Patient Quality, Safety and Outcomes Committee

Tuesday 6 October 2026, 09:30 - 12:30

MS Teams

Agenda

09:30 - 09:30
0 min

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Chair

1.2. Apologies for Absence

Chair

1.3. Declarations of Interest

Chair

1.4. Draft Minutes of the last Meeting held on 28th July 2026

Chair

PQSOC 20261006 1.4 PQSOC 20260728 Minutes.pdf (13 pages)

1.5. Committee Action Log

Chair

PQSOC 20261006 1.5 Action Log.pdf (7 pages)

09:30 - 09:30
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2. Items for APPROVAL/RATIFICATION/DECISION

There are no items for inclusion in this section

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3. ITEMS FOR DISCUSSION

3.1. Quality Outcomes Reporting

Director of Nursing & Medical Director & Director of Allied Health Professions & Health Science

PQSOC 20261006 3.1 Quality Outcomes Reporting.pdf (9 pages)
PQSOC 20261006 3.1 Quality Outcomes Reporting Appendix A.pdf (119 pages)

3.2. Quality Management Group Reporting, including escalation through Quality Management System

Director of Nursing

PQSOC 20261006 3.2 QMG Report.pdf (5 pages)
PQSOC 20261006 3.2 QMG Report Appendix A.pdf (14 pages)
PQSOC 20261006 3.2 QMG Report Appendix B.pdf (4 pages)
PQSOC 20261006 3.2 QMG Report Appendix C.pdf (5 pages)
PQSOC 20261006 3.2 QMG Report Appendix D.pdf (5 pages)

3.3. Quality Annual Report 2025/26

Director of Nursing

- PQSOC 20261006 3.3 Quality Performance Report Sept 2026.pdf (8 pages)
- PQSOC 20261006 3.3 Quality Performance Report Sept 2026 Appendix A.pdf (50 pages)

3.4. Putting Things Right Annual Report 2025/26

Director of Nursing

- PQSOC 20261006 3.4 PTR Annual Report.pdf (10 pages)
- PQSOC 20261006 3.4 PTR Annual Report Appendix A.pdf (27 pages)

3.5. Maternity and Neonatal Report

Director of Nursing

- PQSOC 20261006 3.5 Maternity & Neonatal Annual Report.pdf (10 pages)
- PQSOC 20261006 3.5 Maternity & Neonatal Services Annual Report Appendix A.pdf (21 pages)

3.6. Safeguarding Annual Report

Director of Nursing

- PQSOC 20261006 3.6 Safeguarding Report.pdf (4 pages)
- PQSOC 20261006 3.6 Safeguarding Report Appendix A.pdf (22 pages)

3.7. Attorney General of Northern Ireland (AGNI) Supreme Court Ruling

Director of Nursing

- PQSOC 20261006 3.7 AGNI Supreme Court Ruling.pdf (6 pages)
- PQSOC 20261006 3.7 AGNI Supreme Court Ruling Appendix A.pdf (3 pages)
- PQSOC 20261006 3.7 AGNI Supreme Court Ruling Appendix B.pdf (1 pages)
- PQSOC 20261006 3.7 AGNI Supreme Court Ruling Appendix C.pdf (1 pages)

3.8. Quality Management System Annual Review and Development Plan

Director of Nursing

- PQSOC 20261006 3.8 Quality Management System Annual Review.pdf (5 pages)
- PQSOC 20261006 3.8 Quality Management System Annual Review Appendix A.pdf (13 pages)

3.9. Corporate Clinical Audit Framework including the Annual Corporate Clinical Audit Plan 2026/27

Medical Director

- PQSOC 20261006 3.9 Clinical Audit Framework.pdf (6 pages)
- PQSOC 20261006 3.9 Clinical Audit Framework Appendix A.pdf (35 pages)

3.10. Strategic Oversight of Clinical Audit 2026-2029

Medical Director

- PQSOC 20261006 3.10 Strategic Oversight of Clinical Audit 2026–2029.pdf (6 pages)
- PQSOC 20261006 3.10 Strategic Oversight of Clinical Audit 2026–2029 Appendix A.pdf (12 pages)

3.11. Research and Development Annual Report

Medical Director

- PQSOC 20261006 3.11 R&D Report.pdf (3 pages)
- PQSOC 20261006 3.11 R&D Report Appendix A.pdf (33 pages)

3.12. Violence and Aggression Incidents Report

Director of Allied Health Professions & Health Science

- PQSOC 20261006 3.12 Violence and Agression Incidents Report.pdf (4 pages)
- PQSOC 20261006 3.12 Violence and Agression Incidents Report Appendix A.pdf (19 pages)

3.13. Primary Care Quality Report

Chief Operating Officer

- PQSOC 20261006 3.13 Primary Care Quality Report.pdf (5 pages)
- PQSOC 20261006 3.13 Primary Care Quality Report Appendix A.pdf (109 pages)

3.14. Cancer Services Report

Chief Operating Officer

- PQSOC 20261006 3.14 Cancer Services.pdf (47 pages)

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4. Items for INFORMATION

4.1. Review of Committee Programme of Business 2026/27

Director of Corporate Governance

- PQSOC 20261006 4.1 Review of Committee Forward Work Plan 2026-27 Report.pdf (4 pages)
- PQSOC 20261006 4.1 Review of Committee Forward Work Plan 2026-27 Appendix A.pdf (7 pages)

4.2. Committee Risk Report

- PQSOC 20261006 4.2 Committee Risk Report.pdf (6 pages)
- PQSOC 20261006 4.2 Committee Risk Report Appendix A.pdf (1 pages)

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5. OTHER MATTERS

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

Chair

5.2. Any Other Urgent Business

Chair

5.3. Date of the Next Meeting: Tuesday 3rd December

BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD

MINUTES OF THE PATIENT QUALITY, SAFETY & OUTCOMES COMMITTEE

DATE OF MEETING	Tuesday 28th July 2026, 09:30AM-12:30PM
VENUE	Microsoft Teams

PRESENT	Helen Sweetland, Chair
	Penny Jones, Vice Chair
	Paul Deneen, Independent Member
	Vivek Goel, Independent Member
IN ATTENDANCE	Jennifer Winslade, Director of Nursing
	Peter Carr, Director of Allied Health Professionals and Health Science
	Paul Mizen, Clinical Lead Service Transformation (Substituting for Medical Director)
	Rani Dash, Director of Corporate Governance
	Naomi Murtagh, Board Business Manager
	Megan Detheridge, Governance Support Officer
	Nicola Prygodzicz, Chief Executive
	Kye Smith, Head of Quality and Patient Safety (Item 3.1)
	Kelly Downes, Deputy Director of Nursing (Item 3.3)
OBSERVER	None
APOLOGIES	William Smart, ABUHB Vice Chair
	Seema Srivastava, Medical Director

PQSOC/0728/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
PQSOC/0728/02	**Apologies for Absence** The Chair noted the apologies for absence.
PQSOC/0728/03	**Declarations of Interest**

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	There were no declarations of interest raised relating to items on the agenda.
PQSOC/0728/04	**Draft Minutes of the last Meeting held on 02nd June 2026** The minutes of the Patient Quality, Safety and Outcomes Committee held on 6th May 2026 were agreed as a true and accurate record of the meeting. The Committee **APPROVED** the draft minutes.
PQSOC/0728/05	**Committee Action Log** The Committee received the Action Log and reviewed progress against outstanding actions. The Chair highlighted the action relating to the Health and Safety report and sought assurance regarding the route through which the requested information would be reported. Peter Carr (PC), Director of Allied Health Professionals and Health Science, advised that the requested analysis relating to violence prevention and reduction would be considered initially through the Violence Prevention and Reduction Group, before progressing through the Health and Safety Committee and Quality Management Group in line with established governance arrangements. He confirmed that, given the Committee's interest in the matter, a specific report would also be brought to the Committee. PC further noted that health and safety remained a core component of the quality framework and would continue to be reflected within quality reporting where appropriate. Paul Deneen (PD), Independent Member, noted that the annual Health and Safety Report had been expected during the current cycle and sought clarification on its status. PC confirmed that the report had been completed but could not be accommodated within the July Board agenda. He explained that work had been undertaken to prepare

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	the report earlier in the year following previous feedback that it had been presented too late in the annual cycle. Rani Dash (RD), Director of Corporate Governance, confirmed that the report could not be accommodated on the July Board agenda due to competing priorities. RD proposed that the report be circulated to Committee members following Executive Committee consideration, allowing the opportunity to provide feedback before submission to Board in September. The Chair noted the importance of allowing the Committee an opportunity to review and comment on the report prior to its formal submission to Board, particularly given the nature of the issues considered. PC confirmed that the report would be presented to Executive Committee the following week and subsequently circulated to Committee members for review. **ACTION: Director of Allied Health Professionals and Health Science** The Committee **APPROVED** the action log.
PQSOC/0728/06	**Quality Outcomes Reporting** Jennifer Winslade (JW), Director of Nursing, presented the Interim Quality Outcomes Report with the support of Kye Smith (KS), Head of Quality and Patient Safety. JW highlighted continued strong performance in patient experience reporting, ongoing improvements in complaints management, positive outcomes from Ombudsman reviews, improved timeliness in incident closure, and sustained performance across safeguarding and patient safety indicators. The Committee noted the progress made in reducing complaint backlogs and improving the quality of responses through strengthened accountability and revised processes. Helen Sweetland (HS), Chair, welcomed the improvements reported, particularly in relation to complaints management, and sought further information regarding the work undertaken to improve the quality of complaint

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responses. JW advised that improvements had been driven through process redesign and greater clarity regarding accountability. KS added that the complaints process and training for Investigating Officers had been redesigned in April 2025. He explained that ongoing feedback and learning had gradually strengthened the quality of investigations and responses across the Health Board.

Paul Deneen (PD), Independent Member, commended the report and requested additional context regarding patient survey response rates. KS agreed to provide information on response uptake rates and noted that approximately 15% of Emergency Department patients responded to text-based surveys, with higher response rates in some specialist services. PD also highlighted patient waiting times as a recurring source of feedback and sought assurance regarding communications with patients whilst waiting. JW advised that communications were tailored to individual care settings and included programmes to support patients waiting for planned care as well as information and support provided within urgent and emergency care environments.

Timeline and Implementation Plan for the Qlik App

KS provided an update on the implementation of the Quality and Patient Safety Qlik application. He advised that the current phase of development involved validation of mortality, Duty of Candour and calculated quality metrics, which were expected to be available imminently. A subsequent phase would introduce patient experience survey data, audit information and Welsh Nursing Care Record information, with completion anticipated by October 2026. KS explained that the application would enable more meaningful analysis through measures such as incidents per occupied bed day and would support the triangulation of quality, audit, training and patient outcome data.

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	PD sought assurance regarding the use of artificial intelligence within the system. KS explained that artificial intelligence functionality was being explored to support data analysis and identify themes across incidents and complaints; however, outputs required extensive validation before informing assurance reporting. The Chair sought assurance that use of the system was being embedded across the organisation. KS advised that significant training had been delivered to divisional management teams, pharmacists, senior nurses and quality leads, with over 50 staff trained to date. He stated that the intention was for quality assurance to be increasingly driven through operational teams, with corporate teams providing scrutiny and challenge. **Deep Dive into Quarter 4 Never Events** KS presented an overview of the three Never Events reported during Quarter 4. KS advised that the principal themes identified across the incidents were documentation, compliance with safety checks and staff confidence in speaking up. Learning and improvement actions had been identified and would be applied more widely across relevant clinical areas. Penny Jones (PJ), Vice Chair, expressed concern that Never Events were increasingly occurring outside traditional theatre settings and sought assurance regarding mitigating actions. KS advised that the issue had been discussed extensively at the Quality Management Group and that a review of local safety standards for invasive procedures would be undertaken. He acknowledged that significant attention had previously been directed towards theatre-based procedures and confirmed that greater focus would now be placed on procedures undertaken in non-theatre environments. He noted that the Health Board had historically performed well in relation to Never Events but agreed that the emerging trend required close monitoring.

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It was confirmed that additional audit and assurance arrangements were being developed to support this work.

It was noted that all three Never Events had been managed through the Duty of Candour process and that the incidents had resulted in either low or no harm.

Infection Prevention and Control

KS presented a deep dive on Infection Prevention and Control (IP&C), outlining the Health Board's governance arrangements and surveillance processes. He reported that healthcare-acquired infection rates had continued to improve over the last two years and highlighted the Health Board's strong performance in reducing onward transmission of winter respiratory viruses. KS explained that positive laboratory results were reviewed daily through established surveillance systems, allowing rapid identification of outbreaks, clusters and trends. Monthly ward-level reports were provided to divisions, including infection rates, cleanliness audits, hand hygiene performance and training compliance.

JW highlighted the strong governance arrangements supporting infection prevention and control, including oversight through national collaboratives, the Health Board's IP&C Group, Quality Management Group and Ward Accreditation Programme.

The Committee sought clarification regarding testing timescales and public engagement in infection prevention measures. It was highlighted that staff encouraged patients and visitors to follow infection prevention guidance, including hand hygiene and visiting restrictions when required. KS further advised that community infection prevention leads worked closely with care homes and community settings to support management of outbreaks and infection control measures.

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The Chair requested that the Infection Prevention and Control Annual Report be shared with Committee members to support future scrutiny. JW agreed to circulate the report. **ACTION: Director of Nursing.**

Feedback Relating to Patient Waiting Times and Pain Management

KS presented an analysis of patient feedback relating to waiting times and pain management. He advised that the majority of responses originated from urgent and emergency care settings, where patients were frequently awaiting diagnosis and treatment. Themes identified included delays in pain relief, perceived delays in clinical review, communication during waits and patients feeling they were discharged whilst still experiencing pain. KS acknowledged that many of the concerns reflected wider system pressures and waiting times within urgent care services. He noted, that the thematic analysis had been shared with staff in Urgent and Emergency Care and that feedback relating to pain management had reduced in subsequent months.

PJ expressed concern regarding the experience of patients attending Emergency Departments whilst in significant pain and questioned how such patients were supported during prolonged waits. JW advised that all patients were clinically triaged on arrival and provided with appropriate analgesia where required. She confirmed that patients were monitored whilst waiting and that additional support was provided through staff and volunteer services.

Nicola Prygodzicz (NP), Chief Executive Officer, acknowledged that maintaining regular contact and support for patients in waiting areas remained challenging, particularly during periods of high demand and overnight. NP advised that work continued to strengthen communication, comfort measures and pastoral support for patients awaiting treatment.

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	The Chair noted that anxiety, uncertainty and prolonged waiting could further influence patient perceptions of pain and their overall experience. Members welcomed the analysis and noted the opportunities identified to improve communication and support for patients whilst waiting. The Committee **NOTED** the report.
PQSOC/0728/07	**Quality Management Group Reporting, including escalation through Quality Management System** Jennifer Winslade (JW), Director of Nursing, presented the report and highlighted the key quality and safety matters that had been reviewed through the Quality Management Group (QMG). JW reported that QMG had reviewed the ongoing investigation into the Health Services Decontamination Unit (HSDU) and theatre instrument incident. Through the investigation process, gaps had been identified in the traceability of certain additional instrument sets. While traceability arrangements were in place for core sets, assurance had identified the need for a broader solution. A corporate risk assessment and SBAR had been developed and would be escalated to the Executive Committee to support consideration of the required improvements. JW noted that the issue represented a positive example of organisational learning arising from the investigation process. The Committee received an update on implementation of the Call for Concern process. JW explained that, whilst progress continued, digital limitations remained within the Care-flow system, specifically in relation to integrating patient wellness scores and associated escalation questions. These constraints had been escalated through governance processes and work continued to identify solutions. JW advised that implementation challenges were being experienced nationally and were not unique to the Health Board.

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	JW reported that QMG had reviewed transfusion safety arrangements and had identified the need for stronger divisional oversight. Although assurance had been received regarding targeted education, competency assessments and existing system controls, the Group had noted wrong blood in tube incidents and transfusion sample rejection rates of approximately 8–10%. As a result, divisions had been asked to ensure improvement programmes were in place and that risks were reflected appropriately within divisional risk registers. JW advised that QMG had also reviewed assurance relating to venous thromboembolism (VTE) prophylaxis. Although overall VTE rates remained low, audits had identified documentation gaps and incomplete risk assessments. Improvement actions focusing on prescribing practice, record keeping and the Electronic Prescribing and Medicines Administration (EPMA) programme were being taken forward to reduce variation and strengthen compliance. The Committee noted the outlier position of two national clinical audits (National Joint Registry and National Respiratory Audit) and noted that an improvement programme is in place. JW advised that QMG had considered the increase in Never Events occurring outside theatre environments and had agreed additional work to review Local Safety Standards for Invasive Procedures and compliance with National Safety Standards. This work would support greater assurance in non-theatre clinical settings and complement the actions discussed under the previous agenda item. The Committee received an update regarding risks associated with violence, aggression and sexual safety. JW explained that several divisions had highlighted increasing concerns through divisional reporting, particularly within Surgery and Medicine. In response, QMG had noted the Violence Prevention and Reduction Strategic Plan and

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requested a further report particularly on sexual safety, to support monitoring of improvements and cross-divisional learning.

Peter Carr (PC), Director of Allied Health Professionals and Health Science, advised that concerns regarding violence and aggression had been consistently raised through divisional reports and mirrored trends identified within incident data. He explained that the newly established Violence Prevention and Reduction Group was engaging directly with divisions to develop locally informed action plans rather than imposing a centralised approach. PC reported that support arrangements were already in place to assist staff involved in incidents and that opportunities to pursue prosecutions were actively pursued where appropriate. He also outlined measures used to identify repeat offenders and manage future interactions with services where concerns regarding staff safety existed.

JW advised that work was underway to evaluate the current Quality Management System and prepare for the development of a revised quality strategy. She also informed the Committee that a programme of work focusing on Healthcare Inspectorate Wales (HIW) preparedness would be undertaken to ensure services were proactively assessing compliance and implementing improvements ahead of inspections rather than responding reactively.

ACTION: Update on the NJR audit – Medical Director

ACTION: Update on Call4Concern implementation – Medical Director

ACTION: Update on Transfusion Safety issues- Medical Director

The Committee:

- **NOTED** the report.

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	• **ENDORSED** escalations and areas requiring continued oversight • **SUPPORTED** proposed governance routes • **RECOGNISED** areas where assurance remains limited.
PQSOC/0728/08	**Nurse Staffing Levels Wales Act Annual Assurance Report** Jennifer Winslade (JW), Director of Nursing, presented the report with the assistance of Kelly Downes (KD), Assistant Director of Nursing. KD outlined the governance arrangements in place to support implementation, reporting and assurance, and highlighted progress made in maintaining safe nurse staffing levels within designated areas. The Committee were informed that nurse staffing calculations and reviews had been completed in line with legislative requirements and that ongoing monitoring arrangements remained in place to ensure establishments reflected patient need and service demand. Penny Jones (PJ), Independent Member, welcomed the report and sought further information regarding initiatives to support workforce development and retention, beyond the leadership programme referenced within the report. KD outlined the broader range of workforce initiatives being undertaken across nursing services to support recruitment, retention, professional development and succession planning, recognising the importance of maintaining a sustainable workforce to support safe staffing levels. Vivek Goel (VG), Independent Member, sought assurance regarding the impact of patient flow pressures and ward boarding arrangements on nurse staffing and patient care. KD explained that the Health Board continued to monitor staffing levels closely and considered operational pressures

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	through established escalation and workforce management processes. She advised that nurse staffing reviews took account of service demands, acuity of patients and emerging operational challenges to ensure risks were identified and managed appropriately. Patient Safety is the priority and the professional judgement of ward managers is very important. The Committee **NOTED** the report for assurance.
PQSOC/0728/09	**Review of Committee Programme of Business 2026/27** The report was received for Information.
PQSOC/0728/10	**Committee Risk Report** The report was received for Information.
PQSOC/0728/11	**NHS Wales Joint Commissioning Quality Committee Report** The report was received for Information.
PQSOC/0728/12	**Items to be Brought to the Attention of the Board and Other Committees** Items highlighted to be brought to the attention of the Board were: key areas of escalation within QMG report. These include: Digital delivery constraints for C4Concern, weakness in end-to-end theatre instrument traceability. Violence and Aggression reporting will also be brought to the attention of the People and Culture Committee.
PQSOC/0728/13	**Any Other Urgent Business** There was no other urgent business.
PQSOC/0728/14	**Date of the Next Meeting: Tuesday 6th October 2026**

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ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

Outstanding	Overdue: In Progress	Not Due	Completed	Transferred to another Committe

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
June 2026	**PQSOC0206/07**	**Quality Outcomes Reporting** Formal review of 'Listening to People', would be undertaken after three months to collate and assess data.	**Director of Nursing**	September 2026	

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
June 2026	**PQSOC0206/07**	**Quality Outcomes Reporting** report on Quality assurance and the framework for commissioned services should come to the committee in six months.	**Director of Nursing**	December 2026	

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
June 2026	**PQSOC0206/08**	**Quality Management Group Report** Research and Development Annual Report to be brought forward as an agenda item.	**Medical Director**	July 2026	July Update. Item deferred to October meeting.

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
June 2026	**PQSOC 0206/11**	**Update on neonatal services, including progress on listening and lessons learned activity and the forthcoming national review** Updated requested in regards to further bedside and cot-side training.	**Director of Nursing**	July 2026	July Update. Action deferred to October meeting.

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
June 2026	**PQSOC 0206/17**	**Any Other Urgent Business** Updates were requested on the outcomes of the investigations into two recent incidents that been the subject of significant publicity: the sterilisation unit and the lumbar puncture case.	**Director of Nursing/ Medical Director**	October 2026	**Not Due**

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
July 2026	**PQSOC 0728/05**	**Committee Action Log** To circulate the Health and Safety Annual Report with Committee members once it had been scrutinised by the Executive Committee.	**Director of Allied Health Professionals and Health Science**	October 2026	August 2026: Action Complete – Report Circulated

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
July 2026	**PQSOC 0728/06**	**Quality Outcomes Reporting** • **Infection prevention and control** To circulate the infection Prevention and Control Annual Report with Committee members to support future scrutiny.	**Director of Nursing.**	October 2026	

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 aTos 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.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	06 October 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality Outcomes Framework (QOF) for Quarter One (April – June 2026)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing Peter Carr, Executive Director of Therapies & Health Science Dr Seema Srivastava, Executive Medical Director
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, the Health Board continues to operate within the statutory framework of the *Health and Social Care (Quality and Engagement) (Wales) Act 2020* and the national vision set out in *A Healthier Wales*. These frameworks require organisations to demonstrate continuous improvement in quality, safety, patient experience and organisational learning through a mature Quality Management System (QMS).

During Quarter One (Q1) 2026/27, the Quality Outcomes Framework (QOF) continued to provide assurance to the Board, Quality Management Group (QMG), Patient Quality, Safety and Outcomes Committee (PQSOC), and Executive Committee by bringing together intelligence across the six Pillars of Quality. The quarter has been characterised by continued organisational focus on evaluating, refreshing and strengthening the Quality Management System, alongside sustained improvement in a number of key quality and patient safety indicators.

The QOF demonstrates progress in mortality outcomes, incident investigation compliance, ward accreditation, deteriorating patient programmes, patient safety governance and organisational learning. At the same time, continued focus is



required on patient experience variation, complaints performance, safeguarding demand and training compliance, antimicrobial stewardship, workforce safety and system capacity pressures.

Cefndir / Background

The implementation of the Quality Strategy, Patient Experience and Involvement Strategy, Quality Improvement Framework and the developing Quality Management System continue to shape how the organisation measures, understands and improves quality. Over recent quarters, the Quality Outcomes Framework has evolved into a more mature, outcomes-focused assurance framework that supports divisional, corporate and Board governance arrangements.

During 2026/27, the Health Board has commenced a comprehensive review of its Quality Management Framework, governance structures, reporting arrangements and Quality Management Group to strengthen accountability, assurance, organisational learning and improvement. This work will culminate in a refreshed Quality Management Framework for Board approval in January 2027.

Q1 brings together intelligence from patient experience systems, Listening to People arrangements, patient safety incidents, mortality governance, clinical effectiveness programmes, infection prevention and control, health and safety systems, safeguarding, audits, inspections and leadership oversight activities. This provides a comprehensive view of performance, variation, risk, learning and improvement across the Health Board.

Asesiad / Assessment

The Quality Outcomes Framework provides current intelligence on quality and patient safety as mapped against the six Pillars of Quality. These pillars form the core of the Health Board's Quality Management System, supporting a structured approach to quality planning, quality control, assurance and improvement. During Quarter One, the Health Board has continued to strengthen its Quality Management System whilst undertaking a wider review of the Quality Management Framework, governance structures and reporting arrangements.

1. Patient & Staff Experience, Complaints, Concerns and Compliments

- Patient experience feedback remains positive overall, although there are signs of increasing variation across services. CIVICA continues to expand across the Health Board and now supports feedback collection across 636 service areas. Overall patient satisfaction remains high at 85%; however, June recorded the lowest satisfaction score since May 2025, reinforcing the need to better



understand local variation and ensure learning from feedback is consistently translated into service improvement.

- Demand on patient experience services continues to increase, highlighting both organisational accessibility and ongoing system pressures. PALS enquiries increased throughout the quarter, with communication, access to services and appointments remaining the predominant themes. The implementation of the Listening to People approach has strengthened the Health Board's ability to understand patient concerns, provide early support and identify emerging themes requiring action.
- The transition to Listening to People regulations is beginning to demonstrate positive impact. Formal complaint volumes have reduced, there has been increasing utilisation of Early Resolution processes, and the number of overdue formal concerns has reduced significantly. Whilst compliance remains variable, the overall trajectory demonstrates improved organisational grip and a greater focus on resolving concerns as close to the point of care as possible.
- Bereavement and pastoral support services continue to demonstrate value. Activity within the GRACE service has increased substantially, reflecting growing awareness of the service and the importance of providing compassionate support to patients, families and carers following bereavement.

2. Patient Safety and Incident Reporting

- Mortality indicators continue to provide assurance regarding the quality and safety of care. The Health Board reported a RAMI of 88.61 for April and May 2026, which remains below the All-Wales peer group average and demonstrates sustained improvement when compared with previous years. Crude mortality data continues to show a stable and improving position, supported by strengthened mortality governance and enhanced triangulation through mortality reviews and the Learning from Deaths Framework.
- A strong reporting culture continues to be evident across the organisation. Whilst over 8,200 incidents were reported during Quarter One, the majority resulted in no or low harm. This provides assurance that staff continue to identify, report and learn from patient safety incidents and demonstrates growing organisational maturity in relation to safety culture and learning.
- Progress has been made in Nationally Reportable Incident management. Corporate oversight, strengthened investigation processes and improved monitoring arrangements have resulted in the highest level of compliance reported to date. Overdue investigations have reduced considerably and feedback from NHS Performance and Improvement has recognised both improved timeliness and the quality of investigations submitted.
- Pressure ulcer and falls prevention programmes continue to demonstrate positive improvement trajectories. Hospital-acquired pressure ulcers continue to reduce, particularly Category 2 ulcers, while inpatient falls remain largely stable and below the national average for most of the reporting period. Improvement activity continues to focus on prevention, learning and strengthening reliability of care processes.
- Medicines safety and Duty of Candour remain areas of strong governance focus. Enhanced oversight through daily review arrangements, strengthened dashboards and ongoing divisional engagement have supported organisational



learning whilst maintaining appropriate scrutiny of areas where harm has occurred.

- Two Never Events were reported during Quarter One. Investigations and improvement actions are underway, with particular focus on procedural reliability, compliance with NatSSIPs and LocSSIPs, and strengthening organisational learning to reduce the likelihood of recurrence.

3. Clinical Effectiveness

- The Health Board continues to demonstrate strong progress in clinical effectiveness and assurance programmes. Ward Accreditation has expanded significantly and now extends beyond traditional inpatient settings into community, children's and mental health services, helping to strengthen quality assurance and reduce variation in care delivery.
- The deteriorating patient and sepsis programme remains a notable area of achievement. Full implementation of national Early Warning Score requirements has now been completed, including MEWS. Focus has subsequently shifted towards reliability, audit, quality improvement and demonstrating impact on patient outcomes.
- Call for Concern represents a significant step forward in person-centred care. The programme supports patients, families and carers to escalate concerns when worried about deterioration and reinforces the principle that patient and family voices play a central role in safety and quality improvement. Implementation is progressing in a controlled manner to ensure sustainable and reliable adoption.
- Additional work to improve safety-netting and discharge information continues. Progress has been made implementing national Welsh Health Circular requirements, with new safety-netting resources being developed and tested across adult and paediatric services.

4. Health, Safety, Security and Compliance

- Workforce safety remains a key organisational priority. Violence and aggression, sharps injuries and slips, trips and falls continue to be monitored closely. During Quarter One, the Health Board approved its Violence Prevention and Reduction Strategic Plan and initiated a number of targeted quality improvement programmes designed to reduce harm to staff and strengthen reporting culture.
- Compliance with mandatory training remains mixed. Whilst progress has been made in some areas, manual handling and certain statutory training requirements continue to require recovery action. Ongoing work focuses on improving access to training, supporting local delivery and strengthening accountability through divisional governance arrangements.

5. Infection Prevention and Control

- Infection Prevention and Control performance remains broadly stable. Clostridioides difficile infections reduced compared with the previous year and reductions continue to be seen in several important healthcare-associated



infections. This reflects the impact of collaborative working, quality improvement activity and enhanced surveillance.

- Challenges remain in relation to bloodstream infections and antimicrobial stewardship. Whilst some indicators have improved, increases in Staphylococcus aureus and Gram-negative bloodstream infections require continued focus. Antimicrobial stewardship remains a strategic priority, with ongoing work to improve prescribing practice and deliver compliance with Welsh Government targets.

6. Safeguarding

- Safeguarding activity continues to reflect increasing complexity across the wider system. Whilst some referral categories have reduced, demand for safeguarding advice and support continues to increase significantly, indicating greater staff awareness, improved reporting and increasing complexity amongst vulnerable patient groups.
- Training compliance continues to improve but remains an area of focus. The Health Board has seen sustained improvement in adult and children's safeguarding training, including Level 3 compliance. However, further work is required to achieve expected compliance levels and ensure staff have the skills and confidence to identify and respond appropriately to safeguarding concerns.
- Violence Against Women, Domestic Abuse and Sexual Violence and MARAC arrangements continue to experience increasing complexity. Whilst overall activity remains stable, rising case complexity and wider system pressures continue to create challenges for multi-agency services and require ongoing oversight

Areas of Improvement

Quarter One has demonstrated a number of notable achievements and areas of sustained improvement across the Health Board. These improvements reflect the continued commitment of staff and services to strengthening quality, safety, patient experience and organisational learning.

- Quality Management System development has progressed significantly during Quarter One. The Health Board has commenced a comprehensive review of the Quality Management Framework, governance arrangements, reporting structures and the Quality Management Group. This work provides an important opportunity to strengthen accountability, assurance, organisational learning and improvement whilst ensuring clear Ward-to-Board visibility of quality intelligence.
- Mortality indicators continue to provide positive assurance regarding patient outcomes. Risk Adjusted Mortality Index (RAMI) performance remains below the All-Wales peer group average, continuing the longer-term trend of improvement seen across recent years. Mortality governance arrangements have also matured through strengthened oversight, improved triangulation of intelligence and ongoing development of the Learning from Deaths Framework.
- Patient safety governance has strengthened considerably. Significant improvements have been achieved in the management of Nationally Reportable Incidents, with compliance reaching 95%, the highest level reported by the



organisation to date. Corporate oversight, strengthened investigation processes and improved monitoring arrangements have contributed to increased timeliness, improved quality of investigations and enhanced organisational learning.

- The organisation continues to demonstrate a positive reporting and learning culture. Staff continue to actively report incidents, with the majority resulting in no or low harm. This provides assurance that staff remain engaged in identifying risks, reporting concerns and contributing to learning and improvement activity across services.
- Progress continues to be demonstrated in reducing avoidable harm. Improvements have been observed in hospital-acquired pressure ulcers, particularly Category 2 ulcers, alongside stable falls performance that remains below the national average for most of the reporting period. This reflects the impact of targeted improvement activity, strengthened scrutiny and a growing emphasis on harm prevention.
- The deteriorating patient and sepsis programme continues to mature and deliver improvement. Full implementation of the national Early Warning Score requirements has now been achieved, including successful implementation of MEWS. Focus has subsequently shifted towards reliability, audit, organisational learning and demonstrating measurable impact on patient outcomes.
- Ward Accreditation continues to expand and mature. The programme has now progressed beyond inpatient wards into community, mental health, district nursing, health visiting and children's services. This represents an important milestone in strengthening quality assurance arrangements and reducing unwarranted variation across services.
- Patient and family involvement in safety continues to strengthen. The implementation of Call for Concern and development of the Patient Wellness Score represent important developments in person-centred care, ensuring that patients, families and carers play an active role in recognising deterioration and escalating concerns.
- Patient Safety Leadership Visits continue to strengthen visibility, engagement and organisational learning. Positive findings regarding patient care, staff commitment, multidisciplinary working and family-centred care were evident across a range of services, whilst a number of local improvement actions have already been completed following issues identified during visits.
- Safeguarding training compliance continues to improve. Whilst further improvement is required, particularly in Level 3 safeguarding training, sustained progress has been observed across adult and children's safeguarding training programmes, supported by strengthened divisional engagement and recovery plans.

Areas of Focus:

Whilst Quarter One provides assurance in many areas, there remain a number of issues, risks and challenges requiring continued organisational focus. The report provides detailed analysis, actions and assurance arrangements in relation to these areas.

- Variation in patient experience and feedback requires continued attention. Despite generally positive patient satisfaction scores, June recorded the lowest



CIVICA score reported since May 2025 and variation remains evident across services. Further work is required to ensure feedback is consistently captured, understood and translated into meaningful service improvement.

- Listening to People compliance and complaint performance remain areas requiring improvement. Whilst there has been a reduction in overdue concerns and increasing use of early resolution processes, compliance remains variable and further work is required to embed the new regulatory framework and improve timeliness of responses.
- Workforce training compliance continues to present challenges. Manual handling, statutory and mandatory training compliance remain below expected levels in some areas. Recovery plans are in place; however, sustained focus will be required to address backlog activity and ensure workforce competence and compliance.
- Safeguarding demand and complexity continue to increase. Although some safeguarding referral categories have reduced, growing demand for advice, support and safeguarding intervention demonstrates increasing complexity across patient populations. This continues to place pressure on safeguarding services and support functions.
- Level 3 safeguarding training and VAWDASV compliance require ongoing executive oversight. Whilst improvements have been achieved, compliance remains below organisational expectations and Welsh Government requirements, necessitating continued recovery action throughout 2026/27.
- Antimicrobial stewardship remains a key quality and safety priority. Challenges continue in relation to prescribing practice, compliance with national targets and the inappropriate use of broad-spectrum antimicrobials. Ongoing work is required to reduce variation and strengthen antimicrobial governance across primary and secondary care settings.
- Bloodstream infections continue to require focused improvement activity. Whilst positive progress has been achieved in some healthcare-associated infection measures, increases in Staphylococcus aureus and Gram-negative bloodstream infections highlight the need for ongoing surveillance, quality improvement and clinical engagement.
- Workforce health and safety remains an important organisational concern. Violence and aggression, sharps injuries and slips, trips and falls continue to affect staff across a number of clinical settings. Delivery of the Violence Prevention and Reduction Strategy and targeted quality improvement work remains a priority.
- Digital infrastructure and system reliability continue to impact staff experience and operational efficiency. A number of issues identified through Patient Safety Leadership Visits highlighted challenges relating to Wi-Fi, equipment, system integration and digital functionality. Continued partnership working with Digital, Data and Technology services remains essential.
- System capacity pressures continue to influence performance across multiple quality domains. Demand pressures, workforce constraints, patient flow challenges and delays across health and care systems continue to impact services and have the potential to affect the pace of improvement and operational resilience.
- The Health Board's ongoing review of quality governance and reporting arrangements identifies the need to further strengthen assurance structures. The opportunity now exists to simplify reporting, improve triangulation of



intelligence, reduce duplication and ensure there is a clear line of sight between quality intelligence, risk, learning and improvement from ward to Board.

Argymhelliad/ Recommendation

This report provides **ASSURANCE** to the Patient Quality, Safety and Outcomes Committee regarding the continued development and maturity of the Health Board's Quality Management System and governance arrangements. It demonstrates progress against the Duty of Quality and Duty of Candour through strengthened quality intelligence, organisational learning and improvement, whilst highlighting the key risks, pressures and priorities that require continued executive and committee oversight during 2026/27.

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 prrioritise 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.

LEADERSHIP

WORKFORCE

CULTURE

INFORMATION

LEARNING, IMPROVEMENT & RESEARCH

WHOLE SYSTEMS APPROACH

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Quality Outcomes Framework
Quarter One - 2026/27

PERSON CENTRED

SAFE

TIMELY

EFFECTIVE

EFFICIENT

EQUITABLE

The Quality Outcomes Framework

The Quality Outcomes Framework

The Health Board's Quality Outcomes Framework (QOF) brings together intelligence across the six Pillars of Quality to support the identification of emerging risks, variation, learning and improvement. It provides a structured view of quality across:

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

The QOF supports the wider Quality Management System by connecting quality intelligence from services and divisions with oversight through the Quality Management Group, Executive Committee, Patient Quality, Safety and Outcomes Committee and Board.

Review and development during 2026/27

The Health Board is undertaking a comprehensive review of its Quality Management Framework to strengthen the connection between intelligence, accountability, assurance, organisational learning and improvement.

The review includes:

1. Evaluating whether the Quality Management Framework provides clear responsibilities, governance, escalation and assurance from service to Board.
2. Reviewing the purpose, structure and effectiveness of the Quality Management Group and its supporting subgroups, including their reporting requirements, membership, outputs and contribution to organisational assurance.
3. Reviewing quality reporting across the Health Board to reduce duplication, improve consistency and strengthen the triangulation of quality, patient experience, workforce, risk and performance intelligence.
4. Refining the Quality Outcomes Framework so that reporting is more concise, outcomes focused and exception based, with clearer links between variation, risk, improvement actions and evidence of impact.
5. Strengthening the use of digital quality intelligence to provide a more consistent and reliable source of information for services, divisions, executives and the Board.

Engagement and approval

Engagement sessions with the Executive Committee and Public Board members are planned during Quarter 3 of 2026/27. These sessions will test whether the proposed arrangements provide the required oversight and assurance and will inform the future design of the Quality Management Framework.

The findings from the framework review, quality reporting review, Quality Management Group subgroup review and engagement sessions will be brought together into a refreshed Quality Management Framework for Board approval in January 2027.

2026/27 priority: evaluate, refresh and mature the Quality Management System (QMS)

1 Listen and evaluate

Use the QMS workshops and further targeted divisional input.
Opportunity for Divisions to shape and refine QMF and QMG.

2 Refresh the Quality Plan

Refresh the three-year Quality Plan so it articulates Health Board priorities and what Divisions need to deliver. Seeks views, identify priorities that will inform and shape the new plan.

3 Evaluate the framework

Complete a full evaluation of the Quality Management Framework, QMG and reporting routes for governance framework.

4 Strengthen reporting

Confirm reporting captures statutory and mandatory requirements, exceptions, highlights, risks and escalation. Use Qlik, patient experience, workforce indicators, audits, inspections and regulatory activity to identify areas requiring further focus and improvement.

5 Target maturity support

Use maturity assessment to identify established, developing and less mature areas and target support accordingly.

6 Demonstrate impact

Show whether intelligence, learning and improvement have changed practice, reduced variation and improved outcomes.

Next Stage of QMS Maturity

- Recognise progress has been made, acknowledging there is more work to do to strengthen the QMS and quality governance arrangements.
- Establish a clear ward-to-Board line of sight connecting planning, control, assurance and improvement.
- Build on the engagement already undertaken- two multidisciplinary workshops held involving Divisional representatives, including General Management, Nursing, Medical and AHP&HS colleagues, ensuring opportunities to shape the future direction of quality have been provided across the Health Board.
- Use Executive and Board development sessions to refine the Quality Plan and agree future quality priorities.
- Workshop planned with Medical Director and Medical QPS/ Governance leads to shape Quality Plan refresh.
- Continue to work collaboratively with Divisions -ensure priorities reflect operational needs, local intelligence and what matters most to patients and staff.
- Strengthen alignment between quality priorities, the Duty of Quality, Health and Care Quality Standards, professional regulatory requirements and organisational assurance processes.
- Ensure quality improvement, quality control, quality planning and quality assurance are connected through a single framework that supports both regulatory compliance and continuous improvement.



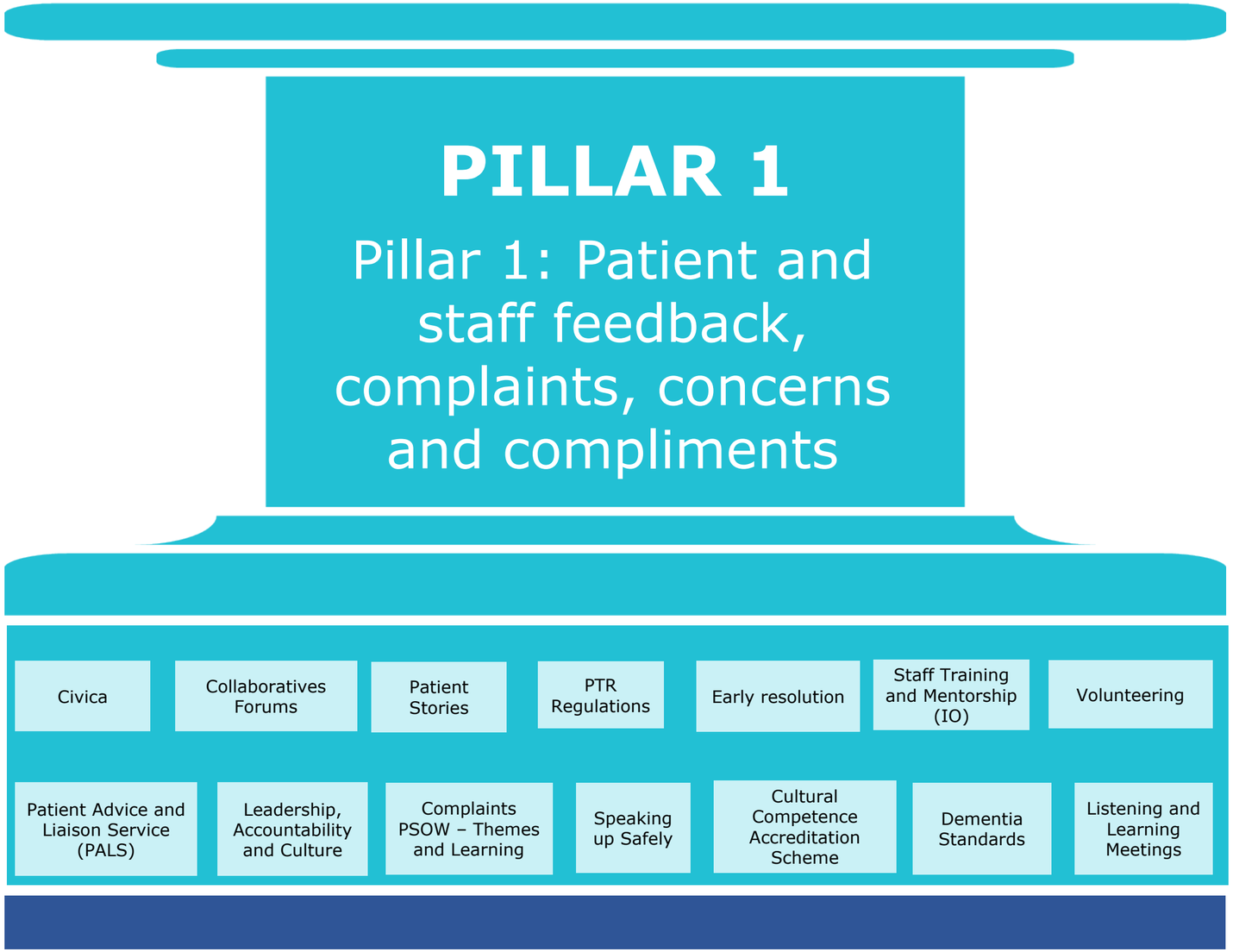
Revised Pillars of Quality



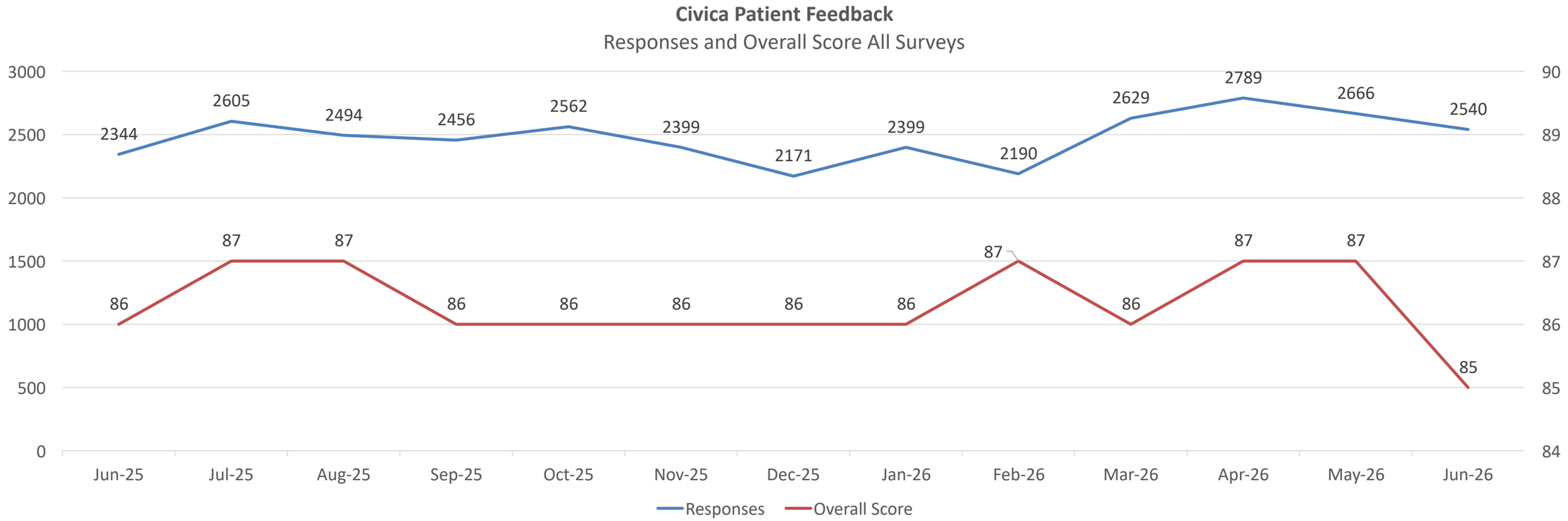
The Health Board's Quality Pillars have been revised in line with changes within the Quality Management Framework and the creation of the Quality Management Group.

PILLAR 1

Pillar 1: Patient and staff feedback, complaints, concerns and compliments



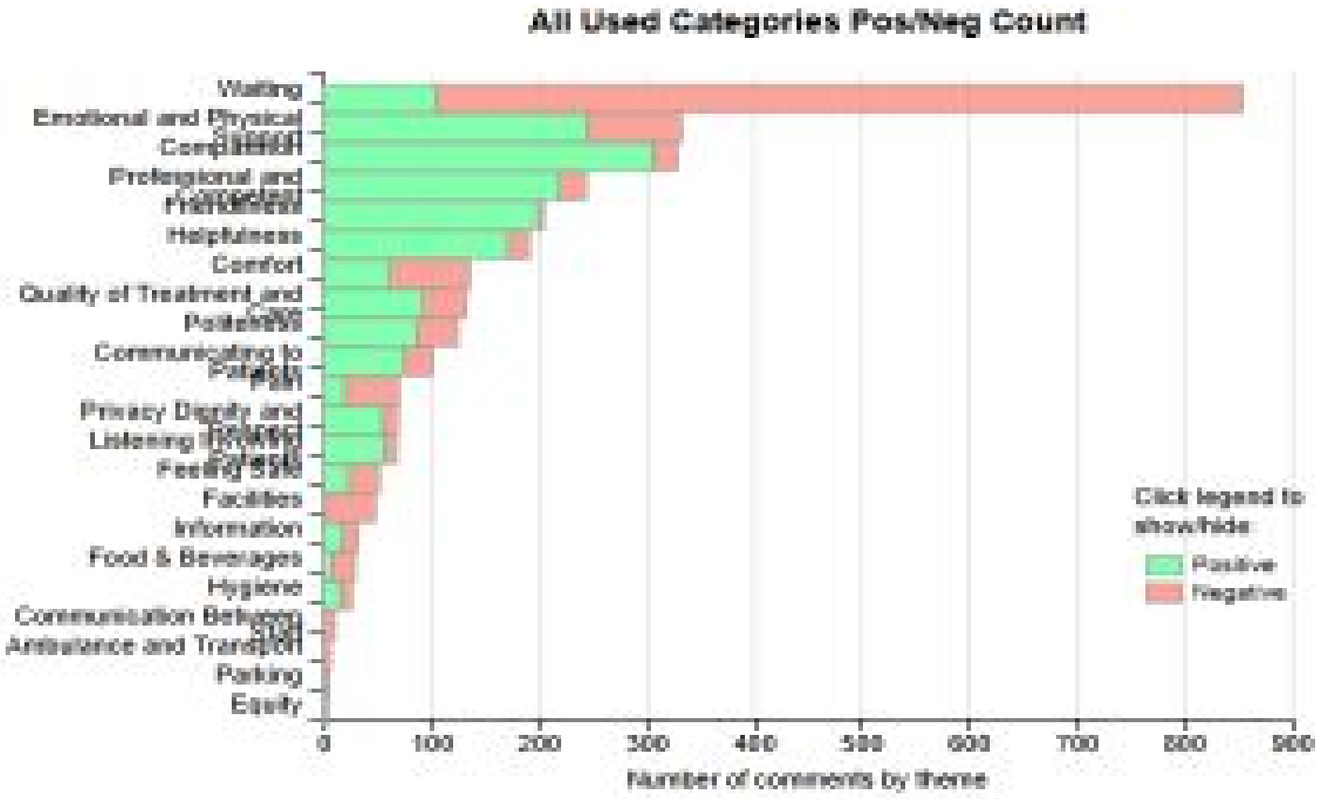
CIVICA Patient Experience Feedback



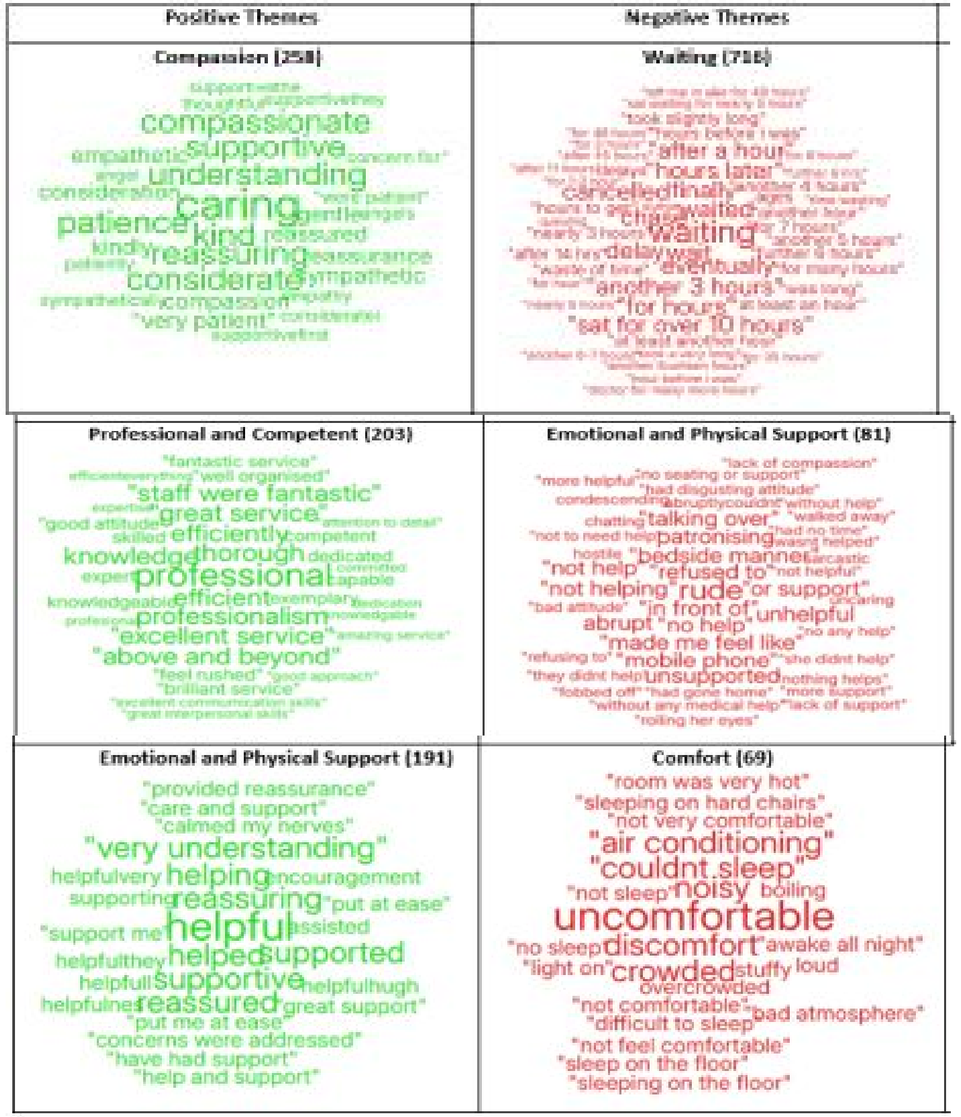
Definition	Analysis	Implications
All data displayed has been extracted from CIVICA and is correct at the point of extraction. Surveys that were already sent (paper and text message) may be completed later giving the impression of data changing.	Patient feedback received through the CIVICA platform continues to provide valuable insight into the experiences of patients, families and carers across the Health Board. As of June 2026, CIVICA was live in 636 service areas, with approximately 61% of those areas having received patient feedback. Overall satisfaction scores remain positive; however, June 2026 recorded the lowest overall satisfaction score since May 2025 at 85%. Analysis also highlights variation in response rates and engagement between services, with some areas demonstrating strong use of patient feedback whilst others have limited participation. Opportunities remain to improve demographic data completeness, engagement with under-represented groups and the consistent capture and reporting of learning arising from patient feedback.	Work continues to expand and strengthen the use of CIVICA across the Health Board, supporting a more consistent approach to capturing and responding to patient experience. During Quarter 1, rollout was extended across inpatient wards and most outpatient services, with 20 surveys available, including 11 national All Wales surveys. Accessibility improvements are being progressed through the introduction of additional languages, British Sign Language (BSL) and Easy Read formats. Regular sharing of intelligence with the Welsh Language Unit and Equality, Diversity and Inclusion teams is supporting improved understanding of the experiences of different patient groups. Training and support also continue, with over 650 staff trained in the use of CIVICA since implementation, alongside ongoing work to strengthen feedback collection, thematic reporting and organisational learning through the "You Said, We Did" approach.

CIVICA Patient Experience Feedback

Themes and emotion analysis of comments

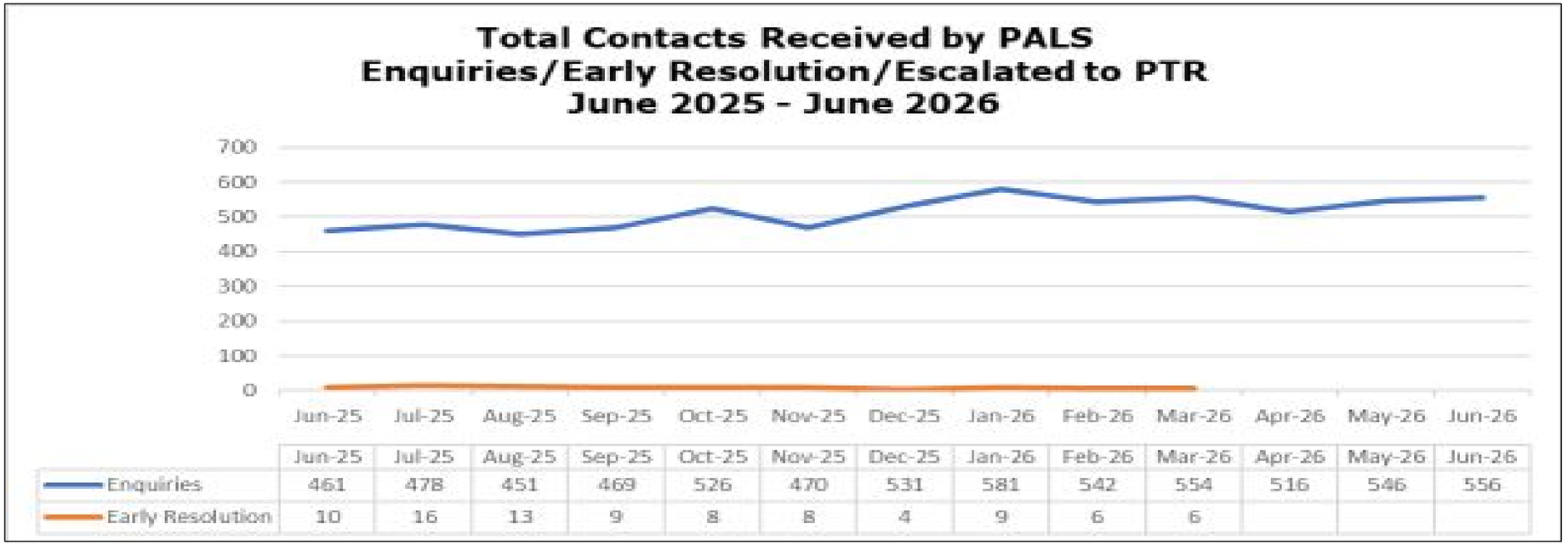


Top 3 Positive and Negative Themes June 2025/26



Patient Advice & Liaison Service (PALS)

Pillar 1 Patient and staff feedback, concerns, complaints and compliments- Patient Advice & Liaison Service (PALS) (June 25-June 26



	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Enquiries	461	478	451	469	526	470	531	581	542	554	516	546	556
Early Resolution	10	16	13	9	8	8	4	9	6	6			

Themes	Count
Communication Issues (including Language)	3139
Access (to Services)	1408
Appointments	570
Patient Care	476
Clinical Assessment / Treatment	262
Discharge issue	149
Complaints handling	88
Record Keeping	83
Post death issues	81
Test and Investigation Result	61

Definition

This data is obtained from the Once 4 Wales RL Datix system, which is populated by the Health Board's Patient Experience Team.

The table (right) shows the enquiry themes from June 2025 to June 2025.

The data is live and is an ever-evolving picture the information stated is accurate at the point of extraction.

Analysis

PALS experienced sustained demand throughout Quarter 1, with enquiries increasing from 516 in April to 556 in June 2026. Communication issues remained the predominant reason for contact, alongside access to services, appointments and patient care concerns. Activity continued to be concentrated within Urgent Care, Medicine and Surgery, with inpatient services generating the majority of contacts.
Analysis continues to demonstrate that improvements in communication, appointment management and access to services would reduce avoidable demand on PALS and improve patient experience. During the quarter, PALS embedded the Listening to People (LtP) approach, enabling ongoing pastoral support to be recorded within a single Datix record, while strengthening thematic reporting and organisational insight into emerging patient experience issues.

Implications

Despite increasing demand, PALS continued to provide effective advocacy, reassurance and early intervention for patients and families, helping to resolve concerns before escalation. Enhanced reporting has improved understanding of demand hotspots and recurring themes, while patient feedback and case studies highlight the positive impact of proactive support, communication and liaison with clinical teams.

Patient Advice & Liaison Service (PALS)

Case Studies

Case Study 1:

Following discharge from hospital, a patient did not receive prescribed medication due to an error. Concerned that a missed dose could affect recovery, the patient's husband contacted PALS for support.

A Patient Support Officer provided reassurance and emotional support while gathering information. At the same time, a PALS Officer liaised with the ward and was advised that the medication had been sent by taxi. When the medication failed to arrive several hours later, PALS coordinated with the hospital switchboard to trace the delivery and establish its location.

The medication was successfully located and delivered to the patient's home. PALS also escalated the matter to the senior nursing team, who contacted the family to apologise for the error and the distress caused.

A follow-up call confirmed that the medication had been received and that the patient's husband was extremely appreciative of the support provided during a highly stressful situation, commenting on the quality of the service received.

This case demonstrates the value of PALS in providing timely intervention, coordination and reassurance, helping to resolve a potentially high-risk situation, reduce distress for the family and support continuity of care following discharge.

Case Study 2:

A young patient with multiple complex medical conditions was admitted to hospital and required care from several specialist teams. The patient's partner contacted PALS feeling overwhelmed and unsure how to access information and support during an extremely challenging period.

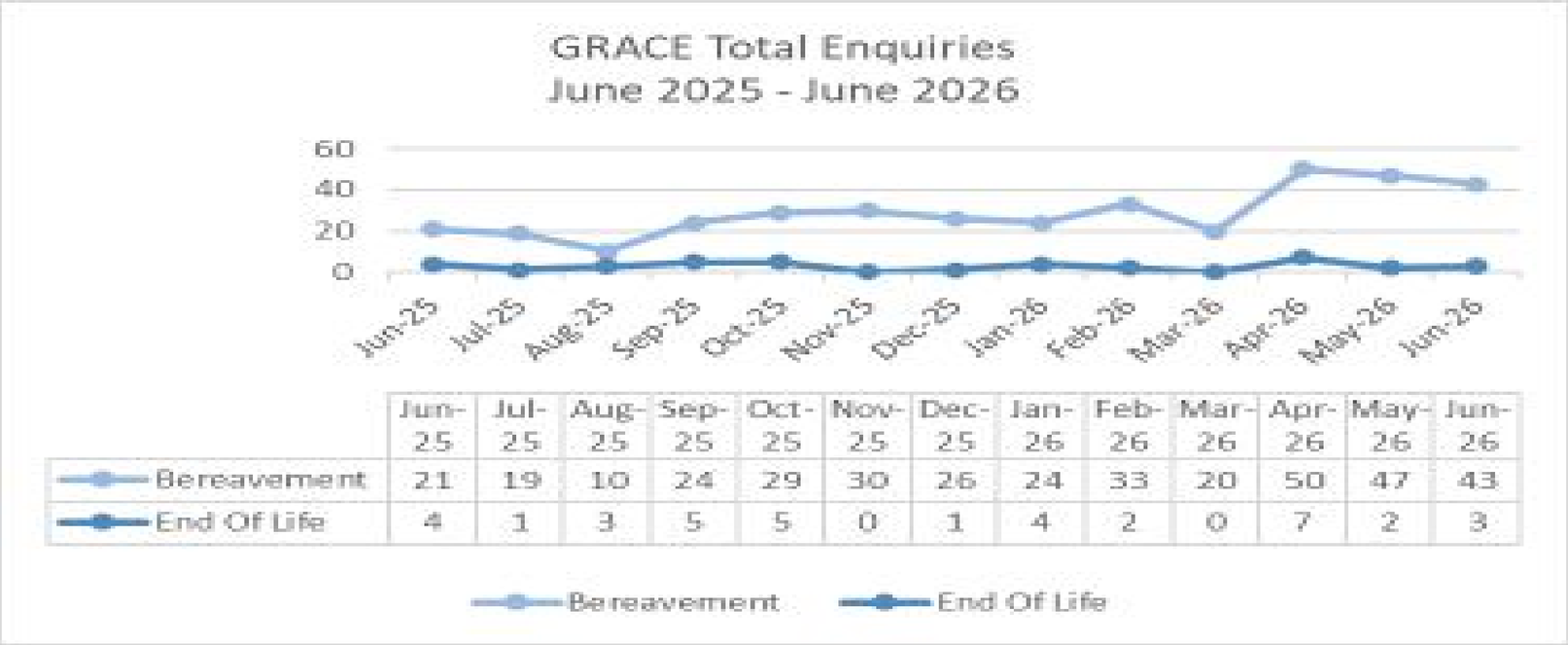
PALS initially became involved to address concerns relating to communication and the patient's care. The PALS Officer worked closely with ward staff, senior clinicians and external Health Boards to support discussions around treatment options, including consideration of a liver transplant assessment. Throughout the admission, PALS acted as a consistent point of contact, ensuring questions were answered, concerns were escalated appropriately and communication between services remained coordinated.

As the patient's condition deteriorated and treatment options became increasingly limited, PALS continued to provide regular contact, practical support and emotional reassurance to both the patient and their partner. Through ongoing engagement, a trusting relationship developed, helping them navigate a complex and emotionally demanding healthcare journey.

Sadly, the patient passed away later that month.

This case demonstrates the value of sustained PALS involvement in complex situations. Through advocacy, communication, coordination and compassionate support, PALS provided continuity and reassurance for both the patient and their partner during a particularly difficult period, helping to improve their overall experience of care.

Patient Advice & Liaison Service (PALS)
GRACE End of Life and Bereavement



	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Bereavement	21	19	10	24	29	30	26	24	33	20	50	47	43
End Of Life	4	1	3	5	5	0	1	4	2	0	7	2	3

Definition	Analysis	Implications
This graph presents the total number of enquiries received by the GRACE End of Life and Bereavement Service between June 2025 and June 2026. A total of 414 enquiries were received during the reporting period. Monthly enquiry volumes ranged from 15 enquiries in August 2025 to 52 enquiries in April 2026, illustrating fluctuations in demand for the service across the year.	The data demonstrates a generally stable level of enquiries between June 2025 and March 2026, with monthly totals averaging around 25–35 enquiries. The lowest level of activity was recorded in August 2025 (15 enquiries), which may reflect seasonal factors such as summer holidays or reduced service activity. Following this, enquiry numbers increased and remained relatively consistent throughout the autumn and winter months. A notable rise in demand occurred from April 2026 onwards, with enquiries increasing sharply to 52 in April, before remaining high in May (49) and June (47). These three months accounted for approximately 36% of all enquiries received during the year, indicating a significant increase in service utilisation towards the end of the reporting period.	The sustained increase in enquiries during the final quarter of the reporting period suggests growing awareness of, and demand for, the GRACE service. This may reflect enhanced visibility of the service, increased referrals, or a greater need for end-of-life and bereavement support within the population. Continued monitoring of enquiry trends is recommended to determine whether the rise represents a temporary increase or an emerging long-term pattern. If higher enquiry volumes persist, consideration may need to be given to workforce capacity, resource allocation, and service development to ensure timely and effective support for individuals and families accessing GRACE services.

Case Study 1:

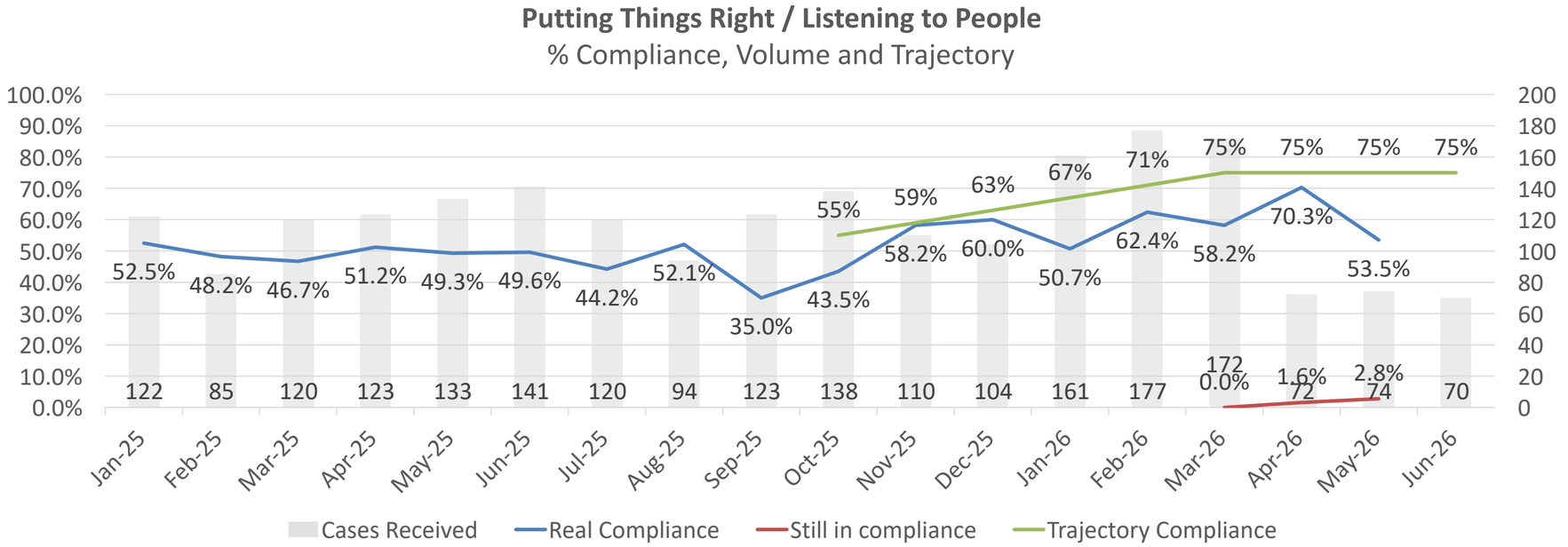
The GRACE team were contacted by a lady who was struggling to come to terms with the sudden death of her younger brother. She explained that her feelings of grief were being intensified by concerns about her own declining health and that she felt unsupported by the services involved in her care.

The lady also described feeling isolated, as she found it difficult to speak openly with family and friends about her brother's death due to the nature of his passing. As a result, she felt she had very limited opportunities to express her thoughts and emotions.

With the lady's consent, a member of the GRACE team contacted the Patient Advice and Liaison Service (PALS) on her behalf to explore whether they could assist in arranging an appointment to address her concerns.

Within a few days, PALS had successfully arranged an appointment for the lady. Having this support in place helped to alleviate some of her anxiety and enabled her to focus more on processing her grief. The GRACE team continue to provide ongoing support through regular telephone calls, giving the lady a safe space to talk openly about her feelings and supporting her as she navigates her grief journey.

Putting Things Right / Listening to People
Compliance with 30-day Target



Please note:
From 1 April 2026, the move from Putting Things Right to Listening to People regulations means formal complaints may follow a 30, 60, 90, 120-day or 6-month process.

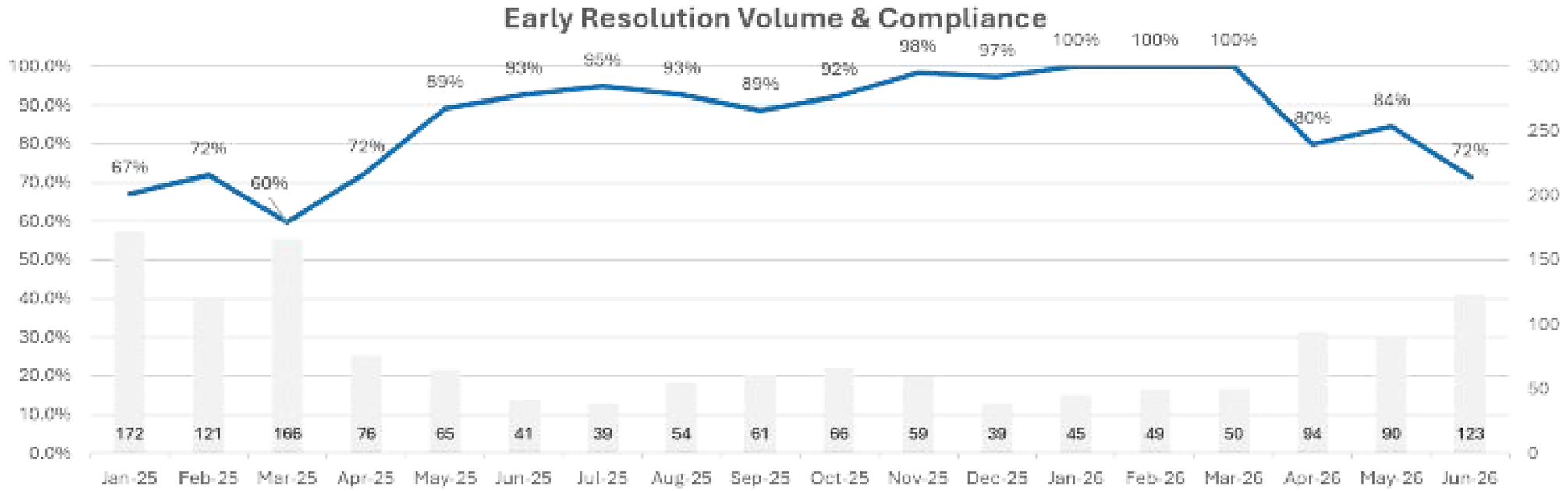
Compliance will therefore show both: the percentage of cases completed and closed within target, and the percentage of open cases still within target.
The narrative will show how many cases entered each process.

Data reporting has been adjusted to better align with the Beacon Dashboard and improve consistency. This may cause small differences from previous reports, as withdrawn cases are now included in the calculations differently.

Definition	Analysis	Implications
The above represents the Health Board's rolling position for compliance with the WG target of responding to concerns managed under Putting Things Right (PTR) / Listening to People (formal). The data is live and is an ever-evolving picture the information stated is accurate as of 12 September 2026.	Since the change in regulations from Putting Things Right to Listening to People in April 2026, the improving compliance trend continued, reaching 70.3% for cases received in April, close to the 75% trajectory and Welsh Government target. May saw a reduction to 53.5% with a further 2.8% of cases still open. The June position remains provisional due to the various investigation timescales now available.	Formal complaint volumes have declined since the inception of Listening to People regulations in April 2026, this reflects a revised regulatory approach to the management of concerns, with the focus on listening, resolving informally where appropriate and putting complainants back at the centre of complaints processes. The Health Board have continued their focus on reducing overdue formal concerns which has seen a reduction from 258 to 133 during Q1. The aim is to eliminate all concerns overdue by more than 3 months.

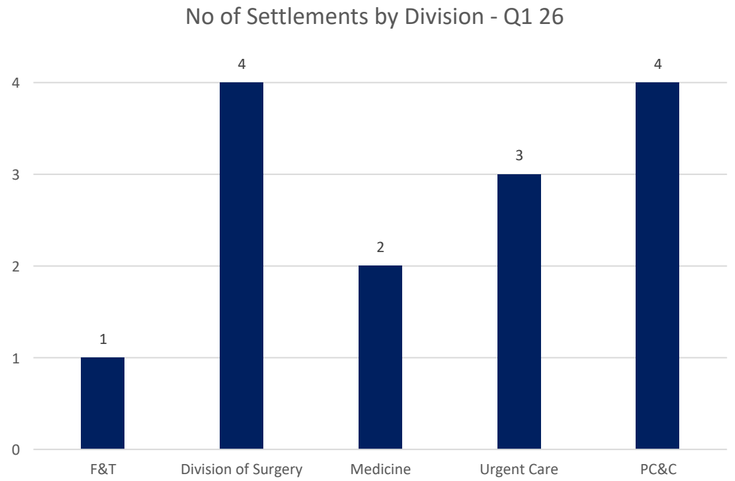
Early Resolution

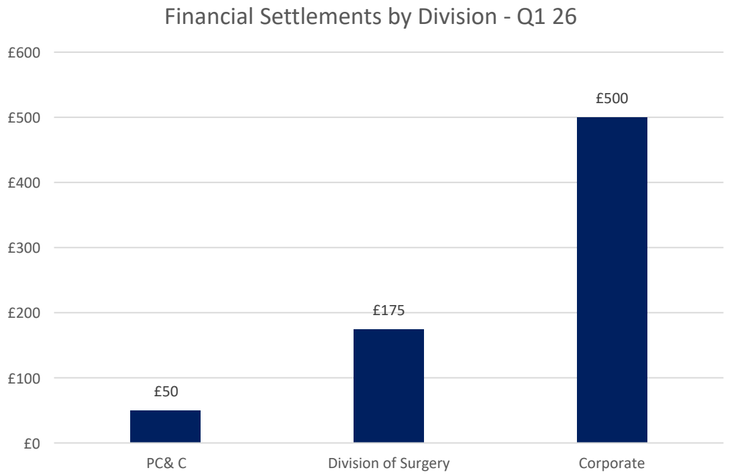
Compliance with 2-day Target

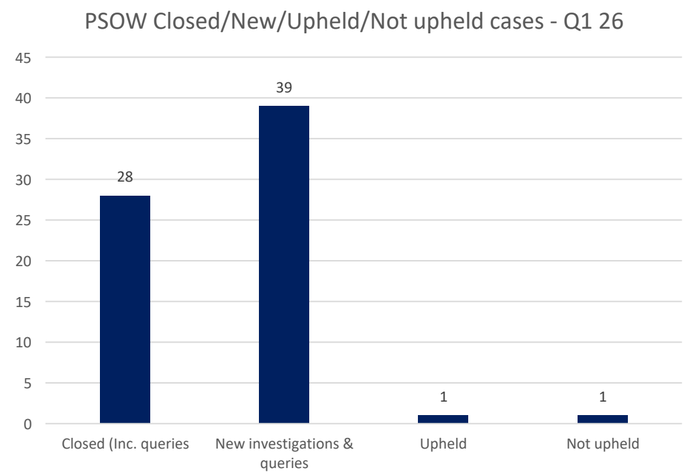


Definition	Analysis	Implications
Information displayed was correct as of 12 September 2026 and extracted from RL Datix.	The graph above shows a notable switch to managing cases under Early Resolution where it is appropriate. The Ministerial target for managing cases through Early Resolution is to reach 40% by the end of Q4 2026/27, so far, the Health Board is achieved in excess of 75%. Whilst the percentage compliance saw a drop to 72% in June 2026 in the context of increasing early resolution cases and the complexity of cases being managed through this process, providing timely resolution to our complainants.	A review of LtP regulations impact on the Health will allow the service to evaluate the effectiveness of triaging concerns, examine if concerns are being placed in the appropriate processes and utilise complainant feedback to ensure their voice is heard.

Putting Things Right
Ombudsman (PSOW)







Learning and Completed Recommendations

Key Learning Points:

During Q1, one PSOW investigation was upheld relating to the failure to make appropriate reasonable adjustments during an ADHD assessment process and subsequent complaint review. The Ombudsman found that reasonable adjustments were not adequately considered when assessing the individual's needs and when responding to a request for a second opinion. Additional PSOW activity highlighted recurring themes associated with complaint handling, including delays in responses, poor communication, lack of updates, insufficient explanations for delays and responses not fully addressing the concerns raised.

Recommendations:

a) Issue a formal apology to the complainant.
b) b) Offer a further assessment with all appropriate reasonable adjustments in place.
c) c) Ensure Mental Health teams undertake training and familiarisation with guidance relating to reasonable adjustments.
d) d) Ensure Complaint Handling teams receive further training and review their handling of the complaint.
e)) Continue organisational learning regarding communication, complaint handling and response quality.

Completed & Ongoing Actions:

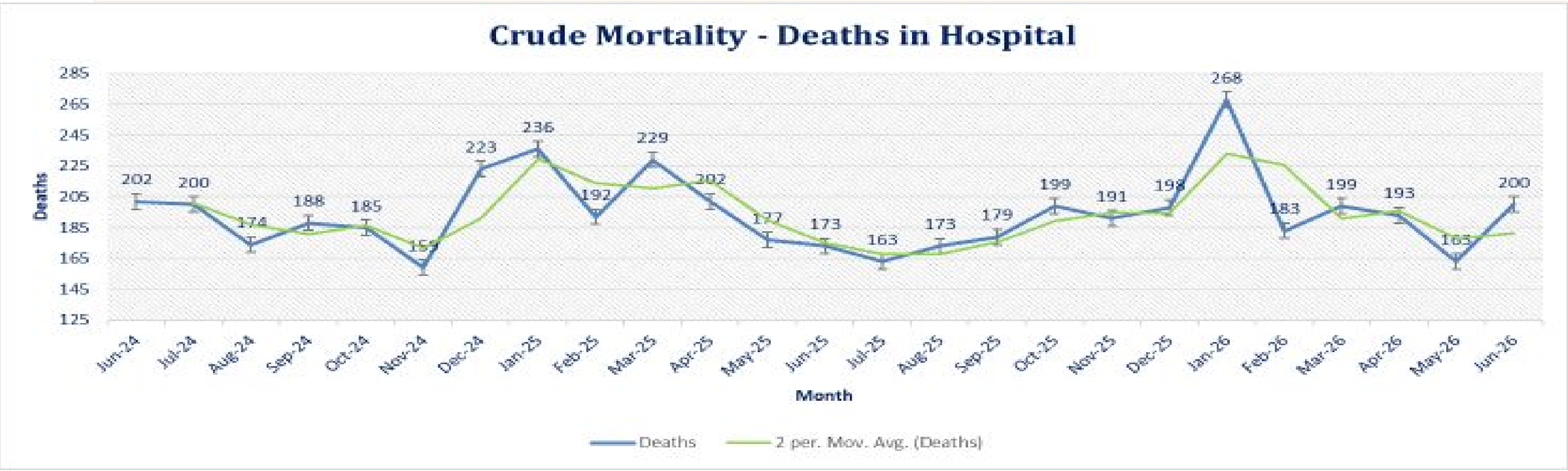
An apology has been drafted and progressed through Divisional review.
The complaints team has already received bespoke Equality, Diversity and Inclusion training, with further training being arranged within Mental Health services.
PSOW monitoring arrangements continue to be strengthened through senior QPS oversight and enhanced Datix reporting dashboards.
Further work will continue in Q2 to improve complaint handling, timeliness of responses, communication with complainants and compliance monitoring

PILLAR 2

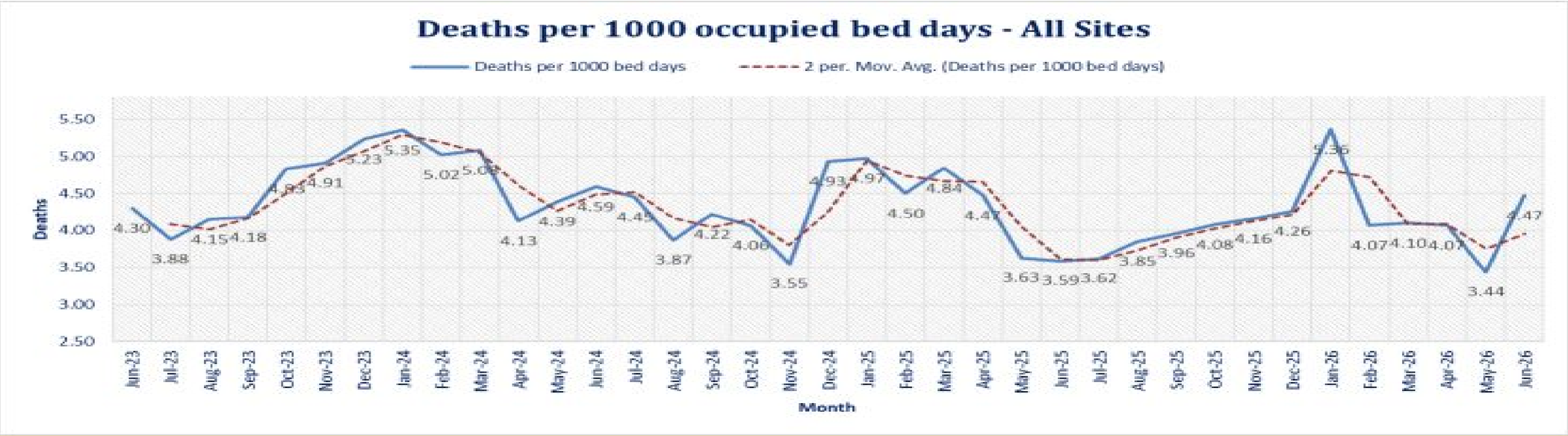
Patient Safety including Incident Reporting

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

Crude Mortality in Hospital

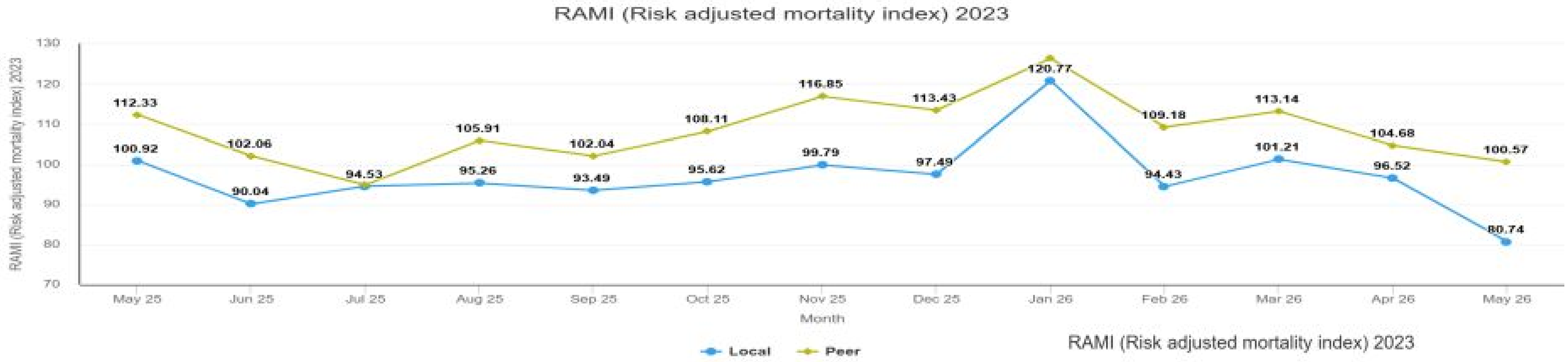


Crude mortality measures the number of deaths in a population over a specific period. It helps understand overall death rates in a community, region, or country by comparing current deaths to the average over the previous two years, identifying trends above or below this average. The data includes all-cause mortality as seen in Aneurin Bevan University Health Board.



The graph shows the actual number of deaths recorded within the Health Board in a hospital environment. In 2026 there have been fewer deaths recorded than previous years. The graph also shows the seasonal variation in the number of deaths, most notably consistent yearly spikes year on year in December and January.

Risk Adjusted Mortality Index (RAMI)

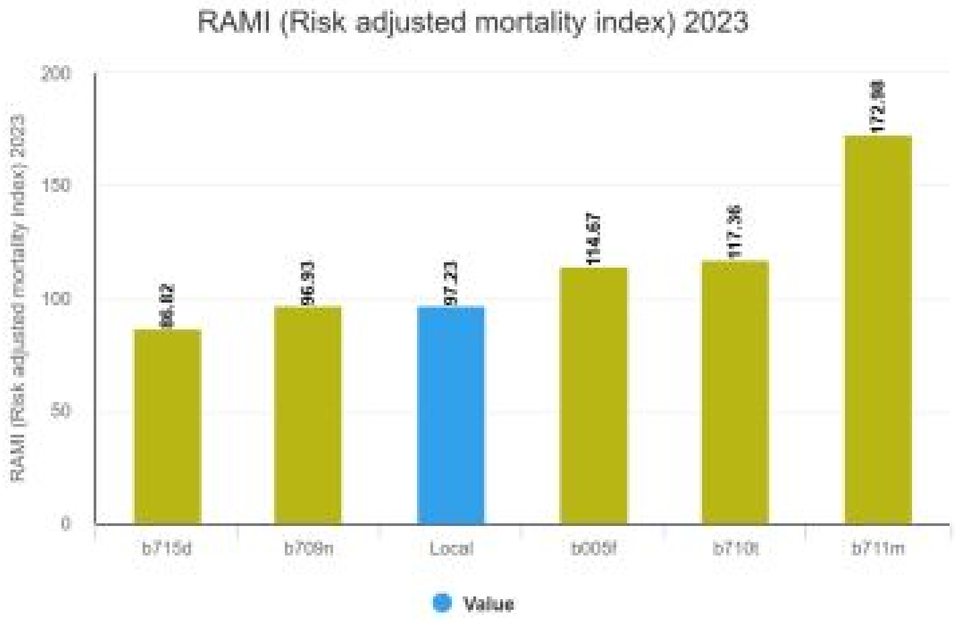


The Health Board's RAMI for Q1 stands at 88.61 (April and May data). This is lower than the FY 25/26 RAMI of 99.97. Seasonal variation is a recognised feature of RAMI, with January typically showing a higher score. Historical trends show that Q4 RAMI often reduces and stabilises as it moves into Q1 of the next FY – as shown on the above chart.

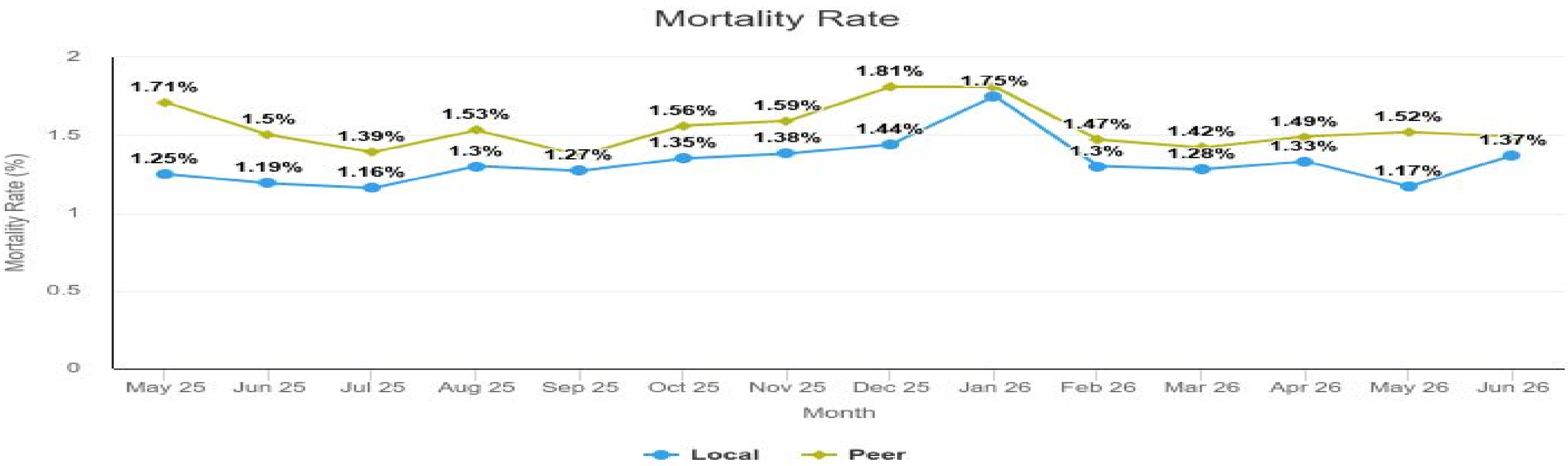
RAMI adjusts for individual patient risk factors and co-morbidities, enabling meaningful comparisons between organisations. Overall, the Health Board, has demonstrated consistent year-on-year improvement in RAMI since 2023, and is below the All-Wales peer group, indicating improved mortality outcomes over time.

The reliability of RAMI is highly dependent on the completeness and accuracy of clinical coding, alongside prompt updates to external systems used by the Health Board. There is a standard 6–8-week delay in clinical coding to support completeness and accuracy, which should be considered when interpreting early quarterly data.

For April and May 2026, ABUHB ranked 3rd among the six members of the All-Wales peer group.

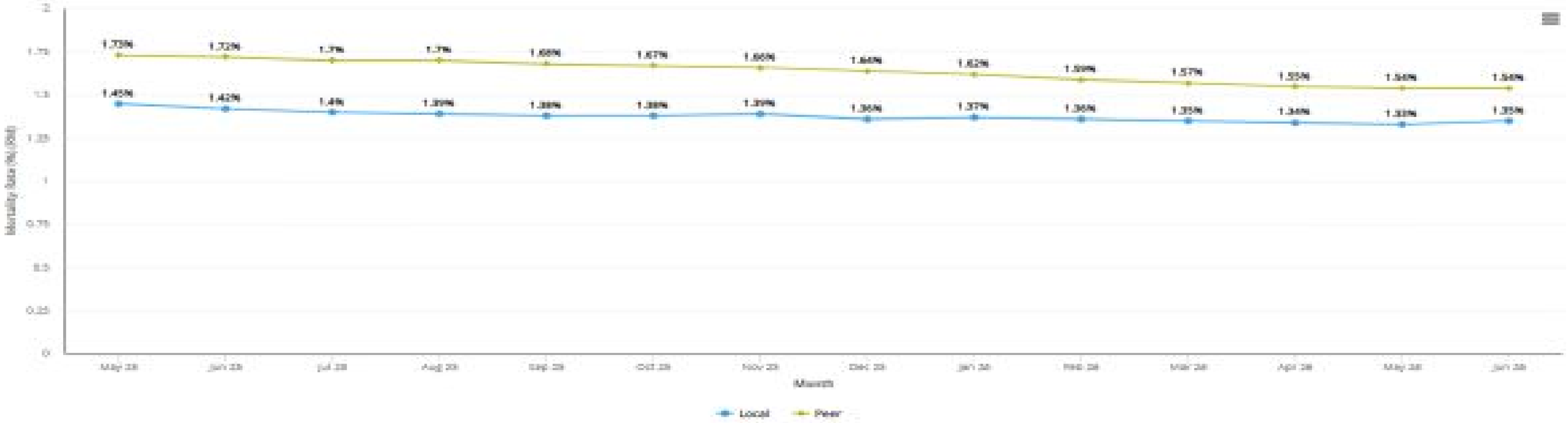


Mortality Rate



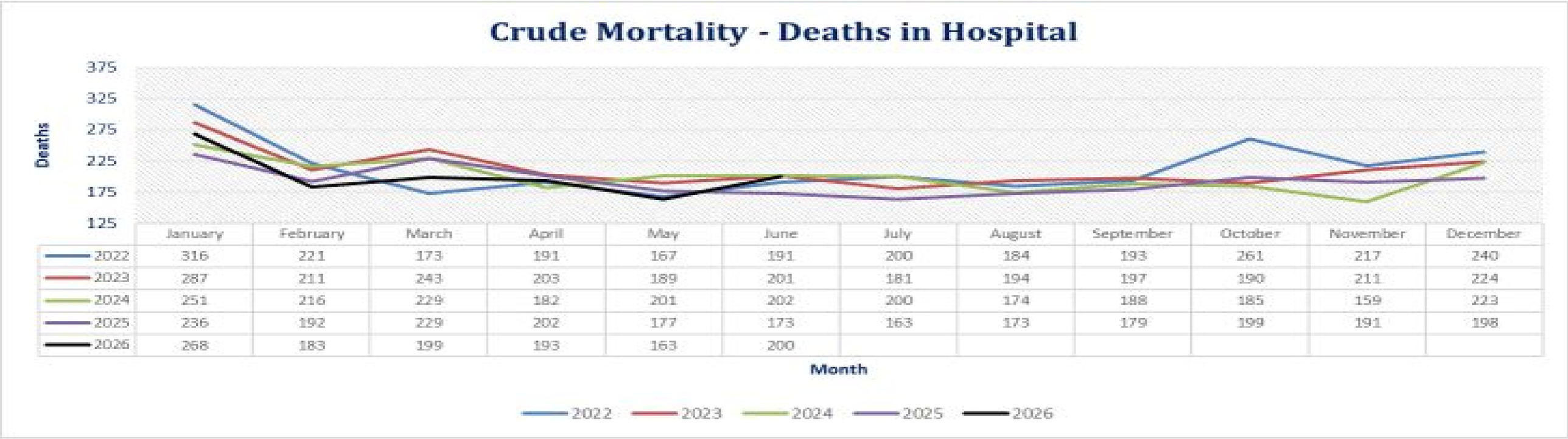
Definition	Analysis	Implications
The above graphs show the % of Hospital spells which end with the discharge method of death. At present latest data (June 2026) 1.37% of ABUHB Hospital spells end with the discharge method of death.	Mortality Rates have remained consistent and have been 1.4% or lower for 11/12 months of the last year and has remained on trend with the Peer Group while achieving a lower mortality rate as a Health Board.	In 2014 Professor Palmer published an independent review of the use of RAMI and the extent to which it provides valid data and recommended a blended approach that considers many sources of information, in addition to RAMI, including that from mortality reviews, national bench-marking and national audit. Addition of the Health Board's learning from death report advocates several approaches to understand performance, this ensures assurance and quality improvement around death, not sole reliance on aggregated retrospective data (e.g. RAMI). This is seen in the additional mortality indicators for reporting.

Rolling Mortality Rate



Definition	Analysis	Implications
The above graphs show the % of Hospital spells which end with the discharge method of death on a rolling monthly basis. At present ABUHB has a rolling Mortality rate of 1.35% for the period within the chart.	Mortality Rates has been on a downward trajectory for the previous few years although has recently been effected by a spike in Mortality during January 2026 which had a mortality rate of 1.75%.	In 2014 Professor Palmer published an independent review of the use of RAMI and the extent to which it provides valid data and recommended a blended approach that considers many sources of information, in addition to RAMI, including that from mortality reviews, national bench-marking and national audit. Addition of the Health Board's learning from death report advocates several approaches to understand performance, this ensures assurance and quality improvement around death, not sole reliance on aggregated retrospective data (e.g. RAMI). This is seen in the additional mortality indicators for reporting.

Deaths in Hospital



	January	February	March	April	May	June	July	August	September	October	November	December
2022	316	221	173	191	167	191	200	184	193	261	217	240
2023	287	211	243	203	189	201	181	194	197	190	211	224
2024	251	216	229	182	201	202	200	174	188	185	159	223
2025	236	192	229	202	177	173	163	173	179	199	191	198
2026	268	183	199	193	163	200						

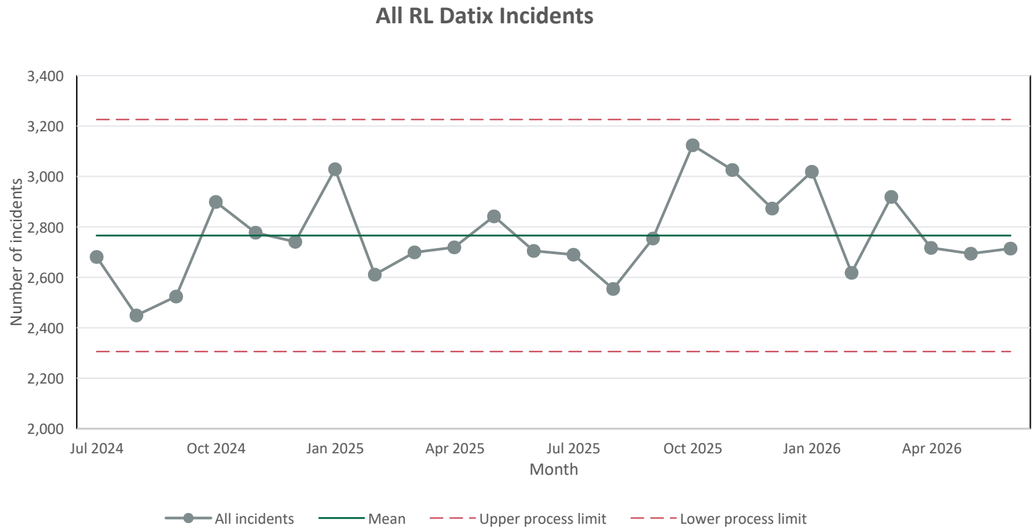
Definition	Analysis	Implications
The chart shows the monthly number of hospital deaths from January 2022 to June 2026. Data from each year are overlaid to enable comparison across years, highlighting year-on-year trends and seasonal variation.	A clear and consistent seasonal pattern is evident across all years, with mortality peaking in winter—particularly in January—and declining through late winter and early spring. The highest peaks occur in January 2022 and January 2023. In contrast, 2024 and 2025 show lower winter peaks and reduced month-to-month variation, indicating moderation of the traditional winter surge. Following the winter peak, deaths fall through February and March and stabilise at lower levels across spring and summer, with the lowest figures typically seen between May and July, most notably in 2025. With the exception of January 2026 less deaths have been recorded within Hospital than previous year.	Compared across years, 2022 and 2023 show higher overall mortality, particularly during winter, reflecting increased system pressure and seasonal demand. In contrast, 2024 and 2025 demonstrate sustained improvement, with lower winter peaks and greater stability throughout the year. The early 2026 position is encouraging, with winter mortality remaining below earlier high-pressure years, although continued monitoring is required given the partial year. Overall, the data confirms a consistent winter effect alongside improving outcomes over time. Reduced winter severity and variability are consistent with strengthened system resilience and ongoing quality and safety work, including deteriorating patient pathways, sepsis improvement, and end-of-life care. Future assurance should continue to focus on winter preparedness, early intervention, and sustaining recent gains.

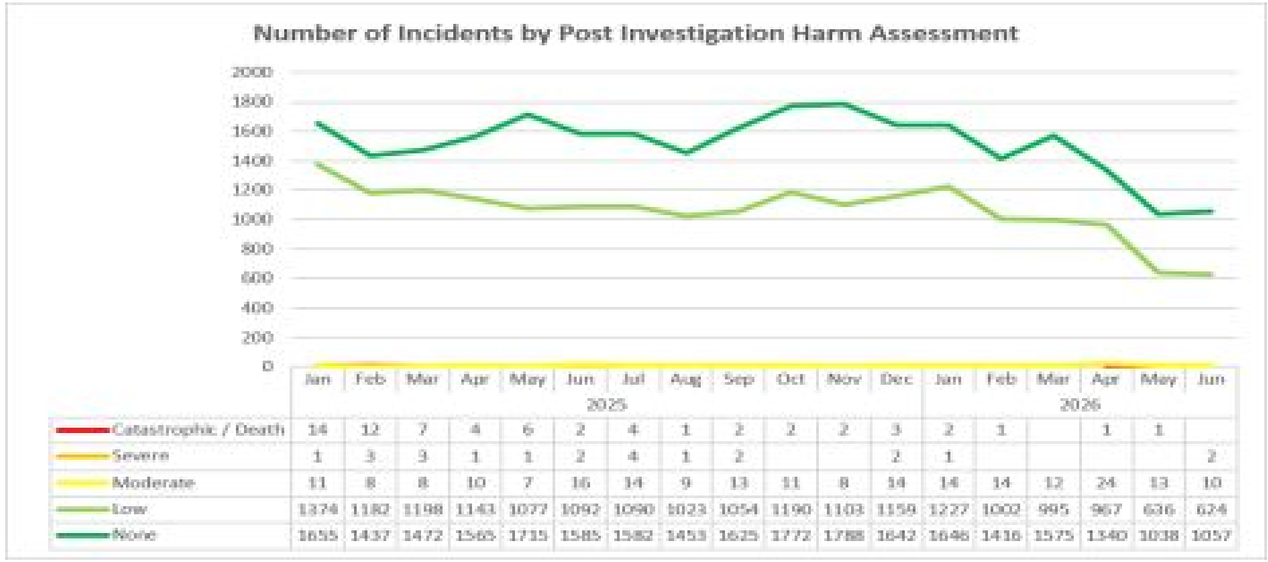
Mortality Actions

Issue	Cause	Learning and Improvement	Who	When
Understanding mortality data and how we implement learning from mortality	There is a need to understand what is reported to PQSOC and to Board for mortality. NHS England produce a Learning from Death framework which enables a standardised mortality report.	The Health Board has presented several Learning from Death reports at PQSOC. This work included the development of a strengthened Learning from Deaths Framework triangulated with insights from the Medical Examiner Service and the Mortality Review Screening Panel. A comprehensive review of our end-to-end mortality process is also underway to ensure robust learning and improves oversight.	Medical Director's QPS team	6 monthly reporting – Next due Oct 2026
Reliability of mortality data	Consistency of mortality reporting and data.	A Mortality Framework has been developed to support consistent reporting of mortality indicators. The framework sets out a tiered approach: Tier 1 – Health Board level, Tier 2 – Divisional level and Tier 3 Directorate level. The QOF currently reports RAMI and crude mortality, aligned to this structure.	QPS Team and Information Manager	Complete
Clinical coding	The national target for clinical code is 95% coding completion one month post episode discharge.	Working with coding team to improve coding rate and depth and understand the variation in RAMI compared to the consistent and flat mortality rate over time.	QPS Team, DDaT team	Ongoing
Future reporting	Align reporting to 2026/27 to the NHS Ministerial Priorities	Work is underway to review reporting of mortality data to look at how ministerial priorities are reported. A deep has been undertaken to review the cases and assist with learning.	QPS Team, DDaT team	Dec 2026
Mortality Data and Clinical Outcomes	Develop a governance process around mortality outliers	QPS Team and Information Manager currently drafting a Standard Operating Procedure for Mortality Outliers and investigation.	Information Manager, DDT and QPS Team	Complete
	Develop process for when to undertake a review of case notes	Develop a deep dive SOP to allow scrutiny of notes for review. This will help to interrogate the notes assessing for accuracy of coding and clinicians' input for learning from deaths.		Complete
	Mortality indicators not available to all	Review with Directorates mortality indicators within CHKS.		Dec 2026

Datix Incidents

Pillar 2 – Patient Safety Including Incident Reporting – RL Datix Incidents Overview

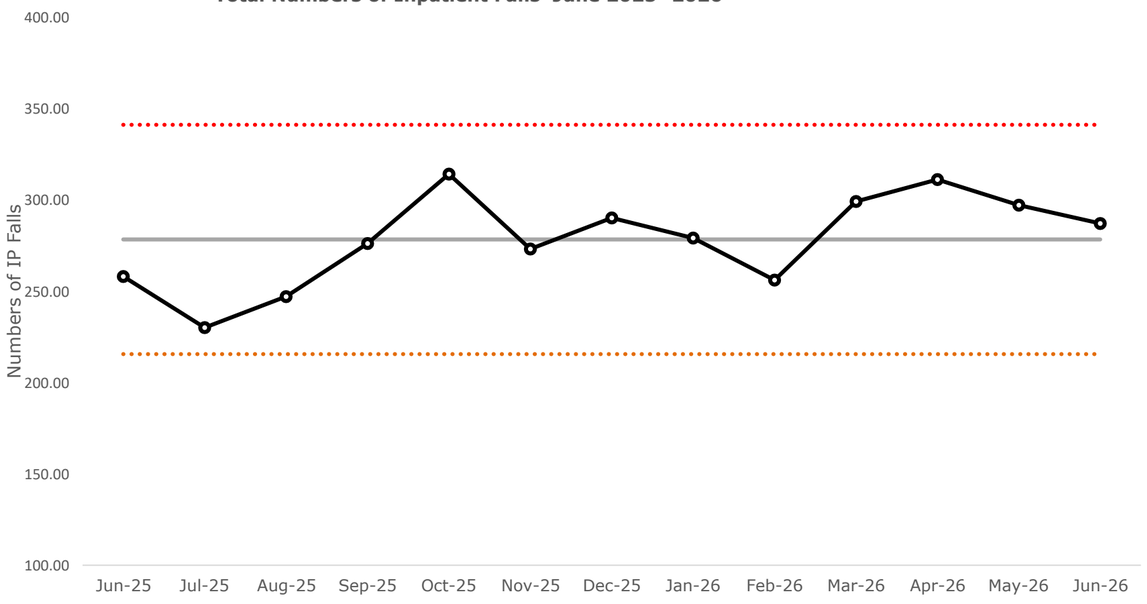


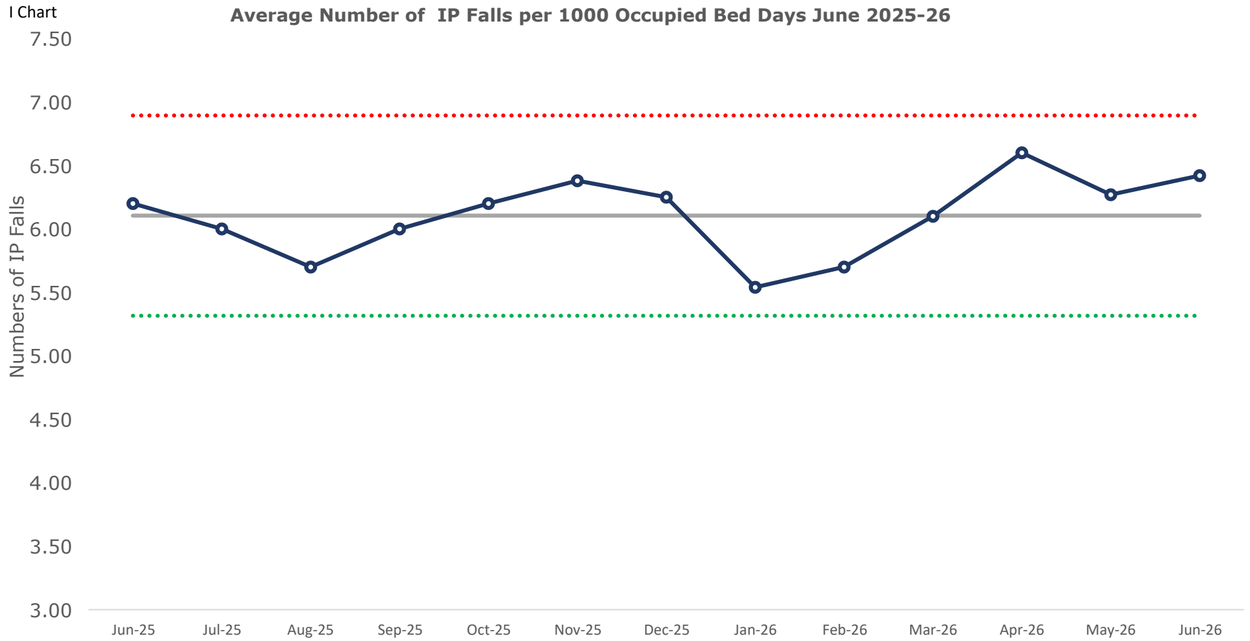


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	2025												2026					
Catastrophic / Death	14	12	7	4	6	2	4	1	2	2	2	3	2	1		1	1	
Severe	1	3	3	1	1	2	4	1	2			2	1					2
Moderate	11	8	8	10	7	16	14	9	13	11	8	14	14	14	12	24	13	10
Low	1374	1182	1198	1143	1077	1092	1090	1023	1054	1190	1103	1159	1227	1002	995	967	636	624
None	1655	1437	1472	1565	1715	1585	1582	1453	1625	1772	1788	1642	1646	1416	1575	1340	1038	1057

Incident Volume and Harm:
8,226 incidents were reported during April to June 2026 compared with 8,556 incidents during January to March 2026, representing a reduction of 330 incidents (3.9%). The incident profile remained broadly unchanged across both quarters, with Pressure Damage, Moisture Damage incidents continuing to account for the largest proportion of reports, followed by Behaviour (including violence and aggression) and Accident, Injury incidents. Medication, IV Fluids incidents and Assessment, Investigation, Diagnosis incidents also remained among the most commonly reported categories, indicating a consistent pattern of reporting across the organisation.
Post-investigation harm assessments continued to indicate that the majority of incidents resulted in no or low harm. During April to June 2026, 2,227 incidents were assessed as low harm, 47 as moderate harm, two as severe harm and two as catastrophic/death, compared with 3,224 low harm, 40 moderate harm, one severe harm and three catastrophic/death incidents during January to March 2026. The number of incidents remaining open beyond 30 working days continues to be an area of targeted improvement to ensure learning for incidents can be rapidly embedded within services.
Learning & Improvement –
Learning and improvement activity focused on translating incident themes into practical action, particularly in relation to medication safety, documentation quality, communication accessibility, incident investigation timeliness and implementation of the Call for Concern model. Positive feedback from Welsh Government recognised the Health Board's high standard of National Reportable Incident submissions and performance against reporting timescales. QMG additionally received assurance that divisions were strengthening local quality and patient safety processes, improving incident closure trajectories and embedding more structured approaches to learning, escalation and quality improvement.

Inpatients Falls

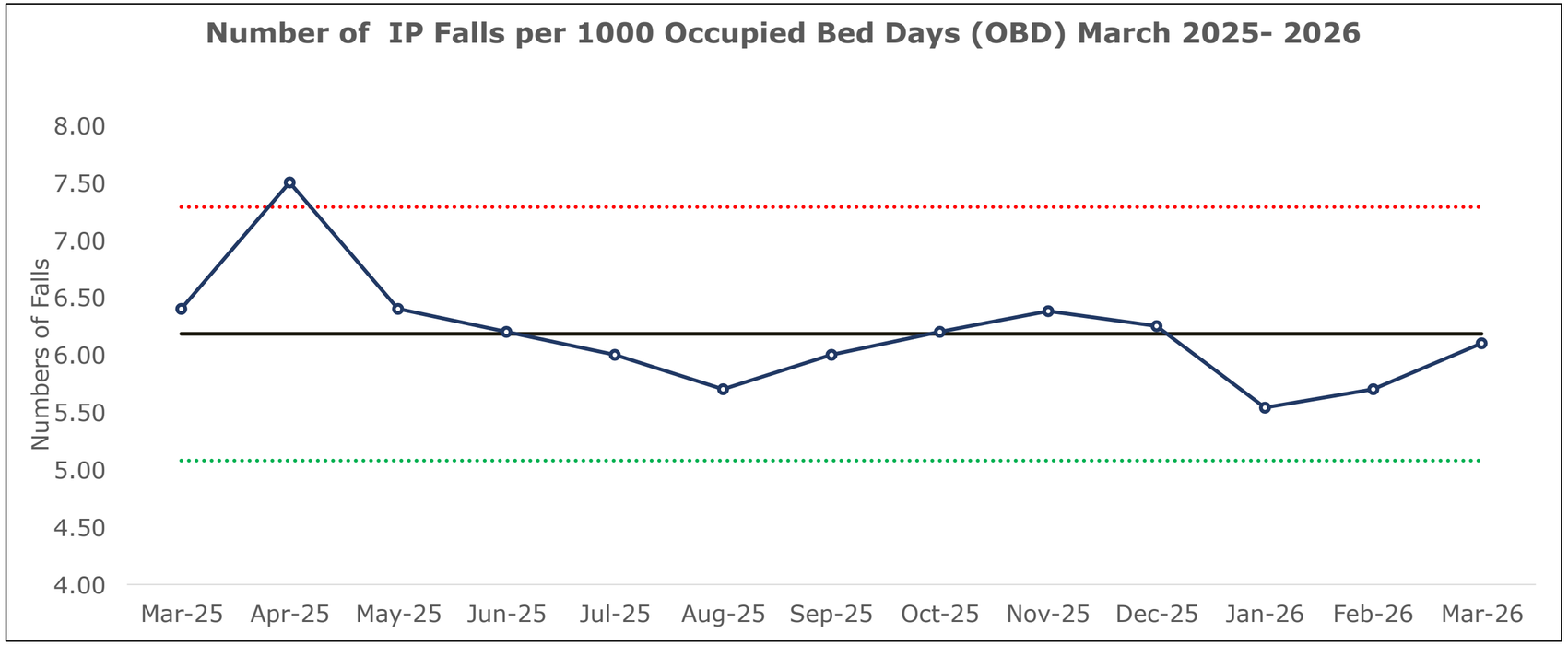




During Q1 2026/27, reported inpatient falls across ABUHB normal month-to-month variation within a stable system, with no statistical evidence of a significant change in performance, with no significant special cause variation identified. April represented the highest point of the quarter, with falls increasing to 311, before reducing to 297 in May and 287 in June. Falls per 1,000 occupied bed days also fluctuated, increasing to 6.60 in April, reducing to 6.27 in May and rising marginally to 6.42 in June, with May and June remaining below the national average of 6.6. The overall position is therefore one of stable but variable performance, with early evidence of an in-quarter reduction in reported falls following the April peak, but not yet a statistically significant improvement trajectory. Harm data should be interpreted with caution, as a proportion of May and June incidents were still awaiting confirmed manager-attributed harm grading at the time of reporting.

Actions during the quarter have focused on strengthening oversight, learning and prevention. Falls data continues to be monitored through RLDatix and Qlik, with ward-level extracts supporting weekly review and monthly Quality Outcomes Framework reporting. Falls resulting in fracture or falls-related head injury are escalated through the weekly Executive huddle and reviewed through the Falls Strategic Oversight Panel, using concise review methodology to identify themes, trends, learning and any associated Duty of Candour or RIDDOR considerations. Wider improvement work is being progressed through the Falls and Bone Health Strategic Group, including Fracture Liaison Services, implementation of the National Community-Based Falls Response Framework for Wales, consideration of the WAST Falls Desk, and the Medicine Division Falls Champions initiative. Current learning highlights the need to maintain ward-level visibility, strengthen thematic review, improve consistency of data quality and address fragmented digital systems, while continuing to translate review findings into practical learning and sustained improvement

Inpatients Falls

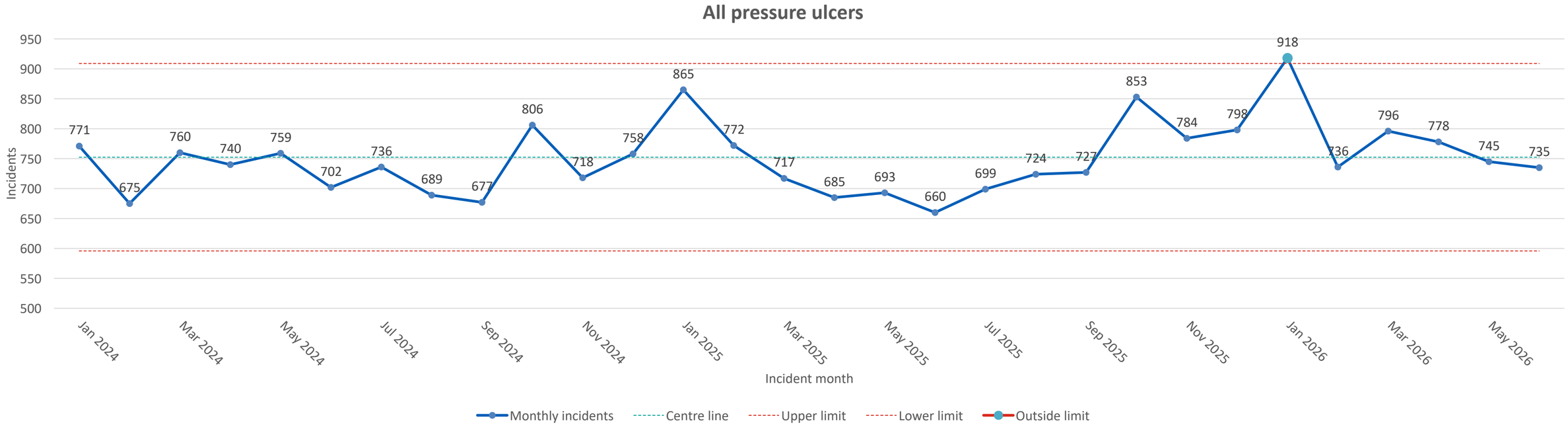


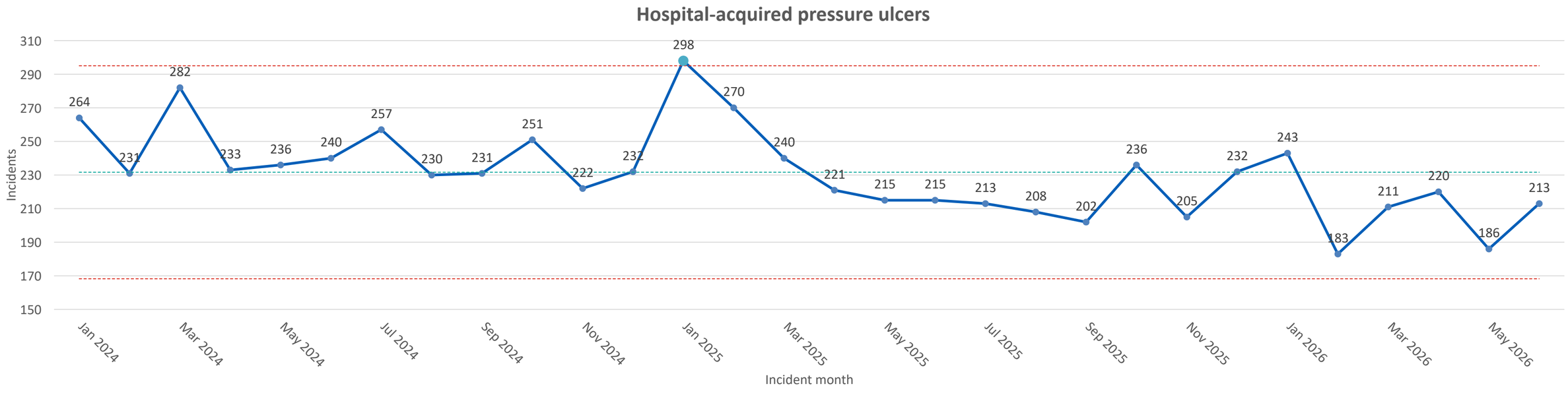
Quarter 4

The data used in this chart has been retrieved from RL Datix and refers to the total numbers of Inpatient reported falls incidents for the period March 2025-26.

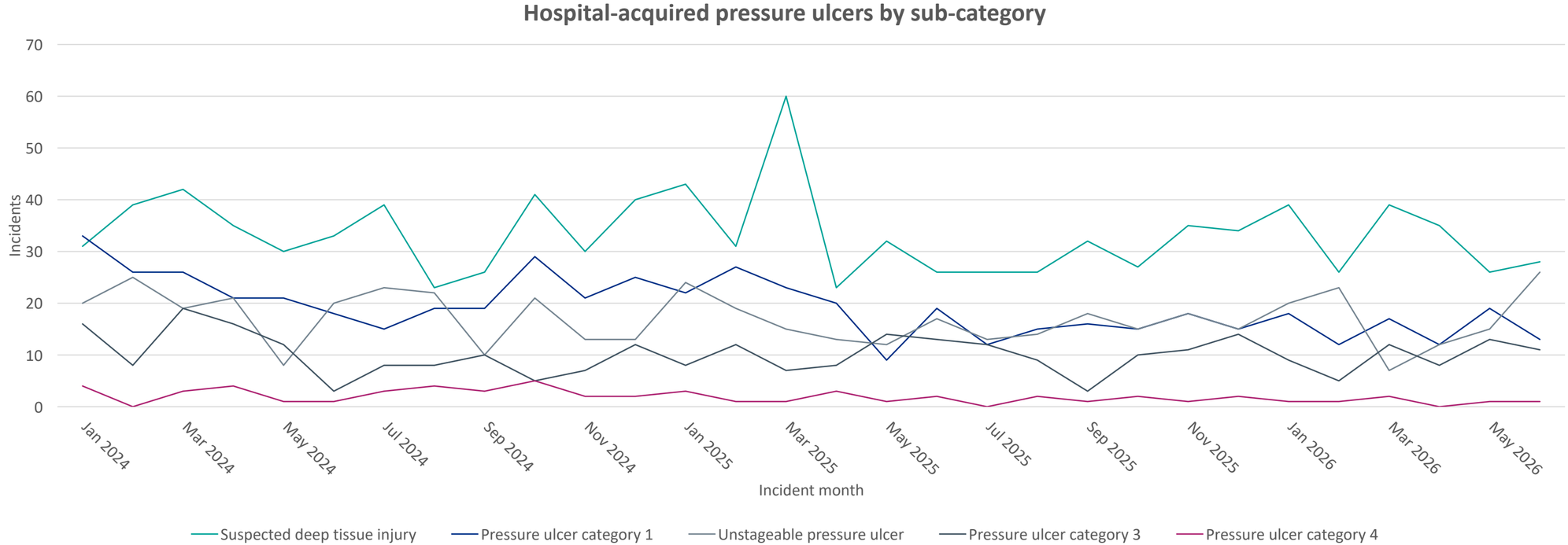
Definition	Analysis	Implications
Reported inpatient fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source for reported falls incidents. The data source for ODB 's has been retrieved	February to March 2026 has seen a marginal rise in the value for falls per 1000 OBDs from 5.70 to 6.10 as reported in the data review for February 2026 (7%). The mean average for the period of analysis March 2025-26 is 6.18. This remains below the National measure of 6.6. This position has been retained for 93% of the year. 10 consecutive months below the National average. In terms of OBD's an increase has been seen between February and March (44,871 & 49,004) – rise of 9.2%. The rise in OBD'S increases the exposure to falls risks and may have contribute to higher numbers of falls for March 2026.	Although falls per OBD's values have increased in Q4 the pattern at present statistically does not meet the criteria for an upwards trend. The values remain within the established control limits and close to the long term HB mean value.

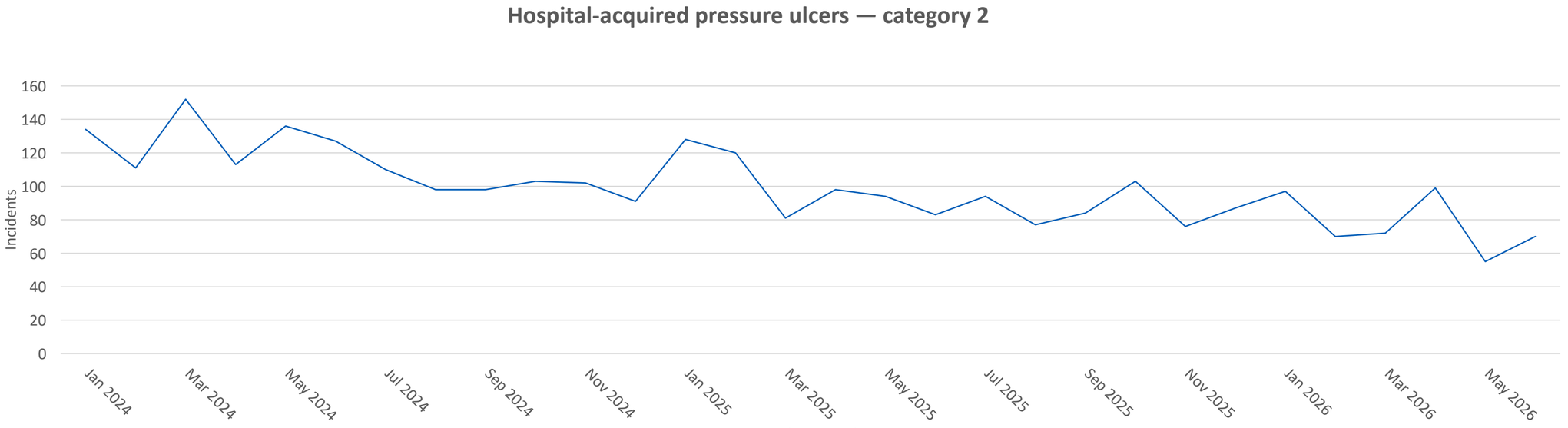
Patient Safety Incident – Pressure Ulcers





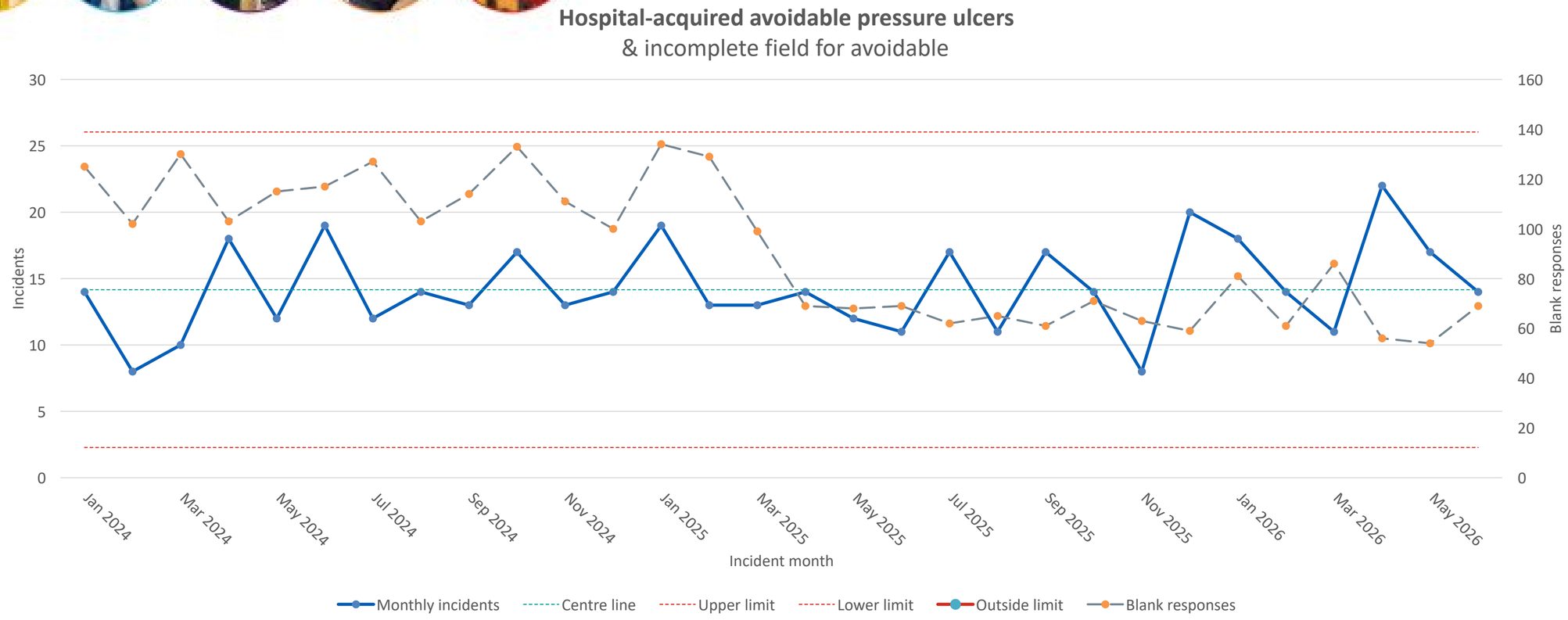
Patient Safety Incident – Pressure Ulcers





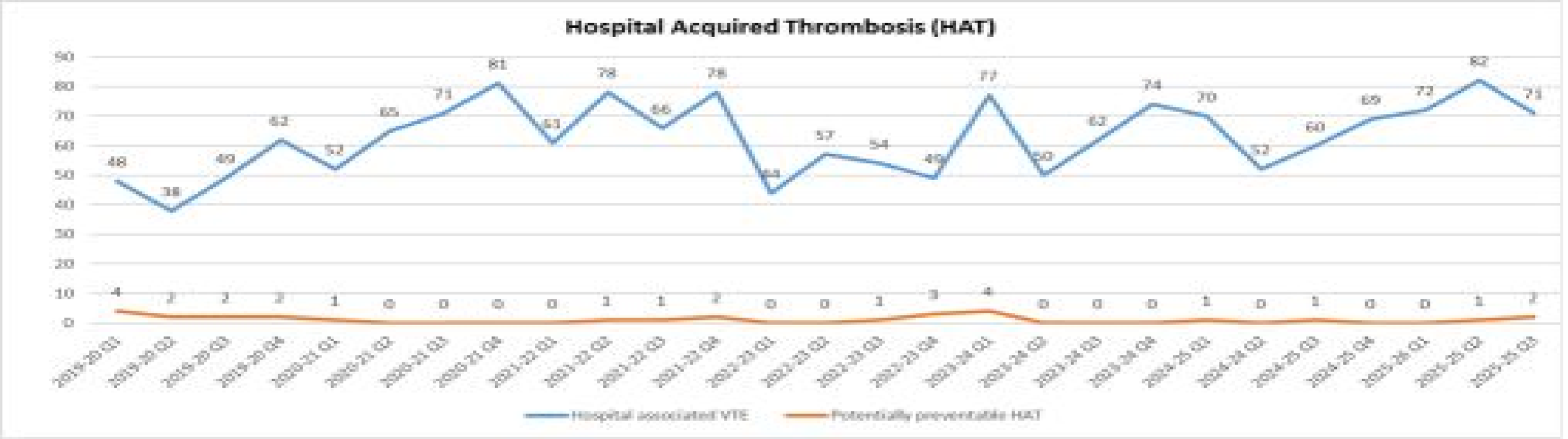


Patient Safety Incident - Pressure Ulcers



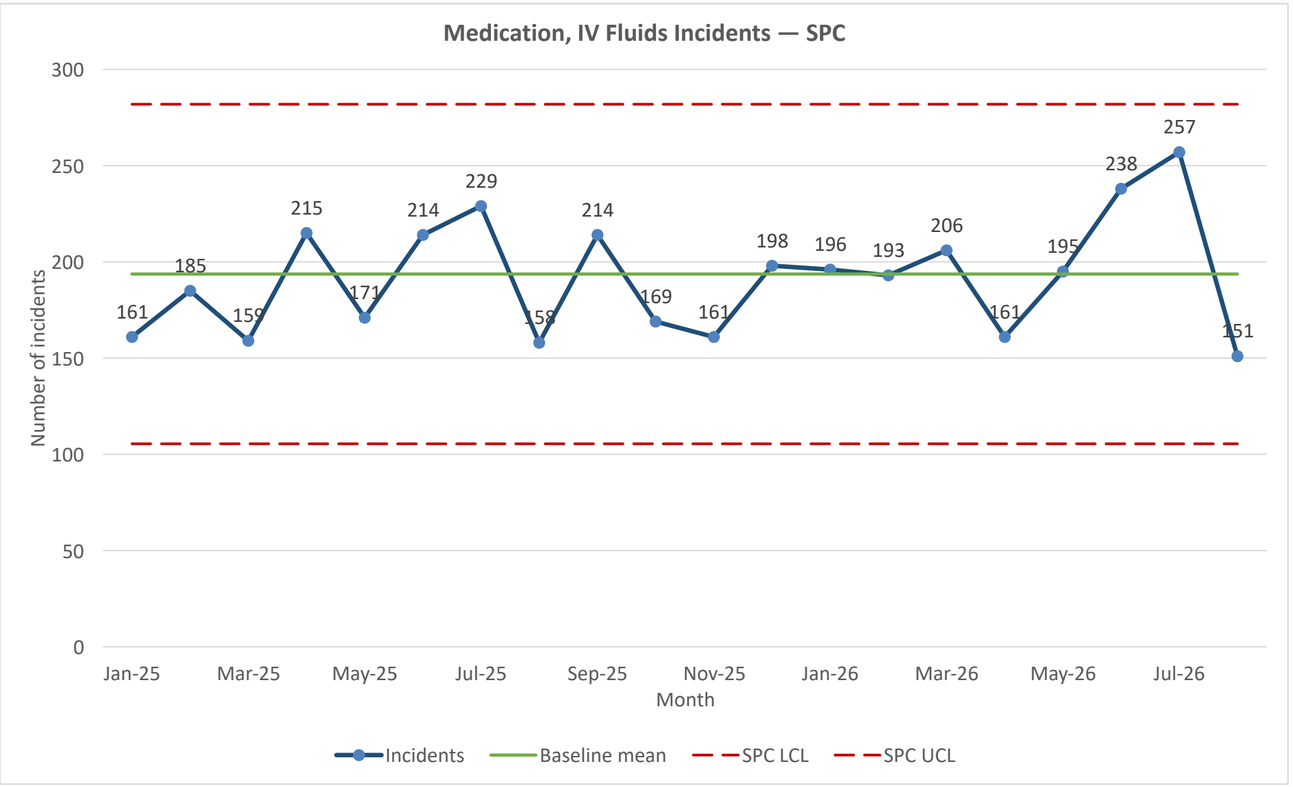
Definition	Analysis	Implications
The data included above is extracted from Datix incident module. The date range displayed is from 01 January 2024 to 30 June 2026.	The number of pressure ulcers has seen an increase, however, the number of hospital-acquired pressure ulcers has seen a steady decline. This has been predominately fuelled by a decline in category 2 pressure ulcers. The graph above shows the number of hospital acquired pressure ulcers where the investigation has determined the pressure ulcer could have been avoided. It also shows the number of incidents closed where the avoidable status has not been completed. This has been a focus of the pressure ulcer professional standards group with the aim of improving data quality.	This trend was noted and discussed at Quality Management Group. An action to explore if community acquired pressure ulcers are increasing due to better identification by staff during admission, if pressure ulcer management in the community is not resolving sores or if patients are not presenting in primary care with this ulcers.

Hospital Acquired Thrombosis (HAT)



Definition	Analysis	Implications
The chart shows the number of suspected hospital associated Venous Thromboembolism events (VTE) and the confirmed number of potentially preventable hospital-acquired thrombosis (HAT). A HAT is a VTE—such as deep vein thrombosis (DVT) or pulmonary embolism (PE)—that occurs during hospitalisation or within 90 days of discharge and could have been avoided if appropriate preventative measures had been taken.	A HAT is reviewed through a structured retrospective process: **1. Identification of suspected HAT cases** – Informatics generate the list of patients discharge data per month and radiology provide the RADIS scanning data (imaging-confirmed VTEs). These are cross-checked against discharge data to identify potential HATs within 90 days of discharge **2. Root Cause Analysis (RCA)** – A Haematologist reviews the RCA form to confirm whether a mandatory VTE risk assessment was completed on admission and whether thromboprophylaxis was prescribed appropriately (correct drug, dose, and duration). **3. Clinical vetting** – The Haematologist then reviews the completed RCA to determine: a. Whether the event meets the criteria for HAT. b. Whether it was unavoidable (prophylaxis was appropriate) or potentially preventable (e.g., missed or incorrect prophylaxis) **4. Reporting and learning** – Confirmed HATs are reported, and insights from these reviews are used to strengthen practice and reduce future harm. WRP are currently refining how Health Boards report HATs on Datix and how learning is reviewed and implemented.	A Hospital-Associated Thrombosis (HAT) is a significant event, accounting for 50–60% of all VTEs and representing one of the leading causes of preventable hospital deaths. The 90-day attribution window is based on strong clinical evidence that VTEs can develop well after discharge due to factors such as reduced mobility, postoperative recovery, underlying medical conditions, or missed/inappropriate thromboprophylaxis. This timeframe ensures that post-discharge events are correctly captured and assessed for any link to the hospital stay, in line with national guidance and policy. Reporting is delayed until case note reviews are completed to determine whether a HAT was potentially preventable. Recent increases in cases reflect a patient cohort with higher BMI and a history of cancer—both recognised risk factors for VTE. The number of preventable HAT cases remains stable and low.

Medicines Management



POST-INVESTIGATION HARM Q4 2025/26		
Harm assessment	Incidents	Share
None	360	60.5%
Low	187	31.4%
Not recorded	45	7.6%
Moderate	3	0.5%
Severe	0	0.0%
Catastrophic / Death	0	0.0%

INCIDENT CATEGORY OVERVIEW Q4 2025/26		
Category	Incidents	Share
Administration errors	236	39.7%
Medication supply errors	149	25.0%
Medication prescribing error	88	14.8%
Medication documentation errors	44	7.4%
Medication storage, security and disposal	42	7.1%
Preparation errors	18	3.0%
Allergic / Adverse reaction (unknown previously)	9	1.5%
Monitoring errors	6	1.0%
Medicines advice errors	3	0.5%

POST-INVESTIGATION HARM Q1 2026/27		
Harm assessment	Incidents	Share
None	364	61.3%
Low	160	26.9%
Not recorded	64	10.8%
Moderate	6	1.0%
Severe	0	0.0%
Catastrophic / Death	0	0.0%

INCIDENT CATEGORY OVERVIEW Q1 2026/27		
Category	Incidents	Share
Administration errors	220	37.0%
Medication supply errors	161	27.1%
Medication prescribing error	93	15.7%
Medication documentation errors	47	7.9%
Medication storage, security and disposal	45	7.6%
Preparation errors	7	1.2%
Allergic / Adverse reaction (unknown previously)	7	1.2%
Monitoring errors	9	1.5%
Medicines advice errors	5	0.8%

Definition

The data included above is extracted from Datix incident module.
The date range displayed is from 01 January 2024 to 31 June 2026.

Analysis

The Health Board continues to report approximately 150-250 medication incidents per month, with administration incidents, particularly omitted doses, remaining the most common category. Most incidents continue to be assessed as low or no harm following investigation.
The wider Health Board incident report for April to June 2026 confirms that medication and IV fluid incidents remain one of the most frequently reported incident categories across the organisation. Learning activity has focused on medication safety, documentation quality, communication and implementation of improvement actions

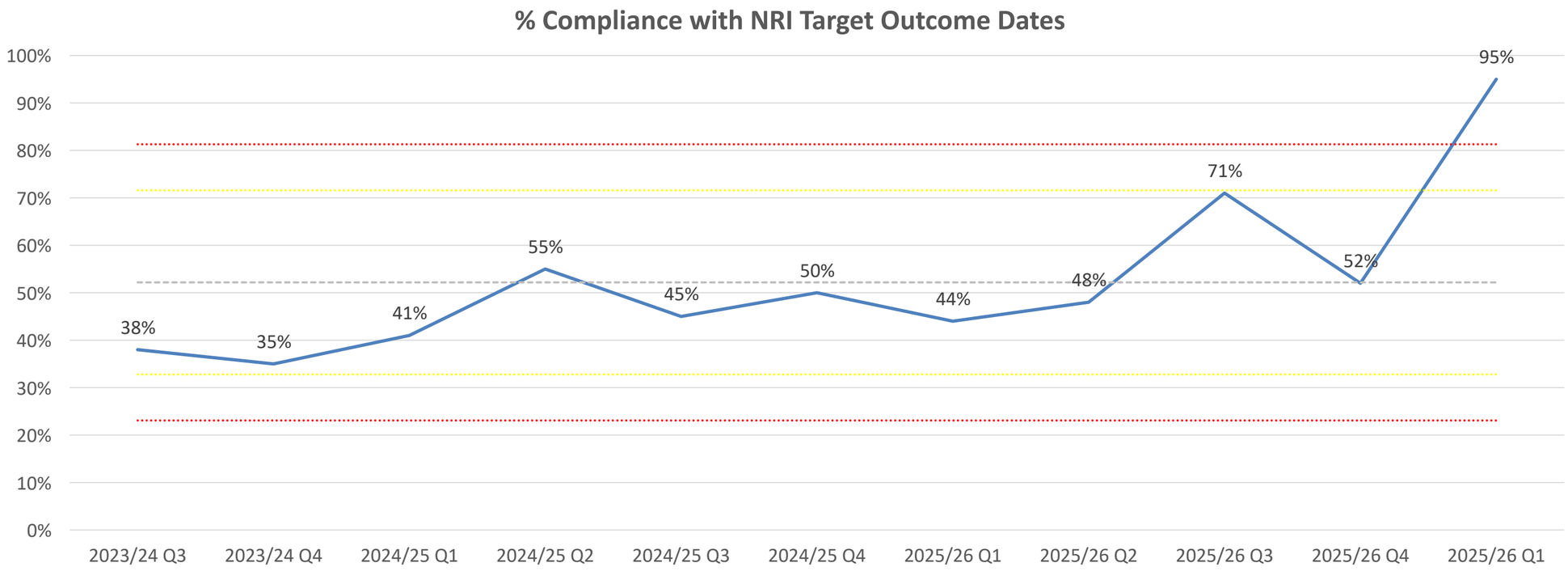
Implications

Medicines Safety Group continues to receive and review medicines incident reporting from all Directorates through divisional exception reports. The most frequently reported themes remain omitted medicines, administration errors, prescribing and documentation failures, and communication issues associated with medicines management. High-risk medicines including insulin, anticoagulants, lithium, clozapine and neonatal medicines continue to receive targeted scrutiny. The Group has identified the need to strengthen organisational learning by improving consistency of divisional reporting, standardising thematic analysis and triangulating incidents across Directorates to identify Health Board-wide trends and opportunities for harm reduction. Most medication incidents continue to result in low or no harm, with improvement actions focused on education, medicines reconciliation, documentation quality, medicine administration processes and enhanced governance oversight.

