

Patient Quality, Safety and Outcomes Committee

Tue 17 February 2026, 13:30 - 16:30

Microsoft Teams



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Agenda

1. PRELIMINARY MATTERS

PQSOC 20260217 Agenda - Approved.pdf (2 pages)

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Draft Minutes of the last Meeting held on Tuesday 2nd December 2025

Attached *Chair*

PQSOC 20260217 1.4 PQSOC 20251202 Minutes.pdf (14 pages)

1.5. Committee Action Log

Attached *Chair*

PQSOC 20260217 1.5 Committee Action Log.pdf (4 pages)

2. ITEMS FOR DISCUSSION

2.1. Quality Outcomes Report

Attached *Director of Nursing*

PQSOC 20260217 2.1 Quality Outcomes Report.pdf (8 pages)

PQSOC 20260217 2.1 Quality Outcomes Report - Appendix 1 Quality Outcomes Framework - Q3.pdf (107 pages)

2.2. Quality Management Group Report

Attached *Director of Nursing*

PQSOC 20260217 2.2 Quality Management Group Report.pdf (5 pages)

2.3. Maternity and Neonatal Report

Attached *Director of Nursing*

PQSOC 20260217 2.3 Maternity and Neonatal Report .pdf (19 pages)

2.4. PALS scheme and Organisational Change programme review outcomes.

Attached *Director of Nursing*

2.5. Healthcare Inspectorate Wales (HIW) reports Update

Attached *Director of Nursing*

 PQSOC 20260217 2.5 Healthcare Inspectorate Wales (HIW) reports Update.pdf (6 pages)

 PQSOC 20260217 2.5 Healthcare Inspectorate Wales (HIW) reports Update - Appendix 1 - Summary of Pending HIW Inspection Actions.pdf (8 pages)

2.6. Putting Things Right Regulations Update

Attached *Director of Nursing*

 PQSOC 20260217 2.6 Putting Things Right Regulations Update.pdf (5 pages)

2.7. Maindiff Court Mental Health Inspection report

Attached *Director of Nursing*

 PQSOC 20260217 2.7 Maindiff Court Mental Health Inspection report.pdf (4 pages)

 PQSOC 20260217 2.7 Maindiff Court Mental Health Inspection report - Appendix 1 Ty Skirrid Inspection Report.pdf (32 pages)

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

Attached *Director of Allied Health Professions & Health Science*

 PQSOC 20260217 2.8 Report on recent Health Safety Executive.pdf (6 pages)

2.9. Committee Risk Report

Attached *Director of Corporate Governance*

 PQSOC 20260217 2.9 Committee Risk Report.pdf (6 pages)

 PQSOC 20260217 2.9 Committee Risk Report - Appendix 1.pdf (8 pages)

2.10. Development of Committee Annual Programme of Business 2026/27

Attached *Director of Corporate Governance*

 PQSOC 20260217 2.10 PQSOC Development of Committee Annual Programme of Business 2026-27.pdf (3 pages)

 PQSOC 20260217 2.10 Development of Committee Annual Programme of Business 2026-27 - Appendix 1.pdf (6 pages)

3. FOR INFORMATION

3.1. Review of Committee Programme of Business 2025/26

Attached *Director of Corporate Governance*

 PQSOC 20260217 3.1 PQSOC Review of Committee Forward Work Plan 2025-26 Report.pdf (4 pages)

 PQSOC 20260217 3.1 PQSOC Forward Work Plan 2025-2026 - Appendix 1.pdf (8 pages)

3.2. NHS Wales Joint Commissioning Quality Committee Report

Attached *Director of Corporate Governance*

 PQSOC 20260217 3.2 NHS Wales Joint Commissioning Quality Committee Report.pdf (13 pages)

 PQSOC 20260217 3.2 NHS Wales Joint Commissioning Quality Committee Report.pdf (7 pages)

3.3. Pharmacy and Medicines Annual Report

Attached *Medical Director*

 PQSOC 20260217 3.3 Pharmacy and Medicines Annual Report.pdf (4 pages)

 PQSOC 20260217 3.3 Pharmacy and Medicines Annual Report - Appendix 1.pdf (67 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: 8th April 2026

**PATIENT QUALITY, SAFETY & OUTCOMES COMMITTEE
AGENDA**

Date and Time	Tuesday 17th February 2026 at 13:30PM-16:30PM
Venue	Microsoft Teams

Item	Title	Format	Presenter
1	PRELIMINARY MATTERS		
1.1	Welcome and Introductions	Oral	Chair
1.2	Apologies for Absence	Oral	Chair
1.3	Declarations of Interest	Oral	Chair
1.4	Draft Minutes of the last Meeting held on Tuesday 2 nd December 2025	Attached	Chair
1.5	Committee Action Log	Attached	Chair
2	ITEMS FOR DISCUSSION		
2.1	Quality Outcomes Report	Attached	Director of Nursing
2.2	Quality Management Group Report	Attached	Director of Nursing
2.3	Maternity and Neonatal Report	Attached	Director of Nursing
2.4	PALS scheme and Organisational Change programme review outcomes.	Attached	Director of Nursing
2.5	Healthcare Inspectorate Wales (HIW) reports Update	Attached	Director of Nursing
2.6	Putting Things Right Regulations Update	Attached	Director of Nursing
2.7	Maindiff Court Mental Health Inspection report	Attached	Director of Nursing
2.8	Report on recent Health Safety Executive (HSE) intervention at Hafan Deg Ward, including the actions taken and the closure of the investigation	Attached	Director of Allied Health Professions & Health Science
2.9	Committee Risk Report	Attached	Director of Corporate Governance

2.10	Development of Committee Annual Programme of Business 2026/27	Attached	Director of Corporate Governance
3	FOR INFORMATION		
3.1	Review of Committee Programme of Business 2025/26	Attached	Director of Corporate Governance
3.2	NHS Wales Joint Commissioning Quality Committee Report	Attached	Director of Corporate Governance
3.3	Pharmacy and Medicines Annual Report	Attached	Medical Director
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: • 8 th April 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 2nd December 2025, 13:30am-16:30pm
VENUE	Microsoft Teams

PRESENT	Helen Sweetland, Chair Penny Jones, Vice Chair Philip Robson, ABUHB Vice Chair Paul Deneen, Independent Member Vivek Goel, Independent Member (until 15:50)
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 Leeanne Lewis, Assistant Director of Quality & Patient Safety Collette Kiernan, Deputy Director of Allied Health Professions and Health Science Arvind Kumar, Interim Divisional Director (Item 2.7 only) Howard Stanley, Head of Safeguarding (Item 2.6 only) Naomi Murtagh, Board Business Manager Gavin Thomas, Committee Secretariat
OBSVERING APOLOGIES	Rhian Gard, Internal Audit Leanne Watkins, Chief Operating Officer Fern Woodhead, Committee Secretariat

PQSOC 0212/01	Welcome and Introductions The Chair welcomed everyone to the meeting.
PQSOC 0212/02	Apologies for Absence The Chair confirmed that there were no apologies for absence.
PQSOC 0212/03	Declarations of Interest There were no declarations of interest raised relating to items on the agenda.
PQSOC 0212/04	Minutes of the previous meeting

	The minutes of the Patient Quality, Safety and Outcomes Committee held on 1st October 2025 were agreed as a true and accurate record of the meeting subject to the requested changes.Action: Committee Secretariat The Committee APPROVED the draft minutes.
PQSOC 0212/05	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 noted that the Health and Safety Executive (HSE) report, which had been expected at the meeting, had instead been presented to the Board the previous week (26.11.25). Peter Carr (PC), Director of Allied Health Professions & Health Science, clarified that the action related to HSE activity encompassed all ongoing visits and investigations, and confirmed that summary updates were routinely included in the quality report under the health and safety pillar. PC would prepare a report summarising the recent HSE intervention at Hafan Deg Ward, including the actions taken and the closure of the investigation, for presentation at the next meeting. Action: Director of Allied Health Professions & Health Science The Committee also noted that Healthcare Inspectorate Wales (HIW) reports had been completed but were not included on the agenda in time for the meeting. Jennifer Winslade (JW), Director of Nursing, confirmed that these reports would be circulated to Committee members after the meeting and formally noted at the next meeting. Action: Director of Nursing The Committee APPROVED the action log.
PQSOC 0212/06	Quality Outcomes Report Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Quality Outcomes Report, which highlighted the transition to six revised pillars of quality, that had been developed in response to feedback from divisional staff and the Board. These pillars included patient and staff feedback, patient safety, clinical effectiveness, health and safety, infection prevention and control, and safeguarding. Divisional reporting had been aligned to these pillars, and the introduction of ward accreditation dashboards was noted as a positive development.

JW highlighted the revised format of the report and the work that was being done on a national quality outcomes framework and the development of the national Beacon dashboard. This would enable bench-marking against our peers and work with the local digital team will increase automation.

JW reported to the Committee that the Patient Experience Survey, was a new all-Wales initiative that started in April. An overall satisfaction rate of 87% had been achieved from nearly 20,000 responses across all surveys. Emergency Department satisfaction had improved to 74%, while maternity and neonatal services reported an 86% satisfaction rate since their launch in September. Positive themes included compassion and support, while negative feedback focused on waiting times and facilities. Divisions were working on plans to address these areas for improvement.

The Committee was advised that the Patient Advice and Liaison Service (PALS) continued to support approximately 450 queries per month, ranging from simple communication issues to complex cases. The data and themes from PALS were fed back to divisions to inform service improvements.

JW discussed compliance with the Putting Things Right (PTR) process, noting ongoing challenges in meeting the 30-working-day target for complaint responses. Although the timeliness of responses remained a concern, the quality of responses had improved, and early resolution rates had reached 92.98%. There was a plan in place to address the delays in responding to complaints. New PTR regulations were expected to extend the early resolution timeframe to ten days, which would further support improvements.

JW provided an update to the Committee on Ombudsman interventions, reporting a reduction in complaints and improved quality of responses. The Committee was assured that regular reporting on actions and learning points would continue.

The Committee reviewed data on patient safety, including mortality rates, incident reporting through Datix, and hospital falls. Peter Carr (PC), Director of Allied Health Professions & Health Science, reported a downward trend in hospital falls and highlighted the impact of ward accreditation and targeted training. The Committee noted that 99.7% of hospital falls resulted in no or low harm, and

	that weekly reviews of moderate, severe, and catastrophic falls were conducted by the Executive team. Further updates were provided on healthcare-acquired pressure ulcers, hospital-acquired thrombosis, medicines management, and duty of candour compliance. JW advised that improvements in reporting incidents and compliance had been achieved over the last year, and that the Health Board was not a national outlier for reportable incidents. PC reported on the steps being taken on staff training to improve RIDDOR reporting. The committee received an update on the Sepsis campaign and the introduction of NEWS-2 scoring systems. The Committee was pleased to hear how the team is reaching schools, young people and GP surgeries with important messages. The Committee discussed infection prevention and control, noting strong performance below the all-Wales average for most infections, except for Pseudomonas and a recent increase in Clostridium difficile. Ongoing work with pharmacy and estates colleagues was highlighted as essential to address these challenges. JW advised the Committee that a significant rise in child duty to report incidents for safeguarding. The reason for this may be due to increased staff training and awareness but this needs to be analysed further. Multi-agency meetings and partnership working with local authorities and police continued to be a priority. The Committee acknowledged the comprehensive nature of the report and the improvements made in data presentation and automation. The Committee expressed appreciation for the clarity of the new format and the inclusion of patient safety leadership visit findings. The Committee agreed that ongoing monitoring and targeted improvement actions were essential to maintain and further enhance the quality of care across the organisation. The Committee NOTED the report.
PQSOC 0212/07	Quality Management Group Reporting Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Quality Management Group (QMG) report. JW informed that the report was concise and covered several areas already discussed earlier in the meeting. JW confirmed that the QMG

received regular reports from divisions for each of the six pillars of quality, ensuring a comprehensive overview of quality management across the organisation.

JW advised the Committee that the QMG had recently reviewed revisions to the Patient Safety Incident Policy and noted that the policy, which was due to be presented to the Board, included important amendments based on organisational learning, particularly regarding the management of complex investigations and challenging family circumstances. The policy had been strengthened to improve training and to clarify the role of the Family Liaison Officer, recognising the specialist skills required to support families through difficult events.

The Committee was updated on the outcome of a recent patient safety visit to 19 Hills. JW advised that the visit identified the need for a standard operating procedure (SOP) to guide staff responses when individuals arrived unwell at the facility, which does not have a designated reception or building owner. A SOP for management of unwell patients in a community setting had been approved. The Committee noted that this alert would be disseminated to 19 Hills and other relevant settings.

The Committee was advised that the QMG had received inspection reports from Health Inspectorate Wales (HIW) for the Royal Gwent Hospital Minor Injuries Unit (MIU) and Ysbyty Ystrad Fawr (YYF) Birth Centre, which would be circulated to members after the meeting. The Committee also received the Pharmacy and Medicines Management Annual Report, which was commended for its thoroughness and quality and would be included for information at the next Committee meeting. **Action: Director of Nursing.**

Risks and highlights identified by the QMG were consistent with those previously discussed, with particular attention given to urgent care flow and future care planning. JW noted that future care planning, including advanced care planning and Treatment Escalation Plans (TEPs), remained an area for further development. The need to embed future care planning across both primary and secondary care was emphasised and it was reported that a lead and programme of work were in place to address this.

The Committee accepted the Quality Management Group report, noting that quality assurance processes and governance arrangements were robust and that

	improvements were being actively progressed. The Committee agreed that ongoing monitoring and reporting would be essential to sustain progress and maintain high standards of care across the organisation. The Committee NOTED the report.
PQSOC 0212/08	Update on Neonatal Service Improvements Jennifer Winslade (JW), Director of Nursing, provided the Committee with an update on the Neonatal Intensive Care Unit (NICU) service improvements. The report outlined the structured approach taken to address persistent challenges within the NICU, focusing on four priority areas: infection prevention and control, medicines management, workforce, and culture. JW reported that a proactive risk management strategy had been established, with weekly oversight meetings chaired by the Director of Nursing. These meetings ensured close monitoring of progress and provided support to maintain momentum. The Executive Team received formal briefings each week, reflecting the organisation's commitment to resolving ongoing issues and safeguarding patient outcomes. The Committee was advised that Infection prevention and control improvements were triggered by benchmarking data and internal inspections, which identified areas for enhancement. The division implemented enhanced cleaning schedules, targeted environmental improvements, and daily audits, achieving compliance rates above the benchmark. Laundry arrangements were reviewed, and a pilot with an external service was introduced to strengthen infection control. Reporting and procedures for venepuncture were also reviewed, with the aim of de-escalating the infection prevention risk. Seema Srivastava (SS), Medical Director, provided further detail on medicines management, describing the collaborative approach involving senior medical, nursing, and pharmacy staff. Immediate actions included the development of standard operating procedures for high-risk processes, improved medication storage and double-checking, and updated guidance for thrombosis management. The team had addressed themes identified in incident reviews, such as gentamicin prescribing practices, and implemented spot audits, medication safety huddles, and updates to the neonatal prescribing handbook. Plans were being made to increase pharmacy

	input and introduce regular audits and micro-teaching for clinical staff. JW advised the Committee that Workforce actions focused on maintaining safe staffing levels, particularly in nursing, where recruitment pressures had eased but sickness absence remained high. Twice-daily situation reports were received from the unit, and visibility of senior staff was increased. Plans were in place to review skill mix and staffing structures, and medical staffing escalation was being addressed. The Committee was assured that the unit had remained safe, with further work ongoing to optimise workforce arrangements. The Committee was advised of the cultural improvement efforts, including an eight-week listening exercise open to all staff groups. The report from this exercise was in final draft and would be shared with the Executive team and division before wider dissemination. This report and further updates to be shared with the Committee at a later date. Action: Director of Nursing. Civility training and human factors approaches had been introduced to support a positive culture, and regular HR support and visibility on the unit continued. JW advised the Committee that weekly monitoring and oversight of the improvement plan would continue until risks were de-escalated to an acceptable level. Once achieved, a wider NICU improvement plan would be developed, aligned with the successful maternity services improvement plan. External assurance visits were expected to further inform targeted improvements. The Committee raised questions regarding pharmacy support and the early adoption of the electronic prescribing system (EPMA), which SS clarified would be phased in across the Health Board to ensure safety and appropriate capacity. The Committee NOTED significant progress in all four priority areas and expressed support for the ongoing improvement efforts. The Committee received the report for ASSURANCE.
PQSOC 0212/09	Year 3 Quality Strategy Implementation Plan Leeanne Lewis (LL), Assistant Director of Quality & Patient Safety, provided the Committee with an overview of the Year 3 Quality Strategy Implementation Plan, which outlined the plan that had been developed to align with

statutory duties for reporting the Duty of Quality and Duty of Candour, and aimed to embed a culture of continuous improvement throughout the organisation.

LL highlighted to the Committee that the implementation plan was built on previous years' work and set out clear priorities for 2025/26. The plan focused on strengthening assurance and governance, improving the quality management system, and automating reporting dashboards to provide divisional and directorate-level insights. The Committee was advised that the six pillars of quality remained central to the strategy, with clinical effectiveness now included as Pillar 3.

The Committee was advised on how the plan incorporated quarterly milestones, which had been mapped from April onwards to ensure progress could be tracked and reported in the annual quality report. The Committee noted that the plan emphasised cultural engagement, psychological safety, visible leadership, and the spread of learning and improvement through dedicated forums.

Jennifer Winslade (JW), Director of Nursing, advised the Committee that an underpinning piece of work on safety culture was planned for the coming year, which would align with national initiatives and further strengthen the organisation's approach to quality and safety.

The Committee discussed the importance of joined-up reporting and the clarity provided by the six pillars and associated metrics. The Committee agreed that the new framework should make it easier to hold the organisation to account and to conduct deeper dives into key issues.

Vivek Goel (VG), Independent Member, asked whether data from sources such as Freedom to Speak Up Guardians was included in the safety framework. LL confirmed that work was underway to integrate multiple data streams from different sources and areas of the Health Board such as workforce, into a central data warehouse, enabling more effective triangulation and reporting within the Quality Outcomes Framework.

The Committee clarified that quarterly milestones had been maintained from the previous year and that progress against these would be tracked and reported in future annual quality reports.

The Committee agreed that the plan provided a clear structure for embedding quality and safety at every level

	of the organisation, with measurable outcomes and a commitment to continuous improvement. The Committee NOTED the report and received ASSURANCE on the ongoing work to deliver the Duty of Quality and Duty of Candour.
PQSOC 0212/10	Update on Safeguarding Level 3 Training Howard Stanley (HS), Head of Safeguarding, provided the Committee with an update on Safeguarding Level 3 Training. The Committee was advised that both child and adult Level 3 safeguarding training were mandated for all regulated professionals, following recent revisions to national intercollegiate guidance. The scope of required training had expanded significantly, resulting in a substantial increase in the number of staff needing face-to-face, interactive training. HS reported that the initial estimates suggested around 4,000 staff would require Level 3 training, but updated workforce data revealed that the actual figure was closer to 6,500. The Committee noted the challenges faced in delivering training at this scale, including limited resources, operational pressures, and attendance issues the training sessions were regularly overbooked to maximise attendance, but capacity constraints remained. HS confirmed that the organisation had adopted a phased implementation plan, aiming to reach 85% compliance over three years and then maintain that level. It was advised that, following additional funding and increased session capacity, compliance for adult Level 3 training had reached 31% by the end of November. The Committee was assured that high compliance rates for Level 1 and 2 online training continued to mitigate patient safety risks, and that staff were actively reporting safeguarding concerns. The Committee discussed the reputational risks associated with low compliance and noted that Aneurin Bevan University Health Board was one of only two health boards fully adhering to the guidance. Paul Deneen (PD), Independent Member, raised concerns regarding the lack of national resources to support delivery and the prescriptive nature of the training requirements. HS confirmed that feedback had been provided to national

	working groups, but changes to the guidance were unlikely in the short term. HS clarified that the training was designed to equip staff with the skills to manage complex safeguarding cases and that the organisation was prioritising high-risk staff Groups, such as health visitors, school nurses, and midwives. The Committee discussed the feasibility of alternative delivery models, but HS confirmed that the current guidance required face-to-face, interactive sessions led by appropriately skilled trainers. HS confirmed that the HB team is working hard to optimise attendance at all the sessions that can be delivered. The Committee NOTED the report and the actions being taken to increase training uptake.
PQSOC 0212/11	Mortuary Incident Action Plan Arvind Kumar (AK), Interim Divisional Director, provided the Committee with an update on the Mortuary Incident Action Plan. The report summarised the progress made since the last report to the Committee, focusing on outstanding actions and new developments within the Pathology Directorate and Care After Death (CAD) services. AK advised the Committee that the implementation of the Eden software had been completed, with user acceptance testing finalised and a go-live date scheduled for mid-December. Integration with the LIMS 2.0 system was pending, and the team was awaiting its launch to ensure full functionality. Improvements to community admissions out of hours had been agreed, with training for relevant staff nearing completion. The team had also worked with police colleagues to improve IT processes for community cases, achieving reasonable compliance. The Committee was advised that electronic audit processes had been successfully implemented in collaboration with nursing colleagues, and the review of the CAD team service Group had concluded that the team should continue in its current form, supporting the Medical Examiner and death certification pathway. The Pathology Academy was developing a career pathway programme for Anatomical Pathology Technologists (APTs), which remained ongoing.

AK highlighted to the Committee the new developments, including the completion of a gap analysis following the release of the Fuller Phase Two recommendations, which had been reviewed by the HTA Governance Committee. The closure of the YAB body store was noted as a risk that had been swiftly addressed with Executive support. An NHS P&I colleague had conducted a review, and a formal response letter had been drafted.

The Committee was updated on the inclusion of YAB in the CAD team portfolio, which had been recommended to the Executive Team and was scheduled for further work. Delays in body release due to Medical Examiner (ME) and death certification processes had been addressed through a new paper proposing the use of the Medical Certificate of Cause of Death (MCCD) document for body release, in line with neighbouring Health Boards and NHS England. This change was expected to reduce unnecessary waiting times for bereaved families by up to seven days.

AK confirmed that no Human Tissue Authority (HTA) reportable incidents had occurred since the last meeting, and that the most recent incident had been identified through the audit process, demonstrating the effectiveness of the new systems. A recent HTA inspection had taken place, and formal feedback was awaited.

Helen Sweetland (Chair) asked about the wellbeing and morale of the team now. AK reported that there was a new manager in place and there was ongoing work to support and develop staff and improve their working arrangements.

The Committee was assured that quarterly HTA Governance Committee meetings were now fully embedded, with dual representation from relevant colleagues and a standard process for assurance reporting to the Executive team, Board and Quality Management Group. Work was ongoing to develop a peer support network with neighbouring Health Boards, pending the implementation of LIMS 2.2.

The Committee **NOTED** the report and acknowledged the progress made in delivering improvements.

	Naomi Murtagh (NM), Board Business Manager, provided the Committee with an overview of the Committee Risk Report, the Committee was advised that there had been no significant changes to the risk profile since the previous meeting. Peter Carr (PC), Director of Allied Health Professions & Health Science, provided an update regarding health and safety risks, confirming that the appointment of a Deputy Head of Health and Safety and additional support for the Datix team had been completed. PC advised that these appointments had contributed to the mitigation of health and safety risks, although further work was required to reach the target risk level. The Committee accepted the Committee Risk Report, noting that the risk environment remained stable and that mitigation actions were progressing as planned. The Committee was assured that appropriate staffing and governance measures were in place to manage strategic risks and agreed to continue monitoring progress at future meetings. The Committee NOTED the report.
PQSOC 0212/13	Ophthalmology Audit Wales Report Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the Ophthalmology Audit Wales Report. The Committee was advised that the Audit Wales report was about the delivery of Ophthalmology services but had highlighted significant risks of harm associated with long waiting lists for ophthalmology appointments. JW summarised the main findings of the report, noting that the Health Board continued to face workforce shortages, with three consultant vacancies and physical space constraints impacting service delivery. It was advised that new appointments had been made for cornea, paediatric, and glaucoma specialists, with further recruitment underway. The Committee noted that non-medical roles, such as optometrists and nurse practitioners, had been expanded to help address capacity issues. The Committee discussed the processes in place for managing incidents and mitigating harm. JW confirmed

	that all incidents were reviewed by a senior nurse practitioner and, where necessary, referred for consultant harm review. The Committee was advised that between 2023 and 2025, 26 nationally reportable incidents had occurred, with 15 relating to glaucoma patients lost to follow-up. These cases had been fully investigated, and learning from the thematic review had been shared across the organisation. Themes included: delays in triaging referrals from opticians, cancelled clinics, delays in rebooking appointments, equipment failure and lack of diagnostic capacity. JW highlighted to the Committee the improvements made in response to the report, including the introduction of a red flag protocol for urgent referrals, the development of subspecialty pathways, and the implementation of electronic systems for patient records and referrals. JW noted that additional diagnostic capacity had been created, and that ongoing validation of waiting lists was being carried out to ensure high-risk patients were prioritised. The Committee discussed the impact of delays on patient safety and the importance of compliance with the Duty of Candour. JW confirmed that cases of severe harm were managed through the serious incident process and reported in accordance with statutory requirements. The Committee acknowledged the risks identified in the Audit Wales report and noted the actions taken to mitigate patient harm and improve service delivery for ophthalmology patients. JW acknowledged that lessons learnt from thematic reviews of other areas of should be presented to the committee on a regular basis. Action: Director of Nursing The Committee NOTED the report and the actions taken.
PQSOC 0212/14	Review of Committee Programme of Business 2025/26 Review of Committee Programme of Business 2025/26 was provided to the Committee for information.
PQSOC 0212/15	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. Members discussed several key issues that had emerged during the meeting. The Committee agreed that the ongoing challenges and resource implications associated with Safeguarding Level 3 Training, particularly the requirement for nearly half the workforce to complete face-to-face training without additional national resources, should be highlighted to the Board. The Committee recognised this as a significant operational and reputational risk. The Committee agreed that the progress and assurance provided by the Mortuary Incident Action Plan, including improvements in digital systems, audit processes, and governance arrangements, warranted formal notification to the Board to demonstrate effective risk management and service improvement.
PQSOC 0212/16	Any Other Urgent Business There was no urgent business.
PQSOC 0212/17	Date of the Next Meeting: 17th February 2026



Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

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

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
December 2025	PQSOC 0212/04	Minutes of the previous meeting Requested changes to the minutes for October's meeting to be updated before publishing to the public.	Committee Secretariat	February 2026	Completed <u>December update</u> Committee secretariat updated the October minutes with the requested changes and published the minutes to the public.
December 2025	PQSOC 0212/05	Committee Action Log A report summarising the recent HSE intervention at Hafan Deg Ward, including the actions taken and the closure of the investigation, for presentation at the next meeting.	Director of AHPs and Health Science	February 2026	Completed <u>December Update</u> Director of AHPs and Health Science confirmed the report was in progress in readiness for February's meeting.



Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					Action has been added to the Committee forward work plan. <u>January update</u> Included on February agenda under item 2.7
December 2025	PQSOC 0212/05	Committee Action Log Healthcare Inspectorate Wales (HIW) reports had been completed and would be circulated to Committee members after the meeting and formally noted at the next meeting.	Director of Nursing	February 2026	Completed <u>December update</u> Action has been added to the Committee forward work plan. <u>January update</u> Included on February agenda under item 2.5 and were shared with members on 07.01.26



Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
December 2025	PQSOC 0212/07	Quality Management Group Reporting QMG had received inspection reports from Health Improvement Wales for the Royal Gwent Hospital Minor Injuries Unit (MIU) and Ysbyty Ystrad Fawr (YYF) Birth Centre , which would be circulated to members after the meeting.	Director of Nursing	February 2026	Completed <u>February update</u> Both reports were shared with the Committee members on 07.01.26
December 2025	PQSOC 0212/13	Ophthalmology Audit Wales Report It acknowledged that lessons learnt from thematic reviews of other areas of should be presented to the committee on a regular basis.	Director of Nursing	February 2026	Completed <u>February update</u> This will be an ongoing action and with the Committees approval it would suggested that QMG captures thematic reviews and escalates these to PQSOC



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



DYDDIAD Y CYFARFOD: DATE OF MEETING:	17 February 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Quality Outcomes Framework (QOF) for Q3 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis – Assistant Director for Quality and Patient Safety Tracey Partridge Wilson - Deputy Director of Nursing

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

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

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

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

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

As an NHS Wales organisation, the Health Board operates within a clear statutory and regulatory landscape shaped by the *Health and Social Care (Quality and Engagement) (Wales) Act 2020* and the national vision set out in *A Healthier Wales*. These frameworks reinforce our collective responsibility to continually strengthen the quality of care and to demonstrate visible progress against our duties of quality, candour, and engagement.



During Quarter Three (Q3), the Quality Outcomes Framework (QOF) continued to support the Health Board's maturing Quality Management System (QMS), enabling clearer oversight over performance, risk, and improvement across the six Pillars of Quality.

Q3 has shown notable improvements in patient experience, mortality indicators, the management of sepsis, and strengthened patient safety processes. At the same time, it has been a quarter defined by sustained winter pressures, marked increases in respiratory infections, heightened operational congestion, and workforce challenges. These pressures have underscored the need for continued vigilance, adaptive leadership, and targeted intervention

Cefndir / Background

The implementation of the Quality Strategy, Patient Experience & Involvement Strategy, and the Quality Improvement Strategic approach has continued to shape how the organisation measures and understands quality. The refinement of the QOF has ensured that our approach to assurance is better aligned to national expectations, while remaining rooted in local learning and patient need.

Over recent quarters, the QOF has evolved into a more comprehensive, dynamic reporting framework. It now:

- Aligns explicitly with the revised Pillars of Quality
- Draws on a richer suite of indicators, blending quantitative metrics with qualitative insights
- Supports divisional and corporate clinical governance pathways
- Enhances our ability to provide transparent assurance to PQSOC, QMG and the Board

The Q3 QOF brings together key touchpoints from patient experience platforms (including CIVICA), complaints management through PTR and PALS, patient safety incident data, mortality reviews, clinical effectiveness, infection control, and safeguarding intelligence. The breadth of this information enables the Health Board to more effectively track system pressures, areas of excellence, and emerging risks.



Asesiad / Assessment

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

Below is an expanded narrative summarising performance across each pillar, providing strengthened context and clearer alignment to strategic priorities.

Patient & Staff Experience, Complaints, Concerns and Compliments

Q3 saw strong engagement with patient experience systems, demonstrating that patients continue to provide constructive feedback even during periods of heightened operational pressure.

- CIVICA: With 7,066 responses (marginally below Q2), patient satisfaction remains steady at 86%. The themes highlight a consistently positive experience of staff interaction and compassionate care, while waiting-time concerns continue to be the lowest scoring area.
- PALS: Contacts increased to 1,548, reflecting both heightened patient need and improved signposting. Communication remains the predominant theme, reinforcing the importance of ongoing staff training in accessible communication and involvement. Enhancements such as bedside stickers and BSL training demonstrate tangible responses to recurring themes.
- GRACE Bereavement Service: Quarter 3 saw the highest number of bereavement contacts to date (90), with more than half now being direct self referrals, demonstrating increased trust and visibility of the service.-referrals, demonstrating increased trust and visibility of the service.
- PTR: The closure of 399 formal complaints demonstrates improved operational grip. The dual approach to managing aged and incoming cases has begun to show impact, particularly in Trauma & Orthopaedics where overdue cases reduced by 35%.
- Early Resolution: Compliance remains strong (85%) and low rates of reopened complaints show that concerns are being managed appropriately at first contact.

Patient Safety and Incident Reporting

Patient safety intelligence for Q3 reflects a system under pressure but maintaining core safety standards.

- Mortality: RAMI at 89.6 (Oct–Nov) places the Health Board 1st in the All-Wales peer group. Crude mortality remains 15% lower than previous years, continuing the positive trend.
- Incidents: Datix incidents increased to 9,198, which is consistent with the time of year and improved reporting culture. Moderate and above harm incidents remain stable.



- Falls: Despite national challenges associated with frailty and winter acuity, November and December showed decreasing fall numbers. Rates remain below the Wales average per 1,000 OBDs.
- Pressure Ulcers: Category 2 ulcers remain the most common, but overall numbers continue to decline, supported by improved documentation and reductions in “no value” cases.
- HAT: Increased detection reflects strengthened screening processes and a cohort with more complex needs. Prevention remains an area of continued focus.
- Medication Safety: Incident levels remain stable, with work underway to strengthen antimicrobial stewardship and support the EPMA transition.
- NRIs: 36 reported in Q3—lower than the previous year—alongside improved compliance (71%).
- Duty of Candour: Triggered cases have stabilised and reduced as staff confidence and capability increase.
- Never Events: No Never Events since November 2024.

Clinical Effectiveness

Q3 represents an important period of progress in strengthening the evidence base for clinical practice.

- Ward Accreditation: 12 new Bronze and 2 Silver accreditations, though progress has slowed due to winter pressures.
- National Audit Participation: ABUHB continues to perform strongly in audit engagement, meeting expectations.
- Sepsis: National early warning score tools (NEWS2, PEWS, NEWTT2) are now embedded. MEWS is planned for March 2026. The UK Sepsis Trust screening tool is being scaled across the Health Board.
- Safety netting leaflets: Leaflets mandated by WHC have been coproduced locally and will be embedded within discharge pathways.-netting leaflets: Leaflets mandated by WHC have been co-produced locally and will be embedded within discharge pathways.

Health, Safety, Security and Compliance

- RIDDOR: While compliance dipped slightly from Q2, the Q3 compliance of 74.1% reflects continued improvement from Q1.
- Workforce Safety: Physical assaults remain the highest incident type but are stabilising. Sharps incidents are rising and a thematic review is underway.
- Training: Essential training (e.g., Fire Safety, Manual Handling) remains below target; recovery plans are in progress.

Infection Prevention & Control (IPAC)

A challenging quarter given winter viruses and operational pressures, but performance overall shows stability or improvement.

- C. difficile: 193 cases YTD—a reduction of 30 compared to last year.
- S. aureus BSI: 112 cases YTD—also reduced by 30.



- E. coli BSI: Stable with a minor downward trend.
- Respiratory Viruses: Increased hospital admissions placed pressure on cubicle availability, affecting isolation compliance.
- Collaboratives: Ongoing work through national collaboratives on urinary infections, line care, and C. difficile pathways.

Safeguarding

Safeguarding activity reflects increasing complexity, especially in children's cases, despite a slight reduction in volumes.

- Adults: Duty to Report referrals have significantly decreased.
- Children: Still very high; slight decline from Q2 peak but sustained pressure remains.
- Persons in Positions of Trust: Increase in referrals; new policy launched January 2026.
- Training: Level 3 training uptake improving but remains a challenge due to workforce scale.
- VAWDASV: Group 1 compliance is 76%; recovery planning is required.
- MARAC: Referral numbers stable but case complexity rising; reduced third sector capacity is impacting system flow.-sector capacity is impacting system flow.

Areas of Improvement

Q3 saw several areas of meaningful progress:

- Successful embedding of early warning scores across acute and community settings
- Strong performance in mortality indicators and All Wales-Wales benchmarking
- Improved PTR timeliness and reduction in aged cases
- Improvements in thematic learning from patient experience data, enabling targeted interventions
- Strong NRI closure performance
- Strengthened antimicrobial stewardship and EPMA preparation
- Sustained improvements in Blood Stream Infection reduction and Infection Prevention and Control performance

Areas of Focus:

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

- PTR compliance in Medicine and Surgery



- Antimicrobial stewardship, particularly clarithromycin duration and Access-category compliance
- Fire safety and manual handling training
- Timeliness of patient isolation and impact of capacity constraints
- Rising safeguarding complexity
- Datix completion timeliness
- Operational pressures affecting ward accreditation timelines
- Continued actions to reduce preventable HAT
- Continued oversight and focus on Level 3 safeguarding training
- Improvements in data and reporting

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

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

Argymhelliad/ Recommendation

This report is to provide ASSURANCE to the Patient Quality, Safety and Outcomes Committee on the Health Board's strengthening Quality Management System and maturing governance arrangements. It demonstrates alignment with the Duty of Quality and Duty of Candour across all clinical and corporate services through the implementation of the Quality Strategy, the Patient Experience & Involvement Strategy, and the Quality Improvement Strategy

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable currently
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 5. Timely Care 6.3 Listening and Learning from Feedback Choose an item.



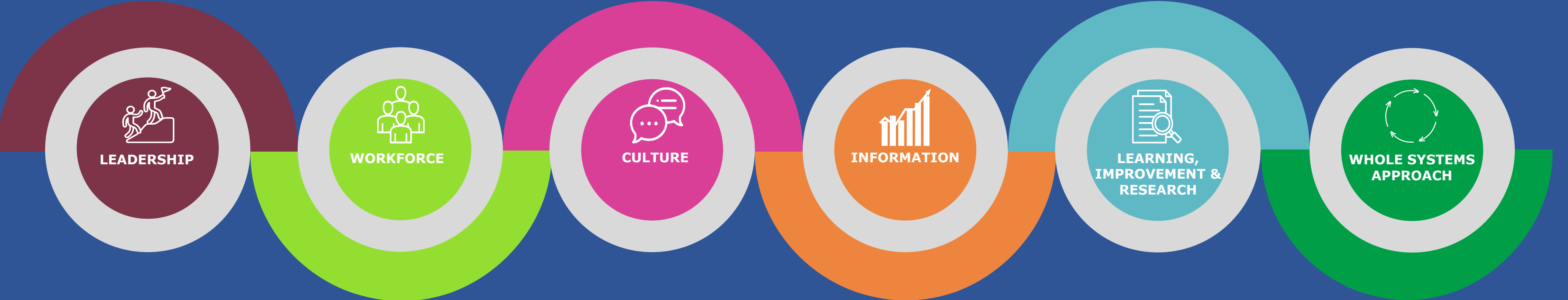
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient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

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

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







Quality Outcomes Framework

Quarter 3 - 2025/26



The Quality Outcomes Framework

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

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

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

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

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

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

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

Revised Pillars of Quality



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

PILLAR 1

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

Civica

Collaboratives Forums

Patient Stories

PTR Regulations

Early resolution

Staff Training and Mentorship (IO)

Volunteering

Patient Advice and Liaison Service (PALS)

Leadership, Accountability and Culture

Complaints PSOW – Themes and Learning

Speaking up Safely

Cultural Competence Accreditation Scheme

Dementia Standards

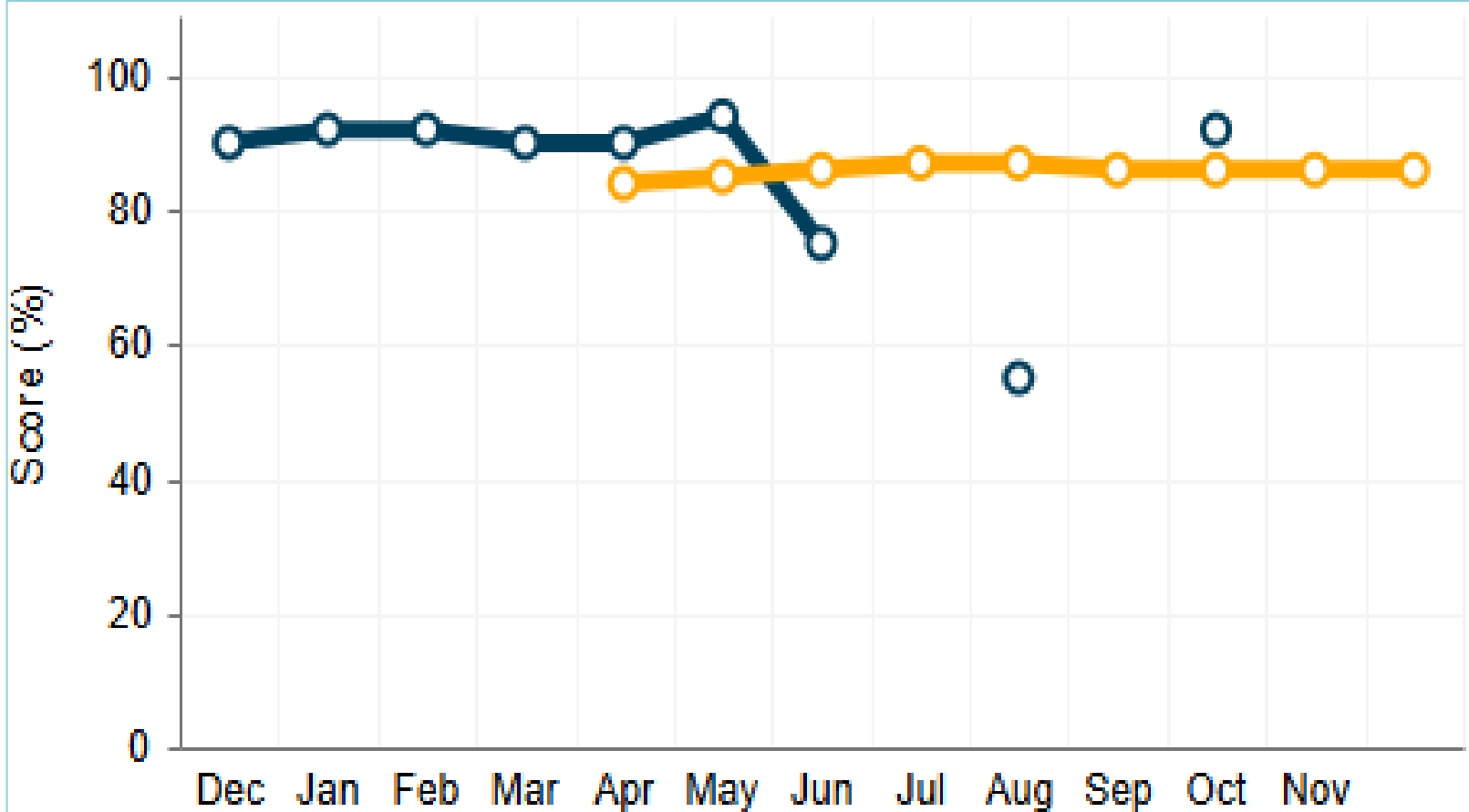
Listening and Learning Meetings

CIVICA Patient Experience Feedback

Responses to Patient Experience Questionnaire



Satisfaction Score Trend



All Surveys

24864
Responses

86%
Satisfaction

Person Centred Care (PCC) & People's Experience (PES)

22016
Responses

87%
Satisfaction

ED - ED Survey & PES Combined

5721
Responses

75%
Satisfaction

Maternity & Neonates Surveys
(Launched Sept)

741
Responses

85%
Satisfaction

Total YTD (April - December)

20936
Responses

86%
Satisfaction

Definition

All data displayed has been extracted from CIVICA and is correct at the point of extraction on 06 January 2026. Surveys that were already sent (paper and text message) may be completed later giving the impression of data changing.

Analysis

Over the previous year the number of responses to CIVICA Patient Experience surveys has increased dramatically, 7066 responses for Q3, slightly down on Q2 (7,538).

Satisfaction Score is 86% for Q3 (all surveys) compared to 87% for Q2. There is also no movement in top three themes in Q3 from Q1 or Q2.

The question 'Was the time you waited' remains the lowest scored question each month for Q3.

Implications

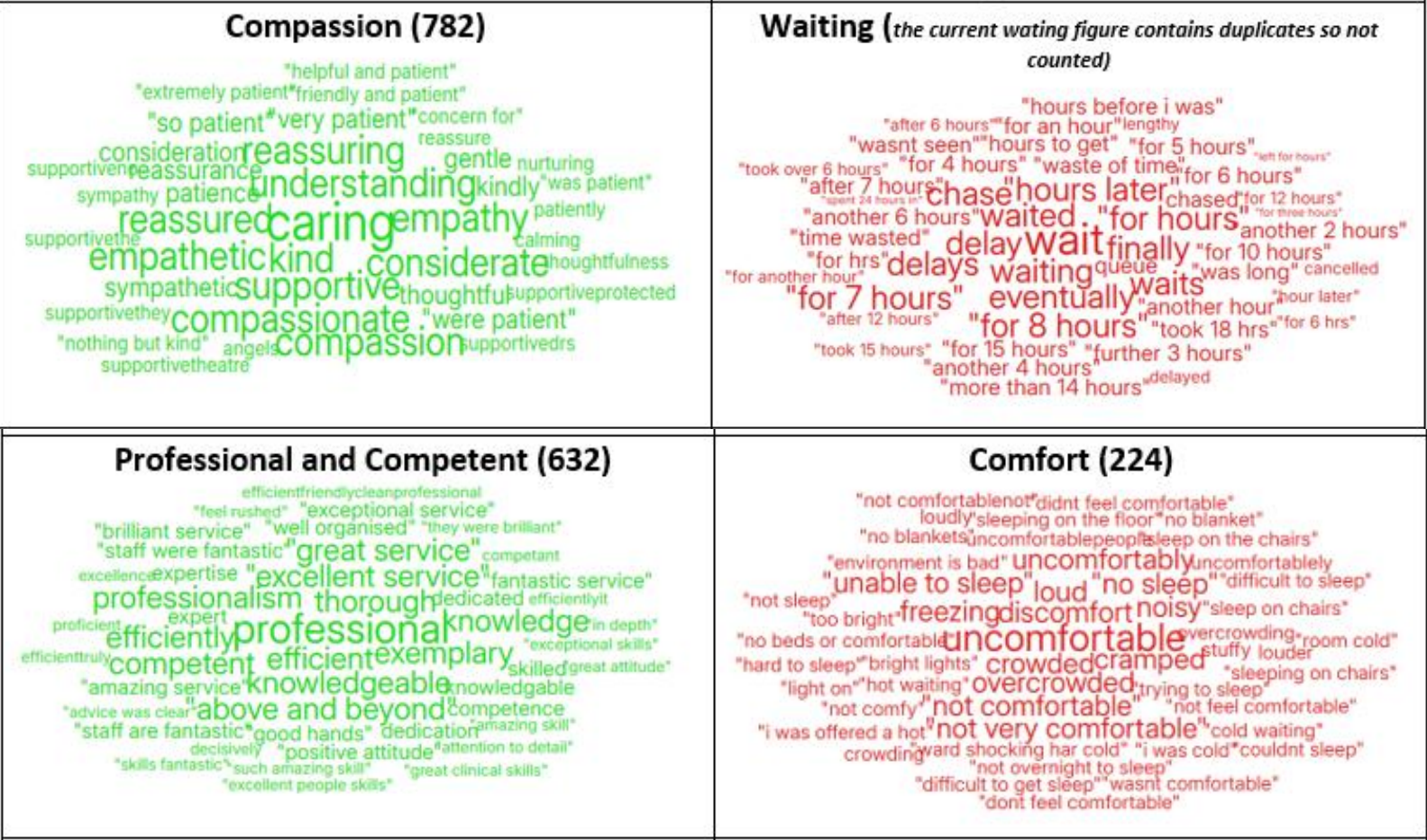
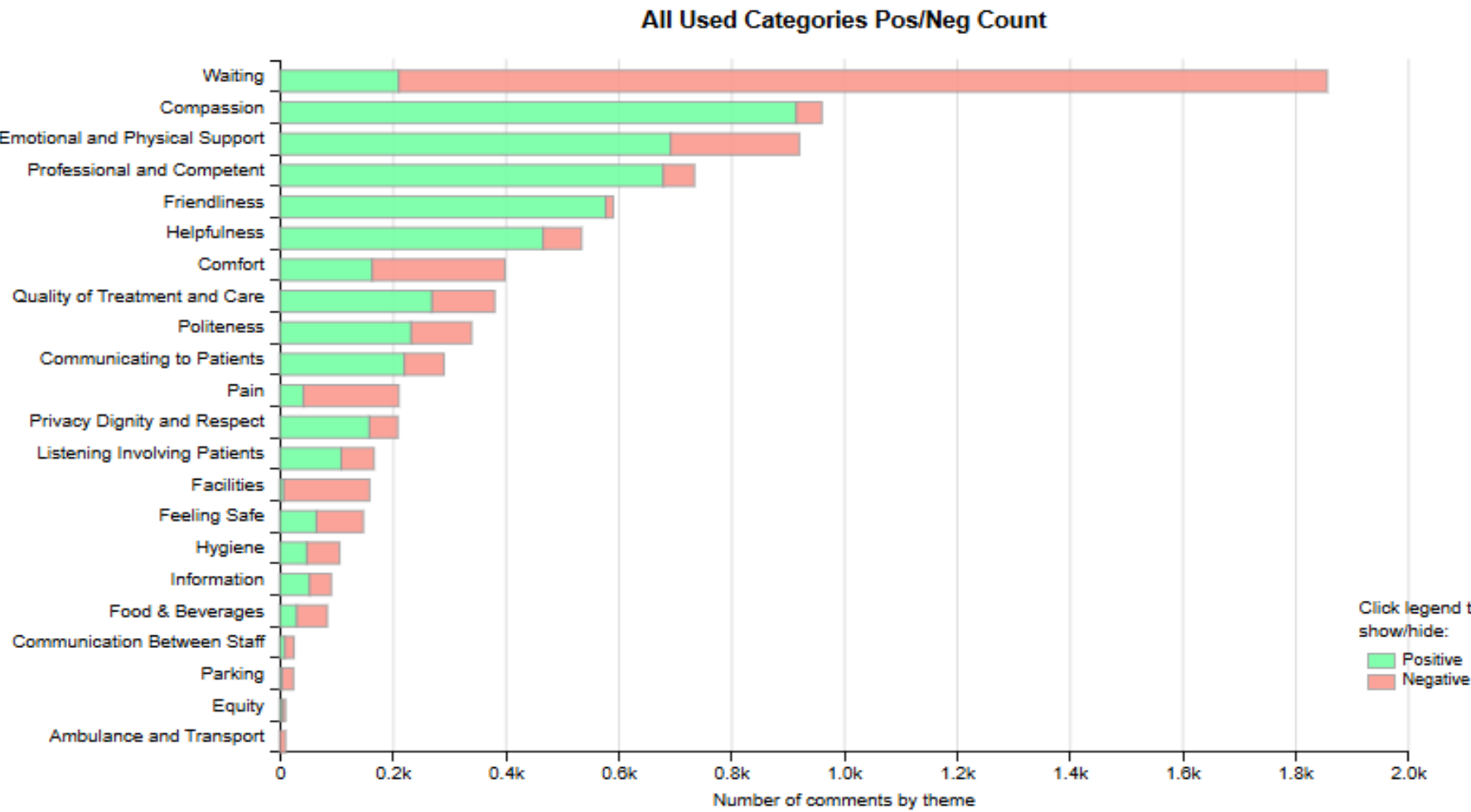
Bespoke reporting continues, themes and patient comments that crossover the Divisions, examples Facilities, Infection Prevention and Control, Food and Beverages, Equality and Inclusion, Welsh Language. Monthly reports are also generated via the system throughout Divisions.

Work has been carried out across Wales to translate the new PES and Maternity Surveys into different languages and BSL. This work will be picked up in 2026 to implement into the Aneurin Bevan CIVICA Feedback System.

CIVICA Patient Experience Feedback

Themes and emotion analysis of comments

Top 2 Positive and Negative Themes Q3 2025/26



Learning and Improvement from CIVICA data:

Learning and Improvement from CIVICA data:
Any themes or trends from comments e.g. E-triage are shared with individual departments to allow for the patient voice to be heard.

Listening and Learning from CIVICA patient feedback by divisions in Nov 2025

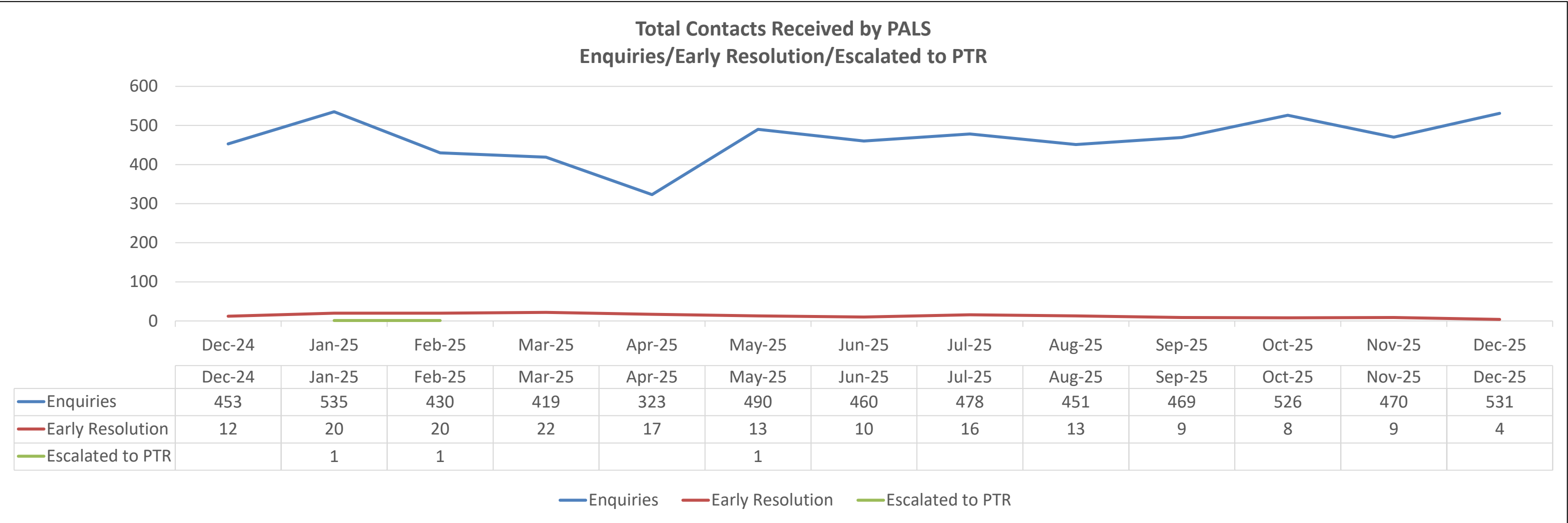
Medicine

B4 GUH has installed a TV screen at the ward entrance displaying a QR code, which has helped increase CIVICA submissions
At NHH, the only negative feedback relates to food, and this has been shared with the facilities manager. Wards are ensuring food trolleys are plugged in to keep meals warm. Staff are also supporting patients with menu completion and helping during mealtimes.

Urgent Care

To support neurodivergent individuals, plans include providing five calm bags and two sets of ear defenders in boxes for RGH and NHH MIUs, stored in reception areas. Once iPads arrive, these boxes will be distributed to departments.
In ED Majors, 10 calm bags and five sets of ear defenders have already been provided, with resources shared with the children’s A&E.
Each box contains a logbook to record usage, helping track when replenishment is needed. iPads for translation support will also be stored in these boxes.

Patient Advice & Liaison Service (PALS)



Themes	Count
Communication Issues (including Language)	3258
Access (to Services)	1539
Appointments	299
Clinical treatment/Assessment	197
Patient Care	190
Discharge Issues	117
Post Death Issues	109
Complaints Handling	60
Record Keeping	43
Admissions	35

Definition	Analysis	Implications
This data is obtained from the Once 4 Wales RL Datix system, which is populated by the Health Board’s Patient Experience Team. The table (right) shows the enquiry themes from December 2024 to December 2025. The data is live and is an ever-evolving picture the information stated is accurate at the point of extraction.	The total number of contacts managed by the Patient Advice & Liaison Service increased in Q3 to 1,548 from 1,436 in Q2. The themes across all PALS contacts remains consistent with almost 50% related to communication issues (including language). The second most common theme is access to services, followed by appointments. Within Early Resolutions managed by PALS the most frequent theme is communication, followed by patient care and clinical treatment/assessment. This has changed since the previous quarter with patient care now sitting ahead of clinical treatment / assessment.	• Roll out of the PALS bedside stickers has continued across Health Board • PALS supporting with patients who are being cared through the 'Your next patient' programme • Exploring avenues of support from PALS service for the Community Assessment Lounge • PALS undertaking Deaf blind awareness training and BSL level 1 to be able to support patients, families and carers • Point of contact for veterans • Team now up to full complement of staff.

Patient Advice & Liaison Service (PALS) Case Studies

Case Study 1:

The PALS team encountered Patient A in the main reception area of the Grange University Hospital who appeared distressed. A Patient Support Officer (PSO) approached to check on her and noticed she was cannulated and in visible pain. The patient explained that she had recently lost her baby due to an ectopic pregnancy, which required emergency surgery to remove the affected fallopian tube.

The PSO supported her by listening and comforting, and contacted the chaplaincy team to offer additional support around baby loss. During this time, the patient disclosed a history of domestic abuse, previous homelessness, and various mental health challenges.

The PSO encouraged her to eat and rest. The patient expressed that she did not want food from the ward. The PSO arranged a missed meal voucher, and offered to take her to the canteen, which she accepted. The patient also mentioned discomfort due to a swollen stomach and a lack of toiletries. The PSO provided three clean sets of suitable pyjamas, a wash kit, and other toiletries from the chaplaincy.

This case highlights the importance of compassionate, holistic care and demonstrates how going beyond clinical needs can significantly improve a patient's experience during a vulnerable time.

Case Study 2:

Patient B contacted the PALS team regarding difficulties visiting her baby, who has been admitted to the Grange University Hospital since birth a few months prior. Patient B reported that she has no access to personal transport and found that there is no public transport available on Christmas Day. She also explained that travelling by taxi would cost approximately £98 each way.

The ward offered Patient B accommodation at the Grange; however, she stated that this was not feasible due to caring responsibilities for her other young children at home.

PALS contacted the Volunteer Service to explore alternative transport options. A volunteer residing in Patient B's area confirmed that they would be travelling towards the Grange on Christmas Day and were willing to collect Patient B, transport her to the hospital, and return her home later in the day.

This arrangement will enable Patient B to visit her baby on Christmas Day without incurring financial hardship or additional stress. This case demonstrates how collaborative working and creative problem-solving can make a significant difference to patient and family experience during challenging times.

Case Study 3:

The PALS team was contacted by staff from the Haematology department to support a patient awaiting confirmation of a lymphoma diagnosis. The patient was experiencing significant anxiety, which made communication challenging. Long waiting times due to transport arrangements added to his distress, causing agitation and irritability.

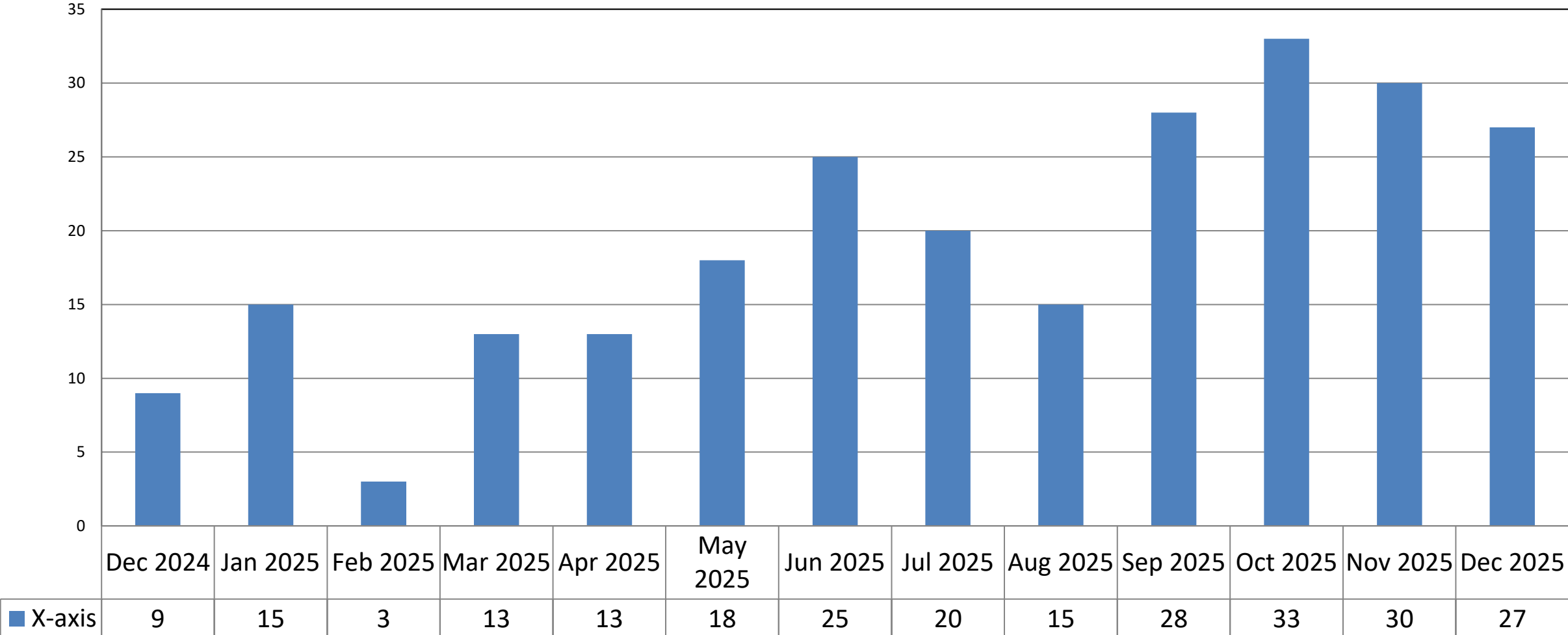
With consent from Patient C, PALS attended medical appointments to provide reassurance during blood tests and remained present for difficult conversations when the patient was informed he had high-grade lymphoma and that chemotherapy was not a viable option. PALS spent considerable time consoling and reassuring the patient and continued to attend follow-up appointments to help ease his anxiety.

This support reduced the time clinical staff needed to spend managing the patient's distress, allowing them to focus on other patients, while helping Patient C feel calmer and more able to discuss his concerns. He expressed gratitude for the ongoing support, which PALS will continue to provide as needed.

This case demonstrates the vital role of emotional support in improving patient experience during life-changing diagnoses and highlights the value of collaborative working across teams.

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

Total Enquiries December 2024-December 2025



Case Study 1:

The GRACE team were contacted by a ward staff member requesting bereavement support for a lady who was currently an inpatient.

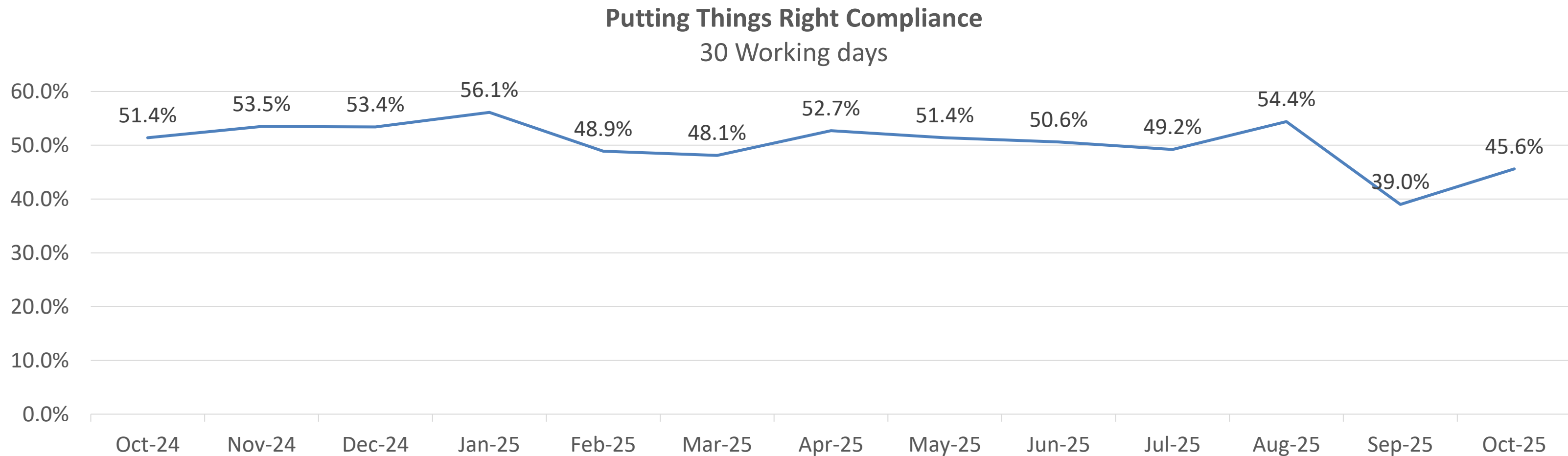
A member of the team visited her on the ward, where she shared how she was struggling to come to terms with the loss of her husband, who had passed away only four weeks earlier. Since his death, she had been in hospital and felt anxious about returning home alone.

During the visit, she spoke about the life she and her husband had built together, the places they visited, and the memories they made. Although these conversations were emotionally difficult, she expressed that talking helped and asked to maintain contact with the team.

The GRACE team continued to support her through phone calls while she remained in hospital and after her discharge home, ensuring she felt connected and supported during this challenging time.

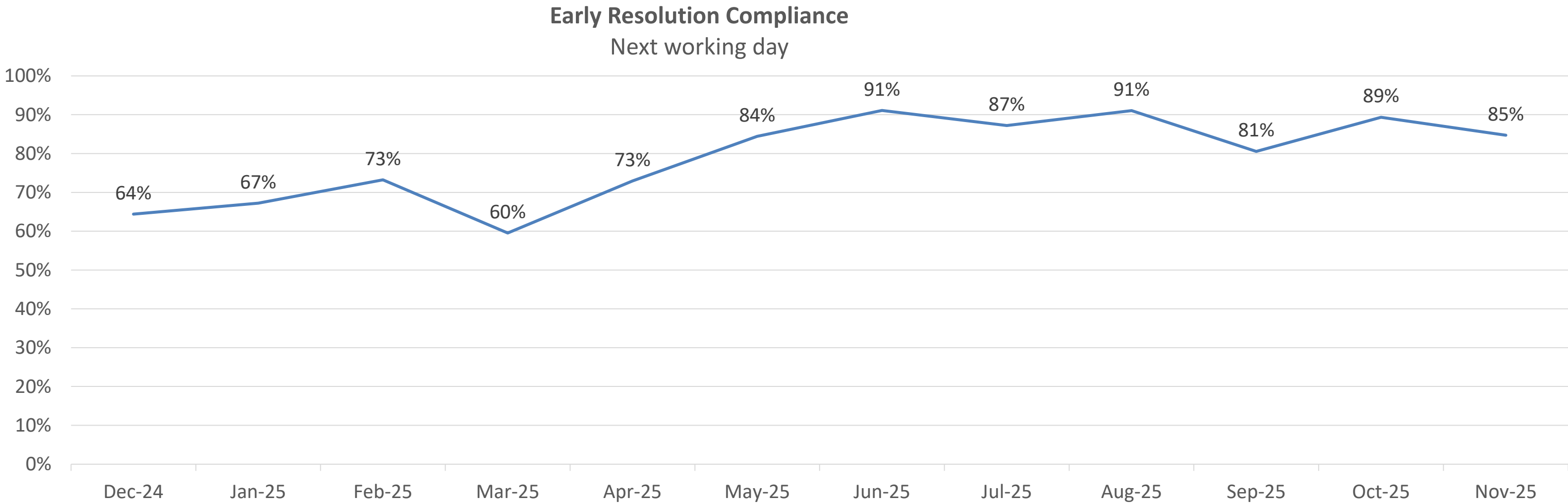
Definition	Analysis	Implications
This data is obtained from the Once 4 Wales RL Datix system, which is populated by the Health Board’s Patient Experience Team. The data is live and is an ever-evolving picture the information stated is accurate at the point of extraction.	Quarter 3 saw the highest number of relatives contacting the GRACE End of Life and Bereavement Service with 90 contacts compared to 63 in Q2. Over half of contacts now come directly from service users from their own homes, rather than being passed to the service from wards, PALS and PTR.	Everyone deserves to live well until the end of their life. We aim to provide compassionate, respectful, and person-centred care for every individual, regardless of who they are, where they come from, or what they believe. Our vision is a future where every person feels heard, valued, and supported in a way that honours their choices, culture, and Dignity.

Putting Things Right Compliance with 30-day Target



Definition	Analysis	Implications
The above represents the organisation’s rolling position for compliance with the WG target of responding to concerns managed under PTR (formal). Reporting is now aligned with NHS Executive Beacon Dashboard, therefore % Compliance is being reported against the month received. This data is obtained from the Once 4 Wales RL Datix system, which is populated by the Health Board’s corporate PTR team.	Achieving 75% compliance remains a key priority and core performance target for the Quality and Patient Safety team. The trend for those matters closed under PTR has been relatively consistent across the reporting period, the organisation closed 399 formal complaints across Q3. There had been a decrease in the number of concerns achieving compliance at the end of Q2 where the focus became the aged cases. A change to management processes throughout October to ensure a dual approach to both aged and incoming cases saw a positive increase at the beginning of Q3.	The Division of Surgery, namely Trauma and Orthopaedics (T&O) have been the focus across Q3. At the start of December T&O had 69 overdue PTR concerns, this month that is down to 51, which is a 35% reduction. The PTR team holds focused weekly meetings to track and escalate cases that need attention, particularly those related to compliance for the upcoming fortnight. This ensures that cases which can be resolved on time are actively managed and supported by concerns support officers and senior management.

Early Resolution Compliance with 2-day Target

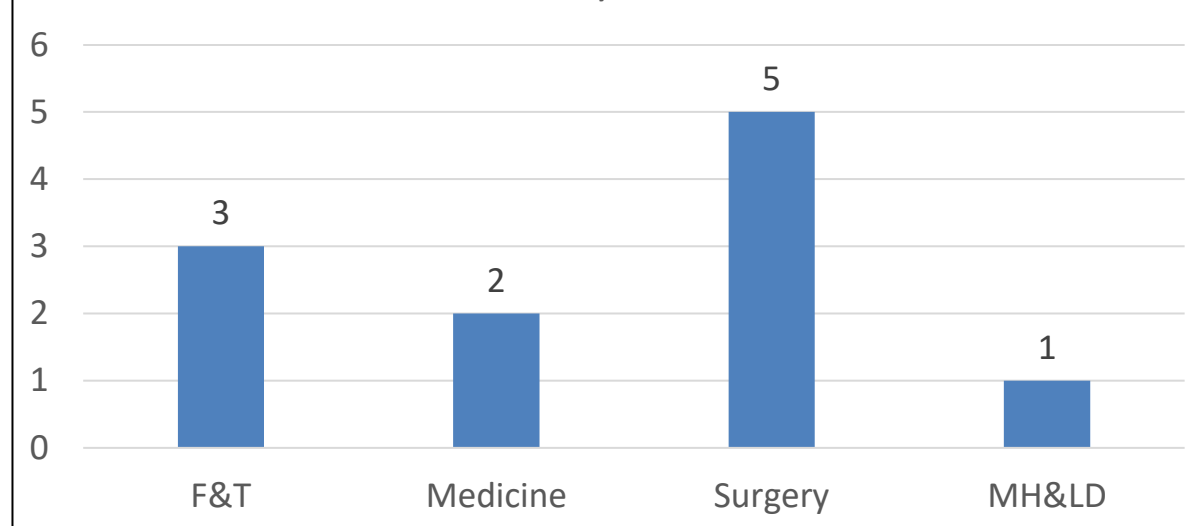


Definition	Analysis	Implications
This data is obtained from the Once 4 Wales RL Datix system, which is populated by the corporate PTR team. The data is live and is an ever-evolving picture the information stated is accurate as of 8 January 2026.	Performance in Early Resolution (ER) has shown significant improvement compared to the previous year. There has been 1 re-opened cases since December 2024, demonstrating the effectiveness of ongoing PTR training at the initial stage and thorough review processes at the final stage. The improved upward trend of Early Resolution compliance has continued to climb across quarter Q3 with an average of 85% ER compliance. Furthermore, complaints that are not resolved within 48 hours are converted to formal in accordance with PTR regulations.	Early Resolution offers much quicker response times compared to formal procedures, addressing concerns with a more person-centred approach. The current timeframes are leading to a number of matters being escalated to formal complaints, which will affect the volume of cases that can be managed as Early Resolution until the Regulations are adjusted in Spring 2026. The Concerns Managers continue to meet with the concerns support officers every week to review open Early Resolution matters and ensure that these are not drifting outside of compliance and are being managed swiftly and appropriately as evidenced by the compliance figure for October.

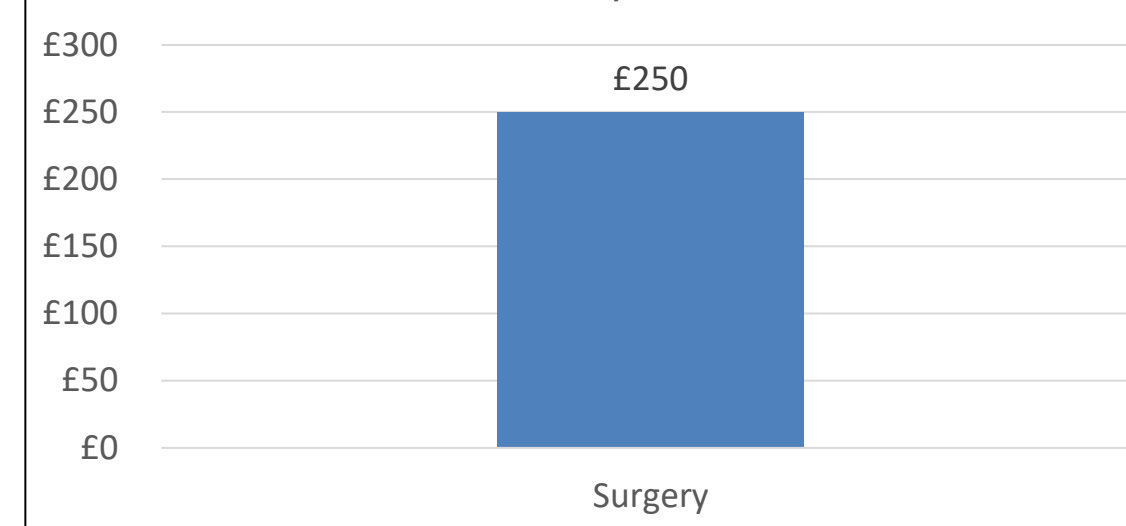
Pillar 1: Patient and staff feedback, complaints, concerns and compliments

Putting Things Right Ombudsman (PSOW)

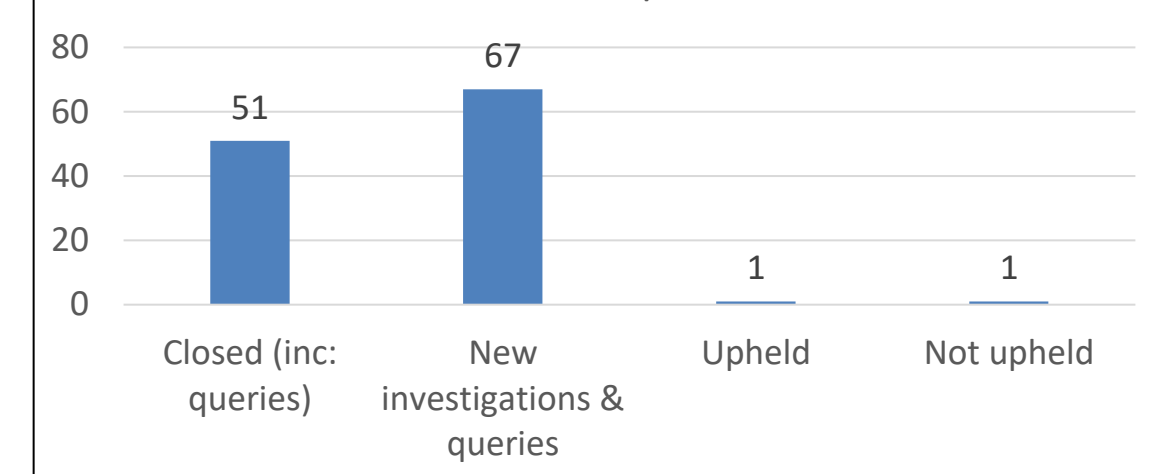
No of Settlements by Division Q3 2025/26



Financial Settlements by Division Q3 2025/26



PSOW Closed/New/Upheld/Not Upheld Cases
Q3 2025/26



Learning and Completed Recommendations

Key Learning Points:

A complaint was raised about the standard of nutritional care provided to the patient during his YYF admission and whether, between 7 - 22 October 2023:

- The Health Board took appropriate action to assess and address nutritional care needs.
- There were appropriate and timely referrals for review by SALT, ENT and/or dietetics to address identified nutritional needs.

PSOW concluded:

There was a delay of 1 week in referring for dietetic review. This would have enabled assessment of the adequacy of nutritional intake, and earlier consideration of non-oral feeding. It was difficult to conclude that an earlier referral for dietetic review would have altered the outcome. However, PSOW accepted that the family's concern about nutritional management and the resulting uncertainty about whether earlier dietetic review may have improved the outcome was itself an injustice. The complaint was therefore upheld to that limited extent

Recommendations:

Consider the learning points to ensure:

- An accurate weight for patients is undertaken when in AMU
- A timely referral to dietetics where indicated is made
- Accurate recording of diet and fluid intake, including the quantities consumed, on food charts and fluid balance charts

Actions:

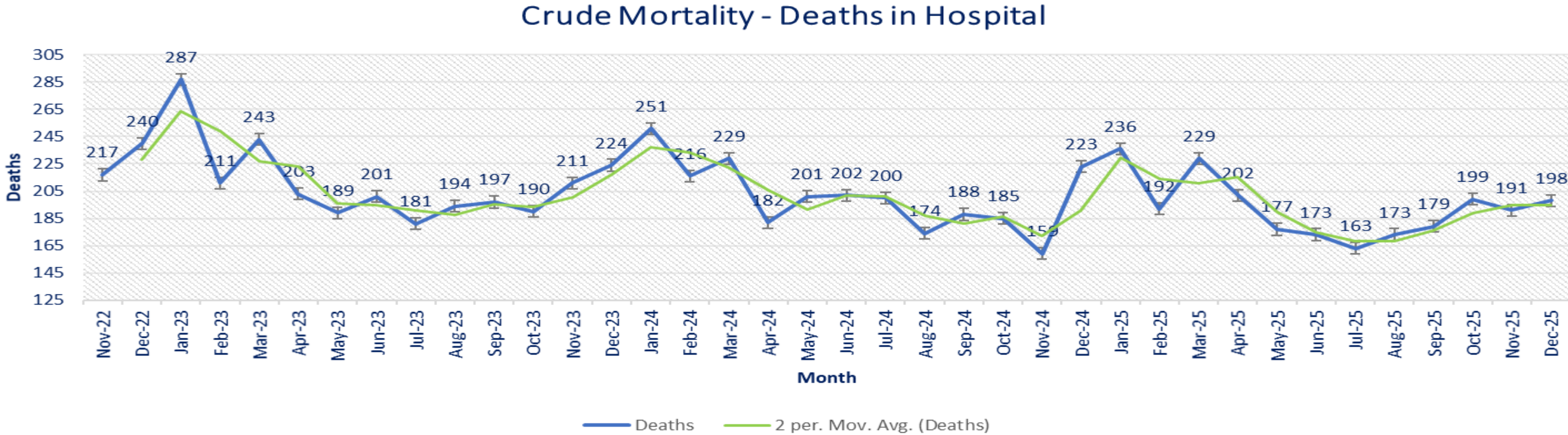
- Action plan completed for AMU
- Education sessions held with nursing staff
- Ward management staff undertake weekly audits
- Staff have attended study days with SALT and Dietetics. Dietetics attended AMU every Wednesday and completed drop-in sessions for staff
- YYF held a nurse training day where the theme was hydration and nutrition

PILLAR 2

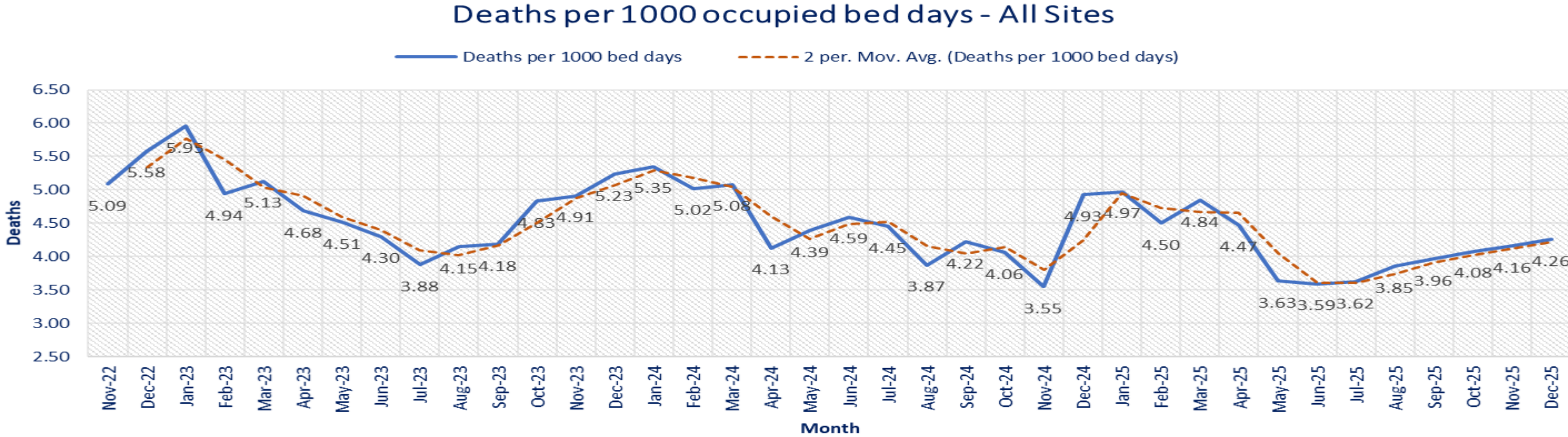
**Patient Safety including
Incident Reporting**

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

Crude Mortality in Hospital

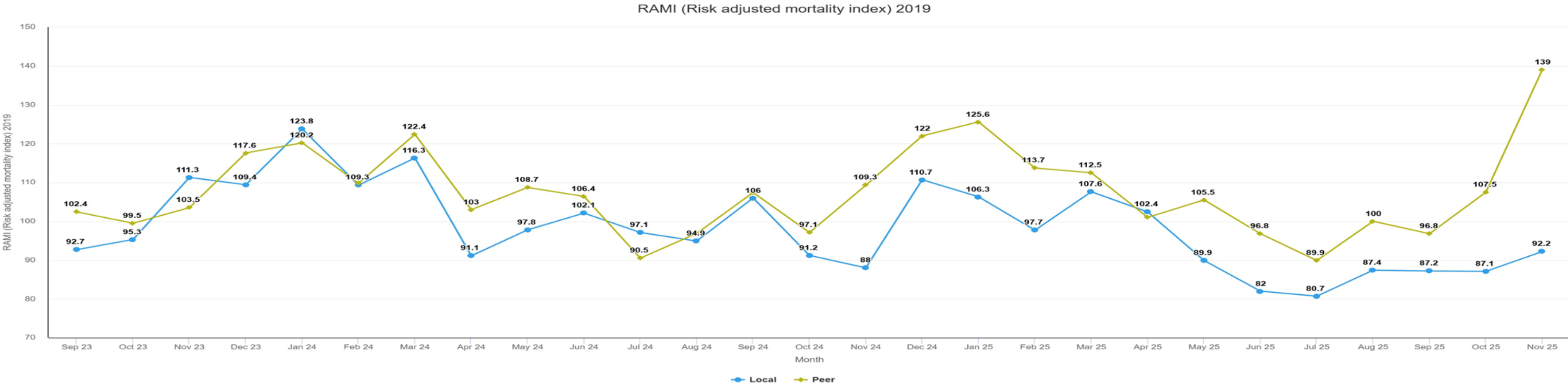


Crude mortality measures the number of deaths in a population over a specific period. It helps understand overall death rates in a community, region, or country by comparing current deaths to the average over the previous three years, identifying trends above or below this average. The data includes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



The graph shows the actual number of deaths recorded within the Health Board in a hospital environment. In 2025 there has been an average 15% lower deaths recorded than previous years. The graph also shows the seasonal variation in the number of deaths, most notably consistent yearly spikes year on year in December and January.

Risk Adjusted Mortality Index

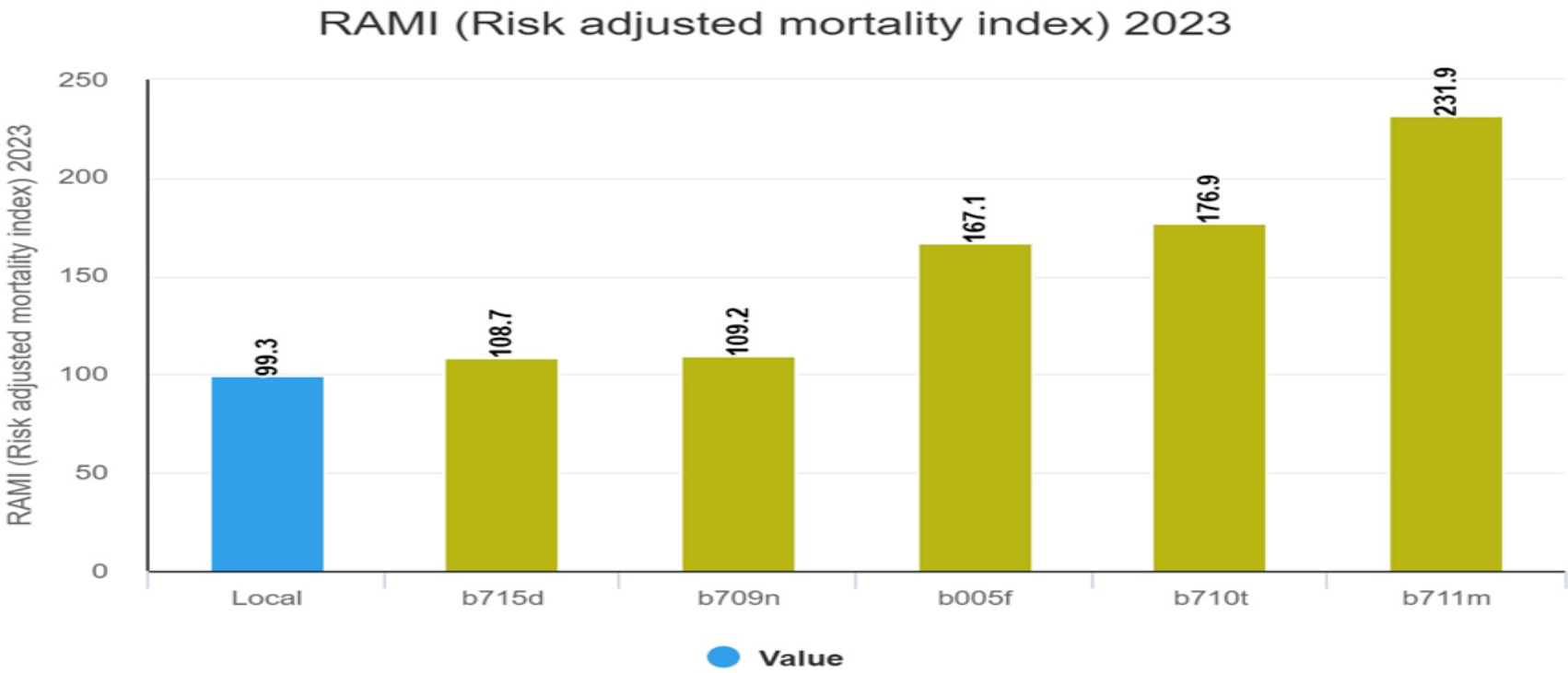


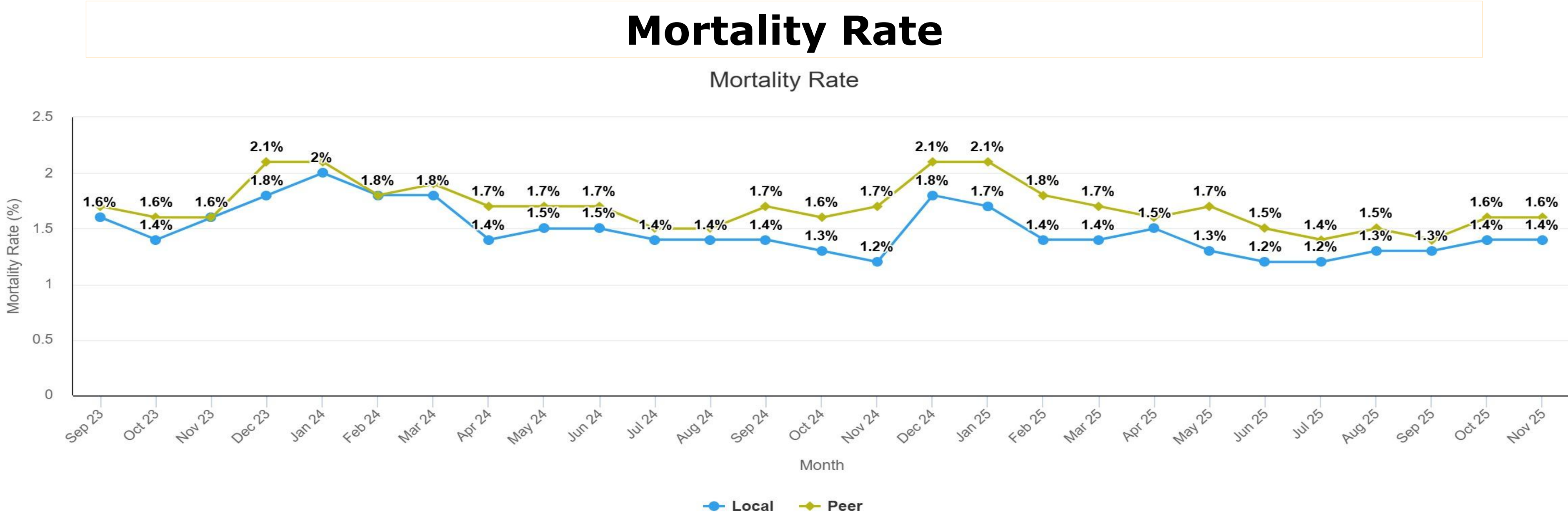
The Health Board’s Risk-Adjusted Mortality (RAMI) for October and November* combined stands at 89.6, an increase from Q2’s figure of 85.6. RAMI accounts for individual patient risk factors and co-morbidities, enabling meaningful comparisons between organisations. Encouragingly, RAMI has shown consistent year-on-year improvement from 2023, and for 2025, remains below the benchmark of 100. This indicates that observed deaths are currently fewer than expected.

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

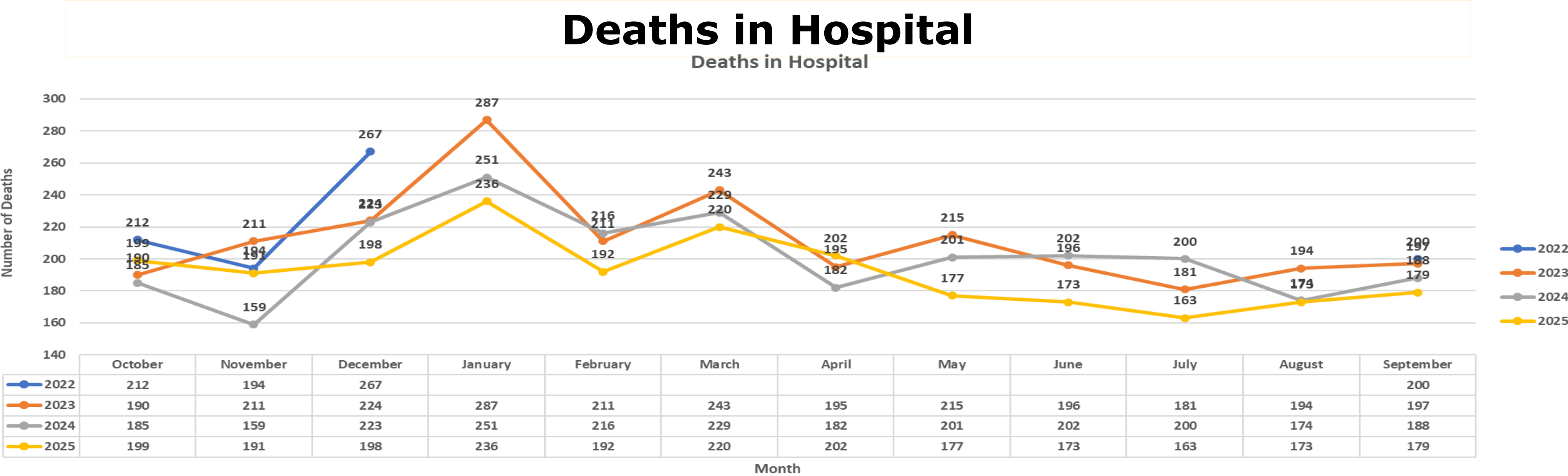
For Q3 (October and November*) 2025, the Health Board ranked first among the six members of the All-Wales peer group.

