Patient Quality, Safety & Outcomes Committee

Wed 08 April 2026, 09:30 - 12:00

Microsoft Teams

Agenda

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Draft Minutes of the last Meeting held on 17th February 2026

Attached *Chair*

PQSOC 20260408 1.4 PQSOC 20260217 Minutes.pdf (18 pages)

1.5. Committee Action Log

Attached *Chair*

PQSOC 20260408 1.5 Committee Action Log.pdf (5 pages)

2. ITEMS FOR DISCUSSION

2.1. Planned Care - Orthopaedics / Impact of Bone Cement Shortage

Presentation *Chief Operating Officer*

PQSOC 20260408 2.1 Planned Care - Orthopaedics - Impact of Bone Cement Shortage.pdf (3 pages)
PQSOC 20260408 2.1 Appendix 1 - Planned Care - Orthopaedics-Impact of Bone Cement Shortage.pdf (4 pages)

2.2. Quality Outcomes Report

Attached *Director of Nursing*

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PQSOC 20260408 2.2 Quality Outcomes Click App report.pdf (8 pages)

2.3. Quality Management Group Report

Attached *Director of Nursing*

PQSOC 20260408 2.3 Quality Management Group Report.docx.pdf (4 pages)
PQSOC 20260408 2.3 Quality Management Group Report- appendox 1.pdf (4 pages)

2.4. Learning from Death Report

Attached *Medical Director*

- PQSOC 20260408 2.4 Learning from Death Report .pdf (6 pages)
- PQSOC 20260408 2.4 Learning from Death Report - Appendix 1.pdf (61 pages)

2.5. Deep Dive into National Reportable Incident processes and performance

Attached *Director of Nursing*

- PQSOC 20260408 2.5 Deep Dive into National Reportable Incident processes and performance.pdf (7 pages)

2.6. Unplanned Caesarean Sections Data

Attached *Director of Nursing*

- PQSOC 20260408 2.6 Unplanned Caesarean Sections Data.pdf (6 pages)

2.7. WRP Penalties and Learning Compliance: Update on Health Board Improvement

Attached *Director of Nursing*

- PQSOC 20260408 2.7 WRP Penalties and Learning Compliance.pdf (7 pages)
- PQSOC 20260408 2.7 WRP Penalties and Learning Compliance - Appendix 1 - WRP Penalties 2024-25 2025-26.pdf (3 pages)
- PQSOC 20260408 2.7 WRP Penalties and Learning Compliance - Appendix 2 - WRP Penalties Summary for Chairs.pdf (4 pages)

2.8. Committee Risk Report

Attached *Director of Corporate Governance*

- PQSOC 20260408 2.8 Committee Risk Report.pdf (5 pages)
- PQSOC 20260408 2.8 Committee Risk report - Appendix 1 - Risk Dashboard and Assessments.pdf (7 pages)

3. FOR INFORMATION

3.1. Review of Committee Programme of Business 2026/27

Attached *Director of Corporate Governance*

- PQSOC 20260408 3.1 Review of Committee Forward Work Plan 2026-27 Report.pdf (4 pages)
- PQSOC 20260408 3.1 Appendix 1 - Forward Work Plan 2026-27.pdf (7 pages)

3.2. Committee Annual Report 2026/27

Attached *Director of Corporate Governance*

- PQSOC 20260408 3.2 Committee Annual Report 2026-27.pdf (30 pages)

4. OTHER MATTERS

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

Oral *Chair*

4.2. Any Other Urgent Business

Oral *Chair*

4.3. Date of the Next Meeting: 2nd June 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	Tuesday 17th February 2026, 13:30am-16:00pm
VENUE	Microsoft Teams

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

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

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

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

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

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

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

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

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

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	into community and domiciliary care settings. JW advised that quality metrics included community services and that close working existed with local authority partners, community nursing teams and care homes, although further joint working opportunities remained. Paul Deneen (PD), Independent Member, raised questions regarding hospital-acquired thrombosis rates and physical assault data. Seema Srivastava (SS), Medical Director, advised that preventable thrombosis rates remained stable and that further analysis was underway to better understand contributory factors. PC advised that further work would be undertaken to analyse physical assault data, including whether incidents related to repeat individuals or specific wards, and this would be brought back to the Committee. **Action: Director of Allied Health Professions & Health Science** The Committee was advised of the key areas of ongoing focus, including PTR compliance in divisions of medicine and surgery, antimicrobial stewardship, safeguarding capacity, statutory training compliance, timely isolation of infected patients, and improving the quality and consistency of data reporting through enhanced use of dashboards and statistical process control. Helen Cunningham (HC) Independent Member, asked about funding for MARAC and JW explained that the safeguarding team were continuing to support the work which was so important. Seema Srivastava (SS), Medical Director, responded to Helen Cunningham's question about the high antimicrobial prescribing rates in some General Practices. SS explained that there was an antimicrobial working group that was addressing this problem in areas of primary care and working with Neighbourhood Care Networks. The Committee **NOTED** the report.
PQSOC 1702/07	**Quality Management Group Reporting** Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Quality Management Group (QMG) Report. JW advised that the QMG continued to receive detailed assurance reports from divisions, alongside consideration of corporate quality and safety themes, and that these matters were reflected appropriately within the report.

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	Helen Sweetland (HS), Chair, advised the Committee that she had attended the most recent QMG meeting and confirmed that the report provided to the Committee represented a comprehensive and accurate record of the discussions held. HS highlighted that there had been strong engagement from divisions and that the QMG seems to function effectively as a key assurance forum within the Health Board's quality governance structure. HS drew particular attention to the emerging issues relating to legal services and redress matters referenced within the QMG discussions. HS suggested that this area warranted further consideration by the Committee at a future meeting, given the potential implications for assurance and governance. JW agreed that a more detailed report on redress and the Legal and Financial Exposure Review (LFER) process could be brought back to the Committee for discussion. **Action: Director of Nursing** The Committee **NOTED** the Quality Management Group Report.
PQSOC 1702/08	**Maternity and Neonatal Report** Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the annual Maternity and Neonatal Report that gave a forward-looking overview of quality, performance and improvement activity across both services. The Committee was advised that the complexity of women presenting to maternity services had increased, with a consequential impact on neonatal care. The caesarean section rate had risen to just under 50%, which reflected both increased clinical complexity and a sustained increase in the number of women choosing to give birth at the Grange University Hospital following the closure of a midwifery-led unit after public consultation. The Committee noted that this change in case mix had influenced the proportion of unplanned and emergency caesarean sections. In relation to workforce, JW advised the Committee that both maternity and neonatal services were in a strong position. Neonatal services were fully recruited, and maternity services were slightly over-recruited, representing a significant improvement from previous years when midwifery vacancies had been a concern. Both services were managing acuity within their existing workforce. JW highlighted the positive role of parent

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

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

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

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

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

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

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	infrequently mentioned in the report and hoped that this would be addressed in future reports as it is a multi-professional directorate. JW reminded the Committee that Maternity and Neonatal teams have to regularly submit data to national audits MBRACE and the National Neonatal Audit Network. No major concerns have been highlighted through this benchmarking. The Committee was advised that both maternity and neonatal services had established improvement plans, which had been regularly reported through governance structures, and that recent focused improvement work continued to be embedded. The Committee requested a further update on neonatal services at the next meeting, including progress on the 'listening exercise' and the lessons learned activity and the outcome of the recent national review. **Action: Director of Nursing** The Committee **NOTED** the report.
PQSOC 1702/09	**PALS Scheme and Organisational Change Programme Review Outcomes** Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the outcomes for the two-year review of the Patient Advice and Liaison Service (PALS) Scheme and its alignment with the Organisational Change Programme. The Committee was advised that the review had been undertaken to assess whether the original assumptions underpinning the establishment of the PALS service had been achieved. JW confirmed that the majority of objectives had been met and that the service had become a visible and valued point of contact for patients, families and carers. However, 1 key assumption had not been realised, the expectation that PALS would enable a reduction in the resource requirement for the Putting Things Right (PTR) team. While PALS had successfully resolved concerns early, it had largely engaged with a different cohort of individuals, many of whom would otherwise have raised concerns informally with clinical teams rather than entering the formal PTR process. JW advised the Committee that very few PALS cases had escalated to formal PTR complaints, demonstrating the effectiveness of early resolution. However, due to existing complaint backlogs and the complexity of forthcoming

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

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

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

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

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

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

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	need to be assessed once the new arrangements were operational, but that there was potential for PALS to play a central role in supporting early resolution. The Committee recognised the strong qualitative benefits of the PALS service, particularly in improving the experience of patients and relatives and providing a consistent, compassionate point of contact for a wide range of queries and concerns, not necessarily related to the PTR process. The Committee acknowledged that it was difficult to quantify the benefits of the work of PALS. The Committee **NOTED** the report.
PQSOC 1702/10	**Healthcare Inspectorate Wales (HIW) Reports Update** Jennifer Winslade (JW), Director of Nursing, provided the Committee with an update on the Healthcare Inspectorate Wales (HIW) inspection activity and the Health Board's approach to monitoring and assuring progress against HIW recommendations. The Committee was advised that HIW inspections generated formal recommendations which required timely and effective action. JW advised that Audit Wales had previously highlighted the need for strengthened assurance and governance arrangements to ensure that actions arising from inspections were consistently monitored, delivered and evidenced. The purpose of the update was therefore to provide assurance to the Committee regarding progress. JW advised the Committee that following each HIW inspection, divisions were required to develop improvement plans detailing actions to address recommendations. Historically, reporting of progress had been fragmented, making it difficult to assess overall delivery and emerging risks. In response to Audit Wales recommendations, the Health Board had implemented a more robust and transparent approach to monitoring. The Committee was advised that the Assurance Monitoring and Tracking (AMAT) system was now being used as the central platform for tracking all HIW-related actions. This enabled clearer visibility of progress, supported escalation where actions were overdue, and provided a consistent assurance framework for both divisional and corporate oversight.

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	JW advised the Committee that there had been good progress in addressing actions arising from recent HIW inspections and that work requested by Welsh Government was progressing as expected. JW confirmed that the majority of actions were either completed or on track, with outstanding actions subject to active monitoring through governance structures. JW proposed that, to strengthen assurance, the Committee should receive regular scheduled updates, rather than ad hoc reporting. It was suggested that a formal update on HIW actions should be provided to the Committee twice yearly, enabling the Committee to maintain oversight of progress, themes and risks across inspection activity. **Action: Committee Secretariat** During discussion, the Committee welcomed the improved visibility provided by AMAT and supported the move towards more structured and routine reporting. The Committee noted the importance of ensuring that learning from HIW inspections was shared across services and embedded into quality improvement activity. The Committee **NOTED** the HIW Reports Update.
PQSOC 1702/11	**Putting Things Right Regulations Update** Rhiannon Price (RP), Senior Quality and Patient Safety Manager, presented an update on forthcoming changes to the Putting Things Right (PTR) regulations and the introduction of the Listening to People framework, which was scheduled to replace the current statutory PTR guidance from 1st April 2026. The Committee was advised that the changes followed a Welsh Government review and public consultation undertaken in early 2024, which had identified several challenges within the existing PTR system. These included concerns regarding communication, compassion, timeliness, transparency, and an excessive focus on process rather than a person centred approach. The revised framework aimed to create a more open, responsive and learning focused system, placing patients and families at the centre of the concerns process. RP outlined the key features of the new framework. These included a mandatory "listening conversation" for all concerns, to be undertaken at the outset via telephone, virtual or face-to-face discussion, led by the needs and preferences of the complainant. This was intended to

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

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

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

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

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

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

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

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

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

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

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

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

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	update on progress with these new regulations later in the year. **Action: Director of Nursing** The Committee **NOTED** the report.
PQSOC 1702/12	**Maindiff Court Mental Health Inspection report** Jennifer Winslade (JW), Director of Nursing, provided an overview of the report on recent Healthcare Inspectorate Wales (HIW) inspection of Maindiff Court, focusing on Ty Skirrid Ward, a 15-bed male mental health rehabilitation unit. The Committee was advised that the inspection was an unannounced visit conducted from 6th to 8th October 2025, with the final report published on 15th January 2026. The inspection had considered patient experience, safe and effective care, and leadership and workforce arrangements. JW summarised the positive findings from the inspection. HIW reported strong therapeutic relationships between staff and patients, with interactions described as respectful, calm and supportive. Relational security was highlighted as a particular strength, alongside effective multidisciplinary team (MDT) working. The ward benefitted from consistent occupational therapy and psychology input, and care and treatment plans were found to be appropriate and aligned with Mental Health Act requirements. Leadership and governance arrangements were described as effective, with a stable workforce and clear escalation routes within the division. The Committee was advised of the areas for improvement identified by HIW. These included the need to strengthen documentation, particularly in relation to recording offers of advocacy and ensuring community care and treatment plans were uploaded promptly to the Welsh Clinical Information System. Inspectors also identified environmental limitations associated with the age of the building, including restricted space, the need for additional vision panels to support patient observation and sleep hygiene, and improvements to storage and laundry facilities. Estates related issues were therefore recognised as a constraint to further improvement. JW advised the Committee that HIW had identified 23 actions across 13 improvement areas, of which 18 actions had already been completed, with the remaining actions in progress and subject to ongoing monitoring. 1 immediate safety issue relating to medication had been addressed at

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	the time of inspection, with the outdated medication removed promptly. During discussion, Penny Jones (PJ), Vice Chair, welcomed the largely positive inspection findings and congratulated staff on their performance, particularly given the challenges posed by the ageing environment and the unannounced nature of the inspection. PJ noted that staff morale appeared positive and that patient experience had been described favourably. PJ raised a question regarding the inspection finding relating to night time staffing, where only one registered nurse was routinely on duty, and asked how this concern would be addressed. JW advised the Committee that staffing models and night time skill mix were being considered as part of wider mental health service reviews and pathway redesign work, and that this issue would continue to be monitored through divisional governance structures. The Committee **NOTED** the report.
PQSOC 1702/13	**Report on recent Health Safety Executive (HSE) intervention at Hafen Deg Ward, including the actions taken and the closure of the investigation** Peter Carr (PC), Director of Allied Health Professions & Health Science, provided an overview of the Health and Safety Executive (HSE) intervention at Hafen Deg Ward, an older adult mental health inpatient ward at County Hospital, and the actions taken to address the findings. The Committee was advised that the HSE had undertaken a routine inspection in June 2025, focusing on the management of risks associated with challenging behaviour. The inspection had identified material breaches of health and safety legislation, and a Notification of Contravention was issued to the Health Board in July 2025. In response, the Health Board had developed a comprehensive improvement action plan, co-produced by the Corporate Health and Safety Team and the Mental Health and Learning Disability Division. PC emphasised that divisional ownership of the action plan had been central to ensuring effective implementation and that the learning from the inspection had been applied beyond Hafen Deg Ward to other older adult mental health units across the Health Board. PC reported that the HSE had undertaken a follow-up visit in September 2025, during which further

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	recommendations had been made to strengthen the improvement plan. The key actions taken were summarised under the main themes identified during the inspection. In relation to absconding risk and environmental security, security checklists had been strengthened to ensure fire escape doors and push bars were fully operational. A new gate and fencing had been installed to ensure that patients exiting via fire escapes remained within a secure external area. Additional environmental risk assessments had been embedded into routine ward safety checks, with particular attention given to climbing risks within the garden area. Regarding violence and aggression management, the Committee was advised that the number of personal alarms available on the ward had been increased, and routine testing of alarms had been incorporated into the security nurse role to ensure reliability and availability at all times. PC outlined improvements to observation practice and therapeutic engagement. The mental health observation policy had been revised and ratified in December 2025, with refresher training rolled out across the division. Documentation standards had been improved to ensure observations were recorded at the actual time undertaken, rather than rounded times. Work had also commenced to explore the use of electronic devices to support real time recording and reduce reliance on paper documentation. In respect of clinical risk documentation, the use of the Wales Applied Risk and Research Network (WARN) risk assessment and associated care and treatment plans had been reviewed. The Audit Management and Tracking system had been used to assess the quality of care plans and environmental standards. As a result of this work, Hafen Deg Ward had achieved bronze accreditation in December 2025, reflecting measurable improvements in quality and safety. PC advised the Committee on restrictive intervention training, confirming that the curriculum for positive management of violence and aggression had been reviewed to ensure it was appropriate for older adult patients, particularly in relation to frailty. Care plans had been updated accordingly, and training compliance was being monitored through divisional quality and patient safety governance arrangements.

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	The Committee was advised that, following completion of the improvement actions, the HSE formally wrote to the Health Board on 2nd December 2025, confirming that the identified material breaches had been fully complied with and that the investigation was closed. During discussion, Penny Jones (PJ), Vice Chair, advised the Committee on the follow up visit undertaken in January 2026, noting that staff reported feeling safer and more supported as a result of the changes implemented. PJ highlighted that minor residual issues, including cleaning of staff facilities, had been identified and were being addressed. The Committee welcomed the positive staff feedback and the improved ward environment and acknowledged the significant work and progress made by the teams. The Committee **NOTED** the report.
PQSOC 1702/14	**Committee Risk Report** Rani Dash (RD), Director of Corporate Governance, provided the Committee an overview of the Committee Risk Report, which outlined the current strategic risks delegated to the Patient Quality, Safety and Outcomes Committee for oversight on behalf of the Board. The report confirmed that the risk environment had remained stable since the previous update, apart from a revised risk score for SR005 due to increase likelihood of problems with patient flow. During discussion, Penny Jones (PJ), Vice Chair, raised a question in relation to the Health and Safety risk, noting that the risk remained rated as high. PJ queried whether the wording and framing of the risk continued to accurately reflect the current position and asked whether the narrative should be revisited in light of ongoing work and recent assurance activity. RD advised the Committee that the Health and Safety risk had been subject to several discussions at Board level. RD confirmed that, while there had been areas of improvement and strengthened assurance, the Board had previously agreed that the risk should remain rated as high given its breadth, regulatory implications and potential impact. Peter Carr (PC),Director of Allied Health Professions & Health Science, confirmed that although there have been improvements, work was ongoing to improve the engagement of staff with health and safety issues.

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

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PQSOC 1702/17	**NHS Wales Joint Commissioning Quality Committee Report** NHS Wales Joint Commissioning Quality Committee Report was provided to the Committee for information.
PQSOC 1702/18	**Pharmacy and Medicines Annual Report** Pharmacy and Medicines Annual Report was provided to the Committee for information.
PQSOC 1702/19	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** The Committee considered which matters from the meeting required escalation or formal notification to the Board and other relevant committees and agreed to escalate the following: • The risks associated with the implementation of the Listening to People complaints framework, including the absence of additional funding, potential capacity constraints and the impact on compliance and delivery. • Ongoing Health and Safety risk considerations, to ensure continued Board-level oversight of regulatory and workforce safety issues.
PQSOC 1702/20	**Any Other Urgent Business** There was no urgent business.
PQSOC 1702/21	**Date of the Next Meeting:** 8th April 2026

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
February 2026	**PQSOC 1702/06**	**Quality Outcomes Report** Further work would be undertaken to analyse physical assault data, including whether incidents related to repeat individuals or specific wards, and this would be brought back to the Committee.	**Director of Allied Health Professions & Health Science**	April 2026	**Completed** March update Action has been included in the Committee forward work plan. This would be an oral update under the Committee action log item at April's meeting. Update: Data on violence and aggression incidents (involving staff and public) will be analysed to identify trends around repeat perpetrators and location of incident. This analysis will be

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					incorporated (were relevant and useful) in the routine quality reports that include Health & Safety data.
February 2026	**PQSOC 1702/07**	**Quality Management Group Reporting** A more detailed report on redress and the Legal and Financial Exposure Review (LFER) process could be brought back to the Committee for discussion.	**Director of Nursing**	April 2026	**Completed** March update Action has been included in the Committee forward work plan. This had been included on the agenda for April's meeting under item 2.7.
February 2026	**PQSOC 1702/08**	**Maternity and Neonatal Report** A further review of the unplanned caesarean sections data and additional information on the increase of unplanned	**Director of Nursing**	April 2026	**Completed** March update Action has been included in the Committee forward work plan.

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		caesarean sections to be brought to the Committee.			This had been included on the agenda for April's meeting under item 2.6
February 2026	**PQSOC 1702/08**	**Maternity and Neonatal Report** A further update on neonatal services at the next meeting, including progress on listening and lessons learned activity and the forthcoming national review	**Director of Nursing**	April 2026	**Completed** <u>March update</u> Action has been included in the Committee forward work plan. Agreed at the agenda setting meeting that the update would be present to Board in March's meeting.
February 2026	**PQSOC 1702/10**	**Healthcare Inspectorate Wales (HIW) Reports Update** Regular scheduled updates on HIW reporting was agreed for twice yearly.	**Committee Secretariat**	April 2026	**Completed** <u>March update</u> Bi annual updates has been included in the Committee forward work plan.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

ACTION LOG

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2026	**PQSOC 1702/15**	**Development of Committee Annual Programme of Business 2026/27** Pharmacy and Medicines Annual Report to be included in the 2026/27 Forward Work Plan to ensure appropriate Committee oversight of medicines safety and related quality assurance.	**Committee Secretariat**	April 2026	**Completed** March update The Pharmacy and Medicines Annual Report has included in the Committee forward work plan.
February 2026	**PQSOC 1702/11**	**Putting Things Right Regulations Update** The Committee requested an update on progress with these new PTR regulations later in the year.	**Director of Nursing**	April 2026	**Completed** March update Action has been included in the Committee forward work plan for June 2026.

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

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:**	08 April 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Bone Cement
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Leanne Watkins
SWYDDOG ADRODD: **REPORTING OFFICER:**	Matt Temby, Deputy Chief Operating Officer

Pwrpas yr Adroddiad **Purpose of the Report**
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The presentation provides an update of bone cement supply across NHS Wales as of 2 March 2026, showing the varying stock positions and resilience levels of each Health Board following the global Palacos shortage.

Cefndir / Background

It visually reflects how different organisations were balancing existing Palacos stock with the introduction of Zimmer as an alternative, highlighting the collective system response, distribution progress, and readiness to maintain trauma activity and restart elective cemented procedures once supply stabilises.

Asesiad / Assessment

The slide outlines the timeline and key developments in the national and local response to the Heraeus Palacos bone cement shortage affecting orthopaedic services across NHS Wales in February–March 2026.

It captures three main areas:

1. **National Situation & Early Response (19–20 Feb)**
    - A global shortage of Palacos bone cement is confirmed.
    - National IMT is established to coordinate supply.

- Trauma surgery is prioritised; elective cemented arthroplasty is paused.
- Zimmer Biomet cement is quickly identified and approved as an alternative.
- ABUHB contributes to national stock reporting and starts ordering replacement stock.

2. Stock Position & Distribution (20–27 Feb)

- Zimmer confirms strong UK supply; stock is distributed from Bridgend.
- ABUHB orders c.450–550 boxes for GUH, RGH and OSU.
- Local approach: use Zimmer for trauma and Palacos for electives until supply stabilises.

3. Clinical Assurance & Restart of Elective Work (23 Feb – 2 Mar)

- National clinical consensus (500 clinicians) agrees no evaluation period required.
- Elective work restarted 2 March.
- Consultants asked for familiarity and trials were planned on local lists.

Argymhelliad / Recommendation

The Committee is asked to note the context surrounding the Bone Cement issue and to recognise the comprehensive actions taken to manage the situation. While the final slide outlines the specific impact for the Health Board, it is important to highlight that the issue was proactively and effectively managed by all professionals involved.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2. Safe Care 2.1 Managing Risk and Promoting Health and Safety 3. Effective Care
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	Choose an item. Choose an item. Choose an item. Choose an item.

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

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

Bone Cement

Patient, Quality, Safety and Outcomes Committee

8th April 2026

Bone Cement Shortage: Overview

1. National Situation & Early Response (19–20 Feb)

- Global Heraeus Palacos shortage confirmed; trauma prioritised; elective cemented arthroplasty paused.
- WG establishes national IMT, begins stock coordination; alternative supplier (Zimmer Biomet) identified and approved.
- ABUHB contributes to national stock reporting and confirms ordering of Zimmer cement.

2. Stock Position & Distribution (20–27 Feb)

- Zimmer assures strong UK-wide stock; first shipments arrive in Bridgend for onward distribution.
- ABUHB orders ~450–550 boxes; stock allocated across GUH, RGH, OSU.
- Local plan: **Zimmer for trauma**, **Palacos for elective**, pending stability.

3. Clinical Assurance & Restart Decisions (23 Feb – 2 Mar)

- 500 clinicians nationally agree no evaluation period needed; elective surgery restart from **2 March**, supply dependent.
- Consultants request hands-on familiarity; trials planned on lists (MK etc.).

Key Issues, Discussions & Actions Taken

4. Operational & Clinical Issues

- Surgeon hesitancy initially slows trials; feedback indicates good handling but longer set times.
- Cost pressure & higher wastage flagged for Zimmer Refobacin; WG to review.
- Need to reinforce central procurement messaging due to rep contact in theatres.

5. Monitoring & Reporting

- Internal stock & wastage monitoring cycle established (bi-weekly).
- National reporting deadlines accelerated; ABUHB contributes data on cancellations, 104-week impacts.

6. Actions Taken (ABUHB)

- Daily touchpoints established.
- Stock levels consolidated nationally; logistic planning aligned with Pharmacy & Procurement.
- Operational plan maintained: maximise non-cemented activity; protect trauma; prepare electives to restart.
- Feedback loop with WG maintained (handling times, trial updates, surgeon experience).

ABUHB Position as of 2/3/26

Health Board	Indicator	19/02/2026	20/02/2026	21/02/2026	22/02/2026	23/02/2026	24/02/2026	25/02/2026	26/02/2026	27/02/2026	28/02/2026	01/03/2026	Total	
Anuerin Bevan	Total Activity Planned	0	47	3	0	42	34	40	23	48	4	5	246	
	Total Elective Activity Delivered		35	0		33	28	34	19	39	3	5	196	
	Total Activity Cancelled/Postponed due to cement issue		12	3		9	6	6	4	9	1	0	50	20.3% of Total Cancelled
	Cancellations from 104+ week cohort due to cement issues		6	1		7	4	2	1	6	1	0	28	11.4% were 104+ cohort

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

DYDDIAD Y CYFARFOD:	08 April 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Update on the development of an analytics platform (Qlik) for Quality and Patient Safety data
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade – Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Kye Smith – Deputy Head of QPS Leeanne Lewis – Assistant Director of QPS Tracey Partridge-Wilson – Deputy Director of Nursing

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

Cefndir / Background

The organisation has historically relied on multiple systems and manual processes to produce quality and performance reports. This has created several challenges:

- Data is extracted from different sources at different times, leading to inconsistencies; Manual compilation increases the risk of error and reduces transparency;

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- Limited analytical tools make it difficult to explore trends or understand variation.
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RLDatix data (feedback and incident modules) has been available but not easily combined with operational or performance data.

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

Asesiad / Assessment

Purpose of the Report

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

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

Background and Current Position

The organisation has historically relied on multiple systems and manual processes to produce quality and performance reports. This has created several challenges:

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Challenges and Risks without an Integrated Analytics Platform

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

Development of the Qlik Sense Analytics

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

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

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

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

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

Alignment with Strategic Priorities

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

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

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

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

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

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

Benefits Realisation and Adoption

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

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

Next Steps

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

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

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

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

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

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

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

Conclusion

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

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

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

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

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

Argymhelliad / Recommendation

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

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

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):	Governance, Leadership and Accountability 3.1 Safe and Clinically Effective Care 6.3 Listening and Learning from Feedback 3.2 Communicating Effectively
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Choose an item.

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

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	08 April 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**QMG Highlight Report**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade (Executive Director of Nursing)
SWYDDOG ADRODD: **REPORTING OFFICER:**	Kye Smith

Pwrpas yr Adroddiad **Purpose of the Report**
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper presents the bimonthly Quality Management Group (QMG) Assurance Report to the Patient Quality, Safety and Outcomes Committee (PQSOC). The report summarises how the Health Board is overseeing and managing the 6 Pillars of Quality, and related statutory responsibilities.

The Quality Management Group is a formal sub-group of the Executive Committee and is required to provide regular, structured assurance to PQSOC on whether effective systems are in place to keep patients safe, learn from harm, and improve care quality across the organisation. This report covers the QMG meeting held on 16 March 2026 and reflects the key risks, assurances, improvement actions and escalation issues discussed.

Cefndir / Background

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

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

- Reviewing intelligence from across all clinical divisions and corporate functions

- Monitoring patient safety incidents, complaints, safeguarding and regulatory findings
- Scrutinising quality improvement delivery and assurance systems
- Identifying risks that require escalation to executive or board level

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

Asesiad / Assessment

The Quality Management Group (QMG) considered a wide range of information at its March 2026 meeting and was able to provide overall assurance that arrangements to monitor, manage and improve quality and patient safety across the Health Board remain in place and are functioning as intended. The Group reviewed evidence from all divisions and relevant corporate services, covering patient safety incidents, complaints, safeguarding, infection control, quality improvement and regulatory requirements. This provides confidence that there is active oversight of key quality risks and that concerns are identified and addressed through established governance processes.

The Group received strong assurance in relation to how the Health Board reviews care and learns from deaths. The Learning from Deaths six-monthly report confirmed there was no evidence of widespread or systemic unsafe care, and this position is supported by additional independent scrutiny through the Medical Examiner system, which now reviews almost all deaths. Together, these arrangements provide assurance that potential concerns are being identified, reviewed appropriately and used to support learning and improvement, rather than indicating underlying failings in care quality.