Medicines Management Learning & Improvement

Item	Action	Who	When
High-risk medication incidents education	Standardised package will be developed N&M Corporate Education team and associated expert for quality and content assurance	Div Practice educators/QPS leads	Q4 2026/27
Medical Gas incidents	Action plan and Tracker to support reporting of Medical Gas incidents to MSG. Discussion at Medical Gas Group in Sept 2026	Medical Gases Group with Medicines Safety Group	Q3 2026
Medicines Governance Audits	New Core audit set to be used to develop a comprehensive medicines audit to report compliance to align with PSN055	Medicines Safety Group	Q3 2026
BESS – error management policy	It was agreed that, rather than making incremental amendments to the current policy, a comprehensive refresh would be undertaken. This will ensure the policy is multi-professional in scope and reflects the organisation's commitment to a Just Culture, although this will extend the implementation timeline.	Medicines Safety Group	Q3 2027 12 month period
Medicines Safety Work Programme 2026-29	The Medicines Safety Group is undertaking a comprehensive review and refresh of its work programme. The revised programme will be socialised with key stakeholders to ensure engagement, feedback, and alignment prior to submission to QMG for approval.	Medicines Safety Group	Q4 2026/27

Nationally Reportable Incidents



A total of **40** Patient Safety Incidents (PSIs) met the criteria for reporting as NRI's in Quarter 1. This is in comparison to **38** in the same period in 2025.

Overdue NRIs

	End of Q3 2025/26	End of Q4 2025/26	End of Q1 2026/27
Over 12 months	4	2	0
Between 6-12 months	2	3	1
Between 3-6 months	3	3	3
Between 0-3 months	9	8	3
Total	18	16	7

Most common NRI categories

Incident Type	Q2 2025/26	Q3 2025/26	Q4 2025/26	Q1 2026/27	4-Quarter Total
HCAI Outbreak	4	9	21	7	41
IUD	4	3	5	7	19
HCAI Associated Death	7	4	7	0	18
Delayed Diagnosis	6	1	3	3	13
Neonatal Death	4	1	7	6	13
Other	3	2	3	5	13
Delayed Treatment	1	1	1	4	7
HCAI Covid Associated Death	2	4	0	1	7
HCAI Covid	1	5	0	0	6
Unstageable PU's	0	0	2	3	5

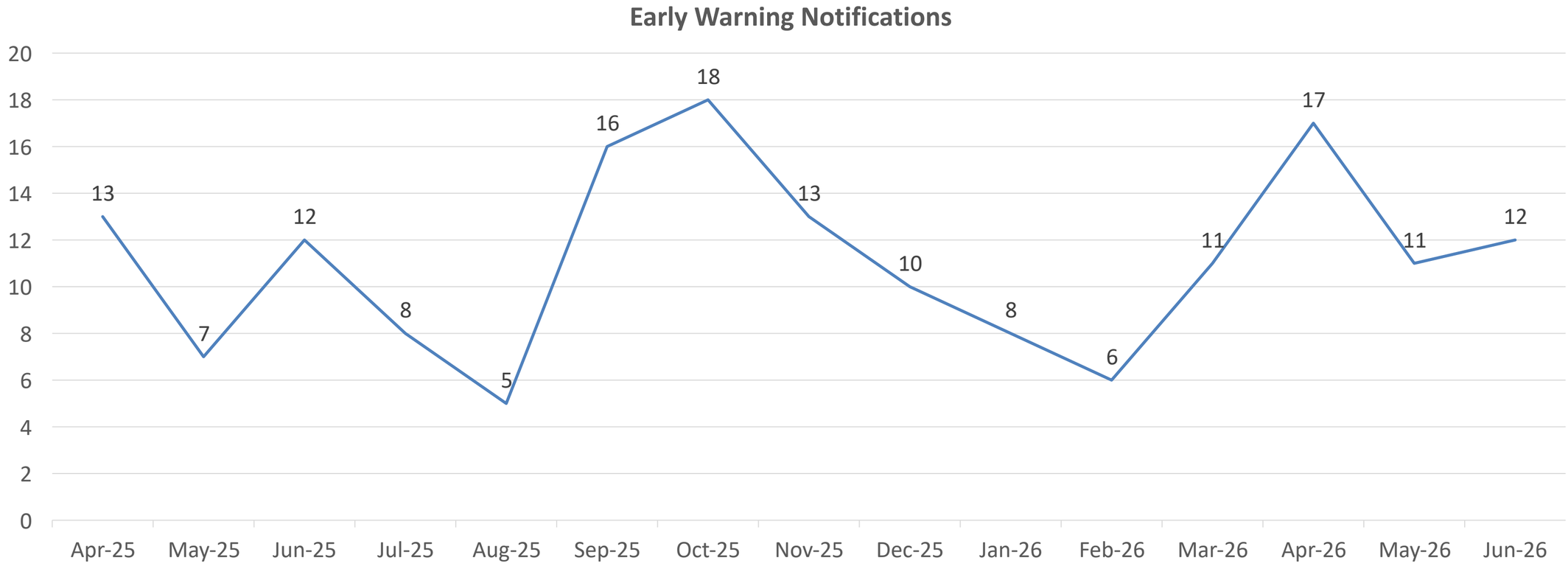
The Patient Safety Incident Team has made significant progress in strengthening the management of Nationally Reportable Incidents (NRIs), with sustained improvements in both compliance and oversight. Overdue NRIs have reduced substantially, down to just 7 at the end of Q1 2025/26 compared to a high of 70 in July 2024. Compliance reached 95% in Q1 2026/27 a record high for the organisation.

Corporate oversight of all NRI cases was introduced in Q1 to improve oversight and early escalation of cases. This has contributed to the improved compliance observed with 58 of 61 NRIs due for closure being completed on or before the NHS P&I deadline. This is reinforced by compliments received from NHS P&I in relation to the improved quality of closure forms and compliance.

Work also commenced to improve data quality, reporting arrangements and governance through the development of dashboards, standard operating procedures and strengthened quality assurance processes prior to closure. Alongside this, development of Family Liaison Officer capability commenced, with national training identified and plans progressing to strengthen support for patients and families affected by serious incidents.

Early Warning Notifications

There were 40 Early Warning Notifications (EWNs) reported to Welsh Government (WG) in Q1, compared to 32 submitted for the same period in 2025/26. The themes reported in Q1 were predominantly related to Mental Health services (45%), including incidents of absconding, suicide attempts and deaths (including unexpected deaths), alongside alleged criminal offences, professional practice concerns (23%), PRUDICs (15%), and GDPR incidents (5%).

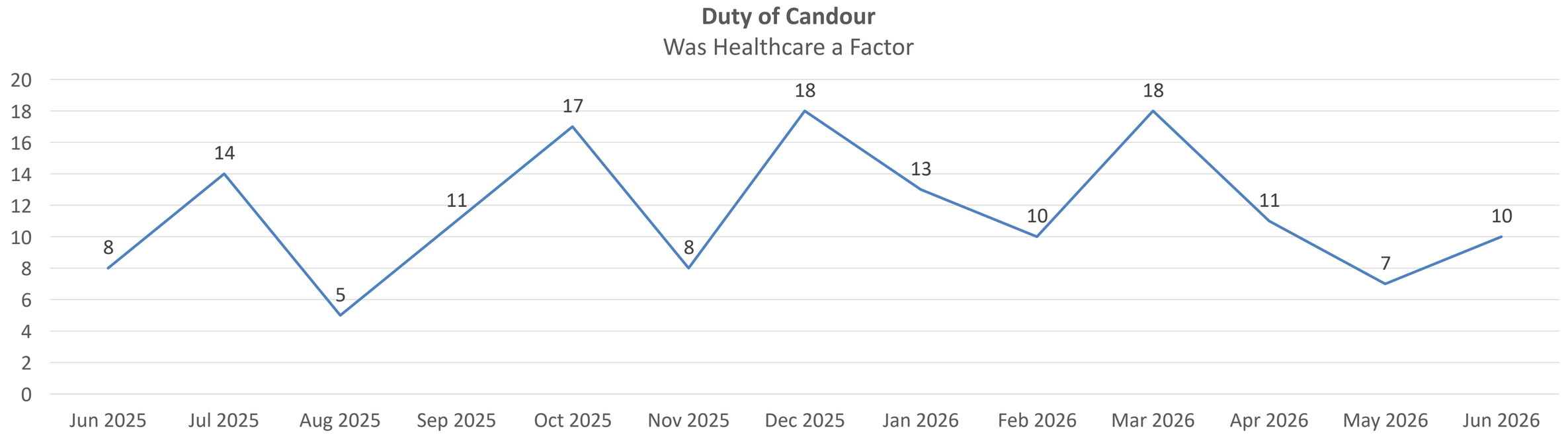


Never Events



Definition	Analysis	Implications
Never Events are serious, wholly preventable patient safety incidents for which national preventative measures are in place. The SPC-T chart is used to show the number of days between Never Events, providing an indication of system reliability over time rather than performance against volume targets.	The graph above shows that prior to 2024 Never Events were relatively frequent occurrences, occurring on average every ~30 days. Throughout 2024 and 2025 the frequency significantly reduced.	During Q1, two Never Events were reported: A dermatology lesion removal procedure was inadvertently performed on an incorrect anatomical site. A patient was inadvertently administered medication via an incorrect route of administration. Work to review the use of NatSSIPs and LocSSIPs to prevent Never Events in surgical procedures is underway, supported by ABCi.

Duty of Candour



The number of Duty of Candour events continues to vary month to month, reflecting the point at which management reviews confirm whether Duty of Candour thresholds are met. This remains an evolving position, with data accurate as of 13 August 2026 and subject to change as reviews are completed.

What is the data telling us
In Q1 2026/27 there were 21 DoC events, compared to 41 in Q4 2025/26 and 26 during Q1 2025/26.
The DoC themes for Q1 were clinical assessment/diagnosis (29%) medication prescribing and treatment / procedure issue (11% each) and Administration errors and patient injury (7% each).

Learning and Improvement

Significant progress was made in strengthening Duty of Candour arrangements. Corporate oversight was enhanced through the introduction of the daily 10@10 review process, ensuring earlier consideration of Duty of Candour, redress and reportability requirements.

Development of a DoC Divisional Dashboard is undergoing validation alongside validation of DoC compliance through Qlik.

PSI Learning and Improvement

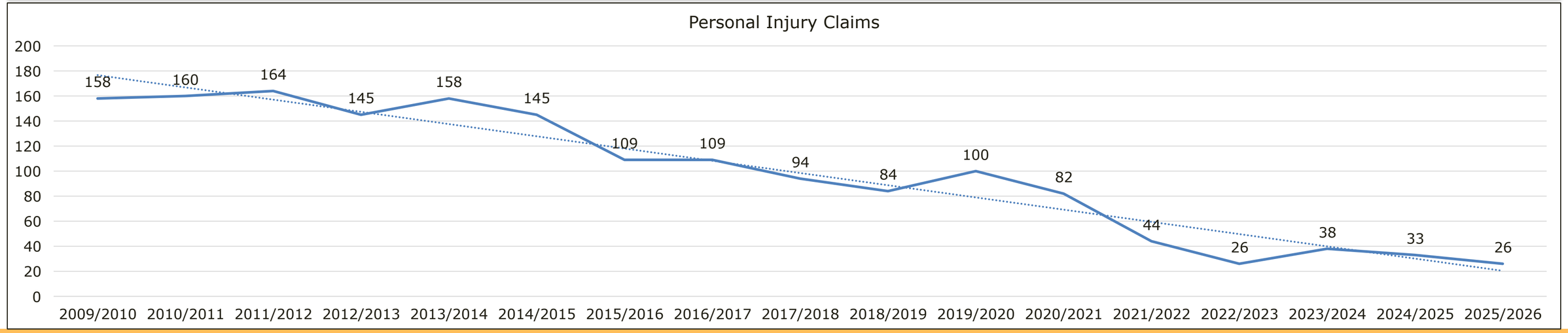
Achievements / Escalations	Update	Next Steps
Rapid review PSI meetings diarised from Q1.	Executive approval to implement daily rapid review meetings, chaired by the Head of Patient Safety and Learning and attended by Divisional QPS Leads. These meetings will provide early review of Patient Safety Incidents, enabling prompt clinical oversight, immediate safety actions and timely escalation.	Review and revise process at the end of Q1.
Regular monitoring of all NRI's to ensure timely and patient centred.	A Datix dashboard has been developed for each corporate incident manager, providing oversight of compliance and caseload progression.	To monitor effectiveness against current progress/compliance with NRI trajectory.
Reconciliation of maternity/neonatal incident to ensure that it aligns to MBRACE and NRI reporting.	The corporate incident managers, in collaboration with the division, are developing and aligning statutory reporting processes to MBRACE, PMRT ensuring consistency and compliance across all areas.	Continued monitoring of compliance.

Legal Services – Regulation 28 & Person Injury Claims

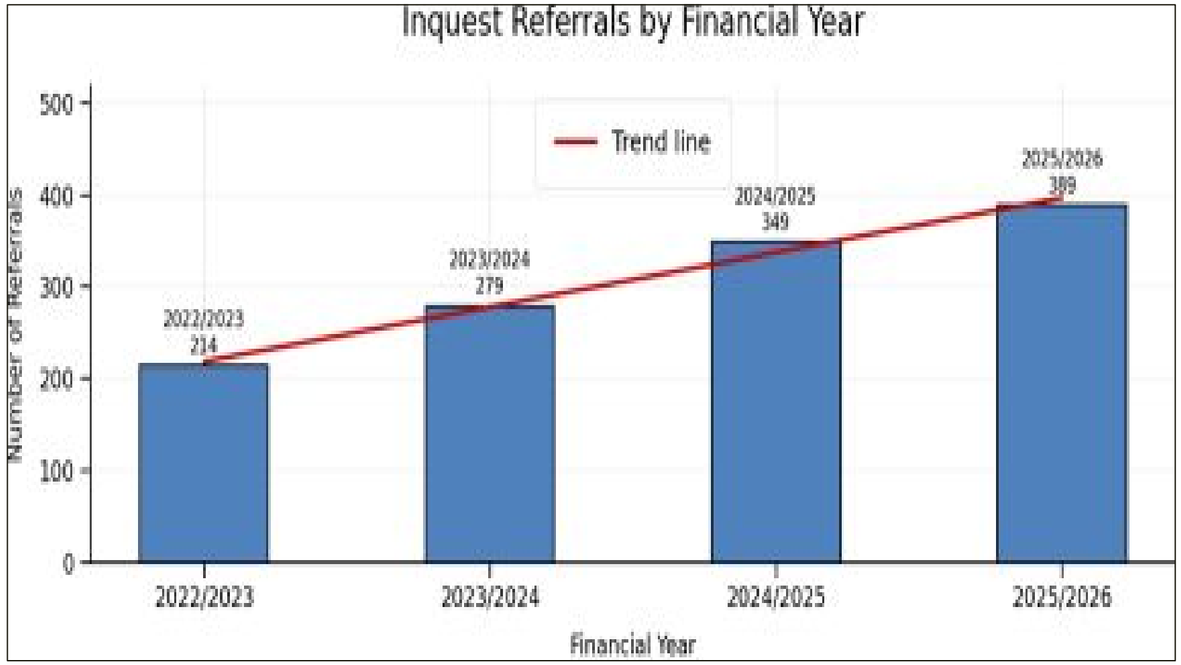
Regulation 28s

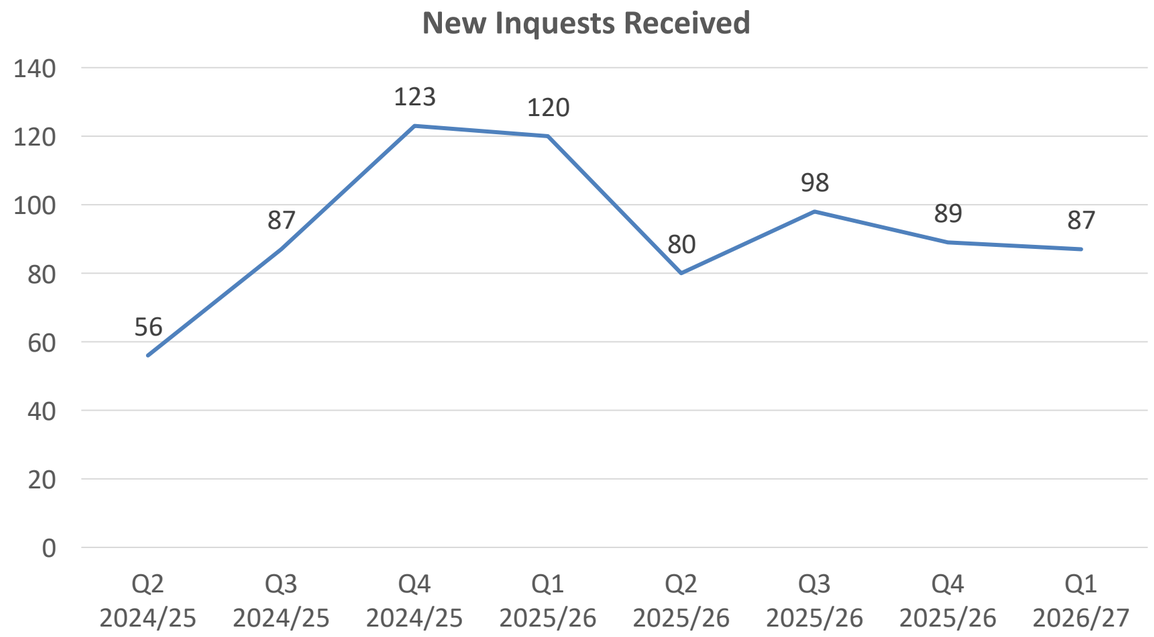
- One Regulation 28 was received by the Health Board during Quarter 1 in relation to antenatal fetal monitoring guidance, management of chorioamnionitis, training, and delays transferring between antenatal and HDU care.

Person Injury Claims



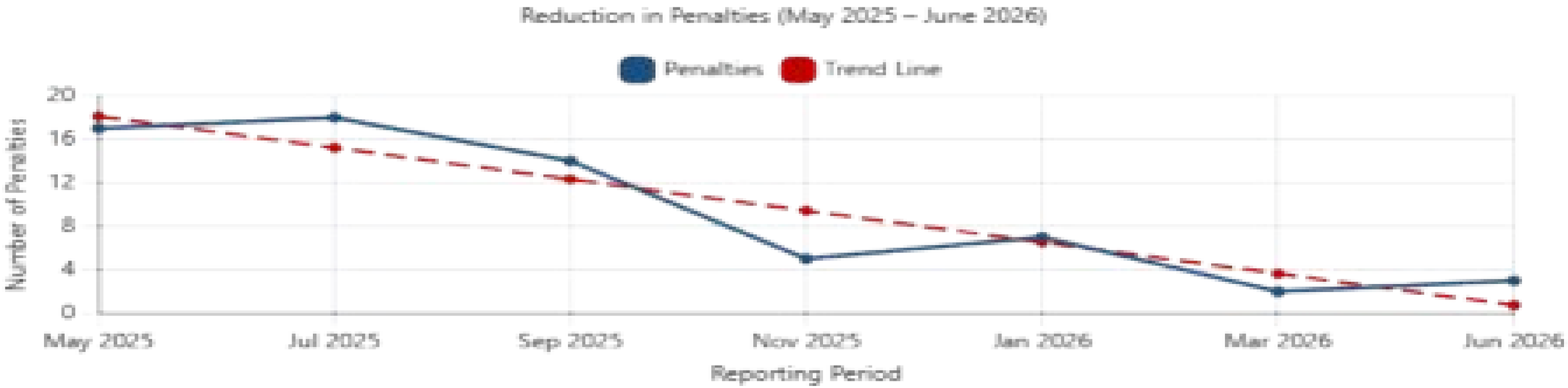
Inquests





Definition	Analysis	Implications
Every Inquest matter is logged and managed via the RL Datix case management system. The above data reflects the annual status position as at 2025-2026.	The Health Board has seen a sustained increased in the number of new inquests received each year since 2022/23. This appears to have plateaued over the last year to 80-100 new inquests each quarter. This is compared to 50-70 inquests per quarter in 2022/23 & 2023/24.	This sustained growth and volume has been impacting on the ability of the Legal Services team to keep pace with demand on its services, raising a number of risks and challenges. Additional administrative resource identified through cost savings elsewhere in the Executive Director of Nursing's portfolio has allowed for recruitment into the team to support for operational pressures of keeping up with the coroner's inquests.

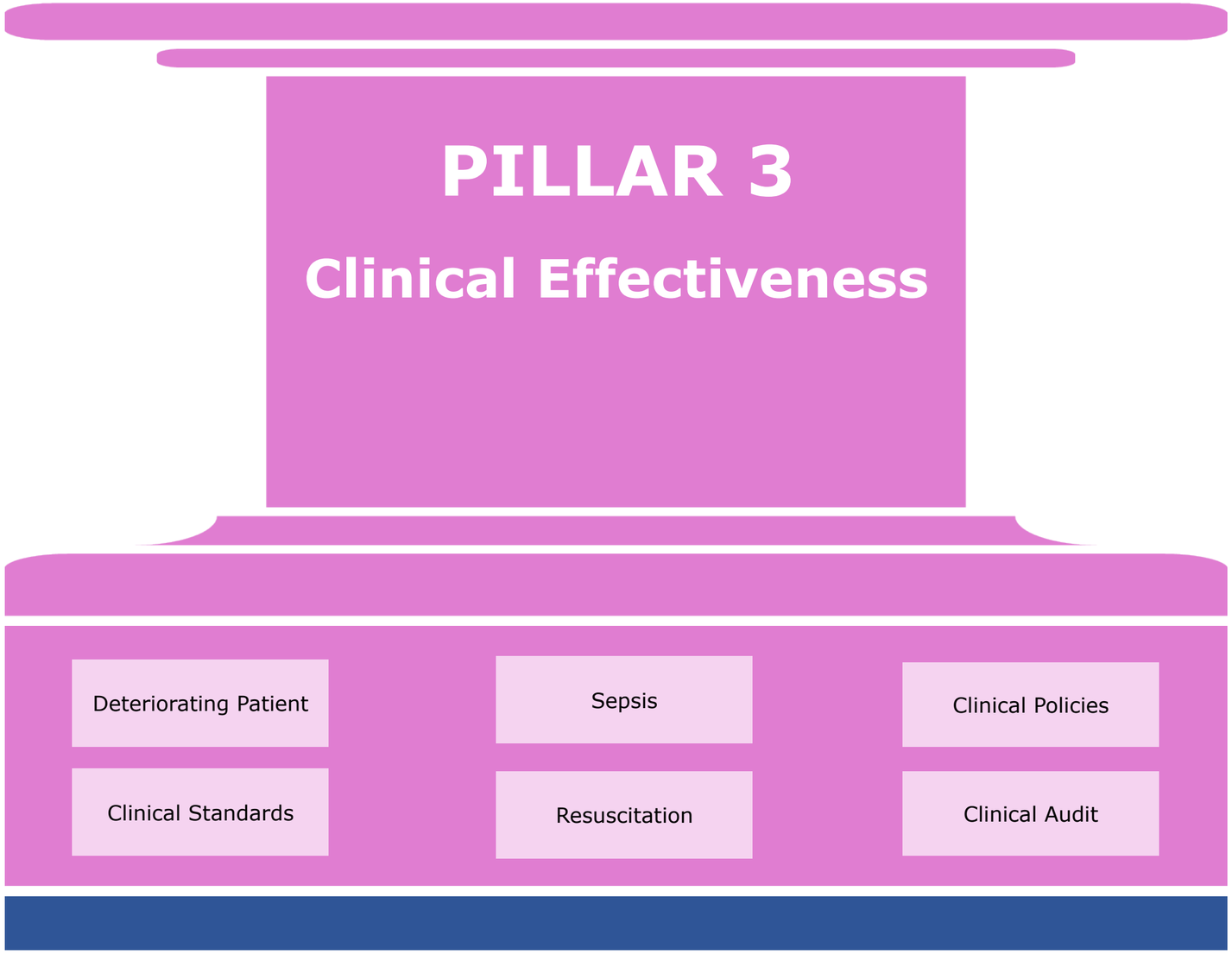
Learning from Events and WRP Penalties



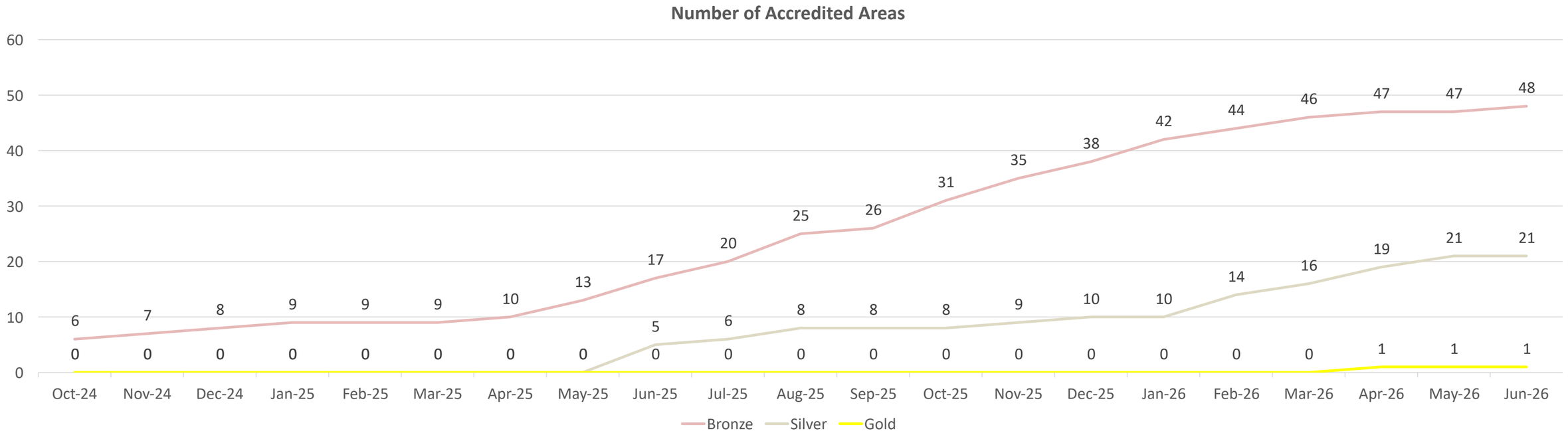
Definition	Analysis	Implications
Once a failing in patient care is identified, it is very important that lessons are learned and actions taken to prevent future incidents and patient harm.	When a decision is made to admit liability in a Clinical Negligence, Personal Injury or Redress matter, the Health Board completes a substantial 'Learning From Events Report' for assurance around learning and actions to prevent future patient harm. Legal and Divisional teams have worked closely over the year to drive improved quality and timeliness of LFER's, reducing the risk of future incidents and patient harm, and reducing WRP financial penalties.	Where LFER's are late and/or insufficient in providing assurance of learning, the Welsh Risk Pool (WRP) can impose fines of £2500 per matter. These fines are repeated bi-monthly until satisfied. Ultimately these fines represent the Health Board's failure to evidence learning from adverse events. Whilst the fines have predominately been due to the timeliness and quality of submissions, rather than the absence of evidence, the improving picture should provide assurance.

Patient Safety Alerts (PSA) and Notices (PSN)

Alert	Compliance Deadline	Action to achieve compliance	Status
PSA020 Harm From Incorrect Recording of a Penicillin Allergy as a Penicillamine Allergy	**30th November 2026**	Action plan in progress and on target. Progressing through the Health Board's Medicine Safety Group, highlighted to Antimicrobial Group and Electronic Prescribing Medicines Administration Group.	In-progress (on target)


PILLAR 3
Clinical Effectiveness
Deteriorating Patient
Sepsis
Clinical Policies
Clinical Standards
Resuscitation
Clinical Audit

Ward Accreditation



The accreditation programme has now progressed beyond traditional inpatient wards and is expanding across multiple clinical settings. Phase 3 implementation commenced during Q1, with accreditation frameworks developed or in development for District Nursing, Health Visiting, School Nursing, Community Mental Health Teams and Child and Adolescent Mental Health Services (CAMHS). This represents a significant expansion of the programme and supports the ambition of achieving full organisational coverage.

The accreditation programme demonstrates sustained engagement across clinical services and increasing organisational maturity. The primary focus during Q1 was not simply increasing award numbers, but establishing the systems, governance and assurance arrangements needed to ensure accreditation delivers measurable improvements in quality, safety and patient experience. This included development of an accreditation assurance framework, creation of an accreditation panel, work towards integrated digital dashboards using WNCR and Careflow data, and the introduction of divisional compliance heat maps and thematic audit tracking.

Deteriorating Patient and Sepsis

Call for Concern - Adopting a patient and family-initiated escalation approach (WHC/2024/040)

- The WHC requires all health boards to adopt a patient and family-initiated escalation approach, known as Call for Concern (CfC), which allows patients, families and carers to quickly raise concerns and request urgent clinical review if they are worried about a patient's deteriorating condition.
- The approach is person-centred, aligns with national quality and safety standards, builds on pilots already undertaken in Wales, and aims to improve patient safety by ensuring concerns are listened to and acted on promptly across all inpatient settings, 24 hours a day, supported by local implementation plans and national oversight. This includes:
  - Patient Wellness Score/Question/Concern (PWS/Q/C): structured self reported wellbeing assessment ensuring that the 'first voice of concern' belongs to the patient and their family
  - Patient and Family Initiated Escalation (PFIE): mechanisms to quickly address concerns about deterioration firstly in the immediate clinical area and for the patient or family to directly activate senior clinical review
- The subsequence WHC Call for Concern: timelines and responsibilities (WHC/2026/001) outlines the timelines for implementation:
  - July 31st 2026– across all acute inpatient settings
  - December 31st 2026 – across all non-acute inpatient settings

Call for Concern: Implementation Update

A prolonged but controlled trajectory to achieve safe, sustainable and consistent embedding

CURRENT POSITION

Implementation is progressing, but full organisational embedding is taking longer than originally planned.

Progress and trajectory

- Successful pilot learning has shaped the Health Board-wide model.
- Acute and specialist rollout is being progressed through planned implementation phases.
- Community and Mental Health and Learning Disabilities pathways require further scoping, adaptation and testing.

Why the approach is controlled

- The Health Board has deliberately avoided a rushed or minimum viable implementation.
- Additional time is enabling education, communications, operational processes and governance to be established reliably.
- The model is being refined through feedback and implementation learning so that it strengthens existing deterioration pathways.

Assurance and next steps

- Programme risks, readiness and delivery milestones remain under formal oversight.
- Progress continues to be reported through Quality Management Group and PQSOC governance routes.
- Focus now is on consistent adoption in practice, monitoring impact and sustaining the model beyond initial launch.

The extended implementation period reflects a deliberate patient-safety control: prioritising readiness, reliability and sustainable embedding over pace alone.

Deteriorating Patient and Sepsis Programme 2026/27

Workstream	Deliverables	Lead	Quarter
Early Warning Scores (EWS)	The requirement of WHC/2024/035 relating to the implementation of EWS was fully delivered by 12 June 26, following successful implementation of MEWS on 18 May 2026. Continue embedding NEWS2, PEWS and NEWTT2.	Clinical leads	Q1
Call 4 Concern	Launch and embed Call 4 Concern in line with Welsh Health Circular requirements.	Call 4 Concern workstream lead	Q2 to Q4
Patient Wellness Score	Develop, pilot and refine the Patient Wellness Score / Questionnaire.	Deteriorating Patient Group task and finish group	Q2
Sepsis recognition and treatment	Embed the UK Sepsis Trust screening tool and NICE-aligned practice.	Sepsis lead	Q2
Education and training	Deliver a refreshed, standardised education programme.	Education leads	Q2
Sepsis Champion network	Sustain the network and its local improvement role.	Sepsis lead	Q3
Audit and assurance	Implement the Deteriorating Patient Audit Programme. Ward accreditation audit on Deteriorating Patient commended June 2026.	Audit lead	Q3
Incident learning and mortality review	Establish themed reviews using Datix, mortality and complaints intelligence.	Patient Safety Team	Q3
Ward and divisional support	Develop a structured review process with divisions and wards.	Deteriorating Patient Group members	Q1 to Q4
Quality improvement programme	Identify and support priority deteriorating patient quality improvement projects.	Quality improvement leads	Q2 to Q4
Communications and awareness	Deliver the Phase 2 communication plan and awareness activity.	Communications Team	Q1 to Q4
Post-sepsis recovery	Develop recovery pathways, discharge information and GP communication.	Clinical leads	Q2 to Q4
Bereavement support	Develop a consistent bereavement approach and supporting information.	Bereavement lead	Q4
National engagement	Participate in national deteriorating patient and sepsis forums.	Programme lead	Ongoing Q1 to Q4

Deteriorating Patient and Sepsis Programme 2026/27

Delivery focus	Key milestones	Expected outcome	Quarter
Implementation and mobilisation	• Complete implementation of MEWS across maternity services as part of Implementation of the WHC (2024/035), national Early Warning Scores. • Confirm Deteriorating Patient Group governance arrangements, reporting cycle and workstream leadership. • Finalise Call for Concern implementation arrangements, pathway requirements and communication needs. • Develop and pilot the Patient Wellness Score / Questionnaire through ward-based PDSA cycles. • Refresh the Sepsis Champion network and clarify expectations for ward-level support. • Confirm the audit scope and baseline assurance approach for deteriorating patient and sepsis care.	The Health Board has completed the remaining mandated Early Warning Score implementation and established the infrastructure required to support Call for Concern, audit, assurance and service-level improvement.	Q1: April to June 2026
Embedding and standardisation	• Embed reliable use of Early Warning Scores and sepsis screening tools across clinical areas. • Progress Call for Concern implementation and staff awareness of escalation pathways. • Complete the evaluation of the Patient Wellness Score / Questionnaire pilot and agree amendments. • Deliver targeted deteriorating patient and sepsis education through agreed learning routes. • Begin structured ward and divisional support using EWS, sepsis and Call 4 Concern data. • Review and refresh public and patient-facing communication materials.	Variation in practice is identified and reduced through education, ward support and early audit activity, with patient escalation pathways becoming established.	Q2: July to September 2026

Deteriorating Patient and Sepsis Programme 2026/27

Delivery focus	Key milestones	Expected outcome	Quarter
Evaluation and improvement	• Triangulate audit, Datix, mortality review, complaints, EWS and sepsis screening data to identify themes. • Commence priority quality improvement projects focused on deteriorating patient and sepsis care. • Use the Sepsis Champion network to share learning and reinforce escalation practice. • Progress post-sepsis recovery work, including discharge information, GP communication and follow-up. • Review existing bereavement support arrangements and identify improvements for families affected by sepsis.	Data-driven quality improvement activity is established, and learning from incidents, mortality reviews and patient experience is translated into improvement actions.	**Q3: October to December 2026**
Sustainability and assurance	• Complete the annual evaluation of programme delivery against the 2026/27 workplan. • Review outcome measures, compliance, risks, gaps and evidence of improvement. • Produce an annual deteriorating patient and sepsis assurance report. • Share learning across divisions and governance structures. • Agree priorities for 2027/28, including sustainability arrangements and outstanding improvement actions.	The programme demonstrates evidence of strengthened assurance, learning, governance and measurable progress in recognising and responding to deterioration and sepsis.	**Q4: January to March 2027**

Deteriorating Patient and Sepsis

Welsh Health Circular (WHC/2025/051) - *Safety Netting Discharge Leaflets for Adults and Children*

- Good progress has been made in both paediatric and adult services, with paediatric materials nearing implementation and adult resources approaching pilot phase. This work provides a strong foundation for a Health Board-wide programme to embed consistent safety-netting and discharge information as part of routine patient care during 2026/27. For AB the leaflets The leaflet includes a QR code linking to the UK Sepsis Assessment Tool and has been updated to incorporate recommendations from the EDI Team.

Health Board Position and Progress:

Children's Services

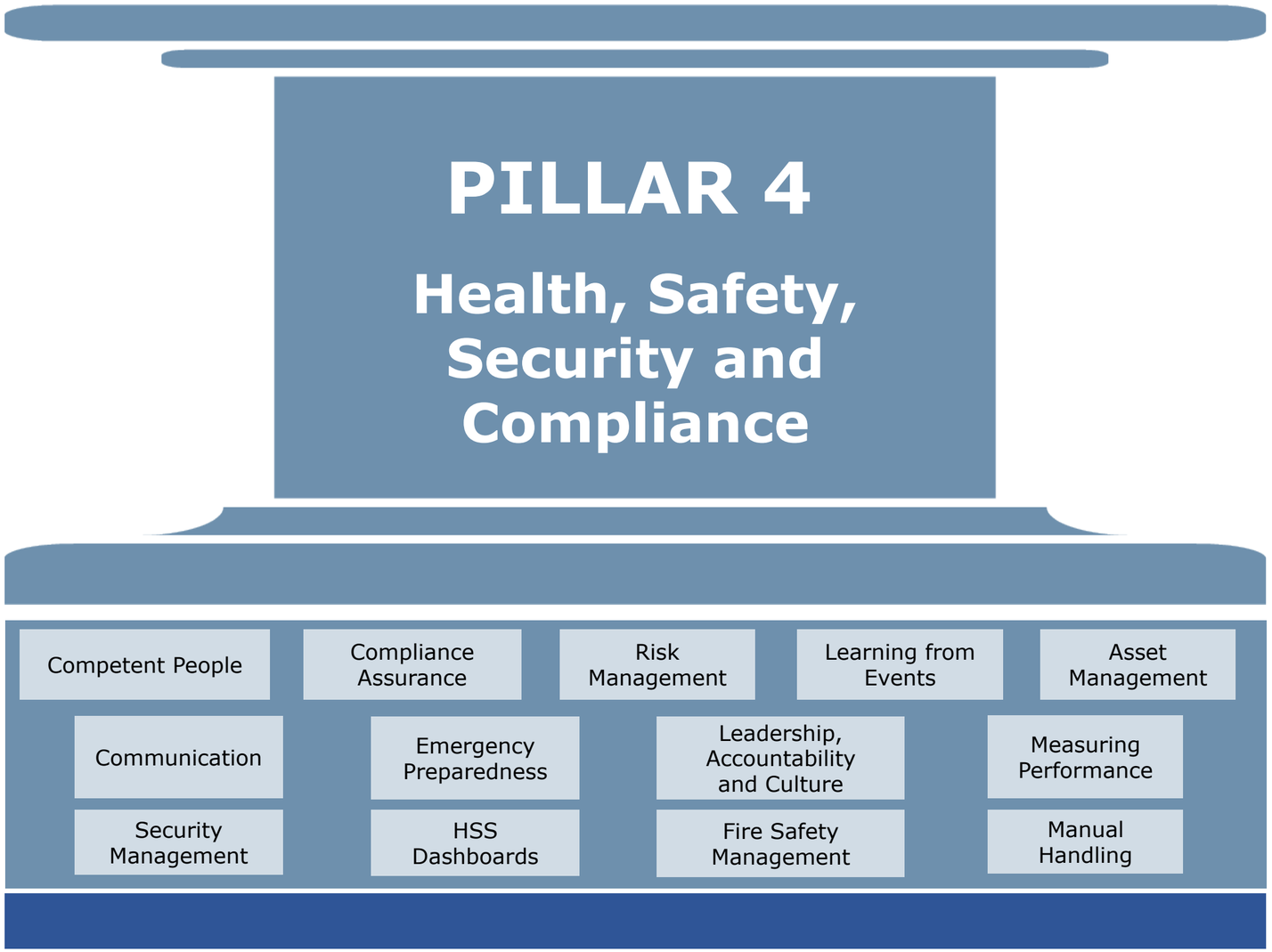
- The inpatient paediatric safety-netting leaflet has been signed off by the Division, received Executive approval and is progressing through Welsh translation ahead of publication and wider distribution.
- Inpatient paediatric services have been routinely issuing the '*Taking Your Child Home'* leaflet since April 2025. A revised Children's Emergency Assessment Unit (CEAU) safety-netting leaflet has been developed and standardised to align with the inpatient version. The leaflet is currently awaiting final Divisional approval before progressing to Executive sign-off.

Adult Services

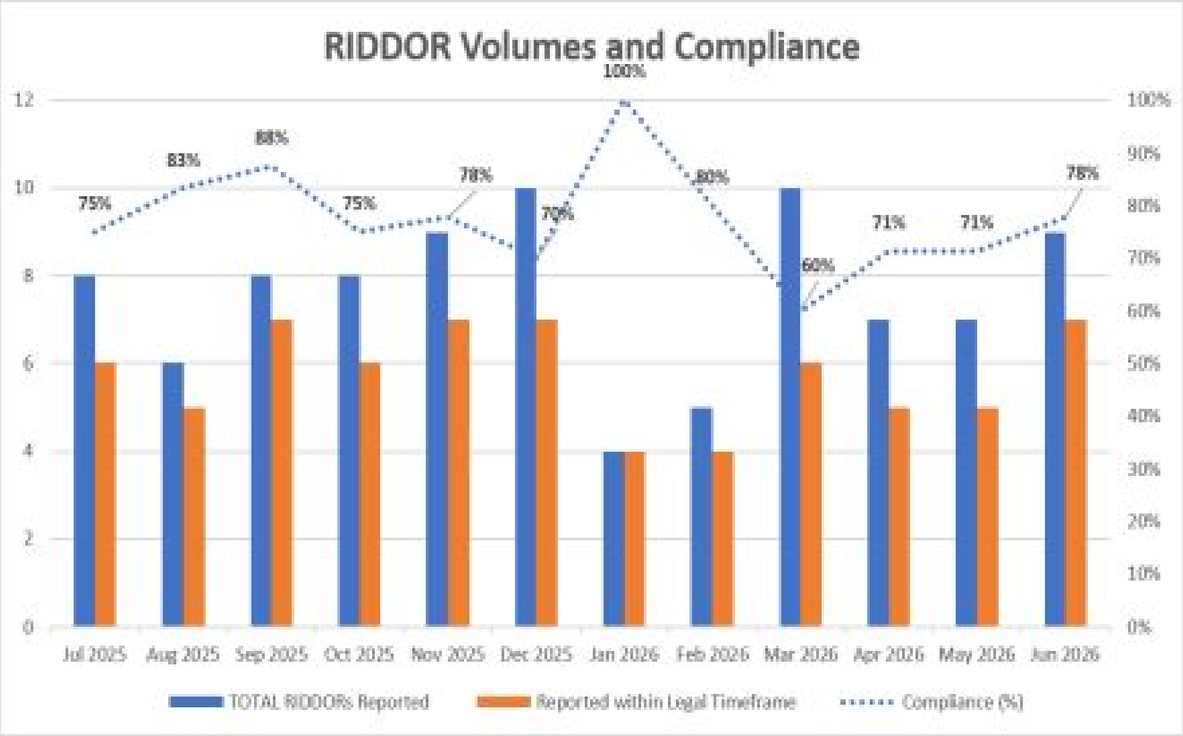
- Development is nearing completion. The document has been adapted from existing local arrangements and aligned to the WHC template to support consistency across services. Subject to final clinical review and approval, the leaflet will be piloted within the Emergency Department before consideration is given to wider implementation across inpatient and other clinical areas.

Next Steps

- Complete Welsh translation and publication of the approved paediatric inpatient leaflet.
- Secure final approval of the CEAU leaflet and progress to implementation.
- Finalise adult leaflet development and undertake Emergency Department piloting.
- Develop a standardised Health Board-wide approach for approval, distribution and monitoring of safety-netting information.
- Include rollout of safety-netting and discharge information leaflets within the Deteriorating Patient Group's 2026/27 workplan to support implementation across all clinical areas


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

Pillar 4: Health, Safety, Security and Compliance



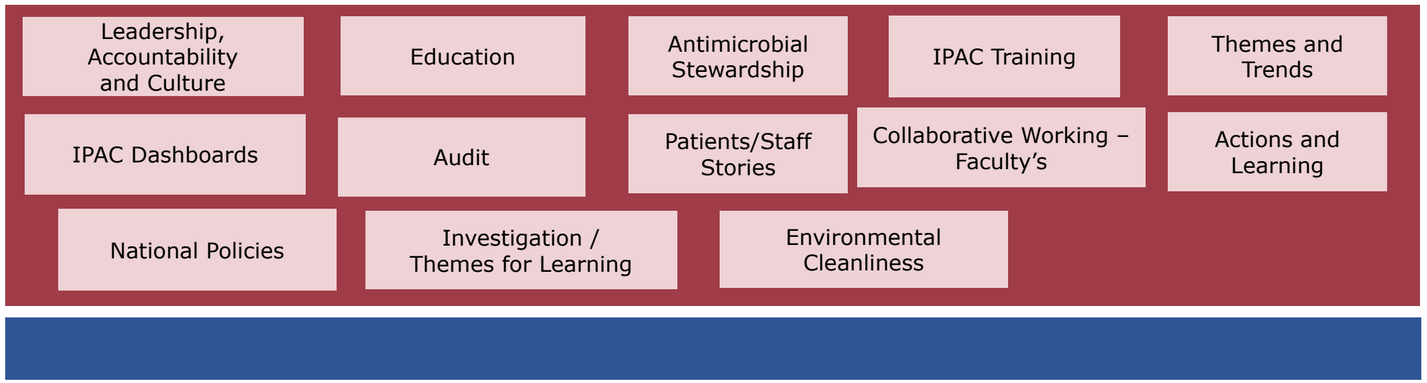
Statutory & Mandatory Training Compliance	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026
Health and Safety	87.0%	87.2%	87.5%	87.1%	87.1%	87.0%
Fire Safety	82.2%	82.4%	83.5%	84.3%	84.3%	84.3%
Manual Handling	65.4%	64.8%	64.5%	64.3%	64.3%	63.3%
Violence Prevention & Reduction	85.2%	85.3%	85.5%	85.2%	85.2%	85.1%

Staff Health and Safety Incident Reporting	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026
Physical assault	91	88	83	107	121	95	45
Contact with needle or medical sharps	24	23	10	21	16	23	22
Verbal assault	14	11	20	16	21	18	11
Slip, trip or fall	7	28	16	8	14	9	13

Issue	Action		Learning and Improvement
Violence towards staff	Violence Prevention & Reduction Strategic Plan approved by Board	Under-reporting and normalisation of abuse	The VPR Strategic Plan sets out objectives to improve reporting and culture
Needlestick & sharps	Reduction in number of injuries in Q4 2025/26	Poor practice relating to safe disposal of sharps identified as a contributory factor to injuries	QI project to reduce needlestick and sharps injuries to commence in Q3 26/27 in conjunction with H&S, IPaC and Occupational Health
Winter slips, trips and falls	Winter falls thematic review conducted by Corporate Health & Safety	Slips, trips and falls in Q4 25/26 significantly above the quarterly average and data for the same period in Q4 24/25	Areas for improvement identified within the thematic review to be shared with Facilities Division
RIDDOR reporting compliance with the legal timeframes	RIDDOR SOP revised	Timely reporting and investigation of incidents to determine an outcome on RIDDOR	RIDDOR Awareness eLearning Training to be implemented in Q3 26/27. Submission to Core Learning Committee in September 2026 to mandate this training for managers
Manual Handling Training	Manual handling training programme developed for 2026/27	Backlog of staff requiring the 2-day People Handling Foundation Training	Focus on supporting Cascade Trainers (Transfer Specialists) to ensure update training is delivered locally

PILLAR 5

Infection Prevention & Control



Healthcare Associated Infections

ABUHB Q1 data compared to All Wales average data for total counts and rates per 100,000 population.

All Wales – Current FY count of specimens

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	50	6	42	96	29	7
Wales	338	21	213	539	172	38

All Wales – Current FY rate per 100,000 population

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	33.33	4	28	64	19.33	4.67
Wales	42.54	2.64	26.81	67.84	21.65	4.78

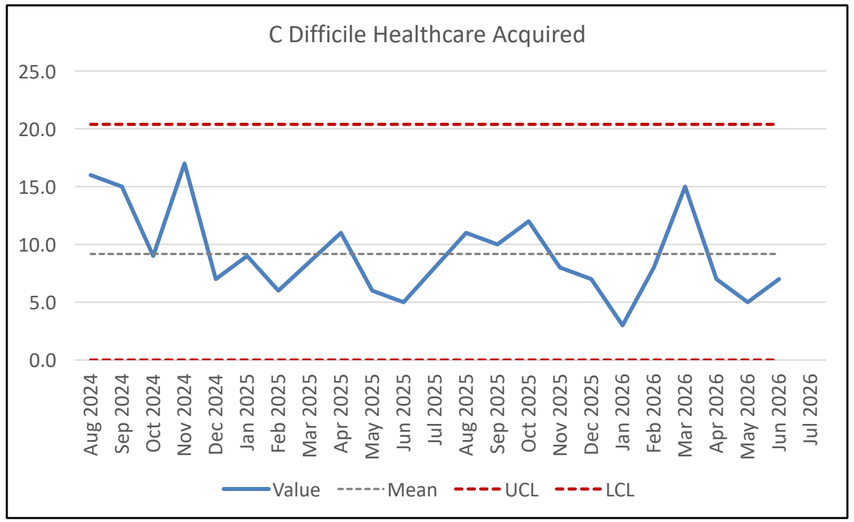
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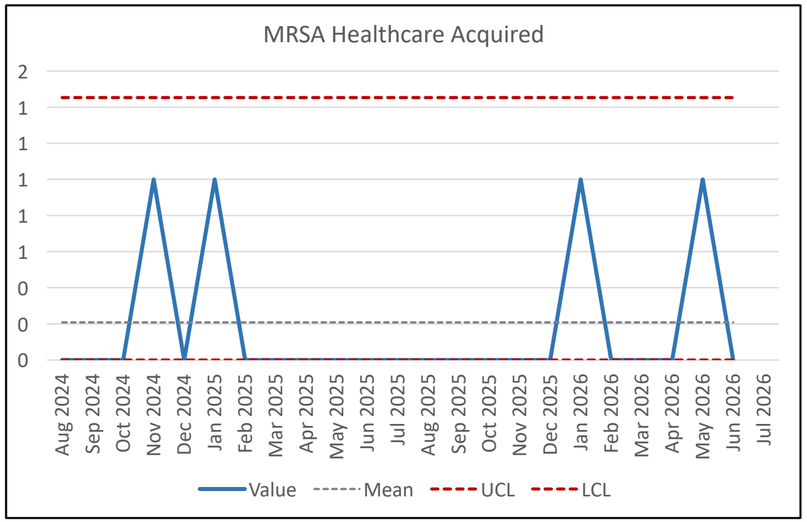
Pillar 5: Infection Prevention & Control

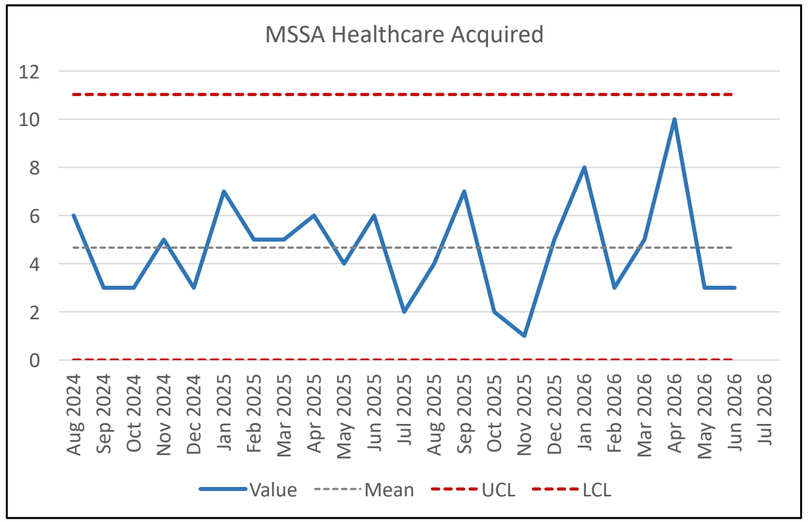
Pillar Five - Infection Prevention & Control

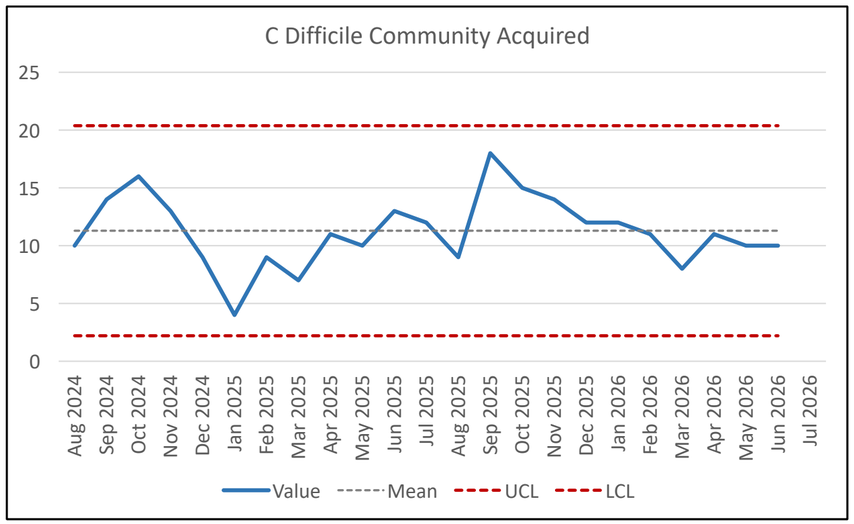
Themes & Trends	Successes	Challenges	Learning & Improvement
C difficile 50 cases reported for April –June 2026. This is 8 less than the equivalent period 2025/26. This is a HB rate of 33.33 per 100,000 population	Enhanced proactive cleaning started within NHH and GUH wards 1 ward environmental upgrade at Royal Gwent Hospital Ongoing QI project Submit a poster for C difficile learning event 09/06/25	Timely isolation at community ward within RGH due to enhanced care Ongoing vacancies and sickness within facilities team Capacity to allow for full ward decant cleans 2 wards clusters identified with geno sequencing.	Checking of mattress and decontamination of near patient equipment HPV cleaned in response to PII IPC advice.
Staph Aureus blood stream infections (MRSA/MSSA) 48 cases (MRSA and MSSA) reported for April – June 2026. This is 9 more than the equivalent period 2025/26. This is a HB rate of 32.00 per 100,000 population	Erase developed for the cleaning of patient skin prior to venepuncture Engagement from 2 medical wards to start QI for line care currently in the process of scoping staff knowledge ANTT paper developed with a recommendation to re-establish ANTT working group. Divisional data included in May dashboard	1 CAI MRSA linked to community acquired wound infection Recall of skin prep products for cannulation associated with heat impact ESR job profiles not linked to ANTT competency requirement making reporting re ANTT compliance difficult. Decontamination of ultrasound probes	Cleaning of skin prior to venepuncture not robust across the HB Divisions supporting the ANTT working group to review training compliance and observational audits re practice Assurance gained care packs are promoted within all TVS training, and the importance of wound hygiene etc. TVN team reviewing patient information leaflet to support best practice SOP developed with key areas outside of radiology

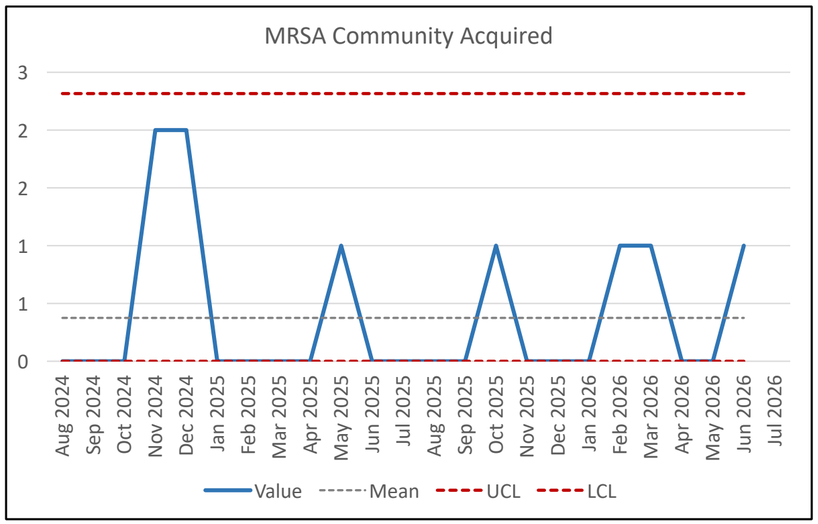
Pillar 5: Infection Prevention & Control

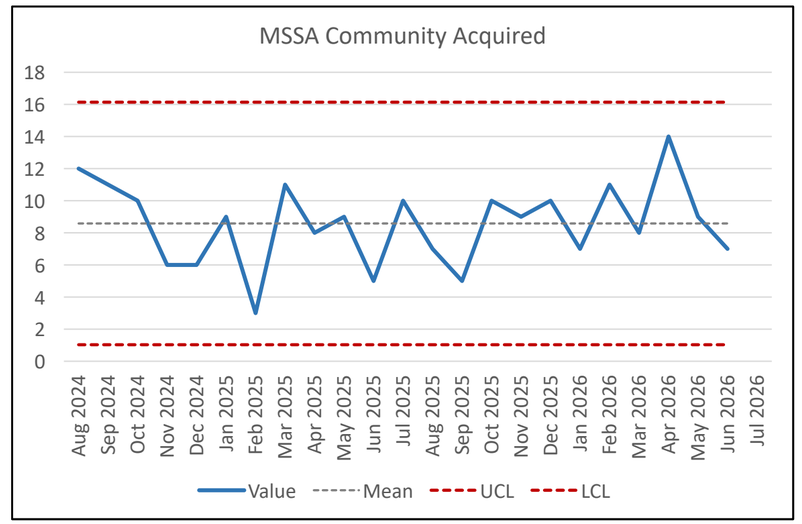








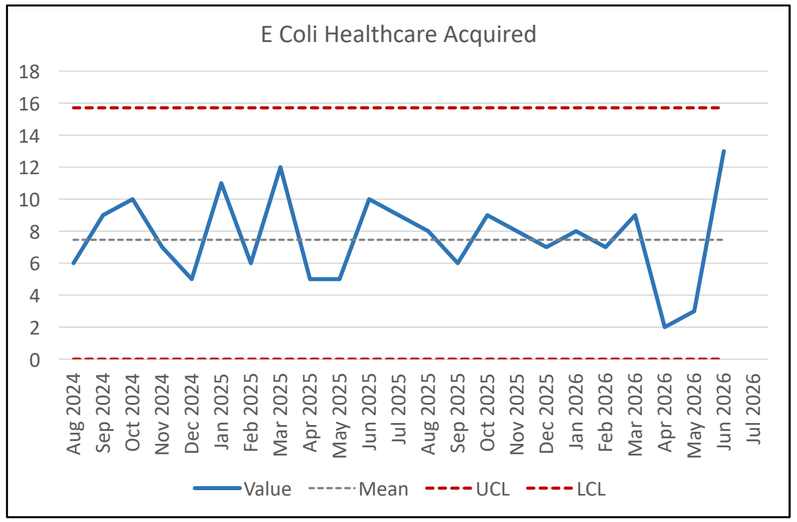


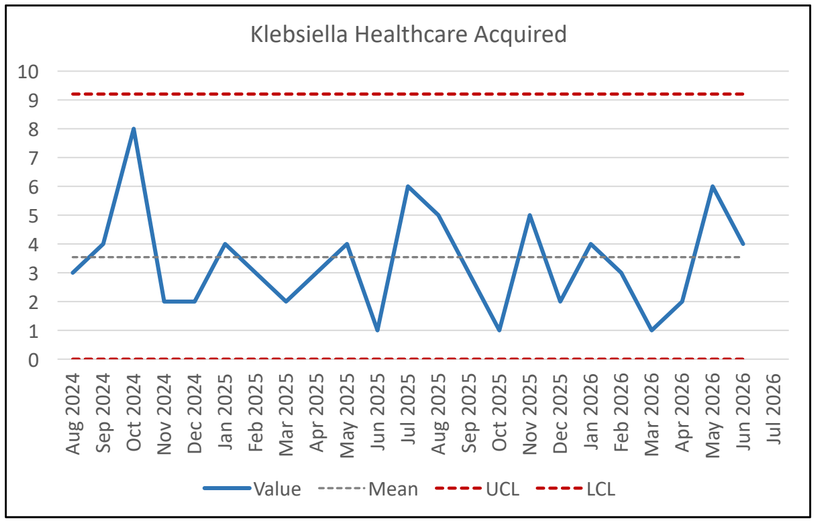


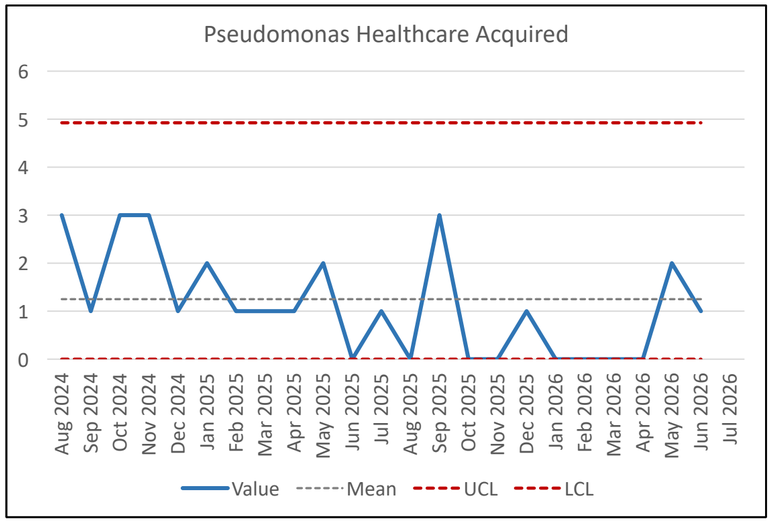
Pillar 5: Infection Prevention & Control

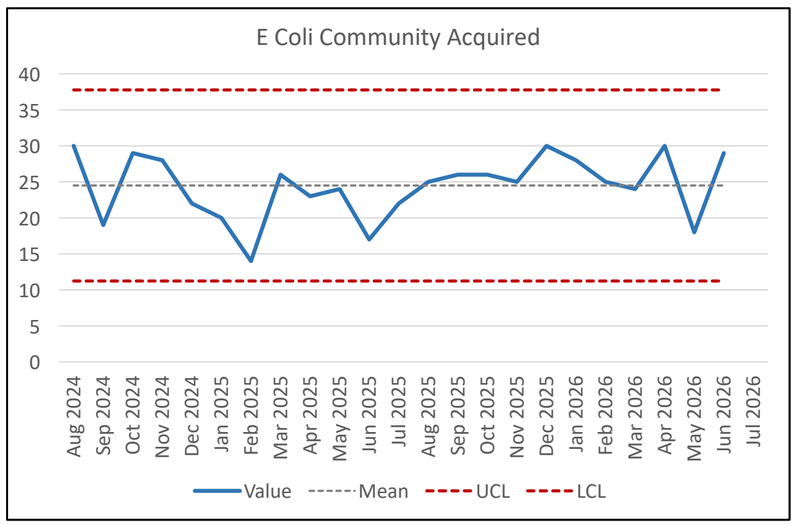
Themes & Trends	Successes	Challenges	Learning & Improvement
Gram Negative blood stream infections 96 cases of **E coli BSI** reported for April –June 2026. This is 12 more than the equivalent period 2025/26. This is a HB rate of 64 per 100,000 population	Paper developed for E coli largest source urinary tract infection Currently lowest rate in Wales for E coli No clusters identified through robust monitoring	Welsh Nursing Care Record does not include the HOUNIDI care bundle Extreme Hot weather - increases risk of acute kidney injury - UTI is the largest burden of infection	Reminder of the importance of selecting correct urine sample pot to support timely treatment plan
29 cases of **Klebsiella BSI** reported for April –June 2026. This is 4 more than the equivalent period 2025/26. This is a HB rate of 19.33 per 100,000 population	No clusters identified through robust monitoring	Extreme Hot weather - potential impact on PPE compliance and procedure packs	Promotion of Wales Urinary Tract Infection Key 9 standards for management and prevention of UTI Link with care home re personal hygiene campaign
7 cases of **pseudomonas BSI** reported for April -June 2026. This is 4 less than the equivalent period 2025/26. This is a HB rate of 4.67 per 100,000 population	No clusters identified through robust monitoring	Wound infection is the largest source of infection	Promotion of patient hydration especially during warmer weather climate

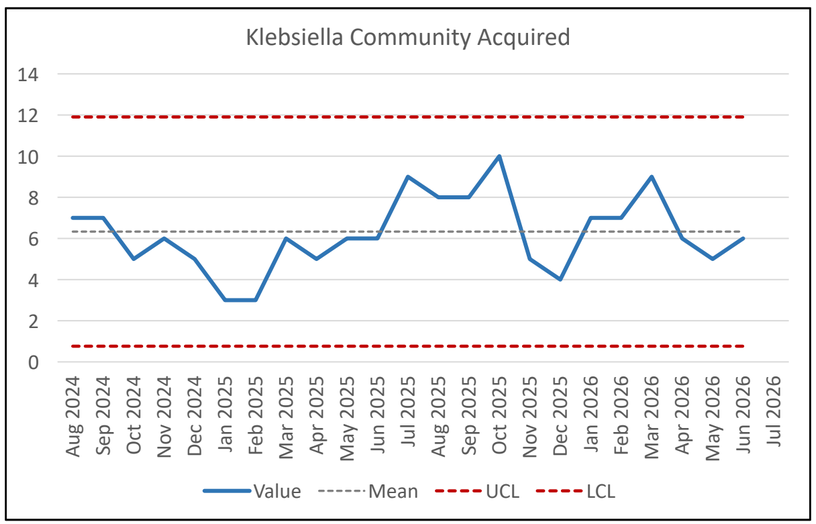
Pillar 5: Infection Prevention & Control

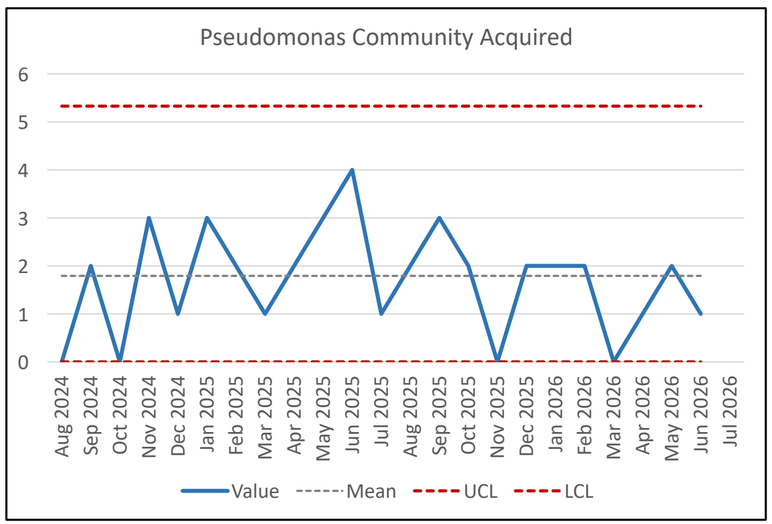










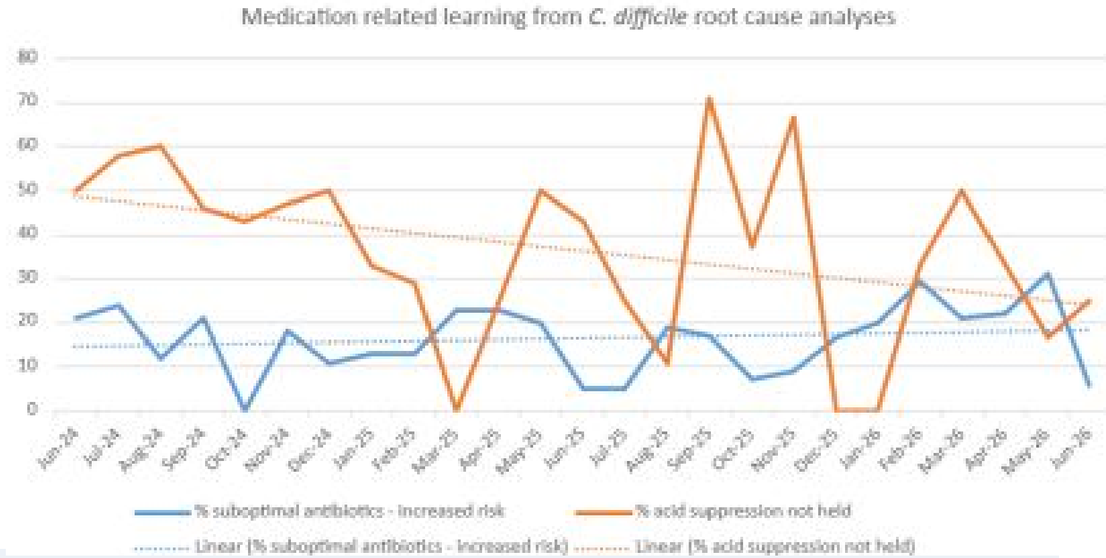


C. diff antibiotic review findings



April 26 to June 26

Antibiotic Finding		HCAI	CAI	Relapse	Indeterminate	Total
No antibiotics received	0	1	1	1	0	3
No suboptimal antibiotics	0	7	8	6	0	21
Possible suboptimal use - no increased risk	0	2	1	1	1	5
Possible suboptimal use - increased risk of C. diff	0	7	1	2	0	10
Awaiting GP response	0	0	8	2	0	10
RCA pending	0	1	1	0	0	2
Total	**0**	**18**	**20**	**12**	**1**	**51**



10 patients received suboptimal antimicrobials outside of guidelines/ Microbiology advice / culture results:

- Tazocin (piperacillin/tazobactam) prescribed for cholecystitis/liver abscess (GUH)
- Tazocin for sepsis ?source continued for 7 days (GUH)
- Tazocin for sepsis ?source continued for 7 days despite PMHx C. diff, although reviewed by micro once escalated to ICU (GUH)
- Repeated courses of tazocin, although several in line with microbiology advice (GUH/NHH)

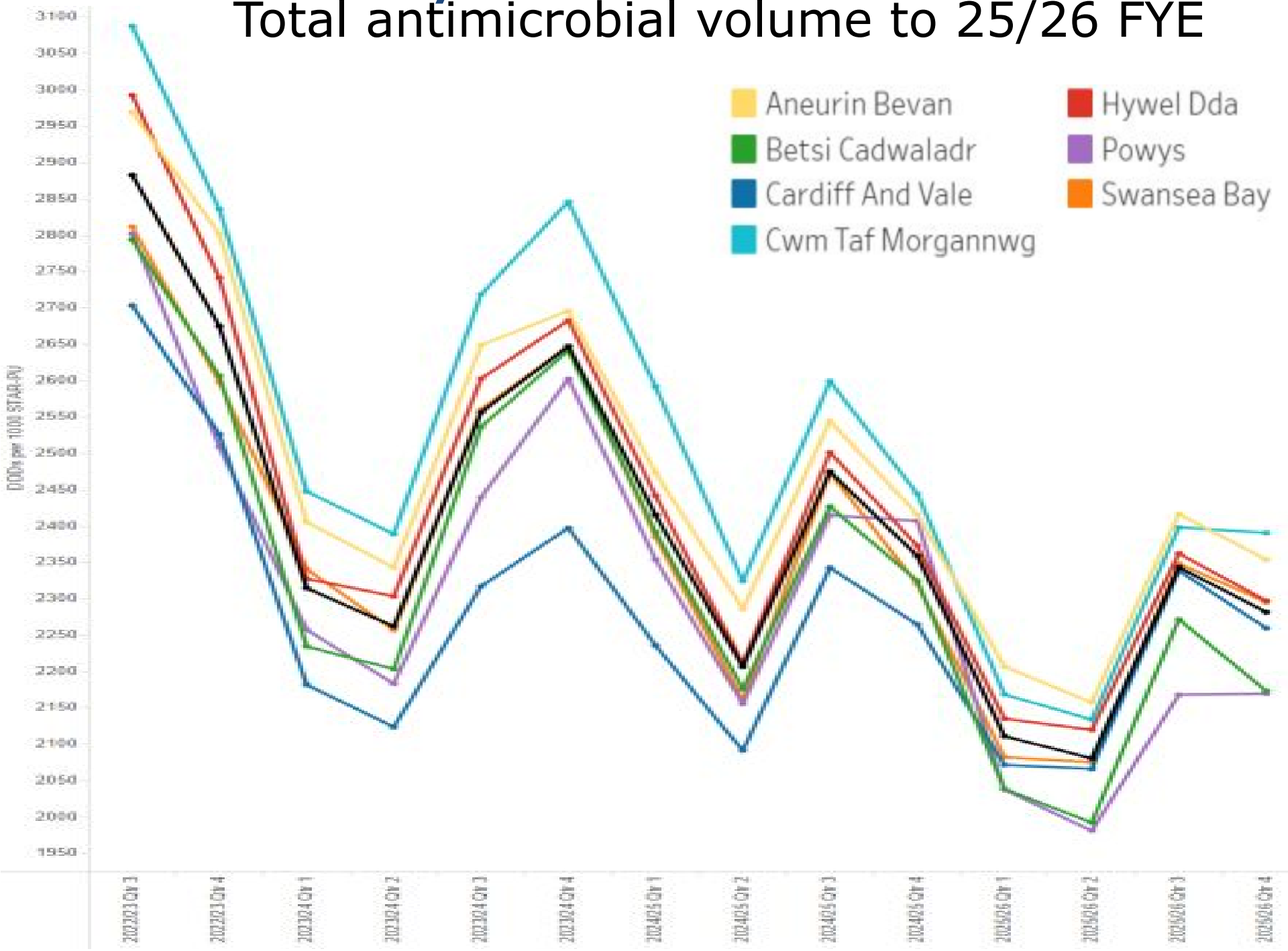
Definition	Analysis	Implications
Patients should not receive antimicrobials outside of guidelines, microbiology advice or culture results, unless good clinical justification.	Increasing proportion of patients receiving suboptimal antibiotics in April/May, N.B. numbers small, and in context of reducing case numbers. Theme around of piperacillin/tazobactam	Individual case learning fed back to relevant teams. Overuse of piperacillin-tazobactam plan being drawn up, in response to RCA findings & results of Nov 25 point prevalence survey & piperacillin/tazobactam audit results, to include: • Audit in targeted areas (guided by high usage) & feed back RCA themes alongside audit findings • Undertake 'attitudes and knowledge of resistance' survey • Tie into divisional assurance work, with divisions & directorates taking ownership of AMS

WG Tier 1 Antimicrobial Targets: Primary Care volume

Total antimicrobial volume trajectory



Total antimicrobial volume to 25/26 FYE

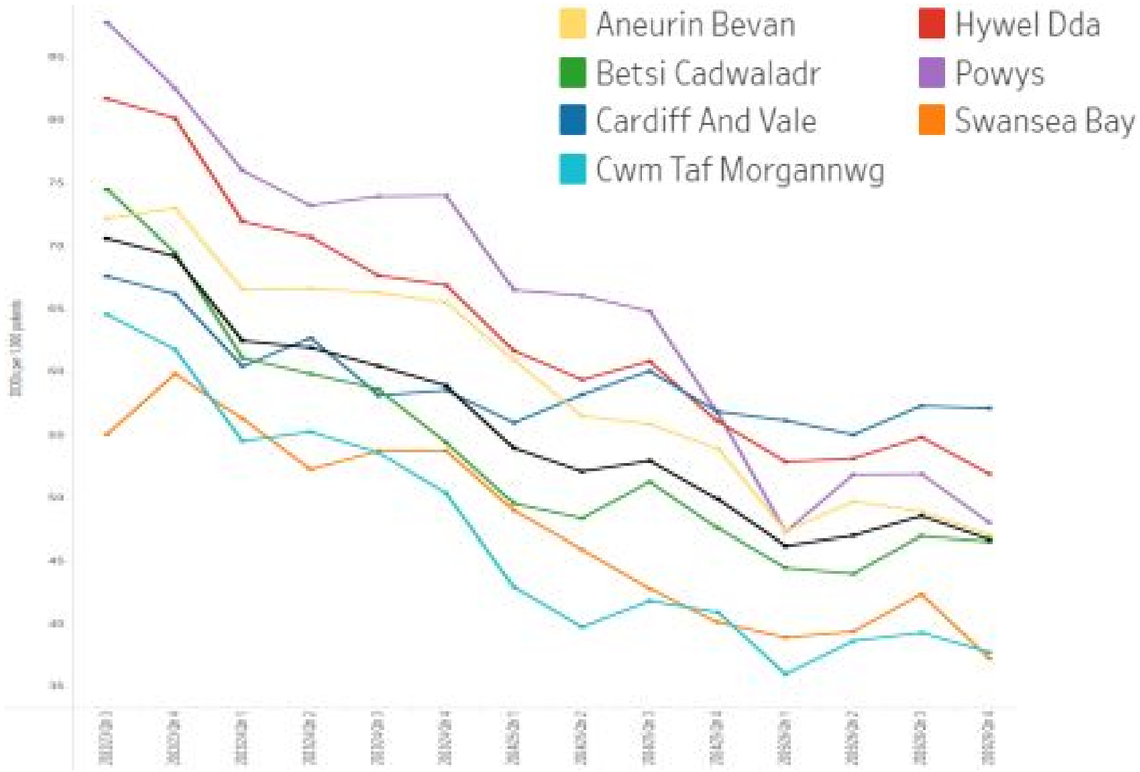


Definition	Analysis	Implications
Target: Reduction in total antimicrobial volume by a minimum of 10% by 2029/30 against 2019/20 baseline (measured in defined daily doses (DDDs) of antibiotics/1000 STAR-PUs)	Data demonstrate a reduction ahead of target. ABUHB remains above the all-Wales average, but is tracking the national trend.	New approach being taken for 2026/27 cost effectiveness prescribing programme (incentive scheme) requesting practices to audit their prescribing and identify opportunities to reduce. This will temporarily replace the pharmacist-led practice audit & feedback cycles, in an attempt to scale up work to reduce prescribing. Associated education will focus on occasions when antimicrobial use can be avoided to drive further reductions. Vacancy pending scrutiny

WG Tier 1 Antimicrobial Targets: Primary Care 'access' use



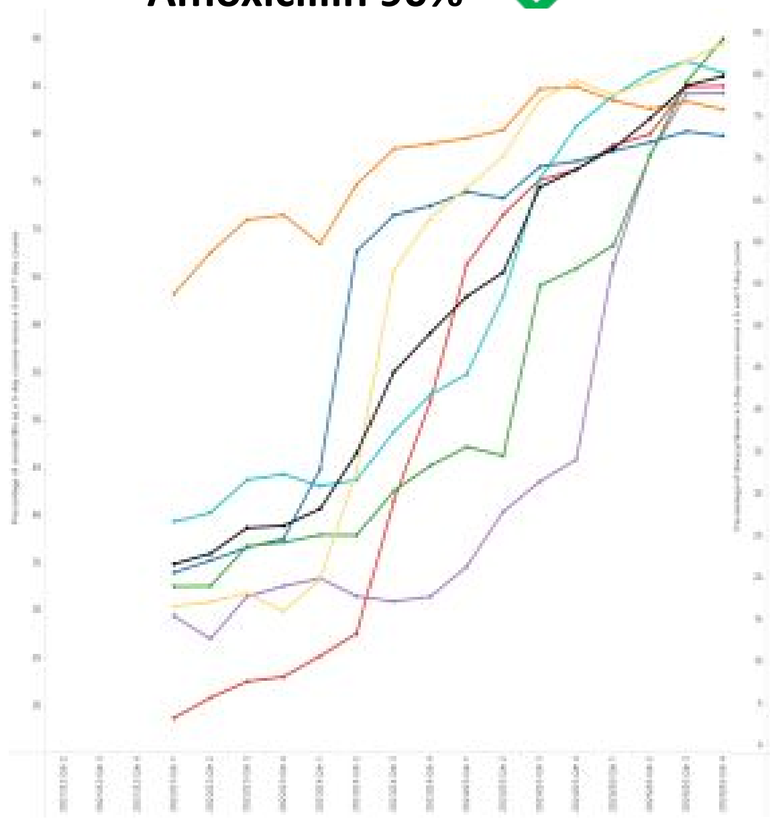
4C antimicrobial volume to 25/26 FYE



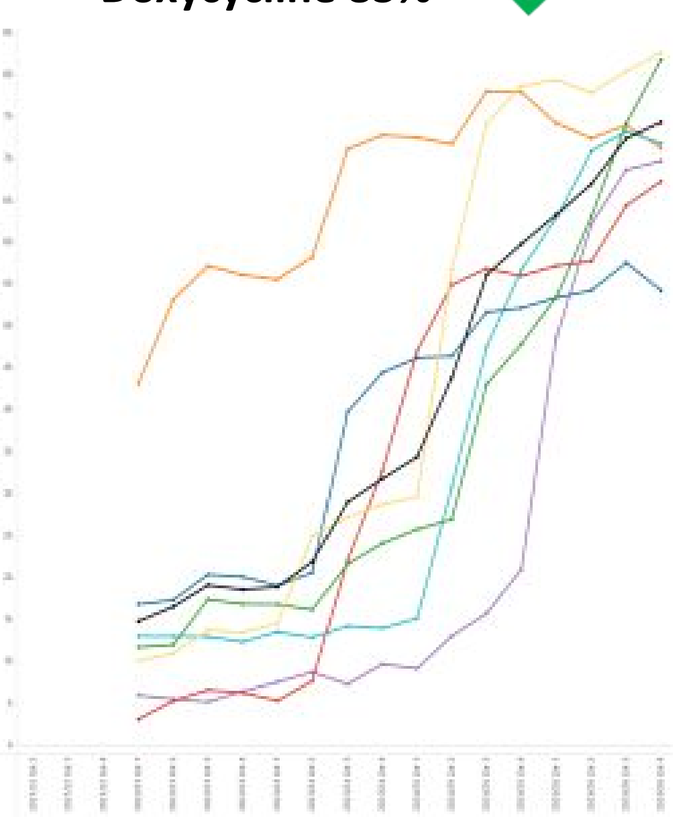
Definition	Analysis	Implications
Target: Minimum of 70% of total antibiotic use from the WHO 'Access' category by 2029/30, measured in defined daily doses (DDDs).	The left-hand graph demonstrates a move away from target, having previously achieved >70% access use. The graph on the right demonstrates a further reduction in use of higher-risk '4C' antimicrobials to the all-Wales average (and significantly below the English average). A reduction in these agents will produce a corresponding increase in the proportion of lower-risk 'access' antimicrobials.	Agreement has been reached at a four nations level to remove methenamine, a urinary antiseptic that has previously been included in figures, from calculations. Recalibrated positions are awaited from PHW, but it is likely to see ABUHB achieving this target.

WG Tier 1 Antimicrobial Targets: Primary Care durations

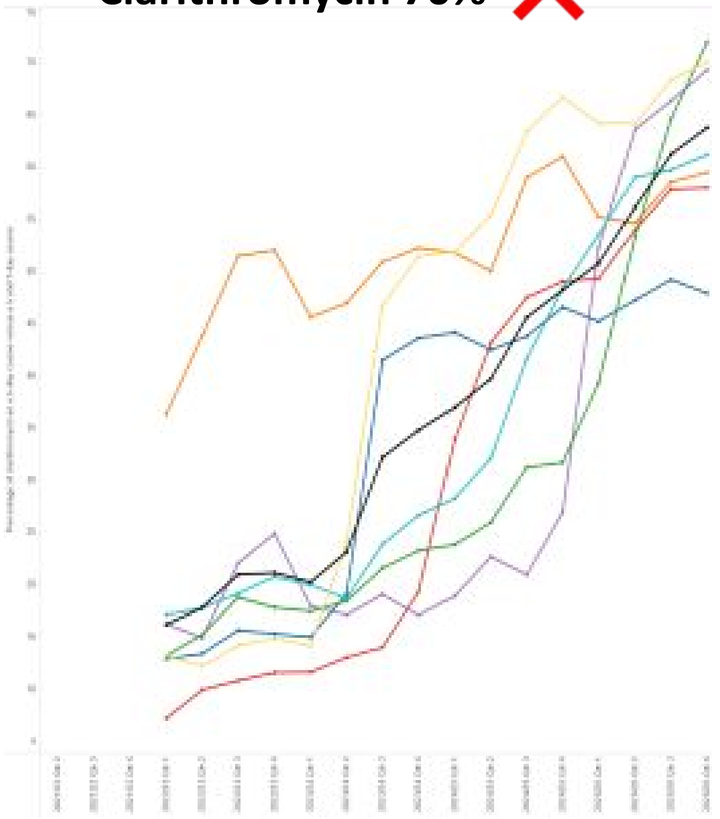
Amoxicillin 90% ✓



Doxycycline 83% ✓



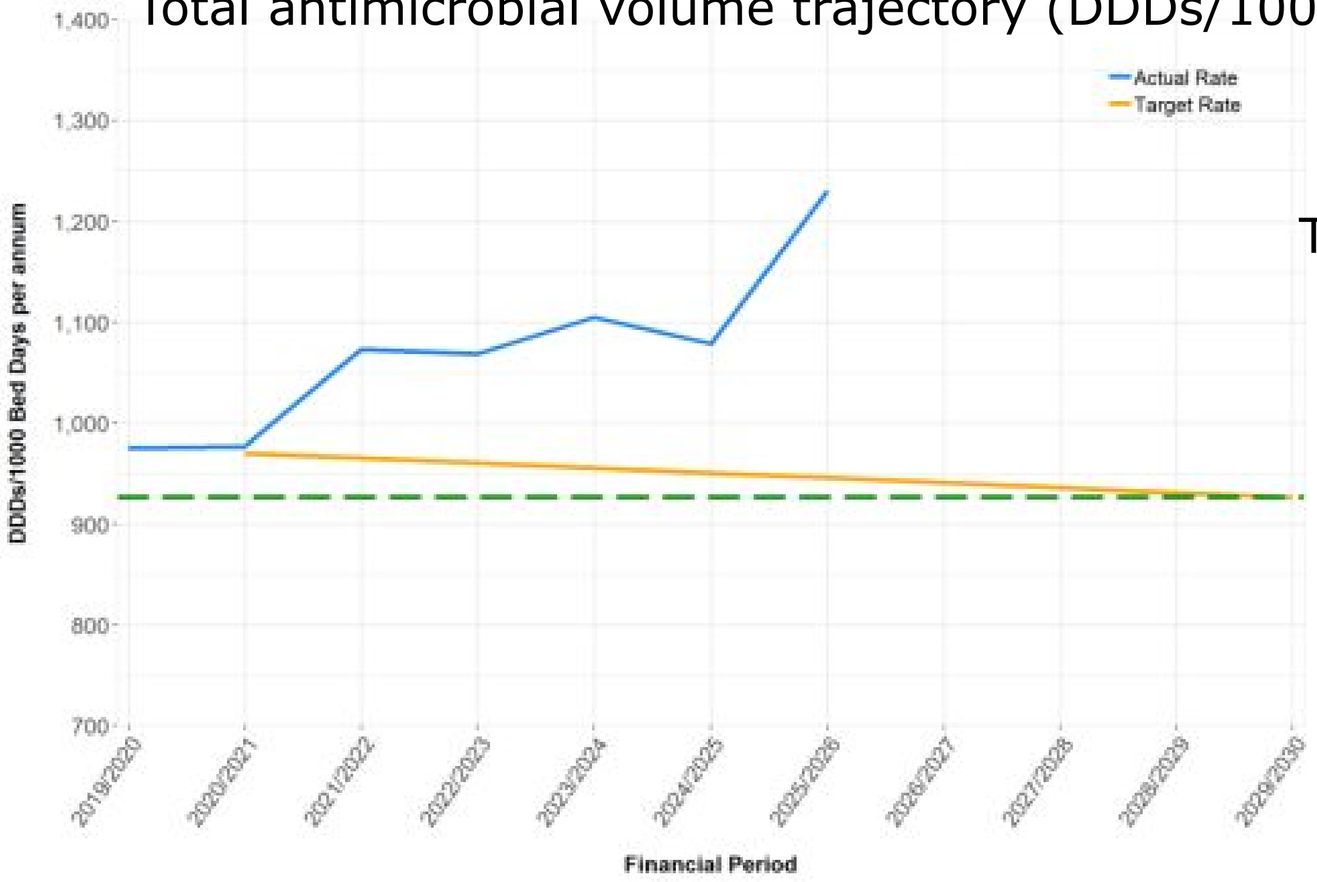
Clarithromycin 70% ✗



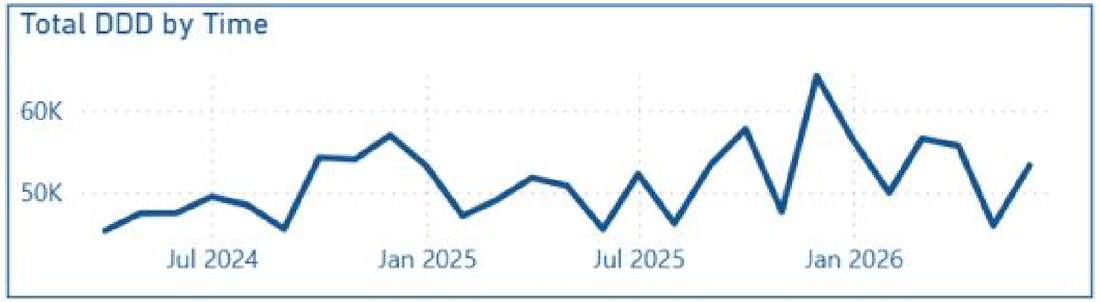
Definition	Analysis	Implications
Target: minimum 75% prescriptions should be as a 5-day duration versus a 7-day duration for 3 key antimicrobials	Progress has been made for all three antibiotics, but has not yet achieved the 75% threshold for clarithromycin. Amoxicillin and doxycycline are most commonly prescribed than clarithromycin, but work is planned to improve uptake of this messaging for clarithromycin.	Further work is required to improve adherence to clarithromycin short courses. Targeted work with a limited number of localities would likely lead to ABUHB achieving the target, but is currently limited by staff sickness. This target is included in the 2026/27 cost effectiveness prescribing programme (incentive scheme) to drive further improvement.

WG Tier 1 Antimicrobial Targets: Secondary Care volume

Total antimicrobial volume trajectory (DDDs/1000 Bed Days)

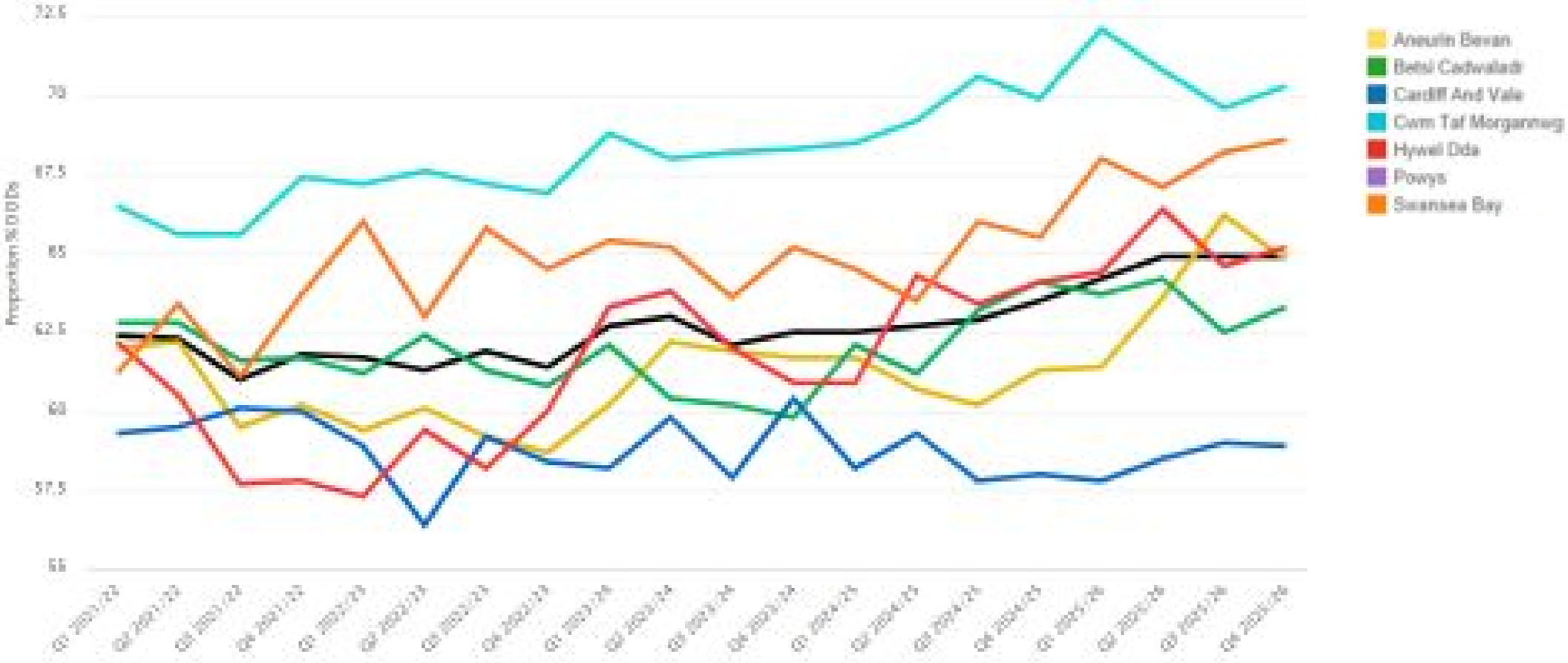


Total antimicrobial volume (DDDs): local data



Definition	Analysis	Implications
Target: Reduction in total antimicrobial volume by a minimum of 5% by 2029/30 against 2019/20 baseline (measured in defined daily doses (DDDs) of antibiotics/1000 bed day)	PHW FYE 25/26 data (left) demonstrate an increase in volume from baseline and away from target trajectory. Whilst other HBs have seen increases rather than the desired decrease in volume, ABUHB remains the highest outlier in this regard. In-house data (right) show no dramatic increase & continues to reinforce the discrepancy between local & PHW data.	The in-house data issues have not yet been resolved for historic data but have been resolved for all new data including May 2026 and after. The new Lead Antimicrobial Pharmacist for Secondary Care started in April, with the new Antimicrobial Data Analyst commencing in May. Initial priorities have been pre- and post-ePMA implementation data to assess the effect of the hard stop of antibiotics at 72 hours, and overuse of piperacillin-tazobactam identified in previous *C. diff* root cause analyses.

WG Tier 1 Antimicrobial Targets: Secondary Care 'access' use

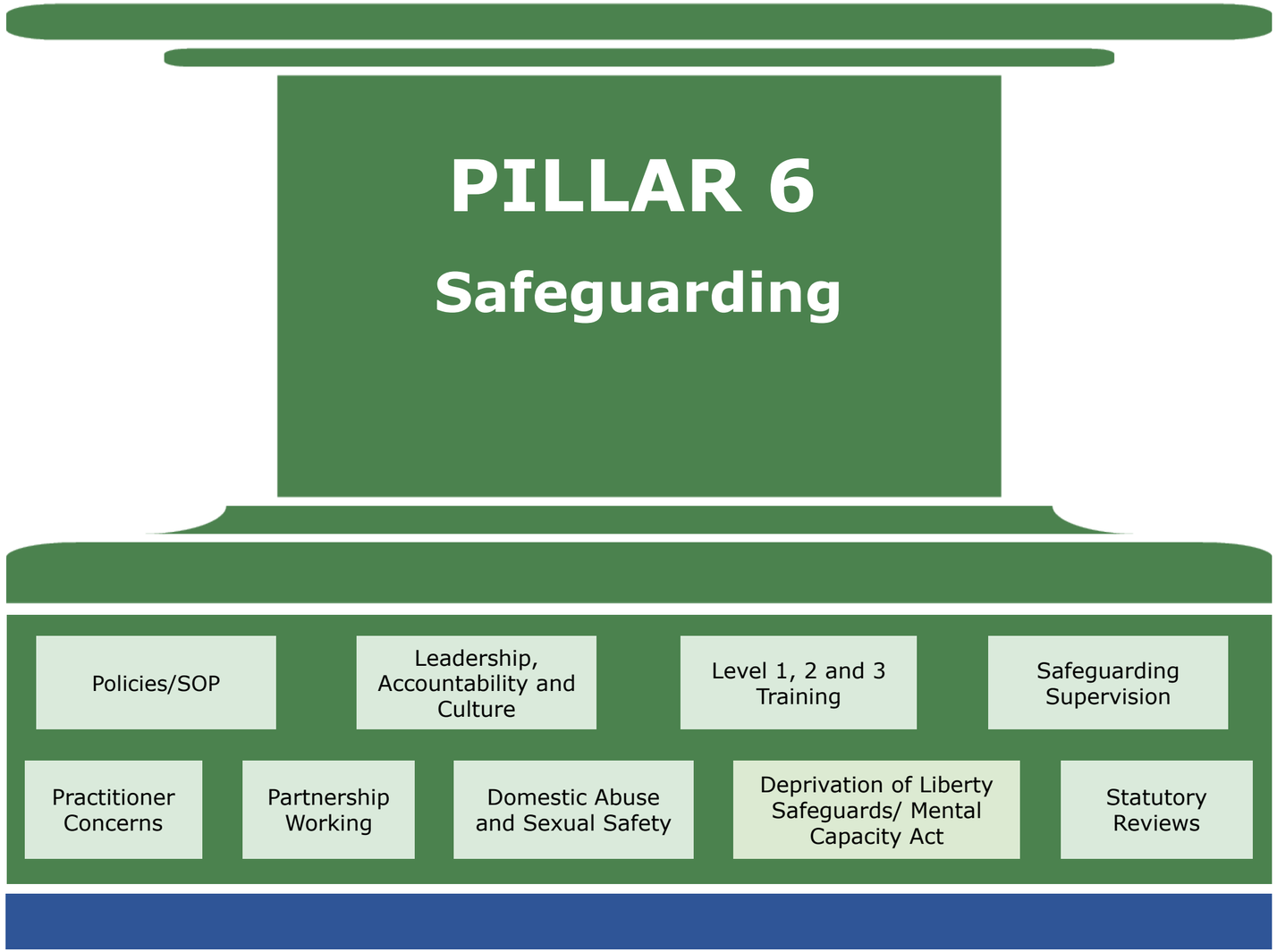


Definition	Analysis	Implications

▪ **Target: WHO 'Access' category – minimum of 70% of total antibiotic use from the Access category by 2029/30, measured in defined daily doses (DDDs).**	ABUHB appears to have improved performance over the last FY, however due to data integrity concerns, this should be interpreted with caution.
	
	In spite of this perceived increase, ABUHB has still not yet achieved the target.
		▪ The decision for electronic prescribing to go live without a hard stop removes the current requirement for antibiotics to be re-prescribed after 72 hours if they are to continue.
		  ▪ The replacement soft stop does not necessitate action by the prescriber, unlike the current paper chart
		  ▪ This is likely to lead to a deterioration in prescribing quality that will impact both secondary care targets
		
		▪ Addressing piperacillin/tazobactam prescribing will assist in moving towards target

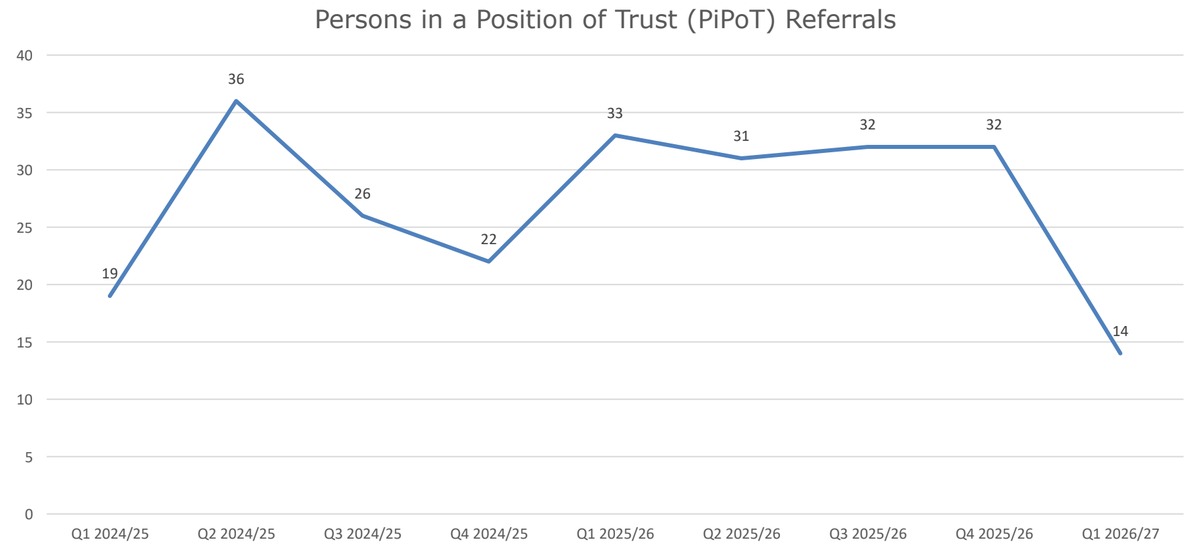
WG Antimicrobial Performance Overarching Actions

Themes	Successes	Challenges	Learning & Improvement
Improvement in primary care antimicrobial volume	Influencing CEPP (GP incentive scheme) to include another antimicrobial audit in 26/27	Easy wins completed. Further reductions become incrementally harder. Blaenau Gwent remains an outlier & not engaging with current offers of support	New report for NCN leads trialled to improve visibility – feedback awaited
Secondary care antimicrobial volume not reducing	ePMA configuration to include order sets (standard prescriptions) complete.	Loss of ARK hard stop functionality that mimics current paper charts is anticipated to detrimentally affect antimicrobial stewardship	
Antimicrobial Stewardship team staffing	Lead Antimicrobial Pharmacist for Secondary Care and Band 5 data analyst posts recruited. Team should reach establishment May 2026	New starters will require significant training before benefits are realised. Requirement for Antimicrobial Pharmacy team to measure impact of change to soft stop on electronic prescribing further limits team capacity	Remaining team attempting to maintain core activities, e.g. antimicrobial ward rounds, C. diff root cause analyses and query answering as far as possible
Theme around use of piperacillin/tazobactam outside of guidelines/culture results/microbiology advice on *C. diff* RCAs	Guideline changes completed to provide alternatives for common presentations, e.g. infection of unknown origin	Lack of capacity to address over next quarter	Point prevalence survey undertaken November 25 to assess piperacillin/tazobactam prescribing; results awaited from PHW

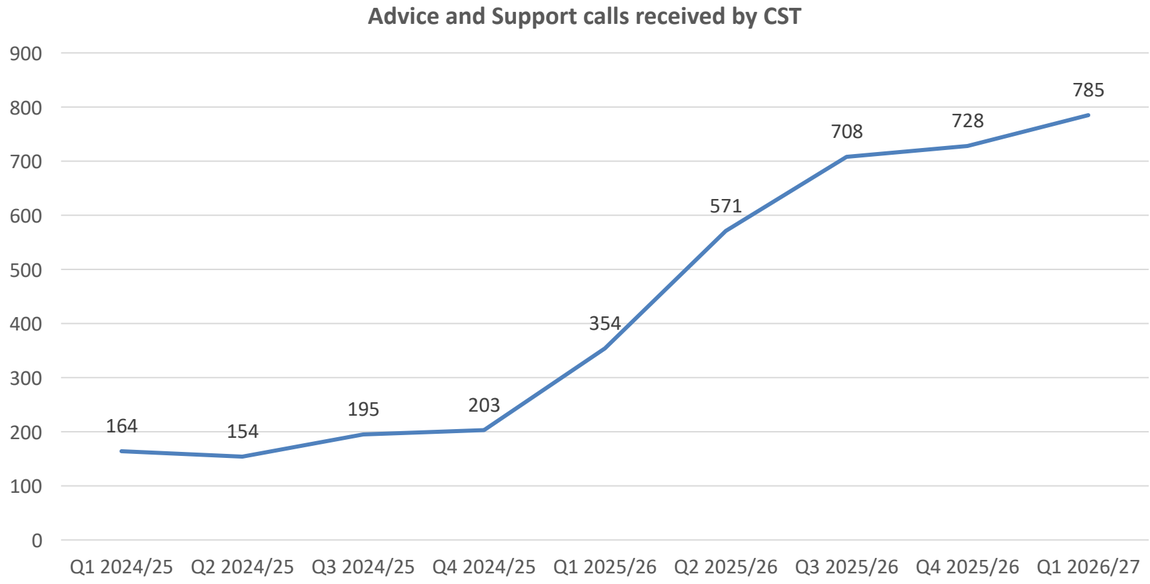

PILLAR 6
Safeguarding
Policies/SOP
Leadership, Accountability and Culture
Level 1, 2 and 3 Training
Safeguarding Supervision
Practitioner Concerns
Partnership Working
Domestic Abuse and Sexual Safety
Deprivation of Liberty Safeguards/ Mental Capacity Act
Statutory Reviews

Pillar 6: Safeguarding

Practitioner Concerns

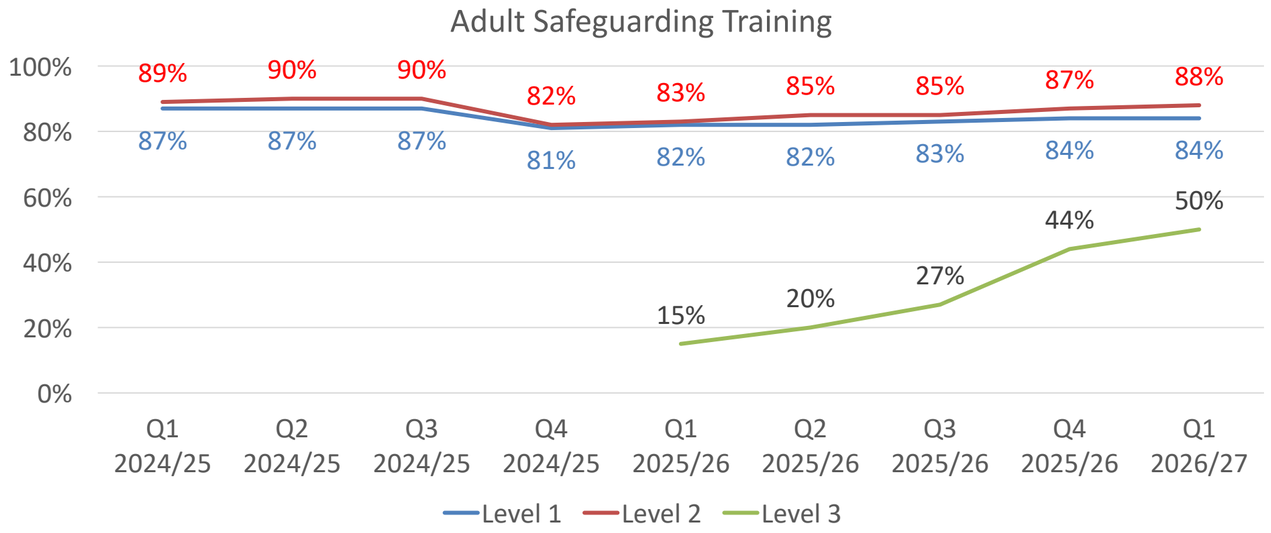


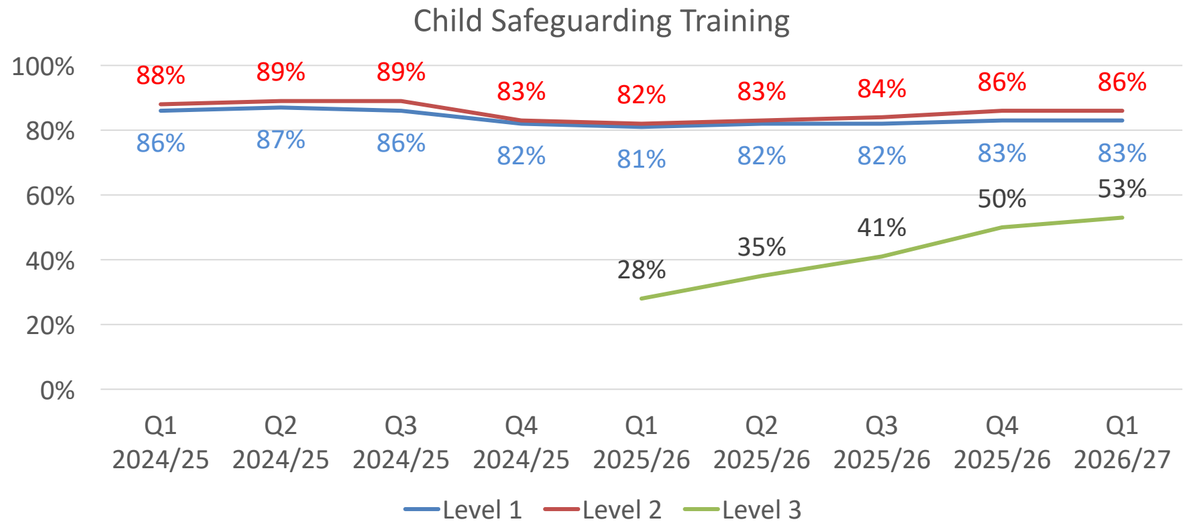
Support and Advice



Definition	Analysis	Implications
The information presented has been extracted from RL Datix and is accurate at the point of recording. This information relates to cases where staff, volunteers or independent contractors have been referred into the Section 5 Process of Wales Safeguarding procedures, which focusses on assessing transferable risk and co-ordinating investigations.	The number of PiPoT referrals declined in Q1 to 14, compared to the quarterly average of 27. Of the 14 referrals made Primary Care (5) and MH&LD (4) made up the majority of referrals. Advice and Support calls have steadily increased since their introduction, allowing Health Board staff to received specialist early interventions, advice and support.	The persistence of concerns relating to intimate examinations highlights the need for strengthened guidance, assurance, and learning. Joint work between Safeguarding and Patient Experience teams has resulted in the development of a toolkit relating to intimate examinations, which is currently awaiting approval. Once approved, this is expected to support improved practice, consistency, and patient experience, and to mitigate future risk in this area.

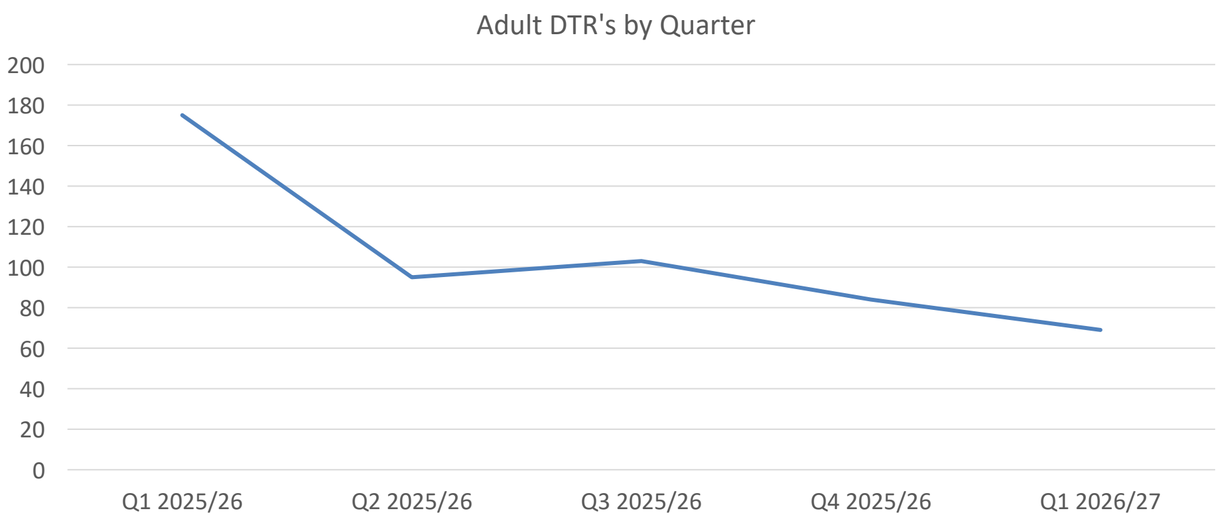
Training Compliance

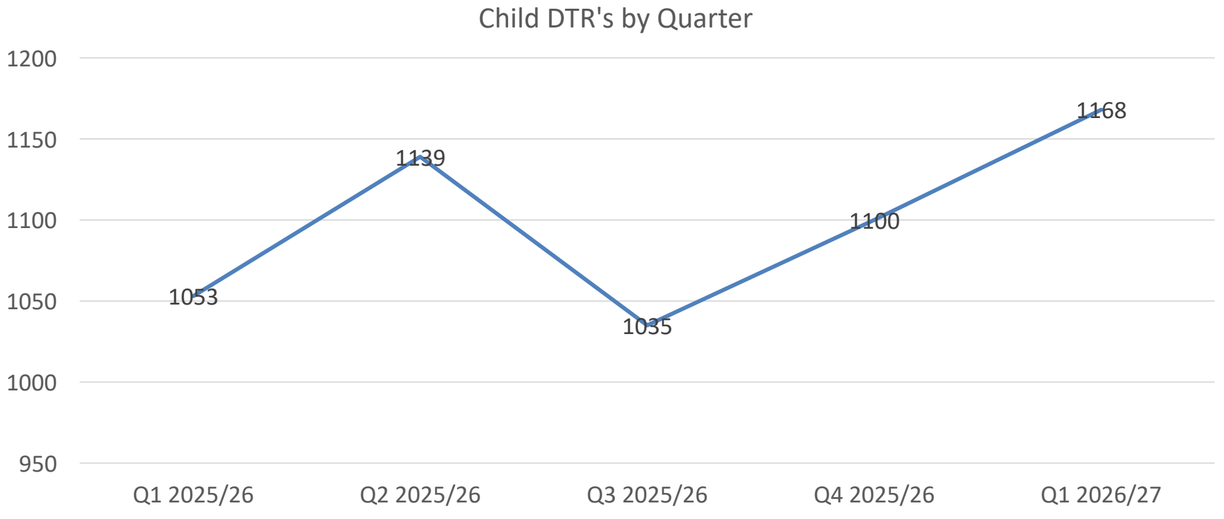


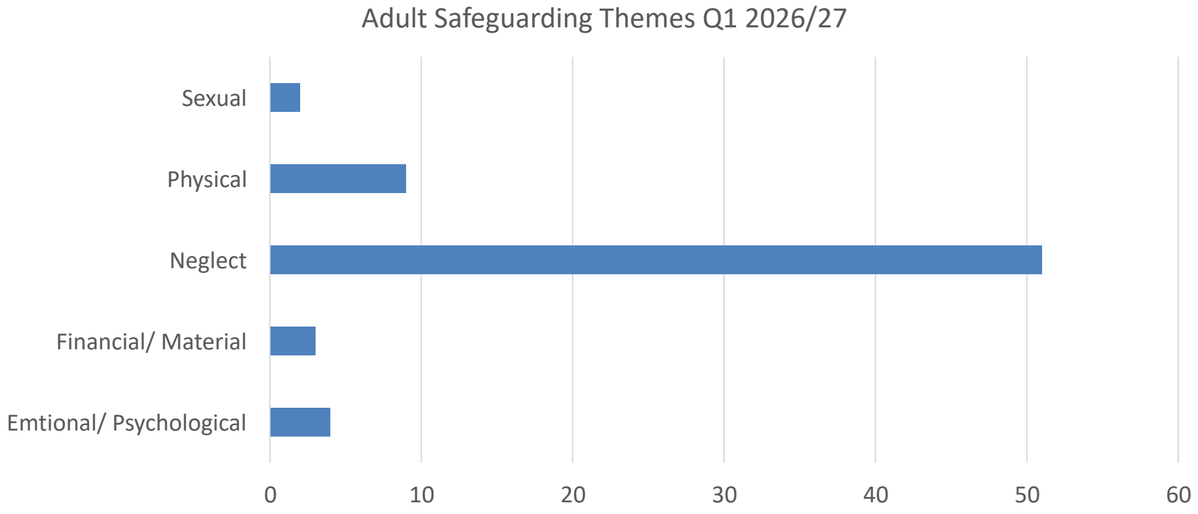


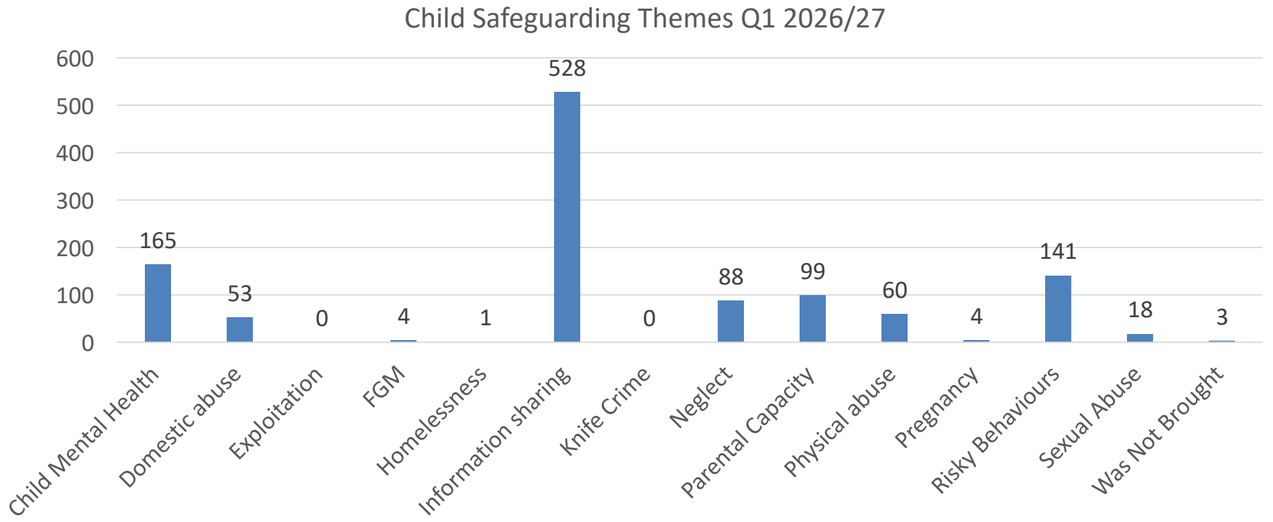
Definition	Analysis	Implications
The information presented has been extracted from ESR and was accurate at the end of Q1. This information relates to Compliance with the three mandated levels of Safeguarding Children and Safeguarding Training. Safeguarding training continues to be provided and monitored, in line with the recommendations of the Intercollegiate Documents for Safeguarding of Children and Adults.	Safeguarding training across all levels in both adult and children has either stayed the same or improved. Level 1 Adult and Child is just below the Welsh Government 80% target. Safeguarding level 3 which was introduced in Q1 2025/26 has seen consistent improvements since its introduction.	Improved Divisional support and attendance at Safeguarding Strategic Group is noted and welcomed. Children's safeguarding training remains below the expected compliance of 85%. Divisional support with groups has improved and monitored in the Children and Young People's sub group. Over 6000 staff in total require training for adult safeguarding level 3 training. Staffing to deliver training and attendees has been challenging however recovery plan has been implemented and increases are continuing. Training is now monitored on a monthly basis and reported on. Divisional support from member of the Safeguarding Strategic Group and sub groups has been sought and support with the recovery plans have been agreed.

Duty to Report

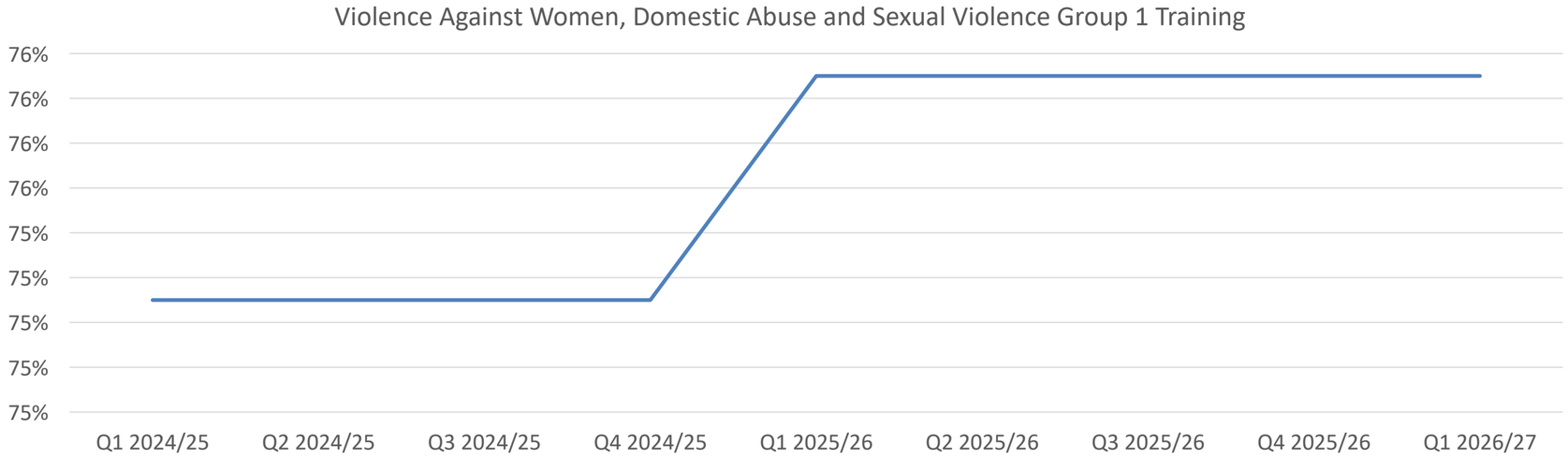






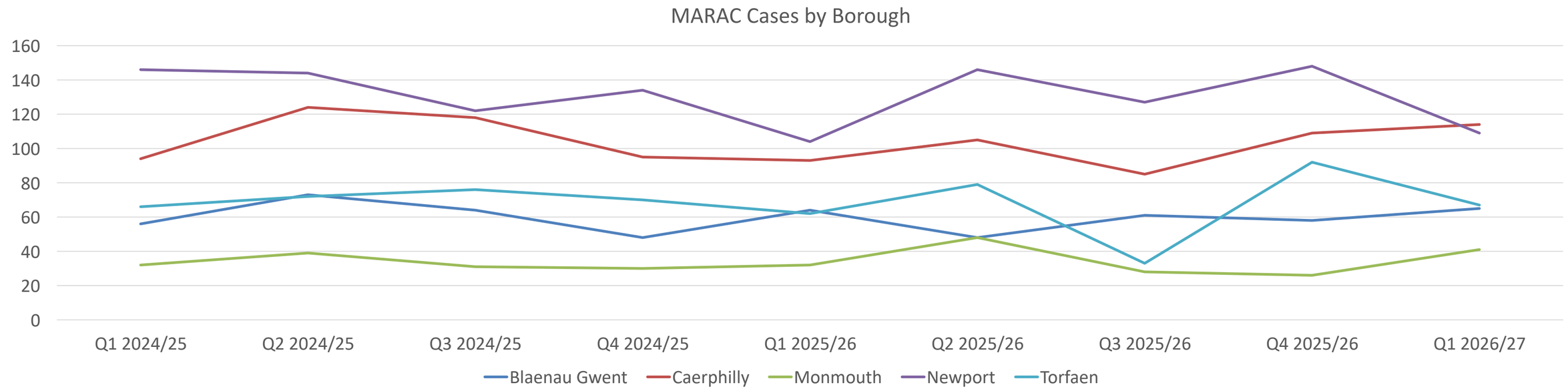


Violence Against Women, Domestic Abuse and Sexual Violence Ask and Act Training



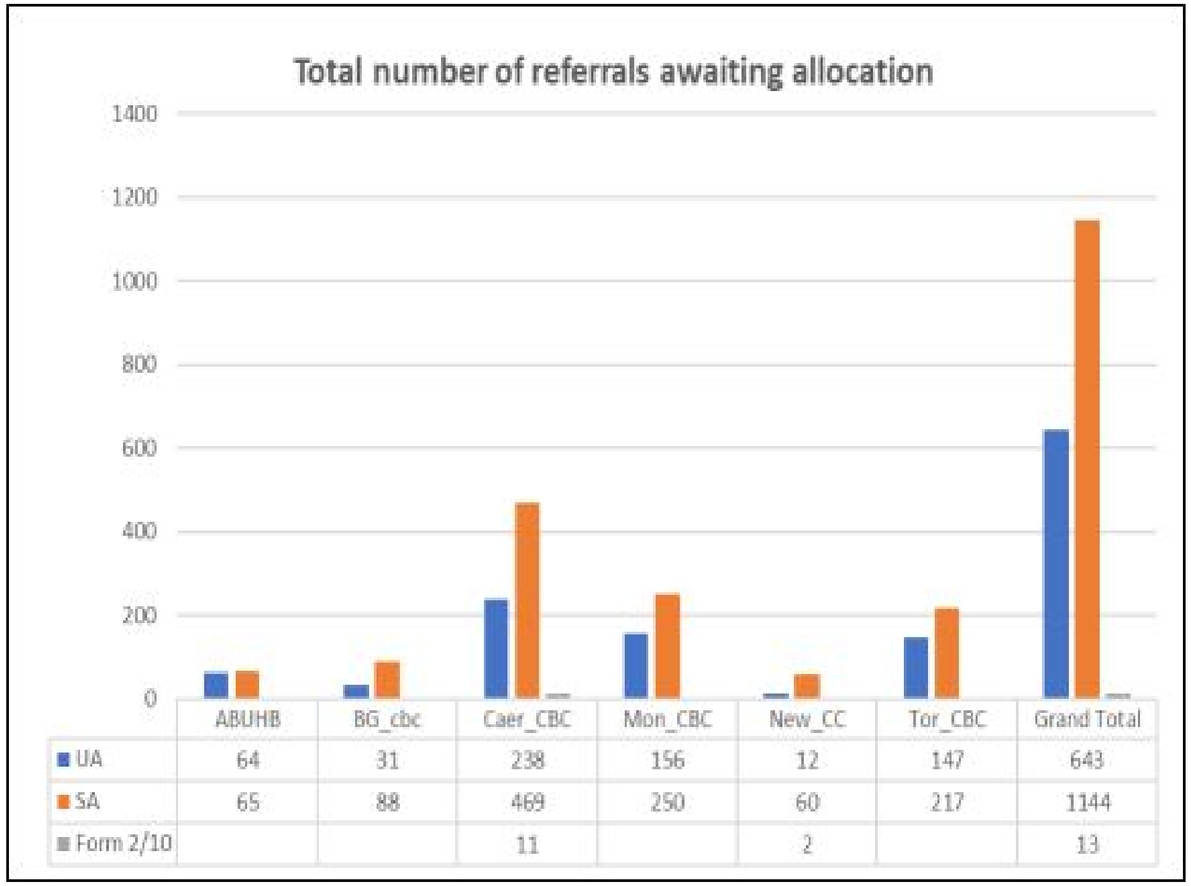
Definition	Analysis	Implications
Training Data was extracted from ESR and reflects compliance with the online national mandated training MARAC Data was taken from locally held Spreadsheets, as the RL Datix Module does not yet support MARAC Group 1 is completed online, via e- learning and is mandated to all staff working within the health board. Group 2 is targeted training, aimed at staff who will be working with patients who may have experienced VAWDASV.	Completion of Ask and Act training contributes to the Health Board's safeguarding arrangements and supports early identification, intervention and protection of individuals experiencing violence, domestic abuse or sexual violence	**Ask and Act** is a statutory training programme under the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015. The training equips staff with the knowledge, skills and confidence to recognise indicators of domestic abuse, sexual violence and other forms of violence against women, undertake appropriate targeted enquiry, and ensure individuals are signposted or referred to the most appropriate support services. The programme forms part of the safeguarding agenda and supports a trauma-informed, person-centred approach to care. Training covers recognising signs and symptoms of abuse, confidentiality and information sharing requirements, risk identification, safeguarding responsibilities, and referral pathways. Staff are supported to respond appropriately to disclosures and to facilitate access to specialist services where required. The training framework consists of: • **Group 1**: Mandatory awareness e-learning for all staff. • **Group 2**: Targeted enquiry training for staff in public-facing, assessment, care delivery, managerial, HR and other relevant roles. • **Group 3**: Advanced/champion-level training for staff with specialist safeguarding or advocacy responsibilities. Completion of Ask and Act training contributes to the Health Board's safeguarding arrangements and supports early identification, intervention and protection of individuals experiencing violence, domestic abuse or sexual violence.

Violence Against Women, Domestic Abuse and Sexual Violence Multi Agency Risk Assessment Conferences (MARAC)

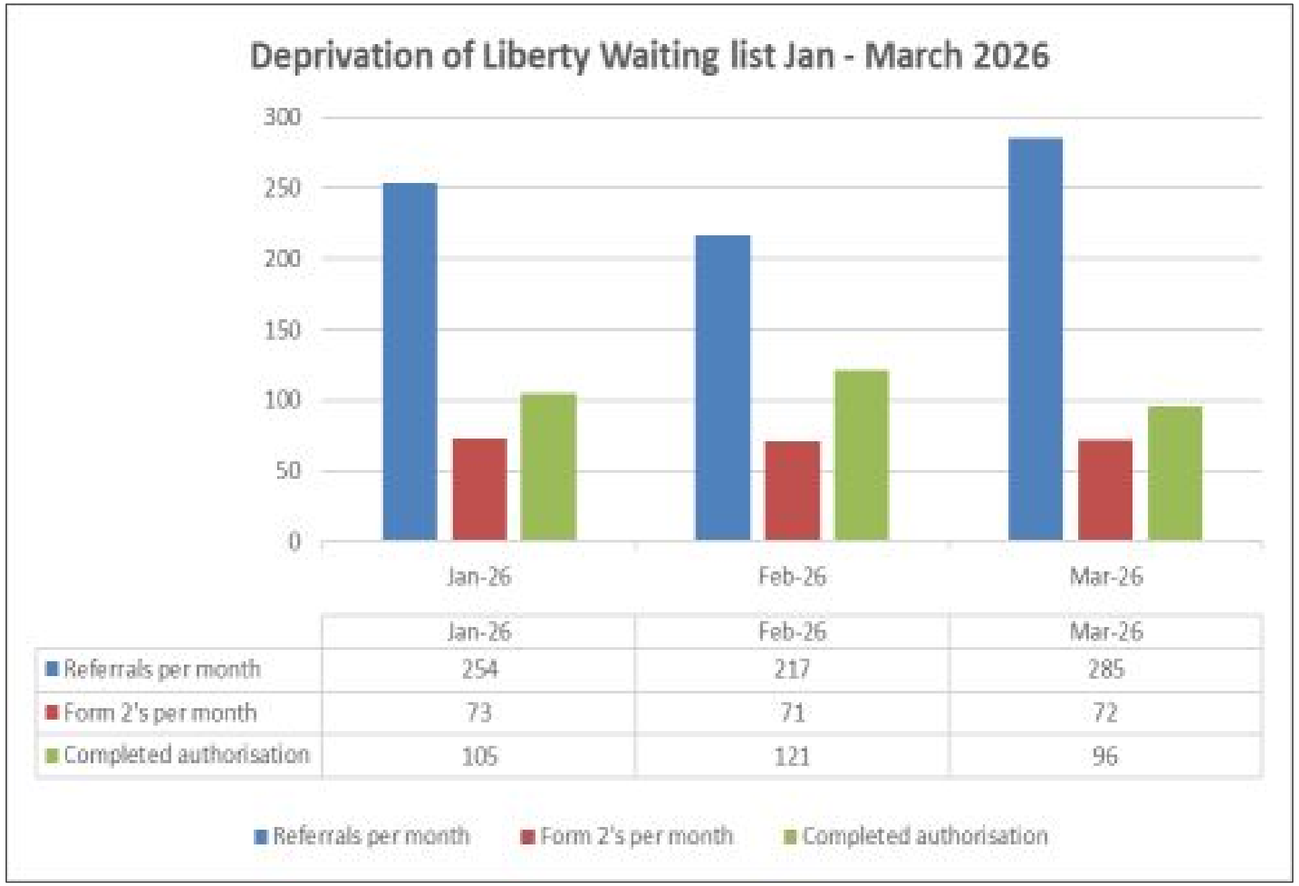


Definition	Analysis	Implications
The information presented in regard of MARAC has been extracted from MS Lists and was accurate at the end of Q3. Multi-Agency Risk Assessment Conferences, are confidential meetings where professionals from agencies share information on high-risk domestic abuse, creating safety plans for victims and their children at risk of serious harm, by combining up-to-date risk information with a comprehensive assessment of their needs.	The volume of MARAC being undertaken is relatively stable, with a small variance from quarter to quarter. This data is regularly reviewed by the Regional MARAC Steering Group and reported to the VAWDASV Board for Gwent. Whilst bit is noted that there is a variance in the volume from the five different localities, those scrutinizing the data feel that this is a reflection of what could be expected given the composition of those areas. Whilst the volume of MARAC appears to be relatively stable, the meetings are becoming longer because of more complex cases and some of the challenges posed by a reduction in third sector provision as a result of financial constraints	The increase in complexity has led to longer meetings, which are already resource intensive to support. In addition, reduction in funding of elements of the VAWDASV process can lead to increased reliance on statutory partners to provide support from within existing resources.

Deprivation of Liberty Safeguards (DoLS)



	ABUHB	BG_cbc	Caer_CBC	Mon_CBC	New_CC	Tor_CBC	Grand Total
UA	64	31	238	156	12	147	643
SA	65	88	469	250	60	217	1144
Form 2/10			11		2		13



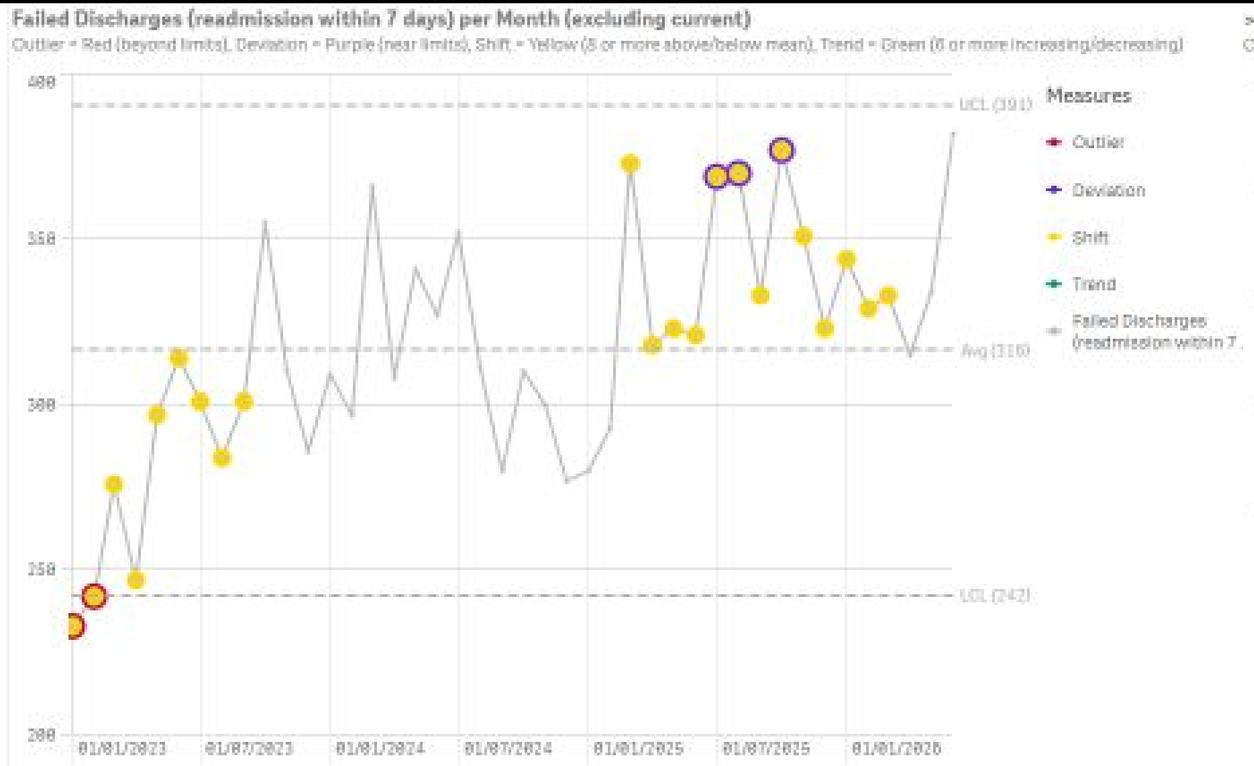
	Jan-26	Feb-26	Mar-26
Referrals per month	254	217	285
Form 2's per month	73	71	72
Completed authorisation	105	121	96

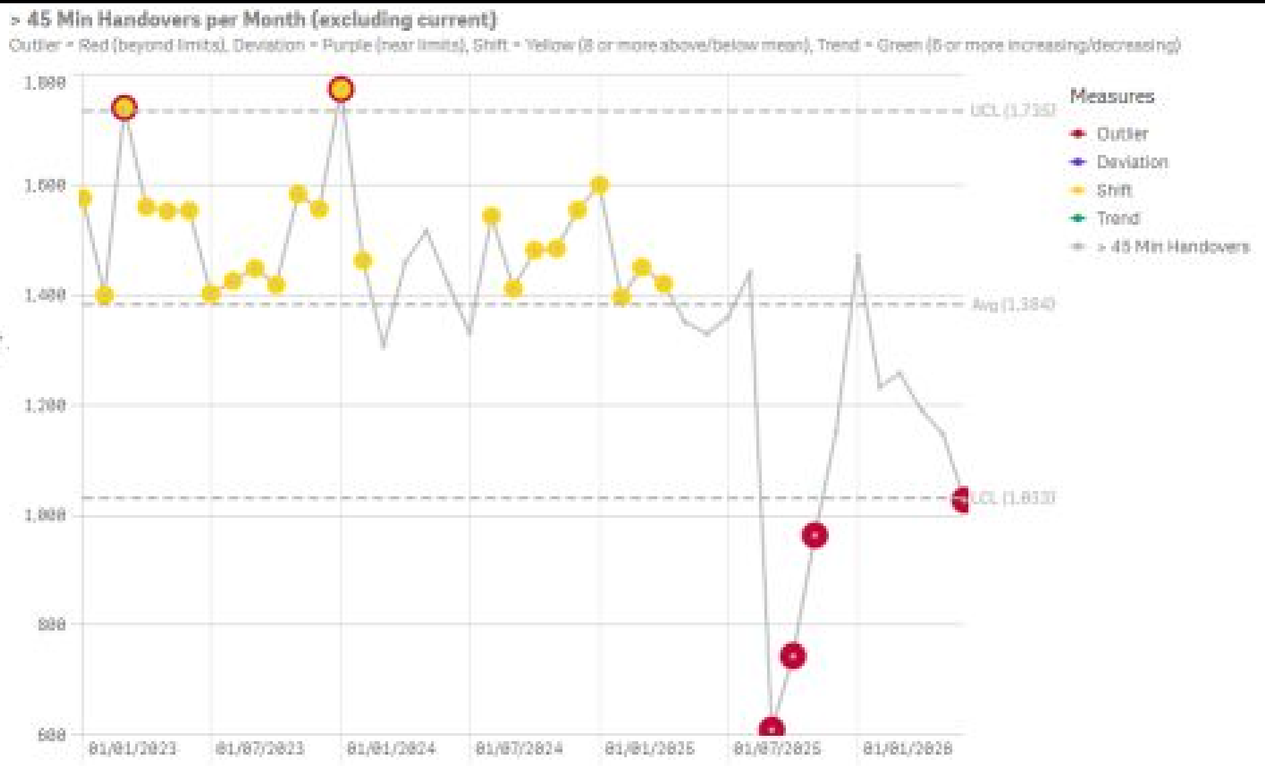
Q1 data to be updated in due course

Quality Assurance for Commissioned Services

- Commissioned services log nearing completion; Divisions currently validating content for accuracy and consistency.
- Service Level Agreement (SLA) proforma in development to ensure a consistent, tailored approach aligned to service requirements and delivery expectations.
- Small commissioning group established to focus on Children and Young People's services, acting as a pilot for potential wider rollout.
- Review of LTA data for C&YP services commissioned in Cardiff underway, supporting pathway evaluation and enhanced quality assurance.
- Development of a checklist to sit alongside the Quality Assurance Framework for Commissioned Services informed by findings from the 26-week outpatient programme report.

Additional Measures





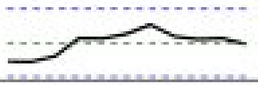
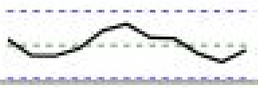
The Health Board is required to report against the WG Ministerial Priority relating to crude mortality and seven-day readmission rates. Current analysis has identified variation in the methodology, definitions and outputs across the CHKS, Qlik and Strategic Forecasting Network (SFN) datasets, resulting in uncertainty regarding the most appropriate source of assurance and the interpretation of performance trends. An internal review has highlighted the need for enhanced data assurance, clinical validation and strengthened governance arrangements before data is submitted to Welsh Government against the Ministerial Priority to achieve a **d**ownward trend in the 12-month rolling average crude mortality rate whilst maintaining a stable seven-day readmission rate.

A programme of work is currently underway to undertake a detailed review of a sample of patient records to confirm that reported seven-day readmissions represent genuine readmission events and to improve confidence in the accuracy, consistency and reliability of the data used for performance reporting and decision-making.

