandable formats.

5

Clarity of Purpose

- The nature and scope of involvement should be defined before participation begins.

6

Cost Effectiveness

- Involvement should add value and be cost-effective.

7

Feedback

- Outcomes of quality improvement activities should be communicated back to participants.

Quality improvement in healthcare aims to enhance patient safety, outcomes, person-centred care, and experiences by measuring and improving the effectiveness of clinical services. Effective quality improvement projects should focus on what matters to patients, involving them throughout the entire process to ensure optimal results.

Patients and the public provide a unique perspective on service development, identifying necessary improvements based on their first-hand experiences. Their involvement offers insights into preferred indicators for measuring the quality of care and identifying what is needed to maintain and improve care quality in the future.

Meaningful involvement in quality improvement should lead to service enhancements and better health and wellbeing for patients and service users. This requires collaboration between patients, the public, and healthcare professionals. Key indicators will ensure that the patient's voice informs quality improvement and assurance.

4. Clinical Effectiveness

Ensuring clinical care is consistently safe, effective, and evidence-based is central to the Health Board's vision. Here's how we are focusing on clinical effectiveness to support quality and patient safety:

National Clinical Audit Programme

The Health Board actively participates in the National Clinical Audit Programme. By using its findings, we benchmark the quality of care we provide and identify areas for focused improvement. Each national audit offers valuable insights into our strengths and areas for development. These insights are discussed by the Clinical Standards and Effectiveness Group and reported to the Patient Quality, Safety, and Outcomes Committee, ensuring clear oversight and accountability.

Structured Audit Participation including local audit

We have developed and implemented a Clinical Audit Strategy, Annual Clinical Audit Plan, and an Annual Audit Report. This structured approach ensures our participation in national and local audits remains purposeful. Local actions and recommendations shaped from audit results help us refine practices, raise standards, and deliver better outcomes for our patients. These actions are recorded on our Audit Management and Tracking (AMaT) system.

Continuous Improvement

Our ongoing focus on clinical effectiveness ensures we continue to improve, respond to evidence, and provide the highest quality care to the communities we serve. We work closely with NHS Wales Boards, Trusts, and the NHS Wales Executive through the Safer Care Partnership. This national collaboration supports local teams in delivering safe, reliable, and high-quality care.

Quality Improvement Initiatives

We have refreshed our approach to quality improvement and strengthened our ability to deliver change. National work continues around caring for deteriorating patients and using standardised early warning scores to keep people safe. Other focused areas include tackling deconditioning (loss of physical ability due to inactivity) and building a strong Quality Management System to guide everything we do.

Learning from Deaths Framework

We have strengthened our approach through the development of a comprehensive Learning from Deaths framework, supported by a detailed report capturing key mortality metrics and insights. This work is triangulated with the Medical Examiner Service, which now covers all deaths within the Health Board. Themes identified through these reviews are shared via newsletters and briefings, ensuring learning is disseminated across teams and embedded into practice.

By focusing on these areas, we ensure that clinical effectiveness supports quality and patient safety, ultimately providing the highest quality care to our communities.

5. Governance Arrangements for Quality in Aneurin Bevan University Health Board

The governance arrangements for quality at Aneurin Bevan University Health Board are designed to ensure accountability, transparency, and continuous improvement in healthcare services. Key elements include:



By implementing these governance arrangements, Aneurin Bevan University Health Board ensures that quality and safety are at the heart of its operations, driving continuous improvement and delivering high-quality care to patients.

- **Patient Quality Safety Outcomes Committee:** A dedicated committee responsible for overseeing quality and safety initiatives, ensuring alignment with strategic goals, and monitoring performance.

- **Quality Management Group:** A formal sub-group of the Executive Committee, providing assurance to the Board through the Patient Quality, Safety, and Outcomes Committee by ensuring the Health Board's Quality Strategy and Patient Experience and Involvement Strategy are effectively implemented and monitored.

- **Executive Leadership:** Senior leaders, including the Chief Executive and Clinical Executives with the Executive Director of Nursing as the lead Director for Quality, are accountable for quality and safety, providing strategic direction and support.

- Promoting a culture where safety is prioritised, and staff feel empowered to report concerns and suggest improvements.
- Encouraging a mindset of continuous improvement, where staff are engaged in identifying and implementing quality improvement initiatives.

- Defining roles and responsibilities for quality and safety at all levels of the organisation.
- Quality Assurance Framework aligning quality governance with other organisational governance structures ensuring a cohesive approach to quality and safety,

5.1 Escalation Arrangements

Effective escalation arrangements are crucial for addressing quality issues promptly and ensuring continuous improvement. Key principles include:



01

Utilise the Health Board Performance Management Framework to be clear on roles and responsibilities at each level. This ensures issues are directed to the appropriate personnel with the necessary authority and expertise to resolve them efficiently.

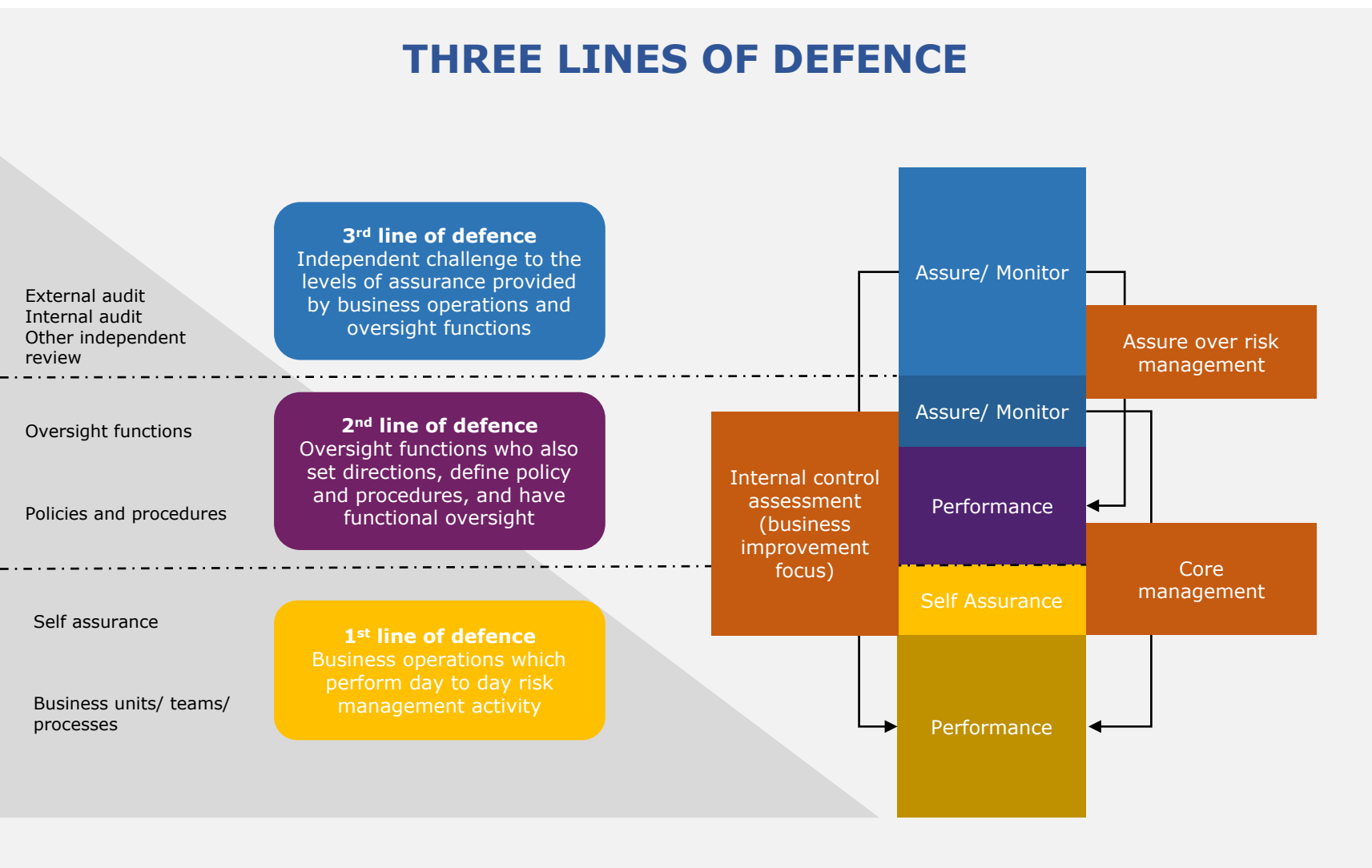
02

Maintain clear communication channels to facilitate prompt and efficient communication throughout the escalation process. As described in the Performance Management Framework. Regular updates should be provided to all involved parties.

03

Focus on identifying the underlying root causes of issues rather than just addressing immediate symptoms. This helps prevent recurrence and drives long-term improvements.

6. Organisational System of Assurance



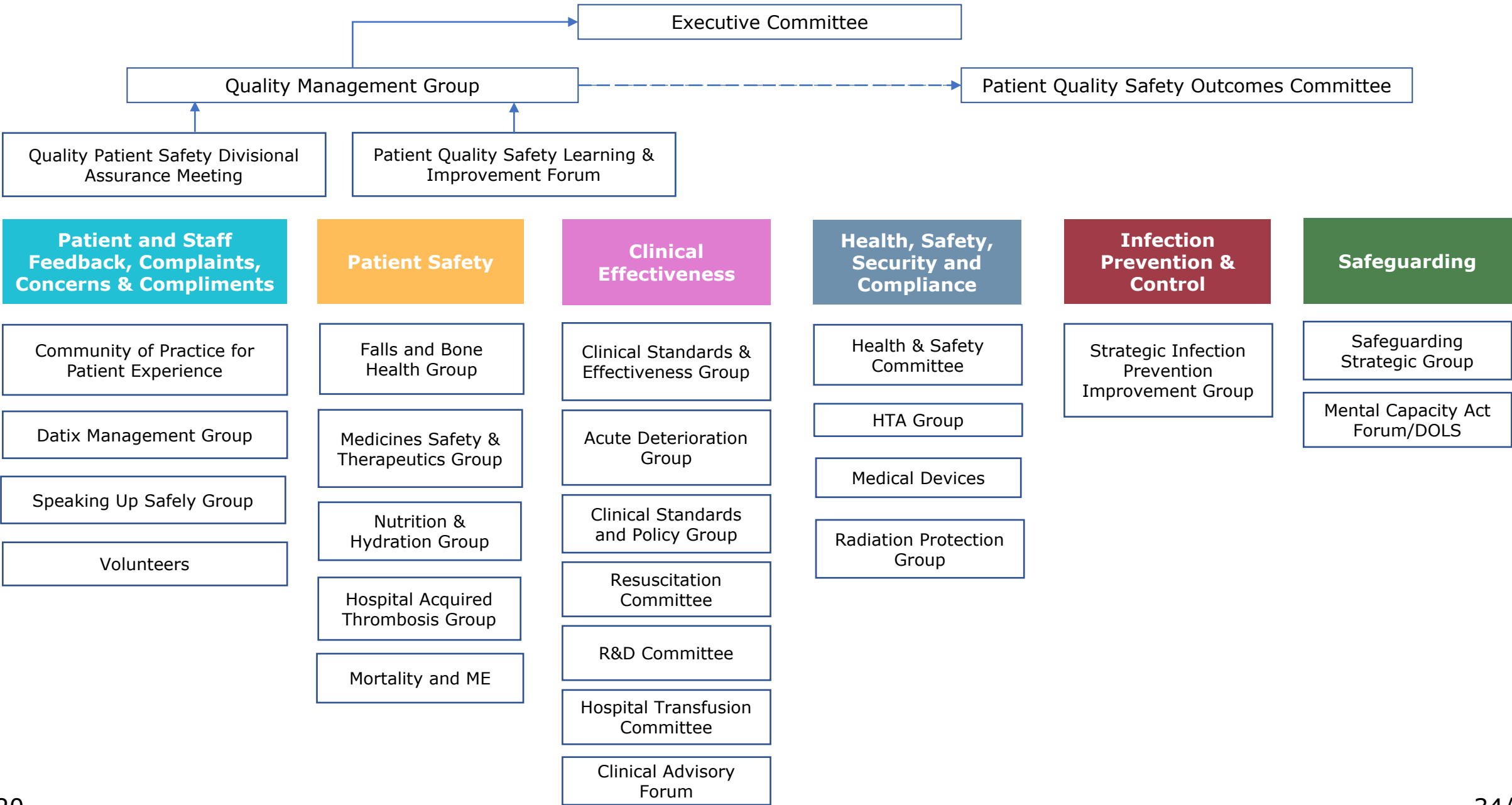
Examples of Assurance Sources for Quality Management		
1 st Line	2 nd Line	3 rd Line
Divisional Quality Assurance Reports	Welsh Risk Pool Reporting	HIW Reviews
Concerns Management Dashboard	Infection Prevention and Control Reports	HSE Inspections
Serious Incident Reviews	Putting Things Right Reports	Llais Reviews and Visits
Quality Improvement Evaluations	Clinical Negligence and Personal Injury Reports	Internal Audit Reviews
	Clinical Audit Reviews	External Audit Reviews
	Patient Safety Alert Compliance	Royal College Reviews

7. Regulatory Compliance for Quality

Key aspects of regulatory compliance for quality in Wales include:

Duty of Quality NHS organisations are legally obligated to continuously improve the quality of services and to ensure they are safe, timely, effective, efficient, equitable, and person-centred.	Regulatory Oversight CIW and HIW are responsible for regulating and inspecting health and social care services, including ensuring compliance with regulations and standards.	Quality Assurance and Improvement Service providers are expected to have effective arrangements in place for ongoing quality assurance and quality of care reviews.	Information and Advice Quality Framework (IAQF) IAQF Wales aims to ensure that information and advice providers meet safety, responsiveness, and effectiveness standards, with a focus on continuous improvement.
Statutory Guidance The Welsh Government provides statutory guidance to assist NHS bodies and others in fulfilling their obligations under the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and related regulations.	Quality of Care Reviews Regulated services are required to conduct regular quality of care reviews to assess the quality and safety of their services, according to Care Inspectorate Wales.	Compliance with Regulations Service providers must comply with the regulations and statutory guidance related to quality and safety requirements.	Citizen Engagement The Duty of Quality aims to ensure a stronger citizen voice and to improve the accountability of services to deliver a better experience and quality of care.

8. Quality Assurance Framework

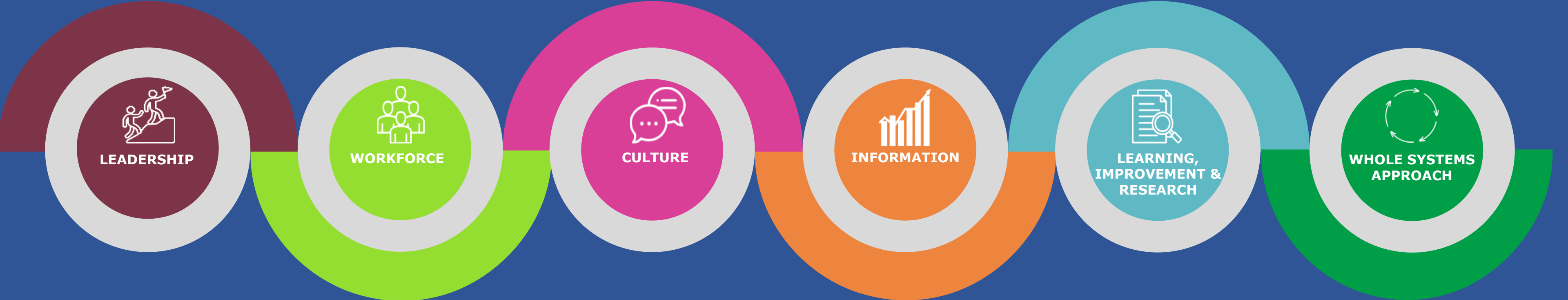


9. Reporting Arrangements

Board	• Focussed narrative report	Quarterly
	• Quality metrics in the Integrated Performance Report	Bi-monthly
Executive Committee	• Exception report from QMG	Bi-monthly
	• Clinical Advisory Forum/QIA outcome report	Quarterly
Patient Quality Safety and Outcomes Committee	• Refreshed and succinct QOF	Quarterly
	• Exception report from QMG	Bi-monthly
Quality Management Group	• Divisional exception report	Bi-monthly
	• Group exception reports	Bi-monthly
Executive Committee Performance Oversight Meeting	• Via Integrated Performance Report	Quarterly

10. Summary

- The Quality Management System Framework for Aneurin Bevan University Health Board aims to ensure that healthcare services are consistently high-quality, focusing on safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. This is achieved through the quadruple aim of Quality Planning, Quality Control and Quality Improvement linked together through Quality Assurance.
- For ABUHB, the Quality Management System will be fundamentally underpinned by Patient and Public Involvement and triangulation of quality data through truly 'hearing' and listening to the experience and stories of patients and their families, enhanced by a culture of 'what matters to me' conversations and Care Aims.
- The experience of staff and the creation of a culture where staff feel safe to raise concerns will further support continuous improvement and the provision of safe care.
- By following this framework, ABUHB aims to create a culture of continuous improvement in an environment where compassion for people and clinical excellence can flourish, this will ultimately lead to better patient outcomes and more efficient care.



Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Quality Outcomes Framework Metrics – Year Three



Pillars of Quality and Quality Outcomes Framework

The Health Board's Quality Strategy is underpinned by "A Healthier Wales," focusing on quality and safety through our 'pillars of quality' program. These pillars help review performance and reporting to the Board and PQSOC, ensuring high standards of care in:

- Patient and staff feedback, complaints, concerns and compliments
- Patient Safety
- Clinical Effectiveness
- Health, safety, security and compliance
- Infection prevention and control
- Safeguarding

The Quality Outcomes Framework is being mapped from the Health and Care Quality Standards to the pillars of quality.

Reflecting 'always on' reporting the primary indicators mapped to the pillars will be updated monthly and reported quarterly to PQSOC.

Working with Digital, Data and Technology a dashboard will be produced that will enable more efficient reporting and trends to be seen.

The other indicators will be available but reported by exception. Once data is available and trends are visible then a deep dive process can be established to determine if there needs to be a highlight report on certain areas.



Quality Outcomes Framework

The Health Board developed a Quality Outcomes Framework (QOF) as part of its Quality Management System is being refined for 2025/26. This framework tracks outcomes to systematically measure, monitor, and enhance healthcare quality.

The QOF aimed to enable continuous improvement with key goals to:

- . Identify improvement areas and patient safety risks
- . Establish benchmarks and quality indicators
- . Promote evidence-based practices
- . Enhance patient satisfaction and experience
- . Ensure compliance with standards and regulations
- . Enable data-driven decisions and resource allocation
- . Foster a culture of accountability, transparency, and learning

The QOF has enhanced **reporting requirements** to the Board and Executive Committee, and providing assurance to PQSOC. Benefits of the QOF have included:

- . Improved patient outcomes and safety
- . Enhanced patient experience and satisfaction
- . Increased adherence to evidence-based practices
- . Efficient resource utilisation
- . Regulatory compliance
- . Improved staff engagement and professional development
- . Accountability and transparency in care delivery

PILLAR 1

Patient and staff feedback, complaints, concerns and compliments

Civica

Collaboratives Forums

Patient Stories

PTR Regulations

Early resolution

Staff Training and Mentorship (IO)

Volunteering

Patient Advice and Liaison Service (PALS)

Leadership, Accountability and Culture

Complaints PSOW – Themes and Learning

Speaking up Safely

Cultural Competence Accreditation Scheme

Dementia Standards

Listening and Learning Meetings

Proposed Metrics: -

- CIVICA data
 - Total new responses
 - Patient satisfaction % positive emotion trend, negative emotion trend
- Staff culture – WF&OD
- 30 day performance
- Complaints
 - Review layers to look at compliance and closure
- Compliments
- PALS (especially early resolution)
- Narrative – AI for themes and use of stories

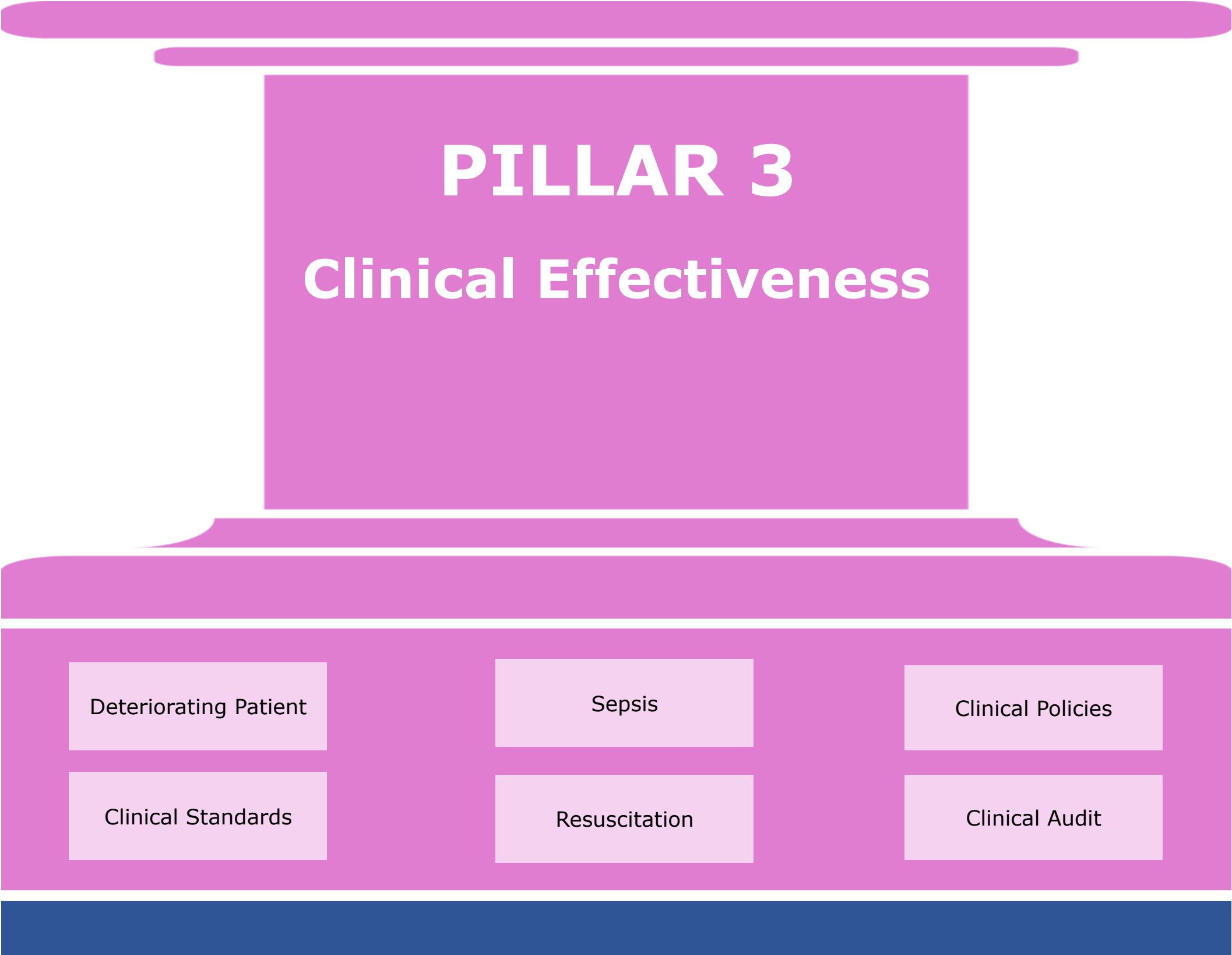
PILLAR 2

Patient Safety including Incident Reporting

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

Proposed Metrics: -

- Mortality
 - Suicide rate
 - Neonatal Death
 - Still births
- Incidents presented as – level of harm and closure date of incident
 - Global category of incident to ensure themes care captured – PUs, falls, HATs, medicines, H&S, RIDDOR
 - Ensure rate is accurate, e.g. DVTS per patient episode, falls – severity of harm against OBD, co-ordinated metric 1,000 bed days
 - Level of harm
 - Trends in severe medicines incidents
 - Closure/ validation compliance
- Nationally reportable incidents, harm & compliance with closure timeframes
- Duty of candour – Datix numbers and themes, indications (WRP report)
- Thematic analysis of Regulation 28 reports
- Thematic analysis of Patient Safety Incidents
- Number of inquests that take place face to face (compared to the number completed on paper), ensuring meeting family needs
- Investigate the possibility of capturing incidents related to urgent care delays / flow in DATIX.



PILLAR 3

Clinical Effectiveness

Proposed Metrics: -

- Number of in-hospital Cardiac Arrests
- Audit – proportion of audit recommendations reported as completed within 12 months
- Audits – review risk, look at proportion with limited assurance and review clinical audit risk
- Ward accreditation - % of wards achieving bronze, silver, gold, platinum
- Low birth weight babies
- Fracture neck of femur pathway – time-based outcomes in relation to fracture and bone health

PILLAR 4

Health, Safety, Security and Compliance

Competent People

Compliance
Assurance

Risk
Management

Learning from
Events

Asset
Management

Communication

Emergency
Preparedness

Leadership,
Accountability
and Culture

Measuring
Performance

Security
Management

HSS
Dashboards

Fire Safety
Management

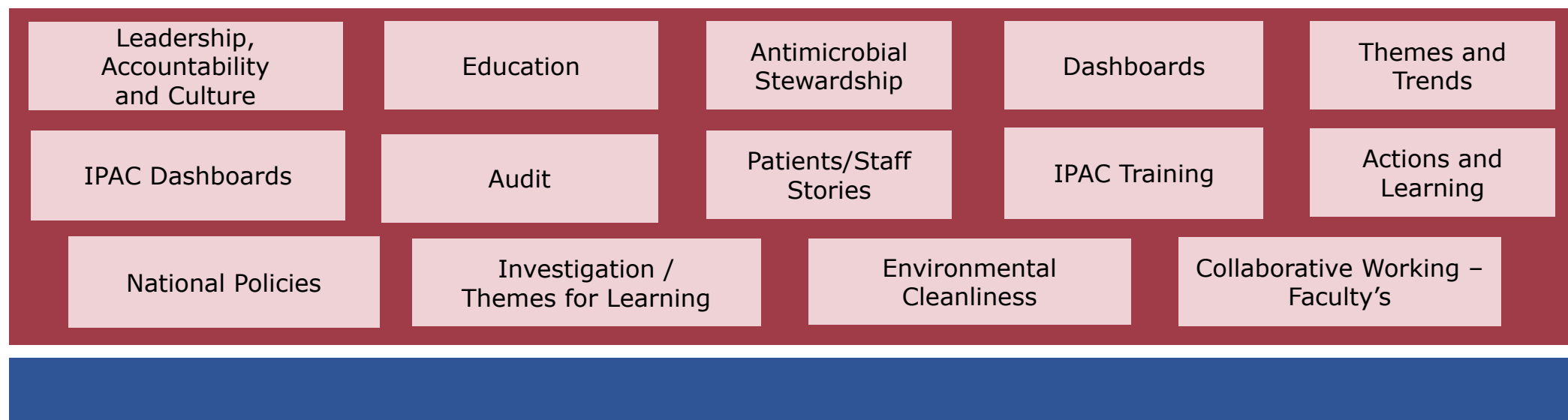
Manual
Handling

Proposed Metrics: -

- RIDDOR reporting compliance (in line with HSE criteria) – target 100%
- Health & Safety statutory and mandatory training compliance – target 85% all modules
- Compliance with the Health Board Health, Safety & Fire risk assessment programme – target 100%

PILLAR 5

Infection Control and Prevention



Proposed Metrics: -

- Infection Control measures including DECI & Hand Hygiene
- Welsh Government Reduction Goals
- C-Section Surgical Site Infections
- AMR prescribing trends
- Audit & Education: Respiratory Infections

PILLAR 6

Safeguarding

Policy/SOP

Leadership,
Accountability and
Culture

Level 1, 2 and 3
Training

Safeguarding
Supervision

Practitioner
Concerns

Partnership
Working

Domestic Abuse
and Sexual Safety

Deprivation of Liberty
Safeguards/ Mental
Capacity Act

Statutory
Reviews

Proposed Metrics: -

- Adult Duty to Report / Child Duty to Report
- Training compliance
- Themes from domestic homicide reviews and serious case reviews

Additional Indicators STEEP

These indicators will form layer two of the QOF expectation of regular reporting will be defined

Safe

- Number of readmissions within 7 days and 28 days
- CEDAR measure (deconditioning)

Timely

- Patient experience themes and reviewing complaints, PREMS for elective services / long waits
- Time limited interventions in stroke pathway – within 4 hours, review thrombolysis and thrombectomy data patient experience impact

Effective Metrics:

- Number of quality improvement coaches / people trained in QI - work with Rachel Trask to review QI measures

Equitable Metrics:

- What measures do we have for dementia?
- To be confirmed - metrics for neurodiversity and learning disabilities in the quality outcomes framework.
- Mortality gap for LD
- BME Group stillbirth rate

Professional Standards

- WF&OD - Staff registered and fit to practice – registered workforce.
- Proportion of staff undergoing a FTP process

Additional Indicators

- Delayed transfers of care (ITU transfers onto wards)
- % occupancy of long stay- steps downs
- Inappropriate conveyance into hospital (patients brought into hospital that didn't need to be). Surrogate measure or readmission. Proportion of ambulance and WAST conveyance rate.
 - Inappropriate attendance
 - Delayed handover
- Preferred place of death (DNACPR/ TEPs)

It was noted not all of these measures may be available, so they would be explored to define what could be reported end of life measure –immediately, and what would be longer term goals for reporting in the QOF.

Next Steps

- Refine measures for 2025/26 and test.
- Work with Digital, Data and Technology to automate reporting
- Align quarterly QOF dates with dates for PQSOC to establish reporting deadlines.
- National QOF is being established and Health Board will need to establish reporting on these indicators. Ensure timelines are established not to duplicate work.
- Develop deep dive process to look at when additional reports are needed for PQSOC.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	03 June 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Quality Performance Quality Outcomes Framework
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis – Assistant Director for Quality and Patient Safety Tracey Partridge Wilson - Deputy Director of Nursing

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

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

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

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

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

Cefndir / Background

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

This report provides a comprehensive overview of the Quality Outcomes Framework (QOF) for the 2024/25 and focus on Quarter Four (January to March 2025). There is a focus on patient safety incidents, patient experience, health and safety, safeguarding and infection prevention and control activity.

Asesiad / Assessment

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

The quality outcomes framework provides current data on quality and patient safety as mapped against the Pillars of quality:

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

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

Areas of Improvement

- Since its launch, the PALS service continues to receive around 481 enquiries per month. Work has been undertaken to review how the service supports the PTR process, allowing issues being resolved at an informal stage.
- Civica has been successfully implemented with a satisfaction rate at 89%, over the 85% benchmark. The new digital solution has helped to increase uptake. The top positive themes are compassion, emotional and physical support and friendlies.
- Mortality - the Health Board has seen improvement in the Risk Adjusted Mortality Indicator (RAMI), RAMI has been consistently lower than the Welsh Peer group for the majority of 2024. The Health Board is currently performing 1st of 6 within its All-Wales Peer Group.



- There were 84 Duty of Candour incidents triggered.
- There have been no new Never Events reported for Q4.
- Falls per 1000 OBD dropped below national average (6.4 in March).
- Pressure ulcer rates have shown improvement.
- Early resolution performance has improved to 71% in Q4. Compliments also increased for this Quarter.
- For this Quarter, the Health Board have reported 12 incidents to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). 84% of these cases were reported within the legal timeframes within the legislation.
- There has been significantly improved rates of uptake of Level 1 and Level 2 Safeguarding training above 80% however this has remained below the 85% requirement.
- The Health Board continues to support a number of nationally recognised quality improvement projects which are significantly improving patient safety and patient experience. The Safe Care Partnership has a number of workstreams, this includes, projects within acute deterioration, deconditioning and improving quality management systems.

Areas of Focus:

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

- Infection rates for C.Difficile have risen over the last 12 months, which is a picture seen across Wales. The reasons for this are complex with rates impacted by community prevalence, the number of people with complex co-morbidities, anti-microbial prescribing and poly pharmacy as well as a need to refresh basic good IPC practice. An improvement plan has been produced and is being enacted.
- Themes from incidents includes delayed diagnosis/ treatment. Healthcare associated infections and falls.
- There is continued focus on improving uptake and recording of level 3 safeguarding training, reporting on compliance will formally commence in Quarter 1 2025/26. The Safeguarding Team has however seen increased interest for Level 3 training with all courses now over subscribed for 2025.
- The Health Board continues to focus on sepsis awareness and prevention. Implementation of standardised early warning scores is underway.



- Legal services have seen emerging challenges with an increase in clinical negligence and inquest activity, this will be subject to increased focus in 2025/26

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

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

Argymhelliad/ Recommendation

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

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable currently
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 5. Timely Care 6.3 Listening and Learning from Feedback Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.



	Choose an item.

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

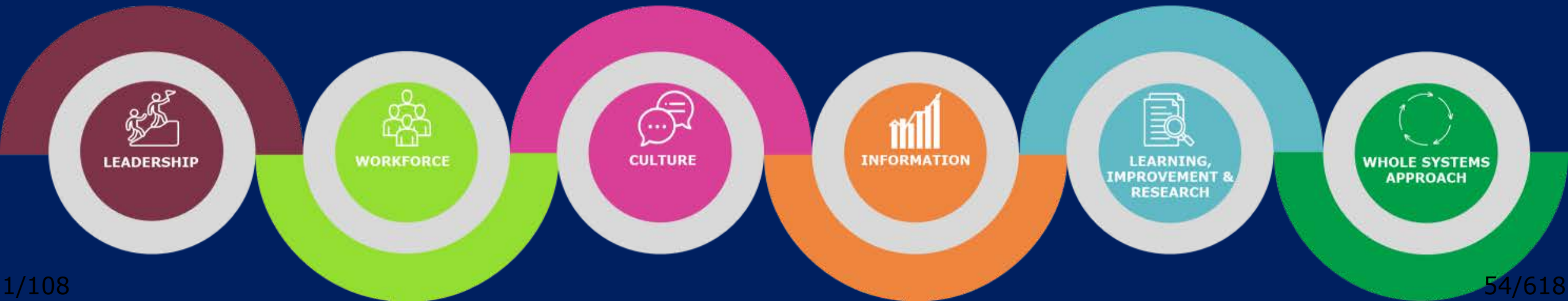
Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for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





Quality Outcomes Framework

Quarter One to Quarter Four: 2024/25



Overview



This is a combined report that includes the measures within quality outcomes framework (QOF) and an update of narrative, themes and learning. This provides the Board / Committee with an overview of the Health Board's quality and safety metrics and summary of performance. It is aligned to the Ministerial priorities and key challenges, to comply with the Duty of Quality.

This also covers the Health Board's quality priorities including the Quality and Safety Pillars, as included in the Quality Strategy, ensuring that the Patient Experience and Involvement Strategy has been embedded throughout the report.

For quarter four the existing QOF indicators have been mapped where possible. The QOF will be refined for 2025/26. There is work underway with Digital, Data and Technology Directorate to automate reporting and enable reports to be standardised, where possible. The use of iconography will provide detail on trends.

The Quarter Four report also focuses on learning and improvement. It includes:

Quality and Safety Pillars

- Indicators mapped to the refined Quality Outcomes Framework, proposed for 2024/25
- Narrative on indicators
- Additional information is available in the report to provide assurance against these standards

Escalated Risk Concerns

Clinical Effectiveness

Information

- Learning and Improvement Forum highlights
- Additional indicators as defined as potential indicators are being mapped as part of the
- iterative process of refining the reporting of the QOF





- The QPS team has undergone a significant restructuring to enhance data analysis and performance. The Deputy Head of QPS role has been redefined to support data and performance analysis, ensuring that our work aligns with the Quality Strategy, Patient Experience and Involvement Strategy and Quality Improvement Strategy .
- The Quality Outcomes Framework (QOF) has been refined to systematically measure, monitor, and enhance healthcare quality. This framework tracks outcomes to identify improvement areas, establish benchmarks, promote evidence-based practices, and ensure compliance with standards and regulations.
- A Quality Management System Framework has been developed and a Quality Management Group has been established with inaugural meeting scheduled for May 2025.
- We have been actively engaging with individuals who have raised concerns to co-create learning events. This collaborative approach ensures that the voices of those affected are heard and integrated into our learning and improvement processes
- The information guide for patients and families involved in Patient Safety Incident investigations has been updated. This guide, developed with input from those who have raised concerns, aims to provide clear and compassionate communication throughout the investigation process





- New guidance has been developed to support the effective chairing of Patient Safety Incident and Strategy Meetings. This ensures that meetings are conducted with clarity, purpose, and consistency.
- Patient Safety Incident Investigation Information Guide for Patients and Families updated with support from people who have raised concerns.
- The Welsh Risk Pool Action Plan is under review and implementation to address recommendations and improve our processes. This includes introducing KPIs for incident reporting and ensuring accurate recording of investigation outcomes.
- Escalation process in place to support Divisional teams implemented to support divisional teams in managing PSOW and other critical issues. This process ensures timely resolution and accountability.
- Regular meetings with the Divisional Triumvirate have been established to ensure alignment and support for the QPS agenda. These meetings facilitate communication, set work plans, and address divisional priorities.
- A comprehensive QPS Accountability Framework has been developed to clarify accountability relationships and roles across the Divisional Triumvirate and central QPSE Teams. This framework ensures robust systems and processes are in place to monitor, manage, and drive the delivery of the QPSE agenda.



Patient Quality and Safety Learning and Improvement Forum Highlights

The Patient Quality, Safety Learning and Improvement Forum held on 28th April focused on various aspects of patient experience, safety, and quality improvement within the Aneurin Bevan University Health Board. Some highlights include:

Patient Story: Patient Advice and Liaison Service (PALS)

A mother in Ireland contacted the PALS team after her son, a student in South Wales, experienced severe pain and long Emergency Department wait times. Frustrated and ready to leave without treatment, he was persuaded by PALS—who liaised with clinical staff and offered reassurance—to stay. This timely intervention led to an emergency appendectomy that evening. The mother later expressed deep gratitude, underscoring PALS's critical role in patient safety and family reassurance.

Organisational Learning and Improvement:

- The Research & Development team highlighted ongoing clinical trials and stressed the need to embed research into everyday clinical practice. Key challenges include limited capacity and the need for stronger interdepartmental collaboration. Positive steps include the Research Champion Programme and Good Clinical Practice training, both aimed at fostering a stronger research culture within the organisation.
- A new psychological support programme for cancer patients has been launched in response to patient feedback. It includes engagement initiatives like cancer cafés and patient panels, staff training on the psychological effects of cancer, and targeted support groups addressing issues such as uncertainty, fatigue, and intimacy.
- Following a HIW inspection in the Emergency Department, several improvements are underway, including new patient waiting areas, a falls assessment tool, and enhanced pain management. The initiative also prioritises staff well-being, effective communication, and timely patient assessments, all supported by real-time feedback from both staff and patients.
- The Nutrition & Hydration task and finish groups have made progress on fluid balance monitoring, standard operating procedures (SOPs), and escalation tools for nutritional needs. A key focus is ensuring timely nutritional support for vulnerable patients, particularly those with learning disabilities.
- A one-year review of the Learning Forum used a structured PDSA approach to assess its effectiveness. Feedback highlighted the forum's value as a safe, reflective space for sharing successes and learning from challenges. Participants appreciated its role in increasing visibility of initiatives, fostering cross-divisional collaboration, and aligning clinical and corporate priorities with real-world impact.

Good Practice

Section 1

Sepsis Progress Report – Update



Sepsis is a syndrome defined as life-threatening organ dysfunction due to a dysregulated host response to infection (NICE, 2024).

The UK Sepsis Trust estimates that in the UK, sepsis:

- Affects 245,00 per year
- Results in 48,000 deaths per year
- 5 deaths per hour

The Medical Director's Quality and Patient Safety team are collaboratively developing a two-year sepsis strategy, with the main objective to enhance patient safety and improve outcomes, by tackling systemic challenges associated with identification and management of sepsis, this includes ensuring compliance with up to date National Institute Care Excellence (NICE) NR51 guidance and adopting the Academy of Medical Royal Colleges (AoMMRC) guidance.

The goals of the sepsis strategy will include:

- **Enhance sepsis recognition and management** – significantly improve recognition, treatment and management of sepsis in ABUHB
- **Strengthen initial treatment** – By assessing current resources, updating the UHB sepsis policies and materials
- **Implement and enhance sepsis tools** – implement new Early Warning Scores across all divisions to aid clinicians' diagnosis of sepsis.
- **Standardise staff education and training** – this will promote consistency, raise awareness and the effectiveness of sepsis recognition, response and management.
- **Audit strategy** – Develop and implement new audit framework for ABUHB to provide assurance and measure the UHB compliance with sepsis management. **Engagement and quality improvement support** – Provide a mechanism for direct support for UHB divisions regarding sepsis and through the application of Quality and Improvement methodology, ensure we are delivering sustainable gold standard care.
- **Service user engagement and enhance communication** – Engage and gather feedback from the public to ensure identification of missed opportunities and understanding of areas for improvement.
- **National engagement and collaboration** – Continued collaboration with UK Sepsis and NHS Wales Health Boards. This will ensure awareness and maintenance of up-to date guidance and will aid exploration of innovative practices.





National Drivers for Deteriorating Patient

The Welsh Health Circular (WHC) 2024/035 standardises the use of Early Warning Scores (EWS) to identify and manage acute patient deterioration, aiming to improve patient safety and outcomes. The Health Board is working to implement these recommendations, with a deadline of 30th September 2025. The Safer Care Partnership, led by NHS Executive and Improvement Cymru, is focusing on this initiative, including the rollout of Martha's rule (Call for Concern). NHS Executive will host the first "APDIN Implementation leads meeting" on the 7th of May, inviting implementation leads from all health boards in Wales. The aim of the group is to present progress, identify challenges, barriers and share examples of opportunities to improve patient outcomes through the implementation of the EWS.

Local Implementation

The Health Board's Sepsis Working Group has divided into smaller task groups to implement NEWS2, focusing on digital, education, implementation, escalation, and audit. A standardised education package is in development and will be presented to the education practitioners in June to enhance awareness and knowledge around using NEWS2 to support early identification of sepsis and deteriorating patient, ahead of implementation of NEWS2 in September 2025. Planning for PEWS is underway, with a target launch in September 2025 and monthly meetings to develop an education plan. For MEWS and NEWTT2, workshops and follow-up meetings have established groups to support implementation. A decision has been made to temporarily revert to paper-based charts due to national delays in availability of digital templates. NEWTT2 will launch in June and MEWS in September. These efforts aim to improve sepsis awareness.

Early Warning Scores

Work to ensure ABUHB is compliant with the WHC mandate has commenced, with implementation groups from across Adult, Paediatric and Maternity/Neonatal services, to review, understand and plan education, policy amendments, ensure resources are available to implement.





Sepsis Progress

A scoping exercise has been undertaken to review the Health Board's sepsis management to align with updated guidance. The Medical Director's Quality and Patient Safety team is collaborating with specialties to develop sepsis expertise, set performance targets, and support improvement initiatives, aiming to enhance sepsis recognition, response, and management. Scoping for primary and community care has begun, with an initial presentation to the Neighbourhood Care Network.

A sepsis workshop in November, with multiple divisions represented, explored patient deterioration and barriers to effective responses. Collaborative discussions and a fishbone exercise with the Quality Improvement team identified improvement strategies. A follow-up workshop will take place and a primary and community care-focused workshop is scheduled.

The Sepsis Trust UK tool is being tested and rolled out, using quality improvement methods and PDSA cycles, in the acute sector. After implementing the National EWS, the tool will be reviewed for compliance and effectiveness in improving patient outcomes across adult, paediatric, and maternity/neonatal environments.

A sepsis awareness campaign was launched internally in November 2024, with public outreach planned for April 2025. It includes a new website, staff pulse page, and awareness resources.

A sepsis awareness campaign was launched internally in November 2024 and phase 2 will be launched to the public in April 2025. It will include a new website, staff pulse page, and awareness resources.

Nationally, the Health Board participates in sepsis forums and contributes to the national sepsis strategy, ensuring alignment with national mandates, including reviewing and providing eLearning materials for staff.



Escalation

Section 2

Urgent and Emergency Care



Performance Trajectories & WTBS @ GUH

First Floor Step Down protocol, compliance audit of the Falls Pathway, the Stroke iPad pilot with WAST, and ongoing efforts to ensure dual pin compliance ongoing.

Refreshed system flow meeting starting the 14th April with data driven metrics.



ED Consultant Recruitment Update

The ED Consultant rota has been updated with new appointments and extra shifts covered, and remaining roster shift gaps have been offered to Locum.

The ED Directorate is progressing well with staffing plans for the interim phase of the new build, ensuring timely transfers to appropriate Assessment Units and addressing challenges to improve the process.



ED Extension of Waiting Area & Internal Reconfiguration

Discussions regarding the interim operating position between the opening of phase 1 and phase 2 are ongoing.

The work on revised models of care and reconfiguration is progressing rapidly.



Transfer Lounge Development

The Transfer Lounge opened on 25th March 2025, with positive feedback from staff and patients.

Weekly data is collected to demonstrate usage. Since opening, admissions have been the highest since COVID/July 2021.

25-30% of throughput is direct from ED, not classed as admissions.

15% of final discharges from GUH via wards come from TL.



Safe to Start (S2S)

Safe to Start (S2S) morning meeting is in place at GUH and RGH with plans to roll out further to rest of eLGHS in the next few weeks.



Further Faster

Progressing AFR & CAATT initiatives to better integrate services, especially at the front door.



Mental Health & Learning Disability



Mental Health & Learning Disability Committee

- Refreshed and launch of the MH&LD Committee with a wider remit and to formally receive the Mental Health Act Monitoring Report – meeting took place on 9th April 2025.

Mental Health & Learning Disability Programme of Work around Patient Flow:

- Digital solutions for ward data, pre-admission interventions, and alternatives to admission are being progressed to improve patient flow and address bed capacity are progressing.

Management of Variable Pay:

- Focus on the increase in variable pay, especially nursing.

Enhanced Care Framework:

- On track in older adults' directorate.
- Training done and implementation in April as planned.

Quality and Patient Safety:

- Management response and action plan in development to progress the recommendations set out in the HIW Annual Report.
- Improved review and timeliness of serious incident investigations.
- Effort to close open cases, identify learning points.

Workforce and Planning:

- Ongoing efforts with workforce and planning.
- LD well-being survey results, retention project for healthcare support workers, addressing overpayments.
- Nursing & HCSW workforce strategy is in development draft to be shared April.

Learning Forums:

- Sharing and disseminating learning across the division.
- Participation in national strategic programme for leadership exchange.

Continuous Improvement Plans:

- Ongoing quality improvement work.
- Positive feedback from Llais Report in March.

National MH & Wellbeing Strategy:

- Engaged in all workstreams of National Programme through NSPB – National Board.

Safeguarding Awareness and Training:

- Bespoke training well-received, 91.6% compliance at Level 1.

Challenges:

- **WCCIS Challenges:** Ongoing issues with the patient information system and user interface necessitate ongoing workarounds to ensure validated data.
- **Recruitment and Retention:** Workforce and capacity challenges persist, but progress is evident with the arrival of the international nurse cohort and the initiation of formal workforce and organisation development programmes.
- **Estate:** Addressing the challenges of an aging estate and maintaining areas to ensure safe and therapeutic environments.

For Discussion

Section 3



Quarter Four Highlights

- N&H strategic steering group met for first time with renewed sub-group structure.
- Food standards sub-group and Clinical sub-group also met. All groups are multidisciplinary groups composing of membership from across the clinical workforce as well as support services and facilities colleagues.
- Interim N&H activity and future workplan report presented at PQSOC. Well received with chair highlighting importance of this group in supporting significant N&H improvement agenda.
- Task and finish groups established to deliver rapid action against patient safety issues: -
 - Fluid Balance T&F group – Have reviewed current behaviours around how we monitor fluid balance within patients and has developed a protocol to ensure highest standards of monitoring. A 7-minute briefing has been developed and the process is currently being piloted in A0 ward at GUH prior to wider roll out
 - Escalation of nutritional need T&F group – Group set up following several occasions where patients did not have their nutritional need met in a timely manner. An action card has been produced to highlight actions to be taken in the event that a delay is identified in enteral feeding requirement. This will link in with learning disabilities teams as well given that several incidents have affected patients who have been unable to advocate for themselves.





Future Requirements

- Work with QPS team and sub-groups to Identify and record service provision quality metrics.
- Ensure review of all N&H related policies takes place. Review should include identification of gaps in process that will require action.
- Work with incoming consultant dietitian to identify 'hot spots' where service improvement projects could be targeted.
- Review organisational need for a multi-disciplinary nutrition support team to enhance the current support available with respect to complex N&H related healthcare requirements.



6 Pillars of Quality



Section 4

Background



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

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

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

PATIENT AND STAFF EXPERIENCE AND STORIES

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

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

COMPLAINTS, CONCERNS AND COMPLIMENTS

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

INFECTION PREVENTION AND CONTROL

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

INCIDENT REPORTING

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

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

HEALTH, SAFETY AND SECURITY

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

SAFEGUARDING

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

PILLAR 1

Patient and staff experience and stories

Civica

Bereavement
Collaboratives

Patient
Stories

IPAC
Dashboards

Volunteer to
Career

Chaplaincy

Volunteerin
g

Patient
Advice and
Liaison
Service
(PALS)

Leadership,
Accountability
and Culture

Deprivation of
Liberty Safeguards/
Mental Capacity Act

Cultural
Competence
Accreditation
Scheme

Dementia
Standard
s

Listening
Meetings

QOF Metrics

Included in report:

- CIVICA data
 - Total new responses
 - Patient satisfaction %
 - positive emotion trend,
 - negative emotion trend

Developing metrics not yet reported:

- Staff culture – metric TBC
- Themes from patient stories – AI repository development

QOF Metric Pillar ONE - CIVICA data total new responses
Patient Experience Feedback April 2024 – March 2025

All Surveys

8985

responses

89%

satisfaction

Person Centred Care (PCC) Survey

7472

responses

91%

satisfaction

Emergency Department Survey

918

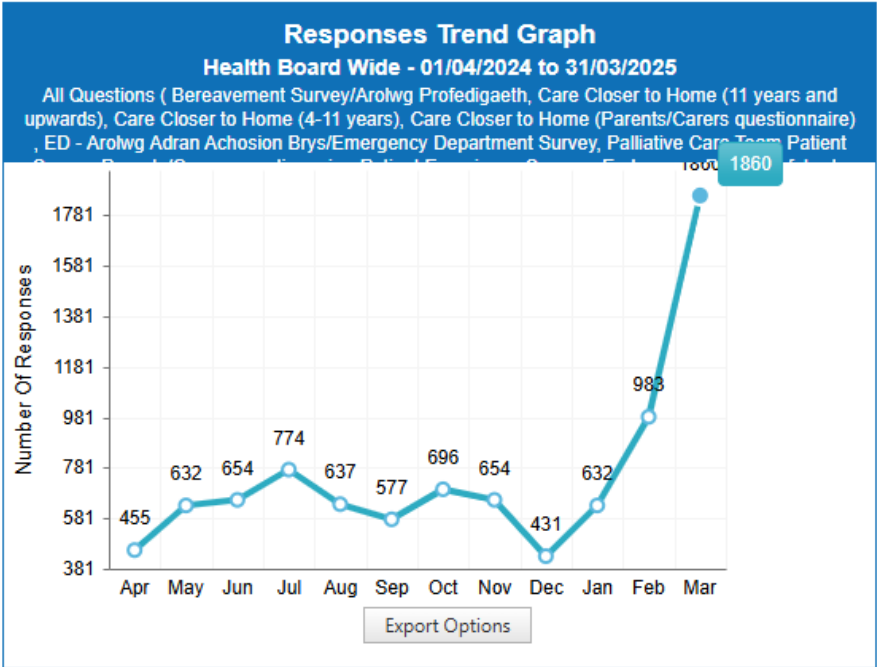
responses

67%

satisfaction

Total Responses
YTD (2024/25)

8985



Quarter	Number of Responses	% Difference	
Q1	1741	-	
Q2	1988	+14%	↑
Q3	1781	-10%	↓
Q4	3475	+95%	↑

QOF Metric Pillar ONE - CIVICA Data Patient Satisfaction, % Emotion Trend

Civica Responses Q4 – 2024/25

[illegible]

Top 3 Themes from PCC Survey

April 2024 – March 2025

What did we do well? Q9	What could we have done better? Q10
Top 3 themes • 1331 comments around Compassion • 1230 comments around Emotional & Physical support • 1014 comments around Friendliness <i>Unchanged top three</i>	Top 3 themes • 264 comments around Waiting • 166 comments around Food & Beverages • 118 comments around Facilities <i>Unchanged top three – although there is a query on the Waiting figure following a recent system upgrade</i>

QOF Metric Pillar ONE - Patient Experience Feedback Q4

- There was a significant increase in responses in February 2025 (prior to SMS) with the highest number to date from QR code/paper alone with 983. The February increase noticeable within the Family & Therapies Division.
- Endoscopy Survey launched in January 2025 with 253 responses.
- SMS successfully launched 3rd March 2025 for ED and MIU, although there has been some delays within CIVICA on messages being sent. This has been escalated and under review.
- A bespoke monthly report continues covering all Divisions concerning facilities, Infection Prevention and Infection Control, Dementia Care and Bereavement and is sent direct to teams to highlight patient comments relating to these areas.
- A Volunteer has started to capture Civica Survey feedback in YYF and 155 completed, although was unable to support during March.
- Introduction of reporting on Compliments from CIVICA to Datix in January 2025 – shown on PALS slides.
- There has been a shift in the last quarter 'themes', with the 2nd negative theme being 'Emotional & Physical Support' which is not usually in the top 3 negative themes.
- Survey changes coming with the launch of the All-Wales Survey – People's Experience Survey (PES) and launch of All Wales Maternity Surveys and Looked After Children Surveys

PILLAR 2

Incident Reporting

Falls

Pressure Ulcers

Medicines Management

Mortality

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

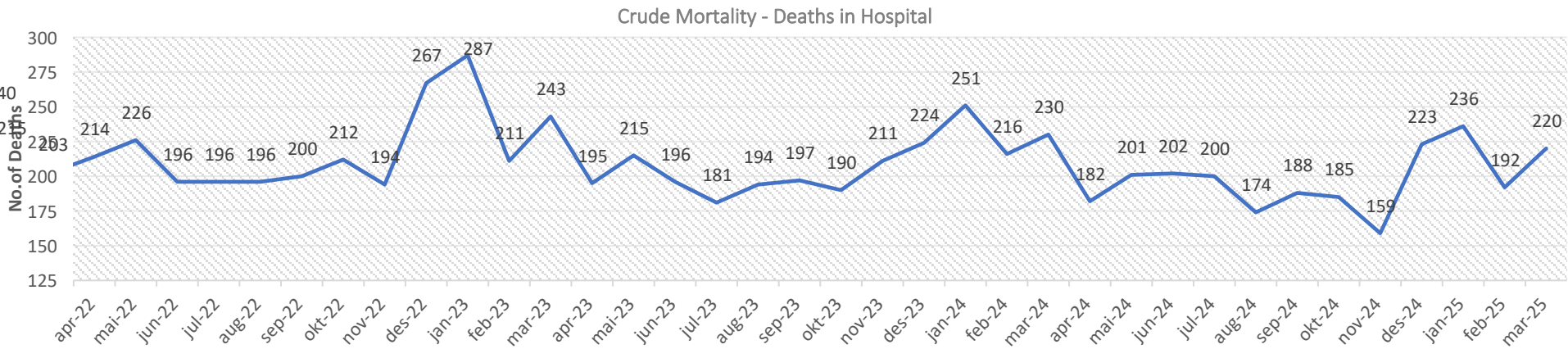
Proposed Metrics: -

- Mortality – Crude mortality and RAMI
- Incidents presented as – level of harm and closure date of incident
 - Global category of incident to ensure themes care captured – PUs, falls, HATs, medicines, H&S, RIDDOR
 - Trends in severe medicines incidents
- Nationally reportable incidents & compliance with closure timeframes
- Duty of candour – Datix numbers
- Thematic analysis of Patient Safety Incidents graded severe
- Thematic analysis of Regulation 28 reports
- Number of inquests that take place face to face (compared to the number completed on paper), ensuring meeting family needs

Developing Metrics: -

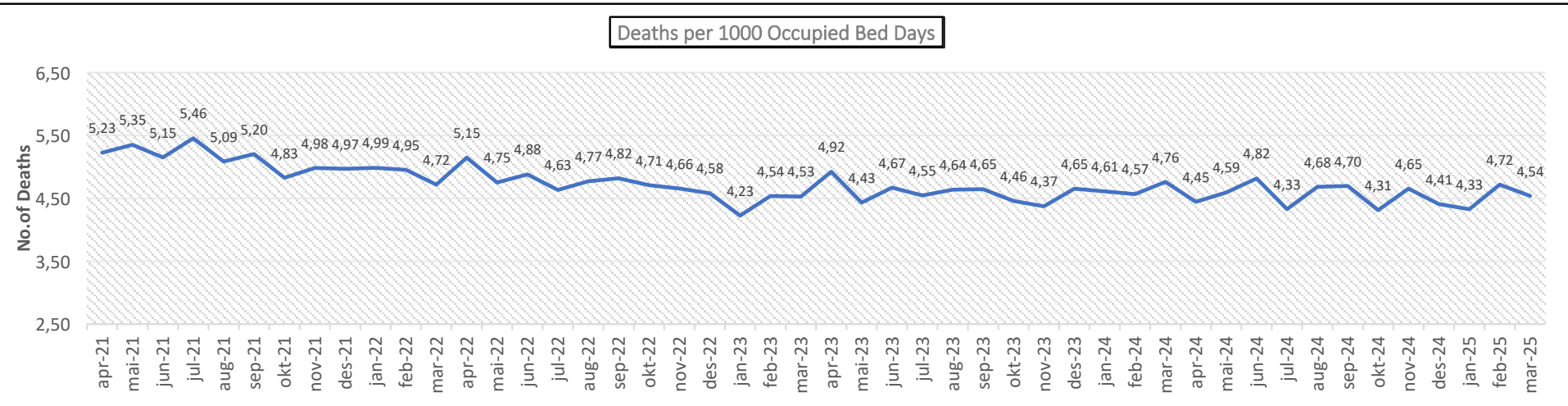
- Investigate the possibility of capturing incidents related to urgent care delays / flow in DATIX.

QOF Metric - Pillar Two Mortality: Crude Mortality in Hospital



The year starts with a gradual decline, stabilises mid-year, and ends with a notable spike in deaths during the winter quarter. This pattern is consistent with typical seasonal mortality trends, where colder months often see higher death rates due to increased vulnerability among elderly and chronically ill patients.

Quarter	Crude Mortality in Hospital	% Difference	
Q1	585	-	
Q2	562	-4%	↓
Q3	567	+1%	↑
Q4	648	+14%	↑



The overall trend suggests a U-shaped curve: a dip in mid-year followed by a steady rise into winter.

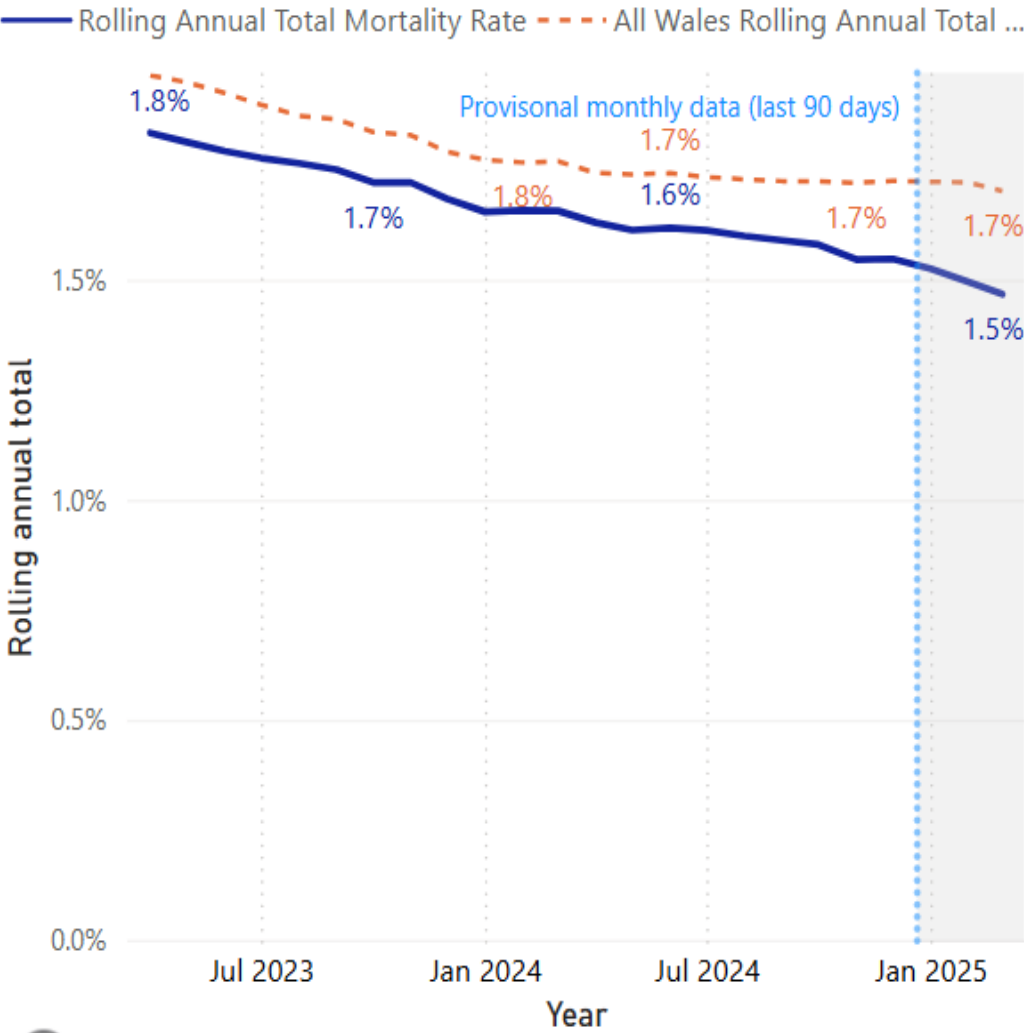
Quarter	Death per 1000 Bed Days	% Difference	
Q1	4.27	-	
Q2	3.43	-20%	↓
Q3	4.45	+30%	↑
Q4	4.52	+2%	↑



QOF Metric - Pillar Two Mortality: Crude Mortality Rate



ABU UHB Rolling Annual Mortality Rates - Mortality Rate - Date Period
Selected: (Apr-23-Mar-25)



ABUHB	Mortality Rate
November 2023	1.6%
December 2023	1.8%
January 2024	2%
February 2024	1.8%
March 2024	1.8%
April 2024	1.4%
May 2024	1.5%
June 2024	1.5%
July 2024	1.4%
August 2024	1.4%
September 2024	1.4%
October 2024	1.3%
November 2024	1.2%
December 2024	1.8%
January 2025	1.7%
February 2025	1.4%
March 2025	1.4%

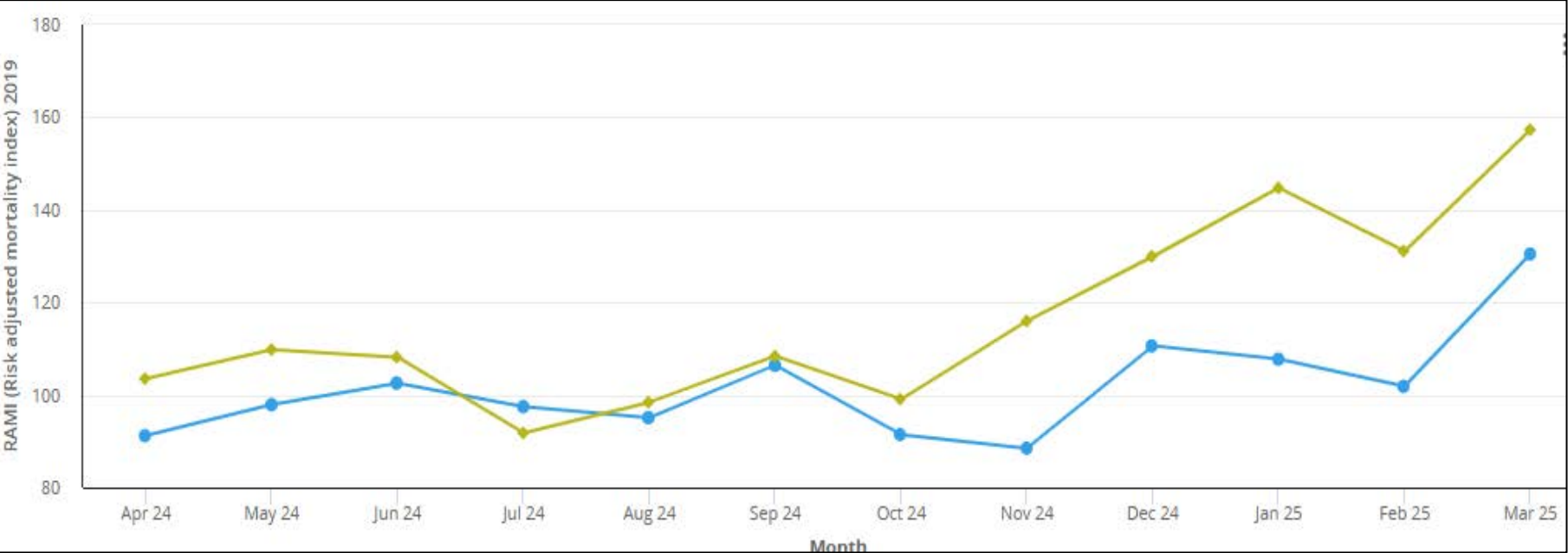
The Health Board’s mortality rate has remained stable, showing a flat and decreasing trend. The most volatile period was between December and January, with a rise and fall. The lowest rate was in November 2024, while the highest was in December 2024. These trends may align with seasonal health patterns.

The Health Board’s Learning From Death report presented twice a year, demonstrates a blended approach to mortality that incorporates multiple sources of information; such as mortality reviews, national benchmarking, and national audits, in addition to RAMI.

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.



QOF Metric - Pillar Two Mortality RAMI (Risk Adjusted Mortality Index)



ABUHB PEER

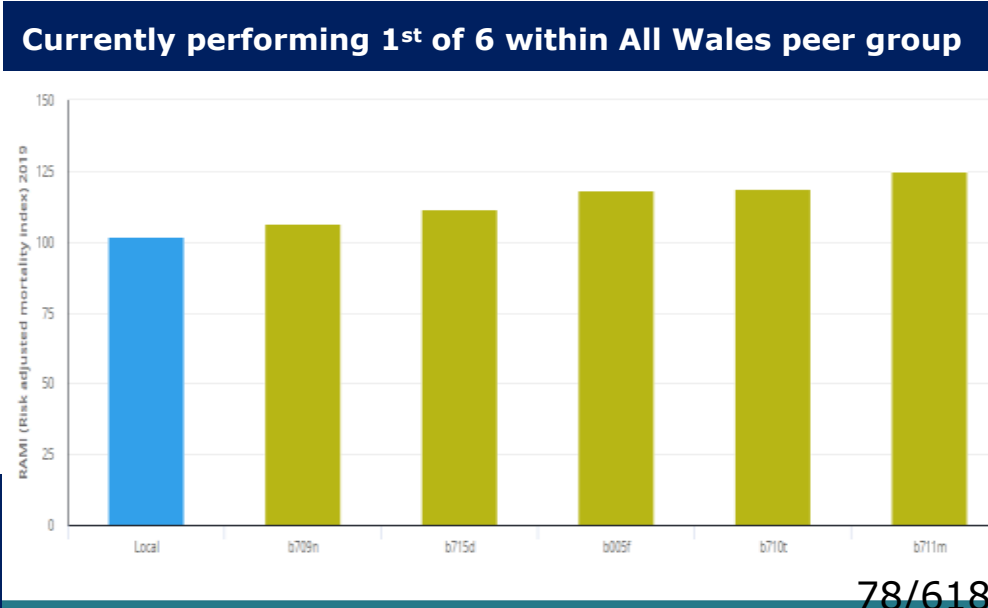
RAMI for Q1-Q4 2024/25 was 101.71, compared to 104.63 for 2023/25. Both lines show a decline in RAMI during mid-year (summer months), followed by a consistent rise through autumn and winter. The sharpest increases occur from October to March, which may reflect seasonal pressures such as winter illnesses or increased hospital admissions.

Chart displays RAMI for Q1 – Q4 2024/25

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

Completeness of coding is more accurate after 8 weeks, which often results in a decrease of RAMI. This is reflected in Q4 being high.

Quarter	RAMI	% Difference	
Q1	97.13	-	
Q2	100.40	+3.4%	↑
Q3	97.23	-3.2%	↓
Q4	112.54	+15.8%	↑



QOF Metric - Pillar Two: Post Investigation Harm Assessment and Closure Date of Incident Average Time to Close



The total numbers of incidents closed during April 2024 to March 2025 can be seen below. The table provides details on the closed incidents by Quarters 1, 2, 3 and Q4 of 24/25 by Post Investigation harm assessment for Moderate or above. The average time to closure is calculated in days.

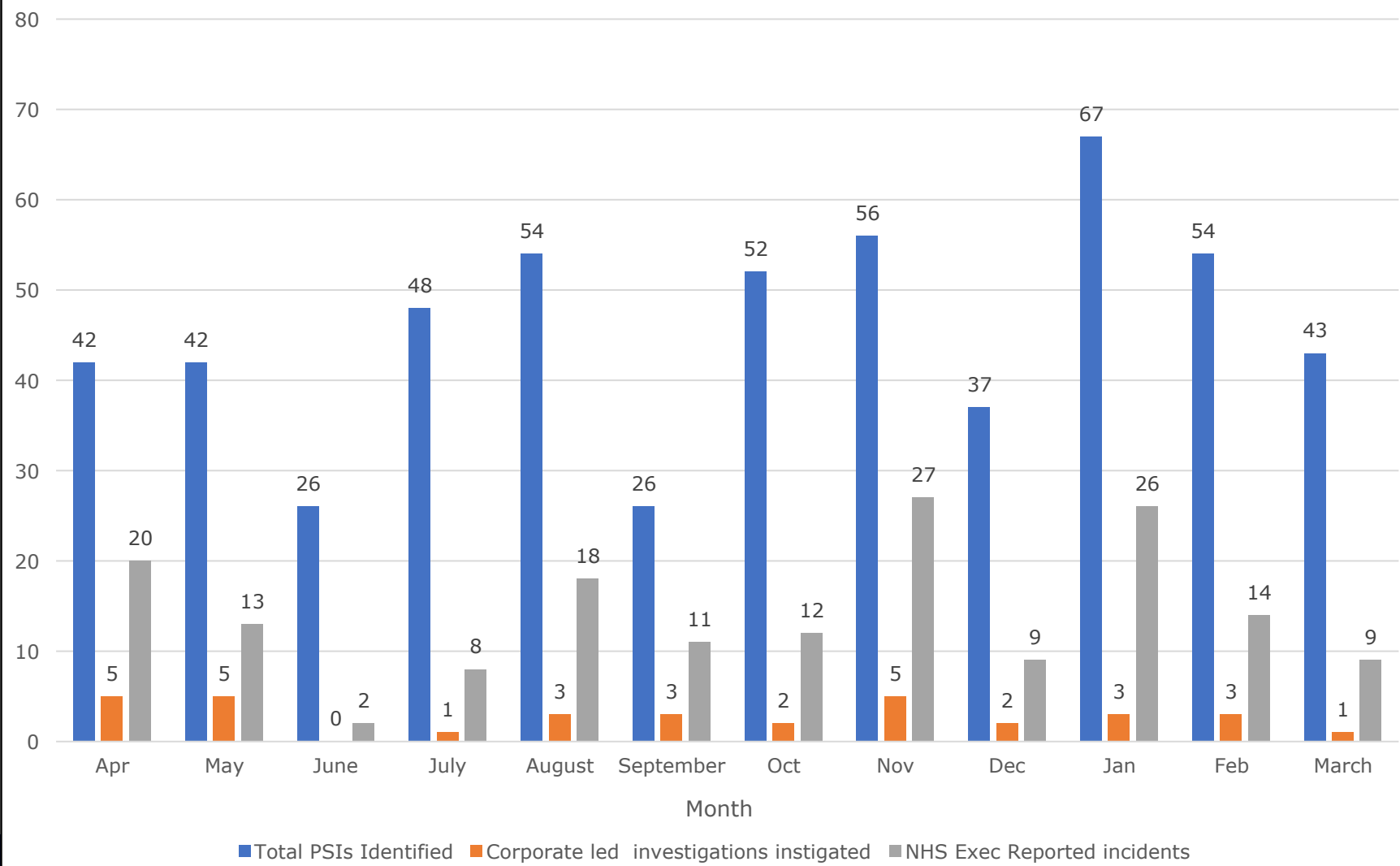
Post Investigation harm assessment	Incidents Closed during Quarter 1 24/25	Average time to closure	Incidents Closed during Quarter 2 24/25	Average time to closure	Incidents Closed during Quarter 3 24/25	Average time to closure	Incidents Closed during Quarter 4 24/25	Average time to closure
Catastrophic / Death	23	149	26	76	42	85	34	166
Severe	14	299	14	281	15	293	7	282
Moderate	124	177	79	123	48	114	49	144
Low	4,649	74	3,580	42	3,961	47	3,893	47
None	4,597	85	3,817	47	4,232	46	4,629	50
TOTAL	9,407		7,516		8,298		8,612	



QOF Metric - Pillar Two: Patient Safety Incidents



Patient Safety Incidents captured highlighting Corporate led investigations and NHS Executive reported incidents April 2024 to March 2025



Quarter	PSI's Identified	% Difference	
Q1	110	-	
Q2	128	+16%	↑
Q3	145	+13%	↑
Q4	164	+13%	↑

A total of 528 Patient Safety Incidents (PSIs) (moderate and above harm) met the criteria for either Corporate or Divisional led Investigation were identified between April and March 2025.

This is in comparison to 537 in the same period in 2023/24.

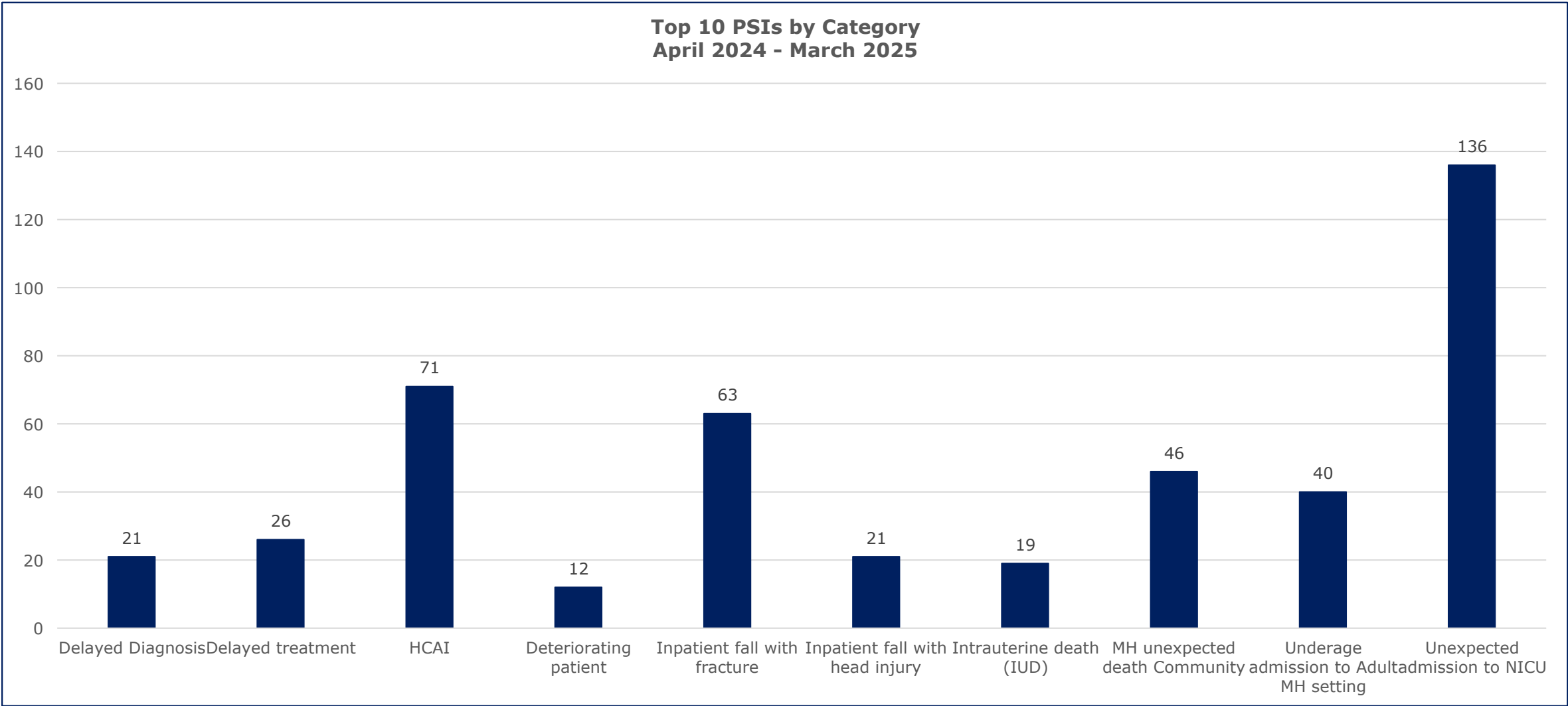
There were no unusual trends identified across the January to March 2025 data.



QOF Metric - Pillar Two: Patient Safety Incidents



Top 10 PSIs by Category
April 2024 - March 2025





PSI Learning Report: Key Learning and Insights

Use of CTG monitoring:

Issue: Delay in recognising the severity of fetal distress during labour.

Insight: Prompt use of fetal scalp electrode (FSE) CTG monitoring following transfer to the labour ward is likely to have identified fetal distress earlier. The infant was discharged home on day 11 on oxygen and NG feeds with planned MDT follow up.

VTE Prophylaxis:

Issue: Insufficient safety netting for high risk VTE patients through the anticoagulation clinic, pharmacy and clinical staff.

Insight: Respiratory and Haematology teams need to review the high risk VTE discharge process across the sites to standardise patient pathways and ensure secondary care are the responsible service for switching patients to DOAC.

- DOAC counselling for high-risk patients to be conducted F2F, Patients discharged on LMWH (with a plan to switch to DAOC) the anticoagulation clinic team will email the discharging clinician to advise they need referral to anti coagulation service.
- Patients discharged with LMWH will have a letter from anticoagulation clinic to advise they ring for an appointment for DOAC counselling once they have switched to their DAOC treatment.
- Exact date of switch from LMWH to DOAC to be clear on discharge summary so pharmacy can accurately calculate medication needed. Full 6 weeks to be supplied as per policy.
- Update junior doctors on discharging responsibilities and anticoagulation safety at F1 teaching sessions.
- Case to be presented at medical grand round.
- All patients with High-Risk PE's / Post Thrombolysis requiring 6 weeks of anticoagulation with LMWH prior to oral switch to be reviewed in RACU for 3/12 trial period. This will ensure safety netting, contact post discharge and assurance of appropriate pathway followed.

Cytoscopy:

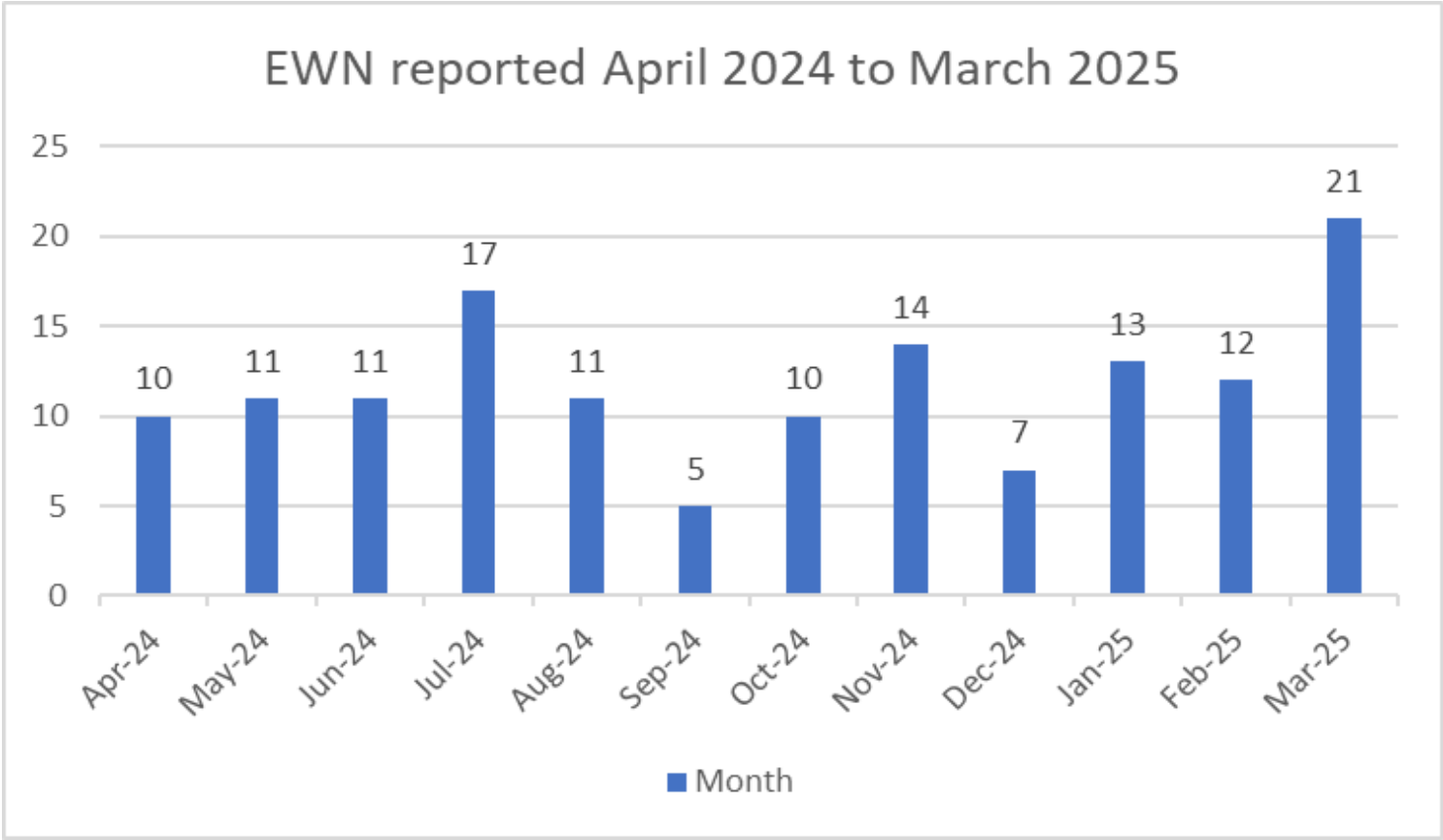
Issue: Concerns that a significant number of Urology patients may have had a missed malignancies or be on the incorrect follow up pathway.

Insight: The Division of Surgery have confirmed that all patients have now been reviewed. 3 patients were identified as definite missed malignancies but timely review and follow up has prevented any harm from occurring as a result. This was reported as an NRI due to the number of patients involved.

QOF Metric - Pillar Two: Patient Safety Incidents – Early Warning Notifications



There were **142** Early Warning Notifications (EWNs) reported to Welsh Government (WG) April 2024 to March 2025. This is in comparison to **127** submitted for the same period in 2023/24.



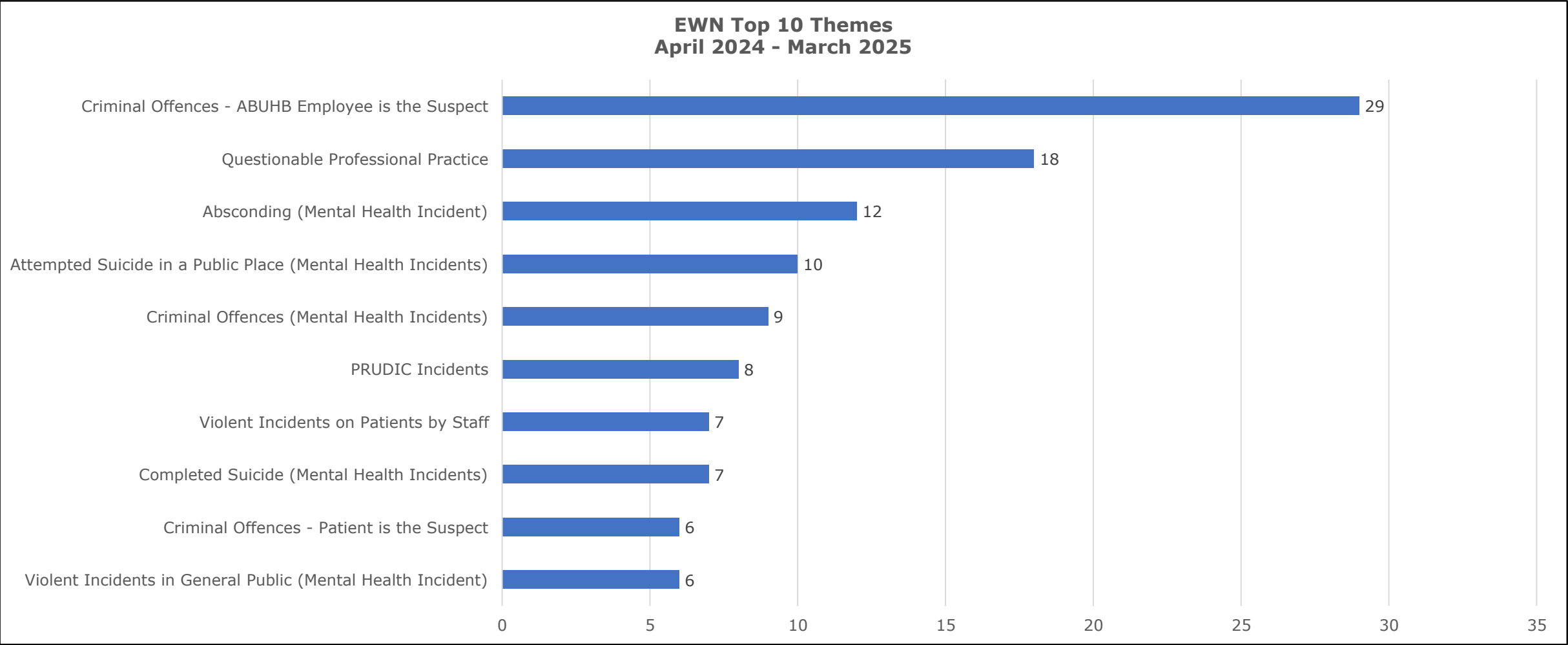
Quarter	Early Warning Notifications	% Difference	
Q1	32	-	
Q2	33	3%	↑
Q3	31	-6%	↓
Q4	46	+48%	↑



QOF Metric - Pillar Two: Patient Safety Incidents – Early Warning Notifications

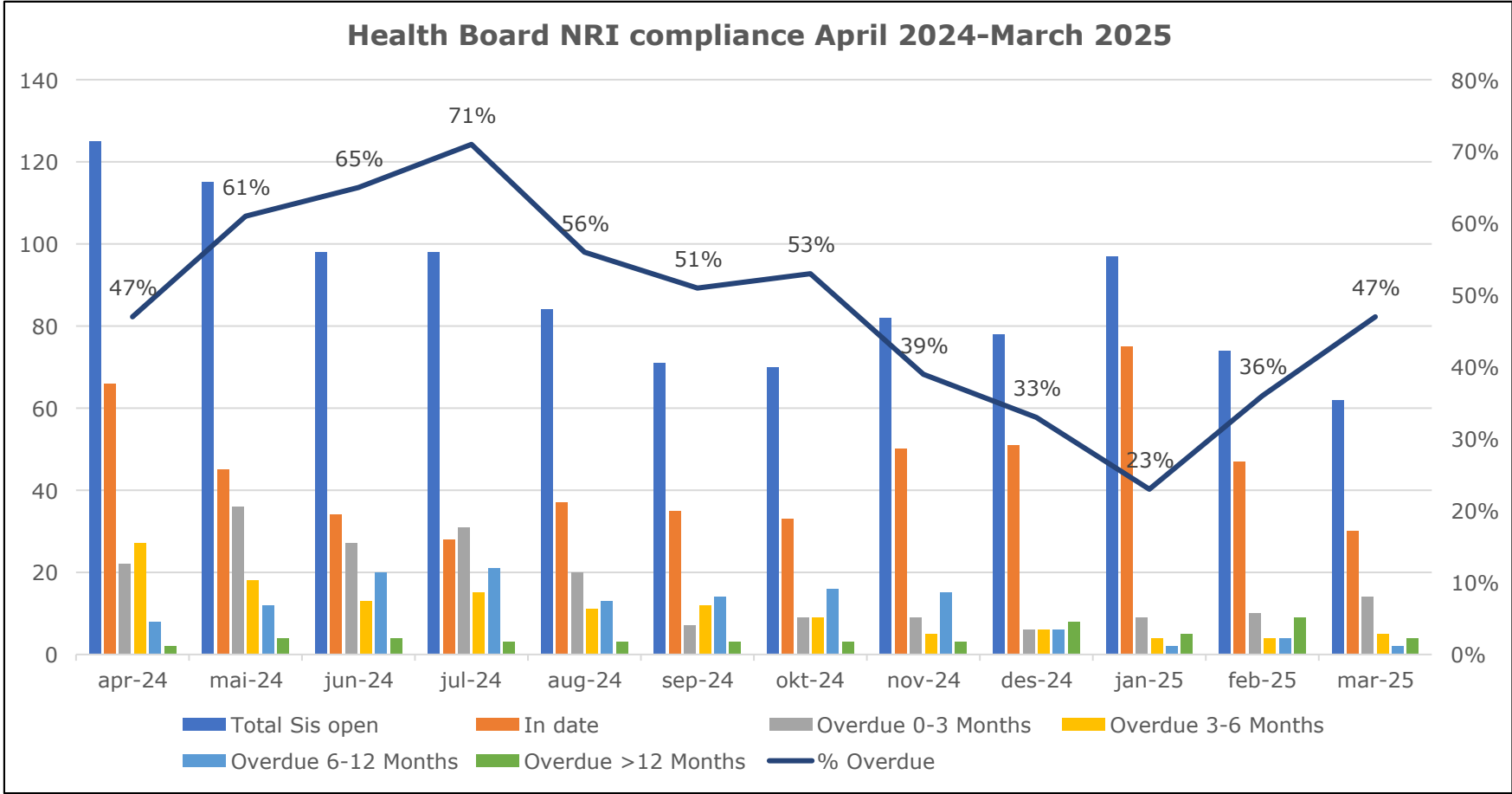


The top then themes for Early Warning Notifications over the year are illustrated in the graph below.



QOF Metric - Pillar Two

Patient Safety Incidents - National Reportable Incidents



Quarter	PSIs	% Difference	
Q1	330	-	
Q2	240	-27%	↓
Q3	155	-35%	↓
Q4	233	+50%	↑

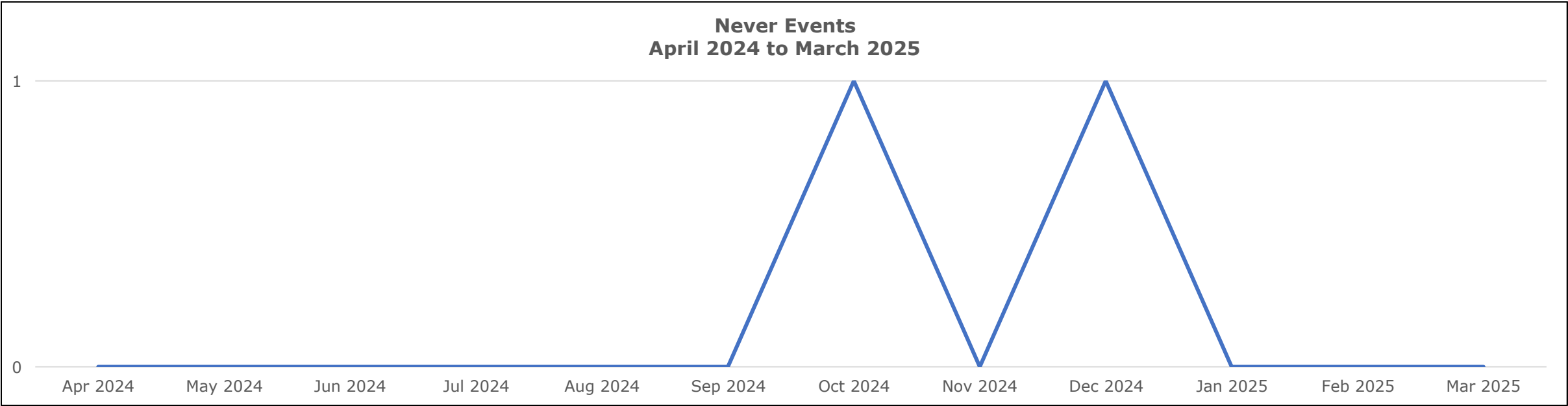
The graph illustrates the NRI compliance over time for comparison. Despite challenges in timely completion of NRI investigations the management of the PSI process remains a focus. Recommendations for improving compliance include regular monitoring, monthly reporting to divisional teams, enhanced communication, increased training for Investigating Officers, standardised follow-up processes, and fostering a culture of learning among Clinical Investigating Officers. These actions aim to meet NHS targets, bolster patient safety, and ensure quality care.



QOF Metric - Pillar Two: Patient Safety Incidents – Never Events



There were no Never Events recorded between January and March 2025. Work remains ongoing across the organisation with improvement and prevention of such occurrences.



Recap: There were two Never Events reported in Q3 (October to December 2024). The first occurred in October and involved a case of wrong site surgery in Dermatology Day Surgery, where a patient had additional lesions removed that were not listed for removal. The second event, reported in December, was a historic retained guidewire from a varicose vein procedure performed 14 years ago. This was discovered incidentally when the patient underwent an unrelated hip x-ray in November 2024. Importantly, neither patient experienced any harm as a result of these incidents.



QOF Metric - Pillar Two: Duty of Candour

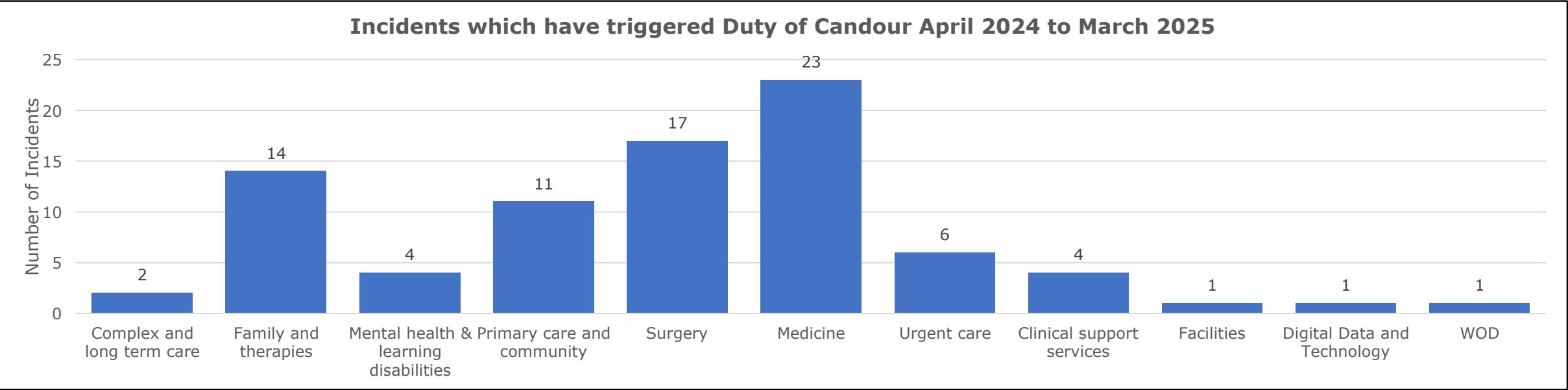


Between April 2024 and March 2025 there were **26661** incidents affecting patients reported on the Datix Cymru system. This is in comparison to **26026** incidents for the same period in 2023/24.

There have been **84** incidents that have triggered Duty of Candour. *This figure is based on the question - **Was Healthcare provided a factor?***

These incidents covered inadequate supervision resulting in a fall, Post-operative complications, Communication around discharges, prescribing, and maternity occurrences. All these incidents have undergone the formal DoC process.

Incidents which have triggered Duty of Candour April 2024 to March 2025



There is a significant amount of work done through creation of divisional dashboards for divisions to monitor their Duty of Candour compliance with statute. The Assistant Head of Patient Safety is leading a project working with the divisional representatives to focus upon fulfilling the DoC requirements and thus increase compliance.



Patient Safety Incidents - Actions, Learning & Improvement



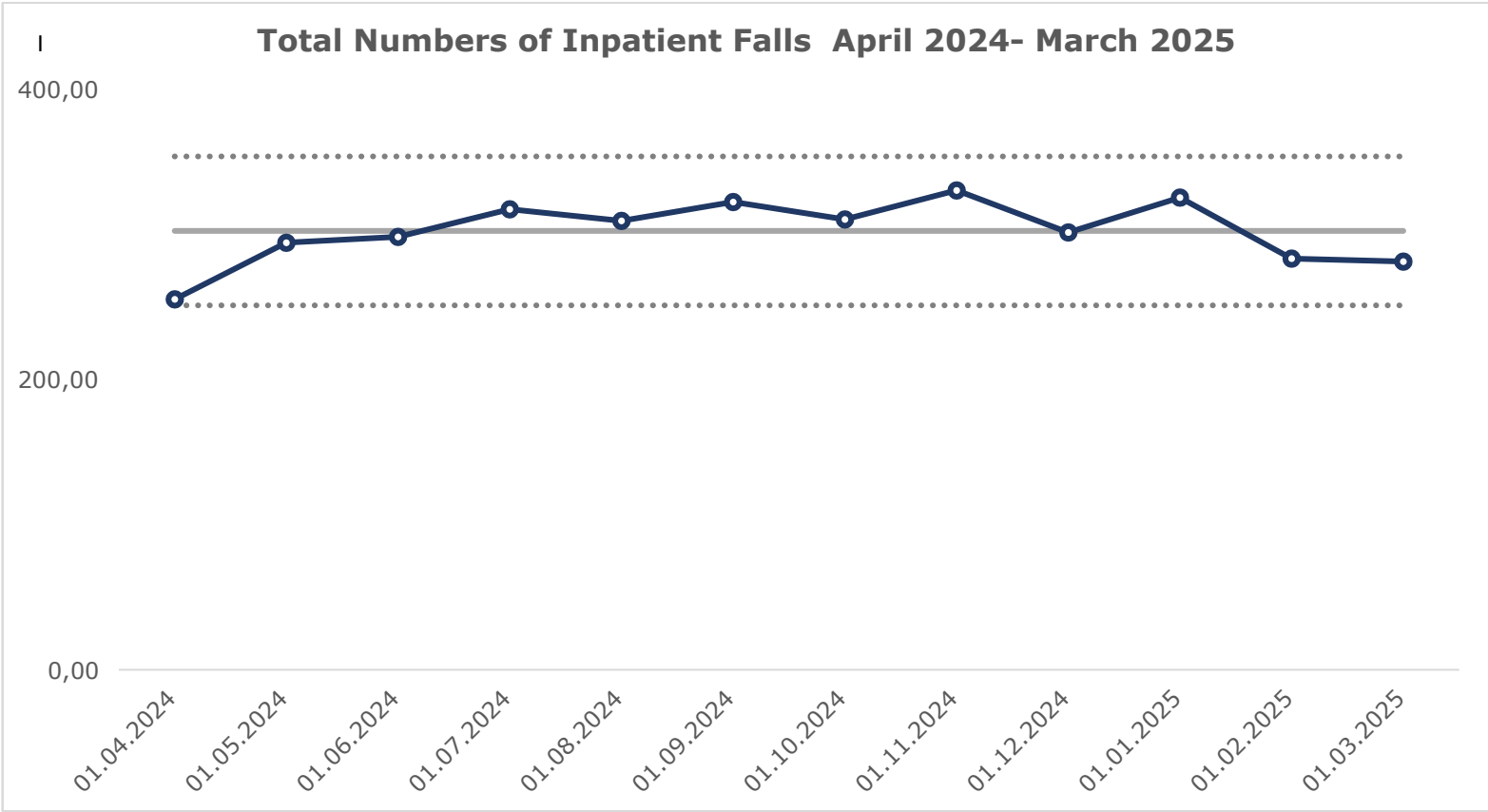
Issue	Proposed Action	Responsible Officer	Timescale
Timely IO availability/capacity to complete investigations/Lack of suitably trained IO's	Continue to work with Divisions PSI team to continue supporting Divisions through meetings and bespoke training	Head and Assistant Head of Patient Safety	March 2025
Clinical teams providing specialist opinions	To develop a PSI escalation process.	Corporate PSI and QPS Teams	
Complex investigations	Bespoke 1-2-1 training		
	PSI team/chair to escalate any delays in clinical opinions		
Complex investigations	Early contact with internal / external stakeholders	Corporate PSI and QPS Teams	Ongoing
	If appropriate arrange a strategy meeting with key stakeholders		
	The PSI team will coordinate meetings and link in with the relevant teams to feedback.		
Family engagement	Working with family members to review and improve the process	Head and Assistant Head of Patient Safety	March 2025
	Reporting template revised to prioritise patients' and families' questions in the Terms of Reference. This information is addressed first in the report, to ensure that this is prioritised	Corporate PSI and QPS Teams	
	Review PSI policy undertaken		
	Roll out communication standards to ensure meaningful and regular engagement with patients and families.		



QOF Metric - Pillar Two: Health Board Wide Inpatient Falls



Total Numbers of Inpatient Falls April 2024- March 2025

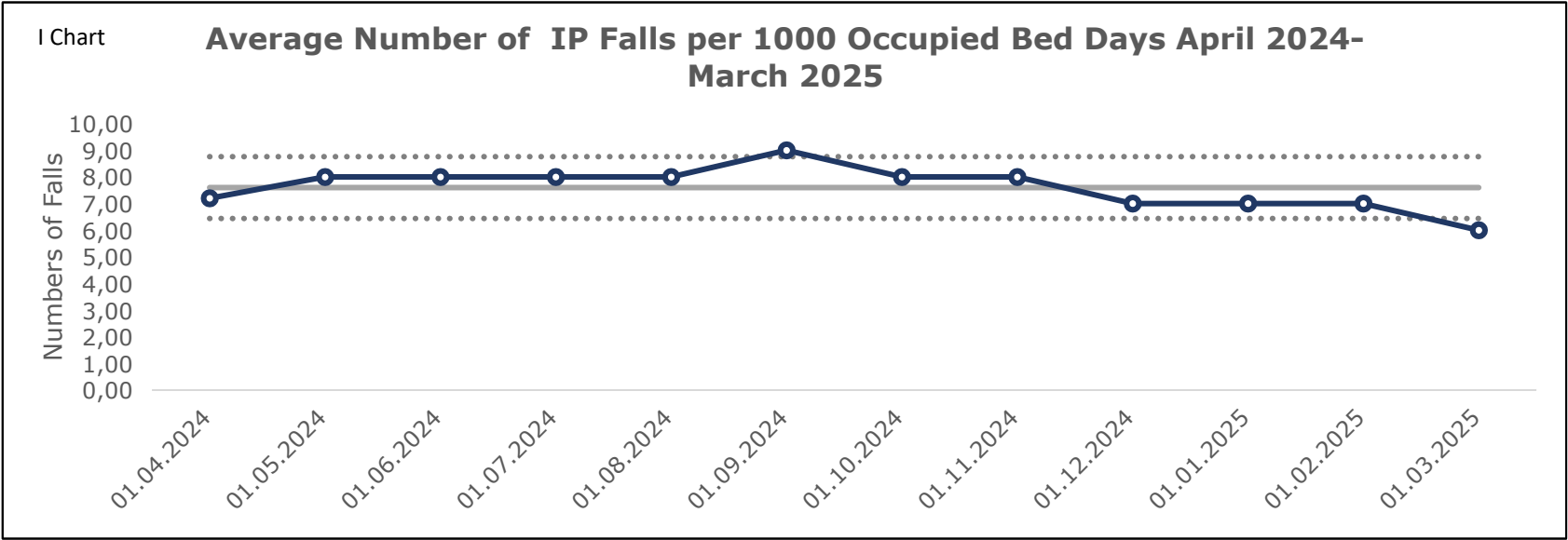


Quarter	Total Number of Inpatient Falls	% Difference	
Q1	847	-	
Q2	948	+12%	↑
Q3	941	-1%	↓
Q4	889	-5%	↓

May 2025 - Context

The data used in this chart has been retrieved from RL Datix and refers to the total numbers of reported falls incidents for the period April 2024-March2025.

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RL Datix as the information source.	- For the given period of analysis, the mean average value of fall incidents is 302. - Q4 - Since January 2025 the numbers of reported falls incidents have been subject to a downward trajectory with a 13% decrease for February 2025 with a further 1% decrease in March 2025 (14%)	For the given period of analysis March 2025 has seen the lowest numbers of reported falls incidents since April 2024 at 281.



May 2025 - Context

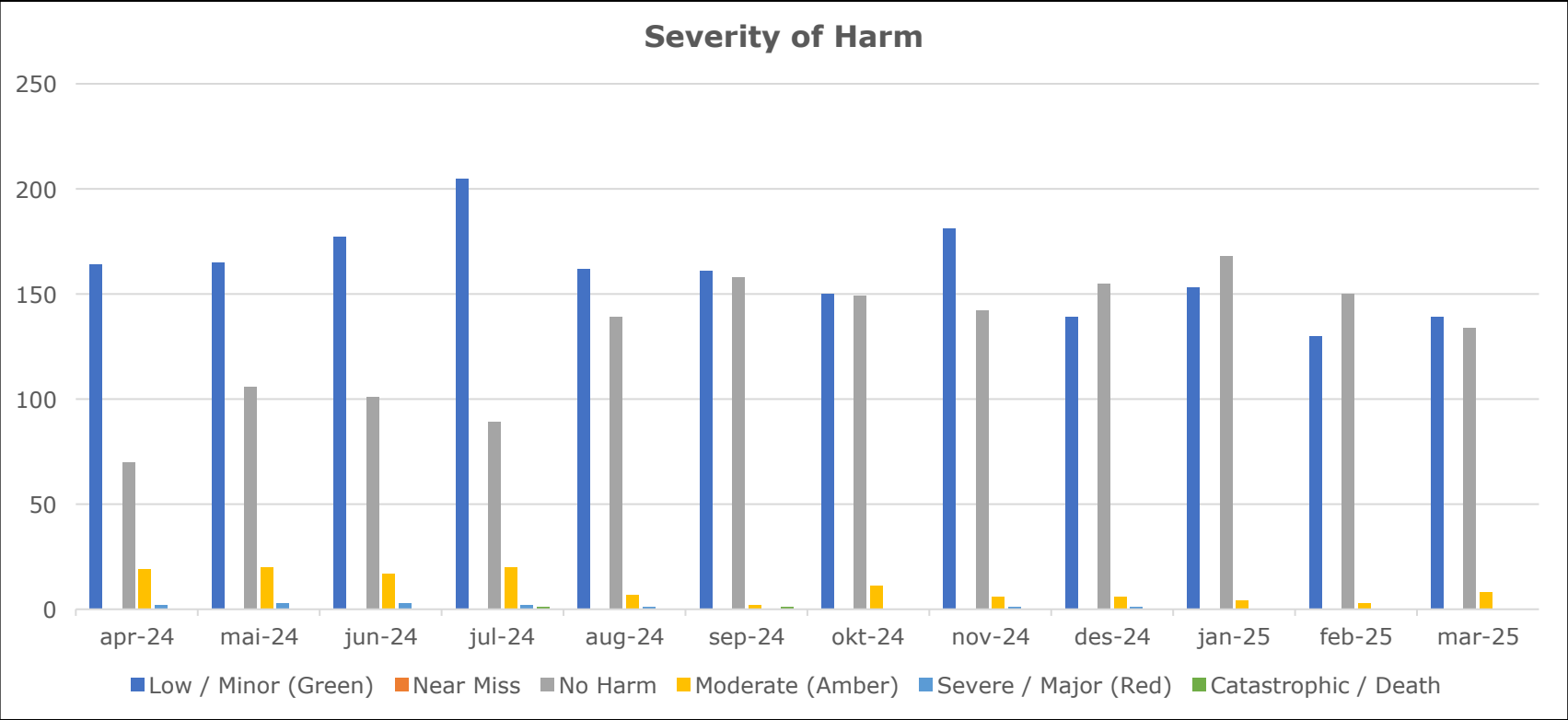
The data used in this chart has been retrieved from RL Datix and refers to the total numbers of reported falls incidents for the period April 2024 -March 25.

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

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RL Datix as the information source.	The value aligned to per 1000 Occupied Bed Days (ODD) is represented by a step change at the beginning February with a sharp downward trend seen in March to the lowest value for the period of analysis at 6.4 This figure is below the National Average of 6.6 A significant change has seen the Falls per OBD for March being below the lower control limit continuing the downward trend represented since November 2024.	Positive variation in that the values represented are below the mean average since December 2024.



QOF Metric - Pillar Two: Health Board Wide Inpatient Falls Severity of Harm



Quarter	Inpatient Falls Severity of Harm (Severe or More)
Q1	8
Q2	6
Q3	2
Q4	0

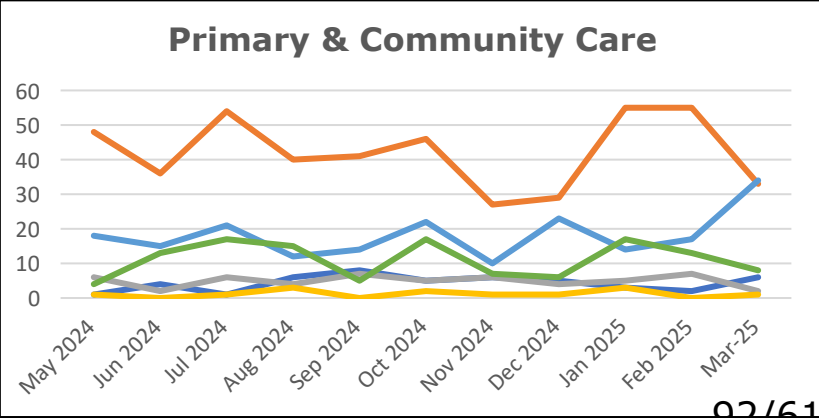
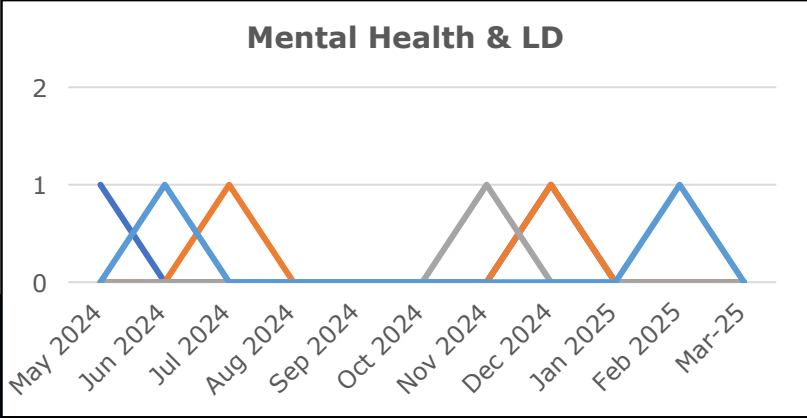
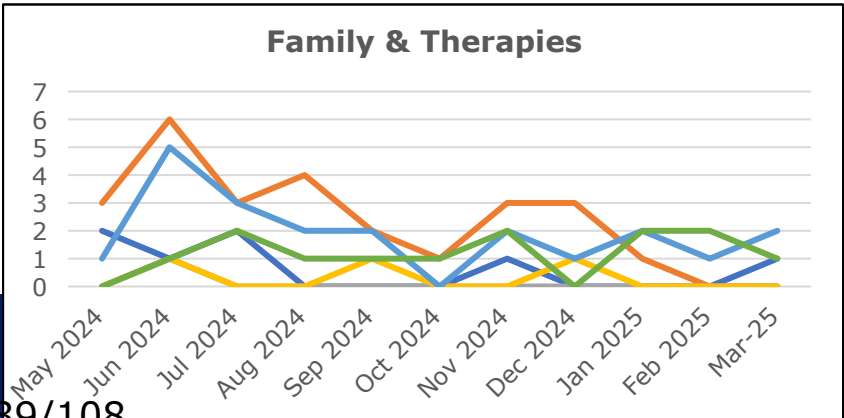
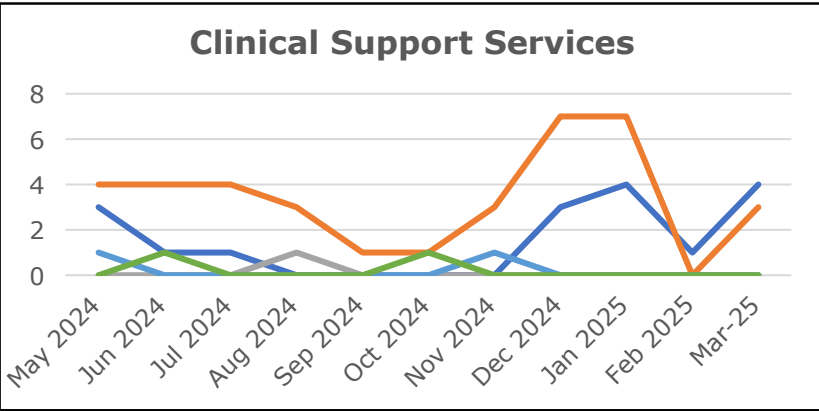
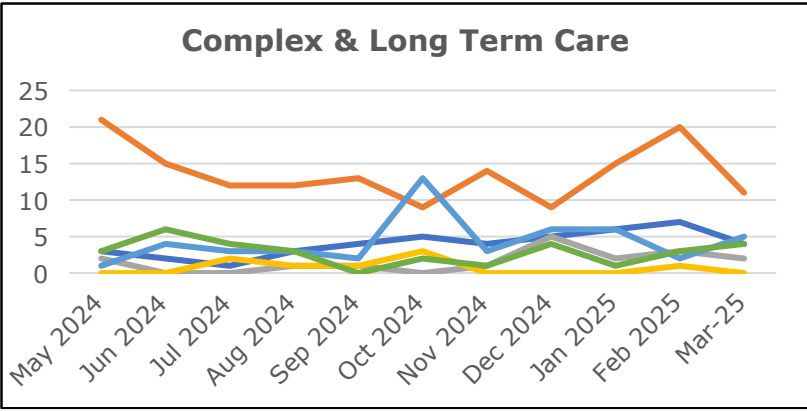
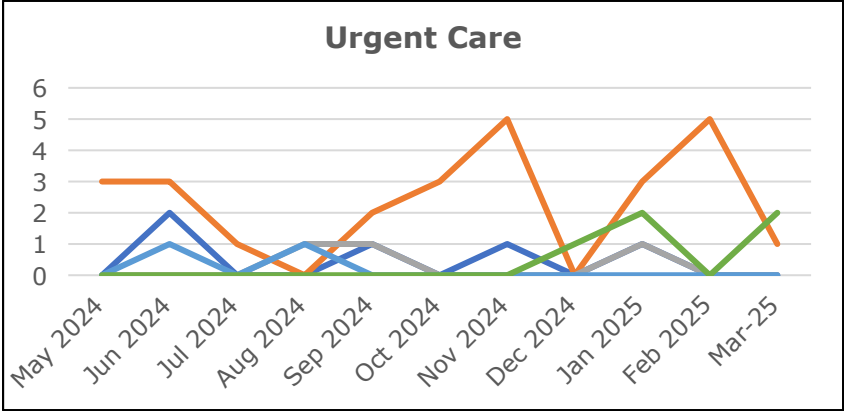
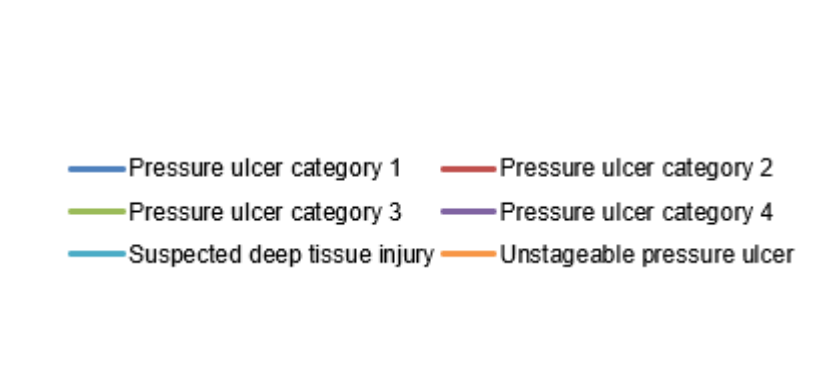
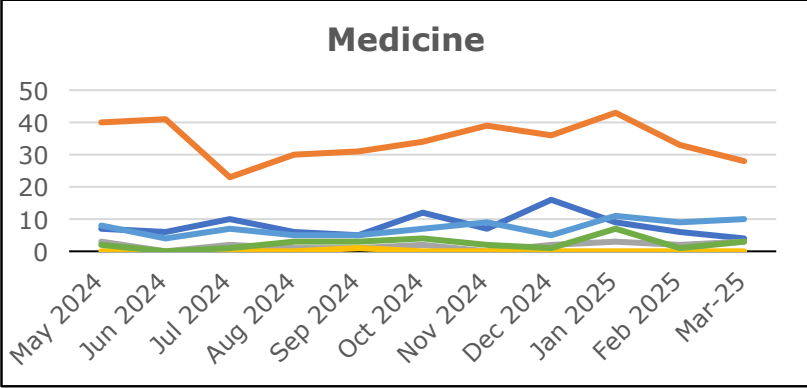
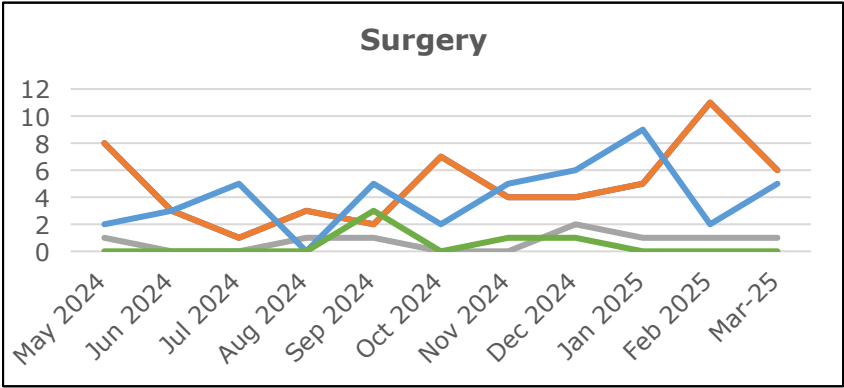
With small numbers the % has not be calculated as it is misleading to indicate harm.

Quarter 4 - Context

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

Definitions	What the chart tells us	Variation/ Analysis
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	Of the total numbers of falls incidents reported for which the severity of harm is categorised for the given period is 3625. For the period identified the following details the severity of harm: • 96.5% No or low harm • 3% - Moderate harm • 0.4% Severe harm • 0.1% Catastrophic	The severity data is reflective of the identified level of harm recorded at the time of data analysis

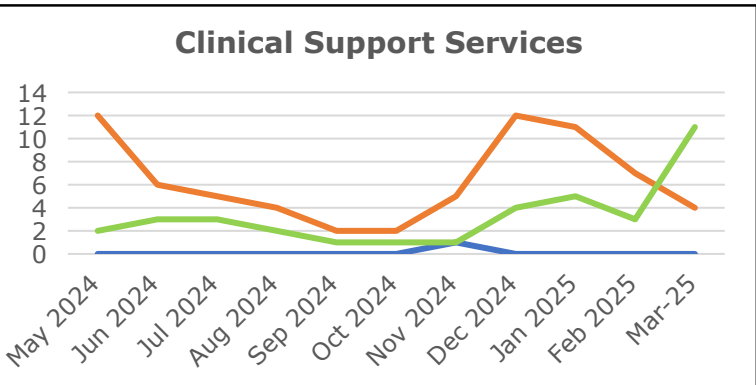
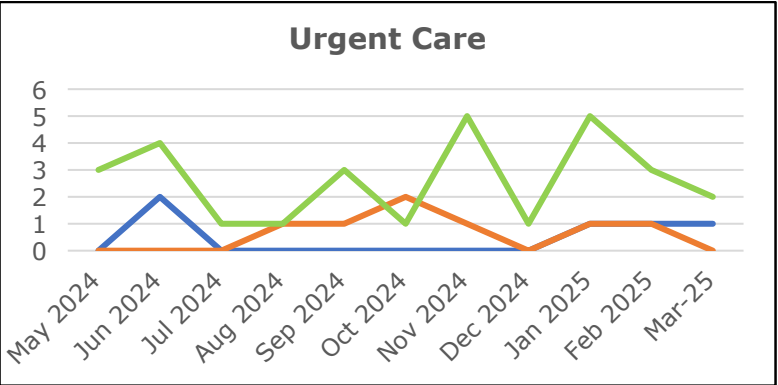
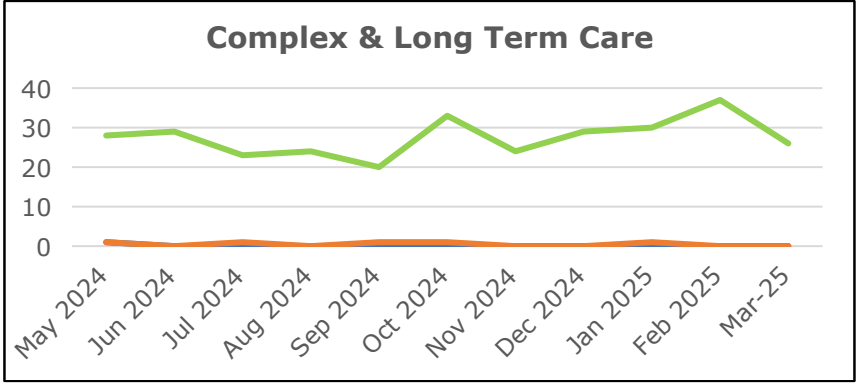
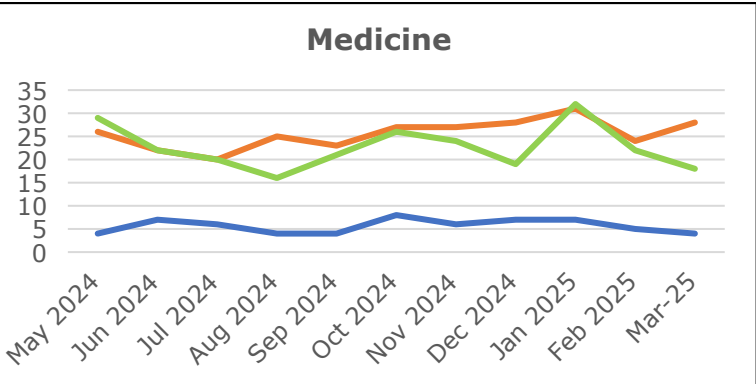
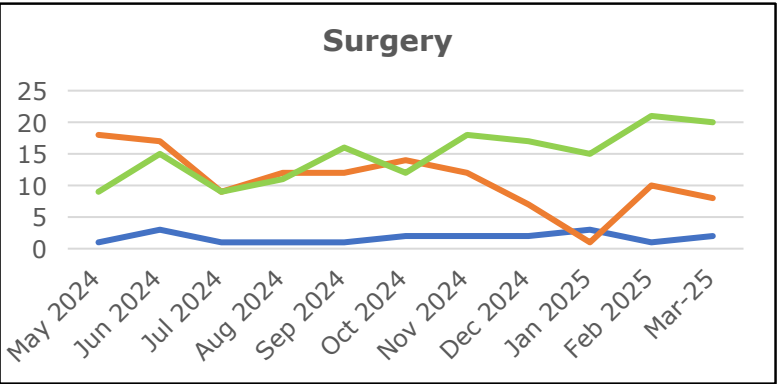
QOF Metric - Pillar Two: Hospital Acquired Pressure Ulcers – Extracted from RL Datix (not validated)



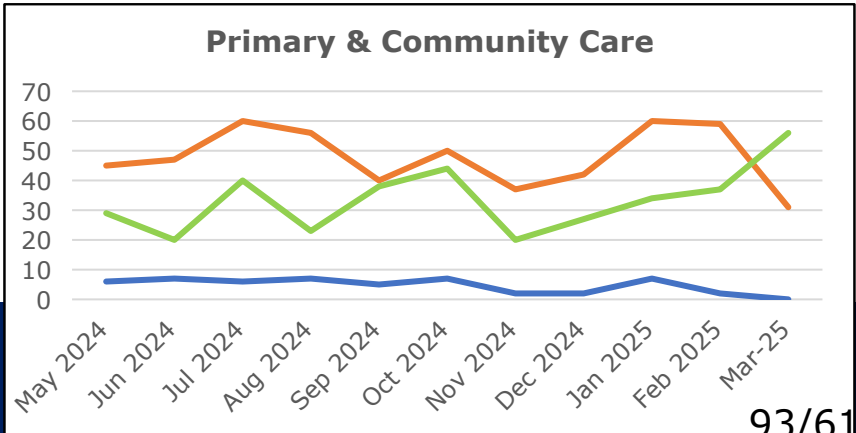
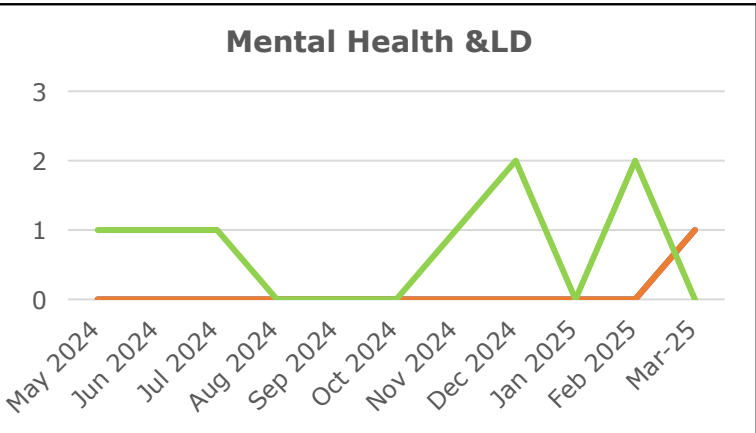
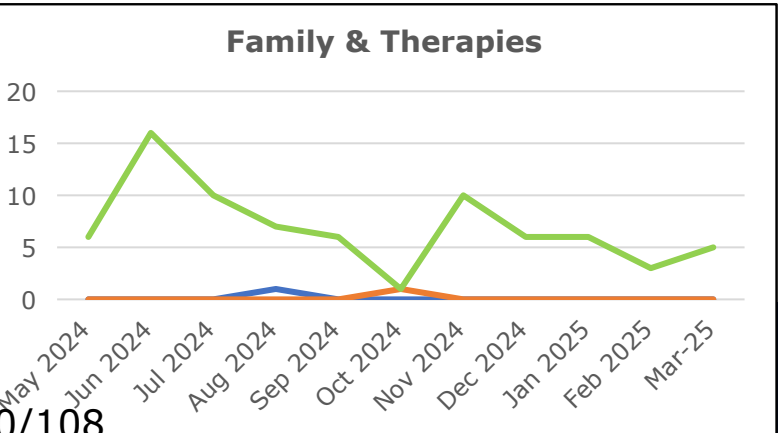
QOF Metric - Pillar Two: Avoidable & Unavoidable HAPU – Extracted from RL Datix (not validated)



Avoidable Unavoidable No value



Quarter	All pressure ulcers	% Difference
Q1	2209	-
Q2	2106	-4.7%
Q3	2286	+8.6%
Q4	2358	+3.15%





What Is the Data Telling Us?

- Positive Progress – Whilst Quarter 4 has the highest number of pressure ulcers, March 2025 data shows a reduction of 54 cases of recorded pressure damage cases compared to February, indicating a positive shift in prevention efforts. Most divisions reported fewer hospital-acquired pressure injuries, reflecting improved awareness and intervention. Grades 1, 2, and 3 pressure damage all declined, suggesting that early identification and response strategies are having an impact.
- Areas for Further Focus - While the overall trend is encouraging, granular analysis is needed to understand division-specific patterns and tailor interventions accordingly. Triangulation of data with clinical reviews is essential to distinguish between avoidable and unavoidable cases, ensuring accurate learning and accountability.

Next Steps

- Establish a Professional Forum Group - Develop clear Terms of Reference to define the group's purpose, scope, and expected outcomes.
- Once Form is being established, enhance assurance around Datix incident reporting. Given the complexity of validating reported incidents, a structured approach is being developed. This will include a monthly meeting with Divisions to review a dedicated dashboard and initiate the design of a validation process. The focus is on sign off all reported incidents relating to pressure damage. This process aims to ensure that focused reviews become a routine and reliable part of the incident management framework.
- Evaluate and Share Impact - Review the effectiveness of current initiatives. Share successful practices across divisions to drive consistency and improvement.
- Strengthen Assurance - Enhance the validation process within each division to ensure data accuracy and reliability.



Learning, Actions & Improvement



Issue	Action	Learning and Improvement	Who	When (RAG)
Quality of Datix Reporting – correct grading, duplication, multiple grades & worsening grades	Data to be validated Completion of Avoidable or Unavoidable Staff to attend tissue viability training via ESR	Grading guides & resources available on the Tissue Viability webpage to support improvement. Critical care have completed bite size training on the unit Share examples of correctly completed documentation	All Divisions	Ongoing
	Re-establish HB steering group to support divisional approach	Collating membership & aim to have first meeting by end of April.	Sue Pearce	30 April 2025
Documentation including skin assessment, nutrition	Carry out audit to identify any themes Support staff with new processes on WNCR with aim to phase out paper documentation	Implement use of symbols on PSAG boards to identify at risk patients Introduce daily huddles to discuss planned care for existing wound care PANDO App for imaging being used successfully Promote RADAR training	All divisions	Ongoing
Access to Datix dashboard	Email Datix lead to arrange access	Utilise dashboard information to improve validation	All divisions	Ongoing
Access to air mattresses	Ensure staff are aware of how to access mattresses via Drive	Posters & booklets available to support mattress choice. Education programme in place at YYF. Plan to roll out to other sites.	All divisions	Ongoing
Mattresses arriving in clean packaging – damaged or contaminated	Report incidents of damaged or contaminated mattresses to Drive immediately	Review process for mattress purchase and hire across all divisions.		
Timely investigation & sharing learning	Establish weekly review meetings. Complete investigations & Yorkshire contributory	Identify themes & actions to improve. Share via QPS forums & HAPU steering	All divisions	ongoing
42/108				95/618

Claims and Redress – 2024/25 Activity



Quarter	Clinical Negligence	% Difference	
Q1	27	-	
Q2	33	+22%	↑
Q3	26	-21%	↓
Q4	37	+42%	↑

Quarter	Personal Injury	% Difference	
Q1	12	-	
Q2	13	+8%	↑
Q3	4	-69%	↓
Q4	8	+100%	↑

Quarter	Redress	% Difference	
Q1	7	-	
Q2	9	+29%	↑
Q3	12	+33%	↑
Q4	6	-50%	↓

Clinical Negligence:

- 37 new clinical negligence matters received during quarter 4.
- 123 new clinical negligence matters received during 2024-2025.
- 419 total number of open clinical negligence matters as at the end of March 2025.

There was a further increase in clinical negligence matters received during this quarter.

Personal Injury:

- 8 new personal injury matters received during quarter 4.
- 37 new personal injury matters received during 2024-2025.
- 82 total number of open personal injury matters as at the end of March 2025.

Personal injury claims remained steady, and at a historic low, during this quarter.

Redress:

- 6 cases were taken through the Health Board's Redress Panel during quarter 4. A total of 34 cases were discussed at the Panel over Quarters 1-4.
- 4 Redress cases were settled during quarter 4.
- The total Redress cases settled across all four quarters was 14.

On average, each case settled through the Redress process will save the Health Board an estimated £30,000 in costs arising had those cases become clinical negligence claims.



Inquests – 2024/25 Activity



Inquests:

- 349 new inquests received during Quarters 1 - 4.
- During Quarter 4, 123 new inquests were received.
- On average, there is approximately 41 new inquests being receive monthly into the Health Board
- This is a monthly increase of 64%

- 291 inquests were concluded during Quarters 1 - 4.
- 67 inquests were held with Health Board witnesses attending in person. Legal Services attended all 67 inquests in support of staff
- 224 inquests were concluded in writing by the Coroner. This meant Health Board staff had prepared statements which were submitted to the Coroner but those members of staff did not need to attend the inquest in person to give oral evidence.

Quarter	Inquests	% Difference	
Q1	66	-	
Q2	55	-17%	↓
Q3	105	+91%	↑
Q4	123	+17%	↑

Reg 28: Prevention of Future Deaths Reports:

There were no Regulation 28 reports issued by the Coroner during Quarter 4.
The Coroner issued a total of 3 Regulation 28 reports during Quarters 1 - 3.
This represented a reduction received by the Health Board from the previous year.

Coroner Update:

- The Coroner has appointed an Area Coroner, Rose Farmer.



Legal Services Team: Updates for Q4



Strengthening Governance and Transparency

- Quarterly Portfolio Reports to the Board - A new formal reporting mechanism has been introduced to ensure visibility and accountability of portfolio activity at Board level. This supports strategic oversight and aligns operational delivery with organisational priorities.
- New SOP for High-Value Cases (£1M+) - A standardised process has been developed for managing high-value cases, ensuring consistent escalation and Board-level approval. This enhances risk management and financial governance.
- New SOP for Inquest Management - A dedicated SOP has been implemented to streamline the management of inquests, ensuring clarity of roles, timelines, and communication protocols across teams.

Legal and Risk Management

- COVID-19 Healthcare Worker Litigation - A briefing paper has been submitted to the Executive Team outlining the legal landscape and organisational response to litigation involving healthcare workers affected by COVID-19.

Learning and Improvement Culture

- Learning from Events Reports (LFERs) - Monthly divisional spreadsheets are now embedded and gaining strong traction. These tools are fostering ownership, reflection, and continuous improvement across clinical and corporate teams.
- LFER Drop-In Sessions - Informal support sessions have been introduced to help divisions interpret and act on LFER data, promoting a culture of shared learning and responsiveness.

Team Development and Focus

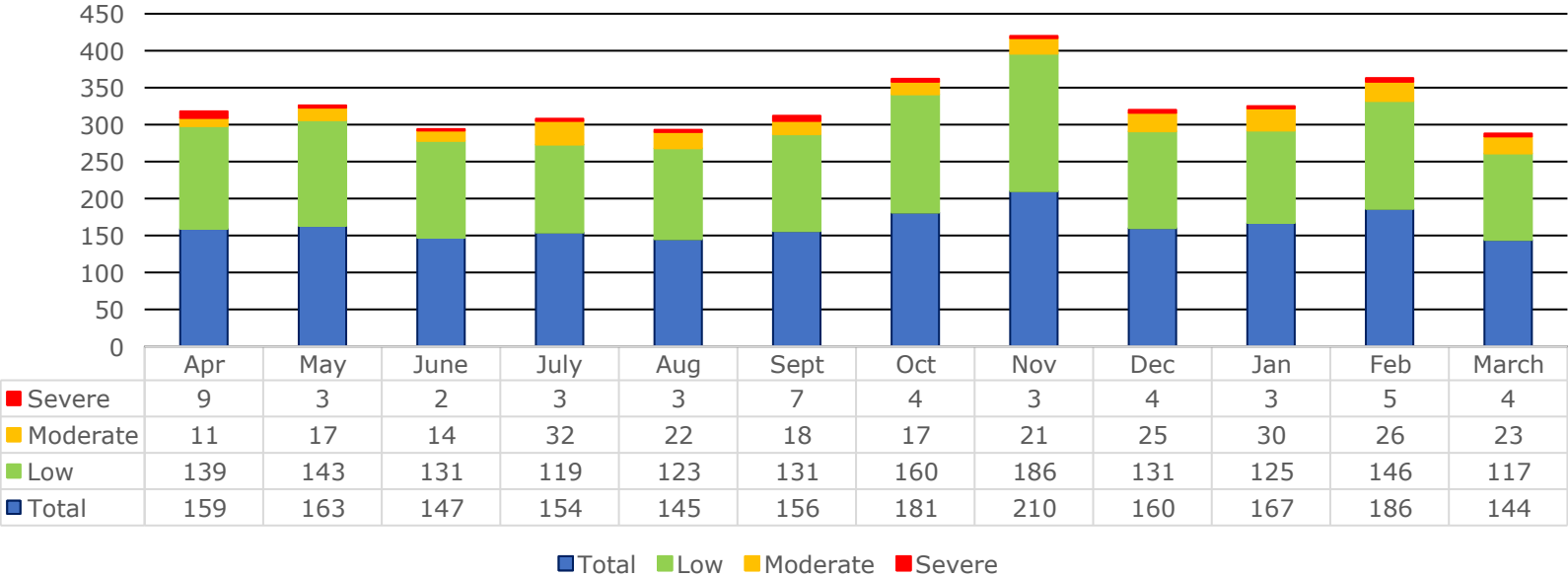
- Specialised Portfolios within the Team - The team has transitioned to a portfolio-based structure, enabling deeper subject matter expertise, improved responsiveness, and clearer accountability.
- Targeted Redress Case Resolution - A focused initiative is underway to clear aged and outstanding redress cases, improving timeliness and reducing backlog-related risks.



QOF Metric - Pillar Two: Trends in Medication Incidents



Reporters Severity of Harm Q1 - Q4. 24-25



Quarter	Moderate	Severe	% Difference	
Q1	42	14	-	
Q2	72	13	+52%	↑
Q3	63	11	-13%	↓
Q4	79	14	+26%	↑

Key Insights:

- Total Reports: Peaked in February (186), followed by a drop in March (144).
- February had the highest overall reports in Q4, driven by a spike in low severity cases.
- March saw a notable decline across all severity levels, especially in low severity reports.
- Severe Cases: Remained stable at 5 in Jan and Feb, slightly decreased to 4 in March.
- Moderate Cases: Showed a gradual decline from 30 (Jan) → 26 (Feb) → 23 (Mar).
- Low Severity Cases: Increased in February (146) after January (125), then dropped sharply in March (117).

Monthly Trends:

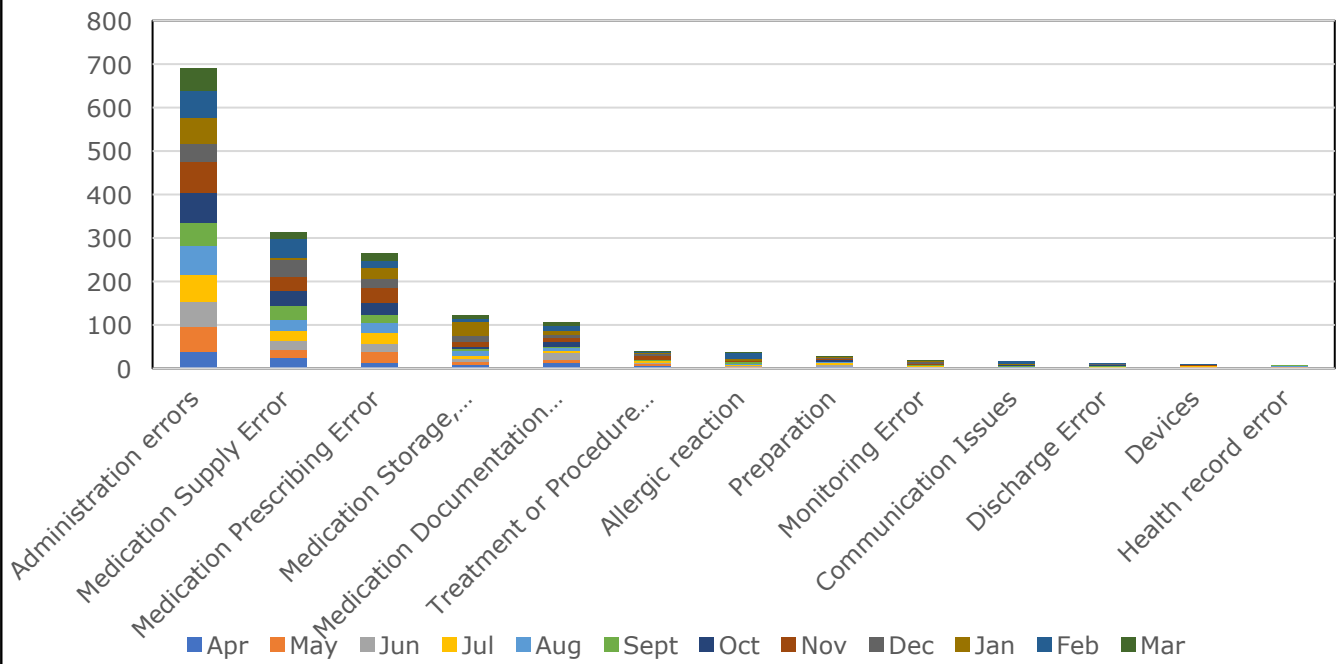
- November stands out with the highest total and low severity reports, suggesting a spike in reporting or incidents during that month.
- July has the highest number of moderate cases (32), despite a relatively average total.
- Severe cases are highest in April (9) and lowest in June (2), but overall remain minimal.
- Low severity reports dominate every month, indicating that most incidents are not critical.



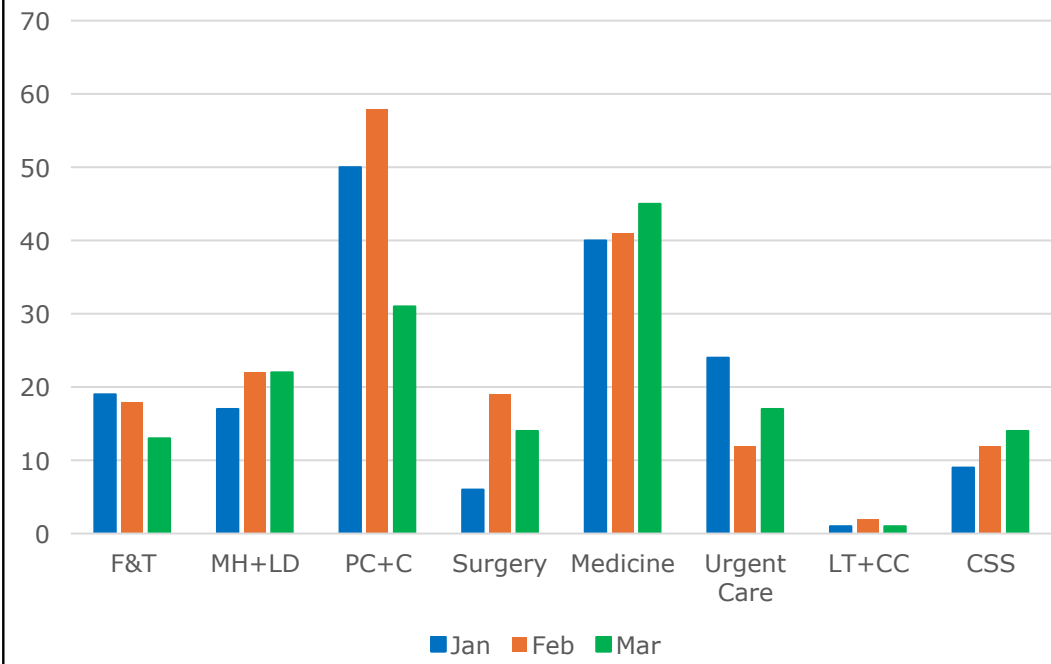
QOF Metric - Pillar Two: Trends in Medication Incidents



Subcategory of Incidents Q1-Q4 2024/25



Total Incidents Reported by Division Q4 2024/25



Key Trends and Insights

- Administration Errors Dominate - consistently records the highest number of incidents across all months. The most frequent type of incident.
- High Incidence in Supply and Prescribing Errors, though not as high as administration errors. Likely the next most significant contributors to overall incident volume.
- Moderate Incidents in Procedure and Allergic Reactions.
- Low Frequency in Documentation and Monitoring Errors. Issues show lower incident counts, suggesting either better control or underreporting.
- Minimal Incidents in Devices and Health Record Errors show the lowest number of incidents, possibly due to fewer interactions or better system controls.
- Stable Monthly Distribution, within each subcategory, the distribution of incidents across months is relatively even. here are no sharp spikes or drops, indicating a steady pattern of incident occurrence throughout the year.