Assurance was also noted in relation to improvement activity across wards and services, with progress continuing on ward accreditation and the development of quality improvement capability across divisions, despite ongoing operational pressures over the winter period.

Across individual service areas, QMG was able to take assurance by exception that known risks are being actively managed. In Mental Health and Learning Disabilities, steady progress has been made with accreditation and a significant reduction in overdue risk assessments. In Family and Therapies, including maternity and neonatal services, assurance was received regarding safety and clinical standards, with high levels of compliance in key areas, although some workforce and demand-related pressures remain under active review. In Medicine, Primary Care and Urgent Care, pressures related to patient flow, capacity and demand continue to present risks, but these are well understood, regularly reviewed and subject to agreed actions and senior oversight.

Alongside this positive assurance, the Group identified a small number of cross-cutting risks that require continued attention at executive and committee level. These include the scale and pace required to safely introduce the Call for Concern model across the organisation, the complexity and timeliness of patient safety incident processes, and gaps in compliance with national training requirements for medication safety. QMG agreed that these issues are not new but represent areas

where improvement programmes need stronger coordination, clear resourcing and ongoing monitoring to ensure they deliver safely and consistently.

Finally, the Group recognised emerging risks linked to new national requirements and uncertainty outside the Health Board's direct control. These include the introduction of new complaints legislation from April 2026, where final confirmation of national regulations had not yet been received, and the absence of a nationally coordinated approach to introducing new syringe driver documentation. These risks have been formally captured, are being managed through established governance routes, and will continue to be escalated as necessary to ensure the Committee and the Board are sighted on potential impacts and required actions.

Argymhelliad / Recommendation

The Committee is asked to receive and note the Quality Management Group Highlight report and to consider whether the level of assurance provided is sufficient. Where necessary, the Committee may wish to seek further explanation or reassurance about how the highlighted risks are being managed and whether additional action or escalation is required.

The Committee is also asked to note the role of the Quality Management Group in providing system-wide oversight of quality and safety on behalf of the Health Board, and the importance of this assurance in maintaining public trust and confidence in how services are governed and improved.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
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. Not applicable to this report

QMG ASSURANCE REPORT

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

KEY ESCALATION AND DISCUSSION POINTS

ALERT

Alert	Action	By whom	Target Date
Call for Concern implementation risk – scale, resourcing and Tier 2 ward response	Pilot completed and presented to QMG. Health Board-wide programme required to determine priority status and enable safe, phased implementation with appropriate governance and resourcing. Delivery and capacity risks escalated to the Executive Team and PQSOC.	Leeanne Lewis / Jonathan Lloyd-Evans	April 2026
Patient Safety Incident process complexity and timeliness	Implement phased PSI redesign including daily 10@10 huddles and rapid review model	Kye Smith / Gemma Couch	Q1 2026
Medication Administration Record (MAR) training non-compliance with national policy	Mandate MAR training via ESR; update Medicines Policy to align with All-Wales MAR requirements	Jonathan Simms / Workforce / QPS	May 2026
CSCI syringe driver chart rollout without coordinated HB implementation	Agree Health Board-wide ownership, training and implementation plan; escalate nationally if required	Jonathan Simms / Executive Medical Director	Immediate

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

•Learning from Deaths six-monthly report confirms no evidence of systemic unsafe care; 2026/27 improvement plan required and aligned to existing programmes.
•Qlik analytics platform Phase 1 complete (DATIX integration); Duty of Candour dashboard and rate-based metrics (per 1,000 bed days / population) in development.
•Quality Improvement operating model proposed: ABCi coaches aligned to divisions with development of QI leads and expanded coaching capacity.
•HBS UK 26-week outpatient programme delivered significant waiting time reductions but identified quality, safety and governance issues requiring formal closure and national learning.
•Safeguarding demand increasing, particularly children; SBAR to be escalated to Executive Team with training compliance improving but non-attendance risk noted.

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

• **Learning from Deaths Report** - Mortality surveillance and targeted specialty deep dives demonstrate no systemic quality failures or unsafe care.

•Medical Examiner system now provides near-universal independent review of deaths, offering strong independent assurance.

•Ward accreditation and Quality Improvement maturity progressing across divisions despite sustained winter pressures.
•No current infection outbreaks; measles oversight group re-established in response to national risk.
•**MH&LD** - Steady progress in ward accreditation (multiple Bronze, one Silver, one pending audit). Safe Discharge Standards steering group established. Datix harm grading review completed; overdue risk assessments reduced by ~70%. No risks escalated. Suicide prevention work to return to QMG.
•**F&T** - Positive assurance on maternity and neonatal safety. Fetal surveillance compliance high (midwifery 97%, obstetrics 91%). Neonatal mortality stable (amber). LAC assessment backlog remains a risk with recovery plan. Neonatal medication safety training an improving position. Cross-divisional Mental Health linkage required for recent safeguarding concern.
•**Medicine** - Operational pressures remain the dominant risk, including boarding in decommissioned areas. PTR backlog addressed through directorate workshops. Violence and aggression incident on A4 under active management. Two PSIs progressing appropriately.
•**CSS** - Update by exception. HSDU incident under PSI investigation. Pathology sample errors from primary care noted. Radiology Datix closure delays persist. HTA actions including mortuary CCTV improvements and discussions are taking place between the Mortuary and Works and Estates.
•S**urgery** - Key risks include QPS Lead vacancy, PTR backlog and glaucoma demand. HIW visit to D2E resulted in immediate NEWS actions now completed. Strong accreditation progress with several areas approaching Gold.
•**Primary Care** - Risks include system pressure from bed capacity and lack of national coordinated rollout of new CSCI syringe driver charts, JS to consider next steps for implementation/ risk management. Safe to Start initiative provides assurance. Falls increased but early improvement seen following education.
•**Urgent Care** - Flow and capacity pressures remain significant. Risks around maintaining Trolley 27 availability persist. Ambulance handover processes amended following PSIs.

Increasing attendances of high-risk young people require closer Mental Health collaboration.

Risks discussed or identified:

- Call for Concern delivery risk – resourcing, scalability and Welsh Government timelines.
- Variation in NEWS2 response and visibility of deterioration monitoring data at ward/divisional level.
- Medicines safety training non-compliance against national MARRS policy and Medicines Policy update required.
- Defibrillator equipment faults and phased replacement programme risk.
- PTR complaints backlog (Surgery, Medicine & F&T).
- Listening to People (new complaints legislation) official confirmation of regulation changes not received despite coming into affect on 01 April 2026, creating a risk of non-compliance.

Matters for the Board or other committees:

- Call for Concern implementation model, resourcing and delivery timescales
- Patient Safety Incident process redesign and assurance model
- MAR training compliance and Medicines Policy alignment
- HBS UK 26-week outpatient programme – quality governance lessons learned
- Escalating child safeguarding meeting demand

MEETING AGENDA ITEMS

Update on the development of an analytics platform (Qlik) for Quality and Patient Safety data	Learning from Deaths Report	Proposal: Plan to enable Quality Improvement (QI) aligned to Divisional priorities
Patient Safety Incident Proposal	Call 4 Concern Pilot Results and Next Steps	Sepsis Safety Netting Leaflets

Attendees	
Jennifer Winslade (Chair)	Executive Director of Nursing
Peter Carr	Executive Director of Allied Health Professions & Health Science
Tracey Partridge-Wilson	Deputy Director of Nursing
Kye Smith	Deputy Head of Quality & Patient Safety
Leeanne Lewis	Assistant Director Quality & Patient Safety
Gemma Couch	Head of Quality Patient Safety & Learning
Jonathan Simms	Clinical Director of Pharmacy
Tanya Strange	Head of Nursing – Person-Centred Care
Trish Chalk	Assistant Director of Planning and Performance
Helen Ronchetti	Deputy Head of Infection Prevention & Control
Collette Kiernan	Deputy Director of Allied Health Professions & Health Science

Jo Hook	Senior Nurse - Patient Experience and Involvement
Natalie Skyrme	Divisional Nurse – Medicine
Karen Collins	Head of Nursing – Medicine
Deb Jackson	Divisional Nurse – Family & Therapies
Donna Challingsworth	Deputy Head of Nursing - Surgery
Aimee Holden	Deputy Head of Nursing – Surgery
Joanne Lane	Divisional Nurse – Primary Care & Community
Chris Morgan	Divisional Nurse – Urgent Care
Jonathan Clarke	Consultant – ENT
Stephen Edwards	Deputy Medical Director
Lilia Delgado	Deputy Head of Health, Safety and Fire
Susan Palmer	Head of Research Delivery

In Attendance to Present	
Jonathan Lloyd-Evans	Consultant Intensivist – ICU / Call for Concern Lead
Rachel Trask	Head of Quality Improvement
Julie Poole	Corporate Services (HBS Report)
Rachel Trask	Head of Quality Improvement

Apologies	
Seema Srivastava	Executive Medical Director
Rob Holcombe	Executive Director of Finance
Craig Roberts	Assistant Director of Allied Health Professions & Health Science
Rebekah White	Divisional Nurse – Clinical Support Services
Helen Sweetland	Independent Member
Jayne Beasley	Head of Midwifery, Gynaecology & Neonates
Rebekah White	Divisional Nurse – Clinical Support Services
Amy Buckley	Divisional Nurse – Mental Health & LD
Moira Bevan	Head of Infection Prevention & Control
Rani Dash	Director of Corporate Governance
Scott Taylor	Head of Health, Safety and Security
Kelly Downes	Deputy Director of Nursing
Tracy Daszkiewicz	Executive Director of Public Health
Amanda Hale	Divisional Nurse – Surgery and Clinical Support Services
Karen Hatch	Assistant Director of Allied Health Professions & Health Science

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	08 April 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Learning from Deaths Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr Seema Srivastava, Executive Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

Cefndir / Background

Aneurin Bevan University Health Board provides care from birth through to end of life. While most patients receive excellent care in the period leading up to their death, there are occasions where the quality of care does not meet expectations. These instances often involve multiple contributory factors, the identification of which can highlight system-wide issues requiring improvement.

In Wales, all deaths are now subject to independent scrutiny by the Medical Examiner (ME) Service, hosted by NHS Wales Shared Services Partnership. The ME Service reviews all deaths not referred to the Coroner, providing an additional layer of assurance.

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

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

Asesiad / Assessment

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

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

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

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

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

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

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

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

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

Next steps

To strengthen the Health Board's approach to learning from deaths, a series of strategic actions are proposed across governance, digital integration, clinical coding and targeted reviews.

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

- Clinical coding remains a critical factor in the accuracy of mortality data. The Health Board will continue its coding improvement programme, with a particular focus on addressing resource gaps and standardising the depth of coding. This will ensure that mortality indicators such as RAMI are reliable and reflective of actual patient risk.
- Receive the next Learning from Deaths report, incorporating full-year trend analysis and the updated RAMI 2023 narrative.

Fostering a culture of learning is vital. This includes promoting the dissemination of insights through newsletters, audit cycles, and divisional Quality and Patient Safety (QPS) meetings.

Argymhelliad / Recommendation

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

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

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

Effaith: (rhaid cwblhau)

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

Learning from Deaths Report

MORTALITY DATA AND NARRATIVE REPORT
April 2025 – September 2025

Introduction

Learning from Deaths Report:
This report provides assurance that Aneurin Bevan University Health Board continues to strengthen its approach to learning from patient deaths, embedding a culture of continuous improvement, transparency, and accountability.
The Learning from Deaths Report presents mortality data across three tiers: Health Board, Division, and Directorate, enabling a comprehensive and systematic view of mortality trends and associated learning.

Framework Implementation and Assurance
Since the previous reporting period (July 2024 – March 2025), the Learning from Deaths Framework has been disseminated across all Divisions to support consistent engagement in the review of patient deaths. The framework underpins a robust ward-to-board assurance process, enabling structured reporting and executive oversight of mortality data.
The framework supports triangulation of condition-specific mortality trends with insights from the Medical Examiner system, ensuring that learning is evidence-based and aligned with governance and regulatory expectations. This approach strengthens organisational oversight and supports a consistent methodology for identifying and responding to potential areas of concern.

Assurance Through Reporting and Governance
The Learning from Deaths Report consolidates all identified learning and provides assurance that the organisation is systematically reviewing deaths, identifying themes, and implementing improvements. The report is submitted to the Quality Management Group and subsequently to the Patient Quality, Safety and Outcomes Committee (PQSOC) on a six-monthly basis, ensuring sustained executive oversight, transparency, and accountability for actions arising from learning.

Aneurin Bevan University Health Board Mortality Framework

Tier 1	Risk Adjusted Mortality Index (RAMI)	ABUHB Crude Mortality Data	All Cause Mortality Data

External Controls	
	Medical Examiner Service Scutiny
	His Majesty's Coroners Processes

Tier 2	Surgery Division	Clinical Support Services	Medicine Division	Urgent Care Division	Primary Care & Community (Including Complex Care)	Family & Therapies Division	Mental Health & Learning Difficulties Division
Internal Mortality Control	M&Ms	M&Ms	M&Ms	M&Ms		PRUDIC	Concise & Comprehensive Reviews
Tier 3	Surgery Division	Clinical Support Services	Medicine Division	Urgent Care Division	Primary Care & Community (Including Complex Care)	Family & Therapies Division	Mental Health & Learning Difficulties Division
	30-Day post elective surgery inpatient mortality	Local mortality measures	Stroke mortality	ED attendance	Local specific mortality	Maternal mortality	Suicide (inpatient and population measure)
	30-Day post non-elective surgery inpatient mortality		Cardiology/MI			Perinatal Motaliity/ 1000 births	Learning disability deaths
						Still birth/1000 births	Drug related death panel
National Audit	NHFD National Cancer Audits	NELA	Cardiology - MNAP		NACEL	Maternity & Neonatal Board	NCISH
		ITU - ICNARC	Stroke - SSNAP			MBRRACE	
						NMPA	

Introduction

Structured Mortality Reviews

- The mortality framework reinforces the Health Board’s commitment to undertaking structured mortality reviews. These reviews are critical in identifying problems in care, extracting learning, and implementing targeted improvements. This structured approach ensures that learning is not only identified but is translated into measurable actions that enhance patient safety and quality of care.

- This report also demonstrates a surveillance exercise undertaken collaboratively with Public Health, involving clinician-led review of deaths. This exercise confirms that a robust and reproducible methodology exists to support more detailed review where required. It has been agreed that, for the purposes of this reporting period, this one-off deep-dive exercise provides sufficient assurance, as detailed in the accompanying report.

- At present, detailed mortality reviews are primarily undertaken by the corporate team. Due to current coding and data maturity limitations, it is essential that mortality indicators are sufficiently robust before extending detailed case-note reviews across additional clinical specialties. There remains an expectation that mortality review forms part of the Health Board’s end-to-end governance processes, including morbidity and mortality review arrangements within clinical services.

- The Health Board continues to work closely with its external software provider (CHKS) to improve understanding of mortality outliers and to strengthen the triggers for deep-dive review. This partnership aims to enhance the timeliness, accuracy, and reliability of mortality intelligence, further strengthening assurance and supporting more targeted review where required.

Mortality Outliers Review- Surveillance Exercise with Public Health

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

Key Findings

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

Mortality Outliers Review- Surveillance Exercise with Public Health

Assurance from Datix and Medical Examiner Review

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

Key Risks Identified

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

Overall Conclusion

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

Recommendations

- The Health Board now has a robust and tested method of assurance for the surveillance of deaths should this type of review be required again. However, it is not considered proportionate or necessary for this to be undertaken as a routine annual exercise.

- To strengthen ongoing assurance and learning, as part of the Learning from Death report, the Health Board will ensure:

  - Targeted mortality outlier reviews, where specific concerns or signals arise, rather than as a standing annual process.

  - Continued linkage with the Coding improvement programme, to strengthen coding accuracy and specialty attribution, ensuring mortality data is interpreted fairly and appropriately.

  - Maintaining focus on existing Learning from Deaths, mortality reviews and governance processes, which provide more meaningful insight into quality of care and opportunities for improvement.

Learning from Deaths – Focused Mortality Reviews

- The focus of this Learning from Death's report cycle has been to undertake detailed specialty-level deep dives into mortality indicators, rather than high-level thematic reviews. This approach was designed to: interrogate crude mortality data in greater depth, identify learning, variation, and emerging trends, assess whether there are any systemic or underlying quality concerns and provide assurance to the Board and Committees regarding standards of care.

- A total of 270 Deep dives (case notes reviews) were undertaken across Anaesthetics (44 cases) Gastroenterology (73 cases) (including Endoscopy (9 cases)), and Respiratory Medicine (144 cases), covering high-volume and high-mortality cohorts.

- The Medical Director's Quality and Patient Safety team, conducted case-level reviews against mortality indicators that were high. Themes for the notes reviews included: assessing preventability, recurrent clinical or organisational themes, data quality and coding accuracy, consistency in escalation, advance care planning, and documentation and considered the impact of coding and consultant attribution on mortality interpretation to avoid misleading conclusions

Key Findings and Learning

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

SYSTEM-BASED ISSUES IDENTIFIED

1. Coding & Data Integrity

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

2. Escalation & Deterioration Systems

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

3. Interface Failures Between Services

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

4. End-to-End Pathway Design Gaps

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

5. Treatment Availability / Process Reliability

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

ORGANISATIONAL ISSUES IDENTIFIED

1. Capacity & Flow

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

2. Communication & Family Liaison

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

3. Consultant & Team Ownership

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

4. Clinical Documentation & Governance

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

5. Workforce & Operational Pressures

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

Learning from Deaths – Focused Mortality Reviews

Based on the depth and breadth of the reviews undertaken:

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

Conclusion

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

Areas to highlight

Tier 1: Health Board-Level Mortality Data and Assurance

- This report still presents mortality data across the Health Board.
- Tier one provides assurance at the Health Board level, highlighting performance, trends, and actions taken to strengthen mortality surveillance and learning.
- For the period April 2025 to September 2025, the Health Board's Risk Adjusted Mortality Index (RAMI) 2019 stands at 88.4, showing a positive improvement from 100.3 from the previous Learning from Death report. This positions the Health Board as the 3rd best-performing Health Board in Wales within its peer group, providing a strong indicator of quality and safety performance.
- While RAMI values fluctuate, crude mortality rates have remained stable, offering further assurance of consistent care delivery. To enhance understanding of areas with higher mortality, the Health Board is developing detailed individual mortality reports. These will support targeted reviews and learning.

RAMI is a key performance indicator that adjusts mortality rates based on patient risk factors. Its reliability is dependent on the quality of clinical coding. Between April and September 2024, 9.3% of consultant episodes remained with an uncoded Primary diagnoses, although 100% of deaths were coded. A targeted clinical coding improvement programme is underway to address this and enhance data accuracy.

Areas to highlight

Tier 3: **Directorate level Data**:

All monitored mortality indicators have shown improvement compared to the previous reporting period, and there are no concerns requiring escalation.

- **Emergency Department Admitted Mortality**: Performance remains better than peer comparators, providing assurance of effective acute care pathways.
- **30-Day Inpatient Mortality – Myocardial Infarction (MI)**: Reduced to 0.8%, down from 2.6% last year, indicating improved clinical outcomes and timely interventions.
- **30-Day Inpatient Mortality – Stroke**: Currently at 7.2%, a slight improvement from 8.%. This remains lower than the All-Wales peer value of 11.7%, reaffirming the Health Board's position as the lowest in Wales for this indicator.
- **Elective Surgery Mortality (within 30 days)**: Currently a rate of 0.01%, compared to 0.0%. There have been 2 recorded deaths for this reporting period.
- **Non-Elective Surgery Mortality (within 30 days)**: Improved to 1.1%, down from 1.2% last year, and remains below the All-Wales peer value of 1.5%, reflecting robust perioperative care and risk management.
- **Clinical Engagement and Learning**: Ongoing collaboration with Clinical Leads continues to enhance understanding of mortality themes and trends. Divisions have contributed examples of learning and improvement, which are detailed in the appendices, supporting a culture of continuous improvement.
- **Forward Assurance Planning**: Work is underway with Divisions to establish meaningful metrics for regular review. This includes the implementation of standardised agendas featuring targeted mortality indicators at Directorate level, strengthening governance and assurance mechanisms.

Areas to highlight – Medical Examiner Reviews

- The Medical Examiner (ME) Service provides independent scrutiny of all deaths not referred to the Coroner, offering a critical layer of external assurance for Aneurin Bevan University Health Board. Medical Examiners are employed by NHS Wales Shared Services Partnership and are independent.
- This structural separation ensures independence from local clinical teams and reduces the risk of bias in the scrutiny of deaths. Each death is reviewed to:
  - Confirm the accuracy of the medical cause of death
  - Assess the circumstances surrounding the death
  - Identify any potential concerns about care or treatment
  - Capture and consider the views and concerns of bereaved families
  - This independent review functions as an external check on the quality and safety of care provided.

- Since full implementation in 2024, including community deaths, all deaths now undergo initial Level 1 screening, ensuring no case is excluded from review. While only a proportion of cases progress to panel or formal investigation, every referral is reviewed to determine the appropriate pathway and avoid duplication.

- Where concerns are identified, cases are proportionately escalated through structured governance routes, including Mortality Review Panels, Serious Incident processes, and specialty reviews. Analysis of ME referrals shows that the majority of deaths reflect good standards of care, with learning largely focused on system and organisational issues rather than unsafe clinical practice.

- Overall, the ME process provides strong assurance that all deaths are independently scrutinised, family concerns are heard, and any identified risks or learning are appropriately managed through robust governance arrangements.

Areas to highlight – Medical Examiner Reviews

Analysis of ME referrals demonstrates that:

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

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

Progress update

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

Areas of development

1. Governance and Assurance Framework

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

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

2. Divisional Ownership and Reporting

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

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

3. Directorate Ownership

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

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

4. Targeted Reviews and Thematic Learning

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

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

Areas of development

5. Digital Integration and Data Maturity

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

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

6. Clinical Coding Quality

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

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

7. Embedding Learning and Culture Change

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

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

8. Equity, Inclusion and Bereavement

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

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

Conclusion

- This Learning from Deaths report provides clear and credible assurance that the Health Board continues to review deaths in a structured, proportionate and meaningful way, with a strong focus on learning and improvement rather than counting deaths alone.

- With a surveillance deep dive in partnership with Public Health and a focus on Tier Three reviews, the vast majority of deaths demonstrated good standards of care, with very limited evidence of preventability and no findings to suggest systemic quality failures or unsafe practice. Where opportunities for improvement were identified, these were predominantly organisational and system-based, including escalation, communication, advance care planning, discharge processes and wider operational pressures. Importantly, no issues were identified that were judged to have directly altered the outcome of death.

- The targeted deep-dive approach undertaken during this reporting period provides strong assurance that observed mortality indicators do not conceal unrecognised clinical risk. Variation in mortality is more strongly associated with case-mix, frailty, palliative complexity, data quality and specialty attribution practices than with deficiencies in care. This reinforces the importance of careful interpretation of crude and risk-adjusted mortality measures, supported by structured case note review and clinical judgement.

- The continued expansion of the Medical Examiner Service strengthens independent scrutiny, transparency and triangulation with M&M reviews, Datix, complaints and inquests. While increasing referral volumes reflect improved awareness and vigilance, they also highlight the need to address capacity, digital interoperability and sustainability to support timely and consistent assurance.

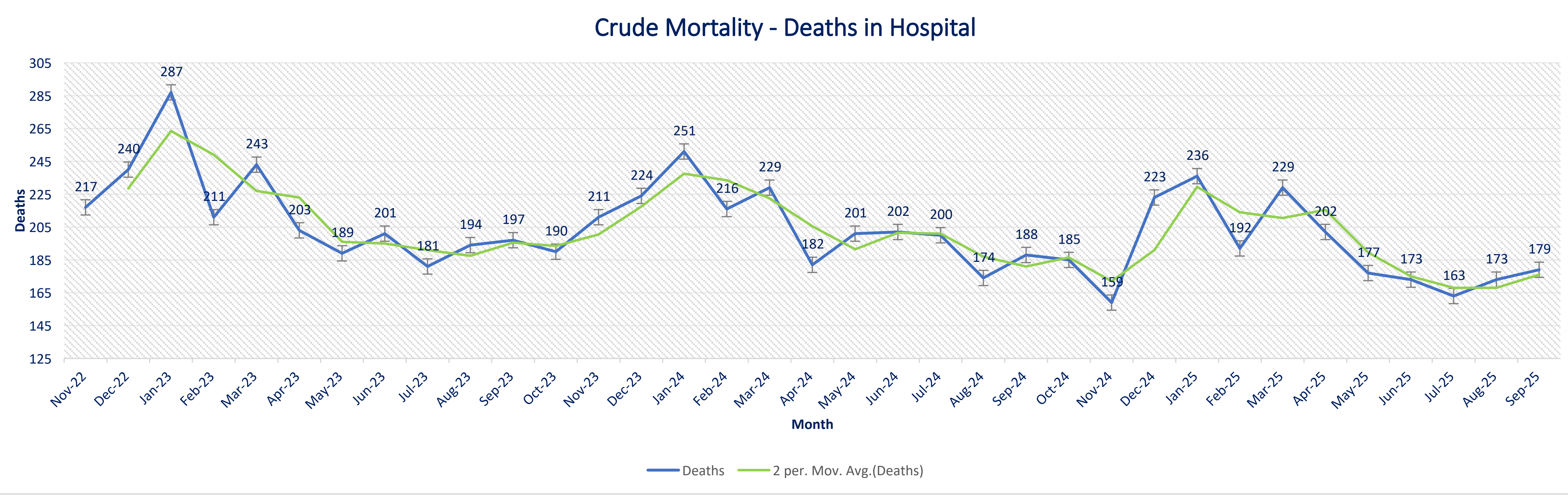
- Overall, this reporting cycle demonstrates a maturing mortality assurance framework, with improving governance, clinical engagement and analytical capability. The Health Board is appropriately focused on system improvement, data quality and learning, rather than individual performance, providing robust assurance to the Board and Committees that deaths are reviewed, learning is identified, and improvement actions are being progressed.

For Information

Mortality Indicators

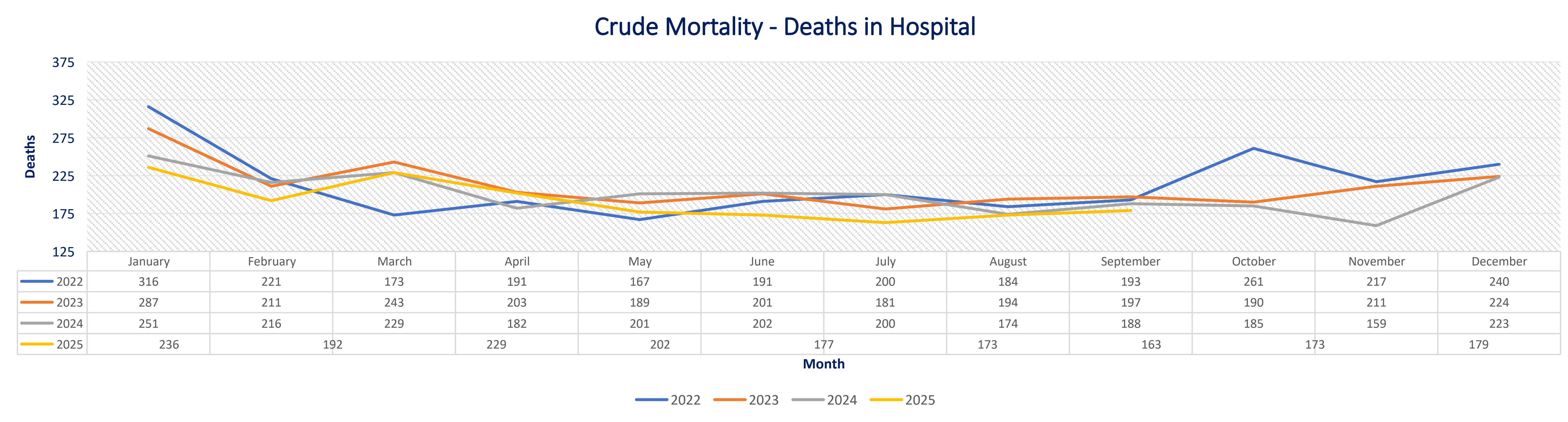
Learning and improvement provided as part of the Health Board mortality framework

Tier One Mortality Indicators – Crude Mortality



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

Tier One Mortality Indicators – Crude Mortality (cont.)