*October and November 2025 is the latest data available due to the 6-8 clinical coding delay





Definition	Analysis	Implications
The above graphs show the % of Hospital spells which end with the discharge method of death. At present latest data (Nov 2025) 1.4% of ABUHB Hospital spells end with the discharge method of death.	Mortality Rates have remained consistent and have been 1.5% or lower for 10/12 months of the last year and has remained on trend with the Peer Group while achieving a lower mortality rate as a Health Board	In 2014 Professor Palmer published an independent review of the use of RAMI and the extent to which it provides valid data and recommended a blended approach that considers numerous sources of information, in addition to RAMI, including that from mortality reviews, national bench-marking and national audit. Addition of the Health Board’s learning from death report advocates several approaches to understand performance, this ensures assurance and quality improvement around death, not sole reliance on aggregated retrospective data (e.g. RAMI). This is observed in the additional mortality indicators for reporting.

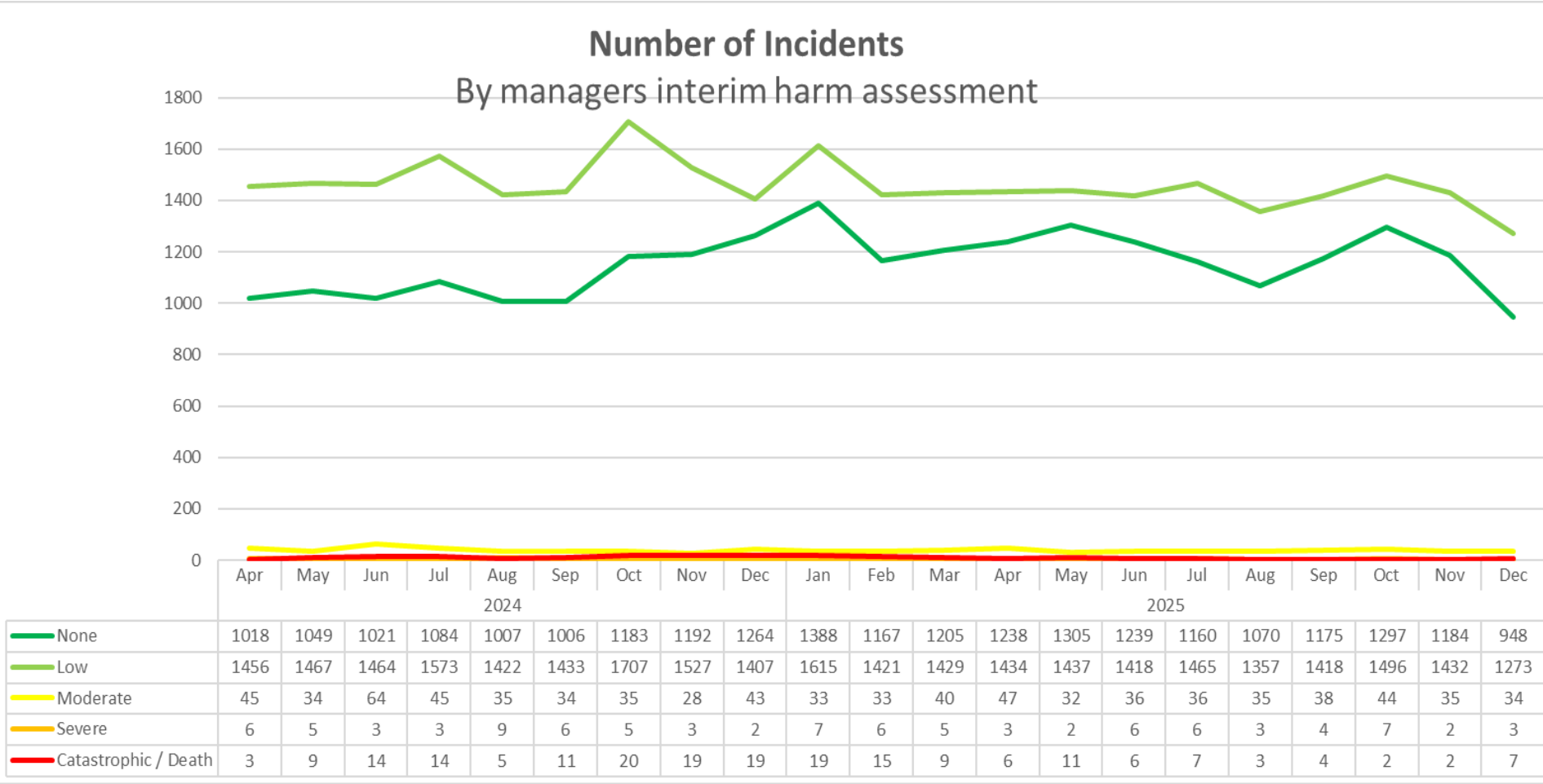
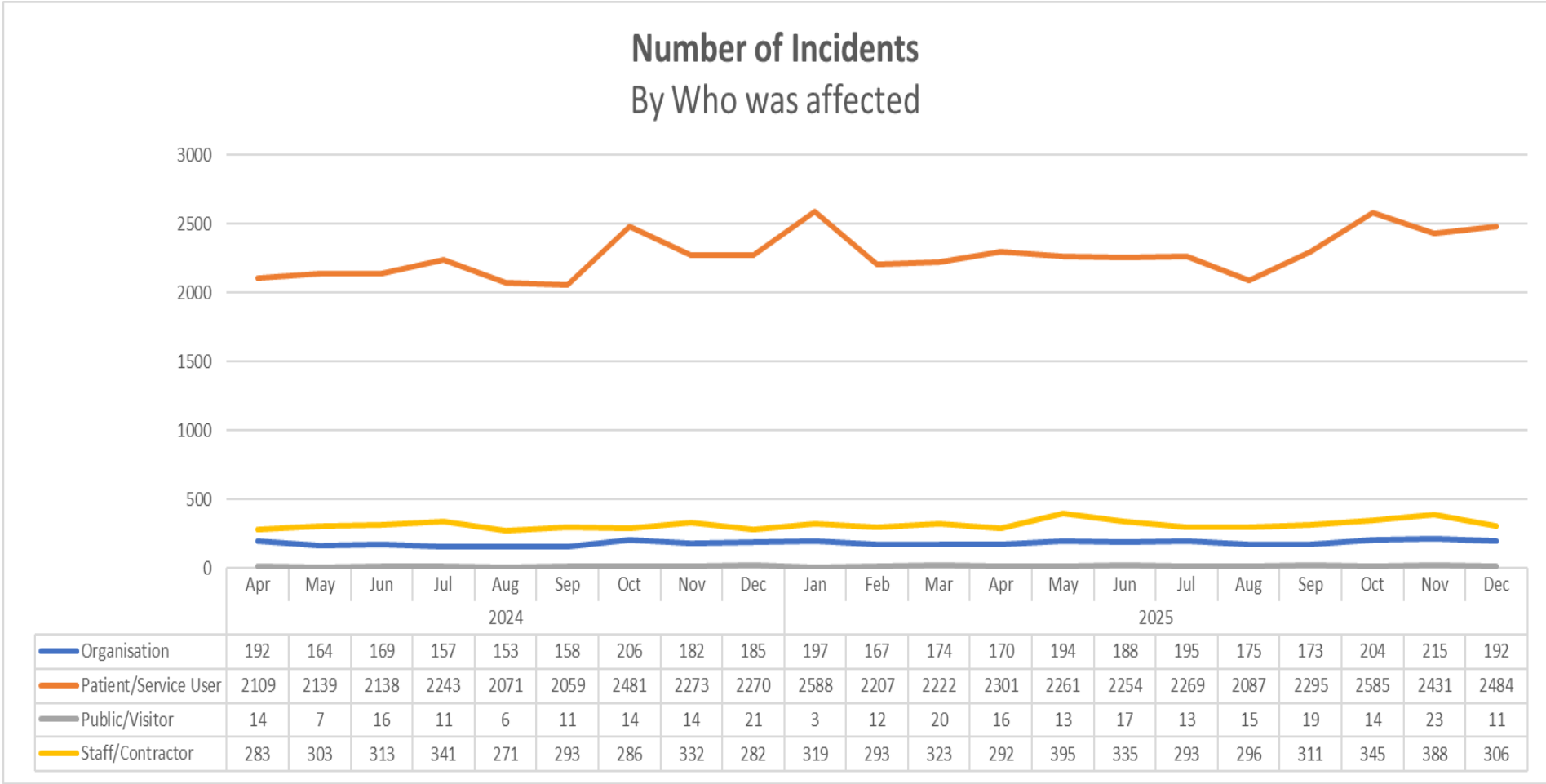


Definition	Analysis	Implications
The chart shows the monthly number of hospital deaths over a four year period from October 2022 to December 2025. Data from each year are overlaid to enable comparison across years, highlighting both year-on-year trends and seasonal variation	Across all four years, there is a consistent seasonal peak in winter months, with deaths rising from December and peaking on January. January represents the highest month in each year shown, most notable in January 2023, which records the highest single monthly figure across the period. The pattern is consistent with increases system pressures typically experiences over winter, inducing higher emergency demand, acuity and the impact of respiratory illness. For the winter peak, deaths generally decline through February and March, with a further reduction evident into April and early summer. From May to July, figures stabilise at a lower level, the lowest monthly totals seen most consistently in July, particularly in 2025.	When comparing years, 2022 and 2023 show higher overall levels than subsequent years, particularly during the winter surge. In contrast, 2024 and 2025 demonstrate a sustained reduction, with lower peaks in January and fewer pronounced fluctuations across the year. The 2025 data in particular remains consistently below previous years from February onwards, suggesting an overall downward trend in inpatient deaths compared to the earlier period. From August to September, there is a slight increase across all years, indicating the beginning of seasonal uplift ahead of winter; however, levels remain below the winter peak. Overall, the data shows: A clear and repeatable winter effect on hospital deaths. Improvement over time, with lower peaks and reduced overall monthly figures in 2024 and 2025. Greater stability in more recent years, with less extreme month-to-month variation. This trend is consistent with a combination of improved system resilience, changes in population health dynamics, and ongoing quality and safety work focused on the management of deteriorating patients and end-of-life care.

Mortality Actions

Issue	Cause	Learning and Improvement	Who	When
Understanding mortality data and how we implement learning from mortality	There is a need to understand what is reported to PQSOC and to Board for mortality. NHS England produce a Learning from Death framework which enables a standardised mortality report.	The Health Board has presented several Learning from Death reports at PQSOC. This work included the development of a strengthened Learning from Deaths Framework triangulated with insights from the Medical Examiner Service and the Mortality Review Screening Panel. A comprehensive review of our end-to-end mortality process is also underway to ensure robust learning and improves oversight.	Medical Director’s QPS team	April 2026
Reliability of mortality data	Consistency of mortality reporting and data.	A Mortality Framework has been developed to support consistent reporting of mortality indicators. The framework sets out a tiered approach: Tier 1 – Health Board level, Tier 2 – Divisional level and Tier 3 Directorate level. The QOF currently reports RAMI and crude mortality, aligned to this structure.	QPS Team and Information Manager	Complete
Clinical coding	The national target for clinical code is 95% coding completion one month post episode discharge. We are currently coding at 87% because of increasing activity.	Working with coding team to improve coding rate and depth and understand the variation in RAMI compared to the consistent and flat mortality rate over time.	QPS Team, DDT team and Information Manager	Ongoing
Mortality Data and Clinical Outcomes	Developing a governance process around mortality outliers	QPS Team and Information Manager currently drafting a Standard Operating Procedure for Mortality Outliers and investigation.	Information Manager, DDT and QPS Team	April 2026
	Develop process for when to undertake a review of case notes	Develop a deep dive SOP to allow scrutiny of notes for review. This will help to interrogate the notes assessing for accuracy of coding and clinicians input for learning from deaths. This will include processes e.g. for MHLD deaths and suicide.		September 2026
	Mortality indicators not available to all	Utilise the mortality indicators module in CHKS.		Complete

Datix Incidents

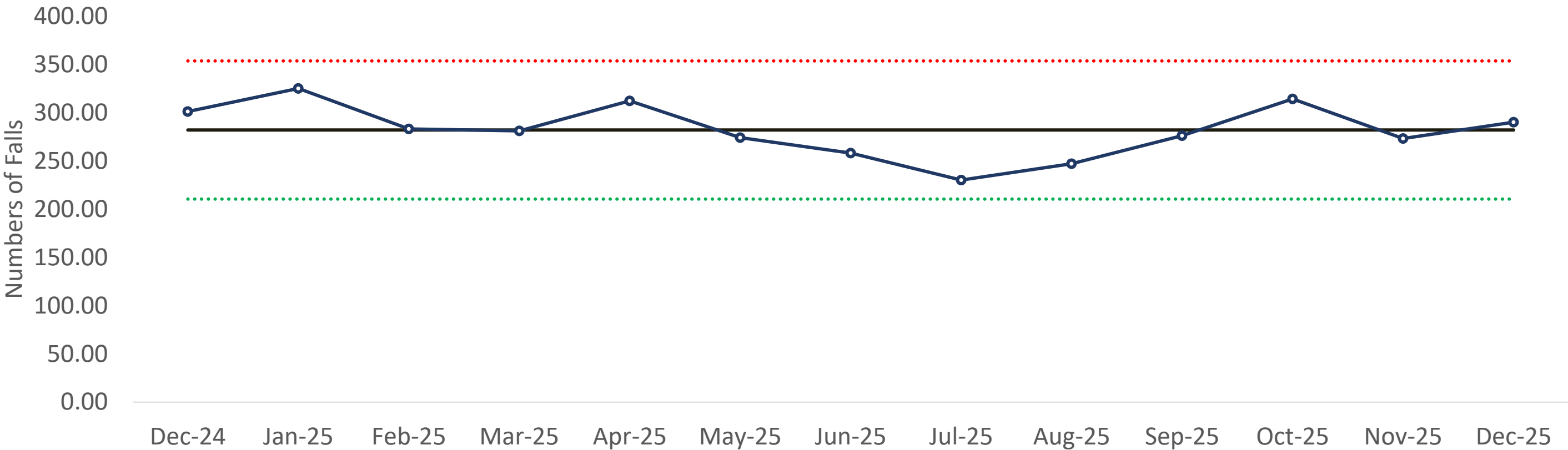


Definition	Analysis	Implications
This data is obtained from the Once 4 Wales RL Datix system, information is reliant on the timely and accurate recording of patient safety incidents. It is valid at the point of extraction (05 January 2026). As the manager’s interim harm assessment may take several days or weeks to complete the decline in recent months should not be misinterpreted as a decline in the number of overall incidents.	The total number of incidents in Q2 increased from 8,141 to 9,198 in Q3, there was also a 7% increase on the same period last year. The number of incidents affecting the organisation increased from 543 in Q2 to 611 in Q3, with 43% of these incidents relating to Infrastructure (including staffing, facilities, environment, security). The number of incidents split by managers interim harm assessment show the number of moderate and above incidents have remained the same (135 in Q2 and Q3), noting that is subject to change as the recent incidents are likely to be pending management review. The most common themes of incident are unchanged (Pressure ulcer present before admission, Slip, trip or fall, followed by Pressure ulcer developed or worsened during care)	At a divisional level a more detailed breakdown of their incidents through the monthly divisional QPS assurance reports. These reports highlight variation in the most common type of incidents, where they are occurring and the harm associated. This report will examine the most common categories of incidents to examine trends, themes and learning.

Inpatients Falls

I Chart

Total Numbers of Inpatient Falls December 2024 - 25



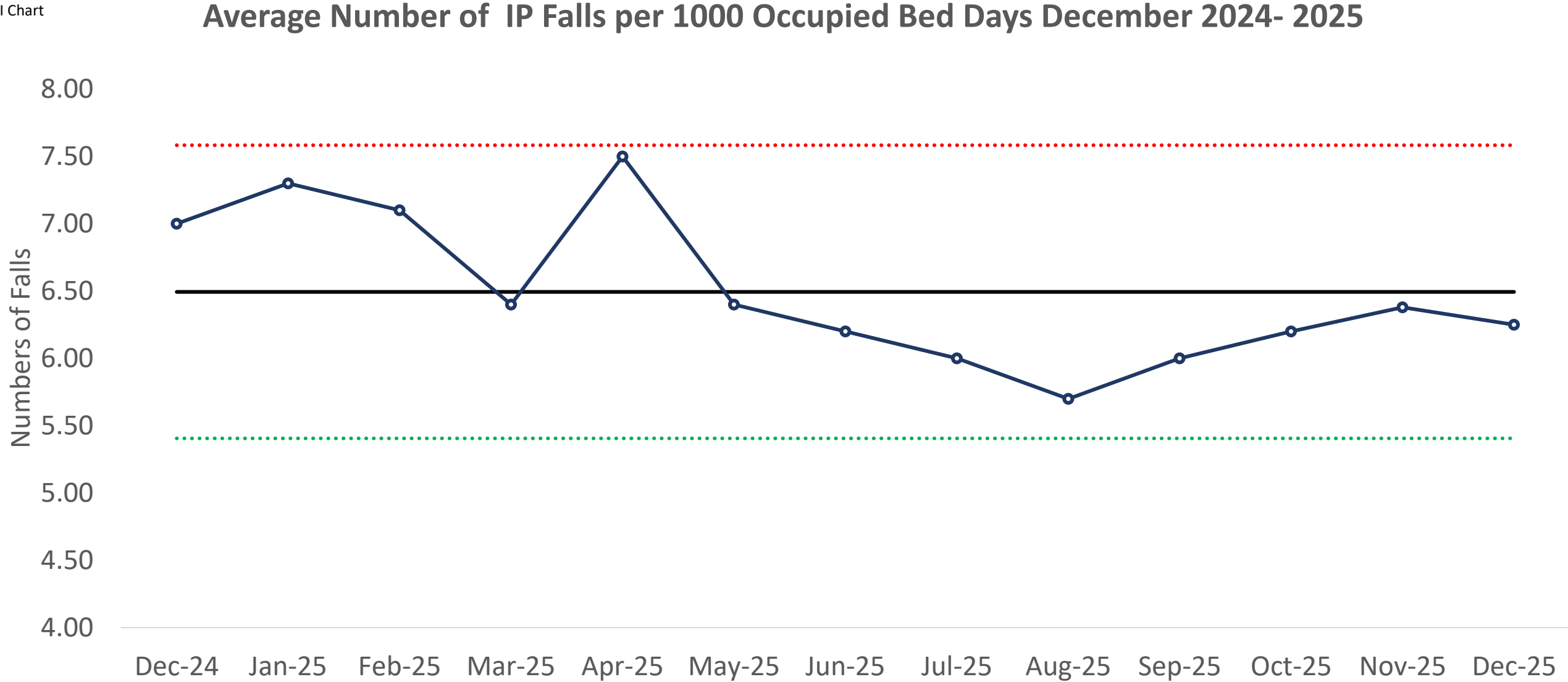
Quarter 3

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

Definition	Analysis	Implications
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	- For the given period of analysis, the mean average value of fall incidents is 282, which represents a marginal decrease from 284 reported in November 2024-25 data review. - Following the upwards trajectory from July to October 2025 quarter 3 has seen a decrease in falls reported incidents for both November and December 2025 (273 & 290 respectively). Both months represent values more closely aligned to the mean average.	The values for Q3 represent percentages below and above the mean average of 282 - October 11% - November 3.19% - December 2.84% An education package for new registered nurses has been trials with further development being undertaken at the direction of the ABUHB Falls & Bone Health Group.

Inpatients Falls

I Chart

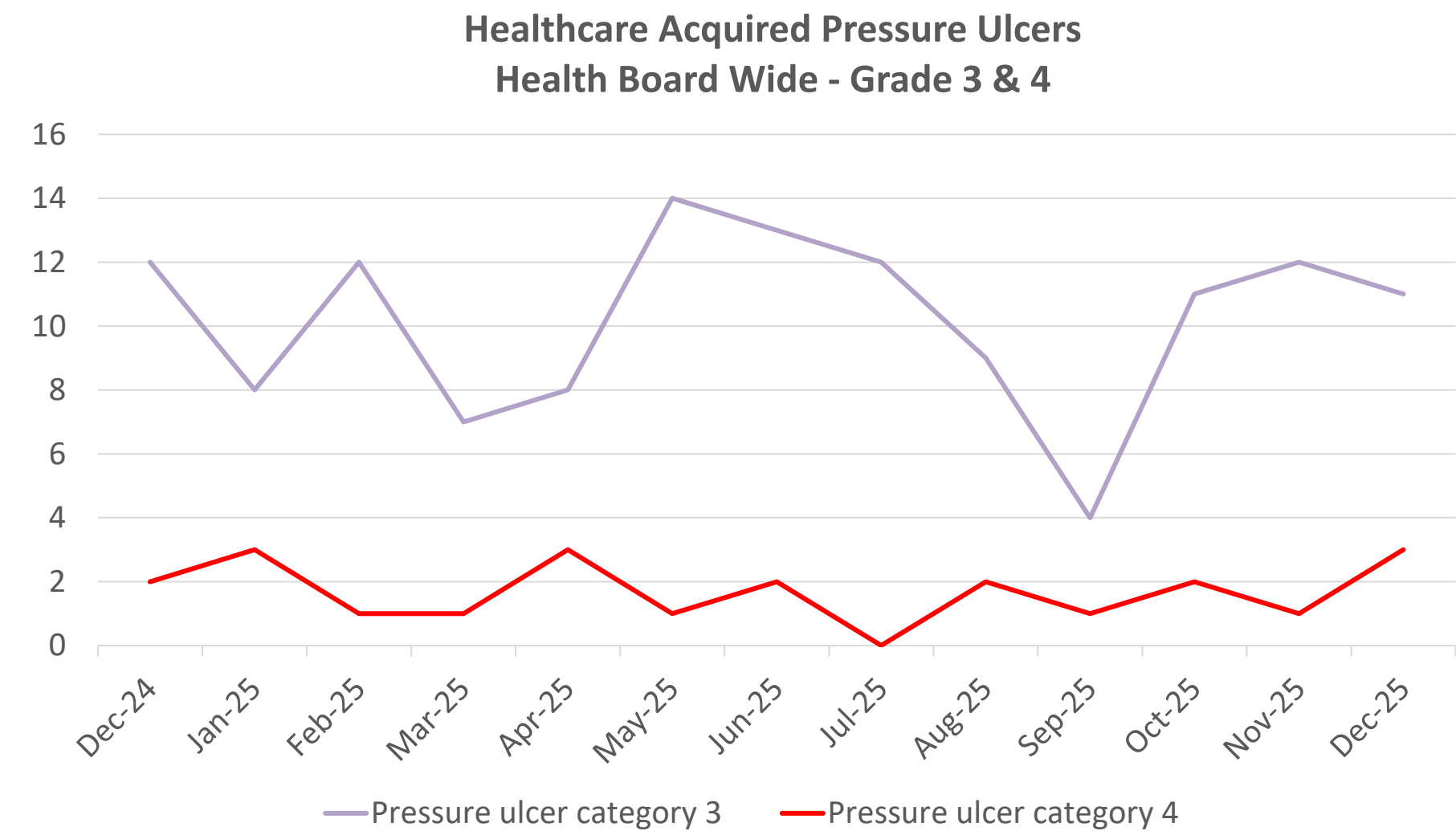
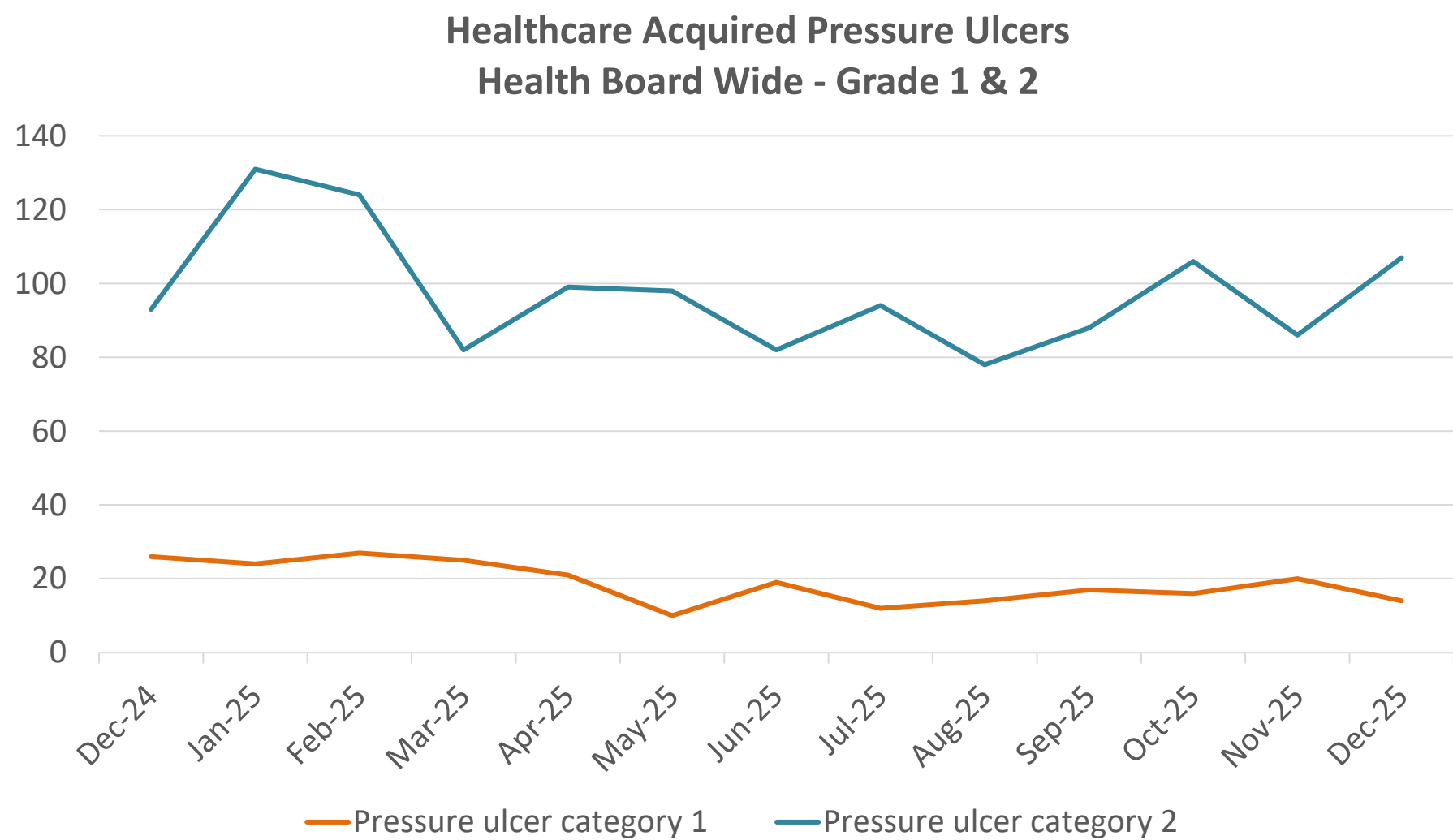


Quarter 3

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

Definition	Analysis	Implications
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	December 2025 has seen a marginal decrease in the mean average value from 6.57 as reported for November 2024-25 data review (1.22%) to 6.49. This still remains 1.3% below the national average (6.6). Following the upwards trajectory from August to November 2025, December has see a return to a downwards course with a value for OBD of 6.25, which is 5.4% below the national average.	Positive variation in relation to OBD’s has returned in December 2025.

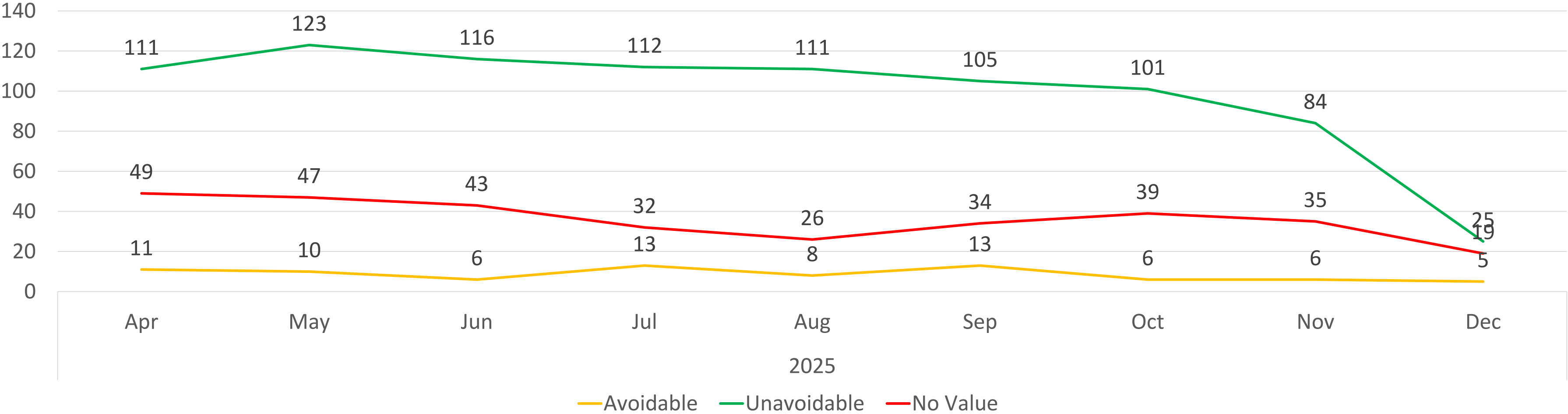
Healthcare Acquired Pressure Ulcers



Definition	Analysis	Implications
The data included above is extracted from Datix incident module. This captures incidents recorded for all divisions.	The majority of Pressure Ulcers recorded are category 2 (partial-thickness skin loss where the epidermis (outer layer of skin) or dermis (deeper layer of skin), or both, are damaged). No statistically significant trends in the category of ulcers can be seen within the past 3 months. The number of grade 1-4 Hospital Acquired Pressure Ulcers since April 2023 have fluctuated between 103 and 201 incidents per month, when viewing trends over this timescale the total number have slowly declined. The monthly average in 2023/24 was 150, in 2024/25 this reduced to 144, so far this financial year the average is 121 (noting there is a seasonal increase in Dec-Feb).	The strategic pressure ulcer group will continue to focus on reducing all avoidable pressure damage. Data is reviewed at each meeting and feedback on themes that have been discussed at divisional scrutiny panels. Focussed piece of work in progress to update flow charts to provide clear guidance for all staff.

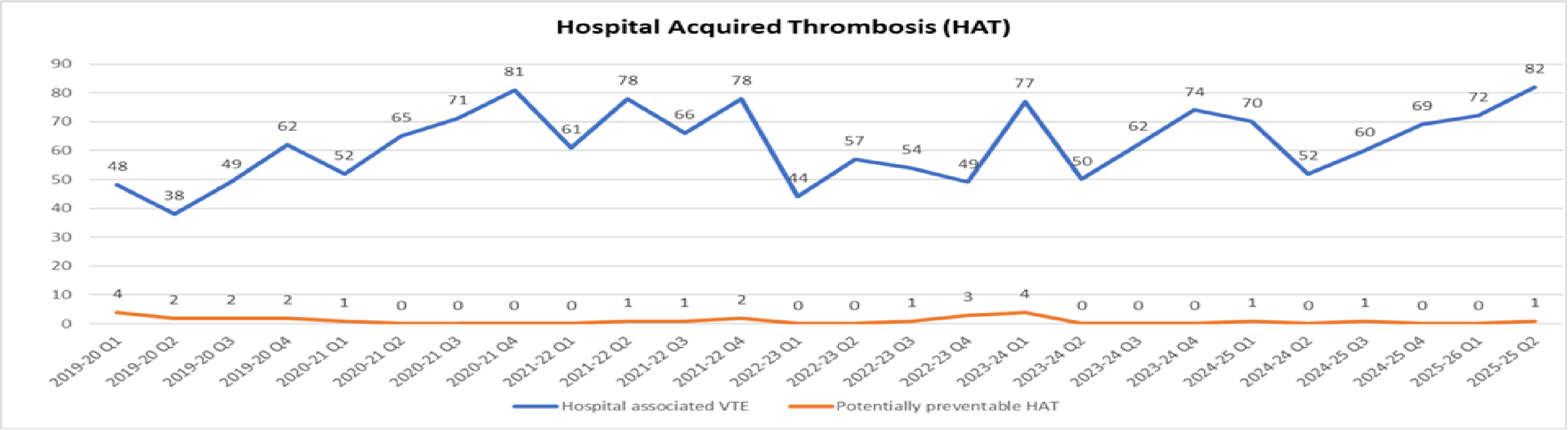
Healthcare Acquired Pressure Ulcers

Hospital Acquired Pressure Ulcers
Closed incidents only - Avoidable status



Definition	Analysis	Implications
The data included above is extracted from Datix incident module of incidents recorded for all divisions. The graph shows the closed Health Care Acquired Pressure Ulcers split by avoidable status.	The number of incidents appears to have declined in recent months, this is because the information displayed only shows the closed incidents, with most of the pressure ulcers reported last month being under review. The number of “No Value” within closed Pressure Ulcer incidents has dramatically reduced to less than 50 per month since April 2025, down from ~100 at the start of the year.	The reduction of closed no value cases provides assurance of the avoidable status of pressure damage. Focussed work being undertaken with divisions that have a significant number of “No Value” cases. The revised process of reviewing all grades of pressure damage will support this.

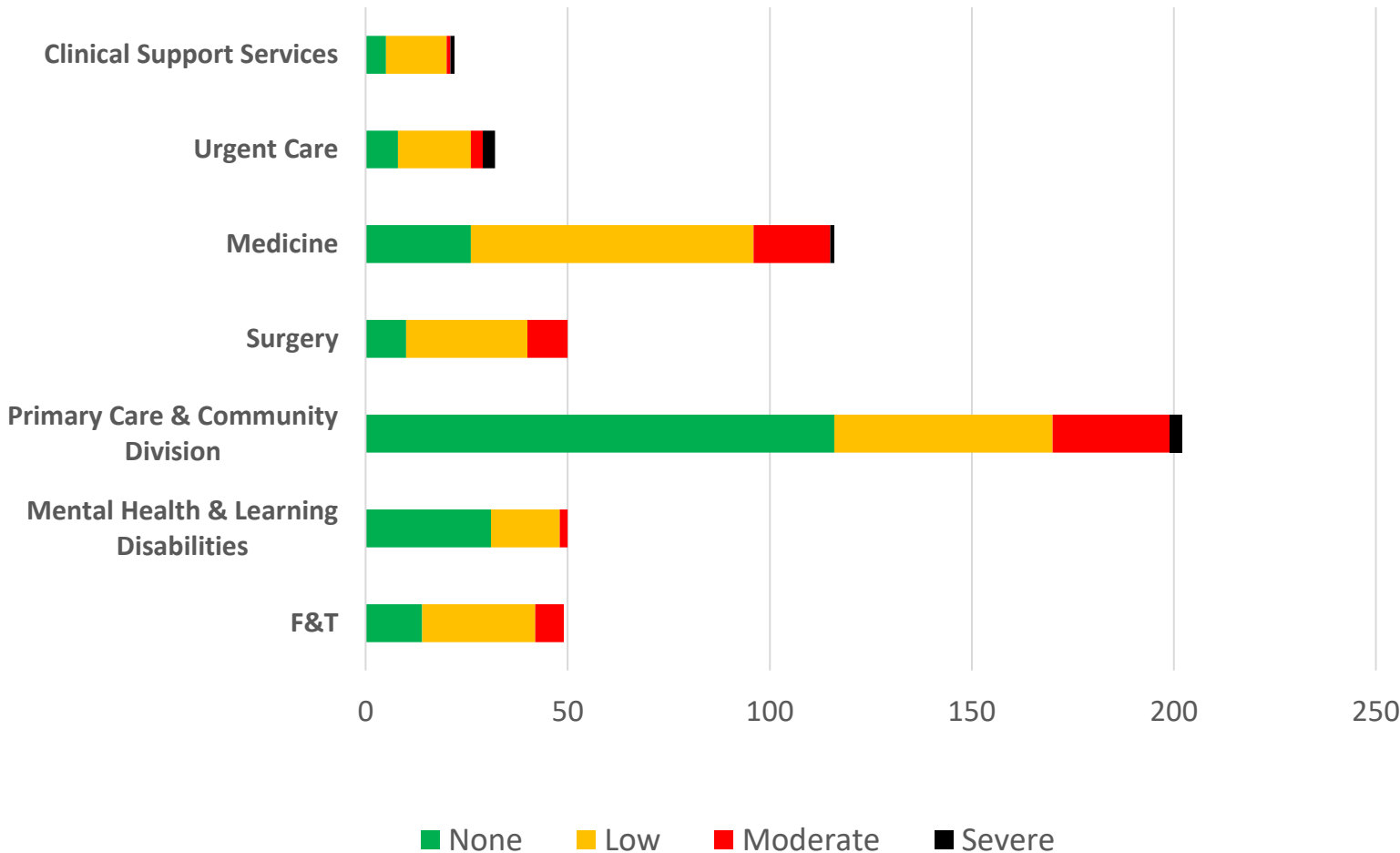
Hospital Acquired Thrombosis (HAT)



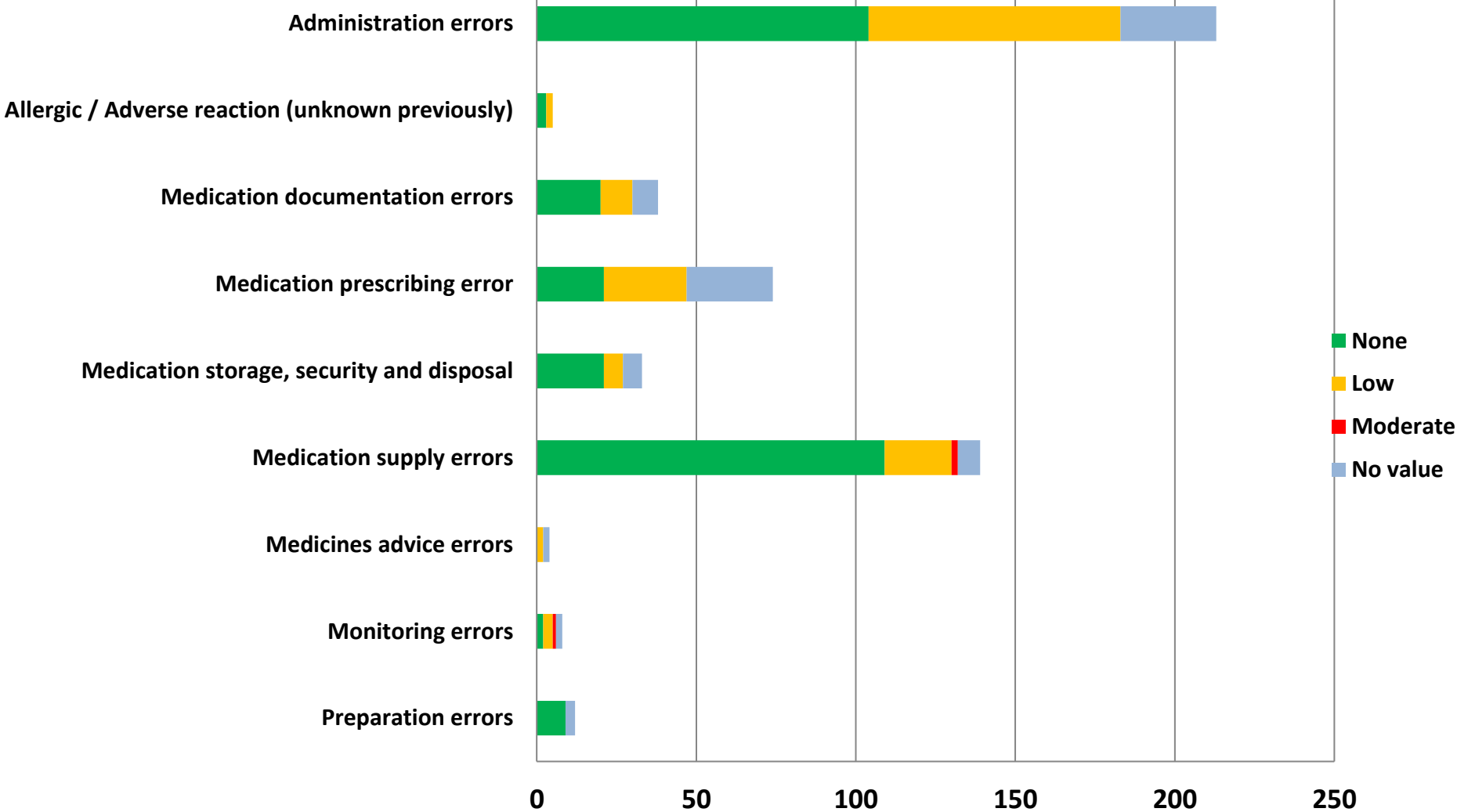
Definition	Analysis	Implications
The chart show the number of suspected hospital associated Venous Thromboembolism events (VTE) and the confirmed number of potentially preventable hospital-acquired thrombosis (HAT). A HAT is a VTE—such as deep vein thrombosis (DVT) or pulmonary embolism (PE)—that occurs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

Medicines Management

Medication Incidents Qtr 3 2025-26



Medication Incidents by Category and Severity Post Investigation - Q3 2025-26

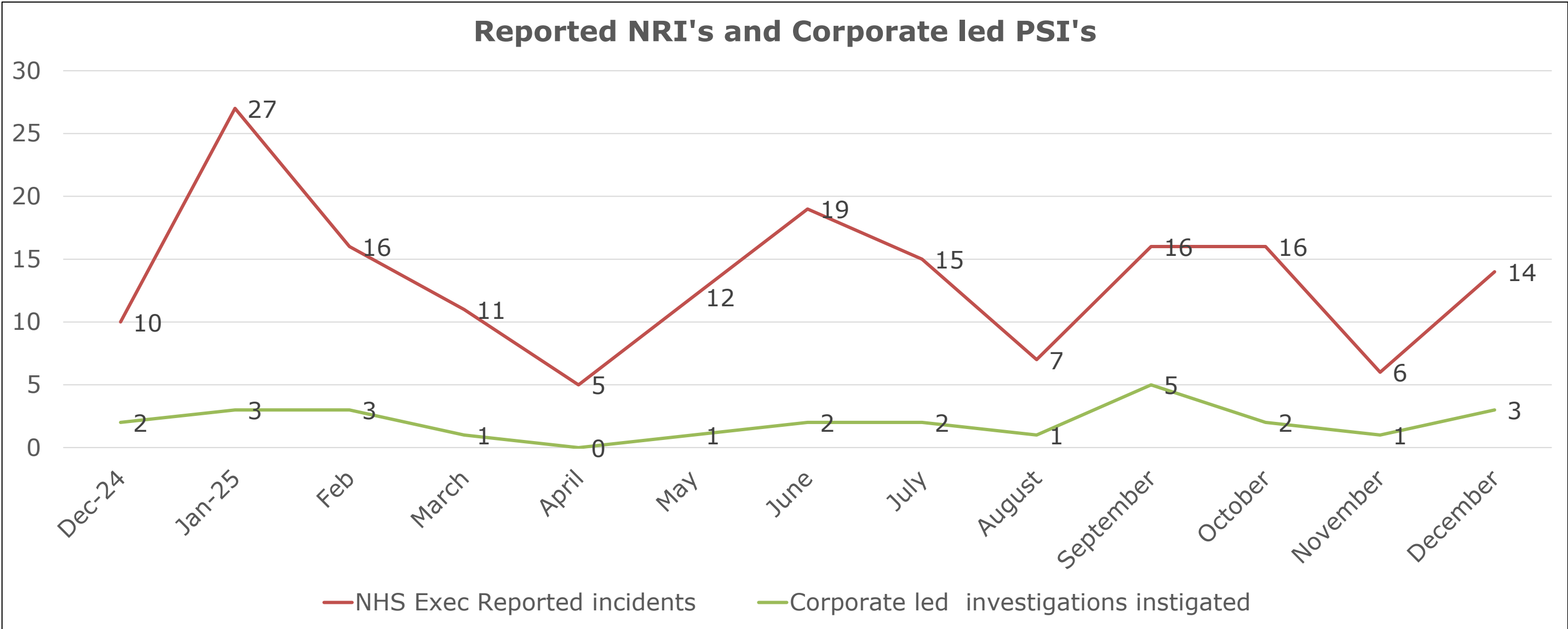


Definition	Analysis	Implications
The information presented has been extracted from RL Datix and is accurate at the point of recording. These are for incidents classified as ‘Medication, IV Fluid’ and affecting patients/service users.	The chart on the left shows the medication incidents reported by Divisions. In Q3, before investigation, reporters classified 8 incidents as severe harm, 72 as moderate harm, 235 as low harm, and 211 with no harm. These reflect the reporter's initial view of the level of harm. The chart on the right shows the post-investigation harm assessments for Q3. The overall number of medication incidents has remained relatively stable across the first three quarters: Q1: 591 incidents, Q2: 560 incidents and Q3: 526 incidents. The chart on the right also outlines the categories of incidents, highlighting the most frequently reported types so that the patterns of prevalence can be seen. Please note that only the most common categories of medication incidents are shown.	Within Divisions multiple improvement projects are ongoing to address local concerns specific to medications or locations, such as anti-coagulants and gentamicin. There is work underway mapping high risks medicines and the impact of EPMA to improve patient safety and learning.

Medicines Management Learning & Improvement

Item	Action	Who	When
High Risk Medication - Categorise and report incidents related to high-risk medications at MSG.	Standardised education needs to be developed for the HB for Nursing and Midwifery staff, will be included as part of the medicine's education process.	Requires Divisional support	Review April 2026
Medicines Governance Audits	Develop a comprehensive medicines audit. This is being developed and tested by revisiting PSN055 on medicines storage. Report compliance	KH/ SP	Tested Dec 2025 April 2026
Controlled Drug SOPs	Pilot CD SOPs Penalta and CC SOPs completed and theatres framework being rewritten.	In progress	Pilot
BESS – error management policy	New format for this process under review. Demonstrated the Policy needed a bigger MDT review to improve embedding it into practice.	KH - CW	December 2025
Nursing and Midwifery Education	Review the education provision for medicines management and safety. Being delivered across all Divisions. Report compliance.	KH/ AK	Complete
Medicines Safety Strategy 2026-28	Small working group to review and update previous strategy in line with current priorities	JT/KH/CW	February 2026

Nationally Reportable Incidents



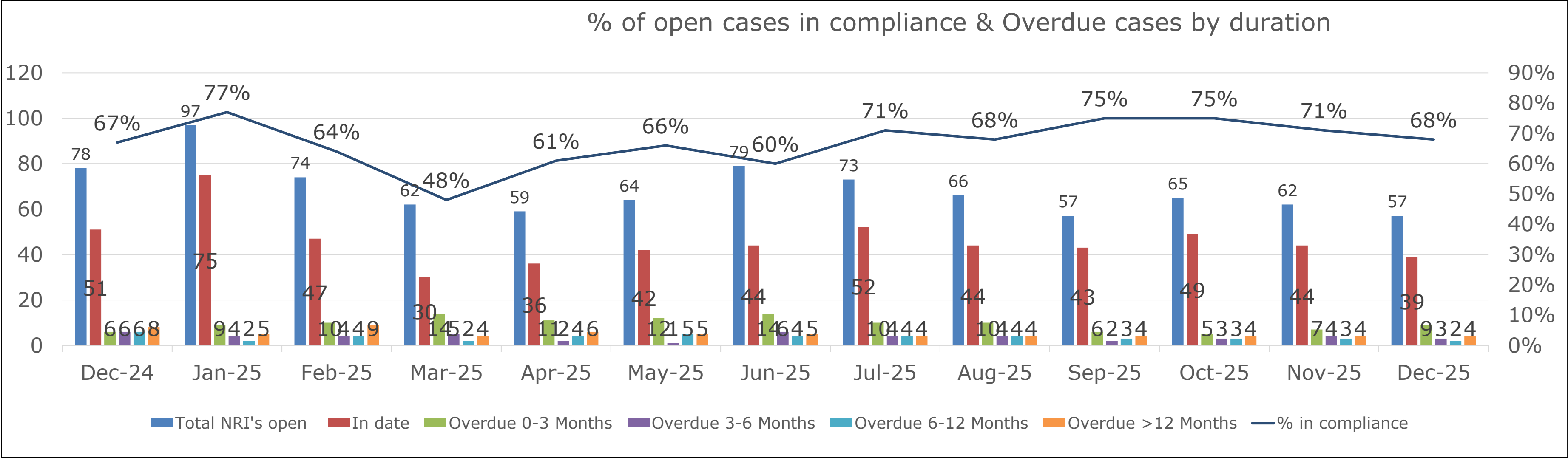
A total of **36** Patient Safety Incidents (PSIs) (moderate and above harm) met the criteria for reporting as NRI's in Quarter 3. This is in comparison to **45** in the same period in 2024.

There were no unusual trends identified across NRI's across this period.

Most common NRI categories

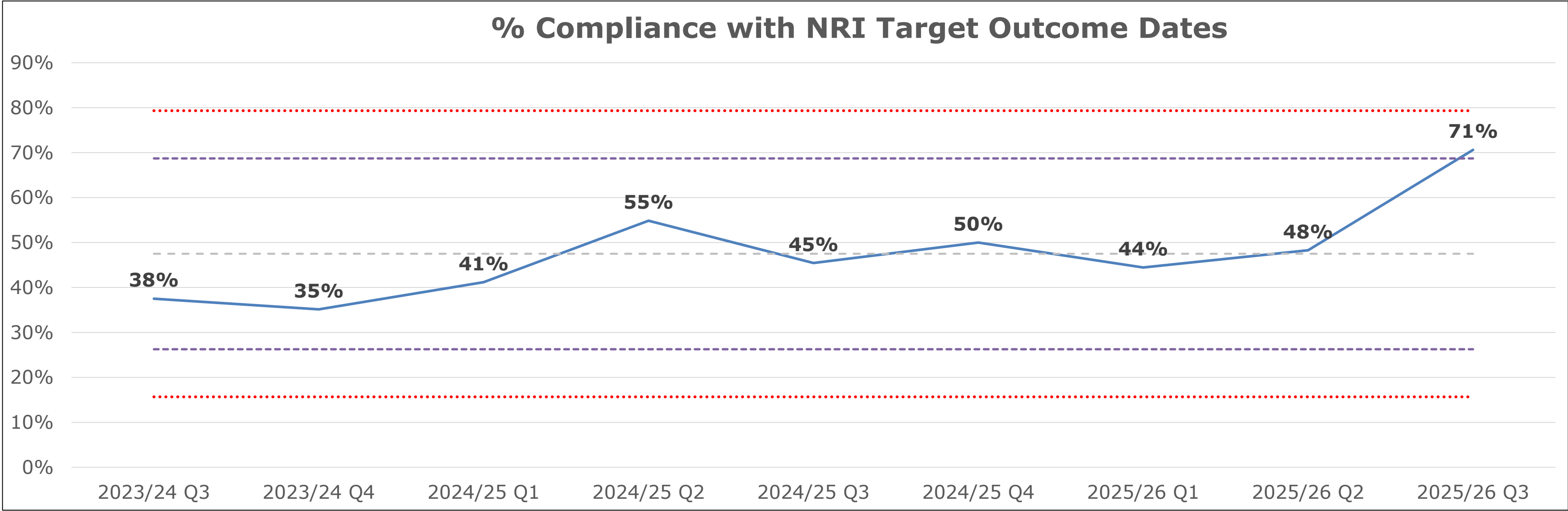
	HCAI Outbreak	IUD	HCAI Associated Death	Delayed Diagnosis	HCAI Covid	HCAI Covid Associated Death	Neonatal Death	Missed Diagnosis	Other	Deteriorating Patient
2025/26 Quarter 1	3	8	2	6	4	1	1	3		2
2025/26 Quarter 2	4	5	7	5	1	2	3	1	3	2
2025/26 Quarter 3	11	4	4	1	4	4	1	1	1	0

Nationally Reportable Incidents



Definition	Analysis	Implications
The graph above shows: The % of open cases that are within the compliance window. The number of open cases are split by in-date and overdue.	At the end of December there were 57 open NRIs, with 39 cases within the compliance window. The number of cases overdue by: 12 months is 4 6-12 months is 2 3-6 months is 3 0-3 months is 9 The number of open NRIs has decreased over the past year which in the context of stable NRI reported numbers shows an emphasis on timely closures. This is combined with a reduction in overdue cases from 26 in Dec 2024 to 18 in Dec 2025 (30% reduction).	The Corporate Patient Safety team continue to review the PSI investigation process and measures that may be put in place to streamline and optimise progression of incident investigation, and thus improve not only NRI compliance, but improve patient/family/staff experiences of the PSI process and outcomes.

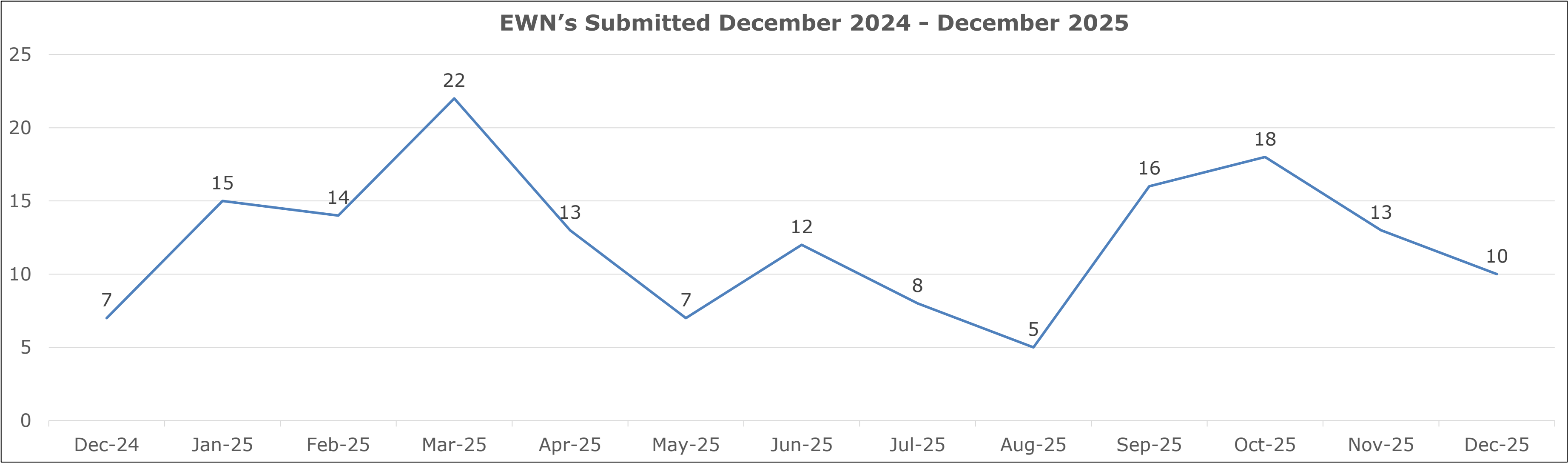
Nationally Reportable Incidents



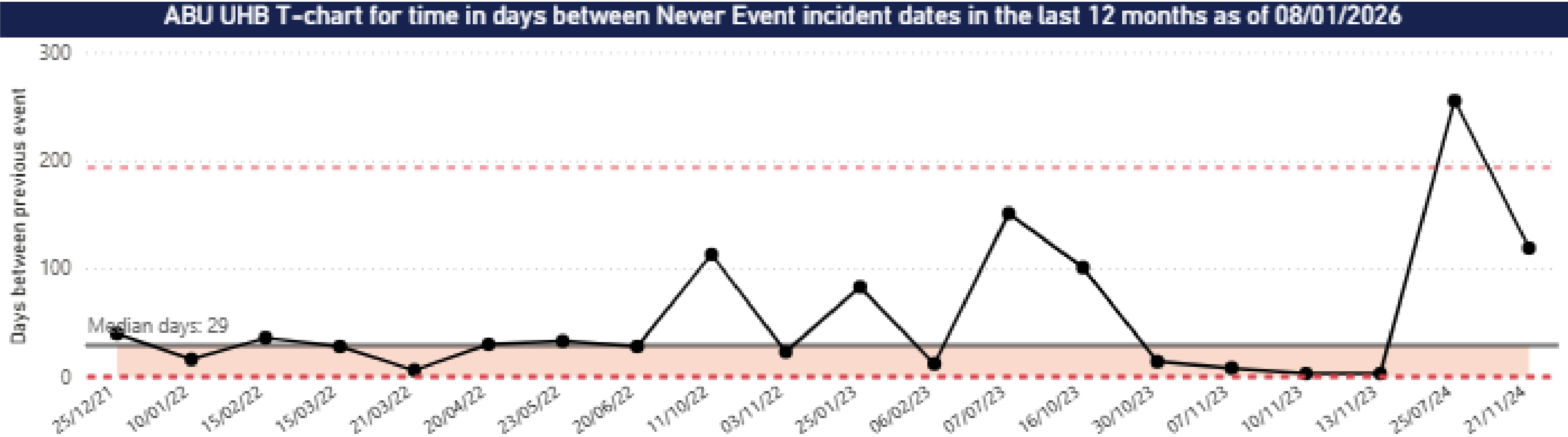
Definition	Analysis	Implications
Nationally Reportable Incidents are Submitted to NHS Wales Performance and Improvement who provide a target completion date. The percentage completion date displayed above is based on the target completion date period, rather than the period the NRI was recorded.	Sustained and significant improvement can be seen in NRI compliance across the period with Q3 2025/26 achieving 71% of cases due for completion being submitted within the target date. Enhanced monitoring of compliance began in Q2 2025/26 and has allowed to early intervention and escalation of cases that are risk of exceeding timescale. It should be noted that it is entirely appropriate that some complex cases exceed timescale and can be complicated by cases with other external agencies such as the police involved.	The Corporate Patient Safety team continue to review the PSI investigation process and measures that may be put in place to streamline and optimise progression of incident investigation, and thus improve not only NRI compliance, but improve patient/family/staff experiences of the PSI process and outcomes.

Early Warning Notifications

There were 41 Early Warning Notifications (EWNs) reported to Welsh Government (WG) in Q3, compared to 31 submitted for the same period in 2024/25. The themes for Q3 include: MH service users absconding; suicide attempts and deaths (including unexpected death) among MH service users; alleged criminal offences by staff or patients; PRUDICS; Professional practice concerns; increased infection control measures in response to rises in Covid cases; a microbiology processing error, and violent incidents by patients involving patients and staff. These do not represent unusual trends.

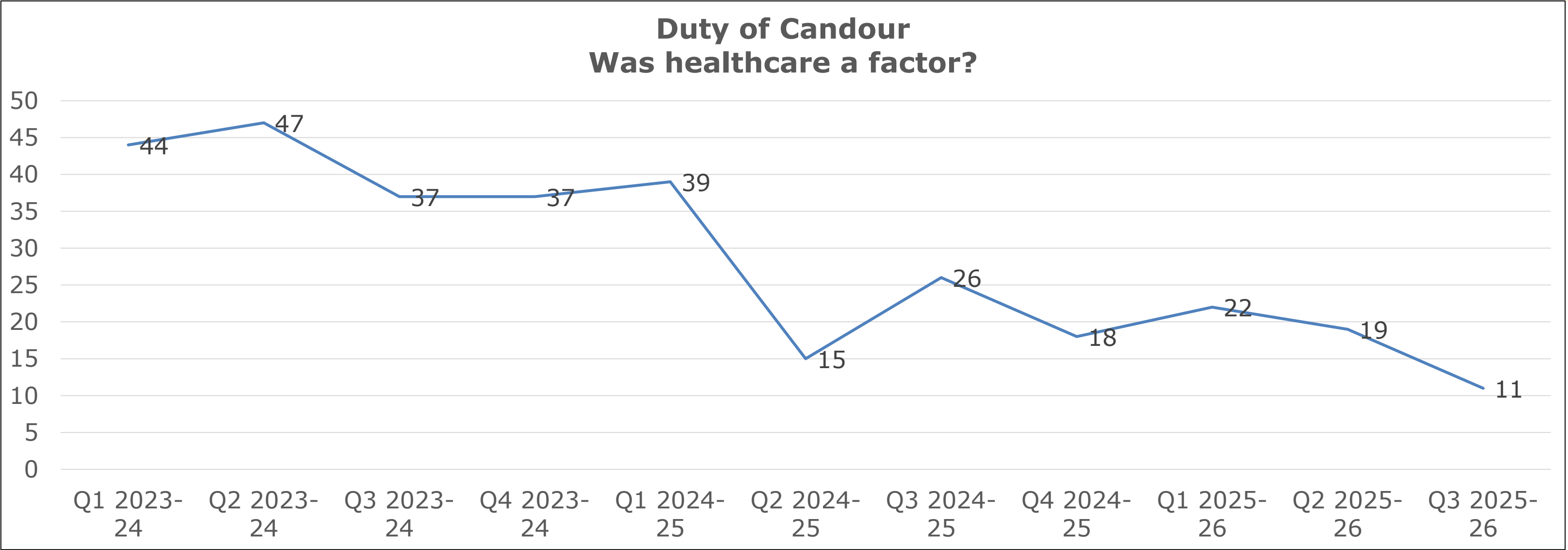


Never Events



Definition	Analysis	Implications
Information provided is extracted the Beacon Dashboard. The SPC-T chart shows the number of days between each Never Event. The higher the number the longer the duration between Never Events.	The graph above shows the frequency of Never Events within ABUHB and how that has changed since December 2021. The last Never Event was recorded in November 2024. The Welsh Government Ministerial Targets from 2026/27 will include the monitoring and reporting of Never Events.	A deep dive review of the progress already made with Never Events will be presented as part of the Quarter 4 Quality Outcomes Framework in preparation for this measure to be monitored as part of the Integrated Performance Report as a Ministerial Target.

Duty of Candour



Definition	Analysis	Implications
Information provided is extracted from RL Datix, based on the question ‘Was healthcare a factor’. The information is accurate at the point of extraction but is an ever changing picture as incidents are investigated.	When Duty of Candour was first introduced the Health Board was recording significantly more incidents as triggering. As training and awareness has improved this number has reduced and reflect a more accurate picture of actual healthcare associated Duty of Candour harm.	Awareness and training of the Duty of Candour Process maintains a Quality and Patient Safety priority with quarter 4 aiming to launch new digital asset and training to support frontline staff.

PSI Learning and Improvement

Issue	Action	Learning and Improvement	Who	When
Increased number of overdue NRI's across the Health Board in 2024-25.	There has been a relative stability in NRI cases within compliance of over 60% since March 2025, and a reduction of open NRI's by 27% compared to end of Q3 in 2024-25. Notably the actual compliance with closure dates has dramatically improved from a low of 37.5% in Q3 2023/24, 45.45% in Q4 2024/5 to 70.59% in Q4 2025/26.	Active engagement with Quality and Patient safety stakeholders, looking prospectively at closure due over the next 60 days. Proactively closing NRI's that don't require a full Corporate or Divisional investigation. Bi-weekly monitoring of cases for escalation has also been introduced.	Corporate PSI team	Ongoing

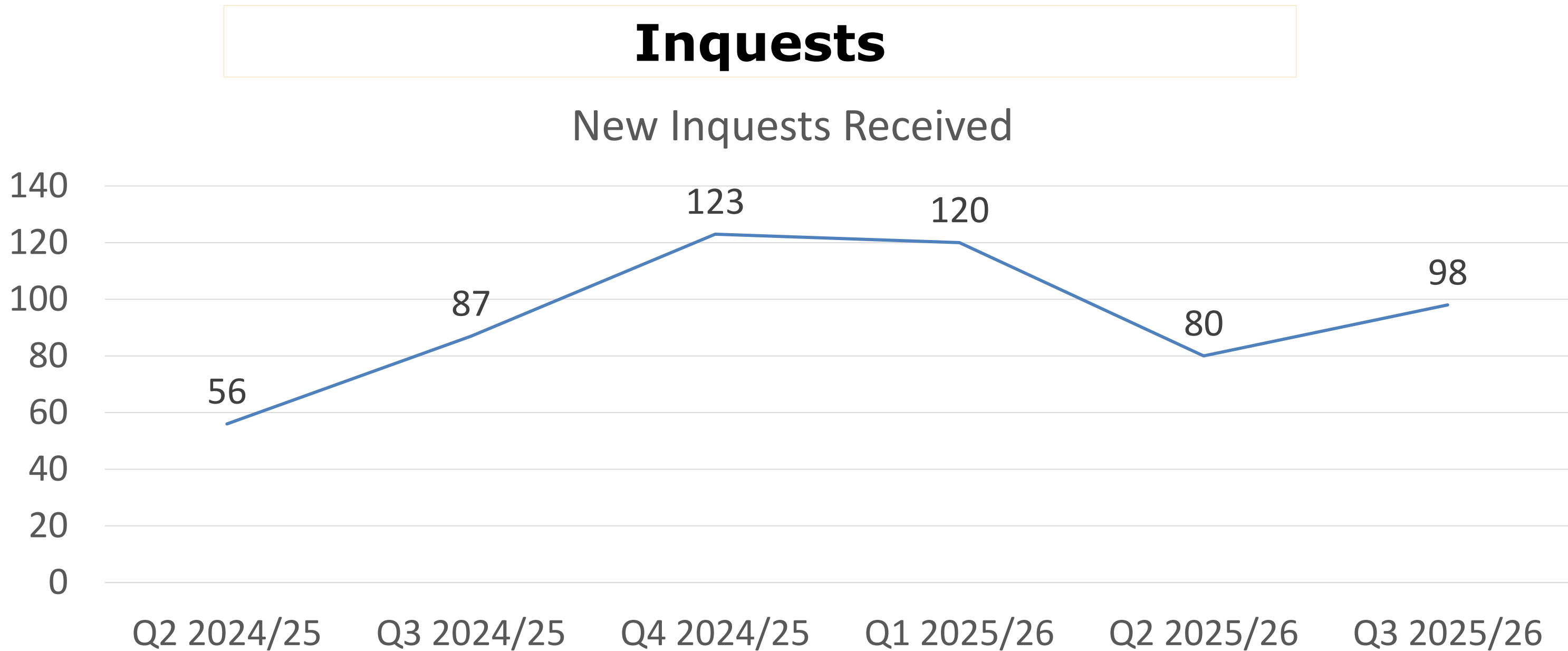
Legal Services – Regulation 28 & Person Injury Claims

Regulation 28s

- During Quarter 3, ABUHB received 1 Regulation 28 Coroner report.
- 1 Regulation 28 response was sent to the Coroner following an Inquest Heard in Quarter 2 - regarding nutrition assessment of dietetic patients between Health Board teams (ABU + Velindre)

Person Injury Claims

- 5 new claims were opened all employer liability claims. 11 claims were also closed during the period.
- Key themes are 1 trip, 1 burn from contact with hot liquids & 1 data breach
- Total live cases now 85 (as of 31 December 2025)



Definition	Analysis	Implications
The graph above shows the number of new inquests received by the Coroner each quarter.	The Health Board is receiving a significant and sustained increase in the number of new Coroner inquests being received. Since the 1 April 2025 as of 7 January 2026 the Health Board had received 306 new Inquests.	There is now 233 active Inquests open which requires significant involvement to appropriately provide evidence. 90 Inquests concluded during Q3 of which 68% were concluded in writing, this prevents Health Board employees attending hearings to give evidence. This is achieved by providing thorough factual statements and evidence. The Health Board received 98 new Inquest matters during Q3 2026. Quarter 3: • Inquests opened – 14% increase in referrals this year in Q3 compared to last year. • Inquests Heard – 36% increase in cases heard this year in Q3 compared to last year. • Inquests in Person – 70.5% increase in in person court hearings heard in Q3 compared to last year. Increases have arisen through combination of increase in Medical Examiner referrals to the Coroner, and continued investment growth and expansion to the Gwent Coroner service, with resulting sustained pressure on Health Board staff and resources.

Patient Safety Alerts (PSA) and Notices (PSN)

Alert	Compliance Deadline	Action to achieve compliance	Status
PSA020 Harm From Incorrect Recording of a Penicillin Allergy as a Penicillamine Allergy	30 th November 2026	Action plan in progress Progressing through the Health Board's Medicine Safety Group, highlighted to Antimicrobial Group and Electronic Prescribing Medicines Administration Group.	In-progress
PSA019 Harm From Delayed Administration of Rasburicase for Tumour Lysis Syndrome	09 th March 2026	Many actions (1–4) within this PSA are being actively advanced in collaboration with the Directorate of Haematology, ensuring clear accountability and oversight. Action 5 is being led by Pharmacy, with assurance mechanisms in place to monitor completion and compliance.	In-progress ON TARGET
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients	30th September 2023	In recent months, this has been the only outstanding PSN, and the Health Board has now confirmed compliance. SBARs have been updated to provide strengthened assurance by clearly outlining the progress made against this PSN and identifying any actions that remain outstanding. The alert is currently being re-scoped to support a comprehensive gap analysis, enabling us to understand how current ABUHB practice aligns with—and where it diverges from—the expectations set out within the PSN.	Completed

PILLAR 3

Clinical Effectiveness

Deteriorating Patient

Clinical Standards

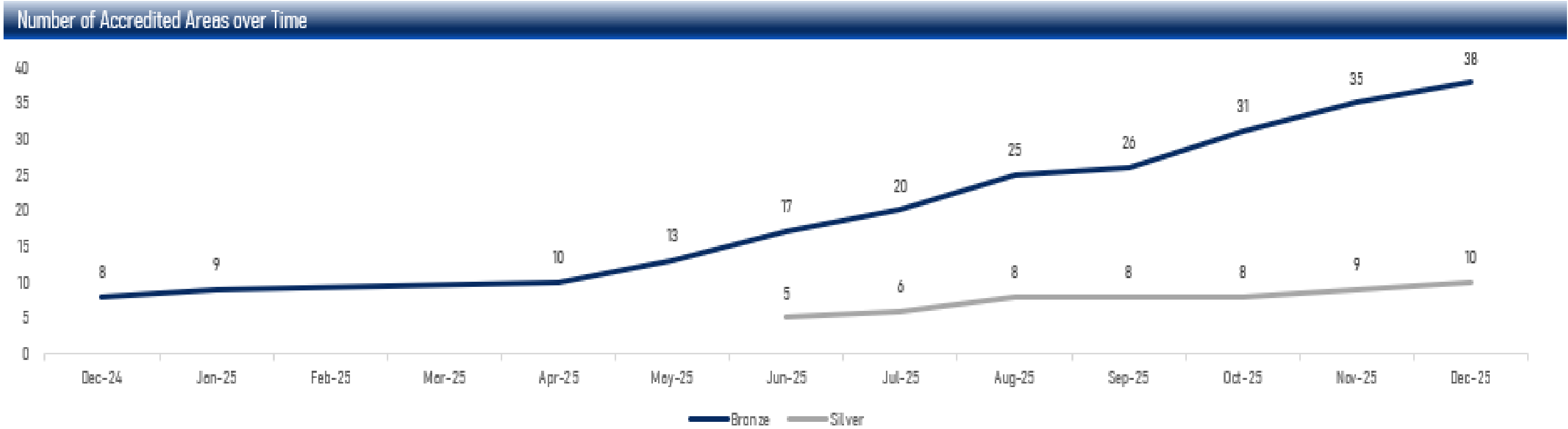
Sepsis

Resuscitation

Clinical Policies

Clinical Audit

Ward Accreditation



Quality Improvement Projects through ward accreditation

12 more areas have achieved bronze accreditation and 2 more areas have reached silver in Quarter 3 2025/26.
More specialist areas are being accredited (theatres / clinics).
Winter pressures are slowing the wards' ability to progress their accreditation.
Roll out to district nursing / complex care and public health nursing in progress

Issue	Action	Learning and Improvement
Resources to undertake independent reviews have been impacted by winter pressures. Some reviews may be delayed slightly depending on availability of senior staff.	Shadowing senior nurses so they can use a peer review in clinic areas for bronze accreditation. Widen scope of staff undertaking reviews : invites sent to QPS / IPAC / Safeguarding	Evaluation of independent review process to streamline accreditation process and prevent delays given notable pressure on clinical teams during the winter period.

Sepsis

National Drivers for Deteriorating Patient Recognition

- The Welsh Health Circular (WHC) 2024/035 mandates the standardised use of Early Warning Scores (EWS) to support the timely identification and management of acutely deteriorating patients. The national initiative is designed to strengthen patient safety, improve clinical outcomes and ensure a consistent approach to recognising deterioration across NHS Wales. Health Boards were required to fully implement the recommendations by 30th September 2025. The work continues to be coordinated nationally through the Safer Care Partnership, led by NHS Performance and Improvement. A key component of the programme includes the rollout of Martha's Rule (Call 4 Concern), ensuring that patients and families have a clear route to escalate concerns about deterioration.

Local Implementation

- To date, NEWTT2, PEWS and NEWS2 have been launched within the Health Board.
- PEWS was initially implemented across inpatient paediatrics and the Fox assessment pod. Its use in Fox was temporarily paused due to concerns about running two different observation charts within the same clinical area. The service is currently awaiting the outcome of ongoing operational discussions regarding its implementation in the shared CEAU space.
- Maternity: MEWS- implementation has been delayed due to restrictions with the digital template. The required template is expected to be available by late march 2026.

Training and Support

- Staff education remains a key priority, with ESR modules funded by the NHSP&I and tailored training packages developed inhouse to complement national training resources. The materials are designed to ensure all staff are confident and competent in applying the new EWS tools in practice. To support the delivery of education:
 - 68 "Train the Trainer" sessions have been delivered for ward managers, deputy ward managers and practice educators, enabling them to cascade training across their areas.
 - 2047 staff have completed the "NEWS2 questionnaire", following training (a separate register for community staff is awaited).
 - 4099 staff have completed ESR training for NEWS2 across acute, Community and Mental Health and Learning Disability settings.
- In addition, NEWS2 education and sepsis awareness sessions continues, with sessions recently delivered across multiple forums, including resident doctor training, the Senior Clinical forum and the Primary Care and Community Nursing JOE preceptorship programme.

Sepsis

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

Aneurin Bevan University Health Board has received a newly published Welsh Health Circular (WHC), which has been prioritised for implementation through the Health Board's Deteriorating Patient Group. The WHC released in December 2025 advises the following:

- Health Boards are required to adopt standardised safety-netting leaflets for adults and children discharged with suspected or confirmed infection.
- The leaflets are designed to support patient understanding, safe self-management at home, and help early recognition of deterioration, encouraging individuals to “think Sepsis”.
- Each leaflet includes QR codes directing patients to NHS 111, the Health Board's public facing Sepsis information page, and for paediatrics, the Healthier Together resource and “Spotting the Unwell Child”.
- Health Boards must create and publish locally branded versions and embed leaflets within all relevant discharge pathways.
- Although no formal deadline has been specified, the mandate advises immediate action and, as such will be prioritised.

Health Board Position:

- Leaflets have been co-designed in partnership with Public Engagement and ABUHB.
- The Health Board's Deteriorating Patient Group are to review, scope and are prepare for implementation of the adult version of the safety-netting leaflet, by working with Divisions to ensure accuracy and consistency of safety netting information.
- Paediatric CEAU/CEAU-based leaflets are already in use within B1, C1, and the Fox Assessment Pod.
- For both adult and paediatric patients being discharge from the Emergency Unit and CEAU further amendments are required to strengthen the safety-netting information before implementation.

Sepsis

- The appointment of a Quality and Patient Safety Assurance Lead under the Medical Director in September 2024, has enabled this programme of work to be delivered and strengthened the Health Board's focus on sepsis, supporting divisional scoping and enhancing engagement with primary and community care.
- The Health Board continues to progress its strategic commitment to improving the recognition, response, and management of sepsis, in line with national mandates and internal quality priorities. Sepsis remains a defined workstream within Year Two of the Quality Strategy, with oversight embedded in the Deteriorating Patient and Acute Deterioration workstreams.
- The Health Board acknowledges the publication of the three updated NICE sepsis guidelines (Adults aged 16+, Under 16s, and Pregnant or Recently Pregnant people). The Deteriorating Patient Group will begin work to ensure these updated are clearly communicated across services, with plans being developed to introduce, embed and achieve full compliance with the new recommendations.
- Promotion and implementation of the UK Sepsis Trust screening tool—introduced in September alongside NEWS2—remains a priority. Audit and monitoring processes will begin to assess its application, effectiveness, and impact on early recognition and clinical escalation.
- Following the updated NICE guidance, the UK Sepsis Trust has revised its Adult Sepsis Tool. This update will be reviewed at the next Deteriorating Patient Working group, where considerations for adoption and implementation across relevant clinical areas will be discussed, ensuring alignment with national best practice.

Engagement and Cultural Change

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

National Collaboration and Assurance

- ABUHB continues to play an active role in national sepsis forums and in the development of an All Wales standardised education and communications strategy across Wales. This includes contribution to the review of eLearning materials and supporting the adoption of the UK Sepsis Trust screening tool across all Health Boards.
- Early 2026 will see the establishment of a "Sepsis Education Task and Finish Group", which will explore and review existing sepsis education materials and work towards a standardised, Health Board-wide approach. The aim is to ensure that all staff receive up-to-date, consistently agreed, high-quality sepsis training across all specialties.

Sepsis

Action	What is needed?	How will this be achieved?	Who	When
Implementation of the WHC (2024/035), national Early Warning Scores & UK Sepsis Trust Screening tool	ABUHB continues to work towards implementing the Welsh Health Circular (WHC) 2024/035 early warning scores, aimed at supporting the national goal of standardising acute deterioration. Alongside the EWS, ABUHB will be launching the UK Sepsis Screening across adult acute divisions, with the aim of conducting PDSA cycles in targeted areas, measuring and auditing the impact. Other health boards in Wales are also looking towards implementation of UK Sepsis Trust Screening tool with an aim of standardising sepsis management throughout NHS Wales.	Implementation focus groups are working towards implementing x4 EWS across ABUHB clinical areas. This includes: - NEWS2 – 9th September 2025 & 29th September 2025 - PEWS – 22nd September 2025 - NEWTT2 – 28th July 2025 - MEWS – TBC – expected end of March 2026 The focus groups and exploring opportunities, resources and actioning barriers to ensure safe and effective implementation the tools. Each group is reviewing key information around Implementation, policy and education. Once delivered, the Deteriorating patient/sepsis group will continue to measure the effectiveness and impact of the EWS tools.	Assistant Quality & Patient Safety Assurance Lead	Completed Sept 2025 MEWS expected March 2026
Standardise Sepsis education	To deliver high-standard sepsis care and comply with NICE guidelines, it's crucial to provide consistent education to all Health Board members. Reviewing and implementing standardised sepsis education will enhance monitoring and impact assessment, enabling opportunities for improvement.	Following the implementation of the WHC and EWS, a standardised education resource will be developed utilising the Sepsis Working group forum and in collaboration with key services, such as critical care, outreach and resuscitation services. The education package with require input from clinical experts within ABUHB, as well as oversight from the Deteriorating patient/ sepsis group and the Wales sepsis group.	Assistant Quality & Patient Safety Assurance Lead	Scoping completed Dec 2025 Education package – April 2026
Building on Standardised Sepsis Education	Ensuring the same message around expectation, management and process surrounding sepsis management is crucial.	An Education Task and Finish group will be established in Q4 to develop a robust training strategy for the workforce ahead of implementing Early Warning Scores and NICE Guidance. Representation at the national group will allow for reviewing and contributing to eLearning education materials. Through working closely with divisions and practice educators, utilising the standardised education package and initiatives from national groups, review and development of training programmes will be undertaken. This will include reviewing, amending and developing the sepsis content for programmes such as the JOE preceptorship, ALERT, BLS, PROMPT. Utilising the Deteriorating patient/ Sepsis group, oversight, feedback and progress will be maintained.	Assistant Quality & Patient Safety Assurance Lead	Delayed due to system pressures – extended to April 2026

Pillar 3: Clinical Effectiveness				
Sepsis				
Action	What is needed?	How will this be achieved?	Who	When
Public Awareness Campaign for Sepsis	Phase 1 has been launched internally, during January 2025 phase 2 launch to the public April 2025. We continue to review the effectiveness of the campaign and assets, whilst ensuring accessibility for patients is maintained. Additionally, we aim to influence nationally to ensure other health boards and services support and continue to share the message around signs, symptoms of sepsis and when the seek urgent medical attention is shared across NHS Wales.	The Health Board maintains communication with the UK Sepsis Trust and uses evidence-based resources. The Comms team and QPS are collaborating on building and updating sepsis assets and sharing where possible. This includes presenting to and supporting the Wales Sepsis group with shared information, assets and encouraging others to continue raising awareness and standardise assets, such as “spotting the unwell child leaflet”. internal sepsis pulse page has been created as well as a public facing sepsis page. This, alongside the social media campaign allows a mechanism to provide update to date information and a platform for information for the public.	QPS and Comms	Completed
Working in Collaboration	Maintaining a collaborative approach in sepsis management is crucial for upholding best practices and mitigating risks. The Sepsis Working Group provides a forum for the multidisciplinary team (MDT) to discuss ongoing issues, identify areas for improvement, and share Health Board and national updates.	Maintaining the Sepsis Working Group will ensure a multidisciplinary approach to discussing and implementing solutions. The Assistant Quality and Patient Safety Assurance Lead will collaborate closely with Directorates, linking services, sharing best practices, and supporting quality improvement initiatives. Working directly with each area/specialty will provide a deeper understanding of the needs for improving sepsis recognition, diagnosis, and treatment. The “Big Conversation” was hosted on the 18th September 2025, allowing a forum for public feedback and allow the QPS team to focus on direct areas of concerns, as highlighted and shared within the event. A mechanism to feedback information around actions generated will be developed.	Division s and QPS	Completed
Continue working with UK Sepsis Trust, national forums and other health boards/trust	Founded in 2012, the UK Sepsis Trust is a valuable resource for NHS England and NHS Wales. It facilitates collaborative practices among Health Boards and Trusts across both countries. The charity offers a range of evidence-based resources, including Sepsis UK screening tools, educational materials, and signs and symptoms awareness posters/leaflets.	Representatives from the UK Sepsis Trust have previously supported the Health Board with the initial NEWS implementation and remain valuable contacts. Maintaining regular communication between ABUHB and UK Sepsis Trust allows for the continued sharing of evidence-based resources to enhance clinical practice. ABUHB continues to represent nationally within Acute Deterioration groups, All Wales Sepsis group, NHS executive forums and recently as part of the “Safe Care Partnership- Deteriorating patient” group. This include exploring escalation processes and a new way to capture response to deterioration.	Division s and QPS	Forward work plan for 2026 to continue
Develop Audit Strategy for Sepsis and ensure learning from incidents	It's essential to establish a consistent method for capturing sepsis data across the Health Board. Currently, varied monitoring approaches hinder the collection of reliable data needed for improvement. Standardising data capture methods will enhance the ability to support clinical practice and drive better outcomes.	Collaboration: Work closely with national groups, divisions and the deteriorating patient working group, to identify universal data requirements and agree on standardised methods for capturing patients with Sepsis. Efficiency: Use AMaT to develop a proforma, ensuring the audit process is efficient and the workforce can input data effectively. Learning System: Develop a system to learn from incidents where Sepsis was missed, including thematic reviews of Datix incidents.	Sepsis Working Group	Being progressed Nationally via SCP September 2026

Sepsis Annual Workplan 2025/26

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

PILLAR 4

Health, Safety, Security and Compliance

Competent People

Compliance
Assurance

Risk
Management

Learning from
Events

Asset
Management

Communication

Emergency
Preparedness

Leadership,
Accountability
and Culture

Measuring
Performance

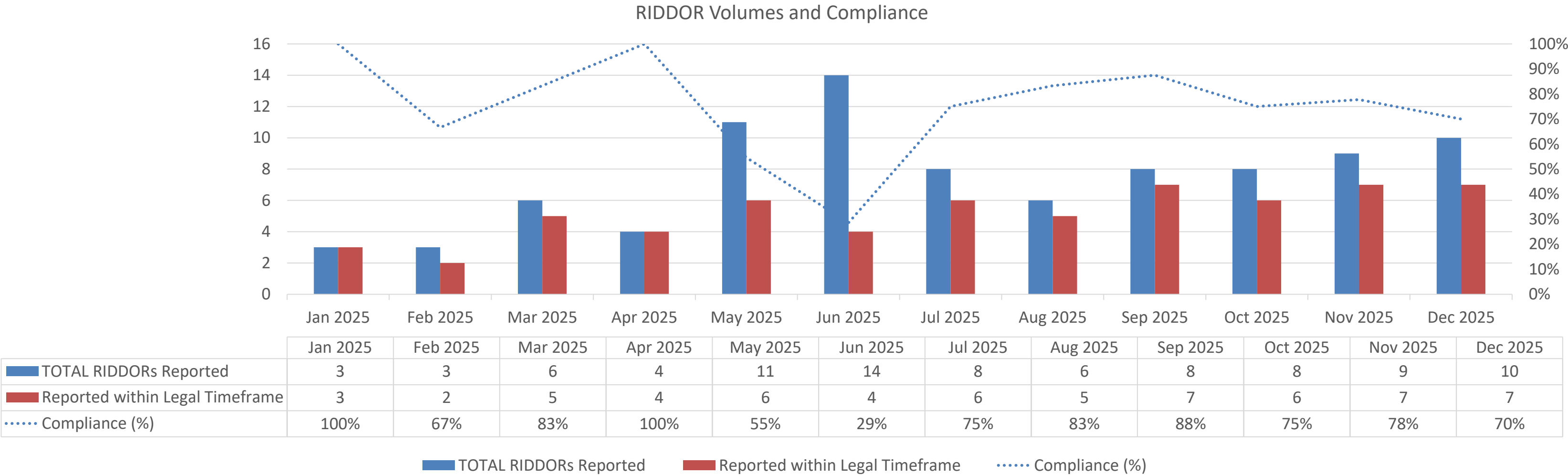
Security
Management

HSS
Dashboards

Fire Safety
Management

Manual
Handling

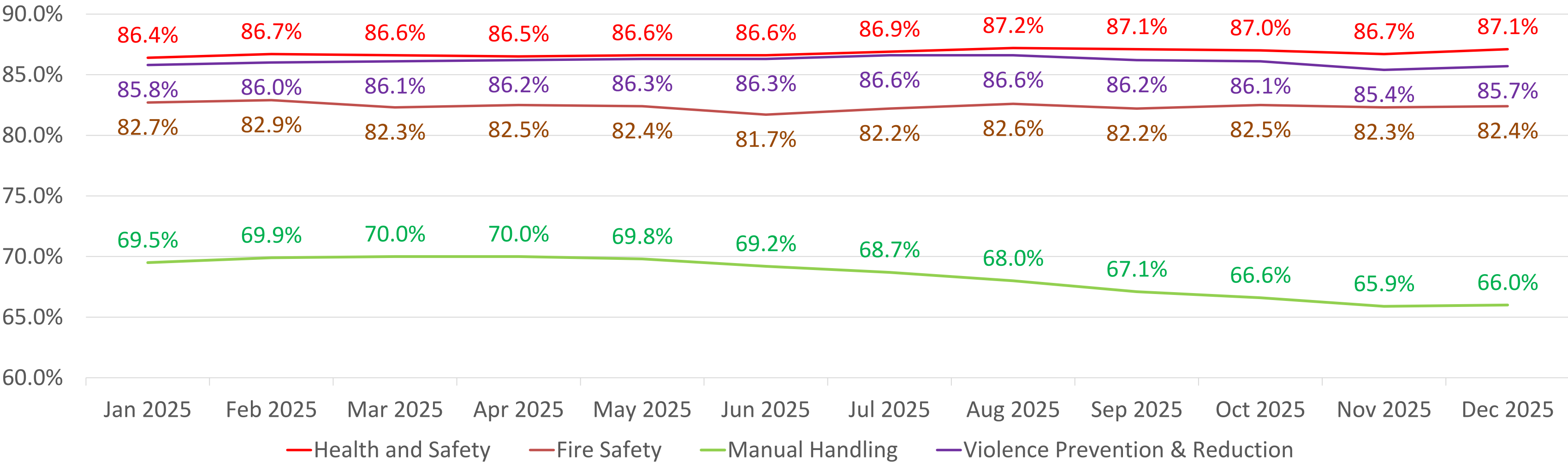
RIDDOR Compliance



RIDDOR Reporting Compliance	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
Total RIDDORS Reported	23	12	29	22	27
Number Reported within Legal Timeframe	11	10	14	18	20
Reporting Compliance	47.8%	83.3%	48.3%	81.8%	74.1%

Statutory and Mandatory Training Compliance

Health & Safety and Mandatory Training



Health and Safety Training Compliance	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
Health and Safety	86.0%	86.6%	86.6%	87.1%	87.1%
Fire Safety	82.7%	82.3%	81.7%	82.2%	82.4%
Manual Handling	69.4%	70.0%	69.2%	67.1%	66.0%
Violence, Prevention & Reduction	85.5%	86.01%	86.3%	86.2%	85.7%

Incident Reporting

Staff Health and Safety Incident Reporting	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26
Physical Assault	189	227	266	203	262
Contact with needles or medical sharps	62	54	56	67	65
Slip, trip or fall	41	30	28	35	26
Verbal assault	22	44	45	25	45
Manual Handling	27	13	18	19	19
Sexual assault and/or sexual inappropriate behaviour	17	13	19	11	19

Issue	Action	Learning and Improvement
Increased number of contact with needles or medical sharps reported in Quarter 2 & 3 (2025/26)	Thematic review to be conducted to identify themes and patterns Health and safety management audits to be carried out for all Inpatient areas in Q4 2025/26	Identification of areas of non-compliance, resulting in delivery of education programmes to target areas
Achieving a high compliance rate of reporting incidents in accordance with RIDDOR with the legal timeframes	Implement RIDDOR Awareness eLearning Training and mandate the course for all managers via the Core Learning Committee	Sharing details of late reports with the Service areas and Senior Managers
Manual handling training compliance is significantly below the 85% target	Targeted approach for staff attending training courses	Competent workforce to deliver manual handling techniques
Fire safety training compliance is below the 85% target	Implement fire safety training framework which is risk based	Competent workforce to manage fire safety risk

PILLAR 5

Infection Prevention & Control

Leadership,
Accountability
and Culture

Education

Antimicrobial
Stewardship

IPAC Training

Themes and
Trends

IPAC Dashboards

Audit

Patients/Staff
Stories

Collaborative Working –
Faculty's

Actions and
Learning

National Policies

Investigation /
Themes for Learning

Environmental
Cleanliness

Healthcare Associated Infections

All Wales – Current FY count of specimens

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	193	5	107	284	90	27
Betsi Cadwaladr UHB	249	6	134	372	100	29
Cardiff and Vale UHB	148	14	97	212	92	24
Cwm Taf Morgannwg UHB	124	5	84	292	105	9
Hywel Dda UHB	129	12	84	285	98	17
Powys THB	21	0	1	1	0	0
Swansea Bay UHB	169	7	90	214	91	19
Velindre NHST	3	0	4	12	0	2
Wales	1036	49	601	1672	576	127

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

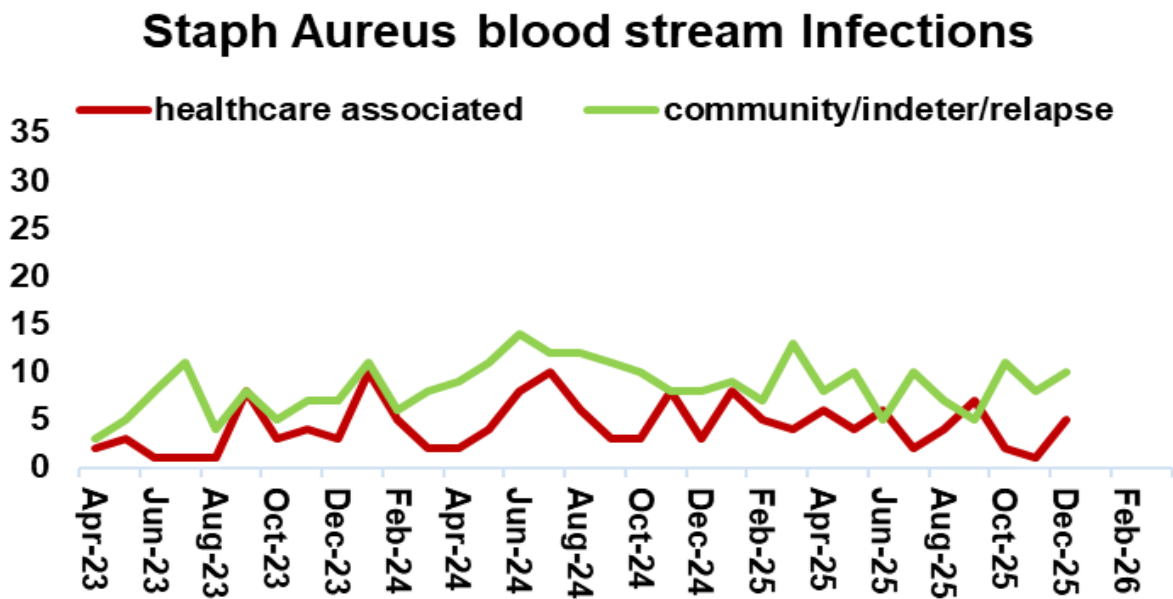
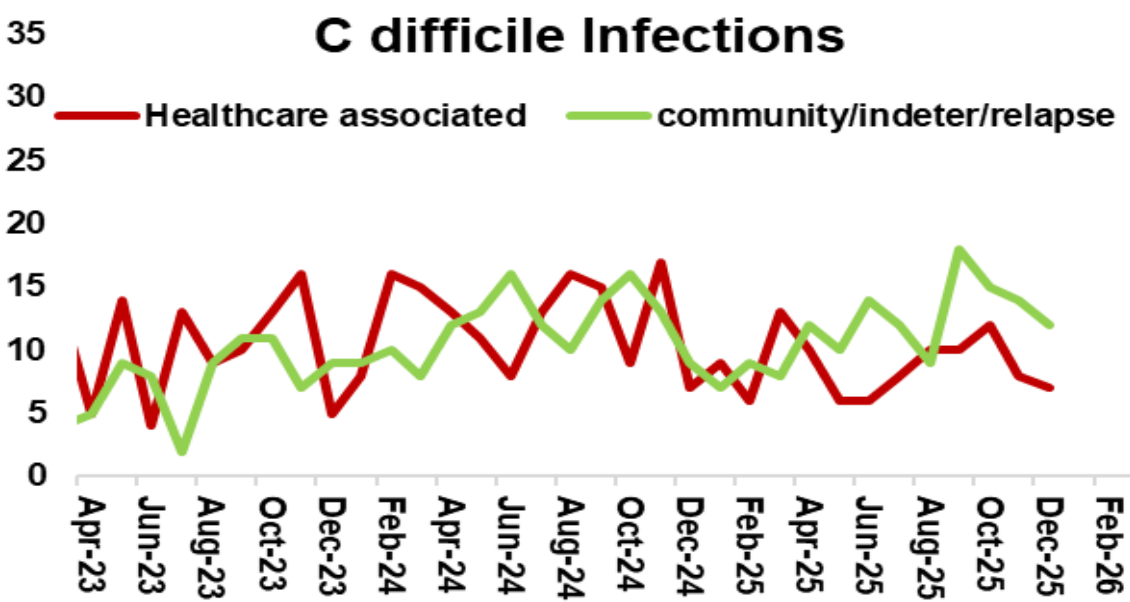
All Wales – Current FY rate per 100,000 population

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	43.02	1.11	23.85	63.31	20.06	6.02
Betsi Cadwaladr UHB	47.76	1.15	25.7	71.35	19.18	5.56
Cardiff and Vale UHB	37.9	3.59	24.84	54.29	23.56	6.15
Cwm Taf Morgannwg UHB	36.86	1.49	24.97	86.8	31.21	2.68
Hywel Dda UHB	44.11	4.1	28.72	97.46	33.51	5.81
Powys THB	20.73	0	0.99	0.99	0	0
Swansea Bay UHB	57.57	2.38	30.66	72.9	31	6.47
Velindre NHST						
Wales	43.45	2.06	25.21	70.13	24.16	5.33

Healthcare Associated Infections

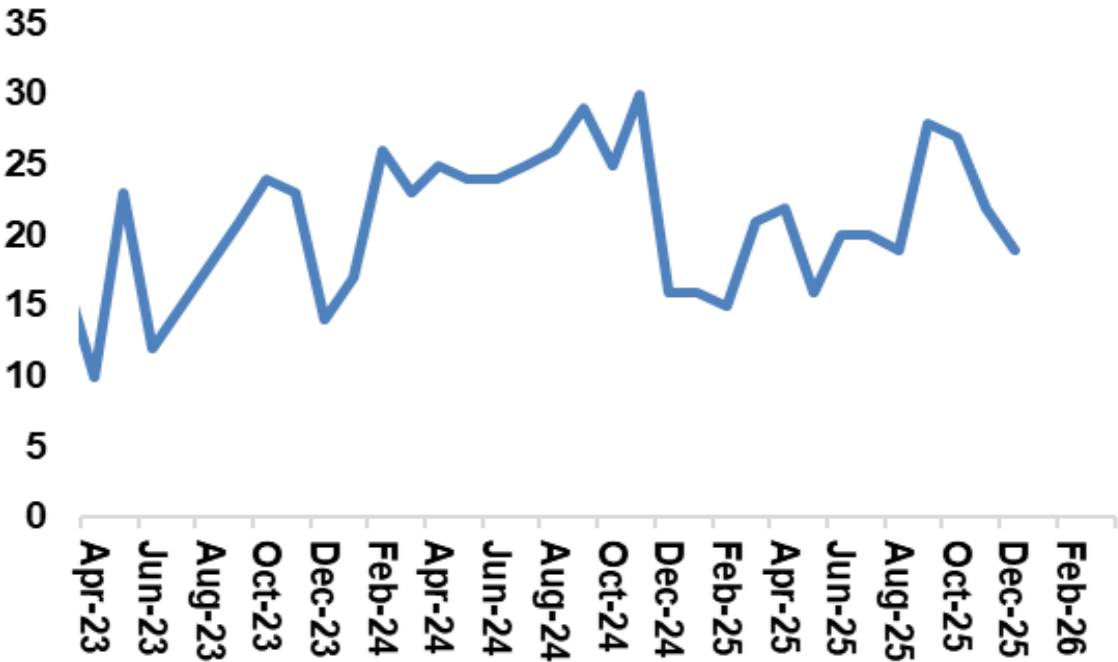
193 cases of C difficile reported from April 2025 to December 2025. This is 30 less than the equivalent period 2024/25. This is a HB rate of 43.02 per 100,000 population

112 cases of Staph Aureus BSI reported from April 2025 to December 2025. This is 30 less than the equivalent period 2024/25. This is a HB rate of 24.12 per 100,000 population

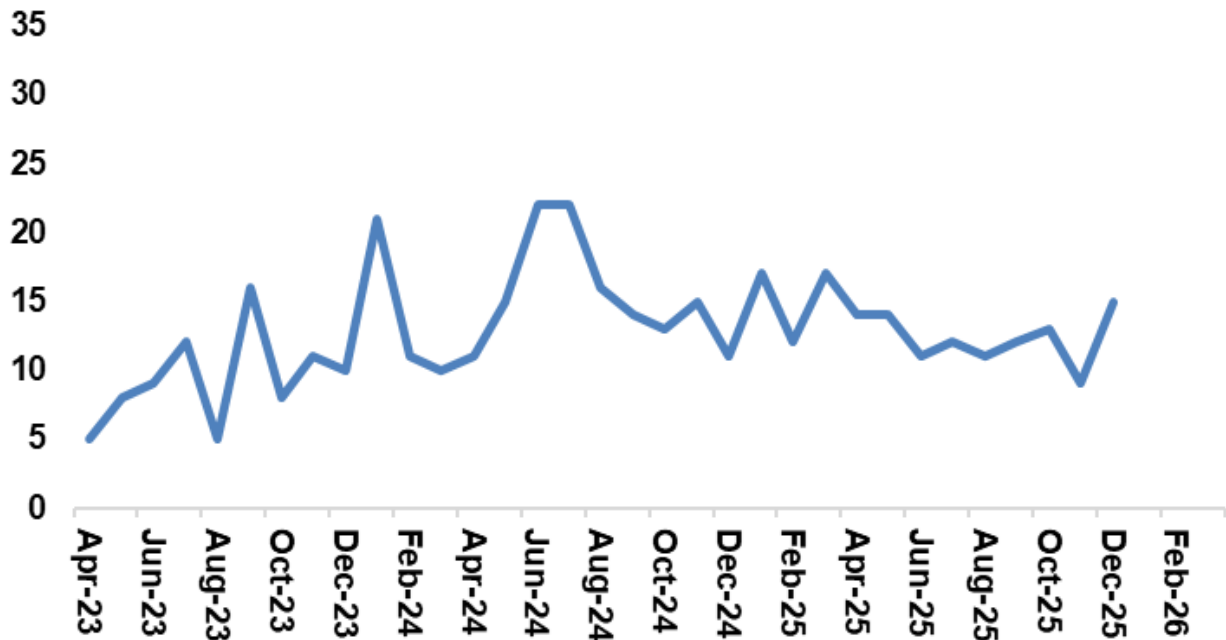


Explanation of data:
The data provided is a combination of local surveillance obtained from ICNET and validated against Public Health Wales data on or around the 9th of each month. It is accurate at the point of being submitted.