QOF Metric - Pillar Two: Medication Safety Group 2024/25



Item	Action	Learning and Improvement Progress	Who	When
Meeting HEIW Standards for Quality Assurance for all Non Medical (NMP) and Supplementary Prescribers (SP)	Action plan for Nursing & Midwifery (N&M) is complete. A multidisciplinary team (MDT) representing Independent Prescribers (IPs) and Supplementary Prescribers (SPs) has convened. A comprehensive action plan for all disciplines is being managed. The Scope of Practice Declaration is well embedded. To support self-assessment, Royal Pharmaceutical Society competencies have been converted into a self-assessment document. A portfolio document for demonstrating competence has been developed and is pending group ratification.	The standardisation process is being embedded by N&M leads. MDT leads are aligning efforts with individual regulatory bodies and HEIW requirements.	Medicines Safety Group - Short life working group	6 – 12 months.
High-Risk Medications – Categories and Incident Reporting	Priority 1: Anticoagulation incidents. A task and finish group will convene to identify: a) current processes for prescribing and administering anticoagulants, and b) risks and barriers to implementing change.	ERASE poster and staff bulletin have been produced to share information. An MDT organisational approach is needed to manage incidents. A deep dive is required to inform the action plan. The current tool from DECI includes some medicines audit requirements; therefore, a separate tool (distinct from AMaT) is needed.	Task and Finish group including Divisional leads/ /Pharmacy lead	
Medicines Governance Audits	Develop a comprehensive medicines audit governance tool.	The current tool taken from the DECI includes some of the medicines audit requirements therefore a separate tool away from AMaT is required	KH/JH /AG 1/5/2025 meeting	
Controlled Drug SOPs	Complete the SOPs for all CD SOP recommended by CQC.	8 CD SOPs to include the journey from ordering to storing within the clinical area are ready for review. This is support the recent ERASE poster sent out for the safe handling of CDs.	In progress	

BESS – Document review in progress, meeting with leads from Primary and Community care for feedback related to BESS.

PILLAR 3

Complaints, Concerns and Compliments

QPSE
Dashboards

PTR
Regulations

Patient and
Staff
Feedback

Complaints –
Themes and
Learning

PSOW –
Themes &
Learning

Psychological
Safety

Leadership,
Accountability
and Culture

Collaborative
Forums

Staff Training
and
Mentorship
(IO)

Early and
Regular
Contact

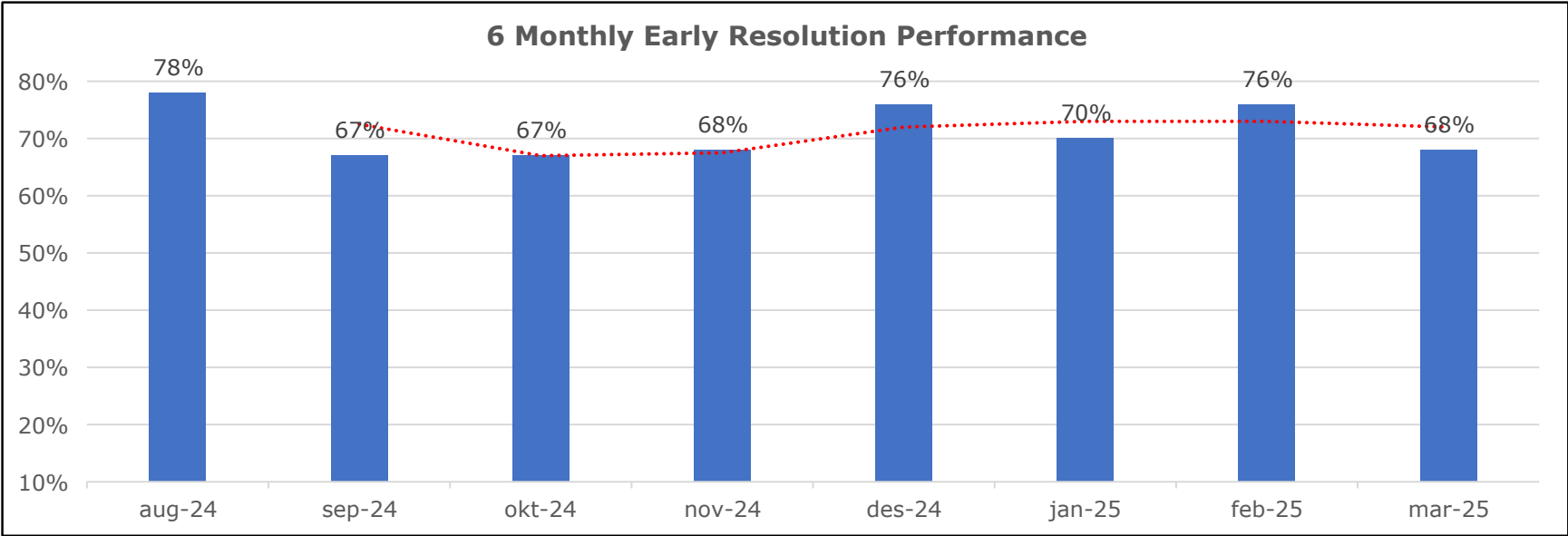
Speaking
up Safely

Metrics: -

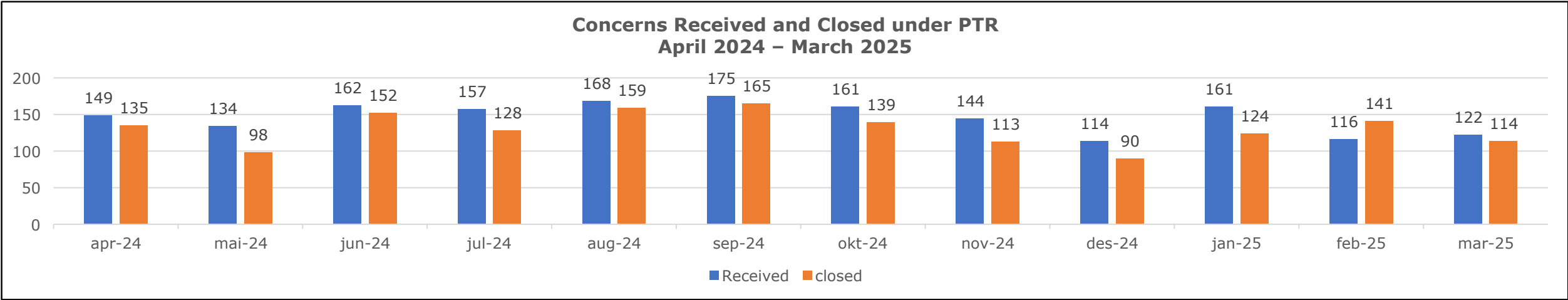
- 30 day performance
- Concerns
 - Review layers to look at compliance and closure
- Compliments
- PALs (especially early resolution)

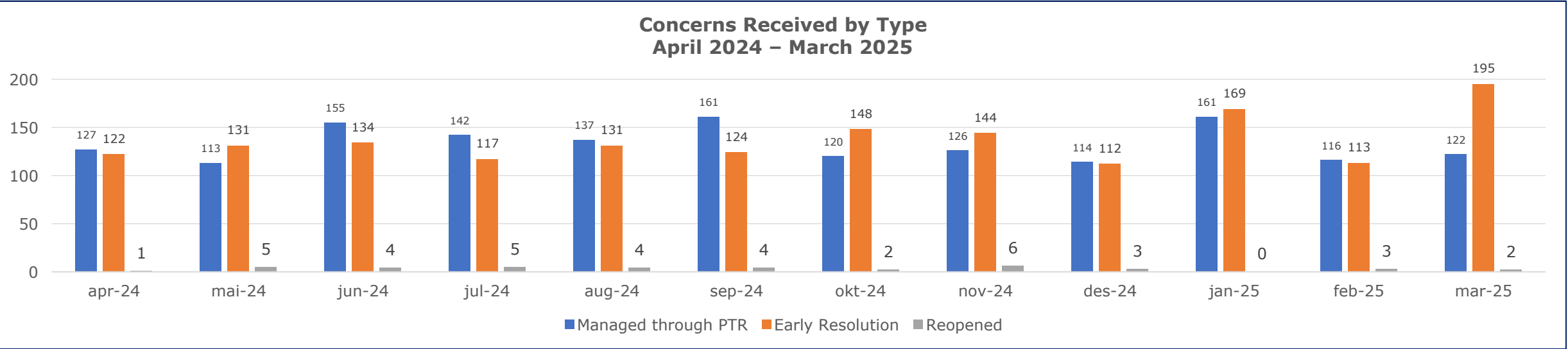
QOF Measure – Pillar 3

Concerns 30 day Performance



Quarter	Early Resolution Performance	% Difference	
Q1	66%	-	
Q2	71%	+8%	↑
Q3	68%	-4%	↓
Q4	71%	+4%	↑





Dedicated teams have been created within each division to focus exclusively on Early Resolution cases, ensuring prompt and effective handling. Additionally, comprehensive training sessions have been conducted to equip staff with the skills needed to identify potential issues early and address them proactively. Regular monitoring and evaluation meetings are being held to track progress and make necessary adjustments. The Health Board has also introduced new reporting tools to streamline communication and ensure transparency in the resolution process. These concerted efforts are anticipated to not only maintain but also enhance the efficiency and effectiveness of managing concerns.

To ensure that the number of closed concerns exceeds those received, the Health Board has instituted several proactive measures throughout the quarter. Firstly, each Division has been diligent in balancing the management of new issues while systematically addressing existing ones. This approach allows for a more efficient resolution process and prevents backlog.

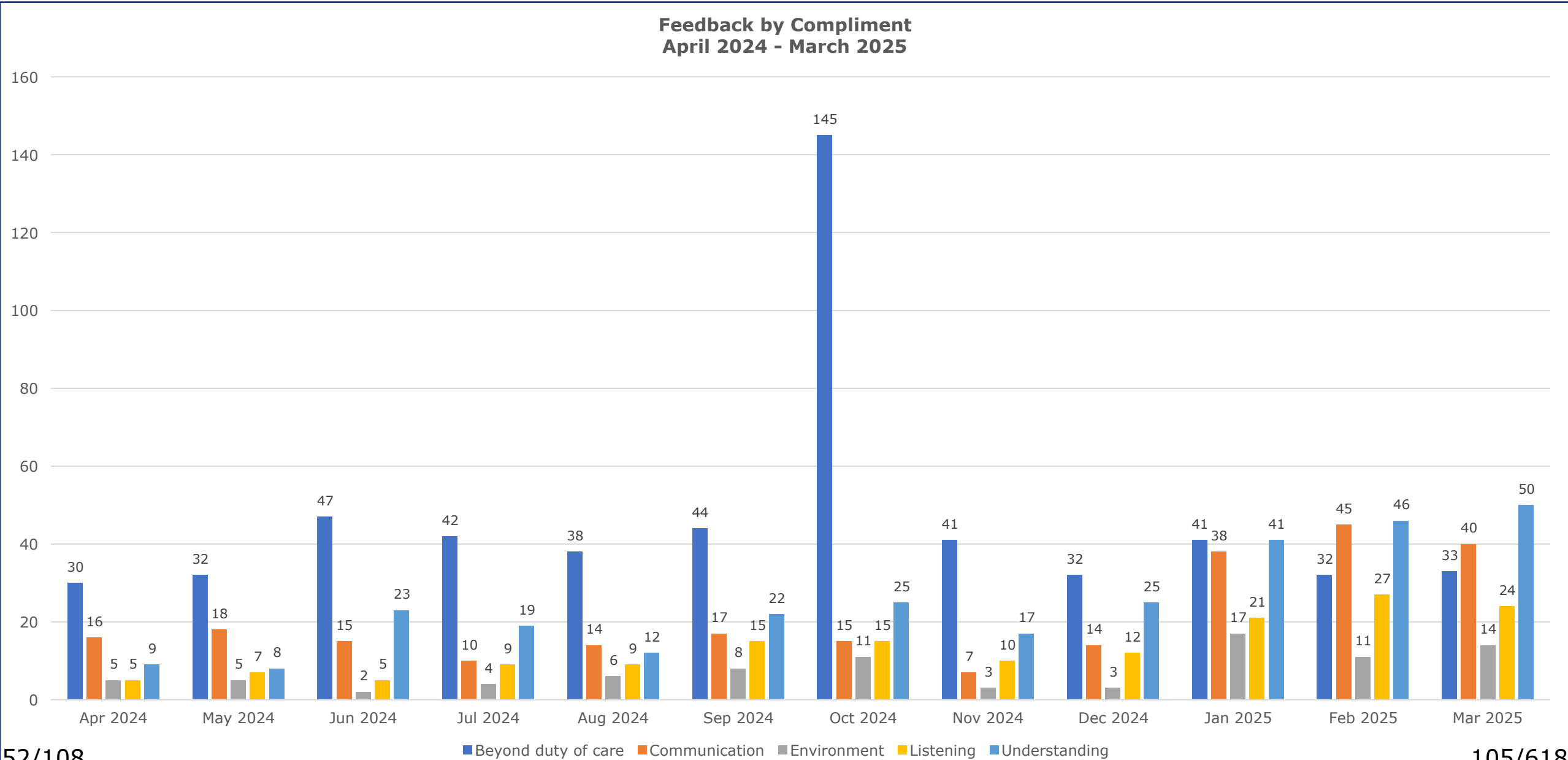
Such efforts underscore the Health Board's commitment to continuous improvement in patient care and service quality within the NHS. This proactive approach is instrumental in maintaining a positive balance between closed and received concerns.



QOF Measure – Pillar 3 Compliments 2024/25



Feedback by Compliment
April 2024 - March 2025



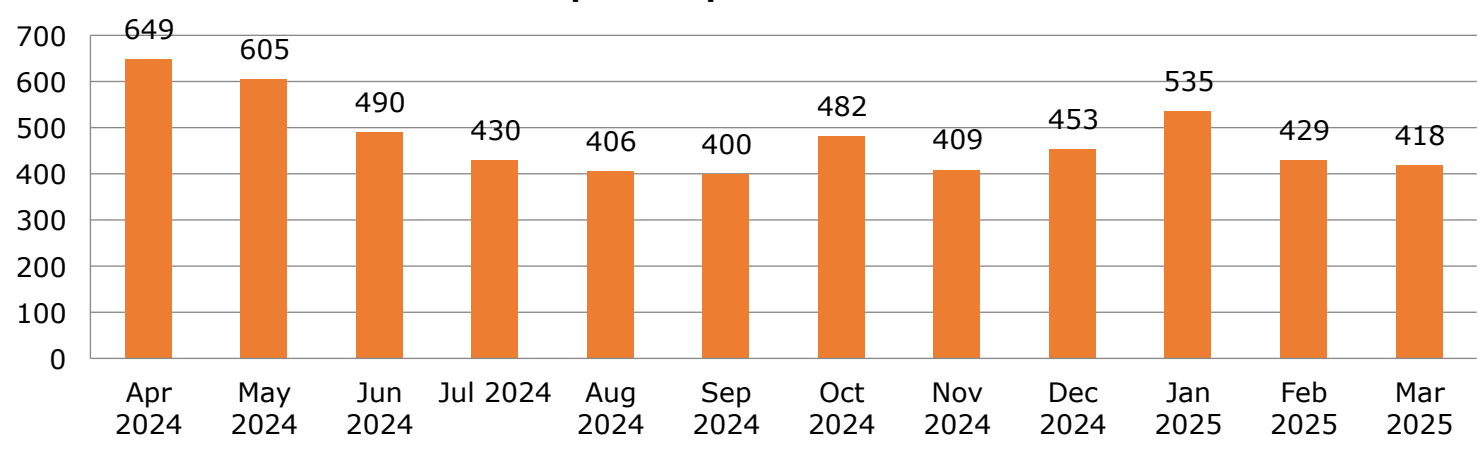


Achievements	Update	Next Steps
Quality Improvement and process mapping	The complaints team have been collaborating closely with ABCI to enhance processes using the LEAN Six Sigma approach. The aim is to streamline systems, reduce variation, and improve quality.	Further work is required in terms of collecting more information to measure successes following planned process changes.
Datix validation and cleansing	An errors dashboard has been created to effectively oversee and monitor the complaints management system. Additionally, it will also support the training needs of the complaints team in using Datix and complying with PTR timelines.	The dashboards have been shared with the complaints co-ordinators for validation of historic data.
Medicine complaints tabletop exercise	In February, the Medicine Division, in collaboration with members of the QPS and complaints team, conducted an in-depth analysis of open complaints to gain a comprehensive understanding of the complaints position and to identify possible opportunities for resolution. As a result of the session, the number of open formal complaints decreased significantly from 129 to 112, representing a 13% reduction. Additionally, Early Resolution complaints were reduced to 3, which constitutes a 50% reduction.	A further debrief is due to be held in March 2025 to discuss the benefits, sustainability and next steps
Regulation 26 (Interim) Responses	A collaborative approach to Reg 26 response has been achieved with PTR and Legal Services to ensure that we are moving concerns; where a breach of duty has been identified and consideration at redress is required timelier.	Ongoing monthly meetings to discuss and confirm Reg 26 response with Legal Services Redress lead and Sr QPS Manager
New call handlers & PTR team members	New call handlers have been introduced to the PTR team to support with planned changes to streamlining of processes to ensure consistent and appropriate concerns management.	Ongoing training across all aspects of the PTR team.



QOF Measure – Pillar 3: Patient Advice & Liaison Service

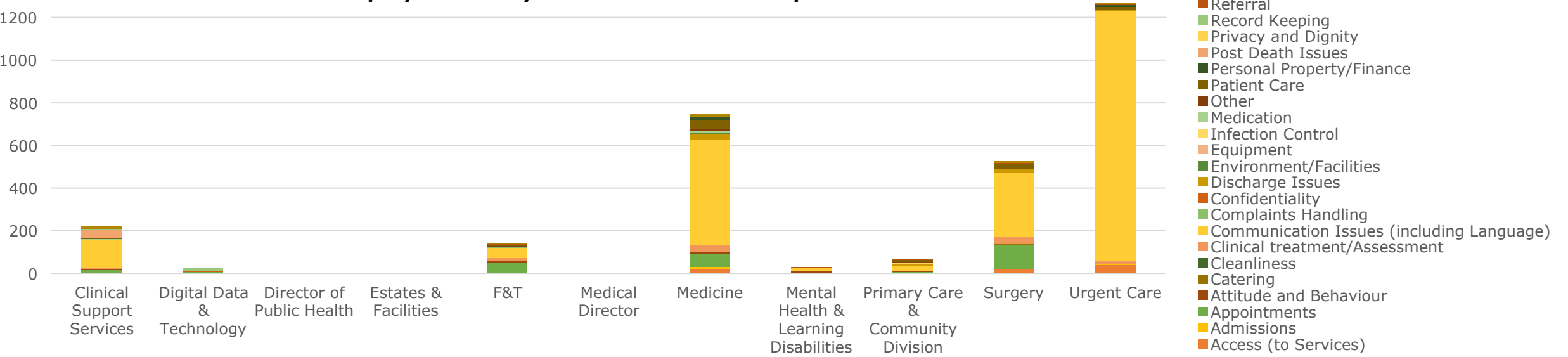
PALS Enquiries April 2024 - March 2025



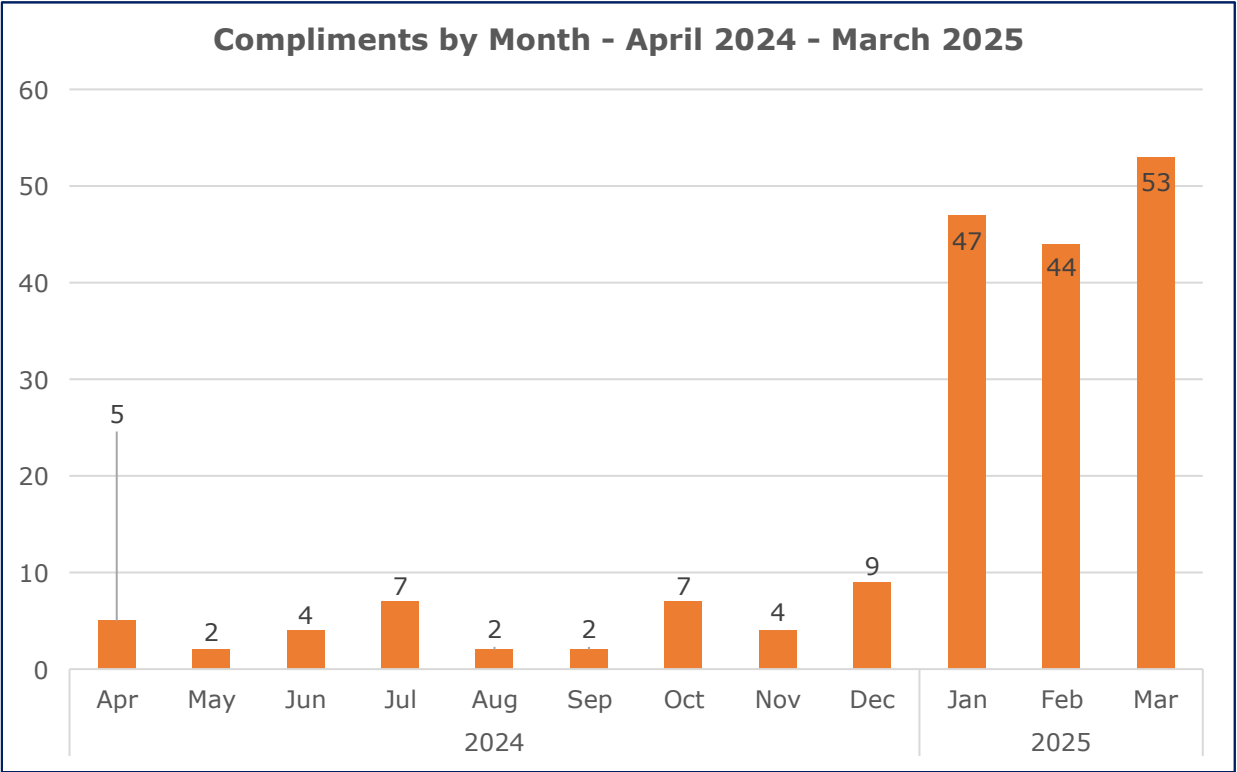
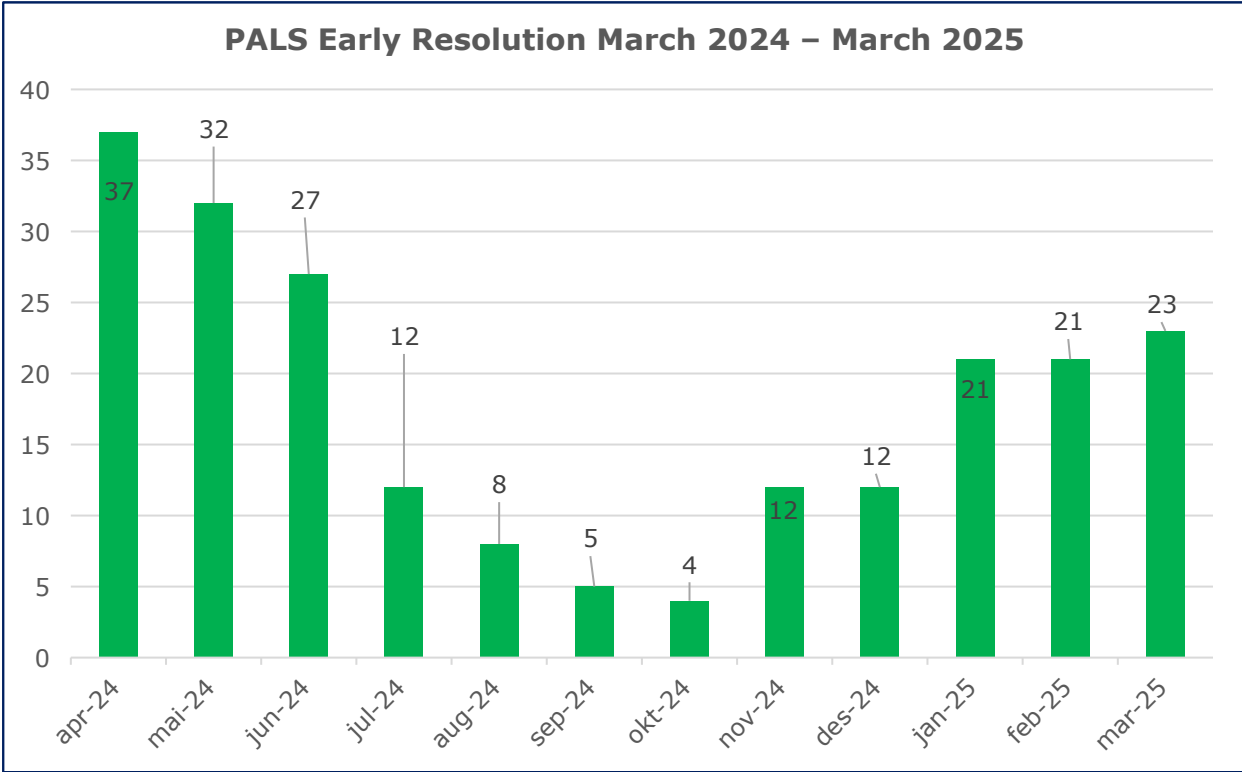
Enquires Overview: -

- **Average number of Enquiries – 476 per month.** The number of Enquires per month dropped after April due to duplication issues with logged enquiries. Therefore, May onwards is a accurate representation of data.
- **Top Theme** - Communication Issues top theme for Enquires for **April 2024 – March 2025.**
- **Enquiry Majority** - relate to lack of updates regarding Emergency Admissions. This is something the PALS, and especially PSO's, deal with on an hourly basis.

Enquiry Themes by Division March 2024 – April 2025



QOF Measure – Pillar 3: Patient Advice & Liaison Service



Early Resolution Complaints Managed via PALS:

Concerns and Enquires received from Putting Things Right are opened as Early Resolution on Datix. July 2024 – November 2024 this guidance changed and PALS only logged Early Resolution’s when service users had specified they were raising a complaint. However, from November 2024 guidance is now all calls transferred from PTR are logged under Early Resolution.

Average number of ER complaints – 18 a month over April 2024 – March 2025

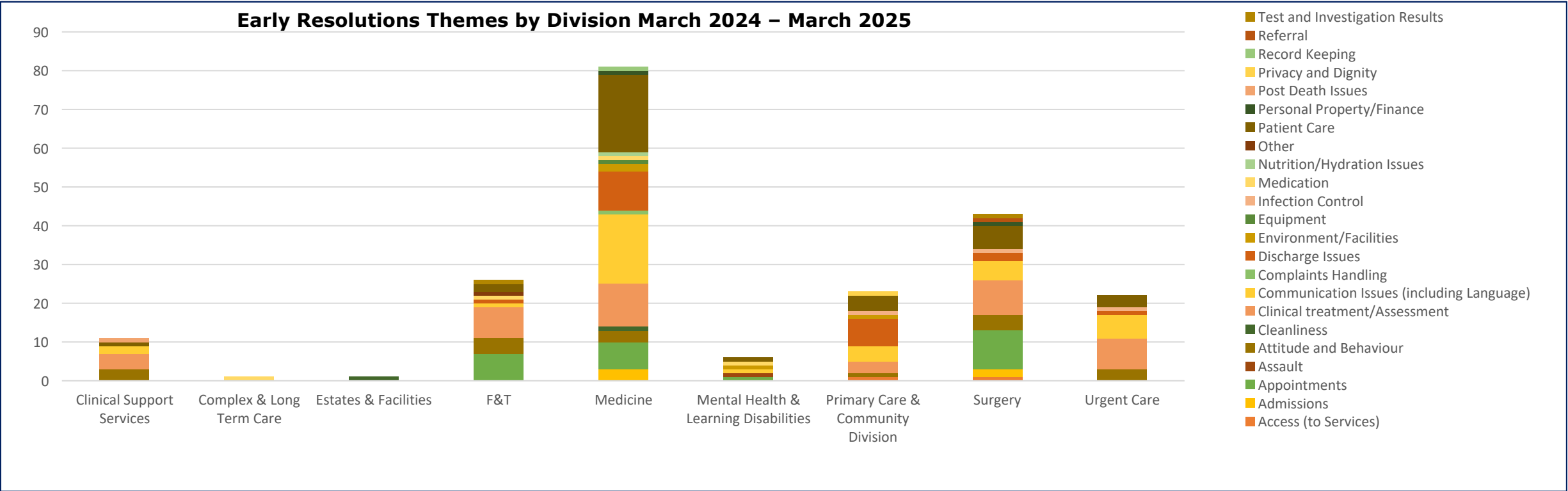
Top Theme – Clinical Treatment/Assessment of Early Resolution Complaints.

As of January 2025, the PALS team now utilise CIVICA to log compliments for each division. Therefore, going forward the number of compliments managed by PALS will increase.

The CIVICA Surveys being utilised are:

- Emergency Department Surveys
- Person Centred Care Survey
- Endoscopy Survey
- Children’s Surveys

QOF Measure – Pillar 3: Patient Advice & Liaison Service



Early Resolution Complaints Managed via PALS:

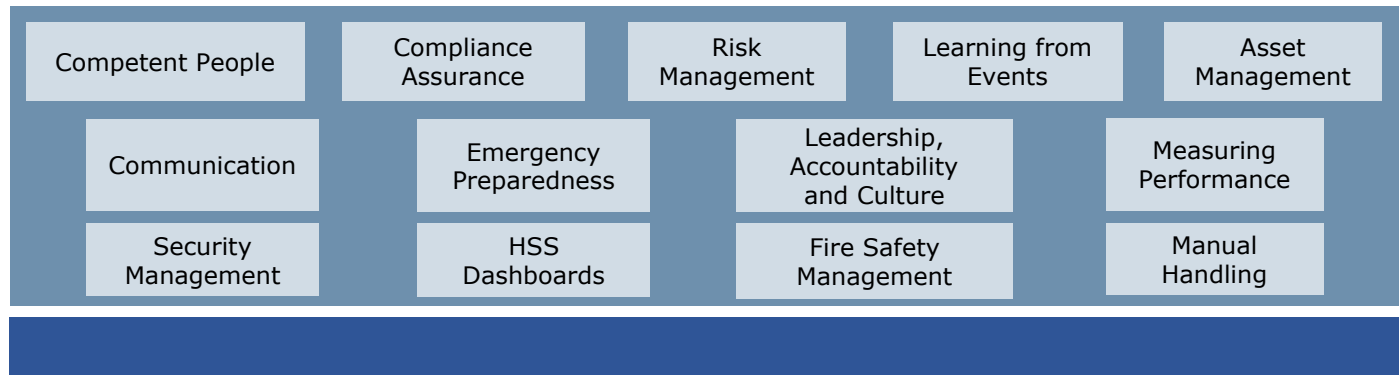
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Average number of ER complaints – 18 a month over April 2024 – March 2025

Top Theme – Clinical Treatment/Assessment of Early Resolution Complaints.

PILLAR 4

Health, Safety and Security



Metrics: -

- RIDDOR reporting compliance (in line with HSE criteria) – target 100%
- Health & Safety statutory and mandatory training compliance – target 85% all modules
- Compliance with the Health Board Health, Safety & Fire risk assessment programme – target 100%

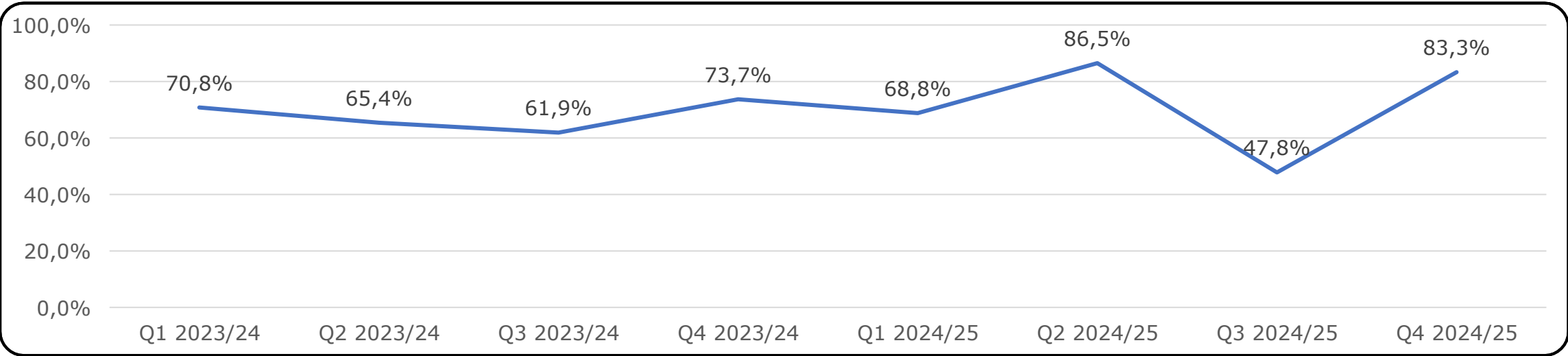


Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

During Q4 2024/25 the Health Board have reported **12 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

83.3% of these cases were reported within the legal timeframes within the legislation.

This is a significant increase on the previous quarter.





Health and Safety Executive Engagement

The Health Board received one enquiry from the HSE during Q4 2024/25. This related to an incident where a patient sustained significant burns as a result of enhanced exposure to ultraviolet light during phototherapy treatment. The Health Board are still awaiting a response from the HSE.

The Health Board have two active cases with the HSE, both relate to fatal patient falls reported in accordance with RIDDOR.

South Wales Fire & Rescue Service Activity

There has been no enforcement activity from South Wales Fire & Rescue Service during Q4 2024/25.

The Health Board have submitted applications for exemption against specific areas of the organisations Estate to ensure SWFRS respond to automatic fire alarms. The Health Board are currently awaiting responses to the applications.





Health and Safety Statutory and Mandatory Training

At end of March 2025 training compliance for the Health Board was reported as:

A programme of manual handling training is being implemented in April 2025 and the target is to increase compliance for high risk areas to at least 85% by December 2025

Health & Safety	86.5%
Fire Safety	82.3%
Violence & Aggression	86.0%
Manual Handling	70.0%

Health and Safety Training Framework

A review of the training framework for Fire Safety and Violence, Prevention & Reduction is planned for Q2 2025/26



PILLAR 5

Infection Control and Prevention

Leadership,
Accountability
and Culture

Education

Antimicrobial
Stewardship

Dashboards

Themes and
Trends

IPAC Dashboards

Audit

Patients/Staff
Stories

IPAC Training

Actions and
Learning

National Policies

Investigation /
Themes for Learning

Environmental
Cleanliness

Collaborative Working
– Faculty's

Metrics: -

- Infection Control measures
- Welsh Government Reduction Goals
- C-Section Surgical Site Infections
- AMR prescribing trends
- Audit & Education: Respiratory Infections

Developing Metrics: -

- DECI and Hand Hygiene

Pillar 5: Infection Prevention – Welsh Government Goals



Current Count of Cases for FY 24/25

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	275	19	170	376	115	42
Betsi Cadwaladr UHB	356	11	169	538	136	25
Cardiff and Vale UHB	210	14	169	286	120	41
Cwm Taf Morgannwg UHB	158	10	121	364	103	14
Hywel Dda UHB	184	11	122	380	106	24
Powys THB	21	0	2	2	0	0
Swansea Bay UHB	275	5	126	224	121	18
Velindre NHST	5	1	3	11	8	0
Wales	1484	71	882	2181	709	164

Rate per 100,000 population

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

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	46.5	3.21	28.75	63.58	19.45	7.1
Betsi Cadwaladr UHB	51.73	1.6	24.56	78.17	19.76	3.63
Cardiff and Vale UHB	41.54	2.77	33.43	56.57	23.74	8.11
Cwm Taf Morgannwg UHB	35.58	2.25	27.25	81.98	23.2	3.15
Hywel Dda UHB	47.78	2.86	31.68	98.68	27.53	6.23
Powys THB	15.68	0	1.49	1.49	0	0
Swansea Bay UHB	71.72	1.3	32.86	58.42	31.56	4.69
Velindre NHST						
Wales	47.39	2.27	28.16	69.64	22.64	5.24

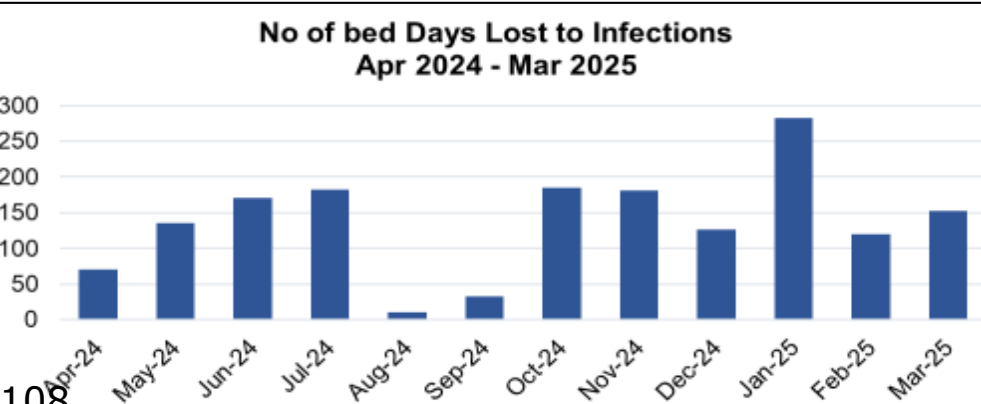
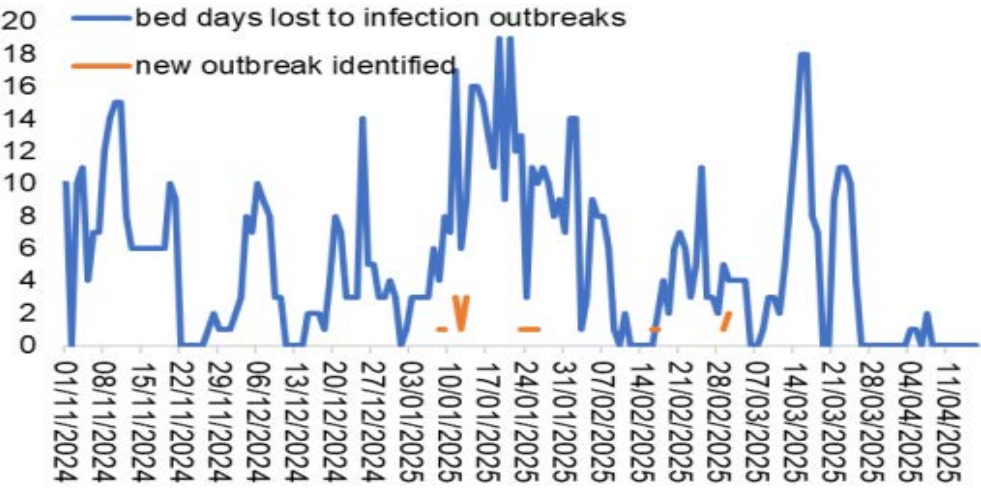


Pillar 5: Infection Prevention – Bed Days Lost



Issue

Total ward closures due to infections Apr 24 – Mar 25:
21 wards due to **C difficile** (2 in Mar – 4/4 & B4)
30 wards due to **Norovirus** (3 in Mar – C6E, C6W, 3/3)
25 wards due to **Covid-19** (0 in Mar)
3 wards due to **Influenza** (0 in March)



Actions

C difficile

- Outbreak control meetings convened
- Incidental finding due to increase of norovirus on ward 4-4

Norovirus

- Enhanced cleaning
- Rapid isolation/cohort of affected patients
- Visitors notices – not to visit if unwell
- Wearing appropriate PPE including masks
- Removed alcohol hand gel & promoted hand washing with soap & water

Covid-19

- Promoted covid safety measures
- Enhanced cleaning of touch point areas
- Patients cohorted on a like for like infection

Influenza

- Risk assess staff working with symptoms
- Wards closed to transfers & discharges

Learning & Improvement

C difficile

- Compliance with fundamental IP
- Ongoing targeted interventions within medicine

Norovirus

- Shared facilities
- Lack of isolation cubicles
- Less impact on staff as been wearing face coverings

Covid-19

- Poor ventilation
- Symptomatic visitors

Influenza

- Unable to isolate MHLN patients

Introduced mask wearing in the clinical area across the Health Board, resulting in fewer staff becoming affected.

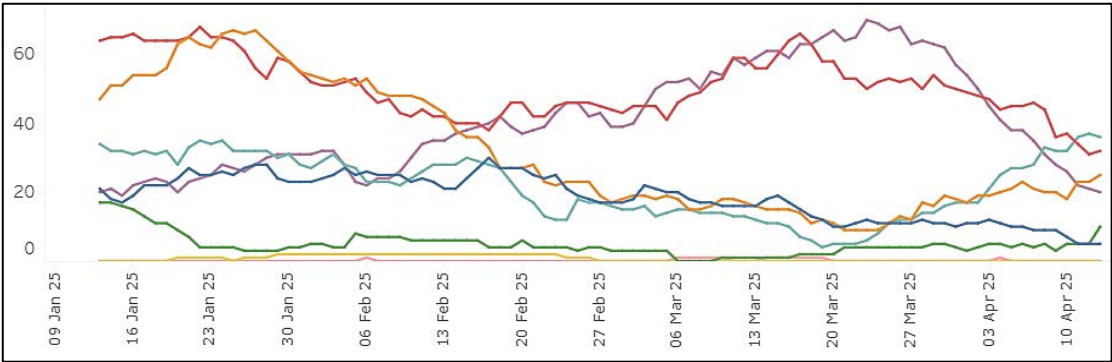
Established Silver Command Group to identify emerging risks and timely solutions, escalation to exec team for decision making.

Pillar 5: Infection Prevention – Respiratory



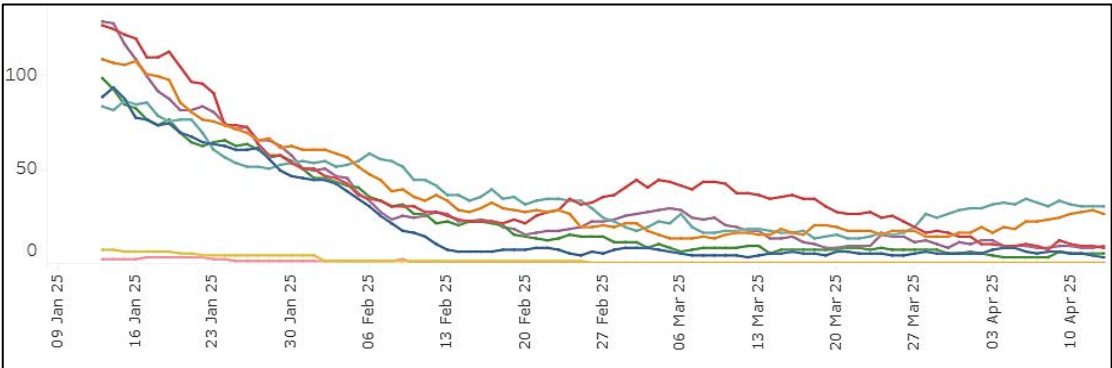
Covid-19

0 full ward closures in February.
Shared facilities impacting on onward transmission within hospital setting and patients being unable to tolerate face coverings.



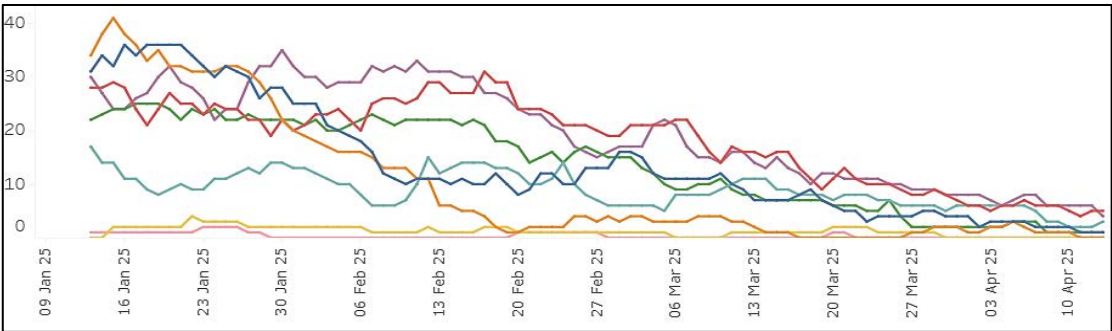
Influenza

0 full ward closures continue with point of care testing within admission units to support safe patient placement



RSV

0 full ward closures, shared facilities contributing to onward transmission within bay on 1 one ward.



- Aneurin Bevan UHB
- Betsi Cadwaladr UHB
- Cardiff and Vale UHB
- Cwm Taf Morgannwg UHB
- Hywel Dda UHB
- Powys THB
- Swansea Bay UHB
- Velindre NHST

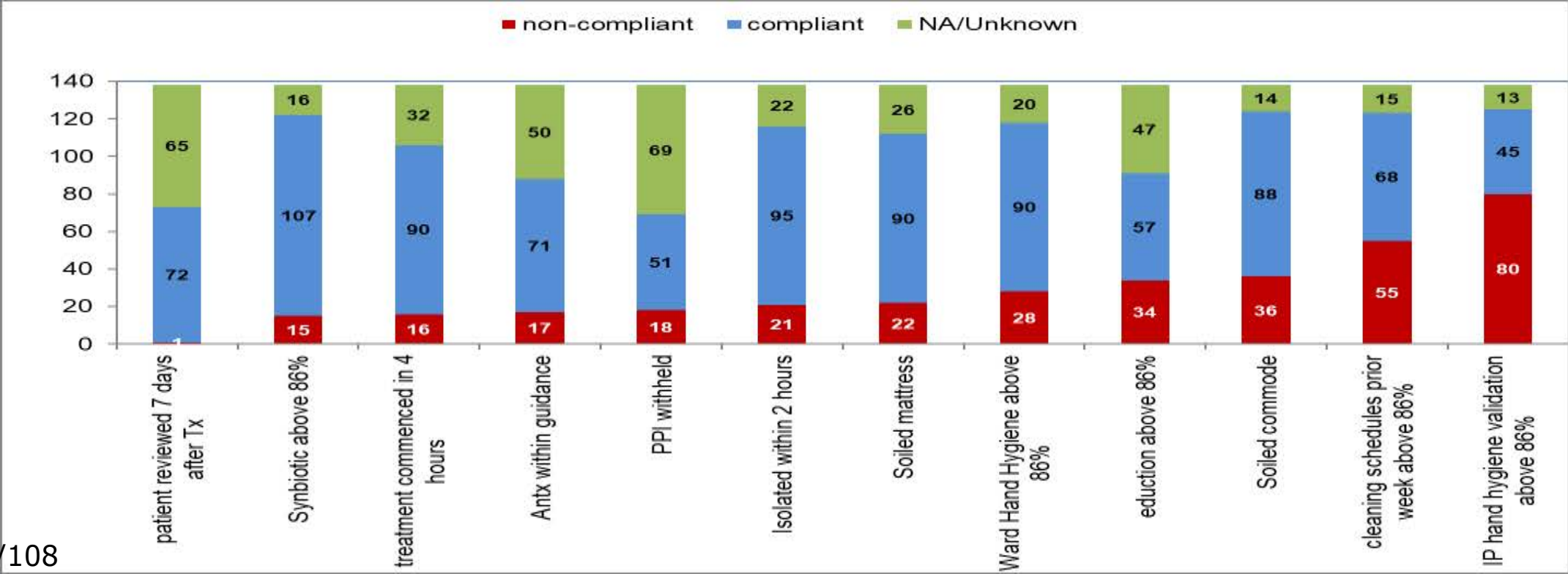


Pillar 5: Infection Prevention – C DIFFICLE



Issue	Action	Learning & Improvement
275 cases. The rate of C difficile in ABUHB is 46.50 per 100,000 population for Apr - Mar 25. This is 20% higher (46 more cases) than the equivalent period 23/24 Healthcare associated = 138 Community acquired = 107 Relapse/indeterminate = 30	▪ QI projects spreading to wards - RGH ▪ Ongoing proactive enhanced cleaning ▪ Ongoing dashboard monitoring via AMAT ▪ Refreshed intranet resources ▪ ERADICATE Cdi webinar – 18th March 2025 ▪ Executive Strategy improvement group and action plan developed ▪ Review cleaning process and staff training	▪ Monitoring discussed with senior leadership ▪ IP standards incorporated in HB leadership programme ▪ Staff survey shared with senior leaders re culture and roles and responsibilities ▪ Additional mattresses purchase ▪ Slippage in proactive clean at YYF and GUH due to capacity ▪ Laundered of mops and replacement process ▪ No genosequencing linked

Compliance with Fundamental Measures (learning from root cause analysis of HAI cases)

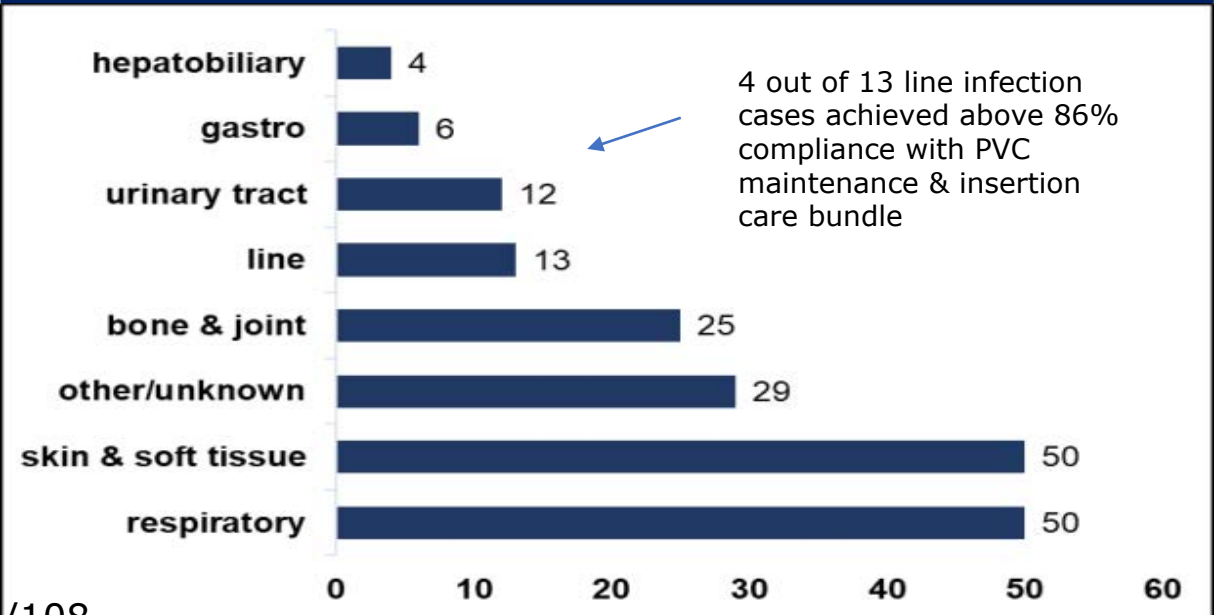


Pillar 5: Infection Prevention – Healthcare Associated Infections

Staph Aureus Blood Stream Infections

Issue	Action	Learning & Improvement
189 cases. The rate of Staph Aureus in ABUHB is 32.07 per 100,000 population for Apr – Mar 25. This is 47% higher (60 more cases) than the equivalent period 23/24. Healthcare Associated = 64 Community Acquired = 116 Relapse/Indeterminate = 9	- Presentations from webinar for line care available on Pulse - ANNT incorporated into ward accreditation - Monitor MRSA screening and bundle compliance via AMAT - Targeted MRSA screening in assessment - One patient reported 6 times for MRSA BSI	- Overview of HB guidance for the management of lines - Compliance increasing several areas now able to achieve bronze accreditation

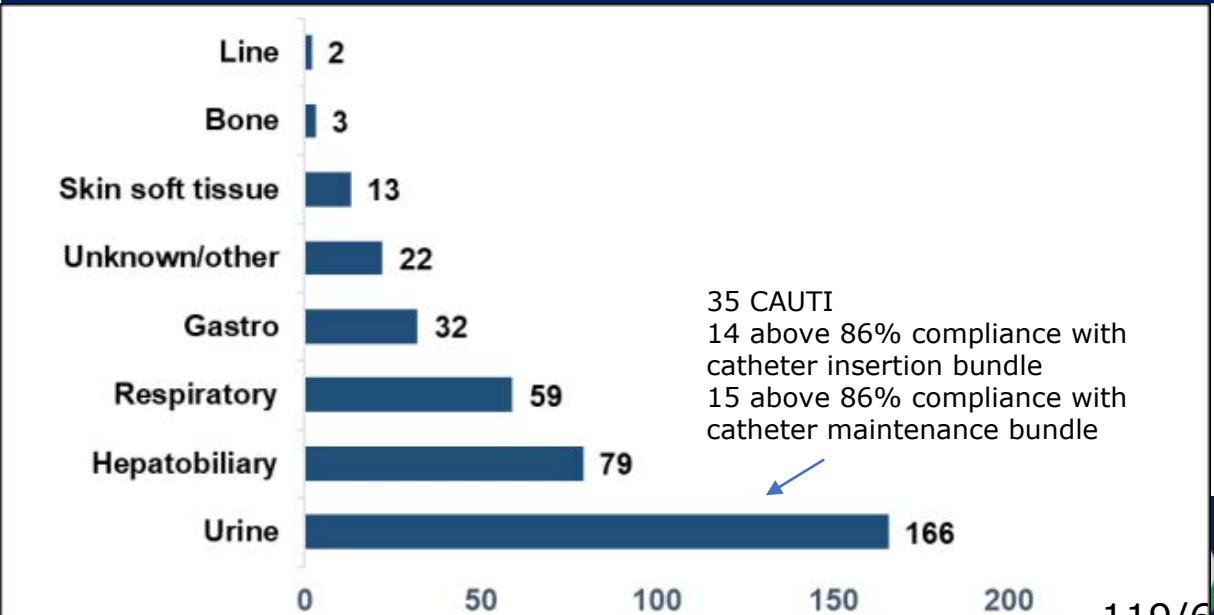
Source of Infection



E coli Gram Negative Blood Stream Infections

Issue	Action	Learning & Improvement
376 cases. The rate of E coli BSI in ABUHB is 63.58 per 100,000 population for Apr – Mar 25. This is 8% higher (27 more cases) than the equivalent period 23/24. Healthcare Associated = 97 Community Acquired = 270 Re-isolate/Indeterminate = 9	- Main source of infection is UTI. - Presentations from webinar available on Pulse - Continue promoting 9 key standards for UTI - Promotion of external devices for ladies - Oral hygiene promotion	- No catheter November arranged for primary care - Access to rescue pack in community for UTI resulting in delay in treatment

Source of Infection

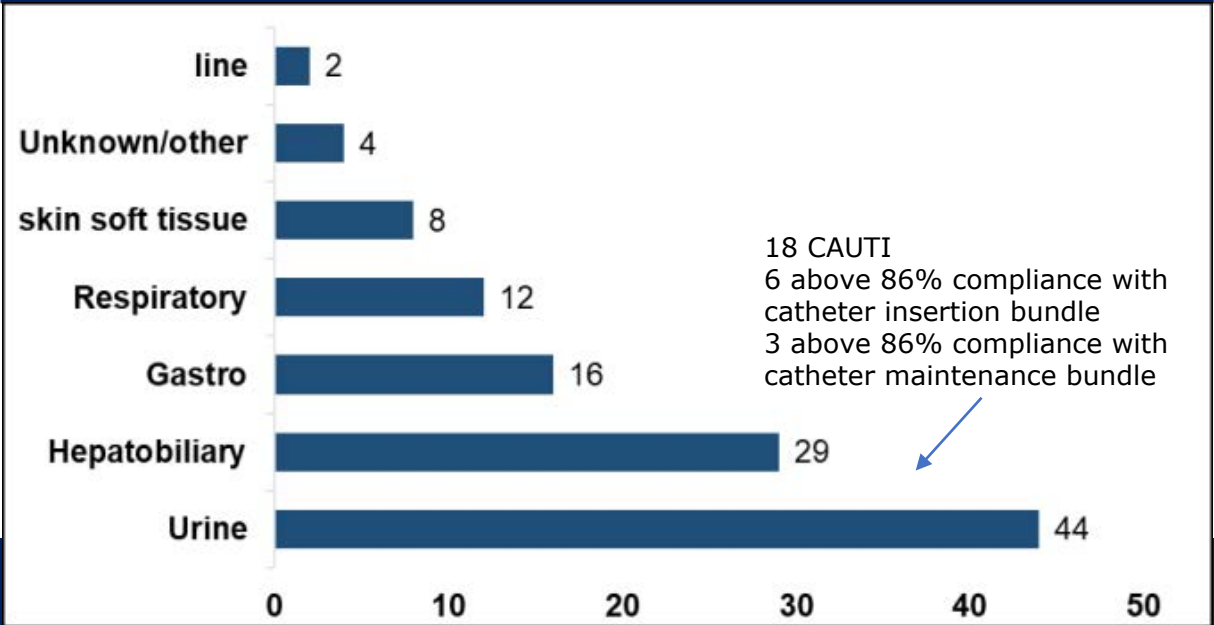


Pillar 5: Infection Prevention – Healthcare Associated Infections

Klebsiella Gram Negative Blood Stream Infections

Issue	Action	Learning & Improvement
115 cases. The rate of Klebsiella BSI in ABUHB is 20.37 per 100,000 population for Apr – Mar 25. This is 15% less (20 less cases) than the equivalent period 23/24. Healthcare Associated = 41 Community Acquired = 71 re-isolate/Indeterminate = 3	▪ Sepsis, Antimicrobial Stewardship and Infection prevention training to new Doctors ▪ Multi drug resistance policy under review	▪ Prescribing within policy ▪ Refocus ANTT ▪ Nursing documentation

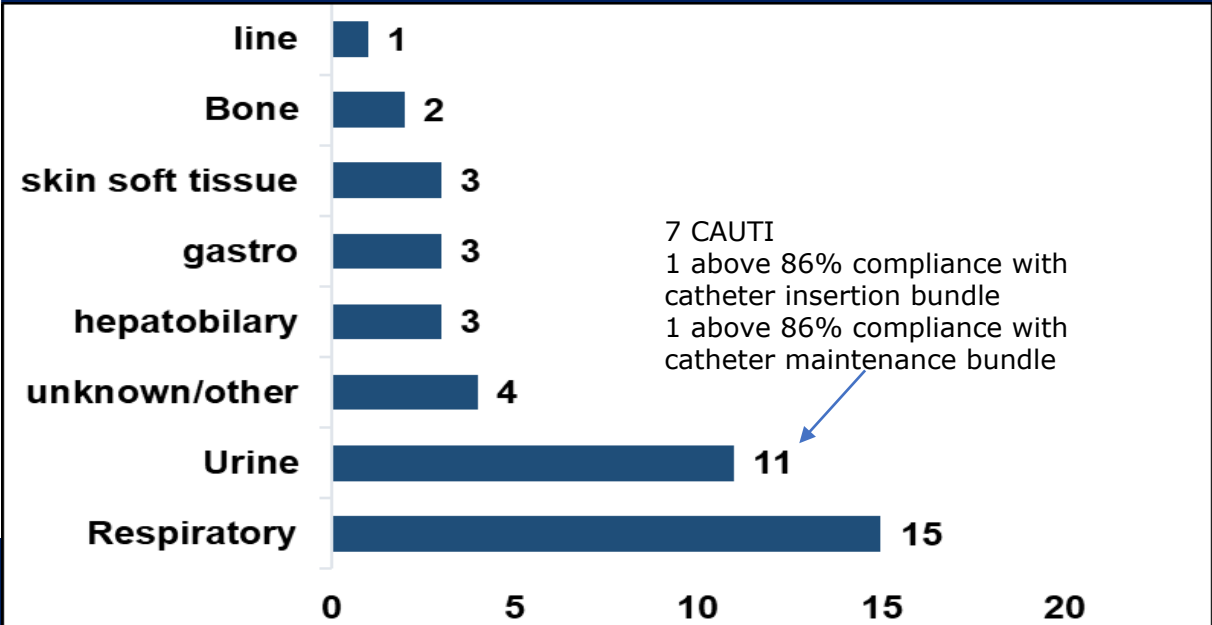
Source of Infection



Pseudomonas Gram Negative Blood Stream Infections

Issue	Action	Learning & Improvement
42 cases. The rate of Pseudomonas BSI in ABUHB is 7.10 per 100,000 population for Apr – Mar 25. This is 68% higher (17 more cases) than the equivalent period 23/24. healthcare associated = 19 community acquired = 23	▪ Reviewed training resources for water flushing ▪ Incorporated flushing onto the ward accreditation environmental audit	▪ Increase staff awareness

Source of Infection



Pillar 5: Infection Prevention – Action, Learning & Improvement – March 2025

Issue	Action Taken	Learning & Improvement	Responsible Officer	Time scale
Above trajectory for Welsh Government healthcare acquired infections	➤ Organisational action plan developed ➤ Strategic leadership group established and action plan ➤ Webinar re line management, UTI, C diff and winter virus ➤ C difficile faculty ➤ Oral Hygiene faculty ➤ News letter promoted ➤ Intranet resources refreshed ➤ Infection Prevention audits via AMAT ➤ Reviewed staff knowledge for cleaning and training provided and QI project developed ➤ Ongoing review organisational policies and SOP ➤ Review of community catheters using the HOUNDI principles ➤ Leadership survey re roles and reasonability's for infection prevention undertaken ➤ IP incorporated into leadership programme ➤ QI projects commenced for ventilator associated infection and surgical site infection in maternity ➤ Attended spring forum focus on Human Factors ➤ Reviewed mattress storage and operational process ➤ Escalation process for winter developed with PHW	• Continue to improve compliance with Health Board antimicrobial stewardship • Continue to improve compliance with fundamental infection prevention via audit and staff education. Within March IPT more present on wards • Identified learning around managing infection prevention measures balanced against additional inpatient capacity. Risk assessment for safe patient placement. UV cleaning increased to bridge the gap of HPV • Ongoing improvement in terms of unable to complete proactive cleans due to additional capacity and time factors. Consider new technology to improve the cleaning process, paper presented to Infection Prevention and Antimicrobial Stewardship group • Continue to improve medical device management and compliance with care bundles via staff education and role out of ANTT several areas working to bronze accreditation • Continue to improve staff knowledge and adherence to policy through education and bespoke ward based training. • Continue to monitor that patient equipment is clean and in good working order (particularly shared equipment). • Continue to monitor that mattresses are clean inside and out and free from rips/tears. • Continue to monitor compliance with admission screening requirements i.e. MRSA/CPO • Establish trigger points for management of winter virus	DMT IPT Antimicrobial pharmacy Facilities	Ongoing

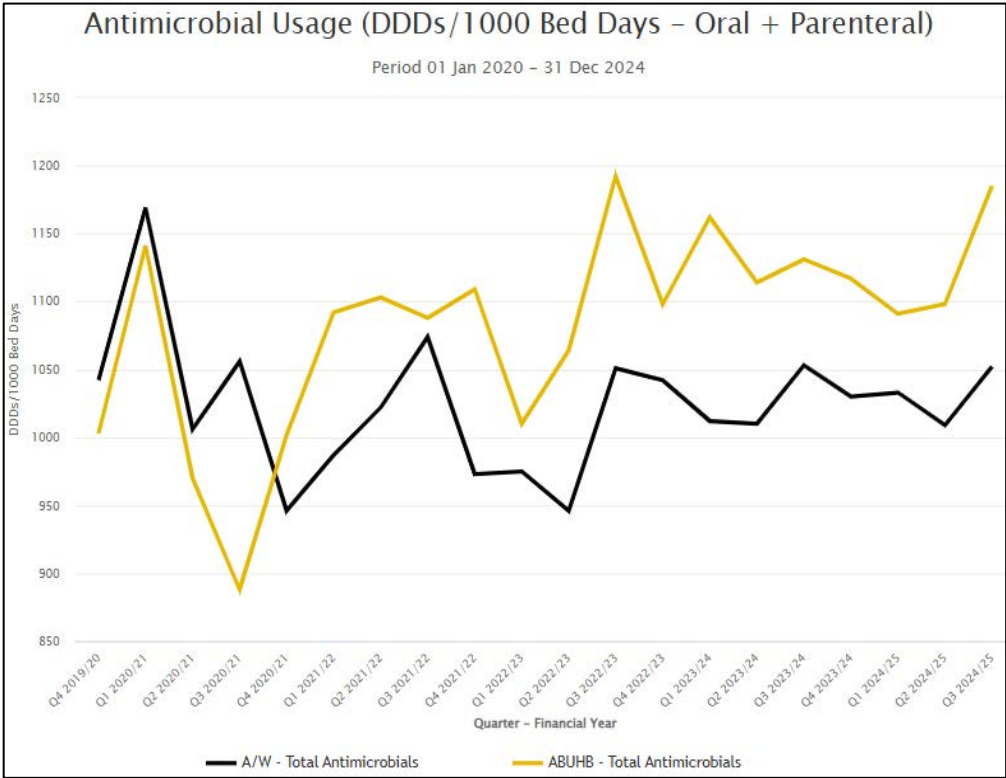
Pillar 5: Infection Prevention – Action, Learning & Improvement – March 2025

Issue	Action Taken	Learning & Improvement	Responsible Officer	Timescale
3 wards closed due to norovirus	➤ Wards monitored daily until last affected patient is 72 hours symptom free ➤ Restricted transfers and discharges ➤ Promotion of hand washing soap and water ➤ Enhance environmental cleaning	• Posters reminding visitors not to visit • Staff returning prior to 48 hours symptom free • Chortling of enhanced care in single room hospital	MDT	ongoing
Suspected MPOX of two patients who had recently travelled to SA	➤ MPOX pathway activated ➤ Patient risk assessment undertaken ➤ Linked with PHW	• One patient not tested as didn't meet the criteria other patient negative • Assurance re pathway gained	IPT PHW Urgent Care Primary care	Ongoing
TB positive patient attended AMU identified TB positive	➤ Contact tracing undertaken to identify staff & patient exposure	• Incidental find following investigation as no common risk factors for TB	IPT OH Respiratory team Directorate	Ongoing
Care homes scabies outbreaks 15 in total throughout the year	➤ Support and advice, education, treatment plans, contact tracing ➤ Care home visits ➤ Reviewed HB policy	• Wearing of PPE, access to prophylactic treatment • IPT action card developed to promote key questions	IPT, care home teams, EHO	As required

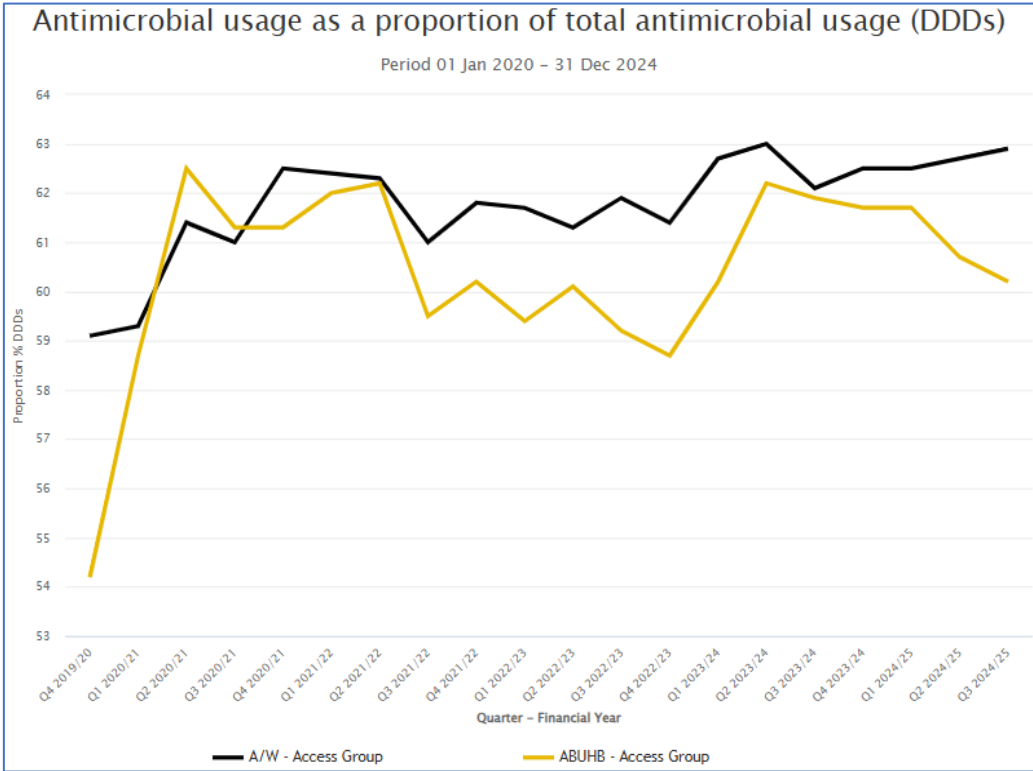


Pillar 5: WG Antimicrobial Performance: Secondary Care

- 🌈 Data from PHW are only available to the end of Q3, but demonstrate an increase in volume (target 5% decrease by 29/30 FYE) and a decrease in proportion of use in the lower risk 'access' group, away from the 70% target.
- 🌈 Business as usual antimicrobial ward rounds have been limited at some sites in Q4 given current Medical Microbiology & Antimicrobial Pharmacist staff shortages. Recruitment is underway to address these gaps as of FYE.
- 🌈 Work is commencing to embed good antimicrobial stewardship (AMS) principles into the new electronic-prescribing system in April 2025, although roll-out is not scheduled to commence until 26/27 FY.

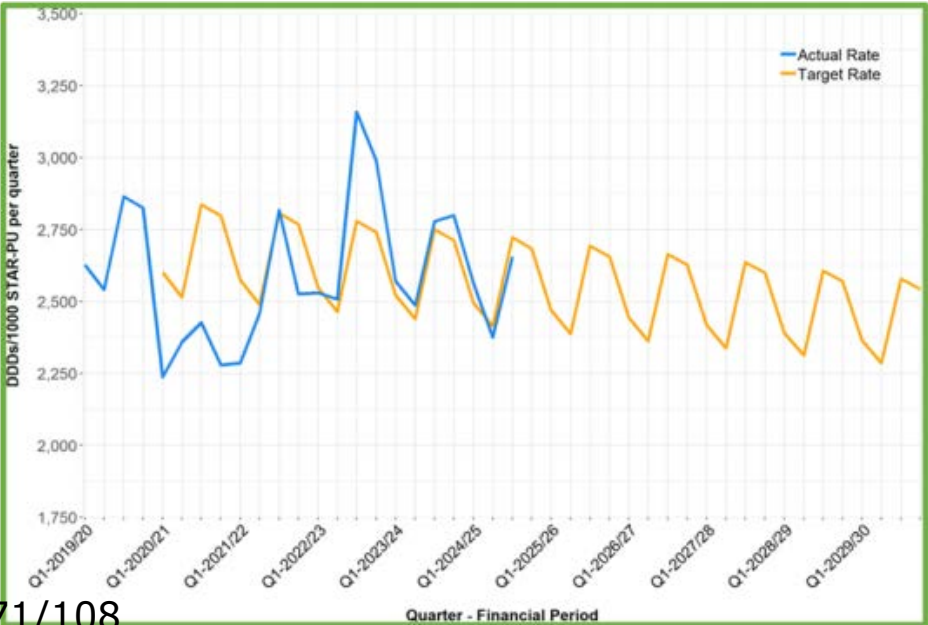
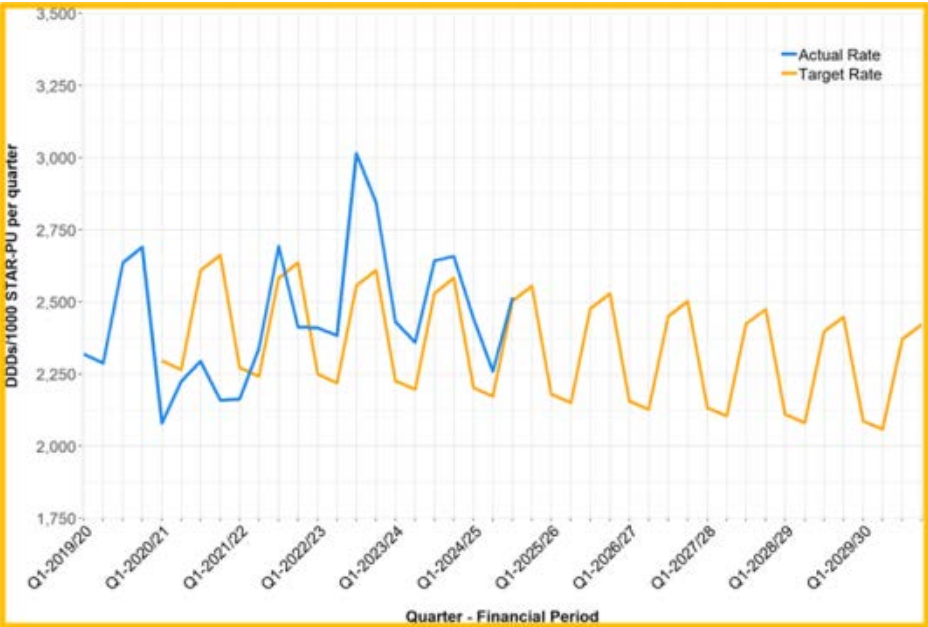


Secondary care volume with ABUHB above the all-Wales average

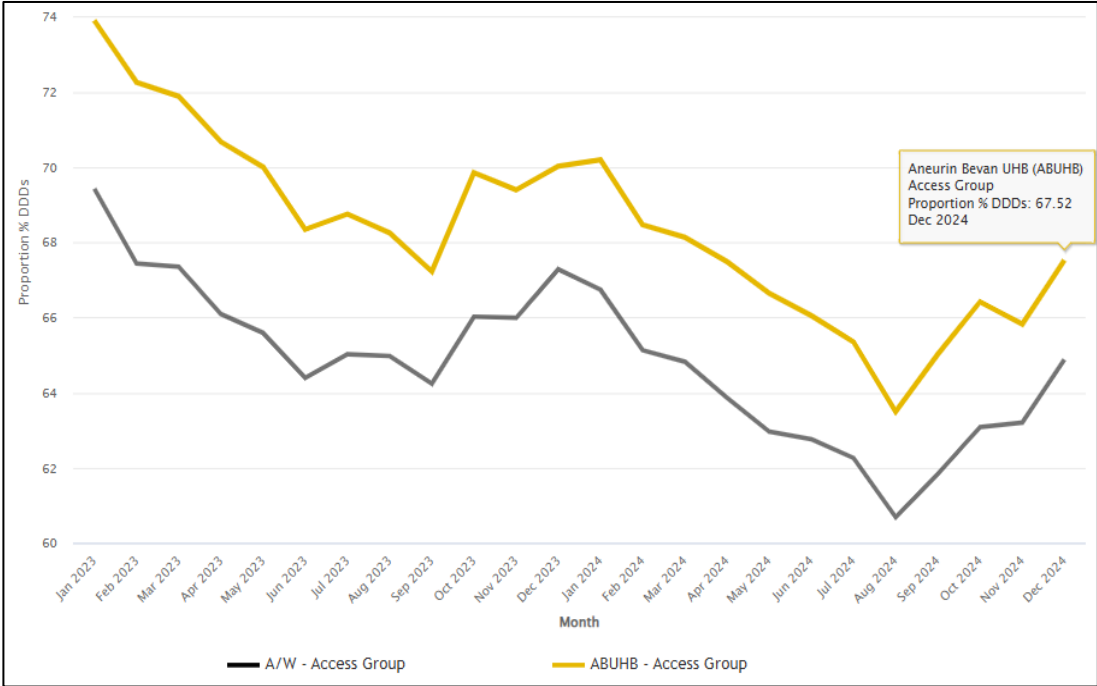


Secondary care 'access' use below the all-Wales average & 70% target

Pillar 5: WG Antimicrobial Performance: Primary Care



- Data from PHW are only available to the end of Q3, but demonstrate a reduction in volume, with ABUHB as a whole achieving the target trajectory
- As anticipated this reduction has had a negative impact on attainment of the 'access' category target, with ABUHB no longer achieving the target of 70% prescribing of lower-risk 'access' antibiotics, but above the all-Wales average
- Work is refocusing on a prescriber-based approach rather than practice as a whole, with an alternative audit methodology to be trialled in high prescribing practices in 25/26.
- The AMS team will also be working with the AB Public Health Team to provide further data insights for action.



Proportion of 'access' prescribing in AB (yellow line) vs. all-Wales average (black line)

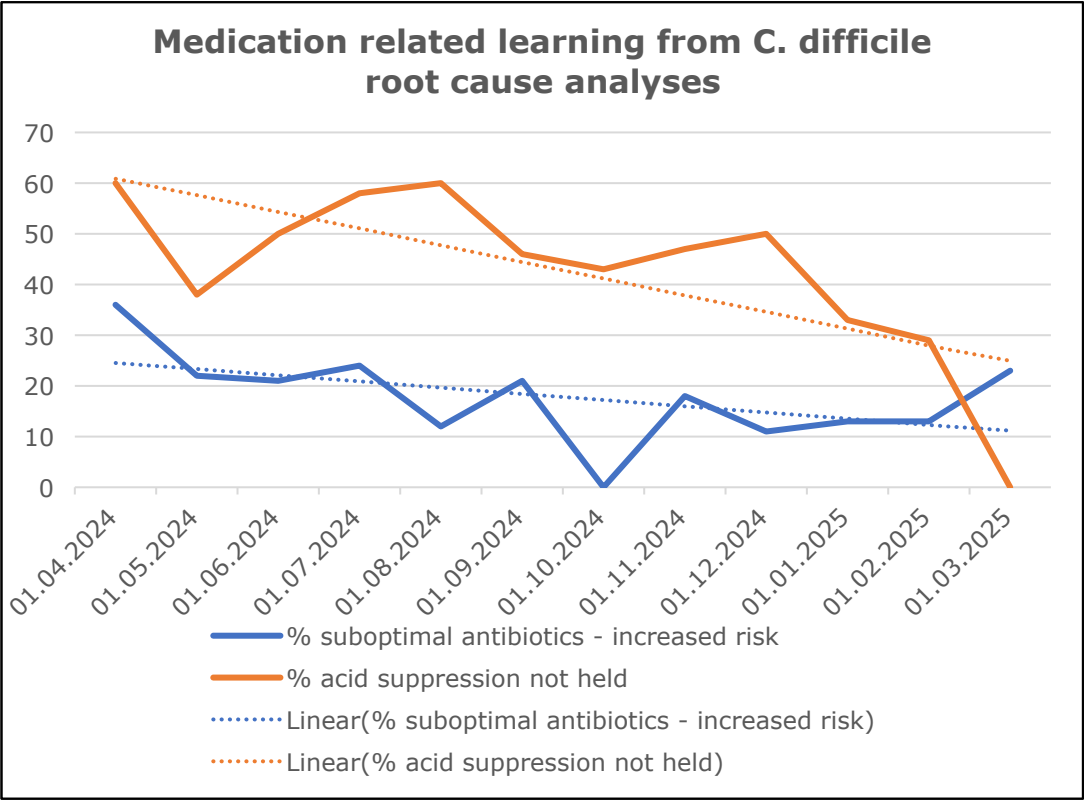
Pillar 5: WG Antimicrobial Performance: Overarching Actions

Issue	Action	Learning and Improvement	Who	When
Primary care in-hours GP antimicrobial usage increasing, in spite of audit & feedback cycles with high-prescribing practices	Attended Primary Care Clinical Directors meeting to discuss. Hybrid strategy agreed: thematic work at scale (e.g. syndrome-based education) plus continue 1:1 work for high prescribing practices with a lighter touch approach.	Met with Assistant Primary Care Divisional Director for Partnerships Jan 25 & agreed approach for high prescribing localities. Agreed by 2 of 3 localities to date. Added to Divisional Annual Plan for 25/26, awaiting further engagement from primary care team.	Consultant Antimicrobial Pharmacist	November 2024
Antimicrobial staffing: 33% vacancies/maternity leave from February 2025 (baseline 4.33 WTE AMS time)	Explored options for maternity leave cover with secondary care pharmacy team. Plan for replacing project support role discussed. Alternative of technician time explored but limited interest.	Available funds collated & fixed term appointment approved. First recruitment round unsuccessful but interviewing for second round in April 2025.	Lead Antimicrobial Pharmacist for Secondary Care	April 2025
Use of order sets (standard prescriptions) in electronic prescribing (ePMA) key to improving antimicrobial use in secondary care. Need to be embedded from go-live to ensure behaviour change	Discuss with ePMA lead pharmacist once in post Collaborate with other health boards using the Better system to share workload AMS team to prioritise developing order sets in 25/26	AMS agreed as a priority area for ePMA development with ePMA lead pharmacist. Weekly meetings commencing April 2025 to review requirements and progress	Consultant Antimicrobial Pharmacist	2025/26 FY
Improve divisional engagement with antimicrobial metrics	Working with Assistant Director for Quality and Patient Safety to embed antibiotic indicators into divisional assurance	Secondary care dashboard finalised Dec 24. Met March 2025 and agreed exception template for divisions, to be trialled with one division in Q1 25/26.	Lead Antimicrobial Pharmacist for Secondary Care	July 2025
Attempt to model primary care antimicrobial usage data against more demographic parameters to better understand drivers of use	Meeting planned with ABUHB Public Health Team to discuss data collaboration		Primary Care Antimicrobial Pharmacist	April 2025

Pillar 5: C. difficile Antibiotic Themes

April 24 to March 25

Antibiotic Finding		HCAI	CAI	Relapse	Indeterminate	Total
No antibiotics received	0	2	8	12	1	23
No suboptimal antibiotics	0	79	15	14	3	111
Possible suboptimal use - no increased risk	1	25	12	5	1	44
Possible suboptimal use - increased risk of C. diff	2	37	14	3	1	57
Awaiting GP response	0	0	31	8	0	39
RCA pending	0	0	1	0	0	1
Total	3	143	81	42	6	275



March 2025 Learning

- **5 patients received suboptimal antimicrobials outside of guidelines:**
 - 3 patients received piperacillin/tazobactam (Tazocin) outside of guidelines for respiratory infections (in GUH ED, YYF MAU & 4/4 NHH). An all-Wales audit of piperacillin/tazobactam prescribing is planned in November 2025 to benchmark practice nationally.
 - Clindamycin for cellulitis (GUH MAU)
 - Extended course of cefalexin & metronidazole for C-section infection (GUH B3)
- **No patients on acid suppression managed inappropriately**

PILLAR 6

Safeguarding

Policy/SOP

Leadership,
Accountability and
Culture

Level 1, 2 and 3
Training

Safeguarding
Supervision

Practitioner
Concerns

Partnership
Working

Domestic Abuse
and Sexual Safety

Statutory Reviews

Metrics: -

- Adult Duty to Report / Child Duty to Report
- Training compliance

Developing Metrics:

- Themes from domestic homicide reviews and serious case reviews

Pillar 6: Safeguarding – Duty to Report



	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Full Year		
	2023/24	2024/25	Increase	2023/24	2024/25	Increase	2023/24	2024/25	Increase	2023/24	2024/25	Increase	2023/24	2024/25	Increase
Adult Duty to Report	72	102	41%	84	90	7.5%	98	145	48%	135	169	25%	389	506	31%
Children Duty to Report	963	1090	13%	928	1116	20%	971	999	3%	911	1085	19%	3773	4290	14%

Ensuring Early Learning and Timely Closure

Over the last twelve months there has been a significant increase in both volume of safeguarding referrals and their complexity. In most of these cases there are actions required at Divisional Level and also by external partners to ensure timely closure of these cases. In addition, where cases are subject to Police investigation, there are delays before full and complete internal investigations can be completed. As such, processes have been put in place to formally escalate al cases that have been open in excess of three months to :

- Ensure that early learning was captured and has been acted upon and that action plans are kept under close review by Divisions
- Cases can be escalated to Divisional Leadership Teams where local actions have not been completed in a timely way
- Cases can be escalated to Senior Officers in Gent Police where timely progress is not being achieved

This process has been in place for two month now and there have been good responses both Divisionally and from Gwent Police, which have provided assurance that early learning is captured and have enabled case closure.



Pillar 6: Safeguarding – Training Compliance



Training Module	Compliance %
Adult Safeguarding Level 1	81%
Children's Safeguarding Level 1	82%
Adult Safeguarding Level 2	82%
Children's Safeguarding Level 2	83%

Safeguarding Training continues to be provided and monitored, in line with the recommendations of the Intercollegiate Documents for Safeguarding of Children and Adults.

All training for Safeguarding Level 1 and 2 has fallen below the requirement of 85% in Q4, which has been brought to the attention of Divisional Leadership Teams

Level 3 Children and Adults Training has now been mandated via ESR to a significant cohort of staff. Formal reporting will be available at the end of Q1 2025/2026. Work is being undertaken to look at how training can be implemented with revised targets each quarter, with an ultimate aim of 85% compliance before March 2028



Safeguarding Actions



Issue	Action	Learning and Improvement	Who	When
Safeguarding Level 3 Training Non-Compliance 2500 Staff for Level 3 Childrens 6500 Staff for Level 3 Adults	- As this will be a three year rolling programme, Divisions have been asked to prioritise staff in leadership positions - Revised targets are being developed for each quarter, with an aim to achieve 85% compliance before March 2028	All mandatory Training should be implemented via ESR to ensure that training provision can be planned and targets can be achieved in a timely way	Corporate Safeguarding	Q1
There was no single IT system to monitor safeguarding concerns, capture actions, produce data reports or monitor themes.	The Once for Wales Datix Safeguarding Module is being implemented internally within the Safeguarding Team, with a view to Health Board wide roll out in a phased approach Full roll out cannot be implemented until Q3 at the earliest, due to changes being made to the system on a national level	Implementation of a single system will enable robust monitoring of cases and produce high quality data reports to inform of future challenges and required improvements	Corporate Safeguarding	Q3
Variances between the five Gwent Local Authorities on whether referrals should be made and how safeguarding concerns should be acted upon	To work with the Gwent safeguarding Board, Gwent police and the five Local authorities to update guidance and ensure thresholds are adhered to, in order to provide consistency and ensure equity	Reducing inconsistency should enable front line staff to properly understand what should be referred and manage expectations of what can be expected following a referral. On completion of new thresholds, information will need to be effectively cascaded to those staff relying upon it	Corporate Safeguarding	Q2



Additional Indicators and Information

Section 5



Current Progress:

Phase 1 (Complete): Adult Wards GUH, MH & LD Wards, Paediatric wards

Ongoing support provided to all areas

Phase 2: (Ongoing)

MAU, SAU, Theatres, Critical Care completed.

- Launched in Theatre areas February 2025.
- Currently reviewing roll out in Mortuary areas
- ED RAZ SDEC will be live in May 2025
- OPD MIU will be implemented by July 2025

Phase 3: (Planned)

HV, DN, Maternity Services, Specialised Teams: commencing July 2025

Independent Reviews:

- ✓ 9 awarded bronze
- ✓ 2 ready for silver assessment
- ✓ 4 ready for bronze assessment
- ✓ 4 areas need compliance in 1 audit to achieve Bronze

Building and maintaining accreditation momentum:

- *Continuous Improvement*
- *Engagement & Action Planning* with Divisions.
- *Awareness Raising* – Communication of data analysis and progress of awards, case stories, attendance at key meetings, through resources (Padlet, News feed)

Work in Progress

- Information resources on Padlet
- Review of SOP
- Reduced duplication of audits
- Data analyst due to commence May 2025



Ward / Team Accreditation



Theme	Action	Learning and Improvement	Who	When
Progression to accreditation.	Reduced duplication of audits. New supporting portfolio format created Action planning with Divisions to determine timeline for accreditation awards	Listening to staff feedback about audit duplication. Portfolio completion has delayed a Bronze award	Professional Standards Team ABCI Accreditation Lead	Achieved April 2025
Maintaining audit compliance / quality	Senior nurse engagement - One Patient One Day monthly audit. Drive audit standards through clinical visits, standards, demonstrate data to improve patient experience.	Clarity needed to accurately audit care delivery.	Accreditation Lead / Senior Nurses	Ongoing
Understanding accreditation process	Update SOP and staff resources / padlet. Communication & Engagement	Review of supporting portfolio criteria to ensure quality indicators are assessed to a framework of standards.	Accreditation Lead	July 2025



Nurse Staffing Levels Wales Act 2016



Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical/surgical and paediatric inpatients wards

Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Total number of incidents/ complaints 1 st January - 28 th -31 st March 2025	Number of closed incidents/complaints 1 st January -28 th -31 st March 2025	Total number of incidents/ complaints <u>not closed</u> and to be reported on/during the <u>next</u> reporting period	Number of incidents/ complaints when the nurse staffing level (planned roster ⁴ was not maintained	Number of incidents/complaints where failure to maintain the nurse staffing level(planned roster) was considered to have been a contributing factor
Avoidable Hospital acquired pressure damage (grade 3, 4 and unstageable)	17	17 (1 unavoidable but not validated by SN)	4 (closed with no value – focussed review not undertaken)	0	0
Falls resulting in Moderate harm or death (i.e. level 3, 4 and 5 incidents)	13 (injurious falls)	13 (nil closed as moderate)	0 (3 awaiting further validation of DOC by QPS teams)	0	0
Medication errors, level 3,4,5 & never events	76	64 (closed as low or no harm)	12 (Under Investigation)	0	0
Complaints about nursing care handled through PTR (excludes early res)	40 (not just nursing)	5	35	0 (questions not answered appropriately in Datix)	0
Infiltration/ extravasation injuries	2	1	1	0 (questions not answered in datix)	0



Nurse Staffing Levels Wales Act 2016



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



Welsh Nursing Care Record (2024/25)



In September 2024, the roll out of the Welsh Nursing Care Record across all adult in patient settings across Aneurin Bevan University Health Board was completed at Chepstow Community Hospital. With the final site completed, it means that 57 wards are using the WNCR system in adult in-patient areas within the health board. Any patients who are transferred between any ABUHB sites will have minimal paper records with the nursing assessment additionally being available to view on the Welsh Clinical Portal (WCP).

Completed Sites

(The dates below show the month the site were completed)



Grange University Hospital – Jan 2023

Royal Gwent Hospital – Aug 2023

Nevill Hall Hospital – Dec 2023

Ysbyty Ystrad Fawr – Feb 2024

St Woolos Hospital - Apr 2024

Ysbyty Aneurin Bevan – Jul 2024

County Hospital– Jul 2024

North Rhymney Resource Centre – Aug 2024

Monnow Vale Hospital – Sept 2024

Chepstow Community Hospital – Sept 2024



83/108

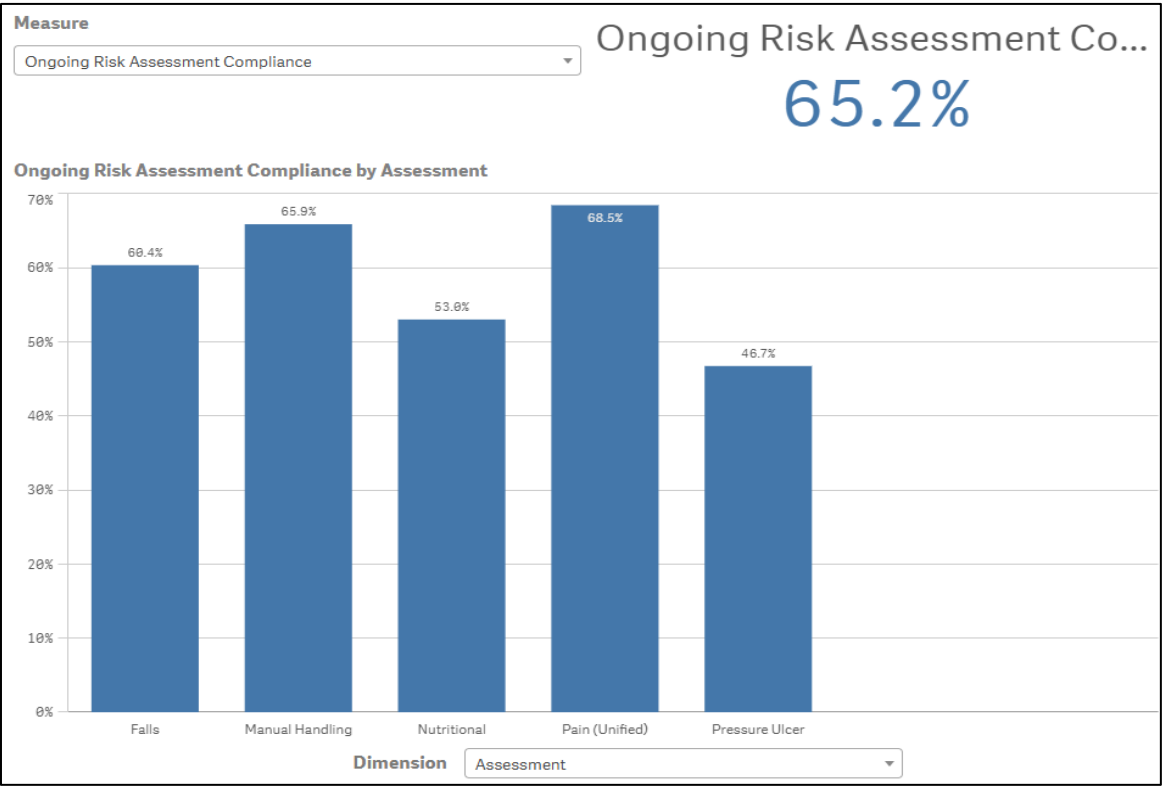
136/618



Percentage of Risk Assessments on admission being completed on time (2024/25)



Percentage of ongoing Risk Assessments being completed on time (2024/25)



Welsh Nursing Care Record



Issue	Action	Learning and Improvement	Who	When
Not currently providing quantitative data to wards to support service improvement due to lack of resources within information team	WNCR Dashboard being developed	Provide divisions with the information required to continue with further improvements.	Information Services (within Digital, Data & Technology)	Q1
Some information being recorded across both digital applications and paper-based systems which may result in duplication. Not all information is able to be recorded on WNCR.	Review of what data items need to be recorded on relevant digital systems.	Ensure the requirements are clearly articulated. Ensure that system development and usage is reviewed regularly to ensure that any additional items are identified in a timely fashion.	CNIO (Identify & Monitor) DHCW (Development & Delivery)	Q4
WPAS patient lists not being updated in a timely fashion results in a delay to the digital record being created or updated in WNCR.	Following engagement with ward-based staff additional WPAS skills training to be delivered.	Staff to raise support calls when issues are identified. Health records to monitor exception reports and reduce frequency of occurrences.	WNCR System Manager / Health Records Team Clinical Nurse Specialist	Q2
Delay in release of further digital nursing documents means an extension to the period where paper documents will continue to be used.	Escalation to DHCW Service Management Board	Progress being made on delivering the nursing documents on an updated all Wales timeframe.	DHCW	Q2





Alert	Compliance Deadline	Action to achieve compliance	Status
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients	Sep-23	An SBAR has been updated to highlight the work that has been progressed as part of this PSN and actions that remain outstanding.	In-progress OVERDUE
PSA018- Risk of oxytocin overdose during labour and childbirth	31 March 2025	This has recently been issued. A task and finish group is being developed within the Families and Therapies Division to map actions.	Compliance achieved 20/01/2025



PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified

Situation:

- ABUHB remains non-compliant with PSN066

Background:

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

Assessment:

Updated current barriers for declaring compliance with this PSN are;

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

Recommendations:

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

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

Following the death of a patient in NHS Wales, a regulation 28 prevention of future deaths coroner's report was issued after the incorrect use of Oxygen CD cylinders manufactured by BOC. Guidance reflects the actions required in PSN041- Risk Of Death And Severe Harm From Failure To Obtain And Continue Flow From Oxygen Cylinders harm (2018). This has been reviewed in collaboration with the Health Board's Medical Gases Group and the Medicines Safety Group and will be linked with the workplan aligned to training for medical devices.

Actions taken:

- Education in the form of information sharing (posters and training video) across the Health Board including;
 - ✓ Pictorial instruction and video on the safe use and initiation of oxygen therapy from a cylinder
 - ✓ To remind staff of the importance of completing a Datix for any incident or near miss which relates to the use of an oxygen cylinder (with reference to the criteria for an MHRA Yellow Card)

Actions In-progress;

- ✓ A module on ESR module is awaiting publication. This includes the safe use and management of oxygen cylinders and is relevant for all clinical staff who use oxygen cylinders. A draft of the module has been reviewed and is pending publication. A different training process is being followed for non-clinical staff. Compliance will be complete with the roll-out of this module with the current posters and video as an interim measure.
- ✓ This training once published needs to be mandated at ABUHB.



Training video for BOC
O2 cylinders

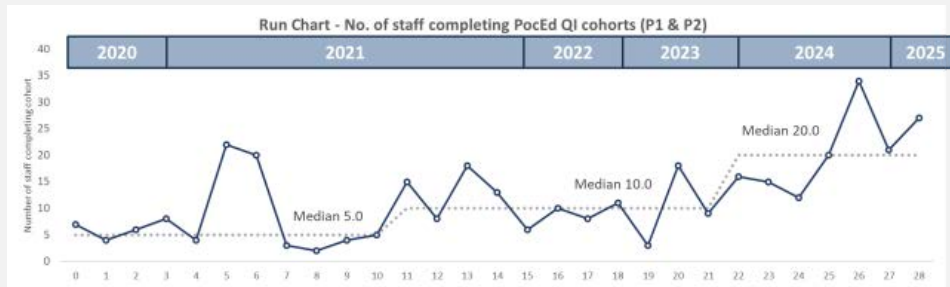
Quality Improvement – Q4



Workforce QI Skills Development Framework

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

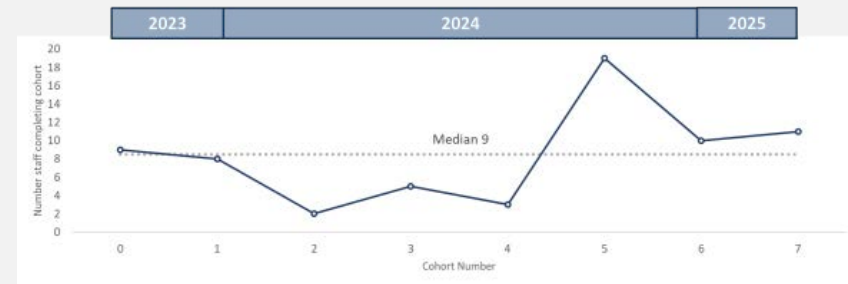
- 349 Staff undertaken training in total
- 32% increase, 102 trained during 2024



PocEd Measurement Training (virtual) – 1 half day

Time Series Data, includes Runcharts and Control Charts (SPC)

- 67 staff trained in total over 8 cohorts



Quality Improvement Coaches embedded

Quality Improvement Coach Programme (face to face) –

4 days total, very interactive, experiential programme.

Coaches sign up to undertake half day coaching each month.

- Cohort 2 started February 2025 with 3 cohorts set for 2025
- 31 coaches in total have completed the programme (inc. 3 external candidates). Further 6 in process.

Aim ‘unleash a million minutes of QI Coaching over next four years’ 17,355/1000,000 minutes of QI Coaching delivered

Next steps: Divisions to support QI Coach protected time.

Agree methods to prioritise QI work and coach allocation.

Leadership for upcoming Safe Care National streams of work.

Quality Management System QI Part of QMS

Ward Accreditation Programme

- Working with Ward/Team Accreditation Programme to develop QI Maturity matrix aligned to Accreditation Levels. Moving from single project to embed QI into practice.



For Information

Clinical Effectiveness

Section 6

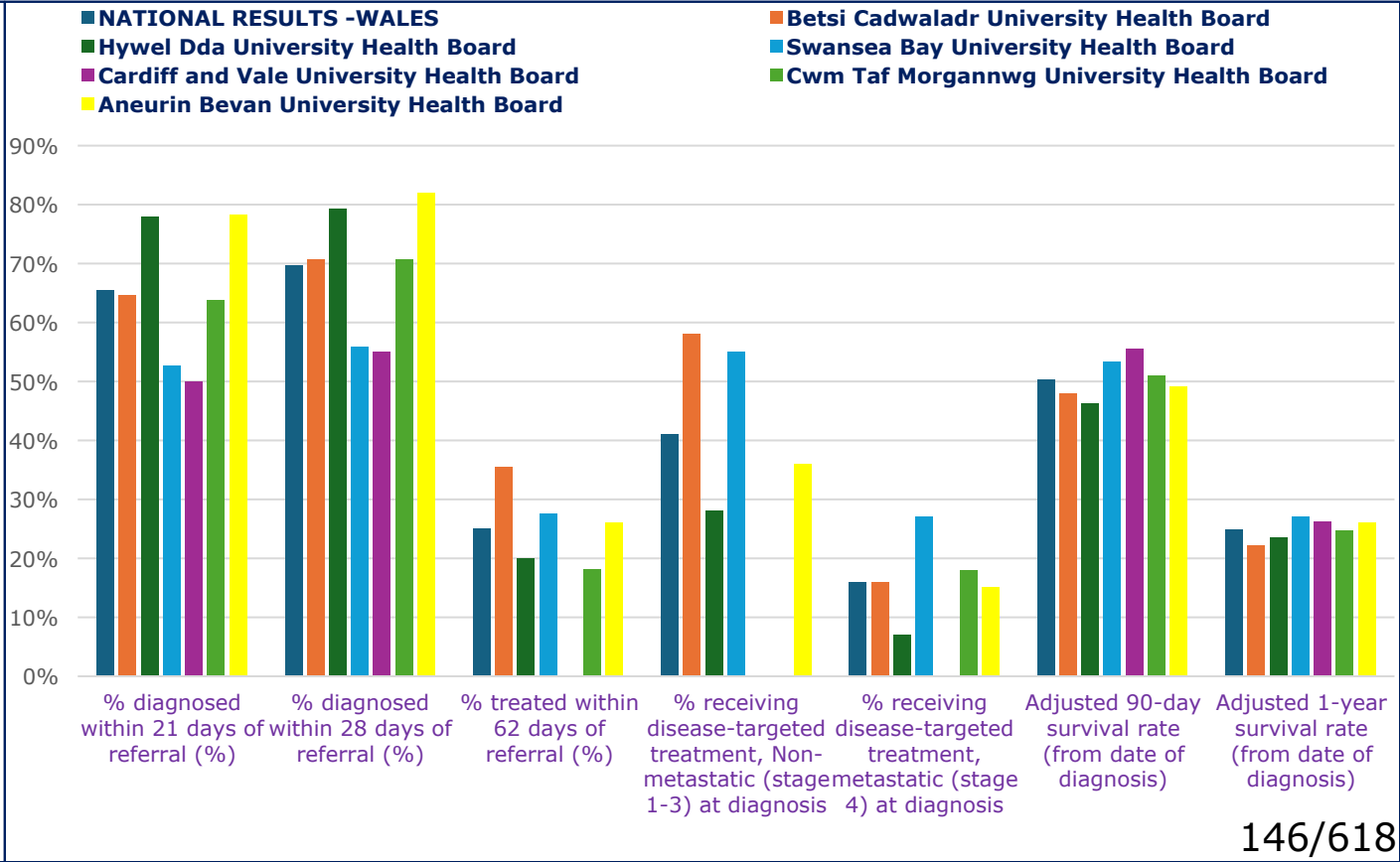
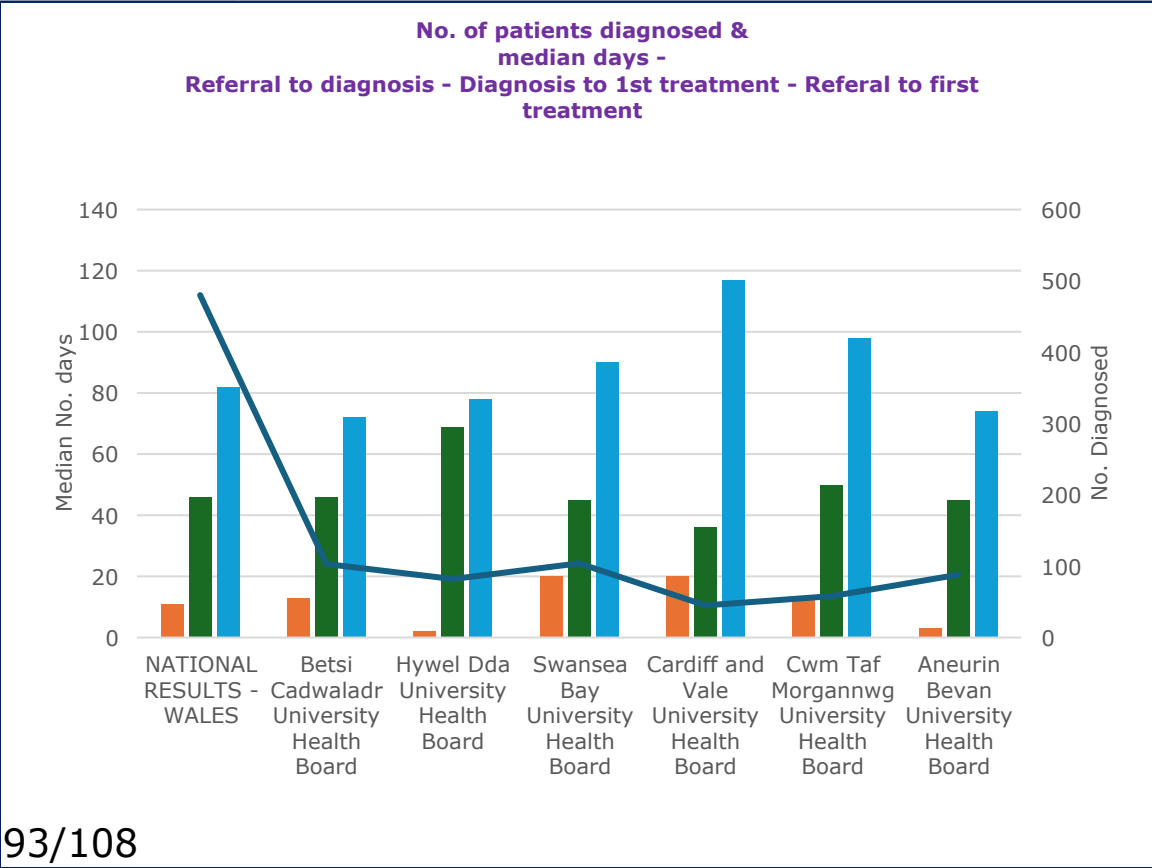
Audit Title:	<i>A broken hip – three steps to recovery</i> , a report on using the National Hip Fracture Database (NHFD)	Clinical Lead:	Dr Muhammad Usman – Orthopaedic Physician
Rationale:	Over 70,000 people in England, Wales, and Northern Ireland suffer a hip fracture each year, primarily due to falls. These injuries are most common in older adults—70% are over 80 years old—and those with osteoporosis. A hip fracture can be life-changing, often leading to long-term mobility issues, reduced independence, and the need for walking aids.		
Objectives:	The report aims to provide readers with a simple guide to all these data and resources by describing the care that hip fracture patients should receive on their journey to recovery: > as they first present with a new hip fracture > as surgery allows them to get out of bed again > through rehabilitation until they are back in their home.		

Audit Standards	Name	Code	KPI 0	KPI 1	KPI 2	KPI 3	KPI 4	KPI 5	KPI 6	KPI 7
			Admission to ortho ward %	Prompt orthogeriatric assessment %	Prompt surgery %	Nice compliant surgery %	Promptly out of bed %	Not delirious post-op %	Return to original residence %	Medication %
	Bronglais General Hospital	BRG	8.4	100	40.2	84.1	72.9	95.3	84	58
	Glan Clwyd Hospital	CLW	0.8	92.8	53.6	76.3	62.2	78.6	78.8	30.5
	Maelor Hospital	WRX	8.5	81.4	70.7	72.3	95.2	63.9	72.5	22.9
	Morrison Hospital	MOR	1.2	97	32.4	72.7	83	74.8	73.2	59.3
	Prince Charles Hospital	PCH	18.9	0	69.8	56.2	69.3	0	71.9	0.9
	Princess Of Wales Hospital	POW	23.7	70.8	62.9	64.1	76.6	72.8	72.1	57.5
	Royal Glamorgan	RGH	12	0	64.9	80.6	70.7	15.5	70.8	0.4
	The Grange University Hospital	GWE	16.9	96.4	56.9	78.1	69.4	79.8	76	73.7
	University Hospital of Wales	UHW	33.1	93	68.9	74.5	82.4	55.5	75.8	68.5
	West Wales General	WWG	10.8	55.1	62.2	65	71.2	69.2	77.9	55.5
	Withybush General Hospital	WYB	6	24	65.4	75	72.3	56.9	69.7	28.2
	Ysbyty Gwynedd Hospital	GWY	9.4	66.8	72.4	51.9	93.2	80.4	84.9	40.9
			Below Average				Average		Above Average	

Assurance level		Description	Select	Report Recommendations:		S.M.A.R.T Actions:	Responsible :	Due Date:	Progress:
Limited		The project did not achieve the standards or criteria being audited against	Yes	1	To ensure that hospitals are ready for the people they know will present each day, so patients receive each step of their care at the right place at the right time.	Trauma service review	Division of surgery/ABUHB	2025	Regular meetings
Risk level	Description		Select						
Minor		Overall treatment or service suboptimal - Minor implications for patient safety if unresolved	Yes						
Has this audit been placed on a Risk Register (N/A if above risk is None)			YES /NO	2	To ensure that all hospitals provide both prompt surgery and optimal peri-operative care so patients can start getting back on their feet as soon as possible.	Trauma service review	Division of surgery/ABUHB	2025	Awaiting Trauma service review date for femoral fracture patients.
If not on a risk register, why not: We are planning to record this on the risk registrar in the near future.									
Report Successes:				3	To ensure rehabilitation and recovery is planned and started early and continues beyond the hospital with measures to prevent another fracture.	Robust postoperative Orthogeriatric care	T&O/Orthogeriatric leads	Monthly hip fracture Governance Meetings	Regular engagement of multiple disciplines to identify and aim to improve care
1	Prompt Orthogeriatric perioperative care								
2	Not Delirious post OP								
3	Falls assessment and bone health treatment								
4	Anaesthesia with nerve block								
5	Nice complaint surgery (cemented Hemiarthplasty, type of prosthesis used)								
Report Concerns:				4	By agreeing a standardised approach to the collection of ethnicity data across all patients’ pathways and provider organisations.	Regular prospective data collection through NHFD.	T&O, Orthogeriatrics	Continuous data gathering and monitoring.	Analysis of NHFD data.
1	Delay in transfer to the orthopaedic ward from A&E								
2	Delay in Surgery within 36 hours of admission								
3	Day 1 Physiotherapy mobilization								
4	Record of AMT scoring on admission (now 4AT tool)			5	By ensuring that people with other injuries benefit from the improvements that have been pioneered among those with hip fracture.	Regular input from the Orthogeriatric service to non-Hip fracture patients on the trauma ward	T&O, Orthogeriatric Medicine	Regular engagement	Maintain the Regular practice
Clinical Leads Local Recommendations: T&O/OG			S.M.A.R.T Actions:			Responsible:		Due Date:	Progress:
1	Extra Theatre space, weekend extra lists		Trauma review - ABUHB			Surgical Division		2025	
2	Ring fence beds to improve delay in A&E								

92/108145/618

Audit Title:	National Pancreatic Cancer Audit State of the Nation Report 2024	Clinical Lead: Miss Tamsin Boyce – Consultant Surgeon
NICE Guidance:	- NICE Guideline NG85: Pancreatic cancer in adults: diagnosis and management - NICE Quality Standard QS177: Pancreatic cancer quality standard	
Rationale:	Each year, approximately 10,500 people in the UK are diagnosed with pancreatic cancer. About 22% of these cases may be linked to smoking. This type of cancer primarily affects middle-aged and older individuals. Unfortunately, pancreatic cancer remains one of the least survivable cancers, with survival rates in the UK showing almost no improvement over the past 40 years.	
Objectives:	The National Pancreatic Cancer Audit (NPaCA) assesses the care and outcomes for pancreatic cancer patients in England and Wales, highlighting regional differences and helping NHS services improve. It evaluates care against standards from key publications like NICE Guideline NG85, NICE Quality Standard QS177, and NHS England's 2024 HPB diagnostic pathway. The first State of the Nation report details the care received by patients diagnosed in England (2020-21) and Wales (2022). Is there anything specific you would like to know more about.	



Assurance level		Description		Report Successes:			
Significant		The project has mostly achieved the standards or criteria being audited against		1	Higher percentage diagnosed within 21 and 28 days compared to rest of Wales/England		
Risk level		Description		2	Shorter median time referral to diagnosis compared to rest of Wales		
Moderate		Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon		3	Existing multidisciplinary clinic with CNS and dietitian support and in parallel to oncology clinic		
Has this audit been placed on a Risk Register (N/A if above risk is None)			YES/NO	Report Concerns:			
If not on a risk register, why not: Much of the risk is out of ABUHB control e.g. time to surgery, delays in pathway eg CT-PET				1	Complex staging pathway, some actions already taken to reduce time to treatment		
				2	Overall poor prognosis due to multiple factors – late/non-specific presentation, limited effective treatment options		
Report Recommendations:		S.M.A.R.T Actions:		Responsible:		Due Date:	Progress:
1	Review referral pathways in centres which diagnose pancreatic cancer to ensure that all people who receive a diagnosis of pancreatic cancer, including those with non-resectable disease, are discussed by a multidisciplinary team (MDT).	- Review local pathways of how referrals to MDTs are made and develop protocols to increase rates of referral – eg. At the end of a clinically suspicious scan report, radiology team to state ‘ensure patient is referred to HPB MDT’ - Ensure MDTs are prepared for increased workload related to a higher volume of patients coming through the MDT – consider extending timings of MDT		Local and regional MDTs		Ongoing	CWS proforma for referral. Liaison with regional MDT
2	Ensure that all NHS pancreatic cancer service providers review their diagnostic pathways and implement hepatopancreatobiliary (HPB) cancer pathway guidance, which sets out recommended sequencing of events for the diagnostic process.	- MDT lead to review local diagnostic services and pathway and identify how an optimal diagnostic pathway would work in their local centre - Review MDT wait times - consider an audit for diagnostic pathway timings and review key areas for improvement or rate-limiting step, eg. Obtaining an ERCP slot - Estimate how many imaging and endoscopy slots are required per week to get patients through this pathway promptly - Monitor turn-around time for radiology and pathology reports and develop local plans to increase radiology and endoscopy capacity - Feedback quarterly data reports on waiting times to the wider MDT		MDT lead and Cancer Services plus regional MDT and HPB Programme Board. Identify specific people for departmental audits/existing data from cancer services Endoscopy team		End 2025	Additional OP ERCP capacity imminent and further appointment anticipated. Radiology access adequate for USC scans.

94/108

147/618

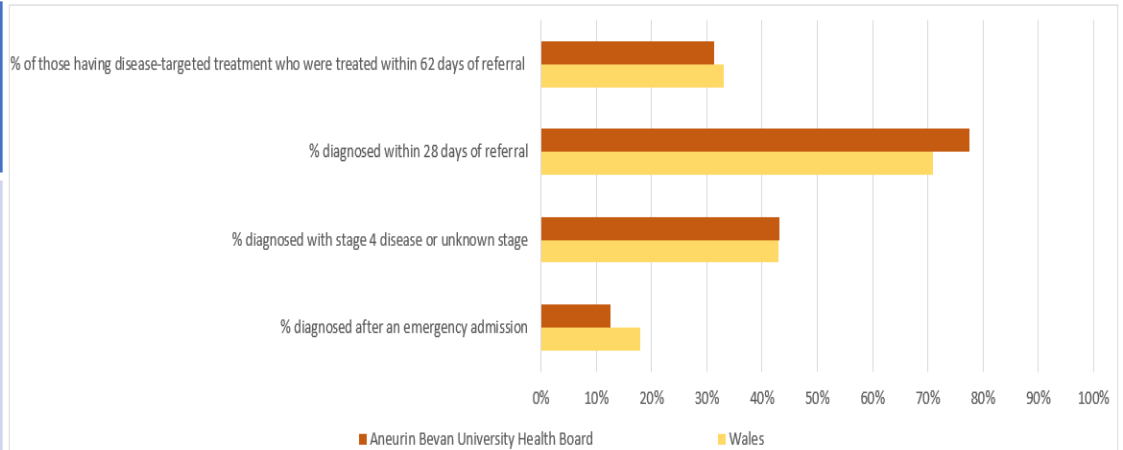
Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
3	Ensure a personalised approach is taken to optimise a person’s fitness, nutrition and medication to prevent deconditioning prior to starting treatment. This may include the implementation of prehabilitation, oncogeriatric services and dietetic support.	- Consider early dietetic and physiotherapy review of pancreatic cancer patients prior to starting treatment to identify areas in which patients could be supported - Consider an older patients service review for more frail patients for a comprehensive medical review of pre-existing conditions - Review and optimise current medications at the first patient consultation to ensure medical conditions are stable prior to starting treatment	MDT/clinic team, dietitian already in clinic, HNA undertaken No frailty service available	Ongoing	Oncogeriatric service not anticipated currently.
4	Review provision of clinical nurse specialists (CNS) in organisations which have a shortfall of newly diagnosed people being reviewed by a CNS, and ensure that everyone diagnosed with pancreatic cancer has access to a specialist CNS, ideally from the point of diagnosis.	- Review how CNS staffing levels compare to the patient workload - Identify clinics where new patients with pancreatic cancer will be reviewed. Allocate a CNS to be present on these clinic days.	New patient clinic already in place with CNS presence. Reduced staffing in CNS team currently.		Recruitment to CNS team needed
5	Consider implementing protocols to ensure that all people diagnosed with pancreatic cancer are assessed for eligibility for pancreatic enzyme replacement therapy (PERT), and that PERT is offered as recommended in national guidance.	- Ensure documentation of whether patients require PERT, or reasons for not offering PERT (or patients declining it) - Consider a local audit of PERT prescribing to review if there are any particular patient groups who are not receiving this treatment - Early dietitian review of all pancreatic cancer patients with clear recommendations on whether patients would benefit from PERT, and whether patients have been educated in how to adjust doses - Raise the profile of PERT prescribing at the specialist and local MDTs	MDT and dietetics Dietitian already in MDT clinic.	Ongoing	Most of recommendations already met

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Ensure CNS team numbers are maintained	Recruit to replacement CNS post	Nursing lead	Summer 2025	Ongoing
2	Optimise inpatient/acute presentation management including via SDEC and Flow Centre	Update referral guidance and pathways in medicine	MDT lead and acute medicine/gastro	End 2025	Ongoing
3	Imminent departure of HPB oncologist, replacement awaited	Velindre to recruit to post	Velindre CD	Unknown	Ongoing

Audit Title:	National Oesophago-Gastric Cancer Audit (NOGCA) - State of the Nation Report Data collection period: 1 April 2021 – 31 March 2023 Clinical Lead: Dr Tamsin Boyce – Consultant Surgeon
Rationale:	Oesophago-gastric cancers (OGCs) are late-stage malignancies with high mortality rates. Emergency presentations lead to poorer outcomes, with 21% of OGC cases in England and 18% in Wales diagnosed this way. The National Oesophago-Gastric Cancer Audit (NOGCA) assesses care and outcomes for these cancers in England and Wales, using routinely collected NHS data for the first time.
Objectives:	Here are the five quality improvement goals for the NOGCA: • Reduce emergency and late-stage diagnoses of oesophago-gastric cancer. • Decrease waiting times for treatment, ensuring fewer people wait over 62 days from referral to first treatment. • Increase access to clinical nurse specialists (CNS) for patients. • Enhance outcomes of potentially curative treatments. • Improve completion rates and reduce complications of palliative chemotherapy.

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

Has this audit been placed on a Risk Register (N/A if above risk is None) If no, why not: Ongoing work to improve patient care and outcomes.	YES/NO



		Diagnosis and staging			Waiting times	
Period (diagnosis date)	Local Health Board	Number of people diagnosed with OG cancer	% diagnosed after an emergency admission	% diagnosed with stage 4 disease or unknown stage	% diagnosed within 28 days of referral	% of those having disease-targeted treatment who were treated within 62 days of referral
1 April 2021 - 31 March 2023	Aneurin Bevan University Health Board	246	13%	43%	78%	31%
1 April 2021 - 31 March 2023	Wales	1322	18%	43%	71%	33%

Report Successes:	
1	Lower proportion of cancers diagnosed as emergency (compared to Wales and England)
2	Higher proportion diagnosed within 28 days of referral (compared to Wales and England)
3	Wales time to treatment better than England but still only 33% vs 26%
Report Concerns:	
1	Difficulties comparing to previous audits as different data collected/published.
2	62-day referral to treatment not being met (as per most tumour sites)
3	Delays in pathway out with local control eg CT-PET

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	In regions with high rates of emergency and late-stage diagnosis, conduct individual patient root cause analysis to look for earlier diagnosis opportunities and to understand how many are potentially preventable; use the resulting findings to develop appropriate local action plans.	Ongoing work across Wales (National Optimal Pathway) to reduce late-stage diagnosis. Local rate lower than national rates already.	Cancer Network		TBC
2	Ensure that all providers of OG cancer care review their patients’ diagnostic and treatment pathways against best practice guidance in order to identify and address barriers to providing timely treatment.	Reduce pathology turnaround times CT-PET capacity Data from regional network needed; SLA review ongoing	Pathology department PETIC Divisional and regional team re SLA	2026?	
3	Prioritise improving the flow of pathology data in England, to ensure patients’ surgical pathology outcome data are submitted to the Cancer Outcomes and Services Data set (COSD) and are available in national cancer datasets.	N/A refers to England only, report says data was almost complete for Wales	N/A	N/A	N/A
4	Regions with high rates of 30-day mortality among people receiving palliative chemotherapy should review the care of people who died within this period, to identify potential issues with patient selection, and ensure that treatment is only offered if appropriate and likely to benefit the patient	Ask Velindre team re data. No data currently.	Cancer Service to ask Velindre oncologists for data?	End 2025	
Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	More detailed data needed re steps/timelines of complex pathway to treatment and outcomes as much is outwith ABUHB influence	Ask cancer services for breakdown of time to treatment	THB/Cancer Services	End 2025	
2	Future plans for local delivery of regional services	Will need new SLA/medium term plan	Divisional and regional teams	End 2026?	Ongoing

Audit Title:	National Bowel Cancer Audit - State of the Nation Report An audit of care received by people with bowel cancer in England and Wales focusing on people diagnosed between 1 April 2022 and 31 March 2023.	Clinical Lead:	Mr Keshav Swarnkar – Consultant Surgeon

	The ten performance indicators, as set out in the NBOCA QI Plan, are:		
	1. Seen by Clinical Nurse Specialist 2. Trust/multidisciplinary team (MDT) volume for rectal cancer surgery 3. Adjusted 90-day mortality after major resection* 4. Adjusted 30-day unplanned return to theatre after major resection* 5. Adjusted 30-day unplanned readmission after major resection*	6. Adjusted 18-month unclosed ileostomy after anterior resection* 7. Stage 3 colon cancer receiving adjuvant chemotherapy 8. Adjusted severe acute toxicity after adjuvant chemotherapy for colon cancer* 9. People with rectal cancer receiving neo-adjuvant treatment 10.Adjusted 2-year survival rate after major resection*	

Rationale:	The National Bowel Cancer Audit (NBOCA) measures the quality and outcomes of care for people diagnosed with bowel cancer in England and Wales. This report focuses on people diagnosed with bowel cancer between 1 April 2022 and 31 March 2023.

Objectives :	NBOCA is part of the National Cancer Audit Collaborating Centre (NATCAN), which aims to enhance NHS cancer services by evaluating treatments and outcomes for cancer patients in England and Wales. NBOCA has established five quality improvement (QI) goals that span the entire patient care pathway, supported by ten performance indicators with local targets and three contextualising measures.

The Covid-19 pandemic caused a drop in referrals, but they have now returned to pre-pandemic levels. However, there are still differences in diagnostic pathways between NHS England and NHS Wales. Screening has expanded in both regions, with age ranges increasing from 50-59 to 50-74 in England and 51-74 in Wales.

Achieved	
NICE guideline [NG151] Quality Standards (QS): - Testing for Lynch Syndrome - Discussion about treatment options for early rectal cancer - Testing to guide systemic anti-cancer treatment - F-up for detecting local recurrence and distant metastases	
Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against
Risk level	Description
None	Standards met and findings demonstrate no risk to patient safety
Clinical Standards: Most standards are met except for stoma closure at 18 months. While there's no direct threat to patient safety, improvements are needed in bowel function, patient experience, and stoma management cost.	
CRN Involvement: Significant improvement noted, but some patients with incidental bowel polyp cancers remain under gastroenterologists for surveillance without direct CRN supervision. Increased detection of polyp cancers may require a separate database and more administrative resources.	
Data on Chemotherapy Toxicity: Lack of data from VCC on adjuvant chemotherapy toxicity needs to be addressed at the Wales Cancer Network level. This issue will be highlighted to the oncologist at MDT.	
Overall, there's no direct threat to patient safety in terms of survival compared to local and national targets. The goal is to achieve the stoma closure target by April 2026.	

Performance indicator: (April 2022 to March 2023 unless otherwise stated)		National results	Local Target	% of trusts/MDTs meeting local target	ABUHB results
1	Seen by Clinical Nurse Specialist <i>(Based on people diagnosed with bowel cancer between 1 Apr 22 and 31 Mar 23)</i>	94%	>95%	61%	85%
2	Trust/MDT volume for rectal cancer surgery <i>(Based on people who underwent rectal cancer surgery between 1 April 2022 and 31 March 2023, for performance indicator 2)</i>	N/A	>20 per year	81%	54
3	Adjusted 90-day mortality after major resection <i>(Based on people diagnosed with bowel cancer between 1 Apr 22 and 31 Mar 23)</i>	2.7%	<6%	96%	2.7%
4	Adjusted 30-day unplanned return to theatre after major resection <i>(Based on people diagnosed with bowel cancer between 1 Apr 22 and 31 Mar 23)</i>	6.4%	<10%	92%	4.7%
5	Adjusted 30-day unplanned readmission after major resection1 <i>(Based on people diagnosed with bowel cancer between 1 Apr 22 and 31 Mar 23)</i>	11%	<15%	81%	8.0%
6	Adjusted 18-month unclosed ileostomy after anterior resection <i>(Based on people who underwent an anterior resection with diverting ileostomy between 1 April 2017 and 31 March 2022)</i>	38%	<35%	41%	50%
7	Stage 3 colon cancer receiving adjuvant chemotherapy <i>(Based on people who underwent surgery for Stage 3 colon cancer between 1 April 2020 and 30 November 2022)</i>	66%	<50%	93%	21%
8	Adjusted severe acute toxicity after adjuvant chemotherapy for colon cancer <i>(Based on people who underwent surgery for Stage 3 colon cancer between 1 April 2020 and 30 November 2022)</i>	21%	<33%	95%	-
9	People with rectal cancer receiving neo-adjuvant treatment <i>(Based on people diagnosed with bowel cancer between 1 January 2022 and 31 December 2022)</i>	34%	10%-60%	89%	-
10	Adjusted 2-year survival rate after major resection <i>(Based on people who underwent surgery for colorectal cancer between 1 April 2020 and 31 March 2021)</i>	82%	>70%	97%	81%
99/108					152/618

Report Successes:		Report Concerns:				
1	Good surgical outcomes for both colon and rectal cancers (survival). Quality assurance across entire pathway with good climate inventory of Colorectal MDT.	1	Stoma closure rates			
2	All rectal cancers managed under unified MDT with significant advances in last 12 months in local treatment for rectal cancers- TAMIS procedure delivered by 2 surgeons.	2	Should CRN be directly involved in Polyp cancers tracking and surveillance? This will require additional resource- CRN/ database management and tracking.			
3	Development of SPECC MDT where Polyp cancers and Rectal Polyp cancers are discussed in depth and appropriate treatment and surveillance planned in keeping with national guidelines.	3	Linking of oncological data with Trust data to provide assurance on quality of oncological treatment.			
Report Recommendations:		S.M.A.R.T Actions:		Responsible:	Due Date:	Progress:
1	Improve data completeness of key items in national cancer registration datasets to allow risk-adjustment of performance indicators. Data items of focus: tumour, node and metastases (TNM) stage, American Society of Anaesthesiologists' (ASA) grade and performance status. - National Disease Registration Service (NDRS) regional Data Liaison Managers to support trusts/multidisciplinary teams (MDTs) with coding, data entry, and quality assurance for the Cancer Outcomes and Services Dataset (COSD). - Local provision of data lead responsible for ensuring the quality of national data submissions	Colorectal Nurses to monitor Polyp cancer patients		K Swarnkar		To be discussed with CRN
2	2. Increase the proportion of people who are offered mismatch repair (MMR) assessment to identify those with Lynch syndrome and inform surgical decision making, and systemic treatments. Ensure timely access to assessment of MMR status as part of the NHS England Lynch syndrome testing and surveillance pathways. NICE QS 1.	We have made it mandatory to do MMR on all cases registered to MDT. Pathology department aware and have assured.		Rachel Jones James Harris		
3	Increase the proportion of people who have their ileostomy closed within 18-months of anterior resection for rectal cancer. - Support trusts/MDTs to identify system-level (e.g. access to theatre/radiological investigations) and patient-level drivers of variation. - Support trusts/MDTs to participate and engage with the local and national quality improv	- Agree pathway - Discuss with radiology - Discuss with oncologist - Stoma nurses to track patient progress. - Protected surgical lists to accommodate stoma closure cases every month.		Stoma nurse and MDT lead K Swarnkar	April 2026	In progress
100/108						153/618

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
4	Reduce variation between trusts/MDTs in the use of chemotherapy for people with Stage 3 colon cancer to optimise cancer survival while maintaining low levels of acute severe toxicity. - Continue to monitor and investigate regional and institutional variation in rates of neo-adjuvant and adjuvant chemotherapy for people with Stage 3 colon cancer and ensure evidence-based chemotherapy policies are in place. - Identify and address barriers to timely access to adjuvant chemotherapy. - Encourage the utilisation of appropriate risk stratification tools for severe acute toxicity including frailty scoring, and integration of geriatric expertise and rehabilitation into shared chemotherapy decision making. - Support the delivery of acute oncology services to optimise the care delivered to people who experience acute toxicity.	Discussion needed at WCN level to facilitate this data capture and linking with TRUST data.	Dr H Williams	April 2026	In progress
5	Understand variation in the utilisation of neo-adjuvant radiotherapy for people with rectal cancer to optimise their outcomes. Cancer Alliances to develop standardised evidence-based neo-adjuvant treatment protocols based on high-quality radiological staging. This will aid decision making and take into account locoregional approaches to neo-adjuvant therapy, incorporating organ preservation techniques and participation in clinical trials.	As above	Dr H Williams		April 2026

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Target to be achieved by April 2026 for stoma closure. Need to have agreed pathway within MDT with stoma nurse at the centre to track and facilitate timely closure	Discuss in MDT Stoma nurses to agree the role.	MDT lead	April 2026	Discussion under way
2	CRN to be made aware of their defined role in polyp cancer cases.	Discussion in MDT	MDT lead	April 2026	

Audit Title:	2024 NVR State of the Nation Report	Clinical Lead:	Mr David McLain – Consultant Vascular Surgeon
	Results for people who had vascular procedures during 2023 in NHS hospitals in England, Wales, Scotland and Northern Ireland.	NICE:	NG19 Diabetic foot problems NG156 Repairing ruptured aneurysms
Rationale:	The State of the Nation report for the National Vascular Registry details the quality and outcomes of care for adults undergoing major vascular procedures in NHS hospitals. It aims to enhance the quality of care provided by vascular services, sharing examples of good practice and identifying areas needing further investigation for improvement.		
Objectives:	The report highlights key findings for both emergency and elective vascular procedures performed in 2023, and includes outcome indicators for procedures from January 2021 to December 2023. It covers three patient groups: 1. People with peripheral arterial disease (PAD) undergoing: <i>lower limb angioplasty / stent, lower limb bypass surgery, or major lower limb amputation</i> 2. People undergoing repair procedures for: abdominal aortic aneurysm (AAA) or aortic dissection 3. People undergoing carotid endarterectomy or carotid stenting		
Key messages: Busy unit. There is a need for the hybrid theatre, as planned for centralisation. Despite planning and WG support from WG, there is no date for the project being funded and it is not clear that WG has £50M to spend on it.			
Assurance level	Description		
Significant	The project has mostly achieved the standards or criteria being audited against		
Risk level	Description		
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon		

Lower limb revascularisation procedures			
Time from non-elective admission to revascularisation for people with chronic limb threatening ischaemia (CLTI)			
Key messages: In 2023, the median time from admission to revascularisation for 5,200 non-elective admissions of people with chronic limb-threatening ischemia (CLTI) was 6 days (IQR: 3-9 days). The proportion of patients revascularised within 5 days was 50%, down from 54% in 2021. Among NHS vascular units performing 10 or more procedures for non-elective CLTI admissions: •27 units had at least 50% of patients waiting more than 5 days. •16 units had at least 25% of patients waiting more than 10 days.			
	Median time (IQR) from admission to revascularisation (days)		% CLTI treated within 5 days
Uk	6		50%
Wales	6		42%
C&VUHB	6		45%
SBUHB	6		44%
BCUHB	11		14%
Key messages: Access to dedicated operating theatre list is inadequate. There is heavy use of CEPOD theatres and bypass cases are often of lower priority than other cases competing for CEPOD time.			
Has this audit been placed on a Risk Register (N/A if above risk is None)			NO
If not on a risk register, why not: Outcomes, so far, continue to be satisfactory. The issues are recognised and we’re addressing them with the network governance structures			
Clinical Leads Local Recommendations: (if applicable)			
1	Continue to apply pressure on WG / CAV to provide a hybrid operating theatre		2 Understand the urgent nature of arterial vascular surgery when interpreting theatre efficiency

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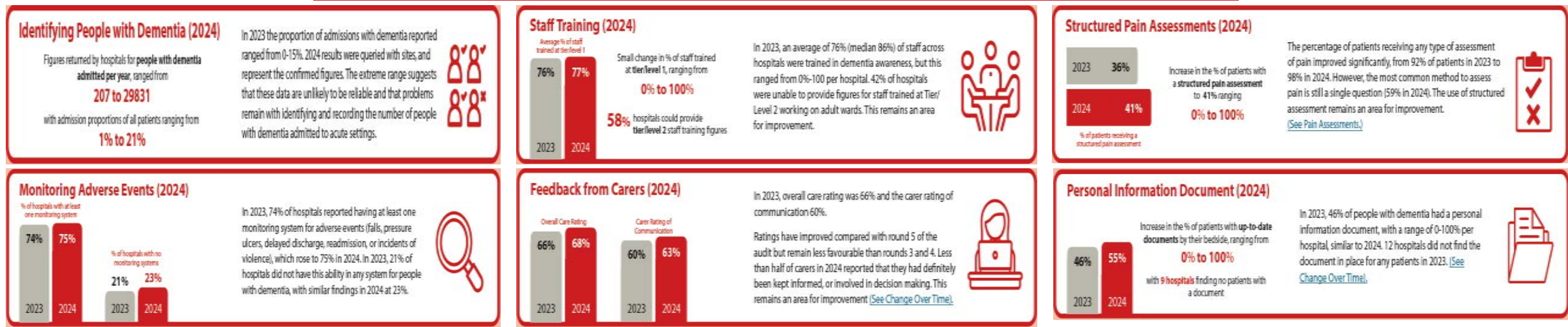
Report Successes:		Report Concerns:	
1	Clinical outcomes are satisfactory.	1	Inadequate access to dedicated main theatre sessions results in routine use of and reliance on CEPOD, with the inevitable delays and cancellations.
2	Started a FEVAR programme, first case treated in Feb 2025 with support from Bristol.	2	The continued lack of delivery of a hybrid operating theatre is compromising patient care and leading to delays in treatment, e.g. EVAR.
Report Recommendations:		S.M.A.R.T Actions:	Responsible: Due Date: Progress:
1	Ensure that people with chronic limb threatening Ischaemia (CLTI) receive care urgently as recommended in the VSGBI Quality Improvement Framework (QIF) for peripheral arterial disease	Sit with C&V	Integrated Care Boards (ICBs) (working with Trusts), Local Health Boards, Vascular Networks.
Time from admission to procedure: median =6 days. 50% of patients are revascularised within 5 days.			
2	Identify reasons for the rise in the number of major lower limb amputations among people with PAD. This might require funding for national research as well as local investigations.	Sit with C&V	Vascular Society Audit and Research committees, ICBs (working with Trusts), Local Health Boards. National Institute for Health & Care Research.
There has been a 16% increase in the number of major lower limb amputations performed in the UK since 2020.			
3	Examine pathways to treatment for people requiring elective aortic aneurysm repair (both screen detected and incidental findings) and carotid endarterectomy (CEA) with the aim of removing causes of avoidable delays and increasing the proportion of people whose wait is within recommended standards. Median time for AAA repair: 86 days; 31% of patients were treated within 8 weeks Median time for CEA: 15 days; 49% of patients treated within 14 days.	Sit with C&V	ICBs (working with Trusts), Local Health Boards, Vascular networks, national AAA screening programmes.
4	Improve access to endovascular repair of ruptured aortic aneurysms in suitable patients. This may require improving network pathways and working arrangements across vascular surgery, interventional radiology and anaesthesia. Proportion of repairs of ruptured AAA performed as endovascular repairs was 46% in 2023 (up from 30% in 2018).	Sit with C&V	NHS England Specialist commissioning, University Local Boards, ICBs (working with Trusts), Vascular networks.
5	Develop better guidance on the coding of: i) TEVAR procedures for Type B Aortic Dissection to distinguish from TEVAR performed for aneurysms ii) FEVARs for juxta or supra renal aneurysms. 15% of procedures with an aortic status of dissection on the NVR used an OPCS code for dissection (L27.4 or L28.4).		VSGBI & BSIR NHS England Specialist commissioning and Digital Health and Care Wales (DHCW).

National Audit of Dementia - Care in General Hospitals 2023-24: Round 6 Audit Report				Clinical Lead: Dr Inder Singh – Consultant Care of the Elderly			
NICE guideline [NG97] Dementia: assessment, management and support for people living with dementia and their carers							
Recommendations:				1.7 Managing non-cognitive symptoms			
1.1 Involving people living with dementia in decisions about their care				1.8 Assessing and managing other long-term conditions in people living with dementia			
1.2 Diagnosis				1.9 Risks during hospital admission			
1.3 Care coordination				1.10 Palliative care			
1.4 Interventions to promote cognition, independence and wellbeing				1.11 Supporting carers			
1.5 Pharmacological interventions for dementia				1.12 Moving to different care settings			
1.6 Medicines that may cause cognitive impairment				1.13 Staff training and education			
Rationale:		The National Audit of Dementia (NAD) evaluates how general hospitals in England and Wales perform against care delivery standards that affect people with dementia during their hospital stay. These standards are based on national and professional guidelines, including NICE Quality Standards and the Dementia Friendly Hospitals Charter.					
Objectives:		Dementia care is a national priority in England and Wales, emphasizing a person-centred approach that respects the rights and dignity of individuals with dementia and their carers. Hospitals have widely adopted this approach, with 90% signing up to John’s Campaign and 82% to the Dementia Friendly Hospital Charter. NICE highlights that people with dementia often face longer hospital stays, delays in discharge, and reduced independent living, which can lead to distress, confusion, and a decline in functioning.					

Assurance level	Description	Risk level	Description
Significant	The project has mostly achieved the standards or criteria being audited against	Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Has this audit been placed on a Risk Register (N/A if above risk is None)		YES/ NO	If not on a risk register, why not: Ongoing quality improvement work

Report Successes:		Report Concerns:	
1	Participation by all 3 sites is good and audited good level of notes	1	Carer satisfaction questionnaire not completed in YYF site
		2	Carer Communication to be improved
2	Delirium screening and pain assessment improved	3	Sustainability of delirium screening, delirium care plan and dementia training is crucial for good practice to be embedded
3	Initiation of DC planning commenced in 24 hours	4	IP falls where dementia has been associated risk should be monitored through HB QPS - as NAD does not cover a 12-month period
4	Delirium screening and care plan at YYF has improved Median LoS in line with other two sites	5	HB/corporate - need to record proportion of people with Dementia having falls in DATIX

Priority Areas for Improvement



Report Recommendations:		S.M.A.R.T Actions:	Responsible: Due Date: Progress:
1	The Medical Director and Chief Nurse should ensure that all people with dementia admitted acutely to hospital are screened for delirium across clinical pathways using the 4-question 4AT. Screening should take place on admission, and at any other point when delirium is suspected.	Already in place	Site leads along with HB Clinical Lead for Dementia YYF – Dr Haddad RGH – Dr Subhan NHH – Dr Adel
2	The Chief Nurse should ensure that staff routinely gather personal information which details preferences and needs of people with dementia, involving care partners in this where possible. This information can then be appropriately shared with the staff providing care to support person centred interventions. Proforma documents, like the 'This is Me' booklet, are accessible at the point of care and serve as a useful example. Usage should then be monitored at Trust/Health Board Executive level.		Karen Collins/Natalie Skyrme – Senior nursing
3	Trusts/Health Boards should make use of NAD reported data, such as the summary Annual Dementia Statement containing information about assessment, use of personal information document, staff training, and monitoring of care, to support and demonstrate Quality Improvement in their hospitals, and within quality assurance reporting to regulatory bodies. Trusts/Health Boards should also encourage use of resources to support quality improvement including the Better Care Fund High Impact Change Model and the Dementia 100 self-assessment framework (due to be published early 2025).		Dr Singh, Amanda Whent

Winners of the MediWales Innovation Awards 2024 for their overall contribution to healthcare delivery in Wales

Rationale:	In England and Wales, approximately 180,000 fractures occur annually due to osteoporosis. One in three women and one in five men will experience a fracture in their lifetime. The Fracture Liaison Service Database (FLS-DB) collects data on patients with fractures to prevent secondary fractures. This year's report compares the number of patients on anti-osteoporosis treatment at 16 and 52 weeks, focusing on ensuring high-risk patients start treatment within 16 weeks of their first fracture.
Objectives:	Half of adults aged 50 or over who experience a fracture after minimal trauma are at high risk of another fracture within the next few years, with over 50% of subsequent fractures occurring within 2 years. Preventing these fractures is a clinical and cost-effective priority for the NHS. Patients should receive anti-osteoporosis treatment based on NICE recommendations. Fracture liaison services (FLSs) aim to close the treatment gap by identifying high-risk patients and ensuring they start anti-osteoporosis treatment within 16 weeks of their fracture diagnosis.