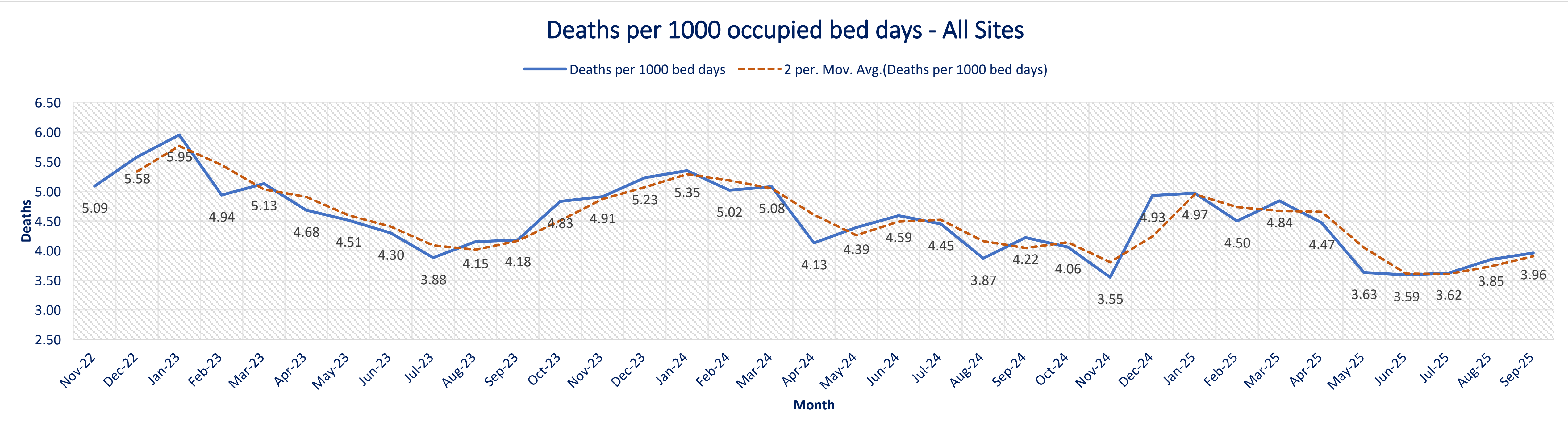


	January	February	March	April	May	June	July	August	September	October	November	December
2022	316	221	173	191	167	191	200	184	193	261	217	240
2023	287	211	243	203	189	201	181	194	197	190	211	224
2024	251	216	229	182	201	202	200	174	188	185	159	223
2025	236	192		229	202	177		173	163	173		179

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

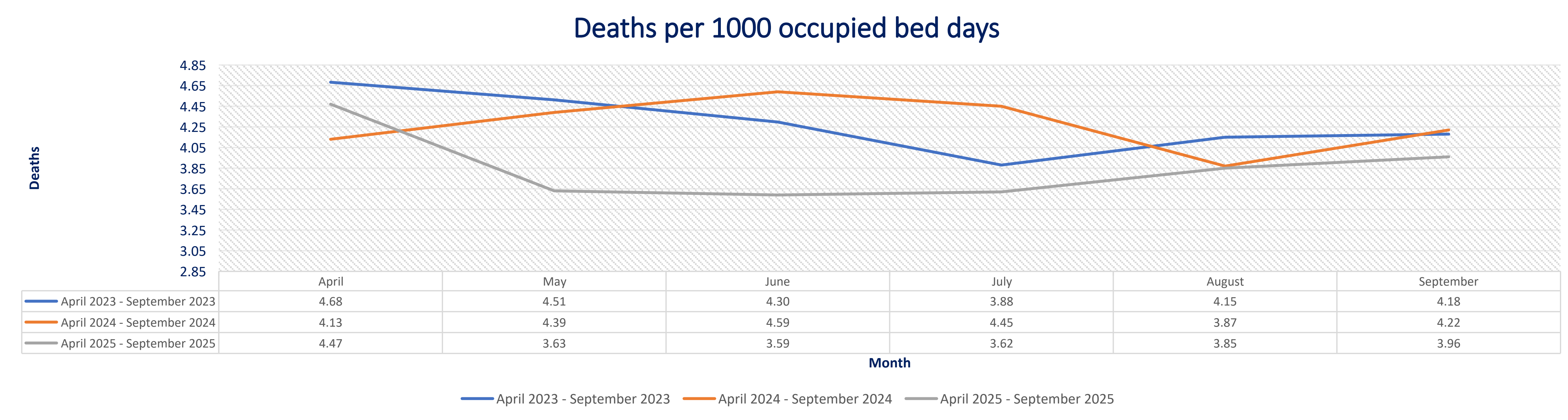
Tier One Mortality Indicators – All-cause Mortality

All-cause mortality measures the total number of deaths from any cause in a population over a specific period. Unlike measures focusing on specific diseases, it counts every death, regardless of the cause. It's usually expressed as the number of deaths per 1,000 people per year.



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

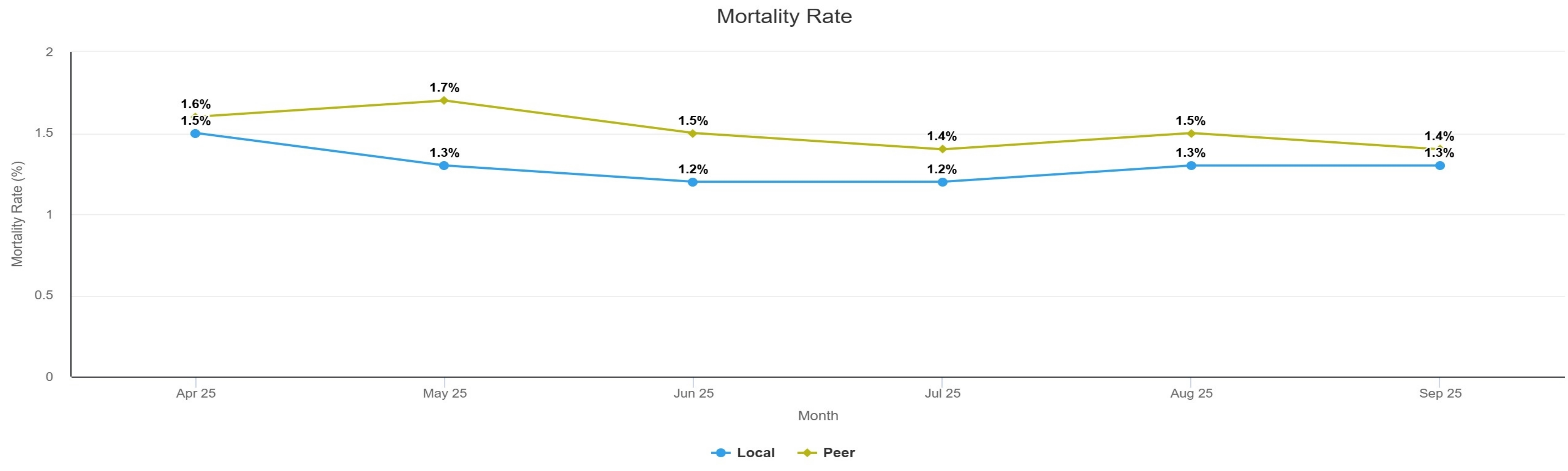
Tier One Mortality Indicators – All-cause Mortality



	April	May	June	July	August	September
April 2023 - September 2023	4.68	4.51	4.30	3.88	4.15	4.18
April 2024 - September 2024	4.13	4.39	4.59	4.45	3.87	4.22
April 2025 - September 2025	4.47	3.63	3.59	3.62	3.85	3.96

- The 2024–2025 period shows a notable reduction in deaths per 1000 occupied bed days compared to the previous two years. The grey line consistently tracks below the blue and orange lines across most months, indicating improved mortality rates relative to bed occupancy.
- December–March: All three years show a rise in mortality rates during winter months, but the 2024–25 values remain lower, suggesting better resilience or interventions during seasonal pressures.
- Notable Improvements The 2023–24 period (orange line) already showed improvement over 2022–23, and the 2024–25 period continues this downward trend, reinforcing a sustained improvement in patient outcomes relative to bed usage.
- This metric—deaths per 1000 occupied bed days—is a key indicator of hospital mortality adjusted for capacity. The downward trend in 2024–25 suggests:
  - Enhanced quality of care and patient safety.
  - Better management of bed utilisation and clinical risk.
  - Potential impact of targeted interventions or service redesigns.

Tier One Mortality Indicators – Rolling Mortality Rate

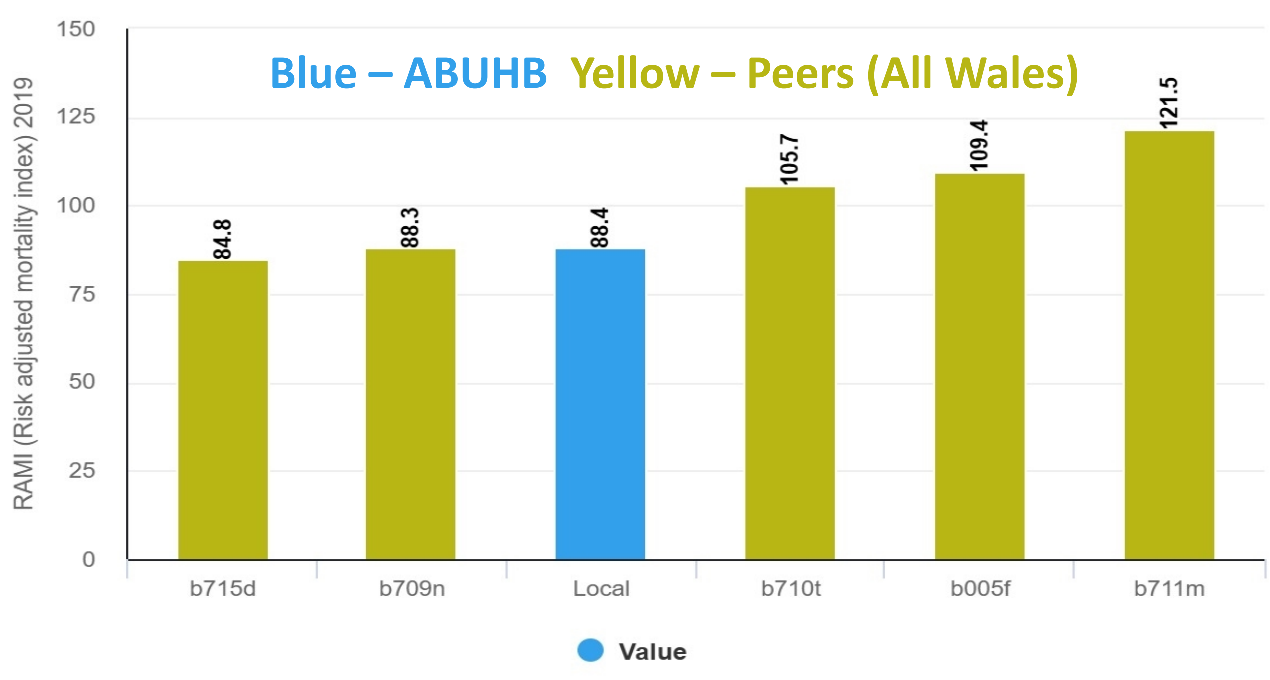


The Health Board's mortality rate has remained stable, showing a flat trend. Actual in-hospital deaths decreased during Q1 2025/26 before a slight increase in Q2.

The report supports adopting diverse methods to assess performance. This approach ensures quality improvement and assurance around mortality without relying solely on retrospective aggregated data like RAMI. Additional mortality indicators are included for reporting to enhance this process.

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

- RAMI is a metric used to measure hospital or treatment-related deaths, considering the initial health status of patients.
- Patient Differences: Patients vary in age, health conditions, and illness severity. Some are at higher risk of dying due to their initial health status.
- Adjustment Process: This metric adjusts the raw death numbers to account for these differences, providing a fairer comparison between hospitals or doctors.
- Fair Comparison: It helps determine if a hospital's death rate is better or worse than expected, given how sick its patients were.
- This way, hospitals treat very sick patients aren't unfairly judged by their higher death rates.
- A Rami of 100 represents the expected mortality rate.
  - Below 100: Fewer deaths than expected (better performance).
  - Above 100:more deaths than expected (potential concern)

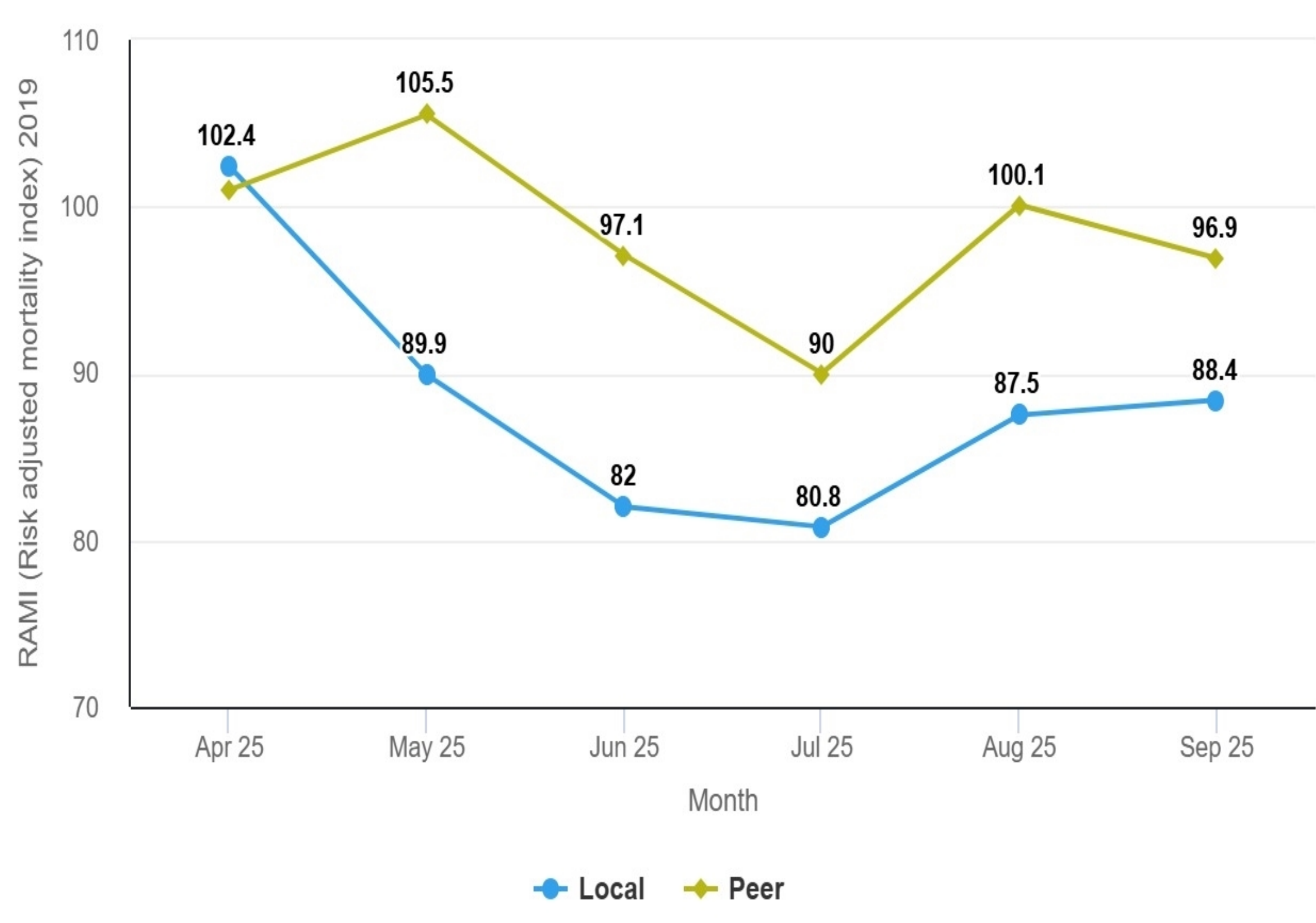


April 2025 – September 2025

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

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

- The accuracy of RAMI (Risk-Adjusted Mortality Index) relies on the completeness and accuracy of clinical coding. Currently coding is on a lag of 12 weeks. This means our RAMI will improve when the coding is updated.
- Between April 2025 and September 2025, 9.4% finished consultant episodes at ABUHB were uncoded.
- In 2014, Professor Palmer reviewed RAMI and questioned its validity as a sole measure. He recommended a blended approach using multiple data sources, including mortality reviews, national benchmarking, and national audits, to ensure quality improvement and assurance around mortality.
- The Health Board is currently performing better than the Welsh Peer Value average as an overall value of RAMI.
- Consistent and linear performance against Welsh Peers from April 2025.

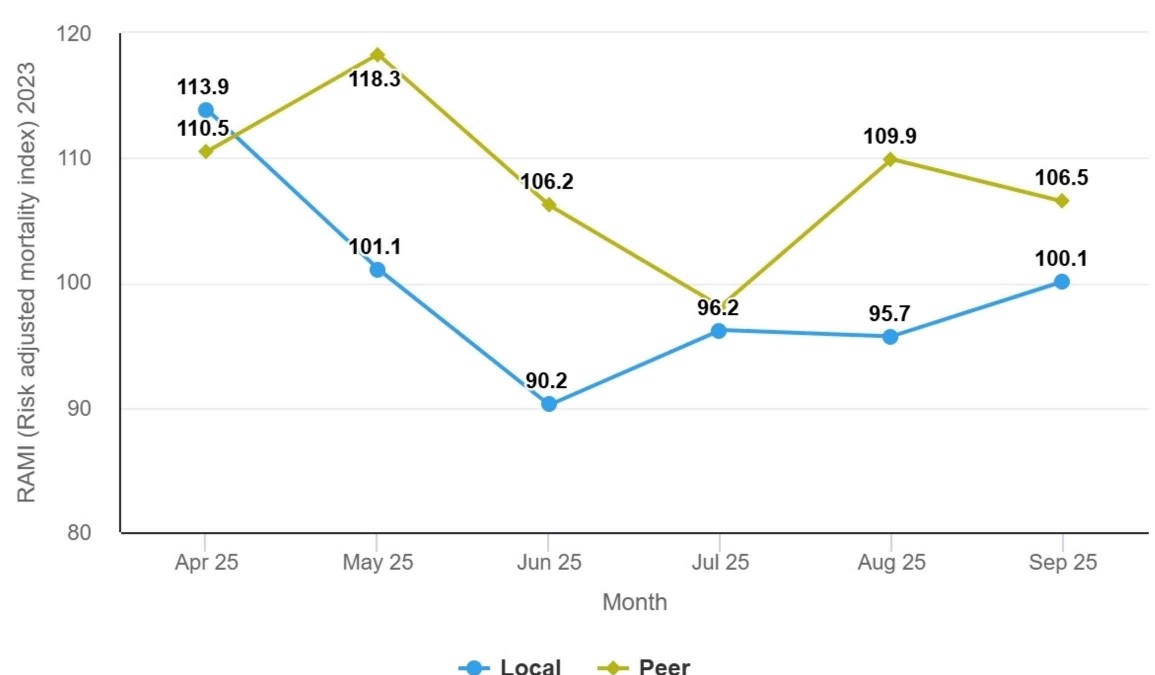


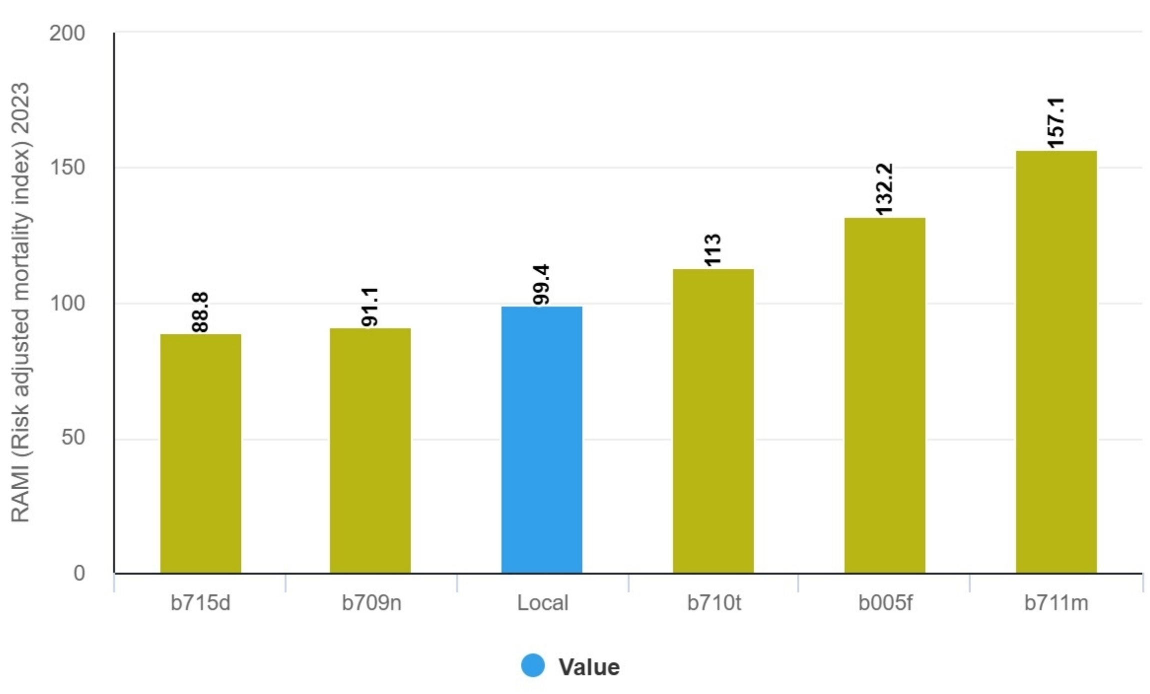
Tier One Mortality Indicators – Risk Adjusted Mortality Index (RAMI)

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

- On average RAMI 2019 is 9 points lower than RAMI 2023, but this is an artefact of the time difference in setting each of the standards rather than an actual difference in risk adjusted mortality.

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

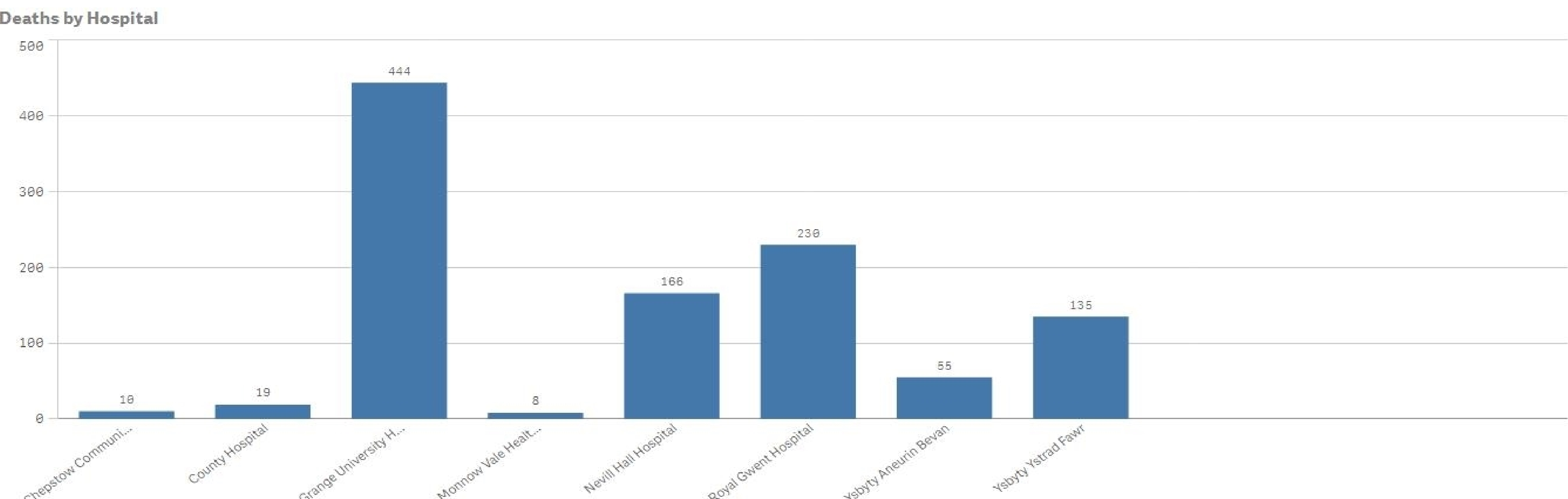




- The Health Board is currently performing better than the Welsh Peer Value average as an overall value of RAMI.
- Consistent and linear performance against Welsh Peers from April 2025.
- The Health Board is currently the 3rd best performing Health Board within the Welsh Peer Value group.
- RAMI 2023 has been re-based as a score of 99.4 compared to 88.4 based on RAMI 2019

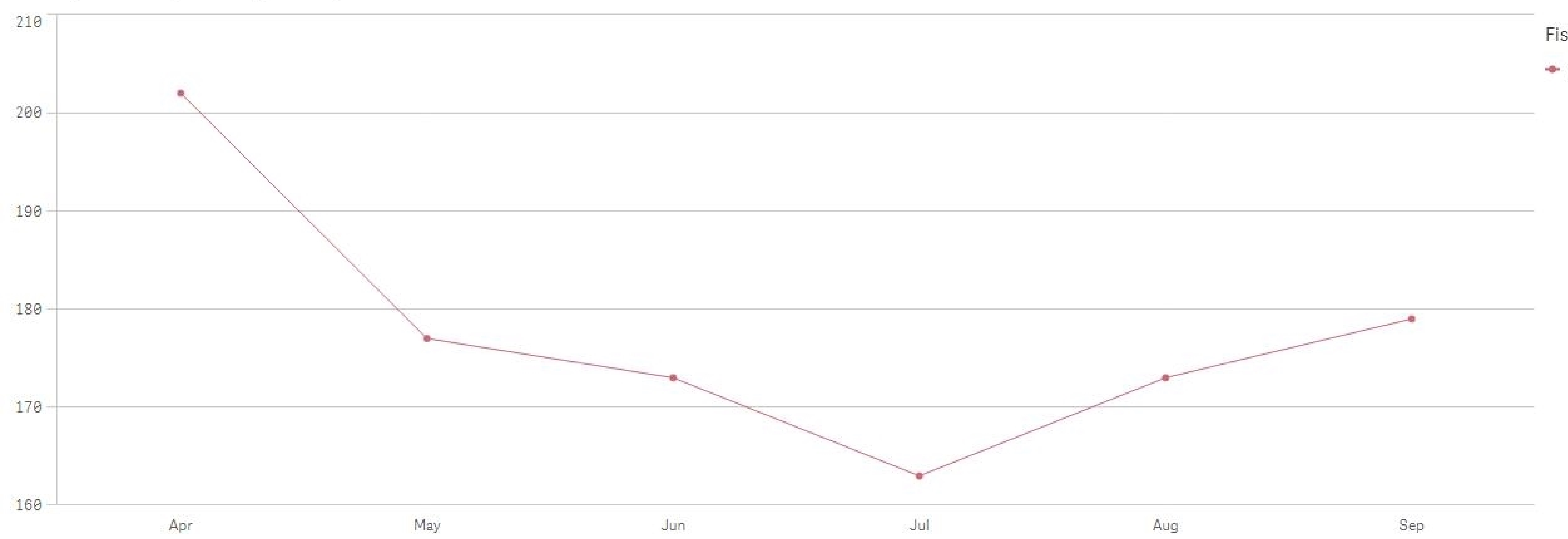
Tier One Mortality Indicators – All-cause Mortality per site

April 2025 – September 2025



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

Tier One Mortality Indicators – All-cause Mortality in Hospital



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

Clinical Coding Performance and Improvement Plan

- **Welsh Government Targets:** 95% coding completeness by the end of the following month (e.g. March discharges coded by end of April). 90% of clinical coding errors corrected within 35 days of identification.
- The Health Board's coding completeness levels have improved to 90% which is a positive development, however, the ongoing increase in activity continues to limit the coding performance.
- A Clinical Coding restructure has been implemented to support national targets and create development opportunities. Ongoing initiatives include: Raising awareness of clinical coding through activities such as *Lunch & Learn* sessions. Developing automation tools to allow coders to focus on more complex cases.

Challenges Identified:

- Increased volume of Finished Consultant Episodes (FCEs).
- Incomplete or unclear patient records.
- Excessive use of abbreviations, which delays coding and limits automation potential.

Performance Against Accuracy Targets:

- The Health Board continues to perform well against Welsh Government accuracy standards.
- The latest DHCW audit (2024/25) shows strong results:
  - 90% target for primary diagnosis and procedure.
  - 80% target for secondary diagnoses.

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

Depth of Coding and RAMI Accuracy:

- Depth of coding refers to the number of additional risk factors (e.g. diabetes, hypertension) captured in the patient record. This significantly influences the accuracy of the Risk Adjusted Mortality Index (RAMI).
- Best practice includes coding: The main condition treated. All relevant procedures/interventions. All documented co-morbidities.

Next Steps:

- Standardising and improving the depth of coding will enhance the accuracy of mortality data and strengthen the reliability of RAMI reporting.

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

Tier Two Mortality Indicators

Identifying and embedding **Divisional-level mortality indicators** will significantly enhance the Health Board's ability to monitor and respond to mortality trends. This approach will:

- **Enable systematic reporting** of mortality data at Divisional Quality and Safety meetings, ensuring consistent visibility and accountability.
- **Support triangulation** with Medical Examiner insights, particularly when mortality rates rise—e.g. through thematic reviews of specific patient groups such as stroke patients.
- **Facilitate case note reviews** to provide assurance in the absence of other clinical review mechanisms.
- **Inform organisational learning** by presenting emerging mortality themes and trends to the Health Board Mortality Review Group.

Strengthening Mortality Oversight Through Divisional Indicators

Family and Therapies	Medicine	Urgent Care	Mental Health	PCC	Surgery
Maternal mortality	Stroke Mortality	ED attendance	Suicide (population measure)	Locality specific mortality	30-day post elective surgery inpatient mortality
Perinatal Mortality/ 1,000 births	Cardiology / MI		Learning disability deaths		30 post non-elective surgery inpatient mortality
Still Birth/ 1,000 births					

Table illustrates the proposed mortality indicators identified in collaboration with the Divisions that will allow reporting of Tier 2 mortality data.