Total C difficile



Total Staph Aureus



BSI = blood stream infection

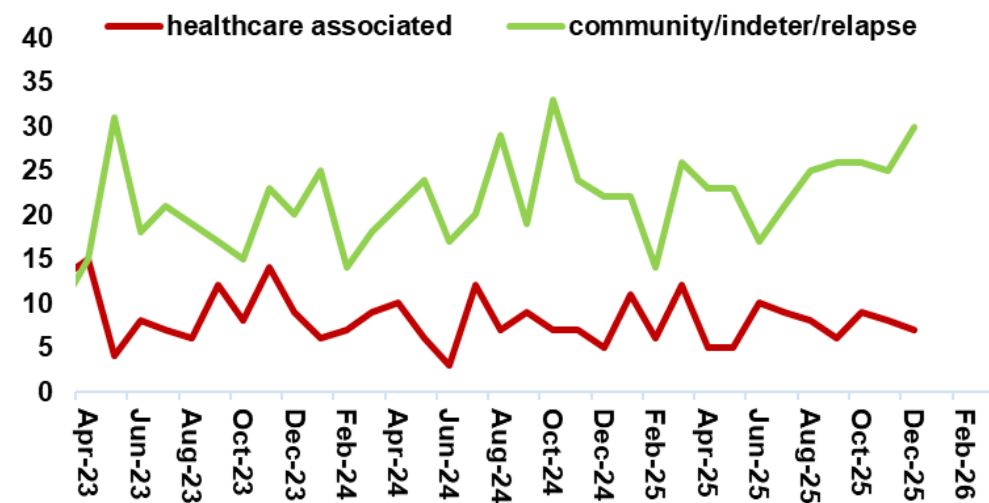
Healthcare Associated Infections

284 cases of E coli BSI reported from April 2025 to December 2025. This is 1 less than the equivalent period 2024/25. This is a HB rate of 63.31 per 100,000 population

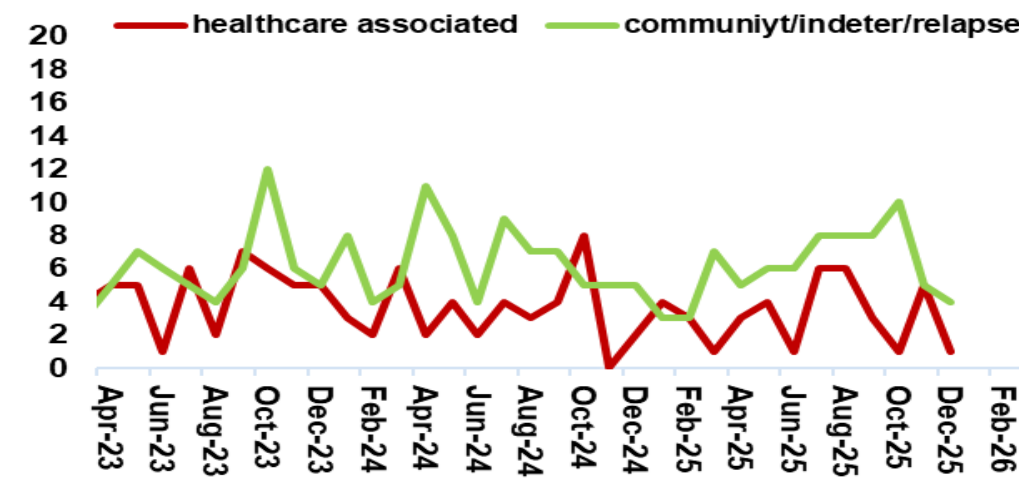
90 cases of Klebsiella BSI reported from April 2025 to 2025. This is 4 less than the equivalent period 2024/25. This is a HB rate of 21.36 per 100,000 population

27 cases of Pseudomonas BSI reported from April 2025 to December 2025. This is 5 less than the equivalent period 2024/25. This is a HB rate of 21.36 per 100,000 population

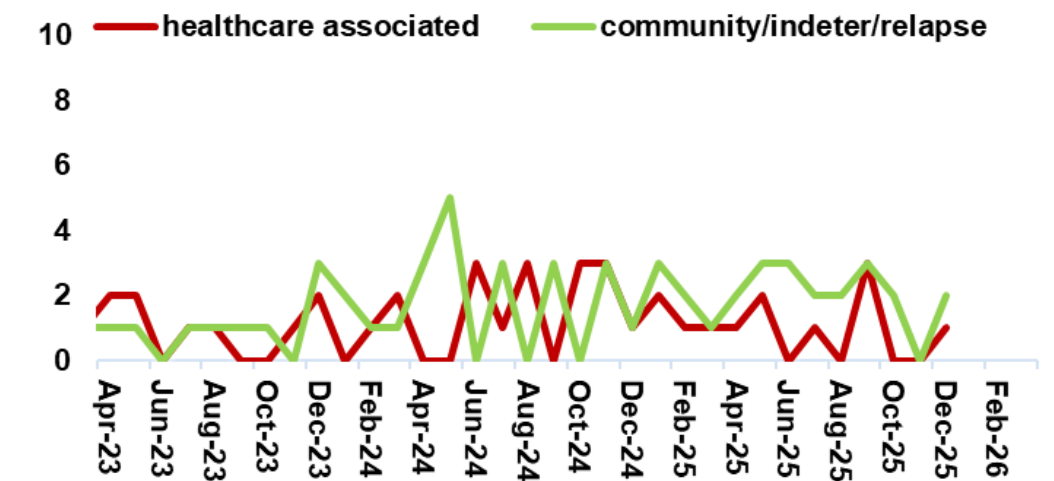
E coli blood stream Infections



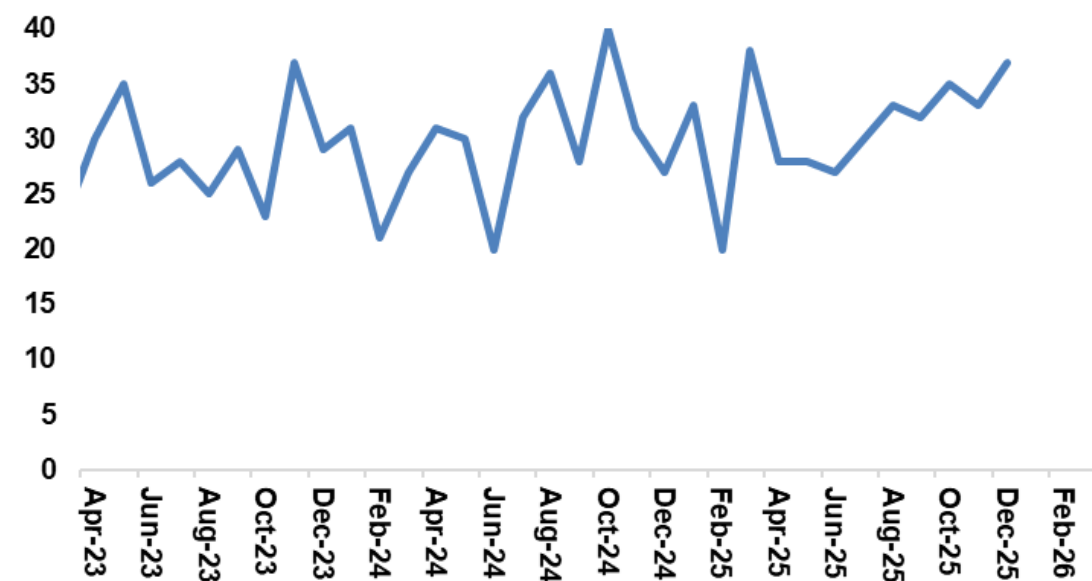
Klebsiella blood stream Infections



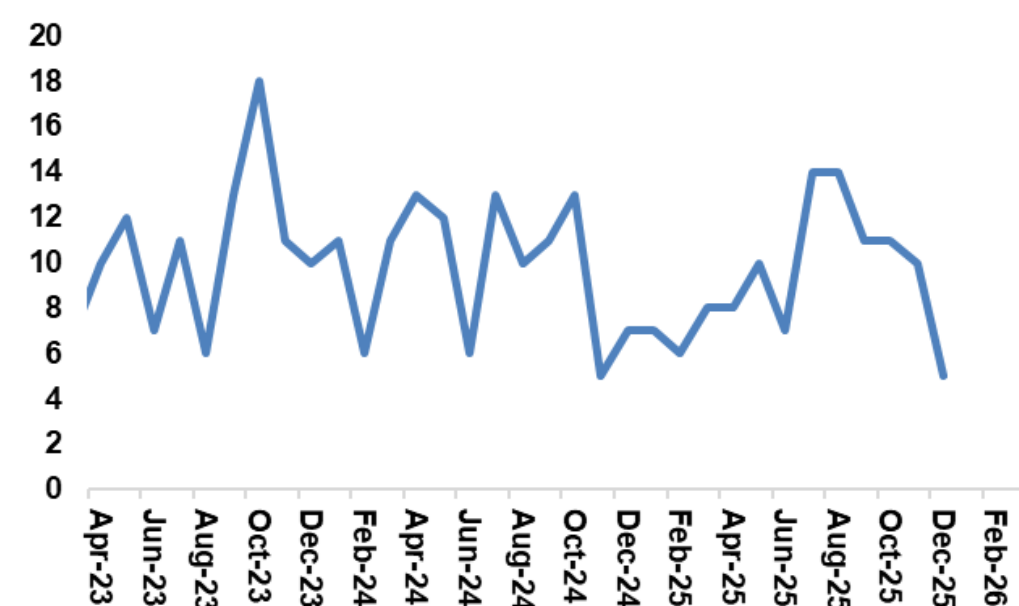
Pseudomonas blood stream Infections



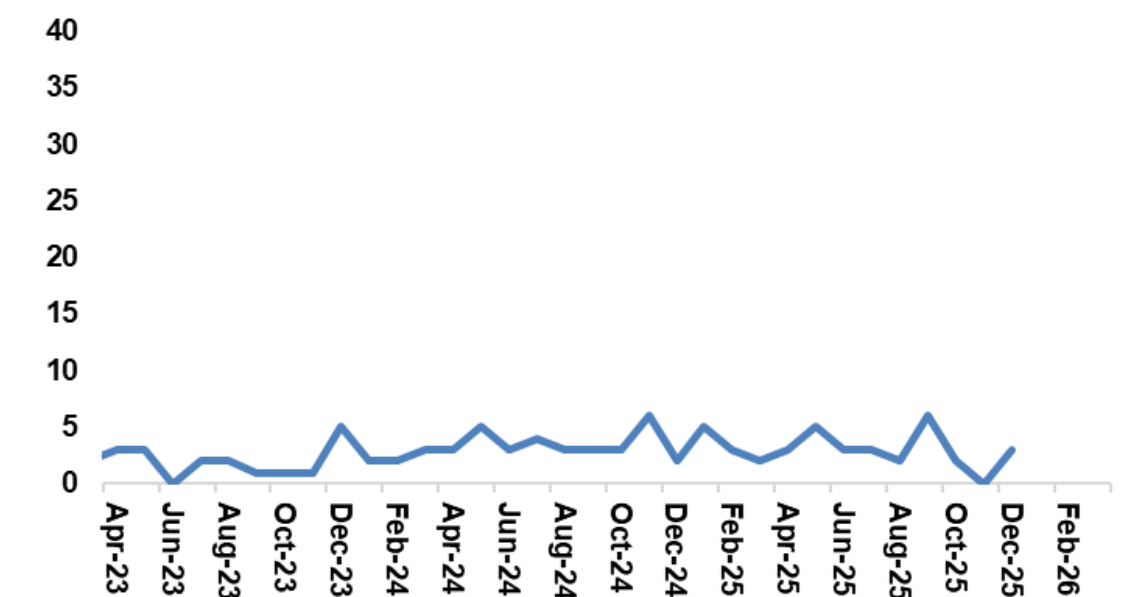
Total E coli BSI



Total Klebsiella BSI

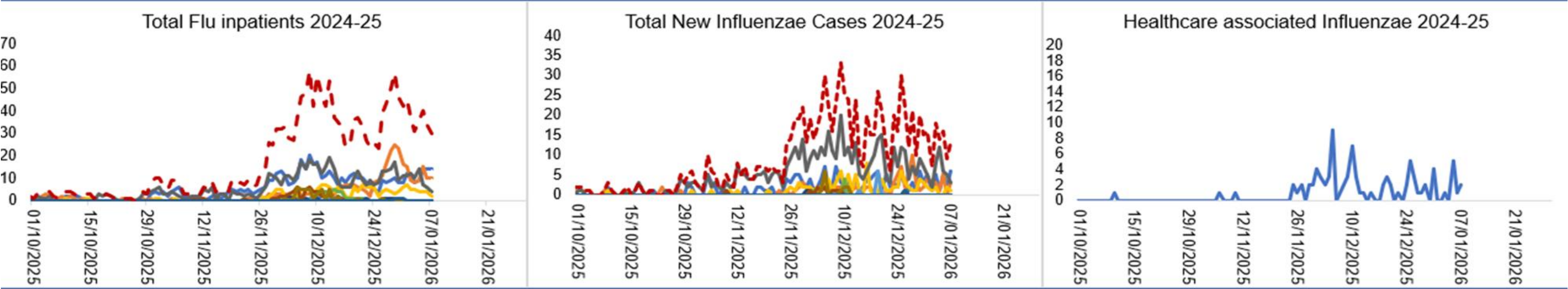


Total Pseudomonas BSI

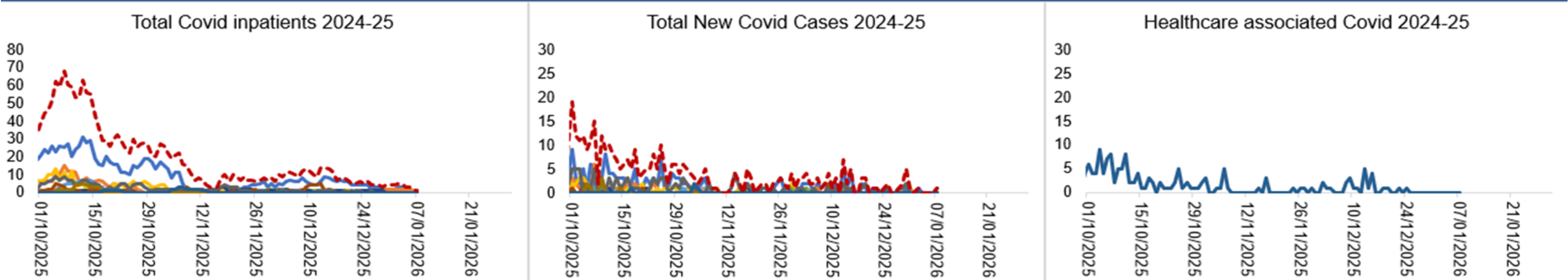


Winter Viruses

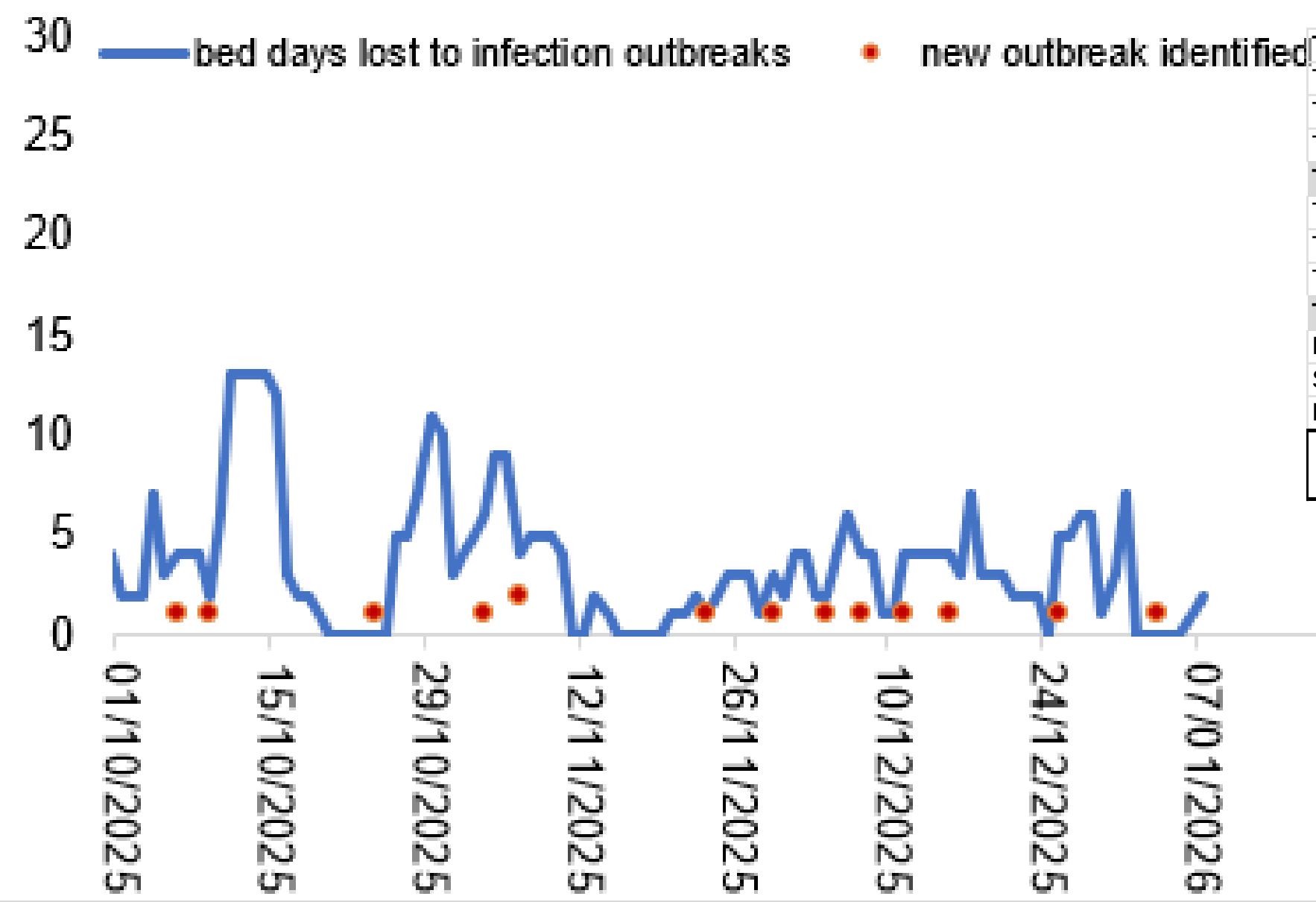
Influenza



Covid-19



Winter Viruses



TRIGGERS	06/01/2026	07/01/2026	08/01/2026	09/01/2026	10/01/2026	11/01/2026	12/01/2026
Total Number of covid positive in patients	2	1	2	3	2	3	3
Total Number of flu positive in patients	34	30	32	33	35	40	26
Total Number of RSV positive in patients	5	3	9	12	12	11	12
TOTAL ARI IN PATIENTS	41	34	43	48	49	54	41
Total number of full ward closures ARI	0	0	0	0	0	0	1
Total number of pods/bays closed ARI	3	3	2	0	5	0	1
Total number of full ward closures D&V/Noro	1	1	2	3	3	3	3
TOTAL AREAS CLOSED	4	4	4	3	8	3	5
Number of patients ventilated in ICU c/o ARI	0	0	0	2	2	2	2
Staff sickness % due to ARI	1.32	1.31	1.41	1.35	1.33	1.31	1.31
Number of Enclosed Settings in incidence	6	6	6	6	6	6	6
ESCALATION LEVEL							

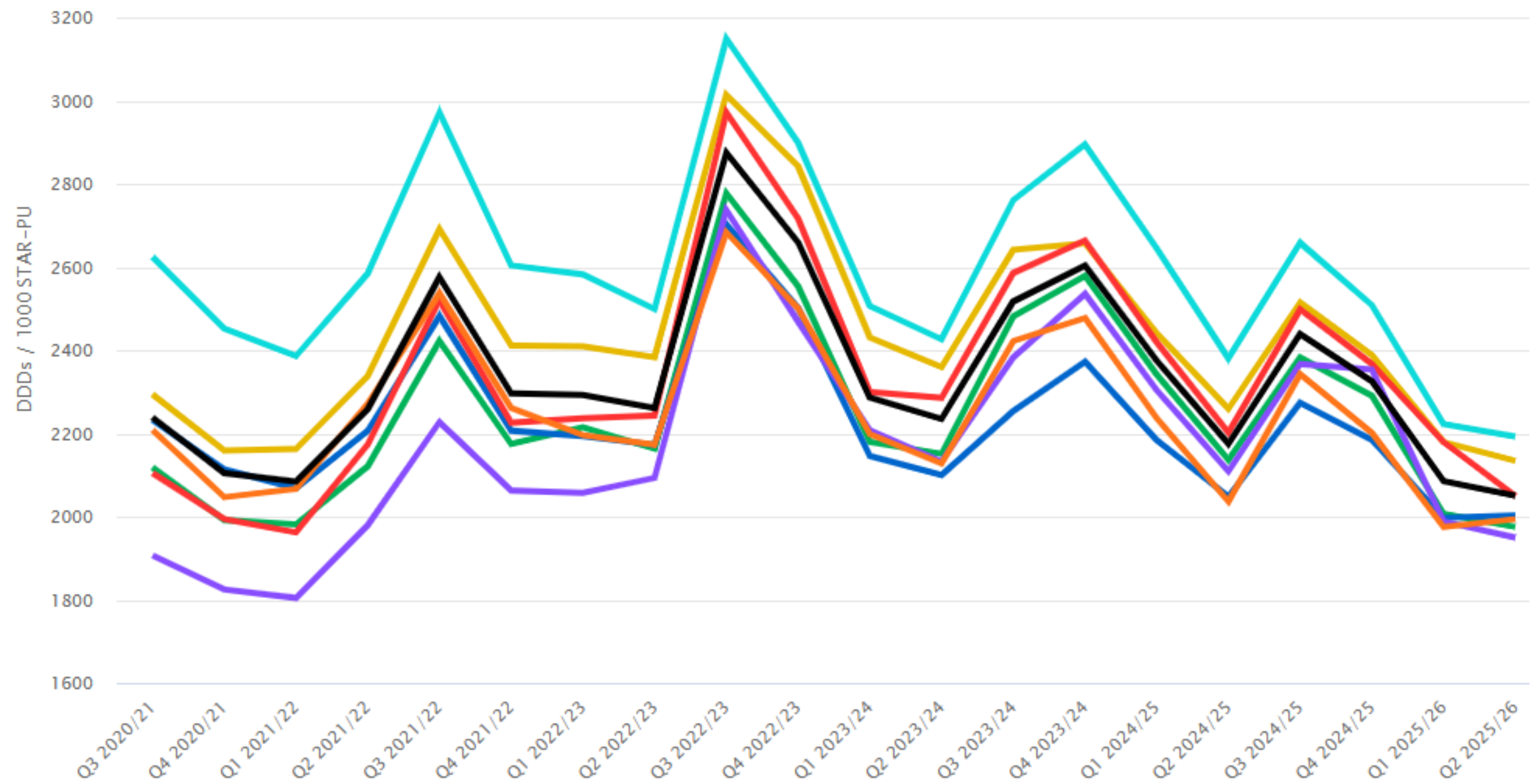
Organism	Number of ward closures
C difficile	12
Covid-19	17
Influenza	5
Norovirus	3

Themes & Trends	Successes	Challenges	Learning & Improvement
Winter Viruses	Health Board escalation standard operation procedure activated	Compliance with promptly isolation of patients due to limited cubicles on RGH/NHH and community sites and staff wearing face coverings.	Shared facilities increases risk of onward transmission Fast track of respiratory screen in hospital sites where cubicles limited

Learning and Improvement

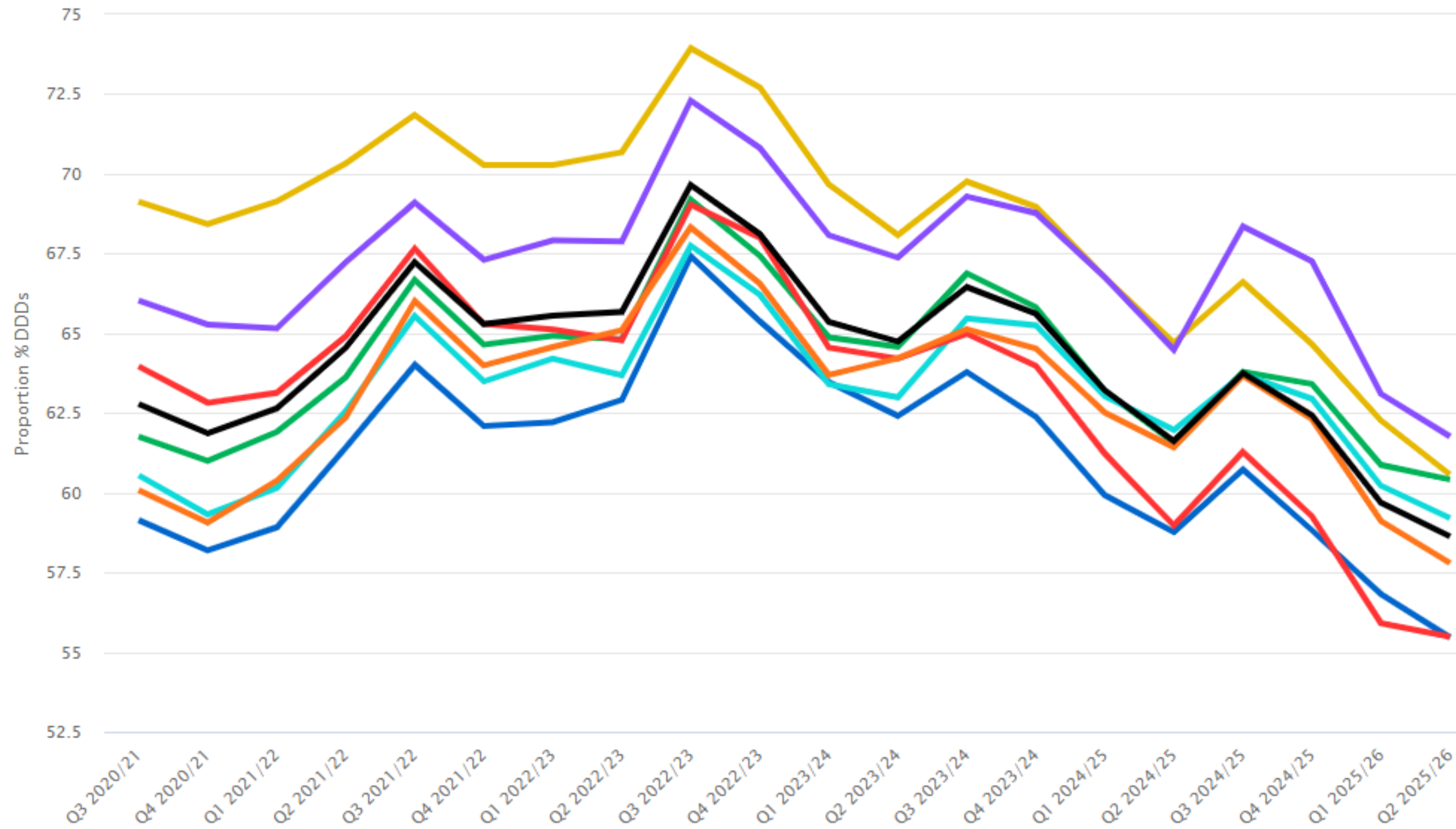
Themes & Trends	Successes	Challenges	Learning & Improvement
C difficile	Two wards participating in the national collaborative	Time and system pressures to ensure improvement and focus Human factors and communication re PPI management	Cleaning process in HB policy not achievable since change of hospital beds Many staff not received training for discharge cleaning Sticker developed to be placed in medical notes
Staph Aureus blood stream infections	Lowest rates for MRSA and MSSA in Wales	Documentation for bundle compliance	Relaunch the IDECIDE and awareness for line care
Gram Negative blood stream infections	Slight reduction in all three areas of reporting compared to previous years	Dip sticking of urine in patients over the age of 65 which is not advocated	ERASE developed and will be promoted via IP newsletter and via coms

Welsh Government Antimicrobial Targets: Primary Care



- **Target: Reduction in total antimicrobial volume by a minimum of 10% by 2029/30 against 2019/20 baseline (measured in defined daily doses (DDDs) of antibiotics/1000 STAR-PU)**
- Previously reported graphs from AWTTC are at odds with data from Public Health Wales presented here. PHW data are used to measure progress against targets. Work is underway with PHW to understand the differences between the two data sets and check the data. Despite a further year on year reduction, ABUHB remains highest prescribers in Wales in Q2 data presented by AWTTC, with a higher prescribing rate than reported by PHW.
- Discussions have commenced to influence the 2026/27 Cost Effective Prescribing Programme (CEPP, the ABUHB incentive scheme) to include evolving antimicrobial content.
- Blaenau Gwent & Caerphilly remain highest prescribing localities in Wales, whilst Torfaen has improved their position nationally.

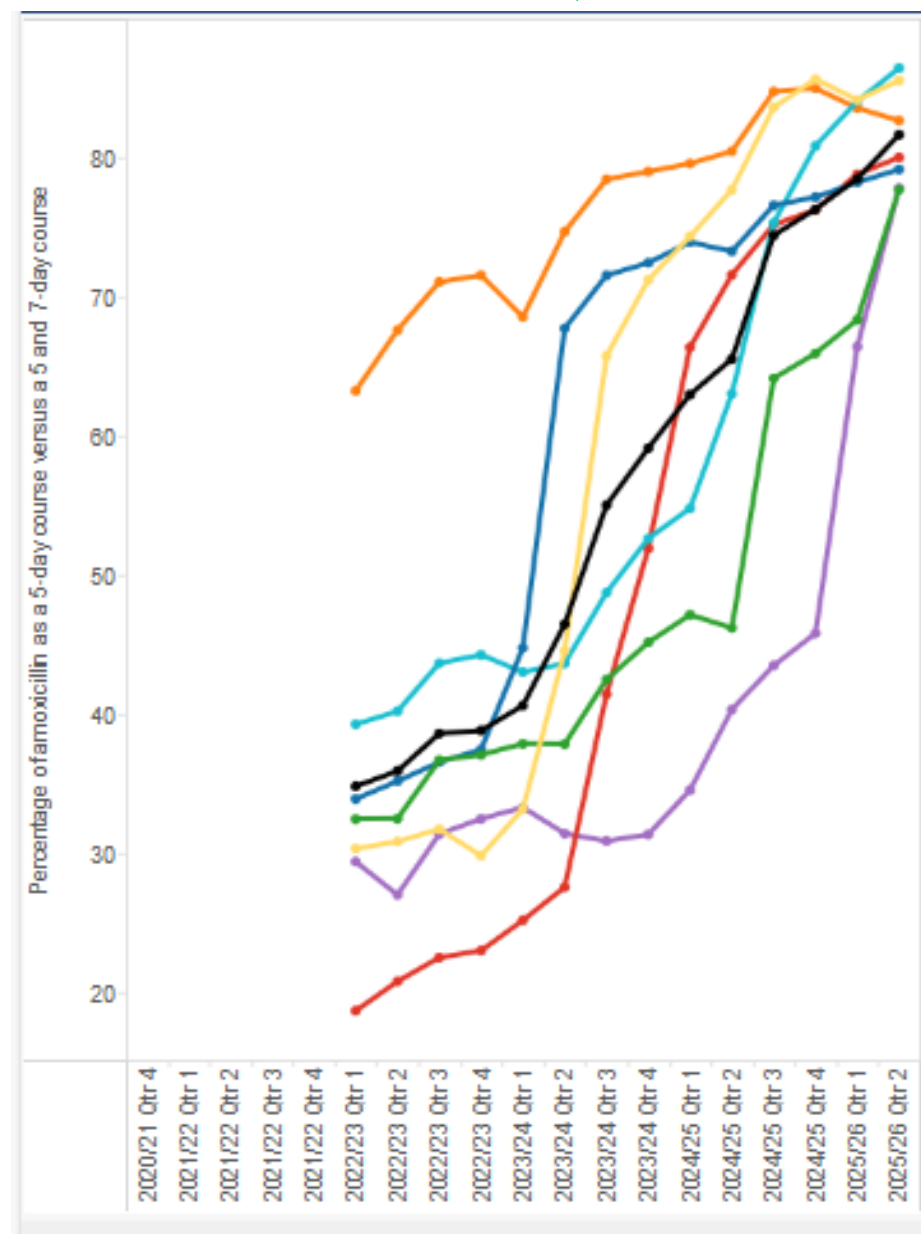
Welsh Government Antimicrobial Targets: Primary Care



- **Target: Minimum of 70% of total antibiotic use from the WHO 'Access' category by 2029/30, measured in defined daily doses (DDDs).**
- Q2 position: **60.6% (moving away from target)**. NB: Actions to reduce antibiotic volume to achieve the previous target have resulted in a reduction in 'access' antibiotic use. This is preferable to maintaining a high volume of use.
- There is national agreement to remove methenamine from calculations (currently comprising a significant proportion of the 'other' category) from calculations, which will result in improvement in performance once actioned by PHW.

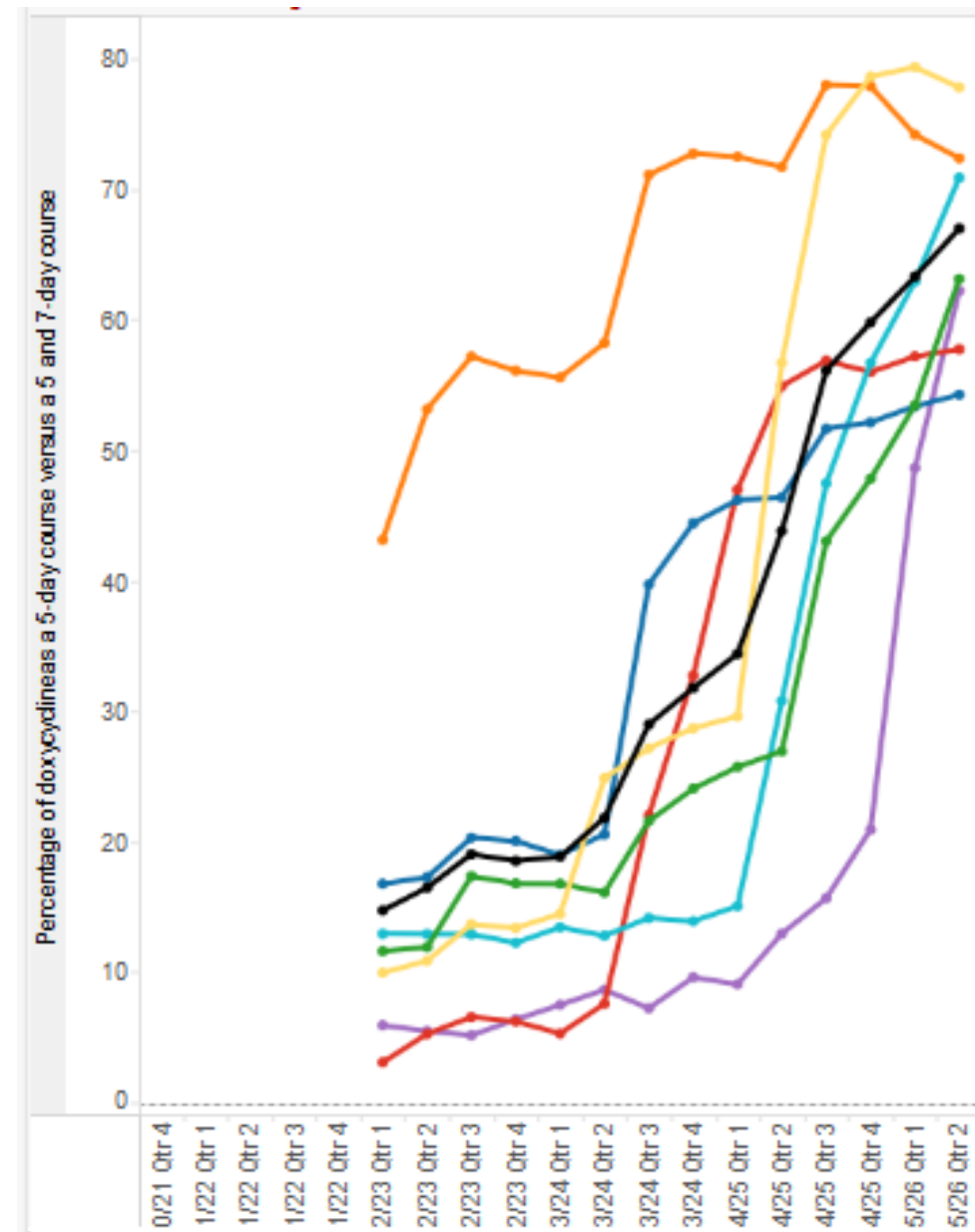
Welsh Government Antimicrobial Targets: Primary Care durations

Amoxicillin ✓



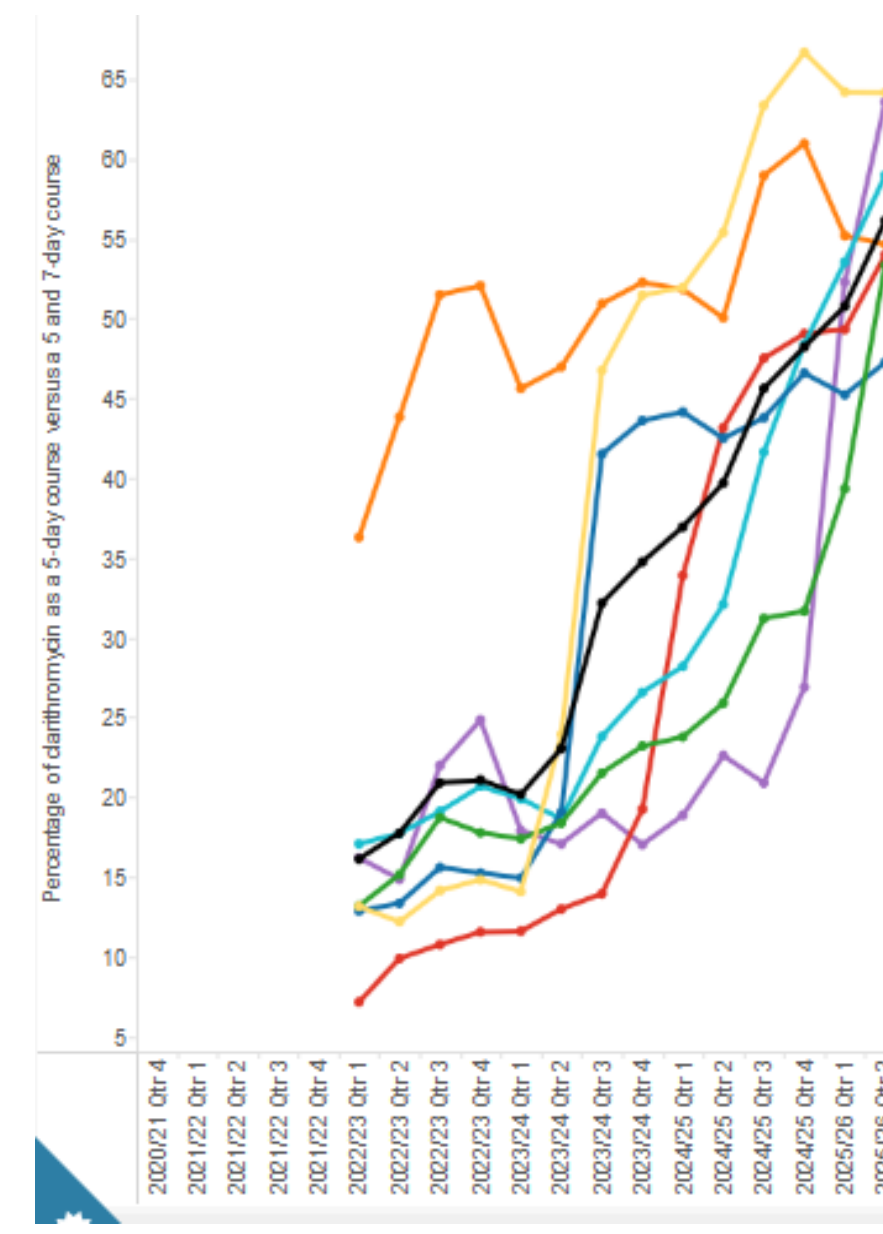
Q2 -ABUHB 85.5%, Wales 81.7%

Doxycycline ✓



Q2 -ABUHB 77.82%, Wales 67.0%
Note –MINUS 1.95% change Q1 to Q2

Clarithromycin ✗



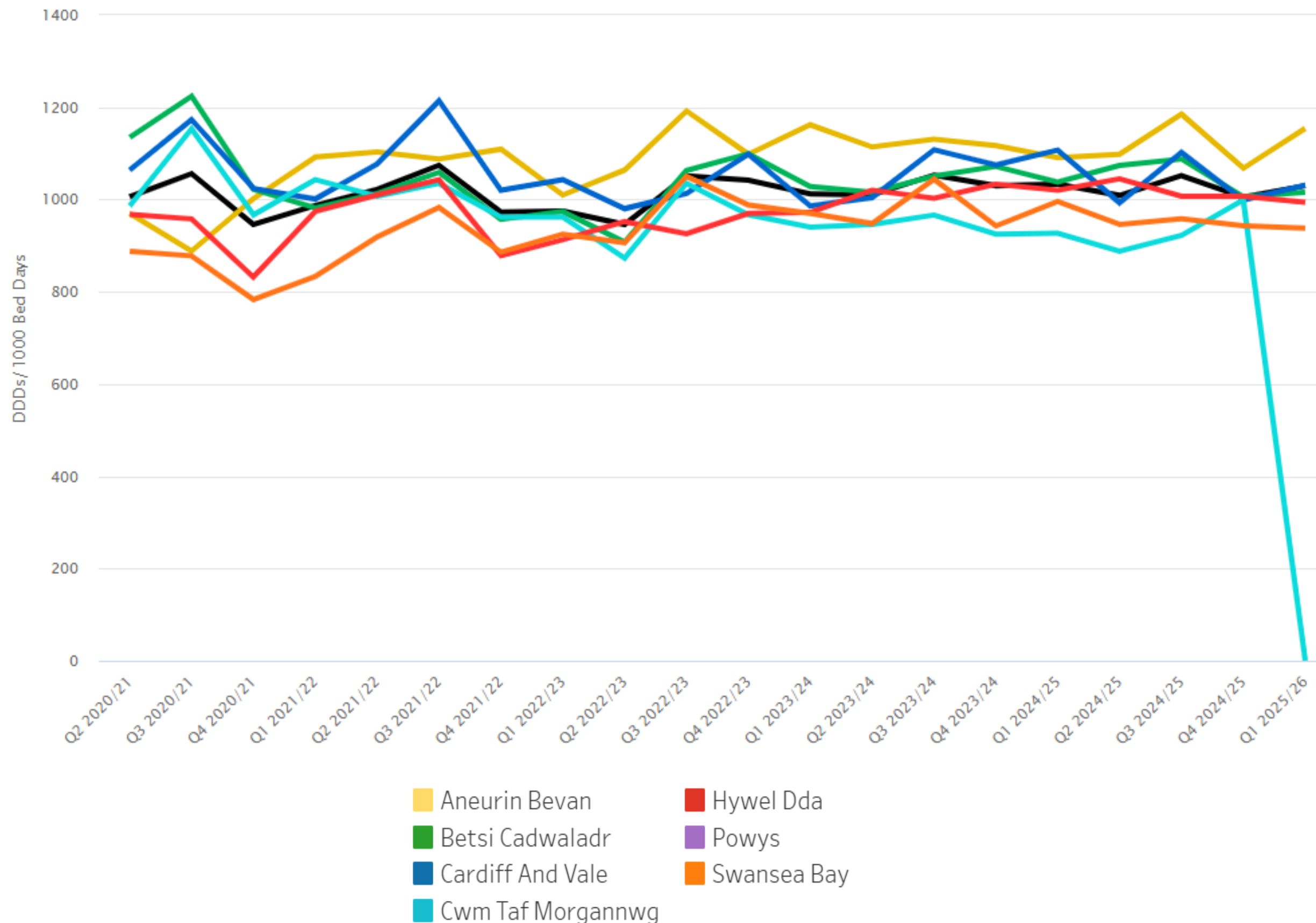
Q2 -ABUHB 64.2%, Wales 56.2%

ABUHB is the yellow line on these graphs.

ABUHB has achieved the target for amoxicillin & doxycycline

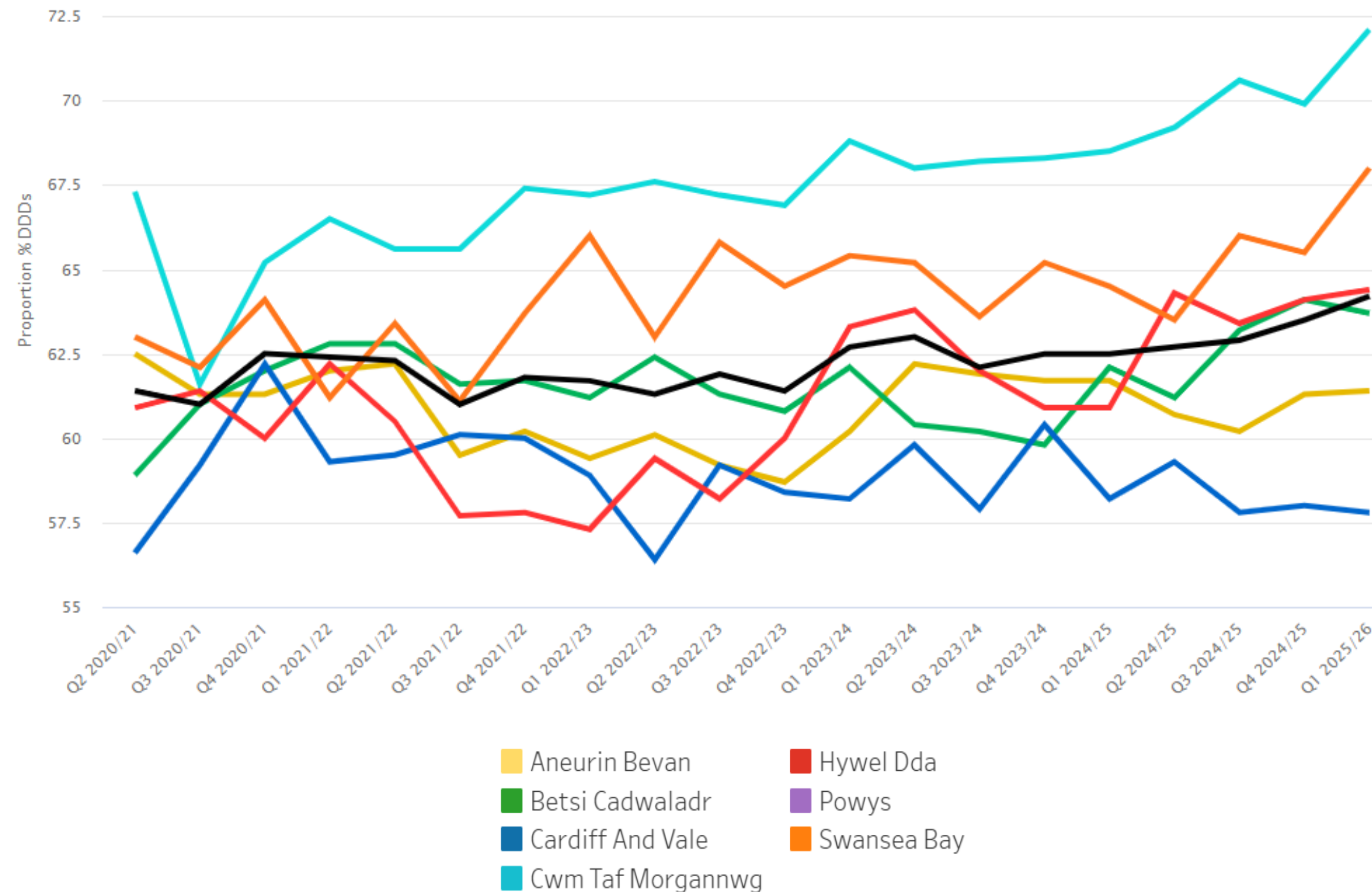
Poorer uptake for clarithromycin is being investigated. Improvement in clarithromycin performance will assist in achieving the previous 'access' target.

Welsh Government Antimicrobial Targets: Secondary Care



- **Target: Reduction in total antimicrobial volume by a minimum of 5% by 2029/30 against 2019/20 baseline (measured in defined daily doses (DDDs) of antibiotics/1000 bed day)**
- Data to Q1 25/26 do not demonstrate any improvement, and a deterioration in position from 24/25 FYE. NB. ABUHB is in a good position when admissions are used as the denominator, but bed days are currently used as the WG target denominator. Work has started with PHW to review data quality.
- Work to embed good antimicrobial stewardship practice into electronic prescribing has progressed well and will be embedded at go live in 2026. A decision to limit antibiotic course lengths was taken by Antimicrobial Working Group, and is anticipated to reduce unnecessarily long course lengths, similar to the initiative in primary care.

Welsh Government Antimicrobial Targets: Secondary Care



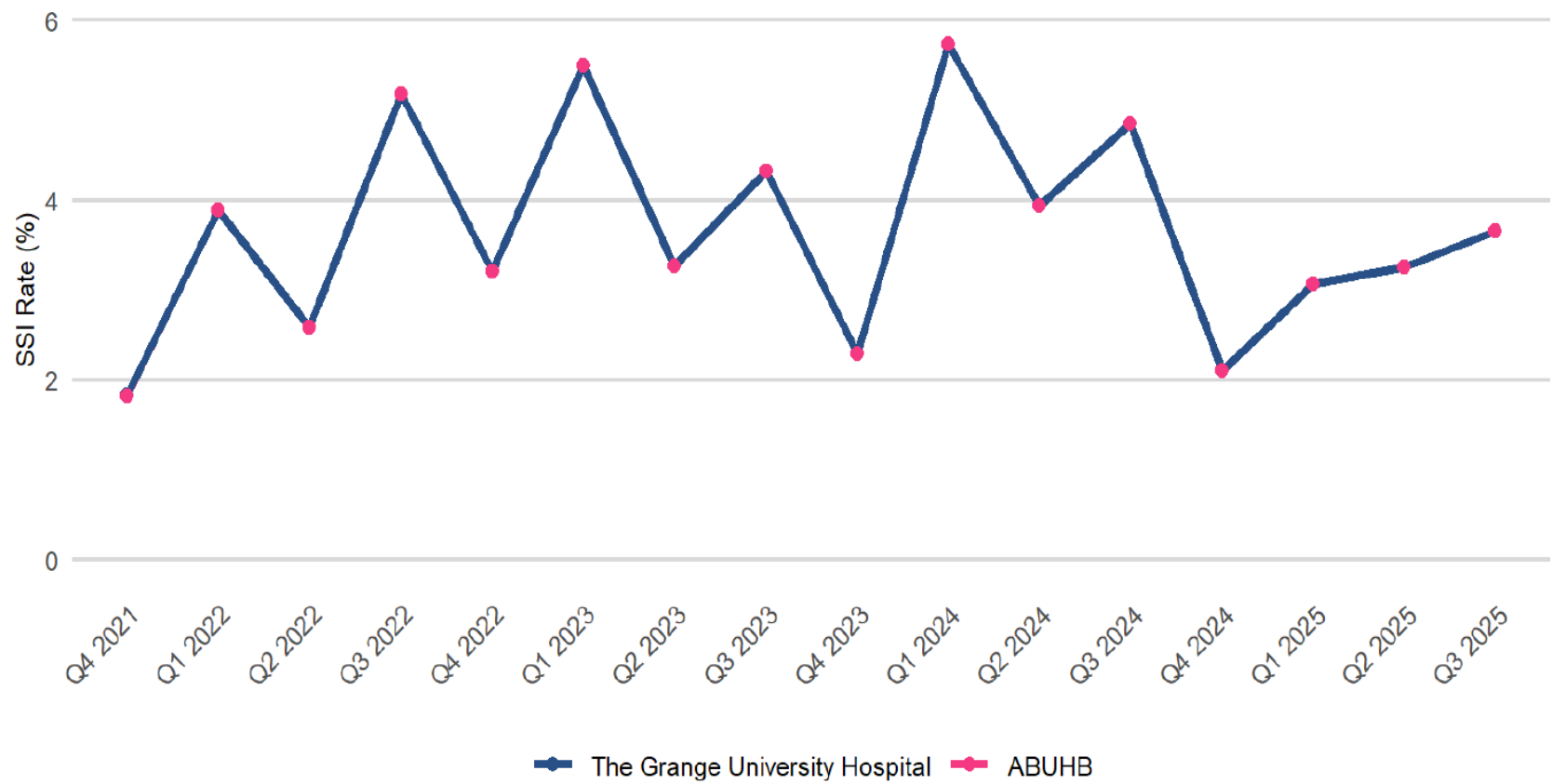
- **Target: WHO 'Access' category – minimum of 70% of total antibiotic use from the Access category by 2029/30, measured in defined daily doses (DDDs).**
- ABUHB 2024/25 FYE position received from Public Health Wales: **62.7% usage in access category** (no improvement from 23/24 FYE)
- New guideline sections have been introduced in Q3 to steer prescribers away from over-using sepsis guidelines, which use predominantly use 'watch' or 'reserve' antibiotics.
- 'Order sets' (standard prescriptions) will be embedded within electronic prescribing from go-live to encourage prescribing in line with the clinical condition, only offering options in line with guidelines.

WG Antimicrobial Performance Overarching Actions

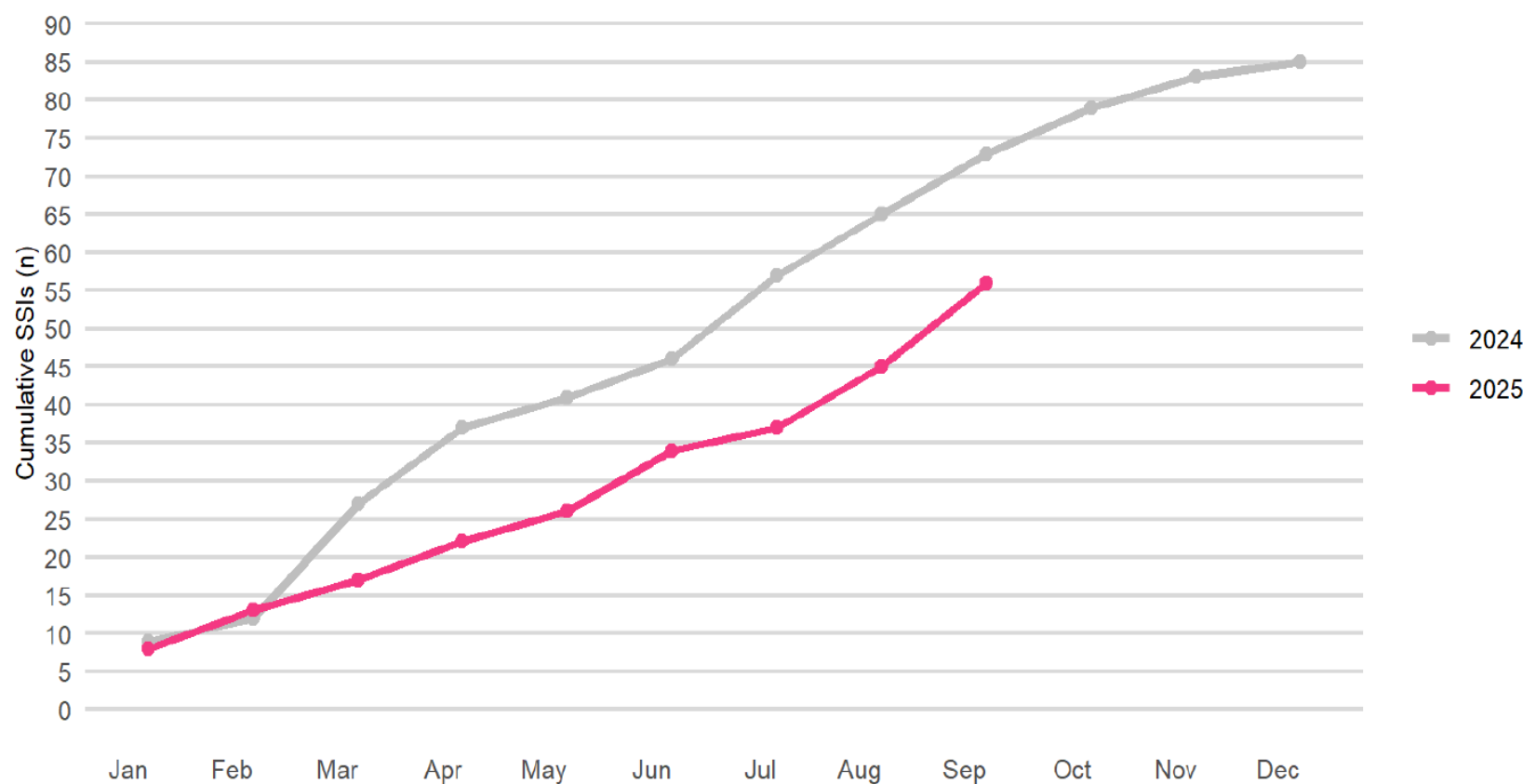
Themes	Successes	Challenges	Learning & Improvement
Blaenau Gwent & Caerphilly remain highest prescribing localities in Wales	Presented at Caerphilly locality protected learning time events delivered Nov 2025	Blaenau Gwent yet to engage. A number of managed practices in BG are poor performers, so being targeted for audit & feedback cycles.	Feedback & subsequent performance awaited from Caerphilly PLT sessions
Clarithromycin durations not yet achieving target	Data from audit & feedback cycles and GP out of hours audit reviewed to identify learning.	Clarithromycin sometimes used as option in patients with penicillin allergy. All-Wales penicillin allergy delabelling protocol for primary care currently in development by national group.	Potential to improve performance noted from audit results, to be used for subsequent feedback sessions
Secondary care antimicrobial volume not reducing	ePMA configuration progressing well. Drug files have relevant warnings and information leaflets attached. Antimicrobial guidelines converted into 'order sets' (standard prescriptions) to enable prescribing by condition within system. Working on coding indications to improve data outputs. Need to support development of training materials prior to go live.	- Start Smart Then Focus audits by Trainee Doctors still not embedded. Discussion with Assistant Director for Quality & Patient Safety around inclusion in trainee doctor essential audit list, and corporate audit plan (to provide validation) - AMS metrics yet to be embedded into divisional QMS highlight reports - Data quality requires review with PHW	Awaiting electronic prescribing pilot to test functionality in real world cohort. Meeting arranged to discuss audits & metrics further. PHW data review underway
Secondary care access category target	Secured by in for MIU audit around bites (as driving co-amoxiclav use at front door)	Open fractures identified as another potential target. Requires update of guidance before improvement work can commence.	Front door prescribing prioritised for action due to knock on effect through system
Antimicrobial Stewardship team staffing: - Lead Antimicrobial Pharmacist for Secondary Care leaving for promotion 02.2026 - Fixed term maternity cover post ends 03.2026	Lead Antimicrobial Pharmacist post recruited 12.2026 with aim to commence 04.2026	Monies available due to flexible working request post-maternity insufficient to employ substantive pharmacist replacement. Scrutiny proforma completed to reinvest monies in data analyst post, which would leverage the wealth of data available from electronic prescribing, and release pharmacist time to undertake more patient-facing activities.	Outcome of scrutiny awaited

Surgical Site Infections

Quarterly Rates



MONTHLY PROGRESS



- Reduction in the SSI rate this quarter, compared to 2024's Quarter 3 (30.85%) - despite doing more procedures (603 in 2025, and 557 in 2024).
- There was a 23.29% reduction in the number of SSIs reported at the end of Q3 2025 when compared to Q3 of 2024.
- 56 SSIs reported up until the end of Sept 2025. 11 Deep, 13 Superficial, and 32 Unknown/not recorded.
- Less SSIs have been reported up to quarter 3 2025 than predicted, 56 SSIs reported whereas 74 were expected.
- SSI rate has been between 3.07% - 3.65% for 2025, slightly increasing with each passing quarter

PILLAR 6

Safeguarding

Policies/SOP

Leadership,
Accountability and
Culture

Level 1, 2 and 3
Training

Safeguarding
Supervision

Practitioner
Concerns

Partnership
Working

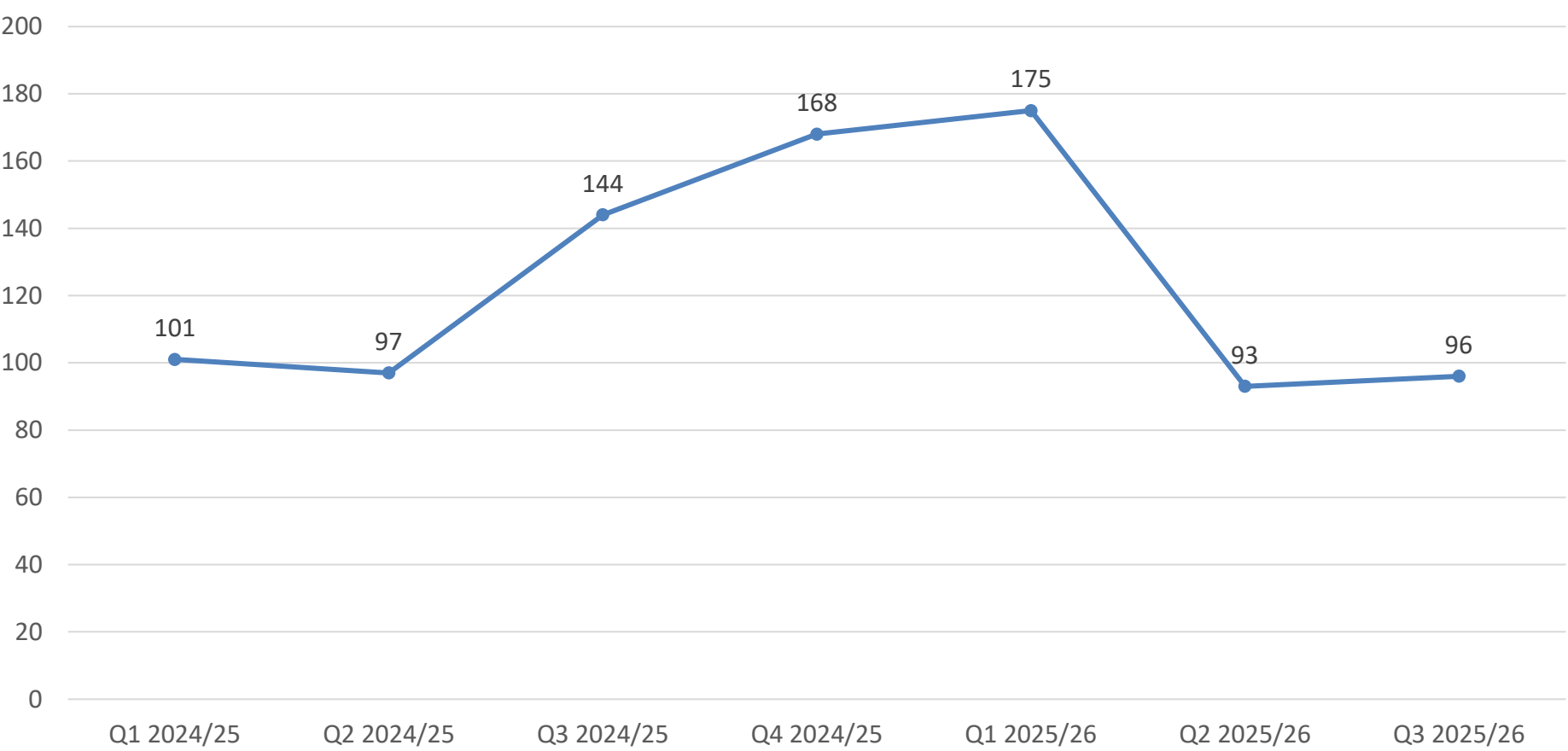
Domestic Abuse
and Sexual Safety

Deprivation of Liberty
Safeguards/ Mental
Capacity Act

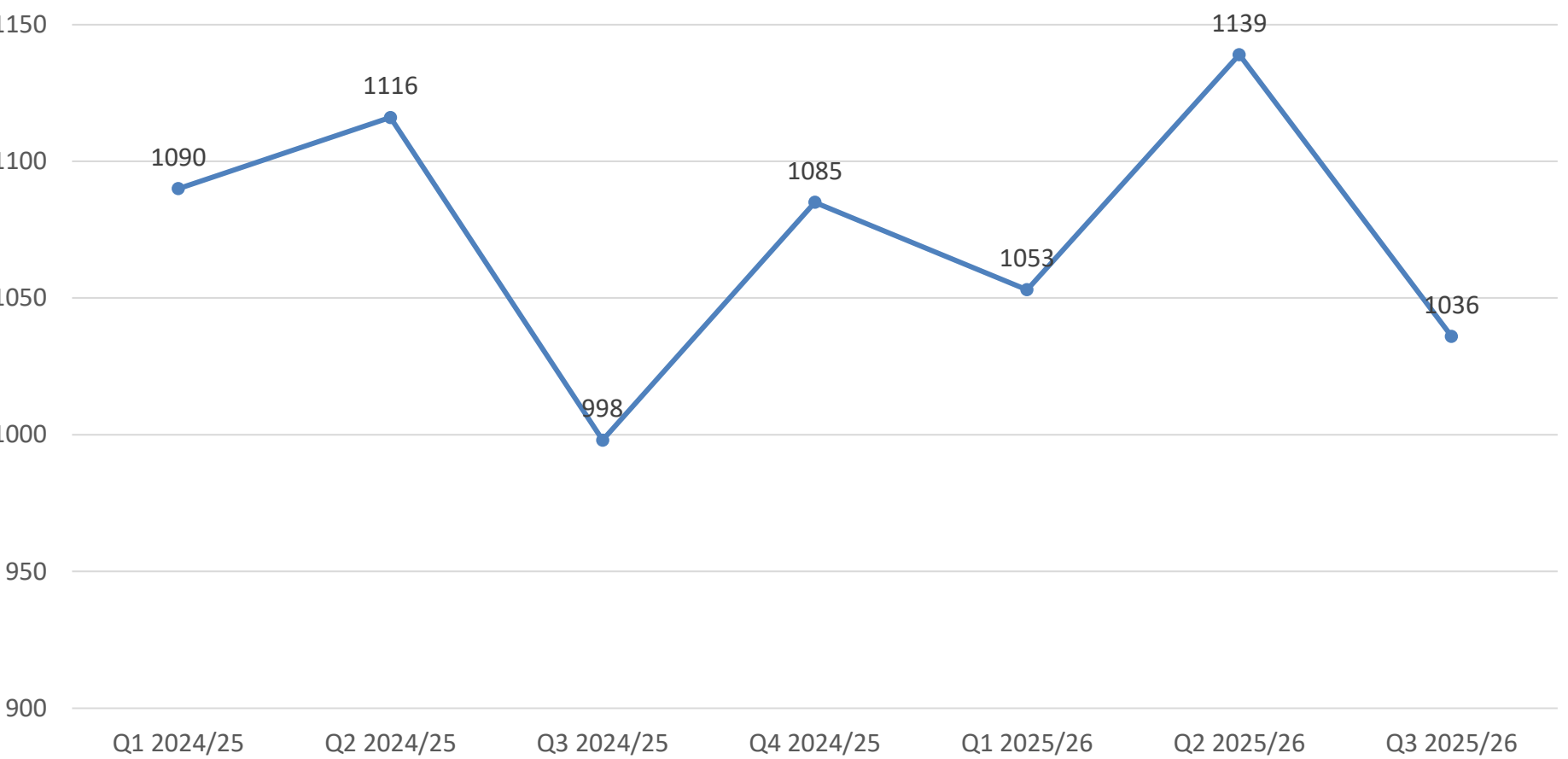
Statutory
Reviews

Duty to Report (Adult and Children)

Adult DTR's by Quarter



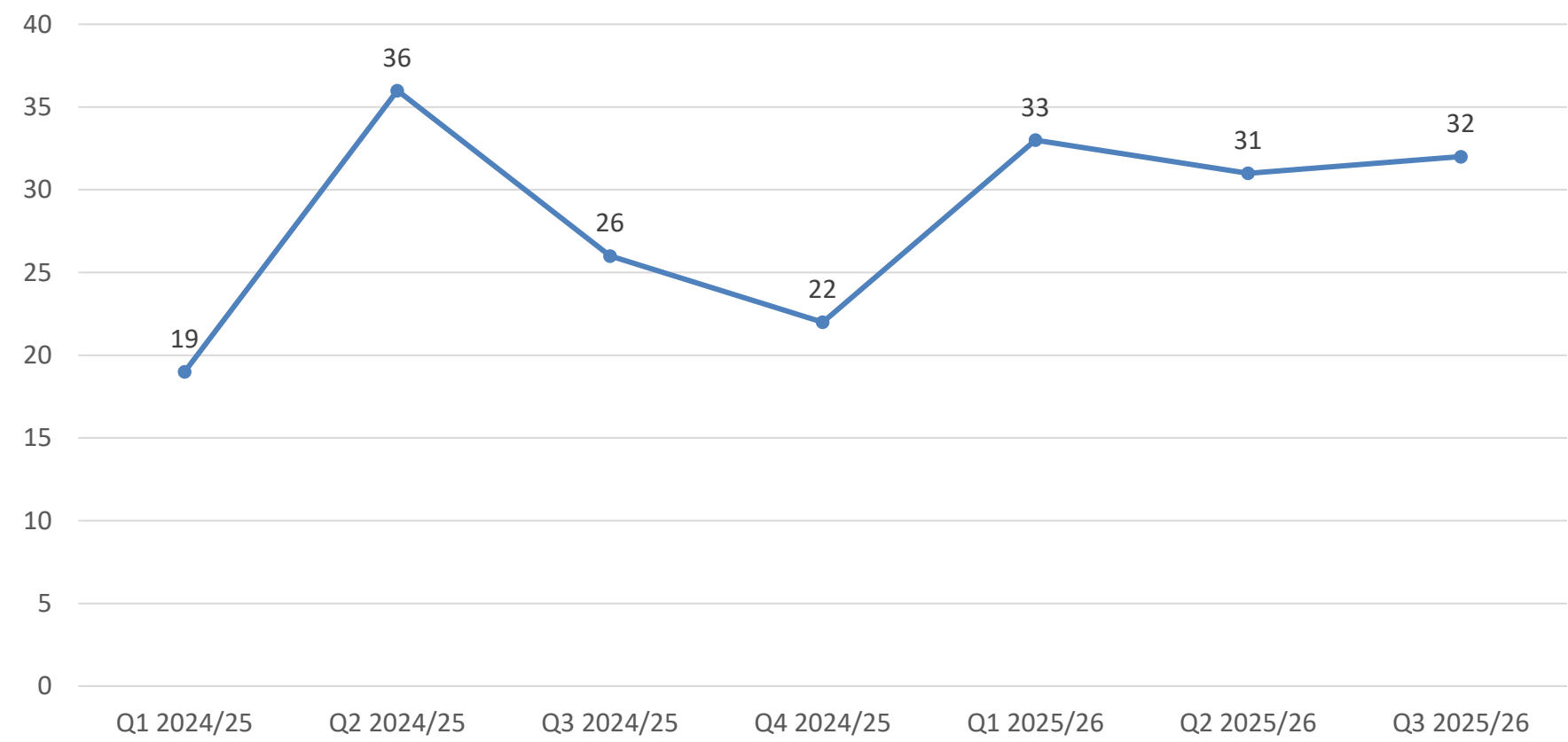
Child DTR's by Quarter



Definition	Analysis	Implications
The information presented has been extracted from RL Datix and is accurate at the point of recording. This information relates to all cases that were managed by or supported by the Corporate Safeguarding Team.	Duty to Reports for adults continued to rise throughout 2024 and in Q1 of 2025. However, it has been noted that there has been a significant drop in Q2 and Q3. The majority of DTR completed have been appropriate and of good quality however, the volume and complexity of safeguarding cases continues to be a challenge to the Health Board and Partners Activity in relation to Children's Safeguarding continues to remain very high, with our highest level of activity to date in Q2 2025/26, a decline was observed in Q3 but still high. There are a number of social and economic factors impacting upon Child Safeguarding within a home setting, as well as challenges created by exploitation and organised crime.	Improved uptake in Safeguarding Adult Training has led to more appropriate and timely referral. A focus of safeguarding training will be around ensuring timely escalation of concerns.

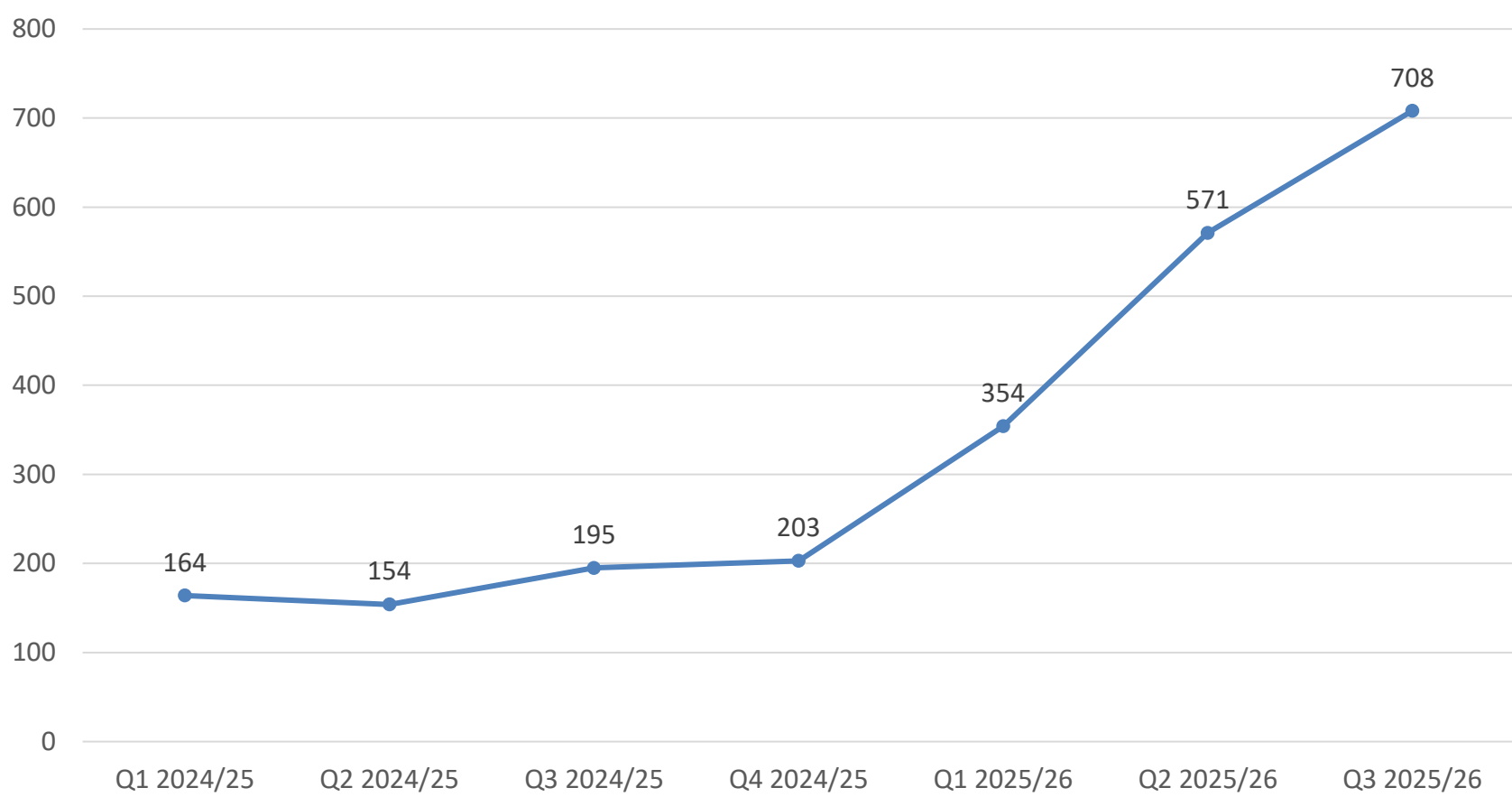
Practitioner Concerns

Persons in Position of Trust Referrals



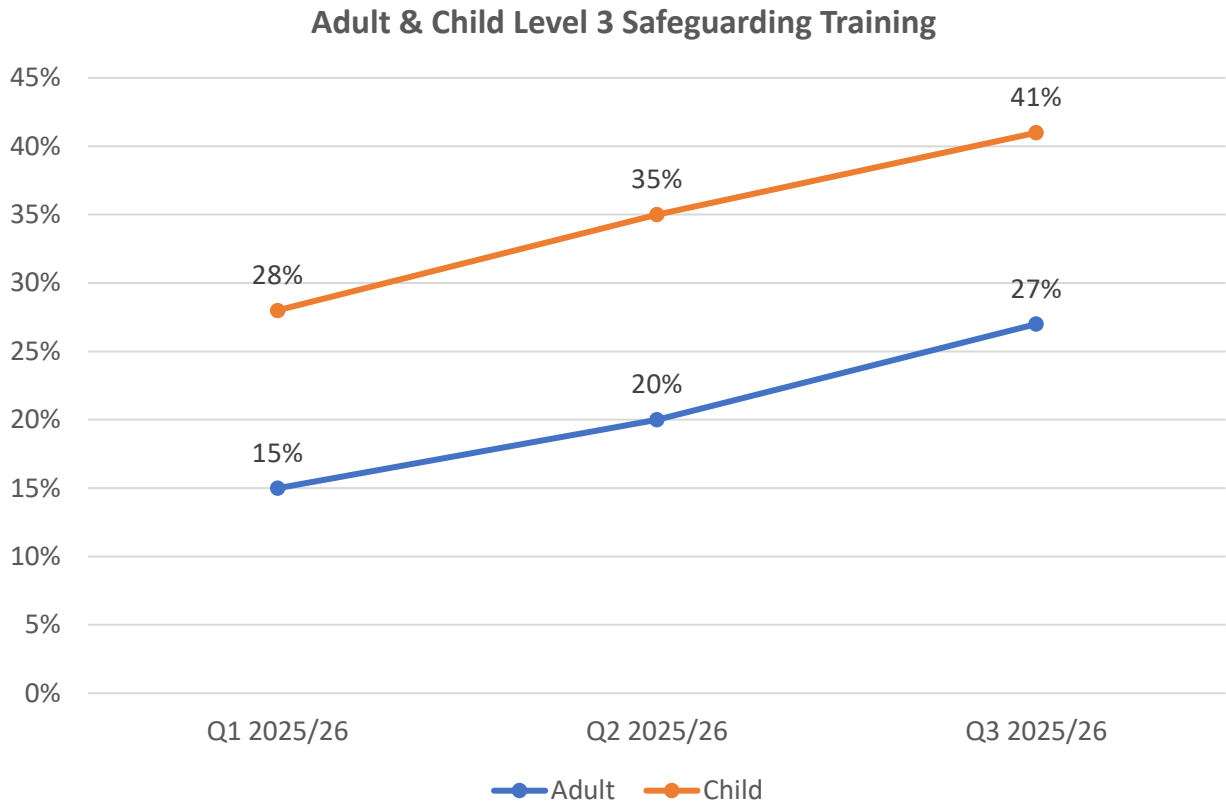
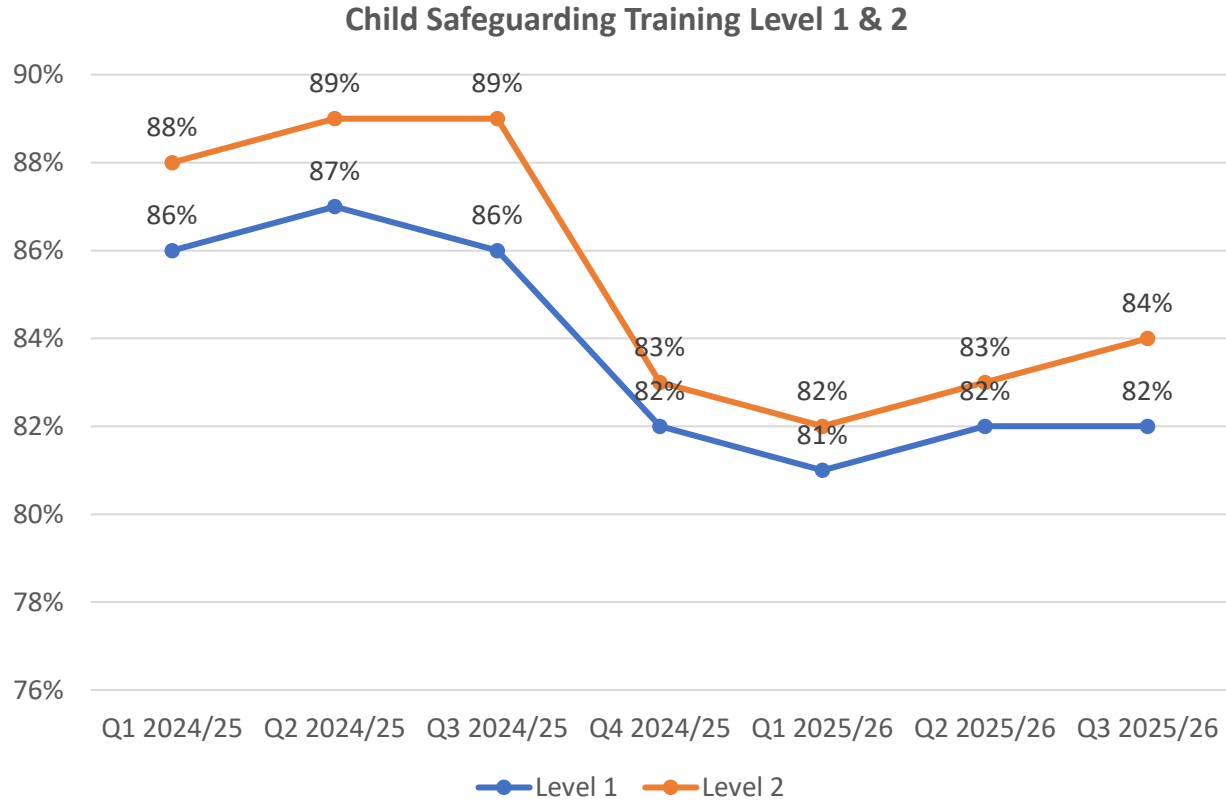
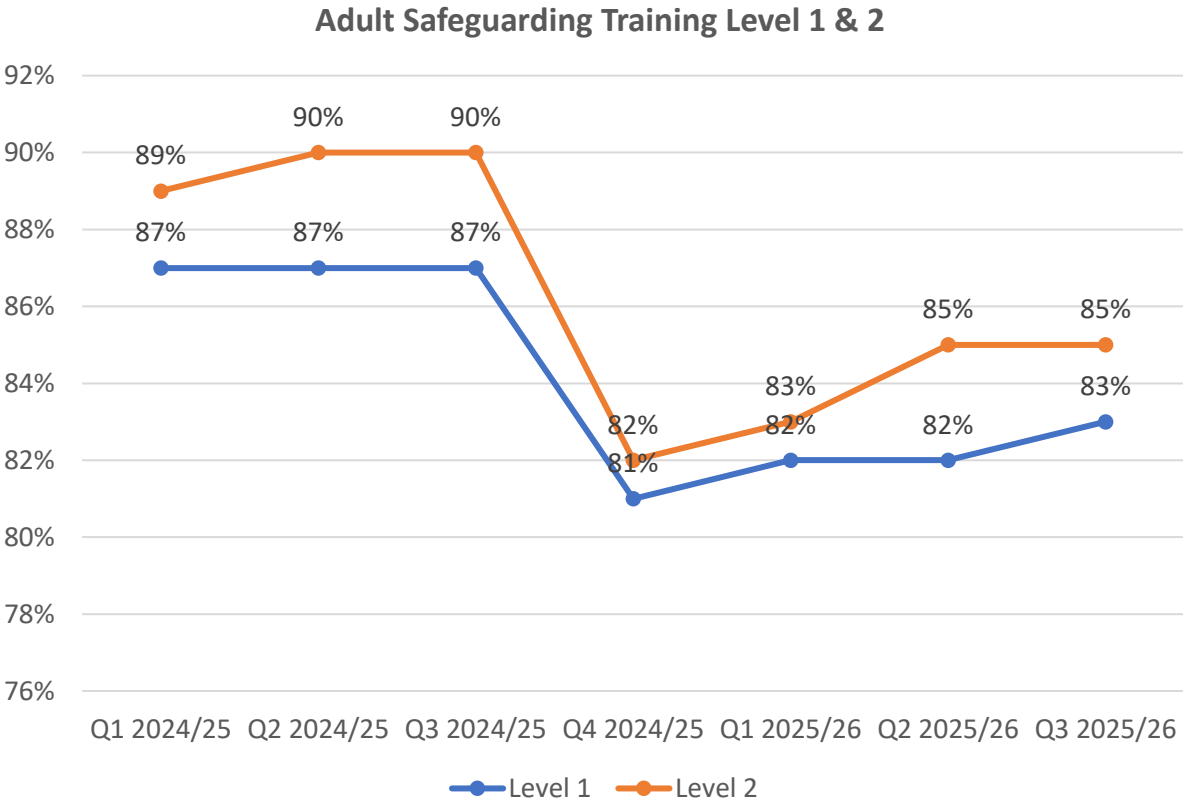
Support and Advice

Advice & Support given by CST



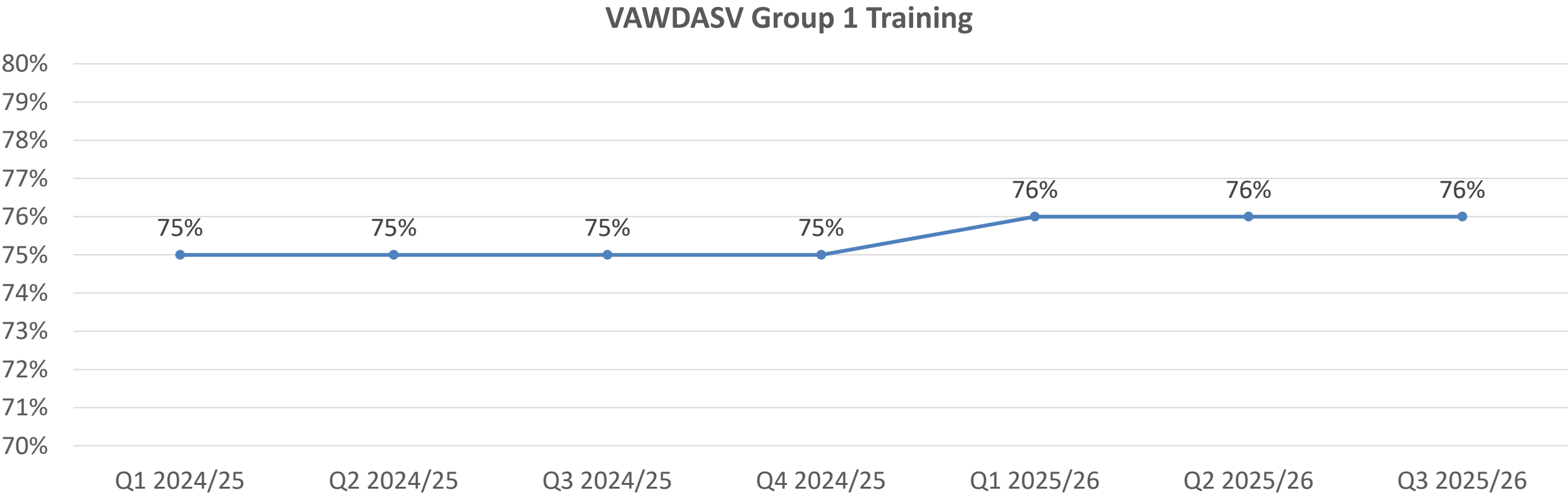
Definition	Analysis	Implications
The information presented has been extracted from RL Datix and is accurate at the point of recording. This information relates to cases where staff, volunteers or independent contractors have been referred into the Section 5 Process of Wales Safeguarding procedures, which focusses on assessing transferable risk and co-ordinating investigations.	The number of referrals in relation to 'persons in a position of trust' have remained stable through the three quarters of this financial year. However, this is an increase on the previous financial year, climbing from 81 to 96 (the first three Qs). The number of contacts to the safeguarding team for advice and support has significantly increased throughout this financial year. The entirety of 2024/25 saw the same level of activity at just Q3 2025/26. This is beneficial as it allows for referrals to be made in a timely and appropriate way, however, a number of these cases can be highly complex and out own learning can be delayed due to formal police investigations.	The People in Positions of Trust Policy will be launched in January 2026. To address the number of 'persons in a position of trust' referrals, Patient and Staff Guidance for intimate examinations is under production with a listening event scheduled for Q4 to properly understand adverse patient experience

Training Compliance



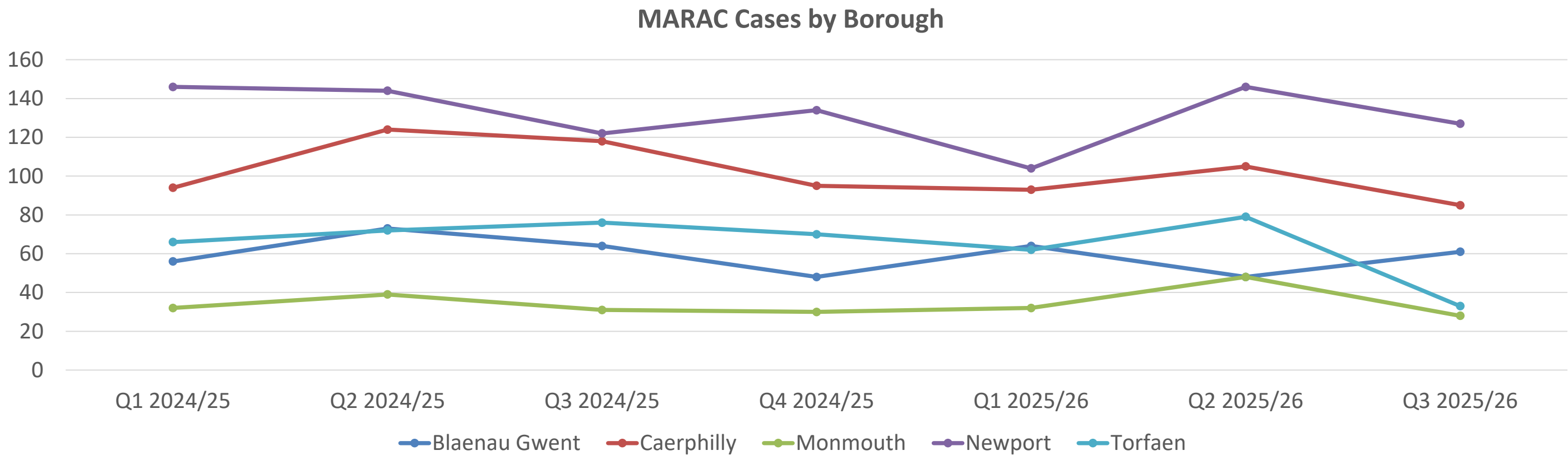
Definition	Analysis	Implications
The information presented has been extracted from ESR and was accurate at the end of Q3. This information relates to Compliance with the three mandated levels of Safeguarding Children and Safeguarding Training. Safeguarding training continues to be provided and monitored, in line with the recommendations of the Intercollegiate Documents for Safeguarding of Children and Adults.	Safeguarding training levels 1 and 2, for both adult and children have followed similar trends, a significant drop between Q3 and Q4 2024/25 and then improvements seen in Q1, 2 & 3 this year. The expectation is that 85% compliance is achieved for all three levels. Safeguarding level 3 which was introduced in Q1 2025/26 has seen consistent improvements over this financial year.	Improved Divisional support and attendance at Safeguarding Strategic Group is noted and welcomed. Children’s safeguarding training remains below the expected compliance of 85%. Divisional support with groups has improved and monitored in the Children and Young People’s sub group. Over 6000 staff in total require training for adult safeguarding level 3 training. Staffing to deliver training and attendees has been challenging however recovery plan has been implemented and increases are continuing. Training is now monitored on a monthly basis and reported on. Divisional support from member of the Safeguarding Strategic Group and sub groups has been sought and support with the recovery plans have been agreed.

