Patient Quality, Safety & Outcomes Committee

Tue 02 December 2025, 13:30 - 16:30

Microsoft Teams

Agenda

1. PRELIMINARY MATTERS

PQSOC 20251202 Agenda - Approved.pdf (2 pages)

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Draft Minutes of the last Meeting held on Wednesday 1st October 2025

Attached *Chair*

PQSOC 20251202 1.4 PQSOC 20251001 Minutes.pdf (17 pages)

1.5. Committee Action Log

Attached *Chair*

PQSOC 20251202 1.5 Committee Action Log.pdf (5 pages)

2. ITEMS FOR DISCUSSION

2.1. Quality Outcomes Report

Attached *Director of Nursing*

PQSOC 20251202 2.1 Quality Outcomes Report .pdf (5 pages)
PQSOC 20251202 2.1 Quality Outcomes Report - Appendix 1 Quality Outcomes Framework - Q2 2025.pdf (97 pages)

2.2. Quality Management Group Report

Attached *Director of Nursing*

PQSOC 20251202 2.2 Quality Management Group Report .pdf (3 pages)

2.3. Nurse Staffing Levels (Wales) Act 2016

Attached *Director of Nursing*

PQSOC 20251202 2.3 Nurse Staffing Level (Wales) Act .pdf (14 pages)
PQSOC 20251202 2.3 Nurse Staffing Levels (Wales) Act - Appendix 1 Board Annual Presentation .pdf (19 pages)
PQSOC 20251202 2.3 Nurse Staffing Levels (Wales) Act - Appendix 2 - Summary of Nurse Staffing Levels November 2025 ABUHB.pdf (8 pages)
PQSOC 20251202 2.3 Nurse Staffing Levels Act - Appendix 2 - Summary of Nurse Staffing Levels November 2025 ABUHB.pdf (4 pages)

PQSOC 20251202 2.3 Nurse Staffing Levels Act - Appendix 2 - Summary of Nurse Staffing Levels November 2025 ABUHB.pdf (9 pages)

2.4. Update on Neonatal Service Improvements

Attached *Director of Nursing*

PQSOC 20251202 2.4 Update on Neonatal Service Improvements .pdf (4 pages)
PQSOC 20251202 2.4 Update on Neonatal Service Improvements - Appendix 1.pdf (7 pages)

2.5. Year 3 Quality Strategy Implementation Plan

Attached *Director of Nursing*

PQSOC 20251202 2.5 Year 3 Quality Strategy Implementation Plan.pdf (5 pages)
PQSOC 20251202 2.5 Year 3 Quality Strategy Implementation Plan - Appendix 1 Quality Strategy - Year Three Implementation Plan 2025-26.pdf (15 pages)

2.6. Update on Safeguarding Level 3 Training

Attached *Director of Nursing*

PQSOC 20251202 2.6 Update on Safeguarding Level 3 Training .pdf (7 pages)

2.7. Mortuary Incident Action Plan

Attached *Chief Operating Officer*

PQSOC 20251202 2.7 Mortuary Incident Action Plan .pdf (7 pages)
PQSOC 20251202 2.7 Mortuary Incident Action Plan - Appendix 1 - Mortuary transformation plan.pdf (7 pages)

2.8. Committee Risk Report

Attached *Director of Corporate Governance*

PQSOC 20251202 2.8 Committee Risk Report.pdf (6 pages)
PQSOC 20251202 2.8 Committee Risk Report - Appendix A Strategic Risk Assessments.pdf (7 pages)
PQSOC 20251202 2.8 Committee Risk Report - Appendix B QPS Governance Structure for Risk Reporting.pdf (1 pages)

2.9. Ophthalmology Audit Wales Report

Attached *Director of Nursing*

PQSOC 20251202 2.9 Ophthalmology Audit Wales Report - ABUHB Eye Care Review Report.pdf (32 pages)
PQSOC 20251202 2.9 Ophthalmology Audit Wales Report - Appendix 1 Ophthalmology Presentation.pdf (8 pages)

3. FOR INFORMATION

3.1. Review of Committee Programme of Business 2025/26

Attached *Director of Corporate Governance*

PQSOC 20251202 3.1 Review of Committee Forward Work Plan 2025-26 Report.pdf (4 pages)
PQSOC 20251202 3.1 Review of Committee Forward Work Plan 2025-26 - Appendix 1 Forward Work Plan 2025-2026.pdf (8 pages)

4. OTHER MATTERS

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

Oral *Chair*

4.2. Any Other Urgent Business

Oral *Chair*

4.3. Date of the Next Meeting: 17th February 2026

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

PATIENT QUALITY, SAFETY & OUTCOMES COMMITTEE AGENDA	
Date and Time	**Tuesday 2nd December 2025 at 13:30AM-16:30PM**
Venue	**Microsoft Teams**

Item	Title	Format	Presenter
1	**PRELIMINARY MATTERS**		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on Wednesday 1st October 2025	Attached	Chair
1.5	Committee Action Log	Attached	Chair
2	**ITEMS FOR DISCUSSION**		
2.1	Quality Outcomes Report	Attached	Director of Nursing
2.2	Quality Management Group Report	Attached	Director of Nursing
2.3	Nurse Staffing Levels (Wales) Act 2016	Attached	Director of Nursing
2.4	Update on Neonatal Service Improvements	Attached	Director of Nursing
2.5	Year 3 Quality Strategy Implementation Plan	Attached	Director of Nursing
2.6	Update on Safeguarding Level 3 Training	Attached	Director of Nursing
2.7	Mortuary Incident Action Plan	Attached	Chief Operating Officer
2.8	Committee Risk Report	Attached	Director of Corporate Governance
2.9	Ophthalmology Audit Wales Report	Attached	Director of Nursing

3	**FOR INFORMATION**		
3.1	Review of Committee Programme of Business 2025/26	Attached	Director of Corporate Governance
4	**OTHER MATTERS**		
4.1	Items to be Brought to the Attention of the Board and Other Committees	Oral	Chair
4.2	Any Other Urgent Business	Oral	Chair
4.3	Date of the Next Meeting: • 17th February 2026		

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

MINUTES OF THE PATIENT QUALITY, SAFETY AND OUTCOMES COMMITTEE MEETING

DATE OF MEETING	Wednesday 1st October 2025, 09:30am-13:30pm
VENUE	Microsoft Teams

PRESENT	Helen Sweetland, Chair Penny Jones, Vice Chair Paul Deneen, Independent Member Vivek Goel, Independent Member (until 10.45)
IN ATTENDANCE	Nicola Prygodzicz, Chief Executive Jennifer Winslade, Director of Nursing Andy Bagwell, Interim Medical Director Peter Carr, Director of Allied Health Professions & Health Science (Item 2.8 only) Leanne Watkins, Chief Operating Officer (Item 2.4 only) Rachel Prangley, Head of Primary Care (Item 2.4 only) Rani Dash, Director of Corporate Governance Leeanne Lewis, Assistant Director of Quality & Patient Safety Collette Kiernan, Deputy Director of Allied Health Professions and Health Science Tracey Partridge-Wilson, Deputy Director of Nursing (Item 2.5 only) Kelly Downes, Deputy Director of Nursing (Item 2.6 & 2.7) Lucy Windsor, Head of Corporate Risk & Assurance (Item 2.10 only) Naomi Murtagh, Board Business Manager Fern Woodhead, Committee Secretariat
OBSVERING	Thokozani Owino, Aspiring Independent Member
APOLOGIES	Philip Robson, ABUHB Vice Chair

PQSOC 0110/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
PQSOC 0110/02	**Apologies for Absence** The Chair confirmed that there were apologies for absence from Philip Robson.
PQSOC 0110/03	**Declarations of Interest**

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	There were no declarations of interest raised relating to items on the agenda.
PQSOC 0110/04	**Minutes of the previous meeting** The minutes of the Patient Quality, Safety and Outcomes Committee held on 3rd June 2025 were agreed as a true and accurate record of the meeting. The Committee **APPROVED** the draft minutes.
PQSOC 0110/05	**Committee Action Log** The Committee received the action log and was content with progress made in relation to completed actions and against any outstanding actions. The Committee **APPROVED** the action log.
PQSOC 0110/06	**Quality Outcomes Reporting** Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the interim performance report for July 2025, which outlined the quality and safety metrics aligned with Ministerial priorities and the Health Board's strategic objectives. Following the launch of the Quality Strategy, Patient Experience & Involvement Strategy, and the Quality Improvement Strategy, the Health Board had continued to refine its approach to quality metrics. These measures were being developed iteratively to ensure they reflected what matters most to patients, their families, and the wider public. The Committee was advised that the report highlighted notable improvements in patient experience, safety, and clinical effectiveness. However, it also identified areas of ongoing risk and opportunities for further action. A more refined approach to the six quality pillars had been adopted and would be reflected in the Quarter 2 reporting framework. To support this work, a Quality Management Group had been established to oversee risk management and ensure alignment with national directives. The Committee was informed of a recent Sepsis Listening Event, which was well received and provided valuable insights from patients who shared their experiences. The Committee expressed appreciation to those who contributed.

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In relation to nutrition and hydration; the Nutrition and Hydration Steering Group was actively working to enhance monitoring and learning, particularly within Mental Health services.

The CIVICA programme continued to demonstrate high satisfaction rates and improved response rates. The team were working with data and digital colleagues to produce an updated Quality and Safety Dashboard that would align with the new Quality Outcomes Framework. It was reported that there was increased involvement of the divisional QPS teams who are reporting now to their dashboards. Emerging themes were incorporated into learning events across divisions so that there were insights from different services. The new systems with the Quality Management Group could help to strengthen governance and monitoring mechanisms.

The Committee also noted a recent site visit from Health and Safety Executive (HSE) representatives at Hafen Deg, which was described as positive, with formal feedback from this visit still awaited. The Committee agreed the written report would be shared with the Committee for information once received. **Action: Director of Nursing**.

The Committee received an update on two divisions that were subject to enhanced monitoring:

- The Mental Health and Learning Disability Division, with significant work underway to strengthen quality and patient safety systems within these divisions. This included improvements in safeguarding practices, targeted staff development, and thematic analysis of incidents such as ligatures and deliberate self-harm. The Division was actively participating in national patient safety programmes, and while progress was being made, some systems were still embedding; and
- Urgent and Emergency Care Division which had improved its handover targets, resulting in positive progress. The Health Board was participating in national reviews and anticipated further learning and reporting at both organisational and national levels. Improvements in patient flow and discharge processes were highlighted, although concerns remained regarding the practice of boarding patients. The Committee was informed that all boarding spaces had been thoroughly reviewed, with changes made where necessary to ensure patient safety, privacy, and dignity.

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	The Committee was advised that the quality and safety programme for maternity and neonatal services had improvement plans in place for both areas, with ongoing work to improve integration between the teams. Key priorities included addressing staffing and sickness especially in neonatal team, enhancing pharmacy and medicines management, and maintaining a strong focus on infection prevention and control. A listening exercise for neonatal services had taken place, with a similar event planned for maternity. There had been no increase in serious incidents reported, and feedback from families remained positive. The Committee agreed for a further update, including the results of the neonatal culture review and outcomes from the listening events, to be provided at the December meeting. **Action: Director of Nursing** Penny Jones (PJ), Independent Member, asked for clarification on the place of 'boarding' for patients and the problems with confidentiality and maintaining the dignity of patients. It was reported that the situation was constantly monitored by senior nursing staff to ensure that boarding is only used as necessary and appropriately. Vivek Goel (VG), Independent Member, asked about the variable staffing to cope with boarding patients. It was explained that currently this was dealt with on an adhoc / risk-based basis, as it was hoped that the boarding situation would improve with time, but the situation was monitored twice a day by senior nursing staff. JW commented on some of the data in the report and the Committee was advised that the safeguarding training position remained positive, with strong compliance for Level 1 and Level 2 training. However, ongoing work was required to improve uptake of Level 3 training, which was mandated for all staff with a clinical contact. The complexity of Level 3 training delivery was noted, as it requires a multi-professional, face-to-face element and cannot be completed solely online. The Committee was informed that 120 anaesthetists were scheduled to complete both Level 2 and Level 3 training within the current month, supporting the Health Board's commitment to safeguarding standards. The Committee acknowledged the positive progress made and the continued efforts to ensure all relevant staff were appropriately trained, recognising that further work was needed to achieve full compliance.

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	Paul Deneen (PD), Independent Member, asked about why the GP programme on Domestic abuse had been discontinued and JW informed the Committee that this had been a risk-based decision and that the safe-guarding team were working with primary and community care on alternative support, alongside some national work in this area. Helen Sweetland (HS),Chair, asked about the increase in Medication Errors which had occurred recently. The Acting Medical Director reported that this was an important area of work and the roll out of EPMA–electronic prescribing and medicines administration would help with some problems. PJ commended the work on the ward accreditation scheme and the positive benefits for quality, safety and team morale. The Committee noted that there was an ongoing review following the Organisational Change programme in 2024 and that the PALS scheme was also being evaluated against the business case. The Committee would requested further information on the outcomes of these reviews**. Action: Director of Nursing** The Committee **NOTED** the report and the ongoing work that is being done to deliver the Duty of Quality and Duty of Candour.
PQSOC 0110/07	**Quality Annual Report 2024/25** Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Quality Annual Report for 2024/25, which outlined the Health Board's achievements, challenges, and strategic direction in relation to quality, safety, and patient experience. The report reflected the organisation's commitment to continuous improvement and transparency in delivering high-quality care across all services. Helen Sweetland (HS), Committee Chair, acknowledged the extensive work undertaken by teams across the Health Board to achieve the improvements, progress the work streams for 24/25 and compile the detailed report. The Committee noted that the document aligned with the six pillars of quality, patient experience, safety, and clinical effectiveness and demonstrated progress to deliver the Duty of Quality. The Committee discussed the importance of ensuring the report was accessible and meaningful to a wide audience, including patients, families, staff, and external

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	stakeholders. The Committee emphasised the need for clear language, visual summaries, and patient stories to enhance engagement and understanding. The Committee welcomed the inclusion of patient feedback and case studies, which illustrated the impact of service improvements. It was agreed that further work would be done to embed patient voice throughout the report, including contributions from Llais and other advocacy groups. The Committee noted the value of showcasing learning from incidents, audits, and service evaluations. The report included examples of how feedback had led to tangible changes in practice, particularly in areas such as nutrition and hydration, mental health services, and urgent care pathways. The Committee noted the improvements to the governance arrangements underpinning quality reporting, including the role of the Quality Management Group and the integration of quality metrics into performance dashboards. It emphasised that risks were being actively monitored and addressed. The Committee commended the report's comprehensive scope and the collaborative effort involved in its production and provided feedback on formatting, clarity, and content, which would be incorporated into the final version. The committee noted the priorities for 25/26 and JW explained that an action plan will be produced for presentation at the next meeting. **Action: Director of Nursing** The Committee **NOTED** the progress of work over the past 12 months as reflected in the Annual Quality Report and supported the submission to Welsh Government.
PQSOC 0110/08	**Quality Management Group Reporting** Jennifer Winslade (JW), Director of Nursing, provided the Committee with an update on the activities and progress of the Quality Management Group (QMG), which had been established to oversee the Health Board's approach to managing quality-related risks and aligning with national directives. The Committee noted the QMG had a central role in supporting the development and implementation of the Quality Management System (QMS), ensuring that quality goals were embedded across services and that performance was monitored and reported effectively.

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	During the meeting, it was noted that the QMG had been instrumental in refining the Health Board's quality pillars patient experience, safety, and clinical effectiveness and in developing a more structured framework for reporting. The framework was expected to be introduced in Quarter 2 and would support more consistent and meaningful measurement of quality outcomes. The Committee was advised that the QMG had facilitated several learning events, particularly within Mental Health services, to strengthen monitoring and enhance quality and safety practices. A review of ligature incidents had identified a training / competency issue and the quality of clinical record keeping which were being addressed. The committee noted the HIW IR(ME)R inspection in March 25 with an overall positive report but some immediate actions completed. The committee was also assured that the HTA Annual report for 24/25 had demonstrated progress in meeting the standards, following serious incidents in the previous reporting year. The Committee noted the report on a visit from Healthcare Inspectorate Wales (HIW) representatives to Pillmawr and Adferiad wards in May. Positive comments were received related to compassionate care in both wards. Areas of concern related to environment, safety, workforce, training and governance. An action plan is in place and is being worked through but risks remain until complete. The QMG would be responsible for reviewing the feedback and coordinating any required actions. The final report to be presented to the committee. **Action: Director of Nursing** The Committee welcomed the report and acknowledged the importance of the QMG in driving forward the Health Board's quality agenda and expressed support for the continued development of the QMS and the integration of learning across services. The Committee **NOTED** the report.
PQSOC 0110/09	**Primary Care Quality Report** Leanne Watkins (LW), Chief Operating Officer, provided the Committee with an overview of the 2024/25 Annual Quality Report for Primary Care. The report provided assurance on the commissioning arrangements and quality oversight across General Dental Services, General Medical Services, Welsh General Optometry Services, and Community Pharmacy.

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The Committee noted the complexity of the services delivered through independent contractors and the Health Board's role in ensuring robust monitoring and governance, highlighting that all commissioning arrangements were compliant with relevant regulations and supported by structured management processes.

The discussion included the reform of dental and ophthalmic contracts, with the Committee noting the challenges posed by independent contractor status and the need for consistent quality assurance across all service areas. The school dental programme and waiting times were identified as areas requiring further attention, particularly in light of ongoing access issues and service demand.

The Committee welcomed the role of the Primary and Community Care Academy in supporting the development of multi-professional teams and enhancing workforce capability. The Committee acknowledged the importance of the initiative in safeguarding the future delivery of primary care services.

The report addressed quality and patient safety, with reference to concerns, Freedom of Information requests, and Health Inspectorate Wales engagement. The Committee noted the inclusion of governance mechanisms such as mid-year and end-of-year reviews, contract variations, and the Quality Assurance System.

During the discussion, the Committee raised questions about the impact of contract reforms, the integration of quality outcomes into service delivery, and the challenges of maintaining standards across diverse provider settings. The Committee was informed that these issues were being actively managed and monitored.

Independent members were concerned about how General Medical Services were monitored for quality assurance and information was provided on the annual contract review process and the Access standards and quality improvement framework. The team reported that they have regular contacts with practices by monthly monitoring of data and quarterly meetings, providing support if there were any concerns.

The Committee expressed appreciation for the comprehensive nature of the report and the collaborative effort involved in its production. The Committee

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	emphasised the importance of continued engagement with contractors and stakeholders to drive improvement. The Committee **NOTED** the 2024/25 Annual Primary Care Quality Report and support the submission of it.
PQSOC 0110/10	**Putting Things Right Annual Report 2024/25** Tracey Partridge-Wilson (TPW), Deputy Director of Nursing, provided the Committee with an overview of the Putting Things Right (PTR) Annual Report for 2024/25. TPW advised that the report provided a comprehensive outline of the Health Board's approach to concerns management, patient experience, legal claims, and organisational learning, underpinned by the principles of openness, honesty, and person-centred care. The Committee was advised that the PTR regulations and the NHS Duty of Candour came into effect on 1 April 2023. These frameworks had been embedded into everyday practice, supporting a culture of transparency and continuous improvement. The Health Board had taken proactive steps to prepare for the revised PTR regulations currently under consultation, ensuring readiness through collaboration with external partners and internal teams. The Committee noted the key achievements that included the implementation of streamlined quality assurance processes to support earlier resolution of concerns and a more consistent approach to investigations. The introduction of an Acknowledgement Team was noted as a significant development, aimed at understanding what mattered most to individuals raising concerns and ensuring timely, meaningful engagement. The Committee was informed that there were over 11 million patient contacts per year and only 0.027% of those lead to a complaint / incident. The Committee was informed that the Health Board had managed a total of 3,190 cases during the reporting period, including 1,518 under PTR, 1,656 through early resolution, and 16 reopened cases. Each case was supported by a Divisional Learning from Events Report, which captured key issues and actions taken to prevent future harm. The Committee welcomed the emphasis on the person-centred approach and the improvements in documentation, investigation quality, and accessibility for service users.

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	The report identified three priorities for ongoing work in 25/26, in anticipation of revised PTR regulations in 2026. The Committee acknowledged the importance of continued engagement with service users and families, recognising their role in shaping safer, more responsive services. The report was commended for its clarity, depth, and alignment with strategic priorities. The Committee **NOTED** the Putting Things Right Annual Report 2024/25 and the three key priorities for 25/26.
PQSOC 0110/11	**Safeguarding Annual Report** Kelly Downes (KD), Deputy Director of Nursing, provided the Committee with an overview of the Safeguarding Annual Report for 2024/25, advising the report outlined the safeguarding activity across the Health Board, including governance arrangements, referral trends, training compliance, and strategic developments. The Committee was advised that there had been an increase in safeguarding referrals during the reporting period, particularly in cases involving neglect and physical harm. This rise had led to a greater number of strategy meetings and multi-agency interventions, reflecting both increased awareness and complexity of safeguarding needs across the region. Challenges were highlighted to the Committee in relation to Level 3 safeguarding training for both children and adults. The large cohort of staff requiring this training had posed logistical difficulties, and the Health Board was working with ESR to integrate the training into the system. Once resolved, the Corporate Safeguarding Team would support the identification and alignment of staff to ensure compliance. The Committee was advised that the report also outlined the governance structures supporting safeguarding, including the Safeguarding Group and its links to the Quality Management Group. The Committee was informed that safeguarding risks were actively monitored and escalated appropriately, with divisional engagement, embedding of supervision and safeguard training, ensuring consistent practices which all contribute to continuous improvement. The Committee discussed the importance of embedding safeguarding principles into everyday practice and

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	ensuring that staff feel supported when managing complex cases. The Committee also reflected on the previous request to include a section in the report outlining support provided to staff, which was addressed in this year's submission. The Committee commended the report for its clarity and depth, acknowledging the efforts of the safeguarding team in responding to increasing demand and maintaining robust governance. The Committee expressed support for the priorities for 25/26, including ongoing work to improve training compliance and strengthen multi-agency collaboration with local authorities and police partners. Following further discussion regarding issues related to level 3 training it was agreed that an update would be brought to the committee. **Action: Director of Nursing** The Committee **NOTED** the Safeguarding Report for 2024-2025.
PQSOC 0110/12	**Nurse Staffing Levels Wales Act 2016: Spring 2025 Recalculations** Kelly Downes (KD), Deputy Director of Nursing, provided the Committee with an overview of the Spring 2025 recalculations report under the Nurse Staffing Levels (Wales) Act 2016 (NSLWA). The report provided assurance on the Health Board's compliance with Section 25B of the Act, which mandates bi-annual recalculations of nurse staffing levels across adult acute medical, surgical, and paediatric wards. The recalculations were informed by the January 2024 acuity audit and conducted through a triangulated approach, as stipulated in the statutory guidance. This involved detailed discussions held throughout March and April 2025 with representation from divisional nursing leads, ward managers, the Nurse Staffing Act Programme Lead, e-rostering and finance teams. The process examined ward type, bed base, funded establishment, e-roster housekeeping, and Safe care compliance. The Committee was advised that there had been a successful rollout of safe care across all Section 25B wards, enabling access to 6 months of acuity data rather than the previous one month snapshot. This enhanced the robustness of the recalculations and supported more informed decision-making. The Committee was informed that the quality indicators from the previous 6 months were scrutinised, including

	hospital-acquired pressure ulcers, patient falls with harm, medication errors, infection rates, and complaints involving nursing care. Staffing deployment, including bank and agency usage and variable pay, were also reviewed. The Committee was advised that the Executive Team had been appraised of the recalculation outcomes and supported the amendments made to the nurse staffing establishments. These changes had a clear governance process in place to inform the Board and Welsh Government. The Committee acknowledged the importance of maintaining appropriate nurse staffing levels to ensure safe, effective, and compassionate care. The Committee commended the comprehensive nature of the recalculations and the collaborative effort across divisions. The Committee **NOTED** the report and **AGREED** to the findings of the Spring 2025 recalculations, as approved at the Executive, subject to continued monitoring and reporting.
PQSOC 0110/13	**Health and Safety Compliance Annual Report** Peter Carr (PC), Director of Allied Health Professions & Health Science, provided the Committee with an overview of the Health and Safety Compliance Annual Report for 2024/25. The report provided assurance on the Health Board's compliance with statutory health, safety, and fire obligations, and outlined key achievements, challenges, and strategic priorities for the coming year. The Committee was advised there had been several improvements in compliance, notably, RIDDOR reporting increased from 67.7% in 2023/24 to 69.8% in 2024/25. It was noted that it should be 100% so considerable work is being done to address this, by improving staff training. Statutory and mandatory training compliance had also improved, particularly in Manual Handling and Violence Prevention & Reduction. It was noted that the team were now taking a risk-based approach to manual handling training so that people engage with appropriate training for their roles. A comprehensive programme of workplace inspections was completed across acute hospitals, community hospitals, and mental health and learning disability sites, yielding an average compliance score of 89.63%. Actions arising from

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the inspections are closely monitored to ensure completion.

The Committee was informed that 226 additional employees had been trained in undertaking Health and Safety Risk Assessments during the reporting period. Fire Risk Assessments were completed or reviewed for 100% of the planned areas, representing a 4% increase compared with the previous year. Capital investment was secured to upgrade fire alarm systems at Royal Gwent Hospital and St Cadoc's Hospital, with a planned replacement programme now in place. The condition of fire barriers was also assessed, identifying improvement needs at Nevill Hall Hospital and Royal Gwent Hospital.

The Committee was informed of the increase in reported H&S incidents, probably related to better reporting, but there has been an increase in needle stick injuries so an improvement project initiated by infection control team.

The Committee was advised of 2 risk areas for 2025/26:

1. **Health and Safety Leadership** – A lack of understanding of health and safety responsibilities among managers and supervisors posed a significant risk to the Health Board.
2. **Health and Safety Assistance** – Limited resources within the Corporate Health and Safety Department could impact the Health Board's ability to meet legislative requirements, such as fire safety, RIDDOR reporting, risk assessments, policy updates and training.

The Committee acknowledged the importance of embedding health and safety principles into operational practice and ensuring that all staff are adequately supported and trained.

Paul Deneen (PD), Independent member, asked about the apparent increase in incidents of violence and aggression towards staff. PC provided further information on the data and the actions that are being taken to support staff who are involved in physical assaults. It was noted that microaggressions and verbal abuse are also areas of concern. PC reported that a strategy for violence prevention and reduction will be presented to People and Culture Committee in the future.

The Committee commended the report's clarity and depth, and endorsed the strategic direction outlined for 2025/26. The Committee emphasised the need for continued

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	investment in infrastructure and workforce development to sustain compliance and improve safety outcomes as Health and Safety was still an area of high risk. The Committee **NOTED** the Health and Safety Compliance Annual Report 2024/25 and **ENDORSED** its findings, subject to ongoing monitoring and future updates.
PQSOC 0110/14	**Learning from Death Report** Leeanne Lewis (LL), Assistant Director of Quality & Patient Safety, provided the Committee with an overview of the Learning from Deaths Report for the period July 2024 to March 2025. The report provided assurance that the Health Board continued to strengthen its approach to learning from patient deaths, embedding a culture of continuous improvement, transparency, and accountability. The Committee was advised that the report outlined the implementation of the Learning from Deaths Framework across all Divisions, supporting a robust ward-to-board assurance process. The framework enabled systematic reporting and oversight of mortality data, triangulating condition-specific trends with insights from the Medical Examiner service. The Committee noted that structured mortality reviews were being undertaken, although currently limited to the corporate team due to constraints with external software, which restricted the identification of mortality outliers. The framework supported the stratification of mortality data into 3 tiers, the Health Board, Division, and Directorate allowing for targeted analysis and learning. The Committee noted that the framework also integrates findings from national clinical audits, mortality and morbidity reviews, medical examiner reports and inquests, ensuring that learning was evidence based and aligned with governance expectations. The Committee acknowledged the challenges in conducting comprehensive mortality reviews and supported the continuation of the clinical coding improvement programme to enhance the reliability of RAMI (Risk Adjusted Mortality Index) data. The Committee emphasised the importance of ensuring that learning from deaths translated into measurable actions that improve patient safety and quality of care. Penny Jones (PD), (Independent Member,) asked about deaths related to mental health issues and it was noted the ongoing work to collate and review unexpected deaths

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	in MHLD division and that the reporting of stillbirth, neonatal and maternal deaths follow a robust internal process and was reported to MBRRACE. The Committee was informed that deep dives were also undertaken if an area of concern was noted by RAMI data. Paul Deneen (PD),Independent Member asked for further information on reported delays on issuing death certificates. (LL) reported that the CMO had asked the team to report on the KPIs related to the length of time for issuing death certificates and there was an ongoing improvement plan working with the mortuary and the Care after Death team. Helen Sweetland (HS), Independent Member, asked for assurance on how the team ensured that lessons were learnt from deaths, especially if unexpected. LL reported that directorates hold regular morbidity and mortality meetings to discuss cases and learn from them. Lessons learnt are also disseminated through newsletters and divisional QPS meetings. The Committee **NOTED** the Learning from Deaths Report and **ENDORSED** the ongoing work to embed the framework and strengthen governance arrangements.
PQSOC 0110/15	**Committee Risk Report** Lucy Windsor (LW), Head of Corporate Risk & Assurance, provided the Committee with an overview of the Committee Risk Report, which outlined strategic risks delegated to the Committee for monitoring on behalf of the Board. The Committee was advised that there had been no changes to the strategic risk scores since the last report in July 2025. The Committee continued to oversee 3 principal risks and 8 sub-risks, all of which remained within the agreed review timeframes. The control environment for each risk was assessed as robust, with assurances tested to ensure effectiveness. The Committee acknowledged the summary of the urgent and emergency care risk, noting that while the report was generally positive, a few findings and recommendations had emerged. These would inform further controls and be incorporated into the next round of risk reporting. The Committee was advised that future reports would begin to include high-level operational corporate risks to

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	ensure the Committee were fully sighted on emerging issues across the organisation. The Committee noted that a new Health and Safety Group had been established alongside the existing Health and Safety Committee. This group included representatives from operational departments and aimed to improve compliance through enhanced risk assessments, RIDDOR reporting, and targeted improvement initiatives. The Committee agreed that an update on Health and Safety Executive (HSE) investigations, including the open investigation related to a fall in 2019 and other cases of interest, would be brought to a future committee meeting. This was to ensure the Committee remained well-briefed on ongoing HSE matters and any implications for the organisation. **Action: Director of AHPS and Health Science** The Committee discussed the importance of divisional engagement in risk management and welcomed the steps being taken to strengthen governance structures. The Committee expressed support for the inclusion of operational risks in future reports and emphasised the need for continued assurance around control effectiveness and risk mitigation. The Committee **NOTED** the Committee Risk Report and **ENDORSED** the proposed developments in reporting and governance.
PQSOC 0110/18	**Review of Committee Programme of Business 2025/26** Review of Committee Programme of Business 2025/26 was provided to the Committee for information.
PQSOC 0110/19	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** To be noted that a Violence Prevention and Reduction Strategy to be presented to the People and Culture Committee in 2026. **Action: Committee Secretariat/ Director of Allied Health Professions & Health Science**
PQSOC 0110/20	**Any Other Urgent Business** There was no urgent business.

PQSOC 0110/21	**Date of the Next Meeting:** 2nd December 2025

DRAFT

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

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
October 2025	**PQSOC 0110/06**	**Quality Outcomes Reporting** The HSE written report would be shared with the Committee for information once received.	**Director of AHPs and Health Science**	December 2025	**Completed** <u>October Update</u> HSE Report has been included in the Committee forward work plan. <u>November Update</u> HSE Report has been included on December agenda under item 2.1.
October 2025	**PQSOC 0110/06**	**Quality Outcomes Reporting** A further update on maternity and neonatal services , including the results of the neonatal culture review and outcomes from the listening	**Director of Nursing**	December 2025	**Completed** <u>October Update</u> Update on Maternity and Neonatal Services has been included in the Committee forward work plan.

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		events, would be provided at the December meeting.			November Update Update on Maternity and Neonatal Services has been included on December's agenda under item 2.4.
October 2025	**PQSOC 0110/06**	**Quality Outcomes Reporting** Further information on the outcomes of the PALS scheme and Organisational Change programme reviews.	**Director of Nursing**	December 2025	**Completed** October Update Action has been included in the Committee forward work plan and will be reported at February's meeting.
October 2025	**PQSOC 0110/07**	**Quality Annual Report 2024/25** The priorities for 25/26 action log would be shared with the	**Director of Nursing**	December 2025	**Completed** October Update

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		Committee at the next meeting.			Action has been included in the Committee forward work plan. November Update Year 3 Quality Strategy Implementation Plan has been included on December's agenda under item 2.5.
October 205	**PQSOC 0110/08**	**Quality Management Group Reporting** The Healthcare Inspectorate Wales final report for Pillmawr and Adferiad wards to be shared with the Committee at the next meeting.	**Director of Nursing**	December 2025	**Completed** October Update Action has been included in the Committee forward work plan. November Update HIW final report has been included in December's agenda under item 2.2
	PQSOC 0110/11	**Safeguarding Annual Report**	**Director of Nursing**	December 2025	**Completed** October Update

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		Following further discussion regarding issues related to level 3 training it was agreed that an update would be brought to the committee.			Action has been included in the Committee forward work plan. <u>November Update</u> Update on Safeguarding Level 3 training has been included on December's agenda under item 2.6.
October 2025	**PQSOC 0110/15**	**Committee Risk Report** An update on Health and Safety Executive (HSE) investigations, including the open investigation related to a fall in 2019 and other cases of interest, would be brought to a future committee meeting.	**Director of AHPs and Health Science**	December 2025	**Completed** <u>October Update</u> Update on HSE has been included in the Committee forward work plan. <u>November Update</u> Included under the performance report under pillar 4 for Decembers meeting.
October 2025	**PQSOC 0110/19**	**To confirm any key risks and issues for reporting/escalation to**	**Committee Secretariat/**	February 2026	**Completed** <u>October update</u>

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
Transferred to PCC		**Board and/or other Committees** Violence Prevention and Reduction Strategy to be presented to the People and Culture Committee in 2026.	**Director of AHPs & Health Science**		Action has been included in the People & Culture Committee forward work plan.

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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	02 December 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality Outcomes Framework (QOF) for Q2 2025/26
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis – Assistant Director for Quality and Patient Safety Tracey Partridge Wilson - Deputy Director of Nursing

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

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

Cefndir / Background

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

The QOF for Q2 2025/26 provides a comprehensive review of quality, safety, and patient experience across Aneurin Bevan University Health Board. It aligns with Ministerial priorities and the Duty of Quality, incorporating both quantitative metrics and qualitative learning. The report is structured around six revised pillars of quality. The QOF aims to drive continuous improvement, regulatory compliance, and assurance to the Board and Executive Committee.

Asesiad / Assessment

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

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

- Patient and staff experience and stories, complaints, concerns and compliments
- Patient Safety
- Clinical Effectiveness
- Health, safety and security
- Infection Control and Prevention
- Safeguarding

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

Areas of Improvement

- Civica digital solution implemented with 87% satisfaction (above 85% benchmark), supported by 19,658 survey responses YTD. Positive themes: compassion, emotional and physical support, communication. Negative themes: waiting times and facilities.
- PALS service handles ~481 enquiries/month (1,393 in Q2), >50% related to communication. Case studies highlight timely, compassionate support.
- Increased compliance with 30-day PTR target, addressing divisions below all-Wales average. Early resolution performance improving and compliments also increased.
- Mortality - the Health Board has seen improvement in the Risk Adjusted Mortality Indicator (RAMI). RAMI for Q2 is 86 (improved from Q1). Mortality rates remain below peer average. Crude mortality 15% lower than previous years. The Health Board is currently performing 2nd of 6 within its All-Wales Peer Group.

- Incidents triggering Duty of Candour have reduced as training and awareness improved.
- There have been no new Never Events reported for Q2.
- Falls per 1000 Operational Bed Days have continued to fall below national average.
- Pressure ulcers - majority are category 2; focused reviews underway to categorise avoid ability.
- RIDDOR reporting compliance improved to 81.8% in Q2. Health and safety training compliance at 87.1%; manual handling and fire safety below target, with recovery plans in place. Physical assault remains the highest cause, but has reduced in Q2. Needle/sharps incidents increased; thematic review planned.
- Child safeguarding activity remains high and rising. Adult referrals dropped significantly in Q2, likely due to improved staff awareness.
- National and local implementation of sepsis screening tools and education, with strong engagement and public awareness campaigns. Implementation undertaken of Early Warning Scores (NEWS2, PEWS, NEWTT2). "Big Conversation: Sepsis" event informed strategy refresh.
- The Health Board continues to support a number of nationally recognised quality improvement projects which are significantly improving patient safety and patient experience. The Safe Care Partnership has a number of workstreams, this includes, projects within acute deterioration, deconditioning and improving quality management systems.

Areas of Focus:

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

- PTR compliance below the all-Wales average (61.29% in July), with improvement efforts focused on the Medicine Division. There is a piece of work looking at trajectories to meet to improve the timeliness with PTR regulation.
- Primary care antibiotic use reduced by 6.6% (target: 10% by 2029/30). Secondary care use increased YoY but is improving. Infection rates for C.Difficile have risen over the last 12 months, which is a picture seen across Wales. The reasons for this are complex with rates impacted by community prevalence, the number of people with complex co-morbidities, anti-microbial prescribing and poly pharmacy as well as a need to refresh basic good IPC practice. An improvement plan has been produced and is being enacted.
- There is continued focus on improving uptake of Level 1, Level 2 and Level 3 Safeguarding training.
- The Health Board continues to focus on targeted campaigns (e.g., sepsis, antimicrobial stewardship, patient experience).

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

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

Argymhelliad/ Recommendation

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

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

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	The Health and Social Care (Quality and Engagement) Wales Act (2020)). Duty of Quality.
Rhestr Termau:	

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

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

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 2 - 2025/26

PERSON CENTRED

SAFE

TIMELY

EFFECTIVE

EFFICIENT

EQUITABLE

The Quality Outcomes Framework

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

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

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

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

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

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

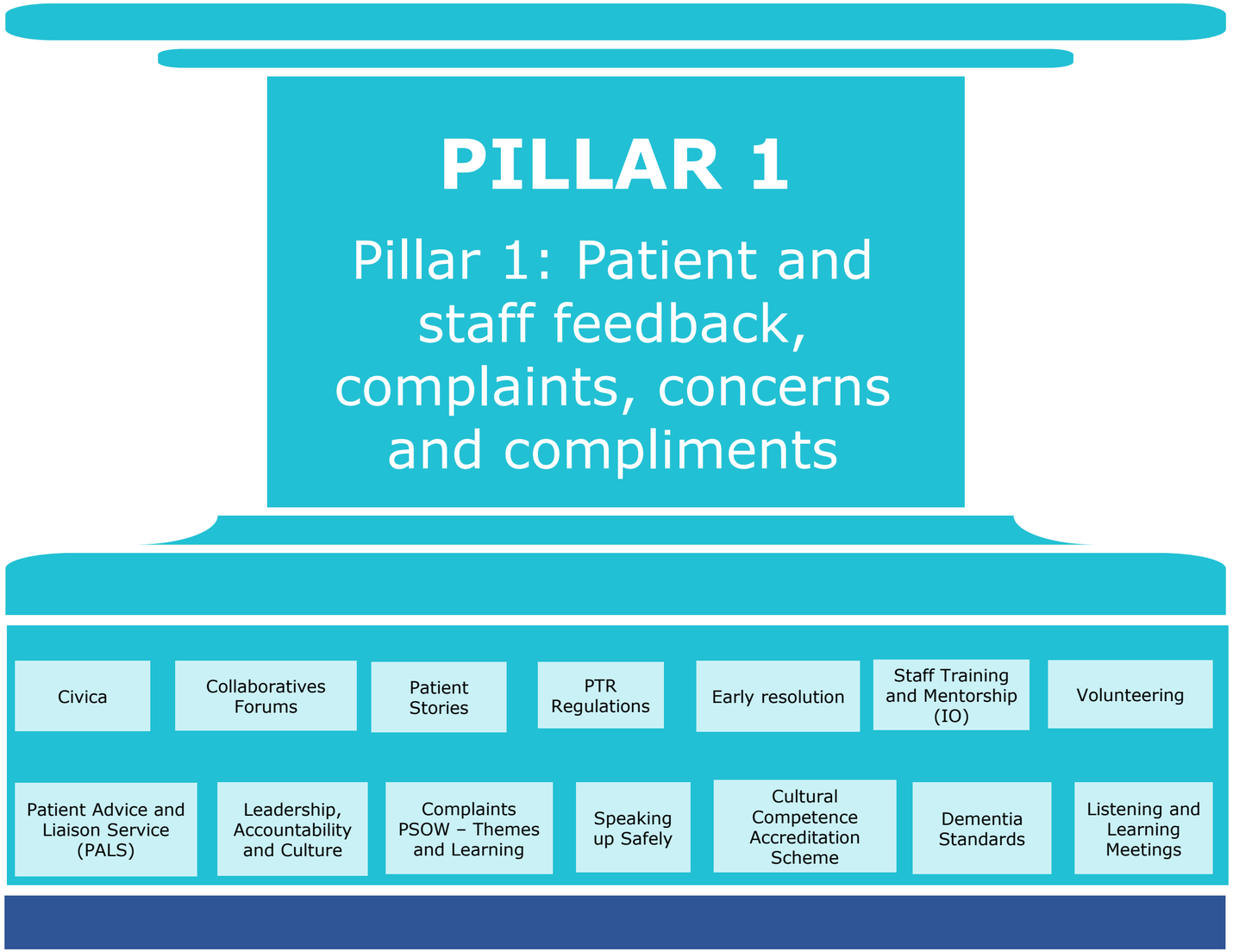
- Improved patient outcomes and safety
- Enhanced patient experience and satisfaction
- Increased adherence to evidence-based practices
- Efficient resource utilisation
- Regulatory compliance
- Improved staff engagement and professional development
- Accountability and transparency in care delivery

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

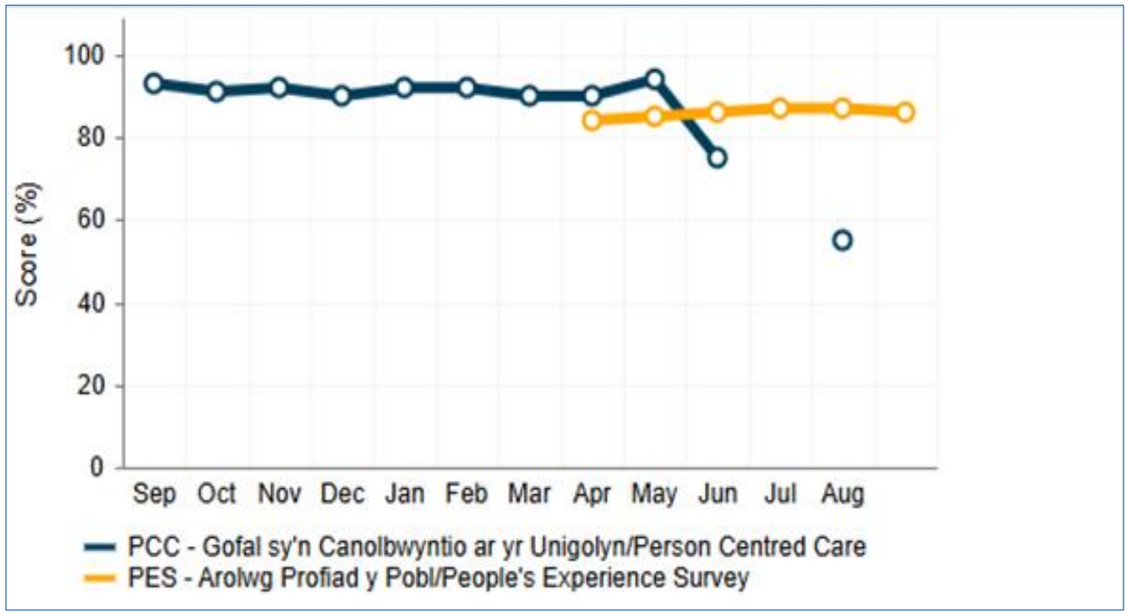
Pillar 1: Patient and staff feedback, complaints, concerns and compliments



CIVICA Patient Experience Feedback

Responses to Patient Experience Questionnaire

Satisfaction Score Trend

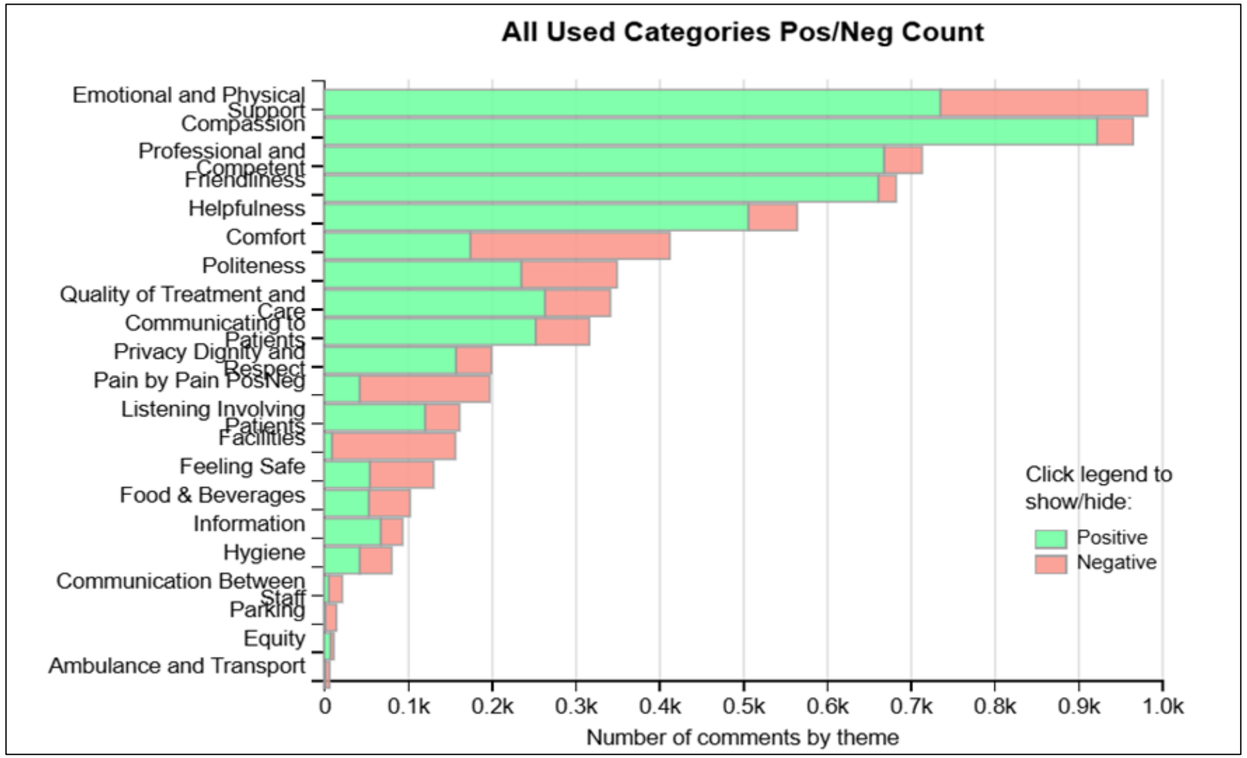


All Surveys		Person Centred Care (PCC) & People's Experience (PES)		ED - ED Survey & PES Combined		Maternity & Neonates (Launched Sept)		Total YTD (2025/26)	
19658 responses	**87%** satisfaction	**17360** Responses	**87%** Satisfaction	**4027** Responses	**74%** satisfaction	**166** Responses	**86%** satisfaction	**13804** Responses	**86%** satisfaction

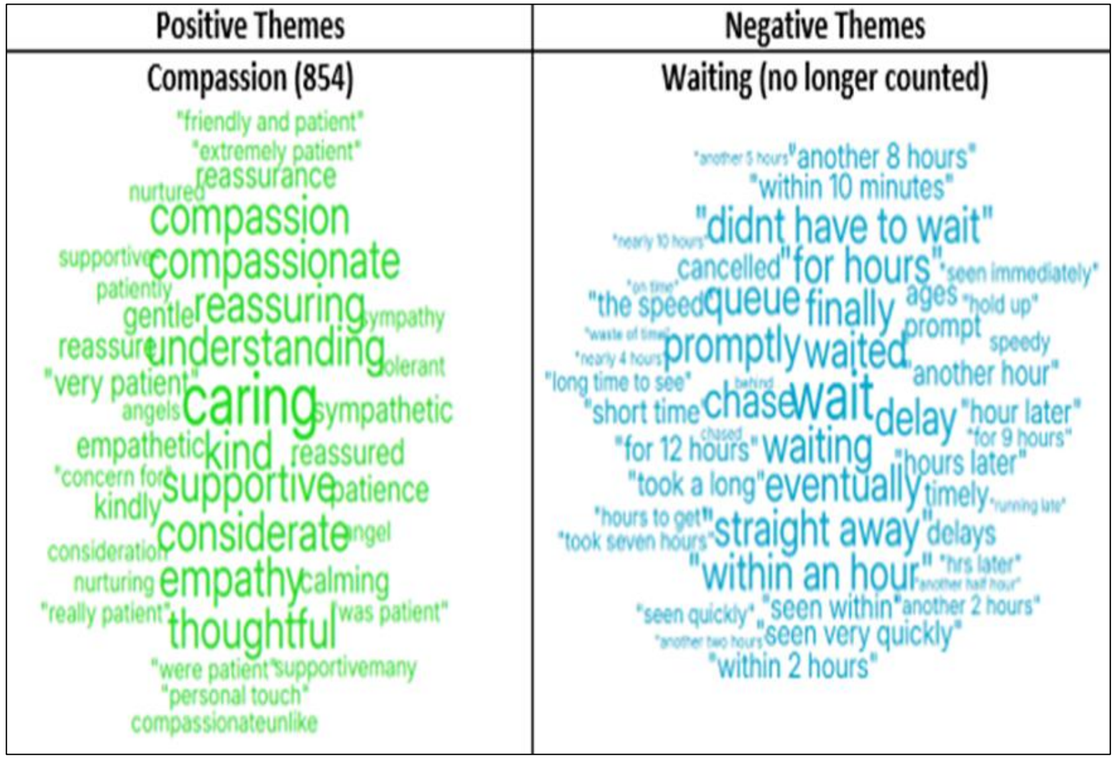
Definition	Analysis	Implications
All data displayed has been extracted from CIVICA and is correct at the point of extraction on 06 October 2025. Surveys that were already sent (paper and text message) may be completed later giving the impression of data changing.	Over the previous year the number of responses to CIVICA Patient Experience surveys has increased dramatically, 7478 responses for Q2, with July 2025 the highest month to date with total feedback responses now being 2596. Satisfaction Score is 87% for Q2 (all surveys) compared to 86% for Q1. There is also no movement in top three themes for Q2 compared to Q1. The question 'Was the time you waited' remains the lowest scored question each month for Q2, with a further decline in September.	Health Visiting survey relaunched including 5 core questions. The core questions are two questions on language, the two open questions on 'what was good' and 'what was bad', and a question regarding overall experience. Five core questions are still to be copied to Endoscopy Survey, however there is work across Wales on a National Endoscopy Survey. All Wales Maternity and Neonate Surveys launched in September via CIVICA SMS. With 166 responses for August and September.

CIVICA Patient Experience Feedback

Themes and emotion analysis of comments



Positive and Negative Themes Q2 2025/26



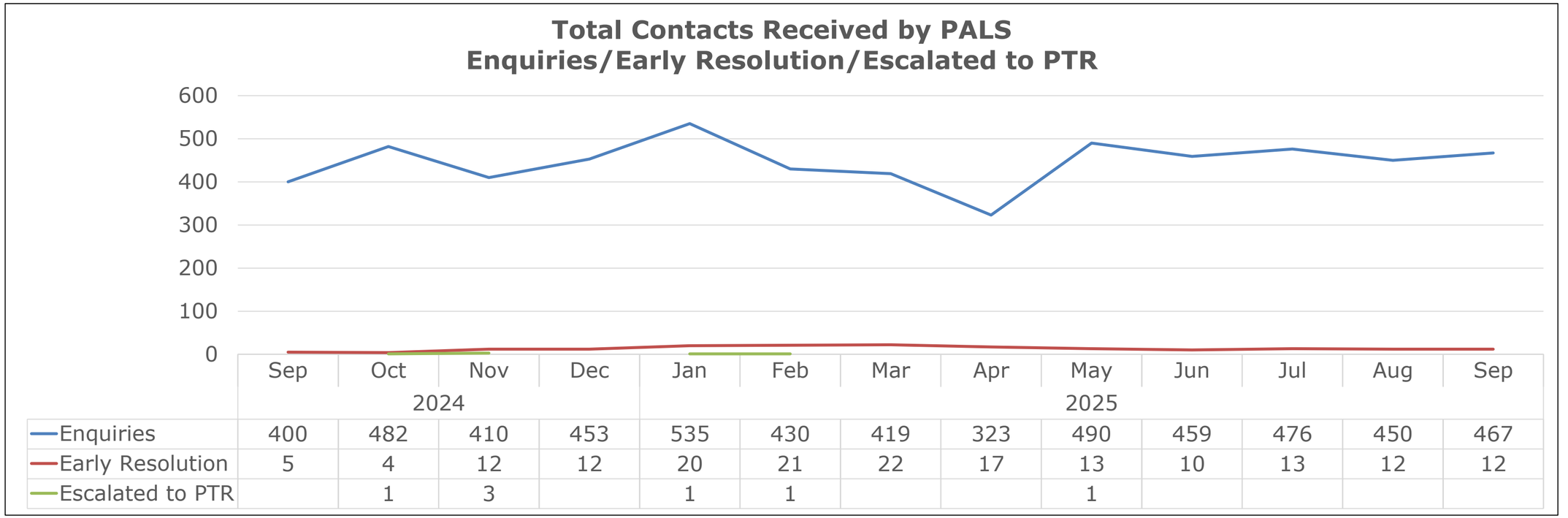
Learning and Improvement from CIVICA data:

Themes celebrated are compassion, emotional support, and communication, while concerns around waiting times and facilities are escalated for action to operational teams. Monthly heatmaps and tailored divisional reports ensure feedback is localised, visible, and actionable. In Q1, key issues were addressed such as neurodiversity, bereavement support for the Deaf community, pregnancy loss, and veteran support. Actions included creating resources and participation panels for neurodiverse individuals, improving accessibility to bereavement services (including British Sign Language resources), and establishing dedicated support and involvement opportunities for veterans and bereaved parents. These initiatives have led to more inclusive, compassionate, and responsive care, with lived experience increasingly shaping service improvements.

In Q2, there was a focus around sepsis, accessibility, and cultural awareness. Efforts included a major sepsis awareness campaign, appointing a project manager to improve accessibility for Deaf people, and collaborating with faith leaders to ensure culturally sensitive end-of-life care. Patient stories and national surveys were used to inform learning and drive change. Examples include:

- Grace's Place bereavement cafés established in all five boroughs, creating safe spaces for peer-led support and community connection.
- People Participation Panel launched to ensure Deaf voices shape services and accessibility improvements.
- Managers Guide to Neurodiversity produced, informed by patient and staff feedback, promoting understanding and inclusive practices.
- Posters introduced in ED and MAU encouraging patients to inform staff of additional needs, directly responding to patient feedback.

Patient Advice & Liaison Service (PALS)



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	2024				2025								
Enquiries	400	482	410	453	535	430	419	323	490	459	476	450	467
Early Resolution	5	4	12	12	20	21	22	17	13	10	13	12	12
Escalated to PTR		1	3		1	1			1				

Themes	Count
Communication Issues (including Language)	2715
Access (to Services)	1280
Appointments	191
Clinical treatment/Assessment	114
Patient Care	113
Post Death Issues	79
Discharge Issues	66
Admissions	29
Complaints Handling	27
Attitude and Behaviour	26

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

Analysis

The total number of contacts managed by the Patient Advice & Liaison Service has been consistent at around ~450 contacts per month with 1,393 contacts made in Q2, an increase on the 1,272 in Q1.

The themes across all PALS contacts remains consistent with over 50% related to communication issues (including language). The second most common theme is access to services, followed by appointments.

Within Early Resolutions managed by PALS the most frequent theme is communication, followed by clinical treatment/assessment and patient care.

Implications

- Roll out of the PALS bedside stickers has commenced across Health Board to enhance visibility and accessibility of support.
- PALS supporting with patients who are being cared for in corridors/boarding, ensuring needs are being met.
- Exploring avenues of support from PALS service for the Community Assessment Lounge.
- Pastoral support is provided to patients and families while formal complaints are being managed, ensuring compassionate communication throughout the process.
- Attendance at appointments to offer reassurance and advocacy where needed.

Patient Advice & Liaison Service (PALS)

Case Studies

Case Study 1:

Patient A contacted the PALS team to raise a complaint about her hospital admission and the upsetting loss of her personal belongings, including a nightgown. She had been transferred from Royal Gwent to The Grange and was visibly distressed and irate when she reached out. In response, the Patient Support Officer (PSO) on duty visited her in person. Simply having someone sit with her and listen attentively helped ease her frustration and made her feel heard.

Recognising the emotional impact of the missing items, the PSO worked with the Chaplaincy team to provide Patient A with a new nightgown and a toiletry bag. The gesture had a profound effect, she described it as feeling “like Christmas” and said she felt truly valued and cared for. Her mood lifted significantly, and she decided not to pursue a formal complaint.

Patient A continued to receive visits from the PALS team during her stay, which further strengthened her trust and comfort in the hospital environment. By the time of her discharge, she had gone from feeling overlooked to feeling supported and respected.

This case illustrates how empathy, timely support, and small acts of kindness can transform a patient’s experience and restore their faith in the care they receive.

Case Study 2:

Patient B was admitted to the Grange Emergency Department following a fall. The PALS Officer took the initial call for updates, met with the patient, and liaised with their husband. A few days later, the husband called again, upset that he couldn’t visit as often as he wished due to his visual impairment and reliance on lifts. Patient B was scheduled to be stepped down to Ysbyty Ystrad Fawr, which posed a significant travel challenge for the couple.

After discussions with the clinical teams and gaining consent from Patient B, PALS successfully advocated to remove Ysbyty Ystrad Fawr from the step-down list. As a compromise, the patient was transferred to Ysbyty Aneurin Bevan - still a distance, but a more manageable drive for the husband during daylight hours.

Throughout the stay at the Grange, the PALS Officer provided consistent emotional support, acted as a liaison between Patient B and their family, and ensured their voice was heard in care planning. Upon transfer, PALS coordinated with a colleague at the new site to continue visits, respecting Patient B’s preference not to receive support from volunteers.

This case highlights the vital role PALS plays in recovery, not only through advocacy, but by providing emotional stability and family connection throughout the care journey.

Case Study 3:

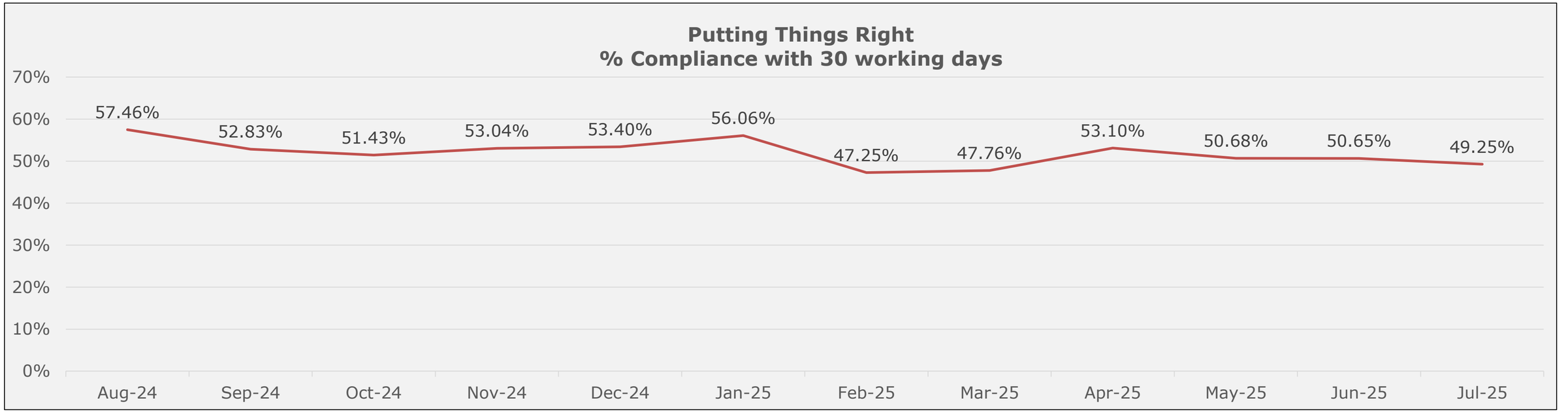
Patient C was under the care of the Gynaecology team but was admitted to the Respiratory Ward, which led to confusion and increasing frustration. She raised concerns with PALS about poor communication, delays in diagnosis, and repeated unsuccessful attempts to fit a coil to manage her pain.

The Ward Manager and Divisional Nursing Team were informed, and the Ward Manager visited the patient to discuss her concerns. The patient also shared her emotional distress, noting limited support from her family, her mother refused to visit, and her sons were uncomfortable discussing her condition, leaving her feeling isolated and tearful.

With the patient’s consent, PALS arranged volunteer support and committed to regular visits. The patient, who was confined to her room due to a catheter and iron infusions, appreciated the emotional support and advocacy provided. PALS facilitated a meeting with the Ward Manager and Gynaecology team, which helped clarify her treatment plan and ease her anxiety.

The patient expressed sincere gratitude for the ongoing support from PALS, which significantly improved her hospital experience. Following discharge, she remained thankful and reassured knowing PALS would be available should she need future support.

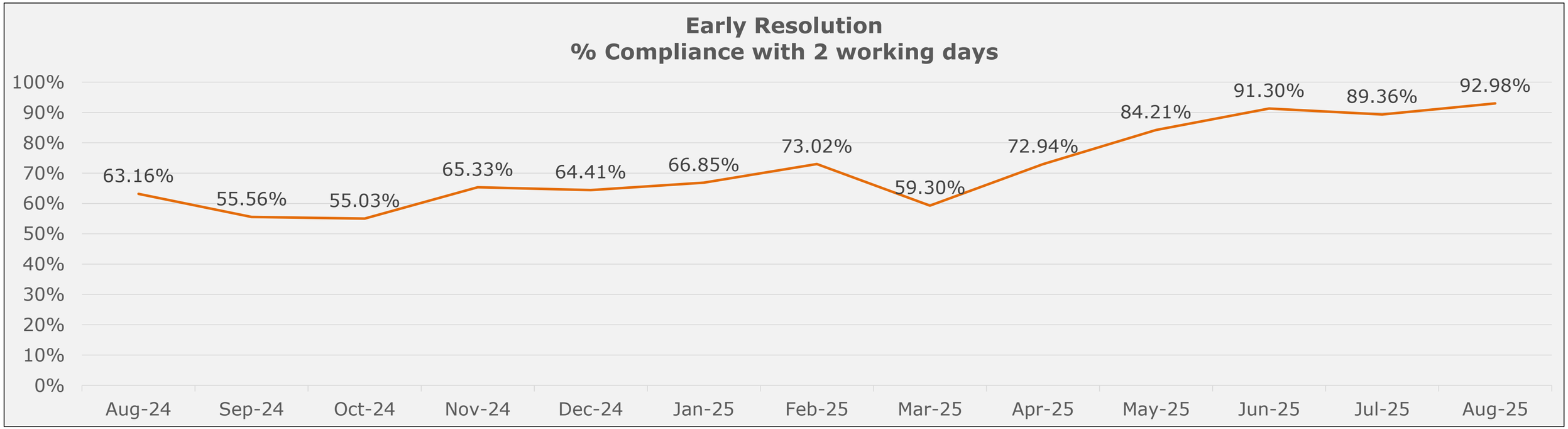
Putting Things Right
Compliance with 30-day Target



Definition	Analysis	Implications
The above represents the organisation's rolling position for compliance with the WG target of responding to concerns managed under *Putting Things Right* (PTR) (formal). Reporting is now aligned with NHS Executive Beacon Dashboard, therefore % Compliance is being reported against the month received. This data is obtained from the Once 4 Wales RL datix system, which is populated by the Health Board's corporate PTR team. The data is live and is an ever-evolving picture the information stated is accurate as of 07/10/2025.	It has remained relatively stable but continues to fall short of the required standard. Achieving 75% compliance remains a key priority and core performance target for the Quality and Patient Safety team. The trend for those matters closed under PTR has been relatively consistent across the reporting period, the organisation closed 108 formal complaints in August. The all-Wales average (Beacon Dashboard) for July was 61.29% completion within 30 working days, putting ABUHB 12.04% below the all-Wales average. The decrease in compliance in July was likely due to periods of annual leave across the organisation due to the summer break.	The Medicine Division have been the focus of the SMT from July - September. Working collaboratively with the Division to drive historic investigations through to finalisation. This has resulted in a significant decrease in open Medicine complaints. Focused weekly sessions continue with the SMT to monitor and escalate where required cases approaching compliance deadline to ensure those which can be achieved within timescale are being driven by the concerns support officers.

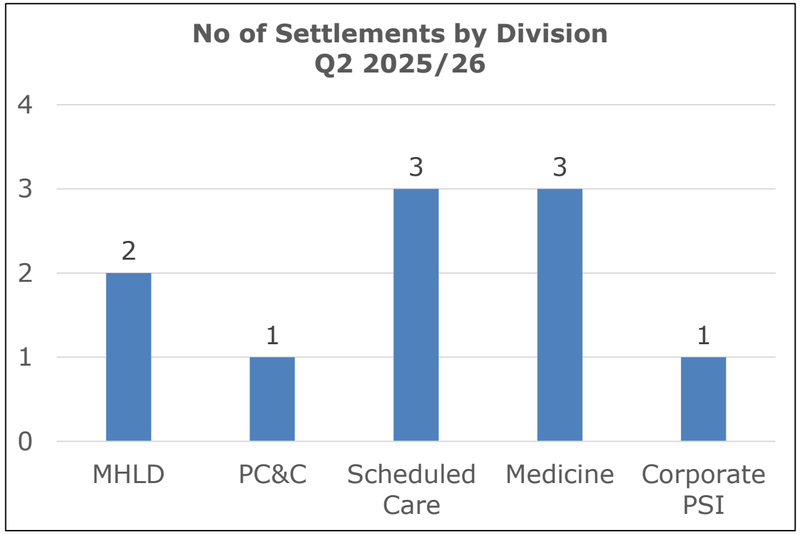
Early Resolution

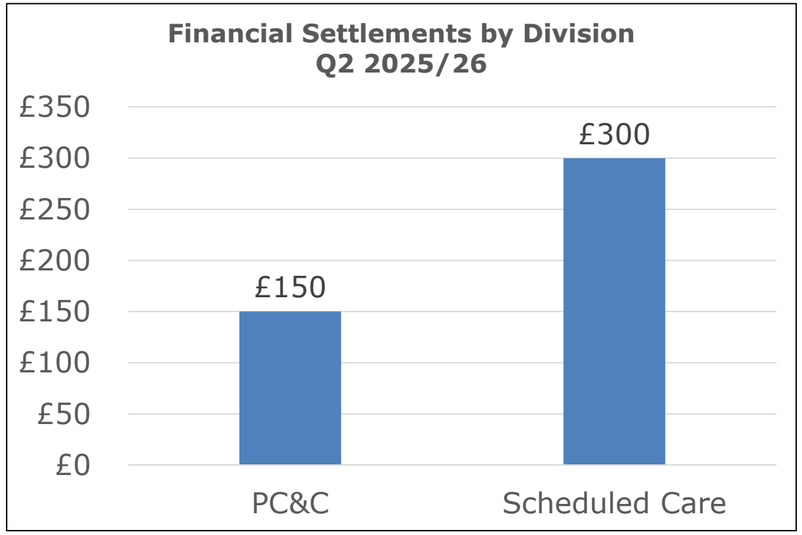
Compliance with 2-day Target

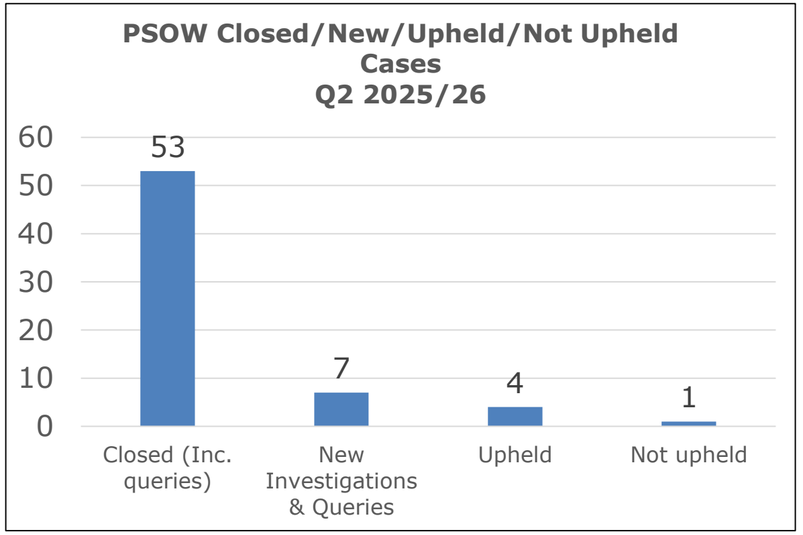


Definition	Analysis	Implications
This data is obtained from the Once 4 Wales RL Datix system, which is populated by the Health Board's corporate PTR team. The data is live and is an ever-evolving picture the information stated is accurate as of 01/10/2025.	Performance in Early Resolution (ER) has shown significant improvement compared to the previous year. There have been no re-opened cases since December 24, demonstrating the effectiveness of ongoing PTR training at the initial stage and thorough review processes at the final stage. The improved upward trend of Early Resolution compliance has continued to climb – achieving nearly 93% compliance with ER targets. Furthermore, complaints that are not resolved within 48 hours are converted to formal in accordance with PTR regulations.	Early Resolution response times are considerably faster than formal processes and resolve the issues raised by individuals through a more person-centred approach. Current timeframes do result in a number of matters being escalated formally. Which will impact the numbers able to be managed as Early Resolution pending adjustment to the Regulations in Spring 2026. The Concerns Managers continue to meet with the concerns support officers every week to review open Early Resolution matters and ensure that these are not drifting outside of compliance and are being managed swiftly and appropriately as evidence by the compliance figure for August 25.

Putting Things Right
Ombudsman (PSOW)







Learning and Completed Recommendations

Key Learning Points:

- Clear, timely nursing documentation is essential: There was inadequate nursing documentation following handover, with insufficient records relating to symptom monitoring and recording.
- Timely administration of medications: Delays in giving prescribed medications can impact patient outcomes. Nursing teams must be vigilant about administering all medications at the scheduled times.
- Anticipatory medications: It is crucial to provide these treatments in a timely manner to manage symptoms proactively and maintain patient comfort.

Recommendations:

- Remind nursing staff of their professional duty to maintain clear, comprehensive documentation according to guidance, and to adhere to planned schedule for medication administration
- Identify and address broader training needs around effective handover procedures and implementing clinician plans, supporting collaborative multi-professional care.