Presented at Clinical Standards and Effectiveness Group – 27th February 2025

FLS-DB	Total No. of patients (%)	KPI 2	KPI 3	KPI 4	KPI 5	KPI 6	KPI 7	KPI 8	KPI 9	KPI 10	KPI 11
ABUHB 2021	875 23.4%	22.6	27.1	21.3	29.2	34.5	57.7	4.8	1.4	8.3	18.4
ABUHB 2022	1649 (44%)	46	36.9	60.3	16.8	79.7	65.7	9.1	19	18.3	16.4
ABUHB 2023	2181 (58%)	61.3	46.8	75	17.5	94.9	65.3	17.1	57.5	46.9	26.2
ABUHB 2024	2638 (70%)	51	149.6	76.9	20.2	96.3	68.9	30.8	39.4	42.9	N/A
Wales 2021		10.8	5.3	65.1	27.1	61.5	56.8	3.9	13.7	10.2	30.2
Wales2022		16.8	8	77.8	36.6	86.1	62.5	6	21.3	16	27.3
Wales 2023		18.6	9.7	79.6	25.4	90.8	66	10.6	41.4	34	19
Wales 2024		18.6	35.6	77.6	17.8	85.6	68.1	19.5	24.1	27.2	N/A

ABUHB - Data entry No.s

2018

2019

2020

2021

2022

2023

2024

0

500

1000

1500

2000

2500

3000

159/618

Report Successes:		Report Concerns:		
1	AB FLS has increased identification by 200% since 2021, this year reaching 70% (target 80%)	1	16 weeks adherence is remains under 50%	
2	AB FLS continued to recommend bone treatment for 65% of patients (target 50%)		2	52 weeks adherence is remains under 25%
3	AB FLS received MEDI Wales Judges award for innovation and partnership working, seen as exemplar service in Wales			3
4	https://abuhb.nhs.wales/hospitals/a-z-of-services/fracture-liaison-service-fls/ The above link details the great work being carried out within the HB by the entire FLS team.			
5	The Health and Social Care Judges' Award, part of the MediWales Innovation Awards, recognizes outstanding contributions to healthcare in Wales. The 2023 winner is the Aneurin Bevan Fracture Liaison Service (AB-FLS), which addresses undiagnosed osteoporosis in patients over 50 to reduce repeat fractures and alleviate healthcare pressures. AB-FLS uses a digital system to integrate data from X-rays, CT, and MRI scans, streamlining fracture management. Developed with the Welsh Government, NHS Wales, and the Royal Osteoporosis Society, it focuses on prevention, early diagnosis, and timely treatment.			

Assurance level	Description	Risk level	Description
Limited	The project did not achieve the standards or criteria being audited against	Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Has this audit been placed on a Risk Register (N/A if above risk is None)		YES/NO	If not on a risk register, why not: Ongoing quality improvement work

Report Recommendations:		S.M.A.R.T Actions: Responsible: Due Date: Progress:
1	35.4% KPI 10 – commencing bone therapy by first follow-up. All integrated care boards (ICBs) and Welsh health boards should provide a strategic plan for effective secondary fracture prevention for their locality. This should be based on relevant NICE recommendations and FLS-DB key performance indicators specifically focusing on KPI 10, which measures the treatment initiation in patients at high fracture risk.	Business case for AB-FLS is presented at PIP and awaiting Executive approvals next month
2	35.4% KPI 10 – commencing bone therapy by first follow-up. 100% of all ICBs and Welsh health boards should report the regional impact of fragility fractures in adults aged 50 or over and publish a high-level strategic plan to improve secondary fracture prevention for their population, focusing on delivering KPI 10. This should be achieved by: > convening a multi-stakeholder FLS working group, including representatives from the ICB/Welsh health board, secondary care, primary care and patient groups > describing the current regional delivery of FLS-DB KPIs and the expected annual number of avoidable fractures by working with the Royal Osteoporosis Society FLS service delivery team (fls@theros.org.uk) > identifying funding pathways needed to support the equitable delivery of FLS identification, assessment, treatment recommendation, initiation and adherence focusing on delivery (KPI 10) > committing to a timescale for initiating a phased introduction and improvement of FLSs in their regions.	AB FLS-DB Clinical Lead

Report Recommendations:		S.M.A.R.T Actions: Responsible: Due Date: Progress:
3	11.9% KPI 11 – adherence to prescribed antiosteoporosis This is in line with the findings from KPI 10 and KPI 11 outlined in appendix A, which demonstrate the lack of availability and prescription of anti-osteoporosis treatment among FLSs. FLSs can utilise the resources created by the FLS-DB to implement this initiative; this includes: > the FLS-DB resources, including the improvement workbook and FLS-DB quality improvement video, to upskill on methods for effective and efficient service improvement > forming a multi-stakeholder improvement group, including 2–3 patients and primary care representatives (refer to FFFAP improvement workbook) > exporting local service data for 2023–24 from the FLS-DB website, and examining the number of patients who had started on each type of osteoporosis treatment by 16 weeks against local/regional osteoporosis treatment recommendations > using these data to co-develop a set of SMART aims and outcomes for FLSs to improve KPI 10 > using service improvement methods to understand the reasons for this current service gap, including reviewing KPI 1–7 to prioritise scalable and sustainable interventions to improve performance; utilising the FLS-DB webinar on how to implement an improvement project > evaluating, learning and modifying changes to practice based on KPI changes, and sharing improvement performance by submitting learnings to the FLS-DB improvement repository through the KPI case study form to share with other FLSs.	Business case for AB-FLS is presented at PIP and awaiting Executive approvals next month AB FLS-DB Clinical Lead
4	55.2% KPI 2 – identification (non-spine), 34.4% KPI 3 – identification (spine fractures) 28% KPI 9 – monitoring contact 12–16 weeks post fracture ICBs and Welsh health boards should support regional advocacy groups for the establishment and improvement of FLSs. These advocacy groups would increase the quality of patient/caregiver engagement for local FLSs service improvement teams and establish the implementation of FLSs in areas without coverage. This is with the aim of increasing identification of patients who require fragility fracture care and ensuring that they receive the appropriate follow-up care. This can be achieved by: > utilising FLS-DB integrated care board data to identify gaps in FLS coverage > supporting new, and enhancing existing local advocacy groups to support regional FLS delivery, such as an ROS local support group > engaging with local clinicians to support the implementation of effective FLSs in the region > supporting local clinical teams to co-develop, implement and improve.	Ongoing and improvements require embedding
5	35.4% KPI 10 – commencing bone therapy by first follow-up 11.9% KPI 11 – adherence to prescribed antiosteoporosis medication at 12 months post fracture ICBs and Welsh health boards should work with FLSs and primary/community care in the co-production of sustainable patient pathways for primary care delivery of anti-osteoporosis treatment, such as injectable treatments. This is with the aim of facilitating better communication and transition of patient management between primary/community care and FLSs. This is in line with the findings from KPI 10 and KPI 11 outlined in appendix A, which demonstrate the lack of availability and prescription of anti-osteoporosis treatment among FLSs.	Business case for AB-FLS is presented at PIP and awaiting Executive approvals next month

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	03 June 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Development and Implementation of the Quality Assurance Framework for Commissioned Services
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade, Executive Director of Nursing Dr James Calvert, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Ann-Marie Matthews, Lead for Clinical Commissioning/IPFR 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

This paper seeks to provide the Executive Committee with an update on the work undertaken to date to support the Quality Assurance Framework for Commissioned Services, and explain the current limitations, and further development work required.

Cefndir / Background

Aneurin Bevan University Health Board has a statutory responsibility to provide healthcare services that meets the needs of our population. Our strategic aim is to ensure there is equitable access to safe, effective, and sustainable services, as close to a patient's home as possible, within available resources. We achieve this by directly providing healthcare or by commissioning healthcare from other service providers.

Aneurin Bevan University Health Board, like many health boards, have had to respond to more challenging performance and financial positions, as well as changes within the commissioning landscape, particularly since the COVID pandemic. Commissioning plays a critical role in driving quality and improvement and setting

out longer term goals with providers by way of setting standards, focussing on improvement in effectiveness, whilst ensuring that patients are at the forefront.

The Quality Assurance Framework for Commissioned Services (QAF-CS) sets out the key principles and approach to commissioning for quality, providing a structure which should be used to support the development of consistent, high quality commissioning practices and associated improvements in outcomes to ensure the Health Board is operating effectively to commission safe, high-quality and sustainable services for our residential population – including the ability to recognise any early action and systematic deterioration in care within a provider organisation.

Asesiad / Assessment

The Health Board is primarily a provider organisation; however, a proportion of its budget is devoted to securing healthcare services, including unscheduled and planned care from neighbouring NHS Wales Health Boards and NHS Trusts in England. This in part is due to our geographical location and cross-border arrangements. The QAF-CS seeks to describe a continuous assurance process to ensure that the services we commission are safe, personal, effective and continuously improving.

What is Commissioning?

In basic terms, commissioning is often described as the purchasing of NHS services from other organisations to meet the health needs of a local population. Aneurin Bevan University Health Board aims to commission services that improve the health and wellbeing of our residential population using a continual process of planning, agreeing, and monitoring our healthcare services. Commissioning is not one action but many, ranging from the health-needs assessment for a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.

This shift towards a more collaborative approach to planning and improving services means that, instead of focusing on procurement and contract management, we will continue to work closely with key partners across the system (including providers) to understand population needs, determine key priorities, and design, plan, and resource services to meet those needs.

Commissioning for Quality

Quality should be at the heart of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales.

Poor quality care can also be costly in terms of harm, waste, and variation. The Health Board needs to ensure that we are operating effectively to commission safe, high-quality, and sustainable services within the resources available, delivering on our statutory duties whilst driving continuous improvement in the quality of services and outcomes achieved for patients.

NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of these quality governance arrangements is



to help organisations and their staff both monitor and where necessary, improve standards of care.

The Health Board already has a clear commitment to ensure the provision of safe and high-quality services, supported by corporate frameworks and improving risk management. Value and behaviours are well established, and the introduction of the new Quality Strategy is further strengthening the Health Boards operational governance. The synergy between these two documents therefore ensures that quality and safety is at the forefront of all we do.

Record of providers and Quality Assurance Data

NHS Long Terms Agreement (LTAs) and Service Level Agreement (SLAs) between NHS bodies for healthcare in relation to NHS statutory functions are embedded in the NHS (Wales) Act 2006. They are not legally enforceable contracts. Within Wales the arbitration process is through the Welsh Government.

Where there is private sector involvement, contracts are legally binding, and procurement is via the NHS shared Services Partnership in line with Standing Financial Instructions. All Wales Frameworks should therefore be used where available.

The commissioning arrangements for some healthcare services are on a collective all-Wales basis. The Joint Commissioning Committee (JCC) is responsible for the joint planning and commissioning of specialised and tertiary services on behalf of all Health Boards in Wales.

Where Aneurin Bevan University Health Board is the commissioner, the principles of good contract management remain an important part of the wider commissioning process. However, commissioning is about more than ensuring providers meet their agreed obligation as it can not only help the Health Board identify and manage its own and its providers risks but can help achieve saving and continuous improvement.

Each Division is responsible for ensuring the services that fall within their service areas are commissioned appropriately and effectively and have adequate monitoring arrangements in place. Further work however may be required by some Divisions to strengthen these arrangements following agreement of this approach to a QAF-CS. As such, whilst the fundamental principles underpinning this approach should be adhered to, we recognise that due to the diversity of each service area, the implementation frameworks for each Division will need to be tailored to drive forward the quality assurance and quality improvement of their respective service areas.

The Central Financial Commissioning team are responsible for agreeing the Health Boards larger LTAs and SLAs, with regular monitoring and performance meetings taking place with providers to ensure adherence to the contracts.

There are currently several ways in which Divisions receive and feedback information regarding commissioned services. This includes inspection reports and both qualitative and quantitative feedback. Whilst some Divisions have developed registers and systems to aid their commissioning processes, the Health Board does



not have a standardised register of commissioned services, and some Divisions hold better records than others.

Work undertaken and findings to date

A small, dedicated working group has been established to conduct a comprehensive review of commissioning arrangements across Divisions. Preliminary findings have highlighted inconsistencies in contract documentation, monitoring mechanisms, and escalation procedures.

To enhance oversight and financial transparency, a structured database has been developed in collaboration with Business Partner Accountants (BPAs) from each Division. This database systematically identifies providers receiving payments for commissioned services under the Health Board, revealing significant gaps where formal agreements are either outdated or absent. Additionally, deficiencies in recorded quality metrics present a potential risk to organisational governance and service accountability.

Further development work / Next steps

Following an initial assessment, the working group acknowledges the significant scope of this initiative and has therefore prioritised a review of cancer services. This decision reflects the limited existing documentation regarding outreach clinics operating between the Health Board and Velindre for Systemic Anti-Cancer Therapy (SACT).

To enhance governance and operational clarity, the group has agreed to develop a standardised Service Level Agreement (SLA) template. This framework will establish clear expectations and responsibilities for both the Health Board and the service provider, ensuring quality assurance, accountability, and compliance with STEEP quality standards. Additionally, adherence to Welsh Language Standards will be integrated into the new template.

With regard to patient experience, the Datix system offers functionality to record concerns by organisation and designate responsibility for resolution. Further analysis is required to determine whether Divisions are actively monitoring reported concerns and incidents involving external providers, enabling the identification of potential declines in service quality.

Furthermore, the establishment of a dedicated commissioning working group is proposed to assess areas requiring additional support within the broader commissioning framework. This initiative will facilitate the development of best practice guidelines while fostering a network of subject matter experts to strengthen knowledge and capability in this domain.

Argymhelliad / Recommendation

The Patient Quality Safety and Outcomes Committee is asked to acknowledge the progress achieved in this workstream to date and endorse the proposed direction for further development, with a focus on enhancing quality in commissioned services.



Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.3 Quality Improvement, Research and Innovation Governance, Leadership & Accountability 3.1 Safe and Clinically Effective Care Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Regional Solutions
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	N/A
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk



Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs 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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	03 June 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Infection Prevention, Antimicrobial Resistance & Decontamination Annual Report 2024/25
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade – Executive of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Moira Bevan – Head of Service for Infection Prevention and Control

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board (ABUHB) has consistently maintained a zero-tolerance policy on avoidable healthcare-associated infections by applying rigorous infection prevention and control practices.

The Infection Prevention and Control Team (IPCT), Antimicrobial Resistance Group, and Hospital Cleanliness have been actively involved in enhancing the experience of staff, patients, and stakeholders, as well as reducing the risk of infections.

Cefndir / Background

Each year, an annual report is submitted to provide assurance on the key principles of infection prevention across the Health Board for the financial year (FY) March to April. The report also provides an update on progress against FY 2024/25 priorities and identifies key objectives for the new financial year.

The report reviews the annual activities of the IPCT, Antimicrobial Resistance Group, and Hospital Cleanliness. Publishing the Infection Prevention and Control Annual Report is required to show good governance, adherence to Health Board values, and public accountability according to the quality framework 2022 (Duty of Quality Statutory Guidance).



The report recognises the contributions of clinical and non-clinical staff, who are essential in enhancing the experience of staff, patients, and stakeholders, as well as reducing the risk of infections.

Effective Infection Prevention and Control is crucial in providing safe and efficient care for those using Health Board services. The Annual Report outlines the Health Board's performance relative to Welsh Government reduction targets, winter virus management, surgical site infections for C-sections, and other key areas. It also identifies areas for improvement in 2025/26.

Asesiad / Assessment

The Health Board has made significant strides in infection prevention and control over the past year. The IPCT has been diligent in monitoring and managing key Welsh Government target infections and other 'alert' organisms, quickly identifying and managing outbreaks to prevent further spread.

Overall, while the Health Board has made progress in several areas, there are still challenges to address, particularly in reducing *Clostridioides difficile* infection (CDI) and *Pseudomonas* bacteraemia cases and meeting antimicrobial stewardship targets.

Breakdown of CDI acquisition Year on Year comparison

Acquisition	2023-2024	2024-2025	Percentage difference	
Healthcare associated	127	138	8%	↑
Community acquired	57	78	36%	↑
Relapse	25	40	60%	↑
Indeterminate	15	11	26%	↓
Other Health Board	5	8		
Total	229	275	21%	↑

Breakdown of E coli acquisition year on year comparison

Acquisition	2023-2024	2024-2025	Percentage difference	
Healthcare associated	104	95	-8%	↓
Community acquired	239	258	7.9%	↑
Relapse/ indeterminate	7	10	42%	↑
Other HB	3	13		↑
Total	349	376	7.7%	



Breakdown of Klebsiella acquisition year on year comparison

Acquisition	2023-2024	2024-2025	Percentage difference
Healthcare associated	57	41	-28% ↓
Community acquired	73	71	-3% ↓
Relapse/indeterminate	5	3	-40% ↓
Total	135	115	-14% ↓

Breakdown of Pseudomonas acquisition year on year comparison

Acquisition	2023-2024	2024-2025	Percentage difference
Healthcare associated	12	19	58% ↑
Community acquired	11	23	109% ↑
Relapse/indeterminate	1	0	-100% ↓
Total	24	42	90% ↑

Breakdown of Staph Aureus acquisition year on year comparison

Acquisition	2023-2024	2024-2025	Percentage difference
Healthcare associated	47	64	36% ↑
Community acquired	80	116	45% ↑
Relapse/indeterminate/other HB	4	9	125% ↑
Total	131	189	44% ↑

REMEDIAL ACTIONS

- Enhanced cleaning paper approved, however slippage in delivery due to capacity constraints
- Webinar on the management of CDI
- Ongoing quality improvement faculty within medicine with primary driver for good governance, fundamental infection prevention and control, prudent antimicrobial prescribing and human factors and safety culture.
- Mattress process reviewed and promoted
- Bespoke education provided to staff where increased incidence
- Promotion of national patient information leaflet
- Promotion of CDI framework and champions identified
- Feedback provided to General Practitioners (GP) and Quality Patient Safety Forums around community acquired cases associated with sub-optimal prescribing.
- Root cause analysis undertaken for each case in collaboration with GP and Community Antimicrobial Pharmacist Team for Community acquired cases



- Alert established for toxin negative cases to promote antimicrobial review/safe patient placement and Hydrogen Peroxide Vapour (HPV) cleaning on discharge
- IPCT attend safe to start or site operation meetings to help risk assess patients requiring cubicles
- Promote the 9 key standards for urinary tract infections (UTI) management
- Roll out of the project HOUDINI – “Make the catheter disappear” which aims to remove a catheter more quickly.
- Promotion of external devices
- Ongoing oral hygiene faculty within Ysbyty Ystrad Fawr
- Webinar of UTI 9 Standards
- Refreshed intranet resources
- ‘No Catheter November’: Community wide audit of people with urinary catheters in November (including residents in care homes). Data collection for this project is now complete, a total of 820 responses have been collected. The first stage of the analysis aims to identify those people who may benefit from a clinical review to explore whether a ‘trial without catheter’ may be of benefit or explore alternatives to catheterisation.
- Root cause analysis (RCA) for all cases of Methicillin Resistant Staph Auereus (MRSA) blood stream infections and intravascular device associated cases
- Invasive device audits
- Promotion of aseptic procedure packs for cannulation and blood culture collection
- Active promotion of Aseptic Non-Touch Technique throughout the Health Board
- Intravenous Catheter access webinar
- MRSA Admission screening audits
- Promotion of correct collection of blood cultures
- Education for sepsis
- Refreshed intranet page
- Educating & Recommendations After Significant Events poster developed for blood cultures to promote best practice

Antimicrobial Stewardship - Progress against Welsh Government Tier 1 Targets:

- **Secondary care:** An increase in antibiotic volume, moving away from the target 5% reduction. A decrease in the proportion of ‘access’ antibiotics used, away from the 70% target.
- **Primary care:** A reduction in volume, with GP in hours narrowly missing the target, but ABUHB achieving the target trajectory. The reduction in antibiotic volume has negatively impacted the attainment of the ‘access’ (antibiotics that are considered first or second-line choices for treating common infections). category target.
- **CDI root cause analyses,** showing a decrease in patients receiving suboptimal antibiotics and inappropriate acid suppression while on antibiotics. Analysis of relapse CDI cases revealed instances of suboptimal antibiotics increasing the chance of relapse.



Key Achievements

- **Development of an automated antimicrobial data dashboard** for secondary care, allowing detailed analysis of antibiotic use at various levels.
- **Implementation of penicillin 'allergy' de-labelling** across secondary care inpatients, reducing the risk of MRSA and CDI.
- **Roll out of Antibiotic Review Kit principles** to community hospitals.
- **Delivery of over 200 hours of antimicrobial ward rounds**, reviewing almost 1400 patients and making over 2000 interventions.
- **Ongoing development and review of local treatment guidelines**, including migration to a new digital platform.
- **Led more than 130 hours of education**, reaching over 1400 healthcare professionals.
- **Appointment of the consultant antimicrobial pharmacist** to the inaugural NICE antimicrobial evaluation panel.
- **Visit from colleagues of the Malawi-Wales Antimicrobial Pharmacy Partnership** to ABUHB pharmacy sites.

Decontamination

Decontamination Operation Group aims to ensure compliance and monitoring for the delivery of the Health Board Decontamination Action Plan. Key activities and issues addressed in 2024/25 include:

- **Community Dental Service washers & autoclaves:** These have not been serviced or tested, indicating non-compliance with required Welsh Health Technical Memoranda 01-05 standard. The lack of works and estates staff to undertake the role has been identified as the cause. Remedial actions include an agreement on the release of monies for band 5 Works personnel to undertake dual roles.
- **Centralised endoscopy unit project:** The project build at the Royal Gwent Hospital (RGH) has commenced with 'first stage' works. An electrical overload occurred in the interim unit leading to unsafe ventilation and peracetic acid monitoring failure. Scopes were diverted to Grange University Hospital (GUH) Hospital Sterilisation Disinfection Unit and local support for scope decontamination at RGH Urology department and theatre.
- **Endoscopy Ysbyty Ystrad Fawr** received an amber rating in the JAG (Joint Advisory Group) audit by John Prendergast, Authorised Engineer (Decontamination). They aim for JAG accreditation by 2nd April 2025 and have made significant progress with works and estates input.
- **Authorised Person (Decontamination)(APD) role:** Not fully functioning from a governance aspect due to lack of APDs and decontamination works trained staff. An operative decontamination staff member is near completion of APD role.
- **Urology department in RGH:** Local decontamination unit environment not fit for use due to significant damp and poor ventilation contributing toward fungi growing on low-level walls. Immediate closure of the unit by decontamination manager on advice by APD.
- **Automated decontamination process for Ultrasound probes in Radiology Units:** Trophon 1s Hydrogen Peroxide Vapour probe disinfectors



are obsolete. Replacement programme within Ultrasound directorate to be finalised.

Cleaning Standards section of the annual report outlines the Health Board's compliance with the Cleaning Standards 2009 1. Key points include:

- **Management of environmental cleanliness:** The Health Board demonstrates clear management arrangements for environmental cleanliness, linked to corporate and clinical governance. Environmental cleaning audit scores are sent to management monthly, and roles and responsibilities of all cleaning elements within healthcare settings have been developed.
- **Local cleanliness strategies:** A consistently high standard of environmental cleanliness is delivered across the Health Board. Operational standard operating procedures and a Cleaning Policy have been developed and are under review.
- **Involving and listening to patients:** Patient views on cleanliness are integrated into the planning, implementation, and monitoring process. Civica is developed for ward feedback, but facilities surveys for patient feedback are yet to be developed.
- **Education and development:** Staff are trained to ensure cleanliness standards are met. A competency booklet has been created, and a new onboarding and training facilitator role has been developed.
- **Risk-based analysis for service provision:** Appropriate cleaning methods and frequencies are applied to specific functional areas within healthcare facilities. Cleaning schedules are being reviewed and updated for all ward areas.
- **Facility management:** HB owned buildings and fixtures are maintained to an acceptable condition to enable effective and safe cleaning of the patient environment. Ongoing monitoring and review of calls logged are conducted.
- **Monitoring of cleaning outcomes:** The standard of cleanliness is assessed by both internal and external audits. Audit scores have improved, but not all areas are reaching All Wales guidance targets. Action plans are developed for areas that fail to reach audit compliance scores.

The section also highlights the use of **Synbiotix**, an integrated Facilities management system that supports precise monthly audits across all high-risk and very high-risk areas. This system helps identify recurring problems and develop action plans to enhance underperforming areas.

The **Cleaning Standards** section of the document highlights several recurring problems that have been identified through audits and monitoring. These include:

1. **Non-compliance with All Wales guidance targets:** Although audit scores have improved, not all areas are reaching the targets set by the All Wales guidance.
2. **Environmental cleanliness issues:** The cleaning audit team logs jobs with Works & Estates as and when failures present themselves during environmental audits.
3. **Need for updated cleaning schedules:** There is an ongoing review and updating of cleaning schedules for all ward areas at RGH, County



Community Hospital, and Monnow Vale Hospital, as well as the Emergency Department at GUH.

4. **Shortfalls in cleaning hours:** Assessments are being conducted to identify any shortfalls in cleaning hours required to achieve the cleaning frequencies and standards.

5. **Action plans for non-compliant areas:** Action and improvement plans are developed for each area that fails to reach audit compliance scores. These plans are shared at the divisional cleaning group meetings.

These recurring problems are being addressed through various remedial actions, including staff training, equipment upgrades, and the development of new communication protocols.

Argymhelliad / Recommendation

The Patient Quality Safety and Outcomes Committee is asked to **NOTE** the Infection Prevention & Control Annual Report 2024-25 and Strategic Plan for 2025/26.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.4 Infection Prevention and Control (IPC) and Decontamination 3.1 Safe and Clinically Effective Care 3. Effective Care 2.1 Managing Risk and Promoting Health and Safety
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:



Ar sail tystiolaeth: Evidence Base:	code-of-practice-for-the-prevention-and-control-of-healthcare-associated-infections.pdf Health and Care Quality Standards 2023 (WHC/2023/013) GOV.WALES Antimicrobial Surveillance - Public Health Wales Public Health Wales welcomes five-year plan to combat antimicrobial resistance - Public Health Wales Infection Prevention Society (IPS) For Health Professionals Healthcare associated infections and antimicrobial resistance goals 2024 to 2025 (WHC/2024/038) [HTML] GOV.WALES
Rhestr Termau: Glossary of Terms:	ABUHB = Aneurin Bevan University Health Board IPCT = Infection Prevention & Control Team FY = Financial Year CDI – Clostridioides <i>difficile</i> infection GP = General Practitioner HPV = Hydrogen Peroxide Vapour UTI = Urinary Tract Infection RCA = Root Cause Analysis MRSA = Methicillin Resistant Staph Auereus RGH = Royal Gwent Hospital GUH = Grange University Hospital JAG = Joint Advisory Group APD = Authorised Person Decontamination IPASG = Infection Prevention & Antimicrobial Stewardship Group
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Agenda 27 th May IPAS

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Is EIA Required and included with this paper No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk



**Deddf Llesiant
Cenedlaethau'r Dyfodol – 5
ffordd o weithio
Well Being of Future
Generations Act – 5 ways
of working**

<https://futuregenerations.wales/about-us/future-generations-act/>

Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives
Choose an item.





Infection Prevention, Antimicrobial Resistance & Decontamination Annual Report 2024 - 2025

Authors:

Moir Bevan – Head of Service Infection Prevention

Ceri Phillips – Consultant Pharmacist/Antimicrobials

Rhys Shorney – Head of Facilities

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Purpose/Introduction

This report reviews the annual activities of the Infection Prevention and Control Team (IPCT), Antimicrobial Resistance Group, and Hospital Cleanliness. Publishing the Infection Prevention and Control Annual Report is required to show good governance, adherence to Health Board values, and public accountability according to the quality framework 2022 ([Duty of Quality Statutory Guidance](#)).

Aneurin Bevan University Health Board (ABUHB) maintains a zero-tolerance policy on avoidable healthcare associated infections by consistently applying good infection prevention and control practices. This ensures users receive safe and effective care.

This report recognises the contributions of clinical and non-clinical staff, who are essential in enhancing the experience of staff, patients, and stakeholders, as well as reducing the risk of infections.

Effective Infection Prevention and Control is crucial in providing safe and efficient care for those using Health Board services. This Annual Report outlines the Health Boards performance relative to Welsh Government reduction targets, winter virus, surgical site infection for C sections. Other areas covered is the supporting groups and incident reviews and identifies areas for improvement in 2025/26.

Governance

The Infection Prevention and Antimicrobial Stewardship Group (IPASG) oversees efforts to reduce healthcare-acquired infections and antimicrobial resistance, monitoring compliance with Welsh Government goals and directing actions, escalating issues to the Executive Team when necessary.

Overall aims include:

- Enhance patient and staff experience
- Provide standards for, and promote safe practices to prevent infections across healthcare care setting
- Promote clean, safe environments for the delivery of patient care
- Minimise transmission for all healthcare associated infections across the Health Board and review learning from outbreak management
- Update and review Health Board risk register
- Promote adherence to antimicrobial stewardship/infection prevention national policies, guidelines and improvement interventions
- Review and endorse new and existing policies

- Review and endorse the annual programme of work and educational strategy
- Develop and dissemination of guidance to assist services for local implementation

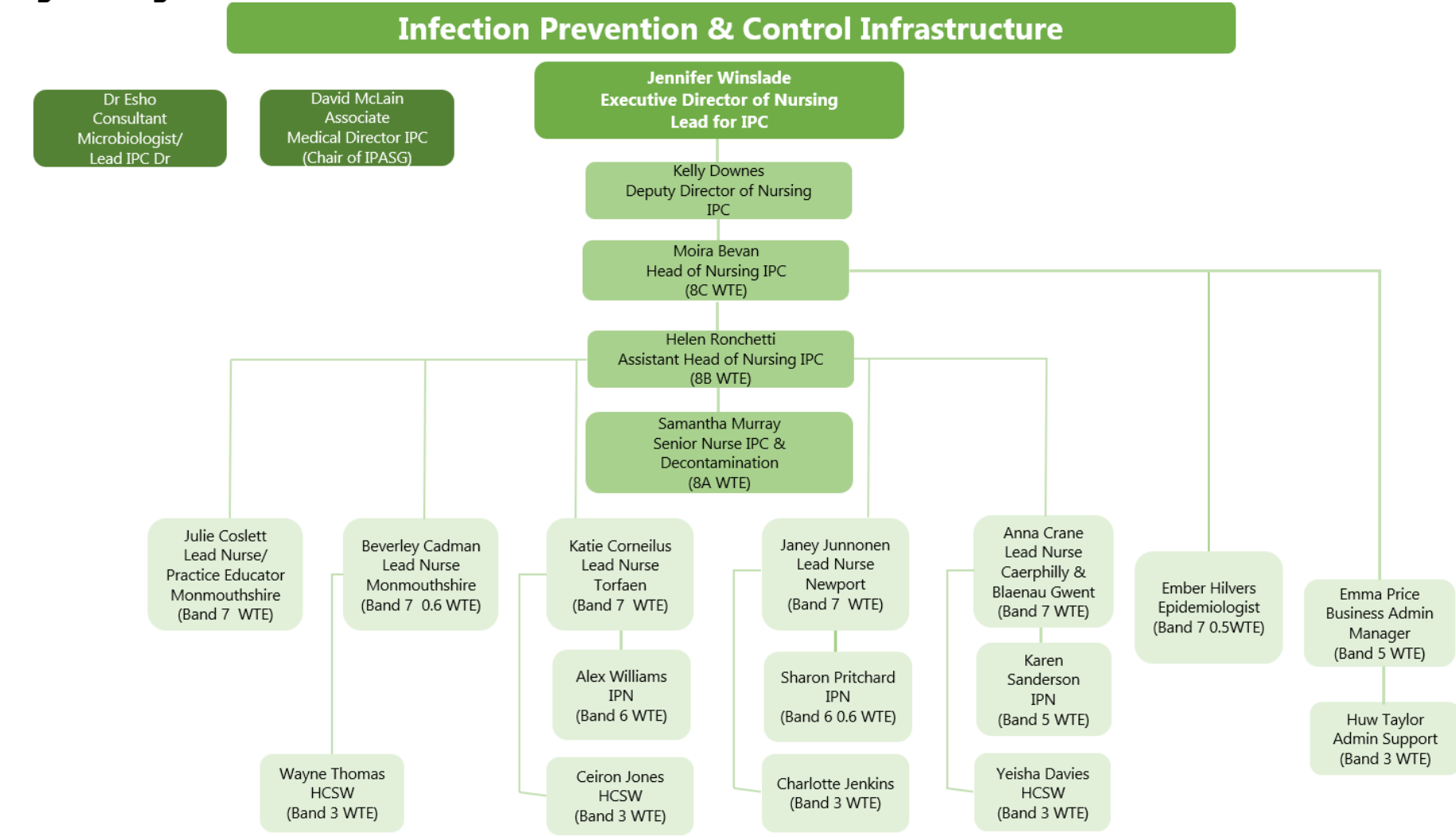
Considering the Health Board's challenges meeting the Welsh Government reduction targets for healthcare-associated infections, a strategic improvement group has been established to provide executive leadership on infection prevention, cleaning standards, and antimicrobial stewardship. The objective is to reduce risks associated with preventable infection transmission by:

- Ensuring compliance and monitoring for the delivery of the Health Board Healthcare Associated Infections Action Plan
- Ensuring compliance with the Quality and Safety Framework and certifying that care meets the six domains of quality; care that is safe, effective, patient-centred, timely, efficient and equitable
- Gaining assurance on the Health and Care Quality Standards 2023 doing the right thing, in the right way, in the right place at the right time and with the right staff
- Receiving organisational learning reports from investigations
- Receiving a performance dashboard for compliance data for infection prevention, cleanliness and antimicrobial stewardship
- Developing and monitoring an Improvement Plan
- Receiving Risks and Issues log from Divisions

Infection Prevention and Control - Workforce

The Infection Prevention and Control Service continue to receive partial funding from the Regional Integration Fund, supporting service provision in Primary Care until March 2027. The IPCT delivers infection prevention and control knowledge and expertise to both Primary and Secondary Care, encompassing all specialities.

Fig. 1: Organisational Chart



The IPCT sickness/absence has been higher than previous years. Mandatory training has also been lower than in previous years, this has been impacted by competing clinical priorities. The IPCT achieved 100% compliance with Performance Appraisal Development Reviews.

Sickness/Absence	Mandatory Training	PADR
 7.53%	 79%	 100%

Moira Bevan, Head of Service was nominated for the Royal College of Nursing Nurse of the Year Award.

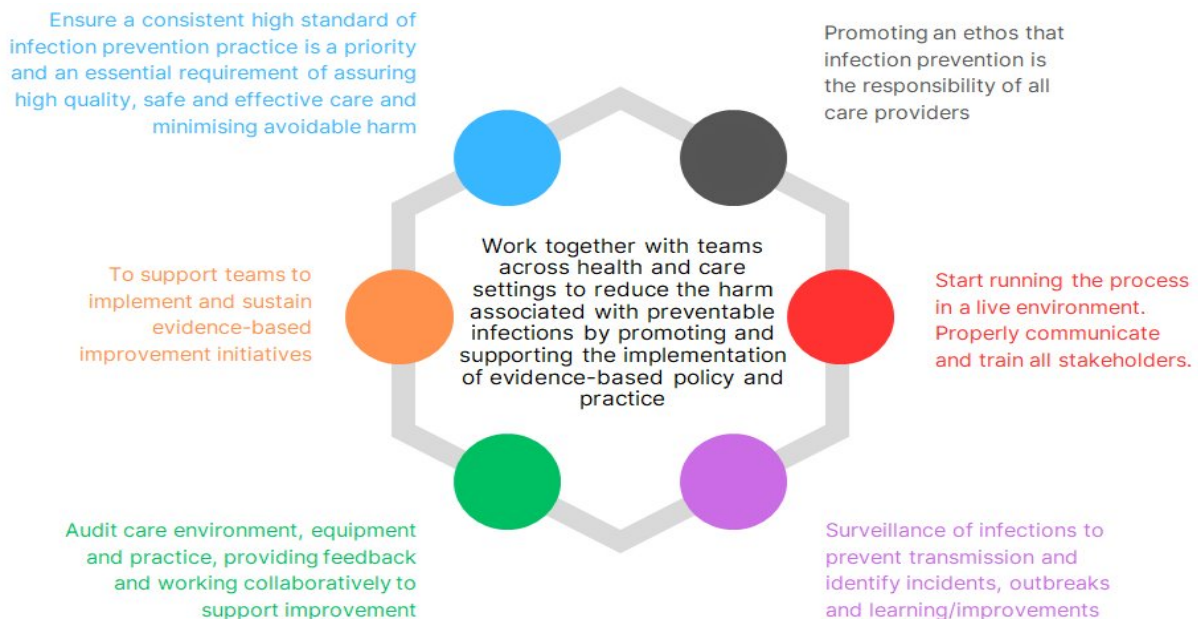
Helen Ronchetti, Deputy Head of Service has been honoured with the Gold Award in the British Journal of Nursing Awards for "Celebrating Excellence in Infection Prevention Nursing".

Samantha Murray, Decontamination Manager/Senior Nurse represented ABUHB at the Central Sterilisation Club Annual Scientific Meeting which is a long standing nationally recognised society.

Anna Crane, Lead Practitioner represented ABUHB at a national conference in London alongside speakers from the United States. Anna presented on the Purewick (female catheter) care bundle developed by ABUHB and Health Board progress with the reduction of catheter associated urinary tract infections (CAUTI)

In September 2024, Julie Coslett and Hannah Bourne, Practice Educators were awarded the Infection Prevention Society award for "Nurturing Infection Prevention & Control Talent" for their work as Infection Prevention Practice Educators in recognition of the role supporting teams throughout the organisation in their drive to reduce infections.

Infection Prevention Team Ethos



Surveillance

The IPCT monitors key Welsh Government target infections and other 'alert' organisms, identifying outbreaks quickly and managing them to prevent further spread. They provide specialist guidance to hospital and community teams and offer feedback when infection rates drop. The team also conducts collaborative post-infection reviews to identify lessons and prevent future cases.

The Health Board continues to use specialist surveillance software ICNet, to review microbiology results providing timely notifications and allowing results review across Wales.

Clostridioides difficile

Clostridioides difficile infection (CDI) is a major cause of healthcare-associated diarrhoeal illness, leading to significant morbidity, mortality, and economic burden. It severely impacts older adults, as well as younger adults and children, affecting their confidence and mobility. CDI transmission in healthcare settings poses a serious patient safety concern. Antibiotic and healthcare exposure, along with advanced age, are the main risk factors for colonisation and infection. Disruption to the gut microbiota, allows CDI to proliferate and cause mild to life-threatening bowel inflammation, precipitating the disease pathology.

The bacterium can be spread directly, or indirectly, between patients from healthcare workers and family members, the environment, or via food and animals when skin, surfaces and fomites are contaminated and not sufficiently cleaned prior to contact. It can persist in the environment, on surfaces, people, animals, food and fabrics, in the form of spores, for extended periods (months to years) and can lead to prolonged transmission events and outbreaks.

Poor hand hygiene, contaminated surfaces and other fomites, like medical devices, are often implicated in transmission, allowing patients to ingest spores that can colonise or infect. In the community, CDI is associated with farming and animals, contaminated food, and can be isolated from soil and wastewater.

There is also evidence of spread between individuals in domiciliary settings, including care homes.

During the financial year 2024/25, there has been a total of **275** CDI positive cases reported across the Health Board, which equates to a rate of **46.5 per 100,000** population. This is an increase of **20%** compared to the previous financial year.

Fig. 2: Cumulative monthly number of hospital onset CDI

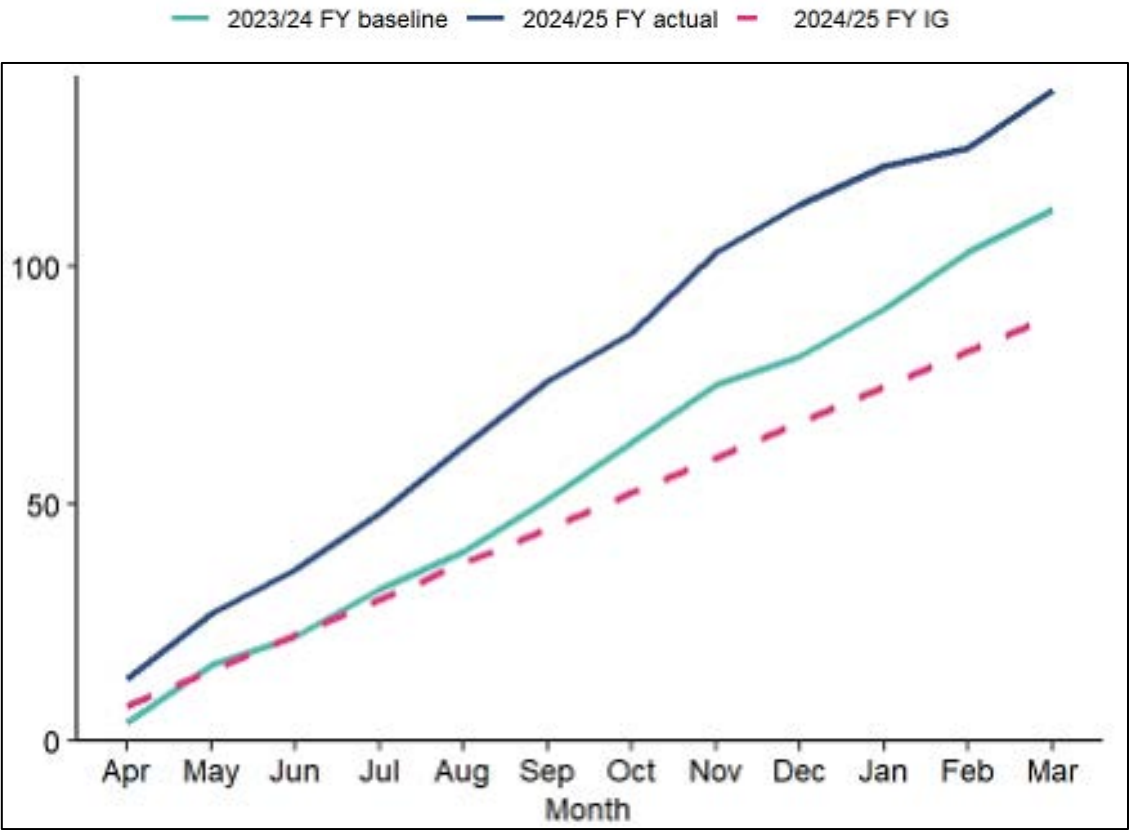
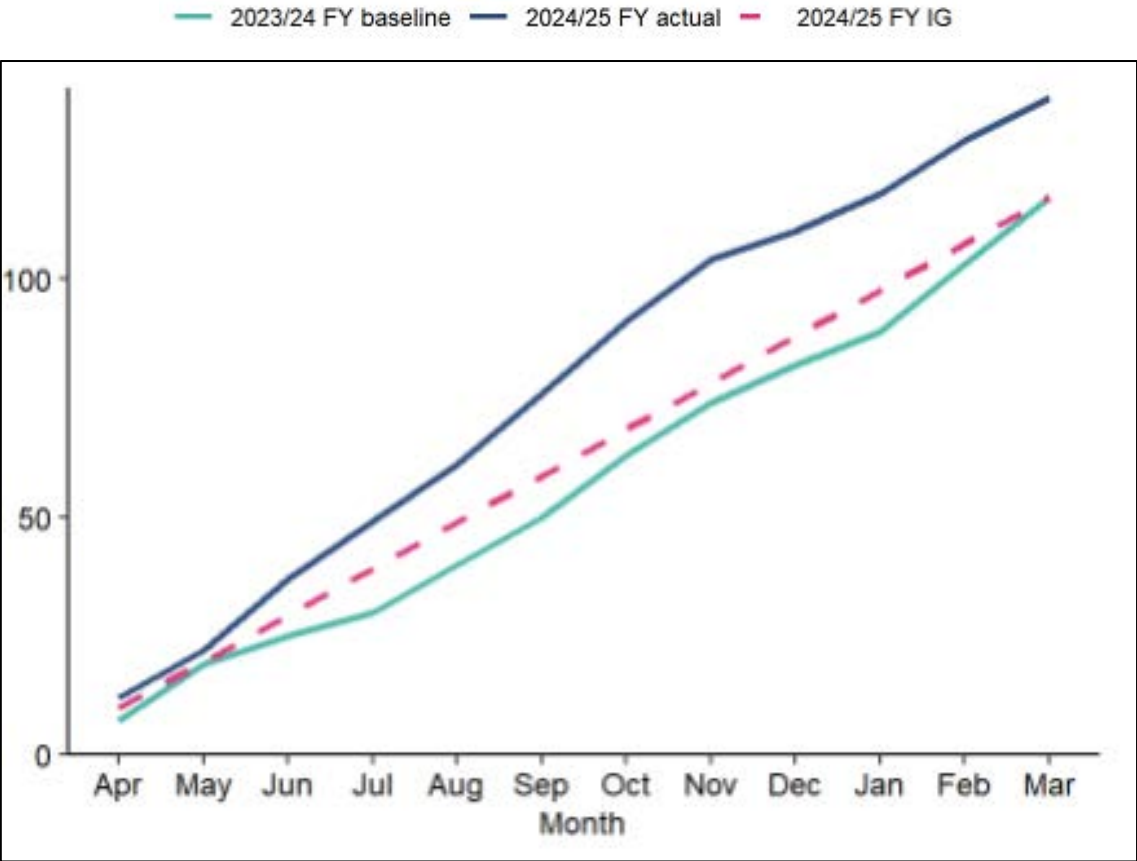


Fig. 3: Cumulative monthly number of community onset CDI



A breakdown of acquisition across the Health Board reveals notable changes in the CDI cases reported over the last two financial years. The data indicates a shift in the distribution of CDI incidents between healthcare-associated and community-acquired cases.

Fig. 4: Breakdown of CDI acquisition Year on Year comparison

Acquisition	2023-2024	2024-2025	Percentage difference
Healthcare associated	127	138	8% ↑
Community acquired	57	78	36% ↑
Relapse	25	40	60% ↑
Indeterminate	15	11	26% ↓
Other Health Board	5	8	60% ↑
Total	229	275	21% ↑

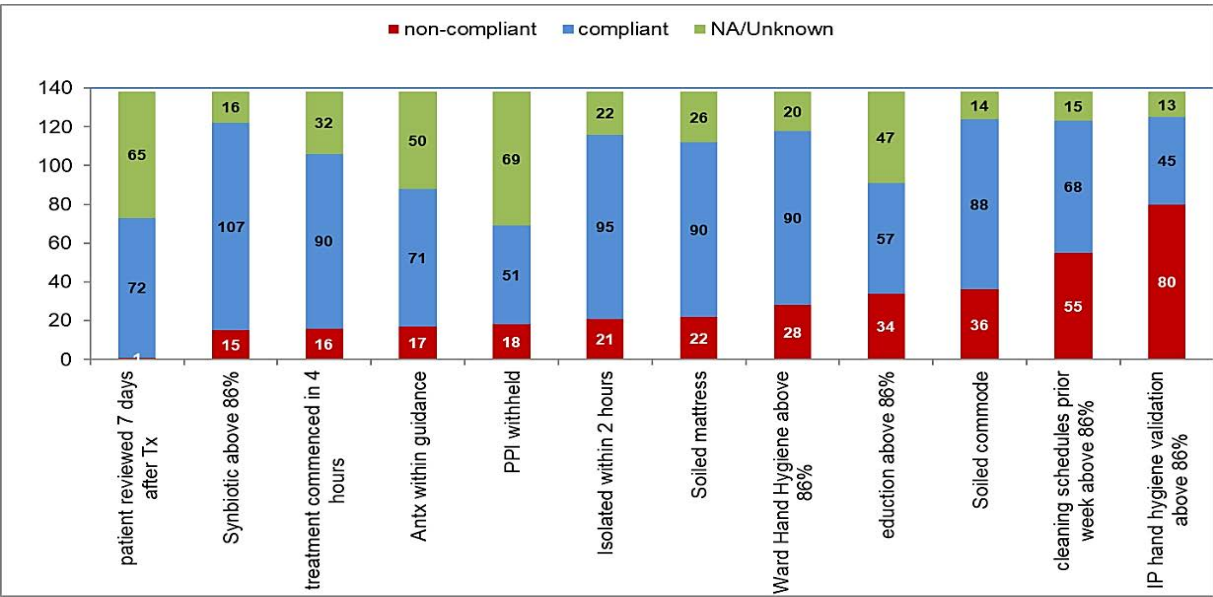
All health associated infections (HAI) cases have been reviewed via a root cause analysis (RCA) approach, revealing insights on basic infection prevention practices (see Fig. 4 below).

Community onset cases are also reviewed, and Antimicrobial Pharmacists give feedback to GP Practices on antibiotic prescribing as needed.

Engaging the Multi-Disciplinary Teams to join or contribute to the RCA process has been challenging throughout the year. To encourage organisational ownership, the IPCT provided compliance feedback through email and supported the organisation's Datix reporting.

Boarding of patients has also contributed to slippage in achieving the proactive HPV cleaning programme plus put additional pressure on clinical teams to turn around patients rooms timely. National reports are indicating that “corridor care” could be leading to overwhelmed staff not following infection prevention control (IPC) methods.

Fig. 5: Compliance with fundamental measures following RCA of HAI CDI cases



Whole Genome Sequencing (WGS) update

A gene sequence is a specific nucleotide sequence that produces a signal indicating its presence in a cell or organism post-transgenesis.

In the 2024-25 period, **643** *Clostridioides difficile* PCR (polymerase chain reaction) positive specimens (both toxin positive and negative) from ABUHB residents and in-patients were whole gene sequenced. Of these, **489** were categorised into **237** clusters, while **154** were unique singletons. This suggests transmission between individuals.

5 clusters, involving 9 patients, were identified over the year, indicating potential transmission events within hospital wards. CDI can persist in patients and hospital environments for long periods. Examining cases over 6 months revealed an additional 14 likely transmissions occurring in hospital settings, even if patient cases were more than 28 days apart or patients weren't on the ward simultaneously.

CDI have increased across all Health Boards in Wales, possibly due to the Covid-19 pandemic. A national framework has been developed to address this issue, with ABUHB monitoring its performance against the implementation objectives: -

- Antimicrobial stewardship
- Infection prevention, control, and investigation
- Laboratory diagnosis, typing, screening and reporting
- Treatment and management
- Surveillance and epidemiology
- Leadership and workforce
- Research and development

Additional remedial actions implemented: -

- Enhanced cleaning paper approved however slippage in delivery due to capacity constraints
- Webinar on the management of CDI
- Ongoing quality improvement faculty within medicine with primary driver for good governance, fundamental infection prevention and control, prudent antimicrobial prescribing and human factors and safety culture.
- Mattress process reviewed and promoted
- Bespoke education provided to staff where increased incidence
- Promotion of national patient information leaflet
- Promotion of C difficile framework and champions identified
- Feedback provided to General Practitioners (GP) and Quality Patient Safety Forums around community acquired cases associated with sub-optimal prescribing.
- Root cause analysis undertaken for each case in collaboration with GP and Community Antimicrobial Pharmacist Team for Community acquired cases
- Alert established for toxin negative cases to promote antimicrobial review/safe patient placement and Hydrogen Peroxide Vapour (HPV) cleaning on discharge
- IPT join safe to start or site operation meetings to help risk assess patients requiring cubicles

Antimicrobial Stewardship 2024-25

The Antimicrobial Stewardship team maintains oversight of antimicrobial usage and implements strategies to optimise use of antibiotics across the health board. The team both chair and provide professional secretariat for the ABUHB Antimicrobial Working Group and Antimicrobial Guideline Group.

Key achievements for 2024/25

- Development of an automated antimicrobial data dashboard for secondary care, allowing data visualisation and interrogation of antibiotic use to division, directorate & ward level.
- Implementation of penicillin 'allergy' de-labelling across secondary care inpatients. A penicillin allergy label is associated with an increased risk of MRSA and CDI and a 0.6% increase in deaths within the following year, compared with patients not reporting an allergy. However up to 95% of people reporting a reaction to penicillin, do not have a true allergy. This new scheme supports staff to risk assess patients and either remove an allergy directly via the history alone or give an oral test dose of a penicillin to patients determined to have a very low risk of allergy.
- Roll out of Antibiotic Review Kit (ARK) principles to the majority of ABUHB community hospitals, following implementation at the main sites in 2022/23.
- Delivery of over 200 hours of antimicrobial ward rounds, reviewing almost 1400 patients. More than 2,000 interventions were made on these rounds, including stopping antibiotics in 17% patients, and switching 10% to oral therapy. This included attendance at Community Resource Team antibiotic multi-disciplinary team meetings from July-December, to review antimicrobials being administered in the out of hospital setting. Ward rounds have been limited in Quarter 4 by Medical Microbiology and Antimicrobial Pharmacist staff shortages, with recruitment underway to address these gaps.
- Ongoing development and review of almost 600 local treatment guidelines, including migration to a new digital platform in summer 2024.
- Led more than 130 hours of education, reaching over 1400 healthcare professionals in all sectors. Grand rounds dedicated multidisciplinary infection induction sessions. New groups reached include GP out of hours and undergraduate pharmacy students on hospital placements.
- The consultant antimicrobial pharmacist has been appointed to the inaugural NICE antimicrobial evaluation panel. The committee will review evidence and judge the value of new antibiotics to the NHS, as part of a world-first model to encourage development of new antibiotics: [A new model for evaluating and purchasing antimicrobials in the UK](#)

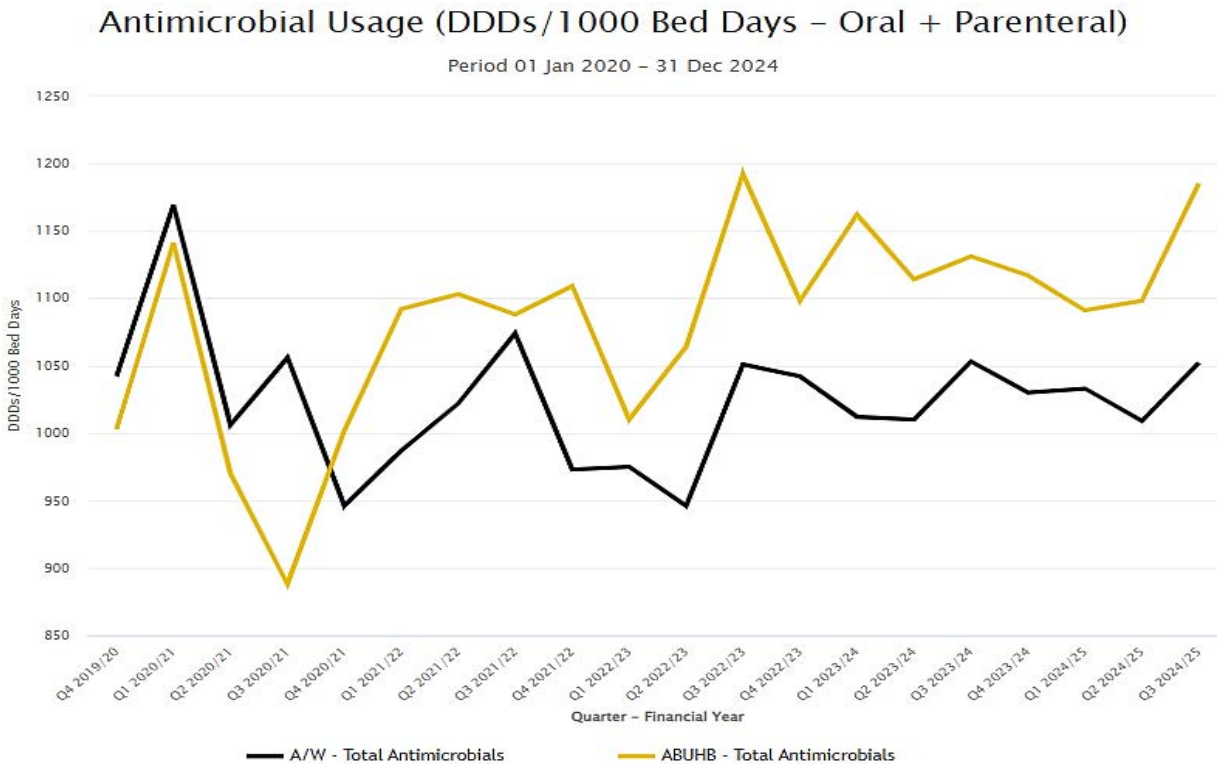
- Colleagues from the Malawi-Wales Antimicrobial Pharmacy Partnership visited two ABUHB pharmacy sites as part of a visit to Wales: [Malawi-Wales Antimicrobial Pharmacy Exchange](#)

Progress against Welsh Government Tier 1 Targets

Secondary care (approximately 25% of antimicrobial use)

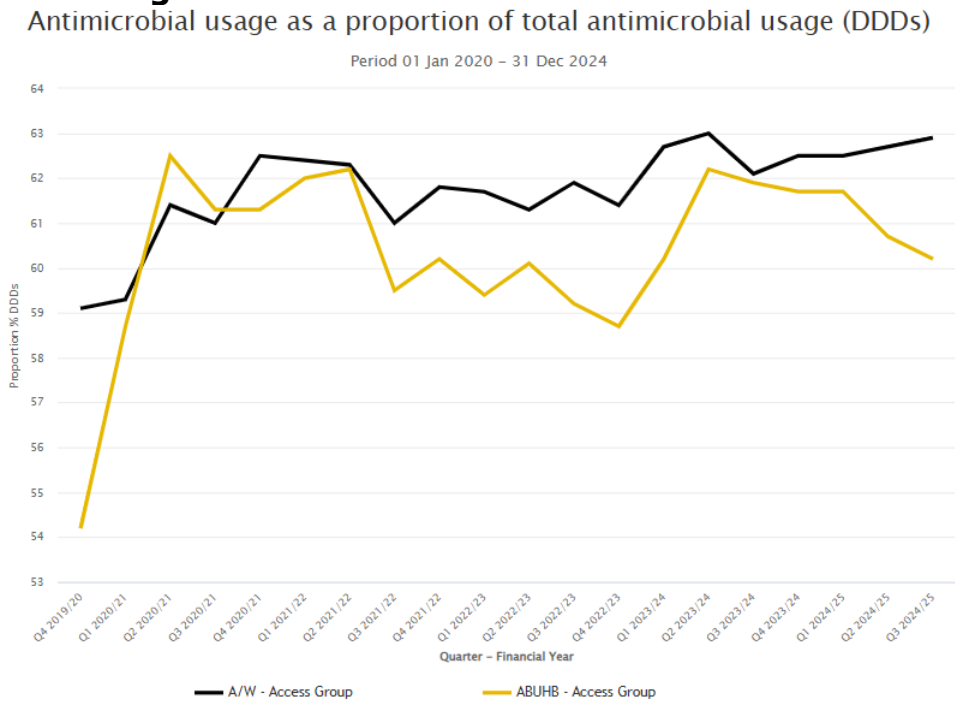
Data from Public Health Wales are only available to the end of Quarter 3. Fig 6 shows an *increase* in antibiotic volume, away from the target 5% reduction by the end of 29/30:

Fig. 6: Secondary care volume with ABUHB above the all-Wales average



The other Welsh Government target for secondary care is that at least 70% of all antibiotics used in secondary care should be in the lower risk ‘access’ category (antibiotics that are considered first or second-line choices for treating common infections). Figure 7 demonstrates a *decrease* in the proportion ‘access’ antibiotics used, away from the 70% target.

Fig 7: Secondary care 'access' use below the all-Wales average & 70% target



Primary care (approximately 75% of antimicrobial use)

Data from PHW are only available to the end of Quarter 3, but demonstrate a reduction in volume, with GP in hours narrowly missing the target, but ABUHB achieving the target trajectory.

Fig 8: GP in hours antimicrobial volume

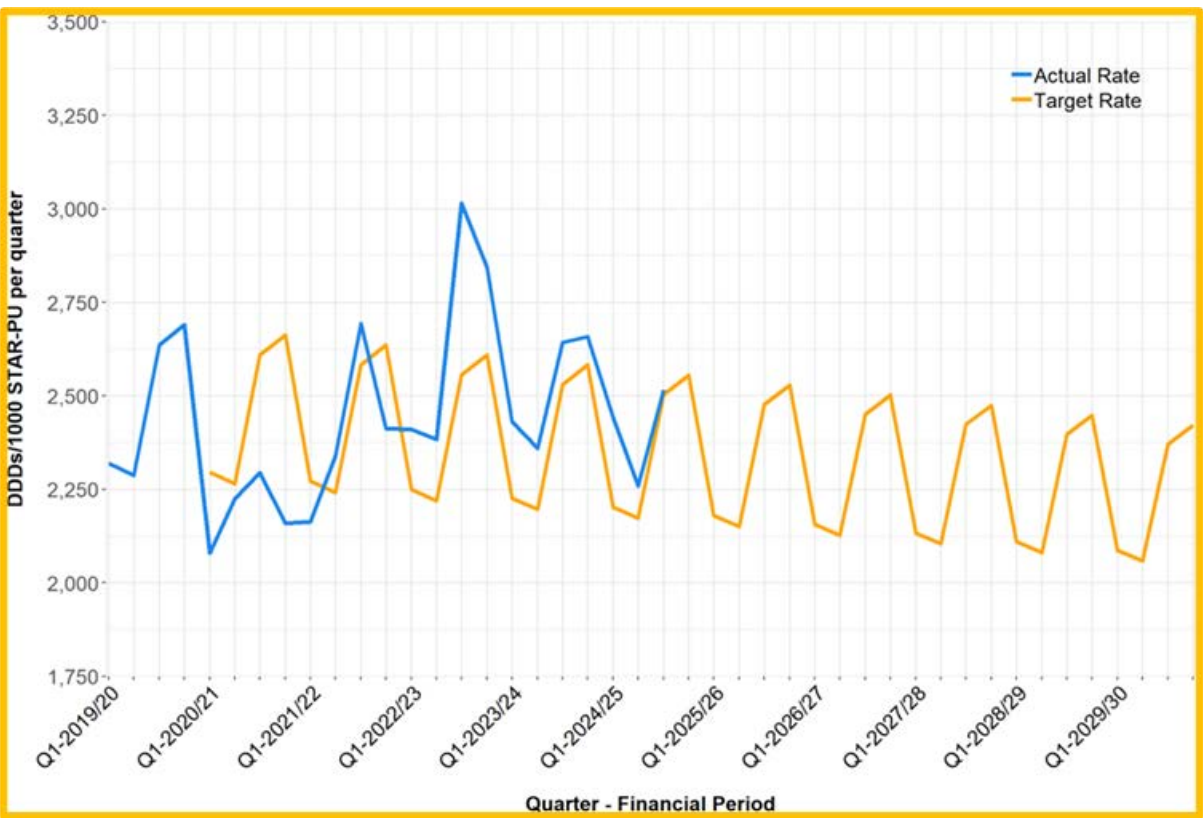
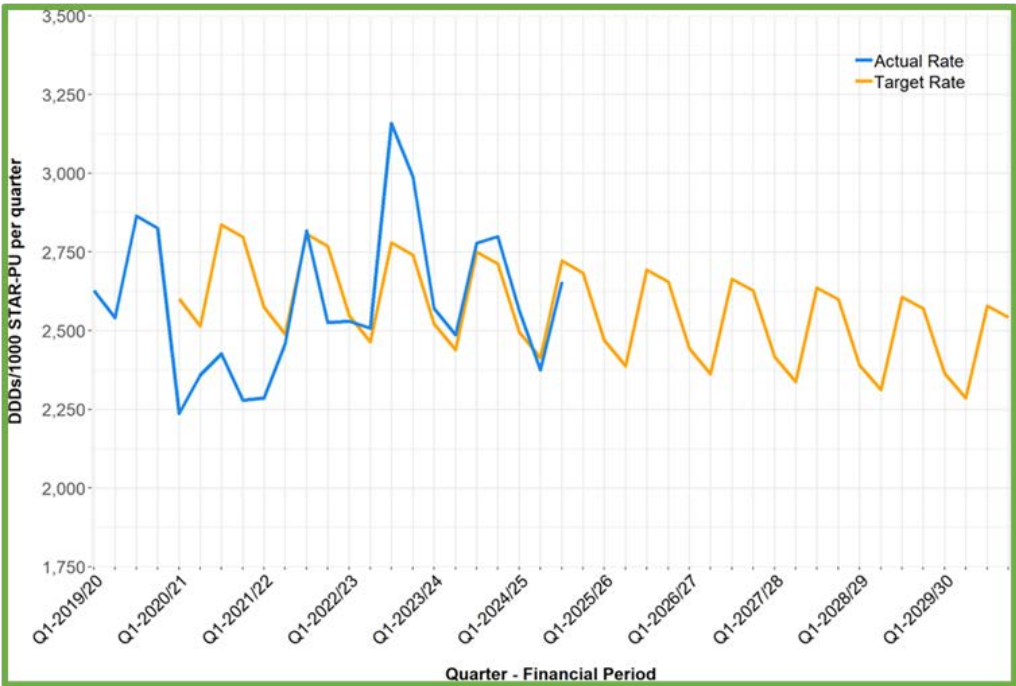
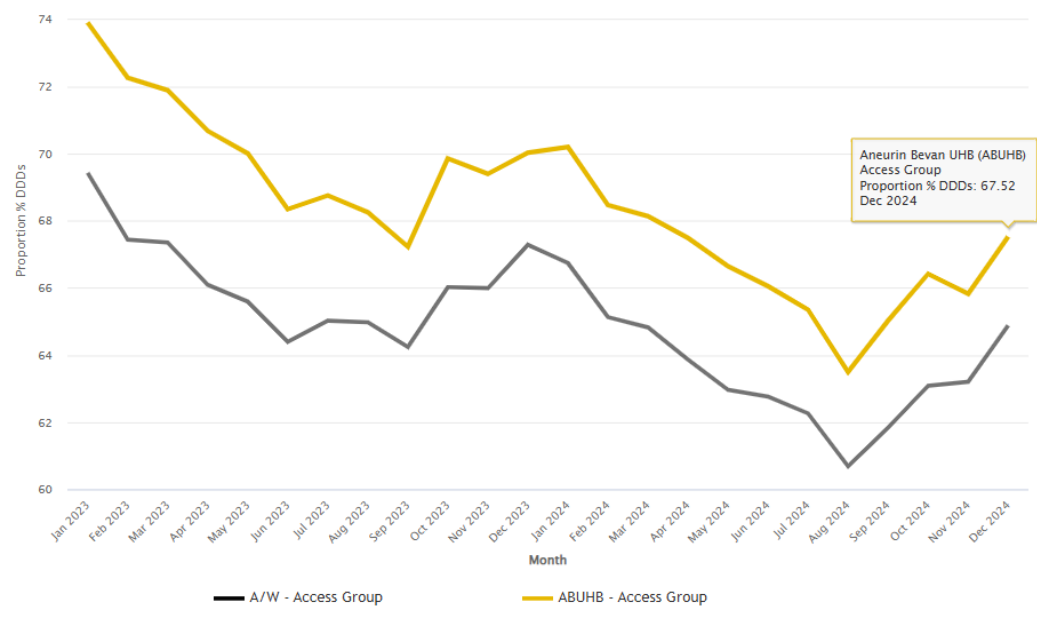


Fig 9: Primary care total volume, including GP out of hours, independent prescribers & community pharmacy



Similar to secondary care, the Welsh Government target is a minimum of 70% of all antibiotic use in primary care should be with lower risk antibiotics in the 'access' category. As anticipated the reduction in antibiotic volume has been mainly in use of lower risk antibiotics, so has had a negative impact on attainment of the 'access' category target. Figure 10 demonstrates ABUHB is no longer achieving the target of 70%, but remains above the all-Wales average.

Fig 10: Proportion of 'access' prescribing in ABUHB (yellow line) vs. all-Wales average (black line)



CDI root cause analyses demonstrate a decrease in the number of patients receiving suboptimal antibiotics, and a decrease in patients where acid suppression was continued inappropriately whilst on antibiotics over the course of the year.

Analysis of the relapse CDI cases revealed three individuals had received suboptimal antibiotics that would have increased their chance of relapse. One related to treatment of the previous episode, one to antibiotics received in primary care, and one to antibiotics given in secondary care.

Gram Negative Bacteraemia

Gram-negative infections, caused by *Klebsiella sp.*, *Pseudomonas aeruginosa*, and *E. coli*, originate from gut bacteria that can become harmful if they spread to other body parts, leading to serious infections and high mortality rates.

Gram-negative bacteria (GNB) are the leading cause of healthcare associated bloodstream infections. It is known that GNB are becoming increasingly resistant to antibiotics and therefore more difficult to treat. Lowering the burden of infection is key to reducing the development of antimicrobial resistance.

E coli Bacteraemia

During the financial year 2024/25, there has been a total of **376** E coli bacteraemia cases reported across the Health Board, which equates to a rate of **63.58 per 100,000** population. This is a 7% increase compared to the previous financial year.

A breakdown of acquisition across the Health Board highlights a shift with fewer healthcare-associated cases, but a notable increase in community-acquired cases over the two financial years.

Fig. 11: Breakdown of E coli acquisition year on year comparison

Acquisition	2023-2024	2024-2025	Percentage difference
Healthcare associated	104	95	-8% 
Community acquired	239	258	7.9% 
Relapse/indeterminate	7	10	42% 
Other HB	3	13	
Total	349	376	7.7% 

Fig. 12: Cumulative monthly number of hospital onset E Coli BSI

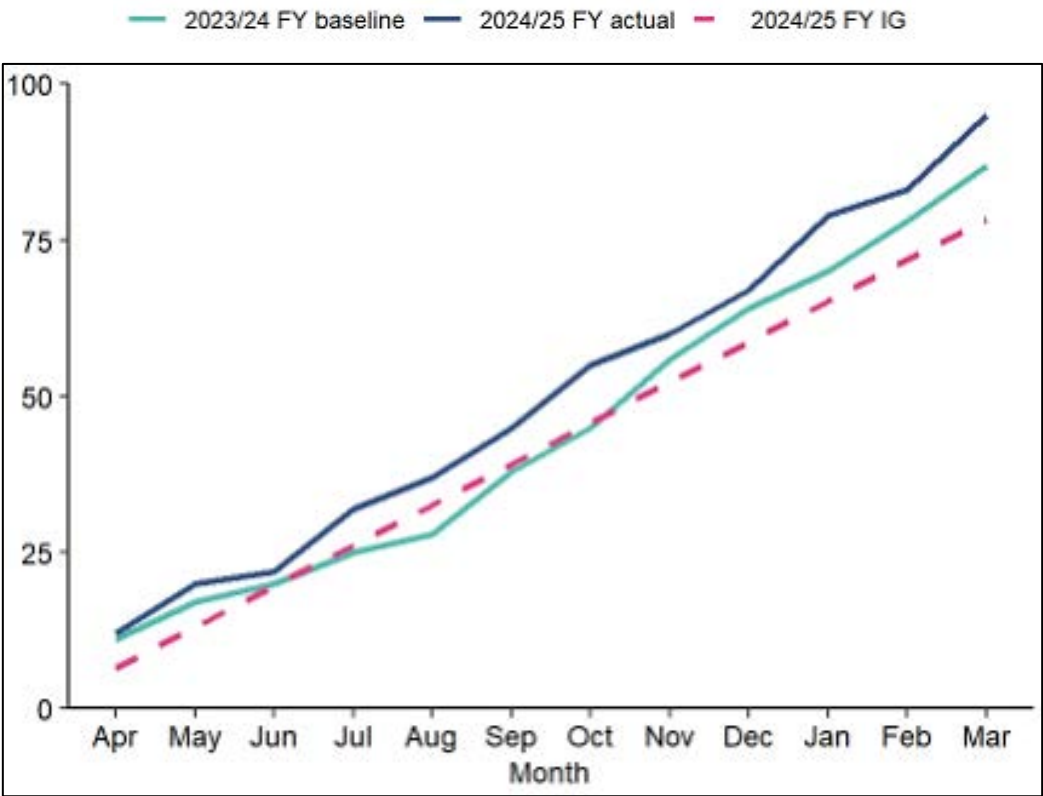


Fig. 13: Cumulative monthly number of community onset E Coli GNB

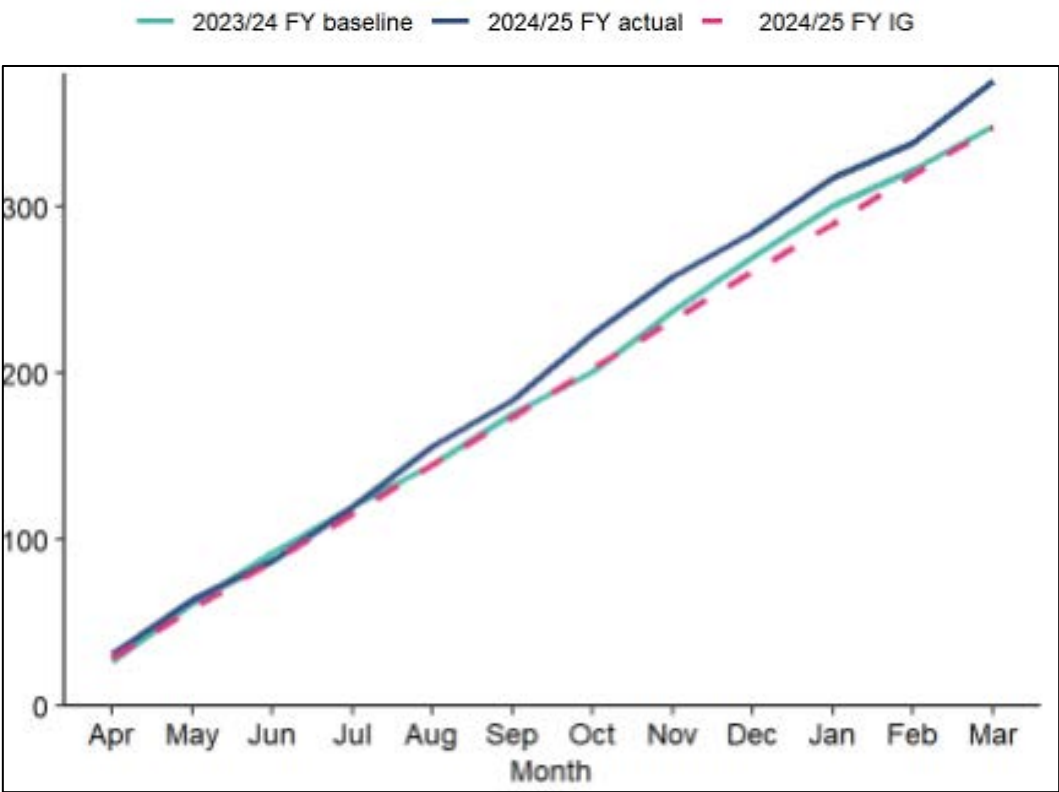
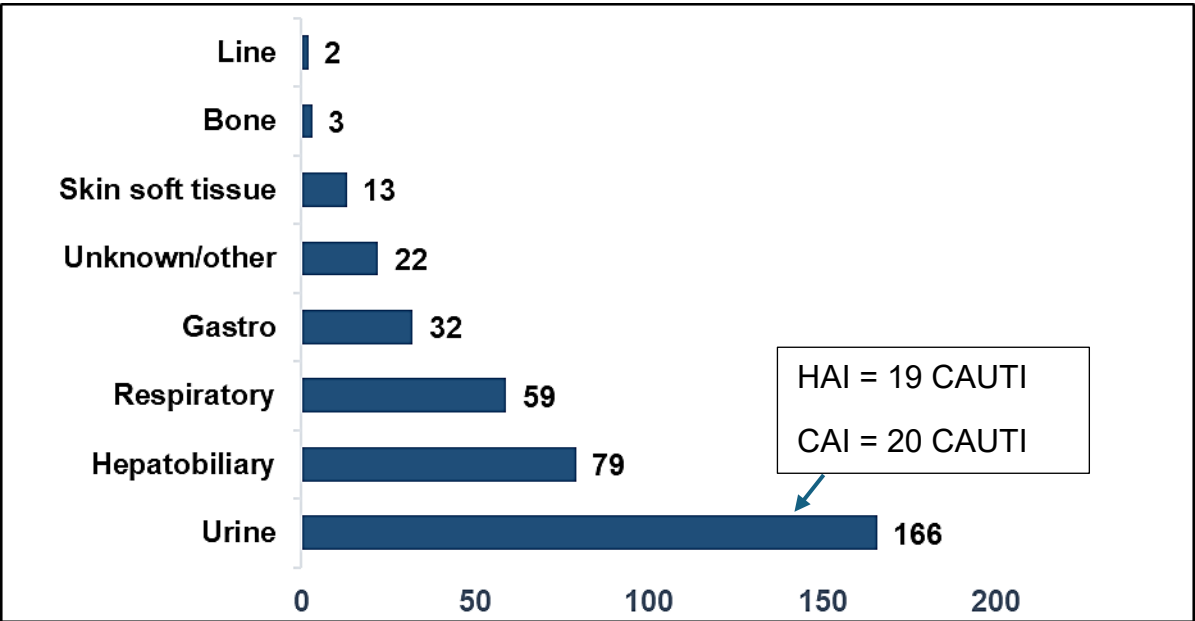


Fig. 14: Source of Infection – E coli BSI



Urine continues to be the highest burden of infection source. IPCT carry out an RCA for HAI cases where urine has been identified as the source and the patient has a catheter in situ.

Klebsiella Bacteraemia

During the financial year 2024/25, there has been a total of **115** cases of Klebsiella bacteraemia reported across the Health Board which equates to a rate of **19.45 per 100,000** population. This is a 14% improvement compared to the previous financial year.

A breakdown of acquisition across the Health Board identifies a significant improvement in the number of healthcare associated Klebsiella BSI.

Fig. 15: Breakdown of Klebsiella acquisition year on year comparison

Acquisition	2023-2024	2024-2025	Percentage difference
Healthcare associated	57	41	-28%
Community acquired	73	71	-3%
Relapse/indeterminate	5	3	-40%
Total	135	115	-14%

Fig. 16: Cumulative monthly number of hospital onset Klebsiella BSI

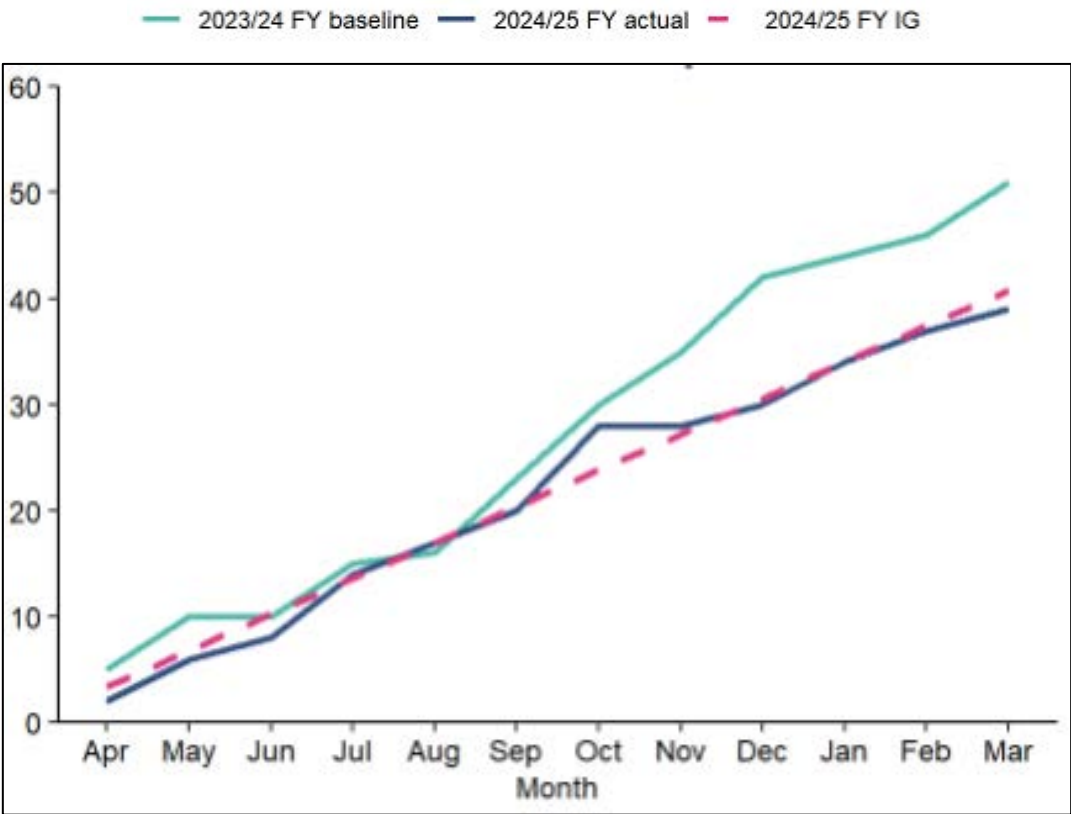


Fig. 17: Cumulative monthly number of community onset Klebsiella BSI

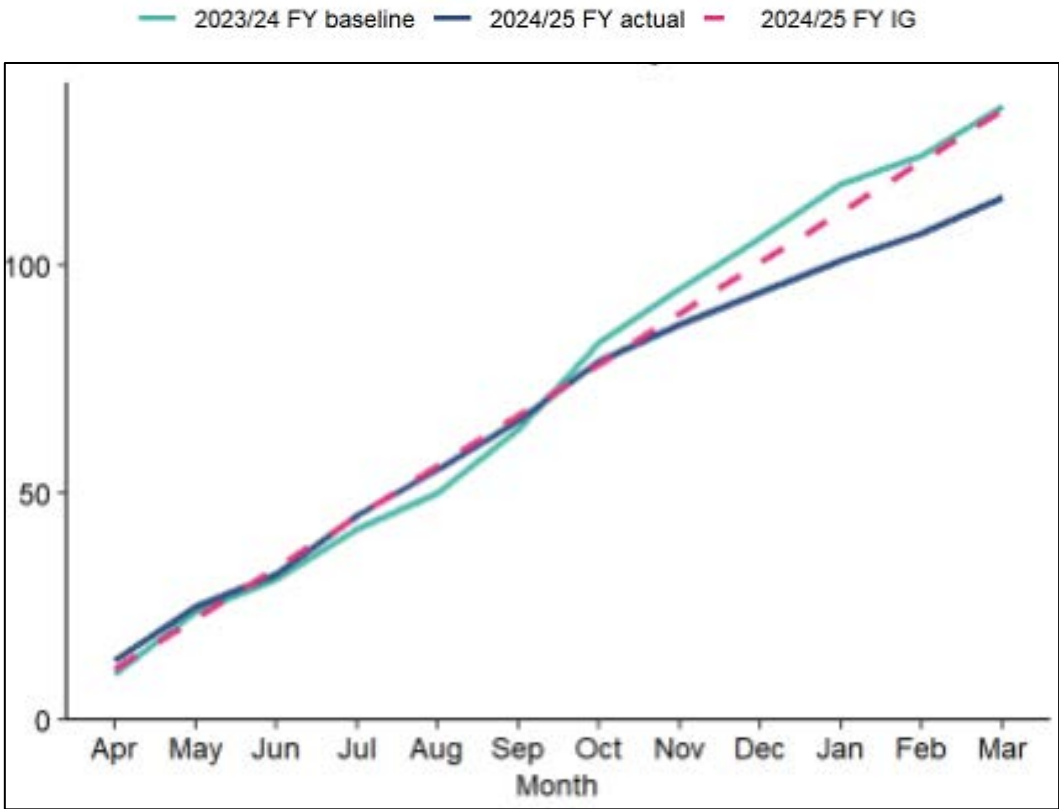
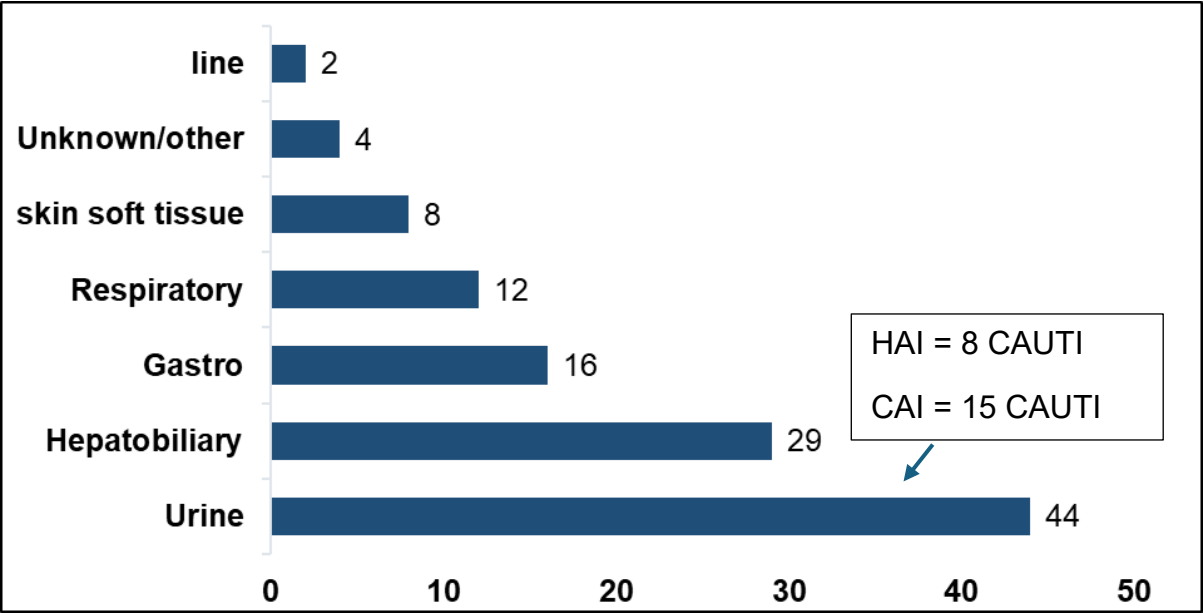


Fig. 18: Source of Infection - Klebsiella BSI



Like E coli BSI, urine continues to be the highest source of infection.

Pseudomonas Bacteraemia

During the financial year 2024/25, there has been a total of 42 Pseudomonas bacteraemia cases reported across the Health Board equating to a rate of 7.1 per 100,000 population. This is an increase of 90% compared to the previous financial year.

A breakdown of acquisitions across the Health Board reveals a significant increase in all acquisitions across the Health Board.

Fig. 19: Breakdown of Pseudomonas acquisition year on year comparison

Acquisition	2023-2024	2024-2025	Percentage difference
Healthcare associated	12	19	58%
Community acquired	11	23	109%
Relapse/ indeterminate	1	0	-100%
Total	24	42	90%

Fig. 20: Cumulative monthly number of hospital onset Pseudomonas BSI

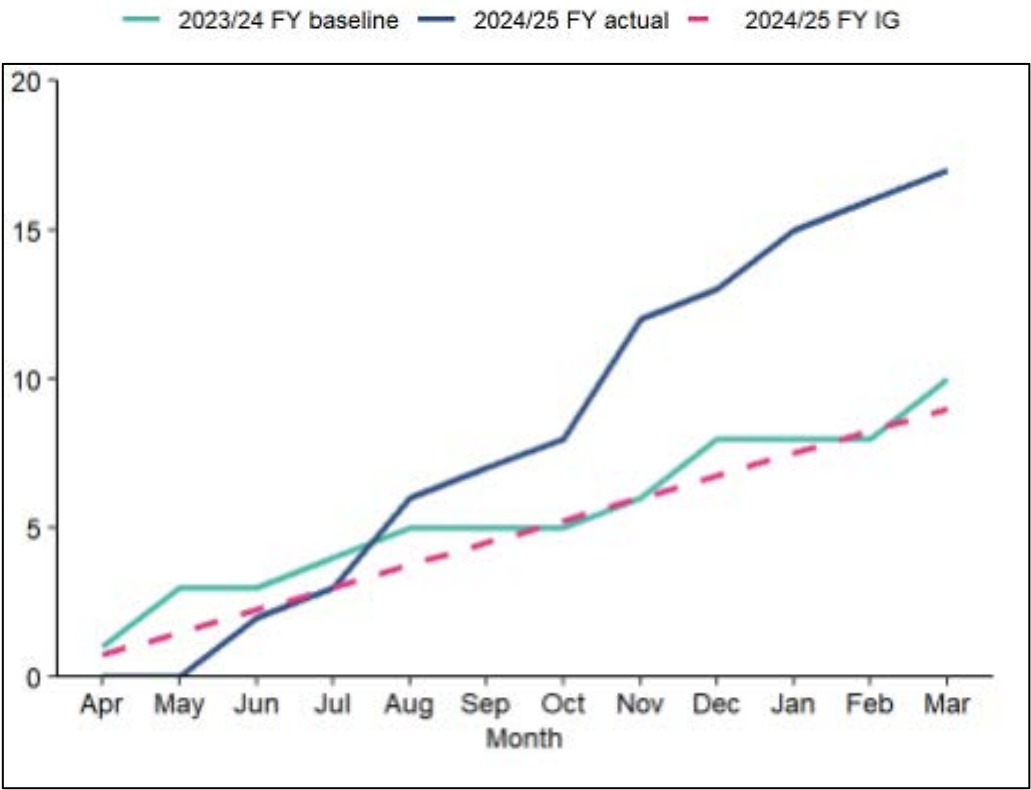


Fig. 21: Cumulative monthly number of community onset Pseudomonas BSI

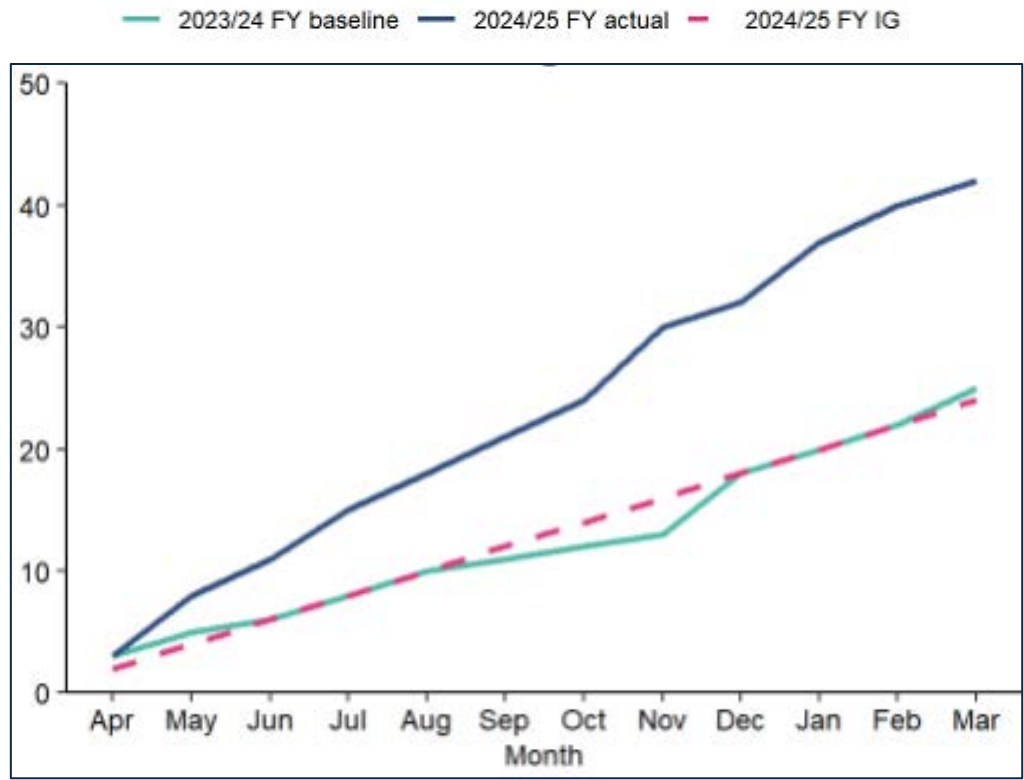
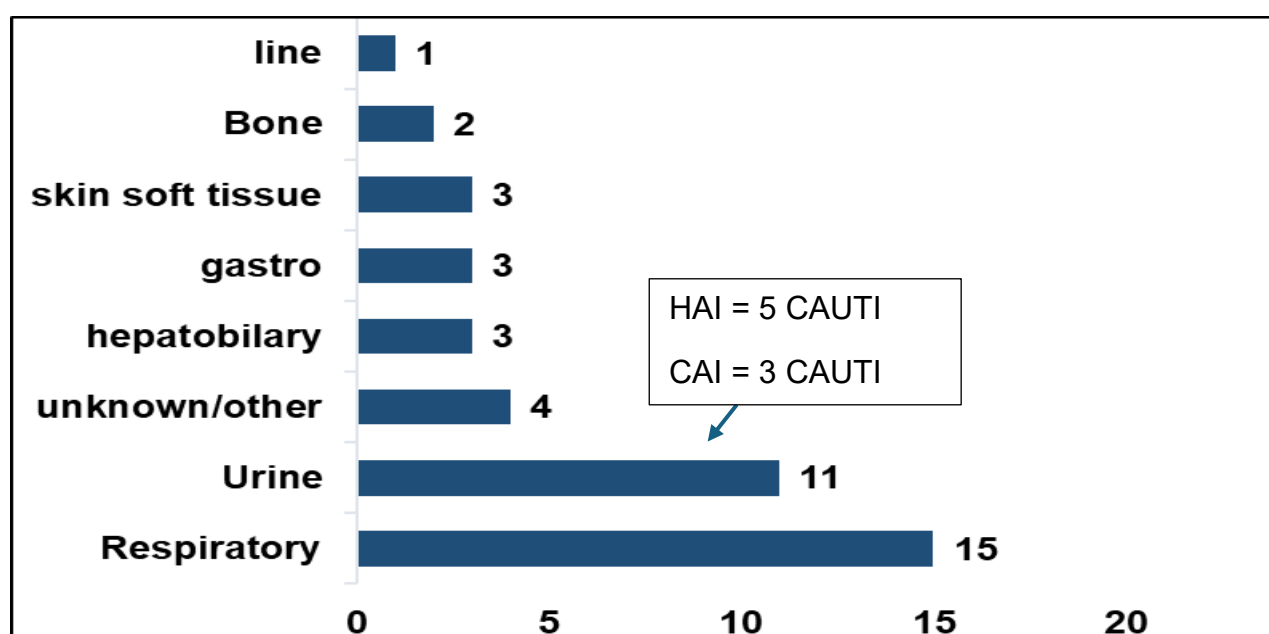


Fig. 22: Source of Infection – Pseudomonas BSI



Unlike E coli and Klebsiella, Respiratory is the highest source of infection.

Remedial actions implemented: -

- Promote the 9 key standards for urinary tract infections management
- Roll out of the project HOUDINI – “Make the catheter disappear” which aims to remove a catheter more quickly.
- Promotion of external devices
- Ongoing oral hygiene faculty within YYF
- UTI 9 webinar
- Refreshed intranet resources
- ‘No Catheter November’: Community wide audit of people with urinary catheters in November (including residents in care homes). Data collection for this project is now complete, a total of 820 responses have been collected. The first stage of the analysis aims to identify those people who may benefit from a clinical review to explore whether a ‘trial without catheter’ may be of benefit or explore alternatives to catheterisation.

Staphylococcus aureus Bacteraemia

Staphylococcus aureus bacteria (SA) lives on (or colonises) the skin and in the nose of many people; it can also colonise chronic wounds. Most of the time it does not cause any harm but can cause infection if it multiplies or enters the body (e.g. via an invasive device or wound). Staph infections can be either methicillin-resistant Staph aureus (MRSA) or methicillin-susceptible Staph aureus (MSSA).

Both types of SA can go on to cause severe infection (e.g. sepsis, endocarditis) particularly in susceptible people vulnerable to infection (e.g. older people, those with acute illness or chronic conditions).

MSSA infections are more easily treatable with antibiotics. However, MRSA infections are resistant to many standard antimicrobials.

During the financial year 2024/25, there has been a total of **19 MRSA** and **170 MSSA** bacteraemia cases reported across the Health Board equating to a rate of **3.21** for MRSA and **28.75** for MSSA **per 100,000** population. This is an increase of 47% compared to the previous financial year.

A breakdown in acquisition of MRSA and MSSA combined across the Health Board identifies a significant increase in the number of relapse and indeterminate acquisition.

Fig. 23: Breakdown of Staph Aureus acquisition year on year comparison

Acquisition	2023-2024	2024-2025	Percentage difference
Healthcare associated	47	64	36% 
Community acquired	80	116	45% 
Relapse/indeterminate/other HB	4	9	125% 
Total	131	189	44% 

Fig. 24: Cumulative monthly number of hospital onset MRSA BSI

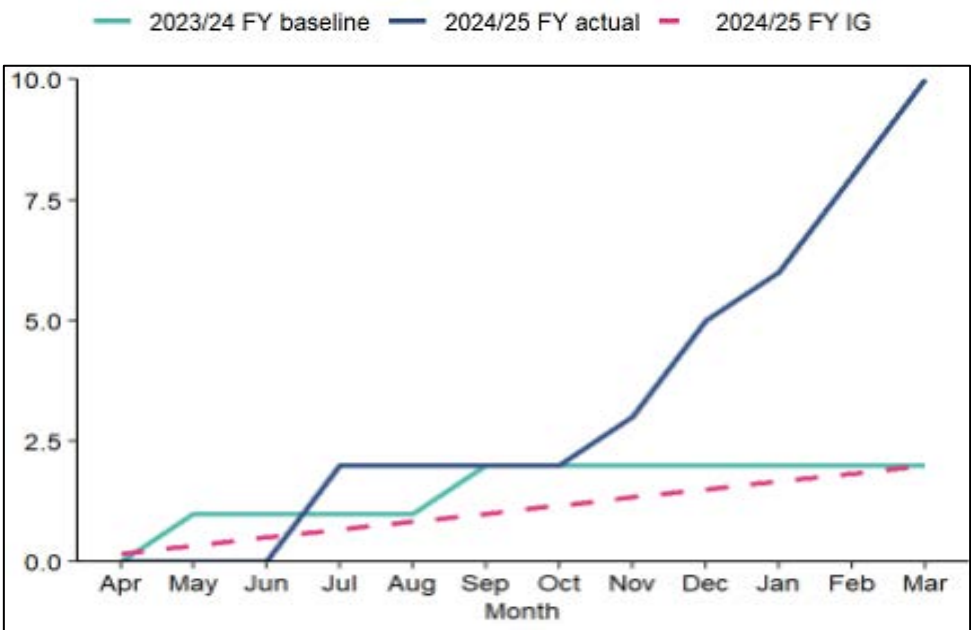


Fig. 25: Cumulative monthly number of hospital onset MSSA BSI

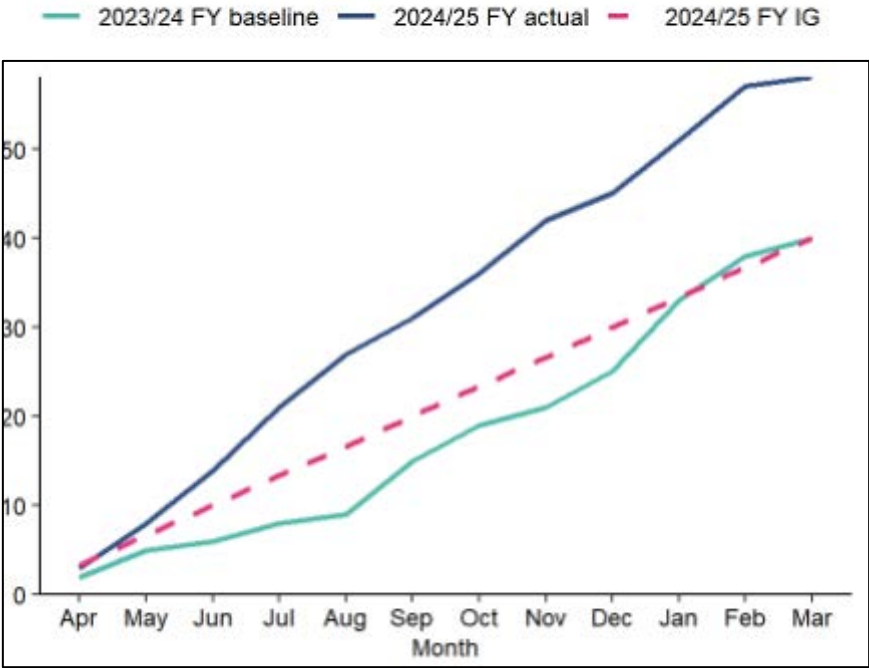
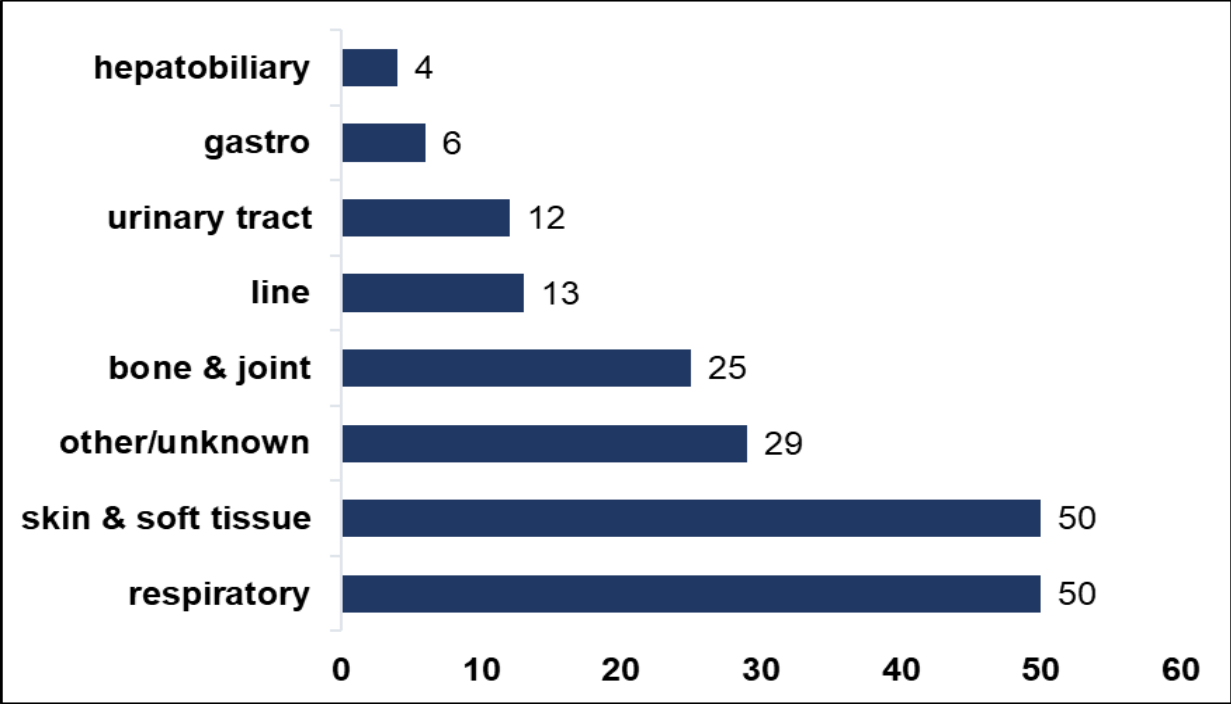


Fig. 26: Source of Infection – Staph Aureus BSI



Remedial action

- Root cause analysis for all cases of MRSA blood stream infections and intravascular device associated cases
- Invasive device audits

- Promotion of aseptic procedure packs for cannulation and blood culture collection
- Active promotion of Aseptic Non-Touch Technique throughout the Health Board
- IV access webinar
- MRSA Admission screening audits
- Promotion of correct collection of blood cultures
- Education for sepsis
- Refreshed intranet page
- ERASE for blood cultures developed to promote best practice

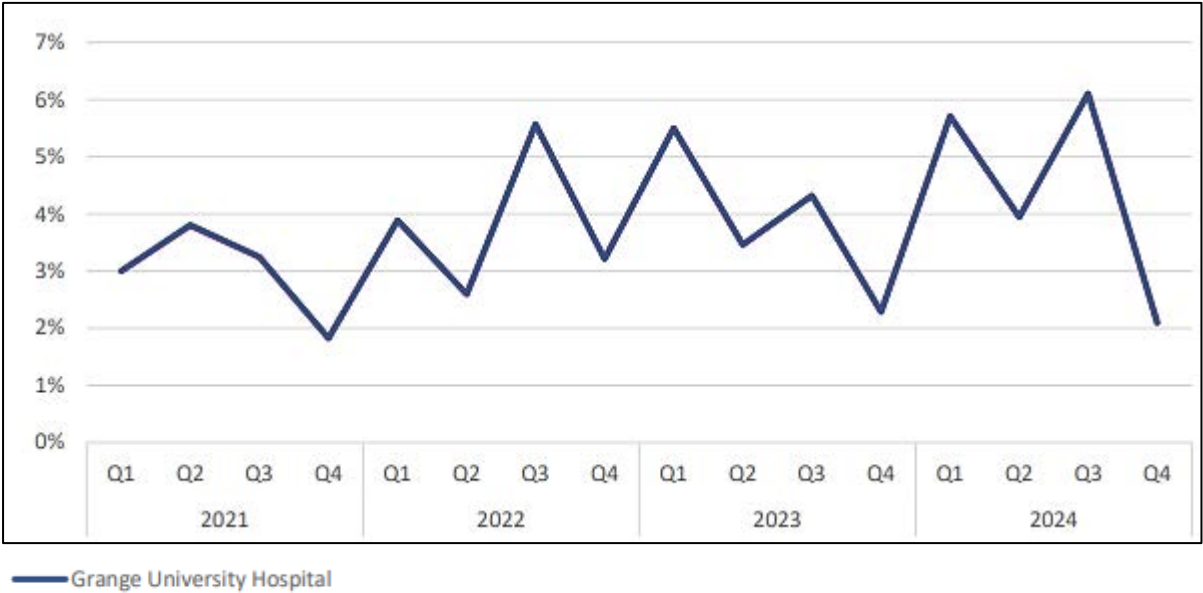
Mortality

Despite the Health Board not achieving a reduction with most Welsh Government goals, the number of mortalities within 28 days of a HAI has been low. Each case of HAI where the causative organism has been cited on the death certificate is subject to a joint mortality review with a Senior Clinician, Microbiology and IPC Head of Service (see NRI update).

Caesarean Section Surgical Site Infections

Surgical site infections (SSIs) are defined to a standard set of clinical criteria for infections, that affect the superficial tissues (skin and subcutaneous layer) of the incision area and those that have affected the deeper tissues (deep incisional or organ space). The Health Board participates in national surveillance for C sections.

Fig. 27: Quarterly rates



The year ended on an 18% increase in SSI’s compared to the previous year.

During this reporting period, a new IT system called BadgerNet was introduced to the maternity division. BadgerNet integrates early pregnancy, maternity and gynaecology services and enables real-time recording of events from pre-conception to postnatal.

Following an all-Wales procurement exercise, another significant change within the Family & Therapies division is the type of wound dressing utilised. Potentially, this change may be contributing to the slight increase in SSI rate and is currently under monitoring and is discussed at the all Wales steering group to establish if other HB are experiencing similar concerns.

To support the SSI reduction, the IPCT have provided face to face training and the directorate have been working on improving patient information and promotion of the SSI pathway. We are delighted that the directorate has also agreed to undertake a quality improvement project in 2025/2026 as a focus area of improvement for reducing surgical site infection.

Carbapenemase Producing Enterobacteriaceae Audit (CPE)

Carbapenem antibiotics are a powerful group of β -lactam (penicillin-like) antibiotics used in hospitals. Until now, they have been the antibiotics that doctors could always rely upon (when other antibiotics failed) to treat infections caused by Gram-negative bacteria.

In the UK, we have seen a rapid increase in the incidence of infection and colonisation by multi-drug resistant Carbapenemase-producing organisms (CPO). Several clusters and outbreaks have been reported in England and Wales during 2024 - 2025, some of which have been contained, providing evidence that, when the appropriate control measures are implemented, these clusters and outbreaks can be managed effectively.

UK Health Security Agency (UKHSA) and PHW CSARO policy recommends that as part of the routine admission procedure, all patients fitting a high-risk category should be assessed and screened on admission for Carbapenemase-producing Enterobacteriaceae status.

National guidance indicated that all patients admitted to critical care or Neonatal unit are screen on admission and weekly for CPO. However, in ABUHB, we take a risk assessed approach to only screen repatriation or known history due to laboratory capacity. It is important to recognise that this group of patients have numerous clinical samples during their stay which would identify CPO if there was a local increase.

Throughout the year, we have identified several patients being positive on admission and one known positive patient who unfortunately was missed as part of admission screening. Contacts of this individual patient, who were assessed as potentially exposed underwent screening and all screening

results returned as negative, indicating no onward transmission. The team has continued to promote CPO screening on admission and now alert to any repats from other HB to support surveillance.

Winter Virus
Covid

Cases of Covid-19 continued to appear in “waves”. The Health Board stepped-down testing requirements and fewer outbreaks were identified during this reporting period.

Fig. 28: Total COVID-19 patient-episodes detected by week (horizontal axis)

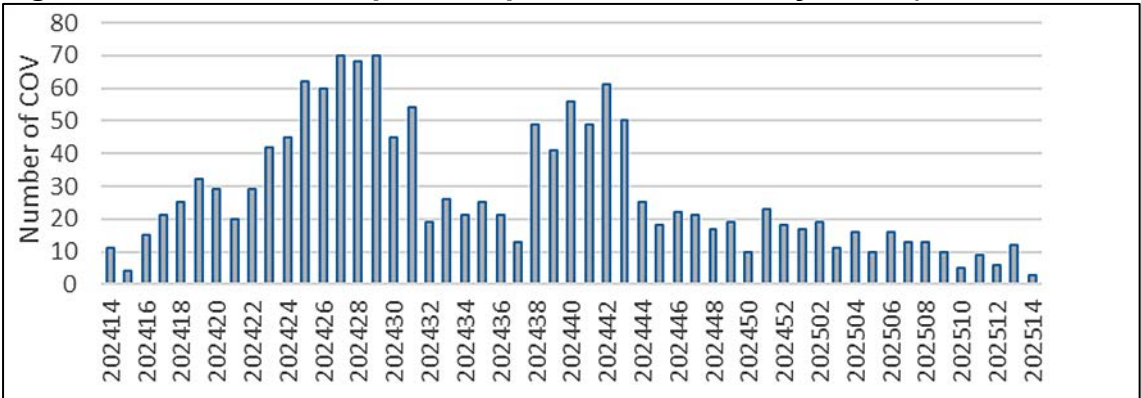


Fig. 29: HCAI rates by Health Board for COVID-19

COVID-19 2024-25fy	Healthboard	All cases	HCAI n	%
	Aneurin Bevan UHB	1446	518	36
	Betsi Cadwaladr UHB	1521	832	55
	Cardiff and Vale UHB	2229	1001	45
	Cwm Taf Morgannwg UHB	1564	961	61
	Hywel Dda UHB	1173	547	47
	Swansea Bay UHB	1264	686	54
	Wales	9197	4545	49

Influenza

Influenza seasonality has returned to expected trends following disruption during the COVID-19 pandemic. Positively, this year is comparable to the previous two seasons.

Activity increased from week 45 of 2024 and peaked between weeks 1 and 2 in 2025. Influenza A dominated, with influenza B causing a longer tail of declining activity.

Fig. 30: Weekly count of specimens testing positive for influenza among residents or inpatients in ABUHB, across the last 3 seasons (seasons shown from week 39 to week 40)

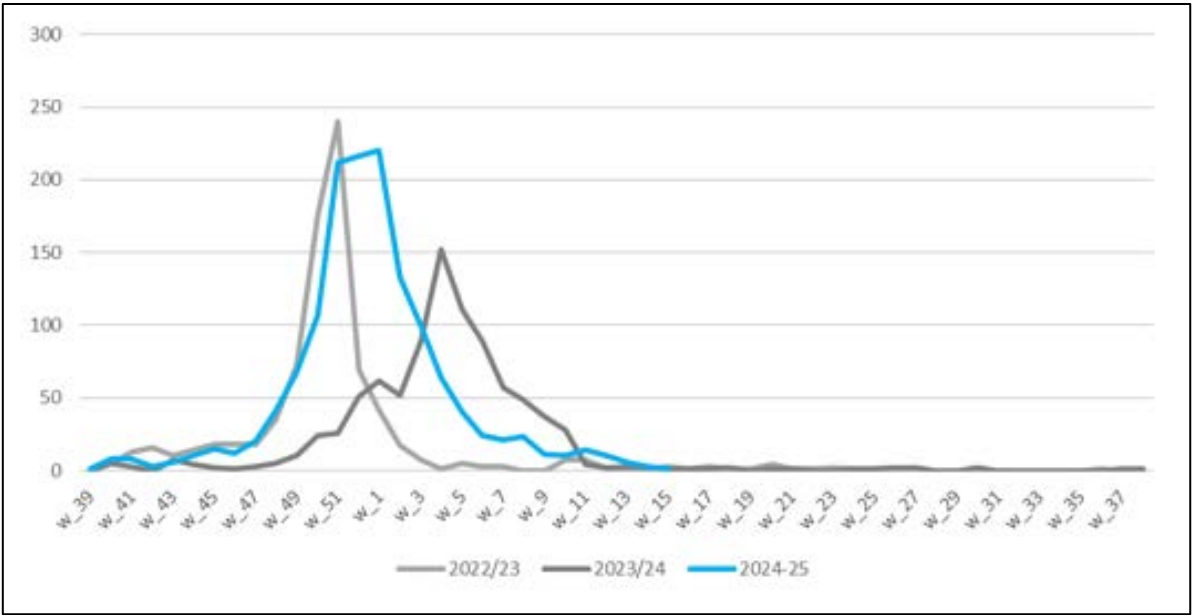


Fig. 31: HCAI influenza cases by HB from 2024 week 40 to 2025 week 15

INFLUENZA	Healthboard	All cases	HCAI n	%
	Aneurin Bevan UHB	1622	159	10
	Betsi Cadwaladr UHB	957	231	24
	Cardiff and Vale UHB	1555	269	17
	Cwm Taf Morgannwg UHB	765	289	38
	Hywel Dda UHB	891	253	28
	Swansea Bay UHB	807	293	36
	Wales	6597	1494	23

Respiratory syncytial virus (RSV)

RSV episodes in ABUHB increased around week 38 of 2024, peaking at week 48. Cases in children aged 5 and under then decreased. However, older age groups saw increases post-week 48, which declined by week 04 of 2025.

Fig. 32: Weekly count of specimens testing positive for RSV among residents or inpatients in ABUHB, across the last 3 seasons (seasons shown from week 39 to week 40)

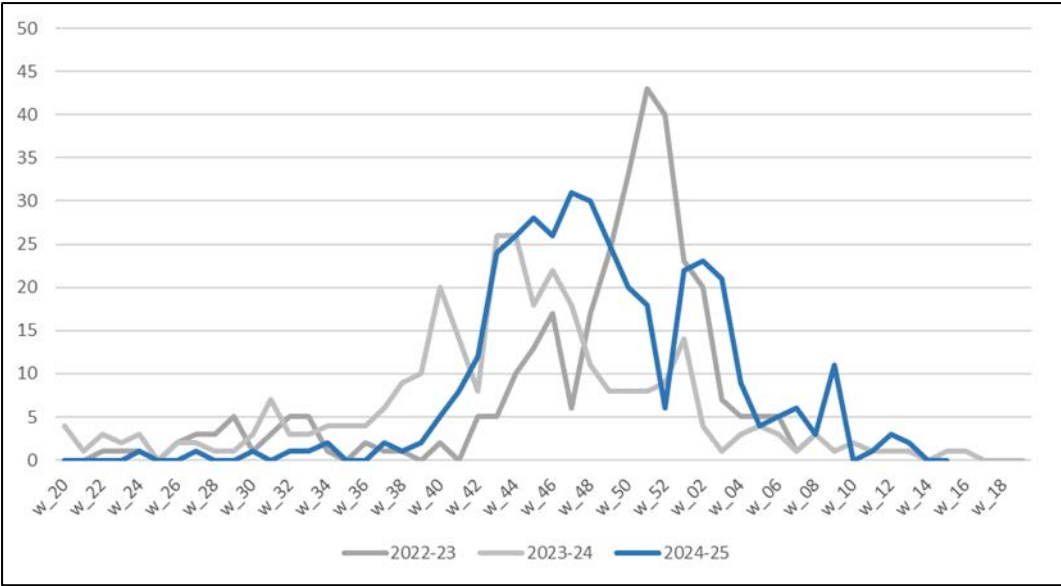


Fig 33: HCAI RSV cases by HB from 2024 week 40 to 2025 week 15

RSV	Healthboard	All cases	HCAI n	%
	Aneurin Bevan UHB	369	139	38
	Betsi Cadwaladr UHB	478	106	22
	Cardiff and Vale UHB	622	116	19
	Cwm Taf Morgannwg UHB	541	99	18
	Hywel Dda UHB	272	66	24
	Swansea Bay UHB	358	120	34
	Wales	2640	646	24

During the pandemic, the Health Board followed national PPE and IPC guidelines to protect staff and reduce hospital transmission, despite challenges like infrastructure, community restrictions, and declining vaccination rates. Point of care testing in emergency departments and assessment units quickly identifies pathogens within 20 minutes. If results are negative for Covid or influenza, teams assess RSV risk according to national guidelines, which may be a contributing factor to the number of hospital-acquired RSV cases.

Influenza Vaccine

The Welsh Government aims for a 75% uptake target for all eligible adults. ABUHB staff have been immunised by flu champions, Occupational Health, or at vaccination centres. Some staff have reported receiving the flu vaccine from their GP, pharmacist, or other locations outside ABUHB.

Fig. 33: Breakdown of staff vaccinated

Staff Group	Denominator	No. Vaccinated	Percentage uptake

Additional Prof Scientific and Technical	498	196	39.4
Additional Clinical Services	3371	1163	34.5
Administrative and Clerical	3105	1239	39.9
Allied Health Professionals	1064	429	40.3
Estates and Ancillary	1412	410	29.0
Healthcare Scientists	280	132	47.1
Medical and Dental	922	351	38.1
Nursing & Midwifery Registered	4544	1776	39.1
TOTAL	15196	5696	37.5

Fig. 34: Divisional Breakdown of vaccination

Division	Denominator	No. Vaccinated	Percentage uptake
Clinical Support Services	1683	719	42.7%
Continuing Health Care / Complex Care	294	146	49.6%
Corporate Workforce & OD	1333	585	43.8%
Family & Therapies	2708	1094	40.3%
Medicine	1986	604	30.4%
Mental Health & LD	1549	389	25.1%
Primary & Community	1889	687	36.3%
Surgery	1735	790	45.5%
Urgent Care	506	225	44.4%
Facilities	1513	457	30.2%
TOTAL	15,196	5696	37.5%

The Health Protection Team aimed to confirm that all staff were offered a flu vaccination, and their responses were recorded for future planning.

- a record of their vaccine recorded onto WIS
- a completed 'had elsewhere form' if they have had their vaccine with their GP or community pharmacy
- a completed 'no thank you' form if they do not wish to have the vaccination.

Outbreak Management

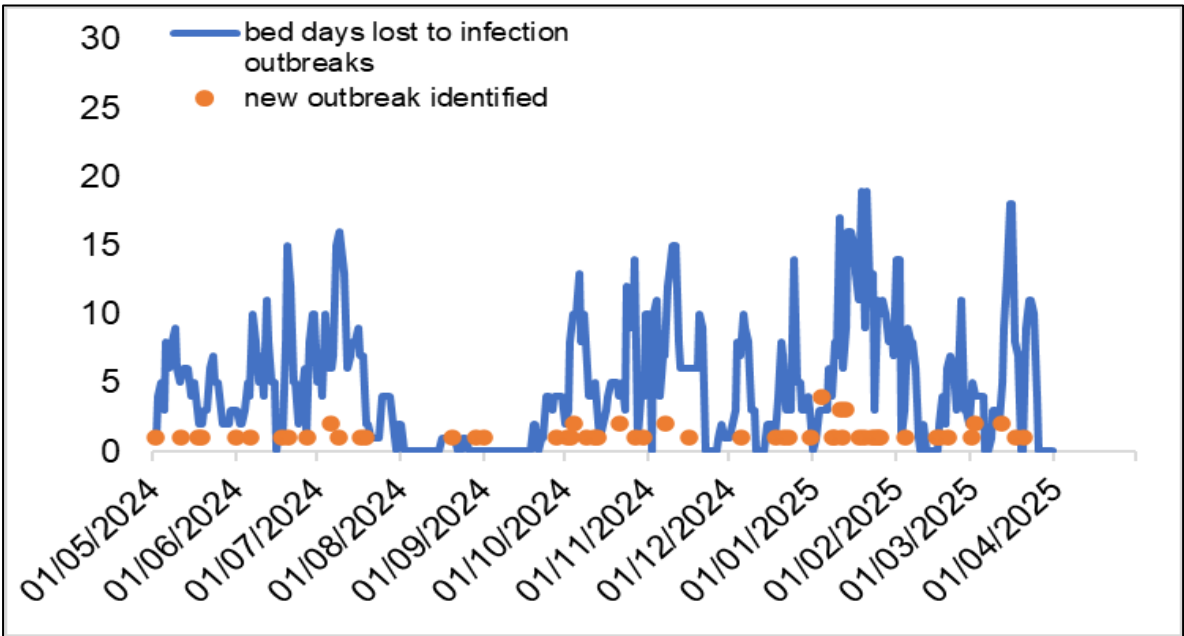
An outbreak is an incident in which at least 2 or more people are affected by the same infectious disease and are linked by time, place, or common exposure (a greater than expected rate of infection compared with the

usual background rate for the place and time where the outbreak has occurred).

The Health Board experienced a significant rise in Norovirus cases this year, along with ongoing Covid-19 and influenza. These outbreaks have substantially impacted healthcare. The IPT collaborated with the Communications team to encourage unwell individuals to avoid healthcare settings or stay isolated from others.

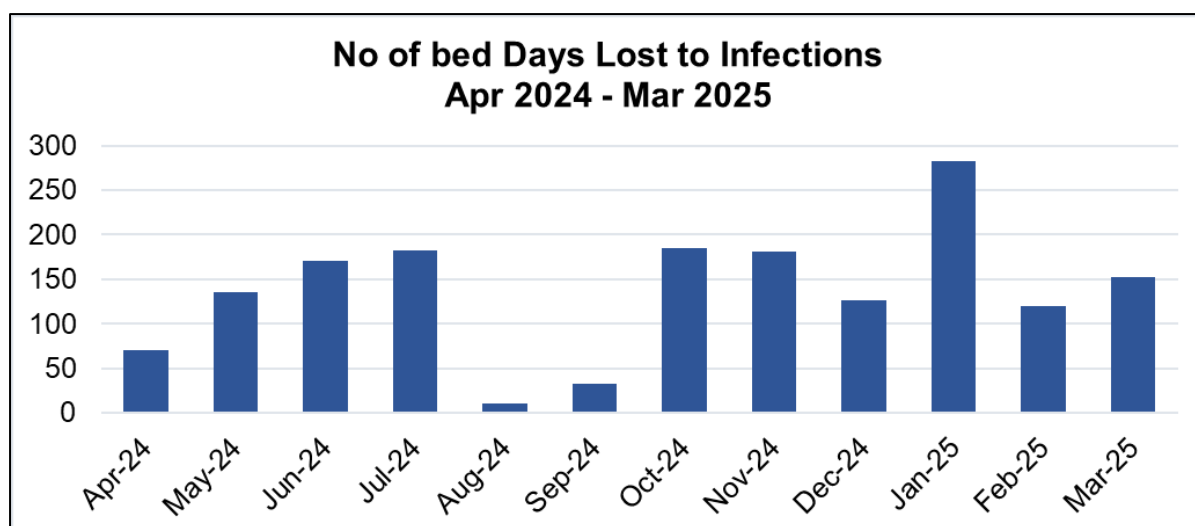
Staff education on the importance of hand hygiene, cleaning of frequently touched areas, and promoting immunisation, which has seen poor uptake both nationally and locally during this reporting period.

Fig. 35a: Bed days lost due to infections including Covid, Norovirus and CDI



The graphs illustrate the significant number of bed days lost due to infections including Covid-19, Norovirus, and Clostridium difficile. It highlights the impact these infections have had on healthcare services, reducing available bed capacity and necessitating robust outbreak management strategies.

Fig. 35b: Monthly total of bed days lost



Infection Prevention and Safety Flow

Prompt isolation of patients with suspected or confirmed infection is essential to reduce transmission. Limited isolation capacity at Royal Gwent, Nevill Hall and some community hospitals means that patients may wait for a single room. To improve availability, isolation rooms must be used appropriately. To support this assessment the IPCT collaborated with the operational team, enabling staff to identify isolated patients and reasons using functionality at bed request, allocation, or movement. Patients in isolation are reviewed every 24 hours with ward teams.

Decontamination

Decontamination is the combination of processes (including cleaning, disinfection and sterilisation) used to make re-usable equipment safe for further use on patients. Effective decontamination of re-usable equipment is essential in reducing the risk of transmission of infections.

Decontamination Operation Group aim: -

- Ensuring compliance and monitoring for the delivery of the Health Board Decontamination Action Plan
- Ensuring compliance with the Quality and Safety Framework and certifying that care meets the six domains of quality; care that is safe, effective, patient-centred, timely, efficient and equitable
- Gaining assurance on the Health and Care Quality Standards 2023 doing the right thing, in the right way, in the right place at the right time and with the right staff
- Receiving organisational learning reports from investigations
- Adhering to Health Technology Memoranda (HTM) and Decontamination standards

Fig. 36: Table outlining decontamination activity

Issue	Cause	Remedial Action	Who	When
Community Dental Service washers & autoclaves have not been serviced or tested indicating non-compliance with required WHTM 01-05 standard.	Lack of works and estates staff to undertake the role and their focus on other decontamination testing, eg HSDU.	All Wales Authorised Engineer (Decon) AE(D) aware. Works & CDS have an agreement on release of monies for band 5 Works personnel to undertake dual role including CDS.	Works & Estates lead. CDS Directorate.	30th April 2025
The centralised endoscopy unit project build at the Royal Gwent Hospital (RGH) has commenced with 'first stage' works. The interim decontamination unit had to vacated.	An electrical overload occurred in the interim unit leading to unsafe ventilation and peracetic acid monitoring failure.	Scopes diverted to GUH HSDU and local support for scope decontamination at RGH Urology dept and theatre. Await outcome of Neqis and Getinge findings.	HSDU facilities with contingency plan. Endoscopy Directorate	7th March 2025
Endoscopy YYF achieved amber rating on Joint Advisory Group (JAG) audit undertaken by AE(D) for JAG accreditation and still seek JAG accreditation by 2nd April 2025.	Identified significant progress with works & estates input. Electronic track & trace (T&T) indicated requirement for green rating.	Ward staff have been trained in and undertake weekly testing for EWDs by Authorised Person (D) (APD). Accepted by AE(D) Wales. T&T should be in place by mid-March. Awaiting report to decide JAG accreditation.	Directorate manager & Senior Nurse	2nd April 2025

AP(D) role not fully functioning from a governance aspect.	Lack of AP(D)s and decontamination works trained staff. Remains under review.	An operative decontamination staff member is near completion of AP(D) role therefore supporting the works decontamination strategy.	General Manager Facilities / Works & Estates	10th April 2025.
Urology department in RGH local decontamination unit environment not fit for use.	Significant damp and poor ventilation contributing toward fungi growing on low level walls.	Immediate closure of the unit by decontamination manager on advice by AP(D). Works & Estates remedial works to be undertaken and completion for fit for use.	Directorate local staff. RGH works lead.	31st March 2025
Risk of losing automated decontamination process for US probes in Radiology Units.	Trophon 1s HPV probe disinfectors are obsolete.	Replacement programme within Ultrasound directorate to be finalised by Directorate lead for Radiology.	Ultrasound Lead	31st March 2025

Cleaning Standards

Fig. 37: Health Board compliance with Cleaning Standards 2009

Standard	Fully Compliant	Partially Complaint	Non-Compliant	Current Position	Next Steps	Estimated Completion Date
Management of environmental cleanliness HBs can demonstrate clear management arrangements for environmental cleanliness, linked to corporate and clinical governance.				• Environmental cleaning audit scores are sent to management monthly • Divisional cleaning service group • Roles and responsibility of all cleaning elements within healthcare setting has been developed	• Health Board cleaning standards group • Review facilities operative current job descriptions • Currently consulting with all supervisors of change to job descriptions/roles & responsibility • Development of KPI for cleanliness for each individual site	5.4.25 31.5.25 30.6.25 30.6.25

Local cleanliness strategies A consistently high standard of environmental cleanliness is delivered in all HBs.				• First draft of operational standard operating procedures has been developed for each cleaning process and elements • First draft of Cleaning Policy	• All standard operating procedures sent for comments/review by cleaning group. • Review and send Cleaning Policy for approval	30.4.25 15.5.25
Involving and listening to patients Patient views on cleanliness are integrated into the planning, implementation and monitoring process.				• Civica is developed for ward feedback which includes cleaning. • There have not yet been any facilities surveys developed for patient feedback.	Review how facilities department can develop Civica surveys specifically for cleaning services and collate meaningful data.	30.7.25

Standard	Fully Compliant	Partially Complaint	Non-Compliant	Current Position	Next Steps	Estimated Completion Date
Education and development Staff are trained to undertake their duties in ensuring that the cleanliness standards are met.				- Cleaning auditing team supporting with the training and development of new and existing staff, non -compliance audit areas are being managed with support of one-to- one training. - Competency booklet created for staff to be signed of as competent to undertake all cleaning tasks.	- A new onboarding and training facilitator role has been developed as part of the supervisor and administration consultation paper and project plan has been developed for a centralised induction programme for new and existing staff - Review to ensure all staff have appropriate and working equipment	30.9.25 30.6.25

Risk-based analysis for service provision - The most appropriate cleaning methods and frequencies are applied to specific functional areas within healthcare facilities				• Every cleaning area has been reviewed with the correct functional risk identified and Synbiotix updated • Review and updating of cleaning schedules is being undertaken for all ward areas for RGH, CCH and MVH. ED at GUH	• Review & updating of all ward cleaning schedules • Review of all other departments cleaning schedules. • Assess all cleaning hours for each area to identify any shortfalls in being able to achieve cleaning frequencies cleaning standards	30.7.25 30.10.25 30.11.25
Facility management HB - owned buildings and fixtures are maintained to an acceptable condition to enable the effective and safe cleaning				• All W&E calls are logged either by the departments on an ongoing basis • The cleaning audit team log all jobs with W&E as and when failures present themselves	• Ongoing monitoring and review of calls logged	Ongoing

of the patient environment				during environmental audit		
Monitoring of cleaning outcomes The standard of cleanliness of the healthcare environment is assessed by both internal and external audit				• Audit team are auditing very high and high areas monthly. • Audit scores have improved since the last annual meeting, but not all areas are reaching All Wales guidance targets.	• Action/improvements plans are developed for each area that fails to reach audit compliance score for the functional risk in line with standards. Action plans will be shared at divisional cleaning group. • New supervisor JD includes internal monitoring of areas	Ongoing 30.9.25

Overview of Synbiotix

Synbiotix, an integrated Facilities management system that has an environmental audit element, was operational and self-managed until August 2024. At this point, Facilities appointed a Systems Manager. Following this appointment, a comprehensive review of the software was conducted, which included a thorough examination of all components, adjustments to various areas, reassessment of risk ratings, updates and renaming of departments, user evaluations, and the establishment of access processes.

This initiative aims to facilitate precise monthly audits across all high-risk and very high-risk areas, supported by a dedicated audit team tasked with assessing all Facilities and nursing tasks, relating to environmental cleanliness. A monthly environmental report that details our findings, with particular emphasis on areas failing to meet established standards is generated and distributed.

This report is circulated throughout the health board, enabling us to pinpoint recurring problems and develop action plans to enhance underperforming areas. Such plans may involve staff training, equipment upgrades, the introduction of new communication protocols, evaluation of cleaning durations, and consideration of individual needs in partnership with the nursing team. Furthermore, domestic staff are now incorporated into the audit process to help identify common deficiencies impacting both teams. New Standard Operating Procedures (SOPs) have been created and implemented in several areas, while others await review by the health and safety team prior to implementation, in line with established protocols. All performance relating to environmental cleanliness is now tracked via the Estates & Facilities Divisional Cleaning Group (Operations) and the organisational Cleaning Standards Group (Strategic). Both groups, chaired by the Head of Facilities, identify and implement recovery plans to maximise cleanliness performance.

Water Safety

The Estates Team are responsible for maintaining the Health Boards water systems across the main hospital sites and satellite properties and reporting their status to the Water Safety Group (WSG), Infection Prevention and Control and Antibiotic Stewardship group. Provisions for water safety are independently tested by experts within augmented care areas and supported by the Health Board Authorised Expert for water safety.

During the year the Health Board identified areas on high counts within Augmented care areas and the following actions was implemented: -

- Education for cleaning a sink and flushing of water
- Filters applied
- Additional flushing with documentation
- Chlorination

Ventilation

Ventilation is key to the prevention of infection and there is evidence for the role of air within a wide range of pathogens: -

- Airborne transmission of communicable diseases i.e Respiratory infections – Tuberculosis measles, influenza, Covid-19
- Airborne transmission of opportunistic pathogens i.e Vulnerable patients (e.g. Cystic Fibrosis) – pseudomonas, aspergillus, pneumocystis, legionella
- Airborne dispersion of HAIs i.e MRSA, C Diff, norovirus, CPE

The Estates team continue to carry out routine inspections and maintenance on all ventilation systems, and formal validations on all Theatre and Critical Areas in compliance with Welsh Health Technical Memoranda (WHTM) 03-01 Part B and carrying out the remedial work where required. Following an annual verification report, there was an area of concern highlighted within theatres due to the flow rate and air tubes caused by the aged estates, remedial work has been undertaken to reduce the risk whilst business cases for general upgrade is being actioned and limited assurance has been gained.

Audits

Audit is a key component of IPC. The assurance provided by audit is vital to delivering safe, quality patient care. There is an extensive standardised IPC audit plan across all sites within the organisation. All audit tools and schedules have been reviewed and updated for the year and include inpatient and outpatient areas plus the wider community such as care homes. The infection prevention team has continued to audit practice across the Health Board based on the Infection Prevention Society audit tool; all data is captured on Audit Management and Tracking (AMAT).

Fig. 38: Audit activity

Type of audit	Number undertaken	6-monthly average compliance
Isolation Precautions	25	92%
Hand Hygiene Audit	74	92%
IPAC Dashboard	61	87%

Ward Accreditation Dashboards	72	91%
Peripheral venous catheter bundles	28 wards (200 patients)	77%
HOUDINI	15 wards (67 patients)	82%

Themes for learning from audit

- Documentations
- Compliance with fundamental infection prevention measures i.e. PPE and hand hygiene
- Decontamination/environmental cleanliness
- Estates

Care Home Audits

The IPCT visited 57 Care home establishments to offer support, guidance and recommendations around infection prevention measures. It is important to note that care home visits are voluntary and some have declined an infection prevention visit.

Training

An IPC eLearning package meets national requirements. It is a Health Board requirement for all patient facing clinical staff to complete their training every 12 months. The IPCT offer classroom training, attendance via Micro Soft Teams and various bespoke training sessions. They also participate in medical student and doctor training. This year, the team conducted several webinars to promote infection prevention and developed a quarterly newsletter.

Fig. 39: Number of staff trained by division during financial year 2024/25

DIVISION	NUMBER OF STAFF TRAINED IN FY 24/25	% COMPLIANCE WITH 12 MONTHLY TRAINING
Clinical Support Services	34	82.98%
Family & Therapies	185	87.06%
Medicine	163	81.36%
Mental Health & LD	23	83.44%
Primary & Community Care	140	88.48%
Surgery	53	78.09%
Urgent Care	11	80.93%
Facilities	101	74.26

Link Champions & Campaigns

A robust group of IPC Link Champions is now established across the Health Board, including Primary and Community Care. The IPCT organised workshops and an annual study day, which have received support from clinical areas to ensure the Link Champions can attend these sessions. These Link Practitioners could prove to be invaluable resources in the event of a pandemic resurgence or a new infection outbreak. The sessions were described as highly informative and interactive, fostering confidence among participants.

Infection Prevention & Control Week – October 2024

During 'International Infection Prevention and Control Week,' the IPT featured daily themes and hosted an infection prevention link champion day. The goal was to enhance staff knowledge and raise awareness of IPC practices across the Health Board.

The IPC Practice Educators refreshed the Infection Prevention Link Champion scheme establishing monthly meetings via Teams to share knowledge, expertise and experiences.

World Hand Hygiene Awareness Day – May 2024

During world hand hygiene day 2024, the IPCT visited various clinical areas and care homes to promote best practice for hand hygiene. This included promoting correct use of gloves, bare below the elbow and increasing the number of staff who can undertake hand hygiene audits. During the week, the IPCT made daily visits to wards and departments, utilising the hand decontamination demonstration unit to improve hand hygiene technique. They also assisted staff in conducting hand hygiene audits as part of the continuous review process and staff engagement concerning IPC best practices.

Gloves Off Campaign

The Gloves Off campaign was launched in 2024. There is now a period of review which includes looking at the number of gloves used currently compared with the numbers from the previous year. In addition, a 'glove use' audit will be conducted to verify if there has been an improvement in practice. The IPC team are keen to widen this out across the organisation whilst sustaining standard precautions and transmission precautions.

Aseptic Non-Touch Technique (ANTT)

Aseptic non touch technique (ANTT) also contributes to exemplary venous access. Mandatory training and assessment are ongoing, with good compliance by nurses, but the Health Board is struggling to engage medical colleagues. This is an all-Wales requirement and is a recommendation from Welsh Government who advocated this is a must for all professional groups. Compliance is monitored via the Divisional highlight reports at the IPAS group.

Face Mask Fit Testing

Fit testing numbers have declined over the past two years despite numerous offers to staff. As the pandemic eases, it remains a legal requirement for staff to undergo fit testing, especially when wearing respiratory protective equipment (RPE) like Filtering Face Pieces (FFP). Health & safety legislation mandates that wearers of RPE must be fit tested. However, fewer staff are participating in fit testing.

The organisation currently has 216 mask trainers, with 14 attending training for the year 2024/2025. Maintaining this resource is crucial as it is a Health & Safety requirement to protect the workforce. The Health and Safety team has raised this issue in the IPAS group meeting, receiving support from divisional leads. This matter will remain a priority for the Health and Safety and Infection Prevention Team, particularly considering emerging pathogens, offering assistance to community and secondary care settings.

Quality Improvement (QI) Project

The IPCT are actively working on two Quality Improvement (QI) projects (see driver diagrams below) aimed at reducing the risk of hospital onset of C difficile and hospital acquired pneumonia. To build on this resource and ethos, each Division has been requested to undertake a QI project supported by the IPCT.

Fig. 40: CDI QI project driver diagram

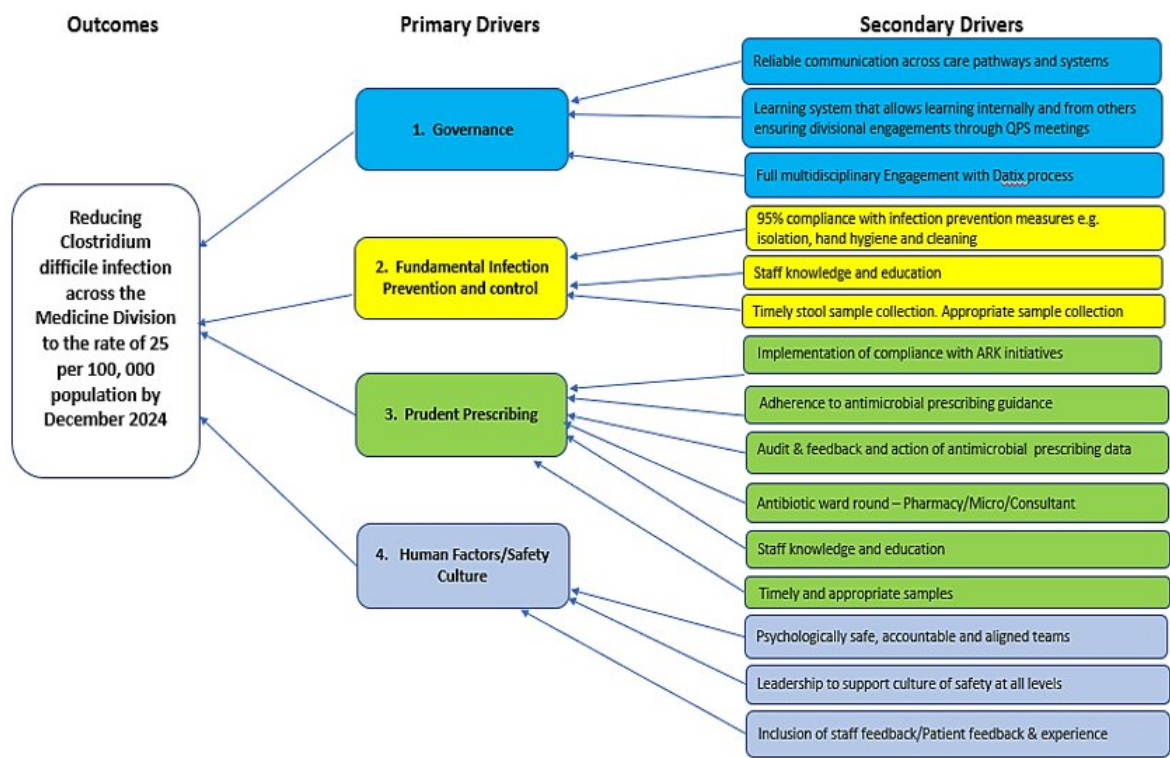
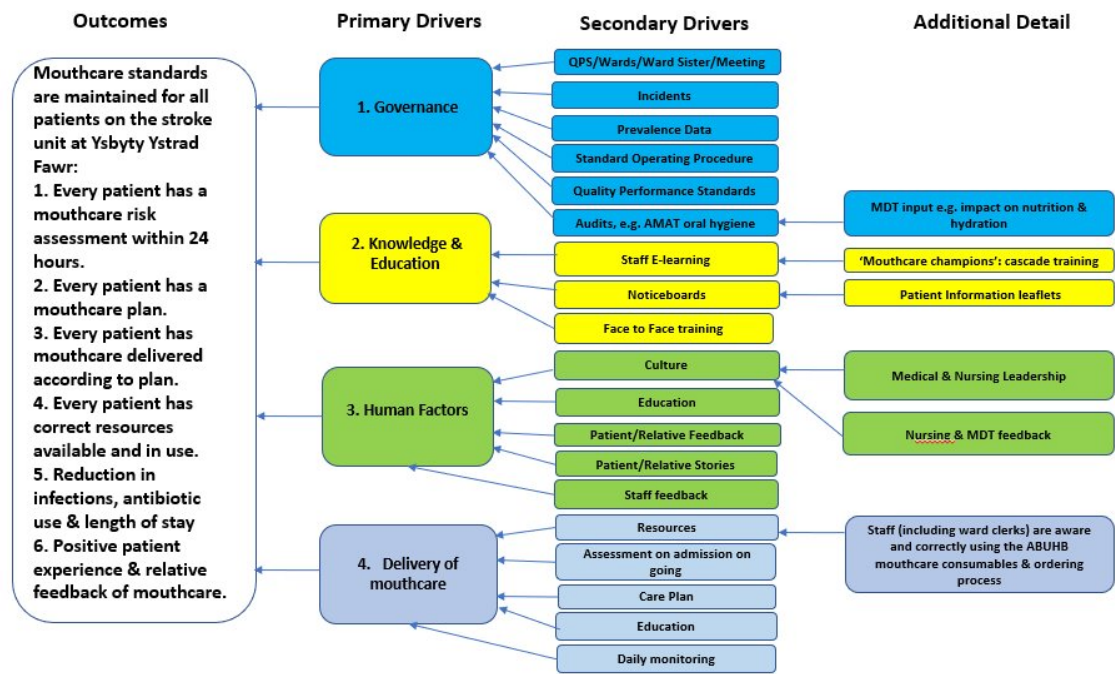


Fig. 41: Mouthcare QI project driver diagram



Patient Information

The staff intranet IPC information pages were refreshed in 2024, with regularly updated information. External links for infection guidance,

including MPOX, measles, and shingles, have been added. Staff can download various patient information leaflets.