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



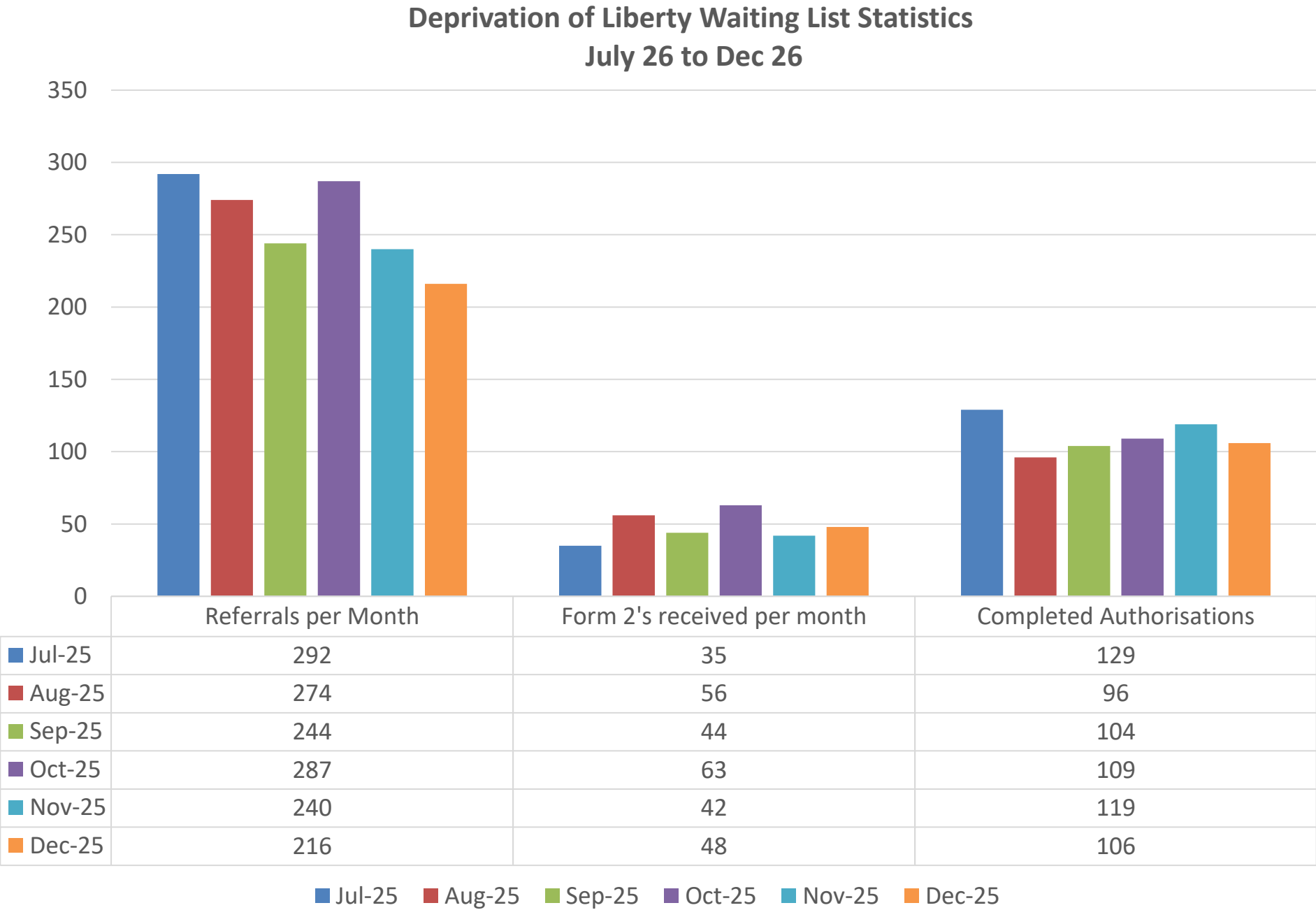
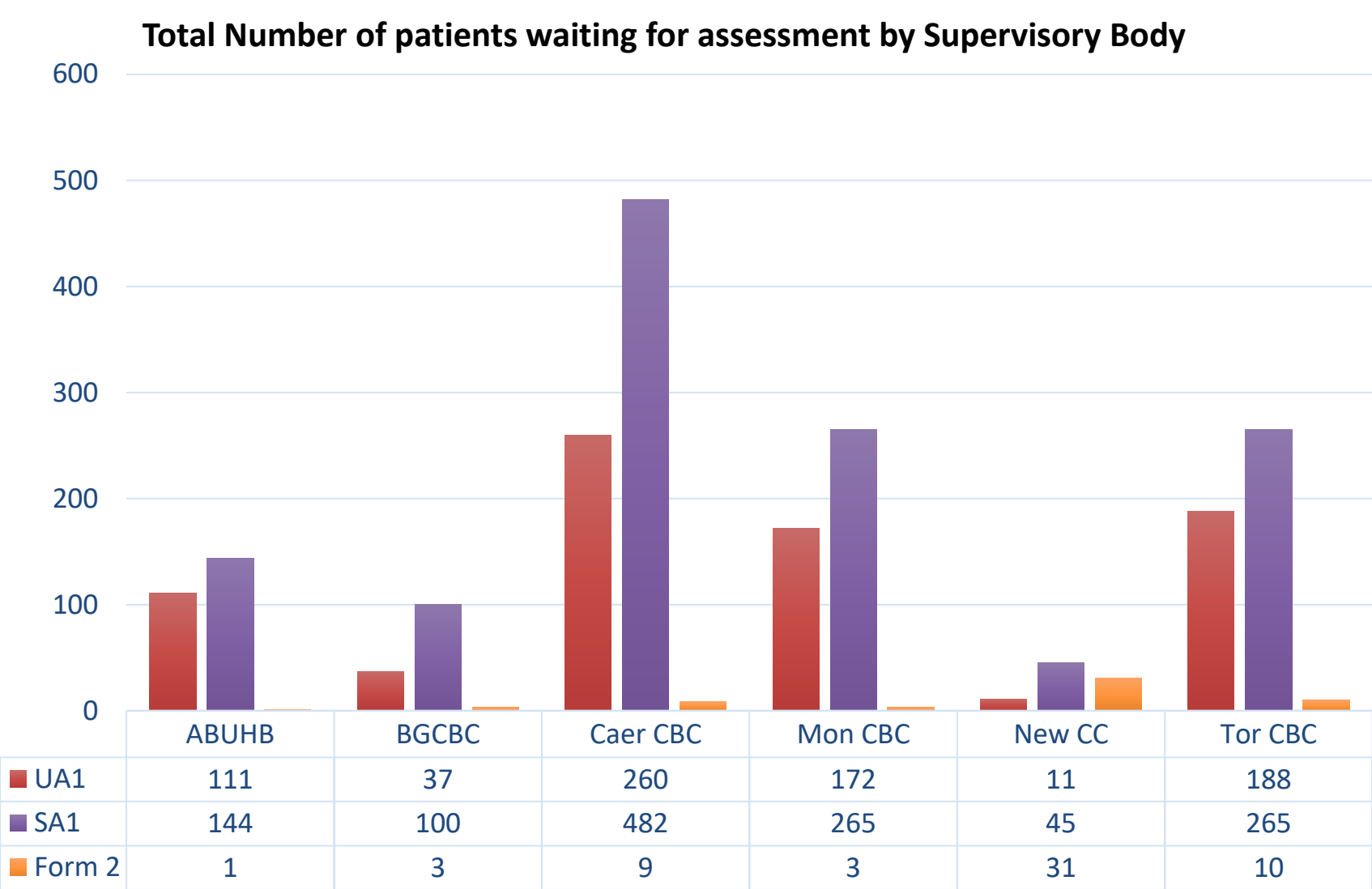
Definition	Analysis	Implications
The information presented in regard of Ask and Act Training has been extracted from ESR and was accurate at the end of Q3. This information demonstrates compliance with the Group 1 Training, Ask and Act is nationally mandated, with different staff groups identified as requiring different levels of training. Group 1 is completed online, via e- learning and is mandated to all staff working within the health board. Group 2 is targeted training, aimed at staff who will be working with patients who may have experienced VAWDASV.	The health board has a target of 85% compliance for Group 1 and Group 2. Current compliance for Group 1 is 76%, which is only an increase of 1% from the last six quarters. The target for compliance is 85%, Having worked with Divisions to identify where in the organisation Group 2 would apply, the Corporate Safeguarding Team are currently working with the ESR Team to determine the exact number of staff who will require Group 2 training.	Group 1 compliance is monitored by Welsh Government through the annual VADASV report. Whilst we are unlikely to be an outlier, this will draw some external scrutiny. This risk will be formally escalated and a recovery plan requested from Divisions, via the Strategic Safeguarding Group. The Group 2 training is nationally prescribed as four-hour training, which has to be co-delivered with the third sector specialist Domestic Abuse providers. As such, the health board will be required to make provision of a trainer from within the corporate safeguarding team and finding for the identified third sector provider. An SBAR has been prepared foe the executive committee, outlining the expected volume of staff that will require the training and highlighting the risks associated with resourcing this.

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



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

Deprivation of Liberty (DoLS)



Additional Measures

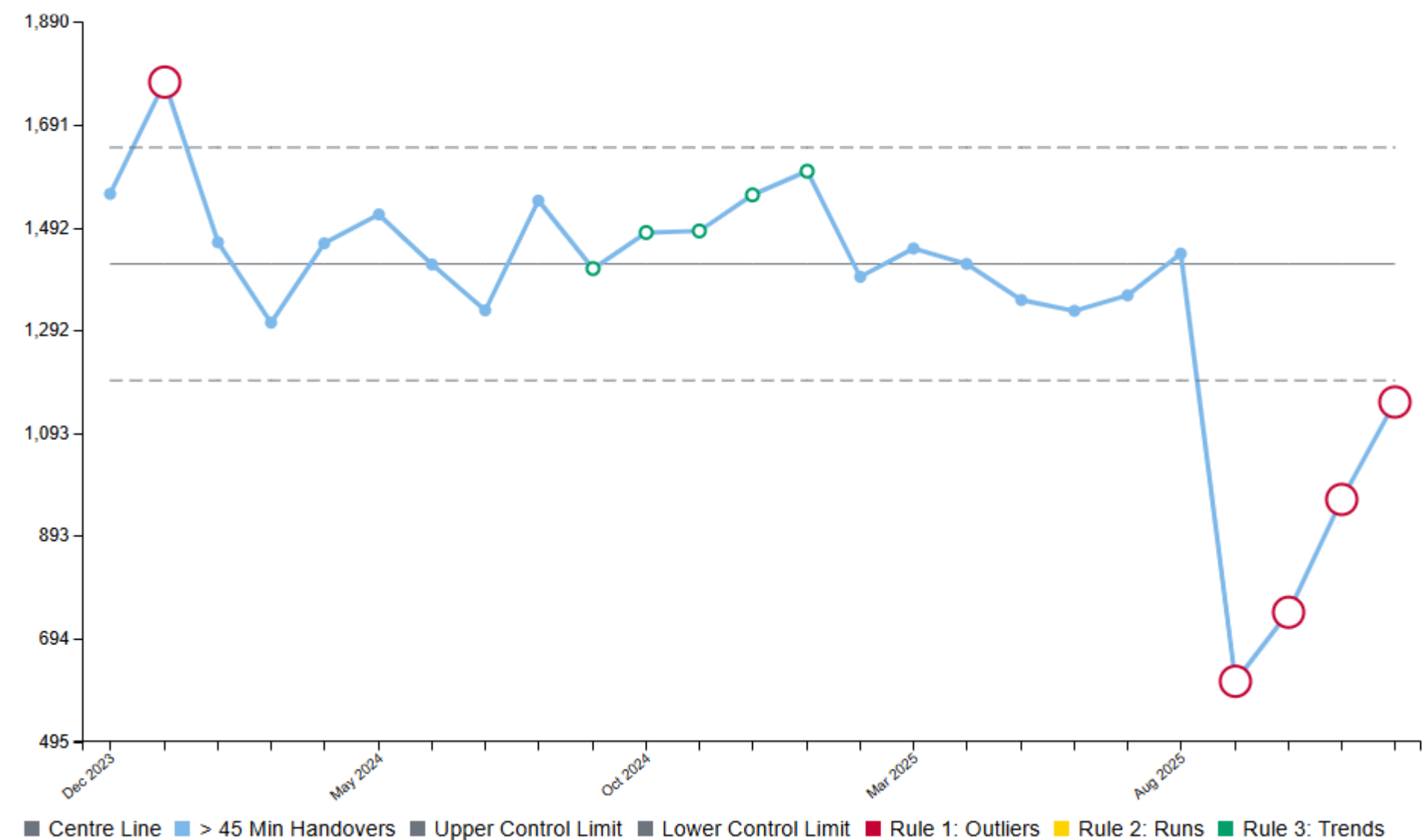
Failed Discharges (readmission within 7 days) per Month (including current)

Outlier = Red (beyond limits), Run = Yellow (7 or more above/below median), Trend = Green (5 or more increasing/decreasing)



> 45 Min Handovers per Month (including current)

Outlier = Red (beyond limits), Run = Yellow (7 or more above/below median), Trend = Green (5 or more increasing/decreasing)



National Quality Outcomes Framework Measures

Safe

ABU UHB Phase 1 Quality Outcome Framework measures

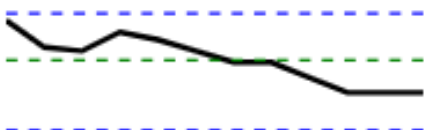
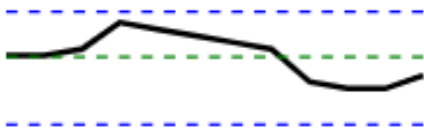
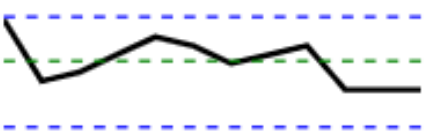
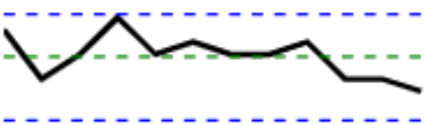
Quality Standard	Measure	Latest period	Latest figure	Previous figure	Last 12 months	Outlier
Safe	Antibacterial items per 1,000 STAR-PUs	Sep-25	234.62	244.97		
Safe	Crude mortality rate (%)	Nov-25	1.39%▲ 2.1%	1.36%		
Safe	Never Events reported to NHS P&I	Dec-25	0	0		
Safe	Percentage of discharges on D2RA Pathway 0	Dec-25	38.93%▲ 19.3%	32.64%		Outlier high
Safe	Percentage of discharges on D2RA Pathway 1	Dec-25	12.72%▲ 29.7%	9.81%		Outlier high
Safe	Percentage of discharges on D2RA Pathway 2	Dec-25	6.75%▲ 38.3%	4.88%		
Safe	Percentage of discharges on D2RA Pathway 3	Dec-25	2.27%▲ 12.4%	2.02%		
Safe	Percentage of discharges with no D2RA Pathway Allocated	Dec-25	39.33%▼ -22.4%	50.65%		
Safe	RAMI (Risk adjusted mortality index) 2023	Nov-25	194.65▲ 91.5%	101.63		Outlier high
Safe	Safeguarding Adults - Lv1 training	Sep-25	83.13%▲ 0.0%	83.12%		

All Wales Phase 1 Quality Outcome Framework measures

Quality Standard	Measure	Latest period	Latest figure	Previous figure	Last 12 months	Outlier
Safe	Antibacterial items per 1,000 STAR-PUs	Sep-25	224.65	231.99		
Safe	Crude mortality rate (%)	Nov-25	1.58%▲ 2.3%	1.55%		
Safe	Never Events reported to NHS P&I	Dec-25	4▲ 33.3%	3		
Safe	Percentage of discharges on D2RA Pathway 0	Dec-25	58.89%▲ 10.0%	53.52%		
Safe	Percentage of discharges on D2RA Pathway 1	Dec-25	13.35%▲ 16.9%	11.42%		Outlier high
Safe	Percentage of discharges on D2RA Pathway 2	Dec-25	4.56%▲ 17.8%	3.87%		
Safe	Percentage of discharges on D2RA Pathway 3	Dec-25	3.36%▲ 15.2%	2.91%		Outlier high
Safe	Percentage of discharges with no D2RA Pathway Allocated	Dec-25	19.84%▼ -29.8%	28.28%		
Safe	RAMI (Risk adjusted mortality index) 2023	Nov-25	189.24▲ 58.2%	119.64		Outlier high
Safe	Safeguarding Adults - Lv1 training	Sep-25	88.42%▼ -0.2%	88.61%		

National Quality Outcomes Framework Measures

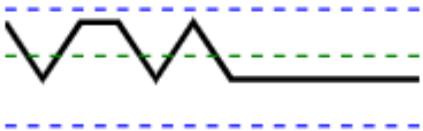
Timely

ABU UHB Timely Phase 1 Quality Outcome Framework measures							
Quality Standard	Measure	Latest period	Latest figure		Previous figure	Last 12 months	Outlier
Timely	Opthalmology R1 appointments attended within target date* (%)	Nov-25	48.77%	▲ 0.4%	48.58%		
Timely	Patients starting first definitive cancer treatment* (%)	Nov-25	60.11%	▲ 4.4%	57.56%		
All Wales Timely Phase 1 Quality Outcome Framework measures							
Quality Standard	Measure	Latest period	Latest figure		Previous figure	Last 12 months	Outlier
Timely	Opthalmology R1 appointments attended within target date* (%)	Nov-25	57.54%	▼ -1.0%	58.11%		
Timely	Patients starting first definitive cancer treatment* (%)	Nov-25	58.44%	▼ -1.6%	59.38%		

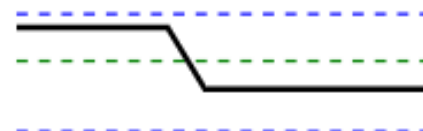
National Quality Outcomes Framework Measures

Effective

ABU UHB Efficient Phase 1 Quality Outcome Framework measures

Quality Standard	Measure	Latest period	Latest figure	Previous figure	Last 12 months	Outlier
Efficient	Agency spend for all staff groups as % of total pay bill	Sep-25	3.13% ▲ 24.1%	2.52%		

All Wales Efficient Phase 1 Quality Outcome Framework measures

Quality Standard	Measure	Latest period	Latest figure	Previous figure	Last 12 months	Outlier
Efficient	Agency spend for all staff groups as % of total pay bill	Sep-25	2.17% ▲ 12.0%	1.94%		

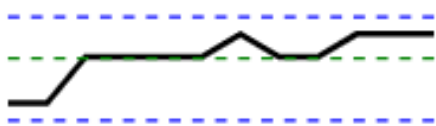
National Quality Outcomes Framework Measures

Efficient

ABU UHB Effective Phase 1 Quality Outcome Framework measures

Quality Standard	Measure	Latest period	Latest figure	Previous figure	Last 12 months	Outlier
Effective	Diabetes patients completing all eight care processes* (%)	Dec-25	44.62%	44.62%		

All Wales Effective Phase 1 Quality Outcome Framework measures

Quality Standard	Measure	Latest period	Latest figure	Previous figure	Last 12 months	Outlier
Effective	Diabetes patients completing all eight care processes* (%)	Dec-25	44.87%	44.87%		

Patient Safety Leadership Visits – Summary

Purpose:

Promote a proactive safety culture across ABUHB.

Key Aims:

Show senior leadership commitment to safety.

Identify and act on safety concerns.

Improve communication and transparency.

Support learning from adverse events.

Who's Involved:

Executive Directors, Independent Board Members, local multidisciplinary teams, and an assistant (to scribe).

Visit Format:

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

Outcome:

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



Overview - October – December 2025

Areas Visited 7

RGH

- D3 West
- Surgical High Care

Children's Centres

- Serennu
- Caerphilly
- Nevill Hall

GUH

- Maternity
- Neonatal



Cancelled Visits: 6

- **Endoscopy, RGH (03/10/2025)** – cancelled by ward (Directorate and clinical leads visiting)
 - **D4 East RGH (03/10/2025)** – cancelled due to covid
 - **Surgical High Care Assessment Unit (A1), GUH** - Cancelled by Executive
 - **Cardiology (A2), GUH** - Cancelled by Executive
 - **Pharmacy, GUH** – Cancelled due to the reintroduction of mask wearing and enhanced infection prevention measures.
 - **C4 East, GUH** - Cancelled due to the reintroduction of mask wearing and enhanced infection prevention measures.
- All will be rescheduled for 2026

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

Positive Findings: Children's Centres October – December 2025

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



Patient Safety Leadership Visits



Positive Findings – Maternity and Neonatal October – December 2025

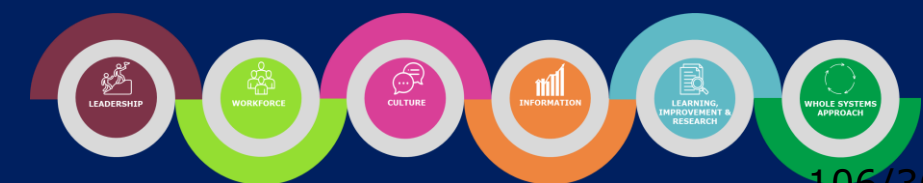
Maternity

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



Neonatal

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



Common Issues

Digital & Technology

- Limited or unreliable Wi-Fi in several areas, impacting clinical systems and staff efficiency.
- Equipment maintenance delays affecting workflow (e.g., hoists, alarms, door mechanisms).

Confidentiality & Privacy

- Shared or open admin spaces reducing confidentiality for sensitive discussions.
- Limited private rooms for clinical conversations and family support.

Operational & Planning

- Space constraints affecting safe patient flow and activity delivery.
- Increasing service demand without corresponding expansion of facilities.



Staffing & Culture

- Strong teamwork and peer support across services, creating a positive and collaborative culture.
- High workload pressures due to increasing service demand, affecting staff wellbeing.

Health & Safety

- Environmental wear and tear (e.g., flooring, equipment deterioration).
- Cleaning and hygiene gaps at peak times (e.g., playmats, shared spaces).

Patient Flow & Transport

- Discharge bottlenecks contributing to congestion and capacity challenges.
- Complex patient needs resulting in longer stays and increased staff workload.

Community & Service Engagement

- Ongoing need to improve patient understanding of service expectations.
- Ongoing need for consistent communication across services to ensure clarity for families.
- Reliance on charitable partners to support family-centred initiatives.

Examples of Completed Actions

Children's Centres – Serennu, Caerphilly and Nevill Hall

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



19 Hills Health and Wellbeing Centre

- **SOP for Management of an Unwell Patient** – SOP established to support consistent and safe response in shared areas.

Vaccination Centre

- **Data capture review** – Processes reviewed; assurance gained that all required data is being recorded.

Examples of Completed Actions

Neonatal - GUH

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

Maternity - GUH

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

AMU - GUH

- **Serious Incident learning** – Ongoing programme of SI learning in progress (on SI 2 of 5), with strong staff engagement.

Decontamination Unit - GUH

- Checklist compliance issues addressed – Linked with Operational Decontamination Manager; included in theatres' "Back 2 Basics" teaching to improve compliance.
- Electronic scanning limitations noted – Incorporated into theatre documentation review to strengthen traceability.

A0 - GUH

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



Examples of Completed Actions

Ward 3-2 - NHH

- **Charitable funds awareness** – Team informed about charitable funding available for equipment such as wheelchairs and replacement chairs.

AMU – NHH

- **Improved signage** – Clear signage installed to help patients and visitors navigate the unit more easily.

Endoscopy – NHH

- **Shared toilet risk assessment completed** – H&S and Infection Control involved, with actions identified.
- **Data protection concerns addressed** – Quotes obtained for creating private spaces to support patient confidentiality during booking and discharge.

Bargoed Ward 2/2 - YYF

- **SWARMS initiative** – Continued engagement with nursing staff, encouraging involvement from therapy and medical colleagues.
- **Therapy room usage** – Escalated to senior management; plan agreed with daily review to ensure suitable access.

Breast Unit - YYF

- **Water fountain installed** – Added for patient use due to long clinic waits.
- **Hearing loop installed** – Improved accessibility for patients with hearing needs.

D3 West - RGH

- **Violence & Aggression ESR training** – All staff reminded to complete mandatory module to improve safety and awareness.
- **Cold debriefs/time-outs introduced** – Implemented following incidents to support staff reflection and wellbeing.

Outstanding Actions

3 Primary Care & Community Ward

- Details of patients' enhanced care status not always provided at handover.
- Providing enhanced care support from core staffing for more than 6 patients when temporary staff not available.
- Safety issues around boarding patient in dayrooms during acute service pressures.
- Frequent cancellation of transport for patients attending orthopaedic clinics at LGHs.
- Insufficient laptops available. Plus being broken when fixed screens close.
- iPads screens small and tablets not regularly updated.
- CWS2 system frequently failing.
- Limited integration between Health Board systems impacting workflow.



For Information

Clinical Effectiveness

Clinical Standards and Effectiveness Group - Processes

Healthcare Quality Improvement Programme (HQIP) Reporting and Communication Process

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

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

Action Planning and Governance - Prior to CSEG meetings, QPS will liaise with the Clinical Lead and Divisional/Directorate Management to confirm that all actions align with report recommendations. Local actions will be defined using the S.M.A.R.T. framework and assigned a six-month review date. New Procedure Applications - Applications for new procedures are considered within the CSEG forum. To date, five applications have been approved.

HQIPO Ref.	Abbrev.	Programme Name	PUBLICATION DATE	CSEG
714	FFFAP	National Audit of Inpatient Falls (NAIF) - State of the Nation Report 2026	08/10/2026	IP Falls Group
722	NNAP	National Neonatal Audit Programme - State of the Nation Report 2026	08/10/2026	CSEG Nov 2026
717	NCAP	National Clinical Audit of Psychosis - State of the Nation Report 2026	08/10/2026	CSEG Nov 2026
716	NELA	Emergency Laparotomy - State of the Nation Report 2026 (Eleventh Annual)	08/10/2026	CSEG Nov 2026
718	FFFAP	National Hip Fracture Database (NHFD) - State of the Nation Report 2026	10/09/2026	CSEG Nov 2026
706	MNI	Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal Mortality and Morbidity Surveillance and Confidential Enquiry 2026 Report	10/09/2026	CSEG Nov 2026
711	Epilepsy12	Epilepsy12 - State of the Nation Report 2026	09/07/2026	CSEG Sep 2026
719	NATCAN	National Ovarian Cancer Audit (NOCA) - State of the Nation Report	11/06/2026	Cancer Board
705	MNI	Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance 2026 Report (2024 births)	11/06/2026	CSEG Jul 2026

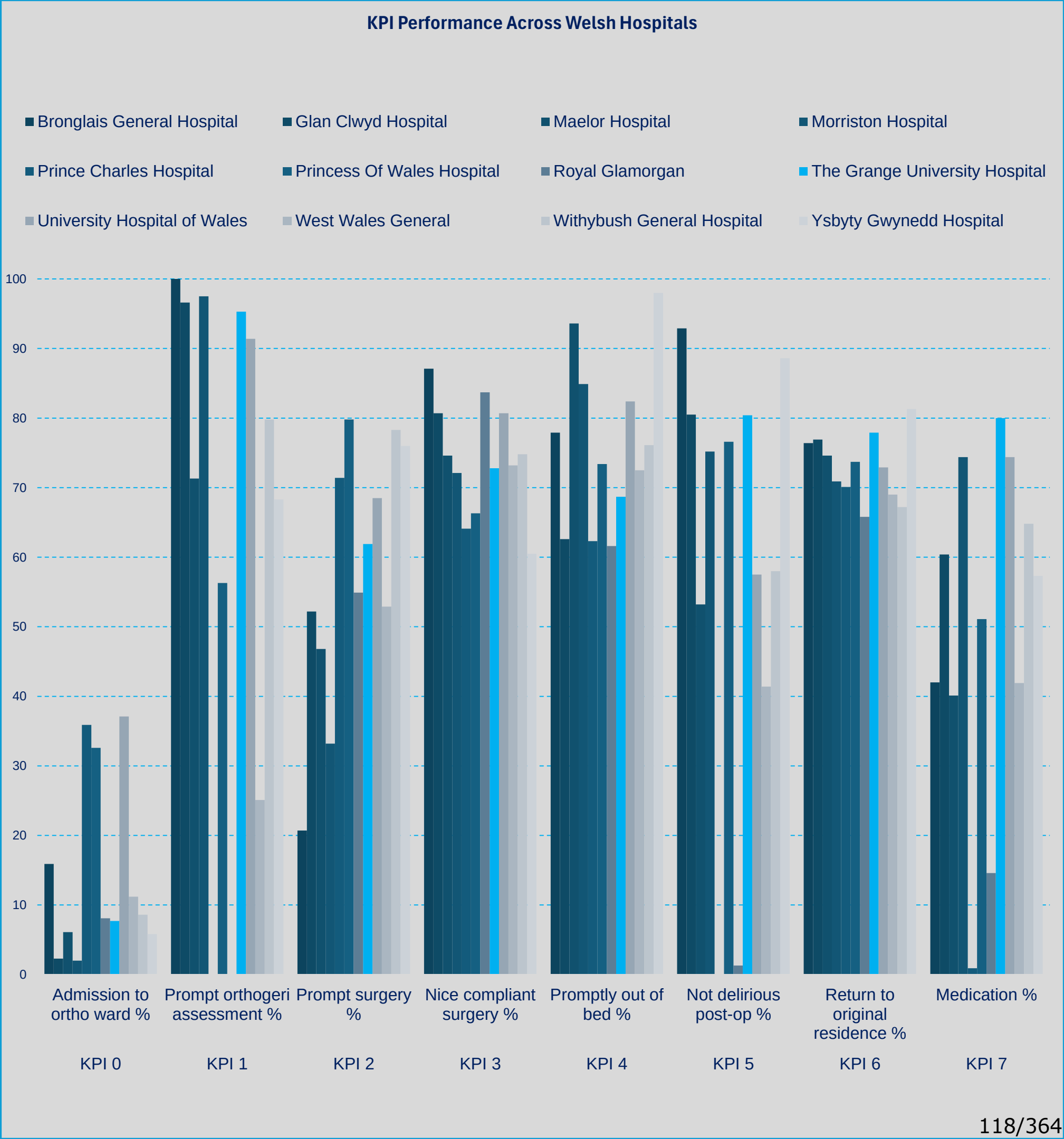
HQIPO Ref.	Abbrev.	Programme Name	PUBLICATION DATE	CSEG
691	NRAP	National Respiratory Audit Programme (NRAP) - State of the Nation 2026 Report	11/06/2026	NRAP
651	NRAP	National Respiratory Audit Programme (NRAP) - Asthma and COPD Primary Care Report	14/05/2026	CSEG Jul 2026
640	NATCAN	National Lung Cancer Audit (NLCA) - State of the Nation Report	09/04/2026	Cancer Board
702	NMPA	National Maternity and Perinatal Audit - Multiple Births Report	12/03/2026	CSEG May 2026
659	NPDA	National Paediatric Diabetes Audit (NPDA) Annual Core State of the Nation Report (2026)	12/03/2026	CSEG May 2026
701	NCISH	Mental Health Clinical Outcome Review Programme - National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) - State of the Nations Report	12/02/2026	CSEG Mar 2026
699	NCAP	National Clinical Audit of Psychosis (NCAP) - State of the Nation Report 2026	12/02/2026	CSEG Mar 2026
641	FFFAP	Fracture Liaison Service Database (FLSD) - State of the Nation Report	08/01/2026	CSEG Feb 2026
NICOR	NICOR 2024/2025 2nd Ed	National Audit of Cardiac Rhythm Management (NACRM) 2024/2025	11/12/2025	CSEG May 2026
NICOR	NICOR 2024/2025 2nd Ed	Myocardial Ischaemia National Audit Project (MINAP) 2024/2025	11/12/2025	CSEG May 2026
NICOR	NICOR 2024/2025 2nd Ed	National Audit of Percutaneous Coronary Interventions (NAPCI) 2024/2025	11/12/2025	CSEG May 2026
NICOR	NICOR 2024/2025 2nd Ed	National Heart Failure Audit (NHFA) 2024/2025	11/12/2025	CSEG May 2026

HQIPO Ref.	Abbrev.	Programme Name	PUBLICATION DATE	CSEG
617	NCEPOD	Child Health Clinical Outcome Review Programme - Emergency paediatric surgery	11/12/2025	TBC for later date
574	NVR	National Vascular Registry (NVR) - State of the Nation 2025 Report	13/11/2025	CSEG Feb 2026
546	NMPA	National Maternity and Perinatal Audit - Induction of labour snapshot report	13/11/2025	CSEG Mar 2026
650	SSNAP	Sentinel Stroke National Audit Programme - State of the Nation report	13/11/2025	Stroke Board
619	NCEPOD	Child Health Clinical Outcome Review Programme - Acute limb ischaemia	13/11/2025	NCEPOD - ABUHB not selected to participate
639	NATCAN	National Bowel Cancer Audit (NBOCA) - State of the Nation Report	09/10/2025	CSEG Feb 2026
605	NELA	NELA - National Emergency Laparotomy Audit - Year 10 State of the Nation report	09/10/2025	CSEG Jan 2026
583	NEIAA	NEIAA - National Early Inflammatory Arthritis Audit - State of the Nation Report 2026	09/10/2025	CSEG Jan 2026
588	FFFAP	National Audit of Inpatient Falls (NAIF) State of the Nation Report 2025	09/10/2025	IP Falls Group
551	NRAP	National Respiratory Audit Programme - Asthma Secondary Care Secondary care outcomes report	09/10/2025	NRAP
638	NATCAN	National Prostate Cancer Audit (NPCA) - State of the Nation Report	11/09/2025	Cancer Board
637	NATCAN	National Oesophagogastric Cancer Audit (NOGCA) - State of the Nation Report	11/09/2025	Cancer Board
636	NATCAN	National Kidney Cancer Audit (NKCA) - State of the Nation Report	11/09/2025	Cancer Board
635	NATCAN	National Non-Hodgkin Lymphoma Audit (NNHLA) - State of the Nation Report	11/09/2025	CSEG Feb 2026

HQIPO Ref.	Abbrev.	Programme Name	PUBLICATION DATE	CSEG
634	NATCAN	National Pancreatic Cancer Audit (NPaCA) - State of the Nation Report	11/09/2025	Cancer Board
633	NATCAN	National Ovarian Cancer Audit (NOCA) - State of the Nation Report	11/09/2025	Cancer Board
632	NATCAN	National Metastatic Breast Cancer Audit (NAoMe) - State of the Nation Report	11/09/2025	Cancer Board
631	NATCAN	National Primary Breast Cancer Audit (NAoPri) - State of the Nation Report	11/09/2025	Cancer Board
618	NCEPOD	Medical and Surgical Clinical Outcome Review Programme - Blood sodium report	11/09/2025	TBC for later date
520	NACEL	NACEL - National Audit of Care at the End of Life - State of the Nation Report	14/08/2025	NACEL
616	NRAP	NRAP - National Respiratory Audit Programme - State of the Nation report - Children and young people’s asthma: Elements of care received by children admitted with near-fatal asthma	12/06/2025	CSEG Feb 2026
616	NRAP	National Respiratory Audit Programme - State of the Nation Report - Adult asthma: Variation in the completion of a discharge bundle	12/06/2025	NRAP
616	NRAP	National Respiratory Audit Programme - State of the Nation Report - COPD: Key elements of discharge bundle provided as part of discharge	12/06/2025	NRAP
616	NRAP	National Respiratory Audit Programme - State of the Nation Report - Pulmonary Rehabilitation: Timely access to pulmonary rehabilitation	12/06/2025	NRAP
552	NCEPOD	Medical and Surgical Clinical Outcome Review Programme - ICU Rehabilitation report	12/06/2025	TBC for later date
NICOR	NICOR 2023/2024	National Audit of Cardiac Rhythm Management (NACRM)	01/04/2025	TBC for later date
553	NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health – UK patient and general population data 2012-2022 - Annual Report 2025	13/02/2025	CSEG Mar 2026

HQIPO Ref.	Programme Name	Name of publication	PUBLICATION DATE	CSEG	Outcome
580	NNAP	NNAP - National Neonatal Audit Programme - State of the nation report 2026	09/10/2025	CSEG Nov 2025	Presented
545	NMPA	National Maternity and Perinatal Audit - State of the nation report (containing 5 years of data)	14/08/2025	CSEG Nov 2025	Presented
NICOR	NICOR 2023/2024	Myocardial Ischaemia National Audit Project (MINAP)	01/04/2025	CSEG Nov 2025	Presented
NICOR	NICOR 2023/2024	National Audit of Percutaneous Coronary Interventions (NAPCI)	01/04/2025	CSEG Nov 2025	Presented
578	MNI	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal Mortality Surveillance and Confidential Enquiry 2025 Report	09/10/2025	CSEG Nov 2025	Presented
581	MNI	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance 2025 State of the nation Report	12/06/2025	CSEG Nov 2025	Presented
501	MNI	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal confidential enquiry	12/12/2024	CSEG Nov 2025	Presented
500	MNI	MNI - Maternal, Newborn and Infant Clinical Outcome Review Programme - Saving lives, improving mothers care report (2021-2023, UK wide)	10/10/2024	CSEG Nov 2025	Presented
577	FFFAP	National Hip Fracture Database (NHFD) - State of the Nation 2025 report	11/09/2025	CSEG Nov 2025	Presented

Room for Improvement: hip fracture care in 2024 – a report from the National Hip Fracture Database (NHFD) Jan-Dec 2024		Clinical Lead: Dr Muhammad Usman – Orthopaedic Physician	
Rationale:	Hip fractures are the most common serious injury in frail older adults and the leading reason they require anaesthesia and surgery. For 16 years, the NHFD has reviewed the care of every person over 60 who sustains this injury. Hip fractures require hospital admission and occupy one in 30 hospital beds, costing around £2 billion annually. Most patients are over 80, and although demographic trends suggest numbers could double by 2060, improvements in population health—such as better osteoporosis management – may explain why this rise has not yet been observed.		
Objectives:	Around 70,000 people in England, Wales and Northern Ireland sustain a hip fracture each year, a number that could double by 2060 as the population ages. Improving care and preventing these injuries remains essential. This report examines how 2024 are aligned with key patient goals: • Admission - how soon will I be made comfortable and admitted to the right ward? • Operation - how is my operation explained and supervised, so I can get up afterwards? • Rehabilitation - how will I be supported to get back on my feet after surgery? • Care quality - will I receive the same quality of care as other people? • Care consistency - does every fracture lead to the same quality of care? While patient experience of care has improved enormously since the NHFD was created nearly 20 years ago, the report highlights variation. Most hospitals can be proud of their achievements, but this report shows how a number of hospitals have fallen behind in the care they are offering and discusses how the NHFD is helping them to catch up with the care being offered elsewhere.		



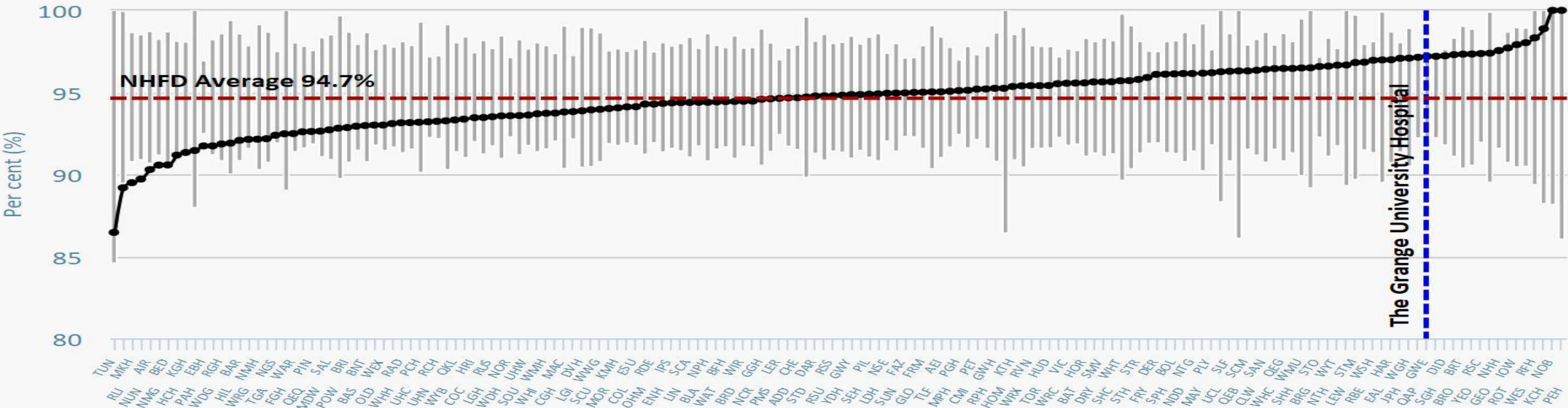
Assessment and Surgery Benchmarking for ABUHB 2021, 2022, 2023, 2024

Assessment Benchmarking		Number of cases submitted	Admitted to orthopaedic ward within 4 hours	4AT Test recorded on admission	Perioperative medical assessment	Physiotherapist assessment by the day after surgery	Mobilised out of bed by the day after surgery	Nutritional risk assessment	Not delirious when tested post-op.	Received falls assessment^	Received bone health assessment^	Met best practice criteria
GUH	2021	685	4.2	60.4	91.1	97	76.4	99.7	78.4	99.3	99	37
GUH	2022	746	9.1	73.3	93.3	97.4	75.1	96.2	79.9	99.3	99.2	39.5
GUH	2023	811	21.9	66.1	96.4	95.7	69.4	98.6	80.2	98.3	98.3	36.5
GUH	2024	751	12	75.6	95.3	98.2	68.7	99.7	81.1	98	98.3	44.4

Surgery Benchmarking		No. of cases submitted	Surgery on day of, or day after, admission	Surgery supervised by consultant surgeon and anaesthetist	General anaesthetic (not rated)	General anaesthetic and nerve block (of all GA)	Spinal anaesthetic (not rated)	Spinal anaesthetic and nerve block (of all SA)	Proportion of arthroplasties which are cemented	Eligible displaced intracapsular fractures treated with THR	Trochanteric fractures (excl. reverse oblique) treated with SHS	Subtrochanteric fractures treated with an IM nail
GUH	2021	685	66.9	47.3	30.8	89.7	68.4	89.4	99.4	24.4	81.3	92.1
GUH	2022	746	57.3	46.7	39.1	86.5	60.6	90.6	97.5	28	78.6	86.5
GUH	2023	811	56.9	44.3	40.7	95.3	59.3	92.1	99.5	30.9	71.9	81.8
GUH	2024	751	61.9	39.5	44.8	95.7	55	95.3	97.5	21.1	63.4	81

Survival At 30 Days (All NHFD Hospitals 2024)

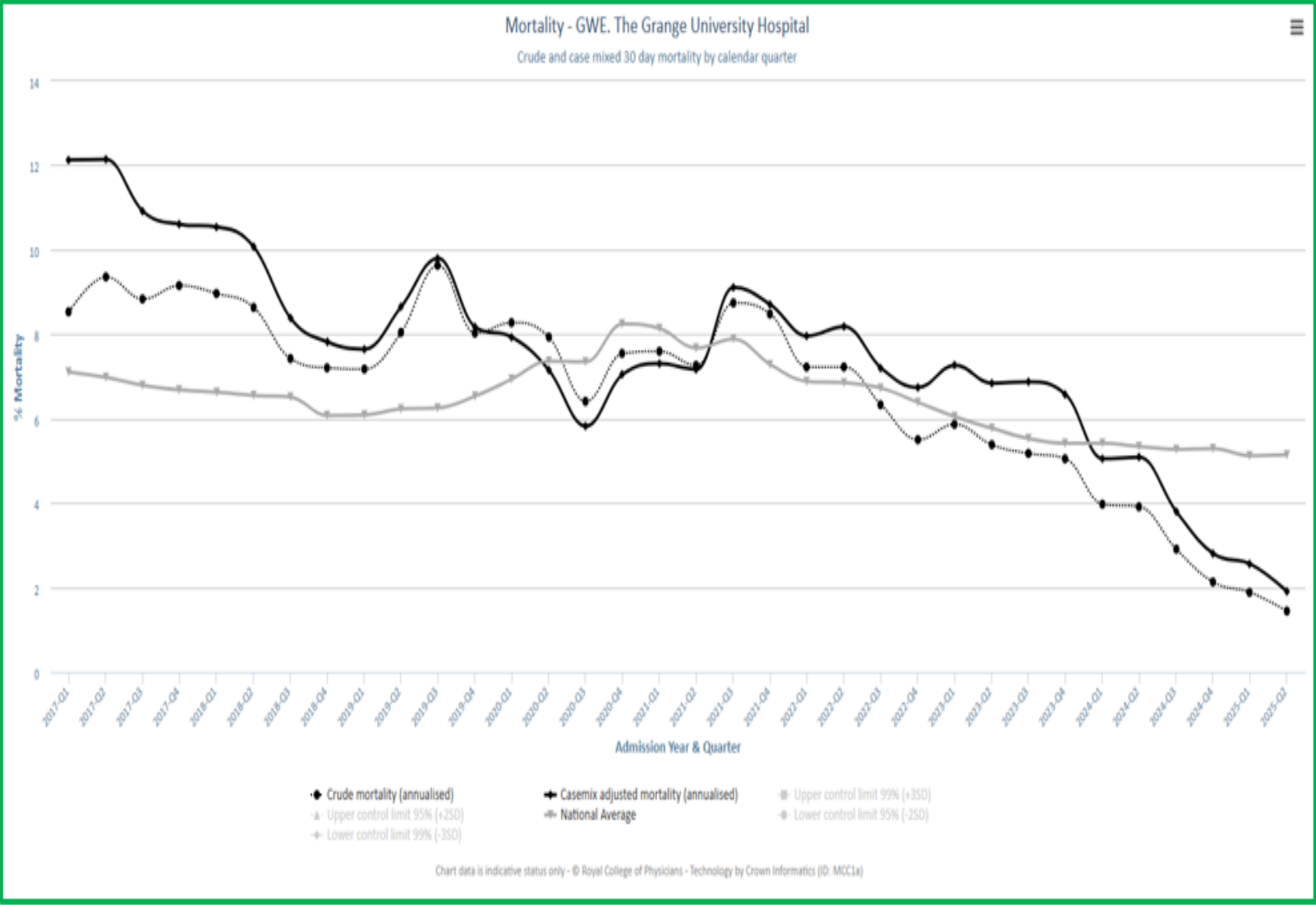
Variability of case mixed mortality. (vs. NHFD average: 94.7%)



Key performance GUH 2021-2024									
		KPI 0	KPI 1	KPI 2	KPI 3	KPI 4	KPI 5	KPI 6	KPI 7
		Admission to ortho ward %	Prompt orthogeriatric assessment %	Prompt surgery %	NICE compliant surgery %	Promptly out of bed %	Not delirious post-op %	Return to original residence %	Medication %
GUH	2021	2	91	67	72	76	77	73	56
GUH	2022	5.5	93.3	57.3	71.2	75.1	78.4	73.9	65.1
GUH	2023	16.9	96.4	56.9	78.1	69.4	79.8	76	73.7
GUH	2024	7.7	95.3	61.9	72.8	68.7	80.4	77.9	80
National	2024	9%	89%	58%	74%	82%	67%	75%	54%
Annualised values based on 767 cases averaged over 12 months to the end of August 2025, except KPI6 and KPI 7 which are delayed to allow for follow up data to be included.									

KPI's as at August 2025									
ABUHB data				WALES data				ENGLAND data	
KPI overview: GWE. The Grange University Hospital				KPI overview: [Wales]				KPI overview: [England]	
Annualised values based on 767 cases averaged over 12 months to the end of August 2025, except KPI6 and KPI 7 which are delayed to allow for follow up data to be included.				Annualised values based on 4,157 cases averaged over 12 months to the end of August 2025, except KPI6 and KPI 7 which are delayed to allow for follow up data to be included.				Annualised values based on 65,714 cases averaged over 12 months to the end of August 2025, except KPI6 and KPI 7 which are delayed to allow for follow up data to be included.	
0. Admission to specialist ward	1. Prompt orthogeriatric review	2. Prompt surgery	3. NICE compliant surgery	0. Admission to specialist ward	1. Prompt orthogeriatric review	2. Prompt surgery	3. NICE compliant surgery	0. Admission to specialist ward	1. Prompt orthogeriatric review
8%	95%	53%	68%	13%	67%	52%	66%	9%	90%
NHFD overall: 9%	NHFD overall: 89%	NHFD overall: 57%	NHFD overall: 70%	NHFD overall: 9%	NHFD overall: 89%	NHFD overall: 57%	NHFD overall: 70%	NHFD overall: 9%	NHFD overall: 89%
4. Promptly out of bed	5. Not delirious post-op	6. Return to original residence	7. Bone medication	4. Promptly out of bed	5. Not delirious post-op	6. Return to original residence	7. Bone medication	4. Promptly out of bed	5. Not delirious post-op
71%	82%	79%	73%	74%	56%	75%	53%	82%	69%
NHFD overall: 82%	NHFD overall: 68%	NHFD overall: 75%	NHFD overall: 57%	NHFD overall: 82%	NHFD overall: 68%	NHFD overall: 75%	NHFD overall: 57%	NHFD overall: 82%	NHFD overall: 68%
6. Return to original residence	7. Bone medication			6. Return to original residence	7. Bone medication			6. Return to original residence	7. Bone medication
75%	57%			75%	57%			75%	57%
NHFD overall: 75%	NHFD overall: 57%			NHFD overall: 75%	NHFD overall: 57%			NHFD overall: 75%	NHFD overall: 57%

GUH - Mortality at one month post Hip Fracture Surgery 2024/25



Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against
Risk level	Description
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon
Report Successes:	
1	Prompt Orthogeriatric assessment (KPI 1)
2	Not delirious post OP (KPI 5)
3	Bone Health Medication prescription on discharge (KPI 7)
4	Return to original residence (KPI 6)
5	Reduce mortality at one month
Report Concerns:	
1	Admission to Orthopaedic ward (KPI 0)
2	Adequate physiotherapy cover for prompt out of bed (KPI 4)

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:
1	Require emergency and orthopaedic departments to agree fast-track admission policies, so that at least one in five patients reach a specialist orthopaedic ward within 4 hours of admission with a hip fracture.	Trauma Review	Orthopaedic/A&E	Dec 2026
2	Review each hospital’s NHFD data to ensure that at least 95% of patients are able to access surgery, that this is documented as having been supervised by a senior surgeon and that it allows them to get up fully weightbearing.	Monthly clinical Governance meeting	Orthogeriatrics/ Orthopaedics	Implemented - Ongoing practice
3	Require each hospital to commission appropriate physiotherapy capacity so that all inpatients recovering from hip fracture can receive at least one session of physiotherapist-directed rehabilitation each weekend.	Trauma review	Therapy Dept/ Orthopaedics	Progress discussed with Clinical Lead
4	Require all hospital teams to review their use of injectable bone protection, so that at least half of all patients are recorded to be on bone strengthening medication 4 months after a hip fracture.	Bone health assessment as part of Orthogeriatric assessment	Orthogeriatrics team	Ongoing
5	NHS England and Welsh government should use the results of the audit of pelvic ring fracture we will be piloting from January 2026 to challenge the main formof inequity in the management of fragility fracture which, as both the NHFD and GIRFT have shown, relates to the care of people with fractures at different sites.	Will be collecting the data from January	Clinical Lead	July 2026

Rationale:

Scope:

The National Neonatal Audit Programme (NNAP) assesses whether babies admitted to neonatal units receive consistent high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards.

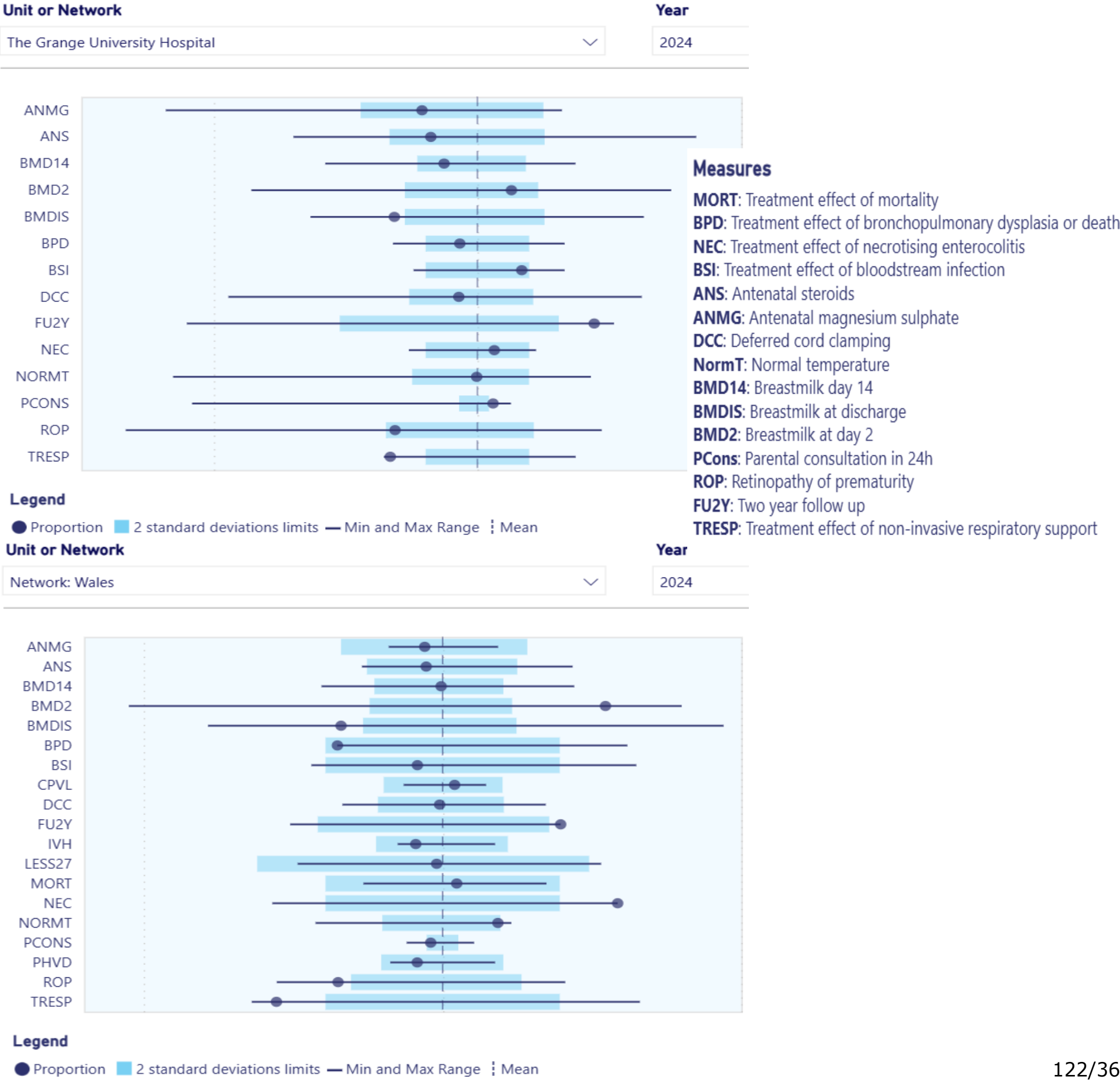
NNAP uses a range of measures to monitor neonatal care and highlight where improvement is required. These measures can vary from year to year and are categorised into the following themes:

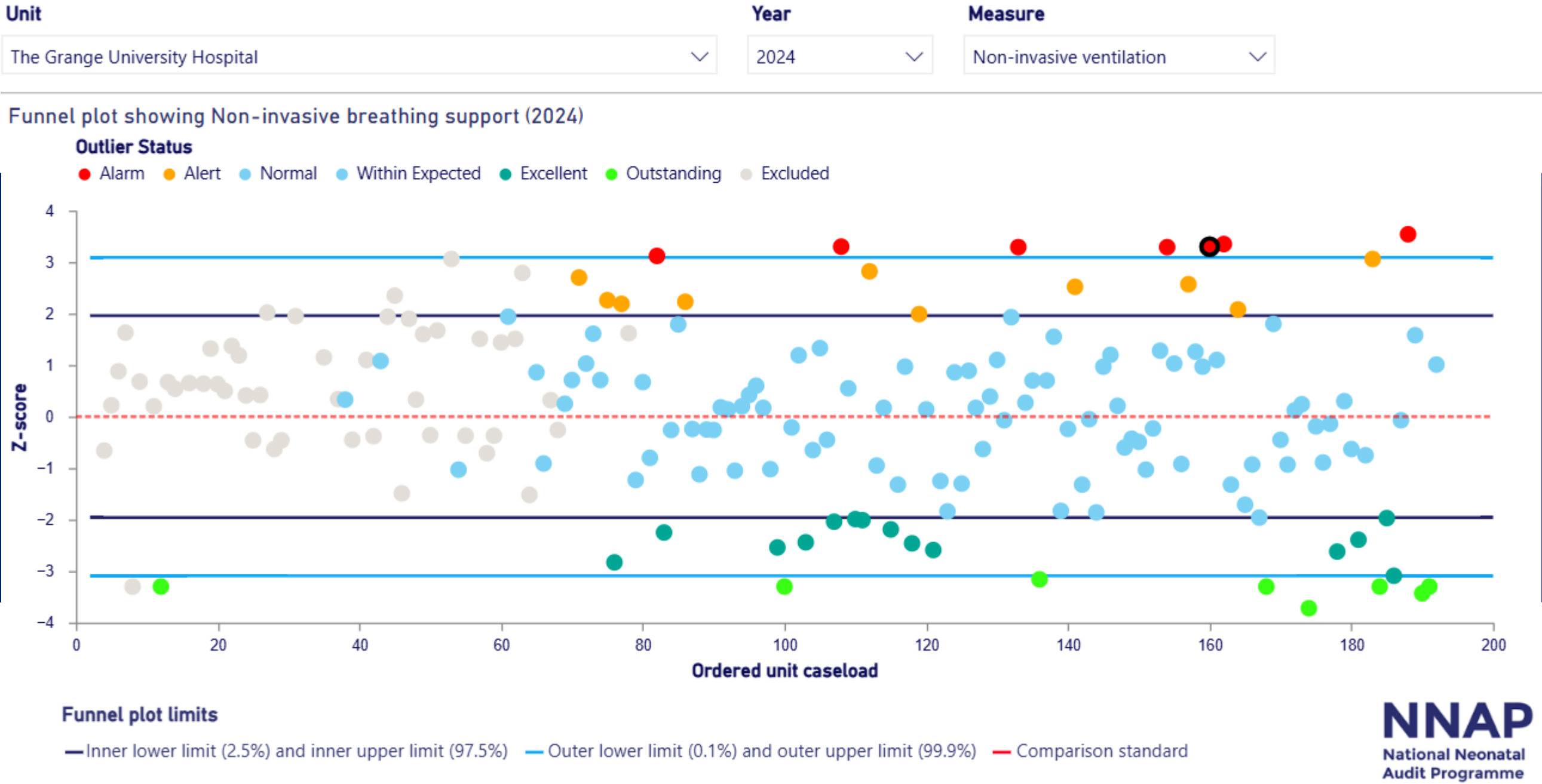
- Outcomes of neonatal care
- Optimal perinatal care
- Maternal breastmilk feeding
- Parental partnership in care
- Neonatal nurse staffing
- Care processes
- Overall network performance

Aims of the audit:

The NNAP has set out a series of supporting objectives, and approaches to stimulating healthcare improvement, which include:

- High quality data outputs that identify areas for action and support stakeholders’ improvement initiatives.
- Sharing best practice and quality improvement resources
- Collaboration and engagement with regional and national initiatives
- Parent and public engagement





Funnel plot showing Non-invasive breathing support (2024)

Outlier Status

Alarm

Alert

Normal

Within Expected

Excellent

Outstanding

Excluded

Funnel plot limits

Inner lower limit (2.5%) and inner upper limit (97.5%)

Outer lower limit (0.1%) and outer upper limit (99.9%)

Comparison standard

NNAP

National Neonatal Audit Programme

The Grange University Hospital is an outlier at ALARM level (3 or more std dev below expected performance)

Not seen any negative effect of the fact that our non-invasive ventilation rates in babies less than 32 weeks is low in the first week.

Assurance level		Description	Risk level	Description
Significant		The project has mostly achieved the standards or criteria being audited against	Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Report Successes:			Report Concerns:	
1	Most of the measures within acceptable limits (close to national levels and within 2 SD)		1	NIV rates alarm level - (though not translating into poor outcomes) QI initiated
2	Excellent with 2 year follow up – commended by NNAP		2	Breast milk at discharge scope to improve- ongoing work
3	Improvement in ROP screening rates		3	Perinatal optimisation could improve- needs team work, PERIPREM work, data monitoring/ cleaning NNAP from maternity side
4	Neonatal outcomes rates good and better than network			

Report Recommendations:				S.M.A.R.T Actions: Responsible: Due Date: Progress:	
1	Neonatal networks should: a) Review their mortality data and, where rates are higher than expected, develop locally prioritised improvement plans. Quality improvement activity should focus on best practices identified from Neonatal Networks exhibiting low mortality, with particular attention given to differences in network structure, staffing, clinical governance, and clinical practices. (Recommendation repeated from the 2023 data report). b) With their constituent units, undertake reviews of deaths in accordance with the BAPM Framework for Practice: Neonatal Mortality Governance (expected to be published in the second part of 2025) and engage with other statutory death review processes. Shared learning from these reviews should inform network governance and unit level clinical practice.			Data is continually reviewed using the NNAP online BI tool and performance data. All data is captured using BadgerNet. Engagement with SBUHB (Singleton Hospital) re NIV rates and processes.	
2	NHS England and health departments in Devolved Governments should: a) Issue clear guidance to neonatal services around the correct reporting of preterm brain injury including PHVD, so that robust data collection can support the achievement of the national ambition for neonatal brain injury. b) Develop a mandatory NHS neonatal information standard to ensure that clinical reporting systems are interoperable, ensuring robust data collection to support effective measurement and reporting of all neonatal processes and outcomes.				
3	Neonatal Networks should ensure that their constituent units are using the NNAP restricted access dashboard to regularly review their rates of optimal perinatal care delivery, identifying instances of non-adherence, and implementing quality improvement activities in response to them.		Data is continually reviewed using the NNAP online BI tool and performance data. All data is captured using BadgerNet.		Dr Reddy and Neonatal Team
4	Neonatal networks and local maternity and neonatal systems should ask their constituent units with below average rates of breastmilk feeding by day 2 to: a) investigate reasons for variation in uptake locally b) with families, co-design targeted, quality improvement programmes	Breastfeeding rates drop after day 2 and at discharge. Breastfeeding support reinforced via Golden Drops project and discharge planning. Ongoing work with Breast Feeding Group to improve breast milk at discharge.		Dr Reddy and Neonatal Team	
5	Neonatal networks and local maternity and neonatal systems should work with the perinatal teams in their constituent neonatal units to: a)ensure that staff receive appropriate and consistent training to confidently ask families about their ethnicity and that of their baby, and to accurately record demographic information, b)use the NNAP dashboard to review how well NNAP process measures are delivered locally, and whether this differs by ethnicity c)where differences exist, seek to understand the underlying causes d)with families, co-design quality improvement programme that directly address those causes.			As above.	

96/107

124/364

MBRRACE-UK

- Ref 500 - State of the Nation Report – Care of women with thrombosis and thromboembolism
- Ref. 501 - State of the Nation Report – Care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death
- Ref 578 - State of the Nation Report – Care of women with ectopic pregnancies
- Ref 581 - State of the Nation report – Perinatal deaths of babies born in 2023

Rationale:	MBRRACE-UK conducts national surveillance and perform confidential enquiries into the deaths of mothers and babies in the UK to identify lessons and improve care, thereby preventing future deaths and serious complications. It does this by collecting detailed data on maternal and perinatal deaths, auditing the care received, and using the findings to produce national recommendations for improving services. The goal is to reduce the number of avoidable deaths and improve outcomes for both mothers and babies.
Objectives:	The aim of MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) is to improve maternal, newborn, and infant health outcomes by: • Conducting national surveillance of maternal deaths, late fetal losses, stillbirths, and neonatal deaths across the UK. • Undertaking confidential enquiries into selected cases of maternal and perinatal deaths and serious morbidity to identify lessons and make recommendations. • Supporting the delivery of safe, equitable, high-quality, and patient-centred care in maternity and neonatal services. • Reducing inequalities in outcomes by examining the impact of factors such as ethnicity, deprivation, and access to care.

Ref 500 - State of the Nation Report - Surveillance findings and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into **Maternal Deaths from thrombosis and thromboembolism, malignancy and ectopic pregnancy 2020-2022, and morbidity findings for recent migrants with language difficulties.**

Recommendations (relevant to ABUHB):

- Clearly define the rapid access pathways for prescribing thromboprophylaxis to ensure that women known to be at risk are able to access thromboprophylaxis when they need it, particularly in the first trimester. **Audience: Integrated Care Boards and Health Boards.**

Ref. 501 - State of the Nation Report - Care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death

Recommendations

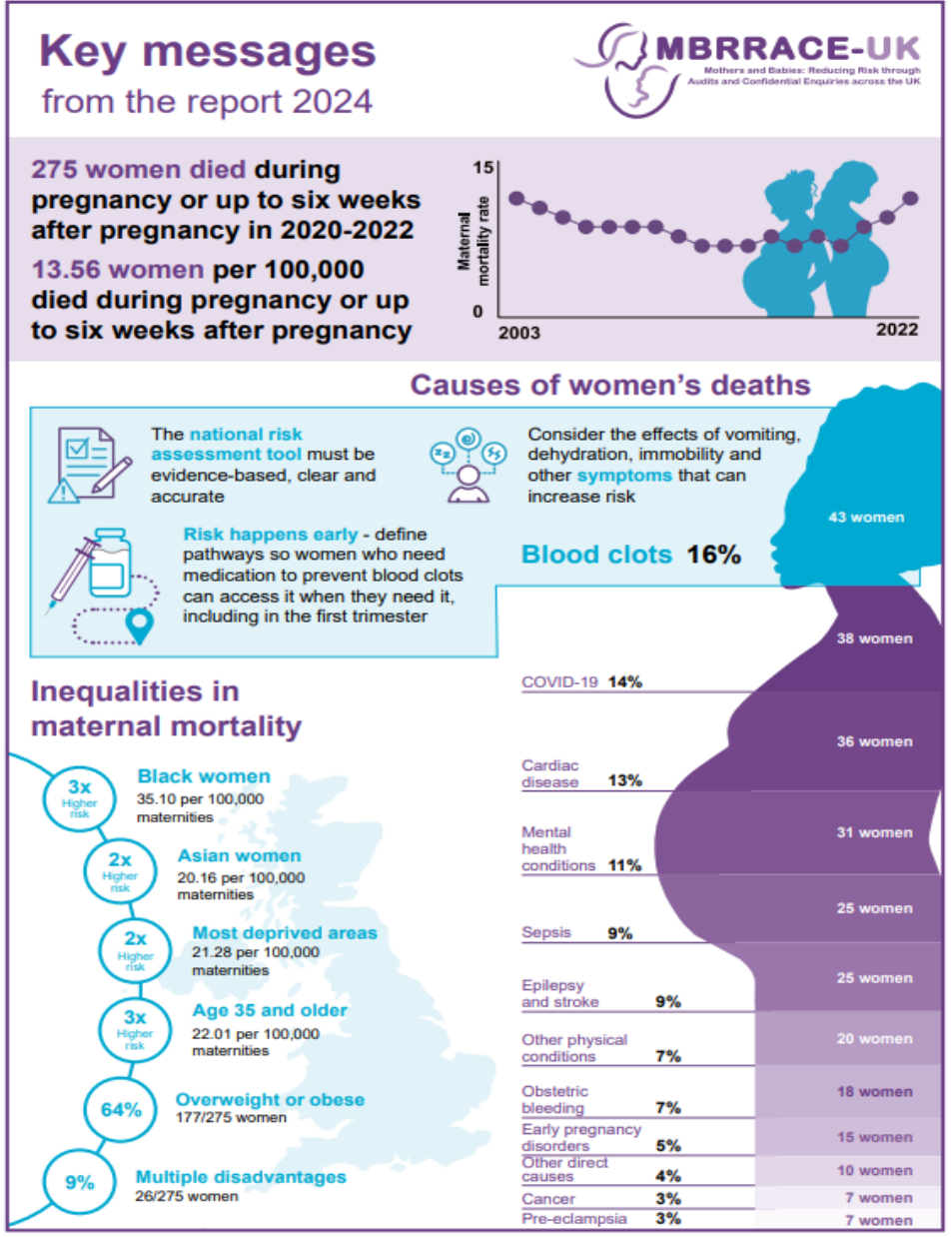
- Ensure that the number of women who require language support, and the support provided at each visit, is recorded systematically. This includes documenting the use of professional interpreting services at clinical care interactions and when supporting women through the navigation of care pathways, as well as recording when these services are not available. The resulting data should be used to implement quality improvement measures and be assessed against existing NICE guidance. **Audience: Integrated Care Boards (England), Health Boards (Wales and Scotland), Local Commissioning Groups (Northern Ireland), research funders.**
- Ensure services provide advocacy for women who have been in the UK for less than a year, or do not speak or understand English, to support care navigation. This should incorporate midwifery and obstetric care when indicated. **Audience: Home Office, Integrated Care Boards (England), Health Boards (Wales and Scotland), Local Commissioning Groups (Northern Ireland), research funders.**
- Pilot the provision of an initial assessment appointment for migrant women of childbearing age when they first access health care services. The purpose would be to carry out a holistic assessment of their reproductive healthcare needs, provide information about reproductive health and availability of maternity services, and to understand any concerns they may have about accessing healthcare services. **Audience: NHS England, NHS Wales, Scottish Government and Northern Ireland Public Health Agency, research funders.**
- Develop provision for multiple routes of access to maternity care. These routes should include the ability for a health or social care professional, in any setting, to make a direct referral to maternity services on behalf of a woman with her consent. **Audience: Integrated Care Boards (England), Health Boards (Wales and Scotland), Local Commissioning Groups (Northern Ireland)."**

Ref 578 - State of the Nation Report - Surveillance findings and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into **Maternal Deaths from hypertensive disorders, cardiac disease, mental health-related causes, homicide and accidents 2021-23, and morbidity findings for women living in the most deprived areas.**

Recommendations

1. Set up an urgent referral pathway in early pregnancy for women with high-risk medical conditions or complex social circumstances to ensure they receive early triage for senior or specialist consultation **Audience: Maternal Medicine Networks in England and Health Boards in devolved nations**
2. Discharge summaries for primary care should clearly indicate in an initial summary box the key conditions that require ongoing support or management and a clear plan for postnatal care. Detailed information about medical, mental health and social complexities and ongoing medications, monitoring requirements or safeguarding concerns must be included to facilitate a clear plan for postnatal care **Audience: Integrated Care Boards and Health Boards**
3. Ensure specialist perinatal mental health teams undertake a leadership role for the care of pregnant or recently pregnant women with mental health conditions even if women are not accepted for care under their services. This should include a risk assessment, provision of advice and guidance, oversight for joint care planning and support to ensure rapid onward referral into other appropriate mental health **services Audience: Integrated Care Boards and Health Boards**

Infographics
Ref - 500

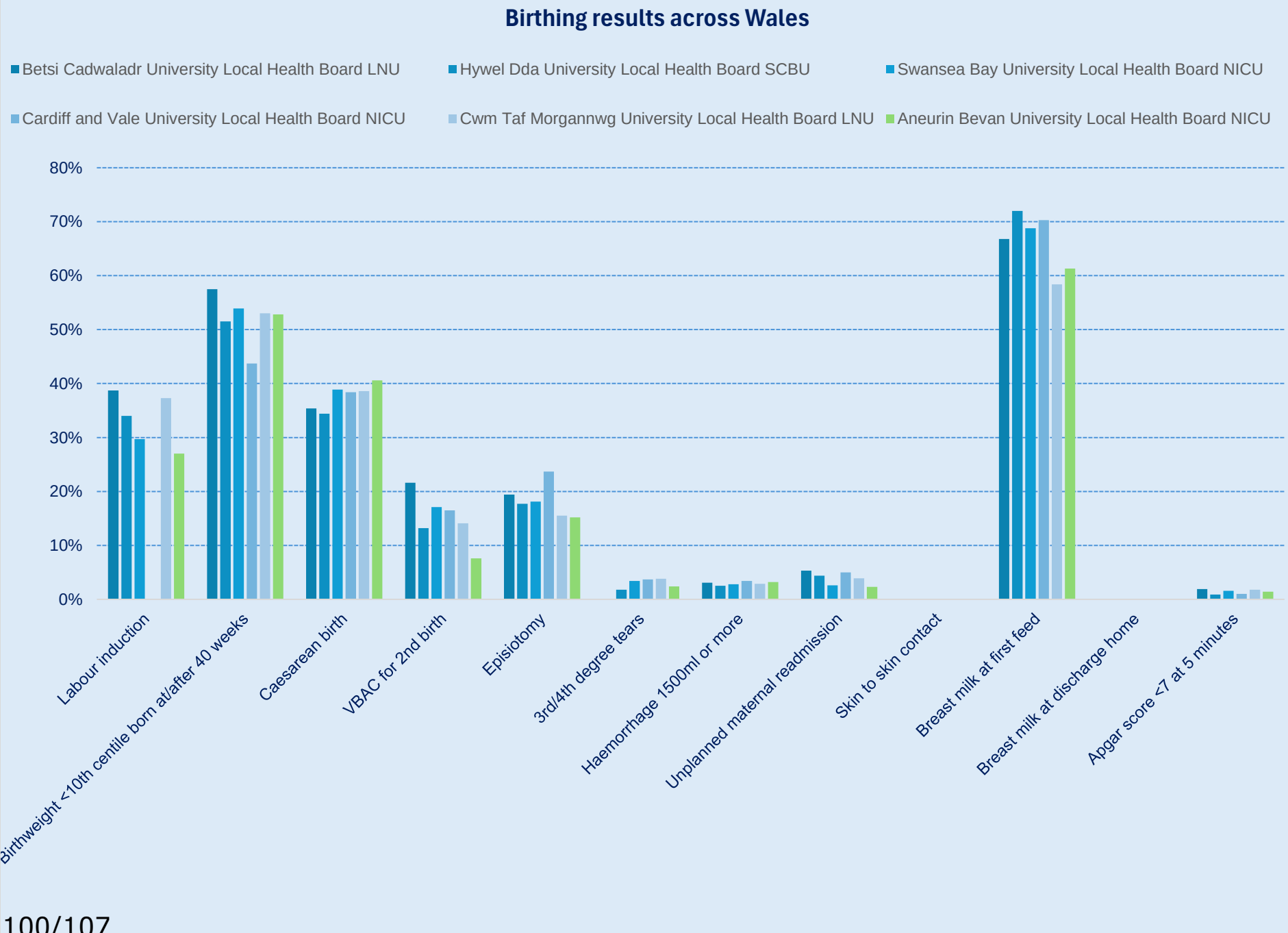


National Maternity & Perinatal Audit – State of the Nation report
based on births in NHS maternity services during 2023
Published September 2025

Clinical Lead: Jayne Beasley

Nice Guidelines
[NG201](#), [NG192](#), [NG235](#)

Rationale:	The National Maternity and Perinatal Audit (NMPA) is a large-scale audit of NHS maternity services across England, Scotland and Wales. The NMPA uses information routinely collected as part of maternity care, combined with information collected when women and birthing people and their babies are admitted to hospital.
Objectives:	Results can be used to benchmark against national standards and recommendations where these exist, and to identify good practice among maternity care providers and specific clinical areas for quality improvement. Only records and maternity services which passed detailed data quality checks are included in these results. This means not every maternity service at every trust/board has results for every measure.



Assurance level	Description
Full	The project has fully achieved the standards or criteria being audited against

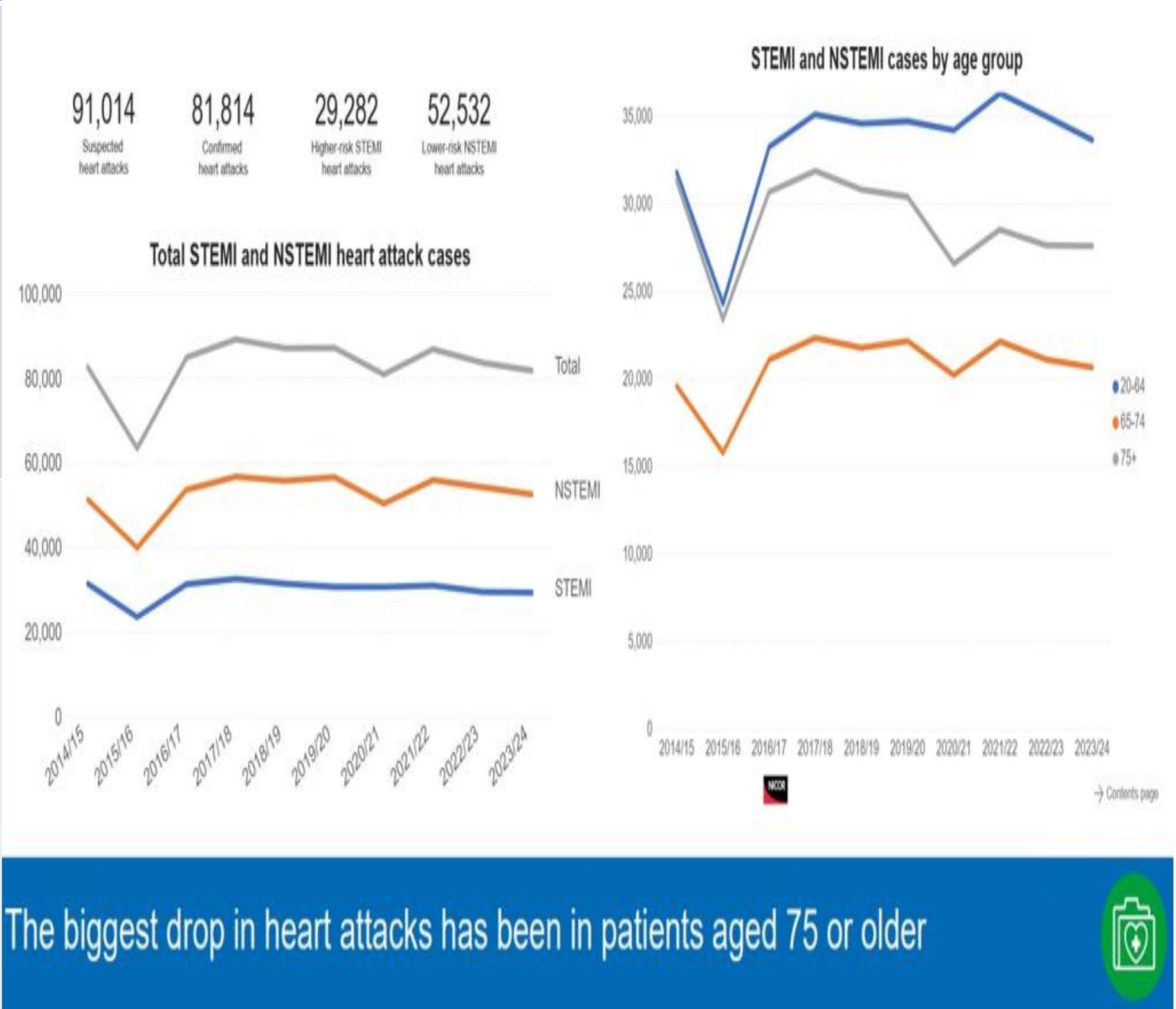
Report Successes:	
1	Rates as expected : readmissions, vaginal tears, PPH, preterm birth,
2	Rates lower than expected: induction of labour, term baby apgar scores < 7 , episiotomy rates,
3	Benchmarking

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

Report Concerns:	
1	Data completeness
2	Rates higher than expected : SGA, late booking after 10 weeks gestation
3	Lower rates of VBAC

Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
Recommendation 1 – Timely pregnancy booking Government health departments should work with stakeholders to develop national and local level initiatives and campaigns targeted at improving rates of timely pregnancy booking. Initiatives should be co-designed with stakeholders to overcome existing barriers to booking and ensure information and access to services are appropriate	SPA referral implemented in 2025 to support direct and early booking for care Monitoring of booking data and direct feedback to lead midwives at bimonthly ELM Information provided in language of choice via digital format	HoM/Digital lead midwife	25/26	Current local data suggests a 12% increase of booking by 10 weeks since 2024 and is 60% overall compliance
Recommendation 2 – The impact of changing trends in maternity care and outcomes Government health departments should incorporate the impact of the changing trends in maternity care and outcomes when reviewing and planning maternity services. This information should be used to: Anticipate and respond with appropriate allocation of resources, such as workforce, bed/cot and obstetric theatre capacity, and finances, to optimise the options women and birthing people have for when and where they choose to give birth.	Implementation of the National perinatal workforce plan	HEIW/local HB	03/26	Draft plan in place workforce review against priorities
	3-month national mat/neo assessment	NHS improvement and performance	12/25	Underway for completion
	Theatre capacity review Birth rate plus review	HoM /SMM	07/25 03/26	Complete increased RGN Planned for Q4 25
Recommendation 3 – Unwarranted variation Maternity care commissioners and maternity networks (the Wales Maternity and Neonatal Network) should use the evidence of variation in care processes and outcomes identified in this report, and the results for their local populations, when working with their constituent units to identify opportunities for improvements in service provision and clinical practice.	Mat/neo discovery phase Mat/neo improvement phase Improvement lead in post	Mat/neo network	23 24/25 25/26	Health Board action plan measures in place Appointed

Rationale:	The Myocardial Ischaemia National Audit Project (MINAP) is part of the National Cardiac Audit Programme (NCAP) which is run by the National Institute for Cardiovascular Outcomes Research (NICOR). This report summarises the care provided within hospitals in England, Wales and Northern Ireland to almost 82,000 people who suffered a heart attack between April 2023 and March 2024.
Objectives:	A key focus of the audit is to support quality assurance and the improvement of services for people suffering a heart attack. The quality of care they receive is assessed against a set of quality improvement (QI) metrics derived from national and/or international standards and guidelines. These cover patients diagnosed with two types of heart attacks: ➤ Higher-risk ST-segment elevation myocardial infarction (STEMI) ➤ Non-ST-segment elevation myocardial infarction (NSTEMI).



The biggest drop in heart attacks has been in patients aged 75 or older

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8% reduction in heart attacks reported to MINAP compared with 2017/18 (2% fewer than 2022/23)



3 minutes improvement in median Call-To-Balloon (CTB) time for patients undergoing primary PCI compared to 2022/23 (first reduction in a decade but still 22 minutes longer than in 2014/15)



3 minutes improvement in Call-To-Door (CTD) time



1 in 10 proportion of patients with higher-risk STEMI heart attacks who self-presented to hospital (compared with 5-7% in the pre-pandemic years)



84 minute additional delay in Symptom-To-Balloon (STB) times for self-presenting patients compared with those brought directly to hospital by ambulance



Only 51% of eligible NSTEMI patients undergo angiography within 72 hours of admission (a 10-year low)



74% proportion of patients with poor heart function prescribed a mineralocorticoid receptor antagonist

Hospital	Local Health Board	STEMI cases (N)	NSTEMI cases (N)	Total MINAP submissions (N)	PEDW cases stringent (N)	Case ascertainment - Stringent (%)	PEDW cases non-stringent (N)	Case ascertainment - Non-stringent (%)
Grange University Hospital	Aneurin Bevan University Health Board	140	393	533	353	150.99	466	114.38

Confirmed quality data/completeness - even by non-stringent criteria ~ captured all cases

STEMI - context

- Not a Primary PCI Centre (even restricted hours)
 - Ad hoc cases as able
 - No dedicated lab for primary cases
 - Only 49 cases for 2023-2024 (centres with < 20 excluded analysis)
 - Skewed case mix (consequential delays)
 - Patients discussed by WAST declined by UHW (e.g. comorbidity concerns)
 - Diagnostic difficulty (WAST) and/or initial non-diagnostic ECG’s
 - Concern to rule out other pathology e.g. ao dissection
 - Self presenters during working hours
- Rare for us to be pre-alerted by WAST ~ that is changing

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

Report Successes:		Report Concerns:	
1	Almost all patents are seen by a cardiologist and admitted to a cardiac ward	1	Poor door to needle times in STEMI reflect skewed case mix and lack dedicated service ** (BUSINESS CASE IN)
2	Angiography rates are high in NSTEMI and above the national average	2	Delays to IP angiography reflect staffing and lab time
3	Echocardiography and cardiac rehabilitation offer rates are high and exceed the national average	3	Slight concern re secondary prevention meds – requires further ix but may reflect less clear evidence base some medications in lower risk cases

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Given the increased rate of self-presentation, staff in emergency departments and other hospital admission areas should rapidly employ robust systems to identify patients with a heart attack. Hospitals must have agreed processes in place to ensure that patients with a probable higher-risk STEMI heart attack are transferred speedily to a cardiac catheter laboratory for primary PCI.		Clinical Director ED and cardiology	Ongoing work with ED	Clinical Lead discussing at Directorate meeting
2	In order to maintain ready access to an emergency ambulance response in the community, ambulance trusts should continue to work with receiving hospitals to facilitate safe and swift handover of patients who are brought to hospital by ambulance. N/A for now as not PPCI Centre				
3	Interventional hospitals should collaborate with local non-interventional hospitals to reverse the decline in the proportion of patients with lower-risk NSTEMI heart attacks who receive an angiogram within 72 hours of admission (e.g. through early identification of suitable patients, rapid electronic referral for angiography, providing weekend elective angiography lists, ring-fencing of beds for NSTEMI patients, and systems for 'treatment-and repatriation' between hospitals).	Increased staffing, support for BC to develop PPCI and upgrade of temporary pacing room to free up 2 nd cath lab space.	Clinical Director Divisional Director	April 2026	Clinical Lead discussing at Directorate meeting
4	Staff in participating hospitals should use the audit data to examine their performance and compare it with others. Where performance for particular aspects of care appears suboptimal, they should first determine whether this reflects issues of data quality before moving on to implement quality improvement initiatives.	Work with team to undertake more detailed audit secondary prevention meds	Clinical Director Divisional Director	April 2026	Clinical Lead discussing at Directorate meeting
5	Staff in participating hospitals should use the audit data to examine their performance and compare it with others. Where performance for particular aspects of care appears suboptimal, they should first determine whether this reflects issues of data quality before moving on to implement quality improvement initiatives.	Work with team to undertake more detailed audit secondary prevention meds	Clinical Director Divisional Director	April 2026	Clinical Lead discussing at Directorate meeting

Rationale:
The National Audit of Percutaneous Coronary Intervention (NAPCI) is part of the National Cardiac Audit Programme (NCAP) which is run by the National Institute for Cardiovascular Outcomes Research (NICOR).