Actions:

An Educating and Recommendations After Significant Events (ERASE) poster has been widely distributed in the Urgent Care Department. The poster reminds staff of the following key points:

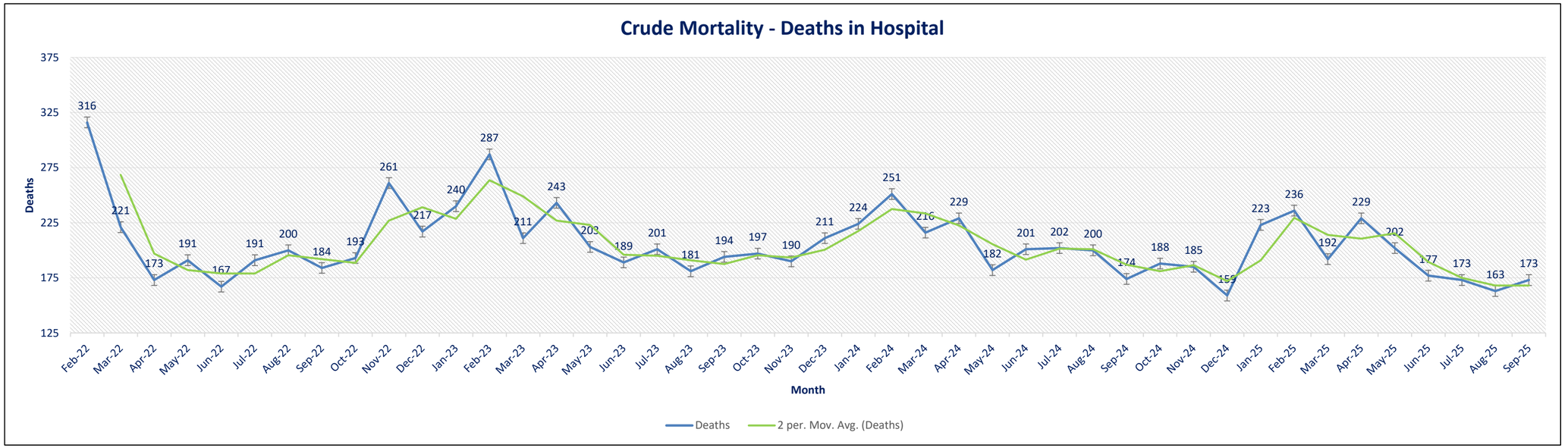
- All staff must follow the Nursing and Midwifery Council (NMC) guidelines by keeping patient records that are accurate, clear and up to date. This means all notes should be factual, easy to read, correctly dated and timed, and signed by the person making the entry.
- During staff handovers, it is important to clearly say which patients need regular checks, especially those who are receiving end of life care. Any special instructions given by the medical team should also be highlighted.
- For patients at the end of life, symptoms should be checked often using the Symptom Early Warning Score (SEWS). If symptoms change, staff must act quickly and appropriately.
- To improve patient care, the Emergency Department (ED) and Acute Medical Unit (AMU) are now working more closely together. AMU staff now help ED staff by administering syringe drivers when necessary.

PILLAR 2

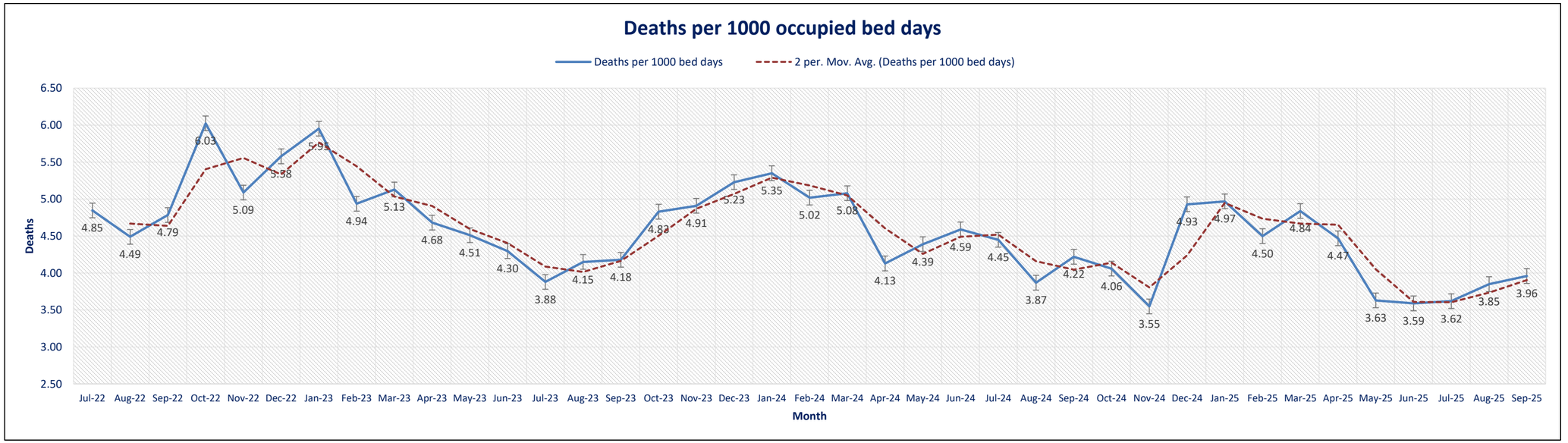
Patient Safety including Incident Reporting

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

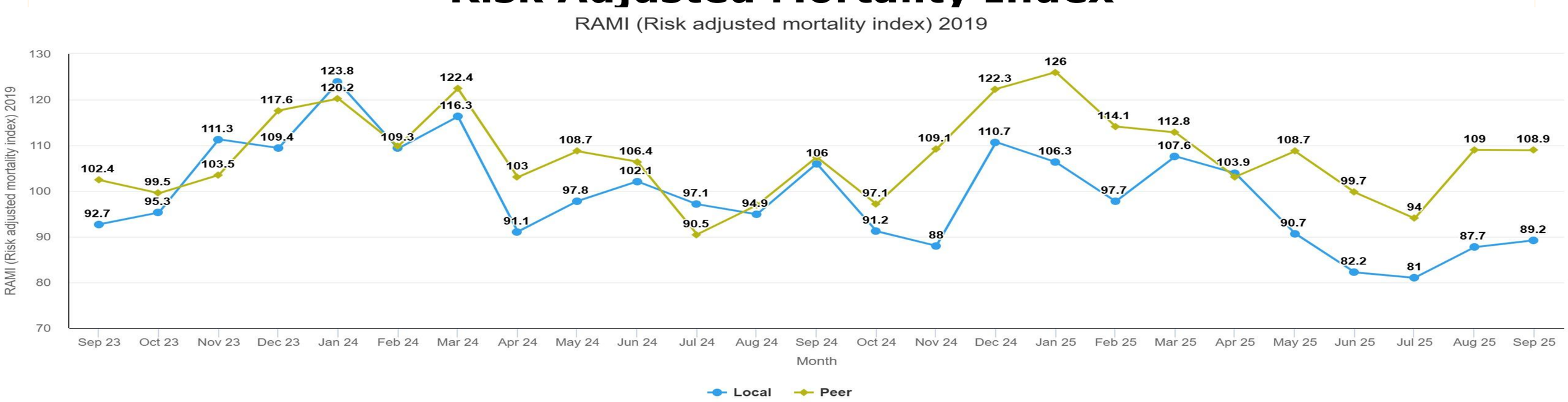


Crude mortality measures the number of deaths in a population over a specific period. It helps understand overall death rates in a community, region, or country by comparing current deaths to the average over the previous 4 years, identifying trends above or below this average. The data includes all-cause mortality and 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 2025 there has been an average 15% lower deaths recorded than previous years. The graph also shows the seasonal variation in the number of deaths, most notably consistent yearly spikes in December and January.

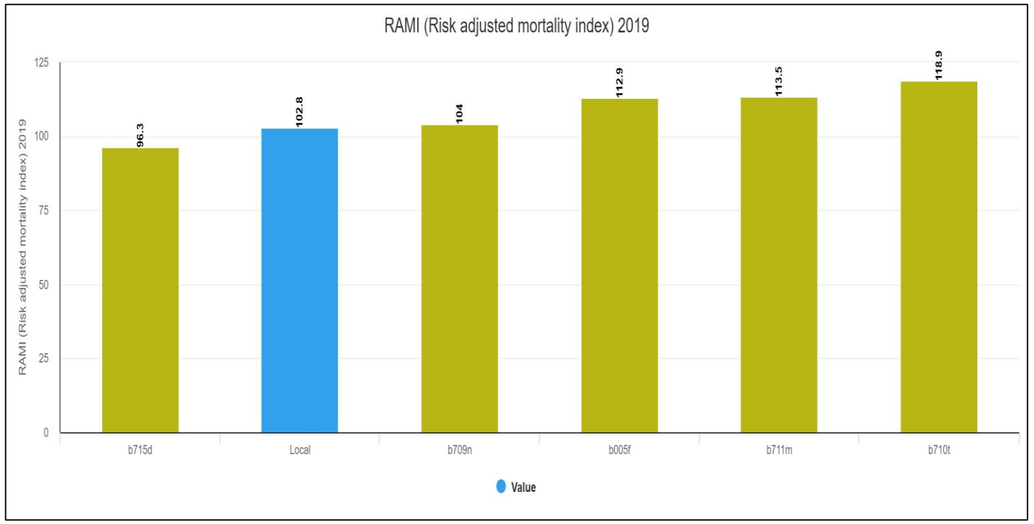
Risk Adjusted Mortality Index



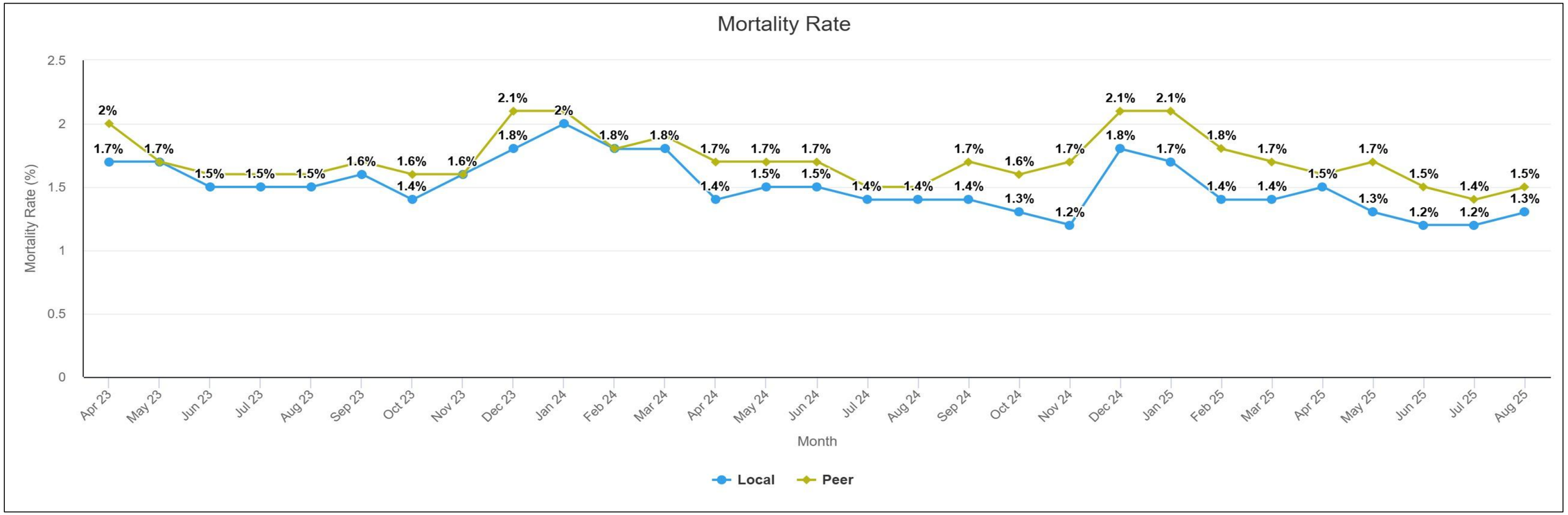
The Health Board's RAMI for Q2 is 86, lower than Q1, which was 92. RAMI adjusts for individual patient risk factors and co-morbidities, enabling meaningful comparison between organisations. RAMI has been consistently improving year on year from 2023 to date and is currently for year 2025 performing under the 100-benchmark suggesting that there are currently less observed deaths than expected.

The accuracy of RAMI is highly dependent on the completeness and precision of clinical coding, as well as timely updates to external systems used by the Health Board. There is a standard 6–8-week delay in clinical coding. This delay ensures sufficient time for coding completion and accuracy in RAMI calculations.

In September 2025, the Health Board ranked second among the six members of the All-Wales peer group.



Mortality Rate

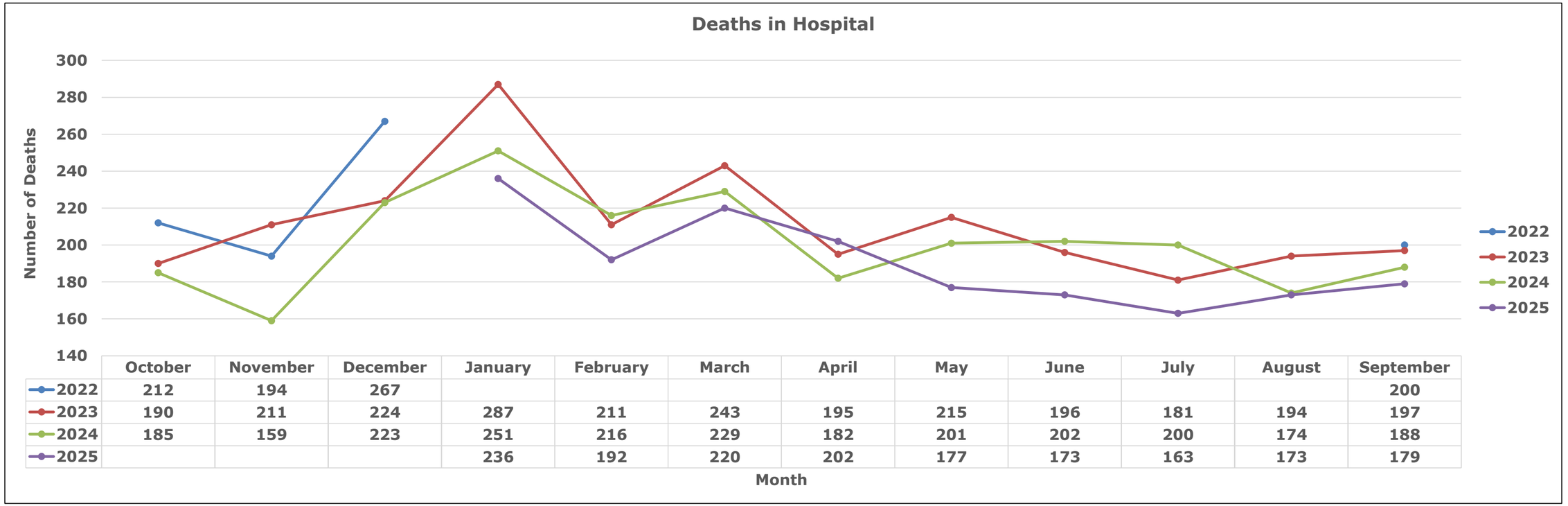


Definition	Analysis	Implications
The above graphs show the % of Hospital spells which end with the discharge method of death. At present latest data (Aug 2025) 1.3% of ABUHB Hospital spells end with the discharge method of death.	Mortality Rates have remained consistent and have been 1.5% or lower for 10/12 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 numerous 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 observed in the additional mortality indicators for reporting.

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 a Learning from Death report at PQSOC. This will continue to be reported every 6 months. This includes the development of Learning from Death Framework, triangulated with learning from the Medical Examiner service and the mortality review screening panel. Reviewing our end to end mortality process.	Medical Director's QPS team	On-going
Reliability of mortality data	Consistency of mortality reporting and data.	Mortality framework developed for reporting mortality indicators. This describes the approach: Tier 1 – Health Board level, Tier 2 – Divisional level and Tier 3 Directorate level. The QOF currently reports RAMI and crude mortality.	QPS Team and Information Manager	Ongoing
Clinical coding	The national target for clinical code is 95% coding completion one month post episode discharge. We are currently coding at 87% because of increasing activity.	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, DDT team and Information Manager	Ongoing
Mortality Data and Clinical Outcomes	Developing 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	On-going
	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. This will include processes e.g. for MHLD deaths and suicide.		
	Mortality indicators not available to all	Utilise the mortality indicators module in CHKS.		

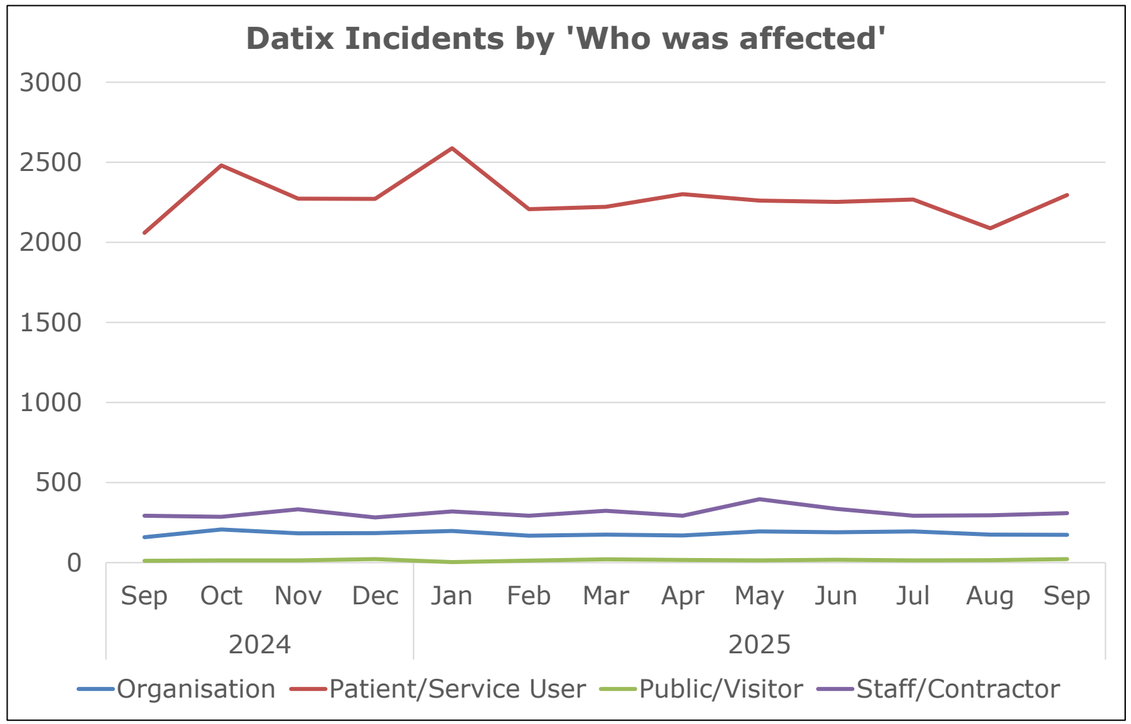
Deaths in Hospital

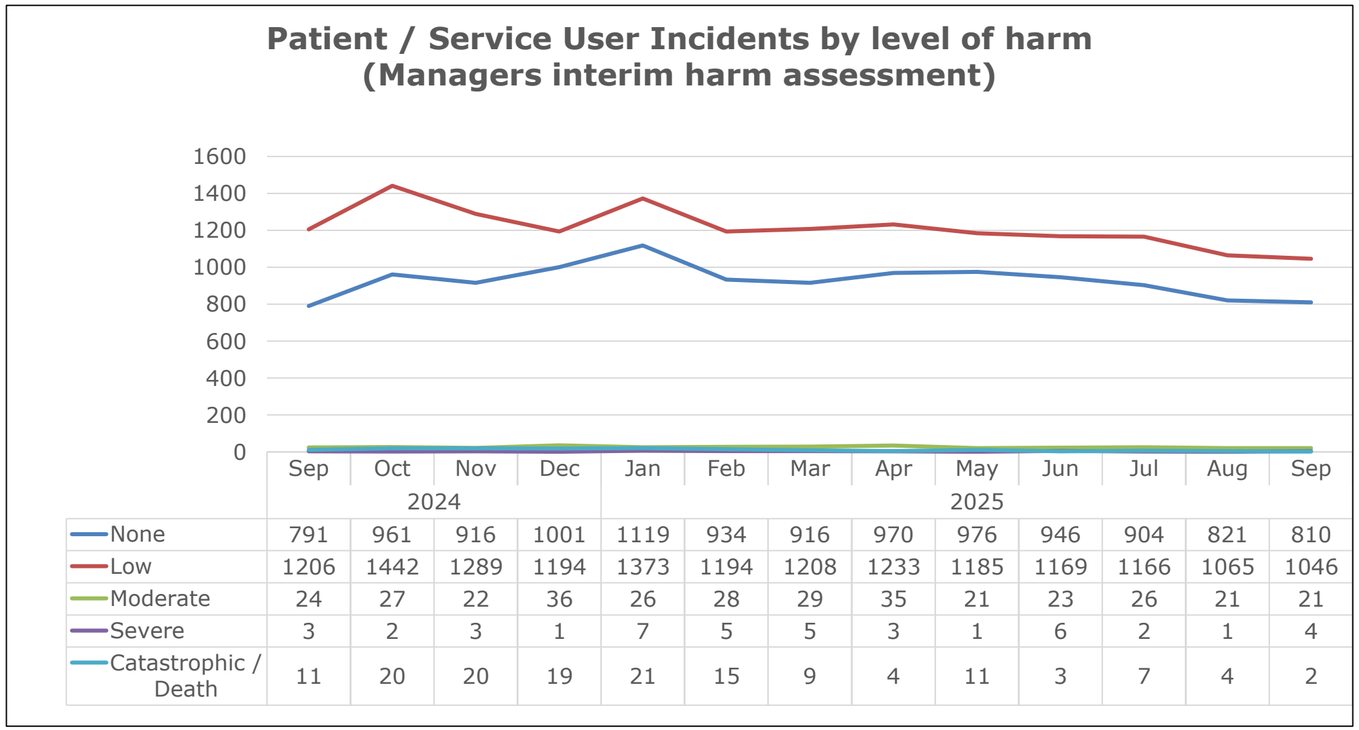


	October	November	December	January	February	March	April	May	June	July	August	September
2022	212	194	267									200
2023	190	211	224	287	211	243	195	215	196	181	194	197
2024	185	159	223	251	216	229	182	201	202	200	174	188
2025				236	192	220	202	177	173	163	173	179

Definition	Analysis	Implications
The chart illustrates the monthly number of hospital deaths from October 2022 to September 2025. Data for each year is overlaid to highlight year-on-year trends and seasonal variation.	All years show higher deaths in winter months (December–February) and lower counts in summer (June–August). Peak Month: 2022 peaked in December (267 deaths). 2023 had the highest peak in January (287 deaths), significantly above other years. 2024 peaked in January (251 deaths). 2025 peaked in December (236 deaths), but overall stayed lower than previous years.	2022 (Blue): Starts at 212 in October, rises sharply to 267 in December, then declines steadily to around 160–180 in summer. 2023 (Red): Shows the most volatility—starts lower than 2022 but spikes dramatically in January (287), then drops and stabilises around 190–215. 2024 (Green): Lowest early winter values (159 in November), then climbs to 251 in January, followed by a gradual decline. 2025 (Purple): Consistently lower than other years after February, reaching the lowest summer figure (163 in July). Winter Surge: Likely linked to seasonal illnesses (e.g., flu, respiratory infections). Improvement in 2025: Deaths are trending downward compared to previous years, especially from April onwards. Summer Stability: All years show reduced deaths mid-year, but 2025 has the lowest summer mortality.

Datix Incidents

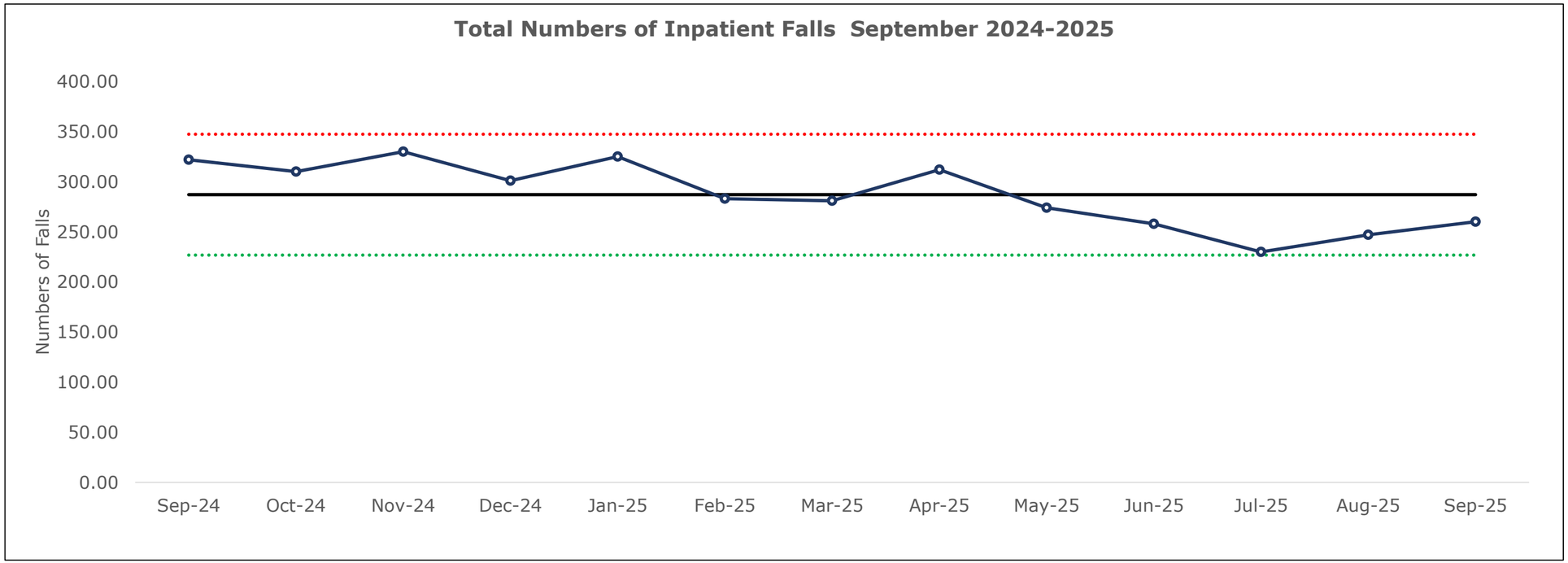




	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	2024				2025								
None	791	961	916	1001	1119	934	916	970	976	946	904	821	810
Low	1206	1442	1289	1194	1373	1194	1208	1233	1185	1169	1166	1065	1046
Moderate	24	27	22	36	26	28	29	35	21	23	26	21	21
Severe	3	2	3	1	7	5	5	3	1	6	2	1	4
Catastrophic / Death	11	20	20	19	21	15	9	4	11	3	7	4	2

Definition	Analysis	Implications
This data is obtained from the Once 4 Wales RL Datix system, information is reliant on the timely and accurate recording of patient safety incidents. It is valid at the point of extraction (13 October 2025). As the manager's interim harm assessment may take several days or weeks to complete the decline in recent months should not be misinterpreted as a decline in the number of overall incidents.	Incident Volume and Harm: Total Datix incidents in Q2 8,141, down from 8,436 in Q1. Compared to Q2 2024/25 (7,774 incidents), this is a 4.7% increase year on year. The distribution pattern remains consistent, with 'Patient/Service users' being most affected. Majority are No Harm or Low Harm. Q2 2025/26: 98.5% no/low harm (manager interim assessment), up from 93.38% in Q1. Q2 2024/25 97.89% of incidents being graded as no/low harm. **Themes from Datix Incidents -** Missing drug details in reports; corrective actions underway. Dashboards track closure rates and overdue cases. Mandatory fields for medication incidents; expanded taxonomy for patient factors. Alignment of Datix dashboards with QMG reporting; antimicrobial prescribing linked to assurance processes. Audits planned for investigation completeness; hybrid dashboard solutions explored.	Whilst the number of incidents has increased when compared to the same period last year, the level of harm of those incidents is lower. H&S Team introduced monthly audits to flag incomplete or incorrect fields. Datix Team now audits closure fields monthly to ensure lessons learned and recommendations are captured. 47% reduction in incidents older than six months, plus a decrease in cases over 12 months. 74% of incidents closed within 30 working days, showing strong progress. Divisions encouraged to continue addressing historic records to maintain momentum. Strengthened patient communication requirements in Datix. Clinical directors encouraged to take ownership of prescribing-related incidents.

Inpatients Falls

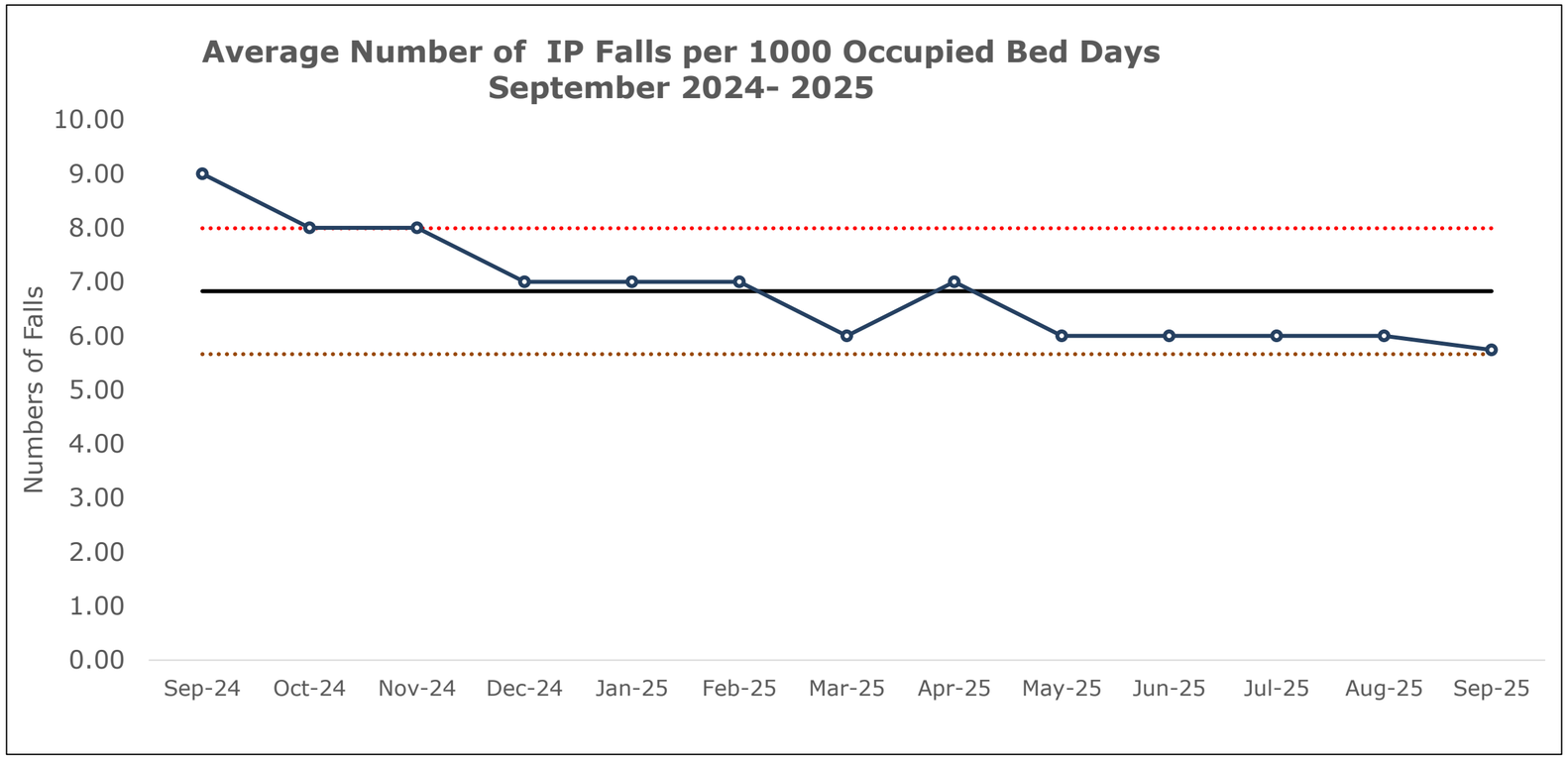


Quarter 2

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

Definition	Analysis	Implications
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	• For the given period of analysis, the mean average of fall incidents is 287 which is a decrease since the last report (293). • July 2025 has seen the lowest value for recorded falls incident for the given 12 months analysed at 230. August and September have seen an upwards trajectory with marginal increases to 247 & 260 falls incidents, respectively. • The numbers of reported falls incidents have been consistently below the mean average for 5 months.	The improving rate coincides with a range of action being taken by the Health Board to reduce the number of inpatient falls, including the introduction of a revised process for reviewing those falls with severe injury which enables more timely learning and corrective action, the publication of the Health Board's revised Hospital Falls Policy supported with awareness raising and training, and implementation at ward level of quality improvement projects targeting falls. During this period of improvement, there has been an enhanced level of monitoring of falls at ward level as part of the ward accreditation framework, thus increasing team awareness and ownership of the opportunities to reduce falls. The values for Q2 represent percentages below the mean average of 287: July 20%, August 14% and September 10%

Inpatients Falls



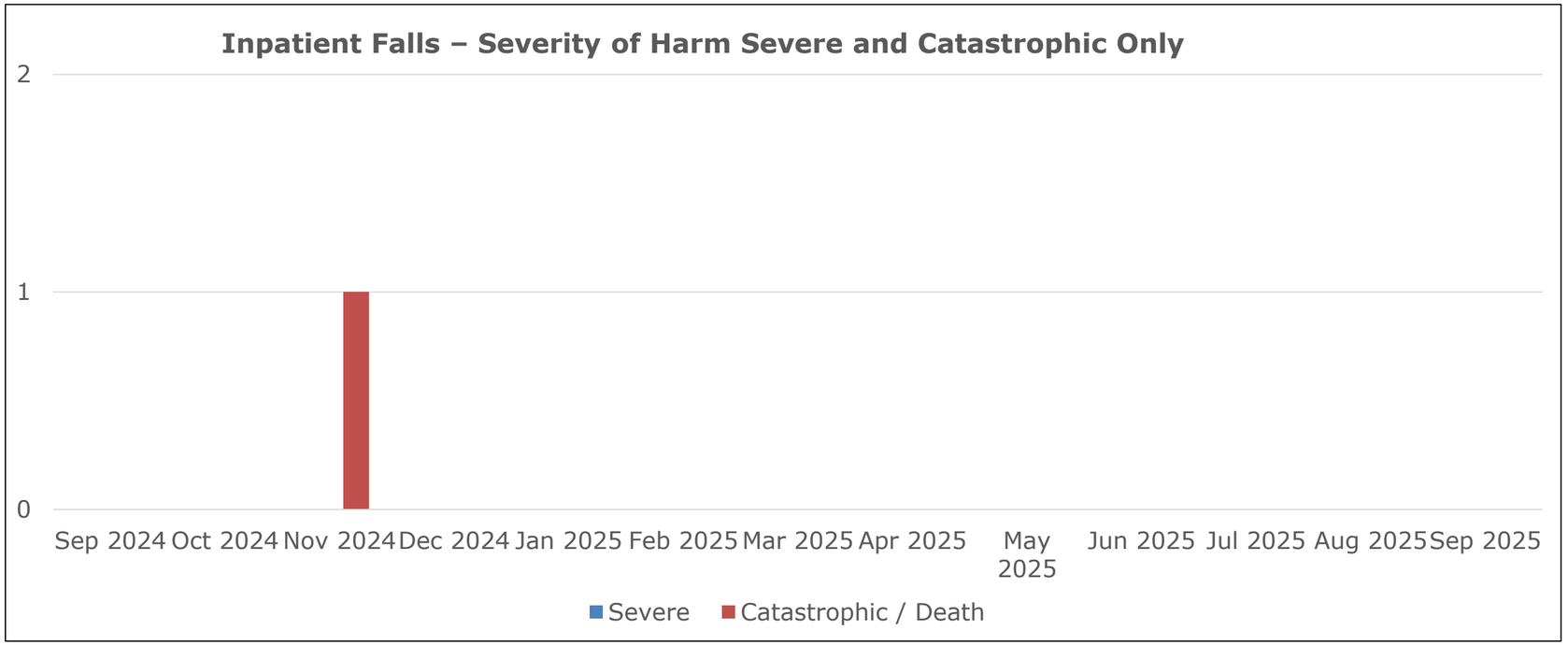
Quarter 2

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 September 2024-2025.

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

Definition	Analysis	Implications
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	September 2025 has seen the lowest value for the 12-month period analysed at 5.74. This represents the lowest ever value for OBD's for the available data. This is 15% lower than the National Average of 6.6 The represents a continuation of the improvement trajectory seen in July and August 2025.	Positive variation for Q1 into Q2 for the period of analysis has been sustained at values more closely aligned to and below the lower control limit.

Inpatients Falls



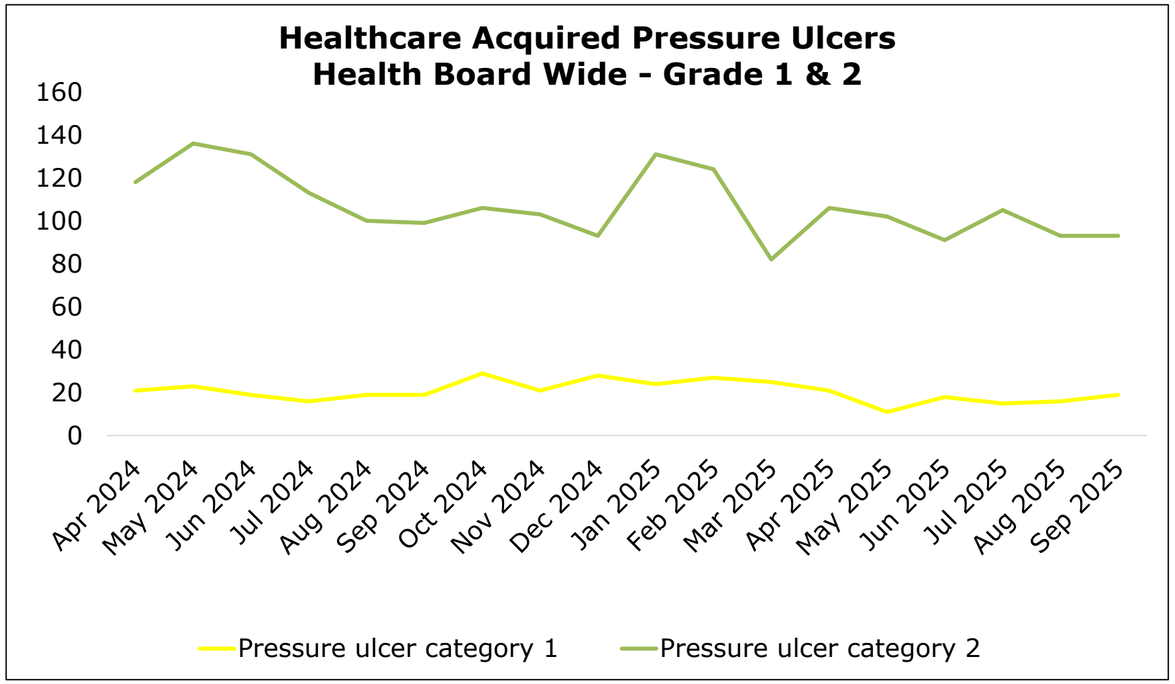
Quarter 2

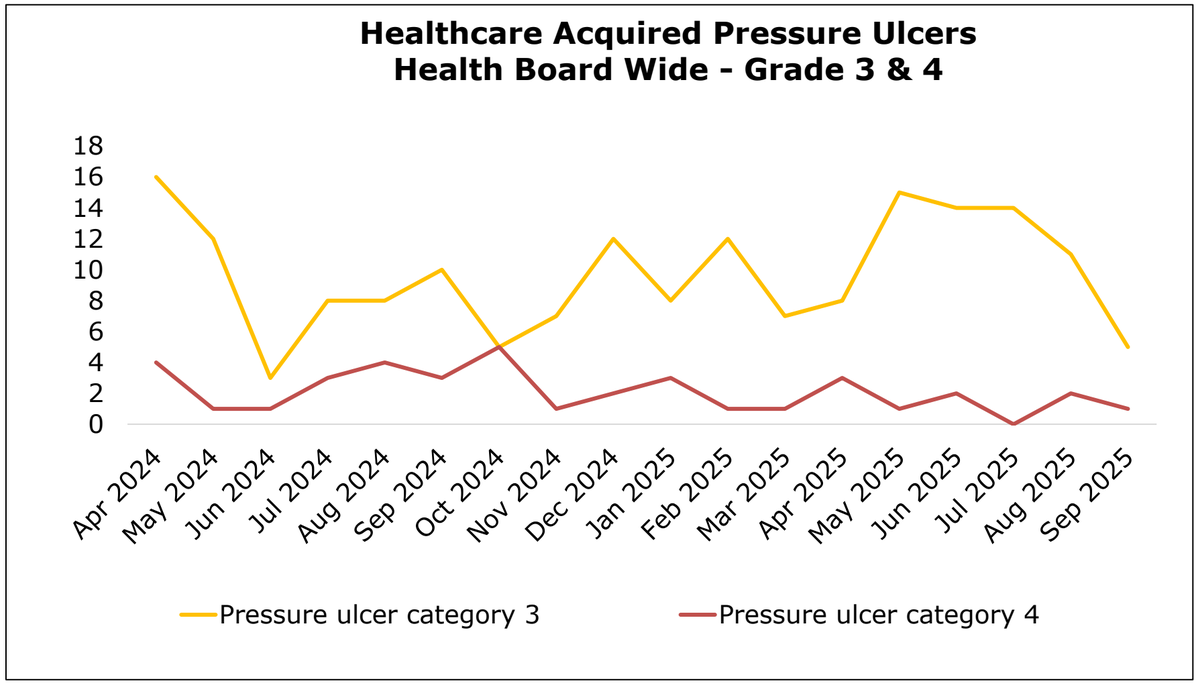
The data used in this chart has been retrieved from RL Datix and refers to the total numbers of reported Inpatient falls incidents for the period September 2024-2025

The severity of harm is that of post investigation.

Definition	Analysis	Implications
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	The total numbers of falls incidents reported for which the severity of harm is categorised for the given period is 3856. For September 2024-25, the following details the severity of harm: • 99.7% - No or low harm • 0.28% - Moderate harm • 0% Severe harm (A validation exercise is being undertaken to review data discrepancies associated with the attributing of severe harm categorisation). • 0.02% Catastrophic	For the period of analysis there have been no reported incidents of falls resulting in a catastrophic outcome since November 2024 with no instances of severe harm for the period of analysis.

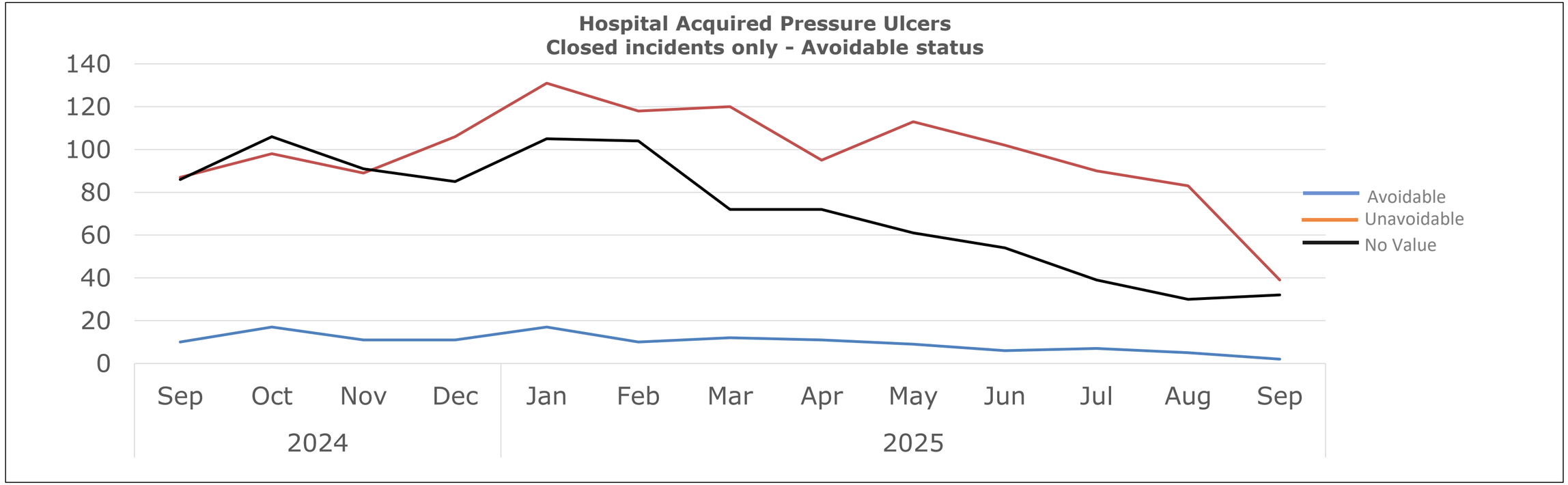
Healthcare Acquired Pressure Ulcers





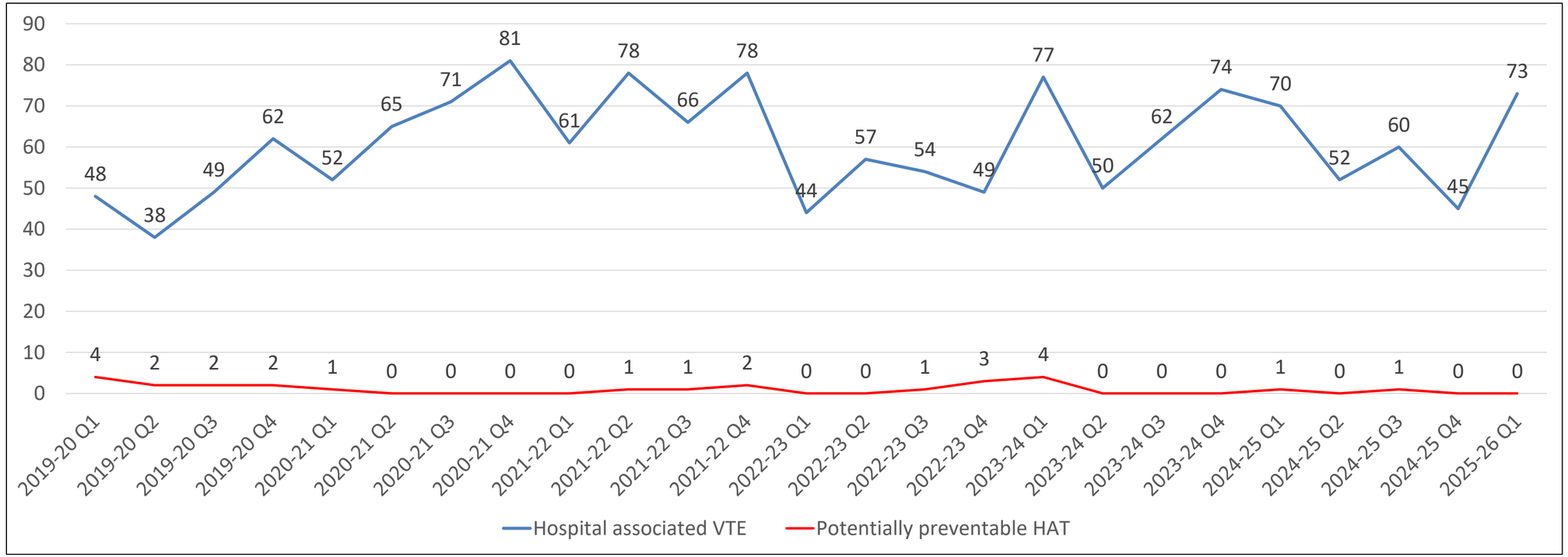
Definition	Analysis	Implications
The data included above is extracted from Datix incident module. This captures incidents recorded for all divisions.	The majority of Pressure Ulcers recorded are category 2 (partial-thickness skin loss where the epidermis (outer layer of skin) or dermis (deeper layer of skin), or both, are damaged). No statistically significant trends in the category of ulcers can be seen within the past 3 months.	Further analysis required on high incidences of grade 2 pressure ulcers to review themes. Completed focussed reviews will provide the detail on these incidences that will inform the nature of improvement work required

Healthcare Acquired Pressure Ulcers



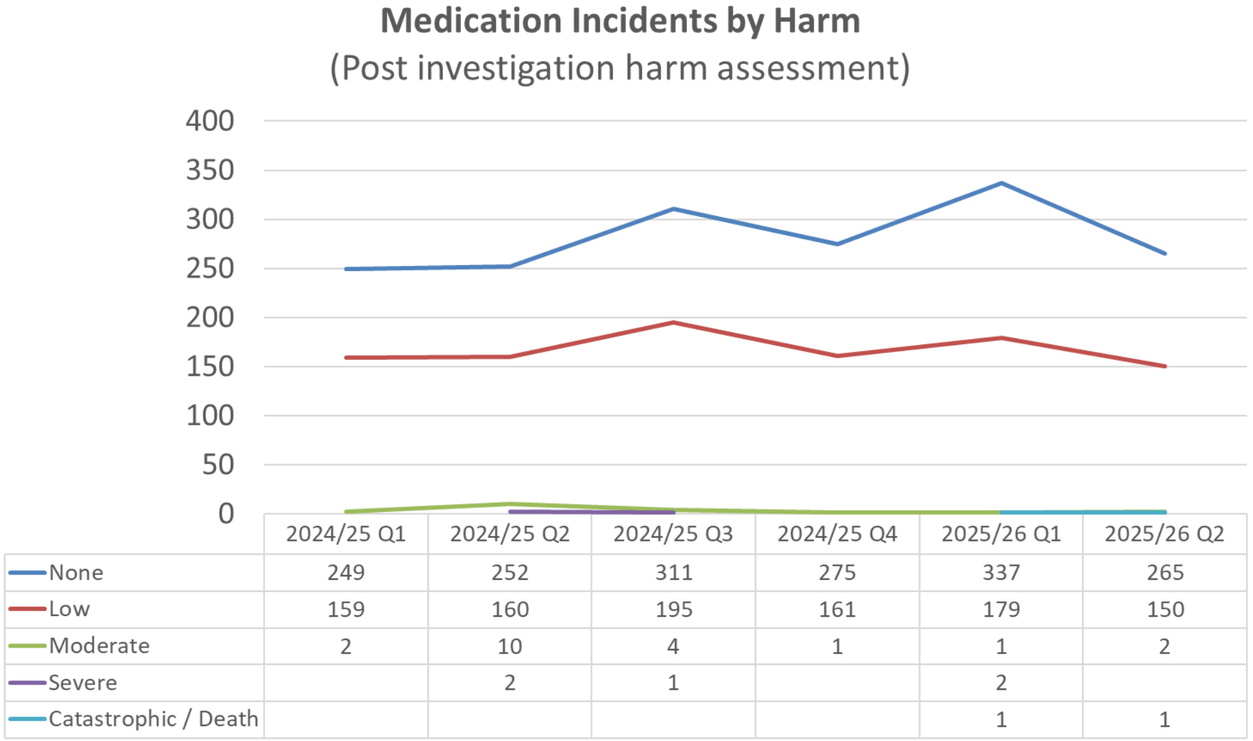
Definition	Analysis	Implications
The data included above is extracted from Datix incident module of incidents recorded for all divisions. The graph shows the closed Health Care Acquired Pressure Ulcers split by avoidable status.	The number of incidents appears to have dropped in September, this is because the data only shows the closed incidents, with most of the pressure ulcers reported last month being under review. The number of "No Value" within closed Pressure Ulcer incidents has dramatically reduced with less than 40 being reports in the past 3 months, down from ~100 at the start of the year.	An unknown level of risk still resides within the number of no value incidents. Targeted work is underway with the Divisions to review and close these incidences. A change has been implemented that requires all grades of pressure damage to have a focussed review, this will allow all cases to be categorised as avoidable or unavoidable. A focussed piece of work is being conducted by the pressure ulcer steering group.

Hospital Acquired Thrombosis (HAT)

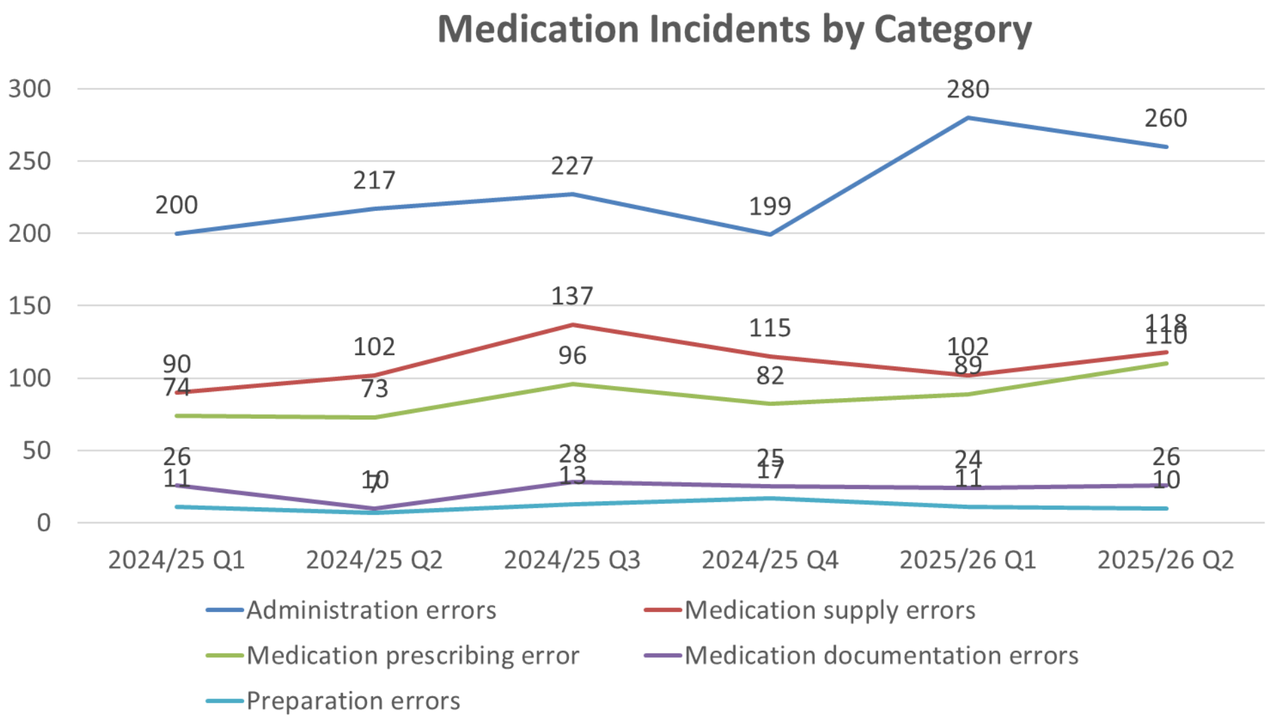


Definition	Analysis	Implications
The chart show the number of suspected hospital associated Venous Thromboembolism events (VTE) and the confirmed number of potentially preventable hospital-acquired thrombosis (HAT). A HAT is a VTE—such as deep vein thrombosis (DVT) or pulmonary embolism (PE)—that occurs during hospitalisation or within 90 days of discharge, and could have been avoided if appropriate preventative measures had been taken.	A HAT is reviewed following a retrospective and structured process: 1. Identification of Suspected HAT Cases - Informatics teams generate lists of patients who had imaging-confirmed VTEs within 90 days of discharge. These are cross-referenced with hospital admission data (e.g. RADIS) to identify potential HATs. 2. Root Cause Analysis (RCA) - A Root Cause Analysis form is reviewed by the Haematologist and checks whether a mandatory VTE risk assessment was completed on admission and whether appropriate thromboprophylaxis was given (drug, dose, duration). 3. Clinical Vetting – the Haematologist reviews the completed RCA forms to confirm: Whether the event qualifies as HAT. Whether it was unavoidable (correct prophylaxis given) or potentially preventable (e.g. missed dose). 4. Reporting and Learning - confirmed HAT cases are reported and lessons learned are used to improve practice and reduce future harm	A HAT is a significant event because they account for 50–60% of all VTEs. They are a leading cause of preventable death in hospitals. The 90-day window is based on clinical evidence showing that VTEs can develop long after discharge, often due to: reduced mobility, surgical recovery, ongoing medical conditions or missed or inappropriate thromboprophylaxis. This timeframe ensures that post-discharge events are captured and assessed for links to the hospital stay. It aligns with guidance and national policy.

Medicines Management



	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	2025/26 Q1	2025/26 Q2
None	249	252	311	275	337	265
Low	159	160	195	161	179	150
Moderate	2	10	4	1	1	2
Severe		2	1		2	
Catastrophic / Death					1	1

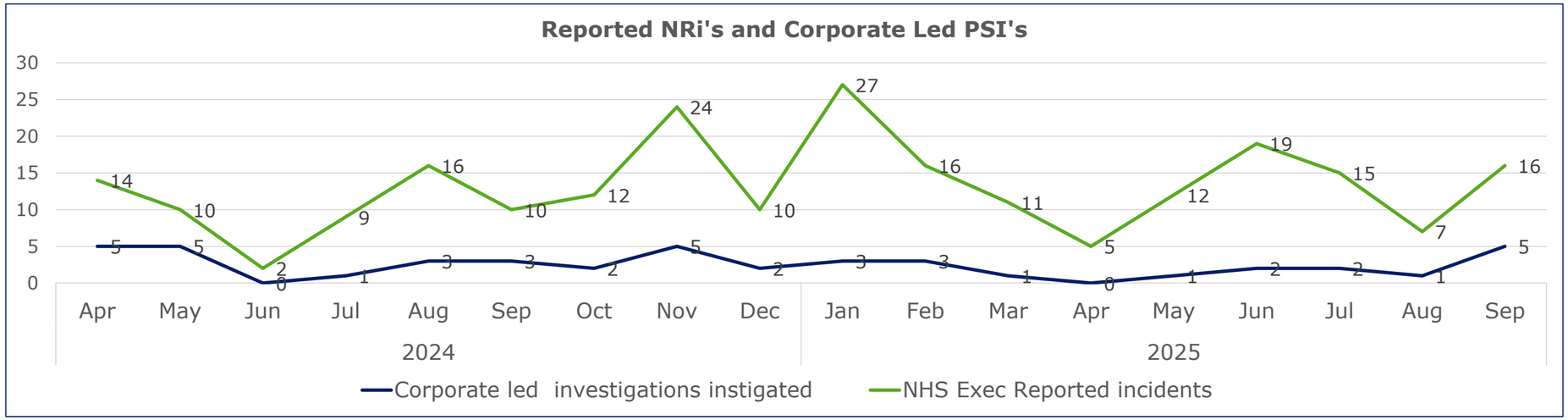


Definition	Analysis	Implications
The information presented has been extracted from RL Datix and is accurate at the point of recording. These are for incidents classified as '*Medication, IV Fluid'* and affecting patients/service users.	The graph on the left shows a the 'Medication, IV Fluid' incidents and the level of harm (post investigation harm assessment). The total number of incidents has remained statistically stable with minor spikes noted in Q3 2024/25 (511 incidents) and Q1 2025/26 (520 incidents). Of note, there were one Catastrophic / Death incident in both Q1 and Q2 2025/26. The 'Category' of 'Medication, IV Fluid' incidents can be seen in the graph on the right. The number of 'Administration errors' and 'Medication prescribing errors' have both increased over the period. Please note these are only the top 5 most frequent category of medication incidents.	The Quality Management Group received escalation through multiple Divisional Highlight reports in September and the chair stated a need for a broader, corporate piece of work, involving the Medication Safety Group and linking with the ePMA rollout. Within Divisions multiple improvement projects are ongoing to address local concerns specific to medications or locations, such as anti-coagulants and gentamicin.

Medicines Management Learning & Improvement

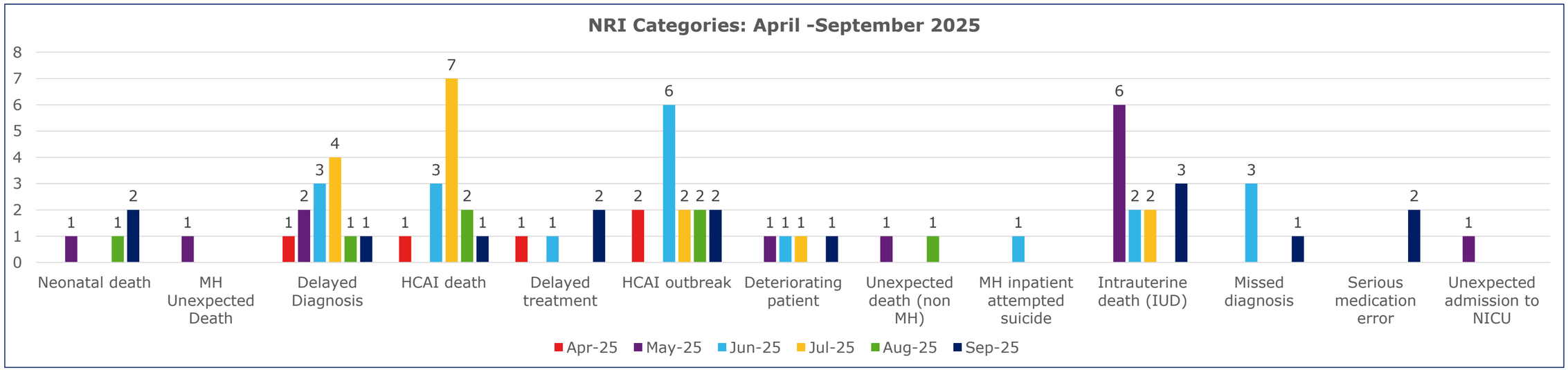
Item	Action	Learning and Improvement Progress	Who	When 10.3.2025
Compliance to the HEIW Competency Assurance Standards for Independent and Supplementary Prescribers (SP)	Action plan for N&M complete. Task and Finish group in place for the HB for N&M, Pharmacy, AHP and HCS to monitor compliance to the annual Declaration of Scope of Practice – well embedded Meetings every 3 months	HCS and Pharmacy teams will need to have a different approach to the evidence required for demonstrating competence. Phased approach for sustainability and embedding practice	KH, member of the short life working group	December 2026.
High Risk Medication - Categorise and report incidents related to high-risk medications at MSG.	Priority 1 – Anticoagulation incidents. All resources now collected T&F group will need to include a medical representative and a representative from F&T for paediatric patients	Need to understand the causes of the incidents to determine education and system changes	Task and Finish group. Divisional leads/ KH/Pharmacy lead CB/JT/JH	Review April 2026
Medicines Governance Audits	Develop a comprehensive medicines audit governance tool working the Nursing Directorate Professional Regulation team and F&T QPS nurse	The medicines Governance audits on AMaT does not meet the necessary requirements for the governance audits.	KH/JH /AG 1/5/2025 meeting	Review December 2025
Controlled Drug SOPs	Complete the SOPs for all CD SOP recommended by CQC.	SOPs will be trialled on Penalta to test before publication	In progress	Review January 2026
BESS – error management policy	New format for this process under review Will include approaches for managing MDT medicines error incidents	We need to move away from this tool and incident reporting as a punitive measure	KN/MSO	Review April 2026
Nursing and Midwifery Education	Review the education provision for medicines management and safety	Require monitoring of compliance to training and competency assessment for assurance	KH/ AK	Review November 2025

Nationally Reportable Incidents

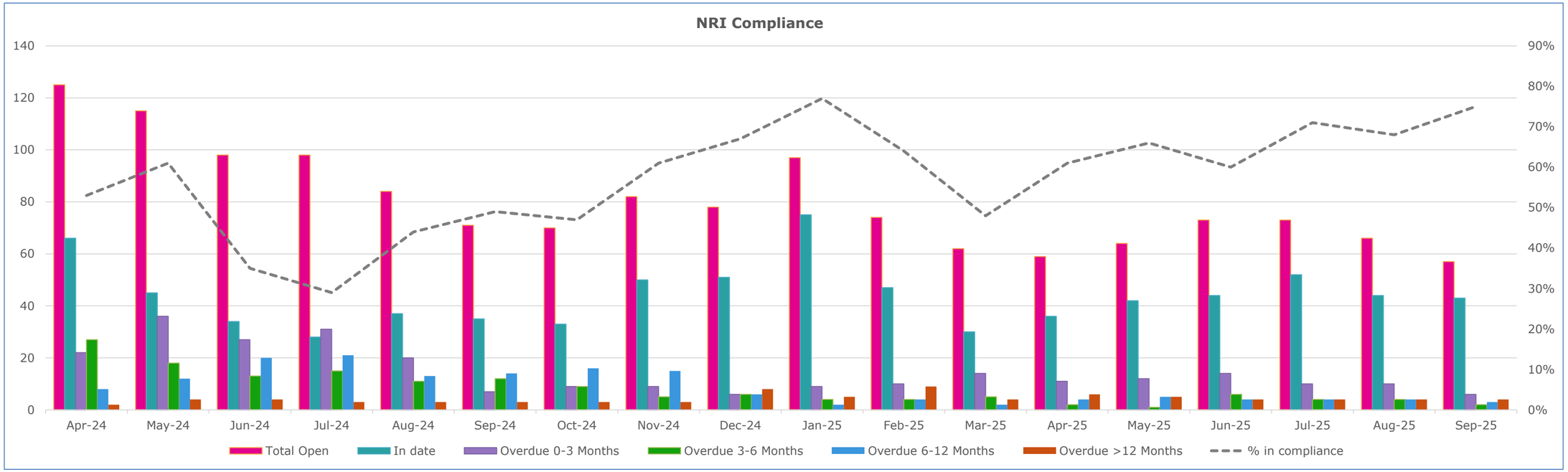


A total of **38** Patient Safety Incidents (PSIs) (moderate and above harm) met the criteria for reporting as NRI's in Quarter 2. This is in comparison to **35** in the same period in 2024.

There were no unusual trends identified across in this period.

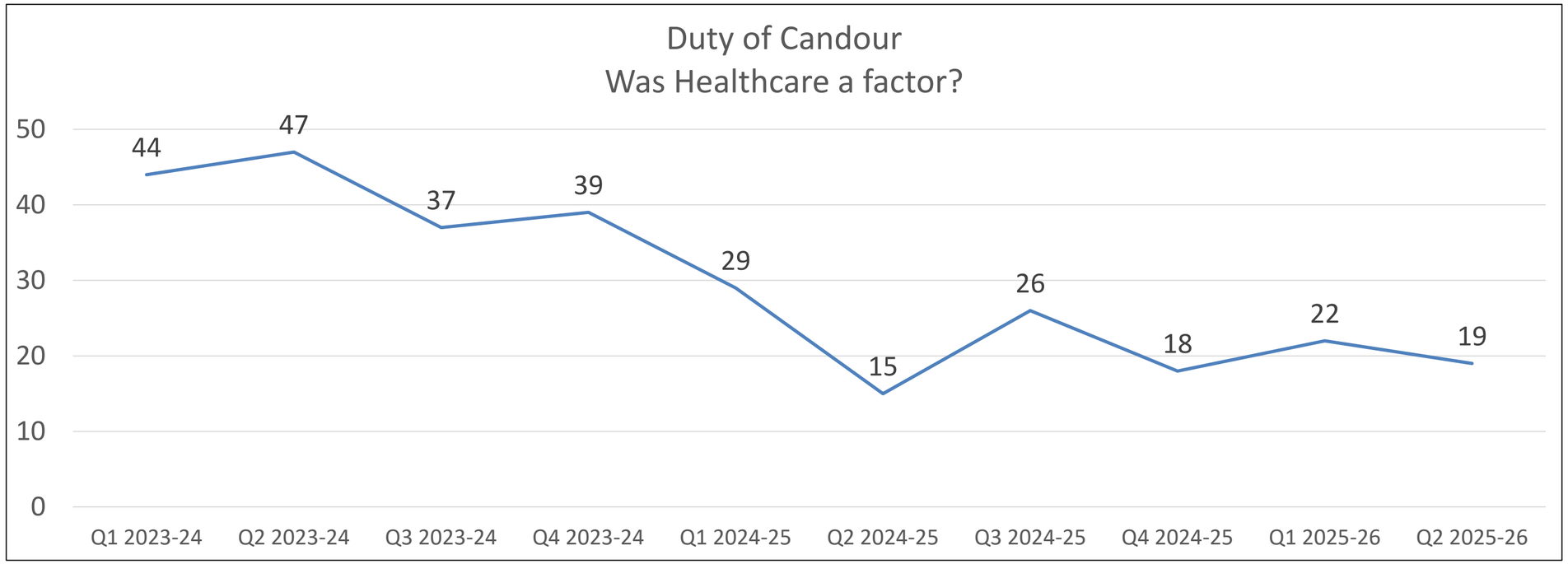


Nationally Reportable Incidents



Definition	Analysis	Implications
The graph above shows: The % of open cases that are within the compliance window. The number of open cases are split by in-date and overdue.	The trends show an upturn in NRI overall compliance. At the end of September there are now 57 open NRIs, with 42 cases within the compliance window. The number of cases overdue by: 12 months is 4, 6-12 months is 3, 3-6 months is 2 and 0-3 months is 6. In September 2024 there were 36 overdue NRIs compared with 15 in September 2025, this represents a 58% reduction. Q2 Slight increase in incidents; August spike followed by September decline. 98.51% of incidents were no or low harm. Key themes: medication safety issues, complaints and investigation training needs, safeguarding concerns in mental health services. Compliance Trend (as of September 2025): Four NRI cases open >12 months due to external complexities. Compliance improved to 68%–75% in the last three months (up from 29%–49% same period last year).	**Actions:** Fortnightly focused action plan meetings with PSI team, QPS leads, and QI support. Collaboration with other Health Boards to share best practice. Clear benchmarks for what 'good' looks like; compliance central to standards. Ongoing action plan for continual progress. Supporting Patients and Families: Development of Family Liaison Officer (FLO) role and training. Benchmarking against other Health Boards; SOP creation in progress. Proposal for training and resource materials under development. **Learning and Improvement -** Feedback from families reinforces need for better communication and staff training for FLO role. Establishment of Falls Strategic Oversight Panel. Standardisation of mortality case reviews and embedding mortality meetings across directorates. Bespoke training for complaints and incident investigations. Medication safety improvement initiatives. Continuous benchmarking and collaborative learning to define and embed best practice.

Duty of Candour

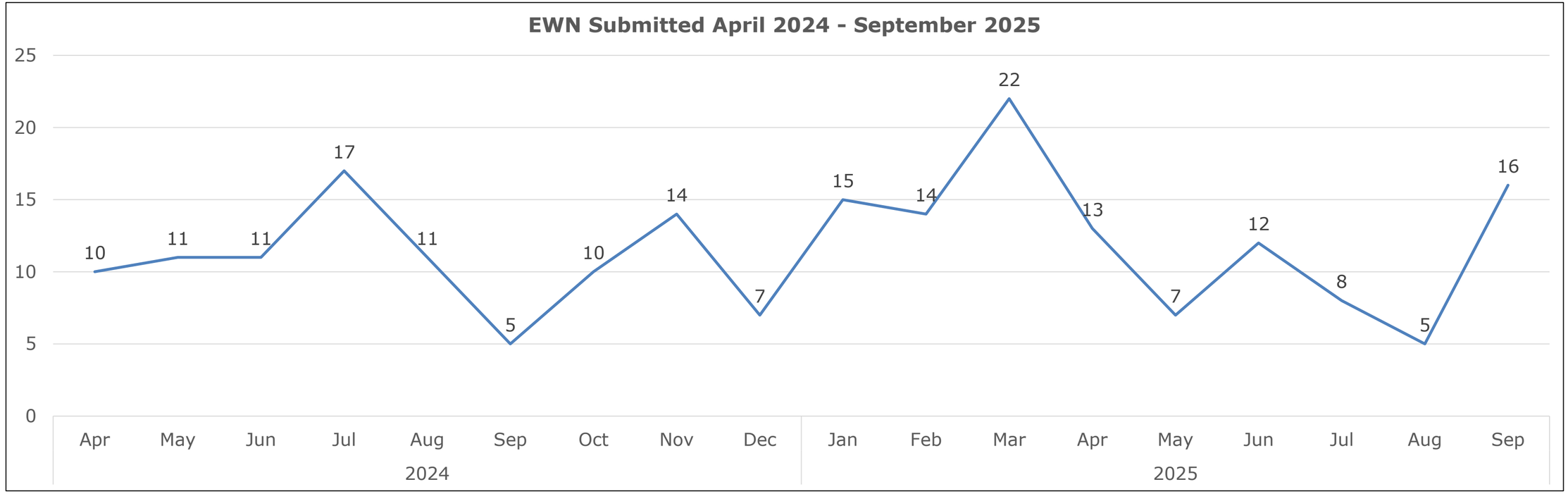


Definition	Analysis	Implications
Information provided is extracted from RL Datix, based on the question '*Was healthcare a factor'.* The information is accurate at the point of extraction (23 October) but is an ever more picture as incidents are investigated.	The number of Duty of Candour (DoC) events remains low. Common Categories of Incidents: *Treatment or procedure issues, Clinical assessment / diagnosis, Slip, trip or fall and Pressure ulcer developing/worsening.* Slight reduction from Q1 to Q2. Q1: 22 incidents triggered DoC, mainly linked to mental health service user incidents, alleged criminal offences, and GDPR/data loss. Q2: 19 incidents triggered DoC, with similar themes plus violent incidents and safeguarding concerns. When Duty of Candour was first introduced the Health Board was recording significantly more incidents as triggering. As training and awareness has improved this number has reduced.	**Actions:** Embedded DoC into Datix Cymru reporting workflow. Introduced structured review process to confirm harm level and trigger DoC where applicable. ESR Duty of Candour (DoC) training: Work in progress to implement mandatory e-learning for all patient-facing staff. **Learning and Improvement:** Mandatory training will strengthen understanding and statutory compliance. Patient and family feedback reinforces the need for timely, compassionate communication during DoC processes. Continuous monitoring of DoC application and training effectiveness. Collaboration with other Health Boards to share best practice and refine SOPs. Cultural shift towards openness and honesty as core principles.

