Patient, Quality, Safety Outcomes Committee

Tue 29 July 2025, 09:30 - 12:30

Microsoft Teams

Agenda

0 min

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Draft Minutes of the last Meeting held on Tuesday 3rd June 2025

Attached *Chair*

PQSOC 20250729 1.4 PQSOC 20250603 Minutes - Approved.pdf (13 pages)

1.5. Committee Action Log

Attached *Chair*

PQSOC 20250729 1.5 Committee Action Log.pdf (2 pages)

0 min

2. ITEMS FOR DISCUSSION

2.1. Quality Outcomes Reporting

Attached *Director of Nursing*

PQSOC 20250729 2.1 Quality Outcomes report .pdf (5 pages)
PQSOC 20250729 2.1 Quality Outcomes report - Appendix 1 Quality Outcomes Framework .pdf (103 pages)

2.2. Quality Management Group Reporting

Attached *Director of Nursing*

PQSOC 20250729 2.2 Quality Management Group report.pdf (3 pages)

2.3. Safeguarding Annual Report

Attached *Director of Nursing*

PQSOC 20250729 2.3 Safeguarding Annual Report .pdf (10 pages)
PQSOC 20250729 2.3 Safeguarding Annual Report - Appendix 1 .pdf (22 pages)

2.4. Learning from Death Report

Attached *Medical Director*

PQSOC 20250729 2.4 Learning from Death report .pdf (7 pages)

PQSOC 20250729 2.4 Learning from Death Report - Appendix 1 .pdf (64 pages)

2.5. Committee Risk Report

Attached *Director of Corporate Governance*

PQSOC 20250729 2.5 Committee Risk Report .pdf (5 pages)

PQSOC 20250729 2.5 Committee Risk Report - Appendix A_Strategic Risk Assessment and Dashboard.pdf (7 pages)

0 min

3. FOR INFORMATION

3.1. Review of Committee Programme of Business 2025/26

Attached *Director of Corporate Governance*

PQSOC 20250729 3.1 Review of Committee Forward Work Plan 2025-26.pdf (4 pages)

PQSOC 20250729 3.1 Review of Committee Forward Work Plan 2025-26 - Appendix 1.pdf (7 pages)

0 min

4. OTHER MATTERS

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

Oral *Chair*

4.2. Any Other Urgent Business

Oral *Chair*

4.3. Date of the Next Meeting: 1st October 2025

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

MINUTES OF THE PATIENT QUALITY, SAFETY AND OUTCOMES COMMITTEE MEETING

DATE OF MEETING	Tuesday 3rd June 2025, 09:30am-12:30pm
VENUE	Microsoft Teams

PRESENT	Helen Sweetland, Independent Member, Committee Chair Penny Jones, Independent Member, Committee Vice Chair Paul Deneen, Independent Member Philip Robson, ABUHB Vice Chair
IN ATTENDANCE	Jennifer Winslade, Director of Nursing James Calvert, Medical Director Peter Carr, Director of Allied Health Professions & Health Science Leanne Watkins, Chief Operating Officer Rani Dash, Director of Corporate Governance Leeanne Lewis, Assistant Director of Quality & Patient Safety Arvind Kumar, Interim Divisional Director (Clinical Support Services) Tracey Partridge-Wilson, Deputy Director of Nursing Karen Hatch, Assistant Director of Therapies and Health Science Naomi Murtagh, Board Business Manager Moira Bevan, Head of Service Infection Prevention and Control Nurse Collette Kiernan, Clinical Director of Therapy Services Ann-Marie Matthews, Lead for Clinical Commissioning Thomas Jaynes, Committee Secretariat Gavin Thomas, Committee Secretariat
OBSVERING	Rhian Gard, NWSSP - Audit and Assurance Services Sara Utley, Audit Wales
APOLOGIES	None

PQSOC 0306/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
PQSOC 0306/02	**Apologies for Absence** The Chair confirmed that there were no apologies for absence.

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PQSOC 0306/03	**Declarations of Interest** There were no declarations of interest raised relating to items on the agenda.
PQSOC 0306/04	**Minutes of the previous meeting** The minutes of the Patient Quality, Safety and Outcomes Committee held on 31st March 2025 were agreed as a true and accurate record of the meeting. The Committee **APPROVED** the draft minutes.
PQSOC 0306/05	**Committee Action Log** The Committee received the action log and was content with progress made in relation to completed actions and against any outstanding actions. The Committee **APPROVED** the action log.
PQSOC 0306/06	**Quality Management Framework** Jennifer Winslade (JW), Director of Nursing, presented the report for approval and discussion. It was highlighted that, in line with the Duty of Quality in Wales, there had been a strategic shift towards the development of Quality Systems. The framework was intended to provide assurance regarding the overall Quality Management System. JW advised the Committee that the framework was strategically aligned with the following key national and organisational priorities: • The Health and Social Care (Quality and Engagement) (Wales) Act 2020, including the Duty of Quality and Duty of Candour; • The Health and Care Quality Standards 2023, underpinned by the principles of Safe, Effective, Patient-Centred, Timely, Efficient, and Equitable care; and • The ABUHB Quality Strategy 2023–2026, which sets out the Health Board's vision for quality improvement. It was noted that the framework would be in place for a three-year period (2025–2028) and would inform the development of the Quality Annual Report to Welsh Government. The Committee noted that the framework was embedded within the Health Board's overarching Quality Strategy. JW further highlighted that the framework integrated national guidance, including from Improvement Cymru and

	Healthcare Inspectorate Wales, and supports the Quadruple Aim through a structured approach encompassing Quality Planning, Control, Improvement, and Assurance. The Committee noted that the framework had received executive oversight, and had been discussed with clinicians and managers. The Committee noted the Quality Management system principles and noted that the framework would improve quality management and quality outcomes in accordance with the Health and Quality Standards 2023. JW advised that a Clinical Advisory Forum was in place with input from clinical professionals across the Health Board which provided Quality Impact Assessments, as a clinical viewpoint to advise Executives on any proposed changes, which feed into the planning of quality management. The Committee noted that this also provided leadership with a focus on quality, that is embedded throughout the Health Board. The Committee was advised that there were Quality Control principles embedded across the Health Board connected to daily operational management, to ensure quality and patient safety was monitored in real time. The Committee noted the Health Board's six pillars of quality had been reviewed and that a revised Quality Outcome Framework would come to the Committee for approval for Q2, after testing on Q1 data. It was noted that a new governance framework was being developed on how people report, what and when they report things / incidents. Rani Dash (RD), Director of Corporate Governance, outlined the three lines of defence model of organisational system assurance which underpinned the risk and assurance framework as part of the assurance framework. The Committee noted this approach was being worked on and would be embedded throughout the Health Board. Peter Carr (PC), Director of Allied Health Professionals and Health Science, informed the Committee of the work being done by the Health and Safety Committee to strengthen and improve its activities. The Human Tissue Authority, Medical Devices, and Radiation Protection Group were all governed by regulation and their compliance with quality was very important. The Committee noted all groups in the new framework were reviewing their purpose and their Terms of Reference. The names would be changed from Committees to Groups.

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	The new Quality Management Group (QMG), would be led by executives and will deal with operational matters. The QMG will receive input from the groups (within each pillar) in the Quality Assurance Framework and the QPS Divisional assurance meetings. The QMG will report to the Executive team. The Committee was advised that high level reports covering the groups within the pillars, clinical learning and improvement forum, clinical advisory forum and the divisional QPS meetings would now come to PQSO from the QMG for assurance. The Committee noted the new reporting arrangements. JW reported that reporting arrangements had also been reviewed. A quarterly narrative report will go to Board. Quality metrics would be embedded in an integrated performance report for Board. PQSO will receive a revised QOF and an exception report from QMG. Helen Sweetland (HS), Chair, welcomed the review and the changes to the new format and structure of reporting and responded to Audit Wales recommendations. HS thanked the team for all the work that had been undertaken. Paul Deneen (PD), Independent Member, queried how this would link into commissioning of external services and how it would ensure quality standards and reporting were the same as those within services directly provided by the Health Board. The Committee was advised that reporting of commissioning for quality would be monitored through the respective divisions and the Quality Management Group in-line with the Commissioning for Quality Framework. PD asked how the team would ensure that staff understand these new arrangements and JW explained that this will be done via the Divisional QPS leads. The Patient Quality Safety and Outcomes Committee **ENDORSED** the implementation of the Quality Management System Framework.
PQSOC 0306/07	**Quality Performance and Outcomes Report** Jennifer Winslade (JW), Director of Nursing, introduced the report for assurance and updated the Committee on the work of the QPS team. The Committee noted the team had restructured and operational patient safety resources had been transferred centrally. The Committee was advised that

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the QPS team was fully recruited and a revised QOF would be reported to the Committee.

Leeanne Lewis (LL), Assistant Director of Quality & Patient Safety, updated the Committee on the progress of Sepsis work and the Committee was advised that regular updates on sepsis would be included in the Quality Performance report. LL noted work was ongoing for a systematic approach to identify sepsis and the management of patients, by ensuring the use of NICE guidance and the Academy of Medical Royal Colleges guidance.

LL provided an update on a Welsh Health Circular on new early warning scores (NEWS) and standardised scoring systems with an implementation date of December 2025. The Committee was advised that the Health Board was responding via a number of working groups to standardise the audit framework and training for staff. An implementation plan had been developed by the Health Board.

Helen Sweetland (HS), Chair, queried how progress would be reported to ensure the efforts and education programmes were working. The Committee was informed that the sepsis campaign was much wider than previous Sepsis campaigns as this includes engagement with the General Public. It was noted that reporting was being worked through and research was taking place in the Public Health team, based on qualitative research with the public to ensure the Health Board gets further information which provided themes for learning.

James Calvert (JC), Medical Director, highlighted the amount of work that had gone into this programme and thanked Matthew Kevadas, Nursing Lead for sepsis, for his exceptional work.

Paul Deneen (JD) asked whether the teams have engaged with General Practice and Llais about the Sepsis campaigns. LL explained that there have been meetings with Neighbourhood Care Networks and a meeting is planned with Llais.

JW updated the Committee regarding the two divisions that were in escalated measures for quality and informed the Committee of the ongoing work regarding the flow in Urgent and Emergency Care and 'Safe to start' to ensure site safety.

Peter Carr (PC), Director of Allied Health Professionals and Health Science, provided an update to the Committee

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	regarding the Nutrition and Hydration Group. This update was in response to recent incidents and focused on task-oriented actions to ensure that nutrition and hydration are consistently delivered on wards. The approach emphasised improved risk assessments, early identification of patients' nutrition and hydration needs, and timely escalation where necessary. The Committee noted an increase in the number of inquests due the work of Assistant Coroners and the impact of this the work on clinical staff, who have to write reports. Paul Deneen (PD), Independent Member, queried the ongoing delays in the issuing of death certificates. JC explained that the median number of days in Wales was 7 days for completion of a death certificate but could be up to 25 days and noted the distress to affected family members. The Committee noted the process was more complex in Wales than England as Medical Examiners who review all deaths are independent from HBs in Wales and this can delay the issuing of death certificates. The Committee was assured work was ongoing to monitor the situation and improve death certification delays. The committee was also informed of the work of the Care After Death team in ABUHB who support relatives. Their work is being reviewed currently to ensure it is staffed appropriately. Phil Robson (PR), ABUHB Vice Chair, queried Patient Safety Incidents and how these were triggered. The Committee noted these were usually triggered by staff but if a patient complains this could be triggered by the Health Board on the account provided by the patient via DATIX. Phil Robson asked how the team ensure that policies such as those related to nutrition and hydration for example are followed on the wards. JW explained that there is ward documentation that should be completed for each patient, which include risk assessments for many areas. The ward manager is accountable for ensuring the ward team appropriately complete these documents The Committee was **ASSURED** by the ongoing work to deliver the Duty of Quality and Duty of Candour, through implementing the Quality Strategy, Patient Experience & Involvement Strategy and the Quality Improvement Strategy.
PQSOC 0306/08	**Development, and Implementation of the Commissioning Assurance Framework**

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	Jennifer Winslade (JW), Director of Nursing, introduced the report for discussion and noted that the Committee had previously approved the approach for the commissioning the assurance framework for quality. The Committee was advised that a working group had been set up and had mapped all of the services the Health Board commissioned. Preliminary findings showed that there were inconsistencies in contract documentation, monitoring mechanisms and escalation procedures. This work was ongoing from a financial, planning and quality perspective. The Committee noted the working group would undertake a pilot and prioritise work on cancer services due to established quality data systems in place, with Velindre NHS Trust. The Committee noted the working group would now be formalised and the Committee was advised that the group would also look at how contracts ensure quality is embedded and how data was pulled on commissioned services. The Committee **ACKOWLEDGED** the progress achieved in this workstream to date and endorsed the proposed direction for further development, with a focus on enhancing quality in commissioned services.
PQSOC 0306/09	**Infection Prevention and Control & Cleaning Standards Annual Report 2024/25** Moira Bevan (MB), Head of Service for Infection Prevention and Control, introduced the annual report for information. MB highlighted the report had been written by divisions in conjunction with the Infection, Prevention and Control team. The Committee noted a number of awards won by the IPC team. The Committee noted Welsh Government Expectation Reduction targets had been missed apart from one exception. The Committee was informed that this was consistent across Welsh Health Boards. MB outlined actions that had been undertaken to improve infection, prevention and control which included; bespoke training for staff; enhanced cleaning regimes; task and finish groups had been set up on certain types of infections and QI projects on oral hygiene; intranet page had been refreshed as well as new communications for staff and public.

	The Committee noted a significant increase in community acquired patients presenting to secondary care which had increased pressure on the Health Board and performance. The Committee noted an increase in Clostridium Difficile (C.Diff) infection but was assured that the testing of 643 samples had identified 5 clusters which suggests onward transmission in only 9 cases. The Committee noted onward transmission was not spread across all sites. The Committee noted pressures caused in the Winter by influenza, covid and RSV, but point of care testing (POC) had enabled timely and appropriate placement of patients. The Committee noted a business case had not yet been developed for the IP&C team as funding had been secured for RIF until March 2027, but this is a potential risk. Penny Jones (PJ), Independent Member, noted that in the enhanced cleaning paper there was slippage in delivery due to capacity constraints and whether this had been overcome. PJ also asked about non-compliance with Welsh technical memorandum for oral / dental equipment cleaning. The Committee noted the slippages in the enhanced cleaning programme and that these had not been implemented in YYF and GUH but a new paper had been written to achieve the enhanced cleaning across Health Board sites. The Committee was assured C.Diff had reduced in YYF regardless. The Committee was advised that it has been decided that Ultra Violet light cleaning was going to be implemented rather than Hydrogen Peroxide, which were quicker. The Committee noted a service review for primary care dentists was taking place and there were funding for cleaning of oral stations. Paul Deneen (PD), Independent Member, queried what was being done to engage with visitors and the general public regarding infectious illnesses. The Committee noted leaflets were provided to hospital visitors to raise awareness of hygiene and infection control. JC reassured the committee that Health Protection Wales and Public Health teams provide regular updates on unusual infectious diseases and were working on important messaging to the general public regarding disease prevention. The Committee **NOTED** the Infection Prevention & Control Annual Report 2024-25 and Strategic Plan for 2025/26.

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PQSOC 3103/10	**Volunteering Annual Report 2024/25** Tanya Strange (TS), Head of Nursing, introduced the report and noted that volunteering across the Health Board continued to grow in scale, impact, and strategic importance. The Committee noted volunteering hours had doubled since the last annual report and five new volunteer roles (experts by experience) had been created. The Committee was informed that volunteers spoke a wide range of languages (40 in total) and twenty volunteers had subsequently become paid employees. The Committee noted the plan for 2025 to try and recruit volunteers who are deaf, LGBTQIA+, neurodiverse and veterans. The Committee noted work had increased with partners across Gwent and working relationships remained strong. The Committee noted challenges of a high case load of volunteers against 3.2wte in the department. The Committee noted 70 volunteers were in recruitment and 500 people, mainly in community, were awaiting to become a volunteer. The Committee was advised that a Charitable Funds bid had been written to request funding for a volunteer coordinator role. Paul Deneen (PD), Independent Member, welcomed volunteer awards as part of the Health Board's Staff awards. The Committee **NOTED** the Volunteering Annual Report 2024/25; **ACKNOWLEDGED** the growing scope, diversity, and impact of volunteer activity; **NOTED** the risks to service sustainability and **SUPPORTED** the ongoing development of the volunteering programme.
PQSOC 0306/11	**Mortuary Incident Action Plan** Leanne Watkins (LW), Chief Operating Officer, introduced the report for assurance and noted the report provided formal update on the Pathology Directorate's progress on the transformational agenda, to enhance the safety and efficiency of the mortuary and Care after Death (CAD) services and the vision and objectives for the future of the mortuary and Care after Death services. LW noted the Health Board was highly regulated by the Human Tissues Authority and the service had strict policies and procedures.

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	The Committee noted the work ongoing to review the work of the Care after Death (CAD) team; plan to implement a new software system which would track deceased patients rather than it being paper based and WG had requested an independent external review to be undertaken of the division's transformation plans. Arvind Kumar (AK), Interim Divisional Director (Clinical Support Services), assured the Committee that the department was working to achieve internal quality improvement accreditation. The Committee welcomed the action plan and commended the response of the division and thanked all those who have been and are still involved with the transformation programme. Update on the Mortuary Incident action plan to come to the Committee in 6 months **Action: Chief Operating Officer** The Committee **RECEIVED** assurance from the report.
PQSOC 0306/12	**Clinical Audit: Annual Report on Clinical Audit Activity 2024/25 and Clinical Audit Plan 2025/26** Leeanne Lewis (LL), Assistant Director for Quality & Patient Safety, presented the report for assurance. She highlighted that clinical audit serves as a key tool for evaluating the safety and effectiveness of clinical services. It provides assurance of compliance with clinical standards and helps identify and reduce risks, waste, and variations from guideline-defined care. The Committee was assured that audit findings are actively used to inform and prioritise areas for improvement, with the overarching goal of enhancing patient outcomes. It was noted that there had been considerable work done on reporting mechanisms and the clinical governance of audits by The Clinical Standards and Effectiveness Group (CSEG) and the regular reports to ARA and PQSO Committees. The Committee was informed that there was a framework around the reporting and some of the achievements were outlined to the Committee. The Committee noted the challenges and the impact on audit at times of significant clinical demand; a lack of substantial funding for AMAT and non-participation in some National Audits which have mainly been English only Audits. The Committee was assured these were small audits. The forward work plan was outlined to the Committee.

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	The Committee noted the significant progress that had been made on clinical audit activities and the clinical audit plan over the last few years. Rani Dash (RD) highlighted that ARAC still expects there to be a Corporate Local Clinical Audit Plan based on areas of risk that feed into the assurance process. JC advised that a business case would probably be required for additional staffing to be able to support the monitoring of local audits. RD acknowledged that local audits are being done but there is a responsibility for central reporting so there is corporate assurance. JC suggested that there is a hierarchy. All divisions have to complete national audits and will be asked to develop a local audit plan which fits around issues raised through their monitoring of complaints/incidents /risks. The third group of audits will arise from ad-hoc events. JW added that the local audits will then be reported at the divisional QPS meetings. Update on development of local audit plans and funding arrangements in 6 months. **Action: Assistant Director for Quality & Patient Safety/ Medical Director** The Committee **AGREED** to the Clinical Audit Plan for 2025-2026 and **RECEIVED** assurance from the Audit Activity Report for 2024-2025 that the Health Board was meeting its obligation to undertake clinical audit.
PQSOC 0306/13	**Committee Risk Report** Rani Dash (RD), Director of Corporate Governance, provided the Committee with an overview of the Committee Risk Register for which the Board had delegated responsibility to the Committee. The Committee was advised that the Committee Risk Register included three high-level risks and three sub-risks, covering service delivery, transformation and partnership working, and compliance and safety. The risk environment had remained stable, and there were no changes to the risk scores for the monitored risks. The Committee **NOTED** the delegated strategic risks and **NOTED** the work being undertaken to ensure the Committee is sighted on all risks that have the potential to impact patient quality and safety.
PQSOC 0306/14	**Development of Committee Annual Programme of Business 2025/26**

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	Rani Dash (RD), Director of Corporate Governance, updated the Committee on the Committee's Annual Programme of Business and noted it now included regular updates from the Quality Management Group and Quality Outcomes report. RD advised that some annual reports had been removed as assurance will now be provided via the routine Quality Management Group reports. The Committee **APPROVED** the proposed Committee workplan for 2025/26 and **NOTED** that it will be brought forward to each future Committee meeting for oversight.
PQSOC 0306/15	**NHS Wales Joint Commissioning Committee's Quality Report** NHS Wales Joint Commissioning Committee's Quality Report was provided to the Committee for information.
PQSOC 0306/16	**Listening & Learning Forum Assurance Report** Listening & Learning Forum Assurance Report was provided to the Committee for information.
PQSOC 0306/17	**Clinical Advisory Group Assurance Report** Clinical Advisory Group Assurance Report was provided to the Committee for information.
PQSOC 0306/18	**Committee Annual Report 2024/25** Committee Annual Report 2024/25 was provided to the Committee for information.
PQSOC 0306/19	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** There were no key risks or issues for reporting or escalation to the Board or other Committees.
PQSOC 0306/20	**Any Other Urgent Business** There was no urgent business.
PQSOC 0306/21	**Date of the Next Meeting:** 29th July 2025

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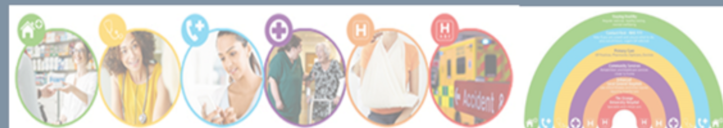
CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
PATIENT QUALITY, SAFETY AND OUTCOMES COMMITTEE

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
June 2025	**PQSOC 0306/11**	**Mortuary Incident Action Plan** Update on the Mortuary Incident action plan to come to the Committee in 6 months	**Chief Operating Officer**	December 2025	**Completed** July Update Mortuary Incident action plan has been included in the Committee forward work plan.
June 2025	**PQSOC 0306/12**	**Clinical Audit** Update on development of local audit plans and funding arrangements in 6 months.	**Assistant Director for Quality & Patient Safety/ Medical Director**	December 2025	**Completed** July Update Development of local audit plans and funding arrangements had been included in the Committee forward work plan.



CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

ACTION LOG

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

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING
GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 July 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Quality Performance – Interim Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis – Assistant Director for Quality and Patient Safety Tracey Partridge Wilson - Deputy Director of Nursing

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

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

Cefndir / Background

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

The Quarter One 2025/26 Quality Outcomes Framework (WOF) provides a comprehensive overview of the Health Board's performance against quality and safety priorities. It aligns with Ministerial priorities and the Duty of Quality, incorporating both quantitative metrics and qualitative learning across six quality pillars.

Asesiad / Assessment

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

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

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

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

Areas of Improvement

- Since its launch, the PALS service continues to receive around 481 enquiries per month. Work has been undertaken to review how the service supports the PTR process, allowing issues being resolved at an informal stage.

- Civica has been successfully implemented with a satisfaction rate at 89%, over the 85% benchmark. The new digital solution has helped to increase uptake. The top positive themes are compassion, emotional and physical support and friendlies.

- Mortality - the Health Board has seen improvement in the Risk Adjusted Mortality Indicator (RAMI), RAMI has been consistently lower than the Welsh Peer group for the majority of 2024. The Health Board is currently performing 1st of 6 within its All-Wales Peer Group.
- There were 84 Duty of Candour incidents triggered.

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

Areas of Focus:

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

- Infection rates for C.Difficile have risen over the last 12 months, which is a picture seen across Wales. The reasons for this are complex with rates impacted by community prevalence, the number of people with complex co-morbidities, anti-microbial prescribing and poly pharmacy as well as a need to refresh basic good IPC practice. An improvement plan has been produced and is being enacted.
- Themes from incidents includes delayed diagnosis/ treatment. Healthcare associated infections and falls.
- There is continued focus on improving uptake of Level 1 and Level 2 Safeguarding training.
- The Health Board continues to focus on sepsis awareness and prevention. Implementation of standardised early warning scores and underway.
- Legal services and managing increased clinical negligence and inquest activity.

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

As part of this work, we are continuing to strengthen our governance structures through Ward-to-Board connections that promote cross directorate and multi-professional working. We have initiated work to ensure that the implementation, measurement and monitoring of our strategy is hardwired through our governance and integrated performance reporting.
Argymhelliad/ Recommendation This report is to provide **ASSURANCE** to the Patient Quality, Safety and Outcomes Committee on the ongoing work to deliver the Duty of Quality and Duty of Candour, through implementing the Quality Strategy, Patient Experience & Involvement Strategy and the Quality Improvement Strategy.

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

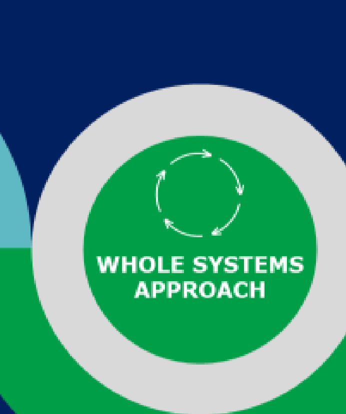
Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	The Health and Social Care (Quality and Engagement) Wales Act (2020)). Duty of Quality.
Rhestr Termau: Glossary of Terms:	

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

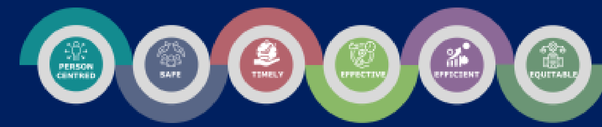
Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal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

Quality Outcomes Framework

Quarter One: 2025/26



Overview



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

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

For quarter one 2025/26 the existing QOF indicators have been used. The QOF is being refined for 2025/26 and the new report will be presented at October's meeting. There is work underway with Digital, Data and Technology Directorate to automate reporting and enable reports to be standardised, where possible. The use of iconography will provide detail on trends.

This report also focuses on learning and improvement. It includes:

Quality and Safety Pillars

- Indicators mapped to the existing reporting arrangements, QOF, as for 2024/25
- Narrative on indicators
- Additional information is available in the report to provide assurance against these standards

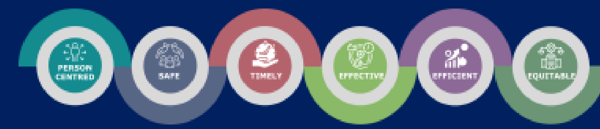
Escalated Risk Concerns

Clinical Effectiveness

Information

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

Quality Patient Safety (QPS) Update



- Quality Management System Framework 2025–2028 Final outlines the Health Board’s structured approach to delivering safe, effective, and equitable care. It promotes continuous improvement and patient-centred services.

- Quality Management group established which reinforces governance oversight via the PQSOC, ensuring strategic alignment with national directives.

- Sepsis & Early Warning Systems (EWS): A comprehensive strategy and rollout improved early recognition and management of deteriorating patients, including the switch over to NEWS2.

- Nutrition & Hydration: Governance structures and pilot protocols were introduced to address fluid balance and nutritional needs. Learning has been shared at the Learning and Improvement Forum. See Good Practice for more information.

QPS Update

- Ward Accreditation: Nine wards achieved Bronze, one Silver.
- CIVICA feedback showed high satisfaction rates. New surveys and reporting tools enhanced visibility of patient voice.
- Data Capture: Refined data capture processes to emphasise insights and actionable outcomes, supported by streamlined dashboards. Roles redefined to support data and performance.
- Dashboards: Dashboards produced, working closely with Divisions and Heads of Service.
- Learning Events: Co-created with individuals who raised concerns.
- Engagement: Regular engagement with Divisional Triumvirate and leads, building stronger networks across the teams.
- Workforce development: Enhanced team-building initiatives with comprehensive induction plans and mentorship programs to align staff with organisational goals.
- Review of OCP through a structured questionnaire- closing date end of June 25

Patient Quality and Safety Learning and Improvement Forum Highlights

The Patient Quality, Safety Learning and Improvement Forum held on 18th June focused on various aspects of patient experience, safety, and quality improvement within the Aneurin Bevan University Health Board. Some highlights include:

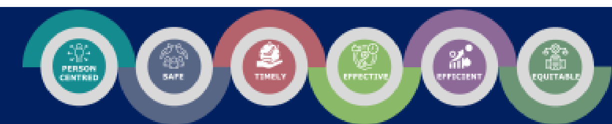
Patient Story: Patient Advice and Liaison Service (PALS)

- A recent patient experience shared by a neurodivergent individual, provided valuable insight into the challenges faced by patients with additional needs in the Emergency Department (ED). The powerful video's testimony highlighted several key issues during her visit, including: the absence of a designated quiet space, limited staff awareness and support during episodes of sensory overload and a missed opportunity to involve the Patient Advice and Liaison Service (PALS) at an earlier stage. Posters and communication boards have been introduced, including visual symbols to indicate the availability of quiet spaces and support for patients with additional needs.

Organisational Learning and Improvement:

- **Patient Identification Issues:** One of the Divisions outlined serious incidents linked to patient misidentification, including wrong blood in tube (WBIT) events. These incidents have resulted in significant clinical risks, such as incorrect blood transfusions, medication errors, and neonatal misidentification. It was noted that the Health Board's Patient Identification Policy has recently been updated. However, discussions revealed recurring issues across clinical areas, including inconsistent patient ID checks, labelling errors, and poor compliance with bedside labelling protocols. These themes appear to be widespread and not isolated to a single department.
- In response, it was agreed that these issues should be collated and escalated to the Quality Management Group for further consideration. Recommendations included reinforcing training and monitoring compliance, as well as exploring digital solutions such as GS1 wristbands and Scan4Safety technologies to reduce manual error. A proposal was also made to establish a task and finish group to address the systemic nature of these challenges and drive sustainable improvements.

- **Body- Worn Cameras Pilot:** A pilot initiative is currently being introduced in the Minor Injuries Unit at the Royal Gwent Hospital and the Emergency Department at The Grange University Hospital to trial the use of body-worn cameras for staff safety.



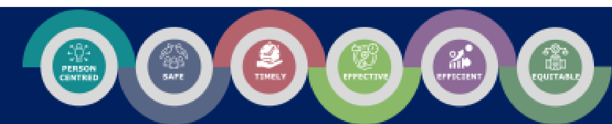
Patient Quality and Safety Learning and Improvement Forum Highlights

Organisational Learning and Improvement:

Nutrition & Hydration improvements: Two key workstreams are currently underway to enhance nutrition and hydration practices across the Health Board. The first focuses on nutrition escalation, where a 7-minute briefing and an action card have been developed to support the timely identification and response to malnutrition. These tools aim to improve staff awareness and consistency in recognising and acting on nutritional concerns. The second workstream addresses fluid balance, where a pilot ward has demonstrated significant improvements in both documentation and staff awareness. This success has been supported by a combination of audit activity, targeted education, and the introduction of a fluid balance action card. As a result of these efforts, compliance with fluid balance documentation has improved, and the work has contributed valuable evidence in support of a Regulation 28 response. The initiative is now being rolled out more widely across divisions, with ongoing audit and feedback mechanisms in place.

Ward Accreditation Progress: The latest round of ward accreditation has seen strong engagement and encouraging progress. A total of 16 wards achieved Bronze accreditation, with four of these progressing to Silver, reflecting a commitment to continuous improvement and high standards of care. The accreditation process identified some common areas for development, particularly around documentation practices, including care planning and discharge planning, as well as compliance with hand hygiene and uniform policies. These themes will inform targeted support and future training.

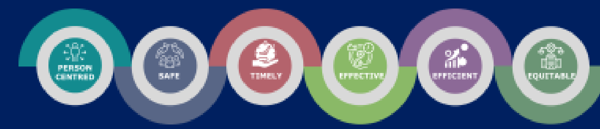
C. difficile Reduction Initiative: A focused Quality Improvement (QI) project has been successfully implemented on a surgical ward to reduce healthcare-acquired Clostridioides difficile (C. difficile) infections. The initiative was driven by a multidisciplinary approach, with a strong emphasis on environmental improvements, staff education, and fostering a sense of ownership among the team.
A task and finish group was established to coordinate efforts, and practical tools such as grab bags and checklists were introduced to support consistent infection prevention practices. These measures have led to a significant outcome—over 130 days without a new case of healthcare-acquired C. difficile on the ward.



Good Practice

Section 1

Nutrition and Hydration Progress Report



Overview The Nutrition and Hydration Task & Finish Group was formed under the ABUHB Nutrition and Hydration Strategic Group to address key concerns raised through complaints, Regulation 28 notices, and audit findings. Two priority workstreams were established: Nutrition Escalation and Fluid Balance Monitoring. These were later amalgamated into a single group to streamline efforts and share learning

Nutrition Escalation - Key Drivers:

- Concerns and complaints, including Regulation 28 notices, highlighted inconsistent escalation of nutritional needs.
- Gaps in awareness and timely action for patients with complex needs (e.g. learning disabilities, swallowing difficulties, tube feeding).

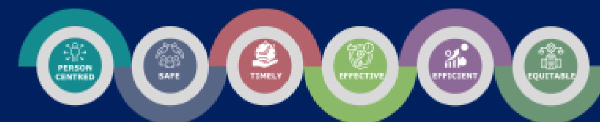
Actions Taken:

- Developed a **7-minute briefing** and **Action Card** to support staff in identifying and escalating nutritional concerns.
- Emphasised use of the **WAASP tool** for risk screening within 24 hours of admission or extended ED stay.
- Provided clear guidance for:
    - Patients unable to participate in assessments
    - Swallowing difficulties (SLT referral pathways)
    - Cultural, religious, or therapeutic dietary needs
    - Tube feeding and out-of-hours feeding protocols
    - Missed meals or extended ED stays

Assurance Measures:

- Dissemination of materials across divisions
- Audit and feedback mechanisms to assess implementation
- Ongoing development of training and escalation procedures

Nutrition Escalation: 7 minute briefing



7-minute Briefing

Nutrition & Hydration Escalation

Use this reference document to guide educational awareness to your team.

Each step is intended should take only 1 minute to deliver

1 — When should a nutrition risk assessment be completed?

*Within **24hrs of admission** to any ward/unit/department
*If in Emergency Department for **more than 24hrs**
*If pt has #NOF initiate #NOF Nutrition Pathway within 24hrs of admission
*Reassess weekly, or sooner if condition/triggers change

2 — How is a nutrition risk assessment (WAASP) carried out?

WAASP

Step 1
*Record weight and height
*Establish if any unintentional weight loss or lack of appetite

Step 2
*Select highest score in each section of WAASP tool

Step 3
*Add up scores from each section
*Record in total box

Step 4
*Take actions based on total risk score

3 — Patient unable to participate in assessment or has additional needs

*Consider contacting relatives/carers for further information
*Contact appropriate specialist teams e.g. SLT, LD, Dementia Care Teams
*If known LD – liaise with LD liaison team **immediately**
*Refer to Hospital Passport if appropriate

4 — Patient has swallowing difficulties

*Check CWS – is pt known to SLT? *Last entry will detail Eating, Drinking, Swallowing recommendations
*If pt known to SLT, and there are concerns about current management plan, email SLT shared inbox
*If pt not known to SLT – refer **as soon as difficulty is identified**

5 — Tube Feeding

Existing Use of Tube Feeding
*Refer to dietetics **as soon as need identified**
*Obtain details of feeding regimen from pt/carers
*Follow 'Community Pts with Tube Feeding' Pathway

Home TPN
*Contact UHW Dietetics if ABUHB Dietetics unavailable

Starting Feeding 'Out of Hours'
*Follow 'Out of Hours' guidance
*Refer to dietetics **as soon as need identified**

6 — Catering Requests

Missed Meal/Extended Stay in ED
*Contact Catering Dept for your site **as soon as need identified**

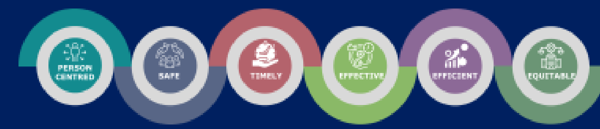
Pt has therapeutic, religious, cultural or lifestyle dietary needs
*Inform Catering of the dietary need **immediately**
*Refer pt to dietetics if additional support required

7 — Key Points

***ALWAYS** contact appropriate specialist teams for support as needed
***ALWAYS** escalate concerns
***ALWAYS** be mindful of patients on Enhanced Care or with any additional needs and requirements who may require assistance and encouragement with nutrition and hydration +/- family/NOK support

****See Action Card for relevant contact details, additional information and further action steps**

Nutrition and Hydration Progress Report



Fluid Balance Monitoring - Key Drivers:

- Regulation 28 concerns around poor fluid balance documentation and associated patient harm.
- Audit findings revealed over half of staff had not received training on completing fluid balance charts.

Actions Taken:

- Developed a **7-minute briefing** and **Action Card** to standardise practice.
- Clarified roles and responsibilities across the MDT (nurses, AHPs, doctors, patients).
- Defined when fluid balance charts are required (e.g. sepsis, AKI, IV fluids, enteral/parenteral nutrition).
- Provided detailed guidance on: Accurate input/output recording, recognising signs of dehydration, measurement standards and receptacle volumes and poor outcomes linked to hydration imbalance.

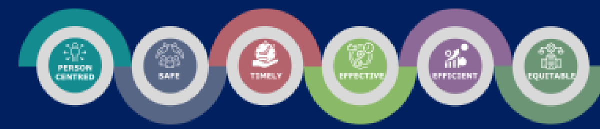
Assurance Measures:

- Pilot audits showed improved practices (e.g. midday calculations, alternate-day weighing)
- PDSA cycles used to refine approach
- SOP and guidelines under review by Clinical Policy Group

Forward Planning

- Continued audit and improvement cycles for both workstreams
- Development of a **Nutrition and Hydration intranet resource hub**
- Annual action plan in development
- Ongoing membership expansion of the Clinical Sub-Group

Fluid Balance: 7 minute briefing



GIG Cymru NHS Wales Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

7-minute Briefing

Fluid Balance

Use this reference document to guide educational awareness to your team.

Each step is intended should take only 1 minute to deliver.

1 What are the indicators for a fluid balance chart?

*Clinical concern, indicated by raised NEWS. *Suspected sepsis. *Acute kidney injury. *Diarrhoea/vomiting.
*Urostomy/Urinary Catheter. *IV fluid administration (inc. medications). *High/Low intake/output.
*Post-op care with IV fluids/& or wound drains. *Dehydration/Overload **See Action Card for full list**

2 Who is responsible for completing &/or monitoring a fluid balance chart?

ALL STAFF

RN
*Identify need. *Clarify plans.
*Assure accuracy.
*Escalate/de-escalate

Dr./AHP
*Daily review.
*Communicate plans.

HCSW
*Assure accuracy.
*Communicate to team

Patient
*Capacity.
*Understanding

3 Completing a fluid balance chart

INPUT
*All fluids, inc. soup & dissolvable medication.
*IV fluids/blood products.
*Parenteral &/or Enteral /

OUTPUT
*Urine.
*Gastric losses
*Blood/wound losses

CALCULATION
*12-hour balance
*24-hour balance
*Record on weekly chart

4 Signs of deterioration

*Hypotension/tachycardia. *Urine output <0.5ml/kg/hr. *Dark concentrated urine.
*Dry mucosa/lips/skin/eyes. *Headache/dizziness. *Tiredness/confusion/irritability. *Constipation .
*Sunken features. **See Action Card for full list**

5 Poor Clinical Outcomes

*Cardiovascular instability. *Urinary tract infections. *Thromboembolism. *Confusion.
*Constipation & associated medication requirements. *Increased hospital stays. *Increased mortality.
See Action Card for full list

6 Measurements

INTAKE
*Glass 200ml. *Cup 160ml.
*Jug 750ml.
*Can of Coke® or similar 330ml

OUTPUT
***ALWAYS** record volumes. ***DO NOT** use ambiguous terms, e.g., PU++, BO, wet pad.
*Weigh **ALL** used pads/dressings & compare to dry weights.
*Have a reference list of dry weights

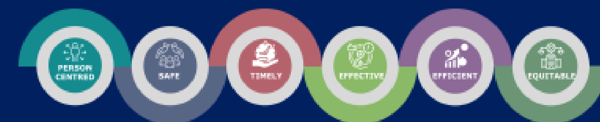
7 Key Points

***ALWAYS review / update** FB charts during hourly rounding to identify deficits/excesses. * **DO NOT** leave to 12/24 hour to review
***ALWAYS** review FB Charts in combination with physiological observations, to identify trends.
***ALWAYS** escalate concerns, fluid deficits &/or excesses * **ALWAYS** be mindful of patients on Enhanced Care, their input requirements, their output, who may require encouragement with fluids +/ - family/NOK support

Escalation

Section 2

Urgent and Emergency Care



Over the past month, Aneurin Bevan UHB has made tangible progress across several key operational transformation areas, with a continued focus on patient flow, workforce resilience, and embedding new models of care.

ED Extension Progress

New ED Waiting Room extension underway
Aims to increase clinical space and improve WTBS time
Supports 12-hour target compliance

Discharge/Transfer Lounge Impact

Alleviates ED congestion and improves bed availability
Supports earlier discharges and patient experience

Consultant Recruitment

Five new consultants onboarded
Three more joining by July 2025
Improves workforce capacity and responsiveness – particularly with ED extension

New Ways of Working (Step-Down Protocol)

First-floor step-down protocol implemented
Frees up ED and acute care capacity
Supports 'SDEC first' model and safe transfers

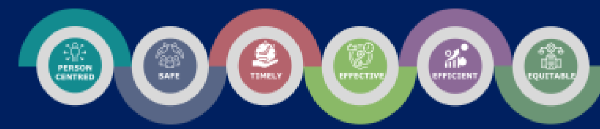
Actions/Focus for Next Month

Complete consultant onboarding and rota integration
Monitor ED extension impact on WTBS and 12-hour targets
Expand discharge lounge use and refine criteria
Evaluate step-down protocol and explore expansion
Align discharge planning and look at criteria led discharge

Risks and Challenges

- Refining processes where there is risk of bottlenecks in areas when step-down pathways are not activated promptly.
- National workforce shortages and competition for experienced staff.
- The completion of Phase One of the extension project has been delayed. Efforts are being made to mitigate the impact of this delay and to prepare for a seamless transition into Phase Two, which will commence immediately after the completion of Phase One. The project team is working closely with all stakeholders to address any challenges and ensure the successful delivery of the extension.

Mental Health & Learning Disability



Mental Health & Learning Disability Committee:

Met for the second time and formally received the Mental Health Act Monitoring Report in June 2025.

MH&LD Programme of Work around Patient Flow:

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

Management of Variable Pay:

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

Enhanced Care Framework:

Remains on track in the older adults' directorate.