This report provides details of the percutaneous coronary intervention (PCI) procedures undertaken in England and Wales during the financial year 2023/24, along with longer-terms trends on the scale and the quality of PCI services. The report focuses on a number of specific quality improvement (QI) metrics in relation to the delivery of PCI services derived from national and/or international standards and guidelines. It is designed to be of value to a wide range of stakeholders and importantly it allows patients and their relatives to better understand how PCI services are delivered.

Objectives:
For most heart attack patients, optimal care includes a PCI procedure. NAPCI data are therefore also combined with that from the NCAP's Myocardial Ischaemia National Audit Project (MINAP) to create a report that focuses on the care given to people admitted to hospital with a heart attack. This includes time delays to treatment for patients presenting with ST-segment elevation myocardial infarction (STEMI) or non-ST-segment elevation myocardial infarction (NSTEMI).

- Primary PCI for ABUHB patients**
- Delivered by Cardiff and Vale University Health Board
 - Will require auditing of Cardiff and Vale figures
 - More work needed to minimise delays in interhospital transfers
 - Thormbolysis could be considered after discussion with Cardiff and Vale as part of SOP
 - Thrombolysis will be considered as part of the SOP when Primary PCI
 - services in ABUHB will be set up as per the ESC guidelines

All data are for 2023/24 unless otherwise stated.



91,092 PCI procedures (7% down on 2017/18)



25% reduction in elective PCI is the biggest change but a slight fall in PCI for acute coronary syndrome (ACS) cases since 2017/18



2.5-fold difference between areas with the lowest and highest PCI volumes per 100,000 population



68% of patients with ST-elevation myocardial infarction (STEMI) taken directly to a Primary Percutaneous Coronary Intervention (PPCI) centre were treated within a Call-To-Balloon (CTB) time of 150 minutes



163 minutes median CTB time for inter-hospital transfers was significantly longer than that for direct admissions to the PPCI centre (119 minutes)



30% of complex PCI cases used intracoronary imaging (up from 16% in 2019/20)



78% of PCI for left main stem artery cases used intracoronary imaging (up from 62% in 2018/19)



59% of primary PCI for STEMI cases were prescribed the more effective P2Y12 drugs (up from 44% in 2019/20)



Use of prasugrel grew faster than ticagrelor but is still below the level recommended by guidelines



35% of PCI cases for in-stent restenosis used drug-eluting balloons (up from 1% in 2018/19)

Recommendation 1 - Treatment times for primary PCI for STEMI are too long, particularly for inter-hospital transfers where there is a failure to achieve target Call-To-Balloon times. ESC guidelines currently recommend thrombolysis if primary PCI cannot be performed within 120 min of the first medical contact.

There is substantial variation in Call-To-Balloon times between hospitals

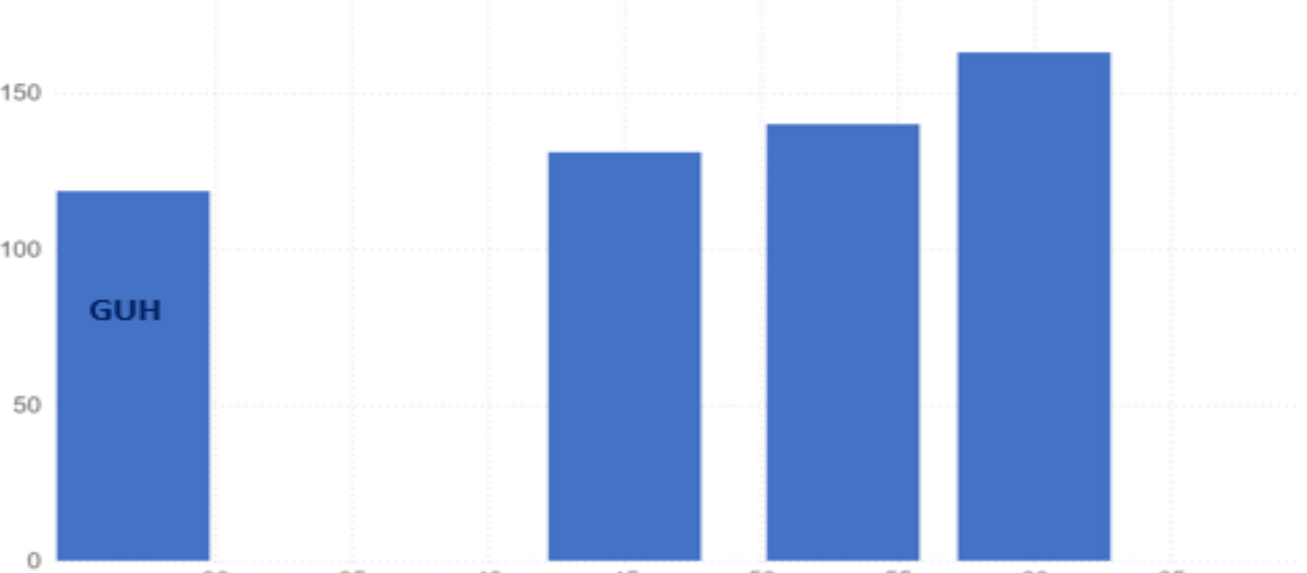
There is considerable variation in the median Call-To-Balloon (CTB) times between hospitals offering a PPCI service to patients with STEMI. The best-performing hospitals achieve times that can be up to half of the worst-performing.

Hospitals can optimise their own care pathways to reduce the Door-To-Balloon (DTB) component. Work at a regional level is required to reduce the Call-To-Door (CTD) component.

For patients who present to a hospital without immediate PCI services, rapid diagnosis and inter-hospital transfer (IHT) of the patient to the PPCI service is essential.

Select a hospital or cardiac network to see their specific data.

Median CTB times (minutes) for PPCI by hospital (2023/24)



Hospital	Median CTB time (minutes)
GUH	119
Hospital 2	135
Hospital 3	140
Hospital 4	165

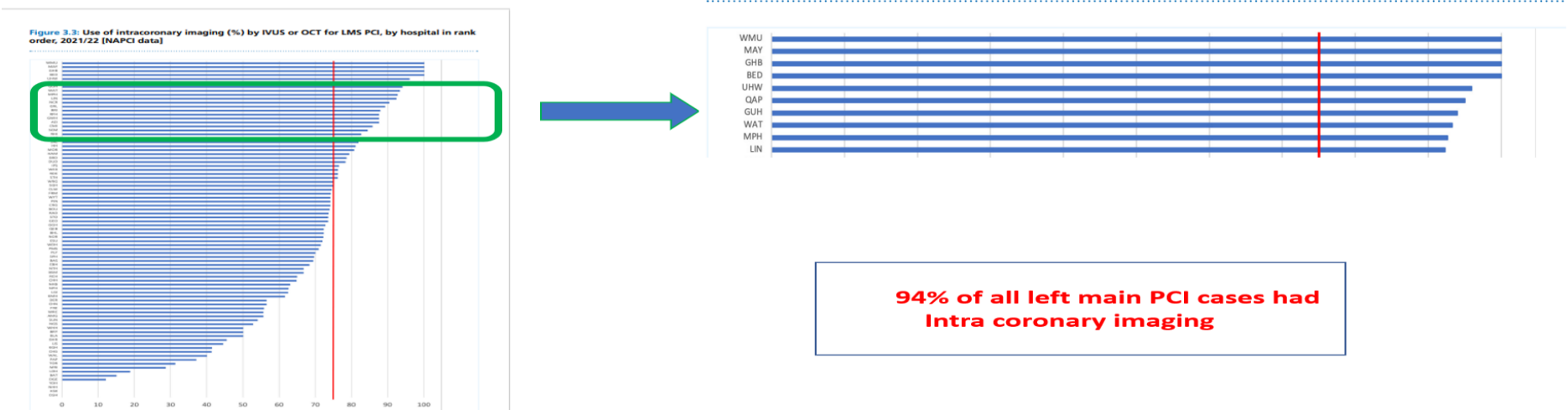
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Recommendation 2 - Centres undertaking PCI for left main stem artery or complex lesions should use intra-coronary imaging in 75% or more of cases.

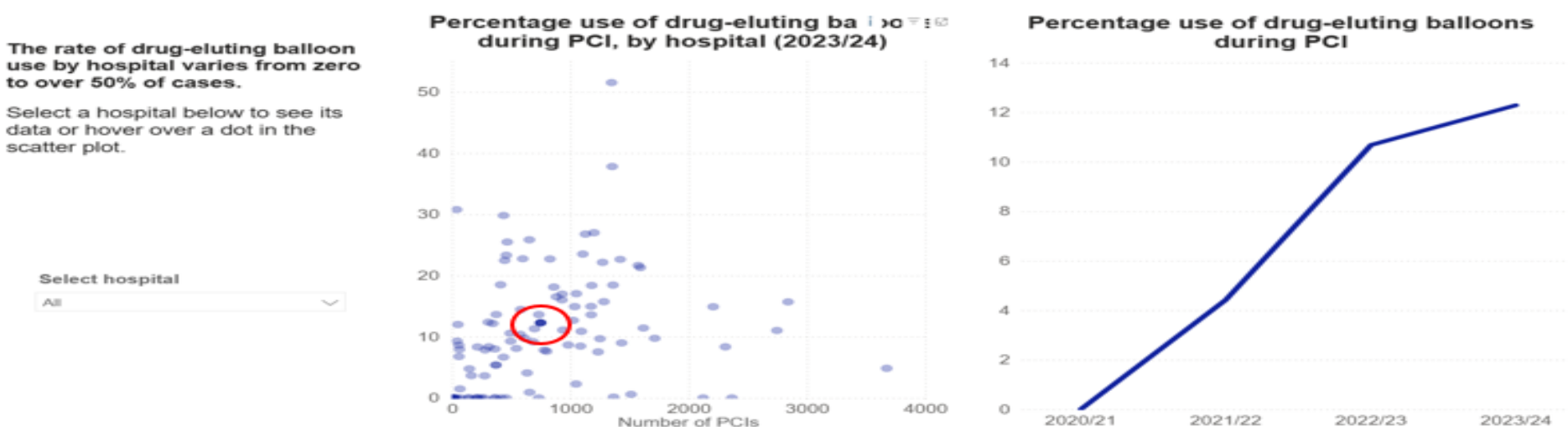
There is a growing use of intracoronary imaging in PCI for left main stem (LMS) lesions

Figure 3.3: Use of intracoronary imaging (%) by IVUS or OCT for LMS PCI, by hospital in order, 2021/22 [NAPCI data]



Recommendation 4 - Recording of drug-coated balloon use in the audit should be improved, as significant differences exist between the NAPCI data and that from the annual BCIS survey. Until randomised trials defining the role of drug-coated balloons begin reporting, outcomes will continue to be assessed using NAPCI data.

Drug-eluting balloon use varies between hospitals with many hospitals not using them and one hospital using them in >50% of cases



Percentage of PCI cases of Drug Eluting Balloon use



Drug eluting balloons

- Used as a stent free alternative
- Various case scenarios
- Good medium to long term data in small vessels
- Avoids the need for increased stent material in complex cases – like bifurcations, in stent restenosis
- More data required in double blind randomised clinical trials
- Most common drug eluting balloons is Paclitaxel eluting balloon
- Newer drugs namely sirolimus and biolimus are currently being tested
- ABUHB drug eluting balloon use has increased
- Planned to enter in Registry studies

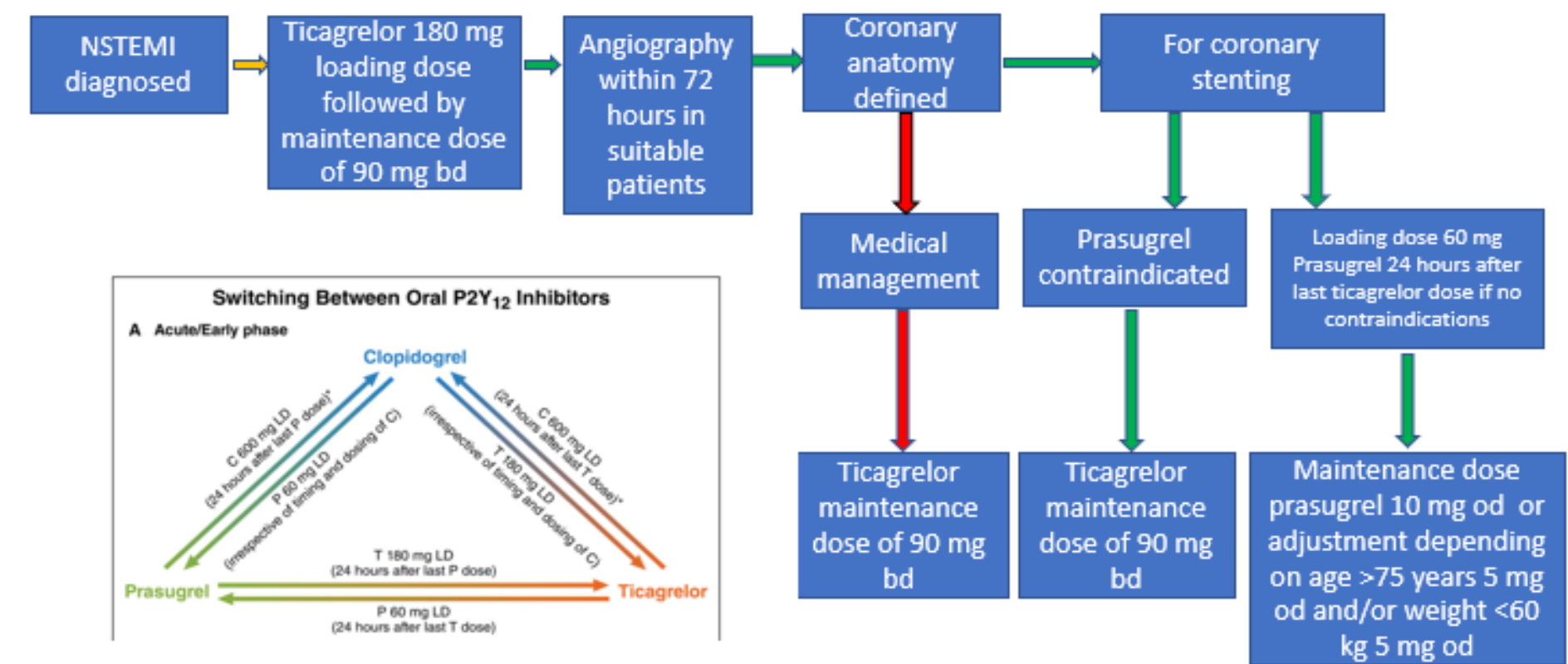
Recommendation 3 - Use of prasugrel is lagging that of ticagrelor, especially in NSTEMI cases. This is despite international guidelines recommending it in preference to ticagrelor in PCI undertaken for ACS indications. Prasugrel should be used in preference to ticagrelor and clopidogrel where there are no clinical contraindications.

There is considerable variation in the use of P2Y12 antiplatelet drugs after PCI for NSTEMI between hospitals

Potential Challenges with Proposed pathway

- Data capture reflects patient already on ticagrelor
- No system to document switch to Prasugrel
- Increase awareness of clinicians to change over medications
- Likely to have errors especially if switch happening after 24 hours
- Data capture can only be accurate on electronic discharge summaries
- No link between McKesson system (for NICOR) and CWS discharge summaries

Proposed Pathway for NSTEMI management within ABUHB



Assurance level		Description	Risk level	Description		
Full		The project has fully achieved the standards or criteria being audited against	None	Standards met and findings demonstrate no risk to patient safety		
Report Successes:						
1	The use of intracoronary imaging in unprotected left main coronary stenting is now mandatory in the standard practice. Both intracoronary imaging modalities namely intra vascular ultrasound (IVUS) and optical coherence tomography (OCT) are available. Trainees in Percutaneous coronary intervention are also encouraged to use these devices when performing left main coronary stenting.					
2	The treatment of left main coronary stenting with ICI in our centre is associated with favourable long term outcomes when compared with the national benchmark figures					
3	Trend of drug eluting balloon use is similar to national trend					
Report Concerns:						
1	Data capture for the use of P2Y12 remains a challenge					
Report Recommendations:			S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Treatment times for primary PCI for STEMI are too long, particularly for inter-hospital transfers where there is a failure to achieve target Call-To-Balloon times. ESC guidelines currently recommend thrombolysis if primary PCI cannot be performed within 120 min of the first medical contact.		Currently not achievable until the Primary PCI services in ABUHB is established Once 24/7 PPCI services in ABUHB established, ESC guidelines will be incorporated into SOP	Lead in Interventional Cardiology services at UHW Divisional/Clinical Director of Cardiology at UHW Divisional Director/Lead in Interventional Cardiology for ABUHB	Undetermined – Require further dialogue between ABUHB and Cardiff and Vale UHB	Need to have access to UHW database identifying ABUHB patients
2	Centres undertaking PCI for left main stem artery or complex lesions should use intra-coronary imaging in 75% or more of cases.		Achieved – No risk to patients. Yearly assessment via the McKesson database	Dr. S. Bundhoo – Audit Lead in Interventional Cardiology	Next CSEG meeting 2026	Already achieved. 96% use of ICI in ABUHB cases versus the national benchmark of 75%
3	Use of prasugrel is lagging that of ticagrelor, especially in NSTEMI cases. This is despite international guidelines recommending it in preference to ticagrelor in PCI undertaken for ACS indications. Prasugrel should be used in preference to ticagrelor and clopidogrel where there are no clinical contraindications.		Proposed switch from Ticagrelor to Prasugrel needs to be discussed at Directorate level		To be confirmed	To be updated in next CSEG meeting
4	Recording of drug-coated balloon use in the audit should be improved, as significant differences exist between the NAPCI data and that from the annual BCIS survey. Until randomised trials defining the role of drug-coated balloons begin reporting, outcomes will continue to be assessed using NAPCI data.		Achieved. The Mc Kesson Database has an option for the use of drug eluting balloon usage. This can be audited		Next CSEG meeting in 2026	Already achieved as data capture is feasible

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Quality Management Group Assurance Report

Meeting Date:	5 February 2026
Chair:	Jennifer Winslade (Executive Director of Nursing)

KEY ESCALATION AND DISCUSSION POINTS

ALERT

Alert	Action	By Whom	Target Date
Listening to People / PTR Regulations not yet released by Welsh Government	Highlight risk to Executive Team and Patient Quality Safety and Outcomes Committee	Jennifer Winslade	February 2026

ADVISE

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

Q3 Quality Outcomes Framework

The change in the formatting to consistently provide the same "definition", "analysis" and "implications" on each slide with a focus on understanding any issues and quality improvement.

It was noted that the general performance of the quality metrics was positive given the high operational pressure during quarter 3 with no notable deterioration seen.

Listening to People – National Implementation Update

An update was provided on what we understand is likely to change (noting the regulation is yet to be released, see the risk section).

Redress claim value is increasing to £50k from £25k and the timescales are being reduced from 12 months to 6 months.

A focus on complaints being patient focused with listening meetings.

Early Resolutions (as they are currently termed) will have the timescales increased from 2 days to 10 days.

One ministerial target agreed, 40% of cases to be managed through early resolution. No other performance measures have been confirmed.

Quality Improvement Planning

A draft proposal was shared on how to create a structured Quality Improvement plan for each division, facilitated through ABCi with oversight of the Quality Management Group. This is essential to establish as part of a robust mature Quality Management System.

Next steps: Agree plan between ABCi and each division on the allocation of coaches and QI projects that will take place over the next financial year. This will be brought back to Q4 QMG for oversight and approval.

Linking this to the organisational priorities through the IMTP.

PROMPT Wales an Implementation Update 2024-25

PROMPT Wales is a maternity and safety learning programme funded by Welsh Risk Pool, that was launched in October 2018 and implemented in all Health Boards across Wales by January 2019. It is an evidence based multi-professional training with a vision to reduce avoidable harm and improve perinatal outcomes. Standard 1: Identify required participants Standard 2: Development of local syllabus Standard 3: Multi-professional faculty Standard 4: 95% multi-professional participation in PROMPT.

Sept 2024 – August 2025 is the first year the Health Board have achieved all 4 of these targets. The paper detailed the progress and how to sustain the success.

ASSURE

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

Q3 Quality Outcomes Framework

PTR compliance and quality of responses was highlighted as improved since Q2. The agreed improvement trajectory for PTR compliance and backlog reduction is being monitored monthly, compliance is on track but the backlog is falling behind the trajectory plan.

QMG Divisional Highlight Report: Mental Health & Learning Disabilities

- Focused action plans across AMH unit to achieve ward accreditation, older adult have been excelling (all bronze, 2 silver).
- National work – safe care standards being embedded
- Obtaining patient/service user feedback continues to be a challenge and work is ongoing to improve this.
- Severity of Datix incidents being reviewed to ensure accuracy and consistency.

QMG Divisional Highlight Report:– Family and Therapies

- Top 3 risks – capacity/demand in maternity, pharmacy support for maternity and neonates (business case being developed), children's assessment backlog.
- Focused work on neonates, maternity and gynae medication errors is seeing improvement with human factors training being reported.
- SSI rates have improved, with 29 fewer infections than predicted following QI project.
- Discussion around delayed to NRI closure due to national network mortality reviews.
- Risk management work going on across the division, to ensure risks are updated and managed appropriately, this work has been supported through the creation of a risk dashboard.

QMG Divisional Highlight Report: Medicine

- Pressure ulcers on C4 has increased and a QI project has been commissioned to tackle this.
- Reduction in falls over the year
- Enhanced care is being more consistent in its use
- Ward accreditation is progressing well with cardiology preparing for gold
- Reduction in medication errors seen recently
- Push on the timely closure of Datix incidents
- Backlog of PTR cases remains a risk

QMG Divisional Highlight Report: Clinical Support Services

- Three biggest risks: defibrillator provision (corporate work ongoing), ITU capacity (surge training to mitigate) and pathology ICT systems.
- Compliance for PTR has reduced and steps put in place to review directorate concerns.
- Decline for time to close incidents has been seen.
- Review of harm assessments to ensure it is consistent and in line with guidance.
- A never event occurred in Theatres which was flagged. This is the first one in over 12 months and the performance is still the best in Wales.

QMG Divisional Highlight Report - Surgery

- Operational pressures have been extremely high over the past 3 months
- Three biggest risks – No clinical QPS lead for a number of months (post now advertised), significant backlog in PTR particularly in T&O (plan in place), number of glaucoma SIs.
- QI work- bowel management learning within T&O following a coroner case starting on A0 then rolling out across division. Medicine management incidents remain static over however, improvements have been noted on some wards and decline elsewhere, this has prompted a review. CDT project on D2 East has been rolled out further and showing positive results.
- Reduction in slips/trips on elective wards as a result of QI work.
- Three wards preparing for gold accreditation.

QMG Divisional Highlight Report – Primary Care and Community

- Community services have been under increased sustained winter pressure.
- Three biggest risks – Boarding/system pressure, patient falls and increased complex patients.
- Divisional QPS leads developing tailored training programme for presentation, escalation and management of community falls risks.
- Complaints remain low and an improvement noted in compliance.
- Work ongoing with Pressure Ulcers which appear to have increased

QMG Divisional Highlight Report – Urgent Care

- Inability to decongest resus has resulted in concern.
- There remain risks of insufficient capacity at the front door to support the Handover position.
- Work to improve education on reporter's harm assessment.
- New waiting room in GUH ED opened before Christmas, risks materialised on opening which continue to be worked through.
- Security provision remains a concern.
- Increase in the number of falls noted. It was noted that the compliance for falls risk assessments need to be monitored as a quality measure.

Healthcare Inspectorate Wales Inspection Report: Ty Skirrid, Maindiff Court

- 12 findings were isolated for improvement, resulting in 23 service actions.
- A number of positive findings were identified including Patient Experience & Therapeutic Relationships, Clinical Practice & MDT Working and Leadership, Workforce & Governance.
- Areas of improvement - Therapeutic Activities & Advocacy, Environment & Estates, Clinical Documentation & Information Recording, Staffing & Skill Mix.
- One immediate concern - Outdated paliperidone injection.
- It was noted the importance of how the division captures the themes from this report to ensure it is spread across the organisation.

Risks discussed or identified:

Q3 Quality Outcomes Framework

- Inquests and Clinical Negligence fines raised due to delays and the HB is an outlier compared to other NHS Wales Health Boards.
- Datix data quality was highlighted as a risk.

Listening to People: National Implementation Update

- Regulations have still not been released which is hampering the ability of the Health Board to make preparation for implementation (April 2026).
- The reduction in timescale for redress from 12 months to 6 months is a risk given the increase in payout from £25k to £50k.

Legal Services Q3 2025/26 Report

- Increase in the number of fines due to late submission of LFERs. Now the worst performing HB in Wales and the only Health Board not to improve.
- Delay in coroner cases due to delay in evidence gathering, investigations and statements.
- These delays are resulting in delayed learning and improving.
- Report to be drafted for Executive Team on this issue.

Matters for the Board or other Committees:

MEETING AGENDA ITEMS

Q3 Quality Outcomes Framework	Listening to People – National Implementation Update	Quality Improvement Planning Proposal
QPS Qlik App and Roll-out Plan	PROMPT Wales an Implementation Update 2024-25	Medical Devices Committee Annual Report 2024/25
Radiation Protection Committee Annual Report 2024/25	HIW Reports	QPS Divisional Highlight Reports

Attendees

Jenny Winslade (Chair)	Executive Director of Nursing
Seema Srivastava	Executive Medical Director
Peter Carr	Executive Director of Allied Health Professions & Health Science
Rani Dash	Director of Corporate Governance
Helen Sweetland	Independent Member
Tracey Partridge-Wilson	Deputy Director of Nursing
Kelly Downes	Deputy Director of Nursing

Leeanne Lewis	Assistant Director – Quality and Safety
Kye Smith	Deputy Head of Quality and Patient Safety
Amanda Hale	Divisional Nurse – Surgery and Clinical Support Services
Stephen Edwards	Deputy Medical Director
Karen Hatch	Assistant Director of Allied Health Professions & Health Science
Jonathan Clarke	Consultant ENT
Deb Jackson	Divisional Nurse – Family & Therapies
Lidia Palmer	Violence Prevention & Reduction Lead
Shelley Williams	Deputy Director of Workforce & OD
Carly Cole	Head of Nursing – Clinical Support Services
Collette Kiernan	Deputy Director of Allied Health Professions & Health Science
Natalie Janes	Deputy Head of Service – Primary Care & Community
Jo Hook	Senior Nurse - Patient Experience and Involvement
Philip Meredith	Finance Business Partner
Trish Chalk	Assistant Director of Planning and Performance
Susan Palmer	Head of Research Delivery
Natalie Skyrme	Divisional Nurse – Medicine
Moirra Bevan	Head of Nursing – Infection Prevention & Control
Chris Morgan	Divisional Nurse – Urgent Care
Nadine Gould	Divisional Nurse – Mental Health & LD
Howard Stanley	Head of Safeguarding
Gemma Couch	Head of Quality and Patient Safety
Amy Buckley	Assistant Divisional Nurse – Mental Health & LD
Jayne Beasley	Head of Midwifery

In attendance to present

Donna Challingsworth	Deputy Head of Nursing - Surgery
Rhiannon Price	Senior Quality, Patient, Safety Manager
Geraint Watts	Quality Improvement Advisor
Rachel Trask	Head of Quality Improvement

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN

ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	17 February 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Maternity and Neonatal Report
CYFARWYDDWR ARWEINIOL:	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Joanna Doyle - Head of Nursing Jayne Beasley - Head of Maternity & Gynaecology

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The Maternity and Neonatal directorates within Aneurin Bevan University Health Board achieve a high level of quality of care through its services. Maternity care covers a wide geographical reach, outpatient and community antenatal services are provided within each Borough for ease of access, with inpatient services for both maternity and neonatal services centralised to the acute site of the Grange University Hospital which offers purpose-built facilities for antenatal, intrapartum obstetric led and midwife led care and postnatal care, as well as a level 3 Neonatal service.

This purpose of this paper is to provide The Patient, Quality Safety and Outcomes Committee with an update on the quality of care, key performance indicators, including patient experience measures, training, culture, leadership and governance processes to provide assurance regarding the safety of its services. Highlighting good and improving practice and areas for ongoing improvement. The report also makes recommendations for consideration.

Cefndir / Background

Aneurin Bevan University Health Board accepts and books more than 6000 women each year for maternity care, resulting in approximately 5100 births per year, the lesser figure representing a small percentage of women who may birth outside of

the Health Board or those who suffer pregnancy loss. There was a slight fall in Bookings and births for 2025 on the preceding year.

Total bookings 2025	Total Births 2025
6125	5177

All 4 places of birth are available and offered to women in line with Royal College of Midwives’ and NICE recommendations. Women can choose to birth at home, in the freestanding birth centre at Ysbyty Ystrad Fawr, within the alongside birth centre or the obstetric led care unit at the Grange University Hospital. In addition, Ysbyty Aneurin Bevan (YAB) also offers a midwife led birthing area.

The Neonatal Intensive Care Unit is a tertiary specialist unit, which is based at the Grange University Hospital (GUH) and opened in 2020 combining the neonatal services that were previously based at Nevill Hall and the Royal Gwent Hospitals. This purpose-built unit consists of 8 intensive care cots (including 1 stabilisation cot), 10 high dependency and 12 low dependency cots, provides an outreach service, is part of the South East Wales transport service (CHANTS) and runs outpatient, neurodevelopment and murmur clinics. Through collaboration with maternity transitional care is delivered, however transitional Care cots are limited and the outcome of the business case supporting dedicated transitional Care cots on the maternity unit is pending this year.

The primary aim of maternity and neonatal services is to continuously deliver high quality, safe and effective care through quality improvement initiatives to drive change to improve health outcomes, reduce inequalities, and ensure positive experiences for women, babies and families. To demonstrate a commitment to providing assurance and improving the quality of Mat/ Neo service delivery, a Maternity Improvement Plan was developed to drive forward excellence in care for 2024-2027. Following this the Neonatal Intensive Care Improvement/ Action Plan was written in June 2025 for (2025-2028). The separate improvement and action plans consist of measurable actions to improve the delivery of services, to include a focus on incivility, culture, leadership and management and ensure that the workforce is supported and equipped with the knowledge and skills to be able to deliver the highest standards of care.

In addition to the NICU and maternity Improvement/ action plans there are several workstreams with separate action plans to provide a focus for excellence in care and assurance:

- **Medication action plan:** to demonstrate learning and actions following a serious medication error.
- **Mat-Neo action plan:** to meet the requirements of the National Maternity and Neonatal Safety support programme (*Ref: Improving Together for Wales, 2023*)
- **Variable Pay action plan:** to manage the spend on variable pay
- **Action plans for the top 5 themes:** These are medication, treatment & procedures, equipment and devices, infrastructure (inc staffing), assessment and diagnosis to focus on reducing the top 5 reported risks on DATIX.



- **IPAC action plan:** to improve IPAC standards and to reduce incidences of infection on NICU
- **SSI action plan** to reduce infection post caesarean section.
- **Caesarean** action plan with a focus on normality
- **Perinatal Quality statement** – to implement the 7 key actions
- **All Wales Perinatal Engagement Framework** – to implement and monitor the 10 commitments to support family engagement

Since the development of the Improvement/ Action Plans extensive work has been undertaken through a multi-faceted approach involving members of the Senior, Divisional and Executive Nursing teams with the support of workforce and operational development, IPAC and Corporate services to deliver the elements of the plan and good progress continues to be made against each of the action plans.

Senior nursing and midwifery staff are also responsible for delivering the range of improvement actions which are closely monitored by the Senior Nurse and Head of Nursing and Head of Midwifery providing regular reports to the Divisional Assurance, Maternity and Neonatal Improvement and Assurance Group (MNIAG) and the Quality Management Group (QMG) who provide oversight and overarching assurance.

Asesiad / Assessment

Quality of care

Booking for pregnancy should occur in early pregnancy and ideally before 10 completed weeks in line with Antenatal Screening Wales Standards. This affords the opportunity to ensure women are provided with early access to screening and information to support their pregnancies and to optimise their health. A recent introduction of a self-referral system called "SPA" system has seen a 12% increase in women being booked by 10 weeks and an 11% increase in the total number of women booked for care prior to 12+6/40. Monthly data obtained from the digital records is currently being populated and shared with the community leads to highlight areas for improvement. Predominantly women who book for care are white British, small numbers of women are teens or over 40 and the average BMI is 28.8.

Public health data for 2025 records average percentage rates :-

Smoking at booking	10%
Carbon monoxide reading at booking	77%
Alcohol use	0.5%
Substance misuse	1.3%
Breast feeding	50%
BMI > 30	17.6%
BMI>35	155%

Making every contact count is vital for information sharing. All midwives receive mandatory training in making every contact count and current rates of training exceed 81% which supports public health information giving regarding diet and



health and wellbeing. This is essential as the Health Boards services a population with high areas of deprivation (average 29%).

The vaccination offer to all women is more than 90% which is positive, and our public health lead midwife has supported video information to improve uptake. Vaccination rates for RSV are 47.6% in July 2025 of all women who received vaccination prior to birth. There has been an upward trend in rates of carbon monoxide monitoring and this has now exceeded 75% uptake. Work is ongoing to increase rates and all community midwives have received sufficient equipment to undertake this assessment. Smoking cessation support is available through dedicated teams and all women are offered referral at booking if they are a smoker or have raised carbon monoxide levels. Approximately 18%% of women have a BMI above 30 and 16% have a BMI above 35. Generally, outcomes for women with a BMI above 30 have demonstrated higher rates of intervention, caesarean birth, postpartum haemorrhage, shoulder dystocia and admission to the neonatal unit. In 2024 funding resumed to support the maternal weight management service. A full team is now in place with the service being offered across the 5 localities, referrals commenced in April 2025. Aqua natal and cooking groups have commenced in Blaenau Gwent and a webpage service leaflet and posters developed.

Workforce

For safe care it is essential to have adequate and sufficiently trained staff. The Mat/Neo Improvement plans reflects the key initiatives that form part of the Strategic Perinatal Workforce Plan- staff retention and recruitment, education, training and development, leadership, succession planning and culture. Work is underway to review workforce data and conduct a gap analysis in line with the requirements of the Strategic Perinatal Workforce Plan and to provide assurance on our compliance with (British Association of Perinatal Medicine (BAPM) Standards. NICU complies with BAPM and All Wales standards. This will involve reviewing demand and capacity, benchmarking against other services, to equip and empower the multi-professional workforce. For maternity the most recent Birth rate plus (a recognised tool to assess midwifery staffing) was completed in 2022/2023 as part of a 3-5 yearly cycle. A further assessment is due in 2026.

The workforce is our most valuable asset and the Health Board has 146 staff (121.56.39wte) currently in post within the Neonatal Unit, which includes Registered Nurses, Advanced Nurse Practitioners, Nursery Nurses, a roster co-ordinator and administrative staff, in addition to medical staff. Whilst the vacancy rate for nursing staff varies on a monthly basis the service takes a proactive approach to recruitment to ensure that posts are appointed to without delay. The service attracts many applicants and as a result of overwhelming interest from streamlining, the service recruited 8.28 WTE nurses in September 2025 and a further 2 WTE nurses have been recruited and will commence in post in March 2026. As a result, the service currently has no vacancies for registered nurses. There are no currently no gaps in the medical cover for Neonates.

Maternity has over 450 staff, midwives, nurses, maternity support workers nursery nurses and administrative staff. Birth rate plus only assesses the clinical component of midwives, nurses and band 3 maternity support workers. Birth rate plus suggests



a total clinical workforce of 242.77 WTE is required and the current clinical midwifery establishment is above this number in line with a positive prudent recruitment undertaken in October 2025. As such there are no midwifery vacancies for band 5/6 midwives with the establishment at **plus 8.34 WTE** midwives. The service appointed into RGN vacancies and has a small number of HCSW hours vacant (1.36 WTE).

Medical staffing ensures that there is 72 hours of consultant cover on the labour ward, which is currently above RCOG recommendations.

Current Midwifery hours vacant

	Vacancies	Sickness	Mat Leave	Secondment
Midwives	0	6.56%	9.2 WTE	2 WTE

Staff absence, particularly in the form of sickness poses a significant challenge to the both services as sickness absence rates can vary considerably on a monthly basis. Over the last year maternity sickness rates have fluctuated from 4.98% to 7.13%.

At present the neonatal unit is experiencing high levels of sickness absence. Focused work is being undertaken to reduce sickness levels which includes timely referral to Occupational Health, signposting to well-being services and regular meetings with staff. Maternity sickness absence varies from 6 to 11% and on average is at 7%. Staff absence is managed in accordance with the All-Wales Managing Attendance at work policy, Workforce and Organisational Development have produced a deep dive report and monthly spot audits are being undertaken to review the management of staff sickness. Although there is an uplift to support absences where there are gaps in the rotas bank staff are used.

Education, Training and Development

The organisation remains committed to promoting the education, training and development of the workforce. For NICU 92% of staff are compliant with Mandatory and Statutory training, and whilst PADR compliance is usually above 80% staff absence and operational pressures has resulted in a drop in compliance to 66%, and due to focused work, this is expected to improve month on month. The nursing workforce is highly skilled and an increasing number of nurses are gaining their qualification in speciality, providing these staff with a unique set of skills to care for neonates. A multi-faceted approach is being adopted to support nurses to obtain this specialist qualification including amending the Band 5 job description in Oct 2024 with a view of supporting Qualified in Specialty (QIS); this has been a success and staff are automatically enrolled onto Module 1 each January, followed by Module 2 in September. Due to the number of streamlining nurses joining the service, the number of QIS nurses has slightly reduced from 66% in July to 61% in December. This is expected to rise to 65% in February when results are available from the latest Module 2 submission. The BAPM target for QIS nurses is 70% of registered nurses.

Maternity has a committed focus to training and development with the provision of 6 mandatory study days for midwives to include, fetal surveillance, PROMPT (MDT



skills training) and recently safeguarding level 3. Current compliance for mandatory training exceeds 80% with a focus on culture, diversity and care through a trauma informed model. Safeguarding level 3 is at 39% overall though to note 71% compliance for community staff.

Training	Midwifery
Intapartum fetal surveillance	98%
PROMPT Hospital	98%
PROMPT community	97%
Basic Life support	92%
Neonatal life support	92%

Quality assurance of the PROMPT training has been very well received with reports of a psychologically safe environment and evidence of teamwork and excellence. PADR is at 73% with a focus to improve with monthly monitoring by the senior team. On line learning is at 77% compliance.

Ward accreditation is underway for the Neonatal Unit, maternity theatres and B3 antenatal and postnatal ward and C3 labour ward.

Culture & Psychological Safety

The provision of a conducive, psychologically safe environment where staff feel that they can ‘speak up safely, confident that concerns will be investigated and addressed is of paramount importance. A multi-faceted approach has been adopted to ensure that all staff are aware of, and have access to, a range of supportive mechanisms including coaching, mentorship, clinical supervision, and restorative clinical supervision. Effective communication is key and staff are kept updated through regular team meetings, communication boards and a monthly newsletter.

Facilitated by Workforce and Organisational Development and supported by staff unions, a Listening Exercise was held during July and September to engage with staff and seek feedback on their experience of working on the NICU. The purpose of the exercise was to conduct an independent internal review of the culture within the NICU, identifying strengths, challenges, and opportunities for enhancing team wellbeing, leadership, values alignment, and collaboration. This intervention was well received by staff who were encouraged by the actions taken to engage with and support the workforce and to address concerns raised. A report summarising the findings of the review has been presented to the Divisional team and is planned to be shared with the wider team over the next few weeks. This has been communicated with the team and encouragement given to support attendance. Recommendations from this will be taken forward in a divisional action plan.

Joint education between maternity services and neonatal services is in place with learning around culture, language, psychological safety and terminology.

Psychological safety is a feature running through PROMPT and fetal surveillance training. Maternity is a known (across the UK) “hot spot” for stressful working and staff wellbeing concerns, due to the complex and sensitive areas of work. A perinatal staff wellbeing strategy has been developed with training commenced to facilitate hot debriefs following untoward incidents- recognising that untoward outcomes may occur in maternity.



Strong, visible and compassionate leadership is crucial to shape a positive organisational culture, to ensure staff feel valued and supported. Following a review of the working practices and lead roles undertaken by the Senior Nurse on the Neonatal Unit, the band 7 staff have increased visibility, undertake professional rounding and actively support the neonatal team working within the clinical area. The increased visibility of senior and divisional staff has been welcomed by the staff and provides opportunities for staff to raise concerns and seek support in real time where needed.

Within the maternity unit the team, are working to develop a wellbeing strategy to support staff working in the areas and create a positive work environment. A Learning culture, civility and positive feedback is promoted and clinical supervision is embedded into practice.

NICU and maternity services have contributed to the divisional professional standards action plan which focuses on improving professional standards and upholding the values and behaviours of the organisation. Compliance with civility training is 89% for NICU and is currently above 80% for maternity, the benefits of this are evident.

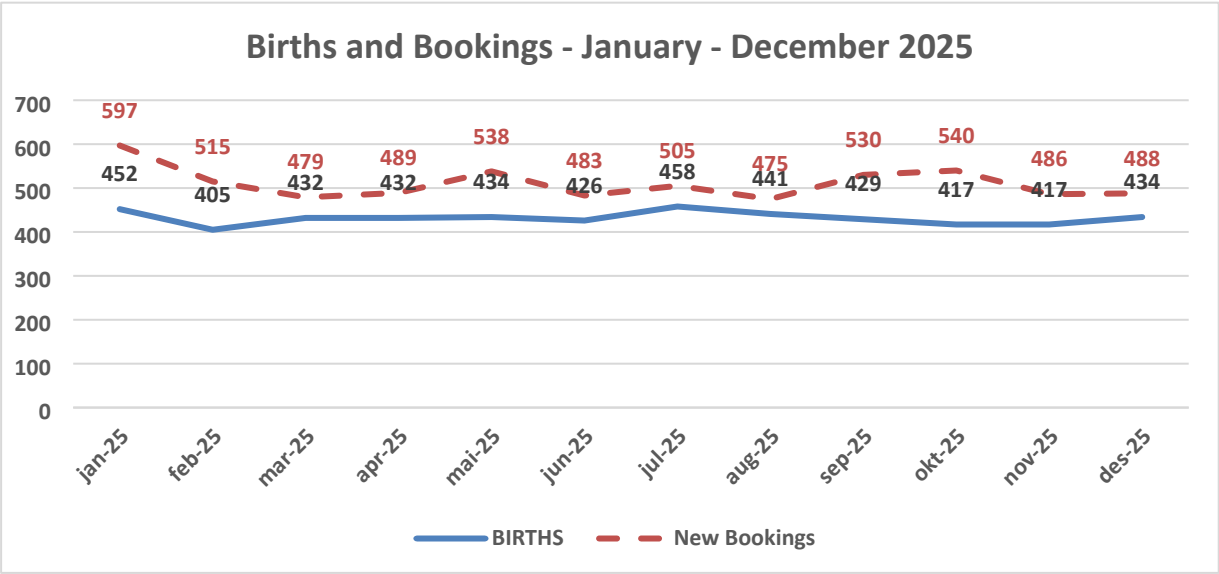
Key patient quality and safety metrics provide valuable intelligence and when compared against local and national standards can provide a useful baseline for providing assurance, measuring improvement and identifying areas where action is required.

The services monitor performance. As the first health board in Wales to introduce digital records for Maternity this allows for the timely capture of effective information. This includes data regarding, ethnicity, public health, activity (body mass index, smoking, mental health and feeding data), mode of birth and birth outcomes. The advantage of the system means that records can be reviewed in real time. Maternity has developed a working live dashboard to demonstrate its key performance indicators. Internally the performance indicators are monitored within monthly governance forums, and via divisional and directorate assurance forums. In addition, scrutiny and monitoring occurs via the Maternity and Neonatal Assurance Group chaired by our Executive Director of Nursing/ Deputy Director of Nursing, reporting into the Executive Committee and the Quality Management Group. Thus, giving clear oversight to the staff in service, the wider division and the Executive team

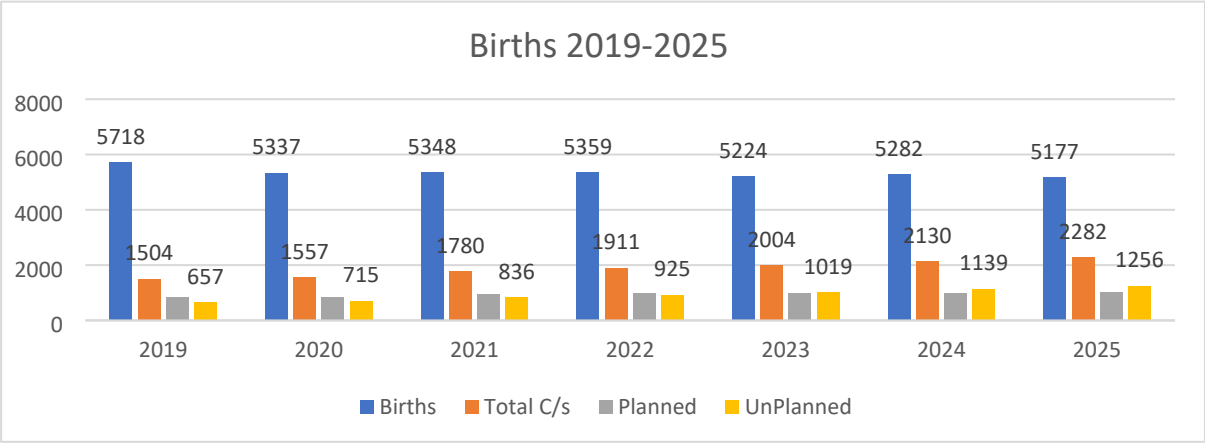
Work is ongoing to incorporate Neonatal data to ensure a comprehensive dashboard is visible to demonstrate measurable performance.



Birth /bookings ABUHB Data 2025



Births 2019-25, caesarean section rates



Intervention rates are increasing, with caesarean birth increasing yearly, with emergency or unplanned caesarean sections seeing the biggest increase. Percentage of births undertaken by caesarean section have increased from 26% in 2019 to 44% in 2025. Whilst this increase is a national picture a working group is reviewing the caesarean births with a focus on normalising birth, health education, audit, care in next pregnancy, and decision making on labour ward. Rates of instrumental births are on average 8.3% (target rate 10%) and additional training is provided to the new doctors rotating into the Health Board. Induction of labour has increased with average rate of 34% an increase of 2% over the preceding year.

Being cared for afterbirth

Postnatal care is a focus for improvements, with the introduction of drug rounds and self-medication. This is being explored as part of the wider work alongside the introduction of the electronic or digital patient medication chart. Additional training is being reviewed to improve breast feeding rates and this is being led by our infant feeding lead midwife. Breast feeding rates require improvement as average rates are 50%, more recent data demonstrates 67% mothers breastfeeding at initiation.

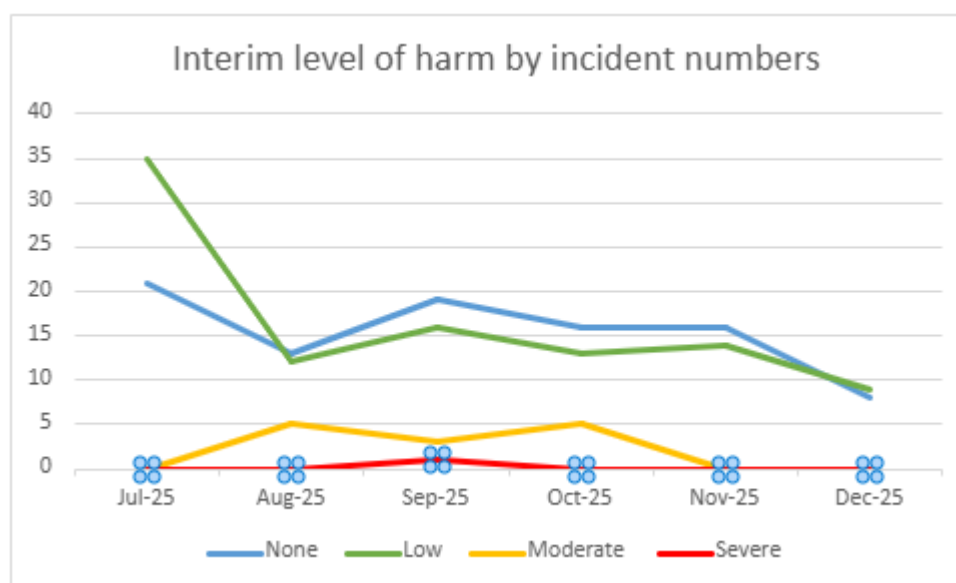


This is being targeted by the infant lead midwife and the Breastfeeding steering group. There is a focus on implementing the 3 tiers of infant feeding support with peer support groups up and running. 3 midwives have completed train the trainer course for baby friendly and a further 2 are undergoing training. A tongue tie pathway has been developed and 2 midwives have undergone training in frenotomy, with clinics due to commence in October of this year.

Incidents

NICU

All incidents are reported via DATIX which is the national incident reporting system and NICU report on average 30 incidences per month, the vast majority of which are classified as resulting in no low levels of harm.



Based on a review of DATIX incidences the top 10 reported incidences have been reviewed and action plans have been developed to address each of the top 5 risks as of June with the aim of reducing the number of incidents that occur. The top 5 themes continue to be closely monitored and the effectiveness of these interventions is being closely monitored as an integral part of the NICU Improvement Plan.

In response to an increase in medication errors a medication improvement plan has been developed which includes the introduction of prescription rounds, a medication forum to include the QPS lead, nurses and medics, medication training updates, prescribing training for medical staff and simplifying the IV prescription charts. A Medication Safety Group consisting of medical staff including a Consultant, nurses and pharmacists has also been convened.

Maternity

Maternity services have a proactive approach to clinical incident reporting and all staff are encouraged to report incidents via the electronic DATIX system and engage with patient safety incidents in line with the Royal College of Obstetrics and Gynaecology and Maternity Service trigger lists. All clinical risk incidents are reviewed on a weekly basis by the MDTs and this provides an open forum for all



staff to engage. In 2025 a Governance lead risk midwife was appointed to support the process.

Of the 1693 incidents during 2025 reported in Maternity the majority were low or no harm. 66 were graded as moderate, 1 catastrophic and 5 moderate. 3 are under management review with the other 3 downgraded to low/no harm.

Clinical incidents, nationally reportable incidents, themes, trends and learning, service user experience, concerns and feedback are monitored and managed by the senior midwifery and neonatal teams and the local governance group, which includes, obstetric, neonatal, midwifery and anaesthetic professionals.

Outcome data for births is monitored and reviewed and shared via assurance forums

2025 Data: -

Term admissions to NICU	4%
Shoulder Dystocia	1%
Post partum haemorrhage >2L	0.3%
Tears 3b, 3c, 4	0.6%

No never events were reported in the last year. Maternity services work within the requirements for duty of candour and in 2025 4 incidents met the threshold for duty of candour. 2 remain under review, 2 cases have been investigated and actions taken, with shared learning through multi-disciplinary forums.

Learning themes and trends from incidents in maternity

- Post-partum haemorrhage well managed
- Positive feedback to staff
- Increased reporting of postnatal readmissions with infection – no commonality
- Medication errors documentary
- Hyperstimulation of uterus
- Obstetric anal sphincter injury – referral
- Documentation errors

National Neonatal Audit Programme (NNAP)

The National Neonatal Audit Programme (NNAP) assesses whether babies admitted to neonatal units in England, Scotland and Wales receive consistent high-quality care, and identify areas for quality improvement. The latest NNAP report that was presented to the Clinical Standards and Effectiveness Group in November showed significant levels of assurance showing that the organisation is above the mean for 8 of the 13 measures and within the mean for 4 of the measures. One measure, timeliness of Retinopathy of Screening Testing we were below the mean, which prompted a quality improvement project being commenced to bring about improvement. In addition the RCPCH have reported on NNAP outlier status for non-invasive ventilation, this is under review and an improvement plan will be put into place.



Maternity and neonatal services undertake PERIPrem Cymru Optimisation Tool. – A perinatal bundle aimed at improving outcomes for babies born prematurely in Wales.

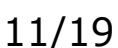
Recent data to June 2025

Whilst the directorates are meeting a number of the standards there is still work to ensure uptake of probiotics and early breast milk and antenatal magnesium sulphate. There is a commitment to support this work and this will form part of an improvement plan to be shared with the Maternity and Neonatal Assurance and Improvement Group.

Bereavement care is sadly part of maternity and neonatal services, and details joined up working and forms part of Perinatal Mortality Review Tool (PMRT) case review. All women receive the offer of follow up, including letters and support via the bereavement lead midwife, and joint appointments with their named consultant. Bereavement care forms part of both maternity and neonatal services improvement plan, with a commitment to implement the bereavement care pathway following its release. In addition, bereavement training has been added to 2025 training agenda. Women who have had an untoward outcome are always offered a family liaison person or point of contact and we are keen to support these families to make improvements in care.

Maternity and Neonatal service collates and reviews all baby deaths via local and national audit and reporting. This is undertaken both independently and as a multi-disciplinary collective across the two directorates. These cases are DATIXED reported as a nationally reportable incident and uploaded to MBRRACE in accordance with reporting pathways. Incident review and investigation occurs via:-

- Multidisciplinary perinatal mortality team
- Local monthly mortality meeting
- National mortality meeting with the maternity and neonatal network
- Local audit
- Clinical Governance and quality and patient safety meetings
- Staff debrief
- For neonatal deaths a 72hour MDT review with representation from medical examiner and decision made whether PRUDIC/Coroner case.
- Learning from reviews cascaded



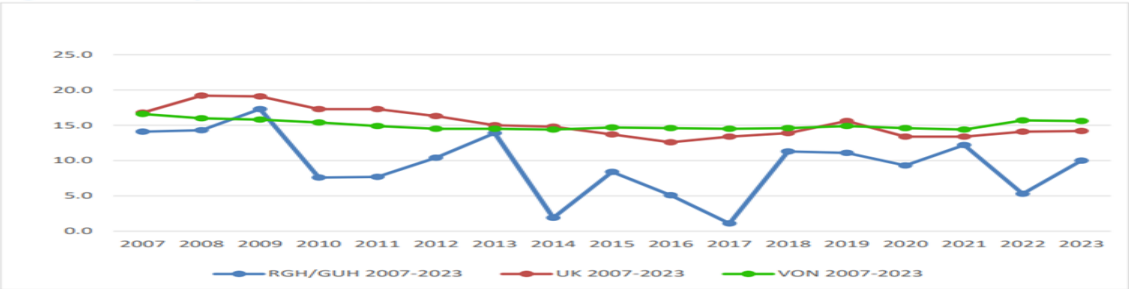
MBRRACE DATA 2019-2023 (2024 and 2025 awaited)

Year	Stillbirth		Neonatal Deaths	
	Crude Rate	Stabilised Rate	Crude Rate	Stabilised Rate
2019	4.9	4.14	0.88	1.48
2020	2.46	3.52	1.14	1.58
2021	4.45	4.17	0.93	1.66
2022	4.25	3.67	0.74	1.15
2023	3.06	3.61	1.9	2.01
2024	4.16	Not available AB data only	1.7	Not available AB data only
2025	3.6	Not available AB data only	1.9	Not available AB data only

For 2023 Perinatal rates (combined stillbirth and Neonatal death) are average to similar Health Boards or trusts. Stillbirth rates are average to similar Health Boards or trusts. Neonatal deaths rates are higher, but when excluding deaths due to abnormality they are average to similar Health Boards or Trusts

The below graph shows the mortality in babies born less than or equal to 1500 grams or born less than 30 weeks over years 2007 to 2023 as a part of VON bench marking. Since 2013, Aneurin Bevan University Health Board mortality rate has been below UK rate and VON rate. (Vermont Oxford Network is a database reporting on very low birth weight babies and NICU admissions- tracking long term outcomes)

Fig 29: Mortality in RGH/GUH, UK and VON 2007-2023



Actions taken following review of care

- Additional trolley area added to Maternity Triage to improve capacity
- Additional CTG machines supported via capital funding – increased monitoring regime for high-risk pregnancies
- Update to guidelines regarding fetal surveillance, including antenatal CTG interpretation.
- Fetal study day incorporates learning regarding chorioamnionitis
- Increased hours for fetal surveillance midwife and additional faculty to support training
- Adoption of the Fetal surveillance standards
- Self-referral pathway for early booking to increase opportunity for early screening and health education



- Update to the bereavement pathway
- Additional training in consent for post mortem
- Mandatory MECC training for maternity and neonatal staff
- MDT engagement to undertake review and cascade learning locally and nationally
- Adherence to Periprem optimisation tool, with lead midwife, obstetrician and neonatologist

Infection, Prevention & Control

Infection, Prevention and Control (IPAC) remains a key priority for the Health Board and NICU have 100% compliance with hand hygiene and Peripheral Vascular Care audits. Following an increase in the number of infection cases on NICU an IPAC action plan has been developed. Action has been taken to improve the standards of cleanliness on the unit, by reviewing the cleaning schedules, routine surveillance of organisms has been enhanced and regular audits are being conducted. Safety briefings are conducted at the start of each shift to update staff and highlight required actions. Both services participate in safe to start.

The Health Board participates in national data collection for Caesarean Section Surgical Site Infection (SSI) via Public Health Wales surveillance programme. Most recent audit cycle demonstrates a fall in SSI rates. A task & finish group is in place between maternity and infection prevention teams, with a keen focus to reduce the SSI rates. Patient education leaflets are in development, with the importance of hand washing being key. Infection prevention and wound care forms part of midwifery mandatory training and for the forthcoming year the allocated time for training has been increased.

Hospital and health board data from 01 Jul 2024 - 30 Jun 2025

	SSI Rate	Change	Valid data
The Grange University Hospital			
Q3 2024 - Q2 2025	3.31%	↓11.73%	100%
Q3 2021 - Q2 2024 *	3.75%		99.91%

Rates over past years since opening The Grange University Hospital range from 3% to 6%.

The Grange University Hospital			
	Procedures*	SSI	SSI Rate (%)
Q3 2024 - Q2 2025	2204	73	3.31
Q3 2021 - Q2 2024 (baseline)	5758	216	3.75
2025	Q2	522	17
	Q1	553	17
2024	Q4	572	12
	Q3	557	27
	Q2	482	19
	Q1	471	27
2023	Q4	524	12
	Q3	509	22
	Q2	490	16
	Q1	491	27
2022	Q4	498	16
	Q3	483	25
	Q2	424	11
	Q1	463	18
2021	Q4	492	9
	Q3	431	14

There has been a focus on infection prevention and the maternity is aiming for ANTT Gold accreditation which will support the management of wound care within clinical practice. Current face to face compliance is more than 85%, with compliance with on line learning only reporting 22%. It is noted that there are discrepancies on this data and this remains a focus for improvement.

Patient Engagement

In 2025 the All-Wales Perinatal Engagement framework was launched by Welsh Government as part of the Mat/Neo Safety Support programme, setting out the minimum standards for service user engagement. A task and finish group has been established to review the framework and to rag rate areas for action. Maternity and neonatal services within ABUHB have developed a joint action plan to self-assess and monitor the delivery against the 10 commitments, currently led by our consultant midwife. Excellent progress has been made, particularly in relation to the training and education to support a listening culture. A job description has been developed for the MNVP chair with remuneration for 2 days a month being reviewed within the Division.

The service has a family experience midwife in post and neonatal services are working towards the Bliss Baby Charter. For NICU parent satisfaction surveys are in place and the feedback remains very positive, 4 formal complaints being received within the last 12 months (2 from the same family).

The Health Board proactively seeks engagement with service users, families and the public. This is not only through themes identified and discussed in our service user engagement forum "BABI", which has since collaborated with the neonatal service user group "Dinky Dragons". All are welcome to attend, to engage proactively shaping change. Maternity services have a very active social media presence, with over 10k followers. Women can access directly into maternity services via this forum, and the service is responsive to those requests. Frequently they are used to share pictures and positive stories, which, with consent we share. The PALS service provides further feedback as does the PTR team, PTR leaflets and information is available in all clinical areas. The timeliness of responses to concerns and the quality of the review are pivotal to improving care and experience. The service has a lead midwife for patient experience and there is a focus on early and effective resolution, supported by all within the senior management team. Themes from concerns are shared as part of governance and local midwifery forums and national meetings. As of November 2025, the service has increased its response rate to >80% and has halved its overdue responses.

The service offers an "after birth" service for women who have ongoing or have traumatic distress post birth. Their experience contributes to ongoing learning and the mandatory study days are conducted through the lens of trauma informed care, utilising anonymised scenarios for learning. QR codes are available within the clinical rooms and CIVICA is in use for women to provide feedback. A bespoke patient survey feedback CIVICA was rolled out in September 2025 for pregnant and postnatal women and families, effectively covering all perinatal duration, including those families who access neonatal services. The HIW visit to GUH in 2023 identified positive patient experience at The Grange University Hospital.



In collaboration with our service users maternity services have committed to support women whose first language is not English. A volunteer support service established. This supports women within their own communities ensuring they are signposted to health. The volunteers have further created on line forums and befriending sessions offering support and friendship, and have been meeting up with women in their local communities to provide friendship, support, and to help women navigate the maternity system and the available resources. One volunteer has established a well-attended breast-feeding support group in Monmouth, with a special focus and support for mothers from the Ukraine who have sought sanctuary in Wales. In recognition of excellence in 2024 the volunteer service was awarded the CNO award, and in 2025 was recognised by HRH patron of the RCM.

"Hello and Welcome" displays in multiple languages are visible in our clinical settings. Displays and picture resources are in place with QR codes, enabling service users to have the option to choose preferred language. There are posters in clinical areas with contact details of our volunteers who speak English as an additional language. The posters are written in the volunteer's first language (for example Hungarian), inviting other Hungarian mothers to get in touch if they would like some help to find and access information in their first language. There is enhanced networking and engagement with the Roma community and a "For Dads, by Dads" group in Torfaen to support new and expectant fathers.

Social media pages have pictures of people representing multiple characteristics including all protected characteristics to celebrate diversity in multiple ways. There is multi-faith celebration on the social media pages which represent inclusive resource for all women. All clinic and community leads have a list of key cultural, religious and community events that are significant for Black, Asian and Minority communities. Teams are encouraged to recognise and celebrate the events.

There has been the establishment of a bespoke antenatal education programme for Bengali women. This was the idea of one of the community midwives who recognised the power of providing care in a familiar language and spoke Bengali. Keen to make improvements for women she now provides antenatal education for women within Newport.

As part of the maternity services booking process, all women are asked their ethnicity, their first language, and whether they need an interpreter. To support safe care, it is vital that service users can communicate with teams effectively. To this end maternity services uses IPADS in all clinical areas including community, this enables the use of language line, google translate and the service was one of the pilot sites for sign live for women who are deaf. In 2023 the service introduced digitised end to end maternity records. All women can review their records in their chosen language. Members of the maternity team including reception and admin teams attended Diverse Cymru's Cultural Competence Awareness Sessions, and forums. This has further created a more welcoming and understanding service. In recognition for the work undertaken and following assessment ABUHB maternity services were awarded Diverse Cymru cultural competencies silver accreditation award. A first in Wales and demonstrates the commitment of the service to its service users and diversity.



There is commitment to ensure the sharing of information. Aneurin Bevan University Health Board is the first Health Board across Wales to implement a digital end to end system for maternity records. This provides women with access to their clinical records, in the form of an app supporting their ability to be partners in care. Detailed appointments are shared, notifications regarding guidelines and leaflets can be shared and the system ensures accurate data reporting. Importantly the midwife can review what the woman has read and this affords the opportunity to revisit any missed information.

NICU regularly seeks feedback from parents about their experience on the unit through the use of parent satisfaction surveys and the feedback remains very positive. From September NICU now utilise CIVICA to obtain patient feedback by distributing links to questionnaires to mothers. By closing the loop and sharing feedback with staff and families, information will be shared and assurance provided that we value their feedback, are committed to learning and acting on concerns, driving quality improvements and service development.

Improvement work

Nationally maternity and neonatal services have been subject to a number of independent reviews to examine the safety and quality of care since 2015. The most recent independent report was released in 2025, reviewing Swansea Bay services. A gap analysis of ABUHB maternity and neonatal services was conducted in July 2025, detailing good and improving practice and areas for improvement, and findings shared with the Executive committee.

All-Wales Perinatal Engagement framework was launched by Welsh Government as part of the mat/neo safety support programme, setting out the minimum standards for service user engagement. To date, a joint action plan has been created to self-assess and monitor the 10 commitments, currently led by maternity services consultant midwife. There has been excellent progress, particularly around the training and education to support a listening culture.

Perinatal Quality Statement 2025 sets out a national commitment to delivering safe equitable and high-quality care for women, babies and families across Wales. It aligns with *A Healthier Wales*, the long-term strategy for health and social care. The Quality Statement requests 7 key actions for the Health Boards, summarised and rag rated for action.

The **maternity and neonatal safety support programme** undertook an initial discovery of services across Wales in 2023 and this was followed up in 2024 by phase 2 the implementation phase, aimed at improving care in maternity and neonatal services. 124 recommendations /actions were noted for areas of improvement. 46 of these were aligned to the responsibility of the Health Board. Maternity and neonatal services have worked collaboratively to undertake a self-assessment and gap analysis which is a working document. There has been successful implementation of NEWTT2 early warning score, to identify at risk babies on the postnatal ward. Work has been delayed around the MEWS early warning score to ensure it aligns with the digital records.



Next steps

Over the next year the services and Health Board will focus on delivering the range of actions plans, which form part of an overarching action plan, prioritising the delivery of the immediate quality and safety actions including:

- Deliver the Medication action plan to support patient safety
- Deliver the IPAC action plan to ensure high standards of infection prevention and control
- Review the common themes generated from the Listening Exercise and progress areas requiring action.
- Review the RCPCH report on the NNAP outlier status and progress the actions required.
- Maternity and Neonatal to continue to work collaboratively to progress the delivery of the MatNeo programme, Perinatal Workforce Plan and All-Wales Perinatal Engagement Framework alongside the NICU Action Plan.
- Implementation of MEWS early warning score
- BSOTS Triage assessment for women to access the service
- Rapid Access card to maternity services for those whose first language is not English
- MUSA – Assessment for midwife led unit
- Collaborative and joined up working of maternity and neonatal services
- Dedicated transitional care.

Regular updates will continue to be presented to the Maternity and Neonatal Improvement and Assurance Group (MNIAG) and the Divisional Assurance to provide assurance that improvements are made to being made to ensure that the workforce are empowered and supported to deliver the highest standards of care.

Argymhelliad / Recommendations

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

Take **ASSURANCE** from this report, the ongoing work to provide a safe service and the commitment to implement national directives, improvement work and supportive actions.

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.

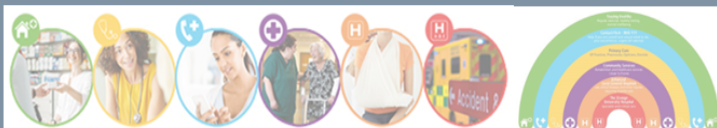
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	NICU – Neonatal Intensive Care Unit
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

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	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



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

Choose an item.



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	17 February 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	PALS 2-year Review
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Jo Hook, Senior Nurse Tanya Strange, Head of Nursing

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 Advice and Liaison Service (PALS) was launched in November 2023 as a proof-of-concept initiative to improve the Health Board's ability to respond to informal concerns through early resolution. Two years on, the service has become a highly visible and valued point of contact for patients, families, and carers across Aneurin Bevan University Health Board.

While the original business case anticipated a site-based model focused on managing early resolution cases referred from the Putting Things Right (PTR) team, the service has evolved into a mobile, seven-day operation that supports a wide range of enquiries and concerns. The team works proactively to resolve issues before escalation, contributing to improved patient experience and reduced pressure on clinical teams.

However, challenges have emerged around the categorisation and recording of concerns, particularly in relation to Datix system limitations and the distinction between Enquiry and Early Resolution cases. These issues have implications for data accuracy, service evaluation, and operational efficiency.

A review of service models across other Welsh Health Boards highlights variation in structure, accessibility, and approach to concern management. This paper presents a review of the existing PALS service based on original assumptions and proposes recommendations to prepare for the new PTR regulations.

Background

The original business case, developed in 2023, marked a significant step toward improving patient experience and engagement within Aneurin Bevan University Health Board. At the time, the Health Board did not have a dedicated PALS service, and patients, carers, and families lacked a single point of contact to raise informal concerns or queries. The proposal aimed to bridge this gap by integrating the existing Patient Support Officer (PSO) service and introducing a dedicated, compassionate resource across hospital and community settings.

The original business case proposed a 12-month proof of concept to establish a PALS model operating across the three main hospital sites (GUH, RGH, and NHH) with coverage extended to community and mental health settings. The service was originally designed to operate from 08:00 to 20:00, with Band 5 PALS Officers (3.81 WTE) and Band 3 PSOs (2.24 WTE) providing weekday and weekend coverage, supported by a Band 7 team manager. The total pump-priming cost for Year 1 was £309,937, with subsequent annual costs projected at £109,731 for the PALS officers and the recurrent funding of £101,815 for the existing PSO officers.

The original position anticipated:

- Pump-priming funding of approximately £309,937 for 12 months to prove the concept before exploring redeployment of existing resources from PTR for sustainability.
- Service operation between 08:00–20:00 across multiple hospital sites, including mental health units
- Single point of access aligned to DATIX/PTR systems.
- Recruitment to fixed-term posts despite potential challenges.
- Improved compliance with Welsh Government PTR targets and delivery of equitable access for all patients, including those with protected characteristics.

These assumptions informed the implementation plan and remains relevant for evaluating progress and sustainability as the service moved from proof of concept to an established model.

A central aim of the original proposal was to improve the Health Board's ability to respond to early resolution concerns, defined as informal issues that could be addressed within 48 hours, thereby reducing escalation to the formal Putting Things Right process. The business case anticipated that all early resolution cases would be managed by the PALS team, freeing up clinical time, improving patient and staff experience, and supporting compliance with statutory obligations under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and the Health and Social Care (Quality and Engagement) (Wales) Act.

Importantly, this initiative positioned ABUHB as an early adopter of best practice under Welsh Government's quality and engagement agenda, reinforcing its commitment to person-centred care and transparency.

As part of the original business case, it was anticipated that a review of divisional Quality, Patient Safety and Putting Things Right resources could support future redeployment into the PALS service. With a projected reduction in formal

complaints through effective early resolution, the potential to realign existing PTR resources was identified as a means of supporting the long-term financial sustainability of the service, in alignment with the Health Board’s QPS Strategy. However, while this remains a strategic goal, the funding has not yet been formally realigned to reflect this with the PTR Team currently managing the majority of ER cases.

The model was aligned to the Patient Experience and Involvement Strategy and the Quality Strategy and was to be evaluated after 12 months to assess its impact and sustainability, including the potential redeployment of existing QPS and PTR resources to support the £109,731 unfunded costs.

Early feedback during the proof-of-concept phase indicated improved patient satisfaction and reduced escalation to formal complaints, validating the need for a dedicated service and demonstrating its cultural impact in promoting openness and responsiveness.

This review reflects on the implementation of the service over the past two years, recognising that the team’s current operational model has evolved from the original proposal as shared above.

Asesiad / Assessment

Achievements Against Original Position- Summary

The original business case for the Patient Advice and Liaison Service (PALS), developed in 2023, set out a proof-of-concept model aimed at improving patient experience through early resolution of concerns. Below is a high-level summary of achievements against those initial assumptions, highlighting progress in service delivery, operational scope, and impact on patient engagement. Key milestones include the successful launch of PALS, integration of Patient Support Officers, and significant reductions in complaint escalation.

For a detailed narrative on the evolution of the service, operational challenges, and benchmarking insights, please refer to the comprehensive review outlined below.

1.	No existing PALS service within ABUHB: within Aneurin Bevan patients, families, and carers lacked a single point of contact for queries or informal concerns.
	Achieved: PALS launched in November 2023 and is now a highly visible, trusted point of contact for patients, families, and carers. Over 12,585 cases managed in two years, averaging 524 per month , with only 0.19% escalating to formal complaints .
2.	Early resolution reduces formal complaints: It was assumed that timely, compassionate handling of concerns will prevent escalation to formal complaints and improve patient experience.
	Achieved: PALS has significantly reduced escalation. Of all cases managed, only 25 escalated to PTR . Average closure time for ER cases improved to 1.68 days , supporting compliance with the 48-hour target.

3.	Integration with current PLO service: The model assumed that existing Patient Liaison Officers (introduced during COVID-19) would be aligned with the new PALS structure.
	Achieved: Patient Support Officers (previously PLOs) are fully integrated into the PALS team (3 Band 3 PSOs, 2.14 WTE), working alongside Band 5 PALS Officers (2.55 WTE).
4.	Pump-priming funding required: It was assumed that initial investment of approximately £309,937 for 12 months would test the concept before considering redeployment of existing resources for sustainability.
	Achieved: Initial investment enabled service launch. Current annual budget is £201,815, with actual costs at £195,953, demonstrating financial control.
5.	Operational hours (08:00–20:00, 7-day model): Assumed service would operate 08:00–20:00, with PALS staff covering weekdays and partial weekend hours across multiple hospital sites (including mental health units).
	Achieved: Service operates 7 days, 8am–8pm, including weekends and public holidays. However, Datix system limitations (core weekday hours only for ER logging) create challenges for compliance and reporting.
6.	Impact on PTR: Assumed that PALS would significantly reduce cases managed through the Putting Things Right process, freeing clinical time and improving compliance with Welsh Government targets.
	Achieved but limited: PALS managed 168 ER cases referred from PTR (13% of PTR ER activity) plus 5,402 direct cases in the same period. Original expectation that PALS would manage all ER cases has not been fully realised due to administrative and national system constraints.
7.	Future resource alignment Assumed that after proof of concept, some existing QPS and PTR resources could be redeployed to PALS for long-term financial stability.
	Not yet achieved: Redeployment of QPS/PTR resources remain a strategic goal but has not been implemented due to the current demands and issues in the QPS/PTR.
8.	Recruitment feasibility Assumed ability to recruit to fixed-term posts despite potential challenges due to non-permanent nature.
	Achieved: Team successfully recruited and retained staff on permanent contracts.
9.	Technology and process alignment Assumed integration with DATIX/PTR systems and establishment of a single point of access (SPA) for public and staff.
	Partially Achieved: PALS uses Datix for logging, but system configuration does not support 7-day operations or ER case management outside core hours. Categorisation inconsistencies (ER vs Enquiry) impact data accuracy.

10.	Positive impact on equity and patient experience Assumed service would improve access for all patients, including those with protected characteristics, through proactive reasonable adjustments.
	Achieved: Service provides proactive support, pastoral care, and champion roles (Neurodiversity, Veterans, Deaf community). All staff are undertaking BSL Level 1 training to improve accessibility.

Narrative Assessment

Since its launch in November 2023, the PALS service has evolved from the original business case proposal into a flexible, responsive model tailored to the needs of patients, families, carers, and staff across Aneurin Bevan University Health Board. The current annual budget is £201,815 (2025/2026).

Overseen by the Senior Nurse, Patient Experience and Involvement, the current team structure comprises 3 Band 5 PALS Officers (2.55 WTE) and 3 Band 3 Patient Support Officers (2.14 WTE), totalling 4.69 WTE. The service operates seven days a week, with extended hours from 8am to 8pm, including weekends and public holidays (PALS Officers: 9am–2pm; PSOs: 8am–8pm). While the original proposal anticipated site-based coverage across multiple hospitals, the team is now based at the Grange University Hospital and travels across the Health Board to deliver support.

PALS provides confidential advice, support, and information on health-related matters, with a strong emphasis on early resolution. Patients, families, carers, and friends contact the service for a range of reasons, from seeking guidance and raising concerns to offering compliments and suggestions. Support may be short-term or continue over several months, depending on individual needs.

The team works closely with the Putting Things Right team and clinical staff, facilitating communication, concern resolution, and face-to-face discussions.

Themes and trends are compiled via Datix, with positive outcomes and compliments shared to inform service improvement.

The current operational model reflects a shift from the original proposal, which anticipated broader site-based coverage. The mobile nature of the team has allowed for greater flexibility and responsiveness, enabling PALS to adopt a more proactive rather than reactive role. The majority of calls received relate to the Grange University Hospital where the team are based.

- PALS assists with:
- Enquiries and early resolution
 - Complaint avoidance
 - Listening meetings
 - Clinical meeting attendance
 - Call 4 Concern escalation
 - Appointment support
 - Pastoral care
 - End-of-life and bereavement liaison

- GP concerns
- Pastoral support for people with open formal complaints
- Collaboratives
- Big Conversations
- People Participation Panels
- Digital Patient Stories
- Champion roles – Veterans, Neurodiversity, Deaf
- Supporting with CIVICIA patient feedback

Currently, most direct calls to PALS are logged on Datix under the category of 'Enquiry', reflecting the informal nature of many initial contacts or following initial discussions with the individual and explanation of the team's remit. In contrast, calls referred from the PTR team are logged under 'Early Resolution', in line with current internal guidance.

It is recognised that many of the PTR referred concerns are similar in nature to those received directly by PALS. This approach, while structured, can result in similar types of concerns being recorded differently depending on referral route. This has implications for consistency in reporting and service evaluation. There is an opportunity to review this process to ensure that categorisation reflects the nature and complexity of the concern itself, rather than solely its origin, allowing for greater flexibility and accuracy in how concerns are managed and recorded.

PTR and PALS

The original business case was developed with the intention of PALS managing all Early Resolution cases. Due to the heavy administrative demands of managing these cases in line with current legislation it has not been possible to transfer all cases for PALS to manage.

The PALS service is designed to provide direct support within clinical areas, particularly for patients currently in hospital. Early Resolution cases for inpatients are appropriately managed by the PALS team. Between October 2024 and September 2025, **168 of the 1,308 Early Resolution** cases received by the Putting Things Right (PTR) team were managed by PALS, representing 13% of PTR's ER activity during that period. In addition to these, PALS independently managed a further **5,402** cases during the same timeframe, the majority of which were logged as Enquiries. These cases were resolved informally, often preventing escalation to formal complaint processes.

The criteria for PTR referrals to PALS are clearly defined:

- All inpatient-related calls
- All Grade 1 and Grade 2 concerns that do not have an existing pathway in place

Referral Routes and Repeat Engagement

The PALS service receives a significant proportion of its contacts directly from patients and families, many of whom return to the service for ongoing support or to raise new concerns. This repeat engagement reflects the trust and visibility the team has built across the Health Board. In addition to referrals from PTR team, PALS receives enquiries through a wide range of other routes, including direct contact from patients, families and carers, advocacy groups such as Llais, care

homes, clinical teams, the CEO office, Corporate Governance, Members of the Senedd (MS), Members of Parliament (MP), the Medical Examiner, and emergency services such as the Police.

The team also responds to contacts generated through the Civica patient feedback system, while surveys are anonymous, patients occasionally leave contact details and request follow-up. PALS contact information is embedded within all survey communications, ensuring patients have a clear route to reach out for further support.

The PALS team has developed into a proactive and highly visible service that patients and families increasingly rely on to ensure concerns are addressed before escalation. Visibility across hospital sites is a key enabler of trust and engagement, allowing the team to intervene early and support resolution in real time.

A core challenge for the team is maintaining the balance between being ward-facing and accessible, while also ensuring timely documentation and compliance with the 48-hour response target for early resolution under PTR regulations. This requires careful coordination between office-based tasks and on-the-ground presence in clinical areas.

The team continues to apply professional judgement and informed consent when determining the most appropriate logging route, ensuring patients and families are aware of the options available to them, including escalation to formal complaint routes if informal resolution is not achieved. This flexible approach allows the service to respond compassionately and effectively to a wide range of concerns, while maintaining transparency and choice for those accessing support.

Categorisation and Recording of Calls

In addition to categorisation challenges, there are also technical limitations within the Datix system that impact how early resolution cases are recorded. While the PALS team operates seven days a week from 8am to 8pm, the Datix system is configured to allow early resolution cases to be opened and closed only during core weekday hours. This misalignment creates practical difficulties in logging and managing concerns in real time, particularly after 5pm, over weekends and public holidays. As a result, it can affect the accuracy and timeliness of reporting for the PTR team and limit the flexibility of the PALS service in responding to concerns outside standard hours. This issue highlights the need for system-level adjustments to better reflect the operational reality of a seven-day service.

Categorisation and Data Handling

The process of categorising concerns within Datix presents ongoing challenges that impact the accuracy and consistency of reported activity. While Early Resolution cases are expected to be closed within 48 hours, this timeframe is not always achievable due to legitimate factors such as delays in clinical responses, complexity of the concern, or difficulty in reaching relevant individuals. In some instances, cases initially logged as ER may be reclassified as Enquiries or reassigned to formal complaint pathways, which can affect how the work undertaken by the PALS team is represented.

These variations in recording practice can lead to discrepancies in how concern management is reported and understood. This may result in underrepresentation of the complexity and time investment involved in resolving certain cases and can obscure the true escalation rate to formal processes.

A consistent and transparent approach to categorisation and data handling is essential to ensure that reporting accurately reflects service activity, supports informed decision-making, and maintains confidence in the integrity of performance data. It also reinforces the need for a clearer delineation of roles between PALS and PTR, where PTR would manage subtypes 'Early Resolution' and 'Putting Thing Right'. formal, and PALS would utilise the 'Enquiry' function in Datix to support informal resolution. This separation would improve consistency in categorisation, enhance data accuracy, and preserve the distinct identity and operational flexibility of the PALS service.

PALS Service Activity Overview

Over the two-year period since its implementation, the PALS service has managed a total of **12,585 cases**, an average of **524 cases per month**. Cases are logged under two primary categories within Datix: 'Enquiry' and 'Early Resolution'. On average, 507 cases per month are recorded as Enquiries, and 17 as ER, with ER cases predominantly originating from PTR referrals.

From the 12,585 cases **only 25** have formally escalated to PTR representing **0.19%** of overall activity. These figures demonstrate the significant volume of concerns managed informally by PALS and the relatively low escalation rate to formal complaint processes, highlighting the team's effectiveness in resolving issues early and improving patient experience.

Pastoral and Holistic Support

In addition to supporting concern resolution, the PALS team provides a wide range of pastoral and relational support that extends far beyond traditional complaint management. The team offers compassionate, person-centred assistance through listening meetings, clinical and appointment attendance, and dedicated support for patients and families during end-of-life care and bereavement. PALS Officers provide pastoral care for individuals with open formal complaints, liaise with GPs, and offer continuity for those navigating complex or emotionally distressing pathways.

The team also facilitates collaborative initiatives such as Big Conversations, People Participation Panels, and Digital Patient Stories, ensuring that patient voice informs service improvement. Due to the increase requests for digital patient stories to support learning, 2 members of the team have recently attended digital patient story training.

Champion roles within the team covering areas such as neurodiversity, veterans, mental health, learning disabilities, and the deaf community further enhance the team's ability to advocate for diverse needs. Additionally, PALS acts as the designated point of contact for any patient who wishes to opt out of receiving CIVICA patient feedback surveys via SMS, ensuring that preferences are respected and actioned appropriately. This holistic approach enables PALS to act as a trusted presence across the Health Board, supporting emotional wellbeing, improving

communication, and ensuring patients and families feel heard, respected, and supported throughout their healthcare journey.

Moving forward: Accessibility and Supporting the Deaf Community

To ensure equitable access for Deaf patients and their families, the PALS team is committed to becoming a recognised point of contact for individuals who may experience communication barriers during their hospital stay. All PALS staff will be undertaking British Sign Language (BSL) Level 1 training, and the team will be equipped with appropriate communication tools, to enable accessible contact via text relay and other digital platforms. PALS also includes Deaf Champions who advocate for improved accessibility and work closely with clinical teams and the Interpretation and Translation Project Manager to ensure timely access to BSL interpreters and appropriate communication support. By embedding these capabilities, PALS aims to provide a safe, trusted, and responsive route for Deaf patients to raise concerns, seek information, or request assistance while in hospital.

Informal Benchmarking of PALS Service Models Across Welsh Health Boards

As part of this review, an informal benchmarking exercise was undertaken to explore how Patient Advice and Liaison Services (PALS) are structured and delivered across other Health Boards in Wales. This comparison highlights notable variation in staffing levels, operating hours, accessibility, and categorisation practices.

Aneurin Bevan University Health Board (ABUHB) operates a seven-day, mobile PALS model with 4.69 WTE staff, offering extended hours and broad accessibility. In contrast, other Health Boards typically operate Monday to Friday services within core hours (9am–5pm), which aligns with the Datix system's configuration for logging Early Resolution cases. As a result, these Health Boards do not experience the same technical limitations faced by ABUHB, where the PALS team operates beyond core hours and encounters challenges in opening and closing Early Resolution cases outside weekday daytime periods.

Categorisation of concerns also varies. Some Health Boards log all contacts as Enquiries, while others use both Enquiry and Early Resolution categories depending on internal guidance. ABUHB's model, which distinguishes between PTR-referred Early Resolution cases and direct Enquiries, presents unique challenges in consistency and reporting.

It is also recognised that other Health Boards undertake pastoral elements within their PALS or equivalent services, including support with communication, attending meetings, and liaising with families. However, ABUHB's model, with the smallest team, offers a broader scope of proactive, patient-facing engagement, including champion roles, bereavement liaison, and participation in strategic initiatives such as Big Conversations and People Participation Panels. This informal benchmarking exercise reinforces the breadth and responsiveness of ABUHB's PALS model, while also highlighting areas for potential refinement in data handling, system configuration, and sustainable workforce planning.

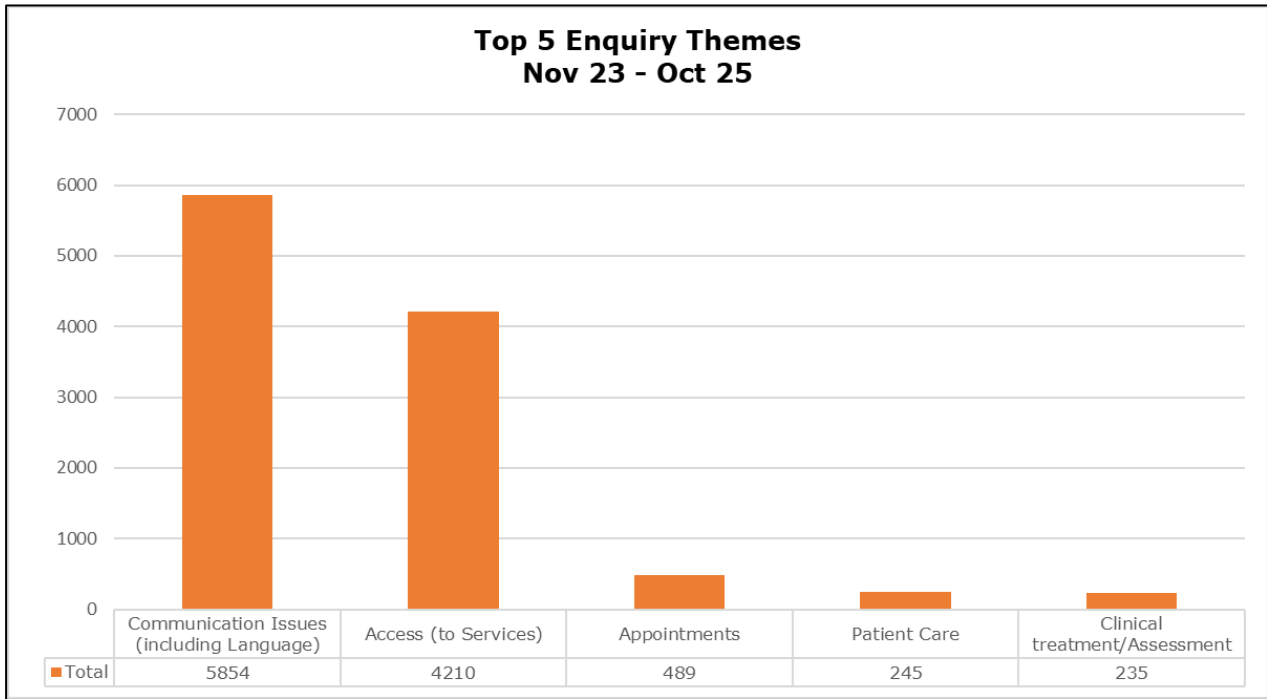
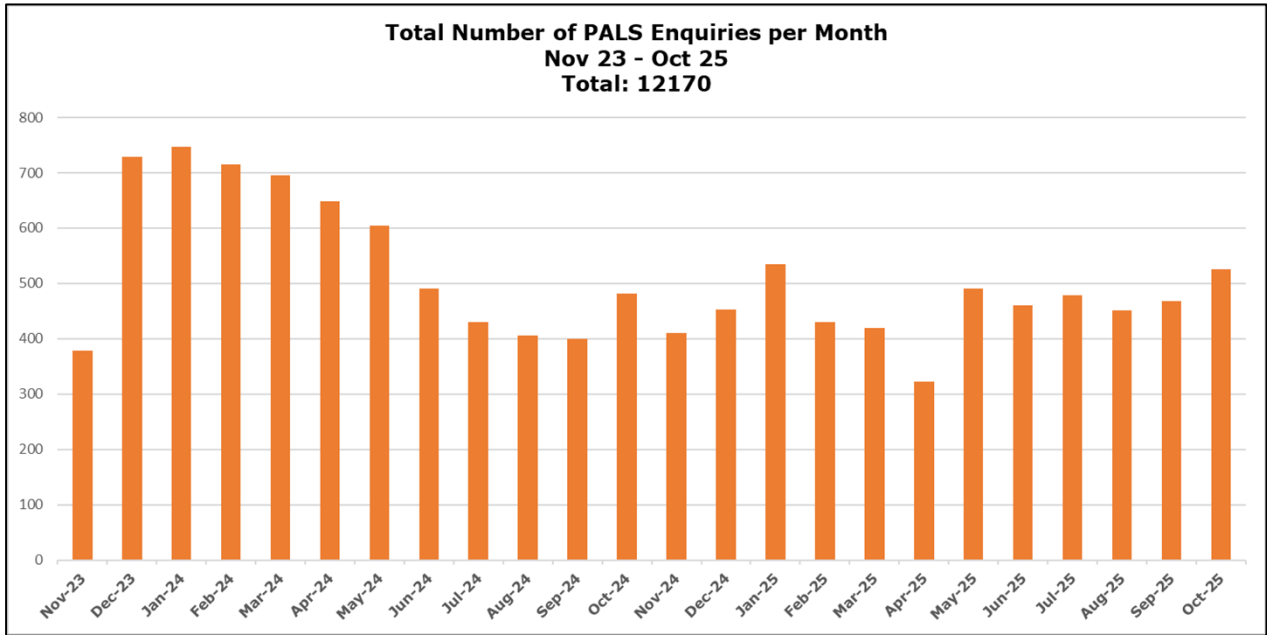
Review of PALS service across other Health Boards in Wales

	ABUHB	BCUHB	HDUHB	SBUHB	CTMUHB
WTE / Bands	2.55 WTE Band 5 2.14 WTE Band 3	9 WTE Band 5 5 WTE Band 3	3 WTE Band 5 6 WTE Band 4 3 WTE Band 3	5 WTE Band 5 Plus vacancies	6.4WTE Band 5
	Total: 4.69 WTE	Total: 14 WTE	Total: 12 WTE	Total: 5 WTE + vacancies	Total: 6.4 WTE
Case Numbers per Month	Approx. 524	Approx. 760	Approx. 250	Unknown	Approx. 300-350
Working Hours	08:00–20:00 7 days a week	09:00–17:00 Monday–Friday	09:00–17:00 Monday–Friday	09:00–17:00 Monday–Friday	08:00–17:00 Monday–Friday
Enquiry / ER Approach	ER from PTR Enquiry all other routes	Enquiries only	Both ER and Enquiries *If ER outside timeframe, managed through PTR	Both ER and Enquiries	Enquiries only
Accessibility	Phone lines open 24/7 with voicemail Call back within 24 hours Email access	Phone lines open 10:00–16:00 MTTF 10:00–12:30 W No voicemail service	Phone lines open 10:00–16:00 No voicemail service	Managed under individual divisions Each division works differently	Phone lines open 24/7 with voicemail Email access
Areas Covered	Health Board wide including some GPs	Health Board wide including managed practice, pharmacy and opticians	Health Board wide	2 acute sites only	Health Board wide

Number of Enquiries

Between November 2023 and October 2025, the PALS team managed a total of **12,170 Enquiry cases**. It is important to note that from November 2023 until April 2024, historical practice by Patient Support Officers resulted in duplicated Datix entries, which may have inflated the reported activity during that period. From May 2024 onwards, the data reflects a more accurate representation of the number of cases actively managed by the team.