Early Warning Notifications/Never Events

There have been no Never Events reported in Q2.

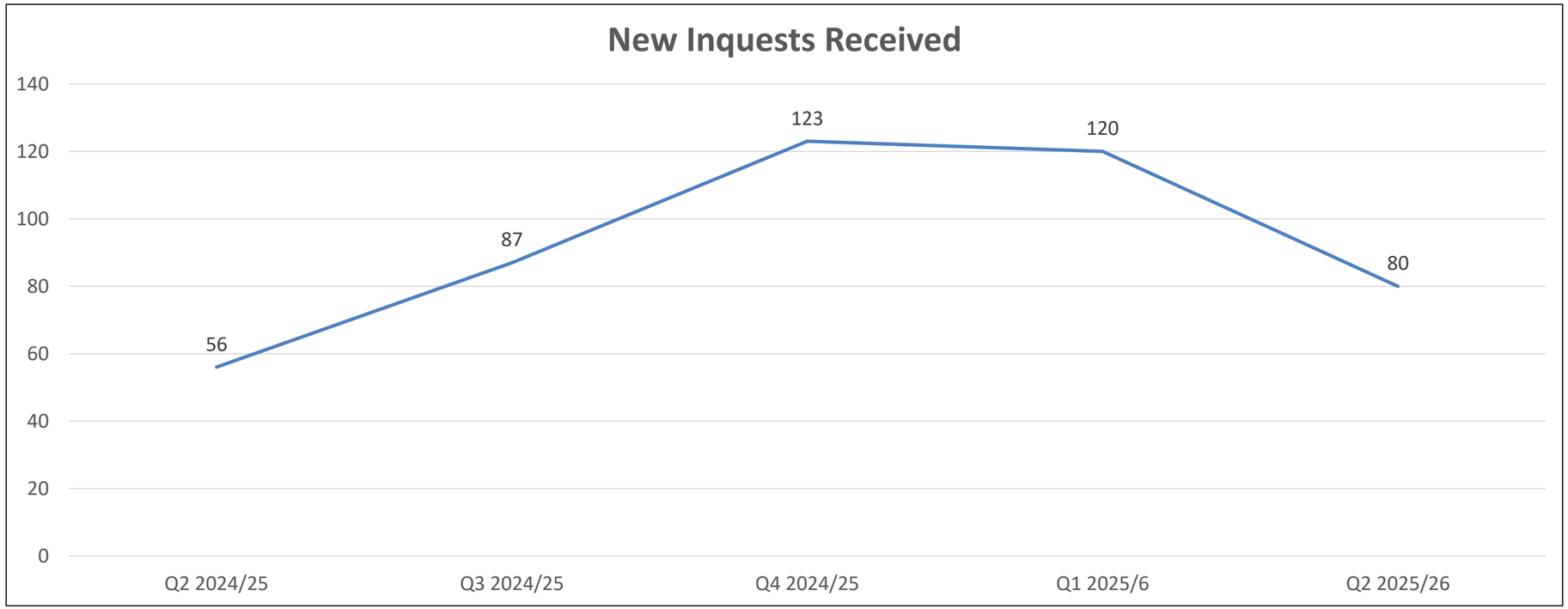
There were 29 Early Warning Notifications (EWNs) reported to Welsh Government (WG) in Q2, compared to 33 submitted for the same period in 2024/25. The themes for Q2 include: MH service users absconding; suicide attempts and deaths (including unexpected death) among MH service users; alleged criminal offences by staff or patients; GDPR and data loss; PRUDICS; Professional practice concerns; reportable infectious diseases; and violent incidents by patients involving patients and staff. These do not represent unusual trends.



Regulation 28

- During Quarter 2, ABUHB received 3 Regulation 28 Coroner reports.
- 2 reports have been formally responded to within required timescales. The 4th response is due 1 December 2025.
- There were no connecting themes between the 3 reports: -
  - Access to GP records by Mental Health Services
  - Ambulance handover at hospital sites (pre new 45-minute turn around)
  - Patient nutrition (Regulation 28 Report issued to ABUHB and Velindre NHS Trust)

Inquests



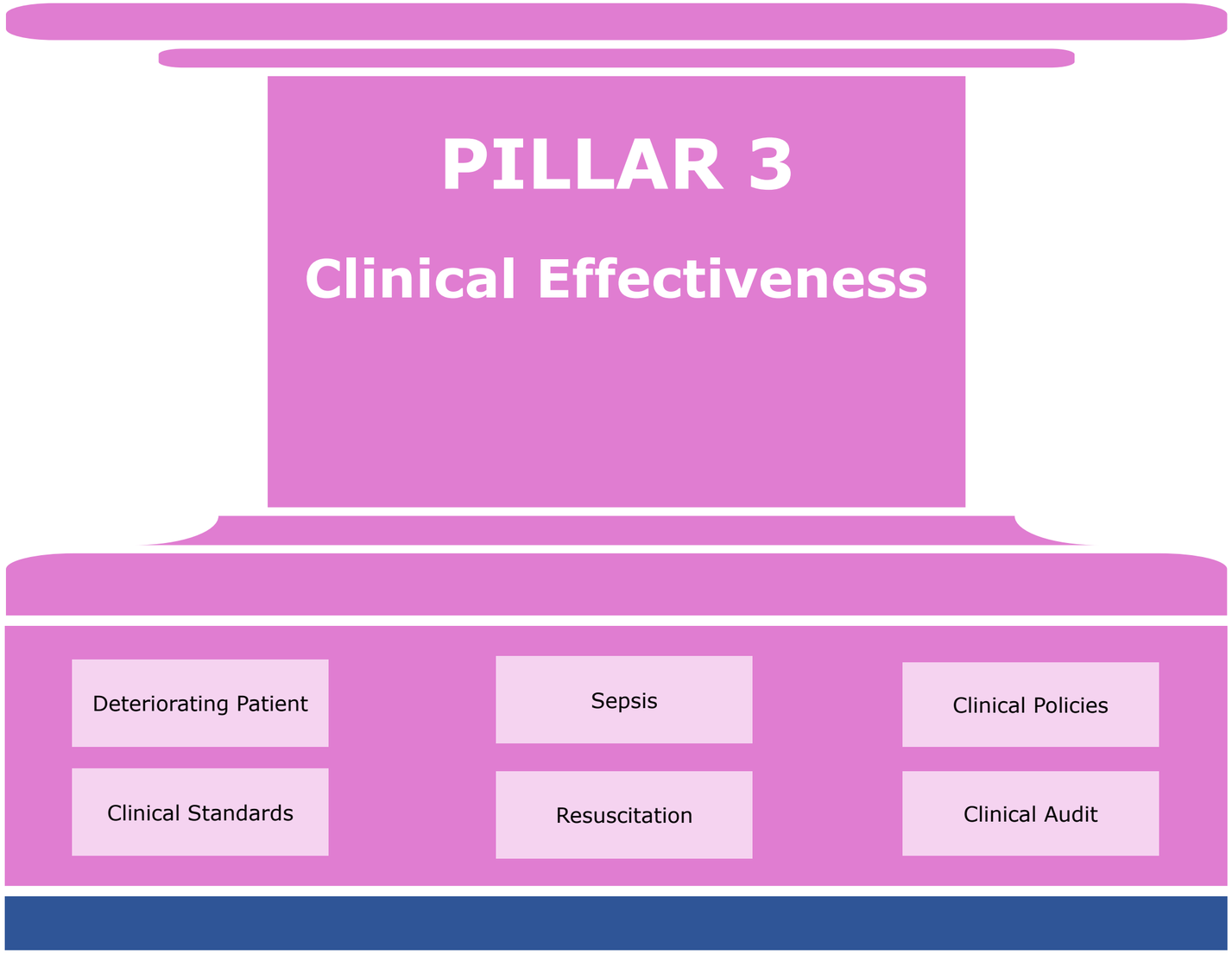
Definition	Analysis	Implications
The graph above shows the number of new inquests received by the Coroner each quarter in Q2 2024/25.	The Health Board is receiving a significant and sustained increase in the number of new Coroner inquests being received, a slight decline in Q2 2025/26 is still a 43% increase compared to the same period in the previous year.	Improved quality and timeliness of witness statements and investigation reports led to a high proportion of inquests concluded in writing (Rule 23), reducing staff court attendance. Proactive submission of Lesson Learning Statements and Divisional Action Plans helped avoid Regulation 28 Reports (issued by Coroner when assurance required to prevent future deaths). Out of 299 inquests concluded during 2024-25, only 3 Regulation 28 Reports were issued. Legal Services provided post-inquest debriefs and preparation support, improving staff confidence and reducing emotional burden. Regular meetings and training with the Coroner; improved collaboration between respective teams and reduced procedural delays. Reputational protection through efficient handling of legal matters, avoiding adverse media and keeping Regulation 28 reports to very low numbers.

Patient Safety Alerts (PSA) and Notices (PSN)

Alert	Compliance Deadline	Action to achieve compliance	Status
PSA019 Harm From Delayed Administration of Rasburicase for Tumour Lysis Syndrome	09th March 2026	The majority of actions (1–4) within this PSA are being actively advanced in collaboration with the Directorate of Haematology, ensuring clear accountability and oversight. Action 5 is being led by Pharmacy, with assurance mechanisms in place to monitor completion and compliance.	In-progress ON TARGET
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients	Sep-23	SBAR has been updated to reflect progress and outstanding actions associated with this PSN. The alert is currently being re-scoped to enable a comprehensive gap analysis, comparing current ABUHB practice against the expectations outlined in the PSN. This approach ensures clear visibility of compliance gaps and supports targeted improvement planning.	In-progress OVERDUE

PSI Learning and Improvement

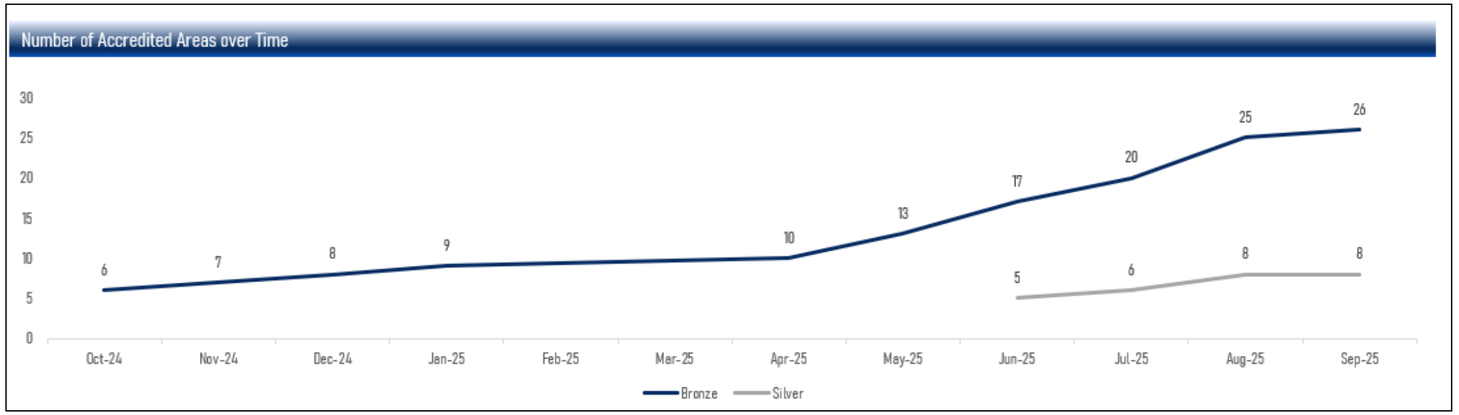
Issue	Action	Learning and Improvement	Who	When
Improving Patient Saftey Incident (PSI) systems and processes within the Health Board.	Fortnightly focused action plan meetings are conducted with a strengthened emphasis on achieving and maintaining NRI compliance. These meetings bring together the PSI team and QPS leads, who are supported by the QI team. Additionally, there is proactive engagement with other Health Boards (HBs) to facilitate the sharing of best practice and foster collaborative improvement. Throughout, there is a clear focus on defining the benchmarks and standards that represent what 'good' looks like in this area, with compliance forming a central part of these criteria.	An ongoing action plan has been established to ensure continual progress and development in PSI systems and processes.	PSI team	Ongoing


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

Team Accreditation

Roll-out Process Q2

NICU
Maternity wards
Endoscopy x4
Cardiac cath lab
Interventional Radiology
MIUs x4
Discharge lounges x3
Specialist Clinics



Quality Improvement Projects Q2:

Ward 4/2: Quality & Dignified Care- improving continence care.
Annwylfan Ward: Reducing Falls with a Focus on Footwear.
Ward 3/3: Timely care – timely risk assessments on admission with a checklist.
OSU: Reducing length of Stay
D3 East: Implementing a structure tool to improve communication with patients.

Issue	Action	Learning and Improvement	Who	When
Sharing learning	Linked accreditation pulse page to learning Hub and ABCi page. Silver projects to be presented at listening / learning forum and other forums.	Wider comms to staff to signpost to platforms for sharing learning	Accreditation lead	Sept 25
Divisions easily reviewing accreditation data.	Live tracker created / managed by data analyst.	Will be launched in October. Drop-in TEAMS sessions TBA for senior teams to learn how to navigate their data.	Senior Data Analyst	October 25

Sepsis

National Drivers for Deteriorating Patient Recognition

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

Local Implementation

- To date, NEWTT2, PEWS and NEWS2 have launched within the health board.
- PEWS was initially implemented across inpatient paediatrics and the Fox assessment pod. However, its use in Fox was temporarily suspended due to concerns around the potential use of two different charts within the same area. The service is currently awaiting the outcome of ongoing operational discussions regarding its implementation in the shared CEAU space.

Go live dates for EWS Implementation

- Adults: NEWS2 – 9th September 2025 (community & MH&LD launch 29th September)
- Paediatrics: PEWS – 22nd September 2025 – withdrawn from Fox assessment awaiting ongoing operational realignment of workstreams
- Neonates: NEWTT2 – 28th July 2025
- Maternity: MEWS – Delay launch due to digital template restriction

Training and Support

- Staff education is a priority, with ESR modules funded by the NHS Executive and tailored packages developed by ABUHB to compliment national training resources. These resources are designed to ensure all staff and confident and competent in applying the new EWS tolls in practice.
- To support the delivery of education, 68 “Train the Trainer” sessions were delivered to support ward managers, deputy ward managers and practice educators to cascade their training.
- Additionally, NEWS2 education and sepsis awareness continues, with sessions recently delivered in multiple forums including resident doctor training, Senior Clinical forum and the Primary and Community nursing JOE preceptorship programme.

Sepsis

- Appointment of the assistance Quality and Patient Safety Assurance Lead under the Medical Director has supported a focus on sepsis, supporting divisional scoping and engagement with primary and community care.

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

- A dedicated Sepsis Working Group, supported by the Medical Director's Quality and Patient Safety team, is leading assurance activities including: Development of divisional sepsis expertise, setting performance targets and supporting improvement initiatives through structured scoping and stakeholder engagement. This group has temporarily disbanded to support NEWS2 implementation and will reconvene post launch.

Implementation and Compliance Monitoring

- The UK Sepsis Trust screening tool launched on the 9th September, alongside NEWS2 in adult secondary care. Quality improvement methods, including PDSA cycles, are being used to test and refine the new screening tool before reviewing the tools suitability before launching across paediatrics, maternity, neonatal, and community settings. Compliance and effectiveness will be reviewed post-implementation to ensure measurable improvements in patient outcomes. This includes: monitoring uptake and fidelity of screening tools, evaluating escalation protocols and clinical decision support systems and aligning digital systems (e.g., CareFlow, BadgerNet) with national EWS timelines.

Engagement and Cultural Change

- The Health Board's internal sepsis awareness campaign launched in November 2024, with a public-facing phase commencing in April 2025. The campaign has achieved over 2 million views to date and has being shared nationally to support wider adoption. The All Wales Sepsis group are reviewing the assets created for the sepsis campaign, including safety netting information and exploring a national approach to raising awareness of signs and symptoms of sepsis.
- The ABUHB Communication and Engagement team has since been nominated for two categories, Social Media Campaign of the Year & Community Impact award at the Orlo Spotlight Awards

National Collaboration and Assurance

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

Sepsis

On the 18th September 2025 Aneurin Bevan University Health Board hosted "**The Big Conversation: Sepsis**" in the parkway hotel, Cwmbran. The day consisted of:

- **Personal Testimonies:** Survivors and bereaved families shared deeply moving accounts of their experiences, offering powerful insights into the human impact and the urgent need for change.
- **Leadership Commitment:** Senior leaders including CEO Nicola Prygodzicz, Executive Director of Nursing, Jennifer Winslade, and Leeanne Lewis, Assistant Director for Quality and Patient Safety, acknowledged past shortcomings and committed to compassionate, person-centred care.
- **Clinical Insights:** Presentations from UK Sepsis Trust and Dr Paul Mizen highlighted national data, the importance of early recognition, and tools like NEWS2 and Sepsis 6. Matthew Kvedaras provided an update on the Early Warning Score implementation, introduction of UK Sepsis Screening tool and the Health Board Sepsis Strategy.
- **Innovative Initiatives:** Launch of Call for Concern (C4C) to empower patients and families to escalate concerns.
- **Awareness Campaigns:** Communications team showcased public-facing campaigns using posters, social media, and community outreach.
- **Roundtable Discussions:** Facilitated sessions captured feedback on themes including post-sepsis support, early recognition, equity, continuity of care, and bereavement.

Outcomes & Next Steps:

- Feedback will inform the Health Board's refreshed Sepsis Strategy.
- Continued collaboration with UK Sepsis Trust and national partners.
- Focus on education, equity, digital tools, and trauma-informed support.
- Commitment to listening, learning, and acting together to save lives.
- A learning report and summary of the event is scheduled for Quality Management Group.

Sepsis

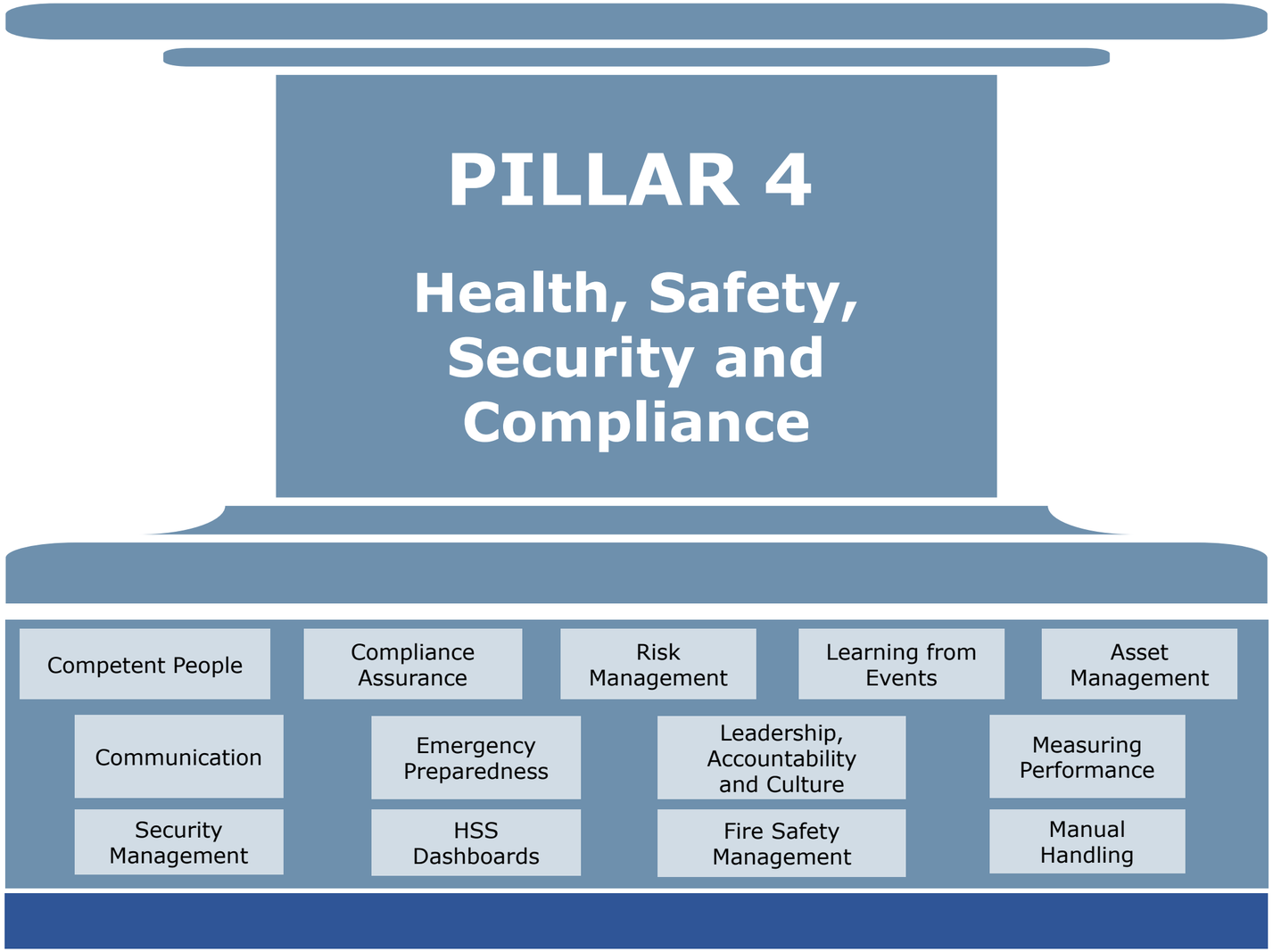
Action	What is needed?	How will this be achieved?	Who	When
Implementation of the WHC (2024/035), national Early Warning Scores & UK Sepsis Trust Screening tool	ABUHB continues to work towards implementing the Welsh Health Circular (WHC) 2024/035 early warning scores, aimed at supporting the national goal of standardising acute deterioration. Alongside the EWS, ABUHB will be launching the UK Sepsis Screening across adult acute divisions, with the aim of conducting PDSA cycles in targeted areas, measuring and auditing the impact. Other health boards in Wales are also looking towards implementation of UK Sepsis Trust Screening tool with an aim of standardising sepsis management throughout NHS Wales.	Implementation focus groups are working towards implementing x4 EWS across ABUHB clinical areas. This includes: • NEWS2 – 9th September 2025 & 29th September 2025 • PEWS – 22nd September 2025 • NEWTT2 – 28th July 2025 • MEWS – TBC The focus groups and exploring opportunities, resources and actioning barriers to ensure safe and effective implementation the tools. Each group is reviewing key information around Implementation, policy and education. Once delivered, the Deteriorating patient/sepsis group will continue to measure the effectiveness and impact of the EWS tools.	Assistant Quality & Patient Safety Assurance Lead	To be completed by Sept 2025
Standardise Sepsis education	To deliver high-standard sepsis care and comply with NICE guidelines, it's crucial to provide consistent education to all Health Board members. Reviewing and implementing standardised sepsis education will enhance monitoring and impact assessment, enabling opportunities for improvement.	Following the implementation of the WHC and EWS, a standardised education resource will be developed utilising the Sepsis Working group forum and in collaboration with key services, such as critical care, outreach and resuscitation services. The education package with require input from clinical experts within ABUHB, as well as oversight from the Deteriorating patient/ sepsis group and the Wales sepsis group.	Assistant Quality & Patient Safety Assurance Lead	To be completed by Dec 2025
Building on Standardised Sepsis Education	Ensuring the same message around expectation, management and process surrounding sepsis management is crucial.	An Education Task and Finish group will be established in Q4 to develop a robust training strategy for the workforce ahead of implementing Early Warning Scores and NICE Guidance. Representation at the national group will allow for reviewing and contributing to eLearning education materials. Through working closely with divisions and practice educators, utilising the standardised education package and initiatives from national groups, review and development of training programmes will be undertaken. This will include reviewing, amending and developing the sepsis content for programmes such as the JOE preceptorship, ALERT, BLS, PROMPT. Utilising the Deteriorating patient/ Sepsis group, oversight, feedback and progress will be maintained.	Assistant Quality & Patient Safety Assurance Lead	To be completed by End of December 2025

Sepsis

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

Sepsis Annual Workplan 2024/25

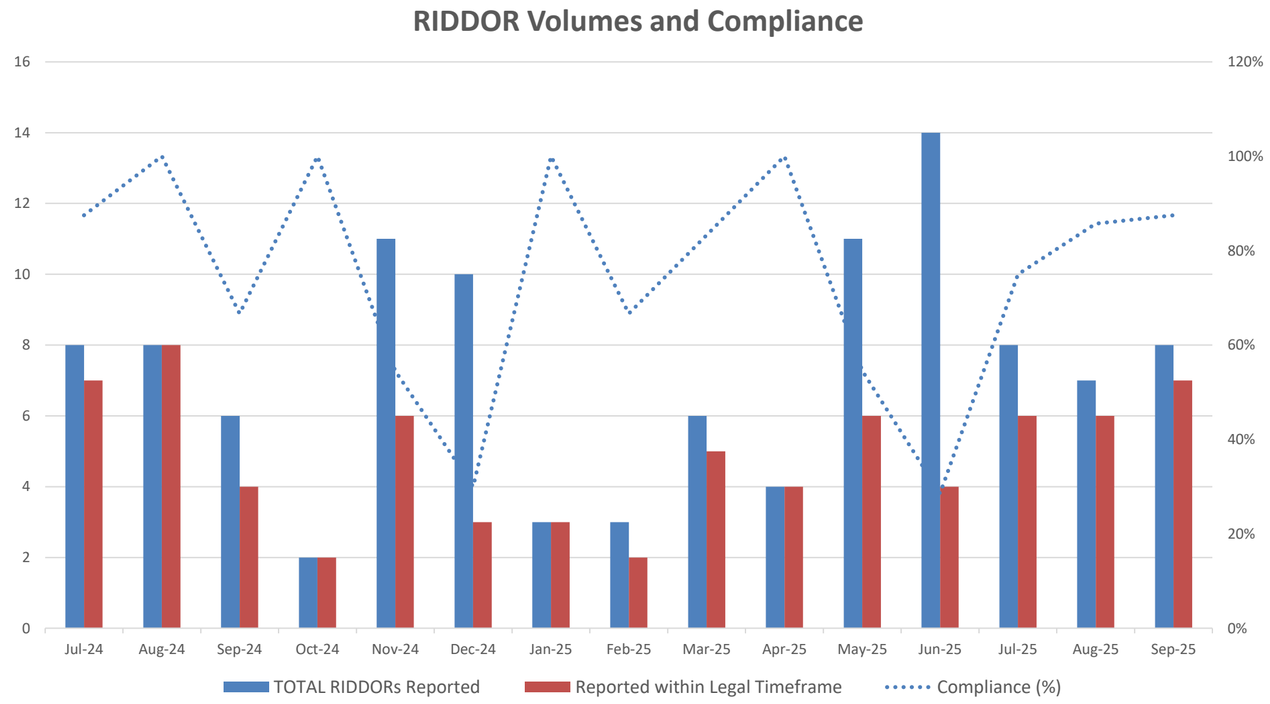
Quarter One	Quarter Two	Quarter Three	Quarter Four
• Continue hosting Task and Finish group to ensure readiness for EWS launch • Review opportunities to capture missed opportunities around deterioration and escalation • Continue work with UK Sepsis Trust and awareness campaign	• Implement Early Warning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


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

RIDDOR Compliance

RIDDOR Reporting Compliance	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26
Total RIDDORS Reported	23	12	29	22
Number Reported within Legal Timeframe	11	10	14	18
Reporting Compliance	47.8%	83.3%	48.3%	81.8%

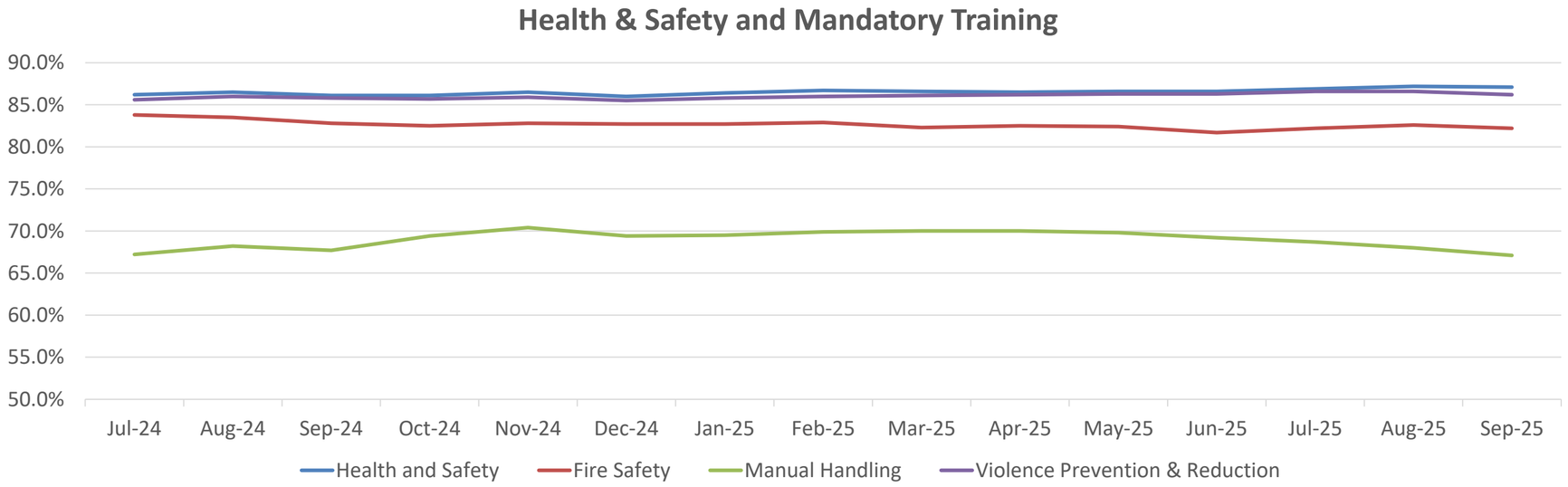
- RIDDOR reporting in Q2 2025/26 is aligned with the quarterly average (21.5)
- RIDDOR reporting compliance with the legal timeframe has increased significantly in Q2 2025/26



Statutory and Mandatory Training Compliance

Health and Safety Training Compliance	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26
Health and Safety	86.0%	86.6%	86.6%	87.1%
Fire Safety	82.7%	82.3%	81.7%	82.2%
Manual Handling	69.4%	70.0%	69.2%	67.1%
Violence, Prevention & Reduction	85.5%	86.01%	86.3%	86.2%

- Health and safety training has increased by 1.1% since the end of Quarter 3 2024/25
- Fire safety training has remained static throughout the reporting period
- Manual handling training has decreased by 2.3% since the end of Q3 2024/25
- Violence, prevention & reduction training has increased by 0.7% since the end of Quarter 3 2024/25



Incident Reporting

Staff Health and Safety Incident Reporting	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26
Physical Assault	189	227	266	203
Contact with needles or medical sharps	62	54	56	67
Slip, trip or fall	41	30	28	35
Verbal assault	22	44	45	25
Manual Handling	27	13	18	19
Sexual assault and/or sexual inappropriate behaviour	17	13	19	11

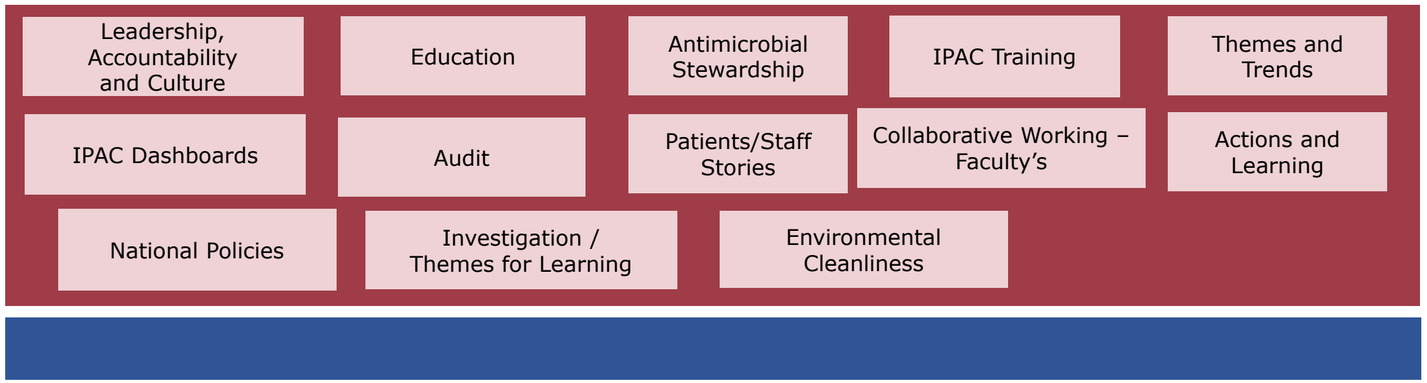
- Physical assault remains the highest cause of staff incidents over the past 12 months, although there has been a significant reduction in Q2 compared with Q1
- Contact with needles and medical sharps has increased in Q2 (25/26)
- Slips, trips and falls to staff reported in Q2 are above the quarterly average (33.5)
- Manual handling incidents reporting in Q2 align with the average for the past 12 months
- The number of verbal assaults reported in Q2 are well below the annual average (34)
- Sexual assaults and/or sexual inappropriate behaviour have reduced in Q2 and are below the quarterly average (15)

Learning and Improvement

Issue	Action	Learning and Improvement	Who	When
Increased number of contact with needles or medical sharps reported in Quarter 2 (2025/26)	Thematic review to be conducted to identify themes and patterns Health and safety management audits to be carried out for all Inpatient areas in Q4 2025/26	Identification of areas of non-compliance, resulting in delivery of education programmes to target areas	Corporate Health and Safety Corporate Health and Safety	November 2025 March 2026
Achieving a high compliance rate of reporting incidents in accordance with RIDDOR with the legal timeframes	Implement RIDDOR Awareness eLearning Training and mandate the course for all managers via the Core Learning Committee	Sharing details of late reports with the Service areas and Senior Managers	Corporate Health and Safety	December 2025
Manual handling training compliance is significantly below the 85% target	Targeted approach for staff attending training courses	Competent workforce to deliver manual handling techniques	Corporate Health and Safety	March 2026
Fire safety training compliance is below the 85% target	Implement fire safety training framework which is risk based	Competent workforce to manage fire safety risk	Corporate Health and Safety	March 2026

PILLAR 5

Infection Prevention & Control



Healthcare Associated Infections

All Wales – Current FY rate per 100,000 population

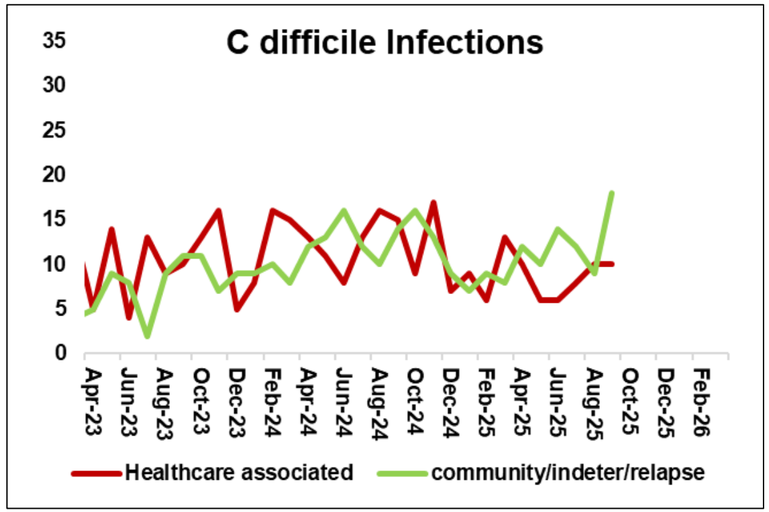
	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	41.87	1	23.78	59.96	21.44	7.37
Betsi Cadwaladr UHB	46.41	1.44	25.08	70.9	19.89	4.32
Cardiff and Vale UHB	40.79	3.46	26.94	53.49	23.86	3.85
Cwm Taf Morgannwg UHB	40.65	0.89	25.01	85.76	32.61	2.23
Hywel Dda UHB	41.11	4.11	27.75	96.09	32.89	5.14
Powys THB	19.29	0	1.48	1.48	0	0
Swansea Bay UHB	61.94	2.56	29.69	70.64	32.25	7.68
Velindre NHST						
Wales	**44**	**2.02**	**25.21**	**68.7**	**24.9**	**4.85**

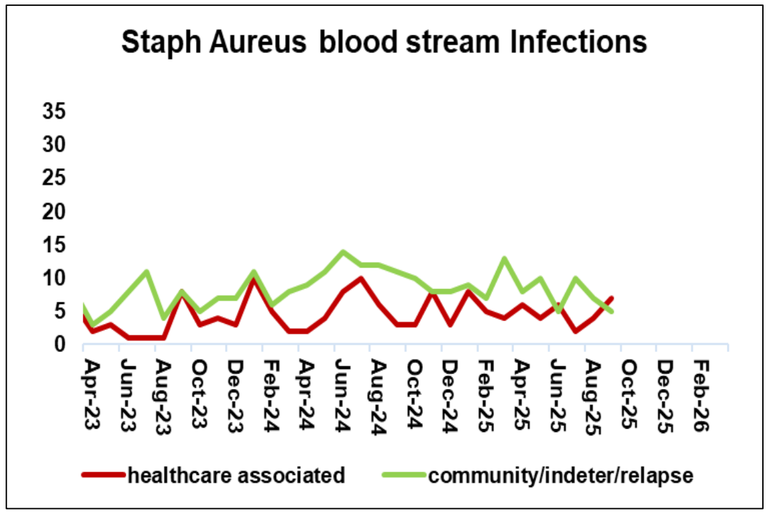
All Wales – Current FY count of specimens

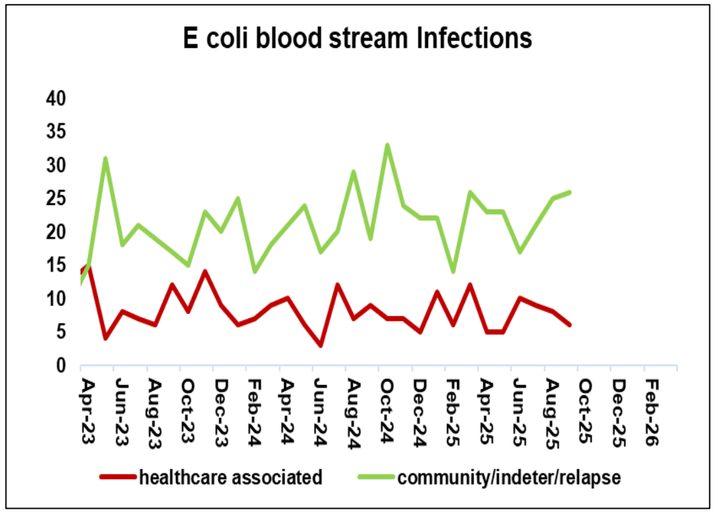
	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	125	3	71	179	64	22
Betsi Cadwaladr UHB	161	5	87	246	69	15
Cardiff and Vale UHB	106	9	70	139	62	10
Cwm Taf Morgannwg UHB	91	2	56	192	73	5
Hywel Dda UHB	80	8	54	187	64	10
Powys THB	13	0	1	1	0	0
Swansea Bay UHB	121	5	58	138	63	15
Velindre NHST	1	0	3	8	0	0
Wales	**698**	**32**	**400**	**1090**	**395**	**77**

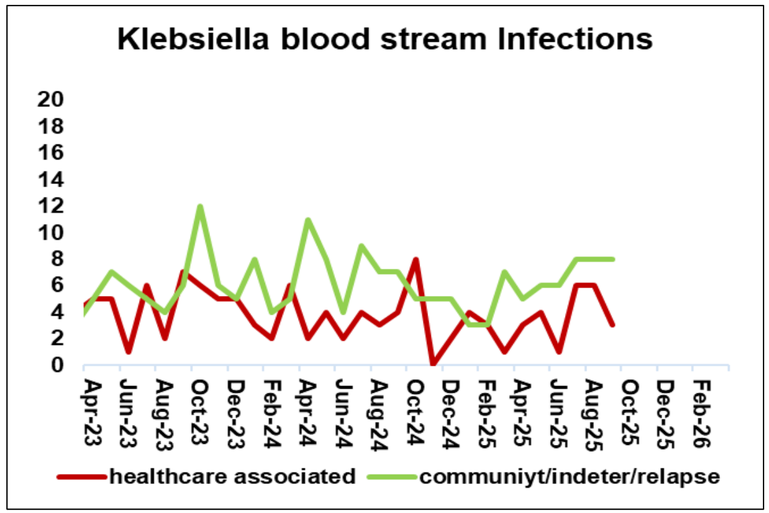
< than same period last FY
= same period last FY
> than same period last FY

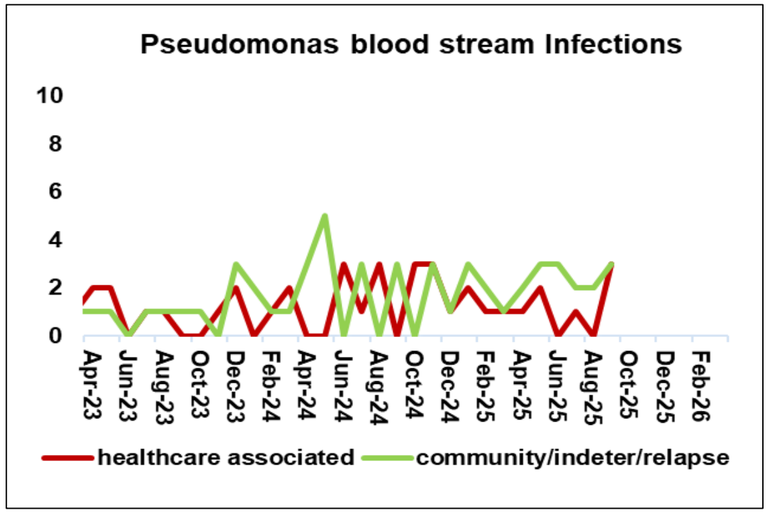
Healthcare Associated Infections









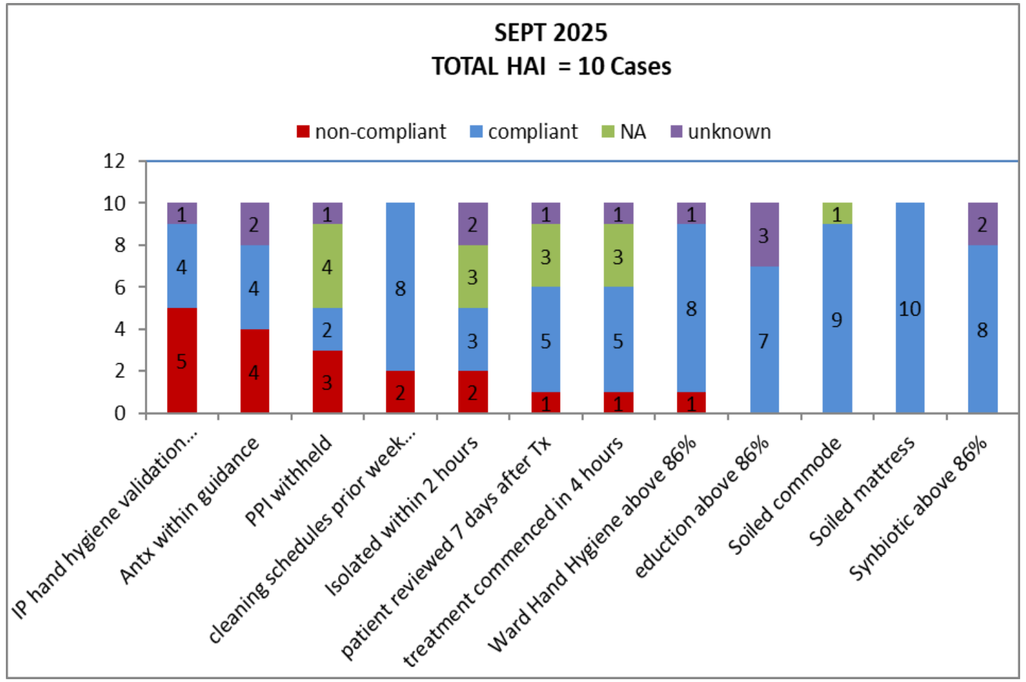


Explanation of Data:

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

Healthcare Associated Infections

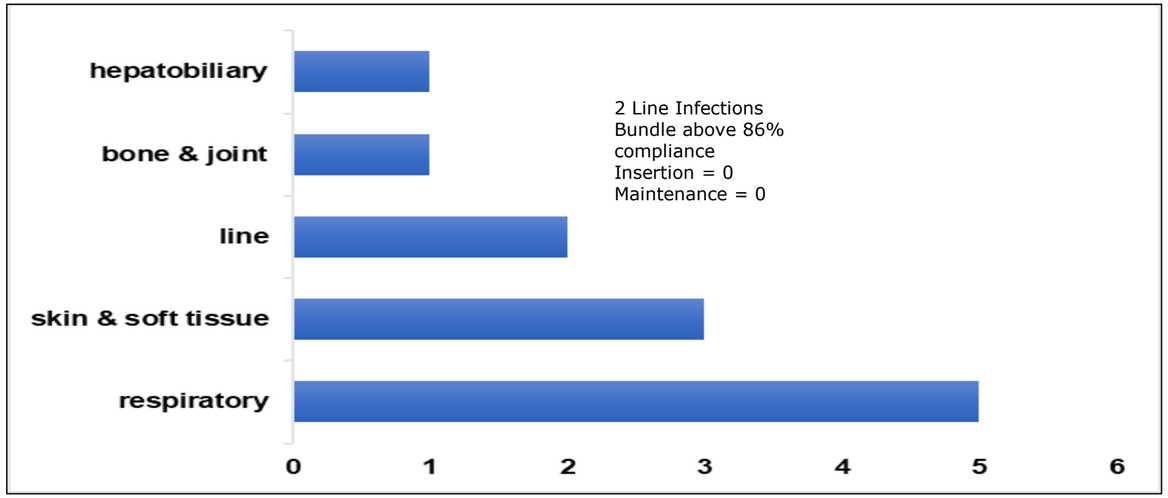
Compliance from RCA for healthcare associated C difficile cases



Definition	Analysis	Implication
C difficile infection Apr 2025 – Sept 2025 = **125 cases** **50** = Healthcare associated **41** = Community acquired **11** = Indeterminate **19** = Relapse **4 =** Other Health Board	RCA undertaken on all HAI plus antimicrobial review for CAI Ongoing reactive cleans Ongoing promotion of fundamental infection prevention Ongoing Quality improvement work Support the all Wales C difficile collaborative 07.10.25	Sample collection Cubicle risk assessment supported at safe to start Allocate bed space cleaning for normal discharge clean takes approximately 35 minutes
Period of increased incident Penallta ward and B3	Outbreak meeting arranged 04.09.25 B3 PII scheduled Oct	Geno sequencing confirmed different strains Cleaning of dirty utility rooms Disposal of bodily fluids within ensuite Extended antibiotic causes

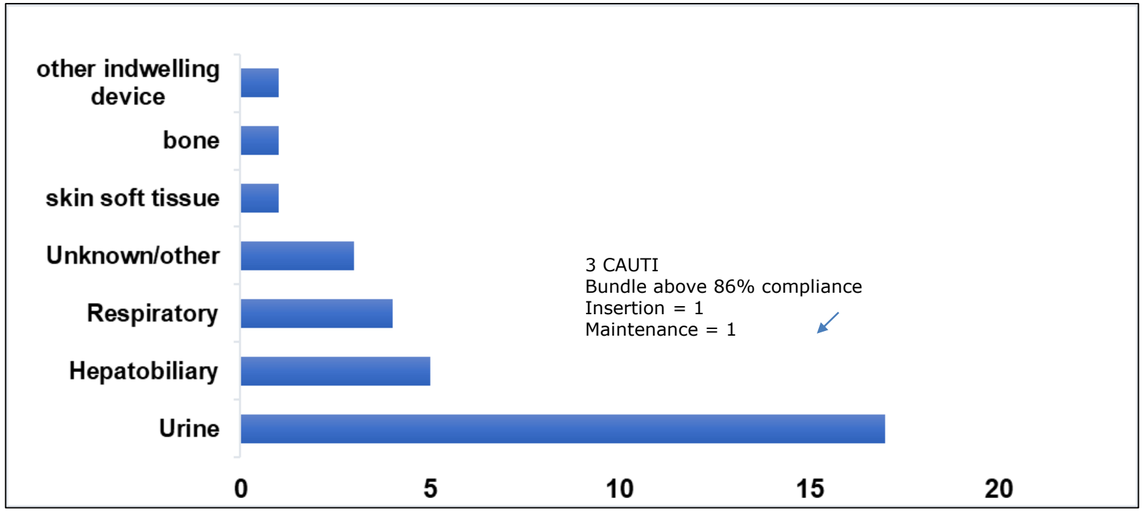
Healthcare Associated Infections

Staph Aureus blood stream infections



Definition	Analysis	Implications
Staph Aureus BSI Apr 2025 – Sept 2025 = **74 cases** **30** = Healthcare associated **40** = Community acquired **1** = Indeterminate **0** = Relapse **3 =** Other Health Board	• Ongoing promotion of ANTT • RCA meeting for line infection • IDECEIDE approved plan launce at link champion day 24.10.25	• Ongoing monitoring of action plan via MANAIG Meeting • IPN representative on the all Wales steering group for procedure packs • Link with CAP/HAP to respiratory infection

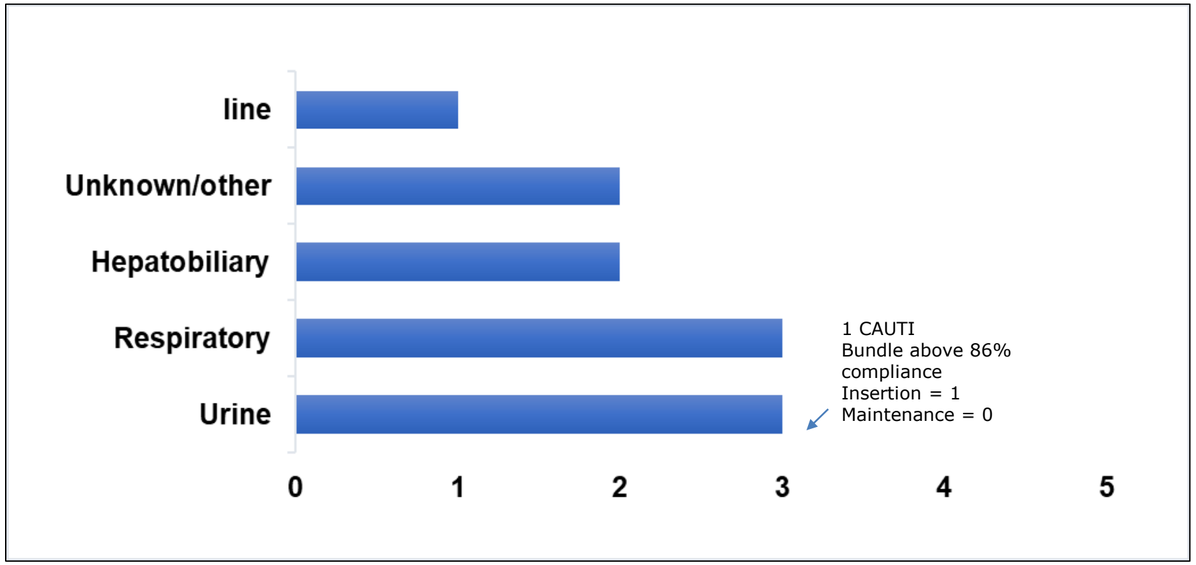
E coli blood stream infections



Definition	Analysis	Implications
E coli BSI Apr 2025 – Sept 2025 = **179** **45** = Healthcare associated **126** = Community acquired **3** = Indeterminate **0** = Relapse **5 =** Other Health Board	RCA for blood stream infection linked to CAUTI continues with ongoing promotion of HOUNDINI Multi drug resistance included in F1 training	• Ongoing review of cleaning schedules and cross reference to national standards • Commencing an alternative product for cleaning on A4 starting 08.09.25 awaiting staff evaluation • All Wales steering group for cleaning products • Next step option appraisal re disinfectant clean due to contact time and dilution required

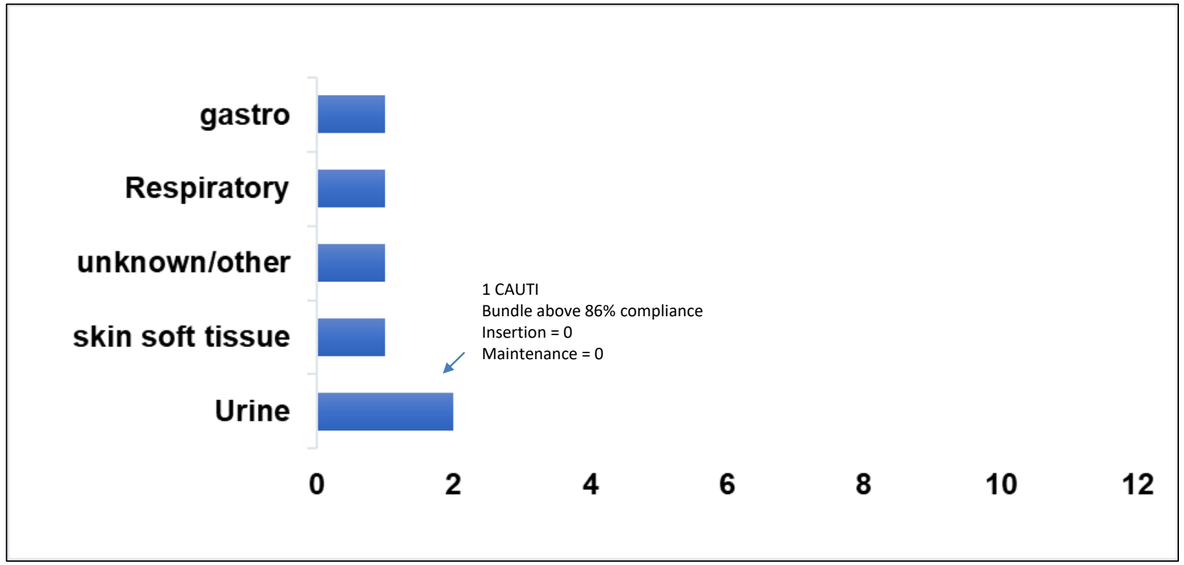
Healthcare Associated Infections

Klebsiella blood stream infections



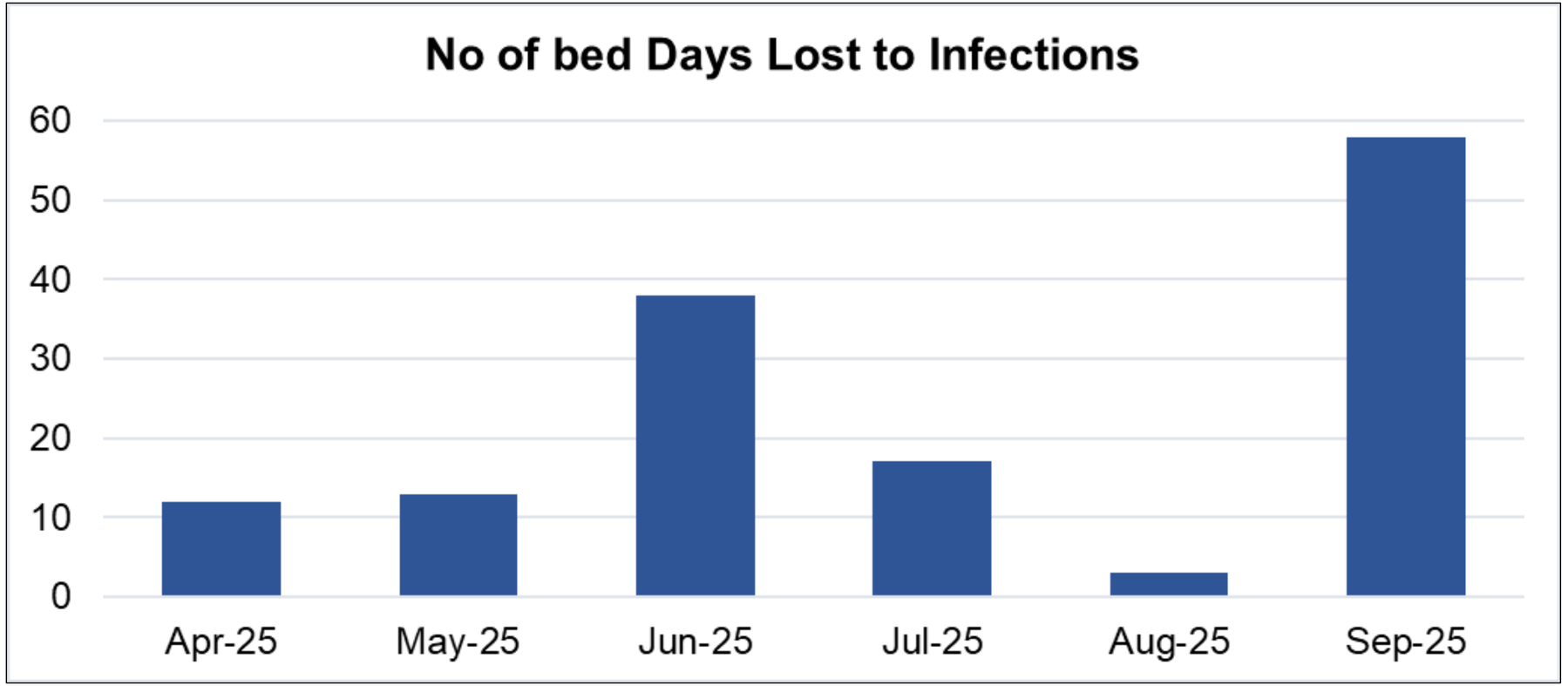
Definition	Analysis	Implication
Klebsiella BSI Apr 2025 – Sept 2025 = **64** **22** = Healthcare associated **39** = Community acquired **1** = Indeterminate **0** = Relapse **2 =** Other Health Board	RCA for device related infections undertaken Drain disinfectant within critical care Ongoing promotion of urinary catheter care bundle	Consider earlier trail without catheter (TWOC) Ongoing review data analysis for community prevalence study

Pseudomonas blood stream infections



Definition	Analysis	Implication
Pseudomonas BSI Apr 2025 – Sept 2025 = **22** **8** = Healthcare associated **10**= Community acquired **1** = Indeterminate **0** = Relapse **3 =** Other Health Board	Continue to promote ANTT Water sampling in augmented care areas	As other BSI

Healthcare Associated Infections



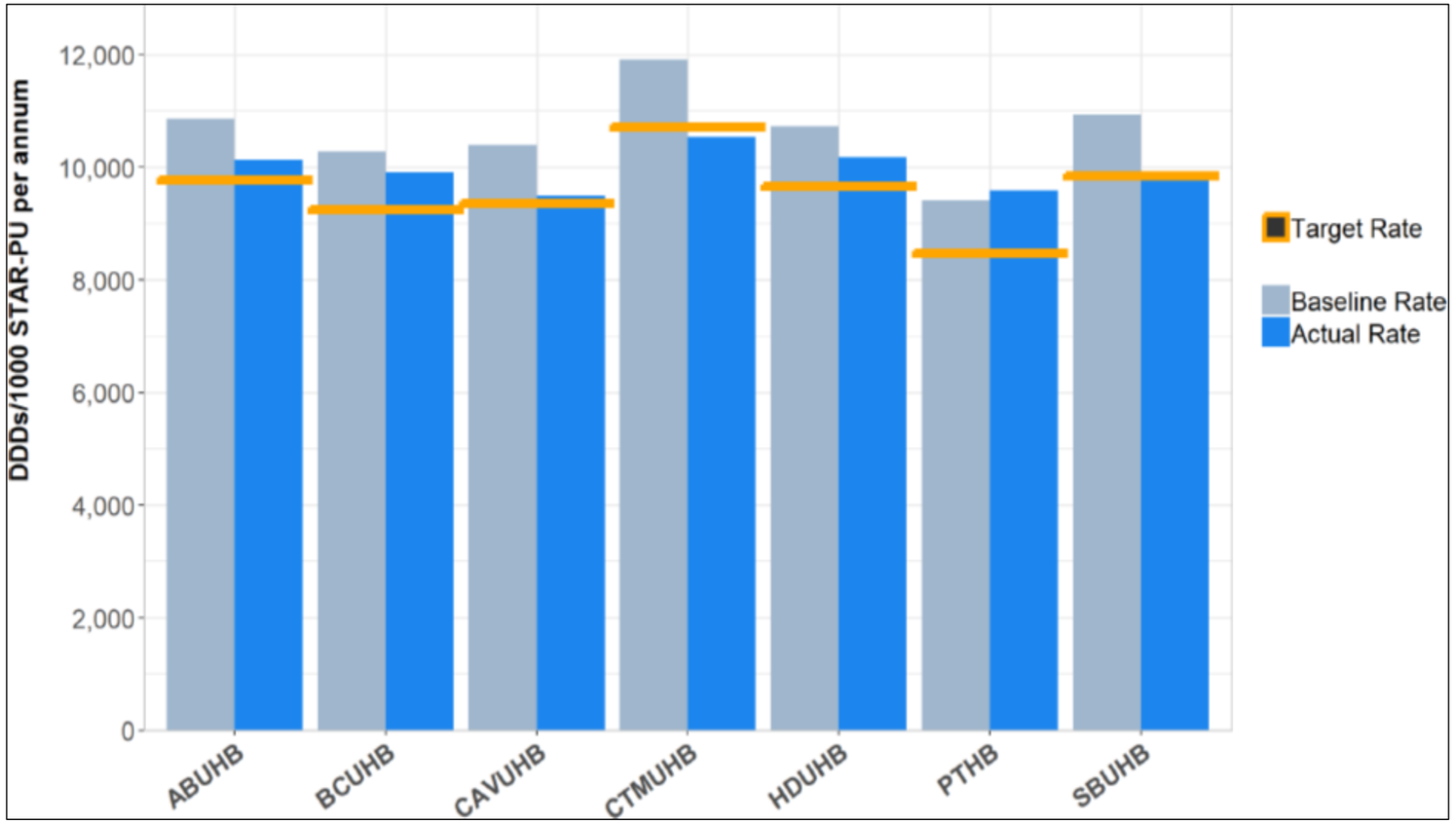
Issue

- Sporadic bays closed and 2 wards with Covid increased risk to patients where shared facilities and communal bathrooms etc
- Enhanced care
- Staff working with respiratory symptoms

Learning and Improvement

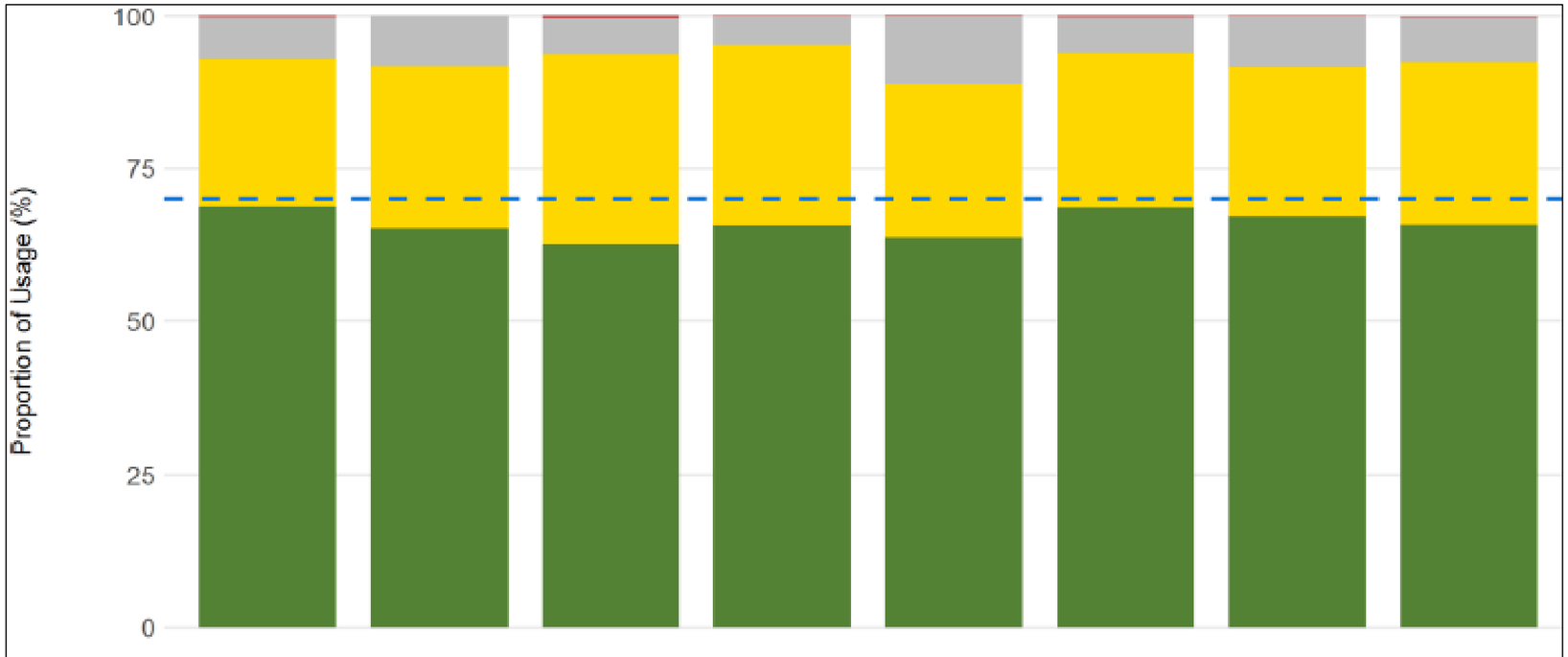
Definition	Analysis	Implications	Who	When
Scabies outbreak on Trefynwy Ward, Monnow Vale.	Contact tracing. Advice/Warn & Inform letter sent to GP of affected patients (4) & exposed patients (21) Mass treatment of staff & patients Curtain & bed linen changed alongside treatment	Early diagnosis of rash Timely referral to Derrm	OCC health Ward staff/GP IPN	Sept completed and under 8 week monitoring
Scabies outbreak on C7E, Royal Gwent Hospital	Contact tracing. Advice/Warn & Inform letter sent to GP of affected patients & exposed patients Mass treatment of staff (apprx. 100) & exposed patients (51) Curtain & bed linen changed alongside treatment	Diagnosis of rash Response to treatment Review scabies polices for action flow chart	OCC health Ward staff/GP IPN	Sept completed and under 8 week monitoring
2 wards closed due to Covid outbreaks MAU Bay, YYF D4E, RGH	Ward closed Droplet precautions Isolation/cohorted of patient Staff risk assessment	Additional cleaning for touch points and shared service Compliance with fundamental IP	Ward staff	Sept
Period of increased incidence of C difficile on B3, family & Therapies	HPV/UV cleaning of room Antibiotic review Review of fundamental infection prevention	Prescribing outside of health board policy	Ward team	Sept
Patients exposed to CPO Patient moved from cubicle into bay while third CPO screen was in progress. Result confirmed positive.	Contact tracing of affected bay Advice letter sent to GP of affected case and 7 exposed patients	Wait for results to be confirmed prior to deescalation of isolation Local team to seek support from infection prevention re risk assessment	Ward staff IPT	Sept
2 patients exposed to smear positive cavitary disease considered significantly infectious for TB.	Contact tracing of patients and staff	Consider TB when review respiratory symptoms Isolation of patients if suspected	Medical team	Sept
Scabies at Woffington House	Around 14 out of the 28 residents have symptoms treat the whole home Around 10-15 have reported that they have symptoms	No specialist Dermatology opinion has been sought, no skin scrapings have been sent	Care home managers/GP	Sept

Welsh Government Antimicrobial Targets: Primary Care



- **Target 11a: 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)**
- ABUHB 2024/25 FYE position received from Public Health Wales: **6.6 % reduction (moving towards target)**
- The reduction of antibiotic course lengths has been pivotal in achieving this target, which was incentivised in the 23/24 CEPP (GP incentive scheme). Review of long-term antibiotic prophylaxis as part of the 24/25 CEPP should result in further reductions in antimicrobial volume.