Quality and Patient Safety:

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

Workforce and Planning:

- Ongoing efforts with workforce planning.
- LD well-being survey results, retention project for healthcare support workers, addressing overpayments.
- Nursing & HCSW workforce strategy is progressing

Continuous Improvement Plans: Ongoing quality improvement work and learning forums set up.

National MH & Wellbeing Strategy:

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

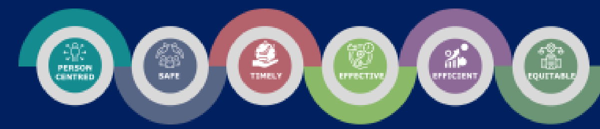
Challenges:

- Ongoing issues with the patient information system (WCCIS) and user interface necessitate ongoing workarounds to ensure validated data.
- Workforce and capacity challenges persist, but progress is evident with the workforce and organisation development programmes.
- Addressing the challenges of an aging estate and maintaining areas to ensure safe and therapeutic environments .

For Discussion

Section 3

Sepsis Progress Report – Update



National Drivers for Deteriorating Patient Recognition

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

Local Implementation

- To support delivery, the Health Board's Sepsis Working Group has established dedicated task and finish groups focusing on: digital systems, education and training, implementation planning, escalation processes, audit and assurance. In parallel, targeted workstreams are in place across Primary and Community care, Paediatrics and Maternity and Neonatal services to ensure readiness for all clinical areas.

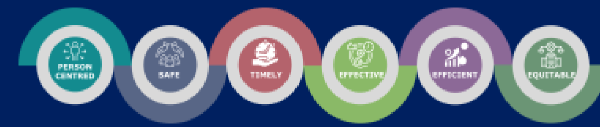
Go live dates for EWS Implementation

- Adults: NEWS2 – 9th September
- Paediatrics: PEWS – 22nd September
- Neonates: NEWTT2 – 14th July
- Maternity: MEWS – TBC

Training and Support

- Staff education is a priority, with ESR modules funded by the NHS Executive and tailored packages developed by ABUHB to compliment national training resources. These resources are designed to ensure all staff and confident and competent in applying the new EWS tolls in practice. Training completion thresholds (e.g., 70%) are being used as go/no-go criteria for implementation readiness.

Sepsis Progress Report – Update



- Appointment of the Quality and Patient Safety Assurance Lead under the Medical Director has supported a focus on sepsis, supporting divisional scoping and engagement with primary and community care.
- The Health Board continues to advance its strategic commitment to improving the recognition, response, and management of sepsis, aligning with national mandates and internal quality priorities. Sepsis is a designated workstream within Year Two of the Quality Strategy, with oversight embedded in the Deteriorating Patient and Acute Deterioration workstreams. The Health Board is actively implementing the updated NICE NG51 guideline and the Academy of Medical Royal Colleges (AoMRC) recommendations, ensuring evidence-based practice across all clinical areas.
- A dedicated Sepsis Working Group, supported by the Medical Director's Quality and Patient Safety team, is leading assurance activities including: Development of divisional sepsis expertise, setting performance targets and supporting improvement initiatives through structured scoping and stakeholder engagement.

Implementation and Compliance Monitoring

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

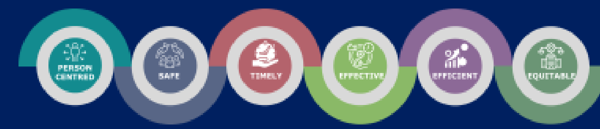
Engagement and Cultural Change

- Following the November 2024 sepsis workshop, preparations are underway for a "Big Conversation" event to engage staff and the public in shaping future sepsis care. This will be complemented by a staff-focused event to capture frontline insights and inform strategy development. The Health Board's internal sepsis awareness campaign launched in November 2024, with a public-facing phase commencing in April 2025. The campaign has achieved over 841,000 views to date and is being shared nationally to support wider adoption.
- **National Collaboration and Assurance**
- ABUHB continues to contribute to national sepsis forums and the development of a standardised education and communications strategy across Wales. This includes reviewing eLearning materials and supporting the adoption of the UK Sepsis Trust screening tool across all health boards.

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 • PEWS – 22nd September 2025 • NEWTT2 – 14th July 2025 • MEWS – TBC The focus groups and exploring opportunities, resources and actioning barriers to ensure safe and effective implementation the tools. Each group is reviewing key information around Implementation, policy and education. Once delivered, the Deteriorating patient/sepsis group will continue to measure the effectiveness and impact of the EWS tools.	Assistant Quality & Patient Safety Assurance Lead	To be completed by Sept 2025
Standardise Sepsis education	To deliver high-standard sepsis care and comply with NICE guidelines, it's crucial to provide consistent education to all Health Board members. Reviewing and implementing standardised sepsis education will enhance monitoring and impact assessment, enabling opportunities for improvement.	Following the implementation of the WHC and EWS, a standardised education resource will be developed utilising the Sepsis Working group forum and in collaboration with key services, such as critical care, outreach and resuscitation services. The education package with require input from clinical experts within ABUHB, as well as oversight from the Deteriorating patient/ sepsis group and the Wales sepsis group.	Assistant Quality & Patient Safety Assurance Lead	To be completed by Nov 2025
Building on Standardised Sepsis Education	Ensuring the same message around expectation, management and process surrounding sepsis management is crucial.	An Education Task and Finish group will be established in Q4 to develop a robust training strategy for the workforce ahead of implementing Early Warning Scores and NICE Guidance. Representation at the national group will allow for reviewing and contributing to eLearning education materials. Through working closely with divisions and practice educators, utilising the standardised education package and initiatives from national groups, review and development of training programmes will be undertaken. This will include reviewing, amending and developing the sepsis content for programmes such as the JOE preceptorship, ALERT, BLS, PROMPT. Utilising the Deteriorating patient/ Sepsis group, oversight, feedback and progress will be maintained.	Assistant Quality & Patient Safety Assurance Lead	To be completed by End of December 2025

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

Sepsis Annual Workplan 2024/25



Quarter One	Quarter Two	Quarter Three	Quarter Four
• Establish task group to update the Deteriorating Patient Policy; develop audit strategy; begin thematic review of missed cases using systems like Careflow and DATIX. • 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 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.

Section 4

Background

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

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

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

PATIENT AND STAFF EXPERIENCE AND STORIES

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

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

COMPLAINTS, CONCERNS AND COMPLIMENTS

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

INFECTION PREVENTION AND CONTROL

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

INCIDENT REPORTING

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

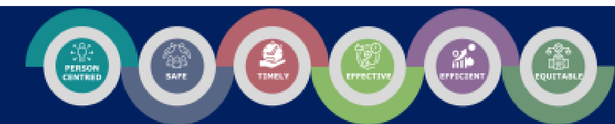
Our commitment to staff is to have a **just** culture, where staff feel safe to report concerns, incidents and near misses, knowing this will result in a timely, fair, comprehensive investigation. Our incident reporting system 'Datix' is a key component in providing insights to data gathering and learning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

HEALTH, SAFETY AND SECURITY

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

SAFEGUARDING

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



PILLAR 1

Patient and staff experience and stories

Civica | Bereavement Collaboratives | Patient Stories | IPAC Dashboards | Volunteer to Career | Chaplaincy | Volunteering

Patient Advice and Liaison Service (PALS) | Leadership, Accountability and Culture | Deprivation of Liberty Safeguards/ Mental Capacity Act | Cultural Competence Accreditation Scheme | Dementia Standards | Listening Meetings

QOF Metrics

Included in report:

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

Developing metrics not yet reported:

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

QOF Metric Pillar ONE - CIVIC CIVICA Patient Experience Feedback - Number of Responses & Satisfaction Score June 2024 – June 2025

All Surveys – Full year effect

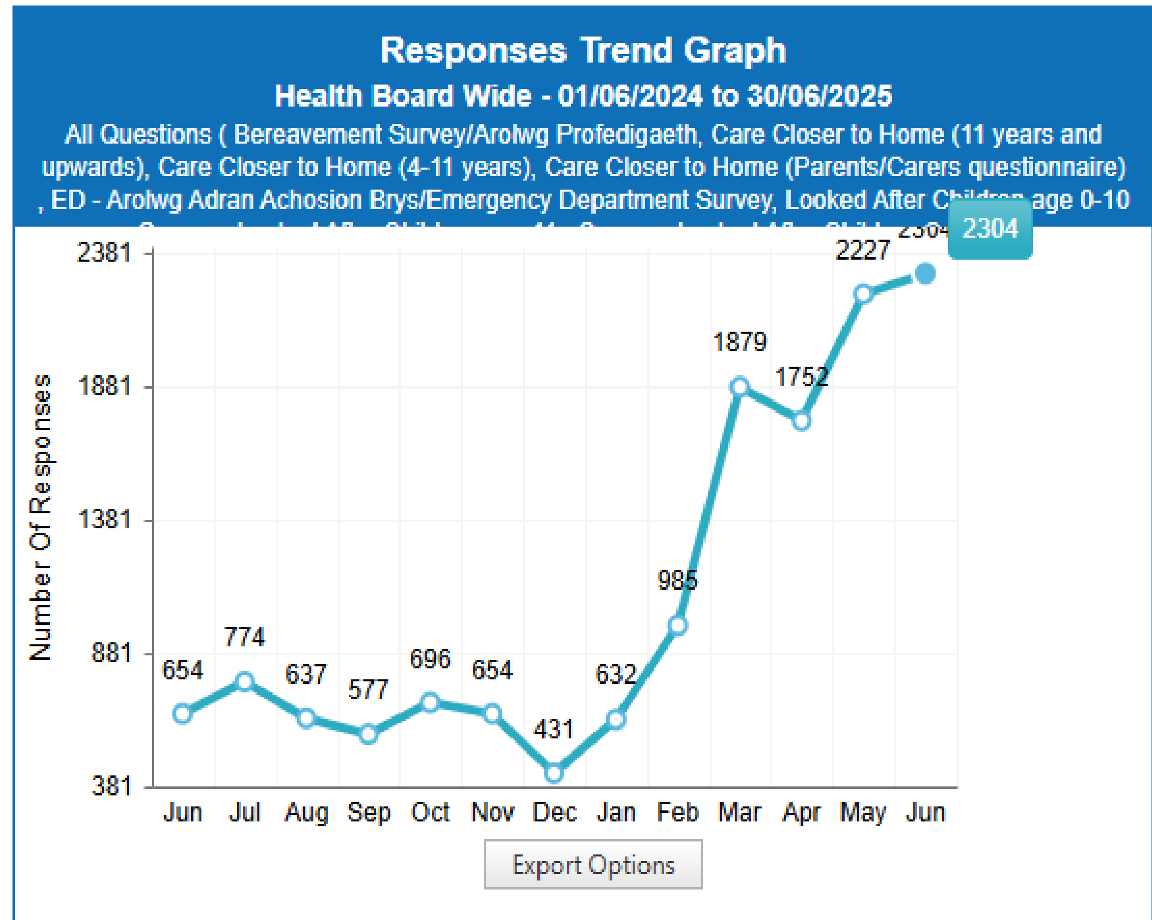
14202	**87%** satisfaction

Person Centred Care (PCC) Survey

12086 responses	**88%** satisfaction

Emergency Department Survey

1356 responses	**68%** satisfaction



	2024							2025					
Satisfaction Score by Month	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Overall – All Surveys	89	91	92	90	89	88	87	93	93	85	86	85	85
PCC/PES Surveys	91	92	92	93	91	92	90	92	92	90	90	84	84
ED Survey	68	72	79	77	61	60	67	77	65	67	70	75	

Total Responses YTD (2025/26) - Q1

6283

QOF Metric Pillar ONE - CIVICA Comments - Themes & Emotions. CIVICA Responses Q1 – 2025/26

Top 3 Themes from PCC/PES – April 2025 – June 2025

Positive Themes	Negative Themes
Compassion (732)	Waiting (no longer counted)
Emotional and Physical Support (602)	Comfort (165)
Professional and Competent (595)	Emotional and Physical Support (145)

Top 3 Themes from PCC/PES (since 1st May this now includes ED feedback) April 2025 – June 2025

What did we do well/Was there anything particularly good about your experience you would like to tell us about?	What could we have done better/Was there anything particularly bad about your experience you would like to tell us about?
Top 3 themes	**Top 3 themes**
• **732** comments around **Compassion**	• **Waiting** (no longer counted)
• **602** comments around **Emotional and Physical support**	• **165** comments around **Comfort**
• **595** comments around **Professional and Competent**	• **145** comments around **Emotional and Physical Support**
Unchanged top two compared to last quarter	*Top three unchanged since last quarter, although last two in different order. Waiting figure is not showing as no longed counted*

Emotions

unacceptable "would like to" ridiculous ignored "was kind" supportive fabulous anxiety empathy awful comfortable worried pleasant fantastic anxious kindness fab rude amazing impressed appreciate compassionate excellent reassuring outstanding friendly exceptional cheerful frustrating happy thanks reassured lovely "at ease" "my concerns" smile welcoming brilliant disgusting dismissive wonderful superb complaint surprised pleased compassion "feel safe" terrible appalling

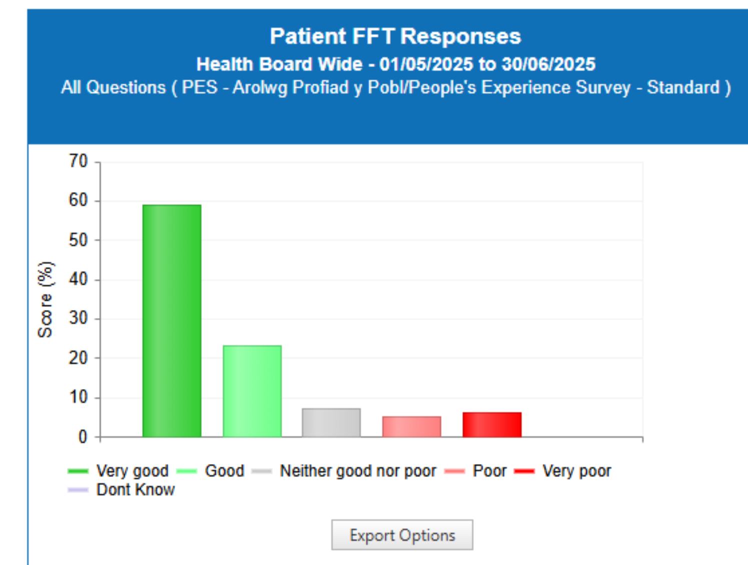
Adborth Cleifion: Gwrando a Dysgu

Patient Feedback: Listening and Learning

QOF Metric Pillar ONE - Patient Experience Feedback Q1 2025/2026

- Since the launch of CIVICA SMS in March (for ED and MIU) there has been a significant increase in feedback, with June the highest month of feedback to date. Some delays have been noted with messages being sent which has been escalated.

- New All-Wales Survey – People's Experience Survey (PES) launched in May 2025 with some additional questions re-added from previous Person Centred Care Survey (PCC).



- The launch of the PES has introduced a Friends and Family Test Question (FFT) – 'How would you rate your overall experience?'. This provides a single snapshot of experience. This question will also be linked to Ward Accreditation.

•Since the launch of the PES the Satisfaction Score has dropped slightly, however there is a discussion across Wales on the scoring of the first question – 'Was the time you waited''

- All Wales Looked After Children Surveys launched.

- Emergency Department National Survey closed 1st May. ED have moved onto PES.

- Cross Divisional bespoke monthly report continues, for example patient comments around facilities.

- Compliments from CIVICA have been recorded during this period but has now stopped since June 2025.

- There has been very little movement in top themes this period compared to last quarter.

- Work continues the All-Wales Maternity and Neonate Surveys which will be sent via CIVIC SMS. Currently working on a live date of the 1st September 2025

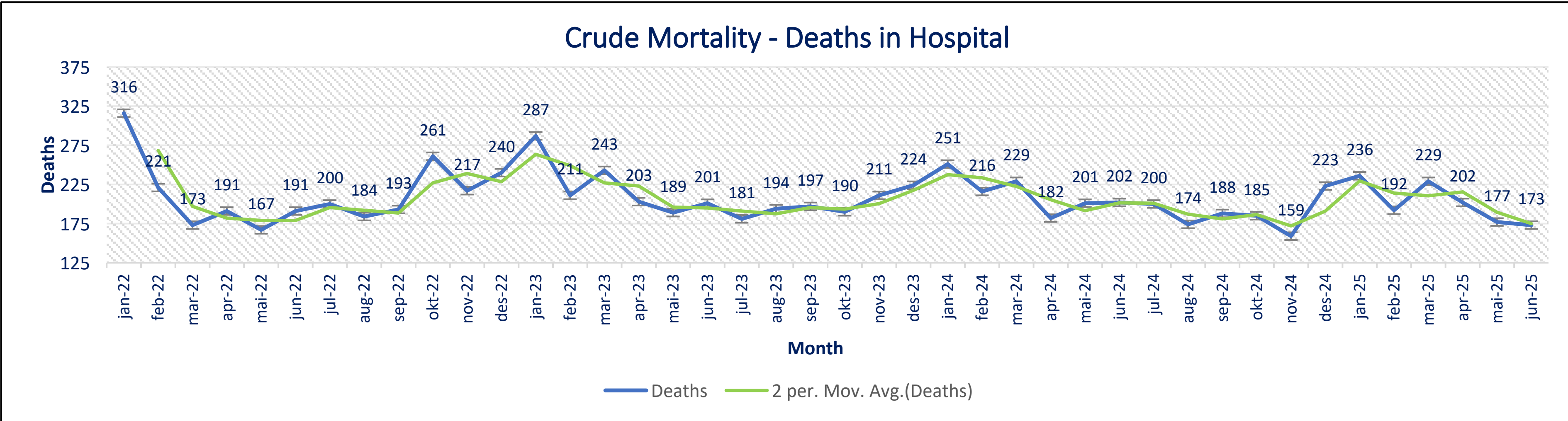
Proposed Metrics: -

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

Developing Metrics: -

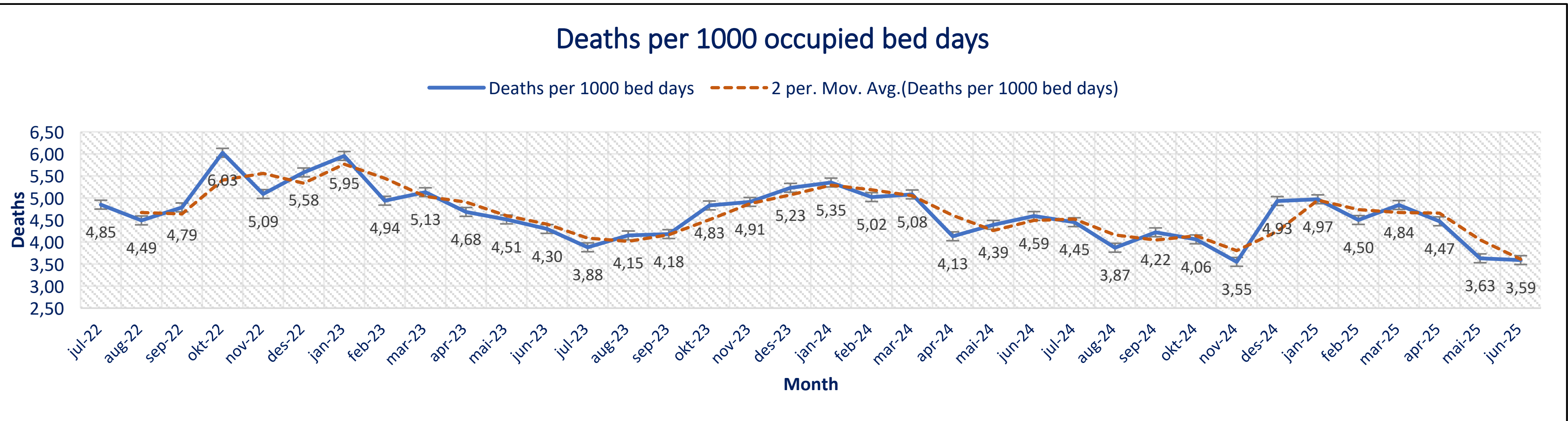
- Investigate the possibility of capturing incidents related to urgent care delays / flow in DATIX.

QOF Metric - Pillar Two Mortality: Crude Mortality in Hospital



Q1 25/26 shows a reduction of nearly 16%, bringing mortality below the levels seen in any of the previous four quarters.

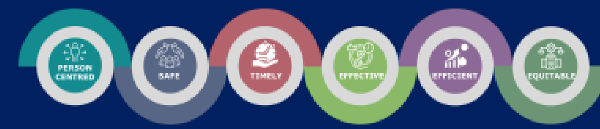
Quarter	Total Crude Mortality in Hospital	% Difference	
Q1 24/25	585	-	
Q2 24/25	562	-4%	↓
Q3 24/25	567	+1%	↑
Q4 24/25	657	+16%	↑
Q1 25/26	552	-16%	↓



Quarter	AVG Death per 1000 Bed Days	% Difference	
Q1 24/25	**4.37**	**-**	
Q2 24/25	**4.18**	**-4.4%**	↓
Q3 24/25	**4.18**	**0%**	↔
Q4 24/25	**4.77**	**+14.1 %**	↑
Q1 25/26	**3.89**	**-18.5%**	↓

After a rise in Q4 2024/25, Q1 2025/26 saw a reduction of 18.45%, bringing the rate down to 3.89. This is the lowest recorded rate in the five-quarter span from Q1 2024/25 to Q1 2025/26.

QOF Metric - Pillar Two Mortality: Crude Mortality Rate



Mortality Rate

Mortality Rate (%)

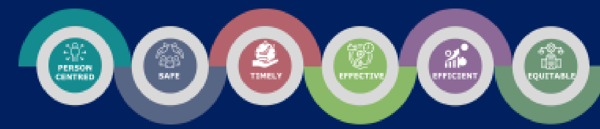
Month: Apr 23, May 23, Jun 23, Jul 23, Aug 23, Sep 23, Oct 23, Nov 23, Dec 23, Jan 24, Feb 24, Mar 24, Apr 24, May 24, Jun 24, Jul 24, Aug 24, Sep 24, Oct 24, Nov 24, Dec 24, Jan 25, Feb 25, Mar 25, Apr 25

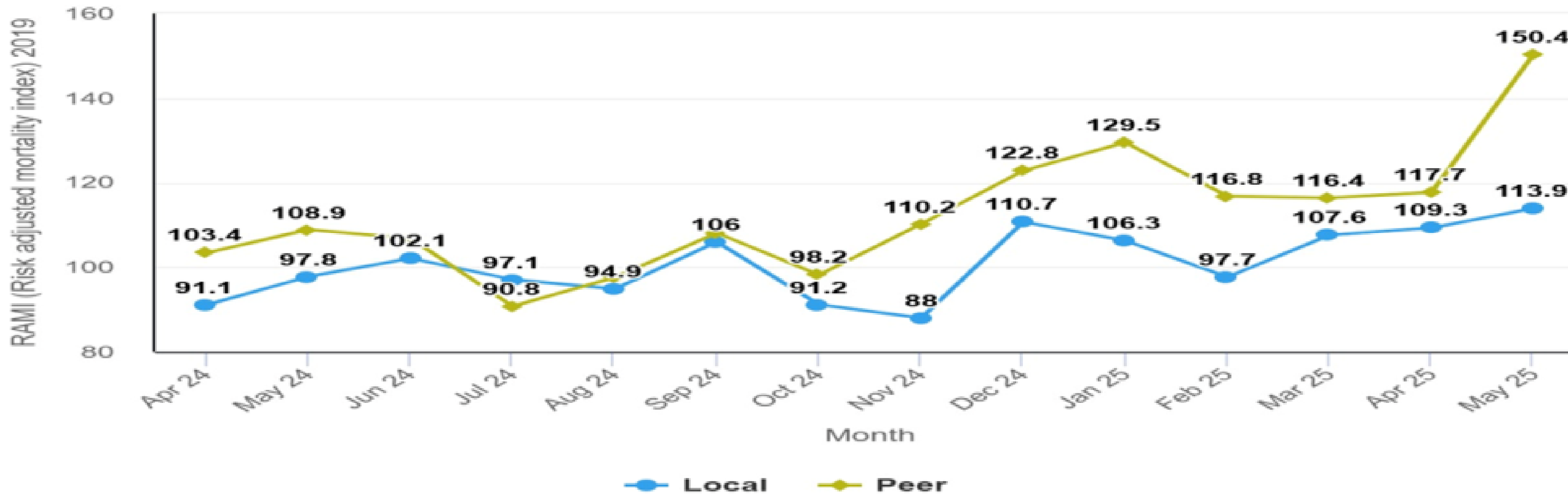
Legend: Local, Peer

Mortality Rates have remained consistent and have been 1.5% or lower for 10/12 months of the last year.

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

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





ABUHB PEER

RAMI for Q1-Q4 2024/25 was 104.63, Both lines show a decline in RAMI during mid-year (summer months), followed by a consistent rise through autumn and winter.
The sharpest increases occur from October to Jan, which may reflect seasonal pressures such as winter illnesses or increased hospital admissions.
RAMI for Q1 is 111.50, which is an increase.

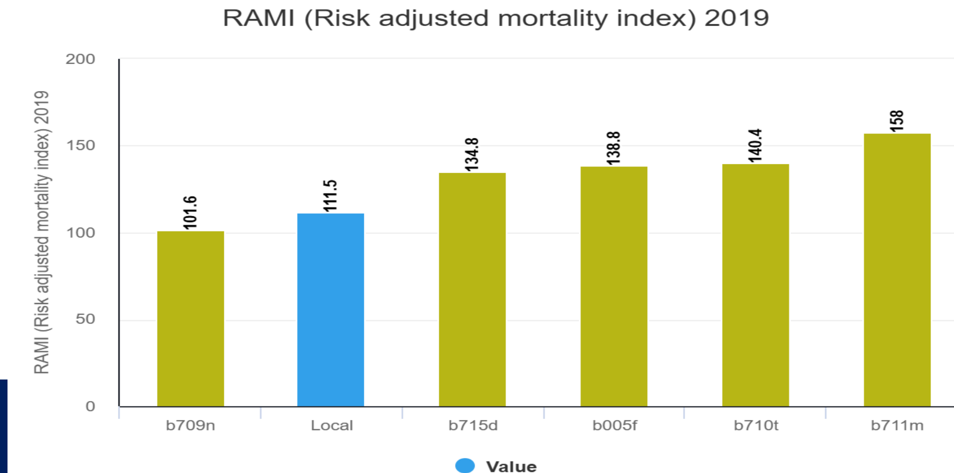
Chart displays RAMI for Q1 – Q4 2024/25

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

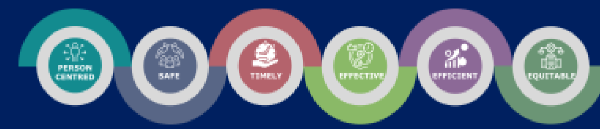
Completeness of coding is more accurate after 8 weeks, which often results in a decrease of RAMI. This is reflected in Q1 25/26 being high.

Quarter	RAMI	% Difference	
Q1 24.25	97.13	-	
Q2 24.25	100.40	+3.4%	↑
Q3 24.25	97.23	-3.2%	↓
Q4 24.25	103.86	+6.9%	↑
Q1 25.26	111.50	+7.3	↑

Currently performing 2nd of 6 within All Wales peer group



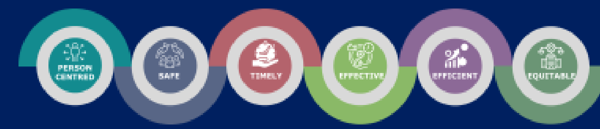
QOF Metric - Pillar Two: Post Investigation Harm Assessment and Closure Date of Incident Average Time to Close



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

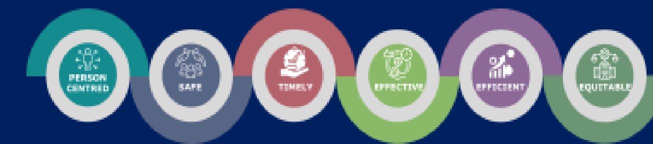
Post Investigation harm assessment	Incidents Closed during Quarter 1 24/25	Average time to closure	Incidents Closed during Quarter 2 24/25	Average time to closure	Incidents Closed during Quarter 3 24/25	Average time to closure	Incidents Closed during Quarter 4 24/25	Average time to closure	Incidents Closed during Quarter 1 25/26	Average time to closure
Catastrophic / Death	23	149	26	76	42	85	34	166	31	172
Severe	14	299	14	281	15	293	7	282	6	194
Moderate	123	178	79	123	47	115	49	142	33	153
Low	4,649	74	3,580	42	3,960	47	3,888	47	3,665	45
None	4,597	85	3,819	47	4,232	46	4,627	50	5,422	60
TOTAL	9,406	81	7,518	46	8,296	47	8,605	50	9,156	55

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

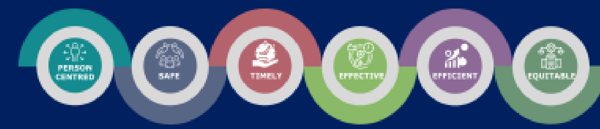


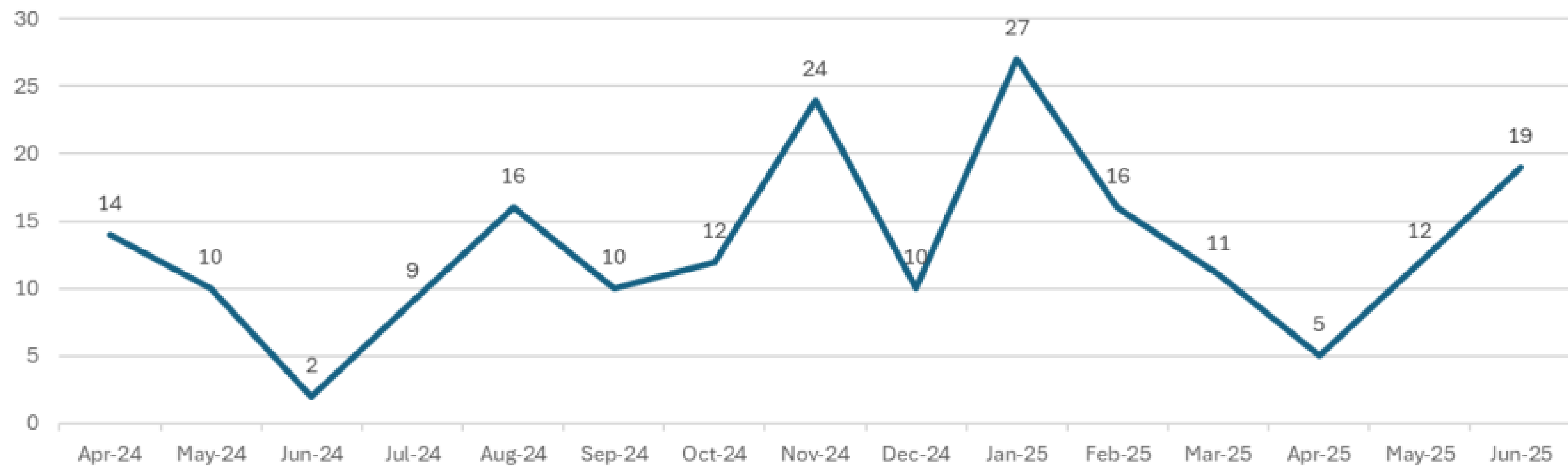
Between April 2024 and June 2025, a total of **175 Early Warning Notifications (EWNs)** were reported to Welsh Government (WG). This marks an increase compared to **137 EWNs** submitted during the same period in 2023/24. From April 2024 to March 2025, 142 EWNs were reported. In **Q1 2025/26**, **34 EWNs** were submitted. Key themes for this quarter include: Practitioner concerns involving Health Board staff, Patient-to-staff assaults, Suicide of mental health service users in the community and Antisocial behaviour by mental health/learning disability service users while in the community

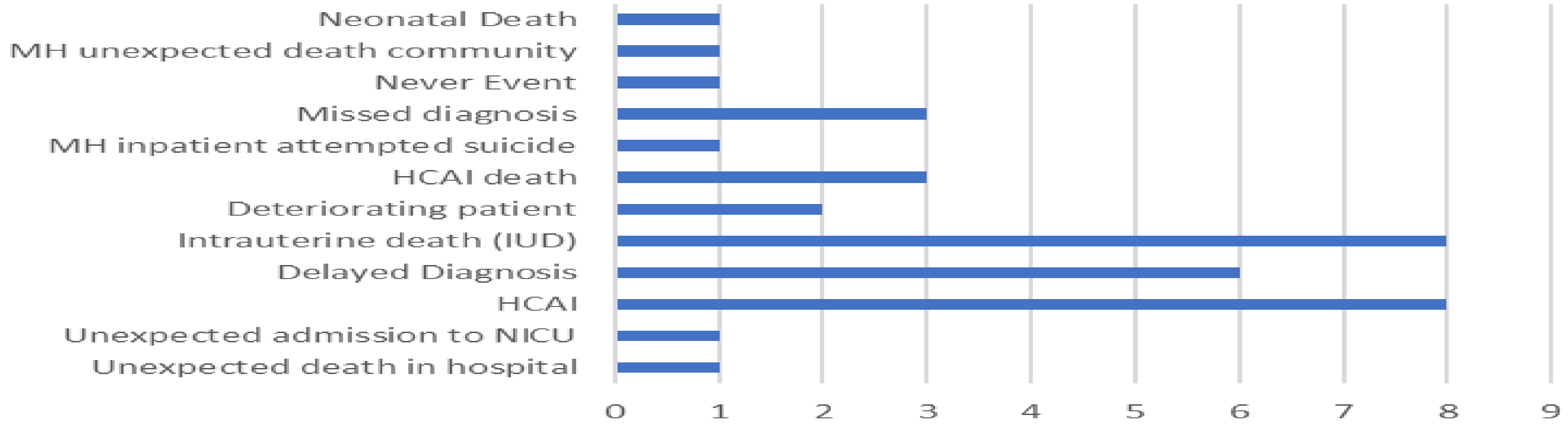
Quarter	Early Warning Notifications	% Difference	
Q1 24/25	**32**	**-**	
Q2 24/25	**33**	**3%**	↑
Q3 24/25	**31**	**-6%**	↓
Q4 24/25	**46**	**+48%**	↑
Q1 25/26	**34**	**-26%**	↓



QOF Metric - Pillar Two
Patient Safety Incidents - National Reportable Incidents





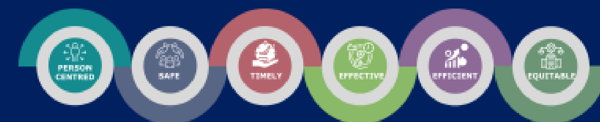


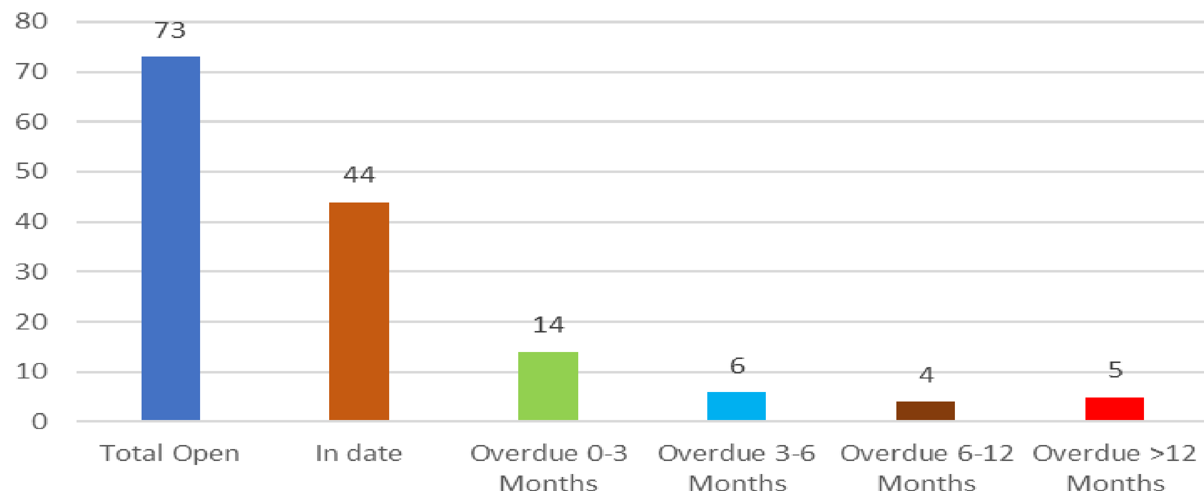
Quarter	NRIs	% Difference
Q1 24.25	26	-
Q2 24.25	35	+35%
Q3 24.25	46	+31%
Q4 24.25	54	+17%
Q1 25.26	36	-33%

A total of 36 Patient Safety Incidents (PSIs) met the criteria for submission of an NRI in Q1.

There were no unusual trends identified across this period.

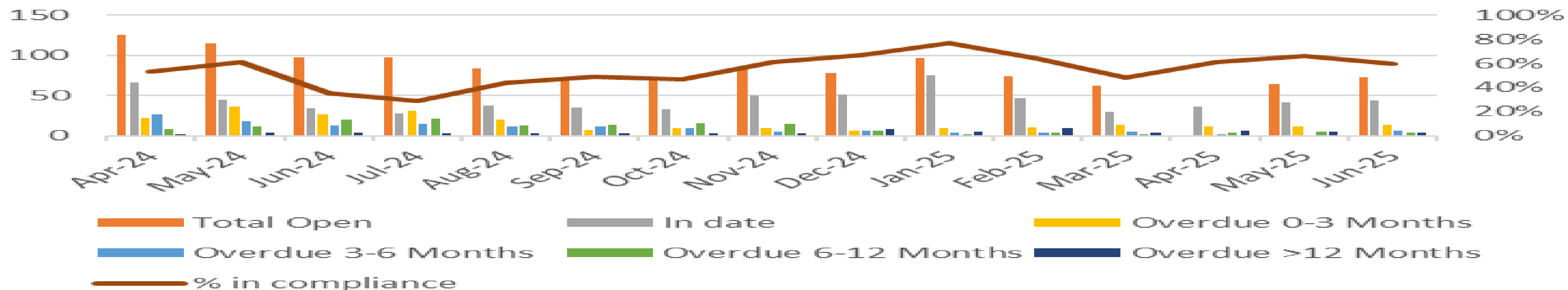
QOF Metric - Pillar Two Patient Safety Incidents – Open National Reportable Incidents



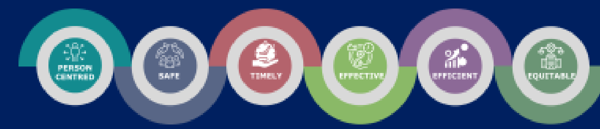


The graph left, shows the number and status of compliance for open NRI's as of the end of June 2025. The five NRI's outstanding over 12 months are currently subject to external process apart from 1 incident which remains with Mental Health. The NHS executive team are aware of these cases and the rationale for non-compliance.

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



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



There were no Never Events recorded in Q1 April – June 2025. Work remains ongoing across the organisation with improvement and prevention of such occurrences.

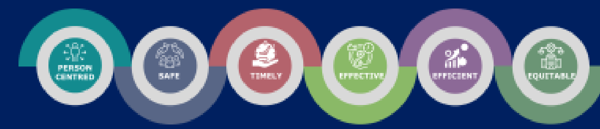
Never Events April 2024 - June 2025

1
0,9
0,8
0,7
0,6
0,5
0,4
0,3
0,2
0,1
0

apr-24 mai-24 jun-24 jul-24 aug-24 sep-24 okt-24 nov-24 des-24 jan-25 feb-25 mar-25 apr-25 mai-25 jun-25

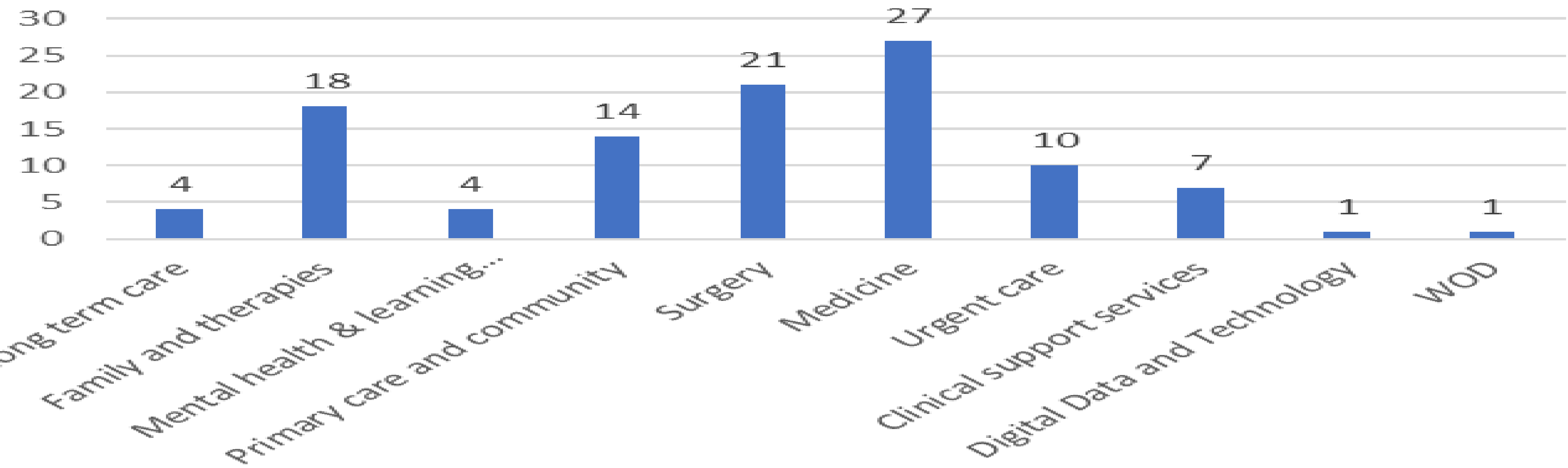
Recap: There were two Never Events reported in Q3 2024/25 (October to December 2024). The first occurred in October and involved a case of wrong site surgery in Dermatology Day Surgery, where a patient had additional lesions removed that were not listed for removal. The second event, reported in December, was a historic retained guidewire from a varicose vein procedure performed 14 years ago. This was discovered incidentally when the patient underwent an unrelated hip x-ray in November 2024. Importantly, neither patient experienced any harm as a result of these incidents.