The IPC intranet webpage provides staff with a host of resources including:

- IPC policies
- Posters and guidelines
- Care Plans
- Details of IPC education and training
- Templates for IPC ward audits
- Decontamination/cleaning information
- Contact details of the members of the IPC team
- Newsletters

The IPCT work closely with the communications department to disseminate information across the Health Board, including visiting guidance which is available on the internet alongside general IPC information.

Infection Prevention and Control Policies

The Health Board has a range of IPC policies in place to support the prevention, reduction and control of risks of infections in line with, national guidance and Infection Prevention code of practice 2014 as best practice. IPC policies undergo a review process every one to three years to maintain their relevance and accuracy. Updates are made promptly, when necessary, such as in response to changes in national guidance. All IPC policies are approved by the medical microbiologist and deputy IPT, with final ratification by the IPAS Group.

During 2024/25 the following IPC Policies and standard operating procedures were reviewed, updated and finally ratified by IPAS group:

- Blood Bourne Virus
- Flea
- Varicella zoster virus policy
- Ectoparasites Scabies
- Faecal microbiota transplant policy
- SOP Mobile Handheld device
- SOP Restricted Bed Movement
- Sharps and Splash Injury Policy
- Major Outbreak Plan
- Ectoparasites (Lice)
- Managing Seasonal Influenza
- Standard Precautions & Source Isolation policy
- Microbiology support for Infection Prevention
- Works & Estates Infection Control in the Built Environment

Sustainability Projects

The IPCT has collaborated with other teams to implement sustainability projects that are either cost-neutral or cost-saving. Examples include the removal of blue couch rolls, standardisation of MRSA screening, and trials of reusable drapes and theatre hats.

High Consequence Infectious Disease (HCID)

The Health Board has an HCID group that meets monthly and maintains the HCID protocol. Two members have attended Personal Protective training in Sheffield, a recognised centre of excellence. Currently, the Health Board is awaiting PPE trolleys to be delivered from Public Health Wales to implement the new training. Meanwhile, the Health Board continues to train staff on the previously agreed PPE. The next steps include updating this change within the Health Board policy.

National Reportable Incidents

Not all outbreaks or incidents are required to be reported as a national reportable incident. Outbreaks are reported if the incident has resulted in in bed days lost or a death associated with the causative organism has occurred within 28. The table below displays incidences that have been subject to a national reportable incident.

Fig. 42: Description of infection prevention related national reportable incidents

Issue	Cause	Remedial Action
Ward closures due to outbreaks: - Covid = 4 Influenza = 3 D&V = 14	• Poor ventilation • Symptomatic visitors • Shared facilities • Lack of isolation facilities	• Promoted IP safety measures including opening windows where possible • Enhanced cleaning of frequently touched areas • Visitors' notices • Introduced mask wearing for a brief period resulting in fewer staff becoming affected • Risk assessed staff working with symptoms • Rapid isolation/cohort of affected patients
Measles	Child not isolated in assessment unit, did not present with typical measles	• Staff training and education • Reviewed screening criteria at triage • Outside triage implemented • Mask fit testing

Increased incidence of CDI = 2	• Poor compliance with fundamental IP • Antimicrobials outside of guidance • Patients not isolated when symptomatic	• Education • Decant deep clean using HPV • Ward audit for antimicrobial prescribing • Exposed patients monitored for symptoms
Group A exposure = 2	Patient not isolated on admission or when become septic	• Prophylactic antimicrobials administered • GP informed of discharged patients • Exposed patients monitored • Staff referred to Occupational Health • Reminder of ANTT • Patient Information leaflets
Scabies outbreak	Husband and wife admitted with rash not isolated	• Contacts of patients and staff given Prophylactic treatment within a 24-hour window • All bedding changed • Promotion of transmission precautions
HAI Mortality CDI = 4 Covid = 31 Influenza = 4	Death within 28 days of positive result where causative organism is cited on the death certificate Existing co morbidities Environmental constraints	• Patient pathways reviewed • Cohorting of patients on like for like • Alert for exposed patients • Promotion of fundamental IP • Prudent prescribing • Promotion of face coverings over high prevalence
MRSA breach of ring-fenced orthopaedic ward – C7W (all potentially exposed patients negative)	Patient admitted and positive result not acted on. Patient was PCR positive culture negative	• Elective orthopaedic surgery ceased for a period • All inpatients screened • Discharged patients screened • Ward deep clean

Critical Incidents

Fig. 43: Unexpected patient safety events that have been investigated by the IPCT

Issue	Action Taken	Learning & Improvement	Responsible Officer	Timescale
Staff member with TB	- Contact tracing undertaken to identify at risk staff & patients - Warn & inform letters sent to staff - No at-risk patients – no action taken due nature of patient group	- Staff member known latent TB - Risk of onward transmission low due to symptoms displayed whilst on duty	IPT OH Respiratory team Directorate	Ongoing
TB positive patient attended AMU and C4E – not isolated	Contact tracing undertaken to identify staff & patient exposure	Timely isolation with known risk factors	IPT OH Respiratory team Directorate	Ongoing
Major drain blockage affecting the pipework servicing C and D block. Impacted on public access to MAU, GP out	- Entrances closed & patient re-directed - Specialist drainage company resolved incident	- Ensure infection prevention are informed of planned works - Communication to key stake holders - Support via emergency preparedness	Estates	Ongoing

of hours and Urology.				
Exposure to shingles in Sexual Health Clinic	• Contact tracing undertaken to identify at risk staff & patients • Staff exposed gave a history of VzV (immunity)	• Timely isolation	Directorate	Resolved
Care homes scabies outbreaks	• Support and advice, education, treatment plans, contact tracing	• Wearing of PPE, access to prophylactic treatment	IPT, care home teams, EHO	As required

Review of Priorities for 2024/25

Priority	Progress	Analysis for progress
1. Review the proactive enhanced cleaning strategy with facilities as decant wards are unavailable and there are constraints on capacity to ensure patients are cared for in a clean environment.		Aimed to implement an opportunistic deep clean however noting some slippage due to capacity constraints at GUH and YYF.
2. Develop the business case for infection prevention team with an overall aim to support sustainability/succession planning and reduce health care associated infection across the Health Board		Was not required as gained Regional Integration funding for until March 2027
3. Undertake a quality improvement work for the reduction of health acquired infection based on surveillance findings.		Implemented tools available on intranet
4. Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection and have the education knowledge and tools.		Implemented via face to face or E learning. Hand hygiene campaign Link Champions Webinars
5. Actively support other specialities in their business cases for reduction of healthcare acquired infection.		As required supported several new builds in primary care and satellite unit at NHH
6. Develop systems to manage and monitor the prevention and control of surgical site infection. These systems use risk assessments, mapping the patient's pathway within secondary and primary care maximising the use of ICNet. This is dependant on an all-Wales process and		Unable to progress due to the all Wales development and interface with Ormis theatre IT system. Team have linked with internal IT and is on the Health Board agenda.

interface with theatre IT systems		
7. Upscale audit & feedback cycles in high antibiotic-prescribing GP practices, focusing on those with high volume and high use of higher-risk '4C' antibiotics.		Two pharmacists now undertaking audit & feedback cycles, although progress limited by an episode of long-term absence
8. Align Health Board antimicrobial stewardship action plan to the new UK 5-year Antimicrobial Resistance National Action Plan, due to be published May 2024.		Updated action plan in place, with progress against new targets being made in primary care by FYE
9. Environmental cleanliness - develop local strategies and focus on education. Review service accordingly to any new published national standards.		Awaiting new standards to be published Operation delivery review in progress

Key Achievements

Although the IPCT did not meet the Welsh Government reduction expectation goals, it continued to process a high number of microbiology results, maintain a comprehensive surveillance system, and respond promptly to periods of increased incidence and critical incidents.

During the 2024/25 period, the Hospital Board consistently managed the challenge of accommodating additional capacity. The IPCT facilitated patient flow by conducting rapid risk assessments to safely allocate patients and minimise the transmission of infections.

The IPCT modernised their approach to delivering teaching, arranging webinars on various topics. The sessions were attended by staff across the HB reaching out to care homes & GP surgeries.

The IPC Strategic Plan 2025/26, as outlined below, describes the strategies by which the IPCT intends to implement improvements.

Conclusion

This report outlines the activities of the IPCT over the 2024-25 period, in accordance with the quality framework 2022 criterion. The elimination of avoidable healthcare-associated infections remains a priority for NHS Wales and the Health Board. The IPCT faced numerous challenges this year,

primarily addressing ongoing respiratory infections, an increase in CDI cases, and meeting Welsh Government reduction targets, along with managing the impact of Norovirus during winter. The work of the IPCT is unpredictable, and the dedication and efforts of the team throughout the year are noted, especially whilst experiencing high sickness absence.

The overview highlights areas for ongoing improvement to ensure the safety of our patients and staff. Our infection control standards are upheld by clinical and therapeutic staff, as well as our facilities teams including caterers, cleaners, porters, volunteers, estates teams, and laboratory colleagues at ABUHB.

Infection Prevention is dependent on teams working together to deliver high standards of practice and cleanliness, and to maintain safe systems of working throughout our health and care system. We appreciate the hard work, commitment, and support across the Health Board throughout this challenging year.

The Health Board is dedicated to preventing and reducing the incidence and risks associated with HCAI. We recognise that further improvements can be achieved through continuous collaboration with colleagues, patients, service users, and carers. Together, we aim to develop and implement a wide range of IPC strategies, quality improvement projects, and initiatives to ensure clean, safe care, with the ambition of eliminating avoidable infections.

IPC Strategic Plan 2025 – 2026

The outline of the Infection Prevention Programme of Work has been developed (Appendix 1). The Team’s aim is to provide a service that supports our clinical teams working across the health and care system to deliver safe clean care. Infection Prevention and Control will continue to be a high priority for the health board and the Infection Prevention and Control Teams have set out an ambitious but flexible programme of work over 2025/26. The Health Board acknowledges that there is further work required to improve the infection rates and reduce the risk of health acquired infection. As a Health board, it is important that we continue to adapt and enhance the services we offer to meet the needs of patients and service users.

Priorities	Action
Review and refresh current process for undertaking RCA/questionnaires for MRSA/MSSA/C.diff/GNBSI	• Work with patient safety team, clinical teams and national reps to review current process • Develop resources to cascade through the Educating &

in consideration of the Health Board increase	Recommendations After Significant Events (ERASE) • Shared learning and improvement • Support measurement focussed QI projects according to data
Review and update the infection prevention and decontamination intranet site	• Assess current content • Update to ensure in line with national guidance/legislation/HB practice
Participate in National audit for decontamination	• Review audit tool • Undertake a GAP analysis for assurance • Updates to be provided to Decontamination organisational group
Develop business case to secure a permanent Community Infection Prevention service (currently supported by regional integration Fund (RIF))	• Link with PHW team • Ensure that training and development opportunities are available, including developing applied research skills • Develop systems to ensure internal and external recognition for our team • Continue to develop resources to support the mental and physical health of our team
Ensure that all policies/protocols are up to date and include alignment where appropriate to the National Infection Prevention and Control Manual implementation	• Policy tracker to be developed and presented at monthly team IPC meeting • Update policies as expire to conform where appropriate with NIPCM • Develop an escalation protocol in collaboration with PHW team
Use of audits to improve practice and promotes sustainability agenda	• Current IPC audits to be reviewed and updated • Work with divisions to review action plans • Present results/action plans at IPAS
Implement and monitor compliance with annual programme of work	• Monthly updates at IPCT meeting • Exceptions to be escalated to IPASG

Review national standards when published for cleanliness	• Review when published
Scope alternative solutions for higher level decontamination	• Trial a peracetic acid for known and suspected infections
Focus on delivery of actions from supervisor and admin review within facilities	• Education new starters and ongoing education • Reduction of admin on current supervisors' role to increase visibility and operational oversight of service of which cleaning is included
Expand the work for improvement projects	• Re-launch of the 'Gloves off' campaign in partnership with the HB sustainability team, and the wider sustainability agenda • Pilot and roll out a HB wide intervention to improve our care of vascular and urinary catheters to reduce the risk of catheter-associated infections
Embed antimicrobial stewardship measures into new electronic prescribing system	• Antimicrobial stewardship team to prioritise configuration activities to ensure good practice embedded from go-live • Development of standard prescriptions (order sets) to improve adherence to local antimicrobial guidelines

Appendix 1 – Annual Programme of Work



IPC annual
programme of work

DYDDIAD Y CYFARFOD: DATE OF MEETING:	03 June 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Volunteering Annual Report: Living our Values through Volunteering (2024-2025)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Tanya Strange, Head of Nursing Kathryn Thomas, Programme Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

Volunteering across Aneurin Bevan University Health Board (ABUHB) continues to grow in scale, impact, and strategic importance. Between January 2024 and March 2025, volunteers contributed over **20,239 unpaid hours**, an increase of more than **13,000 hours** from the previous period. These hours reflect a wide spectrum of contributions to patient experience, staff wellbeing, and community connection across hospital, community, and care home settings. Volunteering is now firmly embedded within care delivery, enhancing services in areas such as end-of-life and dementia care, stroke and neurorehabilitation, audiology, maternity, and peer-led recovery. The expansion of roles, including Companions, Hospital Befrienders, Experts by Experience, and multilingual support, demonstrates the evolving value of volunteers within compassionate, person-centred care.

As demands on health and care services increase, volunteering offers a sustainable, high-impact approach to improving outcomes, building local engagement, and developing future workforce capacity. The Volunteer to Career pathway, for example, has supported 20 individuals into paid roles and more than 30 into further education. The Volunteering Annual Report: Living Our Values Through Volunteering highlights the key achievements for the period January 2024- March 2025.

Cefndir / Background

Aneurin Bevan University Health Board operates within a clear Volunteer Framework that ensures strong governance, risk management, and consistency in how volunteer

activity is developed, delivered, and evaluated. This framework supports safe, meaningful engagement aligned to service needs and Board priorities.

Volunteering activity has grown significantly in 2024/25, with over 20,000 hours contributed, 450 new inductions, and a broader range of roles supporting patients, families, and staff. Strategic programmes such as *Volunteer to Career*, increased diversity, and partnership-led initiatives demonstrate the expanding role of volunteering in enhancing patient experience, improving workforce pathways, and building stronger community connections.

Asesiad / Assessment

Volunteering within Aneurin Bevan University Health Board has matured into a strategically aligned and high-impact programme that supports patient experience, workforce development, and community connection. The Volunteer Framework provides robust governance, enabling safe, meaningful engagement. However, the significant expansion in volunteer numbers, roles, and community expectations now presents capacity, sustainability, and resourcing challenges. Without targeted investment, the service risks being unable to meet future demands or fully realise its potential to reduce pressure on clinical services, promote inclusion, and grow the workforce of tomorrow.

Key Points Outlined within the Annual Report

- **Significant Growth and Reach:**
Over 20,000 volunteer hours delivered between January 2024–March 2025, with a year-on-year increase of more than 13,000 hours. Welcomer volunteers alone supported 18,342 people.
- **Workforce Pipeline Success:**
20 volunteers progressed into paid employment through the Volunteer to Career pathway. Over 30 transitioned into further education, supporting workforce sustainability.
- **Enhanced Diversity and Inclusion:**
Volunteers speak 40+ languages, including Welsh and BSL, strengthening culturally competent care and widening participation.
- **Expanded Roles Based on Need:**
Five new role profiles developed based on patient, staff, and volunteer feedback. Notable growth in dementia and end-of-life companion roles, peer support networks, and telephone befriending.
- **Strong Partnership Model:**
Continued collaboration with key partners (e.g. Helpforce, GAVO, Age Cymru Gwent, British Red Cross) co-produces services, expands reach, and strengthens community trust.
- **Training and Development:**
62 training sessions delivered; 450+ volunteers inducted; increased focus on wellbeing, digital inclusion, and role-specific support.
- **Volunteer Framework in Place:**
A clear Volunteer Framework underpins the service, ensuring safe, structured, and aligned delivery across all settings.
- **Digital and Operational Infrastructure Needs:**
Growth is driving the need for investment in the Assemble digital volunteer management platform, and for new hospital-based volunteer hubs.

Key Risks

- **Capacity Constraints:**

The Health Board wide Volunteer programme is currently supported by only 3.3 WTE Volunteer Coordinators. Without additional staff capacity, there is a risk of volunteer disengagement, inconsistent support, and delayed service response.

- **Funding Volatility:**

Reliance on Charitable Funds and fixed-term grants to support core roles and innovation creates uncertainty. Time-limited funding may affect continuity of strategic programmes (e.g. End of Life Companions, Volunteer to Career).

- **Impact Plateau or Decline:**

Without scaled infrastructure, the ability to sustain growth, develop new roles, and maintain quality volunteer experience may be compromised.

- **Missed Opportunities for Workforce Development:**

The Volunteer to Career pathway may not reach its full potential without embedded mentorship, increased training capacity, and alignment with recruitment strategies.

- **Volunteer Retention Risks:**

Inadequate support or limited progression routes may result in volunteer attrition, particularly in younger, diverse, or career-oriented cohorts.

- **Digital and Data Management Limitations:**

Without full implementation of Assemble, opportunities to streamline recruitment, rostering, and impact reporting will be limited, affecting governance and engagement.

Argymhelliad / Recommendation

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

- **RECEIVE and NOTE** the Volunteering Annual Report 2024/25, which outlines the significant contribution made by volunteers across Aneurin Bevan University Health Board and highlights alignment with strategic priorities including person-centred care, workforce development, and community engagement.
- **ACKNOWLEDGE** the growing scope, diversity, and impact of volunteer activity across clinical and community settings, and the critical role of volunteers in improving patient experience, supporting staff, and strengthening system resilience.
- **NOTE** the risks to service sustainability.
- **SUPPORT** the ongoing development of the volunteering programme, including:
 - Strengthening the Volunteer to Career pathway as a means of supporting recruitment into the health and care workforce.
 - Expanding access and inclusion, particularly for underrepresented groups, Welsh speakers, and individuals with lived experience.
 - Aligning volunteering with wider strategic ambitions such as end-of-life care, dementia support, and improving patient feedback.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care 4.1 Dignified Care 6.2 Peoples Rights
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Dying well as part of life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the wellbeing and engagement of our staff Improve the access, experience and outcomes of those who require mental health and learning disability services Improve the experience of lesbian, gay, bisexual and trans (LGBTQ+) service users and staff

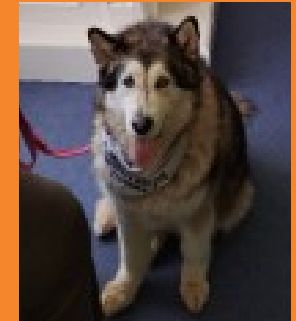
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Patient Experience and Involvement Strategy Quality Strategy Volunteer Framework National Peoples Experience Framework
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Corporate Nursing

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Yes, outlined within the paper
• Service Activity & Performance	Yes, outlined within the paper
• Financial	Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Yes not yet available An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

Volunteering Annual Report: Living our Values Through Volunteering



April 2024 – March 2025



Executive Summary

It is my pleasure to present the Volunteering Annual Report for 2024/25, which reflects the extraordinary dedication and compassion our volunteers bring to Aneurin Bevan University Health Board.

Our volunteers contributed over **20,239 hours**, an **increase of 13,000 hours**, and we welcomed **250 new individuals** into our volunteering community. Welcomer volunteers supported more than **18,300 patients, families, and visitors**, providing comfort and connection when it matters most.

Reflecting the diversity of our communities, our volunteers speak **40 languages**, including Welsh and British Sign Language. We introduced **five new volunteer roles** this year, shaped by the voices of patients, staff, and volunteers themselves.

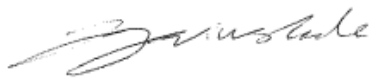
Our expanded **Volunteer to Career programme** has helped **20 volunteers** move into paid health and care roles, demonstrating our commitment to inclusion, growth, and meaningful opportunity.

Through **62 training sessions** and ongoing support, volunteers are well-prepared to provide compassionate care and valuable support across a range of settings, including hospital befriending, telephone support, care homes, and in the community.

These efforts, alongside strong partnerships and community engagement have enriched patient experience and strengthened the vital connection between our Health Board and the people we serve.

I am continually inspired by the generosity and kindness of our volunteers. Their presence brings warmth, dignity, and hope to those in our care, and they remain an indispensable part of our team. Together, we will continue to nurture and grow this remarkable community of care.

On behalf of the Health Board, I would like to extend my heartfelt thanks to every volunteer, both within our hospitals and across our communities, who gives their time, energy, and compassion to support others. Your dedication makes a real difference to people's lives every day. Whether offering a listening ear, providing comfort at difficult moments, or simply being there with a smile, your contribution enhances care and truly embodies the values we hold dear. Thank you for all that you do to make people's experience better.



Jennifer Winslade
Executive Director of Nursing

The Value and Impact of Volunteering at Aneurin Bevan University Health Board

Volunteering continues to make a profound impact across Aneurin Bevan University Health Board, enhancing patient care, supporting staff, and improving the wellbeing of individuals and communities. Volunteers bring time, compassion, and lived experience to our services, supporting people at some of the most significant moments in their lives. Whether offering wayfinding support, companionship on hospital wards, telephone befriending, or signposting to services such as PALS, volunteers help to:

- Improve patient experience
- Reduce anxiety, loneliness, and isolation
- Provide practical help with kindness and empathy
- Share valuable insights to support service improvement

Volunteers are a valued part of our healthcare workforce, working alongside staff to help deliver safer, more compassionate, and person-centred care. Their contributions reflect our Health Board's core **values and behaviours**, with many acting as ambassadors for wellbeing, inclusion, and kindness.

Through our commitment to a **life course approach**, we ensure volunteering remains accessible and meaningful at all stages of life. From young people exploring career paths to retirees seeking purpose and connection, our roles are flexible, inclusive, and tailored to individual strengths. We actively widen access to underrepresented groups, offering additional support and adjustments to ensure everyone can contribute meaningfully.

Currently, **289 directly engaged volunteers** support the Health Board, with many more contributing through valued partnerships with third sector organisations. Over the past year, **414 volunteers**, including those who are engaged by our partners (for example Age Cymru, League of Friends, Red Cross), have made an invaluable contribution across our sites, providing both practical support and emotional care within busy healthcare environments.

Volunteering is not only about giving. It also offers people the chance to grow. Many of our volunteers report increased confidence, improved mental wellbeing, and a sense of purpose. Through initiatives like our **Volunteer to Career pathway**, we continue to support individuals into employment, training, and further education, demonstrating the long-term value of volunteering for both individuals and the health system.

"Volunteering has helped me feel part of something bigger—like I'm giving back, but also gaining so much myself."
— Volunteer, Royal Gwent Hospital

Key Volunteer Highlights-January 2024 – March 2025

Between January 2024 and March 2025, our volunteer community has continued to grow in strength, diversity, and impact. This period saw a remarkable expansion in the number of volunteer hours, new roles developed in response to patient and staff feedback, and increased engagement across hospital and community settings. From providing companionship and language support to enhancing patient experience and contributing to service development, our volunteers have played a vital role in supporting compassionate care. The highlights below capture just some of the outstanding contributions made by our dedicated volunteers over the past 15 months.

Our volunteers have provided over 20,239 unpaid volunteer hours, an increase of over 13,000 hours .	Our Welcomer volunteers at NHH and YYF have supported over 18342 people between January 2024- March 2025, an increase recorded of over 15000 .	We have 40 spoken languages, including different dialects by 56 volunteers, including 23 Welsh Speaking Volunteers and 1 BSL Volunteer.	We have 25 Telephone Befrienders supporting 28 patients, mostly on a weekly basis across the five Boroughs.
We have 47 Dementia Companions and 39 End of Life Companions	We have supported over 450 volunteer inductions between January 2024 to March 2025.	20 volunteers have gained paid employment through our volunteer to career programme.	Listening to patients, staff and volunteers, we have created 5 new volunteer role profiles during 2024.
We have over 20 volunteers become experts by experience. (Mental Health, Cancer, Gastroenterology and Neuro).	We have provided 62 training sessions for volunteers, an increase of 13 sessions.	Newport Friendship Group continues to grow with up to 17 attendees at its weekly group meeting	As part of Volunteers Week celebrations we visited 7 Hospital sites and met with over 53 volunteers.
We have attended 48 volunteer promotion events across the geographical area.	We now have 216 Hospital based Befrienders	We supported call outs for Therapy Dogs to visit patients on the wards, staff wellbeing events and Oversees Nursing event	We have supported over 20 referrals for End of Life or Loneliness on our wards

We had 25 Community Volunteers supporting 35 patients	Through our partnership with Cardiff University, over 109 pharmacy students have gained patient experience volunteering opportunities	We had 8 volunteers visiting in 9 Care Homes	We have received over 270 referrals for Home visits or Telephone calls for this period
We have delivered 13 Wellbeing Sessions with over 50 volunteers attending and have since March 2025 introduced bimonthly face to face sessions, as previously all delivered via Teams.	We recruited new 250 volunteers in 2024/2025 with 125 leaving our team for various reasons such as to go into further education, jobs, personal reasons, moving out of area	Volunteer Hours 20 completed 30 hours 21 completed 50 hours 14 completed 100 hours 6 completed 200 hours 5 completed 300 hours 6 completed 400 hours 5 completed 500 hours 1 completed 600 hours 1 completed 700 hours 1 completed 800 hours 3 completed 900 hours 1 completed 1000 hours	In 2024 , the Volunteer Service has won 3 Volunteer Awards and have been finalists in 2 other awards.

New Volunteer Roles Introduced in 2024/25

This year, we were proud to introduce **five new volunteer roles** designed to respond to emerging needs and enhance patient and staff experiences:

Expert by Experience – Mental Health

Volunteers in this role co-facilitate group sessions for individuals accessing secondary mental health services. They offer companionship to patients who may feel isolated, support digital connections with loved ones, and assist with visits and wayfinding. As individuals with lived experience of mental health challenges, they provide powerful peer support that fosters hope, empathy, and belief in recovery.

Expert by Experience – Cardiac Rehabilitation

These volunteers attend Phase 3 Cardiac Rehabilitation education sessions across North Gwent, sharing their own experiences with heart conditions to inspire others. They advocate for the value of Cardiac Rehab and help patients make informed choices about ongoing exercise and recovery.

Research Champions

Research Champions help raise awareness of research opportunities within the Health Board and the wider community. They play an important role in encouraging public engagement and helping to build a culture of research-informed care.

Breastfeeding Peer Support (BFPS)

Trained volunteers offer friendly, compassionate, and knowledgeable support to breastfeeding and expectant mothers across various settings. They provide emotional encouragement and practical guidance, contributing to a positive and empowering experience for new parents.

Wellbeing Therapist Volunteer

Based at the Trethomas Community Hub, these volunteers support frontline clinical staff by providing massage therapy aimed at improving wellbeing. Staff can access this service through self-referral or line manager recommendation, as part of our broader commitment to staff health and resilience.

Through their generosity, compassion, and lived experiences, our volunteers continue to make a powerful and lasting impact across our Health Board. We are deeply grateful for their ongoing contributions. See **Appendix 2** for a Case Study on the Zen Den.

Extending Volunteer Support During 2024

Over the past year, we have extended our volunteer support across different areas including:

- Cancer Cafés in Sedbury, Monmouthshire and Pontypool Torfaen
- Cancer Services Meet & Greet in Haematology at the Royal Gwent and Nevill Hall Hospitals
- BABI support at antenatal clinic at the Royal Gwent
- Emergency Department at The Grange University Hospital
- Maternity ward at The Grange University Hospital
- Hear in the Community clinic at Caerphilly Library
- Neurostute support at Newbridge Leisure Centre

- Lymphoedema Clinic, St Woolos
- Medical and Assessment Unit (D1West), Royal Gwent Hospital

Contributing to National and Organisational Priorities

Volunteer involvement continues to be closely aligned with and instrumental in advancing the Health Board's strategic objectives.

- **Supporting Patient Experience and Involvement:** Volunteers have actively contributed to delivering the goals outlined in the Patient Experience and Involvement Strategy, promoting inclusion, dignity, and co-production in care.
- **Advancing the Well-being of Future Generations Act:** Volunteer activity supports key priorities such as enhancing social connectedness, reducing health inequalities, and fostering sustainable workforce development.
- **Strategic Planning Participation:** Volunteers have engaged in workshops contributing valuable insights to the Health Board's 10-year strategic plan.
- **Research Collaboration:** Volunteers have supported collaborative research initiatives with the Welsh Institute for Health and Social Care, University of South Wales, and the Centre for Charity Effectiveness at City, University of London. This research, commissioned by Social Care Wales, aims to deepen understanding of volunteering's role in social care.
- **Inclusive Communications:** Volunteers provided feedback on the development of the ABUHB neurodiversity awareness poster, ensuring it reflects diverse perspectives.
- **Recognition and Accreditation:** Evidence of volunteering's positive impact supported the Patient Experience and Involvement team's successful application **for Silver Distinction in the Cultural Competency Certificate.**



Through these contributions, volunteers continue to play a vital role in shaping the future of care and service delivery within the Health Board and beyond.

Volunteer Training and Development

All volunteers receive a comprehensive induction and role-specific training to prepare them for their responsibilities. Over the past 15 months, **272 volunteers** have completed core and refresher training sessions. Feedback consistently highlights that the induction equips volunteers with the confidence and skills needed to begin their roles effectively. Participants particularly valued the interactive group work, videos, and scenario-based learning.

Overall, the training programme continues to provide essential knowledge and confidence, enabling volunteers to contribute positively and safely across our services.

To ensure volunteers are confident and well-prepared to support patients and services, we have continued to expand our training offer—particularly for roles requiring specialist knowledge or lived experience, such as mental health, dementia, and end-of-life care. Over the past 15 months, we delivered **62 bespoke training sessions** to **424 attendees**. This tailored training helps ensure our volunteers are equipped to provide safe, compassionate, and person-centred support.

Staff and Partner Collaboration

Partnerships

The Patient Experience and Involvement Team works closely with a wide range of third sector and voluntary organisations to enhance patient care and support our staff, patients, and their families. We are grateful for the continued collaboration and commitment of our partners, whose contributions significantly strengthen our services.

Key partners include:

Age Cymru Gwent, Helpforce Cymru, Torfaen Voluntary Alliance (TVA), Gwent Association of Voluntary Organisations (GAVO), Wales Council for Voluntary Action (WCVA), Welsh Refugee Council, British Red Cross, Pets As Therapy, Therapy Dogs Nationwide, Plattform, Disability Cando, Blood Bikes, Sled Dog Society of Wales, Bevan Commission, League of Friends, Bridges Centre, Friends of Llanfrechfa Grange Walled Garden, Ysbyty Ystrad FM, and local education institutions including Coleg Gwent, Aspris College, Haberdashers Monmouth School, and Cardiff University School of Pharmacy.

These partnerships are vital to delivering inclusive, person-centred care and strengthening community connections across the Health Board.

Volunteers across Aneurin Bevan University Health Board continue to make an extraordinary contribution, bringing kindness, connection, and practical support to patients, families, and staff. Their work reflects our shared values of compassion, dignity, and partnership. Over the past year, volunteers continued to make a profound difference across our Health Board, bringing language skills, cultural understanding, peer support, and practical help that enhances both care delivery and patient experience. Please see **Appendix 1** for direct staff and partner feedback.

In **Maternity Services**, multilingual volunteers help women from diverse backgrounds better understand their care, offering support in clinics and communities. One volunteer, *Sosan*, makes a long commute each week to support Afghan women, and is deeply valued by the team.

Audiology volunteers run monthly drop-in clinics in local libraries, making hearing aid maintenance and peer support more accessible for those unable to travel to hospital.

In **Stroke and Brain Injury Services**, the *Neuro Peer Partner Network* continues to grow. Volunteers with lived experience now support others during recovery, on wards, in groups, and in targeted buddying roles. Their presence brings hope and emotional connection at a time of great uncertainty.

The **4x4 Volunteer Group** provides vital transport during adverse weather, ensuring staff and patients in remote areas stay connected to care. Their reliability and community spirit are a longstanding asset to the Health Board.

Blood Bikes Wales volunteers offer an essential out-of-hours courier service, transporting urgent medical items such as blood samples, documents, and equipment between hospitals. Their rapid, reliable support helps ensure timely diagnosis and treatment while reducing pressure on NHS transport services, making them an indispensable partner in patient care.

We are also proud of the **End of Life Care Companion Volunteers**, who have been trained to offer calm, compassionate support to patients and families during the most difficult of times—reducing isolation and ensuring dignity at the end of life.

Collaborating for Greater Impact

Many of our most impactful developments have been co-delivered with trusted partners. Our collaboration with **Helpforce Cymru** and **Helpforce UK** has strengthened the *Volunteer to Career* pathway, enabling those with lived experience, particularly in mental health and learning disabilities, to take supported steps toward employment in

health and care. Helpforce also provides expert support for evaluating volunteer impact, helping us build evidence-informed services that truly make a difference.

Torfaen Voluntary Alliance (TVA) plays a vital role in promoting opportunities and linking third sector organisations to our services, helping us widen our reach and ensure local communities can actively shape healthcare through volunteering.

Platform, a mental health and social change charity, supports volunteers who are now actively involved in Ffrind i Mi volunteering, Hospital Radio, and donations through the Perfect Fit project, bringing meaningful connection and creativity into care settings.

Our longstanding relationship with **Sparkle** continues to grow. Sparkle volunteers support children and young people with disabilities across ABUHB children's centres, running clubs, cafés, and administrative services that enhance the lives of families across the region.

Age Cymru Gwent's Robins Service provides trained volunteers who work directly on our wards, helping to ease feelings of loneliness for older patients during hospital stays. Their presence adds a layer of personalised care that uplifts and reassures.

Partnerships with groups like the **League of Friends**, **GAVO**, **Sparkle**, **British Red Cross**, and **Helpforce**, have helped extend the reach of volunteering, from befriending and fundraising to structured student placements and career pathways.

'Helpforce is excited to work with Aneurin Bevan University Health Board (ABUHB) and looks forward to continuing this important collaboration. Together, we are building innovative, person-centred volunteering programmes that not only enhance patient care but also open meaningful pathways into health and care careers.'

Lynne Connolly Helpforce Cymru Manager

Enriching Education and Community Wellbeing

Our volunteer programme also supports learning and intergenerational engagement. Partnerships with **Cardiff University** and **Haberdashers Monmouth School** offer students their first experience in patient-facing roles, building confidence and inspiring future careers in health and care.

Groups like the **League of Friends** at Nevill Hall and Ysbyty Aneurin Bevan continue to raise vital funds and provide everyday comforts through café services, donations, and equipment purchases, supporting both staff and patients through community generosity.

Together, these partnerships and feedback from volunteers tell a powerful story: that volunteering is not just about giving time. It's about building connection, restoring hope, and making care truly person-centred. We are deeply grateful for the continued partnership and passion of all those who support this work.

These collaborations demonstrate how volunteers are not only easing loneliness and enhancing recovery, but also co-producing services and shaping the future workforce, showing the very best of partnership in action.

Ffrind i Mi Volunteer Roles

Hospital Ward Based Volunteers	Community Befrienders	Telephone Befrienders	Cancer Support Volunteers
Dementia Companions	Digital Companions	Adverse Weather Drivers	Research
Therapy Dogs	BABI Volunteers	Welcomers	Hear in Your Community
Patient Survey Volunteers	Experts by Experience Mental Health	Volunteer to Career	Alcohol Care Team Group Support
Faith and Spiritual Volunteers	Friendship Groups	Experts by Experience Stroke Survivors	End of Life Companions

Expanding Volunteer Opportunities

Over the past year, the Health Board has continued to listen to volunteer feedback and respond to service needs by expanding the range of volunteering opportunities available. We now offer **20** dedicated volunteer role profiles, each carefully designed to reflect the diverse interests, life experiences, and aspirations of our volunteers. Volunteers engaged by Aneurin Bevan University Health Board can now contribute across a wide variety of roles, both within our healthcare settings and out in the community. This growing portfolio of roles enables individuals to get involved in areas that align with their passions, make use of their existing skills, or support future career ambitions through hands-on experience. The following list highlights some of the roles currently available, and we continue to review and develop new profiles to meet emerging needs and ensure volunteering remains meaningful, inclusive, and impactful.

Spotlight on Volunteer to Career: Building the Workforce of the Future

The continued success of this programme underscores its value as a vital stepping stone for career development within the health and social care sector.

The Volunteer to Career (VtC) programme is a strategic initiative at Aneurin Bevan University Health Board that supports individuals in transitioning from volunteer roles into paid employment within health and social care. This model not only enhances the employability of participants but also supports workforce development by fostering a pipeline of skilled, compassionate, and community-connected staff.

The programme offers a structured pathway for volunteers, providing access to training, supervision, mentorship, and meaningful exposure to clinical and non-clinical settings across the Health Board. Participants develop transferable skills and gain valuable insight into the realities of working within healthcare environments.

Our partnership with Helpforce, a national charity focused on transforming volunteering in health and care, has been central to the programme's success. Together, we have co-developed and refined a model that is inclusive, evidence-based, and tailored to meet local workforce needs. Through the Impact and Insight evaluation service, we are also able to measure outcomes and continuously improve the pathway based on robust data.

This opportunity is available to all active volunteers, including those who may not hold formal qualifications but demonstrate strong interpersonal skills and a commitment to patient wellbeing. The model is especially supportive for individuals who are re-entering the workforce, changing careers, or exploring employment in healthcare for the first time.

Over the past year, the programme has been further developed in collaboration with colleagues in Workforce and Organisational Development, ensuring alignment with recruitment strategies and operational priorities. To date, 20 volunteers have successfully progressed into paid employment through this route, reflecting the programme's growing impact on workforce diversification and community engagement. Our Volunteer to Career pathway has continued to grow and demonstrates significant success.

- **Employment Outcomes:** Over the past year, numerous volunteers have transitioned into paid employment, particularly within healthcare support roles. To date, **more than 20 volunteers** have secured paid positions, with **16 employed** specifically within Health and Social Care. Additionally, over **30 volunteers** have progressed to further education opportunities.
- **Comprehensive Support and Training:** Participants completed a **minimum of 30 volunteering hours** and benefited from dedicated mentorship alongside access to specialised training in areas such as dementia care, meaningful activity facilitation, and food safety.
- **Bridging to Careers:** This pathway has proven to be an effective and inclusive route into health and care professions, supporting individuals both with lived experience and those **without formal qualifications**.

Volunteers said:

"Thank you very much for our last meeting—it was wonderful to connect. I've submitted my interest form for future opportunities in the Administrative Department, as I hope to gain organisational experience in management." — Atinuke

"I started my five-day clinical skills training today to join the Bank. Thank you for all your help in the Volunteer to Career process—I'm really grateful to be on the course." — Diana

"I've secured employment with one of the agencies you helped me connect with through a reference. I'm now actively seeking a permanent role in the healthcare sector. Thank you for your continued encouragement." — Agath

A case study on our Volunteer to Career model for people with mental health and learning disabilities can be found here:

<https://wcva.cymru/volunteers-in-mental-health-services/>

<https://abuhb.nhs.wales/news/news/health-board-uses-lived-experiences-of-mental-health-to-improve-service-provision-in-gwent/>

Promoting Volunteering

This year, we have prioritised raising awareness of the value and accessibility of volunteering across Aneurin Bevan University Health Board. Through targeted outreach, local partnerships, social media, and events, we have showcased the wide range of volunteering opportunities available, helping to grow a more inclusive, diverse, and engaged volunteer workforce. Over the past year, the team participated in more than **50 promotional events** across Gwent, including:

- School and College Careers Events – Inspiring the next generation.
- Health & Wellbeing Fairs – Connecting with local communities.
- Jobs and Employability Fayres – Promoting volunteer-to-career pathways.
- Volunteer Recognition Events – Celebrating contributions and raising visibility.
- Targeted Outreach – Engaging with ESOL groups, refugee communities, and hard-to-reach populations.

These efforts continue to reinforce our commitment to promoting volunteering as a valuable and accessible way to improve lives, support NHS services, and build stronger, healthier communities.

Awards and Recognition

In 2024, the Volunteer Service received **3 Volunteer Awards** and were finalists in **2 additional award categories**, reflecting the outstanding contributions of our volunteer team.



Looking Ahead: Volunteering Priorities for 2025/2026

Volunteering across Aneurin Bevan University Health Board continues to evolve in response to what matters most to people and communities. Over the next 12 months, our focus will be on:

- Expanding reach and inclusion by recruiting more volunteers from underrepresented groups, including Welsh speakers and those whose first language is not English.
- Enhancing end-of-life and dementia care by growing our Companion models in hospitals, care homes, and community settings, and developing volunteers' roles along the bereavement pathway.
- Strengthening Volunteer to Career pathways in collaboration with Workforce, Staff Side, and Clinical Teams to support sustainable recruitment into paid roles.
- Developing specialty-specific peer support models in areas such as mental health, cancer, cardiac, neuro, and alcohol services.
- Building infrastructure through new hospital-based volunteer hubs and the implementation of the Assemble digital platform for recruitment, rostering, and data management.
- Improving patient experience by involving volunteers in 'what matters' conversations and supporting feedback systems such as Civica and the Poppy Programme.
- Investing in training and cultural competence, with new bespoke training modules, sensory awareness courses, digital literacy support, and a strategic aim to achieve GOLD Cultural Competence Accreditation.

These priorities reflect our commitment to growing a skilled, inclusive, and person-centred volunteer workforce that enhances care quality and community connection across the Health Board.

Conclusion

Between January 2024 and March 2025, our volunteer programme has demonstrated remarkable growth and impact across a broad range of services. Volunteers contributed over **20,239 hours**—an increase of more than **13,000 hours**, supporting thousands of patients, families, and staff. Welcomer volunteers alone assisted over **18,342 individuals**, reflecting a significant rise in engagement.

Our diverse volunteer base, speaking **40 languages and dialects**, including Welsh and British Sign Language, continues to enrich patient care. With more than **450 inductions** completed and **62 training sessions** delivered, volunteers are well-prepared and confident in their roles.

We have expanded volunteer roles based on valuable feedback, introducing five new profiles and supporting over 20 volunteers as Experts by Experience across key clinical areas. The Volunteer to Career programme has successfully enabled **20 volunteers** to transition into paid employment.

Our community outreach remains strong, with active involvement in hospital befriending, telephone support, care home visits, student placements, and wellbeing initiatives. The Newport Friendship Group and Therapy Dog programmes also continue to flourish, enhancing social connection and wellbeing.

Throughout this period, we have recruited **250 new volunteers**, while supporting retention and progression across the service. The sustained enthusiasm and dedication of our volunteers, alongside targeted recruitment and training efforts, position us well to continue meeting the evolving needs of our Health Board and the communities we serve.

For more information on volunteering, please email the Patient Experience and Involvement (Volunteering) Team on abb.ffrindimi@wales.nhs.uk

Appendix 1

Volunteer Annual Report- Volunteer, Staff and Partner Feedback (2025/25)

Feedback from Volunteers

- Sienna – “I gained confidence and communicated with patients more clearly.”
- Sandy – “He thanked me for chatting with him and said what a great service we give.”
- Stephen – “Relatives thanked me for talking to them and supporting their relative.”
- Moria – “Feel very humble when patients thank me for the visits and grateful that I seem to be doing some good.”
- Inoka – “Every day I feel cherished when I talk with these people who feel lonely when they are in the hospital.”
- Christine - “Long chat with this lady. Said I was very kind made her feel cheerful thankful that people like me are around.”
- Eyma – “It's good to see people smile when they have a visitor, makes me feel like I'm doing something beneficial.”
- Christine – “Makes me very blessed to be able to volunteer and they bring some sunshine into the patients stay.”
- Michael – “A doctor asked me to visit this patient who could only move his head and blink. I spent a while with him telling him about my volunteering and something on the pictures on his wall. It was totally 1-way conversation but the doctor had observed us and was pleased the patient who concentrating on my face and apparently understanding what was saying. The doctor recognised me from when we met previously in majors and thanked me for being there.”
- Sandra & Tollen – “New lady. Very bright and cheerful. Was finding single room but lonely as she had transferred from 6 bed bay. She was grateful for the chat.”
- Brett – “The visit helped me build up skills with patients who have poor hearing.”
- Lesle – “A lovely lady who mentioned that we did a great job. We talked about her grandchildren, home life etc. She was in a room without a TV so happy to have the company and looking forward to going home soon.”

Feedback from Staff

Within maternity services, we are grateful to have our volunteers who speak English as an additional language. The volunteers are a contact for women who do not speak English, or women from diverse backgrounds who wish to gain more understanding of processes and pathways of care within maternity. The volunteers use innovative and creative ways to do this, from meeting other women for coffee, being a contact through social media and attending community groups.

Of equal value, is the contribution to experience measures and gaining and representing the views of this group of women, listening to their experiences and ideas for improvement and feeding back to the Consultant Midwife and team to inform service and quality improvements.

The volunteers within maternity services have been invaluable in supporting Maternity ABUHB to achieve Diverse Cymru Cultural Competency accreditation.

One volunteer, Sosan, deserves a special mention for her ongoing commitment and the huge efforts she makes to support the maternity service and the Afghan women attending antenatal clinic. Sosan often has to get 2 buses to commute, giving her time and knowledge to enhance the experiences of others. She is kind, hardworking, committed and highly regarded by all members of the team – **Kerry Jefferies Assistant Directorate Manager, Maternity Services**

The Health Boards 4x4 volunteer group have been in existence for 5 years and provide 4x4 vehicle & driver support across the organisation, they were relied upon during the Covid pandemic to transport medication from hospital and community pharmacies to patients who were shielding, they have been called upon to transport district nurses in Monmouthshire to convey district nurses to rural farms that cannot be reached by conventional 2 wheeled vehicles (this was in place for 3 months), they supported through the recent storms – Bert & Darragh and are always available when we have 'snow' to convey key staff to their place of work or DN's to patients (especially in the Blaenau Gwent area). A recent request involved the transport of a female who had fallen and had a circumference leg break, WAST could not provide an immediate response...with clinical advice a volunteer was able transport the casualty.

The Health Board no longer have a 4x4 capability and as such we are reliant on the good will and constant support of 4x4 volunteers. In the 5 years that I have been coordinator; we have never not been able to support a request. **Andrew Goodenough- 4x4 volunteer group**

We currently have four fully trained volunteers working in the community, with several more undergoing training. Throughout 2024 a monthly clinic has run in Risca Library (4th Wednesday of every month, 2-4pm) and in September 2024, a second clinic opened in Caerphilly Library (1st Friday of each month, 10am-12). The volunteers provide a valuable service in the local community, carrying out basic hearing aid maintenance and repairs and offering advice and peer support to patients. This is such a useful service, especially for those who struggle to access the main hospital sites. **Rachel Bucknall, Audiologist**

Our chaplaincy volunteers continue to do a great job and are very much appreciated. A couple of the volunteers have recently left post after many years of great service, and a few new ones have arrived. All of the feedback from patients has been very positive. **Alan Tyler Chaplaincy Manager**

We are really excited about the development of "neuro volunteers" through the Ffrind i Mi programme. We originally started this journey in 2022 with a handful of stroke survivors who wanted to make a difference to other stroke and acquired brain injury (ABI) survivors. We established a Neuro Peer Partners Network and started to identify key areas for development and improvement for people with stroke and ABI, both during their hospital stay and after this when they move back to their communities and begin the difficult challenge of living life with the aftermath that these conditions bring. These individuals told us stories of the isolation they felt and hopelessness of how they could ever live a meaningful life again.

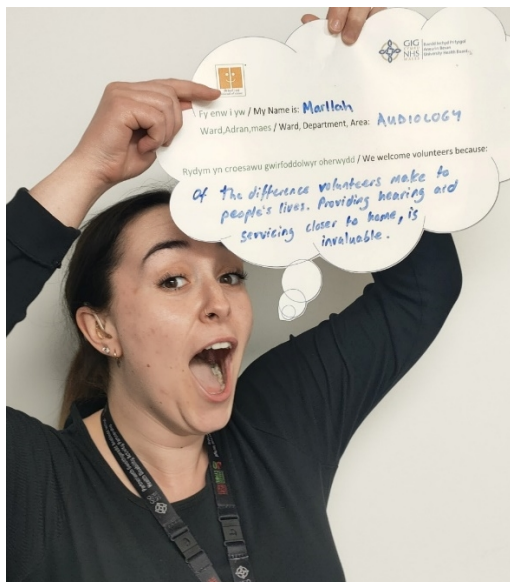
Our original group of peers felt strongly that there needed to be stroke and ABI survivors present in the HASU and the neuro rehabilitation units to share their lived experience of what it is like to recover life after these complex events. This work has grown from strength to strength and we now often hear new survivors tell us how meeting these peers on the wards was a pivotal moment in their recovery.

Since then, we have gone on to explore and expand the roles that our neuro volunteers can apply to engage with. This is done through a collaborative process between staff and people with lived experience. We now have volunteers supporting a range of our Neurostute recovery groups (Copy of NEUROSTUTE BOOKLET) including online groups and in person groups such as our Neuro@NERS collaboration with the local exercise referral teams.

We have also identified smaller groups of people who may already be isolated prior to their neuro event (for example, young mums, carers, or people from minority

communities) and are in the process of referring them into Ffrind i Mi to provide more targeted "buddy" support for others who professionals from the neuro pathway can refer for more individualised peer support.

This has been an enormously rewarding way to work and has helped to highlight that the wider neuro community can play a vital role in helping new survivors to recover a meaningful life and this all supports the wider rehabilitation programme. **Linda Tremain- Community Neurological Rehabilitation Service**



Feedback from Partners:

The League of Nevill Hall Friends continues to provide cafe facilities for visitors, patients and staff. With over 120 volunteers, this year it has committed £103,000 for vital equipment such as eye surgery chairs, dentistry chair, an ocular response analyser, communication accessories, specialised chairs, laptops and various medical trolleys. We thank all our customers for their support and will continue to serve the Nevill Hall community.

We are always looking to recruit new volunteers - it is only a matter of giving 2 hours of time each month to join a happy team! **David Hoddy League of Friends Nevill Hall Hospital**

We love working with ABUHB. Our Year 12 students get so much out the experience. They are wonderfully supported by Kathryn Thomas and her team as they progress from school students to experienced hospital ward volunteers. They gain so much confidence as a result, and they really do feel they are giving back to their local community. Thank you for allowing us to participate in this wonderful scheme **Mr James Boiling History Teacher Haberdashers Monmouth School**

GAVO and Aneurin Bevan have a strong partnership in supporting volunteering efforts, especially through the Ffrind i Mi Befriending Volunteering program. This initiative aims to combat loneliness and isolation by recruiting volunteers to support individuals in need. GAVO's involvement in promoting these opportunities through its Health, Social Care, and Wellbeing Officer's weekly publication (SWAY) and the TSSW provider advertising domain [Welcome - Volunteering Wales](#) helps spread awareness and encourage participation. The annual Volunteer Awards Evening and Volunteers Week celebrations annually provide a great platform to recognize contributions and showcase impactful projects. **Caren White Volunteering Officer (Caerphilly)**

Since beginning our partnership with ABUHB on the lived experience volunteer role, Helpforce has played a role in supporting the development and implementation of the initiative. Our team has worked closely with ABUHB to support the volunteer model, ensuring it aligns with the service needs and is underpinned by a robust evaluation framework. We have provided expertise in developing realistic and measurable outcomes, along with tailored data collection tools to demonstrate the impact of the role. Central to the role is the involvement of volunteers with lived experience of mental health difficulties, who share their stories to inspire hope and belief in recovery.

Helpforce has also supported the implementation of the Volunteer to Career programme, which enables volunteers with an interest in a health and care career to access structured guidance, development opportunities, and career support. The lived experience volunteers interested in this programme will be invited to join the career pathway and embark on a health and care career. **Beth Hughes and Sibel Akbiyik, Helpforce**

We are a group of volunteers that support the staff and patients in Ysbyty Aneurin Bevan Hospital Ebbw Vale. By providing items that are of benefit to the patient's well being to help with their recovery. We have been working for over 25 years doing this for the ABUHB, we meet daily with staff to discuss their needs. **Des Hillman Chairman YAB League of Friends.**

Cardiff University & Aneurin Bevan University Health Board work in collaboration to provide our 1st year pharmacy students with the opportunity to attend 4 sessions of volunteer experience. This is their first opportunity within University to contribute to work that directly benefits patients. The feedback we receive from these placements from both students and staff involved is very positive and we appreciate the collaborative environment we have managed to foster. **Luke Bonome-Davis Cardiff School of Pharmacy and Pharmaceutical Sciences**

Sparkle has recently signed an MoU with the health board to cement our long standing partnership working. Sparkle's team of leisure support workers and volunteers provide a range of activities and leisure clubs for children and young people with disabilities and developmental difficulties who access ABUHB services across the greater Gwent. Sparkle works out of three of ABUHB's children's centres to provide these services and the partnership agreement recently signed by both partners will seek to expand and improve what is available for our share population of vulnerable children, young people and their families.

Sparkle works closely with the Children's Centre Manager Tracey Smith to continually improve both the services for children and young people with disabilities and also the facilities **Becca Tyrrell Head of Sparkle Operations**

Our British Red Cross volunteers play a vital role in supporting both the BRC team and NHS colleagues within the A&E department. They offer essential emotional and practical assistance to patients and their families, providing compassionate and sensitive support in challenging situations such as bereavement, stress, and when dealing with patients who may be frustrated, confused, or disoriented. On a practical level, our volunteers help ensure patients' immediate needs are met—this includes offering nutrition and hydration, providing warm blankets, contacting family members, and attending to other important day-to-day necessities. We work closely with the *ffrind i mi* volunteers, fostering strong relationships and collaboration to ensure patients receive personalised, person-centred care. This partnership also allows us to support one another in our daily work, creating a cohesive and compassionate environment for both patients and staff. **Sinead Pollard British Red Cross**

Appendix 2 - Volunteer Annual Report Case Study: 'The Zen Den'

The pilot was set up in March 2024 to be a staff wellbeing service offering a wellbeing massage at no cost for Caerphilly Front line and Primary Care Staff in recognition of their high-pressured high value roles.

It is the only staff wellbeing service across the NHS offered by a member of staff within the Caerphilly Management Team, who volunteers their time half a day a week. Stella / staff / volunteer is fully qualified in their own right with a passion for holistic wellbeing. Seeing the potential to be able to create a safe spa like environment to offer massage fully endorsed and supported by the Caerphilly Management Team, Divisional Director, General Manager, HR and Workforce and Development.

To date over **200** wellbeing sessions have been undertaken for a variety of staff members in Caerphilly including District Nurses, GP practice staff, hospital staff and consultants, stakeholders and partners linked to Caerphilly. Approximately 54% members of staff from a non-clinical background and 46% clinical have accessed the service.

Initially the pilot had no funding and was only available in the hub within Caerphilly south (Trethomas Health Centre) however through its success, it has been awarded NCN funding to continue into 2025 – 2026 and is now offering pop up sessions hubs within Caerphilly North (Rhymney Resource Centre) and East (Blackwood Medical Centre - Avicenna) which improves accessibility for all staff across the borough.

The success of the pilot speaks for itself with the number of staff who are accessing and promoting it to colleagues, and the feedback has been nothing but positive. Staff have felt many benefits from being supported to attend the wellbeing sessions. Below are some feedback quotes: -

- Absolutely incredible work and concept for staff, fantastic environment and "non work feel"
- The service Stella and the team have set up is outstanding. It is the only service in my entire career that is totally committed to my own wellbeing rather than meeting someone else's agenda. Thank you so much
- The room was just like a spa, treatment exceptional, didn't realise how much stress I was holding, should be rolled out for all staff to access. Thank you
- 110% feel this is beneficial. It is an incredible service and feel so lucky to have accessed it. Thank you so much
- I feel I was able to relax and gather my thoughts which we don't always have the opportunity or time to do, thank you so, so much
- What a wonderful experience, so brilliant to have wellbeing prioritised and help staff to take time to be, and reduce stress levels

In recognition for setting up the pilot and the impact the Wellbeing Sessions have in supporting staff, Stella was nominated for the Employee Health and Wellbeing Award at the Staff Recognition Awards 2024. Stella has been congratulated and thanked by the Executive Team in recognition for the impact this has on staff wellbeing.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	03 June 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Assurance update on the mortuary and care after death transformational agenda
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Arvind Kumar, Divisional Director for Clinical Support Services
SWYDDOG ADRODD: REPORTING OFFICER:	Leanne Watkins, Chief Operating Officer

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides a formal update on the Pathology Directorate's progress with the following:

- The transformational agenda, to enhance the safety and efficiency of the mortuary and care after death services.
- The vision and objectives for the future of the mortuary and care after death services.

The Quality and Patient Safety Committee is asked to consider this report for assurance.

Cefndir / Background

Regulatory Framework and Licensing by the Human Tissue Authority (HTA)

The Mortuary and its body storage facilities operate under the regulatory framework of the Human Tissue Authority (HTA), the independent licensing body for the 'Post-Mortem' sector. This license mandates adherence to:

- The storage of deceased individuals and tissue samples
- The undertaking of post-mortem examinations

- The removal of relevant materials.

HTA Reportable Incidents Compliance and Inspections (2011 – present)

The Health Board has been subject to five HTA inspections within the post-mortem sector in the last 14 years. Since 2015, a total of sixteen HTA Reportable Incidents (HTARIs) have been reported to the HTA. For each of these incidents, the Pathology Directorate submitted comprehensive follow-up reports detailing the corrective and preventative measures put in place, which enabled the HTA to formally close the incidents. It is important to note that the majority i.e. 75% of these incidents originated from, or were directly linked to, Maternity Services, Facilities, and Gynaecological Services (not the mortuary and care after death services).

Actions Following Serious Incidents

After serious incidents in November 2023 and March 2024, internal investigations prompted a full-service review. A formal inspection request was made to the HTA, which agreed to follow its due process. To tackle the issues identified, a Task and Finish group was set up focusing on Staffing, Infrastructure, Regulatory Compliance, and Process improvements. The group implemented 25 actions before establishing a full transformation agenda aimed at sustainable change and leadership.

However, it is important to note, that during this time the HTA conducted an unannounced visit to the ABUHB Mortuary premises on 24th July 2024. This inspection only identified one minor shortfall alongside three recommendations, which evidenced the prompt actions and good work that had been taken by the Task and Finish group. The minor shortfall and the recommendations were resolved well within the HTA's timeframe.

Securing Long-Term Improvement

Recognising the need to embed a culture of continuous improvement within both the Mortuary and CAD Services, the CSS Division employed a Pathology Transformation Manager to drive the transformation agenda forward at pace. This role was filled in October 2024 on a secondment basis, with a clear mandate to enhance the safety, regulatory compliance, modernisation and security of the services. Following the immediate actions that were taken to make the service secure, the task and finish group was stood down and a working group was established by the Transformation Manager which has continued to ensure the completion of the actions outlined in Table 1. A permanent band 7 was recruited in April 2025, indicating a longer-term commitment to the transformation agenda. In June 2025, a Mortuary and CAD Workforce Partnership Group will commence, which will focus on the development of Anatomical Pathological Technician's career pathways and succession planning.

Governance and meeting structure

The Mortuary and Care After Death services report into Pathology Governance, Directorate, Quality, and Training meetings to ensure adherence to standards and continuous improvement. Weekly Performance meetings with Divisional Management are well-established and as Pathology Governance reports directly to DPSQ, this ensures divisional oversight.

The recently re-established HTA Governance meetings aim to seek assurance of the ongoing work across the Health Board to maintain and enhance HTA compliance. Further work is

required to ensure that the HTA Governance terms of reference are clear, ensuring representation from all HTA licenses, and that a deputy chair is defined.

The assessment section below indicates the work undertaken by the Pathology Transformation Manager during the secondment.

Asesiad / Assessment

The culmination of the Transformation Manager’s work can be defined into two areas:

- 1. HTA compliance
- 2. Transformational changes (driving digital transformation, leadership changes and defining the future vision for the service)

The actions and associated outcomes related to the above, have been outlined into *separate tables* below for clarity:

Table 1: HTA compliance
(Each of the following tasks have been completed)

Task undertaken	Rationale / Benefit	Outcome/Status
Verification of Task and Finish group action implementation across the services	To ensure full implementation and embedding of actions, across all sites.	Some actions marked as complete by the Task and Finish group, were recognised to not have been fully embedded in the service across all sites. All actions are now fully embedded e.g. implementation of non-porous identification tags, training matrix fully updated, body condition monitoring process reviewed.
Audit schedule review	Revision was required of all audits to ensure appropriate frequency, instruction and understanding by all staff in order to ensure compliance with HTA audits.	All audits reviewed. Revision in particular of the following: • Cleaning schedules • Security audits • Temperature audits • Tissue traceability audits • Full body occupancy traceability audits A3 audit calendar posters created for all sites to aid completion. Staff trained in revised processes.
Full self-audit against 72 HTA standards (attached as appendix a)	To benchmark current processes against HTA and recognise areas for improvement	The findings of the self-audit are summarised under the 4 HTA domains: <u>Consent</u> fully compliant following completion of actions in February 2025.

		<u>Governance and Quality</u> – SOPs required work to ensure reflected current practice. Inter-dependencies for some actions - required engagement from Gwent Police. <u>Traceability</u> – Tissue traceability was a heavily paper-dependant process. This was revised and moved electronic. Associated SOPs required updating and staff to be trained in new process. Complete. <u>Premises and facilities</u> required engagement and therefore had inter-dependencies with works and estates, security and portering teams. Complete.
Establishment of working group	To build upon the progress established by the Task and Finish group and achieve complete resolution of HTA self-audit findings.	A working group was established to progress the actions identified and to escalate any urgent issues to Directorate/Divisional management in a timely manner. Each task was allocated to an individual or team to ensure accountability for completion.
Ward education on preparation of deceased prior to transfer to mortuary	Incident trends revealed a failure to adhere to established protocols during pre-mortuary transfer e.g. identification bands.	Educational poster devised and cascaded to all ward teams, across all sites, focussing on learning from recent incidents. Discussion at ward team briefs and nurse management meetings. Incidents were monitored to ensure improvement.

Table 2: Transformational changes identified (Requiring further support)

Task	Rationale	Action completed	Further Support required / Status
Review of Mortuary and CAD services software	Reliance on inefficient paper processes and 19 spreadsheets and paper forms, to understand the extent of inefficiencies and the risk of transcription errors (identified by HTA in 2022).	Procurement of an HTA-compliant solution, including audit trail, capacity management, paperless operation, and performance metrics.	Pending go-live date and confirmation of support by ABUHB integration teams (requires patient demographic feed from WPAS or CWS, and notification of death in secondary care from CWS).

Staffing review and development of career pathways	To ensure the appropriate managerial and staffing structure is in place, to provide service with the required support. APT on call rota historically has been covered by 3-5 APTs, 24/7 with no subsequent rest time.	Need for dedicated Band 7 for Mortuary and Care After Death services confirmed. Appointed and commenced role in April 2025.	Complete
		Locum APT appointed and administrative support moved into mortuary team.	Complete
		Mortuary representation at training, quality and cellular pathology management meetings established.	Complete
		On-call APT rota review completed. Urgent requirement for change due to inadequate rest time between shifts, and inability to recruit sufficient numbers of APTs to maintain 24/7 rota. Dependant on Gwent Police compliance with new process of community deceased identification (due to commence June 2025), and facilities undertaking community admissions outside core working hours to maintain HTA compliance.	A cross Divisional task and finish group has been established chaired by the COO to review the feasibility of facilities undertaking community admissions OOH at GUH (as currently takes place on peripheral sites) in order to stand-down the mortuary technician on call rota and provide adequate rest time, and reduce risk of HTARIs.
		HR Partnership Transformation Working Group commencing in June 2025 to develop career pathways and succession planning.	Terms of reference drafted and meetings scheduled.
Review of roles and responsibilities for Care After Death	To ensure the appropriate allocation of tasks relating to physical care of the deceased.	A formal review of the current processes for death certification management is required.	A cross Divisional task and finish group has been established chaired by the COO to review how Bereavement Services are

	The CAD service is currently overwhelmed arising from changes in the Medical Examiner death certification processes.		structured and delivered across the Health Board by the devolved teams, considering stakeholder experience and service outcomes.
Staff wellbeing review	To ensure the emotional and psychological wellbeing support for staff	Regular huddles and meetings established by Mortuary and Care After Death team manager. Monthly collaborative team meetings have a wellbeing focus. Counsellors are planned to support during some meetings to build emotional resilience and psychological safety.	Meetings scheduled. Work ongoing to support staff.
Corporate-led HTA Governance meetings	The recently re-established HTA Governance meetings aim to seek assurance of the ongoing work across the Health Board to maintain and enhance HTA compliance.	Mortuary and Care after Death services provide comprehensive reports indicating progress and an update of recent HTARIs to (and ensure attendance at) the HTA Governance meetings.	Further work is required to ensure the HTA Governance terms of reference and reporting structure is clear, ensuring representation at meetings from all HTA licenses (including PDs, or DIs as appropriate) and that a deputy chair is defined.
Develop collaborative working relationships with key internal, and external stakeholders (Medical Examiner and Coroner)	To streamline processes and improve efficiency of information sharing and coordination among relevant internal and external stakeholders.	Regular meetings established with Medical Examiner, Coroner's office and working relationships developed with Gwent Police. Mortuary and Care After Death are now established in the ABUHB Bereavement Collaborative.	Working relationships established. Work ongoing to improve communication and procedures.

Move to paperless, electronic audit system (AMaT), aiming for QI Accreditation	To provide assurance, audit visibility and reduce inefficiencies in the current paper-based audit system	Mortuary and Care After Death audits built on to AMaT system. For trial June 2025. Go-live date scheduled for July 2025. Mortuary and Care After Death services aim to achieve QI Accreditation following a period of high audit compliance and completion of Quality Improvement projects.	Go-live date scheduled.

The future vision for these services

In summary, the vision for the Mortuary and Care After Death Services is to:

- ✓ Achieve QI accreditation, enhancing the service's reputation and fostering greater awareness of its vital role and significant achievements across the health board.
- ✓ Develop clear career pathways and robust succession planning, ensuring a sustainable and highly skilled workforce for the future.
- ✓ Maintain a proactive and transparent approach through ensuring services operate safely, effectively, efficiently, and transparently, while demonstrating improved responsiveness and a clear focus on strong, well-led service delivery.

SUPPORT

The Directorate and Division require the Health Board's support to continue the transformation and modernisation of Mortuary and Care After Death (CAD) services.

Support from Facilities / Works and estates

Support is required from Facilities/Works and Estates Porters to facilitate out-of-hours community admissions. This would reduce the burden on APTs and reduce the risk to the service from inadequate rest-time following on-call shifts, allowing them to focus on licensed post-mortem tasks.

Following the appropriate training, porters would ensure safe transfer to refrigeration and completion of necessary paperwork, mirroring the current process for hospital deaths (and transfers from peripheral sites without body stores) which already happens outside core working hours. This procedure is contingent on embedding a new standard community admission process with Gwent Police, due to commence in June 2025. Following a period of audit and training, facilities could undertake this task.

Bereavement Service review

A review of the current structure and delivery of Bereavement Services across the Health Board's devolved teams; specifically, the responsibility for the death certification process, with consideration of stakeholder experience and service outcomes.

Consideration of responsibility for Chepstow and YAB Body Stores, should this fall under CAD's remit.

Argymhelliad / Recommendation

The Quality and Patient Safety Committee is asked to consider this report for assurance and note the request for support with regards to:

- Facilities support 'out of hours' for community admissions
- A review of the bereavement service to support ME and death certification process
- Consider including YAB and Chepstow body stores in the Care After Death Service

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Choose an item. Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Not Applicable
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Not Applicable
• Service Activity & Performance	Not Applicable
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Appendix a



HTA%20Full%20Audit.docx

Report summary:

This self-directed assessment of compliance with the 72 HTA Post-mortem license standards, was instigated by the Pathology Directorate and therefore the primary focus is on the Care After Death and Mortuary services in January 2025.

All actions were completed by the end of May 2025.

The report is divided into two key tables.

1. **TABLE 1: (Pages 1-7) A review of all previous HTA reports under this license** (Reports dated: Feb 2011, May 2015, Feb 2019, Nov 2022, July 2024). Outstanding non-conformances or recommendations noted at the commencement of this self-assessment, from the above reports, have been outlined in the table below
2. **TABLE 2: (Page 8 – 72) A review of the current service, measured against the 72 HTA Standards, which are grouped under four headings:**
 - Consent
 - Governance and Quality Systems
 - Traceability
 - Premises Facilities and Equipment.

The HTA Post-Mortem Licensing standards and guidance have been used to complete this review. [Post-mortem licensing standards and guidance | Human Tissue Authority](#). The review was completed using the following means:

- ✓ Review of SOPs, policies and audit templates
- ✓ Review of completed audits, QPulse CAPAs, distribution/copyholder lists on QPulse
- ✓ Observation of practice and discussions with staff
- ✓ Walkaround of premises (GUH, RGH, YYF, NHH)
- ✓ Review of 5 x previous reports completed by HTA

Please note: This self-assessment was peripherally extended with regards to Maternity and Gynaecological services who also work under the HTA Post-Mortem license, with regards to traceability, premises and facilities. Advice and recommendations have been offered to these services to enhance HTA compliance and the responsibility for actioning lies with the respective service managers. Notes have been included in the status column where actions have been assigned to Maternity and Gynaecological services.

TABLE 1: Review of all previous HTA reports under this license

Each of these have now been **resolved**.

Non-conformances identified in previous HTA reports that were outstanding as of January 2025							
Report	Standard	Findings	Shortfall	Action Required	Person completing	Progress notes	Status
November 2022	PFE1 The premises are secure and well maintained and safeguard the dignity of the deceased and the integrity of human tissue.	The inspection team identified the following risks to the security arrangements of the mortuaries: • The decommissioned PM room at the Nevill Hall Hospital satellite site has manual locks to the old changing room area. The changing room has been repurposed to a patient specimen collection area which is now part of pathology. There is a risk should the manual locks not be deployed, of access directly into the mortuary from patients attending this area	Major	Minor works request has raised (09.01.2025 when identified during this self-assessment) to resolve this and make the door closure permanent to remove risk of unauthorised access.	Amelia/Sue Kelly	Complete. Padlock fitted to door Monday 3 rd February 2025.	

Non-conformances identified in previous HTA reports that were outstanding as of January 2025							
Report	Standard	Findings	Shortfall	Action Required	Person completing	Progress notes	Status
November 2022	PFE1 The premises are secure and well maintained and safeguard the dignity of the deceased and the integrity of human tissue.	The viewing rooms at the satellite sites do not have systems in place for staff to be able to raise an alarm should this be required. This may pose a risk of visitors accessing the rest of the mortuary if staff security is compromised. Furthermore, the viewing room at the Royal Gwent Hospital satellite site has a door in the waiting area which leads directly to the rest of the mortuary which was not locked at the time of the inspection and is reliant on the deployment of manual locks.	Major	Health and Safety contacted to advise on alarm options for satellite sites and costs. NB: Only RGH alarm was put in place following the above action (YYF and NHH no alarms in place). Inspection found team does not know how to use alarm, the alarm did not work when tested and there was no program for testing the alarm periodically to ensure it was functional and appropriate actions would be taken. Identified GUH also needs same process – not yet in place.	Amelia	GUH have alarms in place in family room and viewing room. This was tested on 06/02/2025 by Facilities and Works & Estates. The alarm only signals in the control room which is not manned 24/7. Alarm has been re-routed to security and main reception. RGH have alarms in place, now directed and activated appropriately. NHH and YYF installed W/C 19.05.2025 Two APTs/CAD carrying out viewings until in place. Appropriate SOPs and risk updated.	

Non-conformances identified in previous HTA reports that were outstanding as of January 2025							
Report	Standard	Findings	Shortfall	Action Required	Person completing	Progress notes	Status
February 2019	GQ1 All aspects of the establishment's work are governed by documented policies and procedures	Several of the mortuary SOPs had been authored and reviewed by the same individual. Prior to the final report being issued the DI submitted evidence of the actions taken in relation to the shortfall. The HTA has assessed this evidence as satisfactory and considers this standard to be met.	Minor	Some SOPs and Policies reviewed on QPulse still have the same author and reviewer and the distribution list does not go to the entire team (and DI where required.) Review required of all mortuary/CAD related docs and policies QPulse once any required amendments (as per remainder of this document) are made.	Kate R	Complete	

Non-conformances identified in previous HTA reports that were outstanding as of January 2025							
Report	Standard	Findings	Shortfall	Action Required	Person completing	Progress notes	Status
February 2019	PFE2 There are appropriate facilities for the storage of bodies and human tissue.	The temperature of the body store fridges and freezers are manually checked and recorded by mortuary staff during normal working hours, however, this is not routinely or regularly done out-of-hours.	Minor	Temperatures are still not routinely checked out of hours at NHH and YYF (historical agreement with facilities that this is done by porters until automated temperature monitoring system in place [being procured]). Recent audit found zero compliance for OOH temperature checks by porters at NHH, and low compliance at RGH. Improved engagement between facilities and CAD required. Regular audit by CAD manager required with feedback and engagement with porter management to resolve.	Lucy Bennett	Highlighted for support to Ian West at HTA Governance meeting in January 25. Temperature alarm systems which remotely contact via phone/email are being procured for all sites. Weekly audits will be carried out until satisfactory checks are being undertaken. Email sent to Facilities to make them aware and for support. CAPA raised. <i>04.04.25 CAPA pending closure</i> <i>Daily checks undertaken by CAD team, OOH checks undertaken by Porters (Facilities). Lucy is auditing every other Month 12.05.25. Substantial improvement in compliance.</i>	

Non-conformances identified in previous HTA reports that were outstanding as of January 2025							
Report	Standard	Findings	Shortfall	Action Required	Person completing	Progress notes	Status
February 2019	GQ1(a)	Mortuary notification sheets are placed on the chests of the bodies in the refrigerated storage. The DI is advised to consider a process through which these forms are placed in plastic wallets to prevent their potential contamination with body fluids.	Advice	This process had not changed on the commencement of this review. These sheets are placed on the deceased from the wards, prior to arrival of the porters for transfer to mortuary (at time of shrouding). Sheets can be contaminated/soiled overnight before team arrive in morning to check overnight admissions. Review change in practice for ward staff and no sheets to be placed on body (team suggest brought to mortuary and placed next to mortuary register as opposed to introducing plastic wallets at ward level). Any reference to the utilisation of chest sheets must be changed in the relevant SOPs e.g. MO0093 CAD Daily	Andrea B Lucy Bennett/A melia	New notification sheet with instruction sent to nursing management on 04.02.25 for cascade, added to team briefs, nursing management meetings and nursing inductions. Request made to comms team 04.02.25 to replace current document on intranet. Educational poster to support new process cascaded across Health Board. MO0002 updated.	

Non-conformances identified in previous HTA reports that were outstanding as of January 2025							
Report	Standard	Findings	Shortfall	Action Required	Person completing	Progress notes	Status
				Process Point 7, check 'chest sheet' and check/audit implementation			

TABLE 2: SELF ASSESSMENT AGAINST HTA 72 STANDARDS

Consent C1					
Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act) and as set out in the HTA's Codes of Practice					
Standard	Inspection findings	Action required	Person completing	Progress notes	Status
C1a) There is a documented policy which governs consent for post-mortem examination and the retention of tissue, and which reflects the requirements of the HT Act and the HTA's Codes of Practice. Guidance: The policy should include information on who can give consent for post-mortem examination, removal of relevant material from the deceased, and the retention of tissue. References to the 'Next of Kin' should be avoided. The HTA's Codes of Practice provide information on the consent requirements of the HT Act.	CEP0920 appears to cover all the requirements and guidance from the HTA for hospital PMs.	Pathologists have requested minor change to Appendix 2 of CEP0920. Change: "Reflection and additional notes to show understanding" to be changed to "Tick to confirm discussion and understanding has been conveyed. Add comments as required".	Andrea B	Completed, sent to DI for approval on Q-Pulse 04.02.2025, now approved.	
		Folder to be created for each Pathologist office to ensure all relevant paperwork can be accessed in event of hospital PM. Copies of: 1. Appendix 1 and Appendix 2 of CEP0920 2. LFMO0008	Elaine P	Completed	
		LFMO0008 to be printed out and placed in mortuary office so that APTs can provide clinicians with this guidance for families in the	Jo Dunn	SOP printed and placed accordingly. Staff are aware of where to obtain SOP.	

Consent C1					
Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act) and as set out in the HTA's Codes of Practice					
Standard	Inspection findings	Action required	Person completing	Progress notes	Status
		event of hospital PM being requested. Also print out Appendix 1 of CEP0920 for mortuary office – ensure staff know where this is located in the event a hospital PM is required.		Printed and attached to office white board - Completed	
C1b) There is a documented standard operating procedure (SOP) detailing the consent process. Guidance This should include: • who is able to seek consent and what training they should receive; • who can give consent for post-mortem examination, removal of relevant material from the deceased and the retention of tissue (references to the 'Next of Kin' should be avoided); • what information should be provided to those giving consent for postmortem examination and the retention of tissue. The SOP should reference the use of scanning as an alternative or adjunct to post-mortem examination, where this is available. HTA Code of Practice B contains guidance for establishments	CEP0920 appears to cover all the requirements of C1B. Scanning as an alternative to PM is not mentioned within this document as this is not currently available within ABUHB.	None required			

Consent C1					
Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act) and as set out in the HTA's Codes of Practice					
Standard	Inspection findings	Action required	Person completing	Progress notes	Status
on seeking consent for post-mortem examination.					
C1c) There is written information for those giving consent, which reflects the requirements of the HT Act and the HTA's Codes of Practice. Guidance Information should include who can give consent for post-mortem examination, removal of relevant material from the deceased and the retention of tissue. References to the 'Next of Kin' should be avoided. The HTA's Codes of Practice provide information on the consent requirements of the HT Act. Information on consent should be available in different languages and formats, or there should be access to interpreters/translators. Family members should be given the opportunity to ask questions.	LMFO0008c is the All-Wales guide to the hospital post-mortem examination of an adult. This appears to be available in English only on QPulse. There is no reference in document CEP0920 to how this document could be translated if required for the family.	Action - add information as to how to get information for those giving consent translated if required/how to access translators. Add this to CEP0920, under point 7 of section 4.1 METHOD. See above	Andrea	Translation information added 04.02.25. Uploaded to Q-Pulse and distributed to pathologists.	
C1d) Information contains clear guidance on options for how tissue may be handled after the post-mortem examination (for example, repatriated with the body, returned to the family for burial/cremation, disposed of or stored for future use),	LFMO0008c is the All-Wales guide to the hospital post-mortem examination of an adult and contains information relating to C1D. No date	Action – look to see if there is a more up to date version of LFMO0008c All Wales guidance. Ensure what will happen if no decision is made is included in information.	Andrea	No more up to date version of All Wales guidance can be found. LFMO0008c has been updated with what steps will be taken if no decision is made by the relatives as per	

Consent C1					
Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act) and as set out in the HTA's Codes of Practice					
Standard	Inspection findings	Action required	Person completing	Progress notes	Status
and what steps will be taken if no decision is made by the relatives.	evident on the paperwork, unclear if this is the latest version. LFMO0008c does not include information about what steps will be taken if no decision is made by the relatives.			C1d.) and uploaded to Q-Pulse 04.02.2025	
C1e) Where consent is sought for tissue to be retained for future use, information is provided about the potential uses to ensure that informed consent is obtained.	LFMO0008 is the form that is completed for each element of consent. The information about potential uses is clear. LMFO0008c provides this information in the All-Wales Guidance.	None required			
C1f) The deceased's family are given an opportunity to change their minds and it is made clear who should be contacted in this event and the timeframe in which they are able to change their minds. Guidance The time relatives have to reflect on	LFMO0008 covers C1f and gives 24-hour timeframe from completion of form.	None required			

Consent C1					
Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act) and as set out in the HTA's Codes of Practice					
Standard	Inspection findings	Action required	Person completing	Progress notes	Status
their decision and the point up to which they may withdraw consent should be clearly stated and should not be less than 12 hours. The HTA recommends 24 hours. There may be specific occasions where a shorter timeframe is agreed with the family. This should be discussed with the family and documented.					
C1g) The establishment uses an agreed and ratified consent form to document that consent was given and the information provided. Guidance This may be based on the HTA's model consent form for adult post-mortem examinations available on the HTA website, or in relation to infants, the resources pack developed by the Stillbirth and neonatal death charity, Sands. In Northern Ireland, standardised consent forms agreed with the Department of Health Northern Ireland should be used. The consent forms should record the consent given for the post-mortem examination and for the retention and future use of tissue samples. Separate consent should be obtained for the removal and future storage	LFMO0008 is based on the HTA's model. This has been acknowledged on QPulse by Majid, James and Sian. Document history shows it has not been 'approved'.	Action: Send LFMO0008 to all remaining pathologists as copyholders on QPulse. Ensure they have acknowledged. Also needs official approval on QPulse in order to be considered 'ratified' under C1g – no approval history visible on QPulse for this document.	Elaine P	All Pathologists consented.	

Consent C1					
Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act) and as set out in the HTA's Codes of Practice					
Standard	Inspection findings	Action required	Person completing	Progress notes	Status
and use of organs and tissue (including blocks and slides) for scheduled purposes.					
Consent C2					
Staff involved in seeking consent receive training and support in the essential requirements of taking consent					
Standard	Inspection findings	Action required	Person completing	Progress	Status
C2a) There is training for those responsible for seeking consent for postmortem examination and tissue retention, which addresses the requirements of the HT Act and the HTA's Codes of Practice. Guidance Anyone seeking consent for post-mortem examination and tissue retention should have relevant experience and a good understanding of the consent procedure.	Pathologist provides training to the Consultant/Practitioner who will seek consent for the PM. This training discussion is recorded in Appendix 2 on CEP0920	None required			
C2b) Records demonstrate up-to-date staff training. Guidance Refresher training should be available (for example annually). There should be a system to ensure that only staff who have up-to-date training	Formatted spreadsheet exists which highlights those overdue for training. Review shows all currently in date. Associated paperwork (kept in Pathologist's personnel files) shows	Action: Ensure consent seeker training is undertaken annually by the pathologists. This was completed in January 2025 as it was prompted due to this audit, but prior to this it was overdue.	Elaine P	Secretarial team aware annual prompts are required for training.	

Consent C1					
Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act) and as set out in the HTA's Codes of Practice					
Standard	Inspection findings	Action required	Person completing	Progress notes	Status
seek consent (unless they are accompanied by a trained individual).	training most recently completed in January 2025 – Pathologists are trained in consent seeking annually.	Secretary team leader now has annual outlook prompt to book this for the pathologists. Look to add additional fail safes so this is not missed to maintain compliance.			
C2c) If untrained staff are involved in seeking consent, they are always accompanied by a trained individual.	CEP0920 explains that only those who have undergone the training with the Pathologist will be able to seek consent.	None required			
C2d) Competency is assessed and maintained. Guidance There should be a system to ensure that only staff who have been competency assessed seek consent (unless they are accompanied by a trained individual).	LMFO0028 shows the competencies that must be met in order for the pathologist to be considered competent in training consent seekers. Appendix 2 of CEP0920 is a template where the Pathologist can seek assurance from the consent seeker that they have understood their training and are	None required			

Consent C1					
Consent is obtained in accordance with the requirements of the Human Tissue Act 2004 (HT Act) and as set out in the HTA's Codes of Practice					
Standard	Inspection findings	Action required	Person completing	Progress notes	Status
	now competent to seek consent. Both of these must be complete in order to be involved in seeking consent.				

Governance and Quality Systems GQ1					
All aspects of the establishment's work are governed by documented policies and procedures					
Standard	Inspection findings	Action required	Person completing	Progress	Status
Documented policies and SOPs cover all mortuary/laboratory procedures relevant to the licensed activity, take account of relevant Health and Safety legislation and guidance and, where applicable, reflect guidance from RCPATH. These include: GQ1 i. post-mortem examination, including the responsibilities of Anatomical Pathology Technologists (APTs) and Pathologists and the management of cases where there is increased risk; ii. practices relating to the storage of bodies, including long term storage	i) MO0020 appears to cover all required aspects ii) MO0084 describes the	ii) This needs to be reviewed to make it clear	Andrea	Complete.	

Governance and Quality Systems GQ1					
All aspects of the establishment's work are governed by documented policies and procedures					
Standard	Inspection findings	Action required	Person completing	Progress	Status
iii. and when bodies should be moved into frozen storage; iv. practices relating to evisceration and reconstruction of bodies; v. systems of traceability of bodies and tissue samples; vi. record keeping; vii. receipt and release of bodies, which reflect out of hours arrangements; viii. lone working in the mortuary; ix. viewing of bodies, including those in long-term storage, by family members and others such as the police; x. transfer of bodies internally, for example, for MRI scanning; xi. transfer of bodies and tissue (including blocks and slides) off site or to other establishments; xii. movement of multiple bodies from the mortuary to other premises, for example, in the event that capacity is reached; HTA Guidance Updated: April 2024 8 xiii. disposal of tissue (including blocks and slides), which ensures disposal in line with the wishes of the deceased person's family;	process for long term storage. MO0092 describes monitoring care of deceased. This needs to be reviewed to make it clear if this also applies to babies/infants or to direct to the appropriate SOP. iii) MO0020 describes iii. iv) Tissue: MPMO0004 describes fate of tissue process. Body traceability –	that this also applies to babies/infants or how the process differs (direction to another SOP if appropriate). In practice, a process is in place for children/adult body condition checks; however not for babies/infants. This must be implemented whilst babies/infant occupy the mortuary. Team indicate criteria/gestation needs to be specified in the SOP for body condition checks. Full review required of storage arrangements and SOPs with Maternity. Mortuary often used for storage of products of conception. Paperwork provided by maternity sporadic/missing. Urgent review required iv) Tissue traceability: MPMO0004 Needs	Andrea	Advice offered to Maternity and Gynaecological services as to how to enhance HTA compliance with regards to traceability and confirmation of the identify checks taken at the time of release.	

Governance and Quality Systems GQ1					
All aspects of the establishment's work are governed by documented policies and procedures					
Standard	Inspection findings	Action required	Person completing	Progress	Status
xiii. access to the mortuary by non-mortuary staff, contractors and visitors; xiv. contingency storage arrangements. Guidance: Documented policies and procedures should reflect the requirements of the HT Act and the HTA's Codes of Practice. They should also reflect other relevant legislation and guidance. This includes the Health and Safety Executive's document: 'Managing infection risks when handling the deceased' (HSG283, published 2018) which can be found at: https://www.hse.gov.uk/pubns/priced/hsg283.pdf Individual policies and SOPs for each activity are not required. Some policies and SOPs will cover more than one activity. Procedures should be detailed enough to ensure uniformity between staff in the performance of a specific function and should be followed to the letter by all staff who have been appropriately trained. People undertaking the processes should be involved in developing the SOPs to ensure that the written procedures accurately reflect practices. A standard operating procedure (SOP) should be a clear and accurate representation of an existing procedure or process, preferably set out in the format of a stepwise guide (e.g., process chart). SOPs should be understandable to enable new	no single SOP/Policy found to describe how traceability is assured, however: - Audit template (CEPAU0011) - LFMO0050 describes how to update CAD database for admissions/releases - Mortuary SOPs exist for each stage of the process. E.g. MO0002 Admission, MO0007 Release, MO0051 Daybook entry, MO0052 PM entry. <i>Overarching doc to explain how traceability is achieved through occupancy list and use of CAD database (full</i>	updating to reflect practice, especially as process is now being reviewed to introduce electronic patient folders for documentation. (mentions faxes, saving forms to H drive). iv) Body traceability Consider updating MO0087 or another more suitable document to give a summary as to how traceability is achieved through occupancy list/CAD database vii) Once alarms have been installed for viewing areas, update this document for lone working and what measures have been put in place as per HTA advice (CEPP0001)	Andrea Heather		

Governance and Quality Systems GQ1					
All aspects of the establishment's work are governed by documented policies and procedures					
Standard	Inspection findings	Action required	Person completing	Progress	Status
staff to follow a procedure from beginning to end. Procedures should take account of both standard and out-of-hours arrangements. Lone working has the potential for greater risks to staff and the dignity of the deceased and requires careful management and oversight. Establishments may be assisted by the HSE guidance on Lone Working which can be found at: www.hse.gov.uk/pubns/indg73.pdf Access to the mortuary should be strictly controlled with clear policies and procedures which protect bodies from harm and breaches of confidentiality.	<i>process) not found however each stage explained in the above docs.</i> v) MO0087 Quality Control in the mortuary. Procedures also exist for each stage of the IT procedure. MO0051 Daybook entry, MO005 PM entry, MO0085 Same/Similar Names etc vi) MO0002 Admission appears to cover points. vii) CEPP0001 lone working viii) MO0009 covers identification and viewing of the deceased	PRIORITY ix)MO0044 needs updating for inter-site transfers. Only mentions transfers to GUH from “feeder hospitals” – does not describe practice i.e. deceased often transferred to RGH due to capacity. Does not include what or how checks must be made (or using what paperwork) prior to releasing deceased from originating mortuary. Does not reflect practice which is: During core hours, transfers are arranged by CAD team manager (or nominated person in their absence)who emails contracted funeral director with: • Full name • Address • DOB	Andrea	Urgent request placed to change switchboard proforma for transport requests (placed 06.02.2025) to ensure three points of identification and confirmation of whether it is a patient/organ for transport. Comms relayed by HCS to ad hoc courier team who make transfers. Transfer SOP will be urgently revised and team trained and fully informed.	

Governance and Quality Systems GQ1					
All aspects of the establishment's work are governed by documented policies and procedures					
Standard	Inspection findings		Action required	Person completing	Progress
	ix)	and includes long term storage MO0044 describes inter-site transfers and transfers to other establishments	Of each patient they need to transfer. MGR then prints this email (brings this with them to originating site) and utilises the information from the above to complete their own form. This form requires the CAD member to tick and sign that ID bands are present and that ID has been checked, but there is no second check stipulated on this form by the accompanying Funeral Director. This form has then been historically kept by MGR. Practice has recently changed as the CAD manager now ensures these forms are scanned before returning to MGR.		
	x)	MO0040 describes transportation process for specimens to other sites. MO0044 describes transportation of bodies to other establishments.			
	xi)	MO0089 BCP. MO0079 SOP for above BCP.			
	xii)	MO0060 SOP Authorisation Retention and Disposal of Human Tissue	OOH – Transfers over the weekend from any site –The process is the	Andrea	

Governance and Quality Systems GQ1					
All aspects of the establishment's work are governed by documented policies and procedures					
Standard	Inspection findings	Action required	Person completing	Progress	Status
	(Active 2019). LFMO0003 Retention and Disposal of organs RGH mortuary (Active 2024). LFMO0006 Form for recording disposal of blocks and slides under HTA requirements. MO0003 is the Security Procedure for body stores and GUH. It describes visitors needing to sign in to visitor's log book. It also describes the swipe access in place. xiii)	same as above but the facilities team (x2) are called by MGR and they will open mortuary. The deceased is transferred to a fridge, the mortuary book is completed and signed. Details will be added to the relevant fridge/board. All details and deceased will then be checked when CAD are next on shift. <i>This is all detailed in Porter training SOP MPMO 0009</i> Also makes reference to old SOP (SOP Procedure for the removal of patients from the department which appears to be obsolete on Q-Pulse. There is no appendix form to complete for transfers – only that which is utilised by MGR (which provides an audit trail,	Andrea		

Governance and Quality Systems GQ1					
All aspects of the establishment's work are governed by documented policies and procedures					
Standard	Inspection findings	Action required	Person completing	Progress	Status
	xiv) MO0089 BCP. MO0079 SOP for above BCP.	but this is a form which has not been previously authorised/approved by ABUHB) MO0044 does not include what checks would be made between releasing staff member and the courier – engagement with HCS, Switchboard, Maternity and Cellular Pathology required to establish what points of identification must be provided for transport and how this should be utilised upon collection/recorded that a two-person check has taken place.	Andrea		
		xii) Two documents relating to retention and disposal of human tissue (MO0060 and LFM00003) as well as	Andrea		

Governance and Quality Systems GQ1					
All aspects of the establishment's work are governed by documented policies and procedures					
Standard	Inspection findings	Action required	Person completing	Progress	Status
		MPMO0004 which is the SOP for acting in accordance with family's wishes following PM. Review whether all three of these documents are required or if one can be made obsolete (<i>likely MO0060 which does not mention GUH. Check if any content needs to be transferred to LFMO0003 before making obsolete</i>).			
GQ1b) Procedures on evisceration ensure that this is not undertaken by an APT unless the body has first been examined by the pathologist who has instructed the APT to proceed. Guidance Bodies should not be held in unrefrigerated conditions for prolonged periods of time prior to the arrival of the pathologist to undertake the external examination. HTA Guidance Updated: April 2024 9 This is to ensure the dignity and safety of the deceased and to preserve the body and any evidence of the cause of death.	MO0020 states the pathologist will externally check the deceased before signing the form to say evisceration can go ahead. Appendix is a form to be used by the APTs to confirm the Pathologist has made a provisional external examination of the deceased and they can continue with eviscerations. There is a space for the pathologist to	Confirm that this is done in practice (Andrea asked Amelia to discuss with team)	Amelia	It has been confirmed this is done before APT's start evisceration. Depending on the Pathologist, this is done the day before or on the morning of the PM. The Pathologist sign a form with patients details and a form	

Governance and Quality Systems GQ1					
All aspects of the establishment's work are governed by documented policies and procedures					
Standard	Inspection findings	Action required	Person completing	Progress	Status
	write what the exceptions are.			confirming patient is not infectious.	
GQ1c) Procedures on body storage prevent practices that disregard the dignity of the deceased. Guidance Practices such as placing more than one body on a tray, placing bodies unshrouded on trays, or storing bodies in unrefrigerated or unsecured storage areas should not take place. The family's permission should be obtained for any 'cosmetic' adjustments or other invasive procedures prior to release of bodies, for example, sewing the deceased's mouth to close it or the removal of a pacemaker. It is also good practice to discuss with the family any condition that may cause them distress, for example when viewing or preparing the body for burial, such as oedema, skin slippage or signs of decomposition. If identification of the body is to take place before a post-mortem examination, if available, a Police Family Liaison or Coroner's Officer should have a discussion with the family about the injuries and let them know that reconstruction may be required. However, the Pathologist should see the body without any changes being made, so if there is a need to reconstruct or clean a body before the postmortem examination, it should be with the	Unable to find documentation that specifies: • Only single body per tray • That bodies should be fully shrouded Viewing booking form is appendix within MO0009. In practice, these are destroyed after the viewing at GUH. On other sites, these are kept in a file and not scanned.	Further investigation needed to find where the below is documented and confirm this detail is covered in training documents: • Only single body per tray • That bodies should be fully shrouded If not found, this needs to be added to an appropriate document and ensure that training covers this. Viewing records must be kept and scanned to an appropriate folder following viewings. This detail should be added to MO0009 MO0009 should be updated to reflect the	Lucy Bennett Amelia Amelia	Explicit information regarding shrouding recently added to MO0093 CAD daily process. 04.04.25 complete Folder created in SharePoint. All viewing records will be scanned and kept in this folder.	

Governance and Quality Systems GQ1					
All aspects of the establishment's work are governed by documented policies and procedures					
Standard	Inspection findings	Action required	Person completing	Progress	Status
agreement of both the Pathologist and the Coroner. In forensic cases, a viewing cannot normally take place until after the post-mortem examination.	MO0009 does not have detail about who will prepare the family about injuries or appearance before viewings.	guidance for GQ1 with regards to who should discuss conditions with the family which may cause them distress (i.e. police for some cases, APTs/CAD for others) and how this should be discussed to the family. Two training documents exist for viewings and appear very similar. Consider amalgamating or making it clear why they are both different, and update MO0009 to reflect this (there is no mention of training in MO0009 or reference to either document). - LFMO0035 (Family viewings and police identifications) - LFMO0023 (Family viewing or Identification of deceased).	Lucy Bennett amalgamating and sending to Amelia	17.03.25 – Update: Lucy and Amelia to met this week to review the training docs and update MO0009. Amendments completed on Q-Pulse.	

Governance and Quality Systems GQ1					
All aspects of the establishment's work are governed by documented policies and procedures					
Standard	Inspection findings	Action required	Person completing	Progress	Status
		Ensure the above with regards to who/how the conversations about appearance is included in the training documents.			
GQ1d) Policies and SOPs are reviewed regularly by someone other than the author, ratified and version controlled. Only the latest versions are available for use. Guidance Regular review of SOPs will help to prevent incremental departure from written processes with passing time and allow establishments to identify improvements.	All documents need to be reviewed to ensure: ➔ The author and approver are different ➔ The copy-holders are current and everyone is included ➔ Acknowledgment is completed for all, including the DI where required ➔ That SOPs are reviewed by different individuals than the author. ➔ Review dates are not on many of the documents, some are written on the	All documents need to be reviewed to ensure: ➔ The author and approver are different ➔ The copy-holders are current and everyone is included ➔ Acknowledgment is completed for all, including the DI where required ➔ That SOPs are reviewed by different individuals than the author. ➔ Review dates are not on many of the documents, some are only	Kate R	New mortuary and CAD distribution lists. Author and approver changed across all docs.	

Governance and Quality Systems GQ1					
All aspects of the establishment's work are governed by documented policies and procedures					
Standard	Inspection findings	Action required	Person completing	Progress	Status
	document record on QPulse.	written on the document record on QPulse. It would be beneficial to have the date it needs to be next reviewed in the header/footer as a visual prompt to the reader.			
GQ1e) There is a system for recording that staff have read and understood the latest versions of these documents. Guidance This should include all staff who undertake licensed activities, including for example, portering staff, site managers and funeral directors who carry out mortuary activities out of hours.	Q-Pulse in use. Staff receive Q-Pulse training at induction and this is on the training spreadsheet and confirmation is included in training folders.				
GQ1f) Deviations from documented SOPs are recorded and monitored via scheduled audit activity.	Audit activity needs to be improved. Many dates missed in 2023/2024.	To be managed closely and prompts by Secretarial staff. A3 calendar (LFMO0057) in body stores/mortuary to be updated. QPulse to be maintained with audits completed. Audit activity	Jo Dunn Amelia Sue Kelly	Audit calendar clearly displayed on white board in Mortuary Office	

Governance and Quality Systems GQ1					
All aspects of the establishment's work are governed by documented policies and procedures					
Standard	Inspection findings	Action required	Person completing	Progress	Status
		to be scheduled on Q-Pulse.			
GQ1g) All areas where activities are carried out under an HTA licence are incorporated within the establishment's governance framework. Guidance These areas include Maternity departments where storage of fetuses and stillborn babies or removal of samples takes place, areas where material is stored for research, Accident and Emergency Departments for example where removal of samples may take place in cases of sudden unexpected death in infancy. There should be an identified Person Designated in each area of the establishment where licensed activities take place. The Designated Individual has a duty to ensure that suitable practices are carried out by those working under the licence, that the other persons to whom the licence applies are suitable persons to participate in the carrying on of those activities and that the conditions of the licence are complied with.	All licenses are represented at HTA Governance meeting. Meetings re-instated 2025. Clear reporting framework drafted.				
GQ1h) Matters relating to HTA-licensed activities are discussed at regular governance meetings involving establishment staff.	HTA Governance meetings reinstated January 2025.	Check the minutes have been cascaded to both PDs (Gwenan and AB).	Sue Kelly	SK has added AB and Gwenan to distribution list	

Governance and Quality Systems GQ1					
All aspects of the establishment's work are governed by documented policies and procedures					
Standard	Inspection findings	Action required	Person completing	Progress	Status
Guidance Meeting minutes should be recorded and made available to staff involved in licensed activities.					

Governance and Quality Systems GQ2					
There is a documented system of audit					
Standard	Inspection findings	Actions required	Person completing	Progress	Status
GQ2a) There is a documented schedule of audits. Guidance: As a minimum, the schedule should include a range of vertical and horizontal audits checking compliance with documented procedures as outlined in standard GQ1a, the completion of records and traceability of bodies and tissue. Audits should include checking of CCTV as well as records of mortuary access. Audit findings should document who is responsible for follow-up actions and the	CEPAU0002 – Mortuary tissue traceability audit template CEPAU0011 – Mortuary/Body store Body Traceability Audit Template	Move to AMAT with Traceability actions	Gwenan	02.04.25 Audits have been built on AMat. Trial scheduled in June 2025. Go-live date July 2025. Cohort of staff being trained in building audits to ensure further audits can be added/amended as the service requires.	
	Audit template for CCTV/Security in draft/revision form currently.	Q-Pulse does not appear to show that the body audits were completed in December. Upload paperwork/clear actions and ensure it is clear these were done as a priority.	Sue Kelly/Jo Dunn/Amelia	Audits completed in December are on Q Pulse.	
	Same/similar names audit last completed April	Security template to be updated as a priority and added to QPulse. Regular	Amelia/Gwenan	Second draft being reviewed. Will be uploaded to Q-Pulse and used for March audits.	

timeframe for completing these.	2024. ? Frequency. Sarah R wrote in findings that CEPNC848 from AUD3346 to be completed to close shortfall with competency, and that a fuller competency assessment needed to be written. No follow up identified. Vertical audit (LFMO0010) from admission to release to be completed and template to be updated (states Mortuary RGH on template).	audits to be completed for all sites and completed paperwork uploaded to QPulse. Unable to find a Same/Similar names audit template and competency referenced by Sarah R (see left column). MO0085 which describes same/similar name process states in point 11 that this process will be audited as part of the vertical audit (see below), but no reference to this found in the Vertical Audit template. Vertical audit (LFMO0010) template to be updated (states Mortuary RGH on template), and should audit the whole process from admission to release. To be reinstated as a priority and completed for all sites. Define frequency and add to audit calendar (LFMO0057). Add Same/Similar names process as per above. Check the HTA standards	Kate R	04.04.25 Completed 27.03.25 - Gwen and Kate met to review the vertical audit. Removed tasks required for UKAS only. 02.04.14 - Gwen and Kate met with Laura to transpose vertical audit onto AMat. Vertical audit now complete on Q-Pulse and AMat.	

		named in the template are still applicable (standards may have changed since template was created).			
GQ2b) Audit findings document who is responsible for follow-up actions and the timeframe for completing these. Guidance: Staff should be made aware of the outcomes of audits and where improvements have been identified. Processes should be in place to ensure that feedback of audit findings to all staff takes place in a timely and appropriate manner to ensure up to date procedures are embedded and being followed.	No team staff meetings are currently taking place. Staff are made aware of audit findings on an ad hoc basis. Mortuary do not currently produce a quality report for the quarterly CellPath quality meeting.	Joint team staff meetings are to be put in place for CAD/mortuary. Ensure audit findings are part of mortuary/CAD team meeting agenda, and that outcomes/improvements are identified and shared. Mortuary to be represented at Cell Path quality/management meetings and produce quality report to demonstrate recent audit outcomes. Formal audit outcomes to be shared via email/comms/posters/Q-Pulses where appropriate and required, or where it has changed practice.	Amelia Sue Kelly/Amelia Amelia	Amelia scheduling meetings and has drafted agenda to include audit findings/learning from incidents etc. SK has added Amelia to represent mortuary distribution/invite list for Quality meetings	
GQ2c) Regular audits are carried out of tissue being stored so that staff are fully aware of what is held and why and to	See Traceability standards and actions	See Traceability standards and actions	Jo Dunn/Amelia	Process reviewed. See traceability actions. Complete	

enable timely disposal of tissue where consent has not been given for continued retention. Guidance Audits of stored tissue should include samples held under the authority of the police, where applicable.					

Governance and Quality Systems GQ3					
Staff are appropriately qualified and trained in techniques relevant to their work and demonstrate competence in key tasks					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
GQ3a) All staff who are involved in mortuary duties are appropriately trained/qualified or supervised. Guidance This should include all staff who undertake mortuary activities, for example, portering staff, site managers and funeral directors who may carry out mortuary activities out of hours. APTs should be trained in reconstruction techniques to ensure that the appearance of the	APTs are trained in reconstruction techniques as part of their on-site and academic training. Training and competency assessments in place for GQ3a for porters, APTs and CAD.	Check how we ensure funeral directors are appropriately trained in mortuary duties OOH e.g. transfers to other sites, review what duties they take part in e.g. completion of mortuary register, release process OOH at sites when CAD not present. Check if training is completed and where training records are held. Check contract/SLA with contracted FDs, do we have training specified	Lucy Bennett	No training for FDs required. Facilities training completed to ensure processes are abided by, by FDs for OOH transfers.	

Governance and Quality Systems GQ3					
Staff are appropriately qualified and trained in techniques relevant to their work and demonstrate competence in key tasks					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
deceased is as natural as possible. Staff should be encouraged to obtain vocational and educational qualifications relevant to their work.		Health Board Moving and handling training not completed (team/CAD manager say this is due to unavailability of HB courses)– 2 day training still to be completed for each team member. To be prioritised.	Sue Kelly	Sue Kelly in contact with H&S and is arranging for APTs and CAD staff to attend appropriate MH training as a priority. Update 02.04.25 - 4 attending 16.05.25 3 CAD / 1 Mortuary Extra session TBA. All CAD now trained. Further date scheduled to complete outstanding mortuary APTs training in June 2025.	
GQ3b) There are clear reporting lines and accountability.	Mortuary management structure QP1034 to be reviewed and updated. (Includes names which have now changed and numbers of APTs which has also now changed). CAD is not part of mortuary structure document at present.	Mortuary management structure QP1034 to be reviewed and updated. (Includes names which have now changed and numbers of APTs which has also now changed). When new mortuary/CAD management structure is defined this needs included. CAD is not part	Andrea/Simon	Updated following Heather's appointment.	

Governance and Quality Systems GQ3					
Staff are appropriately qualified and trained in techniques relevant to their work and demonstrate competence in key tasks					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
		of mortuary structure document at present.			
GQ3c) Staff are assessed as competent for the tasks they perform. Guidance This should include for all staff who undertake mortuary activities, for example, portering staff, site managers and funeral directors who may carry out mortuary activities out of hours. Assessment of competence should include the standard of APTs' reconstruction work.	LFMO0024 covers competency assessment of reconstruction.	Check how we ensure funeral directors are appropriately trained in mortuary duties, review what duties they take part in e.g. completion of mortuary register, transfer process OOH at sites when CAD not present. Check if training is completed and if competency assessments are completed. Check contract/SLA with contracted FDs, do we have training and competencies specified	Lucy Bennett	Not required for FDs, see above action GQ3a). Porters completed.	
GQ3d) Staff have annual appraisals and personal development plans.		Check if any PADRs outstanding for mortuary team	Sue Kelly	SK has ran a report in ESR and let AB know no one is outstanding at the moment. Will run regular PADR reports on ESR and report back any outstanding to AB and schedule in Diary. Update May 2025: All PADRs in date. None overdue.	

Governance and Quality Systems GQ3					
Staff are appropriately qualified and trained in techniques relevant to their work and demonstrate competence in key tasks					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
GQ3e) Staff are given opportunities to attend training courses, either internally or externally. Guidance: Attendance by staff at training events should be recorded.	HEIW have provided funding for mortuary assistant level 2. Training. CAD member due to start in March. Plan to eventually train all members. Ensure all staff retrain evidence of attending training courses.	Check APTs record attendance where appropriate at training courses.	Sue Kelly	Complete. All training evidence retained in individual folders in mortuary.	
GQ3f) There is a documented induction and training programme for new mortuary staff.	In place. Training spreadsheet up to date apart from maternity leave within CAD team and Lead APT who is off long-term at present. Other training records have been reviewed and are completed.	N/A			
GQ3g) Visiting / external staff are appropriately trained and receive an induction which includes the establishment's policies and procedures. Guidance The qualifications of locum staff should be checked prior to them	Locums have not been in place for several years in mortuary. Team are aware locum induction must include GQ3g)	N/A			

Governance and Quality Systems GQ3					
Staff are appropriately qualified and trained in techniques relevant to their work and demonstrate competence in key tasks					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
commencing work in the mortuary and their competency to undertake each task should be assessed.					

Governance and Quality Systems GQ4					
There is a systematic and planned approach to the management of records					
Standard	Inspection Findings	Level of Shortfall	Person completing	Progress	Status
GQ4a) There is a system for managing records which includes which records must be maintained, how they are backed up, where records are kept, how long each type of record is retained and who has access to each type of record. Guidance Records include records of access to the mortuary (by whom and for what purpose), mortuary registers, electronic management systems, PM examination records, tissue retention forms and records of transfer and return of organs/tissue sent elsewhere for examination.	Security access records in place (available on request from facilities). Instructions for this are included in draft security audit template. See Traceability actions with regards to record keeping for tissue retention and transfer forms	See Traceability actions with regards to record keeping for tissue retention and transfer forms	Amelia (IG) Gwenan (Q-Pulse doc)	Information sought from IG and actioned:- Mortuary register books to be kept indefinitely. All histology samples taken are recorded electronically on specimen archive spreadsheet. All paper records since the opening of GUH (2020) to date have been retained.	

Governance and Quality Systems GQ4					
There is a systematic and planned approach to the management of records					
Standard	Inspection Findings	Level of Shortfall	Person completing	Progress	Status
				Going forward, all paperwork will be saved in folders on SharePoint.	
GQ4b) There are documented SOPs for record management which include how errors in written records should be corrected.	Raising and accepting a change request on Q-Pulse is defined in QP1029. Q-Pulse training is covered as part of inductions and written into the training spreadsheet.	Reference to QP1029 should be added to induction paperwork for mortuary and CAD. Check acknowledgements on Q-Pulse for all team members.	Lucy Bennett/Gwenan Jones working on induction reading list. Kate added as change request on Q-Pulse.	04.04.25 Completed and distributed Complete	
	CEP1002 describes how errors in written records should be recorded and makes reference to an error log.	Ensure error log in place for mortuary.	Heather	Complete	
GQ4c) Systems ensure data protection, confidentiality, and public disclosure (whistleblowing).	MO0026 is the procedure for confidentiality within the mortuary. LFMO0031 is the mortuary trigger list which includes HTARI classifications but also includes 'must report organisational and non-clinical incidents'.	Add reference to MO0026 in induction document to ensure it is read for mortuary and CAD. Check acknowledgements on Q-Pulse for all team members.	Lucy Bennett/Gwenan Jones working on induction reading list.	04.04.25 Completed	

Governance and Quality Systems GQ5					
There are systems to ensure that all untoward incidents are investigated promptly					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
GQ5a) Staff know how to identify and report incidents, including those that must be reported to the HTA. Guidance HTA reportable incidents (HTARIs) and near-miss HTARIs must be reported within five working days of the incident occurring or being discovered. Establishments must not wait until any internal review or investigation is complete before notifying the HTA of the HTARI. Person Designated should register for a HTA Portal account, to ensure that HTARIs can be reported to the HTA within the required timescale in the absence of the Designated Individual. The HTARI reporting requirements and process for reporting incidents should be documented in a standard operating procedure. All staff involved in licensable activities should be aware of the HTARI reporting requirements and	LFMO0031 is the mortuary trigger list which includes HTARI classifications but also includes 'must report organisational and non-clinical incidents'. MPMO003 is dealing with errors and incidents in Mortuary and Body Stores, including HTARI.	Add MPMO003 and LFMO0031 to reading list in induction for mortuary and CAD. Check acknowledgements on Q-Pulse for all team members.	Lucy Bennett/Gwenan Jones working on induction reading list.	04.04.25 reading list complete. Checked QPulse, few acknowledgements left to chase. Gwen to email a reminder Q-Pulse Team acknowledgements completed.	

Governance and Quality Systems GQ5					
There are systems to ensure that all untoward incidents are investigated promptly					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
procedure. This includes staff working in those areas outside of the mortuary, such as pathology, Maternity and Accident and Emergency departments. Incidents that do not fall within the HTARI reporting requirements should be reported and investigated internally.					
GQ5b) The incident reporting system clearly outlines responsibilities for reporting, investigating and follow up for incidents.	LFMO0031 is the mortuary trigger list which includes HTARI classifications but also includes 'must report organisational and non-clinical incidents'. MPMO003 is dealing with errors and incidents in Mortuary and Body Stores, including HTARI.	N/A			
GQ5c) The incident reporting system ensures that follow up actions are identified (i.e., corrective and preventative actions) and completed.	Datix and Q-Pulse used.	N/A			
GQ5d) Information about incidents is shared with all staff to avoid repeat errors.	Ad hoc staff meetings currently taking place. Formalised meetings to be instated with CAD and	Add incidents to staff meeting agenda. Ensure recorded in minutes.	Amelia	Added to meeting agenda. Meetings are scheduled	

Governance and Quality Systems GQ5					
There are systems to ensure that all untoward incidents are investigated promptly					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
	Mortuary teams on a monthly basis.				
GQ5e) The establishment adopts a policy of candour when dealing with serious incidents.	Evidence from recent HTARIs shows duty of candour is adopted when dealing with serious incidents. MP51203 is the Pathology Duty of Candour Policy.	N/A			

Governance and Quality Systems GQ6					
Risk assessments of the establishment's practices and processes are completed regularly, recorded, and monitored					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
GQ6a) All procedures related to the licensed activities (as outlined in standard GQ1) are risk assessed on a regular basis. Guidance Risks to the security, dignity and integrity of bodies and stored tissue should be covered. The HTARI categories provide a good basis for risk assessments. Establishments may also be assisted by the Health and Safety Executive's guidance on the steps needed to managing risk which can be found at:	Risk assessments all within review date and cover the required areas stated by HTA. Staff within the APT team and CAD team have historically reviewed these under GQ6a). Approx. 33 risks under mortuary on DatixWeb, mostly held on local risk register after mitigation.	Review whether some risks can be closed.	Heather	Complete	

Governance and Quality Systems GQ6					
Risk assessments of the establishment's practices and processes are completed regularly, recorded, and monitored					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
https://www.hse.gov.uk/simple-health-safety/risk/index.htm Risk assessments should be reviewed at regular intervals, for example every 1- 3 years or when circumstances change. Relevant staff should be involved in the risk assessment process and should be aware of the risks associated with the activities they undertake.					
GQ6b) Risk assessments include how to mitigate the identified risks. This includes actions that need to be taken, who is responsible for each action, deadlines for completing actions and confirmation that actions have been completed. Guidance Relevant staff should have knowledge of risks and the control measures that have been taken to mitigate them.	Reviewed risk assessments cover GQ6b). Risk assessments are distributed to staff and a record is kept of their distribution.	Check where the risk assessment distribution records are kept. Are these held in individual training folders. Upon spot inspection at each site, teams were unable to explain what risk assessments are in place and what the mitigations are. Add overview of risks and ask for team engagement and feedback at team meetings to ensure understanding and involvement in risk management.	Amelia/Lucy Bennett Amelia/Lucy (Added to team meeting agendas)	Located in training files. Complete. Added to team meeting agendas	
GQ6c) Significant risks, for example to the establishment's ability to deliver	MO0079 Mortuary contingency plan explains	Further mitigation should be added to Point 3 of	Heather	Complete	

Governance and Quality Systems GQ6					
Risk assessments of the establishment's practices and processes are completed regularly, recorded, and monitored					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
postmortem services, are incorporated into the Trust's organisational risk register. Guidance This includes to the relevant Trust, Health Board or Local Authority, and should include appropriate risk mitigation measures.	that post-mortem service could not be delivered due to failure in facilities or significant staff shortage. that deceased would be sent to other licensed establishments 'such as UHW or Bristol' and that this would be the responsibility of the Coroner to agree and arrange transfer. Risk 4983 appears as a high risk on the Directorate Risk Register (Staff shortages resulting in unsafe mortuary service) Risk 8635 appears as moderate risk on the Local Risk Register (major equipment failure which could have significant impact on service delivery)	MO0079: <i>Significant Staff shortage</i> for example the utilisation of locums			

Traceability T1					
A coding and records system facilitates traceability of bodies and human tissue, ensuring a robust audit trail					
Standard	Inspection Findings	Improvements/changes needed	Person completing	Progress	Status
T1a) Bodies are tagged/labelled upon arrival at the mortuary. Guidance The condition and labelling of bodies should always be checked and recorded, and their identity confirmed. Identification labels should be attached to the body. Body bags and shrouds should not be labelled in place of labels attached to the body.	MO0002 For hospital admissions, this procedure describes how bodies should be tagged, reflecting the guidance for T1a). It describes what action should happen if the body is not correctly tagged when transferred from the ward. It does however <i>not</i> say that this should be recorded on datix. For community admissions, the team report that Gwent Police do not tag/place an identification sheet on the body, as South Wales Police do. The pathology transformation manager is in the process of revising this in collaboration with Gwent Police so that tagging at the scene takes place. A draft revision of MO0002 has been completed and is awaiting senior police review.	It is advised that MO0002 is revised to include reporting on datix where a patient has come to the mortuary from the ward without an identification band. A draft revision of MO0002 has been completed and is awaiting senior police review. Engagement with Gwent Police with regards to changes to identification and tagging of body at scene, must continue until completion and new process formally in place. Once in place, this new process should be audited for compliance.	Andrea Andrea/Simon/Amelia Heather	Start date for new process June 2025. Period of audit to follow. Gwent police training their staff, new system in place. MO0002 to updated 20.05.2025 to reflect new process.	
T1b) There is a system to track each body from admission to the mortuary to	Following review and observation, admission and release information is mostly	Pursual of an all-in-one software for CAD and mortuary would prevent the current duplication in	Andrea B	NDSR raised. Divisional support. Discovery phase	

Traceability T1					
A coding and records system facilitates traceability of bodies and human tissue, ensuring a robust audit trail					
Standard	Inspection Findings	Improvements/changes needed	Person completing	Progress	Status
release for burial or cremation (for example mortuary register, patient file, transport records). Guidance Body receipt and release details should be logged in the mortuary register or the electronic database, including the date and name of the person who received/released the body and, in the case of release, to whom it was released. This includes bodies sent to another establishment for PM examination or bodies which are sent off site for short-term storage and which are subsequently returned before release to funeral service staff.	reliably recorded in the paper mortuary register at the time of release. However, on one occasion, a deceased had been moved to RGH and this had not been noted in the mortuary register. There is a delay between release and the updating of LIMS as this tends to be done towards the end of the same/next working day. This information is then duplicated via email to the CAD team so that the CAD Database can be updated – room for error. Evidence of errors found in terms of fridge entry/CAD database not updated with release information.	terms of admission, fridge location and release information, that is needed to update both systems. Live admission/fridge location and release updates into electronic software once in place should be pursued.	Heather	for Eden complete. Procurement complete. Integration planning taking place.	
T1c) Three identifiers are used to identify bodies and tissue, (for example post - mortem number, name, date of birth/death), including at least one unique identifier.	MO0002 and MO0009 describes the identifiers that must be used at admission, and for viewings, and where unknown, what actions should	The record for recording property handover (appendix to MO0009) says Gwent HealthCare Trust. This form should be updated.	Amelia	Amelia is updating this document as part of an earlier action and will change this.	

Traceability T1					
A coding and records system facilitates traceability of bodies and human tissue, ensuring a robust audit trail					
Standard	Inspection Findings	Improvements/changes needed	Person completing	Progress	Status
	be taken to ensure identity confirmed. Observation and review of recent full body audit confirmed application of these SOPs in practice. DOB routinely used to confirm ID, not age, as advised by the HTA.				
T1d) There is a system for flagging up same or similar names of the deceased. Guidance This should consider the sound and spelling of forenames and surnames. The system should include bodies that are moved off site for contingency storage, where they may be returned to the establishment.	All sites operate a Same/Similar Names process by: • Indicating this with a whiteboard magnet • CAD indicate this by giving the individual the code "SN" on the CAD database • GUH create a Same/Similar Names list which is placed on the whiteboard.	Previous HTA report indicates they recommended that the other sites adopt the same process as GUH for Same/Similar names, i.e. by creation of a Same/Similar Names list and having this pinned to the board in the office. GUH team utilise a 'bold' surname first, then forename, process which should be adopted when creating this list.	Lucy Bennett	04.04.25 LB and AB discussed process to stay the same currently. Will change with new system installation	
T1e) Identity checks take place each time a body is moved whether inside the mortuary or from the mortuary to other premises. Guidance HTA Guidance Updated: April 2024.	At GUH, an occupancy list is generated to show fridge locations and the CAD team are also informed when these change so the database can be updated. Team confirmed that white boards are not routinely wiped	Compare transfer and release documentation – ensure ID and information is checked by two individuals before transfers in the same way releases are	Amelia	A new transfer document to be devised. This will be signed by APT/CAD member and courier/Funeral Director.	

Traceability T1					
A coding and records system facilitates traceability of bodies and human tissue, ensuring a robust audit trail					
Standard	Inspection Findings	Improvements/changes needed	Person completing	Progress	Status
Mortuary white boards containing the names of the deceased give potential for error if wiped clean (such as when visitors attend for reasons of confidentiality) and should not be relied upon as the sole source of information about the locations of bodies. Fridge/freezer failures that require bodies to be moved temporarily whilst repairs take place present a risk to traceability. Full identification checks should be made when bodies are placed back into normal storage. Checks should be made to ensure that identification bands on bodies are accessible and legible when bodies are transferred into freezer storage	clean for confidentiality when visitors attend due to potential for error. Spot checks as part of this self-assessment, on all sites, indicate full ID checks are completed as per procedure.			A new inter-site transfer form has been devised and MGR have started to use it.	
T1f) There are procedures for releasing a body that has been in long term storage and is therefore not in the current register.	Bodies are kept on the occupancy list and in the body condition monitoring spreadsheet during their entire length of stay.	A review of the body condition spreadsheet and associated paperwork confirmed that currently body condition checks are not completed on babies/infants. This is to be reviewed as a priority. Team to	Amelia	Body checks will start immediately on babies/infants and body condition check sheet completed. Baby/infant will be	

Traceability T1					
A coding and records system facilitates traceability of bodies and human tissue, ensuring a robust audit trail					
Standard	Inspection Findings	Improvements/changes needed	Person completing	Progress	Status
	Old registers are stored to ensure all information can be accessed when it comes to time of release. A review of the body condition spreadsheet and associated paperwork confirmed that currently body condition checks are not completed on babies/infants. This is to be reviewed as a priority. Team to be briefed on the application of long-term storage SOP to babies/infants.	be briefed on the application of long-term storage SOP to babies/infants.		placed into long term storage if appropriate e.g. awaiting coroner report or PM. SOPs updated.	
T1g) Organs or tissue taken during post-mortem examination are fully traceable, including blocks and slides (including police holdings). The traceability system ensures that the following details are recorded: i. material sent for analysis on or off-site, including confirmation of arrival ii. receipt upon return to the laboratory or mortuary iii. the number of blocks and slides made iv.	i – iii) This is maintained by the APTs in the 'specimen archive' which is a word document saved on a shared system that all of the team can access. iv) The SOP is clear about what steps should be taken however this process has been managed by a single APT for a long period of time and the emails from the Coroner have until recently been contained within a single email address. The remaining team are unaware of the	The Coroner is now using the recently created shared mortuary email inbox for all HTA forms going forward. The tissue traceability SOP MPMO0004 must be shared with the wider team – ensure all have acknowledged on Q-Pulse. A flowchart so the process can be easily followed, needs to be created and put on display in the mortuary office.	Jo Dunn Amelia Andrea	When tissue/blocks/slides are returned Jo to receipt and check HTA1/4 forms for family wishes. Team aware of SOP, flow chart to be created. Flow chart has now been created and sent to all appropriate staff.	

Traceability T1					
A coding and records system facilitates traceability of bodies and human tissue, ensuring a robust audit trail					
Standard	Inspection Findings	Improvements/changes needed	Person completing	Progress	Status
repatriation with the body v. return for burial or cremation vi. disposal or retention for future use. Guidance When material is sent for analysis on or off-site, records should clearly indicate the type and quantity of the samples (including swabs, blood samples, tissue blocks and slides). There should be a system to highlight and follow up if samples have not arrived at the destination within a specified timeframe. Consent information which covers retention/disposal of tissues should be made available to the other site, as appropriate.	process that should be followed.			(Jo to familiarise herself with PM's process and cascade to rest of team (W/C 03.03.2025)	
		Each patient to have an electronic folder created named as: Mortuary Register Number/Coroner Reference Number/Surname. In this folder HTA 1, HTA 4, PM paperwork, Coroner authorisation, Pathologist authorisation for disposal, LFMO0006 (record of disposal) etc. should all be stored for each of tissue traceability.	Jo Dunn/Amelia	Electronic folder created, staff made aware. Transfer data from X drive to share point to be arranged.	
		Tissue traceability audit should be performed once this new process is in place to ensure resolution of issues identified. Increase frequency of audit from every 6 months, to every 3 months and double sample size.	Amelia	Tissue traceability audit was completed 18/02/2025.	
		MO0040 defines the process for transporting organs and	Jo Dunn/Amelia	Flow chart complete and	

Traceability T1					
A coding and records system facilitates traceability of bodies and human tissue, ensuring a robust audit trail					
Standard	Inspection Findings	Improvements/changes needed	Person completing	Progress	Status
		specimens to specialist centres. A flowchart or quick reference guide should be created to ensure that staff know what to do. This should be put on display on the notice board in the mortuary office. Ensure staff acknowledge this document and any changes on Q-Pulse.		added as appendix to SOP.	
T1h) There are documented procedures for transportation of bodies and tissue anywhere outside the mortuary, (such as to the lab or another establishment), including record-keeping requirements. Guidance Formal written agreements with funeral services are recommended. Coroners usually have their own agreements for transportation of bodies and tissue; however, documentation for traceability purposes must still be maintained by the establishment for these cases.	MO0040 details the collection, labelling and transportation requirements for specimens. MO0044 details the procedure for transfer of patients between establishments and associated docs that must be completed MO0092 explains the importance of ensuring body monitoring paperwork accompanies the deceased.	Update MO0044 to include transfer from GUH to satellite sites for contingency storage arrangements when capacity is reached (only transfer to GUH from 'feeder sites' is mentioned) See actions above for T1g)	Andrea		

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Traceability T2					
Disposal of tissue is carried out in an appropriate manner and in line with the HTA's Codes of Practice					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
Guidance The communication flowchart in Code of Practice B (Annex B) provides information on communication for Coroner's post-mortem examinations.	Single APT previously oversaw this process. Due to unforeseen leave there is a backlog of tissue for which the wishes need to be acted upon.	which is no longer used. Shared email inbox now in place, should be added to SOP.			
T2c) Disposal is in line with the wishes of the deceased's family. Guidance: Organs and tissue returned to the body prior to its release should be contained in clear viscera bags, which prevent leakage, are biodegradable and pose no issues for crematoria in relation to emissions and pollution. Clinical waste bags or household bin bags should not be used for this purpose. Tissue blocks and glass slides should not be placed inside the body for the purpose of reuniting tissues with the deceased. Blocks and slides should be placed in a suitable container and transported with the body should the	MO0060 describes the procedure for authorisation, retention and disposal of human tissue. MPMO0004 Procedure for recording and acting in accordance with a Qualifying Individual's wishes for fate of material following a Coroner's post-mortem examination Team have confirmed, and observation confirms that this standard is applied to in terms of clear viscera bags and that the guidance regarding blocks/slides is adhered to. However, I have been unable to find documentation that specifically outlines the guidance for T2c) i.e.	MO0060 requires updating/review. No references to GUH, only Royal Gwent and NHH. MPMO0004 requires updating/reviewing. References Royal Gwent, no GUH. Also mentions receiving forms via fax which is no longer used. Add HTA guidance in italics for T2c to the most appropriate SOP (MO0060 or MPMO0004)	Andrea Andrea	Amalgamated with MPMO004. Complete	

Traceability T2					
Disposal of tissue is carried out in an appropriate manner and in line with the HTA's Codes of Practice					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
family wish to delay the funeral until the slides are returned.	<i>"Organs and tissue returned to the body prior to its release should be contained in clear viscera bags, which prevent leakage, are biodegradable and pose no issues for crematoria in relation to emissions and pollution. Clinical waste bags or household bin bags should not be used for this purpose. Tissue blocks and glass slides should not be placed inside the body for the purpose of reuniting tissues with the deceased. Blocks and slides should be placed in a suitable container and transported with the body should the family wish to delay the funeral until the slides are returned"</i>				
T2d) The method and date of disposal are recorded.	This is part of the process and written in MO0060 but non-conformities were noted during audit.	See actions for T1g, T2a. Re-audit until improvement.	Amelia/Gwenan	Added to electronic spreadsheet. Historically recorded on specimen archive.	

Premises, facilities, and equipment PFE1					
The premises are secure and well maintained and safeguard the dignity of the deceased and the integrity of human tissue					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
PFE1a) The premises are clean and well maintained. Guidance Floors, walls, and work surfaces should be of non-porous construction and free of cracks and chips. The premises should be subject to a programme of planned preventative maintenance, which ensures that the premises, facilities, and equipment remain fit for purpose	No planned preventative maintenance program in place for fridges/freezers across all sites. Annual maintenance recently completed ad hoc for hydraulic trolleys on all sites to make them LOLER compliant (were overdue and out of compliance at time of completion) Annual maintenance recently completed ad hoc for Co-mark temperature monitoring system at GUH. Prior to this had not been completed since installation in 2020. Preventative maintenance program in place for post-mortem tables at GUH and in date. Unable to find preventative maintenance reports for:	Engagement with Estates required on all sites to confirm ventilation systems are having preventative maintenance and to access reports. Preventative maintenance to be arranged for: • Concealment trolleys • Hydraulic trolleys • Ceiling mounted hoist at GUH • Fridge/freezers on all sites	Tim Walbyoff Tim Walbyoff	Ventilation systems confirmed by Estates to have preventative maintenance and readily available reports in respect to GUH. Awaiting confirmation on RGH and NHH (Emailed DK and IC 05.02.25). No commissioning data for RGH or NHH. Ian Crook to arrange measuring the air flows in the areas and calculate the air changes (03.03.25). Facilities to attend site 11/03/2025. Nevill Hall has an air change rate of 2.08.per hour (FYI this is with the 3 doors closed, if the doors are opening in effect the room volume increases, and the air change rate significantly drops.).	

Premises, facilities, and equipment PFE1					
The premises are secure and well maintained and safeguard the dignity of the deceased and the integrity of human tissue					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
	• Concealment trolleys • Ceiling mounted hoist at GUH • Fridge/freezers on all sites Funeral director entrance in YYF opens into body store from a large facilities yard. This resembles the layout at GUH which was inspected by HTA in 2024. HTA advised the the installation of a privacy screen to preserve dignity of the deceased, so that anyone in the facilities yard cannot see into the body store when the door is open. Whilst not obstructing the entrance, catering carts and multiple boxes were also observed immediately outside the Funeral director entrance	Preventative maintenance schedule to be created and put on Q-Pulse to ensure responsibilities for maintenance are clear. There must be prompts/reminders for equipment to be regularly maintained, ensuring it is fit for purpose. Preventative maintenance and ad hoc service reports to be stored in a centralised SharePoint folder or equivalent	Amelia Roberts Heather	Liaising with preferred supplier for provision of a service and maintenance contract, to include preventative maintenance, for all trolleys, PM tables and fridge/freezers (all sites). Site visit arranged for 24.02.2025. Awaiting clarity on the ceiling mounted hoist Procurement exercise underway to provide a new Temperature Monitoring system across all of Pathology to include the Mortuary and Body Stores. Spreadsheet has been created to centralise preventative maintenance contract information and previous reports.	

Premises, facilities, and equipment PFE1					
The premises are secure and well maintained and safeguard the dignity of the deceased and the integrity of human tissue					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
	during this inspection. This area should be kept clear and designated for Funeral Director parking to allow swift transfers and ensure other members of staff are not present in this area. ‘Post-Mortems in progress’ signage still in place at NHH. PMs no longer taking place on site.	Remove post-mortem signage at NHH Body store.	Lucy Bennett	Completed 06/02/2025	
PFE1b) There is demarcation of clean, dirty, and transitional areas of the mortuary, which is observed by staff and visitors.	This is relating to Post-Mortem sites only. These areas are clearly demarcated at GUH. Clinical/Non-clinical areas are not demarcated on other sites. To be demarcated by posters on other sites (No PPE past this point).	Clinical/Non-clinical areas are not demarcated on NHH, RGH, YYF sites. To be demarcated by posters on other sites e.g. (Non-clinical area, No PPE past this point).	Lucy Bennett	Completed 06/02/2025	
PFE1c) There are documented cleaning and	MO0076 details the cleaning procedures and	MO0094 - cleaning schedule for GUH to be reviewed as a priority	Amelia	Cleaning records for GUH now in place and being used.	

Premises, facilities, and equipment PFE1					
The premises are secure and well maintained and safeguard the dignity of the deceased and the integrity of human tissue					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
decontamination procedures and a schedule of cleaning. Guidance There should be records of cleaning and decontamination.	schedule for body stores and mortuary (new schedule established Dec 2024 following engagement with infection control/fridge manufacturer/other mortuaries) MO0094 is the blank cleaning schedule template. Cleaning records were viewed for RGH, YYF and NHH sites during inspection. No completed cleaning records found for GUH.	to ensure implementation as previous completed cleaning records could not be found. Cleaning records in place for all other sites.			
PFE1d) The premises are secure (for example there is controlled access to the body storage area(s) and PM room and the use of CCTV to monitor access). Guidance Security arrangements should be robust, with effective mechanisms to strictly	CCTV in place at all sites. CCTV monitor at YYF is positioned near the ceiling in the CAD office; this is too high for the team to access and view. The mouse for controlling the CCTV monitor is locked in a box above the monitor, which can currently only	CCTV monitor at YYF body store to be repositioned to ensure it can be accessed for security audits and footage review for incidents if required. Investigation has found that 'shared' swipe cards are in use by porters at YYF. Porters must	Amelia Lucy Bennett	Contacted Bowkett for the monitor to be repositioned. Moved W/C 19.05.2025 Shared swipe cards in use by porters deactivated. All porters given access as	

Premises, facilities, and equipment PFE1					
The premises are secure and well maintained and safeguard the dignity of the deceased and the integrity of human tissue					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
control access. This includes body storage units in areas outside of the mortuary such as temporary storage units and storage facilities in maternity departments. Although CCTV is an important security measure, it should not be used in a way that compromises the dignity of the deceased. Systems should prevent the inappropriate access or use of images.	be accessed with a stepladder. All sites are swipe access only however investigation has found that 'shared' swipe cards are in use by porters at YYF. Porters must be given individual card access as a priority to ensure robust audit trail and the shared cards deactivated. MO0003 defines the security measures in place for CCTV. CCTV only plays live entrances to body stores/mortuary. For play back reviews and audits, a password must be entered. The passwords are held centrally by pathology management team and changed every 3 months.	be given individual card access as a priority to ensure robust audit trail and the 'shared cards' deactivated.		required for their role. 04.04.25 Email sent by LB with update. All organised and shared card locked away with signing book for emergencies. Spreadsheet showing those in use by which departments across all sites, for clarity, is in Mortuary SharePoint folder.	
PFE1e) Security arrangements protect against unauthorized access	CEPP0001 includes mortuary lone working. DI	Add poster to notice boards for how to raise a concern. Also include as a standard meeting	Amelia/Lucy Bennett	04.04.25 - Completed, Posters visible in CAD and Mortuary	

Premises, facilities, and equipment PFE1					
The premises are secure and well maintained and safeguard the dignity of the deceased and the integrity of human tissue					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
and ensure oversight of visitors and contractors who have a legitimate right of access. Guidance The Designated Individual, or persons acting under their authority, should use a controlled-access system to monitor entry into the mortuary or body storage facility, either during the day or outside working hours (e.g., by hospital porters, undertakers, and tissue retrieval staff). There should be documented procedures for access as well as a system for recording who has been in the mortuary or body store, the nature of their business and when they arrived and left. Levels of oversight, particularly surrounding mortuary access and mortuary activities undertaken, should be clearly defined and consider	does not appear to be in copy holders list. When asked during inspection, some team members were aware of how they would raise a concern compromising the dignity of the deceased. LFMO0031 is the mortuary trigger list which includes HTARI classifications but also includes '<i>must report</i> organisational and non-clinical incidents'. MO0003 is the security SOP which covers PFE1e).	agenda item – the process for how to raise a concern raise concerns regarding any behaviour within the mortuary which could compromise the dignity of the deceased. Lone working alarms non-conformance at RGH, NHH, YYF, identified in previous inspection. Need implemented, user guide and regular audit to ensure they work and have the desired alert and response from security. Audit template will need to be created and added to Q-Pulse. Add to audit calendar (LFMO0057). Ensure team are briefed on use and testing. MO0003 needs to be clearer that facilities need to be contacted to retrieve a list of who has accessed the body stores/mortuary every month as part of the audit (and how to do this i.e. which department or person to contact). Currently the SOP states contact facilities	Amelia Amelia Gwenan to review/input	Audits implemented to ensure alarms function. Will be added to AMat to ensure oversight continues following trial period. SOP reviewed 04.04.25 - on Qpulse	

Premises, facilities, and equipment PFE1					
The premises are secure and well maintained and safeguard the dignity of the deceased and the integrity of human tissue					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
risks to the dignity of the deceased. Staff should be encouraged to c. Relatives who visit for a viewing should not be able to access the body store area. Security systems and lone working arrangements should consider viewings which take place out of hours. Lone working arrangements should also be overseen and authorised by the Designated Individual. Swipe card access lists should be reviewed and updated regularly. Records of access (electronic and paper-based) and CCTV footage should be regularly audited to ensure adherence to relevant policies and procedures. Anyone entering the mortuary should have a legitimate right of access and audits should scrutinise the purpose, frequency and duration of access and be particularly alert to unusual		<i>"should information on who has accessed the body stores/mortuary be needed".</i> There should be a subsection specifically for the audit and to be clear that retrieving the list of access is a mandatory part of the audit. There should also be a subsection to define what happens where an incident regarding unauthorised access is identified and what to do therefore when a larger footage review is required. This section should explain that a Datix will be raised, the DI will be informed and also include detail on what circumstances would warrant CCTV footage to be downloaded i.e. SI, HTARI, and instructions on how footage should be securely downloaded and stored. The document needs to also make reference to the relevant audit template (not currently referenced in SOP).	Amelia	Complete	

Premises, facilities, and equipment PFE1					
The premises are secure and well maintained and safeguard the dignity of the deceased and the integrity of human tissue					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
patterns, times of entry or other unexplained or suspicious activity which must be investigated immediately.		Manual turnkey door at rear of viewing room at YYF opens into body store. Look to close this permanently as if accidentally left unlocked, family could enter body store.	Lucy	Call logged with Works & Estates 06/02/2025. Completed in new financial year. Alert posters put in place in the meantime.	

Premises, Facilities and Equipment PFE2					
There are appropriate facilities for the storage of bodies and human tissue					
Standard	Inspection Findings	Action required	Person completing	Progress	Status
PFE2a) Storage arrangements ensure the dignity of the deceased. Guidance Storage temperatures should be appropriate to ensure that the condition of bodies is preserved. Refrigeration of bodies should be at a temperature of approximately 4 degrees Celsius. The optimal operating temperature for freezer storage is around -20 degrees Celsius. The Health and Safety Executive's document: 'Managing infection risks when handling the deceased' (HSG283, published 2018) includes guidance on storage of bodies: https://www.hse.gov.uk/pubns/books/hsg283.htm	MO0035 the Procedure for the use of refrigerated cold stores references GUH only. It does explain that the temperatures of fridges are set at 5 degrees and what the alarm trigger points are, and the 30 minute delay for alarm activation. MO0091 covers RGH/NHH. YYF is not mentioned. Upon inspection, YYF has a temperature	Consider amalgamating MO0035 (for GUH only) and MO0091 (for NHH and RGH). It should make it clear which sites have systems have Co-Mark installed and which are reliant on out of hours temperature alarm checks. How YYF temperature is monitored should be included and it is currently not	Lucy Bennett	YYF added to MO0091 and will be monitored going forward from 11/02/2025	

[illegible]

Premises, Facilities and Equipment PFE2					
There are appropriate facilities for the storage of bodies and human tissue					
Standard	Inspection Findings	Action required	Person completing	Progress	Status
		include alert outcome [does alarm system have automated calls] (LMFO0027). Annual temperature calibration to be completed for temperature monitoring system.			
PFE2b) There is sufficient capacity for storage of bodies, organs, and tissue samples, which considers predicted peaks of activity. Guidance Capacity should be regularly reviewed, particularly if contingency arrangements are used regularly or for extended periods. Where storage capacity is identified as an ongoing issue, this should be escalated to the relevant Trust, Health Board or Local Authority.	Capacity monitored every week day by CAD manager and saved in a spreadsheet. This task is written into the BCP (MO0089) but is not written in the CAD Team Daily Tasks. Contingency arrangements for deceased patient storage are found: MO0089 (BCP) MO0079 (SOP to support BCP contingency plans)	Updating the capacity spreadsheet should be part of the CAD Team Daily Tasks (MO0093) to ensure that this is completed in the CAD Manager's absence. Location of spreadsheet should be clear and accessible to all staff members. Record of transfers to be added as a tab to the capacity spreadsheet so this can be easily tracked and analysed over time to ensure	Lucy Bennett Lucy Bennett	Completed 06/02/2025	

Premises, Facilities and Equipment PFE2					
There are appropriate facilities for the storage of bodies and human tissue					
Standard	Inspection Findings	Action required	Person completing	Progress	Status
		sufficient capacity as per PFE2b).			
PFE2c) Storage for long-term storage of bodies and bariatric bodies is sufficient to meet needs. Guidance There should be sufficient frozen storage for the long-term storage of bodies; the HTA advises that bodies should be moved into frozen storage after 30 days in refrigerated storage if there is no indication they are soon to be released or further examined, or before, depending on the condition of the body. Bodies in long-term storage should be checked regularly; this should include confirmation of their identity and the reason for their continued storage. Where there is insufficient freezer storage to meet needs, there should be arrangements with other establishments, or other contingency steps, to ensure that bodies can be stored appropriately. Where storage capacity is identified as an ongoing issue, this should be escalated to the relevant Trust, Health Board or Local Authority.	There are currently 3 x bariatric spaces at GUH which can accommodate deceased up to 65 stone (413kg). Whilst there is sufficient capacity for obese deceased at RGH since the installation of these fridges in the last 2 years, there is a requirement for an increase in the number of bariatric spaces within the health board that can accommodate a greater weight limit and width.	Procure/install three more bariatric spaces at RGH in current vacant fridge space which can accommodate up to 65kg. Funding to be sought. There is a need for a clear SOP for bariatric deceased which defines the process from end-of-life care (and the notification to the CAD team), with dimensions and weight shared so appropriate transfers and provisions can be put in place to maintain patient dignity. This SOP should define what means of transfer are in place on each site for bariatric deceased,	Tim Walbyoff Amelia/Lucy Bennett	Update 17.03.25 Ordered: Quotation exercise undertaken to provide a 3-tier bariatric mobile rack and trays. Preferred supplier identified and site visit arranged for 24.02.25. Cost is below Capital threshold so will be a revenue spend. 3 new bariatric spaces completed	

Premises, Facilities and Equipment PFE2					
There are appropriate facilities for the storage of bodies and human tissue					
Standard	Inspection Findings	Action required	Person completing	Progress	Status
		how they would be transferred from the ward to the body store, when a transfer would be required to GUH or RGH, and how this decision would be made. There should be inclusion and reference to the contract with the Health Board contracted funeral director firm to ensure that they have capacity to transfer deceased of this weight and size to the appropriate site. Consideration should be given to the use of the hydraulic trolleys (which can accommodate this weight) and what manual handling arrangements should be in place. Risk		and installed in RGH 04.2025.	