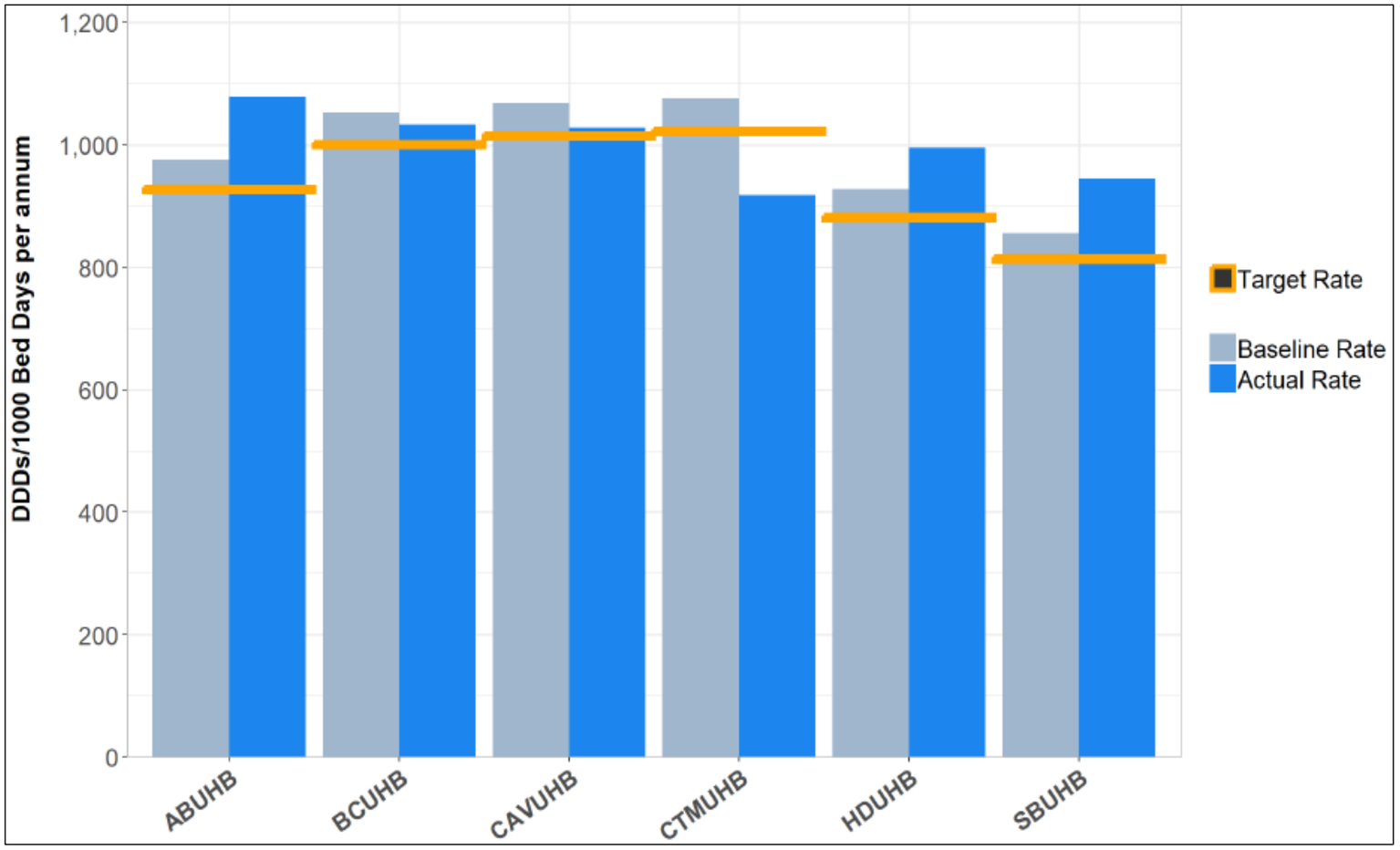
Welsh Government Antimicrobial Targets: Primary Care



	ABUHB	BCUHB	CAVUHB	CTMUHB	HDUHB	PTHB	SBUHB	Wales
Reserve	0.2	0.0	0.3	0.1	0.1	0.2	0.1	0.1
Other	7.0	8.3	6.0	4.7	11.2	5.9	8.3	7.4
Watch	24.0	26.5	31.1	29.5	25.2	25.3	24.5	26.6
Access	68.8	65.2	62.6	65.7	63.6	68.6	67.1	65.8

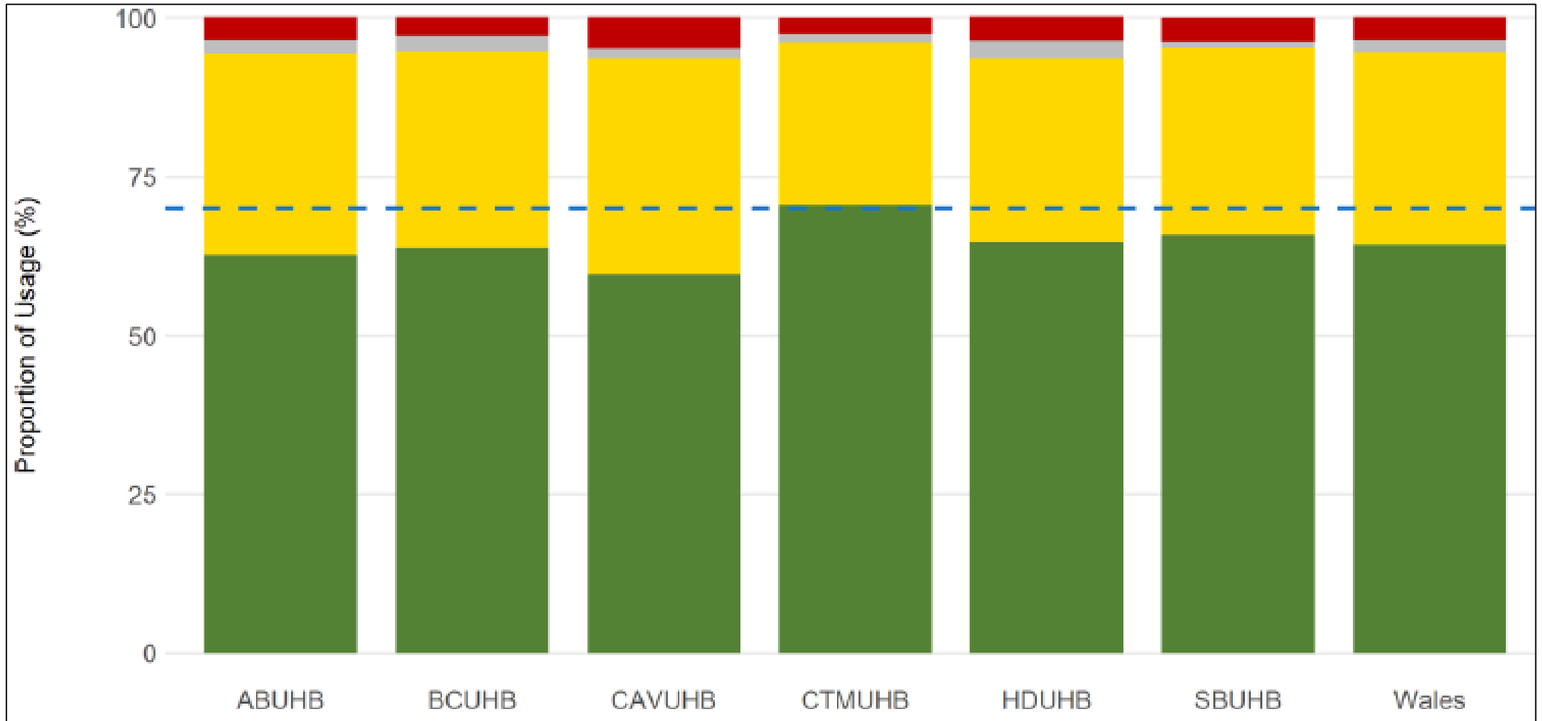
- **Target 12: WHO 'Access' category – minimum of 70% of total antibiotic use from the Access category by 2029/30, measured in defined daily doses (DDDs).**
- ABUHB 2024/25 FYE position received from Public Health Wales: **68.8% (moving away from target).** It should be noted that actions to reduce antibiotic volume to achieve the previous target have resulted in a reduction in 'access' antibiotic use.
- There is a national proposal to remove the 'other' category from calculations, which would result in ABUHB achieving the 70% target.

Welsh Government Antimicrobial Targets: Secondary Care



- **Target 11b: 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)**
- ABUHB 2024/25 FYE position received from Public Health Wales: **10.9% increase** in consumption compared to baseline. This is however a **2.4% reduction** year on year
- Work is progressing at pace to embed good antimicrobial stewardship practice into electronic prescribing ready for go live in 2026. Functionality around limiting antibiotic course lengths will be decided imminently.

Welsh Government Antimicrobial Targets: Secondary Care



	ABUHB	BCUHB	CAVUHB	CTMUHB	HDUHB	SBUHB	Wales
Reserve	3.5	2.7	4.8	2.3	3.7	3.7	3.5
Other	2.0	2.6	1.6	1.5	2.7	0.9	1.9
Watch	31.8	30.9	34.0	25.6	29.0	29.4	30.4
Access	62.7	63.8	59.6	70.5	64.7	65.9	64.2

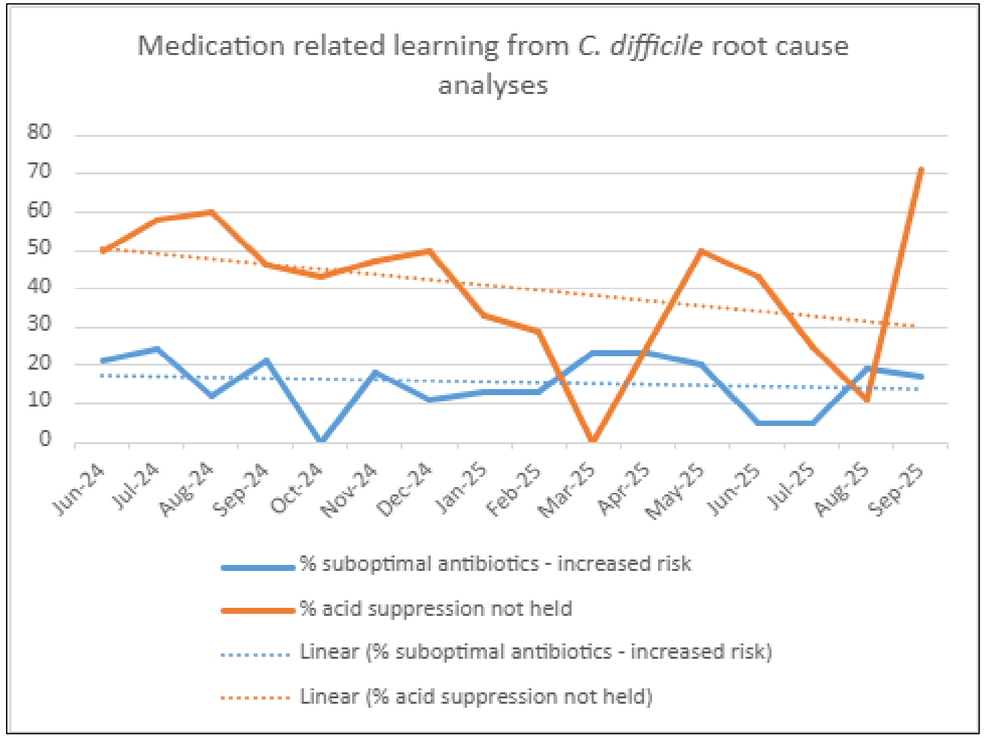
- **Target 12: WHO 'Access' category – minimum of 70% of total antibiotic use from the Access category by 2029/30, measured in defined daily doses (DDDs).**
- ABUHB 2024/25 FYE position received from Public Health Wales: **62.7% usage in access category** (no improvement from 23/24 FYE)
- New guideline sections are being written to steer prescribers away from over-using sepsis guidelines, which use predominantly use 'watch' or 'reserve' antibiotics.

WG Antimicrobial Performance Overarching Actions

Issue	Action	Learning and Improvement	Who	When
Primary care in-hours GP antimicrobial usage increasing, in spite of audit & feedback cycles with high-prescribing practices	Attended Primary Care Clinical Directors meeting to discuss. Hybrid strategy agreed: thematic work at scale (e.g. syndrome-based education) plus continue 1:1 work for high prescribing practices with a lighter touch approach.	Met with Assistant Primary Care Divisional Director for Partnerships Jan 25 & agreed approach for high prescribing localities. Added to Divisional Annual Plan for 25/26, and presented at NCN leads May 2025. Work started with Caerphilly in Q2, other two NCNs yet to engage.	Consultant Antimicrobial Pharmacist	25/26 FYE
Use of order sets (standard prescriptions) in electronic prescribing (ePMA) key to improving antimicrobial use in secondary care. Need to be embedded from go-live to ensure behaviour change	Discuss with ePMA lead pharmacist once in post Collaborate with other health boards using the Better system to share workload AMS team to prioritise developing order sets in 25/26	Drug list, warnings submitted. Standard prescriptions being developed & discussions commenced around ARK functionality. All-Wales group, chaired by AB, now working with NHSE to align system development requests. Ongoing development with weekly progress meetings.	Consultant Antimicrobial Pharmacist	2025/26 FY
Improve divisional engagement with antimicrobial metrics	Working with Assistant Director for Quality and Patient Safety to embed antibiotic indicators into divisional assurance	Secondary care dashboard finalised Dec 24. Exception template developed for divisions, meeting with QPS to discuss pilot/roll out Oct 25.	Lead Antimicrobial Pharmacist for Secondary Care	Dec 2025
Attempt to model primary care antimicrobial usage data against more demographic parameters to better understand drivers of use	Meeting planned with ABUHB Public Health Team to discuss data collaboration	Public Health Team have started to develop dashboard, mapping antimicrobial use against deprivation and admissions.	Primary Care Antimicrobial Pharmacist	25/26 FYE
Guideline updates to reduce overreliance on sepsis guidelines	Develop new guideline section that covers patients without a defined source of infection but are not septic. Deliver directorate teaching to front door areas & respiratory.	Initial drafts prepared for discussion at Antimicrobial Guideline Group – meetings pending. Directorate teaching delivered to respiratory, ED and acute medicine during Q2.	Lead Antimicrobial Pharmacist for Secondary Care	December 2025

C.Difficile Antibiotic Themes

July – September 2025						
Antibiotic Finding		**HCAI**	**CAI**	**Relapse**	**Indeterminate**	**Total**
No antibiotics received	0	0	1	1	0	**2**
No suboptimal antibiotics	0	16	3	5	1	**25**
Possible suboptimal use – no increased risk	0	7	1	1	1	**10**
Possible suboptimal use – increased risk of C. diff	0	8	1	1	0	**10**
Awaiting GP response	0	0	17	1	3	**21**
RCA pending	0	1	0	0	1	**2**
Total	**0**	**32**	**23**	**9**	**6**	**70**



Learning

5 patients received suboptimal antimicrobials outside of guidelines:

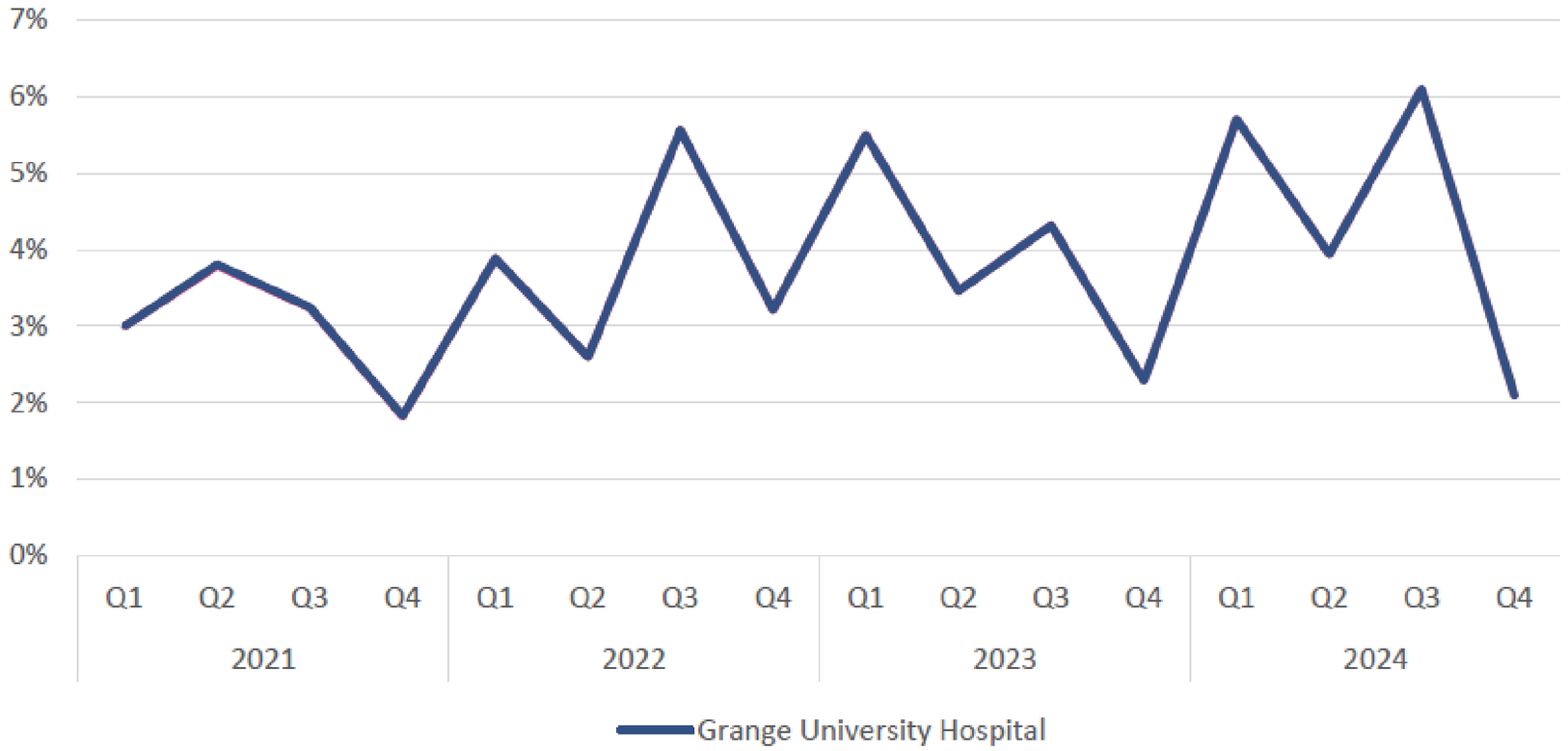
- 1 Prolonged antibiotic course length
- 2 Unnecessarily broad cover
- 2 potentially unnecessary antibiotics: one patient for sterile pyuria, another for ‘sepsis’ when there was a clear alternative diagnosis

5 patients had their acid suppression continued inappropriately:

- N.B. The percentage in the trendline above is high as the majority of patients with C. diff in September were not on acid suppressing medicines

C-Section Surgical Site Infections

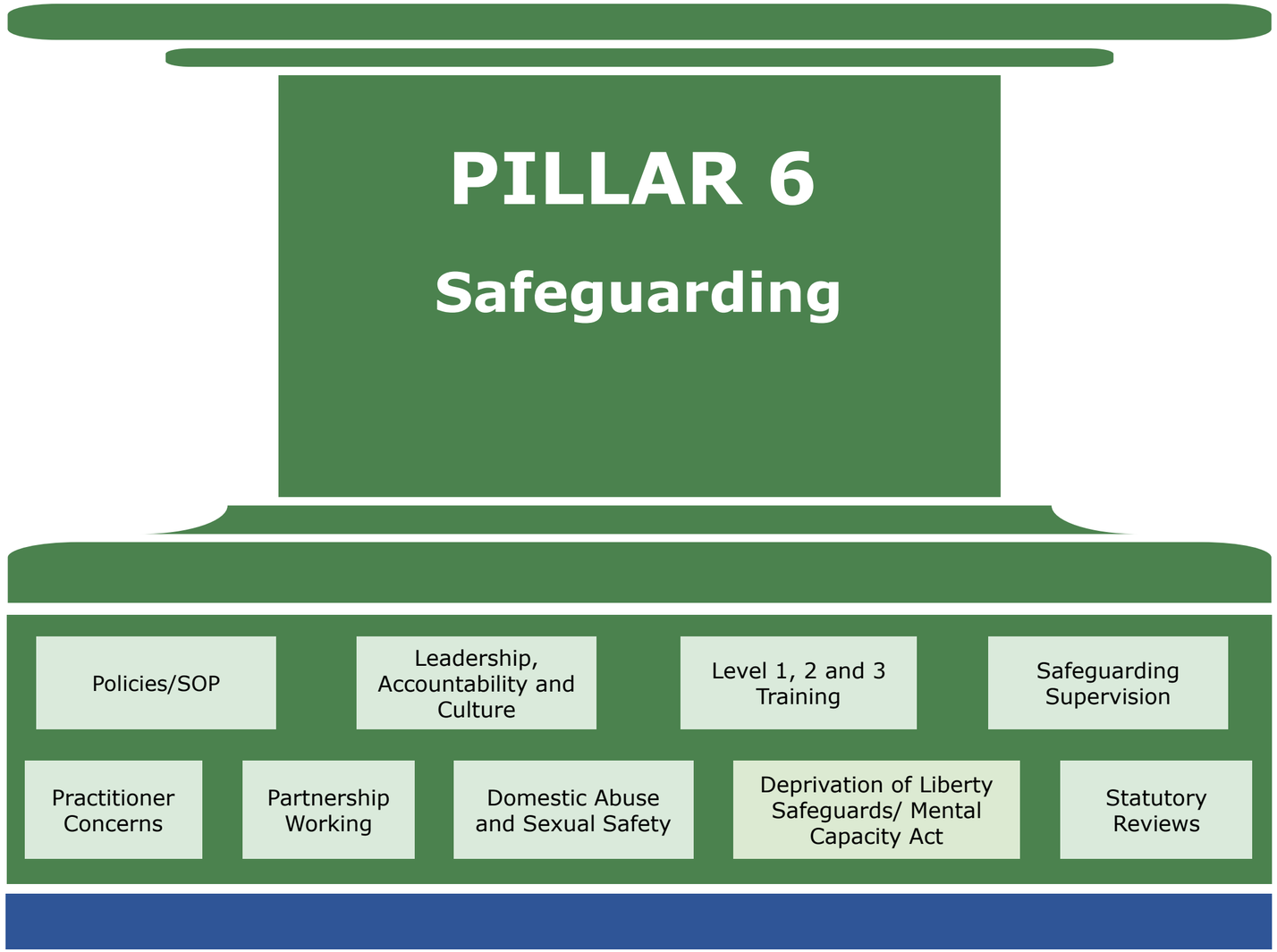
Quarterly rates



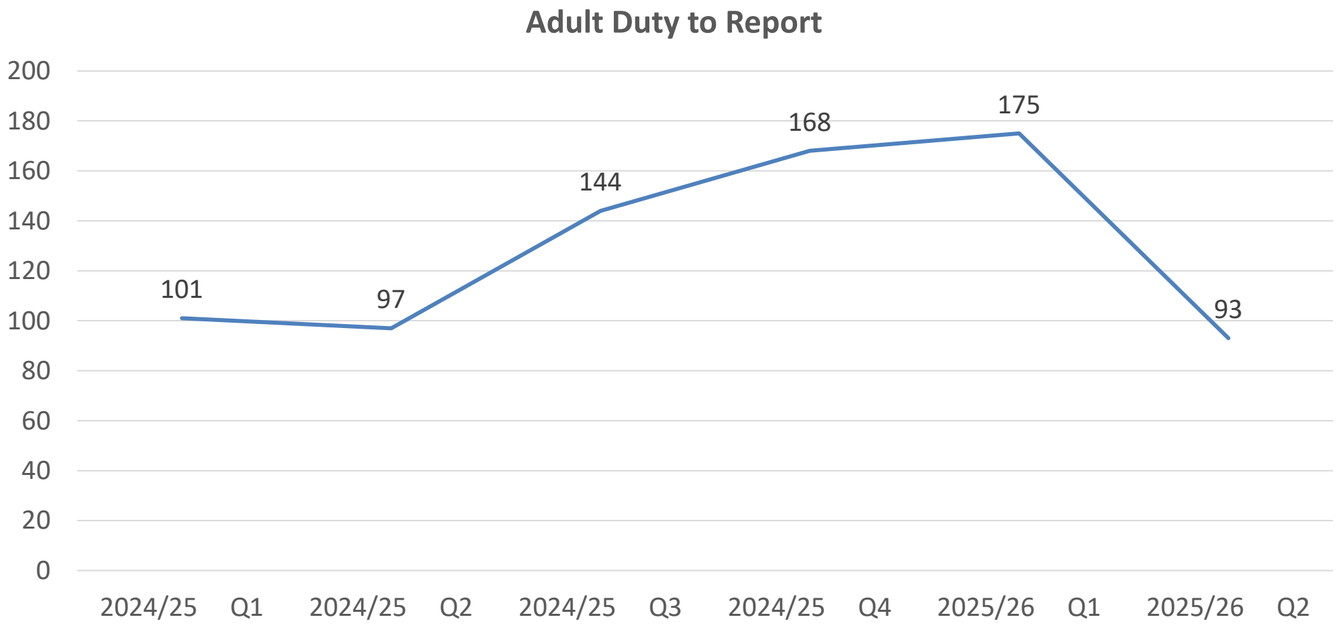
Grange University Hospital

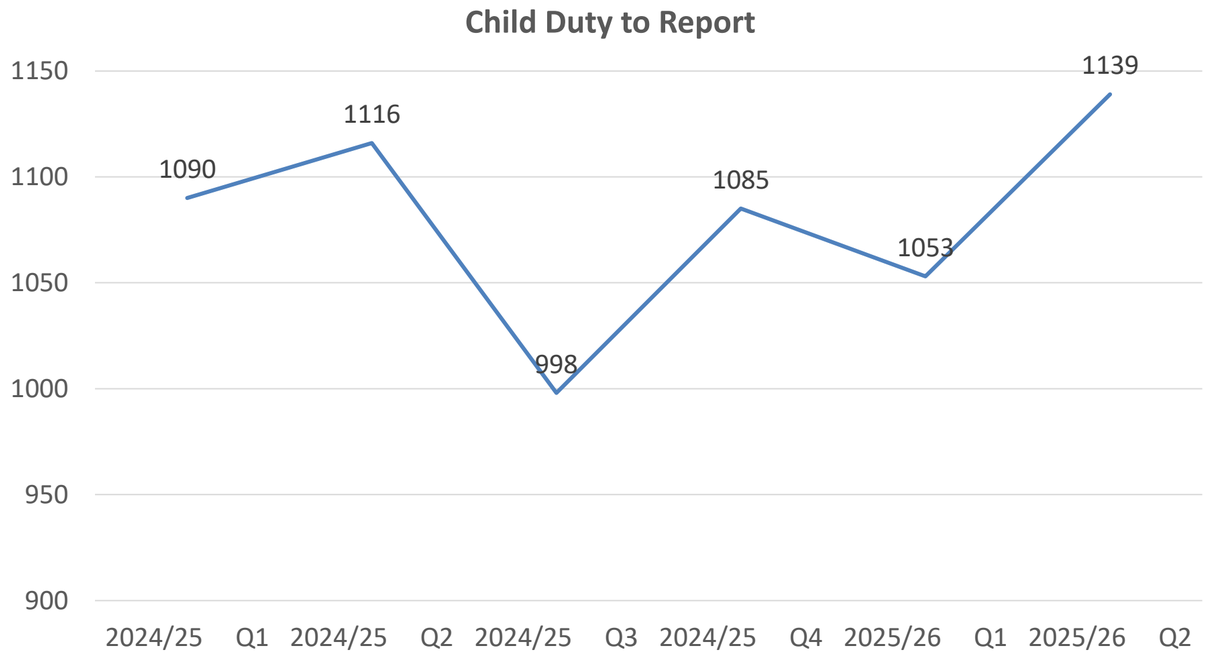
		Procedures*	SSI	SSI rate
Q1 2024 - Q4 2024		**2084**	**92**	**4.4%**
Q1 2021 - Q4 2023 (baseline)		5628	201	3.6%
2024	Q4	572	12	2.1%
	Q3	557	34	6.1%
	Q2	482	19	3.9%
	Q1	473	27	5.7%
2023	Q4	524	12	2.3%
	Q3	509	22	4.3%
	Q2	491	17	3.5%
	Q1	491	27	5.5%
2022	Q4	498	16	3.2%
	Q3	485	27	5.6%
	Q2	424	11	2.6%
	Q1	463	18	3.9%
2021	Q4	492	9	1.8%
	Q3	431	14	3.2%
	Q2	420	16	3.8%
	Q1	400	12	3.0%

+1 SD	4.9%
Baseline	3.6%
-1 SD	2.2%


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

Duty to Report (Adult and Children)

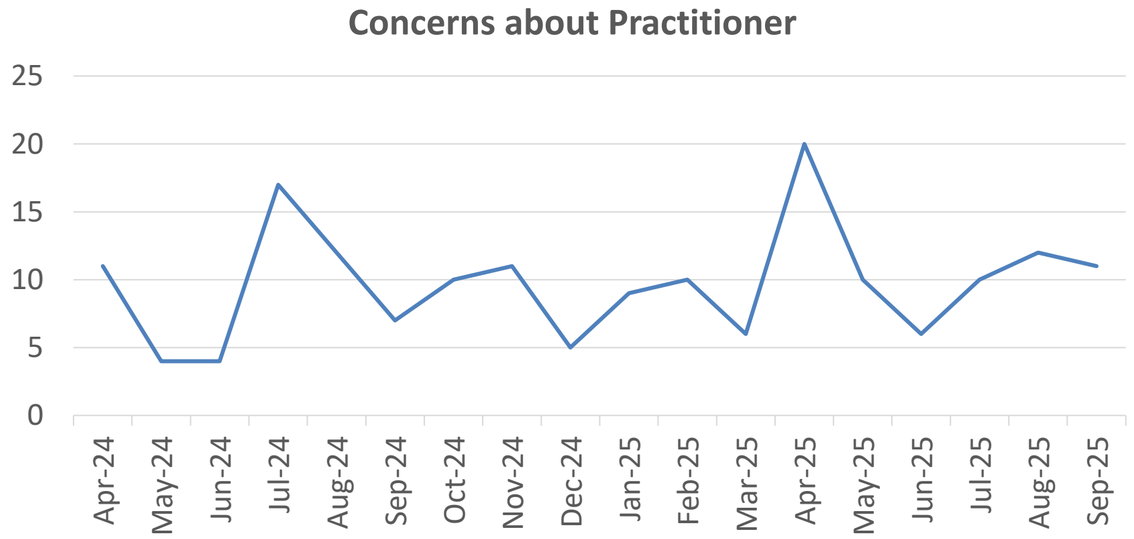




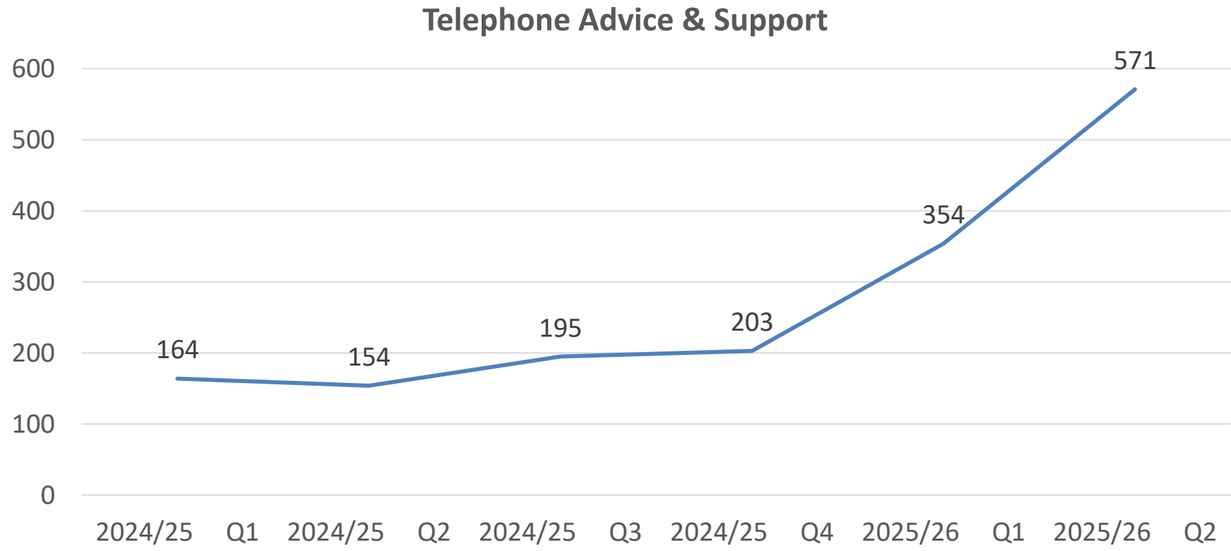
Definition	Analysis	Implications
The information presented has been extracted from RL Datix and is accurate at the point of recording. This information relates to all cases that were managed by or supported by the Corporate Safeguarding Team.	Duty to Reports for adults continued to rise throughout 2024 and in Q1 of 2025. However, it has been noted that there has been a significant drop in Q2 of this year. Whilst this is the first month such a significant drop has been noted, this is felt to be a result of improved staff awareness leading to more appropriate referral Activity in relation to Children's Safeguarding continues to remain very high, with our highest level of activity to date in Q2 2025/26. Following discussion with partner agencies, it is anticipated that this high level of activity is expected to continue, with potential for further increases. There are a number of social and economic factors impacting upon Child Safeguarding within a home setting, as well as challenges created by exploitation and organised crime. Further work is required to ensure that more detailed information is required to reflect categories of abuse in future reports.	The rise in activity in relation to Children's Safeguarding is causing some concerns as to whether any further increase in activity could impact the sustainability of the service. Work is ongoing with the five LA partners to understand the increase in activity and an SBAR is being produced to outline risk and provide assurance as to how this will be mitigated.

Pillar 6: Safeguarding

Practitioner Concerns

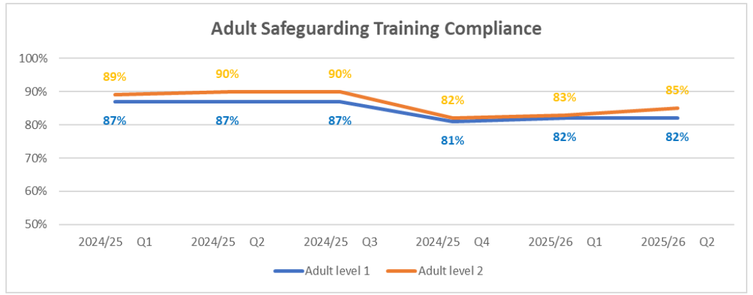


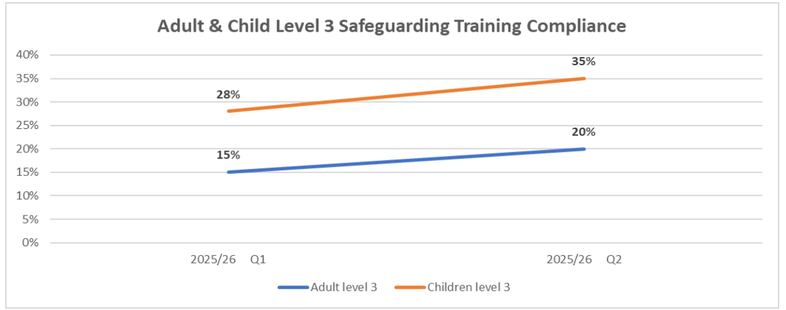
Support and Advice

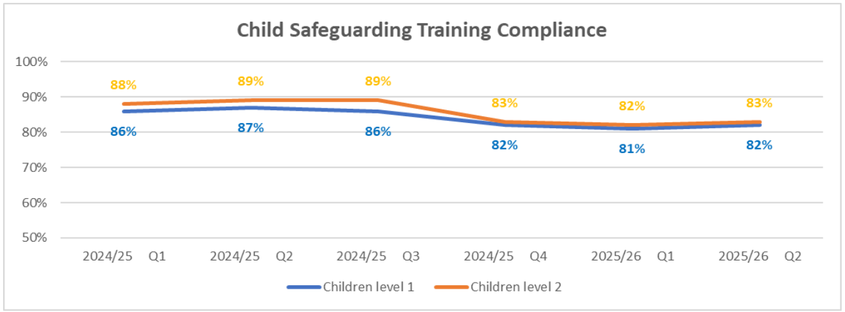


Definition	Analysis	Implications
The information presented has been extracted from RL Datix and is accurate at the point of recording. This information relates to cases where staff, volunteers or independent contractors have been referred into the Section 5 Process of Wales Safeguarding procedures, which focusses on assessing transferable risk and co-ordinating investigations.	Current information only highlights the volume of cases open at any one point, which in itself does not provide the opportunity for thematic analysis. The attached graph shows spikes in open cases, but this is often due to the complexity of some cases causing them to be open for longer periods. Future data sets should provide more meaningful analysis Whilst data in regard of advice and support calls shows an increase, this can potentially be attributed to better recording via the Datix Module, which was launched in April 2025. The increase in advice and support also correlates with the drop off in Safeguarding Adult DTR, as there are discussions held with safegusarding leads prior to making referrals.	Work is ongoing with the Once for Wales Team, to ensure that the Dashboards associated with this area of business enable us to highlight the following: • Breakdown by Division • Breakdown by type of concern • Breakdown by whether the concern is directly related to activity on behalf of the health board or matters relating to their personal life • Breakdown on how long cases have been open The regular advice and support is leading to less inappropriate referrals being made in to the local authority, I regard of adult safeguarding.

Training Compliance

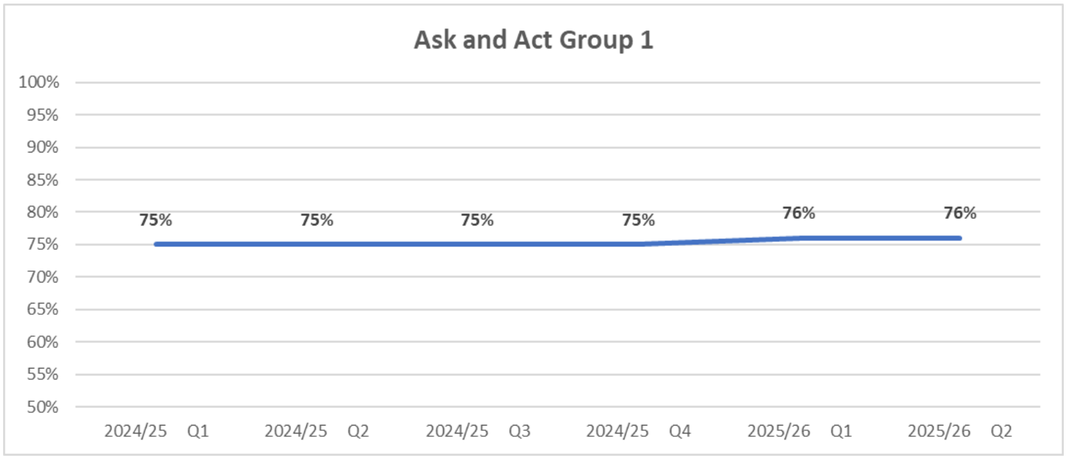






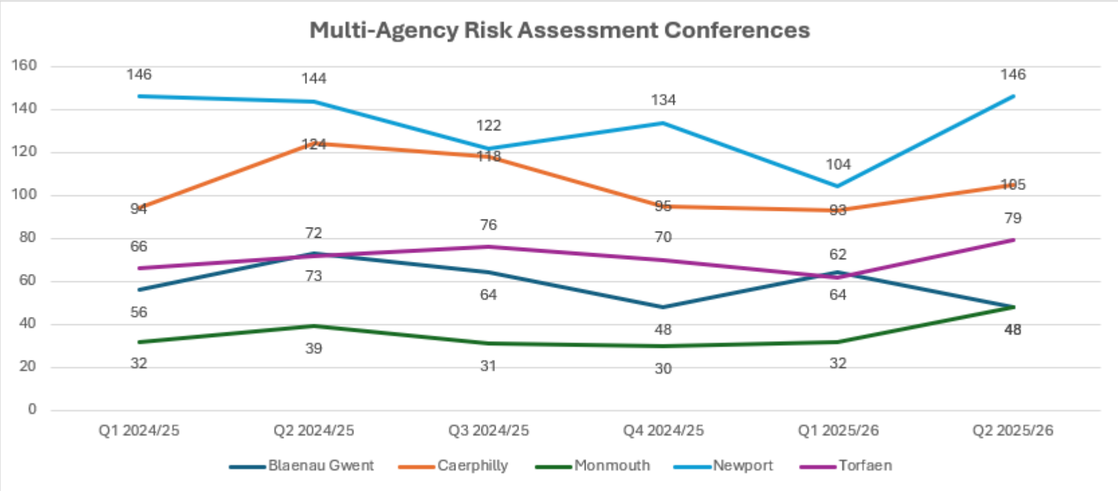
Definition	Analysis	Implications
The information presented has been extracted from ESR and was accurate at the end of Q2. This information relates to Compliance with the three mandated levels of Safeguarding Children and Safeguarding Training. Safeguarding training continues to be provided and monitored, in line with the recommendations of the Intercollegiate Documents for Safeguarding of Children and Adults	Safeguarding Level 1 and 2 has fallen below the requirement of 85% in Q1, which was brought to the attention of Divisional Leadership Teams. Slight increases in compliance are evident in Q2 , though we remain below the recommended 85%. Level 3 Children and Adults Training was mandated in April 2025, with a requirement to deliver Children's Level 3 to a cohort of 2500 staff and Adult Level 3 to a cohort of 6500 staff, with a target to achieve compliance of 85% by March 2028. A risk has been identified that current resources are unlikely to provide enough training places to reach this target, so an SBAR has been prepared for the Executive Team to highlight this risk and offering options as to how it can be mitigated.	At this current time Welsh Government are developing a reporting framework, which will require us to report our training compliance and to illustrate our recovery plan where we are non-compliant Resources will need to be secured to provide additional training. Non recurrent funding has been secured to enable 750 additional training places to be provided in Q3 and Q4. Non-compliance with training targets for Level 3 Safeguarding does not appear to be providing a barrier to safeguarding concerns being recognised and escalated, most likely due to the levels of basic understanding provided by Level 1 and 2 training.

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



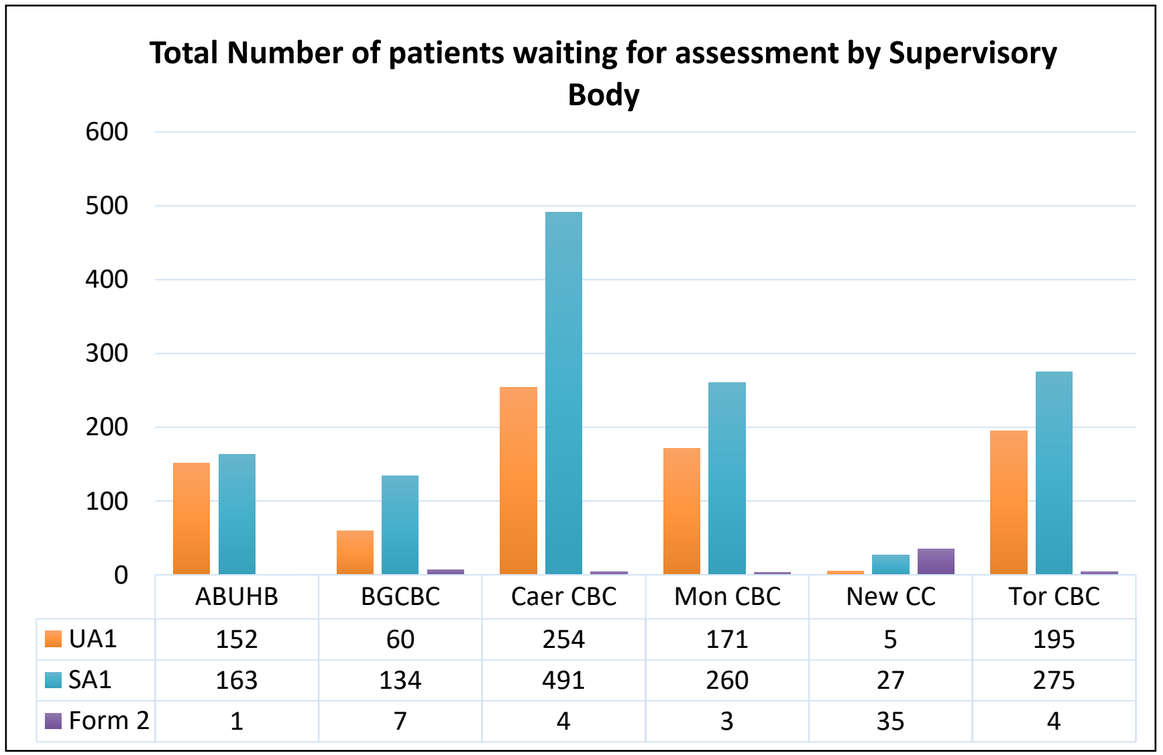
Definition	Analysis	Implications
The information presented in regard of Ask and Act Training has been extracted from ESR and was accurate at the end of Q2. This information demonstrates compliance with the Group 1 Training, Ask and Act is nationally mandated, with different staff groups identified as requiring different levels of training. 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	The health board has a target of 85% compliance for Group 1 and Group 2. Current compliance for Group 1 is 76%, which is only an increase of 1% from the last five quarters. The target for compliance is 85%, Having worked with Divisions to identify where in the organisation Group 2 would apply, the Corporate Safeguarding Team are currently working with the ESR Team to determine the exact number sof staff who will require Group 2 training	Group 1 compliance is monitored by Welsh Government through the annual VADASV report. Whilst we are unlikely to be an outlier, this will draw some external scrutiny. This risk will be formally escalated and a recovery plan requested from Divisions, via the Strategic Safeguarding Group. The Group 2 training is nationally prescribed as four-hour training, which has to be co-delivered with the third sector specialist Domestic Abuse providers. As such, the health board will be required to make provision of a trainer from within the corporate safeguarding team and finding for the identified third sector provider. An SBAR has been prepared foe the executive committee, outlining the expected volume of staff that will require the training and highlighting the risks associated with resourcing this.

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

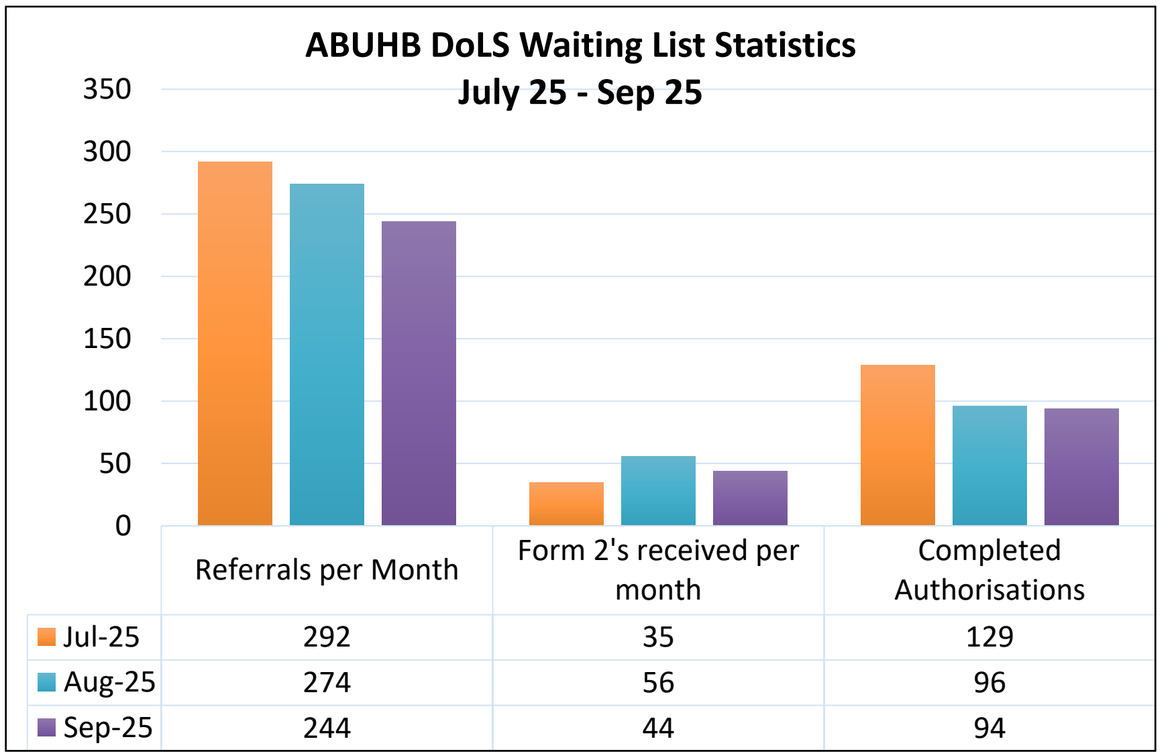


Definition	Analysis	Implications
The information presented in regard of MARAC has been extracted from MS Lists and was accurate at the end of Q2. Multi-Agency Risk Assessment Conferences, are confidential meetings where professionals from agencies share information on high-risk domestic abuse, creating 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. These meetings take place in each of the five Local Authority areas and total 130 each year	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 reductions in services 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. A loss of central funding for the MARAC Chairs has meant that partner agencies (Police, Health Board and Local Authorities) are likely to have to take on chairing responsibilities. This will mean the health board will need to provide a senior member of staff to chair twenty full day meetings per annum, from within existing resources.

Deprivation of Liberty (DoLS)

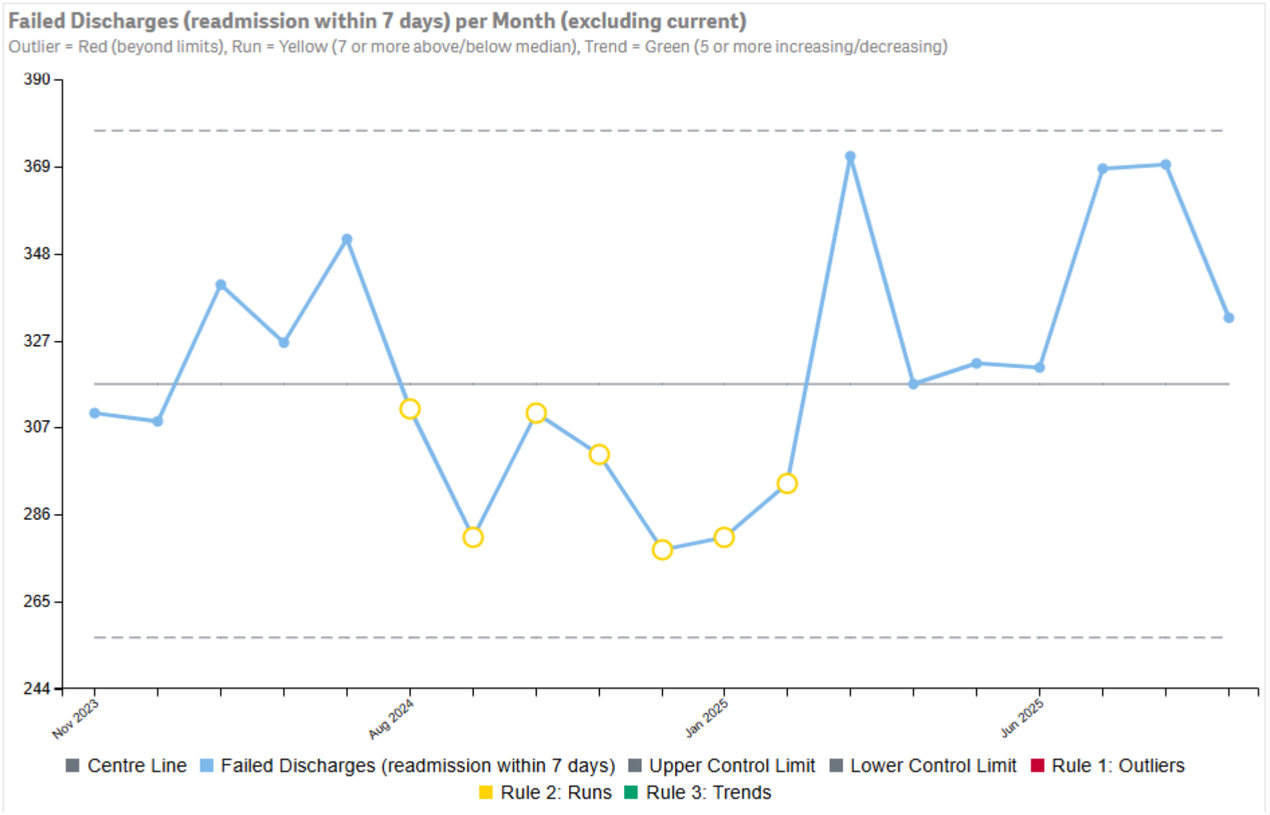


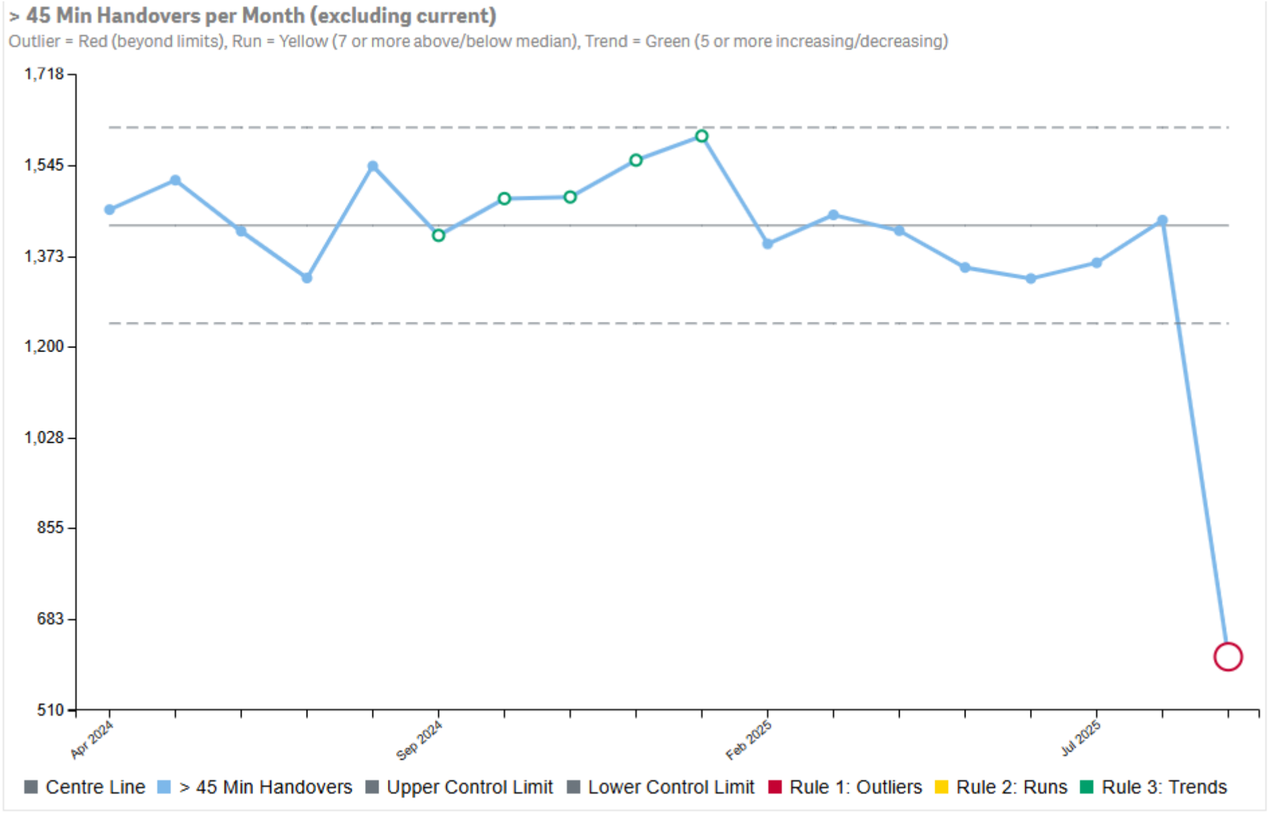
	ABUHB	BGCBC	Caer CBC	Mon CBC	New CC	Tor CBC
UA1	152	60	254	171	5	195
SA1	163	134	491	260	27	275
Form 2	1	7	4	3	35	4



	Referrals per Month	Form 2's received per month	Completed Authorisations
Jul-25	292	35	129
Aug-25	274	56	96
Sep-25	244	44	94

Additional Measures





National Quality Outcomes Framework Measures
Safe

All Wales Safe Phase 1 Quality Outcome Framework measures

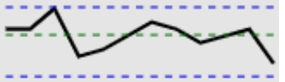
Quality Standard	Measure	Latest period	Latest figure		Previous figure	Last 12 months
Safe	Antibacterial items per 1,000 STAR-PUs	Jun-25	231.99			
Safe	Crude mortality rate (%)	Aug-25	1.52%	▲ 10.9%	1.37%	
Safe	Never Events reported to NHS P&I	Sep-25	0	▼ -100.0%	2	
Safe	Percentage of discharges on D2RA Pathway 0	Sep-25	54.28%	▼ -1.4%	55.02%	
Safe	Percentage of discharges on D2RA Pathway 1	Sep-25	11.00%	▲ 3.4%	10.64%	
Safe	Percentage of discharges on D2RA Pathway 2	Sep-25	3.51%	▼ -8.8%	3.84%	
Safe	Percentage of discharges on D2RA Pathway 3	Sep-25	2.89%	▲ 17.8%	2.45%	
Safe	Percentage of discharges with no D2RA Pathway Allocated	Sep-25	28.32%	▲ 1.0%	28.04%	
Safe	RAMI (Risk adjusted mortality index) 2023	Aug-25	169.46	▲ 56.5%	108.26	
Safe	Safeguarding Adults - Lv1 training	May-25	88.28%	▼ -0.1%	88.37%	
Safe	Violence and Aggression (Wales)	May-25	91.36%	▲ 0.3%	91.09%	

ABU UHB Safe Phase 1 Quality Outcome Framework measures

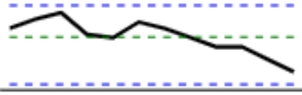
Quality Standard	Measure	Latest period	Latest figure		Previous figure	Last 12 months	Outlier
Safe	Antibacterial items per 1,000 STAR-PUs	Jun-25	244.97				
Safe	Crude mortality rate (%)	Aug-25	1.31%	▲ 12.8%	1.16%		
Safe	Never Events reported to NHS P&I	Sep-25	0		0		
Safe	Percentage of discharges on D2RA Pathway 0	Sep-25	32.81%	▼ -3.5%	34.00%		
Safe	Percentage of discharges on D2RA Pathway 1	Sep-25	8.99%	▼ -10.1%	10.00%		
Safe	Percentage of discharges on D2RA Pathway 2	Sep-25	3.63%	▼ -27.5%	5.00%		
Safe	Percentage of discharges on D2RA Pathway 3	Sep-25	2.60%	▲ 29.8%	2.00%		
Safe	Percentage of discharges with no D2RA Pathway Allocated	Sep-25	51.98%	▲ 6.1%	49.00%		
Safe	RAMI (Risk adjusted mortality index) 2023	Aug-25	180.18	▲ 77.2%	101.67		Outlier high
Safe	Safeguarding Adults - Lv1 training	May-25	82.23%	▼ 0.0%	82.27%		
Safe	Violence and Aggression (Wales)	May-25	89.32%	▲ 0.4%	88.99%		

National Quality Outcomes Framework Measures
Timely

All Wales Timely Phase 1 Quality Outcome Framework measures

Quality Standard	Measure	Latest period	Latest figure		Previous figure	Last 12 months
Timely	Opthalmology R1 appointments attended within target date* (%)	Sep-25	58.45%	▼ -7.8%	63.38%	
Timely	Patients starting first definitive cancer treatment* (%)	Aug-25	61.82%	▲ 1.4%	60.97%	

ABU UHB Timely Phase 1 Quality Outcome Framework measures

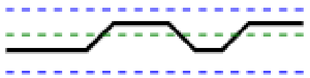
Quality Standard	Measure	Latest period	Latest figure		Previous figure	Last 12 months	Outlier
Timely	Opthalmology R1 appointments attended within target date* (%)	Sep-25	49.45%	▼ -7.2%	53.32%		
Timely	Patients starting first definitive cancer treatment* (%)	Aug-25	58.74%	▼ -7.6%	63.54%		

National Quality Outcomes Framework Measures
Effective

All Wales Effective Phase 1 Quality Outcome Framework measures

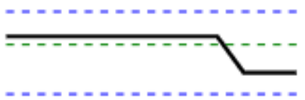
Quality Standard	Measure	Latest period	Latest figure		Previous figure	Last 12 months
Effective	Diabetes patients completing all eight care processes* (%)	Sep-25	44.48%	▲ 0.2%	44.39%	

ABU UHB Effective Phase 1 Quality Outcome Framework measures

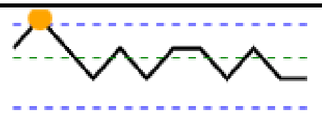
Quality Standard	Measure	Latest period	Latest figure		Previous figure	Last 12 months	Outlier
Effective	Diabetes patients completing all eight care processes* (%)	Sep-25	43.83%	▲ 0.0%	43.81%		

National Quality Outcomes Framework Measures
Efficient

All Wales Efficient Phase 1 Quality Outcome Framework measures

Quality Standard	Measure	Latest period	Latest figure		Previous figure	Last 12 months
Efficient	Agency spend for all staff groups as % of total pay bill	May-25	2.11%	▲ 13.5%	1.86%	

ABU UHB Efficient Phase 1 Quality Outcome Framework measures

Quality Standard	Measure	Latest period	Latest figure		Previous figure	Last 12 months	Outlier
Efficient	Agency spend for all staff groups as % of total pay bill	May-25	3.29%	▲ 8.1%	3.04%		

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 a scribe.

Visit Format:
Informal, discussion-based (not an audit). Focused on safety concerns, teamwork, communication, and incident reporting.

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

Patient Safety Leadership Visits

Overview - May – September 2025 Areas Visited 19

Ysbyty Ystrad Fawr (YYF)

- Ty Cyfannol
- Breast Unit
- Anwylfan
- Bargoed
- Breast Unit YYF

Other Sites

- Bevan Health & Wellbeing Centre (Tredegar)
- Vaccination Centre (Cwmbran)
- 19 Hills Health and Well Being Centre

Rearranged Visits: 2

- **Anwylfan, YYF (02/06/25)** – No management team present due to leave and illness. **Rearranged and completed on 04/08/25.**
- **Breast Unit, YYF (22/07/25)** – Cancelled by Executive due to Board commitments; unable to reassign in time. **Rearranged and completed on 10/09/25.**

Grange University Hospital (GUH)

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

Nevill Hall Hospital (NHH)

- Ward 3/3
- Endoscopy Ward
- AMU
- Ward 3/2

Ysbyty Aneurin Bevan (YAB)

- Ebbw Ward,
- Sirhowy Ward
- Tyleri Ward

Patient Safety Leadership Visits

Positive Findings - May–Sept 2025

- Modern, clean, and welcoming environments across sites
- Strong team morale and supportive leadership
- Streamlined care pathways and coordinated appointments
- Staff-led safety initiatives (e.g. hydration, fluid balance)
- High patient satisfaction and reduced complaints
- Community engagement through events and outreach
- Bronze/Silver ward accreditations achieved
- Multidisciplinary collaboration improving discharge planning and patient flow
- Innovative use of therapy gardens and sensory spaces
- Staff development: flexible nursing routes and training support
- Efficient equipment sterilisation
- Improved audit compliance (e.g. fluid balance from 9% to 90% in 5 weeks – Ward A0)
- Staff wellbeing initiatives (e.g. wellbeing boards, social events, flexible nursing routes)
- Charitable fund bids supporting equipment and therapeutic spaces

Patient Safety Leadership Visits

Common Issues

Digital & Technology

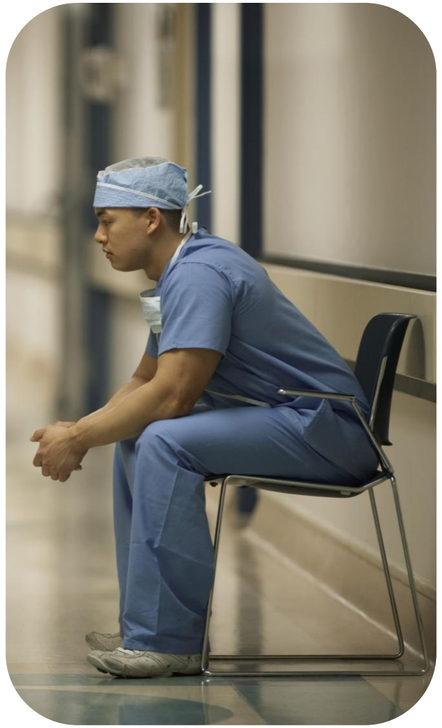
- Non-functional patient booking-in systems at multiple sites
- Limited Wi-Fi access and lack of electronic scanning in theatres

Confidentiality & Privacy

- Shared admin spaces compromising patient confidentiality
- Lack of private areas for sensitive conversations and results delivery

Operational & Planning

- Inadequate therapy and treatment space impacting service delivery
- Poor signage and lack of central reception causing confusion



Staffing & Culture

- Recruitment challenges and high staff turnover in several wards
- Positive morale initiatives including wellbeing boards and peer support

Health & Safety

- Limited hand sanitiser dispensers and daytime cleaning gaps
- Manual handling risks at entrances and lack of panic buttons

Patient Flow & Transport

- Delays in ambulance transport and discharge planning
- Inappropriate referrals and prolonged patient stays due to care package delays

Community & Service Engagement

- Low attendance at outreach events despite active engagement efforts
- Misunderstanding of facility purpose by public, leading to misuse

Patient Safety Leadership Visits

Examples of Completed Actions

Transfer Lounge

- Handover notes are now on CWS
- Hot meals are now available due to second sink being fitted.
- Issues regarding difficulties weighing patients have now been actioned.
- Signage now in position

AMU

Enhance learning from incident reviews – the ward this is on-going as has seen good engagement from staff.

Anwylfan Ward

- Physiotherapy provision for the ward has been raised with Head of Physiotherapy and they have offered support if there are any concerns.

Breast Unit

- Workforce and Organisational Development contacted to install hearing loop system.

Bargoed Ward

- Therapy room usage – escalated to senior management with a plan in place and daily review.
- SWARMS initiative – ongoing engagement with nursing staff, with continued encouragement for therapy and medical colleagues.

Patient Safety Leadership Visits

Examples of Completed Actions

Endoscopy

- Endoscopy and Ophthalmology working alongside each other to maximise space
- Risk assessment for the trailing Oxygen and other cables has been updated by ward. The risk has been mitigated as much as possible. A new nonslip cable cover has been purchased, and all staff are alerted to the possible risk.

Patient Safety Leadership Visits

Outstanding Actions

New PA is now in post and is aware of the extensive list of outstanding actions. She is currently working through these and is in the process of contacting wards and sites to follow up accordingly. These are a snapshot.

Tredegar H&W Centre

- High number of actions due to the centre being newly opened at the time of the visit (May 2025). These are still ongoing in October 2025.

Transfer Lounge

- No side protection on outside ramp - potential issues for patients during inclement weather
- Difficulties locating the Transfer Lounge due to lack of signage
- Ramp not smooth - causing uncomfortable transfers for patients

Ward A0

- Difficulties locating the Transfer Lounge due to lack of signage

3 Primary Care & Community Ward

- Issues are being raised to Jennifer Winslade

Patient Safety Leadership Visits

Outstanding Actions

3 Primary Care & Community Ward - Leeanne Lewis will raise issues to Jennifer Winslade

- Enhanced care status not consistently communicated during handover.
- Core staff supporting more than 6 enhanced care patients when temporary staff unavailable.
- Safety concerns around boarding patients in dayrooms during acute pressures.
- Frequent transport cancellations for orthopaedic clinic patients at LGHs.
- Insufficient and faulty laptops, especially when fixed screens are closed.
- iPads too small and tablets not regularly updated.

AMU

- Patients names visible on NEWS2 chart. CareFlow unable to remove names due to system setup. Ward is hoping to meet with the digital team for possible changes or alternative apps.

YYF Ward 2-2

- Physiotherapy room repurposed for patient bed.

NHH – Endoscopy

- Space
- Oxygen Supply
- Data Protection due to lack of privacy

Patient Safety Learning and Improvement Forum

PQSLI Forum – 22nd October 2025 – Highlight Report (in minutes)

Patient Experience

- Pregnancy Loss Story

Organisational Learning

- Medical Examiner Update
- Mortuary Learning
- Learning from Deaths
- The Fuller Enquiry
- Bereavement for the Deaf Community

Quality Improvement & Innovation

- Sepsis – The Big Conversation
- Bereavement Room Refurbishment
- Incident Reporting
- Digital Accreditation Tracker
- Head & Neck Cancer Care Delays

Divisional Learning

- Bereavement support initiative in the gastro ward improved family experience and reduced complaints.

For Information

Clinical Effectiveness

Clinical Standards and Effectiveness Group - Processes:

Healthcare Quality Improvement Programme (HQIP) Reporting and Communication Process

The Medical Director's Clinical Audit QPS team provide regular updates on anticipated report publication dates. Please note that these dates are subject to change. Any amendments will be communicated promptly to the Clinical Lead and the Divisional Triumvirate. Where appropriate, they will be invited to present Health Board data at the relevant CSEG meeting. Once a report is published, QPS will incorporate local data into a standardised PowerPoint template and arrange a review meeting with the designated presenter. This ensures data accuracy and alignment with AMaT records.

Meeting Summary Logs - Meeting notes have evolved into concise summary logs, providing clear actions and decisions. Audit presentations remain available in accompanying slide decks for detailed reference. All relevant documents, including summary logs and presentations, are accessible to Health Board staff via the Quality and Patient Safety (QPS) intranet page here.

Action Planning and Governance - Prior to CSEG meetings, QPS will liaise with the Clinical Lead and Divisional/Directorate Management to confirm that all actions align with report recommendations. Local actions will be defined using the **S.M.A.R.T. framework** and assigned a six-month review date.

New Procedure Applications - Applications for new procedures are considered within the CSEG forum. To date, five applications have been approved.

Application Name:	Presented by:
Impella use in GUH	Dr Hussain, Consultant Cardiologist
Conduction System Pacing	Dr Charles Lawson, Consultant Cardiologist
Cytosponge	Dr Joshi, Consultant Gastroenterologist
RefluxStop Procedure	Mr Nageswaran, Consultant UGI Surgeon
Capsule Colon	Matthew Evans, ADM Medicine & Dr Joshi, Consultant Gastroenterologist

Key Points:

The team will check progress and request updates at the six month mark. These updates will be presented at the relevant CSEG meeting.

All national audits must be signed off before or near the release of new publications. Only one audit report per audit can be active at any time.

For non annual reports, QPS will conduct a 12-month review.

Processes have been strengthened to enhance communication, streamline workflows, and ensure they remain fit for purpose, supporting robust governance and accountability. The updated pathway is being incorporated into the Clinical Audit Policy. All National Clinical Audit reports are presented at Clinical Standards Policy Group (CSPG). This ensures alignment with organisational standards and provides assurance that audit processes are current, effective, and compliant.