The Health Board has implemented a whole-system improvement programme to reduce ambulance handover delays and the associated risks to patients awaiting care in hospital and the community. This includes the Our Next Patient approach and Rapid Release Protocol, which use early clinical decision-making, designated receiving spaces, pre-emptive patient moves, timely discharge and step-down arrangements, and coordinated action across emergency, assessment, ward and community services to release ambulance crews promptly. A structured red-line escalation process provides senior operational and Clinical Executive oversight of actual or anticipated delays, with decisions, actions, outcomes and learning recorded through a digital workflow to strengthen accountability and auditability. Daily operational coordination, focused improvement activity and joint working with the Welsh Ambulance Services University NHS Trust are supported by quality and patient safety surveillance, including the review of incidents, complaints, deterioration, boarding and care in non-designated clinical areas. These arrangements have contributed to a substantial improvement in handover performance, although this remains sensitive to demand, workforce pressures, discharge activity and the availability of capacity across the wider system.

National Quality Outcomes Framework Measures
Safe

ABU UHB Safe Phase 1 Quality Outcome Framework measures

Quality Standard	Measure	Latest period	Latest figure	Target		Previous figure	Last 12 months	Outlier
Safe	Antibacterial items per 1,000 STAR-PUs	Mar-26	265.74					
Safe	Crude mortality rate (%)	Jun-26	1.37%		▲ 17.0%	1.17%		
Safe	Gabapentin and pregabalin DDDs per 1,000 patients	Mar-26	1596.96					
Safe	Never Events reported to NHS P&I	Aug-26	0		▼ -100.0%	1		
Safe	Percentage of discharges on D2RA Pathway 0	Jul-26	42.33%		▲ 0.3%	42.20%		
Safe	Percentage of discharges on D2RA Pathway 1	Jul-26	11.75%		▼ -7.4%	12.69%		
Safe	Percentage of discharges on D2RA Pathway 2	Jul-26	7.26%		▼ -18.3%	8.90%		
Safe	Percentage of discharges on D2RA Pathway 3	Jul-26	2.22%		▲ 22.1%	1.82%		
Safe	Percentage of discharges with no D2RA Pathway Allocated	Jul-26	36.43%		▲ 6.0%	34.38%		
Safe	Safeguarding Adults - Lv1 training	Jun-26	84.55%	85%	▲ 0.2%	84.34%		
Safe	Time in days since last Never Event (as of NRI module snapshot)	-						
Safe	Violence and Aggression (Wales)	Jun-26	92.03%	85%	▲ 0.8%	91.34%		

National Quality Outcomes Framework Measures
Timely

ABU UHB Timely Phase 1 Quality Outcome Framework measures

Quality Standard	Measure	Latest period	Latest figure	Target		Previous figure	Last 12 months	Outlier
Timely	Opthalmology R1 appointments attended within target date* (%)	Jul-26	49.86%	95%	▲ 0.2%	49.86%		
Timely	Patients starting first definitive cancer treatment* (%)	Jun-26	62.03%	80%	▲ 8.9%	56.98%		

National Quality Outcomes Framework Measures
Effective

ABU UHB Effective Phase 1 Quality Outcome Framework measures

Quality Standard	Measure	Latest period	Latest figure	Target	Previous figure	Last 12 months	Outlier
Effective	Coding errors corrected within 35 days of identification (%)	-					
Effective	Diabetes patients completing all eight care processes* (%)	Jul-26	49.03%	▲ 2.0%	47.12%		
Effective	Inpatient and day-case episodes fully coded within one reporting month of discharge (%)	-					

National Quality Outcomes Framework Measures
Efficient

ABU UHB Efficient Phase 1 Quality Outcome Framework measures

Quality Standard	Measure	Latest period	Latest figure	Target	Previous figure	Last 12 months	Outlier
Efficient	Agency spend for all staff groups as % of total pay bill	Jun-26	2402%	▲ 16.7%	1.73%		
Efficient	Average quantity per item prescribed from start period for the reference basket of medicines	Mar-26		▲ 0.5%			
Efficient	DPIs and SMIs as a percentage of all inhalers	Mar-26	4743.00%	80%			

Data presented is not validated and provided through the Beacon Dashboard

National Quality Outcomes Framework Measures
Equitable

ABU UHB Equitable Phase 1 Quality Outcome Framework measures

Quality Standard	Measure	Latest period	Latest figure	Target	Previous figure	Last 12 months	Outlier
Equitable	Were you able to communicate in your preferred language? (%)	May-26	95.74%	▲ 0.0%	95.72%		

National Quality Outcomes Framework Measures
Person-centred

ABU UHB Person-centred Phase 1 Quality Outcome Framework measures

Quality Standard	Measure	Latest period	Latest figure	Target		Previous figure	Last 12 months	Outlier
Person-centred	People's Experience Survey (PES) - how would you rate your overall experience?	May-26	8.30		▼ -1.3%	8.41		
Person-centred	Staff with Personal Appraisal and Development Review in last 12 months (%)	Jun-26	76.95%	85%	▼ -0.8%	77.58%		

Patient Safety Leadership Visits – Summary

Purpose:
Promote a proactive safety culture across ABUHB.

Key Aims:
Show senior leadership commitment to safety.
Identify and act on safety concerns.
Improve communication and transparency.
Support learning from adverse events.



Who's Involved:
Executive Directors, Independent Board Members, local multidisciplinary teams, and an assistant (to scribe).

Visit Format:
Informal, discussion-based (not an audit). Focused on safety concerns, teamwork, communication, and an opportunity to report any issues.

Outcome:
Key issues and actions are agreed, documented, and shared post-visit.

Patient Safety Leadership Visits

Overview – Q1 April to June 2026

Areas Visited 7

RGH

- D3 West
- Surgical High Care

Children's Centres

- Serennu
- Caerphilly
- Nevill Hall

GUH

- Maternity
- Neonatal



Cancelled Visits: 6 (rearranged for Q2)

- All cancelled visits have been successfully rearranged and rescheduled for Quarter 2.
- The primary reason for cancellation was Infection Prevention and Control (IPAC) considerations, which required visits to be postponed to ensure the safety of patients, staff, and visitors.

Key Note – Children's Centres were allocated extended time, equivalent to six ward visits, to reflect the breadth and complexity of services delivered at each site. Additional time was provided as these areas had not previously received a Patient Safety Leadership Visit. Prioritising these centres further reduced the risk of winter-related ward cancellations.

Patient Safety Leadership Visits

Positive Findings:
Children's Centres April to June 2026

- Welcoming, friendly, non-clinical environments.
- Strong multidisciplinary teamwork and collaboration between services.
- Families feel supported and value the holistic and community-based approach.
- Staff demonstrate dedication, passion, and professionalism.
- Good feedback about staff morale and supportive team culture.
- Regular operational meetings in place.
- Strong partnership working with charities, including Sparkle and Action for Children.
- Shared spaces used creatively to maximise service delivery.
- Centres provide safe, supportive environments for children with additional needs



Patient Safety Leadership Visits

Positive Findings – Maternity and Neonatal

Maternity

- Modern, purpose-built unit with improved privacy through single-bed rooms.
- Multiple care pathways offered (consultant-led, midwife-led, EPAU, post-operative, induction).
- No Never Events in the past year; previous issues resolved through strengthened protocols.
- Strong focus on patient identification and safety processes.
- Central monitoring system enhances visibility and oversight.
- Positive post-discharge feedback from families.
- No agency staff used, maintaining continuity of care.



Neonatal

- Strong family-centred approach (skin-to-skin, rooming-in, 24/7 visiting).
- Key innovations: Golden Drops, Delivery Room Cuddles, Beads of Bravery.
- First in Wales to discharge tube-fed babies with dedicated support (no feeding readmissions).
- Strong psychological and emotional support available for families.
- Two free family accommodation houses available close to the unit.
- Improved outcomes, including lower severe brain injury rates than national average.

Patient Safety Leadership Visits

Examples of Completed Actions

Children's Centres – Serennu, Caerphilly and Nevill Hall

- **First aid provision** – Issue escalated to Health and Safety; guidance and policy signposting provided, including training options to support centres in determining next steps.
- **Comparative written reports** – Combined report for all three centres completed and awaiting Executive sign-off to support consistent improvement.
- **BSL training** – Training options identified and actions progressed to improve communication with families.
- **Lockdown procedures** – Development work undertaken across sites to strengthen emergency preparedness.
- **Panic alarms** – Solutions explored and added to site action plans to improve staff safety.
- **Sink height visibility** – Raised to Health and Safety. Interim measures identified to reduce risk while long-term solutions are explored.
- **Security gate** (Caerphilly) – Gate installed to improve outdoor area safety.

Neonatal - GUH

- **Debrief sessions introduced** – Debrief opportunities are now being offered following challenging events to support staff wellbeing and shared learning.

Maternity - GUH

- **Positive patient ID checks** – Ongoing reinforcement through staff training, posters and audits, strengthening patient safety practice.

A0 - GUH

- Difficulty weighing spinal patients – Alternative assessment methods already in place via Dietetics.
- Consideration of a bed with inbuilt scales discussed with the ward; issue reviewed and closed with specialist team support.

Patient Safety Leadership Visits

Patient Safety Leadership Visits: Learning from the Past 12 Months

Actions raised through Patient Safety Leadership Visits over the past 12 months demonstrate that the majority of matters identified are not immediate patient safety concerns, which is encouraging. However, several recurring operational and environmental themes have been identified. These issues are usually well recognised by the organisation and are being actively progressed or mitigated.

Recurring Themes

- **Digital and Technology:** Unreliable Wi-Fi affecting access to clinical systems and staff efficiency.
- **Equipment and Estates:** Delays in maintaining equipment and infrastructure, including hoists, alarms, doors and flooring.
- **Confidentiality and Privacy:** Limited access to private spaces for sensitive clinical discussions and family support.
- **Operational Capacity:** Space constraints, increasing demand and limited facilities affecting patient flow and service delivery.
- **Staffing and Culture:** Despite strong teamwork and peer support, staff experience workload pressures which affect staff wellbeing.
- **Health and Safety:** Environmental deterioration and cleaning or hygiene gaps during peak periods.
- **Patient Flow and Transport:** Discharge delays, congestion and increasingly complex patient needs.
- **Communication and Engagement:** A need for clearer, more consistent communication with patients and families about services and expectations.

Patient Safety Leadership Visits

Strengthening the Approach

- Wards and clinical teams will be asked whether identified concerns have already been reported, recorded and escalated through the appropriate Directorate or Divisional process.
- Teams will be supported to understand and use the correct escalation route, if discussed as part of the visit, ensuring that issues are owned and progressed through established governance arrangements.
- Actions already being managed through existing processes will not be duplicated as separate visit actions, although the visit record may note that the matter was discussed and identify the route through which it is being managed.
- Patient Safety Leadership Visits will place a greater focus on patient safety concerns, the effectiveness of escalation and assurance that actions are progressing appropriately.
- This will ensure that operational matters are already in hand and are not being left unresolved pending a Patient Safety Leadership Visit.

The revised approach will strengthen the focus of Patient Safety Leadership Visits on patient safety, while ensuring that operational, environmental and workforce concerns are managed through the correct Directorate or Divisional governance arrangements.

-A Patient Safety Leadership Visits

Actions Underway

- **Supporting Appropriate Local Escalation:** Ward, departmental and clinical teams will be asked to demonstrate that concerns have already been reported, logged and escalated through established Directorate and Divisional processes. This will help ensure issues are addressed at the earliest opportunity and through the most appropriate route.
- **Strengthened Escalation Framework:** A clear escalation process is being embedded to ensure that any immediate patient safety concerns identified before, during or following a visit are raised promptly through the appropriate Directorate, Divisional and corporate governance arrangements.
- **Avoiding Duplication of Existing Actions:** Where concerns are already being managed through Directorate, Divisional or corporate processes, these will not be duplicated as separate PSLV actions. Visits may record that the issue was discussed and provide assurance that appropriate escalation and management arrangements are in place.
- **Assurance of Action Progression:** PSLVs will provide assurance that concerns have been appropriately escalated, allocated to the responsible teams and are progressing through the correct governance and accountability arrangements. This will support visibility of issues while reinforcing local ownership and accountability.
- **Monitoring of Recurring Themes:** Recurring themes identified through PSLVs will be reviewed alongside existing governance and performance mechanisms to ensure systemic issues are visible, monitored and addressed through established organisational processes.

-A Patient Safety Leadership Visits

Actions Underway

- **Updated PSLVs Framework:** The Terms of Reference (ToR) and Standard Operating Procedure (SOP) are being reviewed and updated to clarify the purpose, scope, roles, responsibilities, escalation routes, reporting arrangements and expectations of PSLVs.
- **Enhanced Feedback Process:** A formal process for capturing, reviewing and responding to feedback from PSLVs is being established to strengthen organisational learning, accountability and the demonstration of improvement over time.
- **Divisional Feedback and Learning:** A structured mechanism is being developed to ensure themes, findings, good practice and learning from PSLVs are routinely communicated back to Directorates and Divisions, supporting continuous improvement and shared learning across the Health Board.
- **Refocusing on Patient Safety:** PSLVs are being refined to place greater emphasis on patient safety priorities, emerging risks, quality concerns and opportunities for improvement identified by staff, patients and families, ensuring Executive time is focused on areas of greatest risk and learning.
- **Executive Team Engagement and Oversight:** Work is underway to strengthen the partnership between Executive Team members undertaking PSLVs and the Quality and Patient Safety Team, ensuring a shared understanding of the purpose of the visits, a consistent approach to assurance, and effective oversight of patient safety themes and improvement actions.

For Information

Clinical Effectiveness

National Oesophago-Gastric Cancer Audit (NOGCA) State of the Nation Report Version 2 – September 2025 An audit of care received by people diagnosed with oesophageal or gastric cancer between 1 January 2022 and 31 December 2023 in England and Wales.	Clinical Lead:	Miss Tamsin Boyce - Consultant Surgeon
	NICE:	QS176 , NG83
Rationale:	The NOGCA is carried out in order to evaluate the quality of care received by people diagnosed with oesophageal or gastric cancer in England and Wales	
Objectives:	The over-arching aim of the audit is to support NHS Trusts/Health Boards, Cancer Alliances and policymakers to improve outcomes. The focus of the audit is evolving from an emphasis on quality assurance to quality improvement.	
Presented at Clinical Standards and Effectiveness Group – 14th May 2026		

Data Capture

- This report covers patients diagnosed up to the end of 2023 and is published in September 2025 to allow sufficient follow-up for treatment and outcome data.
- Unlike the previous report, which covered April 2021 to March 2023, this edition aligns with the calendar year to enable consistent comparisons across the NATCAN cancer audit portfolio.
- Most indicators are reported over a two-year period to provide robust organisation-level analysis, while surgical outcomes are presented over three years (2021 to 2023) due to lower patient numbers undergoing surgery.
- Results are generally based on the diagnosing NHS trust or health board, with surgical data reported separately for specialist surgical centres.
- Findings should be interpreted in the context of ongoing impacts from the COVID-19 pandemic, particularly during 2021.

NICE QS176

Statement 1 - Adults with oesophago-gastric cancer have access to an oesophago-gastric clinical nurse specialist.

Statement 2 - Adults with oesophago-gastric cancer have their treatment reviewed by a multidisciplinary team that includes an oncologist and a specialist radiologist who both have an interest in oesophago-gastric cancer.

Statement 3 - Adults with oesophageal or oesophago-gastric junctional tumours (except T1a tumours) for whom radical treatment is suitable, have 18-fluorodeoxyglucose positron emission tomography requested and reported within 1 week.

Statement 4 - Adults with oesophago-gastric cancer have tailored specialist dietetic support before and after radical treatment.

Quality Improvement

The NOGCA Quality Improvement priorities were developed in consultation with stakeholders in the Clinical Reference Group and are described in the NOGA Quality Improvement Plan

The following quality improvement goals have been identified for NOGCA:

1. Reduce rates of emergency and late stage diagnosis of OG cancer
2. Reduce the percentage of patients 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.

A Cancer Improvement Plan for Wales 2023 – 2026 has been produced in collaboration with all stakeholders and it sets out the ambition for Wales to improve cancer patient outcomes and reduce health inequalities. It highlights the importance of planning for the future delivery of innovative new service models, treatments and technologies which will secure recovery, sustainability and improvement in line with the 22 Quality Attributes set out in the Quality Statement for Cancer (2021

The plan can be accessed here: Cancer Improvement Plan for NHS Wales 2023-2026

Key Messages for Wales

- People with OG cancer in Wales waited a median of 72 days (IQR 51 to 104) from diagnostic endoscopy to disease-targeted treatment, highlighting delays in this part of the pathway. (Performance Indicator 3).
- People undergoing curative treatment for OG cancer faced longer waits to start treatment compared to those receiving non-curative care. The longest delays were seen in people treated with surgical resection alone, highlighting potential issues in preoperative pathways.

Survival rates following curative surgery for OG cancer remain high: 95.6% in Wales at 90 days after resection surgery (Performance Indicator 7), and 85.7% in Wales at one year. (Performance Indicator 8).

- Overall, 31% of people in Wales with stage 1–3 OG cancer received curative treatment within nine months of diagnosis.
- Receipt of both curative and palliative treatments was strongly associated with patient fitness, emphasising the need for accurate recording of performance status to assess treatment decisions and service planning.

Assurance and Risk

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

Key Success and Concerns

Report Successes:	
1	Diagnoses from emergency admissions are much lower in ABUHB than rest of UK (5% compared to 21% overall in England, 14% in Wales)
2	CNS and dietitian input very high although not data not published for Wales
3	Cytosponge for Barrett's and low-risk OGDs (reflux) being rolled out already

Report Concerns:	
1	No capture of Wales data for deaths within 30/90 days of palliative SACT and other aspects e.g. CNS
2	Multiple aspects of pathways outside of ABUHB control (Velindre/CAV)
3	62-day target not being met (same as most tumour sites)

Report Recommendations:		S.M.A.R.T Actions: Responsible: Due Date: Progress:
1	Expand the use of approaches to improve early diagnosis in community settings, including: ➢ Explore strategies to improve engagement with their local populations and address identified hotspots of emergency cancer presentation. ➢ Case reviews of emergency presentation or late-stage diagnosis by referring hospitals to identify potential missed opportunities and share learning with primary care partners to support earlier diagnosis in the future.	Already a positive outlier with emergency presentation rate of 5% -ensure this is maintained
2	Explore opportunities to streamline diagnostic and decision-making pathways. This includes considering implementation of new models of care that reduce delays and support timely initiation of treatment for people with OG cancer	Cytosponge already being implemented
3	Carry out thorough assessment and counselling for all people being considered for palliative systemic anti-cancer therapy (SACT) to ensure treatment decisions are based on a clear understanding of potential risks and benefits. In older populations, use formalised fitness assessments, such as the Clinical Frailty Scale. Where there is a high risk of early mortality (within 90 days), best supportive care to be discussed as an alternative. To support continuous improvement in decision-making, all people who die within 30-days of receiving palliative SACT to be reviewed through local morbidity and mortality processes.	Would be reviewed through Velindre – would raising threshold for palliative SACT deny some patients valuable treatment? BSC already discussed as an alternative option
4	All people diagnosed with OG cancer to have timely access to a Clinical Nurse Specialist (CNS) ideally within 72 hours of diagnosis. NHS organisations to review CNS provision where data show low levels of CNS contact and take steps to address workforce or service gaps. Accurate recording of CNS involvement to be prioritised in clinical data systems to support ongoing monitoring and improvement.	Nil needed, CNS team now fully staffed – CNS team pick up patients from MDT proforma on CWS and input recorded on CWS

Clinical Leads Local Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Appointment of new UGI consultant to take on MDT input and replace previous outreach service	New consultant to be appointed/in post within 6/12 mths	Directorate/ Divisional team	End of 2026 or sooner	JD is approved and there is an advertising/ shortlisting/interview timeline confirmed, with interviews scheduled for mid-September 2026
2	SLA to be revised	New detailed SLA within 18 months; interim SLA offered by CAV now	Divisional teams across ABUHB/CAV	12 months	Limited – interim SLA under review locally

Audit Title:	National Paediatric Diabetes Audit (NPDA) Report on Care and Outcomes 2024/25 Published 12 March 2026	Clinical Lead:	Dr Davida Hawkes
		NICE:	QS125, NG18
Rationale:	The audit aims to understand what proportion of patients seen in paediatric diabetes units receive key age-specific processes of diabetes care, as recommended by NICE and achieve outcomes within specified treatment targets.		
Objectives:	The effectiveness of diabetes care has been measured against NICE guidelines (NG18, 2015 and QS125, 2016) which include treatment targets, health checks, patient education, psychological wellbeing, and assessment of diabetes-related complications including acute hospital admissions, all of which are vital for monitoring and improving the long term health and wellbeing of children and young people with diabetes		
Presented at Clinical Standards and Effectiveness Group – 14th May 2026			

Quality statements – QS125

Statement 1: Children and young people presenting in primary care with suspected diabetes are referred to and seen by a multidisciplinary paediatric diabetes team on the same day.

Statement 2: Children and young people with type 1 or type 2 diabetes are offered a programme of diabetes education from diagnosis that is updated at least annually.

Statement 3: Children and young people with type 1 diabetes are offered intensive insulin therapy and level 3 carbohydrate-counting education at diagnosis.

Statement 4: Children and young people with type 1 diabetes are offered real-time continuous glucose monitoring (rtCGM).

Statement 5: Children and young people with type 1 diabetes are offered blood ketone testing strips and a blood ketone meter.

Statement 6: Children and young people with type 1 or type 2 diabetes are offered access to mental health professionals with an understanding of diabetes.

Key Messages

Rising Caseloads Across Paediatric Diabetes Services

The number of children and young people receiving care from a paediatric diabetes unit rose to **35,801** in England, Wales and Jersey in 2024/25, marking a **29%** increase in caseload across England and Wales over the past decade.



Gaps in Health Check Completion for Young People

Many young people with diabetes are not receiving all 6 annual health checks, as recommended by NICE:

- **10%** of those aged <12 and **28%** of those aged 12+ with **Type 1 diabetes** missed one or more health checks.
- **69%** of those aged <12 and **60%** of those aged 12+ with **Type 2 diabetes** missed one or more health checks.



DKA at Diagnosis

The rates of diabetic ketoacidosis (DKA) at diagnosis remains high at **22%**, especially in children aged 0-4 years, although rates of post-diagnosis admissions have declined.



Persistent Variation and Inequalities

Whilst the distribution of HbA1c for children and young people with Type 1 diabetes has reduced over time, there remains excessive variation, with the median HbA1c at PDU level ranging from **51.9 mmol/mol to 72.0 mmol/mol**. Inequalities in HbA1c outcomes by deprivation and ethnic group have narrowed in 2024/25, but differences still persist.

Hybrid closed loop (HCL) systems are associated with better HbA1c outcomes, yet uptake ranges from **12% to 94%** at PDU level. Children and young people of all ethnic groups have seen an improvement in their use of diabetes technologies. However, Black children and young people experienced the lowest levels of technology use compared to others.



HbA1c, Microvascular, and Macrovascular Outcomes

The national median HbA1c for Type 1 diabetes has reduced to **58.0 mmol/mol**, a 13 mmol/mol reduction (0.93 mmol/mol/annum) since 2010/11, when the RCPCH published its first report for the NPDA for children and young people with diabetes.

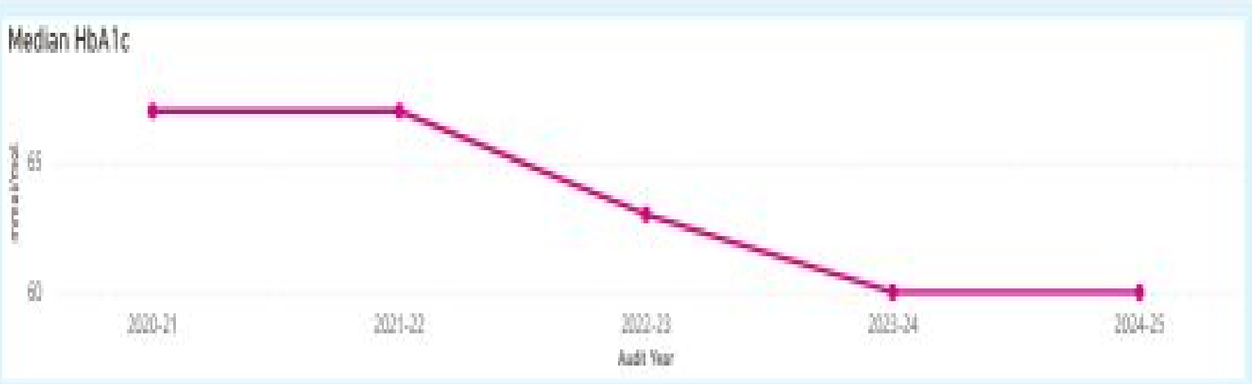
The prevalence of early markers of microvascular and macrovascular disease remains largely unchanged. Children and young people with Type 2 diabetes continue to experience higher rates of albuminuria and hypertension, despite having a lower median HbA1c (**49.0 mmol/mol**) than those with Type 1 diabetes.

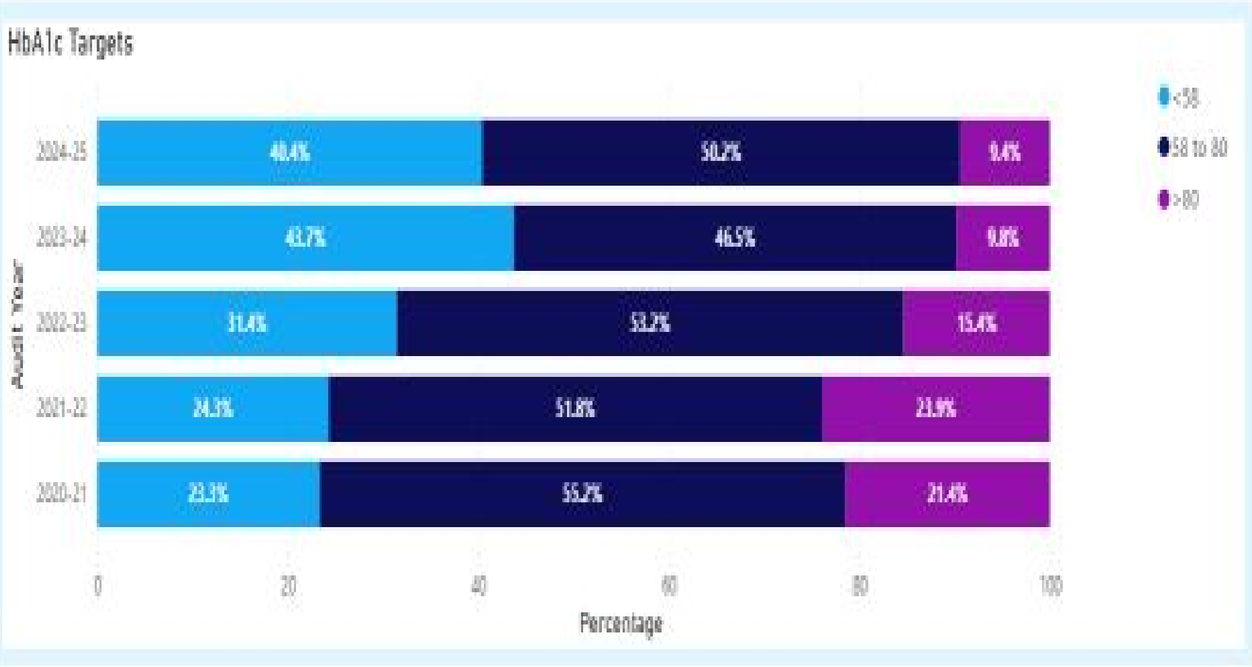
- **44%** of those with Type 1 diabetes and **94%** with Type 2 diabetes had a BMI in the overweight or obese range.
- **14%** of those with Type 1 diabetes and **29%** with Type 2 diabetes had a blood pressure above the 95th centile.
- **8%** of those with Type 1 diabetes and **19%** with Type 2 diabetes had a micro- or macro-albuminuria.



Grange University Hospital Data (HbA1c Outcomes)

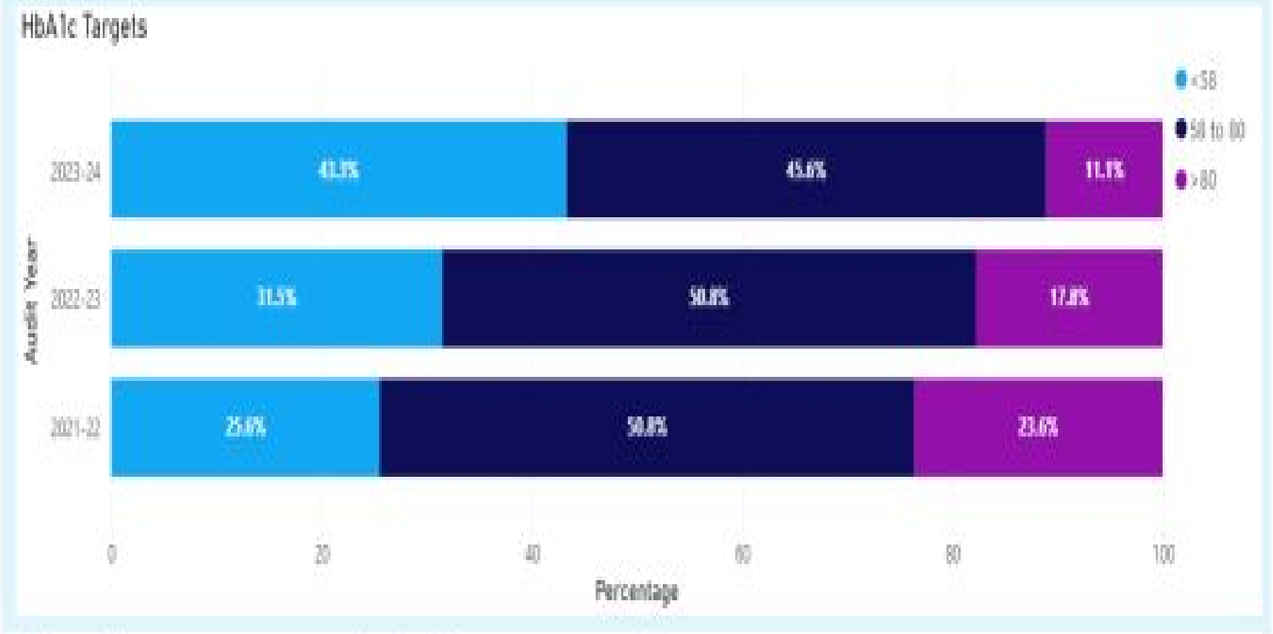
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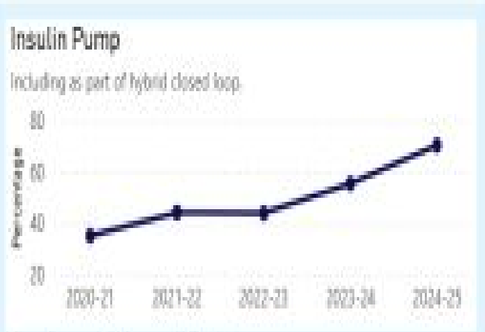




Adjusted HbA1c outcomes are not calculated from 2024-25 onwards.

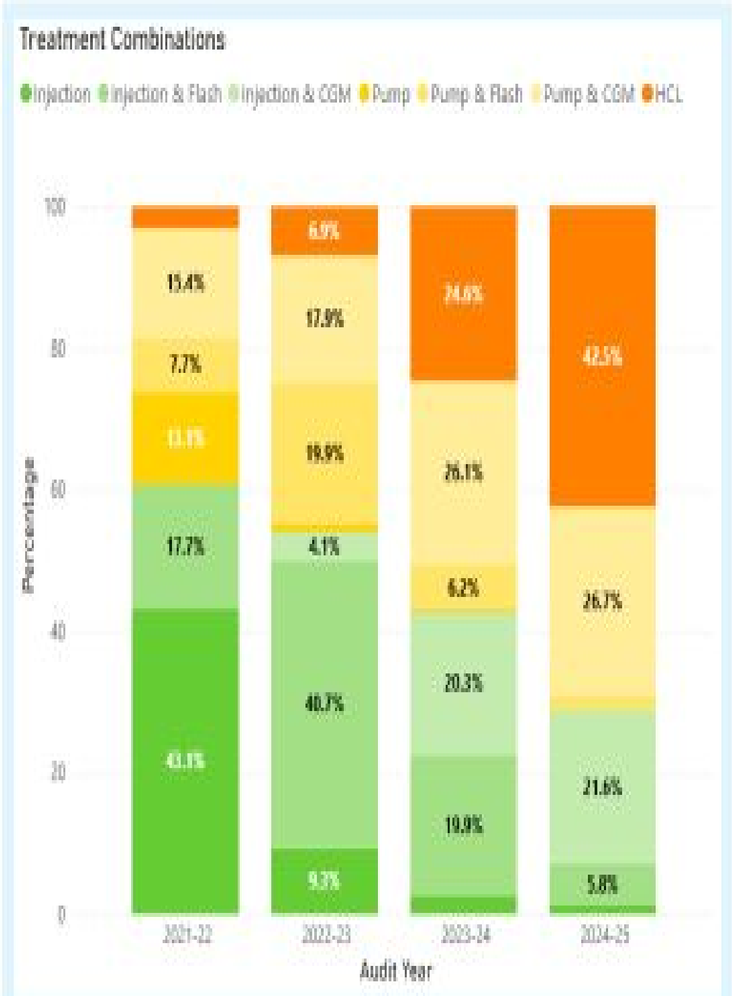
Grange University Hospital Data

(Treatment)

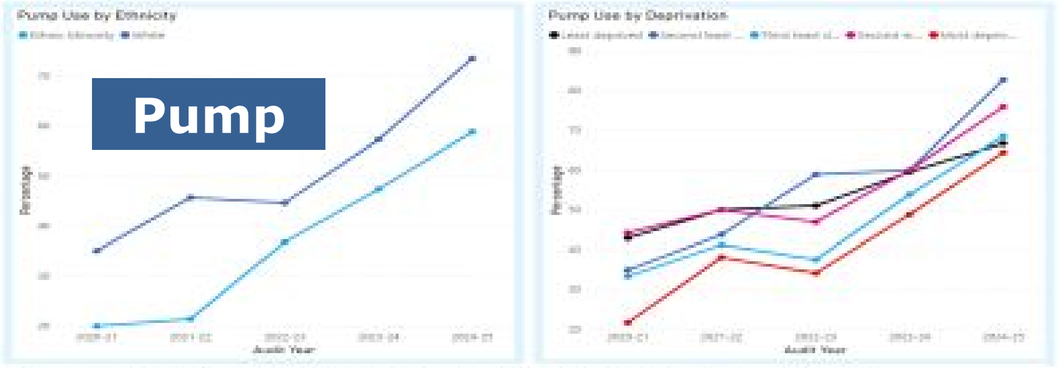




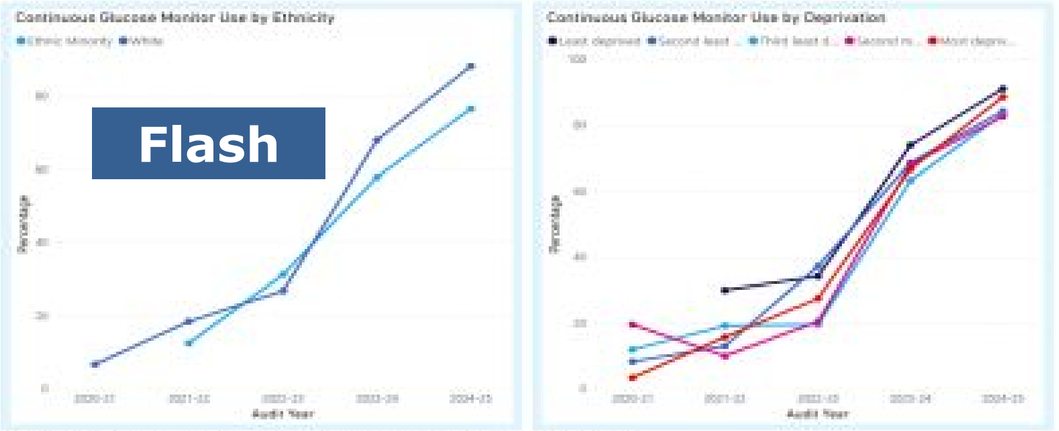




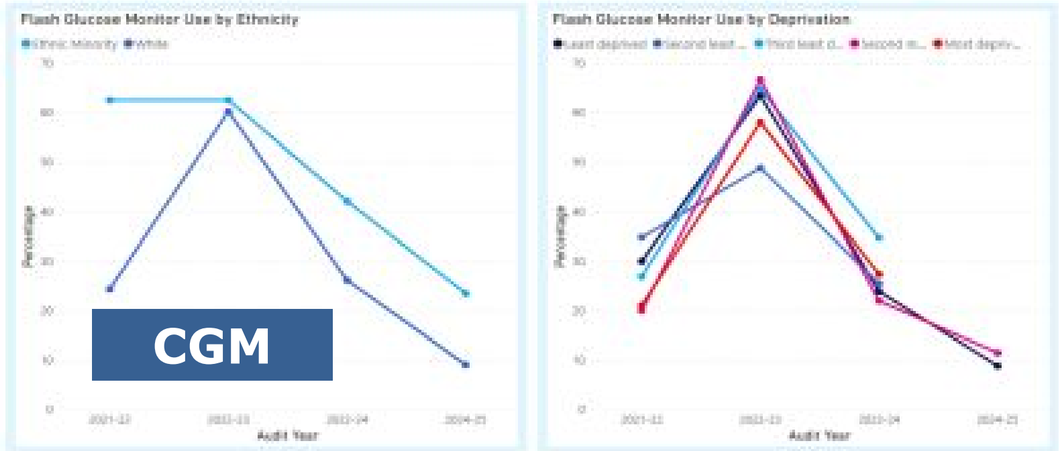
(Technology Access)



Ethnic minority groups have been combined due to small numbers at PDU-level. Small figures may be masked.

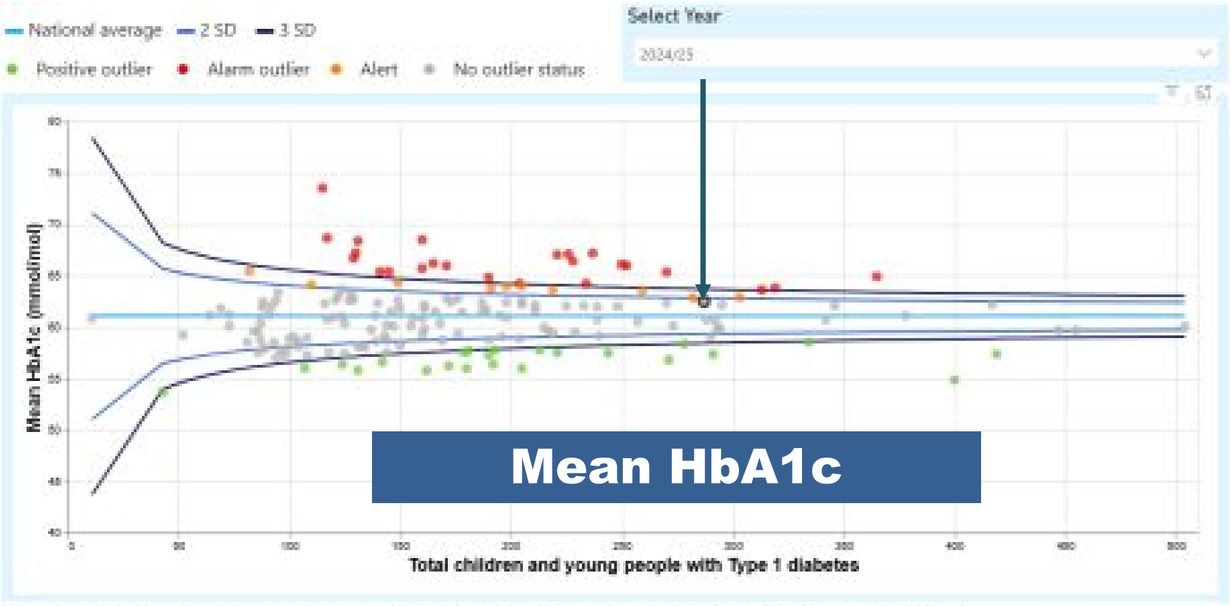


Ethnic minority groups have been combined due to small numbers at PDU-level.

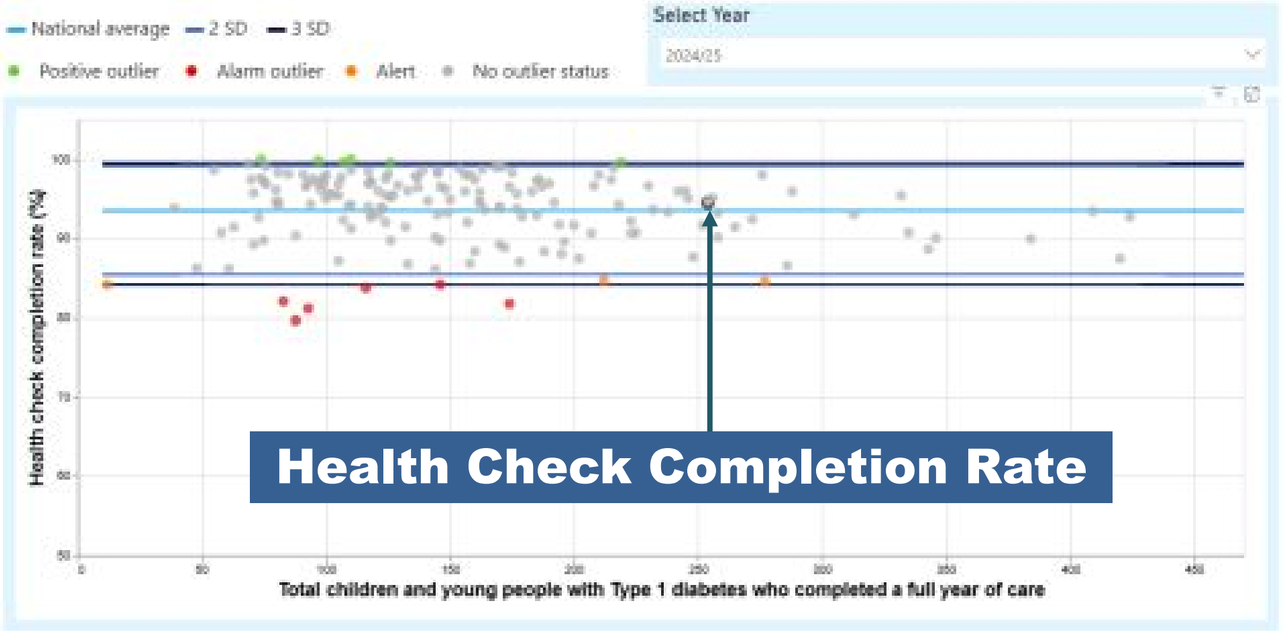


Ethnic minority groups have been combined due to small numbers at PDU-level.

Grange University Hospital Data (Outlier Status)



*Prior to 2024/25, Mean HbA1c was adjusted by age, sex, time since diagnosis, ethnicity, and deprivation.



Assurance and Risk

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

Key Success and Concerns

Report Successes:	
1	Maintained HbA1c despite data no longer being adjusted for deprivation (AB population most deprived in Wales)

Report Concerns:	
1	Continued lack of capacity across Health Board to offer 4 consultant/ MDT clinic appointments per year as per NPDA

	Report Recommendations:	S.M.A.R.T Actions:	Lead:	Due Date:	Progress:
1	Commissioners should assess paediatric diabetes workforce capacity against the Workforce Standards for Children and Young People's Diabetes Services published by the National Children and Young People's Diabetes Network (NCYPDN) in 2024 to support the delivery of minimum standards of care, such as NICE recommended health checks and the optimisation of technology usage, factoring in the 29% increase in the caseloads of paediatric diabetes units over the past decade.	The service has experienced an increase in caseloads driven by the expanding use of diabetes technologies. However, this additional activity and associated workload were not fully reflected within the original business case, creating ongoing capacity pressures. Additional funding will be required to ensure the service can meet the recommendations outlined in the report and maintain the delivery of high-quality care. There is also a need to increase consultant and multidisciplinary team (MDT) clinic capacity to achieve the national standard of a minimum of four MDT-led reviews per child per year. Achieving this standard, alongside responding to increased demand associated with technology-enabled care, will require further workforce investment and recurrent funding. An update on progress will be provided by March 2027.			
2	Fundings bodies should invest in research to understand the progression from childhood signs of microvascular and macrovascular disease to the development of long-term diabetes complications. Research should examine whether treating early markers during childhood and adolescence (e.g. antihypertensive medication for high blood pressure) reduces future risk. **Action by: Research funding bodies such as the NIHR, Diabetes UK, and Breakthrough T1D**				
3	Children and young people who are overweight or obese must be offered holistic, non-judgemental, multidisciplinary support, including dietetic and psychological input. Every child or young person with diabetes should receive clear, practical guidance on healthy eating and active lifestyles, including safe diabetes management during exercise, in line with NICE guidance	Need to develop weight management pathways in response to increasing rates of weight gain associated with improved glucose control, greater dietary flexibility, and the wider use of diabetes technologies. While these advances have delivered benefits for children and young people living with diabetes, they have also introduced additional challenges around healthy weight management. The service will need to work closely with patients and families to develop a supportive, person-centred approach that promotes healthy lifestyles while maintaining positive engagement and avoiding stigma.	Clinical Lead	Nov 2026	To be commenced

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
4	Consideration should be given to reviewing current professional guidance and clinical pathways to ensure they adequately highlight the importance of timely detection of early signs of diabetes (thirst, polyuria, tiredness, and/or weight loss – the 4 Ts: Toilet, Thirsty, Tired, Thinner) with an aim to reduce the frequency of new presentations of diabetes with DKA. Those presenting with such signs/symptoms should have an immediate point-of-care blood glucose test performed. More research is required in this area to reduce presentation of Type 1 diabetes in DKA.	Deliver targeted GP/Primary Care education programmes to ensure diabetes is suspected when certain early signs are displayed. Case based learning from relevant cases, such as DKA presentations	Clinical Lead/ Deputy Medical Director PCC	Update Nov 2026	To be commenced
5	Commissioners should use NPDA data (including the NPDA KPI dashboards and annual reports), alongside other trusted sources, to assess variation in care and outcomes within their areas of responsibility, especially focusing on inequalities by ethnicity and deprivation. This includes identifying barriers to equitable access and take up of diabetes technologies and establishing enablers to reducing inequalities. This relies on complete submission of demographic data into the NPDA by each paediatric diabetes team.	The service needs to address limitations in data entry within the Twinkle database to improve the accuracy, completeness and reliability of clinical information. This will require the introduction of standardised data entry protocols, enhanced staff training and accountability, and routine data quality audits. There is also a need to ensure that all elements of care, including psychology, dietetic and education interventions, are consistently recorded. Strengthening data quality and aligning datasets will support more accurate audit reporting and ensure that reported outcomes reflect true clinical activity and service delivery.	Clinical Lead	Update November 2026	To be commenced

Lots of innovations from MDT to continue to support CYP with diabetes and improve care and outcomes: Support clinics, Burnout clinics, Diabetes Club, Activity days and Moving to year 7 day

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	Clinical Lead:	Dr Divya Sakhuja – Consultant Psychiatrist and Assistant Divisional Director for Mental Health
Guidelines:	This audit does not use a single guideline as its baseline; instead, it is grounded in the NCISH established methodology and aligns its analysis and recommendations with relevant national standards and evidence-based guidance, including NICE guidelines (e.g. for anxiety and treatment approaches) and NHS safety guidance such as "Staying Safe from Suicide" and the Culture of Care standards. Established in 1996 in the UK Commissioned to improve safety in mental health services Based at the University of Manchester. Works closely with NHS England, Welsh Government, and other agencies NICE: CG113 (Generalised Anxiety Disorder and Panic Disorder in Adults (management of anxiety)	
Rationale:	The rationale of this audit is to use national, systematic data on suicide in mental health patients to identify risks, understand care-related factors, and drive improvements in patient safety, clinical practice, and suicide prevention policy.	
Objectives:	The objective of this audit is to systematically collect and analyse national data on suicides—particularly among people recently in contact with mental health services—in order to identify patterns, risk factors, and service-related issues, and to use this evidence to inform clinical practice, improve patient safety, and guide effective suicide prevention strategies at local and national levels. Looking at real cases (especially suicides)- Identify patterns, risks, and service issues. Learning from what went wrong to improve safety it does not use just one guideline, it still checks its findings against recognised national standards: - NICE guidelines - NHS safety guidance "Staying Safe from Suicide" (focus on safer care practices) - Culture of Care standards (focus on compassionate, safe environments)	
Presented at Clinical Standards and Effectiveness Group – 14th May 2026		

- Deaths by suicide of people aged 10 and above, between 2013 and 2023 across the UK (England, Northern Ireland, Scotland and Wales) and Jersey.
- General population- Over 171,700 people die by suicide overall
- Patients in mental health care- Over 43,500 people who had been in contact with mental health services within the past 12 months before they died
- Mental health care refers to care provided by both the NHS and the main private providers. The majority of patients are under NHS care.

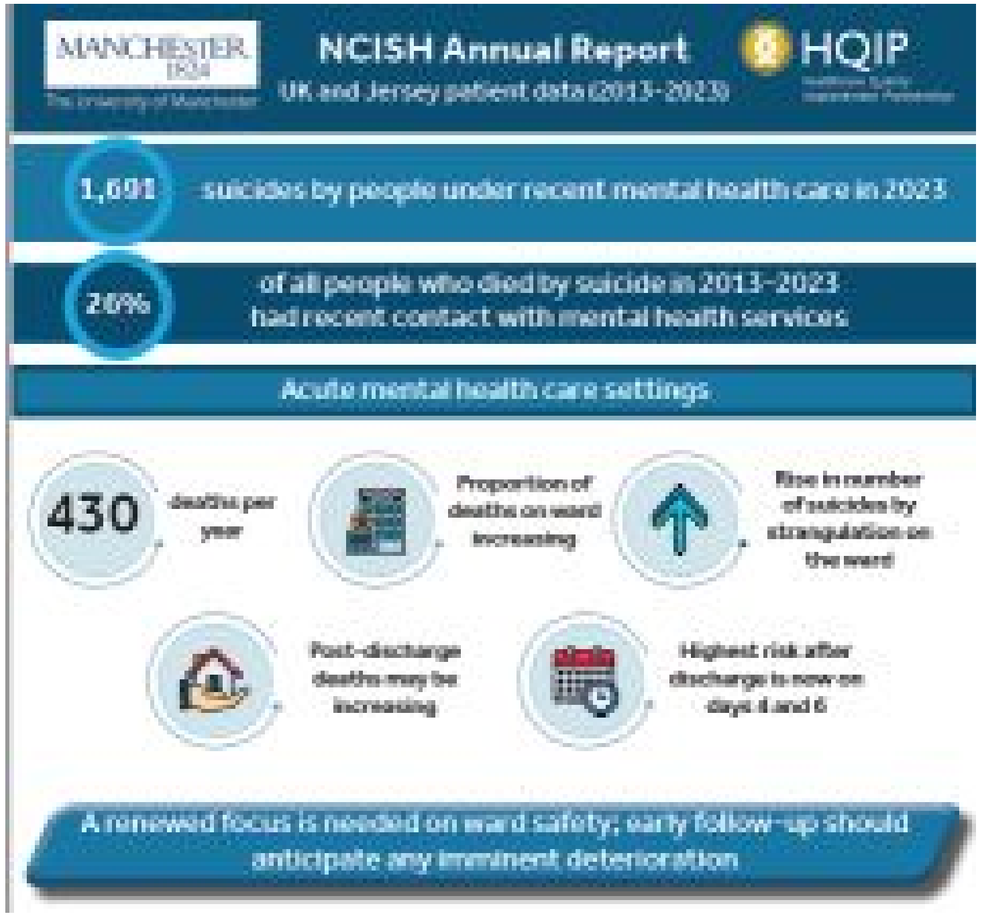
Changes in the NCISH methodology

Broadening the criteria of MH services contact -

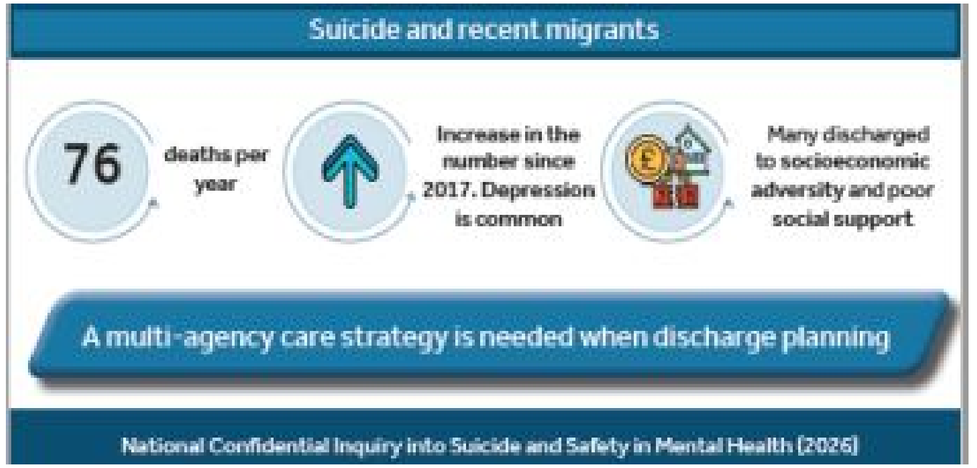
- Assessment in ED
- Assessment by liaison services in GH

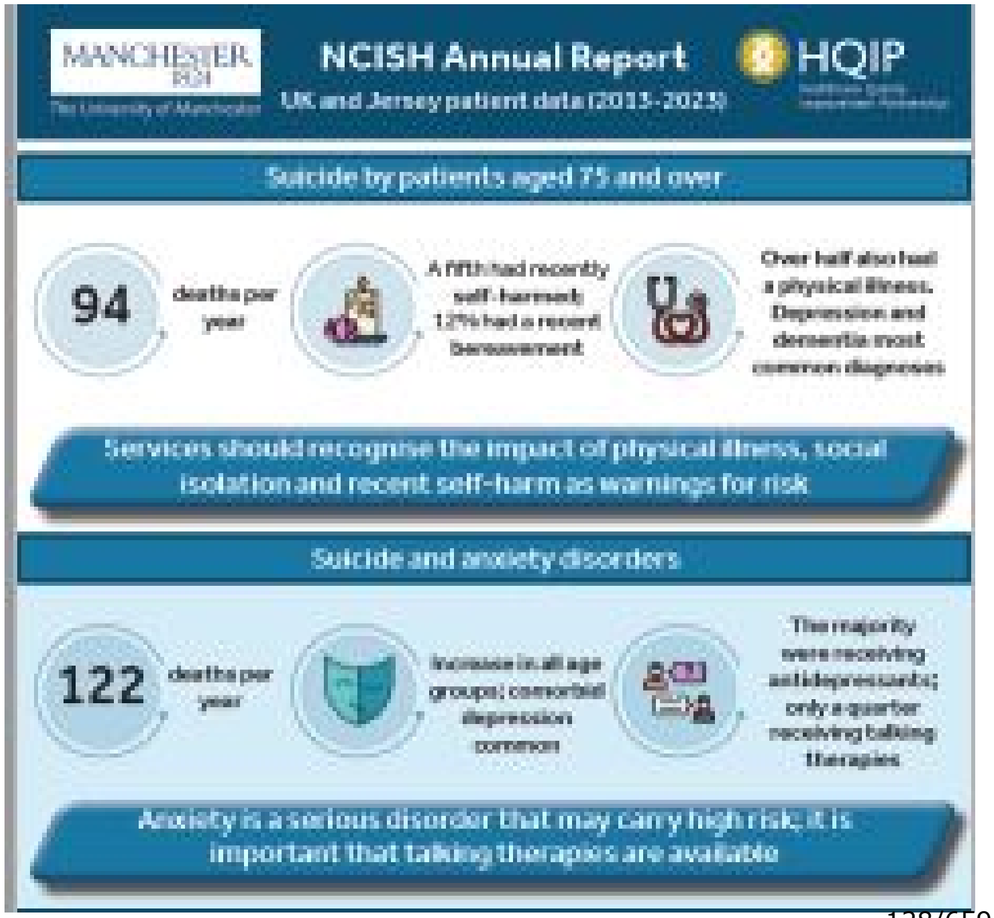
As more evidence is needed to inform suicide prevention in acute crisis care

Older age criteria- older age group was 65 and over now changed to 75 to more accurately reflect the different health experiences of older people and is in line with the minimum age group used in recent public health initiatives







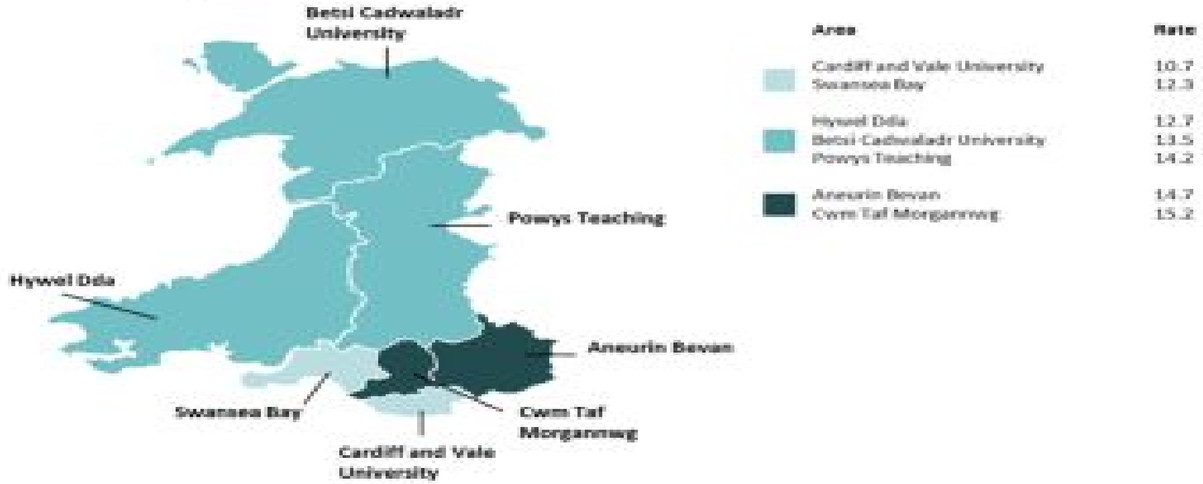


Suicide in the general population and by mental health patients by UK country (2013 – 2023)



General population suicide rates, by area of residence

Figure 1: Rates of suicide per 100,000 population, by Health Board of residence (average rate 2021-2023)

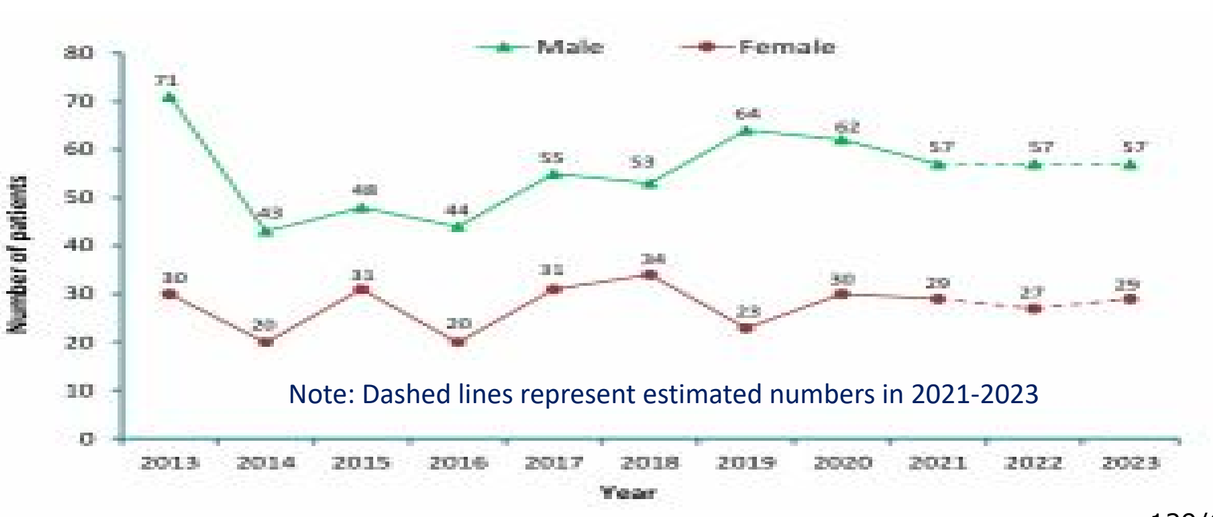


Patients who died by suicide in Wales

Figure 2: Number of confirmed and estimated patient suicides in Wales (2013-2023)



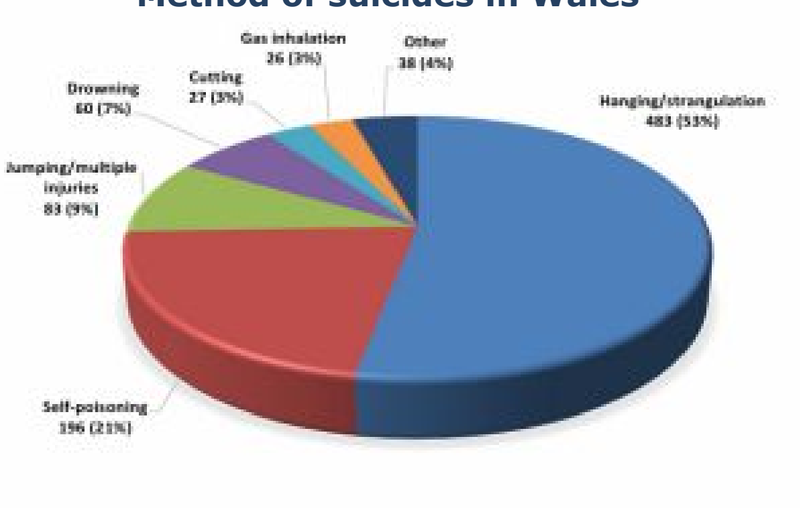
Figure 3: Number of patient suicides in Wales, by sex (2013-2023)



Note: Dashed lines represent estimated numbers in 2021-2023

Figure 4: Patient suicide in Wales: main suicide methods (2013-2023)

Method of suicides in Wales



Social and clinical characteristics

Table 1: Sociodemographic characteristics of patients who died by suicide in Wales (2013-2023)

Characteristic	Total=915[†]	
	Number	%
Age: median (range)	46 (15-96)	
Aged under 18	9	1
Aged under 25[†]	75	8
Male [†]	611	67
Not currently married/cohabiting	557	72
Living alone	351	44
Unemployed	370	49
On long-term sick leave	88	12
Ethnic minority group	19	2
LGBT+[‡]	17	4
Homeless	22	3
In the lowest 20% deprivation score[^]	209	25

[†] includes estimated figures in 2021-2023
[‡] data from 2016 onwards
[^] based on the Welsh Index of Multiple Deprivation (WIMD) 2019

Table 3: Behavioural characteristics of patients who died by suicide in Wales (2013-2023)

Characteristic	Total=915[†]	
	Number	%
History of self-harm	490	61
History of violence	159	21
History of alcohol misuse[†]	420	48
History of drug misuse[†]	359	41
Suicide-related internet use	34	7

[†] includes estimated figures in 2021-2023

Table 2: Clinical characteristics of patients who died by suicide in Wales (2013-2023)

Characteristic	Total=915[†]	
	Number	%
Duration of illness (<12 months)	159	21
Any comorbid (i.e. additional) mental illness	493	60
Any comorbid physical illness	206	27
First contact with mental health services:		
<12 months	181	23
>5 years	434	54
Last admission was a re-admission	73	17

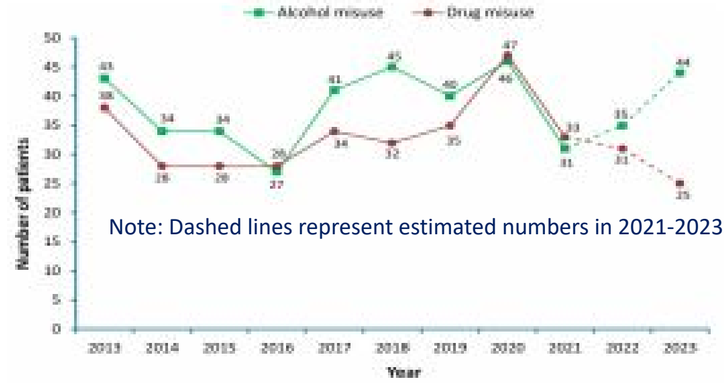
[†] includes estimated figures in 2021-2023

Table 4: Service characteristics of patients who died by suicide in Wales (2013-2023)

Characteristic	Total=915[†]	
	Number	%
In-patient[†]	48	5
Recent (<3 months) discharge[†]	136	15
Under crisis resolution/home treatment services[†]	86	9
Missed last contact with services	152	20
Non-adherence with medication	105	14
Contact with services		
Last contact within 7 days of death	366	44
Short-term suicide risk: low or none	637	89
Long-term suicide risk: low or none	426	64

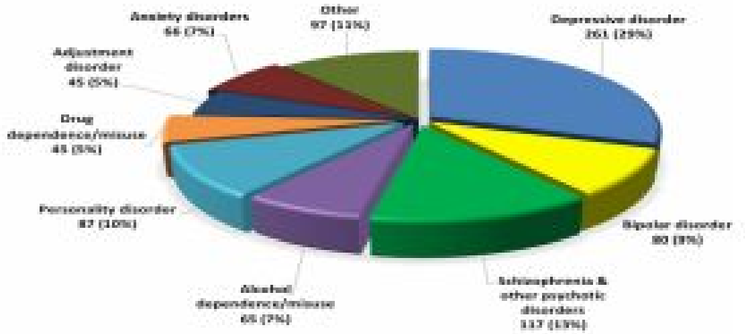
[†] includes estimated figures in 2021-2023

Figure 6: Patient suicide in Wales: number with a history of alcohol or drug misuse (2013-2023)



Note: Dashed lines represent estimated numbers in 2021-2023

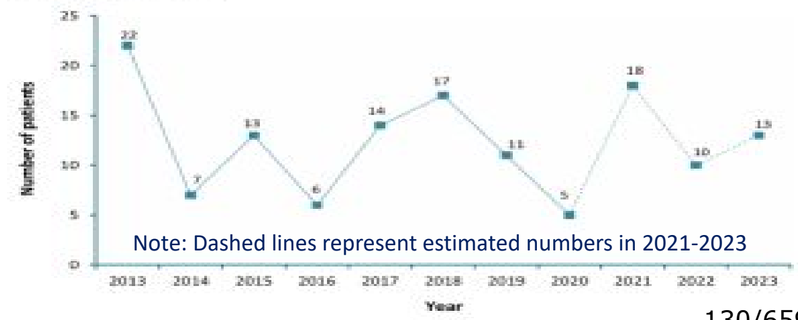
Figure 5: Patient suicide in Wales: primary psychiatric diagnosis (2013-2023)



**"other" diagnoses include: eating disorders, learning disability, conduct disorder, autism spectrum disorder, somatisation disorder, ADHD, organic disorder, drug induced psychosis, dementia and other specified

5.1 PATIENTS RECENTLY DISCHARGED FROM IN-PATIENT CARE

Figure 7: Patient suicide in Wales: number who died within 3 months of in-patient discharge (2013-2023)



Note: Dashed lines represent estimated numbers in 2021-2023

Assurance and Risk

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

Risk register?
Ligature risk, staff shortage is on the register

The NCISH discussion highlights that suicide prevention is not primarily a clinical failure, but a complex system challenge driven by social, behavioural, and service factors, requiring coordinated action across health, social care, and community systems.

Key Success and Concerns

Report Successes:	
1	Captures national trends over 10 years, not just short term fluctuations
2	Identifies high risk groups – demographics, clinical issues, timings
3	Findings are used to inform national policy, clinical guidelines, and safety strategies.

Report Concerns:	
1	Retrospective data- Cannot establish causality, only associations
2	Estimates (e.g., dotted lines in figures) introduces uncertainty making it less reliable
3	26% of suicides had recent mental health service contact. Rest had no contact so finding may not be applicable to the majority 74%- social determinants

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	24 hours crisis teams - improve access to MH services for patients in crisis	Integration of crisis team/ 111 service (24 hours) as a pilot project	Divisional NUrse	12th April 2026 x 6 months	Ongoing – Reduce wait time for assessment. Reduce need for re-referrals Streamlined referral pathway for crisis/ urgent referrals from primary care
2	Safer wards	Wards to become ligature resistant- all wards have had extensive ligature work	Directorate leads	End of this financial year (March 2027)	New policy of ligature risk assessment being implemented Anti ligature doors being rolled out across all inpatient wards Training for ligature risk assessment being rolled Ligature awareness training on ESR- not mandatory

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
3	Personalised risk management	As per the2025 All Wales Safe Discharge Standards, Person centred safety planning being rolled out- personalised plan for the individual based on their needs Discharge summary being developed in line with safe discharge standards	Assistant Divisional Nurse CD	June 2026 August 2026	PCSP being rolled out to crisis, pcmhs, liaison and inpatients Developing discharge packs for patients which will include an array of information and a person centred safety plan
4	Improve access to psychological therapy for patients in crisis	Target resources and clinical interventions at those conditions most prevalent in suicide cases i.e. anxiety and depression	HEIW funding to train professionals CBT being offered by South Gwent HTT		

Clinical Leads Local Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Address service provision gaps for people with suicidal thoughts who don't require MH services	To provide non clinical suicide prevention service in Gwent	Public Health Team	Next week – pilot end date May 2027	Pilot x 12 months Referral **ONLY** from 111 press 2 MDT
2	Division linked with Suicide Prevention and Self-Harm Steering Group & Gwent Suicide Prevention and Self harm Framework and Delivery Plan.	Divisional representation at these meetings	Public Health & MH Division	ongoing	ongoing

National Lung Cancer Audit State of the Nation Report 2026 An audit of care received by adults diagnosed with lung cancer between 1 January and 31 December 2024	Clinical Lead:	Dr M Jones, Consultant Physician on behalf of the ABUHB Lung Cancer MDT

Standards:

- NICE: QS17
- Cancer Clinical Expert Group: National Commissioning Guidance & National Optimal Lung Cancer Pathway

Rationale:	The aim of the National Lung Cancer Audit (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. This State of the Nation report publishes information on the care received by patients diagnosed with lung cancer during 2024 in England and Wales. The management of patients with lung cancer is informed by various national guidelines and the NLCA evaluates current patterns of care against the standards that these set.
Objectives:	• Provide a national overview of lung cancer care for adults diagnosed in 2024. • Measure performance against NLCA indicators (stage, treatment, SACT, waiting times, survival). • Enable benchmarking for Welsh Health Boards and NHS hospitals. • Highlight areas needing improvement to support better outcomes.

Presented at Clinical Standards and Effectiveness Group – 14th May 2026

Data integrity issues

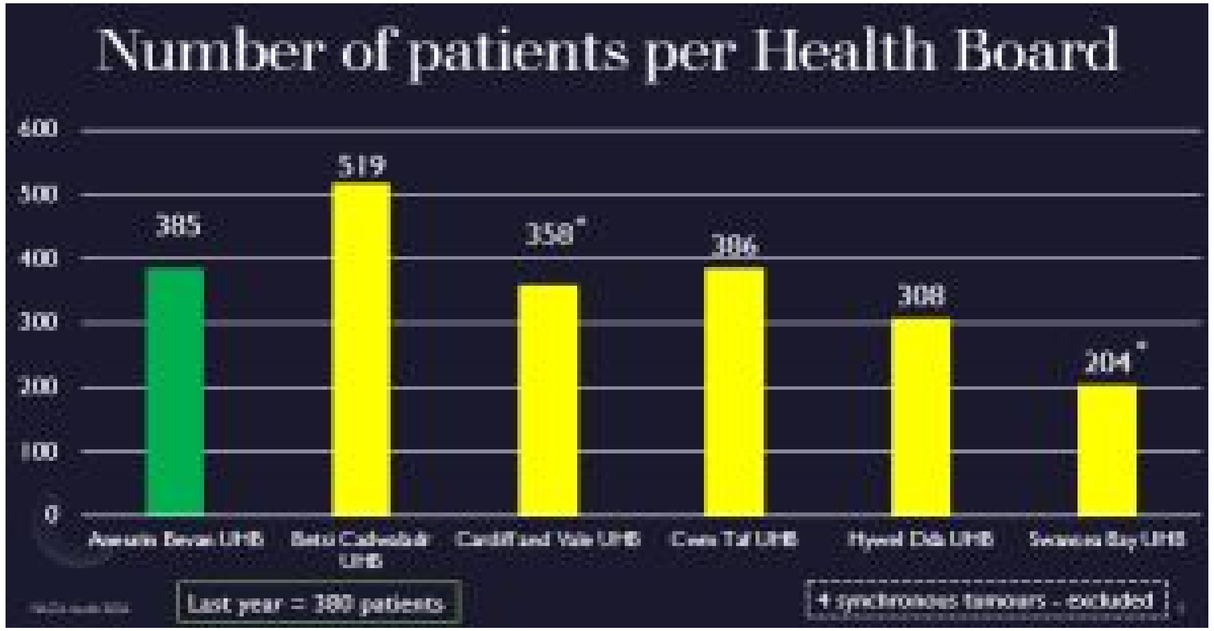
- Of the patients we submitted, 26 were excluded from the published report
- Patients were mis-appropriated to other sites:
  - CAVUHB 25
- 1 was appropriated correctly to Cwm Taf Health Board

- Out of the **25** 20 Stage I
  - 13 of these had surgery
  - 5 had radiotherapy with curative intent
  - 1 had thermal ablation
  - 7 had best supportive care

Figures presented represent adjusted, accurate results – *not the published results (currently being centrally reviewed)*

Data quality indicators

Data is not comparable to English data as data is derived from different dataset collection systems.



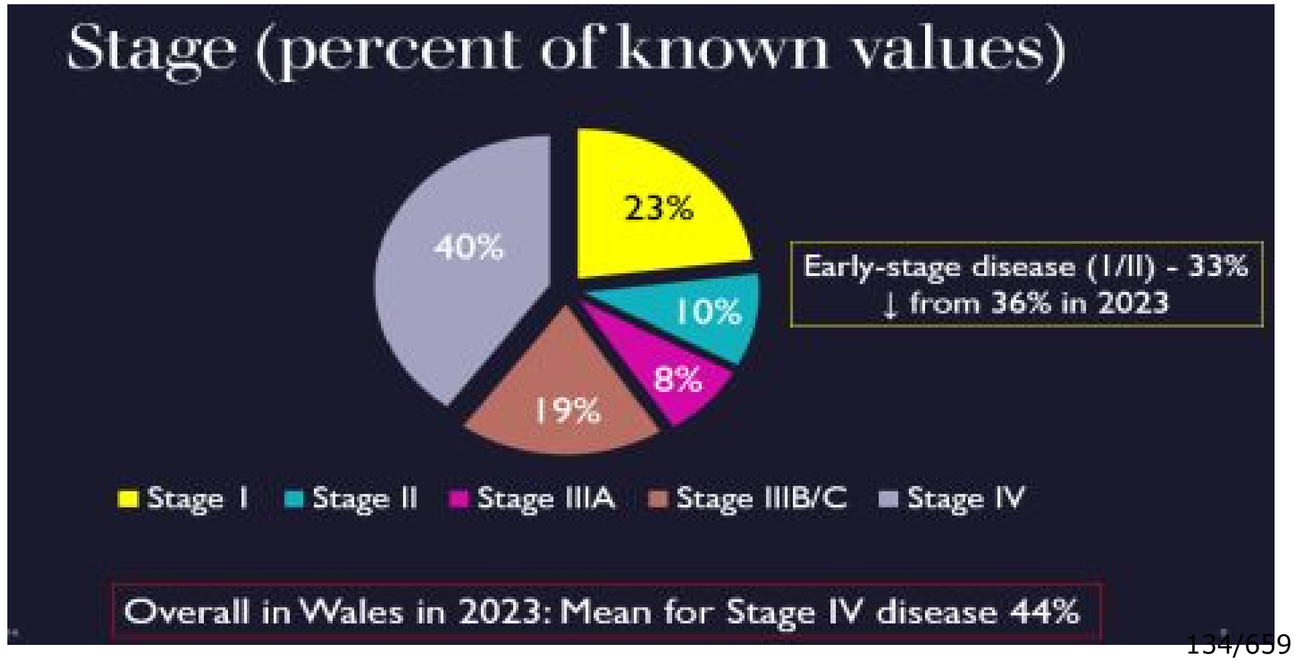
WALES	ABUHB
2,135 patients diagnosed with lung cancer in Wales in 2024 (↓ than 2023). Completeness of key data items in the Welsh data was excellent. Completeness for the 2,135 patients analysed were: • 100% for basis of diagnosis, • 77% for tumour morphology (99% with tissue), • 97% for disease stage, and • 98% for performance status. • 97% of records had data on whether a lung cancer nurse specialist was present at diagnosis. • Smoking status data – 72% (new capture item) • Data for ethnicity absent	385 patients diagnosed with lung cancer in ABUHB in 2024. The completeness of the key data items in the ABUHB data was excellent. The levels of completeness for the 360 published patients analysed were: • 100% for basis of diagnosis, • 74% for tumour morphology (100% with tissue), • 99% for TNM stage, and • 100% for performance status. • 92% for IMD (deprivation) • 99% of records had data on whether a lung cancer nurse specialist was present at diagnosis. • Smoking status data – 84%

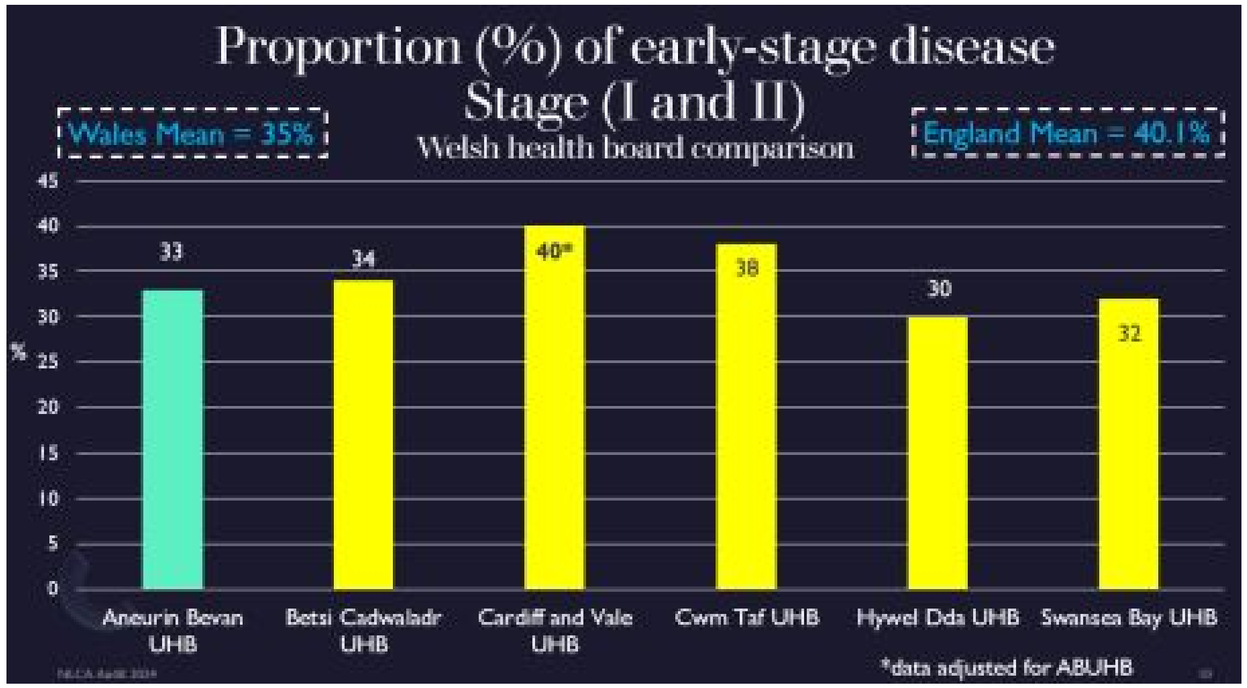
Characteristics of patients diagnosed

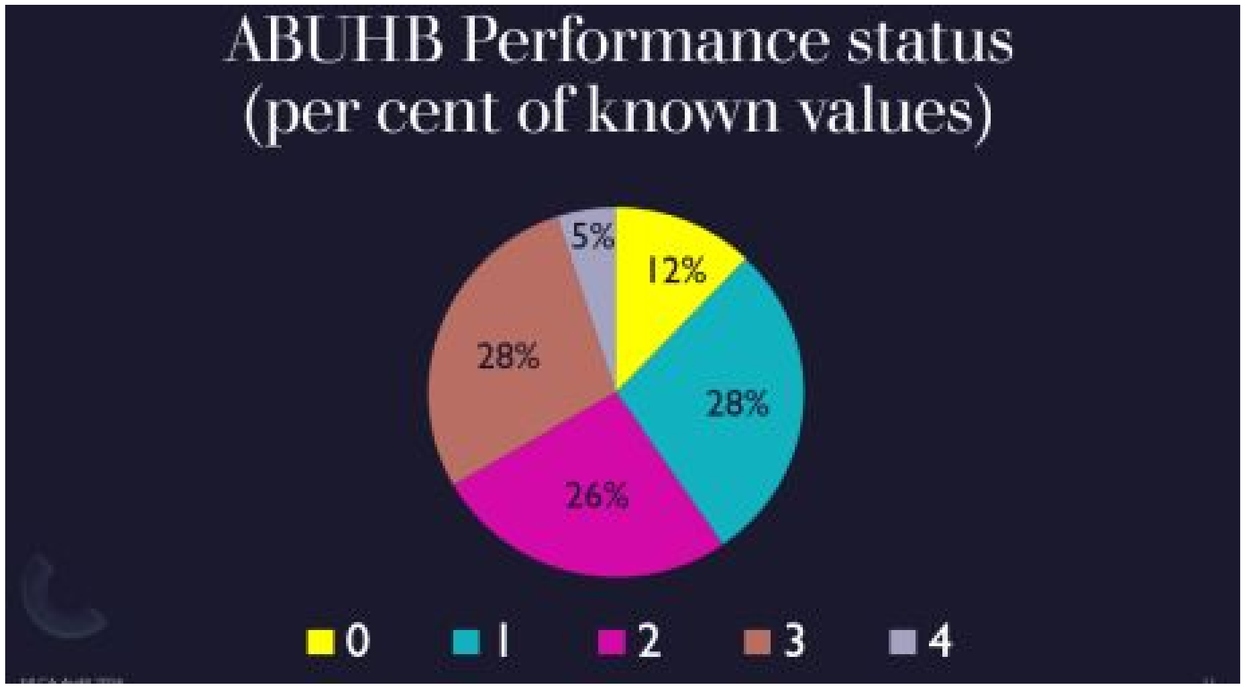
ABUHB Patient Cohort

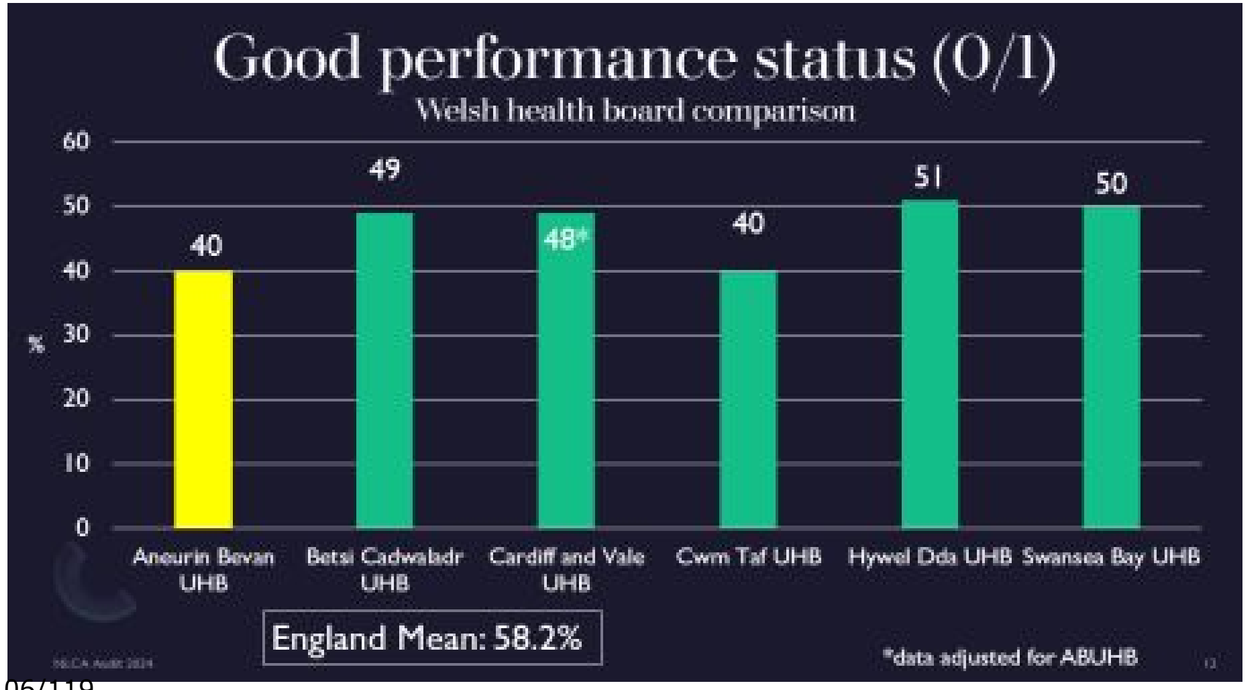
Small Cell Cancer	NSCLC	Unknown (assume NSCLC)	Total Number
47 (12%)	234 (61%)	104 (27%)	375

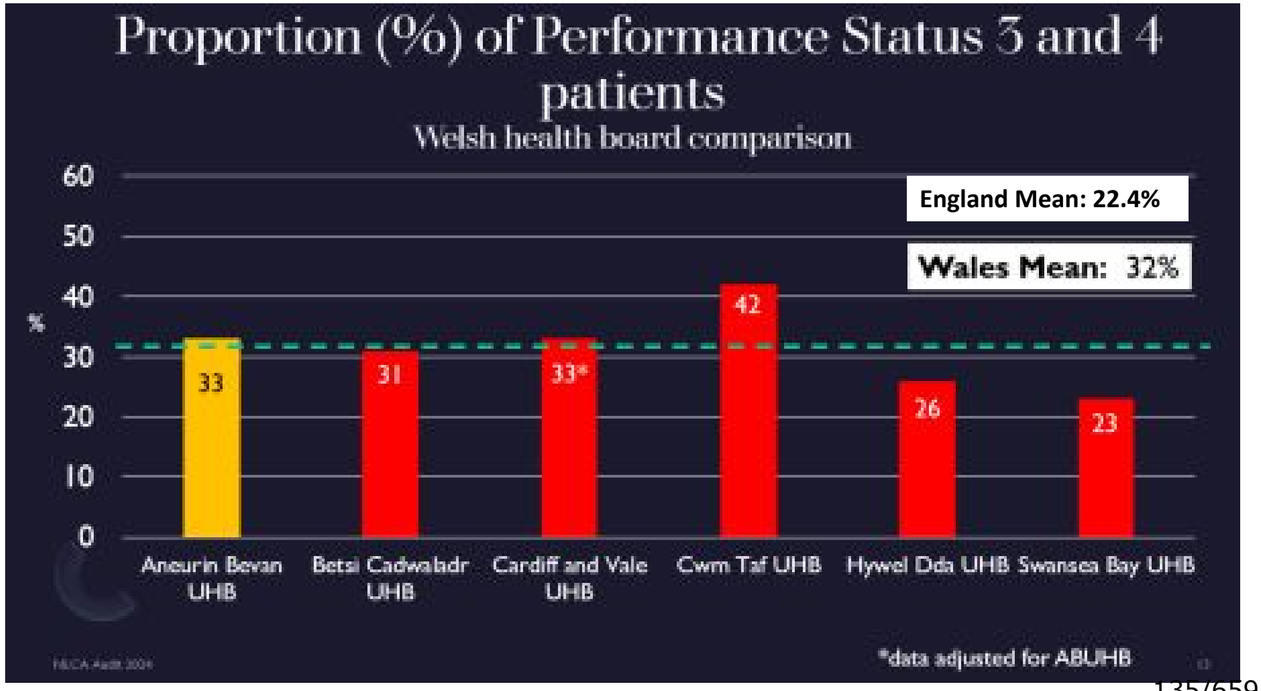
Others:		
	Mesothelioma	13
	Thymus	1
	Anterior mediastinum	1
	Carcinoid	3

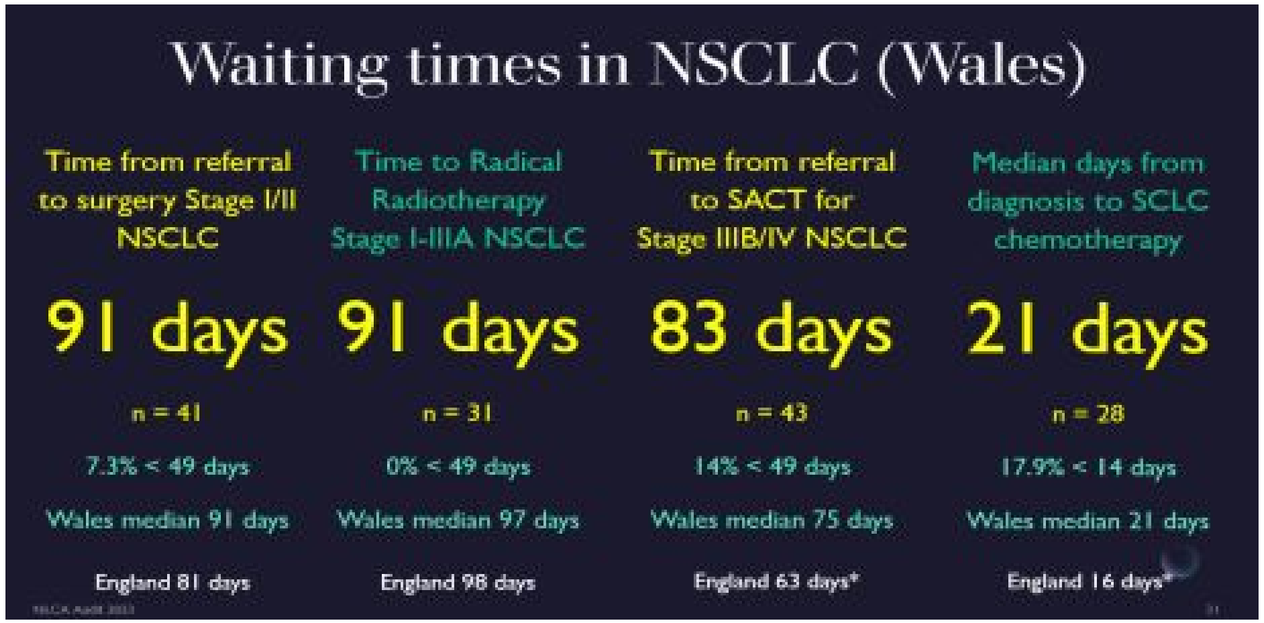


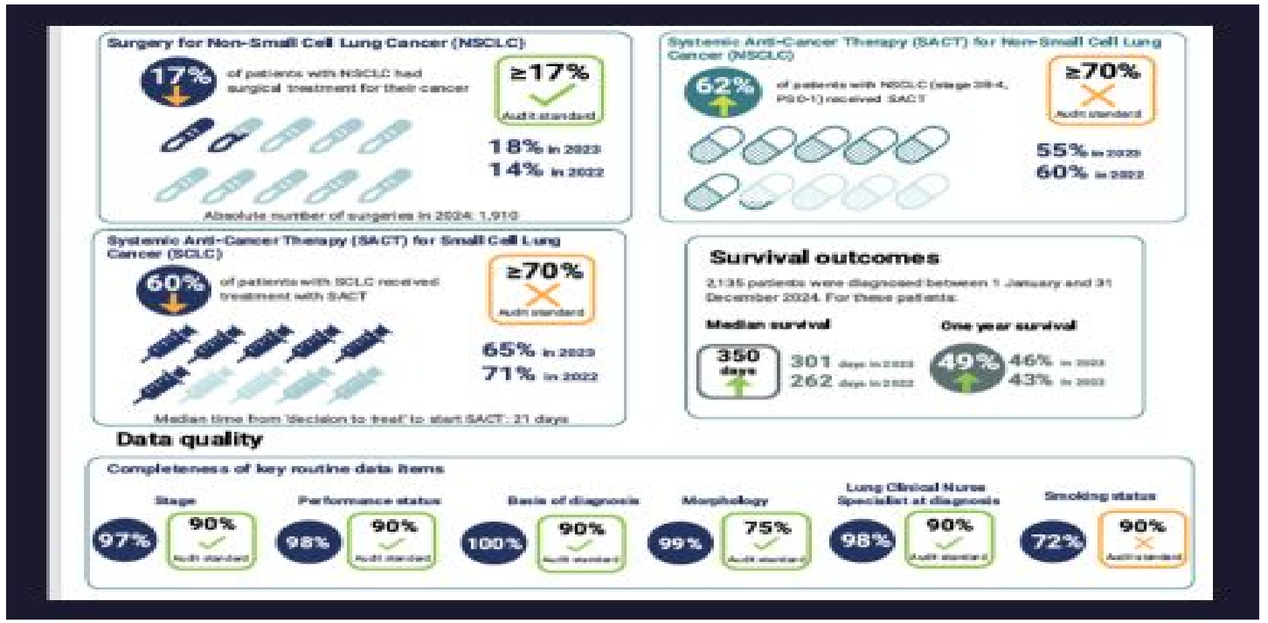

Proportion (%) of early-stage disease Stage (I and II)
Welsh health board comparison
Wales Mean = 35%
England Mean = 40.1%
45
40
35
30
25
20
15
10
5
0
%
33
34
40*
38
30
32
Aneurin Bevan UHB
Betsi Cadwaladr UHB
Cardiff and Vale UHB
Cwm Taf UHB
Hywel Dda UHB
Swansea Bay UHB
*data adjusted for ABUHB


ABUHB Performance status (per cent of known values)
5%
12%
28%
28%
26%
0
1
2
3
4


Good performance status (0/1)
Welsh health board comparison
60
50
40
30
20
10
0
%
40
49
48*
40
51
50
Aneurin Bevan UHB
Betsi Cadwaladr UHB
Cardiff and Vale UHB
Cwm Taf UHB
Hywel Dda UHB
Swansea Bay UHB
England Mean: 58.2%
*data adjusted for ABUHB


Proportion (%) of Performance Status 3 and 4 patients
Welsh health board comparison
60
50
40
30
20
10
0
%
England Mean: 22.4%
Wales Mean: 32%
33
31
33*
42
26
23
Aneurin Bevan UHB
Betsi Cadwaladr UHB
Cardiff and Vale UHB
Cwm Taf UHB
Hywel Dda UHB
Swansea Bay UHB
*data adjusted for ABUHB





Assurance and Risk

Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against

Risk level	Description
None	Standards met and findings demonstrate no risk to patient safety

Report Successes:	
1	NSCLC patients with stage I/II and good performance status (0-2) curative treatment rates 92% - best in Wales
2	Surgical resection rate for patients with NSCLC 18.9% - higher than Wales mean
3	Patients with Stage I/II with PS 0-1 with confirmed pathological staging 92.3%
4	Use of systemic anti-cancer therapy for stage IIIB/IV NSCLC patients (PS 0–1) 64.9% - higher than Wales mean

Report Concerns:	
1	Proportion of SCLC patients having chemotherapy 59.6% - marginally lower than Wales mean, below target
2	NSCLC patients with stage IIIA and good performance status (0-2) curative treatment rates 59.1% - lower than Wales mean*
3	Proportion of patients with lung cancer diagnosed after an emergency presentation 36.7% - highest in Wales cohort
4	Proportion of patients in Quintile 5 (most deprived) IMT 31% - highest in Wales

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Ensure services maximise the uptake of lung cancer screening for people aged 55 to 74 who are at high risk of lung cancer. *The percentage of people with lung cancer diagnosed with stage 1/2 disease in Wales was 33.9% in 2023.* ***Goal 1: Improve early diagnosis of lung cancer***	Lung Health Check Operational Pilot complete HB conducted scoping exercises Ongoing planning required following recent discussions with PHW Lung Screening national leads	PHW Welsh Government Individual Health Boards	Planned to start April 2028 with sessional consultant sessions to be appointed from April 2027	Initial response to recommendations from screening committee submitted. Ongoing engagement with central stakeholders
2	Ensure providers have sufficient thoracic surgery capacity to accommodate the larger number of people with Non-Small Cell Lung Cancer (NSCLC) who are candidates for curative surgery. ***Goal 2: Increase the proportion of patients who have treatment with curative intent***	Surgical resection rate above NLCA target Ongoing increase in patients undergoing surgery Continued early diagnosis and prioritisation of patients requiring surgical intervention, screening will support this No issues with access – but waiting times >4 weeks	CAVUHB/WG MDT members	Ongoing Report recommendations complete	Continued growth going forward and attempts to improve waiting times for surgery (requires central provider support from CAVUHB/WG) Unchanged from last year with ongoing waiting list concerns
3	Audit Multi-Disciplinary Team (MDT) decisions for patients with Non-small Cell Lung Cancer (NSCLC) stage IIIA (Performance Status (PS) 0–2) to identify barriers (e.g. comorbidity management) preventing curative intent treatments *In Wales during 2024, the proportion was 66.67%, an increase from 20232* ***Goal 3: Increase the proportion of people receiving radical treatment and ensure no variation in access***	Improved pathological services – PD-L1 in-house, ctDNA and increased peri-operative therapy will add new dimension to these patients Ensure PS captured accurately – particularly PS2 **Oncology delays – ongoing work to improve efficiency of oncology clinics**	Velindre University NHS Trust ABUHB pathology service All Wales Medical Genomics Service	Audit conducted on this NLCA data – showed appropriate decision making and treatment rate appropriate for patient population.	Above audit standard achieved Ongoing refinement of pathways according to threats

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
4	Ensure NHS hospitals have the necessary resources and capacity to meet the timelines for patients to start primary treatment. *In England and Wales, among key subgroups, most people diagnosed in 2023 did not start treatment within the recommended timeframes* ***Goal 4: Improve the quality of the patient pathway***	All facets of the pathway reviewed at operational meeting 6/5/26 – breach reports, tracker meetings, assessed for utility and new endeavours planned to reduce waiting times of all aspects of the pathway in order to help ensure timely review and treatment from Oncology and Surgical services	CAVUHB/WG MDT members Velindre University NHS Trust AWMGS	This is an ongoing, prospective endeavour – continued action required	Continued service development with ongoing improvement in active treatment rates and achievement of NLCA standards – ongoing vigilance, refinement and improvement is core to our MDT working particularly with lung screening emerging
5	Ensure people diagnosed with stage 1 - 3 cancer are recommended regular aerobic and resistance exercise during treatment with curative intent. This includes recommending preoperative exercise for patients having lung cancer surgery.	Limited access currently with potential surgical candidate having access to prehabilitation with CAVUHB Ongoing engagement with therapies team in HB and wider with WG	ABUHB therapies service	This is a prospective endeavour – no current imminent plans to introduce service	Some access out of health board but no imminent likelihood of unified service

Clinical Leads Local Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Proportion of patients seen by a Lung Cancer Nurse Specialist Target ≥ 90%: ABUHB proportion = 90% Target achieved but below All Wales average	To review feasibility of inpatient review of patients given route of entry with full nursing complement	Lung CNS team ABUHB	Prospective – feasibility to be assessed and planned	Discussed at MDT operational meeting 06/5/26 and planning ongoing
2	Proportion of patients with SCLC receiving chemotherapy Target ≥ 70% ABUHB proportion = 56.2%	Audit conducted Appropriate decisions made	MDT members Oncology services Velindre NHS Trust	Ongoing	Pathway for rapid access to oncology review under ongoing review

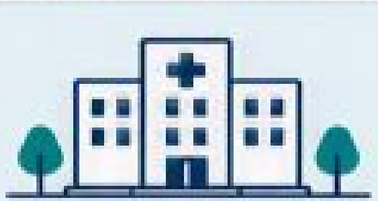
Conclusions

- The ABUHB lung cancer service diagnoses 385 cases of lung cancer per annum [>1 per day]
- Improving indices once again:
  - Better curative rates for early-stage disease
  - Excellent confirmation pathological confirmation rates for early stage, good PS
  - Surgical resection rates for NSCLC above audit standard and improved from 2023
  - Excellent “best in class” treatment rates for early-stage disease with curative intent and good PS
  - SACT treatment rates for late stage disease maintained
- Below target treatment rates Stage IIIA chemotherapy but subsequent audit revealed appropriate decisions made
- Waiting times for diagnosis and treatment remains high
- Concerning number presenting as emergency admissions – more advanced disease, frailty (need to capture accurately) – *also higher deprivation amongst health board population*

Situation: HIW inspection of Hafan Deg Ward

Healthcare Inspectorate Wales (HIW) undertook an **unannounced inspection of Hafan Deg Ward, Ty Siriol Unit, on 18, 19 and 20 May 2026.**

Hafan Deg Ward is a 20-bedded older adult functional mental health assessment ward based at the Ty Siriol Unit, County Hospital, Pontypool.



- 20-bedded ward
- Older adult functional mental health assesement
- Ty Siriol Unit, County Hospital, Pontypool

1. Inspection undertaken

18, 19 and 20 May 2026

2. Response and improvement plan stage

Completing factual accuracy response and improvement plan by **15 July 2026**

3. Draft report publication date

20 August 2026

QOF focus: ensure immediate risks are controlled, wider improvement actions are credible, and evidence of sustained improvement is provided.

Situation: why this matters for QOF

GIG CYMRU NHS WALES
Aneurin Bevan University Health Board
Dyfodol mwy iach
Healthier future

Patient rights

- Concerns about legal authority for detention and treatment under the Mental Health Act (MHA).
- Safeguards for the use of covert medication must be followed and evidenced (capacity, best interests, multidisciplinary input and documentation).

Patient safety

- Medicines storage security and stock management.
- Removal of expired stock and safe handling of high-risk medicines.
- Accurate medication administration records (MAR).
- Infection prevention and control (IPC) standards.
- Safe and effective care planning and observations.

Legal compliance

- Mental Health Act 1983 Code of Practice for Wales (Revised 2016).
- Mental Capacity Act 2005.
- Mental Health (Wales) Measure 2010.
- Health and Care Quality Standards 2023.

Governance oversight

- QOF should seek assurance that actions are:
  - Specific
  - Measurable
  - Achievable
  - Realistic and Timed
- With clear ownership, timescales and evidence of completion and impact.

This is not only a ward-level action plan;
it is a test of divisional assurance, escalation and sustained learning.

HIW = Healthcare Inspectorate Wales **MHA** = Mental Health Act **QOF** = Quality Outcomes Framework

Our collective focus: safe, lawful, compassionate and effective care for every patient, every time.

Background: inspection scope and evidence reviewed

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

What HIW inspected

- Quality of patient experience
- Delivery of safe and effective care
- Quality of management and leadership

Evidence considered

- Patient and family feedback
- Staff feedback
- Observation of practice
- Care record review
- Mental Health Act documentation review
- Medicines management review
- Infection prevention and control arrangements

Required response

- Factual accuracy response
- Improvement plan
- Immediate improvement plan
- Responsible officers
- Timescales
- Evidence of action

Improvement plan response completed by 15 July 2026.

Assessment: areas of positive assurance

GIG CYMRU NHS WALES | Aneurin Bevan University Health Board



1. Patient and family experience

Patients and families gave positive feedback. Staff were described as caring, compassionate, respectful and supportive.



2. Person-centred care

Patients had access to structured activities, occupational therapy, creative work, gardening, indoor space and outdoor space, supporting wellbeing and independence.



3. Safety systems in place

Risk assessment, safeguarding arrangements, incident reporting, emergency procedures, ligature risk processes and multidisciplinary review were in place.



4. Leadership and culture

Staff described visible and supportive leadership, daily touchpoints, quality and safety meetings, Datix reporting, safety briefings, mandatory training compliance and appraisal arrangements.

QMG = Quality Management Group | HIW = Healthcare Inspectorate Wales | Datix = Incident reporting system

Assessment: immediate assurance concerns

Aneurin Bevan University Health Board

1. Mental Health Act compliance

Gaps in statutory documentation included a lapsed Section 2 detention period and a consent to treatment certificate completed after the three-month rule had expired. This created concern about legal authority for detention and treatment.

2. Covert medication safeguards

Documentation did not evidence capacity assessment, best interests decision-making, multidisciplinary input, pharmacy or family involvement, or a clear care plan.

3. Medicines management

Concerns included unsecured medicines storage, expired medication including rectal diazepam, inconsistent controlled drug checks, unclear responsibilities and weak stock control.

4. Infection prevention and control

Concerns linked to suspected crusted scabies included delayed onsite IPC support, inconsistent PPE use and disposal, lack of clear guidance, no care plan, and enhanced observations exceeding the stated two-hour policy limit.

IPC = Infection prevention and control **PPE** = Personal protective equipment

Assessment: wider improvement themes

GIG CYMRU NHS WALES | Aneurin Bevan University Health Board

1. Patient experience, rights and dignity

- Bedroom curtain maintenance
- Privacy and dignity
- Welsh language active offer
- Advocacy awareness
- Spiritual or religious support

2. Care planning and therapeutic practice

- Care and treatment plan quality
- Person-centred detail
- Outcomes and actions
- Behavioural support strategies
- Assessment and specialist input
- Patient involvement
- Family involvement

3. Safe environment and medicines documentation

- Maintenance issues
- Damaged door frames and flooring affecting cleaning and infection control
- Medication administration record omissions
- Signatures, dates and allergy status

4. Workforce, governance and learning

- Regular ward meetings
- Staff engagement
- Staffing levels and skill mix reflecting patient acuity
- Audit effectiveness
- Monitoring systems
- Quality improvement
- Sustained embedding of learning

QMG = Quality Management Group | Audit = Audit and quality review

Recommendations: assurance actions and controls

GIG CYMRU NHS WALES | Aneurin Bevan University Health Board

1 Immediate containment

- Review detained patients' Mental Health Act documentation.
- Confirm no further gaps in legal authority for detention or treatment.
- Complete capacity assessment and best interests process for covert medication.
- Secure medicines storage.
- Remove expired stock.
- Implement IPC guidance and PPE controls.

2 Controlled risk

- Daily safety briefing sign-off.
- Senior nurse monitoring.
- Responsible clinician reminder for Section 62 where consent to treatment gaps occur.
- Read-and-sign process for covert medication policy.
- Ward manager and IPC lead actions.
- Weekly stock checks.

3 Sustained assurance

- Quarterly Mental Health Act audits.
- Review of MHA governance procedures with automation and escalation.
- Revised daily safety briefing standard operating procedure.
- AMaT monitoring.
- IPC audits.
- Evidence to HIW within three months of inspection.

Recommendations: QMG oversight and next steps

GIG CYMRU NHS WALES | Aneurin Bevan University Health Board

1. Ward and Divisional Team

- Implement actions and immediate controls
- Monitor in daily practice
- Provide evidence and escalate concerns

2. MHLD Divisional Quality and Patient Safety Group

- Review assurance and evidence
- Challenge and validate controls
- Monitor progress and escalate as needed

3. Quality Management Group

- Seek assurance
- Identify gaps and risk
- Request evidence by exception
- Escalate and support resolution
- Track delivery and outcomes

4. Patient Quality, Safety and Outcomes Committee

- Receive assurance reports
- Oversee risk and quality performance
- Ensure learning drives improvement across the Health Board

QMG assurance questions

1. Are immediate patient safety and legal compliance risks fully controlled?
2. Is there evidence that actions are embedded in daily practice rather than completed as one-off tasks?
3. Are responsible officers, timescales and evidence requirements clear for all improvement plan actions?
4. What learning should be shared across the wider Health Board to prevent recurrence in other wards or divisions?

Actions for QMG

1. Note assurance received
2. Identify gaps and areas of risk
3. Request evidence by exception
4. Agree escalation route and support required
5. Track delivery through routine governance

The required outcome is sustained assurance, not only completion of the action plan.

AMaT = All Wales Audit Management Tool | MHA = Mental Health Act | IPC = Infection prevention and control

Recommendations: assurance actions and controls

GIG CYMRU NHS WALES | Aneurin Bevan University Health Board

1 Immediate containment

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- Confirm no further gaps in legal authority for detention or treatment.
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- Quarterly Mental Health Act audits.
- Review of MHA governance procedures with automation and escalation.
- Revised daily safety briefing standard operating procedure.
- AMaT monitoring.
- IPC audits.
- Evidence to HIW within three months of inspection.

HIW has evaluated the Health Board's response and action plan, they have concluded it provides sufficient assurance. This is because the improvement HIW identified as being needed has either been addressed or progressed.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	06 October 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Covering Report – QMG Highlight Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade (Executive Director of Nursing)
SWYDDOG ADRODD: **REPORTING OFFICER:**	Kye Smith

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper presents the bimonthly Quality Management Group (QMG) Assurance Report to the Patient Quality, Safety and Outcomes Committee (PQSOC). The report summarises how the Health Board is overseeing and managing the six Pillars of Quality and its related statutory responsibilities.

QMG is a formal subgroup of the Executive Committee and provides structured assurance to PQSOC on whether effective systems are in place to keep patients safe, learn from harm and improve the quality of care. This report covers the QMG meeting held on 16 September 2026 and reflects the principal assurances, risks, improvement actions and matters requiring escalation.

Cefndir / Background

Under its Terms of Reference, the Quality Management Group is responsible for ensuring that the Health Board has sufficient and effective arrangements in place to meet its statutory and regulatory duties for quality and safety, including those arising from the Health and Social Care (Quality and Engagement) (Wales) Act 2020, the Duty of Quality and the Duty of Candour.

QMG provides assurance to PQSOC on behalf of the Executive Committee by:

- Reviewing intelligence from across all clinical divisions and corporate functions
- Monitoring patient safety incidents, complaints, safeguarding and regulatory findings

- Scrutinising quality improvement delivery and assurance systems
- Identifying risks that require escalation to executive or board level

PQSOC, in turn, is responsible for providing assurance to the Board that the Health Board has effective arrangements in place to protect patients, continuously improve care, and comply with national standards and legislation. This paper therefore supports PQSOC in discharging its role on behalf of the Board.

Asesiad / Assessment

QMG received a mixed but broadly positive assurance position. The meeting evidenced strengthening quality governance through improved Learning from Events Review completion and National Reportable Incident compliance, active divisional assurance, maturing specialist subgroup reporting and progress towards a more risk-informed Corporate Clinical Audit Framework. The Group endorsed the Board-level Infection Prevention and Control assurance statement and approved the refreshed People Experience and Involvement Framework. However, material risks continue to constrain assurance and require clear ownership, measurable improvement trajectories and continued executive oversight.

Dysphagia, tube feeding and nutrition safety were escalated following recurring incidents involving modified diets, fluids and tube feeding, including incidents with serious consequences. The Corporate Nutrition and Hydration risk is proposed to increase from 12 to 16. QMG requested an immediate review, a multidisciplinary task and finish group and a return report setting out the findings, improvement actions and governance arrangements.

Divisional reports identify a risk that operational pressures, particularly patient flow and surge capacity, are reducing capacity for professional leadership, quality governance and patient safety oversight. Primary Care and Surgery report the clearest concerns, with related issues identified across other divisions. While there is no evidence of widespread breaches of professional standards, QMG will continue to monitor divisional controls and any impact on safety, experience and quality of care.

The backlog of looked-after children health assessments remains a significant concern affecting a vulnerable population. A total of 403 assessments were reported as outstanding, with recovery constrained by current capacity and the length and complexity of assessments. QMG supported a cross-organisational quality improvement approach involving Family and Therapies, social care and other relevant partners.

Significant issues remain within Ophthalmology services including waiting lists, follow up and clinical care and treatment. Assurance was requested regarding clinical prioritisation, the assessment and recording of waiting-list harm, current mitigations and the risk of harm. A focused review is required for the next QMG meeting, including the waiting-list position, harm review, controls, follow ups and any decisions or support required from the Health Board.

Maternity and neonatal services reported improvement in early pregnancy booking, preterm optimisation, hypoxic-ischaemic encephalopathy, surgical-site infection, breast-milk provision and training. However, resilience remains affected by obstetric consultant presence, resident doctor rota gaps in neonatal services,

inconsistent availability of a second emergency theatre, limited pharmacy support, neonatal vacancies and capacity pressures. These risks require continued oversight through the Maternity and Neonatal Strategic Group and Executive Committee.

Medical device and essential-service risks require further action. Fresenius and BD ambulatory infusion devices are expected to reach the end of their serviceable life during 2027, the replacement timetable, and interim mitigation will be developed and a risk assessment completed. Mortuary and Care After Death staffing issues continue to require business-continuity arrangements, The HTA will review of historic incidents and near misses in the future during inspections, this will require preparation.

The violence and aggression thematic review considered 10,155 incidents. Physical assaults increased, racial abuse more than doubled, repeat offenders accounted for a material concentration of incidents and patients' homes were identified as a significant hotspot. Information-sharing and police-outcome data remain incomplete. Implementation of the Violence Prevention and Reduction Strategic Plan will therefore be targeted towards high-risk services, community staff and repeat offenders, supported by stronger outcome monitoring.

Rapid Release surveillance identified improved ambulance handover performance and no direct correlation with increased patient safety incidents. QMG nevertheless recognised that incident counts alone do not provide complete assurance. Prolonged trolley use, boarding, reduced discharge, patient experience, privacy and dignity, nutrition and hydration, deconditioning, waits in chairs and wheelchairs, and adherence to the operating model will require continued daily, weekly and monthly oversight.

The Healthcare Inspectorate Wales inspection response for Hafan Deg completed immediate actions relating to legal authority, medicines and infection prevention. Positive patient and family feedback, visible leadership, multidisciplinary working and safeguarding arrangements were also recognised. It was noted improvements continue in relation to legal status, covert medication, medicines management, documentation, the environment and governance, with wider learning to be embedded through the developing Healthcare Inspectorate Wales preparedness approach.

The Group received assurance that National Reportable Incident compliance reached 97% in Quarter 1 and that Learning from Events Review completion and organisational learning arrangements had improved. Infection prevention gap analysis identified no areas of non-compliance, with 68% assessed as fully compliant and 32% as partially compliant. The Medical Devices Group reviewed 128 incidents, none of which resulted in moderate or greater actual harm during the reporting period. These positive findings are balanced by continuing operational, workforce, digital, documentation, infection-control and implementation risks.

In summary, QMG was able to provide assurance that quality governance arrangements are active and continuing to mature. Assurance remains limited where evidence of effective and sustained improvement is required, particularly in nutrition safety, looked-after children and ophthalmology. It was noted that maternity and neonatal resilience, mortuary services, infusion-device replacement, urgent and community flow, violence and aggression, infection-control delivery under operational pressure and sustained improvement following regulatory findings will

require continued oversight. These matters will have defined return routes through QMG, Executive Committee, PQSOC and relevant specialist governance groups.

Argymhelliad / Recommendation

The Committee is asked to note the assurance received by QMG; endorse the matters escalated and the areas requiring continued oversight; and support the proposed governance routes for monitoring delivery, risk mitigation and sustained improvement. The Committee is asked to note where further assurance is required with further assurance to be provided through QMG, divisional governance and relevant specialist groups as appropriate.

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):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	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:	QMG Assurance Report, 16 September 2026.
Rhestr Termau: Glossary of Terms:	QMG: Quality Management Group. PQSOC: Patient Quality, Safety and Outcomes Committee. HIW: Healthcare Inspectorate Wales.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	Quality Management Group, 16 September 2026.

Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. Not applicable to this report

CHAIR'S REPORT FROM THE QUALITY MANAGEMENT GROUP

Meeting Date	16 September 2026
Chair	Jennifer Winslade (Executive Director of Nursing)

Chair's Summary

The meeting considered the Health Board's quality position, reviewed the principal areas of risk and progress, and agreed the matters requiring further action or escalation. Members welcomed stronger Learning from Events Review and National Reportable Incident compliance, progress towards a more risk-informed Corporate Clinical Audit Framework, active divisional oversight and maturing subgroup reporting. The Group endorsed the Board-level Infection Prevention and Control statement for Executive approval and recommended the approval of the refreshed People Experience and Involvement Framework. Attention was drawn to risks and issues relating to dysphagia and nutrition safety, the backlog in looked-after children assessments, ophthalmology potential harm, maternity and neonatal workforce and capacity, mortuary resilience, infusion-device replacement, community and urgent-care flow, violence and aggression and the improvement required following the Healthcare Inspectorate Wales findings at Hafan Deg. These matters will remain subject to executive, divisional and QMG oversight.

Follow-up and Reporting

Outstanding actions and escalations will return through QMG, Executive Committee, Patient Quality, Safety and Outcomes Committee or the relevant governance route. The next QMG meeting is scheduled for 10 November 2026. Specific actions include ophthalmology assurance, the dysphagia and tube-feeding review, community-acquired pressure ulcer work, theatre and procedural safety, looked-after children improvement, the medical-air plant briefing, and updates on infusion-device replacement and HIW preparedness.

The report supports the Duty of Quality by bringing together intelligence on safety, effectiveness, experience, workforce, infection prevention, safeguarding, clinical audit, risk and improvement. It identifies where assurance is positive, where evidence remains incomplete, and where escalation or further action is required to improve outcomes and reduce avoidable harm.

Actions Agreed by the Quality Management Group

KEY ESCALATION AND DISCUSSION POINTS

ALERT

Alert	Action	By whom	Target Date
Dysphagia, tube feeding and nutrition safety The Corporate Nutrition and Hydration risk is proposed to increase from 12 to 16 following recurring incidents involving	Complete the immediate review, progress the multidisciplinary task and finish group, and present the findings and improvement plan to the Quality Management Group.	Peter Carr and the Nutrition and Hydration Group	Next Quality Management Group meeting

modified diets, fluids and tube feeding, including incidents with serious consequences.			
Looked-after children health assessment backlog A total of 403 assessments were reported as outstanding. Current capacity and the length and complexity of the assessments are limiting recovery, affecting a vulnerable population.	Recovery plan Establish a cross-organisational quality improvement approach involving Family and Therapies, social care and other relevant partners.	Helen Morgan / ABCi/ Public Health	Progress update to the Quality Management Group
Ophthalmology harm Significant issues remain within Ophthalmology services including waiting lists, follow up and clinical care and treatment There is concern regarding potential avoidable sight loss and insufficient assurance regarding harm assessment and mitigation.	Issues to brought back to QMG and QPS team to explore additional support to expedite mitigations. To be raised through Divisional Assurance	Surgical Division / Ophthalmology / QPS	Next Quality Management Group meeting
Maternity and neonatal resilience Issues include obstetric consultant presence, resident doctor rotas in neonatal services, availability of a second emergency theatre, pharmacy gaps, neonatal vacancies and capacity pressures.	Maintain executive oversight and consolidate the implications of national maternity and neonatal reviews within the improvement programme.	Family and Therapies Division and Maternity and Neonatal leadership	Ongoing through the strategic group and Executive Committee
Infusion devices approaching the end of their serviceable life Fresenius and BD ambulatory infusion devices are expected to reach the end of their serviceable life during 2027. The replacement timetable, procurement and interim risk mitigation plan are in development	Confirm the implementation timetable, procurement arrangements and interim mitigating actions at the next QMG. Risk assessment will be undertaken	Medical Devices Group and Craig Roberts	Return to the Quality Management Group
Mortuary and Care After Death workforce resilience Staffing shortages are being mitigated through business continuity arrangements within service. The HTA will review of historic incidents and near misses in the future during inspections, this will require preparation	Maintain visibility through the Executive Committee and Quality Management Group and confirm sustainable staffing and compliance arrangements.	Human Tissue Authority Group	Ongoing
Violence and aggression and	Target implementation of the	Peter Carr, Lidia	Annual

community staff safety The thematic review covered 10,155 incidents. Physical assaults increased, racial abuse more than doubled, repeat offenders accounted for a material concentration of incidents, and patients' homes were identified as a significant hotspot. Information-sharing and police-outcome data remain incomplete.	Violence Prevention and Reduction Strategic Plan towards high-risk services, community staff and repeat offenders. Strengthen information-sharing and the monitoring of outcomes.	Palmer and the Violence Prevention and Reduction Strategic Group	update to the Quality Management Group
Rapid Release and urgent-care capacity Ambulance handover performance improved and no direct correlation with increased patient safety incidents was identified. However, prolonged trolley use, boarding, reduced discharge, patient experience and deconditioning remain concerns.	Continue weekly and monthly safety and patient-experience surveillance, restore adherence to the operating model, and include complaints, chair and wheelchair waits and deconditioning within the assurance arrangements.	Urgent Care, Medicine and Corporate Quality and Patient Safety	Ongoing clinical and executive oversight
Hafan Deg sustained improvement Immediate Healthcare Inspectorate Wales assurance actions were completed. However, the inspection identified concerns relating to legal status, covert medication, medicines management, infection prevention and control, documentation, the environment and governance. Sustained assurance and cross-divisional learning are required.	Continue weekly divisional oversight, evidence sustained compliance and embed the learning within the proactive Healthcare Inspectorate Wales preparedness approach.	Chris Jones, Mental Health and Learning Disabilities Division and Corporate Nursing	Ongoing, with reporting through divisional assurance

ADVISE
(Detail any areas of on-going monitoring, approvals, or new developments to be communicated)

- QMG endorsed the Board-level Infection Prevention and Control assurance statement. It will be incorporated into the Infection Prevention and Control Annual Report and progressed to Executive Committee and Board for approval.
- The draft Quarter 1 Quality Outcomes Framework report was received. The Quality Management Framework, subgroup structure, risk and issue-review arrangements and reporting routes are being refreshed, with engagement planned before Board consideration. Members supported a more focused, intelligence-led and exception-based model without losing necessary assurance.
- The refreshed People Experience and Involvement Framework was approved. It places greater emphasis on showing how feedback shapes decisions, service design and improvement, with stronger attention to equity, accessibility, seldom-heard groups and public accountability.
- The Corporate Clinical Audit Framework, Annual Plan 2026/27 and Strategic Oversight

of Clinical Audit 2026-2029 were approved. The approach formalises a risk-informed audit universe, transparent prioritisation, SMART actions, follow-up and evidence of sustained impact.

- Revised Transmission Based Precautions were supported for implementation. The model uses updated respiratory-transmission terminology and a contextual risk-assessment approach, with communication, staff education and visible guidance required before winter.
- The Maternity and Neonatal Annual Report was received, noting improvements in early booking, preterm optimisation, hypoxic-ischaemic encephalopathy, surgical-site infection, breast-milk provision and training, alongside continuing capacity, workforce, pharmacy and theatre risks.
- The acute inpatient Call for Concern requirement was due by 31 July 2026, but full Health Board implementation was not achievable by that date. A phased, safety-led approach was planned, with education and readiness activity during September 2026 and phased implementation from October 2026. The interim model remains dependent on paper recording pending possible CareFlow integration, with unresolved dependencies relating to out-of-hours senior nursing resilience, switchboard and bleep business continuity, and consistent application across emergency and community pathways.
- Attendance at children's safeguarding strategy meetings was reported at approximately 80%, creating a risk that the Health Board may not consistently contribute to timely multi-agency risk assessment and protection planning. A revised corporate risk was progressing through the Executive Team approval route, with divisions asked to identify additional mitigation.
- The Human Tissue Authority Group reported that CCTV recommendations arising from the Fuller Inquiry had been completed and the associated corrective action closed. Access permissions had also been strengthened, including removing unnecessary access for more than 70 individuals. However, licensed establishments were required to undertake a retrospective review of Human Tissue Authority incidents and governance records dating from 1 April 2015 in preparation for revised inspection expectations.
- The Duty of Quality, Putting Things Right, Health, Safety and Fire, Safeguarding and Volunteer Annual Reports were received through the consent agenda without substantive discussion.

ASSURE
(Detail here any areas of assurance the Committee has received)

- Learning from Events Review completion and organisational learning arrangements have improved following concerted divisional and corporate action.
- National Reportable Incident compliance reached 97% in Quarter 1, the highest level referenced in the meeting, strengthening timeliness of investigation and feedback to patients and families.
- Rapid Release surveillance has not identified significant variation above baseline or evidence of a direct correlation with increased patient safety incidents. Governance includes daily, weekly and monthly review, although experience and deconditioning measures require continued attention.
- Mental Health and Learning Disabilities reported a reduction in open Datix incidents.
- The Hafan Deg inspection response completed immediate legal, medicines and infection-prevention actions. Positive patient and family feedback, visible leadership, multidisciplinary working, safeguarding and incident-reporting arrangements were also recognised.
- The Infection Prevention and Antimicrobial Stewardship Group reported that the Health Board's gap analysis against the Infection Control Code of Practice identified no areas of

non-compliance, with 68% assessed as fully compliant and 32% as partially compliant. Revised Transmission Based Precautions, supporting communications and education materials are being implemented, and the winter respiratory escalation arrangements have been reviewed in preparation for increased respiratory illness.

- The Maternity and Neonatal Improvement and Assurance Group reported improved compliance across most elements of the Perinatal Optimisation Programme, external recognition for early breast-milk provision, a reduction in hypoxic-ischaemic encephalopathy cases, positive training compliance and a reduction of approximately 23% in maternity surgical-site infection. Most reported maternity and neonatal medication incidents were assessed as low or no harm, with monthly safety-group oversight and targeted learning arrangements in place.
- The Medical Devices Group reviewed 128 medical-device incidents and reported that none resulted in moderate or greater actual harm during the reporting period. Business-continuity controls are in place for the Zoll defibrillator pad shortage, including central stock management, clinically assessed alternatives and additional emergency stock. The Group also reported strengthening clinical-safety governance for artificial intelligence-enabled technologies and improved thematic analysis of medical-device incidents.
- The Mortality Review Screening Panel continues to meet weekly to review referrals from the Medical Examiner Service, ensure proportionate investigation and close cases with a documented rationale. The report recorded 211 referrals, 45 cases discussed at Level 2, 19 Level 3 cases fed back to the Panel and 457 cases closed on Datix. It identified next-of-kin concerns as the most common referral theme, followed by discharge, communication and delay concerns.
- Research and Development reported strong performance against national study set-up metrics, with only two studies outside target timescales, both attributed to Principal Investigator absence rather than systemic process failure. Governance arrangements have been aligned with the Clinical Effectiveness pillar, and a dedicated Band 7 Research and Development Finance Manager post has been approved, although recruitment was unsuccessful at the time of reporting.
- Subgroup assurance demonstrated active governance across infection prevention, mortality review, thrombosis, medical devices, safeguarding, workforce, research, maternity, resuscitation and other specialist areas, while also identifying material gaps requiring escalation.

Risks discussed or identified:

Workforce and specialist capacity

- Workforce constraints continue across several safety-critical services. Within maternity and neonatal services, minimum obstetric consultant presence, resident doctor rota gaps in neonatal services remain, and neonatal Band 6 vacancies may affect compliance with workforce standards. The inconsistent availability of staff to open a second emergency obstetric theatre, limited dedicated pharmacy support and constrained transitional-care capacity reduce service resilience during periods of increased activity and clinical acuity. These matters require continued divisional and executive oversight through the Division.
- Physiotherapy workforce constraints are affecting clinical delivery and require consideration of the associated quality impact assessment alongside the wider therapy review and budget-versus-establishment position. Speech and Language Therapy capacity is also a concern due to increasing dysphagia demand and the specialist input required to support training, incident review and multidisciplinary improvement.
- Further workforce pressures affecting palliative care, safeguarding, mortuary and Care After Death services, Research and Development, pharmacy and out-of-hours clinical pathways. Safeguarding capacity is affecting the Health Board's attendance at children's safeguarding strategy meetings. Mortuary staffing issues continue to require business-

continuity arrangements, although regulatory compliance is currently being maintained. Out-of-hours senior nursing capacity and response arrangements also remain dependencies for the safe implementation of Call for Concern.

Operational flow, capacity and clinical environment

- Patient flow and capacity pressures remain cross-organisational risks. Boarding, prolonged trolley use, reduced discharge performance and the use of Rapid Release areas as core capacity may affect privacy, dignity, nutrition, hydration, mobility, medicines administration and the timely recognition of deterioration. Some patients were reported to remain on Rapid Release trolleys for more than 24 hours.
- Monitoring had not identified a direct correlation between Rapid Release and increased patient-safety incidents. However, incident numbers alone do not provide complete assurance. Complaints, patient feedback, chair and wheelchair waits, prolonged trolley use, deconditioning and adherence to the Rapid Release operating model require continued monitoring through the rapid release quality reporting.
- High occupancy, boarding and frequent patient movement reduce opportunities to empty bed spaces for enhanced cleaning and may delay the isolation of patients with known or suspected infection. Limited side-room capacity and constraints within emergency and assessment environments increase reliance on prompt identification of infection status, effective communication between teams and consistent application of transmission-based precautions.
- Maternity services also reported pressure on room capacity alongside increasing acuity and intervention rates. Community services continue to manage surge capacity, staffing and discharge-support pressures. Environmental risks include restricted emergency-department cubicle capacity, estate limitations affecting Child and Adolescent Mental Health Services and older infrastructure that may constrain effective cleaning and infection-control arrangements.

Digital systems, data quality and clinical documentation

- Fragmented digital systems, incomplete information and continued reliance on manual processes limit the strength of organisational assurance. Warning markers for patients with a history of violence and aggression are not consistently visible across primary care, emergency, mental-health and other clinical systems because the systems do not interoperate. Safe care therefore depends on effective communication between services and divisions.
- Violence and aggression records do not consistently capture staff absence, sanctions, police outcomes, triggers, antecedents or the clinical context of incidents. This limits the Health Board's ability to understand workforce impact, evaluate interventions and identify the most effective preventive measures.
- Call for Concern remains dependent on an interim paper-based Patient Wellness Score pending digital integration. This creates risks relating to documentation reliability, accessibility, auditability and consistent use across different clinical pathways. Switchboard and bleep arrangements are also potential single-point dependencies and require effective business-continuity controls.
- Other data-quality concerns include inconsistent access to nursing workforce metrics, incomplete thrombosis risk assessments and anticoagulation documentation, incomplete recording of harm associated with waiting lists, and limited nutrition and hydration outcome measures beyond incident reporting. The Health Board also lacks a reliable mechanism for identifying patients participating in clinical research at other organisations, particularly cancer trials delivered through specialist centres. This limits clinical visibility, continuity of care and assurance regarding equitable access to research.

Infection prevention, environmental cleanliness and antimicrobial stewardship

- The gap analysis against the Infection Control Code of Practice identified no areas of non-compliance, with 68% assessed as fully compliant and 32% as partially compliant. However, significant delivery risks remain.
- Operational pressure and the inability to release beds are contributing to slippage in planned enhanced cleaning. Limited isolation facilities, high occupancy and frequent patient movement may affect the timely implementation of infection-control precautions. Infection risks are also being managed in the context of early respiratory illness activity and continuing outbreaks and exposures, including scabies within Mental Health and Learning Disabilities services.
- Attendance and multidisciplinary participation at healthcare-associated infection reviews are inconsistent. Current reviews have been described as overly focused on nursing and infection-prevention input, with insufficient engagement from wider clinical and operational teams. This may weaken divisional ownership of learning, action planning and sustained improvement. A revised review process, with clearer divisional ownership of actions, is being developed.
- Secondary-care antimicrobial use remains above the intended reduction trajectory and is increasing. Reviews identified prescribing outside guidance, microbiology advice or culture results, including recurring concerns involving piperacillin and tazobactam. Electronic prescribing arrangements have also resulted in fewer antimicrobial reviews being documented within 72 hours. Targeted audit, surveillance and clearer divisional ownership are required to determine whether existing controls are improving prescribing practice.
- Implementation of revised Transmission Based Precautions introduces new terminology and a more contextual approach to mask and respiratory protective equipment selection. Successful implementation depends on staff understanding, updated policies, clear communication, mask fit-testing capacity and consistent application across services. Mask fit-testing and High Consequence Infectious Disease training compliance remain particular concerns within urgent and emergency care.

Medicines, medical devices and clinical equipment

- The continuing disruption to Zoll defibrillator pad supplies is recorded as a corporate risk with a score of 20. Central stock control, clinically assessed alternatives and additional emergency stock provide immediate mitigation, but the risk remains until normal supply is restored. A wider defibrillator replacement programme is also progressing following the abandonment of the initial procurement exercise.
- Fresenius and BD ambulatory infusion devices are expected to reach the end of their serviceable life during 2027. A formal risk assessment, replacement timetable and interim mitigation plan will be developed to provide assurance that device availability and maintenance can be sustained.
- End-to-end electronic traceability of theatre instruments is not yet available, creating difficulty in rapidly identifying affected instruments and patients following an incident or product recall. This is recorded as a risk with a score of 16 and requires executive consideration of the proposed investment and implementation arrangements. This matter was recently considered by the Executive Committee.
- Additional medicines risks include a lack of robust dedicated pharmacy support in family and therapies, anticoagulation dosing and discharge reconciliation, and the medicines-management concerns identified through the Hafan Deg inspection. These included medicines storage, controlled-drug checks and incomplete capacity and best-interest documentation for covert medication. Immediate actions were reported as complete, but sustained monitoring is required to demonstrate embedded improvement.
- The contaminated medical-air plant at Ysbyty Aneurin Bevan has been switched off, with outlets capped and compressor nebulisers available. QMG supported decommissioning

rather than repair, subject to Executive Committee ratification and confirmation that the clinical, operational and business-continuity implications have been fully considered.

Patient safety, clinical outcomes and experience

- The strategic Nutrition and Hydration risk increased from 12 to 16 following recurring incidents involving dysphagia, modified diets and fluids, and tube feeding, including incidents of harm. Contributing issues include inconsistent compliance with care plans, communication failures, training and competency gaps, fragmented policy governance, limited outcome information and constrained Speech and Language Therapy capacity. An immediate review and multidisciplinary task and finish group are intended to establish the full scale of the risk and develop an organisational improvement plan.
- Community-acquired pressure ulcers remain a cross-divisional concern. A review is required covering patients known and not known to Health Board services, with improved engagement between relevant divisional and specialist leads. The work will determine whether reported harm is associated with access, recognition, prevention, care-home interfaces, community pathways or the reliability of existing controls.
- Inpatient falls increased to 313 in July 2026, compared with 287 in June. The rate of 6.7 falls per 1,000 occupied bed days was marginally above the quoted national average of 6.6 but remained within established control limits. Two falls involving catastrophic outcomes had been confirmed and three additional incidents involving possible falls-related catastrophic harm remained under review. The position requires continued monitoring, but the increase in reported incidents should not automatically be interpreted as evidence of worsening safety without considering activity and occupied bed days.
- Significant ophthalmology delays remain following the loss of the proposed Trevethen Health Centre solution. Assurance is required regarding clinical prioritisation, assessment of waiting-list harm, mitigation of deterioration and the potential for avoidable sight loss. A focused review of harm, current controls and the business-case position was recommended.
- One confirmed preventable hospital-associated thrombosis was identified during the reporting period. The case involved discharge on a lower dose of dalteparin than documented in the specialist management plan. A further case remained classified as potentially preventable pending investigation. Assurance is required that learning relating to medication reconciliation, anticoagulation dosing, patient weight and documentation has been implemented and tested.
- Further safety and experience concerns include patient absconsions from local hospitals, delayed discharge summaries, formal complaint backlogs, prolonged waits in chairs, wheelchairs or on trolleys, and the pastoral support available to patients experiencing extended waits. These issues may not always result in moderate or severe physical harm but can affect dignity, communication, continuity, emotional wellbeing, deconditioning and public confidence.

Safeguarding capacity and multi-agency protection arrangements

- Attendance at children's safeguarding strategy meetings remains approximately 80%. This creates a risk that the Health Board may not consistently contribute to timely multi-agency risk assessment and protection planning. The revised corporate risk is progressing through the Executive Team governance route, with divisions asked to identify additional support and mitigating action.
- Associated safeguarding risks include increasing demand on the Corporate Safeguarding Team, Violence against Women, Domestic Abuse and Sexual Violence training compliance below the 80% target, and the sustainability of Multi-Agency Risk Assessment Conference chairing and Independent Domestic Violence Adviser provision. Implementation of the RLDatix safeguarding module also depends on data quality, system integration and

readiness across internal services and local-authority partners.

- Safeguarding, mental capacity, domestic abuse, self-neglect and complex social circumstances must remain explicitly considered within Rapid Release and discharge decisions. Updated guidance following the relevant Supreme Court judgement also requires divisions to strengthen formal mental-capacity assessments and recording of best-interest decisions.

Regulatory, statutory and governance assurance

- The Healthcare Inspectorate Wales inspection of Hafan Deg identified concerns involving legal authority for detention, consent to treatment, mental-capacity and best-interest documentation, covert medication, medicines security, controlled-drug checks, infection prevention, personal protective equipment, care planning, privacy and dignity, Welsh-language provision, environmental maintenance and governance.
- Immediate actions were reported as complete. However, weekly divisional oversight and continuing evidence submission are required to demonstrate that improvements are sustained. The learning has wider relevance across the Health Board, particularly for medicines management, infection prevention, resuscitation equipment, assessment quality and clinical record keeping.
- A proactive Healthcare Inspectorate Wales preparedness assessment is being developed to support ward-level review and peer assurance before future inspections. This provides an additional control but will require consistent implementation, effective escalation and evidence that identified gaps are addressed.
- Mortuary and Care After Death services must complete a retrospective review of Human Tissue Authority incidents and governance records dating from 1 April 2015 in response to revised inspection expectations. Corrective actions relating to closed-circuit television and access controls have progressed, staffing shortages, governance capacity and business-continuity pressures are in place. Completion of the retrospective review and delivery of enhanced audit arrangements will need to be factored into plans.
- Across the wider governance system, the timely closure and evidencing of actions following audits, inspections, incidents and external reviews remain essential. Recorded completion of an action does not, on its own, demonstrate that the control is effective or that improvement has been sustained. Future assurance should therefore distinguish between action completion, implementation, evidence of effectiveness and sustained compliance.

Professional standards and operational pressures

- Quality Management Group (QMG) divisional reports identify increasing tension between operational demands and the capacity to maintain professional standards, quality governance and patient safety oversight. Primary Care has identified "professional standards versus patient flow" as one of its three principal risks, reflecting increased use of surge capacity and boarding arrangements. Surgery similarly reports that sustained patient flow expectations are constraining senior nursing and management capacity to maintain focus on professional concerns, quality, patient safety and governance.
- Other divisional reports identify other themes, issues and trends. These include medication management, Mental Health Act administration, Mental Capacity Act compliance, infection prevention and control, venous thromboembolism incidents and practitioner concerns being managed with Workforce and Safeguarding. Improvement actions and additional controls are being implemented in response.
- The reports do not provide evidence of widespread or systemic breaches of professional standards. However, they indicate a developing assurance concern that sustained operational pressures may reduce the capacity available for professional leadership, oversight, governance and improvement. QMG will continue to monitor the position, the

effectiveness of divisional controls and any emerging impact on patient safety, experience and quality of care.

Divisional Updates

Mental Health and Learning Disabilities

The Division reported a significant reduction in its open Datix incident backlog, from approximately 1,800 incidents to around 440, alongside reductions in restrictive-practice incidents. Further positive assurance was provided through plans to implement Safe Wards across all 14 wards, introduce sensory-regulation resources and improve quality dashboards, communication-safety work and pathways intended to avoid unnecessary admission or reduce length of stay.

The Division also reported continuing limitations in the quality and interpretation of restrictive-practice data, particularly the absence of consistent information about triggers and antecedents. QMG identified opportunities to transfer learning from Mental Health and Learning Disabilities on enhanced care, dementia and restrictive practice to other inpatient services.

The Healthcare Inspectorate Wales inspection of Hafan Deg identified concerns relating to legal documentation, consent to treatment, covert medication, medicines management, infection prevention and control, personal protective equipment, care planning, privacy and dignity, Welsh-language provision, environmental maintenance and governance. Immediate containment actions were reported as complete, with continuing weekly directorate and divisional oversight. QMG emphasised the need to evidence that improvement is sustained and to apply the learning across other divisions through the developing Healthcare Inspectorate Wales preparedness process.

Family and Therapies

The Division reported increasing maternity demand and acuity, high levels of caesarean activity, pressure on available rooms and continuing gaps in pharmacy support across maternity, neonatal and paediatric services. The Maternity and Neonatal Annual Report described improvement in early pregnancy booking, optimisation of babies born before 34 weeks, hypoxic-ischaemic encephalopathy rates, surgical-site infection, breast-milk provision and key elements of training. However, continuing risks were identified in relation to medical staffing in neonatal services, pharmacy capacity, neonatal vacancies, obstetric-consultant presence and inconsistent availability of a second emergency theatre.

There were 403 outstanding looked-after children health assessments. The service reported that assessments are complex and lengthy and that current capacity is insufficient to address the backlog. Proposed mitigations included increasing clinic-based activity, strengthening social-care input, improving the information available before assessment and remodelling the team. QMG requested a cross-organisational improvement discussion involving Family and Therapies, social care and other relevant partners.

Significant safety concerns were also identified where patients with documented dysphagia plans had received unsuitable food or drink. QMG requested an immediate review, establishment of a multidisciplinary task and finish group and a subsequent paper setting out findings, actions and governance arrangements. The Division additionally reported waits exceeding one year within weight-management services and workforce constraints affecting physiotherapy delivery. The proposed prioritisation approach for weight-loss medication and adult weight-management services is to return to Executive Committee, while the

physiotherapy quality impact assessment is to be considered alongside the wider therapy and establishment review.

Medicine

The Division reported continuing pressure arising from patient flow, boarding and high occupancy. Three patient absconsion had occurred at local hospitals, resulting in local investigation and consideration of wider patient-safety learning. The Division also highlighted delayed discharge summaries, falls, complaints and the effect of operational pressure on patients and staff.

Mitigating actions included enhanced monitoring of incidents, re-establishment of falls forums, weekly review of complaints and a recovery plan for the discharge-summary backlog. QMG recognised the work underway but noted that the interaction between flow, boarding, avoidable harm, patient experience and delayed discharge information requires continued divisional and corporate oversight.

Clinical Support Services

The Division reported risks associated with the defibrillator replacement programme, pathology information-technology changes, imaging demand, incident backlogs and potential diagnostic delays. These matters require continued oversight to ensure that equipment, digital transition and workforce constraints do not adversely affect timely diagnosis or treatment.

Positive assurance was reported through improved cleaning and audit compliance in critical care and the redesign of pre-assessment services. The revised pre-assessment model reduced the number of face-to-face appointments, increased available capacity and reduced routine waiting times to approximately four weeks.