QOF Metric - Pillar Two: Duty of Candour



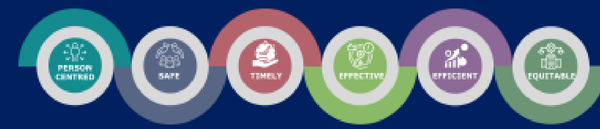
Between 1 April 2024 and 30 June 2025 there have been **107** incidents that have triggered Duty of Candour (DoC). *This figure is based on the question - **Was Healthcare provided a factor?***

During Q1 there have been ***22 incidents that have triggered DoC.***



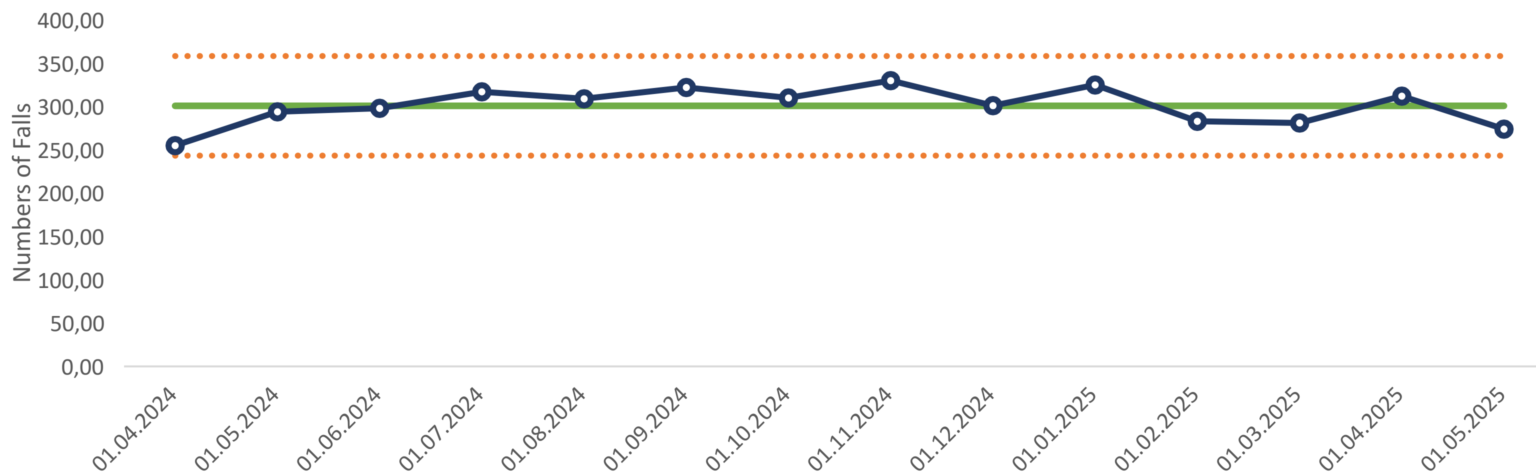
A DoC workshop has taken place to set out the work plan for DoC in line with the All Wales DoC Strategic Group. The workshop was attended by the Divisional QPS leads and their deputies. There has been a significant amount of work undertaken through creation of divisional dashboards for divisions to monitor Duty of Candour statutory requirements. The Deputy Head of Quality, Patient Safety and Learning and Assistant Head of Patient Safety are leading this project.

Patient Safety Incidents - Actions, Learning & Improvement



Achievements	Update	Next Steps
Face to Face IO Training	Face-to-face training sessions for Investigating Officers recommenced in May 2025, with monthly sessions thereafter. Excellent feedback from the first cohort.	Monthly IO training and continued bespoke support
PSI workshop	The Corporate PSI team has undertaken a workshop in May to review the Patient Safety Incident processes, engaging all QPS leads and foster unified approach. The forum will address challenges and explore strategies to enhance patient safety outcomes.	Workshop and review of PSI systems and processes
Thematic review	Multiple incidents related to ligatures, heparin or anticoagulant use, and delays in the follow-up of radiological findings have been reported. While not every incident resulted in patient harm, these events have driven thematic reviews supported by senior clinicians and executives.	Thematic analysis

QOF Metric - Pillar Two: Health Board Wide Inpatient Falls

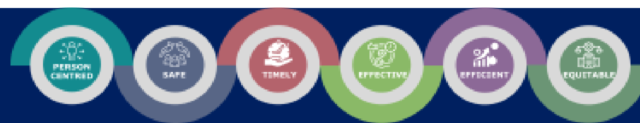


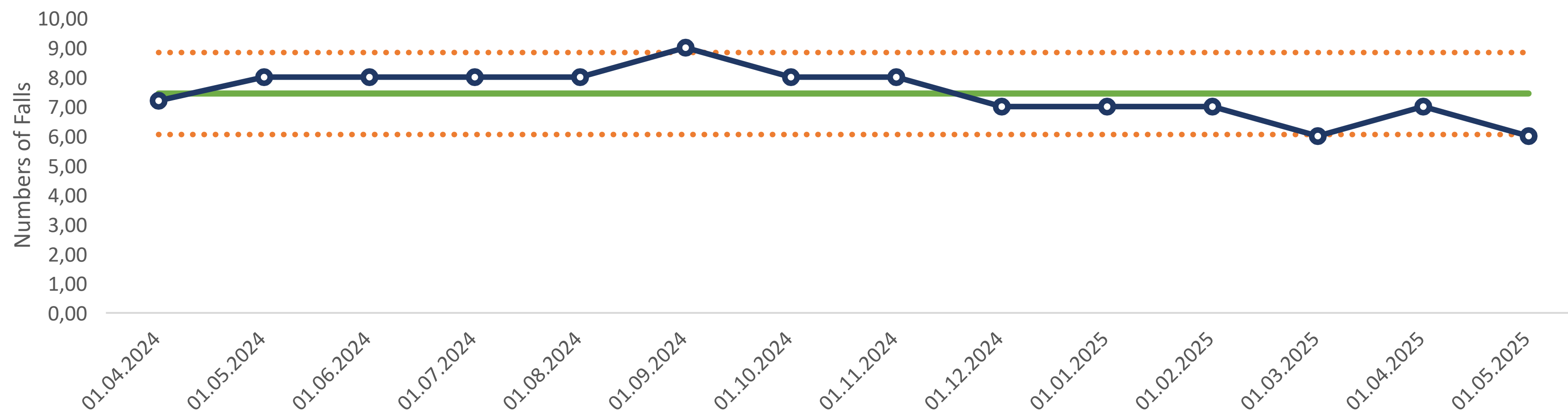
July 2025 - Context

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

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	• For the given period of analysis, the mean average of fall incidents is 300 with minimal variation which represents a decrease in relation to the last report. • Although April saw a rise in reported falls incidents, subsequently the numbers for May 2025 has seen the lowest value since April 2024 (274).	Minimal variation for period of analysis. No values exceeded the identified control limits.

QOF Metric - Pillar Two: Health Board Wide Inpatient Falls per OBD





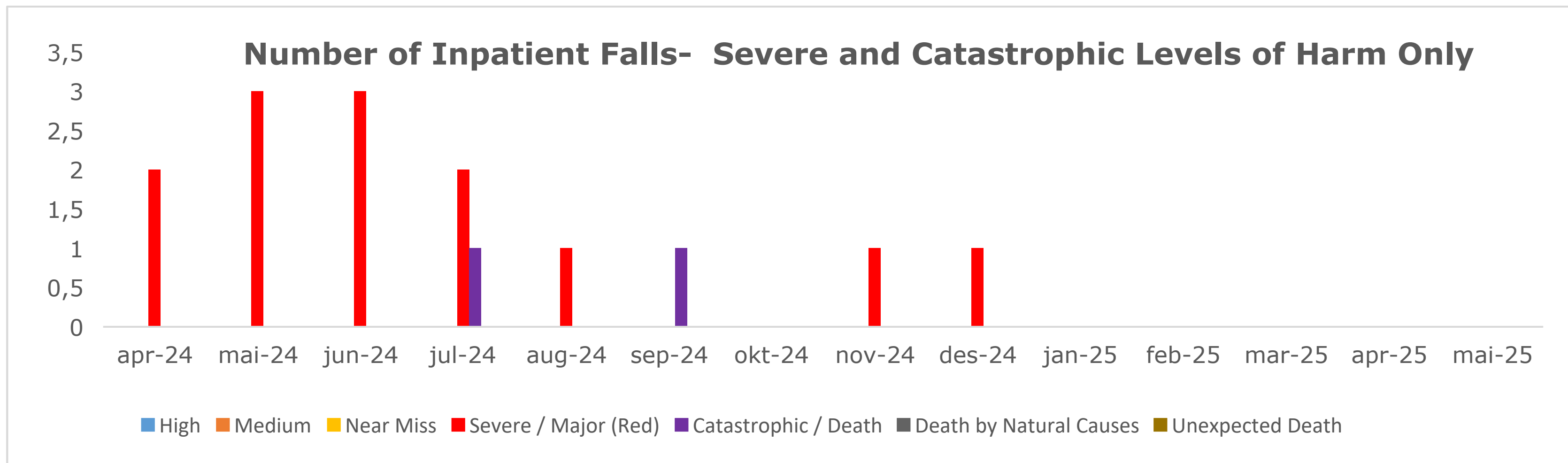
July 2025 - Context

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

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

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	The value aligned to per 1000 Occupied Bed Days (ODD) has been below the mean average value for the period of analysis for 6 consecutive months.. Both March and May values for OBD's represent the lowest for the period of analysis (6.4), which is below the National average (6.6). The increase in April 2025 shows some corelation with the increased numbers of reported falls incidents for that month.	Positive variation in that there has been a positive downwards trajectory since September 2024.

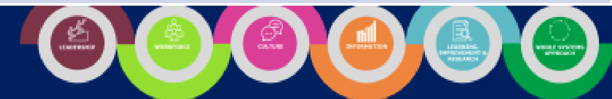
QOF Metric - Pillar Two: Health Board Wide Inpatient Falls Severity of Harm



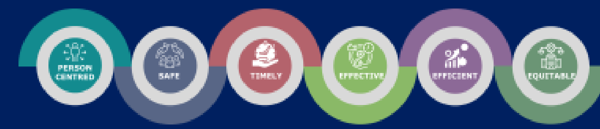
July 2025- Context

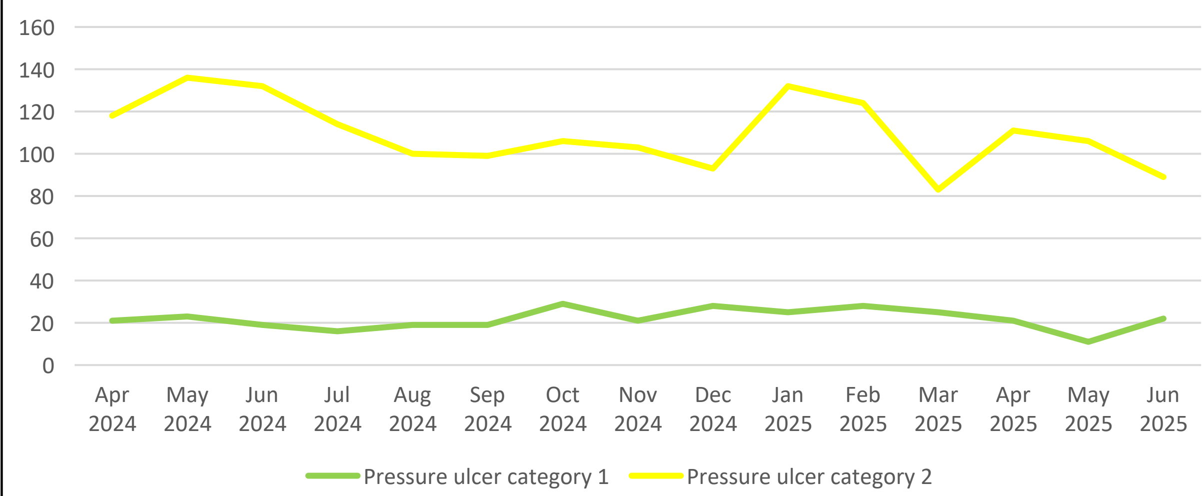
The data represents the collective information for ABUHB and refers to the severity of harm for reported falls incidents for the period April 2024 to May 2025

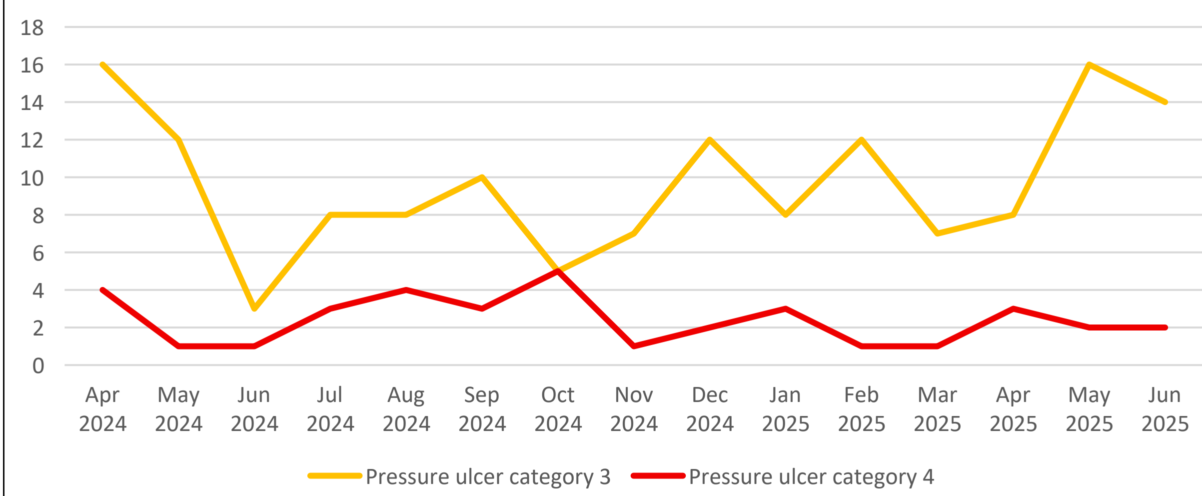
Definitions	What the chart tells us	Variation/ Analysis
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source.	The total numbers of falls incidents reported for which the severity of harm is categorised for the given period is 4211. Of the total April 2025 (312) = 7.4%, whilst May 2025 (274) = 6.2%. For **April and May 2025**, the following details the severity of harm: • 99% - No or low harm • 1% - Moderate harm • 0% Severe harm • 0% Catastrophic	For the period of analysis there have been no reported incidents of falls resulting in a catastrophic outcome since September 2024 with no instances of severe harm since January 2025. Such severities of harm for the period of analysis (April 2024 – May 2025) is as follows • 0.29% Severe harm • 0.05% Catastrophic

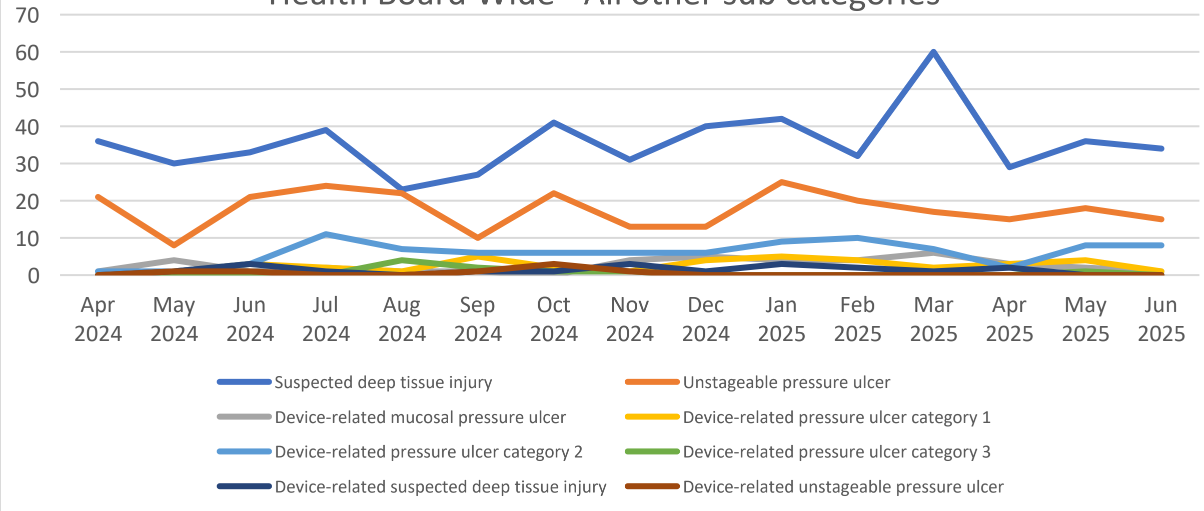


Hospital Acquired Pressure Ulcers

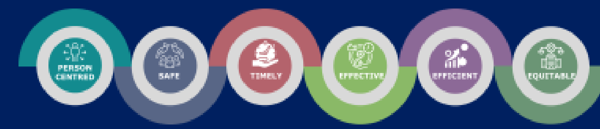


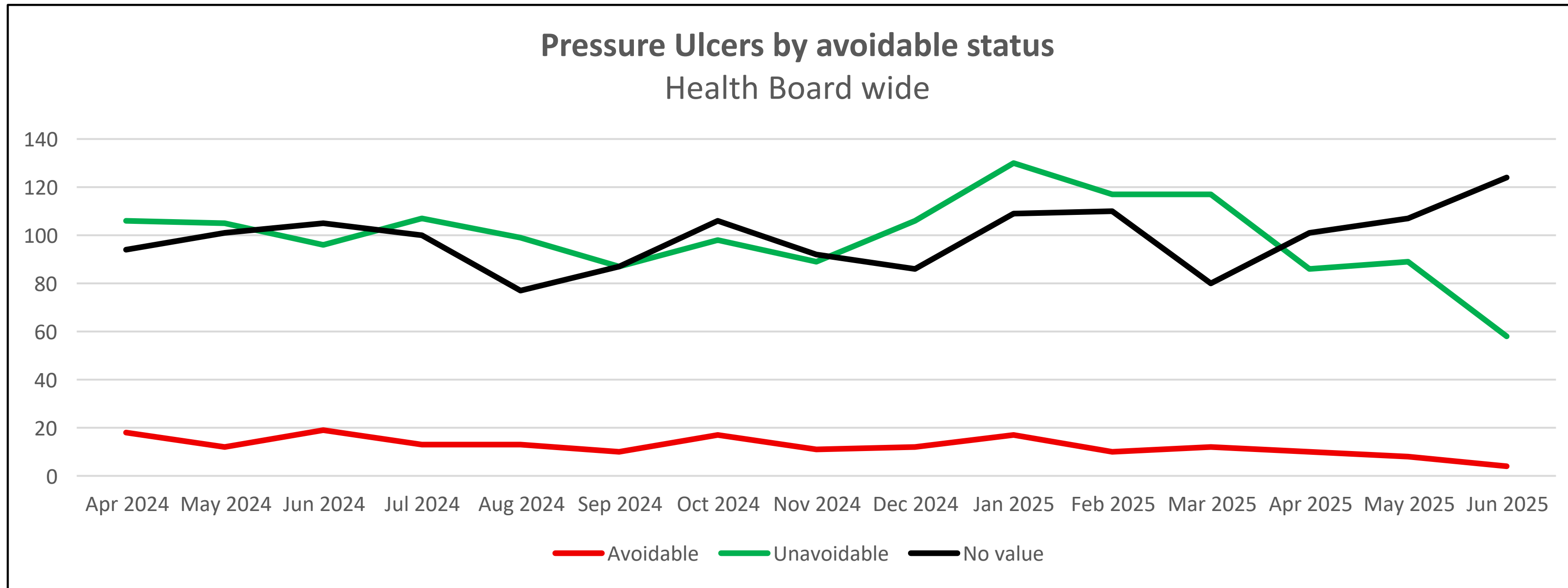






Hospital Acquired Pressure Ulcers

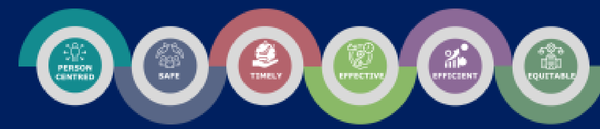




High occurrence of **"No Value"** incidents.

No Value incidents pertain to incidents that have not been assessed through a Datix Focus Review to ascertain whether the damage is Avoidable or Unavoidable. Consequently, a key objective of the steering group is to assist divisions in thoroughly reviewing any outstanding cases (No Value) to enhance the validation process.

Pressure Ulcer Steering Group



❑ Re-established Steering Group – Divisional Representation

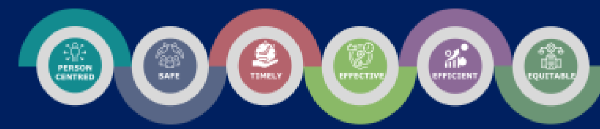
❑ Agreed Terms of Reference

- The aim of the group is to eradicate the incidences of avoidable hospital acquired pressure ulcer damage and moisture lesions.
- Develop a reliable validation process to ensure accurate reporting
- The 6 pillars of quality will underpin the work of the group, which will embrace a whole-systems approach. Measuring and assessing quality is essential for monitoring progress and identifying areas for improvement.

❑ Primary Focus

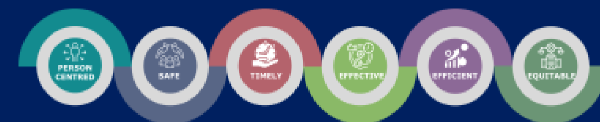
- **Improve Datix reporting**
  - **Reducing No Value entries**
  - **Timely review of outstanding cases awaiting closure**
- **Scrutiny panels**

Learning, Actions & Improvement



Issue	Action	Learning and Improvement	Who	When (RAG)
Quality of Datix Reporting – correct grading, duplication, adding a value (Avoidable or Unavoidable), Focus Reviews & closure	Through the Steering Group. work with divisions to develop achievable processes to improve the validation of incidents	Grading guides & resources available on the Tissue Viability webpage to support improvement.	All Divisions	Ongoing
Access to air mattresses Mattresses arriving in clean packaging – damaged or contaminated	Ensure staff are aware of how to access mattresses via Drive Report incidents of damaged or contaminated mattresses to Drive immediately	Posters & booklets available to support mattress choice. Education programme in place at YYF. Plan to roll out to other sites. Review process for mattress purchase and hire across all divisions.	All divisions	ongoing
Timely investigation & share learning	Establish regular scrutiny panels Complete investigations & Yorkshire contributory factors on Datix	Identify themes & actions to improve. Share via QPS forums & HAPU steering group	All divisions	ongoing
Validation for Grade 2 pressure ulcers	Senior Nurse review and sign off for all grade 2 pressure ulcers. Provide information for clinical teams on reporting , roles and responsibilities and the focussed review process.	Flow chart developed by Division of Surgery. To test the process, feedback to group, learning to be shared and flow chart implemented across divisions.	Deputy Head of Nursing – Division of Surgery	September 2025

Claims and Redress – 2024/25 Activity



Quarter	Clinical Negligence	% Difference
Q1 24.25	27	-
Q2 24.25	33	+22%
Q3 24.25	26	-21%
Q4 24.25	39	+50%
Q1 25.26	22	-44%

Quarter	Redress	% Difference
Q1 24.25	7	-
Q2 24.25	9	+29%
Q3 24.25	12	+33%
Q4 24.25	6	-50%
Q1 25.26	7	+17%

Clinical Negligence:

- 22 new clinical negligence matters, including GMPI, received during quarter 1.
- Down on Q4 2024/25 when 39 new matters received
- 425 total number of open clinical negligence + General Medical Practice Indemnity matters as at end of June 2025.

Year on year, overall numbers remain steady

Personal Injury:

- 7 new personal injury matters received during quarter 1.
- Of the 7, 5 were employees (71%)
- 89 live open personal injury matters as at the end of June 2025.

Personal injury claims continue to remain steady, at a historic low, during this quarter

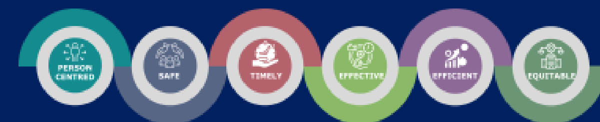
Quarter	Personal Injury	% Difference
Q1 24.25	12	-
Q2 24.25	13	+8%
Q3 24.25	4	-69%
Q4 24.25	8	+100%
Q1 25.26	7	-13%

Redress:

- 7 cases taken to Panel. 5 had QL, 3 required further investigation
- 10 cases not for Redress following sifting/review
- 3 returned to Divisions for further work and re-submission
- Redress enquiries are increasing across the Health Board (Duty of Candour impact)

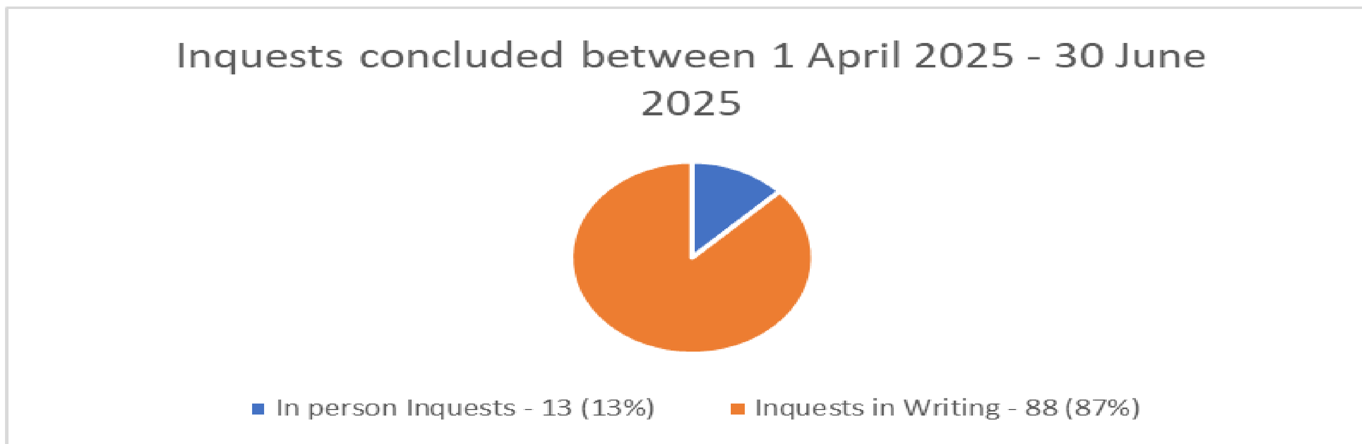
On average, each case settled through the Redress process will save the Health Board an estimated £30,000 in costs arising had those cases become clinical negligence claims.

Inquests – 2024/25 Activity



Inquests:

- **120** new inquests received during Quarters 1. This represents **40 new inquests a month coming in**
- This represented a **43% increase** on the same period Q1 2024
- **101** inquests were concluded during Qrt1.
- **13 inquests** concluded in Court, staff supported at all 13 by Legal Services Team
- **88** inquests **(87%)** were concluded in writing by the Coroner, avoiding the need for staff attendance

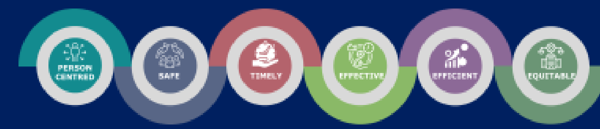


Quarter	Inquests	% Difference	
Q1 24.25	66	-	
Q2 24.25	55	-17%	↓
Q3 24.25	105	+91%	↑
Q4 24.25	123	+17%	↑
Q1 25.26	120	-2%	↓

Reg 28: Prevention of Future Deaths Reports:

- The Coroner issued 1 Regulation 28 report during Quarter 1.
- The report raised concerns with nutrition and hydration of patients.
- A comprehensive response compiled, setting out assurance of the steps taken to embed sustained improvements, a dedicated governance structure, including the Strategic Nutrition and Hydration Group.

QOF Metric - Pillar Two: Trends in Medication Incidents



Medication Incidents	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Total
None	63	46	50	63	54	47	77	83	59	52	57	60	56	68	68	**903**
Low	63	71	66	64	60	71	84	83	58	61	82	73	105	77	82	**1100**
Moderate	9	17	12	28	23	19	18	19	24	26	22	13	15	9	19	**273**
Severe	5	5	1	4	6	5	3	4	4	4	4	1	1	2	3	**52**
Catastrophic / Death	0	0	0	0	0	2	1	0	0	0	0	0	0	0	2	**5**
Total	**140**	**139**	**129**	**159**	**143**	**144**	**183**	**189**	**145**	**143**	**165**	**147**	**177**	**156**	**174**	**2333**

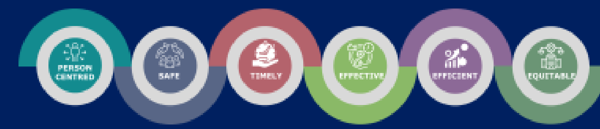
Quarter	Moderate	Severe – Catastrophic	% Difference	
Q1 24.25	38	11	-	
Q2 24.25	70	17	+78%	↑
Q3 24.25	63	12	-14%	↓
Q4 24.25	61	9	-7%	↓
Q1 25.26	34	8	-40%	↓

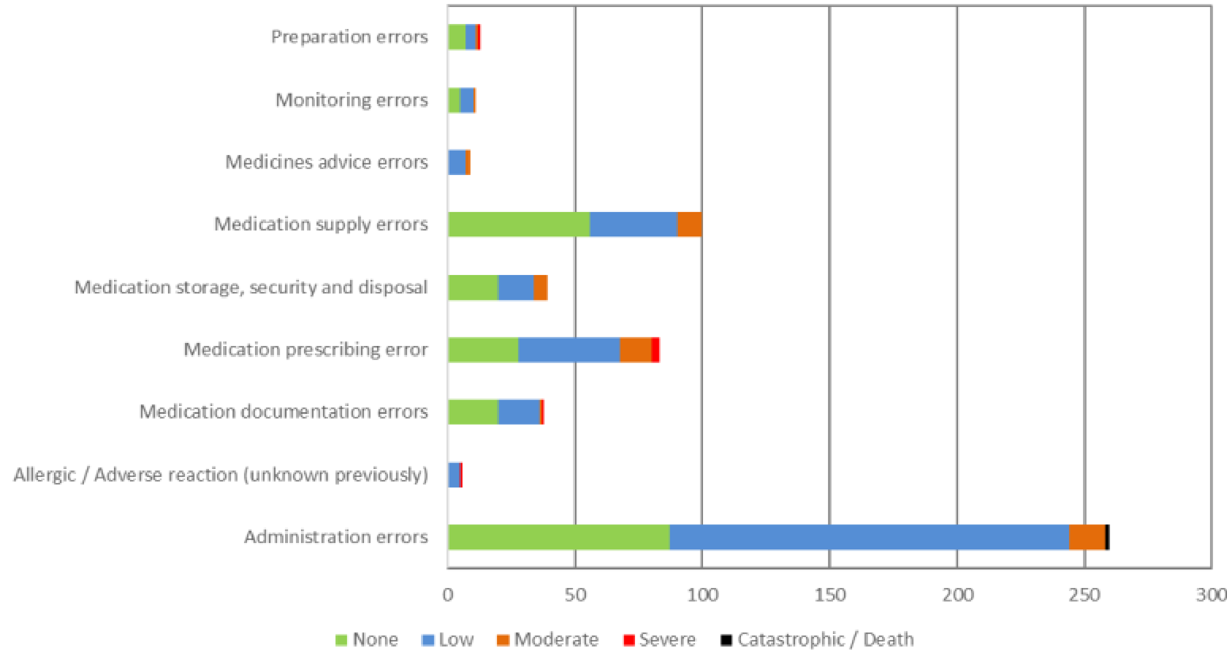
Narrative Summary of Quarterly Trends

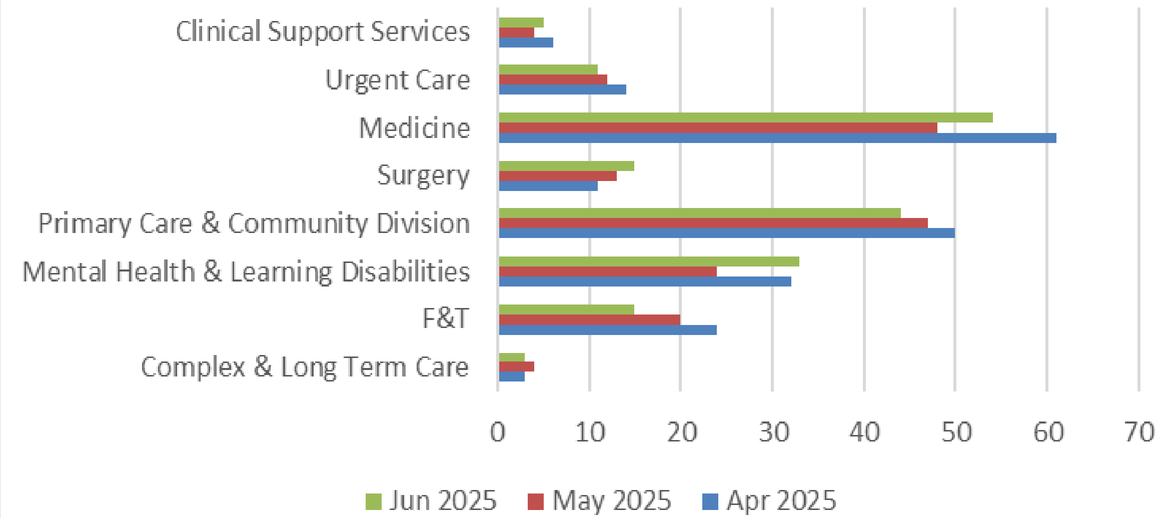
The data reveals a **notable fluctuation** in incident volumes across the five quarters:

- **Q1 to Q2 2024** saw a sharp increase of 78%, indicating a significant rise in reported incidents. This could reflect either a genuine spike in moderate-severity events or improved reporting and awareness during this period.
- **Q2 to Q3 2024** experienced a 14% decrease, suggesting that some corrective actions or interventions may have begun to take effect, though the reduction was modest.
- **Q3 to Q4 2024** continued the downward trend with a 7% decrease, indicating a gradual stabilisation but still relatively high incident levels compared to Q1.
- **Q4 2024 to Q1 2025** marked the most substantial drop, with a 40 decrease, potentially reflecting the impact of sustained quality improvement efforts, policy changes, or targeted training initiatives.

QOF Metric - Pillar Two: Trends in Medication Incidents







Administration errors are the most frequent, with the highest number of incidents.
Medication prescribing errors are the second most common.
Other notable categories include: Medication documentation errors, Monitoring errors and preparation errors
Medicine consistently reports the highest number of incidents across all three months.
Most divisions show fluctuations across the three months, but no single month stands out as universally higher or lower across all divisions.

DIVISION	Apr 2025	May 2025	Jun 2025	Total
Complex & Long Term Care	3	4	3	10
F&T	24	20	15	59
Mental Health & Learning Disabilities	32	24	33	89
Primary Care & Community Division	50	47	44	141
Surgery	11	13	15	39
Medicine	61	48	54	163
Urgent Care	14	12	11	37
Clinical Support Services	6	4	5	15
Total	**201**	**174**	**180**	**555**

QOF Metric - Pillar Two: Medication Safety Group 2025/26

Item	Action	Learning and Improvement Progress	Who	When
Meeting the HEIW Standards for Quality Assurance for all Non Medical (NMP) and Supplementary Prescribers (SP)	Action plan for N&M complete. MDT group representing IPs and SPs met and action plan for all disciplines will be managed. Declaration of Scope of Practice – well embedded Royal Pharmaceutical Society – competencies converted to self-assessment document Demonstrating competence – Portfolio document developed and awaiting ratification by the group.	Standardisation process is now being embedded by N&M leads MDT leads engaging and aligning within individual regulatory bodies and HEIW requirements. Meeting held June 2025 with professional representatives and HB action Plans populated for nursing, pharmacy and allied health care professionals	Karla Hobbs, member of the short life working group Includes Karen Hatch (HCPC), Hana Thabrees (pharmacy)	6 – 12 Ongoing work with updates provided to quarterly Med safety group.
High Risk Medication - Categorise and report incidents related to high-risk medications at MSG.	Priority 1 – Anticoagulation incidents. Task and finish group will meet and identify; a. The processes in place for prescribing and administering anticoagulation b. The risks and barriers to target change Priority 2 – Time critical Medicines Priority 3 - Insulin	ERASE poster and Staff bulletin –MDT and organisational approach required to manage incidents. A deep dive required for anticoagulant action plan and review processes and protocols. T & F group met June 2025 New Dashboard in development to capture and analyse anticoagulant and time critical medicines incidents	Task and Finish group. Divisional leads/ KH/Pharmacy lead CB/JT/JH Dashboard Support from Lynne Davies	
Medicines Governance Audits	Develop a comprehensive medicines audit governance tool. .	Current tool taken from the DECI includes medicines audit requirements Separate tool from AMaT is required. Work with divisions to identify all medicines storage areas	KH/JH /AG Met May 2025 Support from Grace Hargreaves	
Controlled Drug SOPs	Complete the SOPs for all CD SOP recommended by CQC.	8 CD SOPs to include the journey from ordering to storing within the clinical area are ready for review. This is support the recent ERASE poster CD SOP for use in community under review	Karla Hobbs – In progress working with pharmacy and QPS leads	

BESS – Document review in progress, meeting with leads from Primary and Community care for feedback related to BESS. BESS – Document review in progress, meeting with leads from Primary and Community care for feedback related to BESS. Education and Revalidation review for N&M –Divisional N&M Practice educators met March 2025. Ongoing key stakeholder engagement to progress the policy. Final draft policy due by Sept 2025.

PILLAR 3

Complaints, Concerns and Compliments

QPSE Dashboards

PTR Regulations

Patient and Staff Feedback

Complaints – Themes and Learning

PSOW – Themes & Learning

Psychologica l Safety

Leadership, Accountability and Culture

Collaborative Forums

Staff Training and Mentorship (IO)

Early and Regular Contact

Speaking up Safely

Metrics: -

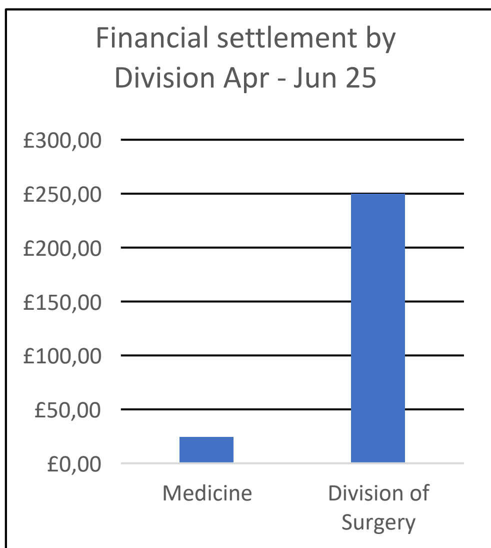
- 30 day performance
- Concerns
  - Review layers to look at compliance and closure
- Compliments
- PALs (especially early resolution)

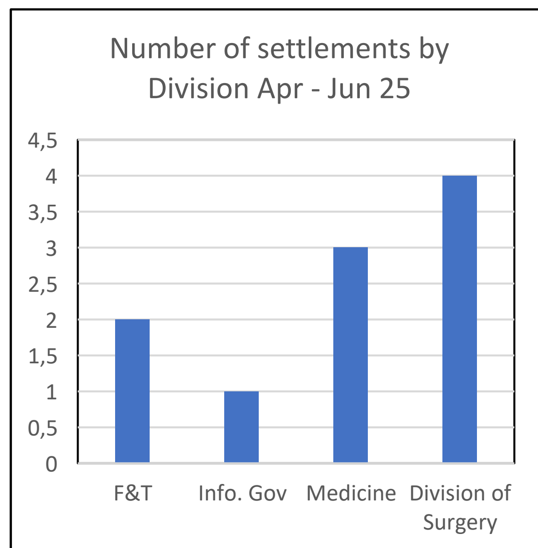
QOF Measure – Pillar 3 Concerns Compliance with 30 days target

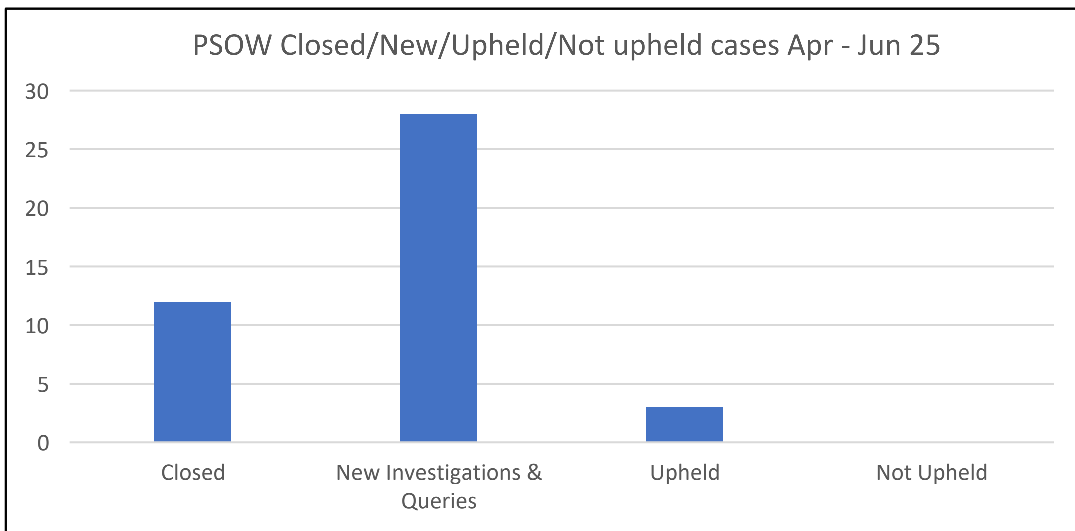
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
	2024								2025				
Compliant	53.91%	45.86%	50.68%	57.35%	51.88%	50.93%	51.67%	51.43%	54.81%	46.74%	46.32%	50.69%	52.45%
Non-Compliant	46.09%	54.14%	49.32%	42.65%	48.13%	49.07%	48.33%	48.57%	45.19%	53.26%	53.68%	49.31%	44.76%
Outstanding - Compliant	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.80%

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. The data is live and is an ever-evolving picture as matters are opened and closed by several members of the team during the course of the mandated timeframes for recording concerns –9-5, Mon-Fri.	The data is reported up to May to align with the Beacon dashboard and to ensure that inaccurate data is not recorded, noting 2.80% of cases received in May are still open within the compliance timescales and being expedited. The trend for those matters closed under PTR has been relatively consistent across the reporting period, this has been achieved through considerable validation work by the PTR and QPS SMT. It is intended that benchmarking will be provided in the future, to offer a more meaningful comparison of performance and measurement on a National scale.	The SMT have given considerable time to the validation work. Further dedicated time has been allotted to continue work with Divisional colleagues to decrease aged cases. Closure of any case which is >30-working days will negatively impact cases that are being closed within compliant timeframes. This intends to be balanced by improved documentation to bridge the transition between Early Resolution to PTR matters. This will also improve compliance with the WG target on a longer-term basis until the PTR regulations are updated to 10-working days in 2026.