National Clinical audits due for publication and being presented at future CSEG:

Programme Name		Publication Date	Division	CSEG Date
NCEPOD	Emergency paediatric surgery	11/12/2025	F&T	CSEG Jan 2026
NMPA	National Maternity and Perinatal Audit - Induction of labour snapshot report	13/11/2025	F&T	CSEG Jan 2026
MNI	Perinatal Mortality Surveillance 2026 Report (2024 births)	11/06/2026	F&T	CSEG Jul 2026
NMPA	National Maternity and Perinatal Audit - Multiple Births Report	12/03/2026	F&T	CSEG May 2026
NPDA	National Paediatric Diabetes Audit(NPDA) - Annual Core State of the Nation Report (2026)	12/03/2026	F&T	CSEG May 2026
MNI	Saving lives, improving mothers care report (2021-2023, UK wide)	10/10/2024	F&T	CSEG Nov 2025
MNI	Perinatal confidential enquiry	12/12/2024	F&T	CSEG Nov 2025
MNI	Maternal Mortality Surveillance and Confidential Enquiry 2025 Report	09/10/2025	F&T	CSEG Nov 2025
MNI	Perinatal Mortality Surveillance 2025 State of the nation Report	12/06/2025	F&T	CSEG Nov 2025
NMPA	National Maternity and Perinatal Audit - State of the nation report (containing 5 years of data)	14/08/2025	F&T	CSEG Nov 2025
NNAP	NNAP - National Neonatal Audit Programme - State of the nation report 2026	09/10/2025	F&T	CSEG Nov 2025
NRAP	National Respiratory Audit Programme - State of the Nation report - Children and young people's asthma: Elements of care received by children admitted with near-fatal asthma	12/06/2025	F&T	CSEGJan 2026
FFFAP	National Audit of Inpatient Falls (NAIF) - State of the Nation report 2025	09/10/2025	Health Board Wide	CSEG Nov 2026
NCAP	National Clinical Audit of Psychosis (NCAP) - State of the Nation report 2026	12/02/2026	MH&LD	CSEG Mar 2026
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) - State of the Nations report	12/02/2026	MH&LD	CSEG Mar 2026
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)- NCISH Post inquest data only release (UK only) Q2	09/10/2025	MH&LD	CSEG Mar 2026
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health: Annual Report 2025 UK patient and general population data 2012-2022	13/02/2025	MH&LD	CSEG Jan 2026
NCEPOD	Acute limb ischaemia	13/11/2025	Surgery & CSS	CSEG Jan 2026
NVR	National Vascular Registry - State of the Nation 2025 report	13/11/2025	Surgery & CSS	CSEG Jan 2026
FFFAP	National Hip Fracture Database (NHFD) - State of the Nation 2025 report	11/09/2025	Surgery & CSS	CSEG Nov 2025
NELA	NELA - National Emergency Laparotomy Audit - Year 10 State of the Nation report	09/10/2025	Surgery & CSS	CSEG Nov 2025
NRAP	National Respiratory Audit Programme - Asthma Secondary Care report	09/10/2025	Surgery & CSS	CSEG Jan 2026

National Clinical audits due for publication and being presented at future CSEG continued:

Programme Name		Publication Date	Division	CSEG Date
NATCAN	National Primary Breast Cancer Audit (NAoPri) State of the Nation report (England & Wales)	11/09/2025	Surgery & CSS	CSEG/Cancer Board
NATCAN	National Metastatic Breast Cancer Audit (NAoMe) State of the Nation report (England & Wales)	11/09/2025	Surgery & CSS	CSEG/Cancer Board
NATCAN	National Ovarian Cancer Audit (NOCA) State of the Nation report (England & Wales)	11/09/2025	Surgery & CSS	CSEG/Cancer Board
NATCAN	National Pancreatic Cancer Audit (NPaCA) State of the Nation report (England & Wales)	11/09/2025	Surgery & CSS	CSEG/Cancer Board
NATCAN	National Kidney Cancer Audit (NKCA) State of the Nation report (England & Wales)	11/09/2025	Surgery & CSS	CSEG/Cancer Board
NATCAN	National Oesophagogastric Cancer Audit (NOGCA) State of the Nation report (England & Wales)	11/09/2025	Surgery & CSS	CSEG/Cancer Board
NATCAN	National Prostate Cancer Audit (NPCA) State of the Nation report (England & Wales)	11/09/2025	Surgery & CSS	CSEG/Cancer Board
NATCAN	National Bowel Cancer Audit (NBOCA) State of the Nation report (England & Wales)	09/10/2025	Surgery & CSS	CSEG/Cancer Board
NATCAN	National Non-Hodgkin Lymphoma Audit (NNHLA) State of the Nation report (England & Wales)	11/09/2025	Urgent Care & Medicines	CSEG/Cancer Board
NEIAA	NEIAA - National Early Inflammatory Arthritis Audit - State of the Nation Report 2026	09/10/2025	Urgent Care & Medicines	CSEG Jan 2026
NRAP	National Respiratory Audit Programme - State of the Nation 2026 report	11/06/2026	Urgent Care & Medicines	CSEG Jul 2026
NRAP	National Respiratory Audit Programme - Asthma and COPD Primary Care report	14/05/2026	Urgent Care & Medicines	CSEG Jul 2026
FFFAP	Fracture Liaison Service Database (FLSD)FLSDB- state of the nation report	08/01/2026	Urgent Care & Medicines	CSEG Mar 2026
NATCAN	National Lung Cancer Audit (NLCA) State of the Nation report (England & Wales)	09/04/2026	Urgent Care & Medicines	CSEG May 2026
NCEPOD	ICU Rehabilitation report	12/06/2025	Urgent Care & Medicines	CSEG Jan 2026
NCEPOD	Blood sodium report	11/09/2025	Urgent Care & Medicines	CSEG Jan 2026
NICOR	Myocardial Ischaemia National Audit Project (MINAP)	01/04/2025	Urgent Care & Medicines	CSEG Nov 2025
NICOR	National Audit of Cardiac Rhythm Management (NACRM)	01/04/2025	Urgent Care & Medicines	CSEG Nov 2025
NICOR	National Audit of Percutaneous Coronary Interventions (NAPCI)	01/04/2025	Urgent Care & Medicines	CSEG Nov 2025

Clinical Standards and Effectiveness Group → April - September 2025
Clinical Standards and Effectiveness Group Meetings are usually held bi-monthly during the months of:
May, Jul, Sep, Nov, Jan, Mar

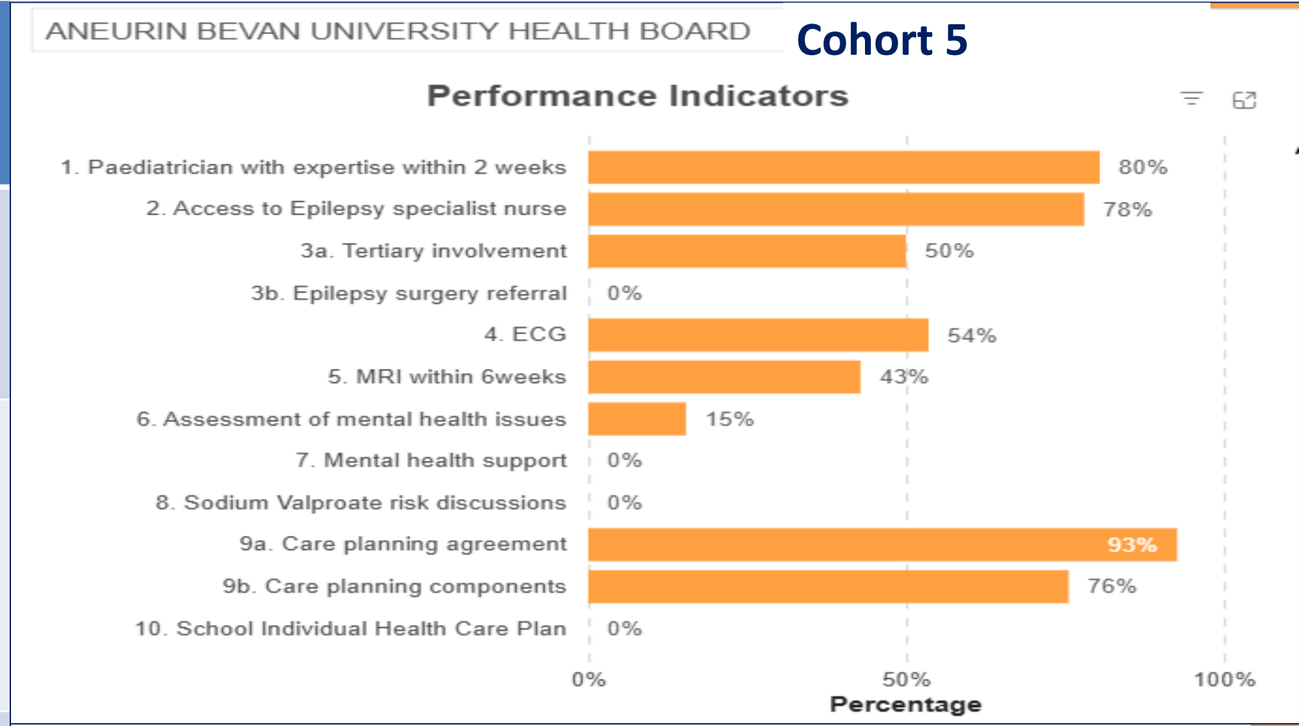
Due to operational demands the July2025 meeting was postponed

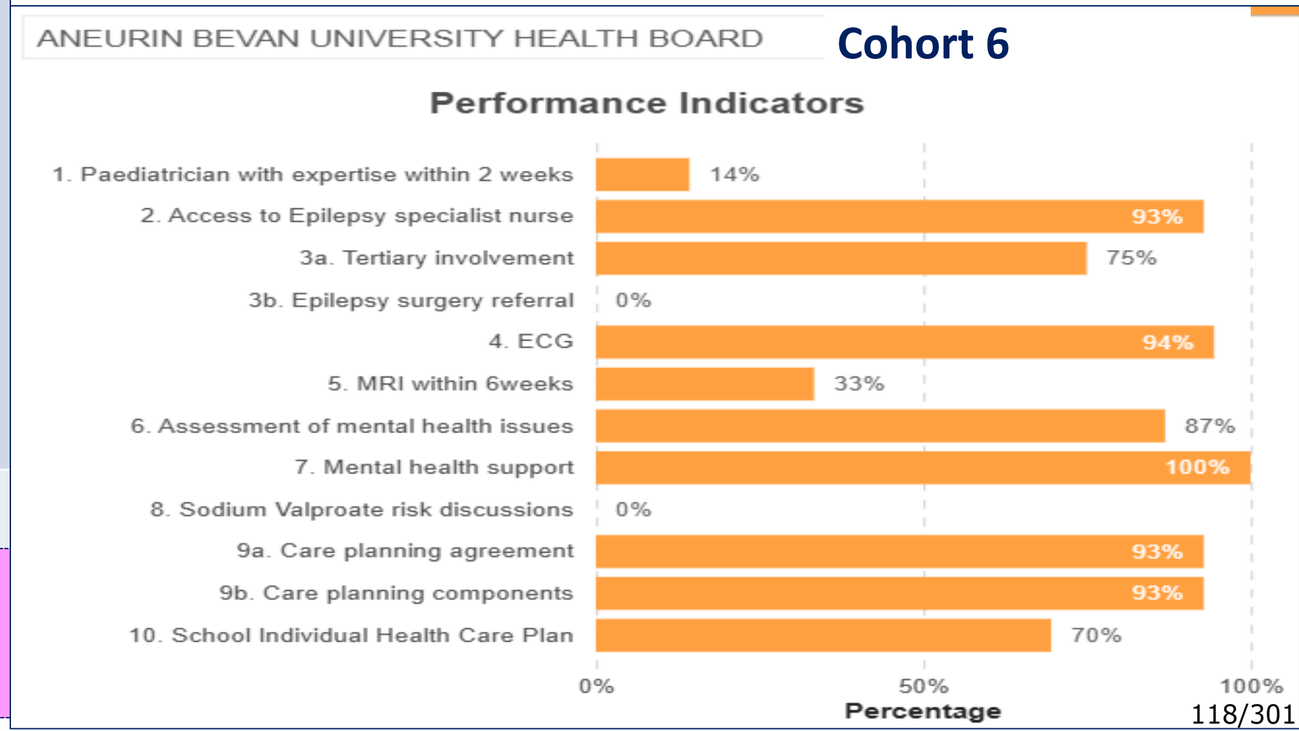
What we said we would achieve in our Clinical Audit Plan and what was achieved:

Abbrev	Project Name	Full Report Title	Publication Date	CSEG Intended Date	Outcome
NLCA	NATCAN - National Cancer Audit Collaborating Centre	National Lung Cancer Audit State of the Nation report 2025	**10/04/2025**	CSEG May 2025	**Presented May 2025** ✅
NPDA	NPDA - National Paediatric Diabetes Audit	Report on Care and Outcomes 2023/24	**10/04/2025**	CSEG May 2025	**Presented May 2025** ✅
NMPA	NMPA - National Maternity and Perinatal Audit	State of the nation report (containing 5 years of data)	~~**10/07/2025**~~ **14/08/2025**	CSEG Jul 2025	**Joint presentation in Jan 2026** (Due to Lead availability and changes to publication dates)
		Induction of labour snapshot report	~~**12/06/2025**~~ **13/11/2025**	CSEG Jul 2025	
		Neonatal outcome measures of maternity care snapshot audit	**No longer on the NCAORP Schedule**		
MNI	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme	Perinatal Mortality Surveillance 2025 - State of the nation Report	**12/06/2025**	CSEG Jul 2025	
NCEPOD	Medical and Surgical Clinical Outcome Review Programme	ICU Rehabilitation report	**12/06/2025**	CSEG Jul 2025	**Postponed until Nov 2025**
NRAP	NRAP - National Respiratory Audit Programme	State of the Nation report	**12/06/2025**	There are national issues with participation in NRAP. This is being addressed within the Directorate.	
Epilepsy12	National Clinical Audit of Seizures and Epilepsies for Children and Young People	Annual Report 2024	**11/07/2025**	CSEG Sep 2025	**Presented Sep 2025** ✅
SSNAP	SSNAP - Sentinel Stroke National Audit Programme	Sentinel Stroke National Audit Programme State of the Nation 2024	**14/11/2024**	CSEG Sep 2025	**Presented Sep 2025** ✅
NHFA	National Heart Failure Audit	2025 Annual Report	**01/04/2025**	CSEG Sep 2025	**Presented Sep 2025** ✅

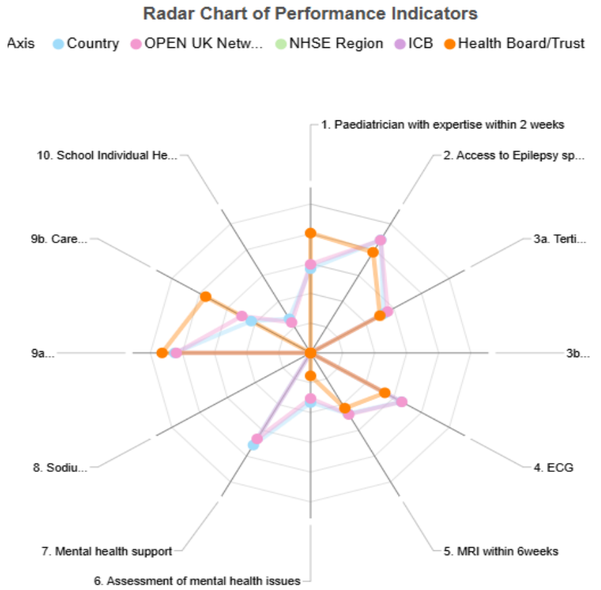
Epilepsy12 - 2025 combined organisational and clinical audits: Report for England and Wales **Clinical Cohort 6 – The first year of care for children and young people following a first paediatric assessment undertaken between 1 December 2022 and 30 November 2023**	**Clinical Lead(s): Dr Nadeem Syed – Consultant Paediatrician**	
	NICE guidance:	**NG217 / QS211** Epilepsy12 Power BI tool
Rationale:	Epilepsy12, established in 2009, aims to support epilepsy services and health commissioners in assessing and improving the quality of care for children and young people with seizures and epilepsy. Epilepsy is the most common serious long-term neurological condition in childhood, affecting approximately 112,000 children and young people in the UK.	
Objectives:	**Epilepsy12** aims to raise the standard of care for children and young people with epilepsy by auditing clinical practice and service organisation. It collects and analyses data on patient care and service delivery to identify strengths and areas for improvement. The programme has three core components: • Auditing of clinical care • Quality improvement • Epilepsy12 Youth Advocate	
CSEG date:	25th September 2025	

Epilepsy12 and Wales
Wales currently has representation on the UK Epilepsy Programme Board and OPEN UK. Epilepsy12 and NHS Wales are collaborating to formalise Welsh representation within the Epilepsy12 Project Board.

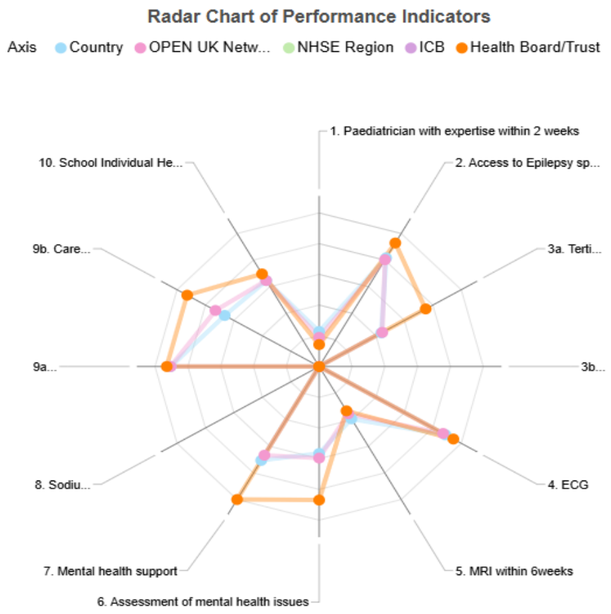




Cohort 5



Cohort 6



Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against

Risk level	Description
Low	Peripheral element of treatment or service suboptimal

Report Successes: (to be completed by the Clinical Lead)	
1	Significant improvement in KPI2 – Children and YP seen by an ESN within the first year of care
2	Improvement in KPI4 – Children and YP with convulsive seizures had an ECG within the first year of care (94% vs 55% in cohort 5)
3	Significant improvement in assessing/asking for mental health KPI 6 (87% vs 15% in cohort 5)
4	Significant improvement in documented evidence of care planning KP1 9B (93% vs 76% in cohort 5)

Report Concerns: (to be completed by the Clinical Lead)	
1	Not able to see children and young people within 2 weeks (KP1) by consultants with expertise in epilepsy (14%)
2	Failing to achieve MRI within 6 weeks of request (33%)
3	Continue struggling with backlog and significant delays in getting an EEG. However this has improved since previously.

Report Recommendations: (national)	Progress:
Support Health Boards and Trusts identified as nonparticipation outliers. Identify specific barriers and enablers to facilitate and resource epilepsy team involvement. Work with young people and families, including the Epilepsy12 Youth Advocates and RCPCH Engagement Team, to help promote and support local participation. **Action by:** Integrated Care Boards across England and Local Health Boards across Wales.	Regular participation in RCPCH Epilepsy 12 audit achieved. There is some allocation of time in consultants job plan, this would be reviewed in forthcoming job planning.
Improve timely and equitable access to tertiary and epilepsy surgery services by: ❖ Reviewing and updating referral criteria and pathways for epilepsy surgical evaluation, ensuring ongoing consistency between the evidence base, national recommendations and regional and local practices. ❖ Reviewing the specification of tertiary neuroscience services to ensure commissioning towards a sustainable workforce and capacity to meet the needs of local populations. **Action by:** NHS England, the Children's Epilepsy Surgery Service (CESS) in England and Integrated Care Boards across England. The Welsh Government and Local Health Boards across Wales.	Not applicable in secondar care services. Children requiring epilepsy surgical evaluation is referred timely to tertiary services at UHW who are the gate keepers of further referrals.
Support improvements in mental health provision, including screening, signposting, triaging, co-locating and clinical management, for children and young people with epilepsy in England and Wales. This could be achieved by: ❖ Completing the evaluation of mental health pilots in England including how they impact on Epilepsy12 performance metrics. ❖ Identifying opportunities for scaling and sustaining equitable mental health provision. **Action by:** NHS England Epilepsy Oversight Group and Integrated Care Boards across England. The Welsh Government and Local Health Boards across Wales.	Significant improvement in assessing/asking for mental health concerns. Sign posting to SPACE wellbeing and clinical psychologist (ACT therapy) available though needs increase in their capacity with recruiting more psychologists.

State of the Nation Report 2024
SSNAP - Sentinel Stroke National Audit Programme

Stroke care received between April 2023 to March 2024

Clinical Lead:
Dr Yaqoob Bhat
Clinical Director Stroke Medicine Presented by Rhys Monk - Directorate Manager for Stroke, CoTE, Neurology & Nephrology

- National Clinical Guideline for Stroke (2023) and NICE guidelines (Stroke and TIA, NG128; Stroke rehabilitation, NG236; and Quality standard for stroke)
- National policy documents including the NHS Long Term Plan, the National Stroke Service Model, the National service model for an integrated community stroke service and the Quality statement for stroke.

Rationale:	SSNAP measures the quality and organisation of stroke care across England, Wales and Northern Ireland.
Objectives:	The overall aim of SSNAP is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered. Processes of care are measured against evidence-based quality standards referring to the interventions that any patient may be expected to receive.

Presented at Clinical Standards and Effectiveness Group – 25th September 2025

Sentinel Stroke National Audit - Key Changes:

- **New metrics introduced in Oct 2024.**

> Significant changes to measurements

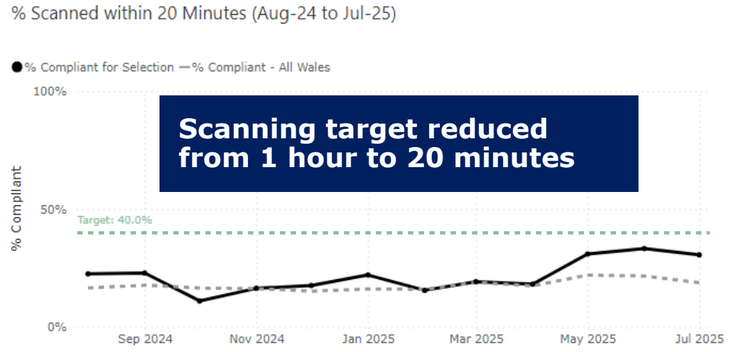
> Raised the expectation on delivery of stroke services

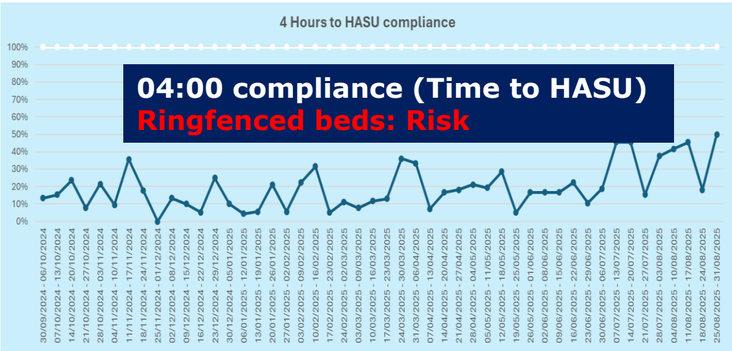
> Old measures not comparable to new measures

> Expected that most hospitals will revert to D/E grading

> Most recent quarter (Jan-Mar 2025) **not** released to the public

- **Performance dropped due to higher standards**



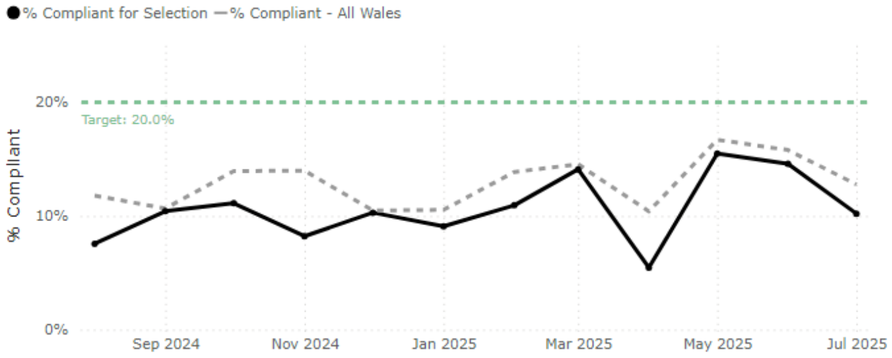


SSNAP Scoring Summary:
See "Outline of report" for further information about this section of the report

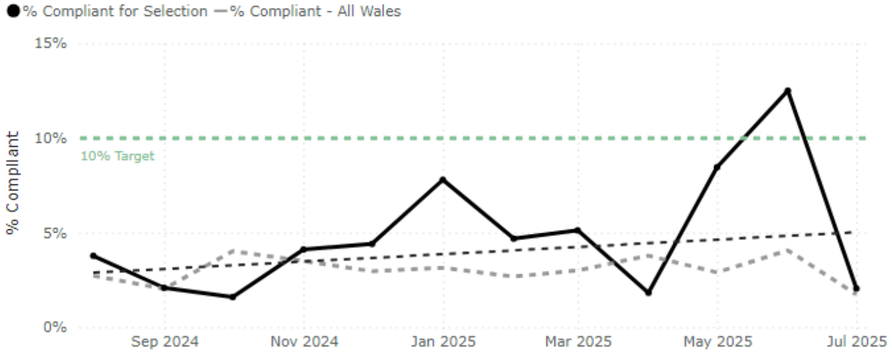
Team Type		Routinely admitting team
		Wales
ISDN		
Trust		Aneurin Bevan University Health Board
Team		*Grange University Hospital*
Time Period		Jan - Mar 2025
	SSNAP level	E
	SSNAP score	21.4
	Case ascertainment band	A
	Audit compliance band	B
	Combined Total Key Indicator level	E
	Combined Total Key Indicator score	22.5
Patient-centred KI levels:		
Patient-centred Domain levels:	1) Hyperacute assessment	E
	2) Specialist pathway	E
	3) Reperfusion	D
	4) MDT assessment	E
	5) Therapy intensity	E
	6) Therapy frequency	E
	7) Standards by discharge	E
Patient - centred KI level	Patient-centred Total KI level	E
	Patient-centred Total KI score	22.5
	Patient-centred SSNAP level	
	(after adjustments)	E
	Patient-centred SSNAP score	21.4
Team-centred KI levels:		
Team-centred Domain levels:	1) Hyperacute assessment	E
	2) Specialist pathway	E
	3) Reperfusion	E
	4) MDT assessment	E
	5) Therapy intensity	E
	6) Therapy frequency	D
	7) Standards by discharge	E
Team - centred KI level	Team-centred Total KI level	E
	Team-centred Total KI score	22.5
	Team-centred SSNAP level	
	(after adjustments)	E
	Team-centred SSNAP score	21.4

Thrombolysis & Thrombectomy

% Thrombolysed (Aug-24 to Jul-25)

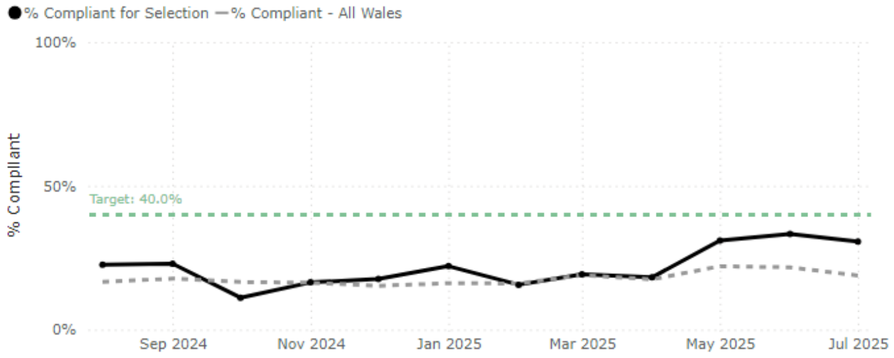


% Received Thrombectomy (Aug-24 to Jul-25)



Stroke Consultant assessment <1 hour

% Scanned within 20 Minutes (Aug-24 to Jul-25)



Scanning within 20 minutes & CTA

Stroke Consultant < 1 hour

Double up of CNS on front end

Demand has increased x% year on year

Time to HASU <4 hours

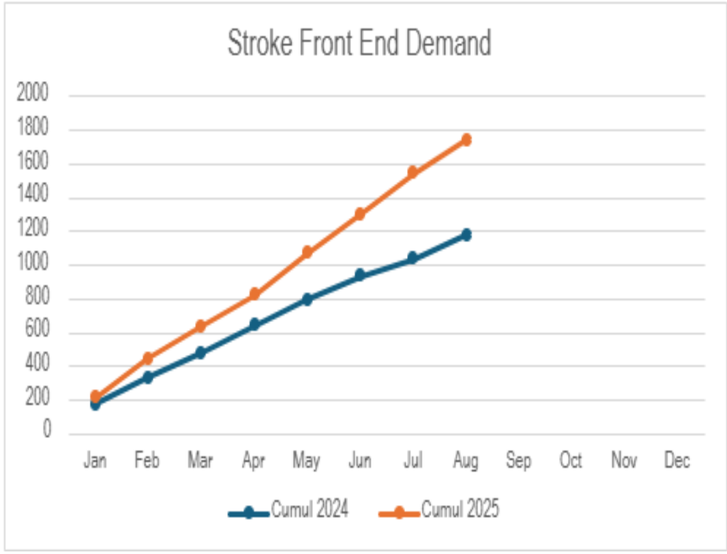
Organisational priority needed

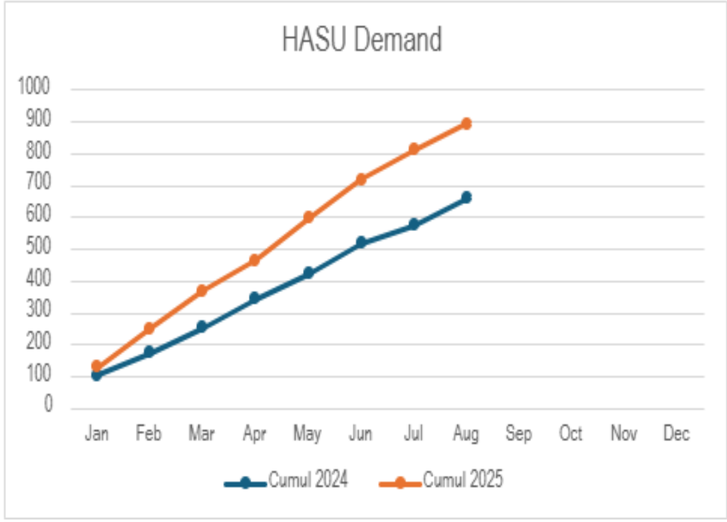
Ringfence of beds

Priority on patient flow through system (Scans, beds, transport)

Therapies

Business case to meet staffing guidelines





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

Actions: This is presented at Stoke Board

- Continue embedding flow coordinators.
- Expand thrombectomy access via Cardiff centre.
- Improve scanning and consultant review times.
- Support business case for therapy staffing.

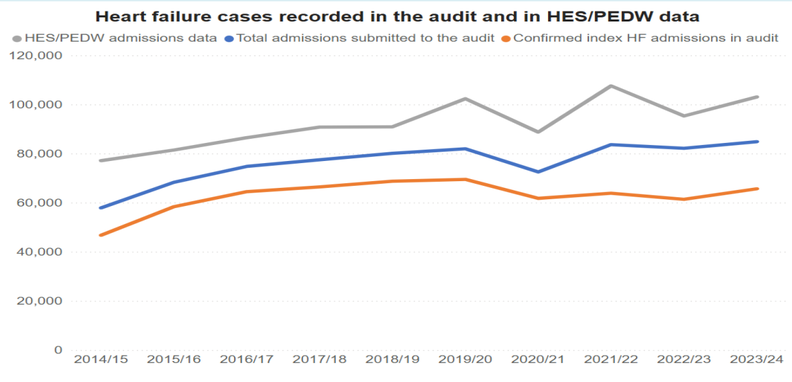
National Cardiac Audit Programme - National Heart Failure Audit (NHFA)	Clinical Lead: Linda Edmunds – Consultant Nurse, Cardiac Rehabilitation, supported by Karen Hazel, Heart Failure Nurse Specialist
Rationale:	The National Heart Failure Audit (NHFA) monitors the care of patients admitted unexpectedly to hospitals in England and Wales who are discharged with a primary diagnosis of heart failure. The latest report covers the period April 2023 to March 2024 and provides a comprehensive review of care delivery for these patients. It examines patient characteristics, hospital investigations, treatments received, access to specialist care, discharge planning, and post-discharge follow-up.
Objectives:	The audit aims to enhance the quality of diagnosis, treatment, and management of heart failure. It is managed by NICOR and forms part of the National Cardiac Audit Programme within NHS England. The audit collects data on clinical indicators associated with better outcomes for heart failure patients and encourages the use of recommended diagnostics, treatments, and referral pathways. The dataset is regularly updated to ensure alignment with current clinical guidance.

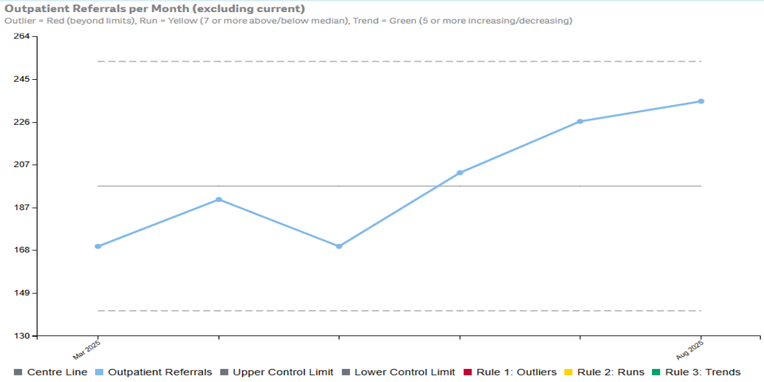
CSEG date: 25th September 2025

Confirmed index HF admissions rose to 65,679 HES/PEDW. The total admissions submitted to the audit and the confirmed index HF admissions is approaching the numbers pre covid.

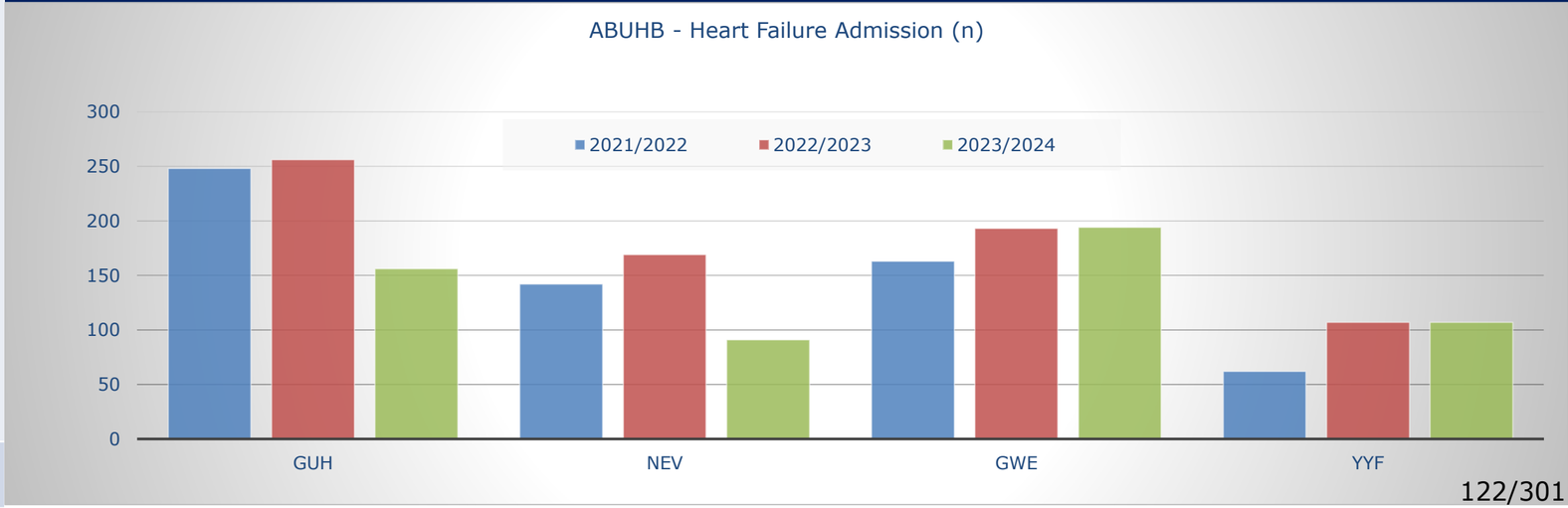
Discrepancy between audit submissions and confirmed index HF admissions has doubled This likely reflects the change in the audit dataset.

Note: The index admission for a patient is either their only acute HF admission or the first HF admission when more than one was submitted in the audit year. This ensures data from repeated admissions does not distort the statistics. In both instances the audit captures data from patients where heart failure is in the primary diagnostic position and therefore taken as the cause of the admission. The term 'confirmed' is used when the data submitted are verified as an acute HF admission.





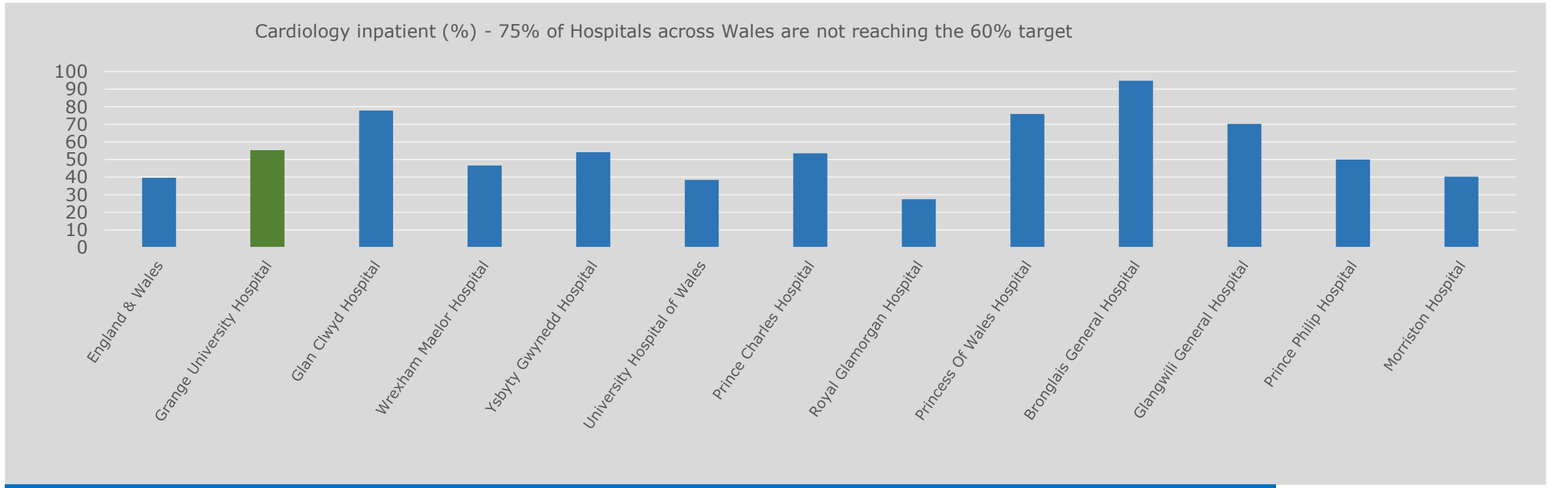
In the past 6 months, there have been a total of 1,105 Out Patient referrals to Cardiology Heart Failure recorded. This is around 181 referrals each month, ranging between a low of 146 in Feb 2025 and a high of 225 in July 2025.

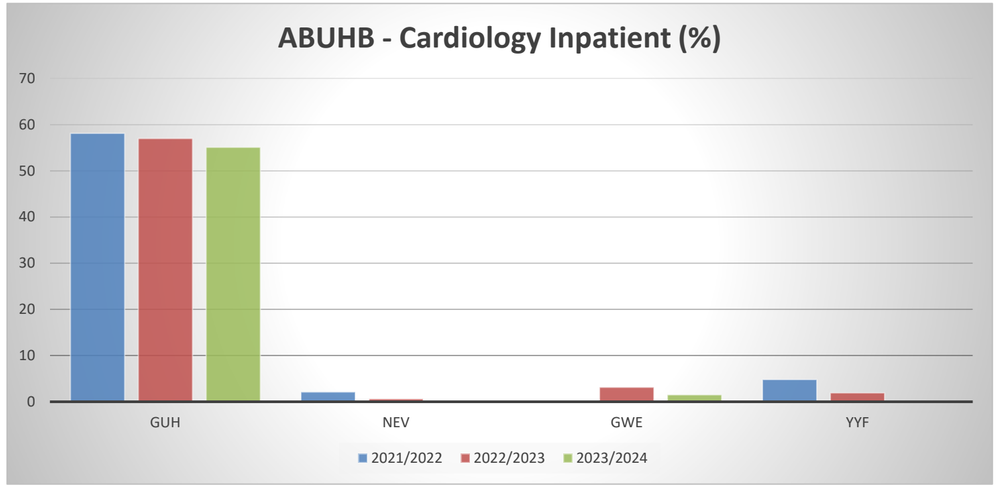


Recommendations

Specialist care

- Heart failure patients, who are among the highest risk cardiac patients, should have improved access to a cardiology ward. Hospitals not achieving the 60% minimum target should review their Acute Heart Failure Pathways to facilitate this.





Nationally only 39% of HF patients care cared for on a cardiology ward – ABUHB patients in 2023/2024 main place of stay was 55.1% in cardiology ward

- Hospitals should ensure consultant cardiologists are involved in the care of HF patients in non-cardiology wards.

Nationally 81% of HF patients were seen by a specialist heart failure team. ABUHB 62.8% of patients had input from Consultant Cardiologist & 64.7% received input from the HF specialist team.

- Specialist HF nurses should provide more support for 'non-HFrEF' patients – current service only funded for HFrEF.

Follow-up

- Patients should be referred for Cardiology & Specialist HF Nurse follow-up irrespective of their heart pump function. This should include leaving hospital with their first appointment already arranged.

38% of ABUHB patients were referred for Cardiology F-Up

Best Practice Drugs

- A renewed focus on the importance of prescribing MRA's for HFrEF.

Nationally 68% are discharged on MRA - ABUHB 85.5% are discharged on MRA

- Use of anticoagulation for HF and AF should be improved.

Nationally 18% of HF & AF patients anticoagulated on discharge ABUHB of HF & AF patients anticoagulated on discharge – data not available

- The medication at discharge should be captured for all patients and accurately reported into the audit.

ABUHB - bespoke digital HF Nurse service documentation is in place on CWS. Forms are updated every six months to record disease modifying drugs and reasons for contraindications or delayed initiations.

Assurance level	Description	Risk level	Description
Significant	The project has mostly achieved the standards or criteria being audited against	Low	Peripheral element of treatment or service suboptimal

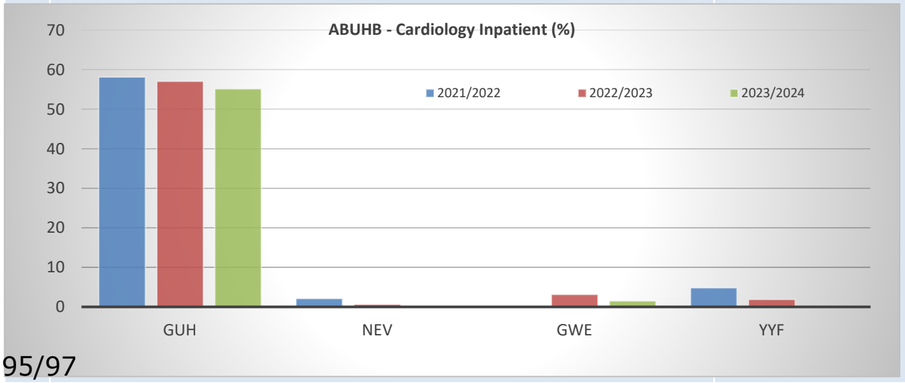
Has this audit been placed on a Risk Register (N/A if above risk is None)	No

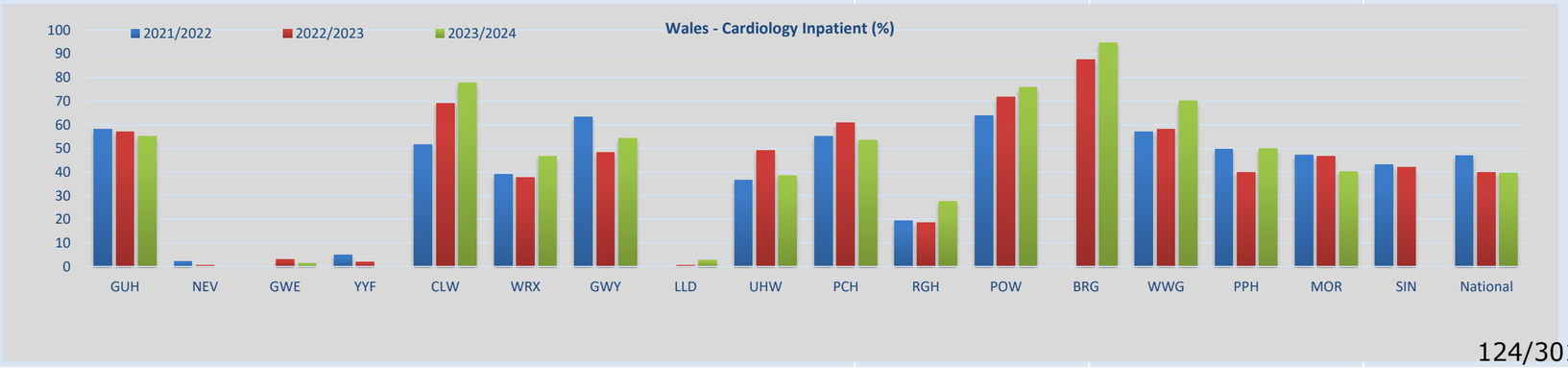
If not on a risk register, why not: To be discussed Cardiology Directorate

	Report Successes:
1	Increasing inpatient referrals year on year- AMaT development.
2	Improved discharged planning and inpatient signposting.
3	All appropriate patients receive a 2 week follow up outpatient appointment following discharge.
4	In person medical support in all satellite hospitals from October 24 – June 25.
5	HF cardiac rehab now rolled out to all sites

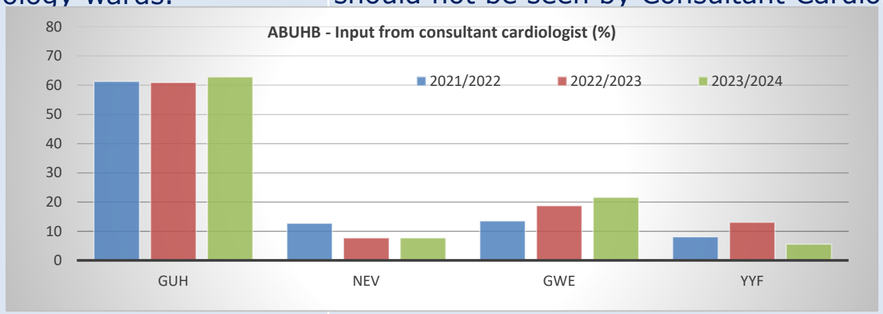
	Report Concerns:
1	Increasing numbers of HFpEF – no current HF service provision.
2	Increasing inpatient and outpatients referrals to HF service year on year – demands vs capacity to maintain operational waiting targets.
3	No dedicated HF medical provision to establish bespoke HF management in the satellite hospitals.
4	No live data to track timely in-patient service performance.
5	No acute HF dedicated team

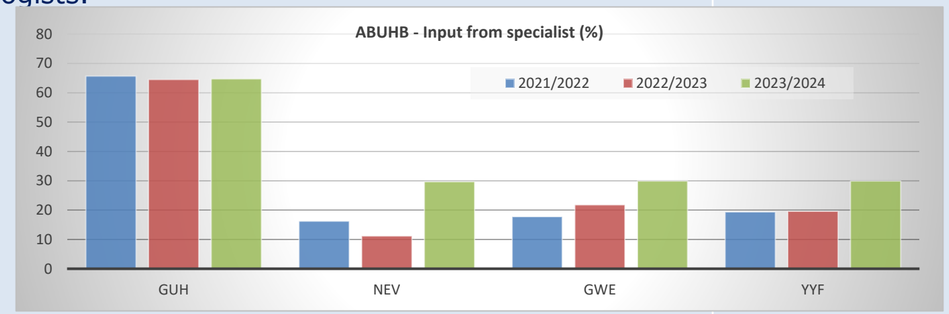
	Report Recommendations: (national)	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Heart failure patients, who are among the highest risk cardiac patients, should have improved access to a cardiology ward. Hospitals not achieving the 60% minimum target should review their Acute Heart Failure Pathways to facilitate this.	• Retrospective 3-month internal audit to ascertain the characteristics of patients that are not referred. • AMAT-live data. • Findings of the report presented in the Directorate/Clinical Governance Meeting. • Agree action plan, assign responsibilities, establish timeline for effective implementation and follow up.	Karen Hazel	*Jan-March 2026* *November 2025*	

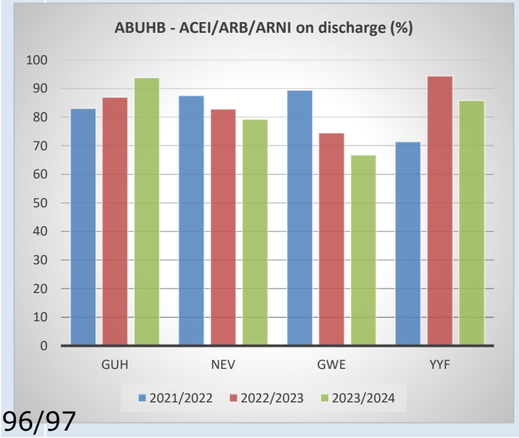


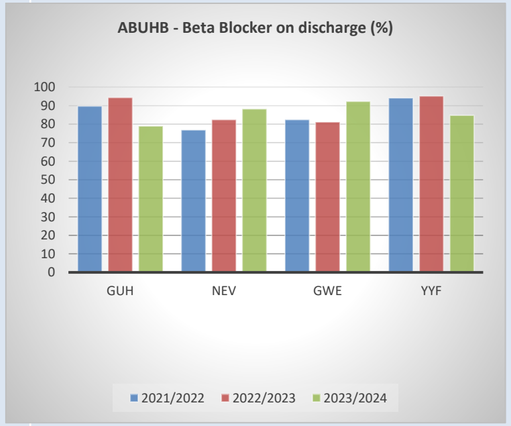


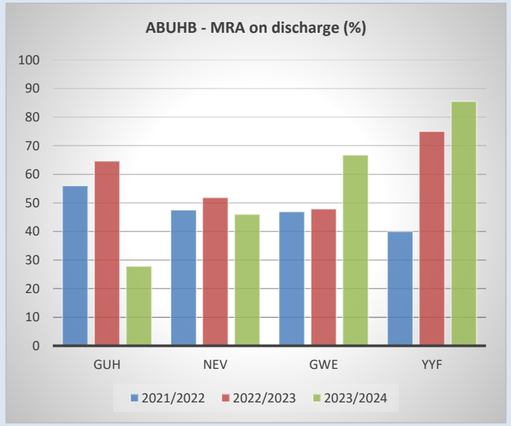
Report Recommendations: (national)	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
2 Hospitals should ensure consultant cardiologists are involved in the care of HF patients in non-cardiology wards.	Encompassed in the retrospective audit work, fulfilling the above actions. Develop, agree and sign off a clinical guidance within cardiology to confirm which patients should not be seen by Consultant Cardiologists.	Karen Hazel	Jan-March 2026 April –May 2026	
3 Specialist HF nurses should provide more support for 'non-HFrEF' patients.	Additional resource required. Outcomes of the audit presented in: Clinical governance meeting, SMT meeting, Audit Team Consultant Cardiologists review pending the outcome a business case to be developed, if that is what is required.	Karen Hazel	Jan-March 2026 April 2026	
4 All patients with HFrEF, irrespective of age or place of care, should receive best-practice disease-modifying drugs unless there is a contraindication.	Maintain inpatient quarterly education sessions. Present findings at Grand round Agree action plan with COTE, GEN medicine	Karen Hazel HF team	Ongoing Q1-4 April 2026	

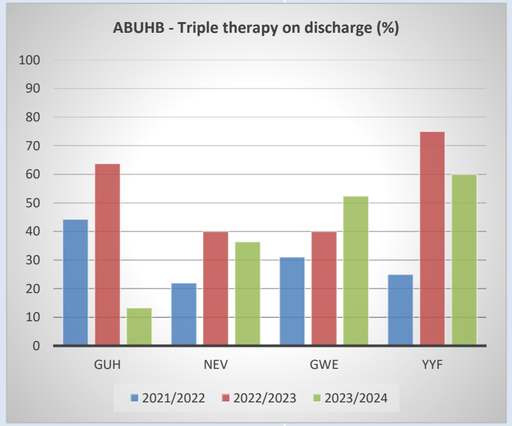


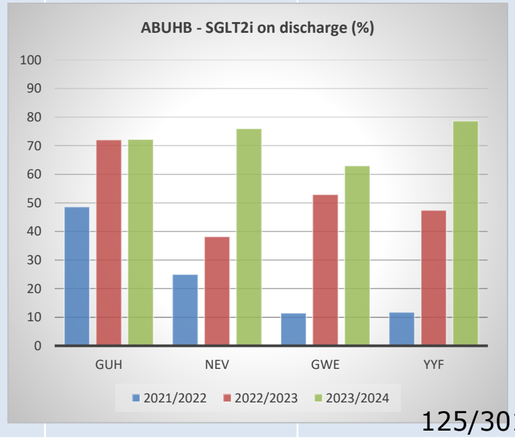












		Grand round	HF team	February 2026	
6	Use of anticoagulation for patients with HF and AF should be improved.	Review internal audit data to gain deeper understanding Wider Consultant Discussion	Karen Hazel	Jan-March 2026	
7	The medication at discharge should be captured for all patients and accurately reported into the audit.	• Build the NICOR dataset into AMaT. • NICOR forms will be completed for all patients seen by the Inpatient HF service, irrespective of coding. Patients coded appropriately will be fed into NICOR. • Maintain inpatient quarterly education sessions to continue to raise the profile. Provide evidence from live data, with the premise to capture all medical teams to improve measure across all HF phenotypes.	Joanne Simpson Karen Hazel Karen Hazel	December2025 Dec 2025 Q1-4 ongoing	
8	Patients should be referred for Cardiology & Specialist HF Nurse follow-up irrespective of their heart pump function. This should include leaving hospital with their first appointment already arranged.	Additional resource required Outcomes of the audit presented in: Clinical governance meeting SMT meeting Audit Team Consultant Cardiologists review pending the outcome a business case to be developed, if that is what is required.	Karen Hazel	April 2026 May 2026	

Recommendations

Specialist care

1. Heart failure patients, who are among the highest risk cardiac patients, should have improved access to a cardiology ward. Hospitals not achieving the 60% minimum target should review their Acute Heart Failure Pathways to facilitate this.
2. Hospitals should ensure consultant cardiologists are involved in the care of HF patients in non-cardiology wards.
3. Specialist HF nurses should provide more support for 'non-HFrEF' patients.

Best-practice drugs

4. All patients with HFrEF, irrespective of age or place of care, should receive best-practice disease-modifying drugs unless there is a contra-indication.
5. There should be a renewed focus on the importance of prescribing MRAs for HFrEF.
6. Use of anticoagulation for patients with HF and AF should be improved.
7. The medication at discharge should be captured for all patients and accurately reported into the audit.

Follow-up

8. Patients should be referred for Cardiology & Specialist HF Nurse follow-up irrespective of their heart pump function. This should include leaving hospital with their first appointment already arranged.

QMG ASSURANCE REPORT

Meeting Date	18 November 2025
Chair	Jennifer Winslade (Executive Director of Nursing)

KEY ESCALATION AND DISCUSSION POINTS

ALERT

Alert	Action	By whom	Target Date

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

- **Patient Safety Incident Policy Revision**: KS presented revisions to the patient safety incident policy, focusing on bespoke training, early intervention for complex cases, and the role of family liaison officers, with JW, HS, DD, and others discussing implementation, support needs, and the policy approval process. Policy to be circulated for comments, before going to Clinical Policies Group and finally Public Board.
- **Alert for Unwell Persons in Community Settings SOP**: LH introduced a new process for managing unwell patients, staff, and visitors in primary care and community settings, JW, LL, and others discussing dissemination, adaptation for other settings, and plans for raising awareness. The SOP was approved
- **Sepsis Big Conversation and Lived Experience Integration:** TS and LL reported on the 'Big Conversation' event on sepsis, summarising lived experiences shared, roundtable findings, and plans for people participation panels, KD & SS raised training, escalation, and the integration of lived experience into strategy and education. The meeting recognized the importance and success of this event
- **Ward and Team Accreditation Programme Progress:** KD presented an update on the ward and team accreditation programme, detailing its structure, achievements, and challenges, with discussion on multi-professional engagement, workforce metrics, and national sharing as one of the first Health Boards to embed this model.
- **HIW Inspection Reports:** CM reported on positive HIW inspections at the Royal Gwent MIU and the improvement actions required. JB presented the positive HIW inspection at YYF Birth Centre and the associated improvement actions.

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

- **Year Three Quality Strategy and QMS Implementation**: LL presented the year three quality strategy and QMS implementation plan, discussion at the group which focused on the alignment of reporting, inclusion of unheard voices, and representation from estates and facilities. The strategy implementation plan was supported.
- **Quality Outcomes Framework Q2 Reporting and Benchmarking**: LL and JW presented the Q2 Quality Outcomes Framework, detailing data visualization, exception reporting, and divisional comparisons. Discussion points focused on benchmarking challenges, national data limitations, and plans for further collaboration externally and internally and automation of data.
- **Pharmacy and Medicines Management Annual Report**: JS presented the comprehensive pharmacy and medicines management annual report, highlighting major service changes, achievements, and challenges. SB queried high-cost drugs and forward planning, JS confirmed ongoing peer group actions and assurance processes. The group endorsed the report for submission to PQSOC, with no further questions raised.
- **Complaints Trajectory and PTR Framework Update:** GC and KS presented the updated complaints

trajectory and PTR framework, detailing current performance, regulatory changes, and plans to reduce backlog. Discussion focused on the realistic delivery of the trajectory.

- **Family and Therapies Division**: JB reported the division is conducting deep dives into a number of clinical areas, listening events were planned or underway, with ongoing work to address overdue PTR responses and enhanced staff support.
- **Medicine Division**: NS reported that the division is collaborating with pharmacy, infection control, and safeguarding teams to address quality and safety learning. Submission of learning as part of clinical negligence claims and regulatory challenges with PTR were discussed.
- **Surgery Division**: AH discussed medical QPS lead gap in the division, PTR challenges, Ophthalmology Sis. Improvements were noted in pressure ulcers, fluid balance management, infection control initiatives, falls reduction, communication training, medication safety, and bowel management training.
- **Clinical Support Services (CSS**): Rebekah raised the division is implementing safety measures, tracking quality improvement projects, and focusing on timely closure of incidents and PTR cases. The risk related to the Defibrillator replacement programme.
- **Urgent Care Division**: The division is addressing acuity and resuscitation area capacity, the impact of the 45 minute handover target and sharing of learning across divisions.

Risks discussed or identified:

- **High-Cost Drugs and Forward Planning:** Approach to high-cost drugs and future priorities. JS confirmed that the director of pharmacy peer group is developing a consistent assurance report format, which will include forward-looking plans and actions. The report details the work of the high-cost drug implementation group and escalation processes for NICE-mandated treatments.
- **Medicine Division**: NS highlighted risks related to system pressure, PTR backlog, and waiting lists, with mitigation through daily and monthly risk assessments, enhanced care audits, and improvement projects on medication errors, TEPS compliance, and falls.
- **Family and Therapies Division**: JB raised the risks related to PTR compliance and quality and safety improvement
- **Clinical Support Services (CSS**): Risk of defibrillator replacement programme.
- **Surgery Division**: Learning in relation to the Ophthalmology
- **Urgent Care Division**: Risks were discussed in relation to flow in the system and wait to be seen
- **Legal Services Monitoring** - Fines in relation late submissions of Learning was identified - it was agreed this needed to be reported in more depth at the next meeting
- **Complaints Trajectory and PTR Framework Update:** the deliverability of the target and the impact of seasonal pressures was discussed

Matters for the Board or other committees:

SS to review the risk related to Defibrillator replacement and report to the relevant group

MEETING AGENDA ITEMS

Q2 Quality Strategy and QMS Implementation Plan	Q2 Quality Outcomes Framework	Pharmacy and Medicines Management Annual Report 2024/25
PSI Policy (Revision)	PTR Complaints Trajectory	Management of Unwell Patients, Staff or Visitors in ABUHB Primary Care and Community Settings: Alert
Big Conversation on Sepsis	HIW Reports – Maternity YYF & MIU RGH	Divisional Highlight Reports X 7

Attendees

Jenny Winslade (Chair)	Executive Director of Nursing
Seema Srivastava	Executive Medical Director
Amanda Hale	Divisional Nurse – Surgery and Clinical Support Services
Karen Hatch	Assistant Director of Allied Health Professions & Health Science
Shelley Williams	Deputy Director of Workforce
Natalie Skyrme	Divisional Nurse - Medicine
Leeanne Lewis	Assistant Director – Quality and Safety
Craig Roberts	Assistant Director of Allied Health Professions & Health Science
Kye Smith	Deputy Head of Quality and Patient Safety
Dan Davies	Chief Business Officer
Gemma Couch	Head of Quality and Patient Safety
Amy Buckley	Divisional Nurse Mental Health
Howard Stanley	Head of Safeguarding
Collette Kiernan	Deputy Director of Allied Health Professions & Health Science
Moira Bevan	Head of Nursing – Infection Prevention & Control
Kelly Downes	Deputy Director of Nursing
Helen Morgan	Divisional Nurse – Family & Therapies
Jayne Beasley	Head of Midwifery
Lilia Delgado	Deputy Head of Health, Safety & Fire
Jayne Beasley	Head of Midwifery
Susan Palmer	Head of Research Delivery
Christopher Morgan	Divisional Nurse – Urgent Care
Tanya Strange	Head of Nursing Person Centred Care
Rebekah White	Divisional Nurse – Clinical Support Services
Lloyd Hambridge	Divisional Director of Primary Care

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	02 December 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Nurse Staffing Levels (Wales) Act 2016: Annual Presentation of Nurse Staffing Levels 2025
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Kelly Downes - Deputy Director of Nursing Laura Thomson – Nurse Staffing Act Lead

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

Er Sicrwydd/For Assurance

The Annual Presentation to Board (appendix 1) presents the outcomes of the Spring and Autumn 2025 recalculations conducted across all 25B wards, providing assurance regarding the Health Board's compliance with the Nurse Staffing Levels (Wales) Act 2016 (NSLWA).

Sefyllfa / Situation

In accordance with the NSLWA 2016, Health Boards and Trusts have a bi-annual duty to use the triangulated approach to calculate the nurse staffing levels in adult acute medical and surgical wards, and paediatric wards. There is also a requirement to report compliance in maintaining the nurse staffing levels as a means of providing assurance to the public, the Board and Welsh Government.

The All-Wales Nurse Staffing Group agreed a Once-for-Wales approach to provide consistency in reporting across all Health Boards. A clear governance process is required to inform the Board, or delegated committee, of any changes following the Bi-annual recalculations.

The Executive Team were appraised of the proposed changes to 25B Ward roster templates following the Spring 2025 recalculations. The changes were agreed to be supported with variable pay, pending further recalculation in the Autumn.

A summary of both Spring & Autumn 2025 calculations are presented below in the Assessment section.

Cefndir / Background

The NSLWA became law in 2016 and requires Health Boards to have regard for the provision of appropriate nurse staffing levels to ensure nurses have time to care for patients sensitively.

The designated person must calculate the nursing workforce appropriate to provide patient-centred care that meets all reasonable requirements in that situation.

In practice the nursing workforce means:

- the number of registered nurses (this being those with a live registration on sub parts 1 or 2 of the Nursing and Midwifery Council register) (Band 5 and Band 6)
- the number of rostered Assistant Practitioner (Band 4) (this will be superseded by the Registered Nursing Associate role once introduced in Wales).
- the number of Nursing Support Workers (Band 3).
- the number of Health Care Support Workers (Band 2).

The ward manager is not included in the planned roster and the required establishment needed to deploy the roster. Each ward will have a supernumerary ward manager.

In accordance with the Act, multi-professional roles are not included within the nurse staffing level calculation (the planned roster and the required establishment). However, consideration needs to be given to the presence and contribution that the multi-professional team and other healthcare professionals play in the delivery of patient care and the impact that not having these staff available will have on the duties that the ward nursing team will be required to undertake to ensure the provision of sensitive care.

Asesiad / Assessment

A robust, legislatively mandated triangulated methodology was applied to all Section 25B wards. This process involved multidisciplinary input from Divisional Nurses, Senior Nurses, Ward Managers, the Nurse Staffing Programme Lead, Health-Rostering, and Finance Teams. Professional judgement was central to decision-making, ensuring staffing levels were appropriate to each ward's needs.

The divisions followed a well-established terms of reference to guide recalculation meetings. Discussions encompassed ward type, bed capacity, funded establishment, Health-rostering efficiency, and Safecare compliance. Acuity data

from the preceding six months was reviewed alongside deployed staffing levels, including bank and agency usage and variable pay expenditure.

The successful rollout of Safecare to all 25B wards, has enabled ward staff to have access to monthly acuity data in the form of visualisers to help inform the recalculation meetings as opposed to a 1-month snapshot in previous years.

Quality indicators from the same period were analysed, including hospital-acquired pressure ulcers, patient falls with harm, medication errors, infection rates, and complaints related to nursing care. Incident-related learning was shared, and ward managers were encouraged to highlight examples of good practice.

Progress in Ward Accreditation, PADR completion, mandatory training compliance, and staff sickness rates were also examined.

Following these reviews, collaborative professional judgement was applied to determine whether staffing levels are sufficient to deliver sensitive patient care. A standardised template for each Section 25B ward was then completed by the Divisional Nurse and submitted to the Executive Director and Deputy Director of Nursing during challenge and support meetings.

Spring 2025 Calculations (March-April 2025)

A total of 33 wards reviewed during the Spring calculations, no changes required to the wards in surgery, gynaecology and paediatrics. 5 of 19 medical wards proposed roster template changes, which the Executive Director of Nursing supported.

Medicine-proposed roster templates

The Division of Medicine identified 5 wards requiring amendments to roster templates to support the delivery of timely nursing care. The revised templates aim to enhance workforce stability, as current reliance on bank and agency staff has resulted in unfilled shifts. These changes are also expected to reduce variable pay costs, improve continuity of care, and promote equity across services.

Proposed changes to Establishments

Ward 4.4, Nevill Hall Hospital (30 Bedded Care of the Elderly Ward)

- **Change**: Increased Band 2 HCSW staffing to 4 per day, 7 days/week (2.8 WTE).

- **Rationale**: This ward was repurposed from a semi-acute respiratory ward to a Care of the Elderly (COTE) ward following the respiratory and general medicine reconfiguration in Autumn last year. The ward staff have found adjusting to a different patient profile challenging and have struggled to work within the previously agreed roster template. Due to consistent use of variable pay to support ward acuity—and to align staffing with other COTE wards on the Nevill Hall site.

- **Cost**: £103,499/year.

- **Roster Change**:

  - Previous: Day – 4 RN / 3 HCSW | Night – 2 RN / 4 HCSW
  - Proposed: Day – 4 RN / **4 HCSW** | Night – 2 RN / 4 HCSW

Bargoed Ward, Ysbyty Ystrad Fawr (27 Bedded Stroke Rehabilitation, capacity to board 2 patients)

- **Change**: Increased RN staffing to 4 per day, 7 days/week (2.84 WTE).

- **Rationale**: This ward functions as a Stroke Rehabilitation Unit with high levels of acuity and patient dependency. Following the centralisation of stroke services, patients are now being transferred from GUH earlier in their stroke pathway, resulting in a higher proportion of acutely unwell individuals. Many require PEG feeding, which significantly increases the time required for medication administration by a RN. To address this, an increase to 4 RN, 7 days per week (2.84 WTE) is required. This proposed change will bring Bargoed Ward in line with Oakdale Ward. The model also includes a review of Band 4 Assistant Practitioners, with a view to enabling them to work across both Bargoed and Oakdale Wards, ensuring equitable service delivery and consistent staffing levels across the two Stroke Rehabilitation Wards at YYF.

- **Cost**: £163,752/year.

- **Roster Change**:
  - Previous: Day – 3 RN / 6 HCSW | Night – 2 RN / 4 HCSW
  - Proposed: Day – **4 RN** / 6 HCSW | Night – 2 RN / 4 HCSW

Oakdale Ward YYF (28 bedded Stroke rehabilitation ward, no Surge Capacity)

- **Change**: Increased HCSW staffing to 5 per day, 7 days/week.

- **Rationale**: This ward operates as a Stroke Rehabilitation Unit with high acuity and patient dependency. Following the centralisation of stroke services, patients are now being transferred from GUH earlier in their stroke pathway, resulting in

a higher proportion of acutely unwell individuals. Many require PEG feeding, which significantly extends the time required for medication administration by a RN. The current establishment includes 4 RN during the day to support these prolonged medication rounds. However, due to the high dependency of patients, a professional judgment review, supported by variable pay data, concluded that the number of HCSW should be increased to 5 during the day, 7 days per week.

- **Cost**: £103,499/year.

- **Roster Change**:
  - Previous: Day – 4 RN / 4 HCSW | Night – 2 RN / 4 HCSW
  - proposed: Day – 4 RN / **5 HCSW** | Night – 2 RN / 4 HCSW

C6E Royal Gwent Hospital (30 bedded General Medical Ward, no Surge capacity)

- **Change**: Increased night HCSW staffing by 1 (7 days per week).

- **Rationale**: Patient dependency on this ward is high, and concerns have been raised regarding the Core Care Model, with the ward manager expressing a need for 4 RN during the day. However, this will be revisited following a full review of the Core Care Model and its alignment with the future Registered Nurse Associate role. It was noted that variable pay usage on this ward is consistently high, particularly due to additional HCSW shifts created at night to support patient dependency and enhanced care needs. To address this and ensure continuity of care, it was agreed to increase the establishment by 1 HCSW during the night, 7 days per week. This change is expected to help offset variable pay expenditure.

- **Cost**: £124,000/year.

- **Roster Change**:
  - Previous: Day – 3 RN / 5 HCSW | Night – 2 RN / 3 HCSW
  - Proposed: Day – 3 RN / 5 HCSW | Night – 2 RN / **4 HCSW**

C6W Royal Gwent Hospital (28 bedded Endocrinology ward with some General Medicine Beds)

- **Change**: **Cost-neutral** adjustment swapping RN night and HCSW day.

- **Rationale**: The Ward Manager highlighted that the current planned roster does not meet the operational needs of the ward. It was proposed that the ward would function more effectively with an additional RN during the day shift to better manage workload. Additionally, an extra HCSW is consistently required at night to support patient acuity and enhanced care needs, contributing to increased

variable pay. Following professional discussions, a cost-neutral adjustment to the roster was agreed. The revised roster will replace the RN on the night shift with an HCSW on the day shift. This change is expected to better align staffing with patient needs while maintaining cost neutrality.

- **Roster Change**:

  - Previous: Day – 3 RN / 5 HCSW | Night – 3 RN / 3 HCSW
  - Proposed: Day – **4 RN** / **4 HCSW** | Night – **2 RN** / **4 HCSW**

Summary of amendments required to establishments post Spring 2025 recalculations *Excluding Supernumerary Ward Manager							
Ward	Pre-Calculation			Post-Calculation			Additional Annual cost
	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	Total WTE	
4.4 NHH	17.32	19.58	36.99	17.32	22.36	39.68	£103,499
Bargoed ward YYF	14.48	27.99	42.47	17.32	27.99	45.31	£163.752
Oakdale ward YYF	17.32	22.4	39.72	17.32	25.19	42.51	£103,499
C6E RGH	14.48	22.42	36.9	14.48	25.2	39.68	£124,000
C6W RGH	17.32	22.42	39.74	17.32	22.42	39.74 cost neutral	0
Total Cost							**£494,750**

Roster efficiency

The E-rostering team have conducted roster efficiency analyses on the 4 wards requesting template increases, covering the period October 2024-March 2025.

There were high additional duties created for both grades in all areas. The working day unavailability has been used mainly when staff require supervision for instance when newly qualified staff or international nurses require supervision and cannot be included in the shift numbers.

Unavailability reasons

HCSW

- Sickness Absence:

Sickness levels were high across all areas, predominantly short-term.
Long-term sickness cases: Oakdale (3), Bargoed (6), NHH (7), C6W RGH (4)

- Study Leave:

Oakdale had an exceptionally high study leave recorded (1064.5 hours), with some individuals off for up to 3 weeks (attributed to international nurse induction and staff undertaking flexible route to registered nurse training).

- Bank Staff:

Bargoed: Low bank fill rate but high bank hours.

- Unfilled Hours:

High in all areas.

RN

- Sickness Absence:

High across all areas, mostly short-term.
Long-term sickness cases: Bargoed (2), 4/4 (1), C6W (3)

- Agency Use:

High in all areas, exceptionally high in Oakdale

The Divisional lead has given assurance that sickness is monitored and managed appropriately across the sites.

In addition to sickness, additional shifts have been created to reflect the acuity on the sites and the subsequent need to increase the number of staff on duty over and above the agreed template.