QMG requested follow-up on the cross-divisional review of theatre and procedural safety systems. The review is intended to consider whether learning and controls are being applied consistently across services undertaking invasive procedures.

Surgery

The Division reported more than 54 overdue formal complaints, continuing pressure on the Surgical Assessment Unit and significant ophthalmology delays following the loss of the proposed Trevethen Health Centre solution. The ophthalmology position raised particular concern about how the Division identifies, assesses and mitigates the risk of harm associated with extended waits, including the potential for deterioration or avoidable sight loss.

QMG requested a focused ophthalmology review for its next meeting. This should set out the current waiting-list position, the approach to clinical prioritisation and harm review, existing mitigations, the position of the business case and any decisions or support required from the Health Board.

Positive assurance was reported in relation to accreditation activity, work addressing deconditioning, orthopaedic pathway improvement and the use of patient feedback. These improvements should be considered alongside the unresolved risks associated with complaints, urgent surgical flow and ophthalmology capacity.

Primary Care and Community Services

The Division reported pressures associated with boarding and surge capacity, staffing and variable-pay controls, reduced palliative-care capacity, pharmacy vacancies and governance

arrangements for hosted practices. These risks were compounded by wider patient-flow pressures and the need to maintain safe community capacity and discharge support.

Improvement activity included senior oversight of discharge, development of a future palliative-care model, involvement of care homes in pressure-ulcer root cause analysis, development of a falls root cause analysis pathway, delivery of 17 quality-improvement projects and accreditation work within community nursing.

QMG requested an update on the cross-divisional review of community-acquired pressure ulcers, including analysis of patients known and not known to services. The Group also requested confirmation that the matter had been included on the divisional nurse meeting agenda. Safe-to-start arrangements for community services remained an outstanding matter requiring follow-up.

Urgent Care

The Division reported continuing congestion across urgent and emergency care. Rapid Release spaces were increasingly being used as core capacity, with some patients remaining on trolleys for more than 24 hours. Other priorities included improving time to be seen, reviewing the safety of the mental-health assessment environment in Room 28, supporting implementation of the Welsh Emergency Care Data Set and completing the required Welsh-language functionality.

The Rapid Release update demonstrated substantial improvement in ambulance handover performance. Safety monitoring included daily review of moderate-harm or potentially related incidents, weekly review of incidents and patient-experience concerns, and a monthly deep dive across acute admission, boarding and enhanced local general hospital locations. The analysis presented to QMG had not identified significant variation above baseline or evidence of a direct correlation between Rapid Release and increased patient-safety incidents.

However, QMG noted that the assurance position must extend beyond incident counts. Complaints, patient feedback, waits in chairs or wheelchairs, prolonged trolley use, boarding and deconditioning should remain part of the assessment. The Group also requested that the available pastoral support within emergency and assessment areas, including volunteer, third-sector and chaplaincy provision, be mapped against the needs of patients experiencing extended waits.

Matters for the Board or other committees:

The Board-level Infection Prevention and Control assurance statement was endorsed by the Quality Management Group but required a formal decision by the Executive Committee to be incorporated within the Infection Prevention and Control Annual Report. Please see Appendix 1.

The medical-air plant decommissioning proposal for Ysbyty Aneurin Bevan required an Executive Committee ratification. Please see Appendix 2

Dysphagia and tube-feeding risk, including the proposed increase of the Nutrition and Hydration risk from 12 to 16, will have continued corporate risk and QMG oversight.

Maternity and neonatal workforce, pharmacy, theatre, capacity and flow risks will remain visible through the revised strategic group and Executive Committee.

Infusion-device lifecycle and replacement - a plan with a clear procurement and an implementation trajectory will be developed.

Mortuary and Care After Death workforce resilience and the mitigating actions will be monitored by the Division and by Executive Committee.

Ophthalmology harm will continue to be monitored closely through Divisional structures and QMG

Violence Prevention and Reduction Strategic Plan implementation will be monitored through its strategic group, with annual QMG updates and appropriate visibility to workforce and quality committees.

Rapid Release assurance will continue through clinical and executive governance, incorporating patient safety, complaints, experience, deconditioning and adherence to the operating model.

HIW actions and wider HIW preparedness will remain under divisional and corporate oversight

MEETING AGENDA ITEMS

Minutes of the meeting held 8 July 2026 and matters arising	Board-level assurance statement for Infection Prevention and Control	Quarter 1 Quality Outcome Report, draft
Violence Prevention and Sexual Safety Reduction Strategic Plan and thematic review	People Experience and Involvement Framework	Rapid Release operational, performance and quality update
Quality and Patient Safety divisional assurance reports	Corporate Clinical Audit Framework, Annual Plan and Strategic Oversight	Maternity and Neonatal Annual Report 2025/26
QMG pillar assurance reports	Transmission Based Precautions changes	Healthcare Inspectorate Wales inspection report and Hafan Deg Improvement Plan
Consent agenda: Duty of Quality, Putting Things Right, Health, Safety and Fire, Safeguarding and Volunteer annual reports		

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In Attendance	
Jennifer Winslade	Chair, Executive Director of Nursing
Kye Smith	Deputy Head of Quality and Patient Safety
Kelly Downes	Deputy Director of Nursing
Leeanne Lewis	Assistant Director Quality and Patient Safety
Seema Srivastava	Executive Medical Director
Peter Carr	Executive Director of Allied Health Professions and Health Science
Tanya Strange	Head of Nursing, Person-Centred Care
Jayne Beasley	Head of Midwifery, Gynaecology and Neonates
Helen Ronchetti	Deputy Head Infection Prevention Service
Joanne Lane	Divisional Nurse, Primary Care and Community Division
Christopher Morgan	Divisional Nurse, Urgent Care
Craig Roberts	Assistant Director of Allied Health Professions and Health Science
Jonathan Simms	Pharmacy
Jonathan Clarke	ENT / ABCi
Carly Cole	Head of Nursing, Clinical Support Services

Lidia Palmer	Violence Prevention & Reduction Lead
Trish Chalk	Planning
Emily Clark	Consultant in Public Health Medicine
Susan Palmer	Research and Development
Helen Morgan	Division Nurse F&T
Collette Kiernan	Deputy Executive Director of Allied Health Professions and Health Science
Howard Stanley	Head of Safeguarding
Donna Challingsworth	Head of Nursing, Surgery
Chris Jones	Head of Nursing, MH&LD
Karen Collins	Head of Nursing, Medicine
Samantha Matthews	Business Support Officer

In Attendance to Present	
Matthew Temby	

Apologies	
Moira Bevan	Head of Infection Prevention and Control
Tracey PartridgeWilson	Deputy Director of Nursing
Amy Buckley	Divisional Nurse, Mental Health and Learning Disabilities
Deb Jackson	Nursing
Natalie Skyrme	Divisional Nurse, Medicine
Rebekah White	Divisional Nurse, Clinical Support Services
Amanda Hale	Divisional Nurse, Surgery
Clifford Jones	Primary Care and Community Division
Stephen Edwards	Medical Director's Office
Scott Taylor	Health, Safety and Security
Tracy Daszkiewicz	Public Health

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	06 October 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	To approve the Board level assurance statement for Infection Prevention
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade – Executive Nurse Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Moira Bevan – Head of Service Infection Prevention

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

Ar Gyfer Penderfyniad/For Decision

The purpose of this paper is to provide an overview of the requirement of the Code of Practice for a Board level assurance statement for infection Prevention and approve accordingly.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Currently, Aneurin Bevan University Health Board's does not have an official Board statement outlining collective responsibility for minimising the risk of infection and antimicrobial resistance, and the controls in place to prevent these risks.

However, there is regular update provided for infection prevention assurance during the year on infection rates, risks and mitigating actions, which is also incorporated into the Health Board risk register.

Cefndir / Background

Current arrangements provide a structured approach for monitoring, reporting and escalating Infection Prevention and Control and Decontamination risks. Performance is reviewed monthly, with trends analysed and reported through the Infection Prevention and Antimicrobial Stewardship Group and Quality Management Group



In March 2026 Welsh Healthcare Associated Infection Board Assurance Framework was developed and adapted to the Welsh HCAI Code of Practice and Welsh Government Quality Statement. The Board assurance framework is structure around twelve key standards. Under section one which requires appropriate organisational governance and accountability structures and management systems for infection prevention and control are in place.

Asesiad / Assessment

Currently there is partial compliance with section one an response to the new requirement a suggest Board level statement has been developed below:-

The Health Board is committed to delivering safe, high-quality care by minimising the risk of healthcare-associated infection (HCAI) and ensuring robust decontamination practices across all services. The Executive Team and various committees/groups receive regular assurance or mitigations that effective systems are in place to prevent and control infection and to maintain safe decontamination standards. This includes compliance with national legislation, professional standards, and Welsh Government requirements.

- An identified Infection Prevention and Control (IPC) and Decontamination escalation framework is in place, supported by clear policies, procedures, and governance arrangements.
- There are executive leadership and accountability, with a designated Board-level Director responsible for IPC/environmental cleanliness and Decontamination, antimicrobial stewardship and water/ventilation safety
- Surveillance systems monitor healthcare-associated infections via ICNET, including mandatory reporting of key organisms (e.g. *Staphylococcus aureus* bacteraemia, *Clostridioides difficile*, Gram-negative bloodstream infections).
- Performance is reviewed monthly, with trends analysed and reported through Infection Prevention and Antimicrobial stewardship group and Quality Management Group.
- Decontamination services (including sterilisation, disinfection and equipment management) meet required HTM standards and are subject to audit and validation.
- Staff training and compliance with IPC practices, including hand hygiene and standard precautions, are promoted and monitored accordingly.

Risks and ongoing mitigations are recorded and monitored via the corporate risk register

Argymhelliad / Recommendation

Risks and ongoing mitigations should continue to be recorded and monitored through the corporate risk register, with regular escalation and assurance provided to the appropriate Executive Team and committees/groups. Continued oversight



should ensure that governance arrangements remain effective, standards are maintained, and any emerging risks are addressed promptly

The Patient Quality, Safety and Outcomes Committee is asked to note the report and recommendations to agree the proposed Board level assurance statement.

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 2.4 Infection Prevention and Control (IPC) and Decontamination 3.1 Safe and Clinically Effective Care 3.2 Communicating Effectively
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	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	Choose an item. Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr 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.



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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	06 October 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Decommissioning of Medical Air at YAB and Redwood
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr Seema Srivastava Executive Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Jonathan Simms Clinical Director of Pharmacy

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 air plant at Ysbyty Aneurin Bevan (YAB) has recently been shut down following oil contamination of the filters. Currently there is a backup manifold which can provide medical air to the site. However, there has been an ongoing review assessing the need for medical air across the estate following a patient safety incident. This has resulted in the capping off of all medical air outlets on wards at YAB and other sites.

At the meeting of the Medical Gases Safety Group on the 16th September 2026 it was recommend that the medical air plant and the manifold are decommissioned. In addition, it is recommended that the medical air manifold

which serves the Redwood Suite at Rhymney Integrated Health & Social Care Centre is also decommissioned.

Cefndir / Background

An internal patient safety alert was issued in April 2026[1] following a patient safety incident which resulted in a patient being connected to medical air instead of oxygen.

A review of actions in relation to PSN036 (Reducing the risk of oxygen tubing being connected to air flowmeters)[2], issued in November 2016, has also been undertaken.

As part of the action plan for the 2016 alert, a paper was presented to the Executive Committee which recommended the use of compressors to drive nebulised treatment rather than medical air. This paper also recommended that medical air outlets should be capped off with lockable caps which can only be accessed using a dedicated tool. (See appendix1).

Works and Estates have undertaken an inspection of medical air outlets across wards at YYF, YAB, RGH, NHH and SWH to locate any ports where caps have been removed. This has been followed up with the installation of new caps to prevent unintended access.

Asesiad / Assessment

It has been confirmed that the wards at YAB have access to nebuliser compressors. In addition, there are no other departments that would require access to medical air at YAB. The Redwood suite is currently in the process of purchasing a nebuliser compressor to remove their need for piped medical air.

It is the view of the Medical Gases Safety Group that there is no clinical need for piped medical air if nebuliser compressors are available at YAB and the Redwood suite. Therefore, the repair of the medical air plant at YAB is not justified from a clinical or financial perspective.

The decommissioning of the manifolds will save money in terms of cylinder rental charges. The Manifold rental for 24 J size air cylinders per month is £111.46 (including VAT). This will also provide an opportunity to use the medical air cylinder racking for the storage of J oxygen cylinder to support the changing of a full bank of cylinders. There will also be a benefit on reducing the staff time and costs associated with routine quarterly QC testing and ongoing maintenance.

This action will also remove the risk of inadvertent connection to medical air instead of oxygen at these sites.
Argymhelliad / Recommendation The Patient Quality, Safety and Outcomes Committee is asked to approve the recommendation of the Medical Gases Safety Group to decommission the YAB air plant and the medical air manifolds at YAB and the Redwood suite.

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):	2.6 Medicines Management 2. Safe Care 3. 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	Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working**	Choose an item. Choose an item.

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

The Removal of Medical Air Flow meters from all clinical areas.

Following the publication of PSN036 Reducing the risk of oxygen tubing being connected to air flowmeters a further low harm incident occurred within the Health Board whereby medical air was administered in place of Oxygen in an emergency.

The error was noted within seconds and the patient was admitted to ITU where he made a complete recovery and was discharged home. This could have been catastrophic if there had been a delay in identifying the error.

PSN036 Reducing the risk of oxygen tubing being connected to air flowmeters, which was issued in November 2016, acknowledged this issue and identified a number of incidents that have occurred across the UK two of which resulted in fatalities and two graded as severe harm. In ABUHB there have been 3 recent incidents where whereby medical air was administered in place of Oxygen in an emergency.

The compliance date for PSN036 was 4th August 2017. ABUHB have not yet declared compliance.

This paper seeks approval for actions to reduce the risk of Medical Air being administered in place of Oxygen. In addition, these actions, once completed, would result in the Health Board achieving compliance with PSN036.

Financial Assessment and link to Financial Recovery Plan	
Risk Assessment	*The risk of administering Medical Air in place of Oxygen can be minimised if medical air flow meters are not available or are removed or capped off when not required.*
Standards for Health Services Wales	*This issue applies to Health and Care Standards 3.1: Safe and Clinically Effective Care and* *2.9: Medical Devices, Equipment and Diagnostic Systems.*

Equality Impact Assessment	*No equality issues identified*

1 Introduction

Piped Medical air is available in many ward areas across all hospitals within the Health Board and is most frequently used to drive the administration of nebulised medication. One notable exception is Nevill Hall Hospital where only the Respiratory wards have piped medical air installed. No issues have been reported from the wards where piped medical air is not provided and the use of medical air cylinders is minimal.

The flow meters are attached to the wall next to the flow meters for Oxygen. Although it is difficult to attach a Medical Air flowmeter to an Oxygen wall port the connections for the patient tubing are universal meaning that it is possible to connect the tubing intended for Oxygen to the Medical Air flow meter.

PSN036 Reducing the risk of oxygen tubing being connected to air flowmeters acknowledged this issue and identified a number of incidents that have occurred across the UK two of which resulted in fatalities and two graded as severe harm. In ABUHB there have been 3 recent incidents (low harm) whereby medical air was administered in place of Oxygen in an emergency.

PSN036 lists 3 actions that should be taken to reduce the risk of further incidents occurring:

- Medical air terminal units (wall outlets) are covered with designated caps in areas where there is no need for medical air
- Medical air flowmeters are removed from terminal units (wall outlets) and stored in an allocated place when not in active use
- Air flowmeters are fitted with a labelled, movable flap

In line with these recommendations, the following actions have already been taken:

- Movable flaps have been in use within the Health Board since the previous NPSA Rapid Response Report in 2010. Unfortunately these are not very robust devices and once broken or removed are not always replaced. The lasts incident occurred in an area where the devices had been in use but not replaced once removed.
- An Internal alert has been sent to all areas requiring all Medical Air flowmeters to be removed from the Medical Air ports. A minimal number should be kept on the medication trolley for use where Medical Air is required to drive the nebuliser and must be removed after use. Unfortunately there is always the possibility that the Medical Air flowmeter will not be removed when no longer required.

The staff will have become used to only Oxygen flow meter being available and the risk of a similar incident occurring still exists.

- A further local action was also put into place prior to the latest incident but in response to PSN036. A letter was sent from the Medical Director to all Consultants asking that where nebulisers are prescribed that the prescription indicates whether Air or Oxygen should be used to drive the medication.

2 Options

Option 1

Apply lockable caps to all Medical Air Ports in all ward/department areas and supply a key to each ward/area that may uses medical air (ie. Respiratory areas).

Also continue as now with the Medical Air flow meters being placed on the medication trolley and used as required.

The risk still exists that staff will forget to remove the flow meter and recap the port meaning that the Medical air flow meter is left in place.

Option 2

Air compressors are available that are small electrical portable box shaped devices that pull air in from the atmosphere to drive a nebuliser. The Health Board currently utilises these machines in areas such as Chest Clinic. With the exception of Respiratory Wards each ward would only need to hold 2 or 3 of these devices. The cost of the Air Compressors is approximately £60 each.

Once these are available the Medical Air ports in the walls could be capped off with lockable caps so that they could only be accessed by using a dedicated tool. It should be noted that Medical Air would never be required in an emergency.

In order to implement these devices they would need to be purchased and training provided to all staff required to use them. The Senior Nurse for the Respiratory Wards has agreed to support this. On review of the user instructions and discussion with the Health Board EBME manager it should be noted that these devices contain no serviceable parts and no maintenance is required. There is a filter that needs to be changed frequently.

The dedicated Respiratory wards may still need the provision of piped Medical Air but this would need to be agreed by the Directorate and managed as per option 1. Alternatively a decision would need to be made around the adoption of the medical air compressors as for the other wards.

Option 3

All Medical Air ports would be fitted with the lockable wall caps but a portable air cylinder would need to be available for those patients who need medical air. The use of gas cylinders has been discouraged in recent years due to the risk of injury to staff and patients.

This option is not recommended by the working party.

3 The Financial Context

The cost of the Air Compressors is approximately £60 each. Each ward identified as requiring the compressors in order to administer nebulised medication would need to purchase 2-3. The Respiratory Wards may require more due to the number of nebulised drugs administered.

Replacement filters would be required and changed as necessary.

The compressors do not require a service and maintenance contract but if they become broken or unusable they would need to be replaced. The compressors would be delivered to the Health Board Medical Electronics department at St Woolos Hospital to undergo an electrical safety test and logging onto the asset register prior to delivery to the wards. This would have an impact on the workload of this department until they have all been delivered.

In addition funding would be required for the capping of all Medical Air wall ports by Works and Estates. The estimated cost for capping Medical Air wall ports and the provision of the tool to unlock the cap would be £3500.

Recommendations

Option 2 provides the lowest risk as the Medical Air flow meters will no longer be available.

Training and support in the use of the Air compressors would be provided by the Respiratory team.

The dedicated Respiratory wards may still need the provision of piped Medical Air but this would need to be agreed by the Directorate and managed as per option 1.

The Health Board would be able to declare compliance with PSN036 Reducing the risk of oxygen tubing being connected to air flowmeters

Prepared by: **Susan Hallybone – Risk Manager Patient Safety**
Carolyn Middleton – Associate Nurse Director
Neil Pearce – Head of Estates
Mark Francis – EBME Manager
Liz Waters - Associate Nurse Director

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	06 October 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality Annual Report 2025/26
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing Peter Carr, Executive Director of Therapies & Health Science Dr Seema Srivastava, Executive Medical Director Tracy Daszkiewicz, Executive Director of Public Health
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety Tracey Partridge-Wilson, Deputy Director of Nursing

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board's Annual Quality Report for 2025/26 provides a balanced account of the quality, safety, effectiveness and experience of care delivered during the year. It describes the progress made, the learning identified, the areas where further improvement is required and the priorities that will guide the next stage of the Health Board's quality journey.

The report fulfils the Health Board's statutory reporting responsibilities under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. It demonstrates how the Duty of Quality and Duty of Candour are increasingly embedded within strategic decision-making, governance, incident management, organisational learning and everyday practice. During 2025/26, the Health Board's focus moved beyond establishing the initial requirements of the duties

towards demonstrating how they influence decisions, strengthen openness and support continual improvement in outcomes and experience.

The report is structured around the Health Board's six Pillars of Quality and maps these to the six domains and six enabling standards within the Health and Care Quality Standards for Wales. It sets out the evidence and achievements within each Pillar, how assurance is obtained, what has been learned and changed, the continuing risks and challenges, and the priorities for 2026/27.

The central narrative for 2025/26 is the strengthening of the organisational arrangements that connect quality governance, intelligence, learning and improvement. This includes the establishment of the Quality Management Group, the refresh of the Quality Outcomes Framework, closer alignment between quality and divisional performance arrangements, the development of organisational learning systems, the establishment of Clinical Effectiveness as a distinct Pillar and the expansion of quality improvement capability.

The Annual Quality Report is presented for assurance, recognising that the evidence demonstrates both important progress and areas where further action, validation and sustained monitoring are required.

Cefndir / Background

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 came into effect across NHS Wales in April 2023, introducing the Duty of Quality and Duty of Candour and placing continual improvement, openness and citizen voice at the centre of healthcare. The 2025/26 reporting year represents the final year of the Health Board's Quality Strategy 2023–2026.

During the three years of the strategy, the Health Board has progressively developed its Quality Management System, bringing together the four interdependent components of quality planning, quality control, quality improvement and quality assurance. During 2025/26, the principal focus was on strengthening these foundations and improving the connections between quality intelligence, frontline care, divisional governance, executive oversight and Board assurance.

The Quality Management Group was established as an executive forum for bringing together intelligence from patient and family feedback, concerns, complaints, incidents, mortality reviews, clinical audit, claims, external reviews, workforce information and performance data. The refreshed Quality Outcomes Framework and closer alignment with divisional performance arrangements have improved visibility from frontline services through to Executive and Board oversight.

The Health Board has also strengthened its organisational learning arrangements through the Listening and Learning Framework, Learning and Improvement Forum, Learning Repository and divisional Learning from Events Reports. These arrangements provide a more systematic route for identifying themes, agreeing actions, sharing learning and translating insight into measurable improvement. Human Factors work complements this approach by supporting a fair, open and systems-focused culture.

The report reflects the contribution of patients, families, carers, volunteers and staff through surveys, patient stories, complaints, compliments, participation panels, the Patient Advice and Liaison Service, co-design, safety visits and Big Conversation activity. Their insight has identified strengths, highlighted barriers and influenced service development and improvement.

As the Quality Strategy 2023–2026 concludes, the Health Board will undertake a comprehensive evaluation of its Quality Management System. The findings will inform a refreshed Quality Plan for 2026/27 and beyond, with a greater focus on demonstrating measurable and sustainable improvements in care, outcomes and experience.

Asesiad / Assessment

The Annual Quality Report provides reasonable assurance that the Health Board has strengthened the arrangements through which quality intelligence is identified, brought together, scrutinised and escalated. The Quality Management Group, Quality Outcomes Framework, divisional governance arrangements and Patient Quality, Safety and Outcomes Committee provide clearer lines of sight between frontline services, Executive teams and the Board.

The Health Board has made progress across the six Pillars of Quality.

1. Patient and staff experience, concerns, complaints and compliments

Patient experience insight expanded during the year through Civica, the All-Wales People's Experience Survey, PALS, concerns and complaints, participation panels, patient stories, co-design, volunteering and bereavement support. Feedback consistently identified compassionate, professional care and staff kindness as strengths, while waiting, communication, comfort and emotional support remained areas for improvement. Complaint response timeliness remains below the required standard, and further work is required to strengthen the representativeness of feedback and demonstrate more consistently how listening has led to measurable change. [

2. Patient safety

Patient safety oversight was strengthened through daily incident reviews, DatixCymru dashboards, enhanced investigation arrangements, multidisciplinary review, thematic analysis and increased scrutiny through established governance routes. Targeted improvement programmes continued to address falls, pressure damage, medicines safety, nutrition and hydration. The overdue investigation backlog reduced during the year, although compliance with national investigation timescales remains below expectation and avoidable harm requires continued attention.

The Learning from Deaths Framework, Medical Examiner Service and structured mortality review processes identified opportunities to improve documentation, clinical coding, continuity of care, end-of-life communication and treatment escalation planning. Final mortality indicators and a number of patient safety measures remain subject to reconciliation and validation before publication.

3. Clinical effectiveness

Clinical Effectiveness was established as a distinct Pillar during 2025/26, bringing together evidence-based practice, clinical audit, outcomes, research and improvement. The Audit Management and Tracking system has improved oversight of audit recommendations, actions and assurance. Electronic deterioration systems were introduced across adult, paediatric and neonatal services, and the Call for Concern pilot tested a direct route for patients and families to escalate concerns.

Further work is required to strengthen audit participation, re-audit, clinical coding, outcomes reporting and evidence of sustained implementation. Priorities for 2026/27 include wider implementation of Call for Concern, completion of remaining deterioration and escalation initiatives, expansion of Ward and Team Accreditation, and implementation of the Corporate Clinical Audit Framework 2026/27.

4. Health, safety and security

The Health Board continued to strengthen the identification and management of health, safety and security risks through inspections, leadership walkabouts, risk assessment and organisational learning. Work undertaken through the Violence Prevention and Reduction Strategic Plan strengthened prevention, de-escalation, incident response and support for staff. Violence and aggression, mandatory training compliance, statutory reporting and risks associated with the ageing estate remain areas requiring continued oversight.

5. Infection prevention and control

The Infection Prevention and Antimicrobial Steering Group provided oversight of infection prevention, outbreak management and antimicrobial stewardship. Targeted work addressed healthcare-associated infection, hand hygiene, environmental cleanliness and prudent antimicrobial prescribing. The report identifies progress in some areas while recognising that Gram-negative bloodstream infections, antimicrobial resistance, seasonal pressures, isolation capacity and estate constraints continue to present challenges. Some infection surveillance information requires final validation and reconciliation

6. Safeguarding

Safeguarding governance continued through the Safeguarding Strategic Group and its subgroups, supported by multi-agency working across Gwent. Improvements were made to the management of People in Positions of Trust referrals through enhanced use of the Datix Safeguarding Module, strengthened oversight and action to address increasing demand. Safeguarding complexity, workforce capacity and compliance with safeguarding and Ask and Act training remain important areas of focus for 2026/27.

- Organisational learning and improvement

The report demonstrates a more systematic route from listening and intelligence to action, improvement and assurance. Common learning across incidents, complaints, claims, mortality reviews, clinical audit, accreditation and patient and staff feedback included communication, documentation, pathway reliability, timeliness, data quality and the need for stronger evidence of sustainability.

Improvement capability expanded during the year through implementation of the Quality Improvement Capability Framework 2025–2028, improvement education, coaching, structured improvement methods and increased alignment with organisational priorities. The next stage is to move beyond measures of activity and capability and demonstrate more consistently whether improvement has changed care, improved outcomes, reduced variation and been sustained and spread across services.

- Person-centred care, equality and involvement

The report demonstrates continued progress in listening to and involving patients, families, carers, staff and communities. Developments include participation panels, the Deaf People Participation Panel, accessible feedback routes, bereavement support, volunteering, neurodiversity initiatives and the Big Conversation on Sepsis. Further work is required to improve demographic information, Welsh-language assurance, representation of underrepresented communities and evidence showing how people’s feedback has influenced decisions and improvements.

Overall assurance and continuing risks

The Board can take reasonable assurance that the Health Board understands its principal quality risks and has established governance, escalation and oversight arrangements for monitoring them. Assurance is strongest in relation to the development of governance and quality management systems, the Quality Outcomes Framework, organisational learning arrangements, patient safety systems, clinical audit and focused quality improvement programmes.

However, assurance remains more limited where sustained impact, consistent implementation and reduction in unwarranted variation have not yet been fully demonstrated. Areas requiring continued scrutiny include:

- timely completion and closure of actions arising from incidents and complaints;
- themes of avoidable harm;
- healthcare-associated infection and antimicrobial resistance;
- workforce pressures and training compliance;
- safeguarding complexity and capacity;
- violence and aggression against staff;
- estate and infrastructure risks;
- data quality and completeness;
- Welsh-language and demographic intelligence;
- consistent implementation across divisions; and
- evidence that improvements have been sustained and spread.

The report appropriately distinguishes between increased capability, implementation of an intervention, improved process reliability, early outcome evidence and validated sustained improvement. A number of quantitative measures remain provisional and require confirmation of their baseline, numerator, denominator, reporting period, data source and validation status before final publication.

Looking ahead to 2026/27, the Health Board will focus on maturing the Quality Management System, reducing avoidable harm, strengthening clinical effectiveness, improving how it listens and responds, supporting its workforce, improving Welsh-language and accessible care, and making quality information more reliable, integrated and useful. Priority programmes will require clear accountability, validated measures, defined trajectories, evidence of involvement, equity analysis and assurance that improvements have been sustained.

Argymhelliad / Recommendation

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

- **NOTE** the progress made during 2025/26 in strengthening the Health Board's Quality Management System, quality governance, organisational learning arrangements and improvement capability.
- **RECEIVE** the Annual Quality Report for 2025/26 and take **assurance** that the Health Board has established and continues to strengthen arrangements for identifying, triangulating, scrutinising and escalating quality risks and concerns.
- **NOTE** the areas where assurance remains more limited, particularly where evidence of sustained impact, consistent implementation, timely action closure, reduction in unwarranted variation or reliable validated data has not yet been fully demonstrated.
- **SUPPORT** the priorities identified for 2026/27, including reducing avoidable harm, strengthening clinical effectiveness, improving patient and family involvement, supporting the workforce, improving Welsh-language and accessible care, strengthening quality intelligence and demonstrating measurable and sustainable improvement.

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

	areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr 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/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Annual Quality Report

2025/26

Assurance through quality, safety, learning, experience and improvement



1. Patient and staff experience, concerns, complaints and compliments

2. Patient safety

3. Clinical effectiveness

4. Health, safety and security

5. Infection prevention and control

6. Safeguarding

How to read this report

The report is presented to fulfil our statutory obligations through a combination of the Health and Care Quality Standards, framed through the Health Board's Six Pillars of Quality.

Six Pillars of Quality

1. Patient and staff experience, concerns, complaints and compliments
2. Patient safety
3. Clinical effectiveness
4. Health, safety and security
5. Infection prevention and control
6. Safeguarding

Health and Care Quality Standards

Six domains of quality

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Person-centred

Six enabling standards

- Leadership
- Workforce
- Culture
- Information
- Learning, improvement and research
- Whole-systems approach

A consistent assurance sequence

1. Evidence and achievement
2. How we are assured
3. What we learned and changed
4. Risks and challenges
5. Priorities for 2026/27

Each pillar chapter follows this sequence, using a range of evidence sources and data-validated insight to show progress, lessons learned and the actions we will take forward.

Chief Executive introduction



Nicola Prygodzicz
Chief Executive
Aneurin Bevan University Health Board

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

Strengthening quality

During the year, we strengthened the way quality is planned, controlled, improved and assured. The Quality Management Group brought together intelligence from patient and family feedback, concerns, incidents, complaints, mortality reviews, clinical audit, claims, external reviews and performance information. This insight identified strengths, exposed barriers and shaped improvement. The refreshed Quality Outcomes Framework improved the line of sight from frontline care to executive and Board oversight.

Our workforce

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

Our priorities

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

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

Working together

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

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

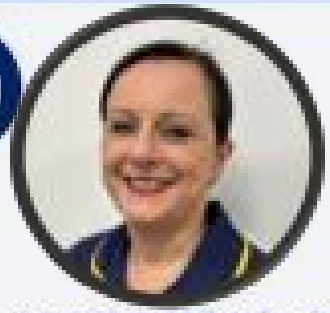
Thank you.

Clinical Executive foreword

The progress described in this report was achieved in a demanding environment of rising need, workforce pressure and financial constraint.
During 2025/26, the Health Board continued to strengthen its Quality Management System, connecting governance, assurance, improvement, risk management and organisational learning.

The Duty of Quality and Duty of Candour are increasingly embedded within routine decision-making and incident management, reinforcing openness, fairness and learning when care does not go as planned.

The report provides balanced assurance. It records improvement in patient feedback reach, investigation oversight, deterioration systems, ward accreditation, bereavement support and improvement capability.



Jennifer Winslade

Executive Director of Nursing



Dr Seema Srivastava

Executive Medical Director



Peter Carr

Executive Director of Allied Health Professions and Health Science



Tracy Daszkiewicz

Executive Director of Public Health and Strategic Partnerships

Why the Annual Quality Report matters

Demonstrates accountability

Explains how we are fulfilling our statutory duties and responsibilities.

Provides balanced assurance

Identifies progress, learning, continuing risks and areas where evidence remains incomplete.



Shows how people influenced quality

Describes how patients, families, carers, staff, volunteers and communities shaped services and improvement.

Supports continual improvement

Connects evidence, learning, action, outcomes and priorities for 2026/27.

Statutory and strategic context



Duty of Quality

Requires quality to be considered in decisions about healthcare services and requires continual improvement in outcomes.

Duty of Candour

Requires openness and transparency when the statutory threshold is met.

Health and Care Quality Standards

Provide the framework of six quality domains and six enabling standards against which quality is assessed.

Llais

Provides an independent statutory voice for people who use health and social care services in Wales.

Putting People at the Heart

A continuous commitment to listening, involving and acting on the experience of people and communities.

Health Board framework for mapping quality priorities and reporting



Health Board Quality Strategy 2023–2026

Together with the People's Experience and Involvement Strategy.

Our organisational framework for mapping quality priorities, planning delivery and structuring quality reporting.

Focus for the past 12 months: Our quality data is mapped to the Quality Management System, enabling consistent planning, control, improvement and assurance across the Health Board.

The Quality Management System

The Quality Management System provides the organising framework for quality planning, quality control, quality improvement and quality assurance.



Health Board framework for mapping quality priorities and reporting.

Health Board Quality Strategy 2023–2026

This has been the focus for the Health Board over the past 12 months, mapping our quality data to the Quality Management System.

Quality Management System developments during 2025/26



Quality Management Group established

Created an executive forum for triangulating intelligence, decision-making, escalation and oversight.



Quality Outcomes Framework refreshed

Strengthened the visibility of quality information and alignment with performance management.



Organisational learning arrangements developed

Created more systematic routes from insight to action, improvement and assurance.



Improvement capability expanded

Increased access to improvement education, coaching and project support.



Quality and performance arrangements aligned

Strengthened divisional accountability and visibility from ward to Board.



Stronger foundations, with assurance dependent on reliable data, timely investigations, ownership and sustained impact.



Reliable data



Timely investigations

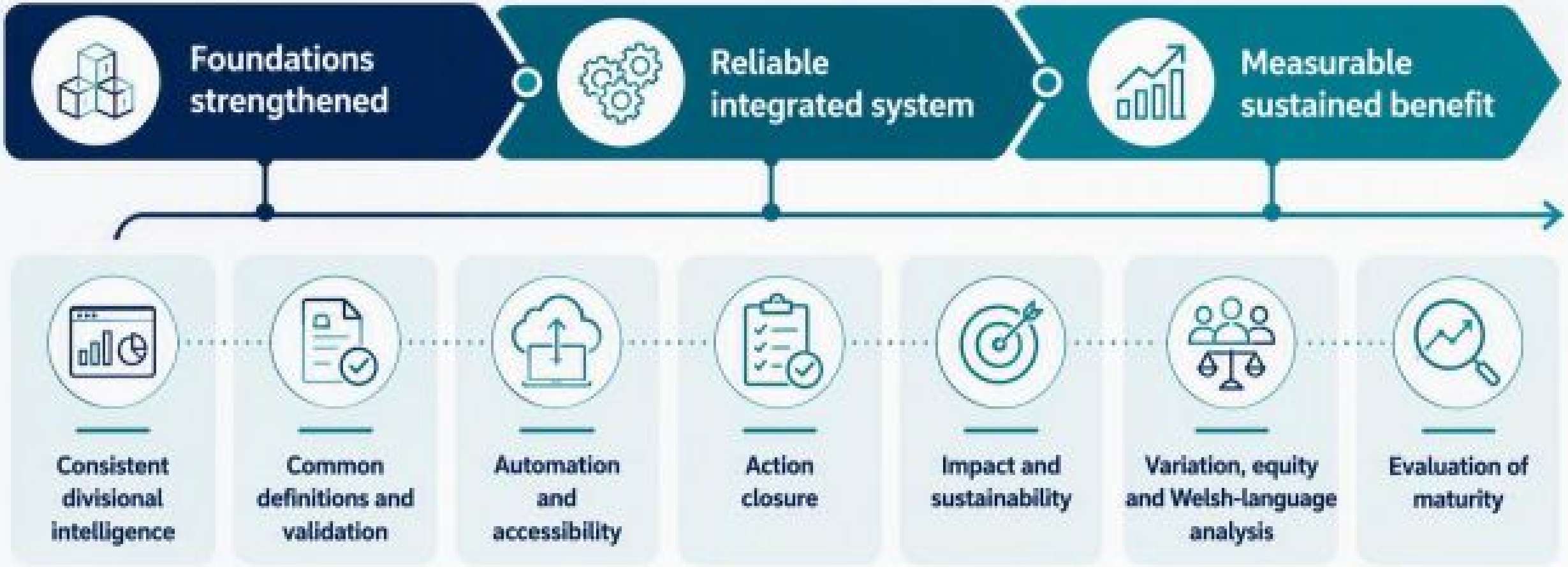


Ownership



Sustained impact

The next stage of Quality Management System maturity



During 2025/26, the Health Board strengthened the **foundations** of its Quality Management System. During 2026/27, the focus will move towards demonstrating that these arrangements operate **reliably** as an integrated system and produce **measurable improvements**.

Duty of Quality in practice

The Duty of Quality requires quality to be considered in decisions about healthcare services and requires continual improvement in outcomes.



Quality is embedded in how the Health Board plans, decides, improves and assures.

Duty of Candour

The Duty of Candour requires openness and transparency when the statutory threshold is met.

We have refined our Duty of Candour process during 2025/26 to strengthen timeliness, consistency, action completion and reduced recurrence.

Our progress and next steps are reported in the Putting Things Right Annual Report.

1 Daily rapid review

Daily reviews support early consideration of whether the Duty of Candour threshold may have been met.

2 Early identification

Early identification helps to ensure that people are informed without unreasonable delay.

3 Openness and apology

We are open, honest and transparent and offer a sincere apology where appropriate.

4 Patient and family involvement

Patients and families are involved in decisions, information sharing and the investigation where appropriate.

5 Investigation

Incidents are investigated proportionately to understand what happened and why.

6 Shared learning

Learning is shared across services to drive improvement and reduce the risk of recurrence.

Continuing focus: timeliness, consistency, action completion and reduced recurrence.

- Timeliness
- Consistency
- Action completion
- Reduced recurrence

Our progress and next steps are reported in the Putting Things Right Annual Report.

What we learned during 2025/26

1. **Triangulation provides stronger assurance**



2. **Timeliness is a component of quality**



3. **People identify risks that metrics may not reveal**



4. **Implementation does not itself demonstrate improvement**



5. **Variation remains a risk to reliable care**



These lessons help the Health Board focus on what matters most: understanding risk, learning together and demonstrating meaningful improvement.

We have developed key quality metrics into the Qlik App to provide a single source of data. This has strengthened transparency, empowered decision-making and aligned quality intelligence from frontline services to executive and Board oversight.

2025/26 Highlights

Stronger quality governance, learning and improvement arrangements supported broader assurance and progress across several services.

Civica patient feedback

636 service areas

28,269 responses

86% satisfaction

Separate All-Wales People's Experience Survey

24,332 responses

83% positive

Patient Advice and Liaison Service

5,995 cases

Concerns and complaints

2,465

749 early resolutions

126 Early Warning Notifications

175 Nationally Reportable Incidents

Investigation backlog reduced by more than 30%

37 national clinical audits

80% of hip-fracture surgery within 36 hours

14 accreditation reviews

GRACE's Place across five boroughs

310 referrals

More than **11,000** volunteer hours

43 improvement coaches

Increased from 20

More than **360** foundational learners

70 advanced learners

Progress alongside continuing challenges

Timeliness, recurring harm, infection, workforce and estate pressures, variation, data quality and evidence of sustained impact require continued attention.

All figures remain provisional until approved by the relevant data owner.
The Civica and All-Wales survey figures represent separate datasets and must not be combined.

Key Achievements

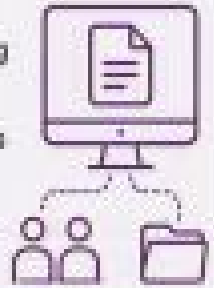
Quality governance

The Quality Management Group was established and the Quality Outcomes Framework refreshed, strengthening executive triangulation and visibility from frontline services to Board oversight.



Listening and Learning

The Listening and Learning Framework, Learning and Improvement Forum, Learning Repository and divisional Learning from Events Reports created a more systematic route from insight to action.



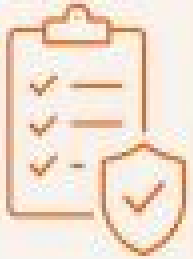
Experience

Patient feedback expanded to 636 service areas, with further development of participation, Patient Advice and Liaison Service, bereavement support, volunteering and staff networks.



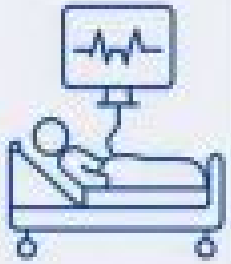
Patient safety

Incident oversight improved and the overdue investigation backlog reduced by more than 30%, although compliance with national timescales remained below expectation.



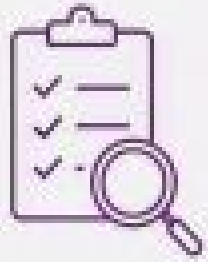
Deterioration

Electronic early-warning systems were introduced across adult, paediatric and neonatal services. Maternity implementation remained planned for 2026/27.



Clinical effectiveness and improvement

Clinical Effectiveness became a distinct Pillar, with progress in clinical audit, accreditation, bereavement support, safeguarding partnerships and improvement capability.



These achievements provide stronger foundations for quality. Assurance remains dependent on reliable data, timely investigations, clear ownership and evidence that actions have produced sustained improvement.

Six Pillars of Quality



Pillar One: patient and staff experience

Civica feedback:

636

service areas and
more than 28,000 responses



Separate All-Wales survey:

more than

24,000

responses



2,465

concerns and complaints

749

early resolutions

Almost

6,000

PALS contacts

GRACE's Place

across five boroughs

More than

11,000

volunteering hours

Keep the two datasets separate and visibly qualified.



Pillar One: assurance, learning and challenges

How we are assured



- Patient-experience surveys
- Patient Advice and Liaison Service
- Concerns, complaints and compliments
- Participation panels and volunteers
- Divisional governance and reporting

Learning and change



- Compassionate, professional care and staff kindness
- Waiting, communication, comfort and emotional support
- Patient stories, co-design and real-time feedback

Remaining challenge

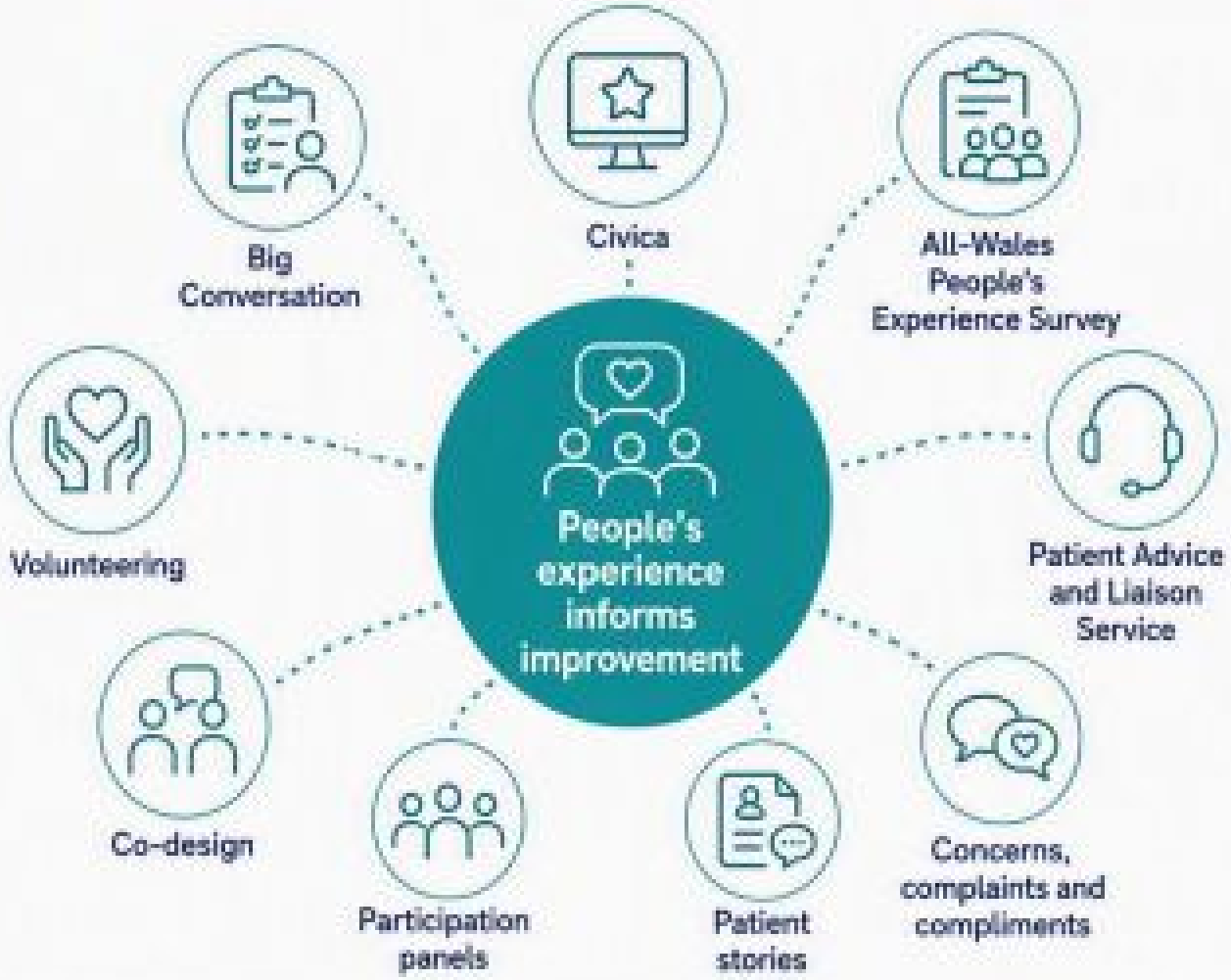


- Complaint timeliness
- Representation
- Accessibility
- Welsh-language experience

How people shaped quality during 2025/26

What people told us

- Kindness and compassionate care were consistent strengths.



Where we need to improve

- Waiting, comfort, access, communication and emotional support were recurring areas for improvement.

People, communities and staff continue to shape our services and improvement.

Pillar One: priorities for 2026/27



1	Improve concerns and complaints timeliness, towards 75% compliance	Timely responses that respect people and build confidence
2	Strengthen co-production	Services shaped with people, not just for people
3	Reach underrepresented communities	More inclusive services that meet everyone's needs
4	Act on recurring experience themes	Better care where people tell us it matters most
5	You Said, We Did, What Changed	Clear evidence of how feedback leads to real change

Pillar Two: assurance, learning and continuing risk

How we are assured

- Daily incident review
- DatixCymru dashboards
- Divisional governance
- Quality Management Group

What we learned and changed



Continuing risk

- Timeliness
- Mortality reconciliation
- Deterioration and sepsis

Information collected → Reviewed and understood → Actions taken and implemented → Outcomes monitored

Pillar Two: priorities for 2026/27

Reduce avoidable harm

- Reduce avoidable harm
- Improve investigation and action closure



Strengthen learning

- Strengthen Learning from Deaths
- Improve investigation and action closure



Recognising deterioration

- Improve recognition and response to deterioration
- Support patient and family escalation



Prevention and safety → Learning and insight → Action and improvement → Better outcomes for people

Pillar Three: clinical effectiveness



Pillar Three: assurance, learning and continuing risk

ASSURANCE

- Clinical Standards and Effectiveness Group
- Clinical Advisory Forum
- Audit
- Outcomes review
- Accreditation



LEARNING AND CHANGE

- Reliable implementation
- Documentation
- Evidence-based pathways



CONTINUING RISK

- Operational pressure
- Re-audit
- Coding
- Data quality
- Sustained improvement



Evidence and learning are strengthened through governance, partnership and frontline engagement, but continued focus is required to reduce risk and deliver sustainable improvement.

Pillar Three: priorities for 2026/27

1. Implement Call for Concern
2. Complete deterioration initiatives including maternity
3. Strengthen clinical audit and re-audit
4. Expand accreditation
5. Use evidence and innovation
6. Develop the Corporate Clinical Audit Framework



Pillar Four: health, safety and security



Safety inspections and walkabouts

Regular inspections, walkabouts and local reviews help identify, manage and reduce risk.

Mandatory training

Health and safety, fire safety, violence prevention and manual handling remain key priorities.

Fire-safety improvements

Actions from external reviews and local assessments have strengthened fire safety.

Slips, trips and falls prevention

Practical action continues to reduce slips, trips and falls across our sites.

Violence Prevention and Reduction Strategic Plan

Strengthens prevention, de-escalation, incident response and support for staff.

Some training data subject to validation.

Pillar Four: assurance, learning and continuing risk

How we are assured

Incidents and near misses	Reported by teams and reviewed to identify hazards and reduce risk.
Inspections	Planned and unplanned inspections check environments and controls.
Risk assessments	Regular assessments identify, prioritise and manage risks.
Safety communications	Updates and alerts share learning and promote safe practice.
Frontline ownership	Teams understand local risks, take action and maintain effective controls.



What we learned and changed

- Frontline engagement helped identify hazards earlier and strengthened local ownership.
- Fire-safety improvements and actions from external reviews strengthened controls.
- Environmental reviews informed practical action to reduce slips, trips and falls.
- The Violence Prevention and Reduction Strategic Plan advanced prevention, de-escalation and post-incident support.
- Support for staff following incidents was strengthened.

Continuing risk

- Violence and aggression
- Training compliance
- Ageing estate
- Fire and environmental risks
- RIDDOR compliance

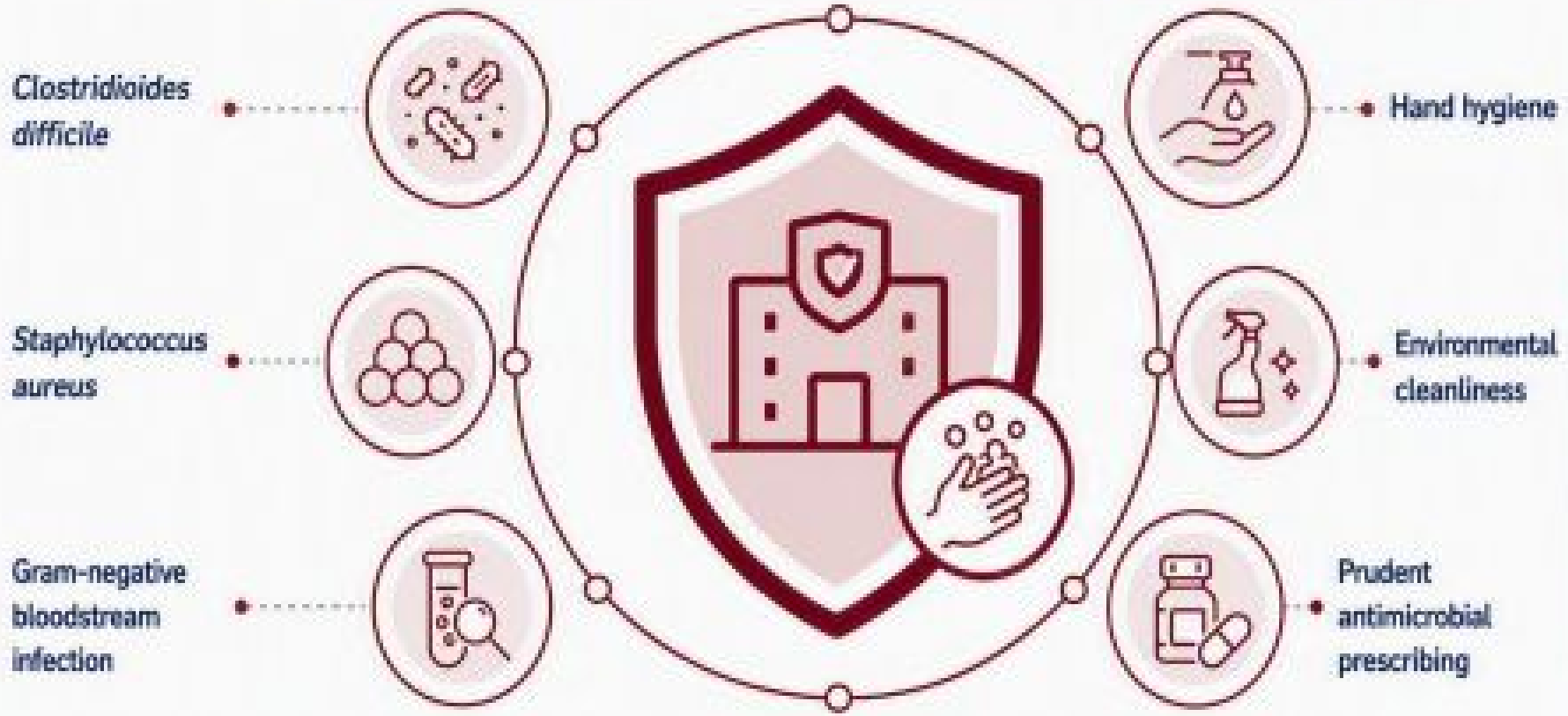
Pillar Four: priorities for 2026/27

1. Improve mandatory training compliance
2. Improve statutory reporting
3. Continue violence prevention and reduction
4. Manage estate, fire and environmental risk
5. Strengthen local ownership



Pillar Five: infection prevention and control

Infection Prevention and Antimicrobial Steering Group



Reported reduction in healthcare-associated *C. difficile*

Maternity surgical-site improvement

Data reconciliation required

Pillar Five: assurance, learning and continuing risk

How we are assured

- Surveillance
- Audit
- Outbreak reporting
- Pharmacy oversight
- Specialist infection prevention advice

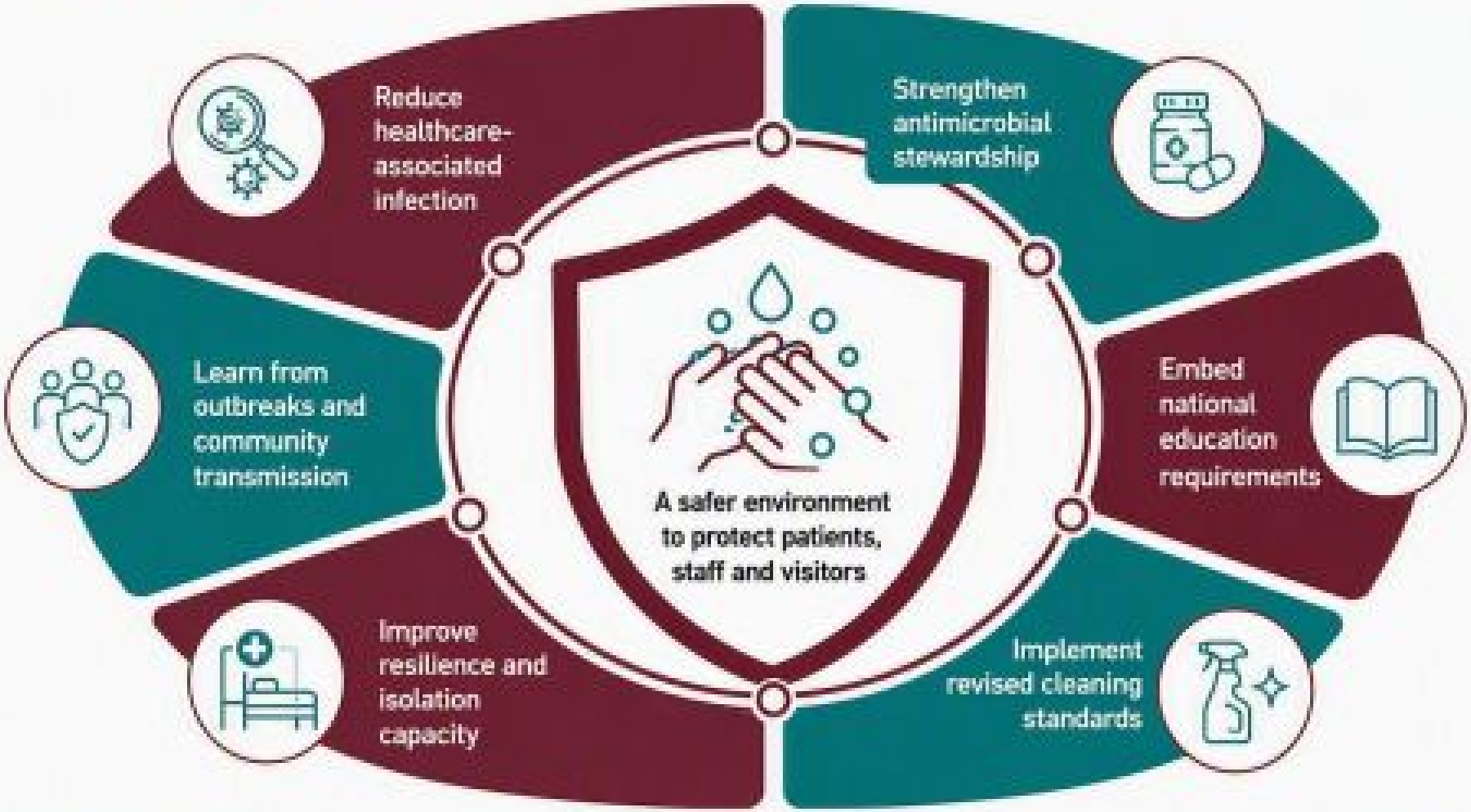
What we learned and changed

Early isolation › Patient placement › Environmental cleaning › Multidisciplinary coordination › Start Smart Then Focus › Recovery and sustainment

Continuing risk

- Seasonal infection
- High occupancy
- Isolation capacity
- Antimicrobial resistance
- Validation

Pillar Five: priorities for 2026/27



Surveillance | Hand hygiene | Environmental cleanliness | Isolation and placement | Multidisciplinary coordination | Prudent antimicrobial use

Pillar Six: safeguarding



Safeguarding Strategic Group

Safeguarding governance and strategic oversight.

Child safeguarding

Multi-agency working to protect children and young people.

Violence Against Women, Domestic Abuse and Sexual Violence

Strategic oversight and support across Gwent.

People in Positions of Trust

Management and oversight of referrals.

Datix Safeguarding Module

Strengthened recording, governance and monitoring of safeguarding activity.

Training

Level 1 and Level 2 compliance, with a three-year Level 3 programme in place.

Partnership working

Working with regional boards, local authorities, police, probation and specialist agencies.

Ask and Act

Identify, advise, advocate and refer.

Independent Domestic Violence Advisers

Specialist support for safety, advice and advocacy.

Children's activity rising, adult activity stable

Activity levels showing these trends.

Pillar Six: priorities for 2026/27



Delivery against the 2025/26 quality priorities

	Delivery during 2025/26	Remaining assurance gap
1 Continuous improvement and learning	Quality management and learning arrangements were developed and improvement capability expanded.	Strong evidence of sustained impact and spread is still required.
2 Patient safety and clinical effectiveness	Harm reduction, investigation oversight, Learning from Deaths, audit tracking and deterioration systems progressed.	Timeliness, variation, audit capacity and data quality remain concerns.
3 Patient and staff experience	Feedback reach, participation, bereavement support, volunteering and staff networks expanded during the year.	Complaint timeliness, representation and evidence of impact require improvement.
4 Openness, candour and accountability	Candour embedded in incident management. Early resolution and learning routes strengthened.	Timeliness and validated performance information remain important.
5 Workforce wellbeing and leadership	Human Factors, improvement capability, leadership visits and wellbeing initiatives developed further.	Workforce pressure, safety and training continue to affect reliability.
6 Digital tools and integration	Use of DatixCymru, Civica, Audit Management and Tracking, Qlik and dashboards progressed.	Integration, automation, definitions and analytical capability require development.

Quality evidence influencing major decisions

Decisions during 2025/26 were informed by a wide range of quality intelligence, ensuring that quality considerations influence real choices and actions.

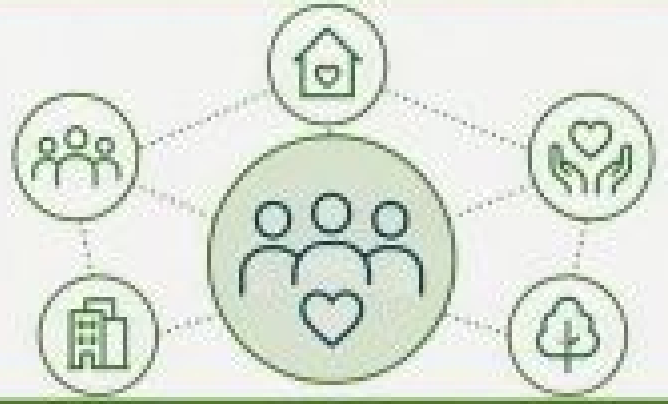
- Patient and family feedback
- Patient safety incidents
- Mortality reviews
- Clinical audit
- Workforce information
- Performance data
- Equality considerations
- Risk assessments



Deteriorating Patient and Sepsis Improvement Programme



Neurodiversity Emergency Department Improvement Project



Gwent Bereavement Collaborative

These examples demonstrate how quality evidence, involvement and the Duty of Quality shaped decisions, implementation approaches and monitoring arrangements.

Strategic decision: deterioration and sepsis

1	Decision	The Health Board approved and prioritised a comprehensive Deteriorating Patient and Sepsis Improvement Programme.
2	Quality evidence considered	Patient safety incidents, mortality review findings, sepsis compliance data, clinical audit, workforce capability, training information, national guidance and associated operational and financial risks.
3	Involvement	Multidisciplinary clinical teams, patient safety specialists and divisional governance groups contributed to the programme. Learning from patients, families and staff informed the approach.
4	Effect of the Duty of Quality	**Standardised Early Warning Scores, escalation and sepsis management.**
5	Monitoring	Delivery is monitored through compliance, escalation and treatment measures, incident trends, mortality review findings and established governance arrangements.



Strong leadership, reliable processes and effective escalation help to ensure that deterioration is recognised earlier and sepsis is treated promptly.

Strategic decision: neurodiversity in Emergency Departments

Evidence, involvement and the Duty of Quality shaped improvements to better meet the needs of neurodivergent patients.

1

Decision

The Health Board approved a Neurodiversity Emergency Department Improvement Project.

2

Quality evidence considered

- Patient experience feedback
- Concerns and complaints
- Equality and health inequalities
- Staff feedback
- Environmental assessment
- Best practice guidance

3

Co-production

Designed with people with lived experience, families, carers, clinical teams and partner organisations.

4

- Environmental adaptations
- Improved communication methods
- Additional staff support
- Monitoring



Improvements aim to create a more accessible, respectful and person-centred experience for neurodivergent patients and their families.

Strategic decision: coordinated bereavement support



Decision

The Health Board supported the Gwent Bereavement Collaborative and associated bereavement improvement programme.



Quality evidence considered

Patient and family experience, mortality review learning, concerns and complaints, staff feedback and partnership opportunities.





Involvement

Developed with bereaved families, clinical teams, patient-experience representatives, local authorities, voluntary-sector organisations and wider system partners.



Effect of the Duty of Quality

A collaborative model was selected to improve the consistency of bereavement support and promote a coordinated, compassionate and person-centred approach across Gwent.



Monitoring

Progress is monitored through feedback from bereaved families, patient-experience measures, agreed improvement actions and governance reporting.



Coordinated, compassionate and person-centred support across Gwent.

Improvement capability during 2025/26

43
improvement coaches, increased from 20

More than
360
staff completed foundational improvement training

70
staff undertook advanced development



Quality improvement is aligned to our capability framework

Our improvement work follows a clear capability framework for our coaches, learners and teams, ensuring consistent skills, support and standards across the organisation.

Training demonstrates capability, not by itself improved outcomes.
Impact is demonstrated through reliable data, evaluation and sustained improvement.

Learning translated into action

LEARNING THEME	STRENGTHENED ACTION	INTENDED EFFECT
Timeliness and reliability	Daily reviews, dashboards, action tracking and clearer escalation were strengthened to identify delay and risk earlier.	Earlier identification of risk and faster response to issues that affect quality and safety.
Recurring themes across evidence sources	The Quality Management Group and Learning and Improvement Forum supported triangulation and a fuller understanding of underlying issues.	More consistent understanding of risks and opportunities across services and Divisions.
Patient and family insight	Panels, patient stories, co-design, Big Conversation activity and Call for Concern ensured that lived experience informed improvement.	Improvements better reflect what matters to patients, families and staff.
Improvement capability	Quality improvement coaching, Human Factors, Audit Management and Tracking and central learning repositories strengthened testing, measurement and follow-through.	More reliable improvement methods, stronger action completion and clearer evidence of impact.
Variation	Audit tracking, mortality review, accreditation and standardised tools strengthened comparability, compliance and reliability.	Reduction in unwarranted variation and more reliable care across services.

Insight drives action, action drives improvement and improvement strengthens assurance.

Learning-to-impact examples

1 Falls causing harm



Problem
Falls causing harm remained at a risk for patients.

Change
Prevention focus and local oversight were strengthened.

Evidence status
A validated harm rate, baseline and sustained trend remain required.

2 Pressure damage



Problem
Pressure damage remained at a risk for patients.

Change
Prevention work and accreditation oversight continued.

Evidence status
The reported downward trend requires confirmation of the measure, baseline and sustainability.

3 Complaint timeliness

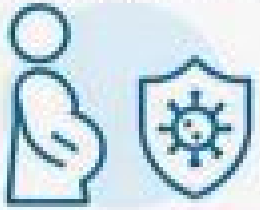


Problem
Complaint response timeliness remained below the required standard.

Change
Training, case review, dashboard monitoring and early resolution were strengthened.

Evidence status
Annual definitions and denominators require validation.

4 Maternity infection



Problem
Infection risk in maternity care required further reduction.

Change
Targeted improvement work was undertaken.

Evidence status
The exact reported reduction has not yet been validated within the source report.

5 Deterioration and sepsis



Problem
Delayed recognition and response to deterioration remained a risk.

Change
Early-warning and sepsis pathways were implemented.

Evidence status
Early outcome findings remain provisional and require continuing monitoring and re-audit.

6 Bereavement support



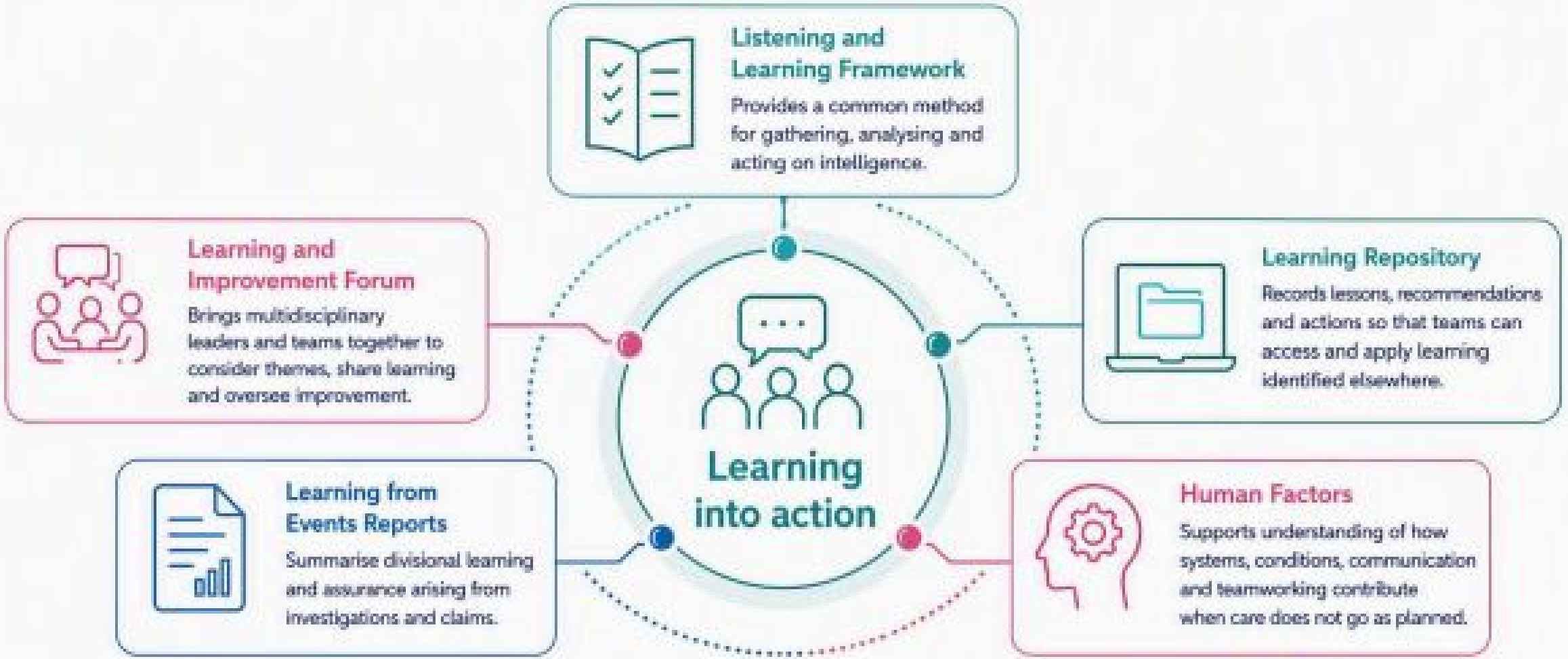
Problem
Bereaved families identified variation in support.

Change
GRACE's Place expanded across five boroughs.

Evidence status
Reach, experience, equity and outcome evidence require further validation.

Measures, baselines and sustainability require validation where stated.

Listening and learning arrangements



This connected approach ensures that insight is understood, acted upon, stored, reported and translated into safer, more effective and more person-centred care.

Equality, prevention and whole-system outcomes

Equality and inclusion

- Accessible feedback and services
- Deaf People Participation Panel
- Targeted engagement
- Neurodiversity Staff Network
- Bereavement collaboration

Prevention and early intervention

- Deterioration and sepsis improvement
- Infection prevention programmes
- Ask and Act training and support
- Early resolution through PALS
- Community sepsis awareness



Whole-system working

- Primary care and general practice
- Local authorities and social services
- Safeguarding partners and police
- Community and voluntary organisations
- Academic partners and national programmes

Remaining evidence need

- Demographic information
- Variation
- Reasonable adjustments
- Accessibility
- Shared outcomes

Working together across services and communities to improve care, reduce inequalities and deliver better outcomes for everyone.

Welsh language and the Active Offer

Why this matters for quality

Safe, equitable and person-centred care

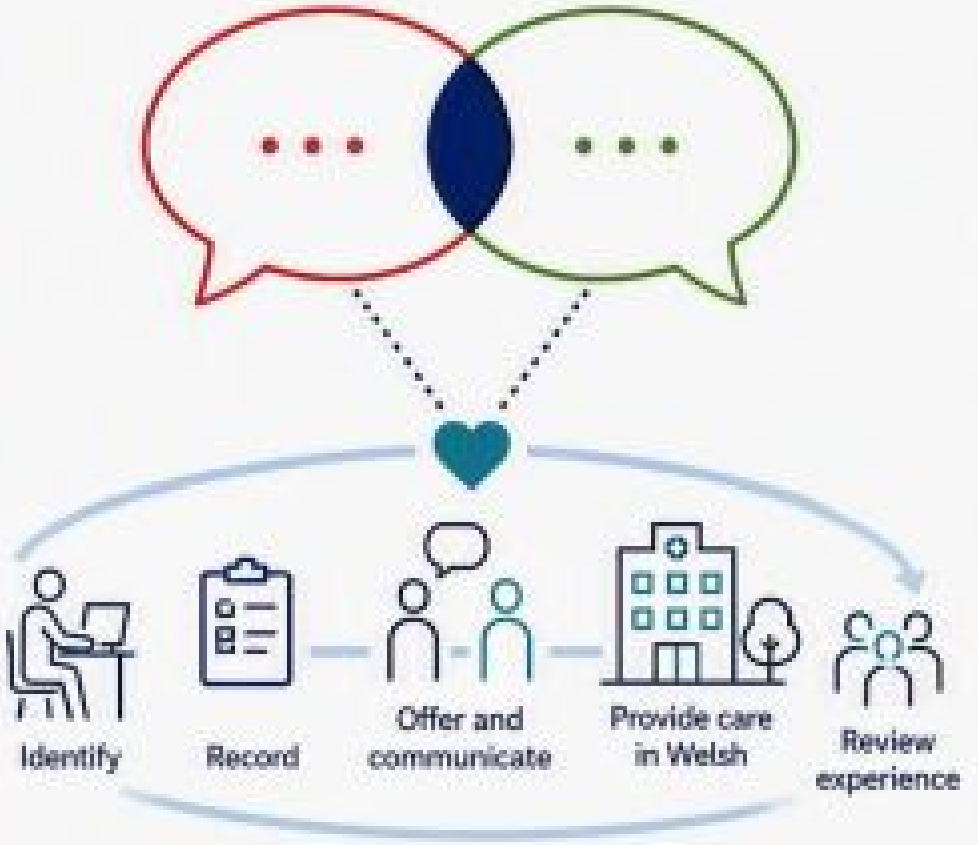
Receiving care in Welsh is an important component of safe, equitable and person-centred care.

Proactively offer Welsh-language services

The Active Offer means proactively offering Welsh-language services rather than requiring people to ask.

Identify and record language need

Language needs should be identified and acted upon as part of safe, high-quality care.



What will be strengthened in 2026/27

- Identify and record language need
- Workforce capability
- Access to Welsh-language services
- Patient, family and staff experience
- Validated measures and reporting arrangements

Validated measures, improvement trajectories and reporting arrangements will be developed with the Welsh Language Unit before being incorporated into routine quality reporting.

Quality priorities for 2026/27



Conclusion and forward direction

Stronger foundations established during 2025/26



Quality governance
Quality Management Group established.

Quality intelligence
Reporting and quality-assurance arrangements refreshed.

Organisational learning
Learning processes and routes from insight to action strengthened.

Clinical effectiveness
Clinical Effectiveness established as a distinct Pillar of Quality.

Improvement capability
Improvement skills, coaching and organisational support expanded.

Together, these developments provide a stronger foundation for Board assurance, organisational oversight and frontline action.

Balanced assessment of quality

Evidence of progress

- Quality reporting and learning
- Early resolution and investigation oversight
- Patient and family involvement
- Recognition and management of deterioration
- Clinical audit and accreditation
- Bereavement care and safeguarding partnerships
- Infection prevention
- Workforce and improvement capability

Continuing challenges

- Timeliness of responses, investigations and actions
- Recurring harm and unwarranted variation
- Healthcare-associated infection
- Mandatory training compliance
- Workforce and estate pressures
- Welsh-language and demographic intelligence
- Reliability of some data sources

The evidence provides a balanced assessment, identifying areas of sustained improvement alongside matters requiring further attention, validation and continued scrutiny.

Towards a mature and sustainable Quality Management System

The developments made during 2025/26 are important building blocks in establishing a systematic, intelligence-led and continuously improving approach to quality.



Reduce avoidable harm

Improve outcomes and experiences

Strengthen learning and improvement

Address inequity

Keep quality central to decision-making

The Board can take assurance that the governance arrangements, quality intelligence, learning systems and improvement capability described in this report provide a strong foundation for delivering safer, more effective, person-centred and equitable care.

Continued scrutiny will be required to ensure actions are delivered, improvement is sustained and intended benefits are realised.

Appendix: STEEEP assurance map

Safe

Evidence:	Incident review, harm reduction, infection prevention, safeguarding, deterioration systems and candour.
Remaining gap:	Recurring harm, investigation timeliness and unresolved safety data.
2026/27 action:	Sustain harm reduction and improve investigation and action closure.

Timely

Evidence:	Patient Advice and Liaison Service, early resolution, escalation systems, Early Warning Notifications and deterioration tools.
Remaining gap:	Waiting, complaint and investigation delays.
2026/27 action:	Set and monitor improvement trajectories.

Effective

Evidence:	Clinical Effectiveness, audit, Audit Management and Tracking, mortality, accreditation and research.
Remaining gap:	Re-audit, coding, outcome reliability and sustained implementation.
2026/27 action:	Strengthen outcome measures, action closure and re-audit.

Efficient

Evidence:	Integrated reporting, electronic tracking, pathway improvement and stewardship.
Remaining gap:	Manual collation, duplication and incomplete integration.
2026/27 action:	Automate and integrate intelligence while protecting clinical reliability.

Equitable

Evidence:	Participation panels, accessible support, Deaf People Participation Panel, neurodiversity work and borough-wide bereavement support.
Remaining gap:	Demographic analysis, under-represented voices and Welsh-language evidence.
2026/27 action:	Improve demographic analysis, accessibility and Welsh-language assurance.

Person-centred

Evidence:	Civica, Patient Advice and Liaison Service, complaints, patient stories, co-design, bereavement and Call for Concern.
Remaining gap:	Uneven coverage and limited public evidence of what changed.
2026/27 action:	Strengthen "You Said, We Did, What Changed" and broaden involvement.

Appendix: quality enablers assurance map

Leadership

Evidence:	Quality Management Group, executive oversight and divisional governance.
Remaining gap:	Consistent divisional ownership and closed-loop action.
2026/27 action:	Strengthen ward-to-Board accountability.

Workforce

Evidence:	Improvement and Human Factors development, coaching and specialist training.
Remaining gap:	Workforce pressure and variation in training compliance.
2026/27 action:	Agree measurable recovery and capability plans.

Culture

Evidence:	Candour, just culture, speaking up, incident reporting and learning communication.
Remaining gap:	Evidence of impact on psychological safety and behaviours.
2026/27 action:	Use staff measures and local action plans to test cultural change.

Information

Evidence:	Dashboards, DataCymru, Civica, Audit Management and Tracking, Qlik and Quality Outcomes Framework.
Remaining gap:	Definitions, integration, coding, manual processes and data quality.
2026/27 action:	Approve common definitions and validation controls.

Learning, improvement and research

Evidence:	Learning Forum, Repository, Learning from Events Reports, improvement capability, audit, research and innovation.
Remaining gap:	Spread, sustainability, re-audit and outcome evaluation.
2026/27 action:	Require learning-to-impact and sustainability evidence.

Whole-systems approach

Evidence:	Regional, safeguarding, primary care, local authority, community, academic and national partnerships.
Remaining gap:	Shared outcomes are not consistently evidenced.
2026/27 action:	Define partnership outcomes and report collective impact.

Appendix: Quality Strategy 2023-2026

Year-three delivery summary

- Continuous improvement and learning
- Patient safety and clinical effectiveness
- Patient and staff experience
- Candour and accountability
- Workforce wellbeing and leadership
- Information and digital technology

2023	2024	2025/26
Foundations	**Implementation**	**Year three**
Built the foundations for governance, systems and capability.	Implemented priorities, strengthened processes and engaged teams.	Progressed delivery, improved oversight and built improvement capacity.
Frameworks and structures established	Learning routes strengthened	Learning embedded and capability expanded
Safety systems aligned	Harm reduction programmes progressed	Clinical effectiveness and oversight improved
Feedback channels expanded	Participation strengthened	Involvement and support further developed
Candour principles embedded	Early resolution and oversight improved	Openness and learning routes strengthened
Leadership and wellbeing focus	Training and capability developed	Workforce support and leadership expanded
Digital platforms introduced	Dashboards and reporting improved	Integration and digital reporting progressed

Sustained impact

Deliver measurable, reliable and equitable improvements for patients, families, carers and staff.

Stronger foundations: next stage is reliable implementation and sustained outcomes.

Appendix: strategic enablers and milestones



1. Governance and leadership

Quality Management Group, Clinical Advisory Forum, divisional governance and Patient Safety Leadership Visits.

2. Improvement capability

Quality Improvement Capability Framework, coaching, development and ABCi support.

3. Listening and learning

Listening and Learning Framework, Forum, Repository and Learning from Events Reports.

4. Safety and effectiveness

Clinical audit, Audit Management and Tracking, deterioration systems, Call for Concern, Human Factors and accreditation.

5. People and communities

Participation panels, patient experience, Civica, PALS, GRACE's Place, volunteering and co-design.

6. Workforce and culture

Neurodiversity Staff Network, wellbeing, speaking up, just culture and recognition.

7. Digital and information

Quality dashboards, DatixCymru, Civica, Audit Management and Tracking, Qlik and system integration.

8. Whole systems

Regional, national, academic, safeguarding and integrated care partnerships.

Appendix: 2026/27 monitoring and escalation framework

		Baseline	Direction	Review	Escalation
1	Safer, more reliable care	**Baseline:** Validated baselines to be confirmed.	**Direction:** Reduce harm and improve process reliability.	**Review:** Monthly operational and quarterly corporate assurance.	**Escalation:** Immediate escalation for serious safety concerns.
2	Stronger clinical effectiveness	**Baseline:** Audit, re-audit, accreditation and coding baselines require validation.	**Direction:** Improve audit completion, action closure and reliability.	**Review:** Quarterly.	**Escalation:** Data set discrepancies, overdue high-significance action or data-quality failure.
3	Effective learning organisation	**Baseline:** Investigation timeliness, action impact and spread require confirmation.	**Direction:** Faster closure and stronger evidence of sustainability.	**Review:** Monthly or quarterly according to the measure.	**Escalation:** Repeated themes, overdue actions or recurrence without evidenced control.
4	People, leadership and culture	**Baseline:** Training, staff experience, violence reduction and capability measures require validation.	**Direction:** Improve compliance, staff safety and psychological safety.	**Review:** Quarterly.	**Escalation:** Performance below the approved trajectory or a material staff-safety concern.
5	Quality intelligence and digital integration	**Baseline:** Data-definition, validation, automation and dashboard-timeliness baselines are to be confirmed.	**Direction:** Improve definitions, automation, timeliness and reliability.	**Review:** Quarterly.	**Escalation:** Data set discrepancy, delayed reporting or loss of confidence in a control measure.
6	Collaboration, involvement and innovation	**Baseline:** Representation, Welsh-language, partnership and public-reporting measures are to be confirmed.	**Direction:** Broaden involvement and demonstrate partnership and innovation outcomes.	**Review:** Quarterly or programme-specific.	**Escalation:** Persistent underrepresentation, undelivered action or deteriorating outcomes.

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	06 October 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	PTR Annual Report 2025-2026
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tracey Partridge-Wilson - Deputy Director of Nursing Gemma Couch - Head of QPS, Learning and Improvement

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Putting Things Right Annual Report 2025/26 has been prepared in accordance with Regulation 51 of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. It describes the operation and effectiveness of the Health Board's arrangements for handling concerns between 1 April 2025 and 31 March 2026.

The Annual Report provides assurance on the management of complaints, concerns, patient safety incidents, redress, Duty of Candour, Public Services Ombudsman for Wales cases, Patient Advice and Liaison Service activity, patient experience feedback, bereavement support and legal services. It also evaluates progress against the priorities established for 2025/26 and sets out the areas requiring continued focus during 2026/27.

The report concludes that the Health Board continued to manage a significant and complex volume of activity during a challenging operating period. Governance, early resolution, redress arrangements, patient experience feedback, organisational learning and preparations for Listening to People strengthened during the year. However, further improvement is required in formal complaint compliance, the reduction of overdue complaints, consistent implementation of the Duty of Candour and the demonstration of measurable and sustained improvement arising from learning.

Cefndir / Background

Regulation 51 requires responsible bodies to prepare and publish an annual report describing the operation and effectiveness of their arrangements for handling concerns. The report provides assurance to the Board and the public that the Health Board has discharged its statutory responsibilities relating to concerns, complaints, incidents and redress.

The report brings together information from the Putting Things Right team, Patient Advice and Liaison Service, Patient Safety Incident team, Datix incident reporting, Safeguarding, Legal Services, Quality and Patient Safety teams and the Health Board's divisions. It considers not only how concerns and incidents were managed, but how learning was identified, escalated through governance arrangements and translated into improvement activity and organisational planning.

During 2025/26, oversight was strengthened through monthly divisional Quality and Patient Safety assurance reporting and the establishment of the Quality Management Group. These arrangements enabled complaints, incidents, safeguarding, mortality reviews, patient experience, learning and improvement activity to be considered together and provided a clearer line of sight between divisional activity, executive oversight and Board assurance.

Assessment

1. Complaints, concerns and enquiries

During 2025/26, 2,465 concerns and complaints were managed through the Putting Things Right process. This comprised 1,716 formal complaints and 749 Early Resolutions. The Putting Things Right team also managed 2,467 enquiries, while the Patient Advice and Liaison Service responded to 5,875 enquiries.

The Health Board recorded 1,309,654 patient interactions during the reporting period. Concerns and complaints represented 0.188% of those interactions. The principal themes were clinical treatment and assessment, access to services and appointments, communication, discharge planning and staff attitude or behaviour.
Of the 2,465 concerns received, 87, representing 3.53%, were investigated and found to involve a breach of duty by the Health Board. This included 68 Regulation 24 responses where a breach was identified but the criteria for qualifying liability were not met, five Regulation 24 responses where the potential value exceeded the scope of redress and 14 Regulation 33 responses where a qualifying liability was considered to exist.

2. Timeliness and complaint performance

Formal complaint compliance remained below the national target of 75%. Performance was affected by complaint volumes, winter pressures, complex investigations and workforce capacity. However, the comparative position improved during the latter part of the year, with the Health Board exceeding the NHS Wales average in November and December 2025 and February and March 2026. This was the first time the Health Board had exceeded the national average since national benchmarking was introduced in April 2024.

Progress was made in reducing the oldest overdue complaints. As of 31 March 2026, the number of overdue complaints had reduced to 258 and there were no cases older than 365 working days.

Early Resolution performance improved from 72% in April 2025 to 100% in January, February and March 2026. This improvement was supported by clearer triage, regular review of open cases and closer working between the Putting Things Right, Quality and Patient Safety and divisional teams.

The reduction in Early Resolution cases, alongside the increase in enquiries, reflected more accurate classification of requests for information, clarification, signposting or assistance where no substantive concern about care had been raised. Total recorded Putting Things Right team activity increased from 4,702 contacts in 2024/25 to 4,932 in 2025/26, an increase of 230 contacts or 4.9%.

3. Public Services Ombudsman for Wales

The Health Board received 69 referrals requiring action from the Public Services Ombudsman for Wales. A further 185 cases were assessed as premature, outside jurisdiction or not requiring further investigation.

Of the 69 referrals requiring action, 55 were concluded through the Ombudsman's Early Resolution process, five final reports were not upheld and nine final reports were upheld. Learning most commonly related to adult mental health, clinical care and treatment, record keeping and the coordination of care. This learning was considered alongside complaints, incidents and redress through divisional assurance and wider quality governance arrangements.

4. Patient safety incidents

A total of 33,380 incidents were recorded through Datix during 2025/26. Following investigation, 99.4% were assessed as causing no harm or low harm. High reporting levels were considered to reflect a mature reporting culture and the continued encouragement of staff to report adverse events and near misses.

The most frequently reported themes were pressure damage at 26.9%, behavioural incidents at 17.0%, accidents and injuries including falls at 15.0%, medication errors at 6.7%, and assessment, investigation and diagnosis at 5.8%. Of the reported pressure damage incidents, 223, representing 2.4%, were determined to be avoidable.

Learning and improvement activity included revised risk assessments and care plans, audit activity, refresher training and pharmacy-led assurance. Progress was monitored through divisional governance arrangements and specialist assurance groups.

5. Duty of Candour

The statutory Duty of Candour requires NHS bodies in Wales to be open and transparent when a person receiving health care experiences harm that meets the statutory threshold and the provision of care was, or may have been, a factor. When the duty is triggered, the Health Board must notify the person or their representative, offer an apology, explain the process that will be followed, undertake an investigation and provide a written account of the findings and any actions taken to reduce the risk of recurrence. An apology is an important acknowledgement of the person's experience and does not, in itself, constitute an admission of liability.

During 2025/26, the Duty of Candour was initiated in relation to 106 incidents. At the reporting position, 59 incidents had been confirmed as meeting the statutory

threshold of moderate harm or above, 26 incidents had been reassessed as low or no harm following investigation, and 21 remained under investigation. Cases were identified across all principal service areas. The most frequently recorded incident categories related to clinical assessment and diagnosis, treatment or procedural care, pressure damage, unexpected deaths, falls, medication administration, diagnostic testing and delayed access to services. The number of cases should not be interpreted in isolation as a measure of service safety. It also reflects the identification of potential harm, staff reporting, investigation maturity and application of the statutory process.

The events that triggered Duty of Candour identify recurring system priorities rather than a predominant pattern of isolated individual error. Clinical assessment, diagnosis, recognition and escalation featured in 72.6% of these records. Training, competence and reflective learning featured in 64.3%; documentation and record keeping in 57.1%; audit, governance and assurance in 57.1%; medication and prescribing safety in 56.0%; and policy, pathway or procedural compliance and workforce, capacity or operational flow each in 54.8%. As recommendations could address several connected aspects of care, these themes overlap and percentages do not total 100%

The strongest cross-cutting learning concerned pathway reliability. In a number of investigations, an appropriate clinical intention, such as arranging follow-up, acting on a result, continuing treatment or escalating a deteriorating patient, did not reliably lead to the required action being completed. The recommendations included stronger arrangements for acknowledging and escalating abnormal results, risk-based prioritisation of referrals and waiting lists, clearer handovers, timely senior review, more explicit prescribing instructions, improved care planning and documentation, and audit of compliance with revised pathways. This supports a move towards closed-loop systems in which actions are assigned, acknowledged, completed and checked, with overdue or incomplete steps actively escalated.

The focus of learning varied according to the nature and setting of the incident. Diagnostic and assessment cases emphasised recognition of red flags, interpretation and actioning of investigation results, escalation of uncertainty and prevention of patients being lost to follow-up. Medication and treatment cases highlighted prescribing clarity, medicine reconciliation, monitoring, checking processes and reliable transfer of responsibility between teams and care settings. Pressure-damage cases consistently identified the importance of accurate risk assessment, skin inspection, repositioning, pressure-relieving equipment, wound documentation, timely specialist referral and involvement of patients and families. Maternity and neonatal learning included fetal surveillance, escalation of abnormal observations, medication safety, multidisciplinary communication and visibility of individualised plans during transitions of care.

Training, reflection and dissemination of learning were frequently recorded as improvement actions. These included focused teaching, mandatory training, induction updates, simulation, case-based learning, safety communications and consideration through clinical governance or morbidity and mortality meetings. Stronger assurance was evidenced where education was accompanied by pathway redesign, competency assessment, audit, validation or formal governance oversight.

The Duty of Candour also applies to care provided through services commissioned by the Health Board, with responsibilities dependent on the statutory status of the

provider and the commissioning arrangements. Eight of the 106 cases related to independent contractors commissioned by the Health Board. Four were confirmed as meeting the threshold of moderate harm or above, three were reassessed as low or no harm and one remained under investigation at the time of reporting.

Learning from commissioned and externally provided care included pressure-damage prevention, risk assessment, wound management, record keeping, timely reporting, communication with families, staff training and oversight of provider action plans. In the strongest examples, Root Cause Analysis was followed by Health Board quality assurance review, consideration through a specialist panel, a provider learning action plan and planned validation to assess whether actions had been embedded. This provides a strong model for commissioned-service assurance as it extends oversight beyond receipt of an investigation report to confirmation that agreed improvements have been implemented in practice.

The analysis also identified the need for clearer interfaces where care crosses organisational boundaries, including communication between primary and secondary care, independent providers, commissioned services, ambulance services and external diagnostic providers. Investigations emphasised the importance of clearly assigning responsibility for urgent prescribing changes, significant results, referrals, handovers and follow-up.

6. Redress and legal services

During the reporting year, 48 cases were accepted and opened for consideration of redress. 27 cases were returned as not suitable or not ready for redress consideration at the point of referral.

The management of redress was strengthened through a new referral form, targeted training and guidance, a Redress Standard Operating Procedure, a dedicated Redress Team and administrator, a dedicated mailbox and refreshed intranet resources. Referrals were subject to greater scrutiny and returned to divisions where investigations were incomplete or learning had not been sufficiently demonstrated.

Every case referred for redress was required to include evidence of learning and actions intended to prevent future harm. This reinforced the expectation that redress should operate as part of organisational learning, quality improvement and patient safety rather than as a standalone legal or compensation process.

7. Patient support and experience

The Patient Advice and Liaison Service managed 5,875 enquiries and 120 Early Resolution contacts. Only one case was recorded as escalating to the formal Putting Things Right process. Communication issues, including language needs, were the most frequently recorded theme, followed by access to services and appointments.

CIVICA recorded 28,208 patient experience survey responses during 2025/26. The overall satisfaction score remained stable at between 86% and 88%, with a year-end score of 86%. The Health Board moved to the national People's Experience Survey in May 2025. Text message invitations were extended to maternity and neonatal services in September 2025 and to patients receiving cancer treatment from February 2026.

The GRACE End of Life and Bereavement Service managed 297 enquiries. The year-end review also recorded 143 attendances at GRACE's Place, more than 100 bereaved relatives receiving individual support and 136 staff attending six grief awareness sessions. GRACE provided an alternative route for people seeking support, explanation or assurance about learning without necessarily wishing to make a formal complaint.

8. Learning, improvement and assurance

Monthly divisional Quality and Patient Safety assurance reporting became embedded during 2025/26. Complaints, incidents, safeguarding, mortality reviews, patient feedback and improvement activity were considered together to support triangulation, earlier identification of risk and clearer divisional accountability.

The Quality Management Group provided executive oversight of complaints, incidents, redress, patient safety investigations and Learning from Events Reports. Governance of Learning from Events Reports was strengthened through a corporate Standard Operating Procedure, divisional improvement plans, central monitoring and structured escalation. The report states that these changes resulted in measurable reductions in Welsh Risk Pool financial penalties.

The Listening and Learning Framework, Learning Repository and Patient Quality and Safety Learning and Improvement Forum supported the capture and sharing of learning and good practice. Development of Qlik improved the statistical analysis and presentation of complaints and incident information.

Although these arrangements provide evidence of developing organisational learning, the report identifies a continuing need to demonstrate more consistently that actions have been completed, evaluated and translated into measurable and sustained improvements in care and patient experience.

9. Overall assurance position

The priorities established for 2025/26 were substantially progressed. The Health Board strengthened concerns management, improved Early Resolution performance, reduced its oldest complaints, prepared for Listening to People and developed more integrated governance and learning arrangements.

Positive assurance is provided through strengthened governance, high incident reporting, improved Early Resolution performance, enhanced redress scrutiny, wider patient experience feedback and continued support for patients and bereaved families.

The principal areas requiring continued oversight are formal complaint compliance, the remaining overdue complaint backlog, workforce resilience, consistent Duty of Candour practice, data quality and clearer evidence that learning and patient feedback have resulted in completed, measurable and sustained improvement.

Summary of progress against 2025/26 recommendations

The 2024/25 Annual Report identified a number of priorities to support continued improvement during 2025/26. These focused on strengthening concerns management and compliance with the Putting Things Right Regulations, reducing historical complaint backlogs, enhancing governance and accountability arrangements, improving organisational learning from concerns and incidents,

developing Duty of Candour implementation, and strengthening the use of patient and carer feedback to inform quality and safety improvements.

Good progress was made across a number of these areas during the year. Early Resolution arrangements were strengthened, performance improved significantly, and all formal complaints older than 12 months were eliminated by year end. Governance arrangements were enhanced through strengthened divisional assurance reporting, establishment of the Quality Management Group, and improved oversight of learning from events and redress referrals. The Health Board also strengthened its culture of learning and improvement through implementation of the Listening and Learning Framework, the further embedding of the Patient Quality, Safety, Learning and Improvement (PQSLI) Forum as a mechanism for sharing learning across services, increased use of patient and carer feedback, and enhanced arrangements to support learning from concerns, incidents and Learning from Events Reports. Preparatory work for implementation of the Listening to People Regulations continued alongside the further embedding of Duty of Candour processes, training and reporting arrangements.

Whilst the overall direction of travel remains positive, some priorities require continued focus during 2026/27. These include improving compliance with formal complaint timescales, reducing the remaining backlog of overdue concerns, ensuring consistent application of Duty of Candour, strengthening workforce resilience, and demonstrating more clearly the impact of learning and improvement actions on patient outcomes and service quality.

Priorities for 2026/27
The report identifies three priorities for 2026/27.

Priority 1: Embed the Listening to People Regulations
The Health Board will embed Listening to People across all divisions and services. Policies, procedures, communications and training will be updated to reflect the new requirements, with particular emphasis on proportionate triage, meaningful listening discussions and timely, compassionate and accessible resolution.

Priority 2: Undertake a full review of the service model
A review will assess whether the structure, workforce, responsibilities and allocation of work remain appropriate following implementation of Listening to People. It will consider the relationship between the Listening to People Team, Patient Advice and Liaison Service, Quality and Patient Safety teams and divisional services.

Priority 3: Improve the quality and compliance of complaint handling
The Health Board will continue to improve formal complaint compliance and reduce overdue cases through stronger monitoring, senior oversight and targeted divisional engagement. Quality assurance will focus on ensuring that investigations address the concerns raised, explain findings clearly and identify meaningful learning and improvement actions.

Argymhelliad / Recommendation

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

- APPROVE the Putting Things Right Annual Report 2025/26
- NOTE the assurance provided regarding the continued operation of the Health Board's statutory Putting Things Right arrangements during 2025/26.
- NOTE the areas requiring continued improvement, particularly formal complaint compliance, reduction of overdue complaints, consistent implementation of the Duty of Candour and clearer evidence of measurable and sustained learning.
- ENDORSE the three priorities for 2026/27 relating to embedding Listening to People, reviewing the supporting service model and improving the quality and compliance of complaint handling.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	**CRR002**
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 3.1 Safe and Clinically Effective Care 6.3 Listening and Learning from Feedback 3.2 Communicating Effectively
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	Putting Things Right Annual Report 2025/26; Datix incident reporting data; Public Services Ombudsman for Wales case data; Patient Advice and Liaison Service activity data; CIVICA patient experience survey data; Duty of Candour reporting data; Redress and Legal Services records; divisional Quality and Patient Safety assurance reports.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee; Quality Management Group; divisional Quality and Patient Safety governance arrangements.

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**	No specific workforce impact arising directly from this report. The report notes workforce resilience and capacity as areas requiring continued oversight in relation to complaint handling, Duty of Candour and learning processes.
• **Service Activity & Performance**	Yes. The report summarises service activity and performance relating to complaints, concerns, enquiries, Patient Advice and Liaison Service activity, incidents, Duty of Candour, redress, Public Services Ombudsman for Wales cases and patient experience feedback.
• **Financial**	No direct financial impact arising from this report. The report notes that strengthened governance of Learning from Events Reports resulted in measurable reductions in Welsh Risk Pool financial penalties.
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No. An Equality Impact Assessment is not required because this report is for assurance and information and does not propose a new policy, strategy, service change or implementation plan. 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.

Putting Things Right Annual Report 2025/26

Listening, learning and improving from concerns, incidents and patient experience



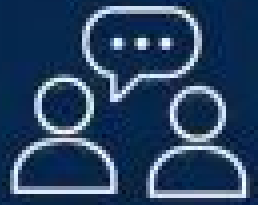
2,465

Concerns and complaints managed



33,380

Patient safety incidents recorded



28,208

Patient experience survey responses

Reporting period: 1 April 2025 to 31 March 2026

Every concern provides an opportunity to listen, learn and improve

Putting Things Right is central to our commitment to openness, fairness and improvement. Every concern raised provides an opportunity to understand the experience of patients, families and carers, and to strengthen the safety, quality and compassion of the care we provide.

Jennifer Winslade
Executive Director of Nursing



Provide assurance on the operation and effectiveness of Putting Things Right



Demonstrate how concerns, incidents and redress were managed

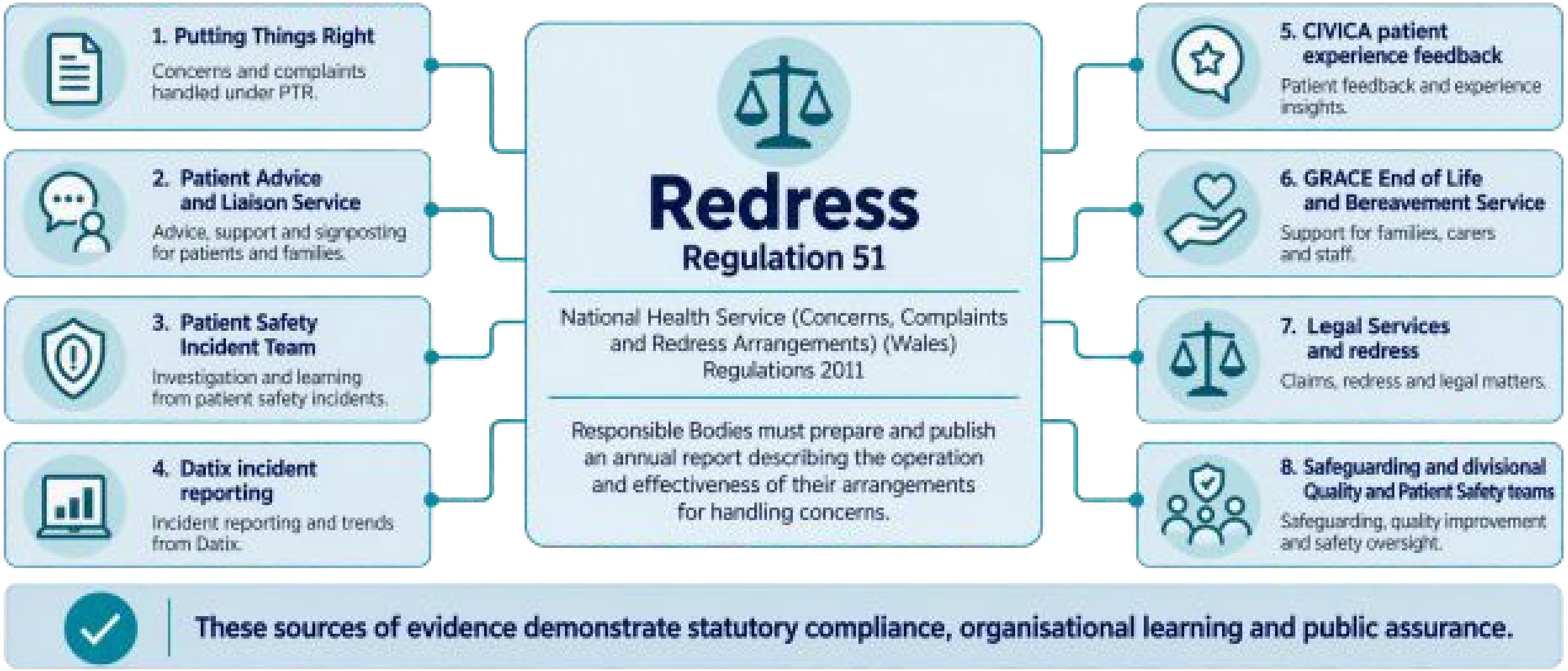


Explain how learning was identified, escalated and translated into improvement



Responding to concerns is not solely a regulatory process. It is an essential part of a learning health system.

The annual report fulfils a statutory requirement and provides public assurance

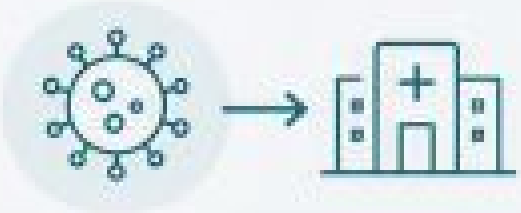


These sources of evidence demonstrate statutory compliance, organisational learning and public assurance.

Statutory reporting period: 1 April 2025 to 31 March 2026

Putting Things Right activity has remained high while the nature and complexity of concerns have evolved

1 Earlier period



- COVID-19-related pressures
- Disruption to access
- Changes to service delivery

2 Developing position



- Post-pandemic backlogs
- Workforce fatigue
- Waiting lists
- Communication challenges
- Fragmented pathways

3 2025/26 position

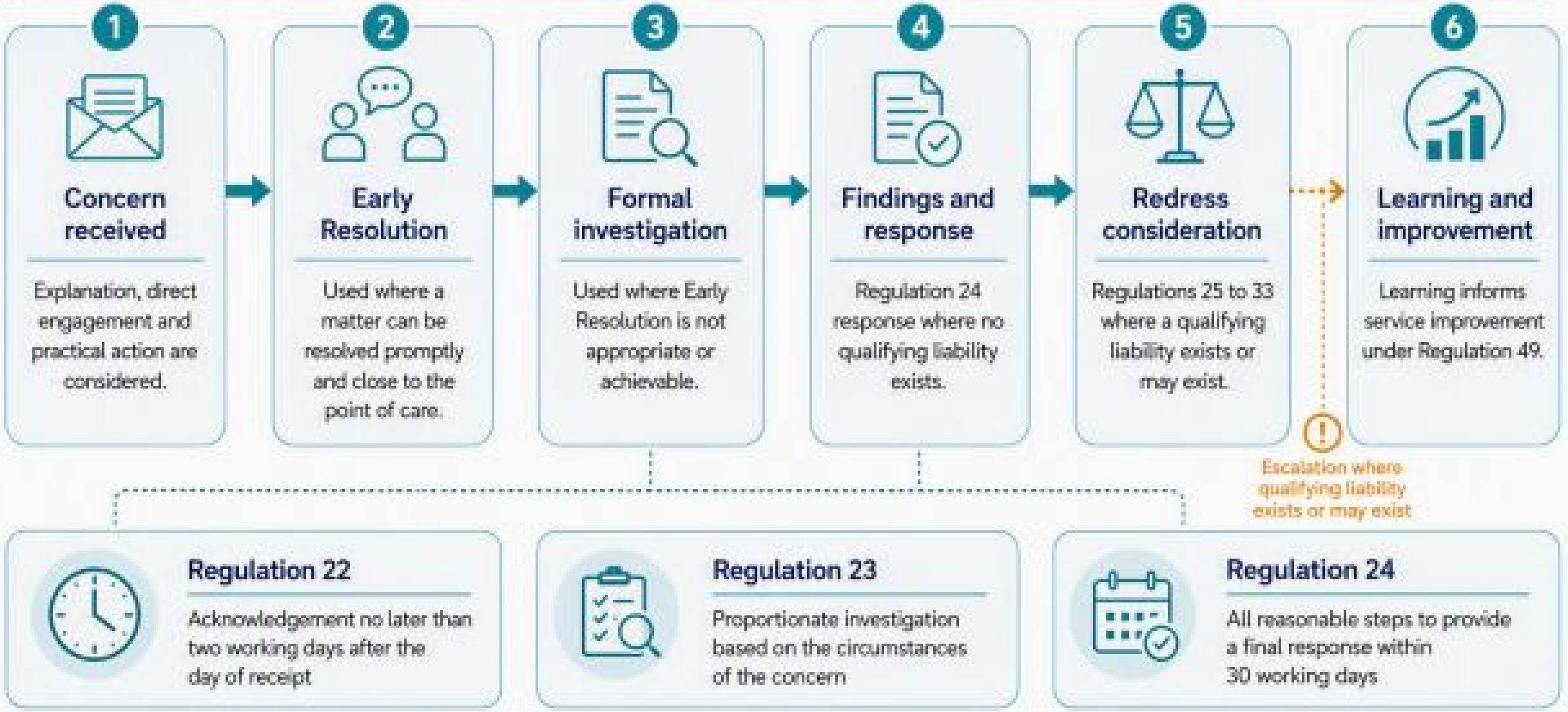


- Greater emphasis on multi-service pathways
- Continuity of care
- Discharge
- Access
- Communication
- Interfaces between hospital, community and primary care

Continuing improvement requirements

1. Greater consistency in investigation quality
2. Clearer articulation of learning
3. Stronger feedback loops
4. Compassionate and person-centred communication
5. Increased oversight of complex cases

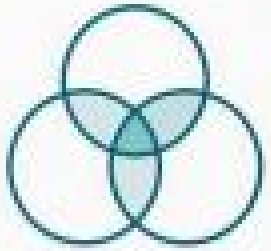
Concerns are managed proportionately according to their nature, complexity and seriousness



Strengthened governance provides a clearer line of sight from frontline learning to Public Board



Monthly divisional assurance strengthened triangulation, accountability and escalation



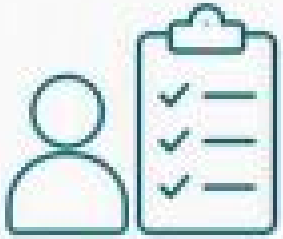
1. Integrated oversight

Complaints, concerns, incidents, safeguarding, mortality reviews, learning and quality improvement considered together.



2. Earlier identification

Emerging risks and themes identified through multiple sources of intelligence.



3. Divisional accountability

Greater visibility of investigation quality and delivery of improvement actions.



4. Corporate escalation

Issues requiring corporate or executive oversight escalated through established governance arrangements.



Quality Management Group established on 1 June 2025

Routine oversight of complaints, incidents, redress, patient safety investigations, divisional assurance and Learning from Events Reports.

Governance and Early Resolution improved, while timeliness and demonstrable impact remain key areas for attention

Positive assurance

- Stronger governance and divisional assurance
- Improved Early Resolution performance
- Strengthened redress arrangements
- Expanded patient experience and bereavement support
- Preparation for Listening to People

Partial assurance

- Learning structures are established and increasingly integrated
- Duty of Candour arrangements have strengthened
- Patient feedback is collected at significant scale
- Evidence of sustained impact requires further development

Continued improvement required

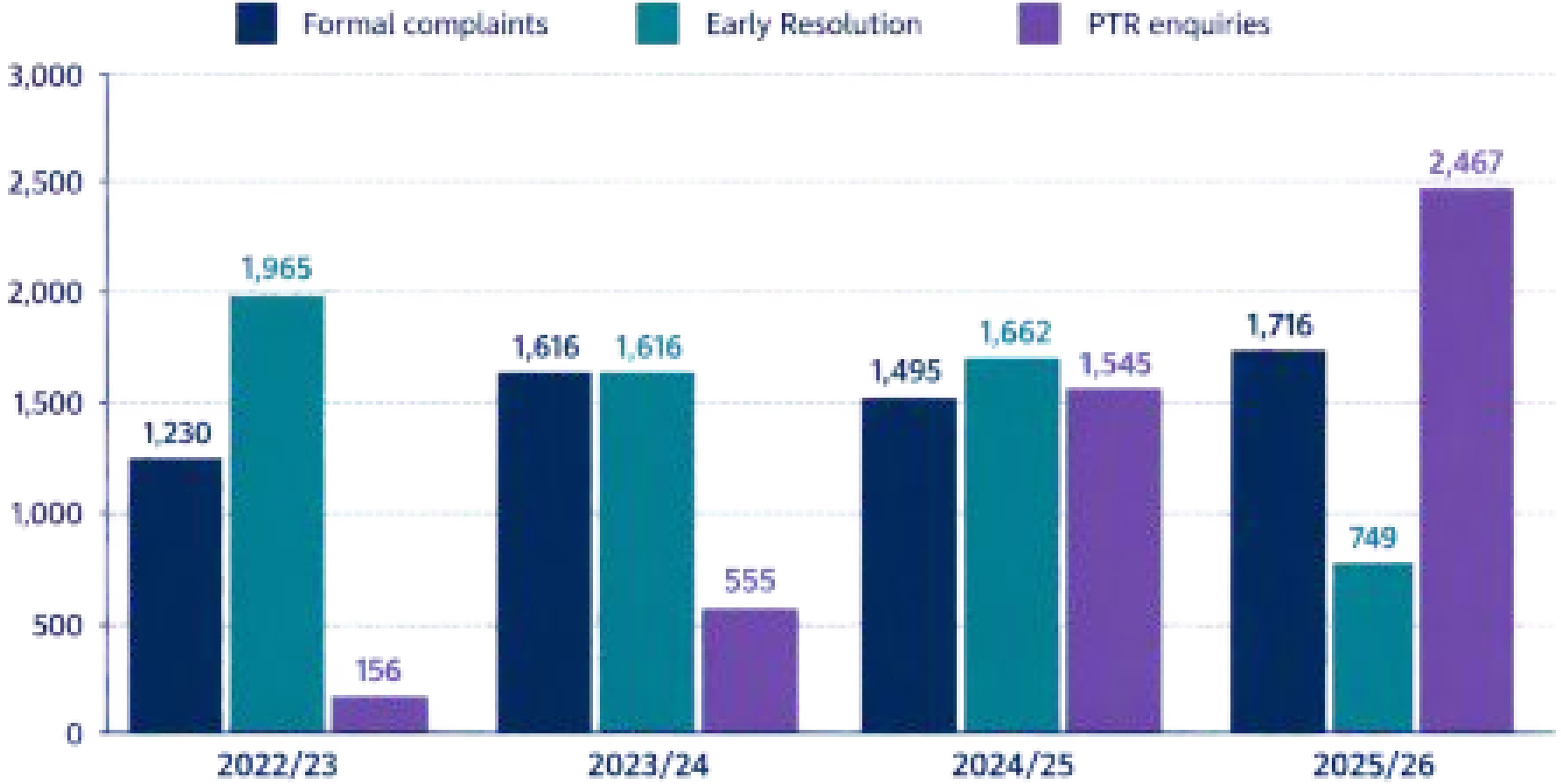
- Formal complaint compliance remained below 75%
- An overdue complaint backlog remained
- Workforce pressures affected operational resilience
- The measurable impact of learning was not consistently demonstrated

Overall position: priorities were substantially progressed, but sustained oversight remains necessary.

A significant volume of concerns, feedback and safety intelligence was managed during 2025/26



Overall demand continued to increase, but the composition of activity changed substantially



4,932
Total PTR team contacts in 2025/26

+230 contacts
compared with 2024/25

+4.9%
annual increase

Total activity was **47.2% higher** than in 2022/23.

Improved triage resulted in requests for information, clarification, signposting and assistance being recorded more accurately as enquiries rather than Early Resolution cases.

Clinical treatment, access and communication remained central themes within the concerns received

2,465
Concerns and complaints managed

1,716
Formal complaints

749
Early Resolutions



These themes were identified across acute, community, mental health and primary care settings and reflected both service pressures and patient experience challenges.

Most concerns were initially graded as no or low harm



Initial grading is based on the information available when a concern is received. It supports proportionate triage and investigation.
Grading remains under review and does not predetermine the final finding, actual harm or qualifying liability.

A small proportion of concerns were found to involve a breach of duty

87
concerns

3.53% of 2,465 concerns received

68
Regulation 24 responses

Breach identified, but no qualifying liability

5
Regulation 24 responses

Potential claim value exceeded the scope of redress

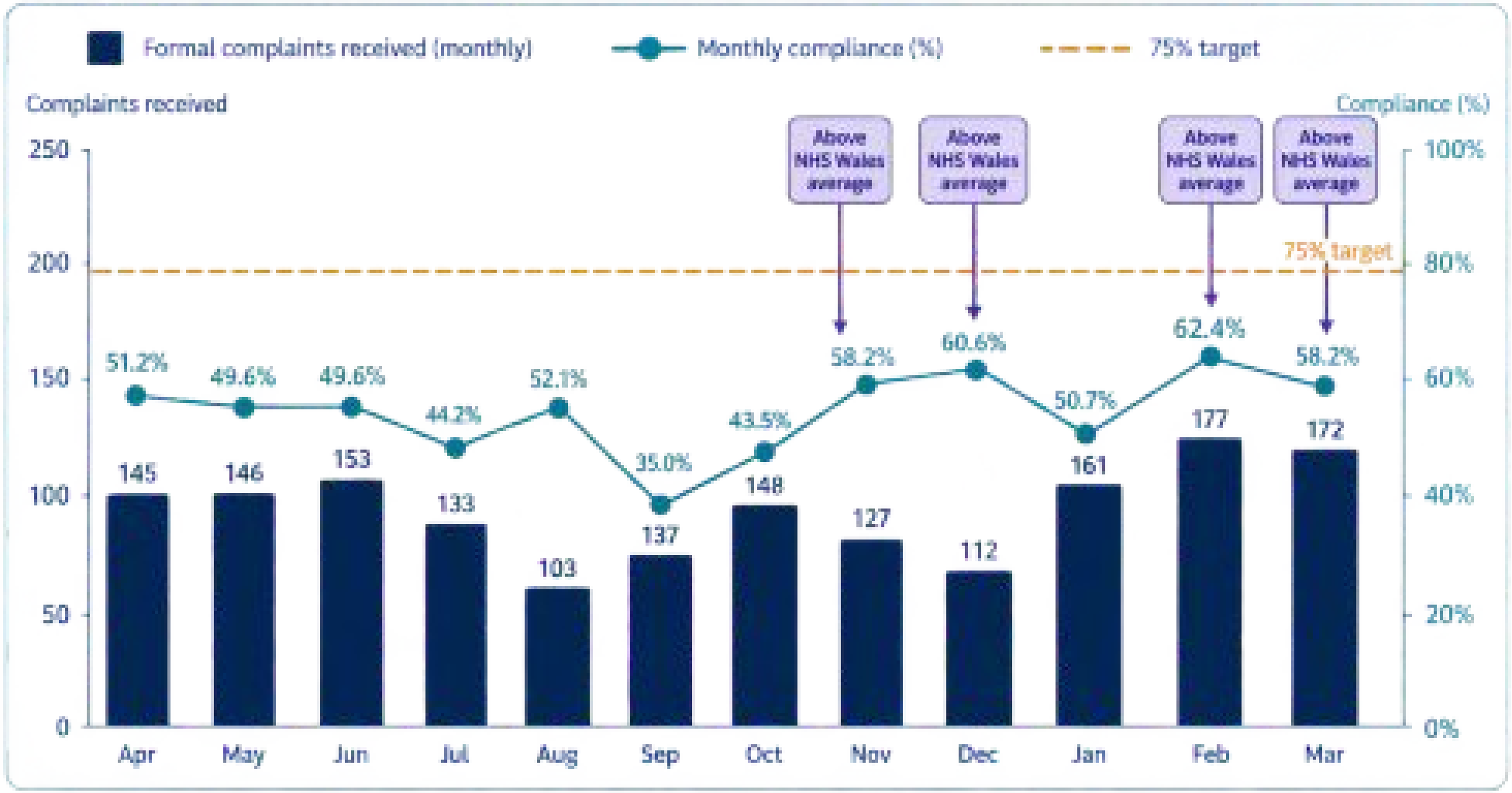
14
Regulation 33 responses

Qualifying liability identified

These cases generally involved allegations of harm, significant distress or complex clinical issues and required more detailed investigation.

Legal Services supported cases requiring redress, legal consideration or independent clinical consideration.

Formal complaint compliance improved comparatively but remained below the 75% target



Performance improved comparatively during the latter part of the year.

Targeted monitoring, review of approaching deadlines, closer divisional engagement and additional PTR and Quality and Patient Safety support contributed to improvement.

Overdue formal complaints 2025/26

258
overdue complaints

at the end of 2025/26

from a peak of
324 in September 2025

No cases older than
365
working days

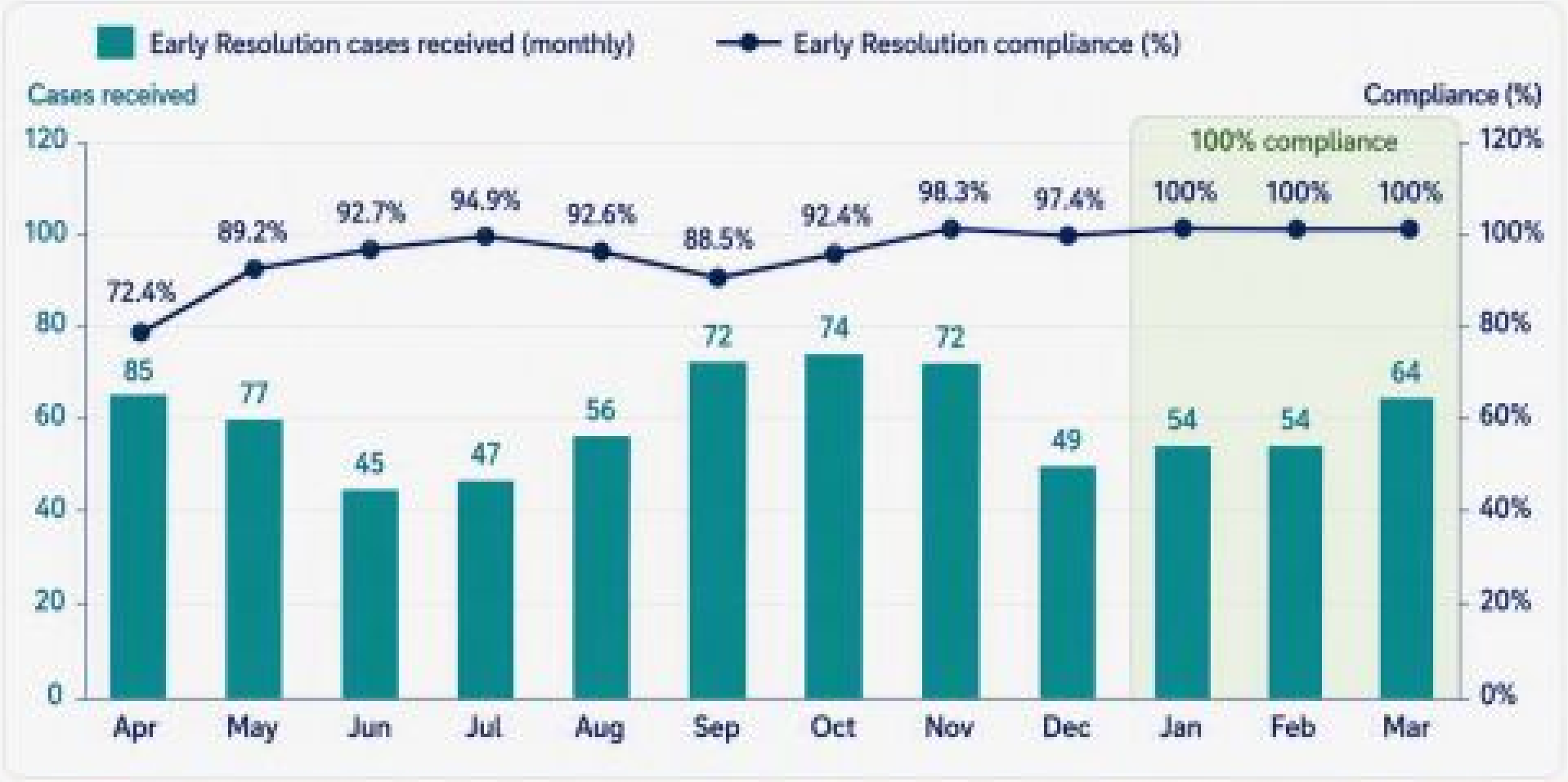
Progress achieved

- Stronger monitoring of approaching or overdue cases.
- Closer engagement with divisions.
- Standard response templates.
- Clearer expectation-setting.
- Tailored training.
- Additional drafting support.

Continuing challenge

- Formal compliance remained below the 75% target.
- Complaint volumes.
- Winter pressures.
- Complex investigations.
- Workforce capacity.
- A remaining backlog entered 2026/27.

Early Resolution compliance improved consistently and reached 100% in the final quarter



Improved triage distinguished substantive concerns from requests for information or assistance.

Regular review of open cases helped prevent drift beyond the Early Resolution timeframe.

Closer engagement between PTR, Quality and Patient Safety and divisional teams supported improvement.

Sustained performance depends upon clinical and operational teams providing information within short timescales.

PALS managed sustained demand while preventing almost all contacts from entering the formal complaints process

5,875
Enquiries

120
Early Resolution contacts

1
Escalated to formal PTR

581
Peak monthly enquiries

PALS enquiries and Early Resolution contacts (monthly)



1 contact was escalated to formal PTR during the year.

This represents a very small proportion of all PALS enquiries and demonstrates PALS' effectiveness in resolving or signposting concerns before they become formal complaints.

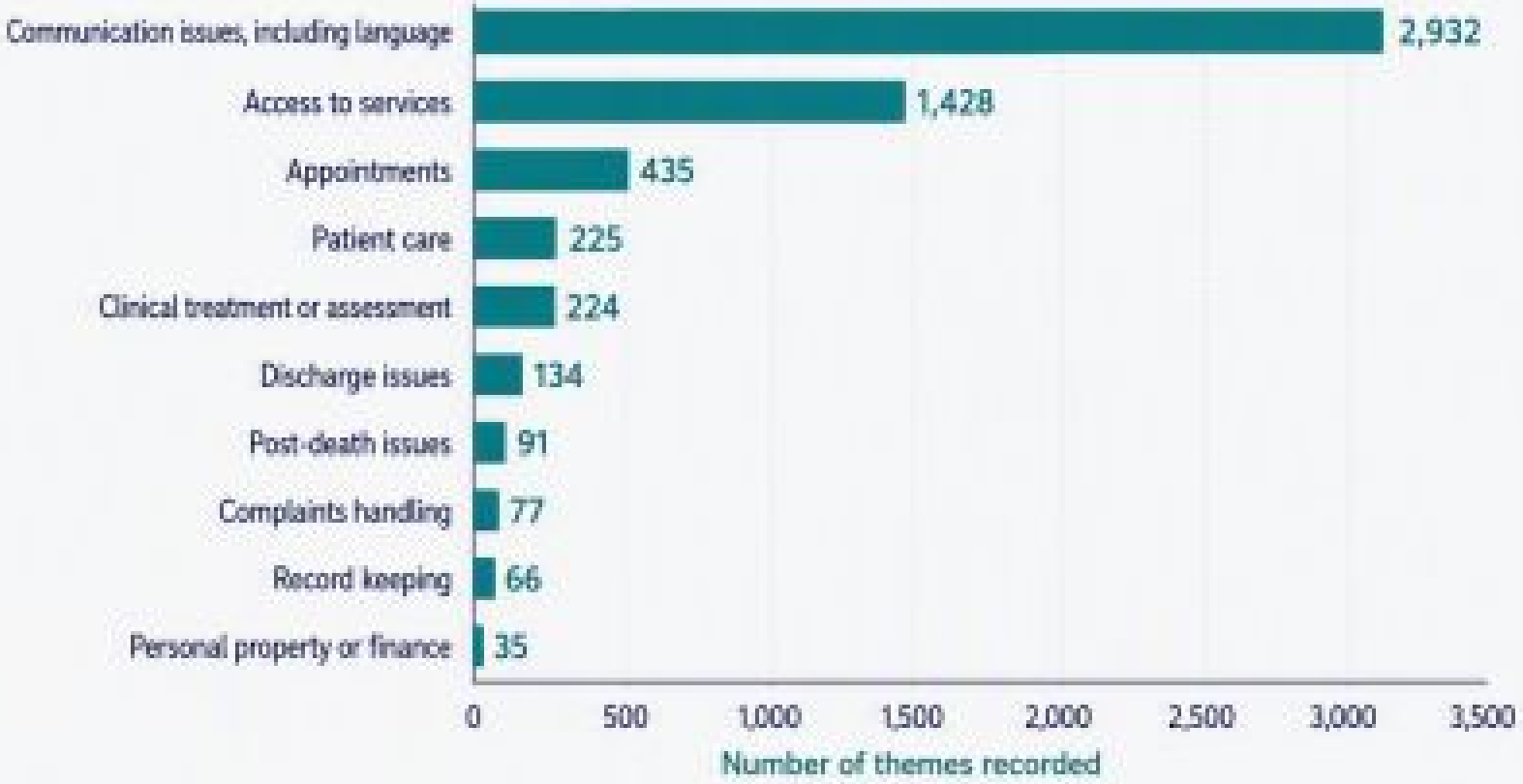
How PALS supports patients, families and carers

- Responding to questions
- Helping people obtain information
- Facilitating communication with services
- Supporting prompt resolution while care was ongoing
- Directing people to the most appropriate route

Communication and access accounted for most themes recorded by PALS

Communication and access represented approximately **77%** of the **5,647** themes recorded.

PALS themes recorded (by category)



How PALS themes make a difference

- Timely and accessible information
- Effective signposting and navigation
- Advocacy between people and services
- Appropriate escalation of concerns about care or treatment

Themes are recorded at the time of contact and may include more than one issue within a single enquiry. Totals may therefore exceed the number of enquiries.

PALS support ranged from practical assistance to sustained advocacy across care pathways

1 Difficult diagnosis



Need Support during investigation and communication of a significant diagnosis

Action PALS attended appointments and supported communication

Continuity of support for the patient and reduced pressure on clinical staff

2 Delayed procedure



Need Prolonged waiting for a procedure affecting quality of life

Action Sustained advocacy and discussion through multidisciplinary arrangements

The patient's circumstances remained visible to the clinical team and surgery was subsequently completed

3 Urgent access



Need Significant symptoms following departure from the Emergency Department

Action PALS contacted the general practice and requested urgent triage

A same-day pathway back into hospital was arranged

4 Continuity across care settings



Need A proposed transfer would have made family visiting difficult

Action PALS supported discussion with clinical teams

An alternative transfer location was agreed

Participation remained strong and satisfaction was stable as the reach of feedback expanded

28,208
total responses

86% to 88%
monthly satisfaction

86%
year-end overall score

2,614
responses in March 2026



1 May 2025
Transition to the national People's Experience Survey

2 September 2025
Text invitations extended to maternity and neonatal services

3 February 2026
Text invitations introduced for people who had received cancer treatment

Positive feedback recognised compassion, support and professional care. Improvement themes included waiting, comfort and occasions where people felt unsupported or not listened to.

GRACE provided compassionate support, explanation and an alternative route to formal complaint



297
GRACE enquiries

143
GRACE's Place attendances

More than 100
Bereaved relatives receiving individual support

136
Staff attending grief awareness sessions

6
Grief awareness sessions

1. Compassionate listening and practical guidance
2. Facilitated discussion with clinical teams
3. Feedback on agreed actions and learning

GRACE's Place support was available across all five boroughs.

GRACE helped bereaved families obtain answers, assurance and evidence of learning

Concern without formal complaint

1. A bereaved relative wished to raise concerns and ensure learning occurred but did not wish to make a formal complaint.
2. GRACE listened to the relative's account.
3. A discussion with the ward manager was facilitated and agreed actions were identified.
4. Actions were shared with the relative and a follow-up meeting checked that the actions had been implemented.

Outcome: the relative was satisfied that the required learning had taken place.

Questions and closure

1. A bereaved relative was satisfied with the care provided but had questions about diagnosis and care.
2. GRACE arranged a meeting with the consultant and senior nurse.
3. Questions could be discussed directly with the clinical team.
4. Ongoing emotional support and access to GRACE's Place were offered.

Most Ombudsman contacts did not progress to an upheld formal report





Learning from Ombudsman cases was triangulated with complaints, incidents and redress and reviewed through divisional assurance and the Quality Management System.

The report identifies a continued reduction in progression to full investigation while recognising that a range of factors may contribute.

Safety and redress intelligence strengthened the wider picture of harm, learning and organisational response

Patient safety incidents

33,380
incidents

99.4%
no harm or low harm following investigation

1	Pressure damage	26.9%
2	Behavioural incidents	17.0%
3	Accident and injury, including falls	15.0%
4	Medication errors	6.7%
5	Assessment, investigation and diagnosis	5.8%

223 pressure damage incidents, 2.4%, were determined to be avoidable.

Redress

48
cases opened for consideration

- New referral form
- Training and guidance
- Standard Operating Procedure
- Dedicated team and administrator
- Dedicated mailbox
- Refreshed intranet resources

Cases were returned where investigation or evidence of learning was insufficient.

Safeguarding

- Early recognition of potential harm
- Timely referral
- Effective information sharing
- Appropriate escalation
- Concerns processes managed without compromising safeguarding, criminal or other statutory enquiries

Duty of Candour

106 initiated incidents

59	26	21
confirmed as meeting the statutory threshold	downgraded to low or no harm	remained under investigation

Independent contractors: 8 cases — 4 confirmed | 3 downgraded | 1 under investigation

Duty of Candour was initiated in 106 cases during 2025/26

Events occurred across all main service areas, with clinical assessment and treatment issues accounting for the largest recorded categories.

Duty of Candour initiated
106
Duty of Candour cases recorded during 2025/26

Average per month
8.8
Average number of cases initiated each month

Peak month
15
December 2025

Training compliance
81.5%
9,523 of 11,691 staff requiring training recorded as trained

Duty of Candour events initiated by month



Monthly activity fluctuated between 4 and 15 cases. The highest recorded month was December 2025, with further higher activity in May 2025 and February 2026.

Month is based on the date the NHS body first became aware that Duty of Candour had been triggered.

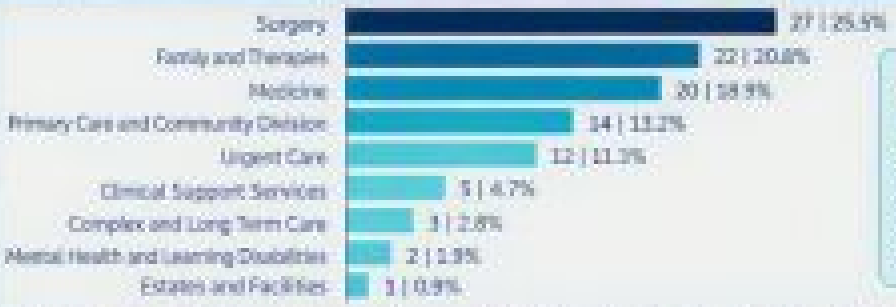
Ten most frequently recorded incident categories



48 cases

The three most frequently recorded categories accounted for **45.3%** of all Duty of Candour cases.

Duty of Candour events by division



69 cases

Surgery, Family and Therapies, and Medicine together accounted for 69 of the 106 cases, equivalent to **65.1%**.

Counts are not adjusted for service size, clinical activity, case mix or reporting practice and should not be interpreted as a divisional safety ranking.

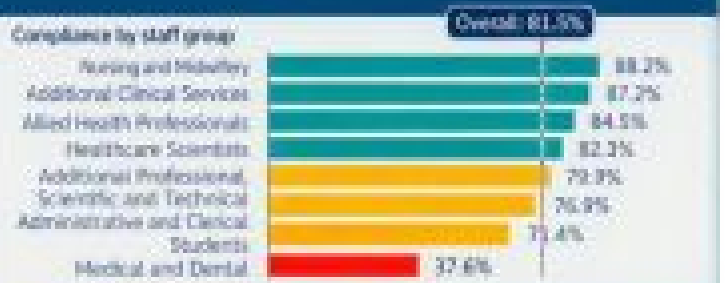
Duty of Candour training compliance



9,523 trained
2,168 outstanding
11,691 staff requiring training

Staff marked 'Not Required' are excluded from the compliance denominator.

Compliance by staff group



Medical and Dental recorded the largest outstanding cohort: 936 staff.

Nursing and Midwifery Registered recorded the highest training compliance at 88.2% overall.

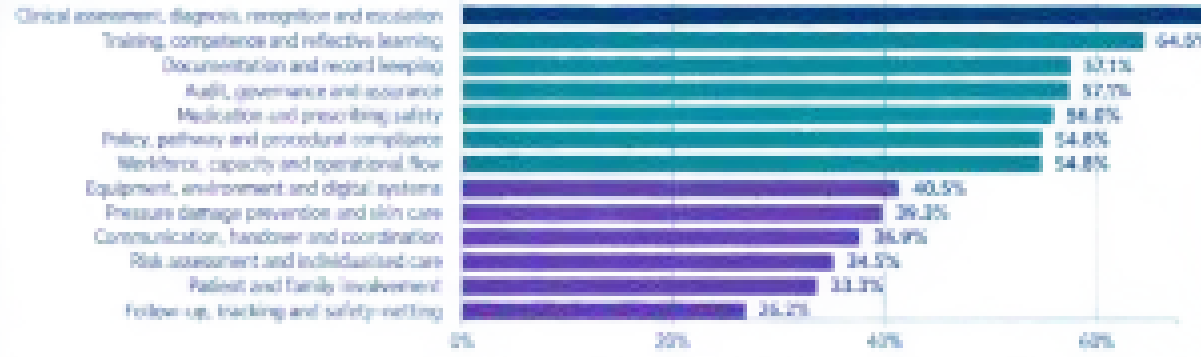
Source: Duty of Candour case workbook and Duty of Candour training compliance summary. Incident analysis uses 106 unique case identifiers and the date the NHS body first became aware that Duty of Candour had been triggered. Percentages may not total 100% due to rounding. Cases recorded against 'Not Applicable' assignments are excluded from the denominator.

Duty of Candour was initiated in **106 cases** during 2025/26. Events were recorded across **all nine listed divisions**, with clinical assessment, treatment and pressure damage categories most prominent. Overall training compliance was **81.5%**, although marked variation between staff groups indicates that targeted improvement remains necessary.

Learning from Duty of Candour incidents identified recurring system priorities

Analysis of records containing substantive recommendations shows that improvement most often focused on clinical recognition, staff capability, documentation, governance and reliable care pathways.

Where substantive recommendations were most frequently focused



Themes overlap
One recommendation may address several aspects of care or service delivery.

Percentages show the proportion of records with substantive recommendations in which each theme was identified. Recommendations could contribute to more than one theme.

Central learning



The recurring weakness was not confined to a single stage of care. Important findings, decisions or treatment requirements were sometimes not reliably carried through the complete pathway.

Safer systems require closed-loop processes.

The required action is assigned, acknowledged, completed and checked, with overdue steps escalated.

Assessment, diagnosis and follow-up



Diagnostic incidents frequently identified missed red flags, incomplete interpretation of results, delayed senior review and failures to track referrals, results or follow-up appointments.

Clinical intention must reliably lead to completed action.

Medication and treatment safety



Recommendations commonly addressed omitted or delayed treatment, unclear prescribing instructions, medicine reconciliation, monitoring, and the transfer of responsibility between teams or care settings.

Time-critical decisions must be explicit, communicated and verified.

Pressure damage and individualised care



Learning focused on accurate risk assessment, skin inspection, repositioning, pressure-relieving equipment, wound documentation, timely specialist referral and discussion with patients and families.

Risk assessments must translate into consistent care at the bedside.

Different settings showed different concentrations of learning

Surgical services
Recommendations placed greatest emphasis on clinical recognition, pathway compliance, follow-up, procedure assurance and governance.

Family and Therapies
Learning particularly emphasised training, documentation, clinical escalation, fetal or neonatal surveillance and multidisciplinary planning.

Medical services
Recommendations frequently connected clinical recognition and medication safety with workload, capacity, senior oversight and operational flow.

Primary and community care
Learning focused on documentation, pressure damage prevention, referral accuracy, communication across services and formal quality assurance.

Urgent care
Recommendations emphasised triage, recognition of deterioration, pre-alerts, senior review, safe placement and communication during operational pressure.

Differences reflect service context, incident type and the maturity of individual investigations. They should not be interpreted as a directional or safety ranking.

Learning provides assurance only when improvement can be demonstrated

1. Learning identified → 2. Action assigned → 3. Change implemented → 4. Compliance measured → 5. Impact demonstrated

Evidence of implementation and sustained effect was inconsistent across the records.

Governance priority

Standardise action plans so that every recommendation has a responsible owner, completion date, measurable outcome and evidence that the change has been embedded.

Training and reminders should be accompanied by competency assessment, audit or outcome monitoring where appropriate.

Analysis includes only records containing substantive recommendations. Themes were coded from the investigation report, recommendations and action plans. Organisational learning was not coded. Evidence of implementation was limited to records that described completed actions.

Substantive recommendations demonstrate broad organisational learning, with the strongest emphasis on clinical recognition, staff capability, documentation, governance and reliable pathways. Partial assurance remains because evidence that actions were implemented, sustained and reduced recurrence was not recorded consistently.

The Health Board strengthened its learning system, with three priorities identified for 2026/27

- Listening and Learning Framework
- Learning Repository
- Patient Quality and Safety Learning and Improvement Forum
- Qlik business intelligence



Learning from Events

Learning from Events governance strengthened through a corporate Standard Operating Procedure, divisional improvement plans, central monitoring and structured escalation.

1 Embed Listening to People

- Update policies, procedures, communications and training
- Embed proportionate triage and meaningful listening discussions
- Review variation and implementation issues

2 Review the service model

- Assess structure, workforce, responsibilities and workload
- Clarify relationships between Listening to People, PALS, Quality and Patient Safety and divisional services
- Align resources with activity and complexity

3 Improve complaint quality and compliance

- Improve timeliness
- Reduce overdue cases
- Strengthen investigation quality
- Ensure responses are open, balanced, compassionate and accessible

Statutory arrangements remained in place and governance, Early Resolution, redress and learning arrangements strengthened during 2025/26. Continued oversight is required to improve formal complaint compliance, embed consistent Duty of Candour practice and demonstrate measurable and sustained improvement.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	06 October 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Maternity and Neonatal Annual Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade (Executive Director of Nursing)
SWYDDOG ADRODD: **REPORTING OFFICER:**	Jayne Beasley (Head of Maternity & Gynaecology)

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 annual report provides the Committee with assurance about the quality, safety, experience, outcomes and performance of maternity and neonatal services during 2025/26. It forms part of the Health Board's arrangements for overseeing these services and demonstrating how it meets its statutory Duty of Quality and wider national maternity and neonatal assurance responsibilities.

The report identifies improvement across several important areas. These include earlier access to antenatal care, improved care for babies born prematurely, strengthened infection prevention and control, more robust management of patient safety incidents, positive patient and family engagement, and progress in recruiting maternity and neonatal staff.

The overall assurance position is positive despite a number of issues that need to be addressed. Established governance, monitoring and improvement arrangements are in place, but sustained oversight is required. The principal areas requiring attention include rising rates of operative birth, neonatal capacity, access to specialist pharmacy and therapy support, workforce resilience, sickness absence, mandatory training, antenatal screening, breastfeeding support, medicines safety and implementation of national maternity and neonatal recommendations.



Cefndir / Background

Aneurin Bevan University Health Board provides community and outpatient antenatal services across each borough. Inpatient maternity care and level 3 neonatal care for babies requiring intensive, high-dependency or specialist care are provided at the Grange University Hospital. In 2025, 6,176 women booked for maternity care and there were 5,124 births. The Neonatal Intensive Care Unit has eight intensive care cots, ten high-dependency cots and twelve low-dependency cots. The level of care provided by each cot reflects the severity and complexity of a baby's clinical needs.