The average time between case opening and closure is approximately **1.31 days**. While there is no designated timeframe for closing Enquiries, this figure demonstrates the responsiveness of the PALS team in addressing concerns promptly and effectively.



Number of Early Resolution

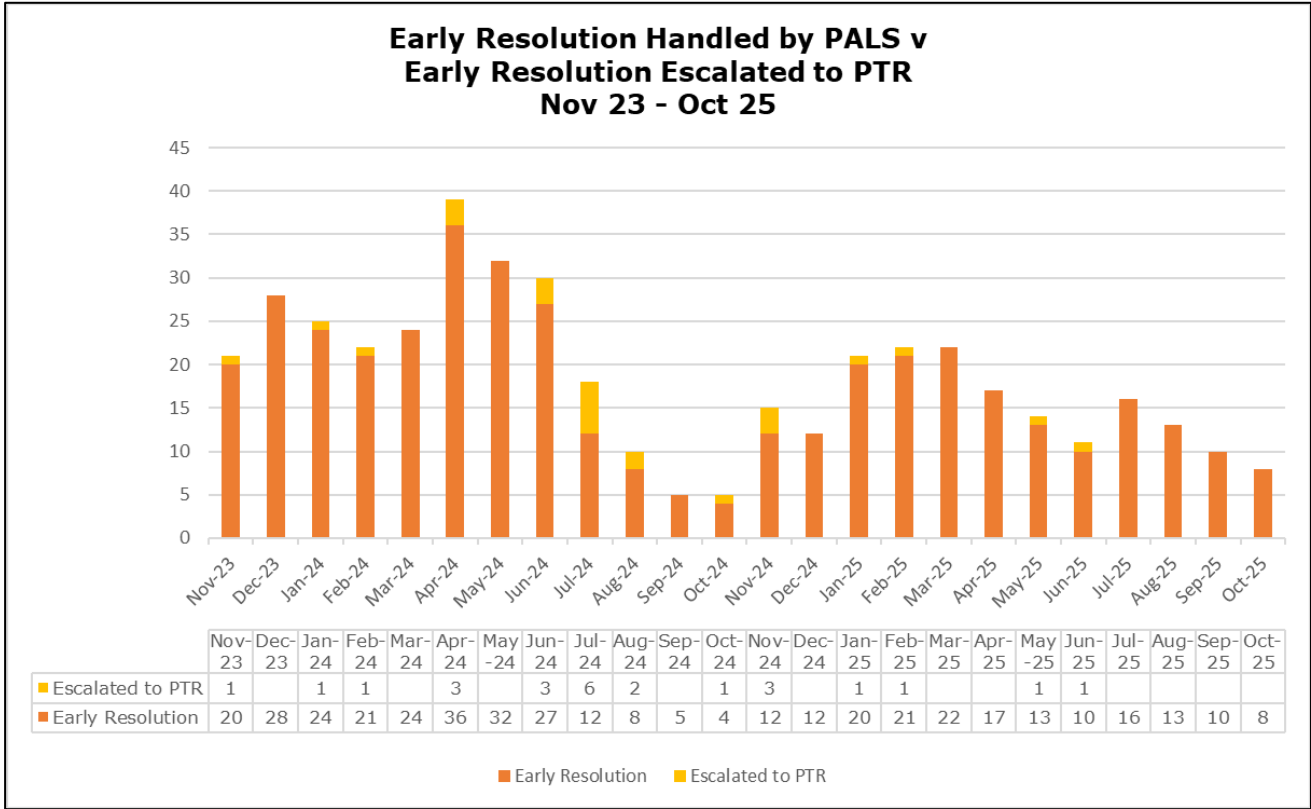
Between November 2023 and October 2025, the PALS team managed **415 Early Resolution (ER) cases**.

During the initial phase (November 2023 to August 2024), PALS was allowed to log some direct calls as ER in addition to PTR-referred concerns. At that time, the team could use the “managed outside of timeframe” option in Datix for cases that exceeded the 48-hour target. As a result, the average closure time for ER cases during this period was 6.51 days.

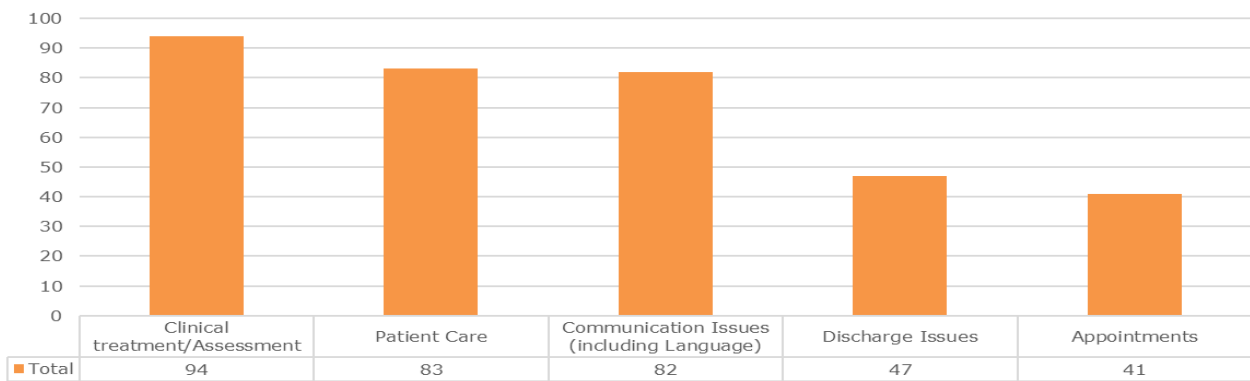
In September 2024, the directive changed: PALS was instructed to log PTR-referred calls as **Enquiries only**, which caused a noticeable dip in the number of ER cases recorded.

In November 2024, the directive was revised again. All calls referred from PTR to PALS were to be logged as ER, but without using the “managed outside of timeframe” option. Since this change, the average closure time for ER cases has improved significantly to 1.68 days, supporting compliance with the 48-hour Early Resolution target.

Despite these changes in logging practice, the number of cases escalated to formal PTR remains very low.



Top 5 Early Resolution Themes Nov 23 - Oct 25



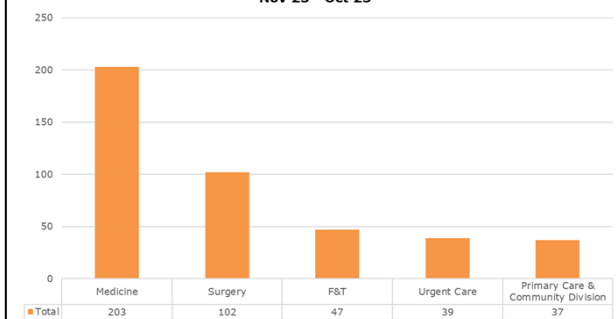
Divisional Data Overview Early Resolution

Between November 2023 and October 2025, the top five divisions receiving Early Resolution concerns were: Medicine (203), Surgery (102), Families & Therapies (47), Urgent Care (39), and Primary Care & Community (37).

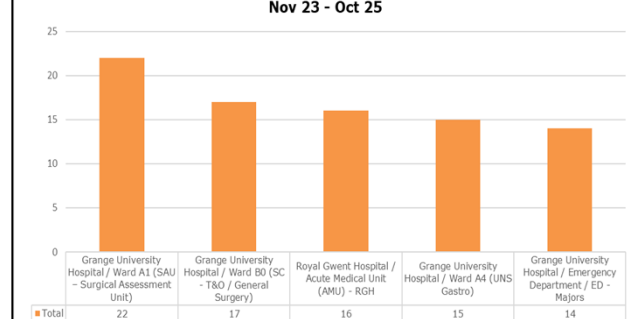
Within these divisions, the top five wards or departments where ER concerns were recorded include: A1 GUH (22), B0 GUH (17), AMU RGH (16), A4 GUH (15), and ED GUH (14).

Analysis of the themes associated with ER concerns across these wards and departments shows that 'patient care' is a consistent theme throughout. However, 'clinical treatment and assessment' emerges as the most prominent theme, particularly concentrated within one specific ward or department.

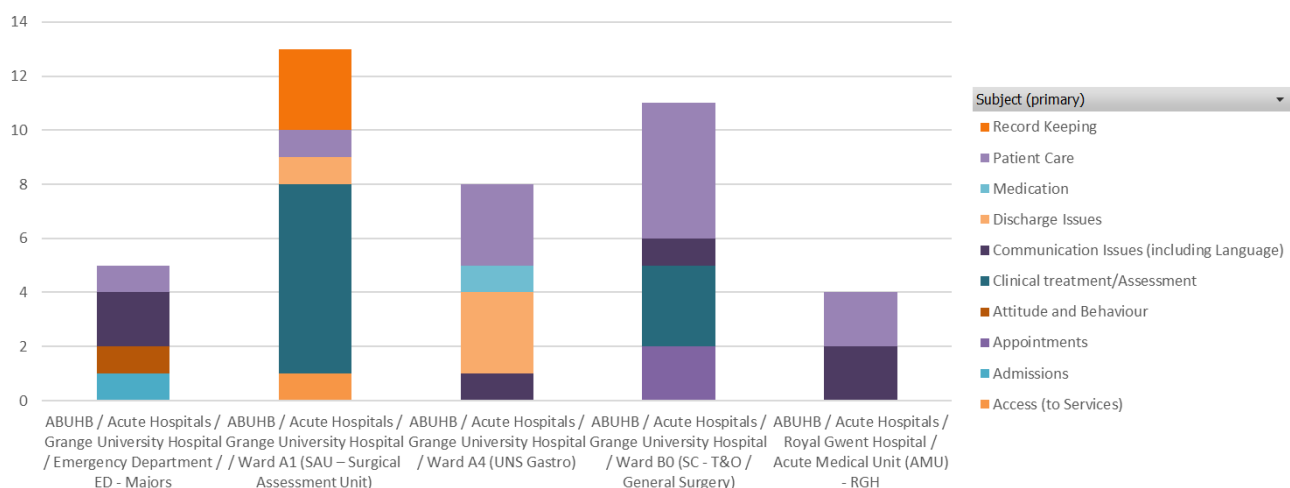
Top 5 Divisions for Early Resolution Handled by PALS Nov 23 - Oct 25



Top 5 Sites/Wards Relating to Early Resolution Handled by PALS Nov 23 - Oct 25



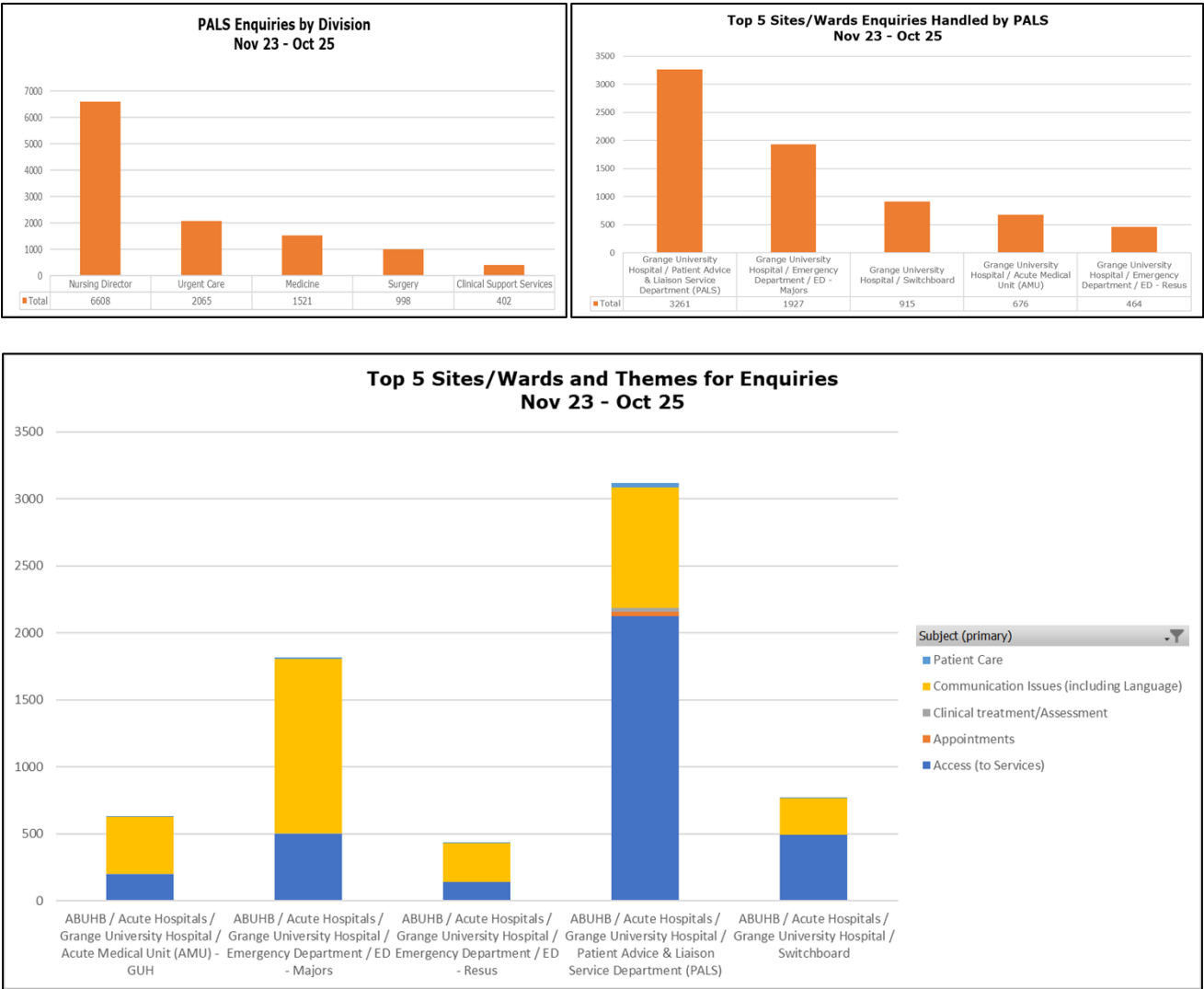
Top 5 Sites/Wards and Themes for Early Resolution Nov 23 - Oct 25



Divisional Data Overview Enquiries

Between November 2023 and October 2025, the top five divisions receiving Enquiry cases were: Nursing Directorate (6,608), Urgent Care (2,065), Medicine (1,521), Surgery (998), and Clinical Support Services (402). The Nursing Directorate shows the highest volume of Enquiries, largely due to historical Datix logging practices by Patient Support Officers, who recorded cases under PALS as the primary service rather than attributing them to the relevant clinical area.

Similarly, the top five wards or departments where Enquiries were recorded include: PALS (3,261), ED Majors at GUH (1,927), Switchboard (915), AMU GUH (676), and ED Resus GUH (464). The prominence of PALS and Switchboard in this data again reflects historical logging practices, where the primary service was recorded as the point of contact rather than the service the enquiry related to. Across all five areas, the dominant themes for Enquiries were 'Communication' and 'Access to Services', highlighting consistent patterns in patient enquiries.



Operational Challenges and Risks

System Limitations

- Both the Putting Things Right (PTR) team and the Patient Advice and Liaison Service (PALS) use the same electronic system (RL Datix) to record enquiries and concerns.
- This "Once for Wales" system is not configured to support PALS seven-day service model.

- PTR legislation requires Early Resolution cases to be managed within strict “working day” timescales. However, PALS operates evenings and weekends.
- This mismatch creates errors when PALS manages cases outside weekday hours, despite the clear benefit of resolving inpatient concerns promptly.

Legislative Constraints

- If an Early Resolution case cannot be resolved within the required timeframe (next working day), it must be escalated under PTR and managed formally.
- Expecting PALS, a frontline, patient-facing team, to comply with these administrative requirements would pull staff away from their core duties.

Recommendation from PTR

- PTR advises that only the PTR team should use RL Datix subtypes “Early Resolution” and “Putting Things Right.”
- All PALS cases should be recorded as “Enquiries.”
- This change does not reduce the importance of PALS cases, but clear communication and education will be needed to ensure stakeholders understand the new approach.

Service Delivery and Capacity Risks

- Balancing ward visibility with documentation and compliance targets is challenging.
- Limited team size (4.69 WTE) compared to other Health Boards with larger teams.
- High demand at the Grange University Hospital, with less consistent presence across other sites.
- Seven-day service model is not fully supported by Datix configuration (e.g., ER cases cannot be logged outside core weekday hours).

Data and Reporting Risks

- Reclassification of ER cases to Enquiries or PTR-managed cases affects data accuracy.
- Lack of consistent communication when cases are reclassified leads to discrepancies.
- Risk of underreporting PALS workload and overstating PTR escalation rates.
- Attribution issues: reassigned cases may appear as PTR-managed, obscuring PALS contributions.
- Data inconsistencies may compromise transparency and integrity of performance reporting.
- Potential reputational risk if concern handling appears inconsistent or unclear.

Conclusion

The PALS Service has proven to be a highly effective and valued patient engagement resource, managing over 12,500 cases with only 0.19% escalating to formal complaints. It provides a seven-day, patient-facing model that improves experience and reduces pressure on clinical teams. This success positions PALS as a key partner in supporting the Health Board’s compliance with the new Listening to People regulations.

The original premise was that the PALS model would be self-funding through a reduction in complaints handling resource, thereby avoiding the need for an

additional £200K investment. However, while PALS continue to deliver an important patient engagement and early resolution function, this has not resulted in a reduction in the volume or complexity of formal complaints.

Although the anticipated financial release has not materialised, PALS remain actively engaged in early resolution work. Their ability to take on more cases is constrained by limitations within the national Datix system, which does not fully support the operational model. Cases that have come directly to PALS rather than through PTR have been logged as 'Enquiries' rather than 'Early Resolution', despite being of a similar nature and complexity.

Senior nursing leads for Patient Experience and Involvement and Quality, Safety and Learning have met to discuss and agree how PALS and PTR will work together under the new Listening to People Framework, ensuring clarity of roles and compliance with statutory requirements.

Moving forward, PALS should play a central role in frontline resolution and patient engagement, working alongside PTR to ensure clarity of roles and compliance with statutory requirements. This includes PALS acting as a Single Point of Contact, embedding listening meetings as a standard practice, maintaining responsibility for inpatient and low-harm cases, and strengthening patient voice through initiatives such as Digital Patient Stories and champion roles.

Argymhelliad / Recommendation

The Patient Quality Safety and Outcomes Committee is asked to:

- **NOTE** the contents of the PALS Service Review Report.

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):	4. Dignified Care 2. Safe Care 5. Timely Care All Health & Care Standards Apply
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Older adults are supported to live well and independently
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up

Strategic Equality Objectives 2020-24	of services is lower or outcomes are worse Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Yes, outlined within the paper
• Service Activity & Performance	Yes, outlined within the paper
• Financial	Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	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	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Involvement - The importance of involving people with an interest in achieving the well-being goals,

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

and ensuring that those people reflect the diversity of the area which the body serves

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	17 February 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Review of Healthcare Inspectorate Wales Inspection – Pending Actions
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade – Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Tracey Partridge-Wilson – Deputy Director of Nursing

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

Healthcare Inspectorate Wales (HIW) inspections generate recommendations that require timely and effective action. Audit Wales has highlighted the need for strengthened assurance and governance to ensure these actions are monitored and delivered. The Health Board must provide PQSOC with clear visibility of progress against these improvement plans to demonstrate compliance and accountability.

Cefndir / Background

Following each HIW inspection, Divisions submit improvement plans detailing actions to address identified recommendations. Historically, reporting has been fragmented, limiting the ability to assess overall progress and identify risks. Audit Wales has recommended a more robust and transparent approach to monitoring these actions. To address this, the Health Board will utilise the Assurance Monitoring and Tracking (AMAT) system as the central platform for tracking all HIW-related actions.

Asesiad / Assessment

Following receipt of an Inspection Report, the findings are scheduled for presentation at Quality Management Group and subsequently the Patient Quality, Safety and Outcomes Committee to provide a clear overview of outcomes and required actions.

All associated Improvement Plans are uploaded to AMAT. Any actions that remain outstanding are followed up with the designated leads to obtain an update. Where revised timescales are required, Divisions must provide a supporting rationale. Progress and assurance updates will be reported to both QMG and PQSOC to maintain oversight and ensure effective governance.

The following outlines the remaining actions arising from inspections conducted in 2024 and 2025. A summary of the specific actions is provided in Appendix 1.

Work is progressing on the actions relating to National Reviews. An update will be provided at the next meeting.

Adferiad and Pillmawr Ward, St Cadoc's (03838) – 19-21 May 2025

Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of Completed Actions	No. of actions pending
21 August 2025	33	54	42	12

Birth Centre, Ysbyty Ystrad Fawr (03842) – 18-19 June 2025

Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending
19 September 2025	7	18	16	2

Minor Injuries Unit, Royal Gwent Hospital (03841) – 9-11 July 2025

Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending
19 September 2025	4	9	9	0

Ty Skirrid, Maindiff Court Hospital (03839) – 6-8 October 2025

Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending
15 January 2026	12	23	18	5

Torfaen Community Learning Disability Team (04055) – 29 September-1 October 2025				
Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending
Not yet received	8	15	1	14

IR(ME)R Nuclear Medicine, Nevill Hall Hospital – 4-5 March 2025				
Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending
19 June 2025	2 (immediate)	11	11	0
	15	24	23	1

Carn-y-Cefn, Ysbyty Aneurin Bevan (03682) – 15-17 October 2024				
Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending
17 January 2025	10	29	27	2

Ty Lafant, Llanfrechfa Grange (03631) – 22-24 April 2024				
Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending:
8 August 2024	27	55	55	0

Talgarn Ward, County Hospital (03390) – 5-7 February 2024				
Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending
9 May 2024	16	53	51	2

Emergency Department, Grange University Hospital (03698) – 2-4 October 2024				
Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending
15 January 2024	16	112	110	2

Argymhelliad / Recommendation

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

- **NOTE** the summary of pending actions contained within Appendix 1.

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 Termiau: 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.

Healthcare Inspectorate Wales Inspections: 2025 Breakdown of Pending Actions

Adferiad and Pillmawr Ward, St Cadoc's (03838) – 19-21 May 2025					
Report Publication Date		No. of Recommendations	No. of Service Actions Identified	No. of Completed Actions	No. of actions pending:
21 August 2025		33	54	42	12
Rec. Ref.	Issue / Improvement Needed	Service Action	Original Timescale	January 2026 Update	Revised / Expected Completion
1	Garden areas require redevelopment (Adferiad & Pillmawr)	Working Group & capital bid development	18/07/25	Costings received. RPB Capital Bid to be submitted by end Feb 2026. Procurement process to follow with Estates.	Feb 2026 (Bid submission)
3	Standardised health promotion information boards	Boards in situ; final content list being agreed	Ordered 04/07/25	Final meeting held 3 Feb; standardised boards to be displayed by end Feb 2026 on all wards.	End Feb 2026
4	Review of single room occupancy / estates planning	Linked to Mental Health Service Model & Estates Strategy	Discussion 11/07/25	Update to be provided by Planning & Estates by April 2026	April 2026
6	ECA suite refurbishment (light & temperature)	Capital bid submitted to RPB	End of July 2025	Awaiting outcome of bid; works planned for FY 26/27	FY 2026/27
7	Kitchen refurbishments (Adferiad)	Two kitchens being refurbished	Commence Nov 2025	First kitchen complete; second kitchen due for completion 9 Feb 2026	9 Feb 2026
19	CD oxygen cylinder training – compliance	Ongoing monitoring of mandatory training compliance		Adferiad 67% (two absences preventing 100%); Pillmawr 100%	Ongoing
20	Clinical room temperatures – need air conditioning	Capital bid submitted	July 2025	Capital funding released; works commence w/c 23 Feb 2026	w/c 23 Feb 2026
24	OT-led activity plan and cooking sessions	Activity plan development	July 2025	Weekly timetable displayed; full MDT Activity Plan in development for March 2026	March 2026
27	Mental Health Act training compliance	Increase percentage compliance		Adferiad 78%; Pillmawr 55%; further dates issued	Ongoing
31	Policy reviews – All Wales Treatment Escalation and Rapid Tranquillisation	Policy review and ratification	September 2025	Working group progressing revised policy due for completion March 2026.	March 2026

Birth Centre, Ysbyty Ystrad Fawr (03842) – 18-19 June 2025					
Report Publication Date		No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending:
19 September 2025		7	18	16	2
Rec. Ref.	Issue / Improvement Needed	Service Action	Original Timescale	January 2026 Update	Revised / Expected Completion
6	Leadership Structure Review	Continue review and strengthening of maternity leadership structure. Includes exploration of Director of Midwifery role.	January 2026	Wider review planned for Q4; Director of Midwifery discussions ongoing.	March 2026 (proposed)
4	Midwifery Unit Standards (MUSA) – Full Implementation	Completion of MUSA pilot work, training Programme, audit, and environmental improvements.	Anticipated Jan 2026	Significant progress across philosophy of care, training, audits, community of practice; work remains ongoing into 2026 with further review planned.	Ongoing into 2026

Minor Injuries Unit, Royal Gwent Hospital (03841) – 9-11 July 2025				
Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending:
19 September 2025	4	9	9	0

Ty Skirrid, Maindiff Court Hospital (03839) – 6-8 October 2025							
Report Publication Date		No. of Recommendations		No. of Service Actions Identified		No. of completed actions	No. of actions pending:
15 January 2026		12		23		18	5
Rec. Ref.	Issue / Improvement Needed	Service Action		Original Timescale	January 2026 Update		Revised / Expected Completion

2	Explore installation of <i>vision panels</i> to support sleep hygiene	• Obtain Minor Works costings • Add to MH Capital Priorities Register	April 2026	Actions remain the same; costings & capital allocation to be explored in new FY (Apr 2026)	Pending – timescale unchanged (dependent on FY 2026 capital processes)
3	Secure a room for consistent or permanent use	Re-explore availability with Senior Nurse	Meeting 5/12/25	Options explored; IT access issues at Lindisfarne; other options raise dignity/ privacy issues. Timescale extended to April 2026	Pending – timescale extended
12	Address risks linked to only one registered nurse on duty	Establishment review; options appraisal	Jan 2026	No additional funding; escalated to Division; to be discussed in establishment reviews	Pending – requires Divisional decision
12	Consider future of Maindiff Court site	Part of wider MH & LD estates strategy	Ongoing	Ongoing	Ongoing – strategic decision
12	Ensure timely review/ratification of policies	Reviewed via Divisional Policy Group	Ongoing	Ongoing	Ongoing

Torfaen Community Learning Disability Team (04055) – 29 September-1 October 2025

Report Publication Date		No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending:
Not yet received		8	15	1	14
Rec. Ref.	Issue / Improvement Needed	Service Action	Original Timescale	January 2026 Update	Revised / Expected Completion
1	Conduct a full environmental audit of Alders House, prioritise repairs and upgrades, and install clear, accessible signage. Ensure compliance with accessibility standard	Since the inspection all windows in Alders have been or are in the process of being replaced. In addition, all guttering and soffits are being replaced. A full environmental audit will be undertaken to assess further DDA facilities that will be required. If it is not possible to make the building DDA compliant, the Directorate would look to secure alternative clinical space that would meet the needs of our population group. The Directorate will work	December 2025	All windows on the ground floor have been replaced. All guttering and soffits have been replaced. Arrangements are being made for the windows on the first floor to be replaced. An environmental assessment is being arranged with H&S colleagues to understand what work would be required to make the building DDA compliant – the outcome of this assessment will be reviewed to determine whether DDA compliance is achievable. The Directorate has engaged with W&E in relation to the installation of appropriate	Ongoing

		with Works & Estates to ensure there is appropriate signage to the building. The Directorate will also work with our Gwent Ambassadors (Individuals with a learning disability) to provide assurance that the building is suitably accessible.		signage – this is currently being actioned by W&E	
2.	Review caseload distribution and introduce triage protocols to prioritise urgent needs.	The Directorate has already introduced a caseload triage tool to enable prioritisation of nursing caseload. The Directorate will ensure that this is embedded in line management supervision. The Directorate has also introduced a RAG rated caseload tool to support prioritisation of caseloads on a team approach basis which should be submitted to the Senior Nurse on a monthly basis to ensure oversight and appropriate support is provided. The Directorate will ensure that this is embedded in practice.	January 2026	No update available	
3.	Review and improve accessibility of care and support plans. Introduce a review schedule with audit checks	The Directorate will work with clinicians to ensure that when care and support plans are developed, reviewed or updated, they will be available in accessible formats. The Directorate will introduce a review schedule aligned to the timely review of care and support plans which will be audited as part of the Quality and Patient Safety agenda. The Directorate will also engage with individuals with a learning disability to develop a standardised user friendly care and treatment plan template which can then be populated by clinicians.	Commence immediately January 2026 January 2026	The Directorate is in the process of establishing a T&F group with representation from across the Directorate to develop a standardised format for accessible care plans. The Directorate is collecting a full list of all care plans within the Directorate which will be used to develop a review scheduled against which accessible care plans can be monitored.	Ongoing Ongoing Ongoing

4.	The health board should strengthen the use of outcome focused interventions, to prepare for legislative change and promote improved choice and independence for people.	The Directorate is in the process of developing a shared lives pilot for individuals with a learning disability which will be accessible by individuals receiving joint and fully funded care. This pilot is due to be in situ from December 25 – February 26 with the evaluation taking place in March 2026. Commissioning team are currently reviewing Direct payments in line with Welsh government guidelines	March 2026	The Shared Lives pilot for individuals with a learning disability commenced on 12.1.26 and will run until the end of March. This pilot will then be evaluated and any learning will be used to inform the Directorate's Model of Care going forward	In date
5.	Streamline documentation systems, centralise records where possible, and provide staff training on consistent filing and retrieval.	Process to be reviewed in collaboration with Mental Health act administration. To ensure legal documentation is stored on EHR and available to staff.	December 2025	Revised timescale – 27.2.26	February 2026
6.	Conduct a usability review of current systems. Provide targeted training and consider system enhancements or simplification to improve efficiency.	The Health Board is in the process of procuring a new electronic patient record system. A preferred supplier has been identified and the Health Board is working with the supplier to develop the required system. The Learning Disabilities Directorate are engaged in the Steering Groups that have been set up to take forward the development of the new system.	March 2026	Ongoing – the Directorate continues to be engaged in the development of the new electronic patient record system	In date
7.	Review and improve health board wide links between Primary Care and CLDT teams. Consider improving links with primary care liaison role with primary care to coordinate access. Develop pathways for	The Learning Disabilities Primary Care Health Liaison team work proactively to support individuals with a learning disability to access Annual Health Checks and support GP practices to make reasonable adjustments. However, this is heavily reliant on GP practices proactively offering appointments	February 2026	The Directorate is progressing discussions in relation to the role of the Primary Care Health Liaison team as part of its Model of Care work. The Directorate now has access to the Primary Care Portal where it can see the number of AHC being completed.	In date

	long-term nursing care and ensure annual health checks are supplemented with routine access.	and engaging with individuals with a learning disability. Directorate to review primary health care liaison service ensuring that the scope of practice covers improving overall access to primary care service. Operational policy to be in place. Directorate to consider process of communication with complex care – to discuss change in individual primary needs in timely manner			

IR(ME)R Nuclear Medicine, Nevill Hall Hospital – 4-5 March 2025					
Report Publication Date		No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending:
19 June 2025		2 (immediate)	11	11	0
		15	24	23	1
Rec. Ref.	Issue / Improvement Needed	Service Action	Original Timescale	January 2026 Update	Revised / Expected Completion
1	The health board is to ensure that bilingual documentation is available for patients.	Radiology review of patient letters ongoing as part of the RIS project (due to go live in ABUHB Nov 25). Consideration will be made as to Welsh translations for all new letter templates within RIS and the impact on the printing/automated envelope-filling capacity.	January 2026	RISP Go Live date has now been delayed until May 2026 for ABUHB. This remains an action which will align with RISP, therefore a new timescale of Aug 26 proposed.	August 2026

Healthcare Inspectorate Wales Inspections: 2024 Breakdown of Pending Actions

Carn-y-Cefn, Ysbyty Aneurin Bevan (03682) – 15-17 October 2024					
Report Publication Date		No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending:
17 January 2025		10	29	27	2
Rec. Ref.	Issue / Improvement Needed	Service Action	Original Timescale	January 2026 Update	Revised / Expected Completion
9	Ensure all staff are familiar in how to operate the portable oxygen cylinder	All staff to complete the BOC (oxygen cylinders) online training	28/06/25	Compliance is 67% - plan in place for staff to complete over next two weeks	February 2026
10	Ensure the numbers of ILS trained staff are strengthened	100% compliance for ILS training to be achieved by March 2025	March 2025	Compliance is 92%. 2 newly qualified staff need to complete. Awaiting new dates to become available	March 2026

Ty Lafant, Llanfrehfa Grange (03631) – 22-24 April 2024				
Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending:
8 August 2024	27	55	55	0

Talygarn Ward, County Hospital (03390) – 5-7 February 2024									
Report Publication Date		No. of Recommendations		No. of Service Actions Identified		No. of completed actions		No. of actions pending:	
9 May 2024		16		53		51		2	
Rec. Ref.	Issue / Improvement Needed		Service Action		Original Timescale	January 2026 Update			Revised / Expected Completion

9	Ensure that the SALT therapist attend the ward to see patient	The triage process for SLT is to complete telephone screening in the first instance to inform whether an assessment is clinically indicated. In this instance, an assessment was not clinically indicated and advice was given to staff accordingly.	December 2024	Further email sent to Alison Williams (SLT Lead) on 13/01/26 by Deputy Directorate Manager to request a meeting. The need for SALT input on Talygarn ward is limited.	
14	Rapid tranquilisation protocol review date November 2023	The policy is currently under review. In the interim, the existing policy remains extant.	January 2025	Working group progressing revised policy due for completion March 2026.	March 2026

Emergency Department, Grange University Hospital (03698) – 2-4 October 2024					
Report Publication Date		No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending:
15 January 2024		16	112	110	2
Rec. Ref.	Issue / Improvement Needed	Service Action	Original Timescale	January 2026 Update	Revised / Expected Completion
1	Must maintain the efforts to improve patient flow through the department and across the wider hospital.	Review of Flow Centre Pathways to ensure patients go to the right place first time	March 2025	There is wider work being commissioned in the Flow Centre to develop a Single Point of Access. As part of this piece of work pathways of care will be reviewed.	Ongoing
7	Ensure staff are aware of the health and safety risk assessments and audits that are carried out for patient safety purposes.	Review of area to assess ability to make an assessment area ligature free	December 2024	Review of dept undertaken with mental health colleagues. Risk assessment completed and needs to progress via Divisional assurance with the Deputy COO regarding investment in an anti-ligature free room. All patients reviewed and appropriate staffing put in place to mitigate the risk.	Ongoing

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	17 February 2026 Click here to enter a date.
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Putting Things Right Regulations Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade – Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Tracey Partridge-Wilson – Deputy Director of Nursing Gemma Couch – Head of QPS and Learning Garvin Jones – Head of Legal Services Tanya Strange – Head of Nursing, Patient Experience and Involvement

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 Welsh Government has completed a review of the Putting Things Right (PTR) regulations. As a result, the PTR Guidance will be replaced in April 2026 by the "Listening to People NHS Complaints, incidents and redress process Guidance" process, requiring significant updates to policies and procedures across NHS Wales.

Cefndir / Background

A public consultation in early 2024 identified challenges in the current PTR system, including communication, compassion, timeliness, and transparency. The revised guidance aims to create a more transparent, responsive, and learning-focused complaints system, placing patients at the centre and promoting a culture of openness and continuous improvement.

Asesiad / Assessment

Key changes include:

- Mandatory 'listening discussions' within five working days of acknowledging a concern with documented evidence.
- Reducing the timescale for closing redress cases from 12 months to 6 months (120 working days).
- There will be a requirement to review training material to ensure that the resources cover all aspects of the new regulations.
- Enhanced support for Welsh language and inclusive communication. This will likely increase translation and interpretation costs.
- Considerable increase on the focus of bereaved people raising concerns.
- These changes will also require significant upskilling, additional resources, and robust assurance mechanisms to ensure readiness for implementation.
- System changes will be necessary, including updates to digital reporting and data capture systems.
- Doubling the financial compensation limit for redress from £25,000 to £50,000.
- The Health Board policies and guidance will need to be updated in line with the regulatory change.
- Coproduction with patients and staff will be required in readiness for the new regulations.
- Given the demand for these proposed changes, it is likely that additional resources will need to be considered to fully implement the changes. Moreover, it is recognised that public consultation will help raise awareness of the changes which could potentially increase demand further.

Additional information will be incorporated into regular reports as it becomes available.

Impact of Proposed Changes to Putting Things Right (PTR) Regulations:

Financial and Operational Implications:

The proposed amendments to the PTR regulations will result in changes for Aneurin Bevan University Health Board. The financial threshold for redress cases will be increased from £25,000 to £50,000, effectively doubling the upper limit for settlement. Changes to the rights of people accessing legal advice may also have a financial impact. Additionally, the timeline for resolving redress cases will be significantly shortened, with the closure period reduced from 12 months to approximately 6 months (120 working days). There will be an increased demand for comprehensive staff training, the revision of existing policies, and improved communication channels with both patients and their families.

There may be increased costs associated with translation and interpretation for activities such as Listening Meetings and other engagement forums. This reflects a growing commitment to ensuring that all individuals can participate meaningfully, regardless of language, communication needs, or sensory impairment. For example, providing enhanced support for the Welsh language and for inclusive communication (including British Sign Language, Deafblind interpreters, easy read, large print, and alternative formats) will be essential to achieving genuine accessibility and equity.

To sustain these improvements and maintain public confidence, robust assurance mechanisms will be necessary. These should monitor readiness, quality, and consistency of implementation, ensuring that commitments to accessibility and

language equity are fully embedded in practice rather than delivered on an ad hoc basis.

Requirements for Listening Meetings:

To facilitate listening meetings under the revised PTR regulations, skilled facilitators and administrative support will be essential.

Implementing these changes and undertaking listening meetings will require significant investment in workforce upskilling, including awareness and competency in inclusive communication and accessible engagement methods. Additional resources will likely be needed to fund interpretation, translation, and communication support services, as well as the time and coordination required to plan inclusively.

Challenges and Readiness:

While the changes are designed to promote greater transparency and support, they also introduce challenges related to organisational capacity and the need for staff upskilling. Addressing these impacts is critical for the Health Board's preparedness in adopting the new "Listening to People" process. Continued commitment to quality, safety, and ongoing learning will be vital to ensure a smooth transition and sustained improvement in service delivery.

Monitoring and Progress:

- Establish a dedicated Readiness Group by end of October 2025.
- **Key deliverables:**
 - Gap analysis against new guidance including any potential financial impact
 - Updated SOPs for complaints, redress, and incident handling
 - Staff training plans and materials
 - Stakeholder engagement strategy
 - Readiness report for Executive oversight
- **Timeline:**
 - Gap analysis and implementation plan and full readiness report by January 2026.
 - Stakeholder engagement and communication strategy
Co-produce implementation materials with patients, carers, and staff; design accessible communications (Easy Read, BSL, Welsh language, alternative formats); and raise public awareness of the new process.
- **Equality Impact Assessment (EqIA) and Accessibility Action Plan:**
Assess impacts on people with protected characteristics; ensure compliance with Welsh language and accessibility standards; and outline how inclusive communication will be operationalised.
- **Digital and data system updates**
Align Datix (or equivalent) and redress tracking systems with new reporting requirements, data fields, and monitoring dashboards for compliance and learning.

Argymhelliad / Recommendation

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

- **NOTE** the establishment of the Health Board Readiness Group, led through the Quality Management Group, to coordinate implementation of the revised Putting Things Right (PTR) regulations and the new Listening to People (LTP) process.
- Receive **ASSURANCE** from the Quality Management Group on progress against key deliverables.
- **SUPPORT** the Health Board's preparation and transition to the revised PTR regulations and LTP process.

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 3.2 Communicating Effectively 6.3 Listening and Learning from Feedback 7.1 Workforce
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 Termiau: Glossary of Terms:	NA

Partion / 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/	Not Applicable Choose an item.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	17 February 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Healthcare Inspectorate Wales Inspection Report: Ty Skirrid, Maindiff Court Hospital (03839)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade – Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Nadine Gould – Divisional Nurse Mental Health & LD

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

Healthcare Inspectorate Wales (HIW) conducted an unannounced inspection of Ty Skirrid Unit, Maindiff Court Hospital from 6–8 October 2025. The report was published on 15 January 2026. The inspection focused on patient experience, safe and effective care, and leadership and workforce. The Ty Skirrid Unit is a 15-bed male rehabilitation service for both detained and informal patients.

Cefndir / Background

The unit operates as an unlocked rehabilitation environment with strong relational security and MDT-led care pathways. A multidisciplinary inspection team including HIW inspectors, clinical reviewers, and a patient experience reviewer conducted the assessment. Patient and staff feedback was gathered through questionnaires.

Asesiad / Assessment

The inspection found a positive therapeutic environment at Ty Skirrid, with calm, respectful staff–patient interactions and good relational security. Patients had timely access to occupational therapy and psychology, delivered through a mix of one to one and group work. MDT processes were effective, with patients and carers involved in ward rounds, and Care and Treatment Plans and Mental Health Act documentation were compliant. -to-one and group work. MDT processes were effective, with patients and carers involved in ward rounds, and Care and Treatment Plans and Mental Health Act documentation were compliant.

Leadership was stable and well connected to divisional governance, contributing to a generally well run unit. Areas needing further development included clearer ownership and structure of therapeutic activities and more consistent recording of advocacy offers in clinical notes. -connected to divisional governance, contributing to a generally well-run unit. Areas needing further development included clearer ownership and structure of therapeutic activities and more consistent recording of advocacy offers in clinical notes.

Several environmental improvements were also highlighted, including the installation of vision panels, improved access to an additional room, prioritisation of estates tasks, better storage solutions, and inclusion of high level cleaning in routine schedules.-level cleaning in routine schedules.

Clinical documentation processes require strengthening, particularly timely upload of CTP review minutes to WCCIS and consistent recording of legal status on medication charts. Staffing feedback about having only one registered nurse at night also needs continued consideration to maintain safe skill mix and mitigate operational risks.

One immediate concern, an outdated paliperidone injection, was resolved promptly during the inspection.

HIW identified a total of 13 areas for improvement during the inspection, which the Division translated into 23 individual service actions. As of 21 January 2026, 18 actions have been fully completed, with the remaining 5 actions continuing in progress and monitored through established governance routes.

Argymhelliad / Recommendation

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

- **NOTE** the contents of the Inspection Report
- **NOTE** the ongoing progress against the improvement plan.

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	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services Choose an item. Choose an item.

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

Hospital Inspection Report (Unannounced)

Ty Skirrid Unit, Maindiff Court
Hospital, Aneurin Bevan University
Health Board

Inspection date: 6, 7 and 8 October 2025

Publication date: 15 January 2026



This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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Digital ISBN 978-1-80633-908-2

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do.

We are:

- Independent - we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.



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1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our [website](#).

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at Maindiff Court Hospital, Aneurin Bevan University Health Board on 6, 7 and 8 October 2025. The following hospital wards were reviewed during this inspection:

- Ty Skirrid Unit - 15 beds providing male rehabilitation services. At the time of the inspection, the patient cohort included forensic, those detained under the Mental Health Act, and informal patients
- Lindisfarne - three step-down beds providing independent living with a reduced staffing presence.

Our team, for the inspection comprised of one HIW senior healthcare inspector, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one patient experience reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of seven questionnaires were completed by patients or their carers and 13 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

The service prioritised patient independence, supporting skill development for successful community reintegration. Patients had access to tailored therapeutic input, needs-based assessments, and meaningful activities. While the overall approach was positive, the structure and consistency of activity provision could be strengthened.

Staff-patient interactions were consistently respectful, calm, and informed, with staff demonstrating a commitment to meaningful engagement. However, aspects of the physical environment require improvement to support patient wellbeing, particularly in relation to sleep hygiene.

Patients were actively encouraged to take responsibility for daily tasks, such as laundry and accessing community services. Staff promoted autonomy through a decreasing degree support, aligned with the rehabilitation model of care.

For detained patients, leave was generally well facilitated and balanced against individual risks and preferences. Leave arrangements were reviewed regularly to ensure continued appropriateness.

Patients' rights under the Mental Health Act were upheld, with access to written information, advocacy services, and involvement from families and carers where appropriate.

There was clear evidence of patient engagement in care planning and treatment, including participation in ward rounds and pre-meeting check-ins. Overall, patient engagement levels were found to be good.

This is what we recommend the service can improve:

- The roles, responsibilities and ownership of activities could be strengthened
- Aspects of the environment should be strengthened
- Proximity of the smoking area to the main unit building should be reviewed

This is what the service did well:

- Staff-patient interactions were respectful and calm
- There was good relational security between staff and patients
- There was a good range of therapeutic input available to patients, with a focus on skills development and community re-integration

Delivery of Safe and Effective Care

Overall summary:

The unit operates an unlocked rehabilitation model of care, underpinned by robust individual risk assessments and strong relational security between staff and patients.

Admissions were carefully managed; however, an inherent level of risk remains. We recommend the health board uses this inspection to reinforce the importance of continuing to stringently assess patient moves and admissions, as far as possible and despite wider bed pressures.

The multidisciplinary team (MDT) comprised a broad range of healthcare professionals. Staff reported feeling heard and respected during ward rounds and MDT forums. Patients confirmed consistent involvement in ward round meetings, receipt of information about their care and treatment, and opportunities for family and carer involvement where desired.

Patients benefited from dedicated occupational therapy and psychology input, tailored to individual needs. This included one-to-one, group, and focused support.

Care planning was well aligned with the Mental Health (Wales) Measure, with comprehensive care and treatment plans that reflected the Measure's domains and were regularly reviewed. All patients had access to a named nurse acting as care co-ordinator.

Records for patients detained under the Mental Health Act 1983 were reviewed and found to be legally compliant.

Incidents of challenging behaviour requiring escalation were low. The unit worked collaboratively to minimise escalation risks through individualised, evidence-based risk assessments, reviewed regularly and as needed.

While some environmental improvements had been made, such as the renovated kitchen, the overall indoor and outdoor spaces would benefit from further enhancement to support a therapeutic setting.

This is what we recommend the service can improve:

- Patient moved and admissions to the unit must continue to be stringently assessed to ensure staff and patient safety and well-being
- Estates issues affecting the unit should be given sufficient attention and priority to maintain a therapeutic environment
- Aspects of care documentation recording

This is what the service did well:

- There was a good range of therapeutic input available to patients from dedicated Occupational Therapy staff and Psychology provision, as required
- There was evidence of effective MDT arrangements
- Care Planning was well aligned with the Mental Health (Wales) Measure, and all detained patients were done so legally.

Quality of Management and Leadership

Overall summary:

Governance and oversight processes were found to be effective, supporting clear information flow between the unit, senior nursing leadership, and divisional-level forums.

We observed good nursing and medical leadership on the unit. Staff worked collaboratively throughout the inspection, with positive feedback received regarding the ward manager. The senior nurse was visible, knowledgeable, and actively engaged with patients.

The workforce was generally stable. While bank staff were used to some extent, efforts were made to ensure consistency by deploying regular bank staff familiar to patients.

Mandatory training and annual appraisal rates were maintained at a good overall level, except for basic life support (BLS) and Mental Health Act training. Imminent plans were in place to address these gaps. Staff were supported to pursue further learning and development aligned with their roles and career aspirations, including formal management, vocational, and nursing training.

The unit maintained close working relationships with other mental health services, the local authority, and supported living providers to facilitate appropriate placements and timely discharge planning. Although some delays were noted, discharge planning remained a central focus, with regular meetings held to monitor progress.

This is what we recommend the service can improve:

- Staff training gaps must be strengthened at the earliest opportunity
- Staff feedback should be reviewed and considered by the health board
- Policies and procedures must be reviewed and updated, according to their clinical priority and level of risk

This is what the service did well:

- Staff feedback in relation to line management and senior managers was generally positive
- There was evidence of good partnership working for the benefit of patients and effective operation of the unit
- Audit activities were undertaken and generally well scored.

3. What we found

Quality of Patient Experience

Patient feedback

We spoke to number of patients informally during the inspection and received seven completed patient questionnaires, and one patient/ carer questionnaire.

Patient comments included:

" I don't have much to say. It is the best place I've been... It would be good for more activities though"

" More outdoor activities"

Family and carer comments included:

"Bigger visitors room, it's very small"

"It's costly [to get to the hospital] and public transport is poor to hospital"

Person-centred

Health promotion

The service focused on maintaining and building patients independence to aid skills development and independence for community living. This included access to dedicated unit staff and a range of needs-based assessments, focused and individualised therapeutic input, and a structured approach to each day.

Physical health needs were assessed, monitored and acted upon. This included smoking cessation advice and the offer of nicotine replacement therapy. Despite efforts, smoking outside the unit was prevalent and the health board should consider the proximity of the smoking area to the main unit building, in line with Welsh Government smoke-free legalisation.

The health board must review the proximity of the smoking area to the main unit building in line with smoke-free legislation.

It was positive to see that blanket restrictions were limited and that there was a positive risk-taking approach adopted, underpinned by individual risk assessments and care planning. One example was the consumption of energy drinks on the unit,

whereby a health promotion and educative approach was favoured, with information boards displayed and verbal advice offered to patients.

There were a range of meaningful activities on the unit for the patients to access, with a good focus on accessing the community to aid independence and re-integration. Whilst engagement reportedly fluctuates, staff were knowledgeable of the individual needs and preferences in how patients choose to engage and spend their time. To support uptake and engagement with the structured approach of timetabled activities, we recommend that roles, responsibilities and ownership of these activities are more clearly defined.

The health board should ensure that roles, responsibilities and ownership of structured activities is strengthened.

Dignified and respectful care

We observed positive interactions between staff and patients. This included knowledgeable, respectful and calm conversations, with staff taking the time to engage meaningfully with patients.

Staff were seen to knock on patient doors before entering. All patients had access to their own bedrooms, which they could lock and personalise, if desired. There were two bathrooms, both of which were communal spaces. However, bedroom doors did not have vision panels, which meant that staff were required to open patient doors at least hourly during the night, dependent upon each patient's observation level. This affects good sleep hygiene, which is an important aspect of rehabilitation care.

The health board must explore if vision panels can be installed to improve sleep hygiene.

We noted that available rooms and space on the unit were extremely limited. This meant that there was limited space for MDT meetings, visiting, and one-to-one work with patients. This resulted in patients having restricted space at times, including inappropriate spaces sometimes being used for meetings which would benefit from a private space.

The health board must explore if a room on the site can be made available to the Unit on a more consistent, if not permanent, basis.

Individualised care

Staff demonstrated a good knowledge of the patients on the unit, which was reflected in care planning documentation and day-to-day engagement between staff and patients.

Patients were supported according to their needs, preferences and goals. This included skills development, such as kitchen assessments. One patient that we spoke with commented positively about the skills he had learnt in this respect, noting that they had moved from eating ready meals each day to now cooking their own meals.

Patients were encouraged to take responsibility for their own everyday tasks, such as laundry and accessing services within the community. Staff provided encouragement to empower patients to make decisions for themselves and with a decreasing degree of supervision and support from staff, in line with the rehabilitation mode of care.

For patients who were detained, leave from the unit was balanced against wishes, individual risks, and was generally well facilitated by staff. This was reviewed in weekly ward rounds to ensure its on-going appropriateness.

Patients were able to keep their own devices, such as mobile phones and tablets, on the unit. Wi-Fi was available to encourage patients to stay in touch with friends and family.

Timely

Timely care

In the lead up to, and throughout the inspection, staffing numbers and skill mix was stable. We confirmed that staffing could be adjusted to meet patient needs and acuity, including increased observation levels, when necessary. The need for this, however, was reportedly limited due to the designation of the unit. Use of regular bank staff was favoured, where available, to ensure familiarity with patients and their needs.

The unit and patients benefitted from a well-functioning MDT, which included a consultant psychiatrist, registered mental health nurses, an occupational therapist and technician, healthcare support workers and a psychologist and psychology assistant. Whilst some roles, such as the psychiatrist and psychology team were not based on the unit full-time, we found this to not inhibit professional dialogue or timely patient care and input.

Equitable

Communication and language

Language preferences and communication needs were recorded in each patients care and treatment plan, and we observed staff being mindful of these needs when engaging with patients.

Whilst most patients were able to advocate for themselves, use of advocacy services were available, with regular attendance by the service to the unit. However, we would recommend recording of the offer and uptake or decline of advocacy services could be strengthened. Unit staff may wish to include this in patient notes at the pre-ward round check-in for consistency. It was positive to see clear record of wishes regarding patient instructed involvement of relatives and carers, as desired.

The health board should strengthen the recording of advocacy offer and uptake or decline.

Rights and equality

We confirmed that patient's rights in relation to the Mental Health Act were being upheld. Patients were provided with, or had the offer of, written material to explain their rights. Where desired, access to advocacy and / or family and carer involvement was noted.

There was evidence of patient engagement relating to their care and treatment, including invitations to attend weekly ward round meetings and pre-ward round check in's completed by their named nurse. We found engagement from patients to be generally good.

It was positive to see daily morning meetings taking place on the unit, which facilitated a conversation between staff and patients on a range of topics, including daily activities and feedback. These were well attended, and patients were empowered to speak up. We would recommend that monthly community meetings are undertaken on the ward, as a further means of encouraging wider feedback on the unit and in support of maintaining a therapeutic environment.

The health board should seek to introduce community meetings to supplement daily morning meetings.

Delivery of Safe and Effective Care

Safe

Risk management

The unit operates an unlocked rehabilitation model of care. This was underpinned by appropriately evidenced individual risk assessments and strong relational security between staff and patients.

Admission processes were carefully managed, but there remains an inherent degree of risk for the unit due to its layout, relative isolation, registered nurse staffing by night, and other factors which were provided in the verbal feedback session. We recommend the health board uses this inspection as an opportunity to underline the importance of continuing to stringently assess patient moves and admissions, as far as possible and despite health board wide bed pressures. This is to ensure staff and existing patient safety and wellbeing, on what was found to be an otherwise settled and well-functioning unit.

The health board must continue to stringently assess patient moves and admissions, as far as possible and despite known bed pressures, to ensure staff and existing patient safety and wellbeing.

Positively, there was a low number of incidences of challenging behaviours that required escalation, and the unit worked well collectively to minimise the risk of behaviours escalating. There is, however, potential for behaviours to unexpectedly challenge staff who are not frequently exposed to these events. PMVA (Prevention and Management of Violence and Aggression) training was provided to staff, with good compliance, and is a training area that we would advise continues to promote staff and patient safety and wellbeing.

The environment has not benefitted from an anti-ligature programme of works, but was subject to general and individual risk assessments, as required. We confirmed that any patient with active suicidal ideation would not be admitted to the unit and care would be stepped up accordingly.

Other aspects of estate issues and ward maintenance were reported by staff and reviewed by the health board's estates department in a generally timely manner. However, remedial works were reportedly not always carried out in a consistently timely way. Whilst certain areas of the environment had been improved, such as the recently renovated kitchen, the overall indoor and outdoor environment would benefit from improvement to ensure patients can benefit from a therapeutic environment, as far as reasonably possible.

The health board should ensure that estates issues affecting the unit are given sufficient attention and priority to maintain a therapeutic environment.

Infection, prevention and control and decontamination

The unit was generally well organised and clean throughout the inspection, against the backdrop of an aging building and generally high footfall on and off the unit.

Domestic staff were found to be working diligently, and cleaning schedules were comprehensive and up-to-date. However, we would recommend that high level cleaning is included onto these schedules, and a storage solution is found for the patient laundry room.

The health board should ensure that high level cleaning is included in cleaning schedules and that a storage solution is found for the patient laundry room.

Staff compliance with mandatory training was good and there were processes in place to check and maintain effective IPC, which included regular nursing audits, by a nominated nurse with responsibility for IPC.

Safeguarding of children and adults

There were appropriate processes in place to safeguard vulnerable adults. This included a robust recording and understanding of patient histories and associated risk factors. The unit worked to established health board processes and procedures, and there was good compliance with staff training according to their roles and responsibilities.

The overall number of safeguarding incidents on the unit were low, but staff were able to articulate examples of safeguarding concerns and an appropriate set of actions that would be taken in response.

Oversight of safeguarding incidents was monitored within senior nursing and operational governance meetings. Staff confirmed that support and oversight from health board safeguarding teams is provided.

Medicines management

There were good arrangements in place to appropriately manage medication on the unit. The clinic was locked at all times, with keys being held by a registered member of staff.

Medication charts were found to be well completed, with prescribing and administration of medications found to be appropriate. However, there were some

omissions in ensuring that the legal status of patients was consistently completed on the front sheet.

The health board must ensure that patient's legal status is included on medication charts.

The unit benefitted from pharmacy input on a weekly basis, with evidence of pharmacist-led stock checks and audits being undertaken.

Emergency equipment and drugs were readily accessible and routine checks were completed. Fridge temperature checks also consistently recorded to ensure medication efficacy.

Effective

Effective care

The unit MDT comprised of a wide range of healthcare professionals. There was a consensus amongst staff that they felt listened to and had their professional views respected during ward rounds and other MDT forums. Staff commented positively on the fresh direction taken by the consultant psychiatrist who had been in post for several months. Patients shared a similar view that they were consistently invited to ward round meetings, received information about their care and treatment, and felt involved in their care. This included the involvement of families and carers, as desired.

It was positive to note that the patients received dedicated occupational therapy input, together with psychology input-based patient needs. This included individual, group and intensive support, as required. Staff commented that patients are generally able to receive therapeutic support in a timely manner, which was confirmed in the records that we reviewed.

Relational security on the ward was good, which contributed towards a calm atmosphere, with a low number of incidents. It was positive to note that all seven respondents to our patient survey indicated that they felt safe on the unit.

Nutrition and hydration

Patients had access to two kitchens to prepare meals. One kitchen had recently undergone a refurbishment, providing patients with a pleasant environment to prepare and eat meals. Given the rehabilitation designation of the unit and its relative isolation, patients were provided with a weekly allowance to complete food shopping. Essential food supplies, such as bread, cereals and hot drinks, were provided for patients by the service.

Patients were supported to use the kitchen, and assessments were undertaken by a dedicated occupational therapy team. One patient positively expressed that they had only ever eaten microwave meals prior to their admission, and that they are now able to cook their own meals.

Nutrition and hydration needs were appropriately assessed using the All-Wales Nutritional Risk Screening Tool (WASSP). Where required, appropriate follow-up actions had been taken.

Patient records and Monitoring the Mental Health (Wales) Measure 2010: care planning and provision

Care planning was well aligned with the Mental Health (Wales) Measure. This included comprehensive care and treatment plans that reflected the domains of the Welsh Measure and were regularly reviewed. However, care and treatment plan review minutes were not always uploaded onto the electronic records system in a timely manner. All patients had access to a named nurse, who assumed the role of care co-ordinator.

The health board should ensure that Care and Treatment Plan review minutes are uploaded onto WCCIS in a timely manner.

The unit used individualised, evidence-based risk assessments for assessing and managing clinical risk in patients. These were reviewed at regular intervals and when necessary.

Physical health needs were met in several ways. This included new and existing arrangements with a local GP practice, although staff noted that GP access can sometimes present challenges and is an area being explored by the service. Ward based nursing and medical input was also provided, and we noted referrals to other healthcare professionals were made in a timely manner. Patients were encouraged to access other services, such as optometry and dentistry, in the local community.

Mental Health Act monitoring

We reviewed the records of all patients who were detained under the Mental Health Act 1983 and found all legal documentation related to their admission to be compliant with the Act. There was documented evidence that patient rights were being upheld in line with the Act, and patients were regularly presented with their rights, and provided with written information to this effect.

Detention documentation could be navigated with ease, and it was positive to identify improvements had been sustained since the last inspection. However, we

recommend that previous Section 17 leave and consent to treatment certificates are clearly marked with 'no longer valid' to ensure that staff refer to the most recent document.

We found mental capacity to be assessed and recorded in patients ward round notes, alongside careful consideration of patient views and wishes. However, we recommend that the unit utilises the health board wide corporate checklist for assessments to ensure that there is consistency in approach and remains in line with the code of practice.

The health board should ensure that aspects of Mental Health Act documentation are strengthened, as set out in the body of this report.

Quality of Management and Leadership

Staff feedback

We invited staff to complete a survey about their experience working on Ty Skirrid Unit, as well as for the wider organisation. In total, we received 13 responses.

A representative sample of staff comments included:

" The ward team work well together to improve patient experience. The HCSW's have recently been shortlisted for the HCSW Team of the Year within the Health board which they are pleased with."

" Another space/room for interventions/activities and MDT meetings to allow patients usual use of the ward."

"The only concern I have is the night shift qualified. There is only one qualified by night where they cannot have a break or leave the ward and leaves a lot of responsibility to the one nurse."

"I think the ward could improve by employing an activities co-ordinator to work aside the OT s and ward staff to support social interaction with some of the patients who struggle and then work on their strengths and weaknesses..."

"The ward manager is very supportive, friendly, approachable, knowledgeable, very professional and a really good role model for junior members of staff. In all of my roles in and outside of the NHS this manager is the best one I have had by far!"

The health board should consider the staff feedback regarding only on registered nurse on duty by, which impacts on their ability to take a break or leave the ward. This must include mitigations for any risks, such as appropriate level of skill mix on duty, a two-nurse checks for certain medications, and they needs for the registered nurse to leave the ward.

Leadership

Governance and leadership

Governance and oversight processes appeared to work well, enabling a flow of information between the unit, senior nursing, and divisional level meetings.

Matters raised in these meetings involved patient care, workforce, quality and safety.

We found evidence of good management and leadership on the unit. All staff on the ward appeared to work well together throughout the inspection. Positive feedback was provided about the ward manager, and the senior nurse was visible and actively engaged with patients in a knowledgeable manner during the inspection.

All staff who responded to the staff survey confirmed that their immediate manager can be counted on to help them with a difficult task at work. All but one agreed that they are given clear feedback and slightly fewer agreed that they are asked for their opinion before decisions are made that affect their work

In relation to senior managers, most staff members agreed that senior managers are visible and that communication is effective, and all agreed that they are committed to patient care.

Several policies and procedures were in the process of being updated. We recommend that review and ratification of policies and procedures are prioritised, according to their level of clinical risk. This must include the policy relating to patient restraint, which was due for review in 2019.

The health board must ensure that policies and procedures are reviewed and ratified in a timely manner. These should be prioritised according to their level of clinical risk.

Workforce

Skilled and enabled workforce

It was positive to find a generally stable workforce, with a committed team of staff, several of whom had worked on the unit for several years. There was a degree of bank usage on the unit, but staff confirmed that they make every effort to ensure regular bank staff are used to help ensure patients are familiar with the staff who are providing their care and treatment.

There was evidence of good medical leadership on the unit, with staff and patients complementing the care provided by the consultant psychiatrist. Staff and patients were also complementary of the therapeutic offer available to patients.

When asked in our survey if there are enough staff to do their job properly, two staff disagreed. This is reflective of comments received and set out earlier in this

report relation to nurse staffing by night. However, all staff responded that they can meet conflicting demands on their time at work.

Positively, mandatory training and annual appraisal completion rates were maintained to an overall good level, except for basic life support (BLS) and Mental Health Act training. However, we confirmed that there were imminent plans in place to resolve this.

Several staff were supported to undertake additional learning, development and training relevant to their roles, responsibilities and future career intentions. This included formal management, vocational and nursing training.

Culture

People engagement, feedback and learning

There were opportunities for patients, relatives and carers to provide feedback, complements and complaints. Patients were provided with a booklet upon admission, which encourages patients to speak with the ward manager. We confirmed that the ward manager has an open-door policy.

Patients could attend morning meetings to resolve any minor worries or concerns and could also speak with their named nurse. We have recommended earlier in this report that the unit should explore re-instating community meetings to ensure that wider feedback and concerns can be captured and responded to.

There were a low number of formal complaints, however, we confirmed that patients wishing to make a formal complaint would be directed to the appropriate NHS Wales Putting Things Rights process and with the support of an advocate, if required.

Information

Information governance and digital technology

Patient records were found to be securely stored on the unit. This included paper and digital records. The patient status board was always kept out of view, to maintain patient privacy and confidentiality.

Learning, improvement and research

Quality improvement activities

There were several nursing led audits undertaken on the unit. Some of these included audits in infection prevention and control, the environment, and patient records. The audits were generally well scored, using a health board audit

template and system, ensuring consistency in completion and reporting. Audits were monitored by ward management, senior nurse and fed into divisional quality, performance and safety meetings to ensure senior oversight.

Whole-systems approach

Partnership working and development

The unit works closely with other mental health services within the health board. This helps to ensure that wards and units can share a professional dialogue in a timely manner, including highlighting and resolving concerns, and to aid patients in accessing the right level of care and in a timely manner.

The unit and divisional team maintained close working relationships with the local authority and supported living providers to help identify suitable placements for patients to aid timely discharge planning. Whilst there were some delays experienced in this regard, discharge planning was a prominent feature of patients care on the unit and regular meetings take place to monitor progress.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's [website](#).

Appendix A - Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
One recently outdated paliperidone injection was found in the clinic	Outdated medication can affect its efficacy	This was flagged to the nurse in charge	We confirmed that routine checks are undertaken by the pharmacy department, who attend the ward on a weekly basis. Ward staff confirmed that this would be flagged for their attention.

Appendix B - Immediate improvement plan

Service:

Date of inspection:

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Not applicable					
2.						
3.						
4.						

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Appendix C - Improvement plan

Service: Ty Skirrid Unit, Maindiff Court Hospital

Date of inspection: 6-8 October 2025

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Page 11	The health board should ensure that roles, responsibilities and ownership of structured activities is strengthened.	Health and Care Quality Standards 2023 Person-centred / Effective	1. Ward to update activities timetable to reflect role of staff to undertake each activity.	Ward manager/ Occupational Therapist	1/12/2025
				2. Activity timetable is on display on main ward and individualised available in each patient bedrooms		Complete
2.	Page 11	The health board must explore if vision panels can be installed to improve sleep hygiene.	Person-centred / Effective	3. Minor Works costings to be obtained to determine next steps.	Service Improvement Manager	April 2026 due to Health Boards minor works procedures

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				4. To be added to the Mental Health Capital Priorities register for funding.		Complete
3.	Page 11	The health board must explore if a room on the site can be made available to the Unit on a more consistent, if not permanent, basis.	Person-centred / Effective / Workforce	5. Ward Manager to re-explore availability of a room on site to use on a regular basis with the Senior Nurse	Ward manager	Meeting with Senior Nurse 5/12/2025 to discuss options
4.	Page 13	The health board should strengthen the recording of advocacy offer and uptake / decline.	Person-centred / Effective	6. Discuss and offer advocacy in patients' 3-weekly ward rounds.	Ward Manager	4/12/2025 (1 st Patient Ward Round)
				7. Document advocacy discussions and outcomes in the ward round entry.	Ward Manager	4/12/2025 (1 st Patient Ward Round)
5.	Page 13	The health board should seek to introduce community meetings to supplement daily morning meetings.	Person-centred / Effective	8. Meetings are now in place on a monthly basis	Ward Manager	Complete
6.	Page 14	The health board must continue to stringently assess patient moves and admissions, as far as	Effective / Safe / Leadership	9. Maintain established process for rehab referrals, overseen by the Responsible Clinician and agreed via MDT.	Clinical Director for Adult Mental Health	Complete and continue to monitor

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
		possible and despite known bed pressures, to ensure staff and existing patient safety and wellbeing.		10. Any patients transferred outside of this process are agreed with the locality responsible clinician.		Complete and continue to monitor
7	Page 15	The health board should ensure that estates issues affecting the unit are given sufficient attention and priority to maintain a therapeutic environment.	Person-centred / Effective / Safe	11. Outstanding maintenance lists to be reviewed weekly by dedicated housekeeper and escalations sent to the directorate Service Improvement manager to escalate appropriately.	Ward Manager	Complete and continue to monitor
				12. Escalate issues to the directorate Service Improvement Manager as needed.		Complete and continue to monitor
8.	Page 15	The health board should ensure that: • High level cleaning is included in cleaning schedules • A storage solution is found for the	Person-centred / Safe	13. Meeting scheduled for the facilities manager to address these issues.	Ward Manager / Facilities Manager	Meeting scheduled 12/12/25
				14. All Patients' belongings have now been returned to bedrooms and areas decluttered.		Complete and continue to monitor

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
		patient laundry room.				
9.	Page 16	The health board must ensure that patient's legal status is included on medication charts.	Effective / Safe	15. Continue weekly checks of medication charts to ensure patient legal status is included.	Pharmacist/ SHO/Responsible Clinician	Complete
10.	Page 17	The health board should ensure that Care and Treatment Plan review minutes are uploaded onto WCCIS in a timely manner.	Effective / Safe	16. Remind all staff of the correct procedure for uploading review minutes onto WCCIS.	Ward Manager/ Senior Nurse	Complete and continue to monitor via AMAT and Divisional Audit processes
				17. Monthly audit of compliance with WCCIS		January 2026
11.	Page 18	The health board should ensure that aspects of Mental Health Act documentation are strengthened, as set out in the body of this report.	Effective / Safe	18. Capacity Checklist for Mental Health Act is now in place to ensure there is consistency in approach and remains in line with the code of practice.	Responsible Clinician/ Mental Health Act Admin Manager to	Complete and continue to monitor via Clinical Director

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				19. Monthly audit of MHA documentation	provide oversight	Complete and continue to monitor via Clinical Director
12.	Page 19	The health board should consider the staff feedback regarding only on registered nurse on duty by, which impacts on their ability to take a break or leave the ward. This must include mitigations for any risks, such as appropriate level of skill mix on duty, a two-nurse checks for certain medications, and they needs for the registered nurse to leave the ward.	Workforce	20. Ward is currently undergoing an establishment review to consider options or alternatives to address the staffing levels	Lead Nurse	Establishment reviews to be completed by January 2026
				21. Options Appraisal has been developed to address immediate safety concerns on site.		Options appraisal complete. Awaiting discussions - to take place in December 2025
				22. The future of Maindiff Court site is currently under review as part of the wider health board Mental Health		Ongoing

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
				& Learning Disability & estates strategy		
12.	Page 20	The health board must ensure that policies and procedures are reviewed and ratified in a timely manner. These should be prioritised according to their level of clinical risk.	Effective / Safe / Leadership	23. Ensure all policies and procedures are reviewed in the Divisional Policy Group and prioritized by clinical risk.	Divisional Policy Group	Ongoing

Oversight and monitoring of the improvement plan will be undertaken by the following groups: -

- Action Plan meeting
- Directorate Quality Patient Safety Meeting
- Divisional Quality Patient Safety Meeting
- Senior Management Team
- Quality Management Group
- Quality Patient Safety Outcomes Committee

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Nadine Gould

Job role: Divisional Nurse

Date: 27/11/25

DYDDIAD Y CYFARFOD: DATE OF MEETING:	17 February 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Summary report on learning in response to a Health and Safety Executive Notification of Contravention issued to Hafan Deg Ward, County Hospital
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Peter Carr Executive Director of AHPs and Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Peter Carr Executive Director of AHPs and Health Science

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

ADRODDIAD SCAA SBAR REPORT
<u>Sefyllfa / Situation</u>
On 9 July 2025, the Health and Safety Executive (HSE) issued a Notification of Contravention following an inspection of Hafan Deg Ward on 19 June 2025. The inspection identified material breaches of health and safety legislation relating to the management of violence and aggression, environmental security and absconding risk, self-harm risk management, and the suitability of restrictive intervention training for older adults. These findings represent a significant regulatory, safety and reputational issue for the Health Board and required sustained executive oversight. They also highlight systemic learning relevant to all mental health inpatient wards.

Cefndir / Background

The HSE inspection focused on arrangements for managing risks associated with challenging behaviour on Hafan Deg Ward. While the visit was separate from the ongoing police investigation into a patient death in February 2025, the HSE identified weaknesses in ward level systems, controls and assurance processes.

In response, a comprehensive action plan was developed and implemented, with an additional compliance site visit from the HSE in September 2025 and further recommendations. The themes arising from the inspections point to opportunities for strengthened governance, assurance and consistency across mental health inpatient services.

Asesiad / Assessment

The HSE findings present a significant strategic risk to the Health Board, exposing it to further regulatory action, financial penalties through the Fee for Intervention process, and the potential for ongoing harm to patients and staff if improvements are not fully embedded and sustained.

Without strengthened assurance and consistent implementation, there is a risk of continued variability in safety practices, gaps in compliance, and reduced organisational resilience.

Following the inspections of Hafan Deg Ward, significant improvement actions have been undertaken to strengthen safety, therapeutic engagement, and violence prevention measures across the Older Adult Mental Health inpatient areas.

The information below provides a summary of the key findings from the HSE, actions taken and outcomes/assurance this provides the Health Board.

ABSCONDING RISK AND ENVIRONMENTAL SECURITY

HSE Findings

- A push-bar fire exit (Door TY88) giving direct access to hospital grounds.
- Lack of physical checks across all exit doors.
- Garden area risks (e.g. movability of furniture, inconsistent perimeter checks).

Actions Taken

- Security checklist updated to include mandatory "push-bar" testing for all fire exits and individual garden perimeter questions.
- New gate and fence installed for the Fire Door area following assessment by Facilities and Fire Team. Further improvements to the area are being assessed, for example assessment of lighting to improve visibility for staff in the evenings in the event of an evacuation, also removal of redundant fencing.
- Environmental risk assessment completed and undergoing final amendments.
- Environmental checklists have been incorporated into the security nurse and nurse in charge roles to provide assurance on issues identified in alarms, environments and outdoor safety in garden areas.



Outcome / Assurance

Hafan Deg now operates a strengthened, standardised physical security assurance process that is being used as a benchmark across other Older Adult inpatient areas.

Outcome / Assurance

Hafan Deg ward now operates a strengthened, standardised physical security assurance process that is being used as a benchmark across other Older Adult inpatient areas.

VIOLENCE & AGGRESSION

HSE Findings

- Insufficient personal alarms during peak staffing.
- No system for battery replacement or testing of alarms.
- Affray alarms not routinely tested.

Actions Taken

- An additional 20 personal alarms procured and now on ward.
- Daily alarm testing embedded within the Security Nurse role; alarms tested each shift.
- Three-monthly battery replacement cycle implemented and diarised.
- Weekly affray alarm testing added to the security checks.
- Updated security checklist template developed to document battery change dates.

Outcome / Assurance

A reliable, auditable alarm-management system now exists and has been shared with all Older Adult wards for adoption.

OBSERVATIONS PRACTICE & THERAPEUTIC ENGAGEMENT

HSE Findings

- Observations recorded at regularised intervals (00/15/30/45) rather than actual time.
- Inconsistent recording of breathing checks at night.
- No clear ward policy for night-time observations.
- Observation templates insufficient for meaningful clinical entries.

Actions Taken

- The Observation Policy was revised and ratified on 10 December 2025, with training being rolled out for all Divisional areas by February 2026.
- Division-wide review of the Therapeutic Observation & Engagement Policy
- Staff reminded to avoid pre-populated times; meaningful narrative entries encouraged.
- Plan for refresher training and incorporation of tablet-based documentation being explored.

Outcome / Assurance

The Therapeutic Observation & Engagement Policy, incorporating learning from HSE inspections. The revised policy includes clearer operational procedures,



enhanced documentation standards, and strengthened risk communication processes.

CLINICAL RISK DOCUMENTATION

HSE Findings

- Limited detail in Wales Applied Risk Research Network (WARRN) risk assessments and care plans regarding violence and aggression and/or and self-harm risks.
- Key risk information not reliably communicated to staff undertaking observations.

Actions Taken

- Audit Management and Tracking (AMaT) accreditation audits used to assess care-plan quality.
- AMaT is used to monitor clinical and environmental standards with oversight from Senior Nurse, Assistant Head of Nursing, Divisional Nurse and Corporate Nursing through accreditation. Hafan Deg Ward achieved Bronze Accreditation on 5 December 2025.
- Focused audit of WARRN and Care and Treatment Plan (CTP) documentation scheduled and being used to inform divisional improvements.
- Handover procedures have been reviewed with drop in spot checks of standards by the Senior Nurse.

Outcome / Assurance

Results will inform divisional standardisation of risk communication processes.

RESTRICTIVE INTERVENTIONS TRAINING (OLDER ADULT SUITABILITY)

HSE Findings

- Need for assurance that restraint techniques reflect age-related frailty and cognitive impairment.

Actions Taken

- Review of Positive Management Violence & Aggression (PMVA) curriculum undertaken, confirming suitability with age-specific adaptation.
- Additional ward specific training provided where techniques need modification.
- Care plans updated to reflect individual frailty risks.
- Training is monitored through Quality and Patient Safety meetings in the Directorate with assurance being provided from Ward Managers across the Directorate into the inpatient workstreams commencing 18 February 2026.

LEARNING IMPLEMENTED ACROSS MENTAL HEALTH INPATIENT UNITS

Standardised Daily Security Assurance Framework

- Revised security checks adopted in other units (push-bar testing, affray alarm checks, garden checks).
- Consistent battery management system for personal alarms now in place across Older Adult wards.



Strengthened Observation Standards

- Hafan Deg pilot informing Divisional rollout.
- New templates emphasising meaningful engagement and real-time documentation are being used as a standard for all Older Adult wards.

Enhanced Clinical Risk Information Flow

- Findings have influenced a division wide review of how WARRN and CTP information is communicated, especially to temporary staff.

Collectively, these issues highlighted the need for stronger executive assurance, clearer accountability, and a systematic approach to organisational learning across services.

The HSE inspection findings at Hafan Deg Ward have highlighted critical areas requiring organisational learning and systemic improvement, particularly relating to environmental security, observation practice, violence and aggression controls, and the strength of clinical documentation. The actions taken to date demonstrate positive progress and a clear commitment to strengthening safety for both patients and staff.

Argymhelliad / Recommendation

The Committee is asked to note this summary report on learning in response to a Health and Safety Executive Notification of Contravention issued to Hafan Deg Ward, County Hospital.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	NA
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse



	Improve the access, experience and outcomes of those who require mental health and learning disability services 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:	Executive Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	NA
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.



DYDDIAD Y CYFARFOD: DATE OF MEETING:	17 February 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 **Purpose of the Report**

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 December 2025, 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

Changes in Risk Exposure Requiring Committee Attention

Since the last report to the Committee in December, one material change in risk exposure has been recorded. Risk SRR 005A, relating to the potential likelihood of the Health Board maintaining adequate arrangements to ensure system-wide



patient flow, has increased in likelihood from a score of 3 (Possible) to 4 (Likely), resulting in a revised total risk score of 16.

In recent months, the Health Board has experienced increasing pressure on patient flow across the hospital system, arising from a combination of interrelated factors. Higher levels of patient acuity have resulted in more complex clinical needs and extended lengths of stay, while delays in arranging care packages and sustained pressures within social care have constrained the system's ability to discharge patients in a timely manner. Consequently, patients entering the system via urgent and emergency care frequently remain in acute settings for longer periods, reflecting reduced flexibility and capacity across the wider hospital flow pathway. The increasing acuity of patients presenting to the Emergency Department has further contributed to prolonged waiting times and challenges in maintaining effective flow.

Collectively, these pressures have informed the Welsh Government's recent decision to escalate the Health Board from Level 3 to Level 4 for performance and outcomes relating to the urgent and emergency care system at the Grange University Hospital Emergency Department. This escalation reflects ongoing national concern that, notwithstanding a range of improvement actions already underway, performance has not yet achieved the level of consistency required in key areas including patient flow, waiting times, and overall patient experience. Welsh Government has highlighted that system pressures remain significant and that accelerated and sustained improvement is required to meet expected urgent and emergency care standards.

Audit Wales has acknowledged that the Health Board has strengthened its planning, monitoring, and governance arrangements in relation to urgent and emergency care demand, providing a more robust platform for improvement. However, the persistent complexity and volatility within the system mean that these arrangements have not yet translated into sustained improvements sufficient to reduce delays, congestion, and wider flow challenges across the emergency care pathway.

In response to the increased escalation level, the Health Board is further strengthening its internal controls and assurance mechanisms to enhance visibility, rigour, and oversight of delivery. This includes enhanced scrutiny of performance trajectories, clearer accountability for delivery, strengthened risk controls, and closer alignment between operational and strategic improvement plans. A central focus of these arrangements is to ensure that patient safety remains paramount, with risks arising from delays and congestion actively identified, mitigated, and escalated as appropriate.

The increase in the risk score reflects the current pressures within the urgent and emergency care system and the continued requirement for coordinated, whole-system action, underpinned by strengthened controls and assurance, to deliver sustained improvements in performance and patient safety.

The updated risk assessment set out in Appendix A identifies a number of additional controls for implementation. It should be noted, however, that many of



these controls are already in place and operating, and are subject to ongoing testing, refinement, and strengthening to ensure they effectively reduce either the likelihood or impact of the risk.

Risk Exposure Aligned with Risk Appetite

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

With the establishment of the Health and Safety Operational Group and the strategic Health and Safety Committee, there is cautious optimism that the strengthened governance arrangements, coupled with closer monitoring of divisional performance, will lead to further reductions in risk exposure over the coming months. This trajectory should bring the risk into alignment with the Board's risk appetite for safety risks, which is set at ultra-safe, meaning only minimal residual risk exposure, with a negligible or low likelihood of occurrence as far as is reasonably practicable.

Closing Position

As at February 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:

- **NOTE** the increase in risk score and exposure for SRR 005A;
- **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.



- **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.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The Strategic Risk Register is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

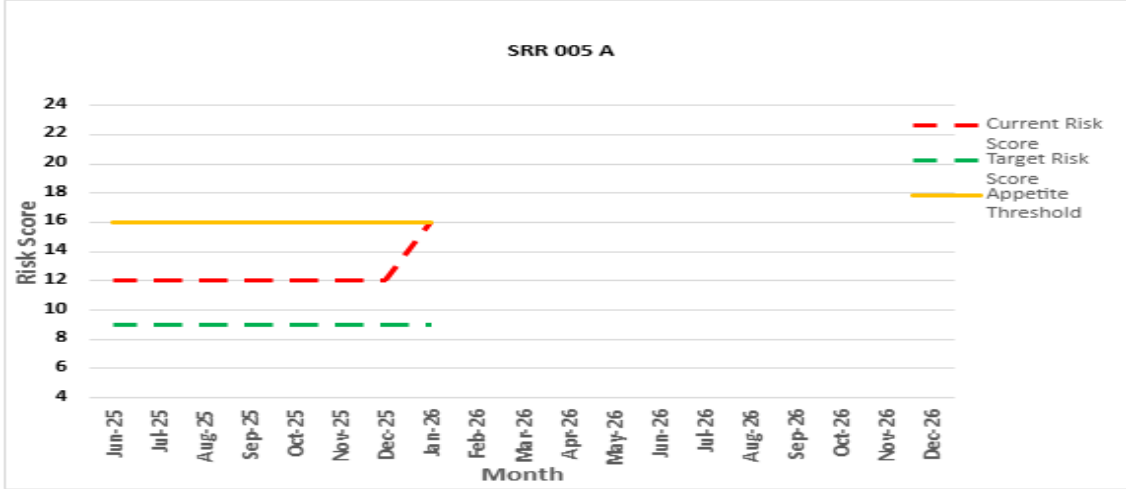
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termiau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	The Board and respective Committees of the Board have considered risks contained within the Strategic Risk Register



Effaith: (rhaid cwblhau) Impact: (must be completed)	
Asesiad Cydraddoldeb Equality Impact Assessment (EIA) completed	Is EIA Required and included with this paper No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf 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 <i>(As a result of)</i>	Due to inadequate arrangements to support system-wide patient flow			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> - Avoidable deaths and significant harm. - Delayed discharges from acute and non-acute settings resulting. in deteriorating patients. - Delays in releasing ambulances from hospital sites back into the community.	<u>Staff</u> - Increased workload - Fatigue & burnout	<u>Organisation</u> - Litigation & Financial Penalties - Reputational damage and loss of public confidence	Risk Appetite Threshold – OPEN SCORE 17 AND BELOW Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Chief Operating Officer	Risk Exposure	Current Level	Target Level	
Monitoring Committee / Group	Patient Quality, Safety and Outcomes Committee	Likelihood	4 (Possible) x	3 (Possible) x	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)	
Last Reviewed	February 2026	Risk rating	= 16 (Extreme)	= 9 (High)	
Next Review (Monthly based on risk score)	March 2026				

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>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)</i>
- 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.	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. - 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.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
- The Escalation Framework has been enacted and ineffective in mitigating threats and impact to services. - Performance report against measures/metrics - Daily 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.	- 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 <i>(Executed by risk management and compliance functions)</i>		
- 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 <i>(Implemented by both auditors internal and external independent bodies)</i>		
Internal Audit Reviews - Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024. - External inspections/visits. - IQPD Monthly Meetings focus on key areas - GIRFT visit Report attached - Accelerated Design Event / Programme of work – report attached - 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)	N/A

	• 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	
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 <i>(As a result of)</i>	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.																																																																																	
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> - Unmet patient needs resulting in patient harm. - Ineffective use of combined resources - Delayed decision making - Adverse impacts on delivery of care to patients across acute and non-acute settings - Negative experience of care - Distress and frustration. - Carer stress.	<u>Staff</u> Staff dissatisfaction Frustration Increased absence. Loss of confidence.	<u>Organisation</u> - Failure to deliver health board priorities, required improvements and achieve longer-term sustainability - Reputational damage and loss of public confidence	Risk Appetite Threshold – OPEN SCORE 17 and Below All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.																																																																																	
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Lead Director	Director of Nursing	Risk Exposure	Current Level	Target Level	<table><caption>SRR 008 Risk Score Data</caption><thead><tr><th>Month</th><th>Current Risk Score</th><th>Target Risk Score</th><th>Appetite Threshold</th></tr></thead><tbody><tr><td>Jun-25</td><td>8</td><td>4</td><td>16</td></tr><tr><td>Jul-25</td><td>8</td><td>4</td><td>16</td></tr><tr><td>Aug-25</td><td>8</td><td>4</td><td>16</td></tr><tr><td>Sep-25</td><td>8</td><td>4</td><td>16</td></tr><tr><td>Oct-25</td><td>8</td><td>4</td><td>16</td></tr><tr><td>Nov-25</td><td>8</td><td>4</td><td>16</td></tr><tr><td>Dec-25</td><td>8</td><td>4</td><td>16</td></tr><tr><td>Jan-26</td><td>8</td><td>4</td><td>16</td></tr><tr><td>Feb-26</td><td></td><td></td><td></td></tr><tr><td>Mar-26</td><td></td><td></td><td></td></tr><tr><td>Apr-26</td><td></td><td></td><td></td></tr><tr><td>May-26</td><td></td><td></td><td></td></tr><tr><td>Jun-26</td><td></td><td></td><td></td></tr><tr><td>Jul-26</td><td></td><td></td><td></td></tr><tr><td>Aug-26</td><td></td><td></td><td></td></tr><tr><td>Sep-26</td><td></td><td></td><td></td></tr><tr><td>Oct-26</td><td></td><td></td><td></td></tr><tr><td>Nov-26</td><td></td><td></td><td></td></tr><tr><td>Dec-26</td><td></td><td></td><td></td></tr></tbody></table>	Month	Current Risk Score	Target Risk Score	Appetite Threshold	Jun-25	8	4	16	Jul-25	8	4	16	Aug-25	8	4	16	Sep-25	8	4	16	Oct-25	8	4	16	Nov-25	8	4	16	Dec-25	8	4	16	Jan-26	8	4	16	Feb-26				Mar-26				Apr-26				May-26				Jun-26				Jul-26				Aug-26				Sep-26				Oct-26				Nov-26				Dec-26			
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Last Reviewed	September 2026	Risk rating	= 8 (Moderate)	= 4 (Low)																																																																																	
Next Review (Six monthly based on risk score)	March 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. - Patient Experience and Involvement Strategy - DATIX - Oversight of Medical Examiner reports to determine patient experience actions - Public Engagement- Big Conversation Bereavement held 20th March 2024	- Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. - PCCT staff training to support Civica data entry and retrieval. - Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. - Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to Quality Management Group - Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. SMS provision to be implemented in Feb 2025 across ED and all MIU's. 5 National Maternity Surveys to launch via SMS 1st Sept 2025 - National directives around new national surveys that need to be managed additional to internal roll out programme – National People's Experience Survey live 1st May 2025 and default survey for majority of live areas. - Volunteer feedback to be reviewed to identify themes. - Development of End of Life and Bereavement models in progress and improve bereavement offer to meet Bereavement Standards. Resources being scoped. - Community of Practice for Patient Experience and People Participation Panels now agreed and to be progressed.