The study leave is high on Oakdale ward because there are several staff undertaking the flexible route to nursing and International Nurses requiring induction.

It must be noted that in areas such as YYF it is more difficult to fill the bank shifts, therefore increasing the pressures on the wards.

Spring Calculation Outcome

The paper was presented to the Executive Committee on 18 September 2025, where it was agreed that the Division of Medicine would implement the cost-neutral roster change for Ward C6W.

Regarding the proposed amendments for Ward 4.4 at Nevill Hall Hospital, Oakdale and Bargoed Wards at Ysbyty Ystrad Fawr, and Ward C6E at the Royal Gwent Hospital; to ensure compliance with the Nurse Staffing Levels (Wales) Act, the Committee supported the continued use of variable pay to maintain staffing levels as outlined in the Spring recalculations.

A further multidisciplinary review involving workforce, finance, and nursing teams was agreed as part of the Autumn recalculation process, prior to confirming any permanent funding or roster adjustments.

Autumn 2025 Calculations (March-April 2025)

A total of **35 wards** were subject to staffing calculations Autumn 2025, comprising:

- **21 Acute Medical Wards**
- **13 Surgical Wards** (including 1 Gynaecological Ward)
- **1 Paediatric Ward** (50 beds)

The number of permanent medical 25B wards has increased by 1 following the reclassification of Penallta Ward at YYF—a 28-bed COTE and palliative care ward—which now meets the criteria for a 25B designation. Additionally, a staffing calculation was carried out for Ward D7W at RGH (Winter Ward).

Outcome

The Surgical, Gynaecological, and Paediatric Nurse Staffing Templates remain the same, no changes to roster templates required.

Medical Wards

Medical wards retained Spring adjustments, (Ward 4.4 NHH, Bargoed & Oakdale wards YYF, & C6E RGH) and are carried forward to the Autumn calculations

with the additional changes to:

- Ward C4 GUH, respiratory ward, increase RN Late shift 7 days/week
- Penallta ward YYF, increase of 1 HCSW 7 nights/week
- Ward D7W, winter pressure ward – Calculation was undertaken to agree the template for temporary winter pressure ward.

Ward C4 GUH (45 bedded respiratory unit- spread over 3 areas, capacity to board a further 3 patients)

- **Change**: Increase RN late shift (7 days/week).
- **Rationale:** There is a need for a coordinator role to be in place for 12 hours a day due to the ward's extensive footprint and fast-paced environment. Patient turnover is high, with increasing acuity and elevated NEWS (National Early Warning Score) results. The intensity and pressure on the ward are sustained throughout the day, making the coordinator role essential for ensuring smooth and effective ward operations. (This role has been utilised using variable pay

following the reconfiguration of Respiratory and General medicine services. There is a clear need to receive permanent funding for this post).

- **Cost**: £75,053/year.

- **Roster Change**:
  - Previous: Early 9 RN / 7 HCSW, late 8 RN / 7 HCSW, Night 8 RN / 7 HCSW
  - Proposed: Early 9 RN / 7 HCSW, **late 9 RN** / 7 HCSW, Night 8 RN / 7 HCSW

Penallta Ward YYF (28 bedded COTE and Palliative Care ward), capacity to surge by 1

- **Change:** Increase HCSW by Night (7 days/week)

- **Rationale:** Penallta Ward has been reclassified as a 25B ward following a review of criteria. Now under the care of a General Medicine consultant, it admits Gen Med, COTE, and Palliative care patients. Although previously listed as 25A, it has consistently undergone biannual staffing calculations alongside other 25B wards at YYF due to its similar patient profile. Historically, professional discussions have supported the need for an additional HCSW at night, (currently, the additional HCSW is consistently utilised through variable pay). To ensure equity and reduce variable pay, the proposal is to increase night staffing from 3 to 4 HCSWs by night

- **Cost:** £124,000 /year

- **Roster Change**:
  - Previous: Day – 4 RN / 4 HCSW | Night – 2 RN / 3 HCSW
  - Proposed: Day – 4 RN / 4 HCSW | Night **–** 2 RN / **4 HCSW**

Ward D7W RGH (23 bedded Winter Pressure ward operational 3 months- January 2025 to end of March 2026).

A nurse staffing template was developed for the temporary winter pressure ward, based on comparable ward staffing model.

Nurse Staffing Template for Temporary Winter Pressure Ward
A nurse staffing template was developed specifically for the temporary winter pressure ward. This template was designed by referencing an established staffing model from comparable wards, ensuring that the approach aligns with best practice and meets the anticipated needs during the winter period.
To ensure safety and continuity, the ward will be overseen by a seconded Band 7 and Band 6, with support from redeployed substantive RNs and HCSWs from other areas, backfilled by temporary staff.

There is currently an advert on the Health Board pulse page encouraging substantive staff to register an interest to be redeployed to the winter ward. Additionally, the Nurse Bank will advertise 3-month temporary contracts to allow for consistency in filling the shifts.

Proposed Roster: Day: 3 RN / 3 HCSW | Night: 2 RN / 3 HCSW

This equates to WTE - B7 x1, Band 6 x1, B5 x 13.48, Band 2 x 13.98

Summary of amendments

The table below outlines the whole-time equivalent (WTE) figures before and after the Autumn calculations. Annual costings for each post have been provided by the Finance Partner for Medicine. These costings have increased compared to the Spring calculations due to this year's pay awards. Additionally, the Finance Business Accountant has revised the costing for the RN on Bargoed Ward, as the original Spring calculation was based on night shift rates rather than day shifts, resulting in an overestimation.

Summary of amendments required to establishments post Autumn 2025 Recalculations-including rollover of 4 wards from Spring calculations.

***Excluding Supernumerary Ward Manager**

Ward	Pre-Calculation			Post-Calculation			Additional Annual cost	Variable Pay expenditure Oct 2024-September 2025
	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	Total WTE		
4.4 NHH	17.32	19.58	36.99	17.32	22.36	39.68	£104,338	£147, 621
Bargoed ward YYF	14.48	27.99	42.47	17.32	27.99	45.31	£139,100	£140, 057
Oakdale ward YYF	17.32	22.4	39.72	17.32	25.19	42.51	£104,338	£146, 220
Penallta ward YYF	17.32	19.56	36.88	17.32	22.36	39.68	£131,341	£253,701
C6E RGH	14.48	22.42	36.9	14.48	25.2	39.68	£131,341	£145, 026
C4 GUH	47.2	39.65	87.42	49.59	39.65	88.24	£75,053	£142, 573
Total Cost							**£685,511**	**£975,198**

Assurance Measures in Budget Oversight and Roster Monitoring

To provide assurance, divisional leads convene monthly meetings with business finance partners, senior nurses, and ward managers to review budget performance and address any areas of overspend. Key areas of focus include:

- Whole Time Equivalents (WTEs) versus vacancies
- Variable pay expenditure
- Monitoring of additional shifts against appropriate coding within the health-roster system

For enhanced assurance, the E-Roster team distributes monthly **SafeCare** reports to ward managers to support compliance with the twice-daily acuity census. Additionally, Divisional Leads have access to the workforce Divisional Nursing Hub dashboard, which allows them access to monthly reports on:

- Bank and agency usage
- Filled and unfilled shifts
- Roster efficiencies
- Sickness absence
- Pay scale Metrix
- Roster approval
- Supply and demand tracker
- Staff in post with age profile

The E-rostering team have conducted roster efficiency analyses on the 5 wards requesting template increases, covering the two months leading up to this report (August and September).

Overall, roster efficiencies are satisfactory, particularly in managing annual leave and other absences. However, sickness levels among HCSW are notably high, as is the allocation of study leave for Band 4 staff.

The Divisional Lead has confirmed that sickness is being effectively managed on the three wards requesting increased HCSW staffing. Sickness absence management processes and stages are discussed during weekly budget meetings.

The elevated study leave figures are attributed to Band 4 International Nurses currently undergoing induction and working towards NMC registration and band 4 nurses undertaking the flexible route to nurse registration.

Both ward C4 GUH and Bargoed ward YYF, are currently holding RN vacancies. The Divisional Lead has confirmed that these vacancies are being addressed through student streamlining on Ward C4 and the placement of International Nurses on Bargoed Ward. Once these posts are filled, RN vacancies will reduce to 0.22 WTE on Ward C4 and 0.21 WTE on Bargoed Ward.

The Divisional Lead is confident that all necessary steps are being taken to manage absences, improve roster efficiencies and reduce variable pay. Additionally, Senior Nurses are auditing enhanced care documentation to ensure compliance with policy. A clear escalation process is in place for requesting additional duties related to enhanced care needs.

It is important to note that the six wards requesting an increase to their staffing templates have consistently operated at the proposed levels over the past year through variable pay expenditure.

Executive Committee Discussion

The report was presented to the Executive Committee on 13 November 2025. The Executive Committee considered the options to meet the staffing requirements and supported the recommendation that the revised roster templates will be met through Variable pay with a request for further analysis of acuity to be undertaken.

Appendix 1: Annual Presentation of Nurse Staffing Levels
Appendix 2: Summary of Nurse Staffing levels

Argymhelliad / Recommendation

The Health Board has a duty to implement the statutory guidance and ensure compliance with the requirement of the Nurse Staffing Levels (Wales) Act.

The Committee is asked to take assurance that: -

- The Health Board is meeting its statutory requirement to calculate the nurse staffing levels for all wards that fall under Section 25B of the NSLWA.
- The proposed changes to 6 planned rosters in the division of medicine outlined above and in Appendix 1 (Annual Presentation of Nurse Staffing levels) will be met through Variable Pay whilst a further review of acuity is undertaken

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 7. Staff and Resources 2. Safe Care Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	• Nurse Staffing Levels (Wales) Act 2016 • Health and Social Care (Quality and Engagement) (Wales) Act 2020.
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.

	If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

Annual Presentation of Nurse Staffing Levels to the Board	
Health Board	ABUHB
Date of annual presentation of Nurse Staffing Levels to Board	25 November 2025
Period Covered	This report outlines the biannual Nurse Staffing Level Calculations undertaken across all 25B wards and details amendments to ward nursing establishments for the period 1 October 2024 to 30 September 2025.
Number and identity of section 25B wards during the reporting period. • **Adult acute <u>medical</u> inpatient wards** • **Adult acute <u>surgical</u> inpatient wards (inclusive of Women's Gynaecological inpatient wards)** • **<u>Paediatric</u> inpatient wards**	The Board is required to consider and have due regard to its duty under Section 25A of the Nurse Staffing Levels (Wales) Act to ensure sufficient nursing staff are available to provide sensitive and safe care wherever patients are receiving nursing services. This includes a responsibility to continuously review and undertake comprehensive, systematic assessments of nurse staffing levels. Under the Act, Health Boards and Trusts are also required to report on the calculation process and outcomes for all wards that fall under Section 25B. These include all acute medical, surgical, and paediatric wards. A total of 33 wards were classified as 25B wards during the Spring calculation, increasing to 35 following the Autumn review. This change is due to Penallta Ward at YYF now being designated as a Care of the Elderly (COTE) and Palliative Care ward, meeting the criteria for 25B classification. Additionally, a staffing template was developed for the temporary Winter Pressure Ward (D7W) at the Royal Gwent Hospital to support seasonal demand.

<table>
<tr><td></td><td colspan="6">Total number of 25B wards

<table><tr><th></th><th>Spring 2025</th><th>Autumn 2025</th></tr><tr><td>Acute Medical:</td><td>19 Wards</td><td>21</td></tr><tr><td>Surgical:</td><td>12 Wards</td><td>12</td></tr><tr><td>Gynaecology:</td><td>1 Ward</td><td>1</td></tr><tr><td>Paediatrics:</td><td>1 Ward (50 beds)</td><td>1 Ward (50 beds)</td></tr></table></td></tr>
<tr><td></td><td colspan="2">Adult acute <u>medical</u> inpatient wards</td><td colspan="2">Adult acute <u>surgical</u> inpatient wards</td><td colspan="2">Paediatric inpatient wards</td></tr>
<tr><td></td><td colspan="2">19 / 21</td><td colspan="2">13</td><td colspan="2">1</td></tr>
<tr><td rowspan="2">Required establishment (WTE) calculated (November 2024 following respiratory reconfiguration)</td><td>RN</td><td>HCSW</td><td>RN</td><td>HCSW</td><td>RN</td><td>HCSW</td></tr>
<tr><td>359.22</td><td>459.49</td><td>233.5</td><td>250.53</td><td>70.22</td><td>17.06</td></tr>
</table>

WTE of required establishment funded (November 2024 following respiratory reconfiguration)	359.22	459.49	233.5	250.43	70.22	17.06
Staffing requirements following Spring Cycle (May 2025)	**Adult acute medical inpatient wards**		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	
Required establishment (WTE) calculated (May 2025)	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
	362.06	467.84	230.5	247.18	70.22	17.06
WTE of required establishment funded (May 2025)	359.22	459.49	230.5	247.18	70.22	17.06
Staffing requirements at end of reporting period (September 2025)	**Adult acute medical inpatient wards**		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	
Required establishment (WTE) calculated (September 2025)	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
	380.8	481.44	230.5	247.18	70.22	17.06

WTE of required establishment funded (September 2025)	359.22	459.49	230.5	247.18	70.22	17.06
WTE Supernumerary band 7 sister/charge nurse at end of reporting period (funded but excluded from planned roster)	20		13		1	
Using the triangulated approach to calculate the Nurse staffing level on section 25B wards	**Evidence of Triangulated Approach** A robust, legislatively mandated triangulated methodology was applied to all Section 25B wards. This process involved multidisciplinary input from Divisional Nurses, Senior Nurses, Ward Managers, the Nurse Staffing Programme Lead, e-rostering, and finance teams. Professional judgement was central to decision-making, ensuring staffing levels were appropriate to each ward's needs. Key considerations included: • Ward specialty, bed base, and current roster • Funded establishment and budget alignment • Health-Roster efficiency and Safecare compliance					

	• Monthly patient acuity visualisers vs. deployed staffing • Variable pay data • Supplementary roles (e.g., ward clerks, discharge coordinators) • Care quality indicators (e.g., pressure ulcers, falls, medication errors, nursing complaints) • Staff performance metrics (e.g., PADR compliance, training compliance, sickness rates) • Ward accreditation and improvement initiatives Following these reviews, ward-specific templates were completed and presented to the Executive Director of Nursing, Deputy Director of Nursing, and Nurse Staffing Programme Lead for challenge and assurance. Spring recalculations were submitted in June 2025; Autumn recalculations in October 2025. The Board has assurance that all Section 25B wards received a **26.9% uplift** to Registered Nurse establishments to account for leave and training. Ward Managers remain supernumerary, with the uplift applied to their roles to ensure cover of the role in their absence. The HCSW establishment receive a **24.8%** uplift.
Finance and workforce implications	**Spring Recalculations (March / April 2025)** **Surgery, Gynae & Paediatrics** Following the in-depth recalculation meetings; the Divisions of Surgery and Family & Therapies deemed the planned rosters, and funded establishments were appropriate to meet the needs of patients. No changes were required to previously agreed roster templates.

Medicine

The Division of Medicine identified five wards requiring amendments to roster templates to support the delivery of timely nursing care. The revised templates aim to enhance workforce stability, as current reliance on bank and agency staff has resulted in unfilled shifts. These changes are also expected to reduce variable pay costs, improve continuity of care, and promote equity across services.

Proposed changes to establishments

Ward 4.4 Nevill Hall Hospital (30 bedded Care of the Elderly Ward, with the capacity to board 1 patient).

This ward was repurposed from a semi-acute respiratory ward to a Care of the Elderly (COTE) ward following the respiratory and general medicine reconfiguration in Autumn last year. The ward staff have found adjusting to a different patient profile challenging and have struggled to work within the previously agreed roster template. Due to consistent use of variable pay to support ward acuity—and to align staffing with other COTE wards on the Nevill Hall site—it was concluded that Band 2 Healthcare Support Worker (HCSW) provision should be increased to four staff, seven days a week (2.8 WTE). This adjustment, at an annual cost of £103,499, will help offset some of the current variable pay expenditure and stabilise the workforce.

Previous roster: Day 4 RN / 3 HCSW - Night 2 RN / 4 HCSW

	Proposed Roster: Day 4 RN / **4 HCSW** - Night 2 RN / 4 HCSW Presented to and approved by DMT in 6th May 2025 **Total Cost: £103,499 per annum.** **Bargoed Ward Ysbyty Ystrad Fawr (27 Bedded Stroke Rehabilitation ward (Capacity to board 2 patients).** This ward functions as a Stroke Rehabilitation Unit with high levels of acuity and patient dependency. Following the centralisation of stroke services, patients are now being transferred from GUH earlier in their stroke pathway, resulting in a higher proportion of acutely unwell individuals. Many require PEG feeding, which significantly increases the time required for medication administration by a Registered Nurse (RN). To address this, the staffing template will be increased to four RNs, seven days a week—equating to an uplift of 2.84 WTE at an annual cost of £163,752. This proposed change will bring Bargoed Ward in line with Oakdale Ward. The model also includes a review of Band 4 Assistant Practitioners, with a view to enabling them to work across both Bargoed and Oakdale Wards, ensuring equitable service delivery and consistent staffing levels across the two Stroke Rehabilitation Wards at YYF. Previous roster: Day 3 RN / 6 HCSW - Night 2 RN / 4 HCSW Proposed Roster: Day **4 RN** / 6 HCSW - Night 2 RN / 4 HCSW Presented to and approved by DMT 6th May 2025 **Total Cost: £ 163,752 per annum.** **Oakdale Ward YYF (28 bedded Stroke rehabilitation ward, no Surge Capacity).**

	This ward operates as a Stroke Rehabilitation Unit with high acuity and patient dependency. Following the centralisation of stroke services, patients are now being transferred from GUH earlier in their stroke pathway, resulting in a higher proportion of acutely unwell individuals. Many require PEG feeding, which significantly extends the time required for medication administration by a Registered Nurse (RN). The current establishment includes four RNs during the day to support these prolonged medication rounds. However, due to the high dependency of patients, a professional judgment review—supported by variable pay data—concluded that the number of Healthcare Support Workers (HCSWs) should be increased to five during the day, seven days a week. This adjustment, at an annual cost of £103,499, will ensure both Stroke Rehabilitation Wards are aligned in terms of staffing and service delivery. Previous Roster: Day 4 RN / 4 HCSW - Night 2 RN / 4 HCSW Proposed Roster: Day 4 RN / **5 HCSW** - Night 2 RN / 4 HCSW Presented to and approved by DMT by 6th May 2025 **Total Cost: £ 103,499 per annum** **C6E Royal Gwent Hospital (30 bedded General Medical Ward, no Surge capacity).** Patient dependency on this ward is high, and concerns have been raised regarding the Core Care Model, with the ward manager expressing a need for four Registered Nurses (RNs) during the day. However, this will be revisited following a full review of the Core Care Model and its alignment with the future Registered Nurse Associate role. It was noted that variable pay usage on this ward is consistently high, particularly due to additional Healthcare Support Worker (HCSW) shifts created at night to support patient dependency and

	enhanced care needs. To address this and ensure continuity of care, it was agreed to increase the establishment by one HCSW during the night, seven days a week. This change, at an annual cost of £124,000, is expected to help offset variable pay expenditure. Previous roster: Day 3 RN / 5 HCSW - Night 2 RN / 3 HCSW Proposed Roster: Day 3 RN / 5 HCSW - Night 2 RN / **4 HCSW** Presented to and approved by DMT 6th May 2025 **Total cost £124,000 per annum** **C6W Royal Gwent Hospital (28 bedded Endocrinology ward with some General Medicine Beds).** The Ward Manager highlighted that the current planned roster does not meet the operational needs of the ward. It was proposed that the ward would function more effectively with an additional Registered Nurse (RN) during the day shift to better manage workload. Additionally, an extra Healthcare Support Worker (HCSW) is consistently required at night to support patient acuity and enhanced care needs, contributing to increased variable pay. Following professional discussions, a cost-neutral adjustment to the roster was agreed. The revised roster will replace the RN on the night shift with an HCSW on the day shift. This change is expected to better align staffing with patient needs while maintaining cost neutrality. Previous Roster: Day 3 RN / 5 HCSW - Night 3 RN / 3 HCSW Proposed Roster: Day **4 RN / 4 HCSW** - Night **2 RN / 4 HCSW** Presented to and approved by DMT 6th May 2025

Cost neutral

Summary of amendments required to establishments post Spring 2025 recalculations

***Excluding Supernumerary Ward Manager**

Ward	Pre-Calculation			Post-Calculation			Additional Annual cost
	RN WTE	HCSW WTE	Total WTE	RN WTE	HCSW WTE	Total WTE	
4.4 NHH	17.32	19.58	36.99	17.32	22.36	39.68	£103,499
Bargoed ward YYF	14.48	27.99	42.47	17.32	27.99	45.31	£163.752
Oakdale ward YYF	17.32	22.4	39.72	17.32	25.19	42.51	£103,499
C6E RGH	14.48	22.42	36.9	14.48	25.2	39.68	£124,000
C6W RGH	17.32	22.42	39.74	17.32	22.42	39.74 cost neutral	0
Total Cost							**£494,750**

Outcome

	This paper was discussed at the Executive Committee on 18 September 2025, where it was agreed that the Division of Medicine would implement the cost-neutral roster change on C6W. Regarding the requests for 4/4 staffing at Nevill Hall Hospital, Oakdale Ward and Bargoed Ward at Ysbyty Ystrad Fawr, and C6E at the Royal Gwent Hospital, it was agreed that the current approach—utilising variable pay to staff these wards as outlined in the Spring calculation—would continue in order to meet the requirements of the Act. A further review involving workforce, finance, and nursing teams was agreed as part of the Autumn calculation process, prior to any decisions on permanent funding arrangements or roster changes. **Autumn Recalculations 2025 (August / September 2025)** Surgery, Gynae Paediatric wards During the Autumn cycle, 12 surgical wards, one gynaecology ward, and the 50-bedded paediatric unit were reviewed. The planned rosters for these areas were deemed appropriate and therefore roster templates did not require any changes. Medicine During the Autumn recalculations, 21 medical wards were reviewed, including a staffing calculation for the upcoming Winter Pressures Ward. The proposed changes to four of the five planned roster templates from the Spring review—Bargoed Ward (YYF), Oakdale Ward (YYF), Ward 4.4 (NHH), and C6E (RGH)—have been retained. These proposed changes, previously agreed to be supported through variable pay, remain in place.

	In addition to the four template changes carried forward from the Spring calculations, the Autumn review concluded that there is a requirement to increase staffing templates for the following wards: **Ward C4 GUH (45 bedded respiratory unit- spread over 3 areas, capacity to surge by 3 beds).** Following the Respiratory and General Medicine reconfiguration, the ward footprint was extended to include a wing on B4—bringing the total to 39 beds—and an additional 6 high-care respiratory beds on C2 (total 45 beds). The staffing template and funded establishment currently includes a Registered Nurse (RN) coordinator role for 6 hours per day, 7 days a week. Professional discussions highlighted several factors: the difficulty in managing the expanded bed base across three areas, further compromised by increased activity from the "Your Next Patient" initiative, the fast-paced environment, increasing patient acuity, and elevated NEWS (National Early Warning Score) on many patients all contribute to increased ward pressures. It is evident that to ensure safe and effective ward operation, the coordinator role should be extended to 12 hours per day, 7 days a week permanently. The Divisional Lead, in agreement with the Senior Nurse and Ward Manager, has confirmed that the 12-hour coordinator role is essential. It should be noted that, following the respiratory reconfiguration, this role has consistently been fulfilled through variable pay to maintain patient safety and operational efficiency. To meet this requirement, an increase of 1.42 WTE RN is proposed, at an annual cost of £75,053. Previous roster: Early 9 RN / 7 HCSW, late 8 RN / 7 HCSW, Night 8 RN / 7 HCSW Proposed Roster: Early 9 RN / 7 HCSW, **late 9 RN** / 7 HCSW, Night 8 RN / 7 HCSW

	Penallta Ward Ysbyty Ystrad Fawr (28 bedded, Gen Med and Palliative care ward, capacity to surge by 1 bed). Following a review of the 25B criteria, Penallta Ward has been classified as a 25B ward. The ward is now overseen by a Gen Med consultant and accepts Gen Med, COTE and Palliative care patients. Despite previously being categorised as 25A, Penallta ward has consistently undergone biannual calculations along with the 25B wards in YYF due to its similar patient profile. The only exception being it was previously overseen by a CRT consultant. Professional discussions have consistently highlighted the need to increase the HCSWs by night and for this to be reflected in the funded budget. This ward in line with the other wards in YFF consistently operates with 4 HCSW's by night, supported through variable pay. Therefore, to offset variable pay and ensure equity of services across the YYF site, there is a need to increase the funded establishment by 1 HCSW at night, 7 days a week at a cost of £124,000 per annum. Previous roster: Day 4 RN / 4 HCSW - Night 2 RN / 3 HCSW Proposed Roster: Day 4 RN / 4 HCSW - Night 2 RN / **4 HCSW** **Total cost £124,000 per annum** **Ward D7W RGH (23 bedded Winter Pressure ward operational 3 months- January to end of March 2025- Acute COTE).** A calculation was undertaken to agree a Nurse Staffing Template for the temporary winter pressure ward on the Royal Gwent site. Despite not having data to review, professional judgement was used

	by the Divisional Leads in Medicine to determine the nurse staffing levels, based on wards with a similar patient profile. To ensure safety and stability, the ward will be overseen by a seconded band 7 and band 6. where possible the ward will be supported with the redeployment of substantive RNs and HCSWs from the medical and surgical wards who will be backfilled with temporary staff. The Nurse Bank will advertise for 3-month contracts to help ensure continuity of temporary staff. Proposed Roster: Day 3 RN / 3 HCSW - Night 2 RN / 3 HCSW This equates to WTE - B7 x1, Band 6 x1, B5 x 13.48, Band 2 x 13.98 *Please note – the figures for the winter ward are not included in the required establishment and funded establishment table above – as the ward was not open during this reporting period. **Summary of required amendments** The table below outlines the whole-time equivalent (WTE) figures before and after the Autumn calculations. Annual costings for each post have been provided by the Finance Partner for Medicine. These costings have increased compared to the Spring calculations due to this year's pay awards. Additionally, the Finance Business Accountant has revised the costing for the Registered Nurse (RN) on Bargoed Ward, as the original Spring calculation was based on night shift rates rather than day shifts, resulting in an overestimation. **Summary of amendments required to establishments post Autumn 2025 Recalculations include -rollover of 4 wards from Spring calculations plus Autumn proposals.**

*Excluding Supernumerary Ward Manager								
Ward	Pre-Calculation			Post-Calculation			Additional Annual cost	Variable Pay Expenditure Oct-2024-Sept 2025
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Total Cost		**£685,511**	**£975.198**

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To provide assurance, divisional leads convene monthly meetings with business finance partners, senior nurses, and ward managers to review budget performance and address any areas of overspend. Key areas of focus include:

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For enhanced assurance, the E-Roster team distributes monthly **Safecare** reports to ward managers to support compliance with the twice-daily acuity census.

Additionally, Divisional Leads have access to the workforce Divisional Nursing Hub dashboard, which allows them access to monthly reports on:

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- Pay scale Metrix
- Roster approval
- Supply and demand tracker
- Staff in post with age profile

The E-rostering team have conducted roster efficiency analyses on the wards requesting template increases, covering the two months leading up to this report (August and September).

Band	Org.Unit/Metrics	Vacancies	Additional Duties	Total Unavailability	Annual Leave %	Other Leave %	Parenting %	Sickness %	Study Day %	Study Day Hours
HCSW	MED 2/1 Oakdale YYF	Over Established by 1	94	41.32%	12.51%	0.64%	4.51%	12.44%	8.92%	332.5
HCSW	MED 4/4 COTE/Resp NHH	0.90wte vacancies	128	45.29%	6.60%	0.88%	0.00%	24.75%	3.37%	92
HCSW	MED C6E Respiratory RGH	2.5wte vacancies	34	44.41%	14.58%	6.31%	1.34%	10.28%	5.98%	187.5
RN	MED 2/2 Bargoed YYF	2.2wte vacancies	54	24.73%	11.22%	0.00%	0.00%	10.13%	3.16%	65
RN	MED C4 Respiratory GUH	2.6wte vacancies	8	23.94%	11.32%	0.18%	2.21%	8.71%	1.44%	33.75

Overall, roster efficiencies are satisfactory, particularly in managing annual leave and other absences. However, sickness levels among Health Care Support Workers (HCSWs) are notably high, as is the allocation of study leave for Band 4 staff.

The Divisional Lead has confirmed that sickness is being effectively managed on the three wards requesting increased HCSW staffing. Sickness absence management processes and stages are discussed during weekly budget meetings.

The elevated study leave figures are attributed to Band 4 International Nurses currently undergoing induction and working towards NMC registration and band 4 nurses undertaking the flexible route to nurse registration.

Both ward C4 GUH and Bargoed ward YYF, are currently holding RN vacancies. The Divisional Lead has confirmed that these vacancies are being addressed through student streamlining on Ward C4 and the placement of International Nurses on Bargoed Ward. Once these posts are filled, RN vacancies will reduce to 0.22 WTE on Ward C4 and 0.21 WTE on Bargoed Ward.

The Divisional Lead is confident that all necessary steps are being taken to manage absences, improve roster efficiencies and reduce variable pay. Additionally, Senior Nurses are auditing

enhanced care documentation to ensure compliance with policy. A clear escalation process is in place for requesting additional duties related to enhanced care needs.

It is important to note that the six wards requesting an increase to their staffing templates have consistently operated at the proposed levels over the past year through variable pay expenditure. Formal recruitment into these posts will help stabilise the workforce and reduce reliance on variable pay.

Options Appraisal

Option 1: Approve Permanent Changes and Funding for Five Wards
It is recommended that permanent changes and associated funding be approved on the 6 wards to align budgets with the updated roster templates in Healthroster. Recruiting into these posts will enhance workforce stability and ensure consistent shift coverage. The revised templates support equity in service delivery, continuity of care, and patient safety—particularly critical as we approach the winter period.

Option 2: Continue Supporting Proposed Roster Templates Using Variable Pay
Continuing to support the proposed roster templates through variable pay may help maintain bed stability and support Health Board compliance with the mandated 45-minute ward handover and continuous flow model. However, this approach does not provide assurance of a stable workforce. There is no guarantee that shifts—particularly Band 2 HCSW shifts—will be consistently filled, which may compromise timely care and patient safety.

Conclusions and Recommendations

	The Board is asked to: • Acknowledge the Health Board is meeting its statutory requirement to calculate the nurse staffing levels for all wards that fall under Section 25B of the NSLWA. • Note the proposed changes to 6 planned rosters in the division of medicine outlined above and in Appendix 1 (Annual Presentation of Nurse Staffing levels) • Note the financial cost of increasing ward establishments should be weighed against the advantages in terms of safe care delivery. • Note the Executive Committee decision to opt for option 2 – continue with variable pay, with the addition of further more detailed analysis of acuity to be undertaken.

2

Appendix 2: Annual Presentation of the Nurse Staffing Level to the Board report. A summary of Nurse Staffing Levels for wards where Section 25B applies.

Health board/trust:	ABUHB
Period of the report	October 2024-September 2025
Adult Acute Medical wards	

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report (INSERT HYPERLINK) on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Adult Acute Medical inpatient wards

Site	Name of Ward	Reported to the Board in November 2024: SHIFT	Planned roster as stated within the annual presentation to the Board report (in November 2024): RN (band 5 &6)	Planned roster (November 2024): HCSW (bands 2,3 &4)	Required Establishment as stated within the annual presentation to the Board report (in November 2024) including uplift 26.9%: TOTAL WTE RN (bands 5 &6)	Required Establishment (November 2024): TOTAL WTE HCSW (bands 2,3 &4)	TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Calculated during spring 2025cycle: SHIFT	Planned roster calculated by the designated person during the spring 2025 cycle: RN (band 5 &6)	Planned roster (spring 2025): HCSW (bands 2,3 &4)	Required Establishment as calculated by the designated persons during the spring 2025 cycle including uplift 26.9%: TOTAL WTE RN (bands 5 &6)	Required Establishment (spring 2025): TOTAL WTE HCSW (bands 2,3 &4)	TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	Calculated during autumn 2025 cycle: SHIFT	Planned roster calculated by the designated person during the autumn 2025 cycle: RN (band 5 &6)	Planned roster (autumn 2025): HCSW (bands 2,3 &4)	Required Establishment as calculated by the designated persons during the autumn 2025 cycle including uplift: TOTAL WTE RN (bands 5 &6)	Required Establishment (autumn 2025): TOTAL WTE HCSW (bands 2,3 &4)	TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	Biannual calculation cycle reviews, and any changes made & rationale during the spring 2025 & autumn 2025 calculation cycles: Completed (Yes/No)	Changed	Rationale	Any reviews outside of biannual calculation, if yes, provide rationale for any changes made: Completed (Yes/No)	Date	Changed	Rationale
	MEDICINE																											
		E						E							E													
		L						L							L													
GUH	A2	LD	4	3	20.16	16.78	1	LD	4	3	20.16	16.78	1	07/05/2025	LD	4	3	20.16	16.78	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	3	3				N	3	3					N	3	3											
		E						E							E													
		L						L							L													
GUH	A4	LD	5	4	25.85	22.38	1	LD	5	4	25.85	22.38	1	07/05/2025	LD	5	4	25.85	22.38	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	4	4				N	4	4					N	4	4											
		E						E							E													
		L						L							L													
GUH	B4 changed following respiratory reconfiguration Nov 24	LD	3	3	17.32	16.78	1	LD	3	3	17.32	16.78	1	07/05/2025	LD	3	3	17.32	8	1	27/10/2025	Yes	No	roster template appropriate for this ward (rerconfigured Nov 24	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	3	3				N	3	3					N	3	3											
		E	9					E	9						E	9												
		L	8					L	8						L	9												
GUH	C4 incresed following respiratory reconfiguaration Nov 24	LD		7	47.17	39.65	1	LD		7	47.17	39.65	1	07/05/2025	LD		7	48.59	39.65	1	27/10/2025	Yes	No	Increase of RN Late 7 days a weel	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	8	7				N	8	7					N	8	7											
																	5											
		E						E							E													
		L						L							L													
RGH	C4E	LD	3	5	14.48	25.26	1	LD	3	5	14.48	25.2	1	07/05/2025	LD	3	5	14.48	25.2	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
RGH	C6E	LD	3	5	14.48	22.42	1	LD	3	5	14.48	25.2	1	07/05/2025	LD	3	5	14.48	25.2	1	27/10/2025	Yes	No	increase HCSW by night- following Spring calculation- supported with Variable pay-no permanent funding available	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	3				N	2	3					N	2	3											
		E						E							E													
		L						L							L													
RGH	C6W	LD	3	5	17.32	22.42	1	LD	4	4	17.32	22.42	1	07/05/2025	LD	4	4	17.32	22.42	1	27/10/2025	Yes	No	Spring Calculation - cost neutral change. RN from N to Day, HCSW from Day to Night.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	3	3				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
RGH	D4E	LD	3	5	14.48	25.26	1	LD	3	5	14.48	25.26	1	07/05/2025	LD	3	5	14.48	25.26	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
RGH	D4W	LD	3	5	14.48	25.26	1	LD	3	5	14.48	25.26	1	07/05/2025	LD	3	5	14.48	25.26	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
RGH	D5W	LD	3	5	14.48	25.26	1	LD	3	5	14.48	25.26	1	07/05/2025	LD	3	5	14.48	25.26	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
NHH	3.1	LD	3	5	14.48	25.2	1	LD	3	5	14.48	25.2	1	07/05/2025	LD	3	5	14.48	25.2	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
NHH	3.2	LD	3	5	14.48	25.2	1	LD	3	5	14.48	25.2	1	007/05/2025	LD	3	5	14.48	25.2	1	27/10/205	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	3				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
NHH	3.3	LD	3	6	14.48	27.95	1	LD	3	6	14.48	27.95	1	07/05/2025	LD	3	6	14.48	27.95	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
																Corrected												
		E						E							E													
		L						L							L													
NHH	3.4	LD	3	5	14.48	25.2	1	LD	3	5	14.48	25.2	1	07/05/2025	LD	3	5	14.48	25.2	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
NHH	4.4 change following respiratory reconfiguaration Nov 24	LD	4	3	17.32	19.58	1	LD	4	4	17.32	22.36	1	07/05/2025	LD	4	4	17.32	22.36	1	27/10/2025	Yes	No	Increase HCSW by day following Spring calculation- supported with Variable pay-no permanent funding availablee.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
YYF	EFU	LD	4	4	17.32	22.36	1	LD	4	4	17.32	22.36	39.72	07/05/2025	LD	4	4	17.32	22.36	1	27/10/2025	Yes	No	No Change at this time	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
YYF	OAKDALE	LD	4	4	17.32	22.4	1	LD	4	5	17.32	25.19	1	07/05/2025	LD	4	5	17.32	25.19	1	27/10/2025	Yes	No	Increase HCSW by day following Spring calculation- supported with Variable pay-no permanent funding availablee.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
YYF	BARGOED	LD	3	6	14.48	27.95	1	LD	4	6	17.32	27.95	1	07/05/2025	LD	4	6	17.32	27.99	1	27/10/2025	Yes	No	Increase RN by day following Spring calculation- supported with Variable pay-no permanent funding availablee.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
YYF	RISCA	LD	4	4	17.32	22.38	1	LD	4		17.32	22.38	1	07/05/2025	LD	4	4	17.32	22.38	1	27/10/2025	Yes	No		No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
YYF	PENALLTA	LD						LD							LD	4	4	17.32	22.38	1	27/10/2025	Yes	N/A	Now classified as 25B - increase HCSW from 3 to 4 by night.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N						N							N	2	4											
		E						E							E													
		L						L							L													
RGH	D7W (Winter Ward)	LD						LD							LD	3	3	14.48	13.98	1	27/10/2025	Yes	N/A	calculation undertaken to agree staffing template for 3 month winter pressure ward.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N						N							N	2	3											
Total					359.22	459.69	19				362.06	467.98	57.72					380.8	481.62	21								

Appendix: Annual Presentation of the Nurse Staffing Level to the Board report

Health board/trust:	ABUHB
Period of the report	October 2024 - September 2025
Adult Acute Surgical Inpatient Wards	

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report (https://bcuhb.nhs.wales/about-us/health-board-meetings-and-members/health-board-meetings/25-5-23-agenda-bundle-public-vf2-compressed-n-v3-0/) on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Adult Acute Surgical Inpatient Wards

Site	Name of Ward	Reported to the Board in November 2023					Calculated during spring 2024 cycle						Calculated during autumn 2024cycle						Biannual calculation cycle reviews, and any changes made & rationale during the spring 2025 & autumn 2025 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
		SHIFT	Planned roster as stated within the annual presentation to the Board report (in November 2024)		Required Establishment as stated within the annual presentation to the Board report (in November 2024) including		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	SHIFT	Planned roster calculated by the designated person during the spring 2025 cycle		Required Establishment as calculated by the designated persons during the spring 2025 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	SHIFT	Planned roster calculated by the designated person during the autumn 2025 cycle		Required Establishment as calculated by the designated persons during the autumn 2025 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)				RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)									
GUH	A0 Surgical	E						E							E							Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
		L						L							L													
		LD	5	6	25.85	30.75	1	LD	5	6	25.85	30.79	1	07/05/2025	LD	5	6	25.85	30.79	1	09/10/2025							
		TW						TW							TW													
		N	4	5				N	4	5					N	4	5											
GUH	B0 Surgical	E						E							E							Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
		L						L							L													
		LD	5	5	25.85	27.99	1	LD	5	5	25.85	27.99	1	07/05/2025	LD	5	5	25.85	27.99	1	09/10/2025							
		TW						TW							TW													
		N	4	5				N	4	5					N	4	5											
GUH	C0 Surgical	E						E							E							Yes	No	Spring Calculations - Changed to original template following loss of Machen beds	No			
		L						L							L													
		LD	5 S & M 6 Tue-Sat	5 Sat pm &M 6 tue-Frid	29.3	28.55	1	LD	5	5	25.85	25.2	1	07/05/2025	LD	5	5	25.85	25.2	1	09/10/2025							
		TW						TW							TW													
		N	4 Sat-Mon 5 Tues-Thu	4 Sat-Mon 5 Tues-Thu				N	4	4					N	4	4											
GUH	A3 Gynae	E						E							E							Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
		L						L							L													
		LD	4	3	20.16	13.98	1	LD	4	3	20.16	13.98	1	07/05/2025	LD	4	3	20.16	13.98	1	09/10/2025							
		TW						TW							TW													
		N	3	2				N	3	2					N	3	2											
RGH	C7E Surgical	E						E							E							Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
		L						L							L													
		LD	3	5	14.48	25.2	1	LD	3	5	14.48	25.2	1	07/05/2025	LD	3	5	14.48	25.2	1	09/10/2025							
		TW						TW							TW													
		N	2	4				N	2	4					N	2	4											
															2													
RGH	C7W Surgical	E						E							E							Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
		L						L							L													
		LD	3	4	14.48	19.61	1	LD	3	4	14.48	19.61	1	07/05/2025	LD	3	4	14.48	19.61	1	09/10/2025							
		TW						TW							TW													
		N	2	3				N	2	3					N	2	3											
RGH	D2E Surgical	E						E							E							Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
		L						L							L													
		LD	3	2	14.48	8.38	1	LD	3	2	14.48	8.38	1	07/05/2025	LD	3	2	14.48	8.38	1	09/10/2025							
		TW						TW							TW													
		N	2	1				N	2	1					N	2	1											
RGH	D2W Surgical	E	1 M-S					E	1 M-S						E	1 M-S						Yes	Yes	No Changes required-following professional discussions-roster deemed appropriate.	No			
		L						L							L													
		LD	2 M-F 1 S&S	1	11.23	3.59	1	LD	2 M-F 1 S&S	1	11.23	3.59	1	07/05/2025	LD	2 M-F 1 S&S		11.23	3.59	1	09/10/2025							
		TW						TW							TW													
		N	2 M-F 1 S&S	0 M-F 1 S&S				N	2 M-F 1 S&S	0 M-F 1 S&S					N	2 M-F 1 S&S	0 M-F 1 S&S											
RGH	D3E Surgical	E						E							E							Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
		L						L							L													
		LD	3	5	17.32	19.62	1	LD	3	5	17.32	19.62	1	07/05/2025	LD	3	5	17.32	19.62	1	09/10/2025							
		TW						TW							TW													
		N	3	2				N	3	2					N	3	2											
RGH	D3W	E						E							E							Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
		L						L							L													
		LD	3	5	14.48	22.46	1	LD	3	5	14.48	22.46	1	07/05/2025	LD	3	5	14.48	22.46	1	09/10/2025							
		TW						TW							TW													
		N	2	3				N	2	3					N	2	3											
RGH	D7E Surgical (reported incorrectly Nov 24)	E						E							E							Yes	No	No Changes required-following professional discussions-roster deemed appropriate	No			
		L						L							L													
		LD	3	4	14.48	16.77	1	LD	3	4	14.48	16.77	1	07/05/2025	LD	3	4	14.48	16.77	1	09/10/2025							
		TW						TW							TW													
		N	2	2				N	2	2					N	2	2											
SWH	OSU Surgical	E	1					E	1						E	1						Yes	No	No Changes required-following professional discussions-roster deemed appropriate	No			
		L						L							L													
		LD	3	2	16.91	8.39	1	LD	3	2	16.91	8.39	1	07/05/2025	LD	3	2	16.91	8.39	1	09/10/2025							
		TW	1 M-F					TW	1 M-F						TW	1 M-F												
		N	2	1				N	2	1					N	2	1											
NHH	Ward 4/2 Surgical	E						E							E							Yes	No	No Changes required-following professional discussions-roster deemed appropriate	No			
		L						L							L													
		LD	3	5	14.48	25.2	1	LD	3	5	14.48	25.2	1	07/05/2025	LD	3	5	14.48	25.2	1	09/10/2025							
		TW						TW							TW													
		N	2	4				N	2	4					N	2	4											
Total					233.5	250.49	13				230.05	247.18	13					230.05	247.18	13									

Appendix: Annual Presentation of the Nurse Staffing Level to the

Health board/trust:	ABUHB
Period of the report	October 2024 - Sep
Paediatric Inpatient Wards	

Paediatric Inpatient Wards

			Reporte
Site	**Name of Ward**	**SHIFT**	**Planned as state the ar present the B repo Nove 202**
			RN (band 5 &6)
GUH	**Paediatric 50 bedded unit C1 & C2**	E	
		L	
		LD	**12**
		TW	
		N	**12**
Total			

Board report

tember 2025

The number of staff per shift needs t

In accordance with the requireme
to whom nursing duties have beer
the delivery and coordination of p
(https://bcuhb.nhs.wales/about-us
contribute to the coordination and

d to the Board in November 2023				Calcula		
d roster d within nnual ation to oard rt (in mber 24)	Required Establishment as stated within the annual presentation to the Board report (in November 2024) including		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	SHIFT	Planned roster calculated by the designated person during the spring 2025 cycle	
HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)			RN (band 5 &6)	HCSW (bands 2,3 &4)
	70.22	17.06	1	E		
				L		
3				LD	12	3
				TW		
3				N	12	3
	70.22	17.06				

o be entered. The information should reflect the information on the informing patient template

nts of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidar
n delegated by a registered nurse - required to deliver the planned roster. It is acknow
atient care and treatment. However, these staff are not included within the data for thi
s/health-board-meetings-and-members/health-board-meetings/25-5-23-agenda-bundle
delivery of patient care.

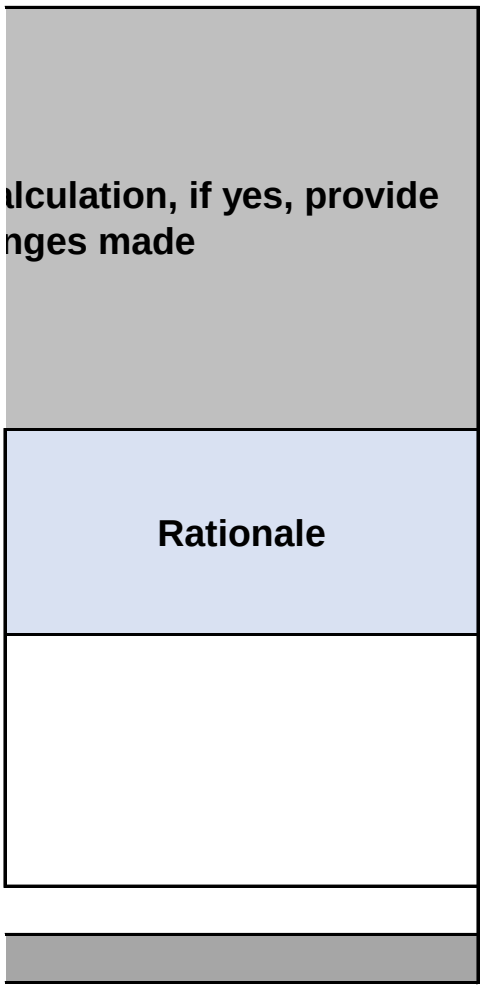
ated during spring 2024 cycle					
Required Establishment as calculated by the designated persons during the spring 2025 cycle including uplift 26.9%		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**SHIFT**	**Planned calcula the des person the au 2025**
TOTAL WTE RN (bands 5 &6)	**TOTAL WTE HCSW (bands 2,3 &4)**				**RN (band 5 &6)**
70.22	**17.06**	**1**	**17/04/2023**	E	
				L	
				LD	**12**
				TW	
				N	**12**
70.22	**17.06**				

e.

nce, the ‘nurse staffing level’ is the establishment of registered nurses - and other staff
vledged that there is a range of additional healthcare professionals that contribute to
is report. Further information is provided within the annual assurance report
e-public-vf2-compressed-n-v3-0/) on the additional multi-professional staff that

Calculated during autumn 2024 cycle					
d roster ated by ignated during utumn cycle	Required Establishment as calculated by the designated persons during the autumn 2025 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	Biannual cal changes spring 202
HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)			Completed (Yes/No)
	70.22	17.06	1	17/10/2023	Yes
3					
3					
	70.22	17.06	1		

culation cycle reviews, and any made & rationale during the 25 & autumn 2025 calculation cycles		Any reviews outside of biannual ca rationale for any cha		
Changed	**Rationale**	**Completed (Yes/No)**	**Date**	**Changed**
No	**No Changes required-following professional discussions-roster deemed appropriate**	**N/A**		


lculation, if yes, provide
nges made
Rationale

Appendix 2: Annual Presentation of the Nurse Staffing Level to the Board report. A summary of Nurse Staffing Levels for wards where Section 25B applies.

Health board/trust:	ABUHB
Period of the report	October 2024-September 2025
Adult Acute Medical wards	

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the "nurse staffing level" is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report (INSERT HYPERLINK) on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Adult Acute Medical inpatient wards

		Reported to the Board in November 2024						Calculated during spring 2025cycle						Calculated during autumn 2025 cycle						Biannual calculation cycle reviews, and any changes made & rationale during the spring 2025 & autumn 2025 calculation cycles				Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
Site	**Name of Ward**	**SHIFT**	**Planned roster as stated within the annual presentation to the Board report (in November 2024)**		**Required Establishment as stated within the annual presentation to the Board report (in November 2024) including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**SHIFT**	**Planned roster calculated by the designated person during the spring 2025 cycle**		**Required Establishment as calculated by the designated persons during the spring 2025 cycle including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**SHIFT**	**Planned roster calculated by the designated person during the autumn 2025 cycle**		**Required Establishment as calculated by the designated persons during the autumn 2025 cycle including uplift**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**Completed (Yes/No)**	**Changed**	**Rationale**	**Completed (Yes/No)**	**Date**	**Changed**	**Rationale**
			RN (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)			**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)				**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)									
	MEDICINE																											
GUH	**A2**	E						E							E													
		L						L							L													
		LD	4	3	20.16	16.78	1	LD	4	3	20.16	16.78	1	07/05/2025	LD	4	3	20.16	16.78	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	3	3				N	3	3					N	3	3											
GUH	**A4**	E						E							E													
		L						L							L													
		LD	5	4	25.85	22.38	1	LD	5	4	25.85	22.38	1	07/05/2025	LD	5	4	25.85	22.38	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	4	4				N	4	4					N	4	4											
GUH	**B4 changed following respiratory reconfiguration Nov 24**	E						E							E													
		L						L							L													
		LD	3	3	17.32	16.78	1	LD	3	3	17.32	16.78	1	07/05/2025	LD	3	3	17.32	8	1	27/10/2025	Yes	No	roster template appropriate for this ward (rerconfigured Nov 24	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	3	3				N	3	3					N	3	3											
GUH	**C4 incresed following respiratory reconfiguaration Nov 24**	E	9					E	9						E	9												
		L	8					L	8						L	9												
		LD		7	47.17	39.65	1	LD		7	47.17	39.65	1	07/05/2025	LD		7	48.59	39.65	1	27/10/2025	Yes	No	Increase of RN Late 7 days a weel	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	8	7				N	8	7					N	8	7											
																5												
RGH	**C4E**	E						E							E													
		L						L							L													
		LD	3	5	14.48	25.26	1	LD	3	5	14.48	25.2	1	07/05/2025	LD	3	5	14.48	25.2	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
RGH	**C6E**	E						E							E													
		L						L							L													
		LD	3	5	14.48	22.42	1	LD	3	5	14.48	25.2	1	07/05/2025	LD	3	5	14.48	25.2	1	27/10/2025	Yes	No	increase HCSW by night- following Spring calculation- supported with Variable pay-no permanent funding available	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	3				N	2	3					N	2	3											
RGH	**C6W**	E						E							E													
		L						L							L													
		LD	3	5	17.32	22.42	1	LD	4	4	17.32	22.42	1	07/05/2025	LD	4	4	17.32	22.42	1	27/10/2025	Yes	No	Spring Calculation - cost neutral change. RN from N to Day, HCSW from Day to Night.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	3	3				N	2	4					N	2	4											
RGH	**D4E**	E						E							E													
		L						L							L													
		LD	3	5	14.48	25.26	1	LD	3	5	14.48	25.26	1	07/05/2025	LD	3	5	14.48	25.26	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
RGH	**D4W**	E						E							E													
		L						L							L													
		LD	3	5	14.48	25.26	1	LD	3	5	14.48	25.26	1	07/05/2025	LD	3	5	14.48	25.26	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
RGH	**D5W**	E						E							E													
		L						L							L													
		LD	3	5	14.48	25.26	1	LD	3	5	14.48	25.26	1	07/05/2025	LD	3	5	14.48	25.26	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
NHH	**3.1**	E						E							E													
		L						L							L													
		LD	3	5	14.48	25.2	1	LD	3	5	14.48	25.2	1	07/05/2025	LD	3	5	14.48	25.2	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
NHH	**3.2**	E						E							E													
		L						L							L													
		LD	3	5	14.48	25.2	1	LD	3	5	14.48	25.2	1	007/05/2025	LD	3	5	14.48	25.2	1	27/10/205	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	3				N	2	4					N	2	4											
NHH	**3.3**	E						E							E													
		L						L							L													
		LD	3	6	14.48	27.95	1	LD	3	6	14.48	27.95	1	07/05/2025	LD	3	6	14.48	27.95	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A

		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
																Corrected												
		E						E							E													
		L						L							L													
NHH	3.4	LD	3	5	14.48	25.2	1	LD	3	5	14.48	25.2	1	07/05/2025	LD	3	5	14.48	25.2	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
NHH	4.4 change following respiratory reconfiguaration Nov 24	LD	4	3	17.32	19.58	1	LD	4	4	17.32	22.36	1	07/05/2025	LD	4	4	17.32	22.36	1	27/10/2025	Yes	No	Increase HCSW by day following Spring calculation- supported with Variable pay-no permanent funding availablee.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
YYF	EFU	LD	4	4	17.32	22.36	1	LD	4	4	17.32	22.36	39.72	07/05/2025	LD	4	4	17.32	22.36	1	27/10/2025	Yes	No	No Change at this time	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
YYF	OAKDALE	LD	4	4	17.32	22.4	1	LD	4	5	17.32	25.19	1	07/05/2025	LD	4	5	17.32	25.19	1	27/10/2025	Yes	No	Increase HCSW by day following Spring calculation- supported with Variable pay-no permanent funding availablee.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
YYF	BARGOED	LD	3	6	14.48	27.95	1	LD	4	6	17.32	27.95	1	07/05/2025	LD	4	6	17.32	27.99	1	27/10/2025	Yes	No	Increase RN by day following Spring calculation- supported with Variable pay-no permanent funding availablee.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
YYF	RISCA	LD	4	4	17.32	22.38	1	LD	4		17.32	22.38	1	07/05/2025	LD	4	4	17.32	22.38	1	27/10/2025	Yes	No		No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
YYF	PENALLTA	LD						LD							LD	4	4	17.32	22.38	1	27/10/2025	Yes	N/A	Now classified as 25B - increase HCSW from 3 to 4 by night.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N						N							N	2	4											
		E						E							E													
		L						L							L													
RGH	D7W (Winter Ward)	LD						LD							LD	3	3	14.48	13.98	1	27/10/2025	Yes	N/A	calculation undertaken to agree staffing template for 3 month winter pressure ward.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N						N							N	2	3											
Total					359.22	459.69	19				362.06	467.98	57.72					380.8	481.62	21								

Appendix: Annual Presentation of the Nurse Staffing Level to the Board report

Health board/trust:	ABUHB
Period of the report	October 2024 - September 2025
Adult Acute Surgical Inpatient Wards	

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report (https://bcuhb.nhs.wales/about-us/health-board-meetings-and-members/health-board-meetings/25-5-23-agenda-bundle-public-vf2-compressed-n-v3-0/) on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Adult Acute Surgical Inpatient Wards

Site	Name of Ward	Reported to the Board in November 2023					Calculated during spring 2024 cycle						Calculated during autumn 2024cycle						Biannual calculation cycle reviews, and any changes made & rationale during the spring 2025 & autumn 2025 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
		SHIFT	Planned roster as stated within the annual presentation to the Board report (in November 2024)		Required Establishment as stated within the annual presentation to the Board report (in November 2024) including		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	SHIFT	Planned roster calculated by the designated person during the spring 2025 cycle		Required Establishment as calculated by the designated persons during the spring 2025 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	SHIFT	Planned roster calculated by the designated person during the autumn 2025 cycle		Required Establishment as calculated by the designated persons during the autumn 2025 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)				RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)									
GUH	A0 Surgical	E L LD TW N	 5 4	 6 5	25.85	30.75	1	E L LD TW N	 5 4	 6 5	25.85	30.79	1	07/05/2025	E L LD TW N	 5 4	 6 5	25.85	30.79	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
GUH	B0 Surgical	E L LD TW N	 5 4	 5 5	25.85	27.99	1	E L LD TW N	 5 4	 5 5	25.85	27.99	1	07/05/2025	E L LD TW N	 5 4	 5 5	25.85	27.99	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
GUH	C0 Surgical	E L LD TW N	 5 S & M 6 Tue-Sat 4 Sat-Mon 5 Tues-Thu	 5 Sat pm &M 6 tue-Frid 4 Sat-Mon 5 Tues-Thu	29.3	28.55	1	E L LD TW N	 5 4	 5 4	25.85	25.2	1	07/05/2025	E L LD TW N	 5 4	 5 4	25.85	25.2	1	09/10/2025	Yes	No	Spring Calculations - Changed to original template following loss of Machen beds	No			
GUH	A3 Gynae	E L LD TW N	 4 3	 3 2	20.16	13.98	1	E L LD TW N	 4 3	 3 2	20.16	13.98	1	07/05/2025	E L LD TW N	 4 3	 3 2	20.16	13.98	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
RGH	C7E Surgical	E L LD TW N	 3 2	 5 4	14.48	25.2	1	E L LD TW N	 3 2	 5 4	14.48	25.2	1	07/05/2025	E L LD TW N	 3 2	 5 4	14.48	25.2	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
RGH	C7W Surgical	E L LD TW N	 3 2	 4 3	14.48	19.61	1	E L LD TW N	 3 2	 4 3	14.48	19.61	1	07/05/2025	E L LD TW N	 3 2	 4 3	14.48	19.61	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
RGH	D2E Surgical	E L LD TW N	 3 2	 2 1	14.48	8.38	1	E L LD TW N	 3 2	 2 1	14.48	8.38	1	07/05/2025	E L LD TW N	 3 2	 2 1	14.48	8.38	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
RGH	D2W Surgical	E L LD TW N	1 M-S 2 M-F 1 S&S 2 M-F 1 S&S	 1 0 M-F 1 S&S	11.23	3.59	1	E L LD TW N	1 M-S 2 M-F 1 S&S 2 M-F 1 S&S	 1 0 M-F 1 S&S	11.23	3.59	1	07/05/2025	E L LD TW N	1 M-S 2 M-F 1 S&S 2 M-F 1 S&S	 0 M-F 1 S&S	11.23	3.59	1	09/10/2025	Yes	Yes	No Changes required-following professional discussions-roster deemed appropriate.	No			
RGH	D3E Surgical	E L LD TW N	 3 3	 5 2	17.32	19.62	1	E L LD TW N	 3 3	 5 2	17.32	19.62	1	07/05/2025	E L LD TW N	 3 3	 5 2	17.32	19.62	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
RGH	D3W	E L LD TW N	 3 2	 5 3	14.48	22.46	1	E L LD TW N	 3 2	 5 3	14.48	22.46	1	07/05/2025	E L LD TW N	 3 2	 5 3	14.48	22.46	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
RGH	D7E Surgical (reported incorrectly Nov 24)	E L LD TW N	 3 2	 4 2	14.48	16.77	1	E L LD TW N	 3 2	 4 2	14.48	16.77	1	07/05/2025	E L LD TW N	 3 2	 4 2	14.48	16.77	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate	No			
SWH	OSU Surgical	E L LD TW N	1 3 1 M-F 2	 2 1	16.91	8.39	1	E L LD TW N	1 3 1 M-F 2	 2 1	16.91	8.39	1	07/05/2025	E L LD TW N	1 3 1 M-F 2	 2 1	16.91	8.39	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate	No			
NHH	Ward 4/2 Surgical	E L LD TW N	 3 2	 5 4	14.48	25.2	1	E L LD TW N	 3 2	 5 4	14.48	25.2	1	07/05/2025	E L LD TW N	 3 2	 5 4	14.48	25.2	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate	No			
Total					233.5	250.49	13				230.05	247.18	13					230.05	247.18	13								

Appendix: Annual Presentation of the Nurse Staffing Level to the Board report

Health board/trust:	ABUHB
Period of the report	October 2024 - September 2025
Paediatric Inpatient Wards	

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report (https://bcuhb.nhs.wales/about-us/health-board-meetings-and-members/health-board-meetings/25-5-23-agenda-bundle-public-vf2-compressed-n-v3-0/) on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Paediatric Inpatient Wards

		Reported to the Board in November 2023						Calculated during spring 2024 cycle							Calculated during autumn 2024 cycle							Biannual calculation cycle reviews, and any changes made & rationale during the spring 2025 & autumn 2025 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
Site	**Name of Ward**	**SHIFT**	**Planned roster as stated within the annual presentation to the Board report (in November 2024)**		**Required Establishment as stated within the annual presentation to the Board report (in November 2024) including**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**SHIFT**	**Planned roster calculated by the designated person during the spring 2025 cycle**		**Required Establishment as calculated by the designated persons during the spring 2025 cycle including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**SHIFT**	**Planned roster calculated by the designated person during the autumn 2025 cycle**		**Required Establishment as calculated by the designated persons during the autumn 2025 cycle including uplift**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**Completed (Yes/No)**	**Changed**	**Rationale**	**Completed (Yes/No)**	**Date**	**Changed**	**Rationale**
			RN (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)			**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)				**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)									
GUH	**Paediatric 50 bedded unit C1 & C2**	E						E							E							**Yes**	**No**	**No Changes required-following professional discussions-roster deemed appropriate**	**N/A**			
		L						L							L													
		LD	**12**	**3**	**70.22**	**17.06**	**1**	LD	**12**	**3**	**70.22**	**17.06**	**1**	**17/04/2023**	LD	**12**	**3**	**70.22**	**17.06**	**1**	**17/10/2023**							
		TW						TW							TW													
		N	**12**	**3**				N	**12**	**3**					N	**12**	**3**											
Total					**70.22**	**17.06**					**70.22**	**17.06**						**70.22**	**17.06**	**1**								

Appendix 2: Annual Presentation of the Nurse Staffing Level to the Board report. A summary of Nurse Staffing Levels for wards where Section 25B applies.

Health board/trust:	ABUHB
Period of the report	October 2024-September 2025
Adult Acute Medical wards	

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the "nurse staffing level" is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report (INSERT HYPERLINK) on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Adult Acute Medical inpatient wards

		Reported to the Board in November 2024						Calculated during spring 2025cycle						Calculated during autumn 2025 cycle						Biannual calculation cycle reviews, and any changes made & rationale during the spring 2025 & autumn 2025 calculation cycles				Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
Site	**Name of Ward**	**SHIFT**	**Planned roster as stated within the annual presentation to the Board report (in November 2024)**		**Required Establishment as stated within the annual presentation to the Board report (in November 2024) including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**SHIFT**	**Planned roster calculated by the designated person during the spring 2025 cycle**		**Required Establishment as calculated by the designated persons during the spring 2025 cycle including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**SHIFT**	**Planned roster calculated by the designated person during the autumn 2025 cycle**		**Required Establishment as calculated by the designated persons during the autumn 2025 cycle including uplift**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**Completed (Yes/No)**	**Changed**	**Rationale**	**Completed (Yes/No)**	**Date**	**Changed**	**Rationale**
			RN (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)			**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)				**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)									
	MEDICINE																											
GUH	**A2**	E						E							E													
		L						L							L													
		LD	4	3	20.16	16.78	1	LD	4	3	20.16	16.78	1	07/05/2025	LD	4	3	20.16	16.78	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	3	3				N	3	3					N	3	3											
GUH	**A4**	E						E							E													
		L						L							L													
		LD	5	4	25.85	22.38	1	LD	5	4	25.85	22.38	1	07/05/2025	LD	5	4	25.85	22.38	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	4	4				N	4	4					N	4	4											
GUH	**B4 changed following respiratory reconfiguration Nov 24**	E						E							E													
		L						L							L													
		LD	3	3	17.32	16.78	1	LD	3	3	17.32	16.78	1	07/05/2025	LD	3	3	17.32	8	1	27/10/2025	Yes	No	roster template appropriate for this ward (rerconfigured Nov 24	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	3	3				N	3	3					N	3	3											
GUH	**C4 incresed following respiratory reconfiguaration Nov 24**	E	9					E	9						E	9												
		L	8					L	8						L	9												
		LD		7	47.17	39.65	1	LD		7	47.17	39.65	1	07/05/2025	LD		7	48.59	39.65	1	27/10/2025	Yes	No	Increase of RN Late 7 days a weel	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	8	7				N	8	7					N	8	7											
																5												
RGH	**C4E**	E						E							E													
		L						L							L													
		LD	3	5	14.48	25.26	1	LD	3	5	14.48	25.2	1	07/05/2025	LD	3	5	14.48	25.2	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
RGH	**C6E**	E						E							E													
		L						L							L													
		LD	3	5	14.48	22.42	1	LD	3	5	14.48	25.2	1	07/05/2025	LD	3	5	14.48	25.2	1	27/10/2025	Yes	No	increase HCSW by night- following Spring calculation- supported with Variable pay-no permanent funding available	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	3				N	2	3					N	2	3											
RGH	**C6W**	E						E							E													
		L						L							L													
		LD	3	5	17.32	22.42	1	LD	4	4	17.32	22.42	1	07/05/2025	LD	4	4	17.32	22.42	1	27/10/2025	Yes	No	Spring Calculation - cost neutral change. RN from N to Day, HCSW from Day to Night.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	3	3				N	2	4					N	2	4											
RGH	**D4E**	E						E							E													
		L						L							L													
		LD	3	5	14.48	25.26	1	LD	3	5	14.48	25.26	1	07/05/2025	LD	3	5	14.48	25.26	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
RGH	**D4W**	E						E							E													
		L						L							L													
		LD	3	5	14.48	25.26	1	LD	3	5	14.48	25.26	1	07/05/2025	LD	3	5	14.48	25.26	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
RGH	**D5W**	E						E							E													
		L						L							L													
		LD	3	5	14.48	25.26	1	LD	3	5	14.48	25.26	1	07/05/2025	LD	3	5	14.48	25.26	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
NHH	**3.1**	E						E							E													
		L						L							L													
		LD	3	5	14.48	25.2	1	LD	3	5	14.48	25.2	1	07/05/2025	LD	3	5	14.48	25.2	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
NHH	**3.2**	E						E							E													
		L						L							L													
		LD	3	5	14.48	25.2	1	LD	3	5	14.48	25.2	1	007/05/2025	LD	3	5	14.48	25.2	1	27/10/205	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	3				N	2	4					N	2	4											
NHH	**3.3**	E						E							E													
		L						L							L													
		LD	3	6	14.48	27.95	1	LD	3	6	14.48	27.95	1	07/05/2025	LD	3	6	14.48	27.95	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A

		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
																	Corrected											
		E						E							E													
		L						L							L													
NHH	3.4	LD	3	5	14.48	25.2	1	LD	3	5	14.48	25.2	1	07/05/2025	LD	3	5	14.48	25.2	1	27/10/2025	Yes	No	roster template appropriate for this ward	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
NHH	4.4 change following respiratory reconfiguaration Nov 24	LD	4	3	17.32	19.58	1	LD	4	4	17.32	22.36	1	07/05/2025	LD	4	4	17.32	22.36	1	27/10/2025	Yes	No	Increase HCSW by day following Spring calculation- supported with Variable pay-no permanent funding availablee.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
YYF	EFU	LD	4	4	17.32	22.36	1	LD	4	4	17.32	22.36	39.72	07/05/2025	LD	4	4	17.32	22.36	1	27/10/2025	Yes	No	No Change at this time	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
YYF	OAKDALE	LD	4	4	17.32	22.4	1	LD	4	5	17.32	25.19	1	07/05/2025	LD	4	5	17.32	25.19	1	27/10/2025	Yes	No	Increase HCSW by day following Spring calculation- supported with Variable pay-no permanent funding availablee.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
YYF	BARGOED	LD	3	6	14.48	27.95	1	LD	4	6	17.32	27.95	1	07/05/2025	LD	4	6	17.32	27.99	1	27/10/2025	Yes	No	Increase RN by day following Spring calculation- supported with Variable pay-no permanent funding availablee.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
YYF	RISCA	LD	4	4	17.32	22.38	1	LD	4		17.32	22.38	1	07/05/2025	LD	4	4	17.32	22.38	1	27/10/2025	Yes	No		No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N	2	4				N	2	4					N	2	4											
		E						E							E													
		L						L							L													
YYF	PENALLTA	LD						LD							LD	4	4	17.32	22.38	1	27/10/2025	Yes	N/A	Now classified as 25B - increase HCSW from 3 to 4 by night.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N						N							N	2	4											
		E						E							E													
		L						L							L													
RGH	D7W (Winter Ward)	LD						LD							LD	3	3	14.48	13.98	1	27/10/2025	Yes	N/A	calculation undertaken to agree staffing template for 3 month winter pressure ward.	No	N/A	N/A	N/A
		TWL						TWL							TWL													
		N						N							N	2	3											
Total					359.22	459.69	19				362.06	467.98	57.72					380.8	481.62	21								

Appendix: Annual Presentation of the Nurse Staffing Level to the Board report

Health board/trust:	ABUHB
Period of the report	October 2024 - September 2025
Adult Acute Surgical Inpatient Wards	

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report (https://bcuhb.nhs.wales/about-us/health-board-meetings-and-members/health-board-meetings/25-5-23-agenda-bundle-public-vf2-compressed-n-v3-0/) on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Adult Acute Surgical Inpatient Wards

Site	Name of Ward	Reported to the Board in November 2023					Calculated during spring 2024 cycle						Calculated during autumn 2024cycle						Biannual calculation cycle reviews, and any changes made & rationale during the spring 2025 & autumn 2025 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
		SHIFT	Planned roster as stated within the annual presentation to the Board report (in November 2024)		Required Establishment as stated within the annual presentation to the Board report (in November 2024) including		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	SHIFT	Planned roster calculated by the designated person during the spring 2025 cycle		Required Establishment as calculated by the designated persons during the spring 2025 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	SHIFT	Planned roster calculated by the designated person during the autumn 2025 cycle		Required Establishment as calculated by the designated persons during the autumn 2025 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)				RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)									
GUH	A0 Surgical	E L LD TW N	 5 4	 6 5	25.85	30.75	1	E L LD TW N	 5 4	 6 5	25.85	30.79	1	07/05/2025	E L LD TW N	 5 4	 6 5	25.85	30.79	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
GUH	B0 Surgical	E L LD TW N	 5 4	 5 5	25.85	27.99	1	E L LD TW N	 5 4	 5 5	25.85	27.99	1	07/05/2025	E L LD TW N	 5 4	 5 5	25.85	27.99	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
GUH	C0 Surgical	E L LD TW N	 5 S & M 6 Tue-Sat 4 Sat-Mon 5 Tues-Thu	 5 Sat pm &M 6 tue-Frid 4 Sat-Mon 5 Tues-Thu	29.3	28.55	1	E L LD TW N	 5 4	 5 4	25.85	25.2	1	07/05/2025	E L LD TW N	 5 4	 5 4	25.85	25.2	1	09/10/2025	Yes	No	Spring Calculations - Changed to original template following loss of Machen beds	No			
GUH	A3 Gynae	E L LD TW N	 4 3	 3 2	20.16	13.98	1	E L LD TW N	 4 3	 3 2	20.16	13.98	1	07/05/2025	E L LD TW N	 4 3	 3 2	20.16	13.98	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
RGH	C7E Surgical	E L LD TW N	 3 2	 5 4	14.48	25.2	1	E L LD TW N	 3 2	 5 4	14.48	25.2	1	07/05/2025	E L LD TW N	 3 2	 5 4	14.48	25.2	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
RGH	C7W Surgical	E L LD TW N	 3 2	 4 3	14.48	19.61	1	E L LD TW N	 3 2	 4 3	14.48	19.61	1	07/05/2025	E L LD TW N	 3 2	 4 3	14.48	19.61	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
RGH	D2E Surgical	E L LD TW N	 3 2	 2 1	14.48	8.38	1	E L LD TW N	 3 2	 2 1	14.48	8.38	1	07/05/2025	E L LD TW N	 3 2	 2 1	14.48	8.38	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
RGH	D2W Surgical	E L LD TW N	1 M-S 2 M-F 1 S&S 2 M-F 1 S&S	 1 0 M-F 1 S&S	11.23	3.59	1	E L LD TW N	1 M-S 2 M-F 1 S&S 2 M-F 1 S&S	 1 0 M-F 1 S&S	11.23	3.59	1	07/05/2025	E L LD TW N	1 M-S 2 M-F 1 S&S 2 M-F 1 S&S	 0 M-F 1 S&S	11.23	3.59	1	09/10/2025	Yes	Yes	No Changes required-following professional discussions-roster deemed appropriate.	No			
RGH	D3E Surgical	E L LD TW N	 3 3	 5 2	17.32	19.62	1	E L LD TW N	 3 3	 5 2	17.32	19.62	1	07/05/2025	E L LD TW N	 3 3	 5 2	17.32	19.62	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
RGH	D3W	E L LD TW N	 3 2	 5 3	14.48	22.46	1	E L LD TW N	 3 2	 5 3	14.48	22.46	1	07/05/2025	E L LD TW N	 3 2	 5 3	14.48	22.46	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	No			
RGH	D7E Surgical (reported incorrectly Nov 24)	E L LD TW N	 3 2	 4 2	14.48	16.77	1	E L LD TW N	 3 2	 4 2	14.48	16.77	1	07/05/2025	E L LD TW N	 3 2	 4 2	14.48	16.77	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate	No			
SWH	OSU Surgical	E L LD TW N	1 3 1 M-F 2	 2 1	16.91	8.39	1	E L LD TW N	1 3 1 M-F 2	 2 1	16.91	8.39	1	07/05/2025	E L LD TW N	1 3 1 M-F 2	 2 1	16.91	8.39	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate	No			
NHH	Ward 4/2 Surgical	E L LD TW N	 3 2	 5 4	14.48	25.2	1	E L LD TW N	 3 2	 5 4	14.48	25.2	1	07/05/2025	E L LD TW N	 3 2	 5 4	14.48	25.2	1	09/10/2025	Yes	No	No Changes required-following professional discussions-roster deemed appropriate	No			
Total					233.5	250.49	13				230.05	247.18	13					230.05	247.18	13								

Appendix: Annual Presentation of the Nurse Staffing Level to the

Health board/trust:	ABUHB
Period of the report	October 2024 - Sep
Paediatric Inpatient Wards	

Paediatric Inpatient Wards

			Reporte
Site	**Name of Ward**	**SHIFT**	**Planned as state the ar present the B repo Nove 202**
			RN (band 5 &6)
GUH	**Paediatric 50 bedded unit C1 & C2**	E	
		L	
		LD	**12**
		TW	
		N	**12**
Total			

Board report

tember 2025

The number of staff per shift needs t

In accordance with the requireme
to whom nursing duties have beer
the delivery and coordination of p
(https://bcuhb.nhs.wales/about-us
contribute to the coordination and

d to the Board in November 2023				Calcula		
d roster d within nnual ation to oard rt (in mber 24)	Required Establishment as stated within the annual presentation to the Board report (in November 2024) including		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	SHIFT	Planned roster calculated by the designated person during the spring 2025 cycle	
HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)			RN (band 5 &6)	HCSW (bands 2,3 &4)
	70.22	17.06	1	E		
				L		
3				LD	12	3
				TW		
3				N	12	3
	70.22	17.06				

o be entered. The information should reflect the information on the informing patient template

nts of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidar
n delegated by a registered nurse - required to deliver the planned roster. It is acknow
atient care and treatment. However, these staff are not included within the data for thi
s/health-board-meetings-and-members/health-board-meetings/25-5-23-agenda-bundle
delivery of patient care.

ated during spring 2024 cycle					
Required Establishment as calculated by the designated persons during the spring 2025 cycle including uplift 26.9%		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**SHIFT**	**Planned calcula the des person the au 2025**
TOTAL WTE RN (bands 5 &6)	**TOTAL WTE HCSW (bands 2,3 &4)**				**RN (band 5 &6)**
70.22	**17.06**	**1**	**17/04/2023**	E	
				L	
				LD	**12**
				TW	
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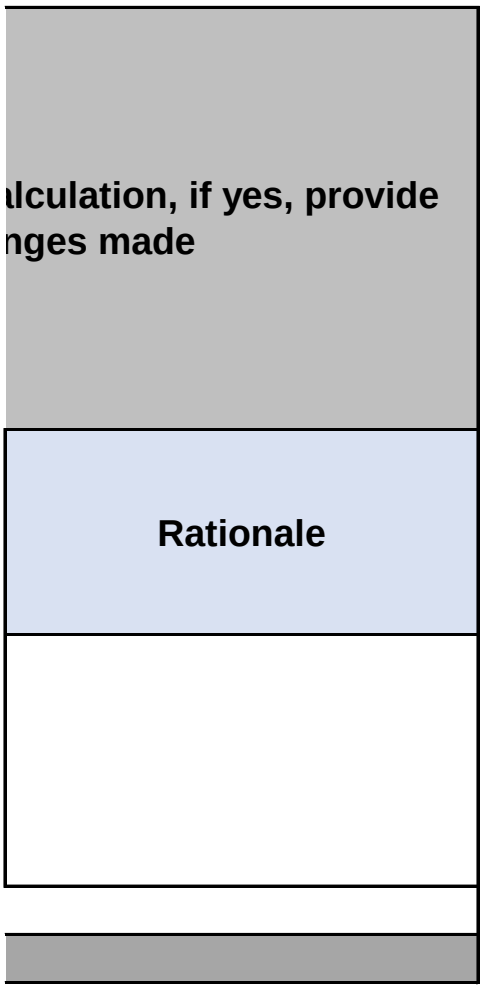
70.22	**17.06**				

e.

nce, the ‘nurse staffing level’ is the establishment of registered nurses - and other staff
vledged that there is a range of additional healthcare professionals that contribute to
is report. Further information is provided within the annual assurance report
e-public-vf2-compressed-n-v3-0/) on the additional multi-professional staff that

Calculated during autumn 2024 cycle					
d roster ated by ignated during utumn cycle	Required Establishment as calculated by the designated persons during the autumn 2025 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	Biannual cal changes spring 202
HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)			Completed (Yes/No)
	70.22	17.06	1	17/10/2023	Yes
3					
3					
	70.22	17.06	1		

culation cycle reviews, and any made & rationale during the 25 & autumn 2025 calculation cycles		Any reviews outside of biannual ca rationale for any cha		
Changed	**Rationale**	**Completed (Yes/No)**	**Date**	**Changed**
No	**No Changes required-following professional discussions-roster deemed appropriate**	**N/A**		


lculation, if yes, provide
nges made
Rationale

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	02 December 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Update on Neonatal Service Improvements
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade – Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Kelly Downes – 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

The Neonatal Intensive Care Unit (NICU) is currently navigating a period of significant challenge and transformation. Over recent months, the unit has faced persistent issues affecting the quality of care, workforce stability, and the overall culture within the team.