National maternity and neonatal assurance arrangements require Health Boards to maintain effective governance from service level through to the Board, monitor clinical practice and outcomes, ensure that information is accurate and reliable, and provide regular Board-level reports on risks and improvement plans. Mandatory national maternity and neonatal data requirements also support consistent reporting, assurance and improvement across Wales. This report therefore brings together information on activity, clinical outcomes, patient safety incidents, mortality, workforce, education and training, patient and family experience, risk and improvement. It supports transparent Board scrutiny of compliance with statutory duties, national standards, professional requirements and agreed improvement priorities.

Asesiad / Assessment

Antenatal care and public health

Earlier access to antenatal care improved significantly during 2025. Antenatal care is the care provided throughout pregnancy to monitor the health and wellbeing of the woman and baby. In 2025, 68% of women booked for maternity care before ten completed weeks of pregnancy, compared with 52% in 2024. By twelve weeks, 88% had booked, compared with 75% in 2024. Earlier booking enables health and social needs to be identified promptly and allows screening, advice and appropriate support to be offered at the recommended stage of pregnancy.

Performance against Antenatal Screening Wales standards also improved. Antenatal screening includes tests offered during pregnancy to identify certain infections, chromosomal conditions and other factors that may affect the health of the woman or baby. Although the overall direction of travel is positive, some indicators remain rated red because performance is more than 10% below the relevant target. These areas require further improvement and monitoring. Public health information identifies continuing population health needs within the maternity population. At booking, 41% of women reported a mental health issue and 33% had a body mass index above 30. In addition, 9.4% of women reported smoking within the previous 14 days. This reduced to 5% at 36 weeks of pregnancy, indicating a reduction in smoking as pregnancy progressed.

Vaccination during pregnancy provides protection for women and can also protect babies during the period immediately after birth. A pilot involving trained vaccinators in five antenatal clinics increased uptake of the Respiratory Syncytial Virus



vaccination to 60%. The pregnancy weight-management pathway was relaunched in April 2025 and receives between 100 and 120 referrals each month. The pathway provides women with tailored advice and access to dietary, physical activity and weight-management support during and after pregnancy.

Births and maternity pathways

The number of births reduced, from 5,282 in 2024 to 5,124 in 2025. Although the total number of births reduced, the proportion involving clinical intervention increased. Caesarean sections accounted for 43% of births in 2025, compared with 41% in 2024, with emergency caesarean sections accounting for 25% of all births. The service will continue to review these trends, including clinical indications, outcomes and opportunities to support informed choice and appropriate birth pathways.

Instrumental births increased slightly from 8.3% in 2024 to 8.5% in 2025. The rate remained below the reported target of 10%. Induction of labour, where labour is started artificially using medicines or other clinical methods, increased by one percentage point to 33%. The service continues to offer four potential places of birth, subject to individual clinical needs and informed choice.

A Midwifery Unit Oversight Group has been established to strengthen oversight of clinical safety and outcomes, workforce and training, access, informed choice and arrangements for transferring women to obstetric care where additional clinical support is required, this forms part of the midwifery units standards for self assessment. Some women may choose a place or type of birth that falls outside recommended clinical guidance. A multidisciplinary pathway is in place to support these women. The pathway is intended to support informed and personalised decision-making while ensuring that clinical and organisational risks are clearly considered.

Neonatal care and perinatal optimisation

Perinatal optimisation for babies born before 34 weeks of pregnancy improved to 74%, compared with 64% in 2024 and 53% in 2023. Perinatal optimisation refers to a package of evidence-based interventions provided before, during and shortly after birth to improve outcomes for babies who are born prematurely. Local data identifies improvement in delayed clamping of the umbilical cord, maintaining a baby's temperature on admission to the neonatal unit, screening for retinopathy of prematurity and the provision of breast milk.

Further improvement is required in the timely administration of antenatal steroids, probiotics and early breast milk. Antenatal steroids are given before an anticipated premature birth to help the baby's lungs develop. Probiotics are beneficial microorganisms that may be given to some premature babies to support their digestive health and reduce the risk of serious bowel disease. Validated 2025 National Neonatal Audit Programme data was not available at the time of reporting. The findings relating to perinatal optimisation are therefore based on local data.

Neonatal cot occupancy and staffing capacity are reviewed twice each day. This enables the service to consider the number and clinical needs of babies alongside



the availability and skills of staff. An escalation process is in place where demand, acuity or staffing pressures could affect the service's ability to provide safe care. Maternity and neonatal services also participate in three national situation-report meetings each week. These meetings support assessment of capacity and pressures across maternity and neonatal services in Wales.

Patient safety and Duty of Candour
Maternity governance arrangements were strengthened during 2025 through the appointment of a Risk and Governance Lead Midwife and additional administrative support. This has increased the service's capacity to oversee patient safety incidents, investigations and wider governance processes.

All reported incidents are reviewed through weekly multidisciplinary discussion. Following review, most incidents were assessed as having caused no harm or low harm. Incident reporting is an important component of a positive safety culture because it enables services to identify risks, investigate concerns and share learning. Sixteen maternity patient safety investigations were undertaken during 2025. These covered a range of events, including unexpected neonatal admissions, cases of hypoxic-ischaemic encephalopathy, neonatal and intrauterine deaths, swab-counting incidents and a medication-administration incident. Each case was reviewed through the appropriate patient safety and mortality review arrangements to identify learning and improvement actions.

Hypoxic-ischaemic encephalopathy is a type of brain injury that can occur when a baby's brain does not receive enough oxygen or blood around the time of birth. Its effects can vary, and not every baby affected will experience long-term harm. The reported rate reduced from 2.47 per 1,000 births in 2024 to 1.73 per 1,000 births in 2025. There were no reported Never Events.

Four neonatal incidents triggered the Duty of Candour procedure during 2025. The Duty of Candour requires NHS organisations to be open and transparent with people when care has resulted in, or could result in, certain levels of harm. Learning from the incidents included separating the preparation of gentamicin from the collection of blood samples, strengthening the handover of outstanding blood results and investigating an incident involving extravasation.

Following an increase in neonatal medication incidents in July 2025, the service introduced targeted quality improvement work, a medication forum, human factors training and additional medication education. Compliance with the additional medication education was reported as above 90%. Monitoring following the increase in July 2025 indicates a subsequent reduction in reported medication incidents. Continued oversight is in place to sustain this improvement.

Mortality
Maternity and neonatal deaths are reviewed through the Perinatal Mortality Review Tool and local and national multidisciplinary arrangements. Deaths are recorded through Datix, reported through the nationally reportable incident process and submitted to Mothers and Babies: Reducing Risk through Audits and Confidential



Enquiries across the United Kingdom. This national programme examines maternal and baby deaths to identify learning and improve care.

The national mortality information relates to babies born in 2024. It records 22 stillbirths, with a crude rate of 4.16 and a stabilised rate of 3.55, and eight neonatal deaths, with a crude rate of 1.52 and a stabilised rate of 1.93. Available comparison data indicates that the reported mortality rates were within the range observed among comparable health boards. These figures relate to babies born in 2024 and should be considered alongside the number of cases, the stabilised rates and the findings from individual mortality reviews.

Infection prevention and control

Infection prevention and control was a priority during 2025/26, with the services implementing a targeted improvement programme. The programme strengthened cleaning and laundry arrangements, environmental monitoring, blood-culture reporting, venepuncture practice, aseptic non-touch technique, audit and corporate oversight.

Following implementation of the improvement programme, the available information did not identify a further upward trend in reported infection prevention and control incidents. Performance continues to be monitored through established infection prevention and control arrangements. Neonatal hand-hygiene and peripheral vascular catheter audits reported 100% compliance for the period measured. This result will continue to be monitored to support sustained compliance and identify any variation in practice. The caesarean-section surgical-site infection rate was 2.27% in quarter four of 2025. The reported rate represented a reduction of 24.75%, despite an 8% increase in the number of procedures during the same period.

Patient experience and engagement

A bespoke patient-experience survey was introduced in September 2025 to obtain feedback across the maternity and neonatal pathway. Overall user experience exceeded 85%, and there were no overdue formal concerns at the time of creating this report.

Patient and family feedback is obtained through the BABI and Dinky Dragons service-user groups, social media, the Patient Advice and Liaison Service, Listening to People services, birth-reflection support and the after-birth service. These arrangements provide different opportunities for women and families to share their experiences and contribute to service improvement. The service is also implementing the national Perinatal Engagement Framework, which is intended to support active listening and meaningful involvement of women and families across maternity and neonatal services.

Workforce, training and culture

Maternity recruitment resulted in an establishment above the staffing requirement identified by the 2023 Birthrate Plus assessment. Birthrate Plus is an established workforce-planning tool that assesses the number of midwives required by considering birth activity and the level of care women need. A further assessment is



being undertaken during 2026. The service has also recruited 15 whole-time equivalent newly qualified midwives through the 2026 streamlining process.

During 2025, the neonatal nursing establishment was reported as meeting the relevant British Association of Perinatal Medicine standards. Recruitment remains under way to address current vacancies and support the resilience of the service, including agreed recruitment of six whole-time equivalent band 5 nurses. Although therapy support is available, current provision does not meet British Association of Perinatal Medicine standards. A business case has therefore been developed to increase psychology and occupational therapy support.

Overall mandatory training compliance is reported at 80% for neonatal services and 75% for maternity services. Areas requiring further improvement include neonatal qualified-in-speciality training at 68% - 70% target, maternity safeguarding level 3 training at 72%, neonatal blood transfusion training at 75% and maternity Gap and Grow training at 69%.

Maternity sickness absence ranged from 4.98% to 8.04% between June 2025 and May 2026. Neonatal sickness absence varied between 5.54% and 14.86% during the period. Reducing sickness absence and strengthening workforce resilience remain priorities, supported by detailed workforce reviews, monthly monitoring and oversight by the Divisional Management Team. Recent performance indicates improvement, although sustained progress will continue to be monitored. Neonatal appraisal increased to above 80% and maternity appraisal compliance continues to fluctuate between 66% and 69%.

A range of actions is being taken to strengthen workplace culture and psychological safety. Current actions include clinical supervision, coaching, mentorship, restorative supervision, increased leadership visibility, regular staff communication and joint maternity and neonatal education. Actions arising from the 2025 neonatal listening event are being implemented, and a maternity listening event is planned for 2026.

Priorities for the year ahead

The maternity and neonatal services have identified several areas where further development would support the delivery of consistently high-quality care. Within maternity services, priorities include strengthening pharmacy support, maintaining high standards in the interpretation of cardiotocography, improving compliance with Gap and Grow, ensuring service capacity is aligned with demand and improving information sharing between BadgerNet and the Child Health System.

Within neonatal services, improvement priorities include reviewing cot and transitional care capacity, strengthening arrangements for managing transfer requests during periods of high demand, improving access to pharmacy and therapy support, ensuring the availability of appropriately skilled staff and developing sustainable medical rota arrangements.

Priorities for the coming year are to maintain delivery of the overarching improvement plan; respond to national and local recommendations; develop



dedicated transitional care; strengthen neonatal pharmacy and therapy support; review workforce requirements against Birthrate Plus and British Association of Perinatal Medicine standards; continue work to support a positive workplace culture, human factors, equality and diversity; maintain training compliance; and encourage innovation and quality improvement.

Progress will continue to be monitored through the established maternity and neonatal governance arrangements. This will support oversight of improvement activity, identification of areas requiring additional focus and the provision of appropriate assurance to Health Board committees.

Argymhelliad / Recommendation

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

1. Take assurance from the Maternity and Neonatal Annual Report 2025/26
2. Note the improvements made in the Maternity and Neonatal Services in 2025/26
3. Note the priorities for improvement in 2025/26

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):	2.1 Managing Risk and Promoting Health and Safety 2.4 Infection Prevention and Control (IPC) and Decontamination 6.3 Listening and Learning from Feedback 3.3 Quality Improvement, Research and Innovation
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Every Child has the best start in life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.



Strategic Equality Objectives 2020-24	

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	The report is informed by local maternity and neonatal activity, quality, safety, workforce, patient-experience and outcome information for 2025/26, together with relevant national standards, audit programmes, statutory guidance and external reviews. The principal evidence sources are: 1. Health and Social Care (Quality and Engagement) (Wales) Act 2020 and Duty of Quality Statutory Guidance 2023. 2. Health and Care Quality Standards 2023. 3. Maternity and Neonatal Safety Support Programme. 4. Perinatal Quality Statement for Wales. 5. All-Wales Perinatal Engagement Framework. 6. The Path to Safer Beginnings. 7. Antenatal Screening Wales standards. 8. National Neonatal Audit Programme. 9. PERIPrem Cymru optimisation measures. 10. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the United Kingdom reports and local perinatal mortality information. 11. Perinatal Mortality Review Tool reviews. 12. British Association of Perinatal Medicine standards. 13. Birthrate Plus workforce assessment. 14. Relevant National Institute for Health and Care Excellence and Royal College professional guidance. 15. Local Datix incident and risk information, patient safety investigations, Duty of Candour reviews, infection prevention and control audits, workforce information and patient-experience feedback. 16. Relevant national and independent maternity and neonatal reviews, including

	the Swansea Bay review, the Nottingham maternity review and the Amos report.
Rhestr Termau: Glossary of Terms:	**Antenatal:** Care provided during pregnancy. **BadgerNet:** An electronic clinical record system used in maternity and neonatal care. **BAPM:** British Association of Perinatal Medicine. **Birthrate Plus:** A workforce-planning tool used to assess the number of midwives required according to activity and clinical need. **Body mass index:** A measure using height and weight to assess whether a person's weight may increase the risk of certain health conditions. **Cardiotocography:** Electronic monitoring of a baby's heart rate and the woman's contractions during pregnancy or labour. **Datix:** The Health Board's system for recording and managing incidents and risks. **Duty of Candour:** The legal duty requiring NHS organisations to be open and transparent when care has resulted in, or could result in, specified levels of harm. **Extravasation:** Leakage of fluid or medicine from a vein into the surrounding tissue. **Gap and Grow:** A national programme supporting the identification and management of babies who may not be growing as expected during pregnancy. **Hypoxic-ischaemic encephalopathy:** A type of brain injury that can occur when a baby's brain does not receive enough oxygen or blood around the time of birth. **MBRRACE-UK:** Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the United Kingdom. **Neonatal care:** Specialist care provided to newborn babies who are premature, unwell or require additional monitoring and treatment. **Never Event:** A serious patient safety incident considered largely preventable because established national safety measures should have been implemented. **NNAP:** National Neonatal Audit Programme. **Perinatal:** The period covering pregnancy, birth and the time immediately following birth. **Perinatal optimisation:** A package of evidence-based interventions intended to improve outcomes for babies born prematurely. **PMRT:** Perinatal Mortality Review Tool.



	Respiratory Syncytial Virus: A common respiratory infection that can cause serious illness in young babies. **Retinopathy of prematurity:** An eye condition that can affect babies born prematurely. **Surgical-site infection:** An infection affecting the area of the body where an operation has taken place. **Transitional care:** Care that enables babies requiring additional monitoring or support to remain with their mothers where it is safe and appropriate. **Whole-time equivalent:** A standard measure of staffing hours, with one whole-time equivalent representing the hours worked by one full-time member of staff.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Quality Management Group

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	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.



Aneurin Bevan University Health Board

Maternity and Neonatal Services

Annual Report 2025/26

Public Board



Executive Summary

This annual report provides the Board with an overview and assurance regarding the quality, safety and delivery of maternity and neonatal services during 2025/26. It brings together information on antenatal care, birth outcomes, neonatal care, patient safety, mortality, infection prevention and control, patient and family experience, workforce, education, culture and the delivery of national and local improvement priorities.



Positive assurance

There is evidence of improvement across several important measures. Early booking improved from **52%** to **68%**, and PERIPrem optimisation reached **74%**.

The rate of hypoxic-ischaemic encephalopathy reduced from **2.47** to **1.73** per 1,000 births. Retinopathy of prematurity screening improved from **69%** to **78%**, breast milk measures improved, and there were no maternity Never Events.

Improvement priorities

- Quality and Patient Safety initiatives; including human factors training, medication safety, infection prevention, and a perinatal dashboard
- Support to access additional training, prioritisation of staff wellbeing, access to supervision, regular appraisal and workforce development
- Future development will focus on peri-natal pathways, dedicated transitional care and pharmacy and therapy support

Purpose, Scope and Assurance

PURPOSE



Maternity and neonatal services use a range of clinical, operational, workforce and patient experience measures to assess the quality and safety of care.

This report provides the Board with an overview of care delivered during 2025/26 and identifies where evidence provides positive assassurance, where improvement is continuing and where risks require sustained oversight.

SCOPE



The report considers:

- Antenatal provision and public health
- Birth activity and midwife-led care
- Neonatal outcomes
- Patient safety incidents and Duty of Candour
- Mortality and bereavement
- Infection prevention and control
- Patient and family experience
- Workforce, training and organisational culture
- Delivery of local and national improvement priorities

ASSURANCE ROUTES



- Maternity and Neonatal Improvement and Assurance Group
- Quality Management Group
- Patient Quality, Safety and Outcomes Committee
- Executive Committee
- Directorate and divisional governance arrangements



Service Profile

MATERNITY SERVICES

Maternity services provide outpatient and community antenatal care across each borough, supporting local access for women and families.

Inpatient maternity and neonatal services are provided at the Grange University Hospital, including antenatal care, obstetric and midwife-led intrapartum care, high dependency care and postnatal care.



6,176
women booked for maternity care in 2025

5,124
births recorded in 2025

NEONATAL SERVICES

The Neonatal Intensive Care Unit is a level 3 service comprising:



- **8** intensive care cots
- **10** high dependency cots
- **12** low dependency cots

The service is supported by neonatal outreach, the South East Wales transport service, outpatient clinics, neurodevelopmental clinics and murmur clinics.

Transitional care is delivered collaboratively by maternity and neonatal services. Work continues to establish a dedicated transitional care environment.

Improvement and Assurance Framework



Women, families and babies

Safe and effective care

Our people

Our future

The improvement plans bring together measurable actions arising from local priorities, national programmes, quality standards and external reviews. Progress and outstanding actions are monitored through maternity, neonatal, divisional and corporate governance arrangements.

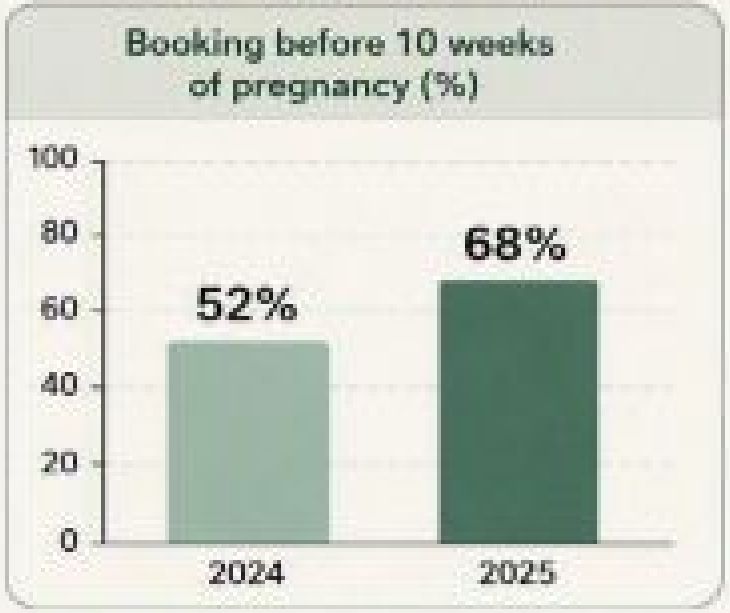
Antenatal Access and Early Booking



Early access to maternity care supports timely antenatal screening, identification of clinical and social needs, public health advice and informed decision making.

A total of **6,176** women booked for pregnancy in 2025. This was **748** fewer than the **6,924** bookings recorded in 2024.

Gestational age at booking	2025 number	2025 percentage	2024 number	2024 percentage
Before 10 weeks	4,162	68%	3,635	52%
Before 12 weeks	5,446	88%	5,212	75%
Before 13 weeks	5,640	91%	5,510	79%
Before 14 weeks	5,791	93%	5,709	82%
Before 20 weeks	5,925	95%	5,854	84%



The improvement from 52% to 68% for booking before 10 completed weeks represents positive progress. Continued monitoring is required to understand variation between localities and identify women who may experience barriers to early access.

Public Health and Health Inequalities

9.4%
Smoked within the previous 14 days at booking

5%
Smoked at 36 weeks

70%
Carbon monoxide reading recorded at booking

41%
Mental health issue recorded at booking

33%
Body mass index above 30

15.5%
Body mass index above 35

Maternity services work in partnership with Public Health Wales and have a Lead Midwife for Public Health. Public health information is used to identify need and support targeted intervention.

The reduction in smoking between booking and 36 weeks provides positive evidence of change during pregnancy, supported by the smoking cessation service. Carbon monoxide monitoring was not recorded for all women and remains an area for improvement.

The pregnancy weight management pathway was relaunched in April 2025. It receives approximately 100 to 120 referrals each month and provides group support, individual advice and access to community-based activity and education.



Vaccination and Antenatal Screening

Vaccination

93.1% Women offered pertussis vaccination before birth

81.4% Women offered respiratory syncytial virus vaccination

83.7% Women offered seasonal influenza vaccination

52.3% Women recorded as receiving respiratory syncytial virus vaccination before birth

A pilot involving trained vaccinators in five antenatal clinics increased respiratory syncytial virus vaccination uptake to 60%, with higher uptake reported in more deprived areas.

Vaccination uptake is not held centrally across all maternity datasets because some vaccinations are delivered through primary care.



Antenatal Screening

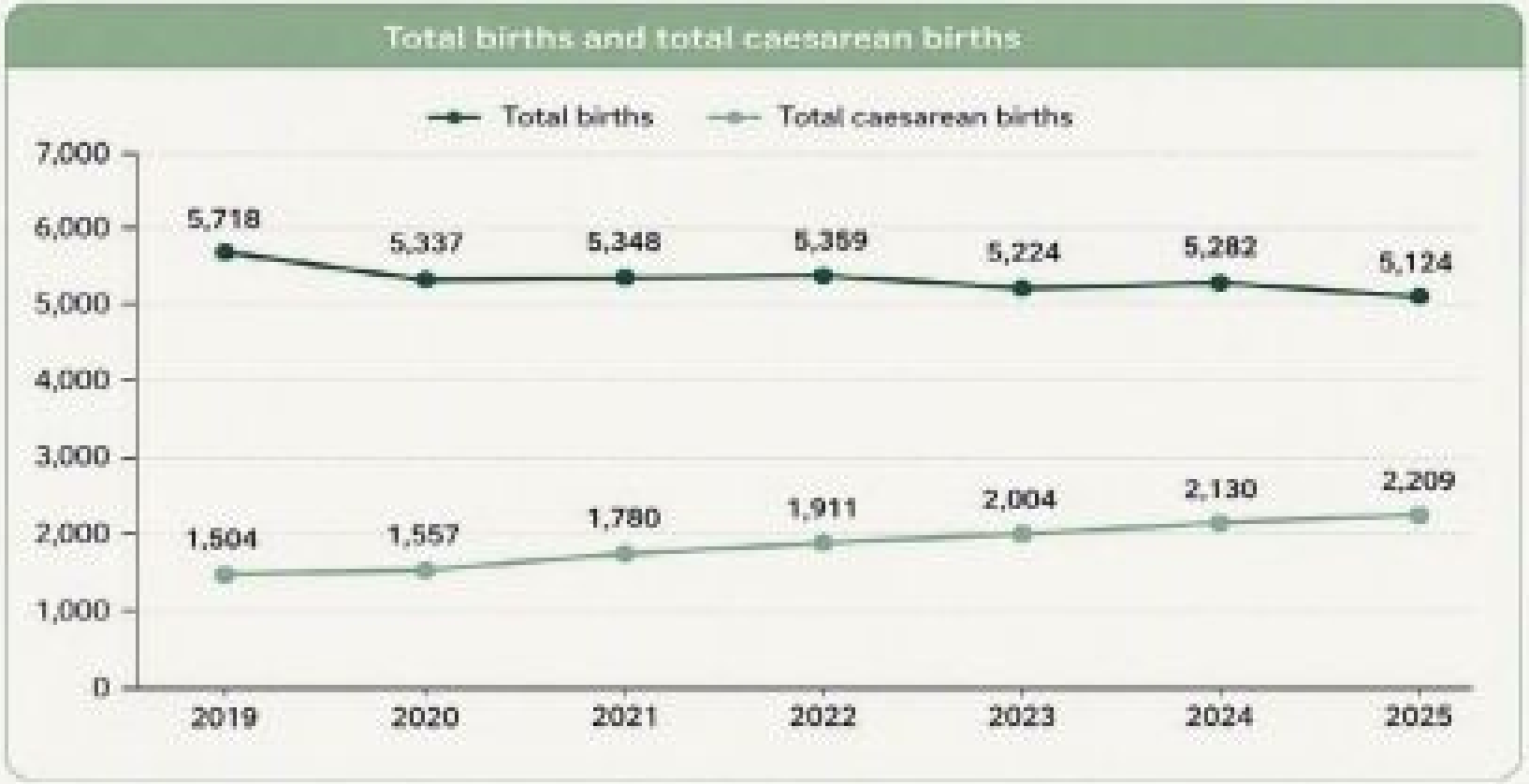
Antenatal Screening Wales performance indicators were monitored during the year. Expected compliance levels increased in April 2025.

The Health Board showed improving performance and favourable comparison with several All Wales standards, although some indicators remained rated red because performance was more than 10% below target.

The performance data in the source report related to October 2025 and should be interpreted as a specific reporting-point assessment rather than a full-year measure.



Birth Activity and Intervention



43% Caesarean birth rate in 2025

25% Emergency caesarean births as a proportion of all births

8.5% Instrumental birth rate

33% Induction of labour rate

5,124 Total births in 2025

The number of births continued to reduce during 2025, while the number and proportion of operative births increased. The caesarean birth rate increased from 41% in 2024 to 43% in 2025.

Emergency caesarean births represented 25% of all births. The instrumental birth rate was 8.5%, compared with 8.3% in 2024, and remained below the stated target of 10%. Induction of labour increased from 32% to 33%.

The continued increase in operative birth requires ongoing review alongside maternal acuity, clinical risk, informed choice and national patterns.

Midwife-Led Care and Informed Choice

Maternity services remain committed to supporting informed choice and access to midwife-led care.
In the absence of additional clinical need, women default to a midwife-led pathway.

Home birth



Freestanding midwifery unit at Ysbyty Ystrad Fawr



Alongside midwifery unit at the Grange University Hospital



Obstetric-led unit at the Grange University Hospital



Ysbyty Aneurin Bevan also provides a midwife-led birthing area.

Practice is supported by the All Wales Midwife Led Care Guideline and the All Wales Normal Labour Pathway. Weekly transfer meetings review cases where women transfer from midwife-led to obstetric care.

A Midwifery Unit Oversight Group provides oversight of quality, safety, workforce, sustainability, patient experience, equity, informed choice and transfer arrangements.

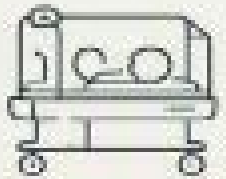
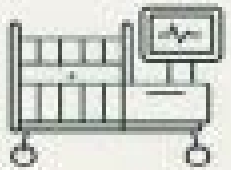
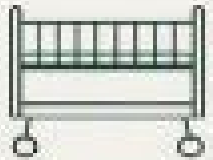
A monthly multidisciplinary forum reviews birth plans where women choose care outside recommended guidance. The forum supports informed decision making and consideration of clinical and organisational risks.



Neonatal Capacity and Safe Operation

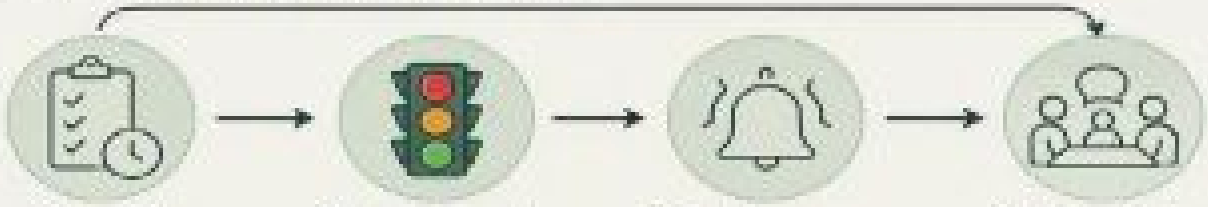
Neonatal Unit Capacity

The Neonatal Intensive Care Unit is a level 3 service providing intensive, high dependency and special care.

Intensive care cots	High dependency cots	Low dependency cots
		
8	**10**	**12**
intensive care cots	high dependency cots	low dependency cots

Safe Operation Model

Cot occupancy is reviewed against available staffing twice each day. The position is rated using a red, amber and green assessment to support oversight of safe care and escalation.



Where clinical acuity is high, an escalation process and policy support decisions regarding staffing and capacity.

Current Improvement Priorities



Maintaining staffing in line with British Association of Perinatal Medicine standards



Improving alignment between staffing rosters and available cot capacity



Developing dedicated transitional care



Securing appropriate pharmacy and multidisciplinary therapy support



Maternity and neonatal services continue to work collaboratively to provide safe, high quality care for babies and families. Ongoing monitoring and improvement activity support the delivery of sustainable, person-centred care.

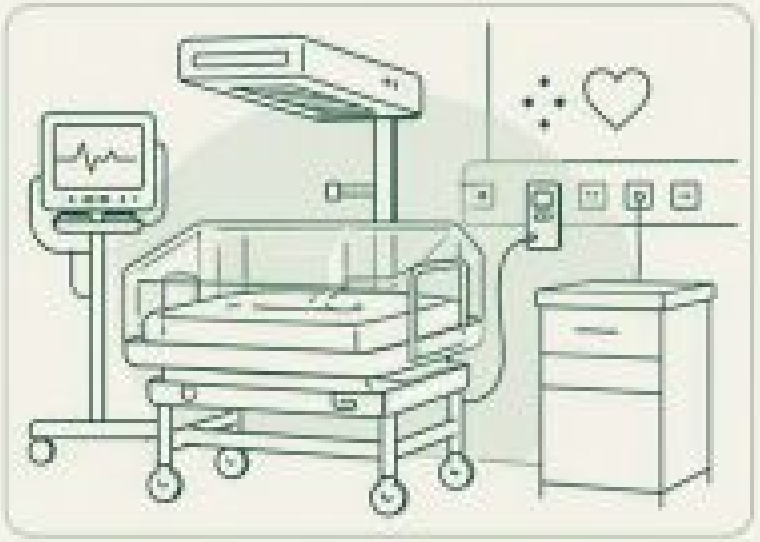


PERIPrem Cymru Optimisation

PERIPrem Cymru is a perinatal bundle intended to improve outcomes for babies born prematurely.

Validated National Neonatal Audit Programme data for 2025 was not available within the reporting material. The table therefore presents local 2025 data.

Measure	GUH 2024	GUH 2025
Antenatal Steroids	46.3%	54%
Magnesium Sulphate	81.3%	83.3%
DCC>1min	70.7%	86%
Temp on admission in range	79%	81.7%
Non-invasive ventilation, 1st 7 days	29.8%	26.3%
ROP screening	69%	78%
Bloodstream infection - clear	1.2%	6.7%
Bloodstream infection – not clear	13.4%	13.3%
NEC	2.6%	8.7%
Breast milk day 2	71.6%	86.2%
Breast milk day 14	75.8%	84.9%
Breast milk at discharge	52.9%	63.6%
BPD(or death) by 36 weeks (high risk group)	42.1%	42.4%



74%

Overall optimisation for babies born before 34 weeks

2023: **53%**

2024: **64%**

2025: **74%**

Infant Feeding

Maternity and neonatal measures are presented separately as they relate to different populations and time points.



Maternity feeding measures

73%	Babies with recorded skin-to-skin contact
61%	Breastfeeding at birth
60%	Breastfeeding on discharge
57%	Breastfeeding at day 10
51%	Breastfed babies supplemented with formula

Neonatal breast milk measures

	2024	2025
Breast milk at day 2	71.6%	86.2%
Breast milk at day 14	75.8%	84.9%
Breast milk at discharge	52.9%	63.6%

Improving breastfeeding initiation, continuation and exclusivity remains a priority. Maternity services are working with public health through the Best Start in Life delivery plan.

Improvement work includes peer support, enhanced midwifery skills, the tongue-tie pathway and collaborative action with public health.

The source report identifies infant feeding as an area requiring continued improvement.

Governance and Patient Safety

MATERNITY SERVICES

Maternity services strengthened governance arrangements during 2025 through the appointment of a Risk and Governance Lead Midwife and administrative support.

An updated maternity incident trigger list identifies incidents that must be reported. Reported incidents are reviewed through weekly multidisciplinary discussion.

Incident type	Cases
Unexpected neonatal admission associated with hypoxic-ischaemic encephalopathy	9
Neonatal death included within the above cases	2
Intrauterine death	2
Swab counting	2
Medication administration	1

16 maternity patient safety investigations were undertaken.

Five maternity incidents met the Duty of Candour threshold.

No Never Events were reported.

Strong governance and patient safety are supported by collaboration, accountability and shared learning.

SHARED LEARNING

Learning is disseminated through governance meetings, mandatory training, clinical supervision, lessons of the month and feedback to families.

NEONATAL SERVICES

Neonatal services maintain proactive incident reporting and multidisciplinary review. Most neonatal incidents were assessed as no or low harm following investigation.

Four neonatal incidents triggered the Duty of Candour during 2025.



Hypoxic-Ischaemic Encephalopathy



Hypoxic-ischaemic encephalopathy is a brain injury caused by reduced oxygen or blood flow around the time of birth. It may result in harm, disability or death, although outcomes vary between babies.

2024	2025
2.47	1.73
per 1,000 births	per 1,000 births

The United Kingdom Government has identified a rate of 2.5 per 1,000 as a target. Welsh Government has not set a corresponding target, and the source report notes that reliable benchmarking has been challenging.

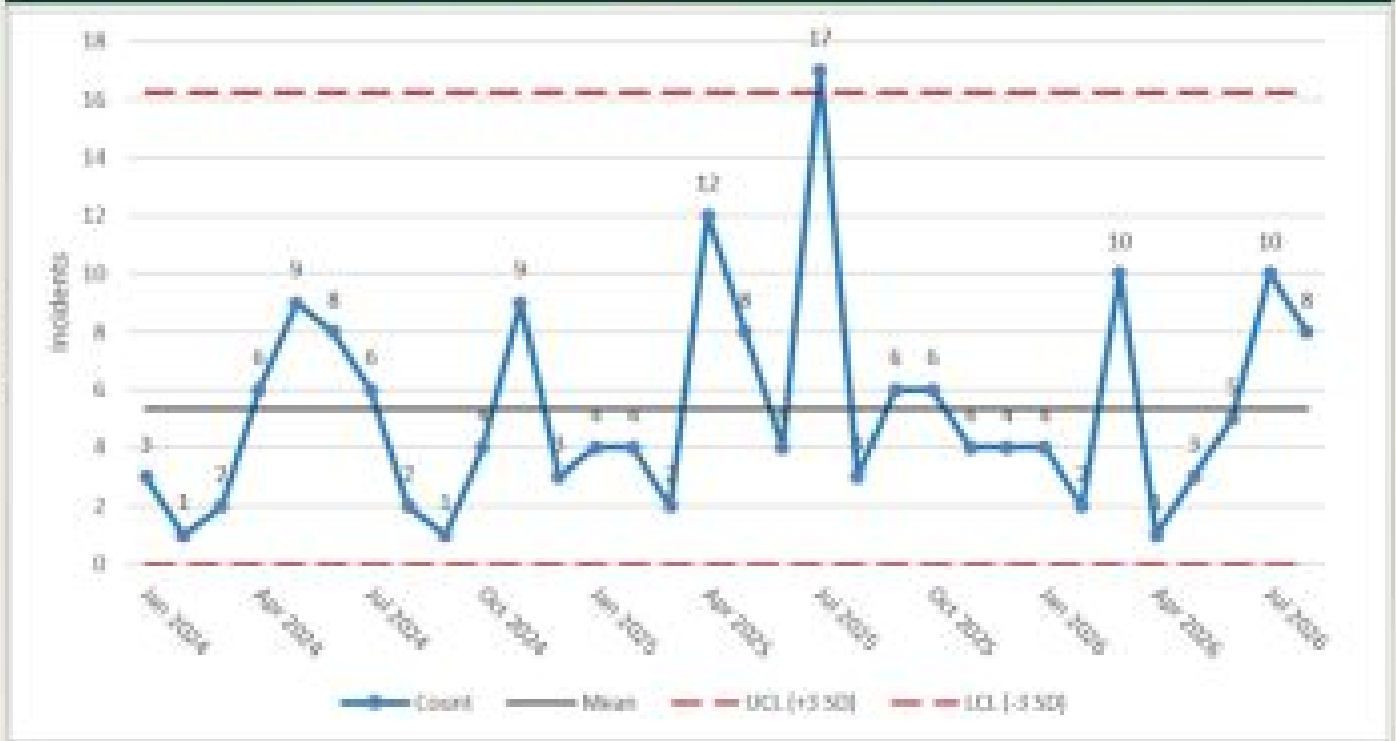
A formal review of the Health Board's cases was completed and shared with the Quality Management Group.

Ongoing assurance should consider findings from individual investigations, fetal surveillance, recognition of deterioration, escalation, training and learning across the maternity and neonatal pathway.

Reducing the rate of hypoxic-ischaemic encephalopathy remains a priority. Continued focus on high quality care, prompt recognition and response, effective escalation and shared learning will support improvement across the maternity and neonatal pathway.

Medication Safety

Medication, IV Fluids Incidents
Neonatal Unit



Reporting period: January 2024 to August 2026

Improvement actions

- Quality improvement projects
- Medication forum
- Human factors training
- Medication education and competency work
- Multidisciplinary incident review

Medication training compliance

above

90%

All staff groups



The Statistical Process Control chart identifies special-cause variation in July 2025, when 17 incidents exceeded the upper control limit of 16.2. Incident numbers reduced to 3 in August 2025 and remained within the control limits for the remainder of the reporting period. Monthly variation continued, including 10 incidents in March 2026 and 10 incidents in July 2026.

The reduction following the July 2025 special-cause point provides evidence of improvement. However, the subsequent monthly variation demonstrates the need for continued monitoring, multidisciplinary review and oversight of improvement actions. Incident counts should be considered alongside reporting culture, activity, case mix, investigation findings and the level of harm. The chart alone does not establish whether changes reflect deterioration or improvement in medication safety.

Mortality and Bereavement Care

Maternity and neonatal services use a collaborative process to review stillbirths and neonatal deaths. Cases are reported through Datix and national reporting processes and are reviewed through the Perinatal Mortality Review Tool.

Year	Stillbirth number	Crude rate	Stabilised rate	Neonatal deaths	Crude rate	Stabilised rate
2019	28	4.90	4.14	5	0.88	1.48
2020	13	2.46	3.52	6	1.14	1.58
2021	24	4.45	4.17	5	0.93	1.66
2022	23	4.25	3.67	4	0.74	1.15
2023	17	3.06	3.61	10	1.90	2.01
2024	22	4.16	3.55	8	1.52	1.93



The MBRRACE report released in 2025 considered babies born during 2024 from 24 completed weeks. It identified that the Health Board's stillbirth and neonatal mortality outcomes were comparable with similar Health Boards and United Kingdom trusts.

Review arrangements include multidisciplinary perinatal mortality review, local and national mortality meetings, audit, governance review, staff debrief and a 72-hour multidisciplinary review for neonatal deaths.

Families are offered information, feedback and bereavement support. The bereavement care pathway was launched during summer 2026, with audit through the AMAT audit system.



Infection Prevention and Control

Infection prevention and control remained a priority for maternity and neonatal services during 2025/26.

2025/26 improvement programme

- Cleaning schedules and laundry arrangements
- Targeted environmental improvements
- Blood culture reporting and venepuncture practice
- Daily environmental audits
- Aseptic Non-Touch Technique training and compliance monitoring
- Routine trend monitoring and safety checklists
- Corporate infection prevention and control walkabouts

100%
Neonatal hand hygiene audit compliance

100%
Neonatal peripheral venous catheter audit compliance

2.27%
Quarter 4 caesarean surgical site infection rate

24.75%
Reported reduction in the surgical site infection rate

The number of procedures increased by **8%** during the same period.


Hand hygiene


Environmental cleaning


Aseptic technique


Clinical audit

The report states that no further upward or changing infection trend was identified following implementation of the improvement programme.

Continued assurance is required to confirm that improvements are sustained and embedded across practice.

Workforce and Staffing Assurance



This annual report provides the Board with an overview and assurance regarding the quality, safety and delivery of maternity and neonatal services during 2025/26.

MATERNITY

- Maternity services employ more than 450 staff, including midwives, nurses, maternity support workers, nursery nurses and administrative staff.
- The previous Birthrate Plus assessment identified:
  - **242.77 whole-time equivalent staff for clinical care**
  - **269.47 whole-time equivalent staff when management, specialist midwifery and Band 3 maternity support workers were included**
- A further Birthrate Plus assessment was undertaken in 2026. The findings were awaited at the time of the report.
- During 2025, maternity services achieved a positive establishment of eight whole-time equivalent midwives. Following attrition, this reduced to a positive establishment of two whole-time equivalent.
- Executive approval supported recruitment of 15 newly qualified midwives through the 2026 streamlining process.

NEONATAL

- The neonatal service was fully staffed against British Association of Perinatal Medicine standards during 2025.
- A roster recalculation was undertaken in 2026 to improve roster management and alignment between staffing and cot availability.
- Band 6 vacancies were progressing through the approval process.
- **Six whole-time equivalent Band 5 nursing posts had been agreed through streamlining.**
- Therapy provision did not meet British Association of Perinatal Medicine standards. A business case had been developed to increase psychology, occupational therapy and wider multidisciplinary therapy provision.
- **Dedicated neonatal pharmacy and therapy support remains an area of focus.**

Attendance, Training and Development

Sickness Absence

Maternity sickness absence ranged from **4.98% to 8.04%.**

Neonatal sickness absence ranged from **5.54% to 14.86%.**

Absence is monitored monthly to identify trends and support timely intervention.

Training compliance

Training measure	Neonatal	Maternity
Mandatory training	80%	75%
Neonatal life support	78%	82%
Medication training	100%	Not reported
Qualified in speciality	68%	Not applicable
Safeguarding Level 1 and 2	88%	88%
Safeguarding Level 3	85% target	72%
PROMPT	Not applicable	87%
Intrapartum fetal surveillance	Not applicable	88%
GAP and GROW	Not applicable	69%

Attendance management

- Managers review absence trends monthly.
- Individual attendance plans are agreed and reviewed.
- Wellbeing support is offered where appropriate.
- Clear escalation processes ensure timely action.



- Development opportunities are aligned to service priorities and individual goals.
- Learning needs are identified through appraisal and supervision.
- Staff are encouraged to grow skills and progress careers.
- Strong attendance and training support safer care and better experiences.

Culture, Improvement and Priorities for 2026/27

1. Culture and psychological safety

The services recognise that safe care depends on a culture in which staff feel supported, able to raise concerns and confident that concerns will be investigated and addressed.

Support includes coaching, mentorship, clinical supervision, restorative clinical supervision, team meetings, leadership visibility and local communication.

A neonatal listening event undertaken during 2025 identified themes relating to leadership visibility, positive feedback, teaching and training. Associated working groups and a cultural improvement plan were established.

Joint maternity and neonatal education on culture, language and psychological safety achieved compliance above 85%. A maternity listening event was planned for 2026.

2. Progress achieved

- Early booking before 10 weeks improved to 68%.
- Overall PERIPrem optimisation increased to 74%.
- The hypoxic-ischaemic encephalopathy rate reduced to 1.73 per 1,000 births.
- Retinopathy of prematurity screening improved from 69% to 78%.
- Breast milk provision improved at day 2, day 14 and discharge.
- The quarter 4 caesarean surgical site infection rate reduced to 2.27%.
- MEWS, NEWTT2 and BSOTS were implemented.
- The bereavement care pathway was launched.
- Governance arrangements were strengthened.
- CIVICA and the Perinatal Engagement Framework were embedded.

3. Priorities for 2026/27

- Deliver the maternity and neonatal improvement plans and actions arising from national and local recommendations.
- Maintain focus on infection prevention and control, medication safety and statutory and mandatory training.
- Develop dedicated transitional care.
- Progress neonatal pharmacy and multidisciplinary therapy support.
- Review workforce requirements against Birthrate Plus and British Association of Perinatal Medicine standards.
- Continue work on culture, psychological safety, human factors, equality and diversity.
- Improve Personal Appraisal and Development Review compliance and attendance management.
- Progress the validated perinatal dashboard.
- Embed quality improvement, research and innovation.



Regular assurance reports should continue through the Maternity and Neonatal Improvement and Assurance Group, Quality Management Group and Executive Committee.

The Board is asked to note the progress made, the remaining risks and the priorities for continued improvement.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	06 October 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Safeguarding Annual Report 2025-26
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Howard Stanley, Head of Safeguarding

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Safeguarding Annual Report provides an overview of the 2025/2026 position in terms of how Aneurin Bevan University Health Board (ABUHB) has managed its statutory responsibilities in regard of safeguarding. It outlines progress against objectives, performance, emerging themes and trends, including lessons learnt and the subsequent roadmap for 2026/2027.

Cefndir / Background

The Report focuses on, and describes the successes and challenges in relation to Safeguarding, during the reporting period. It encompasses, the work of the Safeguarding Strategic Group, its Sub Groups and the Health Boards contribution to statutory regional partnerships. It includes activity data and highlight areas of risk, before outlining forward plans to meet both current and emerging challenges.

This Report was written with input from the Mental Capacity Act Team, Looked After Childrens Team and the health Board Prevent Lead.



Asesiad / Assessment

2025/26 has seen a considerable shift in both the volume of safeguarding activity and the complexity of cases being managed in the safeguarding arena.

To summarise the organisational 2025/26 position is as follows: -

Partnership Working
ABUHB continues to engage actively with the Safeguarding Board and VAWDASV, as well as with its subgroups, fulfilling our statutory responsibility.

Single Unified Safeguarding Reviews
Whilst no reviews have been published during the reporting period, the Health Board is currently a contributing partner to a number of reviews relating to Children and Adults from the five Gwent Local Authority areas.

Training
There has been significant work undertaken in regard of mandatory Safeguarding Training, at the levels set out in national guidance, with compliance increasing at the planned rate. Further work is underway to ensure a similar level of compliance can be achieved in relation to VAWDASV training.

Assurance
Completion of an internal audit gave reasonable assurance, with four areas identified for improvement. Actions in respect of these fur areas have been completed and their progress monitored via existing governance structures.

Operational
A significant and unavoidable increase in Child Safeguarding activity has placed significant pressure on the existing service. This is recorded on the Corporate Risk Register as an area of high risk and actions have been set to establish how this risk can be mitigated.

Key Priorities for 2026/27

- Continuing improvements in regard of training compliance
- Utilising data to monitor themes and trends, to identify areas for improvement
- Developing a sustainable workforce
- Ensuring an effective multi agency response in respect of VAWDASV

Argymhelliad / Recommendation

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

- **NOTE** the Safeguarding Annual Report 2025/2026
- **NOTE** the key priorities for 2026/27



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):	2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care 3.2 Communicating Effectively 6.3 Listening and Learning from Feedback
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Workforce and Culture 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 prrioritise areas where evidence shows take up of services is lower or outcomes are worse Work in partnership to reduce the incidence of domestic abuse, 'honour' based violence and elder abuse Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	• The Children Act 2014 • Wales Safeguarding procedures 2019
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	• ABUHB Safeguarding Strategic Group

Effaith: (rhaid cwblhau)

Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working 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 Choose an item.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Safeguarding Annual Report 2025/26

Introduction

Aneurin Bevan University Health Board recognises its statutory responsibility to ensure robust safeguarding measures are in place to protect individuals at risk. This duty is underpinned by key legislative frameworks including:

- **Health and Care Standards for Safeguarding Children and Adults at Risk** (Welsh Government and NHS Wales, 2015)
- **Social Services and Well-being (Wales) Act** (Welsh Government, 2014)
- **Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Act** (Welsh Government, 2015)

This Safeguarding Annual Report outlines the Health Board's compliance with these legislative requirements and provides a comprehensive overview of safeguarding activities undertaken between April 2025 and March 2026. The report aims to:

- Provide assurance to the Board that statutory safeguarding obligations are being met effectively.
- Demonstrate to external partners and regulatory bodies that proactive measures are in place to prevent abuse and mitigate harm to vulnerable individuals.
- Inform the Board, staff, partners, and stakeholders about the roles, responsibilities, and achievements of the Safeguarding & Vulnerabilities Team.
- Highlight the governance and assurance structures that support safeguarding practices within ABUHB.
- Identify key risks addressed during the reporting period and outline current risks along with their mitigation strategies.
- Summarise significant safeguarding initiatives and contributions at both local and national levels.
- Outline strategic priorities and areas for improvement in safeguarding for implementation in the 2026/2027 period.

Multi-Agency Partnership Working

The ABUHB Safeguarding Team continues to fulfil its statutory responsibilities through active membership of the Gwent Joint Children and Adult Safeguarding Board and the Gwent VAWDASV (Violence Against Women, Domestic Abuse and Sexual Violence) Partnership Board. In addition to these core roles, the team contributes to a wide range of sub-groups and committees that support the delivery of strategic safeguarding priorities across the region.

The Gwent Joint Children and Adult Safeguarding Board is a multi-agency partnership committed to embedding safeguarding at the heart of all services across Gwent. Its work is underpinned by a number of sub-groups that oversee both core business functions and targeted thematic workstreams aligned to annual strategic objectives.

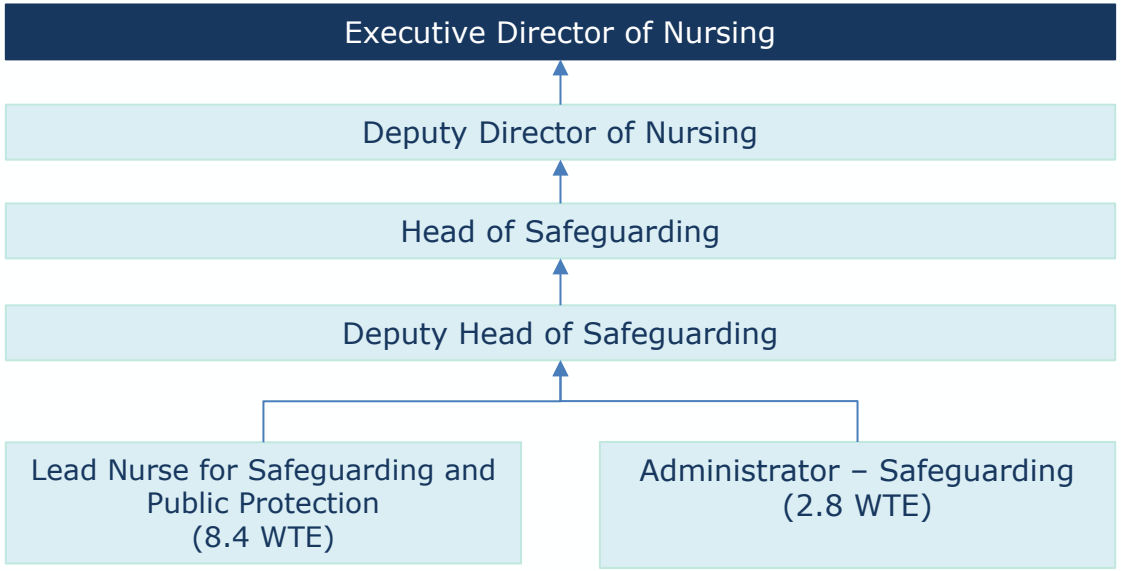
The Gwent VAWDASV Partnership Board brings together agencies across the region to prevent violence against women, domestic abuse and sexual violence. Its focus is on improving outcomes for individuals at risk or affected by such harm, as well as for their families and support networks, through coordinated and collaborative action.

Staffing

Aneurin Bevan University Health Board maintains a clear and robust safeguarding governance structure to ensure that its responsibilities are met effectively across all services. The Chief Executive holds overall accountability for safeguarding, with executive leadership delegated to the Executive Director of Nursing. This role is supported operationally by the Deputy Director of Nursing.

Strategic oversight is provided by the Head of Safeguarding, who is supported by a Deputy. Together, they offer assurance on safeguarding arrangements and represent the Health Board on regional partnership boards.

As the strategic lead, the Head of Safeguarding is responsible for the development and implementation of safeguarding systems and policies. This includes oversight of training provision and compliance, support for operational safeguarding practice, and the establishment of mechanisms to monitor the quality and effectiveness of safeguarding activity across the organisation.





The Wales Safeguarding Procedures (2019) sets a clear expectation that a multi-agency strategy meeting should be convened where Social Services have reasonable cause to suspect that a child is at risk of significant harm, as defined by The Children Act (1989).

There has been a significant increase in both the volume and complexity of these meetings over the course of 2025/26, reaching a point where the Corporate Safeguarding Team no longer have sufficient capacity to fulfil this obligation.

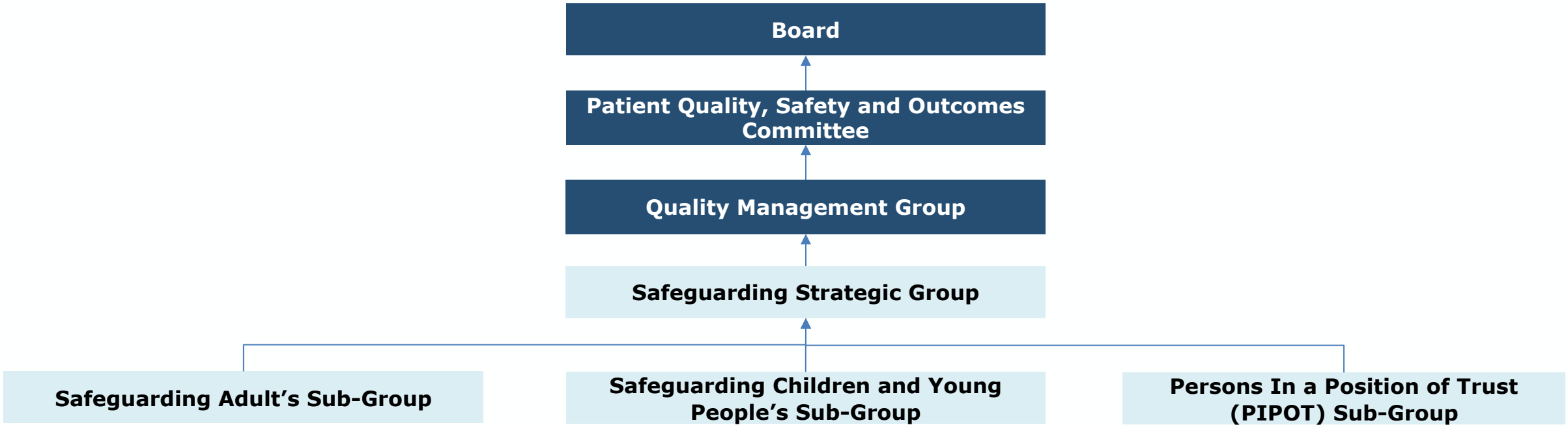
In September 2024, responding to increased activity, additional hours were allocated to both the adult and children's safeguarding teams by converting Band 8a full-time equivalent (FTE) hours into Band 7 FTE hours.

Despite these changes, activity has continued to rise and is expected to increase further.. The complexity of cases is also growing, demanding more intensive involvement. As a result, the team currently lacks the capacity to absorb additional responsibilities.

This risk is highlighted on the Corporate Risk Register and mitigations are in place with the objective of decreasing risk.

Governance

The Safeguarding Strategic Group is an established group within the Health Board's governance framework. It provides assurance to the Patient Quality and Safety Outcomes Committee through the Quality Management Group and holds delegated authority to oversee and monitor safeguarding practices for Adults, Children, and Young People.



This group is responsible for setting the Health Board's Safeguarding Strategy, defining objectives that promote continuous improvement and ensure compliance with both national and local safeguarding policies.

To support its work, the Strategic Group is backed by three dedicated sub-groups that focus on developing and implementing robust, auditable, and effective quality monitoring systems. These sub-groups also play a key role in raising awareness of safeguarding issues and provide quarterly feedback to the Strategic Group.

The sub-groups are:

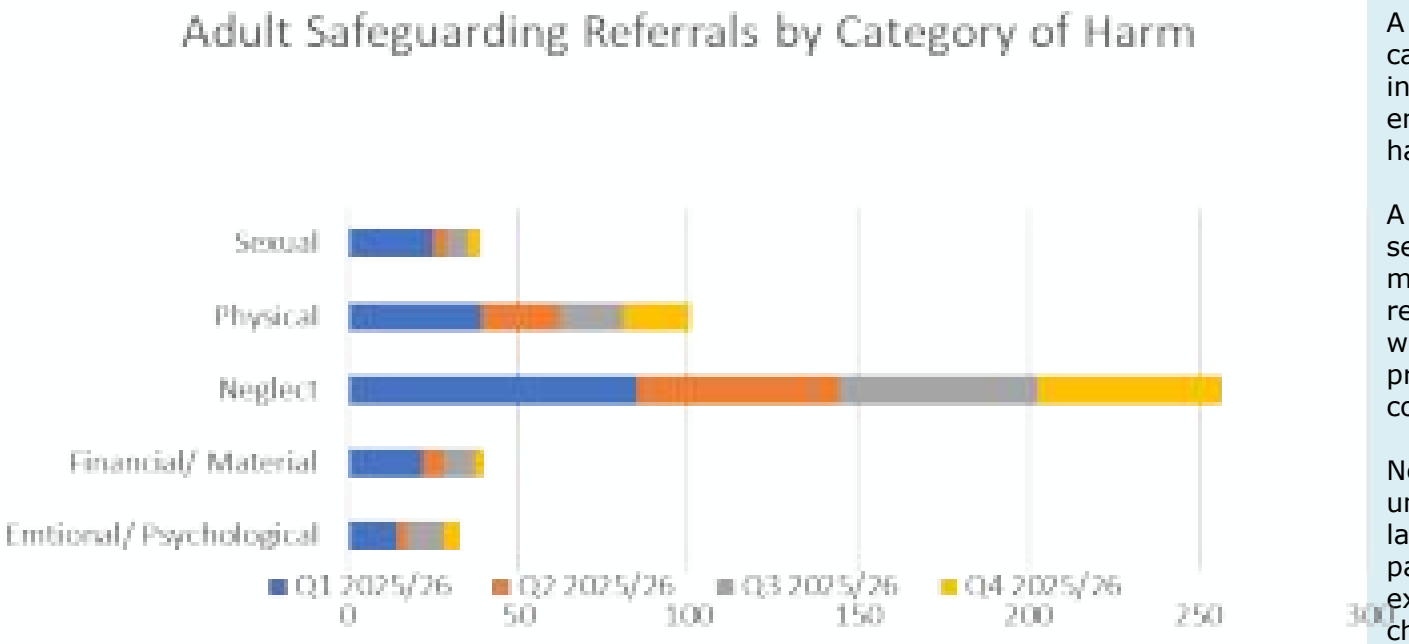
- Safeguarding Adults Sub-group
- Safeguarding Children and Young People Sub-group
- Persons In a Position of Trust (PIPOT) Sub-group

Safeguarding Adults

The Adult Safeguarding function within the Corporate Safeguarding Team receives Duty to Report submissions from Local Authority and then subsequent enquiries are made with Divisions. These reports enable the assessment of concerns and, where appropriate, referral to multi-agency partners for adults at risk.

These cases include instances where safeguarding concerns may involve the Health Board as a contributing factor, as well as those where external individuals or organisations are implicated.

The following illustrate the referrals by and Category of Harm.



When examining the data by type of harm, it is evident that Neglect is the most frequently reported category. This includes allegations of neglect with sub-themes such as discharge concerns, pressure ulcers, and medication errors.

A more detailed review of incidents involving physical harm reveals that most cases are patient-on-patient assaults. Investigations have shown that these incidents are largely unavoidable due to the nature of client groups and environments, with all appropriate, reasonable and proportionate mitigations having been in place.

A concerning area is the number of reports related to allegations categorised as sexual assault. While the volume of incidents remains troubling, they do not meet the criminal definition of serious sexual harm. It is noted most of these related to patients having adverse experiences related to intimate examinations, which arose due to a disconnect between the patients understanding of the procedure and what they had consented to, often exacerbated but communication challenges and appropriate use of chaperones.

Noting the issues with intimate examinations, significant work has been undertaken in collaboration with the Patient Experience Team, including the launch of the Chaperone Policy. This will be supplemented by the launch of patient and staff information leaflets and guidance notes in relation to intimate examinations, the importance of effective communication and the role of the chaperone.

Partnership working with Divisions has continued throughout 2025/26. The quality and timeliness of DTRs has improved, with a strong commitment from leadership teams to resolve safeguarding concerns and improve patient outcomes.

Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust

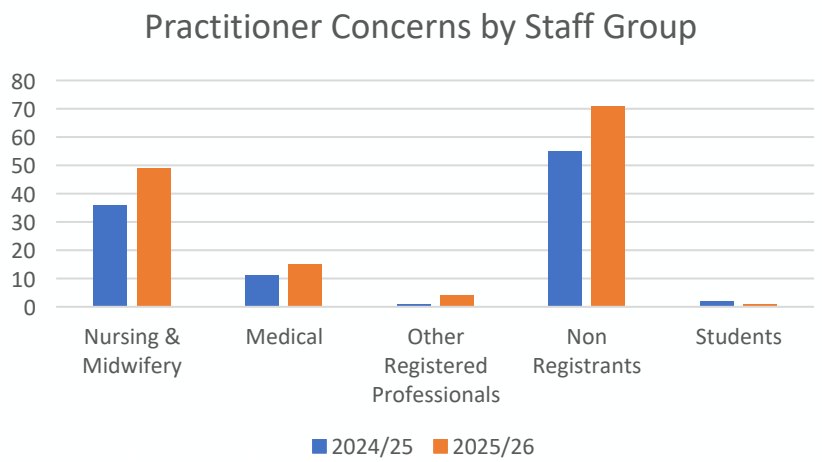
In 2025/26, a total of 140 safeguarding allegations or concerns were raised involving ABUHB staff, an increase of 26 on the previous year.

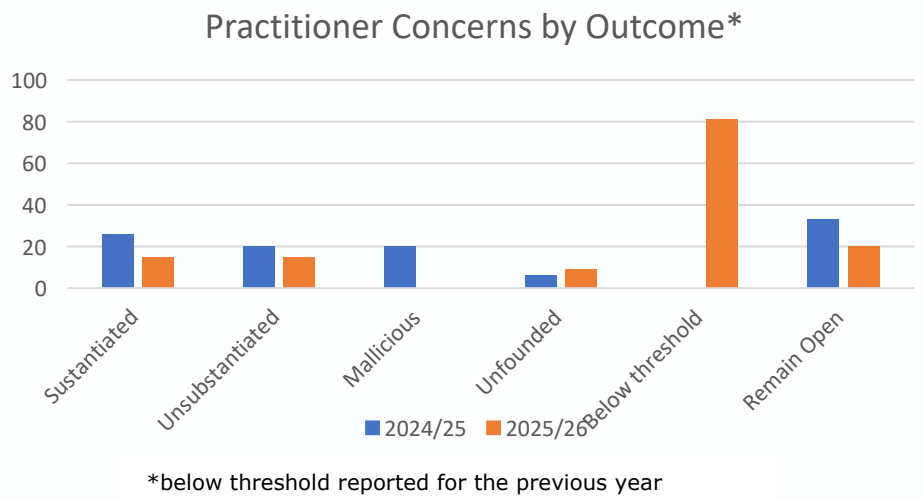
To provide further context:

- 66 allegations related to incidents within the workplace.
- 74 incidents occurred outside of work.
- Not all cases involved directly employed ABUHB staff; some concerned independent contractors, Nurse Bank personnel and agency staff.

Whilst a significant volume of referrals made lead to the process not continuing, it is noted that there has been an increase in the volume of cases that are substantiated. In these instances cases are passed to Divisions and Workforce to determine the individuals longer term suitability to continue in their role. These cases also result in referral to DBS and Professional Regulators.

Review of data has historically highlighted that cases were often not making timely progress, often due to ongoing criminal investigations. Whilst there can be no formal changes to the process as a result of this, relationships have been strengthened with Gwent Police Public Protection Team. This involves monthly review of open cases, mechanisms to ensure timely sharing of information and processes for escalation where actions aren't being completed in a timely way.





*below threshold reported for the previous year

Domestic Abuse

Domestic abuse is defined by the Welsh Government (2015) as "any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality."

In Wales, the health sector holds a crucial position in tackling domestic abuse, serving as a primary point of contact for recognising and supporting those affected. Health professionals are expected to play an active role in identifying signs of abuse and responding appropriately, with an emphasis on early intervention and connecting individuals to specialist services. The Welsh Government promotes a public health model, embedding domestic abuse awareness into healthcare delivery and ensuring victims and survivors receive holistic support.

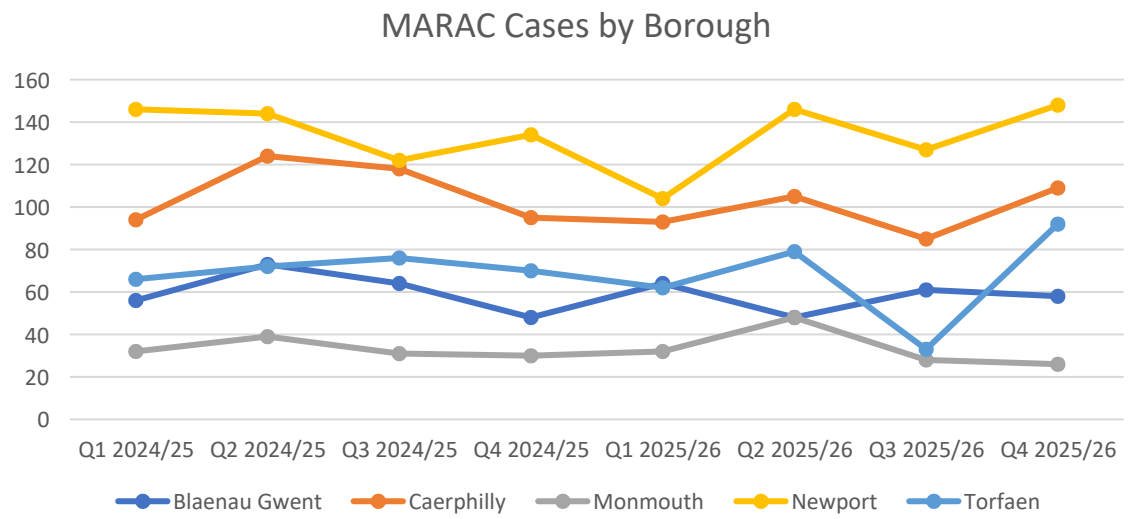
The responsibilities of the health sector include:

- Identifying and referring individuals at risk
- Delivering support and clinical care
- Focusing on prevention and early action
- Working collaboratively with partners and agencies
- Engaging with perpetrators to address harmful behaviours
- Implementing relevant legislation and policy frameworks

Multi Agency Risk Assessment Conference (MARAC)

The Safeguarding Team plays a vital role in supporting victims of domestic abuse who are at high risk, through active participation in Multi-Agency Risk Assessment Conferences (MARAC). These multidisciplinary meetings focus on individuals assessed as being at high risk of serious harm or homicide, with the aim of coordinating safeguarding actions across agencies.

Each Local Authority within the Gwent area currently convenes a MARAC panel on a fortnightly basis. As a statutory agency, the Safeguarding Team is committed to attending all of these meetings. Notably, the number of referrals discussed at MARAC remain high for each of our Local Authority areas.



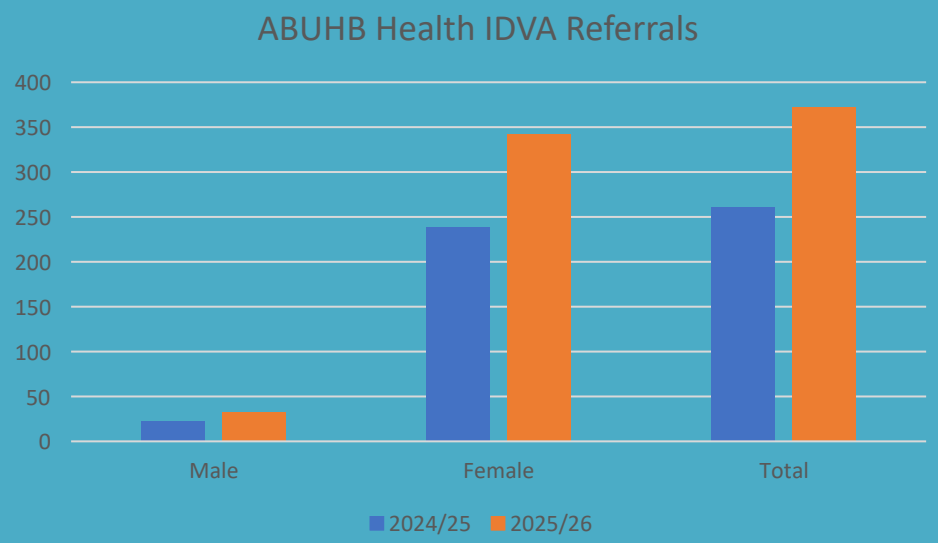
This picture reflects the growing number of individuals experiencing domestic abuse who are assessed as medium or high risk using a nationally accredited risk assessment tool. In addition to this significant group, there remains a high volume of individuals accessing our services who are assessed as standard risk. These cases are typically managed by a single agency, often our own teams or independent contractors.

IDVA Role and Activity

The Health Independent Domestic Violence Advisor (IDVA) is a specialist role placed in Aneurin Bevan University Health Board, based in The Grange University Hospital, as the Emergency Department generates on average two thirds of the referrals into the service.

This IDVA service provides direct support to patients, including conducting risk assessments, creating safety plans, assisting with Police disclosures, and facilitating access to housing and specialist support services.

In the year April 2025 to March 2026, there were **374** referrals, compared to the previous year where there were 261 referrals, demonstrating a **43%** increase.



IDVA Governance and Funding

The Independent Domestic Violence Advisor (IDVA) service operates across Gwent and is currently hosted by Newport City Council.

This service is jointly funded by the five Gwent Local Authorities, Aneurin Bevan University Health Board and the Office of the Police and Crime Commissioner (OPCC), Ministry of Justice and Welsh Government VAWDASV funding.

Across Gwent the Service has been very successful, with multi agency reviews highlighting the success of the service, in particular the strength and impact of the Health IDVA.

Following the successful integration of the IDVA role within ABUHB, a second IDVA was introduced in late 2024, to met demand and to help with early intervention to safeguard vulnerable Gwent residents.

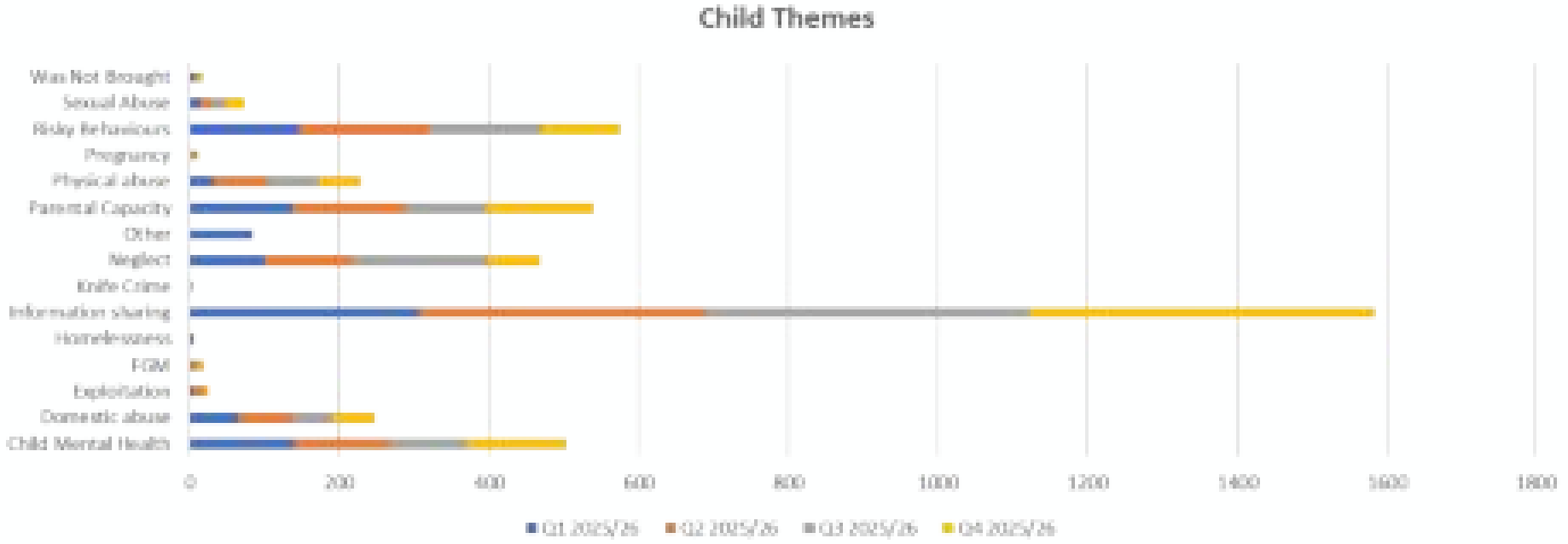
A review of the funding arrangements was commissioned by the Regional VAWDASV Board, to address the growing demand and workload.

It is anticipated that the review will highlight a need for increased funding to sustain the increased activity and to maintain delivery of a successful and impactful service.

Safeguarding Children

Throughout 2025/26, the Corporate Safeguarding Team has continued to collaborate with partner agencies, both reactively on individual cases and proactively through the Safeguarding Board, to manage a number of highly complex and at risk children.

Whilst the volume of referrals has not increased, the complexity of safeguarding has increased. This complexity is associated with an increase in risks outside the home, often associated with organised crime and the increase in online exploitation. Whilst this is challenging to the local safeguarding system, it reflects the overall picture in Wales and the wider United Kingdom Alongside this, following review of multi agency processes by regulators, it has been determined that a much higher volume of cases need to be formally managed via multi agency strategy meetings.



The above chart highlights the significant number of children at risk in Gwent, where the Health Board has fulfilled its statutory duty to report children at risk of harm, neglect or abuse. It captures activity and is categorised by the defined harm types which are subject to national reporting by our LA partners.

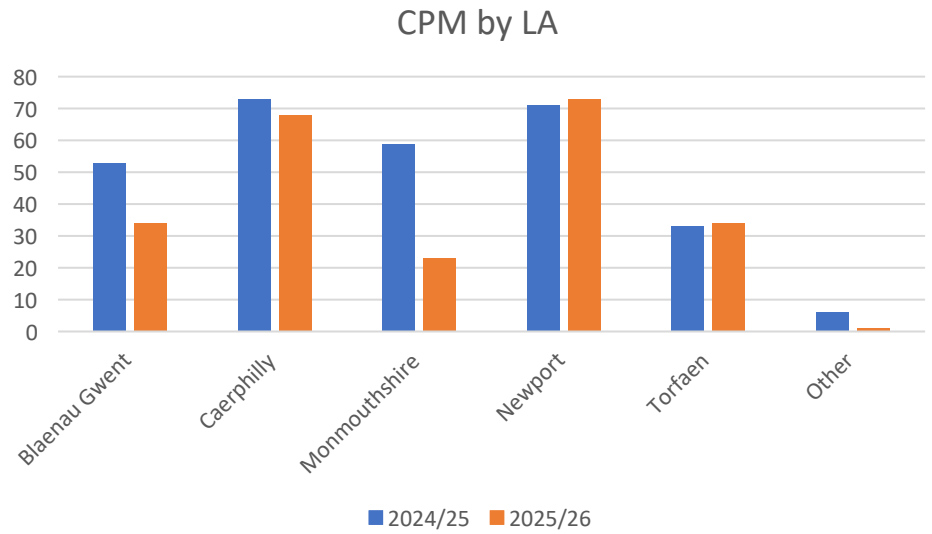
In each of these cases a multi agency approach is taken to managing the concern and can result in admission or engagement with a number of our Health Board services to ensure timely diagnostics, treatment, support and follow up care.

Over the past year significant work has been ongoing with Social Services and Education partners to tackle the issues relating to Domestic Abuse, Risky Behaviours and Violent Crime, with a focus on primary prevention.

Child Protection Medicals (CPM)

Child Protection Medicals are assessments carried out to identify any signs of abuse or neglect in children and young people.

In 2025/2026, a total of **234** Child Protection Medicals were conducted, a reduction of 61 on the previous year.



This data provides a local authority breakdown but should not be interpreted in isolation.

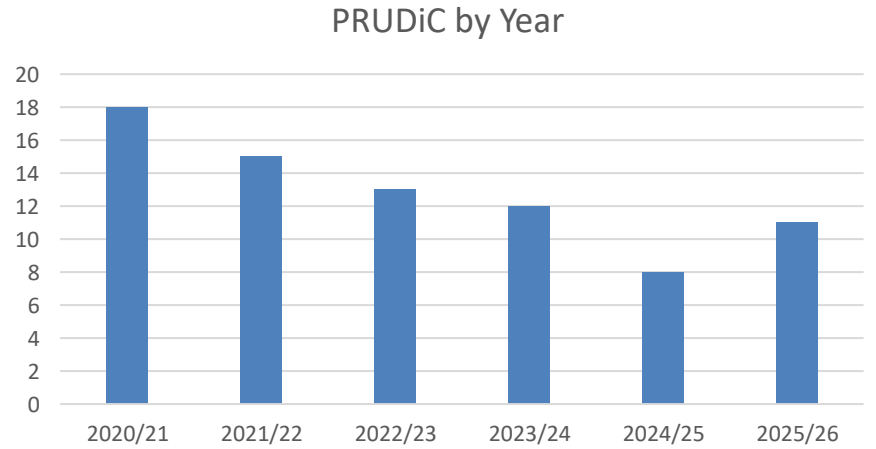
Timeliness and Peer Review:

In line with policy, all Child Protection Medicals were completed within 24 hours of the request being accepted. Each case undergoes monthly peer review by medical staff to maintain service quality and encourage professional challenge.

Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

PRUDiC outlines the minimum response required following an unexpected child death. It ensures a coordinated, safe, and compassionate approach through effective communication, joint action, and information sharing.

In 2025/2026, **eleven** child deaths in the ABUHB area met the PRUDiC criteria. This reflects an increase on the previous year, where there had previously been a steady decline year on year.



All PRUDiC cases are reported to the Welsh Government in line with statutory guidance .This enables monitoring of patterns and trends. Whilst there have been a number of unexpected child deaths in Gwent over the six years of reporting, there has not been any correlation noted through review of these incidents by the Health Board or the Wales Child Death Review Team, which would require a single agency response from us as a Health Board.

Single Unified Practice Reviews (SUSR)

Gwent Safeguarding Board SUSR
In 2025/26, the Gwent Safeguarding Board has not published any SUSR or Practice Reviews. however the Gwynedd Practice Review, supported by Betsi Cadwaladr University Health Board, drove forward a significant amount of work locally.

A number of reviews have been agreed and are at various stages of development, with regular updates being provided to the Gwent Safeguarding Board.

Our Bravery Brought Justice
In October 2025, a Child Practice Review (CPR), titled 'Our Bravery Brought Justice,' was published in North Wales which outlined over 50 missed opportunities to prevent the sexual and physical abuse perpetrated by Headteacher Neil Foden.

This review highlighted children not being listened to, poor agency communication, and systemic failures in safeguarding including failure to act on concerns about Foden's abuse and misuse of restraint as punishment, prompting apologies from local authorities. There were concerns relating to a lack of professional curiosity and inadequate training, leading to recommendations for major safeguarding reforms in Welsh schools. The Child Practice Review made twenty-seven recommendations across the following themed areas:
Listening to the voice of the Child

- The management of allegations and concerns about adults who work with children - the multi-agency response
- The need for training – 'thinking the unthinkable and 'it could happen here.'
- The governance of schools in Wales
- Restrictive Practices
- Crisis Management
- Recommendations for Safeguarding Partners

The Gwent Safeguarding Board, of which we are a statutory partner, has established a Task Group to provide assurances to Gwent Safeguarding Board that the Gwynedd Child Practice Review recommendations have been fully reviewed by Gwent partners and that we can demonstrate, as a region, where we are compliant and what action plans are in place to address any areas for improvement.

The recommendation made to Betsi Cadwaldr University Health Board (Recommendation 27) states:

- Considers the sharing of anonymised CAMHS data with Local Authorities to identify hotspots and thematic concerns
- Provide assurance to the Regional Safeguarding Children's Board that health professionals seek safeguarding advice when a child presents at an appointment accompanied by a third party without parental consent.

Each of these actions have been completed within the Health Board, with reports provided to the Executive Committee. The wider plan is subject to ongoing monitoring by Gwent Health board, with partners being assured of the changed implemented within ABUHB and their impact noted.

Safeguarding Training

Safeguarding training remains a fundamental responsibility of the Safeguarding Team and is mandatory across the Health Board. Compliance is expected to align with the Welsh Government's national target of 85%. Training is delivered through a combination of e-learning and face-to-face sessions.

Level 1 and Level 2 Safeguarding Training
This training consists of online mandatory training via ESR. It equips professionals with the knowledge and skills to recognise safeguarding concerns involving both adults and children, and to respond appropriately when necessary.

As of 31 March 2026, compliance was over 85% for Level 2 and just under 85% for Level 1. Although ABUHB reached the 85% compliance target at several points during the year, this standard was not consistently upheld. Current figures suggest that only minor improvements are needed to regain the 85% benchmark.

Level 3 Safeguarding Training
Level 3 Safeguarding Training is now a mandatory, interactive module—delivered either face-to-face or virtually—for all registered professionals within the Health Board. In accordance with the Intercollegiate Document (RCN, 2019) and the Wales Safeguarding Training, Learning and Development Standards (2022), staff are required to complete a minimum of eight hours of interactive training every three years.

As of 1 April 2025, this requirement was formally embedded into the Electronic Staff Record (ESR) system for relevant staff groups.

The training equips professionals with the essential knowledge and skills to effectively assess, plan, intervene, and evaluate the needs of individuals, ensuring the safeguarding of both adults and children at risk.

Training is currently delivered as a full-day session—either in person for groups of up to 50 or virtually via Microsoft Teams for up to 30 participants. Given the high volume of staff requiring training (over 6000) it was agreed that this training would be implemented over three years.

Training is on course to be delivered within the required timeframe, exceeding the target of 35% in the first year.







Domestic Abuse Training

Ask and Act Training Overview

Ask and Act training equips professionals to respond effectively to individuals affected by gender-based violence, domestic abuse, and sexual violence.

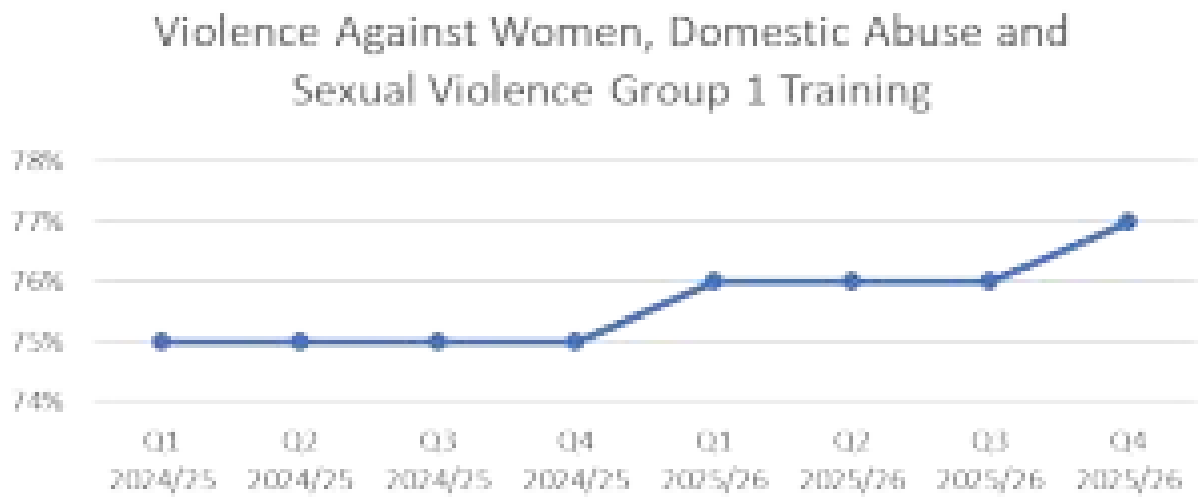
The training is structured similarly to standard safeguarding levels—Groups 1, 2, and 3—based on participants' responsibilities and learning needs.

- **Group 1** is the foundational training and is mandatory for all ABUHB staff.
- **Group 2** is designed for those who work directly with victims and are responsible for identifying, assessing, and referring cases.

In 2025/26, 77% of eligible ABUHB staff completed Group 1 Ask and Act training, reflecting a slight increase in compliance compared to 2023/24 and 2024/25

Group 2 training continues to present challenges in tracking compliance due to limitations in ESR reporting. As a result, it will remain a focus area in the 2025/26 Training Needs Analysis.

The graph illustrates Group 1 compliance rates



Prevent

The Prevent duty is a UK legal requirement under the Counter-Terrorism and Security Act 2015 that directs public organizations to stop people from being drawn into terrorism. It forms part of the national counter-terrorism strategy, **CONTEST**, functioning similarly to standard safeguarding duties used to protect individuals from other harms like abuse or gang involvement

Whilst the Prevent portfolio is not hosted within Corporate Safeguarding, the activity supports the wider organisational work to protects Children and Adults at risk with the Executive Director of Nursing as the Accountable Executive

- A new susceptibility assessment form was introduced by the Home Office and Counter Terrorism Policing considering mitigating and protective factors

- Over the past year most referrals have come from Educational settings, relating to young people

- Alongside recognised ideologies there has been an increase of individuals with a Fascination with committing an Extreme Violence or Mass Casualty Attack (FCEVMCA) This category is defined as:

  Where an individual does not have an identifiable terrorist/extremist ideology but evidence of a fascination in committing an extreme violence or mass casualty attack, the consequences of which may have no specific racial, religious, or political motivation.
  and
  "Intense interest" takes a topic to an extreme degree exhibiting strong feeling or seriousness. It is expressed by great enthusiasm, energy, determination, or concentration.

- There are multi-agency Channel Panels, led by each local authority, working with partners to support those referred through the Prevent process

- The ESR training for Prevent has been revised and is now available for staff to access and there has been a focus on delivering group training to Paediatrics, CAHMS, ED, Health Visiting and School nursing staff this year given the increase on younger referrals

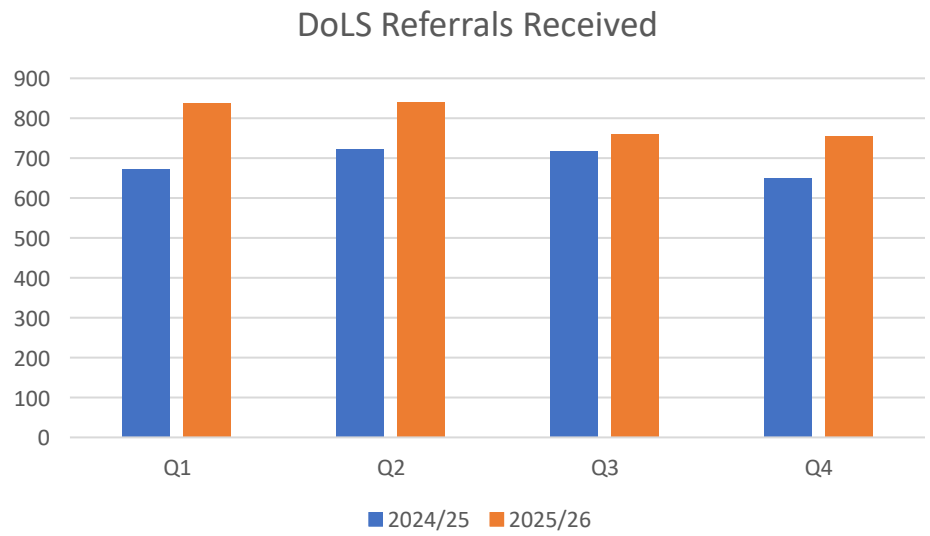
- Phase 1 of Southport Public Inquiry has been published and recommendations are being address to determine how they will affect Prevent response and delivery

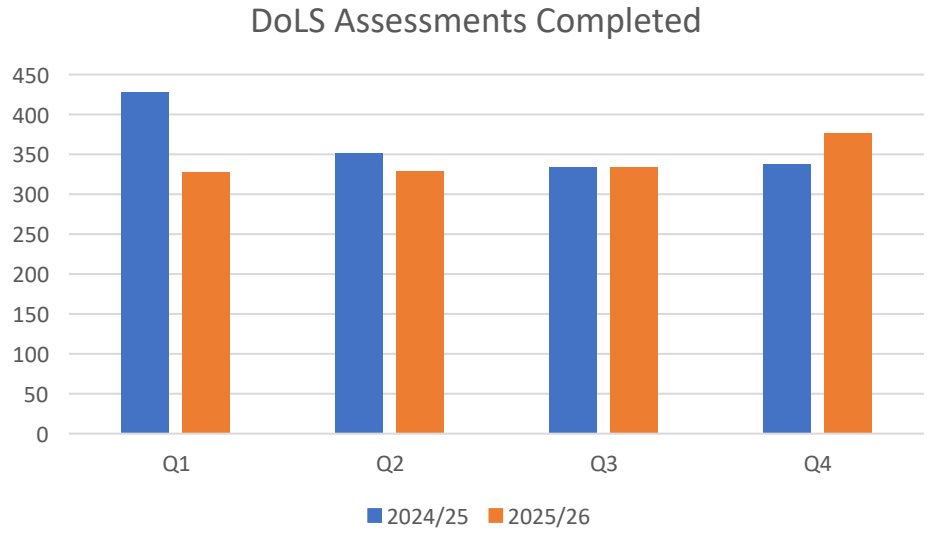
Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS)

Within the Health Board, MCA & DoLS function does not fall directly under the portfolio of the Corporate Safeguarding Team. However, it is closely aligned, and strong professional relationships exist between the two teams. The health board continues to fulfil its statutory responsibilities regarding the Deprivation of Liberty Safeguards (DoLS) and the broader requirements of the Mental Capacity Act 2005. Additionally, the Health Board actively participates in the All Wales MCA/DoLS Network.

MCA training has now been made mandatory across ABUHB and is in the process of being aligned with ESR for accurate recording and compliance monitoring. Training, clinical support, and an audit cycle have been embedded into MCA practice across the Health Board. MCA/DoLS training is offered at three levels, culminating in skills workshops designed to help staff develop clinical competencies.

MCA practitioners remain available to support and advise clinical teams with MCA assessments and Best Interest (BI) meetings.





Looked After Children (LAC)

Looked After Children and young people are those in the care of the Local Authority, either temporarily or permanently, because they are unable to live safely with their parents, carers, or guardians.

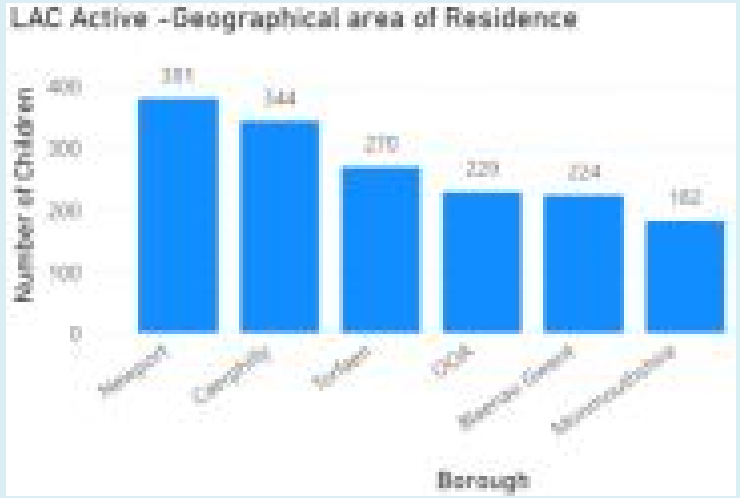
The Health Board plays a crucial role in safeguarding and promoting the health and wellbeing of these children and young people. It is responsible for ensuring they receive high-quality, timely statutory health assessments, as well as services that meet their individual needs through a holistic approach.

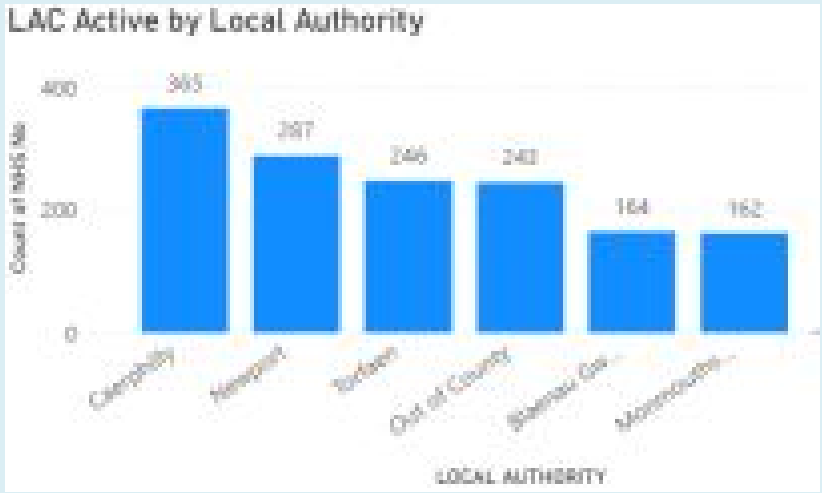
The LAC Nursing Team is responsible for service delivery, caseload management, and the completion of statutory health assessments, which operates separately from the Corporate Safeguarding Team. However, both teams work closely together, liaising and providing support where necessary to ensure coordinated care.

At the end of the financial year 2025/2026, there were **1,852 children** looked after within the LAC service. Of these:

- **282** were under 5
- **1570** were over 5
- **142** were in the adoption process
- **84** were unaccompanied asylum-seeking children
- **243** were placed within ABUHB by external Local Authorities
- **229** were placed outside the Health Board area but remained the responsibility of Local Authorities within ABUHB







Review of Priorities for 2025/26

1	To finalise the framework for delivering and monitoring Level 3 Safeguarding training.		Level 3 Adult and children Safeguarding has been successfully implemented, with a three year delivery programme underway. At the end of 2025/26 the ambition to achieve 35% compliance had been exceeded
2	To ensure the provision of appropriate Safeguarding Adult Supervision for teams within the Mental health and Learning Disability Division.		Significant changes to the leadership team in the MHLD Division, has prevented full completion. A pilot is being evaluated and a wider implementation plan developed
3	To develop and launch a suite of Safeguarding Policies that staff can easily access and apply, supporting the effective safeguarding of individuals and staff across ABUHB		Policies have been written, consulted, approved and published in regard of PiPoT, MAPPA, VADWASV and Safeguarding.
4	To implement functionality within the ESR platform that enable accurate monitoring and Divisional reporting of Ask & Act Group 2 training compliance.		The required level of support from Workforce was unable to be sourced, but this issue has been resolved and this objective should gather pace in Q1 of 2026/27
5	Launch of the DATIX Safeguarding Module to facilitate better case management of cases open to the safeguarding processes.		The RL Datix Safeguarding Module has been fully implemented as the recording system for safeguarding activity within the Health Board. Exploration of wider functionality, including integration with partner agencies, is being explored nationally
6	To continue developing internal assurance measures relating to Safeguarding and Domestic Abuse, which will contribute towards ward accreditation processes.		Measures relating to Safeguarding are embedded in the accreditation programme. A national project has implemented routine enquiry of Domestic Abuse in mandated areas and will be embedded as part of the audit programme for 2026/27
7	To work collaboratively with Local Authority and Police partners to reduce the duration cases remain open and to establish processes that support early learning.		Whilst no changes to formal processes can be agreed, local collaboration agreements have been reached that will ensure local processes can nearly always work in parallel to criminal investigations.
8	To collaborate with Police and Local Authority partners to ensure the consistent and equitable application of nationally revised Section 5 processes.		The Publication of National Guidance was delayed until July 2026. A gwent Gwent Safeguarding Board Task and Finish Group has been established to ensure equitable implementation, following publication.

Conclusion

The year 2025/26 presented significant challenges for the Corporate Safeguarding Team, driven by a notable rise in safeguarding activity alongside the team's ongoing statutory responsibilities.

Despite these pressures, key achievements were realised in the following areas:

- Delivery of Level 3 Safeguarding Training.
- Mandating Level 3 Safeguarding compliance via the ESR platform.
- Proactive management of an increased and more complex caseload.
- Expansion of safeguarding supervision across wider areas.
- Strengthening the Independent Domestic Violence Advocate (IDVA) role within urgent care settings.
- Establishment of a well-attended and effective Strategic Safeguarding Group, supported by dedicated sub-groups.
- Successful planning and delivery of the implementation of the Datix Safeguarding module.

ABUHB remains firmly committed to prioritising the safeguarding of both children and adults. This commitment will continue into 2026/27, with a focus on addressing both existing and emerging challenges.

Ongoing collaboration with the community and partner organisations will be essential to support continued development and adaptation.

Priorities 2026/27

The Health Board recognises that further progress will strengthen safeguarding for children and adults at risk. As a Health Board, it is essential that we continue to evolve and enhance our services to meet the needs of a modern and changing society.

The way in which priorities have been established for the coming year is under four key priority areas:

- VAWDASV
- PIPOT
- Safeguarding Children
- Safeguarding Adults

The objectives and how they will be measured is set out over the next four slides.

Monitoring of progress will be via the Safeguarding Strategic Group.

People in Positions of Trust Priorities

Key Metrics	Targets	Baseline	Trajectory
Volume of new referrals by LA	N/A	N/A	There is no desired trajectory as this monitors activity which can be influenced by factors external to our control
Volume of new referrals by Division	N/A	N/A	There is no desired trajectory as this monitors activity which can be influenced by factors external to our control
Volume of new referrals Percentage of cases closed in 13 weeks by LA	100%	Data not previously collected	It is anticipated that the functionality to report on this may be place by Q3
Volume of new referrals by setting (internal/ external) by LA	N/A	N/A	There is no desired trajectory as this monitors activity which can be influenced by factors external to our control

Objectives	
Quarter 1	• Meet with Gwent Police to understand barriers to swift investigation closure
Quarter 2	• Develop improvement strategy to ensure we respond to the needs of partners and remove any obstacles • Work with the Once for Wales Team to ensure that relevant data can be reported
Quarter 3	• Implement improvement strategy to ensure pace is maintained
Quarter 4	• Evaluate improvements and determine if they are reducing length of time cases are open

VAWDASV Priorities

Key Metrics	Targets	Baseline	Trajectory
Ask and Act Group 1 Training (Online)	>85%	77%	This is online training which forms a part of mandatory training and should be maintained in excess of 85% by end of Q1
Ask and Act Training Group 2	>85%	Unknown	The volume of staff requiring training has not yet been mapped by ESR
Volume of MARAC Cases by LA	N/A	N/A	There is no desired trajectory as this monitors activity which can be influenced by factors external to our control.
Volume of MARAC Attended	100%	100%	On Track

Objectives

Quarter 1	• Determine volume of staff requiring VAWDASV Group 2 • Develop a model for implementation • Develop standardised information template for MARAC research to ensure consistency
Quarter 2	• Set dates for VAWDASV Group 2 Training • Go live on ESR for VAWDASV Group 2 • Develop a clear strategy regarding Health Board support for survivors of Domestic Abuse, in partnership with Public Health (IDVA/IRIS)
Quarter 3	• Begin Delivery of VAWDASV Group 2 Training • Evaluate MARAC research template
Quarter 4	• Review compliance with VAWDASV Group 2 and whether delivery model is sustainable

Safeguarding Adult Priorities

Key Metrics	Targets	Baseline	Trajectory
Volume of Duty to Report by LA Area	N/A	N/A	There is no desired trajectory as this monitors activity which can be influenced by factors external to our control
Volume of Duty to Report by Category	N/A	N/A	There is no desired trajectory as this monitors activity which can be influenced by factors external to our control
Volume of Duty to Report by Division	N/A	N/A	There is no desired trajectory as this monitors activity which can be influenced by factors external to our control
Level 1 Adult Safeguarding Training	85%	84%	This is online training which forms a part of mandatory training and should be maintained in excess of 85%
Level 2 Adult Safeguarding Training	85%	87%	This is online training which forms a part of mandatory training and should be maintained in excess of 85%
Level 3 Adult Safeguarding Training	85%	44%	The planned trajectory, based upon available resources is 8% per quarter. As this is face to face training we would want to achieve and then maintain above 85% compliance over a three-year period

Objectives

Quarter 1	• Ensure resources available to implement Level 3 Safeguarding Training in current prescribed method • Review first years DATIX data to determine if there are any identified themes and trends that would highlight required areas of focus • Launch Chaperone Toolkit
Quarter 2	• Explore alternate methods of delivering Level 3 training that maintain compliance but reduce required resources, with support from National Safeguarding Service • Trial Safeguarding Supervision in MHLD Nursing Leadership Team
Quarter 3	• Trial alternative model of training delivery • Review DATIX data on "intimate examinations" to evaluate impact of Chaperone Toolkit.
Quarter 4	• Evaluate revised model of training delivery • Evaluate Safeguarding Supervision in MHLD Nursing Leadership Team

Safeguarding Children Priorities

Key Metrics	Targets	Baseline	Trajectory
Volume of DTR by LA Area	N/A	N/A	There is no desired trajectory as this monitors activity which can be influenced by factors external to our control.
Strategy Meetings Requested/Attended	100%	79%	There are currently conversations ongoing to determine resource to improve compliance
Strategy meetings by LA	N/A	N/A	There is no desired trajectory as this monitors activity which can be influenced by factors external to our control
Level 1 Child Safeguarding Training	85%	83%	This is online training which forms a part of mandatory training and should be maintained in excess of 85%
Level 2 Child Safeguarding Training	85%	86%	This is online training which forms a part of mandatory training and should be maintained in excess of 85%
Level 3 Child Safeguarding Training	85%	50%	The planned trajectory, based upon available resources is 8% per quarter. As this is face to face training we would want to archive and then maintain above 85% compliance over a three-year period)
Volume of PRUDIC by: • **Setting** • **LA**	N/A	N/A	There is no desired trajectory as this monitors activity which can be influenced by factors external to our control

Objectives	
Quarter 1	• Meet with Health Visiting and Midwifery to scope available resources to support strategy meetings. • Develop operational guidance to ensure that resources are used effectively and overlap is reduced/avoided • Brief Exec on challenges in resourcing increased/increasing volume of strategy meetings
Quarter 2	• Brief partners on revised model of working to support strategy meetings
Quarter 3	• Evaluate revised model of working, including partners from LA and Police in evaluation
Quarter 4	• Update Exec regarding compliance and sustainability of Strategy Meeting Attendance

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	06 October 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Implementation of the AGNI Supreme Court Judgment: Implications for DoLS and MCA
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tom Grace MCA Strategic Lead/ DoLS Lead Gwent Consortium

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

Ar Gyfer Penderfyniad/For Decision

To inform Patient Quality, Safety and Outcomes Committee of the implications of the AGNI Supreme Court judgment for Mental Capacity Act and Deprivation of Liberty Safeguards practice, provide assurance regarding actions taken to date, and seek support for the proposed implementation approach.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The UK Supreme Court judgment issued on 2 June 2026 represents a significant change in the interpretation of deprivation of liberty under Article 5 of the European Convention on Human Rights, overturning the long-standing *Cheshire West* (2014) "acid test". The Court determined that deprivation of liberty should no longer be assessed solely on the basis of continuous supervision and control and whether a person is free to leave. Instead, a broader, person-centred and multifactorial assessment is required, taking account of the individual's circumstances, wishes and feelings, the purpose and effect of care arrangements, and whether the person is capable of expressing valid consent to those arrangements despite lacking legal capacity. This ruling has immediate effect and impacts practice across health and social care settings, including hospitals, supported accommodation, and private homes. For further information please see: A Reference by the Attorney General for Northern Ireland of a devolution issue under paragraph 34 of Schedule 10 to the Northern Ireland Act 1998 - UK Supreme Court



For Health Boards in Wales, this judgment has potentially significant implications for current Deprivation of Liberty Safeguards (DoLS) practice, Mental Capacity Act processes, safeguarding arrangements and Court of Protection activity. The Supreme Court recognised that the *Cheshire West* approach has contributed to substantial increases in DoLS applications, assessment backlogs, administrative burden and system costs, while also subjecting some individuals and families to intrusive legal processes where care arrangements are consistent with the person's wishes and best interests. Although national policy and operational guidance for Wales are yet to be updated, the judgment signals a shift towards greater recognition of autonomy, voice and person-centred decision-making for people who lack capacity.

Executive oversight is required to understand the legal, operational and workforce implications for the Health Board and to ensure preparedness for any changes to Welsh Government policy, DoLS practice and wider liberty protection arrangements arising from this landmark decision. The Health Board is required to respond immediately to ensure compliance with the updated legal framework and support practitioners to apply the new multifactorial test.

Cefndir / Background

Following the UK Supreme Court judgment in *A Reference by the Attorney General for Northern Ireland* (AGNI), the Department of Health and Social Care (DHSC) published implementation guidance on 15 June 2026 clarifying the revised interpretation of deprivation of liberty and the implications for health and social care organisations (UK Supreme Court 2026 judgment on what constitutes a deprivation of liberty - GOV.UK). The judgment overturns the *Cheshire West* "acid test" and introduces a broader, multifactorial approach to assessing deprivation of liberty, placing greater emphasis on the individual's wishes, feelings, and ability to express acceptance of their care arrangements.

National Progress: Nationally, a programme of webinars, legal briefings and Mental Capacity Forum workshops is underway to support implementation and to consider the implications for current DoLS and Mental Capacity Act practice. Within Wales, discussions have commenced between NHS Wales Performance and Improvement, Welsh Government and professional networks; however, formal Welsh Government guidance has not yet been issued. The Aneurin Bevan University Health Board MCA Lead, in their role as Chair of the All-Wales MCA/DoLS Network, is actively engaged in these national discussions and helping to shape a consistent Welsh response.

Local Progress: Recognising the significance of the judgment, the Health Board has commenced local implementation activity pending the publication of national guidance. The revised AGNI test has been incorporated into all new DoLS assessments, and a new screening tool is being developed to support consistent decision-making and referral management.

Training materials are being revised to reflect the new legal position, while Best Interests Assessors (BIAs) are receiving enhanced support through weekly professional forums and supervision arrangements. In addition, a Gwent-wide



DoLS Consortium has been established to promote a coordinated regional approach to implementation, share learning, and identify any operational, workforce and governance implications arising from the judgment. These actions are intended to ensure that the Health Board remains compliant with current legal requirements while preparing for any future Welsh Government policy direction or changes to the legislative framework.

Asesiad / Assessment

The AGNI judgment represents a fundamental change in the legal and operational approach to deprivation of liberty, replacing the established *Cheshire West* "acid test" with a more complex, multifactorial assessment that requires consideration of an individual's wishes, feelings, circumstances and ability to express acceptance of their care arrangements. While the judgment aligns with principles of autonomy, dignity and person-centred care, it significantly increases reliance on professional judgement and introduces a greater risk of variation in decision-making across practitioners, services and organisations.

For the Health Board, the judgment is expected to have significant implications for existing DoLS waiting lists, current authorisations and Community Deprivation of Liberty (CoPDoL) cases involving individuals supported within community settings, including supported living arrangements and family homes. The impact is likely to be most pronounced within Community Learning Disability Teams and services supporting individuals with complex needs. Although the revised approach may reduce the number of cases requiring formal deprivation of liberty authorisation, the full effect remains uncertain pending Welsh Government guidance and further legal clarification. As a result, there is a risk of inconsistent interpretation and application across Health Boards and local authority partners during the implementation period.

The requirement to evidence an individual's wishes, feelings and acceptance of their care arrangements is likely to place additional demands on Mental Capacity Act and DoLS services, Best Interests Assessors (BIAs), managing authorities and wider clinical teams. There is a risk of inconsistent application, legal challenge and unintended variation in practice if staff are not adequately supported through training, supervision and decision-support tools. The judgment also creates a need to review local policies, assessment processes, governance arrangements and quality assurance mechanisms to ensure they remain legally compliant and capable of demonstrating robust decision-making.

In the absence of formal Welsh Government guidance, there remains considerable uncertainty regarding future expectations for practice across Wales. Clear local leadership, governance and interim direction will therefore be required to support safe, lawful and consistent implementation across the Health Board. Ongoing engagement through the All-Wales MCA/DoLS Network, NHS Wales Performance and Improvement, regional partners and legal advisors will be essential to monitor emerging guidance, share learning and mitigate organisational risk whilst national policy continues to develop.

Risk Mitigation



In the absence of national guidance, an assessment of preparedness has been completed. It is proposed that the following actions are taken whilst guidance is awaited.

Immediate Actions

- Review all current referrals and waiting lists against the AGNI test.
- Implement review process for all current DoLS authorisations (Schedule A1).

Revised Screening Tool

To ensure all new assessments apply the AGNI multifactorial test, a Gwent-wide AGNI screening and decision-support tool (attached) has been developed to support consistent application of the revised legal test, assist prioritisation of referrals and provide initial scrutiny of whether cases are likely to meet the threshold for deprivation of liberty under the AGNI judgment

Community DoLS (CoPDoL)

- Review all existing and proposed community cases to determine whether they meet the revised threshold.

Training and Workforce Development

- Embed AGNI requirements into all MCA/DoLS training programmes.
- Deliver urgent briefing sessions for:
  - DoLS signatories
  - Divisional teams
  - Recently trained staff (bespoke updates)
- Commission specialist external legal/training support for MCA practitioners and BIAs.

Communication

- Issue organisation-wide communication (e.g., via Pulse) outlining the change and immediate expectations.

Note: An organisation-wide communication outlining the implications of the judgment and immediate expectations was circulated across the Health Board on 2 July 2026.

Operational Support

- Maintain weekly BIA support and enhanced supervision arrangements.
- Develop a practical decision-making tool for managing authorities (wards/services) to support referral decisions.

To support implementation, a Gwent-wide screening and decision-support framework has been developed, comprising both a practitioner scrutiny tool and a frontline referral screening checklist and algorithm (attached Appendix 2 and 3)

This will help wards and services decide whether they should submit a DoLS application following the AGNI judgment. It is more operational than the earlier Gwent scrutiny tool and is intended to support referral decisions



Strategic and National Engagement

- Continue active participation in All Wales networks and national forums.
- Align Health Board practice with emerging Welsh Government and national guidance when published.

Argymhelliad / Recommendation

To ensure safe, lawful, and consistent implementation, the Patient, Quality, Safety and Outcomes Committee is asked to:

- **CONSIDER** the legal, operational and workforce implications arising from the AGNI judgment and the risks associated with implementation pending Welsh Government guidance.
- **AGREE** the proposed interim approach to implementation, including review of existing caseloads, application of the AGNI test to new assessments, and use of interim screening and decision-support tools.
- **SUPPORT** the ongoing programme of workforce development, communication, supervision and legal support to ensure safe and consistent implementation across the Health Board.
- **SUPPORT** continued engagement through All Wales MCA/DoLS networks and national forums to inform the development of a consistent Welsh approach.
- **AGREE** to receive a further update once Welsh Government guidance has been published or where significant operational implications emerge.

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):	5. Timely Care 6. Individual care 3.1 Safe and Clinically Effective Care 6.3 Listening and Learning from Feedback
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse



Strategic Equality Objectives 2020-24	Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Mental Capacity Act Supreme Court Judgement June 2026 Deprivation of Liberty Safeguards
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	**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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives



Draft pending official guidance

Staff Communication: Important Changes to Deprivation of Liberty Safeguards (DoLS) – June 2026

Date: June 2026

Audience: All clinical and care staff

Key Message

On 2 June 2026, the UK Supreme Court made an important legal decision in relation to the test for a Deprived of their Liberty under article 5 ECHR.

A Reference by the Attorney General for Northern Ireland of a devolution issue under paragraph 34 of Schedule 10 to the Northern Ireland Act 1998 - UK Supreme Court

The legal test for Deprivation of Liberty has changed.

However, the Deprivation of Liberty Safeguards (DoLS) process under Schedule A1 **remains in place** and **must** continue to be used.

What has changed?

The new SC judgment has replaced the '**Acid Test'** laid down **Cheshire West 2014** with a new **'multifactorial approach'** to help decide whether a person is Deprived of their Liberty and if a DoLS authorisation should be granted.

The multifactorial approach states that we need to consider the person's overall situation and whether P is objecting to the arrangements including:

- The type of restrictions they are experiencing
- How long the restrictions are in place
- The impact the restrictions have on them

- Their wishes, feelings and experiences
- The care setting they are in

There is no longer one simple ACID test that determines whether a deprivation of liberty exists.

What does this mean for staff?

The DHSC has published interim guidance

UK Supreme Court 2026 judgment on what constitutes a deprivation of liberty - GOV.UK

Whilst we await further official guidance staff should continue to follow existing Mental Capacity Act and DoLS processes.

Could all staff please:

- To safeguard people, continue to identify and refer people where you believe a deprivation of liberty may be occurring (consider whether care arrangements are restrictive)
- Continue to complete mental capacity assessments and best interest decisions where required.
- Ensure care planning and decision-making are person-centred and clearly documented.
- Use professional judgement at all times
- Seek advice if you are unsure.

If in doubt, continue to make a DoLS referral.

What has NOT changed?

The following remain exactly the same:

- The Mental Capacity Act (2005) remains in force.
- The MCA should continue to be used where people lack capacity to consent to their care arrangements
- DoLS remains the legal process for authorising a deprivation of liberty in hospitals and care homes.
- Existing referral processes remain in place.
- Staff must continue to follow current policies and procedures.

What you need to do now

- Continue to apply DoLS as normal if you believe DoL is occurring
- Ensure decisions are person-centred and clearly documented.
- Seek advice if unsure whether arrangements amount to a deprivation of liberty.
- Attend training updates when provided.

What happens next?

National organisations and governments across the UK are currently developing further guidance to help organisations understand and apply the new judgment.

- The Health Board is actively monitoring developments and reviewing any implications for local practice.
- Further guidance, training and updates will be provided as more information becomes available.

Further Support

If you require advice or support, please contact the MCA/DoLS team. Further guidance and training will be provided as national direction develops.

Mental Capacity Act (MCA)

Deprivation of Liberty Safeguards

Tel: 01495 745801

Email: DoLS.Team@wales..nhs.uk

ABB.MentalCapacityAct@wales.nhs.uk

Tom Grace MCA / DoLS Lead

Deprivation of Liberty Safeguards checklist

Has P been assessed as having capacity to consent to admission for care and treatment?	YES	NO

P lacks capacity - Indicators of a Deprivation of Liberty

	YES
P is expressing a wish to leave	
P is asking to go somewhere else (home, work)	
P is distressed about placement	
Exit seeking	
Resistive to care or supervision	
Medication used to supress objection	
Uncertain of P's wishes/feelings	
Passive compliance	
Evidence of restraint or the use of force	
P is compelled/forced to reside somewhere they do not want to	

If P's care arrangements/presentation include any of the above submit a DoLS application

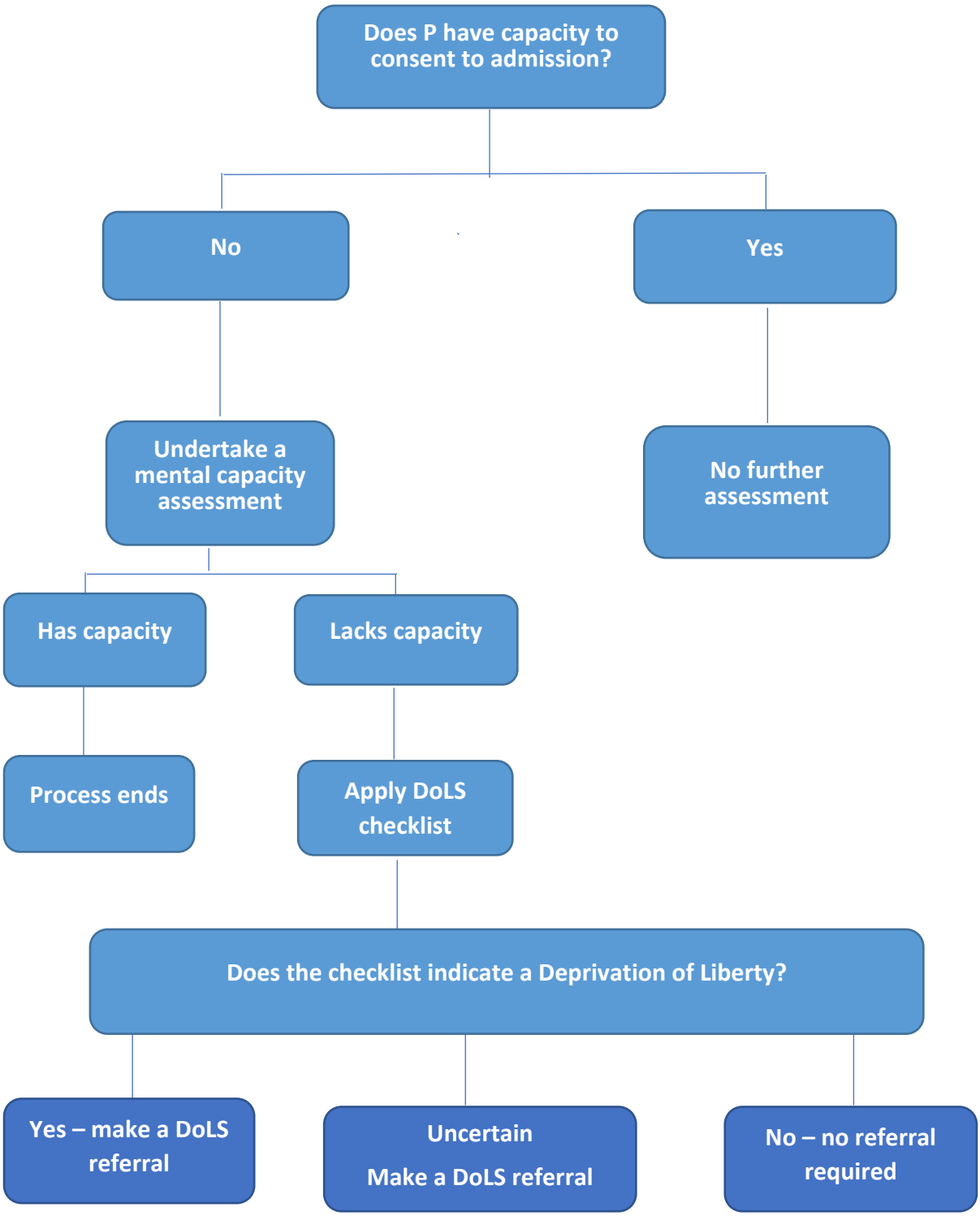
P lacks capacity - Indicators that by virtue of wishes and behaviours they are consenting

	Yes
P appears content	
P has an understanding about where they are residing	
P expresses positive wishes or feelings about where they reside	
P engages with the care needs	
No verbal objection (asking to leave)	
No behavioural objection (resistance, distress, exit seeking)	
No medication to sedate or ensure compliance	
Restrictions not intrusive or distressing	
P is not compelled/forced to reside somewhere they don't wont to	
P is unable to exercise liberty due to physical condition (hospital patients	

If P's care arrangement/presentation include the above DoLS application is not required

If no clarity when completing the checklist, care arrangements/presentation is a combination of both checklists submit a DoLS application

Deprivation of Liberty Safeguards Algorithm



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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	06 October 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality Management System Annual Review and Development Plan
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety Tracey Partridge-Wilson, Deputy Director of Nursing

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

ADRODDIAD SCAA **SBAR REPORT**
Sefyllfa / Situation Although the Health Board has established the core architecture of a Quality Management System (QMS), including the Quality Management Framework, Quality Management Group (QMG), Quality Outcomes Framework (QOF), divisional assurance arrangements and developing Qlik intelligence capability, the system needs to be fully embedded. The annual review identifies that the next phase of development should focus on embedding the QMS as the organisation's operating system for quality, ensuring a stronger connection between quality intelligence, accountability, organisational learning and improvement
Cefndir / Background The review has been developed in response to NHS Wales Performance and Improvement requirements and aligns with the Health and Social Care (Quality and Engagement) (Wales) Act 2020, including the Duty of Quality and Duty of Candour. The Health Board has made significant progress in establishing governance

structures and reporting mechanisms which provide improved visibility of quality risks, themes and performance from ward to Board. However, variability remains in the maturity of quality planning, assurance, learning systems, triangulation of intelligence, improvement capability and translation of QMS principles into frontline practice.

Asesiad / Assessment

The annual review concludes that the Health Board is in a strong developmental position, with solid foundations in place but requiring further maturity to achieve a fully integrated Quality Management System. Key strengths include established governance arrangements, growing intelligence capability through Qlik, strengthened divisional reporting structures and the development of a clear Quality Management Framework.

The review identifies several areas requiring further development:

- Strengthening accountability and ownership of quality risks, intelligence and improvement across all organisational levels.
- Refining the QOF and Qlik platforms to provide concise, outcome-focused and actionable intelligence that supports decision-making.
- Repositioning QMG as the executive led forum for system learning, assurance, escalation and quality improvement.
- Implementing a pragmatic maturity assessment process to identify and address variation in QMS development across divisions.
- Establishing a closed-loop organisational learning system that demonstrates how learning from incidents, complaints, audits, patient experience and staff feedback leads to measurable change.
- Strengthening improvement capability, measurement literacy and use of improvement methodology across the organisation.
- Enhancing safety culture, staff and patient involvement, and ward-to-Board communication to ensure quality priorities are informed by lived experience and frontline intelligence.

The review also highlights key delivery risks, including the maturity of Qlik products, data quality and timeliness, divisional capacity to undertake improvement work, maintaining assurance while reducing reporting burden, and achieving consistent adoption of QMS principles across services.

Relevant roadmap priorities are summarised in the transformation roadmap.

Argymhelliad / Recommendation

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

- **NOTE** the findings of the 2026/27 Quality Management System Annual Review and maturity assessment.
- **SUPPORT** the proposed Organisational Development Plan and the seven priority workstreams designed to move the Health Board from foundation building to full QMS embedding.
- **PROVIDE ASSURANCE** that the proposed direction of travel reflects the Health Board's strategic ambition to strengthen quality planning, control, assurance, improvement and organisational learning in line with national expectations and the Duty of Quality.
- **ENDORSE** ongoing oversight through QMG and PQSOC, reporting arrangements, with progress monitored through quarterly review of the roadmap and maturity assessments.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 3.1 Safe and Clinically Effective Care 3.3 Quality Improvement, Research and Innovation Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr 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/	Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

Aneurin Bevan University Health Board

Quality Management System Organisational Development Plan 2026/27

Purpose of this plan

This document sets out the Health Board's 2026/27 organisational development response for its Quality Management System. It describes the aspirational state, assesses the current state and identifies priorities for the next 12 months across quality planning, quality control, quality assurance, quality improvement and the key Quality Enablers.

1. Executive Summary

This plan sets out Aneurin Bevan University Health Board's (ABUHB) 2026/27 organisational development response for its Quality Management System. It recognises the substantial foundations already established across the Health Board, including the Quality Management Framework, Quality Management Group, Quality Outcomes Framework, divisional assurance reporting, Qlik development, Quality and Patient Safety structures and accountability framework materials. It also recognises that the system is not yet fully embedded and that the next phase should move from foundation building to embedding the Quality Management System as the Health Board's operating system for quality.

The central organisational development challenge for 2026/27 is to strengthen the connection between intelligence, accountability, learning and improvement. Current arrangements have improved visibility of quality themes and risks, but further maturity is required in relation to triangulation, outcome measurement, consistent divisional and subgroup reporting, data interpretation, closed loop learning and the translation of the Quality Management System into ward and service level practice.

For 2026/27, ABUHB will focus on seven priorities: clarifying the accountability model; refining the Quality Outcomes Framework and Qlik as a shared intelligence platform; repositioning the Quality Management Group as a system learning and improvement forum which identifies and manages quality risks from ward to board; implementing a pragmatic Quality Management System maturity approach; building a closed loop organisational learning system; strengthening improvement capability and measurement literacy; and improving safety culture, involvement and ward to Board communication.

The plan is intentionally candid. It describes progress, identifies the work still required and avoids presenting reassurance as assurance. It is designed to provide Welsh Government, NHS Wales Performance and Improvement, the ABUHB Executive

Committee and the Public Board with a clear, credible and evidence-based account of the next stage of Quality Management System maturity.

2. Introduction and Context

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 provides the legislative context for this plan, including the statutory framework for the Duty of Quality and Duty of Candour. Within NHS Wales, a Quality Management System is expected to provide a broader approach to managing and improving quality by connecting quality planning, quality control, quality assurance and quality improvement into one coherent organisational model.

ABUHB has already undertaken substantial development work. The Quality Management Framework describes how the organisation plans, monitors, improves and assures the quality of care. The Quality Management Group provides executive oversight of quality performance, risks, learning and improvement. The Quality Outcomes Framework and emerging Qlik infrastructure provide a basis for more timely quality intelligence, including information drawn from systems such as RLDatix to support reporting on incidents, concerns and quality measures.

This final submission narrative builds on earlier ABUHB drafting and internal evidence. It retains the core direction of travel, namely the transition from foundation building to embedding, and strengthens the focus on accountability, Quality Management Group development, learning systems, improvement capability, safety culture and ward to Board communication.

3. Current State Assessment

ABUHB has established a credible foundation for a Health Board-wide Quality Management System. Established areas include the Quality Management Framework, Quality Management Group, Quality Outcomes Framework reporting, divisional Quality and Patient Safety reporting, emerging Qlik infrastructure, centralised Quality and Patient Safety support and routine executive and committee reporting routes.

Current arrangements provide a broader view of quality across the six Pillars of Quality and have improved visibility of key issues, themes and risks at the Quality Management Group, Patient Quality, Safety and Outcomes Committee and Board. The Health Board is also developing stronger links between quality intelligence, divisional assurance and executive oversight.

The developing areas are integrated intelligence, Qlik maturity, exception reporting, divisional accountability, outcome measurement, maturity assessment and consistent use of the Quality Management System language across services. The Quality Outcomes Framework remains comprehensive but can be data heavy, and some reporting still depends on manual narrative rather than an integrated intelligence product.

The less mature areas are closed loop learning, consistent spread and scale of improvement, systematic triangulation across quality, workforce, planning, operational, inequality and experience data, and a shared ward to Board language for the Quality Management System. Workshop feedback identified that senior staff understand elements of the system, but articulation to ward level staff remains variable. The Health Board will therefore need to be open about work still required while maintaining confidence in the foundations already established.

In 2025 the Performance Management and Accountability Framework was revised and updated. The PMF provides the operating mechanism for implementing and demonstrating the Quality Management System (QMS). It aligns with the four QMS domains of Planning, Control, Assurance and Improvement by establishing clear accountability, performance monitoring, governance arrangements, and escalation processes. The PMF aligns the strategic objectives with operational delivery through establishing clear measures and milestones, and integrating quality, workforce, finance, and performance.

Planning

- Aligns performance management with the IMTP, NHS Wales Performance Framework and organisational objectives.
- Establishes clear accountability conditions, objectives, metrics and trajectories for delivery.
- Integrates quality, performance, workforce, risk and finance into a single framework.

Control

- Defines clear roles, responsibilities and accountability from Board to team level.
- Monitors performance across five domains: Quality & Safety, Leadership, Corporate Governance, Finance and Operational Delivery.
- Provides structured escalation and intervention processes when performance falls below expected standards.

Assurance

- Creates a comprehensive assurance structure through Board, Committee, Executive and Divisional review processes.
- Provides regular reporting through Integrated Performance Reports, Quality Outcomes Framework reporting and assurance reviews.
- Supports effective scrutiny, oversight and evidence-based decision making.

Improvement

- Promotes a culture of continuous improvement and organisational learning.
- Uses improvement plans, deep dives, recovery processes and targeted support to address areas of concern.

- Links performance monitoring directly to improvement actions, support mechanisms and de-escalation criteria.

4. Aspirational State

ABUHB's aspirational state is a practical, whole organisation Quality Management System in which quality is planned, controlled, improved and assured through a single operating model from ward to Board. In this state, the Quality Management Group operates as the executive system forum for quality, the Quality Outcomes Framework provides concise exception-based intelligence, divisions own and act on their quality intelligence, and the Board receives assurance that distinguishes clearly between reliable evidence, emerging risk and reassurance that is not yet supported by evidence.

Quality planning will be connected to the Quality Plan, Integrated Medium Term Plan, divisional plans and national priorities. Divisions and directorates will be able to describe how local quality priorities contribute to the Health Board's agreed objectives, and the Health Board will be able to articulate a defined set of system level quality risks and priorities.

Quality control will be visible where care is delivered. Teams will have access to timely, interpretable intelligence that supports daily, weekly and monthly decision making. Qlik and other intelligence sources will support local understanding of variation, early recognition of risk and practical quality control at service level.

Quality assurance will be proportionate, intelligence led and improvement oriented. Assurance discussions will focus on signals, risk, learning, ownership, improvement action, escalation and evidence of impact. Reports should support scrutiny and decision making, rather than simply providing information.

Quality improvement will be explicitly linked to assurance and learning. Improvement activity will not be a separate programme owned by one team; it will be the core method for converting insight into measurable and sustained change. Divisions will own improvement priorities, with corporate and specialist teams providing support, challenge, coaching and methodological consistency.

The key enablers will be leadership, workforce, culture, information, learning and whole systems working. ABUHB's aspiration is that every staff group understands its contribution to safe, effective, person centred, timely, efficient and equitable care, and that the Quality Management System is understood as the way the organisation manages quality rather than as an additional corporate requirement.5.

5. Transformation Roadmap for 2026/27

Priority	Current position	Future state	Key actions	Measures of success	Governance route	Indicative period
1. Clarify the accountability model	Quality and Patient Safety structures, divisional support and escalation triggers are in place, but roles and escalation require continued clarification.	Divisions, corporate Quality and Patient Safety teams, specialist groups and Executives have explicit accountabilities for quality intelligence, risk, action and improvement.	Finalise and embed the Quality and Patient Safety Accountability Framework; define divisional ownership of quality risks; standardise escalation criteria; clarify specialist group ownership of risks and actions.	Divisional reports identify owner, risk, action and improvement outcome; escalation is consistent; duplication reduces.	Quality Management Group, Executive Team and Patient Quality, Safety and Outcomes Committee.	Q1 to Q2
2. Refine the Quality Outcomes Framework and Qlik as integrated intelligence	The Quality Outcomes Framework is established but can be data heavy; Qlik is emerging as a significant enabler.	A concise, exception based and outcome focused intelligence product supports decisions from service to Board.	Redesign Quality Outcomes Framework narrative; increase Qlik use in Quality Management Group and Board reports; add available measures for	Reports show variation, risk, action and outcome; Qlik becomes a routine source of quality intelligence; unnecessary reporting	Quality Management Group, Patient Quality, Safety and Outcomes Committee, Board, Business Intelligence and Digital, Data and	Q1 to Q4

			Duty of Candour, patient experience, safeguarding, Infection Prevention and Control, mortality, falls and workforce.	volume reduces.	Technology routes.	
3. Reposition the Quality Management Group	The Quality Management Group provides visibility, but its added value as a system forum requires further development.	The Quality Management Group operates as the executive forum for system quality, risk identification, learning, challenge, assurance and improvement.	Refresh terms of reference; revise paper standards; adopt a signal, risk, learning, action and outcome discipline; track action closure and impact.	Agendas focus on exceptions, cross cutting themes, escalation and improvement outcomes.	Quality Management Group to Executive Team and Patient Quality, Safety and Outcomes Committee.	Q1 to Q2
4. Implement Quality Management System maturity assessment	The maturity matrix has been introduced for discussion and supports self assessment across the Quality Management	ABUHB has a realistic, evidence-based maturity baseline and targeted divisional action plans.	Complete organisational and divisional maturity assessments; identify established, developing and immature areas;	Completed baseline; action plans linked to gaps; progress evidenced through the Quality	Quality Management Group, Aneurin Bevan Continuous Improvement and divisions.	Q1 to Q3

	System quadrants.		review progress quarterly.	Management Group.		
5. Build closed loop organisational learning	Learning forums and repositories exist, but spread, sustainability and evidence of changed practice remain developing.	Learning from incidents, complaints, audit, excellence, patient voice and staff voice is translated into practice change and tested for impact.	Define the organisational learning cycle; create a single route for learning themes; triangulate recurring actions; test whether actions reduce recurrence.	Repeated themes reduce; learning actions have impact measures; divisions demonstrate spread and sustainability.	Patient Quality and Safety Learning and Improvement Forum, Quality Management Group and Patient Quality, Safety and Outcomes Committee.	Q2 to Q4
6. Strengthen improvement capability and measurement literacy	Quality improvement support is present, but alignment with divisional priorities and assurance routes requires further development.	Improvement is planned, measured, supported and sustained through divisional capability and corporate coaching.	Agree organisational and divisional improvement priorities through the Quality Management Group and divisional assurance routes; align Aneurin Bevan Continuous Improvement and Quality Improvement leads to those priorities; develop	Improvement plans include aim, measure, change theory and outcome; leaders interpret variation safely; repeated action plans reduce.	Aneurin Bevan Continuous Improvement, Quality Management Group and divisional assurance routes.	Q2 to Q4

			improvement coaching; provide Statistical Process Control and variation training; connect action plans to quality improvement methodology and agreed quality priorities.			
7. Strengthen safety culture, involvement and ward to Board communication	National patient safety expectations emphasise listening, leadership and learning, and ABUHB workshops identified the need to translate the Quality Management System to the front line.	Staff, patients, families and communities can see how their voice informs priorities, action and learning.	Link staff voice, speaking up, patient experience, Civica, Patient Advice and Liaison Service, complaints and learning from excellence into quality intelligence; develop a simple ward to Board feedback product; strengthen safety walkabouts and local feedback loops.	Staff can describe local quality priorities; patient and staff themes inform the Quality Management Group; ward teams receive feedback on changed practice.	Divisional assurance, Quality Management Group, Patient Experience and learning routes.	Q1 to Q4

6. Governance and Oversight

Governance will be strengthened through a clear ward to Board line of sight. At ward, team and service level, quality control should focus on daily reliability, use of local measures, escalation of concerns and immediate action. At divisional level, assurance should triangulate incidents, complaints, audit, patient experience, workforce, operational performance and risk, and should show what action is being taken and whether it is working. At corporate level, the Quality Management Group should identify risk, cross cutting themes, test assurance, agree escalation and ensure learning is converted into improvement.

The Quality Management Group will have a specific role in agreeing the Health Board's system-wide quality priorities and coordinating improvement work aligned to those priorities. This will support a more disciplined approach to sequencing improvement activity, avoiding duplication, identifying where corporate or specialist support is required, and ensuring that improvement effort is focused on the areas of greatest risk, variation, learning opportunity and potential impact.

ABUHB will describe its oversight through three lines of defence. The first line is operational and divisional ownership of safe care, risk management, local data use and improvement action. The second line is corporate Quality and Patient Safety, specialist groups, Aneurin Bevan Continuous Improvement, Business Intelligence, Digital, Data and Technology and executive quality systems that provide support, challenge, standardisation and thematic analysis. The third line is independent and formal assurance through Board committees, audit, inspection, regulatory review and national reporting.

This model will support the Health Board to distinguish assurance from reassurance. Assurance will require evidence that a system is working, that risks are understood and controlled, and that actions have changed practice or outcomes. Reassurance alone will not be relied upon where evidence is incomplete, untested or not yet triangulated.

7. Delivery Assurance and Impact

Delivery of the roadmap will be supported through a clear delivery discipline. Each priority will have an identified executive sponsor or senior responsible owner, a delivery lead, agreed milestones, key risks, dependencies and evidence requirements. Progress will be reviewed through the Quality Management Group, with escalation to the Executive Team, Patient Quality, Safety and Outcomes Committee and Board where delivery is off track, risks are increasing or additional organisational support is required.

The expected impact by March 2027 is that patients, families, staff, divisions and the Board can see clearer evidence that quality intelligence is being used to inform

priorities, reduce avoidable harm, improve experience, strengthen accountability and support measurable improvement. For divisions, this should mean a more consistent approach to quality planning, escalation and improvement. For the Board, it should provide a clearer evidence base on where the Quality Management System is maturing, where further intervention is required and whether actions are improving outcomes.

Key risks and dependencies will be actively monitored. These include the maturity and usability of Qlik products, data quality and timeliness, divisional capacity to engage with improvement work, the ability to reduce reporting burden while strengthening assurance, availability of improvement and measurement capability, and the pace at which Quality Management System language and behaviours are adopted at ward and service level. Mitigations will include prioritised delivery sequencing, targeted support for divisions, standardised reporting expectations, clearer escalation routes and use of maturity assessment to focus effort where the greatest gaps remain.

Given the ambition of the plan, delivery will depend on clear prioritisation, realistic sequencing and explicit ownership of both outputs and outcomes. The Health Board will therefore distinguish between completion of products or processes and evidence that those products have changed practice, reduced variation, improved experience, strengthened assurance or supported measurable improvement in quality and safety.

Delivery risk or dependency	Potential impact	Mitigation
Qlik maturity, usability and data quality	Quality intelligence may remain data heavy, retrospective or insufficiently actionable.	Prioritise core quality measures, strengthen data definitions, involve Business Intelligence and test products with divisions and the Quality Management Group.
Divisional capacity and competing operational priorities	Delivery may become inconsistent and improvement actions may not be sustained.	Sequence priorities, identify delivery leads, provide targeted corporate support and escalate capacity constraints through the Quality Management Group.
Measures focused on activity rather than outcome	Progress may be reported without clear evidence of changed practice or improved quality.	Define measures that include aim, baseline, expected direction of change, frequency of review and evidence of impact.

Resources to support delivery will include executive sponsorship, divisional leadership, corporate Quality and Patient Safety support, specialist group input, Aneurin Bevan Continuous Improvement expertise, Business Intelligence and Qlik

development support, Digital, Data and Technology input, patient experience and learning routes, and established governance capacity through the Quality Management Group, Executive Team, Patient Quality, Safety and Outcomes Committee and Board. Where gaps in capacity, capability or sequencing affect delivery, these will be escalated so that priorities can be adjusted, support can be targeted and expectations remain realistic.

Progress will be measured through quarterly review of the roadmap, maturity reassessment, action closure, evidence of learning and improvement impact, and triangulated quality intelligence. Patient, family, staff and community insight will be considered alongside incidents, concerns, mortality, safeguarding, infection prevention and control, workforce, operational performance, inequalities and experience data to ensure that assurance reflects the lived experience of care as well as organisational performance information.

8. Key Organisational Development Commitments for 2026/27

- Embed the Quality Management System as the Health Board's operating system for quality, connecting planning, control, assurance and improvement rather than treating it as a corporate reporting process.

- Implement a clearer accountability model so that divisions, specialist groups, corporate teams and Executives can describe their responsibilities for quality intelligence, risk, learning and improvement.

- Refine the Quality Outcomes Framework and use Qlik more consistently so that quality intelligence is timely, exception based, outcome focused and actionable.

- Develop the Quality Management Group as the executive forum for Quality Management System oversight, system learning, triangulated assurance, escalation and improvement follow-through.

- Complete a pragmatic Quality Management System maturity assessment and use it to drive divisional and organisational action plans, recognising that different parts of the system are at different levels of maturity.

- Build a closed-loop organisational learning system that demonstrates how learning from incidents, complaints, audit, patient experience, staff voice and excellence changes practice and reduces recurrence.

- Strengthen improvement capability and measurement literacy across the organisation, enabling staff to interpret variation, use data safely, and ensure improvement is prioritised, measured and sustained.

- Establish clear arrangements for agreeing, coordinating and overseeing improvement priorities, ensuring improvement activity is aligned to Health Board strategic objectives, focuses on areas of greatest impact, and maximises the effective use of organisational resources, expertise and learning.

- Strengthen safety culture and involvement by ensuring patient, family, staff and community insight informs quality planning, assurance and improvement.

9. Conclusion

ABUHB is in a strong but not yet fully embedded position. The Health Board has established the key architecture for a Quality Management System, including the Quality Management Group, Quality Outcomes Framework, Qlik development, divisional assurance and corporate Quality and Patient Safety support. The next stage is to mature those arrangements into a reliable operating system that gives clearer line of sight from ward to Board, converts intelligence into action and demonstrates whether learning and improvement are changing outcomes.

The 2026/27 development plan recognises progress while identifying gaps in triangulation, outcome measures, learning, spread, data interpretation, frontline articulation and accountability. This balanced position gives Welsh Government, NHS Wales Performance and Improvement, the Executive Committee and the Public Board a credible account of the Health Board's next phase of Quality Management System maturity. Delivery of this roadmap will support ABUHB to meet the Duty of Quality, align with national patient safety expectations and provide evidence-based assurance that quality is being planned, controlled, improved and assured across the Health Board.

Appendix A: Evidence Base Used to Inform the Submission

The submission has been informed by national requirements, Welsh legislation, NHS Wales patient safety and Quality Management System expectations, ABUHB Quality Management Group materials, Quality Management Framework review information, internal workshop feedback, Qlik development evidence, maturity matrix materials and the earlier ABUHB draft organisational development plan. Hyperlinks and link text have been removed from this final submission version to ensure the document is suitable for Welsh Government, NHS Wales Performance and Improvement, ABUHB Executive Committee and Public Board audiences.

Evidence source type	Evidence used	Influence on final submission
National requirement	QMS Organisational Development Plan Guide January 2026.	Set the submission structure and minimum content expectations.
Legislation and national policy	Health and Social Care (Quality and Engagement) (Wales) Act 2020 and NHS Wales Quality Management System expectations.	Anchored the plan in the Duty of Quality, Duty of Candour and national quality expectations.
National patient safety	National Patient Safety Plan for NHS Wales 2026 to 2031.	Strengthened the alignment to listening, leadership, learning, Quality Management System development and safety culture.
ABUHB evidence	Quality Management Group July 2026 materials and Quality Management Framework review evidence.	Added specificity on governance, Quality Outcomes Framework refinement, Qlik maturity, divisional assurance and ward to Board line of sight.
Workshop evidence	Internal workshop evidence on the Quality Management System and Quality Plan.	Informed the candid current state assessment and roadmap priorities.
Maturity approach	Quality Management System maturity matrix materials.	Provided the proposed maturity assessment approach and language for established, developing and immature areas.