QOF Measure – Pillar 3 Ombudsman (PSOW)







Issue	Action Taken Position/ Learning & Improvement
Settlement was reached following a complainant's dissatisfaction with an initial early resolution outcome. The PSOW intervened to request that the HB provide a formal response.	Divisional coordinators now engage with complainants at the outset to determine and agree upon the most appropriate resolution pathway, whether formal or through early resolution.

Learning and Completed Recommendations

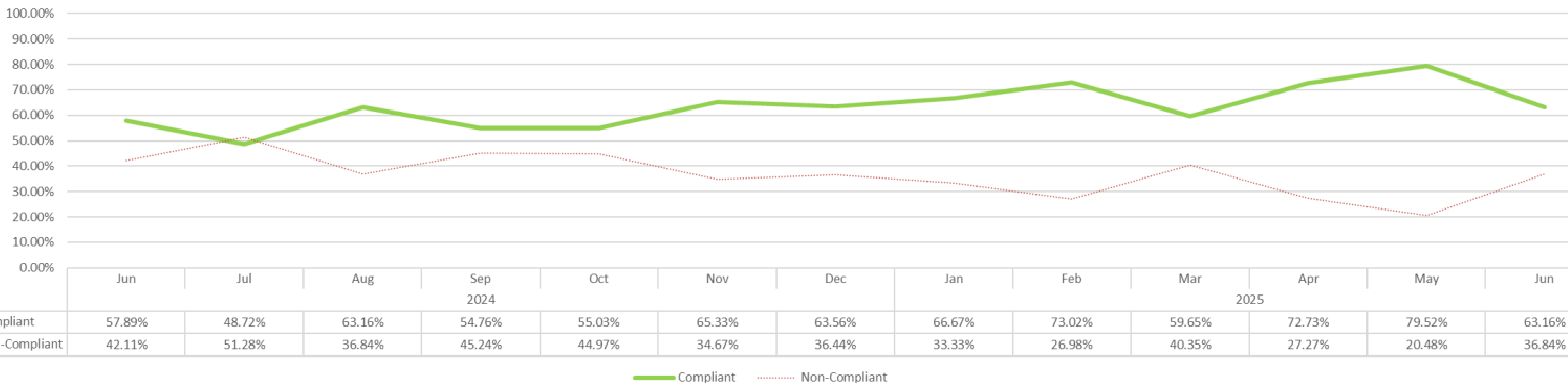
Issue: Identification of a fracture/delayed clinical assessment.
Learning & Actions: The importance of screening surrounding joints has been communicated to staff via the ABUHB Physiotherapy Service. During the Physiotherapy Rehabilitation Executive meeting, it was highlighted that any change in mobility in an elderly person should raise a higher suspicion of a fracture. The Medicine Division has agreed to share this important reminder across all sites as a learning point for the entire Division.

Issue: There was a delay in conducting a clinical assessment. In addition, two occurrences of incorrect NEWS scoring were identified, as well as a delay in the provision of appropriate pain relief.
Learning & Actions: The Urgent Care Division will disseminate the recommendations to the team, and the results of this report will be reviewed at the upcoming Safety Meeting.

Issue: Post-procedure pain and discomfort should have led to re-admission for assessment, which could have identified peritonitis and bowel perforation earlier.
Learning & Actions: The incident and learning were discussed at the Quality and Patient Safety Directorate meeting in May. 2025. The discharge leaflet has been revised to include clear advice for post-procedure discomfort and 24-hour contact numbers. Specialist Screening Practitioners now follow up patients following difficult procedures via telephone. Lessons learned will be shared at the QPS Listening and Learning Forum and the Endoscopy Users Group meeting.

QOF Measure – Pillar 3 Concerns–
Early Resolution Compliance with 2 working days

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	2024							2025					
Early Resolution	133	117	133	126	149	150	118	180	126	171	88	83	76
Managed through PTR	154	143	132	158	106	116	102	134	90	134	142	144	119
Reopened	3	5	4	3	2	4	3	1	2	2	2		2



	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	2024							2025					
Compliant	57.89%	48.72%	63.16%	54.76%	55.03%	65.33%	63.56%	66.67%	73.02%	59.65%	72.73%	79.52%	63.16%
Non-Compliant	42.11%	51.28%	36.84%	45.24%	44.97%	34.67%	36.44%	33.33%	26.98%	40.35%	27.27%	20.48%	36.84%

Definition

The above represents the organisation’s rolling position for compliance with responding to concerns to be managed as Early Resolution – which is day of receipt +1(informal). Reporting is now aligned with NHS Executive Beacon Dashboard, therefore % Compliance is being reported against the month received. This data is obtained from the Once 4 Wales RL datix system, which is populated by the Health Board’s corporate PTR team.

The data is live and is an ever-evolving picture as matters are opened and closed. This data does include some matters being recorded by the PALS team.

Analysis

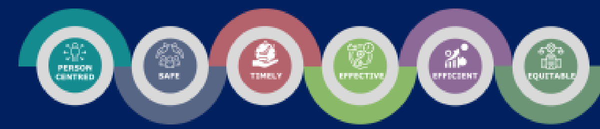
The data does note a decrease in the number of cases being reported as Early Resolution matters. This is as a result of improved triaging at the point of receipt. Understanding from the outset whether the contact with the PTR team equated to an enquiry or was a concern which could be resolved verbally within the prescribed timeframes. This is being agreed with people accessing our services straight away.

The beginning of the reporting period did achieve a positive compliance figure, June remains live and therefore, there is the opportunity for some of these matters to be concluded in timeframe or to achieve PTR compliance if necessary.

Implications

The SMT recognise the challenges for operational teams in trying to achieve day of receipt +1 (which may for example be 16:50hours for instance) for closure of Early Resolution matters to achieve compliance. This is being offset by an improved process to bridge Early Resolution to PTR matters.

QOF Measure – Pillar 3
Compliments 2024/25



Number of Compliments Received

180
160
140
120
100
80
60
40
20
0

Jun 2024 | Jul 2024 | Aug 2024 | Sep 2024 | Oct 2024 | Nov 2024 | Dec 2024 | Jan 2025 | Feb 2025 | Mar 2025 | Apr 2025 | May 2025 | Jun 2025

Definition	Analysis	Implications
The graph above shows the number of compliments recorded on Datix from June 2024 to June 2025.	Two obvious spikes are visible in October 2024 and March 2025, these correlate with increased capacity to record paper/email compliments received.	Compliments and feedback can be provided to the Health Board through various routes and the trend the themes within this feedback allow viability of good practice.

QOF Measure – Pillar 3: Patient Advice & Liaison Service

	jun-24	jul-24	aug-24	sep-24	okt-24	nov-24	des-24	jan-25	feb-25	mar-25	apr-25	mai-25	jun-25
Escalated to PTR	2	6	2		1	3		1	1			1	
Early Resolution	27	12	8	5	4	12	12	20	21	22	18	15	17
Enquiries	490	430	406	400	482	409	453	535	429	419	323	488	457

Enquires Overview: -

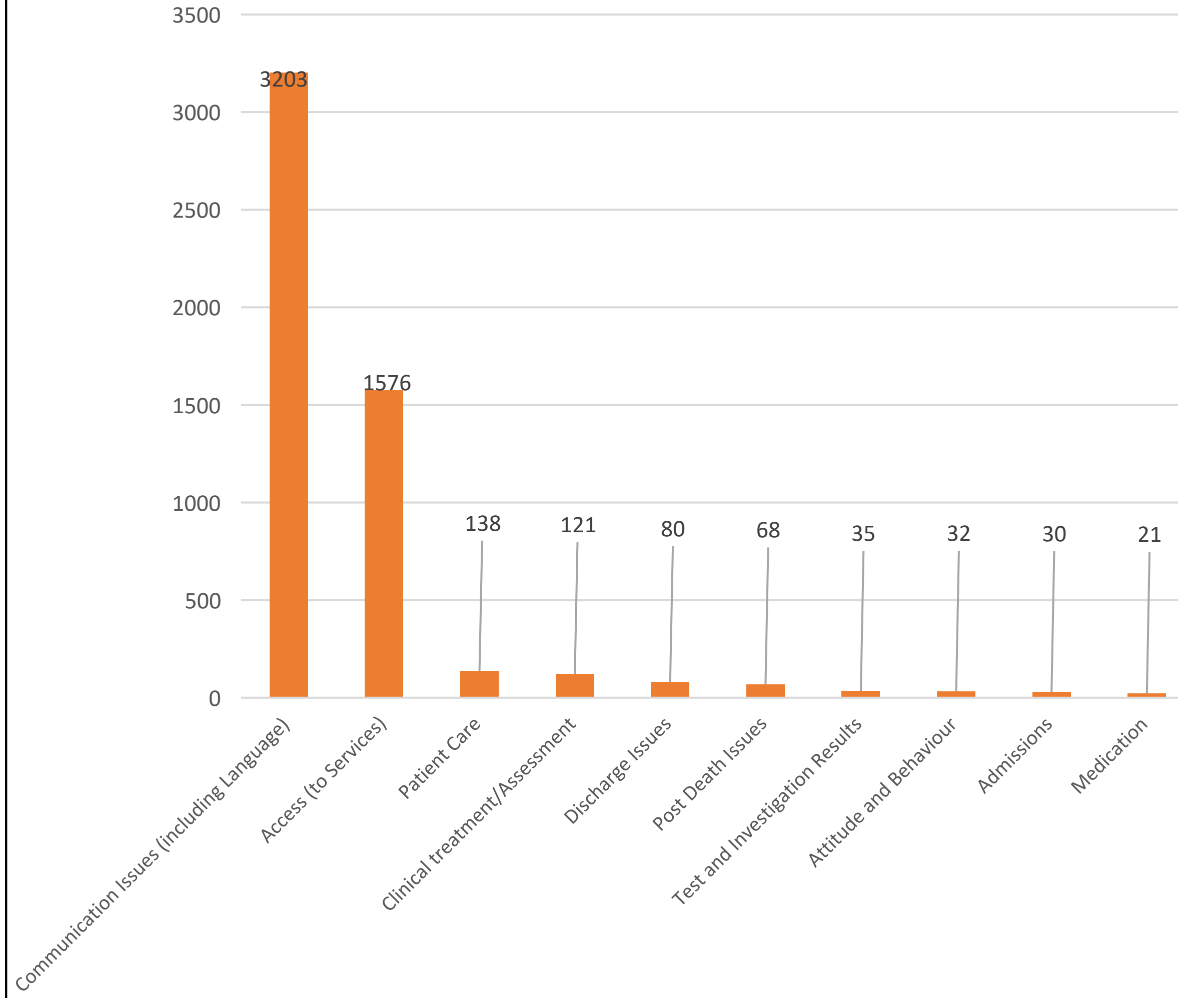
June 2024-June 2025

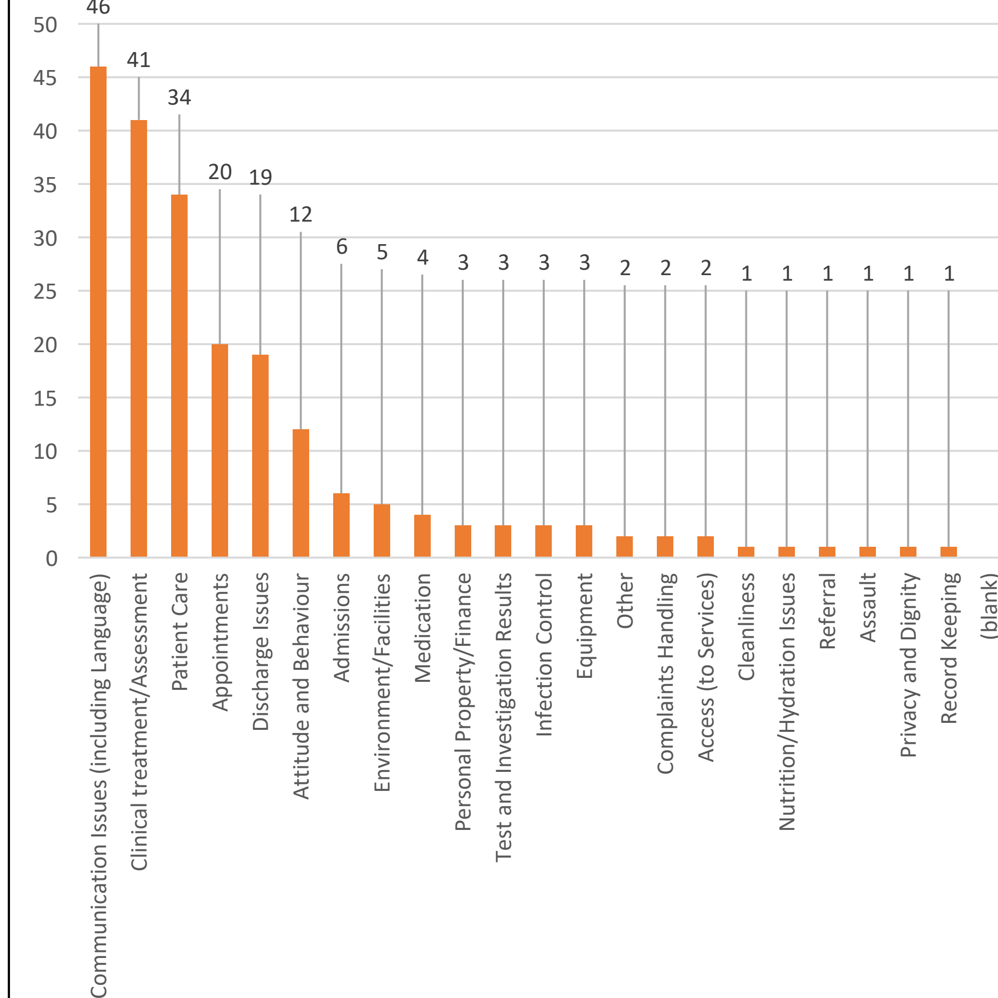
- 5932 cases managed by PALS
- 17 Escalated to PTR = 0.28%
- Early Resolution primarily applies to concerns sent from PTR to PALS.
- PALS deal with many concerns that could be listed as Complaints, however PALS manage them under Enquires due to complexity of some cases.

Quarter One 2025.26

- Enquiries remain the dominant contact type, with a slight increase in May before dipping in June.
- Early Resolution contacts are relatively stable across the quarter, ranging between 17 and 18.
- Escalations to PTR peaked in April (22), then declined in May (15). The value for June is not clearly specified but appears to be lower or missing.

QOF Measure – Pillar 3: Patient Advice & Liaison Service





Of 5721 Enquires the overall Theme is Communication Issues, with 3203 Enquiries related to Communication - 56%

211 Early Resolution Complaints
46 concern Communication Issues -22%

QOF Measure – Pillar 3: Patient Advice & Liaison Service

Case Study 1: Trauma-Informed Support Transforms Patient Experience
A patient with complex PTSD had a distressing interaction with a consultant at The Grange, which worsened her symptoms. Her husband raised a formal complaint via the Putting Things Right team. A PALS Officer, also a qualified counsellor, visited the patient, used grounding techniques, and built a trusting relationship. They created a tailored support and visiting plan and worked with ward staff to ensure ongoing awareness. As a result, the patient chose not to proceed with the complaint, highlighting the positive impact of PALS involvement.

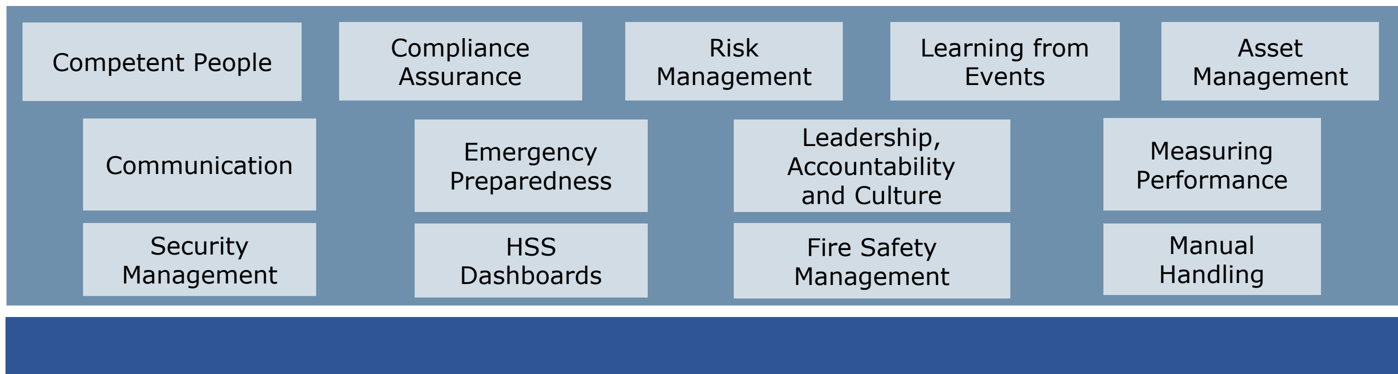
Case Study 2: Proactive Planning for a Vulnerable Patient
A familiar patient contacted PALS post-discharge, expressing fear and isolation due to lack of family and communication tools. The team developed a proactive plan: if readmitted, hospital staff would notify PALS, who would then provide support and inform her friends and community. When she was readmitted weeks later, the plan was activated successfully. This case demonstrates how PALS builds long-term, anticipatory relationships that extend beyond single episodes of care.

Case Study 3: Compassionate Connection Across Continents
A man in Canada, unable to reach the Emergency Department, contacted PALS for an update on his mother. The PALS Officer provided reassurance, visited the patient, and conveyed her son's love. The elderly patient, distressed and alone, was comforted by the Officer's presence and conversation. She later expressed deep gratitude. The PALS team continues to support her during her inpatient stay, showing how a single call can lead to sustained, meaningful care.

Case Study 4: Neurodiversity-Aware Support Reduces Distress
A neurodivergent patient (autism and ADHD) experienced a panic attack after PICC line insertion. A Patient Support Officer contacted a PALS Officer, who travelled from another site. By the time they arrived, the patient was calmer. The Officer, knowledgeable in neurodiversity, helped the patient explore safe self-regulation strategies and provided ongoing support. This improved the patient's wellbeing and reduced pressure on nursing staff. Upon discharge, the patient expressed a desire to stay involved with PALS, offering her lived experience to help others.

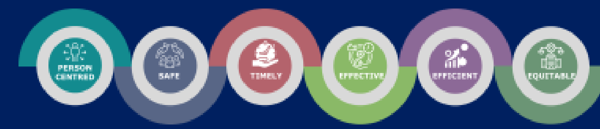
PILLAR 4

Health, Safety and Security



Metrics: -

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

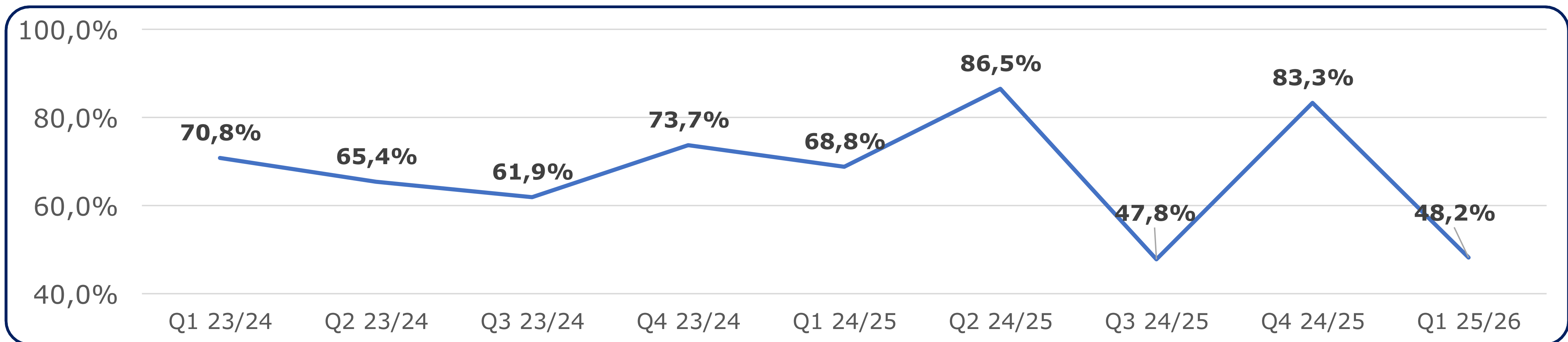


Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

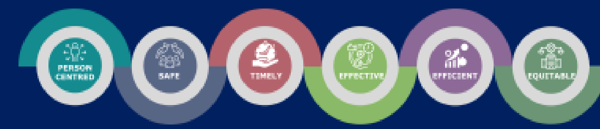
During Q1 2025/26 the Health Board have reported **29 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

48.2% of these cases were reported within the legal timeframes within the legislation.

This is a decrease on the previous quarter. The majority of incidents were reported outside the legal timeframes due to late notification to Corporate Health and Safety



Health, Safety and Security



Health and Safety Executive (HSE) Engagement

The HSE inspected Hafan Deg Ward at County Hospital in June 2025. The focus of the inspection was on the management of challenging behaviour and how that impacts on staff managing the risk of violence and aggression and the safety of patients from absconding, self harm etc. The HSE have issued a notification of contravention letter identifying breaches in health and safety law. The health Board needs to provide a response to the recommendations by 30 September 2025.

An action plan has been developed to address the recommendations to support the response.

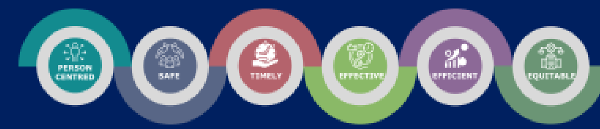
In addition to the above, the Health Board have two active cases with the HSE, both relate to fatal patient falls reported in accordance with RIDDOR.

South Wales Fire & Rescue Service (SWFRS) Activity

The has been no enforcement activity from South Wales Fire & Rescue Service during Q1 2025/26.

The Health Board have received exemption against specific areas of the organisations Estate to ensure SWFRS respond to automatic fire alarms. These are prominently Inpatient areas in Community Hospitals. The Health Board are currently awaiting responses to the applications submitted for specific risk areas at Nevill Hall and Royal Gwent Hospitals.

Health, Safety and Security



Health and Safety Statutory and Mandatory Training

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

There has been a small increase in training compliance for Health & Safety and Violence Prevention & Reduction, however, compliance against Fire Safety and Manual Handling has reduced slightly

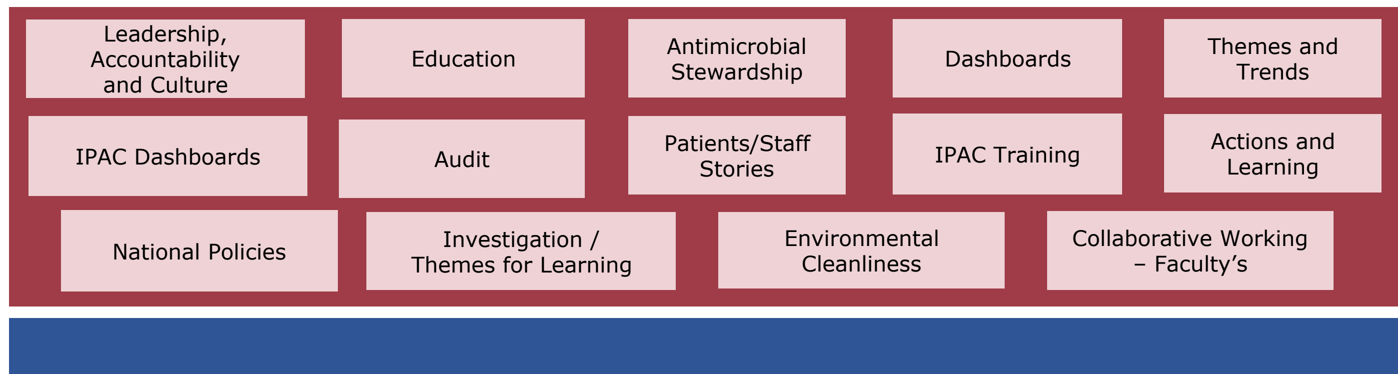
Health & Safety	**86.6%**
Fire Safety	**81.7%**
Violence & Aggression	**86.3%**
Manual Handling	**69.2%**

Health and Safety Training Framework

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

PILLAR 5

Infection Control and Prevention



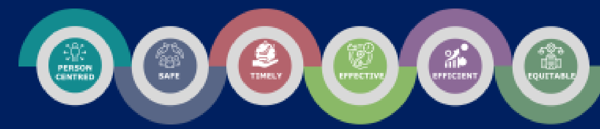
Metrics: -

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

Developing Metrics: -

- DECI and Hand Hygiene

Healthcare Associated Infections



All Wales – Current FY rate per 100,000 population

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	39.07	2.02	24.25	56.59	16.84	7.41
Betsi Cadwaladr UHB	42.31	2.9	27.24	74.19	19.71	2.9
Cardiff and Vale UHB	37.15	3.87	28.64	51.85	20.12	4.64
Cwm Taf Morgannwg UHB	32.34	0.9	22.46	88.03	28.75	2.69
Hywel Dda UHB	48.57	4.13	27.9	86.8	32.04	5.17
Powys THB	14.92	0	2.98	0	0	0
Swansea Bay UHB	54.56	2.06	30.88	66.91	27.79	9.26
Velindre NHST						
Wales	**40.56**	**2.54**	**25.86**	**67.18**	**22.18**	**4.94**

Green: < than same period last FY

Amber: = same period last FY

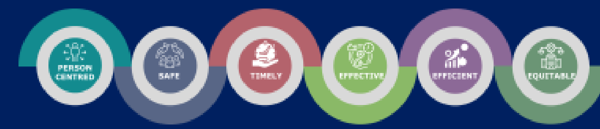
Red: > than same period last FY

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	58	3	36	84	25	11
Betsi Cadwaladr UHB	73	5	47	128	34	5
Cardiff and Vale UHB	48	5	37	67	26	6
Cwm Taf Morgannwg UHB	36	1	25	98	32	3
Hywel Dda UHB	47	4	27	84	31	5
Powys THB	5	0	1	0	0	0
Swansea Bay UHB	53	2	30	65	27	9
Velindre NHST	0	0	1	4	0	0
Wales	**320**	**20**	**204**	**530**	**175**	**39**

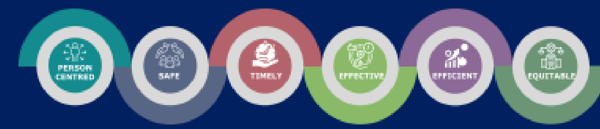
Issue	Action	Learning and Improvement	Who	When
C difficile infection Apr 2025 – Jun 2025 = **58 cases** **22** = Healthcare associated **20** = Community acquired **5** = Indeterminate **9** = Relapse **2 =** Other Health Board	RCA for all Healthcare associated infection Antimicrobial request to GP for all Community acquired infections Participated in national learning event Paper drafted for proactive enhance cleaning	Continue to promote fundamental IP and antimicrobial stewardship Define a process for mattress storage and ordering Quality improvement project re ward cleanliness tested on D5W	All Divisions	Ongoing
Wards closed due to C difficile **nhh 3/3** **rgh D2E**	Outbreak meeting implemented Ward HPV cleaning Increased monitoring for fundamental Infection Prevention	Currently no links via geno sequencing D2E participating in C difficile collaborative on further investigation one case CAI and second case linked to AMU or D2W	Wards IPT	
Staph Aureus BSI Apr 2025 – Jun 2025 = **39 cases** **17** = Healthcare associated **20** = Community acquired **0** = Indeterminate **0** = Relapse **2 =** Other Health Board	RCA for line associated infection implements Continue to promote ANTT Linked with AMU and ED re potential contaminant blood stream infection	Planned quality improvement project within urgent care for blood cultures Linked with BD to support ongoing education for blood collection	All Divisions	Ongoing

Fundamental IP Measures



Compliance from RCA for healthcare associated C difficile cases

Source of Infection



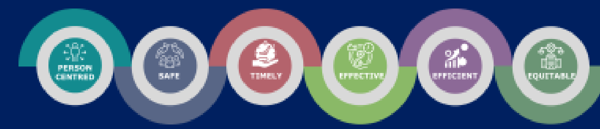
Staph Aureus blood stream infections

Source	Count
line	1
hepatobiliary	2
other/unknown	5
bone & joint	6
skin & soft tissue	11
respiratory	13

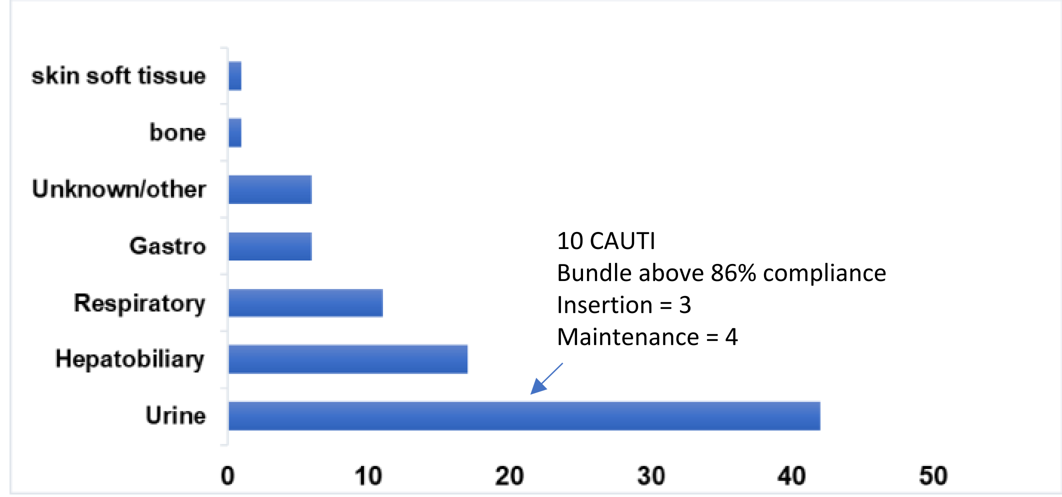
1 Line Infection
Bundle above 86% compliance
Insertion = 1
Maintenance = 0

Issue	Action	Learning and Improvement	Who	When
E coli BSI Apr 2025 – Jun 2025 = **84** **21** = Healthcare associated **63** = Community acquired **0** = Indeterminate **0** = Relapse **0 =** Other Health Board	Catheter associated blood stream infection RCA implemented Developed an ERASE for best proactive for collection of blood cultures	Storage of urinary catheter stands AKI promote hydration Ongoing care for HOUDINI now on electronic nursing records to promote awareness and compliance Quality improvement project re ward cleanliness tested on D5W	Divisions IPT	Ongoing
Klebsiella BSI Apr 2025 – Jun 2025 = **25** **8** = Healthcare associated **16** = Community acquired **0** = Indeterminate **0** = Relapse **1 =** Other Health Board	Catheter associated blood stream infection RCA implemented	As above	Divisions IPT	Ongoing
Pseudomonas BSI Apr 2025 – Jun 2025 = **11** **3** = Healthcare associated **5** = Community acquired **1** = Indeterminate **0** = Relapse	Catheter associated blood stream infection RCA implemented	As above	Divisions IPT	Ongoing

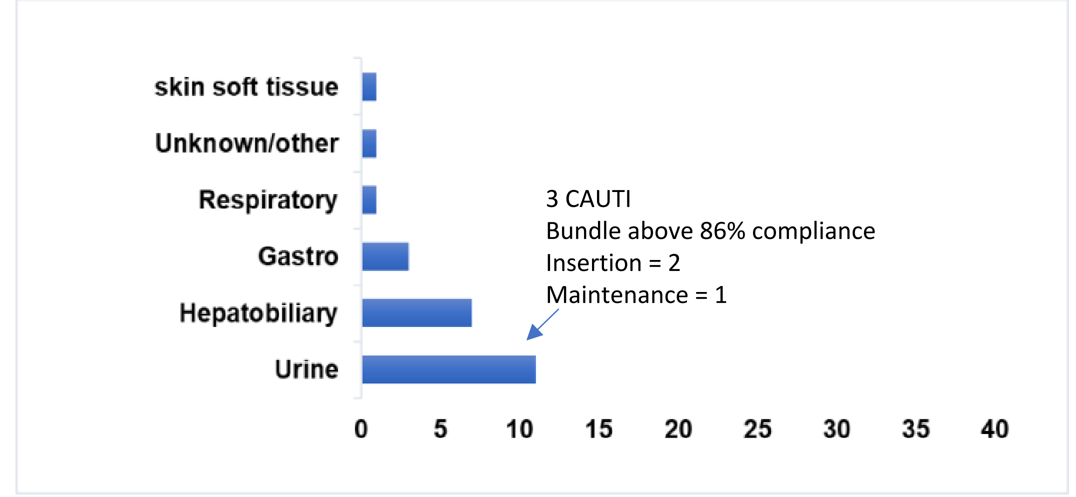
Source of Infection



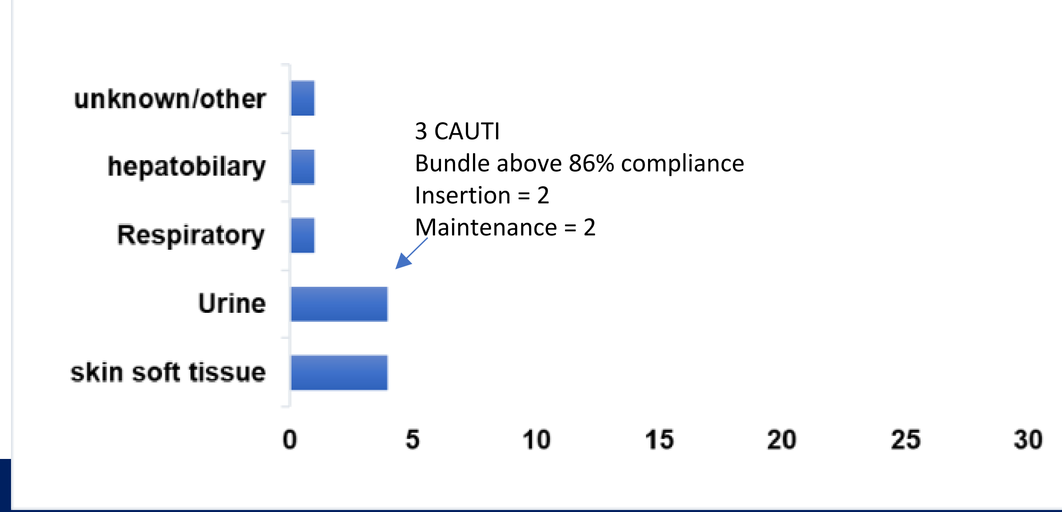
E coli blood stream infections



Klebsiella blood stream infections

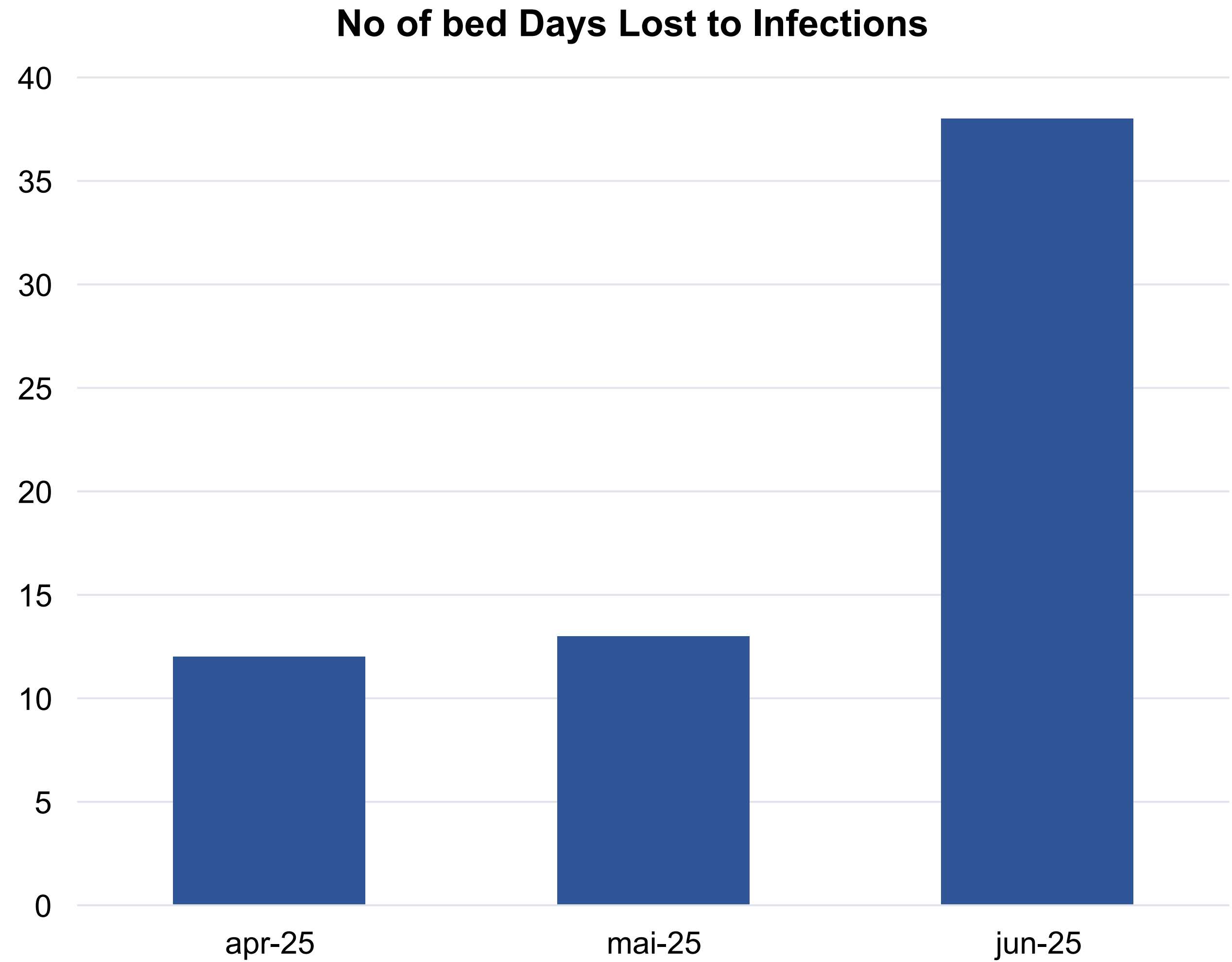


Pseudomonas blood stream infections



Bed Day Lost to Infections – June 2025

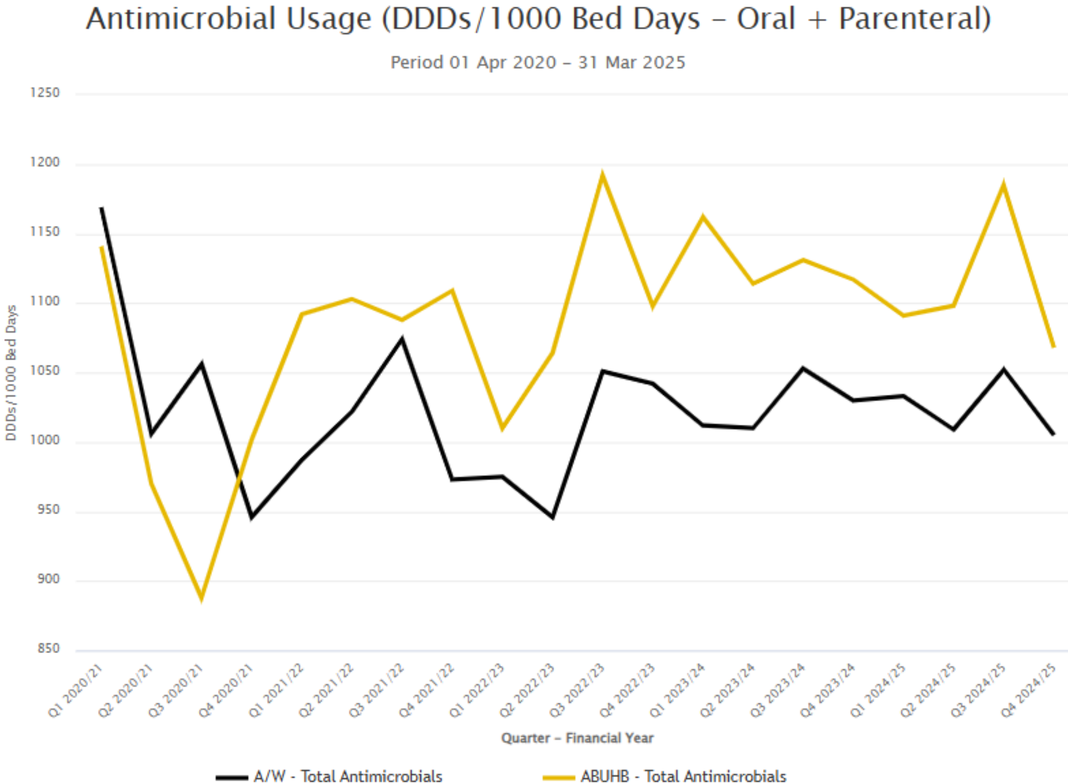
- RGH D4W closed due to Covid
- Increase of C difficile on NHH 3/3 & RGH D2E



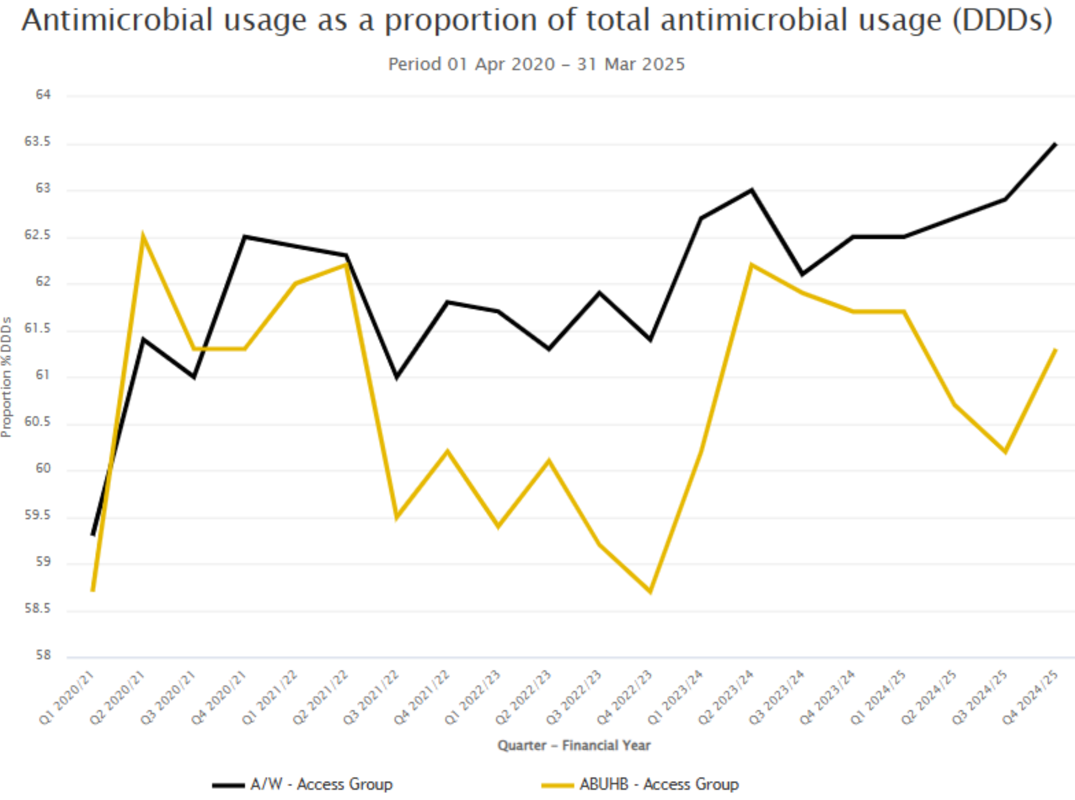
Issue	Action	Learning and Improvement	Who	When
Three patients tested positive for enterococcus infections post-surgery while on ward 4/2 at Nevill Hall Hospital. All three patients had positive urine results and had been catheterised at some point. The infections were identified post-surgery, and the patients had undergone T&O surgery.	• Increase the frequency of hand hygiene audits • Drain disinfection using parasitic acid. • Declutter of ward environment • Conduct weekly Houdini audits with a focus on practical observation rather than just documentation. • Undertake a dashboard audit alongside senior nurse	Ensure sufficient supply of catheter stands and that they are cleaned independently and not reused. Storage of equipment within bathrooms Ongoing promotion of fundamental infection prevention practice	Ward Manager Facilities Senior Nurse Infection Prevention	Up to 4 weeks if no further cases
Healthcare associated Carbapenemase producing organism linked to Ward A4 at The Grange	• Increase the frequency of hand hygiene audits • Undertake compliance audit for MRSA & CPO screening • Cleaning with increased strength Actichlor solution • Mattress check • Meeting arranged for 08/07/25	Patient did not fit national screening criteria Frequent admission to ABUHB risk factors include IVDU Follow up of hostel contacts Patient alerted	Ward Manager Urgent care Primary care	Ongoing
2 residents & 2 staff diagnosed with scabies at The Oak Residential Home	• Treatment programme commenced for residents & staff • Staff to wear long sleeved gowns when performing close contact care • Contacts advised to seek treatment advice from	Ensure diagnosed is linked with specialist advice or via some observation Repeat treatment 1 week later and monitor for 8 weeks	Care home/GP	Ongoing

Pillar 5: WG Antimicrobial Performance: Secondary Care

- As data are reported in arrears, the position from PHW describes 24/25 FYE. Q4 demonstrates a decrease in volume, towards the all-Wales average. Whilst this welcome progress, in real terms however, there is no significant decrease from the 2019/20 baseline (target 5% decrease by 29/30 FYE)
- Q4 saw an increase in proportion of use in the lower risk ‘access’ group, but remains a way off the 70% target by 29/30 FYE.
- Business as usual antimicrobial ward rounds have resumed in Q1 25/26 due to improved Medical Microbiology & Antimicrobial Pharmacist staffing. Work is starting to introduce antimicrobial rounds to medical wards at GUH in autumn 2025.
- Work continues to embed good antimicrobial stewardship (AMS) principles into the new electronic-prescribing system, with roll-out commencing in 26/27 FY.