Tier Three Mortality Indicators

- The current phase of work has deliberately focused Tier 3 on structured deep-dive reviews within Directorates demonstrating the highest RAMI values and greatest number of deaths, as set out in this report. This targeted approach is intended to strengthen learning, provide focused support, and enhance assurance where the mortality signal is greatest.

- During this reporting period, Tier 3 activity has centred on structured, case-based mortality reviews, enabling a deeper understanding of variation, contributory factors and opportunities for improvement. This work is underpinned by RAMI-aligned benchmarking and CHKS analytical measures, ensuring consistency, robustness and comparability.

- The next phase will further strengthen assurance through triangulation of mortality outcomes using national clinical audit data alongside local intelligence.

- This work will continue to focus on building a robust governance framework aligned to the Learning from Deaths Framework, including structured reporting through Directorate Quality and Patient Safety meetings, triangulation with Medical Examiner, M&M and Coroner intelligence, formal escalation arising from M&M reviews, and exception-based assurance reporting.

- Overall, the Tier 3 approach ensures that mortality data is actively used to drive learning, support Directorates, and provide assurance that identified risks are understood and addressed, rather than solely monitored.

Tier Three Mortality Indicators – Crude Mortality - Specialty

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

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

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

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

Tier Three Mortality Indicators – RAMI - Specialty

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

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

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

Actions and further assurance:

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

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

Tier Three Mortality Indicators – RAMI - Anaesthetic / ITU Review

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

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

Tier Three Mortality Indicators – RAMI - Anaesthetic / ITU Review

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

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

- One case involved a delay in the initiation of antibiotics prior to ITU admission.
- One postoperative death occurred in a patient with COPD, where an alternative anaesthetic approach may have altered the outcome; however, there was no pre-operative indication to suggest this, and the approach taken was considered reasonable.
- In the third case, clinical decision-making was appropriate based on the information available at the time.

- Several cases highlighted organisational factors where care processes could potentially be strengthened. These predominantly related to ITU admissions occurring due to reduced capacity in respiratory high-care units, with one case identifying a delay in medical review in the Emergency Department.
- The review also identified system-level variation across Wales in how ITU patients are attributed to consultant specialty. Differences in whether patients are coded to intensivists or specialty teams limits the comparability of crude mortality data between organisations.
- Overall, the review did not identify significant concerns relating to ITU care delivery.
- Key learning from the review is that specialty attribution and coding practices materially influence crude mortality measures and must be carefully considered when interpreting mortality data and benchmarking performance.

Tier Three Mortality Indicators – RAMI - Gastroenterology Review

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

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

Similar coding issues were identified to those noted in Anaesthetics.

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

Quality of Care Assessment (73 patients)

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

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

Tier Three Mortality Indicators – RAMI – Endoscopy Review

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

Total procedures reviewed: 9 endoscopic cases

Key Findings

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

Tier Three Mortality Indicators – RAMI - Respiratory Review

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

Total cases reviewed: 144

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

Preventability Assessment

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

Room for Improvement – Clinical (8 cases)

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

Room for Improvement – Clinical and Organisational (2 cases)

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

Room for Improvement – Organisational (4 cases)

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

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

Tier Three Mortality Indicators

Cross-Cutting and System-Wide Learning

Documentation and Communication

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

Data Quality and Comparability

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

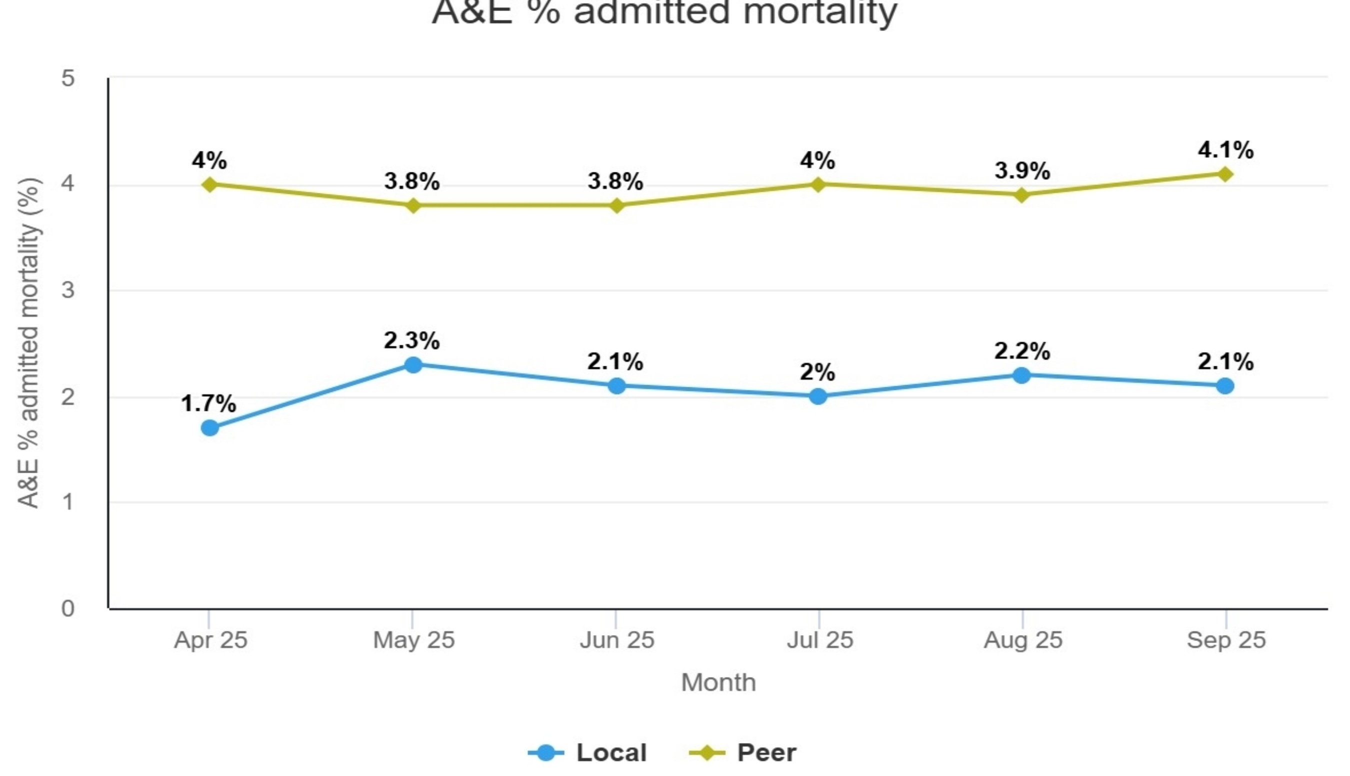
Key Learning

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

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

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

Tier Three Mortality Indicators – ED admitted Mortality

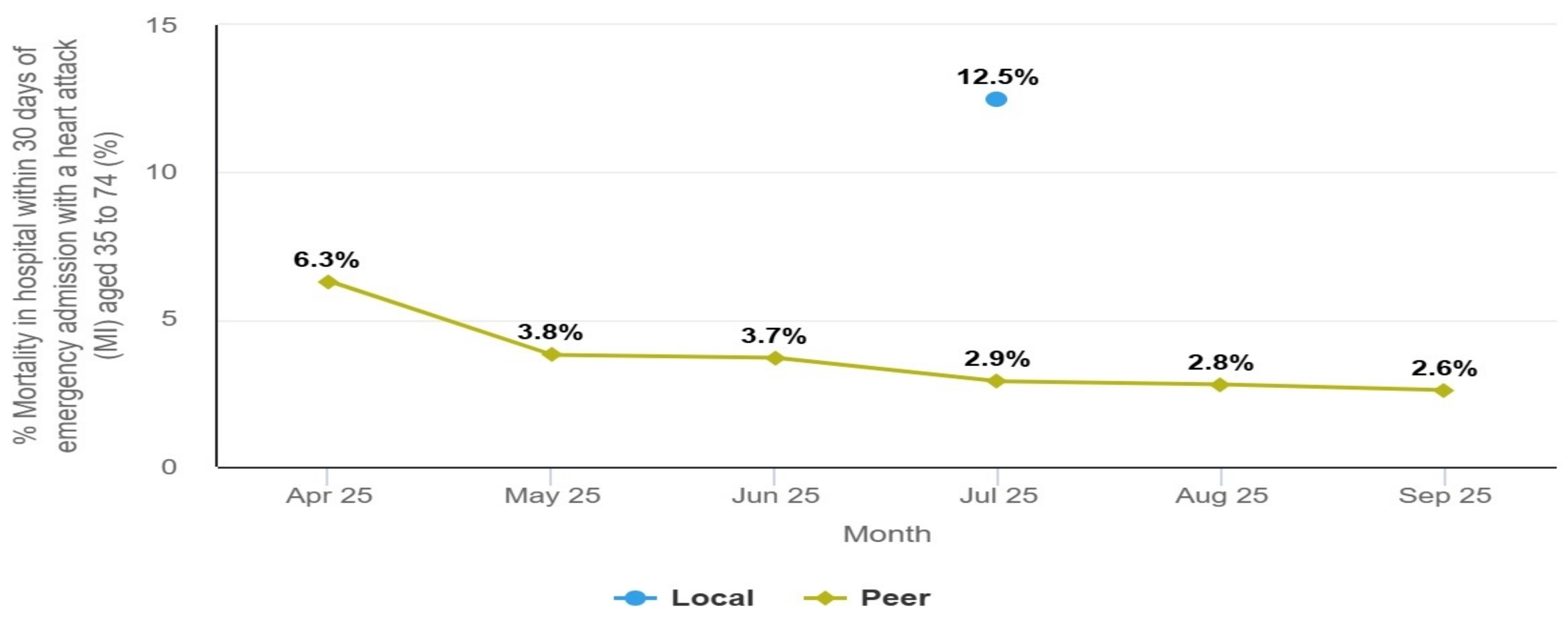


- ABUHB has consistently performed below the Welsh Peer Value for ED admitted Mortality

ED Admitted Mortality Indicator

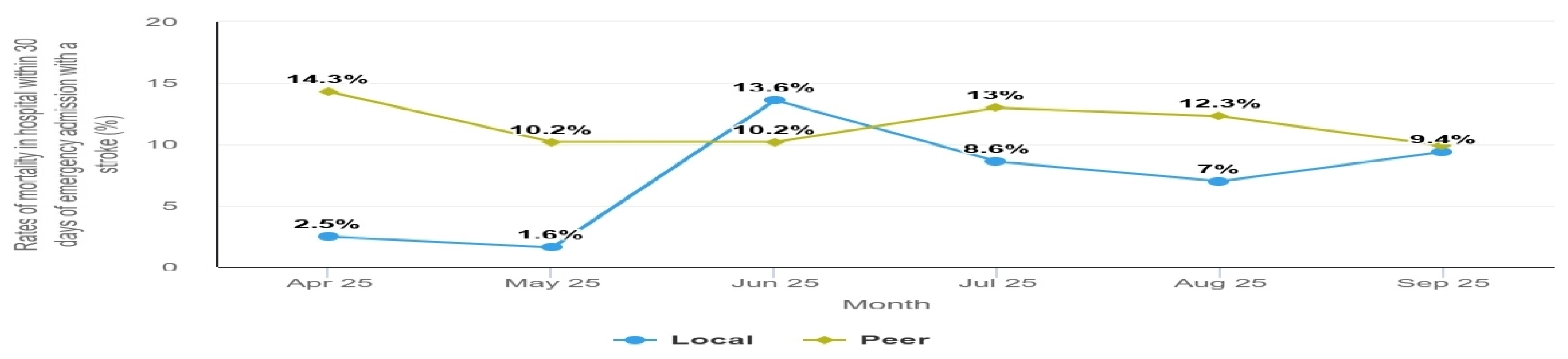
- **What It Measures**: The percentage of patients who die after being admitted from ED.
- **Purpose**: Assesses the quality of emergency and overall hospital care, highlighting potential issues like delays in treatment or inadequate assessments.
- **Influencing Factors**:
  - **Severity of Cases**: Higher mortality rates in hospitals with more severe cases.
  - **Timeliness of Care**: Delays in diagnosis or treatment can increase mortality rates.
  - **Quality of Care**: Availability of specialist services and adherence to clinical guidelines impact mortality rates.
- **Benchmarking and Improvement**: Used to compare performance with other hospitals and national standards, helping to implement targeted interventions to reduce mortality rates.

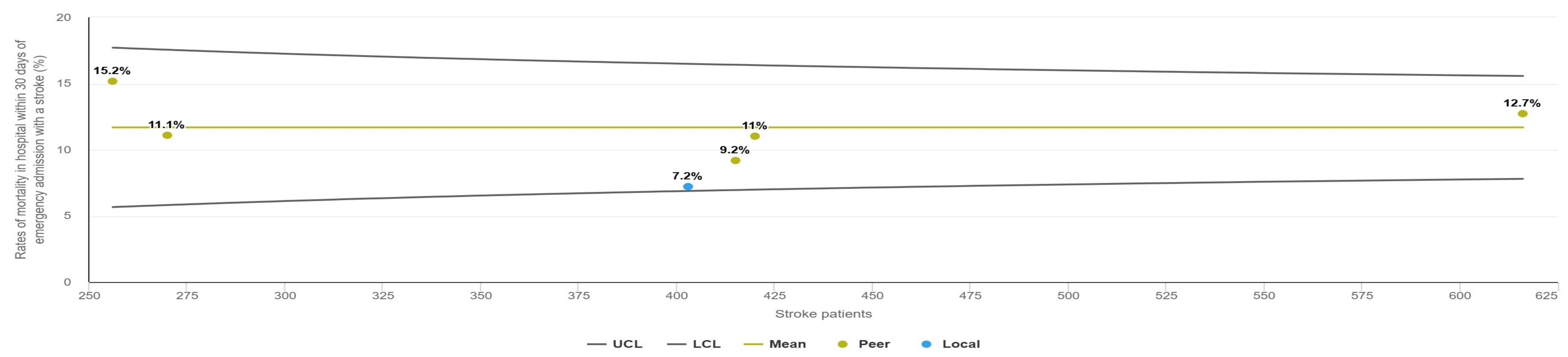
Tier Three Mortality Indicators – Condition Specific Mortality - MI



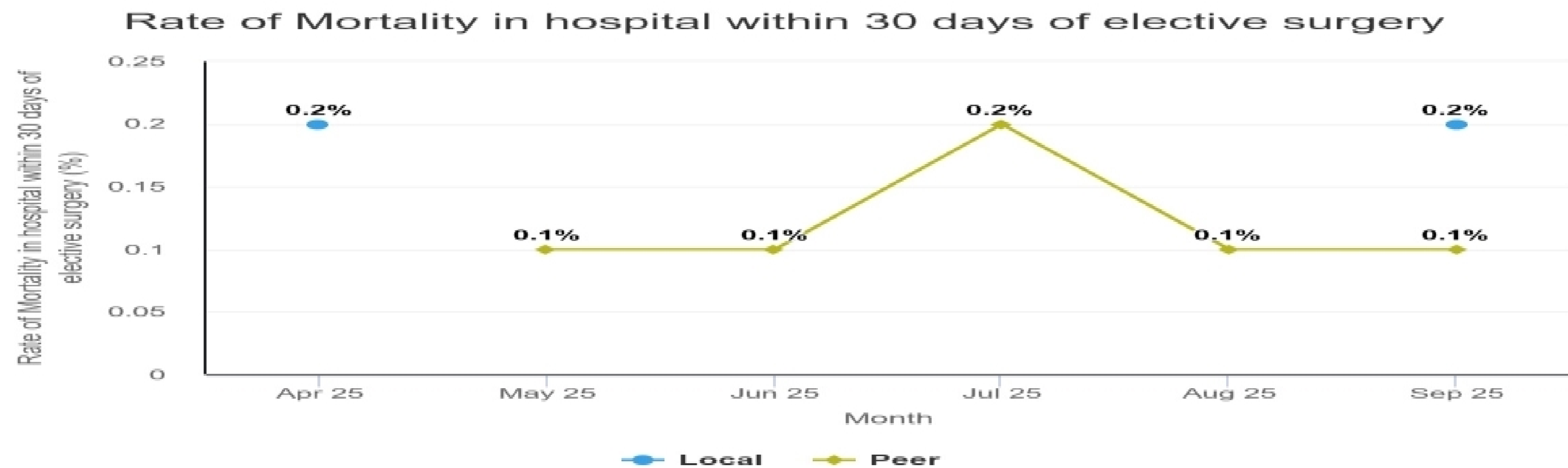
- 1 deaths between April 2025 – September 2025
- Period mortality – ABUHB 0.8% Peers (All Wales) 3.6%
- Patients with remediable issues are transferred to Cardiff for intervention

Tier Three Mortality Indicators – Condition Specific Mortality - Stroke

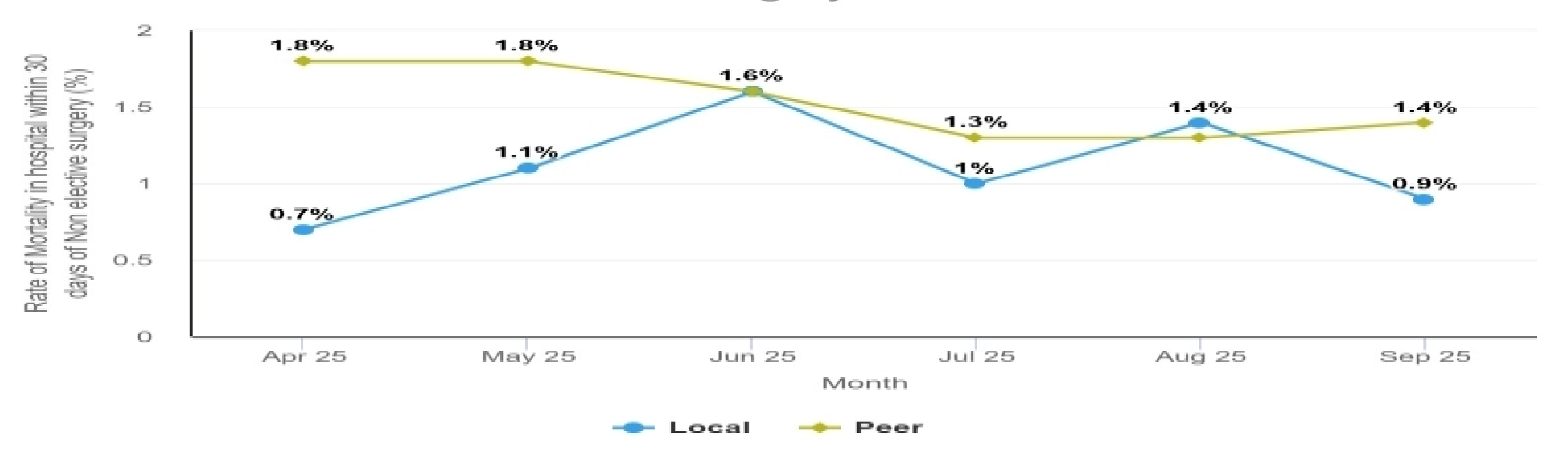




Tier Three Mortality Indicators – Surgery Mortality



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



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

Tier Three Mortality Indicators – Surgery Mortality

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

- 53 Deaths were recorded of patients who have died within 30 days of non-elective surgery
- General Surgery and T&O have the highest mortality level
- Gastroenterology is an outlier for ABUHB as it is higher than the peer average of 7.4% with a mortality rate of 9.7% for the period April 2025 – September 2025. A deep dive is underway in this area as this was also highlighted in the previous edition of the Learning From Death Report.

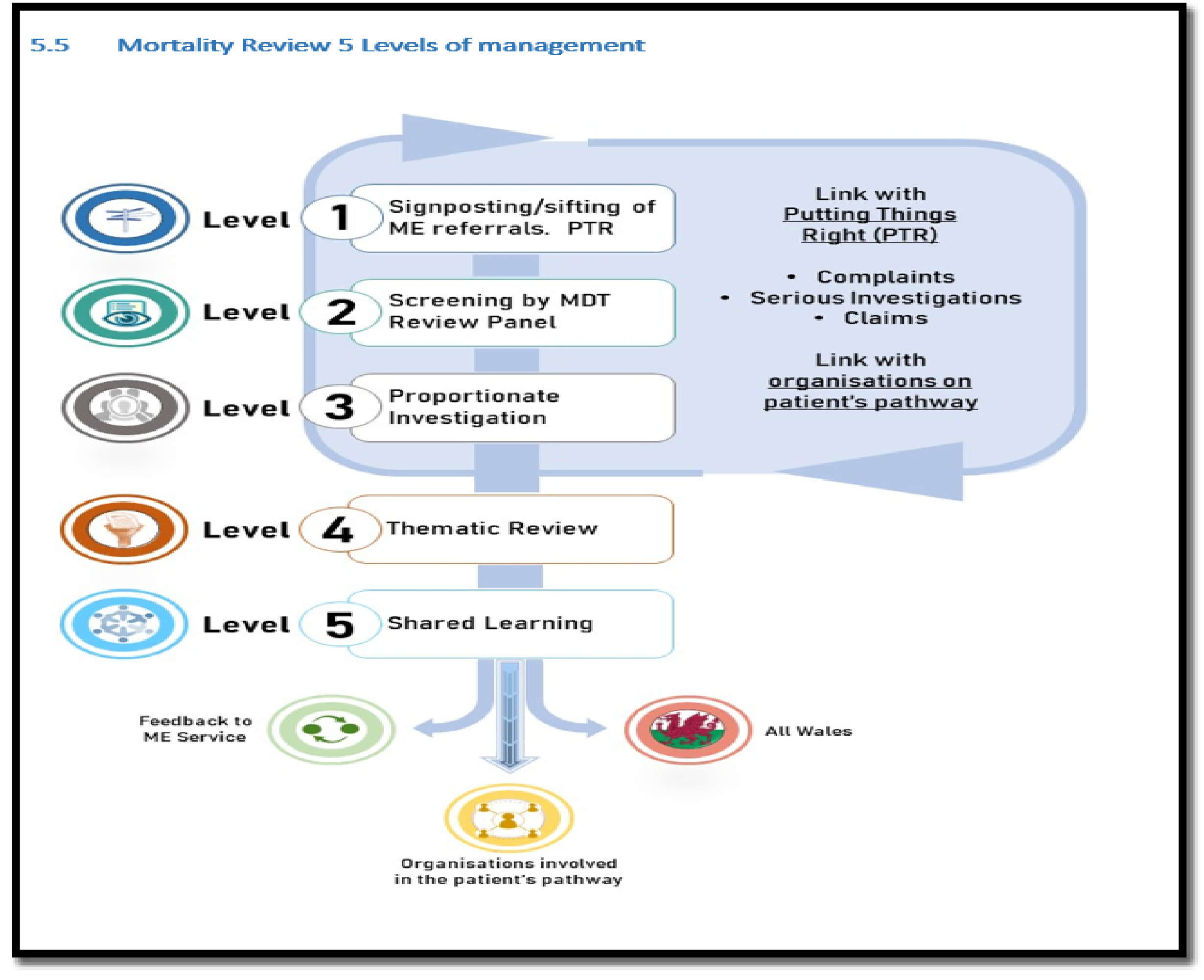
The Medical Examiner Service

The Medical Examiner (ME) Service in Wales is hosted by NHS Wales Shared Services Partnership (NWSSP). The ME Service provides independent scrutiny of all deaths that are not investigated by the coroner (HMC). Scrutiny is undertaken by an ME, who is an experienced doctor with additional training in death certification and the review of documented circumstances of death. Their job is to ensure that an accurate cause of death of recorded, to identify any concerns surrounding the death itself (which can then be further investigated if necessary), and take the views of the bereaved into consideration.

In order to provide the highest level of independent scrutiny of the cause of, and circumstances surrounding a death, all MEs and Medical Examiner Officers (MEO) in Wales are directly employed by NWSSP, and Medical Examiners are not involved in the scrutiny of deaths in the area in which they work. Updates can be found at: Medical Examiner Service - NHS Wales Shared Services Partnership.

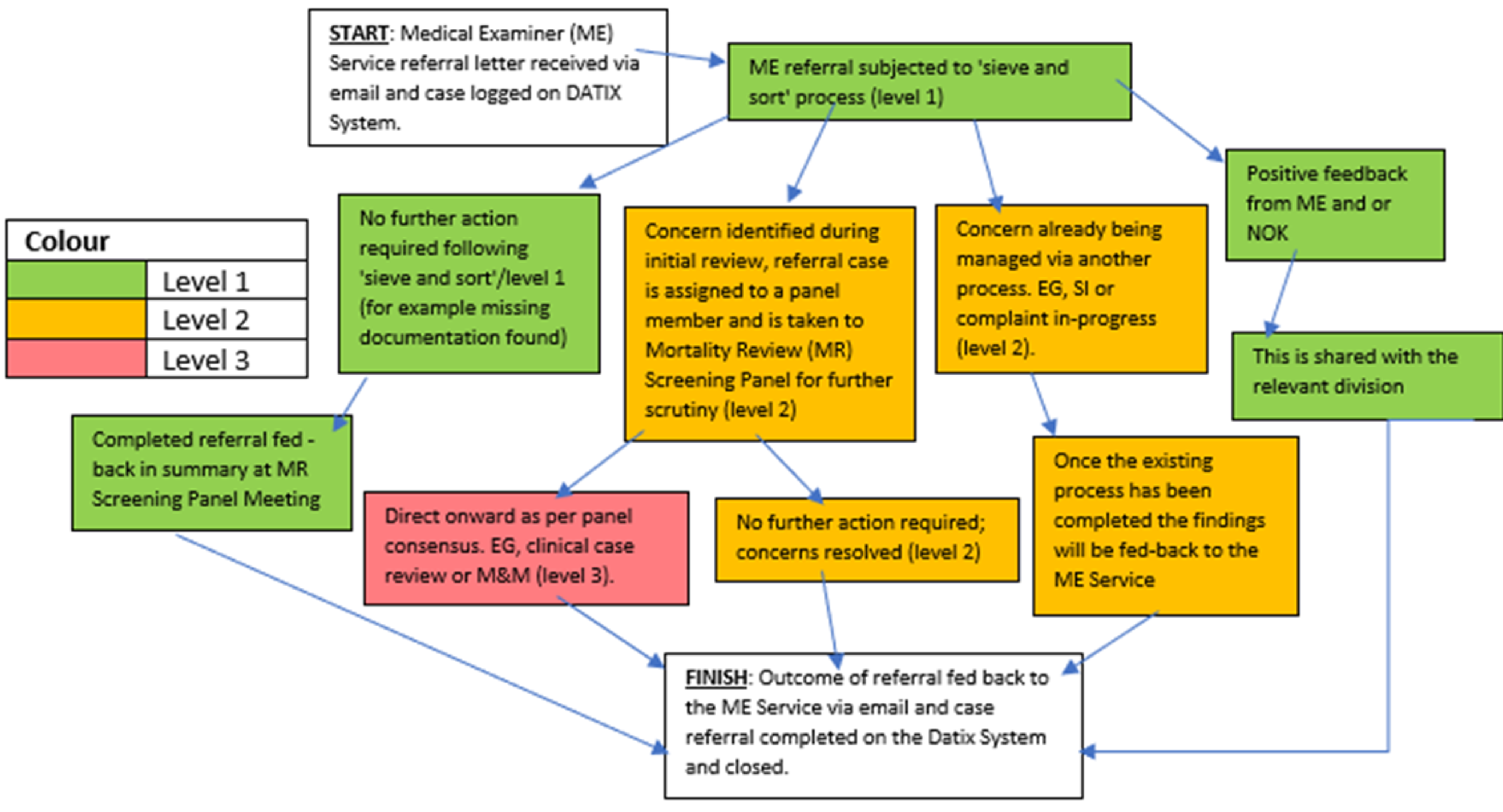
The ME Service system provides external, independent scrutiny of the treatment and care delivery and reports back cases for concern to the Health Board for further review.