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	06 October 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Clinical Audit Framework and Annual Corporate Clinical Audit Plan 2026/27
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr Seema Srivastava, Executive Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to present the Corporate Clinical Audit Framework and Annual Corporate Clinical Audit Plan 2026/27 to the Patient Quality, Safety and Outcomes Committee for scrutiny and assurance.

The Framework establishes a consistent, risk-informed approach to the selection, prioritisation, delivery, reporting and follow-up of Corporate Clinical Audit across Aneurin Bevan University Health Board. It brings together the enduring governance framework and the proposed 2026/27 Corporate Clinical Audit Plan within a single controlled document.

The Framework positions Corporate Clinical Audit as a systematic quality-improvement process that measures clinical practice against explicit standards,

identifies variation and non-compliance, supports improvement action and uses re-audit or another agreed follow-up method to establish whether improvement has been achieved and sustained. It also makes clear that Corporate Clinical Audit informs organisational assurance but does not provide an independent audit opinion equivalent to Internal Audit, Audit Wales or Healthcare Inspectorate Wales.

The proposed 2026/27 plan contains the planned Corporate Clinical Audits, with two additional audits identified for consideration should capacity become available. The programme remains subject to formal approval, final clinical scoping and verification of relevant risk references and mandatory requirements.

Cefndir / Background

The Health Board requires a clear and consistent approach to Corporate Clinical Audit so that finite audit capacity is directed towards areas of greatest clinical, organisational and patient-safety significance.

The Framework has been developed to:

- focus corporate audit capacity on issues of corporate significance and cross-organisational concern;
- complement, but not replace, Local and Divisional Clinical Audit or mandatory participation in National Clinical Audits;
- establish a transparent Corporate Clinical Audit Universe;
- introduce a structured, weighted and risk-informed prioritisation methodology;
- clarify Executive, clinical, service and corporate responsibilities;
- define the full audit lifecycle, from proposal and scoping through to action monitoring, evidence-based closure and re-audit;
- strengthen the reporting and escalation of significant findings, persistent non-compliance and overdue actions; and
- ensure that reporting demonstrates what was found, what changed and whether improvement has been sustained.

The governance model retains clinical ownership and responsibility for improvement actions within the relevant Division, Directorate or service. The Corporate Clinical Audit Team coordinates methodology, programme delivery, reporting, action monitoring and escalation. Routine management oversight is proposed through the Quality Management Group, while PQSOC will scrutinise material findings, patient impact, improvement action and evidence of sustained change.

The Framework also proposes twice-yearly reporting to the Audit, Risk and Assurance Committee on programme delivery, performance, risks and the governance of the Corporate Clinical Audit Programme. The precise routine oversight route between the Clinical Standards and Effectiveness Group and the

Quality Management Group, together with the formal approval route for the Framework and Annual Plan, requires confirmation before final approval.

Asesiad / Assessment

The framework provides:

A clearer and more robust governance framework has been established. The Framework defines the respective responsibilities of the Executive Medical Director, Assistant Director for Quality and Patient Safety, Corporate Clinical Audit Team, Executive sponsors, clinical leads, services and action owners. It confirms that responsibility for operational improvement remains with the relevant service and is not transferred to the Corporate Clinical Audit Team through audit registration or reporting.

The proposed programme is explicitly risk-informed. Potential audit topics will be assessed against patient safety, serious incidents and complaints, statutory or regulatory requirements, performance concerns, Executive or Committee requests, evidence gaps, national priorities, external review findings, corporate or strategic risks, previous audit results and the time elapsed since the previous audit. Greater weighting is applied to patient safety, mandatory requirements and material organisational

The scoring methodology supports transparent decision-making but does not replace professional judgement. Audit topics are scored against 11 criteria, producing a priority score out of 100. Scores will inform programme selection alongside the suitability of Clinical Audit as the methodology, the availability of measurable standards, the reliability of intelligence, potential duplication, data feasibility, capacity, dependencies, re-audit commitments and emerging risks. Any departure from the ranked order will require a documented rationale and approval through the agreed governance route.

The proposed core programme provides a minimum of ten Corporate Clinical Audits. The planned topics are Decision Making and Consent; DNACPR; NG Tube; Coroner Discharge Notifications; Coroner Death Notifications; Seven-day Rolling Re-admission Rate; Consent for Blood Transfusion; Medicines Documentation and Storage in Mental Health; Learning from Serious Incidents in Neonates; and the Deteriorating Patient.

The programme reflects known quality, safety and assurance priorities. The proposed audits include areas linked within the draft to legal or mandatory requirements, Healthcare Inspectorate Wales findings, external scrutiny, evidence gaps and corporate risks outside appetite. However, the Framework appropriately requires risk reference numbers and any description of an audit as mandated to

be verified against current sources before approval. Additional audits can be identified, if there is capacity to undertake these.

Audit completion will no longer be defined solely by the issue of a report. Completion requires proportionate improvement actions, named owners, agreed dates, evidence-based closure and re-audit or another agreed follow-up method where appropriate. Actions will be reported as open, in progress, overdue, reprofiled, awaiting evidence or closed under defined closure categories.

The escalation arrangements are proportionate to clinical significance. Significant findings, including failure against critical standards, actual or potential serious harm, statutory or regulatory non-compliance, widespread failure or repeated failure despite previous action, will require prompt notification, immediate safety measures where necessary, a SMART improvement plan and escalation to PQSOC where material.

The Framework has a clear person-centred and equitable focus. Audit scoping and interpretation will consider patient experience, accessibility, equality, Welsh-language needs and variation between populations where relevant. The Audit Universe includes safe, effective, equitable, person-centred, timely and efficient care.

There are risks to successful delivery. These include limited corporate or clinical capacity, poor data access or quality, unclear ownership, competing urgent requests, weak evidence supporting action closure, failure to undertake re-audit, duplication with other review activity, information-governance failure and ambiguity in governance routes. The Framework sets out corresponding controls, including annual capacity assessment, core and reserve programmes, named owners, evidence-based closure, early data testing, controlled reprioritisation and escalation through established governance arrangements.

Overall, the Framework provides a more systematic and transparent basis for Corporate Clinical Audit. It strengthens the connection between audit selection, organisational risk, clinical ownership, improvement action, evidence-based closure and sustained impact. The proposed governance arrangements also give PQSOC a clearer basis on which to scrutinise material findings, patient impact and whether agreed improvements have been implemented and sustained.

Argymhelliad / Recommendation

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

- **NOTE** the development of the draft Corporate Clinical Audit Framework and the proposed Annual Corporate Clinical Audit Plan 2026/27.

- **SUPPORT** the principles and governance arrangements set out within the Framework, including risk-informed prioritisation, clear clinical ownership, SMART improvement actions, evidence-based closure and re-audit or alternative follow-up where appropriate.
- **RECEIVE ASSURANCE** that the proposed Framework establishes a structured approach through which Corporate Clinical Audit findings, material non-compliance, associated patient-safety risks, improvement actions and evidence of sustained change will be monitored and escalated.

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 prrioritise 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:	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.

Corporate Clinical Audit Framework

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Annual Corporate Clinical Audit Plan 2026/27

This document combines the enduring governance framework with the annually refreshed Corporate Clinical Audit Plan.

Appendix E may be updated annually through the approved governance route without rewriting the whole Framework.

Contents:

Executive Summary
1. Introduction
2. Purpose and Scope
3. Strategic Alignment and Principles
4. Governance, Accountability and Responsibilities
5. Corporate Clinical Audit Universe
6. Developing the Annual Corporate Clinical Audit Programme
7. Corporate Clinical Audit Delivery Lifecycle
8. Findings, Improvement Actions and Follow-Up
9. Reporting, Escalation and Learning
10. Programme Management, Resources and Capacity
11. Digital Systems, Data Quality and Information Governance
12. Key Performance Indicators and Measures of Impact
13. Risks to Delivery and Mitigating Actions
14. Annual Programme Review
15. Conclusion
16. References
17. Appendices

Appendix A: Roles and Responsibilities Matrix

Appendix B: Corporate Clinical Audit Universe

Appendix C: Prioritisation and Scoring Methodology

Appendix D: Glossary

Appendix E: Annual Corporate Clinical Audit Plan 2026/27

EXECUTIVE SUMMARY

Corporate Clinical Audit is a systematic quality-improvement process that measures clinical practice against explicit standards, identifies variation and non-compliance, supports improvement action and uses re-audit or another agreed follow-up method to determine whether improvement has been achieved and sustained.

The Framework:

- Focuses finite corporate capacity on matters of organisational significance and cross-Health Board concern;
- Complements, but does not replace, Local or Divisional Clinical Audit and mandatory National Clinical Audit participation;
- Establishes a transparent Audit Universe and risk-informed prioritisation process;
- Clarifies clinical ownership, action ownership and corporate coordination;
- Defines the complete lifecycle from proposal and approval to evidenced closure and follow-up;
- Establishes the approved digital system as the definitive programme record; and,
- Requires reporting to demonstrate what was found, what changed and whether improvement was sustained.

1. INTRODUCTION

The Health Board requires a consistent approach to selecting, delivering, reporting and following up Corporate Clinical Audit. This Framework establishes the methodology, governance, accountability and risk-based planning arrangements for the corporate programme.

Corporate Clinical Audit examines matters of organisational significance where consistent measurement is required across services, Divisions, sites or professional boundaries.

Success is not measured by participation or report production alone. It requires reliable evidence, clear ownership, implementation of improvement actions and

proportionate follow-up that demonstrates impact on practice and patient care.

2. PURPOSE AND SCOPE

2.1 Purpose

The purpose of Corporate Clinical Audit is to improve the quality and safety of care by:

- Evaluating practice against recognised standards,
- Identifying required improvement, supporting implementation and determining whether change has been achieved and sustained;
- Measure compliance with explicit clinical standards;
- Identify unwarranted variation, risk, non-compliance and good practice;
- Provide evidence for quality management, clinical governance and organisational decision-making;
- Support review of strategic and corporate risks and patient-safety priorities;
- Produce SMART actions with named owners, dates and evidence requirements;
- Monitor, escalate and evidence closure of actions; and
- Share learning and good practice across services.

2.2 Scope and Boundaries

Corporate Clinical Audit focuses on matters of corporate significance. It may examine an issue across more than one Division, Directorate, site, pathway or service; respond to a material quality or patient-safety concern; or provide consistent measurement where a Health Board-wide view is required.

It does not remove responsibility from services for local governance, clinical ownership, action delivery or participation in National Clinical Audit.

Activity	Primary purpose	Governance boundary
Corporate Clinical Audit	Measurement against explicit standards for a matter of corporate significance.	Coordinated by the Corporate Clinical Audit Team; clinical ownership and action delivery remain with the relevant service.

Activity	Primary purpose	Governance boundary
Local / Divisional Clinical Audit	Measurement against standards to improve care within a service, Directorate or Division.	Authorised and governed locally. Registration does not transfer ownership to the corporate team.
National Clinical Audit	Participation in a nationally specified audit or outcome-review programme.	National methodology applies; local participation, data quality, action and governance remain necessary.
Service evaluation	Assesses how well a current service is operating, without necessarily testing explicit external standards.	Managed through the relevant service and governance arrangements.
Quality improvement	Tests and implements changes intended to improve care.	Owned by the service or improvement programme; audit may identify need or measure impact.
Research	Generates new, generalisable knowledge.	Governed through Research and Development and ethics arrangements where applicable.
Independent assurance	Independent review of governance, risk management and control.	Outside Corporate Clinical Audit and may provide formal assurance opinions.

Classification will be determined by the activity's primary purpose, scope, methodology and governance requirements. Advice must be sought before work begins where classification is uncertain.

3. STRATEGIC ALIGNMENT AND PRINCIPLES

Corporate Clinical Audit forms part of the Health Board's Quality Management System and aligns with the:

- Duty of Quality;
- Quality Strategy;
- Integrated Medium-Term Plan; and,

- Risk-management arrangements.

Alignment will be evidenced for each audit and will not be described as legal or regulatory compliance unless the applicable requirement has been verified.

Principle	Requirement
Person-centred and equitable	Consider patient experience, accessibility, equality, Welsh-language needs and relevant population variation.
Standards-based	Use explicit, accepted criteria and define the expected level of compliance.
Risk-informed and proportionate	Reflect clinical significance, evidence gaps, feasibility and available capacity.
Clinically owned	Identify an Executive sponsor and clinical/service lead; services retain ownership of actions.
Transparent	Record selection decisions, methodology, limitations, findings, actions and closure evidence.
Improvement-focused	Seek safer, more effective and consistent care, not simply completion of a report.
Evidence-led	Use validated data, report limitations and avoid unsupported conclusions.
Complete-cycle	Require action, evidence-based closure and follow-up or re-audit where appropriate.
Clear assurance boundary	Inform assurance without issuing an independent assurance rating.

4. GOVERNANCE, ACCOUNTABILITY AND RESPONSIBILITIES

4.1 Accountability

The Executive Medical Director is accountable for ensuring appropriate Clinical Audit arrangements are in place.

The Assistant Director for Quality and Patient Safety provides senior operational leadership.

The Corporate Clinical Audit Team coordinates the programme.

The audited Division, Directorate or service retains clinical ownership and responsibility for implementing and evidencing actions.

4.2 Assurance model

Level	Role
Service and Divisional ownership	Identify local requirements, deliver Local and Divisional audits, participate in National Clinical Audits, review findings, implement actions, evidence impact, manage associated risks and escalate significant themes.
Corporate oversight and challenge	Set minimum requirements; coordinate the corporate programme; monitor participation, findings, actions and re-audit; assess information quality; triangulate themes with wider quality and risk intelligence; and escalate systemic concerns.
Independent assurance	Internal Audit, Audit Wales, Healthcare Inspectorate Wales and other independent bodies may assess the adequacy and effectiveness of the Clinical Audit system and related controls.

4.3 Governance and Reporting Route

Each audit will be reported to the governance forum best placed to scrutinise its subject matter, findings and improvement plan. The reporting route will be agreed in the audit protocol and aligned with the Quality Management Framework.

Area / Forum	Responsibilities
Audited service or Division	Owns the response, actions, evidence and related risk management.
Clinical Standards and Effectiveness Group	Scrutinises clinical standards, clinical-effectiveness findings and learning where within its remit.
Quality Management Group	Provides routine management oversight of programme delivery, themes, actions and risks.
Patient Quality, Safety and Outcomes Committee	Scrutinises material findings, patient impact and sustained improvement.
Audit, Risk and Assurance Committee	Receives periodic assurance on the adequacy, delivery and governance of the Corporate Clinical Audit system; it is not part of the routine operational reporting chain.
Board	Receives material escalations and organisational assurance through the approved committee architecture.

Further detail is set out in Appendix A.

5. CORPORATE CLINICAL AUDIT UNIVERSE

The Corporate Clinical Audit Universe at Appendix B identifies potential areas for corporate audit across the six Duty of Quality domains. It is the population from which priorities may be selected and is distinct from the Annual Corporate Clinical Audit Plan.

Inclusion in the Universe does not mean that every topic requires a separate audit, annual review or corporate response. A topic will be considered for the annual programme only where Clinical Audit is an appropriate method and explicit standards and measurable data are available. Topics have one primary domain for counting and planning purposes; relevant secondary domains may be recorded during scoping.

The Universe will be reviewed at least annually and when a material new concern emerges. Changes will reflect current risks, standards, audit findings, evidence

gaps, national requirements and organisational priorities.

6. DEVELOPING AND PRIORITISING THE ANNUAL PROGRAMME

6.1 Sources of Intelligence

Source	Examples
Strategic and planning frameworks	IMTP, Welsh Government priorities, Health Board objectives and Duty of Quality priorities.
Risk profiles	Strategic and Corporate Risk Registers and material Divisional or Directorate risks.
Standards and guidance	National clinical standards, NICE guidance, professional standards and National Clinical Audit requirements.
Independent findings	Audit Wales, Internal Audit, Healthcare Inspectorate Wales, Welsh Risk Pool and other external reviews.
Clinical governance intelligence	Incidents, mortality, complaints, claims, patient experience, performance and emerging themes.
Requests and evidence gaps	Executive or Committee requests and absence, weakness or age of evidence that standards are being achieved.

6.2 Prioritisation Methodology

Potential topics will be scored against the 11 weighted criteria in Appendix C.

Each criterion is scored from 0 to 5 and multiplied by its weighting. The weighted total is converted to a score out of 100 to provide a transparent basis for comparison.

The score informs, but does not solely determine, inclusion. The Corporate Clinical Audit Team will also assess:

- Whether Clinical Audit is the appropriate method;

- Availability of explicit standards and reliable data;
- Duplication with existing Local, Divisional, National or independent review activity;
- Corporate Clinical Audit Team and service capacity;
- Feasibility, dependencies and timing;
- Existing re-audit commitments; and
- The need to respond to urgent or emerging risk.

Scores will be moderated through a multidisciplinary process. Any decision to include a lower-scoring topic, defer a higher-scoring topic or depart from ranked order will have a documented rationale and approval through the agreed governance route.

6.3 Determining Programme Coverage and Size

The size of the Annual Corporate Clinical Audit Plan will be informed by the prioritised Audit Universe, rather than being determined solely by a fixed annual target.

Following scoring and moderation, topics will be grouped according to their relative priority. Consideration will then be given to the appropriate review cycle for each topic, taking account of:

- the significance and immediacy of the risk;
- the strength, scope and age of existing assurance;
- previous Clinical Audit findings and evidence of sustained improvement;
- statutory, regulatory or national requirements;
- emerging quality and patient-safety concerns;
- whether Corporate Clinical Audit is the most appropriate methodology; and
- the availability and reliability of standards and data.

This assessment will be used to estimate the level of annual audit coverage required across the Universe. It will be considered alongside existing re-audit commitments, urgent or emerging priorities, work carried forward from the previous year and the capacity of the Corporate Clinical Audit Team and participating services.

The proposed Annual Plan will state:

- the number of new corporate audits proposed;

- the number of re-audits and follow-up reviews required;
- the priority profile of the selected topics;
- the proportion of the eligible Audit Universe receiving coverage;
- any higher-priority topics not included and the reason for deferral; and
- any gap between the assessed level of audit need and available capacity.

The 2026/27 Corporate Clinical Audit Plan is set out in Appendix E.

6.4 Rolling Forward Programme

The Health Board will move towards a rolling three-year approach to Corporate Clinical Audit planning. This will support broader and more systematic coverage of the Corporate Clinical Audit Universe, enable re-audits and follow-up activity to be planned, and help identify future capacity and resource requirements.

The rolling programme will be developed following completion of the prioritisation, moderation and capacity assessment processes set out in this Framework. Potential topics will be reviewed annually against current risks, national requirements, previous audit findings, available assurance and emerging organisational priorities.

Future-year priorities will be developed through the agreed methodology and presented through the relevant governance arrangements. Reference to potential future audits will not constitute approval or a commitment to delivery.

7. CORPORATE CLINICAL AUDIT DELIVERY LIFECYCLE

The steps within the corporate clinical lifecycle are set out below and described under in more details under sections 7.1, 7.2 and 7.3.

1. **Proposal and initial assessment.**
2. Classification, screening and prioritisation.
3. Approval and appointment of Executive and clinical leads.
4. Scoping, protocol, standards, methods and data sources.
5. Information-governance, patient, equality and Welsh-language considerations.
6. **Fieldwork and data collection.**

7. Validation and quality assurance.
8. Analysis against each standard and assessment of variation.
9. Stakeholder factual validation.
10. **Final report and SMART improvement plan.**
11. Action monitoring and escalation.
12. Evidence-based closure.
13. Re-audit or agreed alternative follow-up.
14. Impact, sustainability, learning and programme review.

7.1 Scoping and Protocol

Before fieldwork, each audit will have an Executive sponsor, clinical/service lead, Corporate Clinical Audit Team coordinator and agreed stakeholders. The protocol will define the objective, scope, inclusion and exclusion criteria, standards, target compliance, sample rationale, methodology, data sources, timetable, governance route, information-governance controls and follow-up expectations.

Services will contribute operational expertise. The Corporate Clinical Audit Team will retain responsibility for agreeing a consistent and proportionate methodology in collaboration with the clinical lead.

7.2 Fieldwork, Analysis and Validation

Data will be collected using the approved tool and protocol. Proportionate quality checks will address completeness, consistency, duplicates, source verification and exclusions. Quantitative findings will normally report the numerator, denominator, percentage compliance, required standard and whether it was met.

Qualitative evidence may be used where professional judgement or narrative evidence is necessary.

Draft findings will be validated with relevant clinical and operational stakeholders. Factual corrections, additional evidence, limitations and disputed interpretations will be documented. Evidenced non-compliance will not be removed because it is unwelcome.

7.3 Implementation and Completion

An audit is not complete when the report is issued. Completion requires proportionate actions, monitoring of implementation, evidence-based closure and re-audit or another agreed follow-up method where required.

8. FINDINGS, IMPROVEMENT ACTIONS AND FOLLOW-UP

8.1 Findings and Reports

Findings will be reported against each agreed standard and will identify material variation, good practice, limitations and the clinical significance of gaps. Reports will not use Internal Audit-style assurance ratings unless separately approved for a defined purpose.

Finding type	Definition	Required response
Significant finding	Failure against a critical standard; actual or potential serious harm; statutory or regulatory non-compliance; systemic failure; or repeated failure despite previous action.	Prompt Executive and governance notification; immediate safety measures where required; SMART action plan; escalation to PQSOC where material.
Other non-compliance	Gap against an agreed standard that does not meet the significant-finding threshold.	Proportionate SMART action, named owner, timescale, evidence and monitoring route.
Good practice	Practice that meets or exceeds expected standards and may support wider learning.	Share through appropriate local and organisational routes.

8.2 Actions and Closure

Each action will be specific, measurable, achievable, relevant and time-bound, with a named owner, accountable service, due date, expected evidence, intended measure of improvement and escalation route.

The audited service owns implementation; the Corporate Clinical Audit Team coordinates monitoring and escalation.

Status	Definition
Open	Agreed action not yet evidenced as complete.
In progress	Implementation has begun and remains within the agreed date.
Overdue	The agreed date has passed without approved completion evidence.
Reprofiled	A revised date has been authorised with a recorded rationale and risk assessment; the original date remains visible.
Awaiting evidence	Completion is reported, but sufficient evidence has not been validated.
Closed: implemented	Proportionate evidence confirms implementation.
Closed: impact demonstrated	Follow-up or re-audit demonstrates the intended improvement.
Closed: alternative decision	The action is no longer appropriate, with documented clinical and governance approval.

An action will not be closed solely on an owner's statement. Where the intended effect must be demonstrated, implementation evidence alone is insufficient.

8.3 Re-Audit and Sustained Improvement

Each report will state whether re-audit is required and identify the scope, timing and owner. Re-audit may focus on the standards and risks requiring follow-up. Where re-audit is not appropriate, an alternative measure and rationale will be recorded. Sustainability will be tested over a clinically meaningful period where proportionate.

9. REPORTING, ESCALATION AND LEARNING

9.1 Individual Audit Report

Each report should include the following information as a minimum:

- purpose, scope and governance route;
- standards, target compliance and methodology;
- sample, data sources, exclusions and limitations;
- quantified findings against each standard and relevant qualitative evidence;
- variation, good practice, clinical significance and risk links;
- SMART improvement plan; and
- re-audit or alternative follow-up requirement.

9.2 Programme Reporting

Routine programme reports will show core and reserve audits, milestones, delays, dependencies, findings, action status and ageing, re-audit, impact and risks to delivery. Historic open actions will remain visible until closed through the evidence standard in this Framework.

9.3 Escalation and Learning

Immediate safety concerns, material findings, repeated non-compliance, inadequate action plans, overdue significant actions, disputed ownership and programme delivery risks will be escalated through the agreed route. Immediate concerns must also be managed through existing patient-safety and risk processes and must not wait for the audit report.

Learning and good practice will be shared proportionately through governance forums, briefings, dashboards, bulletins, professional networks and improvement routes, with consideration of applicability to other services and protection of confidential information.

10. PROGRAMME MANAGEMENT, CAPACITY AND CHANGE CONTROL

The programme will be supported by an annual capacity assessment covering Corporate Clinical Audit Team availability, clinical and service input, analytical support, specialist advice, data access, digital readiness and follow-up commitments.

No fixed workforce establishment is specified because operational staffing may change.

A programme plan will identify milestones, dependencies and pressure points.

Urgent work may be added only through an explicit priority and capacity decision.

Significant changes, including addition or removal of an audit, material scope change, substitution or delay affecting agreed coverage, will be reported through QMG and PQSOC, with ARAC informed through programme assurance reporting where relevant.

11. DIGITAL SYSTEMS, DATA QUALITY AND INFORMATION GOVERNANCE

11.1 Definitive Record

AMaT will be used as the definitive record for Corporate Clinical Audit activity, subject to confirmation that it supports all required programme controls. Until full implementation is confirmed, any parallel records will be reconciled and the definitive source identified in each programme report.

The minimum record will include approval, status, leads, scope, standards, findings, actions, owners, due dates, evidence, escalation, re-audit, closure and impact.

11.2 Data Quality and Information Governance

Reports will describe data completeness, reliability, validation, exclusions and limitations. Audit activity will use the minimum necessary information, apply Health Board confidentiality and information-security requirements, ensure authorised access and secure storage, and escalate information-security incidents through existing procedures.

12. KEY PERFORMANCE INDICATORS AND MEASURES OF IMPACT

Performance measures will balance programme control with evidence of benefit. Targets will be approved with the Annual Plan and will not be carried forward without review.

Measure	Purpose
Delivery against milestones	Demonstrates programme control.
Reports scrutinised through the agreed route	Demonstrates completion of reporting obligations.
Action status, ageing and significance	Shows follow-through and visibility of residual risk.
Re-audit completed by agreed date	Shows completion of the audit cycle.
Change in compliance against standards	Shows whether measured practice improved.
Outcome and balancing measures	Shows whether intended benefit occurred without unacceptable effects.
Sustained improvement	Shows whether change was embedded.
Learning disseminated and adopted	Supports organisational learning.
Relevant variation reviewed	Tests whether aggregate improvement masks inequality.

Each completed audit will state the baseline, expected improvement, actions, post-implementation measure, remaining gaps and further follow-up. Where patient outcomes cannot reasonably be measured within the period, justified process and balancing measures may be used.

13. RISKS TO DELIVERY AND MITIGATING ACTIONS

Risk	Potential effect	Control
Insufficient capacity	Delay, reduced scope or incomplete follow-up.	Annual capacity assessment, core and reserve programme, explicit reprioritisation.

Poor data access or quality	Unreliable findings or delay.	Early testing, validation, analytical support and clear limitation reporting.
Unclear ownership	Actions not implemented.	Named Executive, clinical and action owners and escalation of disputed ownership.
Competing urgent requests	Approved programme displaced.	Controlled out-of-cycle process and recorded decision.
Weak completion evidence	Premature closure.	Evidence-based closure and validation.
Failure to re-audit	No evidence of improvement.	Follow-up decision in every report and programme monitoring.
Duplication	Waste and stakeholder burden.	Screen against local, national and independent review programmes.
Information-governance failure	Confidentiality or security risk.	Minimum necessary data, controlled access and existing incident procedures.
Unclear governance route	Delayed or duplicated scrutiny.	Confirm route in the protocol and reflect it in programme reporting.

14. ANNUAL REVIEW

At year end, the Assistant Director for Quality and Patient Safety will provide an assessment of programme delivery and impact. It will cover audits delivered, deferred or cancelled; findings; action status and ageing; re-audit; demonstrated and sustained improvement; learning; capacity; data limitations; changes to the Universe; and recommendations for the next programme.

The annual review will inform programme development, risk review, quality priorities and relevant governance reporting. It will not provide an independent overall opinion on the adequacy or effectiveness of the Health Board’s governance, risk management or control environment.

15.CONCLUSION

This Framework establishes a proportionate, clinically owned and improvement-focused approach to Corporate Clinical Audit. Its effectiveness depends on transparent selection, reliable standards and data, clear action ownership, disciplined follow-up and evidence that change has improved care.

The Annual Plan at Appendix C applies these requirements to 2026/27 and will be refreshed and approved annually.

16. REFERENCES

- Duty of Quality and Health and Care Quality Standards materials applicable to NHS Wales.
- Health Board Quality Strategy, Quality Management Framework and Integrated Medium-Term Plan.
- Relevant National Clinical Audit, professional, regulatory and clinical standards identified in each audit protocol.
- Aneurin Bevan University Health Board Clinical Audit Policy.
- Aneurin Bevan University Health Board Clinical Audit Strategy 2023–2026 and subsequent approved Strategic Aims for Clinical Audit 2026-2029.

17. APPENDICES

Appendix A: Roles and Responsibilities Matrix

Appendix B: Corporate Clinical Audit Universe

Appendix C: Prioritisation and Scoring Methodology

Appendix D: Glossary

Appendix E: Annual Corporate Clinical Audit Plan 2026/27

Appendix A: Roles and Responsibilities Matrix

Role	Accountable / responsible for	Not responsible for
Board	Overall quality governance and consideration of material assurance and risk through committee arrangements.	Operational delivery of individual audit actions.
Executive Medical Director	Ensuring appropriate clinical-audit arrangements and executive accountability for the programme.	Independent audit opinion.
Assistant Director for Quality and Patient Safety	Senior operational leadership, programme development, and escalation.	Owning service actions.
Corporate Clinical Audit Team	Programme coordination, methods, fieldwork support, records, reporting, action monitoring, and escalation.	Implementing operational actions belonging to audited services.
Executive sponsor for an audit	Senior sponsorship, removal of barriers and escalation.	Substituting for the clinical/service owner.
Clinical/service lead	Clinical scope, standards, stakeholder engagement, interpretation, and response.	Transferring clinical accountability to the audit team.
Division / Directorate / service	Resources, access, factual validation, action implementation, evidence, and local governance.	Treating registration as transfer of ownership.
Action owner	Delivering the assigned SMART action and evidence by the agreed date.	Self-authorising closure without validation.

Role	Accountable / responsible for	Not responsible for
CSEG / QMG	Functions described in Appendix F, subject to final approved route.	Independent audit opinion.
PQSOC	Scrutiny of quality, safety, outcomes, learning and improvement.	Routine operational action management.
ARAC	Oversight of the audit system, risk alignment, delivery and open-action visibility.	Clinical ownership or independent rating by the Corporate Clinical Audit Team.

Appendix B: Corporate Clinical Audit Universe

The Universe contains 100 distinct topic areas, each assigned to one primary domain for planning and counting purposes. Secondary domain links may be recorded when an audit is scoped.

Domain & Objective	Topic Areas
Safe Care (30) Measuring practice against explicit standards to identify and reduce avoidable harm.	Deteriorating Patient (NEWS2)
	Sepsis
	Falls Prevention
	Pressure Ulcers
	Venous Thromboembolism (VTE)
	Patient Identification
	Safeguarding Adults
	Safeguarding Children
	Mental Capacity Act
	Deprivation of Liberty Safeguards
	Resuscitation
	Infection Prevention & Control
	Healthcare Associated Infections
	Never Events
	Serious Incident Learning
	Harm Reviews
	Mortality Reviews
	Controlled Drugs
	High Risk Medicines
	Prescribing Safety
	Medicines Storage
	Blood Transfusion
	CTG Interpretation

Domain & Objective	Topic Areas
	Maternity Safety Standards
	Obstetric Emergencies
	Risk Assessment (Mental Health)
	Observation Standards
	Rapid Tranquillisation
	Professional Registration
	Clinical Competency Assessment
Effective Care (29) Measuring whether care is evidence-based and clinically effective, and identifying improvements needed to optimise outcomes.	NICE Compliance
	National Guidelines
	Clinical Pathways
	Care Bundles
	National Clinical Standards
	Royal College Standards
	Welsh Government Guidance
	Medicines Reconciliation
	Antimicrobial Stewardship
	Oxygen Prescribing
	Stroke Pathways
	STEMI Pathways
	Trauma Pathways
	Enhanced Recovery
	Diagnostic Quality
	Radiology Reporting Quality
	Endoscopy Standards
	Neonatal Care
	Perinatal Mortality Reviews

Domain & Objective	Topic Areas
	Paediatric Early Warning Score
	Immunisation
	Physical Health Monitoring in Mental Health Settings
	Community Rehabilitation
	Community Therapies
	Tissue Viability
	MDT Compliance (Cancer)
	SACT
	Radiotherapy
	Clinical Decision Support Systems
Equitable Care (10) Measuring whether patients receive fair access to services and consistent standards of care regardless of location, background or circumstances.	Cancer Pathways
	Non-reportable Waiting Lists
	Mental Health Crisis Access
	Paediatric Emergency Care
	Community IV Therapy
	District Nursing Services
	Community Falls Assessment
	Access to Diagnostics
	Compliance with National Standards Across Services
	Data Quality (supporting equity monitoring)
Person-Centred Care (11) Measuring whether care is respectful, compassionate and responsive to individual needs, preferences and values.	Consent
	Care Planning (Mental Health)
	Duty of Candour
	Complaints Learning
	Shared Decision Making

Domain & Objective	Topic Areas
	Communication Standards
	PROMs (Patient Reported Outcome Measures)
	PREMs (Patient Reported Experience Measures)
	Child Protection Documentation
	Breastfeeding Standards
	Surgical Documentation
Timely Care (12) Measuring whether patients receive the right care at the right time and identifying changes needed to minimise delay.	RTT Pathways
	Diagnostic Waiting Times
	Cancer Waiting Times
	Emergency Department Standards
	Ambulance Handover Performance
	Time Critical Pathways
	Radiology Reporting Times
	Pathology Turnaround Times
	Follow-up Waiting Lists
	Waiting List Validation
	Clinical Prioritisation of Referrals and Waiting Lists
	Deteriorating Patient Response Times
Efficient Care (8) Measuring whether resources are used effectively and services operate productively while maintaining quality and safety.	Theatre Productivity
	Day Surgery
	EPMA Utilisation
	Point of Care Testing
	Workforce Mandatory Training Compliance
	Clinical Supervision
	Appraisal

Domain & Objective	Topic Areas
	Surgical Pathway Efficiency

Appendix C: Prioritisation and Scoring Methodology

Each proposed audit topic will be scored from 0 to 5 against the criteria set out below. The raw score for each criterion will be multiplied by its agreed weighting, reflecting the relative significance of that criterion

The weighted scores will be totalled to produce an overall priority score out of 100. The overall score is divided by the combined weighting of 20. This will provide a consistent and transparent basis for comparing potential audit topics across the Corporate Clinical Audit Universe.

Domain	Weighting and Max Score	Criterion					
		5	4	3	2	1	0
Patient Safety	**×3 = 15**	Potential catastrophic or widespread harm	Potential major or significant harm	Moderate harm or recurring safety concern	Minor harm or limited concern	Minimal safety impact	No identified safety impact
Serious Incidents / Complaints / Claims	**×2 = 10**	Recurrent severe events or systemic failure	Multiple serious events or increasing trend	Recurring events or emerging trend	Isolated event	Rare events with no evident trend	None
Statutory / Regulatory Requirement	**×3 = 15**	Statutory or mandatory requirement with current non-compliance	Explicit regulator or Welsh Government requirement	National professional or clinical standard	Local mandatory policy requirement	Good-practice expectation	No requirement

Performance Concerns	**×2 = 10**	Sustained and worsening material failure	Repeated material failure against standards	Variable performance or recurring concern	Isolated or minor failure	Standard consistently met; validation may add value	No concern
Executive / Committee Request	**×1 = 5**	Time-critical Board, Chief Executive, PQSOC or ARAC request	Executive Director request	Divisional Director request	Clinical governance group request	Local clinical team request	No request
Evidence / Measurement Gap	**×2 = 10**	No reliable evidence that standards are being achieved	Limited evidence or a material measurement gap	Partial, outdated or inconsistent evidence	Generally adequate evidence with a minor gap	Recent, reliable and comprehensive evidence	No material evidence or measurement gap
National Priority	**×1 = 5**	Time-critical ministerial or national priority	Mandatory national programme	National improvement initiative	Regional priority	Local priority	No identified priority
External Review Findings	**×1 = 5**	Significant external finding requiring prompt action and follow-up measurement	Repeated or material external finding	Open recommendation or concern	Minor external finding	Closed issue where follow-up measurement may add value	No external finding

Corporate / Strategic Risk	**×2 = 10**	Strategic or Corporate Risk outside appetite	Strategic or Corporate Risk within appetite or material strategic objective	Divisional risk or cross-Directorate concern	Local service risk with wider relevance	Low local significance	No identified link
Previous Clinical Audit Results	**×2 = 10**	Poor compliance; actions not delivered or no re-audit	Low compliance or material actions outstanding	Mixed compliance or re-audit due	Broad compliance with minor actions	Strong recent compliance and actions complete	Current audit or reliable current evidence
Time Since Previous Audit	**×1 = 5**	Never audited or more than 5 years	4–5 years	2–4 years	1–2 years	Within the previous year	Currently under audit

Weighted score	Priority classification	Proposed treatment
75 to 100	**Priority 1**	Strong case for inclusion in the core Corporate Clinical Audit Programme
55 to 74	**Priority 2**	Consider for the core or reserve programme, subject to capacity and feasibility
35 to 54	**Priority 3**	Retain within the Audit Universe and monitor, or consider Divisional audit
0 to 34	**Priority 4**	No current requirement for Corporate Clinical Audit

Appendix D: Glossary

Term	Meaning
AMaT	Audit Management and Tracking system.
ARAC	Audit, Risk and Assurance Committee.
Audit Universe	The full population of potential Corporate Clinical Audit topics; not the annual programme.
Clinical Audit	Systematic review of care against explicit criteria, followed by improvement and further monitoring where indicated.
Corporate Clinical Audit	Clinical Audit of corporate significance, often cross-organisational or linked to material quality and safety concern.
CSEG	Clinical Standards and Effectiveness Group.
Executive sponsor	Executive leader supporting an individual audit and escalation of barriers.
QMG	Quality Management Group.
PQSOC	Patient Quality, Safety and Outcomes Committee.
QMS	Quality Management System.
Re-audit	Repeat measurement after action to determine whether improvement occurred and was sustained.
SMART	Specific, measurable, achievable, relevant and time-bound.
Welsh Risk Pool	NHS Wales risk-sharing and learning arrangements associated with claims and relevant standards.

Appendix E: Clinical Audit Plan 2026/27

The proposed programme of ten corporate clinical audits represents the initial delivery programme while the Audit Universe is fully scored, moderated and assessed against existing sources of assurance.

The application of this methodology will determine whether ten audits remains an appropriate minimum for future years or whether the proposed level of coverage should be revised.

Status: Proposed programme awaiting formal approval. The audit list below reflects the latest reconciled direction available in the source material. It distinguishes planned and reserve audits. Any change following final clinical scoping or formal approval must be recorded in programme control documentation.

Audit ID	Audit	Objective	Selection Rationale	Quarter
CA001	Decision Making & Consent	To measure compliance with legislative requirements, professional standards and Health Board policies for decision-making and consent, and identify improvements needed to support informed decisions about care and treatment.	Person-Centred Care Mandatory requirement with legal, ethical and patient-safety significance.	Q1
CA002	DNACPR	To measure whether DNACPR decisions are made, documented, reviewed and communicated in accordance with national guidance, legislation and Health Board policy, and identify any required improvement.	Safe and Person-Centred Care Mandatory requirement affecting lawful, ethical and consistently communicated decisions.	Q1

Audit ID	Audit	Objective	Selection Rationale	Quarter
CA003	NG Tube	To measure compliance with national safety standards for nasogastric tube insertion, placement verification and ongoing management, and identify action needed to reduce avoidable harm.	Safe Care Mandatory national safety requirement with potential for serious avoidable harm.	Q2
CA004	Discharge Notifications	To measure whether required notifications to the coroner following a patient's discharge are completed accurately, consistently and within agreed timescales, in accordance with the relevant procedure	Effective Care Concerns regarding the consistency and timeliness of notifications to the coroner and the associated legal and governance risks.	Q2
CA005	Death Notifications	To measure whether deaths meeting the criteria for referral to the coroner are identified, documented and notified accurately and within the required timescales, in accordance with statutory requirements and Health Board procedures.	Effective Care Linked to statutory death-reporting requirements and the need to ensure eligible deaths are identified, notified and reviewed appropriately.	Q2

Audit ID	Audit	Objective	Selection Rationale	Quarter
CA006	7-day Rolling Re-admission Rate	To measure compliance with agreed standards for identifying, recording and reviewing unplanned readmissions within seven days of discharge, and to identify improvements required to reduce avoidable readmissions.	Effective and Timely Care Early unplanned readmissions may indicate gaps in clinical management, discharge planning or continuity of care and require further review and improvement.	Q2
CA007	Consent Blood Transfusion	To measure whether informed consent for blood transfusion is obtained, documented and managed in accordance with legal requirements, national guidance and Health Board policy, and identify any required improvement.	Safe and Person-Centred Care Mandatory legal and national requirement for informed consent.	Q3
CA008	Medicines Documentation & Storage Mental Health	To measure compliance with legislation, professional standards and Health Board procedures for medicines prescribing, documentation, storage and management in Mental Health services, and identify action needed to reduce medication-related harm.	Safe Care HIW findings identify a priority need for measurement and improvement within Mental Health services.	Q3

Audit ID	Audit	Objective	Selection Rationale	Quarter
CA009	Learning from Serious Incidents Neonates	To measure whether agreed learning from serious neonatal incidents has been implemented and embedded in clinical practice, and identify further action needed to reduce recurrence and improve patient safety.	Safe Care CRR 002 is outside appetite, with significant concerns and external scrutiny in neonatal services.	Q4
CA010	Deteriorating Patient	To measure compliance with agreed standards for recognition, escalation and management of deteriorating patients, including NEWS2, escalation protocols and treatment-escalation planning.	Safe and Timely Care CRR 036 is outside appetite and the topic has significant patient-safety relevance.	Q4

Additional Audits for consideration if capacity is identified within the 2026/27 Plan			
Audit ID	Audit	Objective	Selection Rationale
CA TBC	Waiting List Harm Review Ophthalmology	To measure whether ophthalmology waiting-list harm reviews are completed consistently against agreed standards and support timely identification, prioritisation and management of patients at risk of harm.	Equitable and Timely Care Linked to SRR 005, CRR 011 and Audit Wales findings, with potential waiting-list harm.

CA TBC	Healthcare Acquired Infections Area TBC	To measure compliance with national and Health Board infection prevention and control standards, identify variation or non-compliance, and agree actions to reduce healthcare-associated infection.	Safe Care CRR 005 is outside appetite and there is a known area of concern requiring prompt corporate measurement and improvement.

Annual Plan control notes

"Proposed" does not mean formally approved. Approval decisions and any amendments must be recorded.

Executive and clinical leads marked TBC must be agreed before fieldwork.

The applicable standards, sample, data sources, dependencies, information-governance requirements and re-audit timetable will be defined in each audit protocol.

Reserve audits are not part of the committed programme unless formally activated through the programme-change process.

Risk reference numbers and any description of an audit as mandated must be verified against the current source before approval.

Agenda Item:

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	06 October 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Strategic Oversight of Clinical Audit 2026–2029
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr Seema Srivastava, Executive Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Stimpson – National 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

The refreshed Strategic Oversight of Clinical Audit 2026–2029 sets out the Health Board's approach to strengthening clinical audit as a core component of clinical effectiveness, quality assurance, improvement and organisational learning. It supersedes the Clinical Audit Strategy 2022–2025 and supports delivery of the Duty of Quality, the Health and Care Quality Standards, the Quality Outcomes Framework and Pillar Three, Clinical Effectiveness, within the Health Board's Pillars of Quality Programme.

The framework proposes a clear shift:

- From audit as activity to audit as intelligence.
- From participation to assurance.

- From recommendations to SMART improvement actions.
- From action tracking to evidence of impact.
- From compliance-focused reporting to demonstrable clinical effectiveness, learning and improved outcomes.

By 2029, the ambition is for clinical audit to be a mature, strategically aligned and digitally enabled function, embedded within business as usual and focused on whether audit activity has led to measurable and sustained improvement in patient care.

Cefndir / Background

The previous strategy established the foundations for a more systematic approach to clinical audit. This included scrutiny of national clinical audit findings, development of local and corporate audit programmes, registration of audit activity on the Audit Management and Tracking (AMaT) system, SMART action planning, Divisional governance oversight and reporting through the Clinical Standards and Effectiveness Group (CSEG).

Progress since 2022 includes:

- **Strengthened governance:** The Clinical Standards and Effectiveness Group has become the operational forum for scrutiny of national and local audit findings, risks, assurance levels and improvement actions, with established reporting through the Quality Management Group, Patient Quality, Safety and Outcomes Committee, Audit, Risk and Assurance Committee and Board.
- **Implementation of AMaT:** AMaT has been implemented as the Health Board's organisational system for audit registration, data collection, reporting, action planning and re-audit. The Clinical Audit Policy requires audits, results and SMART action plans to be recorded within the system.
- **Improved national audit oversight:** The Health Board has developed a more structured approach to participation in the National Clinical Audit and Outcome Review Plan, including Clinical Lead engagement, CSEG scrutiny, action planning, assurance ratings and risk consideration.
- **Development of corporate audit planning:** The Corporate Local Audit Framework and Plan 2026/27 introduces a more formal, risk-informed approach, with audit topics selected according to strategic priorities, risks, serious incidents, investigations, external requirements and areas for improvement.
- **Alignment with the Quality Management System:** Clinical audit contributes to quality planning, quality control, quality assurance and quality improvement by identifying priorities, testing standards, providing assurance and informing targeted change.

Despite this progress, challenges remain in relation to variable Divisional ownership, operational and central team capacity, national audit participation and

data quality, completion of action plans, consistent use of AMaT and the ability to demonstrate that audit has resulted in sustained improvement.

Asesiad / Assessment

The framework provides a stronger basis for moving clinical audit from a predominantly activity-based process to an integrated source of quality intelligence and Board assurance.

Clinical effectiveness and patient outcomes: Audit will be used to test whether care is evidence-based and aligned with recognised standards, identify unwarranted variation and determine where focused improvement is required. Success will be judged by implemented change, re-audit and evidence of improved care, rather than by the volume of audits completed.

Clearer line of sight from clinical services to Board: The proposed governance route moves from Clinical Services, Directorates and Divisional Quality and Safety Forums through CSEG, QMG, PQSOC and ARAC to Board. CSEG will provide clinical scrutiny; QMG will triangulate audit intelligence with wider quality information; PQSOC will consider quality, safety, outcome and improvement implications; and ARAC will oversee the robustness of clinical audit planning and governance arrangements.

Divisional ownership is fundamental: Divisions will be expected to develop risk-based audit plans, identify named clinical leads, oversee audit findings and actions through their governance arrangements, escalate risks and complete re-audit. This is necessary to reduce reliance on the central Quality and Patient Safety Team and embed clinical audit within routine clinical governance.

AMaT must become an assurance and learning platform: The next stage requires better use of AMaT, rather than simply increased usage. Priorities include stronger data quality, clearer dashboards, consistent assurance ratings, routine escalation of overdue and high-risk actions, standardised evidence for action closure and improved reporting of re-audit and impact.

National audit participation must be linked to action: Participation alone does not provide sufficient assurance. National audit findings will require timely clinical review, benchmarking, SMART actions, escalation of outliers, re-audit where required and evidence that learning has resulted in improvement.

Audit intelligence must be triangulated: Audit findings will be considered alongside Quality Outcomes Framework measures, incidents, Never Events, complaints, patient experience, mortality, claims, inquests, regulatory findings, clinical guidance and Divisional and corporate risks. This will strengthen the Health

Board's understanding of quality and support proportionate escalation and organisational learning.

Corporate audit should remain targeted and risk-based: The Corporate Clinical Audit Plan will focus on cross-cutting, high-risk or high-impact areas where corporate oversight is necessary, multiple Divisions are affected, external scrutiny exists or an assurance gap has been identified. It will complement, rather than replace, Divisional clinical audit programmes.

Delivery will require sustained organisational commitment: Operational pressures, central audit team capacity, multi-site complexity, data acquisition, administrative burden and competing clinical priorities have previously affected participation, ownership and completion of actions. The proposed model therefore depends upon visible Executive sponsorship, clear accountability and sufficient Divisional capacity to undertake audit activity and deliver improvement actions.

These seven strategic priorities for 2026–2029 are to strengthen clinical effectiveness; strengthen governance and assurance; deliver national audit excellence; develop AMaT as the audit intelligence platform; build workforce capability and audit culture; embed Divisional ownership; and demonstrate impact and learning.

Delivery will be phased across three years:

1. **Year One, foundation and standardisation:** finalise the governance model, approve the Corporate Clinical Audit Framework and Plan, standardise CSEG reporting, strengthen AMaT use, confirm Divisional planning expectations and improve escalation of overdue or high-risk actions.
2. **Year Two, maturity and triangulation:** connect audit intelligence with QOF, incidents, complaints, mortality, patient experience and risk, with audit becoming part of thematic quality intelligence and Divisional assurance.
3. **Year Three, impact and sustainability:** strengthen re-audit, outcome summaries, learning dissemination and Board assurance that audit has led to sustained improvement in care.

Argymhelliad / Recommendation

The Committee is asked to:

- Take assurance that the Strategic Oversight of Clinical Audit 2026–2029 provides a robust framework for clinical audit as a key component of the Health Board's Quality Management System, supporting clinical effectiveness, assurance, improvement and organisational learning.

- Note the strategic priorities for 2026–2029 and the planned transition from measuring audit activity to demonstrating assurance, learning, impact and improved patient outcomes.
- Take assurance regarding the governance and escalation arrangements that provide a clear line of sight from clinical services to Board through CSEG, QMG, PQSOC and ARAC.

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 prrioritise 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:	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.

Aneurin Bevan University Health Board

Medical Director's Quality and Patient Safety Team

Strategic Oversight of Clinical Audit 2026-2029:



Strategic Oversight of Clinical Audit 2026–2029

1. Executive summary

Clinical audit is a core enabler of clinical effectiveness, assurance, improvement and organisational learning. For 2026–2029, Aneurin Bevan University Health Board will move from a model that primarily demonstrates participation and activity, to one that demonstrates assurance, learning, measurable improvement and impact.

The *Strategic Oversight of Clinical Audit 2026–2029* refreshes and supersedes the Clinical Audit Strategy 2022–2025, positioning clinical audit as a core component of the Health Board's Quality Management System and an essential mechanism for quality assurance, improvement and organisational learning.

This update ensures alignment with the Duty of Quality, the Health and Care Quality Standards and the Quality Outcomes Framework. Furthermore, it supports the delivery of Pillar 3 (*Clinical Effectiveness*) within the Health Board's Pillars of Quality Programme by assuring the implementation of evidence-based practice, monitoring compliance with recognised standards, and driving measurable improvements in the quality and effectiveness of care.

The strategic shift is clear:

- From audit as activity to audit as intelligence
- From participation to assurance
- From recommendations to SMART improvement actions
- From action tracking to evidence of impact
- From compliance language to clinical effectiveness, learning and better outcomes

Clinical audit will support the Health Board to understand whether care is being delivered in line with evidence-based standards, where unwarranted variation exists, where risks require escalation, and where improvement is needed. It will be embedded within Divisional governance, reported through the Clinical Standards and Effectiveness Group (CSEG), triangulated through the Quality Management Group Pillar (QMG) reporting, and escalated through Patient Quality, Safety and Outcomes Committee (PQSOC), Audit, Risk and Assurance Committee (ARAC) and Board as appropriate.

The National Quality Outcomes Framework (QOF) emphasises Board assurance, system-level quality knowledge, and triangulation of data to support learning and improvement, which is directly aligned to the intended role of clinical audit in this strategic oversight document.

2. Looking back: what we achieved, 2022–2026

2.1 What the 2022–2025 strategy set out to achieve

The 2022–2025 Clinical Audit Strategy set a clear foundation for clinical audit as a mechanism to support quality, patient safety, patient experience, and clinical effectiveness. It described clinical audit as a quality improvement process, using the NICE definition of systematic review of care against explicit criteria, implementation of change, and further monitoring to confirm improvement. It also stated that clinical audit provides assurance of compliance with clinical standards, identifies and minimises risk, waste and variation, and improves quality of care and patient outcomes.

The strategy was built around four priorities: scrutiny of national clinical audit performance with robust improvement plans; Divisional identification of audits linked to quality and safety risk; support for trainees to undertake meaningful audits; and commissioning of audit by Health Board groups and committees where no other evidence of assurance exists. It also introduced a systematic approach to national audit governance: national reports and local results would be uploaded to AMaT, Divisions and Clinical Leads would be notified, action plans would be developed, findings presented to the Clinical Standards and Effectiveness Group, and risks considered for Divisional risk registers.

For local audit, the strategy expected Divisional Triumvirates to develop clinical audit programmes aligned to quality and safety priorities, including nationally reportable incidents, patient safety themes, clinical outcomes, new guidance, mortality reviews and morbidity and mortality learning. It required all audits to be registered on AMaT, monitored through appropriate quality and safety forums, and reported through Divisional governance, with biannual reporting to the Clinical Standards and Effectiveness Group. It also required SMART action planning and standardised reporting of good practice, areas for improvement and actions to be taken.

2.2 Progress made between 2022 and 2026

Since 2022, the Health Board has made progress in strengthening the infrastructure for clinical audit. The Clinical Standards and Effectiveness Group has become the operational forum for scrutiny of national clinical audit findings, local results, assurance levels, risks and improvement actions. The 2024/25 Annual Clinical Audit Plan describes the process from national report publication, engagement with the Clinical Lead, presentation at CSEG, agreement of SMART actions, recording on AMaT and onward presentation to Patient Quality, Safety and Outcomes Committee.

Governance has also matured. Clinical audit is now increasingly described as one input into the Quality Management System and as part of a wider system of clinical effectiveness, quality assurance and improvement. Clinical audit as one tool for assessing whether clinical services are safe and effective, and as an input into the QMS, with the forward plan intended to move from a description of activity towards assurance,

learning and improvement. There has been strengthened governance through CSEG, QMG, PQSOC and ARAC, with audit embedded within established committee structures for scrutiny and Board-level assurance.

The web-based Audit Management and Tracking (AMaT) system has been a major development. Throughout 2024/25 AMaT had been fully implemented, rolled out through staff training, and used across the audit cycle to support registration, reporting, action tracking and assurance. AMaT has been utilised as the single source of truth for audit activity, supporting audit registration, data collection, reporting, action planning and re-audit within one system. The strengthened approach requires all audit activity to be recorded on AMaT, with mandatory fields for successes, concerns, assurance, risk and SMART action planning.

The National Clinical Audit Programme has also matured. The 2024/25 annual report demonstrated a stronger focus on mandatory participation in National Clinical Audit Outcome Review Plan (NCAORP), collaboration between the Quality & Patient Safety (QPS) audit team and Clinical Leads. There has been a discussion of results at CSEG, SMART actions linked to national recommendations, and the allocation of assurance and risk status. The Health Board has also developed a more structured annual audit plan aligned to the Healthcare Quality Improvement Partnership (HQIP) and Welsh Government rolling schedule, allowing national audit reports to be scheduled across CSEG meetings and governance forums.

Corporate audit planning has developed a more reactive programme into a more formalised, risk-informed approach. The Corporate Local Audit Plan 2026/27 formalises the process to provide corporate-level assurance, align with strategic priorities, respond to internal and external requirements, and use AMaT to monitor recommendations, assurance levels, risk and SMART actions. Audit topics will be selected based on risk, strategic alignment and potential impact, drawing from the corporate risk register, serious incidents, investigations and areas for improvement.

2.3 Remaining challenges

Whilst it was envisaged Divisions to take ownership of audit work, there has been time pressures and resource constraints from operational teams which has meant the Quality and Patient Safety Team continued to carry responsibility. There have been resource pressures in the central audit team, challenges tracking completion of audit action plans, competing clinical priorities, and ongoing need to embed AMaT governance structures.

Participation and data acquisition remain a risk in some national audits. Examples of ongoing challenges with limited participation in some national audits, include operational constraints, multi-site complexity, data accuracy issues, administrative burden and risks to assurance where full participation is difficult. Whilst full participation is necessary, it must be accompanied by reliable data, clear clinical ownership, action on findings and evidence of improvement.

The final challenge is demonstrating impact. The 2026/27 forward plan explicitly recognises the need to judge success less by the number of audits completed and more by the difference audit makes to patient care and safety, including action implementation, re-audit and outcome-focused summaries. This is the central maturity shift for 2026–2029.

3. Strategic context and alignment

3.1 Duty of Quality and Health and Care Quality Standards

The Duty of Quality came into force in Wales in April 2023 and requires NHS bodies to improve quality and establish leadership and management systems to secure improvement. The Health and Care Quality Standards provide the practical framework for applying the Duty, built around six domains of quality — safe, timely, effective, efficient, equitable and person-centred — and six quality enablers: leadership, workforce, culture, information, learning, improvement and research, and whole systems approach.

Clinical audit contributes most directly to the Effective domain and to Pillar Three – Clinical Effectiveness. It provides structured evidence of whether care is aligned with best practice, whether variation exists, and whether changes lead to improvement.

3.2 Quality Management System

NHS Wales describes a Quality Management System as an operating framework to continuously, reliably and sustainably meet the needs of the population, with four interdependent elements: Quality Planning, Quality Control, Quality Improvement and Quality Assurance.

The Health Board's Quality Management System Framework 2025-2028 states that Pillar Three emphasises clinical effectiveness through evidence-based practice, robust clinical audit processes and adherence to clinical standards to improve outcomes, reduce variation and support continuous improvement.



Clinical audit supports all four QMS components:

- **Quality Planning** by identifying where audit is needed based on risk, standards, intelligence and improvement opportunity.
- **Quality Control** by testing whether agreed standards are reliably embedded in practice.
- **Quality Assurance** by providing evidence to Divisions, Executive Committees, PQSOC, ARAC and Board.
- **Quality Improvement** by informing targeted change where standards are not met.

3.3 Quality Outcomes Framework

The NHS Wales Quality Outcomes Framework provides a suite of quality measures to support national and local assurance, learning and improvement against harm and safety indicators. It also enables triangulation of QOF measures with wider quality and safety data and supports Board-level reporting and quality conversations. Clinical audit should therefore sit alongside QOF, not separate from it: audit provides deeper review against standards, while QOF provides longitudinal system measures and broader quality intelligence.

3.4 National Clinical Audit and Outcome Review Plan

The Welsh Government National Clinical Audit and Outcome Review Plan confirms the audits and outcome reviews in which Welsh Health Boards and Trusts are expected to participate where they provide the service, and describes national audit as a means to measure and drive improvement in quality and safety. The Plan states that national audits benchmark performance, identify best practice, provide assurance, monitor change and support improvement. The strategic aims therefore commits the Health Board to full participation, but places equal emphasis on learning, action and impact.

4. Our vision for the next three years

By 2029, clinical audit in Aneurin Bevan University Health Board will be recognised as a mature, strategically aligned and digitally enabled function that supports clinical effectiveness, assurance, improvement and learning.

Our ambition is that clinical audit will be:

A driver of clinical effectiveness, ensuring care is evidence-based, reliable and aligned to national and local standards.

Embedded in business as usual, with Divisions owning audit priorities, action plans and re-audit as part of routine quality governance.

A core source of quality intelligence, triangulated with incidents, concerns, claims, mortality, patient experience, staff experience, performance, QOF measures and risk registers.

A catalyst for improvement, with audit findings translated into proportionate, SMART, deliverable actions.

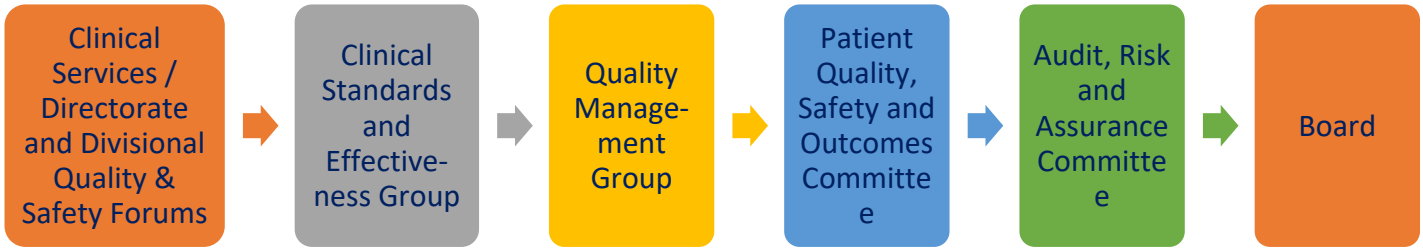
Digitally enabled, using AMaT as the single source of truth for audit registration, reporting, assurance, action tracking, escalation and re-audit.

Focused on impact, with success judged by what changes as a result of audit, not by the number of audits completed.

Clinically owned and corporately assured, with clear accountability from clinical services through Divisions to Board.

5. Governance and assurance framework

Clinical audit will operate through a clear "ward to Board" assurance route:



This route should be understood as an integrated assurance pathway with complementary responsibilities. CSEG provides clinical scrutiny of audit findings, standards, variation, risks and SMART actions. QMG triangulates audit intelligence with wider quality intelligence and determines where escalation or organisational learning is required. PQSOC considers the quality, safety, outcomes and improvement implications of audit findings. ARAC oversees the robustness of the audit governance system, the local audit planning process and whether arrangements provide appropriate assurance. The Director of Corporate Governance clarified that ARAC should oversee local clinical audit planning and delivery arrangements, while PQSOC should consider the outputs of local and national audit activity in line with agreed plans.

The Health Board QMS Framework describes QMG as a formal sub-group of the Executive Committee that provides assurance to Board through PQSOC, and describes PQSOC as responsible for overseeing quality and safety initiatives, alignment with strategic goals and monitoring performance.

Clinical audit will therefore provide both quality assurance and governance assurance, but it will not become internal audit; its primary purpose remains improvement in patient care and outcomes through systematic review against standards.

Audit intelligence will be triangulated with:

- QOF measures and integrated performance reporting.
- Incident themes, Never Events and patient safety learning.
- Complaints, concerns, compliments and patient experience.
- Mortality reviews, Medical Examiner themes and Learning from Deaths.
- Claims, inquests and regulatory findings.
- Divisional risk registers and corporate risks.
- National audit outliers and benchmarking.
- Clinical guidelines, NICE, HTW and professional standards.

6. Audit Management and Tracking (AMaT): implementation, impact and next stage of maturity

AMaT has transformed the visibility and governance of clinical audit by creating a common platform for audit registration, data capture, reporting, action planning, monitoring and evidence storage. The Health Board's Clinical Audit Policy requires all audits to be registered on AMaT, all results to be entered onto the tool or uploaded, and action plans to be recorded as specific, measurable, achievable, realistic and timely.

The strategic value of AMaT is that it moves audit from local spreadsheets and disconnected evidence into a single organisational system. It supports standardisation, enables consistent reporting to CSEG, provides visibility of assurance and risk levels, and enables action tracking. It also allows clinical leads and Divisions to evidence good practice, identify concerns, assign actions, monitor progress and prepare for re-audit.

For 2026–2029, AMaT will be developed further as an assurance and learning platform. The next stage is not simply more usage; it is better use. This means stronger data quality, clearer dashboards, routine escalation of overdue or high-risk actions, consistent use of assurance ratings, standardised evidence requirements for action closure, and improved reporting of impact.

7. Corporate Clinical Audit Plan

The Corporate Clinical Audit Plan will provide a structured annual programme of audits aligned to organisational priorities, national requirements, corporate and strategic risks, serious incidents, regulatory findings and areas of known variation. The 2026/27 Corporate Local Audit Plan describes this shift from historically coordinated corporate audits toward a formal annual plan that provides corporate-level assurance, supports improvement and aligns with strategic priorities.

The Plan will not replace Divisional audit. It will focus on cross-cutting, high-risk or high-impact themes where corporate oversight is required, where multiple Divisions are affected, where external scrutiny exists, or where assurance gaps have been identified. Topics will be selected through a risk-based prioritisation process and reviewed annually to remain responsive to emerging intelligence.

The aim is to ensure that audit effort is targeted where it can add greatest value. Audit should not be commissioned because "we need an audit"; it should be commissioned because there is a standard to test, a risk to understand, a gap in assurance, or an improvement opportunity that requires structured review.

8. Strategic priorities 2026–2029

Strategic priority	Strategic aim	Why it matters	Key actions	Success measures	Expected outcomes
1. Strengthen clinical effectiveness	Use audit to test whether care is evidence-based, effective and aligned to standards.	Clinical effectiveness is central to Pillar Three and the Effective domain of the Health and Care Quality Standards.	Align audits to NICE, HTW, national audits, clinical standards and QOF priorities. Prioritise audit where variation, harm or weak assurance is identified.	Audit topics clearly linked to standards, risks or quality priorities. Findings demonstrate good practice, variation and improvement opportunities.	Greater confidence that care is reliable, evidence-based and improving.
2. Strengthen governance and assurance	Provide a clear line of sight from clinical services to Board.	HQIP guidance describes clinical audit as a Board assurance tool within a broader quality improvement framework.	Standardise reporting through CSEG, QMG, PQSOC and ARAC. Clarify escalation thresholds and roles.	Clear reports answering what was audited, why, what was found, what changed, what remains a risk.	Board and Committees receive clearer assurance and fewer disconnected reports.
3. Deliver national audit excellence	Move beyond participation to learning, benchmarking and improvement.	NCAORP requires participation where services are provided and uses audit findings to measure and drive quality and safety improvement.	Ensure full participation, clear clinical leads, timely review of reports, action plans and outlier escalation.	National audit reports reviewed through CSEG with SMART actions and re-audit, where required.	Stronger national benchmarking, reduced unwarranted variation and clearer response to outliers.
4. Develop AMaT as the audit intelligence platform	Use AMaT as the single source of truth for audit assurance, action tracking and impact.	Local policy requires registration, results and SMART actions on AMaT.	Improve data quality, dashboards, overdue action escalation, action closure evidence and re-audit tracking.	AMaT reports show audit status, assurance, risks, actions, evidence and re-audit outcomes.	Greater visibility, accountability and consistency across Divisions.

Strategic priority	Strategic aim	Why it matters	Key actions	Success measures	Expected outcomes
5. Build workforce capability and audit culture	Ensure staff understand audit as improvement, not bureaucracy.	Clinical audit supports professional development, accountability, learning and patient involvement.	Provide practical training, templates, coaching and targeted support for high-risk audits. Support trainees to deliver meaningful audits aligned to priorities.	Staff can design, register, report and close audits consistently. Trainee audits contribute to Divisional priorities.	Audit becomes a valued improvement method and supports professional development.
6. Embed Divisional ownership	Make audit part of Divisional quality governance and business as usual.	The original strategy required Divisions to develop local audit programmes linked to quality and safety priorities.	Require Divisional audit plans, named leads, governance forum oversight and escalation of risks.	Divisional plans are risk-based, reviewed and reported through governance structures.	Stronger ownership, reduced reliance on central teams, and better local improvement.
7. Demonstrate impact and learning	Show what changed as a result of audit.	The 2026/27 plan shifts success from audit volume to evidence of improvement and patient safety impact.	Introduce impact summaries, thematic learning reports, re-audit expectations and learning dissemination.	Reports describe implemented actions, sustained change, learning shared and remaining gaps.	Audit closes the loop and becomes a visible source of organisational learning.

9. Delivery approach

Year 1: foundation and standardisation

The first year will focus on finalising the governance model, approving the Corporate Clinical Audit Plan, standardising CSEG reporting, strengthening AMaT use, confirming Divisional audit planning expectations, and improving escalation for overdue actions and high-risk findings.

Year 2: maturity and triangulation

The second year will focus on triangulating audit intelligence with QOF, incidents, complaints, mortality, patient experience and risk. Audit reports will increasingly form part of thematic quality intelligence and Divisional assurance, rather than being standalone reports.

Year 3: impact and sustainability

The third year will focus on demonstrating impact. The Health Board will strengthen re-audit, outcome summaries, learning dissemination and Board assurance on whether audit has led to sustained improvement in care.

10. Conclusion

- This refreshed framework positions clinical audit as a core enabler of clinical effectiveness and a vital component of the Health Board's Quality Management System.
- It builds on the foundations established between 2022 and 2026: CSEG scrutiny, AMaT implementation, stronger national audit governance, emerging corporate audit planning and improved visibility of audit activity.
- It also acknowledges the remaining challenges: variable Divisional ownership, action completion, participation complexity, resource pressures and the need to evidence impact.

GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	06 October 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Research and Development Annual Report
CYFARWYDDWR ARWEINIOL:	Dr Seema Srivastava
SWYDDOG ADRODD: REPORTING OFFICER:	Susan Palmer & Anna Roynon

Pwrpas yr Adroddiad / Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA / SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board (ABUHB) Research & Development has completed its 2025–26 Annual Report.

The report demonstrates strong research delivery performance, significant workforce and infrastructure investment, and clear progress against the Research Strategy 2022–27.

The report also highlights increasing national expectations, regulatory change, and the need to ensure sustainability of Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG) funded capacity beyond 2029.

Cefndir / Background

- Research is a core pillar of ABUHB's University Health Board status and is associated with improved patient outcomes, staff engagement, and system performance.
- The organisation is now in Year 4 of the 5-year Research Strategy (2022–27), moving from foundation-building to consolidation and growth.
- In response to national decline in UK commercial trials, ABUHB secured £1.4m VPAG funding (to March 2029) to expand commercial and complex trial capacity. It is important that we capitalise on this funding as from 2029 the work will need to be self-funding.
- Significant UK-wide changes are imminent, including new Clinical Trial Regulations (April 2026), updated GCP, and a new All-Wales R&D Finance Policy.

Asesiad / Assessment

Performance and delivery

Performance and delivery metrics for research are set by Welsh Government, this year ABUHB have exceeded Wales averages:

- 100% of commercial studies delivered to time and target.
- 513 participants recruited in 2025–26.
- Faster than national benchmarks for study set-up and first recruitment.

This year also saw the creation of an Early Phase and Complex Trials Team, that has strengthened our ability to support studies involving novel therapies, intensive monitoring, and more complex trial designs.

Workforce and culture

- Protected research time expanded for medics and non-medics using SPA guidance and VPAG funding.
- Appointment of ABUHB's first Clinical Research Fellow has removed a key delivery bottleneck.
- Significant growth in research leadership pathways, including a >50% increase in uptake of the NIHR Associate PI Scheme.
- The Research Champion Programme has become a visible, inclusive mechanism for embedding research culture across services, including volunteers.

Governance, quality and systems

- Audit programme re-established using a risk-based approach.
- Florence eBinders, have been fully implemented, modernising site file management and improving inspection readiness. Florence provides a secure digital platform for managing essential study documentation, replacing traditional paper site files with a consistent and compliant system.
- Sponsorship capacity has been strengthened, with ABUHB currently sponsoring two studies.
- Comprehensive preparation for regulatory changes and updated ethical frameworks.

Risks and challenges

- Research capacity remains stretched, reflecting the pressures faced by the wider NHS.
- Inequitable research availability across sites (notably GUH and YYF).
- VPAG-funded roles and infrastructure require a clear sustainability plan beyond 2029.
- New research metrics will be introduced over the coming year, requiring the R&D team to be increasingly nimble and agile in responding to opportunities.

Argymhelliad / Recommendation

Note**:**

- the strong performance, national recognition, and delivery assurance demonstrated in the 2025–26 Annual Report
- continued investment in protected research time, embedded delivery models, and leadership development across professions
- outcome-focused forward objectives (e.g., readiness of the Early Phase and Complex Trials, growth in Research Champions, improved site equity through the Estates strategy).
- that research is a strategic enabler for patient outcomes, workforce sustainability, innovation, and system resilience.

Approved by QMG – 12-05-26
Published – June 2026

Research & Development

Annual Report 2025-2026



YMCHWIL & DATBLYGIAD
Bwrdd Iechyd Prifysgol Aneurin Bevan
Aneurin Bevan University Health Board
RESEARCH & DEVELOPMENT

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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Foreword

Welcome to the 2025–26 Annual Report for the Research and Development (R&D) Department at Aneurin Bevan University Health Board (ABUHB). This report provides an overview of what we have accomplished over the past year and what we look forward to achieving in the years ahead.

Research is an integral part of the Health Board and is one of the three pillars on which its University status rests. Research engagement is associated with improved healthcare performance across the organisation and improved job satisfaction (1). It is also a gateway through which patients can access the latest cutting-edge treatments. Research is therefore of benefit to everyone who works within, and is cared for by, the Health Board.

Our progress is underpinned by our five-year strategy, *Research – A Core Activity* (2022–27), which sets out our ambition to embed research as a fundamental part of Health Board activity. This has been further strengthened by our success in securing approximately £1.4 million in competitive funding in 2024 through the Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG), enabling the growth of commercially sponsored and funded interventional pharmaceutical research across a range of departments.

Within this report, you will read about the early benefits of this success, including the creation of protected time for both medics and non-medics to build capacity for research engagement. You will also read about the appointment of our first Clinical Research Fellow, and the positive impact this has already had on research delivery and clinical teams.



Seema Srivastava
Executive Medical Director



David Bosanquet
Associate Medical Director



Helen Sweetland
Independent Member



Jeanette Wells
Research & Development Director



Sue Bale
Research & Development Director



Susan Palmer
Head of Research Delivery



Abby Waters
Research Delivery Manager



Anna Roynon-Reed
Research Delivery Team Lead



Danielle Gunter
Research and Development Manager

Foreword continued

We continue to deliver a nationally recognised Research Champion scheme and maintain a robust teaching programme to support the development of research-active healthcare professionals across the organisation.

Our strong research delivery metrics reflect not only the expertise of the R&D team, including their work to embed research within clinical teams, but also the commitment and support of directorates and their managers. This work has been recognised nationally, with the SANDBOX study receiving the MediWales Innovation Award for Health and Social Care Research Partnership with Industry.

Delivering these achievements requires a robust governance framework, including clear checks and balances, audit processes and the use of Florence, an electronic research documentation and data management system, described later in the report, to ensure research is delivered safely, ethically and to the highest standards

While I am delighted with the trajectory we are on, we recognise that challenges remain. New research metrics will be introduced over the coming year, requiring the R&D team to be increasingly nimble and agile in responding to opportunities. Research availability across the Health Board remains inequitable, with an urgent need to strengthen our presence at GUH and YYF. Capacity for delivery also remains stretched, reflecting the pressures faced by the wider NHS. These challenges can only be addressed through collaborative working, and with this in mind, I am delighted to welcome our new Executive Lead, Dr Seema Srivastava, Medical Director, whose experience and expertise will support us as we navigate what comes next.



As you read this report, I hope you will recognise the enthusiasm, passion and commitment of the ABUHB R&D team, the healthcare professionals delivering research, and the directorate teams that support this work. I also hope you will recognise the value we place on the many research participants who have given their consent to help build a stronger evidence base for the future.

Finally, I hope you will agree that research is something everyone within the Health Board can, and should, champion.

Professor David Bosanquet
Associate Medical Director for Research
Aneurin Bevan University Health Board

Our Strategy

Building on Strong Foundations

Our five-year Research Strategy (2022–2027) continues to guide the development of a sustainable, streamlined, and innovative research infrastructure across the Health Board.

Our annual report provides an important opportunity to reflect on the progress we have made, celebrate the achievements of our research community, and consider our priorities for the year ahead. Now in the fourth year of our five-year Research Strategy (2), we are beginning to see the impact of the strong foundations laid in earlier years - through strengthened infrastructure, expanded capacity, and a growing culture of collaboration across the Health Board. This report highlights the milestones reached over the past year, the difference they are making for staff and patients, and the next steps that will continue to drive a sustainable, innovative, and high-quality research environment.

Our Objectives:

1. A Sustainable and Supported Research Workforce
2. Investment in Staff and Infrastructure
3. A Streamlined, Efficient, and Innovative Research Programme

Progress Since Last Year

In last year's report, we outlined how the strategy was being implemented through dedicated workstreams, each supported by flexible task groups and overseen by the Quarterly Research Strategy Group. This structure has continued to provide strong governance, ensuring that projects remain aligned with our long-term objectives while allowing us to respond to emerging opportunities.

As we enter the next phase of the strategy, our focus is on consolidation and continued growth. The existing workstream and oversight model will continue to provide structured review, guidance, and support for ongoing development. This approach ensures that our research system remains responsive, financially sustainable, and aligned with evolving Health Board and Health and Care Research Wales (HCRW) priorities.

The strategy continues to provide a clear direction of travel, ensuring that research remains a core activity within the Health Board and that staff and patients benefit from a strong, connected, and forward-looking research environment.



External Funding Streams

Voluntary Scheme for Branded Medicines Pricing, Assess & Growth (VPAG)

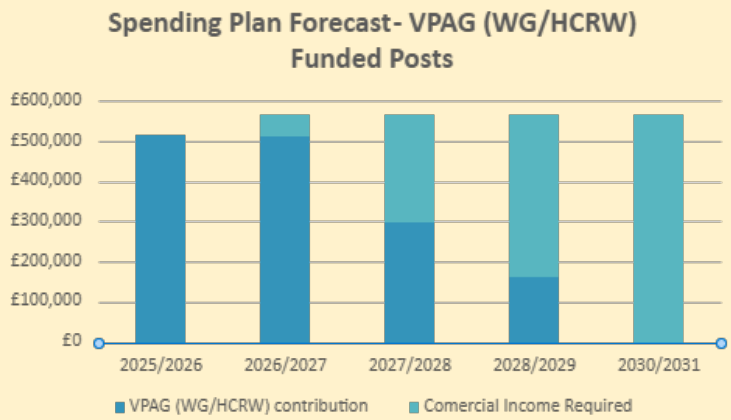
Lord O'Shaughnessy's Review of Commercial Clinical Trials (May 2023) highlighted a significant decline in the UK's commercial clinical trial activity, with the UK falling from 4th to 10th internationally for phase III trials.

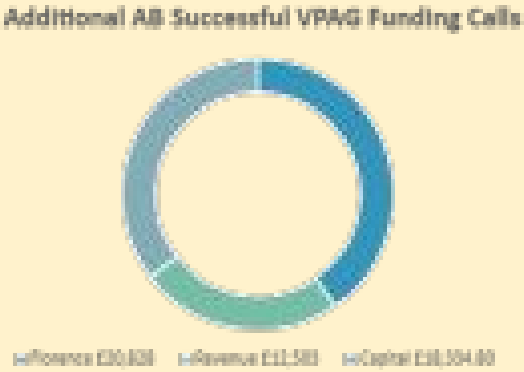
The report highlights the impact of this decline on commercial clinical trial activity, such as fewer opportunities for UK patients to have access to innovative treatments that could improve, extend, or save their lives. Furthermore, there is a financial loss to the NHS from a reduction in commercial activity. Many therapies, medications, and healthcare services that would have been funded by a pharmaceutical company instead have to be funded by Health Boards and Trusts (3).

In response, a major public–private collaboration between the NHS and the Association of the British Pharmaceutical Industry (ABPI) has resulted in a £400 million UK-wide investment to revitalise commercial research, stimulate economic growth, and strengthen the UK's global competitiveness in clinical trial delivery (4).

Securing VPAG Funding for ABUHB

Through this initiative, Aneurin Bevan University Health Board has secured £1.4 million over a five-year period, ending in March 2029. This funding has been allocated to Health Boards through Health and Care Research Wales on behalf of Welsh Government (WG). This comes with the expectation of sustainability at the end of the funding term.





External Funding Streams

Voluntary Scheme for Branded Medicines Pricing, Assess & Growth (VPAG)

Strengthening Capacity

The intention of the VPAG funding is to remove barriers to delivering commercial interventional pharmaceutical clinical trials, including:

- Limited clinician time to act as Principal Investigators (PIs)
- Insufficient medical cover to support PIs
- Capacity issues in research delivery, governance, and financial support.

To address these challenges, we have invested in the following:

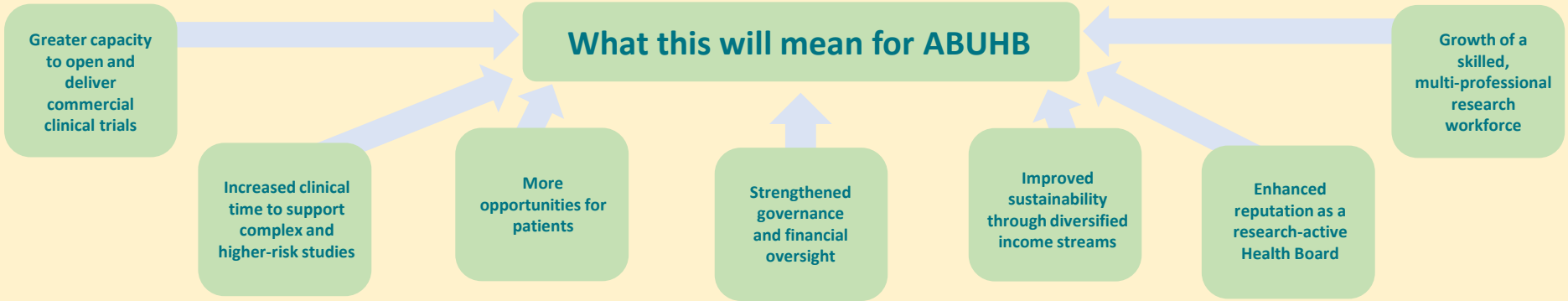
- A Clinical Research Fellow
- Clinical sessional time for three consultants, one specialist nurse, and one podiatrist
- Additional research nurses and research officers
- Strengthened support within the research governance team
- A forthcoming Finance Business Officer, who will play a crucial role in ensuring the success of the VPAG initiative

Looking Forward

The VPAG investment presents a significant opportunity for ABUHB to expand the range of commercial clinical trials we are able to deliver, including studies that may not previously have been feasible within the organisation. Over the coming years, this will help us offer patients earlier access to emerging and innovative treatments while also generating economic benefit through increased commercial income and cost-avoidance.



Our focus now is on capitalising on this opportunity and building a sustainable model that will continue to support commercial research activity beyond the end of the funding period in 2029. By strengthening capacity, embedding new roles, enhancing governance processes, and supporting clinicians to take on research responsibilities, we aim to ensure that these expanded clinical trial opportunities become a long-term feature of research delivery across the Health Board.





Sustainable and Supported Research Workforce

Protected Research Time

Embedding research within everyday clinical practice depends on staff having the time and support to take part in studies alongside their clinical responsibilities. Last year, we introduced new guidance to help ensure that research-active consultants could secure appropriate Supporting Professional Activities (SPA) time within their job plans. This work has continued, and clearer expectations are now helping more clinicians to incorporate research into their working week.

Expanding Dedicated Research Time Through VPAG

In 2025, we strengthened this approach through funding secured from Welsh Government via the Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG). This investment has enabled several specialties to increase their dedicated research capacity, including Dementia and Neurodegeneration, Rheumatology, Wound Healing, and Haematology.

By providing funded sessional time and additional operational support, VPAG is helping to remove long-standing barriers to research participation. Clinicians now have greater opportunity to act as Principal Investigators, lead studies, and support the delivery of commercial and non-commercial research. This is expanding the range of trials available to patients and contributing to the Health Board's growing research portfolio.

Why Protected Time Matters

Protected research time allows clinicians and wider multidisciplinary teams to:

- Lead and deliver studies safely
- Access and offer new treatments to patients
- Build research skills and confidence
- Strengthen partnerships with commercial sponsors
- Support cost-avoidance through industry-funded diagnostics and therapies

As more staff gain structured time for research, we are seeing a broader cultural shift towards research being embedded within routine care.

Looking Ahead

Over the coming year, we will continue to expand protected research time across a wider range of professions. Building on the progress made through SPA guidance and VPAG-funded sessional time, our focus will be on ensuring that nurses, allied health professionals, and other clinical staff have structured opportunities to participate in and lead research. This includes developing clearer pathways for non-medical Principal Investigators and strengthening the support available to teams taking on commercial and non-commercial studies.

We will also work with directorates to embed protected time within routine job-planning processes, ensuring that research activity is recognised, planned, and supported consistently across the Health Board. By broadening access to dedicated research time and continuing to invest in research capacity, we aim to increase the number of studies available to patients and further integrate research into everyday clinical care.

Sustainable and Supported Research Workforce

Protected Research Time

Embedding Research Through Dedicated Time - Haematology

Haematology continues to demonstrate how protected research time can transform a service's research activity. With dedicated sessional time and strengthened operational support, the department has expanded its research portfolio, opening multiple studies and increasing opportunities for patients to access emerging therapies. Consistent delivery performance has also strengthened relationships with commercial sponsors, positioning the service as a reliable site for future trials.



Embedding research within routine clinical care relies not only on dedicated research roles and clinician time, but also on strong, proactive support from Directorate Management. Within Haematology and Rheumatology, effective leadership has been essential in enabling teams to balance high clinical demand with increasing research activity.

Under the leadership of Directorate Manager **Rhys Knight**, operational oversight has ensured that VPAG-funded consultant sessional time is used to maximum benefit and that research is aligned with service priorities. This approach has supported the opening of new studies at pace and contributed to notable achievements, including Haematology becoming the **highest recruiter in the UK for three commercial trials** over the past year.

This partnership-driven model is helping research become recognised as an integral part of standard care. Reflecting on this progress, Rhys explained:

"We aim to further expand our research portfolio across Haematology and Rheumatology and, where possible, develop clinical support to extend this into Dermatology.

There are significant patient benefits to undertaking clinical trials in these areas, particularly in providing access to new and potentially more effective treatments that are not yet available through routine NHS care. Any time saved in treating and managing blood cancers and rheumatological conditions can have a life-changing impact.

In many cases, patients receive closer monitoring through more frequent reviews, symptom checks, and specialist input from our consultants. This can lead to earlier detection of changes in their condition and provides greater reassurance. Patients often describe feeling more in control of their treatment when participating in research, gaining a deeper understanding of their condition and the options available to them.

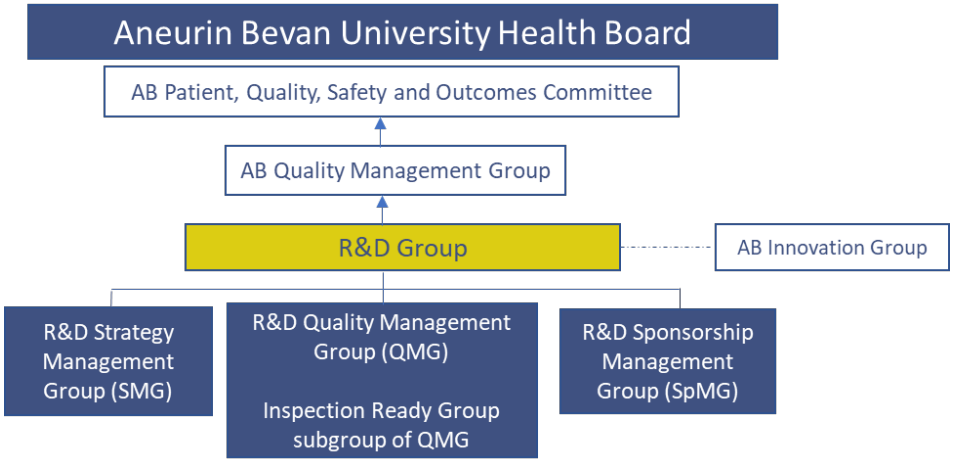
Financially, participation in commercially sponsored or portfolio trials can result in significant cost avoidance for the Health Board. High-cost medications, funded diagnostics, and enhanced monitoring offset expenditure that would otherwise sit within the directorate. At a time when many outpatient areas are under strain, the ability to shift appropriate activity into R&D also releases capacity back into clinical units.

The department has also generated commercial income at levels that have enabled the funding of additional research nursing capacity."

Research Governance

Audit Programme

Audit within research plays a key role in ensuring ethical practice, participant safety, data integrity, and compliance with legal, regulatory and Health Board requirements. The Research and Development Department, supported by its Quality Management System and the governance structure comprising the R&D Quality Management Group (QMG) and the R&D Group, provides assurance on the risks associated with hosted and sponsored studies.



The internal audit programme, fully operational before COVID-19, was paused due to capacity constraints. This provided an opportunity to review and strengthen the process, incorporate learning from earlier audits, align more closely with MHRA expectations and adopt improved tools from the UK Clinical Research Facility Network. These changes have supported a more structured approach to risk identification, escalation, and assurance mapping.

A risk-based study selection tool was developed and approved through the governance structure to support objective and proportionate audit planning. During 2025, three of six planned audits were completed, with the remainder postponed due to capacity constraints. No 'for-cause' audits were required.

One audited study had been pre-categorised as high-risk and two as medium-risk through the departmental risk assessment process.

Findings from the audits have informed corrective action plans and are contributing to ongoing improvements in research governance processes.

Engagement from Principal Investigators and research teams has been positive. The programme supports a more open and proactive approach to quality, in line with the statutory Duty of Quality, which requires all NHS organisations in Wales to demonstrate that their decisions, systems and processes promote safe, effective and high-quality care.

A provisional audit plan for 2026 has been developed and agreed within the governance structure and will be presented to the R&D Group for final approval.



Implementation of the plan will further strengthen oversight of hosted and sponsored studies and enhance the Health Board's overall research governance assurance.

Sustainable and Supported Research Workforce

Florence

In our last annual report, we were pleased to confirm that Health and Care Research Wales had approved the use of VPAG funding to implement *Florence,* a digital site file management system. The introduction of Florence eBinders marks a major step forward in modernising how research is governed and delivered across the Health Board. Florence provides a secure digital platform for managing essential study documentation, replacing traditional paper site files with a consistent and compliant system.

Our Journey So Far

Implementation began in July 2025, when superusers within the team completed their training. Wider staff training and a phased rollout followed in September 2025, enabling teams to adopt the system in a structured and supported way.

Key Milestones Include:
- All research delivery staff trained and confidently using the system
- Migration of all existing electronic site files onto Florence
- All new studies requiring an electronic site file now set up directly with Florence
- Positive feedback from Sponsors, with study monitors reporting ease of use for monitoring activities

Strengthening Quality and Compliance

Florence enhances research governance by ensuring that essential documentation is stored securely and consistently. Features such as version control, audit trails, and role-based access help ensure that teams are always working with accurate, compliant information. This strengthens our readiness for audit and inspection, supports national and international regulatory standards, and provides sponsors with confidence in our digital research infrastructure.

Next Steps

Over the coming year, we will focus on:
- Completing training for remaining staff
- Refining local processes to embed Florence into routine practice
- Continuing to gather staff feedback to guide improvements
- Ensuring consistent use across all research areas

How Florence Supports Research In the Health Board

Secure & Compliant
Meets Regulatory standards for research data.

Organised & Quality
Ensures accuracy, consistency & compliance, all stored in one accessible place, reducing duplication.

Collaborative
Enables smoother communication across research teams with the ability to sign documents from any AB site.

Efficient & Greener
Reduced paperwork and manual processes.

Future Proof & Scalable
Can adapt to evolving regulations, research practices and increasing number of studies.

Sustainable and Supported Research Workforce

Research Governance

Sponsorship Management

Over the past year, significant progress has been made in developing the Sponsorship Management function within ABUHB. The core documentation required to support the Health Board's role as a research sponsor has been standardised and further strengthened. Several applications for ABUHB sponsorship have been reviewed, with particular focus on ensuring that all sponsorship documentation is up to date, proportionate, and accurately reflects the risks associated with undertaking the role of sponsor.

The Health Board currently supports two ongoing sponsored studies:

Genicular Artery Embolisation (GAE) as a Minimally Invasive Intervention for Patients with Mild to Moderate Knee Osteoarthritis
Expected completion: June 2026

Hospital to Community: The Value of Community Low Vision Optometrists in Providing Certification of Visual Impairment in Dry Age-Related Macular Degeneration (CVI)
Recruitment completed: March 2026



In addition, we are working in collaboration with the Centre for Trials Research (CTR) in Cardiff on funding applications to Health and Care Research Wales and the NIHR EME programme to support two multi-centre studies, which, if funded, would be sponsored by ABUHB. This partnership is helping to strengthen the Health Board's capacity to act as a sponsor for high-quality research.

Why Research Governance Matters

Learning from the past to Shape the Future – Research Regulation

2026 marks the most significant update to UK Clinical Trial Regulations in over two decades (5). This provides an important opportunity to build on the foundational principles that underpin clinical research governance and how they have evolved to protect participants, support high quality research, and maintain public trust.

Modern research governance has been shaped by lessons learned from earlier periods in history, including grave abuses of human rights during the Second World War. These events highlighted the profound harm that can occur when research is conducted without ethical oversight, respect for individual dignity, or informed consent.

In response, the post-war Nuremberg Trials prompted fundamental questions about medical ethics and led to the development of the Nuremberg Code for 1947. This established core principles for human research, including the requirements for voluntary, informed and competent consent, principles that remain highly relevant almost 80 years later (6).

Although not legally binding, the Code has profoundly influenced national and international research regulation. These principles were further developed through the Declaration of Helsinki, first adopted in 1964 and most recently updated in 2024, and the Belmont Report (1979), which formalised ethical frameworks for research activity. Together with Good Clinical Practice, these frameworks form the ethical and scientific foundation of research governance today.

In the current clinical trials environment, adherence to these principles is essential. Significant deviation from these established standards would undermine participant safety and data integrity, ultimately risking the credibility of research outcomes, with potential legal and regulatory consequences for research and sponsors. Robust governance therefore enables research to be conducted safely, ethically and with public confidence (7).

While these principles have been reinterpreted for a modern research landscape, their underpinning values are clearly reflected in the updated Medicines for Human Use (Clinical Trials) (Amendment) Regulations 2025 (5), which will be fully implemented at the end of April 2026.

These frameworks ensure that research participants can take part with confidence, knowing that their safety, dignity and consent remain central to all research activity.

Investment in staff and infrastructure

Workforce Opportunities

Partnerships and Collaborations

Collaborative working remains essential to how we grow, support, and deliver research across the Health Board. Our partnerships span internal teams, national organisations, academic institutions, charities, and specialist networks. These relationships ensure research is aligned with local priorities, reflects national direction, and remains accessible across our workforce and communities.



National Partnerships & Strategic Contribution

This year, we collaborated with a range of national partners, including:

- Contributing to and promoting the national work that informed the *Strategic Action Plan for Building Research Capability for Nursing, Midwifery and Allied Health Professions in Wales (8)*, and supporting local implementation of Priority II
- Engaging with HCRW Communications & Involvement Alliances to strengthen alignment with Wales-wide research priorities
- National disease-specific research networks and HCRW-funded programmes providing specialist developmental support
- The Primary Care and Community Research Delivery Network, as we explore opportunities to broaden research activity across community settings

Alignment with Health Board Strategies

Research continues to align closely with several key Health Board strategic areas, including:

- The Cancer Strategy
- The Nursing Strategy
- The Strategic Equality Plan
- The Digital Transformation Strategy
- The Data, Analytics and Information Management Strategy

With several of these strategies approaching renewal, we are well positioned to contribute to the next iteration of organisational priorities, ensuring research remains central to service improvement and patient outcomes. This includes ongoing engagement with Planning colleagues to ensure that research requirements are aligned with the Health Board's Estates Strategy, ahead of its planned refresh in 2028.

We continue to collaborate with nursing, workforce, digital, and communications colleagues to strengthen research awareness, support consistent messaging, and promote a culture where research is visible and understood across the Health Board.

Investment in staff and infrastructure

Workforce Opportunities

Partnerships and Collaborations

Integrated Medium-Term Plan (IMTP)

This year, the NHS R&D Framework assessment (9), IMTP planning cycle, and the Annual R&D Strategy Report were completed in parallel for the first time. This strengthened early engagement with Planning Business Partners and supported the inclusion of research within divisional plans and business cases, helping to establish research as a routine part of organisational planning rather than an additional activity.

Building on this approach, we will expand involvement to include additional corporate departments in future assessments and reporting. To support this, we are developing targeted awareness sessions and strengthening cross-departmental engagement, ensuring colleagues understand the research agenda and can embed research within routine service development.



Academic and External Partnerships

Academic collaboration remains central to developing future research leaders.

Our work with Cardiff University continues to support:

- Academic affiliations and honorary titles for emerging Chief Investigators (CIs)
- Development opportunities for non-medical and AHP researchers aspiring to lead research
- Lunchtime learning sessions highlighting academic pathways, CI development, and grant opportunities

We are developing a centralised database of research development resources on the R&D intranet page, including contacts such as the CEDAR Centre for Healthcare Evaluation, Life Sciences Hub Wales, and national disease-specific research networks or projects. We are also actively linking with these groups to provide tailored support, grant application guidance, and training opportunities for staff.

The appointment of our Associate Medical Director for Research as an Honorary Professor at Cardiff University has further strengthened our academic links. In this role, **Professor Dave Bosanquet** continues to support emerging Chief Investigators within the Health Board, including guidance on the development and submission of funding applications.

Sustainable and Supported Research Workforce

Clinical Research Fellow

The establishment of a Clinical Research Fellow post within the Clinical Research Facility has been a major milestone in strengthening research capacity across the Health Board. This role was created in response to increasing demand on our research-active clinicians, whose growing expertise and reputation have led to a significant rise in commercial and complex study opportunities. As highlighted in last year's report, the absence of dedicated medical support had become a bottleneck in trial delivery, particularly for studies involving investigational medicines or requiring intensive clinical oversight.



We are pleased to report that the post has now been successfully appointed, with Dr Mohammod K Islam joining the team in August 2025.

Dr Islam said:

"To be part of this growing and expanding area is a great learning opportunity. It's a new role, there hasn't been a Clinical Research Fellow in the department before so we're shaping it to see how we can better support both the department and the Health Board. It's exciting to contribute to how research is delivered across the Health Board."

A New Role Shaping the expansion of Research Delivery in ABUHB

As the first Clinical Research Fellow within the Health Board, Dr Islam is helping to shape how the role evolves to meet the needs of a growing research portfolio. He has played a key part in supporting study set-up, undertaking medical assessments, and ensuring safe delivery of investigational products within the Clinical Research Facility.

This new capacity is enabling Principal Investigators to expand their research portfolios, supporting more equitable access to research across specialties, and helping the Health Board respond to increasing opportunities, and demand.

The introduction of this role marks a significant step in building sustainable research capacity

Next Steps

Over the coming year, the focus will be on:

- Embedding the Clinical Research Fellow role into routine research delivery
- Evaluating the impact of the post on study support capacity and clinical oversight
- Exploring opportunities for additional Fellow posts as research activity continues to grow
- Strengthening links between the Clinical Research Facility and clinical Directorates
- Supporting the development of future research-active clinicians

Research Delivery

Early Phase and Complex Trials Team

This year saw the creation of an Early Phase and Complex Trials Team, strengthening our ability to support studies involving novel therapies, intensive monitoring, and more complex trial designs.

The team brings together clinicians, research nurses and officers, supporting services, and other key staff with experience in delivering higher-intensity commercial studies.

This development reflects our commitment to expanding the breadth and complexity of commercial research, including earlier-phase studies requiring enhanced safety oversight, monitoring and clinical input, and to ensuring that clinical teams have access to the expertise needed to deliver these studies safely and effectively.





The team's core functions include:

- Assessing feasibility and capacity for early-phase and complex commercial studies
- Providing specialist oversight for studies requiring enhanced safety processes
- Coordinating complex trial activities that need rapid and reliable organisation
- Supporting governance and regulatory compliance for higher-intensity studies
- Building capability across research teams through targeted training and mentorship

Research Delivery

Study Set-up

Improving the speed of commercial clinical trial set-up is a national priority. The UK Government has set a national ambition for commercial clinical trials to progress from regulatory submission to first patient recruited within 150 days by March 2026. This forms part of wider UK work to strengthen clinical research delivery and ensure that studies can begin more quickly (10).

National partners have since set out clearer expectations for each stage of the start-up pathway, including timelines for approvals, site set-up, and first patient recruitment. The aim is to reduce delays, improve consistency, and make the UK a more attractive location for commercial research.

Our own study set-up times remain consistently strong, as reflected in our research metrics later in this report, and this year we have introduced a more standardised and transparent internal process to support further improvement. This includes clearer internal timelines, earlier engagement with supporting departments, and a more coordinated approach to feasibility and capacity assessments. These changes reduce duplication, improve communication, and help address common operational barriers that can delay site activation.

A more efficient start-up process strengthens our ability to host commercial studies by reducing set up timelines and operational burden, enhances our competitiveness and attractiveness to sponsors, and increases opportunities available for patients to take part in research.



Sustainable and Supported Research Workforce

Embedding into NHS Operational Delivery

Embedded Research Delivery

Last year's report set out ABUHB's intention to expand embedded research delivery by building capability within operational clinical teams and reducing reliance on the central research delivery workforce. That approach continues to develop, supported by closer collaboration between clinical services, research delivery, and governance teams.

Unique within Wales, ABUHB has a dedicated specialist research nurse whose role is to strengthen embedded research activity within clinical services where studies are delivered as part of routine practice. This provides targeted expertise to ensure that research is planned, resourced, and delivered to a consistently high standard.

The specialist nurse supports teams by:

- leading feasibility assessments to confirm that studies can be delivered safely within existing clinical capacity
- strengthening study planning and coordination
- mentoring teams with limited research experience
- embedding research processes into routine workflows and supporting adherence to regulatory and sponsor expectations
- working in collaboration with other delivery staff to facilitate access to training and PI mentoring

This model has enabled more clinical areas to take on research activity without requiring additional permanent research delivery staff, supporting a broader and more sustainable expansion of commercial research across the Health Board.



PI Dr Hayden Stephenson and CO-PI Emily Phillips for VIP3

ABUHB Research Performance

Metrics 2025-2026

Our primary performance indicator remains recruitment to time and target, which reflects our ability to recruit participants to research studies in line with agreed milestones and timelines. This is a key national measure, as sustained underperformance can impact sponsor confidence and future funding allocations.

89

Total number of studies ***open*** in 2025/26

513

Total number of participants recruited in 2025/2026 financial year

81

Total number of studies in ***follow up*** during 2025/26

	Commercial	Non-Commercial
Percentage of Closed Studies Recruiting to Time and Target	**ABUHB 80%**	**ABUHB 100%**
	Wales 68%	**Wales 77%**

Alongside this, we monitor a wider set of nationally reported performance indicators that provide assurance on the quality, efficiency and consistency of research delivery across commercial and non-commercial studies. Together, these metrics demonstrate that ABUHB's study set-up and delivery performance is consistently strong and, in several areas, compares favorably with the wider Welsh position.

30

New studies ***opened*** in 2025/26

	Commercial	Non-Commercial
Median days from date site selected to recruitment of 1st participant	**ABUHB 146**	**ABUHB 118**
	Wales 165	**Wales 150**

ABUHB Research Performance

Emerging Metrics 2026-2027

These emerging areas of measurement reflect national programme-level work that is shaping future approaches to evaluation. While the detailed definitions and targets are still being finalised, the intended areas of focus are becoming clearer. This includes metrics linked to VPAG-funded activity, alongside measures relating to access to cancer research opportunities through the Tackling Cancer Through Research programme (11). This includes understanding how patients registered with the organisation are supported to access cancer research studies, regardless of where those studies are delivered.

Access to Cancer Research Opportunities

Increases in the number of participants into cancer interventional trials

Growth in Commercial Activity



Increases in the number of commercial trials opened

Timely Review of Commercial Study Opportunities



Review 100% of commercial research opportunities within 48 hours



Commercial Study Set-Up Timelines

Studies progressing from site selection to greenlight within 60 days
First participant recruited within 30 days of greenlight

Recruitment to Time and Target (RTT)



Studies closing to recruitment having met their agreed recruitment target – Commercial & Non-Commercial

Sustainable and supported research workforce

Research Finance

NHS research in Wales is funded from a variety of sources.

Covering the financial year 2025-2026, ABUHB R&D received:-

From **HCRW** (Our main funder)

- **£1,842,523** to fund the delivery of research (includes pay and non-pay)
- **£17,553** for an All-Wales Specialty Lead post for Old Age Psychiatry, hosted by ABUHB
- **£15,928** Excess Treatment Costs, to fund treatment costs within research studies that are not standard of care.

R&D Capacity Building

This is income generated from commercial research which is reinvested into enabling further research within the organisation.

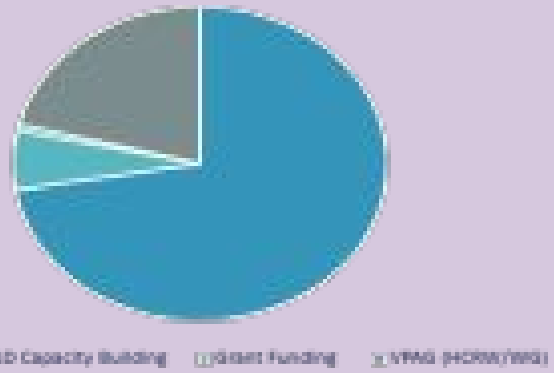
- **£98,898** this year has funded our AMD role and R&D Director posts, alongside a part time research development post
- Haematology funding for research posts totalling **£58,572**

VPAG Funding (WG/HCRW)

- **£490,211** pay
- **£51,665** non-pay

Grant funding (NIHR, HCRW)

- For research posts of **£17,225**



NHS R&D Finance Policy 2026

March this year saw the release of the updated All-Wales finance policy for research. The policy is supported by a Welsh Health Circular (12) and is one of the NHS organisation's core research governance policies. It sets out the framework for the costing, management, and accountability of all research funding within NHS organisations within Wales.

Next Steps

Over the next six months, R&D, in collaboration with our finance colleagues, will be operationalising this policy. To help with the implementation, our colleagues in finance systems are supporting us to build finance dashboards within our Cliksense system to enable more robust reporting and better demonstrate transparency in our accounting processes.

This work will be supported by a new finance role, for which we have secured funding through the VPAG workstream, which will be advertised early in the new financial year. This role will support the business management of all research finance, but also help with the sustainability element of the VPAG programme.

Sustainable and supported research workforce

Education

Building Capability, Confidence and Research Culture

Research education remains a key enabler of our strategy, underpinning safe, high-quality study delivery and a visible research culture across ABUHB.

This year, we continued to invest in skills, induction, and support for investigators, while aligning with organisational priorities such as ward accreditation, induction excellence, and workforce development. Our focus in 2025–26 has been to strengthen the pipeline of research-active clinicians, with a particular emphasis on the NIHR Associate Principal Investigator (API) Scheme (13).

Preparing for Updated Standards and Regulatory Changes

In anticipation of the forthcoming updates to ICH GCP E6 (R3), the revised Declaration of Helsinki (2024), and changes to UK clinical trials legislation, the department has undertaken extensive preparatory work to ensure readiness across the specialist research team and wider Health Board staff with research involvement. All departmental Standard Operating Procedures (SOPs) have been reviewed and updated to reflect the new requirements and a shift towards a more risk-based approach to the management of study activities, supporting continued clarity and consistency in our processes and documentation standards.,

Staff are now being signposted to the updated NIHR GCP curriculum, which includes revised introductory and refresher modules. Alongside this, all departmental GCP facilitators have completed their own updates, enabling them to deliver refreshed face-to-face HCRW training sessions in GCP Consolidation, Managing Essential Records in Research, and Valid Informed Consent. Our established PI Workshop is also undergoing revision to ensure alignment with the upcoming changes. Following implementation in April, we will additionally offer HCRW GCP Refresher and Good Research Practice training (for non-drug studies), ensuring proportionate support for research-active staff across the organisation.

To support Health Board-wide preparedness, we have provided regular updates outlining the key changes, timelines, and expectations associated with the updated guidance. These communications have been complemented by Lunchtime Learning sessions, supporting staff to feel informed, confident, and ready for the transition.



Education

Building a Specialist Research Delivery Workforce





As we expand our capacity to deliver more complex and earlier-phase clinical trials, emergency preparedness remains essential to our development as a specialist research delivery team. Research roles are sometimes viewed as separate from frontline clinical practice; however, the work of our dedicated team continues to demonstrate the high level of clinical skill and judgement required to support safe and effective study delivery.

Our Emergency Scenario Training programme has continued throughout the year and is now progressing towards a more structured model. Plans for the coming year include increasing session frequency and introducing unannounced scenarios, supporting staff to respond confidently to unexpected clinical situations. This reflects the level of preparedness required for early-phase and higher-risk research environments.

Life support capability has also strengthened. The majority of senior clinical staff (Band 6+) have now completed Immediate Life Support (ILS) training, supported by a specialist clinical research nurse who is an ILS trainer and able to deliver regular in-house sessions. A Basic Life Support (BLS) cascade trainer provides training for staff not eligible for ILS, ensuring a consistent baseline of emergency readiness across the department.

These developments support our strategic ambition to build a highly skilled, responsive research workforce capable of contributing to a broader portfolio of complex and early-phase studies while maintaining the highest standards of participant care and safety.

Sustainable and Supported Research Workforce

Developing the Next Generation of Research Leaders

Improving Uptake and Retention in the NIHR Associate Principal Investigator (API) Scheme

This year, we undertook a focused Quality Improvement Project to strengthen participation in the NIHR Associate Principal Investigator (API) Scheme (13), an important pathway for developing future research-active clinicians. Previously, participation at ABUHB was affected by limited awareness, variable information for staff when joining the scheme, and occasional preventable withdrawals.

To address this, we introduced targeted measures including clearer introductory information, Lunchtime Learning sessions, proactive matching of interested clinicians to eligible studies, and early 1:1 support from R&D staff. These changes were designed to ensure that staff feel informed, supported, and confident from the outset

The impact has been significant. Applications increased by more than 50%, and withdrawals returned to previous low levels during the improvement period, resulting in sustained net growth for the first time. Clinicians reported clearer expectations, better communication, and greater confidence throughout their involvement.

This work has transformed the API pathway into a stable and well-supported route for clinicians who wish to develop their research skills. Building on this progress, we will continue to strengthen peer support and explore opportunities to integrate the scheme into clinical training pathways to sustain long-term growth.

Supporting Research Awareness Across the Wider Workforce What We Did This Year



Gold Ward Accreditation
Research is now a requirement for Gold-level accreditation within the Health Board, with one of the criteria being the identification of a Research Champion.



IMG Induction
Research introduced at International Medical Graduate induction, where sessions have generated new interest in research & referrals into the API scheme.



CeSR Research Sessions
Well attended session delivered by research staff, raising awareness for CeSR doctors.



Grand Round & Specialist Teaching
Delivered presentations at HB and All Wales specialist meetings & departmental events.



Intranet Resources
Easy access materials developed to support research promotion, understanding and education across departments and multiple professions.

The SANDBOX Study

In 2025, Aneurin Bevan University Health Board received the MediWales Innovation Award for Health and Social Care Research Partnership with Industry, recognising the strength of its collaboration with Prima Mente on the UK-wide SANDBOX study. The study is testing new diagnostic approaches for Alzheimer's dementia by combining blood-based biomarkers, genetic testing, digital cognitive assessment tools, and artificial intelligence within routine clinical pathways.

ABUHB was the first site in the UK to open to recruitment. As an early adopter, the team worked closely with the sponsor to design how SANDBOX would be delivered in day-to-day clinical practice, ensuring the tools could integrate smoothly with NHS workflows in Wales.

This has demonstrated how NHS–industry collaboration, supported by Health and Care Research Wales for study set-up and coordination, can accelerate delivery while maintaining a strong focus on participant experience.

Why this matters for patients

Traditional diagnostic pathways often involve multiple appointments, long waits, and tests that can be intrusive or inconclusive. SANDBOX is assessing whether blood tests, combined with structured assessments and AI-enabled analysis can offer earlier clarity for patients and families.

Collaboration across Wales

Delivery of the study has been led by **Principal Investigator Dr Chineze Ivenso,** supported by colleagues in Older Adult Mental Health and the research delivery team. Set-up required coordinated work across services to ensure assessments, laboratory processes, and follow-up procedures ran reliably. Learning from this work has been shared nationally, helping create consistent study set-up across Wales.

Initial feedback from participants indicates that the combination of structured assessments and dedicated contact with research staff is valued. Several have highlighted that taking part has given them more confidence in the diagnostic process and greater reassurance during what can be an uncertain period.



"For the first time in a long while, I felt that someone was looking at the whole picture, not just one test at a time. Being part of this study has given me more hope and a clearer sense of direction."

- SANDBOX participant

Although SANDBOX is still at an early stage, the experiences of participants are already showing the value of testing new diagnostic approaches within real clinical settings. Participants have described the process as more joined-up and more reassuring, with a clearer understanding of what their assessments mean and how their care is progressing.

These insights reflect the wider role of research within our Health Board: improving the patient journey, supporting informed participation, and helping shape pathways that meet future care needs across Wales.

Our Research Champion Programme One Year On

Launched in late 2024, the Research Champion Programme was created to make research more visible, accessible, and integrated across ABUHB. One year later, the programme has developed into a thriving network of staff and volunteers from a wide range of roles, many with little or no previous research experience, who are collectively helping to build a stronger research culture across the organisation.



In November 2025, the programme celebrated its one-year anniversary with a special induction in the morning, (joined by colleagues from Health and Care Research Wales), a well-attended celebration lunch for all Champions, and an afternoon Research Department Open Day. The sense of community, achievement and shared purpose was felt strongly throughout the day. To mark the milestone, each Champion received a limited-edition Research Champion clipboard, further strengthening the sense of identity and pride within the group.

Our 1st Year:

- 6 cohorts completed
- 45 **ABUHB Research Champions**
- including 6 volunteers
- 4 inductions each year
- 12 members of staff already booked for future inductions
- 40 members of staff expressed interest but not yet attended

Building a Diverse Community

Champions are drawn from across ABUHB, including clinical teams, mental health, emergency care, libraries, administrative services, coding, frontline services, and volunteer programmes. The fact that most entered the programme with little or no prior research experience demonstrates its inclusivity and accessibility.

Induction sessions, now well established and delivered quarterly, combine introductions to research, department tours, networking activities, and opportunities to meet the wider Research Team. Feedback shows these sessions build confidence and make research feel achievable for everyone.



Champions Making a Real Difference

Broadening the Programme

Volunteers are becoming an increasingly important part of the Champion community, with plans to integrate the Research Champion role further into existing Health Board volunteer pathways. The programme is also exploring roles for volunteers within the Research Centre, ensuring that they are meaningfully involved and supported.





Looking Ahead

As the programme enters its second year, several priorities will guide its development:

- **Re-evaluating research knowledge and confidence**, using baseline data collected at induction to monitor progress over time.
- **Reviewing workforce representation** to identify underrepresented staff groups and exploring whether more flexible pathways may help remove barriers.
- **Understanding non-attendance patterns** among staff who express interest but do not progress to induction, ensuring the programme remains accessible and supportive.
- **Expanding volunteer involvement**.
- **Building recruitment into our existing opportunities**, such as inviting attendees at the PI Workshops to become Champions.
- **Developing a streamlined route for experienced research-active staff** to join without needing the full induction.

Over the past year, Champions have shown how small, practical actions across many teams can make a meaningful difference to how research is understood and talked about within ABUHB. Their involvement has already improved local awareness of research and supported activity in a range of settings. This work has laid a solid foundation for the programme, and we will continue to build on this momentum as it develops in the year ahead.



The Impact of Listening in Research Pathways

Lived experience and research delivery often look like separate worlds, but for many families, and for many staff, they're not.

My own experience of inherited cardiac disease sits alongside my professional role, and that dual perspective continually exposes a simple truth: knowing the science is not the same as living the uncertainty.

Genetic results don't always give clarity. In my own family, the same gene variant has led to very different experiences. Those differences raise everyday questions about risk, timing, and what information is genuinely useful. Families sit with that ambiguity long before a study protocol is designed.

In research delivery we spend a lot of time predicting when and how people will want to engage with studies. Despite best intentions, we still get it wrong. We assume we know people's priorities or emotional readiness. We assume our pathway options are the only viable ones. Even with public and patient involvement, representation gaps remain.

One study demonstrated this clearly. Recruitment was poor until we asked patients and families about a timing point we previously felt was "too overwhelming." Their response was unequivocal: "*ask us then*". We changed the pathway, and recruitment accelerated. The improvement didn't come from a new method; it came from listening.

Meaningful involvement is not straightforward, and it shouldn't be. It challenges assumptions, broadens thinking, and keeps research grounded in real lives rather than theoretical ones.

When lived experience shapes design and delivery from the beginning, outcomes, engagement, and trust all improve. This is how research becomes something people recognise, value, and want to be part of.



Anna Roynon Reed
ABUHB Research Delivery
Senior Team Lead Nurse

Forward Plan

As we move into the fourth year of our five-year Research Strategy (2022–2027), Aneurin Bevan University Health Board is in a strong position to build on the progress made to date. The coming year will see major changes across the UK research landscape, including new Clinical Trial Regulations (5) and updated Good Clinical Practice guidance (14). Against this backdrop, our focus will be on consolidating what works well, strengthening areas where further development is needed, and ensuring our research system remains responsive, sustainable, and aligned with national expectations.



Strengthening Capacity, Capability and Workforce Development

Over the next year, we will continue to expand protected research time across professions, ensuring that job-planning and PADRs increasingly recognise the importance of research activity. The Clinical Research Fellow role will be fully embedded and formally reviewed to understand its longer-term value and potential application in other specialities. We will also continue to support early-career and non-medical researchers through improved access to mentoring, clearer developmental pathways and opportunities to gain experience. Our ongoing partnership with Cardiff University will remain a key part of how we support emerging Chief Investigators to develop and progress. By the end of the current strategy period, this approach will support a broader and more confident pipeline of research active staff across professions, with research activity increasingly recognised and planning within routine job planning processes.

High-Quality, Efficient and Compliant Research Systems

Ensuring ongoing implementation and compliance with new regulatory requirements and the updated All-Wales R&D Finance Policy will remain a central focus. We will deliver the 2026 internal audit plan and continue refining governance arrangements to ensure clarity and consistency. The rollout of Florence eBinders will continue across the Health Board, alongside close working with Digital and Information Governance colleagues to ensure researchers have timely access to the systems and data they need, including improved pathways for MHRA-compliant remote monitoring. This will ensure that, by 2026-27, research governance processes are consistently applied, inspection-ready, and supported by digital systems that enable proportionate oversight and efficient sponsor engagement.

Forward Plan continued

Expanding Commercial Research and Complex Trial Capability

Over the coming year, the Early Phase and Complex Trials Team will continue to strengthen the skills, processes and operational readiness required to support earlier-phase and higher-intensity commercial studies. This includes strengthening feasibility assessment, emergency preparedness, and closer coordination with supporting services to ensure safe and effective delivery of more complex trial designs. By the end of the current research strategy period, this work will support increased readiness to host a broader range of commercial studies and help inform priorities for the next Research Strategy. Alongside this, the VPAG programme will continue to support growth in commercial research, particularly in specialties that have demonstrated strong delivery potential. A key priority will be strengthening the long-term sustainability of VPAG-funded posts and infrastructure through improved income forecasting, more robust financial reporting, and early planning for the period beyond 2029, while continuing to address capacity challenges that may affect the pace of trial delivery.

Embedding Research in Clinical Services and Enhancing Access

We will continue to expand embedded research delivery models, supporting to confidently host and deliver studies as part of their routine work. This will help the consistency of access to research across sites and services. Patient and public involvement will remain central to this work, with a continued focus on inclusion, reducing barriers to participation, and building relationships with communities that have traditionally been underrepresented in research. The Research Champion Programme will continue into its second year, strengthening awareness, confidence and visibility of research across the organisation and supporting wider participation in research activity.

Strengthening Partnerships, Visibility and Strategic Alignment

We will deepen our collaborations and partnerships to widen opportunities for patients and staff. Strengthening Board-level engagement and improving how we communicate research activity and impact will be an important part of embedding research more fully into organisational thinking and planning. By the end of the current strategy period, we aim to strengthen alignment with a wider range of organisational strategies, including ongoing engagement with Planning colleagues to ensure research requirements are considered as the Health Board's Estate Strategy is developed towards 2028.

The year ahead provides an opportunity to build confidently on firm foundations. Our priorities focus on sustainability, strengthening governance, widening access, and deepening collaboration. Ensuring that VPAG-funded roles and infrastructure can be sustained into the future will be a key part of this work.

Our long-term ambition is to make research a normal and accessible part of everyday practice across the Health Board. We remain committed to removing barriers, creating open opportunities, and supporting a diverse multiprofessional community where everyone feels able to contribute. By connecting local priorities with national direction and academic expertise, we will continue building a culture where research is understood, valued and recognised as an essential part of improving care for our patients and communities.

These priorities will help ensure that research remains a central, visible and valued part of how we deliver high-quality care and plan for the future.



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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	06 October 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Thematic Analysis of Violent and Aggressive Incidents within ABUHB 2023-2026
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Peter Carr Executive Director of AHPs and Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	Peter Carr Executive Director of AHPs and Health Science

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Situation:

Violence and aggression remain a significant workforce safety and service-delivery risk. A three-year thematic review of 10,155 Datix Cymru incidents has been completed to identify patterns, impact and priorities for action. The Patient Quality, Safety and Outcomes Committee is asked to note the findings and endorse the proposed response.

The review is attached as Appendix 1

Cefndir / Background

The review covers staff-directed incidents involving patients or members of the public between 1 August 2023 and 31 July 2026. It considers incident types, repeat offenders, hotspot locations, lost time and RIDDOR events, sanctions and police involvement. Findings are based on Datix Cymru categories and identify broad trends rather than definitive incident classifications. The review supports delivery of the Health Board's Violence Prevention and Reduction Strategic Plan 2026-2028, and associated implantation plans.

Assessment

The analysis shows that risk and harm are concentrated and require a targeted response.

- 10,155 incidents were reported, increasing from 3,097 to 3,634 over three years.
- Aggressive/threatening behaviour, physical assault and clinically challenging behaviour accounted for 72.7% of reports.
- Physical assaults rose 32.8% and racial abuse more than doubled.
- MH&LD accounted for 57.1% of incidents, with 10 repeat offenders responsible for more than 1 in 10 divisional incidents.
- Community risk was significant, with more incidents in patients' homes than GUH ED Majors or RGH MIU individually.
- 50 incidents met the RIDDOR threshold, while missing absence data limits understanding of workforce impact.
- Police reporting and complex case management have strengthened, but outcomes and sanctions are not consistently recorded on Datix.
- The VPR Strategic Plan 2026–2028 provides the right direction; limited resources should be targeted where the evidence indicates the greatest risk and potential benefit.
- Repeated exposure can affect staff wellbeing, confidence, service resilience and therapeutic relationships. Clinical context may explain behaviour but does not remove its impact on staff.

Conclusion

The Health Board has an appropriate strategic direction and governance framework to respond to violence and aggression.

This deep dive review provides the evidence to focus limited resources available within the Violence Prevention and Reduction Team towards the areas where the risk and potential benefits are greatest, and support a move from incident-by-incident response to targeted, trauma-informed prevention.

Argymhelliad / Recommendation

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

- Note the findings and the sustained physical, psychological and operational impact of violence and aggression.
- Continue endorsement of the targeted delivery of the Health Board's Violence Prevention and Reduction Strategic Plan 2026-2028, and associated implantation plans, including prioritising high-risk services, community staff and repeat or complex cases.
- Support multidisciplinary reviews and individualised prevention plans for repeat offenders, alongside proportionate sanctions and partnership working.
- Support linkage of Datix, RIDDOR, Workforce and HR absence data, with improved recording of perpetrator identity, sanctions and police outcomes.
- Receive progress through established Violence Prevention and Reduction governance, including measures of incident severity, recurrence, workforce impact and intervention effectiveness.



Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Strategic Risk SRR 010
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1.1 Health Promotion, Protection and Improvement 2.1 Managing Risk and Promoting Health and Safety 7. Staff and Resources Governance, Leadership and Accountability
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	Work in partnership to reduce all hate crime Improve the wellbeing and engagement of our staff 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)	
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	



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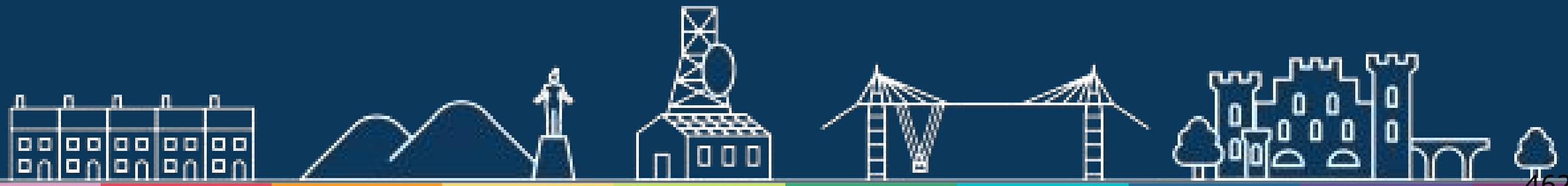


GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

GWENT 35
Better health. Better care. Better lives
Iechyd gwell. Gofal gwell. Bywydau gwell

Violence Prevention & Reduction
A Thematic Review of Violence & Aggression Incidents 2023-2026

Lidia Palmer



Reason for Thematic Review

This is a review on violence and aggression incidents reported across ABUHB over the previous three-year period.

The review will take a thematic and intelligence led approach to understanding where incidents are occurring, who is involved, the impact on staff and services, and current interventions.

The review will focus specifically on:

- Types of incidents reported
- Repeat offenders and patterns of recurring behaviour
- Hotspot locations with high levels of violence and aggression
- Lost time incidents and workforce impact
- RIDDOR reportable events
- Use of sanctions and complex case management
- Police involvement and criminal justice outcomes

For each area, the review will seek to answer two key questions:
What does the data tell us? And **What actions can be taken to improve prevention, response and staff safety?**

Scope & Methodology

This report analyses a three year reporting period of violent and aggressive incidents reported via Datix Cymru where the victim was a staff member and the perpetrator was a patient or member of the public. This report does not include staff on staff incidents. Using the below categories (Table 1).

Categories:
Aggressive/threatening behaviour
Anti social behaviour
Harassment
Inappropriate behaviour / attitude
Inappropriate use of social media
Indecent exposure
Patient clinically challenging behaviour
Physical assault (physical contact)
Sexual (inappropriate) behaviour
Sexual assault
Verbal assault (gender/sexual orientation)
Verbal assault (racial abuse)
Verbal assault (swearing etc.)

Table 1. Categories available with reporting system

Analytical Approach:

1. Extracted three years of V&A incident data from Datix Cymru (01/08/2023 to 31/07/2024, 01/08/2024 to 31/07/2025 and 01/08/2025 to 31/07/2026).
2. Analysed incidents by type, hotspot, repeat offender, staff absence, RIDDOR, sanctions and police involvement.
3. Grouped related categories to identify broader themes and trends.
4. Anonymised repeat offenders and treated “Not Recorded” identities as missing data.
5. Focused on reported volumes and patterns, rather than individual case reviews.
6. Used findings to identify key risks and improvement priorities.

	2023-2024	2024-2025	2025-2026	Total
Total	3097	3424	3634	10155

Table 2. Shows total number of incidents for each year

Executive Summary

- 10,155 incidents were reported, increasing from 3,097 to 3,634 over three years. See Figure 1.
- Aggressive/threatening behaviour, physical assault and clinically challenging behaviour accounted for 72.7% of reports.
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- Police reporting and complex case management have strengthened, but outcomes and sanctions are not consistently recorded.
- The VPR Strategic Plan 2026–2028 provides the right direction; limited resources should be targeted where the evidence indicates the greatest risk and potential benefit.

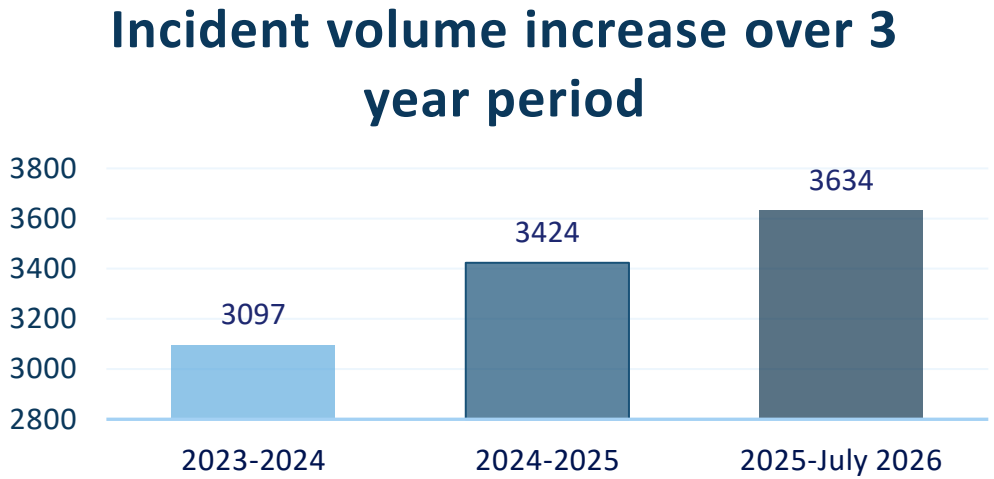
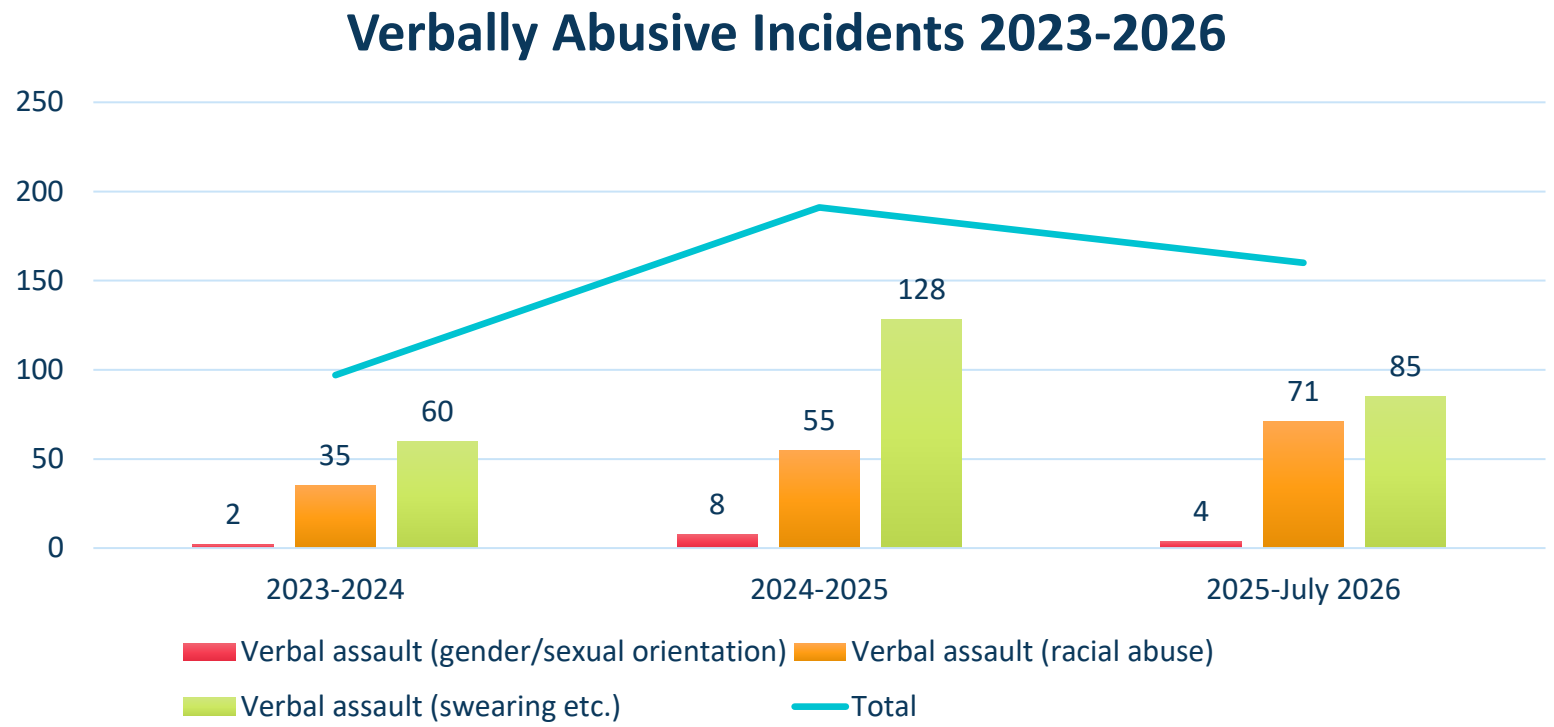


Figure 1. Shows total number of incidents for each year

Implication Move from responding to individual incidents towards a targeted, trauma-informed and intelligence-led approach, prioritising high-risk services, community staff, repeat offenders, staff support and improved data quality.

Types of Incidents

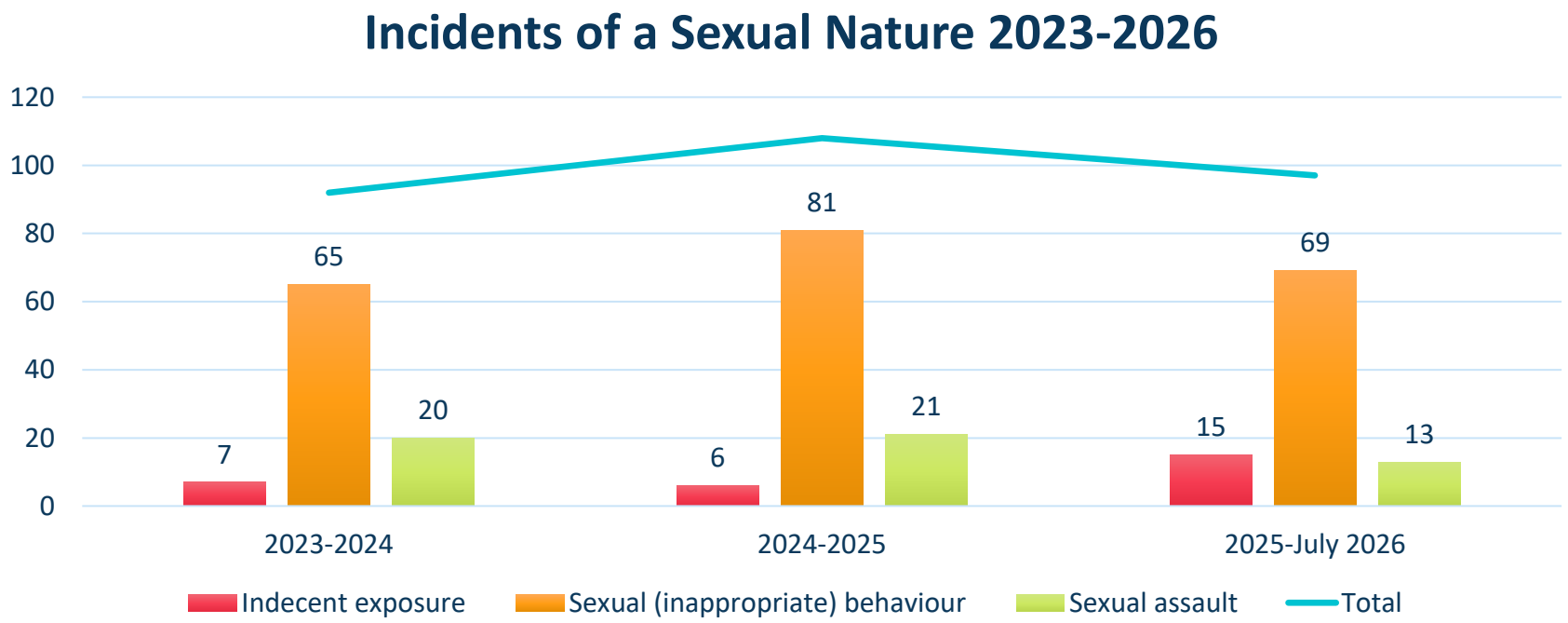




Accounting for 4.5% of incidents recorded over the last 3 years

Figure 2. Shows verbal abusive incidents recorded over 3 year period and total.

Types of Incidents

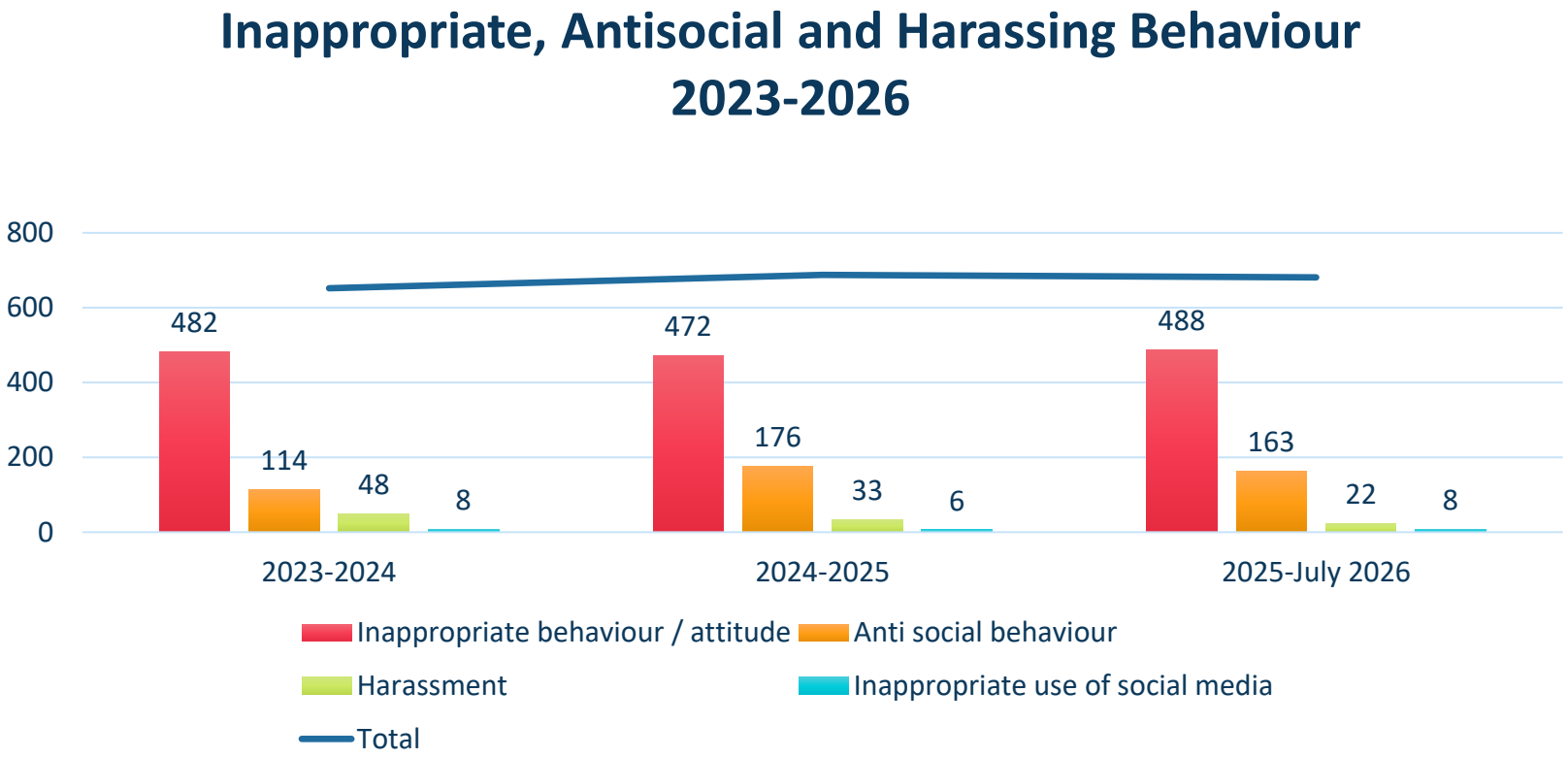




Accounting for 2.9% of incidents recorded over the last 3 years

Figure 3. Shows incidents of a sexual nature recorded over 3 year period and total.

Types of Incidents

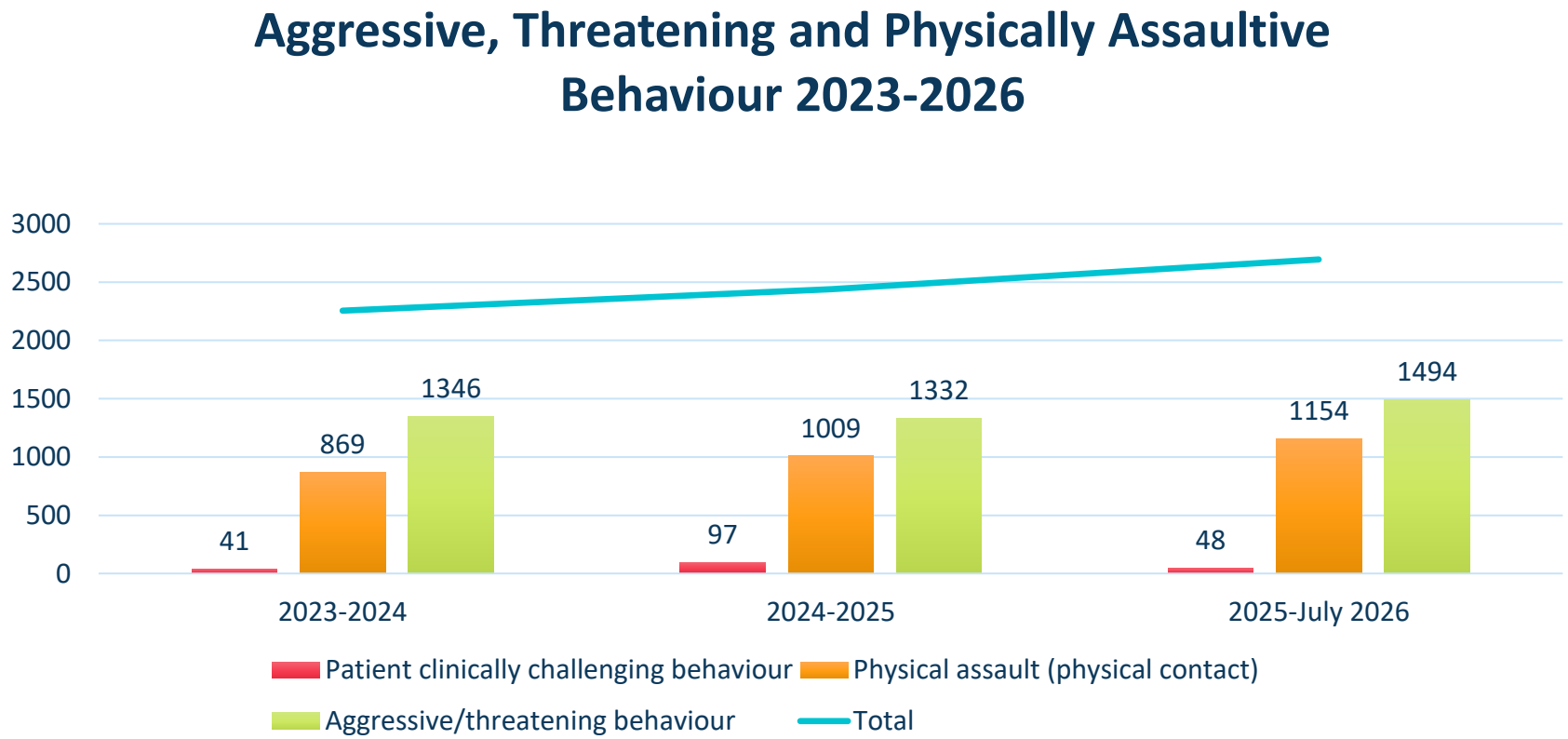




Accounting for 19.9% of incidents recorded over the last 3 years

Figure 4. Shows inappropriate Anti-social and harassing behaviour incidents recorded over 3 year period and total.