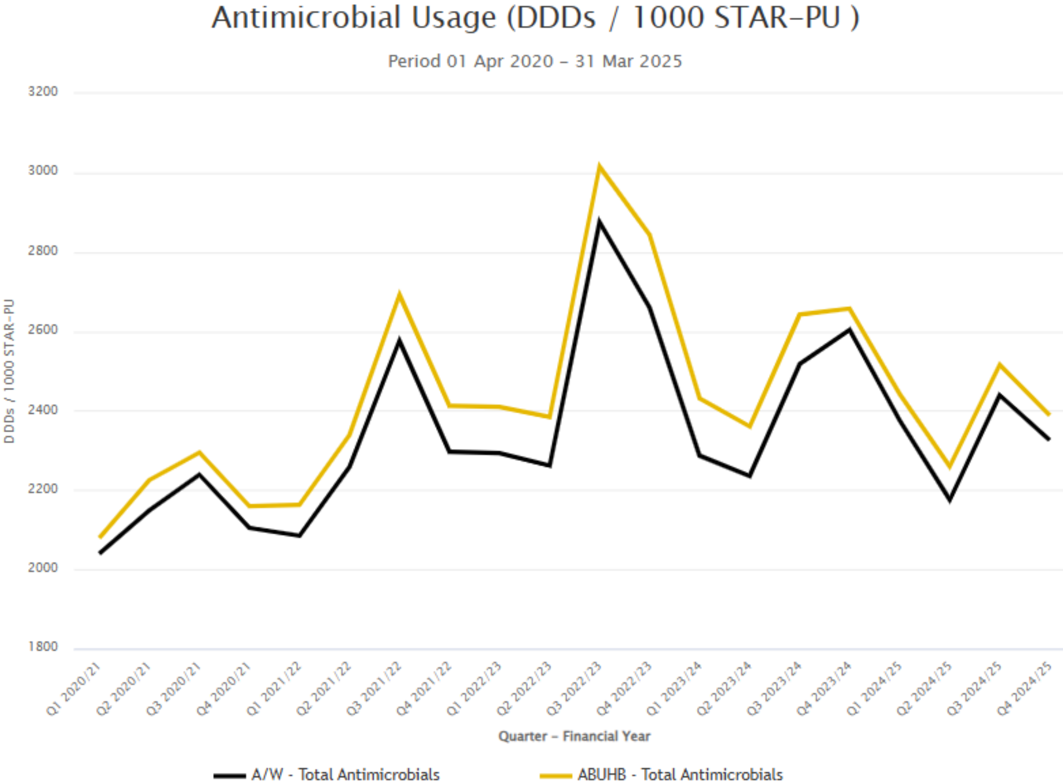
Secondary care volume with ABUHB above the all-Wales average



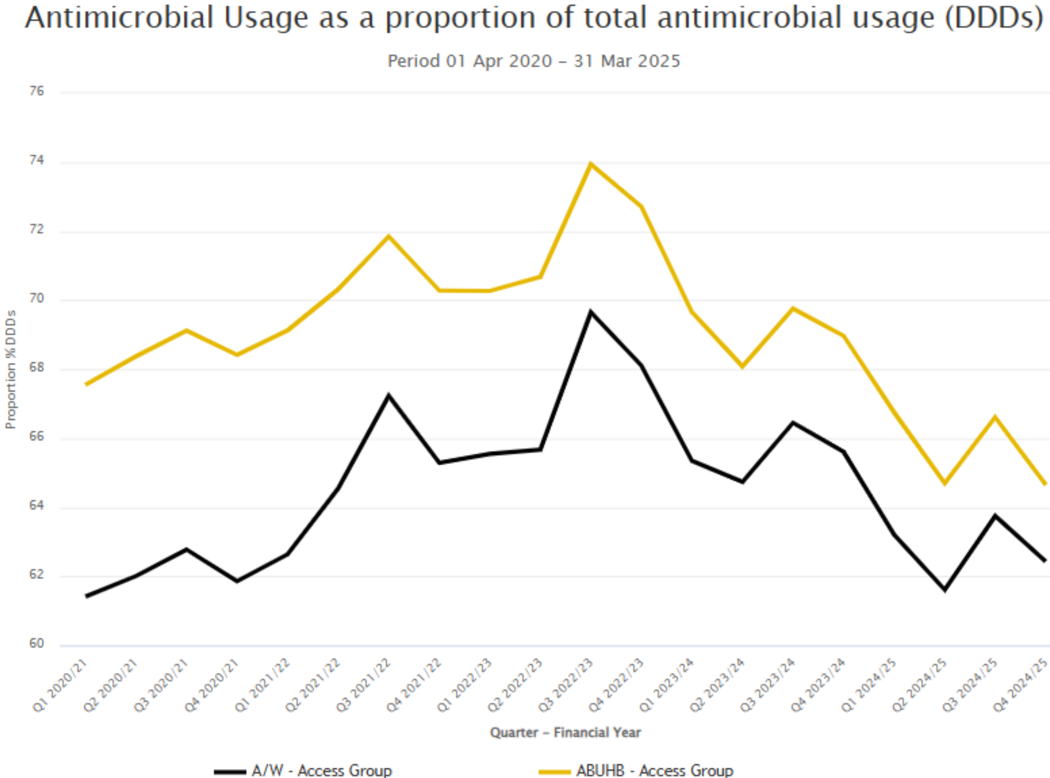
Secondary care ‘access’ use below the all-Wales average & 70% target

Pillar 5: WG Antimicrobial Performance: Primary Care

- Data to 24/25 FYE demonstrate a reduction in volume, but still tracking above the all-Wales average. This reduction has been assisted by the move from 7-day to 5-day prescriptions for 3 antibiotics commonly used for respiratory infections, with ABUHB achieving the best performance in Wales for this metric.
- The reduction in volume continues to have a negative impact on attainment of the 'access' category target, with ABUHB moving away from the target of 70% prescribing of lower-risk 'access' antibiotics, but above the all-Wales average
- The AMS team have met with the AB Public Health Team who will be building a dashboard to map antibiotic usage against key demographic & admissions metrics, in the hope that it will provide actionable insights
- The AMS team have expanded teaching to GP trainees in Q1, and fed back current performance to NCN leads



Primary care volume with ABUHB above the all-Wales average



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

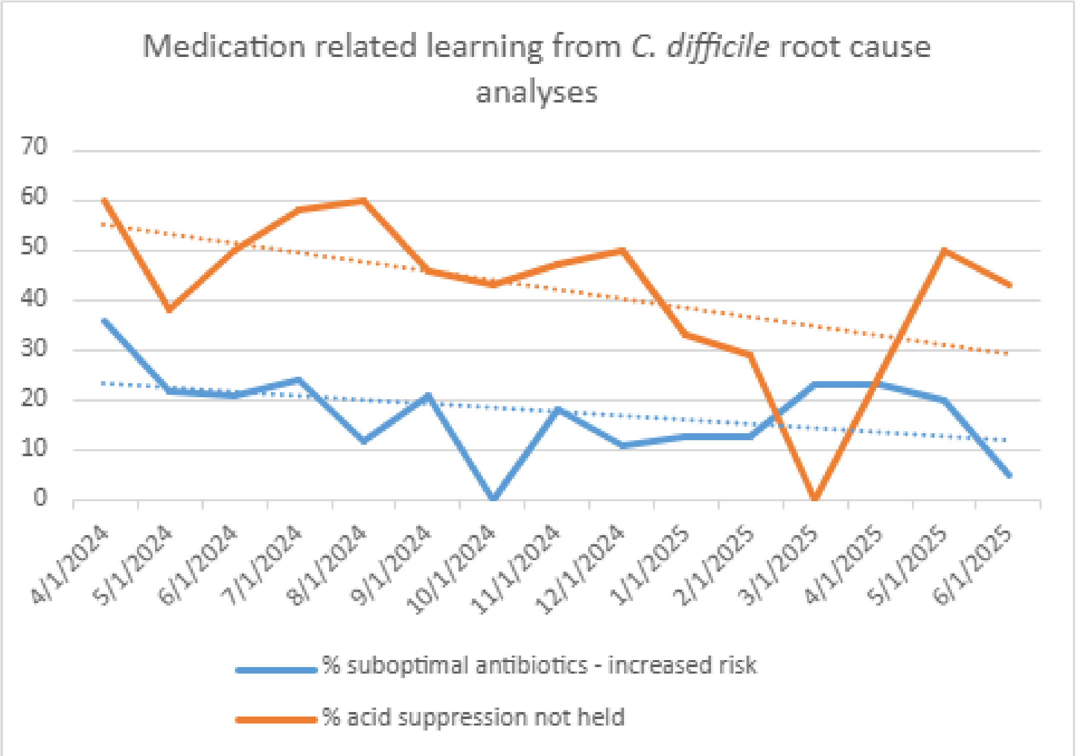
Pillar 5: WG Antimicrobial Performance: Overarching Actions

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

Pillar 5: C. difficile Antibiotic Themes

April 25 to June 25

Antibiotic Finding		HCAI	CAI	Relapse	Indeterminate	Total
No antibiotics received	0	3	1	3	1	**8**
No suboptimal antibiotics	1	9	5	1	1	**17**
Possible suboptimal use - no increased risk	0	2	2	1	1	**6**
Possible suboptimal use - increased risk of C. diff	1	5	1	1	1	**9**
Awaiting GP response	0	0	7	4	2	**13**
RCA pending	0	1	0	1	2	**4**
Total	**2**	**20**	**16**	**11**	**8**	**57**



2025-26 Q1 Learning

- **9 patients received suboptimal antimicrobials, with a few commonalities:**
    - Unnecessarily long antibiotic courses (GUH surgery, GUH critical care & YYF)
    - Piperacillin/tazobactam (Tazocin) and co-amoxiclav use outside of guidelines (GUH AMU & medicine, YYF, GPOOH)
    - Antibiotic cover not reviewed in light of culture results (GUH medicine, GP)
    - Patient given 7 days antibiotics for cellulitis when symptoms likely caused by gout (RGH)

- **Increase in patients on acid suppression managed inappropriately**
    - To be discussed at Antimicrobial Working Group in conjunction with audit findings

PILLAR 6
Safeguarding

Policy/SOP	Leadership, Accountability and Culture	Level 1, 2 and 3 Training	Safeguarding Supervision
Practitioner Concerns	Partnership Working	Domestic Abuse and Sexual Safety	Statutory Reviews

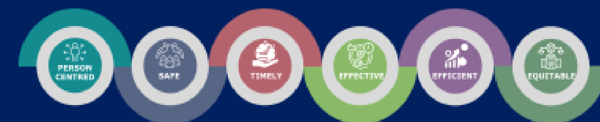
Metrics: -

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

Developing Metrics:

- Themes from domestic homicide reviews and serious case reviews

Pillar 6: Safeguarding – Duty to Report



	Quarter 1			
	2023/24	**2024/25**	**2025/26**	**Increase**
Adult Duty to Report	72	102	173	+140%
Children Duty to Report	963	1090	1053	9%

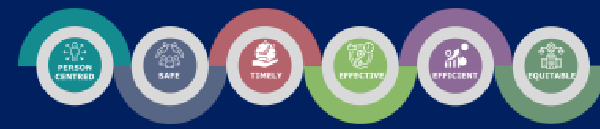
Ensuring Early Learning and Timely Closure

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

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

This process has now been in place for over a full yearly quarter, and there have been good responses both Divisionally and from Gwent Police, which have provided assurance that early learning is captured and have enabled case closure in a timelier manner.

Pillar 6: Safeguarding – Training Compliance



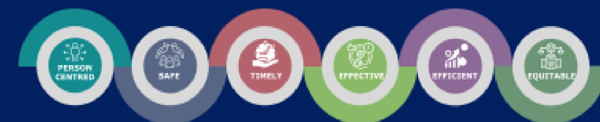
Training Module	Compliance %	Training module	Compliance %
Adult Safeguarding Level 1	82%	**Children's Safeguarding Level 1**	81%
Adult Safeguarding Level 2	83%	**Children's Safeguarding Level 2**	82%
Adult Safeguarding Level 3	15%	**Children’s Safeguarding Level 3**	28%

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

Safeguarding Level 1 and 2 has fallen below the requirement of 85% in Q1, which has been brought to the attention of Divisional Leadership Teams.

Level 3 Children and Adults Training is now mandated via ESR to relevant staff. Efforts are underway to develop a phased training implementation plan, setting revised quarterly targets with the goal to reaching 85% compliance by March 2028.

Pillar 6: Safeguarding – Training Compliance

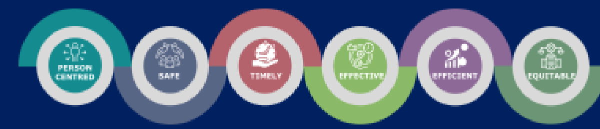


Issue	Action	Learning and Improvement	Who	When
Health Board compliance with level 3 Training and ability to meet the 85% compliance within acceptable time frame. • 2500 Staff for Children's Level 3 • 6500 Staff for Adult's Level 3	Implementation plan under development by the safeguarding team to enable upward compliance trajectory Divisions have been asked to identify staff in order of priority	Challenging to achieve 85% compliance within current arrangements. Options appraisal under development Commitment from divisions to maximise training session attendance	Corporate Safeguarding	Q4
Safeguarding Datix Module to be rolled out Health Board wide to enable staff to complete and submit Duty To Report referrals	Await All Wales multi agency referral form and once completed disseminate Health Board wide.	Implementation of a single system will enable robust monitoring of cases and produce high quality data reports to inform of future challenges and required improvements	Corporate Safeguarding	Q3
Variances between the five Gwent Local Authorities on whether referrals should be made and how safeguarding concerns should be acted upon	To work with the Gwent safeguarding Board, Gwent police and the five Local authorities to update guidance and ensure thresholds are consistent and equitable.	Reducing inconsistency should enable front line staff to properly understand what should be referred and manage expectations of what can be expected following a referral. On completion of new thresholds, information will need to be effectively cascaded to those staff relying upon it	Corporate Safeguarding	Q2

Additional Indicators and Information

Section 5

Accreditation



AWARDS

Total to date:

19 Bronze

6 Silver

Projected by end of year:

6 Gold

15 Silver

40 Bronze.

ROLL OUT:

Phase 1 : Completed

Phase 2 : completed July 2025, 23 areas live and working towards bronze

Phase 3: roll out commenced July 2025.

PROCESS UPDATES:

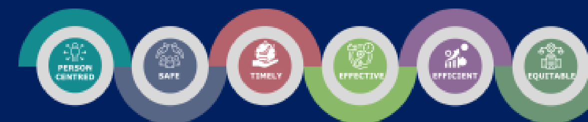
July 2025 - Enhanced Care audits added to the suite of audits

Bronze Independent reviews require 3 consecutive months of compliance in ALL audits

Digital Analyst in post – building a dashboard for accreditation

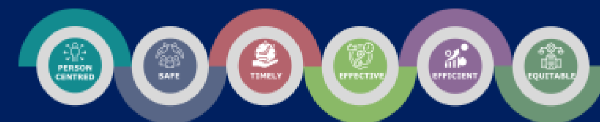
Issue	Action	Learning and Improvement	Who	When
Independent reviews are time and resource heavy.	Independent Reviews deferred for 1-2 audits: Accreditation lead will review deferred audits **only** in 6 weeks	Reduce workload for senior nurses. Quicker review process for deferred areas.	Accreditation Lead	June 2025 (Complete)
Aligning accreditation audit with organisational priorities and updates.	Meet specialist teams to review current audit questions, update where required on specialty advice. Dementia / IPAC / nutrition & hydration / MHLD	Assurance needs to align with organisational action plans / reg 28 actions	Accreditation Lead	Ongoing
Delays in independent reviews due to unavailability of accreditation lead / demand for reviews outweighs supply	Divisional support to lead independent reviews on rare occurrence the lead is unavailable	Avoid delays in process	Divisions	Ongoing

Nurse Staffing Levels Wales Act 2016



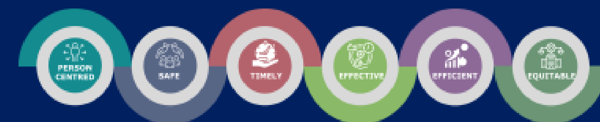
Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical/surgical and paediatric inpatients wards					
Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Total number of incidents/ complaints 1st April 2025 - 30th - June 2025	Number of closed incidents/complaints 1st April 2025 - 30th - June 2025	Total number of incidents/ complaints not closed and to be reported on/during the next reporting period	Number of incidents/ complaints when the nurse staffing level (planned roster was not maintained	Number of incidents/complaints where failure to maintain the nurse staffing level(planned roster) was considered to have been a contributing factor
Hospital acquired pressure damage (grade 3, 4 and unstageable)	7	**1 Avoidable** **4 unavoidable**	**2**	**0**	**0**
Falls resulting in Moderate harm or death (i.e. level 3, 4 and 5 incidents)	**41**	**29 (2 closed as moderate, senior review suggests- do not meet DOC)**	12 under investigation	**0 of the 2 closed as moderate**	**0**
Medication errors, level 3,4,5 & never events	120	104 **(closed as low or no harm)**	16 **(Under Investigation)**	0	**0**
Complaints about nursing care handled through PTR (excludes early res)	81 **(not just nursing, multifaceted)**	2 **(closed as nursing)**	36 **(not just nursing, multifaceted)**	**0 of 2 closed**	**0**
Infiltration/ extravasation injuries	0	0	0	0	**0**

Nurse Staffing Levels Wales Act 2016



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

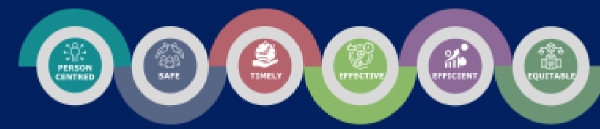
Welsh Nursing Care Record



Update of risk assessment compliance – comparing 2024/2025 to June 2025

Parameter	2024 -2025	June 2025	Status
Overall % of On admission Risk Assessments being completed	67.4%	64.1%	Down by 3.3%
Overall % of Ongoing Risk Assessments being completed	65.2%	60.8%	Down by 4.4%
Overall % of Ongoing Risk Assessments being completed on time	7.4%	10.3%	Up by 2.9%

Welsh Nursing Care Record



Issue	Action	Learning and Improvement	Who	When
Not currently providing quantitative data to wards to support service improvement due to lack of resources within information team. % of Ongoing Risk Assessments being completed on time	WNCR dashboard being developed and data validated	Dashboard under local development. Already had parameters for number and percentage of risk assessment which have been completed on time at admission for those patients who are still admitted. Now looking to develop and validate parameters around patient not seen in the last 48 hours and records not closed for patient that have been discharged. Dashboard will enable divisional oversight to target areas of poor compliance	Information Services (within Digital, Data & Technology)	Some elements n UAT, aiming to have active for ward users by the end of Q1
Upcoming new form releases – catheter care bundle due for release on 1st July 2025	Testing to be undertaken by DDaT with comms to staff prior to release as well as training materials	Significant changes to the WNCR team within DDaT. Plan to use this release to map out a new process for future releases.	Digital, Data & Technology - WNCR team	To be completed after catheter form release and before the end of Q2

Patient Safety Alerts and Notices

Alert	Compliance Deadline	Action to achieve compliance	Status
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients	Sep-23	An SBAR has been updated to highlight the work that has been progressed as part of this PSN and actions that remain outstanding.	In-progress OVERDUE

Patient Safety Alerts and Notices

PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified

Situation:
- ABUHB remains non-compliant with PSN066

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

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

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

Patient Safety Alerts and Notices

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

Declaration of Compliance and Completion of Actions:
Following the death of a patient in NHS Wales, a Regulation 28 'Prevention of Future Deaths' coroner's report was issued concerning the incorrect use of Oxygen CD cylinders manufactured by BOC. This incident prompted a review aligned with the guidance set out in **PSN041 – Risk of Death and Severe Harm from Failure to Obtain and Continue Flow from Oxygen Cylinders** (2018).

In response, the Health Board has undertaken a comprehensive review in collaboration with the **Medical Gases Group** and the **Medicines Safety Group**, ensuring alignment with the broader workplan for medical device training.

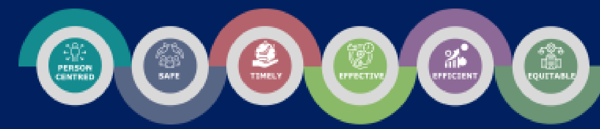
☑ **Actions Completed:**

- **Education and Awareness**:
  - Dissemination of posters and a training video across the Health Board.
  - Visual instructions and video guidance on the safe use and initiation of oxygen therapy from cylinders.
  - Reinforcement of the importance of incident reporting via **Datix** and reference to **MHRA Yellow Card** criteria.
- **Training Compliance**:
  - A dedicated **ESR training module** has been published and communicated across Aneurin Bevan UHB.
  - Staff have been encouraged to complete the module, which is now considered **fully compliant**.
  - No further action is required at this time.

This declaration reflects the Health Board's commitment to patient safety and its proactive approach to implementing national guidance.

Training video for BOC O2 cylinders

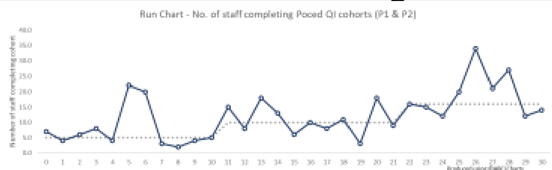
Quality Improvement



Workforce QI Skills Development Framework

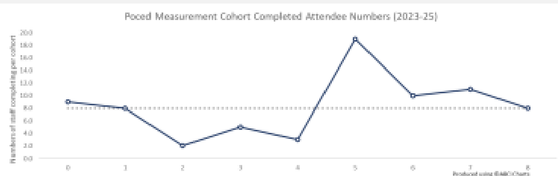
PocEd QI Training (virtual) – 2 half days - QI method/tools

- 375 Staff undertaken training in total



PocEd Measurement Training (virtual) – 1 half day - Time Series Data, includes Runcharts and SPC

- 75 staff trained in total over 9 cohorts



Quality Improvement Advisor Cymru Programme
Year long advanced QI Skills development programme run by QSI Academy

- 3 members of ABUHB staff graduated QIAC
- 2 members of ABUHB staff accepted next cohort

Coleg Gwent Lean Six Sigma

- 2 members of ABCi team gained Black Belt

NHS Elect – Quality Coach Train the Trainer Prg

- Member of ABCi team gained free place

Quality Improvement Coaches embedded

Quality Improvement Coach Programme (face to face) – 4 days total, interactive, experiential prg. Coaches sign up to undertake half day coaching each month. Aim to develop 300 coaches in 4 years

- Cohort 2 complete, Cohort 3 cancelled due to service pressures
- 43 coaches in total have completed the programme (inc. 3 external candidates).
- Cohort 4 fully booked

Aim 'unleash a million minutes of QI Coaching over next four years' 19,980/1000,000 minutes of QI Coaching delivered
Next steps: Divisions to support QI Coach protected time.
Agree methods to prioritise QI work and coach allocation.
QI Coaches attached to upcoming national Safe Care Partnership streams of work.

QI Coach Video
First edit of QI Coaching video complete

Systems to Share Learning

NHS Wales Awards 2025 - applications

- 35 applications from ABUHB across all 12 categories.
- ABCi supported the applications this year or for those not ready, support to develop applications in readiness for next year

QI Delivery

ABUHB Accreditation

- QI maturity matrix mapped to each dimension of the ABUHB Accreditation process: Bronze, Silver, Gold and Platinum. The maturity matrix is structured to develop the following in each area:
  - QI Training
  - QI Practice
  - QI Readiness

QI Programmes

- Theatre Safety Programme – 5 Never Events avoided. Days between events increased from 90 to 518
- Head and Neck Cancer – number of days from suspicion to treatment halved reaching 28 days. Compliance with pathway doubled to 62%

Safe Care Partnership – next slide

Safe Care Partnership - update

The Safe Care Partnership (SCP) is a collaboration between NHS Wales Health Boards, Trusts, Improvement Cymru within HS&I (NHS Executive). The aim of the SCP is to provide nationally coordinated, locally delivered support for safe, reliable and effective care supporting national collaboration and cross boundary learning.

The Safe Care Partnership (SCP) – Next Steps

Deconditioning workstream

Three projects from ABUHB accepted to take part in the Deconditioning workstream:

- Continence promotion – Oak, Rowan, SAU, D4E wards
- Education and Training around deconditioning – C4E
- 'Shred the Bed' – C4E

Additional run across Wales led by CTM Pharmacy

- Self administration of Medication

Also YYF included in research pilot of CEDAR deconditioning tool

Learning sessions due in July and final in November 2025

HCAI – Clostridium Difficile workstream

- Co-design virtual event on 24th June 2025
- Aim to drive C.Diff improvement
- Survey/interviews to gather healthboard expertise/thoughts
- Call for projects July/August
- Learning Sessions – 30th Sept, Feb 2026, June 2026

Acute Deterioration Workstream

The initial phase of this work will be implementation by all health boards and trusts of standardised early warning scores across all ages, supported by the Acute Physical Deterioration Implementation Network (APDIN).

- SCP Acute Deterioration Workstream in person event in July 2025
- Initial focus on implementing early warning score tools ie. NEWS2, MEWS, PEWS, NEWTT2 by 30th Sept 2025
- Focus is on escalation
- Improvement arm of the work to start in the autumn following the implementation phase

Duty of Quality Leaders Workstream

This workstream supports the delivery of effective quality management systems at organisational level, with a QMS learning network being convened and a national resource hub in development to support this.

- Initial co-design workshop took place in April
- Quality Assurance, Quality Improvement, Planning and Data/Information representatives from each health board invited to attend

New – Leading Quality and Safety Improvement Programme

Designed for all professions and grades involved in leading improvement across the SCP workstreams, the programme uses the IHI SREC Framework as its foundation. Applications closing on 11th July, programme to start in September 2025 to May 2026

For Information

Clinical Effectiveness

Section 6

National Non-Hodgkin Lymphoma Audit (NNHLA)- State of the Nation Report 2024 - An audit of care received by people diagnosed with non-Hodgkin lymphoma in England (2020-2021) and Wales (2022)

Clinical Lead: Dr Rachel Trickey – Consultant Haematologist

Rationale:	NNHLA aims to assess care patterns and outcomes for patients with non-Hodgkin lymphoma in **England and Wales**, helping services enhance the quality of care. It is part of the National Cancer Audit Collaborating Centre (NATCAN), which oversees ten national cancer audits and works to improve cancer services by evaluating diagnosis, treatment processes, and patient outcomes across various cancer types.
Objectives:	• Performance Indicator: Aim: to provide a national picture and highlight regional variation in the patterns of non-Hodgkin lymphoma care across England and Wales. • Tumour Characteristics: Aim: to provide context for interpretation of performance indicators • Data Quality: Aim: to shine a spotlight on areas where improvements in data completeness are needed.

Report Successes:	
1	New patients with NHL always see a CNS
2	One-year overall survival for both low and high grade NHL comparable with rest of UK

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

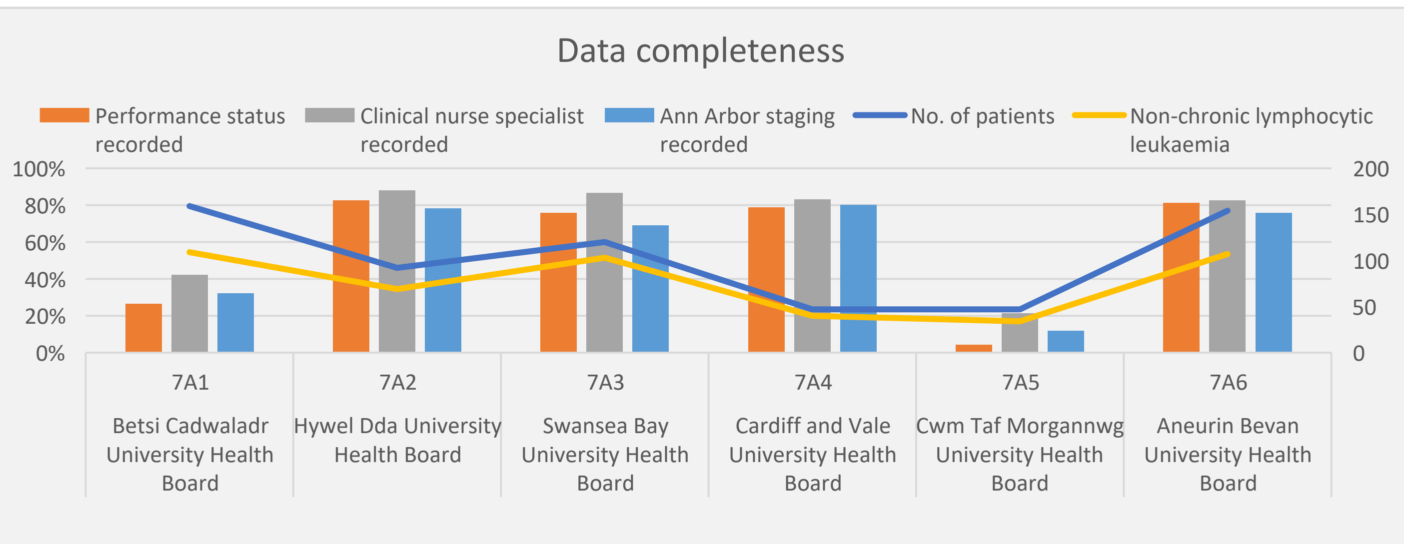
Report Concerns:	
1	Data suggests less than 50% of patients receive chemotherapy within 62 days of referral for high grade NHL-data not in keeping with clinical experience
2	Significant data gaps (not unique to ABUHB, due to way data is captured in Wales)

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

If not on a risk register, why not:
This is a new audit with incomplete data, the current data is not likely to be representative but will continue to be collected and improved on in the future

	Clinical Leads Local Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date:
1	Commenced a new MDT proforma for all haematology MDT discussions, to try and improve recording of staging	This has already been initiated within Haematology for all patients and our aim is for 100% of patients with NHL have staging and PS accurately recorded at the time of MDT	Victoria Williams (Haem MDT lead) Sarah Hine (Cancer services)	Already implemented

Data Completeness:



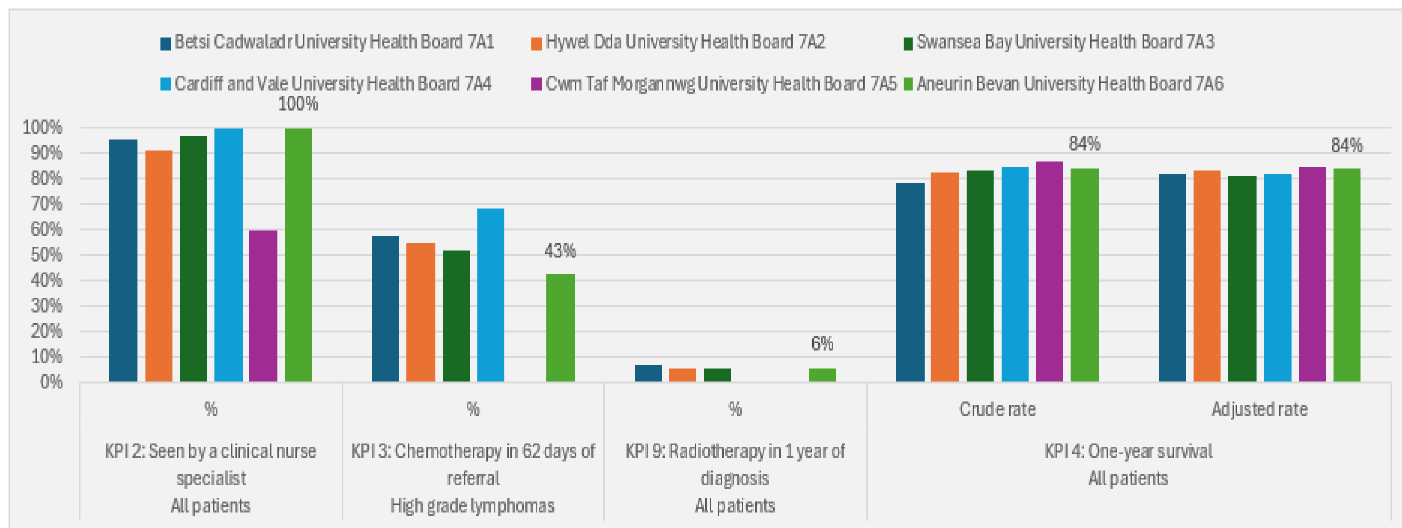
RGH is performing better than the Wales and England for Performance Status and Clinical Nurse Specialist and better than Wales, however slightly reduced on the England result for Staging (Ann Arbor), whilst NNH is performing better than Wales and England in all 3 areas – *Binet staging is only recorded in one HB in Wales.*

Key Message:
NHS trusts and MDTs should ensure key data items are submitted to cancer registries for all people diagnosed with NHL. Particular attention should be given to documentation of staging/prognostic indices, MDT records and CNS involvement in both England and Wales

Key Message:
Less than 67% of people
with high-grade NHL in England and 50% of people with high-grade NHL in Wales receive chemotherapy within 62 days of referral.

Key message:
High 1 year survival of around 90% for people with low-grade lymphoma, and around 70% for people with high-grade lymphoma, with similar results reported for England and Wales.

Key Message: Less than 44% of people with high-grade lymphoma start their radiotherapy within 8 weeks of the end of first line chemotherapy and there is wide variation between trusts. Radiotherapy not often given unless specific indications



Due to current difficulties in radiotherapy capture with existing databases in Wales, only limited conclusions can be drawn from the current data provided for Wales; this may explain lower proportions of radiotherapy delivery in Wales compared to England.

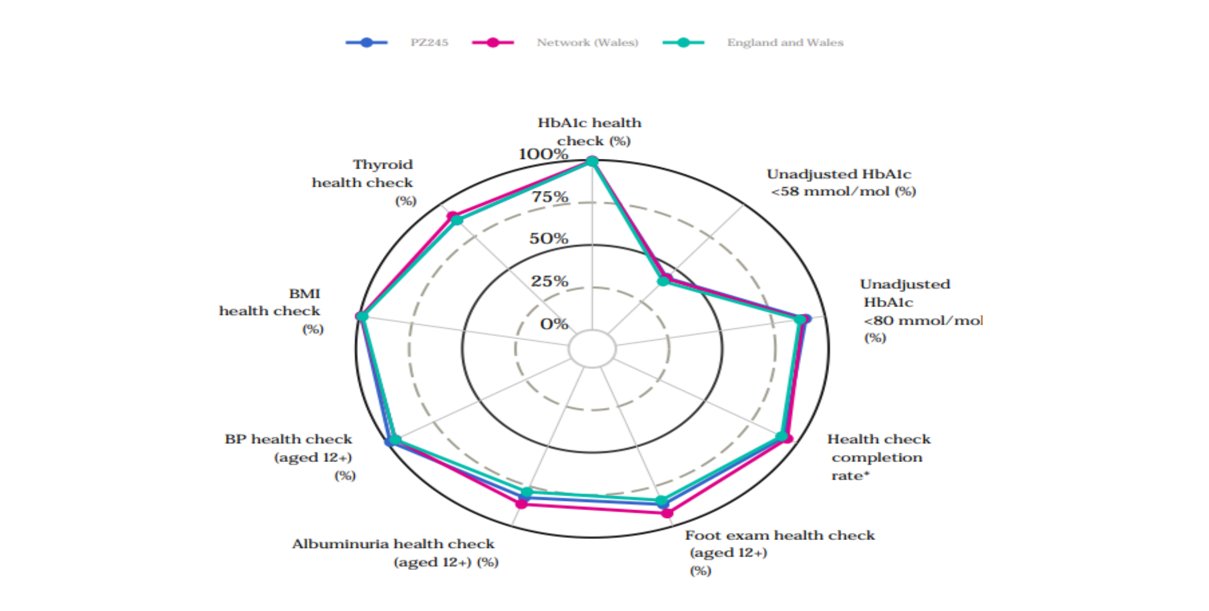
	Report Recommendations:	S.M.A.R.T Actions:Responsible:Due Date:Progress:
1	Identify and address factors delaying people with NHL being discussed at a haematology or lymphoma MDT including referral pathways, staging investigations and record keeping.	Wales 2022: Not available
2	Identify pathway factors contributing to delays in people with high-grade NHL starting chemotherapy within 62 days of referral to develop strategies for process improvement *Wales 2022: 51.2%, ABUHB 43%*	Unlikely the data that has been collected is representative
3	Identify patient and hospital factors contributing to delays in radiotherapy delivery since last administered dose of Chemotherapy	Wales 2022: Not available
4	Ensure adequate resource allocation for data provision. They should support hospitals/trusts/health boards in England and Wales with coding, data entry, and quality assurance to improve quality and completeness of data submitted. Data items of focus include: • Cancer staging (Ann Arbor and Binet) • Prognostic indices for NHL *Ann Arbor Wales 60.0%, ABUHB 76%*	Binet Staging only relates to two Health Boards in Wales, SBUHB – Singleton Hospital and CTMUHB – Royal Glamorgan Hospital.
5	Deliver more comprehensive cancer data in Wales, with particular focus on: • Chemotherapy regimens and delivery • Radiotherapy regimes and delivery This is in the process of being developed with introduction of National Data Resource (NDR) as part of the newly established Digital Health and Care Wales (DHCW) as part of the "Digital Strategy for Wales"	Detailed chemotherapy and radiotherapy information is not currently available for Wales

It should be noted that these provider-specific results are affected by varying levels of data completeness and quality and random variation (i.e., the "role of chance"). At this stage, the audit has not implemented HQIP's formal "outlier process" (i.e., a formal process to assess the performance of healthcare providers with results that are outside the expected range). This is because, although there is sufficient confidence to report the results publicly, it is the first time that provider-specific results are being provided with untested data completeness and quality, and risk adjustment methods are in development. Instead, where results highlight a potential cause for clinical concern, we will contact the providers within one month following publication of the State of the Nation Report, and work with them to explore factors that may explain their results, according to HQIP's formal guidance. This process is with a view to being able to adopt the formal outlier process in 2025.

National Paediatric Diabetes Audit (NPDA) 2025 Report on Care and Outcomes 2023/24
Clinical Lead: Dr Davida Hawkes – Consultant Paediatrician

NICE: NG18 & NICE 2015
TA943 (Technology Appraisal)
No quality statements, recommendations only

Rationale:	The NPDA has been reporting for 20 years. Data is submitted by healthcare professionals in Paediatric Diabetes Units (PDUs) in England and Wales about the care received by the children and young people with diabetes using their service.
Objectives:	The effectiveness of diabetes care is measured against NICE guidelines (NG18, NICE 2015) and includes treatment targets, health checks, patient education, psychological wellbeing, and assessment of diabetes-related complications including acute hospital admissions, all of which are vital for monitoring and improving the long-term health and wellbeing of children and young people with diabetes.