Aneurin Bevan University Health Board Mortality Review Process

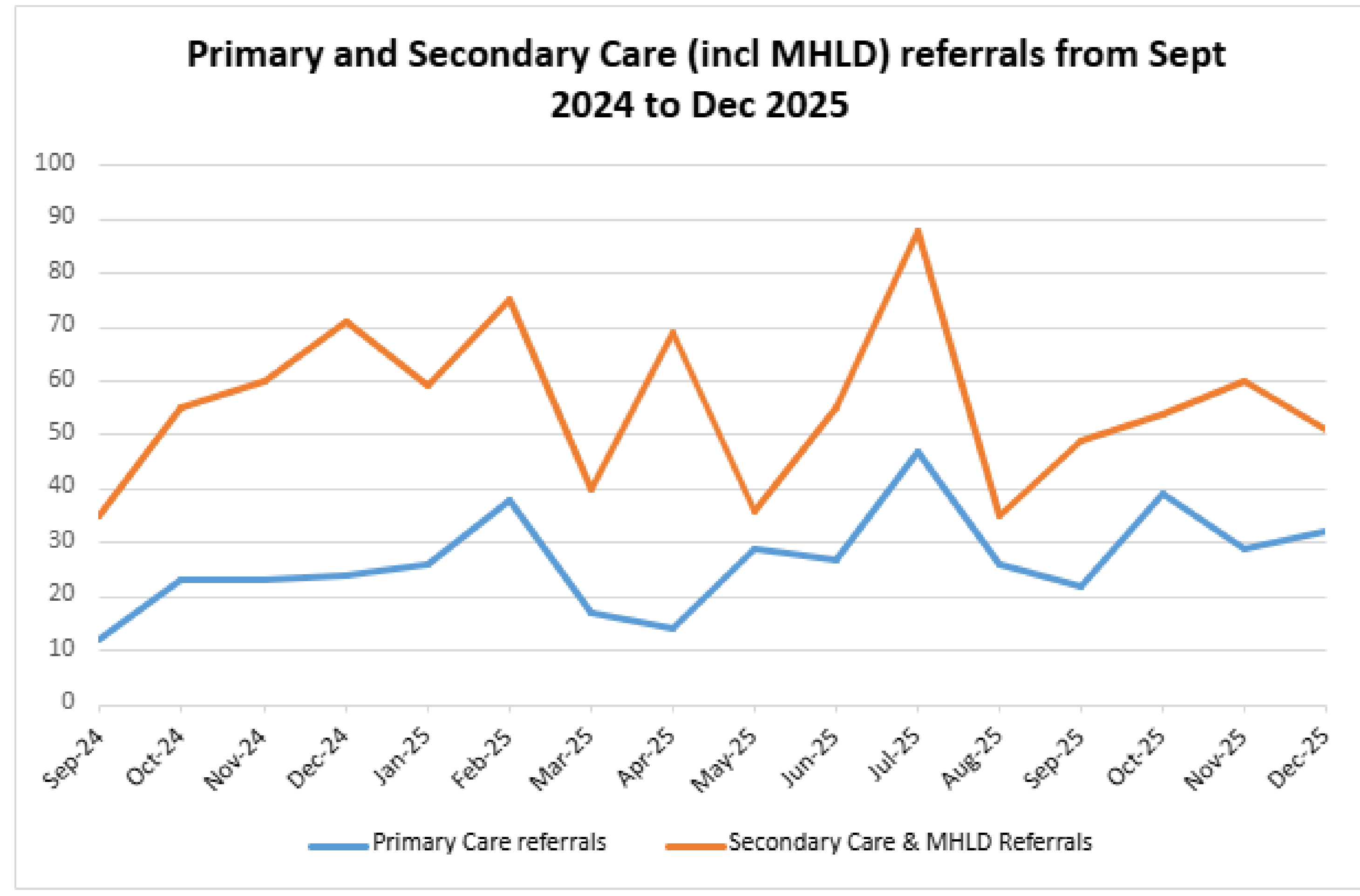


- All mortality cases referred to the Health Board by the ME Service undergo an initial review (level 1) to determine if further action is needed and to avoid duplication of work from existing processes.
- If further investigation is required, the case moves to a level 2 review. There it is discussed by the Mortality Review Screening Panel. This multidisciplinary panel meets weekly to review cases and decide on necessary actions, which are then assigned to relevant teams or clinicians.
- Actions may include clinical reviews at mortality and morbidity (M&M) meetings, investigations under PTR processes, or reviews by specific panels such as the Falls Review Panel. This constitutes a level 3 review.
- The ME service was fully implemented by the end of 2024, covering all deaths, including those in Primary Care and Community. Only 1 paediatric and no maternity death referrals have been received at ABUHB from the ME Service yet.

Aneurin Bevan University Health Board Mortality Review Screening Process



Medical Examiner Referrals Acute Compared to Primary Care & Community

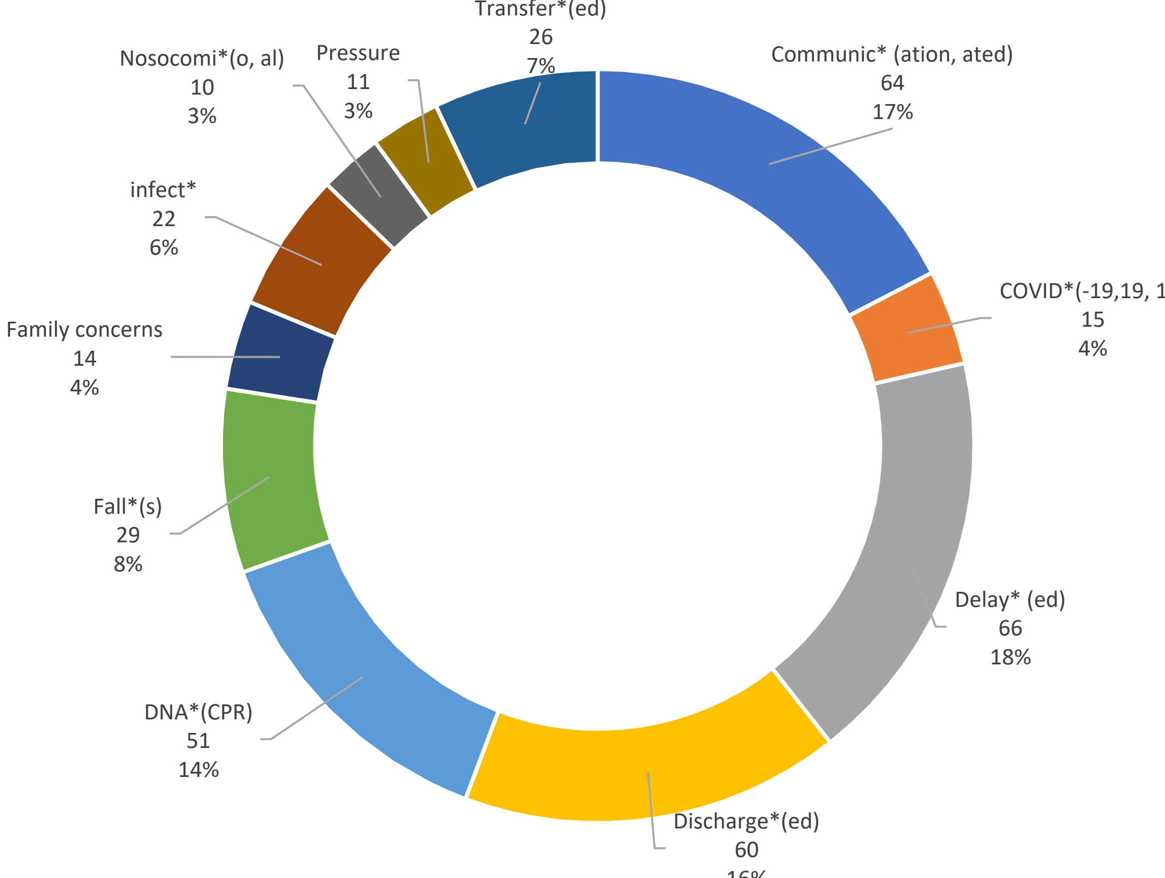


The graph compares referral volumes from primary care with those from secondary care.

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

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

Medical Examiner Referral Themes



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

Delays

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

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

Communication Issues

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

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

Discharge Issues

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

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

DNACPR (Do Not Attempt Cardiopulmonary Resuscitation)

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

Medical Examiner Referrals

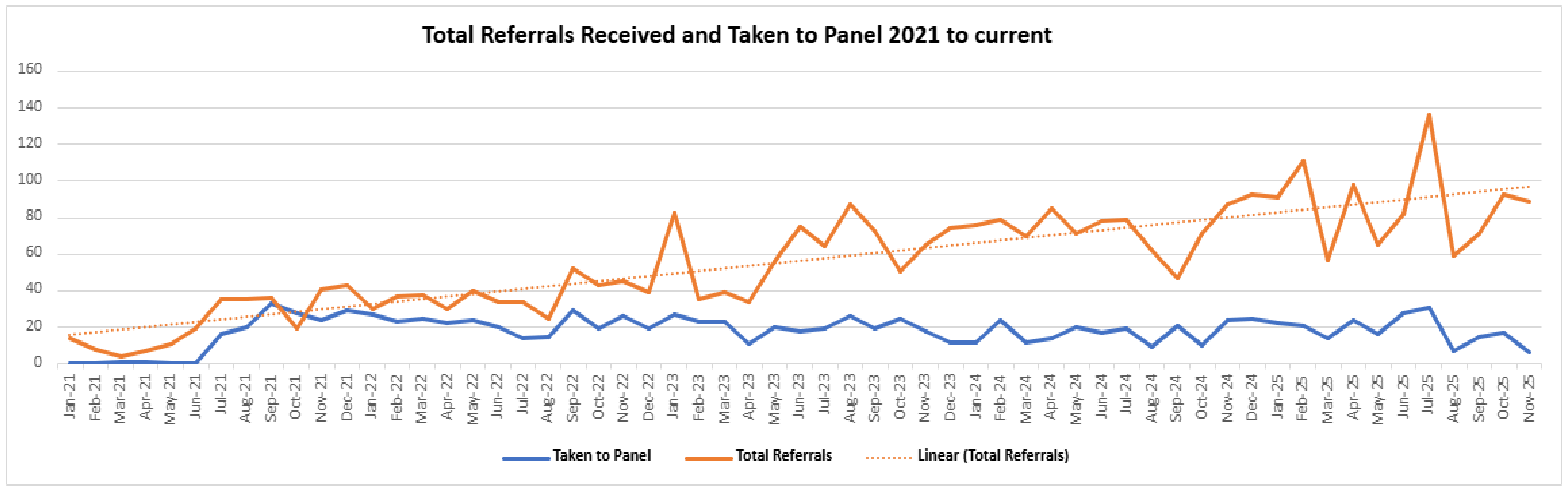
	Data set 1 (01/10/2023-01/12/2023	Data Set 2 (01/12/2023-31/10/2024)	Data Set 3 (01/07/2024-31/03/2025)	Data Set 4 01/04/2025-30/09/2025
Number of days	426	335	273	182
Total ME Referrals	797	783	715	492
No further action	405 (51%)	164 (21%)	120 (17%)	89 (18%)
IP&C	70 (9%)	33 (4%)	12 (12%)	7 (1%)
Resus/Cardiac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

ME Referral Destination

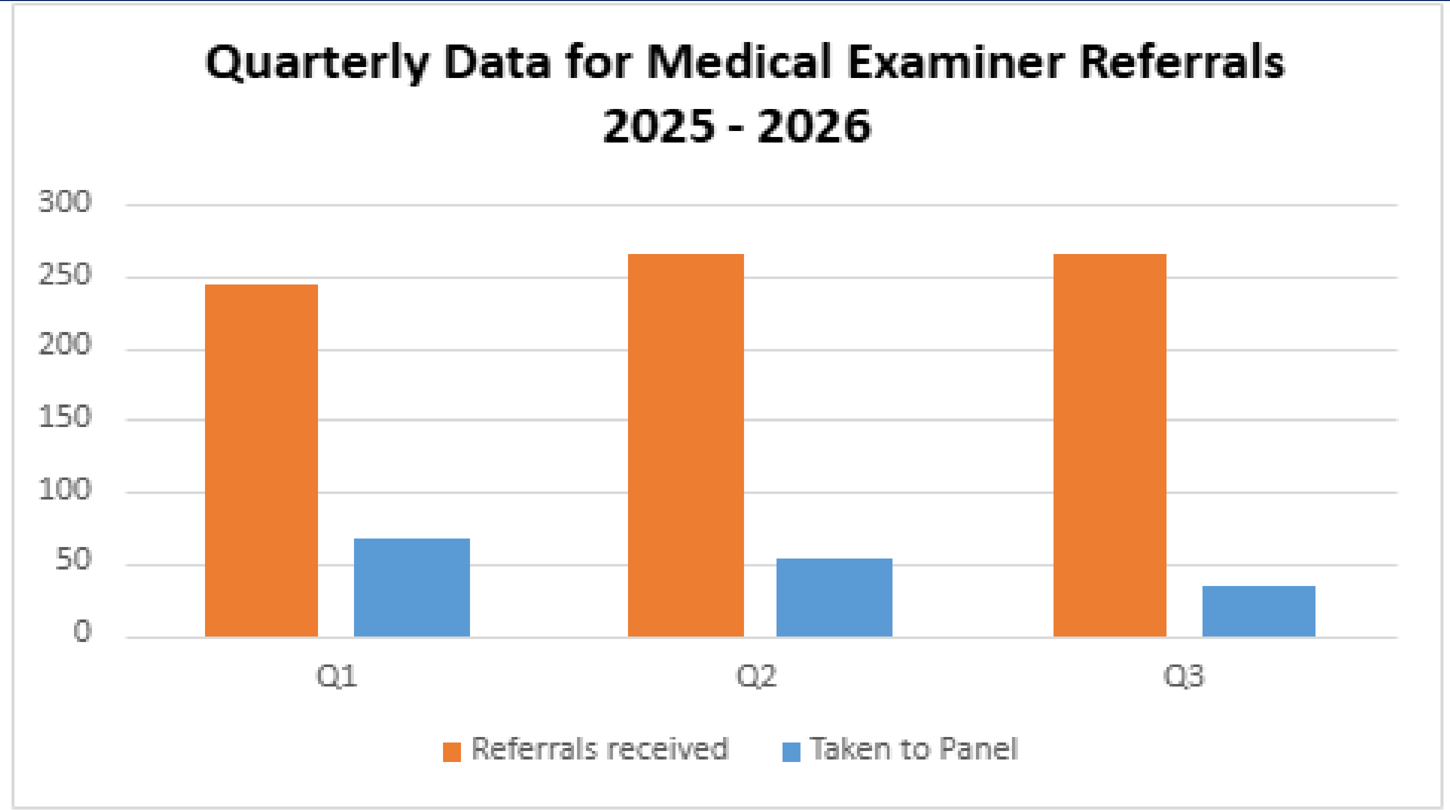
- **No Further Action**: Referrals needing no further action at level 1 are static in percentage from the previous data set. Referrals for ‘no further action’ refer to cases where no review beyond level 1 is required.
- **IP&C Referrals**: These continue to decrease, matching the drop in COVID-19 cases.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

Aneurin Bevan University Health Board Mortality Review Service Growth

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

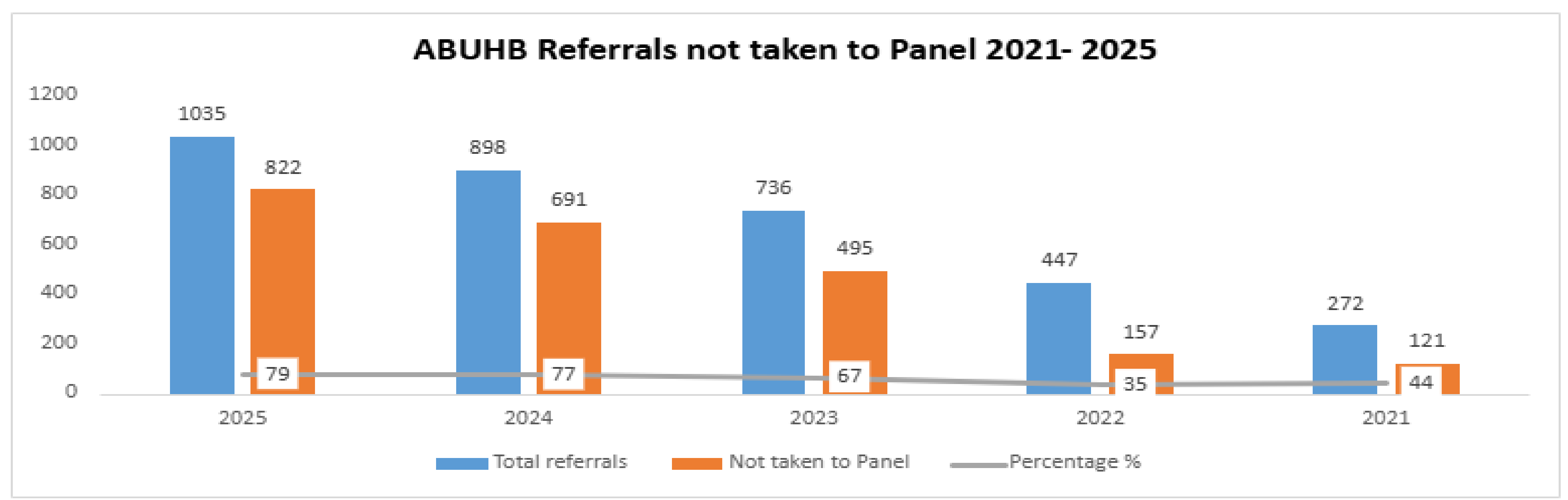


Medical Examiner Referrals by Quarter



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

Aneurin Bevan University Health Board Mortality Review Service Growth



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

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

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

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

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

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

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

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

“They were so kind and supportive to us".

“…At the hospital they were absolutely fantastic…”

Bereavement and End of Life – Learning and Actions

Overview

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

Key Areas of Delivery

1. Public Bereavement Collaboratives

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

2. Inclusion and Health Inequalities

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

3. Staff Bereavement and Workforce Support

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

Bereavement and End of Life – Learning and Actions

Impact and Learning

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

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

Glossary

Definitions of terms within the Report

Graph and chart glossary

- **Risk-Adjusted Mortality Index (RAMI)**
- **What It Shows**: A comparison of hospital mortality rates after adjusting for patient risks like age, health conditions, and severity of illness.
- **How to Read It**: Compare the Health Boards RAMI score to 100. A score **below 100** means fewer deaths than expected; a score **above 100** indicates more deaths than expected
- **Crude Mortality Rates**
- **What It Shows**: The number of patients who died in the hospital without adjusting for risk factors.
- **How to Read It**: A rolling monthly total of mortality within Hospital.
- **Deaths Per 1,000 Occupied Bed Days**
- **What It Shows**: The number of deaths in relation to the total day's hospital beds were used.
- **How to Read It**: Look for trends—if the rate is decreasing, it indicates improvement in patient outcomes. Spikes might suggest seasonal factors or specific issues requiring attention.

Graph and chart glossary

- **MI-Related Mortality**
- **What It Shows**: Death rates within 30 days of admission with an MI
- **How to Read It**: Look for comparisons to the peer averages or trends over time. Lower rates reflect better clinical outcomes.
- **Stoke-Related Mortality**
- **What It Shows**: Death rates within 30 days of admission with a Stroke
- **How to Read It**: Look for comparisons to the peer averages or trends over time. Lower rates reflect better clinical outcomes.
- **A&E Admitted Mortality**
- **What It Shows**: Death rates where patients have been admitted via A&E
- **How to Read It**: Look for comparisons to the peer averages or trends over time. Lower rates reflect better clinical outcomes.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	08 April 2026
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Nationally Reportable Incidents – System-wide Deep Dive
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Maxine Hiscock – Assistant Head of Patient Safety

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Patient Quality, Safety and Outcomes Committee noted concerns regarding the timeliness of Nationally Reportable Incident (NRI) investigations, including a small number of long-outstanding cases. A system-wide deep dive has therefore been undertaken in order to provide assurance on process, performance and learning.

Cefndir / Background

Nationally Reportable Incidents (NRIs) represent the most serious patient safety incidents in NHS Wales and are subject to mandatory reporting. Investigations are undertaken under the Putting Things Right (Wales) Regulations 2011 and the NHS Wales Patient Safety Incident Reporting Policy (2023). The work also supports compliance with the Duty of Candour and Duty of Quality.

When a serious patient safety incident occurs within the Health Board, it is first recognised and recorded locally by staff as part of routine incident reporting. At this earliest stage, the focus is on understanding what has happened, ensuring that immediate actions are taken to make care safe, and supporting those affected. An initial review is carried out to establish the nature of the incident, the level of harm involved, and whether it meets the national criteria to be classed as a Nationally Reportable Incident. Where the criteria are met, the incident is formally notified to NHS Wales.
At the same time, the organisation must meet its Duty of Candour obligations by being open with the patient or family, explaining that something serious has

occurred, offering an apology, and advising that a full investigation will follow. This early phase is often referred to as the pre-investigation stage and can take time where information is incomplete, harm is not immediately clear, or external agencies such as the police or coronial services are involved.

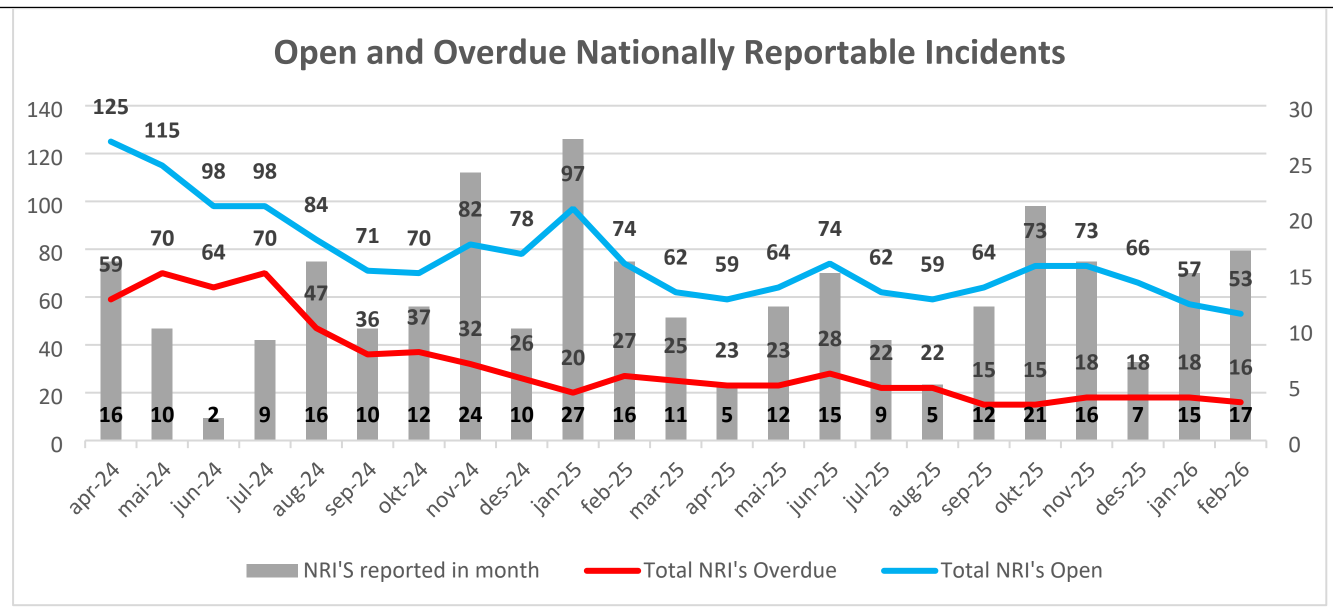
Once the incident has been confirmed as a Nationally Reportable Incident, the process moves into the investigation phase. A decision is made by the Clinical Executive Team on if the incident is a local (divisional) investigation or should be Corporately lead. This decision is based on a number of factors including severity and if the learning is likely to be cross-divisional. An Investigating Officer is appointed and a structured investigation plan is developed. The purpose of this stage is not to apportion blame, but to understand what happened, why it happened, and what can be learned to reduce the risk of similar incidents occurring again. The Investigating Officer reviews clinical records, timelines and other relevant evidence, and may speak with staff involved to understand how systems, processes or communication contributed to the incident. Where appropriate, patients or families are kept informed of progress and offered opportunities to contribute their perspective. The investigation must be proportionate to the complexity and severity of the incident, which means that some cases are straightforward while others involve multiple services, organisations or external reviews. As a result, this peri-investigation stage is often the longest part of the process.

Following completion of the investigation, the process enters the post-investigation phase, which focuses on review, approval and learning. The investigation report is quality checked to ensure that it clearly explains the findings, identifies meaningful learning and includes a robust action plan. The report is then reviewed at the appropriate divisional and executive level to provide assurance that the investigation has been thorough and that the proposed actions are appropriate and achievable. Where further clarification or improvement is required, the report may be returned for amendment before final approval. Once signed off, the incident is formally closed with NHS Wales Performance and Improvement and the organisation’s focus shifts to implementing and monitoring the agreed actions. Learning from the incident is shared to strengthen systems and improve patient safety, supporting the wider Duty of Quality by ensuring that improvement follows harm.

Assessment

Volume and Compliance

The number of Nationally Reportable Incidents (NRIs) submitted to NHS Wales Performance & Improvement have remained consistent year-on-year despite month-on-month variation, as shown in the graph below.



The graph also shows the number of open NRIs and the number of overdue NRIs. From a peak of 70 overdue NRIs in July 2024 a significant reduction (77%) has been achieved with just 16 open NRIs now being overdue.

Currently there are two NRI's that are overdue completion by more than 12 months. One incident occurred in July 2023 and due to pending criminal proceedings the Health Board has been prohibited from investigating, sentencing is due in March 2026 and at this stage local procedures will be allowed to begin. The second incident occurred in January 2024 and has also been delayed due to criminal proceedings, local investigations began in September 2025 and this is currently being reviewed by the Executive lead before closure.

Case Audit and Phase Analysis

An in-depth review of 7 cases that took in excess of 6 months to investigate and close in 2025/26 has been undertaken. The review examined the timescales within the pre, peri and post investigation phases. It has also examined the causes for delayed, themes and lessons to be learnt.

Pre-investigation

The review has determined of the 7 cases, 1 was notably delayed during the pre-investigation phase and 3 more took longer than the timescales recommended within the Health Board's Patient Safety Incident Policy.

The themes identified were delays in:
- Collecting information required to aid decision making;
- Medical input to complete harm reviews;
- Appointment of suitable Investigating Officers;
- Coordination of key stakeholders (Clinical Executives, Chairs, Investigation Officers etc.);
- External processes and pressures (Criminal proceeding or NRIs involving commission care for example).

Peri-investigation

This phase has been identified as the most common cause for delay, with 6 of the 7 reviewed cases experiencing significant delay during this phase.

The themes identified were delays in:

- Time constraints on Investigating Officers (allocated time is not currently mandated);
- Operationally pressures and patient care taking precedence over NRI investigations;
- External reviews which are incompatible with NRI timescales (particularly an issue within Maternity and Neonatal Services);
- Cross divisional, cross-Health Board and multiagency cases result in delays in coordination and information gathering;
- Delay in the creation of Action / Improvement plans.

Post-investigation

This phase resulted in some form of delay in 6 of the 7 reviewed. Whilst the delays were not as significant as the Peri-investigation phase they did provide the following themes:

- Quality of final reports and action plans for Divisionally led investigations can result in unexpected but necessary changes during this final phase;
- Complexity and detail provided within some reports (particularly Mental Health & Learning Disabilities division) result in extremely (unnecessarily) long reports for Clinical Executives to review and sign off;
- Delays in uploading of information on to RL Datix (a requirement for NRI closures to be submitted).

Patient Safety Incident Development Plan 2026/27

Whilst significant improvement has been made to reduce the length of time it takes to investigate and implement learning for Nationally Reportable Incidents the assessment above has highlighted areas for improvement.

Throughout Quarters 3 and 4 of 2025/26 the creation of an annual development plan has been formulated, with a proposal taken to Clinical Executives in February 2026 and the Quality Management Group in March 2026. This proposal aims to learn from the themes identified above in a structured, phased approach across the next financial year.

Pre-investigation Phase

In Quarter 1 the proposal includes a more structured and proactive approach to reviewing new incidents as soon as they are reported. A daily short safety huddle within the Quality and Patient Safety team will provide early corporate oversight of new patient safety incidents (scheduled to go live from 06 April 2026). The purpose of this early review is to ensure that incidents are quickly understood, that Duty of Candour requirements are considered at the outset, and that decisions are made promptly about whether an incident requires further escalation.

Where an incident involves moderate to catastrophic harm, the proposal includes the introduction of a rapid executive-led review. This brings together key clinical, divisional and corporate staff shortly after the incident to establish the facts, agree the scope of any investigation, allocate key roles such as the Investigating Officer and Family Liaison Officer, and identify any immediate learning or actions. It also serves to address the cultural causes for delays by providing senior oversight, appropriate prioritisation and resource allocation.

Peri-investigation Phase

In quarters 2 and 3 the investigation phase of the proposal focuses on improving the quality and efficiency of patient safety investigations once they are underway. Recognising that investigations are often complex and time-consuming, particularly for staff who are balancing this work alongside clinical or operational roles. To address this, the proposal outlines a plan to review and strengthen the support provided to investigators, improve how families are supported and engaged throughout the process, and revise investigation report templates so that they focus more clearly on why events occurred rather than excessive detail. The intention is to reduce unnecessary delays and produce clearer, more meaningful reports that support learning and improvement.

Post-investigation Phase

In quarter 4 the post-investigation phase will address how investigations are reviewed, approved and closed. The proposal includes the need for clearer and more streamlined sign-off arrangements to improve accountability and oversight. It also emphasises the importance of ensuring that action plans arising from investigations are properly recorded, monitored and audited so that learning leads to real and sustained improvement in practice.

Argymhelliad / Recommendation

The Committee is asked to:

- Note the improvements already made in the timely closure of Nationally Reportable Incidents as seen by the reduction in the number of open overdue cases.
- Note the themes and learning obtained following review of the 7 oldest cases to be closed in 2025/26.
- Endorse the 2026/27 Patient Safety Incident Development Plan.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 3.1 Safe and Clinically Effective Care 6.3 Listening and Learning from Feedback Governance, Leadership and Accountability
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	NHS Wales Patient Safety Incident Reporting Policy (2023)
Rhestr Termau: Glossary of Terms:	NA
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	NA

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Yes, outlined within the paper

• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	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/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Choose an item.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	08 April 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Unplanned Caesarean Sections Data
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Jayne Beasley - Head of Maternity, Gynaecology & Neonatal Services

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This purpose of this paper is to provide key updates regarding the Maternity and Neonatal Assurance Report provided to the Patient Quality Safety and Outcomes Committee in February 2026. Namely, in relation to commencement of the Tongue Tie pathway and clinics within Aneurin Bevan University Health Board and the Caesarean section rates.