Premises, Facilities and Equipment PFE2					
There are appropriate facilities for the storage of bodies and human tissue					
Standard	Inspection Findings	Action required	Person completing	Progress	Status
		Assessment also required.			
PFE2d) Fridge and freezer units are in good working condition and well maintained.	MO0091 does not make reference to the refrigerated units at RGH which are currently not in use and are not subject to preventative maintenance.	MO0091 – Information should be added to this document to explain when a decision is made to make the use of particular fridge/freezer unit obsolete, how this will be communicated to staff and how they will be labelled to ensure they are not used.	Lucy Bennett	Completed 07/02/2025	
PFE2e) Fridge and freezer units are alarmed, and the alarms are tested regularly to ensure that they trigger when temperatures go out of upper or lower set range. Guidance This includes storage units in which bodies or tissues are stored under the HTA licence in other areas, for example in maternity departments. The HTA advises that storage units in areas that are not permanently staffed should have a remote alarm system to alert staff to temperature deviations out of hours. Temperature alarm trigger points should be set to ensure that alarms will trigger in the event that the storage temperature deviates from an acceptable range to	LFMO0027 is the GUH Mortuary Fridge Alarm Testing template which includes whether a call has been received from switchboard. The alarm system is no longer linked to switchboard as it was recognised that the Co-mark automated call out system does not recognise when the call has been put on hold or	LFMO0027 to be updated to reflect call received by APT on call (shared mobile phone). Ensure shared APT mobile phone is being utilised as intended and that switchboard is given this number for on-call purposes.	Andrea Amelia	Shared mobile phone now in use. Phone number has been given out to the appropriate staff. This includes switch board and all Funeral Directors. Co-mark system linked to on-call phone.	

Premises, Facilities and Equipment PFE2					
There are appropriate facilities for the storage of bodies and human tissue					
Standard	Inspection Findings	Action required	Person completing	Progress	Status
ensure that the condition of bodies and tissue is appropriately preserved. Staff should be aware of the acceptable temperature ranges and temperature alarm trigger points. Alarm tests should include call out procedures and should be recorded.	if switchboard plays an automated message (the Co-mark system assumes it has been picked up by a person and relays the pre-recorded message). Co-mark system has therefore been recently programmed to ring the on-call APT and a health board mobile phone has been acquired so this is a single point of contact.	Temperature checks and alarm testing arrangements must be checked with maternity.		Recommendations made to maternity to improve HTA compliance.	
PFEf) Temperatures of fridges and freezers are monitored on a regular basis. Guidance This includes storage units in which bodies or tissues are stored under the HTA licence in other areas, for example maternity departments. Temperature monitoring should enable the establishment to identify trends and the extent of any variations in storage temperatures.	MO0091 states that the CAD team update the “Body Store Temperature Monitoring Record” and will monitor for any trends and will inform the CAD Manager. MO0088 describes the use of co-mark in GUH. This was updated in Nov 24 to say that the	MO0091 should be updated to state what action would be taken by the CAD Manager in the event of a concerning trend in the temperature being identified. MO0091 should be updated to state where the completed temperature	Lucy Bennett Lucy Bennett	Completed 10/02/2025 Completed 10/02/2025	

Premises, Facilities and Equipment PFE2					
There are appropriate facilities for the storage of bodies and human tissue					
Standard	Inspection Findings	Action required	Person completing	Progress	Status
	team must login to co-mark at least weekly to: <i>“To print off the weekly range, sign this and store in a folder in the mortuary so this can later be audited to show the temperature range are being regularly checked”.</i>	monitoring records are kept. MO0091: Tracking comments in this document should be removed and should be uploaded as word document to Q-Pulse as opposed to PDF so revisions can easily be made when required. MO0091: Point 7.4 (Contingency Plans) should make reference to the BCP MO0089 and SOP MO0079.	Lucy Bennett Lucy Bennett	Completed 10/02/2025 Completed 10/02/2025	
PFEg) Bodies are shrouded or in body bags whilst in storage. Guidance Shrouding practices should preserve the dignity of the deceased, including during release and transportation. Shrouds should be clean and appropriate for use and checked regularly.	MO0002 states: “All patients brought to the mortuary will wear a shroud or gown or their own clothes, as long as they are covered for dignity, and will be placed in a body bag”.	MO0002 should be updated as not all patients are placed in body bags on satellite sites (this is done for infection risk only). It should be added whether deceased under the age of 16	Andrea	Complete	

Premises, Facilities and Equipment PFE2					
There are appropriate facilities for the storage of bodies and human tissue					
Standard	Inspection Findings	Action required	Person completing	Progress	Status
	During visits to all 4 sites, all deceased were observed as being fully shrouded or in body bags.	are placed in body bags.			
PFEh) There is separate storage for infants and babies. If not, special measures are taken for the bodies of infants and babies.	MO0002 states Fridge 29 is reserved for babies and infants. It should be made clear this is at GUH and that other body stores do not store babies and infants.	MO0002 states Fridge 29 is reserved for babies and infants. It should be made clear this is at GUH and that other body stores do not store babies and infants.	Andrea	Complete	
PFEi) There are documented contingency plans in place should there be a power failure or insufficient numbers of refrigerated storage spaces during peak periods. Guidance Where contingency arrangements involve the transfer of bodies to other premises, these should be assessed to ensure that they are suitable and that traceability systems are of the required standard. Practices such as placing more than one body on a tray or storing bodies in unrefrigerated storage should not take place. Establishments should have documented agreements with any funeral services that they	MO0079 (Mortuary Contingency Plan) and MO0089 (ABUHB Deceased Patient Storage Business Continuity Plan) have sufficient detail for body capacity contingency arrangements. MO0079 has brief detail on the below. These require full consideration and to be	BCP to be created which includes: • Loss of PM service due to insufficient staffing or breach of HTA standards • Or Utility, plant or estate failure including refrigerator failure.	Heather	BCP updated to cover core risks to service. Can be expanded over time.	

Premises, Facilities and Equipment PFE2					
There are appropriate facilities for the storage of bodies and human tissue					
Standard	Inspection Findings	Action required	Person completing	Progress	Status
may use for contingency storage. Consideration should be given to whether the funeral service provides contingency storage for other mortuaries. SOPs should address issues such as risk assessments and same/similar name systems. The hire of temporary storage units should not be the sole contingency arrangement for an establishment. Establishments should put in place other formally agreed arrangements for contingency storage. Where the hire of temporary storage facilities forms part of establishments' contingency arrangements, consideration should be given well in advance and steps taken to ensure availability of funds, and of units for hire. Establishments should consider entering into Mutual Aid Agreements with neighbouring organisations in order that they can provide and obtain support during periods of capacity shortages.	put in BCP format (as insufficient storage capacity has been in MO0089): - Loss of PM service due to insufficient staffing or breach of HTA standards - Or Utility, plant or estate failure including refrigerator failure.	MO0089 could be added to the above so this is an overarching plan for all eventualities. Review risks on DatixWeb and ensure these are appropriately covered in the BCP.			

Premises, Facilities and Equipment PFE3					
Equipment is appropriate for use, maintained, validated and where appropriate monitored					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
PFE3a) Items of equipment in the mortuary are in a good condition and appropriate for use: i. fridges /	New head blocks needed (polystyrene edges on many are damaged).	Damaged head blocks on all sites need to be replaced. All remaining,	Lucy Bennett	Damaged head blocks have been removed. New head blocks	

Premises, Facilities and Equipment PFE3					
Equipment is appropriate for use, maintained, validated and where appropriate monitored					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
freezers ii. hydraulic trolleys iii. post-mortem tables iv. hoists v. saws (manual and/or oscillating) Guidance Equipment should be made of material that is easy to clean, impervious, non-rusting, non-decaying, and non-staining.	Wooden measuring ruler observed in body store at GUH. Wooden material is porous and should be removed/replaced with material as per PFE3a). Paper posters on display in NHH and GUH in body store were not laminated and are therefore porous e.g. 'wide fridge' posters at GUH on fridge doors.	or replaced, head blocks need to be covered with plastic for infection control as the material is porous and not wipeable. Wooden measuring ruler observed in body store at GUH. Should be removed/replaced with material that meets PFE3a). All paper posters to be replaced and laminated in body stores.	Amelia Amelia/Lucy	ordered with plastic covering. Measuring ruler to be replaced with metal ideally. Gwenan sending manufacturer for lab rulers to Amelia. Metal one now in use. All posters in GUH and NHH are now laminated. Preventative maintenance contracts acquired.	
PFE3b) Equipment is appropriate for the management of bariatric bodies.		See findings and actions for <i>PFE2c) Storage for long-term storage of bodies and bariatric</i>	Tim Walbyoff and Amelia	Quotation exercise undertaken to provide a 3-tier bariatric mobile rack and trays. Preferred	

Premises, Facilities and Equipment PFE3					
Equipment is appropriate for use, maintained, validated and where appropriate monitored					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
Guidance The 'safe working load' of mortuary equipment should not be exceeded.		<i>bodies is sufficient to meet needs.</i>		supplier identified and site visit arranged for 24.02.25. Cost is below Capital threshold so will be a revenue spend.	
PFE3c) The ventilation system provides the necessary ten air changes per hour and is checked and maintained at least annually. Guidance The minimum recommended air supply rate to a post-mortem room is ten air changes an hour (AC/h); the recommended extract rate from a post-mortem room is 12 AC/h. The ventilation system should achieve not less than 75% of the design air change rate given in Appendix 2 of Health Technical HTA Guidance Updated: April 2024 24 Memorandum (HTM) 03-01: Specialised ventilation for healthcare premises (Part A): https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM0301-PartA-accessible-F6.pdf Control of Substances Hazardous to Health (COSHH) regulations require a	Ventilation systems confirmed by Estates to have preventative maintenance and readily available reports in respect to GUH PM room, to which PFE3c applies. Estates confirmed recommended air changes for PM room meet PFE3c. Air changes for PM room (GUH) are 10ac/hr on Supply, 12ac/hr on Extract. Air changes for High-Risk PM room (GUH) are 10ac/hr on Supply, 12ac/hr on Extract	To confirm if ventilation systems for body stores are maintained	Tim Walbyoff	Awaiting confirmation for other sites (Emailed DK and IC 05.02.25). Ian Crook to arrange measuring the air flows in the areas and calculate the air changes (03.03.25) Nevill Hall has an air change rate of 2.08.per hour (FYI this is with the 3 doors closed, if the doors are opening in effect the room volume increases, and the air change rate significantly drops.).	

Premises, Facilities and Equipment PFE3					
Equipment is appropriate for use, maintained, validated and where appropriate monitored					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
thorough examination of the ventilation system at 14-month intervals and sets out what the examination should cover. Relevant staff should be notified of servicing and have access to service records.				Facilities to attend site 11/03/2025. Confirmed appropriate ventilation in place. Service reports available on request from Estates.	
PFE3d) Staff have access to necessary PPE. Guidance Where face masks should be worn, they should be face-fitted and the highest efficiency filter (FFP3). Where face-fitted face masks cannot be used, alternative PPE should be provided (for example, fully ventilated hoods). The Health and Safety Executive's document: 'Managing infection risks when handling the deceased' (HSG283, published 2018) includes guidance on PPE. Establishments should also refer to guidance from Public Health England. This can be found here: https://www.hse.gov.uk/pubns/books/hsg283.htm	Staff spoken to upon inspection have access to the appropriate PPE and recognise when it is required.	N/A			

[illegible]

Premises, Facilities and Equipment PFE3					
Equipment is appropriate for use, maintained, validated and where appropriate monitored					
Standard	Inspection Findings	Actions required	Person completing	Progress	Status
	Cold storage in maternity is residential fridge – no temperature digital display. Temperatures are checked by looking at the temperature dial inside the fridge and are recorded daily.			Maternity as this self-assessment focusses on CAD and Mortuary Services.	



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	03 June 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Audit Plan 2025/26 and Annual Clinical Audit Activity Report 2024/25
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr James Calvert, Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Stimpson – Clinical Audit Lead Leeanne Lewis, Assistant Director for Quality & Patient Safety

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

Clinical audit is one tool available for assessing whether clinical services are safe and effective. It is one input into our Quality Management System (QMS). Clinical audit provides assurance against compliance with clinical standards and provides an opportunity to identify and minimise risk, waste, and variation in clinical practice from guideline defined standards of care. The results of audit are used to plan and prioritise domains of care requiring improvement with the aim of improving patient outcomes.

The Health Board's focus has been to ensure mandatory participation in the Welsh National Clinical Audit and Outcomes Review Plan. This includes complying with the requirements of Welsh Government by participating in all mandatory national clinical audits. Our audit plan balances national audit priorities with directorate/ division/ service/ clinician priorities. This enhances patient safety, care quality and compliance with statutory obligations. The plan integrates the use of the Audit

Management and Tracking (AMaT) system to streamline audit processes and improve governance.

This paper serves to provide a summary of Clinical Audit Activity from 2024-2025 and sets out the plan for 2025-2026.

Cefndir / Background

The National Clinical Audit and Outcome Review Plan (NCAORP) is published by Welsh Government (WG) annually.

The plan is one of the cornerstones in the drive to improve quality and safety of healthcare in Wales. It sets out in detail how findings from national clinical audit projects and outcome reviews are to be used to measure the quality and effectiveness of healthcare provided to patients and to assess year on year improvements.

The plan details the full list of national audit projects that all healthcare organisations must fully participate in, where those services are provided. The Health Board's audit plan is based on NCAORP and supports the National Clinical Audit and Patient Outcome Programme (NCAPOP). Clinical effectiveness is a key component of the Health Board's Quality Strategy.

Work this year has included:

- Producing standardised audit reporting templates, which has enabled more consistent reporting and improved scrutiny of action plans.
- Further implementation of the web-based Audit Management and Tracking system (AMaT) has helped facilitate tracking of audit results and the development of action plans.
- The team have trained over 800+ staff and AMaT now has 2,330 users across the Health Board.
- Divisional engagement has improved with structured reporting and raising awareness of the agenda in advance.
- Focusing on a mature and integrated approach to clinical audit with clear governance and reporting to the Clinical Standards and Effectiveness Group (CSEG), Patient Quality and Safety Outcomes Committee (PQSOC) and Audit, Risk and Assurance (ARA) Committee.

All audit is to be recorded on AMaT. AMaT has been used to build audit proformas, capture data, produce results and develop SMART action plans, all within the same platform. Local audit plans are being developed by Directorates and Divisions. are recorded in AMaT.

There is a robust structure underpinning the reporting of Clinical Audit, with Executive Leadership delegated to the Medical Director. Assurance is provided through reporting to the Patient Quality and Safety Outcomes Committee (PQSOC)

which provides scrutiny of National Clinical Audit performance and monitoring of improvement plans.

Clinical audit is an important component of our commitment over the next three years to enable delivery of the Duty of Quality, as mapped to the six domains of quality. This will support the delivery of a sustainable and resilient health and care system.

Asesiad / Assessment

The updated Clinical Audit Plan for 2025/26 and Clinical Activity Report for 2024/25 is now available. The Health Board's Annual Clinical Audit Plan and Clinical Audit Activity report is to be ratified by Patient Quality and Safety Outcomes Committee (PQSOC) in June. The activity report summarises all the audits presented at CSEG for the last twelve months between April 2024 – March 2025.

There is now a well-defined process for the scrutiny of National Clinical Audit Reports, which utilises completion of standardised audit reporting templates in AMaT to clearly delineate examples of good practice, practice that needs improvement and SMART action plans required to address these areas.

Audit reports are then presented to the Clinical Standards and Effectiveness Group (CSEG) following publication. Clinical Lead(s) for the service(s) are informed of the report due date on publication. The Medical Director's Quality and Patient Safety (QPS) clinical audit team registers the audit in the Clinical Audit Area via the web-based Audit Management and Tracking system (AMaT). The relevant documentation is provided to Clinical Leads, who provide CSEG with an analysis of local performance benchmarked against national recommendations. They then provide a "SMART" improvement plan for the Health Board which is available in AMaT so completion deadlines can be tracked.

The nine-month publication schedule for the NCACORP – covering the National Clinical Audit (NCA) programme and also the Clinical Outcome Review Programmes (CORP) has been shared with Directorates. The dates align with presentation of results at Clinical Standards and Effective Group (CSEG). The annual audit plan will continue to ensure mandatory participation in all national clinical audits and national confidential enquiries, including participation in audits on the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

AMaT is also utilised to record compliance with NICE guidance and HTW adoption, which can then be used to identify areas for future clinical audits.

Once National Clinical Audits (NCA) are published on the Healthcare Quality Improvement Partnership (HQIP) webpage, they form part of our annual audit plan. The Health Board are currently reviewing participation in these audits and ensuring these are discussed at CSEG. Where audits are discussed at other Groups or Boards (e.g. Stroke, End of Life Care Board) we are ensuring completion on AMaT. This provides assurance on completion of key results, audit actions and improvement

plans. We will be requesting for these to be reported to CSEG and placed on AMaT to align with the reporting of all other audits in the future.

Audit Management and Tracking (AMaT) is also being widely used across the Health Board for conducting and reporting on local audits agreed in the audit plan. The volume of audits being undertaken and the number of action plans being recorded is rising.

As part of the implementation of the Clinical Audit Strategy; directorate and clinical leads are being asked to confirm their list of audits in advance and identify any other projects that relate to clinical priorities where audit work will support the improvement of patient care. This includes audits that are required arising from clinical incidents, complaints or risks. With the lack of resource in the Medical Director's team to undertake audit this must be managed internally as the corporate team cannot support.

The audit team will continue to work collaboratively with Divisions, clinicians, service managers, divisional governance and quality managers as well as clinical staff to ensure that the clinical audit programme for their directorate meets all clinical, statutory, regulatory, commissioning and other Health Board requirements.

Ongoing training in the use of AMaT will ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development).

The clinical audit team are developing organisational and governance structures within AMaT to support full engagement in audits. This includes consideration of improvements (planned and delivered) and an escalation process to ensure the executive board is made aware when issues around participation, improvement and risk identification against recommendation are identified.

The Health Board is required to participate in all National Clinical Audits. In instances where a notification of non-participation is received, the Medical Director formally communicates with the relevant specialty to reiterate that participation is mandatory. A response is currently being developed in collaboration with respiratory based on non-participation in the National Respiratory Audit Programme, with an action plan determine appropriate to address the issues.

Currently, AMaT operates without a dedicated, recurring funding stream. Licensing has been maintained through successful biennial bids. A proposal was previously put forward to distribute the cost across all Executive portfolios, recognising the system, is widely used by all staff, not just those under the Medical Directors. The system covers the broader audit function and data demonstrates it is used by all Divisions. This proposal has not been actioned and will be revisited in 2025/26 to ensure continuing of licensing and to avoid disruption of services.

Over the next twelve months, as the Quality Strategy is refreshed to incorporate a greater emphasis on Clinical Effectiveness, clinical audit will play a critical role in providing assurance around patient outcomes. This work will involve close collaboration with the Value-Based Healthcare and Patient Engagement and Involvement teams to explore how audit findings can be triangulated with other data sources to offer a comprehensive view of the quality of clinical services as part of our Quality Management System (QMS). Additionally, audit insights will be systematically shared through the Learning and Improvement Forum to ensure that lessons learned are effectively disseminated across all clinical areas, supporting continuous learning and improvement.

Argymhelliad / Recommendation

Agree to the Clinical Audit Plan for 2025-2026 and receive assurance from the Audit Activity Report for 2024-2025 that the Health Board is meeting its obligation to undertake clinical audit.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management 2.9 Medical Devices, Equipment and Diagnostic Systems 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults Adults in Gwent live well healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

	Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	NA – National Average CA – Case Ascertainment
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Clinical Standards and Effectiveness Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Not Applicable
• Service Activity & Performance	Yes, outlined within the paper
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves Choose an item.



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Clinical Audit Plan 2025/2026



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Introduction

The Health Board is dedicated to providing safe and effective care to the population of Gwent.

Aneurin Bevan University Health Board uses [Clinical Audit](#) to improve care quality by measuring adherence to local and national guidelines. After each audit, areas for improvement are identified, implemented, and re-evaluated to enhance care reliability and outcomes.

Clinical audits are recognised by healthcare commissioners and regulators as a key method for ensuring the quality of care. The Health Board's Executive Committee, as required by Welsh Government, certifies that effective systems are in place to monitor and audit compliance with clinical standards. This process aligns with the Healthcare Quality Improvement Partnership (HQIP) National Clinical Audit and Patient Outcomes Programme (NCAPOP), which follows a 9-month publication schedule.

The Health Board's audit plan adheres to the National Clinical Audit agenda and includes local audits at specialty and ward levels across all sites. Local audit plans are developed internally by Directorates and Divisions.

What is Clinical Audit?

Conducting clinical audits according to best practice standards ensures compliance with clinical guidelines, reduces risks, waste, and variations in care, and enhances patient outcomes.

Clinical audit results contribute to a broader Quality Management System aimed at continuous learning and improvement in delivering safe and effective care.

Before starting a clinical audit, check if the topic has been previously audited within the organisation to compare results.

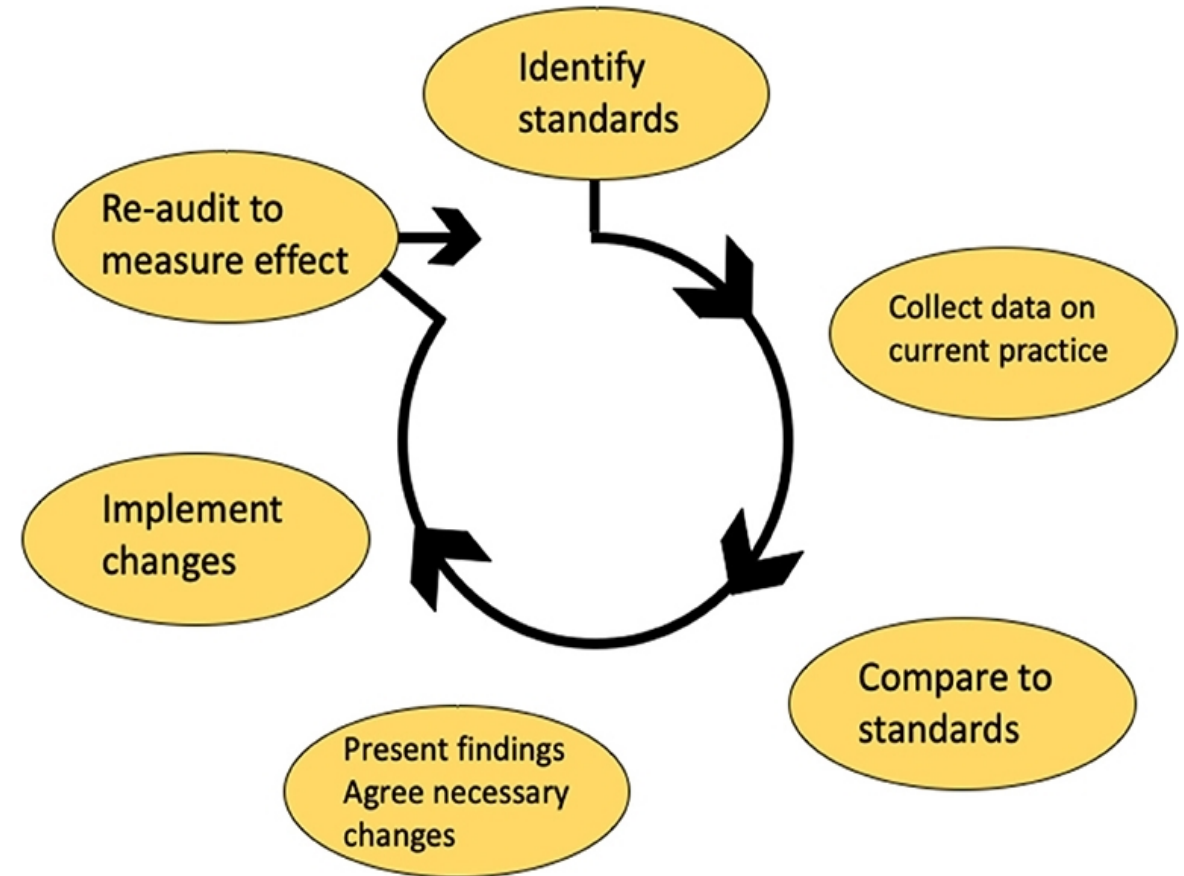


Figure One: The audit cycle

Why is clinical audit important?

Clinical Audit provides the framework to improve the quality of patient care in a systematic way.

Benefits of clinical audit include:

- Promotes awareness of guideline defined standards of care.
- Provides opportunities for education and training.
- Builds relationships between clinicians, clinical teams, managers, and patients.
- Leads to improvements in service delivery and patient outcomes.

Who should be involved in clinical audit?

Everyone who is involved in patient care. If an audit has implications for clinicians or managers working in a particular area, they should be consulted at the planning stage. Clinical audit must also be supported by those who have the authority and commitment to see changes put into practice.

All Divisions within the Health Board should develop robust local audit plans. Topics for clinical audit should reflect national and/or local priorities or areas of concern e.g. Cancer Services or National Service Frameworks, or local priorities identified through incident reporting or introduction of best practice into local services.

Principles of the Annual Clinical Audit Plan

In developing the Aneurin Bevan University Health Board Annual Clinical Audit Plan the following approach has been followed:

Purpose of Clinical Audits:

- Ensure the quality of care for specific conditions or pathways aligns with best evidence.
- Understand variations in care outcomes and assess good practice.

Participation and Compliance:

- Directorates must participate and engage in the National Clinical Audit and Patient Outcomes Programme (NCAPOP), National Confidential Enquiries (NCEPOD), and relevant service reviews.
- Include non-NCAPOP national audits in the Health Board's Quality Plan (e.g., Falls).
- Implement and audit NICE guidance and HTW adoption, subject to external review.
- Service evaluation and re-audit should be conducted following changes in practice.

Audit Management:

- Register all clinical audit activities within directorates.
- Collaborate with clinicians, managers, and audit staff to meet all requirements. This includes all clinical, statutory, regulatory, commissioning and other Health Board requirements.
- Enable healthcare professionals to participate in audits for revalidation and professional development.

Support and Review:

- Ensure resources, governance, and structures support audit engagement.
- Establish a formal process for reviewing performance and improvements.
- Escalate issues to the executive board when necessary.

6/23 Clear process for risk identification following audit.

Aneurin Bevan University Health Board has a [Clinical Audit Strategy 2022-2025](#) with four priorities:

Aneurin Bevan University Health Board has Four Priorities:

1. Scrutiny of national clinical audit performance with robust development, monitoring, and progression of Improvement plans
2. Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risk
3. Trainees are supported to participate in audits that support clinical governance
4. Groups and committees across the Health Board commission clinical audit to support effective assurance where no other evidence is available.



This can be read in conjunction with the Health Board's [Clinical Audit Policy](#) and [The Quality Strategy](#).

Together these documents demonstrate how clinical audit will be developed, delivered and outcomes put into practice through service improvement.

Six Domains of Quality

Clinical audit is essential for improving patient care and ensuring compliance with the Wales Health and Care Quality Standards. It systematically evaluates clinical practices against established standards, providing insights into the quality of care and identifying areas for improvement. This can be demonstrated below:



PERSON CENTRED

PERSON CENTRED care involves patients, relatives, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety. We care about the wellbeing of individuals, families, carers and staff, ensuring everyone is treated with compassion, kindness, dignity and respect. Audits ensure that care is tailored to individual patient needs and preferences, enhancing patient satisfaction and engagement.



SAFE

SAFE – reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information. Care delivered by capable and competent staff. Maximising things that go right and learning from when things that go wrong to prevent reoccurrence. Audits identify and mitigate risks, promoting patient safety and preventing harm



TIMELY

TIMELY care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We will care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority. Audits ensure that patients receive care promptly, reducing delays and improving overall health outcomes.



EFFECTIVE

EFFECTIVE care – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to **improve** outcomes. Audits ensure that clinical practices are evidence-based and aligned with best practices, leading to optimal patient outcomes



EFFICIENT

EFFICIENT by taking a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We will make the most effective use of resources to achieve best value, doing only what is needed, ensuring any interventions represent the best value that will improve outcomes for people. Audits help eliminate waste and improve resource utilization, ensuring sustainable and cost-effective services.



EQUITABLE

Provide **EQUITABLE** care, ensuring equal opportunities for individuals to attain their full potential for a healthy life which does not vary in quality and is non-discriminatory. We will embed equality and human rights and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time. Audits promote equal access to high-quality care for all patients, regardless of personal characteristics.

Six Quality Enablers



LEADERSHIP

Ensure visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality. Our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision. They have the appropriate skills and capacity to create the conditions for a functioning quality management system. We ensure our governance, leadership and accountability is effective in sustainably delivering care.



WORKFORCE

Recruit, retain, develop and extend roles to ensure we have enough, confident people with the right knowledge and skills available at the right time to deliver safe care. We value our people and the commitment and resilience they demonstrate in the care they provide. We care about their wellbeing, protect their rights and support them to feel well and happy at work; and provide them with the tools, systems and environment to work safely and effectively. Our workforce planning focuses on investing in our people and nurturing, growing and transforming our workforce to create a sustainable



CULTURE

Create the right climate and culture to nurture and encourage quality and system safety, valuing people in a supportive, collaborative and inclusive workplace so that our people feel psychologically safe to raise concerns and try out new ideas and approaches. Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture, where people can thrive.



INFORMATION

Ensure information is available and shared appropriately for all who need it. We turn data to knowledge by triangulating quantitative and qualitative performance, experience and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made. We monitor, report and escalate indicators through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement and accountability.



LEARNING, IMPROVEMENT RESEARCH

Create the conditions and capacity for an organisation and system-wide approach to continuous learning, quality improvement and innovation, which it actively promotes. We use new knowledge to influence improvements in practice and to inform our decision-making. We ensure our learning and improvement activity is linked to our strategic vision to deliver transformational, organisation-wide change. We commit to participating in research because research-active organisations provide improved quality of care and outcomes for people.



WHOLE SYSTEM APPROACH

Ensure safety in healthcare goes beyond individual patient safety. We will look within and beyond our organisational boundaries to learn how we can continually, reliably and sustainably meet the evolving needs of people. We will strengthen relationships and work with all of our partners to achieve good outcomes. Our policies incorporate the broader ambitions within the seven well-being goals and five ways of working in the Well-being of Future Generations Act.

Pillars of Quality

The six pillars of quality have been integral to Aneurin Bevan University Health Board's quality journey by providing a comprehensive framework to assess, monitor, and continuously improve care standards. Each pillar addresses a critical aspect of healthcare, contributing to a holistic approach to quality and safety. Here's how Clinical Audit can support and drive improvements in our Pillars of Quality Programme:

Patient and Staff Experience:	Clinical audits prioritise patient and staff experiences, ensuring care remains person-centred and fostering a positive environment for healthcare workers. This is essential for delivering compassionate and effective care, which audits help to measure and improve.
Incident Reporting:	Systematically tracking incidents like falls, pressure ulcers, medicines management, and mortality allows clinical audits to identify patterns, address systemic issues, and prevent recurrence. This enhances patient safety by ensuring that care practices are continuously evaluated and improved.
Complaints, Concerns, and Compliments:	Engaging with feedback through clinical audits enables the Health Board to identify areas for improvement and replicate effective practices. This strengthens trust and accountability by demonstrating responsiveness to patient and family experiences.
Health, Safety, and Security:	Clinical audits ensure that facilities and processes meet the highest standards to protect patients, staff, and visitors. This supports a safe environment for care delivery by regularly evaluating and improving safety protocols.
Infection Control and Prevention:	By addressing infection control as a dedicated pillar, clinical audits enhance practices that reduce healthcare-associated infections. This improves overall patient outcomes by ensuring that infection control measures are effective and consistently applied.
Safeguarding:	Placing safeguarding as a core pillar in clinical audits ensures that vulnerable individuals receive necessary protection and support. This aligns care with ethical standards and legal obligations, ensuring that safeguarding practices are regularly reviewed and improved.



Aneurin Bevan University Health Boards Organisational Priorities – as part of our Integrated Medium-Term Plan (IMTP) and how this links with National Clinical Audit (NCA)

PRIORITY 1 – EVERY CHILD HAS THE BEST START IN LIFE - We believe that every child deserves the opportunity to have the very best start in life.

PRIORITY 2 – GETTING IT RIGHT FOR CHILDREN AND YOUNG ADULTS - Young people are an important group and nurturing of future generations is crucial for our communities.

National Clinical Audits that support this priorities 1 & 2 are:

- National Pregnancy in Diabetes
- National Paediatric Diabetes Audit
- National Clinical Audit of Seizures and Epilepsies for Children and Young People
- National Paediatric Diabetes Audit
- National Maternity and Perinatal Audit
- National Child Mortality Database
- National Neonatal Audit Programme
- Paediatric Asthma – National Respiratory Audit Programme

PRIORITY 3 – ADULTS IN GWENT LIVE HEALTHILY AND AGE WELL - We want our citizens to enjoy a high quality of life into old age we want them to be empowered to take more responsibility for their own health and care, so that they can retain independence.

National Clinical Audits that support this priority are:

- National Cancer Audits – Bowel, Breast, prostate and more
- Nation Respiratory Audits – COPD, Asthma Adults and Paediatrics
- National Diabetes Audits – Type 1 and Type 2 in young people and adults

PRIORITY 4 – OLDER ADULTS ARE SUPPORTED TO LIVE WELL AND INDEPENDENTLY

National Clinical Audits that support this priority are:

- National Audit of Dementia
- Falls and Fragility audits
- National Early Inflammatory Arthritis Audit

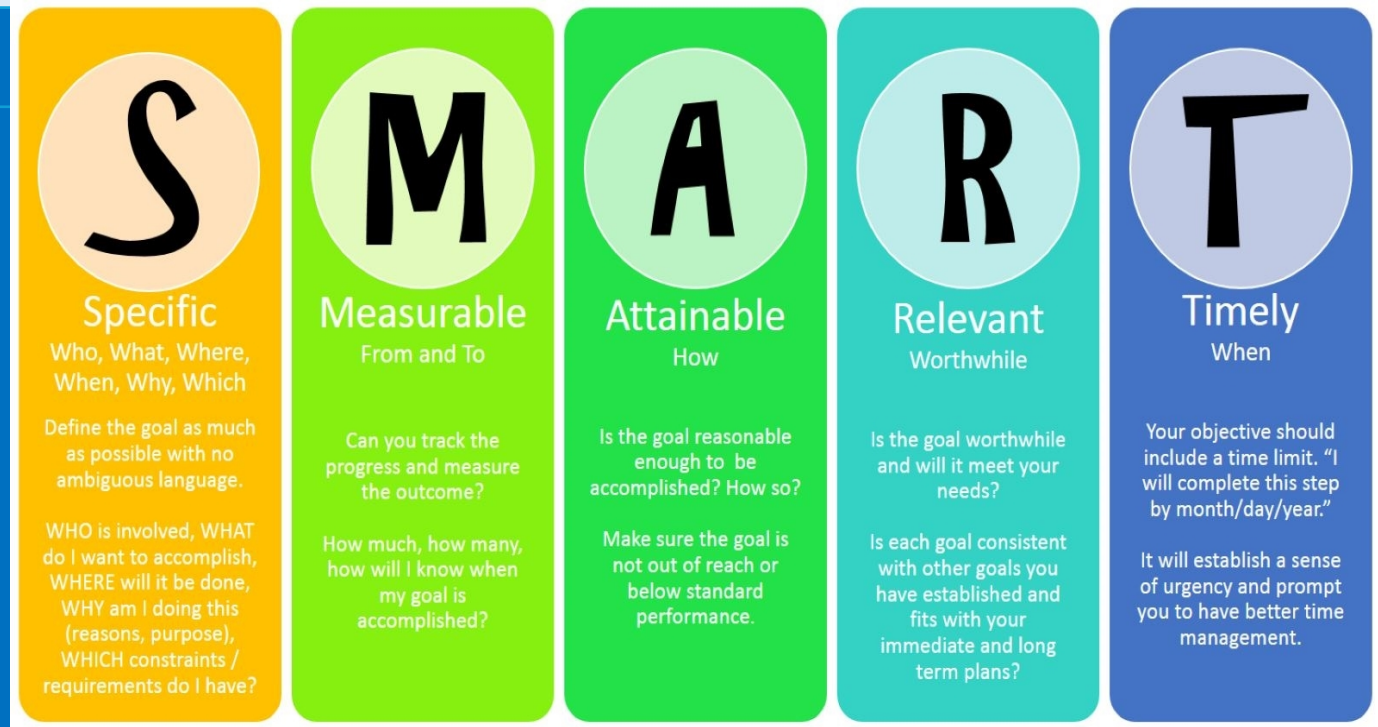


PRIORITY 5 – DYING WELL AS A PART OF LIFE

- National Audit of Care at the End of Life ¹⁰

Recommendations from Clinical Audit

1. Clinical Audit reports and outcomes identify recommendations for service
2. Improvement and Quality Improvement (QI) work where data shows variation from standard of care
3. National and Local audit recommendations are reviewed by the ABUHB Clinical Lead
4. Risks are identified by clinical leads/teams, to ensure risks are escalated and recorded on risk register



The process of clinical audit is managed through the Clinical Standards and Effectiveness Group (CSEG). Steps are:

1. National report published
2. The Medical Director's Quality and Patient Safety (QPS) Audit Team link with Clinical Lead/representative with audit results
3. Results presented at CSEG by Clinical Lead
4. SMART actions agreed against standards and/or good practice highlighted
5. Minutes are saved on the intranet to reflect which audits have been discussed
6. Action plan placed on the web based Audit Management and Tracking (AMaT) system
7. Summary report presented to Patient Safety and Quality Outcomes Committee (PQSOC)



What is AMaT ?

Aneurin Bevan University Health Board has implemented AMaT, a software package that simplifies and speeds up the auditing process. Over the past 24 months, staff have been trained to use AMaT at all stages of the audit cycle, ensuring audit results and outcomes are tracked and teams are supported.

Audits are crucial for improving patient care, managing risk, and meeting reporting requirements. While traditionally time-consuming, AMaT has streamlined audit activities, providing real-time insights and reporting for clinicians, wards, and the quality and patient safety audit department. It is used for local audits and tracking actions and improvement plans for National Clinical Audit.

AMaT has been easy to implement and has been integrated into the Clinical Audit Strategy. Data can be entered and accessed in real-time on various devices, giving healthcare staff more flexibility and time with patients.

The system simplifies audit tracking, allowing users to allocate SMART actions and instantly view data results in numerical or graphical formats. Key successes, concerns, risks, and assurances can also be recorded.

Clinical Audit Plan - Priority One: Clinical Audit Strategy

There is scrutiny of national clinical audit performance with robust development and monitoring of improvement plans

Aneurin Bevan University Health Board's Clinical Audit Plan reflects national and local drivers for quality improvement. The Clinical Audit Plan is updated annually to refine and improve audit processes within the Health Board. The Plan is used by the Medical Director's Clinical Audit team to forecast and produce an annual publication timeline supporting delivering of the Clinical Audit Strategy. The National Clinical Audit and Patient Outcomes Programme (NCAPOP), commissioned by HQIP, and the NHS Wales National Clinical Audit Outcome Review Plan (NCAOPR) follow a rolling nine-month schedule.

The Annual Audit plan prioritises clinical audit activities over the same 9-month period, with publication dates currently extending until January 2026, allowing planning of CSEG meetings and agendas.

All National Clinical Audits (NCAs) are managed in AMaT, using a standardised audit report template for consistent reporting to PQSOC. Participation in the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is included in the Health Board's plan, aiming to improve care standards through confidential reviews and national recommendations.

The publication list for 2025/26 can be found in Appendix One and the planned date for presentation at CSEG.

Clinical Audit Plan - Priority Two: Clinical Audit Strategy

Divisions will identity clinical audits that allow scrutiny and assurance associated with quality and safety risk

Clinical audit programme requirements for Divisional Triumvirates:

- Programme Development: Divisional Triumvirates must develop clinical audit programmes supporting governance and assurance aligned with quality and safety priorities.
- Priorities: Focus areas include nationally reportable incidents, patient safety themes, clinical outcomes, new evidence-based guidance (including NICE), and themes from mortality reviews.
- Reporting and Oversight: Each division must present updates on their clinical audit plans at Clinical Standards and Effectiveness Groups meetings.
- Registration and Monitoring: All clinical audits must be registered on AMaT, have an identified lead, and be monitored at predefined quality and safety forums.
- Results and Action Plans: Audit results and action plans must be reported and recorded on AMaT. The Divisional Triumvirate oversees audits and ensures action plans are progressed and monitored.
- Standing Agenda Item: Clinical audit will be a standing agenda item on Divisional Quality and Patient Safety Group agendas.
- Biannual Reporting: Divisions must produce biannual reports detailing audit activity, results, and improvements, and present these at the Clinical Standards and Effectiveness Group.

This structure ensures comprehensive oversight and continuous improvement in clinical audit processes.

Priorities Three and Four come within the Divisions remit

National Clinical Audit Template

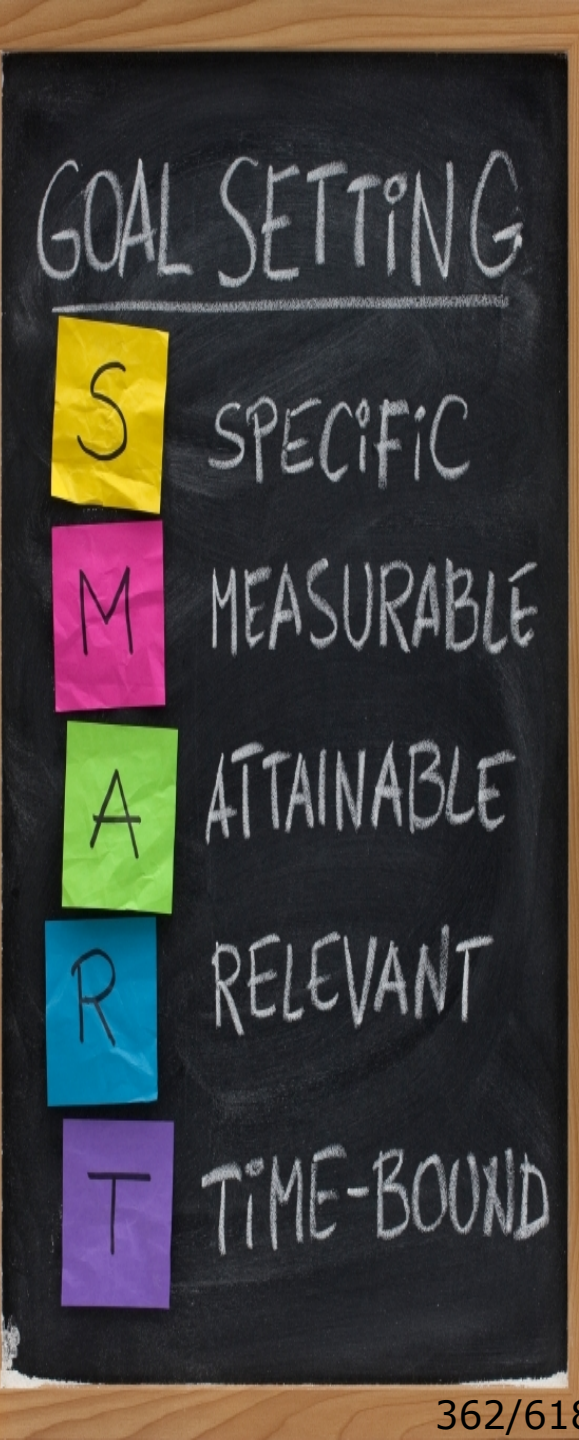
The Health Board has developed a standardised report template for National Clinical Audits, aligning with the AMaT layout to ensure consistent reporting. The report includes key elements for comprehensive and uniform audit documentation. The report includes:

- Title/Clinical Lead
- Rationale
- Objectives
- Local data at Health Board level (national level if local not available)
- Assurance Level
- Risk Level (in cases where the risk level is anything other than 'no risk' there is a requirement to state if placed on a Risk Register – if 'No' if selected, then a reason must be provided)
- Successes
- Concerns
- Report recommendations (national level – not always applicable to the Health Board)
- Local recommendations
- SMART action planning

During 2023/2024 and 2024/2025, the Health Board's audit process has demonstrated great success, ensuring CSEG and PQSOC are well-informed about the performance of each National Clinical Audit within the Health Board's regular operations. This effective process is set to continue into 2025/2026, reinforcing our commitment to maintaining high standards of care and patient safety.

Current Corporate Audits/Results

DNACPR	Corporate audits undertaken are decided by governance issued raised during the Health Boards usual business or raised at national level which can be recorded using the same dataset (proforma) in AMaT.
Consent	
Quality of notes audit	
Mortality review audits	
Review of Nasogastric feeding tubes in adults	



Clinical Audit Governance and Reporting Arrangements

- The Medical Director's Quality and Patient Safety (QPS) team coordinates delivery of the Clinical Audit Plan with Clinical Leads. This ensures mandatory compliance with the National Clinical Audit and Patient Outcomes Programme (NCAPOP), commissioned by HQIP, and the NHS Wales National Clinical Audit Outcome Review Plan (NCAOPR). The team collaborates with Divisional structures to document and track audit participation.
- At the operational level, **the Clinical Standards and Effectiveness Group (CSEG)** is multidisciplinary forum that is focused on reviewing audit data, identifying risks to clinical effectiveness and patient safety, and promoting improvements in care. This group ensures clinical audit findings are discussed in a system-wide context, facilitating shared learning and cross-divisional alignment.

From a governance perspective, the reporting routes are clearly defined and set out below:

- The **Patient Quality, Safety, and Outcomes Committee (PQSOC)** looks at audit outcomes and the improvements made as a result. It focuses on how findings translate into better patient care and safety, aligning with the Health Board's commitment to continuous improvement.
- The **Audit, Risk, and Assurance Committee (ARAC)** oversees the governance and assurance framework supporting the clinical audit programme. It ensures the plan is robust, informed by risk, and aligned with strategic priorities. ARAC also seeks assurance that audit findings are being actioned appropriately and that the process is leading to demonstrable change.
- By maintaining these distinct but complementary oversight functions, the Health Board ensures that both assurance and improvement are built into the audit cycle, connecting front-line clinical practice with corporate risk governance

Conclusion

Since its initiation in June 2022, AMaT has significantly increased audit activity, with over 2,330 users contributing to audits across the Health Board.

The Clinical Audit Team continues to provide tailored training. To date, over 800 staff have been trained, and supports 115 members who create datasets and 6 Super Users who manage AMaT structures.

The implementation of AMaT has enhanced the efficiency and accountability of local audits, enabling teams to identify and share good practices and areas for improvement. Planning for National Clinical Audits is streamlined, though local audits can be challenging due to service pressures.

Future efforts will focus on sharing audit learnings across the organisation and communicating them to staff and patients. Patient experience, quality, and safety remain central to our mission to improve care and outcomes.

Clinical audit is a key component of our commitment to delivering high-quality care and fulfils our statutory obligation under the Duty of Quality.

Appendix One - National Clinical Audit Outcome Review Plan (NCAORP) – 9-month Schedule

The NCAORP schedule is update monthly, which is then recorded in the Quality and Patient Safety Team (QPSt) Activity and Planning 2025/2026 working document. On publication of a report date, this is planned into the closest suitable Clinical Standards and Effectiveness Group (CSEG) meeting and the Clinical Lead, and the Divisional Triumvirate are invited, due to clinical commitments this date may be negotiated for a more suitable date. This is often the reason behind any delays in presenting. The Clinical Leads for the reports below, have been invited to those future Clinical Standards and Effectiveness Group dates.

Over recent years the engagement from the Health Boards Clinical Leads has greatly increased. On publication of the reports, the QPSt will locate any local data and provide the Clinical Lead with this data.

Below is a schedule of the planned activity for April 2025 to January 20206, which is available on HQIP [here](#):

HQIP Ref.	Abb	PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG
519	NLCA	NATCAN - National Cancer Audit Collaborating Centre	National Lung Cancer Audit State of the Nation report (England & Wales)	10/04/2025	CSEG May 2025
532	NPDA	NPDA - National Paediatric Diabetes Audit	Type 2 Diabetes Spotlight Audit Report	10/04/2025	CSEG May 2025
545	NMPA	NMPA - National Maternity and Perinatal Audit	State of the nation report (containing 5 years of data)	08/05/2025	CSEG Jul 2025
581	MNI	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance 2025 State of the nation Report	12/06/2025	CSEG Jul 2025
546	NMPA	NMPA - National Maternity and Perinatal Audit	Induction of labour snapshot report	12/06/2025	CSEG Jul 2025
552	NCEPOD	Medical and Surgical Clinical Outcome Review Programme	ICU Rehabilitation report	12/06/2025	CSEG Jul 2025
616	NRAP	NRAP - National Respiratory Audit Programme	State of the Nation report	12/06/2025	NRAP
547	NMPA	NMPA - National Maternity and Perinatal Audit	Neonatal outcome measures of maternity care snapshot audit - Full report	10/07/2025	CSEG Jul 2025

HQIP Ref.	Abb	PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG
NICOR	NICOR	National Audit of Cardiac Rhythm Management (NACRM)	National Cardiac Audit Programme (NCAP) 2025 report (2023/2024 & 2021/2024 data)	2025	CSEG Sep 2025
NICOR	NICOR	National Heart Failure Audit (NHFA)		2025	CSEG Sep 2025
NICOR	NICOR	National Audit of Percutaneous Coronary Interventions (NAPCI)		2025	CSEG Sep 2025
NICOR	NICOR	Myocardial Ischaemia National Audit Project (MINAP		2025	CSEG Sep 2025
576	EP12	Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Annual report 2024	10/07/2025	CSEG Sep 2025
586	NCMD	NCMD - National Child Mortality Database	Thematic report: Palliative care	10/07/2025	CSEG Sep 2025
520	NACEL	NACEL - National Audit of Care at the End of Life	State of the Nation report	14/08/2025	CSEG Sep 2025
631	NATCAN	National Primary Breast Cancer Audit (NAoPri)	National Primary Breast Cancer Audit (NAoPri) State of the Nation report (England & Wales)	11/09/2025	CSEG Nov 2025
632	NATCAN	National Metastatic Breast Cancer Audit (NAoMe)	National Metastatic Breast Cancer Audit (NAoMe) State of the Nation report (England & Wales)	11/09/2025	CSEG Nov 2025
633	NATCAN	National Ovarian Cancer Audit (NOCA)	National Ovarian Cancer Audit (NOCA) State of the Nation report (England & Wales)	11/09/2025	CSEG Nov 2025

Ref.				DATE	
634	NATCAN	National Pancreatic Cancer Audit (NPaCA)	National Pancreatic Cancer Audit (NPaCA) State of the Nation report (England & Wales)	11/09/2025	CSEG Nov 2025
635	NATCAN	National Non-Hodgkin Lymphoma Audit (NNHLA)	National Non-Hodgkin Lymphoma Audit (NNHLA) State of the Nation report (England & Wales)	11/09/2025	CSEG Nov 2025
636	NATCAN	National Kidney Cancer Audit (NKCA)	National Kidney Cancer Audit (NKCA) State of the Nation report (England & Wales)	11/09/2025	CSEG Nov 2025
637	NATCAN	National Oesophagogastric Cancer Audit (NOGCA)	National Oesophagogastric Cancer Audit (NOGCA) State of the Nation report (England & Wales)	11/09/2025	CSEG Nov 2025
638	NATCAN	National Prostate Cancer Audit (NPCA)	National Prostate Cancer Audit (NPCA) State of the Nation report (England & Wales)	11/09/2025	CSEG Nov 2025
618	NCEPOD	Medical and Surgical Clinical Outcome Review Programme	Blood sodium report	11/09/2025	CSEG Nov 2025
577	NHFD	FFFAP - National Falls & Fragility Fracture Audit Programme	National Hip Fracture Database (NHFD) State of the Nation 2025 report	11/09/2025	CSEG Nov 2025
580	NNAP	NNAP - National Neonatal Audit Programme	State of the nation report 2025	09/10/2025	CSEG Nov 2025
583	NEIAA	NEIAA - National Early Inflammatory Arthritis Audit	State of the Nation Report 2025	09/10/2025	CSEG Nov 2025
605	NELA	NELA - National Emergency Laparotomy Audit	Year 10 State of the Nation report	09/10/2025	CSEG Nov 2025
20/23					367/618

HQIP Ref.	Abb	PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG
578	MNI	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal Mortality Surveillance and Confidential Enquiry 2025 Report	09/10/2025	CSEG Nov 2025
588	FFFAP	FFFAP - National Falls & Fragility Fracture Audit Programme	National Audit of Inpatient Falls (NAIF) State of the Nation report 2025	09/10/2025	CSEG Nov 2026
551	NRAP	NRAP - National Respiratory Audit Programme	Asthma Secondary Care Secondary care outcomes report (TBC)	09/10/2025	CSEG Nov 2026
639	NATCAN	National Bowel Cancer Audit (NBOCA)	National Bowel Cancer Audit (NBOCA) State of the Nation report (England & Wales)	09/10/2025	CSEG Nov 2025
619	NCEPOD	Acute limb ischaemia	Acute limb ischaemia	13/11/2025	CSEG Jan 2026
574	NVR	NVR - National Vascular Registry	State of the Nation 2025 report	13/11/2025	CSEG Jan 2026
650	SSNAP	Sentinel Stroke National Audit Programme	State of the Nation report	13/11/2025	CSEG Nov 2025
617	NCEPOD	Child Health Clinical Outcome Review Programme	Emergency paediatric surgery	11/12/2025	CSEG Jan 2026
585	NCMD	NCMD - National Child Mortality Database	Thematic report: Consanguinity	11/12/2025	CSEG Jan 2026
641	FFFAP	Fracture Liaison Service Database (FLSD)	FLSDB state of the nation report	08/01/2026	CSEG Mar 2026
21/23					368/618

Appendix Two - Examples of local audits completed by Divisions

Urgent Care Audits
Time to ECG from book in in chest pain and time seen by Dr
Time to XR from request
Non-essential cannulations
Asthma management and documentation in >16yo
Trauma call activation and who attended
Time to formal CT/MRI report
Time of referral to time seen by medical team
WP10 prescription and documentation
Seizure checklist
Time of referral to time seen by surgical team
Dermatology
Hidradenitis audit
Camouflage clinic audit
Paediatrics high-cost drugs

Medicine	
DECI	PSAAG audit
FOC	D2RA audit
H&CS	Fridge temperatures
1pt 1 day	Resus trolley
Infection control dashboard	Falls
Hand hygiene	Diabetic
Call bells	Continence
Wrist bands	Nutrition and hydration
Enhanced care	Fluid balance audit
Dementia audit	Care flow audits
Kings fund audit	Fridge temperatures
Nutritional audit	Resus trolley
Ward assurance audits	Being implemented



CLINICAL AUDIT AWARENESS WEEK

FEATURING THE CLINICAL AUDIT HEROES AWARDS 2025

2-6 JUNE 2025

Don't
Miss
Out

#CAAW25



HQIP

Healthcare Quality
Improvement Partnership

IN COLLABORATION WITH



- ❖ 2 June 2025: Patient Safety – Effectively utilising clinical audit to prevent avoidable harm
- ❖ 3 June 2025: Patient & Public Involvement (PPI) – Effectively utilising clinical audit to improve health and care by involving, engaging and informing patients and the public
- ❖ 4 June 2025: Healthcare Inequalities – Effectively utilising clinical audit to address inequalities in health and care
- ❖ 5 June 2025: Influencing Change – Effectively utilising clinical audit to influence change
- ❖ 6 June 2025: Efficiencies – Effectively utilising clinical audit to make healthcare sustainable.



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University Health Board

ANNUAL CLINICAL AUDIT ACTIVITY REPORT 2024/2025



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Introduction

Welcome to the Aneurin Bevan University Health Board Clinical Audit Activity Report 2024/2025.

Clinical audit is a cornerstone in building the highest quality health and care system for Wales, ensuring everyone receives safe, effective, and reliable care at the right place and time. By systematically evaluating clinical practices against established standards, clinical audits enhance patient outcomes across medical, surgical, and mental health specialties. Engaging healthcare professionals in this process provides invaluable insights into the quality of care and highlights areas for improvement.

Audit is part of clinical effectiveness, as mapped in the Duty of Quality. Audit is crucial for improving patient care, as it ensures that healthcare practices are based on the best available evidence, leading to better patient outcomes, enhanced safety, and higher quality of care.

This report highlights our achievements, challenges, and ongoing commitment to delivering high-quality, safe, and effective care to the population of Gwent. We are proud to share our progress and the positive impact of our initiatives over the past year.

This report showcases the clinical audit activities undertaken within Aneurin Bevan University Health Board during 2024/2025, reflecting our commitment to excellence in patient care.

Smart. Measurable. Attainable. Realistic. Timely.

What is Clinical Audit?

Clinical Audit is integral to improving clinical practice standards. Audit topics reflect national and local priorities, such as Cancer Services, National Service Frameworks, incident reporting, or best practice introductions. Clinical audits measure care delivery against agreed standards, identifying and implementing improvements to enhance reliability and outcomes.

Key benefits include:

- High-quality, safe care for patients
- Cost-effective and sustainable clinical services
- Local engagement in National Audits
- Compliance with NHS Wales Health and Social Services and Public Health Wales regulations
- Assurance through compliance reports
- Quality improvement projects aligned with Health Board priorities
- Demonstrable NICE compliance and best practice implementation



Smart. Measurable. Attainable. Realistic. Timely.

The Health Board demonstrates through Clinical Audit that:

- Patients receive the highest standards of care based on the best available evidence.
- Clinical teams identify opportunities to improve patient care quality.
- Processes are tested to ensure they effectively enhance patient outcomes, experience, safety, and quality of care.
- Re-audits are conducted to ensure sustained improvements in patient care quality.
- Health Board outcomes exceed the national average by participating in National Clinical Audits within the NCAPOP and making data available per HQIP guidance.
- The Health Board can show stakeholders that clinical audits are managed and actioned in line with NHS standards and are available for scrutiny by Public Health Wales (PHW) and other external agencies.

Six Domains of Quality

Clinical audit is essential for improving patient care and ensuring compliance with the Wales Health and Care Quality Standards. It systematically evaluates clinical practices against established standards, providing insights into the quality of care and identifying areas for improvement. This can be demonstrated below:



PERSON CENTRED

PERSON CENTRED care involves patients, relatives, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety. We care about the wellbeing of individuals, families, carers and staff, ensuring everyone is treated with compassion, kindness, dignity and respect. Audits ensure that care is tailored to individual patient needs and preferences, enhancing patient satisfaction and engagement.



SAFE

SAFE – reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information. Care delivered by capable and competent staff. Maximising things that go right and learning from when things that go wrong to prevent reoccurrence. Audits identify and mitigate risks, promoting patient safety and preventing harm



TIMELY

TIMELY care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We will care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority. Audits ensure that patients receive care promptly, reducing delays and improving overall health outcomes.



EFFECTIVE

EFFECTIVE care – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to **improve** outcomes. Audits ensure that clinical practices are evidence-based and aligned with best practices, leading to optimal patient outcomes



EFFICIENT

EFFICIENT by taking a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We will make the most effective use of resources to achieve best value, doing only what is needed, ensuring any interventions represent the best value that will improve outcomes for people. Audits help eliminate waste and improve resource utilization, ensuring sustainable and cost-effective services.



EQUITABLE

Provide **EQUITABLE** care, ensuring equal opportunities for individuals to attain their full potential for a healthy life which does not vary in quality and is non-discriminatory. We will embed equality and human rights and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time. Audits promote equal access to high-quality care for all patients, regardless of personal characteristics.

Six Quality Enablers



LEADERSHIP

Ensure visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality. Our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision. They have the appropriate skills and capacity to create the conditions for a functioning quality management system. We ensure our governance, leadership and accountability is effective in sustainably delivering care.



WORKFORCE

Recruit, retain, develop and extend roles to ensure we have enough, confident people with the right knowledge and skills available at the right time to deliver safe care. We value our people and the commitment and resilience they demonstrate in the care they provide. We care about their wellbeing, protect their rights and support them to feel well and happy at work; and provide them with the tools, systems and environment to work safely and effectively. Our workforce planning focuses on investing in our people and nurturing, growing and transforming our workforce to create a sustainable



CULTURE

Create the right climate and culture to nurture and encourage quality and system safety, valuing people in a supportive, collaborative and inclusive workplace so that our people feel psychologically safe to raise concerns and try out new ideas and approaches. Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture, where people can thrive.



INFORMATION

Ensure information is available and shared appropriately for all who need it. We turn data to knowledge by triangulating quantitative and qualitative performance, experience and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made. We monitor, report and escalate indicators through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement and accountability.



LEARNING, IMPROVEMENT, RESEARCH

Create the conditions and capacity for an organisation and system-wide approach to continuous learning, quality improvement and innovation, which it actively promotes. We use new knowledge to influence improvements in practice and to inform our decision-making. We ensure our learning and improvement activity is linked to our strategic vision to deliver transformational, organisation-wide change. We commit to participating in research because research-active organisations provide improved quality of care and outcomes for people.



WHOLE SYSTEM APPROACH

Ensure safety in healthcare goes beyond individual patient safety. We will look within and beyond our organisational boundaries to learn how we can continually, reliably and sustainably meet the evolving needs of people. We will strengthen relationships and work with all of our partners to achieve good outcomes. Our policies incorporate the broader ambitions within the seven well-being goals and five ways of working in the Well-being of Future Generations Act.

Pillars of Quality

The six pillars of quality have been integral to Aneurin Bevan University Health Board's quality journey by providing a comprehensive framework to assess, monitor, and continuously improve care standards. Each pillar addresses a critical aspect of healthcare, contributing to a holistic approach to quality and safety. Here's how Clinical Audit is supporting to drive improvements in our Pillars of Quality Programme:

Patient and Staff Experience:	Clinical audits prioritise patient and staff experiences, ensuring care remains person-centred and fostering a positive environment for healthcare workers. This is essential for delivering compassionate and effective care, which audits help to measure and improve.
Incident Reporting:	Systematically tracking incidents like falls, pressure ulcers, medicines management, and mortality allows clinical audits to identify patterns, address systemic issues, and prevent recurrence. This enhances patient safety by ensuring that care practices are continuously evaluated and improved.
Complaints, Concerns, and Compliments:	Engaging with feedback through clinical audits enables the Health Board to identify areas for improvement and replicate effective practices. This strengthens trust and accountability by demonstrating responsiveness to patient and family experiences.
Health, Safety, and Security:	Clinical audits ensure that facilities and processes meet the highest standards to protect patients, staff, and visitors. This supports a safe environment for care delivery by regularly evaluating and improving safety protocols.
Infection Control and Prevention:	By addressing infection control as a dedicated pillar, clinical audits enhance practices that reduce healthcare-associated infections. This improves overall patient outcomes by ensuring that infection control measures are effective and consistently applied.
Safeguarding:	Placing safeguarding as a core pillar in clinical audits ensures that vulnerable individuals receive necessary protection and support. This aligns care with ethical standards and legal obligations, ensuring that safeguarding practices are regularly reviewed and improved.



Aneurin Bevan University Health Boards Participation in National Clinical Audit (NCA) Programme mapped to the Integrated Medium-Term Plan (IMTP)

PRIORITY 1 – EVERY CHILD HAS THE BEST START IN LIFE - We believe that every child deserves the opportunity to have the very best start in life.

PRIORITY 2 – GETTING IT RIGHT FOR CHILDREN AND YOUNG ADULTS - Young people are an important group and nurturing of future generations is crucial for our communities.

National Clinical Audits (NCAs) participated in and support priorities 1 & 2:

- National Pregnancy in Diabetes
- National Paediatric Diabetes Audit
- National Clinical Audit of Seizures and Epilepsies for Children and Young People
- National Paediatric Diabetes Audit
- National Maternity and Perinatal Audit
- National Child Mortality Database
- National Neonatal Audit Programme
- Paediatric Asthma – National Respiratory Audit Programme

PRIORITY 3 – ADULTS IN GWENT LIVE HEALTHILY AND AGE WELL - We want our citizens to enjoy a high quality of life into old age we want them to be empowered to take more responsibility for their own health and care, so that they can retain independence.

NCAs participated in and support priority are:

- National Cancer Audits – Bowel, Breast, prostate and more
- Nation Respiratory Audits – COPD, Asthma Adults and Paediatrics
- National Diabetes Audits – Type 1 and Type 2 in young people and adults

PRIORITY 4 – OLDER ADULTS ARE SUPPORTED TO LIVE WELL AND INDEPENDENTLY

NCAs participated in that support this priority are:

- National Audit of Dementia
- Falls and Fragility audits
- National Early Inflammatory Arthritis Audit



PRIORITY 5 – DYING WELL AS A PART OF LIFE

NCA participated in that support this priority:

- National Audit of Care at the End of Life ⁷

Audit Goals – Achievements and Progress 2024/2025	
Achievements We're Proud Of	
Goal	Status
✓ Provided assurance to the Audit, Risk and Assurance Committee with a part-year report evidencing achievements to date	🏆 Achieved
✓ Improved clinical engagement and attendance at the Clinical Standards and Effectiveness Group	🏆 Achieved
✓ Ensured continued mandatory participation in National Clinical Audit and Patient Outcomes Programme (NCAOP) and local engagement	🏆 Achieved
✓ Secured future funding stream for AMaT	🏆 Achieved
✓ Delivered on the Duty of Quality by embedding clinical audit to drive high-quality, safe, and effective care	🏆 Achieved
✓ Completed local corporate audits relating to Consent, DNACPR, and Nasogastric Feeding Tube	🏆 Achieved
The Health Board has made strong strides this year—successfully achieving six of our key goals and progressing steadily on the rest. These achievements reflect a committed effort across teams to embed quality, safety, and learning through audit at every level.	
8/135	8 378/618

Audit Goals – Achievements and Progress 2024/2025	
Ongoing Commitments We're Building On	
Goal	Status
❑ Develop local audit plan with Divisions	🔄 Ongoing
❑ Continue to fully embed AMaT, including governance structure completion	🔄 Ongoing
❑ Ensure audit actions and findings are monitored and used to inform service improvement and future planning	🔄 Ongoing
❑ Align national clinical audits with Health Board planning and Integrated Medium-Term Plan (IMTP)	🔄 Ongoing
❑ Triangulate learning from clinical audits to drive service improvement	🔄 Ongoing
❑ Complete data acquisition project to enhance clinical audit participation	🔄 Ongoing
We remain committed to driving continuous improvement through our ongoing audit initiatives. Current priorities focus on embedding robust governance structures, aligning clinical audit activity with strategic planning, and ensuring that learning from audits is effectively translated into service improvement. These efforts are vital to sustaining high-quality, safe, and patient-centred care across the Health Board	

Challenges in 2024/25	
	The original plan, as outlined in the Clinical Audit Strategy 2022-2025, envisioned divisions taking ownership of their audit work. However, due to time, pressures and resource constraints within the divisions, the Quality and Patient Safety Team has continued to manage this responsibility.
	Resource pressures are also felt within the Medical Director’s Quality and Patient Safety Audit team, which currently has 1WTE supporting the training and management of all modules of AMaT. This includes chasing overdue actions and obtaining evidence to mark actions as complete. Additionally, the team are responsible for training all Health Board staff on all aspects of AMaT.
	Risks reported in AMaT have been updated to align with the Health Board's Risk Assessment and Scoring Guidance, providing four levels of assurance and five levels of risk. Details are provided in slide 16 of this report.
	The Healthcare Quality Improvement Partnership (HQIP) plans nine months ahead, and the Audit team uses this schedule to organise CSEG meetings throughout the year, ensuring an even spread across the CSEG programme and proper management of mandated reports. Non-participation is highlighted internally, and outlier status is attributed to the audit owner, such as the Royal College of Surgeons.
	Tracking the completion of audit action plans is challenging. When actions are not completed with evidence by the due date, they become overdue. The Clinical Audit Team makes every effort to communicate with clinical leads to ensure actions are appropriately updated.
	Clinical priorities often supersede audit responsibilities, posing a challenge for busy clinical teams.
	A recurring funding stream for AMaT that is distributed across all Executive portfolios.
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Our EFFECTIVE Commitments as mapped to the Quality Strategy for 2023-2026

Clinical audit helps the Health Board deliver consistent, evidence-based care by reducing variation, promoting best practice, and ensuring reliable, high-quality outcomes for patients.

This Annual Report outlines the National Clinical Audits (NCAs) undertaken by the Health Board between April 2024 and March 2025. The findings are embedded within the Health Board’s evolving Quality Management System, developed in response to the Duty of Quality introduced in April 2023. These audits play a vital role in supporting the 'Effectiveness' domain of the Duty of Quality, helping ensure care is consistently evidence-based and outcome-driven.

Provide effective care

- Deliver care that is consistently effective and reliable, following best practices.
- Foster a culture that encourages innovation to improve outcomes.
- Ensure patient care is based on the best available evidence.
- Support divisions in driving improvement priorities through learning.

Implement the mandatory National Audit Programme

- Participate in relevant national audits to ensure effective care delivery.
- Use audit findings to support continuous quality improvement by sharing learning and best practices across the organization.
- Develop action plans to monitor and ensure that audit-related actions are measurable and achievable.

Building audit capability across the organisation through skills development

- Create a training programme that encompasses all staff groups.
- Enhance audit capabilities across the organisation by implementing the web-based Audit Management and Tracking System (AMaT).
- Leverage Clinical Audit expertise to provide the evidence base and measurement functions that drive quality improvement initiatives.

To increase engagement with audit and clinical effectiveness work

- Enhance the visibility of clinical audit results by implementing the Clinical Audit Strategy.
- Develop an internal registry as part of this strategy.

Implement NICE Guidance and adoption of Health Technology Wales guidance

- Regularly assess and implement relevant NICE and specialist national guidance to deliver interventions based on the best possible evidence.
- Utilise best practice evidence and benchmark data to improve outcomes.

Annual Reflection on National Clinical Audit across Aneurin Bevan University Health Board

- The Health Board's strategic focus on National Clinical Audit has ensured mandatory participation in the Welsh National Clinical Audit and Outcomes Review Plan (NCAORP).
- Over the past 12 months, the Quality and Patient Safety (QPS) audit team have collaborated with clinical leads to discuss National Clinical Audit results at the Clinical Standards and Effectiveness Group (CSEG).
- In 2024/2025, participation in NCAORP increased, with clinical leads providing S.M.A.R.T. actions based on national reporting recommendations and allocating assurance levels and risk status.
- Additionally, several National audits, such as those on stroke and falls, were discussed at various Boards and Committees throughout the Health Board, reflecting our commitment to continuous improvement and excellence in patient care.
- Standardised templates for local data ensured consistent reporting across NCAORP programmes, aligning with AMaT's Audit Management and Tracking areas. This allowed clinical leads to provide the Clinical Standards and Effectiveness Group (CSEG) with necessary assurances for submission to the Patient Quality and Safety Outcomes Committee (PQSOC). Divisional management teams were kept informed and actively participated in these processes.
- With the expansion of our Audit Management and Tracking (AMaT) system, registered users grew to 2,394, including 118 users who could create proformas and register audits. Ongoing training ensured AMaT's effective use across the Health Board.
- Divisional teams identified clinical audits as part of their local audit plans, allowing scrutiny and assurance of quality and safety risks from Datix, complaints, and care outcomes.
- Collaboration with Aneurin Bevan Continuous Improvement (ABCi), Value Based Health Care Team (VBHC), and Research and Development ensured Health Board staff understood where their projects fit within the organisational structure.

Examples of National Clinical Audits:
National Clinical Audits presented to the Clinical Standards and Effectiveness Group in 2024/25, showcasing both successes and areas of concern. These findings are shared with the Patient Quality and Safety Operational Committee.

AUDIT TITLE	Celebrating Success - 2024/2025	Areas for improvement for 2025/2026
National Oesophago-Gastric Cancer Audit (NOGCA) - State of the Nation Report	✓ A lower proportion of cancers diagnosed as emergency (compared to Wales and England) ✓ Higher proportion diagnosed within 28 days of referral (compared to Wales and England)	❑ 62-day referral to treatment time needs improvement to meet target time ❑ Delays in pathway out with local control e.g. CT-PET
National Lung Cancer Audit (NLCA) - State of the Nation Report 2024 ALL ACTIONS COMPLETED & AUDIT CLOSED	✓ Non-small cell lung cancer treated curatively rose from 31.7% to 57.1% ✓ Exceptional Lung Cancer Nurse Specialist input with plans to see inpatients	❑ Surgical resection rates are under target, although have improved since 2021 ❑ High rate of emergency presentations
National Audit of Dementia (NAD) - Care in General Hospitals 2022-2023 Round 5 Audit Report	✓ Delirium screening and pain assessment has improved (previously an outlier) ✓ Discharge planning now initiated within 24 hours	❑ Improvements considered for how to enhance carer communication ❑ Work to define a measure to record proportion of people with Dementia having falls on DATIX
Fracture Liaison Service Database (FLS-DB) Annual report - You've had a fracture; how can we prevent another? 	✓ AB FLS continued to recommend bone treatment for 65% of patients (target 50%) ✓ AB FLS has increased identification by 200% since 2021, this year reaching 70% (target 80%)	❑ 16 weeks adherence remains under 50% ❑ 52 weeks adherence remains under 25% 

Examples of Audit Actions Fully Completed in 2024/2025

(all actions can be viewed on AMaT)

 Focused on embedding improvements – patient safety, clinical excellence, and system change.

Audit Title	Action Taken	Outcome
NRAP – Breathing well: Paediatric Asthma	Smoking status now recorded on proforma; cessation advice included in discharge pack	✔ Smoking advice integrated into care templates
NELA – Emergency Laparotomy	MDT and risk assessments enhanced for elderly/frail patients	✔ Ongoing input from CoTE and service development supported
MBRRACE – UK Perinatal Mortality	Developed maternity improvement plan; linked to IMTP and public health	✔ Forms part of IMTP; digital audit and cessation data embedded
National Hip Fracture Database	Theatre delays escalated; Medical Director involved	✔ Escalated to Exec level for improvement action

Throughout 2024/25 the Clinical Audit team has focused on ensuring clinical audit actions are completed and recorded by embedding them into AMaT with clear ownership, deadlines, and oversight, providing robust assurance to governance committees

The National Clinical Audit and Patient Outcomes Programme (NCAPOP)

- NCAPOP is commissioned and managed by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS Wales.
- The programme includes over 30 national audits related to common conditions, collecting and analysing data from local clinicians to provide a national picture of care standards.
- Locally, NCAPOP audits offer individual benchmarked reports to trusts and health boards, highlighting compliance and performance, and providing comparative findings to identify necessary improvements.
- Most projects involve services in England and Wales, with some also including Scotland and Northern Ireland.
- In addition to the national clinical audits, NCAPOP includes the four Clinical Outcome Review Programmes (CORP), which assess healthcare quality and stimulate improvement by learning from adverse events and other relevant data.

What is our Clinical Audit Strategy?

The Health Board has a Clinical Audit Strategy which sets out the vision for clinical audit for the Health Board. The vision is to be recognised as the best healthcare provider in our class, consistently performing within the top 10% nationally. The mission is to safeguard the health and well-being of the population we serve and to abide by our Health Board values.

The values we aim to show are:

People First

**Personal
Responsibility**

**Passion for
Improvement**

**Pride in What
We Do**

The Health Board Audit Strategy has Four Priorities:

- ❖ Scrutiny of National Clinical Audit performance with robust development, monitoring, and progression of improvement plans
- ❖ Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risk
- ❖ Trainees are supported to participate in meaningful clinical audits that support clinical governance
- ❖ Groups and committees across the Health Board will commission clinical audit to support effective assurance where no other evidence is available.

Clinical Audit Governance and Reporting Arrangements

- The Medical Director's Quality and Patient Safety (QPS) team coordinates delivery of the Clinical Audit Plan with Clinical Leads. This ensures mandatory compliance with the National Clinical Audit and Patient Outcomes Programme (NCAPOP), commissioned by HQIP, and the NHS Wales National Clinical Audit Outcome Review Plan (NCAOPR). The team collaborates with Divisional structures to document and track audit participation.
- At the operational level, **the Clinical Standards and Effectiveness Group (CSEG)** is multidisciplinary forum that is focused on reviewing audit data, identifying risks to clinical effectiveness and patient safety, and promoting improvements in care. This group ensures clinical audit findings are discussed in a system-wide context, facilitating shared learning and cross-divisional alignment.

From a governance perspective, the reporting routes are clearly defined and set out below:

- The **Patient Quality, Safety, and Outcomes Committee (PQSOC)** looks at audit outcomes and the improvements made as a result. It focuses on how findings translate into better patient care and safety, aligning with the Health Board's commitment to continuous improvement.
- The **Audit, Risk, and Assurance Committee (ARAC)** oversees the governance and assurance framework supporting the clinical audit programme. It ensures the plan is robust, informed by risk, and aligned with strategic priorities. ARAC also seeks assurance that audit findings are being actioned appropriately and that the process is leading to demonstrable change.
- By maintaining these distinct but complementary oversight functions, the Health Board ensures that both assurance and improvement are built into the audit cycle, connecting front-line clinical practice with corporate risk governance

Health Board results - National Clinical Audit Outcome Review Plan (NCAORP)

Participation in NCAORP 2024/2025 and presentation at CSEG

	Number of audits
NCAORP 2024/2025	
Published Apr 24 – March 25	48
Presented at CSEG to date 2024/2025	26
Arranged for future CSEG (May & Jul 2025)	10
NHS England (not applicable)	8
ABUHB Non-participation	4
	48
%	
Presented at CSEG 2024/2025	54%
Arranged for future CSEG (May & Jul 2025)	21%
NHS England (not applicable)	17%
ABUHB Non-participation	8%
	100%

Total number participated in is 36. to date, 26 presented at CSEG and 10 will be presented throughout 2025.

Total of non-participation is 16 and reasons are:

- NHS England data only (8 audits).
- The Health Board has not participated in the National Respiratory Audit Programme (3 audits). Due to non participation the Health Board has received an outlier notification. The Medical Director has formally written to the relevant specialty, reinforcing the participation is mandatory. An action pan will be developed to address the issues. This is under review to ensure 2025/26 participation.
- National Confidential Enquiry into Patient Outcome for the audit – ‘Death on Planning for the End’ – under review of the quality of care provided to adult patients (1 audit).

Assurance and Risk Levels:

Assurance		Risk	
Full	6%	None	6%
None	0%	Minor	56%
Significant	56%	Moderate	25%
Limited	38%	Major	13%
Very Limited	0%	Catastrophic	0%
	100%		100%

Risk and Governance

In the Health Board risk refers to the potential for any event or action to adversely affect the achievement of the organisation's objectives, including patient safety, service delivery, and overall organisational performance. Effective risk management is crucial for identifying, assessing, and mitigating these risks to ensure high-quality healthcare services.

As part of the audit plan Clinical Leads completed the risk level and assurance level for the Clinical Audit. To reduce risk across the Health Board, high level risk areas must be added to the relevant risk register and risks analysed, evaluated and treated.

The risk levels were adjusted during 2024/2025 to align with the Healths Boards Risk Scoring Matrix, in collaboration with the Health Board's Corporate Governance team:

Risk Level

None	Standards met and findings demonstrate no risk to patient safety
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon
Major	Non-compliance with national standards with significant risk to patients if unresolved – Major risk to patient safety
Catastrophic	Totally unacceptable level or quality of treatment/service - Gross failure to meet national standards – Gross failure to meet standards



Assurance Level

Full	The project has fully achieved the standards or criteria being audited against
Significant	The project has mostly achieved the standards or criteria being audited against
Limited	The project did not achieve the standards or criteria being audited against
Very limited	The project failed to achieve the standards or criteria being audited against

Assurance and Risk Levels				
Risks reported to CSEG for 2024/25 for National Clinical Audit Programme				
CSEG Date	Audit title	Assurance	Risk	Update
May-24	National Lung Cancer Audit State of the Nation report (01/01-31/12/2022 data; Eng & Wales)	Significant	Minor	All report recommendations have been achieved. Actions are fully completed by Clinical Lead.
May-24	National Audit of Dementia - Care in General Hospitals 2022-2023 Round 5 Audit Report	Limited	Major	The Clinical Lead is actively collaborating with site leads and support staff across the Health Board to drive improvements. However, there are some overdue actions that need to be addressed to ensure the service meets its goals.
May-24	Fracture Liaison Service Database (FLSDB) Annual Report 2024: Improved FLS identification with gaps in monitoring: a call to action for national and regional planners (January-December 2022)	Limited	Major	Two out of three actions are fully complete, while one remains partially complete and overdue due to staffing resource issues. Over five years, the total annual cost for ABUHB FLS, including staff, overheads, and prescribing costs, is estimated to be between £450,376 and £883,488. The annual benefits across acute care are £1,439,436, with total benefits, including community and social care, reaching £2.1 million.
Jul-24	National Diabetes Foot Care Audit (NDFCA) State of the Nation report, 01/04/2021-31/03/2022 TBC; Eng & Wal.	Significant	Minor	Continuous Quality Improvement (QI) work is being carried out to enhance patient care. All report recommendations are being successfully achieved.
Sep-24	National Respiratory Audit State of the Nation report - PAEDIATRIC ASTHMA	Significant	Minor	One action has been completed. There will be a meeting to discuss the joint pathways with Primary Care and Adult Services.
Sep-24	NCEPOD - Endometriosis	Significant	Moderate	There is a comprehensive action plan in place which is to be completed by 31st March 2025.
Sep-24	MBRACCE-UK Perinatal mortality surveillance July 2024 - State of the nation report	Significant	Minor	All recommendations have been achieved.
Nov-24	National Emergency Laparotomy Audit State of Nation report 2024	Significant	Minor	Presented to CSEG in November 2024, with actions related to COTE consultant expansion and patient-level data entry both set to be resolved by 2026
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Risks reported to CSEG for 2024/25 for National Clinical Audit Programme				
CSEG Date Audit title		Assurance	Risk	Update
Nov-24	National Ovarian Cancer Audit (NOCA) - State of the Nation	Limited	Minor	A new audit has been submitted to NATCAN, with ongoing actions planned throughout 2025. This audit is more advanced in England, so there are expectations for improved data for Wales moving forward
Nov-24	National Neonatal Audit Programme 2024 report	Significant	Minor	The metrics within the audit are improving year on year and are continuously monitored using the updated Dashboard.
Nov-24	National Primary Breast Cancer Audit (NaoPri) - State of the Nation	Significant	Minor	Two recommendations have been completed within the Health Board and three actions are planned to be completed during 2025.
Nov-24	National Metastatic Breast Cancer Audit (NaoMe) - State of the Nation	Limited	Moderate	Three actions are to be completed during 2025.
Jan-25	National Hip Fracture Database (NHFD)	Limited	Moderate	Presented to CSEG in January 2025 and three actions are to be completed during 2025.
Jan-25	Epilepsy12 State of the National report, England and Wales (2021-23)	Significant	Minor	Business case submitted to improve EEG waiting times in Neurophysiology. Ongoing discussions across the team to improve services.
Jan-25	National Early Inflammatory Arthritis Audit State of the Nation 2024 Annual Report	Full	None	All report recommendations are in place and the service has improved from previous outlier status.
Jan-25	National Pregnancy in Diabetes (NPID) Annual Data Only Release and Dashboard Update (2023; Eng Only)	Significant	Minor	No recommendations were provided as this was dashboard release only.
Jan-25	National Respiratory Audit Programme Primary Care Report (cohort TBC)	Limited	Moderate	Presented to CSEG in January 2025 there is an extensive action plan of which some recommendations have been fully completed and other actions are to be completed during 2025
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Summary of Completed Actions in the National Clinical Audit and Patient Outcomes Programme (NCAPOP)

Total Number of actions presented to CSEG	
Number fully completed	18
Number partially completed (overdue)	16
Number ongoing (not overdue)	27
No longer relevant	2
Number overdue	26
	89

% fully completed	20%
% partially complete	18%
% ongoing	30%
% overdue	29%
(3% no longer relevant)	100%

Those fully completed were completed within 12 months.
However, only 7% (5 of 70) were completed within the stated timeframe
All overdue actions are being highlighted to the Clinical Leads and the Divisional triumvirates.

- ACTIONS
- A SMART action plan is completed on AMaT based upon the report recommendations and/or the Clinical Leads local recommendations.

Some of the report recommendations may already be achieved within the Health Board – these are noted as already achieved.

Ongoing actions may be actions that take a longer time to put in place or could have had a shorter deadline which has then been extended.

All actions for National Clinical Audits are monitored by the Medical Director’s Clinical Audit QPS team and chased with the relevant nominated responsible person and are updated accordingly in AMaT.

The Clinical Audit team have produced an escalation SOP and will look at how this is enacted for actions that are overdue to ensure completion and follow up.

Audit Management and Tracking System (AMaT)

Update on AMaT Implementation



- Purchased in 2022, as part of the Clinical Audit Strategy the Medical Director's team has been implementing use of the system and carrying out training for staff.

User Statistics:

- 2,330 registered users have been trained to use AMaT, contributing to the audit programmes.
- 115 staff members can create audit questionnaires.
- 6 SUPER USERS can maintain the data management area.

Inspection Area Usage:

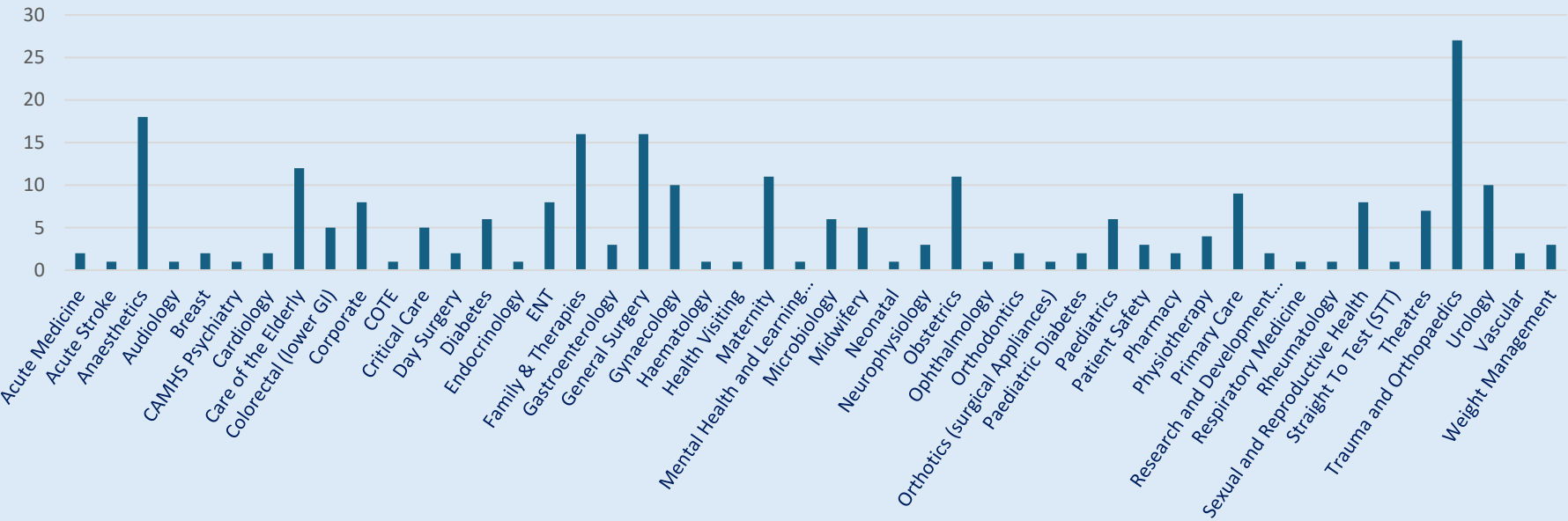
- 16 inspections registered with actions:
 - 8 In Progress
 - 1 Partially Complete and Overdue
 - 42 Overdue
 - 352 Completed (awaiting approval)
 - 34 Completed

Guidance Module:

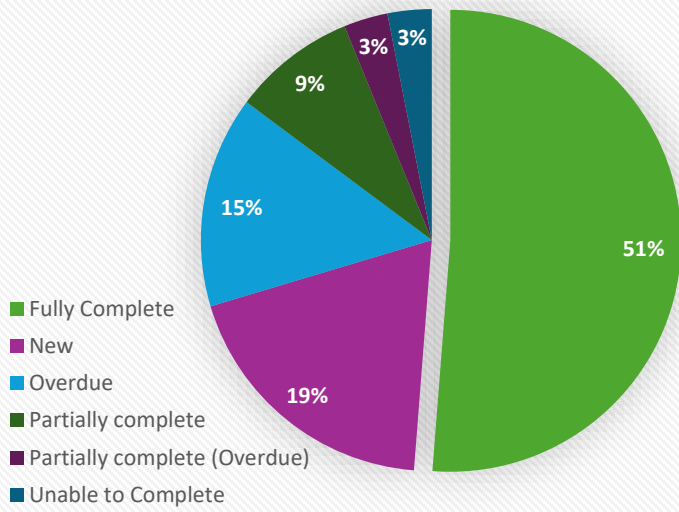
- 15 guidance statements:
 - 10 Achieved
 - 3 Overdue
 - 1 Partially Achieved – Acceptable status (PAA)
 - 1 Not applicable



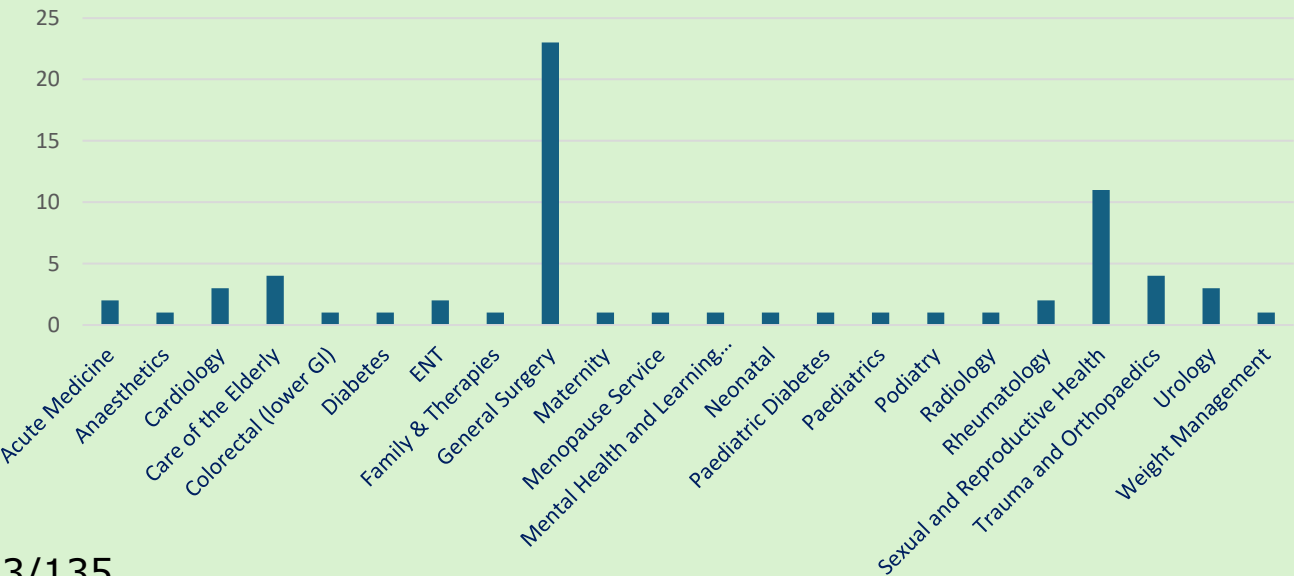
Active projects by specialty – (total 252)



Progress of actions for 2024/2025



Closed projects in AMaT by Specialty - 67



- Through the accessibility of AMaT to all staff, there are currently 252 active projects across local and national levels, with 67 projects closed and signed off.
- In 2024/2025, 51% of allocated actions have been fully completed.
- The Quality and Patient Safety team monitors these actions.
- Efforts are underway to use AMaT for capturing National Clinical Audit Data, specifically for the NICOR Heart Failure audit.

LOCAL AUDIT AUDIT MANAGEMENT AND TRACKING (AMaT) – WARD AREA

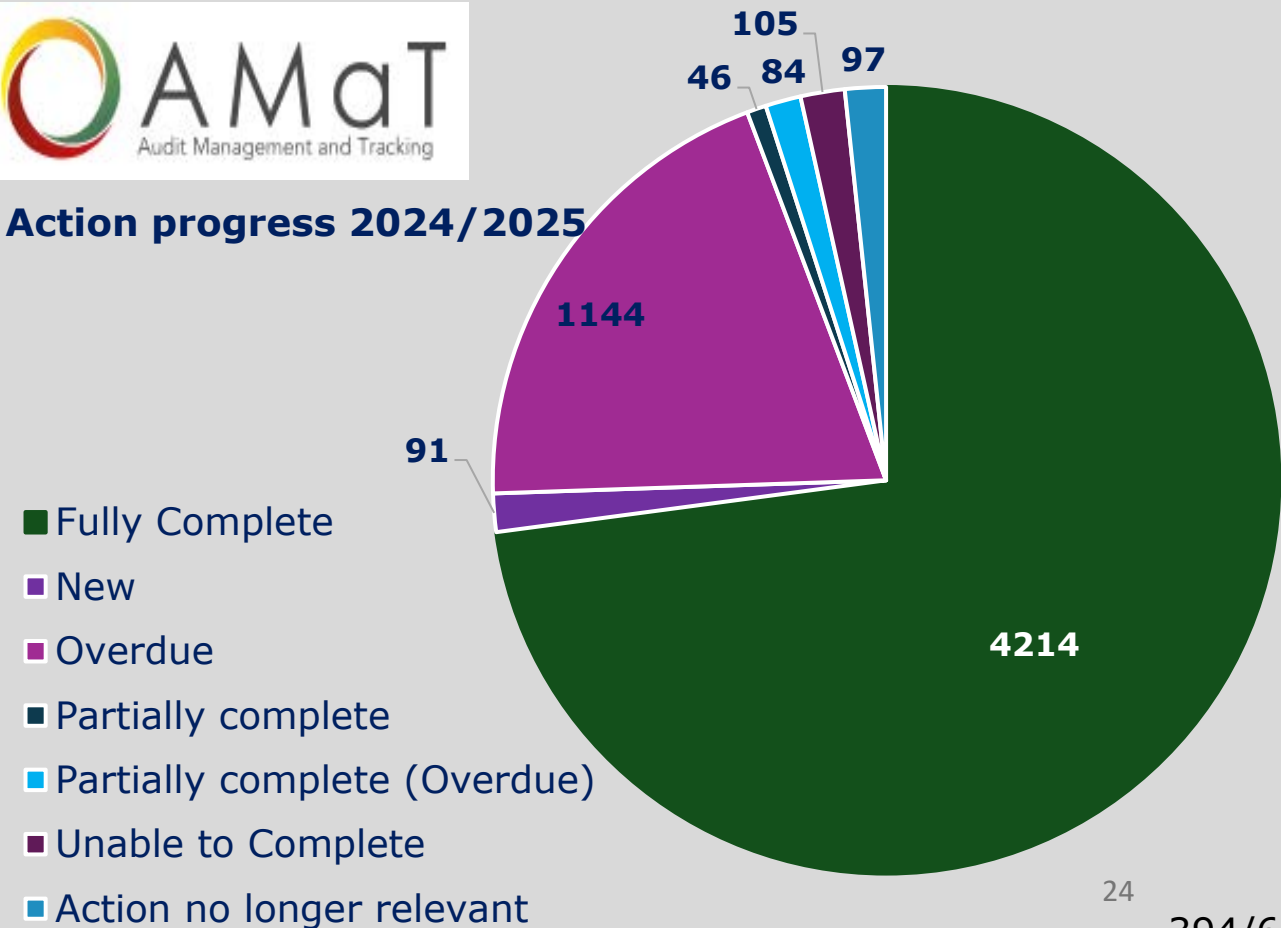
- In 2023/2024, 20 projects were recorded in the Ward Area of AMaT. This doubled to 40 projects in 2024/2025. Each project may encompass multiple audits—for example, the Ward Accreditation project includes 15 audits spanning up to 62 clinical areas.
- A total of 5,781 audits have been registered, with 4,212 actions completed. However, 233 of these actions remain without supporting evidence, and 1,228 actions are currently overdue.
- Across all audits, 10,122 clinical areas have completed assessments and can view their results. Of these, 3,165 achieved a score of 100%, while 7,347 scored 90% or above, demonstrating strong overall performance and engagement.

Examples of Completed Actions:

- All staff are compliant with the *Bare Below the Elbows* policy
- The patient's *First Language Spoken* is recorded in the clinical record
- The *Mental Health Section* of the documentation has been fully completed
- Staff are wearing *Personal Protective Equipment (PPE)* correctly and consistently
- Evidence of *Discharge Planning* is documented in nursing/medical records or on the PSAG board
- The *Care Plan* is regularly reviewed and updated
- *Dementia-friendly signage* is clearly visible and appropriately placed on the ward



Action progress 2024/2025



Patient Experience captured through audit		
Increasing Patient Involvement: • More audits are incorporating patient feedback. The Health Board are asking family, carers, and friends about their views on the treatment provided by the Health Board and how we can improve. • As usage of CIVICA to capture patient experience increases, work with the Patient Experience and Involvement Team is vital to ensure feedback can be incorporated into Audit results.		
Dimensions of Person-Centred Care: Through this strategy, the Health Board is committed to: • Respecting people’s values, preferences, and expressed needs. • Improving information and education. • Enhancing access to care. • Providing emotional support to relieve fear and anxiety. • Involving family, friends, and significant others in patient care. • Ensuring continuity and smooth transitions between healthcare settings. • Providing physical comfort. • Delivering coordinated care. Working is needed with the value-based healthcare team to understand any measures collected on patient experience. In the context of healthcare, PREM stands for Patient Reported Experience Measures. These measures capture patients' experiences and perceptions of the care they receive, providing valuable insights into the quality of healthcare services from the patient's perspective. PREMs are used to inform improvements in patient care and service delivery.		
25/135	National Audits with patient related quality improvement measures are:	
	• National Early Inflammatory Arthritis Audit (NEIAA)	
	• National Audit of Care at End of Life (NACEL)	
	• National Dementia Audit (NAD)	
	• National Neonatal Audit Programme (NNAP)	
		25 395/618

Audit Goals and Key Objectives for 2025/26

These goals and objectives aim to build on the successes of the previous year while addressing ongoing areas for improvement.

Enhance Clinical Engagement - Improve clinical engagement and attendance at the Clinical Standards and Effectiveness Group.

Expand Audit Participation - Ensure mandatory participation in NCAPOP and NCAORP.

Develop Local Audit Plans - Collaborate with Divisions to develop comprehensive local audit plans. Build stronger connections with Divisional Management Teams.

Embed AMaT - Fully integrate the Audit Management and Tracking System (AMaT) into the governance structure. Run additional training sessions and raise audit awareness. Improve governance and reporting structures within AMaT.

Monitor Audit Actions - Monitor actions and findings from national clinical audits to inform future planning. Promote ownership and tracking of audit results and recommendations in AMaT.

Inform Future Planning - Use national clinical audits to inform the Health Board’s future planning and integrate them into the annual Divisional Integrated Medium-Term Plan (IMTP).

Triangulate Learning - Triangulate learning from clinical audits to drive service improvements. Evaluate mechanisms to triangulate learning from clinical audits and other sources.

Complete Data Acquisition Project - Finalise the data acquisition project for effective participation in clinical audits. Evaluate Medical Director's quality and safety structures and resources within the audit team.

Quality and Effectiveness Commitment - Maintain the commitment to delivering high-quality care, patient safety, patient experience, and clinical effectiveness through clinical audits.

Collaborative Efforts - Work with the Value-Based Healthcare team to review the impact of measures that complement audit and benchmarking results. Collaborate with the Patient Experience and Involvement team to strengthen audit data with CIVICA and patient experience data.

Secure a dedicated funding stream for AMaT that is shared across Executive Directors.

Conclusion

- The Clinical Audit Quality and Patient Safety Team has elevated the profile of clinical audit across the Health Board. By actively engaging with Divisional Management Teams and Clinical Leads for National Audit programmes. This has supported evidence-based results and ensured tracked implementation of SMART actions based on recommendations. Despite the challenges posed by competing priorities and high service demands, the team has made remarkable strides.
- Throughout 2024/25, there has been a focus on ensure Clinical Audit is integrated into core services, making it "business as usual." The embedding of AMaT has greatly improved the efficiency of audit completion and the effectiveness of monitoring actions arising from audits. The use of AMaT to produce standardised reporting templates and SMART action plans has provided robust assurance to CSEG and PQSOC.
- This report includes a comprehensive collection of national audit reports from the past 12 months. Future efforts will focus on ensuring that learning from audits is shared across the Health Board and communicated to both staff and patients.
- Patient experience, quality, and safety are central to our work, driving improvements in the quality of care and services we deliver, and enhancing outcomes for the population we serve.
- Clinical audit continue to be a vital component of our commitment to EFFECTIVE care, supporting the delivery of the Duty of Quality as mapped to the six domains of quality.
- Clinical Effectiveness will soon become a Pillar of Quality and this will support the work on Clinical Audit.

National Quality Improvement Programmes

- The Healthcare Quality Improvement Partnership (HQIP) has been a cornerstone in the landscape of national healthcare quality improvement since its establishment in 2007. As an independent, not-for-profit organisation, HQIP is led by the Academy of Medical Royal Colleges and the Royal College of Nursing. Its mission is to enhance health outcomes through evidence-based, patient-centred quality improvement initiatives.
- One of HQIP's flagship responsibilities is managing and commissioning the National Clinical Audit and Patient Outcomes Programme (NCAPOP) on behalf of NHS England, the Welsh Government, and occasionally other devolved authorities. NCAPOP is a comprehensive programme that encompasses two main sub-programmes: the National Clinical Audit Programme and the Clinical Outcome Review Programmes. These initiatives are pivotal in driving improvements in clinical practice and patient outcomes across the UK.
- HQIP's relationship with NHS Wales Health Boards is integral to the success of these national quality improvement programmes. By collaborating closely with these health boards, HQIP ensures that the audits and reviews are tailored to meet the specific needs and challenges faced by healthcare providers in Wales. This partnership fosters a culture of continuous improvement and accountability, ultimately leading to better patient care and outcomes.
- In practice, HQIP supports improved health outcomes by commissioning national clinical audits and outcome review programmes, as well as providing registry data and resources. These efforts are complemented by a range of other quality improvement and patient engagement activities, all aimed at fostering a healthcare system that is responsive to the needs of patients and grounded in robust clinical evidence.

National Quality Improvement Programmes

- For the last 12 months, the publication list for 2024/2025 outlined the projects scheduled for presentation at the Clinical Standards and Effectiveness Group (CSEG). However, it is important to note that some projects may be presented in 2025/2026 due to various factors such as meeting schedules, clinical commitments, or decisions by clinical leads to delay the scheduled dates. This flexibility ensures that the quality and relevance of the audits and reviews are maintained, allowing for the most accurate and impactful findings to be shared with the healthcare community.
- The HQIP publication programme for 2024/2025 identified 56 audits. However, the Health Board did not need to provide assurance for all these publications. Some audits used only English data or published quarterly dashboards, and if these services were not part of the Health Board's daily operations, they were not included in the Clinical Standards and Effectiveness Group (CSEG) process.
- Of the 48 audits, 26 were presented to CSEG. The remaining 10 are due in 2025.
- Additionally, the NICOR National Cardiac Audit Programme (NCAP) included:
 - National Audit of Cardiac Rhythm Management (NACRM)
 - National Heart Failure Audit (NHFA)
 - National Audit of Percutaneous Coronary Interventions (NAPCI)
 - Myocardial Ischaemia National Audit Project (MINAP)
- These audits were previously commissioned by HQIP with annual reports but were later available as interactive reports on the NICOR website. All four sub-specialty clinical leads were requested to attend the CSEG meeting in September 2025.

Appendix Two – Audit Plan 2024/25. Publication Date and when presented at CSEG					
HQIP Ref.	Abb	PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG
536	NCEPOD	Child Health Clinical Outcome Review Programme	Juvenile Idiopathic Arthritis report	13/02/2025	Jul 2025
473	Epilepsy12	Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12 State of the National report, England and Wales (2021-23)	11/07/2024	Jan 2025
521	FLS-BD	FFFAP - National Falls & Fragility Fracture Audit Programme	Fracture Liaison Service Database 2024 State of the Nation report	09/01/2025	Feb 2025
469	FFFAP	FFFAP - National Falls & Fragility Fracture Audit Programme	National Hip Fracture Database State of the Nation 2024	12/09/2024	Jan 2025
561	FFFAP	FFFAP - National Falls & Fragility Fracture Audit Programme	National Hip Fracture Database (NHFD)	31/10/2024	Jan 2025
459	NCEPOD	Medical and Surgical Clinical Outcome Review Programme	Endometriosis report	11/07/2024	Sep 2024
472	NCEPOD	Medical and Surgical Clinical Outcome Review Programme	Medical and Surgical Clinical Outcome Review Programme: End of Life Care report 2024	14/11/2024	End of Life (NCEPOD)
500	MNI	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Saving lives, improving mothers care report (2021-2023, UK wide)	10/10/2024	July 2025
501	MNI	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal confidential enquiry	12/12/2024	May 2025
497 30/135	NAD	NAD - National Audit of Dementia	Annual report 2024	12/12/2024	Feb 2025 400/618

HQIP Ref.	Abb	PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG
516	NOGCA	NATCAN - National Cancer Audit Collaborating Centre	National Oesophago-Gastric Cancer Audit (NOGCA) State of the Nation report (England & Wales)	09/01/2025	Feb 2025
517	NPCA	NATCAN - National Cancer Audit Collaborating Centre	National Prostate Cancer Audit (NPCA) State of the Nation report (England & Wales)	09/01/2025	Feb 2025
518	NBOCA	NATCAN - National Cancer Audit Collaborating Centre	National Bowel Cancer Audit (NBOCA) State of the Nation report (England & Wales)	09/01/2025	Feb 2025
465	NKCA	NatCan - National Cancer Audit Collaborating Centre	National Kidney Cancer Audit (NKCA) - State of the Nation	12/09/2024	Feb 2025
463	NPaCA	NatCan - National Cancer Audit Collaborating Centre	National Pancreatic Cancer Audit (NPaCA) - State of the Nation	12/09/2024	Feb 2025
464	NNHLA	NatCan - National Cancer Audit Collaborating Centre	National Non-Hodgkin Lymphoma Audit (NNHLA) - State of the Nation	12/09/2024	May 2025
462	NOCA	NatCan - National Cancer Audit Collaborating Centre	National Ovarian Cancer Audit (NOCA) - State of the Nation	12/09/2024	Nov 2024
461	NaoMe	NatCan - National Cancer Audit Collaborating Centre	National Metastatic Breast Cancer Audit (NaoMe) - State of the Nation	12/09/2024	Nov 2024
460	NaoPri	NatCan - National Cancer Audit Collaborating Centre	National Primary Breast Cancer Audit (NaoPri) - State of the Nation	12/09/2024	Nov 2024
453	NVR	NVR - National Vascular Registry	National Vascular Registry state of the nation report 2024	14/11/2024	Nov 2024
466 31/135	SSNAP	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme State of the Nation 2024	14/11/2024	Nov 2024 401/618

HQIP Ref.	Abb	PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG
567	NCAP	NCAP - National Clinical Audit of Psychosis	State of the Nation report (Bespoke data)	13/02/2025	May 2025
553	NCISH	NCISH - Mental Health CORP	National Confidential Inquiry into Suicide and Safetyin Mental Health: Annual Report 2025 UK patient and general population data 2012-2022	13/02/2025	Jul 2025
478	NCMD	NCMD - National Child Mortality Database	Child Death Reviews Data year ending 31/03/2024	14/11/2024	Jul 2025
540	NDA	NDA - National Diabetes Audit (adults)	Young Type 2 Annual Data Only Release and Dashboard Update (2022-23; Eng and Wales)	12/09/2024	Jan 2024
539	NDA	NDA - National Diabetes Audit (adults)	National Pregnancy in Diabetes (NPID) Annual Data Only Release and Dashboard Update (2023; Eng Only)	08/08/2024	Jan 2025
543	NDA	NDA - National Diabetes Audit (adults)	Complications and Mortality Annual Data Only Release and Dashboard Update (Up to 2023; Eng and Wales)	14/11/2024	Jan 2025
544	NDA	NDA - National Diabetes Audit (adults)	National Diabetes Audit (NDA) Core Annual Data Only Release and Dashboard Update (2023-24; Eng and Wales)	12/12/2024	Jan 2025
533	NDA	NDA - National Diabetes Audit (adults)	National Diabetes Foot Care Audit (NDFA) State of the Nation report, 01/04/2021- 31/03/2022 TBC; Eng & Wal.	09/05/2024	Jul 2024
428	NEIAA	NEIAA - National Early Inflammatory Arthritis Audit	National Early Inflammatory Arthritis Audit State of the Nation 2024 Annual Report	10/10/2024	Jan 2025
413	NELA	NELA - National Emergency Laparotomy Audit	National Emergency Laparotomy Audit State of Nation report 2024	10/10/2024	Nov 2024

HQIP Ref.	Abb	PROJECT NAME	FULL REPORT TITLE	PUBLICATION DATE	CSEG
444	NLCA	NLCA - National Lung Cancer Audit	National Lung Cancer Audit State of the Nation report (01/01-31/12/2022 data; Eng & Wales)	11/04/2024	May 2024
498	NNAP	NNAP - National Neonatal Audit Programme	National Neonatal Audit Programme 2024 report	10/10/2024	Oct 2024
496	NPDA	NPDA - National Paediatric Diabetes Audit	Parent and Patient Reported Experience Measures (PREMS) report 2024 (24/07/2023 - 23/01/2024)	14/11/2024	Nov 2024
535	NPDA	NPDA - National Paediatric Diabetes Audit	Annual Core State of the Nation Report (Year 3)	13/03/2025	Mar 2025
434	NRAP	NRAP - National Respiratory Audit Programme	State of the Nation report (01/03/2022–31/03/2023, England & Wales)	11/07/2024	Jul 2024
541	NRAP	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit Programme Primary Care Report (cohort TBC)	12/09/2024	Sep 2024
434	NRAP	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit State of the Nation report - PAEDIATRIC ASTHMA	11/07/2024	Jul 2024
440	NRAP	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit Programme Combined Organisational Report	14/11/2024	Nov 2024
434	NRAP	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit State of the Nation report - ADULT ASTHMA	11/07/2024	Jul 2024
434 33/135	NRAP	NRAP - National Respiratory Audit Programme (was NACAP)	National Respiratory Audit State of the Nation report - COPD	11/07/2024	Jul 2024 403/618

Appendix Three – Patient Quality Safety and Outcomes Committee submissions

Date of Meeting:	Monday 2nd September 2024
Tuesday 30 April 2024 – Presented on March 2024	Tuesday 12th November 2024
Tuesday 4th June 2024 – no Clinical Audit update	Monday 20th January 2025
Tuesday 30th July 2024 – no Clinical Audit update	Monday 31st March 2025

The **Patient Quality, Safety, and Outcomes Committee (PQSOC)** looks at audit outcomes and the improvements made as a result. It focuses on how findings translate into better patient care and safety, aligning with the Health Board’s commitment to continuous improvement.

Audits Presented to Clinical Standards and Effectiveness Group (CSEG) and Patient Quality and Safety Outcomes Committee (PQSOC)	
1	National Oesophago-Gastric Cancer (NOGCA) Audit - State of the Nation Report - Data -1 Apr 2020 – 31 Mar 2022
2	National Lung Cancer Audit (NLCA) - State of the Nation Report 2024 - An audit of care received by patients diagnosed with Lung Cancer in England and Wales during 2022
3	National Audit of Dementia (NAD) - Care in General Hospitals 2022-2023 - Round 5 Audit Report
4	Fracture Liaison Service Database (FLS-DB) - Annual report – Improved Fracture Liaison Service (FLS) identification with gaps in monitoring: a call to action for national and regional planners
5	National Paediatric Diabetes Audit (NPDA) - Report on Care and Outcomes 2022/23
6	National Diabetes Foot Care Audit (NDFA) - Are services providing effective diabetes foot care?
7	Report on the 2022 National Audit of Quality Standards for Adult Hearing Rehabilitation Audiology (Wales)
8	SSNAP Annual Report 2023 - Sentinel Stroke National Audit Programme – State of the Nation - Stroke care received between April 2022 to March 2023
35/135	Audit Title: MBRACE-IUK - Perinatal mortality surveillance 2024 - State of the nation report - 405/618

Audits Presented to Clinical Standards and Effectiveness Group (CSEG) and Patient Quality and Safety Outcomes Committee (PQSOC)	
10	NCEPOD - Twist and Shout - Testicular Torsion
11	Paediatric Asthma - Breathing well - An assessment of respiratory care in England and Wales
12	NCEPOD - Endometriosis: A Long and Painful Road - A review of the quality of care provided to adult patients diagnosed with endometriosis
13	NELA - Ninth Patient Report of the National Emergency Laparotomy Audit - December 2021 to March 2023
14	National Ovarian Cancer Audit - State of the Nation Report 2024 - An audit of care received by women diagnosed with ovarian cancer in England in 2021 and in Wales in 2022
15	National Neonatal Audit Programme (NNAP) - Summary report on 2023 data
16	National Audit of Primary Breast Cancer - State of the Nation Report 2024 An audit of care received by people diagnosed with primary breast cancer in England and Wales during 2019-2021
17	National Audit of Metastatic Breast Cancer (MBC) - State of the Nation Report 2024 - An audit of care received by people diagnosed with metastatic breast cancer in England and Wales during 2019-2021
18	National Hip Fracture Database (NHFD) - A broken hip – three steps to recovery, a report on using

Audits Presented to Clinical Standards and Effectiveness Group (CSEG) and Patient Quality and Safety Outcomes Committee (PQSOC)	
19	National Hip Fracture Database (NHFD) - A broken hip – three steps to recovery, a report on using the National Hip Fracture Database (NHFD)
20	National Pancreatic Cancer Audit State of the Nation Report 2024
21	National Oesophago-Gastric Cancer Audit (NOGCA) - State of the Nation Report - Data collection period: 1 April 2021 – 31 March 2023
22	National Bowel Cancer Audit - State of the Nation Report - An audit of care received by people with bowel cancer in England and Wales focusing on people diagnosed between 1 April 2022 and 31 March 2023.
23	National Vascular Registry 2024 - State of the Nation Report - Results for people who had vascular procedures during 2023 in NHS hospitals in England, Wales, Scotland and Northern Ireland.
24	National Audit of Dementia - Care in General Hospitals 2023-24: Round 6 Audit Report
25	Fracture Liaison Service Database (FLS-DB) Annual report - You’ve had a fracture; how can we prevent another? Data from 1 January 2023 – 31 December 2023
26	Epilepsy12 - 2024 combined organisational and clinical audits: Report for England and Wales. Cohort 5 – The first year of care for children and young people after a first paediatric assessment between 1 Dec 2021 and 30 Nov 2022
27	Audit Title: National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Summary Report 2024 - Data Collection Period: 1 April 2023 – 31 March 2024 Year 6
37/135	National Pregnancy in Diabetes Audit Dashboard 2023 (01 January 2021 to 31 December 2023)

Audit Title:	National Oesophago-Gastric Cancer (NOGCA) Audit State of the Nation Report Data -1 Apr 2020 – 31 Mar 2022 Published January 2024	Clinical Lead: Miss Tamsin Boyce, Consultant, Surgery

Rationale:	NOGCA is commissioned by Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

Objectives:	It aims to promote quality improvement in patient outcomes, and to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales.

Presented at Clinical Standards and Effectiveness Group 23rd May 2024

Upper GI cancer treatment is not delivered in ABUHB. Treatment centralised within Cardiff and Vale UHB (CVUHB). Radiotherapy undertaken at Velindre Cancer Centre (VCC). The Health Board is only responsible for the front end of the patient pathway. Referral to Treatment times (RTT) has increased over the last 10 years due to improved staging and diagnostics as well as an increase in demand.

	ABUHB	National
Patients diagnosed after an emergency admission (lowest rate in Wales SBUHB 20.4% & CVUHB 21.6%)	14.1%	13.1%
% of patients who waited >62 days form urgent referral to 1 st treatment	83.3%	
Patients having a treatment plan for curative treatment	32.4%	37.2%
Patients having a treatment plan for non-curative treatment	67.6%	62.8%
Patients with non-curative plans having chemotherapy or radiotherapy	42.8%	34.7%

100% of ABUHB patients completed Radiotherapy

Key Success and Concerns	
Report Successes:	
1	Doing well with CT Staging, (96.9%) higher than the national rate.
2	Of the patients with a plan for non-curative treatment, 42.8% are having chemotherapy or radiotherapy, nationally this is 34.7%.
3	With higher diagnosis rate in the Health Board compared to the rest of Wales, the Health Board maintained face to face contacts and MDT's during the pandemic.
4	Lower rates of diagnosis after emergency admissions than other organisations across Wales, although not as good at the UK national rate. ABUHB 14.1% v National 13.1%.
5	Straight To Test endoscopy CT scans done same day if applicable.

Report Concerns:	
1	Lower rates of patients having a plan for curative treatment than the national rate, the Health Board being 32.4% and nationally 37.2%.
2	The Health Board has a lower rate for patients having a plan for non-curative treatment at 67.6% compared to nationally 62.8%
3	Increase in RTT 62-day measure, form 80 days in 201/-2020 to 82.5% in 2020/2022.

Assurance Level
Limited - The project did not achieve the standards or criteria being audited against
Risk Level
Major - Non-compliance with national standards/Significant risk to patients if unresolved
Not on Risk Register within the Health Board as much of the pathway is outside of the Health Boards control - Upper GI cancer treatment delivered in CVUHB and radiotherapy in VCC.

Report Recommendations:		S.M.A.R.T Actions: Responsible: Due Date: Progress:	Report Recommendations:		S.M.A.R.T Actions: Responsible: Due Date: Progress:
1	Cancer Alliances and Wales Cancer Network should review patient pathways in their region to identify opportunities to intervene and reduce high and variable rates of diagnosis following emergency admission and late-stage diagnosis. <i>Action by:</i> Cancer Pathway Boards, Cancer Alliances, Welsh Health Boards, Wales Cancer Network	Ongoing work across Wales (National Optimal Pathway) to reduce late-stage diagnosis.	4	Given the often profound impact of OG cancer on patients' nutritional status, Cancer Alliances and Wales Cancer Network should review specialist dietetic provision across their region, and ensure OG cancer units are resourced according to national specifications to ensure that all patients have access to appropriate dietetic input. <i>Action by:</i> Cancer Pathway Boards, Cancer Alliances, Welsh Health Boards, Wales Cancer Network	Specialist OG dietician already present in clinic, there is definitely the workload for further input, there is also OG Dietetic cover in the MDT.
2	Review oesophago-gastric (OG) cancer care pathways against best practice guidance to identify ways to reduce the proportion of patients with OG cancer waiting more than 62 days from urgent referral to first treatment. <i>Action by:</i> Cancer Pathway Boards, Cancer Alliances, Welsh Health Boards, Wales Cancer Network	Ongoing work with National Optimal Pathway. Update to Service Level Agreement (SLA) in progress and obtain 2022/2023 data to see accurate performance	5	In Cancer Alliances with low rates of active treatment for high-grade dysplasia (HGD), review reasons for non-treatment and determine if more patients with HGD could be eligible for endoscopic therapy <i>Action by:</i> Cancer Alliances	Numbers are so small it is difficult provide a comment. There have been issues, 2 patients delayed pathways for HGD due to uncertainties regarding funding. This is delivered by Cardiff and not specifically covered in the SLA. This caused delays in treatment resulting in more advanced disease at treatment. This has since improved, and processes are less complicated and protracted. Long term funding and workforce remains fragile.
3	Explore reasons for non-completion of palliative chemotherapy regimens, including review of patients with OG cancer who died within 90 days of starting treatment, and review patient selection for palliative chemotherapy where appropriate. <i>Action by:</i> Cancer Pathway Boards, Cancer Alliances, Welsh Health Boards, Wales Cancer Network	Specialist OG dietician already present in clinic, there is definitely the workload for further input, there is also OG Dietetic cover in the MDT.			

Audit Title:	State of the Nation Report 2024 An audit of care received by patients diagnosed with Lung Cancer in England and Wales during 2022	Clinical Lead: Dr Mat Jones Medical Consultant
	National Lung Cancer Audit (NLCA)	

Rationale:	Aim of NLCA is to evaluate the patterns of care and outcomes for patients with lung cancer in England and Wales. To support services to improve the quality of care for these patients.

Objectives:	Management of patients with lung cancer is informed by various national guidelines. The NLCA evaluates current patterns of care against standards. These standards were defined in publications from: The National Institute for Health and Care Excellence (NICE) QS17, Roy Castle Lung Cancer Foundation’s national commissioning guidance, the National Optimal Lung Cancer Pathway and the 2022 “Getting it Right First Time” (GIRFT) report. The NLCA has developed a set of indicators to reflect these and encourages healthcare professionals to review the findings of this report and to understand why unwarranted differences in practice exist.

Presented at Clinical Standards and Effectiveness Group – 23rd May 2024

The Health Board has the largest number of patients with 100% data quality on key data items:

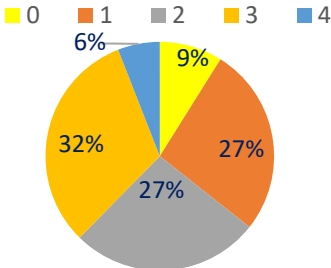
- 100% for basis of diagnosis,
- 100% for tumour morphology,
- 100% for disease stage, and
- 100% for performance status.
- 100% of records had data on whether a lung cancer nurse specialist was present at diagnosis.

There are two cohorts: a) Small Cell Cancer – 12%, b) Non-Small Cell Lung Cancer (NSCLC) – 88%. There are 5 stages of disease:

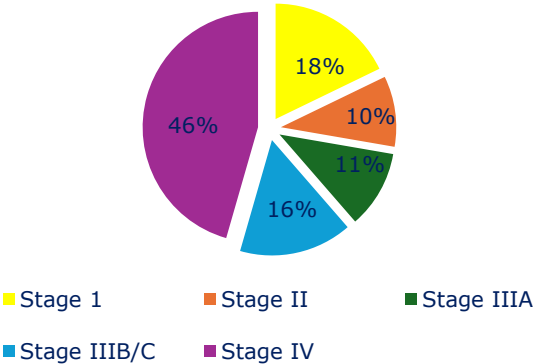
- Stage I – 18%
- Stage II – 10%
- Stage III – 27%
- Stage IV – 46%

Unfortunately, the highest numbers are in the late stage of lung cancer disease due to late presentation or being asymptomatic at the time of detection.

There are 4 Performance Status (PS) levels, which is based on patients’ daily capabilities from independent to bed bound. Low numbers present with a low PS.



ABUHB Performance status (per cent of known values)

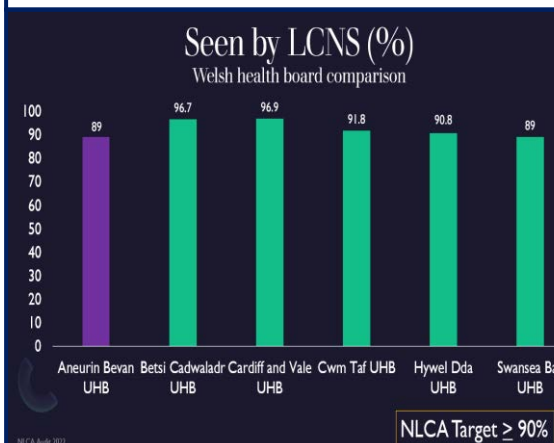
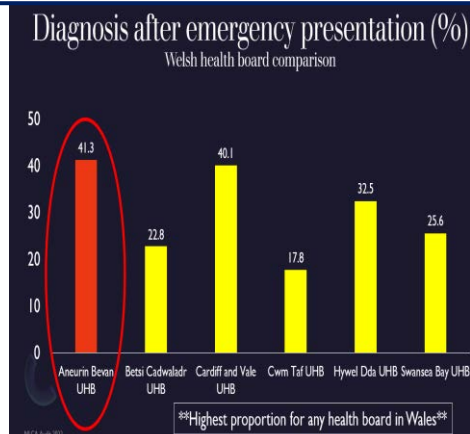


ECOG PERFORMANCE STATUS	
ECOG Performance Status Developed by the Eastern Cooperative Oncology Group, Robert L. Comis, MD, Group Chair.*	
GRADE	ECOG PERFORMANCE STATUS
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours
3	Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry on any selfcare; totally confined to bed or chair
5	Dead

*Oken M, Creech R, Tormey D, et al. Toxicity and response criteria of the Eastern Cooperative Oncology Group. *Am J Clin Oncol*. 1982;5:649-655.

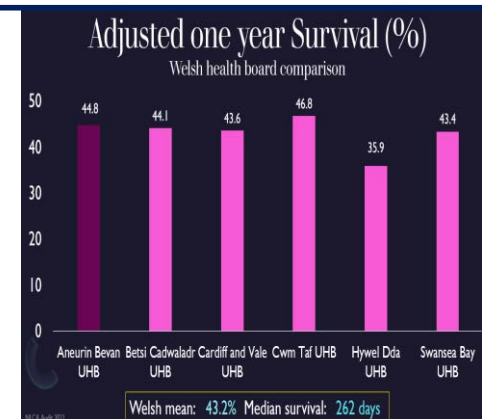
- The Health Board has a lower proportion of PS 0/1 compared to All Wales data, above the average proportion of patient in PS 3 & 4, 38% compared to 35.3%. These are not often suitable for curative treatments and more suited to palliative management as have higher rates of co-morbidities with increased risk of side effects from treatments. This ultimately impacts the HB treatment rates. PS 2 for the Health Board is 27% compared to Wales mean of 23.5%.
- Patients with Stage I/II with PS 0-1 - Confirmed pathological staging NLCA target is >90% within the Health Board was 89.4% (74.5% in 2021) compared to a Wales mean of 89.1%.
- NSCLC patients having surgical resection NLCA target > 17%, the Health Board 15.5% (adjusted for co-morbidities and deprivation), increased from 10.9 & in 2021 and above the Wales mean of 14.3%. In NHS England this is around 18% due in part to increased diagnosis at the early stage through lung cancer screening which is not yet carried out across Wales outside of a pilot Lung Health Check in CTUHB. Ambitions should be to achieve 20%.
- NSCLC patients Stage I/II with PS 0-2 having curative treatment is not always possible due to many factors. These include patient choice, co-morbidities, deterioration during investigation and factors relating to the tumour. The NLCA target >80%, the Health Board rate is 77.9% and improved from 2021 (66.7%) and higher than the Wales mean of 75.8%.
- For SCLC (more aggressive tumours) patients having chemotherapy ,the Health Board treatment rate was 50% in 2021 and in 2022 increased to 61.7% compared to Wales mean of 71.2%. The NCLA target is set at >70%. The Health Board had a high proportion of patients, 47 in total, which was 12% of our whole cohort who presented with small cell cancer. This is a higher-than-average proportion, and these patients are very challenging, often very co-morbid and often present through hospital and emergency settings.
- For NSCLC patients Stage IIIA with PS 0-2 (more advanced disease associated with further spread to Lymph Nodes) the Health Board is pushing boundaries with regards to cancer management. For those achieving curative treatment in this group, the Wales mean is 59.3% with the Health Board achieving 57.1% in 2022 compared to 31.7% in 2021, possibly linked to the pandemic and restriction in treatments during that time.
- NSCLC patients Stage IIIB/IV with PS 0-1 (advanced disease spread to outside the lung) having Systemic anti-cancer treatments (SACT) improved from 2021 rate of 56.6% to 57.8% in 2022 with a Wales mean of 61.8%. This suggests that people are potentially being missed due to challenges such as pathology waiting times and being reliant upon oncology services outside of the Health Board.

The Health Board has the highest proportion of diagnosis after emergency presentation across Wales with 41.3% presenting in this way, which was interesting compared to the emergency admission rate for NOGCA. However, lung cancer patients generally present with a higher bulk of disease, more co-morbidities, advanced age and poorer PS status when they present in this way. In England, emergency presentations are reduced due to the screening programme. Last year's data was low at 6.3%, but the data was inaccurate and since then the data recording has been managed carefully to ensure the data was robust this year.



The NCLA target for patients being seen by a Lung Cancer Nurse Specialist (LCNS) is 90% and the Health Board is at 89%. This is an improvement on the previous year's data however this is impacted upon by patients presenting as an emergency. This is being addressed to try and bring LCNS into seeing inpatients, to support patients and aid decision making, as the LCNS are pivotal in the management of lung cancer patients and without them the service would not be able to run efficiently. There are plans to develop the LCNS roles going forward.

Looking at how all this impacts patient survival, we know that lung cancer outcomes have been poor in recent years, and with developments in detection and treatments, survival rates have increased. In the Health Board although 1 year survival is still low at 44.8% it is above the Welsh mean at 43.2%, second only to Cwm Taf UHB who do have a screening programme at pilot stage, which may be impacting on survival outcomes. The Welsh median survival in days is 262 which is less than England 327 potentially due to the emergence of screening and reduced deprivation indices as a whole. The chart demonstrates the survival associated with disease stage, highlighting the importance of early detection.



Successes	Concerns	Key Messages ABUHB compared to Wales	Wales (n=2211)	ABUHB (n=400)
Introduction of Physician of the week to prioritise lung cancer patients	Below target treatment rates for surgical resection in NSCLC, SCLC chemotherapy and NSCLC advanced stage good PS treated with SACT (but all improved from 2021). Concerning numbers presenting as emergency admissions.	Curative treatment rates of NSCLC patients with stage I/II and good performance status (0-2)	76.2%	77.9% ↑
Improved curative rates for early-stage disease and excellent pathological confirmation rates for early-stage disease and good PS.		Curative treatment rates of NSCLC patients with stage IIIA and good performance status (0-2)	61.2%	57.1% ↓
More patients with SCLC having chemotherapy	Many of the HB patients have high PS and present with advance disease making curative treatment less viable.	Surgical resection rate (adjusted) for patients with NSCLC	14.3%	15.5% ↑
Large increase from 31.7% to 57.1% of NSCLC with stage IIIA and PS 0-2 receiving curative treatment.	Surgical resection rates are under target, although have improved since 202, under the 17% target set by NLCA.	Proportion of patients with lung cancer diagnosed after an emergency presentation	29.4%	41.3% ↑
Lung Cancer Nurse Specialist input very good with plans to seen inpatients.	High rate of emergency presentations (41.3%).	Proportion of patients seen by a Lung Cancer Nurse Specialist	92.4%	89% ↓
Adjusted one year survival rate is second best in Wales at 44.8%.		Use of systemic anti-cancer therapy for stage IIIB/IIIC–IV NSCLC patients (PS 0–1)	60.1%	57.8% ↓

Conclusions

- The ABUHB lung cancer service diagnoses 400 cases of lung cancer per annum [>1 per day]
- The service also deals with abnormal imaging, large numbers of suspected malignancy and metastatic disease
- It is an expanding service with ever changing challenges including a population with severe co-morbidities/ frailty
- Improving indices compared to 2021 data
 - Better curative rates for early-stage disease
 - Excellent confirmation pathological confirmation rates for early stage, good performance status (PS)
- Below target treatment rates for surgical resection in NSCLC, SCLC chemotherapy and NSCLC advanced stage good PS treated with SACT (*but all improved from 2021*)
- Concerning number presenting as emergency admissions – more advanced disease, frailty

Report Recommendations:		Progress:
1	Ensure services are implementing targeted lung cancer screening for people aged 55 to 74 who are at high risk of lung cancer.	Lung Health Check Pilots No imminent HB plans
2	Ensure providers have thoracic surgery capacity to meet both current demand for curative surgery and to accommodate the increase in activity caused by the national rollout of the Targeted Lung Health Check programme. Wales: 14% of NSCLC patients diagnosed in 2022 had a lung resection, compared with 16% in 2019	Surgical resection rate below NLCA target No issues with access – but waiting times >4 weeks
3	Ensure NHS hospitals have the necessary resources and capacity (1) to reduce the proportion of patients waiting more than 21 days from diagnosis to first treatment, and (2) for biomarker testing and the timely delivery of results for patients considered for systemic anti-cancer therapy (SACT) Wales: For patients with stage IV NSCLC, the median time from diagnosis to SACT was 52 days (47 days in 2021). For patients with SCLC, the median was 21 days (16 days in 2021).	Ongoing oncology and surgical delays Improved pathological services – PD-L1 in-house from next month, QuicDNA ctDNA project pioneers
4	Ensure at least 70% of patients with NSCLC stage IIIB-IVB and PS 0-1 receive systemic anti-cancer therapy (SACT) in line with NICE guidance. Wales: 60% of patients with NSCLC stage IIIB-IVB and PS 0-1 had SACT, increased from 57% in 2021 - ABUHB: 57.8%	SACT for advanced stage disease below NLCA target Complex patients, frail, multi-morbidity, patient choice
5	Aim to achieve high levels of data completeness in the cancer registration datasets, particularly the Rapid Cancer Registration Dataset and Cancer Outcome and Services Dataset (COSD) in England. Wales: Completeness of data was excellent overall, 98-100%, in key data items (97-100% in 2021)	The only Data Quality measure that the Health Board is not meeting is Morphology (all Patients) 69% Likely transposition error – rates of NSCLC not specified (NOS) remains small

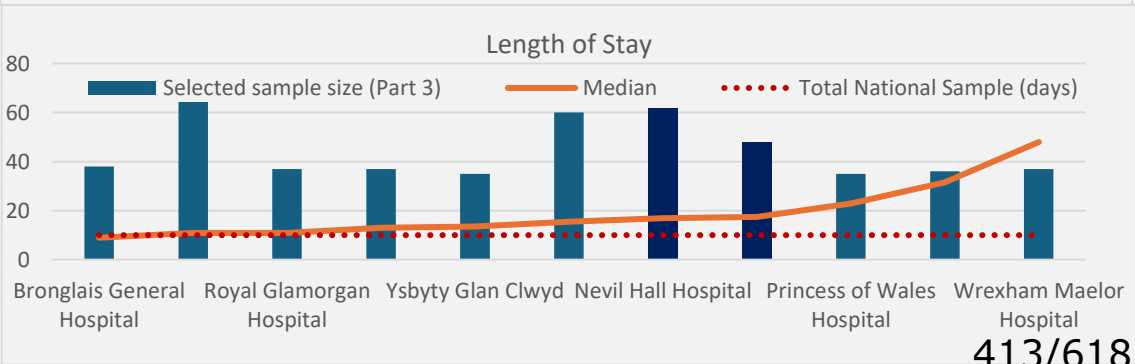
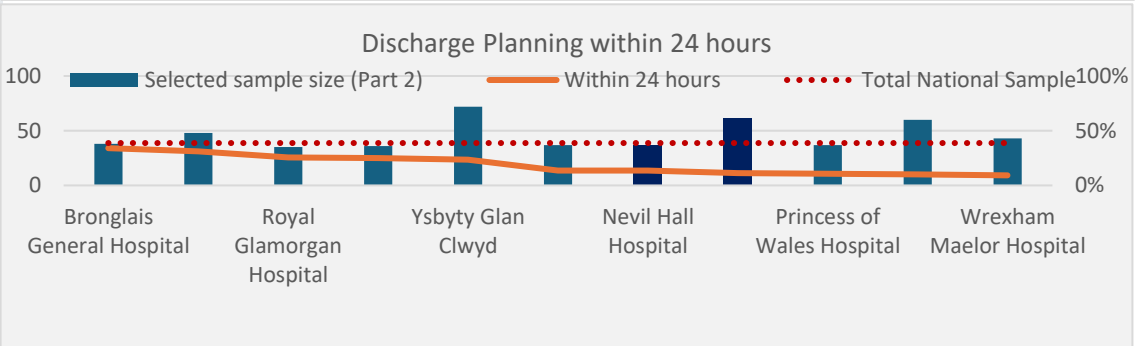
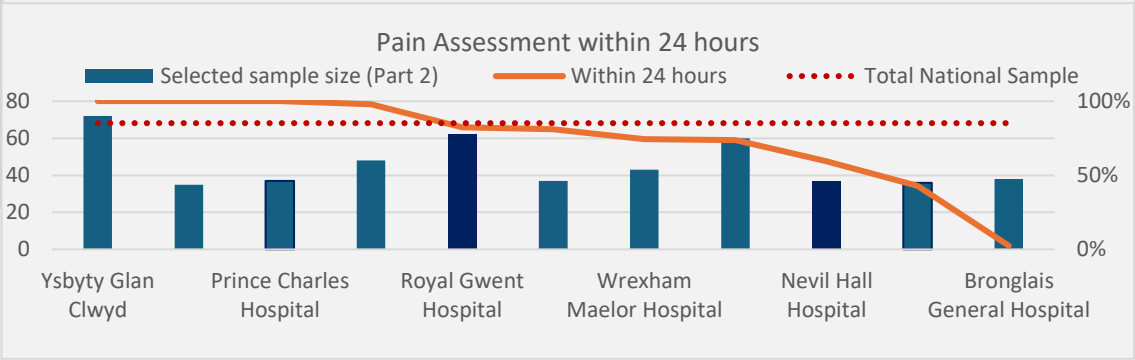
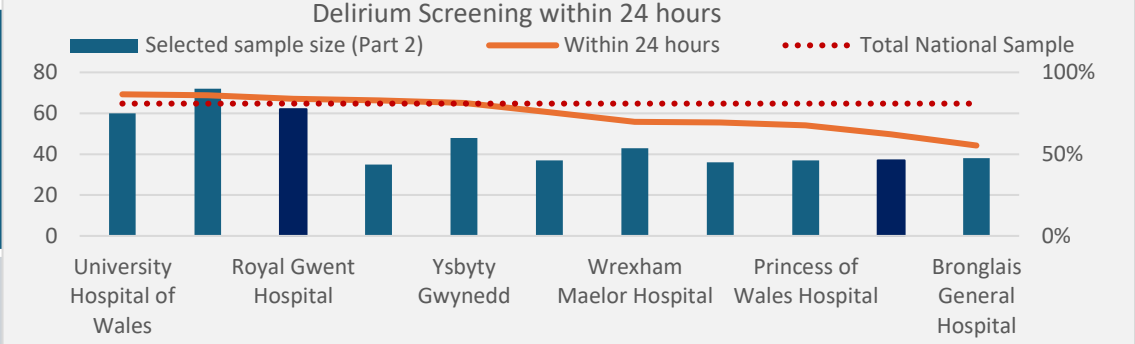
Audit Title:	National Audit of Dementia (NAD) Care in General Hospitals 2022-2023 Round 5 Audit Report Published August 2023	Clinical Lead: Dr Inder Singh Site Leads: Dr Sheriff (RGH) Dr Subhan (YYF) Dr Adel (NNH)

Rationale: Report presents results of the 5th round of the NAD. Improving dementia care remains a key national priority for health services in England and Wales, highlighted in the Prime Ministers Challenge on Dementia 2022 and the Welsh Government Dementia Action Plan. An extremely high proportion (92%) of eligible hospitals participated in this important audit once again. For the first time the audit was undertaken prospectively, enabling hospitals to take earlier action to improve patient care and experience.

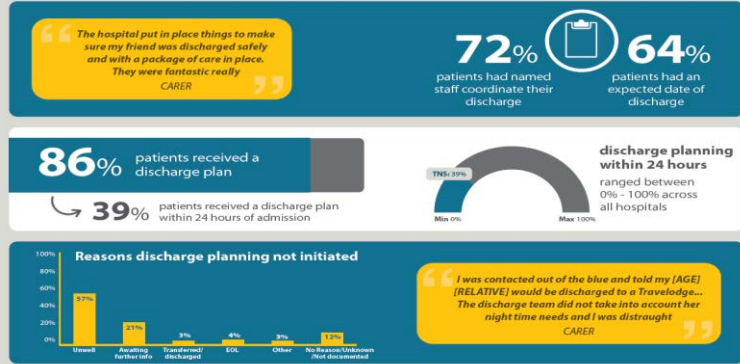
Objectives: NAD measures the performance of general hospitals in England and Wales against standards relating to care delivery which are known to impact people with dementia while in hospital. Standards include NICE Quality Standards and guidance, the Dementia Friendly Hospitals Charter, and reports from the Alzheimer’s Society, Age Concern and Royal Colleges. Standards are updated for every round of audit.

Presented at Clinical Standards and Effectiveness Group – 23rd May 2024.