Above shows GUH Health Checks compared to national rates, below right, shows 2023/24 versus 2022/23 ABUHB and below left ABUHB additional Health Checks

ABUHB no longer negative outlier for HbA1c

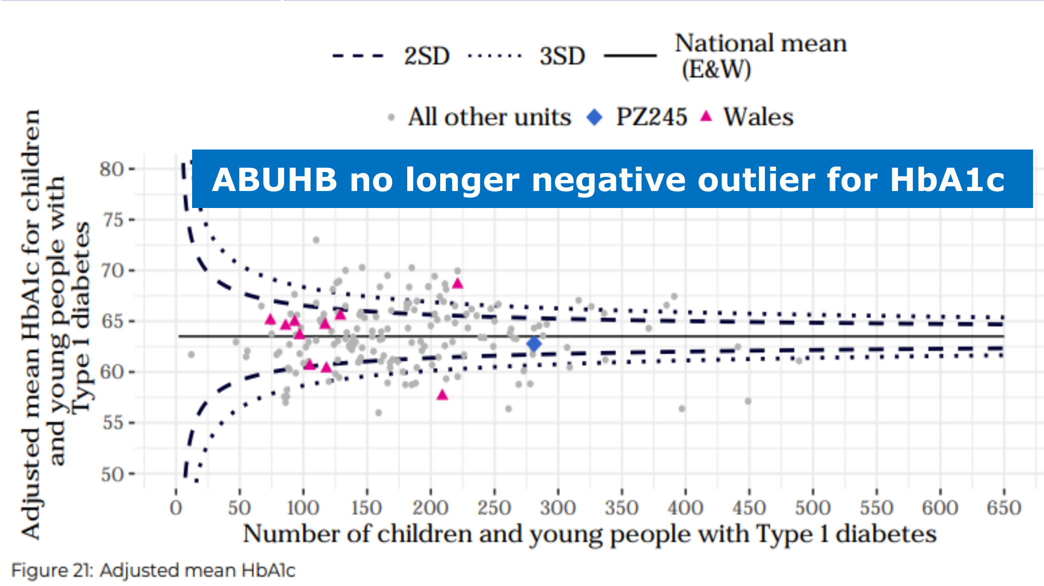
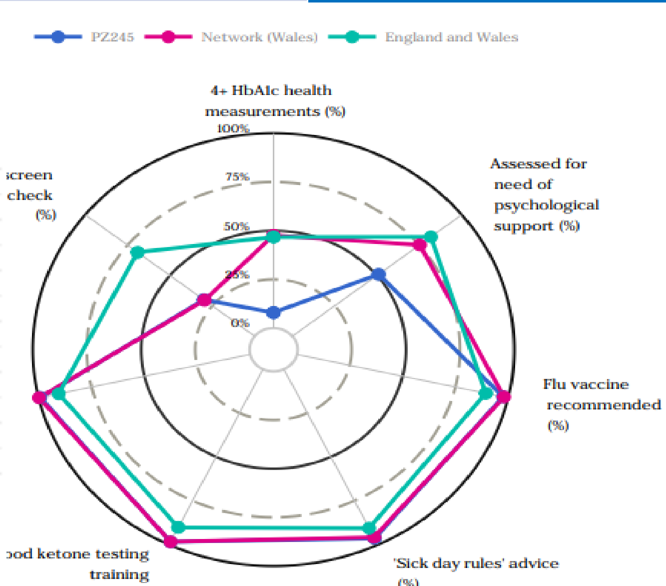
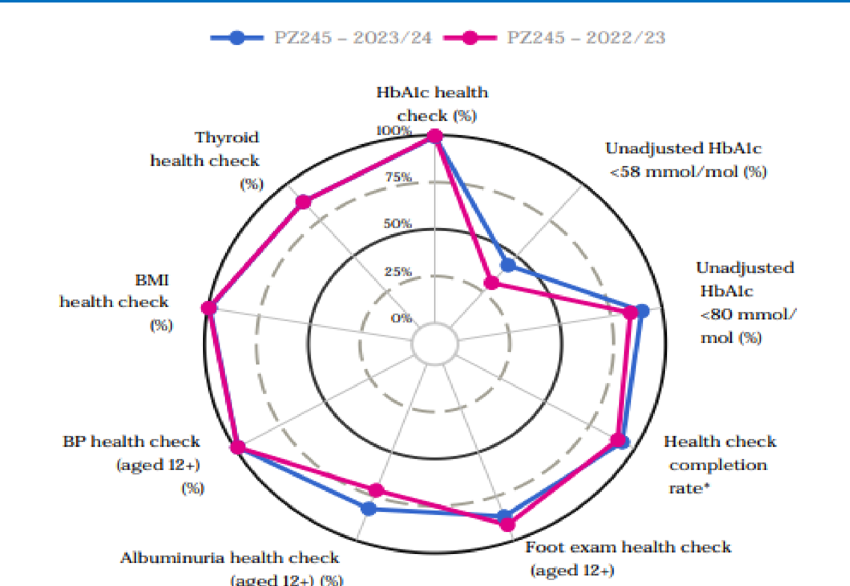


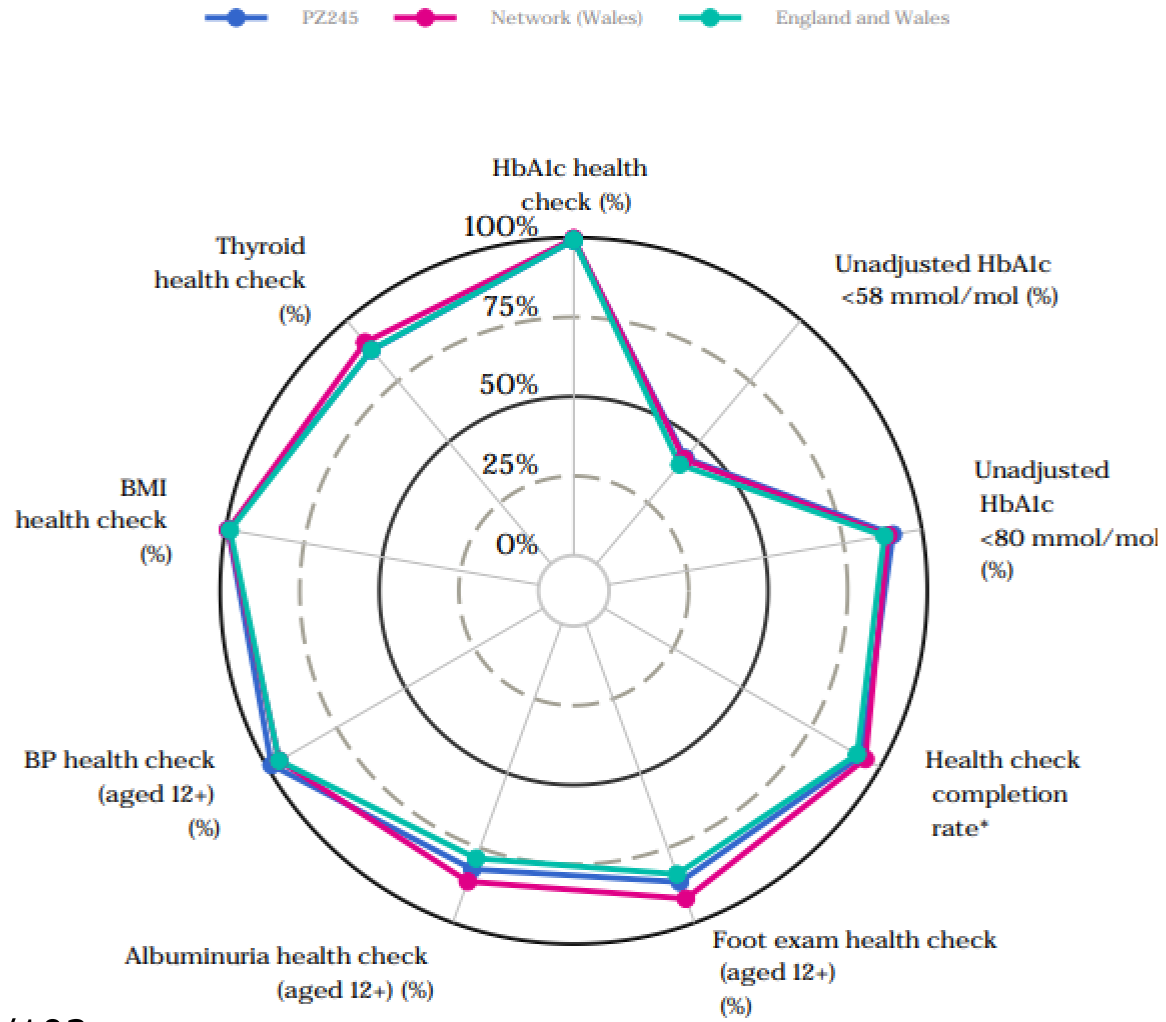
Figure 21: Adjusted mean HbA1c





DIABETES HEALTH CHECKS COMPLETION RATES

The chart below demonstrates that the Health Board is performing similarly to the rest of the Welsh Health Boards and compared to the overall national rates.



PZ245 – 2023/24
PZ245 – 2022/23

HbA1c health check (%)
100%
75%
50%
25%
0%
Unadjusted HbA1c <58 mmol/mol (%)
Unadjusted HbA1c <80 mmol/mol (%)
Health check completion rate*
Foot exam health check (aged 12+) (%)
Albuminuria health check (aged 12+) (%)
BP health check (aged 12+) (%)
BMI health check (%)
Thyroid health check (%)

The Health Board has improved in relation to Unadjusted HbA1c <58mmol/mol & <80mmol/mol in 2023/24 compared to 2022/23 and has Albuminuria (aged 12+) with a slight reduction in foot examination (aged 12+)

Assurance level	Description	Risk level	Description
Significant	The project has mostly achieved the standards or criteria being audited against	Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon

Report Successes:				Report Concerns:	
1	Reduction I median HbA1c	3	Improvement in numbers completing health care checks	1	Still not offering the recommended 4 MDT appointments per year for majority
2	No longer negative outlier for HbA1c	4	Increased numbers of CYP on Hybrid closed loop pumps		

	Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date: Progress:
1	PDU workforce numbers should be mapped against the guidelines published by the National Children's and Young People's Diabetes Network in 2024 (NCYPDN), taking into account the 16% increase in children and young people with diabetes in their care.	Refer back to business case for pumps- request for increased staffing is being met – not yet requested additional staff for increased incidence	Diabetes leads	Dec 2025
2	The variation in outcomes by geography should be investigated and addressed to ensure that children and young people with diabetes have equitable access and care for diabetes. Commissioners should use NPDA data (three monthly and annual PDU level reports), alongside other trusted data sources and peer review programmes, to assess equity of care within and between their regions.	All CYP in ABUHB have access to same care by MDT and same access to Technology	MDT	
3	Studies should be funded to understand the progression from childhood signs of micro- and macro-vascular disease to the development of future diabetes complications, and to inform preventative interventions.	Action by: Research funding bodies and diabetes charities such as Diabetes UK and Breakthrough T1D.		
4	Diabetes services should offer holistic multidisciplinary support, including dietetic input, to children and young people with diabetes who are overweight or obese.	All CYP have access to specialist nurses specialise dietitians and specialist psychologists	MDT	Dec 2025
5	Children and young people with Type 1 diabetes, regardless of ethnicity and social deprivation, should have equitable access to diabetes-related technologies. This could include engagement with families that may experience inequalities (such as those within the Core20PLUS5 framework) and healthcare professionals to better understand the barriers to equitable access.	All cyp in abuhb have access to diabetes tech regardless of ethnicity or deprivation	MDT	Dec 2025
6	Hybrid Closed Loop (HCL) systems should be offered to all eligible children in England and Wales in line with NICE Technology Appraisal guidance (TA943) and the implementation plans in England and Wales.	All CYP with type 1 DM in abuhb are offered HCL pumps as per nice tech appraisal still a waiting list of over 6 months but much reduced	MDT	Dec 2025

State of the Nation Report 2024 - Audit of Early Intervention in Psychosis (EIP) Provision in England and Wales in 2022/23 and 2023/24. Clinical Lead: Dr Gemma Williams, Consultant Psychiatrist, EIP.

NICE QS 80 – See slide 9	NICE QS 102 – see slide 9

Rationale:

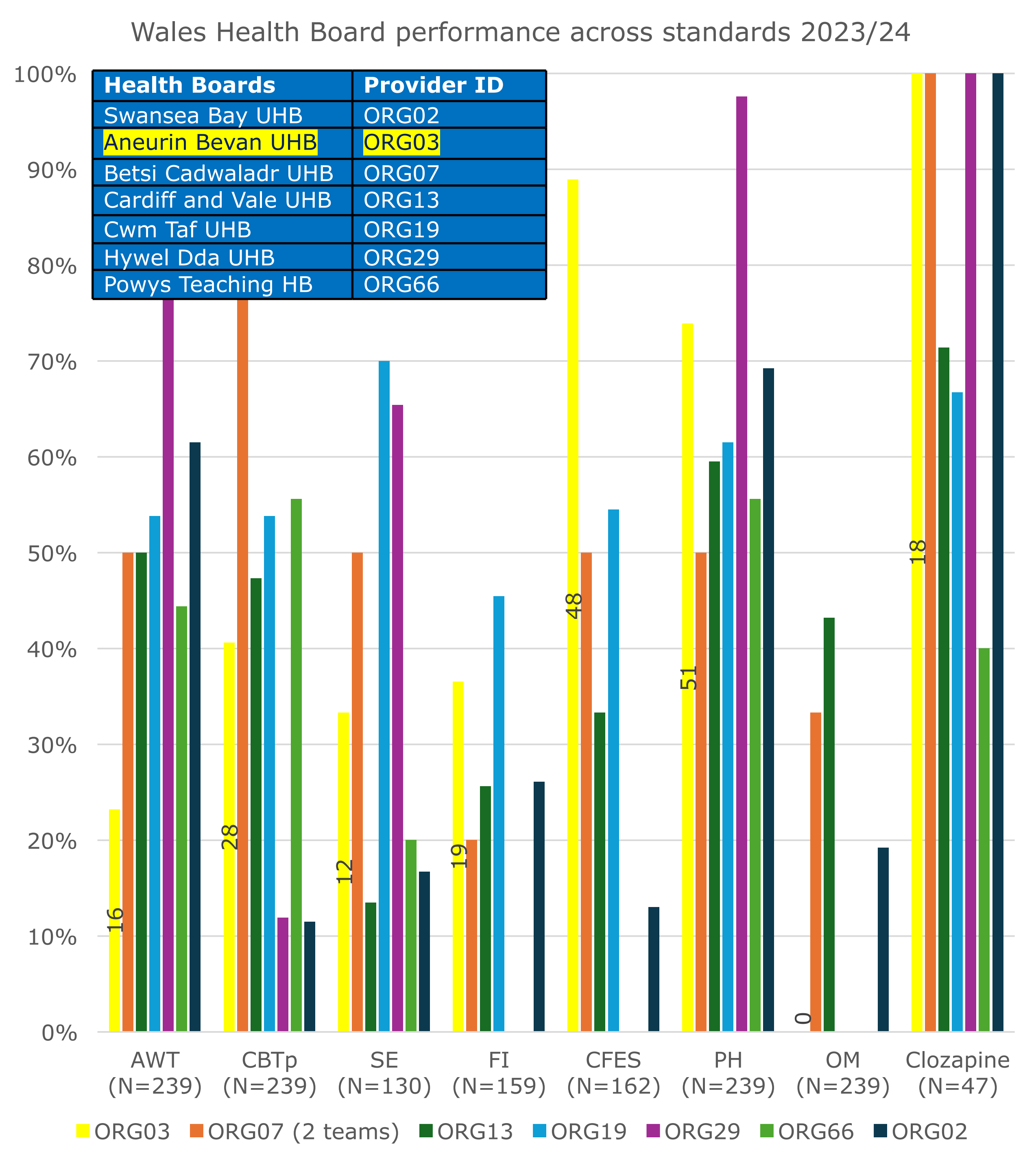
EIP services support individuals experiencing psychosis or at-risk mental states (ARMS) by delivering care aligned with NICE guidance. The National Clinical Audit of Psychosis (NCAP), led by the Royal College of Psychiatrists, evaluates EIP services in England and Wales against standards including: Waiting times, Cognitive Behavioural Therapy for psychosis (CBTp), Education and employment support, Family and carer interventions, Clozapine use
Outcome measures and Physical health screening and interventions
NCAP has audited EIP services since 2018, providing feedback at team, trust, regional, and national levels to inform and improve local service delivery.

Objectives:

This approach involves tracking changes over time through repeated data collection to monitor progress against care standards. It includes: Comparing performance across teams, Trusts/Health Boards, and regions. Analysing variation by health inequalities such as age, gender, and ethnicity. Identifying opportunities to reduce inequalities. Providing Quality Improvement (QI) guidance to support initiatives aimed at enhancing care in areas measured by the audit.

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:	
1	Physical health monitoring and interventions (74%)
2	Carer focussed education and support (89%)
3	Supported Education and Employment (33% taken up)

Report Concerns:	
1	Access and Waiting Time (23%)
2	Outcome Measures (0%)
3	Provision for Children and Young People (BUT error with reporting)

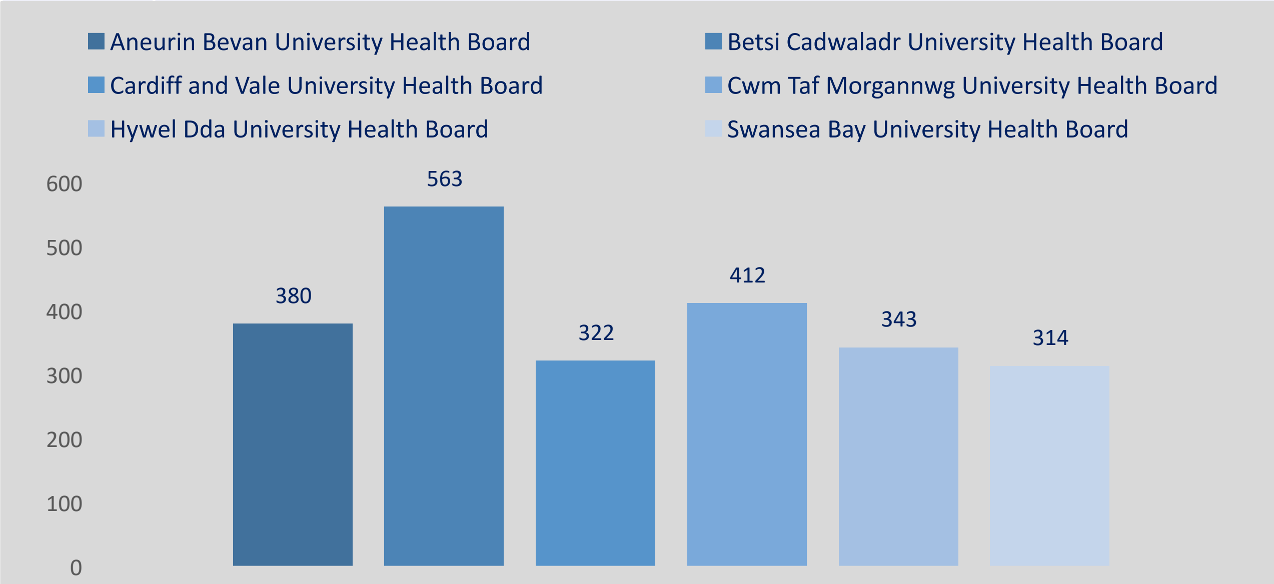
	Report Recommendations:	S.M.A.R.T Actions:Responsible:DueDate:	Progress:
1	Focus on sustaining performance; notably around timely access and addressing factors affecting delivery of NICE concordant EIP and ARMS provision across all age groups, particularly Family Intervention (FI) in England, Cognitive Behavioural Therapy for psychosis (CBTp) in Wales and CBT for ARMS in England and Wales.	CBTp: new psychologists (trained or training in CBTp) in post should improve provision.	Ongoing
2	Improve lipid measurement screening in England and referral for blood pressure treatment by an appropriate clinician in response to elevated cardiovascular risk when completing physical health checks in both England and Wales.	Physical health monitoring and intervention workstream in Wales.	Ongoing
3	Routinely use standard nationally agreed outcome measures (DIALOG and ReQoL for Wales; DIALOG, ReQoL and GBO for England) and use of outcome measures data to evaluate EIP outcomes in England and Wales.	Routine collection following OPAs. NCAP routine data collection.	Ongoing
4	Continue to record and monitor which interventions get offered to whom. Actively seek to address health inequalities both in offer and take-up related to regional and health board variation, gender, ethnicity or age in both England and Wales.	Routine NCAP data collection is allowing us to be more proactive in addressing this. Ongoing discussions around how to improve awareness and referrals into the service.	Ongoing
5	Ensure the National Institute for Health and Care Excellence (NICE) recommended specialist EIP and ARMS interventions and care are available to Children and Young People (CYP) with First Episode Psychosis (FEP) and ARMS (England and Wales).	We offer joint working with CAMHS. No ARMS provision at present but we will continue to discuss how this can be offered within our current resource.	Partially complete

	Clinical Leads Local Recommendations:	S.M.A.R.T Actions:	Responsible:Due Date:Progress:
1	Access and waiting time needs to be improved in line with target of 60% being seen within 14 days of referral.	QI project completed to improve awareness of target within the team and change process of screening and allocating referrals	Achieved. (Data from last 6 months show 64% allocated within 2 weeks and 85% within 4 weeks.)
2	Completion of two outcome measures to be done as standard	Care coordinators are already more aware of the need to complete these. Discuss again within MDT and check outcomes via NCAP monthly audit data	Ongoing

National Lung Cancer Audit (NLCA) - State of the Nation 2025
An audit of care received by people diagnosed with lung cancer in England and Wales during 2023
Clinical Lead: Dr Mat Jones – Medical Consultant
NICE:NG122, QS17

It is important to note that data is not comparable to the English data as data is derived from different dataset collection systems.

Rationale:	The aim of the NLCA is to evaluate the patterns of care and outcomes for people with lung cancer in England and Wales, and to support NHS services to improve the quality of care for these individuals.
Objectives:	The National Lung Cancer Audit (NLCA) assesses how well current lung cancer care aligns with national guidelines. These include: NICE Quality Standard QS17, National commissioning guidance from the Lung Cancer Clinical Expert Group and the National Optimal Lung Cancer Pathway. Using these standards, the NLCA has developed quality improvement goals and indicators, shaped through consultation with its clinical reference group and Patient and Public Involvement (PPI) forum. These are detailed in the NLCA Quality Improvement Plan.



Data quality indicators

WALES

2,334 patients diagnosed with lung cancer in Wales in 2023.
Completeness of key data items in the Welsh data was excellent.
Completeness for the 2,334 patients analysed were:

- 100% for basis of diagnosis,
- 69% for tumour morphology (100% with tissue),
- 99% for disease stage, and
- 100% for performance status.
- 98% of records had data on whether a lung cancer nurse specialist was present at diagnosis.
- Data was not provided for the ethnicity or smoking status data items.

ABUHB

380 patients diagnosed with lung cancer in Wales in 2022.
The completeness of the key data items in the Welsh data was excellent.
The levels of completeness for the 380 patients analysed were:

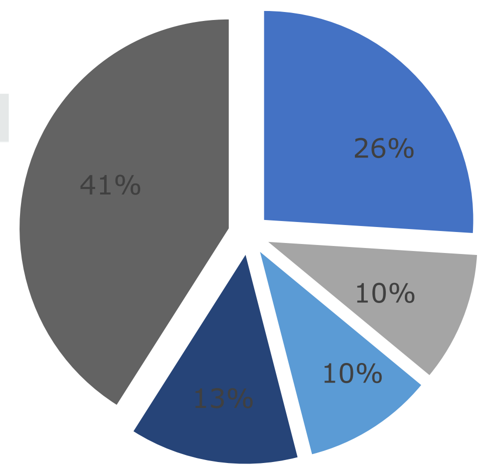
- 100% for basis of diagnosis,
- 71.3% for tumour morphology (100% with tissue),
- 99.74% for TNM stage, and
- 100% for performance status.
- 95.26% for IMD (deprivation) – 2nd in Wales
- 100% of records had data on whether a lung cancer nurse specialist was present at diagnosis.
- Data was not provided for the ethnicity or smoking status data items.

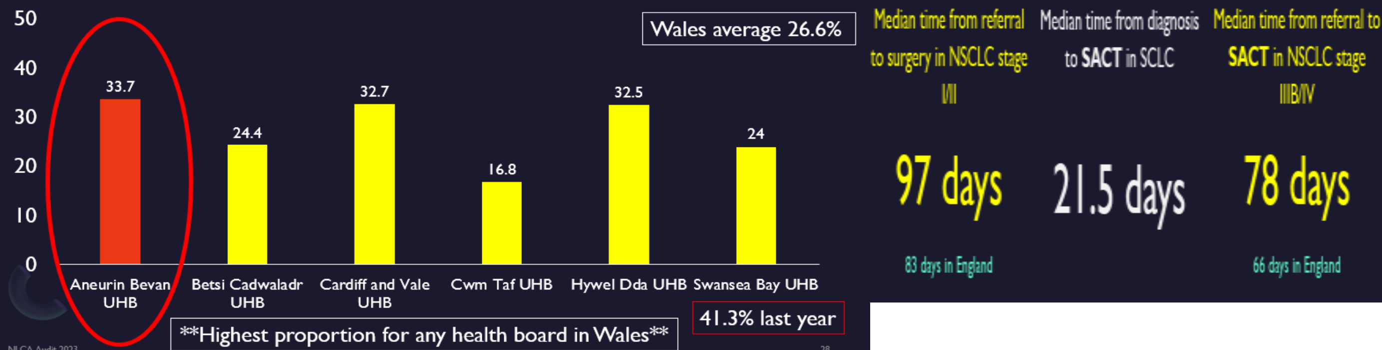
NLCA Audit 2023

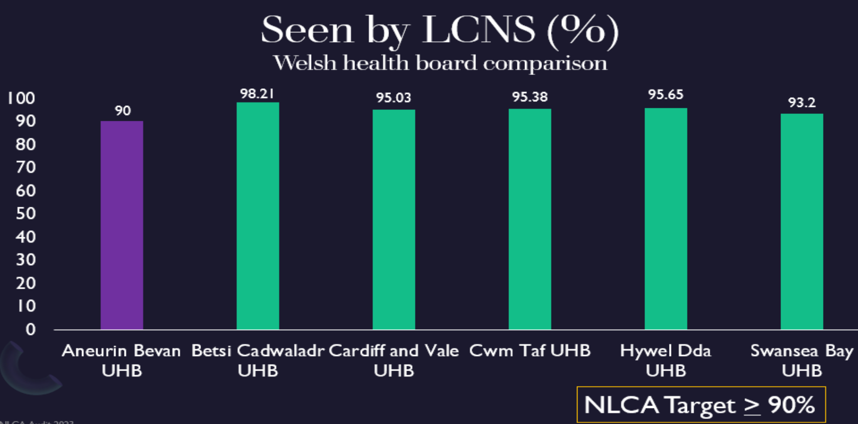
ABUHB Patient Cohort

Small Cell Cancer	NSCLC	Unknown (assume NSCLC)	Total Number
32 (8.42%)	239 (62.89%)	109 (28.68%)	380

Others: Mesothelioma 10
Carcinoid 11







One year and median survival (%) Wales as a whole

Median survival	One year survival
301 days	46%
262 days in 2022	43% in 2022
222 days in 2021	39% in 2021
224 days in 2020	40% in 2020

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

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

Report Successes:	
1	NSCLC patients with stage I/II and good performance status (0-2) curative treatment rates 81.2% - higher than Wales mean
2	NSCLC patients with stage IIIA and good performance status (0-2) curative treatment rates 78.2% - higher than Wales mean
3	Surgical resection rate for patients with NSCLC 17.47% - higher than Wales mean
4	Use of systemic anti-cancer therapy for stage IIIB/IV NSCLC patients (PS 0–1) 72.2%- higher than Wales mean
5	Patients with Stage I/II with PS 0-1 confirmed pathological staging 95.1% - higher than Wales mean

Performance indicator values

- Velindre treatment data no longer input into Canisc as in previous years
- No national functioning radiotherapy or SACT dataset (Wales)
- Each cancer site database managed by different team and obtain information differently
- Manual systems to treatment data into audit spreadsheet for submission – not a robust solution
- This year – we were unable to review the data prior to submission
- We had gone through the data, highlighting treatments prior to submission – validation
- Concerns concerns over this in November 2024 – no reply

Report Concerns:	
1	Proportion of SCLC patients having chemotherapy 56.2% - lower than Wales mean
2	Proportion of patients seen by a Lung Cancer Nurse Specialist – lower than Wales mean but above audit standard
3	Proportion of patients with lung cancer diagnosed after an emergency presentation 33.7% - highest in Wales cohort
4	Proportion of patients in Quintile 5 (most deprived) IMT 31.5% - highest in Wales (England 15.11%)

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Ensure services maximise the uptake of lung cancer screening for people aged 55 to 74 who are at high risk of lung cancer. *The percentage of people with lung cancer diagnosed with stage 1/2 disease in Wales was 33.9% in 2023.* ***Goal 1: Improve early diagnosis of lung cancer***	Lung Health Check Operational Pilot complete HB conducted scoping exercises – part of nationwide ongoing endeavours Evaluation 2 submitted and PHW report and recommendations awaited	PHW Welsh Government Individual Health Boards	Decision pending from WG on next steps	Initial response to recommendations from screening committee submitted. Ongoing engagement with central stakeholders
2	Ensure providers have sufficient thoracic surgery capacity to accommodate the larger number of people with Non-Small Cell Lung Cancer (NSCLC) who are candidates for curative surgery. *In Wales, 364 people had surgery in 2023, up from 276 in 2022.* ***Goal 2: Increase the proportion of patients who have treatment with curative intent***	Surgical resection rate above NLCA target Ongoing increase in patients undergoing surgery Continued early diagnosis and prioritisation of patients requiring surgical intervention No issues with access – but waiting times >4 weeks	CAVUHB/WG MDT members	Ongoing Report recommendations complete	Complete – continued growth going forward
3	Identify opportunities for increasing the proportion of people with NSCLC stage 3B-4 (PS 0-1) to have Systemic Anti-Cancer Therapy (SACT) as per NICE guidance, such as help people maintain their fitness for SACT throughout the care pathway. *In Wales during 2023, the proportion was 55.2%, a fall from 2022 (=60.1%)* ***Goal 3: Increase the proportion of people receiving SACT and reduce variation in access***	Improved pathological services – PD-L1 in-house, QuicDNA ctDNA project pioneers and imminently to be provided as part of the National Test Directory **Oncology delays – recent resignation of oncologist – replacement pending and some delays related to external tissue processing**	Velindre University NHS Trust ABUHB pathology service All Wales Medical Genomics Service	ctDNA with NGS panel to be added to the National Test Directory imminently Ongoing liaison with Velindre NHS trust – replacement appointment anticipated this year	Above audit standard achieved Ongoing refinement of pathways according to threats

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
4	Ensure NHS hospitals have the necessary resources and capacity to meet the timelines for patients to start primary treatment. *In England and Wales, among key subgroups, most people diagnosed in 2023 did not start treatment within the recommended timeframes* ***Goal 4: Improve the quality of the patient pathway***	All facets of the pathway to be assessed on an ongoing basis to ensure efficiency – breech reports, tracker meetings, engagement from wider MDT. Ensure timely review and treatment from Oncology and Surgical services	CAVUHB/WG MDT members Velindre University NHS Trust AWMGS	This is an ongoing, prospective endeavour	Continued service development with ongoing improvement in active treatment rates and achievement of NLCA standards – however, ongoing vigilance, refinement and improvement is core to our MDT working
5	Ensure NHS hospitals have the necessary resources and capacity so that biomarker test results are delivered within 14 calendar days of the test being performed, as defined in the National Optimal Lung Cancer Pathway. *England: Between 2017 and 2021, approx. 25% of people with stage 4 (PS 0-1) had genomic testing.* ***Goal 4: Improve the quality of the patient pathway***	This remains a challenge and is unachievable with current structures Turnaround time for AWMGS is 14 days from receipt of sample – therefore attainment impossible Ongoing review of timeliness ABUHB pathology service processing of samples	AWMGS ABUHB pathology services	This is a prospective endeavour – ongoing liaison with AWMGS no current plans to change service centrally	With the advent of ctDNA, this may speed up one aspect of the pathway and allow a T.A.T of 14 days No current opportunity to achieve T.A.T of 14 days for tissue samples

Clinical Leads Local Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Proportion of patients seen by a Lung Cancer Nurse Specialist Target $\geq$ 90%: ABUHB proportion = 90% Target achieved but below All Wales average	To review feasibility of inpatient review of patients given route of entry	Lung CNS team ABUHB	Prospective – feasibility to be assessed and planned	Discussed at MDT operational meeting 21/5/25 and planning ongoing
2	Proportion of patients with SCLC receiving chemotherapy Target $\geq$ 70% ABUHB proportion = 56.2%	Audit conducted Appropriate decisions made	MDT members Oncology services Velindre NHS Trust	Ongoing	Patient prioritisation for oncology review under ongoing review

Quality Management Group (QMG) ASSURANCE REPORT

Meeting Date	01/07/2025
Chair	Jennifer Winslade (Executive Director of Nursing)

KEY ESCALATION AND DISCUSSION POINTS

ALERT

Alert	Action	By whom	Target Date
Nothing to note			

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

Proposal to hold a Big Conversation on Sepsis

- The group heard and agreed with the principles to host a "Big Conversation on Sepsis" to include staff and patients, in line with the wider Health Board Sepsis Strategy. The risks and challenges were clearly articulated with mitigating steps discussed, noting the reputational risk around this topic.

Structures/Reporting/Data

- The function, structure and governance arrangements for QMG and how that interfaces with the wider Health Board were discussed. Next steps to mature these arrangements were agreed with standardisation, integration of quality reporting, and development of quality assurance within the Divisional Assurance Reporting. Communication and engagement with the Divisions will be ongoing until embedded.

Quality Impact Assessment

- A Standard Operating Procedure was endorsed to undertake standardised Quality Impact Assessments with divisions with a formal review at the Clinical Advisory Forum.

Clinical Audit Activity Report and Plan

- The group agreed to the Clinical Audit Plan for 2025/26, for the National Clinical Audit Programme. Last year's Annual Audit Activity Report provides assurance back to the group for the audits that have been undertaken. How to improve divisional cooperation and engagement was discussed with "local audit plans" at directorate level.

MEWS and NEWTT 2

- The Executive Team was asked to approve a delay in going live noting the risk described below. It would result in non-compliance with the Welsh Health Circular.

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

Neonatal Assurance Report

- Culture, relationships and working practice within the Neonatal unit were discussed. Three-year improvement plan being developed and 150-point delivery plan. QMG agreed to receive updates after 6 and 12 months. The group agreed to review if opportunities were missed to detect this earlier and what transferable learning can be implemented elsewhere, delivered through a Culturing Listening Exercise.

People's Experience Framework and Self-Assessment

- The self-assessment against each standard has been RAG rated with the majority being Amber. Positive work is being undertaken against each standard to improve the People's

Experience Framework.

Community of Practice

- Development of the Community of Practice and People Participation Panels supports the People's Experience Framework standards. Development of groups to receive feedback from patients, relatives and staff to improve service. It was noted that Patient Reference Groups have been well-established, and rebranding is required across the organisation. Planning recommended a mapping exercise of these groups to ensure organisational oversight and a gap analysis.

RISKS
(Detail of risks discussed)

MEWS and NEWTT 2

- Welsh Government Circular (WHC/2024/35) in relation to standardisation in management of acute deterioration. NEWTT2 and MEWS will be delayed until Q3 2025/26, this will not be in line with the Welsh Government target of September. This is due to the BadgerNet system (maternity) and a delay in updating this & differing systems between children and adult assessment areas. Listed on the Families and Therapies Division's risk register.

Neonatal Assurance Report

- 40% of Neonatal staff on some form of sickness management, only one case identified with work related stress, the most common reason being stress more generically.

Clinical Audit Activity Report and Plan

- It was noted that alignment of local clinical audit activity with divisional and corporate priorities and objectives requires development. It was noted the resource within the corporate audit team under the Medical Director is not sufficient to cover local audit and will be challenging to implement fully.

Management of Health Board Inquests

- Significant risks with the rise in coroner activity is leading to from a quality and safety, reputational, staff wellbeing, and financial perspective whilst the review is completed. This will be entered on the risk register.

Matters for the Board or other committees:

Clinical Audit Activity Report and Plan

- The group agreed to the Clinical Audit Plan for the next 12 months. An Annual Audit Activity Report provides assurance back to the group. How to improve divisional cooperation and engagement was discussed with "local audit plans" at directorate level.

MEETING AGENDA ITEMS

MEWS and NEWTT 2	Neonatal Assurance Report	People's Experience Framework and Self-Assessment
Community of Practice	Proposal to hold a Big Conversation on Sepsis	Structures/Reporting/Data
Quality Impact Assessment Process	Clinical Audit Activity Report and Plan	Management of Health Board Inquests

Attendees

Jenny Winslade (Chair)	Executive Director of Nursing
Amanda Hale	Divisional Nurse – Surgery and Clinical Support Services
Joanne Lane	Divisional Nurse – Primary Care and Community
Tanya Strange	Head of Nursing – Patient Experience and Involvement
Leeanne Lewis	Assistant Director – Quality and Safety
Craig Roberts	Assistant Director of Allied Health Professions & Health Science
Kye Smith	Deputy Head of Quality and Patient Safety
Rani Dash	Director of Corporate Governance
Gemma Couch	Head of Quality and Patient Safety
Peter Carr	Executive Director of Allied Health Professions & Health Science
Eleanor Edwards	Deputy Head of Safeguarding
Chris Morgan	Divisional Nurse – Urgent Care
Moira Bevan	Head of Nursing – Infection Prevention & Control
Tracey Partridge-Wilson	Deputy Director of Nursing
James Calvert	Executive Medical Director
Deb Jackson	Divisional Nurse – Family & Therapies
Jayne Beasley	Head of Midwifery
Garvin Jones	Head of Legal Services
Scott Taylor	Head of Health, Safety & Fire
Collette Kiernan	Deputy Director of Allied Health Professions & Health Science
Christopher Dawson-Morris	Deputy Director Strategy Planning and Partnerships
Christopher Morgan	Divisional Nurse – Urgent Care

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 July 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Safeguarding Annual Report 2024-2025
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade – Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Kelly Downes – Deputy Director of Nursing Eleanor Edwards – Deputy Head of Safeguarding

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Aneurin Bevan University Health Board has experienced a notable rise in safeguarding referrals this year. The Safeguarding Annual Report 2024/25 outlines key progress, ongoing challenges, and strategic priorities, highlighting the board's commitment to protecting vulnerable individuals.

Cefndir / Background

The Health Board recognises its statutory responsibility to ensure robust safeguarding measures are in place, supported by key legislative frameworks such as the Health and Care Standards for Safeguarding Children and Adults at Risk, the Social Services and Well-being (Wales) Act, and the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Act.

The Safeguarding Team is actively involved in multi-agency partnerships, including the Gwent Joint Children and Adult Safeguarding Board and the Gwent VAWDASV Partnership Board.

Asesiad / Assessment

Staffing and Governance

The health board maintains a robust safeguarding governance structure. The Chief Executive holds overall accountability, with executive leadership delegated to the Executive Director of Nursing, supported by the Deputy Director of Nursing. The Head of Safeguarding, along with a Deputy, oversees safeguarding systems, policies, training, and operational practices, ensuring compliance and quality monitoring.

Since 2022/23, there has been a significant rise in Duty to Report (DTR) referrals, with Adult Safeguarding referrals increasing by 94% and Children's Safeguarding referrals by 132%. In response, the team structure was revised in September 2024 to support the growing complexity of cases and increased workload. This continues to be kept under review.

The Safeguarding Strategic Group, reporting to the Quality Management Group and Patient Quality and Safety Outcomes Committee, oversees safeguarding practices for Adults, Children, and Young People. This group sets the Health Board's Safeguarding Strategy and defines objectives for continuous improvement. It is supported by three sub-groups focusing on safeguarding adults, children and young people, and persons in a position of trust (PIPOT), which provide quarterly feedback and drive quality improvement.

Single Unified Safeguarding Reviews (SUSR)

Launched in Wales in October 2024, the Single Unified Safeguarding Review (SUSR) merges different review processes into one coordinated approach for serious safeguarding incidents. SUSR lessens family stress, fosters interagency learning, and improves service understanding. The process examines what occurred and why, promoting collaborative improvement and resulting in actionable plans to strengthen future safeguarding of vulnerable individuals across agencies.

Safeguarding Adults

The Adult Safeguarding team assesses Duty to Report submissions, coordinating with Divisions and multi-agency partners for adults at risk. In 2024/25, DTR submissions rose sharply to 510—an increase of 41% from 362 in 2023/24—reflecting the team's expanding workload and responsibilities.

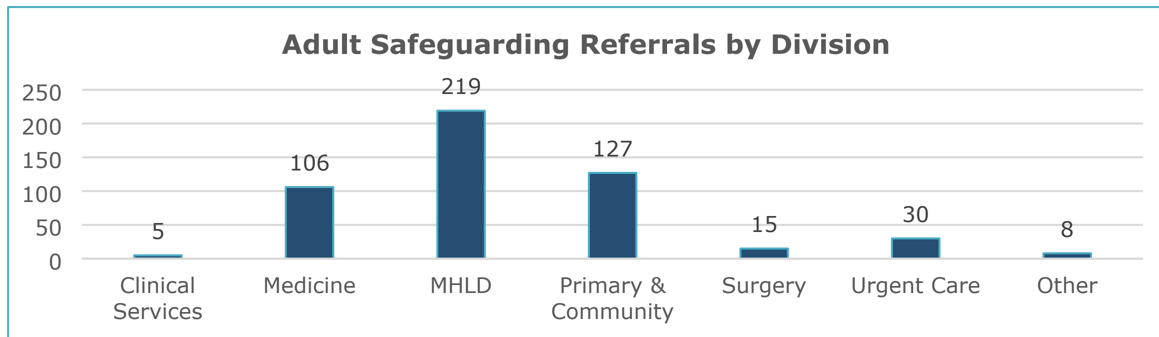
When examining the data by type of harm, it is evident that Neglect is the most frequently reported category. This includes allegations of neglect with sub-themes such as poor discharge practices, pressure ulcers, and medication errors.