Recognising the urgency of these concerns, the Executive Director of Nursing (EDoN) has taken a proactive role in coordinating improvement initiatives.

A structured risk management approach has been established, focusing on four critical areas: Infection Prevention & Control, Medicines Management, Workforce, and Culture.

Weekly oversight meetings, chaired by the EDoN, ensure that progress is closely monitored and that support is provided to maintain momentum. The Executive team receives formal briefings each week, underscoring the organisation's commitment to resolving these issues and safeguarding patient outcomes.

Cefndir / Background

The impetus for these improvement efforts stems from a series of adverse trends within the NICU. There has been a noticeable increase in infection rates, medication

errors, and ongoing difficulties in maintaining safe staffing levels. Additionally, cultural challenges have surfaced, impacting staff morale and psychological safety.

In response, comprehensive risk assessments have been conducted to evaluate the effectiveness of current mitigation strategies and to identify further actions required for assurance and risk de-escalation.

Asesiad / Assessment

A detailed review of each priority area reveals both progress and ongoing challenges.

In terms of Infection Prevention & Control, the unit has implemented enhanced cleaning schedules and targeted environmental improvements, resulting in daily audit compliance rates between 84% and 93%. A pilot for external laundry services is nearing completion, showing promising results for further strengthening infection control. However, risks persist due to inconsistent practices and cleaning provision that remains below recommended levels.

Medicines Management has also been a focal point, following an increase in medication errors. The team has responded by strengthening pharmacy support, launching a dedicated Quality Improvement project, and piloting the Druggle model to improve medication safety. Human Factors training is underway, and regular audits are informing further actions. Despite these efforts, challenges remain, particularly around inconsistent pharmacy support and the early adoption of the EPMA system, which is not yet fully configured for neonatal care.

Workforce stability continues to be a concern, with persistent staff absences and recruitment pressures impacting the ability to maintain safe staffing and the necessary specialist skills mix. Initiatives to enhance retention and career development are being developed, and twice-daily SITREPS help ensure safe staffing levels. Increased visibility of senior staff has been welcomed, providing real-time support and opportunities for staff to raise concerns. Nevertheless, high absence rates and recruitment difficulties continue to pose challenge.

Cultural improvement is also underway, with an eight-week independent listening exercise having gathered confidential feedback from staff. Human Factors training and ongoing collaboration with HR are supporting staff wellbeing, and 60% of improvement actions have been completed since June. However, systemic cultural factors and the need for sustained organisational development remain as ongoing risks.

Next Steps

To ensure sustained improvement and risk reduction, weekly oversight and risk monitoring will continue until all identified risks reach acceptable tolerance levels.

The division is actively working to ensure that priority actions are completed efficiently to mitigate risk levels. Once these risks have been reduced, improvement measures should be integrated into standard business processes.

Regular reporting and assurance to the Executive Committee, Quality Management Group, and Patient Quality and Safety Committee will be essential to maintain oversight and drive continuous improvement in the quality and safety of neonatal care.

Argymhelliad / Recommendation
The Patient Quality Safety and Outcomes Committee is asked to: Receive the report for assurance.

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):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
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	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Improve the wellbeing and engagement of our staff

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.

Update on Neonatal Service Improvements

Patient Quality Safety and Outcome Committee
December 2025

Neonatal Intensive Care Unit – The need for enhanced support

The Executive Director for Nursing (EDoN) oversees the coordination and improvement initiatives addressing quality, workforce, and cultural risks within the Neonatal Intensive Care Unit (NICU).

- A structured approach to key risk management has been confirmed, with risk assessments completed to evaluate current mitigations and identify further actions for assurance and de-escalation.
- Four priority areas have been identified for timely risk de-escalation which include: Infection Prevention & Control, Medicines Management, Workforce, and Culture.
- A weekly oversight meeting is chaired by the EDoN, where improvement actions are monitored and support provided to ensure de-escalation of risks is achieved and maintained to an acceptable level
- The Executive team are formally briefed on progress each week.

Infection Prevention and Control

Following an increase in the number of infection cases on NICU and IPAC action plan has been developed. to strengthen cleanliness, reduce cross-contamination, and minimise infection rates. Immediate actions/assurance agreed include:

- Enhanced cleaning schedules and targeted environmental improvements to prevent cross-contamination.
- Daily audits consistently achieving compliance rates between 84% and 93%, highlighting positive progress and ongoing areas for improvement.
- A review of laundry arrangements is underway, with an external laundry service pilot nearing completion; initial outcomes are promising for further strengthening infection control.
- Reporting and procedures for venepuncture are under review, supported by ongoing audits and input from the IPC team.

These coordinated efforts demonstrate a clear commitment to achieving and maintaining the highest standards of infection control and patient safety.

Medicines Management

In response to an increase in medication errors, the learning has identified a need to focus on medication prescribing and administration errors, mainly caused by inconsistent pharmacy support and varied safety practices. Immediate actions include:

- Strengthening pharmacy cover, closer integration of pharmacy expertise, and
- Improve prescribing and administration processes through a dedicated Quality Improvement project on medication safety, piloting the DRUG-gle model, advancing EPMA adoption, and updating protocols for storage and administration guidance.
- Human Factors training underway
- Regular audits for medication administration and prescribing
- Medication incidents reviews, with learning shared through safety briefings and governance groups.

These actions and improvements are a coordinated approach from the Quality Patient Safety Team NICU, pharmacy and the Medical Directorate, drawing in national examples of best practice

Workforce

The NICU acknowledges ongoing challenges in maintaining safe staffing levels and the specialist skills mix required for exceptional neonatal care, due to persistent staff absences and recruitment pressures. Immediate actions include:

- Targeted retention and career development initiatives are being developed to enhance progression opportunities and minimise turnover.

- Regular review of the skill mix and flexible deployment options ensures sustainable cover for all shifts. Twice daily SITREPS to ensure safe staffing.

- Collaboration with HR via regular meetings and sickness management discussions further supports staff. The development of a future workforce plan will be undertaken in conjunction with workforce to ensure safe staffing into the future

- Band 7 staff have increased visibility and undertake professional rounding and actively support the neonatal team working within the clinical area. The increased visibility of senior and divisional staff has been welcomed by the staff and provides opportunities for staff to raise concerns and seek support in real time where needed.

These actions are an important commitment to delivering safe, high-quality neonatal care by supporting staff and fostering a resilient workforce.

Culture

The provision of a conducive, psychologically safe environment where staff feel that they can 'speak up safely, confident that concerns will be investigated and addressed is of paramount importance.

- An eight-week cultural listening exercise, conducted by an independent team, gathered confidential feedback from current and former staff through interviews, questionnaires, drop-in sessions, and review of ex-employee concerns. This approach aimed to understand workplace culture, highlight teamwork factors, and assess leadership's impact. Staff engagement was widely encouraged, including those absent, and anonymised findings are now under review by the EDoN, with a communication plan pending.

- Targeted Human Factors training is underway.

- Ongoing collaboration with HR supports staff wellbeing via regular audits and case reviews.

There is a shared commitment to fostering a positive, respectful, and high-performing culture focused on continuous improvement and delivering exceptional neonatal care.

Assurance & Governance

Weekly oversight will continue until all risks reach acceptable tolerance levels. Oversight includes:

- Regularly assessing performance indicators relating to the four main quality issues.
- Closely monitoring risk assessments, ensuring timely escalation of identified concerns and deescalation of risks as appropriate
- Supporting the delivery and track progress of the improvement plan.
- Report progress and provide assurance to the Executive Committee and Quality Management Group (QMG), with assurance to the Patient Quality and Safety Committee.
- The delivery of the wider NICU improvement plan will embed these actions into BAU once the risks are deescalated,

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	02 December 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality Strategy – Year Three Implementation Plan
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis – Assistant Director for Quality and Patient Safety Tracey Partridge Wilson - Deputy Director of Nursing

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

As Aneurin Bevan University Health Board enters the third year of its ten-year Quality Strategy, the organisation stands at a pivotal moment. The focus for 2025/26 is to deepen the culture of continuous improvement and strengthen the systems that assure both the Board and the public of the quality and safety of care. This year's implementation plan is designed to ensure that every action taken is measurable, transparent, and aligned with statutory duties—specifically, the Duty of Quality and Duty of Candour.

Cefndir / Background

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

The QOF for Q2 2025/26 provides a comprehensive review of quality, safety, and patient experience across Aneurin Bevan University Health Board. It aligns with

Ministerial priorities and the Duty of Quality, incorporating both quantitative metrics and qualitative learning. The report is structured around six revised pillars of quality. The QOF aims to drive continuous improvement, regulatory compliance, and assurance to the Board and Executive Committee.

The Health Board's commitment to quality is rooted in the Health and Social Care (Quality and Engagement) (Wales) Act 2020, which emphasises transparency, honesty, and learning. Since launching the Quality Strategy and Patient Experience and Involvement Strategy in 2023, Aneurin Bevan UHB has established robust frameworks and groups to drive improvement. These include the Quality Outcomes Framework, a Quality Management Group, and a centralised Learning Repository, all of which support a systematic approach to measuring and enhancing healthcare quality.
Over the past year, the organisation has focused on refining governance and assurance, ensuring that improvements are not only initiated but sustained.

Asesiad / Assessment

Year Three of Aneurin Bevan University Health Board's Quality Strategy focuses on embedding a *just and learning safety culture* and delivering measurable improvements through strong governance and assurance.

The Health Board aims to foster psychological safety, openness, and continuous improvement in everyday practice. Leadership visibility will be strengthened through safety walkarounds, capability building through human factors and quality improvement training, and real-time assurance via digital dashboards. Staff engagement and cultural measurement will underpin this approach, with quarterly tracking to demonstrate impact.

Year Three Priorities: -

1. **Embed Continuous Improvement and Learning**: Roll out the Quality Improvement Framework (2025–2028) and empower staff to lead improvement activities.

2. **Strengthen Patient Safety and Clinical Effectiveness**: Reduce harm from falls, pressure ulcers, infection, and sepsis; improve incident reporting and clinical audits.

3. **Enhance Patient and Staff Experience**: Expand real-time feedback, strengthen bereavement and volunteer support, and ensure inclusivity.

4. **Promote Openness, Candour, and Accountability**: Maintain robust Duty of Candour processes and centralise complaints handling.

5. **Optimise Workforce Wellbeing and Leadership**: Invest in training, coaching, and wellbeing initiatives to support staff.

6. **Leverage Digital Tools and System Integration**: Refine dashboards, automate reporting, and integrate systems for audit, safeguarding, and infection control.


Revised Six Pillars of Quality: -

Pillar 1	Patient and Staff Experience, Complaints, Concerns, and Compliments
Pillar 2	Incident Reporting and Patient Safety
Pillar 3	Clinical Effectiveness
Pillar 4	Health, Safety, Security and Compliance
Pillar 5	Infection Prevention and Control
Pillar 6	Safeguarding

Each pillar has quarterly milestones and mapped indicators to ensure measurable progress and accountability.

Quality Outcomes Framework (QOF)
The QOF is the Health Board's core mechanism for measuring and reporting quality. It aligns indicators to the Six Pillars of Quality and statutory duties, streamlines metrics to focus on what matters most, and uses automated dashboards for real-time visibility and assurance.

Quality Management System (QMS)
The QMS integrates all quality activities—performance reporting, audits, patient experience, and improvement—into a unified, standardised framework. It supports ward accreditation, automates reporting, and triangulates data with feedback and learning to ensure evidence-based assurance.

Quality Management Group (QMG)
QMG provides strategic oversight, reviews quarterly milestones, monitors progress against indicators, and ensures accountability across all workstreams. It acts as a central forum for governance, learning, and risk escalation.

Quarterly milestones mapped to QOF indicators underpin each priority. Automated dashboards and standardised reporting provide real-time assurance, while feedback loops ensure patient and staff voices inform service redesign. This integrated approach guarantees transparent, evidence-based governance and sustained improvement.

Argymhelliad/ Recommendation

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

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable currently

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 5. Timely Care 6.3 Listening and Learning from Feedback Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Quality Strategy

Year Three Implementation Plan

Patient Safety, Quality, Experience and Learning

Strategic Direction and Milestones 2025/26






Executive Summary

Jenny Winslade
Executive Director of Nursing

Dr Seema Srivastava
Executive Medical Director

Peter Carr
Executive Director of Allied Health Professions & Health Science

As Aneurin Bevan University Health Board enters Year 3 of its ten-year Quality Strategy, we reaffirm our commitment to delivering safe, effective, and compassionate care to the communities we serve. This year represents a critical stage in embedding a culture of continuous improvement while also strengthening the assurance and governance mechanisms that provide confidence to the Board, our workforce, and the public.

This implementation plan sets out in detail how we will continue to deliver on our statutory Duty of Quality and Duty of Candour, align our improvement activity to the Six Pillars of Quality, and ensure that every action taken results in measurable outcomes that can be monitored and reported with transparency. The plan emphasises patient safety and quality outcomes as the foundation of our work, supported by robust assurance and reporting mechanisms that flow from frontline practice through to Board-level oversight.

Progress will be tracked through the Quality Outcomes Framework (QOF), which provides an integrated, data-driven mechanism to measure healthcare quality across all domains. Reports will be automated where possible, ensuring timely visibility of data, and will be used to drive decision-making, identify risks, and evidence improvement.

Strategic Context

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 introduced both a Duty of Quality and a Duty of Candour, reinforcing the importance of transparency, honesty, and learning within the NHS in Wales. For Aneurin Bevan University Health Board, these duties have provided a clear framework through which to embed cultural and system-wide change.

In 2023, the Health Board launched the Quality Strategy alongside the Patient Experience and Involvement Strategy. These strategies established the principles by which we continue to improve the safety, effectiveness, and experience of care.

To improve governance and assurance, for the past twelve months there has been continued focus on:

- Implementation and refining of a Quality Outcomes Framework (QOF) to systematically measure and enhance healthcare quality.
- Establishment of a Quality Management Group to provide strategic oversight and quality improvement.
- Development of a ‘Listening and Learning Framework’ and introduced a Learning and Improvement forum to embed continuous improvement, alongside the creation of a centralised Learning Repository.
- Developed a Learning from Death framework and mortality report.

Year 3 of the Quality Strategy builds on this strong foundation. The focus now is not only on maintaining these systems, but on ensuring that they deliver consistent, reliable, and evidence-based assurance. The ultimate goal is to continue to improve the safety and quality of care, to meet the health needs of our citizens, and to demonstrate through both data and experience that improvements are sustained and embedded.

To continue to improve, we will focus on delivering the highest quality of care, meeting the health needs of our Citizens and People Using Healthcare Services, and improving health outcomes. Our commitment to quality, equality, and learning will be central to our service, demonstrated through our Listening and Learning Framework. This framework ensures consistent learning from incidents and feedback, promoting a culture of continuous improvement.

We are committed to a Health Board wide culture change, ensuring patients are informed and have equitable access to services. We will improve by listening, learning, and working together continuously.

- Ensuring the best possible health and care experience for everyone, delivering safe and effective services.
- Embracing transparency, accountability, and knowledge, celebrating success, sharing learning, and actively seeking improvement.
- Creating a culture where staff feel listened to, based on transparency, accountability, ethical behaviour and trust.
- Valuing people, providing safe and supportive environments, and empowering them to act on improvements
- Nurturing quality and system safety through actively listening to our population and responding to ensure a good experience for all.
- Promoting a 'Just Culture' that supports safety and psychological safety, encouraging staff to ‘speak up safely’.

As Aneurin Bevan University Health Board moves into 2025/26, our commitment to delivering safe, effective, and compassionate care remains unwavering. Building on the achievements of previous years, our priorities are designed to embed a culture of continuous improvement, strengthen patient safety and clinical effectiveness, enhance patient and staff experience, and promote openness, equity, and accountability across all services.

These ambitions are underpinned by our statutory duties and mapped to the Six Pillars of Quality and Six Quality enablers, with clear quarterly milestones to drive progress and assurance.

Year 3 of the Quality Strategy Implementation Plan continues our ten-year ambition to embed quality, safety, and learning at the heart of Aneurin Bevan University Health Board. Building on the achievements and lessons of the past two years, this plan sets out our priorities and workstreams for 2025/26, ensuring we remain responsive to emerging challenges, national policy, and the needs of our patients, staff, and communities.

Strategic Statement

Our Year Three priority is to establish a just and learning safety culture throughout the organisation, where psychological safety, openness and continuous improvement are embedded in everyday practice. We will benchmark against national and international best practice, drawing on insights from investigations, frameworks, and major inquiries, and engage with peer networks to map successful approaches.

Delivery will focus on visible leadership through safety walkarounds, capability building through human factors and quality improvement training, and real-time assurance using digital dashboards and structured feedback loops. Staff engagement and cultural measurement will underpin this approach, with progress tracked quarterly to demonstrate impact and sustainability.

Overarching Priorities

1

Embed a Culture of Continuous Improvement and Learning:

Implement the Quality Management Group and Framework for real-time monitoring and assurance and roll out the Quality Improvement Framework (2025–2028), empowering staff at all levels to lead and participate in improvement activities.

2

Strengthening Patient Safety and Clinical Effectiveness:

Focus on reducing harm from falls, pressure ulcers, infection, and sepsis; ensure robust incident reporting and timely investigations; and embed clinical effectiveness through structured audit and benchmarking.

3

Enhance Patient and Staff Experience:

Expand real-time feedback mechanisms, strengthen bereavement and volunteer support, and ensure services are inclusive and responsive to individual needs.

4

Promote Openness, Candour, and Accountability:

Maintain robust Duty of Candour processes, centralise complaints handling, and use feedback to drive service improvements.

5

Optimise Workforce Wellbeing, Development, and Leadership:

Invest in staff training, QI coaching, human factors education, and wellbeing initiatives to empower teams to deliver safe, compassionate care.

6

Leverage Data, Digital Tools and System Integration:

Refine dashboards and reporting structures for real-time monitoring, and integrate digital systems for audit, incident tracking, infection control, and safeguarding.

These ambitions are firmly grounded in our statutory duties and are mapped to the Six Pillars of Quality and Six Quality enablers, with clear quarterly milestones to drive both progress and assurance.

The milestones, agreed in March 2025, are designed to hold us accountable for delivering improvements in our data and outcomes, as measured against each of the six pillars of quality.

Quarterly Milestones by Pillar 2025/26

These milestones will support us progressing our ambitions in the quality strategy. Quarter Two 2025/26 reflects an update in the Pillars of Quality, Pillar Three.

	Quarter 1 2025/26	Quarter 2 2025/26	Quarter 3 2025/26	Quarter 4 2025/26
Pillar 1 Patient and Staff Experience and Stories, Complaints, Concerns, and Compliments	• Launch Patient and Family Support Officer role; ensure Civica feedback coverage; embed Care Aims. • Prepare for updated PTR Regulations; establish Acknowledgement Team; develop Communication Standards.	• Trial SMS feedback in ED; introduce People Participation Panels; involve Llais in Nutrition and Hydration. • Strive for 30-day PTR target; enhance early resolution; implement staff training.	• Share patient stories at Board/Committees; review Patient Experience Team work programme. • Audit new PTR processes; collaborate with external stakeholders for feedback.	• Use AI to capture narrative from patient and staff feedback. • Promote transparency and accountability.
Pillar Two Incident Reporting	• Establish Falls Strategic Oversight Panel; standardise mortality case review; embed mortality meetings. • Update Hospital Falls Policy; monitor/report incidents; use WNCR MFRA data for compliance.	• Deliver bespoke training for complaints and incident investigations; improve medication incident reporting. • Accelerate QI initiatives; prepare for NAIF data entry; adopt concise review methodology.	• Use Datix for medication safety themes; expand QI for pressure ulcers; support Tissue Viability Service. • Develop falls training and communication strategies; implement learning events.	• Launch Nutrition and Hydration escalation groups to embed learning from high-impact incidents. • Collaborate nationally on falls pathways; develop sustainable care model; progress whole systems approach.
Pillar 3 Clinical Effectiveness	Pillar being refined	Refine measures and include pillar for reporting	Spread of ward accreditation	Refine the measurement for number of in-patient cardiac arrest

Quarterly Milestones by Pillar

These milestones will support us progressing our ambitions in the quality strategy. Quarter Two 2025/26 reflects an update in the Pillars of Quality. Pillar Three.

	Quarter 1 2025/26	Quarter 2 2025/26	Quarter 3 2025/26	Quarter 4 2025/26
Pillar Four Health, Safety, Security and Compliance	• Deliver Health & Safety Improvement Plan; embed Management System.	• Implement Governance Framework; use local monitoring checklists.	• Revise strategy for inanimate load handling training.	• Achieve 85% compliance for manual handling in high-risk areas.
Pillar Five Infection Control and Prevention	• Review cleaning measures; develop Infection Prevention Team business case; conduct QI initiatives.	• Educate staff; assist specialties with infection reduction; develop surgical site infection systems.	• Increase audit cycles for antibiotics; align with UK Antimicrobial Resistance Plan; review cleanliness strategies.	• Embed AMS indicators; co-develop AMS package for GP practices; expand AMS ward rounds.
Pillar 6 Safeguarding	• Measure patient experience in safeguarding; develop assurance for ward accreditation.	• Establish safeguarding subgroups for learning and improvement.	• Refine measurements for Quality Outcomes Framework	• Thematic analysis of safeguarding data to inform future priorities.

Quality Management System

We will enhance our Quality Management System by setting meaningful targets, monitoring, measuring, and reporting performance to ensure excellent care standards. This is recognised through the development of our Quality Outcomes Framework. We will continue to standardise processes across the Health Board and create corporate support roles to streamline operations and enhance assurance mechanisms to consistently meet quality and safety standards. Additionally, we will leverage existing resources and support systems, ensuring all initiatives align with the Health Board's commitment to quality, safety, and patient experience.

Once the new Quality Outcomes Framework is established for Q2 2025/26, these milestones will be reviewed for the year ahead.

Quality Management System Implementation Plan 2025/26

The QMS implementation plan aims to integrate quality management systems across Aneurin Bevan University Health Board to ensure continuous improvement and report data under the Pillars of Quality.

The quality management framework is a structured, data-driven system that integrates all quality activities. Over the next 12 months there is a focus on automation and standardised reporting, and ensures robust assurance through regular, evidence-based submissions to executive and committee levels. This approach in addition focuses on triangulating data and evidence with experience and learning to ensure that we are able to demonstrate continuous improvement and compliance with health standards across the Health Board.

Our approach to themes, trends, learning and improvement is central to delivering safe, effective, and compassionate care. We will systematically identify recurring themes and emerging trends from incidents, complaints, audits, mortality reviews, and patient feedback, ensuring that insights are triangulated to inform priorities. Learning will be embedded through structured reviews, thematic analysis, and clear governance, with improvement actions tracked for impact and sustainability. By creating accessible repositories of lessons learned and fostering a culture of openness, we will enable staff to share knowledge and adopt best practice. Engagement with patients, families, and staff will shape improvement initiatives, ensuring that feedback translates into service redesign and innovation. This cycle of learning and improvement will underpin our Quality Management System, driving continuous enhancement of care and outcomes.

1. Integration of Quality Systems

- The framework brings together performance reporting, patient experience, clinical audit, and quality improvement into a unified system.
- There is a strong focus on automating reporting and reducing the number of metrics to those most meaningful for quality improvement.

2. Quarterly Objectives and Actions

- Each quarter has specific actions, measurable targets, and monitoring mechanisms to ensure progress and accountability.

3. Ward Accreditation and Audit

- The addition of the new pillar of Quality – Clinical Effectiveness will support reporting.
- The framework supports the ward accreditation programme, with clear targets for implementation and regular progress reviews.
- It also includes identifying and acting on areas for improvement highlighted by national clinical audits, with SMART action plans and regular review.

4. Digital Support

- Collaboration with digital teams ensures that data visualisation and reporting tools (like Qlik) are leveraged for quality improvement and assurance.

Key Goals and Actions for Quality Outcomes Framework (QOF) Reporting

	Quarter 1 2025/26	Quarter 2 2025/26	Quarter 3 2025/26	Quarter 4 2025/26
Action	Reconcile the performance report and QOF, collaborating with Digital, Data and Technology to develop automated reporting via the Qlik app.	Publish an updated QOF version mapped to the new pillars structure. Standardise reporting formats and charting, iteratively expanding as more measures become available in the data warehouse.	Integrate and triangulate patient experience data, incorporating learning from lived experience to provide richer qualitative insights.	Scope the NHS Exec National QOF to ensure all required metrics are incorporated into the Health Board's QOF.
Measurable Target	Reduce metrics to a maximum of 4–5 per quality domain by end of Q1. Map all metrics to the Duty of Quality and Quality Pillars by Q2. Achieve full automation of reporting by Q3.	QOF reporting fully aligned to the new pillars of quality.	QOF reporting continues to align with the new pillars, with enhanced qualitative data.	QOF reporting remains fully aligned to the new pillars and national requirements.
Monitoring & Assurance	Regular progress updates, including IQPD (NHS Exec), quarterly QOF reports to the Quality Management Group (QMG), and reporting to PQSOC.	Quarterly analysis and presentation of QOF to QMG and PQSOC.	Quarterly QOF analysis and assurance reporting to QMG and PQSOC	Quarterly QOF analysis and assurance reporting to QMG and PQSOC.

Ongoing:

1. Work with Digital, Data and Technology Team to support SPC charts in Qlik/Google Cloud.
2. Automatic phasing on Qlik SPC charts, monitored as part of QI strategy check-ins.

Summary of the Six Quality Pillars and Proposed Quality Outcomes Framework Key Metrics

1 Pillar One: Patient and Staff Feedback, Complaints, Concerns and Compliments

- **Civica:** Total new responses, % patient satisfaction, and trends in positive/negative emotions.
- **Putting Things Right:** Measures 30-day and 2-day compliance for complaint responses, percentage of reopened cases, and review rates.
- **Compliments:** Number and themes of compliments received.
- PALS (Patient Advice and Liaison Service): Volume and nature of cases handled, including early resolution.
- **Staff Culture:** Workforce & Organisational Development (WF&OD) metrics.

2 Pillar Two: Patient Safety (including Incident Reporting

- **Mortality:** Crude mortality rate, RAMI, Suicide rate, neonatal deaths, stillbirths.
- **Incidents:** Level of harm, closure date, focus on pressure ulcers, falls, hospital-acquired thrombosis.
- **Medicine Incidents:** Numbers and Trends, especially for serious incidents.
- **NRIs (Nationally Reportable Incidents):** Numbers , compliance, and themes.
- **DoC (Duty of Candour):** Numbers and themes
- **Thematic Analysis:** Regulation 28 reports and patient safety incidents.
- **Inquests:** Number held face-to-face vs. in writing.

3 Pillar Three: Clinical Effectiveness

- **Audit:** Proportion of audit recommendations completed within 12 months; review of risk and assurance levels.
- **Ward Accreditation:** Percentage of wards achieving bronze, silver, gold, or platinum status.
- **Readmission:** Rate of readmission within 7 days.

Summary of the Six Quality Pillars and Proposed Quality Outcomes Framework Key Metrics

4 Pillar Four: Health, Safety, Security and Compliance

- **RIDDOR Reporting:** Compliance with Health & Safety Executive (HSE) criteria (target: 100%).
- **Training Compliance:** Statutory and mandatory training (target: 85% for all modules).
- **Risk Assessments:** Number of open health & safety risk assessments within divisions.

5 Pillar Five: Infection Control and Prevention

- **Infection Rates:** Five main organism infection rates, benchmarked against Welsh Government reduction goals.
- **Surgical Site Infections:** C-section infection rates.
- **Antimicrobial Resistance (AMR):** Prescribing trends.

6 Pillar Six: Safeguarding

- **Duty to Report:** Adult and child reporting compliance.
- **Practitioner Concerns:** Volume and themes.
- **Training Compliance:** Safeguarding training rates.
- **DOLs (Deprivation of Liberty Safeguards):** Awaiting further feedback.

Each pillar has a set of specific metrics and focus areas to monitor and drive improvement in quality, safety, effectiveness, compliance, infection control, and safeguarding. These are tracked through a combination of quantitative data (e.g., compliance rates, incident numbers) and qualitative feedback (e.g., patient and staff experience).

How the QMS Implementation Plan Works

Integration: The plan is designed to bring together performance reporting, patient experience, clinical audit, and quality improvement into a unified system.

Automation: There is a strong focus on automating reporting and reducing the number of metrics to those most meaningful for quality improvement.
People's Experience: Triangulating data from patient surveys and lived experience is central, ensuring that qualitative feedback informs improvement.

Ward Accreditation: Supporting and monitoring the ward accreditation programme is a key action, with clear targets for implementation.

Audit and Improvement: The plan includes identifying and acting on areas for improvement highlighted by national clinical audits, with SMART action plans and regular review.

Digital Support: Ongoing collaboration with digital teams ensures that data visualisation and reporting tools (like Qlik) through dashboard functionality are leveraged for quality improvement.

How Reporting Works

Regular Progress Reports: Submitted to via the IQPD process to Welsh Government, quarterly Quality Outcomes Framework (QOF) reports, and performance reports for the Patient Quality Safety and Outcomes Committee (PQSOC).

Quarterly Reports: Developed in line with the pillars of quality and Health and Quality Standards, scheduled for consideration by QMG.

Annual Reports: Developed in line with statutory requirements to PQSOC

Audit Committee Reviews: Quarterly reviews of national clinical audits and tracking of action plan implementation.

Automated Dashboards: Use of digital tools to provide real-time data and analytics for assurance.

Feedback Loops: Incorporation of staff and patient feedback to ensure the system is responsive and effective.

Assurance Mechanisms

- The framework ensures clear, evidence-based reporting across all committee and group levels to assure delivery of Health and Care Standards.
- New reporting templates and guidelines are developed and implemented, with key areas requiring audits identified and scheduled.
- Standardisation efforts are made to ensure consistency in care delivery and reporting.
- Work collaboratively with NHS Performance and Improvement for on the National QOF and to adopt any identified changes.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	02 December 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Safeguarding Training
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 Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Following presentation of current compliance data, the committee requested a more detailed report into the situation in relation to Level 3 Safeguarding Training.

This paper will outline: -

- What the training requirement is
- Risks associated with non-compliances
- Barriers to achieving compliance
- Work currently underway to address areas of low compliance and support improvement

Cefndir / Background

National Safeguarding Training, Learning and Development Standards (2025)

The purpose of these standards is to make sure everyone in Wales gets consistent and good quality training, learning and development that's relevant to their role and responsibilities, and that we, as practitioners, can safeguard people to the best of our ability.

Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2024) and **Adult Safeguarding: Roles and Competencies for Health Care Staff 2025**

These documents were developed by the RCN, in collaboration with a number of the other Royal Colleges and set out the training requirements for healthcare staff in different roles.

All three of the above documents have endorsed by the Chief Nursing Officer for Wales.

Training Requirement

Levels 1 and 2 Child Safeguarding and Level 1 and 2 Adult Safeguarding are online training modules, that have long been embedded as a component of statutory and mandatory training.

Roles and Competencies for Healthcare Staff (March 2025) mandates Level 3 Safeguarding Children Training to all clinical staff working with children or young people.

Roles and Competencies for Healthcare Staff (July 2024) mandates Level 3 Safeguarding Adults Training as the minimum level required for all registered health care staff.

Both documents set out: -

- The breadth of topics to be covered within the training
- The number of hours required over a three-year period
- A requirement that the training should be participatory
- A requirement that the training should be face to face

In order to meet these requirements, both the Adult and Child training is mandated as a face-to-face training day, limited to 50 per session, to ensure the single facilitator can fulfil the objective of participatory training

The purpose of the Level 3 Training, both for Children and Adults, is to provide staff with the knowledge and skills to evaluate the needs of children or adults experiencing abuse or neglect, so that they can competently work with partner agencies to assess, plan and deliver care.

Work was undertaken in 2023 and an SBAR was presented to Executive Committee, whereby it was agreed which staff groups the training would be mandated to. There were a number of challenges in 2024 in understanding how the requirement for Level 3 Training could be attached to ESR, but training was made available and Divisional Leadership Teams were asked to encourage staff to attend.

Asesiad / Assessment

Current Position

The requirement for Level 3 Training has been long standing, but until 2023 it had never been clearly established within the Health Board in regard of exactly which staff groups should undertake the training or how it would be mandated.

In March 2025 we were able to attach this requirement to ESR identifying:

- 2500 staff requiring Children Level 3
- Compliance of 25%.
- 6200 staff requiring Adult Level 3
- Compliance of 15%

The volume of staff identified for Safeguarding Children was broadly what was expected. However, the volume of staff identified as requiring Level 3 Safeguarding Adult is considerably higher than had been predicted.

The following table shows the compliance as of 1 October 2025, for each of the eight clinical divisions.

Division	Compliance (Target 85%)					
	C1	C2	C3	A1	A2	A3
Clinical Support Services	82	81	8	82	82	23
Complex Care	81	79	N/A	78	76	34
Family and Therapies	88	86	52	88	87	24
Medicine	83	84	21	84	86	17
Mental Health and Learning Disabilities	86	83	25	86	85	47
Primary Care and Community Services	88	90	42	89	91	14
Surgery	79	79	8	80	80	18
Urgent Care	82	84	39	82	85	30
Overall*	82	84	38	82	85	24

*The overall figure includes data for staff who are not included in the eight Clinical Divisions as set out on ESR

Barriers to Full Compliance

Phased Implementation: Given the volume of staff and the need for training to be delivered every three years, it was agreed that we would put in place an annual target for compliance, with an overall target of 85% at the end of three years and being maintained thereafter. As such, whilst we are not at 85% currently, the current aim would be to be at 14%. Whilst we are currently at 15%, which is theoretically ahead of schedule, this figure takes in to account some staff who had undertaken the training prior to 1 April 2025.

Training Availability: There is a requirement to have available approximately 181 training places each month, to ensure that each identified staff member is able to book on to training at some point in the three-year cycle. To achieve 85% compliance, there is a need to have 154 places available each month. Utilising current resources, we are able to offer 100 places per month, which if fully utilised would achieve 56% compliance at the end of three years, being maintained thereafter.

Attendance: Training has been available to book on ESR since 1st April 2025, with all sessions being fully booked. However, the average attendance is 70%, with staff not offering any notice that they won't be attending. If this trend continues, it is unlikely that we will break through 40% compliance over a three-year period.

Risk and Mitigation

Reputational Risk: As of April 2025, there has been a requirement to report training compliance to the National Safeguarding Service in Public Health Wales. This information is shared in national forums which include representation from the National Independent Safeguarding Board and Welsh Government. However, conversations with the other eight health agencies have highlighted that we are unlikely to be an outlier in regard of lower compliance at this time.

Patient Safety: In terms of the risk to patients, it is not anticipated that there is a risk associated with patients at risk of harm, neglect or abuse not being identified or concerns not being shared and/or reported through appropriate routes, due to a high level of compliance with the Level 1 and 2 safeguarding training. However, without the Level 3 Training there are likely to be gaps in staff understanding what action to take to safeguard patients at risk. This is mitigated by the presence of the Corporate Safeguarding Team, who provide high levels of support and advice to frontline staff.

Resources: Without front line staff having the knowledge and skills to manage the safeguarding cases they are responsible for, there is a strong reliance on the Corporate Safeguarding Team to actively support the assessment and planning of patients in the safeguarding process. Due to high levels of activity the volume of support required by front line staff may not be sustainable.

A risk relating to safeguarding training non-compliance is currently captured on the risk register.

Actions to Address Non-Compliance

Provision of Additional Training: Due to a small amount of non-recurrent funding having been secured, the Safeguarding Team have been able to release an additional 650 places (13 sessions) for Safeguarding Adult Level 3. This represents 10% of the overall ask but will not tackle the longer-term objectives of full compliance and maintenance. Longer term resources are not available to deliver

additional training, so this will only be available in Quarters 3 and 4 of this financial year.

Overbooking: As a result of 30% (15 spaces) not being utilised, it has agreed that 60 places will be made available for booking, in a hope that closer to 50 attendees take up the session.

Executive Committee SBAR: An SBAR has been produced and scheduled for the Executive Committee in November. This paper highlights the risks highlighted in this document and offers options which include increasing the resource required to provide the training or accepting the current level of risk and mitigation.

Divisional Reporting: Due to the poor attendance, a reporting process has now been put in place where Divisional Leadership teams will receive monthly reports which will include their current compliance but will also provide them the details of those that did not attend. Divisions will be asked to report back thematically on the reasons for non-attendance, to inform planning of future sessions and mechanisms for booking.

Level 1 and 2 Training – Those who require Level 3 Safeguarding training will have undertaken the Level 1 and 2 training, so should have a basic awareness to enable them to recognise harm, neglect and abuse, as well as an awareness of how to raise concerns.

Management of Concerns – The Level 3 training should provide those working directly with vulnerable patients the skills to manage the safeguarding concern. In the absence of training, the Corporate Safeguarding team take a very active role in the case management. Noting that this is a protective factor, it is also very resource intensive and impacts upon a small safeguarding team.

Supervision – within the Intercollegiate Guidance there is a mandate for safeguarding supervision. This provides those working with some of our most vulnerable client groups with the opportunity to discuss complex cases. Much of this is done in a peer group setting, which provides opportunities for learning and development.

Argymhelliad / Recommendation

The Committee is asked to **NOTE** the content of this report and the action being taken to increase training uptake and to mitigate the risks associated with non-attendance.

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):	2.7 Safeguarding Children and Safeguarding Adults at Risk Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Older adults are supported to live well and independently
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Regional Solutions Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Work in partnership to reduce the inciende of domestic abuse, 'honour' based violence and elder abuse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	• National Safeguarding Training, Learning and Development Standards 2025 • Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2024 • Adult Safeguarding: Roles and Competencies for Health Care Staff 2025 •
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)

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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	02 December 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Assurance update on the mortuary and care after death transformational agenda
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Arvind Kumar, Divisional Director for Clinical Support Services

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 paper provides a formal update on the ongoing transformation of the Mortuary and Care After Death (CAD) services within the Pathology Directorate, following the assurance report presented to the Patient Quality, Safety and Outcomes Committee (PQSOC) in June 2025.

Cefndir / Background

The paper presented to PQSOC in June 2025 confirmed completion of key actions relating to HTA compliance, including embedding of Task and Finish group recommendations, audit schedule revisions, improved workforce resource and digital innovation.

The below table outlines progress made on actions that were pending or in progress at the time of the last report.

Task	Rationale	Action Status	Further Support / Status
Implementation of Mortuary and CAD	To improve efficiency and compliance with HTA standards.	Eden system currently in User Acceptance Testing (UAT); go-live scheduled for second	New Data Service Request (NDSR) submitted to further reduce inefficiencies by linking software to TCLE

services software	Reduce transcription errors and aid traceability.	week of December 2025.	(where histology samples are taken).
Facilities to undertake community admissions outside core working hours	To ensure APT staff adequate rest time between shifts, reducing risk of HTA Reportable incidents.	The process of Gwent police ID tagging and providing a Sudden Death Evidence Continuity Card (SDECC) has been in place since June 2025. Organisational change policy in progress for APTs. Porter training commenced to support community admissions; completion expected end of November 2025.	Support required from Facilities team and Unions, to continue to release porters for training, and promote importance of change. Although the envelope-style coverings currently used are compliant with Human Tissue Authority (HTA) standards, sealed body bags may be required to: 1. Uphold the dignity of the deceased and reduce the risk of porters encountering individuals who are not fully shrouded during transfers 2. To further reduce the need for an APT to be called on to site for e.g. decomposition / traumatic death.
All paper based audits transferring to electronic AMaT software	To improve efficiency, HTA compliance, audit visibility and assurance and support green healthcare strategy.	Audits now live on AMaT, including CCTV/security, fridge monitoring, full body checks, and tissue traceability.	Further audits to be added once Eden and OCP (Porter admissions) are implemented and access of audit dashboard to be arranged for higher management for assurance.
Review of scope of CAD and how this links with bereavement services	COO-led task & finish group incorporating Facilities, Pathology and Bereavement services conducted between June-November 2025, to review scope of CAD and bereavement	Following full-service review and audit of workload, T&F group concluded that the CAD services scope is to remain unchanged within pathology. Bereavement services to seek further resources as a separate ask.	None required

	services and appropriate resources.		
HR Workforce Career Pathways	To support sustainable workforce planning and succession for APTs and CAD staff.HR Partnership Transformation Working Group commenced. Career pathway development underway. Progressing. Outputs to be reviewed and aligned with long-term workforce strategy.	HR Partnership Transformation Working Group commenced. Local and national career pathway development underway (in which Mortuary Management are engaged). Level 2 in mortuary support in Wales has been drafted and waiting approval. This work is also to be included in the Pathology Academy Wales Network on the Y Ty Dysgu platform and will be accessible to all in the near future.	None required

Asesiad / Assessment

Progress Since June 2025

In addition to the updates on previously pending actions, a number of new developments have taken place since the last report to PQSOC. These developments reflect the continued delivery of service improvements in response to regulatory requirements, operational needs, and strategic priorities.

The following table outlines key progress made since June 2025:

Development	Summary	Implications / Actions Required
Phase 2 HTA Fuller Report Gap Analysis	Phase 2 report released July 2025. Gap analysis initiated and discussed at HTA Governance meetings.	CCTV required at YAB to enable security audits. Additional CCTV must be installed in GUH PM room. 'Specialist security oversight' needed in the event of any mortuary/body store security breach investigations – with Facilities to action and determine who the internal, or external, Point of Contact would be for this.
Chepstow Body Store Closure	Chepstow body store formally closed following review of infrastructure,	Complete. No further action required.

	usage and executive approval.	
NHS P&I External Review of HTA Audit	External review of ABUHB's self-audit against 72 HTA standards conducted by NHS P&I.	Meeting held with NHS P&I following feedback to ensure full scope of transformation was understood. Feedback letter has been drafted and is awaiting review and approval by Execs.
Inclusion of YAB in CAD Service	YAB body store identified as requiring oversight under CAD remit.	Additional resources needed to support inclusion and ensure HTA compliance.
Adoption of 'ME signed MCCD' instead of Green Form	Audit completed found that on average, length of stay was reduced by 7.2 days where the patient was released using the ME Signed MCCD, as opposed to the 'Green Form' which is issued at time of death registration.	Supported by HTA Governance Group. Awaiting Executive approval. Aligns ABUHB with practice across other Welsh Health Boards.
Presentation at All-Wales Post Death Care Event	Pathology presented service improvements and learning from incidents in 2023/24 at the All Wales Post Death Care event in September 2025, attended by HTA representatives.	None required. For assurance only. The presentation was well received and demonstrated the effectiveness of current monitoring and governance systems.

HTA Reportable Incidents

There have been no HTA Reportable Incidents (HTARIs) since April 2025. The most recent incident **did not** involve Mortuary or Care After Death staff and was identified through Mortuary and CAD CCTV audit processes, demonstrating the effectiveness of the current monitoring systems.

No inspections have been conducted by the Human Tissue Authority (HTA) at Aneurin Bevan University Health Board during this period.

HTA Governance Group

Quarterly Corporate-led HTA Governance meetings have been fully reinstated, with formal Terms of Reference established. Meetings have most recently been held in July and October 2025, providing a structured forum for scrutiny and assurance. Fuller Report gap analysis and SBAR submissions were reviewed, and following each meeting, the Chair submits an assurance report to the Quality Management Group in line with corporate governance protocols.

Transformation

As previously reported, a significant service transformation programme has been undertaken (please see appendix a).

Next steps:

Next Step	Summary	Timing / Dependencies
Rotational Peer Review System with neighbouring Health Boards	Formalised, rotational peer review process to monitor HTA compliance and implementation of Fuller Report recommendations, with neighbouring health boards.	Neighbouring Health Boards have confirmed their interest in developing a peer review system. This is to be scheduled following LIMS implementation and resolution of winter pressures.

Argymhelliad / Recommendation

The Patient Quality, Safety and Outcomes Committee is asked to acknowledge the progress made in delivering improvements to ensure a safe Mortuary and Care After Death service, and to consider support for the following:

- Executive-level approval for the Green Form change, endorsed by HTA Governance and consistent with national practice.
- Review of the proposed response to the NHS P&I review of the 72 HTA standard self-audit.
- Resource required to bring YAB under CAD remit and ensure HTA compliance (in light of Fuller Phase 2 recommendations for all body stores to operate to this standard, regardless of licensing).
- A review of the impact of the September 2024 Medical Examiner process changes on length of stay, certification timelines, and workload, and seek assurance from the ME service regarding turnaround times and their effect on patient and family experience.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Choose an item. Choose an item. Choose an item. Choose an item.

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Not Applicable
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Mortuary Services Transformation Plan

Task	Rationale	Notes	Current Status
Verification of Task and Finish group action implementation across the services	To ensure full implementation and embedding of actions, across all sites.	Some actions marked as complete by the Task and Finish group, were recognised to not have been fully embedded in the service across all sites. All actions are now fully embedded e.g. implementation of non-porous identification tags, training matrix fully updated, body condition monitoring process reviewed.	
Audit schedule review	Revision was required of all audits to ensure appropriate frequency, instruction and understanding by all staff in order to ensure compliance with HTA audits.	All audits reviewed. Revision in particular of the following: Cleaning schedules Security audits Temperature audits Tissue traceability audits Full body occupancy traceability audits A3 audit calendar posters created for all sites to aid completion. Staff trained in revised processes.	
Full self-audit against 72 HTA standards	To benchmark current processes against HTA and recognise areas for improvement	The findings of the self-audit are summarised under the 4 HTA domains: Consent fully compliant following completion of actions in February 2025. Governance and Quality – SOPs required work to ensure reflected current practice. Inter-	

		dependencies for some actions - required engagement from Gwent Police. Traceability – Tissue traceability was a heavily paper-dependent process. This was revised and moved electronic. Associated SOPs required updating and staff to be trained in new process. Complete. Premises and facilities required engagement and therefore had inter-dependencies with works and estates, security and portering teams. Complete.	
Establishment of working group	To build upon the progress established by the Task and Finish group and achieve complete resolution of HTA self-audit findings.	A working group was established to progress the actions identified and to escalate any urgent issues to Directorate/Divisional management in a timely manner. Each task was allocated to an individual or team to ensure accountability for completion.	
Ward education on preparation of deceased prior to transfer to mortuary	Incident trends revealed a failure to adhere to established protocols during pre-mortuary transfer e.g. identification bands.	Educational poster devised and cascaded to all ward teams, across all sites, focussing on learning from recent incidents. Discussion at ward team briefs and nurse management meetings. Incidents were monitored to ensure improvement.	
Review of Mortuary and CAD services software	Reliance on inefficient paper processes and 19 spreadsheets and paper forms, to understand the extent of inefficiencies and the risk of transcription	Procurement of an HTA-compliant solution, including audit trail, capacity management, paperless operation, and performance metrics. Go-live scheduled Dec 2025.	

	errors (identified by HTA in 2022).		
Staffing review and development of career pathways	To ensure the appropriate managerial and staffing structure is in place, to provide service with the required support. APT on call rota historically has been covered by 3-5 APTs, 24/7 with no subsequent rest time.	Need for dedicated Band 7 for Mortuary and Care After Death services confirmed. Appointed and commenced role in April 2025. Further admin support allocated to Mortuary to assist with tissue traceability process. Need for OCP and wider work identified to ensure appropriate rest time between shifts. See further actions.	
Review of roles and responsibilities for Care After Death	To ensure the appropriate allocation of tasks relating to physical care of the deceased. The CAD service is currently overwhelmed arising from changes in the Medical Examiner death certification processes.	A formal review of the current processes for death certification management was required. A cross Divisional task and finish group was established and chaired by the COO to review how Bereavement Services are structured and delivered across the Health Board by the devolved teams, considering stakeholder experience and service outcomes. Current services to remain 'as is' in regards to CAD/bereavement service management.	
Staff wellbeing review	To ensure the emotional and psychological wellbeing support for staff	Regular huddles and meetings established by Mortuary and Care After Death team manager. Monthly collaborative team meetings have a wellbeing focus. Counsellors are planned to support during some meetings to build emotional resilience and psychological safety.	

Corporate-led HTA Governance meetings	The recently re-established HTA Governance meetings aim to seek assurance of the ongoing work across the Health Board to maintain and enhance HTA compliance.	Mortuary and Care after Death services provide comprehensive reports indicating progress and an update of recent HTARIs to (and ensure attendance at) the HTA Governance meetings.	
Develop collaborative working relationships with key internal, and external stakeholders (Medical Examiner and Coroner)	To streamline processes and improve efficiency of information sharing and coordination among relevant internal and external stakeholders.	Regular meetings established with Medical Examiner, Coroner's office and working relationships developed with Gwent Police. Mortuary and Care After Death are now established in the ABUHB Bereavement Collaborative.	
Move to paperless, electronic audit system (AMaT), aiming for QI Accreditation	To provide assurance, audit visibility and reduce inefficiencies in the current paper-based audit system	Mortuary and Care After Death audits built on to AMaT system. Mortuary and Care After Death services aim to achieve QI Accreditation following a period of high audit compliance and completion of Quality Improvement projects.	
Facilities to undertake community admissions outside core working hours	To ensure APT staff adequate rest time between shifts, reducing risk of HTA Reportable incidents.	The process of Gwent police ID tagging and providing a Sudden Death Evidence Continuity Card (SDECC) has been in place since June 2025. Organisational change policy in progress for APTs.	

		Porter training commenced to support community admissions; completion expected by early Dec 2025. Support required from Facilities team and Unions, to continue to release porters for training, and promote importance of change. Although the envelope-style coverings currently used are compliant with Human Tissue Authority (HTA) standards, sealed body bags may be required to: 1. Uphold the dignity of the deceased and reduce the risk of porters encountering individuals who are not fully shrouded during transfers 2. To further reduce the need for an APT to be called on to site for e.g. decomposition / traumatic death.	
HR Workforce Career Pathways	To support sustainable workforce planning and succession for APTs and CAD staff.HR Partnership Transformation Working Group commenced. Career pathway development underway. Progressing. Outputs to be reviewed and aligned with long-term workforce strategy.	HR Partnership Transformation Working Group commenced. Local and national career pathway development underway (in which Mortuary Management are engaged). Level 2 in mortuary support in Wales has been drafted and waiting approval. This work is also to be included in the Pathology Academy Wales Network on the Y Ty Dysgu platform and will be accessible to all in the near future.	
Phase 2 HTA Fuller Report Gap Analysis	Phase 2 report released July 2025. Gap analysis initiated and discussed at	CCTV required at YAB to enable security audits. Additional CCTV must be installed in GUH PM	

	HTA Governance meetings.	room. 'Specialist security oversight' needed in the event of any mortuary/body store security breach investigations – with Facilities to action and determine who the internal, or external, Point of Contact would be for this.	
Chepstow Body Store Closure	Chepstow body store formally closed following review of infrastructure, usage and executive approval.	Complete. No further action required.	
NHS P&I External Review of HTA Audit	External review of ABUHB's self-audit against 72 HTA standards conducted by NHS P&I.	Meeting held with NHS P&I following feedback to ensure full scope of transformation was understood. Feedback letter has been drafted and is awaiting review and approval by Execs.	
Inclusion of YAB in CAD Service	YAB body store identified as requiring oversight under CAD remit.	Additional resources needed to support inclusion and ensure HTA compliance.	
Adoption of 'ME signed MCCD' instead of Green Form	Audit completed found that on average, length of stay was reduced by 7.2 days where the patient was released using the ME Signed MCCD, as opposed to the 'Green Form' which is issued at time of death registration.	Supported by HTA Governance Group. Awaiting Executive approval. Aligns ABUHB with practice across other Welsh Health Boards.	
Presentation at All-Wales Post Death Care Event	Pathology presented service improvements and learning from incidents in 2023/24 at the All Wales Post Death Care event in	For assurance only. The presentation was well received and demonstrated the effectiveness of current monitoring and governance systems.	

	September 2025, attended by HTA representatives.		
Rotational Peer Review System with neighboring Health Boards	Formalised, rotational peer review process to monitor HTA compliance and implementation of Fuller Report recommendations, with neighboring health boards.	Neighboring Health Boards have confirmed their interest in developing a peer review system. This is to be scheduled following LIMS implementation and resolution of winter pressures.	

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	02 December 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

Ar Gyfer Trafodaeth/For Discussion

The purpose of this report is to provide a summary of the current strategic risks that have been delegated to the Patient Quality, Safety, and Outcomes Committee (the Committee) for monitoring, on behalf of the Board.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation & Cefndir / Background

At the last Committee meeting in October 2025, it was reported that the risk environment remained stable, with no changes to the risk scores of the monitored risks. This stability has continued into the current reporting period.

As of the time of writing, the Committee Risk Register includes three high-level risks and three associated sub-risks, spanning the areas of service delivery, transformation and partnership working, and compliance and safety.

Asesiad / Assessment

Committee Strategic Risk Register

Table 1 below provides the current status of the three strategic risks. In accordance with best practice, all risks have been reviewed within the appropriate timeframe for their respective levels of risk.

The review focuses on the control environment, ensuring that the controls remain robust and adequate for managing the identified risks. Additionally, the assurances are tested to verify the robustness of the controls. Detailed information is provided in **Appendix A** (Strategic Risk Dashboard and individual risk assessments).

Table 1

Risk Ref:	Risk Description	Sub-Risk	Risk Level	Within Appetite
SRR 005 Chief Operating Officer **Theme** Service Delivery **Appetite** Open Score 17 and below	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	Due to inadequate arrangements to support system-wide patient flow.	**High** **3 x 4** **(12)**	**Y**
SRR 008 Director of Nursing **Theme** Transformation & Partnership Working **Appetite** Open Score 17 and below	There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.	**Moderate** **2 x 4** **(8)**	**Y**
SRR 010 Director of Therapies & Health Science **Theme** Compliance & Safety **Appetite** Minimal Score 8 and below	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974.	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed, and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	**High** **3 x 4** **(12)**	**N**

Risk Exposure Aligned with Risk Appetite

Risks **SRR 005** and **SRR 008** remain within the Health Board's defined risk appetite, providing assurance that current controls are effective and proportionate.

Ongoing engagement with risk owners will ensure these controls continue to mitigate potential threats appropriately.

The Board maintains a minimal risk appetite for compliance and safety, reflecting its commitment to statutory obligations and the protection of patients, staff, and visitors. In line with this position, any risk with a residual score above eight must be actively managed, reduced, or eliminated where possible. Such risks are subject to targeted interventions and close executive oversight.

SRR 010 remains outside the Board's agreed risk appetite and continues to be closely monitored by the Executive Committee. Since its initial identification, notable progress has been made in reducing both the likelihood and impact of this risk, primarily through the implementation of the Health and Safety Improvement Plan.

Health and Safety Performance and Assurance

The Health Board continues to strengthen its governance arrangements for health and safety, ensuring compliance with the Health and Safety at Work Act 1974 and associated Welsh Government requirements. Oversight is provided through the Health and Safety Operational Group (HSOG), which monitors performance, reviews compliance, and escalates significant concerns to the Health and Safety Committee.

Delivery of the Health and Safety Improvement Plan has resulted in measurable progress, including:

- **Policy and Governance Alignment**
  Policies and procedures have been reviewed and updated to reflect legislative changes and best practice guidance.

- **Risk Assessment and Mitigation**
  Comprehensive risk assessments have been undertaken across all sites, with targeted actions implemented to address high-risk areas such as fire safety, manual handling, and security.

- **Incident Management and Learning**
  Incident reporting and investigation processes have been strengthened through Datix, enabling timely analysis and organisational learning, supporting harm reduction and improved responsiveness.

- **Training and Workforce Development**
  Mandatory health and safety training compliance has improved, supported by enhanced induction programmes and refresher courses for high-risk roles.

- **Performance Monitoring**
  KPIs and audit results demonstrate improved compliance across key areas of

delivery. Exception reports are reviewed by HSOG, ensuring corrective actions are prioritised and escalated where necessary.

Progress against the Health and Safety Improvement Plan is monitored quarterly and reported through the governance framework. The Health Board is on track to deliver the objectives set out in the Plan, with continued focus on risk assessment, training compliance, and incident management to further strengthen assurance and maintain statutory compliance.

Mechanisms for Horizon Scanning

The Quality Management Group (QMG), a formal sub-group of the Executive Committee, provides strategic oversight of quality and safety. In accordance with its Terms of Reference, the QMG offers a structured mechanism for collating, analysing, and escalating thematic risks identified through the various operational and assurance groups that report into it (see Appendix B for the quality and safety risk reporting schematic).

The QMG identifies thematic risks through systematic review of quality, safety, and patient experience data across the organisation. Intelligence is triangulated from divisional assurance meetings, operational quality forums, and external regulatory reports to detect recurring issues and emerging trends. Where risks are assessed as significant, impacting patient safety, compliance, or organisational objectives, the QMG recommends escalation to the Executive Committee and, where appropriate, inclusion on the Corporate Risk Register (CRR).

By consolidating intelligence, promoting early intervention, and aligning escalation pathways, the QMG strengthens governance and supports the delivery of safe, high-quality care.

In addition to thematic risk escalation, significant quality and safety risks can also be raised through the organisational governance structure, following a "Ward to Board" pathway. This ensures that issues identified at the point of care are systematically reviewed, managed, and, where necessary, escalated through divisional and corporate forums to the Executive Committee and Board for oversight and assurance.

The developing CRR currently contains a number of quality and safety risks, with risk assessments underway to determine current exposure and identify actions required to reduce high-level operational risks to within the agreed risk appetite.

Argymhelliad / Recommendation

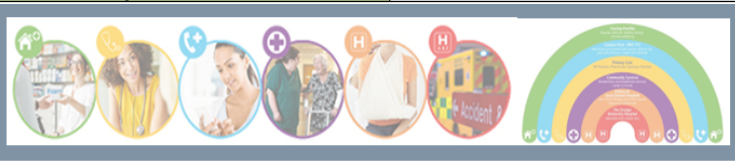
The Committee is asked to:

- **CONSIDER** whether it has sufficient assurance that the strategic risks are being assessed, managed, and reviewed appropriately and effectively, considering the detailed analysis and ongoing mitigation efforts outlined in this report.

- **NOTE** the continued efforts to bring all risks to within the agreed threshold for the risk appetite, and;
- **NOTE** the work being undertaken to ensure that risks with the potential to impact patient quality and safety are systematically identified and incorporated into the forward work plans of key groups and sub-committees of the Health Board.

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

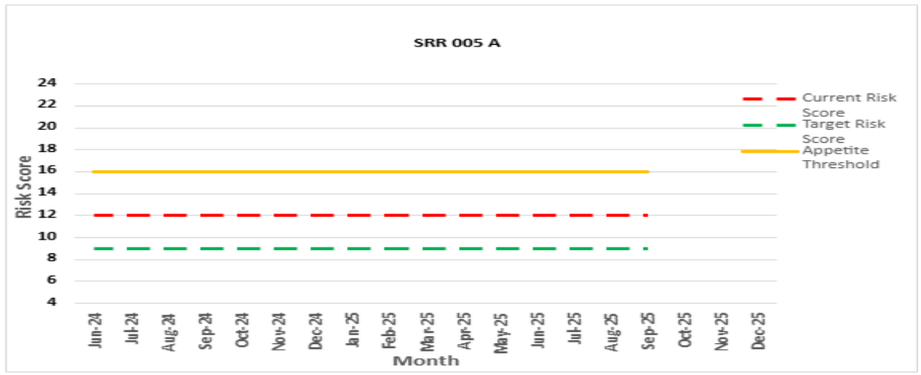


Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation 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 ID and Description				IMTP Link	Risk Score												
					2	3	4	5	6	8	9	10	12	15	16	20	25
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow	System Change							X		●		◊		
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	Quality			X			●					◊		
SRR 010	Director of Allied Health Professions and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	Quality & Workforce & Culture					X	◊			●				

Key		
	Current Score	●
	Target Score	×
	Appetite Threshold	◊

RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	SECTION 3: SYSTEM CHANGE				
Strategic Risk SRR 005 A	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate arrangements to support system-wide patient flow**			**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Avoidable deaths and significant harm. • Delayed discharges from acute and non-acute settings resulting. in deteriorating patients. • Delays in releasing ambulances from hospital sites back into the community.	**Staff** • Increased workload • Fatigue & burnout	**Organisation** • Litigation & Financial Penalties • Reputational damage and loss of public confidence	**Risk Appetite Threshold – OPEN SCORE 17 AND BELOW** Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is **OUTSIDE** of target level but WITHIN appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Chief Operating Officer	Risk Exposure	**Current Level**	**Target Level**	
Monitoring Committee / Group	Patient Quality, Safety and Outcomes Committee	**Likelihood**	**3** (Possible) x	3 (Possible) x	
Initial Date of Assessment	01 June 2023	**Impact**	***4** (Major)*	3 (Moderate)	
Last Reviewed	01 September 2025	**Risk rating**	**= 12 (High)**	***= 9 (High)***	
Next Review (Quarterly based on risk score)	01 December 2025				



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Escalation Policy. • Performance and Accountability Framework • Operational Framework • Major incident Procedures • Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. • Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. • fortnightly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. • Enhanced monitoring in place for U&EC • Range of performance measures/metrics in place • Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. • Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. • Planned care recovery meetings with the NHS execs. • Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. • WG – IQPD meetings to review areas of focus	• New developments and pathways coming online into FY25/26 • New expanded transfer lounge o New ED extension and reconfiguration • Additional ED consultants coming onboard • Safety Flow agenda delivering wider developments and improvements

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• The Escalation Framework has been enacted and ineffective in mitigating threats and impact to services. • Performance report against measures/metrics	• Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. • The impact of the Performance and Accountability framework in improving patient flow	• Close monitoring and reporting of the frameworks in practice to support learning and improvements.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Divisional Assurance reviews. • Performance against measures/metrics reported to the Executive Committee	• Effectiveness of the Operational Framework	• The Operational Framework process commenced in November 2024, initiating a series of in-depth reviews across specific services. This is an iterative approach designed to remain active and adaptable, ensuring it continues to meet the evolving needs of the services.
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit Reviews • Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024. • External inspections/visits. -	None	N/A

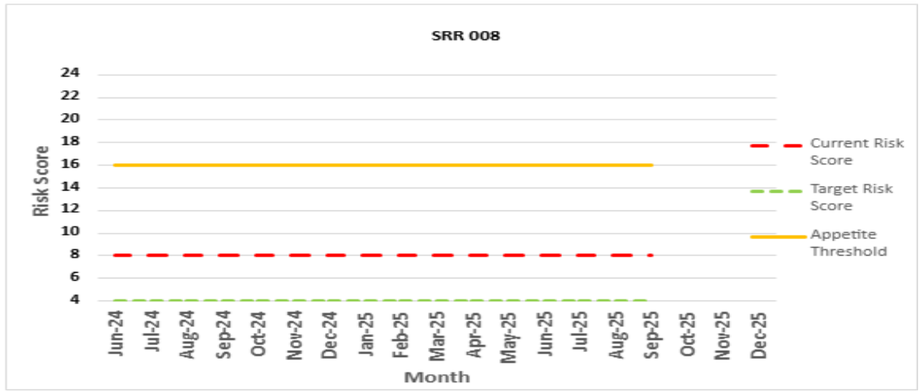
Assurance Rating (*Overall Assessment of controls and assurances)* *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

RISK THEME	**TRANSFORMATION AND PARTNERSHIP WORKING**			
LINK TO IMTP	**SECTION 4: ENABLER - QUALITY**			
Strategic Risk SRR 008	**There is a risk that the Health Board fails to build positive relationships with patients, staff and the public.**		**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.**			
Impact *(Consequences of the threat)*	**Patient** • Unmet patient needs resulting in patient harm. • Ineffective use of combined resources • Delayed decision making • Adverse impacts on delivery of care to patients across acute and non-acute settings • Negative experience of care • Distress and frustration. • Carer stress.	**Staff** Staff dissatisfaction Frustration Increased absence. Loss of confidence.	**Organisation** • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence	
Lead Director	Director of Nursing	Risk Exposure	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	**2** (Unlikely) x	**2** (Unlikely) x
Initial Date of Assessment	01 June 2023	**Impact**	***4** (Major)*	**2** (Minor)
Last Reviewed	01 August 2025	**Risk rating**	**= 8 (Moderate)**	***= 4 (Low)***
Next Review (Six monthly based on risk score)	01 February 2026			

Risk Appetite Level – OPEN
Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.

Risk Appetite Threshold – OPEN SCORE 17 and Below
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

SUMMARY
The current risk level is **OUTSIDE** of target but **WITHIN** the appetite threshold. Target level is **WITHIN** the set appetite threshold.