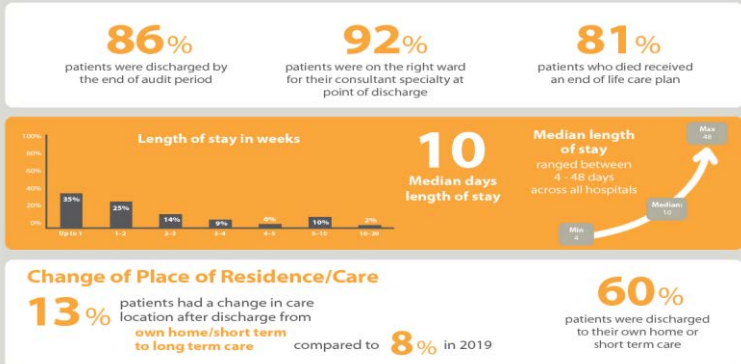
Key Metrics National Round 5	National	RGH	NHH	YYF
% Delirium screen (inc. noted on admission)	87%	98%	70%	94%
% Pain assessment	92%	100%	69%	82%
% Pain reassessment	92%	100%	59%	22%
% Pain tool – question only	61%	0%	100%	100%
% Initiation of discharge plan in first 24 hours*	45%	11%	14%	19%
Carer rating overall care quality	66%	100%	75%	85%
Carer rating communication	60%	67%	72%	88%



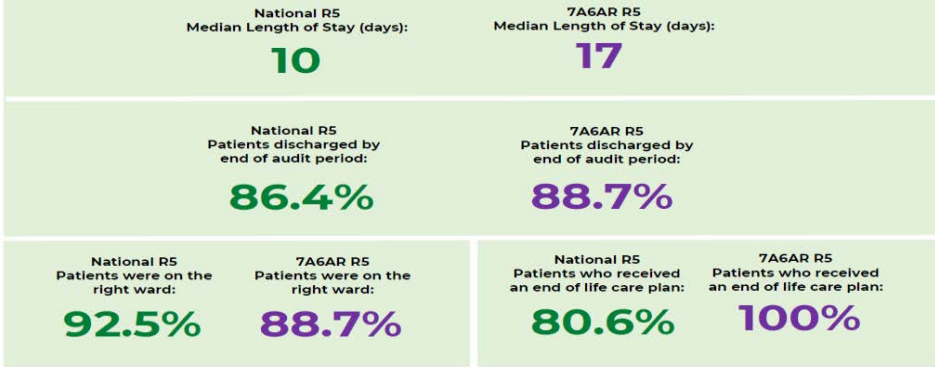
Discharge Planning



Discharge Information

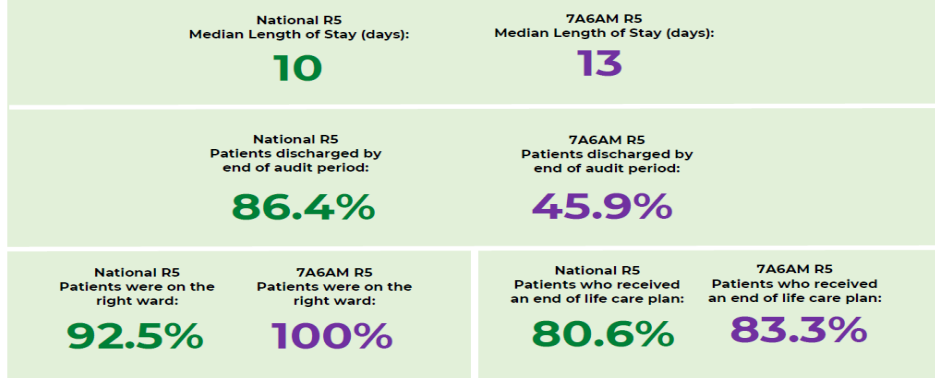


Discharge Information RGH



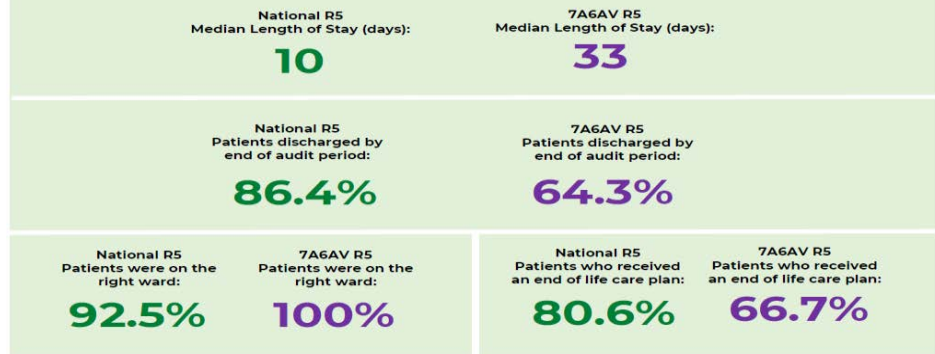
NB. EOL care plan information was only collected for patients who died during admission

Discharge Information NHH



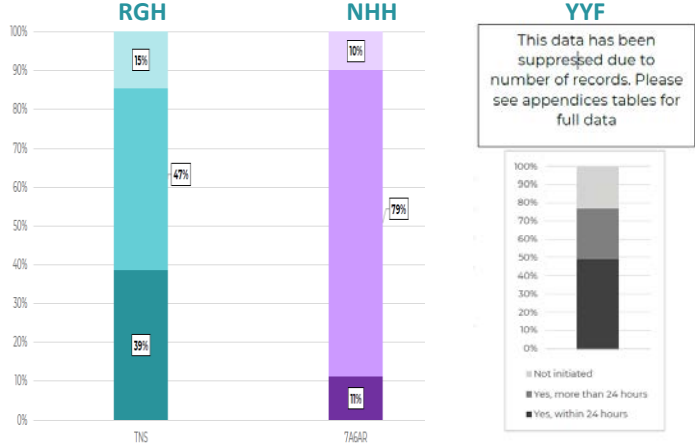
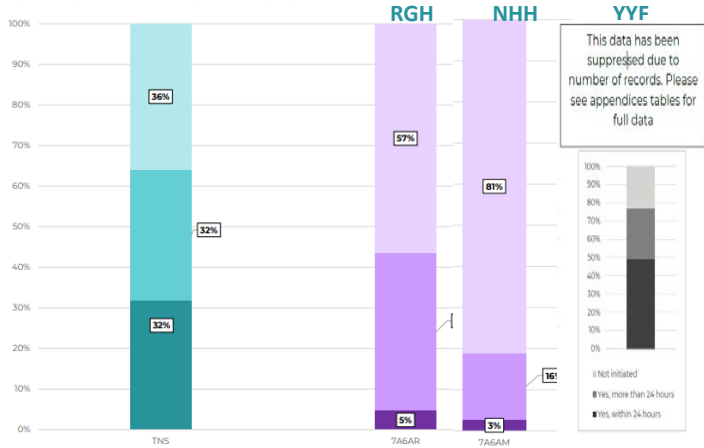
NB. EOL care plan information was only collected for patients who died during admission

Discharge Information YYF



NB. EOL care plan information was only collected for patients who died during admission

Figure 10: Expected Date of Discharge Recorded (n=62)



Assurance level

Limited The project did not achieve the standards or criteria being audited against

Risk level

Moderate Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

Not in risk register as actions and improvement work remain ongoing

Report Successes:	
1	Pain Assessment and re-assessment in RGH at 100% and YYF pain assessment 82%
2	Delirium Screening noted on admission - RGH 98% and YYF 94% compared to national 87%
Report Concerns:	
1	Expected discharge date (EDD) - RGH - 5% within 24 hours, 39% more than 24 hours, 57% initiated NHH - 3% within 24 hours, 16% more than 24 hours, 81% not Initiated - difficulties with EDD due to patient complexities and delays in social measures YYF - not enough data to analysis
2	Pain Assessment NHH 69% (outlier notification received for NHH data)
3	Lack of use of the Abbey Pain Score tool
4	Discharge planning not carried out within 24 hours for RGH and not completed in NHH - lack of data for YYF
5	Length of Stay median: RGH 17 days, NHH 13 days, YYF 33 days
6	Pain re-assessment for YYF 22%
7	Delirium Screening NHH - 70%

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
Carer feedback	Improve Carer questionnaire completion across the HB	Use the teams currently across the wards (volunteers, PALS etc.) to encourage the carers to complete the questionnaire	Sonya Foley	31/03/2024	
End of Life	End of life care for patients with Dementia	Regular teaching sessions for doctors and nurses across all sites, by palliative care team – Dr Subhan has discussed this option with Palliative Care Consultant. Palliative care team is interested to provide this focused teaching as part of their palliative care teaching	Dr Subhan	31/03/2024	Ongoing

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date/Progress:
1	Integrated Care Boards/Welsh Government should seek assurance from Trusts/Health Boards regarding their actions and progress with recommendation one.	Reported to Clinical Standards and Effectiveness Group and Patient Quality and Safety Group	Dr Inder Singh	Ongoing
2	Comprehensive pain assessment The National Report recommends the Medical Director and Chief Nurse should ensure that staff are trained and supported in the use of appropriate tools for comprehensive pain assessment (e.g. e-Ifh Pain Management Programme) This should include: - Understanding the need for structured pain assessment. - How pain interacts with symptoms of dementia, and that people with dementia may not articulate pain. - The regular use of an appropriate pain tool for assessing people with dementia on the ward.	Need to introduce and improve structure pain assessment across HB sites (use of the ABBEY if clinically indicated) Link with Education team to review current training	Dr Inder Singh, Sue Pearce (Divisional Nurse), Amanda Whent	Ongoing

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
3	The Chief Executive Officer should ensure that the Trust/Health Board has a nominated Board member responsible for dementia in addition to the clinical lead, whose responsibilities will include: - Establishing and implementing hospital systems capable of - identifying people with dementia admitted to the hospital and - showing the proportion of people with dementia affected by falls, delayed discharges, readmissions, pressure ulcers and incidents of violence/aggression, so that accurate figures may be supplied to NHS England Emergency Dashboard and other national dashboards. - Monitoring the proportion of ward-based staff who have received Tier 2 level training in dementia, and assessing the impact this has on quality of care, as experienced by patients and carers. - Scrutinising feedback from patients and carers and reports of NAD. - Tabling the Trust/Board Annual Dementia Statement for review. - Providing regular reports to the Integrated Care Board/Welsh Government relating to the appropriate governance and monitoring of care of people with dementia. - Developing action plans based on areas identified for improvement in care and patient experience, including ensuring that personal information about their care preferences and needs has been gathered and is available at the bedside; regular review of the environment against "Dementia Friendly" criteria using a standardised tool (e.g. Enhancing the Healing Environment, The King's Fund (kingsfund.org.uk); Patient-Led Assessments of the Care Environment (PLACE) – NHS Digital)	Dementia alert on CWS in practice and currently linking with Improvement Cymru in establishing a benchmark (once achieved CL will be establishing other metrics inc. IP Falls) Dementia training and awareness is ongoing. Good Work Learning and Development Framework level 1. - Informed level 86% on ESR - Skilled level bi-annual reporting to WG - Influencer level presenting on boards, meetings and conferences Feedback review is led by Sue Pearce. Dr Singh and Amanda Whent report to the Board Dementia care plan and environment – Sue Pearce and Amanda Whent	Dr Inder Singh – Clinical Lead Amanda Whent – Dementia Lead Nurse Sue Pearce – Senior Divisional Nurse	6 months	All ongoing

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
Dementia alert	To promote the use of dementia alert (136) in Welsh PAS (Myrddin)	Promote Ward Clerks entering the Dementia Code (136) into WPAS	Sue Pearce	31/08/2024	Ongoing
Delirium screening and care plan	ABUHB - Quarterly point prevalence audit for the duration of 1 week on assessed for Delirium screening on patient with Dementia	- To provide LoS on the Delirium Audit carried out quarterly - Review the if diagnosis of delirium also have dementia and assess for:- EDD was established, DC planning commenced within 24 hrs, and time (total number of days) away from home.	- Dr Singh - Dr Singh	31/08/2024 31/08/2024	Ongoing Ongoing
	Improve nursing attendance and engagement with Delirium training – SQID, 4AT	- Continuing with Delirium teaching every 8 weeks (led by Dr Z Subhan) – target audience doctors, staff nurses, HCSW - Involve senior nurses for individual sites to encourage nurse attendance - To deliver focused delirium teaching (SQID) in the ward settings – Dr Subhan to explore this with senior nurses	- Kertrina Collins, Natalie Webb, Helen Price - Dr Subhan	31/08/2024 31/08/2024	Ongoing Ongoing
	Measure the outcome of Delirium teaching and training	- Encourage Delirium Champions from each ward in YYF, who will help with the teaching and training for the nurses - A QIP on Delirium Time Bundle has already commenced – to complete the first cycle and present the result to the stakeholders - Delirium training attendance certificate to help with re validation - using AMaT certificate function	- Dr Subhan - Joanne Stimpson	31/08/2024 Ongoing	Ongoing Ongoing
	Measure the outcome of Delirium teaching and training	Compliance of recording delirium diagnosis on quarterly basis using IT (WPAS) - link with Kathleen Hyde.	Joanne Stimpson	Ongoing	Ongoing
	Improving assessment of delirium in hospital and communication of diagnosis to all teams/carers				

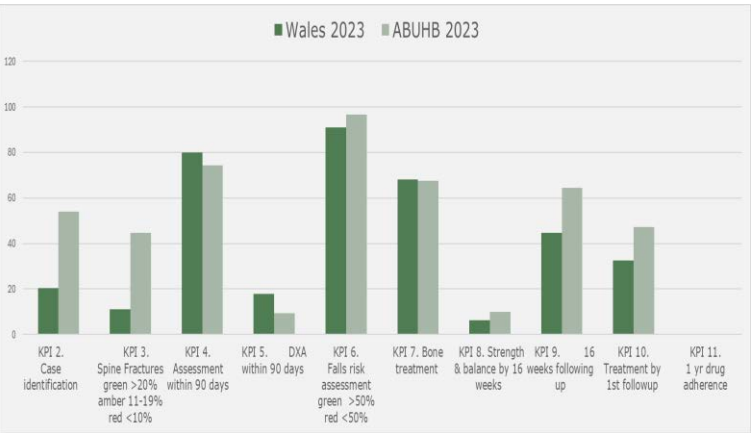
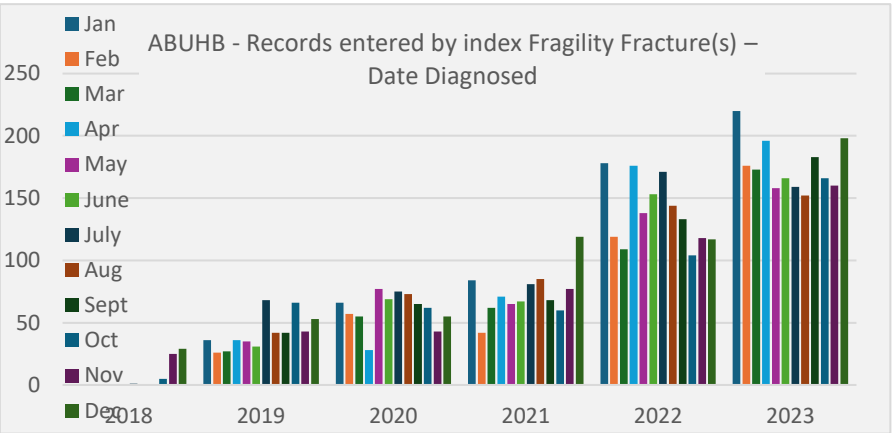
Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
Pain assessment/ Re-assessment	Quarterly one day Audit all patients who scored on pain assessment	Proportion of patients who had dementia to be assessed for pain using a recommended ABBEY pain scales	• Dr Singh	31/10/2024	Ongoing
	Improve pain assessment and re-assessment	- Training and teaching of Abbey Pain score for nurses Dr Subhan has already discussed this with Palliative care Consultant, Dr Patten. Dr Patten has agreed to deliver this training with the help of Palliative care CNS. Dr Patten to discuss with her CNS and update Dr Subhan - To continue with pain assessment using Care Flow question only assessment - After standard clinical assessment and pain score assessment should be used for patient who cannot communicate pain - has been Further work needed to decide on what pain score screening tool is going to be used across the HB - to ensure continuity.	Dr Subhan/Dr Patten	31/03/2024	Ongoing
			• Dr Subhan/Dr Adel	31/03/2024	Ongoing
			• Dr Singh	31/03/2024	Ongoing
Dementia training	Look at compliance figures on ESR for mandatory All Wales dementia module by site.	To be looked at in the senior nurse monthly/cross divisional nurse meetings to see if this is beneficial information	• Sue Pearce	31/03/2024	Ongoing
Discharge planning/EDD	Improve compliance in completing the Estimated Discharge Date (EDD)	DISCHARGE PLANNING TO BE COMMENCED IN 80% OF PATIENTS WITHIN 24 HOURS - to prevent de-conditioning in the hospital (goal 5 and goal 6). To encourage all staff to agree EDD in the post take round/MAU board rounds. Discharge coordinators/ward managers to take the initiative in putting an EDD for every patient during board rounds. This should also be discussed in the weekly MDT.	• Dr Subhan/Dr Adel/Dr Sheriff	31/03/2024	Ongoing
	Look at HB LoS wide rather than episode	Compare LoS from episode to HB LoS	• Dr Singh	31/04/2024	Ongoing

Audit Title:	Annual report – Improved Fracture Liaison Service (FLS) identification with gaps in monitoring: a call to action for national and regional planners	Clinical Lead:
	Data - Jan 2022 to 31 Dec 2022 Published - Feb 2024	Dr Inder Singh

Rationale:	FLS ensures that patients aged 50 and over who sustain a broken bone after a fall have their bone health and falls risk checked and managed to lower their risk of a subsequent fracture. The FLS is made up of a team of healthcare professionals led by a Clinical Lead who liaise with wider teams to provide bone health care plan. FLSs bring clear benefits to the patient and the system in the long term and have been shown to be clinically and cost-effective.
Objectives:	Fractures after a fall from standing height or less in adults aged 50 years and over often indicate osteoporosis and increased falls risk. Without urgent management, the risk of serious fractures due to osteoporosis will increase. Fracture liaison services (FLSs) deliver secondary fracture prevention using clear pathways to identify those with potential osteoporotic fractures, deliver systematic assessment, treatment recommendations in line with national guidelines, and monitoring to ensure recommendations are initiated and adhered to. The delivery of this pathway is mapped across key performance indicators (KPI) to support local FLSs to check and improve their local services.

Presented at Clinical Standards and Effectiveness Group – 23rd May 2024

The Health Board has improved on all but one KPI from 2022 to 2023 with two of the KPI’s moving up into the higher metric grouping:	
KPI 2	Case Identification has increased from 22.6% in 2021 to 42.6% in 2022 with a further increase in 2023 to 54.1%, and from 2022 to 2023 increased from red into amber and is performing better than Wales and National average.
KPI 3	Spine Fractures metric is >20% is green, and in 2021 was 26.1%, in 2022 the increased to 35.4% and a further increase in 2023 to 44.6%
KPI 4	Assessment within 90 days has increased from 21.3% and red in 2021 to 60.3% and amber in 2023 remained amber but increased to 74.2% and although worse than the Wales average is better than the National average
KPI 5	Dexa scan with 90 days was 23.3% in 2021, this decreased in 2022 to 12.4% and a further decrease in 2023 to 9.4%
KPI 6	Falls risk assessment was 34.7% in 20021 however significantly increased to 80.2% in 2022 and a further increase in 2023 to 96.6%, this measure green if over 50%
KPI 7	Bone treatment has a lesser growth although all years are in the green at 57.7% in 2021, 65.7% in 2022 and 67.5% in 2023
KPI 8	Strength and balance by 16 weeks is red for all years at 4.8% in 2021 and 9.1% in 2022 and 10% in 2023 which is increasing and is performance better than the Wales and National average
KPI 9	16 week follow up have significantly improved from 1.4% in 2021 to 19.1% in 2022 and a significant increase to 64.4% in 2023 and performing considerably better than the Wales and National averages
KPI 10	Treatment by 1 st Follow up although remains in the red, the performance has increased from 8.3% to 18.1% to 47.3%
KPI 11	1 Year drug adherence for 2022 the Health Board is under performing compared to the Wales and National average at 13.6%. No comparison data for 2023 is available to date



National, Wales and ABUHB data for all KPI's for 2021, 2022 & 2023

		KPI 2. Case identification	KPI 3. Spine Fractures green >20% amber 11-19% red <10%	KPI 4. Assessment within 90 days	KPI 5. DXA within 90 days	KPI 6. Falls risk assessment green >50% red <50%	KPI 7. Bone treatment	KPI 8. Strength & balance by 16 weeks	KPI 9. 16 weeks following up	KPI 10. Treatment by 1st followup	KPI 11. 1 yr drug adherence
green as 80%											
amber as 50-79%											
red as <50%											
National Average 2023	68341	34.7	23	65.5	31.7	61.7	56.9	7.8	28.6	29.2	Not applicable
National Average 2022	80015	40.6	22.5	63.2	29.2	62	56.6	6.8	27.1	28.9	21.9
National Average 2021	74647	37.9	20.3	66.5	31.2	60.8	55.2	5.6	24.5	29	22.3
Wales 2023	3403	20.4	11.1	79.9	17.8	90.9	68.2	6.2	44.6	32.6	Not applicable
Wales 2022	3152	18.9	10.1	77.8	33.5	86.3	62.5	6	21.4	16	24.9
Wales 2021	2030	12.2	6.6	65.2	22.9	61.6	56.7	3.9	13.8	10.3	30.3
ABUHB 2023	2097	54.1	44.6	74.2	9.4	96.6	67.5	10	64.4	47.3	Not applicable
ABUHB 2022	1649	42.6	35.4	60.3	12.4	80.2	65.7	9.1	19.1	18.1	13.6
ABUHB 2021	875	22.6	26.1	21.3	23.3	34.7	57.7	4.8	1.4	8.3	18.4

Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against
Risk level	Description
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

Resource and Costs by Staff Band		WTE required				Annual cost £			
		Nursing	Admin	Radiology	Consultant	Nursing	Admin	Radiology	Consultant
Band 1									
Band 2									
Band 3			2.5				£77,581		
Band 4				0.4				£13,518	
Band 5									
Band 6		2.0		0.2		£96,489		£9,649	
Band 7		2.7				£158,438			
Band 8a									
Band 8b									
Band 8c									
Band 8d									
Band 9									
Consultant					0.2				£21,705
Total Staff		4.7	2.5	0.6	0.2	£254,927	£77,581	£23,167	£21,705
Overheads						£38,239	£11,637	£3,475	£3,256
Total		4.7	2.5	0.6	0.2	£293,166	£89,218	£26,642	£24,961

Financial benefits		Hip fracture (inpatient)	Other fracture site (inpatient)	Other fracture site (outpatient)	Clinical vertebral	Total	Average benefit per year
Acute care	Year						
	2024	£585,330	£34,599	£7,961	£19,780	£647,670	
	2025	£995,061	£52,809	£12,151	£35,604	£1,095,625	
	2026	£1,424,303	£67,377	£15,503	£49,450	£1,556,633	
	2027	£1,697,457	£80,124	£18,436	£57,362	£1,853,379	
	2028	£1,873,056	£87,408	£20,112	£63,296	£2,043,872	
	All years	£6,575,207	£322,317	£74,163	£225,492	£7,197,179	£1,439,436

Estimate of service costs

The Royal Osteoporosis Society has a separate tool to help clinicians, managers and commissioners accurately calculate the costs of your FLS service for the number of patients shown in this FLS Benefits Calculator. The costs shown below are an approximation of the likely range of a what a service would cost for the number of patients expected in your service. **These are approximations only and must not be used in a business case.** For an accurate calculation using local salary, tariff activity, MFF and prescribing data please talk to your Royal Osteoporosis Society contact. All costs are for year 1 only.

	Lower estimate	Upper estimate
Estimate of staffing costs	£378,810	£635,559
Trust overhead charge of 15% applied to staff costs	£56,822	£95,334
Estimate of additional prescribing costs*	£14,744	£152,595
Total costs of FLS	£450,376	£883,488

* Prescribing costs will increase as the number of patients on osteoporosis therapy increases cumulatively each year

420

National, Wales and ABUHB data for all KPI’s for 2021, 2022 & 2023

		KPI 2. Case identification	KPI 3. Spine Fractures green >20% amber 11-19% red <10%	KPI 4. Assessmen t within 90 days	KPI 5. DXA within 90 days	KPI 6. Falls risk assessment green >50% red <50%	KPI 7. Bone treatment	KPI 8. Strength & balance by 16 weeks	KPI 9. 16 weeks following up	KPI 10. Treatment by 1st followup	KPI 11. 1 yr drug adherence
green as 80%											
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Risk level	Description
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

Resource and Costs by Staff Band

	WTE required				Annual cost £				
	Nursing	Admin	Radiology	Consultant	Nursing	Admin	Radiology	Consultant	Total
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Band 4			0.4				£13,518		£13,518
Band 5									£0
Band 6	2.0		0.2		£96,489		£9,649		£106,138
Band 7	2.7				£158,438				£158,438
Band 8a									£0
Band 8b									£0
Band 8c									£0
Band 8d									£0
Band 9									£0
Consultant				0.2				£21,705	£21,705
Total Staff	4.7	2.5	0.6	0.2	£254,927	£77,581	£23,167	£21,705	£377,380
Overheads					£38,239	£11,637	£3,475	£3,256	£56,607
Total	4.7	2.5	0.6	0.2	£293,166	£89,218	£26,642	£24,961	£433,987

Financial benefits

	Year	Hip fracture (inpatient)	Other fracture site (inpatient)	Other fracture site (outpatient)	Clinical vertebral	Total	Average benefit per year
Acute care	2024	£585,330	£34,599	£7,961	£19,780	£647,670	
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	2026	£1,424,303	£67,377	£15,503	£49,450	£1,556,633	
	2027	£1,697,457	£80,124	£18,436	£57,362	£1,853,379	
	2028	£1,873,056	£87,408	£20,112	£63,296	£2,043,872	
	All years	£6,575,207	£322,317	£74,163	£225,492	£7,197,179	

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Estimate of additional prescribing costs*	£14,744	£152,595
Total costs of FLS	£450,376	£883,488

* Prescribing costs will increase as the number of patients on osteoporosis therapy increases cumulatively each year

Report Recommendations:		S.M.A.R.T Actions:	Responsible: Due Date: Progress:
1	More FLSs are now delivering over 80% identification rates for non-spine fractures. FLS that have prioritised improvement in KPI 2 and 3 should contact these services to share best practice for funding and identification pathways.	Based on the annual activity/no. of fragility fractures ABUHB FLS of 4209, The HB needs 4.7 - WTE nursing staff 2.5 - admin 0.6 - radiology staff (dexa scan) 0.2 consultant. The total annual cost for this is £433,987. The Medical Division has invested 2 WTE CNS and 1 WTE Administrator (147K). Over the period of 5 years the total annual cost for ABUHB FLS including staff cost, overhead charge of 15% and prescribing costs be approx. £450,376 to £883,488. The annual benefits across acute care is equal to £1439,436 and all benefits inclusive of community and social care will be 2.1 Million.	Dr Inder Singh Ongoing
2	To meet the healthcare recovery targets from the pandemic, FLS funding should be prioritised based on expected number of avoided fractures from a comprehensive service. FLSs should describe their capacity gaps and the expected benefit vs effort from re-organising pathways to ensure that at least 80% of higher risk patients are checked within 16 weeks of their fracture. <i><u>This may result in lower rates of identification for lower fracture risk patients.</u></i>		
3	FLSs should work with their local DXA providers to ensure access to DXA is based on patient need. This may require FRAX before DXA pathways, increasing follow up based on evidence and using FRAX only recommendations to clear backlogs of patients that are unlikely to be cleared in the next four months.		
4	FLS care pathways should acknowledge that specific patient groups need a personalised approach to assessment, decision-making and support. This includes providing patient-facing materials that reflect the languages of their local population.		
5	All senior executive decision-makers should hold a key stakeholder meeting to explore how local needs for fragility fracture patients can be met. Patient representatives and members of the Royal Osteoporosis Society should be invited to the meeting, and it should plan for effective and sustainably resourced FLSs based and designed on the KPIs from the FLS-DB.	FLS is regularly discussed in the Falls and Bone Health Committee but with Patient representation and ROS representation	Peter Carr 8 th April 2024 To be discussed

Clinical Leads Local Recommendations: (if applicable)		Responsible:	Due Date:	Progress:
1	FLS for the ABUHB continues to be a centralised service and this is already achieved, however this needs to be continued.	Dr Singh	Ongoing	Improving
2	Wider partnership with Community Team, Primary Care and third sector.	Dr Singh	Ongoing	Improving

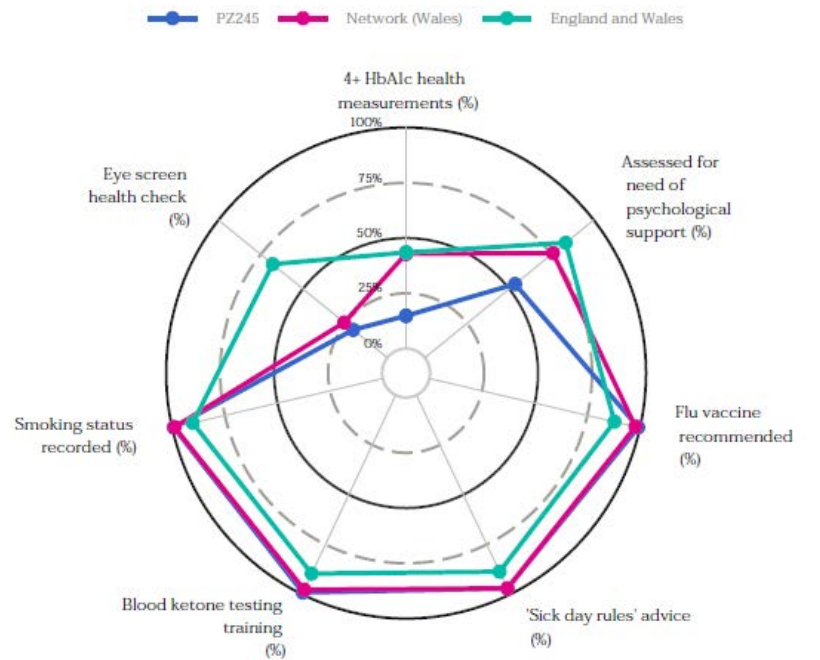
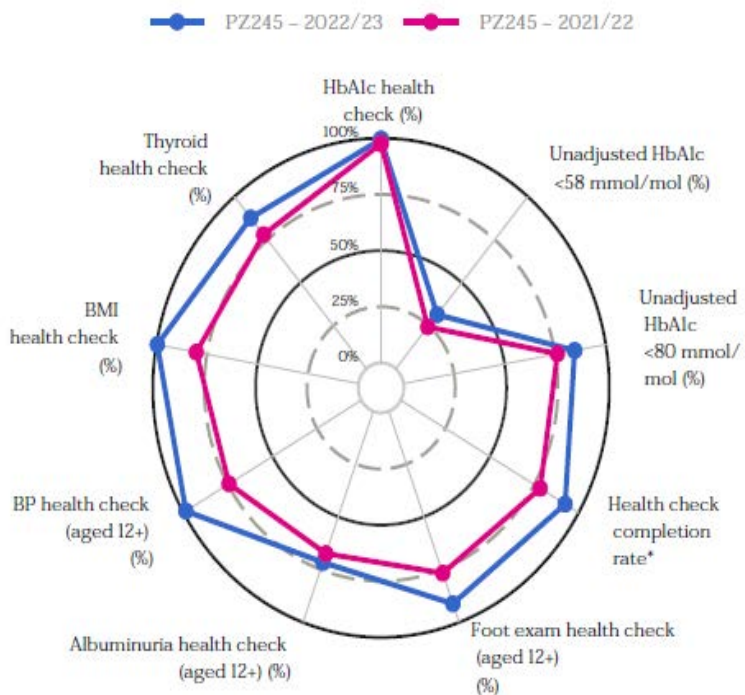
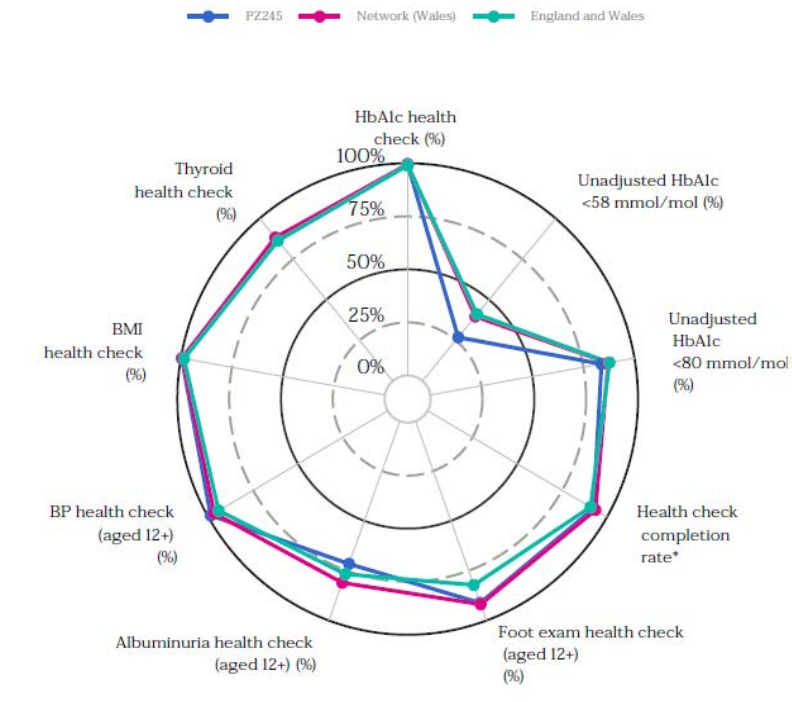
PQSOC Sep 2024		
Audit Title:	National Paediatric Diabetes Audit (NPDA) Report on Care and Outcomes 2022/23	Clinical Lead: Dr Davida Hawkes, Consultant Paediatrician
Rationale:	The National Paediatric Diabetes Audit (NPDA) has published a report on care and outcomes 2022/23. It found that the prevalence of children and young people cared for in Paediatric Diabetes Units (PDUs) in England and Wales has increased from 33,251 in 2021/22 to 34,371 in 2022/23, despite a fall in the incidence of new cases. It also found that the percentages of children and young people with Type 1 and Type 2 diabetes receiving all six key annual healthcare checks have increased, but there remains much variability between PDUs (and completion rates for those with Type 2 remain lower than for those with Type 1). The report also states that, despite improvements in outcomes and use of technologies across different ethnicities and areas of deprivation, inequalities remain evident. In terms of rtCGM use, the inequality gap by deprivation has reduced, however the difference in use between Black and White children with Type 1 diabetes has widened from 8.6% in 2021/22 to 14% in 2022/23.	
Objectives:	• Build on and improve the previous joint adult and paediatric audit • Collect a clinically meaningful dataset • Engage clinicians, patients and parents • Improve awareness of NPDA findings and maximise their use to drive national policy • Develop the use of NPDA data in local and national quality improvements • Use a regional network approach to data collection • Capture patients' experiences • Collaborate with the suppliers of the adult audit to ensure information around transition to adult care is captured • Report at timely and regular intervals • Develop user-friendly tools to interrogate the dataset • Support centres wishing to develop local action plans to improve diabetes care • Maximise the use and availability of data for research	
Presented at Clinical Standards and Effectiveness Group – 25 th July 2024		

Key messages
The prevalence of children and young people cared for in PDUs in England and Wales has increased from 33,251 (2021/22) to 34,371 (2022/23), despite a fall in the incidence of new cases. The overall median HbA1c for England and Wales has fallen from 60.5mmol/mol (2021/22) to 60.0mmol/mol, but excessive PDU (paediatric diabetes units) variability in this outcome measure still persists. The percentages of children and young people with Type 1 and Type 2 diabetes receiving all six key annual healthcare checks has increased but there remains much variability between PDUs, and completion rates for those with Type 2 remain lower than for those with Type 1. Use of diabetes related technology has increased in 2022/23 with around half of children and young people with Type 1 diabetes using insulin pumps (45.3%, compared to 40.3% in 2021/22) and half (48.6%, compared to 30.0% in 2021/22) using a real time continuous glucose monitor (rtCGM). Use of hybrid close loop systems doubled since the previous audit year, with 14.7% now using this technology compared to 7.5% in 2021/22. Lower HbA1c was associated with use of a hybrid closed loop system or rtCGM. Percentages of young people with early signs of micro and macrovascular complications for both Type 1 and Type 2 diabetes show very little change in 2022/23 compared to the previous audit year. Despite improvements in outcomes and use of technologies across different ethnicities and areas of deprivation, inequalities remain evident. In terms of rtCGM use, the inequality gap by deprivation has reduced however the difference in use between Black and White children with Type 1 diabetes has widened from 8.6% in 2021/22 to 14% in 2022/23.

GRANGE UNIVERSITY HOSPITAL

A total of 328 children and young people (CYP) with diabetes who received treatment at The grange university hospital were included in the 2022/23 audit. A small number of people for whom data was provided were not included in the audit as they did not meet the audit criteria or did not have the minimum demographic data required. The charts below show the age and type of diabetes distribution.

Radar plot showing PDU, region and national performance on the six key health checks, % achieving an HbA1c of below 58 mmol/mol and % achieving an HbA1c of below 80 mmol/mol	Figure 2: Radar plot showing PDU performance in 2021/22 and 2022/23 on the six key health checks, % achieving an HbA1c of below 58 mmol/mol and % achieving an HbA1c of below 80 mmol/mol	Figure 3: Radar plot showing PDU, region and national performance on additional health checks



*The health check completion rate is calculated by dividing the total number of health checks completed in each PDU by the total expected number of health checks: each patient aged 12 and above with Type 1 diabetes who completed a full year of care should receive 6 health checks. Children under 12 with Type 1 diabetes who completed a full year of care should receive 3 health checks (see section 3 for further information about health checks). In previous years, the health check completion rate metric excluded children under the age of 12.

HbA1c - All the data presented on HbA1c relates to the results for the 280 children and young people with Type 1 diabetes who had one or more valid HbA1c measurements in the audit period. This may differ from the number of children and young people included in the denominator for HbA1c as a health check as it includes those who have had a valid HbA1c at least 90 days after diagnosis irrespective of whether they had a complete year of care. Where more than one valid HbA1c was recorded during the year per child or young person, the median value was used. The NPDA recommends using the PDU median to compare your year-on-year progress towards lower average HbA1c, as the median is less affected by extreme results than the mean (see Figure 19).

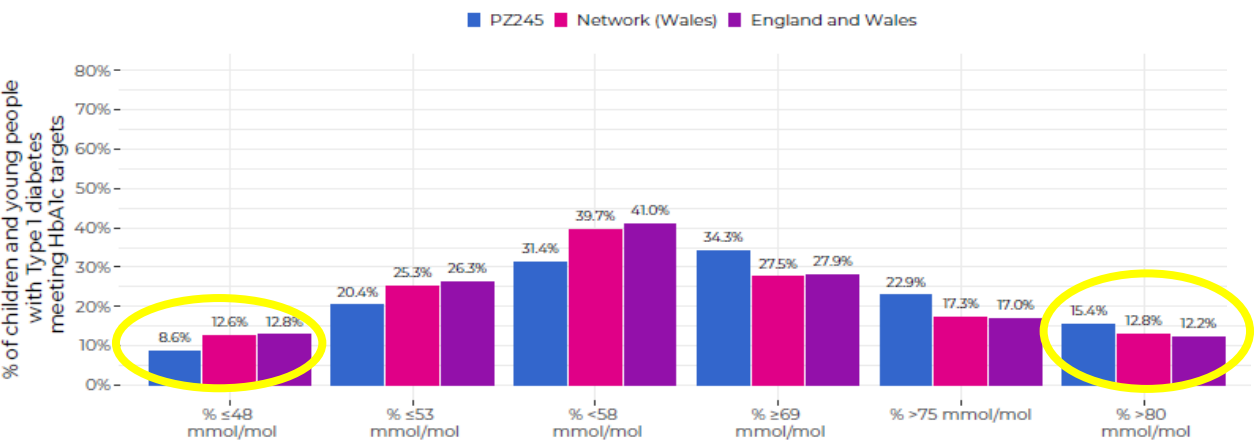


Figure 19: Percentage of children and young people with Type 1 diabetes meeting HbA1c targets

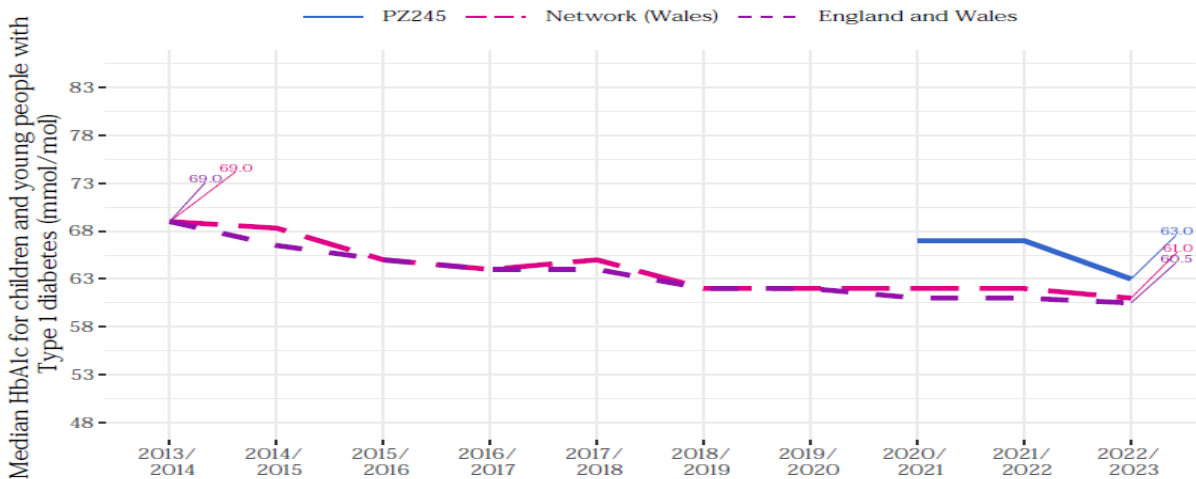
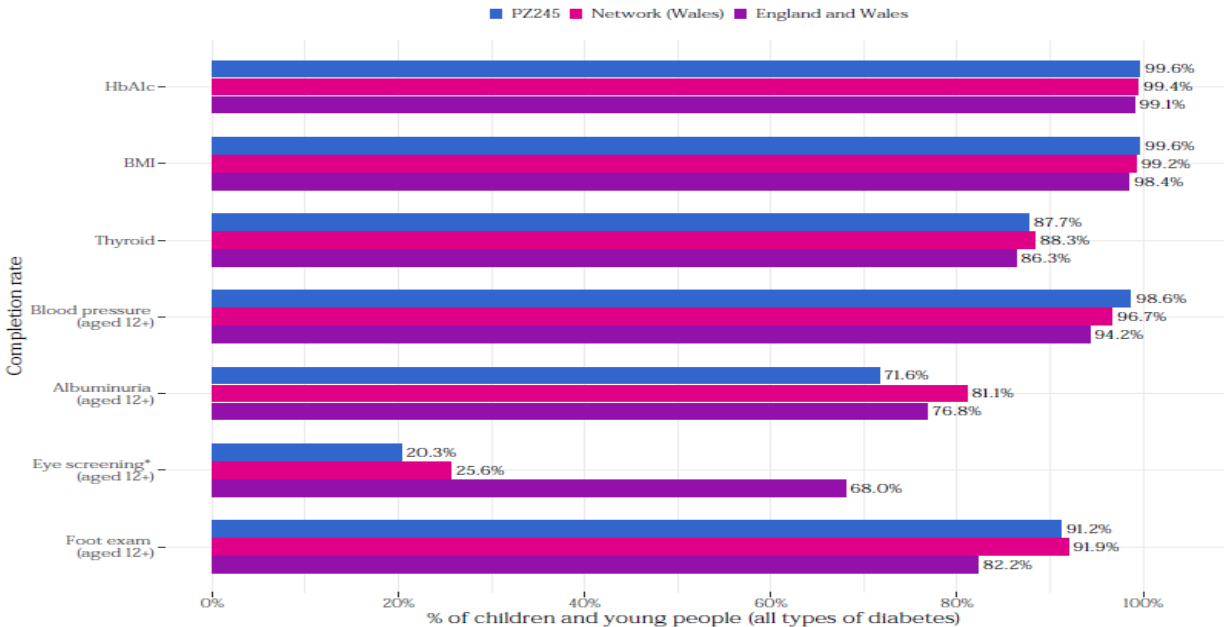


Figure 19: Median HbA1c for children and young people with Type 1 diabetes

3.1 Key health check completion



Percentage of children and young people with Type 1 diabetes with a complete year of care who received additional health checks – 4+ HbA1c measurements poor – can be impacted by late booking



The outlier status of The Grange University Hospital on the performance indicator Adjusted Mean HbA1c for 2022/23 is: Alert.

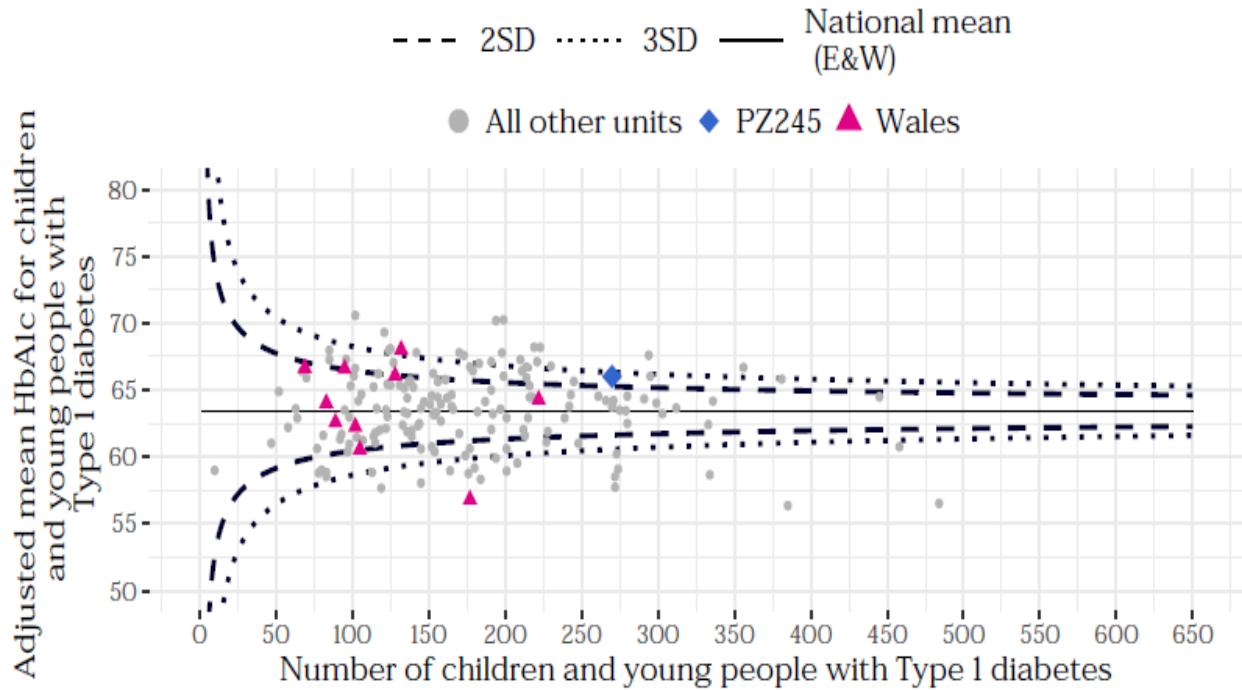


Figure 21: Adjusted mean HbA1c

The NPDA defines services with a result above two standard deviations of the expected value on this metric as an ‘alert’, and above three standard deviations as an ‘alarm’, which confers negative outlier status in accordance with HQIP guidance (2017). In Figure 21 above, PDUs above the top dotted line (3SD) are considered ‘alarm’ outliers as their adjusted mean HbA1c is significantly higher than the overall mean in England and Wales. Conversely, services with results below three standard deviations are considered positive outliers on this metric.

The Health Board Adjusted Mean HbA1c in 2021/2022 was an Alarm status (3SD) for 2022/2023 the Health Board has improved, however remains an outlier, at Alert level (2SD). HDUHB is a positive outlier and ABUHB will visit HDUHB for learning.

8.1 Treatment regimen

The data presented below is for the 302 children and young people with Type 1 diabetes in PZ245 who had a valid treatment regimen recorded.

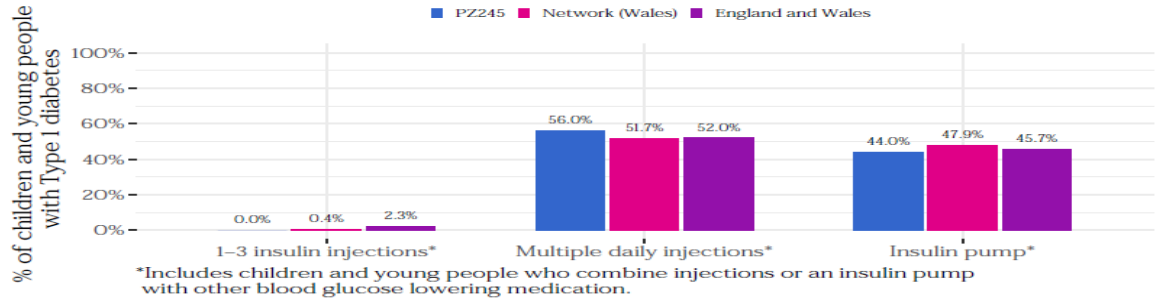


Figure 29: Treatment regimen of children and young people with Type 1 diabetes

8.4 Closed-loop system

At The Grange University Hospital, 5.4% of all children with Type 1 diabetes were using a closed-loop system.

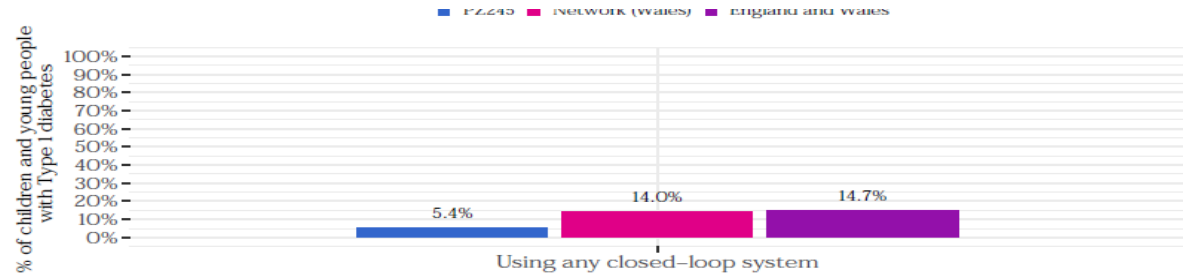


Figure 35: Percentage of children and young people using a closed-loop system

8.2 Continuous glucose monitoring

In GUH, 250 children and young people with Type 1 diabetes were reported as either using or not using rtCGM with alarms within the audit period. The proportion recorded as using rtCGM at last visit is reported below

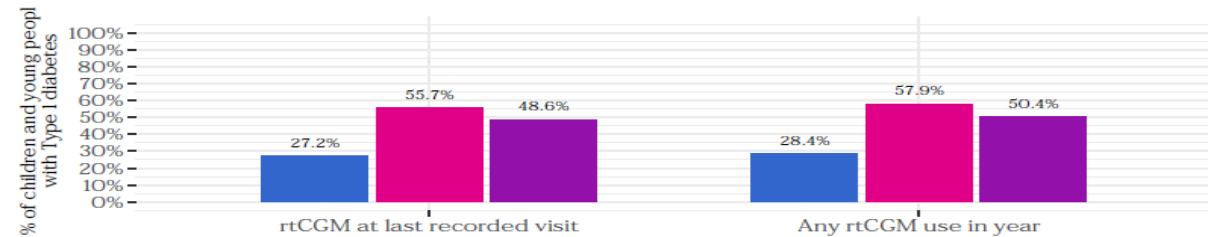


Figure 32: Percentage of children and young people using rtCGMs with alarms

Assurance and Risk

Assurance level	Description	Risk level	Description
Limited	The project did not achieve the standards or criteria being audited against	Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on
Has this audit been placed on a Risk Register (N/A if above risk is None)			YES

Key Success and Concerns

Report Successes:		Report Concerns:	
1	ABUHB paediatric diabetes team continue to reduce HbA1c, reducing to Alert status and no longer Alarm status and we are Reducing the gap	1	Other teams continue to improve so always playing catch up
		2	Business case has not resulted in investment in the service to date

NPDA Recommendations and Health Board actions:

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Commissioners of care should make sure that multidisciplinary diabetes teams are adequately staffed to manage the growing numbers of children and young people with Type 1 and Type 2 diabetes since 2020. These teams should be trained to encourage the best use of new diabetes-related technologies. Action by: Integrated Care Boards across England and Local Health Boards across Wales.	Business case was submitted prior to the last audit period	Requires Health Board Approval	Immediately	Ongoing
2	Children and young people with Type 1 and Type 2 diabetes should have equitable access to diabetes care, regardless of social deprivation, ethnicity, or geography. Action is required to increase the proportion of those with Type 2 diabetes receiving recommended key annual health checks and to improve equity of access to diabetes treatment technology for Type 1 diabetes. Action by: Integrated Care Boards across England; Local Health Boards across Wales, and the RCPCH, to provide a better understanding of ethnic and social deprivation variability.				
3	Young people with diabetic retinopathy recorded in their previous annual screen should be invited for annual re-screening. Paediatric diabetes teams should be aware of which patients in their service have retinopathy and encourage them and their family to attend screening appointments when offered so that diabetes management advice can be appropriately tailored. Action by: NHS Diabetic Eye Screening Programme in England (DESP), Diabetic Eye Screening Wales (DESW), Clinical teams within paediatric diabetes units in NHS Trusts and Local Health Boards across England and Wales.	*Eye screening was reduced to biennial frequency in many NHS Trusts in England and Health Boards in Wales from 2020/21 and has been excluded from compound 'key annual check' reporting by the NPDA since (section 3.2). However, the denominator for this metric includes all children and young people with Type 1 diabetes who completed a full year of care.			

Audit Title:	<u>National Diabetes Foot Care Audit (NDFA)</u> <u>Are services providing effective diabetes foot care?</u>	Clinical Lead: Melissa Blow - Clinical Lead for Podiatrist Diabetes and Tissue Viability
	England and Wales, 2018–23 Published 9 May 2024	

Rationale:	NDFA enables all services that treat people with diabetes related foot disease to measure their performance against National Institute for Health and Care Excellence (NICE) guidance.

Objectives:	The NDFA aims to: 1. Measure factors associated with increased risk of ulcers and adverse ulcer outcomes. 2. Provide data on diabetes related foot disease that can be used by service providers, local commissioners and national policy makers to monitor patient outcomes and to benchmark against peers. 3. Share best practice information to enable the highest quality of care of diabetes related foot disease in England and Wales. National Diabetes Foot Care Audit - NHS England Digital Diabetic foot problems: prevention and management NICE guideline [NG19]

Presented at Clinical Standards and Effectiveness Group – 25th July 2024

The audit looks at three key areas:

1

Structures

Are the nationally recommended care structures in place for the management of diabetes related foot disease?

2

Processes

Does the treatment of active diabetes related foot disease comply with nationally recommended guidance?

3

Outcomes

Are the outcomes of diabetes related foot disease optimised?

NDFA - Key finding One

Shorter times to First Expert Assessment (FEA) led to greater chance of being alive and ulcer free at 12 weeks.

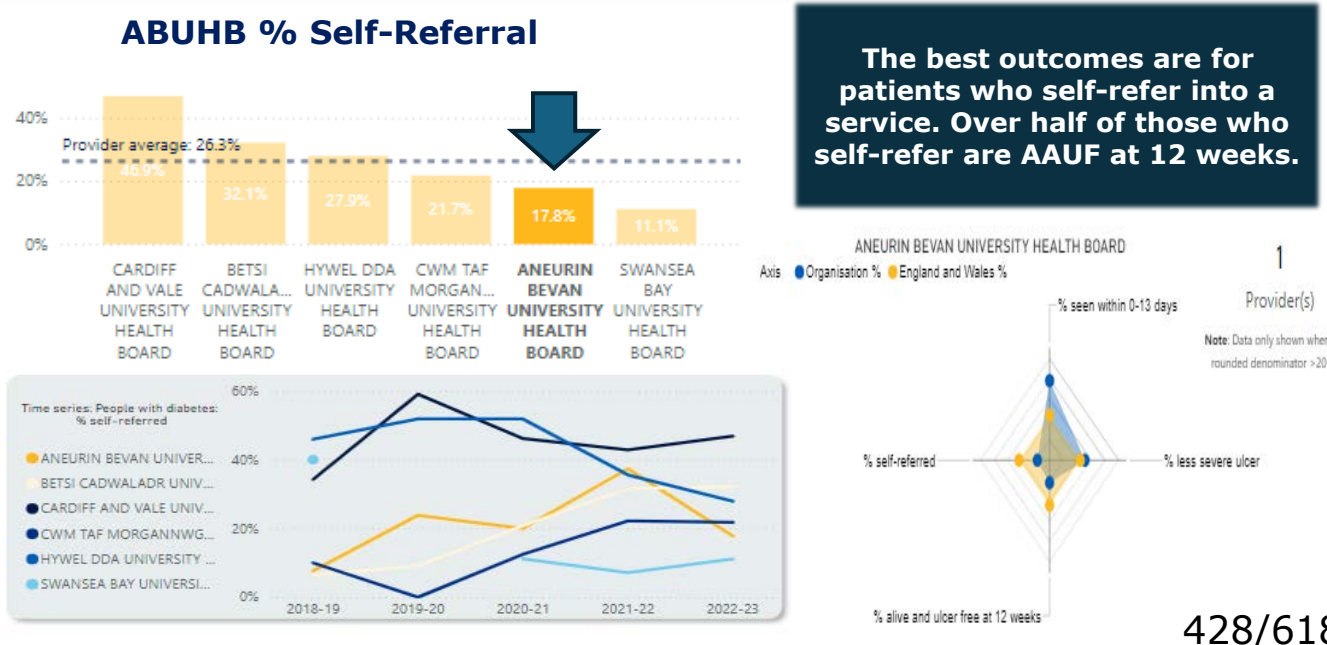
Early expert assessment of all new foot ulcers is important. The NDFA has shown that faster referral to specialist foot care services leads to fewer severe ulcers and greater chance of being alive and ulcer free (AAUF) at 12 weeks.

Twelve weeks after the First Expert Assessment (FEA), foot care services record whether:

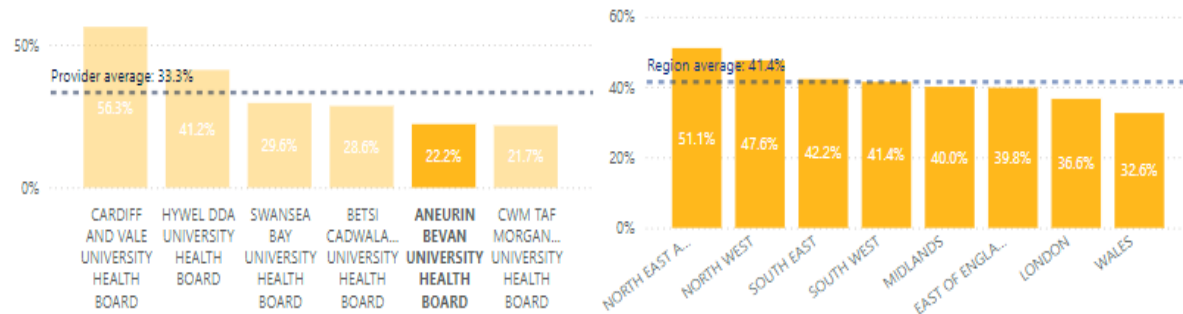
- The person is alive.
- The ulcer is healed.
- The person does not have new foot ulcers.

Recommendation 1:

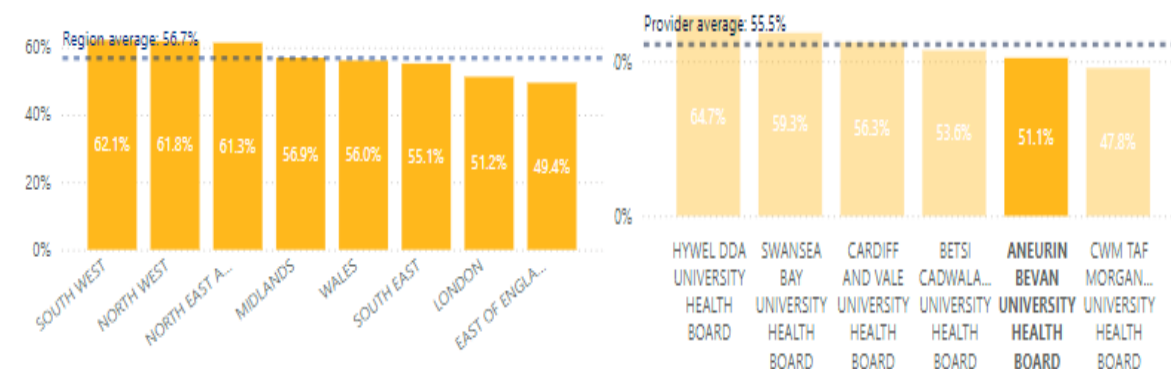
Integrated care boards (ICBs) and Welsh local health boards (LHBs) should ensure that health care providers (HCPs) arrange early expert assessment of all new foot ulcer episodes following either health care professional referral or self-referral. In every ICB or LHB more than **70%** of new ulcers should receive FEA within 0-13 days by 2026.



Alive And Ulcer Free (AAUF) at 12 weeks



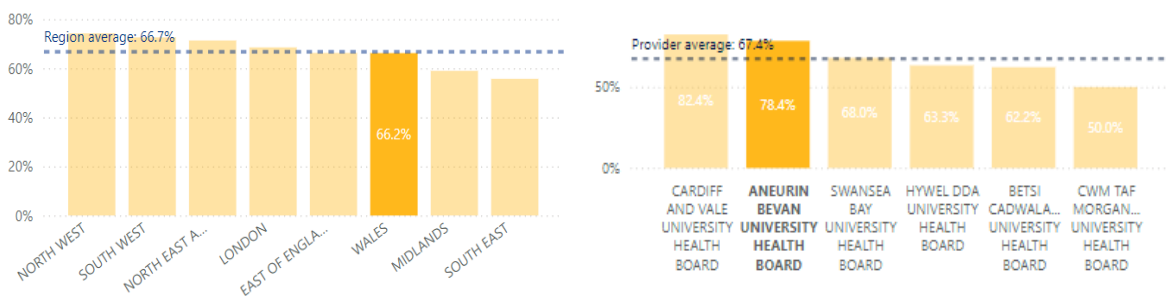
% less severe ulcer



Key finding Two

There is a marked difference between regions, ICBs, LHBs and services in terms of assessment and outcomes.

First Expert Assessment (FEA), 0-13 days

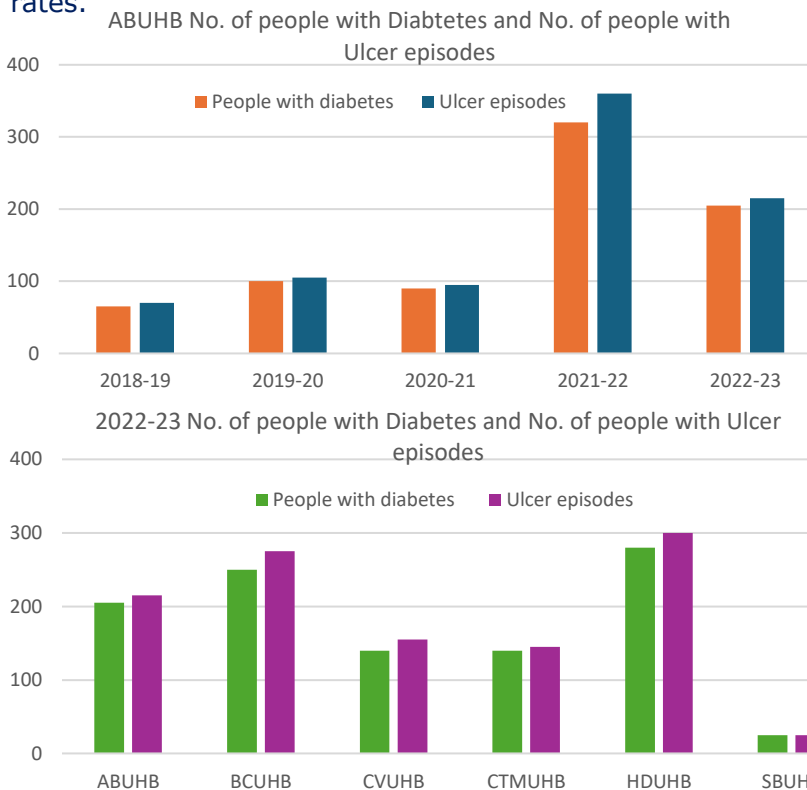


Recommendation 2:

ICBs ICBs and Welsh LHBs should make sure they are aware of local diabetes foot care pathways and understand reasons for variability. They should ensure that specialist clinical foot care services are accessible to all people with diabetes related foot ulcers and are appropriately resourced.

Key finding Three

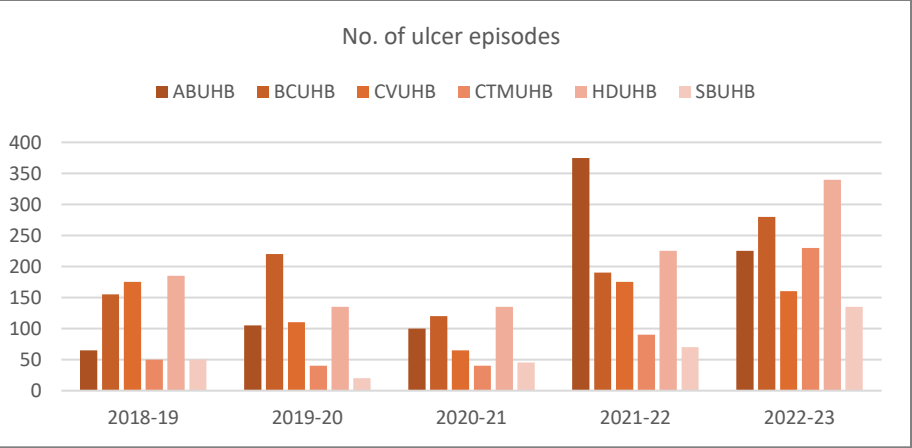
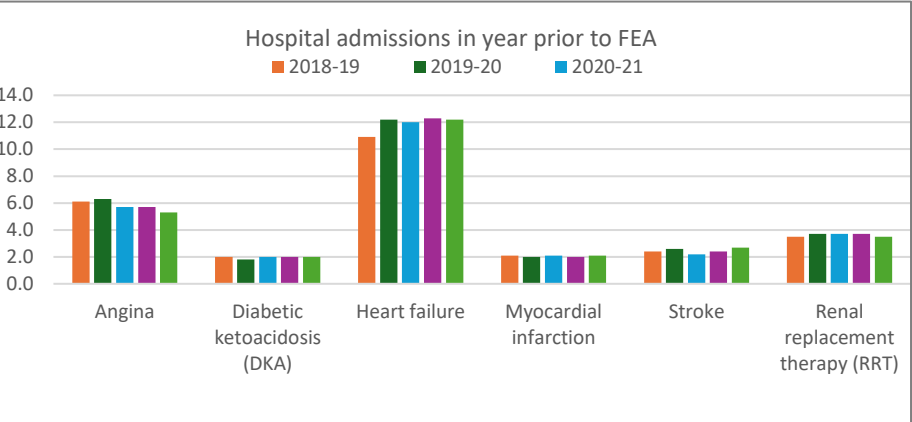
There are wide-ranging differences between regions, ICBs and services in ulcer registration rates.



Recommendation 3:

ICBs and Welsh LHBs should mandate all providers to submit data to the NDFA and, using the NDFA dashboard, review their provider organisations benchmarked processes and outcomes. These should include the number of ulcer registrations, time to FEA, ulcer severity at FEA and 12 week outcomes.

Additional Data



The service does not have electronic processes and uses paper processes which affects staff workloads and can impact data recording. Ascertainment rates are continuously promoted and monitored.

Report Recommendations:		Progress:
1	Integrated care boards (ICBs) and Welsh local health boards (LHBs) should ensure that health care providers (HCPs) arrange early expert assessment of all new foot ulcer episodes following either health care professional referral or self-referral. In every ICB or LHB more than 70% of new ulcers should receive FEA within 0-13 days by 2026.	Already achieved and continue monitoring the HB 7-day target
2	ICBs and Welsh LHBs should ensure that specialist clinical foot care services are accessible to all people with diabetes related foot ulcers and are appropriately resourced.	Achieved across the 5 boroughs and looking to introduce a drop-in clinic in Newport, Caerphilly and Monmouthshire.
3	ICBs and Welsh LHBs should review their provider organisations, using the NDFA dashboard including the number of ulcer registrations, time to FEA, ulcer severity at FEA and 12-week outcomes to improve referral rates.	Achieved

Assurance and Risk Level

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against

Risk level	Description
Low	Peripheral element of treatment or service suboptimal

Has this audit been placed on a Risk Register (N/A if above risk is None) - No

Report Successes:

- 1
- ABUHB First Expert Assessment (FEA) within 0-13 days after referral during 2022-23 was 78.4% within a range of 82.4% - 50.0% across Wales. The target has been set at being more than 70% (0-13 days) by 2026. (Professional and Self-referrals)

Report Concerns:

- 1
- ABUHB AAUF rate was 22.2% and this ranged from 56.3% to 21.7% across Wales – although the data does not reflect the complexities of ABUHB patients in 12 weeks (less severe ulcer in more complex patients) – work planned to improve on this result
- 2
- % self-referrals for ABUHB was 17.8%, with a range of 46.9% to 11.1% across Wales. Self-referral access generates higher levels of AAUF at 12 weeks – Each HB was recording self referral different and national agreement on this has been achieved

Audit Title:	Report on the 2022 National Audit of Quality Standards for Adult Hearing Rehabilitation Audiology (Wales)	Clinical Lead: Wendy Trump
Rationale:	To provide an overview of Aneurin Bevan University Health Board on the performance of their Adult Audiology service against the Quality Standards for Adult Audiology (Wales) version 2. During November 2022, all Adult Audiology Services in Wales were audited using version 2 of the Quality Standards for Adult Audiology (2016).	
Objectives:	The audit process includes 83 criteria which are; • Deliberately limited to audit items that are specific to Audiology or are particularly worthy of emphasis • Provide a specific and evidence-based contribution to help define a good quality service that will provide the best outcomes for patients. • Describe good practice and use of tools to provide evidence of health outcomes. • Compliance with the standards should not be used in isolation to quantify the efficacy of services in terms of health outcomes and patients' satisfaction.	
Presented at Clinical Standards and Effectiveness Group 25 th July 2024		

The audit process

These Quality Standards are relating to the step changes which were audited in November 2022:

- Increase in target minimum assessment scores, from 75% for each individual standard in 2017 to 80% in 2019 and from 75% overall in 2017 to 85% in 2019.
- The scoring sheet used was updated to Version 3.4, which includes the self-assessment scores and the actual audit scores on the day in the same spreadsheet.

As in previous years:

- Audiology Heads of Services were asked to complete a self-assessment for each of their services; these were forwarded to the audit teams by the Audit Coordinator prior to the audit visits.
- All Health Boards had one audit visit, except for Powys, where the service is split between three Health Boards.
- Each audit team was led by a Senior Audiologist from an external Health Board. Local patient representatives were invited to attend each audit. An independent, external 3 auditor, recruited from the third sector, also attended every audit to ensure consistency in scoring.
- Following audit visits, the audit team produced a report on the assessed service performance. Summary reports were sent to the Chief Executive of the respective Health Board and Head of Service.
- An All-Wales report, incorporating the Quality Standards Adult Audiology Rehabilitation Services results for all services, has been provided to Audiology Standing Specialist Advisory Group (ASSAG) for approval prior to submission to the Welsh Government.

QS outcome reflects a high standard of delivery but has not identified the high-risk factor to patient due to extremely long waiting times

The individual standards, criteria and marking scheme used are the same as used for the external audit in 2017. The target minimum assessment scores have, however, increased since 2017, from 75% for each individual standard to 80% and from 75% overall to 85%.

The Quality Standards are arranged as 9 standards:	
QS	ABUHB results
1. Accessing the Service	85%
2. Communicating with Patients	94.64%
3. Assessment	96.43%
4. Developing an Individual Management Plan	100%
5. Implementing an Individual Management Plan	91.67%
6. Clinical Effectiveness	100%
7. Clinical Skills and Expertise	96.43%
8. Collaborative Working	96.43%
9. Service Improvement	100%

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	To reduce waiting time for new and existing patients	To liaise with the Directorate management to increase capacity	Wendy Trump/Directorate management team	Review at CSEG Nov 2024	New
2	Address low scoring criteria linked to long waiting times.				
3	Version 3 is out for consultation to address weakness in V2 and include changes to Audiology practices.				

There were 83 individual criteria. Low scoring criteria were judged as those scoring less than 2 on the Quality Rating Tool (QRT).

- 0 = No elements of the quality statement are met (or not evident)
- 1 = Few elements of the quality statement are met
- 2 = Meets around half of the elements of the quality statement criteria
- 3 = Almost fully meets the quality statement criteria
- 4 = Fully compliant with good to best practice as indicated by quality statement criteria

8 out of 9 services met, or exceeded, the compliance target of an overall score of 85%.

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against
Limited	The project did not achieve the standards or criteria being audited against

Risk level	Description
Major	Non-compliance with national standards/Significant risk to patients if unresolved

Has this audit been placed on a Risk Register (N/A if above risk is None) - YES	

Report Successes:	
1	1a.1 Excellent detailed pathways were seen throughout the audit. Ideal for new and existing staff to refer to.
2	2a.6 Good evidence of feedback from service users.
3	3a.7 Staff are always being supported and encouraged to participate in learning new processes and to review existing.
4	5c.2 Good referral pathway to Hearing Therapy services.

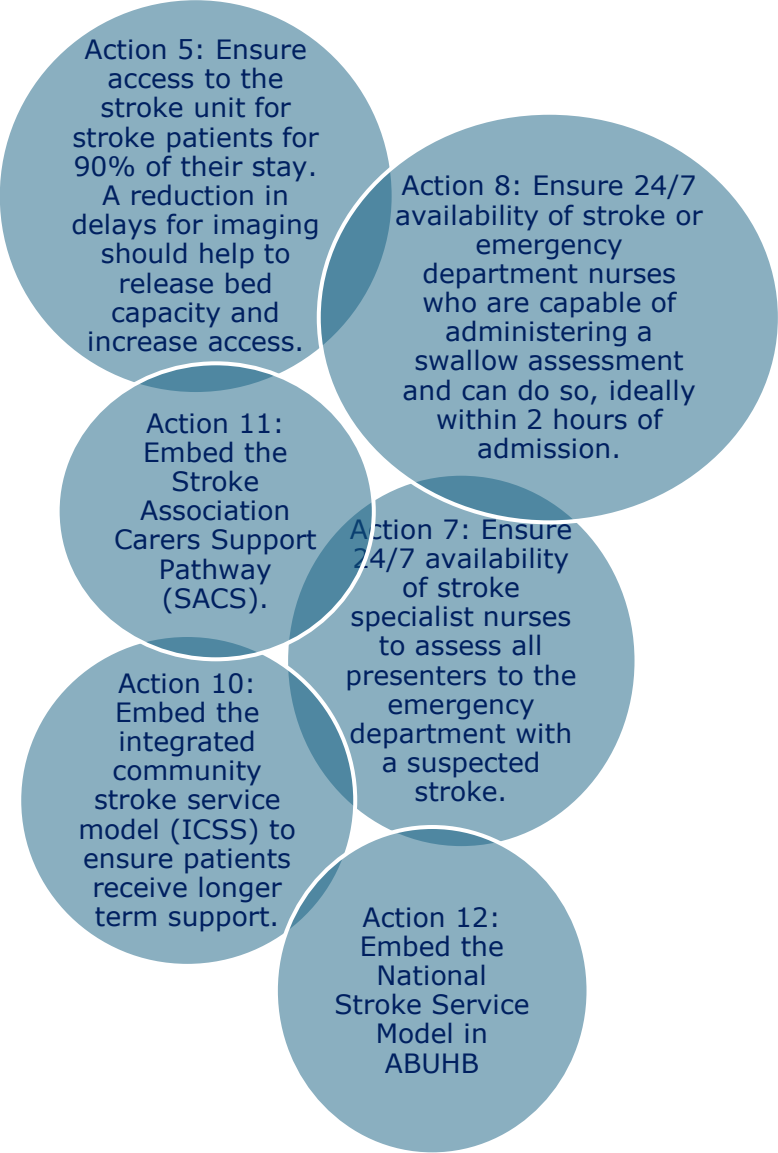
Report Concerns:	
1	Accessing the service one criteria scored 0 - Since Covid the department have been unable to maintain 14-week RTT for existing and new patients. Covid also led to the suspension of the volunteer service. Plans are in place to address the above.
2	Implementing an Individual Management Plan one criteria scored 0 - No plans to currently offer a 3 years reassessment - This applies to all Audiology Services across Wales

Audit Title:	SSNAP Annual Report 2023 Sentinel Stroke National Audit Programme – State of the Nation Stroke care received between April 2022 to March 2023	Clinical Lead(s): Dr Yaqoob Bhat – Acute Dr Jonathan Hewitt - Stroke Rehab	A Action 1: Record data in real time, with audit compliance and assurance processes built into the individual sites’ Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP data for clinical assurance.
Rationale:	SSNAP measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence-based standards. The overall aim of SSNAP is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered. Processes of care are measured against evidence-based quality standards referring to the interventions that any patient may be expected to receive.	B	Action 2: Commission an ESD pathway process flow map. ... support a move to having only two stroke specific rehabilitation units ... therefore improving flow through the stroke pathway.
			Action 3: Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB to embed the Optimal Stroke Imaging pathway. The use of first line MRI for patients with mild symptoms or with diagnostic uncertainty may release bed capacity.
			17.3% Action 6: Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis.
			Action 15: Deliver adequate psychological and emotional support for stroke survivors and their families.
Objectives:	SSNAP's information is used as a tool to improve the quality of care that is provided to patients. Healthcare professionals involved in audit have voted SSNAP the most effective national clinical audit in the UK every year since 2012.	92.1% Action 16: ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly ‘compliance’ meeting to provide assurance.	
Presented at Clinical Standards and Effectiveness Group – 25 th July 2024. SNAP reported to the Stroke Board and Executive Committee and actions have been added to AMaT.			76.9% Action 17: Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised, and a weekly ‘compliance’ meeting put in place to provide assurance.
The GIRFT Report Undertaken in 2022 with 20 recommendations to be undertaken across the rest of Wales through the National Stroke Network ABUHB/GIRFT Progress tracker Complete In Progress In Progress (Need Support) Not Started 1 4 6 9			96.4% Action 18: Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.
			TBC Action 20: Standardise post discharge reviews using the GM-SAT six-month post stroke review tool .

63/135

433/618

Ongoing work

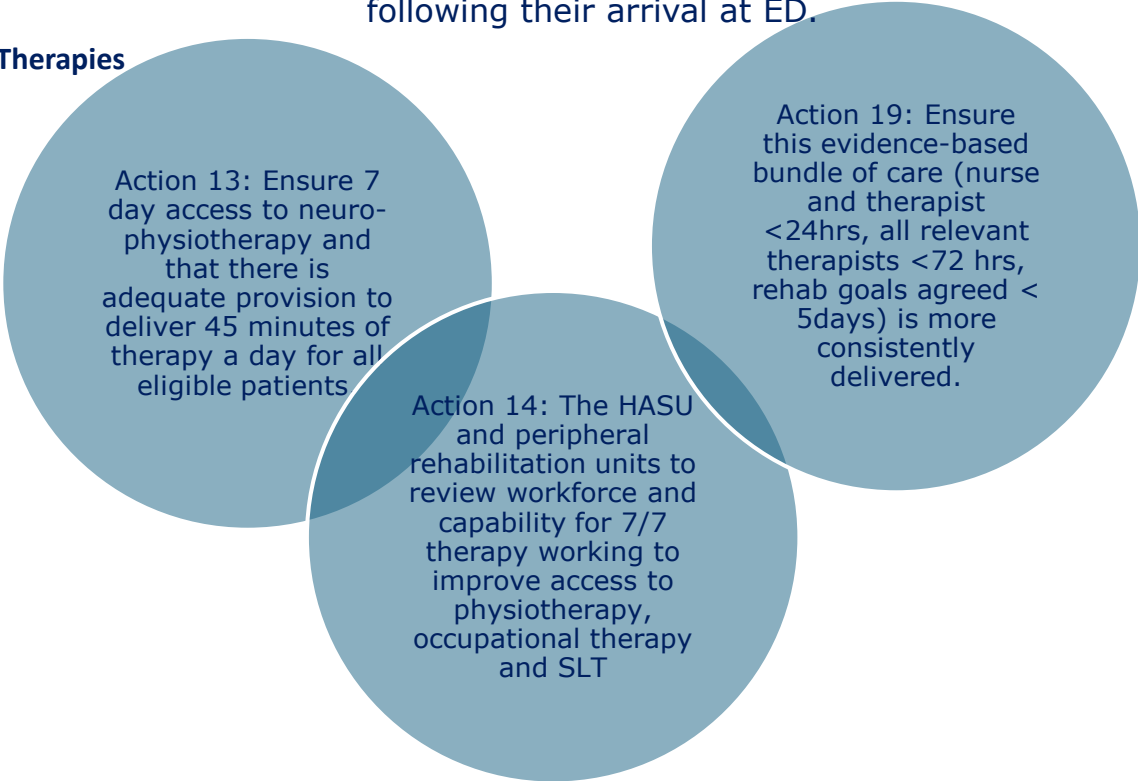


Actions that need support 4/20

Acute Stroke

Action 4: ABUHB to develop a strategy to improve direct access to the stroke unit within 4 hours of presentation. Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome. Ringfenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ringfenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.

Therapies



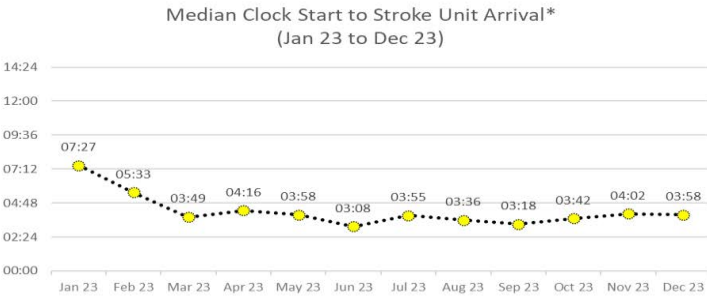
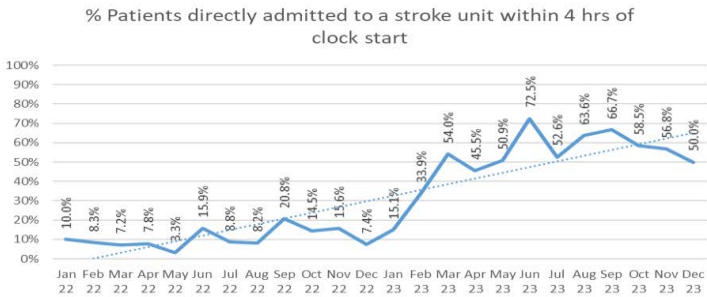
There is good evidence of early supported discharge and the delivery of therapy in people’s homes. There are, however, significant social care delays. Findings from the Stroke Association survey show that 50% of patients feel abandoned following discharge.

ABUHB took part in the Welsh Leadership academy that ran last year and found the outcomes very valuable. They put a cohort of staff groups (e.g. doctors, 3rd sector, managers etc) through the programme and found that this is invaluable when it comes to team working and improving leadership and effectiveness of a service. Several staff also enrolled on the first Wales Stroke and Neuro Leadership Programme which ran into the pandemic

This course has ceased to be available. Alternative course are being investigated.

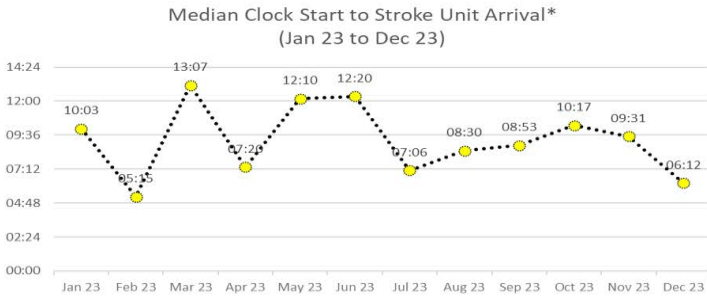
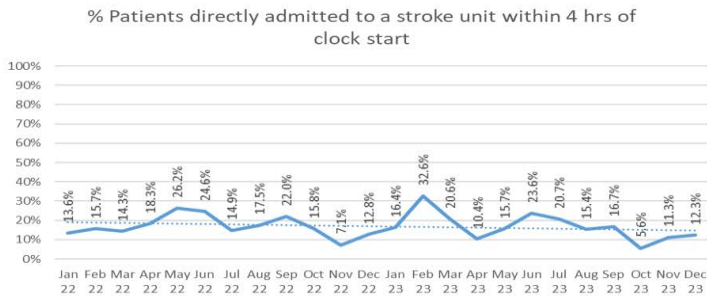
A comparison:

C&VUHB



- Stroke at GUH: 15 HASU beds + 4 'overflow' beds + 3 boarding spaces.
 - 21 beds are currently under stroke jurisdiction.
- Stroke admissions to HASU per day (average): 2.1
 - + Neurorehabilitation//Mimic/TIA demand: 1
- Average LOS on HASU: 4.4 days.
- Minimum** requirement of 4 beds to be ringfenced.
 - This can be two beds (bay/cubicle), and two boarding spaces.
 - Ideally, full ringfencing of all stroke beds.
- Any non-stroke patient on the HASU, or in the boarded/overflow beds must be moved off as a priority if strokes are waiting for admission.
- Maximum capacity for 21 admitted stroke patients (up from 15 in the Clinical Futures model).
- Essential that Rehabilitation beds in YYF are ringfenced to facilitate flow from the acute site.
- Stroke admissions come in waves, there will be times that beds will be empty, but the demand will come.

ABUHB



Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against
Risk level	Description
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on
Has this audit been placed on a Risk Register (N/A if above risk is None) - YES	
Local recommendations:	
1	Review of Medical JDs and job plans to make them more attractive
2	Adjustment of frequency of high-intensity weeks to reduce Consultant burn out on the HASU
3	Development of live dashboard to give real time performance data (need organisational support to do this)
4	Proposal to ring fence stroke beds

Report Successes:		Report Concerns:	
1	69% of patients spent at least 90% of their hospital stay in a specialist stroke unit compared to 73% nationally ~ ABUHB 68% 2021/2022	1	51% of applicable patients received swallow screening within 4 hrs of admission compared to 72% nationally ~ ABUHB 56% 2021/2022
2	92% of patients were assessed by stroke specialist within 24 hrs of admission compared to 83% nationally ~ ABUHB 92% 2021/2022	2	20.1% of patients were directly admitted to a stroke unit within 4 hrs of hospital arrival compared to 40% nationally ~ ABUHB 23 % 2021/2022
3	12.7% of all stroke patients received compared to 10.7% nationally thrombolysis ~ ABUHB 11.8% 2021/2022	3	73% of patient received stroke specialist nursing assessment within 24 hrs of admission compared to 89% nationally ~ ABUHB 90% 2021/2022
4	Thrombolysis rates are within range as per GIRFT (15-20%)	4	50% pf patients received brain imaging within 1 hr of hospital arrival compared to 57% nationally ~ ABUHB 58% 2021/2022
5	Implementation of BRAINOMIX AI decision support tool	5	17.1% of applicable patients directly admitted to a stroke unit within 4 hours of clock start AND who either receive thrombolysis or have a pre-specified justifiable reason ('no but') for why it could not be given compared to 40.1% nationally ~ ABUHB 22.1% 2021/2022
6	Reconfiguration of Rehabilitation Services to centralise in YYF, resulting in increased throughput on the HASU and reduced LOS (+4 patients per week, and -0.8 days respectively).	6	Getting patients to HASU within 4 hours of presentation, this is covered in the paper and presentation, as well as a proposal to improve this
		7	Recruitment of Senior Medical Staff, we are exploring the opportunity to appoint Specialist Doctors to backfill vacant Consultant posts
		8	Therapies staffing levels, circa 50% below recommended levels
		9	6-month follow-up metrics 0% - this will improve going forward now that the CNS team are returning from Maternity Leave.

	Recommendation (R) (Audience)	Report findings underlying this recommendation National:	ABUHB:	Progress:
R1	Reverse the recent decline in hyperacute specialist access for stroke. For action by: Acute trusts, Local Health Boards (LHBs), Regional Medical Directors (RMDs) and Integrated Stroke Delivery Networks (ISDNs).	40.2% of patients were directly admitted to a stroke unit within 4 hours in 2022/23, compared to 44.4% in 2021/22. 72.9% of patients spent at least 90% of their stay on a stroke unit in 2022/23, compared to 76.5% in 2021/22.	20.1% of patients were directly admitted to a stroke unit within 4 hours in 2022/23, compared to 23% in 2021/22. 68% of patients spent at least 90% of their stay on a stroke unit in 2022/23, compared to 76.5% in 2021/22.	Work ongoing (action 5)
R2	Increase the proportion of patients receiving the appropriate imaging immediately on arrival at hospital, to accelerate the identification of patients eligible for reperfusion treatments. For action by: Acute trusts, LHBs, RMDs, Radiology Networks and ISDNs.	56.9% of patients received brain imaging within 1 hour of arrival in 2022/23, compared to 54.6% in 2021/22.	58% of patients received brain imaging within 1 hour of arrival in 2022/23, compared to 50% in 2021/22.	Yet to be commenced (action 2)

	Recommendation (R) (Audience)	Report findings underlying this recommendation National:	ABUHB:	Progress:
R3	Increase the proportion of days on which people recovering from stroke receive rehabilitation therapy, both inside and outside hospital. For action by: Acute and community trusts and LHBs.	Percentage of days a patient requires therapy on which therapy was received: In hospital - OT: 61% in 2022/23 compared to 64.9% in 2021/22 - PT: 68.1% in 2022/23 compared to 72.3% in 2021/22 - SLT: 48.2% in 2022/23 compared to 51.7% in 2021/22 - Psychology: 9% in 2022/23 compared to 9.9% in 2021/22	Percentage of days a patient requires therapy on which therapy was received: In hospital - OT: 52.5% in 2022/23 compared to 56.6% in 2021/22 - PT: 59.9% in 2022/23 compared to 64.9% in 2021/22 - SLT: 44.3% in 2022/23 compared to 50.4% in 2021/22 - no data	Yet to be commenced (action 19)
R4	Increase the proportion of patients accessing stroke/neuro ESD and/or CRT. For action by: LHBs, acute and community trusts, supported by ISDNs and regional SQuIRE (Stroke Quality Improvement Rehabilitation) leads.	61% of patients discharged with a stroke/neurology-specific service (ESD and/or CRT) in 2022/23, compared to 60.1% in 2021/22.		Yet to be commenced (action 12)
R5	Reverse the recent decline in the proportion of stroke survivors who receive formal follow-up 6 months after their stroke. For action by: Acute and community trusts and Integrated Care Board (ICB) and LHB commissioners, supported by ISDNs and regional SQuIRE leads.			

Audit Title: MBRRACE-UK
Perinatal mortality surveillance
2024
State of the nation report

UK perinatal deaths of babies
born in 2022

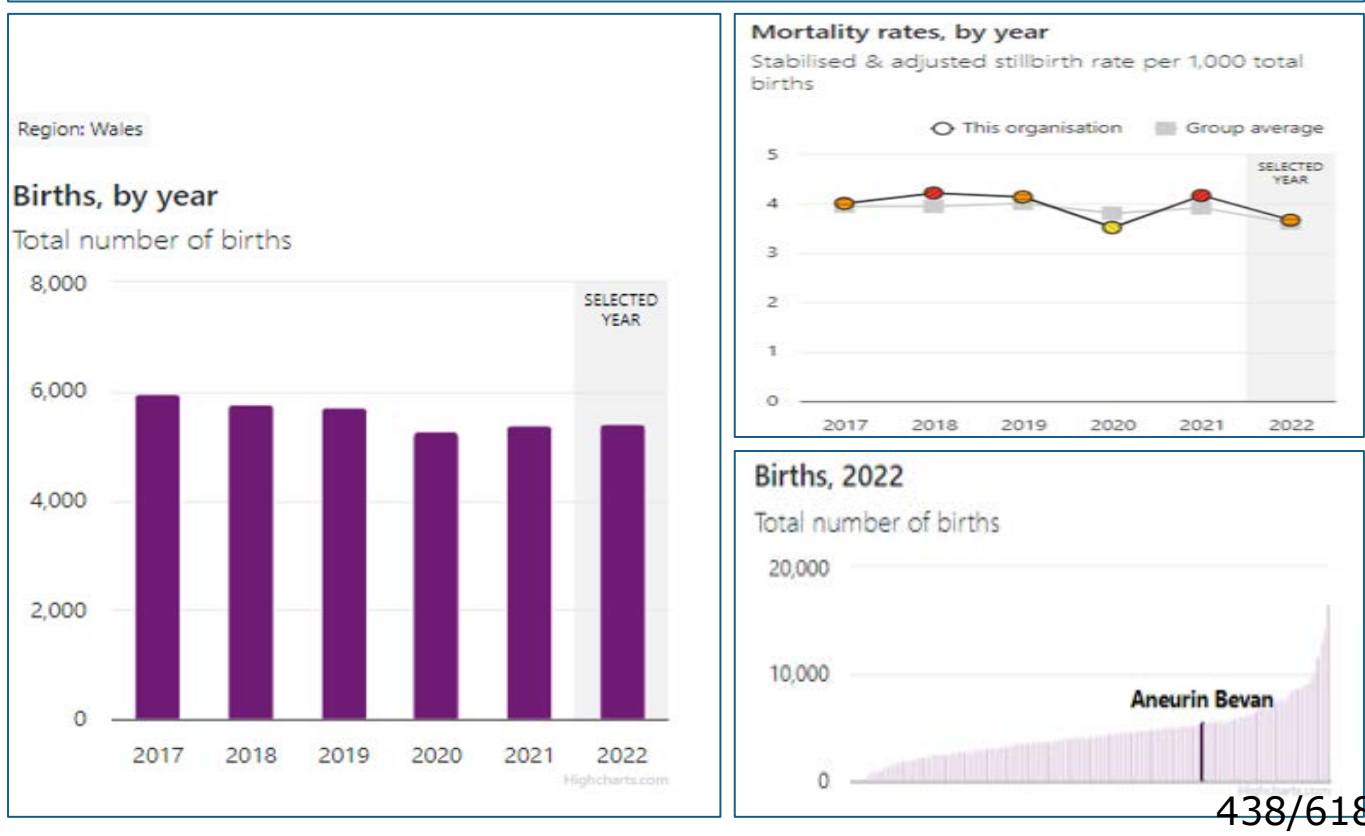
Clinical Lead:
Jayne Beasley - Head of
Midwifery & Gynaecology (& on
behalf of Dr Maity – Consultant
Neonatologist)

Rationale:	The report is divided into five sections: perinatal mortality rates in the UK; mortality rates for Trusts and Health Boards; mortality rates by gestational age; mortality rates by ethnicity and socioeconomic deprivation; and a description of the causes of perinatal death
Objectives:	This report focuses on births from 24 completed weeks' gestational age, with the exception of the section on mortality rates by gestational age, which also includes information on births at 22 to 23 completed weeks' gestational age. This avoids the influence of the wide disparity in the classification of babies born before 24 completed weeks' gestational age as a neonatal death or a late fetal loss.
Presented at Clinical Standards and Effectiveness Group – 26 th September 2024	

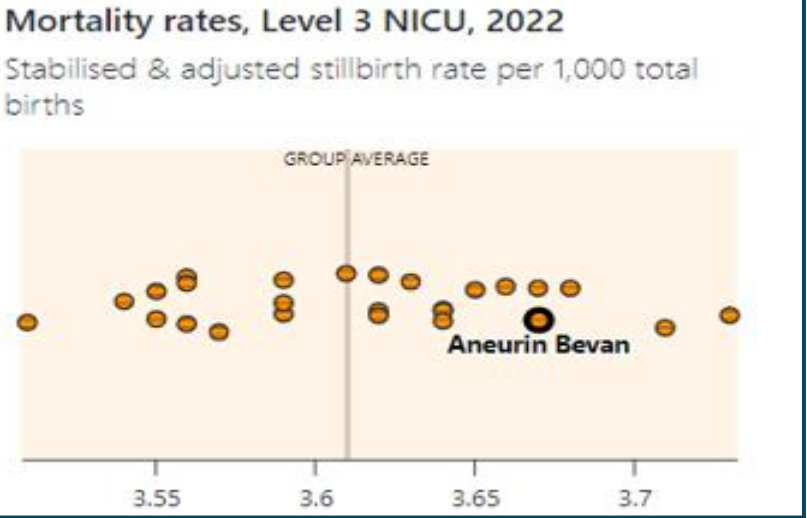
- Key messages
- Extended perinatal mortality rates decreased across the UK in 2022 (UK extended perinatal mortality rate: 5.04 per 1,000 total births) after a rise in 2021, although rates remain higher than both 2019 and 2020.
 - Compared with rates in 2021, stillbirth rates per 1,000 total births in 2022 were lower across all the devolved nations except Scotland, where there was a small increase: 3.35 (UK); 3.33 (England); 3.31 (Scotland); 3.63 (Wales); and 3.49 (Northern Ireland).
 - There were increases in the neonatal mortality rate per 1,000 live births in England and Wales compared with 2021: 1.69 (UK);1.67 (England); 1.59 (Scotland); 1.91 (Wales); and 2.29 (Northern Ireland).
- 68/135

Aneurin Bevan University Health Board

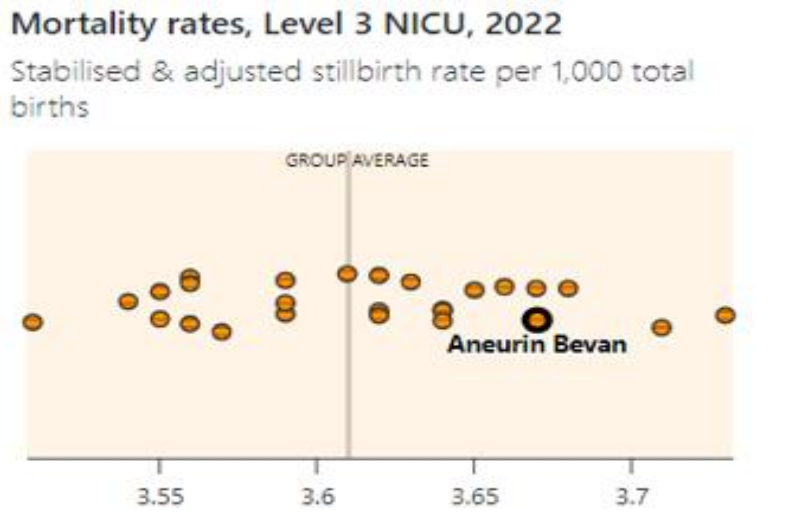
Year	Births	Crude stillbirth rate	Stabilised & adjusted stillbirth rate	Stabilised & adjusted stillbirth rate (95% CI)	Crude neonatal mortality rate	Stabilised & adjusted neonatal mortality rate	Stabilised & adjusted neonatal mortality rate (95% CI)	Crude extended perinatal mortality rate	Stabilised & adjusted extended perinatal mortality rate	Stabilised & adjusted extended perinatal mortality rate (95% CI)
2017	5,975	4.02	4.01	(3.32 to 4.74)	0.50	1.50	(0.90 to 2.36)	4.52	5.50	(4.76 to 6.97)
2018	5,778	5.02	4.22	(3.39 to 5.32)	2.26	2.26	(1.47 to 3.51)	7.27	6.47	(5.40 to 8.38)
2019	5,710	4.90	4.14	(3.47 to 5.28)	0.88	1.48	(0.93 to 2.48)	5.78	5.59	(4.81 to 7.25)
2020	5,292	2.46	3.52	(2.69 to 4.57)	1.14	1.58	(1.05 to 2.40)	3.59	5.09	(4.20 to 6.51)
2021	5,398	4.45	4.17	(3.23 to 5.36)	0.93	1.66	(1.05 to 2.51)	5.37	5.81	(4.80 to 7.62)



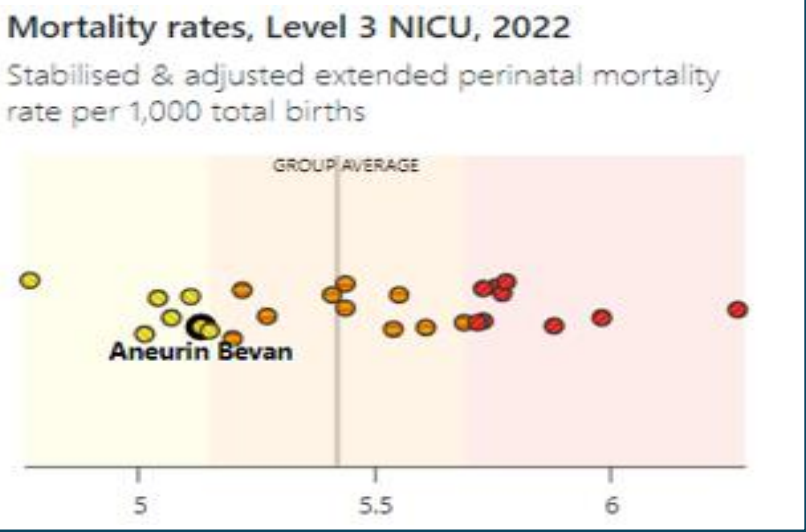
Mortality rates, Level 3 NICU, 2022
Stabilised & adjusted stillbirth rate per 1,000 total births



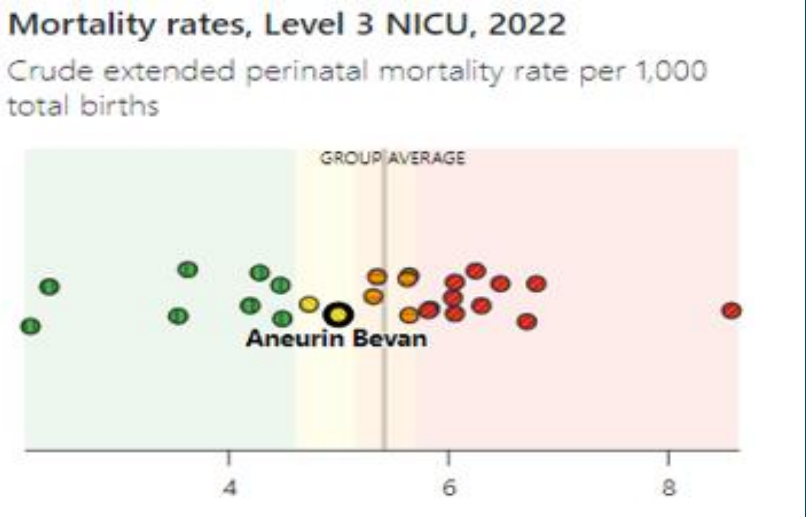
Mortality rates, Level 3 NICU, 2022
Stabilised & adjusted neonatal mortality rate per 1,000 live births



Mortality rates, Level 3 NICU, 2022
Stabilised & adjusted extended perinatal mortality rate per 1,000 total births



Mortality rates, Level 3 NICU, 2022
Crude extended perinatal mortality rate per 1,000 total births



Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against
Risk level	Description
Minor	Overall treatment or service suboptimal-minor implications for safety if unresolved
Report Successes:	
1	Raising awareness regarding stillbirths and neonatal deaths to the public and professionals – Nil intrapartum stillbirths, NND green
2	Increased support re public health messaging – MECC and smoking cessation
3	Increased support and funding re sonography services – detection of Small babies
4	Implementation of local and national audit and case reviews & Perinatal optimisation 97% compliance with audited data for MBRRACE 100% offer of PM
5	Development of maternity improvement plan – re PH messaging

Report Concerns:					
1	Variation in Still Birth rate in comparison to level 3 units, increase in 2021, reduction in 2020 and 2022 – prematurity greatest risk factor for NND	3	Higher % babies born post mature (5.6% as opposed to 1.5%)		
2	Mothers giving birth more likely to live in deprived areas (31%)	4	93% stillbirths reported within 7 days 13% NND reported within 7 days – target 100%		

Report Recommendations: <i>Audience: Commissioners</i>		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:

New Recommendation:					
1	Ensure neonatal intensive care capacity and resources reflect the increase in the numbers of babies born before 24 completed weeks’ gestational age receiving survival-focused care.	Review of cot capacity	S Papworth Clinical Director & C Satherley Service Group Manager	Ongoing	NICU GUH follow BAPM recommendations as per: The Perinatal optimisation pathway, Welsh Neonatal Network Peri prem pathway and National Cot configuration

Previous recommendations supported by most recent data – Audience: <i>UK Governments, Royal Colleges, Commissioners</i>					
2	Support external clinical input into the rigorous review of all stillbirths and neonatal deaths across the UK, to identify learning and common themes related to clinical care and service provision, delivery and organisation.	Monthly review of cases as per PMRT Monthly review of cases All Wales	PMRT Team & maternity and neonatal network	Ongoing	All cases undergo local review and form wider All Wales mat/neo network monthly review Local and national learning disseminated
3	Ensure healthcare providers adopt and use the BAPM Perinatal Optimisation Pathway, to improve preterm outcomes.	BAPM perinatal optimisation pathway adopted	A Pinto/ S Papworth maternity and neonatal network	Ongoing	In place with monthly audit of all standards across Wales
4	Continue to develop and implement targeted action, at national and organisational levels, to support the reduction of direct and indirect health inequalities.	Development of maternity services improvement plan	HoM – senior management team	Ongoing	Improvement plan in place, Forms part of IMTP, Working with P Health- smoking cessation, Audit cases, Digital data system

Local Recommendations:	S.M.A.R.T Actions:	Progress:
Monitoring of all stillbirth and Neonatal Deaths	Ongoing yearly Audit, MDT - PMRT review, Feedback and learning to wider local and national teams	Ongoing
There should be targeted Public Health messaging	MECC training, Maternity improvement plan, Smoking cessation carbon monoxide monitoring, Review of AN services and community continuity, Reintroduction of Healthy weight pathway, Digitalisation and information sharing – language	Ongoing
IOL to be offered at <42 weeks	Change in IOL for term plus women (T+12)	Complete
MBRRACE to receive 100% of cases by 7 days	Bereavement lead midwife in place, NICU have designated nurses supporting	Complete
Continued implementation of periprem pathway	Review of monthly audit of periprem standards, Wider feedback and learning	Ongoing

Audit Title:	Twist and Shout – Testicular Torsion	Clinical Lead:	Mr John Pollitt Consultant Surgeon
Ratio	To review the complete pathway and quality of care provided to children and young people 2 – 24 years of age who present to hospital with testicular torsion.		
Objectives:	The Study Advisory Group (SAG) identified the following areas to address: • Patient and parent/carer knowledge of torsion prior to the clinical episode and the availability of information for patients and parents/carers • Pre-hospital care • The admission process, including assessment and decision-making • The use of accurate diagnostic tools • Protocols for the management of testicular torsion and scrotal pain suggestive of torsion • Staffing availability, training, and use of networks of care • The timeliness of surgery including emergency surgery access • The appropriateness of transfer arrangements • The consent process • Surgical practice in respect of fixing testicles at the time of orchidectomy/exploration • Post-operative complications and follow-up of the patient • Audit of services		
Presented to Clinical Standards and Effectiveness Group: 26 th September 2024			

Testicular torsion occurs when the spermatic cord twists and cuts off the blood supply to the testicle. Testicular torsion is a surgical emergency requiring prompt diagnosis and surgical intervention to preserve the testicle. Delay in recognising testicular torsion and delay in presenting to hospital is known to lead to poorer outcomes. There needs to be greater public awareness about testicular torsion. Hospitals need to be equipped to deal with testicular torsion as an emergency operation, with senior clinicians able to decide whether surgery is needed and to be able to perform the surgery/anaesthetise the patient. If these services are not available, then there should be robust transfer arrangements in place to get the patient to theatre. Patients will need good information at discharge, and the option to return for further follow-up should they need psychological support or wish to discuss the use of a prosthesis.

NCEPOD Studies do not provide local data breakdown other than the participation numbers



Testicular torsion was not recognised by 157/239 (65.7%) patients or 83/239 (34.7%) parents/carers.

Only 294/403 (73.0%) patients had contacted a healthcare professional within six hours of developing symptoms.



60/475 (12.6%) patients were referred by a GP, 34/475 (7.2%) from an urgent treatment centre and 25/475 (5.3%) NHS 111.

91/143 (63.6%) hospitals reported that patients were transferred out of the hospital for treatment on occasions.

Patients not on a pathway were more likely to have their testicle removed (154/389; 39.6%) compared with those who were (16/67; 23.9%).



136/435 (31.3%) patients had their first assessment on arrival at hospital performed by a junior specialist trainee.

113/422 (26.8%) patients had not had their first ST3+ surgical review within two hours of arrival and 40/422 (9.5%) patients waited more than four hours.

There was a delay in making a diagnosis in 116/635 (18.3%) patients which impacted their care in 69/116 (59.5%) cases.



Information on prosthetic replacements could only be found in the case notes of 139/534 (26.0%) patients who had a testicle removed, with an explanation recorded for 83/139 (59.7%) patients.

Adequate written information given to the patient and family at discharge could only be found in the case notes of 123/233 (52.8%) patients.

IN THIS STUDY:

- The Patients aged 2 to 24 years, inclusive, admitted to hospital who had a diagnosis of testicular torsion (ICD10 code N44), and who underwent a non-elective operation for testicular torsion (OPCS codes N03.4; N05; N06; N08; N09; N13.2; N13.3 and N13.5) between 1st April 2021 and 31st March 2022.
- Patients admitted with scrotal pain (ICD10 codes N45 and N508) were also identified for context but were not sampled for inclusion in the clinical peer review process.
- The audit consists of 3 elements:
 - Organisational Questionnaire
 - Clinical Questionnaire
 - Case Note review

	Number of participating hospitals	Number of organisational questionnaires received	Number of cases selected	Number of clinician questionnaires returned	Number of sets of case notes returned
Aneurin Bevan UHB	1	1	4	4	4
Betsi Cadwaladr UHB	3	0	19	0	0
Cardiff & Vale UHB	1	1	6	6	6
Cwm Taf Morgannwg UHB	3	0	10	5	10
Hywel Dda UHB	3	1	7	5	7
Swansea Bay UHB	1	1	5	5	5

WHAT PATIENTS AND PARENTS/CARERS SAID

Young people and parents/carers were asked about their experience of care following admission to hospital and an operation for testicular torsion. The age of children and young people at the time of their operation ranged between 3-24 years with a median age of 14 years.

WHAT IS THE ONE THING YOU THINK COULD CHANGE TO IMPROVE CARE FOR FUTURE PATIENTS WHO HAVE TESTICULAR TORSION?



Only 3/17 young people were taught about testicular torsion at school or college.

12/17 young people felt that their symptoms were an emergency... HOWEVER, four of them delayed telling anyone about their symptoms and two of them said they experienced a delay before going to hospital.

Better public information - it's a surgical emergency and not a lot of people know it's a thing!!

Education for boys at school about symptoms to be aware of, how important it is to seek urgent assessment in hospital and not to be embarrassed to tell someone

Education for emergency department triage staff

Giving patients information about possible outcomes

GPs to ask the question so preventative surgery could be done

Report Recommendations: RECOGNITION OF TESTICULAR TORSION IN PRIMARY CARE AND THE EMERGENCY DEPARTMENT		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
2	Update training modules for primary care, and emergency department staff, to emphasise the importance of early recognition of testicular torsion, including atypical or warning presentations, urgent referral pathways and timely surgery	Training for 1 st assessing clinicians (GP/A&E /NHS111)	RCGP/RCEM		
3	Reduce delays for patients with testicular pain/suspected testicular torsion by: - Minimising transfers to another hospital by referring patients to a hospital where scrotal exploration can be performed safely on-site – ideally including a pre-alert to the receiving hospital. - Ensuring that any essential transfer is as urgent as possible*, including when patients self-present but need to be at another hospital. - Having a clear, documented clinical pathway of care for patients with testicular pain/suspected testicular torsion in hospitals where surgery for testicular torsion is undertaken, which is communicated to all healthcare professionals involved in the care of this group of patients. - Auditing the testicular torsion pathway, at least annually, to identify areas for improvement.	Education of GPs A&E triage staff WAST			
4	Patients with suspected testicular torsion should have an urgent* referral and clinical review by a senior surgical decision-maker (minimum ST3 or equivalent) specialising in urology, paediatric surgery, or general surgery.	Pathway for testicular torsion in place at ABUHB Senior/EPIC A&E to delegate to surgical specialty. Annual audit	Senior A&E on site Surgical consultant on call Urology consultant on call MJKP (CL)		

Report Recommendations: PATHWAY IN HOSPITAL		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
5	A consensus is needed on the role of Doppler ultrasound in the care pathway for suspected testicular torsion to aid surgical decision-making whilst not adding delay to surgery.	Consensus to be drawn- Current practice is not to USS suspected torsion in this HB	BAUS/RCS/BAPS		
6	Perform surgery for testicular torsion as an immediate or urgent procedure (NCEPOD 1 or 2)*, once the decision to operate has been made.	Booked cat 1			

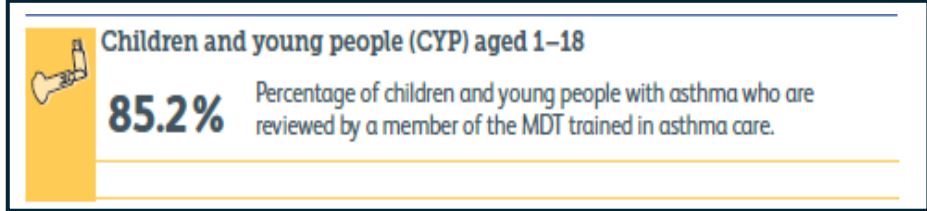
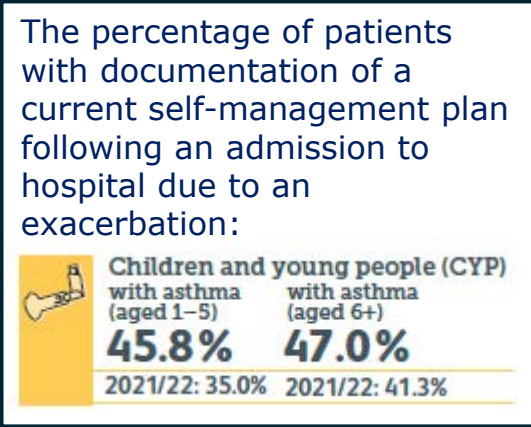
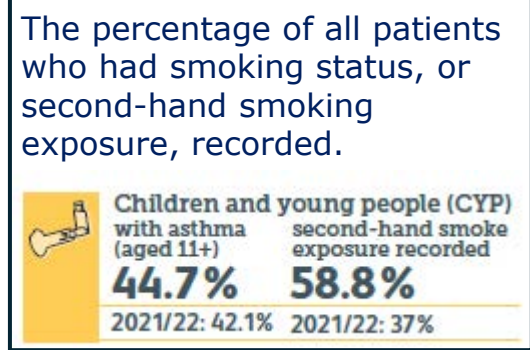
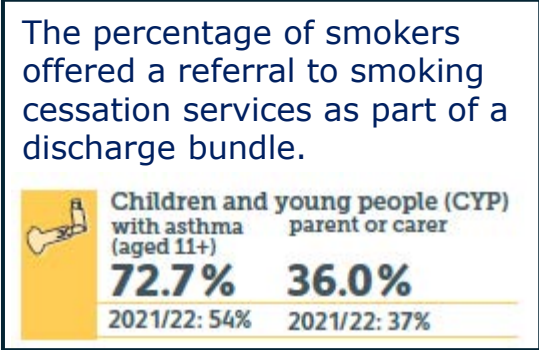
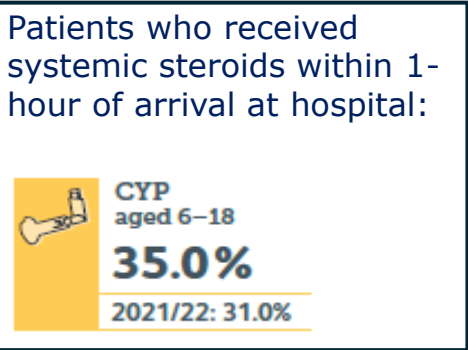
Report Recommendations: DISCHARGE AND FOLLOW-UP		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
7	Discharge information for patients, and parent/carers should include: a) Any follow-up arrangements. b) Delayed side effects that might occur following orchidectomy, or the risk of late testicular atrophy in patients who had an operation that led to no orchidectomy, but fixation (orchidopexy), including risks to fertility. c) Details of patient-initiated follow-up (PIFU) follow-up e.g. to discuss prosthetic implants for patients who underwent an orchidectomy. d) How to access psychological support.	All proven torsions are followed up at GPS clinic Or Urology if >16	Surgical team on d/c		
8	Review the care of all patients who underwent an orchidectomy in a multidisciplinary morbidity and mortality meeting. This should include primary care and, ideally a regional approach to shared Learning and quality improvement.	Audit of orchidectomies 2dry to torsion.	CL- GS & Urology	Feb 2025	In progress

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Optimise testicular pain pathway at ABUHB		MJKP/A&E		Ongoing discussion with A&E/Urol/GS directorates
2	Education of at risk group at school level to minimise delayed presentation				

Audit Title:	Breathing well An assessment of respiratory care in England and Wales	Clinical Lead:	Dr Pierrepont - Paediatrician								
Rationale:	NRAP works with patient panels run the Royal College of Paediatrics and Child Health (children and young people) to ensure our audit programme focuses on improvements in the areas most important to people living with respiratory conditions. The Asthma &Me Ambassadors are aged 13–21 and have joined together from across the country with a shared mission to improve asthma care and services for children and young people. Some of them have personal experiences of asthma, others have an interest through family or friends, all have a passion to make a difference. They have collected voices from children, young people and families, and hope to represent their voices in NRAP, with the support the support of decision makers to act and implement the changes they say are needed.										
Objectives:	Children aged 1-5 admitted to hospital with an exacerbation of asthma <table><tr><td>30.6%</td><td>22.7%</td><td>17.8%</td><td>16.2%</td><td>12.1%</td></tr></table> Children aged 6+ admitted to hospital with an exacerbation of asthma <table><tr><td>32.1%</td><td>23.4%</td><td>17.3%</td><td>14.4%</td><td>11.9%</td></tr></table> Most deprived Least deprived ■ Quintile 1 ■ Quintile 2 ■ Quintile 3 ■ Quintile 4 ■ Quintile 5 There is a national focus on health inequalities in respiratory care, as outlined in the NHS Long Term Plan and the Core20PLUS5 approaches for all age groups. Among people admitted to hospital with a COPD or asthma exacerbation, the highest proportion of people live in the most deprived. Importantly, in current analyses, it has not been observed that key outcomes related to the quality of care as inpatients vary based on the level of deprivation of a person’s postcode. This suggests that the interaction between socio-economic inequalities and important clinical outcomes, including hospitalisation and mortality, are complex and driven by deep-rooted structural and societal factors associated with respiratory ill-health. Even though we need to see an improvement in the wider drivers of respiratory outcomes, it is crucial that we do everything we can to ensure that the standard of care given to all patients, regardless of their background, is as high as it can be.	30.6%	22.7%	17.8%	16.2%	12.1%	32.1%	23.4%	17.3%	14.4%	11.9%
30.6%	22.7%	17.8%	16.2%	12.1%							
32.1%	23.4%	17.3%	14.4%	11.9%							
Presented at Clinical Standards and Effectiveness Group – 26 th September 2024											

Spotlight on healthcare improvement
Providing optimal care remains a key healthcare improvement area for NRAP. We suggest the following areas of improvement for services:

- All services should participate in NRAP and achieve a minimum of 50% case ascertainment.
- Hospitals in England should ensure resources generated from achievement of asthma and COPD best practice tariff (BPT) are available to frontline clinical and administrative teams to support NRAP participation and quality improvement.
- Locally collected NRAP data should be reviewed at least annually by both providers and commissioners to monitor delivery of optimal care and drive improvement.
- Specifically, this should generate locally agreed actions plans to improve performance against national guidance on the first hour of care and specialist respiratory review within 24 hrs.



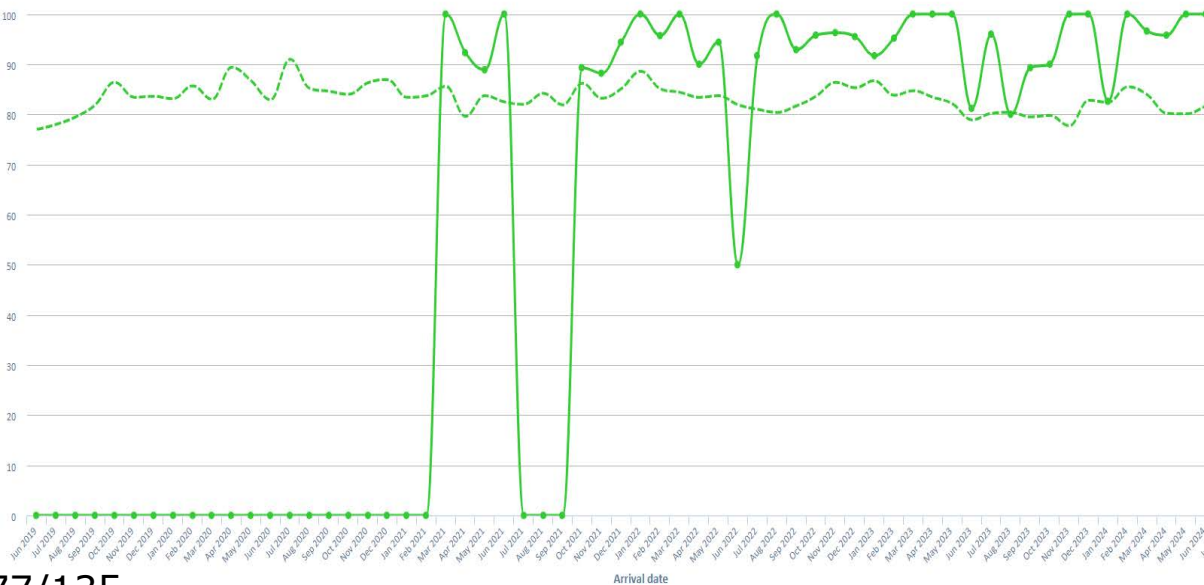
Hospital / Unit		KPI 1: Steroids administered within 1 hour of arrival (aged 6 - 18 years)%	KPI 2: Current smokers (patients 11+) with tobacco dependency addressed %	KPI 3: Current smokers (Parent/carers) with tobacco dependency addressed %	KPI 4: Inhaler technique checked as part of discharge planning %	KPI 5: Personalised Asthma Action Plan (PAAP) issued/reviewed as part of discharge planning %
The Grange University Hospital	Cases 47	27.8	0.0	27.3	91.5	91.5
All audit data	3,307	41.8	26.7	44.9	65.1	51.9

NHS Regional totals		KPI 1: Steroids administered within 1 hour of arrival (aged 6 - 18 years)%	KPI 2: Current smokers (patients 11+) with tobacco dependency addressed %	KPI 3: Current smokers (Parent/carers) with tobacco dependency addressed %	KPI 4: Inhaler technique checked as part of discharge planning %	KPI 5: Personalised Asthma Action Plan (PAAP) issued/reviewed as part of discharge planning %
Wales	Cases 148	26.1	0.0	44.1	77.8	65.3
All audit data	3,307	41.8	26.7	44.9	65.1	51.9

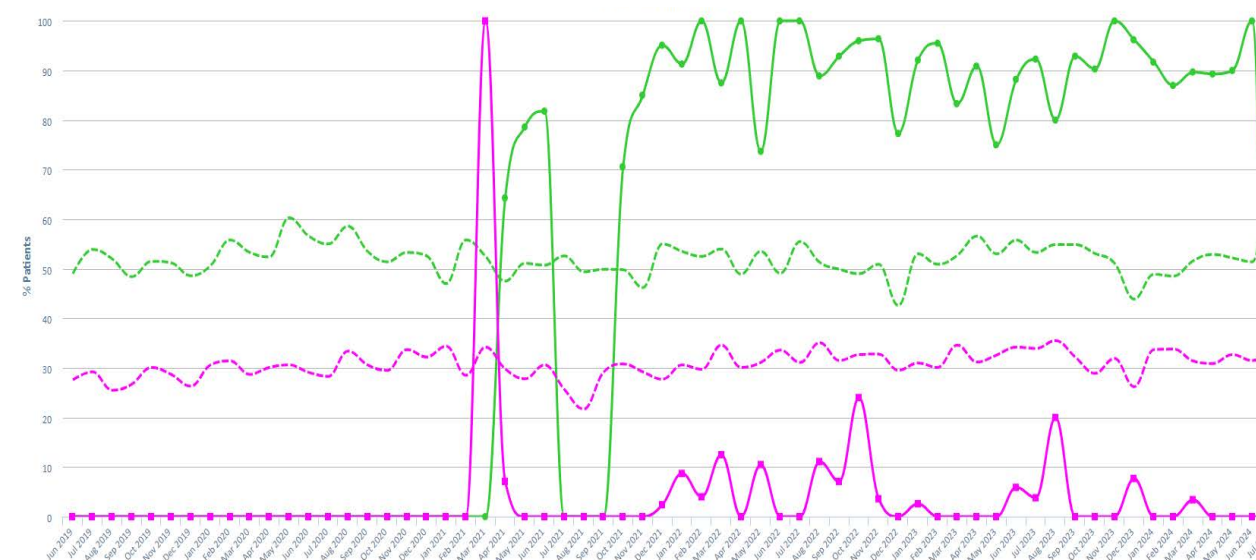
GUH – Green -% with inhaler technique checked
 Pink - % with PAAP issued
 Dotted line National data – solid lines relate to ABUHB



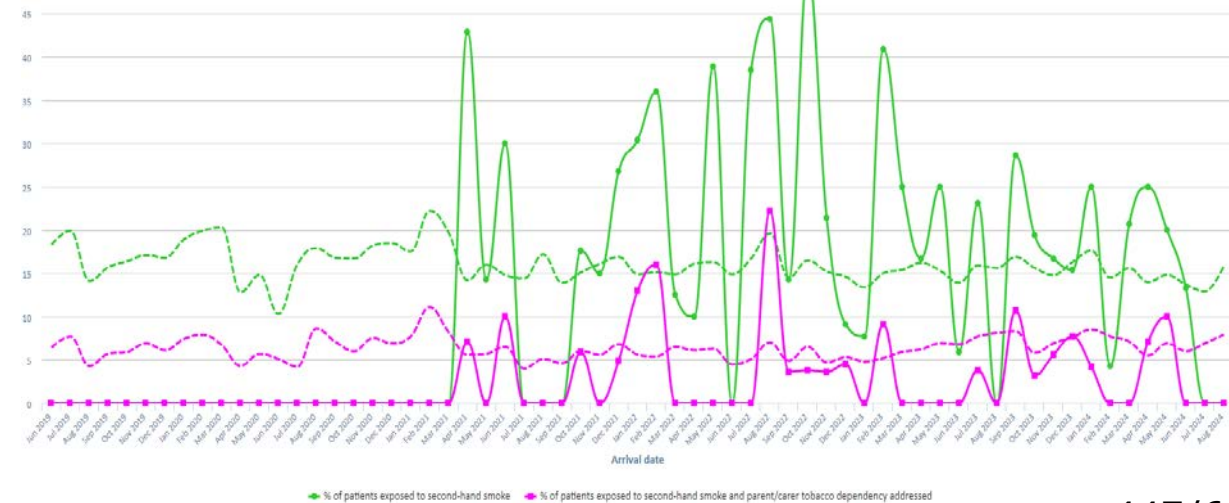
GUH - % Discharge Steroids
 Dotted line National data – solid line relate to ABUHB



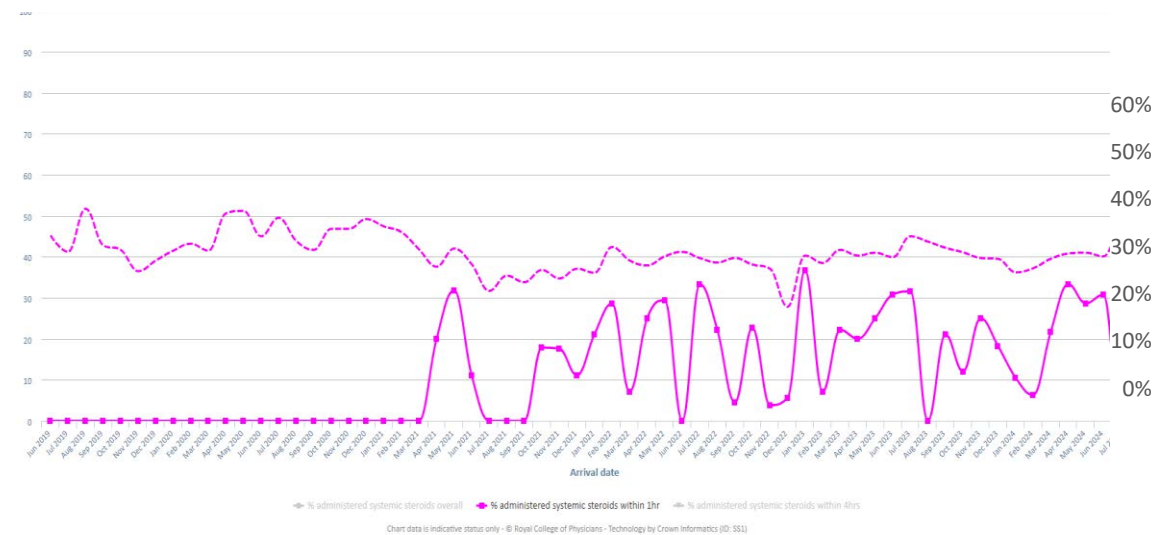
GUH – Green - % in receipt of a discharge bundle
 Pink - % referred to clinic within 4 weeks
 Dotted line – National Data, solid line – ABUHB data



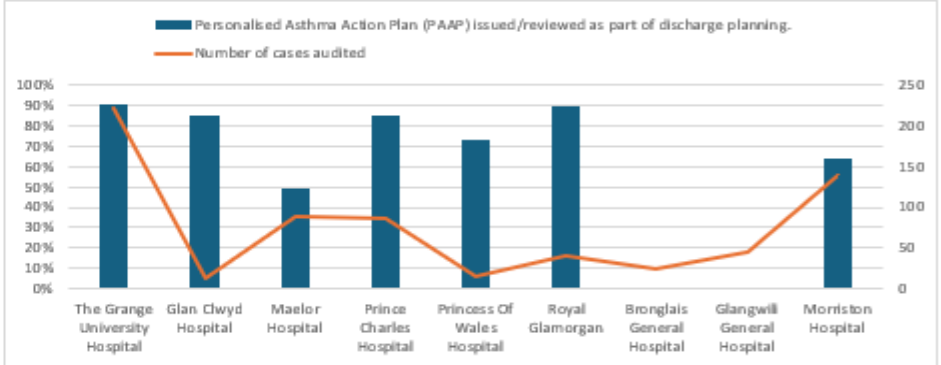
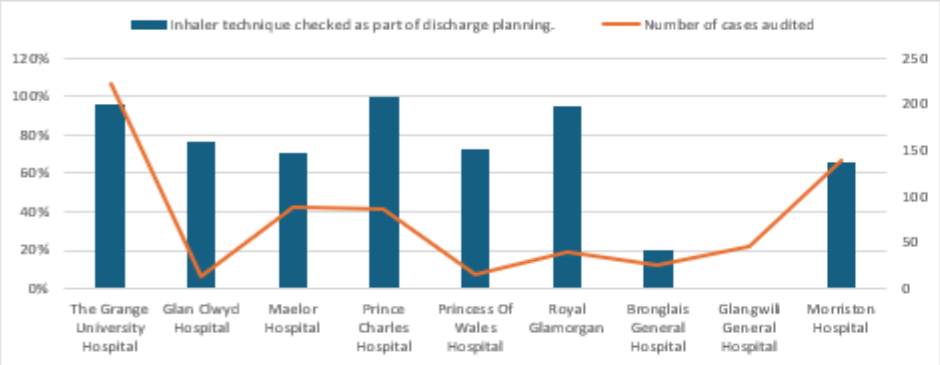
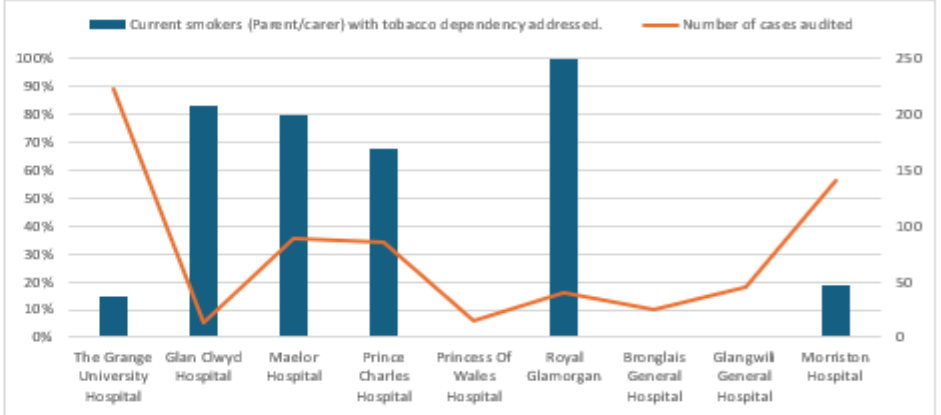
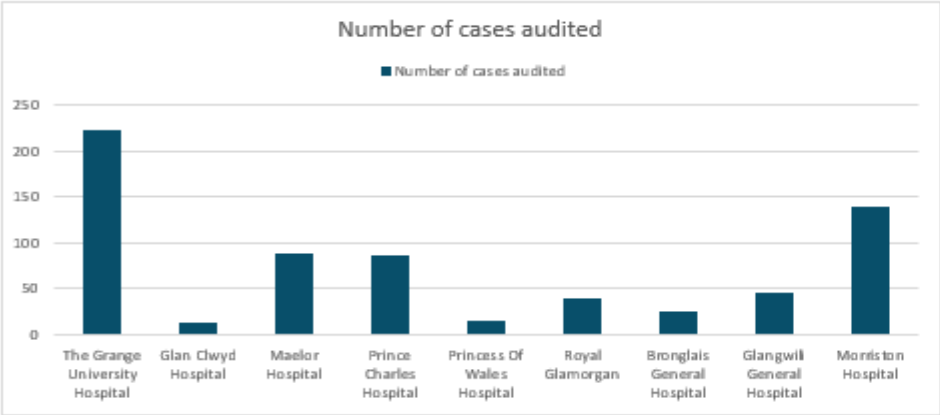
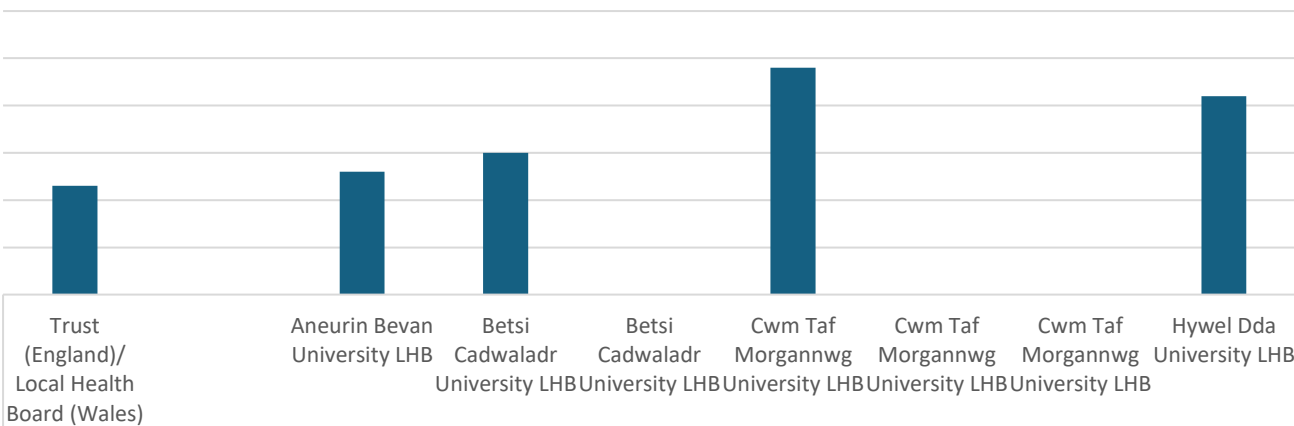
GUH – Green - % children exposed to second hand smoke
 Pink - % children exposed to second hand smoke & parent/carer tobacco dependency addressed
 Dotted line National data – solid line relate to ABUHB

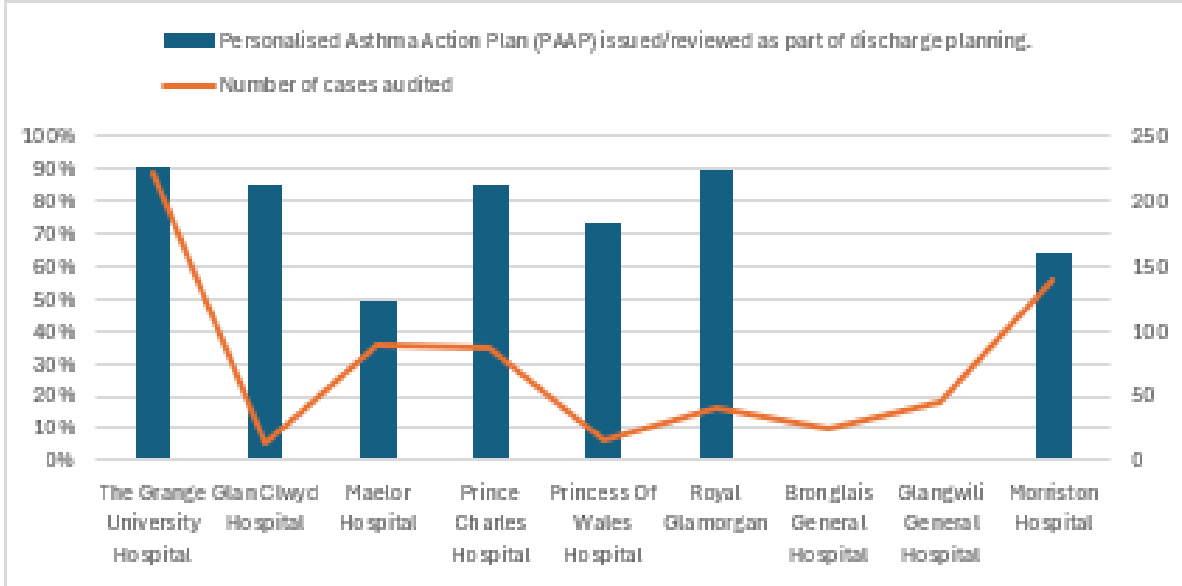
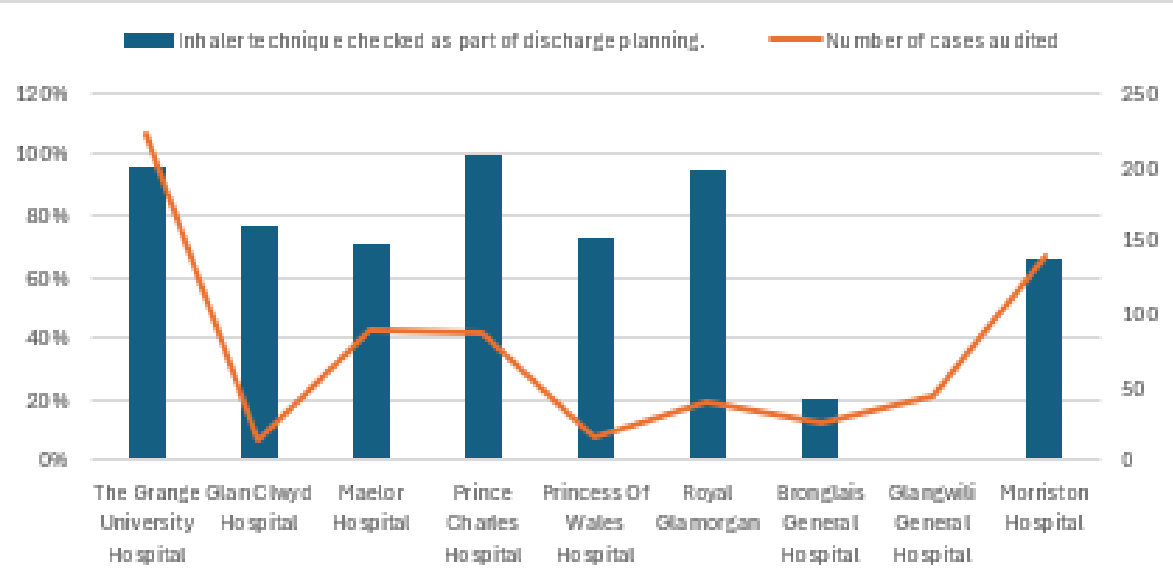
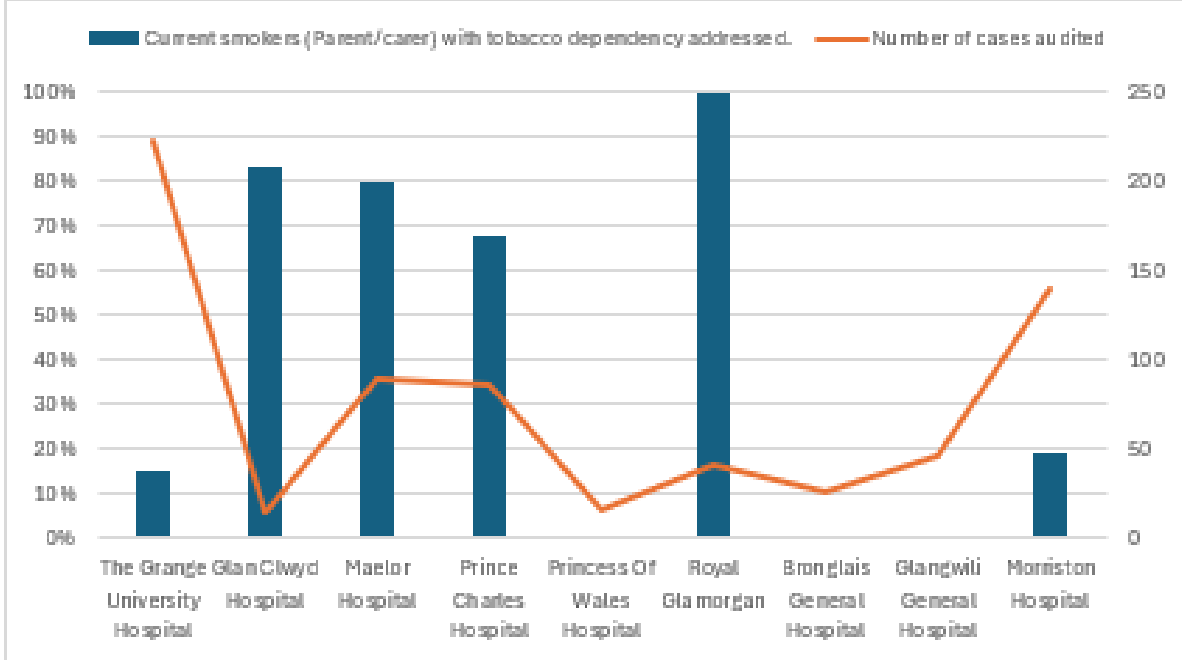
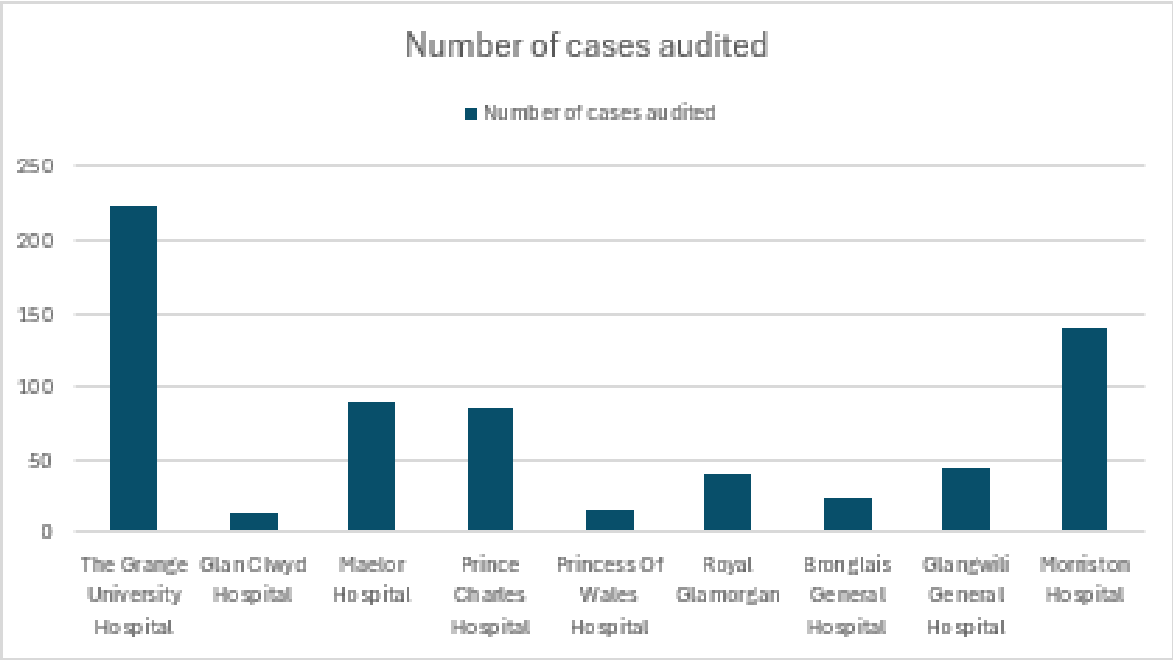


GUH - % Steroids in 1st hour
Dotted line National data – solid line relate to ABUHB



Steroids administered within one hour of arrival at hospital for children and young people of 6 - 18 years old.