• People Participation Panel ED in Progress • 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 in Newport, Caerphilly and Monmouthshire to support bereaved people	• Dementia community hubs in each borough of Gwent will enable accessible opportunities for feedback and signposting, plans to increase hubs in more areas of Gwent.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Concerns are fed back to divisional teams when identified. - Outcome of the volunteer feedback to drive improvements. - Patient Experience and Involvement Team undertaking Culturally Competent Accreditation, receiving a silver distinction award in Oct 2024 - Immediate feedback and escalation to clinical teams following PALS queries and concerns - Civica patient feedback in in the process of being rolled out across all – all divisional leaders receive reports for their live areas monthly. - Bereavement survey built with CIVICA – Nov 2024 - CIVICA SMS launched 3rd March 2025 across ED and MIU’S	- Currently there is limited SMS provision to increase the number of surveys. - No single point of contact or ‘drop in’ provision for patients/families/staff to raise initial patient experience concerns. - Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards. - CIVICA team have the ability to pull and view feedback that has been left by patients/family. The listening and learning from the feedback to be shared by each department/directorate/division i.e., / ‘you said, we did’ / quality improvement projects.	- SMS provision for patient experience feedback launched in ED and all MIU’s in February 2025. - PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing ‘drop in’ clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Need to have discussions with facilities around rooms. - Patient experience KPI’s and common themes by department/directorate/division need to be identified and pulled from the civica system left on surveys feedback. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation. - Development of a ABUHB bereavement survey has been built within CIVICA and tested. Launch date likely early 2025.	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) - Listening and Learning reported through QPSOG/ Outcomes Committee - Implemented PALS DATIX Module	None	N/A	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Bi-monthly LLais Reports - HIW inspections - Advocacy reports	None	N/A	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable

RISK THEME	COMPLIANCE AND SAFETY																																																																																					
LINK TO IMTP SECTION 4: ENABLER	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 <i>(As a result of)</i>	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements				Risk Appetite Level – MINIMAL Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below.																																																																																	
Impact <i>(Consequences of the threat)</i>	Patient - Unintended physical harm to patients - Psychological trauma	Staff - Unintended physical harm to staff - Psychological trauma - Increased levels of staff sickness	Organisation - Punitive actions from the Health and Safety Executive (HSE) - Loss of estates due to unsafe environments - Financial implications - Adverse publicity - Reputational damage.		Risk Appetite Threshold – SCORE OF 8 or Below Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls.																																																																																	
					SUMMARY The current risk level is OUTSIDE of target level and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.																																																																																	
Lead Director	Director of Allied Health Professions and Health Science		Risk Exposure	Current Level	Target Level	SRR 010 <table><caption>SRR 010 Risk Score Data</caption><tr><th>Month</th><th>Current Risk Score</th><th>Target Risk Score</th><th>Appetite Threshold</th></tr><tr><td>Jun-25</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Jul-25</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Aug-25</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Sep-25</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Oct-25</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Nov-25</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Dec-25</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Jan-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Feb-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Mar-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Apr-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>May-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Jun-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Jul-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Aug-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Sep-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Oct-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Nov-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Dec-26</td><td>12</td><td>6</td><td>8</td></tr></table>	Month	Current Risk Score	Target Risk Score	Appetite Threshold	Jun-25	12	6	8	Jul-25	12	6	8	Aug-25	12	6	8	Sep-25	12	6	8	Oct-25	12	6	8	Nov-25	12	6	8	Dec-25	12	6	8	Jan-26	12	6	8	Feb-26	12	6	8	Mar-26	12	6	8	Apr-26	12	6	8	May-26	12	6	8	Jun-26	12	6	8	Jul-26	12	6	8	Aug-26	12	6	8	Sep-26	12	6	8	Oct-26	12	6	8	Nov-26	12	6	8	Dec-26	12	6	8
Month	Current Risk Score	Target Risk Score	Appetite Threshold																																																																																			
Jun-25	12	6	8																																																																																			
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Oct-25	12	6	8																																																																																			
Nov-25	12	6	8																																																																																			
Dec-25	12	6	8																																																																																			
Jan-26	12	6	8																																																																																			
Feb-26	12	6	8																																																																																			
Mar-26	12	6	8																																																																																			
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Nov-26	12	6	8																																																																																			
Dec-26	12	6	8																																																																																			
Monitoring Committee	Patient Quality, Safety and Outcomes Committee		Likelihood	3 (Possible) x	2 (Unlikely) x																																																																																	
Initial Date of Assessment	01 December 2023		Impact	4 (Major)	3 (Moderate)																																																																																	
Last Reviewed	December 2026		Risk rating	= 12 (High)	= 6 (Moderate)																																																																																	
Next Review (Quarterly based on risk score)	March 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)
- Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices. - Health and Safety Policies and Procedures - Dedicated Health and Safety site on ABPULSE - Provision of dedicated health and safety expertise and advice to meet the requirements of the Management of Health and Safety at Work Regulations 1999, Regulation 7 ‘Health and Safety Assistance’. - Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression) - Partial Programme of Health and Safety Monitoring (Active & Reactive) - Corporate and Directorate Health and Safety Risk Register established. - Board Training /development (Completed 24 April 2024) - Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern. - Health and Safety Governance and reporting arrangements (Health and Safety Committee)	- Develop and implement a 3-year health and safety culture plan, including the implementation of a new Health and Safety Management System - Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments) - Consultation and communication with the workforce regarding compliance with the Act - New ways of working with Divisions to ensure accountability for health and safety is recognised. - Implement key performance indicators to monitor health and safety compliance. - Review the governance arrangements for the Health & Safety Committee - Health and Safety Policies and Procedures to be reviewed. - Onboard further Manual Handling trainers across the organisation to improve compliance. - Scope for training non-Health Board staff - Learning from events to be documented and communicated to the organisation.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
Health and Safety compliance data extracted from ESR and Datix and reported 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 <i>(Executed by risk management and compliance functions)</i>			
• 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 <i>(Implemented by both auditors internal and external independent bodies)</i>			
Internal Audit 2024/25 Plan • Health and Safety Internal Audit – Concluded Limited Assurance • Performance reviews at All Wales Health and Safety Management Steering Group • South Wales Fire & Rescue Service fire safety audit programme. Health and Safety Executive reviews/inspections.	• Recommendations from the 2024/25 Internal Audit	• Implement actions to address the findings and recommendations set out in the Limited Assurance Internal Audit Report	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	17 February 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Patient Quality, Safety and Outcomes - Committee Forward Work Plan 2026/27
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Board Business Manager/Governance Support Officer

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

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Patient Quality, Safety and Outcomes Committee is asked to consider the draft Committee Forward Work Plan appended to this report for approval. The Forward Work Plan has been developed with due regard to recommendations from the Committee to enable the Committee to : -

- Fulfil its Terms of Reference; and,
- Seek assurance and provide scrutiny on behalf of the Board, in relation to those items identified within the Committees terms of reference.

Cefndir / Background

The purpose of the Patient Quality, Safety and Outcomes Committee is to support the Board by seeking assurance in respect of all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services.

In line with good governance practice, a Committee Forward Workplan has been developed to ensure statutory requirements for items of Committee business are scheduled in across the year. The workplan can therefore be utilised as a tool for informing and pre-empting committee business and support the agenda setting process.

Asesiad / Assessment

The Committee is requested to approve the Committee forward workplan as outlined in **Appendix 1** noting that the workplan will be presented at each Committee meeting for oversight and noting.

Argymhelliad / Recommendation

The Committee is requested to:

- **RECIEVE** and **APPROVE** the proposed Committee workplan for 2026/27 and **NOTE** that it will be brought forward to each future Committee meeting for oversight.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termiau: Glossary of Terms:	N/A

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Not Applicable
• Service Activity & Performance	Not Applicable
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Annual Programme of Business for 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
			8 th April 2026	2 nd June 2026	28 th July 2026	6 th Oct 2026	1 st Dec 2026	16 th 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	✓			✓		
Listening and Learning Framework Annual Review	DoN	AN	✓					
Serious Incident Learning Report	DoN	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		✓				

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	
v	Scheduled agenda item in FWP

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

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	17 February 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 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Governance Support Officer

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

Er Gwybodaeth/For Information

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Patient, Quality Safety and Outcomes Committee is asked to review the agreed Committee Forward Work Plan appended to this report. The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2025/26 and to enable the Committee to: -

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

Cefndir / Background

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

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

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

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

Additional items on the Forward Work Plan that will be presented at February 2026 meeting:-

- Healthcare Inspectorate Wales Reviews;
- Report on recent HSE intervention at Hafan Deg Ward, including the actions taken and the closure of the investigation;
- Putting Things Right Regulations report;
- Pharmacy and Prescribing Report.

Items deferred on the Forward Work Plan;

- Committee Annual Report 2025/26 was deferred from February 2026 to April 2026 meeting;
- Quality Management System and Assurance Framework Annual Review was deferred from February 2026 to June 2026 meeting;
- Learning from Death Report was deferred from February 2026 to April 2026 meeting.

These changes have been reflected on the updated Forward Work Programme.

Argymhelliad / Recommendation

The Committee is requested to **NOTE** the updated Committee forward work plan as provided in **Appendix 1**.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.

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

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

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

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

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

Not Applicable
Choose an item.

Annual Programme of Business for 2025-26

Patient, Quality, Safety and Outcomes Committee

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

- Aneurin Bevan University Health Board's Standing Orders;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee's self-assessment for 2023/24
- The Board's Strategic Risk Register; and
- Key statutory, national and best practice requirements and reporting arrangements.

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

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

MATTERS TO BE CONSIDERED	Lead	Frequency of Report						
			QTR 1		QTR 2	QTR 3		QTR 4
			31 st March	3 rd June	29 th July	1 st Oct	2 nd Dec	17 th Feb
Attendance and Apologies	Chair	SI	✓	✓	✓	✓	✓	✓
Declarations of Interest	All members	SI	✓	✓	✓	✓	✓	✓
Minutes of the Previous Meeting	Chair	SI	✓	✓	✓	✓	✓	✓
Action Log and Matters Arising	Chair	SI	✓	✓	✓	✓	✓	✓
Development of Committee Annual Programme of Business 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	MD	Action					√	

PQSOC 0306/12								
HSE Report (For Information) PQSOC 0110/06	DoT&HS	Action					✓	
Update on maternity and neonatal services, including results of the neonatal culture review and outcomes from the listening events PQSOC 0110/06	DON	Action					✓	
Update on Health and Safety Executive (HSE) investigations, including the open investigation related to a fall in 2019 and other cases of interest. PQSOC 0110/15	DoT&HS	Action					✓	
PALS scheme and Organisational Change programme review outcomes. PQSOC 0110/06	DON	Action					✓D	✓
Year 3 quality strategy implementation plan PQSOC 0110/07	DON	Action					✓	
The Healthcare Inspectorate Wales final report for Pillmawr and Adferiad PQSOC 0110/08	DON	Action					✓	

Update on Safeguarding level 3 training PQSOC 0110/11	DON	Action					✓	
Ophthalmology Audit Wales Report	DON	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 Hafan 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						✓

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

Frequency of Inclusion	
Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item
An	Annual
1/4ly	Quarterly
BI	1/2 yearly
Schedule of Meetings	
√	Scheduled agenda item in FWP
D	Deferred from this agenda
√D	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

Joint Commissioning Committee

Highlight Report from the Quality, Safety and Outcomes Sub-Committee

Dyddiad y Cyfarfod / Date of Meeting	06/10/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Gareth Mitchell, Corporate Governance Manager, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Susan Elsmore, Chair of Sub-Committee and Lay Member, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Health Boards		Noted

1. SITUATION/BACKGROUND

This report had been prepared to provide NWJCC Joint Committee Members with a summary of the key issues considered by the Quality, Safety and Outcomes (QSO) Sub-Committee at its public meeting on 6 October 2025.

Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

(Links to reports highlighted - [October 2025 - NHS Wales Joint Commissioning Committee](#)).

Status	Update
Alert / Escalate	
Advise	Reports from each of the Directors of Commissioning were received. The following items were discussed and referred to the Joint Committee for noting.: Director of Commissioning for Specialised Services - The significant risk in relation to the Blood and Marrow Transplantation (BMT) and Chimeric Antigen Receptor T-cell Therapy (CAR-T) services delivered by Cardiff and Vale University Health Board (CVUHB); and the linked service at Swansea Bay University Health Board (SBUHB). While the service currently holds Joint Accreditation Committee of the European BMT Society (JACIE) accreditation, existing facilities do not meet the standards required. A JACIE inspection had taken place, and the final report was awaited. - Significant risks reported across the Specialist Services portfolio including plastic surgery outreach clinics and PET-CT for prostate cancer. - An overview of progress within the Phase 2 review of Cardiac Commissioning. This included confirmation that a demand and capacity review for the programme had commenced and that an inaugural Project Delivery Board was scheduled during October to oversee this work. - Escalation Trajectories for specialist services in escalation are attached as Appendix 1 for information. Director of Commissioning for Ambulance Services/111 Report - The implementation of phase two of the ambulance response model was discussed. This included confirmation that traditional Amber and Green Categories would be replaced with Orange (time-sensitive), Yellow (assess-and-respond), and Blue (non-emergency transport) to better reflect clinical need. Enhanced clinical screening would also ensure that patients with conditions like stroke or ST-Segment Elevation Myocardial Infarction received timely and appropriate care, while the Red category continued to target life-threatening emergencies. This phase aimed to improve resource use, reduce unnecessary hospital conveyance, and deliver better clinical outcomes. Plans were in place to deliver a 'go live' date in early December 2025. - Non-Emergency Patient Transport Service (NEPTS) is facing increased demand pressure. This was contributing to

Status	Update
	increased travel distances, rising provider costs, and inefficiencies at the interface between Health Boards and the ambulance service. Assurance and working groups had been set up to co-ordinate and drive improvements in this area. • An update was given in relating to the EMRTS Judicial Review claim. It was acknowledged that an application had been made by the claimant to the Court of Appeal to determine whether the appeal had sufficient grounds to proceed. • The 111 service remained challenging. Further work had been undertaken on call handling capacity, and a 111 Re-roster Project Board had been established to support this. Clinical call-back performance, however, was reported to have improved. Members discussed capacity issues within the NEPTS service and the ongoing work to develop a dashboard to identify performance issues including to track the number of bookings/cancellations in real time with a need for updates to be shared at a future meeting on this important piece of work. Director of Commissioning for MHLDBG Report • A recent visit to Rampton High Secure Hospital had identified significant improvements in patient care. • Significant issues have been identified following a review of the Caswell Clinic would require immediate action and close monitoring thereafter. A meeting had taken place with the SBUHB Executive Team to escalate identified concerns. An official report and action plan had been commissioned and would be shared with SBUHB for action as a matter of urgency. Any impact on escalation levels at the Caswell Clinic would be reported at the next Committee meeting. • Urgent repairs required at the Uned Gobaith Perinatal Inpatient Mental Health Unit at Tonna Hospital. Committee members noted that plans were being formulated to secure alternative capacity for patients given the necessity of a temporary 6-week closure of the unit to complete the required maintenance work. The Incident and Concerns Report highlighted 7 new incidents reported for the period spanning July-August and 6 new complaints, four had been closed and two remain open.
Assure	The JCC Risk Register - QSO risks were received. The Committee received an update about the risks allocated to it from the NWJCC Operational Risk Register (ORR) as at the 31 August 2025. Members noted:

Status	Update
	• Twenty risks (scoring 15/25 or over) were recorded within the ORR, eleven of which were assigned to the Committee for assurance and review. • Two new risks were added to the ORR since the previous update, two risks had been de-escalated, and one risk had been closed. The Regulator Report (Healthcare Inspectorate Wales (HIW) / Care Quality Commission (CQC) was received. An update on regulatory activity was provided. Members noted updates from HIW and the CQC and acknowledged ongoing collaboration with HIW to improve reporting and assurance processes. Members highlighted the need for future reports to provide greater specificity in relation to areas of concern raised by regulators.
Inform	Patient Story – Cystic Fibrosis (CF) A CF patient shared her story and personal experiences of the care received from NHS Wales, illustrating the benefits of shared decision-making and patient engagement. The story included a trial drug that had dramatically changed the patient’s quality of life to the extent that she had successfully completed a cross-Atlantic rowing challenge, the first person with CF ever to do so. All Wales Individual Patient Funding (IPFR) Report The IPFR report would be a standing item at all future QSO meetings. It was agreed that outcome data would be added into the report, going forward. Financial elements of IPFR would continue to be reported to the Planning, Performance and Finance Sub-Committee as part of the NWJCC Finance Report. NWJCC Policy Group Report As per the NWJCC governance arrangements, the NWJCC Policy Group Report was received and noted at the meeting (this was a 6-monthly scheduled report). Welsh Kidney Network (WKN) Report Despite a recent change in governance arrangements (and the Network becoming a part of the NWJCC Specialised Services Directorate), the WKN Report would still be presented as a separate agenda item at the QSO meeting to fully capture work undertaken across the Network. The report was noted at the meeting and members discussed the use of outcome data for service planning, the national system used to track patient journeys and transplant decisions and the effectiveness of kidney

Status	Update
	transplants in terms of survival rates as well as wider economic benefits.
Appendices	None.

3. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective
	Efficient; Equitable; Person-centred; Timely; Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

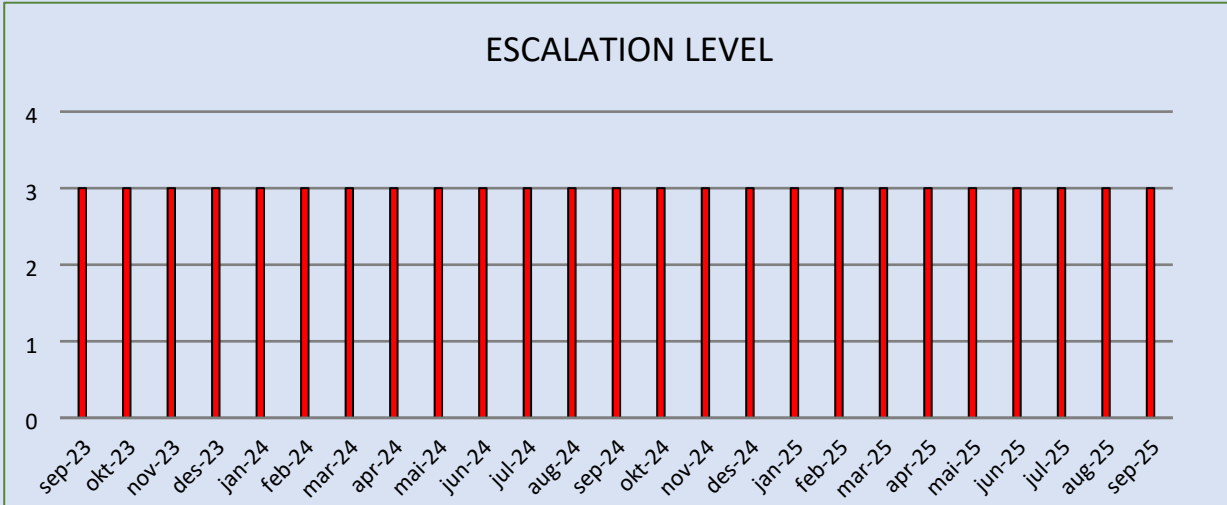
Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is a summary of the

<i>Have you undertaken a Quality Impact Assessment Screening?</i>		latest meeting of the JCC
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i>	Yes: ☒	No: ☒
Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau <i>(Pobl /Ariannol) /</i>	Yes (Include further detail below)	
Resource Impact <i>(People / Financial)</i>	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

4. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 3 of this report.

Executive Director Lead: Melanie Wilkey Commissioning Lead: Amy Lewis Commissioning Team: Women and Children Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24,25/11/24, 15/01/25, 18/03/25, 20/05/25, 01/07/25 Date Last Reviewed by Quality & Patient Safety Committee: 04/08/25 Escalation Trajectory: ESCALATION LEVEL 		Service in Escalation: Neonatal Intensive Care Unit Current Level 3Escalation Escalation Trend Level <table><thead><tr><th>Trend</th><th>Rationale</th><th>Current Trend Level</th></tr></thead><tbody><tr><td>↓</td><td>Escalation level lowered</td><td rowspan="3">↔ September 2025</td></tr><tr><td>↔</td><td>Escalation remains the same</td></tr><tr><td>↑</td><td>Escalation level escalated</td></tr></tbody></table>		Trend	Rationale	Current Trend Level	↓	Escalation level lowered	↔ September 2025	↔	Escalation remains the same	↑	Escalation level escalated				
Trend	Rationale	Current Trend Level															
↓	Escalation level lowered	↔ September 2025															
↔	Escalation remains the same																
↑	Escalation level escalated																
Background Information: There are currently two risks on the CRAF relating to Neonatal services at Cardiff and Vale UHB, lack of cot availability due to workforce and the service being a negative outlier status for blood stream infections, on the National Neonatal Audit Programme (NNAP). Limited progress has also been made against implementing the workforce required to support the cot configuration. NWJCC assurance and confidence level in developments: Low / Medium – First draft of an action plan has been received however further detail has been requested. The mitigations required to support safe staffing levels and improvements against infection rates requires a robust workforce plan which has a medium to long term lead time for completion. Escalation status being discussed at executive level within the JCC. The Paediatric and Neonatal Escalation Reset Meeting is to take place on the 18th of September where an overview of the service will be discussed to gain an understanding from the health boards perspective of where they feel they are in the process, rather than discussing actions and objectives. The overarching objectives for the service are in the development phase and when agreed within the commissioning team they will be shared with the health board for comments and then presented at the reset meeting, to ensure they are agreed		Escalation History: <table><thead><tr><th>Date</th><th>Escalation Level</th></tr></thead><tbody><tr><td>September 2023</td><td>3</td></tr></tbody></table> Rationale for Escalation Status: High levels of cot closures reported across all three levels of care, blood stream infection rates and progress implementing the new cot configuration.		Date	Escalation Level	September 2023	3										
Date	Escalation Level																
September 2023	3																
Actions: <table><thead><tr><th>Action</th><th>NWJCC Lead</th><th>Action Due Date</th><th>Completion Date</th></tr></thead><tbody><tr><td>Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live</td><td>Director of Planning</td><td>16th August 2024</td><td>See comment in development section</td></tr><tr><td>Re-set meeting to discuss and agree actions/objectives in collaboration with the health board</td><td>Senior Planning Manager</td><td>18th September 2024</td><td>18th September 2024</td></tr><tr><td>Escalation meeting to discuss detail and progress against action plan (every 6 weeks)</td><td>Head of Commissioning</td><td>-</td><td>4th November 2025</td></tr></tbody></table>		Action	NWJCC Lead	Action Due Date	Completion Date	Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live	Director of Planning	16 th August 2024	See comment in development section	Re-set meeting to discuss and agree actions/objectives in collaboration with the health board	Senior Planning Manager	18 th September 2024	18 th September 2024	Escalation meeting to discuss detail and progress against action plan (every 6 weeks)	Head of Commissioning	-	4 th November 2025
Action	NWJCC Lead	Action Due Date	Completion Date														
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Escalation meeting to discuss detail and progress against action plan (every 6 weeks)	Head of Commissioning	-	4 th November 2025														

collaboratively. New executive leads for both organisations will be agreed as part of this process to ensure all are in agreement.

Actions/Objectives agreed on the 18th of September in collaboration with the health board. Monthly escalation meetings to re-commence on the 25th of November to monitor progress.

Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live – Phase 1 implementation paper to be taken to management group on 28th November to recommend a way forward to progress with the implementation of the new baseline.

15th January escalation meeting. Health board presented their progress against the agreed actions/objectives. Progress acknowledged. JCC to assess progress report against the objectives. Decision made service to remain at escalation level 3 as more data required ensuring that the improved position is sustained prior to considering de-escalation.

Conversations ongoing regarding implementing phase 1, both internally in the JCC and with the health board. If phase 1 is not implemented as previously agreed by Joint Committee, then there will need to be appropriate communication to all the health boards to advise. The commencing of Phase 2 has been delayed due to the OCP process.

18th March escalation meeting. Health Board presented their progress against the agreed actions/objectives. Progress acknowledged. JCC to assess progress report against the objectives. The escalation level was discussed in the W&C commissioning team meeting on 19th March. The team agreed that the service should remain at escalation level 3.

20th May escalation meeting. Health Board presented their progress against the agreed actions/objectives. Progress acknowledged. JCC to assess progress report against the objectives. Executive Director lead agreed to progress finance conversations around funding. The escalation level was discussed in the W&C commissioning team meeting on 21st May. The team agreed that the service should remain at escalation level 3.

The delay in implementation by the Health Board of the Phase 1 revised cot configuration and agreement on next steps is currently with the Senior Leadership Team. A paper to provide an update to Joint Committee on Phase 1 implementation is in development. Phase 2 under discussion due to delays with the implementation of Phase 1.

1st July escalation meeting held. Health Board presented their progress against the agreed actions/objectives. Progress acknowledged. JCC to assess progress report against the objectives. Executive Director lead agreed to progress finance conversations around funding, as meeting not yet taken place. The escalation level was discussed during the meeting and there was agreement that the service should remain at escalation level 3.

The delay in implementation by the Health Board of the Phase 1 revised cot configuration and agreement on next steps is currently with the Senior Leadership Team. A paper to provide an update to Joint Committee on Phase 1 implementation has been written and is with the Director of Commissioning for Specialised Services. Phase 2 under discussion due to delays with the implementation of Phase 1.

2nd September update – The escalation meeting scheduled for the 23rd of September has been stood down. This is for the JCC to work through the funding matters internally. An internal workshop to discuss Phase 1 progression and the funding matters has been arranged for the 22nd of October 2025. The next scheduled escalation meeting is the 4th of November. The service remains at escalation level 3.

Issues/Risks:

March 24 - The service have not submitted an action plan despite being in escalation since Sept 23, they are unable to increase their cot numbers based on the new cot configuration and reported that they cannot safely deliver on the cots that they are currently commissioned, no progress made with exec to exec meeting, possibility that outsourcing from the service may be required, the service remains at escalation level 3 but if there are no improvements increasing the escalation will be considered.

May 24 - Through quarterly assurance meetings with all neonatal units in the South & West of Wales it has been reported that there has been increased pressure across the network for cot availability

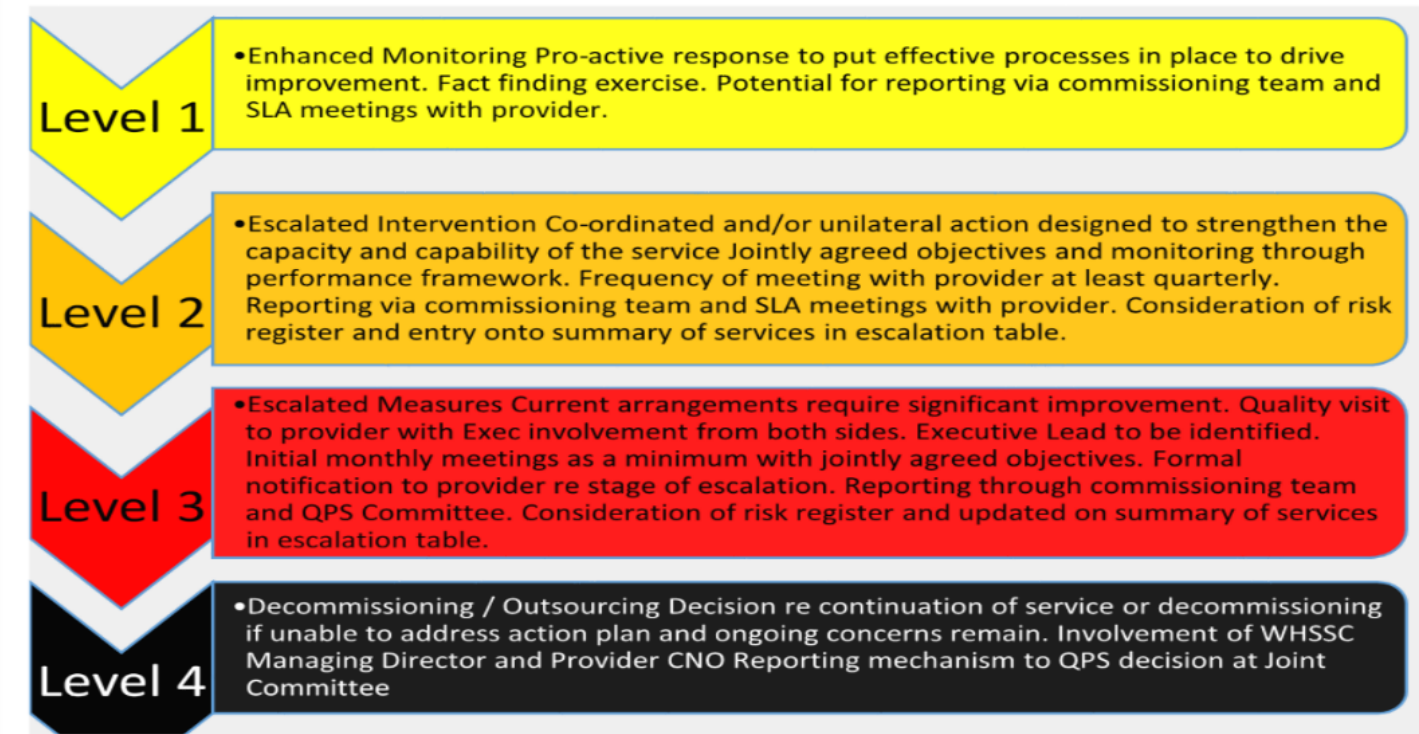
July 24 – Temporary closure of Princess of Wales (PoW) Maternity and Neonatal unit for essential maintenance work from September to December. JCC currently commission 4 High Dependency (HD) cots within the PoW and Prince Charles Hospital (PCH) sites within CTMUHB. PCH are able to flex their cot base from 15 cots to 19 to provide HD capacity and Special Care based on clinical need. Consultation and communication with all stakeholders is underway alongside Maternity users who this will impact upon. Swansea Bay University Health Board and Cardiff and Vale have been asked to support the delivery of maternity care based on demand and demographics of the planned maternity users. Work is currently underway within CMTUHB to gain the appropriate data and demographics of the women currently booked to birth during this period. The Welsh Ambulance Service and the Neonatal network are working with CMTUHB to ensure safe delivery and appropriate preparation of pathways to enable safe transfer and clear guidance for the maternity users and clinical teams. Ongoing weekly project meetings have been put in place, NWJCC have been invited to attend these. Updates from these will be shared within the NWJCC to understand the impact this will have on current commissioned cots. An early warning notification has gone to Welsh Government.

Executive Director Lead: Melanie Wilkey Commissioning Lead: Emma King Commissioning Team: Cardiac		Service in Escalation: Bariatrics		Escalation Trend Level				
Date of Escalation Meetings: Date Last Reviewed by Quality & Patient Safety Committee: 04/08/25 Escalation Trajectory:		Current Level 3 Escalation		Trend	Rationale	Current Trend Level		
				↓	Escalation level lowered	↔ September 2025		
				↔	Escalation remains the same			
				↑	Escalation level escalated			
ESCALATION LEVEL apr-25 mai-25 jun-25 jul-25 aug-25 sep-25				Escalation History:				
				<table><tr><th>Date</th><th>Escalation Level</th></tr><tr><td>April 2025</td><td>3</td></tr></table>	Date	Escalation Level	April 2025	3
Date	Escalation Level							
April 2025	3							
				Rationale for Escalation Status :				
				Update April 2025 – The process for the escalation of the Salford obesity surgery service to Level 3 of the NWJCC Escalation Framework was initiated in December 2024 and endorsed by the NWJCC Senior Leadership Team in January 2025. The service has been subject to formal escalation arrangements due to our long-standing concerns with the obesity surgery waiting list and activity levels.				
Background Information:		Actions:						
The process for the escalation of the Salford obesity surgery service to Level 3 of the NWJCC Escalation Framework was initiated in December 2024 and endorsed by the NWJCC Senior Leadership Team in January 2025. NWJCC assurance and confidence level in developments: Low - A letter was sent to Salford in February informing them of the escalation and process (no response has yet been received). A chasing communication was sent by the Director of Commissioning for Specialised Services in April 2025. An escalation meeting will be arranged with the Salford service as soon as a response has been received from Salford. September 2025 Update – Correspondence was received from Salford on 25th September 2025 to serve notice of 6 months on the contract for bariatric services. Work will progress to look at alternative commissioning options and ensuring patients currently on the waiting list are not adversely affected by this change.		Action		NWJCC Lead	Action Due Date	Completion Date		
		Escalation endorsed by SLT		Director of Commis sioning	Jan 25	Jan 25		
		Escalation letter sent to Salford		Director of Commis sioning	Feb 25	Feb 25		
		Follow up email sent to Salford		Director of Commis sioning	April 25	April 25		
		Head of Commissioning for Cardiac has contacted the Commissioning Lead for Obesity Services (Greater Manchester ICB) in NHSE		Head of Commis sioning	July 25	July 25		
		SBUHB to provide service for 15 patients from this catchment area		Head of Commis sioning	March 26	March 26		
		A follow up letter has been sent to Salford requesting an urgent response to the escalation letter		Director of	September 25	September 25		

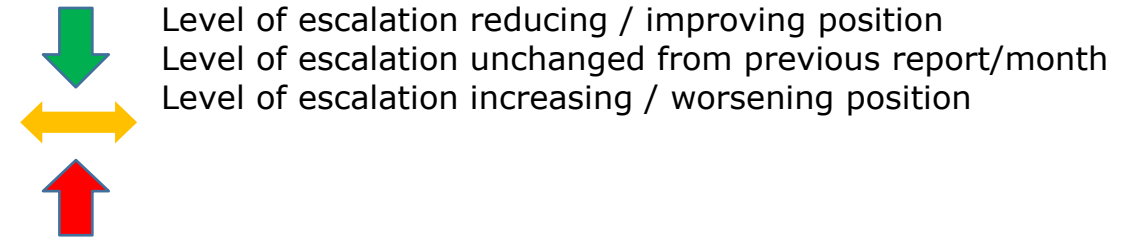
		Commis sioning		
Issues/Risks: September 25 – Notice served by Salford requires alternative provision to be sought before 1 st April 2026.				

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: - No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. - Continued intervention is required at level 1 and a review date agreed. - Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include - Provider performance meetings - Triangulation of data with other quality indicators - Advice from external advisors - Monitoring of any action plans A risk assessment should be undertaken and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the JCC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: - Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. - If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures

Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the JCC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue, but the meetings should ideally comprise of the following personnel as a minimum: • Chair (JCC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • JCC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress, then further escalation will be required to Level 4. On the other hand, if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.
Level 4 DECOMMISSIONING/OUTSOURCING	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the JCC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered, and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified, and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.



SERVICES IN ESCALATION



Joint Commissioning Committee

Highlight Report from the Joint Commissioning Committee

Dyddiad y Cyfarfod / Date of Meeting	25/11/2025
Statws Cyhoeddi / Publication Status	Open/Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Helen Tyler, Head of Governance and Risk, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Huw George, Chief Commissioner, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Huw George, Chief Commissioner, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Health Boards	November 2025	Noted

1. SITUATION/BACKGROUND

This report had been prepared to provide Health Board (HB) Chief Executive Officer Members of the Joint Committee with a summary of the key issues considered by the NHS Wales Joint Commissioning Committee (JC) at its public meeting on 25 November 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the JC is set out in Paragraphs 2.18 and 2.20 of the NWJCC [Standing Orders \(SOs\)](#).

3. HIGHLIGHT REPORT

(Links to reports highlighted [November 2025 - NHS Wales Joint Commissioning Committee](#)).

Status	Update
Alert / Escalate	The financial position remains a key risk. Conversations as to affordability of the current financial position continue. It was noted that the NWJCC had mitigated its financial risk from circa £20m to circa £7.7m, a detailed proposal outlining the approach to additional risk mitigation and savings will be presented at an Extraordinary JC meeting on 16 December 2025.
Advise	Emergency Medical Retrieval and Transfer Services (EMRTS) Update Members received an update regarding the decision to pause work pending the outcome of the Judicial Review. Following conclusion of the legal proceedings, the JC will move forward with implementing Recommendations 1, 2, 3 and 6. Members agreed to revisit Recommendation 4 to ensure alignment with recent operational and financial changes and this work will be incorporated into the Integrated Medium-Term Plan (IMTP) process for 2026-29. A separate update will be presented at a future JC meeting to include a detailed timeline and implementation plan. Ongoing engagement and communication to maintain transparency and public trust was recognised and fully supported. Sexual Assault Referral Centres (SARC) Commissioning Proposals The JC confirmed the transfer of responsibility for commissioning services for survivors of sexual assault from the NHS Performance and Improvement Unit to the JC. Members discussed the partnership approach to commissioning and agreed that further work was required on the financial model due to the complex funding flows that underpin the service. Care Home Framework The JC received an update on proposals for the renewal of the Care Home Framework with four options shared for the future commissioning arrangements. The NWJCC Collaborative Commissioning Leadership Group (CCLG) had previously indicated its support for Option 4 and the JC were asked to support this proposal. The JC were unable to approve this preferred option and requested clarification on previous resources as well as additional detail concerning the

Status	Update
	cost benefit analysis of Option 4. It was agreed that a further detailed update would be considered at the Extraordinary JC meeting on 16 December 2025. • Immunoglobulin Optimisation The JC approved the financial support required to establish the immunoglobulin optimisation team with an expectation that such financial support would result in significant financial savings across all HBs. • Neonatal Services Update Members noted the briefing paper and a summary of the work undertaken to date as part of the Phase 1 rebasing of Neonatal Services. Members approved the undertaking of the Neonatal Commissioning Reset Review for South Wales. The importance of engaging stakeholders and aligning with the upcoming recommendations from the Chief Nursing Officer's review were highlighted. • Corporate Governance Report Minor amendments to the NWJCC Standing Orders relating to the timescales for publication of meeting papers and the All Wales IPFR Policy were approved.
Assure	• Development of NWJCC Integrated Medium Term Plan 2026-29 Members received a presentation on the approach to develop the NWJCC IMTP (2026-29). Members discussed the challenges and the need to focus on efficiency, prioritisation and financial constraints. It was noted that ongoing engagement with HB colleagues would continue in advance of a draft plan being issued in the new year. An IMTP workshop with HB Executive Colleagues is also scheduled in December 2025. • Governance & Risk Management: ○ The Risk Register at 31 October 2025 was received. A discussion was held around the approach to develop and strengthen the commissioner held risks and alignment with provider risks. Work has begun to make actions and controls clearer. Risks will be reviewed by the Sub-Committees before they are brought to the JC for consideration. ○ The Corporate Governance Report including updates on the internal audit programme and forward plan of business were noted.

Status	Update
Inform	- The Chair's Report summarised the JC Strategy Session held on 21 October 2025, which covered topics including the NWJCC Financial Outlook, the NWJCC IMTP, and the Clinical Escalation Process. The update also included changes to the meeting schedule and organisational changes, noting that the recruitment process for a new Chief Commissioner will begin soon and is expected to complete by March 2026. - The Chief Commissioner's Report included an update on: - The progress made in relation to implementing the new organisational structure for the NWJCC (with an improved 15.83% vacancy rate as of October 2025). The Director of Finance and Value was reappointed as the Deputy Chief Commissioner. The position of Director of Corporate Planning and Strategy has been filled on a substantive basis. The second phase of prioritised recruitment has commenced which includes recruitment of a substantive Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups. - Programmes of Work – an update on national programmes (Hospices, SARC, Direct Payments, Positron Emission Tomography and the Voluntary Sector) and the approach to this work was provided. - Reports from each of the Commissioning Directors: Director of Commissioning for Ambulance Services and 111 Members noted: - An update on performance framework updates including the publication of new clinical indicators such as pain score changes. - Updates on Phase 2 of the New Ambulance Response Model in Wales scheduled to launch on 2 December 2025. - The multi-faceted review process underway to ensure a comprehensive evaluation in relation to the Manchester Arena Inquiry. - That a strategic review of the welsh ambulance service's productivity had begun in response to a growing, aging population and rising medical complexity. - Challenges for the Non-Emergency Patient Transport Service including the cancellation of patient journeys. The need to prioritise the use of resources was acknowledged. - An update on collaborative work to improve the response for mental health patients in crisis and recognising the

Status	Update
	needs of those that are detained under the provisions of the Mental Health Act. ○ <u>Director of Commissioning for Specialised Services</u> Members noted: • The NWJCC recently met with clinicians and stakeholders on the development of a service specification for a Functional Neurosurgical Service for Movement Disorders (including Deep Brain Stimulation). The presentation included outcomes from the temporary pathway. The service specification will soon be shared for stakeholder consultation and used to designate providers, with completion expected by March 2026. • That a Joint Accreditation Committee of the European BMT Society (JACIE) accreditation inspection took place on 19 September 2025. The report is awaited. If certification is not maintained, CAR-T services would be suspended due to pharmaceutical supply restrictions, and bone marrow transplant services may require alternative commissioning arrangements. • The Cochlear Implant and Bone Conduction Hearing Implant service at Cardiff and Vale University Health Board (CVUHB) was escalated to Level 3 in October 2025 due to staffing challenges impacting on delivery capacity. • CVUHB's hereditary anaemias service had seen patient numbers double in five years, managed by just one consultant. This poses a risk. The commissioning team will propose increasing capacity in the next IMTP. ○ <u>Director of Commissioning for Mental Health, Learning Disabilities and Vulnerable Groups</u> Members noted: • New admissions to the Caswell Clinic had been suspended. An action plan has been submitted by the provider HB, and weekly meetings are being held to facilitate and monitor the implementation of this plan. Ty Llewellyn in North Wales will be considered initially for any new male medium secure referrals, whilst the independent sector will be used for female referrals. • St Andrew's Hospital remains a service of concern, and all admissions continue to be managed via the Care Quality Commission. • The JC received an update on <u>High-Cost Medicines</u> and it was highlighted that the incremental cost effectiveness ratio (ICER) currently used by the National Institute of Clinical Excellence (NICE) will increase and this will increase the cost

Status	Update
	of any new high-cost drugs for NHS Wales. The risk this poses to the NWJCC is under review. - The JC received the Month 7 Finance Report and the Operational Performance Report. The challenging financial position was noted, and options to further reduce financial risk will be presented and discussed at the Extraordinary JC meeting on 16 December 2025. - The Committee received the following assurance reports: Quality, Safety and Outcomes Sub-Committee Planning, Performance and Finance Sub-Committee Hosted Audit, Risk and Assurance Committee. - The Committee received the following reports for information: Individual Patient Funding Request Panel Report Welsh Kidney Network.
Appendices	None.

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /	Effective
	Efficient; Equitable; Person-centred;

Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Timely; Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / Quality Have you undertaken a Quality Impact Assessment Screening?	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / Equality Have you undertaken an Equality Impact Assessment Screening?	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau (Pobl /Ariannol) / Resource Impact (People / Financial)	Yes (Include further detail below)	
	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

5. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 3 of this report.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	17 February 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Pharmacy and Medicines Management Annual Report 2024-25
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Jonathan Simms, Clinical Director of Pharmacy

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Wales Audit Office (WAO) recommends that health bodies should have an annual agenda item at the Board (or relevant committee) covering pharmacy services, medicines management, primary care prescribing and homecare medicines services.

There is also an expectation from Welsh Government that an annual prescribing report showing progress in priority areas of safe prescribing, antimicrobial stewardship and value is scrutinised by the Board or the Patient Quality, Safety and Outcomes committee.

The annual report, provides an update on these areas together with other key developments which have been mapped to the six domains of quality - safe, timely, effective, efficient, equitable and person centred.

Cefndir / Background

In 2016 the Wales Audit Office (WAO) published a report on 'Managing Medicines in Primary and Secondary Care'¹ following individual health board reviews in acute hospitals and primary care. The report was subsequently considered by the Public Accounts Committee and recommendations published², which have been considered by Welsh Government.

¹ <https://www.audit.wales/news/medicines-management-needs-higher-profile-health-bodies>

² <https://senedd.wales/laid%20documents/cr-ld11478/cr-ld11478-e.pdf>

One of the original recommendations identified in the WAO report was the need for prescribing and medicines management to have a higher profile within health boards and to have an annual agenda item at the Board to discuss an annual report.

Asesiad / Assessment

This annual report recognises the national agenda and the work to deliver the ambitions of 'Pharmacy: Delivering a Healthier Wales to transform pharmacy services in Wales', and the 'All Wales Medicines Strategy for Wales: 2024-2029', which aims to improve patient outcomes, ensure the right medicines are available, minimise medicines related harm and optimise the NHS investment in medicines.

The Committee is asked to specifically note the following areas identified within the report, which highlight and recognise keys pieces of work, challenges, and achievements, and celebrates the successes of the pharmacy and medicines management team during 2024-25.

1. The work of the primary and secondary care pharmacy teams which was recognised at a local and national level.
 - In the ABUHB staff recognition awards, the secondary care staff were highly commended in the categories of Leadership as well as for their Quality, Sustainability and Efficiency work.
 - At the Welsh Pharmacy Awards, two teams were shortlisted for "Pharmacy Team of the year". The Pharmacy team in the Emergency Department (ED) at the Grange University Hospital (GUH) won the award, with the Royal Gwent Hospital (RGH) Pharmacy Technician team commended for their work.
 - The visit by the President of the Royal Pharmaceutical Society to GUH pharmacy department where the team were able to showcase the range of services they provide.
 - The primary care pharmacy Care Home Teams' work, which was accepted onto the Bevan Exemplar Programme.
 - The Value Based Health Care Diabetes Cardio-renal project which was presented at a national level and has secured further funding to expand the team and take it into a third year.
 - The Prison Pharmacy Team work on their novel approach to supporting medication adherence in Usk and Prescoed prison which was presented at the All Wales Therapeutics and Toxicology Centre (AWTTC) Best Practice Day. The team were subsequently visited by the Deputy Chief Pharmaceutical Officer for Wales.
2. The installation of new robotic dispensing system (RDS) in RGH and the dispensary refurbishment. During which, the RGH pharmacy service relocated to an unused ward location within RGH, necessitating the use of manual stock retrieval system. A large proportion of the RGH workload was relocated to GUH and NHH.
3. The pharmacy directorate workforce has evolved in all sectors in line with the Pharmacy Vision and Mission Statement launched in 2024. However, benchmarking data from Health Education and Improvement Wales (HEIW) and NHS Benchmarking continue to demonstrate a lower number of pharmacy staff when compared to other health boards.

4. The Nevill Hall (NHH) Pharmacy licence inspections to review the storage and distribution of stock within the health board and to external organisations.
 - The Home Office Controlled Drug (CD) licence inspection identified a need to review and upgrade CD storage, which has been supported by a successful capital bid.
 - The successful inspection from the Medicines and Healthcare Products Regulatory Agency (MHRA) which confirmed compliance with the Wholesale Distribution Authorisation (WDA) Licence. This has allowed the WDA service to expand to support the Velindre@NHH Satellite Radiotherapy Unit.
5. The launch of the ABUHB inhaler optimisation and decarbonisation app to improve the health of COPD and asthma patients across ABUHB, whilst also supporting the decarbonisation agenda.
6. The work undertaken to improve patient safety and medicines governance through direct patient care and the work of the Medicines and Therapeutics Committee, Medicines Safety Group, and the Controlled Drugs Local Intelligence Network (CDLIN).
7. The significant progress and savings realised against the NHS Value and Sustainability priorities and the ongoing progress in national prescribing indicators, through targeted work and incentives. These are monitored by the Medicines Management Programme Board.

Argymhelliad / Recommendation

The Committee is requested to note the contents of the Pharmacy and Medicines Management Annual Report as assurance that the Health Board is providing a high quality and effective medicines management service.

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



Aneurin Bevan University Health Board

**Pharmacy and Medicines Management
Annual Report 2024-25**

"Our service aims to provide safe, home to home, timely, patient focused care, to empower patients to stay healthy, to improve health, to reduce harm and maximise efficiencies from medicines."

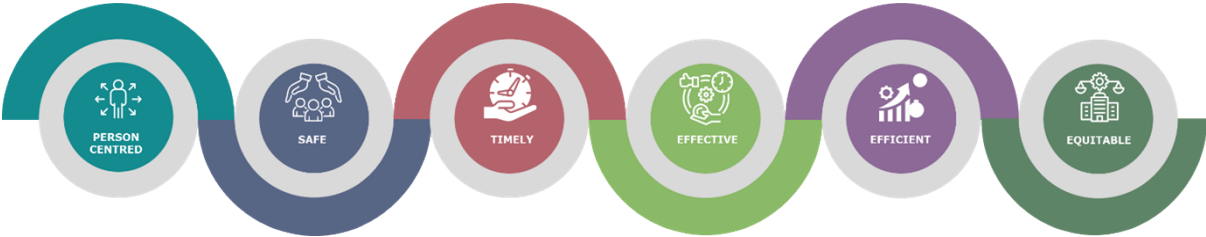


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1. Executive Summary

The Wales Audit Office (WAO) report [Managing medicines in primary and secondary care | Audit Wales](#), recommends prescribing and medicines management maintains a high profile across each health board. This report provides an overview of ABUHB pharmacy services, medicines management (MM), primary care prescribing, homecare medicines services and controlled drugs (CD) management. Additional key developments identified are mapped to the Health and Care Quality Standards 2023 and support the ambitions of 'Pharmacy: Delivering a Healthier Wales to transform pharmacy services in Wales.'

[Next three year plan launched to transform pharmacy in Wales | GOV.WALES](#)

[Pharmacy: Delivering a healthier Wales \(rpharms.com\)](#)

This report highlights and recognises key pieces of work, challenges, and achievements, and celebrates the successes of the pharmacy and MM team during 2024-25.

1.1 Key Drivers/Documents

During 2024-25 the pharmacy agenda continued to deliver its workplan against the [Health and Care Quality Standards - NHS Wales Executive](#) introduced in 2023 with the aim:

- To improve quality of healthcare services
- To improve outcomes for people in Wales

2024-25 saw several key strategic publications, guidance and communications which influence pharmacy services in Wales:

[AWMSG Strategy for Wales: 2024-2029 - All Wales Therapeutics and Toxicology Centre \(nhs.wales\)](#), In April 2024, AWMSG endorsed a new 5-year Medicines strategy improving the health and wellbeing of people in Wales by enabling patients to obtain the best outcomes from their medicines.

The 4 key objectives of the strategy are:

- improving patient outcomes
- ensuring the right medicines are available at the right time
- minimising medicines-related harm and improving safety
- optimising the value the NHS achieves from its investments in medicines

[Medicines shortages | GOV.WALES](#) May 2024

Welsh Government published guidance recognising the ongoing challenges caused by medicines shortages and the resulting impact on services and patient care. This was followed by the Royal Pharmaceutical Society (RPS) document

[Medicines Shortages: Solutions for Empty Shelves](#) November 2024.

Prescribing of branded generics in NHS Wales: Position statement - All Wales Therapeutics and Toxicology Centre October 2024

AWTTC issued a position statement that prescribing of branded generics should not routinely be undertaken in NHS Wales unless there is a specific, clinical reason for doing so.

Prescribing Dilemmas: A Guide for Prescribers updated November 2024

The updated AWTTC document included endorsement of the AWMSG 'All Wales guidance for prescribing intervals' document and a new section on 'Sharing responsibility for prescribing between a private clinician and an NHS prescriber'

The-National-Health-Service-Pharmaceutical-Services-Wales-Amendment-Regulations-2024-Original-Pack-Dispensing.pdf Dec 2024

In January 2025, an amendment to the NHS (Pharmaceutical Services) (Wales) Regulations 2024 came into force, permitting all community pharmacies in Wales to utilise flexibilities which enable original pack dispensing.

1.2 News and Celebrating Success

Staff Recognition Awards (July 2024)

Pharmacy staff were recognised at the 2024 staff recognition awards:

- **Leadership: HIGHLY COMMENDED – Rhys Hamer**, Principal Pharmacist, for exemplary leadership and support during a period of team grief.
- **Quality, Sustainability and Efficiency: HIGHLY COMMENDED - Pharmacy Technician-Led Ward Team** for developing an efficient and sustainable pharmaceutical care model.

Bevan Commission Exemplar (August 2024)

In August 2024 the primary care pharmacy Care Home Team's work was successfully accepted onto the Bevan Exemplar Programme with their project:

Does a Detailed Medication Review from a Clinical Care Home Pharmacist, Improve Patient Outcomes and Reduce Waste in Nursing Homes?



Welsh Pharmacy Awards (September 2024)

The 2024 Welsh Pharmacy Awards recognised outstanding contributions from ABUHB with two teams shortlisted for "Pharmacy Team of the Year". The team from Grange University Hospital (GUH) Emergency Department (ED) Pharmacy Team were crowned winners, while the RGH Pharmacy Technician-led Ward Team were commended for their work.

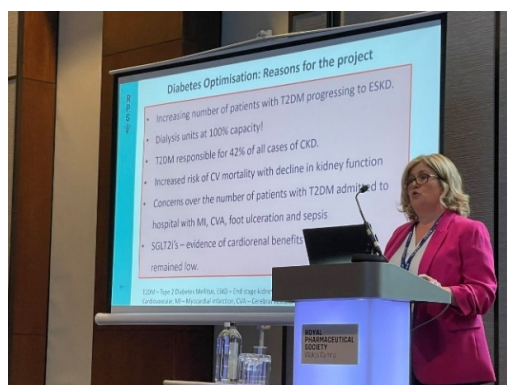


Pharmacy: Delivering a Healthier Wales Conference (PDaHW) (Sept 2024)

At "The Delivering a Healthier Wales" conference, Jonathan Simms, ABUHB Clinical Director of Pharmacy (and Chair of the Welsh Pharmaceutical Committee), together with Elen Jones, Director of RPS Wales, announced the development of the new three-year goals to help pharmacy in Wales advance toward the 2030 vision as outlined in *Pharmacy: Delivering a Healthier Wales* (PDaHW).



At the conference, ABUHB primary care lead diabetes pharmacist presented the invaluable work undertaken by the value-based healthcare diabetes cardio-renal optimisation project.



The ABUHB pharmacy team has PDaHW champions that continue to support and contribute to the delivery to the 2030 Vision for Pharmacy in Wales.



Royal Pharmaceutical Society (RPS) visit to Wales

October 2024 saw GUH visited by the President of RPS, Professor Claire Anderson, which gave ABUHB the fantastic opportunity to showcase the range of teamwork across the acute sites. Claire toured the GUH pharmacy department and met with pharmacy teams delivering patient care in several specialities, including A&E, Gastroenterology and ITU. She spoke to clinical leads from other professions who praised the work of the pharmacy staff and highlighted their essential role within specialist multi-disciplinary teams.



2. Introduction

2.1 Pharmacy and Medicines Management (MM)

2.1.1 Pharmacy Services

The Pharmacy Directorate has responsibility for services across the whole care pathway, with pharmacy professionals working in the managed sector, as well as primary and secondary care. Responsibility for the pharmacy contract and development of services across 125 community pharmacies was transferred to primary care in January 2025.

ABUHB has 286 pharmacy staff, comprising of pharmacists, pharmacy technicians, pharmacy assistants and clerical staff working across primary care, four acute hospital sites, community hospitals, intermediate care and GP managed practices to support safe and cost-effective prescribing, dispensing and administration of medicines. Eight-five per cent of staff work in the secondary care setting.

Pharmacy Staffing	WTE	Headcount
Primary care	23.67	30
Secondary care	220.65	243
CRT	12.8	13
Total	257.12	286

Acute pharmacy services saw significant disruption across all hospital sites between July 2024 and April 2025 with the refurbishment and installation of a new pharmacy robot at RGH. The project meant that the RGH pharmacy and supporting services were closed and removed from the original department, whilst building work saw installation of a brand-new robot and dispensary. During this time, the dispensary and all medicine stock moved to the other end of the RGH site, removing all automation and having to return to laborious and time-consuming manual medication supply processes as a result. Work was also moved to other acute pharmacy dispensaries across ABUHB as a support.

In February and March 2025, ABUHB saw the return of 5 managed practices, 3 of which have directly employed pharmacists. The primary care MM team was asked to put their work plan on hold and support Brynmawr, Aberbeeg and Bryntirion practices who were experiencing difficulties with repeat prescribing systems and prescription backlog which was resolved.

2.1.2 Medicines Management

'Medicines management' covers all processes and behaviours that influence clinical and cost-effective medicine use, as well as positive health outcomes for patients.

Welsh Government wrote to health boards in March and October 2024: **NHS Value and Sustainability – Priorities for reducing medicines expenditure March/October 2024**: This set national priorities for reducing medicines

expenditure and supporting improvements in value and sustainability in 2024/25. These priorities were key to pharmacy and MM work plans.

The analytical sub-group of the Medicines Value and Sustainability Programme requested an investigation into the forecasting of secondary care medicines spend in Wales. In August 2024, this resulted in *A report by the Task and Finish group on the forecasting of medicines spend in secondary care*.

The financial pressure on prescribing continues to grow across all sectors due to an ageing population and introduction of new and innovative medicines. It is therefore imperative that the focus continues to ensure a prudent approach to effective MM, through delivery of cost-savings opportunities and value-based initiatives across all Divisions, supported by pharmacy.

3. Safe

Our healthcare system is a high quality, highly reliable and safe system that avoids preventable harm, maximising incidents that go right and learning when things go wrong to prevent re-occurrence. People's health, safety and welfare are actively promoted and protected; risks identified and monitored, and where possible, risks to safety are reduced or prevented.

3.1 Medicines safety

3.1.1 Medication Safety group (MSG)

MSG met quarterly during 2024-25, chaired by the Clinical Director of Pharmacy, with representation from across secondary care divisions. Divisional QPS Leads attend and submit exemption reports to provide assurance that medication safety incidents have been reviewed and actioned appropriately, including analysing actions taken, identifying trends and themes, and sharing lessons learnt.

The reports and discussions allow MSG to determine if action is required to assure organisational learning e.g., policy changes, ERASE posters or issuing further communication or education. This approach has fostered a culture of collaboration and celebration of work done well. This year's focus has been anticoagulant incidents.

In November 2024, the ABUHB Medicines Safety Officer (MSO) left her post. A new MSO was appointed in March 2025 and the new post holder will start in August 2025.

Keys pieces of MSG work for 2024-25

Item	Action	Learning and Improvement Progress
Meet HEIW Standards for Quality Assurance for all NMP and Supplementary Prescribers (SP)	- Action plan for nursing complete. - MDT group representing IPs and SPs have met; action plan for all disciplines will be managed. - Declaration of Scope of Practice – well embedded. - RPS competencies converted to a self-assessment document. - Demonstrating competence – Portfolio document developed.	Standardisation process embedded by Nurse/Midwifery leads. MDT leads engaged and aligning within individual regulatory bodies and HEIW requirements.
High Risk Medication - Categorise and report incidents related to high-risk medicines at MSG	Priority 1 – Anticoagulants - Task and finish group formed. - Review processes in place for prescribing and administering anticoagulation. - Identify risks and barriers to target change. Priority 2 – Time critical medicines (Desmopressin/Parkinsons)	ERASE poster and staff bulletin produced for sharing information. MDT and organisational approach required to manage incidents. Review of incidents and internal alerts produced.

Medicines Governance Audits	Develop a comprehensive medicines audit governance tool.	Review of DECI with some of the medicines audit requirements. A separate tool from AMaT in development.
BESS (Bennion Error scoring system) policy	Review document. Meeting to be held with leads stakeholders	Review in progress. Education and Revalidation review for N&M. Meeting with Divisional N&M Practice educators held March 2025.

3.1.2 Medication Safety Strategy update

Good progress has been made against the Medicines strategy goals:

- **Goal 1: Improve reporting and learning from medication incidents and good practice.**

Progress on all five actions to achieve goal. All Divisional QPS Leads regularly attend and report back at the quarterly MSG.

- **Goal 2: Support safe and secure storage of medicines.**

Good progress on all four actions to achieve goal, including promotion of the MM e-learning, and safe medicines administration training and roll out of Medicines Administration, Recording Review, Storage and Disposal (MARRS) policy signed off by AWTTC (April 2024).

- **Goal 3: Reduce harm from high-risk medication and transition of care.**

- Anticoagulants: Formation of Anticoagulant Task and Finish group with initial focus on transfer of care and patient journey, with focus on communication and discharge information to GP Practices, including review of existing processes and procedures.
- Time critical medicines: Review of desmopressin incidents and internal alert.
- Development of dashboard to capture incidence of high-risk medicine groups.

- **Goal 4: Learn from, and contribute to, national safety agenda.**

New work includes:

- Use of the ABUHB Learning Repository to share ERASE poster, bulletins and newsletters.
- Closer links with practice educators.
- Medicines Safety SharePoint page to promote Medicines Safety Week.

- **Goal 5: Develop and implement strategies to improve medication safety culture across ABUHB.**

2024-25 has seen continued engagement with Divisions, QPS Leads, with funding secured for Senior Nurse for Professional Practice post to support ABUHB medicines safety agenda. This demonstrates ABUHB commitment to supporting global/national medication safety campaigns and actively encourages staff to be involved in safety work.

3.1.3 High Risk Medicines

3.1.3.1 Anticoagulants

Following a thematic review by the MSO in 2024, a T&F Group was set up including the anticoagulant team, primary care and secondary care nurses, pharmacists, and QPS representatives. The group has focused on learning from a review of DATIX, serious incidents, and pharmacist interventions. The work has focused on:

- Updating “Initiation and Discharge of Patient on Anticoagulation from Hospital” policy.
- Review of current ward processes and procedures.
- Training sessions in areas of high impact (e.g., MAU and ED) to junior doctors, nurses, and physician’s associates to increase understanding of the process.
-

3.1.4 Internal Safety Alerts and Communication

Several internal alerts, memos and communication posters were cascaded in with MSG sign-off to ensure safe use and storage of medication. These include:

Date	Internal Alert/ Safety Memo/ ERASE Poster
April 2024	Omitted Medicines
April 2024	VTE assessment
May 2024	Adrenaline and Calcium Chloride (Aurum) Pre-Filled Syringe Incompatibility and Failure
June 2024	Time critical medicines - Desmopressin
September 2024	Safe use of Oxygen Cylinders
September 2024	Misuse of venous access device alert
October 2024	Bung Coring - Change of Practice to avoid introducing debris into intravenous infusions for injections
March 2025	ERASE POSTER – management of CDs

3.1.5 Medication Safety Campaigns

The tenth annual **#MedSafetyWeek** took place from 3 to 9 November 2024, with a theme ‘**we can all help make medicines safer**’. Great engagement was seen across all sectors with key safety messages being shared and new Medication Safety Boards appearing across wards and clinical areas to highlight best practice.

The week focussed on the importance of reporting suspected adverse reactions to medicines and vaccines, encouraging reporting of suspected problems with medical devices or other healthcare products to the **Yellow Card scheme**. Healthcare professionals were asked to support the campaign and talk to patients and colleagues about side effects and how they can report suspected problems to the MHRA Yellow Card scheme. Messages and materials were shared from **#Medsafetyweek**, **#MHRAYellowCard** and MHRA [MedSafetyWeek | Making medicines and medical devices safer](#).

3.1.6 Yellow Cards

ABUHB has a cross-sector Yellow Card (YC) Champions Group to promote yellow card reporting. Yellow card reporting was included in the 2024-25 GP Incentive scheme (CEPP).

Recent work includes a YC article in the primary care newsletter for community pharmacists and GP practices, and training physician associates in how to report a YC. In addition, the YC Champions engaged with the wider group of healthcare professionals including hospital-based nurses, anaesthetists, surgeons, theatre managers, district nurses, CRT team, care home teams and nurse practitioners.

ABUHB YC data for 2024-25 shows an overall increase of 47% compared to the previous year, with significant increases in primary care as a result of the promotion of the yellow card scheme to contractors.

Sector	2023-2024	2024-2025	% change
GP	41	281	585%
Public	231	173	-25%
Secondary Care	104	90	-13.5%
Community Pharmacy & Others	31	55	+77%
Total ABUHB	407	599	+47%

3.2 National Safety Alerts

3.2.1 PSN055 Safe Storage of Medicines: Cupboards (October 2020)

PSN055 recommended organisations must ensure safe and secure storage of medicines with robust governance arrangements. ABUHB Nurses Safe Storage of Medicines Audit is undertaken annually and forms part of the local audit plan for Medicines Safety.

The third annual "Safe storage of Medicines audit of medication storage in cupboards" was undertaken in Q3 2024, using AMaT by nurses working in clinical areas, as designated by the ward manager. The results from the audit were shared at MSG.

The audit findings identified several actions to improve medicines storage and management across clinical areas:

- Phase out keypad-only access
- Reinforce locking protocols
- Omnicell override key training
- Standardise separation by route of administration
- Ensure original packaging is maintained
- Evaluate storage space concerns including expanding fridge capacity
- Continue temperature monitoring assurance
- Address movable POD lockers
- CD cupboard labelling
- Monitor and maintain fixed cupboards compliance
- Availability of enteral syringes

3.2.2 Valproate

(NatPSA/2023/013/MHRA) Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients

A National Patient Safety Alert (NPSA) was issued in November 2023 requesting organisations to implement new regulatory measures by January 2024. In September 2024, an update was issued alerting that: “a retrospective observational study has indicated a possible association between valproate use by men around time of conception and an increased risk of neurodevelopmental disorders in their children.”

In response, Mental Health and Neurology produced a business case and updated action plans and policies to ensure compliance with the new recommendations for male patients. These were shared with MSG.

3.2.3 Oxytocin

PSA018 Risk of Oxytocin overdose during labour and childbirth (Sept 2024)

The PSA highlighted incidents involving use of oxytocin in labour where woman received the wrong dose. This included a pre-prepared postpartum oxytocin infusion given in place of IV fluids while in labour.

Actions: ABUHB to review and update local clinical procedures, including oxytocin infusion not preprepared in delivery suites and theatres.

ABUHB has confirmed compliance with this safety alert.

3.3 Quality

3.3.1 Research & Development (R&D)

An ABUHB pharmacy R&D strategy has been agreed, which will be rolled out into 2025-26. The monthly R&D peer support group has continued to grow and support individuals to develop and write up research activity, with some staff completing quality improvement training to support projects.

Two staff have completed MScs in specialist areas, and will disseminate dissertation findings of the following:

- The development of criteria and subsequent evaluation of available digital solutions for pharmaceutical care planning across ABUHB, including a baseline assessment of pharmacy staff digital literacy (Victoria Richards-Green)
- Using enzyme indicators and biological indicators in the evaluation of ionised hydrogen peroxide decontamination of pharmacy aseptic units (Sarah Crawford)

There continue to be two pharmacist principal investigators for research studies, one in critical care and one in antimicrobial stewardship.

3.3.2 Quality Improvement projects

The following Quality Improvement projects were undertaken by the pharmacy team during 2024-25:

Pre-reg Pharmacy Technician (PRPT) Audits

- Are we meeting the standard that 80% of discharge prescriptions are being transcribed by Pharmacy Technicians?
- Efficiency of the patient owing's service in RGH pharmacy.

Post registration Foundation Pharmacist QI projects

- Reviewing inconsistent documentation of patient weights at ABUHB haematology wards.
- Optimising MM: Reducing Duplication of Non-Stock Orders Generated by, or on Transfer from the RGH Medical Assessment Unit.
- Increasing number of Good Catch forms completed in NHH.
- Improve prescribing of Venous thromboembolism (VTE) prophylaxis medications for elective orthopaedic surgical patients

3.4 Governance

3.4.1 Controlled Drugs (CDs)

3.4.1.1 CD Local Intelligence Network (CDLIN)

The CDLIN met quarterly during 2024-25. The meetings were held via MS Teams and chaired by ABUHB CD Accountable Officer (CDAO) Jonathan Simms.

A key piece of work was the development of a CD action plan to ensure ABUHB and CDAO meet their obligations and ensure safe use of CDs across ABUHB. The first action was the launch of the ABUHB CD Pulse intranet page [Controlled Drugs](#) which highlights the role and responsibilities of the CDAO and CDLIN, the importance of raising concerns relating to CDs, and reporting incidents via DATIX.

In December 2024, the CDAO met with Divisional nurses to provide a role update and requested Divisional nurses take on responsibility for review and reporting CD

incidents within the Division, including submitting a quarterly report at each CDLIN in line with the CD policy.

CD incidents of concern and themes are discussed at the CDLIN with opportunities for shared learning. Community pharmacy continues to report the largest number of DATIX incidents, with medication supply errors accounting for these. The Medicine Division reports the second highest, with administration, supply and documentation issues being the most reported incidents. Missing CDs and stock control continue to be monitored.

The CDAO meets with the Medicines Governance pharmacist on a fortnightly basis to review all CD DATIX incidents and CD concerns submitted to the CDAO email address. This ensures any issues are raised and escalated in a timely manner to Counter Fraud, Police, Divisional nurses or Medical Director as needed.

3.4.1.2 Police CD Liaison Officer (CDLO)

In 2024, Gwent Police appointed a new CD Liaison Officer (CDLO) and reviewed the role and support provided to ABUHB and CDLIN. The CDLO is a member of the local drug related death group, attends the quarterly CDLIN and meets monthly with the CDAO to provide advice on CD concerns, storage, and intelligence on drugs in the community. During 2024/25, the CDLO accompanied the ABUHB Care Home pharmacist to a care home provider when storage and security concerns were raised.

3.4.1.3 CD Destruction

The CDAO has authority to approve Authorised Witnesses (AWs) to witness CD destruction. ABUHB has pharmacy technicians in secondary care to witness destruction across the acute sites. In primary care, pharmacy technicians are approved and attend independent community pharmacies and GP practices.

Multiple community pharmacies have their own authorised witnesses trained and accredited to witness and submit reports of CD destruction. These are signed off by the CDAO to allow CD destruction within their pharmacies across ABUHB.

3.5 Inspections

3.5.1 Home Office CD licences

In March 2025, Nevill Hall Hospital (NHH) pharmacy department underwent a scheduled renewal inspection by the Home Office. The inspection identified deficiencies in the existing facilities for CD storage, prompting an urgent review of the current infrastructure.

To address these findings and ensure continued compliance with regulatory standards, a capital bid was approved to support the necessary minor works and installation of compliant CD storage cabinets.

These improvements are critical not only for maintaining the NHH Home Office licence to support wards/departments within ABUHB, but also for sustaining the ability for ABUHB pharmacy to support Wholesale distribution (WDA) customers, including St. David's Hospice and Powys Teaching Health Board.

This proactive response underscores our commitment to regulatory excellence and the safe, effective delivery of pharmaceutical services across ABUHB and wider network.

3.5.2 WDA MHRA Licence

NHH pharmacy has held a WDA licence since 2018. This MHRA licence permits the legal distribution and supply of medicines to other licensed entities. Current WDA customers include the Welsh Ambulance Services NHS Trust, Powys Teaching Health Board, and St David's Hospice.

In May 2024, the department underwent a routine MHRA inspection to assess compliance with Good Distribution Practice. Thanks to the dedication and diligence of the pharmacy team overseeing the WDA, the inspection was highly successful, with no critical or major deficiencies identified. Two minor 'other' deficiencies were noted and promptly addressed within the required 28-day response period. As a result, the department was classified as low risk, with the next inspection scheduled in five years.

Over the past financial year, the department has worked to expand its WDA service by supporting the planned opening of the Velindre@NHH Satellite Radiotherapy Unit. This has involved developing a detailed service specification and contributing to the overarching Service Level Agreement (SLA), including identifying the necessary pharmacy resource to support the new service.

Following the MHRA inspection, the department has focused on strengthening its Quality Management System (QMS) by implementing Key Performance Indicators (KPIs) to maintain high standards of service delivery. The principles of GDP and QMS are consistently applied, not only to external WDA customers, but also across ABUHB, ensuring the same level of quality and safety for our patients, wards, and clinical services.

3.6 Electronic Prescribing and Medicines Administration (ePMA)

The secondary care ePMA programme aims to digitalise the process for prescribing, processing, and recording administration of medicines. This will replace the existing paper-based system, including prescription and administration record charts, as well as discharge and outpatient prescription forms, and will connect with existing NHS Wales systems and the new National Medicines Repository.

The project received funding from Welsh Government, and ABUHB implementation has begun. Pharmacy recruited a Lead ePMA pharmacist who is working alongside the ABUHB Digital and Clinical ePMA Team to deliver the project within the programme timelines. Additional posts will be recruited as the project progresses, to undertake key tasks such as the core medicines database and ePMA system

configuration work prior to implementation. The pharmacy ePMA team work is a core component of the project team to provide specialist pharmaceutical advice and knowledge to ensure benefits are realised to improve medication safety and pharmaceutical care for patients, alongside seamless information sharing between care settings. The pharmacy team is scoping potential for additional functionality relating to the ability of the ePMA system, to provide digital medication supply requests, reducing reliance on paper-based systems and enhancing auditability of medication supply.

3.7 Risks & Concerns

3.7.1 Divisional/Directorate Risk

Exception Report for Divisional QPS Meeting

Borough/ directorate		Pharmacy			
Completed by:		Reporting period:	April 2025	To:	March 2025
Date Completed:	March 2025		Date of directorate QPS Meeting:		March 2025
Highlights					
- ROBOT update: On corporate risk register. Continued significant delays to robot project timelines due to ongoing structural and ICT issues. Revised completion date of April 2025. Risk remains re: loss of automation, ongoing manual medication selection; staff morale, impact on other sites pick up work. - MSO left post in November 2024. Delay in recruitment. New MSO starts August 2025. - Pharmacy contract team has moved from pharmacy team to primary care contracting team. - Pharmacy workforce pressures: All-Wales Benchmarking 2023/24 highlighted ABUHB as facing significant workforce challenges. Baseline per 100 beds is low compared to the rest of Wales. Combined with a high vacancy rate of 11%, a 10.4% staff turnover rate, and a high sickness/absence rate of 7%, particularly for pharmacists — results in an increasingly stretched workforce.					
Pillars of HB Quality Strategy					
1. Patient and staff experience and stories					
Highlight areas of good practice / improvement / deterioration / concern					
<u>Decarbonisation and Optimisation Inhaler App</u> developed by Victoria Richards-Green, Respiratory Pharmacist . The app integrates All-Wales Asthma and COPD Guidelines with the Decarbonisation Strategy to create an efficient, patient-centred approach to inhaler use.					
New Recruitments in primary care					
- Expanded pharmacy care home team with recruitment of additional pharmacy technician. - New Medicines Governance Pharmacist post in primary care. - Recruitment of new post: pharmacy support officer to support team.					
2. Incident reporting – falls, pressure ulcers, medicines management, mortality					
Thematic review of data identifying trends & themes – triangulate incidents / concerns / risks. Community pharmacy DATIX reports account for majority of number. Processes in place to manage and close in a timely manner.					
3. Complaints, concerns and compliments					
PTR Compliance (run chart and trajectories (incidents/concerns/risks/PSOW referrals/LFERs redress).					
MSO left post November 2024. Delays in recruitment. New MSO starts August 2025					
4. Health, safety and security					
Mandatory statutory training compliance, environmental risks, Incidents related to Adverse Staffing Levels					
- Mandatory training compliance for pharmacy team is high across all sectors. - Concern over relocation of RGH pharmacy service during robot installation. - Scaffolding in NHH pharmacy due to RAAC concrete.					
5. Infection control and prevention					
ABUHB antimicrobial guidelines moved from Microguide to EOLAS app					
6. Safeguarding					
No Concerns					

Top 3 Risks identified on borough/directorate risk register

Report to be included which presents all risks >12 RAG rated

Description of Risk	Date identified	Action being taken or planned to mitigate	Handler	Review date	Support required from QPS	RAG
Staffing: 29WTE vacancies across acute sites.	2019	Non-patient facing and non-essential services reduced or removed.	Lisa Forey	March 2025	Support recruitment	20-RED
YYF fridge failures: YYF pharmacy department currently has 13 large fridges used to store medicines and vaccines. The majority are over ten years old. There have been several fridge failures over the past 2 years, resulting in loss of large quantities of expensive stock and associated financial cost.	2024	Faults are becoming increasingly difficult to rectify, parts difficult to acquire as discontinued. Significant pressure on department to find appropriate storage for refrigerated medicines. Replacement is necessary to avoid disruption of services e.g. school immunisation programmes, ABUHB influenza programme. PPD submitted to Division to install a walk-in fridge in YYF pharmacy. Update Jan 2025: Capital funding received, POs raised and currently waiting to go-live.	Lisa Forey	March 2025	For info	16

Top 3 Borough/ Directorate Concerns being managed within the borough/directorate (may include clusters/amber incidents/complaints/key safety concerns)

Issue	Action being taken or planned to mitigate	QPS Support	RAG Rating
Robot installation: Substantially higher risk of picking error with manual medication selection on a large-scale basis, lack of automation Delay in installation (Corporate risk register)	Training, SOPs and checking processes in place for pharmacy staff. Update on installation: On Corporate risk register. Significant delays to robot project timelines due to ongoing structural and ICT issues. Revised completion date of March/April 2025. Risk remains re: loss of automation and ongoing manual medication selection; staff morale, impact on other sites as pick up work.	For information	6 20
RAAC in NHH: NHH site contains RAAC	Ongoing structural monitoring to assess site integrity. Installation of temporary structural props within pharmacy department to support skylights located in the flat roof area.	For information	12

4. Timely

Our healthcare system ensures people have access to high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, treat people based on identified and agreed clinical priority.

4.1 Pharmacy Emergency Department (ED) Service

GUH ED pharmacy team was awarded the "Hospital Pharmacy Team of the Year 2024" at the National Pharmacy Awards.

The dedicated pharmacy service to ED has been operational for almost two years. Its work has included:

- Clinical review of patients (increased patient safety and experience).
- Pharmacists with NMP qualification prescribing regular medicines at the beginning of the patient hospital journey including time critical medicines.
- Improvement of ED patient flow by expediting discharges and transfers.
- Providing specialist advice to healthcare professionals including administration, supply and choice of medicine.
- Patient counselling and advice, reducing medicine related re-admissions.
- Addressing governance related issues through closer liaison with ED team, including PGDs, local and national policies and guidelines.
- Highlighting and addressing medicine shortages.
- Encouraging patients to utilise own medicines for use whilst an inpatient, contributing to medicine savings.

On average, 770 patients were seen by the team each month, with approximately 1,600 medicine interventions initiated/alterd.

Interventions ranged from medicines reconciliation within 24 hours (WG, NICE, RCEM recommendations), allergy status updated, regular medicines including critical-time medicines prescribed, recommendation to withhold medicines or initiate new medicines, correction of medicine names, doses and strengths.

Further work:

The ED team has been given access to the financial toolkit, QlikSense, allowing analysis of medicine spend, usage trends and prescribing habits. The Divisional Pharmacist for Urgent Care attends several local and national groups:

- Pharmacy representative at the NHSWE Critical Care, Trauma & Emergency Medicine Strategic Clinical Network.
- Attends ABUHB Major Trauma MM Meetings, sharing any medicines related learning.
- Attends weekly Urgent Care Divisional MM meetings providing feedback on medicine related issues for quality and patient safety.

4.2 Emergency Duty Commitment (EDC) Pharmacist service

The EDC pharmacy service provides out-of-hours pharmacist support to ABUHB, Powys Teaching Health Board and St David's Hospice Care, providing timely support and access to medicines, and enhancing patient care during this period.

The service operates via a dedicated rota comprising of 18 pharmacists, working in pairs, from 5.30pm to 8.30am, Monday to Friday, and 12.30pm to 9.30am on weekends and Bank Holidays.

The EDC pharmacists deliver a range of essential services including:

- Providing medicines advice to healthcare professionals.
- Ensuring emergency access to medicines, including CDs and time-critical medicines.
- Offering a backup service of palliative care medicines in the community.
- Supporting medicine supply during major incidents and site escalation.

During 2024-25, calls to the EDC service originated from the following sites:

- GUH 46%, RGH 17%, NHH 11%, Community Hospitals 10%, YYF 9%, GPOOH/111 6% and other UHBs 1%

The majority (55%) of calls were for medication supply, with medicines advice making up a further 25%. EDC pharmacists have access to remote dispensing, Omnicell Explorer (to view stock across sites) and an automated temperature monitoring system, which allows for most calls to be managed remotely. Only 7% of calls required attendance to one of the four acute hospital sites within ABUHB.

4.3 Critical care

During 2024-25, the ABUHB critical care pharmacy team focused on re-establishing its role beyond clinical ward cover, focusing on robust expenditure reporting, directorate meeting attendance and production of clinical guidelines. Further work included preparing for ePMA implementation to realise the benefits of electronic prescribing to improve patient safety.

The team took part in a peer review of critical care rehabilitation services on behalf of the National Strategic Clinical Network for Critical Care, Emergency Medicine and Trauma. This enabled a deeper understanding of the patient journey post-ICU, and an opportunity to highlight the importance of comprehensive medication reviews.

In April 2024, HEIW commissioned foundation critical care training for pharmacists and pharmacy technicians across Wales. Three cohorts of pharmacists and pharmacy technicians have successfully completed the training. The team has been working with HEIW's secondary care Lead for Education Resource Development to explore critical care advanced practice training funding, and consultant critical care pharmacist roles.

4.4 Transfer Lounge GUH

There has been significant investment in the development of a new transfer lounge at GUH which included the funding of a new pharmacy technician role. The pharmacy technician role has enhanced patient safety, and supports patient flow through the hospital by undertaking the following activities:

- Ensuring patient discharge medication is ready at ward level to prevent delays.
- Undertaking transcription of medications ready for discharge, working with the ward-based staff to facilitate timely discharge.
- Ensuring step-down patients have their medication transferred with them to eLGH/Community Hospitals, avoiding duplication of supply of prescribed medication, allowing for cost savings and reduced waste.
- Supporting MM governance at the Transfer Lounge, to ensure safe and appropriate medicine storage within the clinical area.
- Counselling patients on medications, reducing incidence of re-admission.

A greater number of patients have been counselled on how to take and access their medications as prescribed via WP10HP. Data collected demonstrates an improvement in the movement of medicines across hospital sites.

4.5 Pharmacy systems

4.5.1 RGH Robot

2024-25 saw the installation of the new robotic dispensing system (RDS) in the RGH pharmacy department. This project to upgrade the old RDS has taken several years to implement, whilst the previous robot was used significantly past its useable lifespan. Whilst the new RDS was installed, the RGH pharmacy service relocated to an unused ward location within RGH, necessitating the use of manual stock retrieval mechanisms to facilitate dispensing and distribution activities. A large proportion of the RGH workload was relocated to GUH and NHH to utilise spare capacity within automated dispensing to facilitate the project. In addition to the RDS replacement, the RGH pharmacy dispensary underwent refurbishment, alongside other departmental areas.

As the ABUHB pharmacy distribution hub, the new RDS will provide significant improvement to pharmacy distribution services across the health board, as well as dispensing at RGH. This will release a number of efficiencies, allowing pharmacy staff to spend more time in clinical areas, completing roles that provide direct pharmaceutical care to patients.

4.5.2 Omnicell

Over the past year, the pharmacy systems team have supervised installation of a new robot operating system at GUH, replacing the old ARIM program with the new Pyxis Inventory Connect (PIC), and are in the process of finalising dates to complete the same replacement for the existing machines at NHH and YYF.

A new system was developed using the Prescription Tracking System (PTS) to allow orders to be sent remotely from wards, direct to the dispensary for

processing. This reduced the need for staff to walk back and forth between the decant location and individual wards, reducing unnecessary travelling time and increasing the clinical time pharmacy staff could spend with patients.

At the request of MAU in YYF, the existing Omnicell was moved to a newly refurbished room. A new auxiliary cabinet was installed, increasing cabinet capacity by around 30%. This has reduced the need for the ward to contact pharmacy as often to deal with stock outages and reduced wasted nursing time.

4.5.3 Procurement

The RGH procurement team reviewed the delivery of pharmacy procurement services across ABUHB. In 2024, the YYF pharmacy procurement service was centralised to RGH for the period of the RGH pharmacy RDS replacement scheme as a pilot to the long-term centralisation aim. The pilot was successfully implemented, and subsequently the YYF pharmacy procurement service has been transferred to RGH permanently. This aligned with the national vision for pharmacy procurement and logistics.

Over the past 2 years there have been ongoing challenges filling vacancies of pharmacy technicians within procurement services. As a result, the RGH procurement team recruited 2WTE level 3 pre-registration pharmacy technicians utilising departmental vacancy money, to facilitate upskilling of the future workforce and to meet the needs of the pharmacy procurement service.

4.6 Patient Group Directions (PGDs)/Homely Remedies

ABUHB has 163 PGDs in use in primary and secondary care.

The PGD approval group met 10 times during 2024-25 and reviewed 48 PGDs. The multidisciplinary group meet to review existing PGDs and audit the use of existing PGDs. Two new PGD requests were received to support services in obstetrics and radiology; with updated PGDs presented by sexual health, dental, endoscopy, radiology, physiotherapy, ophthalmology, occupational health and the emergency department.

UKHSA and All-Wales PGD templates were used for all ABUHB immunisation PGDs as determined by national guidance and immunisation programmes. This has also included PGDs for childhood immunisations, influenza and COVID vaccination programmes and for use in community pharmacy. The scope of the ABUHB vaccination service has been extended to allow wider delivery of the immunisation programme for children.

ABUHB Senior Primary Care Pharmacist chairs the All-Wales PGD Advisory Board. The board reviews All-Wales national templates produced by the Welsh Medicines Advice Service. In 2024-25 these included updated versions of counter measure PGDs.

5. Effective

Our healthcare system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure people receive the right care to achieve optimal and possible outcomes that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.

5.1 Medicines and Therapeutics Committee (MTC)

In 2024-2025, MTC met six times, with meetings taking place in May, July, September, November, January, and March. The table below summarises items considered by MTC.

Item	Outcome	Examples
New medicine/formulary application	8/9 approved Nil rejected 1/9 deferred	Uromune Sublingual Vaccine for prophylaxis of recurrent UTIs – Approved as TLS Red Etonogestrel 0.120mg/ ethinylestradiol 0.015mg per 24 hours, contraceptive vaginal ring (CVR) – Approved as TLS Green Pyridostigmine for treatment of orthostatic hypotension with supine hypertension – not approved as clinician failed to attend to present
License extensions for existing formulary medicines	6/6 approved	Abilify Maintena 960mg and 720mg – 2 monthly aripiprazole depot injections – TLS Red
New or revised Shared Care Protocols (SCPs)	4/7 approved 3/7 deferred	Mycophenolate mofetil (MMF) for adult services (non-transplant indications) <i>This was first local adoption of a national standardised SCP, a strategic direction previously approved by MTC.</i> SCPs for 3 x ADHD medications for adults (local adoption of national, standardised SCPs) deferred pending enhance service negotiation with Local Medical Committee (LMC)
Traffic Light Status (TLS) Change	18/18	TLS change for empagliflozin for CKD from TLS Amber to Green TLS change for Cytisinicline (cytisine) for smoking cessation from TLS Red to Green TLS change for alimemazine from TLS Green to Red

		TLS change for topiramate for migraine prophylaxis and epilepsy treatment in women from TLS Green to Amber
ABUHB Prescribing guidelines (new or revisions)	4/5 approved 1/5 deferred	Prescribing Guideline - Primary Care Pathway for Management of Chronic Insomnia Nutritional Monitoring and Medication Post Bariatric Surgery – deferred pending full LMC consultation
Subgroup formularies		Wound Management Group (WMG) resurrected, and membership recruitment completed. Terms of Reference updated, and meeting scheduled to review Wound Management Formulary
Policies	Nil	
Unlicensed Medicines Request for Clinical Area	5/5 approved	Neomycin 500mg tablets, an oral antibiotic prophylaxis in combination with mechanical bowel preparation for those undergoing elective colorectal surgery
SBARs	3 discussed and recommendation given	MTC position on the use of Rocket IPC Products in ABUHB Primary Care Preparation of Elastomeric Pumps to Deliver IV Antibiotics in the Community
Position Statement	Approved pending rewording	ABUHB MTC Position Statement on Prescribing Recommendations from Secondary to Primary Care

A MTC Newsletter is circulated after each MTC meeting to ABUHB prescribers, containing headlines and useful information regarding formulary decisions and prescriber issues.

The MTC Chair and Secretariat review all non-formulary (NF) requests and report to the committee.

- 33 NF requests were received.
- 32 of 33 were approved and 1 was rejected.
- NF requests for lidocaine plasters made up 33% of requests, which is an item of low priority for funding/low value. Reducing lidocaine plasters prescribing continues to remain in the MTC work program with frequent reviews and interventions to reduce prescribing.
- Repeated NF requests for Uromune Sublingual Vaccine for prophylaxis of recurrent UTIs, and subcutaneous parecoxib in the management of pain in palliative care have prompted directorates to submit formulary applications for routine access. The former was approved by MTC early 2025, with the latter due for discussion at July 2025 meeting.

Between March 2024 and May 2025, 74 medicines were approved by NICE. The implementation process and addition to the ABUHB formulary for treatments recommended as NICE Technology Appraisals (TAs) at ABUHB is via the High-Cost Drugs Implementation Planning Group (HCDIPG) - a sub-group of MTC. Following this process and review of directorate implementation plans by HCDIPG, all 75

medicines were added to formulary. MTC agreed the appropriate formulary status for each, which was then recorded on the formulary.

HCDIPG provide an annual report to the Medicines Management Programme Board (MMPB) each winter, providing an overview of work including medicines, Divisions and directorates which have a significant impact on service plans and patient treatment pathways, implementation challenges and horizon scanning.

5.2 Antimicrobial Stewardship

The Antimicrobial Stewardship team maintain oversight of antimicrobial usage and implement strategies to optimise use of antibiotics across ABUHB. The team chair provides professional secretariat support for the ABUHB Antimicrobial Working Group and Antimicrobial Guideline Group.

Key achievements for 2024/25:

- Development of an automated antimicrobial data dashboard for secondary care, allowing data visualisation and interrogation of antibiotic use to Division, directorate and ward level.
- Implementation of penicillin 'allergy' de-labelling across secondary care inpatients. A penicillin allergy label is associated with an increased risk of MRSA/*C. difficile* infection and a 0.6 % increase in deaths within the following year, compared with patients not reporting an allergy. However up to 95% of people reporting a reaction to penicillin do not have a true allergy. This new scheme supports staff to risk assess patients and either remove an allergy directly via history alone or give an oral test dose of a penicillin to patients determined to have a very low risk of allergy.
- Roll out of Antibiotic Review Kit (ARK) principles to the majority of ABUHB community hospitals, following implementation at the main sites in 2022/23.
- Delivery of over 200 hours of antimicrobial ward rounds, reviewing almost 1,400 patients. More than 2,000 interventions were made on these rounds, including stopping antibiotics in 17 % patients, and switching 10% to oral therapy. This included attendance at CRT antibiotic MDT meetings from July - Dec 2024 to review antimicrobials being administered in the out of hospital setting. Ward rounds have been limited in Q4 by Medical Microbiology and antimicrobial pharmacist staff shortages, with recruitment underway to address these gaps.
- Ongoing development and review of almost 600 local treatment guidelines, including migration to a new digital platform in summer 2024.
- Led more than 130 hours of education, reaching over 1,400 healthcare professionals in all sectors. New groups reached include GP out of hours and undergraduate pharmacy students on hospital placements.

- The consultant antimicrobial pharmacist has been appointed to the inaugural NICE antimicrobial evaluation panel. The committee will review evidence and judge the value of new antibiotics to the NHS as part of a world-first model to encourage development of new antibiotics: [A new model for evaluating and purchasing antimicrobials in the UK](#)

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

5.3 National Prescribing Indicators

In October 2003, AWMSG agreed that National Prescribing Indicators (NPIs) were useful tools to promote rational prescribing across NHS Wales, and since then, NPIs have evolved to include secondary care in addition to primary care. It was agreed that NPIs should address efficiency as well as quality, and that targets should be challenging but achievable, and applicable at practice level.

For 2025–2028, the NPI: Supporting Safe and Optimised Prescribing focuses on four priority areas:

- Analgesics
- Antimicrobial stewardship
- Respiratory
- Sodium Glucose Transport Protein-2 (SGLT-2) inhibitors

Supported by safety and efficiency domains:

- Safety
 - Prescribing safety indicators
 - Hypnotics and anxiolytics
 - Yellow Cards
- Efficiency
 - Best value biological medicines
 - Low value for prescribing

This continues with the philosophy of prudent healthcare, enabling higher quality and value through reducing variation, waste, and harm. The four priority areas support two themes in the “Quadruple Aim of a Healthier Wales”, Welsh Government’s plan for health and social care, which supports the achievement of seven national wellbeing goals defined in the Well-being of Future Generations Act.

The two Healthier Wales themes are:

- Population health and wellbeing – better prevention and self-management

- Higher value health and social care – rapid improvement and innovation, enabled by data, focussed on outcomes.

Implementation of NPIs supports the actions of A Healthier Wales.

5.3.1 Clinical Effectiveness Prescribing Programme (CEPP)

The primary care MM team promote safe and cost-effective prescribing through CEPP, the GP prescribing incentive scheme.

For 2024 - 25 the scheme involved:

- Pre-qualifiers:
 - Sign CEPP agreement to confirm 2024-25 practice engagement.
 - Attend practice meeting summer 2024 with MMT.
 - Complete annual valproate prevent pre-assessment patient safety audit.
 - Develop a Practice Interval Prescribing Plan to progress extended interval prescribing from 28-day prescription intervals to 56-day prescription intervals.
- Complete Pregabalin Prescribing Support Package:
 - Complete pregabalin audit
 - Attend Chronic Pain Group training session
 - Review 15 patients prescribed pregabalin
- Show progress in 6 prescribing indicators:
 - 4 national indicators (4C antimicrobial items per 1000 patients, Short Acting Beta Agonist (SABA) inhalers as a percentage of total inhalers, low value for prescribing £ per 1000 patients and Yellow Card reporting)
 - 2 local indicators (optimising antimicrobial duration – percentage of doxycycline 100 mg capsules items prescribed as 5 days and achieve ScriptSwitch acceptance rate of 40 % or more).

5.3.2 ABUHB position against NPIs (March 2024)

The table below shows the extent to which GPs in health boards meet the target or indicator thresholds in March 2025:

- The figure in the cell is the number of practices in each health board meeting target or indicator threshold.
- The percentage figure and cell colour represent the proportion of practices in each health board meeting the target or indicator threshold.
- The target for antibacterial items per 1,000 STAR-PUs is by health board. The tick demonstrates achievement.

It should be noted that the table provides the percentage of practices achieving the threshold target. This is established in the December quarter of the preceding year and based on the best performing quartile of all GP practices in Wales.

Therefore, at baseline only 25% of practices in Wales will achieve the threshold target.