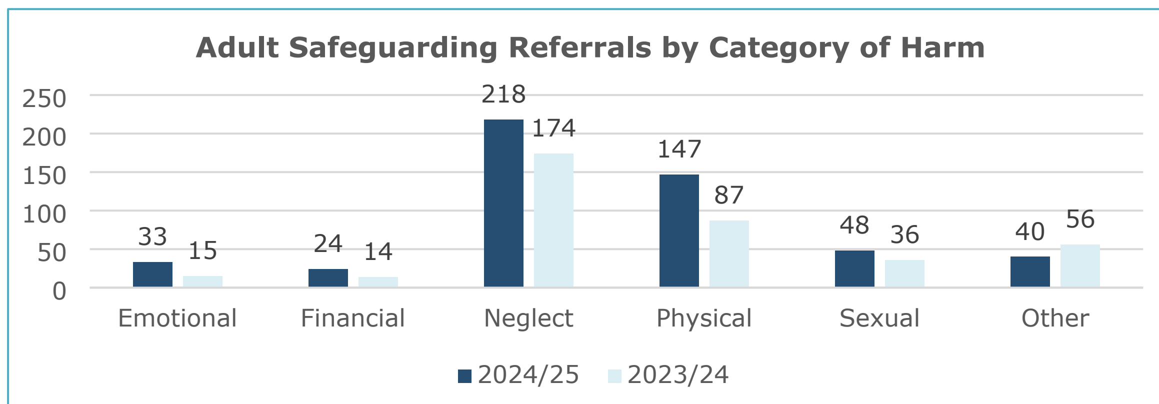
A review of incidents involving physical harm reveals that most cases are patient-on-patient assaults. Investigations have shown that these incidents are largely unavoidable.

A particularly concerning area is the number of reports related to sexual assault, which was also highlighted in the Annual Reports for 2022/23 and 2023/24.

While the volume of incidents remains troubling, they do not meet the criteria for serious sexual harm. Notably, the proportion of sexual abuse cases relative to the total number of DTRs has decreased this year.

The tables below present referrals by division and category of harm:





Collaboration with the Mental Health and Learning Disabilities Division has enhanced DTR quality, with ongoing support from the Safeguarding Team. This engagement and Safeguarding Supervision will continue into the next financial year.

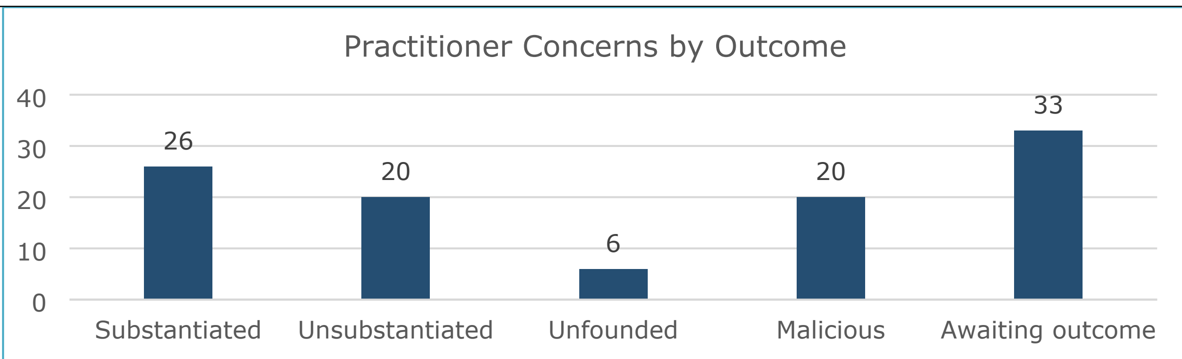
It should be noted that often referrals reported by the Division are unrelated to the care and treatment they directly deliver.

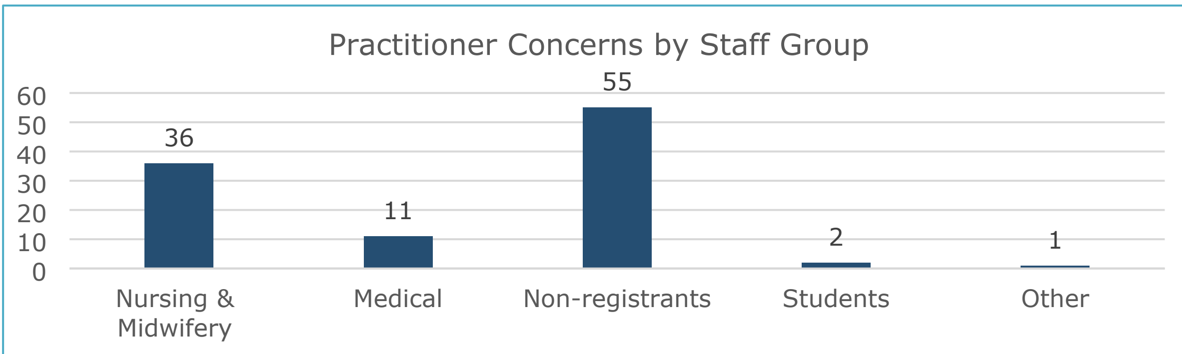
Safeguarding Allegations/Concerns

In 2024/25, 105 safeguarding allegations or concerns were raised involving staff working within the health board, with 26 substantiated cases and 29 progressing to criminal investigation. This marks a significant increase compared to the previous year, which saw 10 substantiated cases, all of which were referred for police investigation.

Of the 105 allegations, 41 were related to incidents within the workplace and 64 incidents occurred outside the workplace. Not all cases involved directly employed health board staff; some concerned independent contractors, staff bank and agency staff.

The tables below present the practitioner concerns by outcome and staff group:



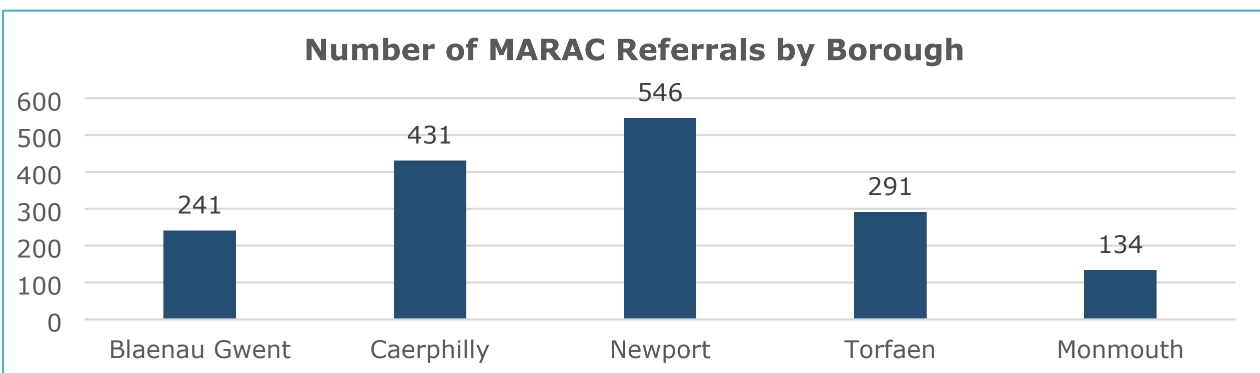


A working group now examines incidents closely, clarifies referral thresholds, and tracks trends. Regular meetings with Police have started to ensure investigations are timely and that emerging issues are addressed.

Domestic Abuse

The Safeguarding Team supports high-risk domestic abuse victims by engaging in fortnightly MARAC meetings for each Gwent Local Authority. As a statutory agency, their attendance is mandatory. Recently, referrals discussed at MARAC have increased across all Local Authorities compared to 2023/24, highlighting the growing need for coordinated safeguarding efforts.

The table below presents the number of MARAC referrals:



The increase highlights a rise in medium and high-risk domestic abuse cases, assessed via a national tool. Additionally, many individuals classified as standard risk continue to seek support, with those cases generally handled by single agencies or independent contractors.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

Whilst MCA & DoLS function does not fall directly under the portfolio of the Corporate Safeguarding Team, it is closely aligned, and strong professional relationships exist between the two teams.

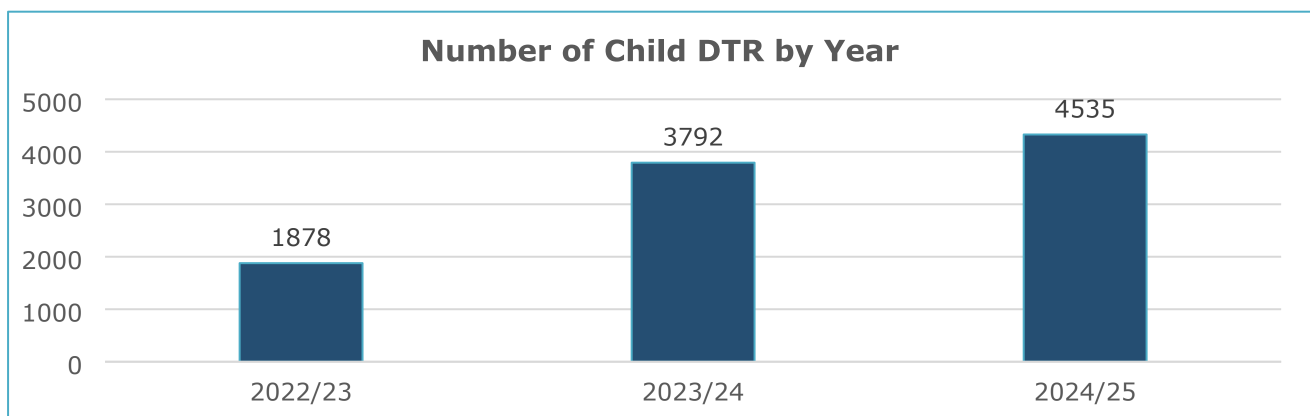
MCA training has now been made mandatory across the health board and is in the process of being aligned with ESR for accurate recording and compliance monitoring.

Throughout 2024/25 at total of 2763 DoLS referrals were received with 1452 assessments completed. Ongoing work is underway to address delays.

Safeguarding Children

During 2024/25, the Health Board made 4,535 Duty to Report referrals regarding suspected child abuse or neglect—an increase of 17% from last year. Case complexity has also risen, with 49% of referrals advancing to strategy meetings, resulting in 2,119 such meetings attended, marking a 33% increase. While improved resourcing and greater safeguarding awareness have contributed, they do not fully explain the surge. The Safeguarding Team collaborates extensively with partners to identify emerging themes, taking a multi-agency approach to provide early intervention and coordinated support for children, young people, and families at risk.

The tables below illustrate the volume of DTRs processed by the Safeguarding Team and the emerging themes (the notably high number of referrals categorised as "other" is attributed to previously inadequate reporting systems and the dual classification of harm types):



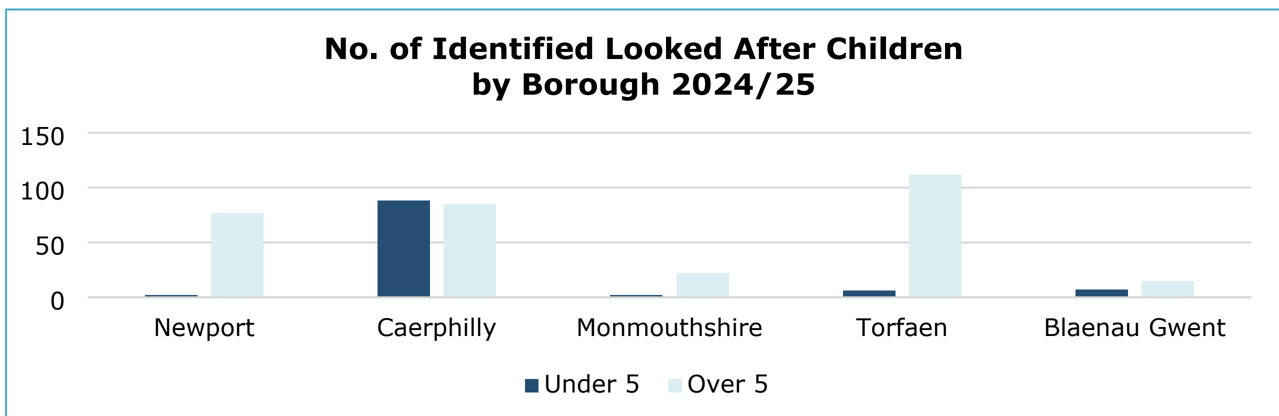
Category of Abuse for DTR's	No.
Neglect	198
Emotional Abuse	80
Sexual Abuse	75

Physical Abuse	275
Financial Abuse	0
Other	3907

Looked after Children (LAC)

Looked After Children (LAC) are cared for by the Local Authority due to unsafe home environments. The Health Board ensures their holistic health needs are met through assessments and services. Although LAC aren't part of the Safeguarding Team, both teams collaborate closely to support these vulnerable children and young people.

The table below presents the number of children who were identified as looked after at the end of the financial year 2024/25:

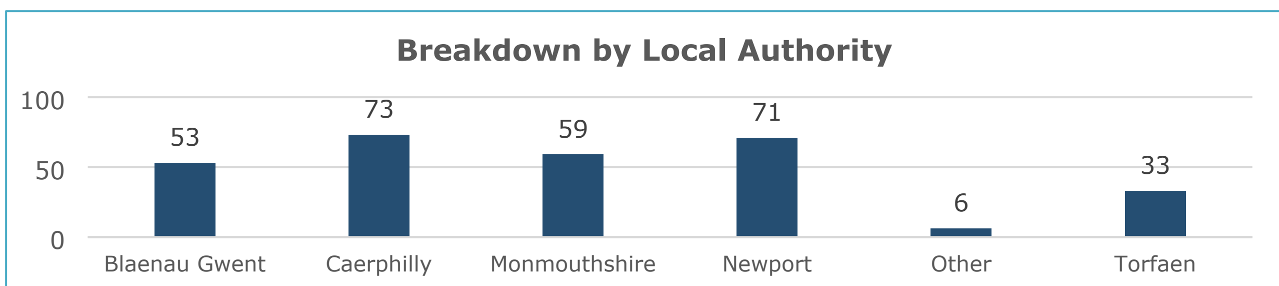


Child Protection Medical Assessments (CPMA)

Child Protection Medicals are assessments carried out to identify any signs of abuse or neglect in children and young people.

In 2024/2025, a total of 295 Child Protection Medicals were conducted—matching the number from 2023/2024.

The table below presents a breakdown by borough:



In line with policy, all Child Protection Medicals were completed within 24 hours of the request being accepted. Each case undergoes monthly peer review by medical staff to maintain service quality and encourage professional challenge.

Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

PRUDiC ensures a coordinated, safe, and compassionate approach through effective communication, joint action, and information sharing. In 2024/2025, 8 child deaths in the health board area met the PRUDiC criteria. This reflects a continued decline since 2020. All PRUDiC cases are reported to the Welsh Government in line with *Putting Things Right* guidance. This enables monitoring of patterns and trends—none of which were identified in 2024/2025.

Safeguarding Supervision

Safeguarding supervision plays a vital role in supporting staff with their safeguarding responsibilities. The Safeguarding Team ensures staff are equipped with essential knowledge and skills through reflective, restorative supervision. This takes place via phone support, post-incident debriefs, one-to-one, and group sessions. The process, aligned with All Wales Safeguarding Supervision Guidance (2024), helps staff develop resilience, well-being, and professional growth, while allowing the Safeguarding Team to identify trends and challenges within the health board.

Training

Safeguarding training is mandatory across the Health Board and is expected to align with the Welsh Government's national target of 85% compliance. During 2024/2025, overall compliance with safeguarding training has shown a positive upward trend, with improved engagement from divisions.

Level 1 Safeguarding Training: Online module for all staff, compliance is 81% for adults and 83% for children as of March 2025.

Level 2 Safeguarding Training: Mandatory for all staff with direct patient contact. Compliance for adults and children are 84% and 81%, respectively.

Level 3 Safeguarding Training: Mandatory for all staff engaging with patient safeguarding concerns. As of March 2025, compliance was 25% for children's and 15% for adults' training, both below the 85% target. Efforts include in-person and virtual sessions, with improvement plans underway to meet compliance standards.

Ask and Act Training: Ask and Act training empowers staff to support individuals facing gender-based violence, domestic abuse, and sexual violence. In 2024/25, 75% of eligible staff completed Group 1 training. Group 2 compliance remains challenging to track, so it will be prioritised in the 2025/26 Training Needs Analysis.

National Contribution

The Safeguarding Team supports the national agenda by participating in working groups such as the National Safeguarding Network and contributing to projects like the Once for Wales Safeguarding Module. A national safeguarding data set is being developed to enable benchmarking and learning across Welsh Health Boards.

Progress on Priorities 2024/2025

The table below presents the priorities that were set for 2024/25 with progress RAG rated (Green completed, Amber ongoing):

Priority	Progress
Primary Care Training	Delivered training and resources for safeguarding compliance, including domestic violence awareness.
Safeguarding Adult Supervision	Piloted group supervision; expansion planned for 2025/26.
Sexual Safety Policies	Developed and published guidance on sexual safety and historical abuse.
Level 3 Safeguarding Training	Made mandatory on ESR with revised delivery and monitoring.
DATIX Module	Launched to enhance safeguarding case management.
Section 5/Practitioner Concerns Guidance	Guidance under revision to align with referral thresholds; work to continue in 2025/26.
Assurance Measures	Integrated within Ward Accreditation to reinforce safeguarding accountability.
Operational Subgroups	Formed to embed learning from reviews and drive improvement, with regular assurance reporting.

Priorities noted as Amber have been carried forward for completion for 2025/26.

Priorities for 2025/26

- Expand Safeguarding Supervision: Extend the adult safeguarding supervision pilot to more teams.
- Revise Guidance: Continue updating and implementing key guidance documents, such as the ABUHB Section 5/Practitioner Concerns Guidance.
- Enhance Training Compliance: Improve safeguarding training uptake and monitoring at all levels, with particular focus on Level 3.
- Strengthen Multi-Agency Collaboration: Deepen joint working with partners to improve outcomes for vulnerable people.
- Deliver Strategic Priorities: Drive forward new initiatives, including the DATIX Safeguarding Module, for 2025/26.

Summary

The year 2024/25 presented significant challenges for the Safeguarding Team, driven by a notable rise in safeguarding activity alongside the team's ongoing statutory responsibilities.

Despite these pressures, key achievements were realised in the following areas:

- Delivery of Safeguarding Training.
- Mandating Level 3 Safeguarding compliance via the ESR platform.
- Proactive management of an increased and more complex caseload.
- Expansion of safeguarding supervision across wider areas.
- Strengthening the IDVA role within urgent care settings.
- Establishment of a well-attended and effective Strategic Safeguarding Group, supported by dedicated sub-groups.
- Successful planning and preparation for the implementation of the Datix Safeguarding module.

The health board remains firmly committed to prioritising the safeguarding of both children and adults. This commitment will continue into 2025/26, with a focus on addressing both existing and emerging challenges.

Ongoing collaboration with the community and partner organisations will be essential to support continued development and adaptation.

The health board remains dedicated to safeguarding children and adults, with continued focus on current and future challenges. Collaboration with partners will support ongoing improvement and adaptation.

Argymhelliad / Recommendation

The Patient Quality Safety and Outcomes Committee is asked to **NOTE** the Safeguarding Report for 2024-2025

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):	2.7 Safeguarding Children and Safeguarding Adults at Risk 3.1 Safe and Clinically Effective Care 2.1 Managing Risk and Promoting Health and Safety 6.2 Peoples Rights
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

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

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Safeguarding Annual Report 2024/25

Introduction

Aneurin Bevan University Health Board recognises its statutory responsibility to ensure robust safeguarding measures are in place to protect individuals at risk. This duty is underpinned by key legislative frameworks including:

- **Health and Care Standards for Safeguarding Children and Adults at Risk** (Welsh Government and NHS Wales, 2015)
- **Social Services and Well-being (Wales) Act** (Welsh Government, 2014)
- **Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Act** (Welsh Government, 2015)

This Safeguarding Annual Report outlines the Health Board's compliance with these legislative requirements and provides a comprehensive overview of safeguarding activities undertaken between April 2024 and March 2025. The report aims to:

- Provide assurance to the Board that statutory safeguarding obligations are being met effectively.
- Demonstrate to external partners and regulatory bodies that proactive measures are in place to prevent abuse and mitigate harm to vulnerable individuals.
- Inform the Board, staff, partners, and stakeholders about the roles, responsibilities, and achievements of the Safeguarding & Vulnerabilities Team.
- Highlight the governance and assurance structures that support safeguarding practices within ABUHB.
- Identify key risks addressed during the reporting period and outline current risks along with their mitigation strategies.
- Summarise significant safeguarding initiatives and contributions at both local and national levels.
- Outline strategic priorities and areas for improvement in safeguarding for implementation in the 2024/2025 period.

Multi-Agency Partnership Working

The ABUHB Safeguarding Team continues to fulfil its statutory responsibilities through active membership of the Gwent Joint Children and Adult Safeguarding Board and the Gwent VAWDASV (Violence Against Women, Domestic Abuse and Sexual Violence) Partnership Board. In addition to these core roles, the team contributes to a wide range of sub-groups and committees that support the delivery of strategic safeguarding priorities across the region.

The Gwent Joint Children and Adult Safeguarding Board is a multi-agency partnership committed to embedding safeguarding at the heart of all services across Gwent. Its work is underpinned by a number of sub-groups that oversee both core business functions and targeted thematic workstreams aligned to annual strategic objectives.

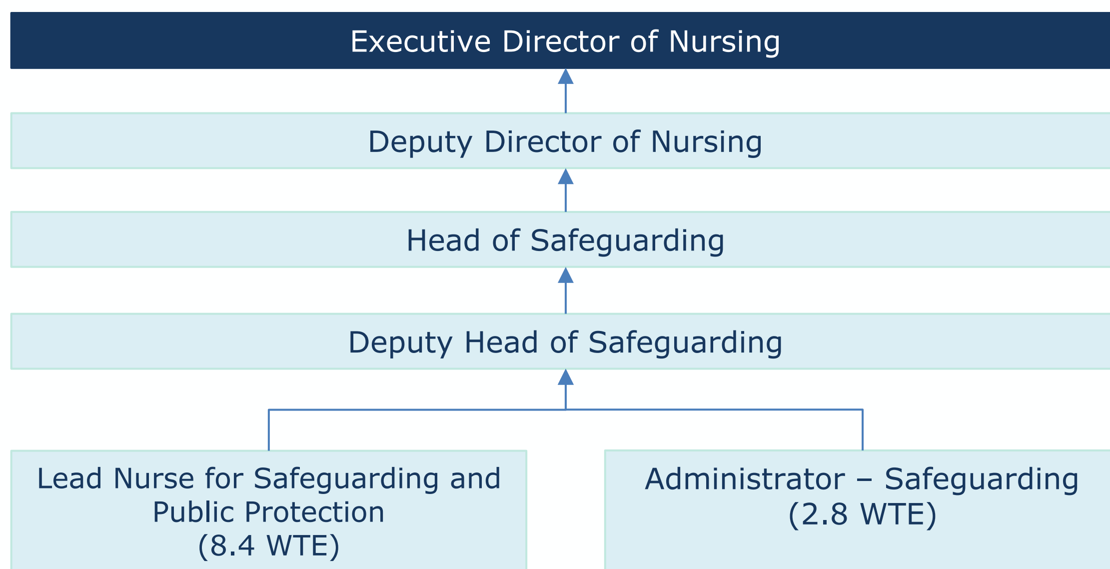
The Gwent VAWDASV Partnership Board brings together agencies across the region to prevent violence against women, domestic abuse and sexual violence. Its focus is on improving outcomes for individuals at risk or affected by such harm, as well as for their families and support networks, through coordinated and collaborative action.

Staffing

Aneurin Bevan University Health Board maintains a clear and robust safeguarding governance structure to ensure that its responsibilities are met effectively across all services. The Chief Executive holds overall accountability for safeguarding, with executive leadership delegated to the Executive Director of Nursing. This role is supported operationally by the Deputy Director of Nursing.

Strategic oversight is provided by the Head of Safeguarding, who is supported by a Deputy. Together, they offer assurance on safeguarding arrangements and represent the Health Board on regional partnership boards.

As the strategic lead, the Head of Safeguarding is responsible for the development and implementation of safeguarding systems and policies. This includes oversight of training provision and compliance, support for operational safeguarding practice, and the establishment of mechanisms to monitor the quality and effectiveness of safeguarding activity across the organisation.



	22/23	23/24	24/25	22/23 – 24/25 Comparison
Adult DTR's	263	382	511	+94%
Children DTR's	1878	3737	4356	+132%

Since 2022/23, there has been a substantial rise in Duty to Report referrals submitted to the Local Authority and processed by the ABUHB Safeguarding Team. Adult Safeguarding has seen a 94% increase, while Children's Safeguarding referrals have surged to 132% over the two financial years. This upward trend is evident across the entire service.

In response, the team structure was revised in September 2024. Additional hours were allocated to both the adult and children's safeguarding teams by converting Band 8a full-time equivalent (FTE) hours into Band 7 FTE hours. This adjustment created the equivalent of six Band 7 days, which were then distributed between the two teams.

Despite these changes, referral activity continues to rise and is expected to increase further as safeguarding training compliance improves. The complexity of cases is also growing, demanding more intensive involvement. As a result, the team currently lacks the capacity to absorb additional responsibilities.

Governance

The Safeguarding Strategic Group is an established entity within the Health Board's governance framework. It reports to the Patient Quality and Safety Outcomes Committee through the Quality Management Group and holds delegated authority to oversee and monitor safeguarding practices for Adults, Children, and Young People.

This group is responsible for setting the Health Board's Safeguarding Strategy, defining objectives that promote continuous improvement and ensure compliance with both national and local safeguarding policies.

To support its work, the Strategic Group is backed by three dedicated sub-groups that focus on developing and implementing robust, auditable, and effective quality monitoring systems. These sub-groups also play a key role in raising awareness of safeguarding issues and provide quarterly feedback to the Strategic Group.

The sub-groups are:

- Safeguarding Adults Sub-group
- Safeguarding Children and Young People Sub-group
- Persons In a Position of Trust (PIPOT) Sub-group

Single Unified Safeguarding Reviews

The Single Unified Safeguarding Review (SUSR), introduced in Wales from 1 October 2024, streamlines the safeguarding review process by combining multiple review types into a single, coordinated approach. This ensures that families affected by serious incidents experience a more efficient and compassionate process, reducing the emotional burden of participating in several separate reviews.

To qualify for an SUSR, the incident must meet the criteria for one of the following:

- Adult Practice Review
- Child Practice Review
- Domestic Homicide Review
- Mental Health Homicide Review
- Offensive Weapons Homicide Review

The SUSR creates a safe and collaborative learning environment for agencies and individuals involved in the incident. Its aims include:

- Gaining a deeper understanding of what occurred and the reasons behind it
- Evaluating how organisational actions influenced the outcome
- Considering whether alternative actions could have led to different results for the child or adult at risk
- Identifying opportunities for learning and improvement
- Developing a clear and actionable plan to enhance future service delivery

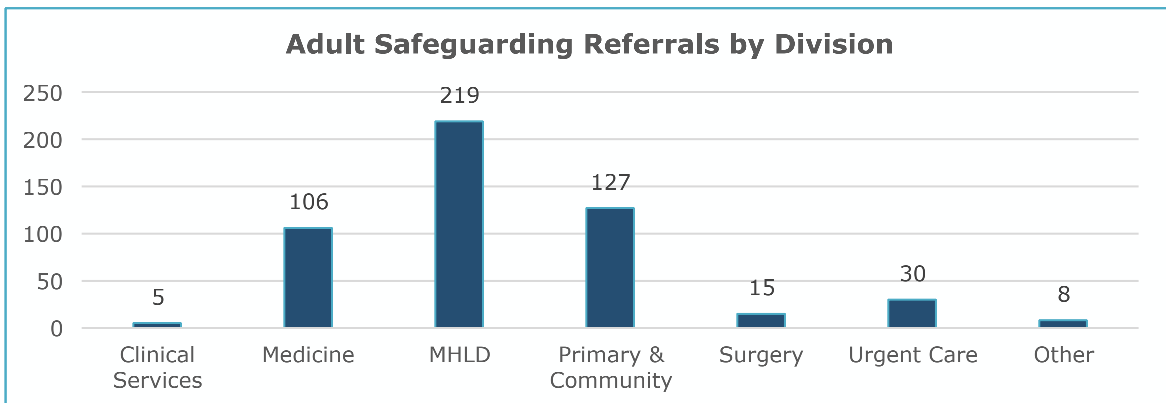
Safeguarding Adults

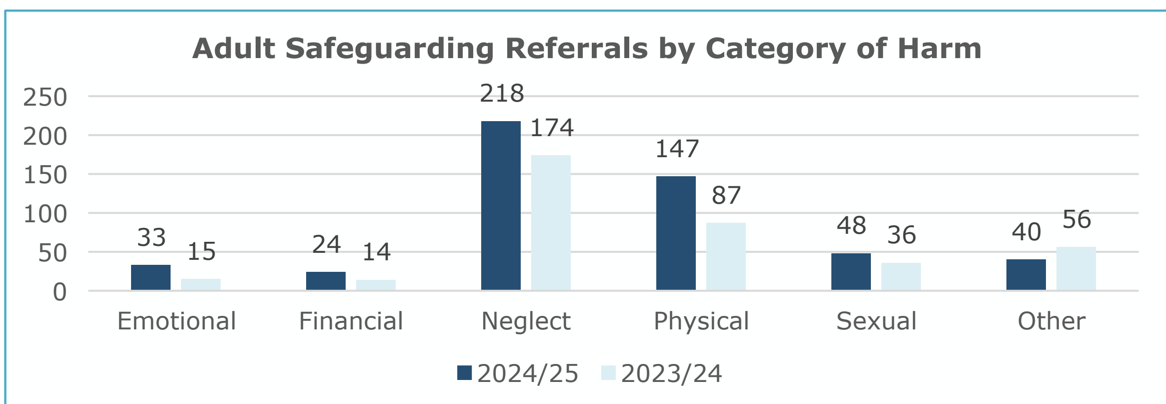
The Adult Safeguarding function within the Corporate Safeguarding Team receives Duty to Report submissions from Local Authority and then subsequent enquiries are made with Divisions. These reports enable the assessment of concerns and, where appropriate, referral to multi-agency partners for adults at risk.

These cases include instances where safeguarding concerns may involve the Health Board as a contributing factor, as well as those where external individuals or organisations are implicated.

In 2024/25, the Safeguarding Team received 510 Duty to Report submissions, an increase of 41% compared to the 362 received in 2023/24. This represents a significant rise in demand on the service.

The following illustrate the referrals by Division and Category of Harm.





The data provided by the Division is shared for informational purposes only and should not be interpreted as comparative. Often, the concerns reported by the Division are unrelated to the care and treatment they directly deliver.

When examining the data by type of harm, it is evident that Neglect is the most frequently reported category. This includes allegations of neglect with sub-themes such as poor discharge practices, pressure ulcers, and medication errors.

A more detailed review of incidents involving physical harm reveals that most cases are patient-on-patient assaults. Investigations have shown that these incidents are largely unavoidable.

A particularly concerning area is the number of reports related to sexual assault, which was also highlighted in the Annual Reports for 2022/23 and 2023/24. While the volume of incidents remains troubling, they do not meet the criteria for serious sexual harm. Notably, the proportion of sexual abuse cases relative to the total number of DTRs has decreased this year.

Targeted collaboration with the Mental Health and Learning Disabilities Division has continued throughout 2024/25. The quality of most DTRs has improved, and the Division maintains strong engagement with the Safeguarding Team. This work is expected to continue into the new financial year, with Safeguarding Supervision being offered as part of ongoing support.

Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust

In 2024/25, a total of 105 safeguarding allegations or concerns were raised involving ABUHB staff — the lowest figure recorded since data collection began. However, cases where practitioners were subject to allegations - but a multi-agency discussion concluded that no further action was required have not yet been formally documented.

Of the 105 referrals that entered the safeguarding process:

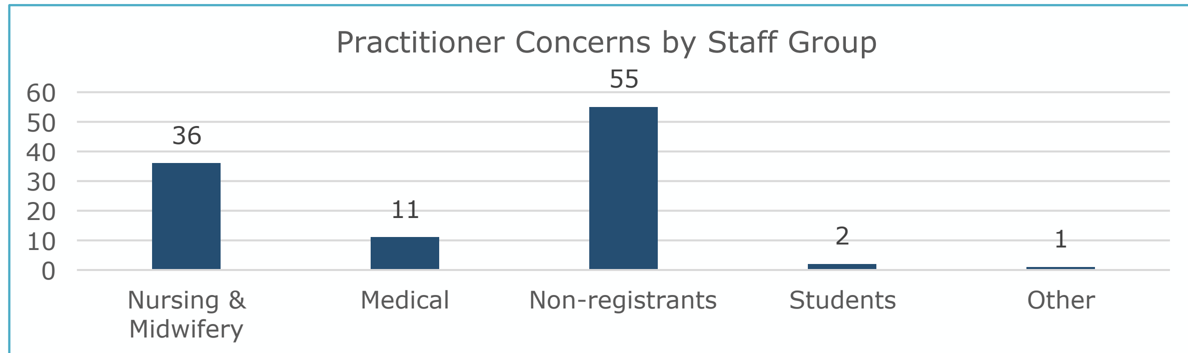
- 26 were substantiated, and
- 29 progressed to criminal investigation.

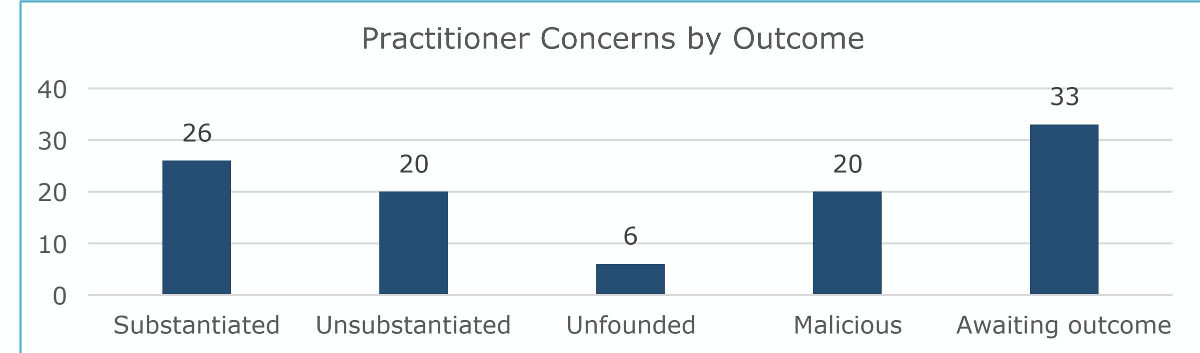
This marks a significant increase compared to the previous year, which saw only 10 substantiated cases, all of which were referred for police investigation. All other referrals noted in the initial figure did not meet threshold for the process.

To provide further context:

- 41 allegations related to incidents within the workplace.
- 64 incidents occurred outside of work.
- Not all cases involved directly employed ABUHB staff; some concerned independent contractors, Nurse Bank personnel and agency staff.

A working group has been established to examine these incidents in greater detail. Their focus includes clarifying referral thresholds and identifying emerging themes and trends. In addition, regular meetings with Police have been established to ensure that investigations progress in a timely manner.





Adult Practice Reviews

In the period 2024/25 there were no Adult Practice Reviews published by the Gwent Safeguarding Board.

Domestic Abuse

Domestic abuse is defined by the Welsh Government (2015) as "any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality."

In Wales, the health sector holds a crucial position in tackling domestic abuse, serving as a primary point of contact for recognising and supporting those affected. Health professionals are expected to play an active role in identifying signs of abuse and responding appropriately, with an emphasis on early intervention and connecting individuals to specialist services. The Welsh Government promotes a public health model, embedding domestic abuse awareness into healthcare delivery and ensuring victims and survivors receive holistic support.

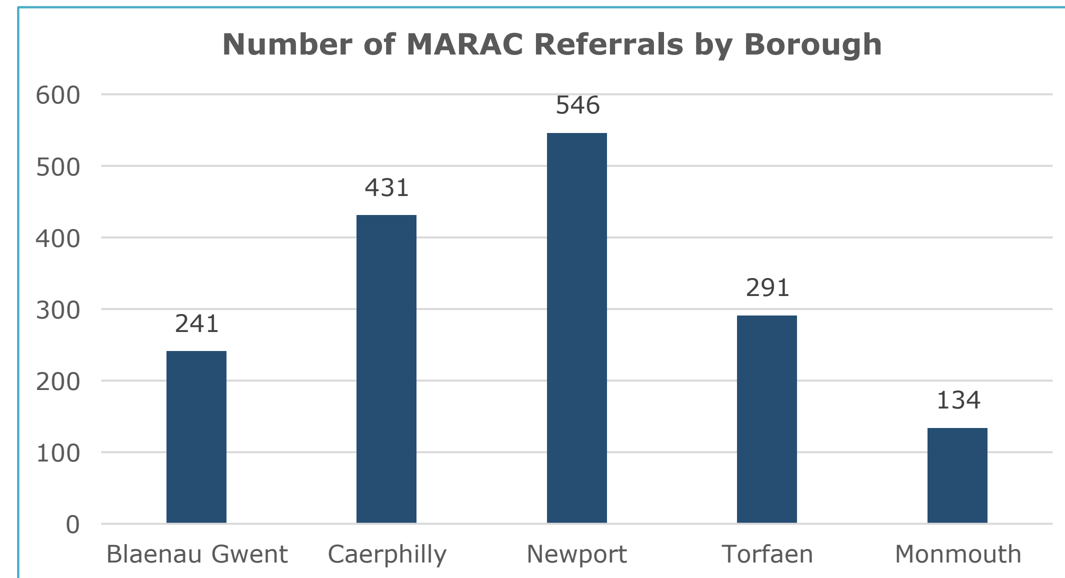
The responsibilities of the health sector include:

- Identifying and referring individuals at risk
- Delivering support and clinical care
- Focusing on prevention and early action
- Working collaboratively with partners and agencies
- Engaging with perpetrators to address harmful behaviours
- Implementing relevant legislation and policy frameworks

Multi Agency Risk Assessment Conference (MARAC)

The Safeguarding Team plays a vital role in supporting victims of domestic abuse who are at high risk, through active participation in Multi-Agency Risk Assessment Conferences (MARAC). These multidisciplinary meetings focus on individuals assessed as being at high risk of serious harm or homicide, with the aim of coordinating safeguarding actions across agencies.

Each Local Authority within the Gwent area currently convenes a MARAC panel on a fortnightly basis. As a statutory agency, the Safeguarding Team is committed to attending all of these meetings. Notably, the number of referrals discussed at MARAC has seen a slight increase across all Local Authorities compared to 2023/24.



This rise reflects the growing number of individuals experiencing domestic abuse who are assessed as medium or high risk using a nationally accredited risk assessment tool. In addition to this significant group, there remains a high volume of individuals accessing our services who are assessed as standard risk. These cases are typically managed by a single agency, often our own teams or independent contractors.

Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS)

Within the health board, MCA & DoLS function does not fall directly under the portfolio of the Corporate Safeguarding Team. However, it is closely aligned, and strong professional relationships exist between the two teams. The health board continues to fulfil its statutory responsibilities regarding DoLS and the broader requirements of MCA. Additionally, the health board actively participates in the All Wales MCA/DoLS Network.

MCA training has now been made mandatory across the health board and is in the process of being aligned with ESR for accurate recording and compliance monitoring. Training, clinical support, and an audit cycle have been embedded into MCA practice. MCA/DoLS training is offered at three levels, culminating in skills workshops designed to help staff develop clinical competencies. MCA practitioners remain available to support and advise clinical teams with MCA assessments and Best Interest (BI) meetings.

Number of referrals received: The chart below details the number of referrals received by month throughout 2024/25.

April	May	June	July	August	September	October	November	December	January	February	March	TOTAL
251	197	225	248	203	272	272	232	214	246	207	196	2763

Number of assessments completed: The chart below details the number of completed assessments by month throughout 2024/25.

April	May	June	July	August	September	October	November	December	January	February	March	TOTAL
160	140	128	147	114	91	137	114	83	99	104	135	1452

Domestic Homicide Reviews

In 2024/25, the Safeguarding Team contributed to three Domestic Homicide Reviews (DHRs), all of which are awaiting publication. Two of these reviews were initiated in the previous year, with one originating in 2020.

Initial findings show that patient support was delivered to a high standard. Nonetheless, opportunities for improvement were identified—particularly in how domestic abuse and associated vulnerabilities are documented in patient records. Enhancing the visibility of such concerns would support better information sharing among professionals involved in the patient's care. Compared to earlier DHRs, there is clear progress in professional curiosity and good practice, especially in ensuring patients are offered the chance to be seen alone.

Traditionally, the Health Board has represented all health agencies during the DHR process. However, in the three most recent reviews, General Practice has taken a more active role, enriching multi-agency discussions and leading to clearer, more actionable recommendations.
Learning from these reviews is being embedded through the SUSR process and will inform future practice. This will strengthen the Health Board's ability to identify not only victims of domestic abuse but also those offering them support.

Independent Domestic Violence Advisers

The Independent Domestic Violence Advisor (IDVA) service operates across Gwent and is currently hosted by Newport City Council. It is jointly funded by the five Gwent Local Authorities, Aneurin Bevan University Health Board and the Office of the Police and Crime Commissioner (OPCC). The role is designed to improve awareness, assessment, signposting, and referral pathways for patients affected by domestic abuse—including coercive control—who engage with Health Board services.

Following the successful integration of the IDVA role within ABUHB, a second position was introduced to address the growing demand and workload identified by staff. In addition to delivering training and raising awareness, the IDVA provides direct support to patients, including conducting risk assessments, creating safety plans, assisting with Police disclosures, and facilitating access to housing and specialist support services.

During the 2024/25 reporting period, the health-focused IDVA service was based at the Grange University Hospital, while continuing to support patients and staff across ABUHB's inpatient and urgent care settings. A total of 261 direct referrals were received—22 involving male victims and 239 involving female victims. Although male referrals remain comparatively low, this data underscores the importance of ongoing efforts to identify and support male victims of domestic abuse.