Assurance level	Description	Select
Full	The project has fully achieved the standards or criteria being audited against	
Significant	The project has mostly achieved the standards or criteria being audited against	yes
Limited	The project did not achieve the standards or criteria being audited against	
Very limited	The project failed to achieve the standards or criteria being audited against	
Risk level	Description	Select
None	Standards met and findings demonstrate no risk to patient safety	
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved	yes
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon	
Major	Non-compliance with national standards with significant risk to patients if unresolved – Major risk to patient safety	
Catastrophic	Totally unacceptable level or quality of treatment/service - Gross failure to meet national standards – Gross failure to meet standards	

Has this audit been placed on a Risk Register (N/A if above risk is None)	YES/NO
If not on a risk register, why not:	

Report Successes:		Report Concerns:	
1	Data Capture is the best in Wales and in comparison, to the rest of the UK	1	Patient Flow issues at front end impact the 1 hr Steroid administration
2	Structure education pathways are good (exc. Smoking)	2	Actions from previous report have not all been actioned re pathways and updating proforma
3	Personalised Asthma Action Plans (PAAP) at discharge one of the best in Wales		

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Integrated care boards and local health boards should ensure that they achieve 100% service participation and that services achieve a minimum 50% case ascertainment in NRAP audits by May 2026. This will require all hospitals having named NRAP clinical leadership and dedicated audit support.				Achieved
2	All people with COPD and asthma who smoke, and smokers who are parents of children and young people with asthma, should be offered evidence-based treatment and referral for tobacco dependency.	To ensure the smoking status data is recorded on the proforma	Dr Marcus Pierrepont	31/12/2024	3/12
3	All people with asthma and COPD discharged from hospital after an acute event should have a current self-management plan. Where this is not achieved, services should work towards a target of 75% by May 2026. Services should prioritise patient-centred approaches and explore the role of clinically approved digitally supported self-management.				Achieved

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	A meeting planned with Primary Care to discuss pathways	Cancelled on 2 occasions	Asthma team in Primary and Secondary Care	31/12/2024	Ongoing
2	A joint meeting with Adult services to discuss internal pathways		Asthma Paediatric & Adults Services	31/12/2024	Ongoing

Endometriosis: A Long and Painful Road
A review of the quality of care provided to adult patients diagnosed with endometriosis

Clinical Lead:
Dr Anita Nargund – Consultant Obstetrics and Gynaecology

Rationale:	Endometriosis is often treated as multiple episodes of acute care, instead of on a continuum like other chronic conditions, such as diabetes or inflammatory bowel disease. This approach needs to change to enable appropriate pathways of care, holistic and medical management, discharge planning and follow-up.
Objectives:	To review remediable factors in the quality of care provided to patients aged 18 and over with a surgical diagnosis of endometriosis To explore the clinical and organisational structures in place for the provision of care for patients with endometriosis, reviewing the entire pathway of care with a focus on: • Triage • Endometriosis specialist centres • Policies/protocols/care pathways in place – including delays • Communication between providers • Information and support for patients • Staffing • Surgical services • Imaging services • Holistic care and multidisciplinary team (MDT) provision • Discharge and follow-up

Presented at Clinical Standards and Effectiveness Group – 26th September 2024

Please note there is no local data for Aneurin Bevan University Health Board

OVERARCHING MESSAGE

Endometriosis is often treated as multiple episodes of acute care, instead of on a continuum such as chronic conditions like diabetes, to enable appropriate pathways of care, holistic and medical management, discharge planning and follow-up.

1. Endometriosis is a chronic condition

Unlike other chronic conditions, such as diabetes, there is no pathway for endometriosis.



36/136 (26.5%) patients had a **delay in initial referral to gynaecology** and in 25/36 patients this impacted on the quality of the care they received.

124/238 (52.1%) patients experienced **recurrence or persistence of endometriosis symptoms** following laparoscopy. 32/124 (25.8%) patients had a **delay in being reseen**.

2. Endometriosis has symptoms and signs that need earlier recognition for appropriate timely management

Signs and symptoms of endometriosis need to be recognised and not just seen as troublesome periods.



Presenting symptoms were most often **painful/irregular/heavy periods** or painful intercourse in 220/234 (94.0%) patients. But **also bowel** in 34/234 (14.5%) and **urinary/bladder** symptoms in 14/234 (6.0%) patients, or an **inability to conceive** in 12/234 (5.1%).

546/941 (58.0%) patients surveyed had **multiple visits to the GP** before any investigations were undertaken or treatment initiated.

3. Endometriosis affects quality of life. All patients should be asked about the effect of disease on their life

Access to supportive services would enable patients with endometriosis to manage their condition.



Failure to refer to supportive services resulted in **less than best practice** for 70/309 (22.7%) patients.

420/941 (44.6%) of survey respondents stated that they were **not asked at any point about the impact of symptoms on their quality of life**.

4. Endometriosis requires holistic, joined-up, multidisciplinary care

Multidisciplinary care is essential to ensure patients with endometriosis have all their care needs met.



Only 73/167 (43.7%) of **hospitals reported MDT meetings** were held for patients with endometriosis.

Reviewers found that only 27/242 (11.2%) patients were **formally discussed in an MDT meeting** and 28/215 (13.0%) patients who were not discussed **should have been**.

Demographics

The study population mainly comprised women of reproductive age with a mean age of 34 years (Figure 2.1).

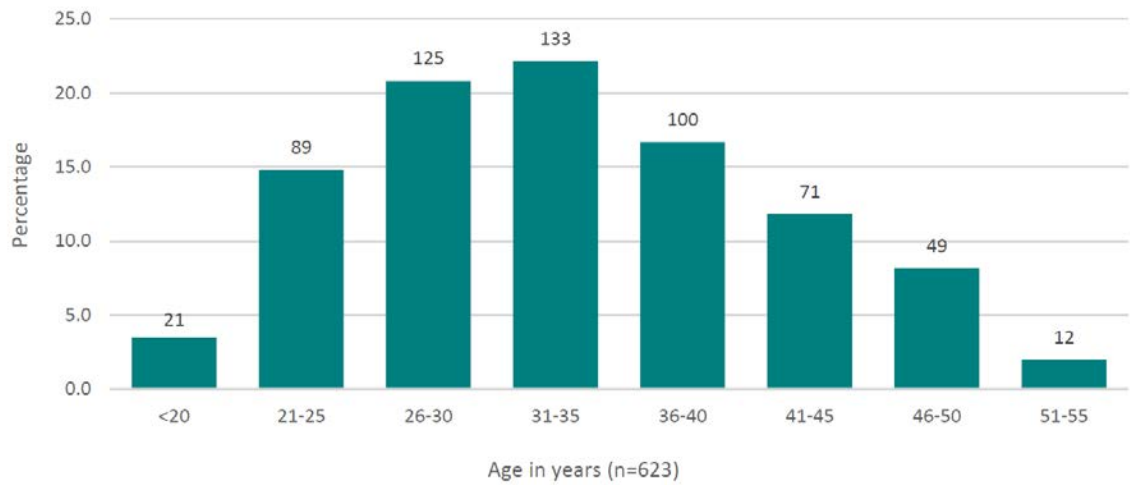


Figure 3.5 demonstrates the timeline of events in the treatment pathway for endometriosis for the patients in this study. It illustrates that once symptoms are recognised and reported, referral to appropriate services takes place and the time delay reduces. This suggests that education of both patients and GPs is essential in helping people to recognise symptoms of endometriosis to reduce the delay in initiating appropriate

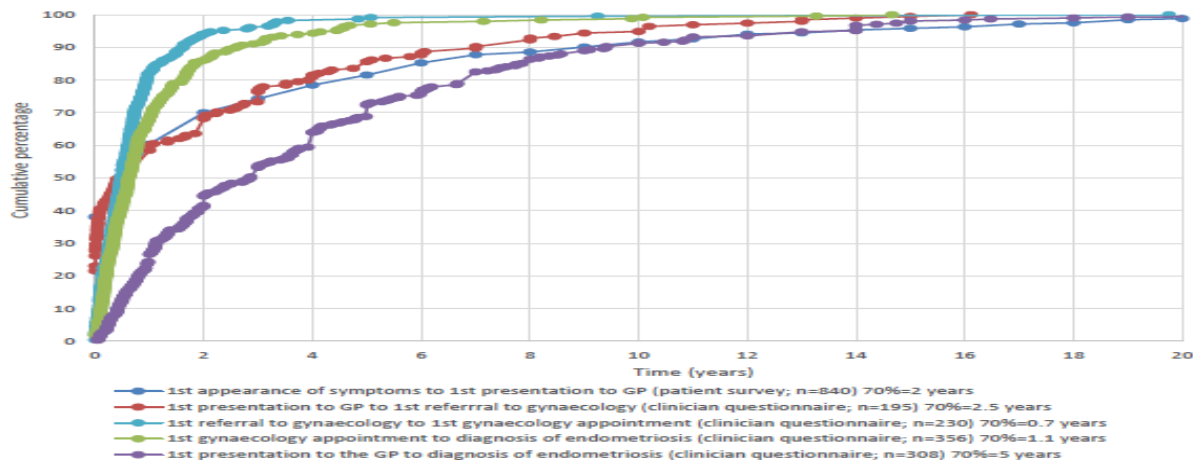


Table 4.1 shows which specialties were involved in the MDTs. However, these were not always whole-time equivalent roles. Within the MDTs, 111/167 (66.4%) hospitals had one whole-time gynaecologist, 34/167 (20.3%) had two, and 36/167 (21.5%) had three or more. Only 8/167 (4.8%) hospitals had more than one whole-time endometriosis clinical nurse specialist. In terms of pain specialists, 25/167 (14.9%) hospitals had one whole-time pain specialist within the endometriosis team, while 6/167 (3.5%) did not have any pain specialist available. Thirty-one hospitals had one or more dedicated colorectal surgeons as part of the service, 26/167 (15.5%) hospitals had one or more whole-time fertility specialist employed in the team and three hospitals had a dedicated physiotherapist. Forty-seven hospitals had at least one or more radiologist specialising in endometriosis.

Table 4.1 All the healthcare professionals who comprised the multidisciplinary team

	Number of hospitals	%
Gynaecologist	160	95.8
Radiologist	96	57.5
Colorectal surgeon	93	55.7
Urologist	85	50.9
Pain specialist	73	43.7
Endometriosis clinical nurse specialist	64	38.3
Reproductive medicine specialist	58	34.7
Physiotherapist	40	24.0
Histopathologist	35	21.0
General surgeon	35	21.0
Pharmacist	33	19.8
General nurse	29	17.4
Gynaecology specialist nurse	19	11.4
Psychologist	17	10.2
Dietitian	10	6.0
Occupational therapist	4	2.4
Other	10	6.0

Answers may be multiple; n=167, organisational data

Assurance level	Description	Risk level	Description
Significant	The project has mostly achieved the standards or criteria being audited against	Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon

Has this audit been placed on a Risk Register (N/A if above risk is None)	No
If not on a risk register, why not: Improvements to the service and work towards completing recommendations remains an ongoing process and the audit is mostly achieving the standards with areas of good practice not part of recommendations.	

Report Successes:		Report Concerns:	
1	ABUHB has been accredited by BSGE as an endometriosis centre.	1	No dedicated theatre list for joint surgery with colorectal surgeon/gynaecologist
2	Raising awareness of endometriosis with the public and patients. Raising awareness with healthcare professionals regarding endometriosis being a chronic condition	2	Cardiff declining referrals
3	CNS support in secondary care	3	If accreditation is not maintained there will be no clear pathway for women with stage 3 and 4 endometriosis involving the bowel which requires colorectal support
4	Simulation training for laparoscopic procedures	4	Withdrawal of pelvic pain MDT clinic
5	Trainees in clinic with consultant for development of skills	5	Lack of CNS in primary care
6	The use of PROM'S and PREM'S to attain quality-of-life and perception of disease	6	Lack of mental health support and psychologist. Need for more procedures to be undertaken as see and treat rather than diagnostic laparoscopy.

Report Recommendations:		S.M.A.R.T Actions:	Responsible:/Due Date:/Progress:
1	Raise awareness about endometriosis symptoms with the public and patients, highlighting that it is a chronic condition and how they can seek help.	- Open access to endometriosis CNS for teaching sessions at schools, universities, fundraising events this has already been taking place at a number of venues including Cardiff University. - Using the Health Boards (HB) social media platforms for Q&A events, short videos to talk about endometriosis. - Using the intranet/HB webpage to promote education around endometriosis. ABUHB has a dedicated page to endometriosis as well as signposting to support sites such as Endometriosis Cymru and Endometriosis UK.	Ms Nargund/ Jo Kitt CNS In Progress - OAK Talks – Patients can self-refer from the community to a zoom call regarding endometriosis and its treatment. There is an endometriosis roadshow planned for 2025 across all HB in Wales.

Report Recommendations:		S.M.A.R.T Actions:	Responsible:/Due Date:/Progress:
2	Raise awareness with all healthcare professionals that endometriosis is a chronic condition and should be treated as such.	Endometriosis/Pelvic pain study days. Offering teaching to GP’s, medical students. This is already incorporated into the teaching programme. Education for consultants working in other specialities. Highlighting endometriosis on the intranet during March which is endometriosis awareness month.	In progress - Development of an online learning tool on ESR for healthcare clinicians to complete.
3	Improve training on the recognition of symptoms of endometriosis, such as pelvic pain and heavy menstrual bleeding. a. In primary care - to support healthcare professionals in the initial assessment, and any ongoing care of patients b. In secondary care - enhanced training on endometriosis should be made available for all health care professionals who might care for patients with endometriosis.	- Training in medical management and excision of endometriosis already incorporated into the ABUHB teaching programme and this has been developed by the endometriosis lead. - Simulation training on a regular basis to teach laparoscopic procedures. - Trainees attending dedicated endometriosis clinics and theatre sessions with endometriosis lead consultant to develop skills.	Completed - ABUHB has achieved accreditation status from the BSGE as we do have the specialist skills/resources available as bowel surgeons are supporting in their own time on an adhoc basis. Outstanding - <i>There are concerns regarding the long term multidisciplinary surgical management of endometriosis as currently there is NO dedicated theatre list for a colorectal surgeon to do a joint case with the gynaecologist. Funding for bowel surgeons is not available and Cardiff are declining referrals due to their own vast caseload.</i>
	<i>If accreditation is not maintained there will be no clear pathway for women with stage 3 and 4 endometriosis involving the bowel which requires colorectal support. This will unfortunately affect patients access to services they should be offered for this complex disease which affects their quality of life significantly.</i> <i>Another concern is the access to a dedicated pelvic pain anaesthetic consultant. ABUHB did have a dedicated multi-disciplinary pelvic pain clinic which involved, anaesthetist, gynaecologist, physiotherapist and psychologist. This was withdrawn during covid, and the funding was withdrawn so we can no longer provide this service to patients.</i>		Outstanding - <i>Dedicated theatre list for complex endometriosis cases on regular basis involving colorectal surgeon.</i> Outstanding - <i>To further develop sonographers' skills to recognise deep infiltrating endometriosis signs.</i>

Report Recommendations:		S.M.A.R.T Actions:	Responsible:/Due Date:/Progress:
4	Ask patients with endometriosis about the effects it has over and above physical symptoms, including its impact on their daily life and refer them as needed to support services (e.g. psychology/pain services), at all stages of the pathway.	The endometriosis CNS is a key contact for initial support. Both the nurse led, and consultant endometriosis clinic has a proforma that asks about patients' quality of life and the impact the disease has on it. This is also recorded on our PREM/PROM data in a quality-of-life score.	Outstanding - Access to mental health support for patients with endometriosis and living with a chronic illness. A dedicated pelvic pain psychologist would have a huge impact on patients' quality of life and perception of the disease. Outstanding - To approach occupational health to be part of our wider MDT to support patients further.
5	Ensure multidisciplinary teams/clinical networks are set up and utilised across all healthcare settings to help agree treatment plans and support women with confirmed endometriosis. Input from specialties should be proportionate to the patient's needs.	This service already exists within ABUHB with consultant and endometriosis nurse led MDT's taking place weekly. Monthly MDTs already exists with bladder, bowel, pelvic physio, sexual health, fertility, menopause, pain CNS as and when required for complex patients. The endometriosis nurse is also able to make contact to the above specialities on an ad hoc basis as required. For any joint cases we hold an MDT pre-operatively with the other specialities to plan the surgical management and ensure patient is fully aware of risks/benefits of procedure. We would benefit from psychology support but at present a business case would be needed for this.	Outstanding - Development and involvement of a primary care lead for endometriosis not just women's health. Occupational health involvement as endometriosis does affect impact on the ability to work. Outstanding - In the future we are looking to develop a nurse led nutritional advice-based clinic.
6	Manage pain effectively for patients who have endometriosis: - Set a low threshold for the prescription of analgesia - Set a low threshold for hormonal treatment which may improve pain as well as other symptoms –while always considering fertility intentions - Refer to pain management services as needed - In parallel, refer patients for non-medical pain management e.g. physiotherapy	This is largely managed in both the consultant led and nurse led endometriosis clinics. Education to patients around taking analgesia, using TENs, living well with pain etc. Advice can also be given to GPs as needed via email queries sent. Making care plans for patients to take to their G.P to explain the need for analgesia to help manage endometriosis. Utilising the ability to refer to pelvic physio.	In progress - We cannot refer direct to pain team if patients are awaiting surgery or any other investigations. There was a pre-existing multi-disciplinary pelvic pain clinic which unfortunately was stopped during covid. This needs to be re-instated with support from anaesthetic team.

Report Recommendations:		S.M.A.R.T Actions:	Responsible:/Due Date:/Progress:
7	Use interactions between patients with endometriosis and prescribing healthcare professionals to undertake a medication review.		Completed
8	Provide patients with clear, written information as part of the process that allows the patient to give informed consent for the laparoscopic diagnosis/treatment of endometriosis. This should form the basis of a documented discussion with the surgeon before the day of surgery. Include: a. What the procedure involves b. The purpose of the procedure e.g. to diagnose, stage, treat the symptoms of endometriosis, or a combination of these c. What the patient's expectations are d. The possible effects on endometriosis symptoms e. Risks, benefits and limitations f. The need for further laparoscopic/open surgery for recurrent endometriosis or if complications arise This is consistent with NICE guideline NG73	Dedicated consent clinic.	In progress - We provide patients with clear, written information as part of the process that allows the patient to give informed consent for the laparoscopic diagnosis/treatment of endometriosis. This process is performed in the endometriosis clinic or in any general gynaecology clinic if listing for diagnostic laparoscopy prior to surgery. Information leaflets should be given regarding proposed surgery, diagnostic laparoscopy or excision of deeply infiltrating endometriosis leaflet.
9	Provide patients with clear, written information at discharge following laparoscopic diagnosis/treatment of endometriosis, including who to contact and how to initiate direct access back into the endometriosis care pathway. a. Who to contact if they have any concerns, e.g. GP, endometriosis clinical nurse specialists, consultant b. The follow-up plan and ongoing management of the endometriosis c. The option of patient-initiated follow-up d. Types and dosages of medication they are on at discharge, including analgesia and hormone therapy e. The consideration of bone health for people with endometriosis on long-term hormonal medication, including nutrition, weight-bearing exercise and alcohol intake	Patients are all offered a follow up appointment or be left on a PIFU pathway and be able to access endometriosis CNS who can then offer an appointment or refer back to the consultant if needed. This ensures long term management of the condition to allow for medication and Implications – the case load is becoming too large for one endometriosis nurse hence ideally an endometriosis CNS is needed in primary care. Numbers into the service are recorded and data collected regarding the value of a PIFU pathway. symptom review as needed.	Completed Outstanding

Report Recommendations:		S.M.A.R.T Actions:	Responsible:/Due Date:/Progress:
10	Formalise a care pathway for patients with or suspected to have endometriosis. This pathway should include implementation of NICE guideline NG73, the European Society of Human Reproduction and Embryology (ESHRE) endometriosis guidelines, as well as the recommendations from this report.	Endometriosis referral pathway.pptx (sharepoint.com) Guidelines Ref Forms - OneDrive (sharepoint.com) Guidelines Ref Forms - OneDrive (sharepoint.com)	Completed
11	a. Collect surgical outcome data, including patient-reported outcomes, for benchmarking. b. Review local practice against NICE guideline NG73, the recommendations in this report. c. Undertake clinical trials to ascertain the efficacy of surgery for endometriosis-associated symptoms, especially for minimal or mild endometriosis. d. Assess the use of pain medication, and the medical treatment of endometriosis. e. Explore the use of imaging modalities in the diagnosis of endometriosis.	• Collect surgical outcome data, including patient-reported outcomes, for benchmarking. • Undertake clinical trials to ascertain the efficacy of surgery for endometriosis-associated symptoms, especially for minimal or mild endometriosis. (R&D are involved to see if we can be selected for trials) • Using PREM's and PROM's to assess the use of pain medication, and the medical treatment of endometriosis. We are already collecting this data in regard to Dienogest.	Completed
Completed		Not Due	In Progress
			Outstanding

Ninth Patient Report of the National Emergency Laparotomy Audit
December 2021 to March 2023

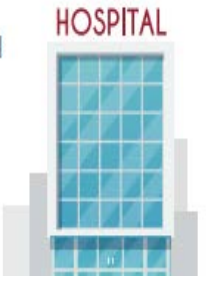
Clinical Leads:
Babu Muthuswamy - Consultant Intensivist & Anaesthetist
Helen Williams - Consultant Anaesthetist
Gethin Williams - Surgical Consultant

Rationale:	The NELA dataset is a comprehensive record of the processes and outcomes of care in England and Wales over 10 years. This dataset provides rich insights into improving the care of patients. Efforts should be made to learn the lessons contained within this data to support and drive local quality and service improvements. NELA is working with THIS Institute on a national programme to improve the timeliness of care in the early pathway. Work began in Spring 2024. Trusts and Health Boards are encouraged to join this work as participants in the discovery and testing phases.
Objectives:	This is the ninth annual report of the National Emergency Laparotomy Audit (NELA) and examines care received by NHS patients in England and Wales undergoing emergency laparotomy (emergency bowel surgery) between 1 December 2021 and 31 March 2023. Year 9 of the audit was extended to align with the NHS financial year
Presented at Clinical Standards and Effectiveness Group 28 th November 2024	

ABUHB No. of cases for year 8 was 331 and for year 9, with the additional 4 months of data to align with the NHS financial year was 410 cases

100% Case Ascertainment and data completeness

27,863 patients who had emergency bowel surgery in England and Wales were included in the Year 9 audit from 173 hospitals.



ABUHB frailty assessment in patient >=65 years improved from 94.1% in year 8 to 97.4% in year 9.

33.2% of patients aged 80 or over, or 65+ and frail, had geriatrician input (31.8% in Year 8).

Median time to antibiotics in patients with suspected sepsis was 3.1 hours from arrival in hospital.



Patients with sepsis suspected at time of arrival in hospital waited a median of **15.5 hours from time of admission** until surgery.

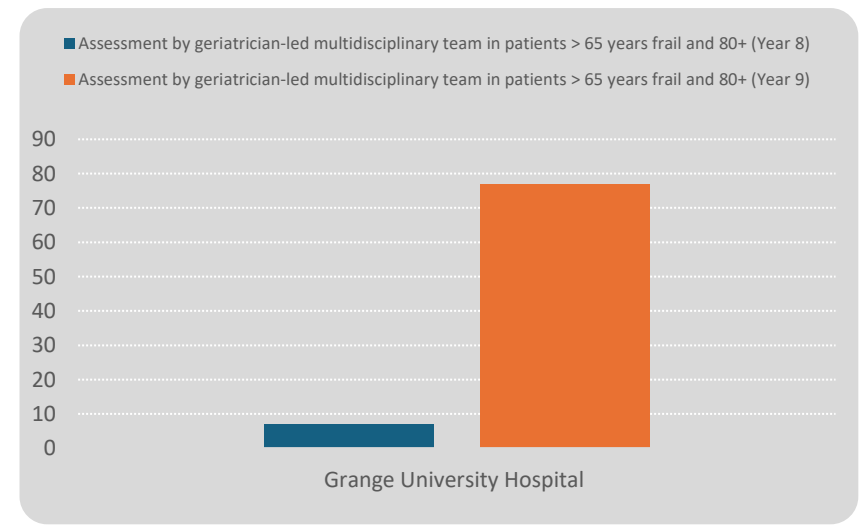
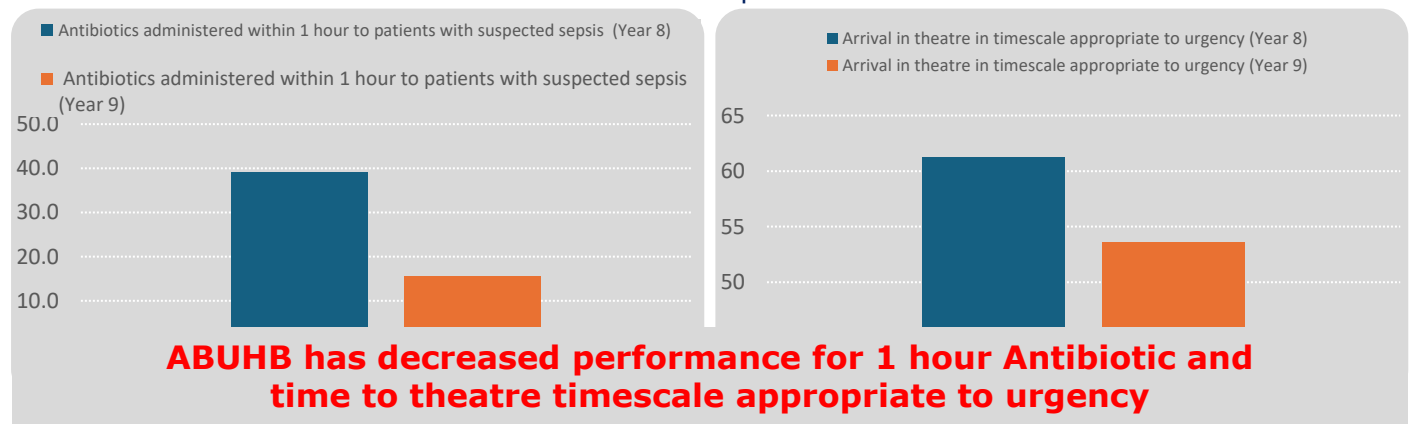


Message 1

Patients with significant and time-sensitive intra-abdominal pathologies, including those with suspected sepsis, frequently did not receive timely care consistent with published guidance.

For example, amongst those with suspected sepsis:

- only 20% received antibiotics within 1 hour
- 25% waited at least 6.5 hours after arrival in hospital before receiving antibiotics
- 50% waited for more than 15 hours before arrival in theatre
- performance varied significantly between hospitals.



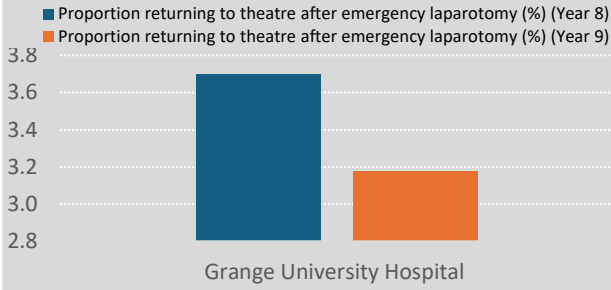
Message 2

The majority of older patients and those living with frailty do not receive expert multidisciplinary care after emergency laparotomy (33% receive input). There is compelling evidence of an association between geriatrician input and reduced mortality, supporting the case for improving this intervention.

Message 3

There is hospital-level variation in risk-adjusted mortality. Additionally, there is higher mortality amongst those from more deprived quintiles in each nation. Differences in outcomes between patients in different hospitals and from varying levels of deprivation need to be recognised and acknowledged. Reasons are likely multifactorial but must be explored further. **There was no change in Adjusted Mortality for GUH from Year 8 to Year 9, both 9.6%.**

Improvements in mortality have plateaued – **in-hospital mortality was 9.3%** compared to 9.2% in Year 8 and 9.1% in Year 7.



ABUHB returning to theatre after emergency laparotomy has decreased from 3.7% in year 8 to 3.2% in year 9,

80.3% of high-risk patients were admitted to critical care postoperatively (79.1% in Year 8). **13.9% of high-risk patients** were admitted to a normal ward.

Message 4

14% of high-risk patients did not receive immediate postoperative critical care contrary to published guidance. Instead, they were transferred to a normal ward following surgery; 7% of these patients subsequently died.

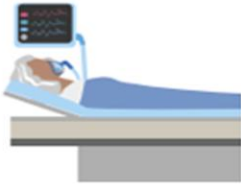
91.1% of patients received a preoperative CT scan **30.8% of patients** had their scan outsourced (26.3% in Year 8, 19.1% in Year 7).



86.1% of patients with a high documented risk had **consultant surgeon** input before surgery. **71.4% of patients** with a high documented risk had **consultant anaesthetist** input before surgery.

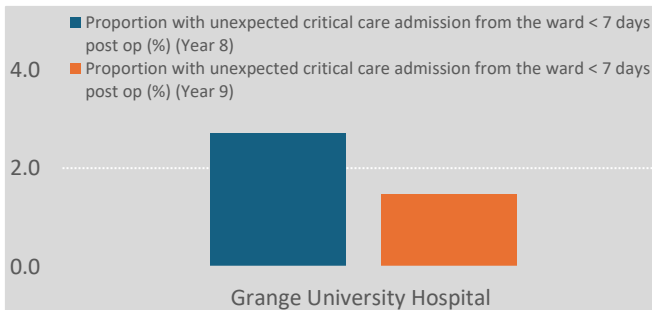
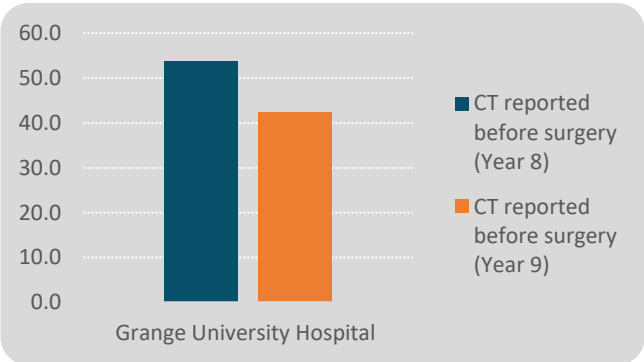
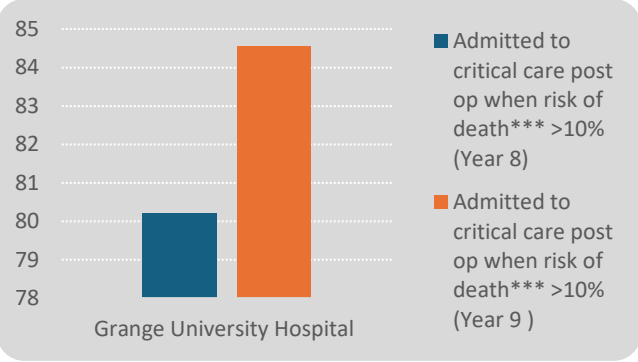


Presence of both **anaesthetic and surgical consultants** during surgery in high-risk patients was **90.4%** (**91.3% in Year 8**).



ABUHB pre-operative input with consultant Surgeon is 89.9% and Consultant Anaesthetists is 89.9% (both 88%)

Consultant Surgeon and Anaesthetist present in theatre when risk of death* >=5% was 77.6% in year 8 and increased to 90.4% for year 9**



Aneurin Bevan University Health Board saw a reduction in patients with unexpected return to Critical Care from the ward within 7 days post operatively.

Preoperative assessment of risk **has dropped below target**, to 84.6% after peaking at 86.8% in Year 8.



ABUHB Risk documented preoperatively in year 8 was 88.5% and has improved in year 9 to 96.1%

Postoperative length of hospital stay (LOS) has not significantly changed over the last five years, **with a median in Year 9 of 11 days.**

ABUHB patients LoS for year 8 was 8 days and in year 9 it has increased to 10 days LoS - this is the average LoS across Wales.

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

Not on Risk register as continuous pathway improvement

Key Successes:	
1	Reduction in the risk-adjusted mortality for NELA patients (significant drop from previous years)
2	Consultant presence for high-risk patients, both in anaesthetics and surgery
3	Return to theatre rates – low
4	Improved rates of COTE review post operatively (vs. national mean)
5	Successful running of the NELA M&M meetings throughout the year

Key Concerns:	
1	Contemporaneous input of patient-level data at the time of surgery (potential impacting on the quality assurance of the timelines for antibiotic administration, for example, and other metrics)
2	Failed business case for improved access to geriatricians for the elderly and frail patients
3	Critical care access could be better (vs elective surgical patients getting care in SHC and Critical care)
4	Timeliness of antibiotic administration to patients with sepsis or, deemed at high risk of sepsis

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Clinical Leads Local Recommendations : (if applicable)		S.M.A.R.T Actions:	Responsible :	Due Date:	Progress :
1	Royal Colleges should work together to publish consensus pathways for patients presenting to hospital who might require emergency laparotomy. These pathways should include: ❑ diagnostic, radiological, and initial management phases of a patient’s presentation prior to a decision to operate ❑ targets for timeliness of each pathway step. Royal Colleges of Emergency Medicine, Radiologists, Surgeons, and Anaesthetists.	NELA CRG to pick up with Royal College representatives on CRG	Royal Colleges		1	COTE consultant expansion needed	Business case taken to SCD	CD Surgery/ Divisional director	2025/26	In progress
2a)	Commissioners should ensure that Trusts/hospitals provide adequate specialist care for older patients and those with frailty following emergency laparotomy, per guidance published by the Royal College of Surgeons of England, British Geriatrics Society, and the Centre for Perioperative Care. Regional and local commissioners (Integrated Care Boards and Health Boards) in England and Wales.	Further expansion of sessional time from Geriatric consultant needed (Currently delivering 2 sessions per week)	Clinical director of surgery and divisional director SCD- aware of the business case. Concerns highlighted	2025/26	2	Contemporaneous inputting of patient level data, at the time of operation	CEPOD lead to be made aware	NELA leads	25/26	In progress
2b)	Commissioners should ensure that Trusts/hospitals provide adequate specialist To expand the pool of clinical staff with the requisite specialist skills, Royal Colleges of Physicians, Surgeons and Anaesthetists should consider working together to develop common competency-based training curriculae around optimising perioperative care for older patients and those living with frailty who undergo emergency surgery. Royal Colleges of Physicians, Anaesthetists and Surgeons.		Royal Colleges							
3	Healthcare services provided to those from more deprived backgrounds need to be matched to their greater need. This requires strategic planning. NHS England; Regional and local commissioners (Integrated Care Boards and Health Boards) in England and Wales	ABUHB to highlight to WG via relevant key stakeholders								

2/135

163/61

National Ovarian Cancer Audit

State of the Nation Report 2024

An audit of care received by women diagnosed with ovarian cancer in England in 2021 and in Wales in 2022

Published September 2024

Clinical Lead:

NICE Guidelines

Leena Gokhale - Consultant Obstetrics & Gynaecology

NG12 & CG122

Rationale:	The care for women with ovarian cancer is informed by various national guidelines. NOCA evaluates care for women with ovarian cancer against standards derived from guidelines for ovarian cancer (NG12 & CG122) that were published by the National Institute for Health and Clinical Excellence (NICE), which include recommendations for the recognition and referral pathways and the treatment of early (stage 1) and advanced (stage 2 to 4) ovarian cancer.
Objective s:	The National Ovarian Cancer Audit (NOCA) aims to evaluate the patterns of care and outcomes for women with ovarian cancer in England and Wales, and to support services to improve the quality of care for these women. Ovarian cancer affects the ovaries. It mostly affects women, but it can affect anyone who has ovaries. This State of the Nation (SotN) report publishes information on the care received by women diagnosed with ovarian cancer in England in 2021 and in Wales in 2022. It is the audit’s first annual assessment of NHS services. It aims to share good practice and highlight where care can be improved.

Presented at Clinical Standards and Effectiveness Group – 28th November 2024

Data Quality Indicators

DQ: Performance status

DQ: Ethnicity

DQ: Stage

DQ: Grade

Health Board	DQ: Performance status	DQ: Ethnicity	DQ: Stage	DQ: Grade
Aneurin Bevan University Health Board	95%	90%	90%	0%
Betsi Cadwaladr University Health Board	60%	20%	80%	0%
Cardiff and Vale University Health Board	50%	25%	90%	0%
Cwm Taf Morgannwg University Health Board	100%	20%	90%	0%
Hywel Dda University Health Board	95%	55%	85%	0%
Swansea Bay University Health Board	95%	50%	95%	0%
Wales	80%	45%	90%	0%

Quality Performance Indicators		
QPI 1	Patients to be discussed at diagnosis at a specialist MDT prior to a decision for treatment	Target 95 % 99%
QPI 2	Patients diagnosed with Stage 2-4 or unstaged Ovarian cancer to receive anticancer treatment of any type	Target 80% 65%
QPI 3	Patients with Stage 2-4/ unstaged ovarian cancer to receive cytoreductive surgery.	Minimum target 55% 46.5% Optimal target 70%.
QPI 4 a	Patients with ovarian cancer should have recording of FIGO stage, WHO performance status, at diagnosis	Target 95% 86%
b	Patients with ovarian cancer undergoing primary or interval debulking surgery should have recording of residual disease	Target 95% 100% (1pt)
QPI 5 a	Patients with non-mucinous epithelial ovarian cancer on histology to be tested for germline BRCA1/2 testing	Target 90%
b	Patients with advanced high grade serous and clear cell cancer on histology to be tested for tumour BRCA1/2 testing	Target 90%
QPI 6	Patients to be enrolled into an NCRI portfolio study at diagnosis.	Minimum Target 5%

Good Practice

Working with acute oncology services to identify women with possible ovarian cancer admitted in general medical and surgical wards and ensuring that decision making for these patients is done in conjunction with gynaecological oncology MDTs.

Data completeness:

12.0% of women with ovarian cancer in England in 2021 and 11.0% in Wales in 2022 did not have histology or cytology recorded in the national cancer registration data and 28.5% women in England and 12.3% in Wales did not have staging information recorded.

Diagnosis & staging

5,735 diagnoses of ovarian cancer in England in 2021

293 diagnoses of ovarian cancer in Wales in 2022 (excluding borderline ovarian tumours)

Stage in England in 2021

Stage in Wales in 2022

4: 31.3 %

1: 22.9 %

2: 6.1 %

3: 39.7 %

4: 33.5 %

1: 25.7 %

2: 5.8 %

3: 35.0 %

(based on those with complete staging information)

Emergency admissions

Approximately four out of ten women diagnosed with ovarian cancer in England in 2021 and in Wales in 2022 had an emergency admission 28 days prior to diagnosis.

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Performance indicator 1: 41.4% of women diagnosed in England in 2021 and 40.6% diagnosed in Wales in 2022 had an emergency admission within 28 days prior to diagnosis.			
Data Completeness Indicator 1: Emergency admission prior to diagnosis	Denominator (N)	Rate (%)	Rank among 130 care providers
Aneurin Bevan University Health Board	57	57.9%	18
Wales	293	40.6%	NA
ENGLAND & WALES	6,028	41.4%	NA
Performance Indicator 1: Emergency admission prior to diagnosis	Denominator (N)	Rate (%)	Rank among 43 cancer systems
South East Wales	133	45.9%	10
WALES	293	40.6%	NA
ENGLAND & WALES	6,028	41.4%	NA
Performance indicator 2: 72.7% of women diagnosed in England in 2021 and 76.7% in Wales in 2022 had any treatment (i.e., surgery and/ or chemotherapy) recorded between one month prior and nine months following diagnosis.			
Performance Indicator 2: Receipt of any treatment (surgery and/or chemotherapy)	Denominator (N)	Rate (%)	Rank among 43 cancer systems
South East Wales	104	79.0%	6
WALES	227	76.7%	NA
ENGLAND & WALES	4,978	72.9%	NA
Performance indicator 4: 69.4% of women diagnosed in England in 2021 and 74.4% in Wales in 2022 were alive one year after diagnosis (IQR across integrated gynaecological cancer systems 64.2% to 72.5% in England; min 63.0% and max 85.6% across three integrated gynaecological cancer systems in Wales).			
Performance indicator 4: One-year survival	Denominator (N)	Rate (%)	Rank among 43 cancer systems
South East Wales	133	75.9%	6
WALES	293	74.4%	NA
ENGLAND & WALES	6,028	69.6%	NA
Performance indicator 4: One-year survival (case-mix adjusted)	Denominator (N)	Rate (%)	Rank among 43 cancer systems
South East Wales	133	70.8%	19
WALES	293	74.4%	NA
ENGLAND & WALES	6,028	69.6%	NA

Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against
Risk level	Description
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Has this audit been placed on a Risk Register – Yes, Local risk register	

Key Successes:	
1	Data capture for Good Practice. AB highest in Wales
2	QPI 2, Receipt of any treatment: SE Wales better than England and the rest of Wales
3	QPI 4, 1 year survival: SE Wales better than England and the rest of Wales
Key Concerns:	
1	57% present as Emergency Admissions
2	No information available for the platinum based chemotherapy numbers
3	Access to data from Tertiary providers including UHW & Velindre

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Working with acute oncology services to identify women with possible ovarian cancer admitted in general medical and surgical wards and ensuring that decision making for these patients is done in conjunction with gynaecological oncology MDTs.	Work with AOS to develop pathways			Meet with newly appointed Lead AOS Nurse

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date: Progress:
1	Reduce the current rate of emergency admissions by: (i) Improving efforts to increase symptom awareness amongst women and primary care professionals. (ii) Reviewing diagnostic pathways to improve timely testing. Goal 1: Increase the proportion of patients receiving timely diagnosis and treatment decisions.	Liaise with PC for early referral	Leena Gokhale - Health Boards working with integrated gynaecological cancer systems.	RDC Referral pathway reviewed and complete. Radiology reporting standardisation agreed
2	Review the percentage of women with stage 2 to 4, or unstaged ovarian cancer who receive treatment (any type), explore and address some of the reasons behind the variation across integrated gynaecological cancer systems. Goal 3: Increase the proportion of patients receiving surgery. Goal 4: Increase the proportion of patients receiving chemotherapy.	Outside of the remit of Cancer Unit. This is within the UHW/VCC SLA	Leena Gokhale - Health Boards working with integrated gynaecological cancer systems.	Not applicable to local Health Board
3	Review the use of platinum-based chemotherapy in women with epithelial ovarian cancer (stage 2 to 4, or unstaged), explore and address some of the reasons behind the variation across integrated gynaecological cancer systems. Goal 4: Increase the proportion of patients receiving chemotherapy.	VCC SLA	Leena Gokhale - Health Boards working with integrated gynaecological cancer systems.	Not applicable to local Health Board
4	Review one-year survival in women diagnosed with ovarian cancer, explore and address some of the reasons behind the variation across integrated gynaecological cancer systems. Goal 5: Improve rates of survival and reduce variation in survival.	CSG and Tertiary unit	Leena Gokhale - Health Boards working with integrated gynaecological cancer systems.	Increasing symptom awareness amongst patients and PCC colleagues. Social Media awareness session posted on HB’s Facebook page
5	Improve the completeness and quality of data items recorded in the national cancer datasets (e.g. percentage of women with recorded diagnosis based on histology or cytology in the national cancer registration data and percentage of women with recorded staging information) Goal 1-5	Within our remit	Leena Gokhale - Health Boards working with integrated gynaecological cancer systems.	This will be audited in 12 months

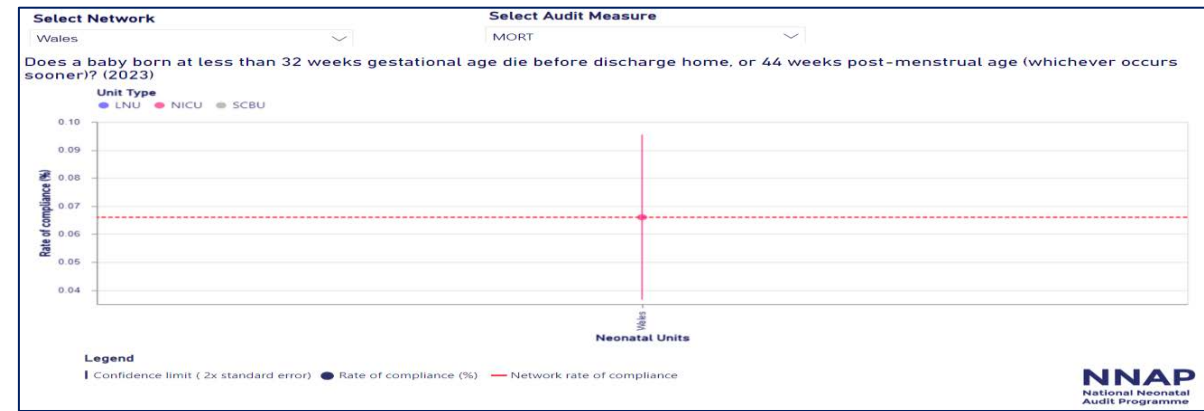
Audit Title: National Neonatal Audit Programme (NNAP) Summary report on 2023 data		Clinical Lead:	Dr Sunil Reddy –Neonatal Consultant
		Nice Guidelines	<u>NICE QS 193</u> Quality Statements 1-5
Rationale:	The National Neonatal Audit Programme (NNAP) assesses whether babies admitted to neonatal units receive consistent high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards. The NNAP also identifies variation in the provision of neonatal care at local unit, regional network and national levels. NNAP supports stakeholders to use audit data to stimulate improvement in care delivery and outcomes.		
Objectives:	The NNAP aims to help neonatal units improve care for babies and their families by identifying area of quality improvement in relation to the delivery and outcomes of care. The NNAP dashboard presents results for each of the 10-performance metrics as annual rolling averages and is updated monthly. 1. Mortality until discharge 2. Optimal perinatal care composite metric (component measures: antenatal steroids, antenatal magnesium sulphate, birth in a centre with a NICU, deferred cord clamping, normal temperature on admission, breastmilk feeding in the first 2 days of life) 3. Clinical outcomes composite metric (component measures: bloodstream infection, BPD, NEC, preterm brain injury) 4. Parental consultation within 24 hours of every admission 5. Parental inclusion in consultant ward rounds 6. Breastmilk feeding composite metric (component measures: breastmilk feeding at day 14, breastmilk feeding at discharge home) 7. Follow-up at two years 8. On-time screening for retinopathy of prematurity 9. Neonatal nurse staffing 10. Non-invasive breathing support		

Presented at Clinical Standards and Effectiveness Group – 28th November 2024

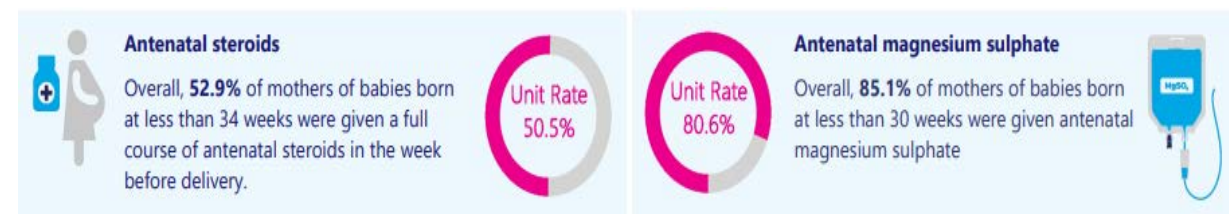
Aneurin Bevan University Health Board 10-performance metrics

Outcomes of Neonatal Care:

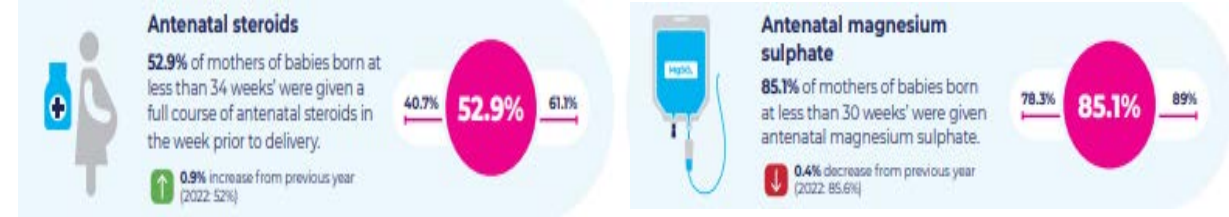
1. Mortality until discharge (Wales rate)
2. Optimal perinatal care composite metric:
 - a) antenatal steroids
 - b) antenatal magnesium sulphate
 - c) birth in a centre with a NICU
 - d) deferred cord clamping
 - e) normal temperature on admission
 - f) breastmilk feeding in the first 2 days of life



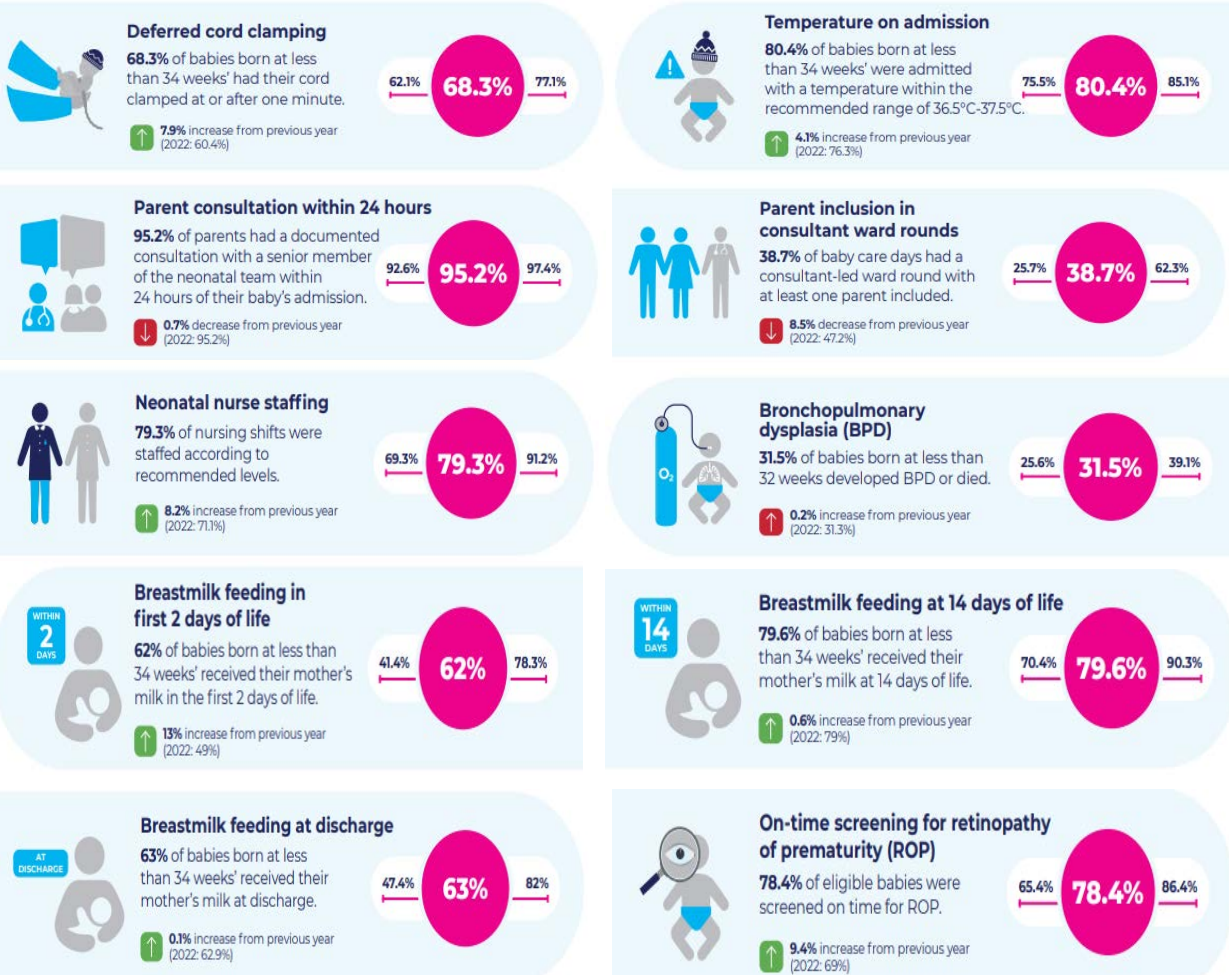
The Grange University Hospital



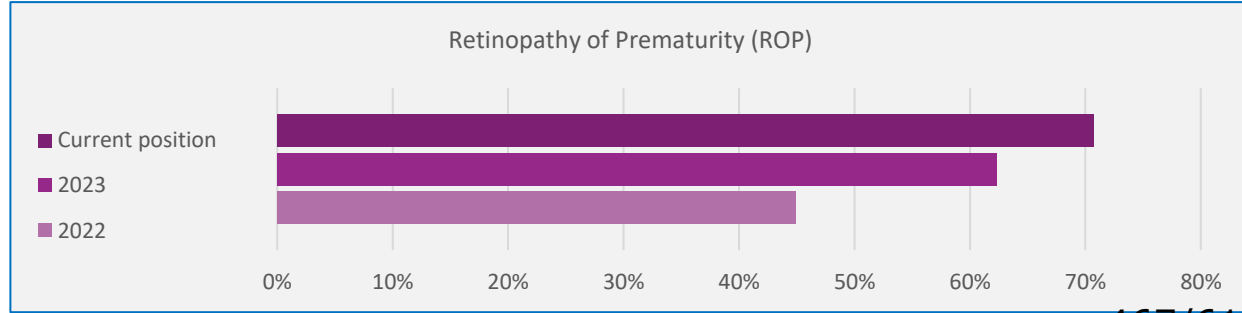
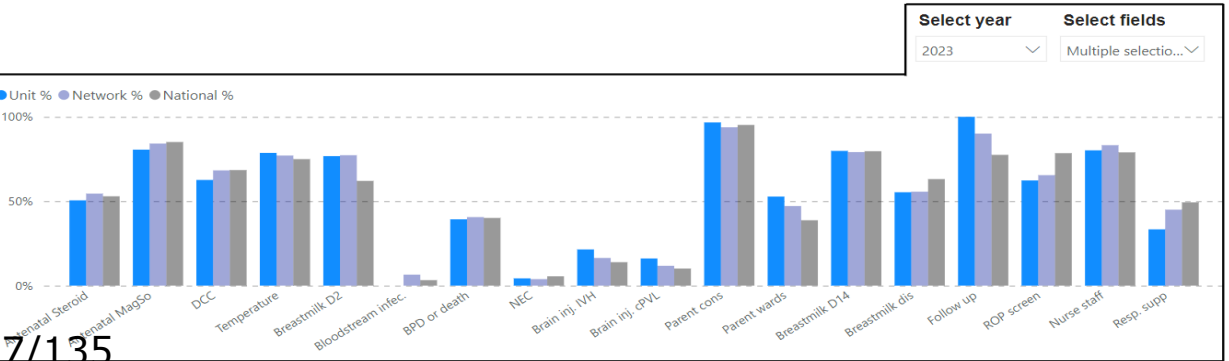
National rate:



National rate:



The Grange University Hospital



NICE Quality statement 1:

Preterm babies having respiratory support soon after birth and before admission to the neonatal unit are given continuous positive airways pressure (CPAP), if clinically appropriate, rather than invasive ventilation.

NICE Quality statement 2:

Preterm babies who need surfactant are given it using a minimally invasive technique if they do not need invasive ventilation.

NICE Quality statement 3:

Preterm babies having invasive ventilation are given volume-targeted ventilation (VTV) in combination with synchronised ventilation.

NICE Quality statement 4:

Preterm babies have a target oxygen saturation of 91% to 95% after stabilisation.

NICE Quality statement 5:

Parents and carers of preterm babies who are having respiratory support are helped to care for their baby.

Non-invasive breathing support

49.3% of babies born at less than 32 weeks' received only non-invasive breathing support in the first seven days of life.

↑ 1.7% increase from previous year (2022: 47.6%)

What proportion of babies born between 22-31 weeks gestation age only receive non-invasive breathing support during the first week of life?

The Grange University Hospital

33.3%

Select Unit or Network



Measures

MORT: Treatment effect of mortality

BPD: Treatment effect of bronchopulmonary dysplasia or death

NEC: Treatment effect of necrotising enterocolitis

BSI: Treatment effect of bloodstream infection

ANS: Antenatal steroids

ANMG: Antenatal magnesium sulphate

DCC: Deferred cord clamping

NormT: Normal temperature

BMD14: Breastmilk day 14

BMDIS: Breastmilk at discharge

BMD2: Breastmilk at day 2

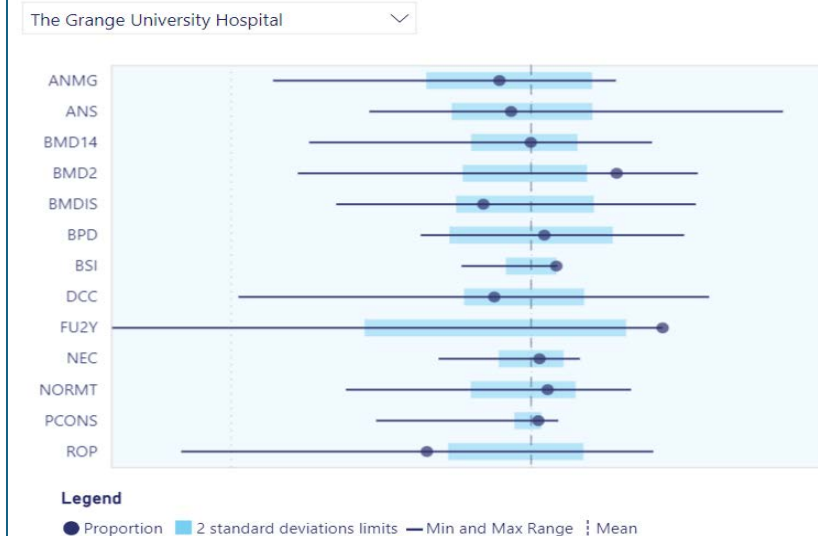
PCons: Parental consultation in 24h

ROP: Retinopathy of prematurity

FU2Y: Two year follow up

TRESP: Treatment effect of non-invasive respiratory support

Select Unit or Network



The above demonstrates Aneurin Bevan University Health Board are mostly within the 2 standard deviation limits, apart from:

- BD2 Breast milk at day 2 – better than std deviation and within max range
- Two year follow up – at 100%

- Retinopathy of prematurity remains outside the std deviation limit and is an ALERT outlier

Assurance level	Description	Key Successes:	
Significant	The project has mostly achieved the standards or criteria being audited against	1	The HB is above the mean on 8 of the 13 measures and within the mean on 4 measures
		2	Breast feeding at d/c – golden drops
Risk level	Description	Key Concerns:	
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved	1	Retinopathy of Prematurity – has increased since 2022 (44.9% to 62.3%) with the current data being 70.7%
Not placed on a Risk Register due to: Achieving most measures with continuous work ongoing to improve outcomes.		2	Work on ensuring data entry for late onset sepsis
		3.	Breast feeding rates at discharge- remains a challenge

Report Recommendations:			S.M.A.R.T Actions:	Responsible:	Due Date: Progress:
1	National Health Service England and health departments in the Devolved Governments should: - Ensure that Neonatal Networks with low rates of survival review their mortality data and develop locally prioritised improvement plans. Quality improvement activity should focus on best practices identified from Neonatal Networks exhibiting low mortality with particular attention given to differences in network structure, staffing, clinical governance, and clinical practices. - Review survival rates in very preterm infants and work with The National Institute for Health and Care Research (NIHR)to support future research investigating the reasons for the observed geographical variation in mortality.		The Health Board participates in the MATNEO & PERIPREM Cymru Networks	Dr Sunil Reddy	Ongoing
2	National Health Service England and health departments in the Devolved Governments should ensure that Neonatal Networks work with their constituent units and are: - Regularly reviewing and addressing their rates of missing data for preterm brain injury (intraventricular haemorrhage, cystic periventricular leukomalacia, and post haemorrhagic ventricular dilatation) and necrotising enterocolitis. - Utilising the NNAP restricted access dashboard to validate these data in order that units and networks can develop quality improvement plans based on babies’ outcomes.		- These are ongoing processes within the Health Board - Dashboards are used for benchmarking continuously	Dr Sunil Reddy	Ongoing
3	In order for perinatal teams to identify and implement the necessary perinatal interventions at the earliest opportunity, the Departments of Health in England, Wales, Scotland, and the Isle of Man should: - Commission public health campaigns aimed at raising public and professional awareness of the nature and importance of the signs and symptoms of preterm labour and the effectiveness of clinical interventions. - Work with relevant manufacturers and distributors to address supply chain challenges in the delivery of quantitative fetal fibronectin testing kits			- Badgernet is not being used within the maternity units. - Steroids & Magnesium Sulphate – already captured Maternity – looking at the data	
4	Neonatal Networks should ensure that their constituent units are using the NNAP restricted access dashboard to review their rates of optimal perinatal care delivery, identifying instances of non-adherence, and implementing quality improvement activities in response to them.			The Health Board is already reviewing dashboard data	
5	Neonatal Networks should work with their constituent units and encourage them to use the monthly data available in the NNAP restricted access dashboard to identify cases where optimal parental partnership in care did not occur. These data will support neonatal units to enhance their delivery of family centred care.			The Health Board is already reviewing dashboard data – good results for parental involvement	
Clinical Leads Local Recommendations: (if applicable)			S.M.A.R.T Actions:	Responsible:	Due Date:Progress:
1	ROP – local awareness, Ophthalmologist, using the RCPCH calculator, dedicated neonatal nurse entering the eligible babies, avoid postponing the exam		Monitor the improvement with online live dashboard	Sunil Reddy	

Audit Title:
National Audit of Primary Breast Cancer
State of the Nation Report 2024
An audit of care received by people diagnosed
with primary breast cancer in England and Wales
during 2019-2021

Published September 2024

Clinical Lead:
Rhiannon Foulkes – Consultant
Surgeon

Nice
Guidelines

NG101
QS12

Rationale:

The purpose of the National Audit of Primary Breast Cancer (NAoPri) is to evaluate the patterns of care and outcomes for people diagnosed with primary breast cancer in England and Wales, and to support services to improve the quality of care for these people.

For people treated in Wales, NATCAN receives the data from the Wales Cancer Network (WCN) in Public Health Wales. WCN provides patient-level data from the Cancer Network Information System Cymru (CaNISC) electronic patient record system.

This State of the Nation report publishes information on the care received by people diagnosed with breast cancer during 2019-21 in England and Wales. Wales also provided 2022 data which has been included. It is the audit’s first annual assessment of NHS breast services and shares examples of good practice as well as highlighting where care needs to improve.

Objectives:

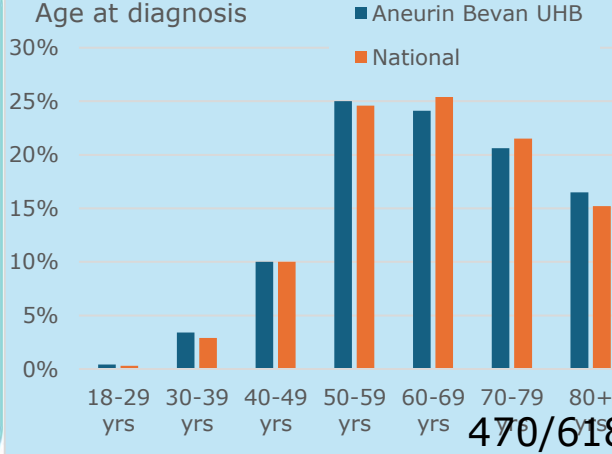
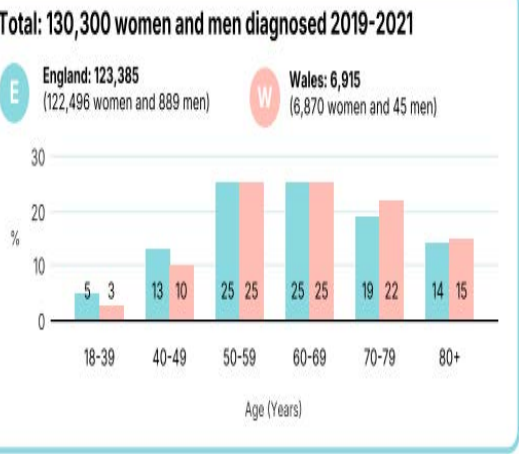
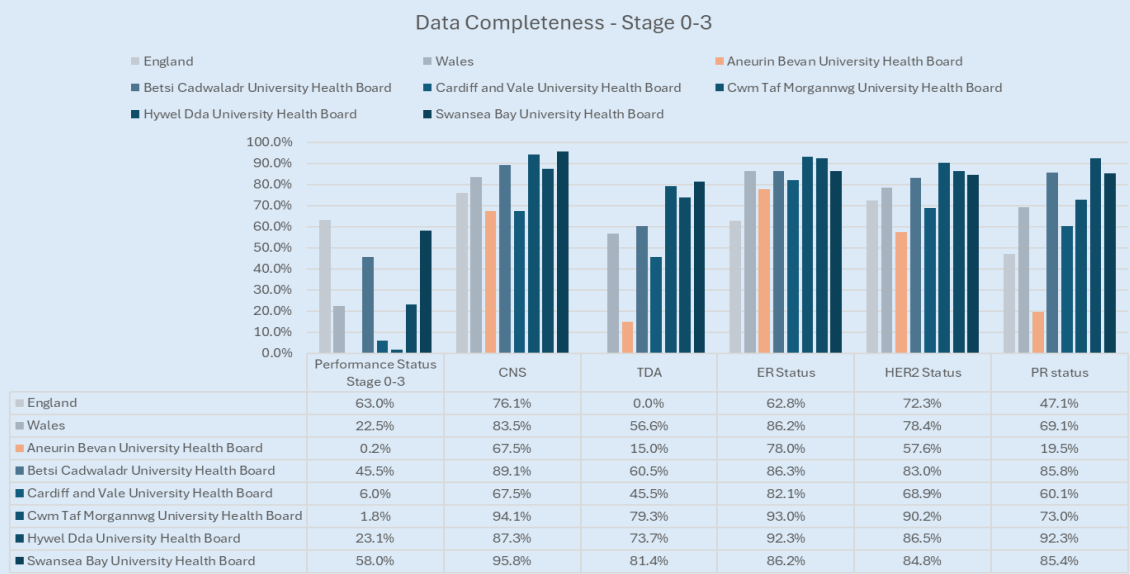
The aim of the National Audit of Primary Breast Cancer (NAoPri) is to evaluate the patterns of care and outcomes for people with primary breast cancer in England and Wales, and to support services to improve the quality of care for these patients. This work builds on that of the National Audit of Breast Cancer in Older Patients (NABCOP) but has been expanded to include younger people and men with breast cancer. This report has focused on the patterns of care at a national level, in England and Wales, for different groups of women and men. We report on indicators that were defined to monitor progress against the 5 NAoPri healthcare QI goals:

1. Improve the movement of patients through the care pathway.
2. Reduce unwarranted variation for patients undergoing surgery.
3. Reduce unwarranted variation for patients having non-surgical oncological treatments.
4. Improve access to breast reconstruction after mastectomy.
5. Improve and reduce unwarranted variation in primary breast cancer outcomes.

Presented at Clinical Standards and Effectiveness Group – 28th November 2024

Key Messages:

NHS organisations should ensure the data on key data items submitted to NDRS and CaNISC are complete. Particular attention should be given to data on “patient seen by a clinical nurse specialist (CNS) at diagnosis,” and date and type of cancer recurrence. Completeness of data on molecular markers (including hormone receptor and human epidermal growth factor receptor 2 (HER2) status), and performance status items should be improved. The reasons for poor data completeness are likely to vary across organisations and data items – recording of information at MDT, data entry/audit resource.



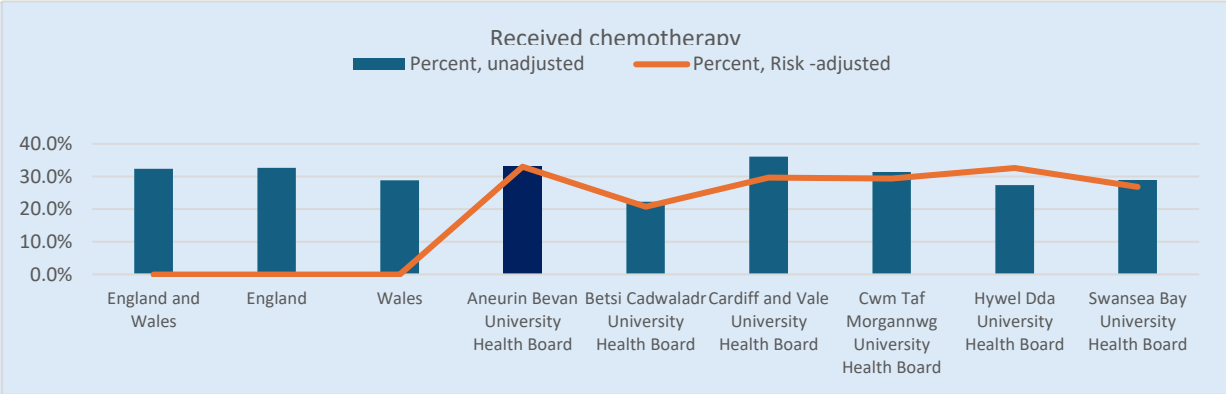
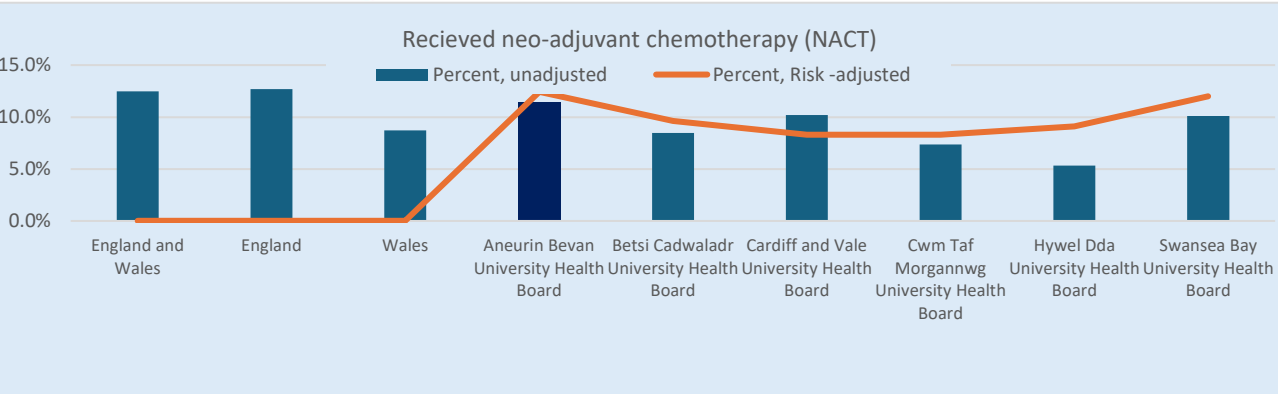
Chemotherapy

13% of people in England and 9% in Wales received neo-adjuvant chemotherapy (chemotherapy before surgery).

Among those with Early Invasive Breast Cancer (EIBC) having surgery, 33% of people in England and 29% in Wales received chemotherapy either before or after surgery.

Key messages:
Among people with EIBC who had surgery within 12 months of diagnosis, 12.5% had neo-adjuvant chemotherapy (NACT) (England = 12.7%, Wales = 8.7%). Few men received NACT. The use of NACT was higher among women with HER2 positive or triple negative disease (stage 2-3A). The use of NACT decreased with age and was rarely used among women aged 80+ years. Rates of NACT were under 10% for 35 NHS breast units and above 20% for 12 NHS breast units (patients allocated to organisation of diagnosis).

Key messages:
Among women and men diagnosed with EIBC (2019-2021) who received primary surgery, the overall percentage of people who had adjuvant chemotherapy was 18.8%. The rates were similar for women and men. When combined with patterns of neo-adjuvant chemotherapy, the overall percentage of people who had chemotherapy was 32.4% (England: 32.6%, Wales: 28.8%). The percentage of women who had primary surgery within 12 months and who received chemotherapy was higher among women with ER negative, ER negative/ HER2 negative and HER2 positive disease (stage 2-3A). Rates of treatment varied by age, with lower use of chemotherapy as age at diagnosis increased.



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

Not on Risk Register due to: Since the publication of this audit ABUHB breast service has now moved to fully one stop TDA

Report Successes:	
1	High compliance for CNS patient contact at diagnosis
2	High levels of eligible patients receiving NACT
3	Acceptable levels of BCS and IBR rates

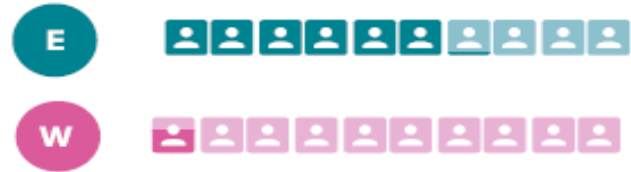
Report Concerns:	
1	Data Recording for ER, PR and HER2 status
2	Recording of Performance Status
3	Limited number of patients with access to same day TDA

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date: Progress:	
1	Ensure that people with breast cancer have access to Triple Diagnostic Assessment (TDA) in a single visit and, if required, identify methods to increase the provision of this service. Goal 1 - Improve the movement of patients through the care pathway.	Aim for >95% of all patients to receive single visit TDA Breast Unit Opened Feb 2024 – now offering TDA in a single visit to all patients	Michael Rees/ Breast care teams and clinical management in Welsh NHS Health Boards.	Nov 24	Achieved
2	Review the use of neo-adjuvant chemotherapy for all patients with early invasive breast cancer in order to reduce the levels of unexplained regional variation. Goal 3 - Reduce unwarranted variation for patients having non-surgical oncological treatments.	Aim to continue current standard All cases discussed at MDT with oncology presence	Michael Rees/ Breast care teams and clinical management in Welsh NHS Health Boards.	Nov 24	Achieved
3	Confirm breast multidisciplinary teams (MDT) have a data lead responsible for ensuring the quality of national data submissions. Reviews of data completeness within breast MDTs should include full tumour characterisation, ER13 and HER213 status (for invasive breast cancer), performance status, the NABCOP fitness assessment14 data items (for people aged 70+ years) as well as data on Triple Diagnostic Assessment (TDA) and contact with Clinical Nurse Specialists (CNS). (Recommendation aligned with the report for the National Audit of Metastatic Breast Cancer15.) Goal 1-5	• Aim for >95% documentation rate for ER, PR and HER2 status • Change to MDT proforma to collect performance status routinely • In house testing of HER2 • Path to test for PR on all tumours	Michael Rees/ Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25	In progress
4	Ensure the recording of date and type of breast cancer recurrence in cancer datasets by: a) Education on the recording of recurrence, sharing the NAOme Guide to collecting COSD data for breast cancer recurrence20 with NHS organisations. b) Reviewing the process of capturing these data within a breast multidisciplinary team (MDT), and ensuring these data are uploaded to cancer datasets. (Recommendation aligned with the report for the National Audit of Metastatic Breast Cancer15.) Goal 5 - Improve and reduce unwarranted variation in primary breast cancer outcomes.	• Aim for >95% rate for recording breast cancer recurrence • All patients to be discussed at MDT • Standard MDT Proforma implemented for data capture of key parameters	Michael Rees/ Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25	In progress
5	Review rates of immediate reconstruction and, where rates are identified as below the mean, act to improve access to immediate reconstruction by ensuring it is offered to all women, unless precluded by comorbidity or adjuvant therapies.	• Aim for >80% BCS rate • Aim for >20% rate for IBR post mastectomy • Cases discussed at MDT	Michael Rees/ Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25	In progress
Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date: Progress:	
1	Revision of MDT proforma to include PS for all new breast cancer diagnoses	Change Proforma with Cancer Services	Michael Rees	Feb 25 - In progress	
2	In house testing for HER2	Business case development with pathology	Michael Rees/James Harrison	Apr 25 - In progress	

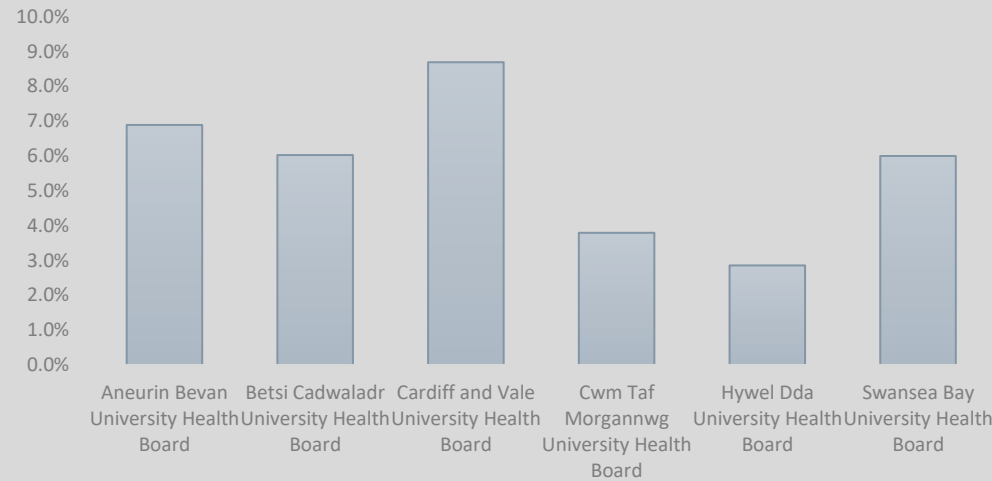
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Multidisciplinary Discussion

In England 61% of women with de-novo MBC had a record of multidisciplinary team discussion of their care. In Wales this was only 6% (low data completeness).



% People with newly diagnosed MBC discussed in an MDT



Percentage of people with recurrent metastatic breast cancer who had a metastatic lesion biopsied to inform care.

No data for Welsh Health Boards , numerator for Wales 269

Percentage of people with ER positive metastatic breast cancer who received CDK 4/6 inhibitors as first line treatment.

No data for Welsh Health Boards , numerator for Wales 216

• **Percentage of people with HER2 positive MBC who received anti-HER2 therapy as first line treatment** - No data for Welsh Health Boards , numerator for Wales 86

Chemotherapy for recurrent disease

In England 40.4% of people with recurrent MBC received chemotherapy. Use of chemotherapy was greater among younger women with triple negative breast cancer.



% People who received Chemotherapy - de novo

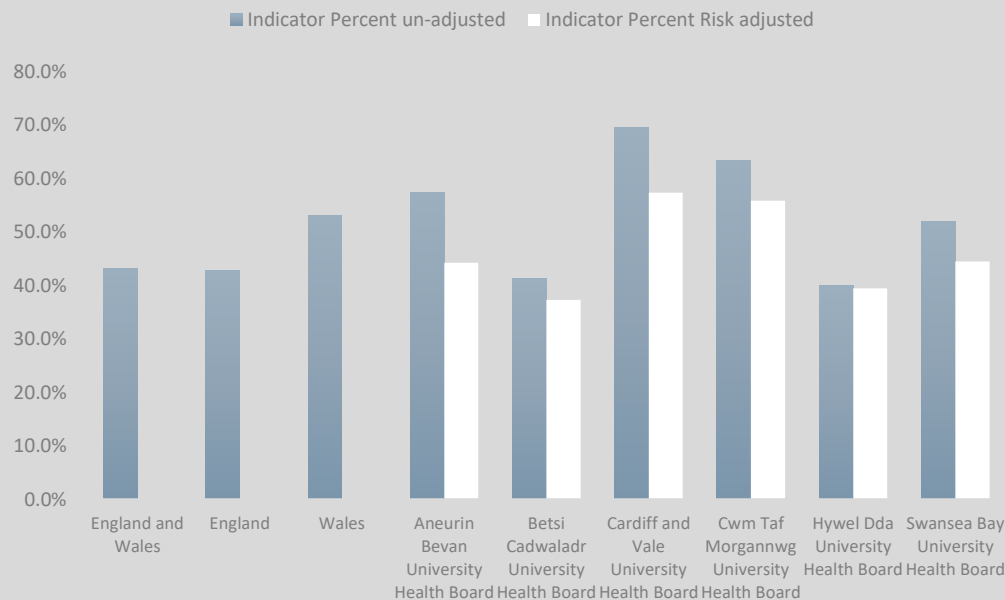
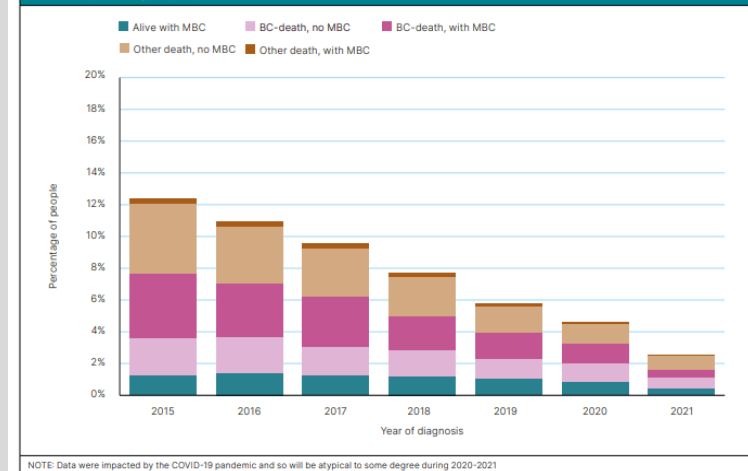


Figure 1. The percentage of people who had recurrent MBC recorded among those diagnosed with primary breast cancer (stage 0 to 3) in England and Wales (2015-21), stratified by the year of diagnosis, whether people had died by 1 June 2023 and by cause of death. The percentage of people who are alive without recurrent MBC are not shown.



NOTE: Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-2021

This chart reflects the decrease in deaths related to MBC across the UK from 2015 - 2021

No data for Welsh Health Boards , numerator for Wales 269

E

Death after chemotherapy

In England,

8%

of women with de-novo MBC and

21%

with recurrent MBC died within 30 days of chemotherapy.

This information was not available for Wales.

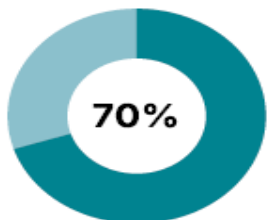
Percentage of women with death recorded within 30 days of a chemotherapy cycle.

No data for Welsh Health Boards , numerator for Wales 250

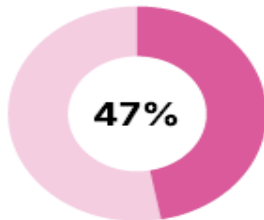
Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against
Risk level	Description
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings
Not on Risk register due to: Poor performance largely the result of incomplete data/poor integration with CANISC records.	
Key Successes:	
1	Recording of grade of cancer
2	Review by CNS at diagnosis
3	Chemotherapy rates in line with national average
Report Concerns:	
1	Limited data completeness for a number of areas
2	Documented low rates of discussion at MDT (?CANISC integration)
3	Documented low rates or patients receiving a biopsy (?CANISC integration)

Survival for de-novo disease

Percent of people who survived for 1 or 3 years after diagnosis in England and Wales (combined).



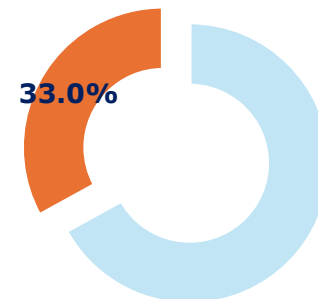
Year 1



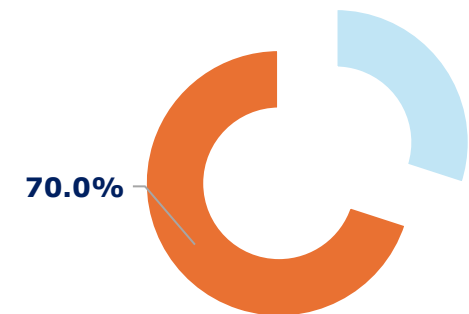
Year 3

Wales de-nono – 3-year Survival – 43%

NAo-Me - Wales - 1 year survival - recurrent



NAo-Me - Wales - 1 year survival - de novo



Wales: Breast care teams and clinical management in Welsh NHS Health Boards.

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date: Progress:
Goal #1 – Improve the movement of patients through the care pathway.				
1	Ensure the care for people newly diagnosed with MBC (either de-novo or recurrent) is discussed within a breast multidisciplinary team (MDT) meeting.	- Aim for >70% of all patients to be discussed at MDT - Better integration with CANISC - Appointment of metastatic BCN	Michael Rees/Simon Waters, Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25 In progress
2	Examine biopsy rates for MBC and aim to increase this where feasible if the results may have therapeutic implications.	- All patients biopsy records to be recorded on MDT proforma - Better integration with CANISC	Michael Rees/Simon Waters, Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25 In progress
3	Confirm breast multidisciplinary teams (MDT) have a data lead responsible for ensuring the quality of national data submissions. Reviews of data completeness within breast MDTs should include full tumour characterisation, ER8 and HER212 status, performance status, the NABCOP fitness assessment data items (for people aged 70+ years) and contact with clinical nurse specialists (CNS). <i>(Recommendation aligned with the report for the National Audit of Primary Breast Cancer8 .)</i>	- Clinical lead currently responsible - Consider separate MDT lead role to ensure better data completion	Michael Rees/Simon Waters, Breast care teams and clinical management in Welsh NHS Health Boards.	Dec 25 In progress
4	Ensure the recording of date and type of breast cancer recurrence in cancer datasets by: (a) Education on the recording of recurrence, sharing the NAOme Guide to collecting COSD data for breast cancer recurrence13 with NHS organisation. (b) reviewing the process of capturing these data within a breast multidisciplinary team (MDT), and ensuring these data are uploaded to cancer datasets. <i>(Recommendation aligned with the report for the National Audit of Primary Breast Cancer14 .)</i>	- Aim for >70% of all patients to be discussed at MDT - Better integration with CANISC - Appointment of metastatic BCN - Consider separate MDT lead role to ensure better data completion - Appointment of metastatic breast care nurse	Michael Rees/Simon Waters, Breast care teams and clinical management in Welsh NHS Health Boards.	Apr 25 In progress

Audit Title:	<i>A broken hip – three steps to recovery, a report on using the National Hip Fracture Database (NHFD)</i>	Clinical Lead:	Dr Muhammad Usman – Orthopaedic Physician
Rationale:	Every year, over 70,000 people in England, Wales and Northern Ireland will fall and sustain a hip fracture. A broken hip usually happens because of a fall or injury. It's more common in older people and people who have osteoporosis. 70% are over 80 years of age. A broken hip can be life-changing, especially for older people with other health conditions. Some of them may never get back the same strength and movement as they had before their break, and they may need to use a walking stick or frame.		
Objectives:	The report aims to provide readers with a simple guide to all these data and resources by describing the care that hip fracture patients should receive on their journey to recovery: > as they first present with a new hip fracture > as surgery allows them to get out of bed again > through rehabilitation until they are back in their home.		

Audit Standards	Name	Code	KPI 0	KPI 1	KPI 2	KPI 3	KPI 4	KPI 5	KPI 6	KPI 7
			Admission to ortho ward %	Prompt orthogeriatric assessment %	Prompt surgery %	Nice compliant surgery %	Promptly out of bed %	Not delirious post-op %	Return to original residence %	Medication %
	Bronglais General Hospital	BRG	8.4	100	40.2	84.1	72.9	95.3	84	58
	Glan Clwyd Hospital	CLW	0.8	92.8	53.6	76.3	62.2	78.6	78.8	30.5
	Maelor Hospital	WRX	8.5	81.4	70.7	72.3	95.2	63.9	72.5	22.9
	Morrison Hospital	MOR	1.2	97	32.4	72.7	83	74.8	73.2	59.3
	Prince Charles Hospital	PCH	18.9	0	69.8	56.2	69.3	0	71.9	0.9
	Princess Of Wales Hospital	POW	23.7	70.8	62.9	64.1	76.6	72.8	72.1	57.5
	Royal Glamorgan	RGH	12	0	64.9	80.6	70.7	15.5	70.8	0.4
	The Grange University Hospital	GWE	16.9	96.4	56.9	78.1	69.4	79.8	76	73.7
	University Hospital of Wales	UHW	33.1	93	68.9	74.5	82.4	55.5	75.8	68.5
	West Wales General	WWG	10.8	55.1	62.2	65	71.2	69.2	77.9	55.5
	Withybush General Hospital	WYB	6	24	65.4	75	72.3	56.9	69.7	28.2
	Ysbyty Gwynedd Hospital	GWY	9.4	66.8	72.4	51.9	93.2	80.4	84.9	40.9
			Below Average				Average		Above Average	

Assurance level		Description	Select	Report Recommendations:		S.M.A.R.T Actions:	Responsible :	Due Date:	Progress:
Limited		The project did not achieve the standards or criteria being audited against	Yes	1	To ensure that hospitals are ready for the people they know will present each day, so patients receive each step of their care at the right place at the right time.	Trauma service review	Division of surgery/ABUHB	2025	Regular meetings
Risk level	Description		Select						
Minor		Overall treatment or service suboptimal - Minor implications for patient safety if unresolved	Yes						
Has this audit been placed on a Risk Register (N/A if above risk is None)			YES /NO	2	To ensure that all hospitals provide both prompt surgery and optimal peri-operative care so patients can start getting back on their feet as soon as possible.	Trauma service review	Division of surgery/ABUHB	2025	Awaiting Trauma service review date for femoral fracture patients.
If not on a risk register, why not: We are planning to record this on the risk registrar in the near future.									
Report Successes:				3	To ensure rehabilitation and recovery is planned and started early and continues beyond the hospital with measures to prevent another fracture.	Robust postoperative Orthogeriatric care	T&O/Orthogeriatric leads	Monthly hip fracture Governance Meetings	Regular engagement of multiple disciplines to identify and aim to improve care
1	Prompt Orthogeriatric perioperative care								
2	Not Delirious post OP								
3	Falls assessment and bone health treatment								
4	Anaesthesia with nerve block								
5	Nice complaint surgery (cemented Hemiarthplasty, type of prosthesis used)								
Report Concerns:				4	By agreeing a standardised approach to the collection of ethnicity data across all patients’ pathways and provider organisations.	Regular prospective data collection through NHFD.	T&O, Orthogeriatrics	Continuous data gathering and monitoring.	Analysis of NHFD data.
1	Delay in transfer to the orthopaedic ward from A&E								
2	Delay in Surgery within 36 hours of admission								
3	Day 1 Physiotherapy mobilization								
4	Record of AMT scoring on admission (now 4AT tool)			5	By ensuring that people with other injuries benefit from the improvements that have been pioneered among those with hip fracture.	Regular input from the Orthogeriatric service to non-Hip fracture patients on the trauma ward	T&O, Orthogeriatric Medicine	Regular engagement	Maintain the Regular practice
Clinical Leads Local Recommendations: T&O/OG			S.M.A.R.T Actions:			Responsible:		Due Date:	Progress:
1	Extra Theatre space, weekend extra lists		Trauma review - ABUHB			Surgical Division		2025	
2	Ring fence beds to improve delay in A&E								

109/135479/618

Assurance level		Description		Report Successes:	
Significant		The project has mostly achieved the standards or criteria being audited against		1	Higher percentage diagnosed within 21 and 28 days compared to rest of Wales/England
Risk level		Description		2	Shorter median time referral to diagnosis compared to rest of Wales
Moderate		Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon		3	Existing multidisciplinary clinic with CNS and dietitian support and in parallel to oncology clinic
Has this audit been placed on a Risk Register (N/A if above risk is None)			YES/NO	Report Concerns:	
If not on a risk register, why not: Much of the risk is outwith ABUHB control eg time to surgery, delays in pathway eg CT-PET				1	Complex staging pathway, some actions already taken to reduce time to treatment
				2	Overall poor prognosis due to multiple factors – late/non-specific presentation, limited effective treatment options
Report Recommendations:		S.M.A.R.T Actions:		Responsible:	
1	Review referral pathways in centres which diagnose pancreatic cancer to ensure that all people who receive a diagnosis of pancreatic cancer, including those with non-resectable disease, are discussed by a multidisciplinary team (MDT).	- Review local pathways of how referrals to MDTs are made and develop protocols to increase rates of referral – eg. At the end of a clinically suspicious scan report, radiology team to state 'ensure patient is referred to HPB MDT' - Ensure MDTs are prepared for increased workload related to a higher volume of patients coming through the MDT – consider extending timings of MDT		Local and regional MDTs	
2	Ensure that all NHS pancreatic cancer service providers review their diagnostic pathways and implement hepatopancreatobiliary (HPB) cancer pathway guidance, which sets out recommended sequencing of events for the diagnostic process.	- MDT lead to review local diagnostic services and pathway and identify how an optimal diagnostic pathway would work in their local centre - Review MDT wait times - consider an audit for diagnostic pathway timings and review key areas for improvement or rate-limiting step, eg. Obtaining an ERCP slot - Estimate how many imaging and endoscopy slots are required per week to get patients through this pathway promptly - Monitor turn-around time for radiology and pathology reports and develop local plans to increase radiology and endoscopy capacity - Feedback quarterly data reports on waiting times to the wider MDT		MDT lead and Cancer Services plus regional MDT and HPB Programme Board. Identify specific people for departmental audits/existing data from cancer services Endoscopy team	
				Ongoing	
				End 2025	
				CWS proforma for referral. Liaison with regional MDT	
				Additional OP ERCP capacity imminent and further appointment anticipated. Radiology access adequate for USC scans.	

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
3	Ensure a personalised approach is taken to optimise a person's fitness, nutrition and medication to prevent deconditioning prior to starting treatment. This may include the implementation of prehabilitation, oncogeriatric services and dietetic support.	- Consider early dietetic and physiotherapy review of pancreatic cancer patients prior to starting treatment to identify areas in which patients could be supported - Consider an older patients service review for more frail patients for a comprehensive medical review of pre-existing conditions - Review and optimise current medications at the first patient consultation to ensure medical conditions are stable prior to starting treatment	MDT/clinic team, dietitian already in clinic, HNA undertaken No frailty service available	Ongoing	Oncogeriatric service not anticipated currently.
4	Review provision of clinical nurse specialists (CNS) in organisations which have a shortfall of newly diagnosed people being reviewed by a CNS, and ensure that everyone diagnosed with pancreatic cancer has access to a specialist CNS, ideally from the point of diagnosis.	- Review how CNS staffing levels compare to the patient workload - Identify clinics where new patients with pancreatic cancer will be reviewed. Allocate a CNS to be present on these clinic days.	New patient clinic already in place with CNS presence. Reduced staffing in CNS team currently.		Recruitment to CNS team needed
5	Consider implementing protocols to ensure that all people diagnosed with pancreatic cancer are assessed for eligibility for pancreatic enzyme replacement therapy (PERT), and that PERT is offered as recommended in national guidance.	- Ensure documentation of whether patients require PERT, or reasons for not offering PERT (or patients declining it) - Consider a local audit of PERT prescribing to review if there are any particular patient groups who are not receiving this treatment - Early dietitian review of all pancreatic cancer patients with clear recommendations on whether patients would benefit from PERT, and whether patients have been educated in how to adjust doses - Raise the profile of PERT prescribing at the specialist and local MDTs	MDT and dietetics Dietitian already in MDT clinic.	Ongoing	Most of recommendations already met

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Ensure CNS team numbers are maintained	Recruit to replacement CNS post	Nursing lead	Summer 2025	Ongoing
2	Optimise inpatient/acute presentation management including via SDEC and Flow Centre	Update referral guidance and pathways in medicine	MDT lead and acute medicine/gastro	End 2025	Ongoing
3	Imminent departure of HPB oncologist, replacement awaited	Velindre to recruit to post	Velindre CD	Unknown	Ongoing

Audit Title:

National Oesophago-Gastric Cancer Audit (NOGCA) - State of the Nation Report
Data collection period: 1 April 2021 – 31 March 2023
Clinical Lead: Dr Tamsin Boyce – Consultant Surgeon

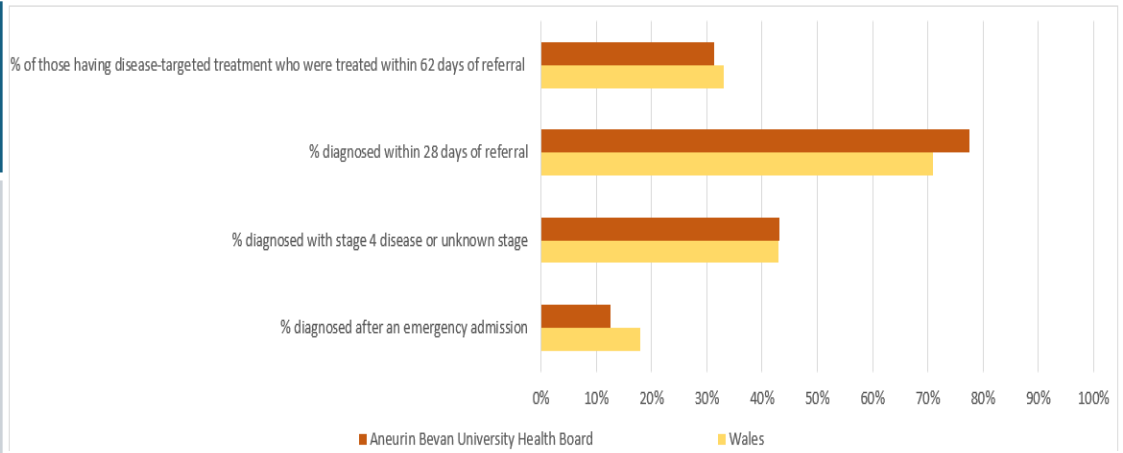
Rationale:

Oesophago-gastric cancers (OGCs) are amongst the late-stage malignancies worldwide and are associated with high disease-related mortality.
Emergency presentations are associated with a poorer prognosis/outcome. Overall, 21% of people with OGC in England and 18% in Wales were diagnosed after being admitted as an emergency.
The National Oesophago-Gastric Cancer Audit (NOGCA) evaluates patterns of care and outcomes for people with oesophageal or gastric cancer in England and Wales. For the first time, the Audit has derived its indicators using information that is routinely collected by the NHS as part of the care and support given to people diagnosed with OG cancer, rather than data collected specifically for the Audit.

- Objectives:

Five quality improvement goals for NOGCA:
1) Reduce rates of emergency and late-stage diagnosis of OG cancer;
2) Reduce the percentage of people with OG cancer waiting more than 62 days from referral to first treatment;
3) Increase the percentage of people with OG cancer who have access to a clinical nurse specialist (CNS);
4) Improve outcomes of potentially curative treatment for people with OG cancer;
5) Improve completion and reduce complications of palliative chemotherapy for people with OG cancer.

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against
Risk level	Description
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Has this audit been placed on a Risk Register (N/A if above risk is None) If no, why not: Ongoing work to improve patient care and outcomes.	



		Diagnosis and staging			Waiting times	
Period (diagnosis date)	Local Health Board	Number of people diagnosed with OG cancer	% diagnosed after an emergency admission	% diagnosed with stage 4 disease or unknown stage	% diagnosed within 28 days of referral	% of those having disease-targeted treatment who were treated within 62 days of referral
1 April 2021 - 31 March 2023	Aneurin Bevan University Health Board	246	13%	43%	78%	31%
1 April 2021 - 31 March 2023	Wales	1322	18%	43%	71%	33%

Report Successes:	
1	Lower proportion of cancers diagnosed as emergency (compared to Wales and England)
2	Higher proportion diagnosed within 28 days of referral (compared to Wales and England)
3	Wales time to treatment better than England but still only 33% vs 26%
Report Concerns:	
1	Difficulties comparing to previous audits as different data collected/published.
2	62-day referral to treatment not being met (as per most tumour sites)
3	Delays in pathway out with local control eg CT-PET

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	In regions with high rates of emergency and late-stage diagnosis, conduct individual patient root cause analysis to look for earlier diagnosis opportunities and to understand how many are potentially preventable; use the resulting findings to develop appropriate local action plans.	Ongoing work across Wales (National Optimal Pathway) to reduce late-stage diagnosis. Local rate lower than national rates already.	Cancer Network		TBC
2	Ensure that all providers of OG cancer care review their patients’ diagnostic and treatment pathways against best practice guidance in order to identify and address barriers to providing timely treatment.	Reduce pathology turnaround times CT-PET capacity Data from regional network needed; SLA review ongoing	Pathology department PETIC Divisional and regional team re SLA	2026?	
3	Prioritise improving the flow of pathology data in England, to ensure patients’ surgical pathology outcome data are submitted to the Cancer Outcomes and Services Data set (COSD) and are available in national cancer datasets.	N/A refers to England only, report says data was almost complete for Wales	N/A	N/A	N/A
4	Regions with high rates of 30-day mortality among people receiving palliative chemotherapy should review the care of people who died within this period, to identify potential issues with patient selection, and ensure that treatment is only offered if appropriate and likely to benefit the patient	Ask Velindre team re data. No data currently.	Cancer Service to ask Velindre oncologists for data?	End 2025	
Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	More detailed data needed re steps/timelines of complex pathway to treatment and outcomes as much is outwith ABUHB influence	Ask cancer services for breakdown of time to treatment	THB/Cancer Services	End 2025	
2	Future plans for local delivery of regional services	Will need new SLA/medium term plan	Divisional and regional teams	End 2026?	Ongoing
114/135					484/618

Audit Title:	National Bowel Cancer Audit - State of the Nation Report An audit of care received by people with bowel cancer in England and Wales focusing on people diagnosed between 1 April 2022 and 31 March 2023.	Clinical Lead:	Mr Keshav Swarnkar – Consultant Surgeon

NICE guideline [NG151] Quality Standards (QS): 1. Testing for Lynch Syndrome 2. Discussion about treatment options for early rectal cancer 3. Testing to guide systemic anti-cancer treatment 4. F-up for detecting local recurrence and distant metastases	The ten performance indicators, as set out in the NBOCA QI Plan, are:	
	1. Seen by Clinical Nurse Specialist 2. Trust/multidisciplinary team (MDT) volume for rectal cancer surgery 3. Adjusted 90-day mortality after major resection* 4. Adjusted 30-day unplanned return to theatre after major resection* 5. Adjusted 30-day unplanned readmission after major resection*	6. Adjusted 18-month unclosed ileostomy after anterior resection* 7. Stage 3 colon cancer receiving adjuvant chemotherapy 8. Adjusted severe acute toxicity after adjuvant chemotherapy for colon cancer* 9. People with rectal cancer receiving neo-adjuvant treatment 10.Adjusted 2-year survival rate after major resection*
Achieved		

Rationale:	The National Bowel Cancer Audit (NBOCA) measures the quality and outcomes of care for people diagnosed with bowel cancer in England and Wales. This report focuses on people diagnosed with bowel cancer between 1 April 2022 and 31 March 2023.
Objectives:	NBOCA is part of the National Cancer Audit Collaborating Centre (NATCAN), a new national centre of excellence to strengthen NHS cancer services by looking at treatments provided for people living with cancer and their outcomes across England and Wales. NBOCA sets out five quality improvement (QI) goals covering the entire patient care pathway. Mapped to these goals, NBOCA has ten performance indicators with local QI targets, and three contextualising measures.

Covid-19 pandemic brought about a reduction in referrals which has since returned to pre-pandemic levels although variations remain between NHS England and NHS Wales in diagnostic pathways. The expansion of screening for both NHS England and NHS Wales has increased with the age ranges expanding from 50-59 to 50- to 74 in England and 51 to 74 in Wales.

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against
Risk level	Description
None	Standards met and findings demonstrate no risk to patient safety
1)Apart from Stoma closure at 18 month, most clinical standards met. NO direct threat to patient safety but needs improving to address Quality of outcome(bowel function, Patient experience, mitigation of stoma management cost) 2) CRN involvement has substantially improved since, but some minor situations need capturing- Patients referred by gastroenterologists who report incidental bowel polyp cancers and remain under gastroenterologists for surveillance. These are discussed in MDT but don't have direct supervision of CRN and may have been missed. All polyp cancers though are registered with colorectal MDT. There are more polyp cancers detected now due to increased endoscopy and BSW and may require separate database for tracking and surveillance . This is likely to need more administrative resource to cover SPECC and Colorectal MDT. 3) Lack of data from VCC regarding toxicity related to adjuvant chemotherapy needs addressing at Wales cancer network level (WCN). This is not captured at ABUHB level, and this will be highlighted to Our Oncologist at MDT (Dr H Williams) However, there is no direct threat to patient safety in terms of survival when compared to local and national targets. It is acknowledged that we aim to achieve stoma closure target by April 2026.	

Performance indicator: (April 2022 to March 2023 unless otherwise stated)		National results	Local Target	% of trusts/MDTs meeting local target	ABUHB results
1	Seen by Clinical Nurse Specialist <i>(Based on people diagnosed with bowel cancer between 1 Apr 22 and 31 Mar 23)</i>	94%	>95%	61%	85%
2	Trust/MDT volume for rectal cancer surgery <i>(Based on people who underwent rectal cancer surgery between 1 April 2022 and 31 March 2023, for performance indicator 2)</i>	N/A	>20 per year	81%	54
3	Adjusted 90-day mortality after major resection <i>(Based on people diagnosed with bowel cancer between 1 Apr 22 and 31 Mar 23)</i>	2.7%	<6%	96%	2.7%
4	Adjusted 30-day unplanned return to theatre after major resection <i>(Based on people diagnosed with bowel cancer between 1 Apr 22 and 31 Mar 23)</i>	6.4%	<10%	92%	4.7%
5	Adjusted 30-day unplanned readmission after major resection1 <i>(Based on people diagnosed with bowel cancer between 1 Apr 22 and 31 Mar 23)</i>	11%	<15%	81%	8.0%
6	Adjusted 18-month unclosed ileostomy after anterior resection <i>(Based on people who underwent an anterior resection with diverting ileostomy between 1 April 2017 and 31 March 2022)</i>	38%	<35%	41%	50%
7	Stage 3 colon cancer receiving adjuvant chemotherapy <i>(Based on people who underwent surgery for Stage 3 colon cancer between 1 April 2020 and 30 November 2022)</i>	66%	<50%	93%	21%
8	Adjusted severe acute toxicity after adjuvant chemotherapy for colon cancer <i>(Based on people who underwent surgery for Stage 3 colon cancer between 1 April 2020 and 30 November 2022)</i>	21%	<33%	95%	-
9	People with rectal cancer receiving neo-adjuvant treatment <i>(Based on people diagnosed with bowel cancer between 1 January 2022 and 31 December 2022)</i>	34%	10%-60%	89%	-
10	Adjusted 2-year survival rate after major resection <i>(Based on people who underwent surgery for colorectal cancer between 1 April 2020 and 31 March 2021)</i>	82%	>70%	97%	81%
116/135					486/618

Report Successes:		Report Concerns:				
1	Good surgical outcomes for both colon and rectal cancers (survival). Quality assurance across entire pathway with good climate inventory of Colorectal MDT.	1	Stoma closure rates			
2	All rectal cancers managed under unified MDT with significant advances in last 12 months in local treatment for rectal cancers- TAMIS procedure delivered by 2 surgeons.	2	Should CRN be directly involved in Polyp cancers tracking and surveillance? This will require additional resource- CRN/ database management and tracking.			
3	Development of SPECC MDT where Polyp cancers and Rectal Polyp cancers are discussed in depth and appropriate treatment and surveillance planned in keeping with national guidelines.	3	Linking of oncological data with Trust data to provide assurance on quality of oncological treatment.			
Report Recommendations:		S.M.A.R.T Actions:		Responsible:	Due Date:	Progress:
1	Improve data completeness of key items in national cancer registration datasets to allow risk-adjustment of performance indicators. Data items of focus: tumour, node and metastases (TNM) stage, American Society of Anaesthesiologists' (ASA) grade and performance status. - National Disease Registration Service (NDRS) regional Data Liaison Managers to support trusts/multidisciplinary teams (MDTs) with coding, data entry, and quality assurance for the Cancer Outcomes and Services Dataset (COSD). - Local provision of data lead responsible for ensuring the quality of national data submissions	Colorectal Nurses to monitor Polyp cancer patients		K Swarnkar		To be discussed with CRN
2	2. Increase the proportion of people who are offered mismatch repair (MMR) assessment to identify those with Lynch syndrome and inform surgical decision making, and systemic treatments. Ensure timely access to assessment of MMR status as part of the NHS England Lynch syndrome testing and surveillance pathways. NICE QS 1.	We have made it mandatory to do MMR on all cases registered to MDT. Pathology department aware and have assured.		Rachel Jones James Harris		
3	Increase the proportion of people who have their ileostomy closed within 18-months of anterior resection for rectal cancer. - Support trusts/MDTs to identify system-level (e.g. access to theatre/radiological investigations) and patient-level drivers of variation. - Support trusts/MDTs to participate and engage with the local and national quality improv	- Agree pathway - Discuss with radiology - Discuss with oncologist - Stoma nurses to track patient progress. - Protected surgical lists to accommodate stoma closure cases every month.		Stoma nurse and MDT lead K Swarnkar	April 2026	In progress
117/135						487/618

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
4	Reduce variation between trusts/MDTs in the use of chemotherapy for people with Stage 3 colon cancer to optimise cancer survival while maintaining low levels of acute severe toxicity. - Continue to monitor and investigate regional and institutional variation in rates of neo-adjuvant and adjuvant chemotherapy for people with Stage 3 colon cancer and ensure evidence-based chemotherapy policies are in place. - Identify and address barriers to timely access to adjuvant chemotherapy. - Encourage the utilisation of appropriate risk stratification tools for severe acute toxicity including frailty scoring, and integration of geriatric expertise and rehabilitation into shared chemotherapy decision making. - Support the delivery of acute oncology services to optimise the care delivered to people who experience acute toxicity.	Discussion needed at WCN level to facilitate this data capture and linking with TRUST data.	Dr H Williams	April 2026	In progress
5	Understand variation in the utilisation of neo-adjuvant radiotherapy for people with rectal cancer to optimise their outcomes. Cancer Alliances to develop standardised evidence-based neo-adjuvant treatment protocols based on high-quality radiological staging. This will aid decision making and take into account locoregional approaches to neo-adjuvant therapy, incorporating organ preservation techniques and participation in clinical trials.	As above	Dr H Williams		April 2026

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Target to be achieved by April 2026 for stoma closure. Need to have agreed pathway within MDT with stoma nurse at the centre to track and facilitate timely closure	Discuss in MDT Stoma nurses to agree the role.	MDT lead	April 2026	Discussion under way
2	CRN to be made aware of their defined role in polyp cancer cases.	Discussion in MDT	MDT lead	April 2026	

Audit Title:	2024 NVR State of the Nation Report	Clinical Lead:	Mr David McLain – Consultant Vascular Surgeon
	Results for people who had vascular procedures during 2023 in NHS hospitals in England, Wales, Scotland and Northern Ireland.	NICE:	NG19 Diabetic foot problems NG156 Repairing ruptured aneurysms
Rationale:	This State of the Nation report for the National Vascular Registry provides information on the quality and outcomes of care for adults who had major vascular procedures in NHS hospitals. It aims to support vascular services to provide high quality of care for these people, and shares examples of good practice as well as highlighting areas which merit further investigation to improve care.		
Objectives:	The report contains key findings for emergency (non-elective) and elective vascular procedures carried out in 2023, along with some outcome indicators for the procedures performed between January 2021 and December 2023. The information covers the following patient groups: 1. people with peripheral arterial disease (PAD) who undergo either a) <i>lower limb angioplasty / stent</i> , b) <i>lower limb bypass surgery</i> , or c) <i>major lower limb amputation</i> 2. people who have a repair procedure for abdominal aortic aneurysm (AAA) or aortic dissection 3. people who undergo carotid endarterectomy or carotid stenting		

Key messages:

We're a busy unit.

We need the hybrid theatre we were promised as part of the centralisation. Despite much planning and apparent support from WG, we're no closer to the project being funded and it is not clear that WG has £50M to spend on it.

Lower limb revascularisation procedures

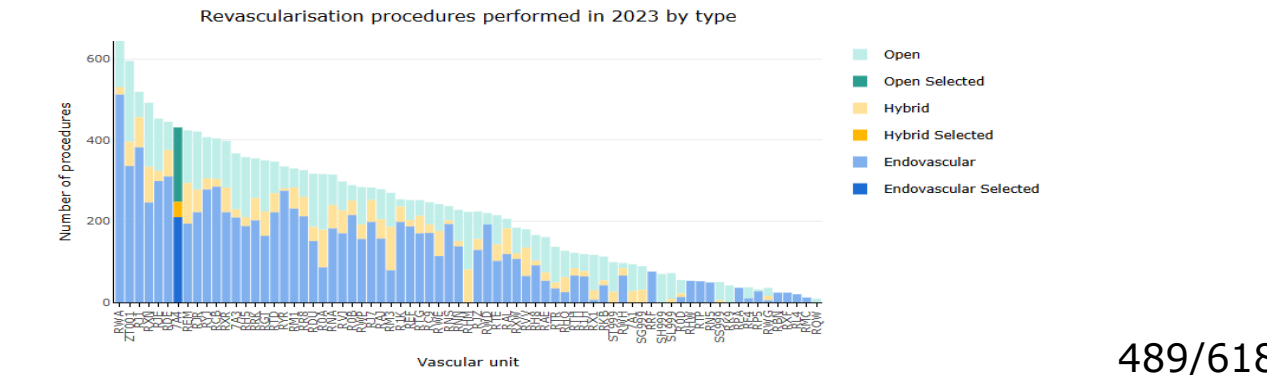
Time from non-elective admission to revascularisation for people with chronic limb threatening ischaemia (CLTI)

Key messages:
The median time (IQR) from admission to revascularisation was 6 (3-9) days among 5,200 non-elective admissions of people with CLTI in 2023. The proportion of people revascularised within 5 days was 50% which is lower than the 54% in 2021. Among the NHS vascular units that performed 10 or more procedures for people with CLTI admitted non-electively:

- 27 units had at least 50% of their patients wait more than 5 days
- 16 units had at least 25% of their patients wait more than 10 days

	Median time (IQR) from admission to revascularisation (days)	% CLTI treated within 5 days
Uk	6	50%
Wales	6	42%
C&VUHB	6	45%
SBUHB	6	44%
BCUHB	11	14%

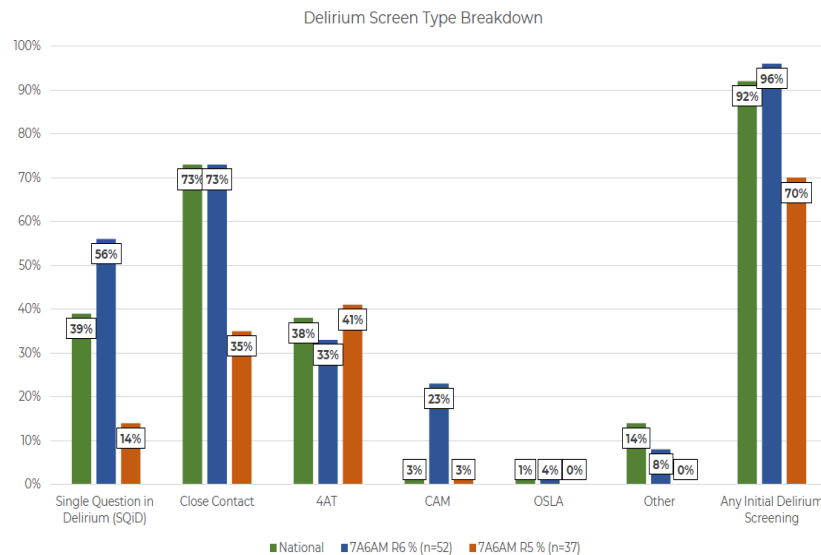
Key messages:
Access to dedicated operating theatre list is inadequate. There is heavy use of CEPOD theatres and bypass cases are often of lower priority than other cases competing for CEPOD time.



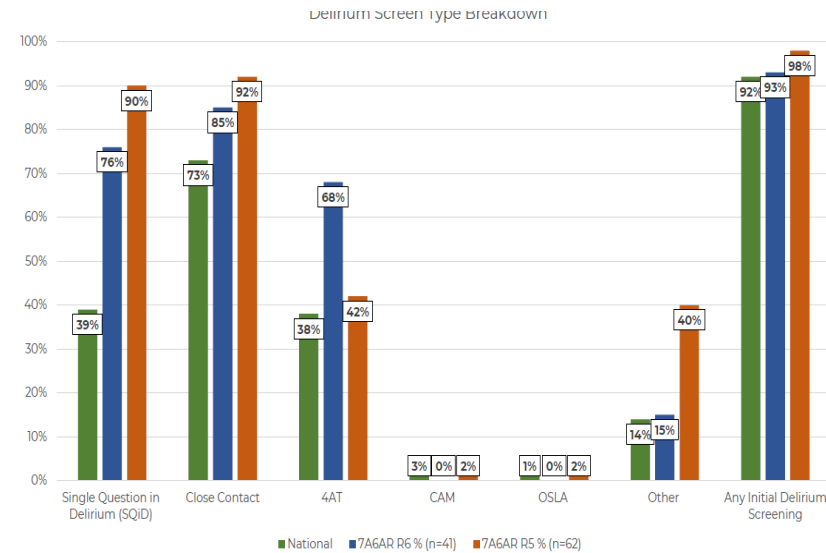
Assurance level		Description		Risk level	Description
Significant		The project has mostly achieved the standards or criteria being audited against		Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon
Has this audit been placed on a Risk Register (N/A if above risk is None)		NO	If not on a risk register, why not: Outcomes, so far, continue to be satisfactory. The issues are recognised and we're addressing them with the network governance structures		
Report Successes:			Report Concerns:		
1	Clinical outcomes are satisfactory.		1	Inadequate access to dedicated main theatre sessions results in routine use of and reliance on CEPOD, with the inevitable delays and cancellations.	
2	Started a FEVAR programme, first case treated in Feb 2025 with support from Bristol.		2	The continued lack of delivery of a hybrid operating theatre is compromising patient care and leading to delays in treatment, e.g. EVAR.	
Report Recommendations:				S.M.A.R.T Actions:	Responsible: Due Date: Progress:
1	Ensure that people with chronic limb threatening Ischaemia (CLTI) receive care urgently as recommended in the VSGBI Quality Improvement Framework (QIF) for peripheral arterial disease				Integrated Care Boards (ICBs) (working with Trusts), Local Health Boards, Vascular Networks.
Time from admission to procedure: median =6 days. 50% of patients are revascularised within 5 days.					
2	Identify reasons for the rise in the number of major lower limb amputations among people with PAD. This might require funding for national research as well as local investigations.				Vascular Society Audit and Research committees, ICBs (working with Trusts), Local Health Boards. National Institute for Health & Care Research.
There has been a 16% increase in the number of major lower limb amputations performed in the UK since 2020.					
3	Examine pathways to treatment for people requiring elective aortic aneurysm repair (both screen detected and incidental findings) and carotid endarterectomy (CEA) with the aim of removing causes of avoidable delays and increasing the proportion of people whose wait is within recommended standards.				ICBs (working with Trusts), Local Health Boards, Vascular networks, national AAA screening programmes.
Median time for AAA repair: 86 days; 31% of patients were treated within 8 weeks Median time for CEA: 15 days; 49% of patients treated within 14 days.					

Report Recommendations:			S.M.A.R.T Actions:	Responsible: Due Date: Progress:
4	Improve access to endovascular repair of ruptured aortic aneurysms in suitable patients. This may require improving network pathways and working arrangements across vascular surgery, interventional radiology and anaesthesia.			NHS England Specialist commissioning, University Local Boards, ICBs (working with Trusts), Vascular networks.
Proportion of repairs of ruptured AAA performed as endovascular repairs was 46% in 2023 (up from 30% in 2018).				
5	Develop better guidance on the coding of: i) TEVAR procedures for Type B Aortic Dissection to distinguish from TEVAR performed for aneurysms ii) FEVARs for juxta or supra renal aneurysms.			VSGBI & BSIR NHS England Specialist commissioning and Digital Health and Care Wales (DHCW).
15% of procedures with an aortic status of dissection on the NVR used an OPCS code for dissection (L27.4 or L28.4).				
Clinical Leads Local Recommendations: (if applicable)				
1	Continue to apply pressure on WG / CAV to provide a hybrid operating theatre		2	Understand the urgent nature of arterial vascular surgery when interpreting theatre efficiency.
National Audit of Dementia - Care in General Hospitals 2023-24: Round 6 Audit Report				Clinical Lead: Dr Inder Singh – Consultant Care of the Elderly
NICE guideline [NG97] Dementia: assessment, management and support for people living with dementia and their carers				
Recommendations:				
1.1 Involving people living with dementia in decisions about their care		1.7 Managing non-cognitive symptoms		
1.2 Diagnosis		1.8 Assessing and managing other long-term conditions in people living with dementia		
1.3 Care coordination		1.9 Risks during hospital admission		
1.4 Interventions to promote cognition, independence and wellbeing		1.10 Palliative care		
1.5 Pharmacological interventions for dementia		1.11 Supporting carers		
1.6 Medicines that may cause cognitive impairment		1.12 Moving to different care settings		
		1.13 Staff training and education		
Rationale:	The National Audit of Dementia (NAD) measures the performance of general hospitals in England and Wales against standards relating to care delivery which are known to impact people with dementia while in hospital. Standards are derived from national and professional guidance, including NICE Quality Standards and guidance, and the Dementia Friendly Hospitals Charter.			
Objectives:	Dementia care continues to be a national priority in England and Wales. The Dementia Care Pathway states the key principles for treatment, support and care for people living with dementia and their carers, highlighting a person-centred approach in which rights and dignity, are fundamental. Across England and Wales hospitals have affirmed this approach, signing up to John’s Campaign (90%) for the right of people with dementia to be supported by their family carers, and the Dementia Friendly Hospital Charter (82%). The National Institute for Health and Care Excellence (NICE) states that “People with dementia often experience longer hospital stays, delays in leaving hospital and reduced independent living. Hospital admission can trigger distress, confusion and delirium for someone with dementia. This can contribute to a decline in functioning and a reduced ability to return home to independent living”.			
121/135		491/618		

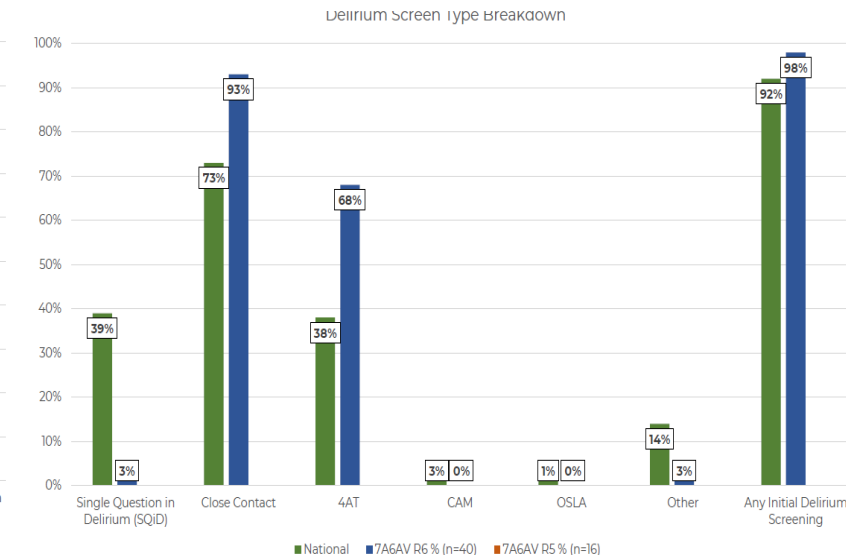
NEVILL HALL HOSPITAL (7A6AM)



ROYAL GWENT HOSPITAL (7A6AR)

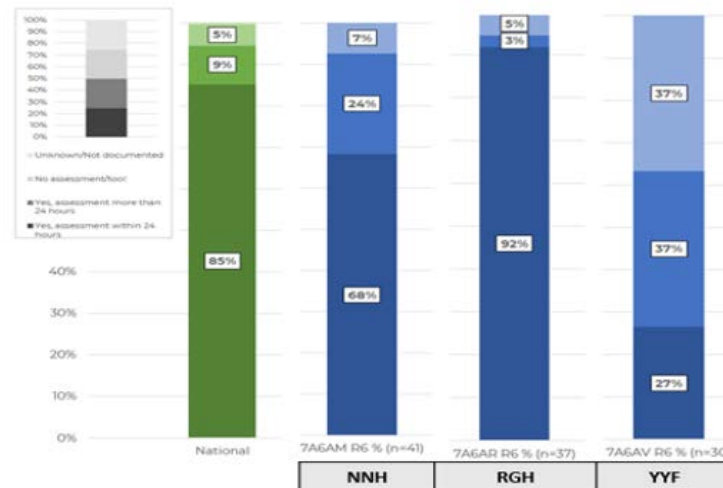
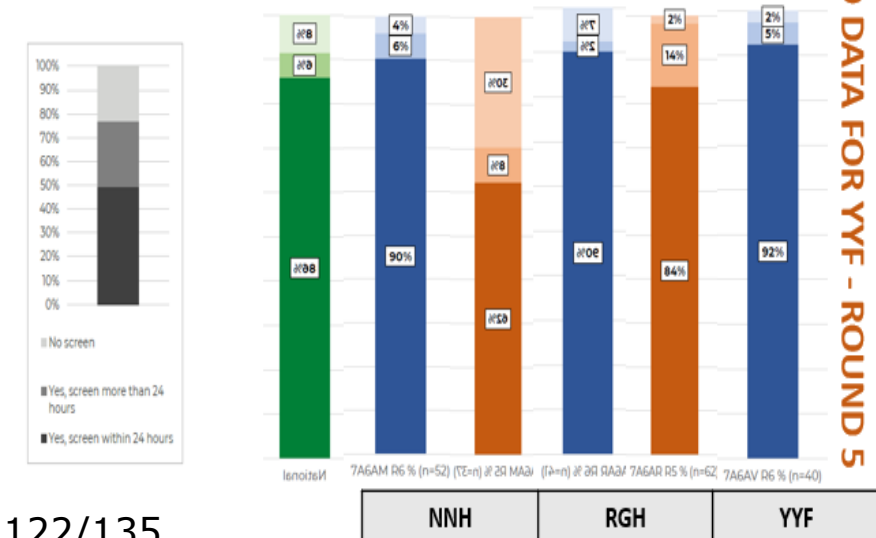


YSBYTY YSTRAD FAWR (7A6AV)



NHH & RGH have increased screening within 24 hours compared to R5 – YYF did not record data for R5, however R6 92% compared to 90% in NHH & RGH.

Structured screening NHH - 38%, RGH – 73.7% and YYF – 69.2%



Pain Assessments

NHH – 64%, are performing less pain assessments within 24 hours than RGH and YYF both 92%.

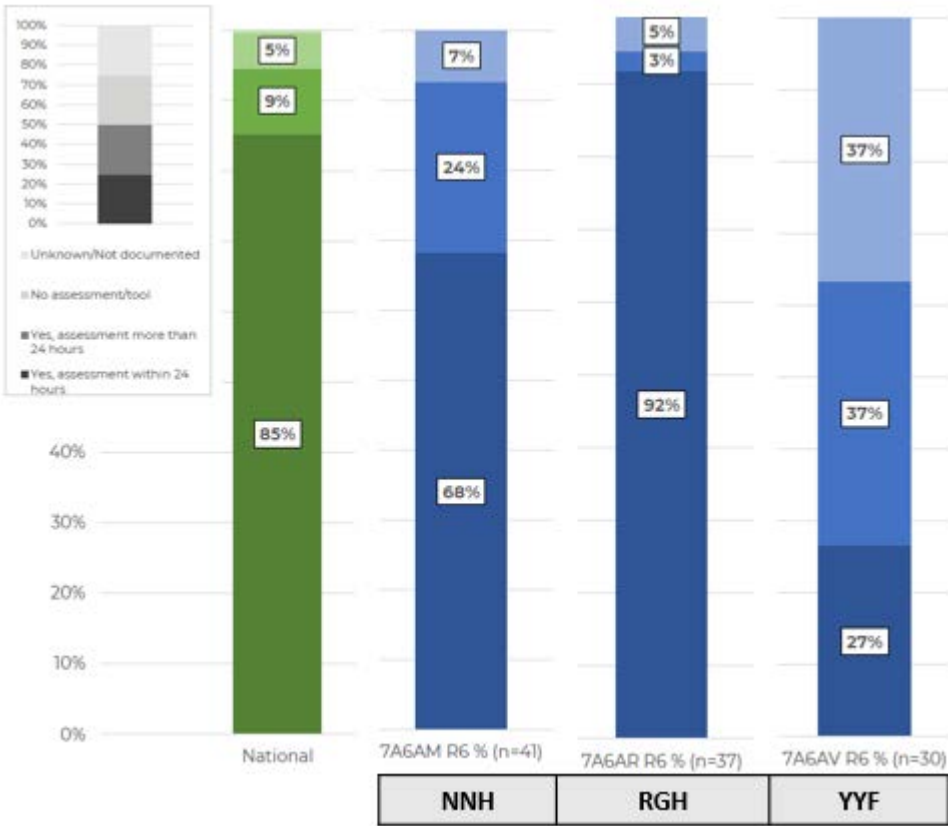
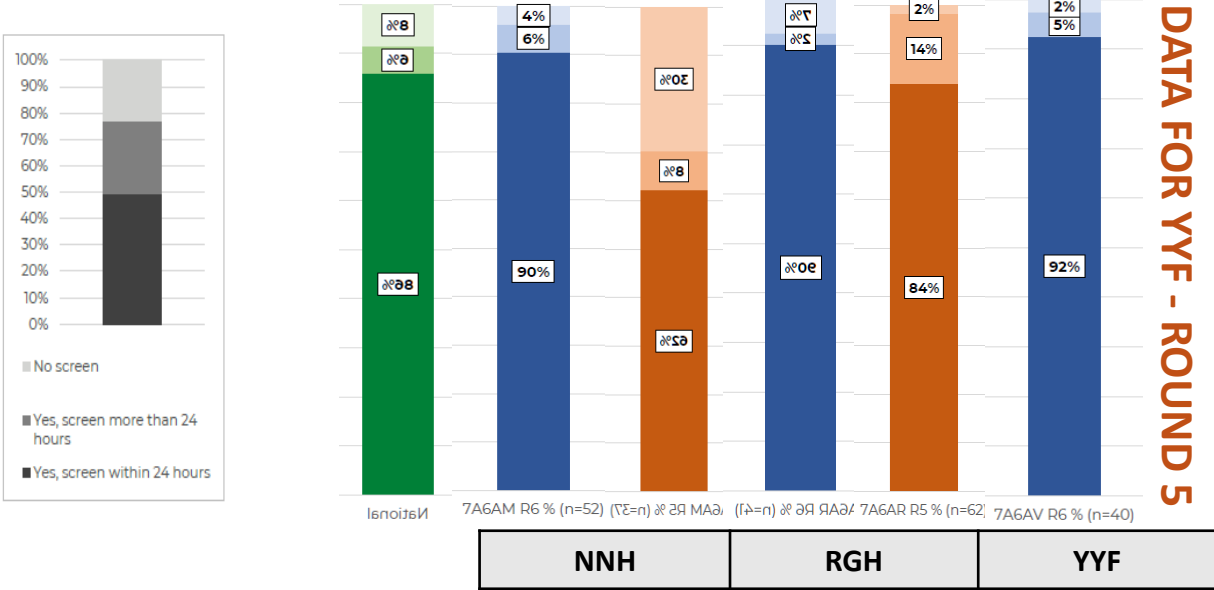
There was not data in R5 for YYF, with NHH increasing for 50% in R5 and RGH has decreased for 98% in R5.

Table 4: Any Pain Assessment

Pain Assessment	National R6 %	Nevill Hal Hospital	Royal Gwent Hospital	Ysbyty Ystrad Fawr
Assessment within 24 hours	92.7%	80.4%	87.5%	71%
Assessment more than 24 hours	5%	0%	5%	25.8%
No pain assessment	2.3%	19.6%	7.5%	3.2%
Any structured pain assessment (Abbey Pain Scale, PAINAID, CNPI)	40.6%	13.7%	85%	32.3%

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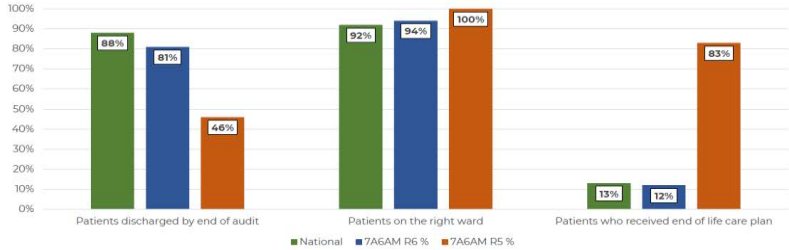
Table 4: Any Pain Assessment

Pain Assessment	National R6 %	Nevill Hal Hospital	Royal Gwent Hospital	Ysbyty Ystrad Fawr
Assessment within 24 hours	92.7%	80.4%	87.5%	71%
Assessment more than 24 hours	5%	0%	5%	25.8%
No pain assessment	2.3%	19.6%	7.5%	3.2%
Any structured pain assessment (Abbey Pain Scale, PAINAID, CNPI)	40.6%	13.7%	85%	32.3%

NEVILL HALL HOSPITAL (7A6AM)



Figure 14: Discharge Information

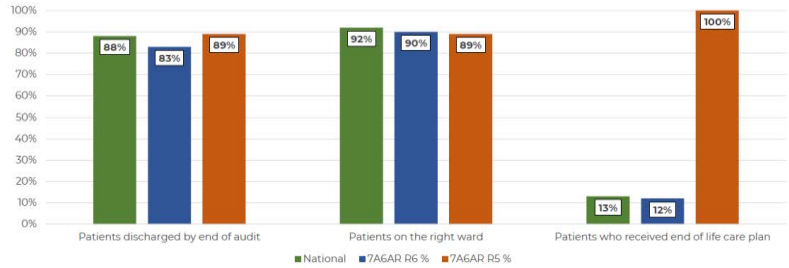


NB. The presence of EOL care plan information was asked for every patient in Round 6. In Round 5, it was only asked for patients who had died. Therefore, the data between Round 5 and Round 6 is **not** comparable.

ROYAL GWENT HOSPITAL (7A6AR)



Figure 14: Discharge Information

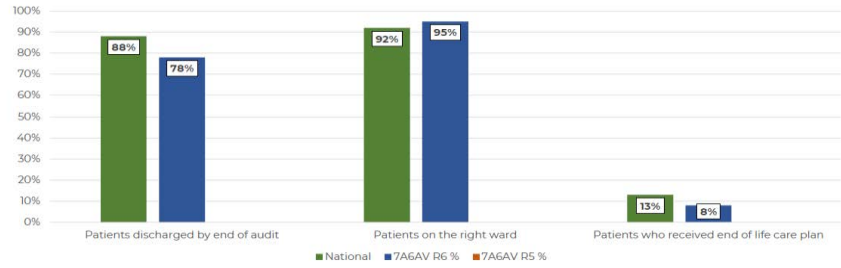


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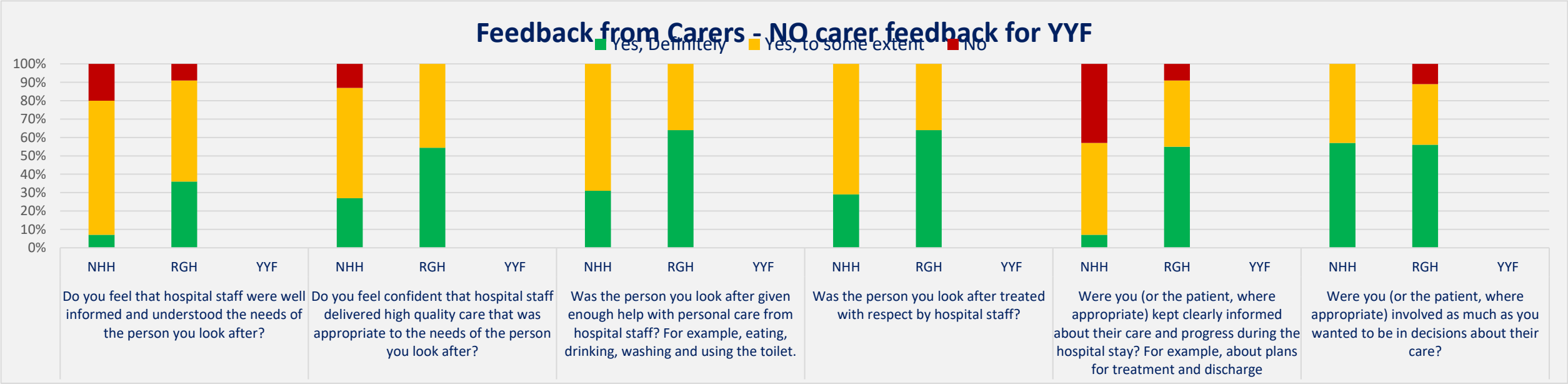
YSBYTY YSTRAD FAWR (7A6AV)



Figure 14: Discharge Information



NB. The presence of EOL care plan information was asked for every patient in Round 6. In Round 5, it was only asked for patients who had died. Therefore, the data between Round 5 and Round 6 is **not** comparable.



Carers of patients in RGH have said that the standard of care better than those at NHH in all areas apart from where asked if carers or patient (if appropriate) were involved as mush as they wanted to be in decisions about care, which were equal at approx. 55%.

There were no negative responses to for patients being given enough help with personal care or being treated with respect.

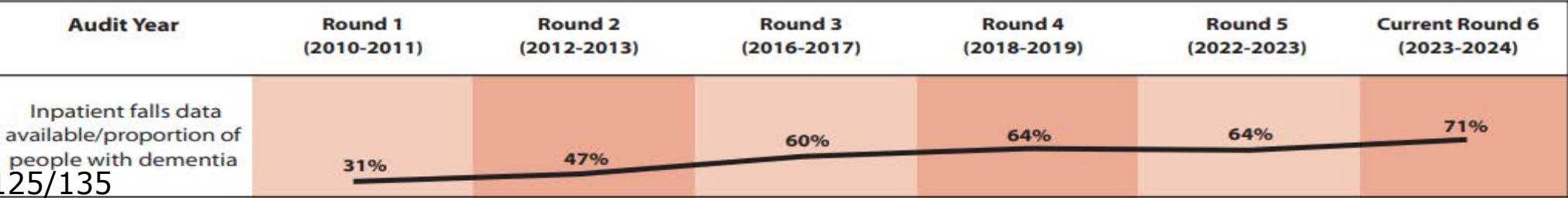
Assurance level	Description	Risk level	Description
Significant	The project has mostly achieved the standards or criteria being audited against	Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Has this audit been placed on a Risk Register (N/A if above risk is None)		YES/ NO	If not on a risk register, why not: Ongoing quality improvement work

Report Successes:	
1	Participation by all 3 sites is good and audited good level of notes
2	Delirium screening and pain assessment improved
3	Initiation of DC planning commenced in 24 hours
4	Delirium screening and care plan at YYF has improved Median LoS in line with other two sites

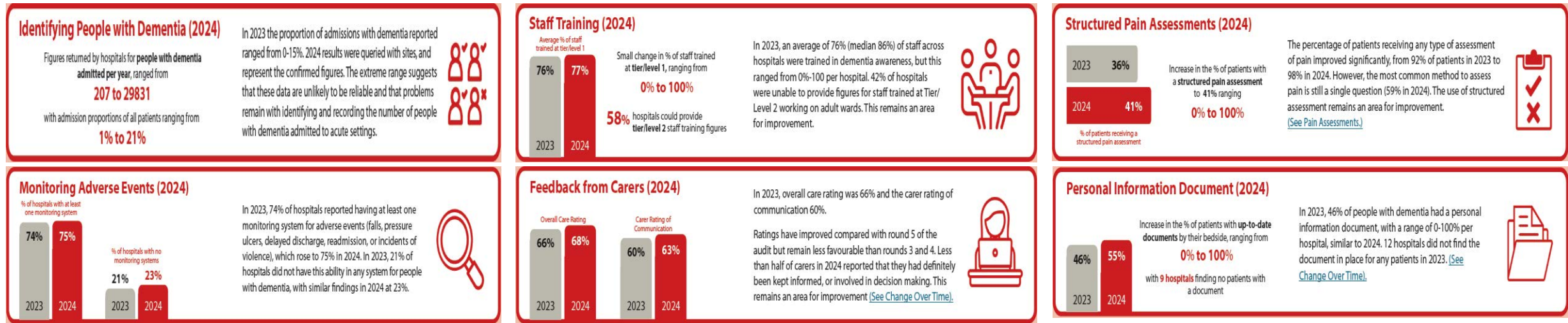
Report Concerns:	
1	Carer satisfaction questionnaire not completed in YYF site
2	Carer Communication to be improved
3	Sustainability of delirium screening, delirium care plan and dementia training is crucial for good practice to be embedded
4	IP falls where dementia has been associated risk should be monitored through HB QPS - as NAD does not cover a 12-month period
5	HB/corporate - need to record proportion of people with Dementia having falls in DATIX

Does your DATIX or other monitoring system identify the proportion of people with dementia within the totals for: Falls in hospital	National R6 % (N/D)	Nevill Hal Hospital		Royal Gwent Hospital		Ysbyty Ystrad Fawr	
Yes	70.9% (122/172)	-	No Data	-	No Data	-	No Data
No	28.5% (49/172)	No	No Data	No	No Data	No	No Data
Not Known/ Undocumented	0.6% (1/172)	-	No Data	-	No Data	-	No Data

HB/corporate - need to record proportion of people with Dementia having falls in DATIX



Priority Areas for Improvement



Report Recommendations:		S.M.A.R.T Actions:	Responsible: Due Date: Progress:
1	The Medical Director and Chief Nurse should ensure that all people with dementia admitted acutely to hospital are screened for delirium across clinical pathways using the 4-question 4AT. Screening should take place on admission, and at any other point when delirium is suspected.	Already in place	Site leads along with HB Clinical Lead for Dementia YYF – Dr Haddad RGH – Dr Subhan NHH – Dr Adel
2	The Chief Nurse should ensure that staff routinely gather personal information which details preferences and needs of people with dementia, involving care partners in this where possible. This information can then be appropriately shared with the staff providing care to support person centred interventions. Proforma documents, like the 'This is Me' booklet, are accessible at the point of care and serve as a useful example. Usage should then be monitored at Trust/Health Board Executive level.		Karen Collins/Natalie Skyrme – Senior nursing
3	Trusts/Health Boards should make use of NAD reported data, such as the summary Annual Dementia Statement containing information about assessment, use of personal information document, staff training, and monitoring of care, to support and demonstrate Quality Improvement in their hospitals, and within quality assurance reporting to regulatory bodies. Trusts/Health Boards should also encourage use of resources to support quality improvement including the Better Care Fund High Impact Change Model and the Dementia 100 self-assessment framework (due to be published early 2025).		Dr Singh, Amanda Whent

Winners of the MediWales Innovation Awards 2024 for their overall contribution to healthcare delivery in Wales

Rationale:	In England and Wales there are around 180,000 fractures each year as a result of osteoporosis. One in three women and one in five men will sustain a fracture in their lifetime. The Fracture Liaison Service Database (FLS-DB) captures the data of patients who have sustained fractures with the aim of preventing secondary fractures. This is the first year we compare the number of patients on anti-osteoporosis treatment at 16 and 52 weeks. The focus of this year’s annual report is on ensuring that patients who are at high risk of another broken bone have started treatment within 16 weeks of their first broken bone
Objectives:	Half of all adults aged 50 or over who break a bone after minimal trauma are at high risk of another fracture in the next few years, with over 50% of subsequent fractures in the next 10 years occurring within 2 years (the imminent fracture risk period). Preventing subsequent fractures is therefore a clinical and cost-effective priority for the NHS. These patients should be offered anti-osteoporosis treatment in line with NICE recommendations based on their fracture risk. All fracture liaison services (FLSs) aim to close this treatment gap effectively by systematically identifying patients at high risk of another fracture and organising an assessment to recommend, start and continue anti-osteoporosis treatment based on fracture risk and comorbidities. To achieve this, FLSs should initiate anti-osteoporosis treatment within 16 weeks of the fracture diagnosis for patients with high fracture risk.