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys and National surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas. • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX • Oversight of Medical Examiner reports to determine patient experience actions • Public Engagement- Big Conversation Bereavement held 20th March 2024 • People Participation Panel ED in Progress • Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams.	• Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. • PCCT staff training to support Civica data entry and retrieval. • Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. • Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to Quality Management Group • Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. SMS provision to be implemented in Feb 2025 across ED and all MIU's. 5 National Maternity Surveys to launch via SMS 1st Sept 2025 • National directives around new national surveys that need to be managed additional to internal roll out programme – National People's Experience Survey live 1st May 2025 and default survey for majority of live areas. • Volunteer feedback to be reviewed to identify themes. • Development of End of Life and Bereavement models in progress and improve bereavement offer to meet Bereavement Standards. Resources being scoped. • Community of Practice for Patient Experience and People Participation Panels now agreed and to be progressed. • Dementia community hubs in each borough of Gwent will enable accessible opportunities for feedback and signposting, plans to increase hubs in more areas of Gwent.

• Dementia Person centred Care team dedicated e mail address. • Dementia Information and signposting through webpages. • Patient feedback on the agenda for each of the dementia workstream meetings. • Dementia - QR code for feedback at each training event and session. • Dementia Thematic review from CIVICA team requested to inform actions and improvements in care. • Dementia - Multi agency partnership workstreams measuring impact of service. • Graces places set up in Newport, Caerphilly and Monmouthshire to support bereaved people	

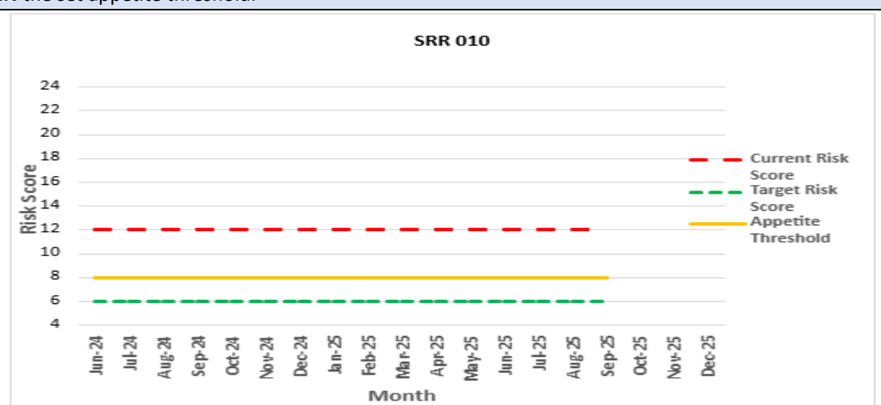
Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		

• Concerns are fed back to divisional teams when identified.
• Outcome of the volunteer feedback to drive improvements.
• Patient Experience and Involvement Team undertaking Culturally Competent Accreditation, receiving a silver distinction award in Oct 2024
• Immediate feedback and escalation to clinical teams following PALS queries and concerns
• Civica patient feedback in in the process of being rolled out across all – all divisional leaders receive reports for their live areas monthly.
• Bereavement survey built with CIVICA – Nov 2024
• CIVICA SMS launched 3rd March 2025 across ED and MIU'S
	• Currently there is limited SMS provision to increase the number of surveys.
	  • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns.
	  • Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards.
	  • CIVICA team have the ability to pull and view feedback that has been left by patients/family. The listening and learning from the feedback to be shared by each department/directorate/division i.e., / 'you said, we did' / quality improvement projects.
		• SMS provision for patient experience feedback launched in ED and all MIU's in February 2025.
		• PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Need to have discussions with facilities around rooms.
		• Patient experience KPI's and common themes by department/directorate/division need to be identified and pulled from the civica system left on surveys feedback. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation.
		• Development of a ABUHB bereavement survey has been built within CIVICA and tested. Launch date likely early 2025.

Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee • Implemented PALS DATIX Module	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Bi-monthly LLais Reports • HIW inspections • Advocacy reports	None	N/A

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable -** adequate evidence that the controls in place are working effectively.	**Positive -** robust evidence that the controls in place are working effectively.	**Reasonable**

RISK THEME	COMPLIANCE AND SAFETY				
LINK TO IMTP SECTION 4: ENABLER	QUALITY			WORKFORCE & CULTURE	
Strategic Risk: SRR 010	**There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974**			**Publication Status**	**Public**
Threat *(As a result of)*	**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**			**Risk Appetite Level – MINIMAL** Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below.	
Impact *(Consequences of the threat)*	**Patient** • Unintended physical harm to patients • Psychological trauma	**Staff** • Unintended physical harm to staff • Psychological trauma • Increased levels of staff sickness	**Organisation** • Punitive actions from the Health and Safety Executive (HSE) • Loss of estates due to unsafe environments • Financial implications • Adverse publicity • Reputational damage.	**Risk Appetite Threshold – SCORE OF 8 or Below** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls.	
				SUMMARY The current risk level is **OUTSIDE** of target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.	
Lead Director	Director of Allied Health Professions and Health Science	**Risk Exposure**	**Current Level**	**Target Level**	
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	3 (Possible) x	2 (Unlikely) x	
Initial Date of Assessment	01 December 2023	**Impact**	*4 (Major)*	3 (Moderate)	
Last Reviewed	01 September 2025	**Risk rating**	**= 12 (High)**	**= 6 (Moderate)**	
Next Review (Quarterly based on risk score)	01 December 2025				



Current Key Controls *(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** ***What further controls are required to reduce the risk exposure to within a tolerable range?*** *(Short, Medium, and Long-Term Plans need to be included)*
• Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. • Health and Safety Policies and Procedures • Dedicated Health and Safety site on ABPULSE • Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 'Health and Safety Assistance'. • Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) • Partial Programme of Health and Safety Monitoring (Active & Reactive) • Corporate and Directorate Health and Safety Risk Register established. • Board Training /development (Completed 24 April 2024) • Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. • Health and Safety Governance and reporting arrangements (Health and Safety Committee)	• Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System • Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) • Consultation and communication with the workforce regarding compliance with the Act • New ways of working with Divisions to ensure accountability for health and safety is recognised. • Implement key performance indicators to monitor health and safety compliance. • Review the governance arrangements for the Health & Safety Committee • Health and Safety Policies and Procedures to be reviewed. • Onboard further Manual Handling trainers across the organisation to improve compliance. • Scope for training non-Health Board staff • Learning from events to be documented and communicated to the organisation.

Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
Health and Safety compliance data extracted from ESR and Datix and reported Statutory reporting data reports and dashboards	• Implementation of a health and safety performance report • Health and Safety Committee Membership and governance to be reviewed to ensure there is robust scrutiny and challenge on compliance with the Act • Compliance on completion of risk assessments and mitigating actions • Consistent adherence and application of policies	• Revise accountability arrangements for Health and Safety being progressed as part of the organisational Health & Safety Governance Framework. • Review the membership and ToRs of the Health and Safety Committee • Risk assessments and mitigating actions to be documented and reported regularly to demonstrate progress against the Improvement Plan
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Established monitoring of H&S at the Executive Committee • Corporate H&S Team report risk and assurance to the Health and Safety Group • Health and Safety Annual Report • Health and Safety Improvement Plan • Established monitoring of H&S at the PQSO Committee	• Thematic Risk Register	• Development of a thematic risk register
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
Internal Audit 2024/25 Plan • Health and Safety Internal Audit – **Concluded Limited Assurance** • Performance reviews at All Wales Health and Safety Management Steering Group • South Wales Fire & Rescue Service fire safety audit programme. Health and Safety Executive reviews/inspections.	• Recommendations from the 2024/25 Internal Audit	• Implement actions to address the findings and recommendations set out in the Limited Assurance Internal Audit Report

Assurance Rating (*Overall Assessment of controls and assurances*) *Guidance*			
Negative – Insufficient evidence that the controls	**Reasonable** - adequate evidence that the controls in place are working effectively.	**Positive** - robust evidence that the controls in place are working effectively.	**Reasonable Assurance**

Executive Committee - CRR

Quality Patient, Safety & Outcomes Committee

Chair: Independent Member

Quality & Patient Safety Risk Register
Oversight Group: Quality Management Group (QMG)
Chair - Executive Director of Nursing

Cross Divisonal Assurance Meetings
Chair: COO
***(Feeds into the Corporate Risk Register)**

Quality & Patient Safety Divisional Assurance Meeting

Patient Quality Safety Learning & Improvement Forum

Patient and Staff Feedback, Complaints, Concerns & Compliments	Patient Safety	Clinical Effectiveness	Health, Safety, Security and Compliance	Infection Prevention & Control	Safeguarding
Community of Practice for Patient Experience	Falls and Bone Health Group	Clinical Standards & Effectiveness Group	Health & Safety Group	Strategic Infection Prevention Improvement Group	Safeguarding Strategic Group
Speaking Up Safely Group	Medicines Safety & Therapeutics Group	Acute Deterioration Group	HTA Group	Antimicrobial Stewardship	Mental Capacity Act Forum/DOLS
Volunteers Group	Nutrition & Hydration Group	Resuscitation Group	Medical Devices	Cleaning Standards Group	
	Hospital Acquired Thrombosis Group	R&D Group	Radiation Protection Group	Strategic Decontamination Group	
	Mortality and ME	Hospital Transfusion Group			
	Datix Management Group	Clinical Advisory Forum			

Divisions

Thematic risks should be recorded on the relevant Divisional Risk Register; actively managed at the point where they are manifesting; reported to the QMG for oversight and potential escalaltion.
These risks should be escalated appropriately through the organisational hierarchy, in line with established governance processes.

Medicine Division	Surgery Division	Clinical Support Division	Urgent Care Division	Mental Health & Learning Disabilities	Primary Care and Community Division	Families & Therapies	Estates and Facilities Division

Key:	
ABC	QPS groups that sit under the QPS risk governance structure. Divisional Representation
	Groups that feed directly into the overarching Quality Management Group (QMG). Divisional Representation
	Duty of Quality Pillars
	TRR Relationship
	Organisational QPS Risk Reporting Route
	Organisational Hierarchy Risk Reporting Route

Archwilio Cymru
Audit Wales

Eye Care Review – Aneurin Bevan University Health Board

Audit year: 2024

Date issued: August 2025

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Contents

Summary

About this report

1 Eye care services are becoming more important as the UK population ages. An ageing population means there are more incidences of age-related eye conditions, such as cataracts, age-related macular degeneration and glaucoma. Many, if caught early, can often be managed effectively with existing treatments and medicines. But delays can also result in increased risk of harm and irreversible sight loss. As a result of the increased risk of harm, in 2019 NHS Wales introduced the 'Eye Care Measure' which is an approach for prioritising and measuring waiting times based on clinical condition and risk of harm. Ophthalmology waits also continue to be recorded and reported as part of the wider referral to treatment time metrics.

2 In March 2021, Welsh Government published NHS Wales Eye Health Care - Future Approach for Optometry Services. The plan forecasts a long-term growth in the prevalence of major eye conditions over the next 20 years including:

- 47% increase in the numbers of people with age-related macular degeneration;
- 50% increase in the numbers of people having cataracts; and
- 44% increase in the numbers of people living with glaucoma.

3 At the end of May 2025, across Wales, 32,683 ophthalmology patient pathways had waited over a year for treatment and 1,730 over two years, and 20,283 over a year for their first outpatient appointment[1]. The three health boards with the most challenging position in respect of ophthalmology waits are Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg University health boards.

4 Given these challenges Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg University Health Boards committed to work in partnership and launched the 2022-2025 South East Wales Regional Ophthalmology Strategy (the regional strategy). Aneurin Bevan University Health Board is the lead organisation for the regional ophthalmology programme. The Auditor General has included a review of eye care services within his local audit plans for all three health boards.

5 This report sets out the findings of our work at Aneurin Bevan University Health Board (the Health Board). We reviewed local and regional plans to improve eye care services, leadership arrangements to drive improvements and address barriers to progress; and whether the Health Board is actively managing the harms resulting from long ophthalmology waits.

6 The work has been undertaken to help discharge the Auditor General's statutory duty under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to secure the efficient, effective, and economic use of its resources. Our work was delivered in accordance with

[1] Data source: Referral to treatment times, Welsh Government.

INTOSAI[2] audit standards. **Appendices 1 and 2** provide more information about our work.

Key messages

Overall conclusions

7 Whilst the Health Board has been able to reduce its longest ophthalmology waits, it has not met the Welsh Government's planned care recovery targets. Performance against the 'eye care measure' is poor and, as a result, some patients are likely to be coming to avoidable harm.

8 In the context of these challenges, there is a need to strengthen local planning of eye care services, broaden the scope of regional working, secure further productivity and efficiency gains, and strengthen board and committee oversight of ophthalmology services.

Key issues

Regional partnership working

- Delivery of the regional eye-care approach sets out a positive direction of travel. However, it was slow to start and diverges from its original specialist service ambitions by focussing on creating short-term service capacity for cataract procedures.
- The regional cataract approach is targeting long waits, but it is not making a marked difference on overall numbers of patients waiting for treatment.
- Governance arrangements to oversee regional strategy delivery are in place, but the process for decision making on business cases can be slow and cumbersome involving multiple groups across the three Health Boards.

Health Board plans for eye care services

- The current planning approach for local eye care services is fragmented, with unclear ambitions and timescales, and insufficient focus on longer term service needs.
- The Health Board is taking appropriate steps to improve the productivity and efficiency of its eye care services, but it has not yet led to sustained improvements.
- Ophthalmology service capacity remains a concern, with consultant vacancies and a 30% reduction in the ophthalmology medical workforce between March 2021 and March 2025.

[2] International Organisation of Supreme Audit Institutions

Leadership and governance

- There is good executive, clinical and operational leadership that are focussing on driving short-term improvements in eye care services.
- There is insufficient Board and committee oversight of eye care services. In particular, the Patient Quality Safety and Outcomes committee should receive clear assurance on the harms caused as a result of a delay and lessons learnt.
- Risk management arrangements do not adequately cover eye-care risks.

Ophthalmology performance

- While referral to treatment ophthalmology waits over two years have significantly reduced, the Health Board has missed Welsh Government's target for those waiting longer than one year. Since April 2023, waiting lists have grown from around 19,000 waits to over 23,000 waits.
- The Health Board has consistently failed to meet Welsh Government's eye-care measure target. Most recent nationally report performance is 44.3% falling substantially short of the 95% target.

Managing the risk of harm

- While appropriate processes are in place to prioritise ophthalmology waiting lists and to identify and learn from any harm caused by delays, there remains an opportunity to strengthen assurance. Some patients have experienced harm, and reporting at committee level does not consistently capture these incidents or provide assurance on how lessons are being applied to reduce future risk.

Recommendations

9 We have set out recommendations arising from this audit in **Exhibit 1**. The Health Board's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: recommendations

Recommendations
Regional ophthalmology strategy
R1 To increase the pace of delivery, regional partners should speed up decision making processes for agreeing business cases. (**see paragraph 17**)
R2 Regional partners should develop a resource plan, to better understand operational and clinical commitment needed from each partner organisation to realistically deliver each phase of the strategy. (**see paragraph 18**)

R3 Regional partners should agree realistic but appropriately ambitious timescales for the three phases of the South East Wales Regional Ophthalmology Strategy. (**see paragraph 18**)

Health Board plan for eye care services

R4 The Health Board should urgently complete development of its eye care plan, seeking to address current and future challenges. The Health Board should ensure the plan is:

- based on current and projected future demand for services.
- includes capacity plans based on realistically ambitious levels of productivity.
- costed, at a minimum, for the medium term (3-5 year).
- supported by resource plans i.e. financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models.
- supported by clear delivery actions and milestones.
- approved by the Board. (**see paragraph 26**)

R5 Once the eye care plan has been approved by the Board, an appropriate committee should receive at least twice-yearly updates on the plan's delivery, clearly articulating any risks to delivery. (**see paragraph 38**)

Managing eye care risks

R6 The Health Board should review its operational and strategic risk registers to ensure risks related to eye care services are appropriately captured and managed. (**see paragraph 40**)

Managing the risk of harm

R7 The Patient, Quality, Safety Outcomes Committee should receive assurance on:

- how patients on the ophthalmology waiting list are managed to prevent harm;
- lessons learned from actual reviews and how lessons have been applied to strengthen arrangements; and
- actual harm caused by ophthalmology waiting delays. (**see paragraph 54**)

Detailed report

Regional partnership working

10 We considered whether the regional ophthalmology strategy supports the delivery of sustainable ophthalmology services, and whether there are appropriate governance arrangements in place to support its implementation.

11 We found that **while now progressing, delivery of the regional eye-care approach was slow to start and diverges from its original specialist service ambitions by focussing on creating short-term service capacity.**

12 In 2022, Cardiff and Vale, Cwm Taf Morgannwg and Aneurin Bevan University Health Boards launched the 2022-2025 Regional Ophthalmology Strategy (the regional strategy). It responds to key issues from the 2021 Pyott Review[3], including rising demand, limited specialist capacity, and reliance on English providers.

13 The strategy sets out a clear vision for sustainable, high-quality services, with complex care delivered regionally and routine care closer to home. It aims to establish a Regional Centre of Excellence and deliver complex eye care regionally, while less complex care is provided closer to patient's homes.

14 The regional strategy identifies key clinical risks, including sight loss from long waits, rising demand, and workforce shortages. It sets high-level targets for 2023–2025, including expanded cataract and emergency services, a regional vitreoretinal service, workforce development, and plans for a Regional Centre of Excellence.

15 Aneurin Bevan University Health Board is the regional lead for the new partnership approach, with involvement and engagement from its regional partners. The programme is split into three phases with annual milestones, these are:

- by 2023: Regional expansion in capacity for cataracts will be fully utilised, Regional Vitreo Retinal Service will be operational, Regional Eye Casualty and Out of Hours Care will be in place (**Phase 1**).
- by 2024: Research, Innovation and Development will be well established, Workforce Development Programme will be in place (**Phase 2**).
- by 2025: Regional Centre of Excellence network funding will be agreed (**Phase 3**).

16 While governance arrangements to oversee regional strategy delivery are clear, there is a risk that the structure is too complex, causing delays. The Regional Ophthalmology Programme Board meets monthly and is supported by the Delivery and Development Group. Both have clear objectives, effective management, and strong clinical engagement from each health board. The Programme Board reports to the Regional Portfolio Oversight Board, which oversees all regional programmes. In April 2025, the Cabinet Secretary for Health and Social Care instructed the south-east region to further establish a joint regional committee during 2025–26.

[3] External Review of Eye Care Services in Wales (rcophth.ac.uk) undertaken by Andrew Pyott

17 While decisions are being made through the established governance groups, they are also being taken separately by each health board. For example, the business case for regional cataract services required approval at ten different meetings, resulting in delay. The creation of the joint regional committee presents an opportunity to also consider how delegated authority and decision-making processes are streamlined (**Recommendation 1**).

18 Phase 1 of the strategy aimed to expand key regional services by 2023, but overall progress has been slower than planned. The focus on creating regional cataract service capacity was pragmatic because of the waiting list backlog, but slow to progress. Other elements of the regional strategy have also been slower to deliver particularly those set out in phases 2 and 3 above relating to a specialist centre of excellence and research. There are many factors constraining progress. This includes the focus on short-term planning detracting attention from the longer-term priorities, and operational and clinical workforce challenges (**Recommendation 2**). To help better monitor strategy delivery, there needs to be clearer reporting against the original strategy commitments, setting out clear delivery timescales (**Recommendation 3**).

19 It is clear that the new regional arrangements are creating new service activity in addition to the core activity provided by each Health Board. In July 2023, Welsh Government agreed £7 million recurrent funding to deliver the Regional Cataracts Business Case. From a slow start, particularly because of recruitment challenges in the Nevill Hall north hub, the levels of cataract procedures have now increased (**Exhibit 2**).

Exhibit 2: Profiled and actual delivery of cataract procedures facilitated by recurrent Welsh Government funding, by delivery hub

Financial year	Provider		Profiled	Actual
2023-24	South hub		2905	2764
	North hub		39	26
	Regionally outsourced		750	676
		Total	**3694**	**3466**
2024-25	South hub		2049	1930
	North hub		950	846
	Regionally outsourced		1308	1308
		Total	**4307**	**4084**

Source: Aneurin Bevan University Health Board

20 While the regional cataract approach is targeting long waits, it is not making a marked difference on overall numbers of patients waiting across the region. The funding used for regional working is being used to treat patients waiting a long time for cataracts services. However, there are more people on the referral to treatment ophthalmology waiting list now then there was in March 2023. In March 2023, there were 45,930 patients waiting across the region and this increased to 54,977 by 2025. Without the regional investments, the position would have been worse, but the regional arrangements are not yet significantly resulting in reduced overall level of ophthalmology waits.

21 In October 2024, Welsh Government awarded the region a further £7.5 million non-recurrent funding to help reduce the long waits, particularly those waiting more than 2 years. Following Ministerial Advisory Group recommendations, and supported by £19.5 million non-recurrent funding, the region may further increase its use of the independent sector during 2025-26.

22 To support equitable access to treatment, regional capacity has not been distributed equally across the three health boards. Instead, it has been focused on patients who have been waiting the longest. Because the proportion of very long waits are not the same across the health boards, the Welsh Government has provided more regional funding to Cwm Taf Morgannwg University Health Board than the others. This targeted allocation aims to reduce waiting lists in a way that promotes fairness across the region. While this may not appear a 'fair share', it reflects a practical and equitable approach to addressing variation in access across the region. This approach is also supported by a regional booking team, helping to ensure more consistent access to treatment

Health Board plans for eye care services

23 To ensure patients receive timely eye care in an appropriate setting, and prevent avoidable, irreversible harm, it is essential that the Health Board has a clear plan to improve its current, community and hospital-based eye care services and develop a sustainable model of care for the future. We considered whether there are realistic plans to improve eyecare services at a local level, considering whether:

- the Health Board has an agreed plan to improve eye care services, covering hospital and community services, which seek to address current and longer-term challenges; and
- the Health Board's eye care plans have sufficient focus on improving the efficiency and productivity of its services.

24 We found that **the Health Board's planning approach for local eye care is fragmented and lacks clear long-term direction, and while steps have been taken to improve efficiency, these have yet to deliver sustained results.**

Local eye care plans

The current planning approach for local eye care services is fragmented, with unclear ambitions and timescales, and insufficient focus on longer term service needs.

25 The Health Board has a good understanding of the barriers to improving eye care services. These include growing service demand, insufficient workforce capacity and inadequate digital and estates infrastructure. However, the Health Board does not have an overarching eye care plan to guide long-term service improvement and address these challenges. Instead, its eye care priorities are articulated in several plans. These include the Health Board's Annual Plan, the supporting ophthalmology service plan, eye care action plan covering hospital and community eye care, and focused plans such as implementing the Getting it Right First Time (GIRFT) recommendations and Welsh General Ophthalmic Services (WGOS) pathways[4]. Whilst there is crossover between these plans, the current approach is uncoordinated and short-term in nature. The Health Board recognises the need to develop a single eye care plan and is in the early stages of this process.

26 The Health Board has recently developed an eye care action plan. The action plan is aligned to the National Clinical Strategy for Ophthalmology, which was launched in October 2024, mirroring its strategic themes[5]. The Health Board reported that it is in the process of developing an approach to deliver its action plan. Initially it will focus on priority areas, with task and finish groups being established to progress work in these areas. The task and finish groups[6] will report to the Eye Care Board. While this progress is positive, the eye care action plan is high-level, the timescales for delivery are unclear, as are the Health Board's long-term ambitions for eye care services. Given the challenges with ophthalmology waiting times, the Health Board must urgently complete its eye care plan, which should be Board approved, to guide long term, sustainable service improvements (**Recommendation 4**).

27 In the short term, the Health Board's service intentions are effectively shaped by demand, capacity and what can realistically be delivered. Each service, including ophthalmology, completes an annual planning template, which includes high-level demand and capacity planning. This helps the Health Board understand current pressures and plan accordingly. For example, the ophthalmology annual plan compares planned and actual activity, such as referrals, outpatient appointments, and emergency admissions, to adjust plans for the following year and identify capacity gaps.

[4] The WGOS (Wales General Ophthalmic Services) pathway is a structured framework designed to enhance eye care services in Wales.

[5] The strategic themes are organisational reform, clinical networks, pathway transformation and sustainable delivery model.

[6] The task and finish groups are as follows: ophthalmology cataract group, regional ophthalmology delivery and development group, medical retina clinical reference group, estates accessibility group and digital ophthalmology groups.

28 The approach above supports the development of a sustainable eye care plan by providing clearer insight into long-term resource needs. However, the capacity of the ophthalmology service is a concern. The Health Board has had three long-standing vacancies for ophthalmology consultants. Encouragingly, all positions have now been successfully filled; however, two of the appointed consultants are not expected to commence their roles until August 2026. In overall terms the Health Board has seen a 30% decrease in its ophthalmology medical workforce between March 2021 and March 2025[7].

Plans for improving service efficiency

While the Health Board is taking appropriate steps to improve the productivity and efficiency of its eye care services, it has not yet led to sustained improvements.

29 The Health Board's is focussing on improving efficiency and productivity. It aims to increase theatre utilisation, increase cataract surgery productivity and reduce outpatient inefficiencies. It also seeks to optimise optometrist roles by implementing the WGOS pathways and upskilling hospital optometrists. Similar measures are outlined in the Health Board's Annual Plan for the planned care service, which includes ophthalmology. This pragmatic approach supports sustainable services by maximising use of current resources. The hospital and community eye care action plans also address broader barriers, with workstreams targeting waiting times, regional collaboration, workforce development, integrated care, and digital transformation.

30 Despite the past and current focus on productivity and efficiency, there are significant opportunities for improvement. As at 4 August 2025, the theatre utilisation rate for the ophthalmology service was 80% against the Health Board target of 90%, the average late start and early finish theatre rates were 37% and 49% respectively, the short notice theatre cancellation rate was 11.9%, attributable to both the patient and hospital, and the 'Did not Attend rate for new ophthalmology outpatients was 8.4%[8].

31 The report from the Ministerial Advisory Group on NHS Wales Performance and Productivity also makes recommendations to reduce unwarranted variation in treatment waiting times and adopting best practice in theatre management. This includes a recommendation to create Local Theatre Optimisation Boards to boost productivity within theatres, and best practice of cases per theatre session. For ophthalmology this means 10 cataract procedures in a 4-hour theatre session, and 8 procedures if it is a training session. Currently, the Health Board's cataract surgery lists include7-8 patients per list. In June 2025, the service successfully

[7] In March 2021, there were 18 full time equivalent ophthalmology medical staff, compared to 12.5 in March 2025. Data source: Welsh Government medical workforce data.

[8] Data source: Aneurin Bevan ophthalmology referral to treatment compelling scorecard, fiscal week 19. Figures shown are based on a 12-week rolling average.

trialled a 10-patient cataract list, with an improvement plan in place to consistently deliver high-volume lists.

Leadership and governance arrangements

32 Clear leadership and governance arrangements are key to supporting well managed service improvement. We considered whether the Health Board has:

- clear and effective executive, operational and clinical accountability;
- appropriate Board and committee level oversight and scrutiny; and
- appropriate arrangements to capture, manage and oversee operational and corporate risks.

33 We found that **there is good executive, clinical and operational leadership to drive short-term improvements, but there is insufficient Board oversight, and risk management for eye-care services needs improving.**

Operational and clinical leadership

The Health Board has good executive, clinical and operational leadership to drive short-term improvements in eye care services.

34 The Health Board has clear leadership and accountability for its eye care services, with the Chief Operating Officer overseeing both acute and primary care. The ophthalmology service, within the surgery division, is led by a strong triumvirate leadership team. The team is made up of an ophthalmology directorate manager, clinical director and two senior ophthalmology nurses. The service has appropriate executive and operational clinical leadership, who oversee clinical governance, performance, and incidents, while community optometry contracts are overseen by the Primary Care Divisional Lead and a dedicated optometry professional lead.

35 In general, we found good executive and operational oversight of ophthalmology performance. Performance is reviewed routinely through the Health Board's Planned Care Programme Board structure, Chief Operating Officer's directorate performance assurance meetings, surgery directorate meetings and ophthalmology service meetings. Oversight mechanisms tend to focus on improving waiting times and service efficiency and productivity, which are valid but have a short-term focus.

36 The Health Board has re-established its Eye Collaborative Care Board and Eye Care Working Group. The Eye Care Working Group is responsible for overseeing development of the Health Board's overarching eye care plan. This should improve the focus on longer-term service improvements.

Board and committee oversight

There is insufficient Board and committee oversight of eye care services.

37 Board level oversight of eye care services needs strengthening. While various committees receive updates, these are often ad-hoc or embedded within other

reports. This makes it difficult to fully understand the totality of service, quality and performance risks. Ophthalmology is featured within the planned care update of the integrated performance report received by the Finance and Performance Committee and the Board, but ophthalmology performance is not separated. The Patient, Quality, Safety Outcomes Committee receive various reports where ophthalmology is mentioned such as the Primary Care Annual Quality Report and the Putting Things Right Annual Report. Only the Partnership Population Health and Planning Committee receives consistent updates focused on regional ophthalmology work.

38 In June 2024, the Health Board conducted a comprehensive ophthalmology deep dive, but this has not featured in any committee papers, neither have updates against the ophthalmology GIRFT recommendations. Given the level of risk posed by the ophthalmology waiting list, there needs to be a greater level of Board assurance. Once the eye care plan has been approved by the Board, an appropriate committee should receive routine progress updates (**Recommendation 5**).

Risk management arrangements

Risk management arrangements do not adequately cover eye-care risks.

39 Generally, the Health Board's ophthalmology directorate and surgery division risk registers capture operational risks. These include issues with medical equipment, follow-up outpatients over their target dates, retina clinic capacity, estate issues, specialist ophthalmic nursing capacity and difficulties recruiting a cornea specialist. However, we note some fundamental gaps, such as risks related to current gaps in the paediatric and glaucoma ophthalmologist workforce and inadequate digital infrastructure, especially related to the use of Open Eyes electronic patient record. The Health Board should review its ophthalmology service risk register to ensure all risks are adequately managed. The Health Board is currently developing its approach to managing corporate risks.

40 Our 2025 planned care review found that planned care risks, including ophthalmology, are reported to the Planned Care Programme Board. However, there is no Planned Care Programme Board specific risk register, which may result in some risks or mitigating actions not being effectively tracked or prioritised. At Board level, the Health Board's strategic risk register includes several risks which are relevant to ophthalmology, such as those related to maintaining high quality and safe services, and inadequate digital and estate infrastructure. However, there is insufficient focus on the risk of patient harm associated with treatment delays (**Recommendation 6**).

Ophthalmology performance

41 We analysed ophthalmology waiting list performance and trends to determine whether the Health Board is meeting Ministerial priorities and Welsh Government national targets related to reducing long waiting lists. The targets are as follows:

- no one waiting longer than a year for their first outpatient appointment by the end of 2022 (target date revised to December 2023);
- eliminate the number of people waiting longer than two years in most specialities by March 2023 (target date revised to March 2026); and
- eliminate the number of people waiting longer than one year in most specialities by Spring 2025.

42 In addition, ophthalmology services are measured using the eye-care measure. This measures the extent of delay for those patients at most risk of harm because of a delay in treatment. This approach is explained in **Exhibit 4.**

43 We found that **while long waits over two years for ophthalmology have significantly reduced, the Health Board continues to fall short of Welsh Government's targets for the eye-care measure and patients waiting over one year.**

Performance against Welsh Government planned care targets

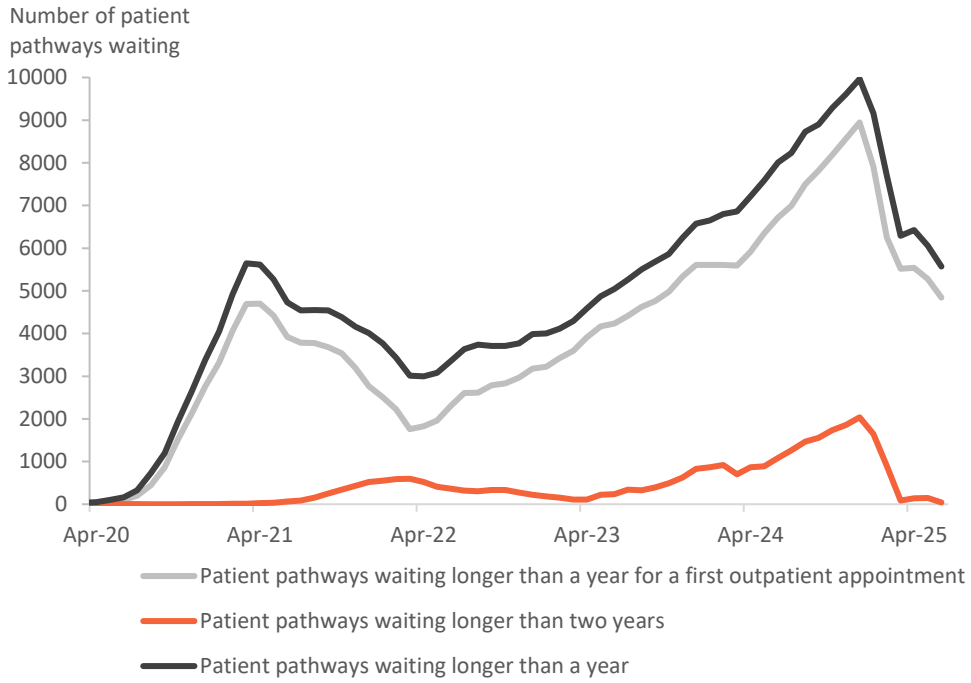
While ophthalmology waits over two years has significantly reduced, the Health Board has missed Welsh Government's target for those waiting longer than one year.

44 **Exhibit 3** shows the Health Board's performance against Welsh Government planned care waiting list targets. In June 2025 the Health Board had:

- 5567 patients waiting longer than a year on the ophthalmology waiting list;
- 4842 patients waiting longer than one year for their first ophthalmology outpatient appointment; and
- 44 patients waiting longer than two years on the ophthalmology waiting list.

45 All three measures have seen a general deterioration since the pandemic. Whilst there has been some improvement from January 2025 onwards, the improvements coincide with additional Welsh Government non-recurrent funding to address long cataract waits. Between April 2021 and April 2025, the Health Board has seen 51% increase in ophthalmology referrals. Overall referral to treatment waits in the last two years has increased from around 19,000 to over 23,000. This growth alongside the long-term trends identified in **Exhibit 3** suggest that the Health Board needs to do much more to address both long waits, and the overall level of waits.

Exhibit 3: the number of ophthalmology patients waiting longer than two years and one year, Aneurin Bevan University Health Board



Source: Referral to treatment times, Welsh Government

Eyecare measure waiting list performance

The Health Board has consistently failed to meet Welsh Government's eye-care measure target, falling substantially short of the 95% target.

46 In addition to the referral to treatment time waiting list, NHS Wales reports patient waits for those who are most at risk of harm because of a delay. **Exhibit 4** provides a basic explanation of this measure.

Exhibit 4: A basic introduction to the eye care measure

Welsh Government introduced the eye care measure to help prioritise those most at risk of harm as a result of a delay in accessing services.

Ophthalmology patients are risk assessed based on their condition and then given a target date to be seen. If a patient who is categorised as the highest risk (R1)[9] waits 25% longer than the clinically assessed target date, then it counts as a breach.

[9] The highest risk is known as Risk Factor 1 or R1. R1 category is for patients that have been assessed as being at risk of irreversible harm or significant adverse outcome should their target date be missed.

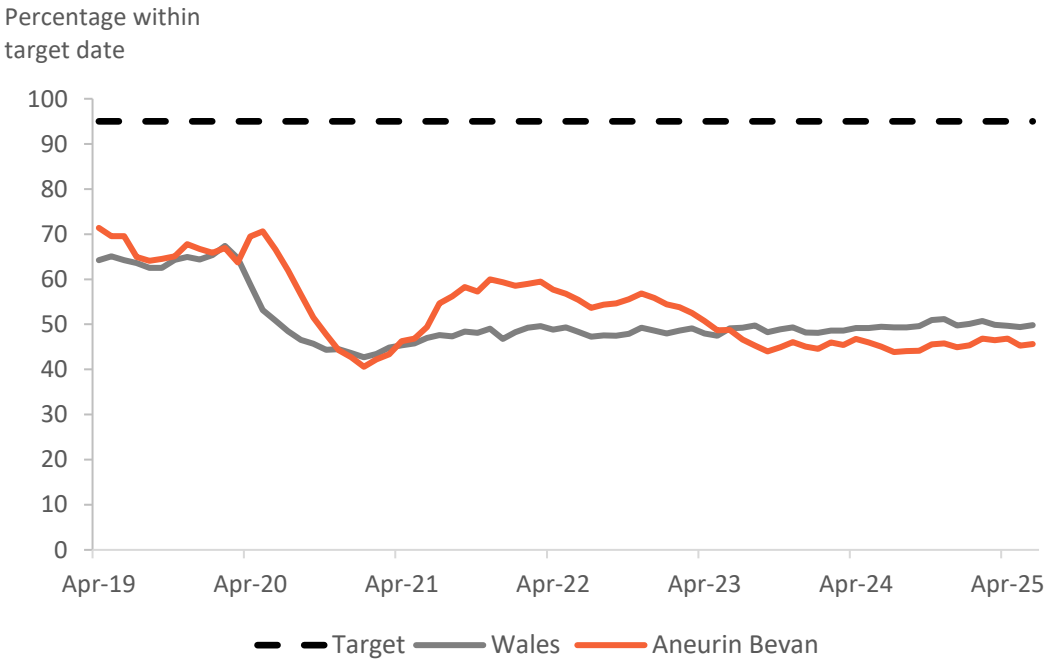
Example: Mrs Jones has wet AMD and has been clinically assessed as needing to be seen in 4 weeks. Mrs Jones waits just over 6 weeks – therefore the target has been breached. Within 5 weeks, this would not have been a breach.

The national target is for 95% of patients on the Eye Care Measure waiting list to be seen by their target date or within 25% beyond their target date.

Source: Audit Wales

47 **Exhibit 5** shows performance against the Welsh Government eyecare measure target. Since July 2023, the Health Board's performance dropped below the Welsh average and has not recovered. In June 2025, performance was 45% against the national target of 95%. Patients identified as Health Risk Factor R1 have an increased potential risk of harm and permanent sight loss.

Exhibit 5: Percentage of eye care patients seen by their target date or within 25% beyond their target date, Aneurin Bevan University Health Board



Source: Eye Care Measure performance, Welsh Government

48 The Health Board's performance against the eye care measure remains a significant concern and means that there is a real and continued risk of patients coming to avoidable harm and suffering irreversible sight loss.

Managing the risk of harm

49 Patients' eye conditions may deteriorate while waiting, causing pain, anxiety, affect their quality of life and ability to work or care for others. It is important that the Health Board actively manages harms associated with long waiting list delays. We considered whether the Health Board:

- has effective processes to record and report on incidence of harm that results from eye care waiting list delays; and
- is taking appropriate action to manage the risk of patient harm, particularly sight loss.

50 We found that **while appropriate processes are in place to prioritise ophthalmology waiting lists and to identify and learn from any harm caused by delays, there remains an opportunity to strengthen assurance. Some patients have experienced harm, and reporting at committee level does not consistently capture these incidents or provide assurance on how lessons are being applied to reduce future risk.**

51 The Health Board has appropriate mechanisms in place to prioritise its waiting list. It uses a risk stratification tool, as recommended by the GIRFT review, to prioritise ophthalmology patients based on clinical need, with R1 patients at highest risk. A separate tool supports glaucoma care decisions, helping to determine whether patients can be managed by community optometrists or require hospital care.

52 Waiting list validation is primarily carried out by validation clerks with clinical input. Some of the validation clerks are relatively new and training is being provided to support more complex case management.

53 The Ophthalmology Service has several processes to identify and review harm. It has invested in a senior nurse dedicated to reviewing current and historic ophthalmology harms recorded on the DATIX system. Regular patient safety meetings and weekly Executive Hub reviews support oversight of serious incidents, some of which may trigger Duty of Candor or Welsh Government's serious incidents process. These reviews help identify learning, shared through forums such as clinical audit meetings and ophthalmology team meetings. They also help correct patient pathways and prioritisation, which may be lost or delayed on the waiting list.

54 The Health Board reported that between July 2024 and July 2025, 10 ophthalmology related incidents involving delays were recorded on Datix. Nine concerning delays in patient assessment and one in treatment. Of these, two were graded as low harm, five as moderate harm, and three as severe harm. We have seen evidence of serious incidence and harm being reported through executive performance reviews, a service specific deep dive and monthly eye care measure reports. While executive and operational oversight arrangements for ophthalmology harms and serious incidents are sound, there is very little reporting of actual ophthalmology harms to the Patient, Quality, Safety Outcomes Committee or assurances that lessons are being applied to reduce the risk of harm in future (**Recommendation 7**).

Appendix 1

Audit methods

Exhibit 6 sets out the methods we used to deliver this work. Our evidence is based on the information drawn from the methods below.

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Regional Ophthalmology Strategy, associated programme management documentation and progress reports. • Local eye care plans (ophthalmology and optometry), delivery/implementation plans and progress reports. • Documentary evidence on the use of Welsh Government funding. • Performance dashboards/reports related to eye care services. • Documents related to programme governance and oversight arrangements related to delivery eye care plans, harms reviews and learning from incidents of harm. • Plans or proposals for insourcing / outsourcing / waiting list initiatives. • Operational risk register(s) for eye care services. • Documents showing procedures, including responsibilities, for clinical assessment of patients on the ophthalmology waiting list.
Interviews	We interviewed the following: • Chief Operating Officer • Deputy Medical Director • Deputy Director of Nursing • Ophthalmology Directorate Manager • Assistant Ophthalmology Directorate Manager • Ophthalmology Consultant and Clinical Director • Senior Nurse Ophthalmology • Senior Interim Nurse Ophthalmology • Assistant General Manager Surgery • Primary Care Divisional Lead • Primary Care Ophthalmology Lead • Consultant ophthalmic surgeon

Element of audit methods	Description
	• Chair of Patient, Quality, Safety Outcomes Committee • Regional Eye Care Programme Lead.
Observations	We observed the South East Wales Regional Ophthalmology Programme Board.
Data analysis	We analysed key ophthalmology service data on: • waiting list performance; • referrals; • medical workforce; • outpatient and inpatient activity and efficiency; • surgical cancellations; and • inpatient and day case admissions.

Appendix 2

Audit criteria

Main audit question: **Does the Health Board have effective arrangements to improve eye care services?**

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
Does the Health Board have realistic plans to improve eyecare services at a regional and local level?	Does the Health Board have an agreed plan to improve eye care services, covering hospital and community services, which seek to address current and longer-term challenges?	• The Health Board has a clear eye care plan, which has been approved at Board level which: – seeks to address current and future challenges with a view to developing sustainable eye care services; and – supports delivery of the Health Board's strategic objectives/priorities and aligns with the ambitions set out in national strategies/plans and legislation. • The eye care plan appropriately reflects regional plans, which the Health Board is invested in, which aim to deliver sustainable ophthalmology services on a regional basis.
	Is the Health Board's eye care plan realistically deliverable?	• The eye plan is supported by/includes a clear delivery plan with clear actions and milestones. • The eye care plan is based on current and projected future demand for services. • Capacity plans are based on realistically ambitious levels of productivity. • The plan is costed, at a minimum, for the medium term (3-5 year). • The plan is deliverable within the resources available to the Health Board.
	Do the Health Board's eye care plans have sufficient focus on improving the efficiency and productivity of its services?	• The Health Board is proactively targeting and improving eye care service efficiency in a range of areas such as reducing DNAs and cancellations in outpatients and surgical settings, improving surgical productivity (particularly cataracts), maximising eye-care theatre list utilisation, and utilising see on symptom and patient initiated follow ups.

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
		• Plans include national and local performance and efficiency measures, and draw upon the work of GIRFT reviews where relevant. • The Health Board is working with others effectively to drive wider efficiency improvements. • The Health Board is making use of digital systems to improve service efficiency. • Use of outsourcing has been considered / implemented as a mechanism to help reduce waiting list backlogs, supported by the necessary considerations of value for money and service safety.
Does the Health Board have appropriate leadership arrangements to drive improvements in eye care services and address the barriers that might inhibit progress?	Are there appropriate governance and leadership structures to drive forward the necessary improvements?	• There is clear Executive and Senior Management accountability for the delivery of eye care improvement plans. • There is clear clinical leadership for the delivery of eye care improvement plans. • There is evidence of operational oversight of the delivery of eye care improvement plans. • There is evidence of oversight and scrutiny of the delivery of eye care plans at the appropriate Committee and at Board. • Risks are appropriately captured within operational and corporate risk registers. • There are escalation mechanisms in place in the event of services failing to meet required standards / targets / milestones.
	Is the Health Board identifying and addressing the barriers to improving its eye care services?	• The Health Board has a clear understanding of the barriers that might prevent it delivering its eye care improvements/improvement plans and intentions. • The Health Board can demonstrate that it is putting in place arrangements to tackle the barriers that could impede delivery of the improvement plans.

Level 2 questions	Level 3 questions	Audit criteria (what good looks like)
	Is the Health Board effectively delivering its improvement plans for eye care services?	• The Health Board can demonstrate that it is making good overall progress implementing eye care plans and initiatives, and the achievement of milestones, targets and outcome measures identified within its plans.
Is the Health Board actively managing the risk of harm resulting from ophthalmology waiting list delays?	Does the Health Board have effective approaches to record and report on incidence of harm that results from eye care waiting list delays?	• The Health Board has appropriate arrangements to identify, capture, and report on harm associated with long waits for eye care treatment: – There is a clear process for identifying and capturing patient harm caused by delays to eye care treatment. – The Health Board is reporting on actual harm caused by delays to eye care treatment to its Quality and Safety Committee. – The Quality and Safety Committee receives assurances that the Health Board is learning from incidence of harm to prevent it in the future.
	Is the Health Board taking appropriate action to manage the risk of patient harm, particularly sight loss?	• The Health Board has an appropriate system to assess patients on the eye care waiting list to ensure those most at risk of sight loss are treated first. • The eye care waiting list is frequently reviewed by a clinician to ensure clinical risks are up to date and correctly prioritised. • The Health Board is managing potential health inequalities in access to eye care services. • The Health Board is applying the principles of Welsh Governments' promote, prevent, and prepare policy to help patents on eye care waiting lists.

Appendix 3

Management response

Exhibit 7 below sets out the Health Board's response to our recommendations.

Recommendation		Management response	Completion date	Responsible officer
R1	To increase the pace of delivery, regional partners should speed up decision making processes for agreeing business cases.	The Regional Joint Committee (RJC) that will come into existence towards the end of 2025 will streamline regional decision making for all regional programmes.	December 2025	Chair of Regional Ophthalmology Programme Board
R2	Regional partners should develop a resource plan, to better understand operational and clinical commitment needed from each partner organisation to realistically deliver each phase of the strategy.	The Regional Programme Plan for 25/26 includes a regional workforce review along with the ongoing demand and capacity reviews for each sub speciality.	March 2026	Chair of Regional Ophthalmology Programme Board

Recommendation	Management response	Completion date	Responsible officer
R3 Regional partners should agree realistic but appropriately ambitious timescales for the three phases of the South East Wales Regional Ophthalmology Strategy.	The Regional Ophthalmology Strategy pre-dates the National Clinical Strategy for Ophthalmology. As a result the Regional Strategy will be reviewed as part of the programme plan in 25/26, with appropriate phasing and timeframes assigned to programme priorities.	March 2026	Chair of Regional Ophthalmology Programme Board
R4 The Health Board should urgently complete development of its eye care plan, seeking to address current and future challenges. The Health Board should ensure the plan is: • based on current and projected future demand for services. • includes capacity plans based on realistically ambitious levels of productivity. • costed, at a minimum, for the medium term (3-5 year). • supported by resource plans i.e. financial, workforce (particularly medical staffing) and infrastructure, reflecting sustainable service models. • supported by clear delivery actions and milestones. • approved by the Board.	The Health Board acknowledges the urgency and importance of completing the Eye Care Plan and is actively progressing work to meet the outlined requirements. The following steps are being taken to ensure the plan is robust, sustainable, and Board-approved: **1. Demand-Based Planning** • The draft Eye Care Plan has been completed. • Ophthalmology capacity and demand modelling takes place yearly, ensuring data remains up to date as service capacity flexes. • The plan is being developed using current service activity data and projected demand modelling, including cataract treatment volumes and outpatient trajectories. • Regional benchmarking and national variation intelligence are being used to inform future service needs. **2. Capacity and Productivity** • Capacity plans incorporate realistic yet ambitious productivity targets, including improvements in theatre utilisation and outpatient throughput. • Initiatives such as the “golden patient” process, interface GP schemes are being scaled to optimise clinical efficiency and the planned insourcing activity with HBSUK.	April 2026	Associate Director of Planned Care

Recommendation	Management response	Completion date	Responsible officer
	3. Medium-Term Costing • Financial modelling has been completed for FY25/26, with further costing underway for a 3–5-year horizon, including sustainability plans for ophthalmology. • Further sustainability plans will be submitted via division by March 2026. **4. Resource Planning** • Workforce plans include confirmed appointments for three ophthalmology consultants (cornea, glaucoma, paediatrics) with start dates through 2026. – Cornea consultant will start 01/09/2025 – Glaucoma consultant has accepted and will start fellowship August 2025 and due to be in post August 2026 – Paediatric consultant has accepted and will start fellowship August 2025 and due to be in post August 2026. • Infrastructure and digital enablers (e.g., E-consent, clinic room booking, theatre system replacement) are being scoped and procured to support service delivery. **5. Delivery Actions and Milestones** • Four key Task and Finish Groups have been established to monitor the workstreams arising from the Eye Care Plan • The Task and Finish Groups meet monthly, with progress updates provided to the Eye Care Board (ECB) on a quarterly basis.		

Recommendation	Management response	Completion date	Responsible officer
	• The Eye Care Working Group and Programme Board have agreed Terms of Reference and are tracking delivery milestones, including pathway redesign and discharge protocols. • Monthly Planned Care Programme Board meetings oversee progress and escalate risks as needed. **Governance and Timelines** The completed draft Eye Care Plan will be further refined and submitted for formal Board approval by April 2026.		
R5 Once the eye care plan has been approved by the Board, an appropriate committee should receive at least twice-yearly updates on the plan's delivery, clearly articulating any risks to delivery.	The Eye Care Plan has now been approved by the Eye Care Board, which meets bi-monthly to review progress against key workstreams. Updates on performance, risks, and mitigation actions are discussed regularly through this forum, ensuring continuous oversight and alignment with Board governance expectations. Once the Eye Care Plan is approved by the Board, the Health Board will ensure that the Finance and Performance Committee receives updates on delivery at least twice a year. These updates will clearly articulate progress, risks to delivery, and any mitigating actions to support transparency and accountability. This will be ensured by adding the Eye Care Plan to the Committee's Forward Work Programme.	April 2026	Associate Director of Planned Care / Director of Corporate Governance

Recommendation	Management response	Completion date	Responsible officer
R6 The Health Board should review its operational and strategic risk registers to ensure risks related to eye care services are appropriately captured and managed.	The Health Board acknowledges the recommendation and is committed to ensuring that risks related to eye care services are appropriately captured and managed within its established governance framework. Ophthalmology risks are managed through the Health Board's Risk Management Framework to support safe, sustainable, and high-quality service delivery. At the operational level, divisional risks - including those related to long waits, workforce shortages, and service pressures are actively monitored and reviewed through directorate and divisional governance structures to ensure timely mitigation and oversight where required. At the strategic level, there are currently no discrete ophthalmology risks recorded on the corporate or strategic risk registers. Relevant issues are reflected within broader strategic risks, such as recruitment and retention across specialties, the adequacy of strategic planning, and the delivery of planned care waiting list targets, which collectively encompass ophthalmology. Specialty-specific risks are owned and managed at the directorate and divisional level, assessed against the Health Board's approved risk appetite and tolerance. This position will be kept under review, with escalation to a corporate ophthalmology risk if thresholds are met. Oversight is maintained through regular reporting to the Eye Care Board and via Directorate and Divisional Assurance meetings.	December 2025	Associate Director of Planned Care

Recommendation	Management response	Completion date	Responsible officer
	The Health Board is further strengthening assurance by: • Ensuring ophthalmology risks are captured and updated within the relevant risk registers. • Providing regular updates on the delivery of the Eye Care Plan to the Finance and Performance Committee, with clear articulation of risks and mitigating actions. • Drawing on learning from harm reviews and best practice to inform a review of long-waiting patients, overseen by the Planned Care Board.		
R7 The Patient, Quality, Safety Outcomes Committee should receive assurance on: • how patients on the ophthalmology waiting list are managed to prevent harm; • lessons learned from actual reviews and how lessons have been applied to strengthen arrangements; and • actual harm caused by ophthalmology waiting delays.	The Health Board acknowledges the recommendation and recognises the need to strengthen assurance on ophthalmology patient safety and waiting list management. The Health Board is committed to ensuring that the Patient Quality, Safety and Outcomes Committee (PQSOC) receives clear assurance on harm prevention, lessons learned, and any actual harm arising from ophthalmology waiting delays. All patient safety incidents in Ophthalmology are assessed via Datix to determine risk and required actions. Any incident resulting in moderate or greater harm triggers a formal harm review, which includes a detailed patient timeline and is assessed using ophthalmology-specific harm criteria. Rapid harm reviews are coordinated by the Quality and Patient Safety (QPS) Team and escalated to the weekly Executive Safety Huddle, ensuring timely oversight and shared learning across the Health Board. Lessons identified from harm reviews are translated into service-level action plans, and shared across the wider clinical team. Thematic	October 2026	Clinical Director for Ophthalmology

Recommendation	Management response	Completion date	Responsible officer
	findings and learning outcomes are reported through Divisional governance, and will form part of the assurance reports to the PQSOC. Through these reports, PQSOC will receive assurance on: The waiting list for initial Ophthalmology appointments is currently being addressed through HBSUK insourcing activity, with the aim of significantly reducing the backlog by the end of the financial year. Early indications show that a good number of patients are being discharged to alternative care pathways, and efforts are being made to target all areas of eye care, noting cataracts are being progressed as part of the regional solution. Additionally, the Patient Initiated Follow-Up (PIFU) initiative is in place as a flexible outpatient care model. This allows eligible patients to arrange hospital appointments themselves when their symptoms worsen, rather than relying on routine scheduling. Together, these activities are part of a broader strategy to minimise harm caused by delays in care and improve patient outcomes. • Lessons learned from harm reviews and how they have been applied, through summaries of completed reviews, resulting actions, and thematic learning. • Any actual harm arising from ophthalmology waiting delays, via aggregated and case-level data from Datix, rapid harm reviews, and formal investigations coordinated by the QPS team and reported through the established governance pathway.		

Recommendation	Management response	Completion date	Responsible officer
	While monitoring and reporting harm remains primarily retrospective and resource intensive this process provides robust assurance of oversight, learning, and continuous improvement. Forward-looking actions, including a bespoke review of long-waiting patients (covering Referral to Treatment and Follow-ups), will further inform PQSOC assurance and strengthen governance around ophthalmology waiting list risks.		

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Audit Wales

Eye Care Review – Aneurin Bevan University Health Board

Recommendation 7 – Managing the risk of harm

Archwilio Cymru
Audit Wales

Background

Current Position:

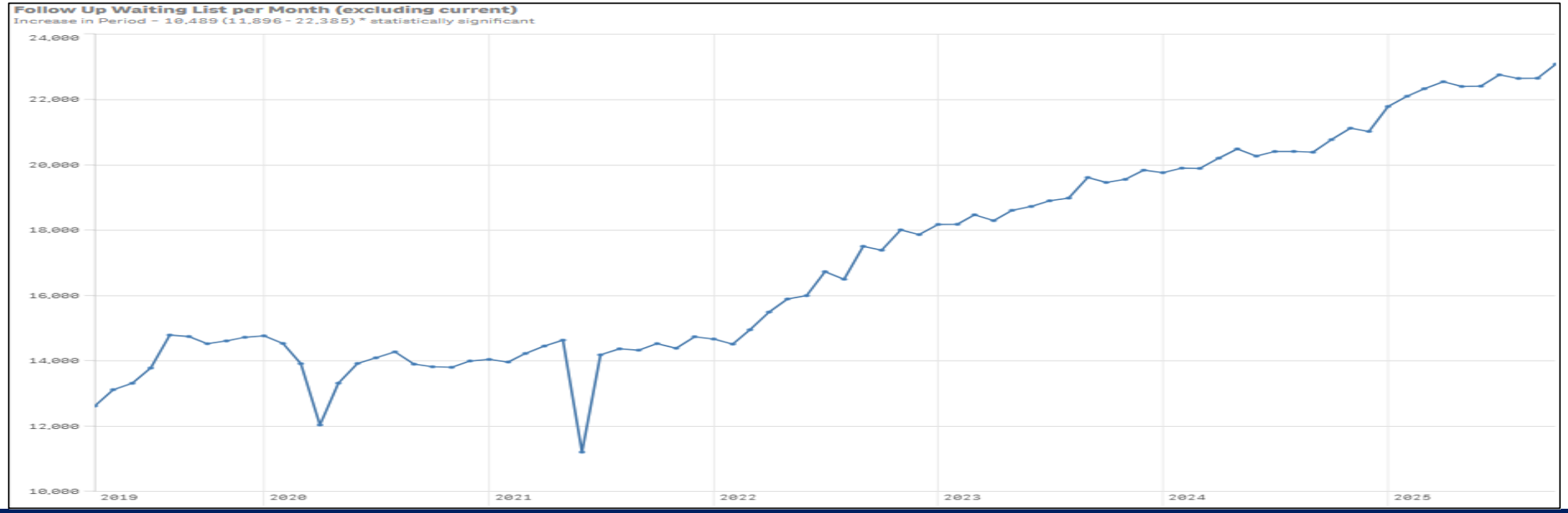
- Ophthalmology services' capacity doesn't meet rising demand
- Covid backlog has left a residual impact
- Waiting lists for new referrals and follow-ups continue to expand
- Delays in accessing specialist care are causing patient harm

Workforce Issues:

- Long-standing consultant shortages with at least 3 WTE vacancies remaining unfilled for a significant amount of time
- Progress now being made:
  - Cornea specialist already appointed
  - Paediatrics and glaucoma specialists due to start in October 2026
  - Middle grade tier now added – 3 WTE in post, further 1 out to advert

Physical Space Constraints:

- Growing challenge as workforce expands
- New non-medical roles and filled senior vacancies increase demand for space
- Limited availability of suitable areas for:
  - Outpatient clinics
  - Diagnostic services
  - Treatment delivery



Harm caused

How Incidents have been managed:
A Datix incident is reported when any patient is suspected of coming to harm because of the delays described.
A senior nurse practitioner is responsible for reviewing each incidents, the patient timelines and pathway is then provided for a consultant harm review.
The All-Wales Ophthalmic Harm Criteria has been used with the whole patient pathway analysed. If moderate or above harm is determined by the harm review the case is escalated and proceeds through the Health Board's Serious Incident Procedure.
A decision was made for all such incidents to be led Corporately and be chaired by Stephen Edwards (Deputy Medical Director) with Clinical Executive sign-off on each individual case.

Summary of incidents
26 Nationally Reportable Incidents have been provided to the NHS Wales Performance and Improvement relating to Ophthalmology treatment and follow up delays between 2023 and 2025 (YTD.
15 of these relate to glaucoma patient's whose care were lost to follow and have been fully investigated and closed with NHS Wales Performance and Improvement.
The thematic review has utilised these 15 closed incidents for the analysis shown in the next slide.
Of the 15 closed investigations, Post investigation harm is 1x low harm, 1x moderate harm, and 13x severe harm. All the investigations were run as Corporately led with executive sign off for all reports.

Thematic Analysis

Main issues	Themes identified
Delayed triaging of referrals from Opticians, due to a lack of Senior Clinical staff to assess referrals and cover the clinics, led to delays in offer of appointment at the Ophthalmic Diagnostic and Treatment Centre (ODTC).	Service Capacity
Demands on ABUHB glaucoma services significantly outstrips the capacity of the service. This resulted in a significant delay in receiving the first outpatient appointment for the investigation of glaucoma.	Technology
Lack of specific risk stratification tool.	Staffing
Clinic lists are cancelled by the schedulers when the consultant is unavailable. The patient then goes back on the list for redating (usually in 4 weeks). Booking staff are administrative and were left to make decisions around deciding which patients should be cancelled for reduced clinics, when capacity not available.	Staff education and training
In one case, a vital piece of equipment was non-functioning, leading to no visual fields testing, and failure to recall or use alternative methods.	Patient empowerment and necessary information to make informed choices
Lack of capacity in nurse led glaucoma clinics.	Documentation sharing and availability.
Use of locum consultants and not glaucoma specialists initiating optimal treatment.	
ODTC capacity does not meet current demand for reviews.	

Lessons Learned

Improvements made
ODTC has discontinued its service, additional resources are being explored through a business case being formulated to the Executive Board.
Diagnostic hub funded by the Health Board became operational in January 2024, running 8 sessions per week.
Recruitment of secondary care optometrists is being focused upon. However, there is a national shortage of qualified staff. Consultant position likely to be filled by summer 2026. 0.8 WTE optometrist has completed diploma in glaucoma. This allows for more senior glaucoma support and open up more sessions to the team. Further NP support has been requested as part of the ODTC cover business case.
The directorate moved around budgeted money to allow for a part-time optometrist to be employed who sees new (and follow-up) glaucoma patients.
New pathway for glaucoma patients went live in November 2024.
A red flag protocol has been developed to ensure that referrals triaged as urgent—either by optometrists or through virtual review—are clearly flagged to the booking team, enabling timely scheduling of high-risk patients. To support this, a retrospective audit was undertaken to assess whether stratification flags are being consistently recognised and acted upon during booking. The findings will inform targeted training and process refinement to strengthen prioritisation and reduce delays.
Review of theatre capacity undertaken to meet increasing demand.
The directorate have implemented inhouse scanning for DCC notes to ensure high risk patients are booked into consultant led clinics in a timely manner with all patient related information available.
Forum installation, a network whereby imaging is stored [electronically] for patients. It has the facility to compare field images (for example) which in turn helps with locating changes and therefore diagnose and treat patients. Forum has successfully been installed in hospital services which has been of huge benefit to patients, however further work to install this into primary care ODTC practices is required.
WG have mandated that all HBs in Wales must have a version of Open Eyes by 31/03/2026. AB project board has been set up with clinical sessions provided for support.
Distinct Subspecialty Pathways has been successfully implemented, enabling clinical and administrative staff to identify specific patient pathways and prevent inappropriate discharges. As a result, high-risk patients can remain under the care of multiple subspecialties, ensuring continuous and coordinated monitoring of their conditions.

Harm prevention

Actions taken to mitigate harm for patients on the Ophthalmology waiting list

- Clerical validation of all waiting lists is ongoing, from pathway management, through to letters to patients ensuring they still require our services.

- A clinical validation is planned to further mitigate potential harm.

- A red flag protocol has been developed to ensure that referrals triaged as urgent—either by optometrists or through virtual review—are clearly flagged to the booking team, enabling timely scheduling of high-risk patients. To support this, a retrospective audit was undertaken to assess whether stratification flags are being consistently recognised and acted upon during booking. The findings will inform targeted training and process refinement to strengthen prioritisation and reduce delays.

- Distinct Subspecialty Pathways has been successfully implemented, enabling clinical and administrative staff to identify specific patient pathways and prevent inappropriate discharges. As a result, high-risk patients can remain under the care of multiple subspecialties, ensuring continuous and coordinated monitoring of their conditions.

Operational Plans

Demand & Capacity Monitoring:

- Directorate works with divisional stakeholders each year to plan safe and sustainable services
- The execution of plans is frequently contingent upon financial support, which is not guaranteed
- Strategies used to bridge funding gaps include:
  - Revising care pathways
  - Using alternative staffing groups
  - Validating existing patient lists

Pathway Management:

- Ensure pathways are fully utilised in Primary Care (WGOS4/5) with new workforce providing admin support
- Appoint non-medical practitioners where possible to strengthen MDT-style working across multi-speciality services
- Align with national priorities via the all-Wales Clinical Implementation Network which include workforce and service-specific projects (e.g., cataracts)
- Regional roll-out has reduced cataract waiting times in SEW region
- Ongoing work to embed a single waiting list and regional pathway approach for equitable cataract services

Operational Plans Continued

A dynamic, overarching action plan for glaucoma services is currently in place, structured around three key strategic themes:

Capacity:

- Additional diagnostic and virtual capacity is needed - ODTC services within Primary Care ended in March 2024. A business case is being developed for Health Board review, proposing a second technician-led diagnostic hub. This proposal includes expanded diagnostic services for glaucoma, medical retina, and corneal care.

Technology:

- A second stratification tool has been implemented to optimize the use of POD-style, multidisciplinary outpatient capacity.
- Open Eyes electronic patient record (EPR) system is scheduled to go live in January 2026.
- Electronic referrals and MS-Form-style templates are now mandatory across services.

Workforce:

- Glaucoma services have been strengthened with the addition of one full-time equivalent (WTE) optometrist.
- Optometry support has also increased across other ophthalmic sub-specialties.
- A second glaucoma consultant has been recruited and is expected to start in October 2026.
- Administrative PODs have been successfully introduced, enabling a single team to manage bookings across the entire glaucoma pathway—enhancing pathway visibility and reducing errors.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	02 December 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Patient Quality, Safety and Outcomes Committee – Review of Committee Forward Work Plan 2025/26
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Governance Support Officer

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Patient, Quality Safety and Outcomes Committee is asked to review the agreed Committee Forward Work Plan appended to this report. The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2025/26 and to enable the Committee to: -

- Fulfil its Terms of Reference;
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- Seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

In line with good governance practice, the Committee has a Forward Work Plan that was developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The Forward Work Plan can therefore

be utilised as a tool for informing and pre-empting Committee business and support the agenda setting process.

To aid the Committee when reviewing its programme of business, the Forward Work Programme captures the timing of when reports are to be submitted, identifies items that have been deferred and captures new requests for reports and enables the Committee to monitor and review its business at each meeting.

During the period the following requests and/or changes to the forward work plan have been included.

Additional items on the Forward Work Plan that were actions from October 2025 meeting and will be presented at December 2025 meeting:-

- Health and Safety Executive report;
- Update on maternity and neonatal services with results of the neonatal culture review and outcomes from the listening events;
- Update on Health and Safety Executive investigations, including the open investigation related to a fall in 2019 and other cases of interest;
- Year 3 Quality Strategy Implementation Plan;
- The Healthcare Inspectorate Wales final report for Pillmawr and Adferiad ;
- Update on Safeguarding level 3 training;
- Ophthalmology Audit Wales Report.

Items deferred on the Forward Work Plan;

- PALS scheme and Organisational Change programme review outcomes report was deferred from December 2025 to February 2026 meeting.
- Development of Committee Annual Programme of Business 2026/27 was deferred from December 2025 to February 2026 meeting.

These changes have been reflected on the updated Forward Work Programme.

Argymhelliad / Recommendation

The Committee is requested to **NOTE** the updated Committee forward work plan as provided in **Appendix 1**.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.

Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Annual Programme of Business for 2025-26

Patient, Quality, Safety and Outcomes Committee

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee's self-assessment for 2023/24
- The Board's Strategic Risk Register; and
- Key statutory, national and best practice requirements and reporting arrangements.

Area of Focus as per the Committee's Terms of Reference:
The scope of the Patient Quality, Safety and Outcomes Committee encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on: a. The robustness of the Health Board's Clinical Quality Governance arrangements; b. the experience of patients, citizens and carers ensuring continuous learning; c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services; and d. the effectiveness of arrangements in place to support Improvement and Innovation.

Where required, the Committee will provide accurate, evidence based (where possible) and timely advice to the Board in respect of citizen experience and the quality and safety of directly provided and commissioned services.

MATTERS TO BE CONSIDERED	Lead	Frequency of Report	QTR 1		QTR 2	QTR 3		QTR 4
			31st March	3rd June	29th July	1st Oct	2nd Dec	17th Feb
Attendance and Apologies	Chair	SI	√	√	√	√	√	√
Declarations of Interest	All members	SI	√	√	√	√	√	√
Minutes of the Previous Meeting	Chair	SI	√	√	√	√	√	√
Action Log and Matters Arising	Chair	SI	√	√	√	√	√	√
Development of Committee Annual Programme of Business 2026/27	Chair & DoCG	AN	√				**√D**	√
Review of Committee Programme of Business 2025/26	Chair	SI	√	√	√	√	√	√
Annual Review of Committee Terms of Reference 2025/26	Chair & DoCG	AN	√					√
Annual Review of Committee Effectiveness 2025/26	Chair & DOCG	AN	√				**√D**	√
Outcome of Annual Review of Committee Effectiveness 2025/26	Chair & DOCG	AN	√					√

Committee Annual Report 2024/25	Chair & DOCG	AN	√					
Committee Annual Report 2025/26	Chair & DOCG	AN						√
Committee Risk Report	DOCG	SI	√	√	√	√	√	√
NHS Wales Joint Commissioning Quality Committee Report	DOCG	SI	√	√	√	√	√	√
Quality Annual Report 2024/25	DoN	AN				√		
Quality Management System and Assurance Framework Annual Review	Clinical Executives	AN	√					√
Quality Outcomes Reporting	DoN /MD & DOTHS	Quarterly	√ **Interim**	√ **Q4**	√ **Q1**	√ **Interim**	√ **Q2**	√ **Q3**
Primary Care Quality Report	COO	Bi-AN				√		
Quality Management Group Reporting, including escalation through Quality Management System	DoN	SI	√	√	√	√	√	√
Healthcare Inspectorate Wales Annual Report	DoN	AN	√					
Healthcare Inspectorate Wales Reviews	DoN	As reported						
Commissioning Assurance Framework Annual Review	Clinical Executives	AN		√				
Commissioning for Quality Outcomes Report	Clinical Executives	Bi-An	√			√		
Putting Things Right Annual Report 2024/25	DoN	AN				√		

Maternity and Neonatal Report	DoN	Bi-An			**√D**			√
Learning from Death Report	MD	Bi-AN			√	√		√
Listening and Learning Framework Annual Review	DoN	AN	√					
Serious Incident Learning Report	DoN	AN					√	
Health and Safety Compliance Annual Report	DoT&HS	AN			**√D**	√		
Safeguarding Annual Report	DoN	AN			√	√		
Ward Accreditation Report	DoN	AN					√	
Nurse Staffing Levels (Wales) Act 3-year report (3-yearly)	DoN	AN					√	
Nurse Staffing Levels Wales Act Annual Assurance Report	DoN	AN				√		
Annual Report on Clinical Audit Activity 2024– 2025	MD	AN		√				
Mortuary Incident action plan **PQSOC 0306/11**	COO	Action					√	
Update on development of local audit plans and funding arrangements	MD	Action					√	

PQSOC 0306/12								
HSE Report (For Information) **PQSOC 0110/06**	DoT&HS	Action					√	
Update on maternity and neonatal services, including results of the neonatal culture review and outcomes from the listening events **PQSOC 0110/06**	DON	Action					√	
Update on Health and Safety Executive (HSE) investigations, including the open investigation related to a fall in 2019 and other cases of interest. **PQSOC 0110/15**	DoT&HS	Action					√	
PALS scheme and Organisational Change programme review outcomes. **PQSOC 0110/06**	DON	Action					**√D**	√
Year 3 quality strategy implementation plan **PQSOC 0110/07**	DON	Action					√	
The Healthcare Inspectorate Wales final report for Pillmawr and Adferiad **PQSOC 0110/08**	DON	Action					√	

Update on Safeguarding level 3 training **PQSOC 0110/11**	DON	Action					√	
Ophthalmology Audit Wales Report	DON	Add 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
DoT&HS	Director of Therapies & Health Science
DoW&OD	Director of Workforce & Organisational Development
DoN	Director of Nursing
MD	Medical Director

DOD	Director of Digital
Chair	Chair

Frequency of Inclusion	
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item
An	Annual
1/4ly	Quarterly
BI	1/2 yearly
Schedule of Meetings	
√	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