Health boards/practices achieving the indicator targets/thresholds – Quarter ending March 2025

Indicator Description	Aneurin Bevan	Betsi Cadwaladr	Cardiff and Vale	Cwm Taf Morgannwg	Hywel Dda	Powys	Swansea Bay
Opioid burden Total OME Per 1,000 Patients	18 26%	27 28%	40 73%	6 14%	9 19%	3 19%	9 20%
High Strength Opioid burden Total OME Per 1,000 Patients	19 28%	22 23%	27 49%	6 14%	6 13%	6 38%	16 36%
Tramadol DODs per 1,000 patients	24 35%	24 25%	32 58%	8 18%	15 32%	7 44%	14 32%
Gabapentin and pregabalin DODs per 1,000 patients	20 29%	21 22%	32 58%	2 5%	15 32%	2 13%	13 30%
Antibacterial items per 1,000 STAR-PUs	✓	✗	✓	✓	✓	✗	✓
4C antibacterial items per 1,000 patients	18 26%	47 49%	20 36%	15 34%	13 26%	2 13%	30 68%
DPIs and SMIs as a percentage of all Inhalers	33 49%	21 22%	40 73%	21 48%	42 89%	4 25%	20 45%
Hypnotics and anxiolytics ADGs per 1,000 STAR-PUs	20 29%	26 27%	37 67%	8 18%	8 17%	8 50%	13 30%
Low Value for Prescribing (UDG) spend (£) per 1,000 patients	2 3%	35 36%	17 31%	4 9%	4 9%	4 25%	7 16%

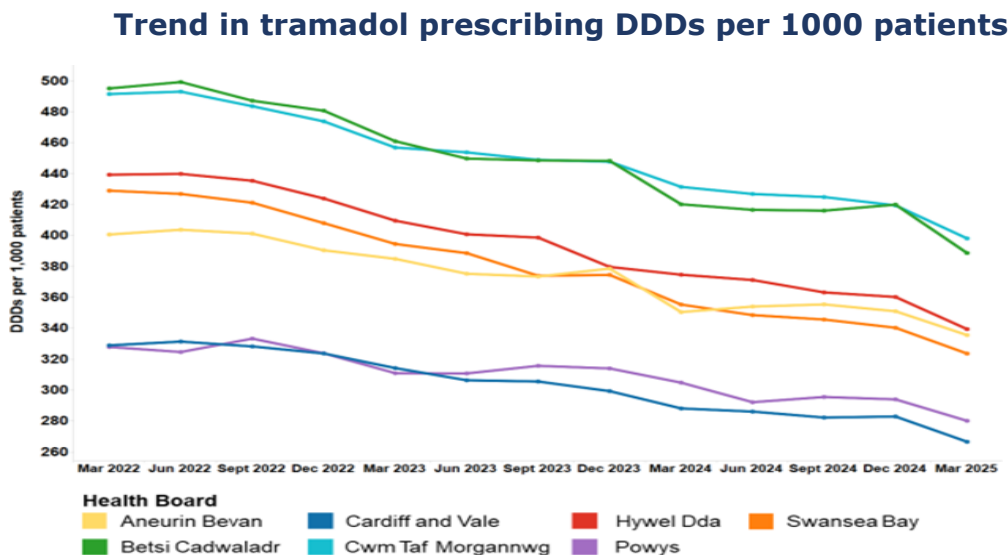
Percentage of practices meeting threshold:



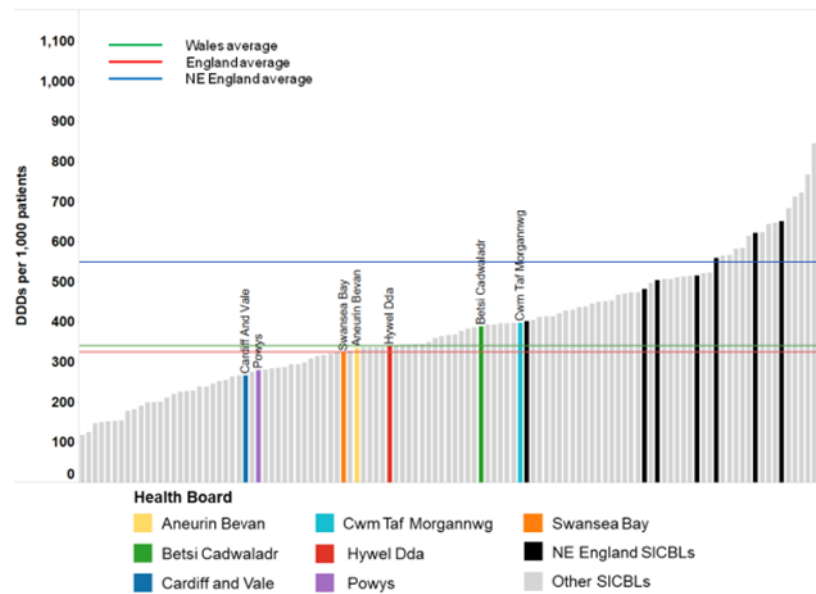
This information should be seen in the context of trends in prescribing performance. Further information is provided in the [National Prescribing Indicators 2024-2025: Quarterly reports - All Wales Therapeutics and Toxicology Centre](#), together with a summary below, which outlines specific actions taken to improve performance.

5.3.2.1 Tramadol DDDs per 1000 patients

ABUHB is the fourth lowest prescriber in Wales and continues to show a reduction in prescribing in line with the aim of the indicator:



Tramadol Items in Welsh HBs and English SICBLs (March 2025 quarter)

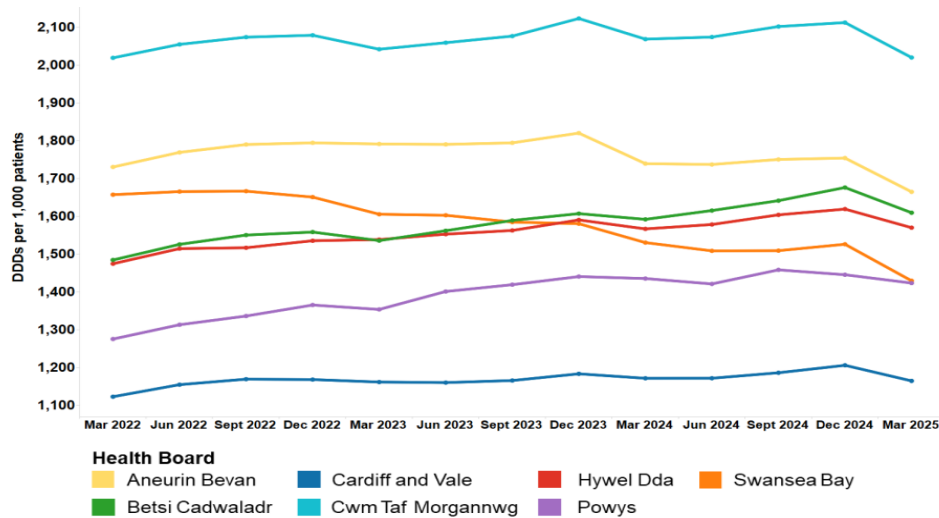


Feedback from practices highlights the difficulty with tramadol deprescribing in established patients. The focus is to limit initiation to new patients. Work is ongoing to deprescribe, albeit slowly, and decreasing trends are evident. Tramadol prescribing levels are monitored through the ABUHB Pain Group. The highest prescribing practice Abersychan, North Torfaen, show a sustained reduction following a visit from the pain team in 2023-24. A targeted whole practice approach to pain review at Village Surgery, Caerphilly South has resulted in a decrease of 64.8% in 2024/25.

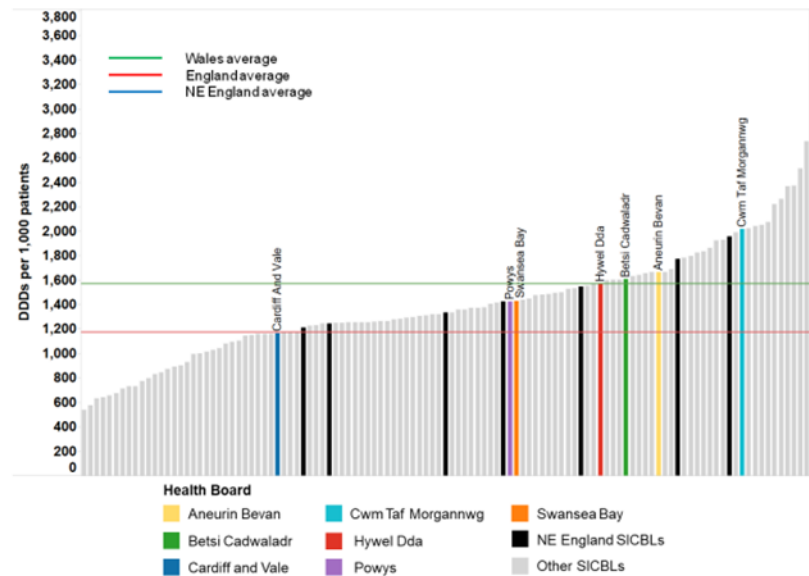
Gabapentin and Pregabalin (DDD per 1000 patients)

ABUHB has a historically high use of these agents for neuropathic pain. Across Wales, pregabalin and gabapentin prescribing showed a sharp reduction in the March quarter 2025:

Trend in gabapentin and pregabalin prescribing DDDs per 1,000 patients (March 2025 Qtr)



Gabapentin and pregabalin prescribing in Welsh health boards and English SICBLs (March 2025 quarter*)



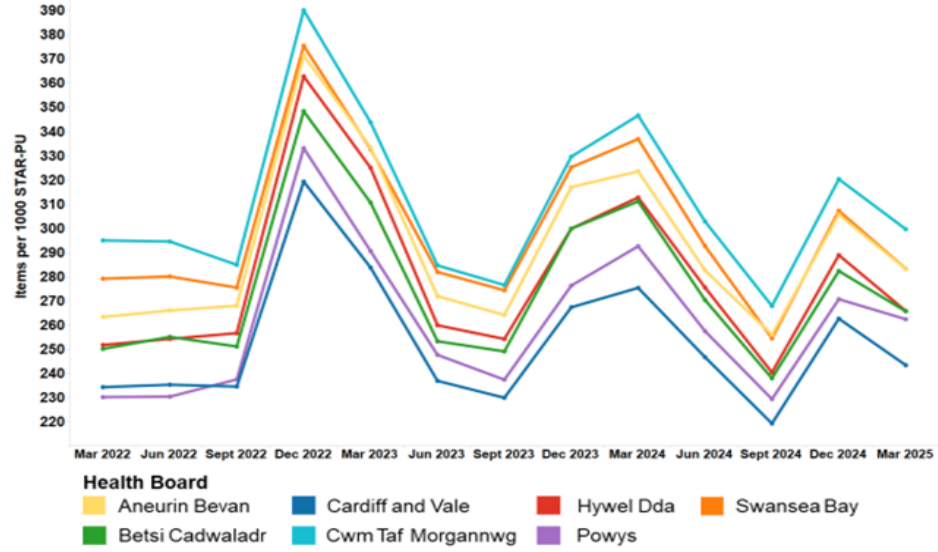
*NE England average line not visible as it is equal to Wales average line

Gabapentinoid prescribing formed a key focus of CEPP 2024/25. This included mandatory attendance at an online training session for GP practices, presented by Dr Kartik Kota (Pain Consultant) with Dr Graeme Yule (GP, St Julians Medical Centre) providing a GP perspective to safe gabapentinoid prescribing. This highlighted the risks and concerns with overuse of opioids and gabapentinoids; and promoted the Gabapentinoid Pain Prescribing Support Pack (developed by the Chronic Pain Group) which provides supportive resources to aid patient reviews and dose reduction plans in primary care.

All practices were asked to undertake a pregabalin audit on the Audit Management and Tracking (AMaT) digital platform to identify indication, initiator (primary or secondary care), high dose use and high-risk patients. Practices were asked to develop an action plan following their audit. The top high use practices had a face-to-face meeting with a pharmacist and Pain Consultant to discuss specific prescribing issues. The highest outlier practice Troisant Lodge, North Torfaen, reduced gabapentinoid prescribing by 15.5% between Q4 23-24 and Q4 24-25.

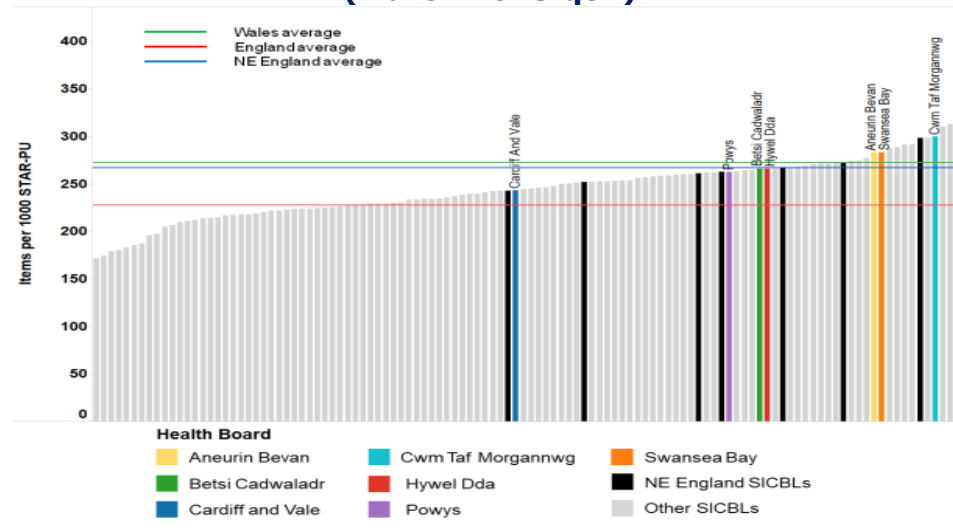
These actions have resulted in an overall ABUHB decrease in gabapentinoid prescribing of 4.29% in 24-25.

Trend in total antibiotic prescribing (Items per 1000 STAR-PUs)



The ABUHB target for this measure is a quarterly reduction of 10% against a baseline of data from April 19 - March 20. The GP practice target is to maintain performance levels within lower quartile, or show a reduction towards the quartile below, based on quarterly data from April 2023–March 2024. ABUHB is ranked fifth in terms of overall performance:

Trend in antibacterial prescribing items per 1,000 STAR-Pus
Antibacterial prescribing in Welsh health boards and English SICBLs
(March 2025 qtr.)



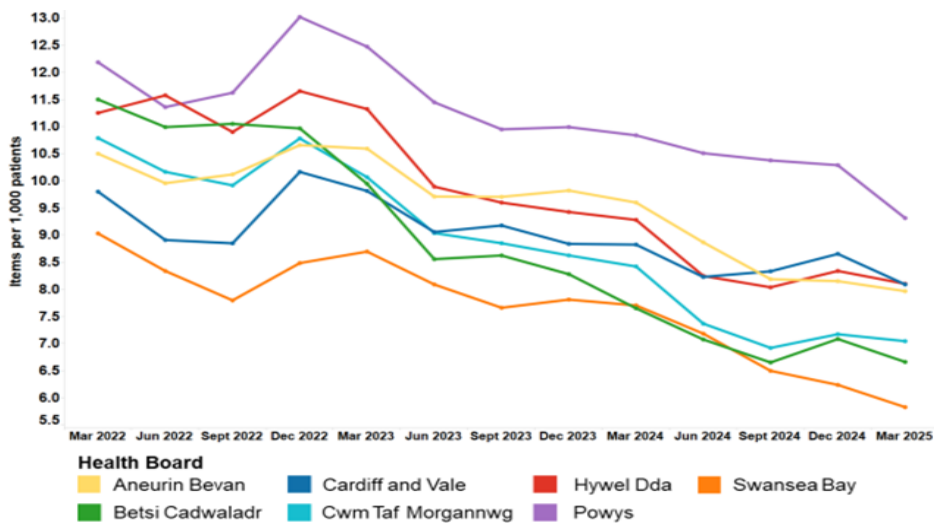
The prescribing trend is in line with other health boards. It should be noted that antibiotic use peaked in winter 2022/23 due to the invasive Group A Strep outbreak, during which the UKHSA, via national media outlets, encouraged patients to present for antibiotics. This has undone many years of public health messaging around antibiotic-seeking behaviours and prescribing levels remain elevated following this event. Significant efforts are required to reverse this.

ABUHB Antimicrobial Stewardship team includes two primary care pharmacists. The team engage outlier practices with audit and feedback cycles to identify prescribing themes, promote prescribing resources and agree an action plan with each practice. This approach has seen a reduction of antibacterial items per 1000 STAR PUs at two targeted outlier practices between Q4 23/4 and Q4 24/25: 18% decrease at Blaenavon Medical Practice and 32% decrease at Abersychan Group Practice, North Torfaen.

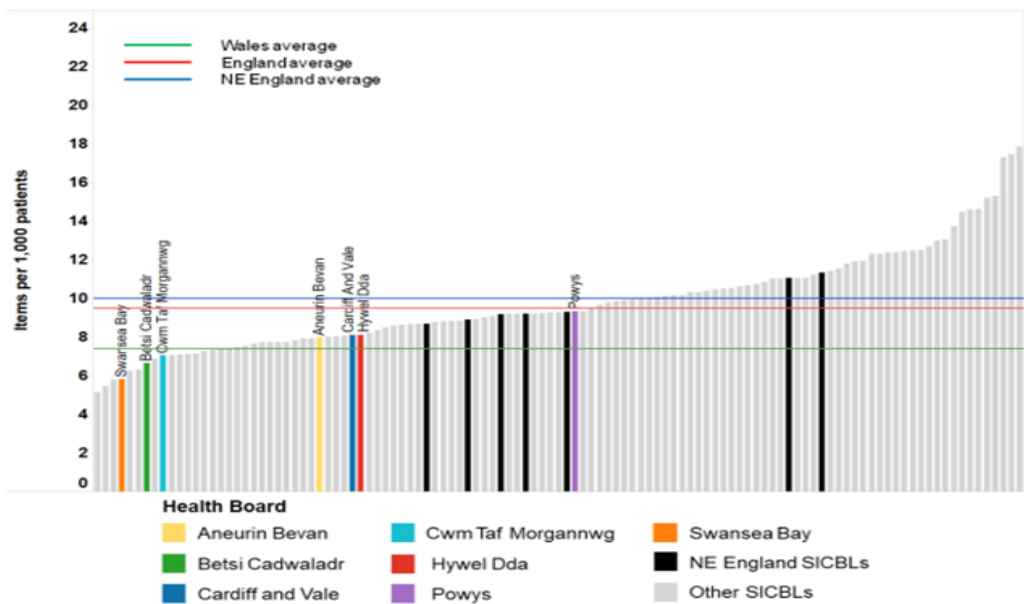
5.3.2.4 4C Antimicrobial Prescribing (items per 1000 Patients)

ABUHB decreased prescribing of 4C antimicrobials by 17% between Q4 23/24 and Q4 24/25 in line with the aim of the indicator.

Trend in 4C antimicrobial items per 1,000 patients



4C Antimicrobial items per 1,000 in Welsh health boards and English SICBLs (March 2025 quarter)



Broad spectrum antibiotics are associated with an increased risk of healthcare associated infections, and this remains a priority indicator in the CEPP.

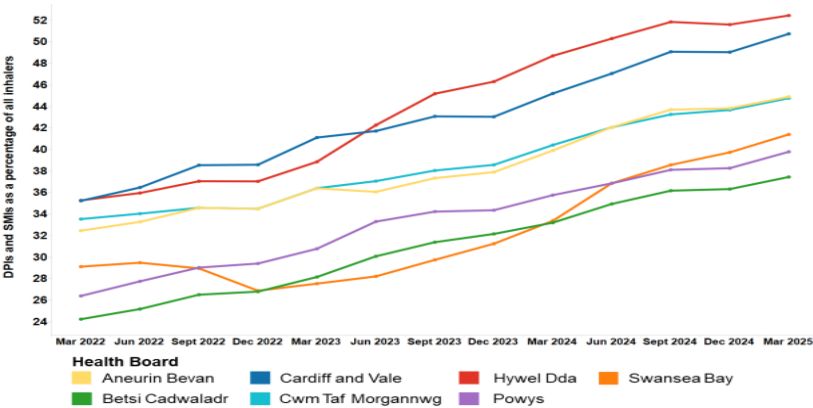
Evidence of benefit has been demonstrated in both Blaenavon Medical Centre and Abersychan Group Practice following support from the primary care antimicrobial pharmacists and both have seen a subsequent significant decrease in 4C prescribing between Q4 23/24 and Q4 24/25: 10.2% decrease at Blaenavon and 24.1 % decrease at Abersychan.

5.3.2.5 Dry Powder Inhalers (DPIs) and Soft Mist Inhalers (SMIs) as a percentage of all inhalers

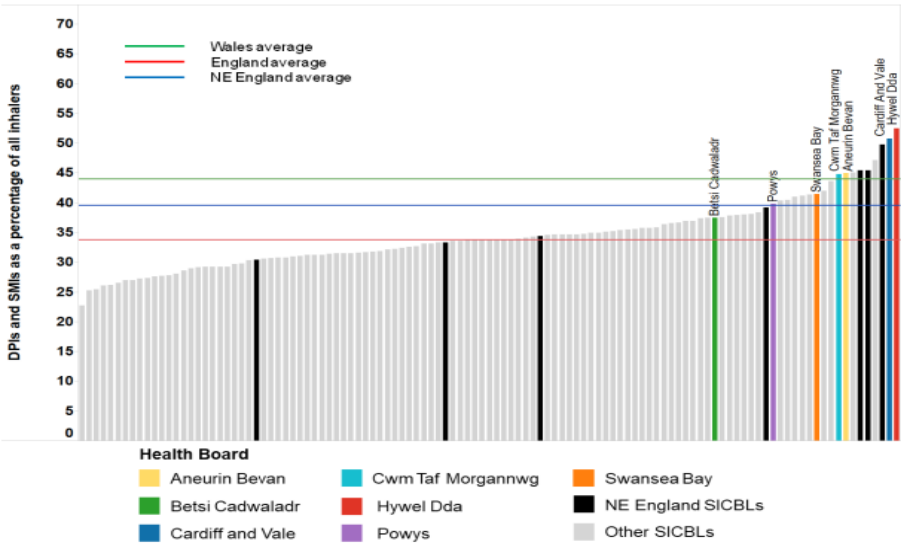
Metered dose inhalers (MDIs) are estimated to be responsible for 4% of the NHS entire carbon footprint. The target is a shift to 80% of inhalers being low global warming potential alternatives (for example, DPIs or SMIs) by 2025.

ABUHB achieved the indicator target threshold of 44.3% in Q4 24/25:

Trend of DPIs and SMIs as a percentage of all inhalers



DPIs and SMIs as % of inhalers in Welsh HBs and English SICBLs (March 2025 qtr)

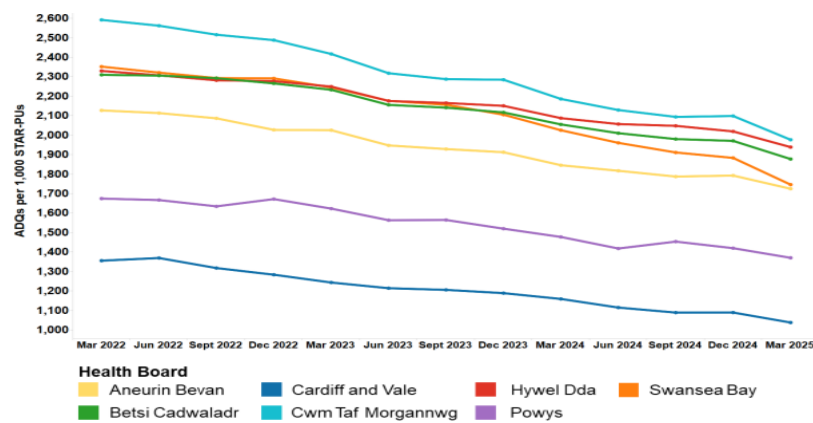


ABUHB continues to make progress towards this indicator target. In response to the [NHS Wales decarbonisation strategic delivery plan GOV.WALES](#), ABUHB started work on the decarbonisation of inhalers with a focussed approach including the indicator in CEPP and supporting General Practice with Green Inhaler QI projects, part of the GMS contract 23/24.

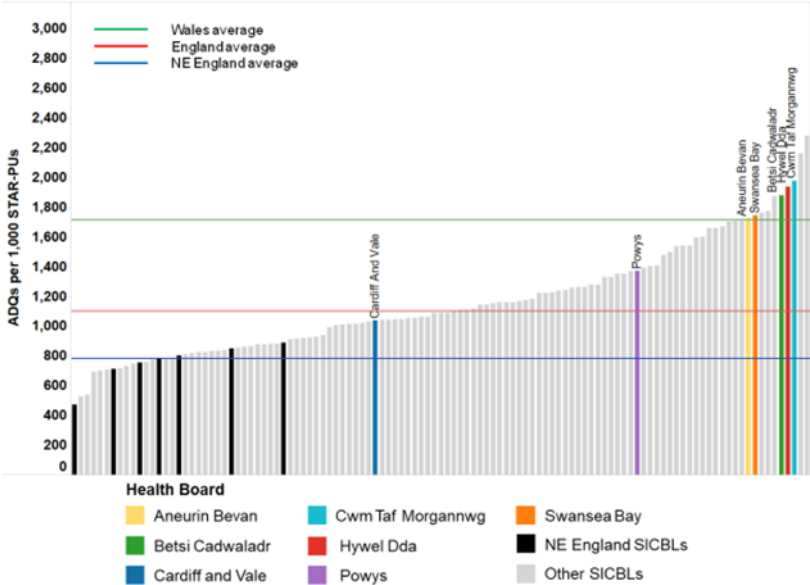
5.3.2.6 Hypnotics and Anxiolytics ADQs per 1000 STAR-Pus

There has been concern with regards to high level hypnotic and anxiolytic prescribing in NHS Wales. ABUHB hypnotic and anxiolytic use is the 3rd lowest in Wales and is comparable with the Welsh average. ABUHB continues to show a downward trend, reducing by 7% between Q4 23/24 and Q4 24/25:

Trend Hypnotics and Anxiolytics ADQs per 1000 STAR-PU



Hypnotic and Anxiolytic prescribing in Welsh HBs and English SICBLs (March 2025 qtr)



Practices are encouraged to use the AWTTTC toolkit to audit patients and deprescribe.

5.3.2.7 Low value prescribing

The aim of the Low Value for Prescribing in NHS Wales initiative is to minimise prescribing items that offer a limited clinical benefit to patients and where more cost-effective treatments may be available.

Three papers, published by AWTTTC, aim to reduce variation in medicines that should not be routinely prescribed within the NHS, which includes the following:

Low Value for Prescribing Paper 1

Item/Item Group	ABUHB Progress Update 2024-25
Co-proxamol	No further action due to minimal prescribing.
Lidocaine plasters	Reinforce ABUHB position to all clinicians. Identify and engage with outlier practices to deprescribe. MTC continue to monitor prescribing adherence with formulary.
Tadalafil once daily	Low priority due to minimal savings and impact.
Liothyronine	In February 2025, MTC reviewed formulary status to Red for new patients only (patients started after April 2025). Patients already established on liothyronine can continue on repeat prescriptions from GP until Endocrinology review and repatriate prescribing responsibilities. Promote lower acquisition cost preparations through ScriptSwitch.
Doxazosin MR	NF message and promote switch to immediate release doxazosin through ScriptSwitch. Consider SOP to target switches. Included in medicine basket for the Value and Sustainability recommendation: "Stop prescribing of medicines on low value list including some over the counter medicines".

Low Value for Prescribing Paper 2

Item/Item Group	ABUHB Progress Update 2024-25
Omega-3 fatty acid compounds	Discussed at MTC in February 2025 with no change of formulary status, but action to audit current patients to see if other lipid regulating agents would be more appropriate. Outlier practices identified in preparation for audit.
Oxycodone and naloxone combination product	NF message on ScriptSwitch
Paracetamol and tramadol combination product	
Perindopril arginine	NF message and promote switch to perindopril erbumine through ScriptSwitch

Low Value for Prescribing Paper 3

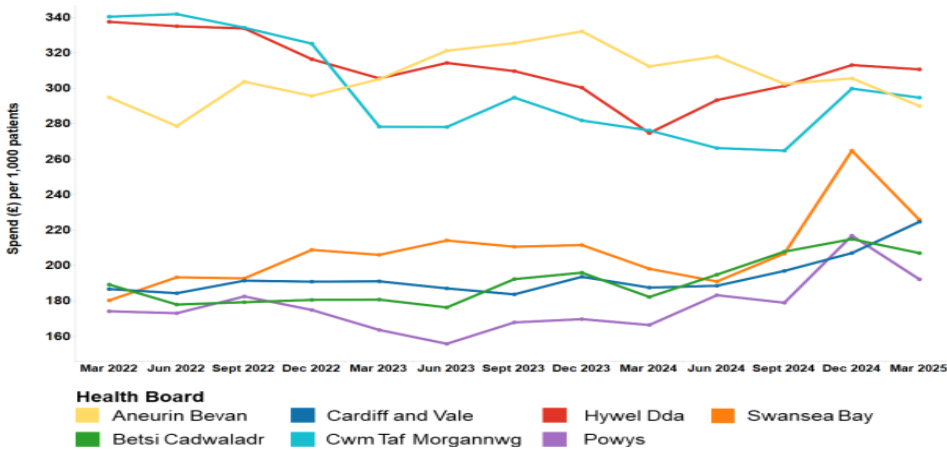
Item/Item Group	ABUHB Progress Update 2024-25
Chloral hydrate	MTC review of formulary status to Red in 2024.
Minocycline	AMS team to advise on actions to reduce prescribing.
Ascorbic Acid	MTC to review current indications for prescribing. To be discussed at June 2025 MTC meeting.
Ketovite	Made NF at MTC in February 2025.
Alimemazine	MTC reviewed formulary status to Red in February 2025.
Blood glucose testing strips	Align with All-Wales procurement review. SOP renewed to enable pharmacy technician-led clinics to switch to All Wales BGTS. Analyse ABUHB data through SPIRA dashboard. Engage with Diabetic Specialist nurse team to refresh ABUHB BGTS Guidance.
Aliskiren Probiotics Selenium Probiotics Rubefacients Silk garments	NF message on ScriptSwitch.

The NPI basket for Low Value for prescribing includes the following selected medicines:

Medicines included in NPI indicator	
• Coproxamol • Lidocaine Plasters • Oxycodone & Naloxone • Alimemazine • Perindopril Arginine • Paracetamol & Tramadol	• Doxazocin MR • Liothyronine • Omega 3 • Rubefacients • Chloral Hydrate

ABUHB spend for low value prescribing has shown a decrease during 24-25 in line with the aim of this indicator:

Trend in Low value for Prescribing (UDG) spend per 1000 patients



5.4 Pharmacy Aseptic Unit



RGH Pharmacy Aseptic Unit (PAU) supplies some of the most high-risk parenteral medicines used within ABUHB, including systemic anti-cancer therapy (SACT) and parenteral nutrition (PN) for adults and neonates. A large proportion of these medicines are prepared by highly skilled pharmacy staff working in the PAU specialist cleanroom facility.

Despite significant and sustained capacity pressures, the PAU supplied a total of just over 17,500 parenteral medicine items between April 2024 and March 2025, an 8% increase on the previous financial year. The table below breaks these down by category and illustrates the difference in product numbers compared to 23-24.

	Number of parenteral medicine items supplied 24-25	Trend compared to 23-24 Numbers in parentheses represent difference in number of items vs 2024-25
SACT	13,459	↑ (+604)
Neonatal PN	1,411	↑ (+120)
Adult PN	2,705	↑ (+659)
Other	21	↓ (-23)
TOTAL	17,596	↑ (+1360)

The PAU has continued to support staff development by taking advantage of specialist training and qualifications to enable role expansion. In May 2024, the PAU senior pharmacy technician achieved accreditation as a Product Approver, a role otherwise restricted to pharmacists. Following successful completion of a two-year course, the PAU promoted a senior pharmacy assistant to become ABUHB first Science Manufacturing Technician. This is a relatively new qualification which provides a technical services-specific pathway to working at a level equivalent to a pharmacy technician.

In addition to providing core aseptic medicines preparation and supply service, the PAU also supports other ABUHB services:

- Under MHRA Manufacturer’s Specials licence, the PAU manufactures non-sterile pre-packs which are used across the sites to facilitate patient treatment, largely by supporting supply of medicines under PGDs. A total of 2,446 pre-pack items were manufactured in 2024-25.
- Quality Assurance (QA) provide advice and assistance on procurement and supply of unlicensed medicines. During 2024-25, QA risk assessed and labelled

1,500 packs of thiamine injection and 220 packs of peginterferon injection as part of strategies to manage medicines shortages.

- The QA lead and senior production pharmacy technician have successfully launched a pharmacy “Train the Trainer” aseptic technique programme for Nuclear Medicine radiographers, using PAU specialist expertise to support safe use of medicines in other high-risk settings.

The PAU continues to operate above maximum capacity, resulting in sustained increased workload and pressure within the system. This has a detrimental effect on staff morale and carries an increased likelihood of product errors. The service is unable to meet increased clinical need in key areas such as haematology/oncology, meaning a number of product requests are refused. The service also cannot maintain the required capacity to ABUHB Clinical Trials.

5.5 Policy development

During 2024-25, six pharmacy policies were updated and ratified by the Clinical Standards and Policy group.

Document Ref	Title	Dated	Review date
ABUHB 0552	Policy for Management of Controlled Drugs	15/08/2024	15/08/2027
ABUHB 0561	Supply of free samples of prescription items policy	15/05/2024	15/05/2027
ABUHB 0093	Dispensing TTH medicines out of hours or in areas without pharmacy support	16/02/2024	16/02/2027
ABUHB 0159	Policy for use of unlicensed medicines and medicines used outside market authorisation	11/09/2024	11/09/2027
ABUHB 0647	Position Statement on appropriate promotion of pharmaceuticals	05/09/2024	05/09/2027
ABUHB 0652	Policy for Managing Potentially Excessive or Inappropriate Prescribing in Primary Care	15/11/2024	15/11/2027

5.6 Clinical Informatics

5.6.1 Digital literacy and Digital Pharmaceutical Care Planning

Using the data and outcomes generated from the 2024 digital pharmaceutical care planning (DPCP) research, DPCP has been added as a workstream to the DHCW digital transformation roadmap. Internal work has started within ABUHB to develop digital induction training based on the data gathered, with an aim to

produce structured training that meets the baseline digital literacy needs of our staff and allow for career development.

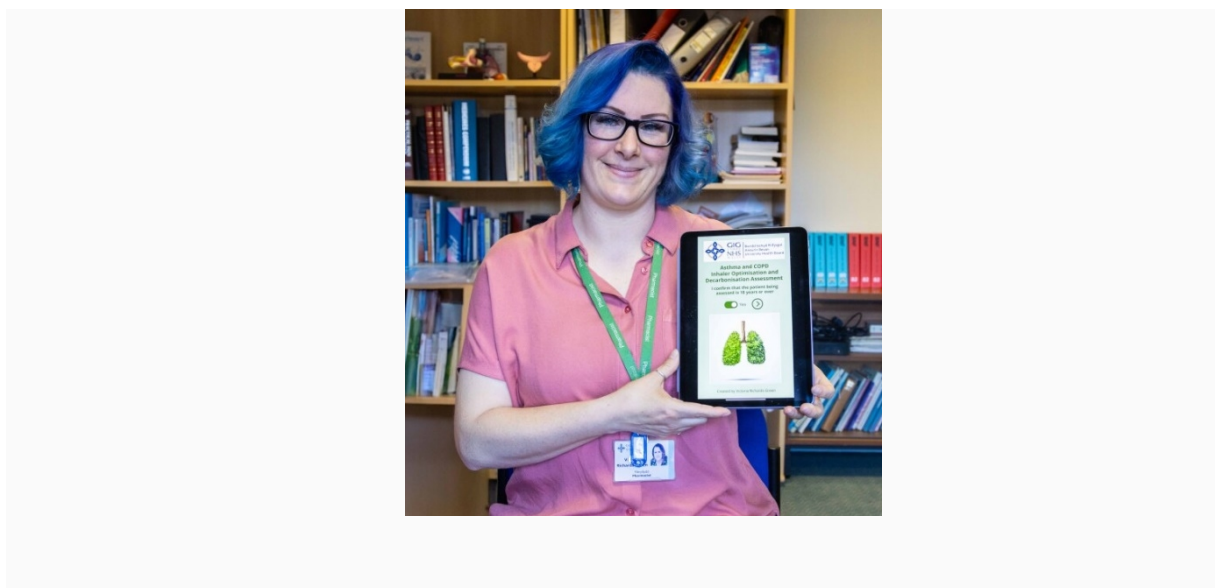
5.6.2 Homecare SharePoint

The Homecare SharePoint pages are now completed for all clinical specialities. The new pages provide access to prescription and communication forms to aid clinical teams to communicate changes to home prescriptions and treatments in a more robust way, as well as access to the homecare service tracker.

5.6.3 Inhaler optimisation and decarbonisation app

This year has seen the launch of the ABUHB inhaler optimisation and decarbonisation app which aims to improve the health of COPD and asthma patients across ABUHB, whilst also supporting the decarbonisation agenda. The app assesses patient's inhaler technique, while also adhering to national guidelines and minimising use of high global warming potential inhalers in favour of lower global warming potential inhalers. This application is available for use by any healthcare professional within any sector. Communications have been sent to all ABUHB GP surgeries, as well as attendance at NCN meetings to showcase the app.

Work has also started with the GUH ED team to utilise the app for respiratory patients attending ED, targeting patients that frequently attend front door services for exacerbations.



The app was developed by Victoria Richards-Green, lead respiratory pharmacist, and integrates the All-Wales Asthma and COPD guidelines with the Decarbonisation Strategy to create an efficient, patient-centred approach to inhaler use.

6. Efficient

Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments that ensure any interventions represent the best value that will improve outcomes for people.

6.1 Medicines Management Programme Board (MMPB)

The MMPB meets monthly and oversees implementation/delivery of the MM workstreams, with the aim to ensure medicines prescribed do the greatest good, with the minimum effective intervention and least harm, within available resources. This supports the implementation of the Health and Care Quality Standards with respect to the domains for effective and efficiency care.

MMPB roles include:

- Leadership on safe and effective medicine use
- Development of the MM Optimisation plan
- Monitoring workstream financial performance
- Maximising benefits of primary/secondary care interface
- Scrutinising performance using KPIs and benchmarking
- Ensuring appropriate actions resulting from internal and external audit
- Approving annual MM Savings plans including any associated components
- Providing oversight on horizon scanning of NICE / AWMSG

6.1.1 Value and sustainability

In October 2023 and March 2024, WG wrote to health boards following meetings of the NHS Value and Sustainability Board. The letter described a series of recommended actions to reduce expenditure and address the significant financial challenge faced by NHS Wales. All health boards were asked to focus on 13 national priorities and ensure that:

1. Best value product is chosen every time
2. Losses from local procurement are minimised
3. No-or-low value prescribing is eliminated

In October 2024, the priorities were updated to provide a consolidated list of ten areas for action by health boards in the remainder of the financial year:

NHS Value and Sustainability Priorities October 2024	
1	Maximise use of biosimilar medicines, including where possible, preferential use of lowest acquisition cost biosimilars (carried over from 2023/24)
2	Ensure compliance with hospital contract pricing for abiraterone, apixaban, lanreotide, lenalidomide, teriflunomide, and sugammadex (carried over from 2023/24)
3	Minimise prescribing of medicines by brand where lower cost generics are available in primary care (carried over from 2023/24)
4	Increase use of apixaban and rivaroxaban as a proportion of all DOACs in primary care (amended from 2023/24 to include rivaroxaban)

5	Stop prescribing of medicines on a low value list including some over the counter medicines (carried over from 2023/24)
6	Reduce prescribing of bath and shower emollients (new for 2024/25)
7	Ensure use of lowest acquisition cost equivalent liothyronine preparations (new for 2024/25)
8	Ensure prescribing of dry eye preparations in primary care is in accordance with local or national formularies (new for 2024/25)
9	Maximise adoption of biosimilar ustekinumab (new for 2024/25)
10	Ensure compliance with hospital contract pricing for specified medicines with contracts awarded in 2024/25 (new for 2024/25)

ABUHB was asked to:

- determine the relative priority of these opportunities, also considering the size of locally determined opportunities not included in this list.
- ensure delivery arrangements are in place to assure new opportunities are realised quickly.
- ensure continued progress against previous recommendations.

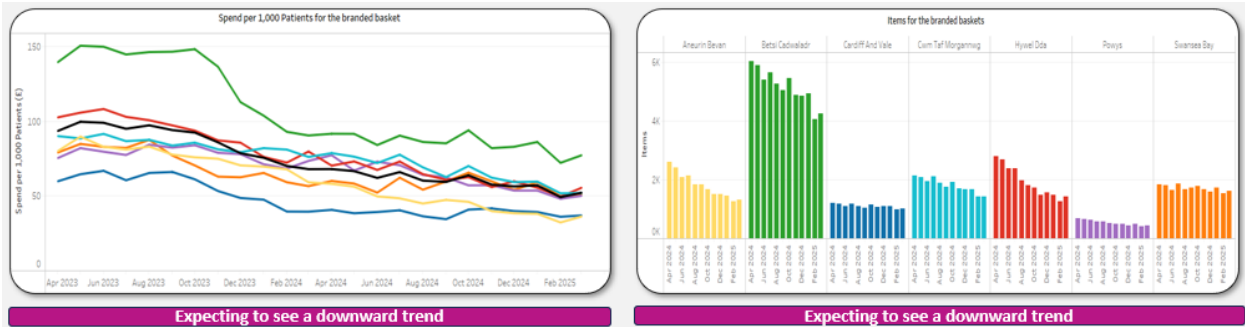
Dashboards have been developed to support monitoring:

- [Optimising Medicines Value Toolkit - Power BI](#)
- [Server for Prescribing Information Reporting and Analysis \(SPIRA\) – All-Wales Therapeutics and Toxicology Centre \(nhs.wales\)](#)

Primary care:

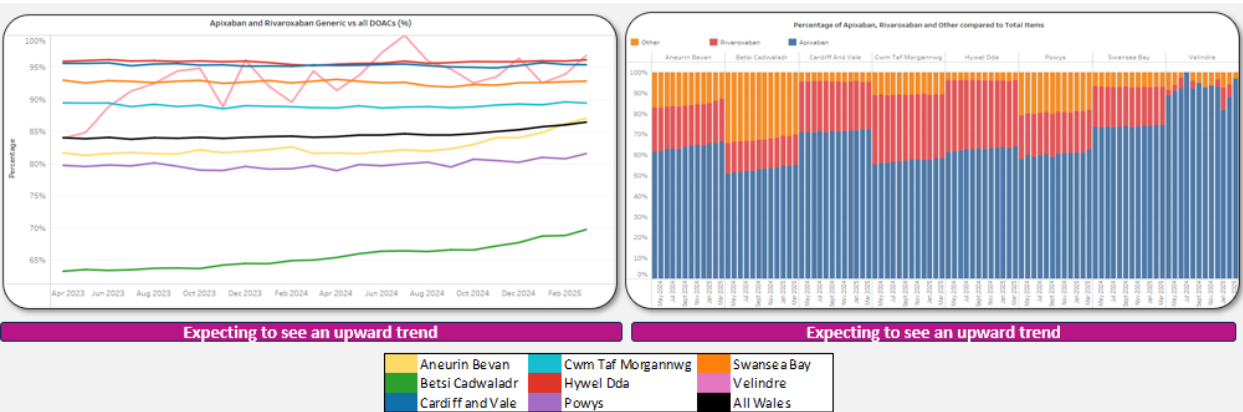
ABUHB progress and savings realised against the NHS Value and Sustainability priorities are monitored monthly through MMPB meetings. The priorities form the focus of the MM workplan for 2024-25 to ensure progress in primary care. Work was carried out in GP practices, referring patient concerns to the Putting Things Right Team and through a tailored IPFR process.

Recommendation 3: Stop prescribing medicines by brand in primary care where lower generics are available.



Targeted work by ABUHB MM Team resulted in £69,348 in year savings. ABUHB now have the lowest spend per 1000 patients in Wales with a 42% reduction in spend over 2024-25.

Recommendation 4: Preferential use of apixaban and rivaroxaban in primary care.

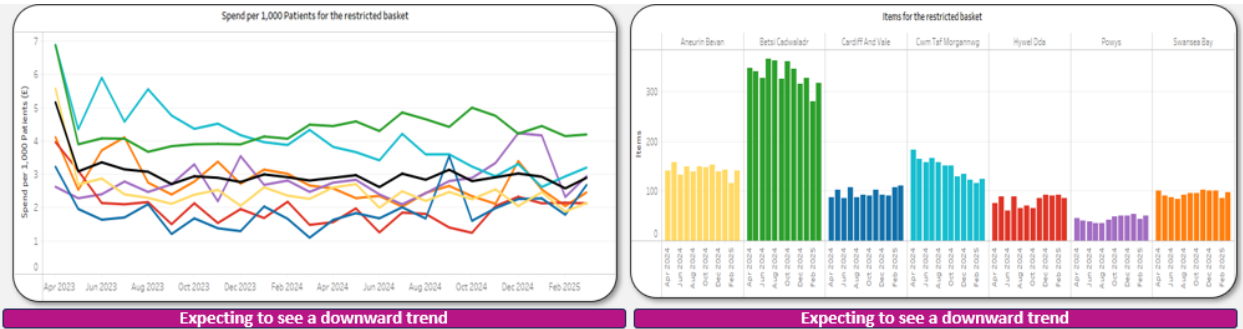


Targeted work by the primary care MM team includes:

- circulating a statement letter to ABUHB clinicians promoting generic apixaban and rivaroxaban as first line DOAC agents in non-complicated NVAf.
- a DOAC-focused primary care newsletter was disseminated to all primary care clinicians to recommend apixaban and rivaroxaban.
- involvement in the Anticoagulant Working group to identify appropriate AF patients to switch from warfarin to apixaban or rivaroxaban.
- development of ABUHB Local Supplementary Service to remunerate practices £60 per patient switched from edoxaban to apixaban or rivaroxaban.

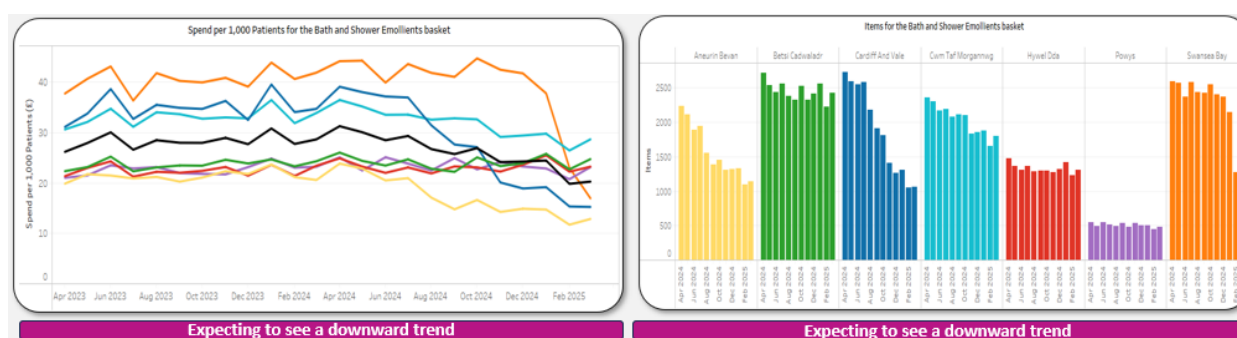
This work resulted in a 21% decrease in edoxaban prescribing and ABUHB exceeded the All-Wales prescribing of apixaban and rivaroxaban prescribed as a percentage of all DOACS in February 2025.

Recommendation 5: Stop prescribing of medicines on low value list including some over the counter medicines.



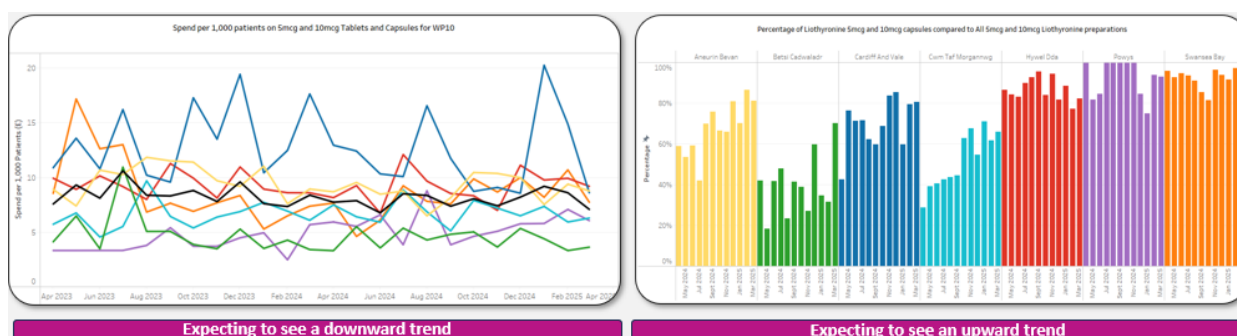
ABUHB MM team promoted review of doxazosin prolonged-release tablets to immediate-release doxazosin tablets through ScriptSwitch, reinforcing the message that doxazosin should be used as a fourth line hypertensive agent.

Recommendation 6. Restrict prescribing of bath and shower emollients.



MM pharmacy technicians work to deprescribe bath/shower emollients resulted in £33,686 in year savings. ABUHB started as the lowest prescribing health board in March 24 and further reduced prescribing significantly by March 25.

Recommendation 7. Selection of lowest acquisition cost liothyronine preparations.



Switching appropriate patients to a low acquisition cost liothyronine capsules resulted in £1,244 in year savings. Barriers to switching were encountered with difficulty achieving an equivalent dosing regime in capsule form.

Secondary care:

In alignment with national priorities set by the NHS Value and Sustainability Board, the secondary care prescribing support team has actively contributed to delivering efficiency opportunities. These initiatives have been progressed collaboratively by the Unscheduled Care and Medicine Divisional Programme pharmacists, in partnership with directorate teams and pharmacy homecare service.

Key achievements include:

NP01: Maximising Use of Biosimilars

- Ophthalmology: Transition from originator *Lucentis* to biosimilar *Ongavia* (Ranibizumab).
- Gastroenterology, Rheumatology, Dermatology: Switch from originator or higher cost biosimilars to *Yuflyma* (Adalimumab).
- Infliximab and Etanercept: Adoption of lowest acquisition cost biosimilars.

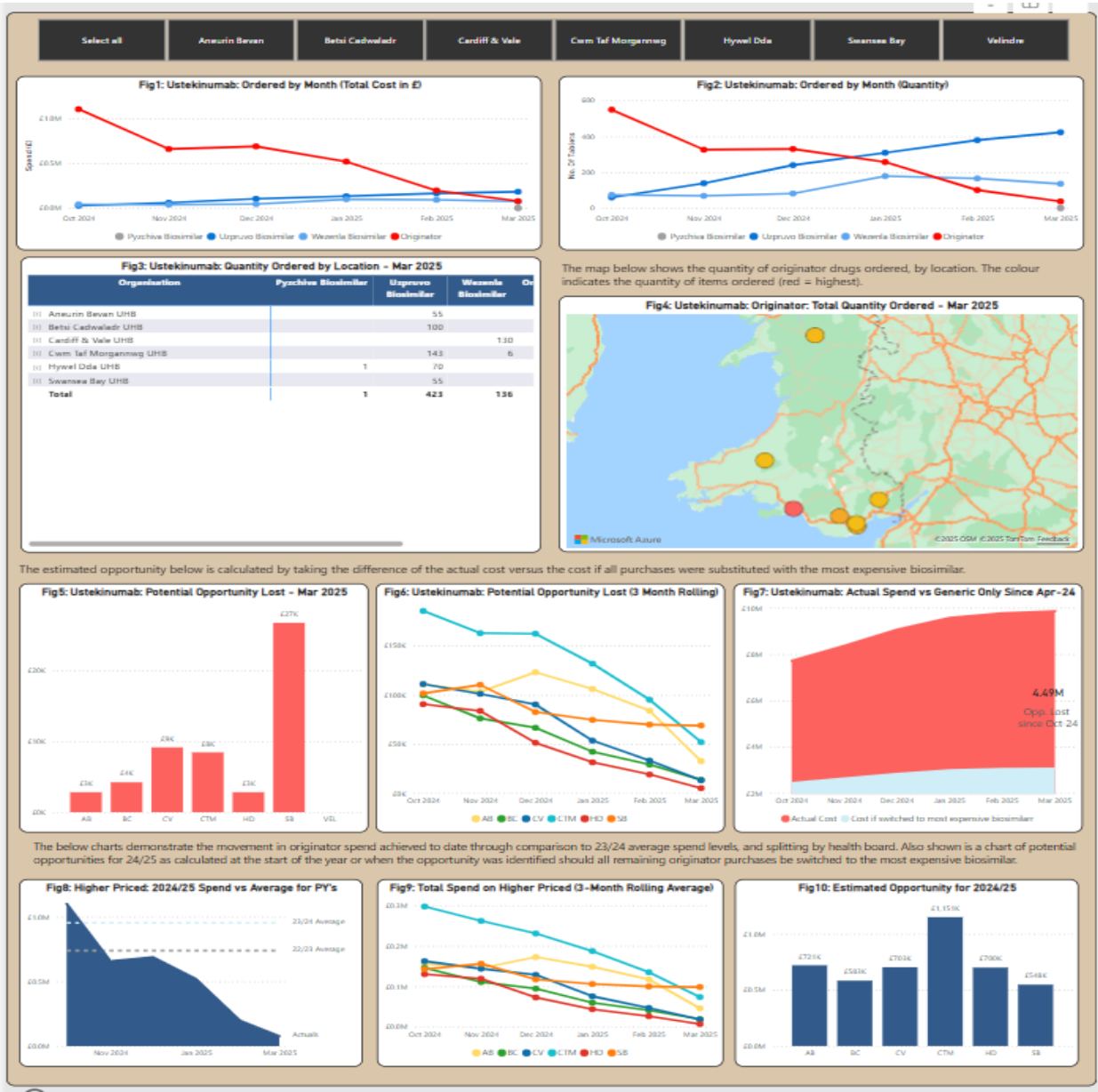
- Ustekinumab: Preparatory work with the pharmacy homecare team to support a smooth transition to biosimilars with minimal patient disruption.

NP02: Compliance with Hospital Contract Pricing

- Ensured adherence to national contract pricing for key medicines including *abiraterone*, *apixaban*, *lenalidomide*, *teriflunomide*, and *sugammadex*.

NP09: Biosimilar Ustekinumab Implementation

- Transition from originator *Stelara* to *Uzpruvo*, the biosimilar allocated to ABUHB by the MVU Ustekinumab Working Group.
- Successful implementation in Q3 of 2024/25, supported by clinical and homecare teams.
- Used across Gastroenterology, Dermatology, and Rheumatology.



6.1.2 Prescribing Efficiencies

The table below shows month 12 savings delivered for each Division and comparative performance in previous years.

The Scheduled Care and Medicine Divisional Programme pharmacists focus on delivering value and sustainability priorities within secondary care, along with directorate and procurement colleagues.

Division	2022-23 Savings Delivered £'000	2023-24 Savings Delivered £'000	2024-25 Savings Delivered £'000
Primary Care	1,180	4,227	4,134
Mental Health	0	269	0
Family & Therapies	49	43	233
Surgery	1,515	1,294	552
Clinical Support Services	0	0	65
Medicine	0	190	566
Urgent Care	0	9	0
All other Divisions	0	0	0
sub-total	1,564	1,804	1,416
Velindre	0	0	0
Other Welsh Health Boards	0	0	0
TOTAL ABUHB	2,744	6,031	5,549

6.1.2.1 Multiple Sclerosis (MS) Medicines Optimisation

- A business case aligned with medication savings enabled implementation of generic switches and expanded homecare utilisation for multiple sclerosis treatments, including *teriflunomide*, *fingolimod*, and *dimethyl fumarate*. This initiative has improved access to cost-effective therapies and supported prescribing efficiencies across ABUHB.
- A key risk has emerged as the business case did not include additional pharmacy resource to support the increased workload. The introduction of treatments—particularly *fingolimod*, which was not previously available within ABUHB—has placed additional pressure on pharmacy services. Without further investment, there is a risk that directorate-level work will be impacted due to limited capacity to manage the associated clinical and operational demands.

6.1.2.2 Therapeutic Reviews and Collaborative Working

- Ongoing therapeutic reviews through MMPB have supported directorate pharmacists in engaging with Clinical Directors and primary care colleagues.
- These reviews have facilitated cross-sector discussions on prescribing trends, cost-saving opportunities, and service alignment.

These initiatives reflect departmental commitment to delivering high-quality, cost-effective care while supporting national sustainability goals.

6.1.3 Script Switch®

In the 2024-25 CEPP scheme, ABUHB again promoted ScriptSwitch, an innovative prescribing decision support tool, delivering savings and improving patient care. GP practices were incentivised to meet an acceptance rate of 40%. ScriptSwitch provides prescribing information and alternative recommendations at the point of prescribing via a clear and pop-up message. Details for the recommendation and cost-benefit in the case of a switch are summarised in the display. Prescribers choose to accept or decline any recommendation.

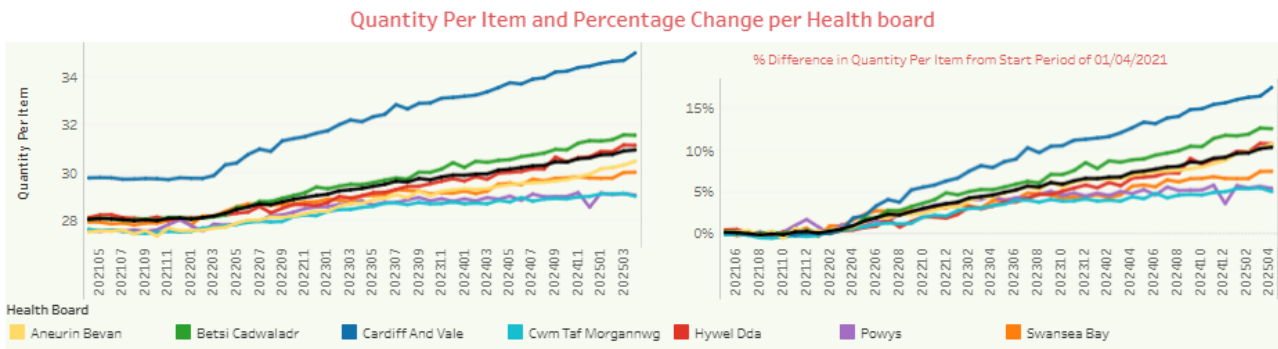
Summary for 2024-25
187,050 switches were offered with overall acceptance rate of 45.4% (84,946).
Return on investment of £8.40 for every £1 spend
ABUHB calculated annual saving
£191,696 of acute prescription savings £1,174,392 of repeat prescriptions savings Total saving £1,366,088

In October 2024, AWMSG published “Prescribing of branded generics in NHS Wales Position Statement”, including recommendations that:

- Prescribers should always use a medicine generic name when prescribing (referred to as generic prescribing) unless there is a clinical reason to prescribe by brand or branded generic.
- Prescribing policies should not encourage use of branded or branded generic medicines where there is no clinical or patient related reason.

<https://awttc.nhs.wales/files/guidelines-and-pils/prescribing-of-branded-generics-in-nhs-wales-position-statement-pdf/>

This has impacted our prescribing savings in the short term but will align with an All Wales approach to bring down Drug Tariff prices in the long term.



6.2 Value Based Healthcare

6.2.1 Diabetes Cardio-renal project

Over the past year, the cardiorenal optimisation service for patients with Type 2 Diabetes (T2DM) has continued to progress across ABUHB. Due to extra funding received, the service expanded into Newport and North Monmouthshire through the recruitment of extra pharmacist hours. The team also recruited an administrative assistant to support sending outpatient letters and telephoning patients to arrange appointments.

In the first 2 years of the project there have been 1,183 face-to-face appointments and 857 patients started on a SGLT2 inhibitor, providing patients with cardiorenal protection. 1,059 patients have been educated on chronic kidney disease and their cardiovascular risk and 79 patients had their prescription of a gliptin stopped. These improvements created a cost saving of just over £28,000.

The service uptake has shown to be extremely positive, with a very low “did not attend” (DNA) rate of 6.5%.

There has been a steady increase of SGLT2 inhibitor prescribing in those patients with a urine albumin creatinine ratio (ACR) 3 - 30 and in those with a urine ACR >30, since the project started in July 2023. ABUHB is performing above Wales as a whole in SGLT2 inhibitor prescribing. This is in part due to the cardiorenal optimisation service, but also due to the educational sessions provided on the management of chronic kidney disease (CKD) in patients with T2DM at GP learning events.

The project secured additional funding in January 2025 to take the project into a third and final year.

6.3 Decarbonisation

6.3.1 Green Inhaler Project

To support the [NHS Wales decarbonisation strategic delivery plan GOV.WALES](#), a local indicator to help reduce salbutamol over-reliance was included as part of the annual Clinical and Effectiveness Prescribing Programme (CEPP). To encourage safe inhaler disposal, working with the NCNs and using resources from Community Pharmacy Wales, posters were printed for GP practices, community pharmacies and hospital sites.

To support patients with chronic obstructive pulmonary disease (COPD), meetings were held with a Pharmaceutical Company and Interface Clinical Services under the Donations of Goods and Services Scheme to agree a targeted patient review project to ensure patients are optimised in line with guidelines. This involved targeting high risk patients and those prescribed therapy outside of guidelines i.e., long-acting muscarinic antagonist (LAMA) monotherapy or multiple inhaler triple therapy.

To support patients with uncontrolled asthma who may benefit from biologic therapy meetings, took place with the secondary care Severe Asthma Team and a pharmaceutical company for a collaborative identification and referral project which started in 2025.

Education sessions on sustainable inhaler prescribing continued to be provided for the primary care element of the Foundation Pharmacist Programme and for GP practices as part of annual CEPP meetings.

6.3.2 Paracetamol practice initiative

Paracetamol is one of the most widely prescribed medicines for hospital inpatients. Many patients receive IV paracetamol, when oral paracetamol would be safer, more effective and provide cost savings and environmental savings.

A project within GUH by anaesthetics in critical care, in conjunction with pharmacy, introduced an intervention using a prompt via the Omnicell dispensing unit to input reasons why IV is needed over oral.

The benefits were:

- Using technology to improve outcome.
- Reduced drug/ consumable expenditure.
- Reduced infection risk.
- Reduced administration/ set-up time.
- Reduced plastic waste.

6,051 switches were made over the first 11 months of the project.

7. Equitable

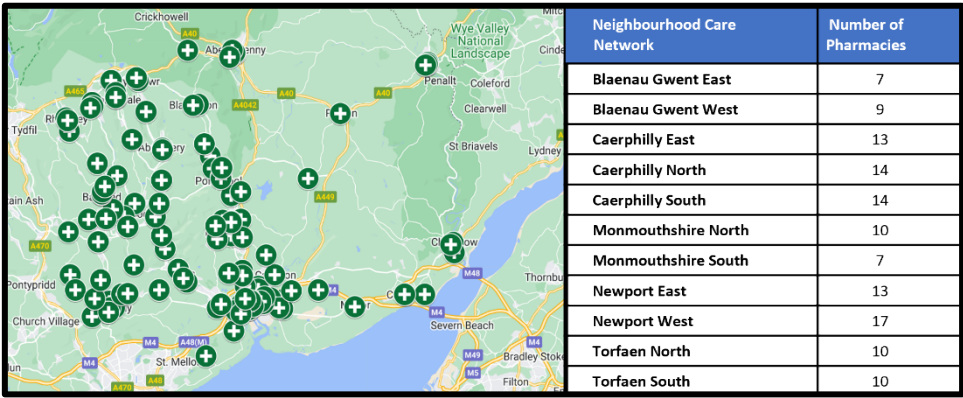
Our healthcare system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality by organisation providing care, location where care is delivered or personal characteristics (such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status, political affiliation). We embed equality and human rights in our health care system.

7.1 Community Pharmacy Services

One hundred and twenty-five community pharmacies provide NHS pharmaceutical services to the citizens of ABUHB in accordance with the terms of service laid out in the NHS Pharmaceutical Services (Wales) Regulations 2020. Alongside dispensing services, the pharmacies provide a range of additional clinical services commissioned using provisions in the Pharmaceutical Services (Clinical Services) (Wales) Directions 2022. As independent contractors, community pharmacies also provide private services outside the remit of the NHS terms of service. These private services include delivery, provision of compliance aids and clinical services such as travel vaccinations.

7.1.1 Pharmacy distribution and opening hours

Community pharmacies are distributed across ABUHB according to previous historical arrangements for control of entry.



Community pharmacies must open for 40 “core” hours to provide NHS pharmaceutical services. They may also open for additional “supplementary” hours. The health board must be notified of all changes to opening hours but only core hours need health board consent for change.

Opening hours range from 8 am to 8 pm Monday to Saturday, with some pharmacies opening between 10 am and 4 pm on Sundays. Most pharmacies are open between 9 am and 6 pm Monday to Friday, and just over half open for at least part of the day on Saturday. Eight pharmacies open on Sundays.

In 2024-25 eleven pharmacies reduced their opening hours including ceasing trading on Saturdays. Nine of these involved a change to core hours. This continues an ongoing trend to reduce total opening hours to maintain viability.

7.1.2 Contract Monitoring

In 2024-25, fifty-five pharmacies received contract monitoring visits, with 49 fully compliant with the terms of service during the monitoring period. Remedial notices were needed to effect change in 13 cases, and 9 breach notices were issued.

7.1.3 Performance Related Sanctions

During 2024-25, one hundred potential breaches of the NHS Terms of Service were investigated, and 13 breach notices issued.

7.1.4 Information Governance

Community pharmacy professionals’ access to NHS data sources (Choose Pharmacy) is monitored using the National Intelligent Integrated Audit Solution (NIIAS) system. During 2023-24, twenty-nine potential breaches were identified, documented and communicated to superintendent pharmacists for investigation and appropriate action.

7.1.5 Patient Safety Incident Reporting

Community pharmacies are obliged by their NHS term of service to report patient safety incidents to the Once for Wales Primary Care Wales National Incident Reporting tool, DATIX Cymru. The nature of the system means that all reports come to the ABUHB community pharmacy lead and a medicines management technician for receipt and closure. Responsibility for investigation and management lies with the pharmacy contractor. During 2024-25, four hundred and six incidents were receipted and closed. For context, over sixteen million prescription items and 100,000 patient consultations were completed during the same period.

7.1.6 Service commissioning

Alongside dispensing services, the clinical services listed below are also commissioned by the health board. The services are directly commissioned via 1234 individual SLAs stipulating provision in line with agreed national or local service specifications. NHS Wales Shared Service Partnership manage an additional 355 agreements for the Clinical Community Pharmacy Service, Seasonal Influenza, and the Pharmacist Independent Prescriber Service.

Service name	Number of pharmacy providers
Care Home Support	4
Clinical Community Pharmacy Service • Common Ailments • Emergency Contraception • Emergency Supply	125
Seasonal Influenza	124
Covid vaccination service	5
Blood Borne Virus	8
Directly Observed Therapy	commissioned on demand
Discharge medication Review	125

Inhaler use review	43
Medicines Administration Record Supply	106
Needle Exchange	27
Out of hours rota	64
Palliative Care Out of Hours	9
Pharmacist Independent Prescriber	55
Prison supply service	1
Smoking cessation level 2	123
Smoking Cessation level 3	93
Sunday rota	25
Supervised Consumption	115
Tuberculosis Compliance Support	2
Urgent Medicines Supply	23
Waste Reduction Intervention	107

7.1.7 Community Pharmacy Activity

During 2024-25 ABUHB community pharmacies:

- Dispensed 16,597,551 prescription items (+1.3 %)
- Provided:
 - 70,435 supervised medication doses (+12 %)
 - 70,637 Common Ailments consultations (+32 %)
 - 23,256 Emergency Supply consultations (supplying 40,458 medicines) (+28 %)
 - 14,563 Seasonal Influenza vaccinations (+3 %)
 - 24,671 Pharmacist Independent Prescriber consultations (+111 %)
 - 4,602 Emergency Contraception consultations (+8 %)
 - 2,376 Medicines Administration Record Charts (-32 %)
 - 2,494 Discharge Medication Reviews (+4 %)

7.2 Prison services

ABUHB is responsible for overseeing healthcare and pharmacy services at HMP Usk and HMP Prescoed. Between April 2024 and April 2025, the prison pharmacy team has continued to enhance service delivery in alignment with both local and national healthcare objectives, as well as key health and justice priorities. These efforts aim to ensure equitable access to healthcare for all residents and to foster innovation in pharmaceutical care within the prison setting.

7.2.1 Pharmacy Provision

Medication supply to both HMP Usk and HMP Prescoed continued to be provided by Raglan pharmacy. The prison pharmacy team works closely with Raglan pharmacy to ensure timely access to medication, with robust processes in place to address medication queries and shortages efficiently.

7.2.2 Prison Pharmacy service

The prison pharmacy team structure is headed by a Lead prison pharmacist (0.2 WTE), a prison pharmacist (0.4WTE) and two band 5 pharmacy technicians (1.42 WTE).

To ensure service sustainability and emergency preparedness, an education programme is being developed to enable the wider MM team to provide support when needed.

Specific prison pharmacist work included:

- face-to-face clinical reviews with prisoners.
- support for rising numbers of prison transfers under the Temporary Presumptive Re-categorisation Scheme (TPRS).
- targeted medication reviews, particularly focusing on codeine use, resulting in a significant reduction in prescribing.
- enhanced pharmaceutical oversight of high-risk medications, including Shared Care Medicines, in line with ABUHB guidelines.

Work by the prison pharmacy team included:

- active participation in Mental Health and Wellbeing events.
- ongoing support for mental health services, including clozapine monitoring.
- collaborative work with prison staff to ensure safe access to over-the-counter medications (e.g., ibuprofen and paracetamol) outside of healthcare hours, supported by new SOPs, audits, and safety posters.
- increased audit and reporting contributions to MM, Drug Strategy, Prison Delivery Group, and Prison Partnership Board meetings.
- continued engagement with DHCW to facilitate rollout of the Electronic Prescription Service (EPS) at both sites.
- continued development and review of SOPs.
- review of Continuous Glucose Monitoring (CGM) practices to ensure safe use and proper education for staff and patients.
- cell medication checks conducted by pharmacy technicians to identify compliance and safety issues.

At the 2024 AWTTTC Best Practice Day the team presented "A Pharmacy Team's Novel Approach to Supporting Medication Adherence in the Prison Population".

The prison pharmacy team continues to network and engage in all Wales activities including:

- Being visited by the Deputy Chief Pharmaceutical Officer for Wales
- Meeting with Public Health Wales on antimicrobial stewardship in prison
- Participating in the Prescription Roadmap for Wales discussions

HMP Prescoed is scheduled for expansion in 2025, with an additional 80 residents. Although this expansion is currently on hold, preparatory work is ongoing to ensure the pharmacy team is equipped to support the increased population when the expansion proceeds.

7.3 Vaccination Service

Since becoming the vaccination service directorate in September 2024, the pharmacy vaccination team has continued to evolve. The team provides a core immunisation resource to support improving uptake rates, address vaccine inequities and mobilise a response to outbreaks and emerging risks. The service is key to the implementation and delivery of the National Immunisation Framework within the health board. The team consist of 6 WTE band 4 senior pharmacy assistant staff, managed by a band 6 senior pharmacy technician, with a band 8b Lead pharmacist overseeing the team.

In addition to delivering the Spring and Autumn Covid-19 vaccine programmes, the pharmacy team has supported with increasing the uptake of child and adult flu vaccines and been involved with the delivery of the new respiratory syncytial virus (RSV) vaccine programme. The RSV pregnancy catch up programme was delivered in antenatal clinics and regular clinics held for eligible older adults and pregnant women whose GP practices were not participating in the programme. The pharmacy team monitor RSV vaccine ordering for commissioned GP practice sites, to ensure orders placed were in line with cohort size and expected uptake rates to reduce waste.

The service vaccine storage and distribution hub is located at Llanfrechfa Grange Hospital site, running vaccination clinics in a variety of community centres and hospital outpatient departments across ABUHB. In addition, a new vaccination centre was opened in Cwmbran town centre. This site opens 6 days a week and provides open access to all vaccines on the routine immunisation schedule, for patients having difficulty accessing vaccines through the usual pathways or require more information about vaccines.

The team has been key to the implementation of central procurement of flu vaccine, working with the primary care GMS team, the community pharmacy lead and hospital procurement team to co-ordinate and validate flu vaccine orders from all commissioned primary care sites and for the occupational flu campaign. During flu campaign the team has a central role in overseeing cold chain and stock management for all primary care sites.

8. Person Centred

Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.

8.1 Patients

8.1.1 Secondary Care

Several developments were enacted during 2024-25 within the secondary care sector to improve person-centred care. These changes were essential, both to maintain pharmacy services during times of severe staff shortages/vacancies, as well as providing opportunities for staff to upskill, learn new skills and improve job satisfaction.

8.1.1.1 Bone health clinic

In 2024-25 pharmacists in RGH successfully piloted and secured funding for pharmacist independent prescribers to work within the Bone Health and Fracture Liaison Service to review patients.

8.1.1.2 Mental Health

Following the 2022 business case for the repatriation of clozapine services, the recruitment of a band 8a pharmacist in 2024/25 has enabled dedicated pharmacy support across adult mental health inpatient beds. This has been complemented by the development of a new team of 8a directorate pharmacists and a strategic restructure, including the restructure of band 7 pharmacist resource from RGH to NHH, pharmacy technician resource and optimisation of pharmacy technician roles to better meet service needs.

Significant progress has also been made with the establishment of a specialist perinatal mental health pharmacist role, in line with national guidance (CR232), following a successful pilot and investment from the Mental Health Division. However, the service faces ongoing risks related to workforce development, particularly the limited training opportunities for band 6 and 7 pharmacists within Mental Health. A business case is planned for 2025/26 to support succession planning and ensure long-term service resilience.

8.1.2 Homecare

The homecare service continued to expand during 2024-25, providing over 115 different therapies to the clinical teams. The total number of patients managed via homecare increased from 2,324 to 2,807, an increase of 20.8%.

Financial savings delivered by avoiding VAT liability totalled £ 2.96 million. The use of best-value biosimilars focussed upon ustekinumab, and a transition of neurology patients on Aubagio®, Gilenya® or Tecfidera® to generic equivalents. Switches to more cost-effective therapies reduced the increase to less than the 3.6 % increase seen within non-homecare secondary care expenditure.

The total value of medication provided via homecare was £ 14,812 million – up by 9.8 % on last year, accounting for over 24 % by value of all secondary care medicine expenditure.

ABUHB expenditure on high-cost medicines procured through secondary care now accounts for 66% of all medicine spend, of which one-third is provided via homecare. However, growth in homecare services has not kept pace with the overall growth in total high-cost medicines expenditure, indicating further potential for additional savings in the forthcoming financial year. Out-of-area recharging reports have identified supplies of high-cost medication made to patients residing outside of ABUHB totalling £2.351 million, of which £180,000 was made to patients of NHS England.

Use of homecare services by the Medicine Division now accounts for 57% of the overall total, up by 4% from last year. The largest growth was seen within Neurology and Respiratory, with Cardiology and Renal teams starting to use homecare for the first time. Within Scheduled Care, the Dermatology directorate saw significant growth in patient volume. Mental Health homecare services closed, with the relevant therapies now provided via secondary care. An increase in VAT liability, was offset by buying medication at All-Wales contract price, and reduction in waste.

2024-25 saw the introduction of the Pharmacy Workforce Development South (PWDS) Prescription Verification and Clinical Validation Training Programme. This is a programme training and assessing pharmacy technicians who handle homecare prescription verification and/or clinical validation of homecare prescriptions before they are dispensed by an external homecare company. This focussed on four medicines within the Neurology and Respiratory directorates.

A checking framework was developed by the directorate pharmacist to guide the pharmacy technician and ensure work is within their scope of practice, improving turnaround times and enhancing efficiencies in the service.

Homecare prescriptions are now tracked from start to finish, enabling identification of 'bottlenecks' and improving patient care.

Homecare service data

Directorate	Homecare Services				Homecare				Non-Homecare	
	No of Pts	Absolute Change	% Change	% total	Fees	HCD Issues	Other Drugs	% total spend	HCD Issues	Other Items
Cardiology	1	1	-	0%	£0	£0	£0	0%	£0	£970
CotE	58	47	427%	2%	£6,174	£139,884	£10,066	10%	£135,650	£1,270,721
Endocrinology	4	0	0%	0%	£0	£0	£0	0%	£72,363	£197,486
Gastroenterology	630	70	13%	22%	£65,612	£2,496,752	£24,537	37%	£3,704,745	£545,715
Neurology	489	164	50%	17%	£49,020	£2,700,415	£0	53%	£2,195,177	£237,876
Renal	1	1	-	0%	£0	£1,981	£0	7%	£0	£26,868
Respiratory	406	83	26%	14%	£81,713	£1,979,276	£0	69%	£415,754	£478,085
Other									£181,573	£2,254,393
Medicine	1589	366	30%	57%	£202,518	£7,318,308	£34,602	39%	£6,705,262	£5,012,115
Dermatology	471	85	22%	17%	£41,230	£2,052,278	£0	93%	£91,173	£55,022
Haematology	203	49	32%	7%	£52,994	£2,286,492	£865,71	28%	£7,077,483	£856,289
Rheumatology	493	36	8%	18%	£21,934	£2,001,165	£33,764	94%	£94,634	£31,099
Other									£7,266,782	£5,444,279
Scheduled Care	1167	170	17%	42%	£116,15	£6,339,935	£899,47	26%	£14,530,07	£6,386,689
Mental Health	0	-66	-	-	£0	£53,802	£0	4%	£739,214	£519,223
F & T	51	13	34%	2%	£9,848	£166,729	£0	6%	£1,849,250	£654,852
Other					£0				£3,596,320	£8,098,432
GRAND TOTAL	2807	483	21%	100%	£328,525	£13,878,775	£934,082	24%	£27,420,119	£20,671,312

8.1.3 Community Resource Team (CRT)

The CRT pharmacy team has had a challenging year. After being awarded Regional Integration Fund (RIF) extension funding in October 2023, the team recruited 8 new posts as part of system resilience: 3 pharmacists (band 8a); 3 pharmacy technicians (1 band 6 and 2 band 5); 2 pharmacy assistants (band 3).

The team remains fully staffed and has worked innovatively ensuring continuity of service throughout. The team remains cohesive and dynamic, supporting each other, either remotely or in person, in times of extra pressure, across ABUHB.

The team has:

- Rolled out the CRT pharmacy service across all 5 Local Authorities.
- Provided cover across all local authorities to improve consistency of service.
- Provided a proactive approach, visiting vulnerable/at risk patients for medicines review at home.
- Provided a new innovative pharmacy technician-led ward pharmacy service to County and Chepstow Community Hospitals.

Progress has been made in all areas including community falls, rapid medical and reablement and interventions, deprescribing and bone health prescribing. Patient/carers feedback showed 100% satisfaction.

The new Community Hospital ward pharmacy service improved availability of discharge medicines and saw an increase in the number of clinical interventions made. Patients were supported to be independent with their medicines administration post discharge with follow-up home visits as needed.

Questionnaires were sent out to County Hospital ward staff and 100% responded with 'very satisfied' to questions relating to the pharmacy service provided. At baseline, the majority of respondents were 'very dissatisfied' with the previous remote pharmacy service provided by the acute pharmacy service which had resulted from staff vacancies and conflicting priorities. Comments from recent questionnaires included:

"The pharmacy team have an excellent working relationship within the MDT and are an invaluable part of the site team"

The CRT pharmacy service placed emphasis on ensuring the right staff skill-mix was in place, enhancing the role of pharmacy technicians to provide clinical interventions and improving safety of the frail elderly patients (with remote pharmacist support).

Pharmacy assistants have joined the team visiting patients undertaking inhaler technique checks and identifying adherence issues, as well as processing WP10HP prescriptions to Community Pharmacies and chasing/checking stocks (previously carried out by registrants). Other work includes providing support to the ward pharmacy service in Chepstow and County Hospital sites. These roles have freed up pharmacy technician and pharmacist time.

8.1.4 Care Homes

The care home pharmacy team recruited an additional pharmacy technician in November 2024 to join their pharmacist, a lead pharmacy technician and existing pharmacy technicians. As part of complex care, the pharmacy team liaise with governance nurses and support them on visits to resolve medication issues.

Since April 2024, the team have:

- visited 39/46 nursing homes to conduct MM audits. This included giving practical advice, providing in-depth written reports containing suggested MM improvements, as well as identifying covert forms, medication and MAR charts requiring review. A targeted report was also sent to the supplying community pharmacy and GP surgery.
- commenced use of care home audit software available on Coordinate Rx (formerly MedOptimise) providing improved accuracy of reporting and a populated dashboard of completed audits, identifying poor areas of practice and themes to focus on.
- assisted care homes with monthly ordering cycle following audit visit. Savings were made by ensuring only items needed were ordered.
- delivered training and education sessions on CD management. A training pack and poster were sent to all homes which included best practice and mandatory training for staff.

- provided education to care home staff to promote safe use of medication, encourage more cost-effective practices, reduce medicine waste and offering practical support on medication ordering.

The Care Home pharmacist completed the NMP qualification and produced work for the Bevan Commission.

- Medication reviews completed across 7 Care Homes provided baseline data for the Bevan Exemplar. The process involved reconciling medication between the MAR and PMR, discussing additional monitoring with nursing staff, remotely completing an in-depth medication review.
- The transcribing policy for district nurses was adapted for use by complex care nurses in the care-at-home team.
- Medication administration sessions were provided to HCSW in the care-at-home team alongside the Complex Care education team, with resources created to raise awareness and improve MM knowledge.

8.2 Staff and resources

8.2.1 Staff Profile

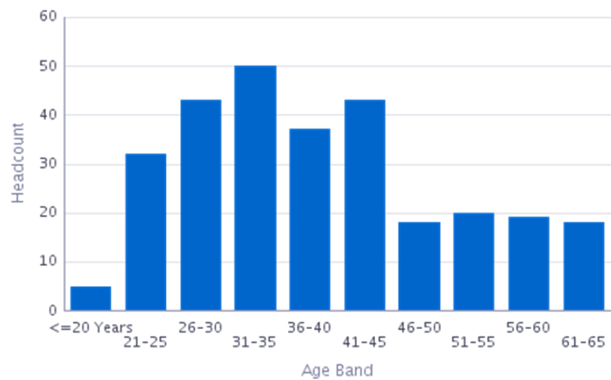
The pharmacy directorate has evolved its workforce in all sectors in line with the ABUHB Pharmacy Clinical Futures workforce plan (and Delivering a Healthier Wales), ensuring skills, expertise and practice are aligned to provide the highest value for local demographic needs. This has included advancing practice and roles for pharmacist, pharmacy technicians and pharmacy assistants, including developing the role of the clinical pharmacy technician and further embedding of pharmacist NMPs into intermediate, primary and secondary care services.

HEIW benchmarking of pharmacy services demonstrates that ABUHB continues to have a substantially lower number of pharmacy staff (hospital and primary care) per 10,000 population across all bands, when compared to other health boards.

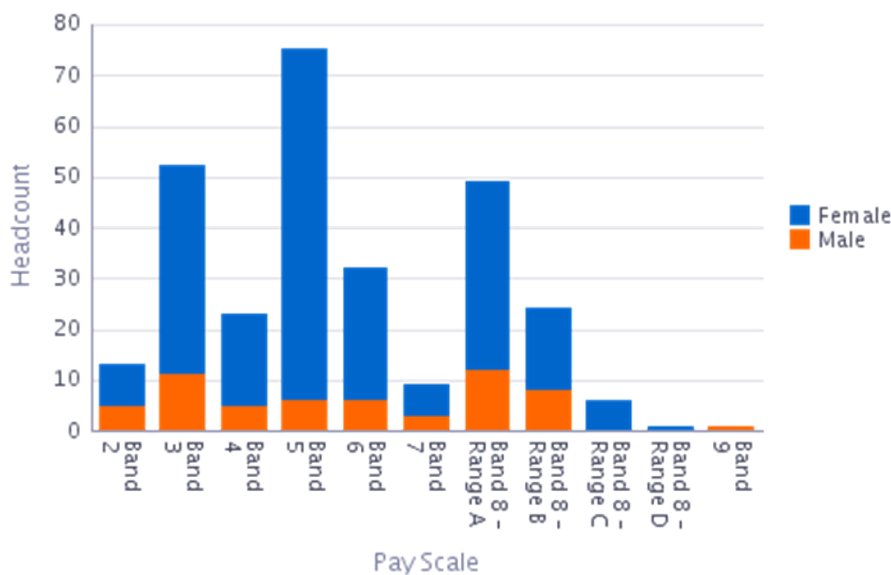
Health board	Population estimated 2024	All pharmacy Staff FTE April 2025	All pharmacy staff FTE/ 10k population
Aneurin Bevan	601,686	273.25	4.54
Betsi Cadwaladr	697,115	489.97	7.03
Cardiff and Vale	519,662	372.33	7.16
Cwm Taf Morgannwg	449,346	310.24	6.90
Hywel Dda	389,160	241.84	6.21
Powys	135,059	28.04	2.08
Swansea bay	394,553	316.22	8.01
All Wales	3,186,581	2,032	6.38

This issue was also identified in the Wales Audit Office review of MM for ABUHB. The low staffing levels impact on ability to deliver services and limit opportunities for staff training and development.

The age profile of the pharmacy team across all sectors shows 20% of the team are over the age of 50.



80% of pharmacy staff are female.



8.2.2 Primary care

The primary care pharmacy team is made up of the core MM team of pharmacists and pharmacy technicians which include the formulary pharmacist, the community pharmacy care home, prison, antimicrobial and diabetes cardio-renal project teams. Following retirement and restructure, 2 new posts were developed and recruited to, in order to support the team - a band 8a Governance pharmacist and a pharmacy support officer.

April 2024 saw the line management of the Neighbourhood Care Network (NCN) pharmacists move to Locality leads. The senior pharmacist and lead pharmacists continued to support the pharmacists on an advisory level and attending annual appraisals (PADRs).

At the request of the Divisional Director, in November 2024, the community pharmacy team, made up of the Community Pharmacy Advisor and Service Development Manager, were moved to the primary care contracting team.

8.2.3 Secondary care

The secondary care pharmacy workforce remains on the national staff shortage list and faces major ongoing challenges in the recruitment and retention of highly skilled and trained staff.

Current ABUHB acute/secondary care pharmacy staffing levels, benchmarked as number of staff per 100 beds, are below both national and Welsh averages. Total WTE in post per 100 beds is 16.4, whilst total WTE in establishment per 100 beds is 19.5, reflecting current vacancy rates.

Acute pharmacy team vacancy rates are 13% (Wales mean 5.8%), placing ABUHB in the upper quartile of peers. The pharmacist vacancy rate is 13% (Wales mean 7.4%), also in the upper quartile. There is a clear vacancy issue with band 7 pharmacists, where ABUHB currently has a 50% vacancy rate compared to the national average of 31%, resulting in a substantial impact on delivery of ward-based services across all sites. Due to the high pharmacist vacancy rate, the pharmacy team relies more heavily on pharmacy technicians compared to peers nationally.

Pharmacy technician roles are a pivotal driver for future development and opportunities across pharmacy services. The requirement for pharmacy technician roles is anticipated to exponentially increase across all sectors. The pharmacy directorate have instigated several pieces of work to meet this demand, including developing new pharmacy assistant roles (band 2/3) to reduce identified staffing gaps and to enable release of pharmacy technician resource to take on more advanced roles.

Retention of band 6 and 7 pharmacists continues to be a significant issue as pharmacists move for promotion to 8a posts in other sectors or neighbouring health boards. ABUHB also has the additional challenge of losing staff across the border to England. Staff are also leaving for portfolio/split role working opportunities which is offered in other sectors. Work has been undertaken exploring new roles to mitigate this risk, such as split HEIW/ABUHB band 7 roles.

8.2.3.1 Pharmacy Assistant Role Development

The pharmacy assistant role has huge potential to positively impact overall pharmacy staffing and the roles of the team. With the upskilling of both pharmacists and pharmacy technicians to step into expanding clinical and technical roles, backfilling with pharmacy assistants is an essential component to ensure medicine supply, ward stocks, patient counselling and similar tasks are maintained across the ABUHB acute sites. The pharmacy directorate recognise that this staffing group is a pre-requisite for continued role redesign; and continue to prioritise the role with opportunities for development and progression. This includes plans to implement pharmacy assistant accuracy checking roles across secondary care.

8.2.3.2 Workforce Development Documents

The directorate continues to build on a suite of documents to serve as key tools in workforce development across all sectors. These promote clear setting of expectations and outline opportunities for personal and professional development for all staff.

The "Pharmacy Career Pathway" and accompanying "Roles and Responsibilities" guidance, give examples and standards of performance in each AFC band for each staffing group. Recent work includes a NMP PADR document and specialist training pathway documents. These are linked directly to the Pharmacy Vision and Mission Statement launched in 2024, and it is intended that this work will be built upon collaboratively with staff.

8.3 Training and Education

The pharmacy team across primary and secondary care works closely with HEIW and universities to provide training and education to undergraduate pharmacy students, pre-registration and post graduate pharmacy staff.

8.3.1 Undergraduate Training

To support implementation of the first year (24/25) of the HEIW Funded Pharmacy Undergraduate Placement Programme (FPUPP), ABUHB pharmacy hosted 120 students across the 4 Acute sites. The whole pharmacy team was involved in delivering high-quality training to allow students to gain first-hand hospital experience and build clinical and professional skills to support graduating as future NMPs in 2026.

The students have had a wide-ranging experience within the services, to develop and hone skills in areas such as MDT working, medication counselling, medicines optimisation, clinically screening prescriptions etc. From the most junior members of the team, to the most senior, everyone has demonstrated a strong commitment to create a supportive and encouraging learning environment for all trainees. This was delivered despite a backdrop of substantial vacancies within the team. The programme has gained overwhelming positive feedback on the placements from students, HEIW and the Universities.

8.3.2 Staff training

Widescale whole system changes have been enacted through recent changes in the GPhC initial education and training standards (IETP) for pharmacists and pharmacy technicians, which has been felt across all sectors and services in the health board.

As part of the commitment to positively engage with these changes, the directorate has invested in the creation of 4 new secondary care specialist Education and Training

(E&T) 8a pharmacist roles. Existing and new HEIW funding opportunities were utilised to provide these highly skilled roles embedded in acute site teams - to facilitate whole scale staff upskilling and support for delivery of all education and training programmes. The 4 roles were recruited between Sept and Nov 24 and have had resounding positive impact across the workforce, including supporting the roll out of the new HEIW FPUPP.

These 4 new roles join the existing Education and Training team, totalling 7 pharmacists and 1 pharmacy technician. Over the last year, a reset of roles and responsibilities has allowed maximum value and impact across the workforce. However, a key issue has been identified in the lack of sufficient dedicated resource based in primary care. At present, there is only an overarching 8C Principal Pharmacist Education and Training/Workforce Modernisation (0.6WTE) role to cover primary care, CRT and secondary care. With the number of changes to education and training and requirements for advancing practice, the directorate recognised increased investment in embedding key education and training specialist posts across sectors would be transformative, and further investment is being explored for a role in primary care. These specialist roles will continue to act as conduits to support the delivery of high quality, effective training and development for all staff and allow ABUHB to successfully meet and overcome the training and development challenges, both now and in the future.

8.3.3 Academy

The Lead Pharmacist Primary and Community Care Academy has developed a recruitment programme to support pharmacy staff in primary care and GP practices.

The academy successfully recruited to 2 posts:

- Primary and Community Care Academy pharmacy technician based in a GP practice.
- Post registration Foundation pharmacist to rotate through primary care and community pharmacy whilst undertaking the HEIW Post-Registration Foundation programme with Cardiff University.

Initial work has been started with primary and secondary care to develop a training programme for multi-sector pre-registration pharmacy technician posts.

8.3.4 Continued Professional Development

The pharmacy directorate continues to focus on opportunities for workforce development wherever possible and fully engages with the utilisation of available resources such as the HEIW Advanced Practice funding to support this agenda.

A range of development including formal, in-house and opportunistic professional development has been successfully utilised by staff. The pharmacy team provide an in-house monthly learning@lunch program open to all staff across primary care, secondary care and CRT.

In primary care, a quarterly practice pharmacist meeting is held at GUH Education Centre. This provides education and training session for NCN and directly employed pharmacists.

8.4 Non-Medical Prescribers (NMP)

Pharmacist NMPs can prescribe any medicine for any medical condition within their area of competence and scope of practice.

At the end of March 2025, there were 64 pharmacist NMPs on the ABUHB register:

- 18 NCN
- 8 primary care
- 3 managed practices
- 3 CRT
- 32 secondary care

These numbers represent a large number of the pharmacist workforce in patient facing roles. ABUHB is committed to ensuring all legacy workforce pharmacists in appropriate roles will either be in NMP training or will commence training over the next 12 months.

Pharmacy continues to work collaboratively with other professions across the health board, to address the requirements of the HEIW national standards for competency assurance and implement the new [Non-Medical Prescribing Policy \(2024\)](#).

ABUHB Pharmacy Vision

"To deliver a gold standard of excellence in everything we do, for the benefit of all"