Presented at Clinical Standards and Effectiveness Group – 27th February 2025											
FLS-DB	Total No. of patients (%)	KPI 2	KPI 3	KPI 4	KPI 5	KPI 6	KPI 7	KPI 8	KPI 9	KPI 10	KPI 11
ABUHB 2021	875 (23.4%)	22.6	27.1	21.3	29.2	34.5	57.7	4.8	1.4	8.3	18.4
ABUHB 2022	1649 (44%)	46	36.9	60.3	16.8	79.7	65.7	9.1	19	18.3	16.4
ABUHB 2023	2181 (58%)	61.3	46.8	75	17.5	94.9	65.3	17.1	57.5	46.9	26.2
ABUHB 2024	2638 (70%)	51	149.6	76.9	20.2	96.3	68.9	30.8	39.4	42.9	N/A
Wales 2021		10.8	5.3	65.1	27.1	61.5	56.8	3.9	13.7	10.2	30.2
Wales 2022		16.8	8	77.8	36.6	86.1	62.5	6	21.3	16	27.3
Wales 2023		18.6	9.7	79.6	25.4	90.8	66	10.6	41.4	34	19
Wales 2024		18.6	35.6	77.6	17.8	85.6	68.1	19.5	24.1	27.2	N/A

ABUHB - Data entry No.s

2018

2019

2020

2021

2022

2023

2024

0

500

1000

1500

2000

2500

3000

497/618

Report Successes:		Report Concerns:	
1	AB FLS has increased identification by 200% since 2021, this year reaching 70% (target 80%)	1	16 weeks adherence is remains under 50%
2	AB FLS continued to recommend bone treatment for 65% of patients (target 50%)	2	52 weeks adherence is remains under 25%
3	AB FLS received MEDI Wales Judges award for innovation and partnership working, seen as exemplar service in Wales	3	Business case for AB-FLS is presented at PIP and awaiting Executive approvals in March 2025
4	https://abuhb.nhs.wales/hospitals/a-z-of-services/fracture-liaison-service-fls/ The above link details the great work being carried out within the HB by the entire FLS team.		
5	Health and Social Care Judges Award – The Health and Social Care Judges’ Award is awarded to the applicant that embodies the spirit of the MediWales Innovation Awards and for their overall contribution to healthcare delivery in Wales. Winners: The Aneurin Bevan Fracture Liaison Service The Aneurin Bevan Fracture Liaison Service (AB-FLS) tackles undiagnosed osteoporosis in patients over 50, aiming to reduce repeat fractures and ease healthcare pressures. Untreated osteoporosis increases fragility fractures, impacting quality of life. AB-FLS integrates data from X-rays, CT, and MRI scans through a digital system to streamline fracture management. Developed with the Welsh Government, NHS Wales, and the Royal Osteoporosis Society, it prioritises prevention, early diagnosis, and timely treatment.		

Assurance level	Description	Risk level	Description
Limited	The project did not achieve the standards or criteria being audited against	Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Has this audit been placed on a Risk Register (N/A if above risk is None)		YES/NO	If not on a risk register, why not: Ongoing quality improvement work

[illegible]

Report Recommendations:		S.M.A.R.T Actions: Responsible: Due Date: Progress:
3	11.9% KPI 11 – adherence to prescribed antiosteoporosis This is in line with the findings from KPI 10 and KPI 11 outlined in appendix A, which demonstrate the lack of availability and prescription of anti-osteoporosis treatment among FLSs. FLSs can utilise the resources created by the FLS-DB to implement this initiative; this includes: > the FLS-DB resources, including the improvement workbook and FLS-DB quality improvement video, to upskill on methods for effective and efficient service improvement > forming a multi-stakeholder improvement group, including 2–3 patients and primary care representatives (refer to FFFAP improvement workbook) > exporting local service data for 2023–24 from the FLS-DB website, and examining the number of patients who had started on each type of osteoporosis treatment by 16 weeks against local/regional osteoporosis treatment recommendations > using these data to co-develop a set of SMART aims and outcomes for FLSs to improve KPI 10 > using service improvement methods to understand the reasons for this current service gap, including reviewing KPI 1–7 to prioritise scalable and sustainable interventions to improve performance; utilising the FLS-DB webinar on how to implement an improvement project > evaluating, learning and modifying changes to practice based on KPI changes, and sharing improvement performance by submitting learnings to the FLS-DB improvement repository through the KPI case study form to share with other FLSs.	Business case for AB-FLS is presented at PIP and awaiting Executive approvals next month AB FLS-DB Clinical Lead
4	55.2% KPI 2 – identification (non-spine), 34.4% KPI 3 – identification (spine fractures) 28% KPI 9 – monitoring contact 12–16 weeks post fracture ICBs and Welsh health boards should support regional advocacy groups for the establishment and improvement of FLSs. These advocacy groups would increase the quality of patient/caregiver engagement for local FLSs service improvement teams and establish the implementation of FLSs in areas without coverage. This is with the aim of increasing identification of patients who require fragility fracture care and ensuring that they receive the appropriate follow-up care. This can be achieved by: > utilising FLS-DB integrated care board data to identify gaps in FLS coverage > supporting new, and enhancing existing local advocacy groups to support regional FLS delivery, such as an ROS local support group > engaging with local clinicians to support the implementation of effective FLSs in the region > supporting local clinical teams to co-develop, implement and improve.	Ongoing and improvements require embedding
5	35.4% KPI 10 – commencing bone therapy by first follow-up 11.9% KPI 11 – adherence to prescribed antiosteoporosis medication at 12 months post fracture ICBs and Welsh health boards should work with FLSs and primary/community care in the co-production of sustainable patient pathways for primary care delivery of anti-osteoporosis treatment, such as injectable treatments. This is with the aim of facilitating better communication and transition of patient management between primary/community care and FLSs. This is in line with the findings from KPI 10 and KPI 11 outlined in appendix A, which demonstrate the lack of availability and prescription of anti-osteoporosis treatment among FLSs.	Business case for AB-FLS is presented at PIP and awaiting Executive approvals next month

Epilepsy12 - 2024 combined organisational and clinical audits: Report for England and Wales. Cohort 5 – The first year of care for children and young people after a first paediatric assessment between 1 December 2021 and 30 November 2022

Clinical Lead(s):
Dr Nadeem Syed – Consultant Paediatrician
Dr Michelle Barber – Consultant Paediatrician -

Rationale:	Epilepsy12, established in 2009, aims to improve the quality of care for children and young people with epilepsy. Epilepsy is the most common long-term neurological condition in childhood, affecting around 112,000 young people in the UK.
Objectives:	Epilepsy12 aims to enhance care standards for children and young people with epilepsy by auditing data on patient care and service organization. This data helps identify strengths and areas needing improvement.
CSEG date:	23 rd January 2025

Key Messages from Cohort 3:

- **Care Plans:** 70% of children and young people (CYP) had updated and agreed comprehensive care plans.
- **Transition Support:** 65% of health boards involved adult epilepsy specialist nurses in transitioning young people to adult services.
- **EEG Timeliness:** 54% of CYP diagnosed with epilepsy received their EEG within 4 weeks.
- **Mental Health:** 5% of CYP aged 5-15 diagnosed with epilepsy had an identified mental health condition.
- **Surgical Referrals:** 36% of CYP with epilepsy who met criteria for surgical referral were referred for surgical evaluation.

Key messages from Cohort 4:

- Participation
- Description of Cohort
- Diagnostic status
- Performance Indicators
- Initial Referral and examination
- Description of episodes
- Investigations
- Treatment
- Care Planning
- Professionals and services involved in care

Assurance level	Description	Select
Significant	The project has mostly achieved the standards or criteria being audited against	Yes
Risk level	Description	Select
Low	Peripheral element of treatment or service suboptimal	Yes

Has this audit been placed on a Risk Register (N/A if no risk is None)	YES/NO

Report Recommendations: (national)	
1	Support epilepsy teams not yet participating in the audit to value and contribute through Epilepsy12 participation. Promote the audit, provide training, develop the workforce and teams, plan jobs, and address local barriers. Integrated Care Boards (ICBs) should identify support routes and engage with quality improvement programs like the Epilepsy Quality Improvement Programme (EQIP) to assess and improve care quality in non-participating services. Action by: Integrated Care Boards (ICBs) in England and Health Boards in Wales, in collaboration with OPEN UK regional networks
2	Increase the scope and breadth of the epilepsy team. Ensure sufficient provision of Epilepsy Specialist Nurses (ESNs) and other professionals to support population needs. Core and specialized competencies required within the team should match population needs, including mental health, transition from paediatric to adult services, learning difficulties, neurodisability, and medical complexity. Action by: Integrated Care Boards (ICBs) in England and Health Boards in Wales
3	Establish or enhance processes and pathways to ensure timely access to care for children and young people. Identify and understand gaps in care provision. Establish structured referral pathways with designated coordinators. Action by: Integrated Care Boards (ICBs) in England and Health Boards in Wales.
4	ICBs and local Health Boards should develop engagement models to enable groups facing inequalities to contribute to service improvement. Use the Core20PLUS5 framework to identify challenges and co-create alternative service models. Ensure equitable access and care for epilepsy, aligning with efforts supporting other long-term health conditions. Action by: Integrated Care Boards (ICBs) in England and Health Boards in Wales, in collaboration with OPEN UK networks
5	Support participation and benchmarking against relevant ongoing quality improvement projects, in order to promote system-wide shared learning, collaboration and knowledge exchange. Action by: Integrated Care Boards (ICBs) in England and local Health Boards in Wales, in collaboration with OPEN UK regional networks.
Report Concerns: (to be completed by the Clinical Lead)	
1	Data entry not in job plans – admin support required
2	Waiting times for first seizure referrals and appointment – sickness within the team

Audit Title: National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Summary Report 2024	Clinical Lead: Dr Non Pugh – Consultant Rheumatologist	
	NICE Guidance :	QS33 – Rheumatoid arthritis in over 16s

Data Collection Period: 1 April 2023 – 31 March 2024 Year 6

Rationale:	Inflammatory arthritis, including rheumatoid arthritis (RA), affects over 400,000 people in the UK. Treatment delays can cause significant disability, reduced quality of life, and loss of productivity. Rare autoimmune rheumatic diseases (RAIRDs) like systemic vasculitides also face adverse outcomes, including permanent disability, due to treatment delays.
Objectives:	The NEIAA aims to enhance care quality for people with rheumatic diseases by collecting data on newly diagnosed patients over 16 in England and Wales. It includes conditions like inflammatory arthritides, systemic vasculitides, and connective tissue diseases. This data helps recommend standardized, effective, and patient-centered care pathways.

Presented at Clinical Standards and Effectiveness Group – 23rd January 2025

- Measures quality of care delivered to patients in England and Wales aged 16 and over with suspected and newly diagnosed early inflammatory arthritis
- Measured against NICE quality standards 33
- Also assesses how inflammatory arthritis affects people’s day-to-day function, mobility, sleep, wellbeing and ability to work
- Rheumatology clinical teams provide information about patient care over the first 3 months after diagnosis. This includes :
 - Referral times
 - Time to treatment
 - Clinical response to treatment
 - Patient Reported Outcome Measures (PROMs) - for 12 months

Key message 1
Increased engagement and data capture • Engagement has improved however the number of cases that are not captured is likely to be greater • Estimated that NEIAA captures approximately one third of cases eligible for enrolment.

Key message 2
Improved treatment timeliness The key metric used for measuring care quality and determining outlier status is the proportion of people living with EIA who start DMARD therapy within six weeks of referral

Key Message 3
• Stable remission rates with geographic variation • Remission rates within 12 weeks of treatment remain stable at 35 • Geographic variation in remission rates persists (see figure 5), There was also geographic variation in the proportion of patients receiving treatment within six weeks (see figure 6). • Remission rates higher in Wales at 49 %

No Local data is available for Key Messages 4, 5 & 6		
Assurance level	Description	Select
Full	The project has fully achieved the standards or criteria being audited against	yes
Risk level	Description	Select
None	Standards met and findings demonstrate no risk to patient safety	yes

THERE ARE NO OUTSTANING REPORT RECOMMENDATIONS FOR ABUHB

Audit Title: National Pregnancy in Diabetes Audit Dashboard 2023 (01 January 2021 to 31 December 2023)		Clinical Lead(s): Mrs Pinto & Mrs Lisa Pilkington, Consultants in Obstetrics and Gynaecology

Rationale:	The National Pregnancy in Diabetes Audit (NPID) is part of the National Diabetes Audit (NDA), managed by NHS England in agreement with the Healthcare Quality Improvement Partnership (HQIP). The NDA, in partnership with Diabetes UK, has been running since 2014.
Objectives:	The audit and dashboard measure the quality of antenatal care and pregnancy outcomes for women with pre-gestational diabetes, supporting quality improvement at various levels. The latest dashboard includes data from pregnancies ending between January 2021 and December 2023, featuring continuous glucose monitoring (CGM) data for the first time. It answers three key questions: preparation for pregnancy, steps taken to minimize adverse outcomes, and occurrence of adverse outcomes. Data are submitted by antenatal services in England and Wales.

Presented at Clinical Standards and Effectiveness Group – 23rd January 2025

Report Successes:	
1	Lower rates of macrosomia
2	Lower rates of NICU admissions
3	Lower rates of preterm births
Report Concerns:	
1	Higher proportion of women not on the right dose of folic acid at the start of pregnancy
2	Higher proportion of women with suboptimal HbA1C at start of pregnancy
3	Higher proportion of women with suboptimal HbA1C in 3 rd trimester
4	Deficit in data submitted to NPID

Assurance level	Description	Select
Significant	The project has mostly achieved the standards or criteria being audited against	Yes
Risk level	Description	Select
Minor	Single failure to meet internal standards/Minor implications for patient safety if unresolved	Yes
Has this audit been placed on a Risk Register (N/A if above risk is None)		NO

No National Report/Recommendations:

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible person	Due Date: Progress:
1	Quarterly meeting AN diabetes forum to continue		AMP	ongoing
2	Clinical pathways for pre-conception care –focussing on T2DM – in development		LPP with primary care	Mar 2026
3	Clinical oversight of data input		AMP and LPI	ongoing

Conclusion..
 As per the report, the HB has lower rates of macrosomia, SCBU admissions and Preterm labour, compared to England and Wales data. Data input to NPID database from GUH is incomplete. The HB has lower proportion of women starting and ending the pregnancy with optimal HbA1c. There is a need to improve data collection (capture all women) and improve successful uploading of data onto the NPID data base

- for NHH- data now entered by clinical team
- for RGH- continuing with MD’s audit office support

Audit Title: Wales Primary Care Clinical Audit Report 2021–23. Publication year: 2024

NICE 2023 QS10 (QS1): People aged over 35 years who present with a risk factor and one or more symptoms of COPD have post-bronchodilator spirometry.

NICE 2018 QS25 (QS1): People aged 5 years and over with suspected asthma have objective tests to support diagnosis

Clinical Lead: Bethan Williams – Senior Nurse Primary Care

Rationale:

This report analyses asthma and COPD primary care data in Wales from the Welsh primary care audit component of the National Respiratory Audit Programme (NRAP). Data collected from 359 general practices in Feb 2024, covering activity from Aug 2021 to July 2023.

Objectives:

The audit builds on previous reports to support NRAP's healthcare improvement goals. It aims to help stakeholders use data to enhance care quality for asthma and COPD patients. The report includes key findings and national recommendations from the 2021–23 Welsh primary care audit, with 96% of Welsh practices participating.

Comparing results with previous reports should be done cautiously due to the significant impact of the COVID-19 pandemic on earlier audit periods. Additionally, younger children aged 1–5 were not included in this audit round.

Presented at Clinical Standards and Effectiveness Group – 23rd January 2025

Recommendation 1

COPD - The percentage of people diagnosed with COPD in the last 2 years who have a post-bronchodilator test with an appropriate numeric value.							
Name	Denominator (N)	Any spirometry ratio codes* ≥0.2 and <0.7 (n)	Any spirometry ratio codes ≥0.2 and <0.7 (%)	Post-bronchodilator code** with spirometry ratio ≥0.2 and <0.7 (n)	Post-bronchodilator code with spirometry ratio ≥0.2 and <0.7 (%)	Any post-bronchodilator code (n)	Any post-bronchodilator code (%)
Wales	13473	3653	27.1	644	4.8	2882	21.4
Aneurin Bevan LHB	2460	587	23.9	99	4	504	20.5

*Other 339 Read codes eg 339j, 339k, 339R

**Read code 339m

Adults with asthma							
Name	Denominator (N)	Any FEV1/FVC code* (+ reversibility) test in the past 2 years (n)	Any FEV1/FVC code (+ reversibility) test in the past 2 years (%)	Any spirometry (+ reversibility) test in the past 2 years (n)	Any spirometry (+ reversibility) test in the past 2 years (%)		
Wales	18032	116	0.6	840	4.7		
Aneurin Bevan Local Health Board	3355	40	1.2	222	6.6		

Children with asthma (6 years and above only)

Name	Denominator (N)	Any FEV1/FVC code* (+ reversibility) test in the past 2 years (n)	Any FEV1/FVC code (+ reversibility) test in the past 2 years (%)	Any spirometry (+ reversibility) test in the past 2 years (n)	Any spirometry (+ reversibility) test in the past 2 years (%)		
Wales	7079	3	0.0	156	2.2		
Aneurin Bevan Local Health Board	1426	0	0.0	50	3.5		

*Read codes 339j, 339m and 339M

Recommendation 2

Results summary

0.7%

of parents/carers of children with asthma were asked about their second-hand smoke exposure.

73.8%

of patients with COPD had their smoking status recorded.

66.3%

of adults with asthma had their smoking status recorded.

40.8%

of children with asthma had their smoking status recorded.

Smoking

Percentage and status of people with COPD and asthma (adults and children) who were asked about tobacco smoking in the last 15 months and their smoking status

COPD									
								Not asked about smoking (n)	Not asked about smoking (%)
Name	Denominator (N)	Non-smoker (n)	Non-smoker(%)	Ex-smoker (n)	Ex-smoker (%)	Current smoker (n)	Current smoker (%)		
Wales	83529	7514	9	31080	37.2	23077	27.6	21858	26.2
Aneurin Bevan Local Health Board	15392	1536	10	5785	37.6	4470	29	3601	23.4

Adults with asthma									
								Not asked about smoking (n)	Not asked about smoking (%)
Name	Denominator (N)	Non-smoker (n)	Non-smoker(%)	Ex-smoker (n)	Ex-smoker (%)	Current smoker (n)	Current smoker (%)		
Wales	175752	60093	34.2	33931	19.3	22574	12.8	59154	33.7
Aneurin Bevan Local Health Board	33785	12287	36.4	6600	19.5	4250	12.6	10648	31.5

Children with asthma (6 years and above only)									
								Not asked about smoking (n)	Not asked about smoking (%)
Name	Denominator (N)	Non-smoker (n)	Non-smoker(%)	Ex-smoker (n)	Ex-smoker (%)	Current smoker (n)	Current smoker (%)		
Wales	8985	3294	36.7	94	1	278	3.1	5319	59.2
Aneurin Bevan Local Health Board	1638	626	38.2	13	0.8	46	2.8	953	58.2

Recommendation 3

Pulmonary rehabilitation (PR)

Percentage of people with COPD who are breathless (MRC scores 2–5) and have been referred to pulmonary rehabilitation in the last 3 years.

COPD (MRC score 2–5)

Name	Denominator (N)	Referred for PR (n)	Referred for PR (%)
Wales	64241	5783	9
Aneurin Bevan Local Health Board	11513	884	7.7

Percentage of people with COPD who are breathless (MRC score 3–5) and have been referred to pulmonary rehabilitation in the last 3 years.

COPD (MRC score 3–5)			
Name	Denominator (N)	Referred for PR (n)	Referred for PR (%)
Wales	33518	4660	13.9
Aneurin Bevan Local Health Board	6154	713	11.5

Results summary

13.9%

of patients with COPD with an MRC score of 3–5 have been referred to PR in the last 3 years.



503/618

Recommendation 4

Personalised asthma action plans			
Percentage of people (adults and children) with asthma who have had a PAAP anytime in the last 15 months			
Adults with asthma			
Name	Denominator (N)	PAAP anytime in the last 15 months (n)	PAAP anytime in the last 15 months (%)
Wales	175752	49009	27.9
Aneurin Bevan Local Health Board	33785	11239	33.3
Children with asthma (6–18 years old)			
Name	Denominator (N)	PAAP anytime in the last 15 months(n)	PAAP anytime in the last 15 months (%)
Wales	24214	5837	24.1
Aneurin Bevan Local Health Board	4731	1381	29.2
Assurance level	Description		Select
Limited	The project did not achieve the standards or criteria being audited against		✓
Risk level	Description		Select
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon		✓
Has this audit been placed on a Risk Register (N/A if above risk is None)			YES/ NO
If not on a risk register, why not:			
Diagnostic spirometry was recovering at the time of the audit. Health boards set up spirometry hubs, managed by the Primary Care Respiratory Nurse Team (PCRNT), to address the Covid-19 backlog. PCRNT delivered education and training programs on spirometry testing and result interpretation to General Practice Nurses (GPNs), Healthcare Support Workers (HCSWs), and GPs. Mentoring of staff in clinic settings as available and provided to support the process.			

Clinical Leads Local Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Spirometry Hubs in process of setup with plan to commence April 25	Number of hubs. No of patients assessed. No referrals received. Number of staff trained.	Primary and community care	April 25	Service implementation plan complete Clinic set up and planning in progress with team. Includes training of new staff
2	Incorrect/inaccurate coding on GP computer systems i.e. codes used not in keeping with codes used within NACAP audit.	Number of reviews undertaken using COPE. SNOMEd coding for Post BD spirometry. Number of referrals	GMS Primary and Community care	ongoing	COPE pilot undertaken in 5 GP practices

Report Concerns:

1	Incorrect/inaccurate coding on GP computer systems i.e. codes used not in keeping with codes used within NACAP audit.
2	Ongoing provision of spirometry in Primary care -Cost of ARTP training/ re accreditation, some GP practices not happy to incur the ongoing costs. Spirometer being undertaken in practices by those who are not ARTP accredited.
3	Staff retention and recruitment – home oxygen, Challenge staff with skills and training, On risk register.

Report Successes:

1	Alignment and adoption of All Wales COPD and Asthma guidelines (Asthma guidelines updated Feb 24) PCRNT providing education in partnership with IPCC Academy. Training provided to both new and existing GPN 34 practices supported with education and training
2	Alignment of inhaler prescribing to decarbonisation strategy - PCRNT supporting individual practices with education and training also providing education In partnership with IPPC Academy, ABUHB GPN nursing forums Green inhaler project undertaken by RNS team- Practices with highest carbon footprint identified by prescribing data supported with education and RNS clinics s. Team finalists in NHS Wales Sustainability Awards 2024
3	Gold standard O₂ service – Service redesign underway, team working as a pooled resource to support demand and needs of service. Single point of referral and contact achieved aligning to recommendation in Primary care model for Wales.
4	Joint working projects with pharma – parallel working with AZ and Research innovation Wales – COPE template. ABUHB leading the way with pilot, aimed to standardise COPD reviews and improve coding (as per recommendation 5 NRAP audit)

Report Recommendations:		S.M.A.R.T Actions:		Responsible:	Due Date:	Progress:
1	Local health boards should implement a strategy to ensure that all patients have access to trained clinicians within primary care settings who can accurately diagnose COPD and asthma. This should ensure that 70% of patients with COPD have undergone quality-assured post-bronchodilator spirometry to confirm obstruction, and 70% of individuals diagnosed with asthma within the past 2 years should have documented at least one objective measurement by July 2025.	1 number of hubs. 2 No of patients assessed. 3 No referrals received. 4 Number of staff trained.		Primary and Community services Jan25	April 25	- Mapping work complete. - Service implementation plan complete. - Commence spirometry hubs April 24 - HCSW roles to support work.
2	Local health boards should ensure that tobacco dependency pathways are embedded in primary care, so that all children and young people with asthma have second-hand smoke exposure recorded, and parents/carers of children with asthma who smoke receive Very Brief Advice and are offered support to quit by July 2025. This will further support the Welsh government’s ambition to be smoke-free by 2030.	Well established pathways in place for Smoking cessation across ABUHB and GMS This work stream is led by PHW Children with asthma pathways responsibility of GMS and secondary care Paediatric respiratory team				
3	Local health boards should provide training resources and increase engagement between providers and primary healthcare practitioners to reduce the identified barriers and increase referral to pulmonary rehabilitation (PR) for appropriate patients with COPD to 70% by July 2025.	Responsibility for Pulmonary rehabilitation currently with secondary care respiratory medicine. - Established pathways in place for referral in from GMS to Secondary care. - PR paused during covid due to this and backlog caused, referrals and communication to encourage referrals was limited - Discussion underway between secondary care and primary & Community care which includes a proposal of how we can work together to support delivery of programmes moving forward and improve uptake and referrals				
4	Local health boards should prioritise and promote the development and use of personalised asthma action plans within primary care settings to ensure that, by July 2025, 75% of patients diagnosed with asthma have the essential tools to help manage their condition.	1. 2. 3.	Number of asthma patients coded with PAAP Number of patients with access to NHS Wales APPs Number of practices receiving support with training and education	GMS Primary and community	Aug 25	
5	Local health boards and DHCW should promote the use of preferred respiratory SNOMED CT codes as used within the NRAP audit to ensure accurate coding for patients with asthma and/or COPD thereby improving the quality of data available for services by the next data extraction in the NRAP audit in August 2025.	1. 2. 3.	Number of reviews undertaken using COPE. SNOMEd coding for Post BD spirometry Number of referrals	Primary and community care	Ongoing	COPE pilot undertaken in 5 GP practices To increase pilot sites as guided by joint working group.
135/135		505/618				

DYDDIAD Y CYFARFOD: DATE OF MEETING:	03 June 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

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

Ar Gyfer Trafodaeth/For Discussion

The purpose of this report is to provide a summary of the current strategic risks that have been delegated to the Patient Quality, Safety, and Outcomes Committee (the Committee) for monitoring, on behalf of the Board.

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation & Cefndir / Background

At the last Committee meeting in March 2025, it was reported that the risk environment remained stable, with no changes to the risk scores of the monitored risks. This stability has continued into the current reporting period.

As of the time of writing, the Committee Risk Register includes **three** high-level risks and **three** associated sub-risks, spanning the areas of service delivery, transformation and partnership working, and compliance and safety.

Asesiad / Assessment

Committee Strategic Risk Register

Table 1 below provides the current status of the **three** strategic risks. In accordance with best practice, all risks have been reviewed within the appropriate timeframe for their respective levels of risk.



The review focuses on the control environment, ensuring that the controls remain robust and adequate for managing the identified risks. Additionally, the assurances are tested to verify the robustness of the controls. Detailed information is provided in **Appendix A** (Strategic Risk Dashboard and individual risk assessments).

Table 1

Risk Ref:	Risk Description	Sub-Risk	Risk Level	Within Appetite
SRR 005 Chief Operating Officer Theme Service Delivery Appetite Open Score 17 and below	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	Due to inadequate arrangements to support system-wide patient flow.	High 3 x 4 (12)	Y
SRR 008 Director of Nursing Theme Transformation & Partnership Working Appetite Open Score 17 and below	There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.	Moderate 2 x 4 (8)	Y
SRR 010 Director of Therapies & Health Science Theme Compliance & Safety Appetite Minimal Score 8 and below	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974.	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed, and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	High 3 x 4 (12)	N

For **SRR 005** and **SRR 008**, the risks remain within the Health Board's defined risk appetite, offering a greater level of assurance that they are being effectively controlled and mitigated. Ongoing engagement with risk owners will ensure that existing controls remain robust and proportionate to prevent the realisation of these risks.



SRR 010 continues to be managed outside the Health Board’s agreed risk appetite, with the residual risk subject to regular scrutiny by the Executive Committee. Since the risk was first identified, considerable progress has been made to mitigate both its likelihood and impact, most notably through the Health and Safety Improvement Plan, which has strengthened legislative compliance and supported ongoing service delivery.

The Board has articulated a minimal risk appetite for compliance and safety, underscoring its commitment to meeting statutory obligations and safeguarding patients, staff, and visitors. In line with this position, any risks with a residual score **above the threshold of 8** must be actively managed, reduced, or eliminated where feasible, and are subject to targeted intervention and close executive oversight.

The table below outlines the corresponding management response to this risk.

Risk ID	Sub Risk Description	Current Score	Risk Management
SRR 010	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	12	Treat the residual risk, but also Take the Opportunity to improve staff safety culture.

Internal Audit has provided valuable input through a pre-audit review, identifying specific areas where the Health and Safety Team can strengthen its processes. The full audit findings are expected to be presented to the Audit, Risk and Assurance Committee in June 2025 and are anticipated to reflect positively on the measures implemented and the progress achieved to date.

The subsequent report to this Committee and the Board should provide the necessary assurance that the likelihood of the risk is being effectively mitigated, which in turn could reduce the potential consequence should the risk materialise.

Horizon Scanning

Update on Nursing Education at Cardiff University

Cardiff University has reversed its initial decision to close its School of Nursing, following widespread opposition from stakeholders including students, staff, unions, and political representatives. The University is now exploring an alternative proposal that would retain adult, child, and mental health nursing programmes, though with a reduced undergraduate intake.

This revised approach aims to sustain nursing education provision while enhancing the student experience and maintaining a research base in Wales.



The Health Board continues to closely monitor developments in this area through multiple channels. These developments will be reflected in the Strategic Risk Register (SRR 001A) relating to workforce recruitment and retention, where nursing education is recognised as a key contributing factor within the Health Board's overall risk portfolio.

Argymhelliad / Recommendation

The Committee is requested to:

- **NOTE** the delegated strategic risks;
- **NOTE** the work being undertaken to ensure the Committee is sighted on all risks that have the potential to impact patient quality and safety.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The Strategic Risk Register is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	N/A



Rhestr Termiau: Glossary of Terms:	N/A
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	The Board and respective Committees of the Board have considered risks contained within the Strategic Risk Register

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. N/A



Reference	Risk Owner	Risk Description	Reason For The Risk	Risk Score Matrix											
				2	4	5	6	8	9	10	12	15	16	20	25
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow						✕ ← - - - ●				◇		
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement		✕ ← - - - ●								◇		
SRR 010	Director of Therapies and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.				✕ ← ◇ - - - ●								
Assessment of adequacy of assurances	POSITIVE = Identified assurances are deemed robust in telling us that the controls in place are working effectively.														
	REASONABLE = Identified assurances are deemed adequate in telling us that the controls in place are working effectively, however some gaps have been identified which need to be addressed.														
	NEGATIVE = Identified assurances are deemed insufficient in telling us that the controls in place are working effectively with substantial gaps identified which need to be addressed.														

Key	Current Score	●
	Target Score	✕
	Appetite Threshold	◇
	Current to Target	← -

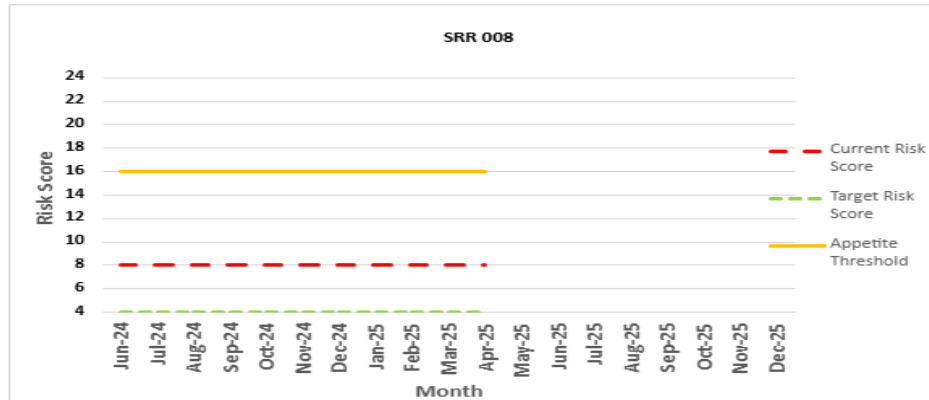
RISK THEME	SERVICE DELIVERY			
LINK TO IMTP	SECTION 3: SYSTEM CHANGE			
Strategic Risk SRR 005 A	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system			Publication Status Public
Threat (As a result of)	Due to inadequate arrangements to support system-wide patient flow			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.
Impact (Consequences of the threat)	<u>Patient</u> - Avoidable deaths and significant harm. - Delayed discharges from acute and non-acute settings resulting in deteriorating patients. - Delays in releasing ambulances from hospital sites back into the community.	<u>Staff</u> - Increased workload - Fatigue & burnout	<u>Organisation</u> - Litigation & Financial Penalties - Reputational damage and loss of public confidence	Risk Appetite Threshold – OPEN SCORE 17 AND BELOW Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.
Lead Director	Chief Operating Officer	Risk Exposure	Current Level	Target Level
Monitoring Committee / Group	Patient Quality, Safety and Outcomes Committee	Likelihood	3 (Possible) x	3 (Possible) x
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)
Last Reviewed	01 May 2025	Risk rating	= 12 (High)	= 9 (High)
Next Review (Quarterly based on risk score)	01 August 2025			

SRR 005 A

Month	Current Risk Score	Target Risk Score	Appetite Threshold
Jun-24	12	9	17
Jul-24	12	9	17
Aug-24	12	9	17
Sep-24	12	9	17
Oct-24	12	9	17
Nov-24	12	9	17
Dec-24	12	9	17
Jan-25	12	9	17
Feb-25	12	9	17
Mar-25	12	9	17
Apr-25	12	9	17
May-25	12	9	17
Jun-25	12	9	17
Jul-25	12	9	17
Aug-25	12	9	17
Sep-25	12	9	17
Oct-25	12	9	17
Nov-25	12	9	17
Dec-25	12	9	17

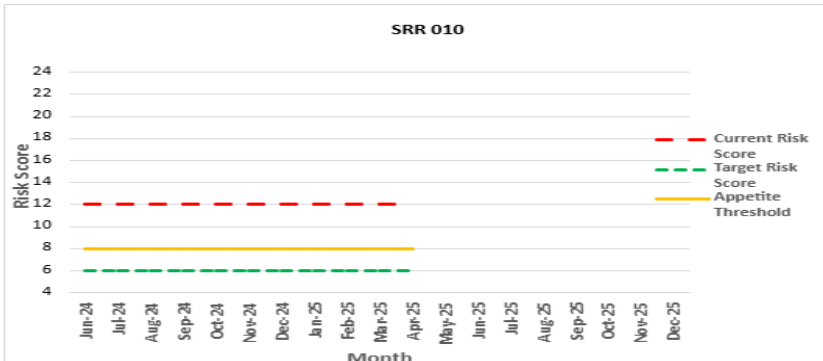
Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- Escalation Policy. - Performance and Accountability Framework - Operational Framework - Major incident Procedures - Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. - Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. - fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. - Enhanced monitoring in place for U&EC - Range of performance measures/metrics in place - Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. - Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. - Planned care recovery meetings with the NHS execs. - Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. - WG – IQPD meetings to review areas of focus	- New developments and pathways coming online into FY25/26 - New expanded transfer lounge o New ED extension and reconfiguration - Additional ED consultants coming onboard - Safety Flow agenda delivering wider developments and improvements

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- The Escalation Framework has been enacted and ineffective in mitigating threats and impact to services. - Performance report against measures/metrics		- Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. - The impact of the Performance and Accountability framework in improving patient flow	Close monitoring and reporting of the frameworks in practice to support learning and improvements.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Divisional Assurance reviews. - Performance against measures/metrics reported to the Executive Committee		Effectiveness of the Operational Framework	Operational framework coming into place in November / December 2024 and will be tested as part of a deep dive exercise.
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit Reviews - Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024. - External inspections/visits. -		None	N/A
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
LINK TO IMTP	SECTION 4: ENABLER - QUALITY				
Strategic Risk SRR 008	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public.			Publication Status	Public
Threat <i>(As a result of)</i>	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.		Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.		
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> - Unmet patient needs resulting in patient harm. - Ineffective use of combined resources - Delayed decision making - Adverse impacts on delivery of care to patients across acute and non-acute settings	<u>Staff</u> N/A	<u>Organisation</u> - Failure to deliver health board priorities, required improvements and achieve longer-term sustainability - Reputational damage and loss of public confidence	Risk Appetite Threshold – OPEN SCORE 17 and Below All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.	
				SUMMARY The current risk level is OUTSIDE of target but WITHIN the appetite threshold. Target level is WITHIN the set appetite threshold.	
Lead Director	Director of Nursing	Risk Exposure	Current Level	Target Level	
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)	
Last Reviewed	01 January 2025	Risk rating	= 8 (Moderate)	= 4 (Low)	
Next Review (Six monthly based on risk score)	01 July 2025				

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- Corporate Engagement Team - Patient Experience and Involvement Strategy- organisational ownership - Person Centred Care (PCC) Surveys and National surveys via CIVICA - PCC KPI's (support PCC Quality pillar) 'You said..... we did' public facing information for service areas. - PLO service at GUH - Introduction of PALS Service (Oct 23) - Volunteer Patient Experience Feedback - Collaboration to recruit community listeners to support Dementia Awareness - Digital patient stories to support listening and learning. - Patient Experience and Involvement Strategy - DATIX - Oversight of Medical Examiner reports to determine patient experience actions - Public Engagement- Big Conversation Bereavement held 20th March 2024 - People Participation Panel ED in Progress - Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams.	- Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. - PCCT staff training to support Civica data entry and retrieval. - Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. - Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to QPSOG - Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. SMS provision to be implemented in Feb 2025 across ED and all MIU's. - National directives around new national surveys that need to be managed additional to internal roll out programme. - Volunteer feedback to be reviewed to identify themes. - Need to develop bereavement model and improve bereavement offer to meet Bereavement Standards. Resources being scoped.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Concerns are fed back to divisional teams when identified. - Outcome of the volunteer feedback to drive improvements. - Patient Experience and Involvement Team undertaking Culturally Competent Accreditation, receiving a silver distinction award in Oct 2024 - Immediate feedback and escalation to clinical teams following PALS queries and concerns - Civica patient feedback in in the process of being rolled out across all – all divisional leaders receive reports for their live areas monthly.	- Currently there is no SMS provision to increase the number of surveys. - No single point of contact or ‘drop in’ provision for patients/families/staff to raise initial patient experience concerns. - Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards. - CIVICA team have the ability to pull and view feedback that has been left by patients/family. The listening and learning from the feedback to be shared by each department/directorate/division i.e., / ‘you said, we did’ / quality improvement projects.	- SMS provision for patient experience feedback will be launching in ED and all MIU’s in February 2025. - PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing ‘drop in’ clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Need to have discussions with facilities around rooms. - Patient experience KPI’s and common themes by department/directorate/division need to be identified and pulled from the civica system left on surveys feedback. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation. - Development of a ABUHB bereavement survey has been built within CIVICA and tested. Launch date likely early 2025.	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) - Listening and Learning reported through QPSOG/ Outcomes Committee - Implemented PALS DATIX Module	None	N/A	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Bi-monthly LLais Reports - HIW inspections - Advocacy reports	None	N/A	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable

RISK THEME	COMPLIANCE AND SAFETY					
LINK TO IMTP	SECTION 4: ENABLER – WORKFORCE & CULTURE					
Strategic Risk SRR 010 A	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974				Publication Status	Public
Threat <i>(As a result of)</i>	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.			Risk Appetite Level – MINIMAL Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below.		
Impact <i>(Consequences of the threat)</i>	Patient - Unintended physical harm to patients - Psychological trauma	Staff - Unintended physical harm to staff - Psychological trauma - Increased levels of staff sickness	Organisation - Punitive actions from the Health and Safety Executive (HSE) - Loss of estates due to unsafe environments - Financial implications - Adverse publicity - Reputational damage.		Risk Appetite Threshold – SCORE OF 8 or Below Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls.	
					SUMMARY The current risk level is OUTSIDE of target level and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
						
Lead Director	Director of Allied Health Professions and Health Science		Risk Exposure	Current Level	Target Level	
Monitoring Committee	Patient Quality, Safety and Outcomes Committee		Likelihood	3 (Possible) X	2 (Unlikely) X	
Initial Date of Assessment	01 December 2023		Impact	4 (Major)	3 (Moderate)	
Last Reviewed	01 May 2025		Risk rating	= 12 (High)	= 6 (Moderate)	
Next Review (Quarterly based on risk score)	01 Aug 2025					

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. - Health and Safety Policies and Procedures - Dedicated Health and Safety site on ABPULSE - Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. - Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) - Partial Programme of Health and Safety Monitoring (Active & Reactive) - Corporate and Directorate Health and Safety Risk Register established. - Board Training /development (Completed 24 April 2024) - Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. - Health and Safety Governance and reporting arrangements (Health and Safety Committee)	- Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System - Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) - Consultation and communication with the workforce regarding compliance with the Act - New ways of working with Divisions to ensure accountability for health and safety is recognised. - Implement key performance indicators to monitor health and safety compliance. - Review the governance arrangements for the Health & Safety Committee - Health and Safety Policies and Procedures to be reviewed. - Onboard further Manual Handling trainers across the organisation to improve compliance. - Scope for training non-Health Board staff - Learning from events to be documented and communicated to the organisation.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
Health and Safety compliance data extracted from ESR and Datix and reported		• Implementation of a health and safety performance report • Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act • Compliance on completion of risk assessments and mitigating actions	• Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Review the membership and ToRs of the Health and Safety Committee • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
• Established monitoring of H&S at the Executive Committee • Corporate H&S report risk and assurance to the Health and Safety Committee Established monitoring of H&S at the PQSO Committee		• Thematic Risk Register	• Development of a thematic risk register to be discussed at the Health and Safety Committee
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit 2024/25 Plan • Health and Safety Internal Audit – To be reported • Performance reviews at All Wales Health and Safety Management Steering Group • South Wales Fire & Rescue Service fire safety audit programme. Health and Safety Executive reviews/inspections.			
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls		Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.
		Reasonable	

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	03 June 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Patient Quality, Safety and Outcomes - Committee Forward Work Plan 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Board Business

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Patient Quality, Safety and Outcomes Committee is asked to consider the draft Committee Forward Work Plan appended to this report for approval. The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2024/25 to enable the Committee to: -

- Fulfil its Terms of Reference; and,
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference.

Cefndir / Background

The purpose of the Patient Quality, Safety and Outcomes Committee is to support the Board by seeking assurance in respect of all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services.

In line with good governance practice, a Committee Forward Workplan has been developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The workplan can therefore be utilised as a tool for informing and pre-empting committee business and support the agenda setting process.

Asesiad / Assessment

The Committee is requested to approve the Committee forward workplan as outlined in **Appendix 1** noting that the workplan will be presented at each Committee meeting for oversight and noting.

Argymhelliad / Recommendation

The Committee is requested to:

- **RECIEVE** and **APPROVE** the proposed Committee workplan for 2025/26 and **NOTE** that it will be brought forward to each future Committee meeting for oversight.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termiau: Glossary of Terms:	N/A

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Not Applicable
• Service Activity & Performance	Not Applicable
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Annual Programme of Business for 2025-26

Patient, Quality, Safety and Outcomes Committee

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee's self-assessment for 2023/24
- The Board's Strategic Risk Register; and
- Key statutory, national and best practice requirements and reporting arrangements.

Area of Focus as per the Committee's Terms of Reference:
The scope of the Patient Quality, Safety and Outcomes Committee encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on: a. The robustness of the Health Board's Clinical Quality Governance arrangements; b. the experience of patients, citizens and carers ensuring continuous learning; c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services; and d. the effectiveness of arrangements in place to support Improvement and Innovation.

Where required, the Committee will provide accurate, evidence based (where possible) and timely advice to the Board in respect of citizen experience and the quality and safety of directly provided and commissioned services.

MATTERS TO BE CONSIDERED	Lead	Frequency of Report						
			QTR 1		QTR 2	QTR 3		QTR 4
			31 st March	3 rd June	29 th July	1 st Oct	2 nd Dec	17 th Feb
Attendance and Apologies	Chair	SI	✓	✓	✓	✓	✓	✓
Declarations of Interest	All members	SI	✓	✓	✓	✓	✓	✓
Minutes of the Previous Meeting	Chair	SI	✓	✓	✓	✓	✓	✓
Action Log and Matters Arising	Chair	SI	✓	✓	✓	✓	✓	✓
Development of Committee Annual Programme of Business 2025/26	Chair & DoCG	AN	✓				✓	
Review of Committee Programme of Business 2025/26	Chair	SI	✓	✓	✓	✓	✓	✓
Annual Review of Committee Terms of Reference 2024/25	Chair & DoCG	AN	✓				✓	
Annual Review of Committee Effectiveness 2024/25	Chair & DOCG	AN	✓				✓	
Outcome of Annual Review of Committee Effectiveness 2024/25	Chair & DOCG	AN	✓					✓
Committee Annual Report 2024/24	Chair & DOCG	AN	✓					

Committee Annual Report 2025/26	Chair & DOCG	AN						✓
Committee Risk Report	DOCG	SI	✓	✓	✓	✓	✓	✓
NHS Wales Joint Commissioning Quality Committee Report	DOCG	SI	✓	✓	✓	✓	✓	✓
Quality Annual Report 2023/24	DoN	AN				✓		
Quality Management System and Assurance Framework Annual Review	Clinical Executives	AN	✓					✓
Quality Outcomes Reporting	DoN /MD & DOTHS	Quarterly	✓ Interim	✓ Q4	✓ Q1	✓ Interim	✓ Q2	✓ Q3
Primary Care Quality Report	COO	Bi-AN				✓		
Quality Management Group Reporting, including escalation through Quality Management System	DoN	SI	✓	✓	✓	✓	✓	✓
Healthcare Inspectorate Wales Annual Report	DoN	AN	✓					
Healthcare Inspectorate Wales Reviews	DoN	As reported						
Commissioning Assurance Framework Annual Review	Clinical Executives	AN		✓				
Commissioning for Quality Outcomes Report	Clinical Executives	Bi-An	✓			✓		
Putting Things Right Annual Report 2023/24	DoN	AN				✓		
Maternity and Neonatal Report	DoN	Bi-An			✓			✓

Learning from Death Report	MD	Bi-AN			✓			✓
Listening and Learning Framework Annual Review	DoN	AN	✓					
Serious Incident Learning Report	DoN	AN					✓	
Health and Safety Compliance Annual Report	DoT&HS	AN			✓			
Safeguarding Annual Report	DoN	AN			✓			
Ward Accreditation Report	DoN	AN					✓	
Nurse Staffing Levels (Wales) Act 3-year report (3-yearly)	DoN	AN					✓	
Nurse Staffing Levels Wales Act Annual Assurance Report	DoN	AN				✓		
Annual Report on Clinical Audit Activity 2023 – 2024	MD	AN		✓				

Lead Officer	
Key	
CEO	Chief Executive
DoCG	Director of Corporate Governance
DoF&P	Director of Finance & Procurement
DoSP&P	Director of Strategy, Planning & Partnerships
COO	Chief Operating Officer
DPH	Director of Public Health
DoT&HS	Director of Therapies & Health Science
DoW&OD	Director of Workforce & Organisational Development
DoN	Director of Nursing
MD	Medical Director
DOD	Director of Digital
Chair	Chair

Frequency of Inclusion	
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item
An	Annual
1/4ly	Quarterly
BI	1/2 yearly
Schedule of Meetings	
v	Scheduled agenda item in FWP
D	Deferred from this agenda
vD	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

Agenda Item

6.2.1

Joint Commissioning Committee

Quality Safety and Outcomes Sub-Committee Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Maxine Evans, Interim Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter	Mandy Rayani, Lay Member
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
N/A		Choose an item.

1. SITUATION/BACKGROUND

This report had been prepared to provide a summary of the key issues considered by the Joint Commissioning Committee Quality, Safety and Outcomes sub-committee at its meeting on 31 March 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the Joint Committee and the sub-committees are set out in Paragraphs 2.18 and 2.20 of the JCC [Standing Orders](#).

The Quality and Safety Outcomes Committee Terms of Reference can be found [here](#).

3. HIGHLIGHT REPORT

RAG Rating	Highlight
Alert / Escalate	Members commented on the importance of developing a video tour for the Mother and Baby Unit and agreed to highlight this in the Chairs report, and to provide feedback to the HB that provides this service.
Advise	- Members were advised that further work was being undertaken on the Quality Newsletter to align it with the JCC communications strategy. This was close to being completed and will be referred to as a Quality Bulletin. - Members received an update on the escalation status of the Paediatric Critical Care Unit (PCCU) and the Neonatal Intensive Care Unit (NICCU) at the Children's Hospital for Wales. The following points were noted: - Improvements in the governance structure including key appointments and regular meetings to ensure clearer oversight and accountability. - Introduction of a dashboard to accurately capture activity and cot availability. - Key improvements demonstrated in neonatal mortality and national benchmarking in areas such as retinopathy, prematurity screening and infection rates. - Positive feedback from patient and families highlighting the improvements in care and the importance of ongoing work to maintain these improvements. - Clear expectations and requirements for de-escalation improved understanding of what was being asked and once established the service was able to provide the necessary information and assurance. - Members received the Welsh Kidney Network (WKN) report which provided a briefing on the current Quality and Patient Safety issues within the WKN commissioned services. The following points were noted: - Oxa 48 e-coli infection identified on a kidney ward and the challenges related to this outbreak. Although this primarily affects kidney patients, it may become a broader infection control concern. It was noted that the environment had been a contributing factor. An

RAG Rating	Highlight
	infection prevention and control meeting is arranged to discuss and agree a consistent approach across Wales. ○ The WKN meetings with the three providers of BCUHB, CVUHB and SBUHB and how the wider JCC will be made aware and kept informed of this issue. This would be highlighted in the QSO Chairs report to the JCC. ○ The diversity of dialysis providers and whether this poses any challenges in terms of applying a uniform approach to protocols and standards. It was confirmed that the renal community work very closely, sharing clinical input and that infection prevention and control issues are driven by the clinical teams within the renal centres. • The Director of Commissioning for Specialised Services provided updates on various specialist services including: ○ The continued challenges in engagement with Salford Royal Hospital obesity services. This will continue to be escalated. Meanwhile, additional capacity has been secured in South Wales. ○ Improvements in plastic surgery waiting times, the data for March 2025 was still pending, but the target of 104 weeks is likely to be achieved. There was insufficient capacity to make any significant in-roads into achieving 52 weeks targets. ○ Prostate-Specific Membrane Antigen (PSMA) due to the ongoing production challenges with Positron Emission Tomography Imaging Centre (PETIC) in CVUHB. A clinical update was provided advising that undertaking clinical revalidation with all the PMSA PET requests has been agreed with a view to shared decision making, noting that these scans were not mandated according to NICE guidance, therefore, the suggested triage involves categorising patients into high, intermediate, and lower risk groups. This positive progress was welcomed. ○ South Wales Specialist Auditory Implant Device Service and the continued lack of progress. This will form part of a broader conversation however there was an action plan in place and the requirements were more visible. • A report for the Commissioning for Ambulance and 111 services was received. The quality and safety dashboard, which includes high-level reports on quality domains was highlighted. In addition: ○ The establishment of a new clinically led 'National Ambulance Patient Handover Improvement Implementation Group.' The work of this group will be

RAG Rating	Highlight
	a key enabler in supporting the JCC in reducing its emergency ambulance services associated risks around utilisation of capacity. ○ The new ambulance performance framework and introduction of new categories was noted which included a purple category for incidents of cardiac and respiratory arrest. ○ High rate of 111 call abandonments and whether the service can cope with demand. The JCC has yet to assess whether it provides sufficient or effective call handling and clinical capacity as a formal strategic demand and capacity review of the 111 system has not yet been conducted. A detailed analysis of the GDPR breaches within the Ambulance and 111 report was requested to understand the causes. ○ A deep dive on Ambulance services, including a patient story, was scheduled for June 2025 where several issues can be addressed. • The Director for Mental Health and Vulnerable Groups report was presented. The following points were highlighted: ○ Improvements in High Secure services through the introduction of positive interaction program (PIP) at Ashworth, reducing long-term segregation numbers, noting that Broadmoor and Rampton were implementing similar strategies. ○ Environmental issues at Caswell Medium Secure Unit and Ty Llewellyn, including lack of seclusion facilities. SBUHB has appointed an independent assessor to undertake an independent review of their mental health services. The JCC needs to stay cited on the work of this review to help with informing strategic commissioning decisions. ○ Inpatient numbers have risen within eating disorder services. Noting ongoing discussions to enhance gatekeeping processes. ○ Plans for two newly commissioned perinatal beds for North Wales patients located in Chester, by October 2025.
Assure	• Members heard a story from a patient's specific experience of the Tonna Mother and Baby Unit stating the challenges she faced as a mother with physical health disabilities. It was noted that the Unit worked hard to address the environment and accessibility issues and the staff's willingness to listen and adapt. To minimise anxiety for patients, the Unit is now planning to produce booklets with

RAG Rating	Highlight
	photographs of the unit and to introduce phone calls between staff and patients prior to admission to discuss and prepare for their stay. A video tour was also planned, however due to resources this has not been possible. The Chair thanked her for her sharing her personal story and wished her well for the future. - Members received the risk register as at 31 January 2025, highlighting the risks relating to the Quality Safety and Outcomes assigned for monitoring and scrutiny purposes. The following areas were highlighted: - Cardiac Device Services, the Chair inquired whether this risk was specific to North Wales or if it represented a broader issue concerning engagement within the service. It was clarified that the service was safe, and the engagement issues relate to the provider. The risk was likely to be resolved by the next meeting. - Paediatric Intensive Care Beds and Neonatal Infection Control which had been covered in the earlier presentation. Whilst these remain on the Risk Register as risks scoring 20, these should also be updated by the time of the next meeting. It was noted however there appeared to be some underlying issues that could be related to the environment. The infections rates appeared to be higher than national averages despite good compliance with infection control measures. - Neurosurgery Sustainability, noting that this risk had been de-escalated from 16 to 8. It was queried if this was premature as the funding had been allocated but the overall sustainability of the service was dependent on successful recruitment. The matter around when a risk is mitigated from a commissioner perspective and becomes a provider risk/issue was discussed. It was suggested that this topic could be addressed in a JCC strategy session since the JCC still needed to conclude their discussions around risk appetite. - C&VUHB Neurosciences Staffing issues/level was queried as the description around the risk being addressed by the rehabilitation strategy was due for consideration by the JCC in Quarter three 2024/2025 but this has now passed. It was agreed to review this outside of the meeting and provide an update at the next meeting.
Inform	The forward plan of business for the next twelve months was presented noting that it was a work in progress and would be used to support Agenda planning for future meetings.

RAG Rating	Highlight
	- A report outlining recent incidents and concerns reported to the JCC from provider and commissioned services covering the period January 2025 – February 2025 was received. - An update on the Regulator Report (Healthcare Inspectorate Wales (HIW) / Care Quality Commission (CQC) regulatory activity was provided noting the ongoing collaboration with HIW to improve reporting and assurance processes.
Appendices	None

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Improve Equity and Population Health
	Ensure Quality
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A More Equal Wales
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> (Duty of Quality Statutory Guidance (gov.wales))	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i>	Person Centred
	If more than one applies please list below: Equitable

(Duty of Quality Statutory Guidance (gov.wales))	
Effaith Amgylcheddol / Cynaliadwyedd (5R) / Environmental / Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / Equality Have you undertaken an Equality Impact Assessment Screening?	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: N/A
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

5. RECOMMENDATIONS

The Joint Committee is asked to:

- **Note** the highlights outlined in Section 3 of this report.

Assurance Report Patient Quality Safety Outcomes Committee

3 June 2025

Meeting:	Patient Quality Safety Learning & Improvement Forum
Chair:	Craig Roberts – Assistant Director of Allied Health Professions and Health Science
Date:	28 April 2025

The Patient Quality, Safety Learning and Improvement Forum held on 28 April 2025 focused on various aspects of patient experience, safety, and quality improvement within the Aneurin Bevan University Health Board. Some highlights include:

1. Patient Experience and Learning Events

The newly launched Patient Advice and Liaison Service (PALS), introduced in November 2023, has proven highly effective, managing over 9,000 calls with only 23 escalated. A notable impact story involved a distressed patient who underwent an emergency appendectomy following PALS intervention. The team offers early resolution, complaint avoidance, pastoral support, and has embedded champions across various inclusion priorities.

A compelling story was shared involving a distressed mother in Ireland whose son, studying in South Wales, was in severe pain and experiencing long wait times in the Emergency Department. Frustrated and prepared to leave the hospital without treatment, he contacted his mother, who in turn reached out to the PALS team. The team acted swiftly—providing reassurance, liaising with clinical staff, and convincing the young man to remain in the department. That decision proved critical: he underwent an emergency appendectomy later that evening. The mother expressed deep gratitude for the team's timely intervention, highlighting the vital role PALS plays in both patient outcomes and family reassurance.

2. Research and Development

The Research & Development team shared progress on ongoing trials and emphasized the importance of integrating research into clinical care.

Challenges include capacity constraints and the need for interdepartmental support. Initiatives such as the Research Champion Programme and training in Good Clinical Practice are helping to embed a research culture.

3. Learning from Patients to develop a psychological programme of care

A new psychological support programme for cancer patients has been developed in response to patient feedback. It features patient engagement through cancer cafes and panels, staff training in managing the psychological impact of cancer, and targeted support groups covering uncertainty, fatigue, and intimacy.

4. ED improvement plan update

Following a HIW inspection, multiple improvement efforts are underway including new patient waiting areas, a falls assessment tool, and enhanced pain management. Emphasis is placed on staff well-being, communication, and timely assessments, supported by real-time feedback mechanisms for staff and patients.

5. Nutrition & Hydration task and finish groups

Progress was shared on fluid balance monitoring, development of SOPs, and escalation tools for nutritional needs. A specific focus is being placed on ensuring vulnerable patients, such as those with learning disabilities, receive timely nutritional support.

6. PDSA – Review of learning forum one year on

A structured review discussion of the Learning Forum's effectiveness was held, aiming to understand its current value and identify areas for enhancement. Feedback gathered during the session reflected strong appreciation for the forum as a space for shared learning, cross-divisional insight, and collaboration on quality improvement initiatives.

Participants noted that the forum provides:

- A safe, reflective environment to share both successes and learning from challenges.
- Greater visibility of initiatives underway across the organisation.
- A valuable opportunity to connect clinical and corporate priorities with real-world impact.

Assurance Report Patient Quality Safety Outcomes Committee 3 June 2025

Meeting:	Clinical Advisory Forum
Chair:	Lloyd Hambridge – Divisional Director Primary Care, Community & CHC Services
Date of Meeting:	10 April 2025

This report provides an assurance overview based on the Clinical Advisory Forum (CAF) meeting held on 10 April 2025. The meeting was chaired by Lloyd Hambridge, Divisional Director of Primary Care, Community & CHC Services, and attended by various key stakeholders from different divisions and services.

The primary focus of the meeting was to review, from a clinical perspective, the Quality Impact Assessments (QIAs) submitted by Divisions.

1. Quality Impact Assessments

Primary Care and Community Care Service

Emergency General Dental Services: The proposal to remove emergency dental services was discussed. Key points included the current commissioning of 96 appointments per week, potential reduction in service, and the impact on patient safety and urgent care services. The recommendation was to conduct further assessment on varying the emergency dental provision capacity before taking any action.

Clinical Support Services

Reduction in Critical Care Bed Base: The proposal to reduce the critical care bed base from 24 to 20 or 6 beds was discussed. The high utilisation rates and potential financial savings were noted, but the recommendation was to conduct further assessment considering the impact of the new discharge lounge and flow systems before any action is taken.

Cessation of Rapid Diagnostic Clinic: The proposal to cease the Rapid Diagnostic Clinic (RDC) was discussed. The decrease in utilisation and conversion rate for cancer diagnosis were noted. The recommendation was

to conduct further evaluation, including consultation with Welsh Government and the GP community, before making any decisions.

Reduction in Point of Care Testing (POCT) for Respiratory Testing:

The proposal to reduce POCT for respiratory conditions was discussed. The high costs and potential impact on patient flow and infection control were noted. The recommendation was to conduct a robust risk assessment involving relevant teams before any action is taken.

Reduction in MRSA Testing: The proposal to reduce MRSA testing was discussed. The high number of tests conducted compared to other health boards was noted. The recommendation was to conduct a quality improvement project to determine the appropriate percentage reduction while ensuring patient safety.

Cessation of Andrology Service: The decision to pull the cessation of andrology services for further consideration and evaluation was noted.

Family & Therapies Service

Acquired Brain Injury (ABI) Service: The proposal to discontinue the ABI service was discussed. The service's significant impact on patient care and system flow was noted. The recommendation was not to proceed with the cessation of the ABI service, recognising its critical role and the need for continued funding.

2. Strategic Items

The discussion included transitioning the forum from a QIA focus to a broader clinical advisory role, introducing a new standard agenda, and reviewing membership to ensure appropriate representation.

An update on the new organisational strategy was provided, emphasising the importance of CAF members' participation in workshops and reviewing the draft working document.

Notes of Meeting Children & Young People Strategic Board

Wednesday 23 April 2025
1:30 – 3:00
Via TEAMS

Present

Jennifer Winslade	Executive Director of Nursing
Helen Morgan	Divisional Nurse Family & Therapies
Deb Jackson	Divisional Nurse Family & Therapies
Suzanne Bryant	Head of OT
Sian Chard	Assistant General Manager F&T
Pippa Cotterill	Designated Clinical Lead Officer F&T
Liz Rees	Deputy Head of Speech & Language Therapy
Clare Lipetz	Divisional Director F&T
Jayne Beasley	Divisional Nurse
Yvette Cloete	Clinical Director Paediatrics
Lorraine Childs	Early Years Lead/Senior Nurse Health Visiting
Marie-Claire Griffiths	Head of Strategic Planning
Hayley Jones	Senior Nurse, Health Visitor
Rachel Raymond	Clinical Lead & Service Manager
Chloe Trinder	Integrated Performance Manager

1) Apologies

Apologies were noted from:

Tracy Daszkiewicz
Jocelyn Richards
Sarah Garland
Diane Chorister
Alison Williams
Natalie Pointer
Rebecca Stanton

2) Board Report and Terms of Reference

Sian presented the Board Report, highlighting the importance of focusing on children's services and the need for a structured approach to address various issues.

The report was well-received by the Board, emphasising the need for yearly updates and addressing gaps in services.

The terms of reference were discussed, with suggestions to align them with the Board report and refine the membership to ensure effective task and finish groups.

Four priority areas were identified:

Best Start in Life
Children's Waits/Commissioning
Transition
Safeguarding and Vulnerability.

Each area was discussed in detail, with specific focus on the need for clear plans, risk registers, and metrics to support the work.

Challenges with commissioning services and relationships with local authorities were highlighted, with a need for better collaboration and support.

The importance of addressing waiting times for children's services was emphasised, with a call for a more structured approach to commissioning.

The need for streamlined reporting and avoiding duplication of effort was discussed, with a suggestion to have an operational group that feeds into both the safeguarding and children and young people's board.

Regular updates on various work programmes, including maternity and neonatal services, school nursing and health visiting, were deemed necessary to include to ensure comprehensive coverage of all relevant areas.

Action: Terms of Reference - Sian to refine and align with the agreed workstreams, reducing membership to a more focussed membership based on delivery of outcomes and ensuring effective task and finish groups.

3) Defining Key Metrics and Outcome Framework

Chloe presented the initial metrics and outcome framework, with input from various directorates. The need for further refinement and collaboration with Planning and Public Health was noted.

The importance of using the correct language and ensuring comprehensive coverage of all relevant areas was emphasised.

Action: Chloe and Sian to work with Planning and Public Health to refine the framework.

4) Emerging Risk Collation

Several emerging risks were identified, including vaping, waiting lists, workforce risks, and issues related to continuing healthcare and looked after children.

These will be formulated into a risk register for the group.

5) Any Other Business

- Update from the new children's clinical network - **Will be included at the next meeting**
- Progress on the national Early Years framework – **Was discussed**
- HV sustainability closure report – **To be received at the next meeting**
- A Quality Statement for Maternity and Neonatal Services – **To be discussed at the next meeting**
- All Wales Perinatal Engagement Framework – **To be discussed at the next meeting**
- Caesarean rates – **Discussed and it was agreed this should be considered at a future meeting**

6) Date of Next Meeting

Wednesday 23 July
11:00 am
TEAMS



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Patient Quality, Safety and Outcomes Committee

Annual Report for 2024-25

February 2025

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Chair's Foreword

I am pleased to present the Patient Quality, Safety and Outcome Committee's (the Committee's) Annual Report for the year ended 31 March 2025.

In this report we provide an overview of the work of the Committee, which extends to the full range of Health Board responsibilities and encompasses all areas of patient experience, quality and safety relating to patients, carers and service users.

Finally, I would like to express my personal appreciation to all who contributed to the patient quality, safety and outcomes agenda over the last 12-months, especially Pippa Britton as Chair and Louise Wright, Independent Member, as their time on the Committee comes to an end.

Diolch yn Fawr / Thank you

Helen Sweetland
Chair
Patient Quality, Safety and Outcomes Committee

1. Introduction

- 1.1 Section 2 of the Standing Orders of the Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB, the Board' or the 'Health Board') provides that:

"The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees".

- 1.2 The Term of Reference of the Patient Quality, Safety and Outcomes Committee (referred to throughout this document as 'PQSOC' or the 'Committee') were approved by the Board in March 2022 (see **Appendix 1**). These were not changed during the reporting year.
- 1.3 The Committee formally adopted its Terms of Reference, following the Board's approval, on 05 April 2022.

The purpose of the PQSOC is to provide: evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and assurance to the Board in relation to the Health Board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.

- 1.4 This report describes how the PQSOC discharged its role and responsibilities during the period 1 April 2024 to 31 March 2025.

2 2024-25 Work Programme

- 2.1 ABUHB Standing Orders require the Board Secretary to produce an Annual Plan of Board business. This should incorporate formal Board meetings, regular Board Development sessions and, as appropriate, planned activities of the Board's Committees and Advisory Groups. The Work Programme adopted for PQSOC in 2024-25 is attached to this report (see **Appendix 2**).
- 2.2 A Work Programme is designed to align to its terms of reference and the requirement for it to seek information to be able to give advice or gain assurance for itself and on behalf of the Board. The Work Programme is, however, a framework rather than a prescriptive

agenda. This gives PQSOC flexibility to identify changing priorities or any need for further assurance or information.

3 PQSO Committee Meetings and Membership

3.1 During 2024-25, PQSOC met six (6) times via Microsoft Teams- in April 2024, June 2024, July 2024, September 2024, November 2024 and January 2025. Detail of the Independent Members and Executive Directors who attended these meetings is provided at **Appendix 3**.

3.2 The Committee comprised the following Independent Members:

Pippa Britton	Chair (Until December 2024)
Helen Sweetland	Vice Chair from May 2024, Chair from December 2024
Paul Deneen	Member
Penny Jones	Member
Louise Wright	Member until May 2024

3.3 In accordance with the Public Bodies (Admissions to Meetings) Act 1960 the organisation is required to meet in public. Following the pandemic, the Committee has continued during the current year to meet virtually and this has therefore meant that the Health Board has not complied with its Standing Orders in this regard and this will be a key consideration for the Improving Board Business action plan.

To ensure business was conducted in as open and transparent manner as possible during this time the meeting agenda packs have been published to the Health Board's [website](#) in advance of meetings.

3.4 The Committee's agenda and papers were made public, save where it was necessary to meet 'in private'. Private meetings are held where it would not be appropriate to discuss a matter in public, due to issues of patient or staff confidentiality, commercial confidentiality, or discussion of serious incidents or escalated concerns which would not be in the public interest. There were no 'in private' meetings held during 2024-25.

4 PQSOC Reporting Arrangements

- 4.1 Following each meeting, the PQSOC submits an Assurance Report to the following Board meeting, outlining topics discussed, areas of concern and areas of risk. All Board papers can be accessed via the following [link](#).

5. PQSOC Work Programme: 2024-25

- 5.1 During the year the Committee received updates in respect of the following items:-
- 5.2 The Committee received regular updates on the key risks allocated to the Committee and the position of each risk. At the end of the year the Committee's risk environment had remained relatively stable, with no changes in the risk score or exposure to the three strategic risks that the Committee monitors, with 3 risks reporting as a risk level of Moderate or High.
- 5.3 In September 2024, the Committee received the Covid-19 Nosocomial Investigation Report that outlined the Health Board's conclusion of its Nosocomial Covid-19 Investigation Programme on 31 March 2024, in line with the objectives set by Welsh Government.

The findings from the investigation highlighted difficulties in regard to communications with family and friends throughout the pandemic, with visiting restrictions having an adverse effect on the patients and family members, however the investigation found the restrictions were necessary to reduce the transmission of the Covid-19.

- 5.4 The Committee received the Listening and Learning Framework which complemented and built on Divisional and Directorate assurance arrangements by supporting the Health Board to learn lessons from a range of internal and external sources, with the framework acting as a learning repository for future use.
- 5.5 The Committee received the Primary Care Quality Report which outlined the areas of focus throughout the year including the following:-
- General Dental Services
 - Urgent Access and Wait Times
 - Orthodontic Services
 - General Ophthalmic Services
 - General Medical Services
 - Enhanced and Supplementary Services
 - Community Pharmacy Services

- 5.6 In July 2024, the Committee received a report on the investigation and subsequent improvement actions of the Mortuary Incident. The Health Board's investigation found that the root causes of the incident were due to failures in staff adherence to Health Board policies and procedures. Whilst the policies were deemed appropriate, they have since been strengthened and simplified for clarity.
- 5.7 The Committee received the Commissioning Assurance Framework which outlined the efforts to create a standardised process for collecting quality information from commissioned services with the aim to ensure consistent and rigorous data collection across the Health Board.
- 5.6 During the year, the Committee received quarterly reports on the Performance of Patient Quality and Safety Outcomes. During the year the following information was reported:-

Duty of Candour Triggers

Between December 2021 to March 2024 there had been 70,645 incidents reported on Datix and 29 incidents of duty of candour since April 2024. The Committee were assured that 95% of the unrejected incidents were closed, with 76% of closed incidents coded as no or low harm.

Infection Prevention and Control

During the year the Committee noted that the main areas of infection concern was C.Difficile with high levels being reported in June 2024. A multidisciplinary team had been established to address the increase and to return rates to within normal levels. This included the implementation of an action plan, with enhanced cleaning continuing and bespoke training in areas of outbreaks.

Enhanced Monitoring

At the last meeting of the year, the Committee was advised that there were 2 areas within the Health Board in enhanced monitoring, with assurance provided that action plans were in place to improve the position of each department – Urgent & Emergency and Mental Health & Learning Disabilities.

Falls incidents

Throughout the year the Committee received regular updates in respect of falls, noting that there had been a decrease in the total number of fall incidents, which averaged at 302 per month, with 99% being no or low harm. There were ongoing efforts to minimise harm, which included collaboration with Divisions to identify any anomalies or areas needing targeted intervention.

Complaints, concerns and compliments

At the January 2025 meeting, the Committee received an update on complaints and concerns, noting early resolution was reporting at 67%. The 30day compliance for responding to complaints was currently 55%, which was below the target of 75%. The Committee was assured that this was a focus for the Health Board.

Health, Fire and Safety

Throughout the year the Committee received regular updates on the progress being made on the Health Board's Health, Fire and Safety action plan. In January 2025, the Committee was advised that 16 incidents were reported to the Health and Safety Executive (HSE) in accordance with Reporting Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) and compliance with RIDDOR had significantly improved at 86%. It was highlighted that work was ongoing to improve the manual handling training compliance, which remained low at 69%.

Ward and Team Accreditation

At the November 2024 meeting, the Committee received an overview of the Ward and Team Accreditation that creates a structured system to continuously raise standards of care through effective goal setting, measurement, feedback and staff engagement which brings benefit to patients, staff and the organisation.

In January 2025, the Committee received an update on the Ward and Team accreditation programme, noting that there had been a positive roll out across several divisions and 3 accreditations had been awarded in December 2024. These wards were now working toward their silver award.

Health Inspectorate Wales (HIW) Inspection

In June 2024, the Committee noted that Health Inspectorate Wales had undertaken an inspection at Ty Lafant, Llanfrechfa Grange in April 2024, and no recommendations had been made. In November, it was noted that there had been a total of 8 Health Inspectorate Wales immediate assurance letter responses.

Never Events

In June 2024, the Committee received an overview of the never events performance noting that, since November 2023, the Health Board had not experienced any Never Events. In January 2025 the Committee was informed that there had been 2 never events between April to December 2024. 1 was within a non-theatre environment and the other being historical and found during a scan. Assurance was provided to the Committee that both events had resulted in no harm.

- 5.7 In July 2024, the Committee received the Maternity Services Organisational Improvement and Action Plan which outlined the plan to improve outcomes for women and babies and support staff, and innovations and improvement in practice for the future. It was noted that there were 95 actions in total as part of the improvement plan over a three-year period.

5.8 **Annual Reports**

Throughout 2024/25, the Committee received the following Annual reports: -

Pharmacy and Medicines Management Annual Report

The report confirmed progress in the priority areas of safe prescribing; antimicrobial stewardship and value was scrutinised.

The following areas were identified within the annual report:-

- In January 2024, the Pharmacy Service published its Vision and Mission Statement;
- The Value and Sustainability work programme established to deliver on the 13 national recommendations set by Welsh Government overseen by the Medicines Management Programme Board;
- Service developments;
- The contribution of pharmacy services to improved patient safety and medicines governance through direct patient care and the work of the Medicines and Therapeutics Committee, Medicines Safety Group, and the Controlled Drugs Local Intelligence Network;
- The performance of the Health Board against the National prescribing indicators.

Volunteering Annual Report

This report celebrated the key achievements over the past year and noted the valuable contribution made by volunteers, with the aim of improving the experience for patients, their families, and carers whilst ensuring volunteer experience.

The Committee noted that as a result of the pandemic the number of volunteers had reduced, and the Health Board was continuing to improve the volunteer provision including end-of-life champions in the community.

Hospital Transfusion Committee Annual Report

This report outlined several achievements, including the successful integration of a Primary Care representative into the HPC (Health Professional Council) and the introduction of a new clinical Standard

Operating Procedure (SOP) for the Haematological Management of Major Haemorrhage.

The programme had begun identifying staff who required essential transfusion practice training and continued to provide training on Blood Track Enquiry.

Quality Annual Report

This report outlined the quality journey throughout the year, a review of the past objectives and the new priorities for improving patient and staff safety, outcomes, and experiences.

The Health Board had adopted the reporting structure from NHS England which mapped progress on quality and patient safety against the pillars of quality, as follows:-

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

The Committee noted that the learning and improving approach had been approved with a meeting structure in place to provide regular updates to the Committee throughout 2024/25.

Putting Things Right Annual Report

This report had been prepared in accordance with the Putting Things Right (PTR) regulations and demonstrated the ongoing commitment to the population of the Health Board.

The report outlined the priorities for the annual work programme for 2024/25 including the following:-

- Putting Things Right Regulations and Health Board Concerns Management;
- Improving Quality Patient Safety experience, Learning and Improving;
- Partnership Engagement & Collaborative working.

Human Tissue Act Annual Report

The Committee received the Annual Human Tissue Act report for assurance that the Health Board were meeting the standards required to maintain the licences within the following areas:-

- Post-mortem provision at the Grange University Hospital, Royal Gwent Hospital and Nevil Hall Hospital;

- Human application bone bank at Royal Grange Hospital;
- Research at Royal Gwent Hospital.

Organ Donation Annual Report

At the September 2025 meeting, the Committee received the Annual Organ Donation report for assurance which outlined what work had been completed throughout 2023/24, noting the following:-

- 8 organ donations over the past 12 months with 13 consented donors which resulted in 19 patients receiving a transplant;
- The Organ Donation Committee Chair, Shelley Bosson, had now retired and a new chair was being sought;
- The Health Board was continuing to raise awareness and encourage people to become donors;
- The Organ Donation team had looked at how they could develop training and protocols throughout the Health Board.

Dementia Care Annual Report

This report reviewed the progress made on the implementation of the dementia standards, noting the Welsh Government's commitment to promote the rights, dignity and autonomy of people living with dementia and the people who care for them. An established Regional Dementia Board had been put in place with a Regional Strategy and Action Plan to drive forward improvement actions against the 6 key aims of the National Plan.

The Committee noted the Gwent Regional Dementia Board and Dementia Friendly Communities programme had delivered against the aims, objectives and priorities aligned to both the Dementia Action Plan for Wales.

Falls and Bone Health Management Annual Report

This report outlined the data analysis, key activities, challenges and next steps in support of reducing falls incidents alongside improving bone health as an ongoing commitment in further enhancing the quality of patient care.

The report also outlined the following areas identified within the annual report:-

- The Health Board was represented nationally across a number of forums and were ensuring the Health Board were following the national guidelines when lifting a patient following a fall;
- A pilot for patients within a hospital setting to be allocated yellow wrist bands to identify which patients were at a high risk of falls and the aim was to roll out across all Health Board sites;

- Training of all staff members in relation to falls remained a challenge for the Health Board, to address this, a Falls Training Strategy was to be completed by March 2025.

Health and Safety Compliance Annual Report

This report identified the opportunities and challenges for the Health Board in ensuring and sustaining compliance within Health and Safety legislation, including specific compliance improvement action delivered in 2023/24.

The Health, Safety and Fire action plan had been created to focus on improving the following area:-

- Fire Safety
- Health and Safety Training Provision
- Manual Handling
- Risk Management
- Violence and Aggression

The Committee noted there had been challenges around the compliance of the Health and Safety policies, to address this, a plan was in place for 2024/25 to review the policies which were out of date.

Radiation Protection Committee Annual Report

This report provided assurance that all activities related to the use of Ionising Radiation and the storage and disposal of radioactive substances in the Health Board had been carried out in accordance with National legislation, published guidance and local policies and procedures.

The Committee noted that the governance structure of the Committee and was assured there were no outstanding areas of concern from the HIW report from April 2023.

Research and Development Annual Report

This report outlined the Health Board's key achievements, progress and planned next steps in implementing the Research and Development Strategy, noting that the Health Board had exceeded the Welsh Government target of the trials open to recruitment, recruiting to time and target with a performance of 95% increased from 89%.

The Committee noted that the focus for 2024/25 was to establish the Research and Development Committee as of the priorities.

Infection Prevention, Decontamination, and Antimicrobial Stewardship Annual Report

At the July 2024 meeting, the Committee received the Annual Infection Prevention, Decontamination, and Antimicrobial Stewardship report. The report confirmed improvements in cleaning standards and the successful use of Regional Integration Funds to enhance care across Primary and Secondary Care. It had been a challenging year with the Health Board reporting below the national average for reportable organisms and experiencing an increase in certain infections due to factors like antimicrobial resistance and suboptimal prescribing.

The following was highlighted within the report:-

- Low respiratory infection rate, below the All-Wales average;
- C-section rate had returned to pre-pandemic levels at 3.9%;
- The target to reduce antimicrobial prescribing by 25% in Primary Care had not been met achieving only a 14.8% reduction, partly due to challenges from Strep A outbreaks.

Safeguarding Annual Report

The Committee receive the statutory Annual Safeguarding report for assurance which outlined progress, performance, emerging trends, lessons learned, and the vision for 2024/2025, noting a significant increase in activity within child and adult cases, which was putting resources under pressure and delaying assurance and improvement work.

The Following was highlighted within the report:-

- Training for levels 1 and 2 safeguarding was exceeding 80% compliance;
- Training for level 3 training safeguarding remained low at 15%, falling short of the 50% target.

6. Patient Centred Care

6.1 On behalf of the Committee at Board level the presentation of Patient-Staff Stories continued. Topics presented included:

- Respecting patient's wishes at end of life, improving communication with families and our bereavement offer;
- Hospital to Home Service;
- Children's Rights - Enabling Children's Voice and the Best Start in Life;
- My Medical Record App.

7. Self-assessment and Evaluation

- 7.1 As part of the Health Board's statutory requirements, each Committee of the Board is required to conduct an annual self-evaluation of committee effectiveness. All Board Members are required to complete a self-assessment for each Committee on which they are a member, to determine its effectiveness and ability to carry out its responsibilities.

The outcome of the assessment will enable the Committee to identify areas of development and focus for the coming year, such as any training and development, as well as changes to processes and procedures.

The self-assessment for the Patient Quality, Safety and Outcomes Committee was shared throughout January and February 2025 with both Committee members and lead Executive Directors. Five responses were received to the questionnaire. Members were requested to score their responses from 1-3, as per the table below.

Score	Measure	Description
1	Room for improvement	The Committee is falling short of requirements and should consider how it can work towards becoming more effective in this area
2	Meeting standards	The Committee is performing to the required standard in this area. There may be room for improvement, but the Committee can be seen to be discharging its responsibilities effectively.
3	Excelling	This is an area where the Committee is performing beyond the standard expectations and is a real area of strength when it comes to exercising its responsibilities.

Following completion of the self-assessments, the sections were analysed to provide an overall score for the section and recommendation for improvements for each section. A summary of the results is provided below. Further detail on the responses can be found at Appendix .

Overall rating based on scores	Areas for Improvement based on comments received	Action
Committee Processes: Composition, Establishment and Ways of Working (Q1 - 26)	Self Assessment: Current questionnaire is too long. Propose that a discussion is held at Committee with a survey to follow up. Induction process: New IMs to meet all the Execs and encourage conversations with other IMs. Site Visits: It would be helpful to be able to visit different areas of the Health Board, so that IMs can see the environment and talk to staff. This should be an ongoing role for IMs Quality of Reports: Reports should be shorter and the successes and challenges addressed under headings, with links only to the main reports Committee meetings: Try to ensure that there is 5 minutes left at end of meeting for final 'wrap up'	• Review Self Assessment process and introduce more discussion amongst members • Revised local Induction Programme being developed for the Health Board • Patient Safety Leadership Visits are in the process of being arranged • Report writing included within Development programme being developed with the Good Governance Institute • Review of agenda format to include a short feedback section at the end of each meeting to enable a 'wrap up'
Clinical Quality Governance Q27 - 31)	Data/Information: The committee would need more information about each pillar and its criteria and a mapping exercise in order to be able to fully scrutinise the information	
Patient Experience & Involvement (Q32 - 34)	Definite progress has been made in this area, but still need to address some clinical areas where response rates are low	

High Quality, Safe & Effective Healthcare (Q35 - 40)	n/a	
Research & Development and Improvement & Innovation (Q41 - 42)	n/a	
Compliance with H&S regulations and Fire Safety Standards (Q43)	n/a	
Overall Assessment		

The findings from the self-assessment will be used to inform a comprehensive annual assessment of the Board’s effectiveness. The effectiveness of the Board’s Business function is reported through the Annual Governance Statement, enabling a focus on the work undertaken with the Board’s Committees, interconnectedness of the committees and escalation to the Board, as well as the culture between the Health Board and its auditors, regulators, and partners.

8. Key Areas of focus in 2025/26

- 8.1 As a result of the work of the Committee in 2024/25 the following areas of focus were identified:
- Explore ways of ensuring greater assurance and opportunities for committee members to be better appraised of patient experience matters.
 - Strengthened focus on reporting of Joint Committee activity to this Committee.
 - Secure a greater understanding of those improvement projects through better reporting to the Committee and to capture this on the forward work plan for the Committee.
 - Health and Safety Assurance reporting to be strengthened to include a focus on risk and assurance gaps.
 - Agendas to include an item on reflection upon meeting to aid ongoing self evaluation.

9. Conclusion

- 9.1 This report provides a summary of the diverse and often complex work undertaken by the PQSOC during 2024-25, and demonstrates that the Committee has complied with its Terms of Reference as approved in March 2025.



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Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Patient Quality, Safety and Outcomes Committee

Terms of Reference – 2022/23

Version: Approved

Date: March 2022

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Date of Document:	March 2022
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1. INTRODUCTION

- 1.2 Section 2 of the Standing Orders of the Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB, the Board' or the 'Health Board') provides that:

"The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees".

- 1.3 The Health Board has established a committee to be known as the **Patient Quality, Safety & Outcomes Committee** (referred to throughout this document as 'the Committee'). The Terms of Reference and operating arrangements set by the Board in respect of this committee are provided below.

2. PURPOSE

- 2.1 The scope of the Committee extends to the full range of ABUHB responsibilities. This encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. The Committee will embrace the Health and Care Standards as the Framework in which it will fulfil its purpose:

- Staying Healthy
- Safe Care
- Effective Care
- Dignified Care
- Timely Care
- Individual Care
- Staff and Resources

2.1 ADVICE

The Committee will provide accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the development of the following matters, consistent with the Board's overall strategic direction

- Citizen Experience; and
- Quality and Safety of directly provided and commissioned services.

2.2 ASSURANCE

In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on:

- a. The robustness of the Board's Clinical Quality Governance Arrangements;
- b. the experience of patients, citizens and carers ensuring continuous learning;
- c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services; and
- d. the effectiveness of arrangements in place to support Improvement and Innovation.

3 DELEGATED POWERS AND AUTHORITY

3.1 With regard to the powers delegated to it by the Board, the Committee will:

- A. Seek assurance that the Health Board's **Clinical Quality Governance Arrangements** remain appropriate and aligned to the National Quality Framework and is embedded in practice.
- B. Seek assurance that arrangements for capturing the **experience of patients, citizens and carers** are sufficient, effective and robust, including:
 - the delivery of the Patient Experience Plan; and
 - the implementation of Putting Things Right regulations (to include patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned.
- C. Seek assurance that arrangements for **the provision of high quality, safe and effective healthcare** are sufficient, effective and robust, including:
 - the systems and processes in place to ensure efficient, effective, timely, dignified and safe delivery of directly provided services;
 - the commissioning assurance arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of those services commissioned for delivery on ABUHB's behalf;
 - the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities;
 - the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response;

- the arrangements in place to ensure that there are robust infection prevention and control measures in place in all settings;
 - the development of the Board's Annual Quality Priorities; and,
 - performance against key quality outcomes focussed indicators and metrics.
- D. Seek assurance on the arrangements in place to support **Research and Development** and **Improvement and Innovation**, including:
- an overview of the research and development activity within the organisation;
 - alignment with the national objectives published by Health and Care Research Wales (HCRW);
 - an overview of the quality improvement activity within the organisation.
- E. Seek assurance that arrangements for **compliance with Health and Safety Regulations and Fire Safety Standards** are sufficient, effective and robust, including:
- the operating practices in respect of: staff health and safety; stress at work; patient health and safety, i.e., patient falls, patient manual handling; violence and aggression; fire safety; risk assessment processes; safe handling of loads; and hazardous substances
- 3.2 The Committee will consider and recommend to the Board for approval those policies reserved for the Board and delegated to this Committee for review, in-line with the Board's Policy Management Framework and Scheme of Delegation and Reservation of Powers.
- 3.3 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the Corporate Risk Register.

Authority

- 3.4 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate.

The Committee may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

- 3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary (subject to the Board's procurement, budgetary and any other applicable standing requirements).

Access

- 3.6 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.
- 3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

- 3.8 The Committee may, subject to the approval of the Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

Committee Programme of Work

- 3.10 Each year the Board will determine the Committee's priorities for its annual programme of work, based on the Board's Assurance Framework and Corporate Risk Register. This approach will ensure that the Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms of Reference are provided as a framework for the Committee's annual programme of work and is not an exhaustive list for full coverage. This approach recognises that the Committee's programme of work will be dynamic and flexible to meet the needs of the Board throughout the year.

4 MEMBERSHIP

Members

- 4.1 Membership will comprise of five (5) members:

Chair: Independent member of the Board

Vice Chair: Independent member of the Board

Other Members: Three other independent members of the Board [*one of which should be the Vice Chair of the Health Board and the Chair of the Audit, Risk and Assurance Committee*]

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following Executive Directors of the Board will be regular attendees:

- Director of Nursing
- Director of Therapies and Health Science
- Medical Director
- Director of Primary, Community Services and Mental Health

4.3 By invitation:

The Committee Chair extends an invitation to the ABUHB Chair and Chief Executive to attend committee meetings.

The Committee Chair will extend invitations to attend committee meetings, dependent upon the nature of business, to the following:

- other Executive Directors not listed above;
- other Senior Managers and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The Office of the Director of Corporate Governance will provide secretariat services to the Committee.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of ABUHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of ABUHB.

Support to Committee Members

- 4.8 The Director of Corporate Governance, on behalf of the Committee Chair, shall:
- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
 - ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5 COMMITTEE MEETINGS

Quorum

- 5.1 At least **three** members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.
- 5.2 Where members are unable to attend a meeting and there is a likelihood that the Committee will not be quorate, the Chair can invite another independent member of the board to become a temporary member of the Committee.

Frequency of Meetings

- 5.3 The Chair of the Committee shall determine the timing and frequency of meetings, which shall be held no less than **bi-monthly (six times yearly)**, and in line with the Health Board's annual plan of Board Business.
- 5.4 The Chair of the Committee may call additional meetings if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

- 5.5 Section 3.1 of ABUHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:
- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
 - issue an annual programme of meetings (including timings and venues) and its annual programme of business;
 - publish agendas and papers on the Health Board's website in advance of meetings;
 - ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and

- through ABUHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

- 5.6 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

- 6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions (as set out within these terms of reference), the Board retains overall responsibility and accountability for all matters relating to performance and resources.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

- 6.2 The Committee will work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:
- joint planning and co-ordination of Board and Committee business;
 - sharing of appropriate information; and
 - applicable escalation of concerns.

In doing so, this contributes to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

- 6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

- 7.1 The Committee Chair shall:
- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;
 - bring to the Board's specific attention any significant matters under consideration by the Committee;
 - ensure appropriate escalation arrangements are in place to alert the Chair of ABUHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.
- 7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.
- 7.3 The Director of Corporate Governance shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of further committees established.
- 7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

- 8.1 The requirements for the conduct of business as set out in ABUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
- Quorum
 - Issue of Committee papers

9. CHAIR'S ACTION ON URGENT MATTERS

- 9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.
- 9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

- 10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

Appendix Two

MATTERS TO BE CONSIDERED	Lead	Frequency of Report	QTR 1		QTR 2	QTR 3		QTR 4
			30 th April	4 th June	30 th July	2 nd Sept	12 th Nov	20 th Jan
Attendance and Apologies	Chair	SI	✓	✓	✓	✓	✓	✓
Declarations of Interest	All members	SI	✓	✓	✓	✓	✓	✓
Minutes of the Previous Meeting	Chair	SI	✓	✓	✓	✓	✓	✓
Action Log and Matters Arising	Chair	SI	✓	✓	✓	✓	✓	✓
Development of Committee Annual Programme of Business 2025/26	Chair & DoCG	AN					✓D	✓D
Review of Committee Programme of Business 2024/25	Chair	SI	✓	✓	✓	✓	✓	✓
Annual Review of Committee Terms of Reference 2024/25	Chair & DoCG	AN					✓D	✓D
Annual Review of Committee Effectiveness 2024/25	Chair & DOCG	AN					✓D	✓D
Outcome of Annual Review of Committee Effectiveness 2024/25	Chair & DOCG	AN						✓D
Committee Annual Report 2023/24	Chair & DOCG	AN	✓					
Committee Annual Report 2024/25	Chair & DOCG	AN						✓D
Committee Risk Report	DOCG	SI	✓	✓	✓	✓	✓	✓

NHS Wales Joint Commissioning Quality Committee Report	DOCG	SI	✓	✓	✓	✓	✓	✓
Pharmacy Robot Risk Assessment	DOCG	Action			✓ (incl. in risk report)			
Quality Strategy - Quality Outcome framework	DoN	Quarterly			✓		✓	
Quality Annual Report 2023/24	DoN	AN				✓		
Quality Assurance Framework Annual Review and Evaluation of Progress (Deferred to March)	Clinical Executives	AN						✓D
Primary Care Quality Report	COO	Bi-AN				✓D	✓	
Performance Report on the Pillars of Quality, to include:- • Patient experience and stories • Incident reporting - falls/ pressure ulcers medicines management and mortality • Healthcare Inspectorate Wales Operational Plan • Complaint, concerns and compliments • Health Safety and Security • Infection Prevention and Control • Safeguarding	DoN/MD & DOTHS	Quarterly		✓	✓		✓	✓

• Clinical Negligence Claims and Coroners Inquests Report • Quality & Engagement (Wales) Act, Preparedness and Implementation • Tracking of Improvement Actions Arising from Inspections and Reviews • Cleaning Standards Annual Report • Infection Prevention and Control • MCA & DOLs • Child and Adolescent Mental Health Quality Outcomes Report, including self-harm and suicide • Clinical Audit • Mental health and learning disabilities assurance • Listening and Learning Framework Outcomes • Never Event Incidents • Clinical Effectiveness and Standards Committee Report (January Meeting) • Closure of incident dates Sbar • Operational Quality updates on: ○ Cancer								

○ U&EC ○ Planned Care								
Pillars of Quality Interim Report	DoN	Bi-Annual	✓			✓		
Healthcare Inspectorate Wales Annual Report	DoN	AN	✓					
Commissioning Assurance Framework, Development, and Implementation	Clinical Executives	AN		✓D	✓			
Commissioning Outcomes Report (deferred to March)	Clinical Executives	Bi-An				✓D	✓D	✓D
Putting Things Right Annual Report 2023/24	DoN	AN				✓		
Maternity Services: Organisational Improvement and Action Plan	DoN	Bi-An			✓			✓
Learning from Death Report	MD	Bi-AN	✓				✓D	✓
Listening and Learning Framework	DoN	AN	✓					
Listening & Learning Forum Minutes	DoN	SI	✓	✓	✓	✓	✓	✓
IPC and Cleaning Standards	DoN	AN		✓D	✓			
Annual Volunteering Report	DoN	AN		✓				
Mortuary Incident Action Plan	DoT&HS	AN		✓D	✓			

Covid-19 Nosocomial Investigations Report	DoN	AN		√D	√D	√		
Challenges in securing improvements within the Mental Health & Learning Disabilities	DoN	Action				√		
Clinical Advisory Committee Minutes	DoN	SI	√	√	√	√	√D	√
Protocol for patients presenting with Sepsis	DoN	Action					√	
PQSOC 3007/07								
Report on time closure of patient safety incidents	DoN	Action					√	
PQSOC 3007/07								
Serious Incident Learning Report	DoN	AN					√	
Medical Devices Annual Report (Deferred to March)	DoT&HS	AN					√D	√D
Radiation Protection Committee Report	DoT&HS	AN					√D	√
Falls and Bone Health Management Annual Report • Deep Dive on Falls PQSOC 3007/07	DoT&HS	AN		√D	√D	√D	√	
Health and Safety Compliance Annual Report	DoT&HS	AN			√D	√D	√	
Human Tissue Act Group Annual Report	DoT&HS	AN				√		

Pharmacy and Medicines Management Annual Report	MD	AN			✓			✓
Safeguarding Annual Report	DoN	AN			✓			
GP Engagement and Child Protection Report PQSOC30/07 3.4	DoN Action	AN				✓		
Update Optimal Antimicrobial Prescribing PQSOC 3007/14 & PQSOC 0209/2.8	MD Action	AN					✓	
Ward Accreditation Report	DoN	AN					✓	
Nurse Staffing Levels (Wales) Act 3-year report	DoN	AN					✓	
Nurse Staffing Levels Wales Act Recalculations	DoN	AN				✓ D	✓	
Update on Staff Members wearing cameras while working policy. PQSOC 0209/2.8	DoT&HS	Action					✓	
Research and Development Annual Report	MD	AN				✓		
Hospital Transfusion Committee Annual Report	MD	AN			✓			
Organ Donation Annual Report	MD	AN				✓		
Annual Report on Clinical Audit Activity 2023 – 2024	MD	AN		✓				

Nutrition and Hydration Committee Update Report	DoT&HS	AN					√D	√D
Review of neurodevelopmental service for U18s	DoN	AN			√			
Children's Rights & Participation Forum	DoN	Bi-AN			√			√
Dementia Care Annual Report	DoN	AN				√		
Children and Young Peoples Board Minutes	DoN	SI				√D	√	√
SOP Deep Dives PQSOC 1211/08	DoN	Action						√
Amendment to the six-monthly Nurse Staffing Act Report due to respiratory service changes (Macken Ward) PQSOC 1211/17	DoN	Action						√
Mental Health Act Monitoring Report	COO	Action						√

Appendix Three

Patient Quality, Safety and Outcomes Committee: Attendance at meetings in 2023-24

Attended	Did Not Attend	Not a Member/Required Attendee

Meeting Dates	April	June	July	September	November	January
Independent Members						
Pippa Britton	X	X	X	X	X	X
Louise Wright	X					
Paul Deneen	X	X	X	X	X	X
Helen Sweetland	X	X	X	X	X	X
Penny Jones	X	X	X	X	X	X
Executive Directors						
Medical Director	X	X	X	X	X	X
Director of AHPs & Health Science	X	X	X	X	X	X
Director of Nursing	X	X	X	X	X	X
Chief Executive	X	X	X	X	X	X
Director of Corporate Governance	X	X	X	X	X	X

PQSOC Committee Self Assessment

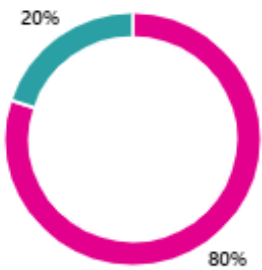
1. Does the Committee have written terms of reference and have they been approved by the Board?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



2. Are the terms of reference reviewed annually?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	1



3. The number of meetings held during the year is sufficient to allow the Committee to perform as effectively as possible?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



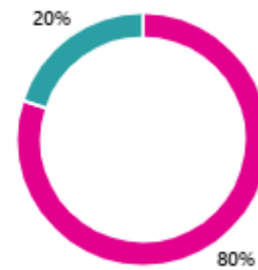
4. Has the Committee been quorate for each meeting this year?

1 - Room for Improvement	0
2 - Meeting Standards	2
3 - Excelling	3



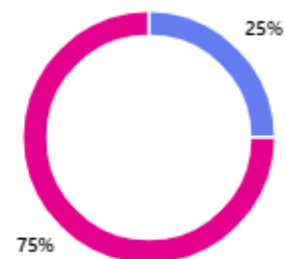
5. In terms of numbers, membership of the Committee is sufficient to discharge its responsibilities?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	1



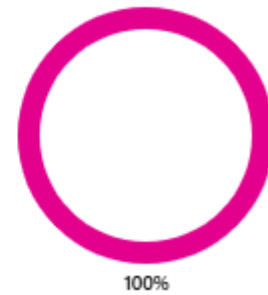
6. Members who have recently joined the PQSOC have been provided with induction training to help them understand their role and the organisation?

1 - Room for Improvement	1
2 - Meeting Standards	3
3 - Excelling	0



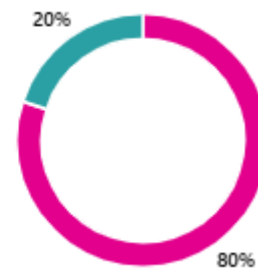
7. The Committee is clear about its role in relationship to other Committees that play a role in relations to patient quality and safety matters?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



8. Committee members understand their responsibilities regarding identifying, declaring, and resolving conflicts of interest?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	1



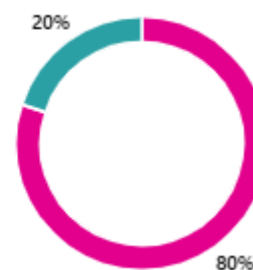
9. The Committee uses assurance mapping to identify where assurance is required and identify any key gaps where no assurance is provided, or where the quality of the assurance is poor?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



10. The Committee has an established a plan of matters to be dealt with across the year?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	1



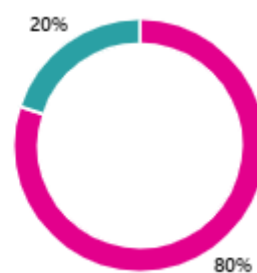
11. Does the Committee consider issues at the right time and in the right level of detail?

- 1 - Room for Improvements 0
- 2 - Meeting Standards 5
- 3 - Excelling 0



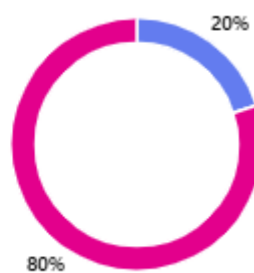
12. The Committee ensures that the relevant executive director(s) attends meetings to enable it to understand the reports and information it receives?

- 1 - Room for Improvement 0
- 2 - Meeting Standards 4
- 3 - Excelling 1



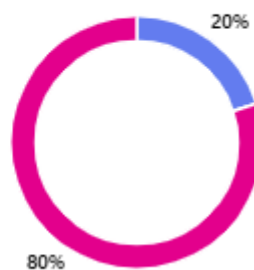
13. Are the Committee's papers distributed in sufficient time for members to give them due consideration?

- 1 - Room for Improvement 1
- 2 - Meeting Standards 4
- 3 - Excelling 0



14. The quality of the Committee's papers received allows Committee members to perform their roles effectively?

- 1 - Room for Improvement 1
- 2 - Meeting Standards 4
- 3 - Excelling 0



15. Committee meetings are chaired effectively?

1 - Room for Improvement	0
2 - Meeting Standards	3
3 - Excelling	2



16. The Committee chair allows debate to flow freely and does not assert his/her own view too strongly?

1 - Room for Improvement	0
2 - Meeting Standards	2
3 - Excelling	3



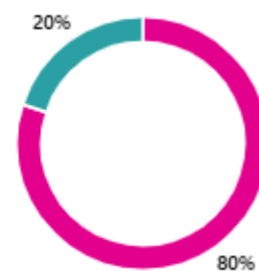
17. The Committee environment enables people to express their views, doubts, and opinions?

1 - Room for Improvement	0
2 - Meeting Standards	2
3 - Excelling	3



18. The Committee challenges management and other assurance providers to gain a clear understanding of their findings?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	1



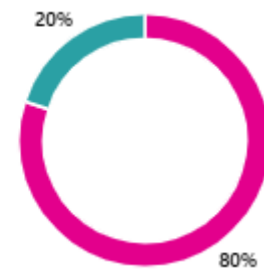
19. Members hold their assurance providers (management) to account for late or missing assurance?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



20. Each agenda item is 'closed off' appropriately so that the Committee is clear on the conclusion; who is doing what, when and how and how it is being monitored?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	1



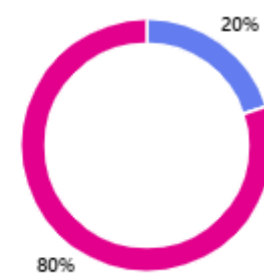
21. At the end of each meeting the Committee discuss the outcomes and reflect on decisions made and what worked well, not so well etc?

1 - Room for Improvement	2
2 - Meeting Standards	3
3 - Excelling	0



22. Decisions and actions are implemented in line with the timescale agreed?

1 - Room for Improvement	1
2 - Meeting Standards	4
3 - Excelling	0



23. Are the outcomes of each meeting and any issues of concern reported to the next Board meeting?

- 1 - Room for Improvement 0
- 2 - Meeting Standards 5
- 3 - Excelling 0



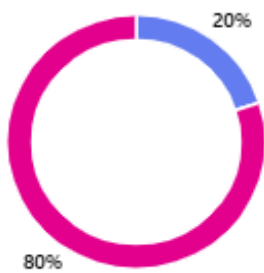
24. Does the Committee prepare an annual report on its work and performance for the Board?

- 1 - Room for Improvement 0
- 2 - Meeting Standards 4
- 3 - Excelling 0



25. The results of the annual self-assessment are used to inform and influence succession planning and improve effectiveness.

- 1 - Room for Improvement 1
- 2 - Meeting Standards 4
- 3 - Excelling 0



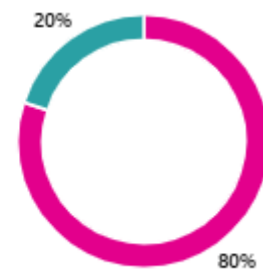
26. The self-assessment is objective and rigorous enough for meaningful conclusions to be drawn?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	0



27. Is the Committee satisfied that there is a credible process for assessing, measuring and reporting on Clinical Quality Governance

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	1



28. Is the Committee assured that the Health Board's Clinical Quality Governance Arrangements remain appropriate and aligned to the National Quality Framework

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



29. Is the Committee assured that Clinical Quality Governance is embedded in practice?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



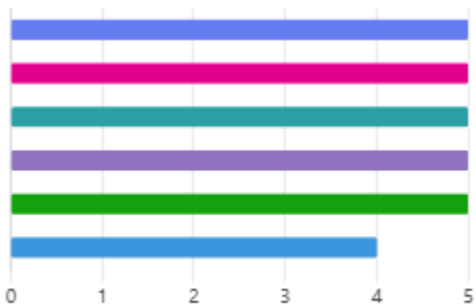
30. Does the Committee receive sufficient assurance that the systems, processes and plans to measure, monitor and enhance the quality of our healthcare services are fit for purpose

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



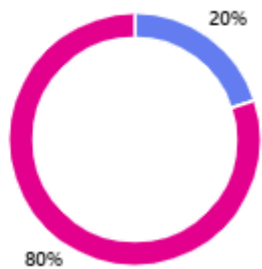
31. Does the committee effectively scrutinise the quality performance issues and key performance indicators (6 pillars):

Person Centred	5
Safe	5
Timely	5
Effective	5
Efficient	5
Equitable	4



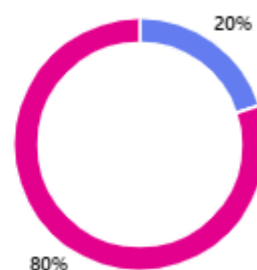
32. Does the Committee receive assurance that the arrangements for capturing the experience of patients, citizens and carers are sufficient, effective and robust?

1 - Room for Improvement	1
2 - Meeting Standards	4
3 - Excelling	0



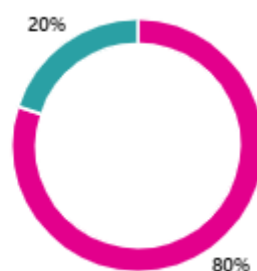
33. Does the Committee review progress against the Patient Experience and Involvement Strategy

1 - Room for Improvement	1
2 - Meeting Standards	4
3 - Excelling	0



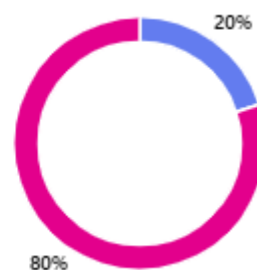
34. Does the Committee receive and consider sufficient information on compliance with Putting Things Right Regulations, including trends and ensuring lessons are learned?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	1



35. Does the Committee receive assurance that commissioning arrangements are in place to ensure the efficient, effective, timely, dignified and safe delivery of those services commissioned for delivery on behalf of ABUHB?

1 - Room for Improvement	1
2 - Meeting Standards	4
3 - Excelling	0



36. Is the Committee satisfied that arrangements are in place to undertake, review and act on clinical audit activity which responds to local and national priorities?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



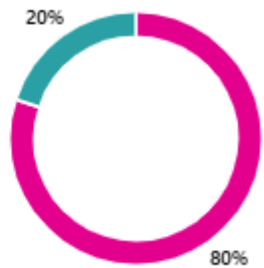
37. Does the Committee consider recommendations made by internal and external review bodies and ensure that action is taken in response?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



38. Does the Committee received sufficient assurance that arrangements are in place to ensure that there are robust infection prevention and control measures in place in all settings?

1 - Room for Improvement	0
2 - Meeting Standards	4
3 - Excelling	1



39. Does the Committee contribute to the development of the Health Board's Annual Quality Priorities?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



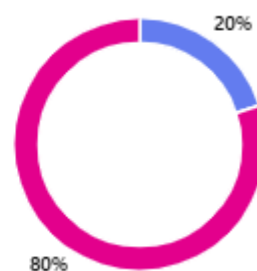
40. Does the Committee consider performance against key quality outcomes focussed indicators and metrics?

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



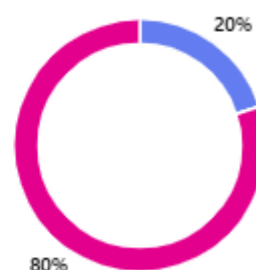
41. Does the Committee receive assurance in respect of the research and development activity within the organisation?

1 - Room for Improvement	1
2 - Meeting Standards	4
3 - Excelling	0



42. Does the Committee receive assurance in respect of improvement and innovation projects to improve the quality and safety of services?

1 - Room for Improvement	1
2 - Meeting Standards	4
3 - Excelling	0



43. Does the Committee receive assurance in respect of arrangements in place for compliance with Health and Safety Regulations and Fire Safety Standards, including operating practices in respect of:

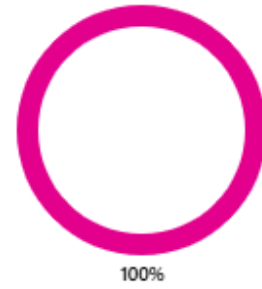
- Staff Health and Safety
- Stress at Work
- Patient Health and Safety (ie falls, patient manual handling violence and aggression)
- Fire Safety
- Risk Assessment processes
- Safe handling of loads
- Hazardous substances

1 - Room for Improvement	0
2 - Meeting Standards	5
3 - Excelling	0



Overall Score

- **Room for improvement** - The PQSOC is falling short of requirements and should consider how it can wo... 0
- **Meeting standards** - The PQSOC is performing to the required standard in this area. There may be... 5
- **Excelling** - This is an area where the PQSOC is performing beyond the standard expectations and i... 0



Quality Governance Follow up Review – Aneurin Bevan University Health Board

Audit year: 2023-24

Date issued: April 2025

Document reference: 4693A2025

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

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Summary report

Introduction

- 1 Quality should be at the 'heart' of all aspects of healthcare and 'putting quality and safety' above all else is one of the core values underpinning the NHS in Wales. Poor quality care can be costly in terms of harm, waste, and variation.
- 2 During 2021-22, the Auditor General reviewed quality governance arrangements across all Health Boards and Health Boards in Wales. That work focused on:
 - operational and corporate approaches to quality governance.
 - organisational culture and behaviours;
 - strategy, structures, and processes; and
 - information flows and reporting.
- 3 Our 2022 review of quality governance at the Aneurin Bevan University Health Board (the Health Board) found that the Health Board had clearly articulated the corporate arrangements for quality governance and its key areas of focus for quality and safety. However, at the time of reporting there remained weaknesses at a divisional and directorate level which could impact the flow of assurance from floor to Board. We made eight recommendations that covered 16 specific recommended areas for improvement. These focussed on risk management, clinical audit, values and behaviours, patient experience, putting things right, quality governance resources, and divisional quality and safety arrangements.
- 4 In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (the Act) became law. The Act has strengthened the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes, but is not limited to, the effectiveness and safety of health services and the experience of service users. Since undertaking our 2022 review, the specific requirements underpinning the Duties for Candour and Quality (introduced under the Act) have been agreed, and all health bodies should have made good progress to implement arrangements to meet those requirements.
- 5 This quality governance follow-up review assesses the Health Board's progress in implementing the 2022 audit recommendations. It also considers whether the Board is receiving necessary assurance that the Health Board is taking appropriate steps to respond to the requirements of the Act.
- 6 The methods we used to deliver our work are summarised in **Appendix 1**.

Key findings

- 7 Overall, we found that the Health Board is making progress implementing our 2022 quality governance recommendations but needs to fully embed the changes. The Health Board is taking reasonable steps to implement arrangements to deliver implementing the duties of quality and candour but needs to improve training compliance and monitoring.

Implementation of previous audit recommendations

- 8 While the Health Board has made progress in implementing previous audit recommendations, but only five of the 16 recommendations are fully complete.
- 9 Our review of progress against our 2022 quality governance review recommendations found that five of the sixteen recommendations have been fully completed, nine are in progress and are progressing well and two have not been implemented:
- **Recommendations completed** – The Health Board has fully implemented five recommendations. The Health Board has updated the clinical audit strategy, policy and plan and strengthened committee oversight. There have been improvements to arrangements to support learning from clinical audit. It has also ensured that patient feedback features more prominently at divisional quality and safety meetings. The Health Board has strengthened wider quality focussed resources and has reviewed the operational patient safety and quality groups to ensure they are effectively supporting the Health Boards quality governance arrangements.
 - **Recommendations in progress** - Good progress is being made against nine recommendations but they remain 'in progress'. The Health Board is embedding the Quality and Governance Framework, improving learning from patient experience of using commissioned services, and strengthening quality reporting across the organisation. However, many of these arrangements are new and need to be embedded before the benefits and necessary assurance are fully realised. The Quality Governance and Assurance Framework also needs to be updated to provide clear and appropriate 'floor/ward to Board' assurance arrangements.
 - **Recommendations not started** - We found no action on two of our previous recommendations. These related to the Health Board taking action to understand why some staff feel they are not treated fairly when reporting errors, and appropriate action is not taken to address concerns raised. However, we did note that the Health Board has introduced a range of arrangements to support staff to raise concerns.

Responding to the requirements of the Duty of Candour and Duty of Quality

- 10 We found that the Health Board is taking reasonable steps to implement arrangements to deliver the duties of quality and candour, however, there is scope to improve training compliance and monitoring.
- 11 The Health Board assessed its readiness against the Welsh Government baseline and developed an implementation programme well in advance of the Act’s April 2023 implementation date indicating a positive commitment to fulfilling these duties. It engaged a range of key stakeholders to ensure readiness, briefed key staff and board members and routinely reports progress on implementation to the Patient Quality, Safety and Outcomes committee. The Health Board developed and published its quality priorities for 2024-25 in its first annual quality report. These priorities continue to align to and support delivery of its duty of candour and duty of quality requirements and is supported by clear workstreams to deliver them.
- 12 Staff are supported via e-learning modules to help understand and respond to the new duties. However, there remain challenges. While training is in place, the Health Board does not monitor training compliance. This creates a risk that there is insufficient staff understanding of requirements under the Act.
- 13 Addressing the recommendations made in our 2022 Quality Governance report and the new recommendations in this report play an important role in ensuring that arrangements to deliver the duties of quality and candour are fully embedded.

Recommendations

- 14 The status of our 2022 audit recommendations is summarised in Exhibit 1.

Exhibit 1: status of our 2022 recommendations

Completed	In progress	Not Started	Superseded	Total
5	9	2	0	16

- 15 Exhibit 2 details the new recommendations arising from this review. The Health Board’s response to our recommendations will be summarised in Appendix 2 once complete.

Exhibit 2: New recommendations (2025)

Recommendations	
R1	The Health Board should take steps to improve its arrangements for staff to raise concerns by: 1.1 updating the procedure for NHS staff to raise concerns so that it is tailored to the Health Board and includes organisation-specific information and contacts. (Paragraph 32) 1.2 monitoring the impact of external support services and accreditation initiatives to ensure that these actions, meet staff needs and are translating into meaningful improvements in staff engagement and patient safety outcomes. (Paragraph 35)
R2	The Health Board should approve an addendum or update to the current 'Putting Things Right' Policy to reflect the current organisational structure and duty of quality and duty of candour requirements. (Paragraph 43)
R3	Within the next 12 months, the Health Board should evaluate the impact of centralising its Quality and Patient Safety teams to ensure the intended benefits are being achieved. (Paragraph 50)
R4	The Health Board should strengthen its arrangements for duty of quality and duty of candour e-learning training. This should include: 4.1 taking steps to increase uptake rates for Duty of Quality and Duty of Candour e-learning, to ensure staff have a good understanding of their responsibilities under the requirements. (Paragraph 58) 4.2 monitoring and reporting on completion rates for the Duty of Quality and Duty of Candour e-learning. (Paragraph 58)

Detailed report

Progress made with implementing our 2022 audit recommendations

- 16 We considered the Health Board progress in implementing each of our 2022 audit recommendations. We found that **the Health Board has made progress in implementing previous audit recommendations, but only five are fully complete.**

Risk management recommendations

2022 Recommendation 1

Divisional risks are presented to Quality and Patient Safety Operational Group, but there was limited evidence of in-depth analysis and discussion. There is also limited evidence that the General Surgery directorate maintains risk registers that adequately identify quality and safety risks and mitigating actions. The Health Board should:

- 1.1 ensure there is appropriate scrutiny, challenge, cross divisional discussion and sharing of good practice around divisional risks at the Quality and Patient Safety Operational Group.
- 1.2 ensure that risk registers are completed and maintained across all directorates that identify quality and safety risks and mitigating actions and there are appropriate risk escalation arrangements.

- 17 We considered whether the Health Board had effective arrangements for managing quality and safety risks. We expected to see the following:
- appropriate scrutiny, challenge, cross divisional discussion and sharing of good practice around divisional risks at the Quality and Patient Safety Operational Group.
 - risk registers are completed and maintained across all directorates which identify quality and safety risks and mitigating actions and there are appropriate risk escalation arrangements.
- 18 We found that **our sample review of directorate risk registers found that that there were omissions in risk information and that some risks may not be reviewed regularly. The Health Board has made changes to arrangements to review operational risks across the organisation, but sharing of risk knowledge and learning across the organisation is not yet routine**
- 19 The Health Board's Quality and Patient Safety Operational Group was stood down in August 2023. It was replaced with the Patient, Quality and Safety and Learning and Improvement Forum (the Forum). The Forum held its first meeting in March

2024, and has met bi-monthly since. The Forum has good representation from across the directorates and divisions, and meetings generally give good focus on learning, improvement, and patient safety.

- 20 The terms of reference for the Forum are well-written, comprehensive and clearly sets out the requirement to identify risks and to share knowledge and associated learning across all divisions. However, our audit found that sharing of risk knowledge and learning is not embedded in Forum meetings. Up until the time of our review, the Forum had not yet received any divisional risk registers. **We consider recommendation 1.1 to be in progress.**
- 21 Each division has a new separate Patient Quality and Safety Outcome Committee. Divisional risks are discussed and escalated as appropriate at committee meetings. There are standardised agendas for divisional committee meetings, and risks are reviewed using live data in DATIX¹. However, we reviewed the General Surgery divisional risk register and identified issues including the absence of mitigating actions and noted that some risks appeared not to have been reviewed for some time. The Health Board needs to ensure that gaps in the general surgery risk register are addressed and ensure that all risks contained in it are regularly reviewed and updated as appropriate. The Health Board should ensure that all divisions maintain up-to-date and comprehensive risk registers and that they consistently use risk escalation procedures, and if necessary, address any gaps. Additionally, the DATIX modules for risk, incidents and clinical audit systems are not integrated which means triangulation of data to identify themes is not automated. Instead, themes and issues are triangulated manually which is inefficient and could result in issues being missed. **We consider recommendation 1.2 to be in progress.**

Clinical Audit recommendations

2022 Recommendation 2

During our review, the Health Board was updating its clinical audit strategy and policy and developing a standalone clinical audit plan. The Health Board's Clinical Effectiveness and Standards group terms of reference were in draft and contained out-of-date information. At an operational level, clinical audit capacity is limited and systems to share learning and good practice are not embedded or systematic. The Health Board should:

- 2.1 complete the work on its clinical audit strategy, policy, and plan. The plan should cover mandated national audits, corporate-wide and local audits informed by areas of risk. This plan should be approved by the Patient

¹ Datix is an online system for staff to report information relating to incidents and risks.

Quality, Safety and Outcomes Committee and progress of its delivery monitored routinely.

2.2 update and finalise the terms of reference for the Clinical Effectiveness and Standards Committee.

2.3 ensure there is sufficient resource and capacity for clinical audit at an operational level.

2.4 ensure systems for learning and good practice from clinical audit are embedded across the organisation.

- 22 We considered whether the Health Board had effective arrangements for clinical audit. We expected to see the following:
- the Health Board has developed a clinical audit strategy, policy and plan which covers mandated national audits, corporate-wide and local audits informed by areas of risk.
 - the Clinical Audit Plan has been approved by the Patient Quality, Safety and Outcomes Committee, which routinely monitors progress of its delivery.
 - the Health Board has updated and finalised the terms of reference for the Clinical Effectiveness and Standards Committee.
 - the Health Board has completed its review of resources and capacity, and addressed any gaps, to support clinical audit at an operational level
 - the Health Board is embedding systems for learning and good practice from clinical audit across the organisation.
- 23 We found **that the Health Board has made good progress in its development of Clinical Audit plans and committee oversight of them. However, resources for delivery continue to be an issue for the Health Board.**
- 24 The Board approved the Clinical Audit Strategy 2022-25 in October 2022. The plan sets out four priorities:
1. There is scrutiny of national clinical audit performance with robust development and monitoring of improvement plans
 2. Divisions will identify clinical audits that allow scrutiny and assurance associated with quality and safety risk
 3. Trainees are supported to participate in meaningful clinical audits that support clinical governance
 4. Groups and committees across the Health Board will commission clinical audit to support effective assurance as required.
- 25 Our work found that the Clinical Audit Strategy is well-embedded and there is routine reporting of progress against the priorities in the strategy. To support the delivery of the strategy, the Audit, Risk and Assurance Committee approved the 2024-25 Clinical Audit Plan in May 2024. The 2024-25 Clinical Audit Plan sets out an appropriate programme of clinical audits including nationally mandated audits

and divisional audits. The plan also contains an appropriate range of risk-based divisional specific clinical audits. The Health Board ensures that it triangulates learning from clinical audit with other intelligence including complaints, incidents, and patient experience. The Patient, Quality and Safety and Learning and Improvement Forum is used to share learning, and reports are also presented to the Patient Quality, Safety and Outcomes Committee.

- 26 There is good committee oversight of both the delivery and outcomes of the clinical audit plan. Both the Patient Quality, Safety, and Outcomes Committee and the Audit and Risk Committee receive regular updates on the plan. However, update reports could be strengthened by more clearly identifying completion rates to determine progress of plan delivery. At an operational level, the Clinical Audit Plan is tracked and monitored via the AMaT system², ensuring audits are completed and signed off at both divisional and Health Board levels. **We consider recommendation 2.1 to be completed.**
- 27 The Health Board has updated its Clinical Effectiveness and Standards Group terms of reference. At the time of our work, the terms of reference were draft and not yet approved. The Health Board has reviewed and amended the membership of the group to ensure it reflects the Health Board's strategic priorities. **We consider recommendation 2.2 to be in progress.**
- 28 At the time of our work, the Health Board was reviewing its operational resources and capacity to support clinical audit. The February 2025 Audit, Risk and Assurance Committee clinical audit plan update highlighted continuing concern regarding local operational resources to deliver clinical audit. However, the Health Board is undertaking a resource mapping exercise with a view to identifying additional capacity. **We consider recommendation 2.3 to be in progress.**
- 29 The Health Board has improved how it shares and applies learning from clinical audit. Following the completion of an audit, improvement actions are incorporated into SMART³ action plans, which are agreed with leadership teams and approved by the Clinical Effectiveness and Standards Group. National clinical audit results are discussed at the Patient, Safety Quality and Outcomes meetings. Additionally, since March 2024, the Health Board holds bimonthly divisional learning forums focussing on learning from clinical audit. **We consider recommendation 2.4 to be completed.**

² AMaT – Audit Management and Tracking tool is a cloud-based clinical audit management tool

³ Specific, measurable, achievable, realistic and timely

Values and behaviours recommendations

2022 Recommendation 3

The Health Board has a well-established values and behaviours framework which sets out its vision for a quality and patient safety focussed culture. However, there is a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns and the action taken by the Health Board to address them. The Health Board should undertake work to understand why some staff feel:

- 3.1 they are not treated fairly or given feedback when reporting errors, near misses or incidents.
- 3.2 that the Health Board does not act on concerns they raise or take action to minimise future of occurrence errors, near misses or incidents.

- 30 We considered whether the Health Board had effective arrangements for values and behaviours. We expected to see the following:
- the Health Board has effective arrangements to ensure that staff are treated fairly and given feedback when reporting errors, near misses or incidents.
 - the Health Board has effective arrangements to promptly act on staff concerns and take action to minimise future occurrence of errors, near misses and incidents.
- 31 We found that, **the Health Board has a good and broad range of initiatives to create a safe environment where staff can disclose concerns. However, it did not underpin the initiatives with an understanding of why staff feel reluctant to raise concerns and think that appropriate action will not be undertaken. The Health Board has not evaluated its initiatives to see if they are having the desired impact.**
- 32 The Health Board's 2022-25 People Plan focuses on "Putting People First" which is underpinned by its well-established values and behaviours framework. The Health Board has a good procedure for NHS staff to raise concerns. However, its Speaking Up Safely procedure, which is based on the All-Wales model, has not been tailored to the Health Board and contains no specific references to the individuals that staff would need to contact (**2025 Recommendation 1.1**). Other health boards in Wales have adapted the procedure to reflect their internal arrangements and contacts.
- 33 The Health Board has introduced a range of initiatives which aim to improve the culture around reporting errors, near misses, incidents, and raising concerns. These include:
- **Just culture** - the Health Board has established the People and Culture Committee to oversee initiatives related to staff well-being, culture, and values.

The committee plays a crucial role by ensuring that policies and practices promote psychological safety, openness, the organisation's desired culture and values, and a learning-focused environment.

- **Listening and learning framework** - designed to create a safe environment where staff can disclose mistakes, enabling lessons to be learned and preventing recurring errors. This initiative aligns with the Health Board's vision of a learning-focused culture.
- **Human factors development programme** - over the past 12 months, the Health Board has rolled out the programme which focuses on developing a culture of openness and improving patient safety through staff engagement.
- **Ward and team accreditation** - with the aim of improving understanding of quality and safety data from ward audit and encouraging ownership and learning within teams.
- **External support services** - in March 2024, the Health Board transitioned from an internal system for raising concerns to commissioning externally provided services (Speaking Up Service and Employee Assistance Programme) with the aim of encouraging staff to raise concerns,
- **Email** – a dedicated internal email address for raising concerns.
- **Wellbeing services** – to support staff in all aspects of their role.

- 34 These Health Board initiatives point to a strong commitment for ensuring that staff feel supported, empowered, and psychologically safe to speak up about patient safety issues. Despite this, we have not found sufficient evidence of an effective response to our recommendations. The Health Board has not sufficiently engaged with staff and does not have adequate information to understand why staff felt;
- they are not treated fairly when reporting errors, near misses or incidents; or
 - that the Health Board did not act on concerns.

Therefore, there is limited assurance that the initiatives are appropriately designed to address staff apprehension.

- 35 Some of these arrangements, such as the ward accreditation programme and external support services are new. Therefore, the Health Board should undertake work to determine whether they are having the desired impact and ensure that the arrangements meet staff needs. **(2025 Recommendation 1.2)**

We consider recommendations 3.1 and 3.2 not started.

Patient experience recommendations

2022 Recommendation 4

Whilst the Health Board uses a range of methods to capture patient experience information, regular patient feedback updates are not always

provided to work areas or departments and arrangements are not systematic across the organisation or the services it commissions. The Health Board should:

- 4.1 undertake work to understand why patient feedback updates are not regularly provided to work areas or departments.
- 4.2 ensure there are systematic arrangements for collating and acting upon patient experience information across the organisation and the services it commissions.

- 36 We considered whether the Health Board had effective patient experience feedback approaches. We expected to see the following:
- the Health Board has effective arrangements to regularly provide patient feedback updates to work areas and departments.
 - the Health Board has effective arrangements for collating and acting upon patient experience information across the organisation and the services it commissions.
- 37 We found **that the Health Board is strengthening its approach for collecting, analysing, reporting and sharing patient experience. The Health Board now needs to complete its work to capture and report the patient experience of the services that it commissions.**
- 38 In March 2023, the Board approved the Patient Experience and Involvement Strategy to improve services, clinical effectiveness, patient safety, and user experience. The Strategy identifies a range of methods for obtaining patient feedback. These include the introduction of the new Patient Advice and Liaison Service (November 2023), the ongoing roll out of the CIVICA citizen experience platform (since February 2023), the continuation of the 'you said, we did' approach and the 'person-centred' care survey.
- 39 Collectively, the arrangements to obtain patient feedback ensure that a range of views is collected and analysed. Although we understand that public engagement is low compared to other health boards. The Patient Quality Safety and Outcomes Committee receives a patient feedback report every two months which identifies themes and trends, lessons learnt, and improvement actions taken in response. Patient feedback now also forms part of the agenda for the Patient Quality and Safety and Learning Forum and is now a standard agenda item on divisional quality and patient safety meetings. **We consider recommendation 4.1 completed.**
- 40 The Health Board recognises the importance of obtaining feedback from patients who are treated in commissioned services. The July 2024 Patient Quality Safety and Outcomes Committee received the Health Boards' Quality Assurance Framework: Commissioned Services. One of the key areas of focus elements of this framework is to use patient experience information to inform commissioning

decisions. The Health Board is currently using Datix to record any patient experience concerns relating to commissioned services. Work is underway to develop a central register of the commissioned services across the Health Board. Once completed, this register will be used to ensure patient feedback is routinely obtained from the entirety of services the Health Board commissions for its residents. **We consider recommendation 4.2 to be in progress.**

Putting things right recommendation

2022 Recommendation 5

The Health Board's Putting Things Right Policy was due to be reviewed in 2018 and contains out of date information. The Health Board should review and update the Putting Things Right Policy as a priority.

- 41 We looked for any updates to the Health Board's putting it right policy and expected to see that the Health Board reviewed and updated its Putting Things Right policy.
- 42 We found that **the Health Board has still not reviewed its Putting Things Right Policy, which was due for review in 2018.**
- 43 The Health Board's Putting Things Right Policy remains out of date and has not been reviewed since 2018. **We consider recommendation 5 to be in progress.** Whilst the all-Wales policy remains under review by the Welsh Government, other health boards in Wales have updated their policies to ensure they remain current. While the Health Board is awaiting new guidance from Welsh Government, it should update its policy in the interim to reflect the current organisational structure, expected standards, and Duty of Quality and Duty of Candour requirements. **(2025 Recommendation 2)**

Quality and Safety framework recommendations

2022 Recommendation 6

The Health Board's Quality Assurance Framework includes a range of committees and groups aligned to Health and Care Standards. The framework is assisting the Health Board in identifying areas which previously had not provided assurance. However, there are still gaps in the flows of assurance from some sub-groups and in relation to elements of the Health and Care Standards. Whilst the framework is comprehensive at

a corporate level, it does not fully articulate the operational structure and processes for quality and safety. The Health Board should:

- 6.1 complete its review of the quality and safety framework to ensure that flows of assurance are appropriate, and that the framework functions as intended.
- 6.2 articulate the operational structures and processes for quality and safety within the quality assurance framework and how they align with the corporate structure to provide 'floor to board' assurance.

- 44 We considered whether the Health Board had effective quality assurance framework. We expected to see the following:
- the Health Board has completed its review of the quality assurance framework to ensure that flows of assurance are appropriate, and that it functions as intended.
 - the Health Board's quality assurance framework clearly articulates operational structures and processes for quality and safety and how they align with the corporate structure to provide 'floor to board' assurance.
- 45 We found that **the Health Board is making progress implementing its Quality Governance and Assurance Framework, however it needs to ensure it sets out clear and appropriate 'floor/ward to Board' assurance arrangements.**
- 46 The Health Board approved its Quality Governance and Assurance Framework in July 2023. Progress on its implementation includes:
- centralisation of the quality and patient safety resource, which we discuss more in **paragraph 50**;
 - new systems for accreditation and performance monitoring, including ward-level data visibility and team accreditation, to support a patient facing approach to learning and improvement;
 - reviewing quality and safety structures of groups and committees to determine if they are effectively discharging their responsibilities;
 - developing standardised Quality and Patient safety group agendas to ensure consistency in approach across the organisation, and
 - appointing a clinical governance lead within each of the divisions to improve clinical engagement with the quality and patient safety team.
- 47 The Health Board is also introducing a new Clinical Governance Assurance and Escalation Framework. Its aim will be to ensure that the Board is clearly sighted on quality issues and assurances across the full range of services. There is a clear implementation plan supporting these changes. We have reviewed progress to date, and although the new framework defines Board and committee quality assurance arrangements, it does not sufficiently describe how directorate and divisional assurances will operate and flow from 'floor to board'. The Health Board

is continuing to refine the framework. It plans to present an updated version to the Patient Safety, Quality and Outcomes committee in summer of 2025. **We consider recommendations 6.1 and 6.2 to be in progress.**

Resources to support quality governance recommendation

2022 Recommendation 7

The Scheduled Care division and General Surgery directorate have designated leads for many keys aspects of quality and safety. However, we found that some designated leads do not have protected time for these roles. The Health Board should ensure operational staff have sufficient time and capacity to effectively fulfil these roles.

- 48 We considered whether the Health Board had effective Quality and Safety framework. We expected to see that the Health Board ensures that operational staff have sufficient time and capacity to fulfil designated quality and safety lead roles.
- 49 We found **the Health Board has introduced new arrangements to strengthen its quality and safety capacity, improve the consistency of approach and train more staff in quality improvement and assurance.**
- 50 The Health Board has taken action to improve quality and safety capacity. In February 2024, it centralised the Quality and Patient Safety Leads⁴ into the corporate Quality and Patient Safety Team. It also appointed a new Head of Quality and Safety and developed a new ‘business partnering’ model. Its new quality and safety partners are allocated to the divisions, but accountable to the Corporate Quality and Patient Safety Team. This is ensuring consistency of approach but also providing a more balanced and equitable allocation of quality and safety resources. The Health Board will need to regularly monitor and evaluate the effectiveness of these changes. This will help ensure that the expected benefits are being realised. **(2025 Recommendation 3)**
- 51 The Health Board has also strengthened wider quality and safety resources. The Scheduled Care division was split into two divisions, general surgery and clinical support services, with more resources provided for quality governance. The Health Board is also investing in additional training through its Quality Initiative plans and developing quality coaches. This investment in staff development is positive and should enhance their understanding of quality governance and ensure its long-term sustainability. **We consider recommendation 7 to be complete.**

⁴ At the time of writing this was 43 members of staff.

Divisional coverage of quality and safety matters recommendations

Recommendation 8

The General Surgery directorate has recently established its own Patient Safety and Quality Group. However, the group does not have a Terms of Reference, standardised agenda, or report templates and minutes of meetings are not taken. Whilst quality and safety did feature in bi-annual reviews with the Executive Team and monthly assurance meetings with the Director of Operations we note the monthly assurance meetings stopped in March 2021. We found limited focus on quality and safety at Scheduled Care Divisional Management Team meetings. The Health Board should:

- 8.1 review the operational patient safety and quality groups to ensure they are effectively supporting the Health Boards quality governance arrangements.
- 8.2 ensure that other operational meetings / forums provide sufficient focus on quality and safety alongside finance, performance, and operational matters.

- 52 We considered whether the Health Board's divisional groups appropriately cover quality and safety matters. We expected to see the following:
- the Health Board has reviewed operational patient safety and quality groups to ensure they are effectively supporting its quality governance arrangements.
 - operational meetings / forums provide sufficient focus on quality and safety alongside finance, performance, and operational matters.
- 53 We found that **the Health Board is making good progress through its new Quality and Governance framework to ensure a consistent and appropriate focus on Quality and Patient safety, more work is needed to ensure this is embedded and covers all areas.**
- 54 As discussed in **paragraph 50**, the Health Board has reviewed its quality and safety structures, and it has also introduced standardised quality and patient safety agendas to ensure consistency in approach. We reviewed a sample of divisional management team and Quality and Safety meeting agenda and papers in the former General Surgery directorate. We also reviewed the mid-year and end of year reports which summarised the activities through the year. We found that quality and safety now feature regularly in weekly Divisional Management Team meetings, with a standing agenda item on patient safety and quality, alongside the finance, performance, and operational matters. Both groups are operating well within the former General Surgery directorate. The Health Board is continuing to implement this approach across all division and service areas. On the basis that this is work that is currently taking place, **we consider recommendation 8.1 to be complete and recommendation 8.2 to be in progress.**

Responding to the requirements of the Duty of Candour and Duty of Quality

55 We considered the extent to which the Health Board has taken steps to implement arrangements to deliver both the Duty of Quality and Duty of Candour. We expected to see the following:

- the Health Board has considered what it needs to do to implement the duties of Quality and Candour, with plans in place to address any gaps.
- the Health Board has clear arrangements in place for monitoring implementation which reflects the timescales and risks associated with delivering the plan.
- progress in implementing the duties of quality and candour is routinely reported to the Board and its committees.
- board members are appropriately briefed on the requirements and plans and have received appropriate training in relation to the duties of quality and candour.
- staff training has been delivered to raise awareness of the requirements under the two duties. The Health Board has identified appropriate strategic, senior, and operational leadership to oversee and deliver the duties. All staff understand their respective responsibilities.

56 We found that the Health Board **is taking reasonable steps to implement arrangements to deliver the duties of quality and candour, however, there is scope to improve training compliance and monitoring.**

57 The Health and Social Care (Quality and Engagement) Act 2020 came into force on 1 April 2023. In advance of its introduction, the Health Board assessed its preparedness for complying with the Act against the Welsh Government baseline position. The Health Board engaged its stakeholders effectively, conducting workshops and sessions with healthcare partners, patients, and staff to ensure readiness for the implementation of the new the duty of quality and duty of candour requirements. To supplement its implementation, the Health Board also created dedicated training resources and intranet content for staff. It also created videos for the public to help raise awareness more widely. The Health Board developed an implementation programme prior to the Act coming into force in April 2023 with progress delivery is reported bi-monthly to the Patient Quality, Safety and Outcomes committee.

58 The Health Board developed and approved its Quality Strategy and briefed Board members in November 2022 prior to the launch of the strategy in April 2023. In May 2024, the Health Board reported progress against its 2023-24 Quality Strategy objectives and set out its quality priorities for 2024-25 in its first annual quality report. The Quality Strategy is aligned to duty of candour and duty of quality requirements and is supported by clear workstreams and SMART objectives. We also found:

- appropriate strategic and senior leadership arrangements for implementing of the duties of quality and candour, led by the Executive Director of Nursing, and supported by her senior leadership team.
- reasonable methods for staff training including the rollout of e-learning modules on the duties of quality and candour. The Health Board also set up clear and accessible intranet pages setting out related arrangements, responsibilities and requirements. However, the Health Board needs to improve uptake of this training and more effectively record and monitor completion rates **(2025 Recommendation 4.1 and 4.2)**.
- the Patient Safety, Quality and Outcomes Committee is actively and appropriately monitoring delivery of quality strategy, the implementation plan and wider quality and safety assurances.

59 Addressing the recommendations made in our 2022 Quality Governance report and the new recommendations in this report play an important role in ensuring that arrangements to deliver the duties of quality and candour are fully embedded.

Appendix 1

Audit methods

Exhibit 4 sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below.

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Quality Strategy Framework • Quality Governance Framework • Internal Audit reports • Patient Experience and Involvement \Strategy • Policies and Procedures • Risk Management • Listening, Learning and Improvement Framework • Quality Performance Reports • Audit Plan • Clinical Audit Activity Reports • Committee Reports for Audit Risk and Assurance • Commissioning Assurance Framework • Putting Things Right Annual report. • Annual Quality Report.

Element of audit approach	Description
Interviews	We interviewed the following: • Executive Director of Nursing. • Executive Medical Director. • Director of Corporate Governance. • Senior Quality Governance Lead. • Assistant Director of Quality and Patient Safety. • Head of Corporate Risk and Assurance • Deputy Director of Nursing • Executive Director of Therapies and Health Sciences • Chair of the Patient Quality Safety and Outcomes Committee
Observations	We observed the Patient Safety, Quality and Outcomes Committee

Appendix 2

Organisational response to new audit recommendations

Exhibit 5 sets out the Health Board's response to our new audit recommendations.

Ref	Recommendations	Organisational response	Completion date	Responsible officer
R1	The Health Board should take steps to improve its arrangements for staff to raise concerns by: 1.1 updating the procedure for NHS staff to raise concerns so that it is tailored to the Health Board and includes organisation-specific information and contacts.	The NHS Wales Raising Concerns Procedure is a national procedure applicable to all NHS Wales organisations and includes how to raise concerns dependent on the nature (e.g., to line manager, Executive Director). We also have a dedicated SharePoint page accessible to all staff which includes specific information and contact details for staff to raise concerns, including named individuals and champions: Speaking Up Safely. We will strengthen our approach to the Procedure for NHS Staff to Raise Concerns by ensuring it reflects our local context and organisational structure. The procedural document and its supporting appendices will be updated to include the Health Board's name where applicable, identify key individuals within the organisation, and align all appendices with the structure of the Health Board.	June 2025	Director of Workforce & Organisational Development Implemented by: Assistant Director of Workforce & Organisational Development

Ref	Recommendations	Organisational response	Completion date	Responsible officer
	1.2 monitoring the impact of external support services and accreditation initiatives to ensure that these actions, meet staff needs and are translating into meaningful improvements in staff engagement and patient safety outcomes.	The update will be taken through the next scheduled meeting of the Workforce and Organisational Development Policy Group for ratification. The Health Board will assess the impact of ward / team accreditation through a post implementation evaluation process, this will help determine whether the initiative is improving staff engagement, patient safety outcomes and will help determine areas for improvement.	September 2025	Director of Nursing Implemented by: Deputy Director of Nursing
R2	The Health Board should approve an addendum or update to the current 'Putting Things Right' Policy to reflect the current organisational structure and duty of quality and duty of candour requirements.	The extant 'Putting Things Right' Policy has been updated to reflect the current organisational structure and duty of quality and duty of candour requirements.	Completed	Director of Nursing Implemented by: Deputy Director of Nursing

Ref	Recommendations	Organisational response	Completion date	Responsible officer
R3	Within the next 12 months, the Health Board should evaluate the impact of centralising its Quality and Patient Safety teams to ensure the intended benefits are being achieved. (Paragraph 50)	The Head of Quality & Patient Safety will undertake a comprehensive review of the centralisation process. This review will include an assessment of the effectiveness of the centralised structure in improving patient safety outcomes, staff engagement, operational efficiency and compliance. This review will involve collecting feedback from staff, analysing performance metrics, and identifying any areas for improvement.	April 2026	Director of Nursing Implemented by: Head of Quality Patient Safety & Deputy Director of Nursing
R4	The Health Board should strengthen its arrangements for duty of quality and duty of candour e-learning training. This should include: 4.1 taking steps to increase uptake rates for Duty of Quality and Duty of Candour e-learning, to ensure staff have a good understanding of their responsibilities under the requirements.	The NHS Wales – Duty of Candour has been through the Core Learning Advisory Committee and formally adopted as a mandatory e-learning module for all relevant staff in the Health Board. The NHS Wales – Duty of Quality training is scheduled to be taken through the Core Learning Advisory Committee and formally adopted as a mandatory e-learning module for all relevant staff in the Health Board.	Completed June 2025	Implemented by: Assistant Director of Workforce & OD Implemented by: Assistant Director of Workforce & OD

Ref	Recommendations	Organisational response	Completion date	Responsible officer
	4.2 monitoring and reporting on completion rates for the Duty of Quality and Duty of Candour e-learning.	Monitoring of all statutory and mandatory training compliance is published on a monthly basis, including Duty of Candour. Duty of Quality will be included once approved by the Core Learning Advisory Committee.	July 2025	Implemented by: Assistant Director of Workforce & OD



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