Types of Incidents

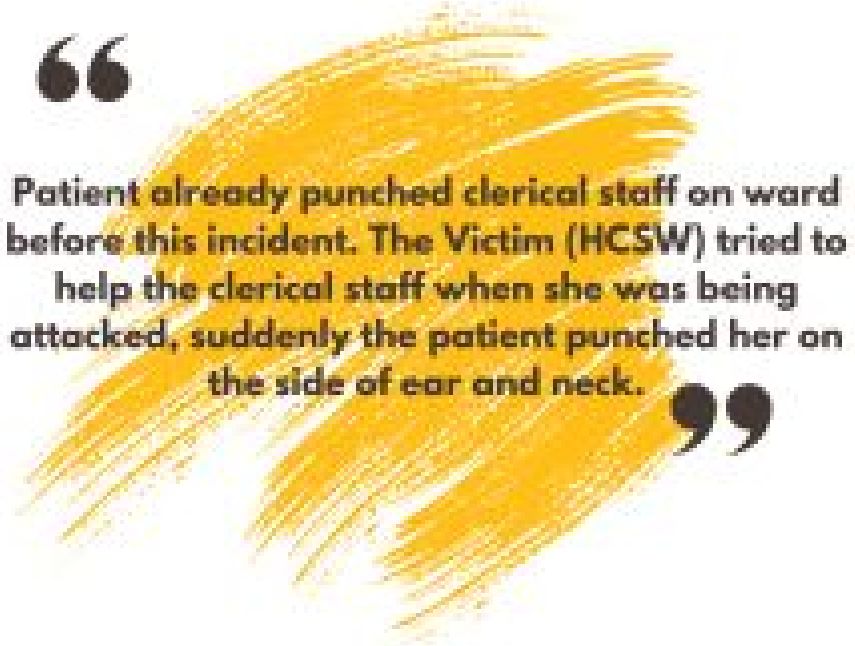


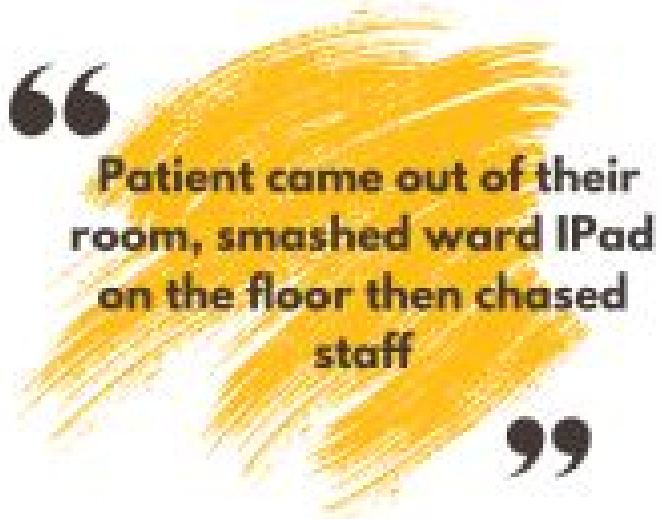


Accounting for 72.7% of incidents recorded over the last 3 years

Figure 5. Shows aggressive, threatening and physical assault incidents recorded over 3 year period and total.

Quotes from Staff reporting incidents:







Themes

- The findings indicate that violence and aggression is **not a marginal or isolated workforce issue**. Aggressive and threatening behaviour increased by 11% and reached its highest level in 2025/26.

- Repeated exposure to verbal threats, intimidation and hostility can affect staff wellbeing, perceptions of safety and willingness to engage confidently with patients. If these behaviours become viewed as simply “part of the job”, there is a **risk of normalisation**, under-reporting and reduced organisational learning.

- **Physical assaults** increased by 32.8%, from 869 incidents in 2023/24 to 1,154 in 2025/26.

- Reports of **racial verbal abuse** increased by 102.9%, from 35 to 71 incidents.

- **Staff are repeatedly managing behaviours** that can disrupt care, affect confidence and influence how safely therapeutic relationships can be maintained.

- An increase in reporting may reflect greater incident frequency, **improved reporting awareness**, changes in patient acuity or a combination of these factors.

- **Datix categories** limit precise interpretation

Repeat Offenders

- Repeat offender impact analysis showed that the ten most repeated offending occurred by patients within Mental Health and Learning Disabilities division. Some of these incidents crossed over into Complex & Long Term Care.
- Overall the MHLD division accounted for 57.1% of all reported V&A incidents.
- Top 10 repeat offenders were responsible for 603 incidents, equivalent to more than 1 in 10 incidents. This highlights the potential value of targeted, multidisciplinary risk management and individualised prevention plans for repeat offenders.
- It is important to note repeat offender analysis was limited by data quality, with 27.8% of incidents recorded without a named perpetrator.



Of incidents on Datix over the last 3 years had no Perpetrator recorded

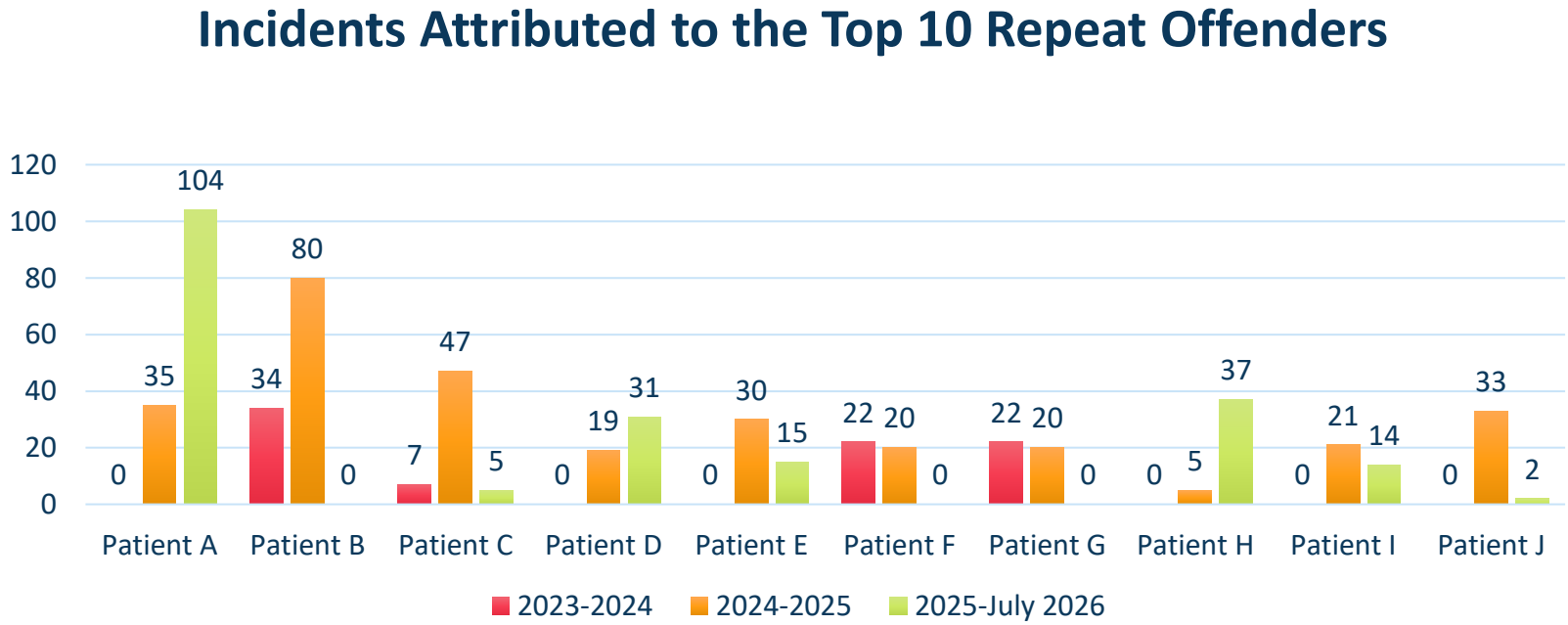


Figure 6. Shows incidents attributed to ten offenders accounting for more than 1 in 10 incidents.

Divisions

- Mental Health and Learning Disabilities accounted for 57.1% of all reported V&A incidents, more than four times the proportion recorded within Medicine, the next highest division.
- The six listed divisions collectively accounted for 93.8% of the Health Board total.

What does this mean?

- A targeted approach is likely to have greater impact than Health Board-wide measures alone.
- Prevention resources should prioritise Mental Health and Learning Disabilities while also focusing on the other highest-reporting divisions. Further analysis is needed to understand whether the high volumes reflect service activity, patient complexity, repeat offenders, environmental factors, or differences in reporting practice.

Division	Total	Percentage of overall total incidents	Average per year
Mental Health & Learning Disabilities	5797	57.10%	1932
Medicine	1250	12.30%	417
Primary Care & Community Division	962	9.50%	321
Surgery	551	5.40%	184
Estates & Facilities	499	4.90%	166
Urgent Care	468	4.60%	156

Table 3. Top Six Divisions by Number of Reported Violence and Aggression Incidents

Hot Spots

Community Risk

- Excluding MHLD locations, **patients' homes** were the highest-ranked hotspot, accounting for 310 incidents, 3.1% of all ABUHB V&A incidents.
- Incidents in patients' homes exceeded both GUH ED Majors and RGH MIU individually in every year reviewed.
- Over three years, GUH ED Majors recorded 109 incidents, 1.1%, and RGH MIU recorded 225 incidents, 2.2%.
- This challenges the perception that V&A risk is primarily concentrated in ED and MIU settings and demonstrates a significant, sustained risk to community-based staff.
- Note: Patients' homes recorded more incidents than each area individually, but not more than GUH ED Majors and RGH MIU combined, which recorded 334 incidents.

What does this mean?

- Community services require the same strategic focus as hospital hotspots, including strengthened lone-working controls, risk information, personal safety measures, incident reporting and targeted prevention plans.

Location	2023-2024	2024-2025	2025-2026	Total
Patients Home	84	117	109	310
Grange University Hospital ED - Majors	36	35	38	109
Royal Gwent Hospital MIU - RGH	82	80	63	225

Table 4. Comparison of V&A Incidents in Patients' Homes, Emergency Department and Minor Injury Unit Settings

Lost Time Incidents

- 50 V&A incidents met the RIDDOR reporting threshold during the review period.
- Of these, 42 incidents (84%) resulted in staff being unable to undertake normal duties for more than seven consecutive days.
- A further 8 incidents (16%) involved a specified injury.
- RIDDOR-reportable incidents remained broadly consistent, with 17 incidents in 2023/24, 17 in 2024/25, and 16 in 2025/26.

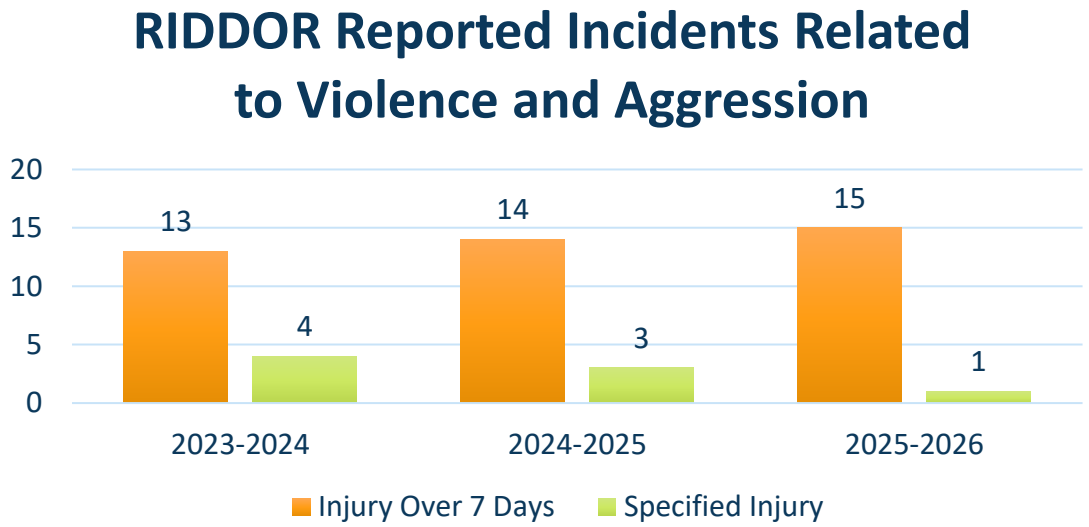


Figure 7. Shows number of RIDDOR reported incidents over 3 year period

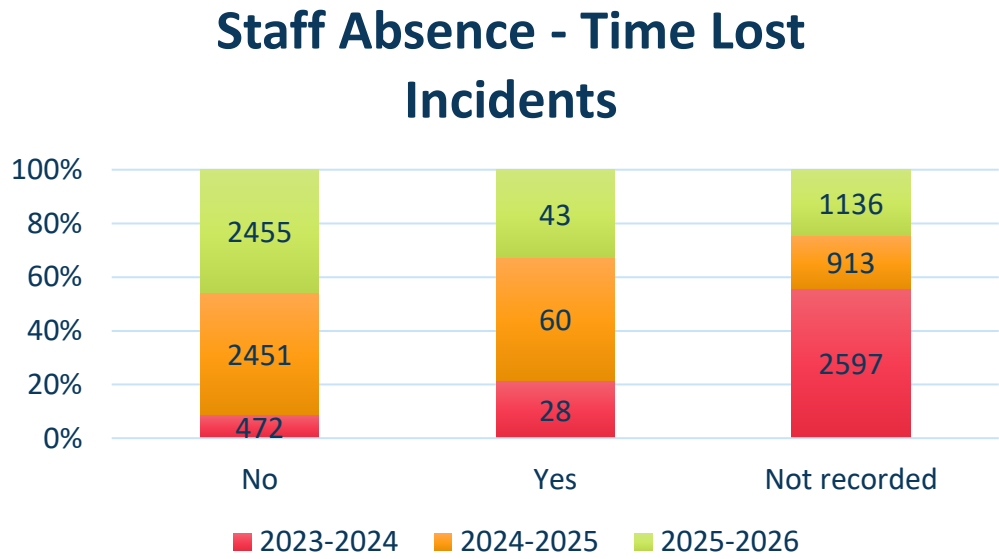


Figure 8. Shows staff absence recorded on Datix Cymru

- The stable annual number should not be interpreted as reassurance. It indicates a sustained level of serious injury that has not reduced during the review period.
- Staff absence can create additional staffing pressures, increase overtime, bank and agency costs, affect continuity of care, and reduce opportunities for consistent therapeutic relationships within clinical teams and patients.

Internal Sanctions and Complex Cases

- Datix Cymru records only 21 sanctions over 3 year period, which is unlikely to reflect the true level of activity.
- New ABUHB complex case guidance, aligned with the All-Wales guidance developed through the Anti-Violence Collaborative within Public Health Wales, was introduced in 2025/26.
- 12 Serious Case Panels were held during 2025/26 to address persistent nuisance, threatening and abusive behaviours. Actions ranged from warning letters to restrictions on how services were delivered.
- One complex case resulted in an individual's access to ABUHB premises being restricted for a 6 month period, except in an emergency, due to serious physical assault on a staff member.

Key gap: Sanctions and panel outcomes are not consistently recorded or linked to the relevant Datix incidents.

Priority: Improve recording to monitor the use, consistency and effectiveness of sanctions and complex case interventions.

Police Involvement

- Police contact recorded on Datix increased from 167 incidents in 2023/24 to 433 in 2025/26. Across the three-year period, police were contacted in 1,108 incidents, representing 10.9% of all reported V&A incidents.
- Although police contact reduced from its peak of 508 incidents in 2024/25, the overall rise may be viewed positively.
- Police outcome information is not consistently entered on Datix, meaning the Health Board cannot reliably determine how many reports resulted in investigation, arrest, charge, prosecution or no further action.

What does this mean?
Increased police reporting may reflect positive cultural and partnership changes, but inconsistent outcome recording prevents the Health Board from understanding the full criminal justice response and learning from reported incidents.

Police Contacted 2023-2024

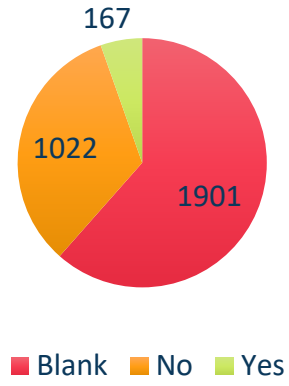


Figure 9. Shows number of police reported incidents recorded 2023-2024

Police Contacted 2024-2025

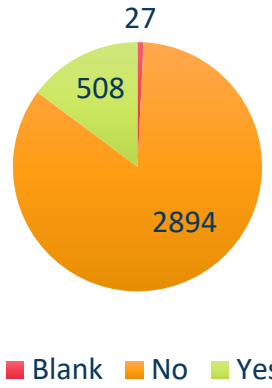


Figure 10. Shows number of police reported incidents recorded 2024-2025

Police Contacted 2025-2026

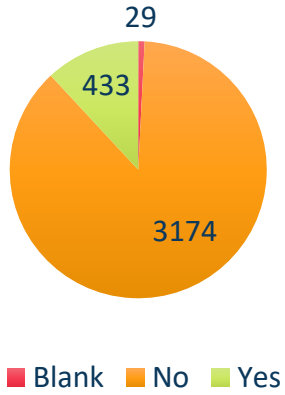


Figure 11. Shows number of police reported incidents recorded 2025-2026

Challenges & Data Limitations

- Findings are based on information recorded in Datix Cymru and the categories selected at the time of reporting.
- Individual incident narratives were not reviewed at this time due to high volume of incidents, so the accuracy and consistency of categorisation cannot be assured.
- Broad categories, such as Patient Clinically Challenging Behaviour, may include verbal abuse, threats, physical assault or inappropriate sexual behaviour.
- Reporting and classification practices may vary between staff, teams and service areas due to experiences and understanding.
- Findings should therefore be viewed as identifying broad themes, patterns and trends, rather than providing a definitive classification of every incident.
- Despite these limitations, every report represents an event considered significant enough by a staff member to record and remains an important indicator of staff experience and organisational risk.

Key challenge: Improve the quality and consistency of Datix recording to support more reliable analysis and targeted prevention.

Organisational Learning: From Insight to Action

What does the data tell us?

- V&A risk is concentrated within specific services, locations, behaviours and repeat-offender cohorts.
- The impact extends beyond physical injury to include staff wellbeing, absence, service resilience and therapeutic care.
- Community staff face significant risks alongside colleagues in acute hospitals and mental health settings.
- Data gaps limit understanding of repeat offending, staff absence, sanctions and police outcomes.

What actions can improve prevention, response and staff safety?

- Target limited resources towards the highest-risk areas and individuals. Including advanced Risk Assessments.
- Strengthen multidisciplinary management of repeat and complex cases.
- Improve staff support following incidents and recognise cumulative harm.
- The need to understand whether particular staff groups are being disproportionately affected and whether support and organisational responses are consistent.
- Improve the quality and linkage of Datix, workforce, sanctions and police data.
- Use these findings to guide delivery of the VPR Strategic and Implementation Plans 2026–2028.

Move from responding to individual incidents towards a targeted, trauma informed and intelligence-led prevention approach.

Violence Prevention & Reduction Strategic Plan

Strategic Response

The VPR Strategic Plan and Implementation Plan 2026–2028 provide a clear framework for addressing the issues identified through the thematic analysis.

Four objectives focus on:

- Trauma-informed and psychologically safe practice
- Improving reporting culture and data quality
- Strengthening equality, diversity and inclusion
- Developing a consistent, evidence-based training framework

- Other areas highlighted in this report including sanctions and complex case management are supporting coordinated responses to repeat and high-risk behaviour.
- Partnership working with Gwent Police, the Anti-Violence Collaborative and other agencies is being strengthened.
- Progress will be monitored using incident data, staff feedback, cultural measures, training outcomes and partnership activity.

What does this mean?

ABUHB has a clear strategic framework and governance in place. This analysis will help focus the Violence Prevention & Reductions limited resources on high-risk areas, repeat offenders, staff support and data quality, while measuring whether interventions improve staff safety.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	06 October 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Annual Quality Report; Primary Care Contracting, Primary and Community Care Academy and Quality and Patient Safety.
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Lloyd Hambridge, Divisional Director of Primary Care, Community Services and Complex and Long-Term Care

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report introduces the 2025/26 Annual Quality Report in respect of Primary Care Contracting, Primary and Community Care Academy and Quality and Patient Safety.

The full report is included as appendix 1.

Cefndir / Background

The annual report provides the detail in respect of commissioning arrangements between Aneurin Bevan University Health Board and its independent contractors across General Dental Services (GDS), Wales General Ophthalmic Services (WGOS), General Medical Services (GMS) and Community Pharmacy (CP).

Approximately 90% of all NHS patient interventions take place in primary care and community settings. The Health Board remains committed to the delivery of safe and effective patient centred, timely, quality health care through local commissioning with robust governance arrangements in place.

Consistent with previous years, the report includes the role of the Primary and Community Care Academy in the development of the multi-professional team within

primary care and a brief overview in respect of Quality and Patient Safety in the primary care context

Asesiad / Assessment

The 2025/26 Annual Quality Report (AQR) confirms the Health Boards commissioning arrangements and the management and monitoring processes in place, in accordance with the relevant Regulations, in respect of the following.

General Dental Services

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

72 General Dental Contracts were commissioned in 2025/26, with 53 practices opting into Contract Reform focusing on prevention and needs-based care, while the rest continued under traditional Units of Dental Activity (UDA) metrics. Activity data is provided in the report demonstrating the level of routine access across the Health Board.

Urgent dental access availability totalled 300 Emergency Dental Service appointments weekly across the Health Board. Capacity continues to meet demand within the service, which has seen an increase as a consequence of multiple GDS contract terminations in anticipation of the regulatory changes, effective 1 April 2026.

The report provides an overview of the GDS reform, the public consultation and associated regulatory changes, the contract terminations as a result and the planned procurement process with a view to recommission NHS GDS services. Also detailed is the management of the Dental Access Portal which support the equitable allocation of patients to NHS dental practices.

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

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

General Ophthalmic Services

In accordance with the National Health Service (Ophthalmic Services) (Wales) 2023 Regulations, during 2025/26, 55 optometry practices provided NHS Welsh General Ophthalmic Services (WGOS) including urgent and essential appointments alongside six domiciliary providers. All practices are required to provide WGOS 1 and WGOS 2, additionally, 35 practices provide low vision services through WGOS 3.

The continued implementation of enhanced services, particularly WGOS 4 and WGOS 5 pathways, enabled more patient to be managed safely within primary care, reducing demand on hospital eye services and improving access to timely assessment and treatment. This progress was supported by workforce development, digital innovation, pathway redesign and close collaboration between primary and

secondary care colleagues, helping to embed a more integrated eye care model across Gwent.

General Medical Services

During 2025/26, through The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023, the Health Board commissioned 68 General Practices, later reduced to 67 due to a merger, with 5 being directly managed by the Health Board.

The Health Board maintained continuity of service through effective contract management, support vulnerable practices, management of contract resignations and implementation of the Vacant Practice Policy. Practices continue to deliver against national quality improvement and access requirement whilst enhanced and supplementary services supported the delivery of care closer to home and improved access for patients. Robust governance and assurance mechanisms provided continued oversight of quality, safety and contractual performance.

Community Pharmacy Services

125 community pharmacies provided pharmaceutical services during 2025/26 in accordance with the terms of service laid out in the National Health Service (Pharmaceutical Services) (Wales) Regulations 2020. Alongside dispensing services, the pharmacies provide a range of additional clinical services commissioned using provisions in the Pharmaceutical Services (Clinical Services) (Wales) Directions 2022.

Alongside dispensing more than 16 million prescription items, pharmacies delivered a growing range of clinical services including independent prescribing, common ailments consultations, urgent medicines supply and contraception services. Activity increased significantly across many commissioned services, demonstrating the sectors contribution to improving access, supporting prevention and reducing pressures elsewhere in the NHS. Despite financial and workforce challenges, community pharmacies remined a key component of the primary care system supported by string governance, contract monitoring and collaborative engagement arrangements.

Primary and Community Care Academy

The Primary and Community Care Academy continued to strengthen workforce development across primary and community care by delivering a broad programme of education, training and professional development. The Academy supported staff at all stages of their career, from induction and transition programmes through to advanced practice development and leadership opportunities. Through multi-professional learning, partnerships with education providers and engagement with schools and universities, the Academy played an important role in supporting workforce sustainability, recruitment, retention and the development of future healthcare professionals across Gwent.

Quality and Patient Safety

Quality and Patient Safety activity throughout 2025/26 focused on supporting a culture of openness, learning and continuous improvement across primary care services. Continued implementation of the Duty of Candour and Duty of Quality, alongside robust incident review and governance arrangements, ensured that patient safety remained a central priority. The team provided support and oversight to independent contractors while promoting organisational learning and strengthening assurance processes to support the delivery of safe, effective and person-centred care across all primary care settings.

The Annual Quality Report for 2025/26 from the Primary Care, Community Services, Complex and Long-Term Care Division provides an overview of activity, performance, governance arrangements and key developments across primary care services during the reporting period.

Argymhelliad / Recommendation

The Patient Quality, Safety and Outcomes Committee is requested to note the detail provided in the 2025/26 Annual Quality Report

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

	Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers

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

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

ANNUAL QUALITY REPORT 2025/26

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

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

2025/26 Annual Quality Report

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Introduction

This annual report provides the detail in respect of commissioning arrangements between Aneurin Bevan University Health Board (ABUHB) and its independent contractors across General Dental Services (GDS), Wales General Ophthalmic Services (WGOS), General Medical Services (GMS) and Community Pharmacy (CP).

Approximately 90% of all NHS patient interventions take place in primary care and community settings. The Health Board remains committed to the delivery of safe and effective patient centred, timely, quality health care through local commissioning with robust governance arrangements in place.

Consistent with previous years, the report includes the role of the Primary and Community Care Academy in the development of the multi-professional team within primary care and a brief overview in respect of Quality and Patient Safety in the primary care context.

1. General/Personal Dental Services

During 2025/26, the Health Board commissioned General Dental Services (GDS) throughout Aneurin Bevan University Health Board (ABUHB) from independent contractors, through The National Health Service (General Dental Services Contracts) (Wales) Regulations 2006.

As of April 2025, there were 72 GDS contracts responsible for providing NHS general dental care to patients across the Health Board area. Since the introduction of the NHS GDS contract in 2006, patients are not registered with individual dental practices. Instead, it is the patient's responsibility to attend a dental practice regularly to maintain access to ongoing dental care. Dental practices receive an annual contract value (ACV) to deliver an agreed volume of NHS dental services for the population they serve, rather than holding a registered list of patients.

Since April 2022, all NHS general dental practices have had the opportunity to either opt into delivering their GDS contract through Contract Reform (CR) arrangements or remain on the substantive Units of Dental Activity (UDA) contract. Practices that have opted into CR are required to deliver against a set of metrics determined by Welsh Government (WG), with a focus on prevention and needs-based care. Whilst the core metrics remain unchanged, their specific application is subject to annual review by WG.

CR was implemented as a contract variation to the existing substantive NHS GDS Contract in accordance with the National Health Service (General Dental Services Contracts) (Wales) Regulations 2006. For those practices that remained with UDAs, they continued to provide dental services in accordance with The NHS (GDS Contracts) (Wales) Regulations 2006.

In 2025/26, 53 NHS GDS practices opted-in to deliver dental services via CR.

Practices that opted into CR in 2025/26, were required to deliver the following:

- *Complete and report **ACORN** (Assessment of Clinical Oral Risk and Needs assessment) findings;*
- *Accept at least 153.62 **New patients** (NP) and 74.61 **New Urgent patients** (NUP) per £197,725 of Annual Contract Value (ACV) (per year);*
- *See a minimum of 1,316.70 **Historical patients** (HP) per £197,725 ACV. A historical patient is defined as someone who a dentist has submitted a claim for in the previous four financial years;*
- *Apply Fluoride Varnish (FV) to at least 80% of all adult patients with risk of (amber), or active decay (red) and at least 80% of all child patients aged 3 and over as well as for child patients aged under 3 with a risk of caries (red or amber);*

- *Deliver 25% of their contracted UDAs; and*
- *Quality Improvement activities.*

The table below provides a summary of the number of practices within each borough that opted into CR or delivered activity against UDAs over recent years.

Table 1 - CR and UDA Practices by borough

Borough	**2023/24**		**2024/25**		**2025/26**	
	CR	**UDA**	**CR**	**UDA**	**CR**	**UDA**
Blaenau Gwent	7	3	9	2	9	2
Caerphilly	13	16	13	12	17	8
Monmouth	5	8	9	3	7	2
Newport	9	6	10	4	10	4
Torfaen	7	6	11	3	10	3
Totals	**41**	**39**	**52**	**24**	**53**	**19**

The following graph, Figure 1, details the total number of patients seen between 2032/24 to 2025/26 at practices who delivered their contract via CR.

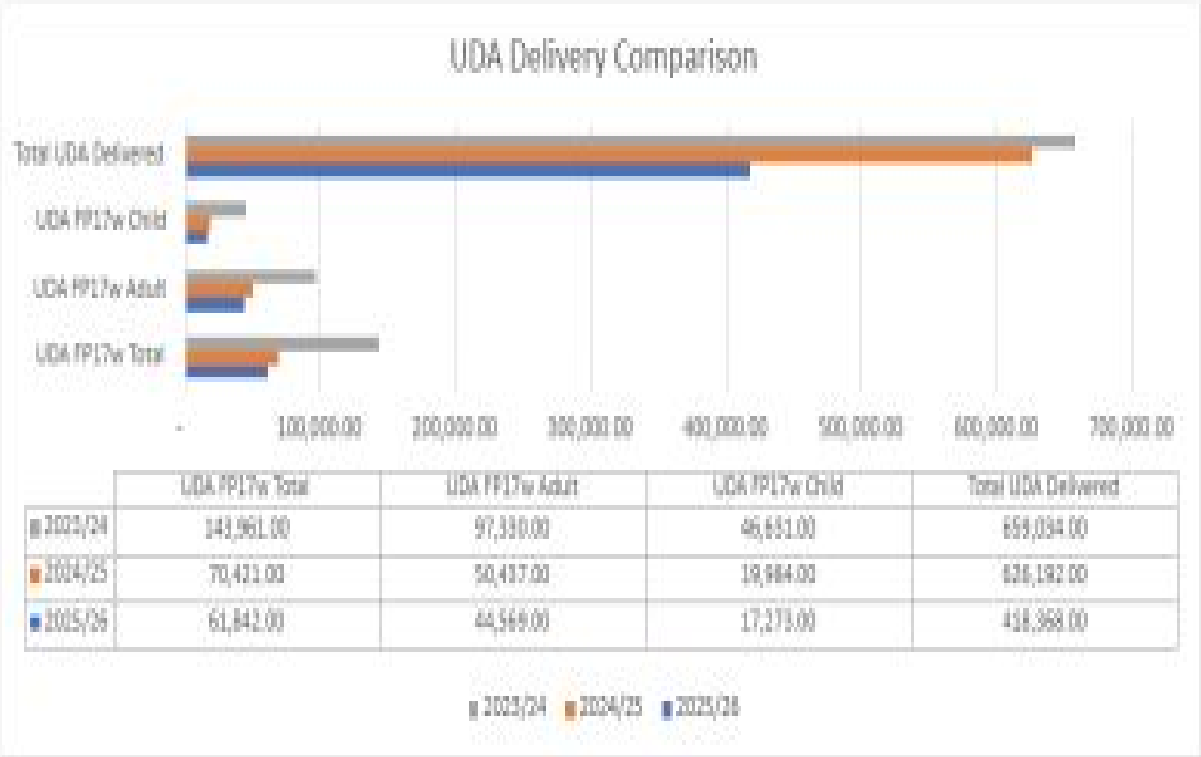


Figure 1 – CR activity between 2023-2026

The data shows a rise in CR activity between 2023/24 and 2024/25; this is due to more practices opting to deliver via CR. Urgent patient activity has steadily declined which is likely due to new patient access increasing.

2025/26 activity sees a slight decrease in overall activity which is due to several contract terminations and contract variations during the year, ahead of the regulatory changes that came into effect in April 2026.

The following graph, Figure 2, details the total number of UDAs delivered and number of FP17w forms submitted between 2023/24 to 2025/26 at practices who delivered their contract via UDA.



	UDA FP17w Total	UDA FP17w Adult	UDA FP17w Child	Total UDA Delivered
2023/24	143,961.00	97,330.00	46,631.00	659,034.00
2024/25	70,431.00	50,437.00	19,994.00	636,192.00
2025/26	61,842.00	44,569.00	17,273.00	418,368.00

Figure 2 – UDA activity between 2023-2026

The reduction in UDA activity between 2023/24 to 2025/26 is reflective of the shift of practices to delivering their contract via UDA to CR, alongside the impact of contract terminations and contract variations that have reduced the overall commissioned UDAs.

As detailed above, practices were also required to undertake quality improvement activities which in turn related to the 2025/26 annual contract uplift.

1.1 Annual Uplift for 2025/26

In January 2026, Welsh Government issued communication to all Health Boards and NHS dental contract holders regarding the NHS Dentistry Annual Pay Uplift for 2025/26. It was confirmed that a 4% contract uplift would be invested subject to the following conditions:

- Every NHS dental contract holder, excluding orthodontic contracts, required to repeat the antimicrobial audit conducted in 2023/24 and 2024/25, compare the findings and discuss the outcome with practice staff to identify any actions to improve antibiotic prescribing by 30 June 2026.
- To undertake a structured review of the current urgent care provision. This review should identify definitive care is being provided and highlight where changes may be needed to align the contracts emphasis on delivering definitive urgent care. It is intended as a whole team learning exercise, with findings to be shared and discussed across the dental team.
- From 2 January 2026, for every paediatric referral for additional/ advanced services practices need to include on the referral form the dates of the two attempts made to treat the child within the practice, prior to making a referral. Practice records should include the date of the treatment attempt, the type of treatment provided, the patients response and the reason for non-completion if necessary. In addition, where referrals are required, a summary of the documented attempts must accompany the referral documentation, along with required radiographs
- From 1 February 2026, all NHS dental contract holders must implement a Did Not Attend (DNA) policy aligned with the Practice of Health DNA protocol.

Confirmation of compliance will be sought, via self-declaration, by the 30 June 2026 in line with the national timescales

1.2 Urgent Access

Urgent Access remains a key priority for the Health Board. From 1 April 2025, the Health Board commissioned 87 core Emergency Dental Service (EDS) appointments per week via EDS Personal Dental Services (PDS) contracts, with an additional 213 EDS appointments commissioned per week as a result of the CR requirements for 2025/26.

The table below, Table 2, is a summary of the number of EDS appointments available per week, per borough over recent years.

Table 2 - EDS appointment available by borough

Borough	2023/24		2024/25		2025/26	
	Contract Reform EDS appts per week	Core EDS appts per week	Contract Reform EDS appts per week	Core EDS appts per week	Contract Reform EDS appts per week	Core EDS appts per week
Blaenau Gwent	34	21	34	21	33	21
Caerphilly	52	6	47	6	63	6
Monmouth	16	12	14	9	26	9
Newport	64	51	56	51	55	42
Torfaen	44	9	32	9	36	9
Total	**210**	**99**	**183**	**96**	**213**	**87**
Annual Total/Week	**309**		**279**		**300**	

The Health Board has maximised the use of these appointments by introducing a pathway between Gwent Urgent Primary Care (UPC) and in hours EDS appointments via the Dental Helpline. A number of appointments have been ring fenced to enable patients that contact UPC the opportunity of an EDS appointment.

The following table, Table 3, details the number of urgent patients seen between April 2023 – March 2026 for EDS care via the EDS PDS providers.

Table 3 - Number of EDS patients seen

	Number of Patients Seen		
Month	**2023/24**	**2024/25**	**2025/26**
April	1104	1105	1114
May	1126	1081	1025
June	1141	1048	1090
July	1200	1028	1163
August	1225	890	1011
September	1118	889	1064
October	1097	945	1138
November	988	830	970
December	870	886	1110
January	777	870	1072
February	638	841	996
March	599	802	1051
Total	**11,883**	**11,220**	**12,804**

The increase in the number of patients accessing the EDS service is reflective of the contract terminations and contract variations which took effect during 2025/26.

The following graph, Figure 3, details the number of EDS appointments available each year and the number of patients seen for EDS care during between 2023/24 - 2025/26.



Figure 3 - Number of EDS patients seen

The Primary Care Contracting Team (PCCT) monitors EDS demand and capacity throughout the year and overall, for 2025/26 practice capacity outweighed patient demand. Recognising this under-utilisation of EDS appointments, the Health Board reduced EDS capacity offered through the PDS arrangements, from August 2025 by 25%.

The table below, Table 4, details the reduction by borough:

Table 4 – EDS PDS reduction by borough

Borough	Original weekly EDS appointments	Reduced weekly EDS appointments (after 25% reduction)
Blaenau Gwent	6	4
Caerphilly	6	4
Newport	42	32
Torfaen	9	7
Total Appt Per Week	63	47

Information has also been issued to all GP practices and community pharmacies to ensure any patients experiencing dental pain are directed to the Dental Helpline where the team can facilitate an EDS appointment if appropriate. Public communication has also been shared via social media and other Health Board channels.

1.3 Backlog/Waiting Times

Since 2023, referrals to Specialist Dental Services have generally remained consistent.

The table below, Table 5, details the referral rates for each sub-speciality as a combined total for primary and secondary care between January 2023 – March 2026.

Table 5 - Referral rates between January 2023 – March 2026

	Number of Referrals			
Speciality	**2023**	**2024**	**2025**	**January - March 2026**
Max Fax	916	1057	1116	293
Oral Surgery	4837	4362	4462	1205
Oral Medicine	837	829	848	180
Orthodontics	4989	4726	4527	1170
Paediatrics	2452	2350	2049	411
Restorative	537	551	518	131
Sedation	457	508	443	125
Special Care	439	401	336	89
Urgent Cancer Referral	501	526	514	139

Referral data is reported January – December

The data reported in table 5 is supported by the following graph, Figure 4.

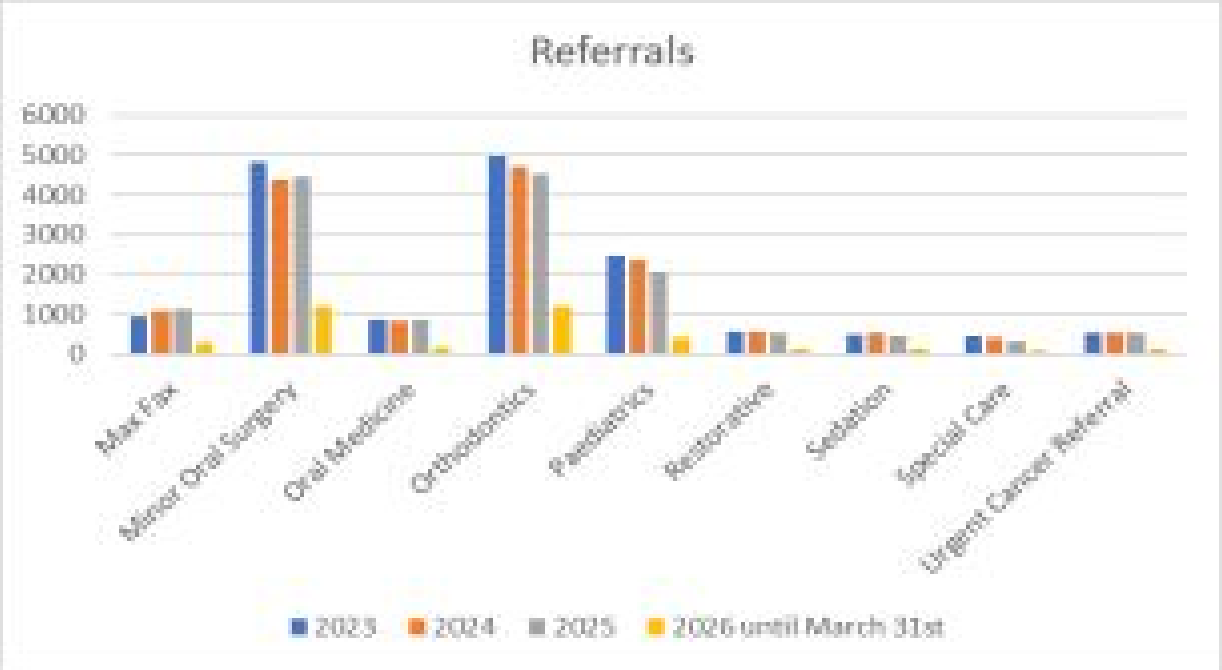


Figure 4 - Referral rates between January 2023 – March 2026

1.3.1 Orthodontics

The Health Board commissioned orthodontic services via six providers during 2025/26. The following table details the orthodontic practices across ABUHB.

Table 6 - Orthodontic Provision by Borough

Borough	Number of Orthodontic Practices 2025/26
Blaenau Gwent	1
Caerphilly	1
Monmouth	1
Newport	2
Torfaen	1
Totals	6

In order to be eligible for NHS orthodontic treatment, patients must score at least a 3.6 as part of the Index of Treatment Need (IOTN) assessment criteria. Following the pandemic, WG advised that patients with an IOTN of 4 or 5 should be prioritised for treatment.

Historically, orthodontic services have always managed a waiting list from referral to assessment and then from assessment to treatment.

The Health Board regularly collates wait times and waiting list numbers from orthodontic practices and in December 2025 the following wait times were reported as an average across all NHS Orthodontic practices:

- Referral to Assessment = up to 2.5 years
- Assessment to Treatment = up to 7 years

Between January and March 2026, the Health Board invested an additional £200,000 into orthodontic services, on a non-recurrent basis, which allowed 113 additional eligible patients to commence NHS orthodontic treatment, and reduced the average assessment to treatment wait time to 6 years.

Commissioning arrangements were based on The Health Services (Provider Selection Regime) (Wales) Regulations 2025 as part of regulation 13, part 2.

There is no national guidance for orthodontic practices to follow with regards to the management of waiting lists. As detailed above some practices will have a longer wait time for an assessment appointment and shorter wait time for a treatment appointment and/or vice versa.

To support both patients and orthodontic practices, the Health Board has developed an orthodontic list closure process which supports the consideration and management of orthodontic provider requests to temporarily close their list to new referrals. Orthodontic providers continue

to manage their waiting lists to full capacity within their attributed funding. By the Health Board agreeing temporary list closures this enables orthodontic providers to appropriately manage their waiting lists and ensures patients are not waiting longer at one provider when an alternative provider has a shorter waiting time.

During 2025/26, three orthodontic practices temporarily closed their lists to new referrals in order to manage waiting list pressures and waiting times; one practice in Blaenau Gwent, one practice in Caerphilly and one in Torfaen. All three practice lists remain closed.

The PCCT monitors each orthodontic contract via its activity delivery and an annual independent Peer Assessment Review (PAR) outcome audit. For 2025/26, orthodontic performers were asked to PAR score 20 completed patient treatments. Where a performer has less than 20 completed patient treatments, they are asked to PAR all. This review process for 2025/26 is in progress and practices have until October 2026 to confirm their review findings. The PAR findings for 2024/25 showed that 103 PAR cases were submitted. 100% of cases demonstrated an improvement in PAR scores. 87 cases achieved greatly improved outcomes, and 16 cases achieved improved outcomes. No cases were identified as worse or no different.

The PCCT also manages patient transfer requests, typically for patients who are receiving active orthodontic care initiated outside of the Health Board area and are relocating within ABUHB. In 2025/26, the team managed 10 transfer requests, supporting 7. The 3 cases not supported were because the patients were not receiving active orthodontic treatment.

The Health Board received 6 patient concerns in 2025/26 relating to wait times in orthodontic services. The concerns were resolved and have been reviewed to identify any recurring themes, and the feedback will continue to inform service improvement initiatives, patient communication, and waiting list management to ensure patients are kept informed and supported throughout.

1.3.2 Oral Surgery

The Health Board commissions a referral-based Primary Care Oral Surgery Service via two dental practices:

- Blackwood Dental Centre, Caerphilly; and
- Kensington Court, Newport.

As of March 2026, the waiting time from referral to assessment, across both sites, was between 2 - 4 weeks, with approximately 566 patients awaiting an assessment. This reflects a positive reduction in demand on the waiting list compared with April 2025, when 715 patients were awaiting an assessment, indicating improved service capacity and access for patients.

The waiting time from assessment to treatment was approximately 22 weeks, with around 390 patients awaiting treatment.

Every six months, the Health Board's Dental Practice Advisors review a sample of patient referrals to ensure clinical appropriateness. During 2025/26, 40 referrals, roughly 10% of those sent in 2025/26, were chosen at random to be audited. The audit found that all referrals reviewed that were accepted and treated were appropriate for the Minor Oral Surgery service. Within the 40 referrals that were reviewed, six referrals were returned to the referring General Dental Practice as they did not meet the clinical criteria for the service due to simplicity

The PCCT continues to monitor service delivery, engaging with the service providers and referring practitioners.

1.3.2.1 Oral Surgery with Sedation

The Health Board historically commissioned an Oral Surgery with Sedation service. However, the service was suspended from 1 April 2023 following the termination of the agreement by the existing provider. During 2023/24, the PCCT successfully procured the service from an alternative provider, with a contract in place from 1 July 2024 - 31 March 2026.

Following the termination of the previous agreement, a cohort of patients had either been referred for Oral Surgery with Sedation or were part way through their treatment pathway. The successful procurement of a replacement contract in 2024 enabled these patients, who had been referred prior to the cessation of the previous service, to receive the treatment they required. As the purpose of the contract was to address the backlog of patients affected by the service suspension, the agreement was time-limited and concluded on 31 March 2026. 301 patient referrals were directed to the provider. Of this, 134 patients were removed from the list, either declining treatment or receiving treatment elsewhere. The remaining 167 patients either completed treatment, DNA’d or the practice could not make contact. Additionally, to support the management of the Oral Surgery Service waiting list, 250 referrals were redirected from one Oral Surgery provider to the Oral Surgery with Sedation provider to enable timely care for patients. Of those 250 patients, 215 received treatment and the remaining 35 patients either declined treatment at the practice or advised that treatment had been received elsewhere

1.3.3 Sedation

Gateway Dental Surgery, Monmouthshire, is commissioned to provide an inhalation sedation service for adults across Gwent, via an NHS PDS contract.

In December 2025 the following wait time was reported:

- Referral to Assessment = up to 11 months / 547 patients waiting
- Assessment to Treatment = up to 2 months / 57 patients waiting

The contract and service continue to be managed as per the NHS PDS Wales Regulations 2006.

1.3.4 Domiciliary Services

A Health Board wide domiciliary service is commissioned via Blackwood Dental Centre.

The purpose of the domiciliary dental care service is to deliver safe and effective oral health care to people whose circumstances make it impossible, unreasonable or otherwise impractical for them to receive care in a dental surgery.

The range of dental care that can be provided safely at a person's home/residence is limited.

The following services are available to domiciliary patients. However, this list is not definitive, and clinicians will assess and provide the best and most appropriate dental care possible under the circumstances presented to them:

- Oral health risk assessment (ACORN) and clinical examination;
- Oral health prevention, oral hygiene instruction and dietary advice;
- Prescription of higher strength fluoride varnish, toothpaste and mouthwashes;
- Denture repair and construction;
- Temporary dental fillings (restorations) or smoothing of sharp teeth;
- Sealing of root remnants, where appropriate;
- Sub and supra gingival debridement (Scaling); and
- Simple extractions that do not require radiographic examination.

Blackwood Dental Centre is supported by an Oral Health Improvement Practitioner (OHIP), which domiciliary patients access following referral by the dentist. The OHIP, employed by Community Dental Services (CDS), provides support to patients, including those in residential homes, as well as providing preventative care.

In addition to this practice, there were three practices; Trefynwy Dental Practice, Teeth for Life and Usk Dental Practice, all within the Monmouthshire borough, that also provided domiciliary care to their own practice patients in 2025/26. From April 2026, this service is no longer available to this cohort of patients due to the NHS GDS regulatory change that took effect from 1 April 2026; however, these patients can access domiciliary dental care from Blackwood Dental Centre.

Requests for domiciliary visits are managed via the ABUHB Dental Helpline with the Community Dental Service triaging those referrals to ensure the patient is seen in the most appropriate setting i.e., CDS or primary care.

In 2025/26 836 referrals were received in total with 305 of those referrals directed to Blackwood Dental Centre. The Health Board will closely monitor the impact of the regulatory change on the service and the wait list, from April 2026.

1.3.5 Prison Services

The Health Board commissions Time for Teeth Ltd to provide General Dental Practitioner and Therapist sessions to the population of His Majesty's Prisons (HMP) Usk and HMP Prescoed to ensure equitable access to NHS Dental Care. The delivery of the service is monitored by the PCCT, and quarterly meetings take place with the service provider.

Regular updates are provided to the Prison Delivery Group and Prison Partnership Board. Patients' complete questionnaires evaluating their overall experience, with the results shared with the Health Board. Overall patients reported a very positive experience.

Time for Teeth Ltd are commissioned to provide 5 sessions per week, the below details a breakdown provided across both sites.

- Tuesday AM – Usk and PM – Prescoed – Dentist
- Wednesday AM/PM - Usk – Therapist
- Wednesday AM/PM - Prescoed – Dentist Assessment Clinic
- Friday AM – Usk and PM – Prescoed – Dentist

1.4 Mid-Year

The NHS GDS contract (2006 Regulations) stipulates a threshold of 30% achievement at mid-year. In 2025/26, of the 19 UDA contracts, 4 contracts achieved less than 30% as of 30 September 2025.

Of the 53 Contract Reform contracts, 20 contracts achieved less than 30% as at September 2025 against the NP, HP metric or any of the combination.

To understand the reasons for under achievement, the PCCT met with practices to discuss the issues affecting contract delivery. All practices identified similar challenges which were attributed to their low performance as detailed below:

- Historic Patient (HP) difficult to achieve due to low recall rates.
- Contractors not having enough HP base.
- High level of did not attend's (DNAs) and late cancellations.

- Software claiming issues.
- Workforce, recruitment and retention issues relating to dental associates and therapists.

Whilst the above were acknowledged as challenges impacting contract delivery at that time, all providers were able to provide the Health Board with assurances, via a detailed business case, that they had instigated processes to remedy the low performance, with the aim for full year contract delivery at year-end. The PCCT agreed with all providers to continue to monitor delivery and maintain dialogue through the second part of the year.

As part of the Mid-Year process any practice can request a meeting with the Health Board to discuss their performance. The Health Board received no requests from providers who had achieved over the required 30% threshold.

1.5 End of Year

During 2025/26, all NHS GDS practices within the Health Board were monitored and managed in accordance with the NHS GDS Wales Regulations 2006. This includes undertaking mid-year reviews as detailed above, and managing end of year (EOY) performance against agreed contractual measures, whether based on UDA targets or CR metrics.

Following consideration of any nationally agreed mitigation and/or offsetting arrangements, financial recoveries are pursued in all instances where underperformance has been identified.

Practices delivering their contracts under CR arrangements were managed in accordance with the Welsh Government EOY Performance Management Guidance issued on 22 January 2025. Practices operating under UDA contracts were managed in accordance with the NHS G/PDS Wales Regulations 2006.

Where a practice was projecting under-performance in March 2026, they were encouraged to commence recoveries early, with the Health Board reconciling at final year-end (June 2026).

Practices were given the option for financial clawback to be recovered via the COMPASS system in instalments or in a lump sum. In addition, practices had the option to pay via a one-off Bacs payment. Where a practice had under-performed recoveries are required to be paid in full by 30 September 2026.

To following tables, detail the indicative End of Year position of all contract types for 2025/26.

Table 7 – CR

CR	Practices Affected
Financial Recovery	11
Carry Forward of underperformance activity 95%-100%	23
Financial Recovery of 5% underperformance activity where a practice achieved < 95%	12
Overperformance (value into 2026/27)	6

Table 8 - UDA

UDA	Practices Affected
Financial Recovery	12
Carry Forward of underperformance activity 95%-100%	5
Financial Recovery of 5% underperformance activity where a practice achieved < 95%	4
Overperformance (value into 2026/27)	5

Table 9 - Orthodontic

Orthodontic	Practices Affected
Financial Recovery	0
Carry Forward of underperformance activity 95%-100%	3
Financial Recovery of 5% underperformance activity where a practice achieved < 95%	0
Overperformance (value into 2026/27)	3

Table 10 - Speciality Breakdown

Breakdown Speciality	Practices Affected
Financial Recovery	0
Carry Forward of underperformance activity 95%-100%	1
Financial Recovery of 5% underperformance activity where a practice achieved < 95%	0
Overperformance (value into 2026/27)	0

The information presented in the tables above are provisional and remain subject to change. Contractors may choose to repay underperformance in

full instead of carrying forward up to 5% into 2026/27. The 2025/26 EOY reconciliation process remains ongoing at the time of reporting.

1.6 Reform of NHS GDS

In the Summer of 2025, Welsh Government undertook a public consultation on the reform of NHS dental services in Wales where consideration was given to how access and quality can be improved. The proposals sought to address longstanding challenges within the existing contractual framework, including the complexity of remuneration arrangements, variations in access, and an over-reliance on routine examinations. Key reforms included the introduction of a single route of entry for patients accessing NHS dental services, a fairer and more transparent remuneration model, a greater focus on clinical need and preventative care, revisions to patient charge arrangements, and amendments to contract terms and conditions.

The consultation concluded in September 2025, with the outcome informing the development of the National Health Service (General Dental Services Contracts and Patient Charges) (Wales) Regulations 2026. The Regulations were subsequently laid in February 2026 and came into force on 1 April 2026, introducing a revised contractual framework designed to improve patient access, support preventative care, increase consistency in service delivery, and provide a more sustainable model for NHS dentistry across Wales.

Throughout 2025/26, the PCCT has worked collaboratively with Welsh Government, the British Dental Association (BDA), Gwent Local Dental Committee (LDC), NHS Dental Contractors and NHS Wales Shared Services Partnership (NWSSP), in order to navigate through these changes. Both Welsh Government and the Health Board held face to face engagement events with the dental profession in quarter 4 of 2025/26 to support practices through the transition to the new arrangements. Additionally, regular stakeholder engagement, dissemination of guidance, contract management discussions and the provision of ongoing advice and assistance to ensure compliance with the revised regulations has taken place over recent months.

1.7 Contract Terminations and Variations

There continues to be many challenges facing NHS dentistry across Wales, and ABUHB has received numerous contract terminations and variations by reduction.

Notably, as a consequence of the uncertainty surrounding the regulatory changes, during 2025/26, the Health Board received notification of 15 contract terminations; 3 taking effect during 2025/26 and 12 taking effect from 1 April 2026. Additionally, the Health Board received notification of 2 contract variations; 1 taking effect during 2025/26 and 1 taking effect from

1 April 2026. More recently, the Health Board received notification of a further 2 contract variations effective from 1 April 2026.

The table below, Table 11, details the contract terminations and variations between September 2025 – April 2026.

Table 11 - Contract terminations and variations

2025/26	Sep-25	Contract Termination	Lodge Dental, New Inn, Pontypool, Torfaen
	Dec-25	Contract Variation	Gateway Dental, Monmouthshire
	Dec-25	Contract Termination	JPTD Limited, Cefn Forest, Caerphilly
	Dec-25	Contract Termination	Edwards Dental, Cwmbran, Torfaen
2026/27	Apr-26	Contract Termination	Chepstow Road Dental, Newport
	Apr-26	Contract Termination	Teeth for Life, Caldicot
	Apr-26	Contract Termination	94 Dental, Newport
	Apr-26	Contract Termination	Cwmbran Dental Spa, Torfaen
	Apr-26	Contract Variation	North View Dental Surgery- Caerphilly
	Apr-26	Contract Termination	Crown Cottage Dental, Caerphilly
	Apr-26	Contract Termination	Devon Place Dental, Newport
	Apr-26	Contract Termination	Thomas & Stroud, Newport
	Apr-26	Contract Termination	Bupa Bassaleg, Newport
	Apr-26	Contract Termination	Red House Dental, Torfaen
	Apr-26	Contract Termination	Thrive Dental, Torfaen
	Apr-26	Contract Termination	Newport Dental Care, Newport (EDS PDS Contract)
	Apr-26	Contract Variation	Bupa Chepstow Community Hospital, Monmouth
	Apr-26	Contract Termination	Rhos Dental Surgery, Caerphilly (EDS PDS Contract)
	Apr-26	Contract Variation	Bupa Dental Care, Newport

Approximately 65,000 NHS patients have been potentially affected by the contract terminations and variations. Patients known to be impacted by these changes are directed to the Dental Access Portal (DAP) to support access to routine NHS dental care. While awaiting allocation to a regular NHS dental practice, if patients require urgent dental care, they may contact the Dental Helpline.

The Health Board recognises the impact on patients if they are unable to access routine NHS dental care and will be procuring for replacement NHS GDS service provision during 2026/27 as per the competitive process of The Health Services (Provider Selection Regime) (Wales) Regulations 2025

1.8 Dental Access Portal

In response to the Welsh Parliament Health & Social Care Committee's recommendations in February 2023, the Dental Access Portal (DAP) was developed to centralise and streamline the dental access list system in Wales. Designed and built by Digital Health and Care Wales (DHCW), the DAP is a digital platform that allows individuals across Wales to register their interest in accessing routine NHS dental treatment. This centralised system enables all Health Boards to manage and allocate available places at NHS dental practices more effectively and equitably, based on local capacity.

The DAP was launched within the Health Board in February 2025, and, from the 1 April 2026 is established as the mandatory route for dental practices

to accept all new patients (NP), in accordance with The National Health Service (General Dental Services Contracts and Patient Charges) (Wales) Regulations 2026.

It is the responsibility of patients to add their details to the DAP if they wish to access routine NHS dental care and have not done so in the previous four years. It is important to recognise that joining the DAP does not facilitate earlier access to routine NHS dental care; rather, it allows for more equitable management of access and supports demand and capacity reporting and analysis.

During 2025/26, the use of the DAP was not a mandatory requirement and 20 practices requested NPs from the DAP, while a number of practices continued to operate their own patient waiting lists.

Within ABUHB, the PCCT coordinates and manages the DAP. This includes overseeing the patient list, allocating patients to practices, supporting with patient and practice queries, and reporting the overall position on a monthly basis at various meeting forums. The information collected through the DAP is also used to inform future service planning, support demand and capacity mapping, identify areas of high need, and help ensure that primary care resources and services are aligned to population requirements across the Health Board.

As of March 2026, a total of 17,661 patients enrolled on the DAP across the five Health Board boroughs. 6,486 patients were allocated to an NHS dental practice and an additional 384 patients deactivated their interest on the DAP; this may be as a result of a patient no longer wishing to access NHS dental care.

The Health Board recognises that receiving new patients via DAP allocations, represents a new way of working for the majority of dental practices. Feedback received from practices since implementation has enabled the PCCT to review and refine the patient allocation process to better support service planning and delivery at both a practice and Health Board level. In response, practice guidance and operational processes have been updated, and a supporting Frequently Asked Questions (FAQ) document has been enhanced to reflect feedback regarding the management of patient communications.

1.9 Governance and Reporting

Robust mechanisms are in place to monitor all contract delivery and activity on a monthly basis, with a formal meeting on a quarterly basis to undertake a more in-depth analysis of contract activity. Members of the quarterly meeting include Health Board Primary Care Contracting Managers, Dental Practice Advisor(s) and NHS Business Service Authority (BSA) colleagues.

Whilst Health Board monitoring of the contract activity occurs monthly, the NHS BSA also undertake independent reviews of contract activity in the form of, Immediate Assurance reports, Peer Assessment Report (PAR), and Provider Assurance Dental (PAD) ACORN support.

Immediate Assurance reports are high level contract reports provided monthly to the Health Boards. The contract data is presented in a way which is benchmarked against the Health Board and Welsh averages to help identify outliers in service provision. If outliers are identified the Health Board can request NHS BSA to undertake a Peer Assessment Report (PAR) audit. This provides the Health Board with an in-depth review of practices claiming data. The process is a supportive mechanism for practices, ensuring inconsistencies are highlighted at the earliest opportunity for practices to make amendments to their claiming processes.

In addition, NHS BSA offer support to Dental Contractors with the completion of an ACORN, via PAD Acorn assessment review. The primary focus of these reviews is around education regarding Oral Health Assessments.

Reports received during 2025/26:

- 14 PAR reports were prepared and shared with practices. All of which will receive a further review in 12 months.
- 4 data reports were compiled with the Dental Practice Advisors meeting with the practices to discuss the findings. The practices now fall under normal review processes.

The PCCT ensures that risk is managed appropriately and through prompt identification and assessment, reported into Dental and or Divisional Quality and Patient Safety (QPS) forum. This ensures that where possible, the Health Board is informed of the risks that are present and how they are managed or mitigated.

The GDS risk register is reviewed regularly and describes risks in sufficient detail so that they are clearly understood. All risks identified are assessed for severity and likelihood of the risk along with necessary actions to treat, remove or minimise the risk.

In addition, the PCCT monitor mid-year and end of year contract activity as per the NHS General/Personal Dental Services Contract (Wales) 2006, as described in sections 1.4 and 1.5.

1.9.1 Quality Assurance System

Hosted and co-ordinated by the Dental Public Health unit in Public Health Wales, the Quality Assurance System (QAS) is an online annual self-

assessment toolkit that supports GDS/PDS providers to identify areas for Quality and Safety improvement in their practice.

QAS is accessed via an up-dated web-based platform, known as Caforb, which satisfies the strengthened requirements for data security.

One of the benefits of Caforb is that it remains live and accessible throughout the year, other than an agreed brief period when Health Board Dental Practice Advisors take a snapshot of the data the practice has entered to analyse and prepare a report for Welsh Government. After this, practices can log in again as many times as they wish to amend any information, so the record will always be up to date which will mean the process will not be arduous year on year. Over time the platform will evolve to introduce new features such as reminders being sent to practices to inform them if audit expiry dates are approaching and anything else which might be useful.

All completed QAS returns are reviewed and RAG rated by the Health Boards Dental Practice Advisor(s) who prepare a report and provide advice to the PCCT in respect of any Quality and Safety concerns arising from the practices' self-assessments. The team liaise with practices regarding any additional information required to satisfy the requirements of the QAS.

The Dental Public Health team produce an annual QAS report based on the summary reports provided by the Dental Practice Advisor(s) across the seven Welsh Health Boards.

The following lists the 'red' categorisation of submissions during 2025/26:

- Compliance with Putting Things Right Policy – inconsistent/unclear documentation;
- Radiology compliance, some practices were unable to provide the name of the Radiation Protection Supervisor for the practice;
- Inconsistencies with Waste disposal protocols/procedures; and
- Incident reporting.

Other common issues highlighted included:

- Infection Control & WHTM 01-05 Compliance;
- Support for Disabled Patients (Non-Mobility Disabilities);
- Equipment Maintenance & Insurance;
- Peer Review & Audits;
- Recruitment & Safeguarding; and
- Welsh Language Requirements.

The Health Board will continue to support practices through targeted communications; contractor engagement and the themes will support planning and topics for future continued professional development (CPD)

events. In addition, compliance with key regulatory requirements, including Welsh language obligations, audit activity and other quality assurance measures, will continue to be monitored through mid-year and annual review processes to provide ongoing assurance and support continuous quality improvement.

The PCCT provides regular updates both internally to the Health Board and externally to provide assurances in respect of quality and patient safety.

1.9.2 Health Inspectorate Wales

Health Inspectorate Wales (HIW) inspect all NHS dental practices for clinical and managerial/administrative compliance, providing a report of each inspection to the practice and the Health Board identifying any areas for improvement. During 2025/26, 7 HIW inspections were undertaken, 7 of which received improvement plans, with 3 having immediate improvement plans.

In summary, practices were reminded to ensure:

- Regular audits are carried out and the findings shared and discussed, also identifying any lessons learnt;
- Staff training is kept up to date;
- Practice policies are kept up to date and easily accessed for staff members;
- Public facing information to be translated to Welsh;
- Equipment is stored securely with cleaning and testing labels attached; and
- Decontamination and WHTM01-05 (Welsh Health Technical Memorandum) Compliance.

Practices engage directly with HIW, but the Health Board offers support and guidance to a practice before and after inspections have occurred, via the Health Board Dental Practice Advisors, and continues to share learning with practices.

1.9.3 Concerns/Freedom of Information

In respect of NHS GDS, during 2025/26 the PCCT managed and responded to:

- 36 –Concerns received via Putting Things Right;
- 24 – Elected Member Requests; and
- 10 – Freedom of Information Requests.

Through the management and investigation of these concerns, the Health Board addresses any specific contractual issues with the relevant provider ensuring any learning points are taken forward.

1.10 Occupational Health

Occupational Health services are commissioned by the Health Board for dental teams working within the Aneurin Bevan area. Services include:

- Pre-placement health assessment and further re-assessment as required;
- Long term health/sickness absence consultation;
- Blood tests and screening *(e.g., screening for hepatitis B / HIV / hepatitis C/ T.B.);*
- Vaccination for work related preventable disease (e.g., hepatitis B, MMR, T.B, chickenpox etc.);
- Flu vaccination (details will be circulated annually, some staff may qualify to receive flu vaccination from their GPs);
- Advice on sharps / body fluid incidents including post-exposure prophylaxis if required; and
- Advice on possible contact with or symptoms of communicable diseases.

339 dental staff accessed the service during 2025/26.

1.11 Provider Selection Regime

It has been detailed previously that commissioning undertaken by the Health Board during 2025/26 has been in accordance with The Health Services (Provider Selection Regime) (Wales) Regulations 2025. These regulations came in to force in 2025 and modernises health service procurement by moving away from routine competitive tendering. It enables more flexible and collaborative approaches that support improved patient outcomes while reducing unnecessary bureaucracy.

The statutory guidance outlines four provider selection routes available to relevant authorities, including local health boards:

- **Direct Award Process 1** – where only one provider is capable of delivering the required service.
- **Direct Award Process 2** – where the incumbent provider continues to meet the required standards and the contract arrangements remain substantially unchanged.
- **Most Suitable Provider Process** – where a provider can be identified without undertaking a competitive process.
- **Competitive Process** – used where the circumstances do not support the use of the other available routes.

In applying the PSR, relevant authorities must ensure decisions are made transparently, fairly and proportionately, with due consideration given to providers from the NHS, independent and voluntary sectors. These principles support the effective commissioning of services and align with the wider objectives of the Health Service Procurement (Wales) Act 2024.

1.12 Looking Ahead

The PCCT continues to work closely with key stakeholders to ensure that access to NHS dental services is maintained and enhanced. The team monitors delivery data on a monthly basis and holds quarterly review meetings at the end of each quarter to assess both the financial position and contractual performance of each provider.

The Health Board facilitated an engagement event in March 2026 detailing how the current NHS dental services will be transitioning to the new National Health Service (General Dental Services Contracts and Patient Charges) (Wales) Regulations 2026 from 1 April 2026 and continues to support the implementation of the new GDS regulations across providers. In addition, the Health Board will facilitate CPD opportunities and Neighbourhood Care Network (NCN) collaboration and engagement events to promote shared learning, best practice and service development.

A DAP communications plan is also being implemented to ensure effective communication, stakeholder engagement and awareness of access arrangements for patients and providers from April 2026.

The PCCT re-established the Dental QPS Group during 2025/26, which meets every four months.

In addition, the Integrated Oral Health Group was also re-established in January 2026. The group will meet on a quarterly basis to support ongoing engagement and collaboration across the wider oral health system.

Acknowledging the current financial challenges, as a Marmot region, the Health Board remains committed to improving access to NHS services, especially in areas of high need and deprivation. To enable patients to continue to access routine NHS dental care, the Health Board will undertake a procurement exercise to fully invest the monies returned following contract terminations/variations received in 2025/26 and 2026 to date.

Additionally, the Health Board will also be increasing the investment to Ringland Dental Centre during 2026/27 as part of a planned agreement following the relocation of the Centre from Ringland Shopping Centre to the Newport East Development, 19 Hills Health and Wellbeing Centre. The relocation enables the practice to increase their workforce to enable additional patients to be seen.

The PCCT continues to engage closely with contractors and key stakeholders to monitor the impact of the reforms on patient access, service delivery, contractual performance and workforce sustainability. Through established contract management, assurance and performance monitoring processes, the Health Board is able to identify emerging issues, support continuous improvement, share best practice and ensure that the

intended benefits of the new contractual arrangements are realised for patients and providers alike.

In addition, the PCCT continues to oversee the commissioning, contract management and performance monitoring of NHS dental services across ABUHB, including GDS, EDS, Domiciliary Dental Services, Orthodontic, Sedation and Oral Surgery Services commissioned through PDS contracts, together with services delivered within HMP Usk and HMP Prescoed. This ongoing oversight ensures services remain responsive to population need, deliver value for public investment and support the Health Board's wider objective of reducing oral health inequalities across Gwent.

2. General Ophthalmic Services

The National Health Service (Ophthalmic Services) (Wales) 2023 Regulations came into force on 20 October 2023 and established the legislative framework for Wales General Ophthalmic Services (WGOS) with WGOS 1, 2 and 3 commencing from that date and additional WGOS service levels implemented subsequently. These regulations and legislative directions replace all previous General Ophthalmic Service instructions for optometry services including all Wales Eye Care Service (WECS) instructions for example, Eye Heath Examinations Wales (EHEW) and Low Vision Services Wales.

The introduction of WGOS has allowed for a whole system change in how eye care services are delivered to patients across Wales. WGOS enables patients to receive appropriate care closer to home and ensure that patients only attend hospital eye services when required, therefore reducing pressures within the hospital eye service. This approach ensures that those patients in need of more complex eye care can be seen sooner in the most appropriate setting.

As part of the Contract Reform Clinical Framework, services are categorised as follows:

- WGOS 1 (Core Mandatory Clinical service) – Eye examination with Holistic Health element;
- WGOS 2 (Core Mandatory Clinical Service) – Previously Eye Health Examinations Wales (EHEW), includes examinations for urgent eye problems;
- WGOS 3 – Low Vision Services Wales (LVSW) and Certificate of Visual Impairment Wales (CVIW) and the School Programme Eye Care Service (SPECS);
- WGOS 4 – Referral Refinement/Monitoring (including, Glaucoma, Medical Retina and Hydroxychloroquine); and
- WGOS 5 – Independent Prescribing Optometric Service (IPOS).

Health Boards are required to manage and monitor service delivery within the allocated financial budget on an annual basis. WGOS 1 services are non-cash limited, and, as a minimum, providers must ensure they are accredited to provide WGOS Levels 1 and 2 as core service provision. All WGOS services are available to all providers that meet the requirements, and Health Boards are expected to commission on that basis with some services commissioned through a Primary Care Contracted Services (PCCS) framework.

In 2025/26 there were 55 optometry practices providing WGOS 1 and WGOS 2, all of which were open for urgent and essential appointments and

could also provide routine sight tests to patients. Practices continue to prioritise and schedule patient appointments based on clinical need and presenting symptoms relative to the risk of sight loss and harm.

Of the 55 practices across the Health Board in 2025/26, 12 practices provide mobile services, 35 practices provide WGOS 3 services, and 36 practitioners/27 practices were eligible to provide the WGOS 5 service. Within ABUHB there are also 6 domiciliary providers.

The WGOS 4 service was launched within the Health Board on 1 November 2024. In 2025/26, 25 practices provided a Medical Retina Service, 11 practices provided a Glaucoma service, and 2 practices were commissioned to provide Hydroxychloroquine (HCQ) monitoring.

The following table shows the number of practices, by Neighbourhood Care Network (NCN) as at 31 March 2026 providing each WGOS service.

Table 12: WGOS service breakdown by practice and Neighbourhood Care Network area

	WGOS 1 & 2	WGOS 3	WGOS 4- Medical Retina	WGOS 4- Glaucoma	WGOS 4- HCQ	WGOS 5
Blaenau Gwent East	2	2	2	-	-	2
Blaenau Gwent West	4	3	2	1	-	3
Caerphilly East	9	7	3	2	-	6
Caerphilly North	4	3	2	1	-	1
Caerphilly South	5	4	3	2	-	3
Monmouthshire North	8	5	3	2	1	2
Monmouthshire South	3	1	1	-	1	1
Newport East	5	2	2	-	-	2
Newport West	8	4	5	2	-	5
Torfaen North	3	2	2	1	-	1
Torfaen South	4	1	-	-	-	
Domiciliary	5	1	-	-	-	1
Total	61	35	25	11	2	27

2.1 Current Position

2.1.1 WGOS 1 and 2 - Fully Implemented

WGOS 1 and 2 are mandatory services for all Ophthalmic practices on the Ophthalmic list and all Optometrists on the Ophthalmic and Supplementary list.

Table 13: provides an overview of each WGOS service

WGOS 1	A sight test as defined by the Opticians Act as well as the inclusion of prevention and wellbeing provision as part of a Patient Management Plan
WGOS 2 Band 1	Examinations for Urgent Eye Problems This examination is for patients who have eye problems of an acute nature. It can also be used to accept referrals from another healthcare provider
WGOS 2 Band 2	Further investigation/examinations These examinations enable patients to have additional investigations following a WGOS 1 or Private sight test only. They can only be used to further inform or prevent onward referral to the hospital eye service
WGOS 2 Band 3	Follow-up examinations This examination enables a patient to be followed up after they have had an initial appointment for a WGOS 2, Band 1 or for a post-operative cataract check

All practitioners performing a WGOS service must have completed mandatory compliance training, which consists of four training modules:

- WGOS;
- Make Every Contact Count (MECC);
- Infection Prevention Control and Sharps Safety; and
- Improving Quality Together-Improvement Foundations Training.

In addition, should Practitioners wish to provide a WGOS 1 and 2 mobile service, they are required to submit a Mobile Service Agreement. Mobile services are for patients who are unable to leave their home unaccompanied.

55 high street practices and 5 domiciliary practices provide WGOS 1 and 2 services in ABUHB. The WGOS 1 Sight Test fee for 2025/26 was £46.20.

The total number of WGOS 1 claims processed in 2025/26 was 181,509, compared with 172,372 in 2024/25. This represents a 5.3% increase in claims for this service.

The figure below provides a breakdown of WGOS 1 claims by month, during 2025/26.

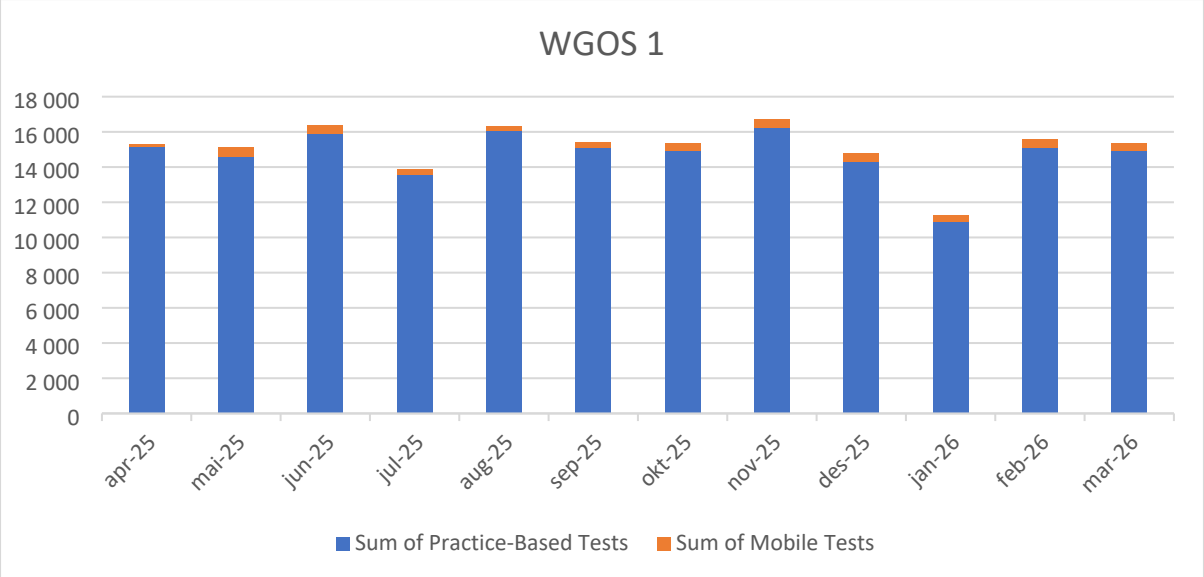


Figure 5: 2025/26 WGOS 1 claiming pattern

The WGOS 2 fees for 2025/26 are detailed below:

- WGOS 2 B1 £72.88;
- WGOS 2 B2 £55.18; and
- WGOS 2 B3 £27.07.

The total number of WGOS 2 claims processed in 2025/26 was 64,510, compared with 58,533 in 2024/25. This represents a 10.2% increase in claims for this service.

The figure below, Figure 6, provides a breakdown of WGOS 2 claims by month, during 2025/26.

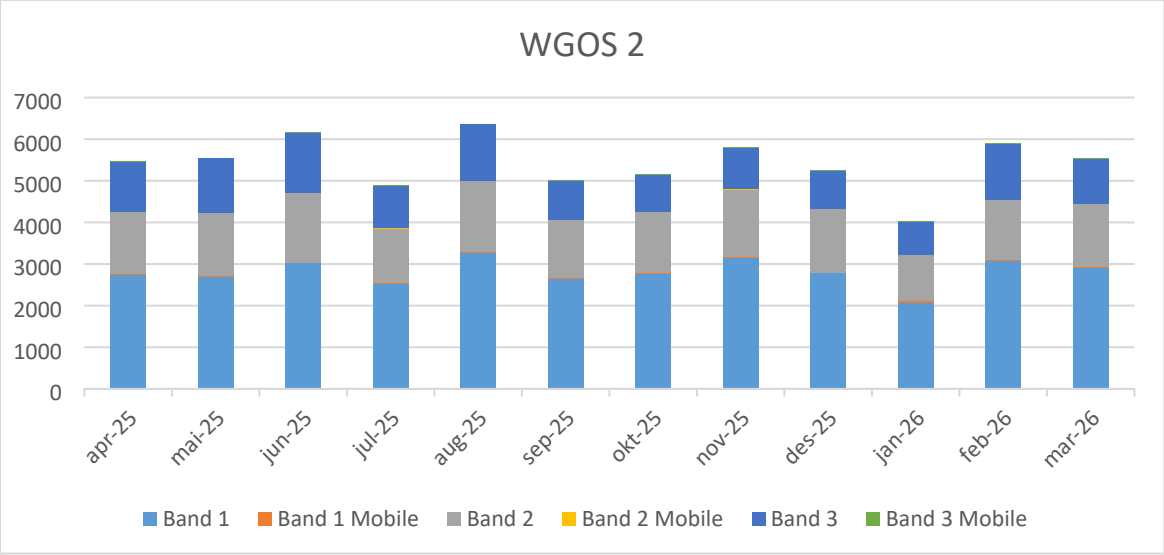


Figure 6: 2025/26 WGOS 2 claiming pattern

2.1.2 WGOS 3 – Fully Implemented

WGOS 3 is an opt in service which is inclusive of Low Vision (LV)and Certification of Visual Impairment (CVI)services as described in the following table.

Table 14: WGOS 3 services described

LVSW	A low vision assessment is for patients who reach the criteria for the service. This assessment helps a patient make the best use of their remaining sight. When a patient first enters the service, they will receive an initial examination, and they are entitled to a follow up examination every year
CVIW	Certification is the pre-requisite to being registered with a vision impairment. Practitioners accredited to provide the Low Vision Assessments are now able to certify eligible people with sight loss

Practitioners must undergo additional training to provide LVSW and have a LV qualification. In order to undertake the training practitioners must practice in Wales, be WGOS compliant and be an Optometrist or Ophthalmic Medical Practitioner registered with the General Optical Council (GOC), or Dispensing Optician registered with the GOC.

In respect of the CVI element of WGOS 3, the WHC (https://www.gov.wales/certification-vision-impairment-primary-and-community-care-whc2024029-html) allows Optometrists to be able to sign a Certification of Visual Impairment (CVI) for patients who meet the following criteria:

- The patient must be aged 16 or over;
- The cause of Vision Impairment must be permanent; and
- The patient must not be currently undergoing treatment which may result in vision returning to non-certification levels.

The Health Board awaits the final manual in respect of SPECS.

The All-Wales patient pathway was introduced to support Optometrists who are also low vision accredited to certify eligible patients with sight loss in the community, which historically, could only be signed by Consultant Ophthalmologists. 35 practices provide the service in ABUHB.

The WGOS 3 fees for 2025/26 are detailed below:

- LVSW Initial Assessment £97.20;
- LVSW Annual Review/Follow £62.96;
- WGOS 3 CVI - Ocular examination claims only £72.88; and
- WGOS 3 Ocular examination and certification £148.88.

The figure below, Figure 7, provides a breakdown of WGOS 3 claims by month, during 2025/26.

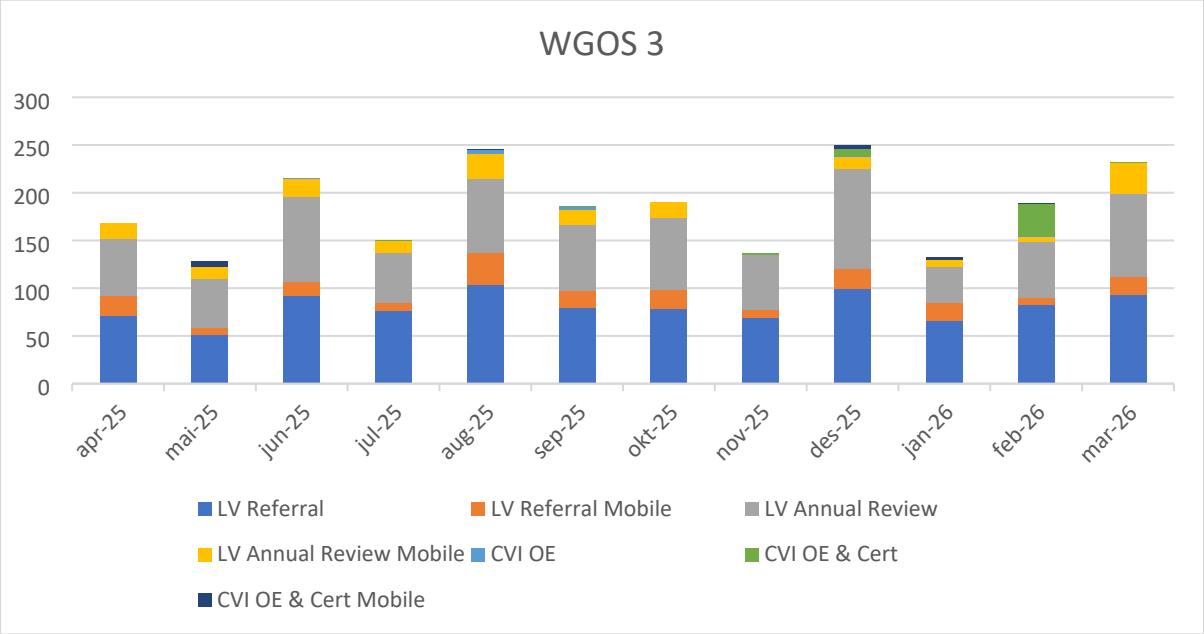


Figure 7: 2025/26 WGOS 3 claiming pattern

2.1.3 WGOS 4 – Partially Implemented

WGOS 4 sees patients who would previously have been referred to/or managed in the Hospital Eye Service (HES) instead remaining in primary care for further enhanced assessment as part of an agreed referral refinement or monitoring pathway for patients:

- with or with suspected medical retina conditions;
- with or with suspected glaucoma or ocular hypertension; and
- who are at risk of retinopathy due to taking hydroxychloroquine or chloroquine.

The WGOS 4 Referral Filtering service was launched within the Health Board on 1 November 2024. Subsequently, the WGOS 4 Medical Retina and Hydroxychloroquine Monitoring services went live on 31 August 2025.

Across the Health Board, work continues to support the safe and sustainable implementation of the WGOS 4 Glaucoma Monitoring Service. Eligible patients have been identified, and primary care is undertaking engagement with the optometry profession to support service development and readiness for implementation. This includes planned engagement events to discuss the pathway in detail, clarify clinical requirements and support practices in preparing for service delivery.

The full rollout of the glaucoma monitoring pathway remains dependent on the implementation of the national Electronic Patient Record (EPR) across both primary and secondary care. The EPR is a key enabler for the safe and effective management of patients within the pathway, ensuring appropriate information sharing, clinical oversight and continuity of care between providers. Until the EPR is operational, within ABUHB, clinical responsibility for these patients will remain with secondary care services. Once implemented, anticipated during 2026/27, the service will support the transfer of suitable patients into community-based monitoring, improving patient access and supporting the delivery of care closer to home.

Through additional Transformation funding allocated by Welsh Government, three Optometrists and two administrative staff members were appointed to support the implementation of WGOS 4 Monitoring. In addition, the team has contributed to WGOS 4 Deflection Service, reviewing patients who had been referred to HES prior to the implementation of the WGOS pathways and redirecting them back to primary care. A total of 1,110 patients were redirected to WGOS 4 providers for an initial referral filtering examination during 2025/26.

The team has also supported School Screening Services, where a cohort of children, who were referred to HES after being identified as needing further assessment during school vision screening, were redirected to primary care for an initial fundus check and cycloplegic refraction, improving access to timely assessment closer to home and helping to ensure that only those that need specialist care are referred onwards. Furthermore, the team has undertaken a review of secondary care services to inform future pathway development.

The introduction of this team has had a positive impact, enabling a more integrated and collaborative approach between primary and secondary care. Their work has strengthened service delivery, supported operational pressures, and enhanced the alignment of pathways across the system.

An audit of secondary care referrals was undertaken in August 2025, which highlighted a reduction in HES referrals since WGOS 4 pathways have been implemented. Glaucoma referrals into HES have reduced by 36% and Medical Retina referrals have reduced by 6%.

As WGOS 4 is an ‘opt in’ service it is anticipated that the number of practices providing each service will continue to increase year on year as more practitioners attain the appropriate qualification. Whilst training placements across Wales are limited, the PCCT continue to support practitioners with training opportunities via Health Education and Improvement Wales (HEIW) training programme.

In 2025/26, 25 practices provided a Medical Retina Service, 11 practices provided a Glaucoma service, and 4 practices were commissioned to provide Hydroxychloroquine monitoring.

The WGOS 4 fees for 2025/26 are detailed below:

- WGOS 4 Medical Retina Referral/Filtering and/or monitoring £98.28:
- WGOS 4 Glaucoma Referral/Filtering and/or monitoring £110.00: and
- WGOS 4 IP/Discharge IP £10.

The total number of WGOS 4 claims processed in 2025/26 was 4,826, compared with 793 in 2024/25. This represents a 508.5% increase in activity for this service. However, it should be noted that WGOS 4 was only partially implemented from November 2024. Given the implementation timeline for WGOS 4 and the continual onboarding of practices, such a sharp rise is expected and reflects the service's expansion rather than an underlying change in demand. The graph below, Figure 8 provides a breakdown of referrals from non WGOS 4 providers to WGOS 4 providers by month, during 2025/26.

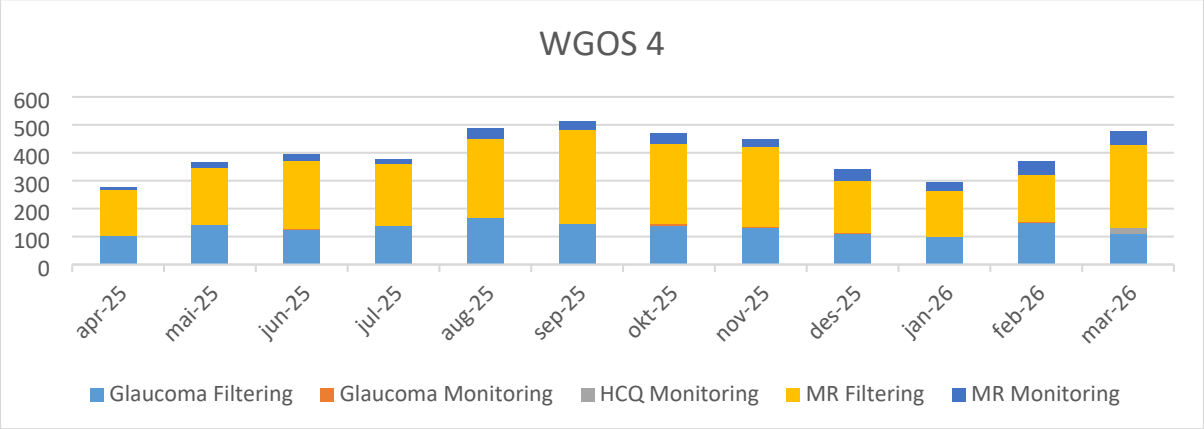


Figure 8: 2025/26 WGOS 4 referral pattern

The figure below, Figure 9, details the number of patients seen for each service under WGOS 4 and the outcome of the examination.

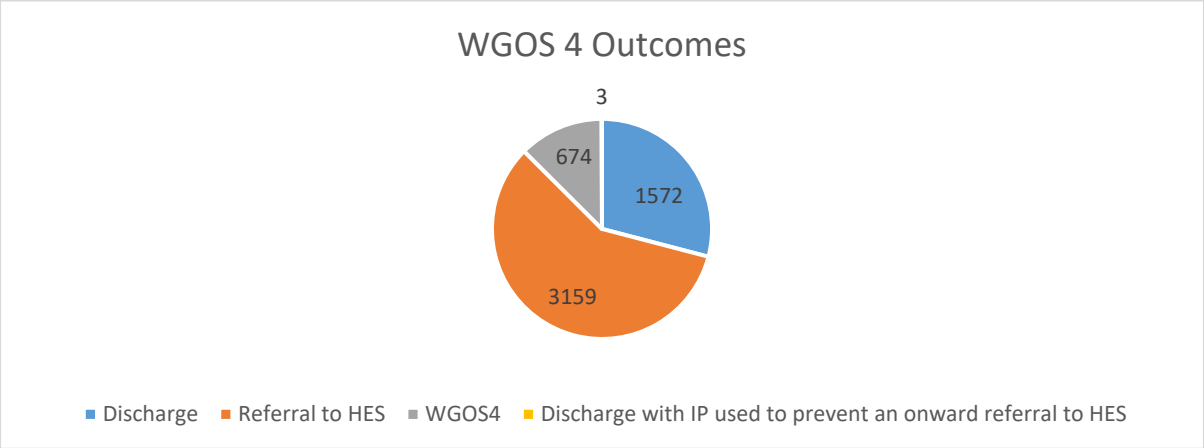


Figure 9: 2025/26 WGOS 4 patient activity by sub specialty

During 2025/26, WGOS 4 services prevented a total 2,249 referrals being made into secondary care which can be directly attributed to the implementation of the WGOS 4 pathways, demonstrating that the services are successfully managing more patients in primary care and reducing unnecessary referrals to secondary care.

2.1.4 WGOS 5 – Fully Implemented

WGOS 5 Urgent services were launched within the Health Board on the 27 November 2023.

The table below describes the difference between a WGOS5 urgent and discharge service.

Table 15: WGOS 5 services described

IPOS – Urgent	Practitioners with an independent prescribing qualification can manage certain acute conditions in primary care for their own patients or following a referral from another WGOS practitioner.
IPOS - Discharge	Practitioners with an independent prescribing qualification will monitor conditions initially seen in hospital eye casualty

In 2024, the WGOS 5 clinical manual was updated to include the HES discharge element of the service, this part of the service was launched on 6 February 2025. The service is provided on a rota basis and all Independent Prescribers (IP) working within ABUHB, with NHS WP10 prescription forms, are expected to provide the service. The PCCT manage the IP rota and circulate to all practices monthly, also publishing on Optometry Wales's secure professional webpage. Non-IP practitioners can refer patients to an IP practitioner but retain responsibility for the patient until they have been accepted by the IP practitioner.

This service is subject to Post Payment Verification (PPV). In addition, prescribing data continues to be reviewed and monitored by the Health Boards Optometric Advisor and Medicines Management team on a quarterly basis to identify trends and any outliers.
The WGOS 5 fees for 2025/26 are detailed below:

- Initial Assessment £135.00; and
- Follow up £66.96.

The total number of WGOS 5 claims processed in 2025/26 was 10,181, compared with 5,851 in 2024/25. This represents a 74% increase in claims for this service. The WGOS 5 service continues to expand and an additional 10 providers and 4 practices were commissioned during 2025/26. As part of the audit of HES referrals, referrals into the Emergency Eye Clinic (EEC) were reviewed and it was noted that these have significantly reduced (96%)

compared to the previous year; this reflects the positive impact of WGOS 5, which is supporting improved management in primary care and contributing to reduced attendance at EEC.

The figure below, Figure 10, details the number of patients seen as part of the WGOS 5 service.

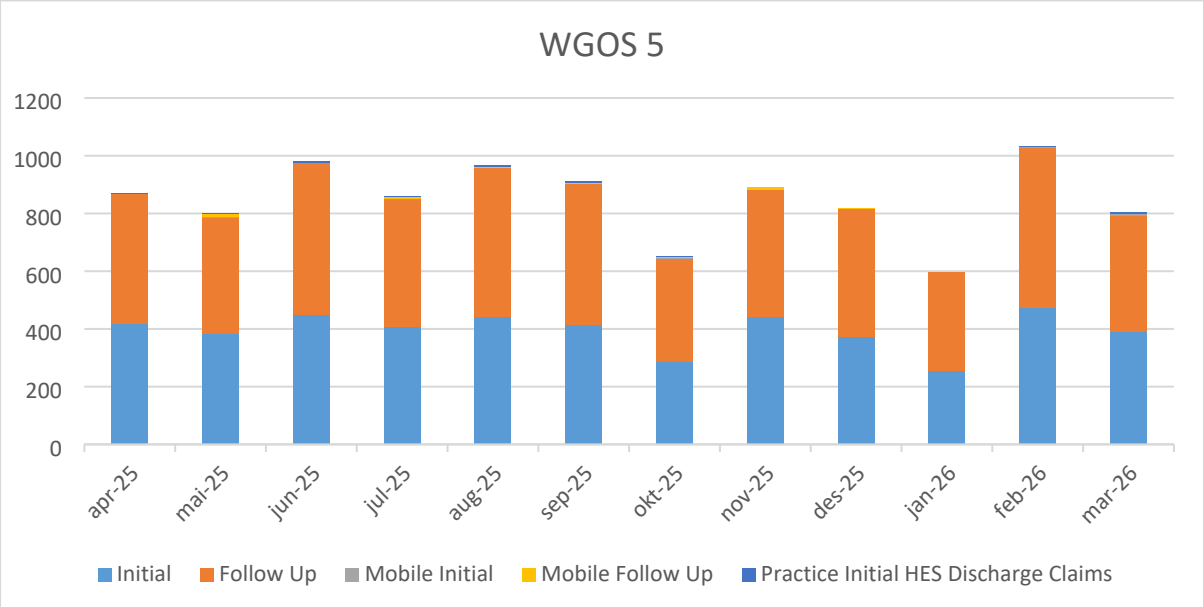


Figure 10: 2025/26 WGOS 5 patients seen

2.1.5 Mobile Services

With the implementation of the WGOS Regulations in October 2023, there was a requirement for Optometrists to reapply to the All-Wales Ophthalmic list and for Contractors to have a Mobile Service Agreement in place with the Health Board, aligned to the location where the service is to be delivered with a predetermined list of equipment required at every domiciliary appointment.

Of the 13 practices with a mobile service agreement in place. 6 are domiciliary providers who provide WGOS 1 and 2 services. 1 domiciliary provider on the Health Board's list provides a WGOS 3 service only.

The table below, Table 16, details the practices that currently have a Mobile Services Agreement with the Health Board, and the services in which they provide.

Table 16: Practices with a mobile services agreement in place

Borough	Practice	WGOS 1 and 2	WGOS 3	WGOS 5
BG West	Gwynns Optician, 90 Queen Victoria St, Tredegar, NP22 3PY	✓	✓	
BG East	Williams & Parry, 50 Church St, Abertillery. NP13 1DB	✓	✓	✓
Caerphilly North	Leighton Rowland (Gwynns Opticians) 39 Hanbury Rd, Bargoed. CF81 8QU	✓	✓	
Monmouth South	Darlington, 2a The Cross, Church Rd, Caldicot, NP26 4HY	✓		
Newport West	RW Cole, 58/59 Commercial Rd, Newport. NP20 2PF	✓	✓	✓
Torfaen South	RJD Jenkins Optician, 13 New St, Pontnewydd, Cwmbran, NP44 1EF	✓	✓	
Dom	Opticall Healthcare Ltd Temple Court Cathedral Road Cardiff CF11 9HA	✓		
Dom	Bristol 1 Domiciliary Specsavers Ltd Specavers Healthcall Pure Offices Kestrel Court Waterwells Drive Quedgeley Gloucestershire GL2 2AT	✓		
Dom	CATVOG Domiciliary Specsavers Limited Specsavers La Villiaze St Andrews Guernsey Channel Islands GY6 8YP	✓		
Dom	Gwent Domiciliary Specsavers Limited Specsavers Home Visits Gwent Specsavers Britannia House Caerphilly Business Park Caerphilly CF83 3GG	✓		✓
Dom	The Outside Clinic The Outside Clinic Stirling House, 10 Viscount Way, Swindon, SN3 4TN	✓		
Dom**LVSW ONLY	South Wales Low Vision Clinic t/a Russell Ham 24 Yeo Close, Newport, NP20 7RS **LVSW ONLY		✓	
Dom	Umayr Ali Home Vision Visits	✓		

WGOS 4 services are currently unable to be carried out in a mobile setting due to equipment requirements.

2.2 Backlog/Wait Times

Secondary care waiting lists continue to be monitored and reported through Eye Care Collaborative Board, with the reduction of Referral to Treatment (RTT) waiting times remaining a key priority for the Health Board. Ongoing review of the waiting lists also provides insights in to demand and capacity, while also enabling the Health Board to identify opportunities for service improvements.

The following table, Table 17, details the wait times within secondary care for eye services as at the end of 2025/26.

Table 17: Secondary Care wait times by eye care specialty

As at 28/02/2026		
Service Name	No. of patients not booked for first appointment	Max Wait - Weeks
Ophthalmology AOM	111	65
Ophthalmology Cataract	3005	70
Ophthalmology Cornea	610	90
Ophthalmology General	141	95
Ophthalmology Glaucoma	456	76
Ophthalmology Laser	745	89
Ophthalmology Minor Ops	85	60
Ophthalmology Neuro	97	80
Ophthalmology Oculoplastic	98	74
Ophthalmology Paeds	588	92
Ophthalmology Regional Cat.	1141	86
Ophthalmology Retina	338	93
Ophthalmology Wet AMD	58	14
Grand Total	9074	

Primary and secondary care colleagues continue to audit referral data/trends but with the implementation of WGOS 4 and 5 it clearly demonstrates a positive impact of patient access, whereby patients can be seen sooner at a primary care practice closer to home.

In addition, and as part of a Regional Ophthalmology Project, additional funding was received from Welsh Government which has supported additional staff, theatres and outsourcing meaning 25,633 patients received Cataract surgery in 2025/26. As of March 2026, there were no patients waiting more the 73 weeks for Cataract surgery.

2.3 Governance and Monitoring

Robust monitoring processes are in place whereby claiming and prescribing data available to the Health Board is reviewed on a monthly and quarterly basis to identify trends and understand claiming and prescribing patterns.

During 2025/26, the PCCT have developed a practice visit plan, operating on a three-year cycle ensuring all practices are engaged regularly and systematically. A total of 12 practice visits were undertaken in 2025/26, including visits to the majority of domiciliary providers. These supportive meetings have offered meaningful insight into day-to-day service delivery and strengthening relationships with providers. Digitalisation emerged as a key theme throughout the discussions, particularly in relation to access to NHS email accounts and the implementation of EPR and Electronic Referral System (ERS). Where required, the Health Board has provided support and signposted practices to relevant resources and guidance. Meetings will continue throughout 2026/27.

WGOS services are also subject to Post Payment Verification (PPV) which is undertaken by NHS Wales Shared Services Partnership (NWSSP) on behalf of the Health Board. The PPV team reviews a sample of claims submitted and processed for payment, identifying any administration or claiming errors. Once the PPV team has undertaken their visit and the report has been finalised, with engagement from the practice, this report is shared with the Health Board. The Health Board reviews each report received and for an error rate of 10% or more, or a recovery value of £1000 or more, a Health Board practice visit is scheduled. For an error rate of 5%-9% an initial letter is issued to practices. Anything less than 5% warrants no action.

During 2025/26, a total of 12 WGOS PPV visits were undertaken. Of the 12 visits completed, 10 resulted in no further action being required, providing assurance that services were being delivered in line with contractual requirements. Letters were issued to 2 providers to highlight areas requiring attention and support improvement where necessary.

Additionally, the Health Board continues to actively engage with stakeholders via the Health Board's Eye Care Collaborative Board and with Welsh Government and the National Eyecare Wales Committee. A South East Wales Regional Optometric Committee (SEWROC) group was established in 2024/25 to support regional working. A number of processes have been agreed through the group and implemented on a regional basis. In light of the strong level of local engagement, with the option to hold ad-hoc meetings as required, bi-monthly meetings have now transitioned to an annual schedule. A local SEWROC and ABUHB liaison meeting continues on a six-weekly cycle. Regular updates are provided to the wider profession by way of local communication.

As part of Contract Reform, a Quality for Optometry package was nationally agreed. As part of the package contractors are required to ensure employees involved in the provision of NHS WGOS have completed the Optometry Improving Quality Together Foundations e-learning package as part of their mandatory WGOS training. Contractors are also required to make a return of the Quality for Optometry (QfO) template at least once every six months. Other requirements of the package include; completion of workforce and Information Governance toolkit, completion of a quality improvement project and annual audits.

The PCCT monitors compliance with these requirements and supports practices to ensure that all required information is submitted within the specified timescales.

In relation to the QFO Toolkit submissions for 2025/26, the Health Board achieved a 98% compliance rate, with only two practices not submitting their returns. These practices were contacted, and submissions received are currently being reviewed in line with an agreed local process. However, in terms of the Information Governance Toolkit element, there was 100% compliance for 2025/26.

There are national considerations regarding the future management of the QfO Toolkit, and any changes to future requirements will be communicated to the profession.

The WGOS risk register is reviewed regularly and describes risks in sufficient detail so that they can be clearly understood. All risks identified are assessed for severity and likelihood of the risk along with necessary actions to treat, remove or minimise the risk.

2.4 Training

In February 2026, six optometrists working in areas with identified service gaps were nominated for Health Education and Improvement Wales (HEIW) training. The priority areas included:

- Monmouth South (Glaucoma);
- Blaenau Gwent East (Glaucoma and Medical Retina); and
- Newport East (Glaucoma).

During 2025/26, the Health Board also supported 31 practitioners to undertake HEIW funded higher qualifications across a range of enhanced optometric service areas, reflecting a continued commitment to developing local workforce capacity and improving access to specialist eye care services. This investment has strengthened local workforce capacity and enabled more patients to be treated closer to home, improved access to care, reduced reliance on hospital eye services, and supported timelier interventions for patients with eye health conditions.

There is a contractual requirement for contractors to update the Primary Care Workforce Intelligence System (PCWIS) detailing their workforce information monthly. The PCCT monitors compliance and will use the data to inform future training opportunities.

2.5 Honorary Contracts

During 2025/26 the PCCT facilitated the process to award 4 Honorary Contracts for Ophthalmology Independent Prescribing placements in the Royal Gwent Hospital.

These placements supported workforce development by enabling practitioners to gain specialist prescribing experience within a hospital setting. The honorary contracts also strengthened partnership working, ensured appropriate governance arrangements were in place, and contributed to the development of a skilled workforce to support the delivery of safe and effective patient care.

2.6 Practice Closures/Relocation

To reflect the WGOS regulatory changes, a robust process is in development across Wales regarding the consistent notification and management of practice changes.

In May 2025, a new domiciliary provider, Home Vision Visits, was added to the Combined List (Supplementary Ophthalmic List). Additionally, an existing provider, Eye Contact Eye Care, opened an additional premise in Ystrad Mynach, Caerphilly.

Following the significant flooding incident within the Monmouthshire area and subsequent damage to their premises, Monnow Eye Care temporarily relocated in January 2026 while refurbishment work was undertaken to

their substantive premise. The Contractor confirmed they had relocated back to their substantive premise in March 2026.

2.7 Neighbourhood Care Networks

As part of Optometry Contract Reform, Welsh Government requires each practice to nominate a Primary Care Collaborative Lead to work with the Collaborative Optometric Lead, with both roles remunerated. Contractors must attend a minimum of four meetings per financial year in line with national regulations.

To ensure compliance with this regulation, the PCCT developed and implemented a robust regional NCN process, which was endorsed by SEWROC. This process is now embedded and supports effective monitoring of attendance, compliance, and associated payments. Attendance has improved to 80%, compared to 73% in 2024/25, demonstrating increased engagement across all collaboratives.

During 2025/26, participation at NCN level continued to support the development and delivery of projects both locally and across Gwent. Key collaborative workstreams included dementia awareness, falls prevention, and embedding smoking cessation discussions within eye examinations. Pan Gwent sessions have also been delivered to support NCN planning and clarify the role of the collaboratives. Collaboratives have also implemented the NHS Futures platform to support communication, enabling file sharing, meeting scheduling via a shared calendar, and direct access for practice leads to join meetings.

There remains an expectation that pathways will continue to be developed and tested, with optometry priorities aligned to the Health Board's overarching NCN plans. The collaboratives are also expected to provide ongoing professional leadership and contribute to the delivery of the Health Board's NCN Intermediate Medium-Term Plan (IMTP).

There are currently Collaborative Optometric Lead vacancies identified in Caerphilly North and South, and Newport East and West. The NCN team continues to work with local practices and SEWROC to secure appropriate leadership in these areas to support delivery of NCN priorities and future development.

2.8 Prison Services

Across Wales, Health Board Prison SLAs are inclusive of the WGOS services provided in community optometry, ensuring equitable services for all. Following a robust procurement exercise in 2023/24, the prison optometry contract was re-awarded to 'The Prison Opticians Ltd' from April 2024 and remains in place.

Four sessions are provided a month, two at HMP Usk and two at HMP Prescoed.

During 2025/26, 231 sight tests were undertaken across both sites. To support ongoing service improvements, patients accessing the service were asked to complete a patient questionnaire to provide feedback on their experience. Although only a small number of patient questionnaires were returned during the year, the feedback received was generally positive.

The PCCT undertakes routine monitoring of the service, in line with the wider processes, reporting into Prison Delivery Board.

2.9 Occupational Health Service

In accordance with the Regulations, the Health Board commissioned the following via Occupational Health from April 2025:

- Needlestick/sharps injury service, including access to any relevant BBV screening including any related blood tests and any onward monitoring related to risk of infection.
- Annual influenza vaccines.
- Pre-placement health check using a standardised questionnaire for new starters, plus the provision of any necessary and essential vaccines and/or immunisations.
- Baseline assessment of the vaccination status of current staff, with the offer of any necessary and essential vaccines and/or immunisations to be undertaken within the first year of the service being established.
- Sickness absence assessment on request to assist with the management of sickness absence (both short and long term); including plans for supporting a return to work following long term absences.

The service is available to Optometrists, Dispensing Opticians and Contact Lens Opticians. The service does include those in pre-registration training (student optometrists) and trainee opticians.

In 2025/26, there was minimal activity through the Occupational Health Service. The Health Board have commissioned the service in 2026/27 with a view to reviewing and updating the Service Level Agreement (SLA) for 2027/28. The service will continue to be promoted through SEWROC, Optometry Wales and direct communication with Contractors.

2.10 Eye Health Needs Assessment

As part of the NHS Legislative Directives each Health Board must prepare and publish an Eye Health Needs Assessment (EHNA) for its area. The first publication was required by March 2025 and every 3 years thereafter.

Primary Care Commissioning were commissioned to facilitate the completion of the EHNA on behalf of the Health Board and several steering group meetings were set up to support. The steering group included representation from several stakeholders including NWSSP, Secondary Care, Llais and the Health Board Communications Team. The EHNA was approved by the Health Boards Eye Care Collaborative Board (ECCB) and has been published on the Health Boards internet. https://abuhb.nhs.wales/hospitals/gps-dentists-opticians-ncns/optician/

In summary, the assessment found that eye care services, across ABUHB is generally good; however, access to WGOS 4 and WGOS 5 services was uneven, with significant gaps in some localities and limited WGOS 4 HCQ capacity due to equipment requirements. Demand for services is expected to increase as the prevalence of long-term conditions and eye disease rises, placing additional pressure on ophthalmology services. Further work is needed to improve public awareness of available services and strengthen data collection to support future service planning and equitable access.

An action plan has been developed based on the gaps and needs identified through the EHNA assessment. This action plan is considered when developing services across both primary and secondary care, and is also used to identify opportunities where targeted training may be implemented to address identified needs. Work has already commenced to address some of the issues highlighted through the assessment, including the development of a communications plan and updates to the WGOS 4 Clinical Manual.

2.11 Annual Report 2025/26

In addition to the Eye Health Needs Assessment and as part of the NHS Legislative Directives each Health Board is required to prepare and publish an annual report for the purpose of monitoring the provision of WGOS 1-5.

The Annual Report for 2025/26 has been published on the Health Boards internet https://abuhb.nhs.wales/hospitals/gps-dentists-opticians-ncns/optician/

The Annual Report for 2025/26 focused on service expansion, pathway development, workforce growth and integration between primary and secondary care and demonstrates the positive impact that WGOS services have had across the Health Board. Service provision increased through additional optometry practices, expanded WGOS 4 Medical Retina provision, and a substantial increase in practitioners delivering WGOS 5 services.

Activity has increased across all WGOS services and a breakdown is provided in the table below, Table 18.

Table 18: WGOS service comparison between 2024-2026

Service	2024/25	2025/26	% difference
WGOS 1	172,372	181,509	5.30%
WGOS 2	58,533	64,510	10.20%
WGOS 3	2,083	2,224	6.80%
WGOS 4	793	4826	508%
WGOS 5	5,851	10,181	74%

2.12 Digitalisation

During 2025/26, ABUHB implemented an interim Electronic Referral System (ERS), which went live on 6 October 2025. The system required practices to complete an MS Form and upload relevant clinical information, including images. The aims of the MS Form were to:

- Create a consistent and streamlined referral process, with referrals received instantly to reduce triage times;
- Reduce referral rejections;
- Ensure one sub-specialism per referral;
- Enable specialist triage, with each sub-speciality managing its own referrals;
- Reduce risks associated with lost referrals, with referrers receiving confirmation once referrals are received and processed;
- Improve pathway transparency; and
- Support better image quality through direct electronic upload to Clinical Work Station (CWS).

The figures below show the trends in the referral method used by type, week by week, from the 6 October 2025 up to and including week commencing 9 February 2026 (data is not available for the period 9 February and 31 March 2026).

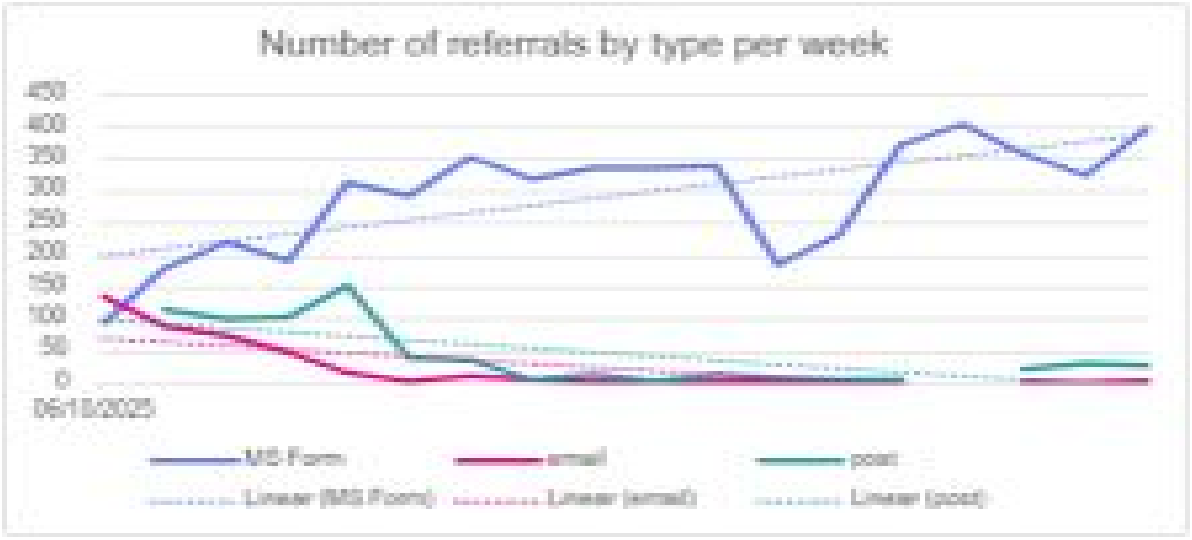


Figure 11: Referral trends between 6 October 2025 – 13 February 2026

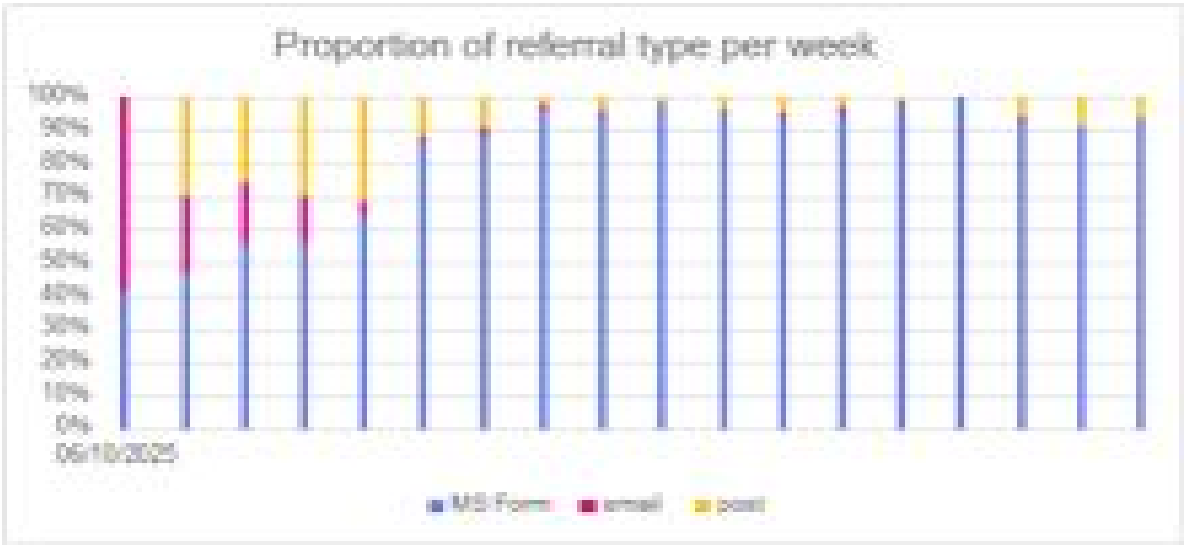


Figure 12: Referral type between 6 October 2025 – 13 February 2026

Referrals by post and email reduced significantly and, in the week, commencing 9 February 2026, 5870 referrals were received via the MS Form and 950 cataract follow up forms were received for information purposes only and uploaded directly to the patient record rather than having to be triaged. Electronic images uploaded directly to CWS improved information upon which to triage. The figures were also used to inform secondary care of the breakdown of referrals by sub-speciality and urgency. The MS Form was well received by the profession.

Following confirmation that a national ERS had been procured, named OPERA, a Project Board was established to support implementation of the national system. The PCCT has worked closely with Digital and Data colleagues to ensure the smooth implementation of OPERAi, within the required timescales. Contractors have been onboarded to OPERAi and are

due to go live in the summer of 2026. Webinars with the suppliers have taken place, where full demonstration of the system was provided.

The national EPR, OpenEyes, was launched within secondary care in March 2026. A Project Board has been established to oversee its implementation within primary care. It is anticipated that OpenEyes will be implemented in primary care during 2026/27.

The Health Board continues to work collaboratively with key stakeholders to ensure WGOS services are delivered safely, effectively and consistently

2.13 Engagement

Over the course of 2025/26, the Health Board has continued to strengthen its engagement with the optometry profession, placing particular emphasis on collaboration, shared learning, and service development. This year has seen a renewed focus on strengthening relationships across primary and secondary care to support the integration of digital solutions, as well as deepening our understanding of practice level activity through direct visits.

In addition, Welsh Government also hosted engagement events in 2025/26, which took place on a regional basis and a series of local engagement events have been hosted by the Health Board. The sessions were designed to support service improvement, share information and encourage open dialogue and feedback. These have included:

- One engagement event focused on the WGOS 4 Deflection Service;
- One engagement event on WGOS 4 Medical Retina Monitoring; and
- One engagement event exploring interim e-Referral Solutions.

These sessions have provided valuable opportunities for teams across the system to reflect on challenges, share learning, and identify areas for greater integration.

Meetings have also taken place with several domiciliary providers, and it is the intention to meet with all domiciliary providers during the first quarter of 2026/27 to discuss WGOS service provision and ensure consistent understanding of expectations.

The PCCT continue to share key updates with the profession through a regular newsletter, ensuring that important developments are communicated clearly and consistently.

Information relevant to WGOS working, including referral pathways, templates, and availability rotas, is maintained on the OW members' page, supporting practitioners in accessing up-to-date operational guidance.

The Health Board's Communications Team has further strengthened public-facing communication this year. A comprehensive communications plan has been developed, supported by:

- Patient-facing posters to raise awareness of Primary Care Optometry services;
- Social media activity, including the sharing of patient stories to highlight service impact; and
- Updates to the staff intranet, including new information and a set of frequently asked questions to support internal understanding.

In addition to the broader communications activity, the Health Board's website continues to be updated as required to ensure patients have access to accurate and current information: https://abuhb.nhs.wales/hospitals/gps-dentists-opticians-ncns/optician/

The ECCB have continued to meet bi-monthly, with operational support from members of the Eye Care Working Group, providing ongoing oversight and strategic direction. Integration continues with the implementation of the National Clinical Strategy for Ophthalmology and Task and Finish groups are being established to support the work and will replace the Eye Care Working Group going forward into 2026/27.

As detailed above, regionally, ABUHB meets with South East Wales Regional Optometric Committee (SEWROC) members, along with Cardiff and Vale University Health Board and Cwm Taf Morgannwg University Health Board, on an annual basis, with local liaison meetings taking place on a six weekly cycle.

The Regional SEWROC group developed an action plan to deliver joint CPD sessions across the region, with the first session taking place in June 2026 on the topic of the Regional Cataract work that has taken place. Speakers from the Regional Ophthalmology Project Team have been secured. The CPD session will attract two interactive CPD points and sessions will be delivered in the Royal Glamorgan and Royal Gwent Hospitals across two evenings

Third Sector services are promoted via the Health Board's newsletters and will be considered as part of the wider Optometry Communication plan. The PCCT continues to work closely with Sight Cymru. Various local transport schemes available to patients, have been publicised should patients require additional support.

2.15 Concerns/Freedom of Information/Datix 2025/26

In respect of WGOS contracted services, during 2025/26 the PCCT did not receive any patient concerns or Datix incident reports.

2.16 Looking Ahead

The PCCT will continue to work collaboratively with Welsh Government, Health Board colleagues, SEWROC, the optometry profession, secondary care ophthalmology services and third-sector partners to support the ongoing transformation of eye care services across ABUHB.

A key priority for 2026/27 will be the safe and sustainable implementation of the WGOS 4 Glaucoma Monitoring Service. Eligible patients have been identified, and engagement with the profession will continue to support service development, readiness and workforce preparedness. This will include dedicated engagement events to discuss the pathway in detail, clarify clinical requirements and ensure practices are equipped to deliver the service safely and effectively.

The full implementation of the glaucoma monitoring pathway remains dependent upon the successful rollout of the national EPR across both primary and secondary care. The EPR will be a critical enabler, supporting information sharing, clinical governance, continuity of care and the safe transfer of appropriate patients from hospital-based services into community optometry settings. Until the EPR is operational, clinical responsibility for these patients will remain within secondary care. Current planning assumptions indicate that OpenEyes, the national EPR, will be implemented during 2026/27, initially across WGOS 4 and WGOS 5 providers.

Welsh Government has confirmed the availability of additional Transformation Funding during 2026/27 to further support the development and expansion of WGOS services. Subject to approval, this investment will support the appointment of an Optometrist to review Hydroxychloroquine (HCQ) and Diabetes Eye Screening Wales (DESW) referrals, identifying patients who may be suitable for ongoing monitoring within primary care. The role will also strengthen collaboration between primary and secondary care through the continued review of ophthalmology pathways, helping to identify opportunities for services currently delivered in hospital settings to be safely transferred into community-based care.

The Optometrist will play a pivotal role in engaging with the profession, secondary care Ophthalmology colleagues, the Third Sector and SEWROC, ensuring that service development remains patient-centred and aligned to local population needs. This work will be supported through the Eye Care Collaborative Board and associated governance structures. Consideration is also being given to the development of an administration function to support the role, including the management of patient transfers from secondary care to primary care, coordinating audits, supporting service planning activities and facilitating stakeholder engagement. Opportunities to incorporate this function within the existing PCCT structure will be explored.

The PCCT continue to review and refine its WGOS monitoring process and work closely with finance and secondary care colleagues to consider service activity and outcomes to help inform the financial position and identify opportunities for improvement to enable future development of WGOS services.

The PCCT will continue to work closely with Digital and Data colleagues, NHS Wales and the profession to support the successful implementation of the national ERS and EPR programmes. These digital developments are fundamental to enabling the future expansion of community-based eye care services and improving integration between primary and secondary care.

Regional collaboration will remain a key focus, with continued participation in SEWROC meetings and wider regional ophthalmology transformation programmes. The team will also contribute to the implementation of the National Clinical Strategy for Ophthalmology, maintaining primary care representation on relevant task and finish groups and supporting the development of future service models. Opportunities for regional service delivery, workforce development and shared training programmes will continue to be explored in partnership with neighbouring Health Boards.

The PCCT will continue to participate in Health Board Sub-Group meetings and support the Health Board WGOS Operational Group in delivering key workstreams during 2026/27. This will include a focus on quality in optometry services and strengthening the toolkit review process on a national basis. In addition, the groups will support the standardisation of other national processes, including practice visits and practice closure procedures. The NCN breach process, agreed by the group will also be utilised to ensure a consistent approach to managing compliance issues

Monitoring of progress against the EHNA Action Plan will continue, alongside consideration of the refresh of the assessment, which is due in 2027/28. Progress will be reviewed, and an Annual Report for 2026/27 will be produced.

Engagement with the profession will remain a priority throughout 2026/27. A comprehensive engagement programme is being developed, with a particular focus on digital transformation, implementation of new pathways and updates to Medical Retina referral guidance. In addition to wider engagement events, the PCCT will continue to provide support and advice to contractors, ensuring contractual compliance and supporting continuous service improvement. The Health Board will also continue to promote the Occupational Health Service, raising awareness of the support available to contractors and their staff.

Recognising the significant benefits that expanded community optometry services can deliver for patients, ongoing communication and engagement with patients, carers and third-sector organisations will remain central to future plans. Through continued partnership working and service

innovation, the Health Board aims to improve access to care, reduce unnecessary hospital attendances and support delivery of high-quality eye care closer to home.

3. General Medical Services

The Health Board is responsible for providing General Medical Services (GMS) to residents throughout ABUHB and commissions services from independent contractors through The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023.

At the start of 2025/26, 68 General Practices were responsible for delivering primary care services during core hours (08:00 to 18:30 Monday to Friday). Patients requiring medical care outside of these hours were supported by the Health Board's Out of Hours Service, which operates overnight, at weekends and on Bank Holidays. Following a successful practice merger in September 2025, the number of practices reduced to 67.

Outside of the period, the Urgent Primary Care Service provides clinical assessment including remote and face to face consultations in urgent care centres in Newport, Abergavenny and Ystrad Mynach and also home visits where patient is medically unfit to attend one of the centres. Patients are initially assessed by the NHS 111 Wales service which is provided by the Welsh Ambulance Service Trust. The Health Board has established an in-hours urgent care service in Newport and Abergavenny for those who have been diverted by the NHS 111 service, the Emergency Department in the Grange University hospital or the Minor Injury Units in Abergavenny, Newport, Ebbw Vale and Ystrad Mynach.

3.1 GMS Contract

Welsh Government issued an update on 12 December 2025 regarding the GMS Contract 2025/26 negotiation outcomes. The agreement confirmed a total of £41.9 million investment into general practice during 2025/26. The following changes were confirmed:

- A 4% uplift to General Practitioner (GP) pay element of the contract, in line with the Doctors' and Dentists' Review Body (DDRB) recommendation;
- A further recurrent £2m award has been agreed to support practices with ongoing business expenses;
- A recurrent £20 million to support immediate practice stabilisation and deliver this year's agreed mandate in preparation for the next phase of reform;
- Continuation of £4 million Additional Capacity Funding for 2025-26;
- Uplifts to Statement of Financial Entitlement (SFE) reimbursements:
    - Apply a 24.1% uplift to the SFE for all GP reimbursement ceilings and equalising the suspended doctors ceiling to other entitlements

- Extend SFE parental leave cover to Independent Prescribers (IPs) at 62.2% of the GP rate;
- Reduce the sickness absence cover rate for IPs to the same 62.2% level;
- Claims for absences from 1st October 2025 will be at the new Welsh rates, with guidance to be issued for practices.

- Uplift the Partnership Premium for the current year, backdated to 1 April 2025, with a 10.5% session rate increase as recommended by the short life working group; and
- A 4% uplift to Quality Improvement (QI) point value in 2025-26.

3.2 Access

The Health Board has a well-established Access Group in place to review, sustain and develop primary care access within GMS to ensure it is sufficient to meet the needs of the patient population and remains sustainable for the future.

Access Group considers any applications received from practices in relation to:

- Branch Surgery Closures/reduction in service provision;
- Boundary Changes: monitor, review and consider applications;
- Plan and prepare for contract terminations/variations; and
- List closure requests or Premise relocation.

The group also review GMS Access achievement and provides a mechanism for quality assurance for access.

There were no GMS list closures or relocations during 2025/26.

3.2.1 Branch Surgery Closure/Reduction

The Health Boards Access Group, comprised of senior ABUHB colleagues, Local Medical Committee and Llais representatives, considered one application in Caerphilly East to permanently close a branch surgery in accordance with the Health Boards Branch Surgery Closure Policy, including a period of patient and stakeholder engagement. Following consideration of the practice's business case and the results of patient and stakeholder engagement members supported the application, subject to the required 3 months' notice and therefore effective 1 December 2025.

3.2.2 Boundary Changes

One practice in Blaenau Gwent East submitted a request to extend their practice boundary in 25/26. The application was considered in line with the

Health Board Practice Boundary Review Policy and Application Process. The process consisted of information gathering and stakeholder engagement prior to review by Access Group panel members, comprised of senior Health Board colleagues, and LMC and Llais representatives.

Taking into consideration the potential impact and concerns of neighbouring practices, panel members felt the application could not be supported, and the practice should demonstrate a period of sustained stability before a request to extend the practice boundary is considered.

3.2.3 Contract Resignations

General practice continues to face significant challenges including recruitment and retention of workforce, financial constraints and managing patient expectations and demand. ABUHB Vacant Practice Policy (VPP) and associated Standard Operating Procedure provide a robust process to consider all GMS contract vacancies and, upon receipt of a contract resignation, the VPP is implemented.

Each Vacant Practice is considered on its individual merit, in line with the Health Boards strategic plan and the local population health needs. When a Practice becomes vacant, the Health Board seeks to determine the most appropriate, sustainable option for the delivery of services to the registered population.

Following acknowledgement and early engagement, in confidence, with interested parties including neighbouring practices and local elected members, a Vacant Practice Panel is convened with representatives from Health Board officials, Llais Cymru and the Local Medical Committee (LMC).

Initial Vacant Practice Panel convenes to determine the most appropriate action for the future provision of primary medical services for the patients impacted by the change.

The following 5 options are available as detailed in the VPP:

Option 1: Aim to fill vacancy through local or national interest under a GMS/ APMS Contract, (the whole practice would be advertised locally and nationally as a vacancy under GMS/ APMS Contract arrangements).

Option 2: Managed list dispersal with existing neighbouring practices (through inviting local expressions of interest). Practices to consider taking on a proportion of the list.

Option 3: If vacancy not filled, the LHB take on the management and delivery of GMS services, in accordance with GMS Regulations.

Option 4: Dispersal of practice list (the LHB decide to disperse the practice list).

Option 5: Fill the vacancy through interest from existing/remaining partners (where clauses 524-529 of the GMS contract do not apply (existing partners agree to the transfer of the existing contract to one or more of the existing partners following dissolution)) aim to fill the vacancy through interest from existing partners.

The Panel will be required to determine the appropriate procurement process to be followed in accordance with the Health Services (Provider Selection Regime) (Wales) Regulations 2025 (PSR). This determination will be made on a case-by-case basis taking into account the specific circumstances of the vacant practice.

The panel recommendation is presented to the Health Boards Executive Team for consideration and ratification.

Following the resignation of a GP partnership from several contracts during 2025 and early 2026, ABUHB assumed direct management of these practices to ensure continuity of care for patients; five under direct management (one of which has subsequently returned to independent contractor status) and three under hosting arrangements as an interim measure whilst a procurement process is undertaken.

Further to the three GMS contract resignations received at the latter end of 25/26, the VPP was instigated and it was determined that the three practices would become 'hosted' by the Health Board from 1 April 2026, for an interim period in order to maintain service delivery and minimise impact to patients and staff whilst undertaking a full procurement process to advertise the vacant practices, in accordance with PSR processes, to secure replacement GP Partnerships to take on the full GMS contracts. It is anticipated that the procurement process will run from April 2026. Should the procurement not be successful, then the practices will transition to directly managed practices and fully align to ABUHB.

During 25/26 the Health Board instigated the VPP and undertook a procurement process for Aberbeeg Medical Practice. The robust procurement process, in accordance with the Health Services (Provider Selection Regime) (Wales) Regulations 2025, commenced on 6 June 2025 and successfully concluded with the full GMS contract for Aberbeeg Medical Practice being awarded to the Dr Shore-Nye and Partners, an established local GP partnership, with effect 1 January 2026.

3.2.4 Practice Mergers

The Health Board first offered a discretionary payment scheme in 2015 to support practices that are considering merging and it was re-launched in 2023/24 and again in 2024/25. The scheme seeks to support working at scale with wider skill mix, achieving economies of scale with a larger critical mass of patients and thus improving quality of care for patients.

The scheme is backed by significant financial incentive payments. Any practice in ABUHB area can apply, regardless of its current sustainability situation, however prior consideration may be given to those considered more vulnerable depending on their sustainability risk matrix scoring. This scheme applies only to practices in ABUHB area. A typical merger between two practices may attract payments of approximately £30,000.

Although the full merger discretionary scheme was not re-launched during 25/26, the Health Board received one expression of interest to merge two practices in Monmouth South. Following partnership changes, both GMS contracts were held by the same GP partnership and the merger provided an opportunity to create a more sustainable unit and create stability in the Monmouthshire South area. Following negotiations with the partnership, a support package reflective of the existing arrangements was agreed by the Health Board in order to support the merger. Both premises were retained, creating one main and one branch site, effective September 2025.

The table below, Table 19, details the contractual changes for 2025/26.

Table 19 – 2025/26 contract changes

25/26	Sep-25	Merger	Mount Pleasant Practice & Wye Dean Practice (Wye Dean as branch of Mt Pleasant)
	Dec-25	Branch Closure	Newbridge – Branch of North Celynen
	Jan-26	Contract awarded	Aberbeeg Medical Practice
	Feb-26	Contract Resignation	Meddygfa Gelligaer Surgery
	Feb-26	Contract Resignation	Pontypool Medical Centre
	Feb-26	Contract Resignation	Lliswerry Medical Centre

3.2.5 Directly Managed Practices

The Health Board assumed direct management for five practices; three from 1 March 2025 and two from 1 April 2025. There was a Divisional response to the contract resignations and, in addition to the robust

contractual process which were implemented, the Division also established an operational oversight team comprised of Clinical Directors, Nursing Colleagues and management support. This dedicated team was aligned to the practices to support them during the initial stabilisation period. As the Health Board cannot enter a contractual arrangement with a directly managed practice, Managed practices are monitored in accordance with the Practice Statement which mirrors the requirements of the GMS Regulations, ensuring equity of access and consistency throughout.

Following an initial stabilisation period, there was a sequential review of the practices to determine the longer- term arrangements for the ongoing delivery of GMS for each practice.

The VPP was successfully implemented in April 2025 in respect of Aberbeeg Medical Practice.

Following the successful award of Aberbeeg Medical Practice, the VPP was implemented in September 2025 in respect of Blaenavon Medical Practice, with a view to returning the practice to independent contractor status. Although there was initial interest, the tender process was unsuccessful, therefore it was determined to retain the practice as a directly managed practice at that time. A full review of the directly managed practices will be undertaken in 26/27.

3.3 Sustainability Assessment Framework

There is a national framework in place that provides a consistent approach to the assessment of the sustainability of practices and enables practices to request support from the Health Board. In lieu of physical resource, ABUHB has a mechanism in place to determine a level of financial support available to practices, under this framework. The reimbursement of locum fees under the Sustainability Assessment Framework (SAF) forms just one element of the overall Health Board response to practices seeking support in respect of sustainability challenges. Each application under the scheme is considered on a case-by-case basis, by a Local Assessment Panel, where the practice score on the Risk Assessment Matrix informs the priority.

A 'financial calculator' applies a consistent formula to enable partial reimbursement for locum sessions for those practices that have a shortfall in their core clinical sessions against the locally agreed benchmark of 1 GP equivalent clinical session per 200 registered patients. The qualifying number of weekly locum GP sessions eligible for reimbursement will be the practice shortfall, based on 1:200, less 15%, to demonstrate shared risk. This ensures the sustainable delivery of services whilst the practice seeks to recruit permanent staff, whilst mitigating some of the financial risk associated with locum engagement.

During 2025/26 3 practices received a financial support package under the framework; two in Torfaen North (both ceased March 2026); and one in Caerphilly North.

With all sustainability applications, financial support is subject to regular review and ongoing monitoring, and the Health Board reserves the right to adjust for any significant changes in circumstances. Practices are required to demonstrate that they are undergoing active recruitment campaigns.

3.4 General Practice Escalation

GMS practices are contractually required to accurately report their escalation level monthly, as a minimum, and/or when it changes. The PCCT and respective borough teams continue to support the practices in escalation in line with the agreed process, with additional on the day support from Urgent Primary Care if required, for practices reporting level 3 and above. LMC continue to promote accurate escalation.

Table 20 – Escalation levels reported during 2024/25 and 2025/26

ABUHB Practice Reported Escalation Status 2025/26				
Escalation Level	**1**	**2**	**3**	**4**
Qtr 1 (Last day of Qtr)	36	26	4	2
Qtr 2	37	25	5	0
Qtr 3	37	26	4	0
Qtr 4	41	19	7	0
ABUHB Practice Reported Escalation Status 2024/25				
Escalation Level	**1**	**2**	**3**	**4**
Qtr 1	36	25	6	1
Qtr 2	38	21	9	0
Qtr 3	31	24	8	5
Qtr 4	33	26	7	2

Whilst demand on GMS remained high throughout 2025/26, the number of practices reporting at level 3 or above reduced from 2024/25.

3.5 Enhanced/Supplementary Services

The Enhanced/Supplementary Services Operational Group (ESOG) is established to develop and monitor primary care enhanced/supplementary services, ensuring a consistent approach is applied to the delivery and management of the services.

Enhanced/Supplementary Services are, in essence, an element of core provision delivered to a higher specification, outside of the normal scope of primary medical services which are designed around the needs of the local

population and provide the Health Board with the opportunity to develop more local and integrated services across primary and secondary care.

Enhanced/Supplementary Services are optional for practices to deliver and are commissioned by the Health Board from those practices who can meet the requirements within the service specification.

In order to deliver effective and efficient Supplementary Services in primary care it is crucial that there are:

- Appropriate facilities in local communities as referred to above. Contractors must ensure they meet required health and safety standards for primary care premises
- Staff with appropriate skills, knowledge and attitude to meet the needs of the local population
- Practices with systems to ensure effective communication in place, between all primary care professionals and patients, to support the delivery of high-quality primary care

During 2025/26 the following services were commissioned:

Table 21 - Directed Supplementary Services (DSS) - all Health Boards must commission or provide

Service	% Practices Commissioned 24/25 (Position on 31/3/2025)	% Practices Commissioned 25/26 (Position on 31/3/2026)
Pneumococcal	100%	100%
Childhood Imms	100%	100%
Asylum Seeker	40%	42%
Violent Patients (Alternative Treatment Scheme)	1 practice commissioned via SLA	1 practice commissioned via SLA
*Minor surgery - Fee A & B	79%	Minor Surgery Level 1 & 2 - 46%
*Minor surgery - Fee B Only	90%	Intra-Penarticular Injections - 62%
Minor Surgery Level 3 (Previously Extended skin LES)	13%	12%
Diabetes Gateway DES	90%	91%
Care Home	72%	73%
Anti-coagulation Level A & B	92%	94%
Anti-coagulation Level B Only	12%	13%
Homeless	13%	28%
Gender Identity for Registered Patients or on behalf of the NCN	50% registered and 10% for NCN	51% registered and 18% for NCN
Complex Multi-Morbidity and Frailty.	68%	Commissioned for 3 months only - 55%, only 22% submitted claims for activity

*New Directed Supplementary Service Directions issued, amending level of commissioning/model of delivery. Not a direct comparison.

Table 22 - National Supplementary Services- all Health Boards should commission or provide however not mandatory

Service	% Practices Commissioned	% Practices Commissioned
GLP1 Monitoring	47%	45%
Flu Immunisation	100%	100%
Unscheduled Immunisations	100%	100%
Non-Routine Imms	90%	90%
Substance Misuse	16%	15%
Shingles	100%	100%
Rota virus	99%	100%
Meningitis	100%	100%
People Fleeing War and Persecution in Ukraine	35%	34%

Table 23 - Local Supplementary Services - optional commissioning of services based on local need

Service	% Practices Commissioned	% Practices Commissioned
DOAC Initiation & Monitoring	84%	87%
DOAC Monitoring Only	18%	9%
Contraceptive Implants (Nexplanon) for Registered and Non-Registered Patients	53% registered/ 4% non-registered	51% registered/ 5% non-registered
Depression/Lithium	50%	48%
IUCD Registered and Non-Registered Patients	54% registered/ 27% non-registered	54% registered/ 27% non-registered
Near Patient Testing	97%	99%
Denusomab	94%	96%
Pertussis	100%	100%
Gonadorelin / Zoladex	100%	100%
Ring Pessary	N/A	45%
Hypertension Case Finding	N/A	75%

During 2025/26 two new Local Supplementary Services were introduced:

- Ring pessary service: to support the provision of routine ring pessary changes in a primary care setting, reducing the need for inappropriate referral into secondary care.

- Hypertension Case Finding: identify people aged 40 to 75 and at risk of having high blood pressure and invite them for a free blood pressure check. During the check healthy lifestyle advice (Making Every Contact Count - MECC) is to be offered and 7-day Home Blood Pressure Monitoring, if indicated.

A Schedule 7 is prepared annually as part of the GMS contract and shared with each practice detailing each Supplementary Service the contractor is commissioned to provide.

3.5.1 Alternative Treatment Scheme

Welsh Government issued WHC 2002 (082) "Stopping Violence against Staff Working in the NHS: Tackling Violence Against those in Primary Care". This guidance stated that professionals and staff working in the health service would not tolerate aggression, violence and threatening behavior by the public. The report recommends that Health Boards adopt a "zero tolerance" approach to patients, relatives and members of the public who use violence and aggression towards NHS staff.

The Alternative Treatment Service (ATS) was introduced as a Directed Enhanced Service in 2004 with the aim of providing a secure environment in which patients who have been violent or aggressive in their GP practice can receive General Medical Services.

The right of individuals to receive mainstream primary care services remains a fundamental principle of the NHS and patients who have been subject to immediate removal from a practice list will not be excluded from receiving primary care services.

The ATS is designed to provide GMS to patients who meet the criteria for inclusion into the Scheme and allows Health Boards to balance the rights of patients to receive services from GPs whilst ensuring that GPs, practice staff and bystanders are able to deliver a service without threats or occurrences of unacceptable behavior.

Any immediate removal of the patient from the practice list and referral into the Scheme, whether it is as a result of unacceptable actions, threats or inappropriate behavior must be in accordance with the GMS Contract Regulations 2023.

During 2025/26 16 referrals were received for the scheme of which, 7 were accepted and 9 rejected as they did not meet the threshold. This is a reduction from 31 referrals in 2024/25.

St Julians Medical Centre in Newport, was commissioned via a Service Level Agreement to provide this service across the Health Board area. The provider advised of 6 months' notice to withdraw from providing the ATS, with effect from 31 May 2026. The Health Board commenced The Most Suitable Provider process in line with the Health Services (Provider

Selection Regime) (Wales) Regulations 2024 to re-commission the service under the existing SLA, seeking Expressions of Interest in the first instance, to commission from June 2026. Providers who expressed an interest will be asked to complete the Basic Selection Criteria - Pass/Fail Qualification Questions.