Cefndir / Background

Tongue Tie Pathway

Maternity services has not had a dedicated tongue tie pathway nor midwife led clinic, this work was formally undertaken by paediatrics and ENT. Due to delays in review for babies and families and capacity for paediatrics this was highlighted as an area of improvement and included within the maternity improvement plan 2024-2027.

Caesarean Section

Intervention rates have been noted to increase, with caesarean birth increasing yearly, with emergency or unplanned caesarean sections seeing the biggest increase. The percentage of births undertaken by caesarean section have increased from 26% in 2019 to 41% in 2024. The service maintains its birth records via the

maternity dashboard. Key patient quality and safety metrics provide valuable intelligence and when compared against local and national standards can provide a useful baseline for providing assurance, measuring improvement and identifying areas where action is required.

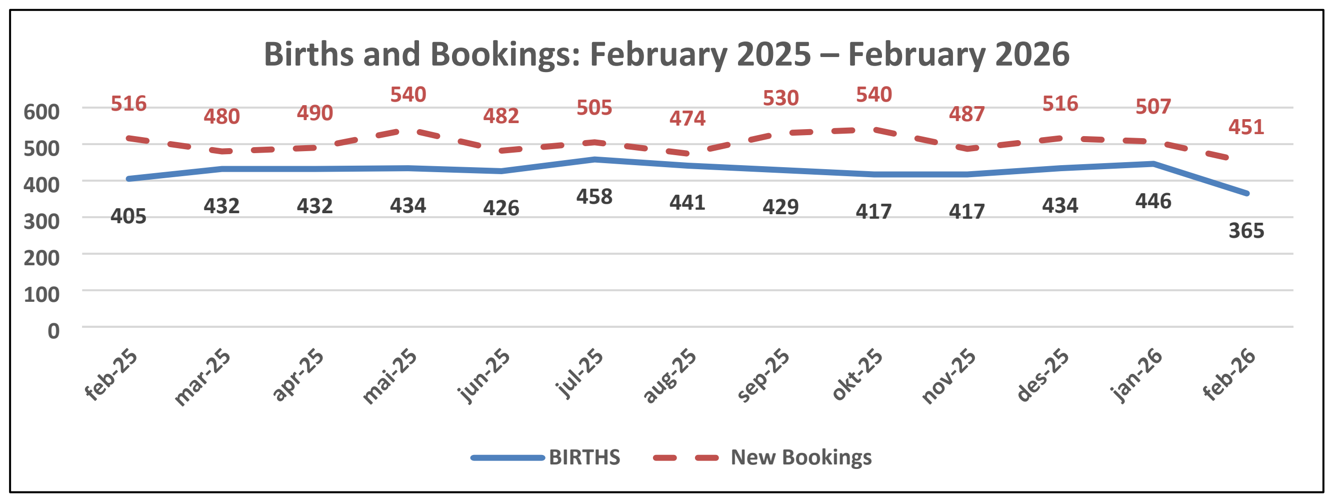
Asesiad / Assessment

Tongue Tie Pathway

- 2 midwives, the infant feeding lead and public health lead midwife have undergone training in 2025
- Tongue tie pathway developed for referral criteria
- Referral incorporated into digital system
- Guideline developed and ratified to support safe care
- Patient information leaflet incorporated into guideline
- Confirmed start date for clinics 7 April 2026

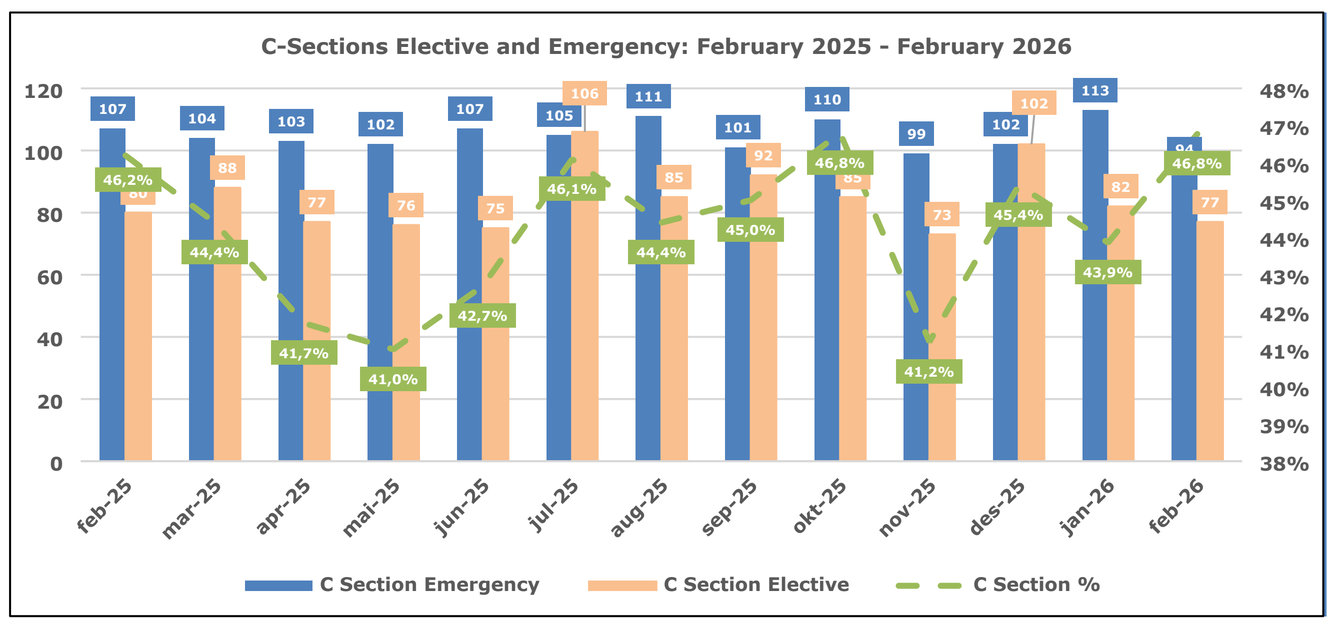
Caesarean Section

- Maternity service monitors caesarean section and key performance indicators monthly via a number of forums, clinical governance, maternity and neonatal assurance group and Divisional assurance meetings.
- Dashboard well established – feeds into All-Wales Beacon dashboard
- Benchmarking undertaken monthly
- Births and bookings stable 2025-2026

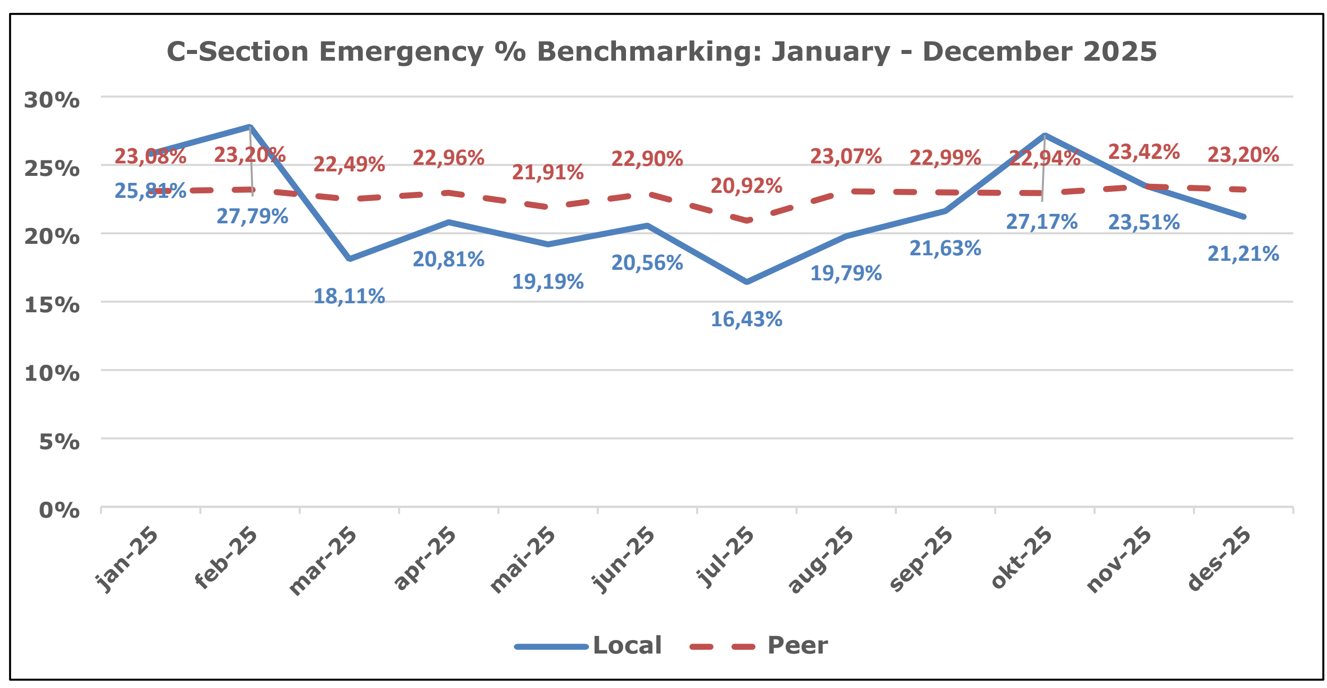


- Caesarean section rates totalling 43-45% - 10% rise since 2022.
- 2023 national data NMPA (National Maternal and Perinatal Audit) suggests unplanned caesarean section **lower** than expected for Aneurin Bevan University Health Board.
- Unplanned Caesarean section (defined as category 1, 2 & 3) higher than planned caesarean sections (defined as category 4)
- Noting subset definitions allows analysis:
  - **Category 1:** Urgent – threat to life
  - **Category 2:** Compromise but not immediately life threatening

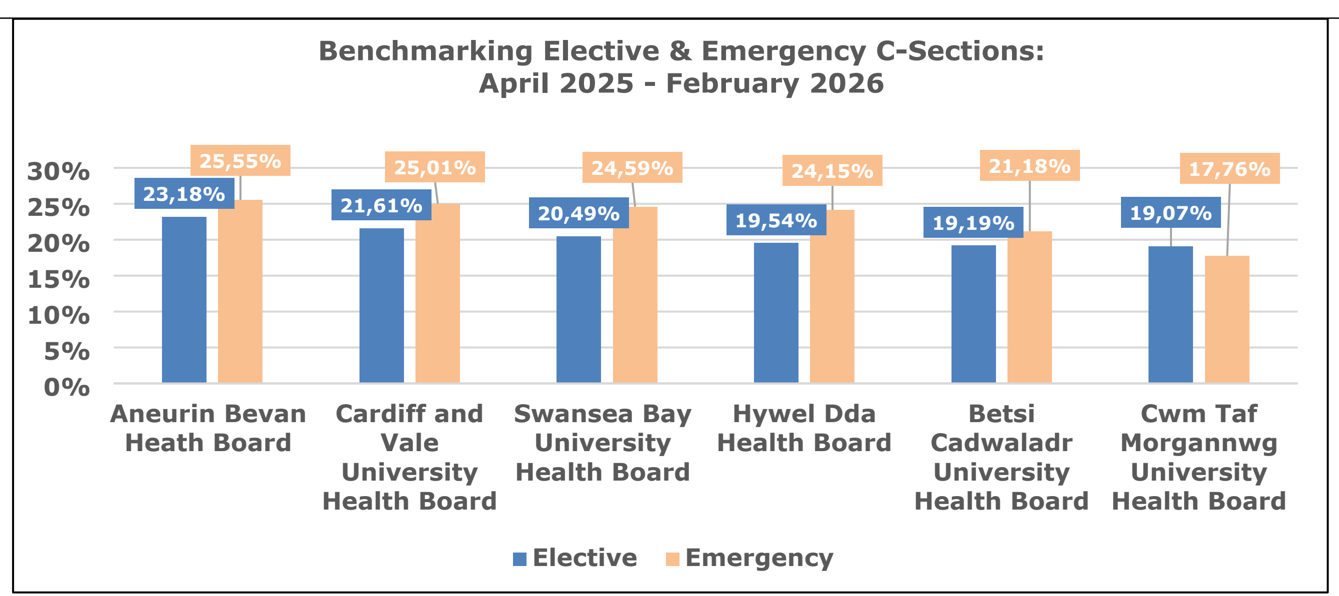
- **Category 3:** Early delivery needed but no immediate risk to life
- **Category 4:** Planned



- Improved data compliance since introduction of digital records sees increase in category 3 caesarean section (early delivery no threat to life can be done up to 24 hours)
- Local data benchmarked below demonstrates similar rates with monthly variation showing lower rates January 2025 December 2025.



- Overall unplanned caesarean section rates (as below) are higher April 25-Feb 2026 at 25.5% for Aneurin Bevan University Health Board – closest similar Health Board Cardiff & Vale at 25.01%.
- Not known if this is comparable data and category 3 captured as unplanned.



The current rates of caesarean birth have seen a gradual rise of 10% since 2022. Unplanned rates have traditionally been lower than planned rates this has seen a move over the last 3 years, with unplanned now being higher than planned.

2025 Data Breakdown of Caesarean by Category 1,2,3 & 4

Category 2: 68% of all unplanned caesarean sections (more urgent and within 75 minutes of decision)

Category 3: 20% of all unplanned caesarean sections (no immediate risk but early birth)

Month	CS Total	Grade 01 <31 mins	Grade 01 >30 mins	Grade 02 <31 mins	Grade 02 31-75 mins	Grade 02 >75 mins	Grade 03	Grade 04	Unable to categorise
Jan-25	188	6	3	4	29	42	23	81	0
Feb-25	178	7	4	5	27	38	22	73	2
Mar-25	188	10	3	4	30	44	17	80	0
Apr-25	176	10	3	3	27	44	18	71	0
May-25	173	5	3	5	27	44	21	68	0
Jun-25	175	7	6	4	29	33	24	72	0
Jul-25	205	3	5	5	14	47	38	93	0
Aug-25	187	6	9	7	32	38	24	70	1
Sep-25	187	8	10	2	26	43	18	80	0
Oct-25	186	8	7	4	31	39	22	73	2
Nov-25	168	4	9	6	38	33	10	68	0
Dec-25	198	6	2	6	31	34	30	89	0
Total	2209	80	64	55	341	479	267	918	5

A number of factors have contributed to this increase: -

- Increased gestational diabetes & Type 2 diabetes
- Failed induction /declined inductions
- Raised body mass index and comorbidities

- Increased maternal age and comorbidities
- Socio economic factors
- Increased fetal monitoring
- Updated guidance /movement from "normal birth "

Actions Taken

- Task and finish group to promote physiological safe birth address public perceptions
- Healthy weight pathway
- Lead midwife for diabetes in post
- Making every contact count with public health lead midwife
- Additional training in instrumental birth
- Fetal surveillance training compliance to support fetal distress assessment in labour
- BABI roadshows re birth
- Induction of labour group – 'nearly there' clinic
- Data collection and audit
- Continued surveillance via dashboard

Argymhelliad / Recommendations

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

NOTE the contents of this paper and the commitment to improvements in care.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 3. Effective Care 6. Individual care 7. Staff and Resources
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Workforce and Culture

Amcanion cydraddoldeb strategol Strategic Equality Objectives [Strategic Equality Objectives 2020-24]()	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
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 requirementsNo does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needsLong Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Choose an item.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	08 April 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	WRP Penalties and Learning Compliance: Update on Health Board Improvement Actions
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Tracey Partridge-Wilson - Deputy Director of Nursing Garvin Jones - Head of Legal Services

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

Ar Gyfer Penderfyniad/For Decision

The purpose of this report is to brief the Patient Quality Safety and Outcomes Committee on the current situation, recovery plan and improvement actions with regard to Welsh Risk Pool Financial penalties related to Learning from Events reports (LFERs).

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Recent all-Wales benchmarking data shared by Welsh Risk Pool (WRP) with the NHS Wales Chairs Peer Group (Appendix 1 and 2) has identified Aneurin Bevan University Health Board as the highest recipient of WRP penalties, with 55 penalties issued between April–December 2025. This reflects a deterioration in year-on-year performance, increasing from 34 to 55 penalties and places the Health Board at the bottom of the national comparison table.

WRP has also reaffirmed that ABUHB remains the only Health Board in Wales not passing penalty costs to relevant Budget Holders, despite this being an agreed national expectation and a recognised driver of improved compliance. Penalties are currently applied to the Legal Litigation Budget.

The scale of penalties, current operational pressures within Divisions and increasing national scrutiny collectively require strengthened action, clearer accountability and focused improvement.

Cefndir / Background

Clinical Negligence, Personal Injury and Redress are 'indemnified activities' under the all-Wales Welsh Risk Pool (WRP) indemnity scheme. When a decision is made to admit liability, this triggers a requirement to submit a 'Learning from Events Report' (LFER) to WRP for assurance around learning and actions to prevent future patient harm.

LFER's and all supporting evidence, are produced by the relevant Division, for ownership of their learning and actions, with divisional directors signing off the learning. Where LFER's are late and/or insufficient in providing supporting evidence of learning/actions, the Welsh Risk Pool (WRP) continue to impose fines of £2500 per matter. These fines are repeated bi-monthly until satisfied. Total Health Board fines to date are approaching £250k. (2023 – March 2026)

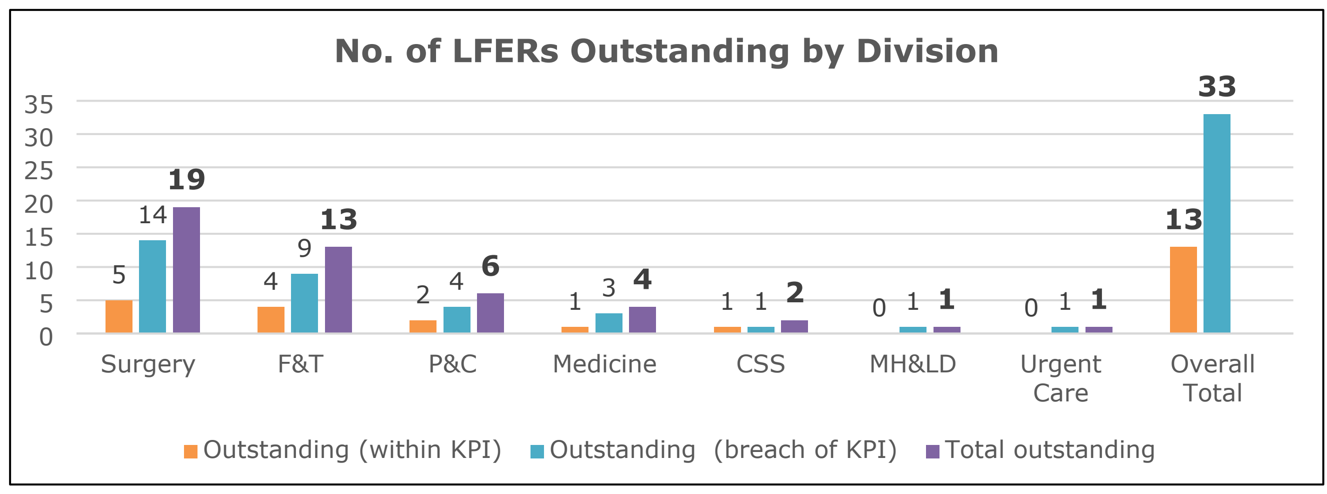
To maximise ownership, accountability and impact of penalties, the Welsh Risk Pool Committee recommended from the outset that health bodies pass the charges to individual budget holders who are responsible for the penalty charge. Whilst the fundamental purpose of LFERs is to prevent future patient harm, it is considered that appropriate application of penalties can be a helpful driver of change.

In the recent WRP Chair Paper, circulated to NHS Wales Chairs, the WRP Operations Team advised that all Welsh health bodies except one have applied this methodology. That Health Board is Aneurin Bevan, which was confirmed to be the worst performer with regards to penalties.

Asesiad / Assessment

1. Current Performance and Divisional Position

January data demonstrates that significant numbers of LFERs remain outstanding across several Divisions:



While some variation is expected due to case volumes, the level of KPI breaches is contributing directly to avoidable penalties.

2. Support Currently Provided by Legal Services

To assist Divisions, the Legal Team provides:

- Monthly LFER spreadsheets (x3) to Senior Triumvirate teams
- RAG-rated overview for rapid prioritisation
- Highlighting of urgent cases
- Divisional drop-in sessions
- Monthly escalation workshops
- Dedicated point of contact (Head of Legal)

Despite this, improvement remains inconsistent and fragile.

3. Further Support being Developed

To provide improved awareness and oversight of LFER performance the Divisional Triumvirate and the Corporate Operational Team will receive monthly slides

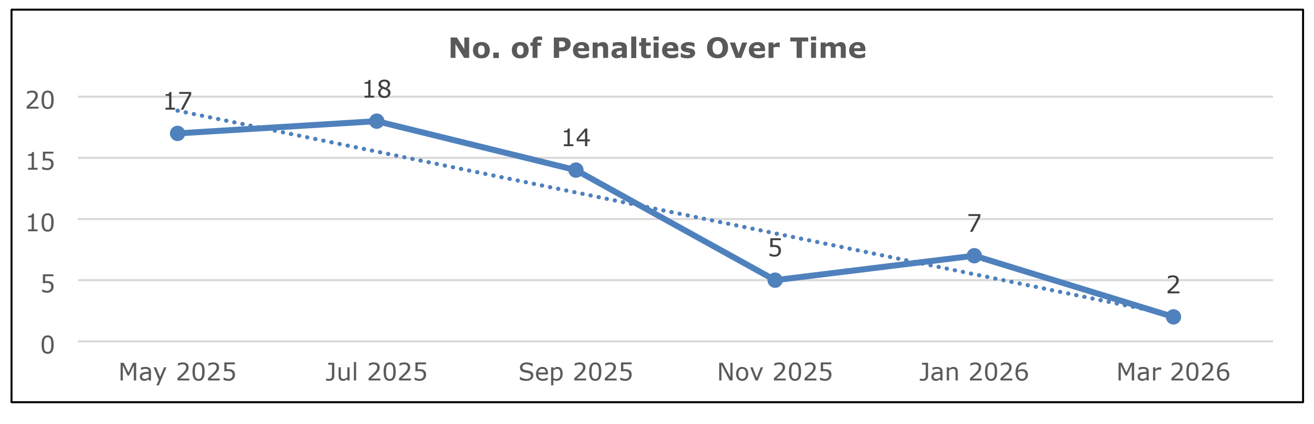
4. Divisional Pressures

Operational pressures, winter surge activity and the continuing demand on services must be fully acknowledged. Divisions and staff continue to operate under significant demand and operational pressures which impacts timely submission of LFERs.

It is equally acknowledged that the scale of financial penalties, national scrutiny and ongoing financial pressures requires renewed focus and strengthened governance to ensure learning is not compromised and penalties avoided. However, the ability of the Health Board to learn and improve is essential to prevent avoidable harm.

5. Improvement Actions

Legal and Divisional teams are working closely, at pace, on a number of improvement actions to recover the current position. QPS and Legal Workshops have been held to develop standardised pathways and flowcharts that may assist across all Divisions; pooling of knowledge and skills to address backlog; regular escalation meetings to drive improved compliance and resulting reduction in penalties. The clear overall trend over the last 12 months is one of reducing numbers of penalties.



6. Key Issues Identified

A review of current processes has identified several system weaknesses:

1. Lack of clear, standardised processes across Divisions (SOP);
2. Financial penalties for LFERs not being assigned to the responsible division;
3. Difficulty for Divisions in locating evidence to submit to WRP;
4. Fragmented and incomplete information being submitted.

These issues collectively hinder timely learning, risk reduction and penalty avoidance.

7. Analysis

1. Currently, each Division has their own informal processes for the management of LFERs. This lacks a formal, documented process that LFERs should follow, leaves significant gaps within the governance / accountability and does not define key role(s) responsible for escalation.

2. As described the LFER fines are currently absorbed by the Legal Litigation budget cost code. This has created a separation of Divisional accountability and the financial implications of non-compliance. It is important to recognise that the financial penalties should not exist as the primary motivator for change. Each fine equates to the Health Board's inability to evidence learning following an adverse event.

3. Difficulties exist in the Divisions locating key documents that are essential for all LFER submissions, such as reflections from staff involved. Whilst completed at the time, these are challenging to locate years later due to variations in record keeping and the time elapsed. A review of the Patient Safety Incident process is underway and will aim to address this record keeping variation through improved Corporate oversight and the creation of a standardised checklist, using RL Datix as the repository for information that may become pertinent in completing LFERs. Whilst this will not immediately result in a reduction of unnecessary fines due to the inability to locate documents it forms part of the wider essential improvement required to create a sustainable LFER process.

4. A significant challenge persists with incomplete submissions of evidence being provided to the Legal Services. As the Legal Services team are not clinically trained, they cannot assess or determine if the information provided is accurate and sufficient. This has resulted in numerous delays with further material required (resulting in additional financial penalties). Improvements are taking place around training and awareness of the Divisional Quality and Patient Safety teams to help support in the coordination of evidence gathering.

5. The number of open LFERs, the inability to evidence learning and the consequential financial penalties since 2023 have been a significant risk. No Health Board recovery plan has yet been agreed. A mandated improvement plan in conjunction with the issues/solutions outlined above (1-4) would allow for clear, monitored improvements for each division, with the expectation that

divisions eliminate financial penalties. From a Health Board perspective an 80% reduction in penalties would bring us in line with the Wales average. This target is known to be achievable based on All Wales WRP data.

From April, Legal Services will be replacing the monthly Divisional spreadsheets with a single report run directly from Datix, our operating case management system. The intention is to run a single report, with ability to filter between Divisions and drill down into specific KPI data. It is hoped this will be a further improvement to provision of LFER data for Divisions to track and take timely action.

This paper forms the basis of Legal Services recovery plan, setting out everything that has been done and is being done to recover the LFER position. The legal team have also developed a SOP setting out agreed standards and KPI timelines for LFER management.

Each division must now create its own standard operating procedures and local improvement plans, as mandated by the approved Option C.

Argymhelliad / Recommendation

The Patient Quality Safety and Outcomes Committee is asked to:

- **NOTE** the significant work and actions underway to recover the current position and improve the Health Board's performance and compliance with LFER requirements, thereby reducing financial penalties.
- **NOTE Option C** has been selected by the Executive Committee on 30 March 2026. General support that accountability needed to sit in the right place
- **NOTE** Penalties will be aligned to relevant budget holders from 1st May 2026

Option A – 'Do nothing' option with nothing mandated to change other than improvements taking place between Legal Services and Quality and Patient Safety teams. This option will likely see a continuation of the risks outlined.

Option B – Mandate the creation of a standardised operation procedure and the other improvements outlined. This option will strengthen the Divisional governance, accountability and escalation processes to drive improvement without attributing financial penalties and setting an improvement plan.

Option C – Begin attributing LFER penalties to the responsible Division and create a Divisional Improvement Plan which sets out the expectations to reduce penalties over 2026/27. In additional to creating a standardised operation procedure and the other improvements outlined.

Option C would be the preferred option.

	Option A	Option B	Option C
1- Divisional SOP	Optional	Mandated	Mandated
2- Financial penalties assigned to Divisions	No	No	Yes
3- Locating evidence for LFERs	Yes	Yes	Yes
4- QPS Coordination	Yes	Yes	Yes
5- Divisional Improvement Plan	No	No	Yes
Executive/ QMG Oversight	Quarterly	Quarterly	Quarterly

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):	3.2 Communicating Effectively 3.2 Communicating Effectively 6. Individual care 6.3 Listening and Learning from Feedback
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Experience Quality and Safety Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Welsh Risk Pool Committee; Learning Advisory Panel; WRP and Internal Audit; NWSSP Legal & Risk Services; RL Datix and Finance Data
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.

WRP CHAIR PAPER

CIRCULATION:	NHS Wales Chairs
DATE:	28th January 2026
Author:	*Jonathan Webb* *Head of Safety & Learning, Welsh Risk Pool*
RESPONSIBLE LEAD	*Tracy Myhill OBE* *Chair of NHS Wales Shared Services Partnership* *Chair of Welsh Risk Pool Committee*

TITLE OF REPORT	Outline of Welsh Risk Pool Penalties *2024-25 and 2025-26 (up to 31/12/2025)*
PURPOSE OF REPORT:	To summarise the background to the application of penalties, value of penalty charges and distribution of charges to health bodies during last year and the current year.
ACTION REQUIRED:	Chairs are asked to **NOTE** the information and direct any queries to welsh.riskpool@wales.nhs.uk

Background

Penalties have been included as part of the Welsh Risk Pool Reimbursement Procedures for a number of years. As part of the introduction of the Safety & Learning function in 2016, Welsh Government asked the Welsh Risk Pool Committee to consider a range of financial incentivisation measures and penalties were formally included in this. Other incentivisation measures include the risk sharing agreement and allocation of project funding.

The value of, and the decision to apply, penalties is discretionary and is determined by the Welsh Risk Pool Committee. A decision has been made to be fair in the application of penalties.

The current level of WRP Penalty was agreed in 2019 by the committee and is set as 10% of the excess payment for a negligence claim (£2,500.00).

Financial Accounting of Penalties

To maximise recognition and impact of penalties, the Welsh Risk Pool Committee has requested that health bodies pass the charge to individual budget holders who are responsible for the cause of the penalty charge. The WRP Operations Team are advised that all health bodies except one have applied this methodology.

Following advice from Welsh Government Finance in 2022, the methodology of accounting for penalties was changed from a deduction from a sum reimbursed in a case to a straight charge levied by the WRP via an NHS-to-NHS invoice.

The charges applied are collect and paid into the Delegated Expenditure Limit (DEL) budget that is used to pay claims in-year. This positively impacts the amount payable by organisations who do not receive penalties.

Driving Behaviour Change

Whilst not a significant sum in isolation, information gathered from participants of the National Learning Advisory Panel strongly indicate the positive driver on behaviour – with budget holders and service leaders taking relevant action to avoid future penalties in a number of organisations.

The impact of penalties have led to strategic programmes in three organisations, each of which have positively impacted performance and quality of learning information.

Reasons for the application of WRP Penalties

Penalties are generally triggered for two reasons

- Significantly Late submission of Learning from Events Reports

This is usually a submission which occurs at least 100 days after the deadline.

- Significantly overdue deferred learning updates

This is usually when there is a delay of at least 3 months past the deadline for approval of the learning.

The rationale for these penalties is that the risk of re-occurrence of the causal factors which led to the claim or redress case remain unaddressed to the satisfaction of an independent panel.

Intensive Support Programmes

From 2024, the WRP Committee determined to invest part of the income received into the DEL budget from penalty charges into the Intensive Support Programme - which applies extensions and additional resources into the claims functions of organisations who have incurred penalties. These has been used differently in each organisation due to the differing setups within health bodies, although a common approach has been to provide additional support & training for the production of learning information.

Work as part of the BCUHB Intensive Support Programme sure a shift from over 70% of submissions triggering a penalty to less than 10% and an ongoing improvement. Some managers who signed LFERs previously admitted that they had not read them, to managers who receive a penalty needing to write a short report on the measures being taken to reduce the likelihood of reoccurrence.

Intensive Support Programme work is currently ongoing with CTMUHB and WAST. The CTMUHB programme involves local learning review panels and the WAST programme involves a recovery process to ensure timely submission of LFERs.

Summary of applied WRP Penalties

Chart 1 outlines the penalties applied to organisations in the two financial years to date. There has been a shift from penalties being applied for very late initial submission of learning information, to penalties being applied for very overdue deferred learning information.

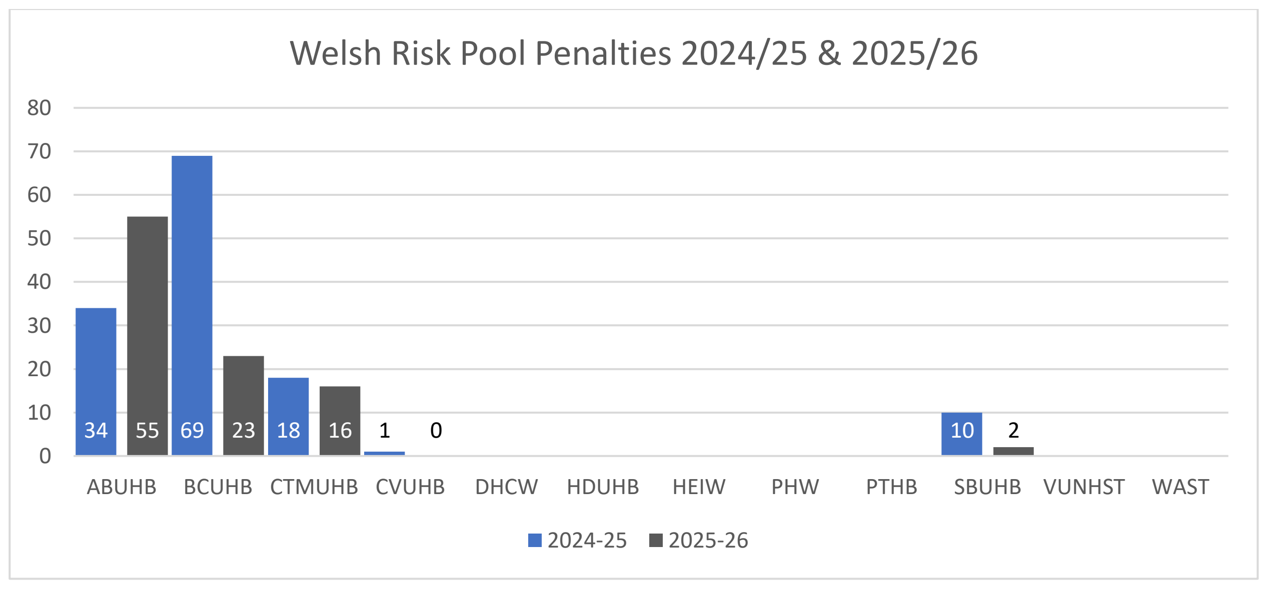


Chart 1 – Outline of WRP Penalties for 24-25 & 25-26

Welsh Risk Pool

WRP Penalties and Learning Compliance Summary
April – December 2025

- ***Penalties applied***
- ***Reason for penalties***

Jonathan Webb
Head of Safety and Learning

Sarah-Jane Williams
WRP Operations Manager

Bahar Chowdhury
Senior Safety and Learning Advisor

Eleri Wright
Senior Safety and Learning Advisor

NHS Wales Chairs Peer Group

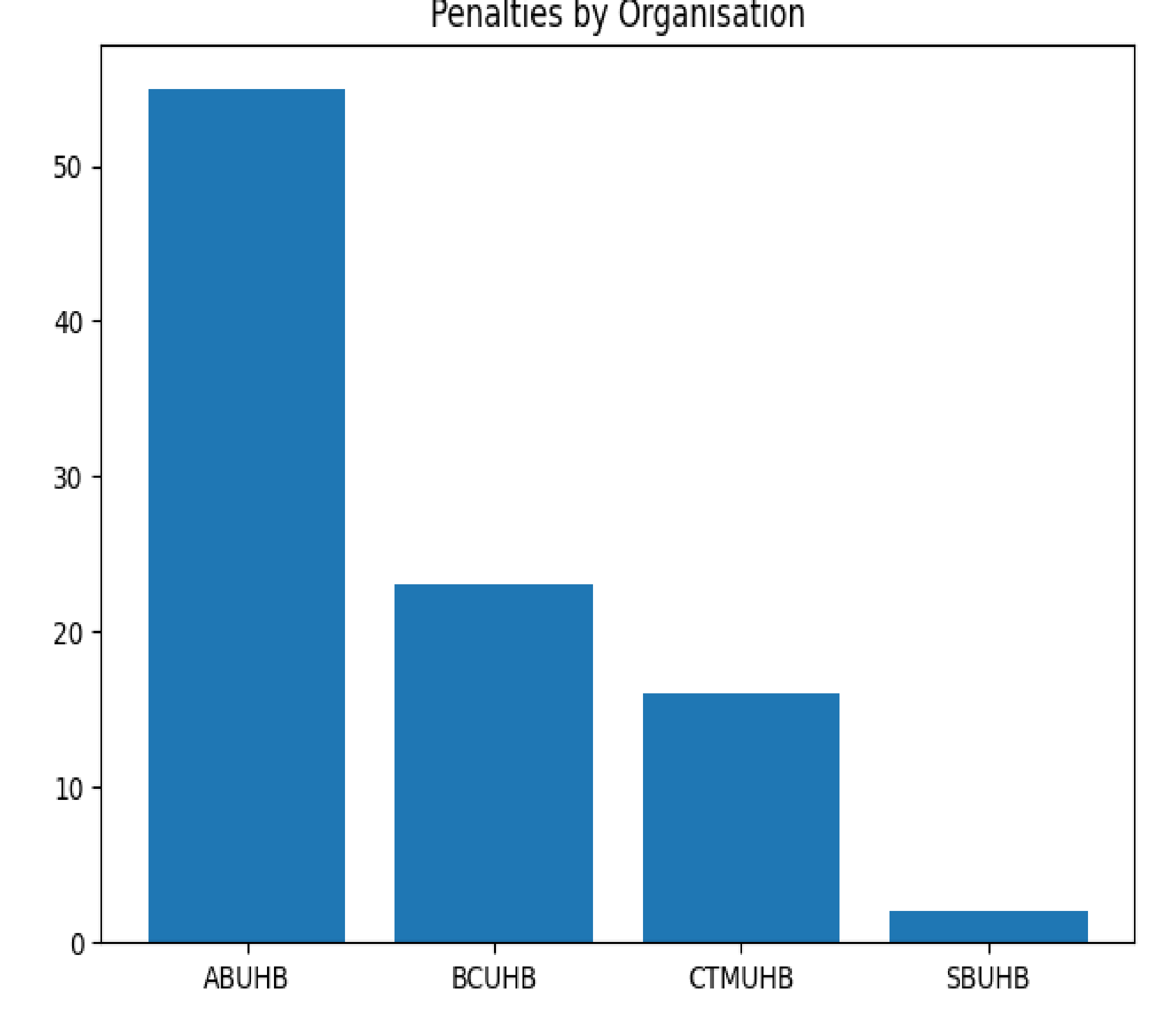
Delivering Value, Innovation and Excellence through Partnership

Welsh Risk Pool penalties

The WRP Safety & Learning Team have reviewed penalties applied between April and December 2025, considered alongside learning submissions and panel outcomes.

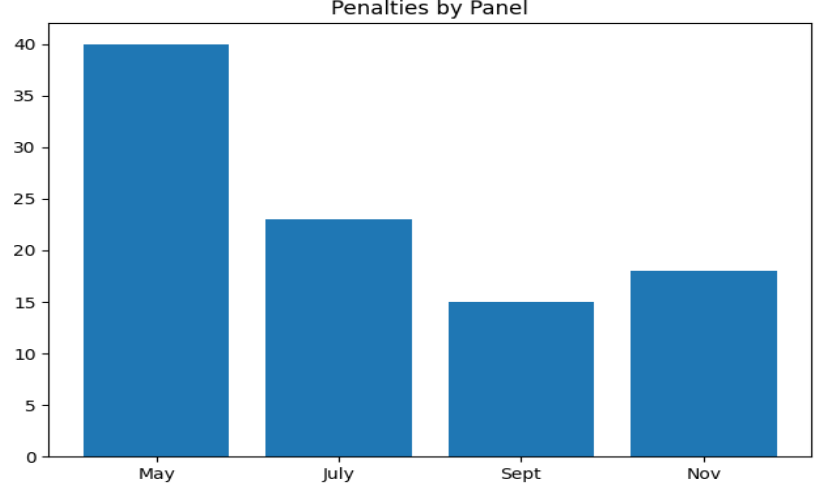
All Wales position

- 559 learning submissions reviewed
- 96 penalty cases applied
- Penalties highly concentrated in three organisations
- Most penalties relate to overdue deferred learning
- ABUHB, BCUHB and CTMUHB account for over 80% of all penalties issued.

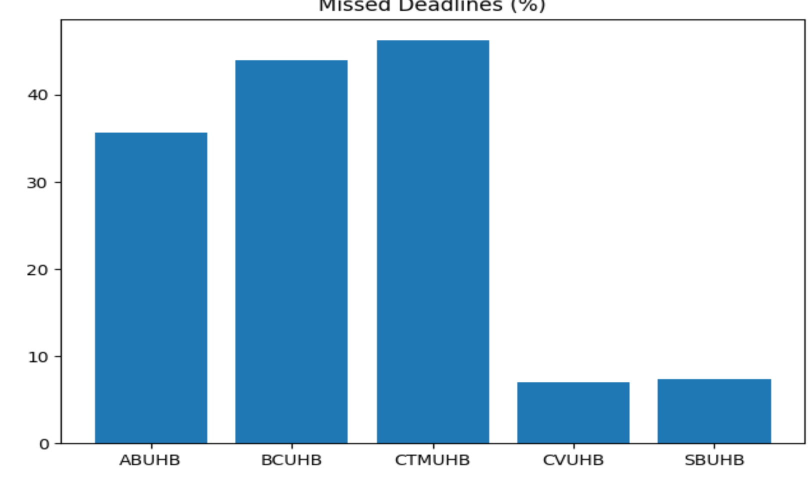


Welsh Risk Pool penalties

- Penalties peaked in May and July panels and have persisted across the year, with repeated penalties for the same cases in some organisations

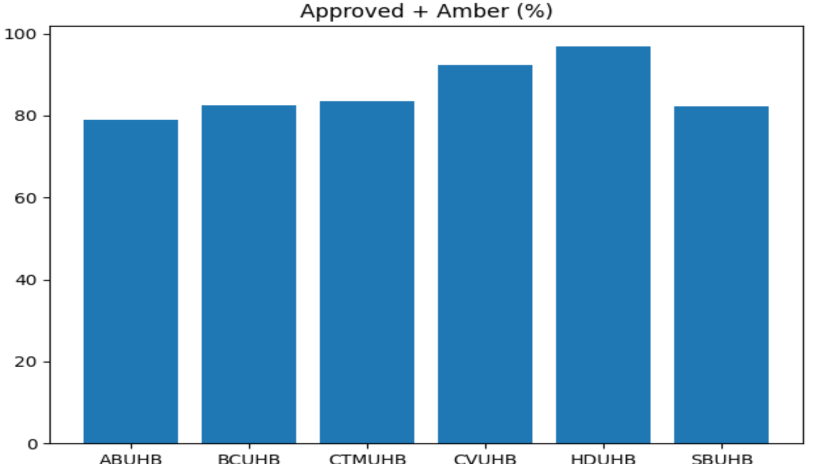


- High penalty organisations also demonstrate high rates of missed deadlines for learning submission. Organisations with good deadline compliance have minimal or no penalties.

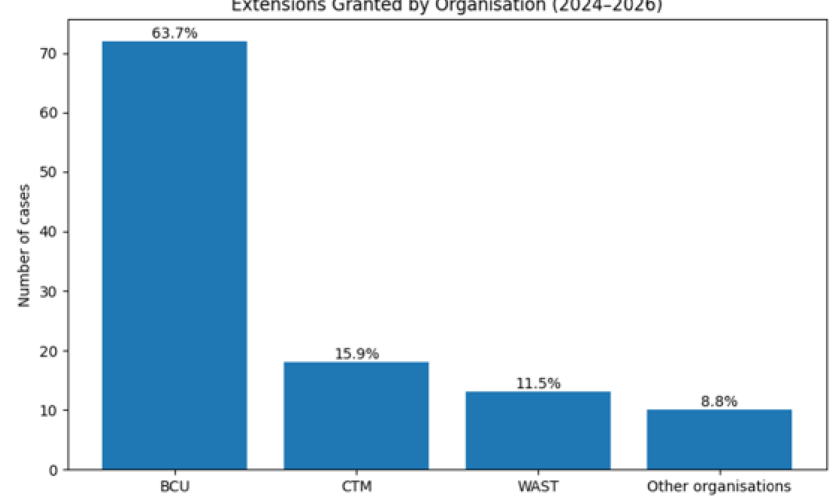


Welsh Risk Pool penalties

- Panel outcomes are broadly consistent across organisations, indicating penalties are driven by timeliness rather than learning quality.



- The application of an extension is delegated to HOSL by the Welsh Risk Pool Committee and is a one-time extension
- Multiple extensions have been granted to organisations who are currently engaged in support programmes to improve learning (CTM, BCU & WAST).



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	08 April 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

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

Ar Gyfer Trafodaeth/For Discussion

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation & Cefndir / Background

At the last Committee meeting in February 2026, it was reported that the risk environment remained stable, with no changes to the risk scores of the monitored risks.

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** **4 x 4** **(16)**	**Y**
SRR 008 Director of Nursing **Theme** Transformation & Partnership Working **Appetite** Open Score 17 and below	There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.	**Moderate** **2 x 4** **(8)**	**Y**
SRR 010 Director of Therapies & Health Science **Theme** Compliance & Safety **Appetite** Minimal Score 8 and below	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974.	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed, and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	**High** **3 x 4** **(12)**	**N**

Since the last report to the Committee in February, there have been no changes in risk exposure for the three risks assigned to this Committee for focused scrutiny.

Risk Exposure Aligned with Risk Appetite

SRR 010 continues to sit outside the Board's agreed risk appetite. While there has

been measurable progress in reducing both the likelihood and impact of this risk, supported by delivery of the Health and Safety Improvement Plan, the current position indicates that improvement is not yet sufficiently embedded or consistently realised across all areas.

As the organisation enters the new financial year, there is a renewed focus from the Corporate Governance Directorate to better understand the extent to which progress is being driven consistently at a divisional level, and where variation in performance or control effectiveness may persist. This is not unique to the health and safety risk, but applies across all strategic risks that remain above appetite. A more granular, deep dive is therefore warranted to assess whether risks are being appropriately scored, to challenge whether current and target risk scores remain valid, and to determine whether target scores are set at the most appropriate level. This will support a clearer understanding of underlying drivers of risk, surface any systemic weaknesses, and ensure that targeted, proportionate interventions are implemented where required.

In support of this, the Health Board's Performance Framework has been strengthened through the introduction of a dedicated Corporate Governance pillar. This enhancement is designed to reinforce accountability for risk management across divisions and corporate directorates, improve visibility of performance, and enable the identification of key themes and emerging risks. Its effectiveness will be central to ensuring that governance arrangements move beyond process and are actively driving improvement, transparency, and ownership of quality and safety risks at all levels of the organisation.

Closing Position

As at April 2026, the Committee's Strategic Risk Register comprises three high-level strategic risks and three associated sub-risks, one of which currently remains outside its defined risk appetite. All risks continue to be monitored actively through the established governance and assurance framework, with particular attention given to those posing the greatest potential impact on patient quality and safety.

Given the position outlined, the Committee may take reasonable assurance that organisational risks are being systematically identified, assessed, and managed, and that appropriate mechanisms for review and escalation are in place where required.

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:	The Board and respective Committees of the Board have considered risks contained within the Strategic Risk Register

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. N/A

					Risk Score												
Risk ID and Description				IMTP Link	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**				
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 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
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.

		Risk Exposure	Current Level	Target Level
Lead Director	Chief Operating Officer			
Monitoring Committee / Group	Patient Quality, Safety and Outcomes Committee	**Likelihood**	**4** (Likely) x	**3** (Possible) x
Initial Date of Assessment	June 2023	**Impact**	**4** (Major)	**3** (Moderate)
Last Reviewed	March 2026	**Risk rating**	**= 16 (Extreme)**	**= 9 (High)**
Next Review (Monthly based on risk score)	April 2026			

SRR 005 A
Risk Score
Month
Current Risk Score
Target Risk Score
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)*

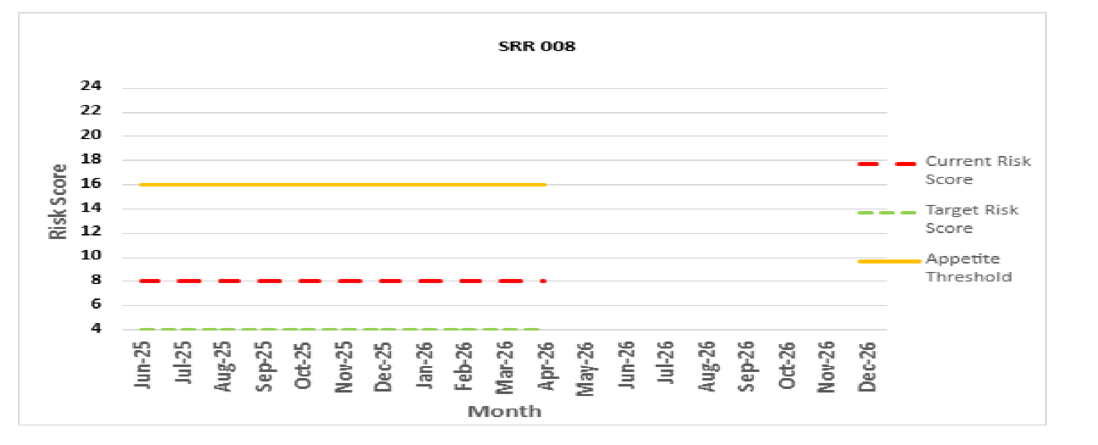
• Escalation Policy.
• Performance and Accountability Framework
• Operational Framework
• Major incident Procedures
• Daily ONP flow meetings - Twice daily ONP calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks.
• Escalation communications – 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.
• Weekly system safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Data driven. action focussed and task driven.
• Enhanced monitoring in place for U&EC – level 4
• 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 (including risk assessed boarding) plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. Full Capacity Protocol is in place.
• Planned care delivery plan agreed and recovery meetings with the NHS execs to support activity.
    • 26-week OP programme is well underway, and HB is currently exceeding numbers for first outpatient appoints.
• Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls.
• WG – IQPD meetings to review areas of focus
    • Regular meetings with Local Authorities to review POC delays and LOS concerns.
	➢ **Continue Refocus on Our New Patient and key pieces of work: -**
	Discharge Acceleration
	• Daily board rounds identify definite and potential discharges early to free up beds before peak demand
	• Weekend discharge lists are shared proactively to maintain flow across all sites.
	Full Capacity Protocol:
	• Boarding continues across sites under strict risk assessment, with escalation to use dayrooms or therapy spaces only as a last resort.
	• Red lines for boarding (e.g., avoiding high-risk patients) are reinforced in SOP discussions.
	Step-Down Coordination:
	• Flow Centre actively books and allocates step-downs; priority is given to patients who can safely move to community beds or lower-acuity settings.
	• Community bed usage is maximized, with reablement teams engaged to expedite transfers.
	• Contingency for Delays - where step-downs stall, escalation includes opening additional community beds and using SDEC for low-acuity patients.
	Rapid Offload Strategy:
	• Flow Centre monitors ambulance waits and redistributes crews to minimise delays.
	• Plans include prioritizing high-risk patients for cubicles and using lounges for temporary placement.
	Standard Operating Procedure (SOP):
	• A simplified SOP is being finalised to standardize escalation pathways, boarding criteria, and discharge prioritization across divisions.
	• Divisional "red lines" (e.g., elective bed protection, infection control limits) are being formalised for consistent decision-making.
	Data-Driven Oversight:
	• Flow Centre dashboards and live trackers are used to monitor patient movement, discharge progress, and capacity in real time.

	• Development of new dashboards to track EDDs and Red Reasons to inform system flow decisions. • New ED extension opened on the 17th December with phase 2 to start in the new financial year • Additional ED consultants in place • New expanded transfer lounge is progressing well, supporting with transport booking and supporting early movement of patients. • Focus Areas for the next month: • Develop Our Next Patient UEC recovery plan – Board review in March • Programme of work has Divisional projects across the system to support flow • Work with social care and PCC division on joint assessment and community bed delays to consistently improve discharge reliability. • Reset regularly — ONP highlights the need for routine reset days/fortnights to correct worsening patterns in flow, WTBS, and handovers.

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 • Regular ONP meetings to review flow • S2S meeting - creates a consistent, standardised process for assessing readiness, escalating issues, and agreeing collective plans, fostering clear accountability from ward to board level. Weekly weekend planning meetings in place to plan for the weekend capacity	• 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 • Outputs and progression of actions from ONP and S2S meetings to sustain system 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)*		
• Monthly Divisional Assurance reviews. • Mid and EoY Reviews for Divisions • Performance against measures/metrics reported to the Executive Committee • Planning and Performance Committee Cross Divisional Meetings – cross divisional thinking, learning and sharing best practice	• The Operational Framework is being developed to define how individual services meet demand and outline the actions required during escalation. This framework is currently under refinement through the Our Next Patient (ONP) work. •	• 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. • IQPD Monthly Meetings focus on key areas • GIRFT visit • Accelerated Design Event / Programme of work • Winter Sprint – December 2025 and January 2026 MAG Report - focus areas for ABUHB	• **Clinical Leadership & Patient Experience:** Strong emphasis on clinically led, data-driven change, with patient stories highlighting the real-world impact of delays. • **Mandated Targets:** The 45-minute ambulance handover target is to be mandated, with an ambition to reach a 15-minute standard for patient safety. • **System-Wide Responsibility:** Improvement requires engagement across all sectors—ED, primary care, community, acute medicine, surgery, and ambulance services. **Improving Performance Together (MAG Report)** • 45 min hand overs, • clarity over fragile services asks and delivery • accountability for regional working in our region • asks around data sharing and use of comparative data sets – definitions are still work in progress • indicates population health management tools will be available – Alignment locally • breathlessness and lung cancer alignment with our own plans • Integrated care hubs • Define the funding and delivery shift from Secondary to Primary Care– with a plan	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.**				**Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact *(Consequences of the threat)*	**Patient** • Unmet patient needs resulting in patient harm. • Ineffective use of combined resources • Delayed decision making • Adverse impacts on delivery of care to patients across acute and non-acute settings • Negative experience of care • Distress and frustration. • Carer stress.	**Staff** • Staff dissatisfaction • Frustration • Increased absence. • Loss of confidence.		**Organisation** • Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence	**Risk Appetite Threshold – OPEN SCORE 17 and Below** All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change. **SUMMARY** The current risk level is **OUTSIDE** of target but **WITHIN** the appetite threshold. Target level is **WITHIN** the set appetite threshold.	
Lead Director	Director of Nursing	Risk Exposure	**Current Level**	**Target Level**		
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	**2** (Unlikely) x	**2** (Unlikely) x		
Initial Date of Assessment	June 2023	**Impact**	**4** (Major)	**2** (Minor)		
Last Reviewed	March 2026	**Risk rating**	**= 8 (Moderate)**	***= 4 (Low)***		
Next Review (Six monthly based on risk score)	September 2026					



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. • DATIX • Oversight of Medical Examiner reports to determine patient experience actions • Public Engagement- Big Conversation Bereavement held 20th March 2024, Big Conversation Sepsis Sept 2025 and Big Conversation Care Homes December 2025 • People Participation Panel ED in Progress, PPP for Deaf People established • Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams. • 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 across all 5 boroughs	• 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 in progress. Short Term grant funding for Band 2 data entry support • 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 and IQPD • 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 launched 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. Continued participation in national meetings • Volunteer feedback to be reviewed to identify themes. This happens weekly • End of Life and Bereavement models published and meets Bereavement Standards. • EOLCB refresh completed to meet National Palliative and End of Life Care Specification and National Competency Framework • Community of Practice for Patient Experience and People Participation Panels (PPP) now agreed and to be progressing. BSL version of PPP leaflet secured. • Dementia community hubs in each borough of Gwent enable accessible opportunities for feedback and signposting, plans to increase hubs in more areas of Gwent. Annual Dementia Report scheduled for Board March 2026

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 • People Participation Panels • Bespoke Big Conversations	• 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. This is being reviewed in light of the new Listening to People framework • 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. Civica lead in regular contact with National Leads and risks identified through Director of Nursing Meetings/SBARs • 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. • PALS and Chaplaincy Team undertaking BSL training to support Deaf Community • 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 have been built into ward accreditation. • Development of a ABUHB bereavement survey has been built within CIVICA and tested. This is being reviewed to better align with the national Patient Experience Survey- anticipated to go live from April 2026 • Community of Practice for Patient Experience commencing March 2026. Topics will include supporting teams to publicise 'You Said/We Did'.
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 • 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 Assurance**

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**	**Staff**	**Organisation**
	• Unintended physical harm to patients • Psychological trauma	• Unintended physical harm to staff • Psychological trauma • Increased levels of staff sickness	• 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	December 2023	**Impact**	**4** (Major)	**3** (Moderate)
Last Reviewed	March 2026	**Risk rating**	**= 12 (High)**	**= 6 (Moderate)**
Next Review (Quarterly based on risk score)	June 2026			

SRR 010

Risk Score: 24, 22, 20, 18, 16, 14, 12, 10, 8, 6, 4

Month: Jun-25, Jul-25, Aug-25, Sep-25, Oct-25, Nov-25, Dec-25, Jan-26, Feb-26, Mar-26, Apr-26, May-26, Jun-26, Jul-26, Aug-26, Sep-26, Oct-26, Nov-26, Dec-26

Current Risk Score
Target Risk Score
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)*
• 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. • Management actions from internal audits

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.	• Findings 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**

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	08 April 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Patient Quality, Safety and Outcomes Committee – Review of Committee Forward Work Plan 2026/27
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Governance Support Officer

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Patient, Quality Safety and Outcomes Committee is asked to review the agreed Committee Forward Work Plan appended to this report. The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2026/27 and to enable the Committee to: -

- Fulfil its Terms of Reference;
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference, and,
- Seek assurance that governance, risk, and assurance arrangements are in place and working well.

Cefndir / Background

In line with good governance practice, the Committee has a Forward Work Plan that was developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The Forward Work Plan can therefore

be utilised as a tool for informing and pre-empting Committee business and support the agenda setting process.

To aid the Committee when reviewing its programme of business, the Forward Work Programme captures the timing of when reports are to be submitted, identifies items that have been deferred and captures new requests for reports and enables the Committee to monitor and review its business at each meeting.

During the period the following requests and/or changes to the forward work plan have been included.