3.6 Welsh Government Additional Capacity Funding

Welsh Government introduced this scheme in 2021/22, to fund additional staff resources (GPs, practice nurses, administration staff, etc) above what is already in place within GMS practices to support recovery from the pandemic.

For 2025/26, the Health Board was allocated £763,630 to enable the reimbursement of up to 50% of the total cost (salary / sessional fee & on-costs) of either additional posts upon appointment (including those in post from December 2021 under the 2021-22 scheme) or additional hours worked by existing post holders. Individual practice allocation is based on patient list size.

Four practices confirmed that they would not be utilising their allocation and this was distributed between the remaining practices in order to maximise uptake and benefit. Reimbursement is made on the submission of verified claims and the total amount of funding utilised in 25/26 totalled £739,862.51. The following table shows the additional hours, by staff role, facilitated through this scheme.

Table 24 - Welsh Government Additional Capacity Utilisation in Hours

Role	2025/26*	2024/25*	2023/24*	2022/23*
GP	6,944.98	8,415.44	5,522.20	9,054.47
Nurse	10,022.93	8,080.62	11,213.91	4,842.84
Other Healthcare	6,382.36	8,075.51	7,744.69	4,312.08
Admin	37,875.24	51,992.85	49,016.17	27,041.96
Total	**60,964.33**	**76,564.42**	**73,496.97**	**45,251.35**

** number of hours is the 100% figure stated on the claim form but funded for 50%

This funding is time limited and will be available up to 31 March 2026.

3.7 Child Health

The Healthy Child Wales Programme (HCWP) sets out what planned contacts children and their families can expect from their Health Boards; from maternity service handover to the first years of schooling. These universal contacts cover three areas of intervention: screening, immunisation and monitoring and supporting child development.

The 6–8-week baby examination is delivered by Health Boards and undertaken by General Practitioners as part of the GMS contract. A Health Board assurance process, developed in collaboration with the Child Health Department has been implemented for the monitoring of the uptake of the 6 to 8-week baby checks in General Practice. This seeks to provide assurance that GP practices are undertaking 6 to 8-week baby checks in line with the Unified Services element of the GMS Contract and the Healthy Child Wales Programme.

The childhood immunisation programme is delivered by Health Boards and undertaken by General Practitioners as a direct enhanced/supplementary service. The Health Board actively monitors immunisation queues in General Practice in order to gain assurance that GP practices are undertaking childhood immunisations in line with the service specification and the Healthy Child Wales Programme. The process has been developed collaboratively with the Health Board immunisation team.

3.8 Quality Improvement Framework

3.8.1 QI Projects

This year's QI cycle ran from 1 April 2025 until 31 March 2026, and the completion of three QI projects was mandatory for practices participating in the QI process, with the allocation of points as set out below:

1. Chronic Kidney Disease-70 points;
2. Improving Cardiovascular Outcomes-70 points; and
3. Continuity of Care-30 points.

Project specifications were provided to practices with an overview of project objectives and requirements to demonstrate achievement. Supplementary information, inclusive of project specifications, poster templates and links to the Royal College of General Practitioners (RCGP) Continuity of Care toolkit, were also made available on the Primary Care One website.

Practices were required to submit evidence demonstrating completion of each of the QI projects for verification using the national templates. The PCCT reviewed all submissions to validate evidence of achievement.

Chronic Kidney Disease: Initial assessment verified 51 practices had completed the projects to meet all objectives, 16 required further information to be included within the poster.

Improving Cardiovascular Outcomes: Initial assessment verified 60 practices had completed the projects to meet all objectives, 7 required further information to be included within the poster.

Continuity of Care: Initial assessment verified 49 practices had completed the projects to meet all objectives, 18 required further information to be included within the poster.

The PCCT liaised with practices regarding additional information required to evidence achievement with a deadline of 15 May 2026 for submission via PCIP, in line with nationally agreed timescales.

67 out of 67 practices within the Health Board met all requirements set out in WG guidance against all mandatory projects, including the requirement to engage in NCN discussions in respect of the QI projects.

3.8.2 Access Commitment

The standards listed in this section were previously referred to as Phase 2 Access Standards and are now referred to only as Access Standards for 2025/26. Participation in the GMS Access Commitment is not mandatory for practices but carries up to 100 Quality and Improvement Framework points for achievement. Health Boards are responsible for verifying achievement and providing assurance to Welsh Government on progress with delivery of the Access Commitment.

Practices are required to achieve all 6 measures, detailed below, in order to receive 40 points for the Standards section of the commitment and 60 points for the Reflective Report.

Table 25 – access standard requirements

Standard	Standard Requirement
1	All existing patient facing staff who did not undertake the national care navigation training package provided by HEIW in the financial year 2022/23 are required to undertake this training, as well as all new patient facing staff completing this training within 3 months beginning with their start date
	Practices will supply names of new starters and date of training undertaken.
2	All patients telephoning the practice are to have their calls received by a standard recorded message, and subsequently calls are answered with appointments made available for advanced booking each day with declaration confirming that every patient contact is supported throughout the day. Patients will be offered an appropriate consultation, whether urgently or through advanced booking consistent with the patient's assessed clinical need, without 4 the need for the patients to contact the practice again. Where clinically appropriate, patients may be signposted to another appropriate service.
3	To maintain a planned and forward-looking approach to consultations, practices to undertake a regular assessment of their scheduling appointment system to ensure a mix of remote, face to face, urgent, on the day and pre-bookable. A more planned and forward-looking approach should be taken to the scheduling of appointments throughout the day, or for future dates, meaning it is no longer acceptable for all appointments for that day to be released at 8.00am.
4	Practices must confirm each quarter that they regularly maintain an automated and standardised public facing dashboard and make this available via a range of communication methods to meet the needs of their patients. (an Infographic is available via the PCIP for practices to use)
5	Practices are required to undertake the national patient experience survey which should include 25 completed questionnaires per 1000 registered patients from a range of practice population and captured through a range of methods
6	Practices are required to undertake care navigation on digital requests in a similar and equitable fashion to telephone requests

Practices are required to produce a reflective report to include; Equality Impact Assessment, Patient Engagement, National Patient Experience Survey, Patient Survey Action plan, Digital Request and Telephone System Intelligence.

Implementation guidance outlining practice requirements was issued to practices in March 2025. For the 2025/26 period, there was a new requirement for practices to submit a mid-year reflective report at quarter 2, outlining the progress made against the previous year's action plan.

The PCCT reviewed all evidence submitted by practices via the Primary Care Information Portal (PCIP), providing support to those facing challenges in uploading the relevant documentation. Where necessary, the team liaised with GP Practices to agree any subsequent adjustments. In total 55% (37) of practices were required to submit additional information to demonstrate achievement of the GMS Access Commitment. Following Health Board

liaison, all 67 GP practices across ABUHB submitted sufficient evidence to allow Health Board validation of all measures.

3.9 Prison

Primary care GMS services are being provided at both HMP Usk and HMP Prescoed via a Service Specification in accordance with the requirements of the GMS contract and in accordance with the NHS (GMS) Contracts Regulations 2023. This includes but is not limited to the provision of Unified Services described in the GMS contract and Supplementary Services as agreed between provider and commissioner.

The Health Board commissioned Malpas Brook Health Centre from 1 April 2025 to provide general medical services for 5 sessions a week across both HMP Usk and HMP Prescoed. Quarterly meetings are held between the provider and the Health Board to review the contract and ensure service delivery is as expected. The contract is currently commissioned until 1 March 2030.

3.10 Governance

The PCCT have robust mechanisms in place to monitor all contract delivery on a monthly basis, and additional processes in place for reviewing claiming data in respect of locum reimbursement payments and Enhanced/Supplementary services to ensure timeliness of submissions. The Enhanced/Supplementary services monitoring also enables the team to identify any gaps or anomalies in claims which may highlight staffing or training issues at practice level. Appropriate support is provided to practices to ensure practice cash flow is maintained, and training issues are addressed. It also allows for the contracting team to identify where practices may be commissioned but not delivering a service and allow for appropriate steps to be taken.

The PCCT ensures that risk is managed appropriately and through prompt identification and assessment, reported into Divisional QPS. This ensures that where possible, the Health Board is informed of the risks that are present and how they are managed or mitigated.

The GMS risk register is reviewed regularly and describes risks in sufficient detail so that they can be clearly understood. All risks identified are assessed for severity and likelihood of the risk along with necessary actions to treat, remove or minimise the risk.

The PPV service is delivered by NWSSP on behalf of Health Boards providing assurance to Health Boards that Supplementary Service claims made by GP Practices are appropriate and in line with the regulations set and guidance documents issued.

The PPV programme runs on a three-year cycle, reviewing a third of the contractors each year. A random sample of claims are reviewed and verified against the patient's clinical record.

Once the PPV team has undertaken their visit and the report has been finalised, this report is shared with the Health Board.

The Health Board reviews each report received and for an error rate of 10% or more or a recovery value of £1000 or more, then a practice visit is scheduled, for an error rate of 5%- 9% an initial letter is issued to practices. Anything less than 5% results in no further action.

During 2025/26 the Health Board received 32 (compared to 20 2024/25) reports for GP practices, 24 of which required PCCT action. In total £50,687.86 was recovered due to claims errors.

HIW inspect all GMS practices for clinical and managerial/administrative compliance, providing a report of each inspection to the practice and the Health Board identifying any areas for improvement. A total of 7 HIW inspections were carried out in 2025/26.

Of the GP practices inspected in 2025/26, three practices received an immediate improvement plan. Two practices submitted acceptable improvement plans agreed by HIW, with one currently outstanding for review.

Practices engage directly with HIW and the Health Board offers support and guidance to a practice before and after inspections have occurred. Prior to a visit a HIW visit template has been developed to share with practices, which outlines key areas that HIW will consider and supports practices in preparation for the visit. Following a visit, support if offered to resolve immediate actions where appropriate, such as maintenance or facilities issues with Health Board owned premises. Reminders are also sent for any upcoming deadlines and meetings offered to discuss any practice concerns as a result of the visit and/or report.

3.10.1 Annual Contract Review

The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023, requires general practice contractors to comply with all relevant legislation and submit an annual return relating to the contract to the relevant Health Board. Failure to comply could result in the Health Board activating remedial notice procedures.

The Unified Contract Assurance Framework (CAF) is used across NHS Wales and by GMS contractors to provide assurance of the delivery of the GMS Unified Contract in a transparent, proportionate and consistent manner with the utilisation of existing data sources, including nationally analysed data, and through the application of agreed national measures. The approach is

developmental wherever possible, while also providing a clear stepwise escalation process for addressing any concerns.

The Assurance Framework indicators are mapped to the 6 domains of quality and 6 enablers as set out in the Health Care Quality Standards.

6 Domains:

1. Safe
2. Timely
3. Effective
4. Efficient
5. Equitable
6. Person-centred

6 Enablers:

1. Leadership
2. Workforce
3. Culture
4. Information
5. Learning, improvement and research
6. Whole-systems perspective

Assurance Framework Process

There are five key stages to the Contract Assurance Framework (CAF) process, ensuring a consistent approach across Wales.

Stage one – Nationally agreed data set for quality, safety, governance and contract management.

A desk top review of practice assurance using the nationally agreed set of indicators including Assurance Indicators, Clinical Governance Practice Self-Assessment Toolkit, Information Governance Toolkit and Annual Contract Returns was carried out for all 67 GP practices within ABUHB.

The desk top reviews were utilised to determine the level of assurance and then prioritise the depth of assessment required for each practice. Information submitted by the practices on the Annual Contract Return was verified by the PCCT to ensure accurate interpretation of the questions posed, as a result of this verification process the weighted scores automatically assigned on PCIP were manually adjusted to reflect the outcome. Across ABUHB, 19 practice scores were amended to reflect a decrease in overall scores and 3 practices reflected an increase. The discrepancies between practice self-reported and Health Board verified scores were as a result of practices mis-interpreting questions where the question included a double negative statement. This discrepancy was recognised across all Health Board's, and a national GMS task and finish

group was established to review and agree the question set for the next reporting period.

Stage two – Prioritisation by Health Boards

The desk top reviews enabled the categorisation of practices based on the following assurance levels;

- Substantial Assurance – few matters require attention, low risk. Action Plan drafted for practices to complete and return, no visit required.
- Reasonable Assurance – some matters require attention with a low to moderate risk until resolved.
- Limited Assurance – more significant matters require management attention with a moderate risk until resolved.
- No Assurance – action required to address the whole framework with a high risk until resolved.

As a result of the desktop reviews, 30 practices were provided with an Action Plan with specific deadlines, identifying areas where review or improvement were required, a reduction from 37 practices in 2024/25. In addition, 11 practices were provided an action Plan which detailed areas for on-going review.. Actions consisted of low to moderate risks that required attention within a given timeframe.

A schedule of practice visits was agreed based on the outcomes of the desktop reviews, Annual Contract Return, National Prescribing Indicators, National Safety Indicators, Contractual Issues, Governance and local intelligence. As a result, 22 practices (32%) were identified to receive a Contract Assurance Visit during 25/26 based on the reporting period 1 April 2024to 31 March 2025.

Stage three – Process for assessing compliance against contractual requirements

Practice visits took place between August 2025 and January 2026, with a multidisciplinary approach. These visits concluded the Health Board's 3-year visit cycle in which 100% of practices would receive at least one face to face Contract Assurance meeting since April 2022. Main areas of discussion included:

- Prescribing Safety Indicators – patient cohorts identified for review;
- Clinical Governance and safety aspects of CGPSAT – areas for focus and improvement which mainly consisted of safeguarding;
- Child Health issues – immunisation queues;
- Significant local safety concerns/national reportable incidents – reported by practice on annual return; and
- PPV recoveries – reported by practice on annual return.

Stage four – Output of visit

Following each meeting a summary report alongside an action plan (where applicable) was provided to the practice. 5 practices had no actions following discussions at the practice visit, with 17 practices receiving an after-visit report and action plan, identifying a total of 46 areas where actions were required.

Table 26 – number of practices with identified actions

Number of Practices:						
With no actions	**With 1 action**	**With 2 actions**	**With 3 actions**	**With 4 actions**	**with 5 actions**	**With 6 > actions**
5	7	3	2	2	1	2

Table 27 - Summary of timeframes for improvements

Number of practices:				
Immediate actions	**Actions within 1 month**	**Actions within 3 Months**	**Actions In 3-6 Months**	**Ongoing Improvement**
1 (1 Actions)	3 (8 Actions)	5 (15 Actions)	6 (11 Actions)	7 (11 Actions)

Stage five- nationally agreed escalation ladder

The Health Board approaches the CAF process in a supportive manner in order to ensure practices are able to meet the requirements and work through any action plans to achieve substantial or reasonable assurance. Should any practice not engage with the process or have limited or no assurance then the escalation ladder supports the management of those scenarios, which ultimately could lead to the Health Board issuing a Remedial or Breach notice.

Stages of the escalation ladder include:

1. Practice contract and governance framework response plan
2. Sustainability Framework
3. Unified and Supplementary service review
4. Remedial/Breach notice issued

All actions identified during the 2025/26 visit cycle have been satisfactorily completed in line with practice response plans, therefore the escalation ladder has not been invoked.

3.10.2 Enhanced Monitoring Arrangements

A single GP partnership previously held eight General Medical Services (GMS) contracts within the Aneurin Bevan University Health Board Area:

- Brynmawr Medical Practice;
- Aberbeeg Medical Practice;
- Bryntirion Surgery;
- Tredegar Medical Practice;
- Blaenavon Medical Practice;
- Meddygfa Gelligaer Surgery;
- Pontypool Medical Centre; and
- Lliswerry Medical Practice.

The contracts for the afore mentioned practices were all standard NHS Wales GMS Contracts, with individual names GPs as the GP partnership to the contract. This is the same NHS GMS contract that is in place for all other GP partnerships across ABUHB. GP partnerships provide care to their population as independent contractors to the NHS, this is the model that has been delivered since the inception of the NHS.

The challenges faced by the partnership have been well rehearsed and, consequently, they were placed under enhanced monitoring arrangements by the Health Board including; bi-weekly assurance meetings, a weekly escalation point, weekly data capture and practice assurance visits. These measures have been in place alongside usual GMS contract monitoring processes.

The ABUHB GMS Enhanced Monitoring Framework is a supportive and transparent process where the Health Board worked with the practices to ensure long term sustainability of GMS. Due to ongoing challenges the partnerships ultimately resigned from all of their ABUHB GMS contracts.

3.10.3 Audit Review

The challenges surrounding the aforementioned GP partnership triggered:

- Internal Audit review of the VPP;
- Audit Wales review; and
- System-wide learning and policy changes.

The Internal Audit review outcome report confirmed that the audit provided reasonable and substantial assurance that general compliance was observed against the Welsh Government legislative/ regulatory requirements, the Welsh Health Circular (2006) 063 (General Medical

Services Practice Vacancies – A Guide to Good Practice) and the local VPP in respect of the process applied. Also provided, was a supplementary advisory report outlining observations and considerations to potentially strengthen the Health Board processes and provide consistency in approach and reduce risk exposure. Both reports supported the development of a comprehensive Standard Operating Procedure (SOP) to complement the VPP, inclusive of process requirements in accordance with the Health Services (Provider Selection Regime) (Wales) Regulations 2025 (PSR)..

The SOP outlines the procedural steps for contract letting of both vacant and Health Board managed practices, with clear roles and responsibilities identified and has been developed to enhance and strengthen the Health Boards processes in relation to GMS Vacant Practice process and the awarding of GMS contracts.

The audit process concluded with the Health Board development of a lessons learned document, to provide assurances to Board members and to ensure strengthened processes are taken forward locally as well as an opportunity to inform the national approach in the development of updated guidance in relation to the VPP.

3.11 Concerns/Freedom of Information

In relation to GMS, in 2025/26, the team investigated and responded to a total of:

- 33 Freedom of Information requests;
- 29 concerns received vis Putting Things Right; and
- 106 MS MP concerns (elected members).

Through the management and investigation of these concerns, the Health Board addresses any specific contractual issues with the relevant provider ensuring any learning points are taken forward. Common themes include access to GP appointments, difficulties in contacting practices and access to vaccines and immunisation.

3.12 Looking Ahead

The following information is based on local knowledge and at this stage there is no indication that any of these practices propose a change to their current service.

Table 28 – local intelligence information

As of 1 April 2026:
Blaenau Gwent

Currently there are no single-handed contractors.

Managed practices:

Practice	Location	List Size
Brynmawr Medical Practice	Blaenau Gwent East	10,840
Tredegar Medical Practice	Blaenau Gwent West	6,832

Caerphilly

Single Handed Contractors:

Practice	Location	List Size
Sunnybank Health Centre	Caerphilly East	5,562
South Street Surgery	Caerphilly North	3,699

Managed practices:

Practice	Location	List Size
Bryntirion Medical Practice	Caerphilly North	10,505

Monmouthshire

Currently there are no single-handed contractors.

Newport:

No Single-Handed Contractors.

Torfaen:

Currently there are no single-handed contractors.

Managed Practices:

Practice	Location	List Size
Blaenavon Medical Practice	Torfaen North	6,609

The Health Board's well established Access Group will continue to be scheduled on a Quarterly basis and the ESOG will continue to be scheduled Bi-annually. The PCCT continue to work closely with all key stakeholders and liaise with Llais and LMC with all policy changes and applications.

The PCCT will continue to work collaboratively with Welsh Government, Health Board colleagues, LMC, secondary care services and third-sector

partners to support sustainability and improvements in GMS provision across ABUHB.

The PCCT has a well-established Business Cycle for core priorities that require continued monitoring each year. The Business Cycle for 2026-27 has been updated to reflect amendments to the National Health Service (General Medical Services Contracts) (Wales) Regulations 2026. Progress against the business will continue to be reviewed on a quarterly basis.

A key priority for 2026/27 will be the implementation and monitoring of the new contractual requirements as illustrated within the guidance issued in March 2026 following announcement of tripartite GMS contract agreement between Welsh Government, NHS Wales and General Practitioner Committee (GPC) Wales:

- Application of staff pay uplift - A declaration will be shared across all GMS providers.
- Workforce Fund 2026/27 – For 2026-27 a 5.8% recurrent funding uplift of the GMS contract will apply from the outset of the financial year. This funding uplift from 2026-27, will provide practices with financial certainty to invest in resources needed for the next phase of reform, including workforce expansion, service redesign and administrative support. Workforce Fund guidance and Claim Form will be adapted and circulated to practices. Allocation of funds will be calculated in line with the guidance and quarterly monitoring of usage will continue throughout the year.
- Patient access to structured coded records - Agreement was reached to make available patient data in the NHS Wales app. Digital Health Care Wales have enabled the functionality ensuring patients now have access to certain coded elements of their record, by default, via the NHS Wales App. Practices must ensure that the functionality is enabled in their system, to ensure a summary patient record is accessible to the individual in a secure view via the NHS Wales App.
- Routine management of high risk and rising risk patients in the community- Agreement was reached to fully embed a consistent approach to the identification of the patient cohort and proactive management of the identified 0.5% high risk population group. From April 2026, practices will be expected to adopt a nationally consistent approach to identification of the high-risk cohort, informed by use of the Rockwood Clinical Frailty Scale and supported by digital tools such as Audit+ and/or system searches.
- Inclusion health services - GP teams are required to undertake actions to identify vulnerable individuals experiencing multiple severe and overlapping disadvantages that significantly increase their risk of poor health and then connect them with appropriate care. Actions expected include the maintenance, annual review and validation of Inclusion Health Registers.

- Eight Care Processes Data Sharing - To support improved planning, monitoring and equity of access to diabetes care, agreement was reached that aggregate practice level data on the completion of the Eight Essential Care Processes will now be automatically shared with Health Boards Primary Care Contracting Teams via the PCIP.
- Structured Medication Reviews - Additional questions have been agreed for inclusion within the Clinical Governance Practice Self-Assessment Toolkit (CGPSAT) to enable better understanding of the adoption of the Welsh National Standards for Medication Review by practices. Practices are not being asked to change clinical practice at this time.

The PCCT will continue to work closely with Digital and Data colleagues, NHS Wales and the profession to support the successful implementation of the national EPS.

Engagement with GP's and Practice staff will remain a priority throughout 2026/27. An engagement programme is being developed by the PCCT in addition to the continuation of Protected Learning Time. In addition to wider engagement events, the PCCT will continue to provide focussed support and advice to contractors, ensuring contractual compliance and supporting continuous service improvement.

4 Pharmaceutical Services (Community Pharmacy)

Community pharmacy plays a key role in supporting the Health Board's statutory responsibilities to secure the provision of accessible NHS pharmaceutical services under the Community Pharmacy Contractual Framework (CPCF).

A network of 125 pharmacies, operated by 57 contractor organisations, provides core dispensing services alongside an expanding portfolio of nationally and locally commissioned clinical services across the Health Board.

Throughout 2025/26, community pharmacies have increasingly functioned as accessible, NHS-funded clinical settings, contributing to system resilience and improving patient access to care. This includes support for common ailments, contraception, dependency, and vaccination services.

In addition to their NHS role, community pharmacies also provide a range of private "paid for" services to their local communities. Initially these were limited to delivery services and the provision of compliance aids, but have now grown to include ear wax removal, private vaccination services and individualised prescribing programmes for specific conditions including weight management and dermatitis.

This report focusses on the NHS pharmaceutical services delivered by community pharmacy independent contractors.

4.1 Distribution of services and opening hours

The table below details the number of pharmacies in each borough across Gwent.

Table 29 – Distribution of community pharmacies



	1
	0
	11
	11
	14
	11
	1
	11
	11
	10
	10

The pharmacies are distributed in accordance with population need, reflecting both historical control of entry arrangements and ongoing access requirements. Together, these pharmacies form a key component of the

primary care system, providing local access to NHS pharmaceutical services, clinical consultations and public health interventions.

Community pharmacies are contractually required to provide a minimum of 40 core opening hours each week, with many pharmacies offering additional supplementary hours to enhance accessibility for local populations. Any changes to contracted core opening hours are subject to Health Board approval to ensure that service provision continues to meet the needs of communities and maintains equitable access across the region.

Whilst traditional dispensing activity remains a core function, community pharmacies increasingly provide accessible NHS clinical services closer to home, including the management of common ailments, emergency contraception, smoking cessation support, substance dependency services, vaccination programmes and independent prescribing. This evolution has further strengthened the role of community pharmacy as an accessible first point of contact for patients seeking advice, treatment and support.

To support this expanded role, community pharmacy services maintain comprehensive opening hours throughout the week. Most pharmacies operate core opening hours between 09:00 and 18:00 on weekdays, with a number of providers offering extended opening times, alongside targeted Saturday and Sunday provision within key population centres. The summary below provides an overview of how pharmacy opening hours are distributed across the Health Board area to support patient access and system resilience.

Table 30 – Summary of access arrangements

Access Period	Availability	What This Means for Patients
Monday – Friday	High	Most pharmacies are open between 09:00 and 18:00, with some opening from 08:00–08:30 and selected providers remaining open until 20:00.
Saturday	Moderate	Many pharmacies continue to provide services, although opening hours are generally reduced compared with weekdays.
Sunday	Targeted	Services remain available through designated pharmacies within major population centres including Newport, Caerphilly, Cwmbran and Monmouth.
Extended Hours	Available	Selected supermarket and national chain pharmacies provide enhanced access during evenings and weekends.

Table 31 – Service availability

Day	Morning	Afternoon	Evening
Monday	High	High	Moderate
Tuesday	High	High	Moderate
Wednesday	High	High	Moderate
Thursday	High	High	Moderate

Friday	High	High	Moderate
Saturday	Moderate	Moderate	Limited
Sunday	Moderate	Moderate	Limited

4.2 Changes in Contractual Opening Hours

Community pharmacy opening hours continue to evolve in response to workforce availability, changing patient demand and the expanding clinical role of pharmacists.

To ensure patient access to NHS pharmaceutical services is maintained, the Health Board operates a formal process for considering changes to pharmacy opening hours in line with the statutory framework governing pharmaceutical services in Wales.

Proposals to amend core opening hours are assessed against local need, existing provision, alternative access arrangements and the potential impact on patients before any changes are approved.

Table 32 - Changes in Contractual Opening Hours

Year	2021/22	2022/23	2023/24	2024/25	2025/26
Change of Hours Applications	17	31	10	10	16

During 2025/26, the PCCT considered 16 applications to amend pharmacy opening hours.

The majority were minor changes that preserved overall opening hours, including the realignment of historical contractual arrangements where core hours recorded within pharmacy applications exceeded the statutory core-hour requirement. Following regulatory changes introduced during 2025, a small number of pharmacies also introduced lunchtime closures as part of their operating model. One pharmacy ceased routine Saturday opening.

All changes to core contractual hours were reviewed and approved through the Health Board's formal governance process and were subject to patient consultation prior to implementation.

Although opening patterns have changed over recent years, the Health Board's approach has been to balance contractor sustainability with the ongoing requirement to maintain equitable access to pharmaceutical services across all localities. As a result, changes have been considered within the context of the wider pharmacy network to ensure that access to NHS pharmaceutical services remains available when and where it is needed.

Table 33 - Community Pharmacy Access Comparison (2021–2025)

Measure	2021	2025/26
Community Pharmacies	132	125
Pharmacies Open on Sundays	11	8
Pharmacies Providing Extended Evening Opening (>18:00)	24	12
Total Weekly Opening Hours	6,119	5,625
Core Hours as a Proportion of Total Hours	87%	89.7%

The data indicates a gradual shift towards a greater proportion of pharmaceutical services being delivered during core contractual opening hours, with fewer pharmacies routinely providing Sunday and extended evening services than in 2021.

Total weekly opening hours have reduced by approximately 8% over the period, whilst the proportion delivered as core hours has increased. This reflects wider changes in workforce availability, service demand and contractor operating models, alongside efforts to maintain service sustainability.

Despite these changes, the overall access position has remained comprehensive, supported by the strategic management of opening hour changes and ongoing assessment of local pharmaceutical need. When considering proposed changes, the Health Board takes account of the wider pharmaceutical services available across the network, including commissioned out-of-hours provision, to ensure equitable patient access is maintained.

4.3 Rota Arrangements and Out-of-Hours Provision

In addition to routine community pharmacy opening hours, the Health Board commissions rota arrangements to support access to NHS pharmaceutical services during periods of reduced provision, including weekday evenings, Sundays and Bank Holidays.

During 2025/26, the Health Board commissioned a total of 2,952 hours of community pharmacy rota provision including revised additional commitments around Easter and Christmas periods.

Table 34 – Community Pharmacy Rota Provision Commissioned During 2025/26

Rota Type	Hours Commissioned
Weekday Evenings	1,742
Sundays	1,032
Bank Holidays	178
Total	2,952

Rota provision remains an important component of the local pharmaceutical service network, helping to ensure access to medicines, pharmaceutical advice and urgent care outside routine opening hours.

The Health Board's preferred approach is to secure rota coverage through voluntary participation by community pharmacy contractors. However, in recent years the number of contractors willing or able to participate has reduced, reflecting wider workforce, operational and financial pressures across the sector.

As pharmacy opening patterns continue to evolve, commissioned rota services provide an important mechanism for maintaining access during periods of reduced routine provision. The Health Board therefore keeps rota arrangements under regular review to ensure services remain accessible, sustainable and responsive to local population need.

Whilst Community Pharmacy Regulations include provisions to support pharmaceutical service availability where necessary, including directed opening arrangements, the Health Board's preference remains to work collaboratively with contractors and representative bodies to achieve appropriate service coverage through locally agreed solutions.

4.4 Pharmaceutical Needs Assessment

The Pharmaceutical Needs Assessment (PNA) is a statutory document that the Health Board must publish every five years.

It provides an assessment of whether existing pharmaceutical services are sufficient to meet the current and future needs of the population and forms the evidence base for decisions relating to applications to join the pharmaceutical list, pharmacy relocations, dispensing provision and changes to core opening hours.

The PNA plays a key role in ensuring that pharmaceutical services remain aligned to local population need and changing patterns of healthcare demand. The Health Board's first PNA was published in October 2021 and has continued to inform regulatory decision making throughout the period.

During 2025/26, significant work was undertaken to develop the revised PNA due for publication in October 2026.

This included the establishment of a multi-disciplinary steering group, detailed analysis of population health needs, pharmaceutical service provision, opening hours, housing growth, wider NHS services and future population trends.

Engagement programmes were undertaken with the public, patients, contractors and other stakeholders to inform the assessment and ensure that the revised PNA will reflect both current service provision and the future needs of our communities.

The revised PNA will provide the Health Board with an updated assessment of pharmaceutical need across Gwent and continue to support strategic planning, regulatory decision making and the ongoing development of pharmaceutical services throughout the Health Board area.

4.5 Contract Monitoring

The PCCT maintains a structured programme of contract monitoring to provide assurance that community pharmacy contractors continue to deliver NHS pharmaceutical services in accordance with their contractual and regulatory obligations.

Monitoring visits are undertaken by the team, and each pharmacy is reviewed, as a minimum, once within a three-year cycle.

2025/26 marked the commencement of a new three-year monitoring cycle, providing an opportunity to refresh the Health Board's assurance framework and assess compliance against the evolving contractual and clinical requirements placed upon community pharmacy contractors. Through this programme, the Health Board reviews governance arrangements, service delivery, patient experience, premises standards, information governance, workforce requirements and compliance with the NHS Terms of Service.

A total of 37 community pharmacies received a contract monitoring visit and of these, 31 achieved a satisfactory outcome by 31 March 2026. The remaining six pharmacies had outstanding actions extending beyond the year-end and remained open at this reporting date. These cases continue to be managed through the Health Board's performance-related sanctions framework to ensure that all required actions are completed and compliance is achieved.

Table 35 Contract Monitoring Activity 2025/26

Indicator	Number
Community Pharmacies	125
Monitoring Visits Undertaken	37
Satisfactory Outcomes Achieved by 31 March 2026	31
Monitoring Visits with Outstanding Actions at Year End	6
Governance Toolkit Compliance	121
Contractors Managed Through Compliance Process for Non-Submission	4

The majority of issues identified through the monitoring programme related to governance and administrative requirements, including standard operating procedures, pharmacy leaflets, information governance arrangements, management of NHS Wales alerts, staff training records and health and safety documentation.

In the majority of cases these matters were resolved through constructive engagement with contractors and agreed improvement actions.

The Health Board's preferred approach is to secure compliance through local resolution wherever possible, working collaboratively with contractors to agree corrective actions and implementation timescales.

Where concerns cannot be resolved informally, or where a breach presents a risk to patient safety, service continuity or public funds, the Health Board is able to escalate matters through a regulatory performance-related sanctions framework. This includes the issuing of remedial notices, breach notices and, where appropriate, the withholding of NHS remuneration. The ultimate sanction in this process is the removal of the pharmacy's NHS contract. All formal actions are considered through the Health Board's Contractual Breach Review Group to ensure they are applied consistently, proportionately and in accordance with the relevant regulations.

In 2025/26, the Community Pharmacy Terms of Service Breach Policy was revised and implemented, strengthening the governance arrangements that support contract monitoring and the management of contractual non-compliance.

4.6 Clinical Governance and Information Governance Assurance

In addition to on-site contract monitoring, community pharmacies are required to complete annual Clinical Governance and Information Governance toolkits. These self-assessment tools, developed nationally for use across Wales, provide assurance that contractors have appropriate arrangements in place for patient safety, clinical governance, information governance, workforce training, standard operating procedures and regulatory compliance.

The PCCT reviews toolkit submissions as part of its wider assurance framework, using the information provided to identify trends, target support and inform the prioritisation of future monitoring visits. Where potential deficiencies are identified through the self-assessment process, contractors are contacted to clarify responses and agree any necessary corrective actions.

During the 2024/25 toolkit submission window (submissions are managed retrospectively), 121 community pharmacies completed and submitted the required governance toolkits. Four contractors failed to complete the process within the required timescales and were managed in accordance with the Health Board's contractual compliance arrangements.

Consistent with the Health Board's wider approach to contract management, concerns identified through toolkit submissions are initially managed through local resolution and engagement with contractors. Where issues remain unresolved, or where contractors fail to demonstrate compliance within an agreed timeframe, the Health Board has the ability to escalate matters through the performance-related sanctions process.

4.7 Temporary Suspensions of Pharmaceutical Services

Whenever pharmaceutical services are temporarily suspended, community pharmacy contractors are obligated to inform the Health Board using a nationally agreed and developed reporting process.

During 2025/26, the Health Board received over 300 notifications relating to temporary suspensions of pharmaceutical services. These notifications arose from a variety of circumstances, including pharmacist sickness, difficulties securing locum cover, severe weather, flooding, premises issues, power failures, road traffic incidents and other unforeseen operational challenges. The duration of the suspension ranged from a few minutes to full days.

Each notification was reviewed through the Health Board's established governance arrangements to determine whether there was good cause for the suspension and whether any further action was required.

In the majority of cases, contractors were able to demonstrate that reasonable steps had been taken to maintain services and that the suspension resulted from circumstances beyond their control. As a result, most notifications required no further action beyond review and monitoring.

The high number of notifications received during the year reflects both the operational pressures facing community pharmacy contractors and the Health Board's strengthened arrangements for monitoring service continuity. The temporary suspensions process provides important assurance that potential risks to patient access are identified promptly and managed consistently across the community pharmacy network.

4.8 Performance related sanctions

Our approach to managing contractual non-compliance is set out within the Community Pharmacy Services Terms of Service Breach Policy, which establishes a clear framework for the management of contractual breaches in accordance with the pharmaceutical services regulatory framework.

The policy supports a graduated approach, from local resolution and contractor engagement, through to formal sanctions where required; ensuring that patient safety, continuity of service and the effective use of NHS resources remain central to decision making.

Consistent with this approach, the vast majority of contractual issues identified during 2025/26 were resolved through local engagement, requests for further information and agreed corrective actions. Formal enforcement action was required only in a small number of cases where the Health Board was unable to establish good cause for a contractual breach or where concerns could not be satisfactorily resolved through local resolution processes.

The most significant contractual compliance issue during the year related to two pharmacy premises operated by Jhoots Pharmacy in Caerphilly and

Risca. Throughout 2025/26, both premises experienced repeated and prolonged failures to provide pharmaceutical services and maintain agreed opening hours. These failures resulted in disruption for patients, neighbouring pharmacies and local GP practices and required a substantial programme of intervention by the Health Board.

Over a period of several months, the contracting team undertook extensive engagement with the contractor, including local resolution activity, formal meetings, remedial notices, breach notices and ongoing review through the Contractual Breach Review Group.

Significant officer time was required to investigate closures, gather evidence, communicate with stakeholders, assess compliance and manage the associated governance and legal processes.

Despite these interventions, compliance was not restored and both premises remained unable to provide consistent pharmaceutical services. Following formal consideration under the statutory process, and having exhausted all reasonable alternatives, the Health Board determined that removal of both premises from the pharmaceutical list was necessary and proportionate to protect patient safety and maintain continuity of pharmaceutical services.

The contractor subsequently exercised its right of appeal to Welsh Ministers. At the time of writing, the appeal process remains ongoing and final determinations have not yet been issued. The proposed removals therefore remain subject to the outcome of those appeals.

In terms of access to services, subsequent to the appeal conclusion, each premises underwent a change of ownership and the legal entity to which the appeals relate no longer exists. Both premises are now functioning as community pharmacies and are compliant with the contractual framework.

4.9 Core Pharmaceutical Service Activity

Whilst community pharmacies now deliver an increasingly diverse range of clinical and public health services, dispensing of medicines remains the foundation of community pharmacy services.

The statutory arrangements governing pharmaceutical services in Wales, require community pharmacy contractors to provide a range of Essential Services designed to ensure patients have safe and consistent access to pharmaceutical care.

These Essential Services include the dispensing of NHS prescriptions and repeat dispensing services, the promotion of healthy lifestyles and self-care, support for patients wishing to dispose of unwanted medicines, signposting to other health and care services, and the provision of advice to support the safe and effective use of medicines.

Contractors are also required to maintain appropriate clinical governance arrangements, including systems for patient safety, risk management, staff

training, complaints handling, information governance, safeguarding and continuous quality improvement.

Community pharmacies contribute significantly to both the delivery of medicines and the wider healthcare system. In addition to supplying medicines, pharmacy teams routinely provide advice on medicines optimisation, treatment adherence, side effects, minor illness management and healthy lifestyle choices, helping patients to achieve the best possible outcomes from their treatment.

As described in previous sections, the Health Board receives assurance that these Essential Services are being delivered through a combination of contract monitoring visits, toolkit submissions, temporary suspension reporting and routine engagement with contractors. Together, these arrangements provide assurance that community pharmacies continue to deliver safe, effective and patient-centred pharmaceutical services across the Health Board area.

Dispensing and medicines supply remain the most frequently accessed NHS pharmaceutical services. During 2025/26, community pharmacies in the Health Board area dispensed 16.26 million NHS prescription items. Equivalent to more than 312,000 prescription items each week.

Although dispensing volume reduced marginally compared with the previous year, the network continued to provide a consistently high volume of pharmaceutical care, demonstrating the ongoing importance of community pharmacy in supporting patients with both acute and long-term health conditions.

Table 36 - Dispensing Activity

Measure	2024/25	2025/26
NHS Prescription Items Dispensed	16,470,704	16,256,986
Average Items per Pharmacy	131,766*	130,056*
Average Items per Week	316,744	312,634
Community Pharmacies	125	125
*. A range of factors affect community pharmacy activity and whilst an average value is described above, it doesn't convey a true picture of activity. Overall, during 2025/26 dispensing activity across the 125 pharmacies in ABUHB ranged from 42,500 prescriptions in the least busy, to 325,448 in the busiest.		

Despite workforce pressures and evolving models of service delivery, community pharmacies have continued to provide safe and reliable access to medicines for the population of Gwent. Whilst dispensing and medicines supply remain the foundation of pharmaceutical services, contractors are increasingly delivering a broader range of commissioned clinical services that support prevention, urgent care, medicines optimisation and the delivery of care closer to home.

This evolution continues to be supported by the development of prescribing and dispensing pathways and the increasing use of digital solutions, which

are helping to improve efficiency, enhance patient access and strengthen integration across primary care services.

4.10 Electronic Prescription Service

The EPS is supporting the digital transformation of prescribing and dispensing across primary care by enabling prescriptions to be sent electronically from GP practices to a patient's nominated community pharmacy. The service improves patient experience, reduces reliance on paper prescriptions and supports more integrated prescribing and dispensing pathways.

During 2025/26, the PCCT continued to support the rollout of EPS across ABUHB, working with GMS providers and community pharmacy contractors to support implementation, adoption and local engagement. EPS forms an important part of the Health Board's wider digital transformation programme and supports greater integration between primary care services.

As at 31 March 2026, 29 GP practices within ABUHB were live with EPS, 112 community pharmacies were enabled to receive electronic prescriptions and approximately 2.3 million prescription items had been issued through the system.

Table 37 – Electronic Prescription Service

Measure	Position
GP Practices live with EPS	29
Community Pharmacies enabled to receive EPS prescriptions	112
EPS prescription items issued	2.3 million

The Health Board will continue to support the rollout and adoption of EPS, recognising its role in improving patient experience, supporting safer medicines management and enabling wider digital integration across primary care services.

4.11 Additional Clinical Services Commissioning

Community pharmacy contractors provide NHS pharmaceutical services under a nationally agreed contractual framework established through the NHS (Wales) Act 2006 and the NHS Wales Pharmaceutical Services Directions. These arrangements define the services that Health Boards may commission from community pharmacies and provide the framework through which pharmaceutical services are planned, commissioned and governed.

The PCCT is responsible for commissioning NHS pharmaceutical services on behalf of the Health Board and ensuring that commissioned services remain accessible, sustainable and aligned with local needs.

During 2025/26, the PCCT managed in excess of 700 individual service level agreements, service specifications and contractual arrangements with community pharmacy contractors across Gwent. These arrangements support the delivery of both nationally directed and locally commissioned services and represent a significant element of the Health Board's primary care commissioning responsibilities.

Community pharmacy commissioning has continued to evolve in response to the expanding clinical role of pharmacy within primary care. Whilst all pharmacies must provide Essential Services and are commissioned to provide the Clinical Community Pharmacy Service, a range of additional services are commissioned to improve access to urgent care, medicines optimisation, public health interventions and specialist pharmaceutical support.

The Health Board utilises a combination of universal and targeted commissioning arrangements. Some services are commissioned from all pharmacies to maximise local access and ensure patients can obtain care close to home. Other services are commissioned strategically from selected providers based on population need, workforce capability, service demand and geographical coverage. This approach enables specialist services, including Urgent Medicines Supply, Needle Exchange and Palliative Care services, to be delivered efficiently whilst maintaining equitable access across the Health Board area.

Table 38 - Clinical Service Commissioning

Service	Pharmacies Commissioned
Clinical Community Pharmacy Service (CCPS)	125
Waste Reduction Service	107
Smoking Cessation Level 2	123
Smoking Cessation Level 3	96
Medication Administration Chart Service	86
Supervised Administration Service	115
Seasonal Influenza	121
Independent Prescriber Service	68
Needle Exchange Service	26
Urgent Medicines Supply Service	25
Out of Hours Rota Service	81
Palliative Care Out of Hours Service	9
Blood Born Virus Screening Service	11
Care Home Service	6
Lateral Flow Test	91
Tuberculosis Compliance Support Service	2
Inhaler Review Service	44

Prison Delivery Service1	1
Commissioning levels reflect service availability during the contractual period and may vary where services were commissioned, suspended or recommissioned during the year.	

The commissioning model also continued to support development of the wider pharmacy workforce. During 2025/26, pharmacy technicians increasingly contributed to the delivery of commissioned services following legislative changes enabling appropriately trained pharmacy technicians to supply and administer medicines under Patient Group Directions. This has improved service capacity, strengthened resilience and supported more effective utilisation of skills across the pharmacy team.

4.12 Clinical Service Activity

The commissioning arrangements described in the previous section enable community pharmacies to deliver a wide range of clinical services that support urgent care, medicines optimisation, public health and prevention.

These services provide patients with convenient access to NHS care without the need for an appointment and support the wider ambition of delivering more care closer to home. During 2025/26, community pharmacies across the Health Board delivered more than 180,000 patient-facing clinical consultations and interventions, demonstrating the increasingly important role of community pharmacy within primary care.

The Clinical Community Pharmacy Service (CCPS) continues to be the principal route through which patients access NHS clinical care from their local pharmacy.

The service incorporates the Common Ailments Service, Emergency Medicines Supply Service and Contraception Service, providing access to assessment, advice and treatment for a range of conditions without the need to attend a GP practice. During 2025/26, community pharmacies delivered 91,240 Common Ailments consultations, an increase of 29.2% compared with 2024/25, reflecting increasing utilisation of community pharmacy as a first point of contact for healthcare advice and treatment.

The Emergency Medicines Supply Service continued to play an important role in maintaining continuity of treatment. During the year, pharmacists undertook 30,414 emergency medicines supply consultations, resulting in the supply of 53,268 medicines. This represents an increase of more than 30% compared with the previous year and demonstrates the value of the service in preventing interruptions to essential treatment whilst reducing avoidable demand on other NHS services.

Community pharmacies also delivered 4,624 contraception consultations during 2025/26, continuing to improve access to reproductive health services within local communities. The accessibility of community pharmacies enables patients to obtain timely advice and treatment in a convenient setting whilst supporting wider public health objectives.

One of the most significant developments within community pharmacy continues to be the expansion of independent prescribing. By the end of 2025/26, 68 community pharmacies were commissioned to provide Independent Prescriber services and collectively delivered 37,789 independent prescribing consultations, an increase of 47% compared with 2024/25. This substantial growth demonstrates both increasing public utilisation of prescribing services and the expanding role of community pharmacists as autonomous clinicians capable of assessing, diagnosing and treating patients within primary care settings.

The year also saw continued growth in condition-specific clinical pathways. Community pharmacies delivered 5,715 Urinary Tract Infection (UTI) consultations and 9,702 Sore Throat consultations, providing timely access to assessment and treatment whilst supporting antimicrobial stewardship through structured clinical assessment and, where appropriate, the use of point-of-care testing. Activity increased significantly compared with 2024/25, reflecting both growing public awareness of these services and increasing availability across the community pharmacy network.

The incorporation of UTI and Sore Throat Test and Treat (STTT) pathways within the CCPS represents a further step in the development of community pharmacy as an accessible NHS clinical setting, supporting earlier intervention, improved patient access and more consistent service provision across Wales.

Medicines optimisation remains a key component of pharmaceutical care. During 2025/26, community pharmacies completed 2,663 Discharge Medicines Reviews, supporting patients following discharge from hospital and helping to reduce the risk of medicines-related harm. Activity increased by 6.7% compared with the previous year, further demonstrating the contribution of pharmacy teams to safer transitions of care.

Table 39 - Community Pharmacy Clinical Activity

Service	2024/25	2025/26	Change
Common Ailments Consultations	70,641	91,240	+29%
Emergency Medicines Supply Consultations	23,256	30,414	+31%
Medicines Supplied via Emergency Medicines Supply	40,459	53,268	+32%
Contraception Consultations	4,602	4,624	
Independent Prescriber Consultations	25,732	37,789	+47%
Urinary Tract Infection Consultations	1,849	5,715	+209%
Sore Throat Test and Treat Consultations	6,123	9,702	+59%
Discharge Medicines Reviews	2,495	2,663	+7%

The growth observed across many commissioned services during 2025/26 demonstrates the continuing evolution of community pharmacy as an accessible NHS clinical setting. Whilst dispensing and medicines supply remain the foundation of pharmaceutical services, community pharmacies

are increasingly providing clinical assessment, treatment, prescribing and medicines optimisation services that improve access to care and support the delivery of healthcare within local communities.

The continued growth of the CCPS further reinforces the role of community pharmacy as a first point of contact for many patients and supports delivery of the Primary Care Model for Wales by ensuring that individuals can access care from the right practitioner, in the right place, at the right time. This improves both patient experience and the effective use of NHS resources, whilst supporting timely access to NHS services across the wider health and care system.

The expansion of independent prescribing, the introduction of pharmacy technician participation under Patient Group Directions, and the continued growth of clinical pathways collectively demonstrate the increasing contribution of the whole pharmacy team to the delivery of NHS care and the ongoing shift towards a more clinically focused community pharmacy model.

4.13 Engagement

The Health Board continues to engage regularly with community pharmacy contractors through the Community Pharmacy Liaison Group (CPLG). The CPLG provides an established forum for discussion between the Health Board and Community Pharmacy Wales, the recognised representative body for community pharmacy contractors in Wales. Through these meetings, stakeholders discuss contractual developments, service delivery, workforce challenges, service redesign and emerging priorities for community pharmacy. This collaborative approach supports co-production, ensures that contractor perspectives inform local decision-making and service development, and enables the Health Board to identify and respond to operational issues affecting the delivery of NHS pharmaceutical services across Gwent.

Supporting the ongoing engagement of the community pharmacy workforce remains a key element of improving access to clinical services delivered closer to home.

During 2025/26, the PCCT delivered dedicated training and engagement events for community pharmacy technicians and pharmacist independent prescribers to support the expansion of contraception services through community pharmacies. Twelve pharmacy technicians and thirteen pharmacist independent prescribers attended these events, which focused on emergency contraception, safeguarding, clinical assessment, prescribing practice and the application of national clinical guidance. Evaluation feedback demonstrated increased confidence and knowledge amongst participants, supporting the continued development of community pharmacy as an accessible provider of reproductive healthcare.

Early service data indicates that this investment is translating into increased service capacity, with emergency contraception consultations delivered by pharmacy technicians increasing from 18 consultations undertaken by six regular providers between April and June 2025 to 42 consultations undertaken by ten regular providers during the same period in 2026.

This work supports the Health Board's wider Women's Health ambition to improve timely access to contraception services, reduce barriers to care and strengthen the role of community pharmacy in delivering preventative and reproductive health services.

4.14 Neighbourhood Care Network Development

The CPCF provides funding to support collaborative working between community pharmacies and wider primary care partners within NCNs.

Historically, a number of NCNs within ABUHB experienced difficulties recruiting Community Pharmacy Collaborative Leads, resulting in vacancies across several NCNs. As a result of targeted engagement and support, all outstanding Collaborative Lead vacancies were successfully recruited by the end of the year. Although the successful candidates did not formally take up their positions until the start of 2026/27, this provides a stronger foundation for future collaborative working and service development.

Community pharmacy engagement with NCN activity remained strong throughout 2025/26. A total of 104 community pharmacies participated in NCN activity during the year, with 195 attendances recorded at Community Pharmacy Collaborative meetings. In addition, 185 meetings were attended with wider health and care professionals across local NCN, supporting integrated working and strengthening relationships between community pharmacy and other primary care providers.

Table 40 – Community Pharmacy NCN Participation 2025/26

Activity	Number
Community pharmacies engaged in NCN activity	104
Attendances at Community Pharmacy Collaborative meetings	195
Meetings attended with wider healthcare providers within NCNs	185

The CPCF also provides funding for individual pharmacies to participate in collaborative meetings each year. These meetings support pathway development, service improvement initiatives and the integration of community pharmacy within wider primary care planning arrangements.

Financial governance arrangements for collaborative working continue to be managed through NHS Wales Shared Services Partnership in accordance with the requirements of the Welsh Drug Tariff, whilst local oversight is provided through established Health Board governance structures.

4.15 Governance of Clinical Pharmaceutical Services

Governance of commissioned pharmaceutical services is supported through a combination of contract monitoring, annual governance declarations, service assurance processes and contractual compliance arrangements. Information obtained through contract monitoring visits, Clinical Governance and Information Governance toolkit submissions, service activity monitoring and routine contractor engagement is used to provide assurance that services are being delivered safely, effectively and in accordance with relevant service specifications.

The PCCT also undertakes targeted review of commissioned clinical services. This includes monitoring service activity, reviewing prescribing trends and identifying variation from expected clinical practice or service requirements. Particular attention is given to services involving IP and those delivered under Patient Group Directions, where service specifications and clinical governance requirements are subject to additional scrutiny.

Where potential concerns are identified, the Health Board's preferred approach is to work collaboratively with contractors to secure local resolution through discussion, support and ongoing monitoring. Where necessary, issues may be escalated through the contractual compliance arrangements described earlier within this report.

Claims for service activity are routinely reconciled against commissioning records and payment schedules administered through NWSSP, providing an additional source of assurance regarding service delivery and contractor compliance.

4.16 Information Governance

The increasing use of digital systems within community pharmacy requires robust information governance arrangements to ensure patient information is accessed appropriately and securely. Community pharmacists and pharmacy technicians utilise national digital platforms, including Choose Pharmacy, to support the delivery of clinical services and patient care.

The PCCT operates a formal monitoring process using the National Intelligent Integrated Audit Solution (NIIAS) to review system access and identify potential instances of inappropriate record access. Where concerns are identified, reports are issued to superintendent pharmacists for investigation and local action. This approach enables potential issues to be managed quickly and proportionately whilst maintaining appropriate oversight of patient information access.

Consistent with the Health Board's wider governance arrangements, local resolution and learning remain the preferred approach. However, where concerns cannot be satisfactorily addressed, system access may be

restricted or removed in accordance with national information governance requirements.

During 2025/26, six potential information governance concerns were identified and referred to contractor organisations for investigation and appropriate action.

4.17 Patient Safety Incident Reporting

Community pharmacy contractors are required to report patient safety incidents through the Once for Wales DATIX Cymru reporting system. Responsibility for investigating and responding to incidents remains with the contractor. However, the Health Board provides oversight through review, receipting and closure of submitted reports.

Patient safety reporting forms an important component of the wider clinical governance framework and supports both local learning and service improvement. Awareness of reporting requirements continues to be reinforced through contract monitoring activity, contractor engagement and governance processes.

487 patient safety incidents were received and reviewed by the Health Board in 2025/26. Whilst incident reports represent a very small proportion of the overall volume of dispensing and clinical activity delivered by community pharmacies, they provide valuable assurance regarding patient safety culture and the effectiveness of local governance arrangements.

4.18 Concerns, Enquiries and Information Requests

During 2025/26, the PCCT received 29 concerns relating to community pharmacy services. The majority of concerns were resolved through existing local processes and did not identify any significant contractual or patient safety issues.

Four concerns related to medicines switching and were referred to the Medicines Management Team for review and consideration. Three concerns related directly to NHS pharmaceutical services and were resolved promptly through local resolution. Of these, two concerns related to national medicines shortages, an issue affecting pharmacy services across Wales and the wider UK.

The remaining 22 concerns related to non-NHS elements of community pharmacy service provision, including delivery services and compliance aids. As these matters fell outside the commissioned NHS contractual framework, the concerns were directed to the relevant pharmacy contractor for local management and resolution.

Through the investigation and management of concerns, the Health Board continues to identify learning opportunities, support quality improvement and ensure that patients receive an appropriate and timely response.

No FOI requests relating specifically to community pharmacy services were received during 2025/26.

4.19 National Collaboration and Consistency of Approach

Community pharmacy services operate within a national contractual and regulatory framework. To support consistency in service development, governance arrangements and contractor oversight, members of the PCCT actively participate in a range of national forums, advisory groups and professional networks relating to community pharmacy.

During 2025/26, the team contributed to the development and implementation of national pharmaceutical services through participation in a number of NHS Wales and Welsh Government groups. These included the Community Pharmacy Digital Applications Board, Choose Pharmacy Service Management Board, National Community Pharmacy Services Management Board, National Community Pharmacy Clinical Advisory Group, Community Pharmacy Services Operational Group, Electronic Prescription Service Advisory Group and a range of national tripartite negotiation short-life working groups supporting the ongoing development of the CPCF.

The PCCT also worked closely with regional partners through groups including the Gwent Harm Reduction Group and the local Community Pharmacy Liaison Group, ensuring that local experience and operational learning informed regional and national policy development. This involvement enables the Health Board to contribute directly to the design and implementation of community pharmacy services whilst ensuring that national developments are informed by practical experience from service delivery across Gwent.

The team continues to work collaboratively with other Health Boards, Welsh Government, Community Pharmacy Wales, NWSSP, Digital Health and Care Wales (DHCW) and Llais to promote consistency, share learning and support equitable access to pharmaceutical services across Wales. These arrangements help ensure that commissioning, monitoring and service development activities remain aligned with national expectations whilst remaining responsive to local population needs.

This collaborative approach supports the consistent application of policy across Wales and helps ensure that community pharmacy remains at the forefront of primary care transformation, digital innovation and service development.

4.20 Looking Ahead

The Health Board remains committed to supporting the continued development of community pharmacy as an accessible, sustainable and increasingly clinical NHS service. Community pharmacy plays a critical role in the delivery of the Primary Care Model for Wales, ensuring patients can access care from the right practitioner, in the right place, at the right time,

whilst supporting the delivery of care closer to home and improving access to NHS services within local communities.

Key priorities for 2026/27 include:

- Further expansion of Pharmacist Independent Prescribing services across community pharmacy settings.
- Continued development and utilisation of the CCPS, supporting timely access to NHS care and ensuring patients receive care from the most appropriate healthcare professional based on their clinical need.
- Anticipated availability of a revised national smoking cessation service to include a wider selection of pharmacotherapy.
- Anticipated availability of a revised national substance misuse service to reduce the administrative burden on pharmacy teams.
- Greater utilisation of pharmacy technicians within commissioned services and clinical pathways, including the continued development of services delivered under Patient Group Directions.
- Reviewing pharmaceutical access arrangements and maintaining appropriate rota provision to support access during evenings, Sundays and Bank Holidays, particularly in areas affected by changes to opening hours or service provision.
- Further strengthening of digital integration, service intelligence and data-driven quality assurance arrangements.
- Ongoing support for Community Pharmacy Collaborative Leads and NCN Development initiatives across Neighbourhood Care Networks.
- Maintaining robust governance, patient safety and information governance arrangements.
- Supporting the resilience and sustainability of the community pharmacy network amidst ongoing workforce, operational and financial pressures.
- Working proactively with contractors and national stakeholders to manage any future changes in service provision and minimise the impact on patient access to NHS pharmaceutical services.

The continued growth of independent prescribing, urgent care pathways, medicines optimisation services and multidisciplinary working demonstrate the increasingly important contribution of the whole pharmacy team to the delivery of NHS care. Community pharmacy will therefore remain central to improving access, supporting prevention, medicines optimisation and the delivery of high-quality healthcare within local communities across ABUHB.

Whilst opportunities for service development remain significant, community pharmacy continues to operate within a challenging environment. National medicines supply issues, increasing drug acquisition costs, concessionary pricing arrangements, workforce shortages and wider inflationary pressures continue to impact contractors' ability to deliver services sustainably.

In addition, rising employment costs, including increases in the National Living Wage, National Insurance contributions and wider business overheads, continue to place significant pressure on community pharmacy contractors.

These challenges are compounded by the fact that community pharmacies largely operate within a fixed NHS contractual funding framework, with limited flexibility to offset increasing costs. Whilst some community pharmacies have developed private service offerings to supplement NHS funding, those in the most deprived areas of the Health Board are unable to do this and represent the greatest sustainability risk.

These pressures may continue to impact the sustainability of some providers and could result in further requests for changes to opening hours, contractual arrangements or service provision. The PCCT will continue to work closely with contractors, Community Pharmacy Wales, Welsh Government and other NHS Wales partners to understand emerging risks, support service sustainability and mitigate any potential impact on patient access wherever possible.

The contracting team also recognises that continued changes to community pharmacy opening hours, workforce pressures and wider financial challenges may increase reliance on commissioned rota services in some localities.

Maintaining equitable access to NHS pharmaceutical services remains a key priority and rota provision will continue to be reviewed alongside wider service sustainability considerations to ensure patients can access pharmaceutical care when and where it is required.

Despite these challenges, community pharmacy remains one of the most accessible parts of the NHS and is well placed to support future transformation across primary care. The continued growth of clinical services delivered by pharmacists, pharmacy technicians and wider pharmacy teams demonstrates the sector's increasing contribution to population health, prevention, medicines optimisation and the wider delivery of NHS care across Gwent.

5. Primary and Community Care Academy

The Primary and Community Care Academy (PCCA) has continued to deliver multi-professional education and training in line with the Divisional and Health Education and Improvement Wales (HEIW) strategic objectives. PCCA activity, focuses on six key areas to deliver quality education and training to Primary and Community Staff:

1) Developing the Primary and Community Care Academy;
2) New to Primary and Community Care;
3) New Roles;
4) Professional Development;
5) Multi-Professional Learning; and
6) Future Workforce.

The PCCA aims to provide positive educational experiences for staff, to allow them to develop skills and confidence, to work at the top of their licence and provide excellent healthcare.

5.1 Developing the Primary and Community Care Academy

Advertising, promoting and organising training and education events requires a significant amount of administrative time. To streamline administrative processes and provide an accessible advertising platform for education and training events, the PCCA has developed a Padlet Course Brochure. The Padlet has been made available across primary and community care settings and also to all Care Homes in the ABUHB area. The PCCA Padlet also allows users to access other educational resources, including links to courses and resources provided by other ABUHB departments. Please see the link for further details: https://padlet.com/abbpccacademy/primary-community-care-academy-7lhaod8k5d5kbr71

Further to the development of the Padlet Course Brochure, the PCCA has redeveloped its Pulse site to promote education and training events and provide links to other resources. Please see the PCCA Pulse page:https://nhswales365.sharepoint.com/sites/ABB_Pulse_Primary_Care/SitePages/Primary-Care-Academy.aspx

Bookings for all PCCA courses and events are now entirely managed through the Medtribe booking system. Each learner has an individual account which allows event booking, notifications, access to course resources, training certificates and an individual learning record. The PCCA currently has over 900 active users on Medtribe. With an expanding portfolio of PCCA education and training, Medtribe offers an effective

platform to organise, manage and report on all PCCA education and training activity. A Medtribe guide is available on the PCCA Padlet Course Brochure.

The PCCA has also developed new administrative systems to improve efficiency and effectiveness. This includes:

- Development of a course planning and recording spreadsheet for accurate record keeping and improved reporting;
- Introduction of rolling education programmes with structured planning and review cycles to improve efficiency;
- Development of Standard Operating Procedures for course advertising and booking through Padlet and Medtribe; and
- Introduction of standard course templates, booking and evaluation forms for Medtribe, to reduce the administrative burden and provide consistency and quality.

A Quality Assurance (QA) process for delivering education and training events has been developed by the PCCA. The QA process provides assurance that the content of any new course being developed by the PCCA reflects current clinical guidance and the latest clinical knowledge. To aid this process, clinical reference groups are being established to provide a robust approval process for new courses. The PCCA QA process also includes a review process for all existing courses to ensure that they remain up to date and clinically safe.

A range of courses and events have been offered to meet the needs of a range of professionals working in primary and community care.

5.2 New to Primary and Community Care

The PCCA continues to provide education and training to support primary and community care staff via several key programmes.

5.2.1 Healthcare Support Worker Programme

Healthcare Support Worker (HCSW) Programme to support primary and community care HCSWs through effective induction and training to allow them to deliver safe, effective healthcare. In 2025/26, six HCSWs enrolled on a HCSW induction and training programme to provide training for HCSWs from primary and community care settings including; healthcare, communication skills, the importance of confidentiality and professionalism in healthcare and clinical skills. The course was delivered in a classroom setting over a 5-day period. Upon completion, the HCSW's are equipped in providing essential care and support to their patients. The PCCA is linking in with corporate nursing and is also involved in a national HEIW working group to further develop HCSW education and training.

5.2.2 General Practice Nursing Foundation Programme

The General Practice Nurse (GPN) programme supports qualified nurses who are new to primary care. This comprehensive programme of training is delivered in collaboration with Swansea University over nine months. Learners receive a Post Graduate Certificate in Primary Care Practice at the end of the programme. The GPN programme provides an effective pathway to support the GPN in the transition to primary care. The availability of the programme allows practices to make the decision to recruit, knowing that support and training is available for the new GPN.

Over the past three years, four cohorts of GPNs have completed the programme; a total of 32 GPNs trained, of which, 28 remain within general practice in the ABUHB area. Retention of trained staff in ABUHB primary care practices, contributes to the continued delivery of patient services as well as the stabilisation and sustainability of practices. In 2025/26, 9 GPNs on cohort three completed the programme in June 2025, with a further 10 starting cohort four in September 2025. GPNs in cohort five will commence the programme in September 2026.

A course brochure for the PCCA GPN programme has been developed to promote the programme.

5.2.3 Journey of Excellence © Programme

The Journey of Excellence (JOE) is a preceptorship programme to support newly qualified nurses in the community, to enable a smooth transition from a newly registered nurse into a confident practitioner. The JOE programme remains the flagship recruitment programme for community care settings within ABUHB. The JOE provides a structured programme designed within ABUHB, aiming to achieve and sustain high levels of performance, quality and innovation within community care. The programme sets clear goals for implementing best practice for newly qualified nurses in community settings.

In 2025/26, cohort six completed their induction week in September 2025 with 23 learners. Confidence rates of learners improved during the programme with 6% of learners being "very confident" at the beginning of the course, improving to 54% at the end of the programme.

The PCCA has been working with the ABUHB Corporate Team to align the PCCA and ABUHB programmes. This will streamline the training offer and reduce unnecessary duplication.

5.2.4 Pharmacists

The Academy Post Registration Foundation Pharmacist programme has been remodelled to address sustainability needs across community pharmacy and general practice. An education and training programme has been developed to support newly qualified pharmacists to increase confidence and competence within primary and community care.

The Academy has recruited three pharmacists to the training programme on 2-year fixed term contracts. The programme includes rotations between general practice and community pharmacy. A Memorandum of Understanding and Service Level Agreement are in place to provide an agreement framework between the three parties. Learner support is provided by a mentor and a competency handbook.

At the end of the programme the pharmacist will achieve 80 level 7 credits, the independent prescribing qualification and the RPS post-registration foundation credential award, providing assurance that they are working at the required level and enabling progression into advanced practice. HEIW Funding and model of support is changing from September 2026, as a result, the Health Board is currently reviewing the ongoing programme.

5.2.5 Internationally Educated Nurse Programme

The Internationally Educated Nurse (IEN) programme is designed to support internationally educated nurses in developing the knowledge, skills, and confidence to work effectively within UK primary and community healthcare settings. 26 Nurses have completed the academy training programme. Feedback from learners was very positive with 100% of learners describing themselves as confident, or very confident, at the end of the programme and 89% of learners would be likely, or very likely, to recommend this training to others.

5.3 New Roles - Pharmacy Technician Programme (Post-Registration)

The aim of the Pharmacy Technician programme delivered through the academy is to showcase the work that pharmacy technicians can undertake within primary care and consequently evidence the more effective use of pharmacist time on more complex clinical tasks. The programme is a revolutionary new transition pathway for pharmacy technicians new to primary care. Three Post Registration Pharmacy Technicians have been recruited to the 14-month training programme, one of which has completed the programme and secured a role in primary care. Evaluation data shows improvement of patient safety and time freed for pharmacist to complete other tasks.

5.4 Professional Development and Clinical Skills Programme

The Clinical Skills Programme offers a range of courses to Healthcare Professionals (HCPs) across primary, community and care home settings to allow them to develop or refresh their clinical skills.

A rolling programme of Clinical Skills training is now in place. A total of 259 have attended clinical skills training in 2025/26. The programme of essential clinical skills delivered to primary and community care Nurses allows the provision of high-quality patient care to be delivered.

5.5 Continuing Professional Development Sessions

A range of CPD sessions, including lunchtime learning events, covering a range of subjects for HCPs have been delivered again in 2025, with the 2026 programme currently being developed. These are either pre-planned or in response to requests to address specific training needs. The PCCA has also delivered Protected Learning Time (PLT) events for GP practices which focussed on Diabetes and Mental Health.

5.6 Advanced Practice Training

Multi professional Advanced Practice Training courses provide the practitioner with opportunity to develop the skills and knowledge to allow them to work at the top of their licence and be effective members of the multidisciplinary workforce. Training for Advanced Clinical Practitioners has included:

Managing Same Day Presentations:

- 8 learners comprised of ANPs and Pharmacists completed the advanced practice module, delivered by Swansea University.
- All respondents reported that the course supported their development in general practice, increased their confidence, improved job satisfaction and that they would recommend the training to other HCPs.

Paediatric Minor Illness:

- Delivered via The Health Academy, through a 3-day online webinar for 10 Learners.
- 80% of respondents were either confident, or very confident, in applying the learning into practice.

Tissue Viability (Masters Module):

- A 12-week course, delivered by Swansea University, for 9 Learners.

Programmes evaluated well and showed a positive impact on clinical practice. Learners felt that improved advanced practice skills will allow them to deal with patients with a range of conditions more effectively.

5.7 Care Homes

There are 100 care homes in ABUHB area. The PCCA continues to work with the Division's Care Home Working Group to provide a coordinated package of training for care homes. The focus area has been Caerphilly, as this was recognised as an area with a higher level of conveyancing, however, training has been made available to all care homes in the ABUHB area. After an initially slow uptake, 81 care home staff attended academy training events. A rolling training programme has been delivered, face to face or via webinar, which includes; Recognising the Deteriorating Resident, Hydration and Nutrition, Skin Integrity and Catheter Care. The education and training programme has allowed access to training for care home staff in key areas, revitalised engagement with care homes, developed working relationships with other stakeholders and contributed to the development of a single point of access for care home training across ABUHB.

5.8 Training for non-clinical staff

A series of training events for non-clinical staff was delivered in early 2026 including:

- Introduction to Practice Management (GMS);
- Practice Management for Partners (GMS);
- Clinical Coding (GMS);
- Summarising Clinical Records (GMS);
- Dealing with Violence and Aggression (all primary care contractors); and
- Excellent Customer Service (all primary care contractors).

Courses were arranged following analysis of Training Needs Analysis data from contractors and aligned to divisional sustainability priorities.

5.9 Women's Health

To support the divisional work around Women's Health, the PCCA organised Ring Pessary training for 35 practice staff across ABUHB, to upskill GPs and practice nurses.

5.10 Psychological Health Practitioners

A Solutions Focused Therapy course for over 30 Psychological Health Practitioners was delivered in February and March 2026 to upskill the PHP workforce and improve patient care.

5.11 Bespoke Community Hospital Training (Winter Ward)

A programme of training and support delivered in early December 2025 for staff in the temporary ward opened to ease winter pressures. Initial training for nurses and 12 HCSWs provided, plus ongoing support during the initial phases of opening.

5.12 Multi-Professional Working

The PCCA aims to promote multi-professional working through delivering courses and programmes which are relevant across different professions. The PCCA is also involved with several national workstreams which aim to promote multi-professional working.

5.12.1 National (HEIW) Workstreams

The PCCA continues to work with HEIW and the Wider Academies Network in Wales to develop national multi-professional training programmes. Programmes have included; Practice Manager Development; Non-Clinical Workforce Development; Advanced Practice Framework Digitisation; Support for Non-Clinical Prescribers; Training Needs Analysis development and Evaluation / Benefits Realisation development. The table below summarises the HEIW workstreams.

Table 41 – HEIW workstreams

Multi-Professional Supervision Guidance	Multi-professional supervision guide produced which is currently out to consultation.
Multi-professional Toolkit Development	Guidance document developed and awaiting HEIW approval. PCCA Clinical Lead has been involved in the development of this. Awaiting discussion on Academy role in promoting this.
Multi-professional Educators Development	Awaiting IG approval on education questionnaire PACC Clinical lead working with T&F group to develop / roll this out
ACP Digitisation Framework	Awaiting guidance on Academy role in the roll out of this from HEIW. Working with the T&F group/digital team to decide how to progress the competency framework
AHP MSK Competency Framework	Working with the T&F group/digital team to decide how to progress the competency framework
Peer Support for Non-Medical Prescribers	On hold at present
Practice Manager Development Programme	The PCCA is involved in the development of the PM competency framework with the national group.

	A Competency Framework has been developed and has been trialled with PMs and Deputy PMs from GMS and GDS
Non-Clinical Staff Development	The PCCA is continuing to work with the T&F group for non-clinical development.
Urgent Care Practitioner Competency Framework	Awaiting further guidance on Academy role in the roll out of this from HEIW. Academies not expected to deliver but to advertise
Training needs analysis development	Working with national group to develop TNA framework. Initially this will be aimed at non-clinical workforce with a view to expanding to other / all professions

5.13 Future Workforce - Schools and Colleges

Engagement with schools and colleges is essential to promote careers in primary and community care to students who are our potential future workforce. The PCCA has attended several engagement events at schools and colleges through the Gwent Schools Programme. These events have been very well received and given PCCA staff an opportunity to explain the range of career opportunities and career pathways in primary and community care.

PCCA staff have attended four streamlining events at Cardiff University and University of South Wales to promote ABUHB community care career opportunities for newly qualified nurses, to final year students. These events are key to the successful recruitment into roles within ABUHB community care and new recruits are supported through the PCCA JOE programme.

6. Primary Care & Community Quality and Patient Safety

6.1 Duty of Candour/Duty of Quality

The Duty of Candour (DoC) requirements in relation to health care providers have been in place since 1 April 2023, with the aim of being open and honest with patients receiving care and treatment.

There is Divisional representation at the national Welsh Risk Pool DoC and learning network, with specific responsibility for promoting and raising awareness for independent contractors, sharing tools, templates, algorithms and direct support when DoC is triggered.

The Primary Care and Community Quality and Patient Safety (QPS) team continue to review all incidents reported by the Division to identify and support with any cases that could potentially trigger the Duty. The team encourage the inclusion of as much information as possible within the initial Datix report and management review sections, to inform identification of whether the duty should be triggered. The number of incidents triggering DoC have remained low, as processes for review and validation have embedded.

For independent contractors, the decision making around DoC sits with the contractor, although the QPS team are available to provide support or guidance. Contractors are responsible for maintaining records in relation to DoC and reporting to the Health Board annually, which can be via Datix or an annual return. Once the duty has been triggered, initial contact (in person notification) is made with the patient/next of kin by the clinically responsible person. This is followed up with a written notification sent to patient or next of kin by day 5.A suggested template has been provided by QPS to ensure all required information to comply with the DoC is captured. The investigation can then commence, and the outcome can be shared with the patient/relative if agreed.

For independent contractors who use Datix for incident reporting, rapid review of incidents by managers is important.

6.2 Monitoring and assurance

Robust mechanisms are in place for the screening of all incidents and concerns and timely escalation within the Division and to the central team where indicated. Daily meetings are in place with all QPS Teams within ABUHB to support the review and escalation of incidents with moderate or above levels of harm. Cross divisional working supports investigation of incidents where multiple services may be involved and the Primary Care & Community QPS Team link with and support independent contractors where multi-divisional incidents are being investigated.

The Health Board is engaging the with national Welsh Risk Pool DoC and learning network to develop a State of the Nation self-assessment to demonstrate to Welsh Government its maturity and progress made for implementation. The Division has contributed case studies to inform the All-Wales DoC casebook to share and promulgate learning identified.

Independent contractors are required to complete an annual submission confirming all incidents which triggered DoC during the year, the Health Board then submits a report to Welsh Government identifying the themes in relation to DoC triggers across primary care.

7. Conclusion

This Primary Care Annual Quality Report for 2025/26 demonstrates the significant breadth of work undertaken across Primary Care Contracting, the Primary and Community Care Academy and Quality and Patient Safety. Through robust commissioning, contract management, quality assurance ad performance monitoring arrangements the Health Board has continued to support the delivery of safe, effective and sustainable primary care services across General Medical Services, General Dental Services, Primary Care Optometry and Community Pharmacy.

Despite ongoing challenges relating to workforce, demand and financial pressures, progress has been made in strengthening governance, supporting service transformation, improving access to care closer to home and investing in workforce development. The Health Board remains committed to working collaboratively with contractors, partners and stakeholders to drive continuous improvement, reduce health inequalities and ensure high-quality, patient centred services for the population of Gwent.

8. Acronyms

Aneurin Bevan University Health Board	ABUHB
Accelerated Cluster Development	ACD
Assessment of Clinical Oral Risk and Needs assessment	ACORN
Annual Contract Value	ACV
Advanced Nurse Practitioners	ANP
Alternative Treatment Service	ATS
B1, 2, 3	Band 1, 2, 3
British Dental Association	BDA
Contract Assurance Framework	CAF
Clinical Community Pharmacy Service	CCPS
Community Dental Service	CDS
Clinical Governance Practice Self-Assessment Toolkit	CGPSAT
Community Pharmacy Contractual Framework	CPCF
Continued Professional Development	CPD
Continuing Professional Development	CPD
Community Pharmacy Liaison Group	CPLG
Contract Reform	CR
Certificate of Visual Impairment Wales	CVIW
Clinical Work Station	CWS
Dental Access Portal	DAP
Doctors and Dentists Review Body	DDRB
Diabetes Eye Screening Wales	DESW
Digital Health and Care Wales	DHCW
Digital Health Care Wales	DHCW
Did Not Attend	DNA
Duty of Candour	DoC
Dental / Divisional Quality and Patient Safety Forum	DQPS
Eye Care Collaborative Board	ECCB
Emergency Dental Service	EDS
Emergency Eye Clinic	EEC
Eye Health Examinations Wales	EHEW
Eye Health Needs Assessment	EHNA
End of Year	EOY
Electronic Patient Record	EPR
Enhanced/Supplementary Services	ESOG
Frequently Asked Questions	FAQ
Freedom of Information	FOI
Fluoride Varnish	FV
General Dental Services	GDS
General Medical Services	GMS
General Optical Council	GOC
General Practitioner	GP
General Practitioner Committee	GPC
General Practice Nurse	GPN
Healthcare Professionals	HCP
Hydroxychloroquine	HCQ
Healthcare Support Worker	HCSW
Health Education Inspectorate Wales	HEIW
Hospital Eye Service	HES
Health Inspectorate Wales	HIW
His Majesty's Prison	HMP
Historic Patients	HP

Internationally Educated Nurse	IEN
Intermediate Medium Term Plan	IMTP
Index of Treatment Need	IOTN
Independent Prescribing Optometric Service	IPOS
Journey of Excellence	JoE
Local Dental Committee	LDC
Local Medical Committee	LMC
Low Vision Services Wales	LVSW
Make Every Contact Count	MECC
Neighbourhood Care Network	NCN
National Health Service	NHS
NHS Business Service Authority	NHS BSA
National Intelligent Integrated Audit Solution	NIIAS
New Patients	NP
New Urgent Patients	NUP
NHS Wales Shared Services Partnership	NWSSP
Oral Health Improvement Practitioner	OHIP
Provider Assurance Dental	PAD
Peer Assessment Review	PAR
Primary and Community Care Academy	PCCA
Primary Care Contracted Services	PCCS
Primary Care Contracting Team	PCCT
Primary Care Information Portal	PCIP
Primary Care Workforce Intelligence System	PCWIS
Personal Dental Services	PDS
Protected Learning Time	PLT
Practice Manager	PM
Pharmaceutical Needs Assessment	PNA
Post Payment Verification	PPV
Provider Selection Regime	PSR
Quality Assurance	QA
Quality Assurance System	QAS
Quality for Optometry	QfO
Referral to Treatment	RTT
Sustainability Assessment Framework	SAF
South Wales Regional Optometric Committee	SEWROC
Statement of Financial Entitlement	SFE
Service Level Agreement	SLA
Standard Operating Procedure	SOP
School Programme Eye Care Service	SPECS
Sore Throat Test and Treat	STTT
Units of Dental Activity	UDA
Urgent Primary Care	UPC
Urinary Tract Infection	UTI
Vacant Practice Policy	VPP
Wales Eye Care Service	WECS
Welsh Government	WG
Wales General Ophthalmic Services	WGOS

Archwilio Cymru
Audit Wales

Are cancer services improving?

Aneurin Bevan University Health Board

August 2026

We have prepared and published this report under section 61(3) (b) of the Public Audit Wales Act 2004.

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Audit snapshot

What we looked at

1 We looked at Aneurin Bevan University Health Board's (the Health Board)'s approach to managing cancer services. This includes how it plans services, prevents cancer, supports early detection, and leads and oversees service performance.

2 We also reviewed trends in cancer service performance. Our 2025 national report on cancer services highlighted data quality concerns and recommended improvements at a national level. We have not reviewed data quality as part of this review.

Why this is important

3 Demand for cancer services is increasing, driven by factors such as:

- an ageing population;
- rising levels of obesity and alcohol use;
- better survival rates, meaning patients need ongoing follow-up and monitoring; and
- the ongoing introduction of new tests and treatments.

4 Cancer outcomes are worse when patients wait too long for treatment. Long waits can shorten life expectancy and reduce quality of life after treatment. This increases pressure on health boards to deliver timely care.

5 Cancer services account for a growing share of NHS spending. This is driven by increasing demand and the costs of new tests and treatments.

What we have found

6 The Health Board has worked well to manage increasing service demand without a corresponding significant worsening of waiting times performance. However, actions to improve cancer services have not yet led to lasting improvement. Performance is still well below the 75% target. In 2025–26, only 61% of patients started treatment within 62 days. The overall average performance also hides wide differences between services. In particular, urology and gastrointestinal pathways are underperforming.

7 The Health Board has taken steps to manage immediate pressures. These include running extra clinics, filling staff vacancies, and changing care pathways. These actions have helped to steady demand in the short term. Whilst they have improved capacity for treating breast and skin cancer, they have not dealt with deeper capacity problems. As a result, overall performance has not improved. The Health Board expects to meet national targets by late 2026–27, but current progress suggests it is not on track.

8 The Health Board has strengthened its cancer service leadership and operational oversight. This has helped to increase focus on cancer care. However, gaps in reporting, limited use of intelligence, and weak Board and committee scrutiny means that progress is slow. The Health Board is proactively taking steps to improve cancer prevention and screening, but we are concerned that scale of these initiatives might not be sufficient to have the required impact.

9 The Health Board understands the challenges it faces. However, its approach is mainly reactive rather than planned ahead. Whilst its working on updating its cancer strategy, it does not have a clear, detailed improvement plan. This makes it harder to respond to rising demand and to meet treatment targets. This is a growing concern, as cancer service costs are rising faster than inflation and there is no clear long-term financial plan.

What we recommend

10 We have made seven recommendations to the Health Board in the following areas:

- approving a new Cancer Strategy;
- monitoring the delivery of the plan;
- developing a costed cancer improvement plan to deliver the strategy;
- developing a long-term cancer workforce plan;
- improving the tracking of cancer improvement actions;
- working with partners to improve analysis of cancer screening data; and
- including a wider range of data in monitoring reports.

Key facts and figures



The number of new suspected cancer referrals rose by 11% between 2022–23 and 2025–26.



Spending on cancer services rose from £90 million to £138 million between 2019–20 and 2023–24. This is £31 million more than if spending had kept pace with inflation over the same period.



In March 2026, most referrals were for suspected lower gastrointestinal (748), breast (392) and upper gastrointestinal (373) cancers.



In March 2026, 63.1% of patients started treatment within 62 days compared with the 75% target.



In March 2026, there was wide variation in treatment waiting times. Performance ranged from 91% for skin cancer to just 36% for gynaecological cancer, against a 75% target.



Between 2002 and 2024 one-year cancer mortality rates have fallen by 15.9%.

Our findings

Cancer service improvement planning

Cancer planning is not joined up leading to fragmented, reactive cancer improvement, rather than longer-term sustainability

Cancer improvement plans

11 The Board approved a Cancer Strategy for 2020–25 that aligned with national policy, national targets and person-centred care. However, the strategy is now out of date and, although a refresh is in progress, the Health Board does not yet have clear reporting mechanisms in place to routinely monitor delivery of the strategy and provide assurance to the Board and its committees that implementation is on track.

12 The Annual Plan 2026–27 sets out high-level priorities for the year. These include redesigning pathways, addressing underperformance, and improving Multi-disciplinary Team governance. While these priorities broadly align with national expectations, the links to the All-Wales Cancer Improvement Plan 2023–26 are unclear. The Annual Plan 2026–27 understandably does not provide detail on the enabling workforce, finances, systems or estate to meet cancer demand in the short- or longer-term. This is a clear gap which a stand-alone cancer plan would need to address.

13 There is no clear approach setting out how the Health Board will meet the Suspected Cancer Pathway (SCP) standard or strengthen services to meet growing demand and growing costs for diagnosis or treatment. Actions to address cancer inequalities are underway, but again these are not yet clearly built into service planning.

14 The Health Board does assess adherence to National Optimal Pathways[1], but planning assumptions appear too optimistic. Recovery actions remain high-level and lack clear timescales, ownership, measurable impact, and clear links to performance recovery. As a result, responses to pressures are often short-term and rely on measures such as overtime and backlog initiatives.

15 The Health Board does not expect to meet national SCP targets until quarter 4 of 2026–27. However, the Health Board has not made sufficient progress against planned improvements to provide confidence that it will meet this aim.

Cancer intelligence and data

16 The Health Board needs to better use data analysis and intelligence to inform service planning. The Health Board uses referral data and projections to support day-to-day scheduling of services. However, this approach is generally reactive and not used to inform medium-to longer-term planning. Intelligence shows a clear increase in cancer demand. However, this has not led to a matching increase in workforce capacity. This could make it harder to achieve the SCP targets and directly affect patient outcomes.

17 The Health Board regularly reports cancer demand and performance data[2]. Operational teams and Executives clearly understand the differing performance and risks for different cancers. This helps the Health Board to identify services that are under pressure and supports occasional detailed reviews.

[1] Standardised, evidence-based care pathways designed to improve cancer diagnosis and treatment.

[2] Cancer demand and performance data includes referral volumes, backlogs, waiting times, conversion rates and SCP compliance.

18 The Health Board collects data on different stages of the pathway, which it primarily uses for operational management. This includes time to first outpatient appointment, compliance with diagnosis within 28-days targets, and the time from decision to treat to treatment start. However, the Health Board does not routinely report this information to committees or the Board. This data would help the Board understand where pressures exist along the pathway to inform medium- to long-term investment prioritisation.

19 The Health Board is not making the best use of outcomes data to inform decision making and targeted action. As a result, focus is on meeting cancer targets rather than whether the Health Board is improving patient outcomes. We understand that the Health Board is planning to introduce a set of outcomes-based metrics. This includes information on survival, stage at diagnosis and longer-term outcomes.

Supporting fragile services

20 The timeliness of cancer treatment depends on the type of cancer a patient has. Most of the patients waiting longer than 62 days on the suspected cancer pathway are in the lower gastrointestinal, upper gastrointestinal and urology pathways.

21 The main causes of pressure are well known and regularly discussed. These include limited diagnostic capacity, shortages of staff and reliance on specialist (tertiary) providers[3]. The challenge using tertiary providers is ensuring timely radiotherapy, chemotherapy and/or specialist procedures. The Health Board has set up Gynaecological, Urology and Colorectal services recovery groups to help address underperformance. This shows a strong understanding of where risks to delivery are highest, and a commitment to address the issues.

[3] Tertiary providers for the Health Board include Velindre University NHS Trust, Swansea Bay University Health Board, Cardiff & Vale University Health Board and NHS England.

22 Cancer is a priority for regional working. The Health Board discusses issues that it cannot resolve locally with their partners through regional planning forums. Regional cancer service models are also being developed, including shared workforce planning, outreach services and joint multidisciplinary team working. However, these arrangements are still developing, and it is not yet clear how or if they will improve service capacity and efficiency.

Financial and resource planning

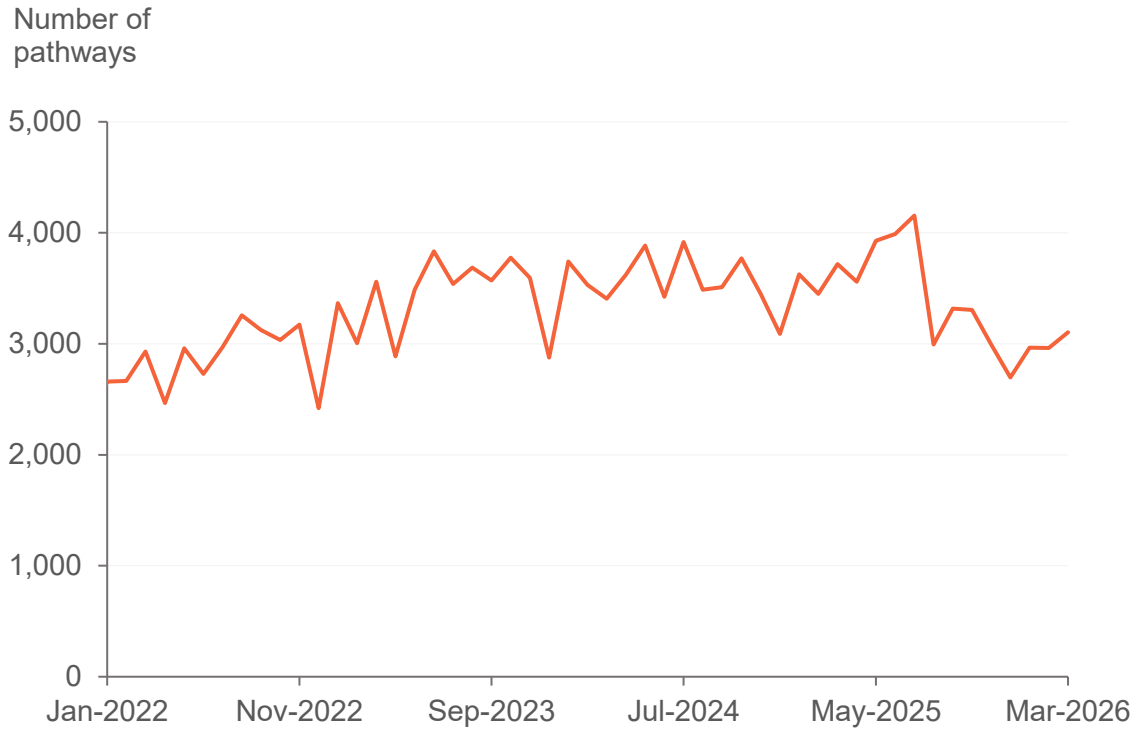
The absence of comprehensive financial and resource plans for cancer services, limit assurance that resources can meet rising demand and national targets

Funding plans

23 The Health Board has not sufficiently costed the total investment required to fund its cancer service improvement actions. Instead, it relies on ad-hoc business cases and short-term funding for local developments. This makes it hard to see the full investment needed to drive service improvements to meet cancer standards and targets. It also does not provide the assurance that the totality of planned improvements needed to meet targets are affordable.

24 **Exhibit 1** shows the number of new suspected cancer pathways opened each month. This shows an ongoing increase until mid-2025, then a reduction. There has been a notable increase in referrals between 2022–23 and 2025–26 in head and neck (+26%), gynaecological (+16%) and breast (+15%) tumour sites. While new referrals are currently lower than a couple of years ago, the costs have risen faster than inflation (**Exhibit 2**).

Exhibit 1: newly opened suspected cancer pathways, Aneurin Bevan University Health Board, January 2022 to March 2026 (number)

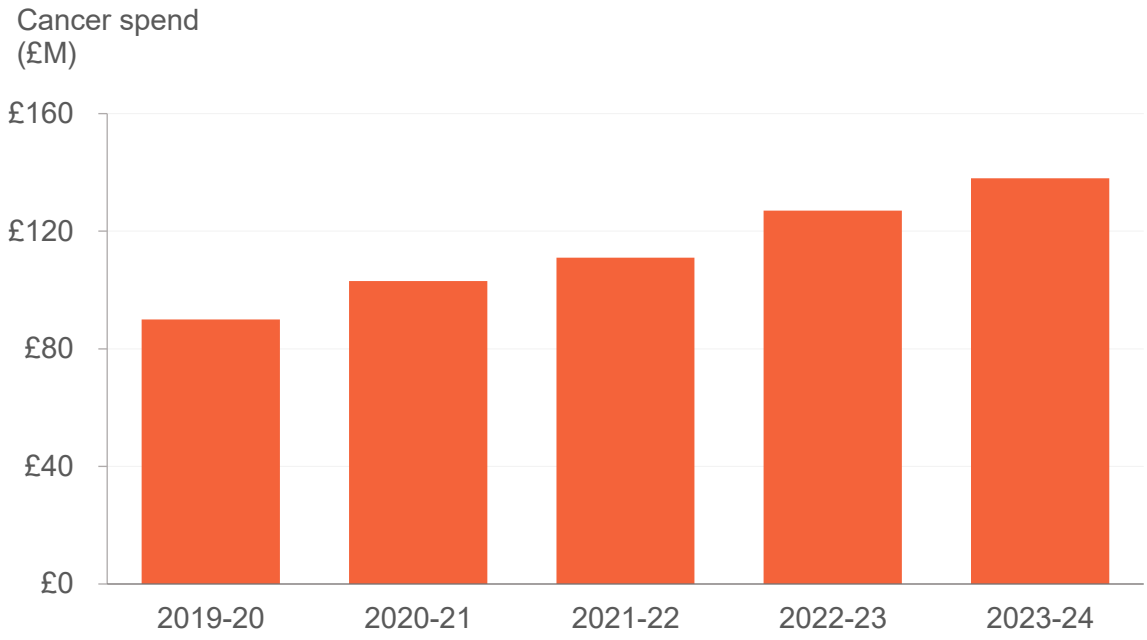


Source: Audit Wales analysis of Digital Health and Care Wales data

Note: Under the suspected cancer pathway (SCP), a pathway starts at the point of suspicion, for example when a GP makes a referral. Pathways are closed, and waiting times end, when patients start their first definitive treatment, are downgraded (told they do not have cancer), choose not to have treatment or if the patient died. Note that patients can be on more than one pathway

25 **Exhibit 2** shows spending on cancer services between 2019–20 and 2023–24. Over this period, the Health Board's cancer spending rose by around 29% above inflation[4]. Hospital cancer medicines spending has also risen. Between 2019–20 and 2024–25, spending on cancer medicines increased from £10 million to around £15.4 million[5,6]. This is about £3.1 million more than if costs had increased in line with inflation (2024–25 prices).

Exhibit 2: actual cancer services spend, Aneurin Bevan University Health Board, 2019–20 to 2023–24, (£million)



Source: Audit Wales analysis of Health Board data, sourced from the Welsh Government

[4] Inflation is calculated using 2023-24 as a baseline and HM Treasury inflation data.

[5] Some speciality medicine costs cover both cancer and other treatments but are included in the total. This is unlikely to have a substantial impact on the overall figures.

[6] Medicine figures cover hospital spending by the Health Board only and exclude costs for patients treated elsewhere.

26 Cancer service costs are not set out in the Annual Plan 2026–27. While the Health Board has set out costs in divisional budgets, it is difficult to identify the totality of the planned cancer spend. This is a significant weakness given the scale of cancer services, rising demand, and ongoing cost pressures, including high-cost drugs. **Exhibits 1** and **2** broadly show that increases in cost align to increased demand. However, cost growth is exceeding inflation and needs to be effectively planned for.

27 The Health Board does not have a single costed delivery programme for cancer services. There is evidence of finance reporting to inform planning at individual service level, including forecasts, pay and non-pay costs, savings schemes, and known financial risks and pressures. However, this information is not used to inform a consolidated, costed plan for cancer.

Wider resourcing requirements

28 The Health Board clearly understands its workforce pressures. This includes vacancies, skills shortages, and limited capacity. These challenges are particularly evident in breast, gynaecology, and urology. It has taken action to manage current risks. This includes recruiting specialist staff and redeploying staff.

29 Workforce challenges are not confined to cancer services, with many staff contributing across both cancer and planned care pathways. While recognising these interdependencies, the Health Board does not have a clear workforce plan that sets out how it will develop and sustain the workforce needed to meet future demand. As a result, workforce planning remains focused largely on addressing immediate pressures rather than building longer-term capacity and resilience.

30 The Health Board includes cancer estates plans in its corporate estates strategy. Major developments, such as cancer centre designations and the Satellite Radiotherapy Unit[7], show that cancer is a priority for estates investments.

[7] The Radiotherapy Satellite Centre at Nevill Hall Hospital in Abergavenny is funded by the Welsh Government. This investment is part of a wider package announced in 2023 to upgrade

31 The Health Board has an established five-year diagnostic equipment replacement programme, including processes to prioritise additional capacity and replacement needs. However, equipment planning is managed separately from cancer service delivery planning and is not brought together within a single cancer delivery plan. As a result, there is limited assurance that future equipment requirements are systematically aligned to anticipated growth in cancer demand.

32 The Health Board recognises that digital capability is important. Live cancer tracking dashboards support day-to-day oversight. However, digital in the main supports day-to-day tracking, rather than service transformation.

radiotherapy services in Southeast Wales, with the facility designed to bring care closer to patients' homes. It is staffed by Velindre University NHS Trust.

Cancer prevention and population screening

While taking positive and innovative action, the Health Board is not maximising the benefits of cancer prevention

33 The All-Wales Cancer Improvement Plan estimates that 38% of cancers each year are preventable. To give this context, if the Health Board prevented 20% of cancers, it could have saved £2.3 million in bed day costs in 2024–25, based on the most recent available financial data. **Exhibit 3** shows the potential gains if the Health Board successfully implemented a cancer prevention strategy.

Exhibit 3: potential capacity gains from cancer prevention, Aneurin Bevan University Health Board, based on 2024–25 activity

	2024–25 actual	-10% reduction	-20% reduction	-38% reduction
Finished consultant episodes	**16,755**	**15,080** (1,676 reduction)	**13,404** (3,351 reduction)	**10,388** (6,367 reduction)
Admission episodes	**14,842**	**13,358** (1,484 reduction)	**11,874** (2,968 reduction)	**9,202** (5,640 reduction)
Bed days	**22,947**	**20,652** (2,295 reduction)	**18,358** (4,589 reduction)	**14,227** (8,720 reduction)
Bed day cost savings		(**£1.2** million)	(**£2.3** million)	(**£4.4** million)

Source: Audit Wales analysis and modelling of Digital Health and Care Wales data from the Patient Episode Database for Wales, Headline Figures and Primary Diagnosis Datasets for Welsh providers

Note:

1) The analysis outlines the broad impact of a 10%, 20% and 38% reduction in cancer cases, based on 2024–25 activity levels.

2) Savings calculation based on £500 per day cost of an NHS bed in Wales used in our 2025 National Cancer Services Report.

Public health risk assessment

34 Population health intelligence is strong and well understood but this isn't yet driving large-scale cancer prevention initiatives. The Health Board has developed a Population Health Cancer Dashboard, which has received national recognition. The dashboard brings together data on cancer rates and key risk factors, such as smoking, alcohol use, and body mass index. It also shows differences by age, gender, deprivation, and location. This helps the Health Board understand cancer risk, variation, and inequalities across the population. It also provides assurance that there is understanding of where targeted prevention work would be beneficial.

35 The Health Board has set up a Cancer Board as a strategic forum for overseeing cancer service delivery. The Cancer Board uses the intelligence to inform discussions and decisions. However, beyond the Cancer Board, the Health Board does not sufficiently use population health data to inform cancer prevention planning, priorities and delivery plans.

Approaches to improving population lifestyles

36 The Health Board is delivering a range of programmes to promote healthy lifestyles that reduces cancer risk. However, the long-term impact of local cancer prevention initiatives is limited due to insufficient funding and prioritisation. The Health Board's Annual Plan 2026-27 clearly sets prevention and population health as priorities. However, interviewees indicated that spending on prevention is a small part of overall Health Board funding and more could be invested to improve overall impact.

37 Ongoing funding supports key programmes such as smoking cessation, healthy weight services, vaccination, and screening uptake. Programme uptake and outcomes are monitored by Public Health team, and some metrics at Finance & Performance Committee. This shows that the Health Board manages and evaluates prevention programmes.

38 The Public Health team also develop local prevention initiatives, along with targeted campaigns in areas of low uptake. These business cases go to the Executive Team for approval and are tested for alignment with priorities. Initiatives such as Alcohol “Try Dry” take an evidence-based approach to address lifestyle risks linked to cancer. However, some activities, such as the community-based skin cancer prevention initiative, depend on short-term funding or have limited staff capacity. This makes it harder to manage and may limit the positive impact that the schemes were designed to achieve.

39 The Health Board also participate in National public health programmes, including Help Me Quit and Healthy Weight Healthy You, strongly shape how prevention funding is used. These programmes support cancer prevention and focus on high-risk groups.

Targeted prevention and population screening

40 There are clear referral routes to diagnosis and treatment for patients whose cancer is detected through each of the national screening programmes. The Health Board has limited access to timely screening data. Screening data is not available in real time, which restricts the Health Board’s ability to monitor and plan to meet demand resulting from screening. Performance data also shows that screening is not consistently leading to timely diagnosis and consequently starting treatment, particularly for colorectal cancer, due to limited colonoscopy capacity.

41 The Health Board has some understanding of inequalities of screening uptake. The Health Board’s Public Health team analyses uptake by deprivation, geography, age and sex. They consider barriers such as access and health literacy to identify targeted actions. These actions include predicting non-attendance, active patient follow-up and the use of patient stories to address fear and disengagement.

42 Human papillomavirus vaccination (HPV) rates are below the Health Board's national target of 90%, last reported at around 77% in September 2025. The Health Board has introduced school-based delivery, community outreach, and other actions set out in the Vaccine Inequity Strategy. Despite this, these actions have not yet led to sustained improvement.

Cancer leadership and oversight

While leadership are supporting operational improvements, there is a need for better oversight of the strategic direction of cancer services

Managerial leadership

43 There is now clear leadership for cancer services, after a period of instability. The Chief Operating Officer has overall responsibility, supported by a Senior Responsible Owner and a Clinical Lead. This provides a clear and more joined-up approach to leadership. Prior to this, the COVID pandemic, changes in senior staff, service changes and regional tensions disrupted leadership stability and continuity. While recent appointments and executive focus aim to address this, the effects are still visible in cancer performance and progress.

44 Senior managers make decisions on priorities and spending within agreed limits. The Health Board's Divisional Management Team meetings are supporting timely decision making, when needed. In the past, this has included approving funding for extra clinics and other short-term actions to meet demand.

45 The Health Board's Cancer Board includes staff, primary care, third-sector partners, and patient representatives. This helps to promote openness and joint working to solve problems. This collaborative approach is also evident at operational level. Structured forums, including assurance meetings and tumour-specific recovery groups help teams keep track of performance and waiting lists and take shared action where needed.

46 Regional working and leadership are essential to make sure that patients get the right cancer care at the right time. In south-east Wales whilst health boards plan and deliver many parts of the cancer diagnosis and treatment pathway, they commission and fund Velindre University NHS Trust to provide non-surgical specialist cancer services[8] for most patients. It is imperative that joint working ensures effective planning, referral, and continuity of cancer care across organisational boundaries.

Oversight and scrutiny

47 The Board and the Finance and Performance Committee regularly review cancer performance information. Reports include performance against the target for 75 per cent of patients to start treatment within 62-days of suspicion. The reports also include, waiting list backlog levels, performance trajectories, key risks, and key actions. This gives a good high-level view. However, reports are missing measures such as average waiting times, tumour-specific performance and cancer outcomes. This is important because the average performance can mask significant variation across tumour sites. This may limit the Board and Finance and Performance Committee's ability to seek targeted assurance on services that have the greatest impact on patient outcomes.

48 Finance and Performance Committee minutes suggest that there has been limited scrutiny when cancer performance targets are missed. Equally, Board and committee minutes show that challenge on the proposed actions needed is weak. This is a greater concern because reported improvement actions are often high-level and lack detail.

[8] including radiotherapy, chemotherapy, and other systemic anti-cancer treatments (SACTs).

49 The Health Board has an established Cancer Board, chaired at Executive level (Chief Operating Officer), which has met bi-monthly since 2020 with consistent clinical engagement. Furthermore, they produce a comprehensive and well-structured Annual Cancer Report that provides assurance that improvement work is ongoing. However, it lacks detail on whether those activities are translating into sustainable improvements in performance and outcomes.

Cancer performance

Some patients are facing unacceptably long waits, and the actions to improve are not enabling the Health Board to meet its targets

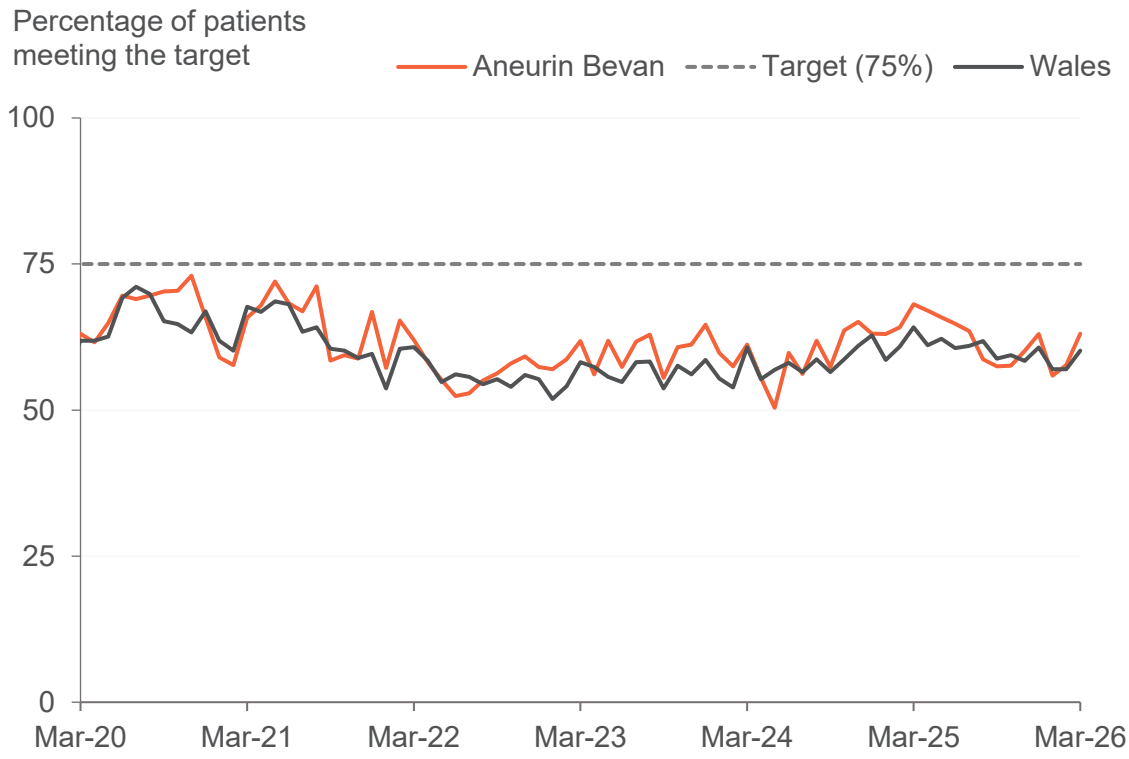
62-day cancer performance

50 The Welsh Government target is for 75% of patients to start their first treatment within 62 days from the first point where cancer is suspected.

51 Early diagnosis and prompt treatment improve outcomes. They increase survival rates and enhance quality of life. Long waits can lead to more advanced cancer. This may reduce life expectancy, limit treatment options and affect physical health after treatment.

52 **Exhibit 1**, outlined earlier in the report, shows that the number of new suspected cancer pathways opened each month has grown. Despite this, the Health Board has done well to ensure performance has not deteriorated. However, the Health Board's performance, although reflecting the average achieved in Wales, is falling well short of meeting the national cancer target (**Exhibit 4**). It is widely accepted that the number of cancer cases will continue to increase in Wales and service pressures are expected to grow.

Exhibit 4: patients meeting the 62-day cancer treatment target, Aneurin Bevan University Health Board, March 2020 to March 2026, (percentage)



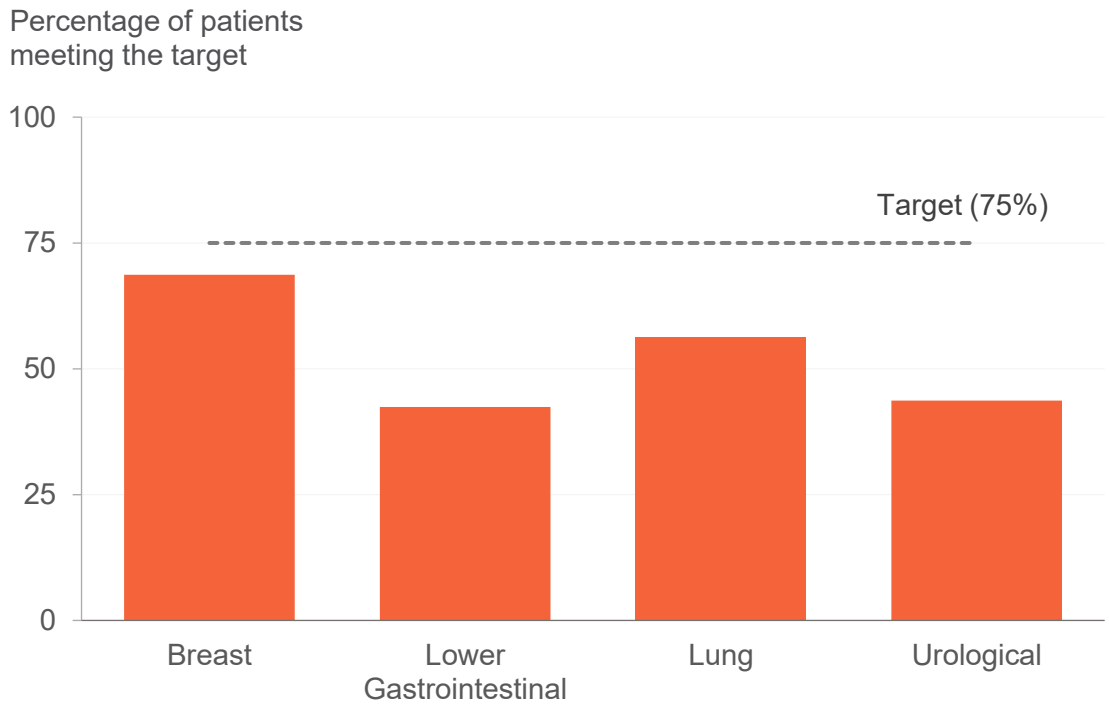
Source: Audit Wales analysis of Digital Health and Care Wales data

Note: The data includes patients who started treatment and those waiting for confirmation that they do not have cancer.

53 The Health Board is not meeting the 62–day Welsh Government target. However, overall performance also hides large differences between sex and tumour types. For example, between December 2025 and March 2026, between 8% and 14% more men than women waited beyond the target.

54 Some areas, such as skin cancer, are performing better. In March 2026, skin cancer pathways met the target with 88.3% of patients starting their treatment within 62 days. **Exhibit 5** shows performance across four common cancer tumour sites. It raises significant concerns about urological and lower gastrointestinal cancer case timeliness.

Exhibit 5: patients meeting the 62–day cancer treatment target by tumour site, Aneurin Bevan Health Board, 12-month average during 2025–26 (percentage)



Source: Audit Wales analysis of Digital Health and Care Wales data

Notes:

1. The data shown average 62- day performance over the most recent 12-month period (March 2025 to March 2026).
2. The data includes patients who started treatment and those waiting for confirmation that they do not have cancer

Impact of action to improve cancer services

55 The action taken by the Health Board is helping to manage short-term risks. But this is not significantly improving performance overall or addressing significant underperformance for some tumour sites. This is likely to be affecting the outcomes for some groups of patients.

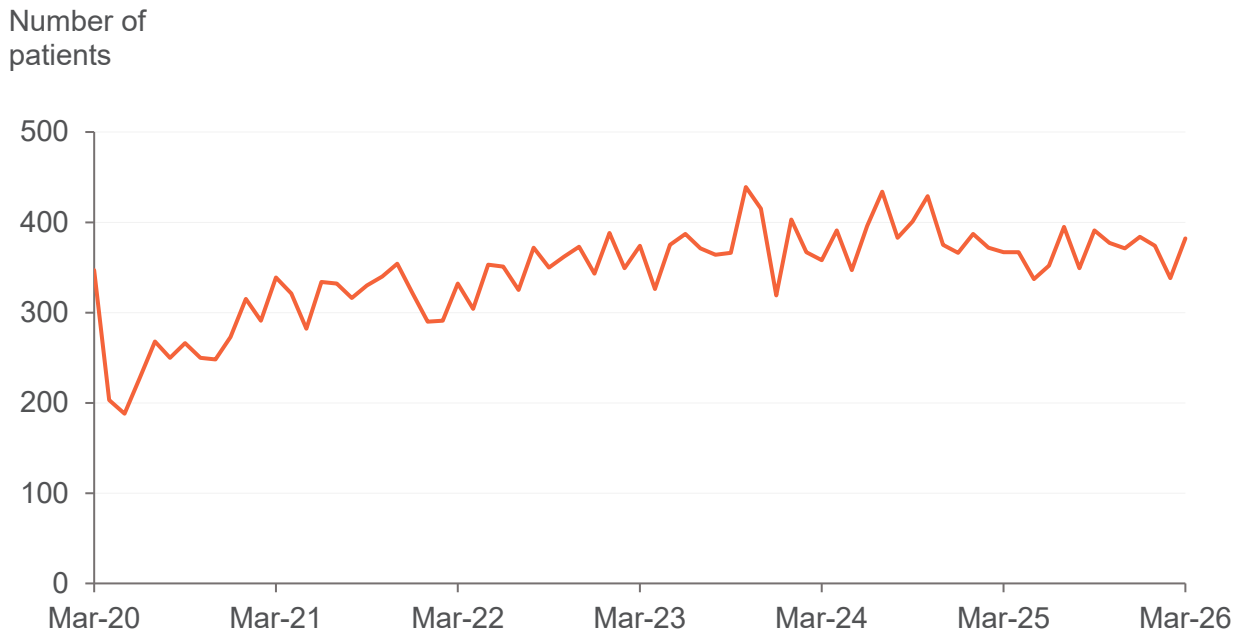
56 Workforce pressures are a major challenge for cancer services. Managers have reactively responded to immediate risks. These include recruiting consultants and cancer nurse specialists, using locums and changing clinic scheduling. However, these actions do not close underlying capacity gaps or sustainably match capacity to demand.

57 The Health Board is trying to address diagnostic and treatment capacity shortfalls. Its actions include redesigning care pathways, speeding up pathology results and waiting list initiatives. If there are issues that teams cannot solve locally, they develop business cases to seek extra funding. This has supported investment in specialist equipment, such as surgical robots, new endoscopy solutions and specialist testing[9].

58 Performance against the 62-day target suggest that the actions taken have not had sufficient impact to improve capacity. The number of new patients starting treatment each month has not notably increased since 2023 (**Exhibit 6**). However, the Health Board has indicated that wider overall treatment activity throughout the pathway have increased.

[9] HER2 testing identifies if breast or stomach cancers have high levels of the HER2 protein or gene, which drives cancer growth. Testing helps determine eligibility for targeted therapies.

Exhibit 6: cancer patients starting treatment each month, Aneurin Bevan Health Board, March 2020 to March 2026 (number)



Source: Audit Wales analysis of Digital Health and Care Wales data

59 The Health Board needs to do more to reflect on the impact of the actions that it is taking. Improvement actions are not clearly prioritised and do not have realistic improvement targets. There is no routine evaluation of the impact of action taken and the resulting impacts. There is little evidence that learning from previous initiatives, including 'Lean systems' training, is consistently applied through formal improvement methods such as PDSA cycles[10].

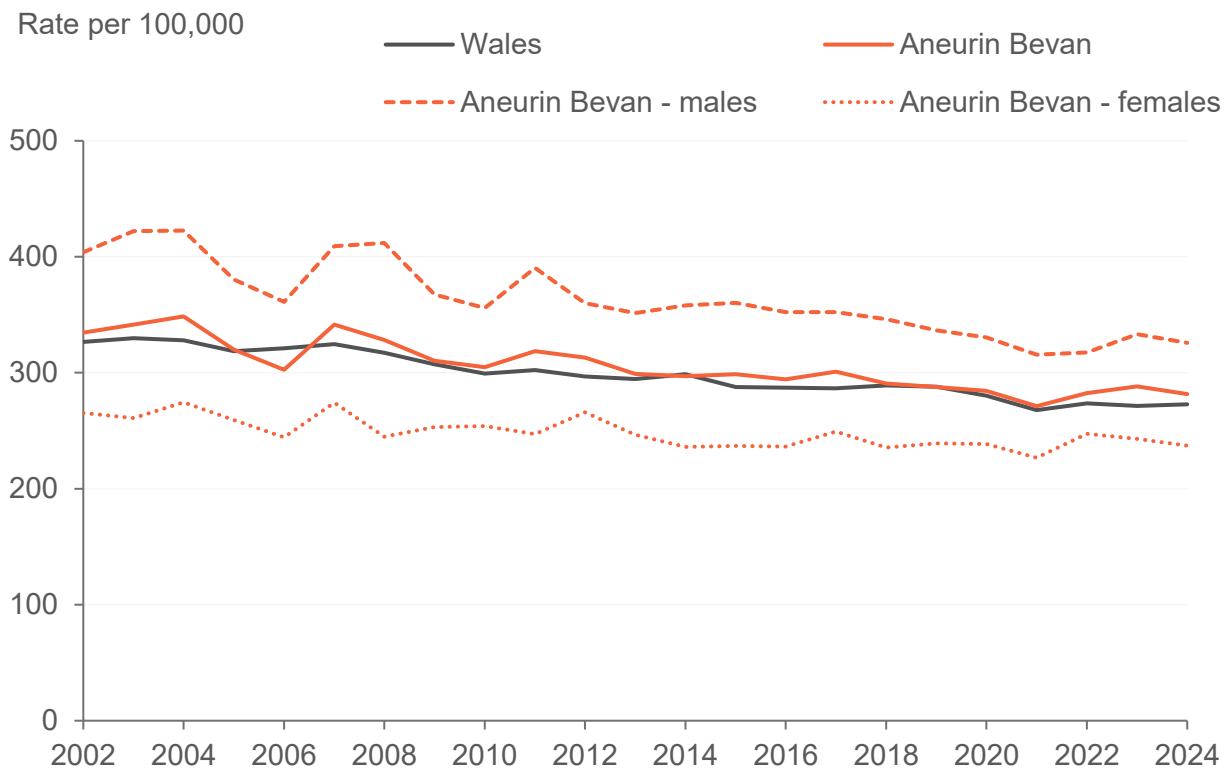
[10] PDSA cycles (Plan-Do-Study-Act) are a four-stage, iterative problem-solving model used to test, implement, and refine changes for process improvement.

Improving cancer outcomes

60 Mortality, stage at diagnosis, PROMs and PREMs data are reviewed in specialty clinical effectiveness meetings. However, there is little evidence that services use outcomes data to inform priorities, recovery planning, or system-wide improvement.

61 **Exhibit 7** shows the one-year mortality rate for the Health Board.

Exhibit 7: one-year cancer mortality, Aneurin Bevan University Health Board 2002 – 2024 (rate per 100,000 population)



Source: Audit Wales analysis of Public Health Wales NHS Trust data

Note: Deaths where cancer is the primary cause, using the European Age Standardised Rate to enable fair comparisons over time and place.

62 Analysis of one-year cancer mortality data from 2002 to 2024 in **Exhibit 7** shows a consistent reduction in one-year mortality over the last 20 years. This represents a positive long-term trend and suggests that improvements in cancer prevention, early detection and treatment are having a beneficial impact. The Health Board's cancer mortality rate is also lower than the Wales average. However, outcomes for males remain worse than for females.

Recommendations

Cancer services planning

R1 The Health Board should prioritise the completion and Board approval of its new Cancer Strategy **(paragraph 11)**.

R2 The Health Board should ensure reporting mechanisms are in place to operationally monitor the delivery of the cancer strategy and provide assurance to the Board and committees that delivery is on track **(paragraph 11)**.

R3 The Health Board should develop a fully costed organisation-wide cancer improvement plan to ensure sustainable delivery of the cancer strategy as demand increases **(paragraph 12)**.

R4 The Health Board should ensure that the cancer improvement plan includes SMART[11] cancer improvement actions with defined responsibilities for delivery **(paragraph 14)**.

[11] Specific, Measurable, Achievable, Relevant, and Time-Bound

R5 The Health Board should develop a clear, long-term cancer workforce plan that sets out how it will address capacity and skills gaps to build sustainable workforce provision tailored to future demand **(paragraph 29)**.

R6 Health boards should work collectively with Public Health Wales NHS Trust to agree as soon as possible a comprehensive set of data analysis on screening services, including:

- Timeliness across each part of the current three cancer screening pathways and lung screening once it is fully rolled out.
- Information on uptake screening rates and variations by population groups (including age, location, sex (where applicable), and ethnicity.

(paragraph 40).

Cancer progress reporting

R7 The Health Board should improve cancer reporting by including average waiting times, tumour-specific performance, and outcomes to better support Board scrutiny and targeted assurance **(paragraphs 47 - 49)**.

Appendices

1 About our work

Scope of the audit

We looked at the following areas:

- How well the Health Board plans its cancer services and whether they align with the National Cancer Plan, Quality Statement and Cancer Recovery Programme.
- How the Health Board seeks to reduce cancer prevalence by targeting preventative actions and supports screening programmes to detect cancer sooner.
- How cancer services are led and managed to drive improvements.
- How services are performing and the actions that the Health Board is taking to drive service improvement and achieve better patient outcomes.

We did not consider service quality, clinical governance or patient experience. We have also not completed an audit of the data used in this review, but we have looked at the all-Wales data validation process.

Audit questions and criteria

Questions

We used the following questions to focus our fieldwork:

- Has the Health Board clearly set out how it will achieve timely and equitable access to cancer diagnosis and treatment?
- Has the Health Board set out a coherent approach to cancer prevention?
- Is the Health Board providing strong leadership and governance for timely and equitable access to cancer diagnosis and treatment?

- Is the Health Board making progress to deliver timely and equitable access to cancer diagnosis and treatment?

Criteria

We assessed the Health Board's arrangements against the following criteria:

- The Health Board has clear funded plans based on sound business intelligence which sets out cancer services priorities and objectives, and the approach it is taking to achieve them.
- The Health Board has a clear approach to target population health improvements as means to reduce cancer prevalence in the longer-term.
- The Health Board's leadership for cancer services work collaboratively and are empowered to drive cancer service improvements in the short and longer-term.
- The Health Board is making continuous improvement on 62-day cancer performance, successfully addressing underperforming services and driving improvements to achieve better outcomes for patients.

Methods

Our audit methods included document review, data analysis, and interviews. We interviewed the following:

- Cancer Services Manager;
- Chief Operating Officer;
- Clinical Lead for Cancer;
- Division Director for Clinical Support Services;
- Head of Public Health; and
- Strategic Lead Cancer Nurse.

We also held a focus group with the operational specialty management leads.

2 Key terms in this report

Term	Description
Admission episodes	The first period of care under a consultant with a health provider's episode of care.
Bed days	A day during which a patient occupies a hospital bed and stays overnight in the hospital.
Bed days cost savings	The financial benefits gained from reducing the number of hospital bed days.
Cancer Quality Statement	National statement outlining quality expectations for cancer care and outcomes across NHS Wales.
Cancer Recovery Programme	Programme of actions intended to restore/improve cancer services post-disruption (e.g., COVID-19), focusing on waits, pathways and outcomes.
European Age-Standardised Rate (EASR)	A rate adjusted to a standard European population age-structure to enable fair comparisons over time/places.
Finished consultant episodes	Refer to the periods of patient care under a consultant's supervision that have concluded due to discharge, transfer, or death.
Multidisciplinary Team	Multidisciplinary Team working is where health and care professionals from different specialisms work together to agree a patient's care.
National Cancer Improvement Plan	National plan setting priorities and actions for improving cancer services across Wales, aligning health boards to common standards and trajectories.

Term	Description
Patient-Reported Experience Measures (PREMs)	Validated questionnaires used in healthcare to evaluate quality from the patient's perspective. PREMs focus on the experience of care (how it was received).
Patient-Reported Outcome Measures (PROMs)	Validated questionnaires used in healthcare to evaluate quality from the patient's perspective. PROMs measure the effectiveness of treatment on health status
Population health risks	Modifiable risk factors (e.g. smoking, obesity, alcohol) associated with cancer incidence in local populations.
Real terms spend	Expenditure adjusted for inflation to reflect true purchasing power over time.
Stage at diagnosis	The extent of cancer spread at the time of diagnosis, strongly linked to outcomes and treatment options.
Suspected Cancer Pathway (SCP)	The all-Wales performance standard that 75% of patients should start their first definitive treatment within 62 days from the point of suspicion.
Systemic Anti-Cancer Therapy (SACT)	Drug treatments circulating via the bloodstream (e.g., chemotherapy, targeted and immunotherapies) to treat cancer
Screening	A preventive medical test designed to detect cancer early, often before symptoms appear, improving the chances of successful treatment
Tumour site	The anatomical location/type of cancer (e.g. lower gastrointestinal, lung, breast, urological, skin).

Term	Description
Waiting list initiatives	Waiting list initiatives are targeted actions or interventions designed to reduce patient waiting times and manage waiting list backlogs (e.g. additional clinics, extra sessions, outsourcing or insourcing).

3 Management response form

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R1 The Health Board should prioritise the completion and Board approval of its new Cancer Strategy.	The Health Board has completed an evaluation of the 2020–2025 Cancer Strategy, which will be considered by the Executive Committee in July 2026. Development of a new Gwent Cancer Plan, aligned to the Gwent 2035 Strategy, is underway. Engagement workshops are being undertaken to inform the six strategic pillars of the plan, which will be submitted to the Executive Committee for approval. Following publication of the Welsh Government National Cancer Strategy, expected in February 2027, the Gwent Cancer Plan will be reviewed and, where necessary, updated to ensure alignment with the national strategic direction, priorities and implementation requirements.	31 March 2027	Chief Operating Officer Supported by: Assistant Medical Director for Cancer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R2 The Health Board should develop a fully costed organisation-wide cancer improvement plan to ensure sustainable delivery of the cancer strategy as demand increases.	The Health Board accepts this recommendation and will develop a fully costed Cancer Improvement Plan aligned to the current Welsh Government Quality Statement for Cancer, Single Cancer Pathway requirements, National Optimal Pathways and the Gwent Cancer Plan. The plan will identify the workforce, digital, infrastructure, service redesign and investment requirements necessary to support sustainable improvement in cancer services. It will include clear priorities, delivery milestones, affordability assessments, expected benefits and defined governance arrangements for implementation and monitoring. Following publication of the Welsh Government National Cancer Strategy, expected in February 2027, the Improvement Plan will be reviewed and updated, where necessary, to ensure alignment with the national strategic direction and implementation requirements.	31 March 2027	Chief Operating Officer **Supported by:** Senior Responsible Officer & Senior Programme Manager for Cancer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
R3 The Health Board should ensure that the cancer improvement plan includes SMART[12] cancer improvement actions with defined responsibilities for delivery.	Cancer Improvement Plans will include defined actions, measurable outputs, named responsible leads and delivery timescales. Action logs will be developed for each tumour site and approved by tumour site leads and divisional teams to support implementation. Progress and delivery against actions will be monitored and reported through Cancer Board governance arrangements.	31 October 2026	Chief Operating Officer Supported by: Cancer Services Manager
R4 The Health Board should develop a clear, long-term cancer workforce plan that sets out how it will address capacity and skills gaps to build sustainable workforce	Directorates will develop integrated workforce plans to support sustainable service delivery and future cancer demand. Plans will include workforce baselines, capacity gap assessments, demand modelling, skills mix reviews and recruitment and retention actions.	31 March 2027	Chief Operating Officer Supported by: Deputy Director of Workforce

[12] Specific, Measurable, Achievable, Relevant, and Time-Bound

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
provision tailored to future demand.	The workforce plan will inform the 2027/28 IMTP process.		
R5 The Health Board should ensure reporting mechanisms are in place to operationally monitor the delivery of the cancer strategy and provide assurance to the Board and committees that delivery is on track.	Oversight of delivery will be provided through Cancer Board reporting to the Executive Committee, with periodic assurance reporting and annual deep dives to the Public Board. Re-established and strengthened the Health Board Cancer Board with clear terms of reference, executive leadership and multidisciplinary membership. Evidence of regular meetings and action tracking is in place. Cancer Programme formally designated as one of the Health Board's priority programmes with executive sponsorship from the COO. This will ensure regular updates into Public Board, and scrutiny via our annual plan / IMTP process.	Completed July 2026	Chief Operating Officer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
	Cancer performance is now reviewed routinely through: • SRO Led performance meetings • Cancer Board • Divisional Performance Reviews • Executive oversight arrangements • Board Deep Dives and Board reporting. A dedicated Cancer Programme Deep Dive has been presented to Board setting out achievements, risks, performance and future priorities. Tumour-specific action plans and programme reporting are being developed to support delivery monitoring and accountability.		
R6 The Health Boards should work with Public Health Wales NHS Trust to	Public Health Wales now provides quarterly screening reports to Health Board representatives. The Health Board will continue to work with Public Health Wales to	Ongoing	Chief Operating Officer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
agree as soon as possible a comprehensive set of data on screening services, including: • Timeliness across each part of the three cancer screening pathways; and • Information on uptake rates and variations by population groups (e.g. age, location, sex (where applicable), and ethnicity.	develop an agreed dataset covering screening timeliness, uptake rates and variation across population groups. Opportunities to enhance reporting through more accessible and interactive platforms will also be explored. Progress is monitored through screening pathway improvement meetings and reported through established cancer governance arrangements.		Supported by: Head of Public Health team ABUHB
R7 The Health Board should improve cancer reporting by including average	Existing cancer reporting will be enhanced to include average waiting times, tumour-specific performance	31 March 2027	Chief Operating Officer

Recommendation	Health Board commentary on planned actions	Completion date	Responsible officer
waiting times, tumour-specific performance, and outcomes to better support Board scrutiny and targeted assurance.	measures and conversion-to-cancer rates by tumour site. Following approval of the Cancer Plan, a revised performance framework will be developed which includes a broader range of outcome measures aligned to the plan's strategic priorities.		Supported by: Cancer Services Manager & Senior Responsible Officer for Cancer

About us

The Auditor General for Wales is independent of the Welsh Government and the Senedd. The Auditor General's role is to examine and report on the accounts of the Welsh Government, the NHS in Wales and other related public bodies, together with those of councils and other local government bodies. The Auditor General also reports on these organisations' use of resources and suggests ways they can improve.

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We welcome correspondence and telephone calls in Welsh and English.

Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	06 October 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Patient Quality, Safety and Outcomes Committee – Review of Committee Forward Work Plan 2026/27
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Governance Support Officer

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Patient, Quality Safety and Outcomes Committee is asked to review the agreed Committee Forward Work Plan appended to this report. The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2026/27 and to enable the Committee to: -

- Fulfil its Terms of Reference;
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- Seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

In line with good governance practice, the Committee has a Forward Work Plan that was developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The Forward Work Plan can therefore

be utilised as a tool for informing and pre-empting Committee business and support the agenda setting process.

To aid the Committee when reviewing its programme of business, the Forward Work Programme captures the timing of when reports are to be submitted, identifies items that have been deferred and captures new requests for reports and enables the Committee to monitor and review its business at each meeting.

During the period the following requests and/or changes to the forward work plan have been included.

Additional items on the Forward Work Plan:

- **Attorney General of Northern Ireland (AGNI) Supreme Court Ruling** has been added to October's Committee Meeting

- **Corporate Clinical Audit Framework including the Annual Corporate Clinical Audit Plan 2026/27** has been added to October's Committee Meeting
- **Strategic Oversight of Clinical Audit 2026-2029** has been added to October's Committee Meeting

Changes to the Forward Work Programme:

- **Learning from Death Report** scheduled for update in December 2026 from October 2026

Argymhelliad / Recommendation

The Committee is requested to **NOTE** the updated Committee forward work plan as provided in **Appendix 1**.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working	Not Applicable Choose an item.

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

Annual Programme of Business for 2026-27

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 2025/26
- 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**
			8th April 2026 Cancelled	**6th May 2026**	**2nd June 2026**	**28th July 2026**	**6th Oct 2026**	**1st Dec 2026**	**16th Feb 2027**
Attendance and Apologies	Chair	SI	**√D**		**√**	**√**	**√**	**√**	**√**
Declarations of Interest	Chair	SI	**√D**		**√**	**√**	**√**	**√**	**√**
Minutes of the Previous Meeting	Chair	SI	**√D**		**√**	**√**	**√**	**√**	**√**
Action Log and Matters Arising	Chair	SI	**√D**		**√**	**√**	**√**	**√**	**√**
Development of Committee Annual Programme of Business 2027/28	DoCG	AN						**√**	
Review of Committee Programme of Business 2026/27	DoCG	SI	**√D**		**√**	**√**	**√**	**√**	**√**
Committee Annual Report 2026/27 • Annual Review of Committee Terms of Reference 2026/27 • Annual Review of Committee Effectiveness 2026/27	DOCG	AN	**√**						**√**

• Outcome of Annual Review of Committee Effectiveness 2026/27									
Committee Risk Report	DOCG	SI	**√D**		**√**	**√**	**√**	**√**	**√**
NHS Wales Joint Commissioning Quality Committee Report	DOCG	SI	**√D**		**√**	**√**	**√**	**√**	**√**
Quality Annual Report 2024/25	DoN	AN					**√**		
Quality Management System and Assurance Framework Annual Review	Clinical Executives	AN			**√D**	**√D**	**√**		
Quality Outcomes Reporting Qlik app – May meeting • Q4 Never Events **PQSOC0206/07** • Infection prevention and control **PQSOC0206/07** • Waiting times and pain-related complaints **PQSOC0206/07**	DoN /MD & DoAHP& HS	Quarterly	**√D 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	**√D**		**√**	**√**	**√**	**√**	**√**
Healthcare Inspectorate Wales Annual Report	DoN	AN						**√**	
Healthcare Inspectorate Wales Reviews	DoN	As reported							

Commissioning Assurance Framework Annual Review	Clinical Executives	AN			√				
Commissioning for Quality Outcomes Report	Clinical Executives	Bi-An					√		
Putting Things Right Annual Report 2024/25	DoN	AN					√		
Maternity and Neonatal Report	DoN	Bi-An				√D	√		
Learning from Death Report	MD	Bi-AN	√D	√			√D	√	
Safeguarding Annual Report	DoN	AN				√D	√		
Ward Accreditation Report	DoN	AN						√	
Nurse Staffing Levels (Wales) Act 3-year report (3-yearly)	DoN	AN						√	
Nurse Staffing Levels Wales Act Annual Assurance Report	DoN	AN				√			
Annual Report on Clinical Audit Activity 2024– 2025	MD	AN			√				
Healthcare Inspectorate Wales (HIW) Reports Update (**PQSOC 1702/10**)	DoN	Bi AN			√			√	
Pharmacy and Medicines Annual Report (**PQSOC 1702/15)**	MD	AN							√

Planned Care - Orthopaedics / Impact of Bone Cement Shortage (presentation) (Action transferred from Exec's)	COO	Action	**√D**	**√**					
Deep Dive into National Reportable Incident processes and performance (Action transferred from MHLDC Committee)	DoN	Action	**√D**						
Update on neonatal services, including progress on listening and lessons learned activity and the forthcoming national review (**PQSOC 1702/08)**	DoN	Action	**√D**		**√**				
Unplanned Caesarean Sections Data (**PQSOC 1702/08)**	DoN	Action	**√D**		**√**				
Report on redress and the Legal and Financial Exposure Review (LFER) process (**PQSOC 1702/07) (WRP Penalties and Learning Compliance)**	DoN	Action	**√D**						
Analyse physical assault data, including whether incidents related to repeat individuals or specific wards (**PQSOC 1702/06)** update given under action log item on agenda	DoAHP&HS	Action	**√D**		**√**				
Healthcare Business Solutions (HBS) Delivery	COO	Ad Hoc	**√D**		**√**				

Progress update on the new PTR regulations **(PQSOC 1702/11)**	DON	Action						√	
RCP Review Cardiology	MD	Ad hoc			√				
Timeline & Implementation plan for the Qlik App **PQSOC 0605/05**	DON	Action				√			
Research and Development Annual Report **PQSOC 0206/08**	MD	Action				**√D**	√		
Violence and Aggression Incidents	Clinical Executives	Action					√		
Attorney General of Northern Ireland (AGNI) Supreme Court Ruling	DON	Action					√		
Corporate Clinical Audit Framework including the Annual Corporate Clinical Audit Plan 2026/27	MD	Ad Hoc					√		
Strategic Oversight of Clinical Audit 2026-2029	MD	Ad Hoc					√		

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
DoAHP&HS	Director of Allied Health Professions & 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	
√	Scheduled agenda item in FWP
D	Deferred from this agenda
√D	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	06 October 2026
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 its meeting in July 2026, the Committee was advised that there had been no change to the scores of the risks within its delegated remit.

The Committee Risk Register comprises three strategic risks and three associated sub-risks, covering 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).

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** **4 x 4** **(16)**	**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**

Since the last report to the Committee in July, there have been no changes in the level of risk exposure for the three risks assigned to this Committee for focused scrutiny. However, work continues to reduce risk exposure, particularly where risks remain high or extreme, or are currently assessed as outside of appetite.

Risks Outside of Appetite

SRR 010: Health and Safety

The evidence presented through the 2025/26 Health, Safety and Fire Annual Report indicates that the position for SRR 010 is improving. Governance and oversight arrangements have strengthened, specialist capacity has increased, compliance monitoring and workplace risk assessment processes have developed, and the annual programme of Fire Risk Assessments has been completed. Progress has also been made in responding to internal audit recommendations and strengthening the strategic approach to violence prevention and reduction.

These improvements address several of the underlying causes of SRR 010, particularly those relating to the adequacy of systems, processes, governance and assurance arrangements. The evidence therefore supports a positive direction of travel and provides increased confidence that the Health Board is better able to identify, monitor and manage health, safety and fire risks.

However, the risk remains above the level the Health Board would ordinarily be prepared to accept. Further improvement is required in relation to manual handling compliance, violence and aggression, the timely completion of improvement actions, RIDDOR-reportable incidents and residual fire safety risks within the estate. The Notices of Contravention issued following Health and Safety Executive investigations also demonstrate that elements of the control environment are not yet operating consistently or effectively across the organisation.

On balance, the available evidence supports a reasonable level of assurance that arrangements are in place to manage SRR 010 and that the position is improving. However, substantial assurance cannot yet be provided because of the continuing compliance gaps and operational weaknesses identified.

Requirements under the Risk Management Framework and Risk Appetite Statement

In accordance with the Risk Management Framework and Board-approved Risk Appetite Statement, risks above appetite require active treatment and enhanced oversight.

The responsible Executive Director must ensure that the risk score is evidence-based, controls and assurances are assessed, and any gaps are addressed through clear, time-bound actions with accountable owners. Progress and impact must be regularly reviewed, with delays or any inability to reduce the risk towards appetite escalated through the appropriate governance route.

The risk treatment plan should prioritise manual handling, violence and aggression, incident reporting and learning, closure of improvement actions, and residual fire safety estate risks.



SRR 005: System Flow

The current risk score is **16**, which is within, but close to, the Board-approved risk appetite threshold of **17** for Service Delivery.

The score reflects the potential quality and safety consequences for patients arising from delays across the healthcare system. The strategic risk is underpinned by a number of corporate risks that reflect specific operational pressures and weaknesses affecting patient flow.

Improvement activity, including the Rapid Release Protocol and Our Next Patient approach, is strengthening system-wide arrangements, supporting more timely ambulance handovers and increasing focus on patients waiting across the pathway.

This demonstrates a positive direction of travel and provides reasonable assurance that the risk is being actively managed. However, continued monitoring of the underpinning corporate risks and relevant patient flow and safety outcomes is required to demonstrate sustained improvement and ensure that risk is not transferred between services.

Strengthening Quality Intelligence and Risk Identification

The ongoing evaluation of the Quality Management System and refresh of the Quality Plan will further strengthen the Health Board's approach to identifying and managing quality-related risks.

This work will support more effective triangulation of intelligence from a range of sources, including incidents, concerns, patient and staff feedback, audits, outcomes, performance information and regulatory findings. Bringing these sources together will provide a more comprehensive view of quality and safety, support earlier identification of emerging themes and risks, and enable proportionate action and escalation before issues become more significant.

Closing Position

As at October 2026, the Committee's Strategic Risk Register comprises three strategic risks and three associated sub-risks. Two risks are within the Board's approved risk appetite, while SRR 010 remains outside appetite.

The evidence presented indicates a positive direction of travel for SRR 005 and SRR 010, supported by targeted improvement activity, strengthened controls and established oversight arrangements. However, further evidence of sustained impact is required, particularly in relation to patient flow outcomes and the remaining health, safety and fire compliance gaps.

On balance, the Committee may take reasonable assurance that the strategic risks within its delegated remit are being actively managed, with appropriate arrangements in place for monitoring and escalation.



Argymhelliad / Recommendation

The Committee is asked to:

- **NOTE** the current position and direction of travel of the strategic risks within its delegated remit;
- **CONSIDER** whether the controls, actions and assurances provide reasonable assurance that the risks are being effectively managed;
- **SEEK ASSURANCE** that risks above appetite are subject to active treatment, enhanced oversight and appropriate escalation; and
- **NOTE** how the ongoing evaluation of the Quality Management System and refresh of the Quality Plan will strengthen quality intelligence and support the earlier identification and management of risk.

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 Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	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 Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. N/A

Risk Information			IMTP Link	Underpinning Corporate Risks	IMTP Performance Measures	Appetite Threshold for Risk	Current Score	Target Score	Assurance the Risk is being Managed Effectively
SRR 005 A Chief Operating Officer	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system**	**a) Due to inadequate arrangements to support system-wide patient flow**	**System Change:** Urgent & Emergency Care **Enablers:** Quality, Workforce, Digital	**CRR 011, 013, 014 015, 036, 037**	• Reduction in one-hour ambulance handovers to 500 and 12-hour waits to 750; • improvement in four-hour performance to 80%; • reduction in delayed pathways to 160.	**17**	**16**	**9**	**Reasonable**
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**	**Enablers:** Quality & Workforce & Culture	**CRR 002, 019, 030**	• 100% of live Civica areas collecting and using feedback; • improved response and early-resolution rates; • improved 30-working-day concerns compliance; • increased completion of feedback actions.	**17**	**8**	**4**	**Positive**
SRR 010 Director of Allied Health Professions and Health Science	**There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974**	**a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.**	**Enablers:** Quality & Workforce & Culture	**CRR 002, 006, 025, 038**	• Reduction in RIDDOR incidents and overdue actions; • 85% manual-handling training compliance; • increased completion of risk assessments.	**8**	**12**	**6**	**Reasonable**

Assurance Rating	Criteria
Positive	Multiple sources of evidence demonstrate the control is consistently effective. Independent assurance supports the conclusion.
Reasonable	Evidence demonstrates the control is generally effective, although some gaps or weaknesses exist.
Limited	Some evidence exists, but it is incomplete, inconsistent or does not fully demonstrate effectiveness.
No Assurance	Little or no evidence exists that the control is effective.