Additional items on the Forward Work Plan that were actions from February's 2026 meeting :-

- Healthcare Inspectorate Wales (HIW) Reports Update, this report would be presented to the Committee bi annually at June and December 2026;
- Pharmacy and Medicines Annual Report, this report would be presented at February 2027;
- Update on neonatal services, including progress on listening and lessons learned activity and the forthcoming national review, this report would be present at Committee in June 2026;
- Unplanned Caesarean Sections Data, this report would be present at the Committee in April 2026;
- Report on redress and the Legal and Financial Exposure Review (LFER) process, this report would be present at the Committee in April 2026;
- Analyse physical assault data, including whether incidents related to repeat individuals or specific wards, this would be an oral update under the Committee action log item;
- Progress update on the new PTR regulations, this report would be presented to the Committee in December 2026.

Additional items included on the Forward Work plan:-

- Healthcare business solutions delivery was requested to be added to the plan by the Chief Operating Officer and would be presented to the Committee in April 2026;
- Planned Care - Orthopaedics / Impact of Bone Cement Shortage was a transferred action from the Executive Committee and would be presented at April 2026 meeting;
- Deep Dive into National Reportable Incident processes and performance was a transferred action from the Mental Health & Learning Disabilities Committee and would be presented at April 2026 meeting.

Items removed from the Forward Work Plan:-

- Listening and learning framework annual report review was requested to be removed from the plan and would be reported through the Quality outcomes framework;
- Serious incident learning report was requested to be removed from the plan and would be reported through the Quality outcomes framework.

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 Corffforaethol 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 2026-27

Patient, Quality, Safety and Outcomes Committee

This Annual Programme of Business has been developed with reference to:

- Aneurin Bevan University Health Board's Standing Orders;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee's self-assessment for 2025/26
- The Board's Strategic Risk Register; and
- Key statutory, national and best practice requirements and reporting arrangements.

Area of Focus as per the Committee's Terms of Reference:
The scope of the Patient Quality, Safety and Outcomes Committee encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on: a. The robustness of the Health Board's Clinical Quality Governance arrangements; b. the experience of patients, citizens and carers ensuring continuous learning; c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services; and d. the effectiveness of arrangements in place to support Improvement and Innovation.

Where required, the Committee will provide accurate, evidence based (where possible) and timely advice to the Board in respect of citizen experience and the quality and safety of directly provided and commissioned services.

MATTERS TO BE CONSIDERED	Lead	Frequency of Report	QTR 1		QTR 2	QTR 3		QTR 4
			8th April 2026	2nd June 2026	28th July 2026	6th Oct 2026	1st Dec 2026	16th Feb 2027
Attendance and Apologies	Chair	SI	√	√	√	√	√	√
Declarations of Interest	Chair	SI	√	√	√	√	√	√
Minutes of the Previous Meeting	Chair	SI	√	√	√	√	√	√
Action Log and Matters Arising	Chair	SI	√	√	√	√	√	√
Development of Committee Annual Programme of Business 2027/28	DoCG	AN					√	
Review of Committee Programme of Business 2026/27	DoCG	SI	√	√	√	√	√	√
Committee Annual Report 2026/27 • Annual Review of Committee Terms of Reference 2026/27 • Annual Review of Committee Effectiveness 2026/27	DOCG	AN	√					√

• Outcome of Annual Review of Committee Effectiveness 2026/27								
Committee Risk Report	DOCG	SI	√	√	√	√	√	√
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 & DoAHP& HS	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			√			
Learning from Death Report	MD	Bi-AN	√			√		
Health and Safety Compliance Annual Report	DoAHP& HS	AN			√			
Safeguarding Annual Report	DoN	AN			√			
Ward Accreditation Report	DoN	AN					√	
Nurse Staffing Levels (Wales) Act 3-year report (3-yearly)	DoN	AN					√	
Nurse Staffing Levels Wales Act Annual Assurance Report	DoN	AN				√		
Annual Report on Clinical Audit Activity 2024– 2025	MD	AN		√				
Healthcare Inspectorate Wales (HIW) Reports Update (**PQSOC 1702/10**)	DoN	Bi AN		√			√	
Pharmacy and Medicines Annual Report (**PQSOC 1702/15)**	MD	AN						√
Planned Care - Orthopaedics / Impact of Bone Cement Shortage	COO	Action	√					

(presentation) (Action transferred from Exec's)								
Deep Dive into National Reportable Incident processes and performance (Action transferred from MHLDC Committee)	DoN	Action	√					
Update on neonatal services, including progress on listening and lessons learned activity and the forthcoming national review (**PQSOC 1702/08)**	DoN	Action	**√D**	√				
Unplanned Caesarean Sections Data (**PQSOC 1702/08)**	DoN	Action	√					
Report on redress and the Legal and Financial Exposure Review (LFER) process (**PQSOC 1702/07)**	DoN	Action	√					
Analyse physical assault data, including whether incidents related to repeat individuals or specific wards (**PQSOC 1702/06)** update given under action log item on agenda	DoAHP&HS	Action	√					
Healthcare Business Solutions (HBS) Delivery	COO	Ad Hoc	√					
Progress update on the new PTR regulations **(PQSOC 1702/11)**	DON	Action					√	

5

Lead Officer	
Key	
CEO	Chief Executive
DoCG	Director of Corporate Governance
DoF&P	Director of Finance & Procurement
DoSP&P	Director of Strategy, Planning & Partnerships
COO	Chief Operating Officer
DPH	Director of Public Health
DoAHP&HS	Director of Allied Health Professions & Health Science
DoW&OD	Director of Workforce & Organisational Development
DoN	Director of Nursing
MD	Medical Director
DOD	Director of Digital
Chair	Chair

Frequency of Inclusion	
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item
An	Annual
1/4ly	Quarterly
BI	1/2 yearly

Schedule of Meetings	
√	Scheduled agenda item in FWP
D	Deferred from this agenda
√D	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

Patient Quality, Safety and Outcomes Committee

Annual Report for 2025-26

March 2026

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Chair’s Foreword

I am pleased to present the Patient Quality, Safety and Outcome Committee’s (the Committee’s) Annual Report for the year ended 31 March 2026.

In this report we provide an overview of the work of the Committee, which extends to the full range of Health Board responsibilities and encompasses all areas of patient experience, quality and safety relating to patients, carers and service users.

I would like to express my thanks to all who have contributed to the patient quality, safety and outcomes agenda over the last 12-months. During this time progress has been made in implementing the Quality Management System Framework and in developing the Quality Outcomes Framework.

Diolch yn Fawr / Thank you

Helen Sweetland
Chair
Patient Quality, Safety and Outcomes Committee

1. Introduction

1.1 Section 2 of the Standing Orders of the Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB, the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.2 The Term of Reference of the Patient Quality, Safety and Outcomes Committee (referred to throughout this document as 'PQSOC' or the 'Committee') were approved by the Board in May 2025 (see **Appendix 1**). These were not changed during the reporting year.

1.3 The Committee formally adopted its Terms of Reference, following the Board's approval, in May 2025.

The purpose of the PQSOC is to provide: evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and assurance to the Board in relation to the Health Board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.

1.4 This report describes how the PQSOC discharged its role and responsibilities during the period 1 April 2025 to 31 March 2026.

2 2025-26 Work Programme

2.1 ABUHB Standing Orders require the Board Secretary to produce an Annual Plan of Board business. This should incorporate formal Board meetings, regular Board Development sessions and, as appropriate, planned activities of the Board's Committees and Advisory Groups. The Work Programme adopted for PQSOC in 2025-26 is attached to this report (see **Appendix 2**).

2.2 A Work Programme is designed to align to its terms of reference and the requirement for it to seek information to be able to give advice or gain assurance for itself and on behalf of the Board. The Work Programme is, however, a framework rather than a prescriptive

agenda. This gives PQSOC flexibility to identify changing priorities or any need for further assurance or information.

3 PQSO Committee Meetings and Membership

3.1 During 2025-26, PQSOC met five (5) times via Microsoft Teams- in March 2025, June 2025, October 2025, December 2025 and February 2026. Detail of the Independent Members and Executive Directors who attended these meetings is provided at **Appendix 3**.

The Committee arranged for July 2025 was cancelled.

3.2 The Committee comprised the following Independent Members:

- Helen Sweetland (Chair)
- Penny Jones (Vice Chair)
- Paul Deneen
- Philip Robson
- Vivek Goel (From June 2025)
- Helen Cunningham (From February 2026)

3.3 In line with the Public Bodies (Admissions to Meetings) Act 1960, public bodies are ordinarily required to conduct meetings in public. Throughout 2025/26, Committee meetings were held virtually, which meant that public attendance was not facilitated. To maintain transparency and public accountability, and following agreement with Audit Wales from October 2025, the Health Board implemented an alternative arrangement whereby summaries of Committee meetings were published on the Health Board's website. These summaries provide an overview of the key discussions, decisions and outcomes of each meeting, ensuring continued openness in the conduct of the Committee's business.

3.4 The Committee's agenda and papers were made public, save where it was necessary to meet 'in private'. Private meetings are held where it would not be appropriate to discuss a matter in public, due to issues of patient or staff confidentiality, commercial confidentiality, or discussion of serious incidents or escalated concerns which would not be in the public interest. There was 1 'in private' meeting held during 2025-26.

4 PQSOC Reporting Arrangements

4.1 Following each meeting, the PQSOC submits an Assurance Report to the following Board meeting, outlining topics discussed, areas of concern and areas of risk. All Board papers can be accessed via the following link.

5. PQSOC Work Programme: 2025-26

5.1 During the year the Committee received updates in respect of the following items:

5.2 The Committee received regular updates on the key risks allocated to the Committee for monitoring and the position of each risk. At the end of the year the Committee's risk environment had one material change in risk exposure had been recorded. Risk SRR 005A, relating to the potential likelihood of the Health Board maintaining adequate arrangements to ensure system-wide patient flow, had increased in likelihood from a score of 3 (Possible) to 4 (Likely), resulting in a revised total risk score of 16.

5.3 During 2025–26, the Committee played a key role in overseeing the implementation and embedding of the Health Board's Quality Management System (QMS). The Committee received assurance that the QMS was aligned to statutory requirements under the Health and Social Care, Quality and Engagement Wales Act 2020, the Health and Care Quality Standards for 2023 and the Health Board's Quality Strategy.

The Committee scrutinised the operation of the Quality Management Group (QMG) as the central operational forum for quality assurance. Assurance was provided that:

- Divisional quality and patient safety arrangements were consistently reported through QMG;
- Risks, themes and learning across the six pillars of quality were triangulated and escalated appropriately;
- QMG provided effective oversight of regulatory actions, inspection outcomes and improvement plans.

The Committee was assured that reporting arrangements had been strengthened, with clearer differentiation between operational quality management (QMG), Executive oversight and Board-level assurance through PQSOC.

5.4 Health and Safety continued to be recognised as a high-level risk for the organisation. Throughout the year, the Committee received the following:

- Regular Committee Risk Reports;
- Updates on statutory compliance and training;

- The Health and Safety Compliance Annual Report;
- Detailed assurance regarding Health and Safety Executive (HSE) activity.

A key assurance milestone during the year was the Committee receiving a detailed report on the HSE intervention at Hafen Deg Ward. The Committee was assured that all material breaches identified by the HSE had been addressed and a comprehensive improvement plan had been implemented. The Committee was also assured that learning had been embedded beyond the individual ward and that the HSE formally confirmed closure of the investigation.

The Committee acknowledged that, while significant progress had been made, Health and Safety remained an area requiring sustained leadership focus, particularly in relation to training compliance, violence prevention and workforce safety.

5.5 During 2025–26, the Committee received Primary Care Quality report which provided assurance on commissioning and quality oversight arrangements across the following areas:

- General Dental Services and General Medical Services;
- Welsh General Optometry Services and Community Pharmacy;
- Contract reform activity;
- Access and waiting times;
- Governance of independent contractors.

The Committee noted the complexity of quality assurance within independently contracted services and recognised the ongoing challenges relating to access and workforce sustainability.

5.6 During 2025-26, oversight of concerns management remained a significant area of focus. The Committee received regular assurance on:

- Putting Things Right (PTR) performance;
- Early resolution activity;
- Ombudsman cases and learning;
- Divisional learning from events reports.

While the Committee noted improvement in the quality of responses and early resolution rates, it continued to express concern regarding compliance with statutory response times. The Committee was assured that targeted improvement work was underway in high-volume specialties, and the Committee requested continuous monitoring.

A focus during the year was organisational readiness for the introduction of the Listening to People framework from April 2026. The Committee scrutinised the scale and complexity of the required cultural and operational change, alongside capacity and workforce implications, including mandatory listening conversations and, financial and system risks arising from the absence of additional national funding.

5.6 During the year, the Committee received quarterly Quality Outcome reports, that were structured around the 6 pillars of Quality:

1. Patient and staff experience
2. Patient safety
3. Clinical effectiveness
4. Health and safety
5. Infection prevention and control
6. Safeguarding

These reports enabled the Committee to monitor performance trends, identify emerging risks and challenge areas of variation across divisions. Key areas of assurance included:

- Continued strong patient experience feedback, with Civica survey results performing above the all-Wales benchmark;
- A sustained focus on waiting times as the lowest-scoring theme within patient feedback;
- Improvements in hospital falls performance, with the majority of incidents resulting in no or low harm;
- Stable mortality indicators, supported by strengthened Learning from Deaths processes;
- Continued challenges in data quality for pressure ulcers and medicines-related incidents, with improvement actions in place.

The Committee noted the increasing maturity of quality dashboards and welcomed ongoing work to improve automation and data triangulation.

5.7 The Committee received regular assurance on maternity and neonatal quality, performance and improvement activity. Key areas of focus included:

- Workforce stabilisation and improved recruitment;
- Cultural improvement programmes, including listening exercises;
- Medicines management and infection prevention improvements in neonatal services;
- Oversight of improvement plans and national review readiness.

The Committee acknowledged the progress made and requested continued updates to ensure sustained improvement and learning.

5.8 Throughout 2025/26, the Committee received the following Annual reports:

- Primary Care Quality Annual Report 2024/25, presented in October 2025, covering General Dental Services, General Medical Services, Welsh General Optometry Services and Community Pharmacy;
- Putting Things Right Annual Report 2024/25, providing assurance on the management of concerns and complaints, early resolution and organisational learning;
- Safeguarding Annual Report 2024/25, providing assurance on safeguarding activity, referral trends and training compliance;
- Health and Safety Compliance Annual Report 2024/25, providing assurance on statutory compliance and key health and safety risks;
- Learning from Deaths Annual Report, providing assurance on mortality review processes and organisational learning;
- Pharmacy and Medicines Management Annual Report 2024/25, providing assurance on medicines governance, safety and management arrangements;
- Annual Quality report, presented in October 2025, with discussion on achievements, learning, governance and priorities, and agreement that an action plan for 25/26 would follow.

5.9 The Committee a received several updates on Safeguarding activity and noted that this area remained a priority area for the Committee during 2025–26. The Committee received assurance that:

- Safeguarding referrals continued to increase, reflecting both complexity and improved awareness;
- Multi-agency working remained strong;
- Safeguarding governance was aligned through QMG and divisional structures.

A significant focus was safeguarding training compliance, particularly in Level 3 training. The Committee noted strong compliance for Levels 1 and 2, but there were significant challenges in delivering face-to-face Level 3 training at the required scale due to national resource and capacity constraints impacting delivery. The Committee recognised the operational and reputational risks associated with this issue and agreed escalation to the Board.

5.10 The Committee maintained oversight of external inspection and regulatory activity, particularly from Healthcare Inspectorate Wales (HIW). During the year, the Committee received regular updates on HIW inspection outcomes and scrutinised progress against improvement actions.

The Committee supported the implementation of the Assurance Monitoring and Tracking (AMAT) system. The Committee welcomed the improved visibility and consistency provided by AMAT and agreed that structured, twice-yearly reporting on HIW actions would strengthen assurance and organisational learning.

5.11 During 2025–26, the Committee escalated several significant risks to the Board, including:

- Risks associated with implementation of the Listening to People framework;
- Ongoing Health and Safety risk exposure;
- Capacity and resource risks related to safeguarding Level 3 training.

6. Patient Centred Care

6.1 On behalf of the Committee at Board level the presentation of Patient-Staff Stories continued. Topics presented included:

- Cryoablation for renal cancer by interventional radiology;
- Early pregnancy and emergency gynaecology: improvements introduced following a patient’s experience of miscarriage care;
- Knee osteoarthritis embolisation service: showcasing innovative alternatives to surgery with strong outcome data;
- Arts in Health Programme for perinatal mental health, showing strong benefits for confidence, emotional regulation and social connection;
- Closed loop insulin pump therapy significantly improving quality of life for patients with Type 1 diabetes;
- Dementia.

7. Self-assessment and Evaluation

7.1 As part of the Health Board's statutory requirements, each Committee of the Board is required to conduct an annual self-evaluation of Committee effectiveness. All Board Members are required to complete a self-assessment for each Committee on which they are a member, to

determine its effectiveness and ability to carry out its responsibilities.

The outcome of the assessment enables the Committee to identify areas of development and focus for the coming year, including any training and development needs, as well as changes to processes and procedures.

The Patient Quality, Safety and Outcomes Committee undertook its statutory annual self-assessment between November 2025 and January 2026, achieving a 50% response rate. The results demonstrated a positive position overall, with strong levels of assurance across Committee governance and membership, clarity of roles and responsibilities, the balance of skills and experience, meeting conduct and challenge, decision-making and follow-up, and the quality and timeliness of information provided to support effective scrutiny and assurance.

The assessment identified some areas for further development, including the need to strengthen and formalise induction arrangements for new members; to establish clearer and more explicit annual objectives; and to introduce a more formalised annual appraisal process to support ongoing evaluation of the Committee's effectiveness and continuous improvement. The Committee reviewed the findings in February 2026 and confirmed actions to address the areas identified. It was also agreed that the outcomes of the self-assessment would inform the Annual Accountability Report and the Governance Statement.

Overall, the Committee concluded that it remains effective and well-supported, with clear strengths in governance, challenge and assurance, and has therefore agreed to take forward a programme of improvement for 2026/27 focused on enhancing induction, clarifying and formalising objectives, and embedding a more structured approach to reviewing and strengthening Committee effectiveness.

8. Key Areas of focus in 2026/27

8.1 As a result of the work of the Committee in 2025/26 the following areas of focus were identified:

- Continued embedding of the Quality Management System and Quality Outcomes Framework;
- Oversight of implementation of the *Listening to People* framework;
- Strengthening safeguarding training compliance and capacity;
- Sustained focus on health and safety risk reduction;

- Continued assurance over maternity, neonatal and mental health services;
- Improved triangulation of patient experience, safety and workforce data.

9. Conclusion

9.1 This report demonstrates that the Patient Quality, Safety and Outcomes Committee has effectively discharged its responsibilities during 2025–26. The Committee has provided robust assurance to the Board across a wide range of complex and high-risk areas, while maintaining a strong focus on patient experience, learning and continuous improvement.

Patient Quality, Safety and Outcomes Committee

Terms of Reference – 2025/26

Version: Approved

Date: May 2025

Document Title:	Patient Quality, Safety and Outcomes Committee

	Terms of Reference – 2025/26
Date of Document:	May 2025
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1. INTRODUCTION

1.2 Section 2 of the Standing Orders of the Aneurin Bevan University Health Board (referred to throughout this document as 'ABUHB, the Board' or the 'Health Board') provides that:

"*The Board may and, where directed by the Welsh Government must, appoint Committees of the Health Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of its business extends equally to the work carried out on its behalf by committees*".

1.3 The Health Board has established a committee to be known as the **Patient Quality, Safety & Outcomes Committee** (referred to throughout this document as 'the Committee'). The Terms of Reference and operating arrangements set by the Board in respect of this committee are provided below.

2. PURPOSE

2.1 The scope of the Committee extends to the full range of ABUHB responsibilities, with the exception of Mental Health and Learning Disabilities services which are the responsibility of the Mental Health and Learning Disabilities Committee. This encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned

services. The Committee will embrace the Health and Care Standards as the Framework in which it will fulfil its purpose:

- Staying Healthy
- Safe Care
- Effective Care
- Dignified Care
- Timely Care
- Individual Care
- Staff and Resources

2.1 ADVICE

The Committee will provide accurate, evidence based (where possible) and timely advice to the Board and its committees in respect of the development of the following matters, consistent with the Board's overall strategic direction

- Citizen Experience; and
- Quality and Safety of directly provided and commissioned services.

2.2 ASSURANCE

In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on:

a. The robustness of the Board's Clinical Quality Governance Arrangements;
b. the experience of patients, citizens and carers ensuring continuous learning;
c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services; and
d. the effectiveness of arrangements in place to support Improvement and Innovation.

3 DELEGATED POWERS AND AUTHORITY

3.1 With regard to the powers delegated to it by the Board, the Committee will:

A. Seek assurance that the Health Board's **Clinical Quality Governance Arrangements** remain appropriate and aligned to the National Quality Framework and are embedded in practice.

B. Seek assurance that arrangements for capturing the **experience of patients, citizens and carers** are sufficient, effective and robust, including:

- the delivery of the Patient Experience Plan; and
- the implementation of Putting Things Right regulations (to include patient safety incidents, complaints, compliments,

clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learned.

C. Seek assurance that arrangements for **the provision of high quality, safe and effective healthcare** are sufficient, effective and robust, including:
   - the systems and processes in place to ensure efficient, effective, timely, dignified and safe delivery of directly provided services;
   - the commissioning assurance arrangements in place to ensure efficient, effective, timely, dignified and safe delivery of those services commissioned for delivery on ABUHB's behalf;
   - the arrangements in place to undertake, review and act on clinical audit activity which responds to national and local priorities;
   - the recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response;
   - the arrangements in place to ensure that there are robust infection prevention and control measures in place in all settings;
   - the development of the Board's Annual Quality Priorities; and,
   - performance against key quality outcomes focussed indicators and metrics.

D. Seek assurance on the arrangements in place to support **Research and Development** and **Improvement and Innovation**, including:
   - an overview of the research and development activity within the organisation;
   - alignment with the national objectives published by Health and Care Research Wales (HCRW);
   - an overview of the quality improvement activity within the organisation.

E. Seek assurance that arrangements for **compliance with Health and Safety Regulations and Fire Safety Standards** are sufficient, effective and robust, including:
   - the operating practices in respect of: staff health and safety; stress at work; patient health and safety, i.e., patient falls, patient manual handling; violence and aggression; fire safety; risk assessment processes; safe handling of loads; and hazardous substances

3.2 The Committee will consider and recommend to the Board for approval those policies reserved for the Board and delegated to this Committee

for review, in-line with the Board's Policy Management Framework and Scheme of Delegation and Reservation of Powers.

3.3 The Committee will seek assurances on the management of strategic risks delegated to the Committee by the Board, via the Corporate Risk Register.

Authority

3.4 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the Committee's remit and ensuring patient/client and staff confidentiality, as appropriate.

The Committee may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- any other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

3.5 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary (subject to the Board's procurement, budgetary and any other applicable standing requirements).

Access

3.6 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.

3.7 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.8 The Committee may, subject to the approval of the Board, establish sub committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

Committee Programme of Work

3.10 Each year the Board will determine the Committee's priorities for its annual programme of work, based on the Board's Quality Framework and Board Assurance Framework/Strategic Risk Register. This approach will ensure that the Committee's focus is directed to the areas of greatest assurance needs. This will therefore mean that these Terms

of Reference are provided as a framework for the Committee's annual programme of work and is not an exhaustive list for full coverage. This approach recognises that the Committee's programme of work will be dynamic and flexible to meet the needs of the Board throughout the year.

4 MEMBERSHIP

Members

4.1 Membership will comprise of five (5) members:

Chair: Independent member of the Board

Vice Chair: Independent member of the Board

Other Members: Three other independent members of the Board *[one of which should be the Vice Chair of the Health Board and the Chair of the Audit, Risk and Assurance Committee]*

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2 In attendance: The following Executive Directors of the Board will be regular attendees:

- Director of Nursing
- Director of Allied Health Professionals and Health Science
- Medical Director
- Chief Operating Officer

4.3 By invitation:
The Committee Chair extends an invitation to the ABUHB Chair and Chief Executive to attend committee meetings.

The Committee Chair will extend invitations to attend committee meetings, dependent upon the nature of business, to the following:

- other Executive Directors not listed above;
- other Senior Managers and
- other officials from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.4 The Office of the Director of Corporate Governance will provide secretariat services to the Committee.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the Chair of ABUHB - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Members shall be appointed to hold office for a period of one year at a time, up to a maximum of their term of office. During this time a member may resign or be removed by the Board.

4.7 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Chair of ABUHB.

Support to Committee Members

4.8 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of development for committee members as part of the Board's overall Development Programme.

5 COMMITTEE MEETINGS

Quorum

5.1 At least **three** members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 Where members are unable to attend a meeting and there is a likelihood that the Committee will not be quorate, the Chair can invite another independent member of the board to become a temporary member of the Committee.

Frequency of Meetings

5.3 The Chair of the Committee shall determine the timing and frequency of meetings, which shall be held no less than **bi-monthly (six times yearly)**, and in line with the Health Board's annual plan of Board Business.

5.4 The Chair of the Committee may call additional meetings if urgent business is required to be taken forward between scheduled meetings.

Openness and Transparency

5.5 Section 3.1 of ABUHB Standings Orders confirms the Board's commitment to openness and transparency in the conduct of all its business and extends equally to the work carried out on its behalf by Committees. The Board requires, wherever possible, meetings to be held in public. The Committee will:

- hold meetings in public, other than where a matter is required to be discussed in private (see point 5.6);
- issue an annual programme of meetings (including timings and venues) and its annual programme of business;
- publish agendas and papers on the Health Board's website in advance of meetings;
- ensure the provision of agendas and minutes in English and Welsh and upon request in accessible formats, such as Braille, large print, and easy read; and
- through ABUHB's website, promote information on how attendees can notify the Health Board of any access needs sufficiently in advance of a proposed meeting, e.g., interpretation or translation arrangements, in accordance with legislative requirements such as the Equality Act 2010 and Welsh Language Standards 2018.

Withdrawal of individuals in attendance

5.6 There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Committee shall resolve:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

In these circumstances, when the Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Committee in public session.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions (as set out within these terms of reference), the Board retains overall responsibility and accountability for all matters relating to performance and resources.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.2 The Committee will work closely with the Board's other committees, joint and sub committees and groups to provide advice and assurance to the Board through the:
- joint planning and co-ordination of Board and Committee business;
- sharing of appropriate information; and
- applicable escalation of concerns.

In doing so, this contributes to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.3 The Committee shall embed the Health Board's agreed Values and Behaviours, as set out in the Board's Values and Behaviours Framework, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:
- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, and the submission of Committee minutes and written reports;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Chair of ABUHB, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, e.g., where the committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's

performance and operation including that of further committees established.

7.4 The Committee shall provide a written annual report to the Board on its activities. The report will also record the results of the Committee's self-assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in ABUHB's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Issue of Committee papers

9. CHAIR'S ACTION ON URGENT MATTERS

9.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Committee. In these circumstances, the Chair of the Committee, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Committee - after first consulting with at least two other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring a decision.

10. REVIEW

10.1 These Terms of Reference shall be reviewed annually by the Committee. The Committee Chair will report any changes to the Board for ratification.

Appendix 2

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						**√D**
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	**√**					**√D**
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			**√**	**√**		**√D**
Listening and Learning Framework Annual Review	DoN	AN	**√**					
Serious Incident Learning Report	DoN	AN					**√**	
Health and Safety Compliance Annual Report	DoT&HS	AN			**√D**	**√**		
Safeguarding Annual Report	DoN	AN			**√**	**√**		
Ward Accreditation Report	DoN	AN					**√**	
Nurse Staffing Levels (Wales) Act 3-year report (3-yearly)	DoN	AN					**√**	
Nurse Staffing Levels Wales Act Annual Assurance Report	DoN	AN				**√**		
Annual Report on Clinical Audit Activity 2024– 2025	MD	AN		**√**				
Mortuary Incident action plan **PQSOC 0306/11**	COO	Action					**√**	
Update on development of local audit plans and funding arrangements **PQSOC 0306/12**	MD	Action					**√**	

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	Ad Hoc					√	
Healthcare Inspectorate Wales Reviews a) Pillmawr & Adferiad Wards, SCH b) Minor Injuries Unit, YYF c) Birth Centre, YYF	DON	Ad Hoc/action						√
Report on recent HSE intervention at Hafen Deg Ward, including the actions taken and the closure of the investigation **PQSOC 0212/05**	DoAHPS &HS	Action						√
Healthcare Inspectorate Wales (HIW) reports **PQSOC 0212/05**	DON	Action						√
Putting Things Right Regulations report	DON	Ad Hoc						√
Pharmacy and Prescribing Report	DON	Ad Hoc						√

Appendix 3

Patient Quality, Safety and Outcomes Committee: Attendance at meetings in 2025-26

Attended	Did Not Attend	Not a Member/Required Attendee

Meeting Dates	March	June	July	October	December	February
Independent Members						
Helen Sweetland	X	X	X	X	X	X
Penny Jones	X	X		X	X	X
Paul Deneen	X	X	X	X	X	X
Philip Robson		X	X	X	X	X
Vivek Goel			X	X	X	X
Helen Cunningham						X
Executive Directors						
Medical Director	X	X	X	X	X	X
Director of Allied Health Professions & Health Science	X	X	X	X	X	X
Director of Nursing	X	X	X	X	X	X