Safeguarding Children: Activity Summary 2024/25

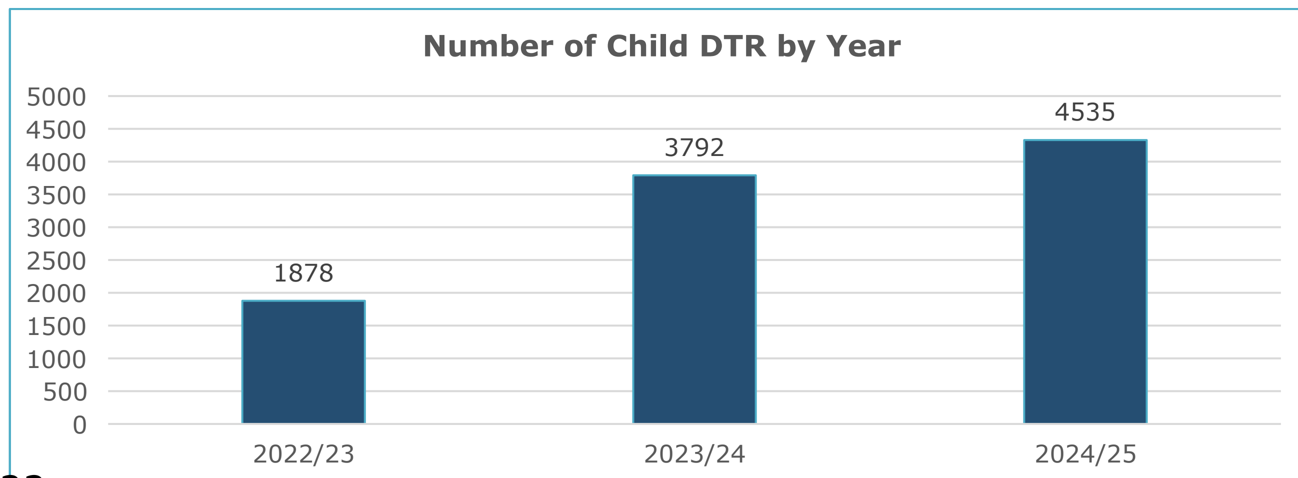
During 2024/25, the Health Board made 4,535 Duty to Report referrals concerning suspected child abuse or neglect across the five boroughs. This represents a 17% increase compared to the 3,736 referrals made in the previous year. In addition to the rise in volume, the complexity of cases has also grown, with 49% progressing to strategy meetings. This equates to 2,119 strategy meetings attended this year, a 33% increase from the previous year.

While some of this increase can be attributed to improved resourcing within Local Authority Safeguarding Teams and enhanced training and awareness around safeguarding, these factors alone do not fully account for the significant rise in activity.

Throughout 2024/25, the Corporate Safeguarding Team has continued to collaborate with partner agencies, both reactively on individual cases and proactively through the Safeguarding Board—to better understand the drivers behind this trend.

The Safeguarding Hub has played a key role in early intervention and safety planning for children at risk. In addition to this, 4535 strategy meetings have been attended to form a multi-agency approach as specified in the Social Services and Wellbeing (Wales) Act (2014). Its multi-agency approach enables staff to provide more effective support to children, young people, and their families at an earlier stage.

The graphs illustrate the volume of DTRs processed by the Corporate Safeguarding Team and the thematic areas emerging from them. The notably high number of referrals categorised as "other" is attributed to previously inadequate reporting systems and the dual classification of harm types.

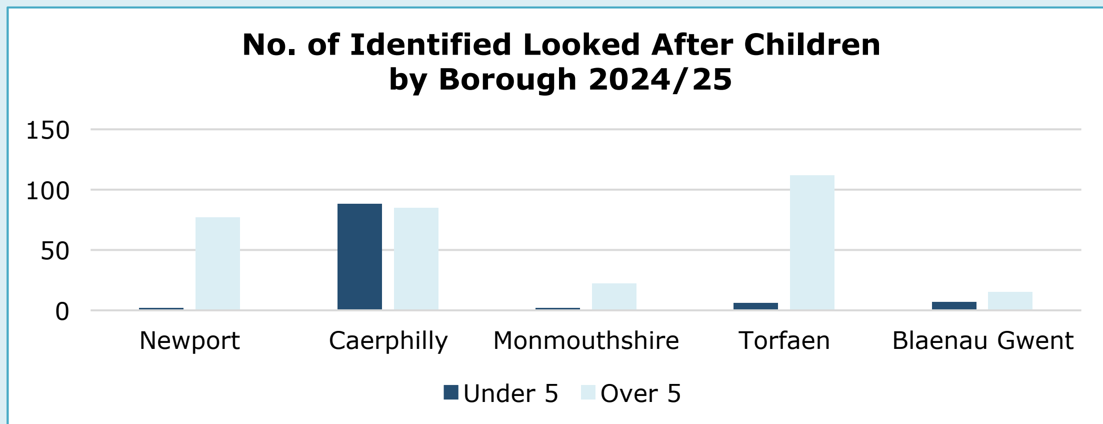


Category of Abuse for DTR's	No.
Neglect	198
Emotional Abuse	80
Sexual Abuse	75
Physical Abuse	275
Financial Abuse	0
Other	3907

Looked After Children (LAC)

Looked After Children (LAC) are those who are in the care of the Local Authority, either temporarily or permanently, because they are unable to safely live with their parents/guardians. The Health Board plays a crucial role in Safeguarding and promoting the health and well-being of these children and young people and are responsible for ensuring that they receive necessary health assessments, services and support their specific health needs in a holistic approach. Each Local Authority holds the responsibility of the children and young people which are LAC. The LAC portfolio is not part of the Safeguarding Team however both teams liaise closely and support where necessary.

By Borough, the numbers below relate to the number of children who were identified as looked after at the end of the financial year 2024/25.



National Contribution

The Safeguarding Team actively contributes to the National Safeguarding agenda. The National Safeguarding Service operates within Public Health Wales as a team of experts who provide a strategic focus and professional lead to improve safeguarding across the NHS in Wales. A data set to encapsulate safeguarding data from all Health Boards is currently under development to provide assurance and enable Health Boards to benchmark and share learning throughout Wales.

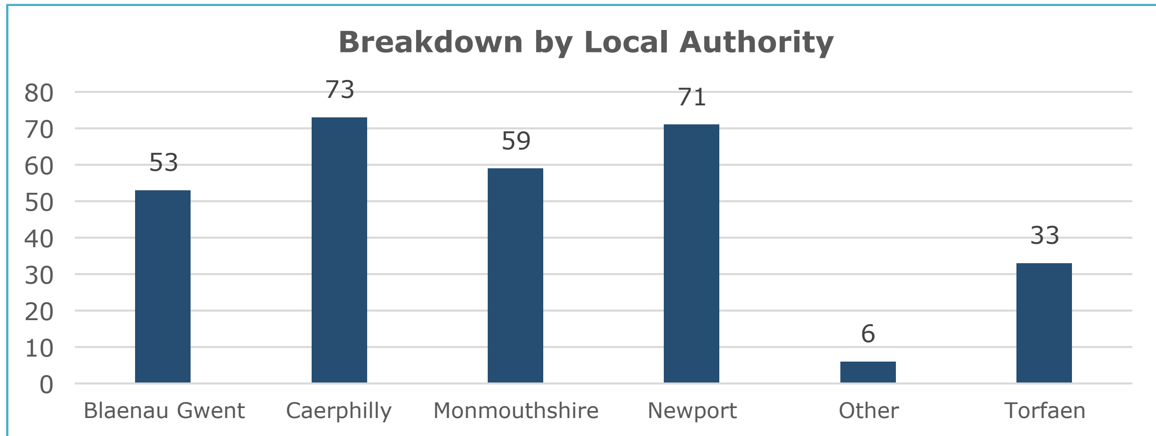
Members of the Safeguarding Team have membership on several national working groups such as:

- National Safeguarding Network
- Safeguarding in Health: Learning Framework
- Learning & Development
- Once for Wales Safeguarding Module
- Restorative Supervision
- Quality Assurance & Accountability Framework

Child Protection Medicals (CPM)

Child Protection Medicals are assessments carried out to identify any signs of abuse or neglect in children and young people.

In 2024/2025, a total of **295** Child Protection Medicals were conducted—matching the number from 2023/2024.



This data provides a local authority breakdown but should not be interpreted in isolation.

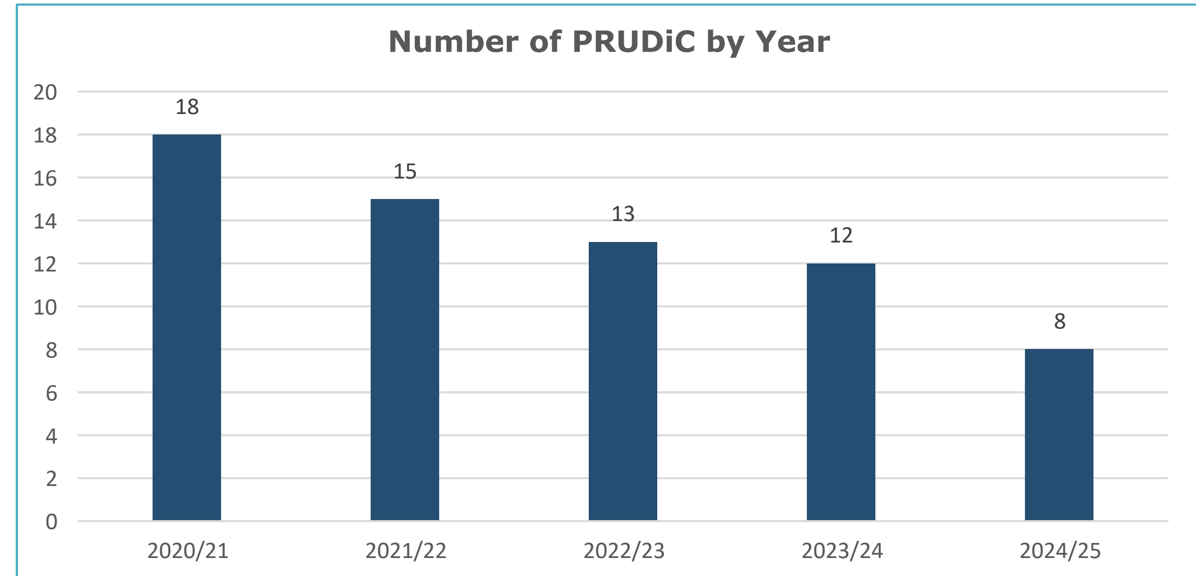
Timeliness and Peer Review:

In line with policy, all Child Protection Medicals were completed within 24 hours of the request being accepted. Each case undergoes monthly peer review by medical staff to maintain service quality and encourage professional challenge.

Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

Prudic outlines the minimum response required following an unexpected child death. It ensures a coordinated, safe, and compassionate approach through effective communication, joint action, and information sharing.

In 2024/2025, **eight** child deaths in the health board area met the PRUDiC criteria. This reflects a continued decline since 2020:



All PRUDiC cases are reported to the Welsh Government in line with *Putting Things Right* guidance. This enables monitoring of patterns and trends—none of which were identified in 2024/2025.

Child Practice Review

In 2024/25, the Gwent Safeguarding Board published a single Child Practice Review, which was shared through the Strategic Safeguarding Group to support learning and improvement.

The review followed the death of a 15-year-old male in August 2021, referred to as *Child D* at the family's request. Born in 2006 and diagnosed with cerebral palsy, Child D had early contact with social services when a Social Worker from the disability team was assigned at age one. At the time of his death, he was living with his grandparents, where professionals observed signs of neglect and poor living conditions.

While the review did not highlight any specific failings or areas for improvement in services provided or commissioned by the health board, it did identify broader learning opportunities. These included strengthening safeguarding frameworks and enhancing supervision practices for staff managing complex cases—offering valuable insights for internal development and continuous improvement.

Further reviews have been agreed and commenced within the timeframe however are not published at this within 2024/25.

1 Background

Following the death of a 15 year old child (Child D), an extended Child Practice Review was commissioned. Child D was born in January 2006 at 24 weeks gestation. He spent 19 weeks in a neo-natal unit and was diagnosed with cerebral palsy. Child D was first known to Children's Services Disability Team at the age of 1 years old for Occupational Therapy support due to his complex health needs.

In 2008, Child D was placed with his maternal grandparents as a Child Looked After due to his mother feeling unable to meet his needs; this was followed by a Special Guardianship Order being granted to them some months later. Child D's mother and father had moved to a different area and Child D continued to reside with his maternal grandparents. Concerns regarding home conditions first came to light in 2015.

2 Context

Child's D's mother returned to the family home in 2016 along with her two children from a different relationship. Whilst residing in another area Children's Services had been involved with Child D due to concerns regarding neglect. Home conditions fluctuated from 2015 up until Child D's death. His health continued to be reviewed with no issues being identified. In 2021 concerns were raised regarding medication management for Child D and later that year his named was placed on the Child Protection Register for Neglect. Throughout the time that Children's Services were involved with child D and his family, they remained as part of the Children's Disability Team within the Local Authority Structure.

Prior to Child D's death his Grandparents went on holiday, extra safeguards were put in place due to mother having caring responsibility for Child D. During this time, it was identified that he was suffering from constipation and a prescription was made by his GP; however, this was not collected. Poor home conditions were noted by paramedics and police attending at the time of Child D's death.

3 Theme:

Understanding a child's lived experiences is vital for effective safeguarding. Child D was predominantly non-verbal due to his complex needs. Complexities with speech and language should not be a barrier to developing an understanding of a child's lived experience. The Children's Disability Team within the Local Authority currently falls within the Adult Services Structure. Physical needs relating to child D's disability were met with professional input from services such as Occupational Therapy. However, there is a lack of focus on child D's lived experiences as a child with disabilities living within a home where there was cumulative neglect over a number of years.

Recurrent Poor Home Conditions and Neglect:. The impact of neglect may be more severe for some children, including those with disabilities such as Child D. The cumulative effect of neglect must be considered by professionals, particularly when children have complex needs.

4 Theme:

Risk Assessments for Carers Understanding of Child D's Needs: Child D was residing with his grandparents under the requirements of a Special Guardianship Order, however, there were times when his care was the responsibility of his mother, for example when his grandparents were on holiday. Child D had complex care needs and it is unclear the extent to which mother had the ability to meet these needs whilst also caring for Child D's siblings, and what grandparents understanding of this was. **Specialist equipment**: Child D required a range of specialist equipment due to his health needs; these changed over time as Child D grew and it must also be considered that as Child D grew and his grandparents aged, it may have become more challenging for them to meet his needs. Specialist equipment was provided for Child D however some items were not used due to them causing Child D distress. There were significant delays in obtaining other items, influenced by the Covid 19 pandemic. This highlights the importance of ongoing assessment.

5 Recommendations:

Recommendation 1: The Safeguarding Board should consider developing practice guidance on the lived experience of children with disabilities to assist practitioner insight, to ensure that the voice of the child is actively heard and to support effective action to safeguard children and young people. **Recommendation 2**: Consideration should be given for the Local Authority to review the strategic responsibility for the Children with Disabilities Team within the directorate of the authority. This consideration could include ensuring consistency across the region. **Recommendation 3:** The Safeguarding Board to explore and consider if information from GP's regarding children who are subject to safeguarding procedures, should be shared with Pharmacists to monitor and share information as appropriate. **Recommendation 4:** The Safeguarding Board to consider the addition of a home conditions threshold to the existing regional neglect guidance. Photographs of home environments should be considered to enable professionals and families to identify and enable change, as appropriate.

6 Recommendations:

Recommendation 4 continued: These could also be used to discuss acceptable standards. A multi-agency approach to a cluttered environment should be considered and agencies such as the fire service to be considered for education regarding risk. **Recommendation 5:** When a child is residing with a parent/carer who no longer holds over-riding parental responsibility, Children Services should complete risk assessments for the parent/carer to prove competence related to the care needs of the individual child. **Recommendation 6:** Risk assessments should be completed by the Local Authority in partnership with other relevant agencies to evidence and therefore enable escalation of poor service from outside companies when waiting times for equipment exceed expected timescales. The impact to the child or young person should be considered within this. **Recommendation 7:** Regular assessments of equipment needed for individuals should be undertaken and equipment removed if appropriate by the Local Authority and partnership agencies. Escalation processes should be clear for all staff across all sectors to enhance the care

7 Good Practice

Child D's educational setting recognised when he was in pain and queried the reasons for this with family.

Professionals recognised that Child D's mother may struggle with his care while grandparents were away and ensured measures were put in place including additional support from extended family, additional school playscheme sessions, and Social Worker home visits.

During the Covid 19 pandemic, school maintained regular contact with the family and Child D was offered and attended a hub placement during school closures.

Local Authority provided support at home to enable grandparents to access virtual core groups during the Covid 19 pandemic.

Safeguarding Supervision

Safeguarding supervision is a fundamental responsibility of the Safeguarding Team, designed to ensure that staff are well-prepared with the knowledge, skills, and confidence needed to meet their safeguarding duties. It also fosters a supportive environment that promotes reflection and ongoing professional growth.

Supervision provides a restorative and reflective space where staff can explore casework, celebrate successes, and identify areas for development. It also enables the Corporate Safeguarding Team to spot emerging trends and challenges faced across the health board. This approach is consistent with the All Wales Safeguarding Supervision Guidance (2024), which highlights the value of restorative practices in building practitioner resilience and supporting well-being.

Staff across the health board can access safeguarding supervision through a variety of formats, including:

- Immediate telephone support
- Post-incident debriefs
- One-to-one supervision
- Group supervision sessions

Child Safeguarding Supervision

Safeguarding supervision continues to be routinely provided for child-focused specialties, including Health Visitors, School Nurses, CAMHS Practitioners, Community Paediatric Nurses, Children's Learning Disability Nurses, Sexual Health Outreach teams, Acute Paediatric Nurses, Health Care Support Workers, Neonatal Intensive Care Nurses, the Neonatal Intensive Care Liaison Team, and Midwives.

The Corporate Safeguarding Team acknowledges the importance of ensuring that health board staff have access to subject matter experts for case discussions and incident reviews. In accordance with the Safeguarding Supervision Policy, it is recommended that staff receive supervision at least twice annually.

While operational managers are responsible for monitoring compliance locally, the Corporate Safeguarding Team has facilitated nearly 50 formal supervision sessions over the reporting year. These sessions have been well-attended and have received positive engagement from staff working across children's services.

Adult Safeguarding Supervision

Unlike the explicit mandate for staff working with children, adult safeguarding supervision is not currently emphasised to the same extent within intercollegiate guidance. This is largely due to a national view that professionals working with adults typically do not maintain formal caseloads and that their interactions with service users are often episodic.

However, within the health board, there is clear evidence that certain teams engage with highly complex and vulnerable individuals over prolonged periods. In recognition of this, a structured model is being developed to support safeguarding supervision within adult services.

To date, the Corporate Safeguarding Team has introduced this supervision model within the Complex Care Team and the High Impact User Service.

Plans are also underway to explore the implementation of more formal supervision arrangements within the Community Mental Health and Learning Disability (MH/LD) Teams.

Safeguarding Training

Safeguarding training remains a fundamental responsibility of the Safeguarding Team and is mandatory across the Health Board. Compliance is expected to align with the Welsh Government's national target of 85%. Training is delivered through a combination of e-learning and face-to-face sessions.

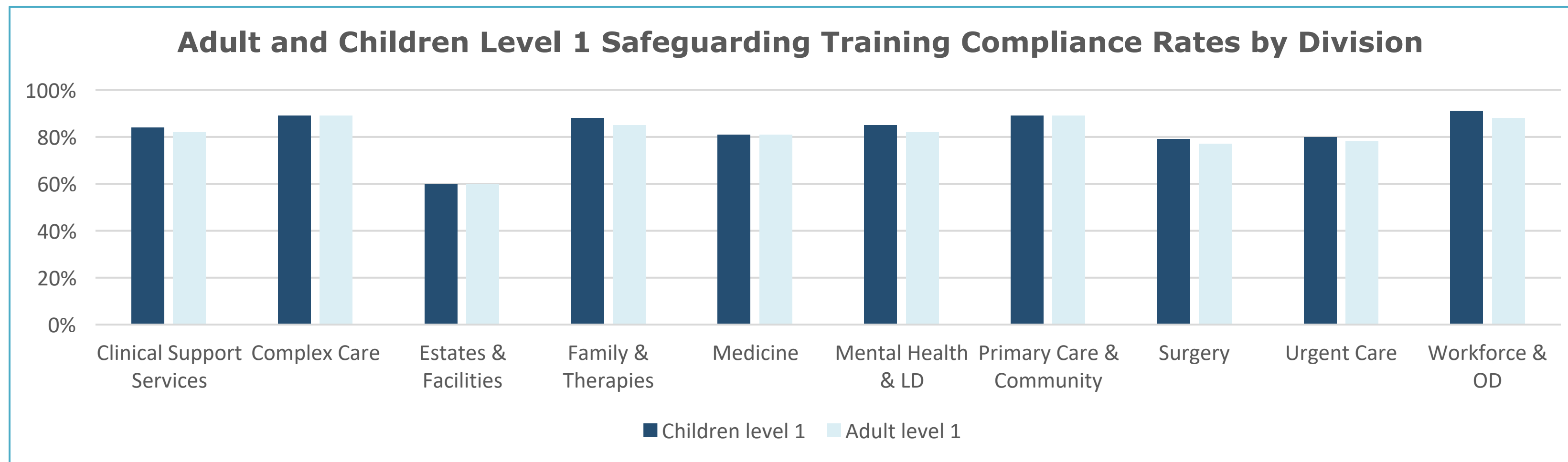
During 2024/2025, overall compliance with safeguarding training has shown a positive upward trend. Notably, there has been a marked improvement in engagement from divisions, which is both recognised and appreciated.

Level 1 Safeguarding Training

Level 1 Safeguarding Training is a mandatory online module for all staff working within ABUHB. It equips professionals with the knowledge and skills to recognise safeguarding concerns involving both adults and children, and to respond appropriately when necessary.

As of 31 March 2025, compliance rates stood at **81% for adults** and **83% for children**. Although ABUHB reached the 85% compliance target at several points during the year, this standard was not consistently upheld. Current figures suggest that only minor improvements are needed to regain the 85% benchmark.

The graph below presents compliance with Level 1 training for both adults and children, broken down by division.



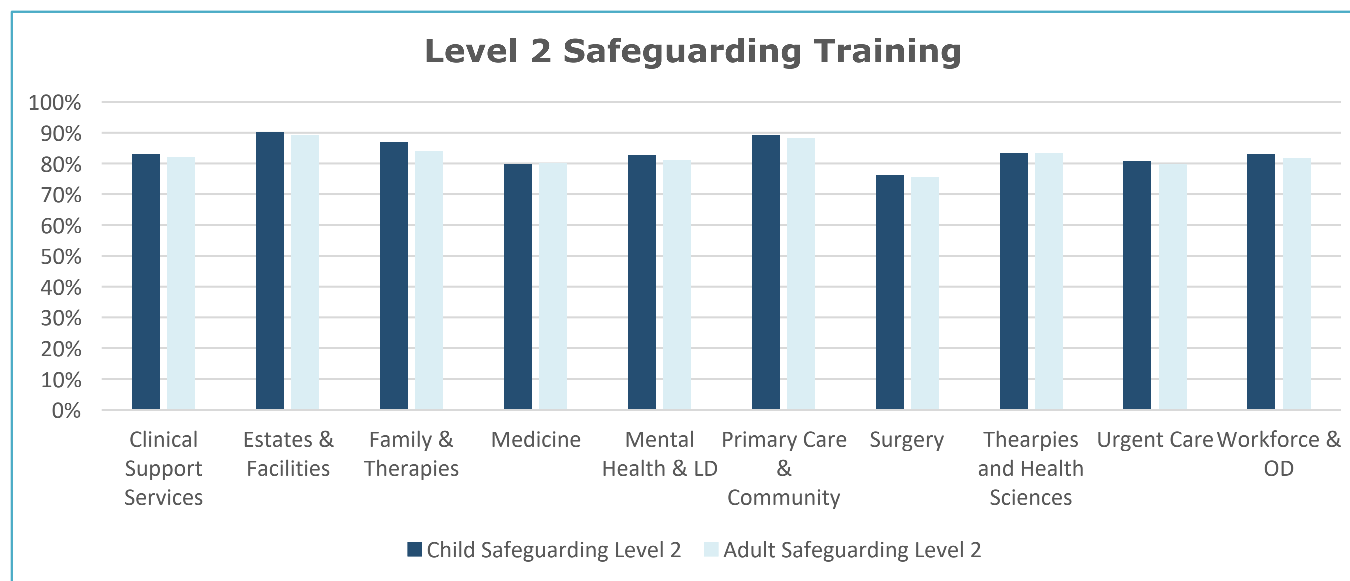
Level 2 Safeguarding Training

Level 2 Safeguarding Training is a mandatory requirement for all ABUHB professionals who have direct patient contact. This training equips staff to recognise safeguarding concerns and respond appropriately, including making referrals and advocating for both adults and children.

As of the current reporting period, compliance rates are 84% for adults and 81% for children, aligning closely with the figures reported in 2022/23.

These results suggest that only minor improvements are needed to reach the 85% compliance target, however this position remains unchanged to the previous year.

The graph below illustrates Level 2 training compliance for both adults and children, broken down by division.



Level 3 Safeguarding Training

Level 3 Safeguarding Training is now a mandatory, interactive module—delivered either face-to-face or virtually—for all registered professionals within the Health Board. In accordance with the Intercollegiate Document (RCN, 2019) and the Wales Safeguarding Training, Learning and Development Standards (2022), staff are required to complete a minimum of eight hours of interactive training every three years.

As of March 2025, this requirement has been formally embedded into the Electronic Staff Record (ESR) system for relevant staff groups.

The training equips professionals with the essential knowledge and skills to effectively assess, plan, intervene, and evaluate the needs of individuals, ensuring the safeguarding of both adults and children at risk.

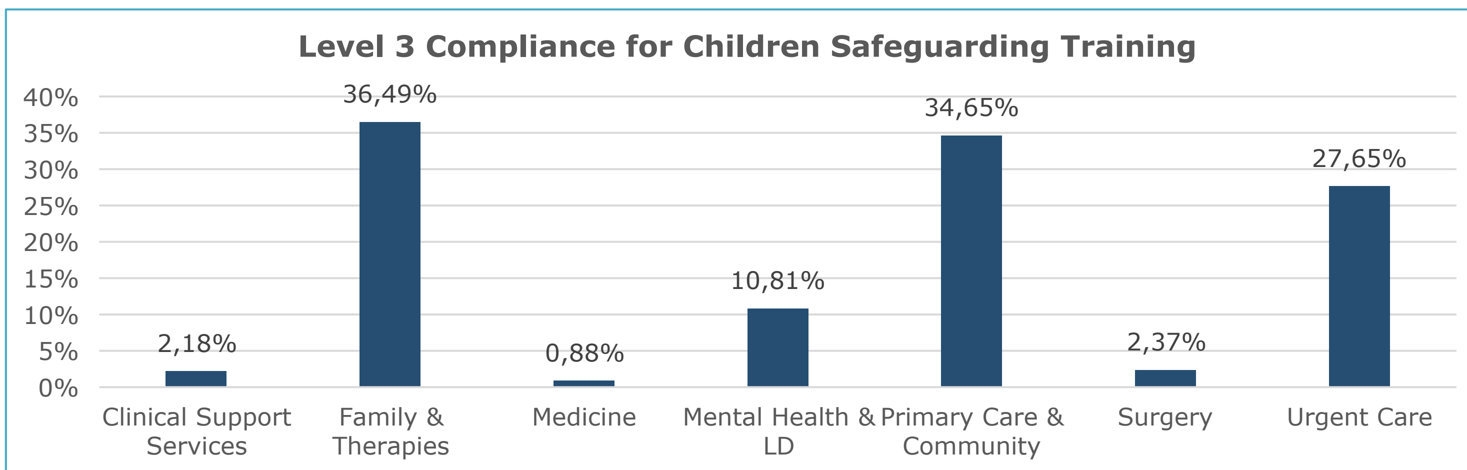
Historically, monitoring compliance with Level 3 training was challenging. However, with ESR now capturing this data, the health board can now track uptake and compliance by staff group and division—bringing it in line with reporting for Levels 1 and 2.

As of March 2025:

- 2,476 staff were identified as requiring Level 3 Safeguarding Children training, with 633 completions, equating to a 25% compliance rate.
- Approximately 6,200 staff were identified as requiring Level 3 Safeguarding Adults training, equating to a starting compliance rate of 15%.

Training is currently delivered as a full-day session—either in person for groups of up to 50 or virtually via Microsoft Teams for up to 30 participants. Despite these efforts, compliance for both adult and children's Level 3 safeguarding training remains below the Health Board's target of 85%.
Based on current delivery methods, capacity and resources:

- Children's Level 3 compliance is expected to reach 50% by March 2026, 80% by March 2027, and meet the 85% target by March 2028.
- Adult Level 3 compliance is projected to reach 55% by March 2028, however alternative training methods are being reviewed to achieve greater compliance at around 85% by March 2028.



Domestic Abuse Training

Ask and Act Training Overview

Ask and Act training equips professionals to respond effectively to individuals affected by gender-based violence, domestic abuse, and sexual violence.

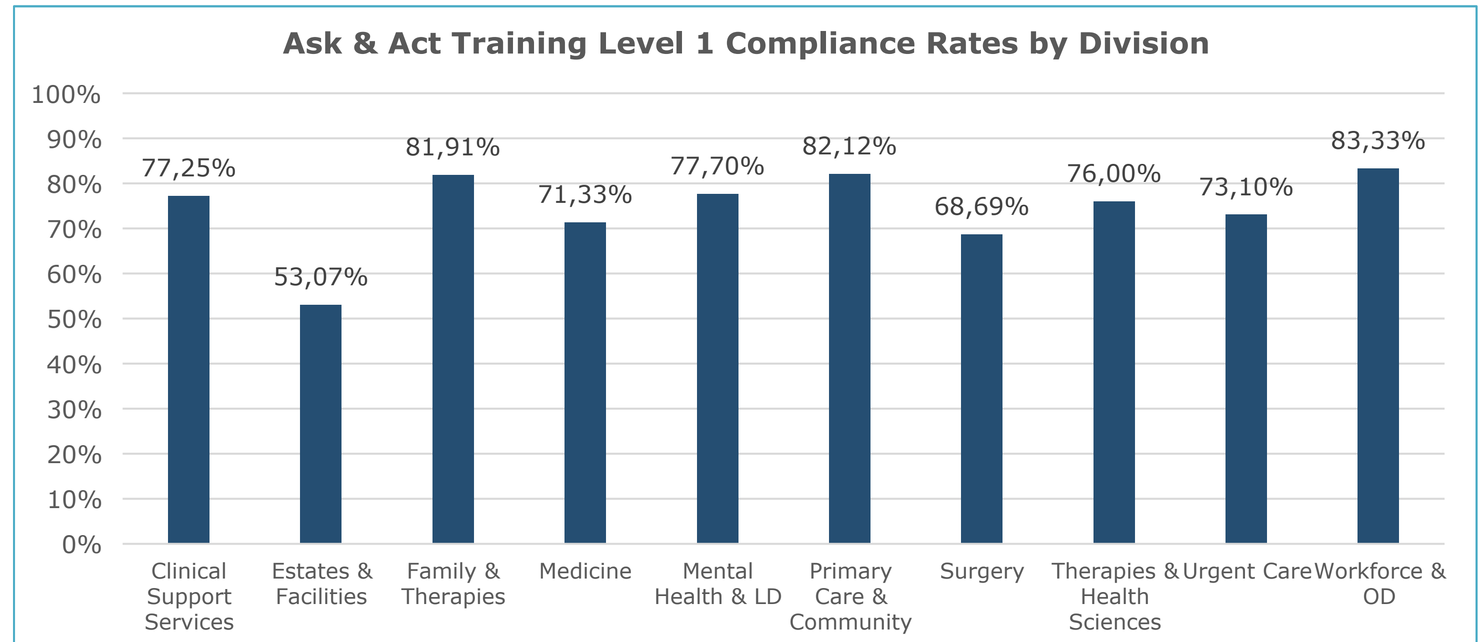
The training is structured similarly to standard safeguarding levels—Groups 1, 2, and 3—based on participants' responsibilities and learning needs.

- **Group 1** is the foundational training and is mandatory for all ABUHB staff.
- **Group 2** is designed for those who work directly with victims and are responsible for identifying, assessing, and referring cases.

In 2024/25, 75% of eligible ABUHB staff completed Group 1 Ask and Act training, reflecting a slight increase in compliance compared to 2023/24.

Group 2 training continues to present challenges in tracking compliance due to limitations in ESR reporting. As a result, it will remain a focus area in the 2025/26 Training Needs Analysis.

The graph illustrates Group 1 compliance rates by division



Review of Priorities for 2024/25

#	Priority	Status	Update
1	To work with Senior Leadership Team in Primary Care to ensure that those working within primary care have the training and resources to ensure compliance with the Wales Safeguarding Procedures.		The Safeguarding Management Team has now completed this work, having delivered presentations across all Boroughs to outline the available training offer on recognising domestic violence. They have also proactively extended ongoing supervision and support to designated safeguarding leads within practices managing such cases.
2	To ensure delivery of appropriate Safeguarding Adult Supervision to teams within the Mental health and Learning Disability Division who are holding caseloads.		Group supervision, initially piloted in selected areas, will be expanded to additional teams throughout 2025/26.
3	To develop and launch a suite of documents in relation to sexual safety, including a Chaperone Policy, a standard operating procedure for referral to SARC and guidelines on internal reporting.		Work on policies addressing sexual safety and historical sexual abuse has commenced, with guidance documents now developed, shared and published on the Safeguarding intranet page.
4	To revise the model for delivery and monitoring of Level 3 Safeguarding training.		Safeguarding Level 3 training is now a mandatory requirement on the ESR platform, enabling accurate tracking of compliance and ensuring Divisions are accountable for meeting their training obligations.
5	Launch of the DATIX Safeguarding Module to facilitate better case management of cases open to the safeguarding processes.		The implementation of the Once for Wales Datix system was backed by the ABUHB Executive Team and the National Safeguarding Service. Following a period of planning, the Safeguarding module officially went live on 1 April 2025.
6	To rewrite the ABUHB Section 5/Practitioner Concerns Guidance to reflect internal processes and to strengthen local application of the national threshold for referral.		A dedicated sub-group of the Strategic Safeguarding Group has been established to support this model of working within ABUHB, with efforts continuing into 2025/26 to deliver on this priority. Awaiting revision of National section 5 policy.
7	To develop a set of internal assurance measures, which can contribute to ward accreditation, in regard of Safeguarding and Domestic Abuse.		Safeguarding has been established as one of the Six Pillars of Quality within ABUHB and is included in ward accreditation audits. This approach reinforces accountability and promotes the understanding that safeguarding is a shared responsibility across all areas.
8	To establish operational subgroups of the safeguarding committee with a focus on embedding learning from statutory reviews and driving quality improvement.		The three sub-groups are now operational and provide assurance through reporting to the Strategic Safeguarding Group. These groups facilitate early learning from reviews and incidents, enabling the delivery of work through a multidisciplinary perspective.

Conclusion

The year 2024/25 presented significant challenges for the Corporate Safeguarding Team, driven by a notable rise in safeguarding activity alongside the team's ongoing statutory responsibilities.

Despite these pressures, key achievements were realised in the following areas:

- Delivery of Level 3 Safeguarding Training.
- Mandating Level 3 Safeguarding compliance via the ESR platform.
- Proactive management of an increased and more complex caseload.
- Expansion of safeguarding supervision across wider areas.
- Strengthening the Independent Domestic Violence Advocate (IDVA) role within urgent care settings.
- Establishment of a well-attended and effective Strategic Safeguarding Group, supported by dedicated sub-groups.
- Successful planning and preparation for the implementation of the Datix Safeguarding module.

ABUHB remains firmly committed to prioritising the safeguarding of both children and adults. This commitment will continue into 2025/26, with a focus on addressing both existing and emerging challenges.

Ongoing collaboration with the community and partner organisations will be essential to support continued development and adaptation.

Priorities for 2025/26

The health board recognises that further progress is needed to strengthen safeguarding for children and adults at risk. As a Health Board, it is essential that we continue to evolve and enhance our services to meet the needs of a modern and changing society.

The priorities for the health board in 2025/26 include:

Priority 1:
To finalise the framework for delivering and monitoring Level 3 Safeguarding training.

Priority 2:
To ensure the provision of appropriate Safeguarding Adult Supervision for teams within the Mental health and Learning Disability Division who are managing active caseloads.

Priority 3:
To develop and launch a suite of Safeguarding Policies (to also include sexual safety and a SOP for SARC referrals) that staff can easily access and apply, supporting the effective safeguarding of individuals and staff across ABUHB.

Priority 4:
To implement functionality within the ESR platform that enable accurate monitoring and Divisional reporting of Ask & Act Group 2 training compliance.

Priority 5:
To launch the DATIX Safeguarding Module to enhance the management and oversight of cases within safeguarding processes.

Priority 6:
To continue developing internal assurance measures relating to Safeguarding and Domestic Abuse, which will contribute towards ward accreditation processes.

Priority 7:
To work collaboratively with Local Authority and Police partners to reduce the duration cases remain open and to establish processes that support early learning.

Priority 8:
To collaborate with Police and Local Authority partners to ensure the consistent and equitable application of nationally revised Section 5 processes.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN** **ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	29 July 2025
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Learning from Deaths Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr James Calvert, Executive Medical Director Dr Stephen Edwards, Deputy Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Assistant Director for Quality & Patient Safety

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The UK Government has enacted legislation requiring the scrutiny of all in-patient hospital and community deaths not referred directly to the Coroner by a Medical Examiner. This marks the implementation of the final recommendation from the Shipman Inquiry.

To ensure the Health Board benefits from this enhanced scrutiny and to enable triangulation with other sources of information relating to patient deaths, a comprehensive **Learning from Deaths Framework** has been developed.

The framework supports the publication of a bi-annual report that captures learning from the deaths of patients under the Health Board's care. It establishes a robust ward-to-board process for reporting and monitoring mortality, using trend analysis and triangulation with multiple data sources—including internal mortality data, national clinical audits, Medical Examiner reviews, Mortality and Morbidity (M&M) reviews, and inquest outcomes.

The framework is structured around three tiers of mortality indicators:

- **Tier One – Health Board Level Indicators**
  These include system-wide measures such as the Risk Adjusted Mortality Index (RAMI), crude all-cause mortality, and inpatient mortality. These

indicators are benchmarked against peer organisations to provide assurance on quality and safety.

- **Tier Two – Divisional Mortality Indicators**
  These support divisional oversight and include:
  - Routine reporting of mortality data at Divisional Quality and Safety meetings.
  - Triangulation with Medical Examiner insights, particularly where mortality trends raise concern (e.g. increased stroke deaths).
  - Case note reviews triggered by anomalies in Tier One indicators.
  - Presentation of emerging themes and trends to the Health Board Mortality Review Group to support organisational learning.
- **Tier Three – Directorate-Level Indicators**
  These are tailored to each Directorate and informed by national audits or benchmarking. Where no existing indicators are available, bespoke measures will be developed in collaboration with the Quality and Patient Safety Team using CHKS data. National clinical audit data will also be reviewed to support benchmarking and assurance.

This framework enables the Health Board to ensure services are safe, effective, and subject to rigorous scrutiny, ultimately supporting continuous improvement in patient outcomes.

Cefndir / Background

Thanks to advances in medicine over the past century, people are living longer—and often healthier—lives. Around 1% of the UK population dies each year, with the majority of these deaths occurring in individuals aged 75 and over. Many of these deaths are predictable and occur following a period of care.

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

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

Medical Examiners are experienced doctors with specialist training in death certification and the review of the documented circumstances surrounding a death. Their role is to ensure that the cause of death is accurately recorded, to

identify any concerns that may warrant further investigation, and to consider the views of the bereaved.

Through this process, the ME Service offers external, independent scrutiny of the quality of care provided. Where concerns are identified, cases are referred back to the Health Board for further review and learning.

Asesiad / Assessment

A learning from death report has been produced for the period July 2024- March 2025.

Data collated for this report is attached and demonstrates that:

Tier One

- RAMI and crude mortality rates show positive trends.
- Coding completeness remains a challenge (13% uncoded episodes), impacting RAMI accuracy.
- Deaths per 1,000 bed days have decreased, with seasonal fluctuations observed.

Tier Two

- Reporting of stillbirth, neonatal and maternal deaths follows a robust internal process and is reported to Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE) and is case specific.
- The collation of data on unexpected deaths within MHLD has been updated as part of the report over the last 12 months. The database used for this report is continually being updated with new variables to help the Health Board better understand and learn from these tragic events. However, this process involves detailed analysis of patient records, which takes time.
- At present, suicide-related data is not yet available, but the team are actively working to prepare this for inclusion in the next report. The team are ensuring the data is accurate, respectful, and informative.
-

Tier Three

- Stroke and MI mortality rates remain below national averages.
- Elective surgery mortality is 0%; non-elective surgery mortality improved to 1.17%.
- Geriatric and Rehabilitation Medicine flagged for higher-than-peer mortality and RAMI.
- ED mortality remains below peer average; learning from M&M reviews is actively applied.

- Critical Care and General Surgery have implemented targeted improvements based on M&M findings.
- Engagement with Clinical Leads ensures an enhanced understanding of mortality themes and trends. For this report many of the Divisions have shared examples learning and improvement to support the report.

- **Cross-Cutting Themes:**
- Bereavement care, end-of-life planning, and communication require continued focus.
- ME referrals highlight delays, documentation issues, and communication gaps.
- Positive patient feedback reinforces areas of good practice.

Medical Examiner (ME)

- The ME Service provides independent scrutiny of all non-coroner-referred deaths, ensuring accurate cause of death documentation and identifying concerns for further investigation. It also incorporates the views of bereaved families.
- The ME Service has expanded to include community cases and continues to adapt to this broader remit.
- Delays were the most frequently cited concern, appearing in 19% of referrals. These included delays in treatment, investigations, ambulance off-loads, and those identified by MEs.
- DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) issues were noted in 14% of referrals, often due to forms not being co-signed by a senior clinician.
- Communication concerns accounted for 17% of referrals, involving interactions with families, clinicians, and the Care After Death Team. Family concerns were specifically noted in 11% of cases.
- Nosocomial (hospital-acquired) COVID-19 referrals decreased from 9% to 7%.
- Pressure damage referrals dropped from 5% to 3%, indicating improvement in prevention or reporting.
- No Further Action referrals have declined, likely due to improved referral quality and more local sharing by the ME Screening Panel.
- HMC (Health and Mortality Committee) referrals have increased, suggesting a shift in escalation and oversight patterns.
- Datix closures have improved, reflecting better follow-through and resolution.

The attached report provides details for areas for improvement and document learning from clinical areas. The report includes the reported mortality indicators as agreed un the Health Board’s mortality framework and is embedded with narrative provided by multiple clinical areas.

Next steps

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

The structured governance framework is being embedded across all levels of the Health Board. This includes ensuring that learning from Mortality and Morbidity (M&M) reviews is consistently escalated to divisional and board-level forums, enabling oversight and accountability.

Digital integration is a key enabler of timely and effective mortality review. The development of the Qlik dashboard should be accelerated to reduce reliance on manual processes. Alongside this, interoperability between CHKS, Medical Examiner reviews, and clinical systems must be improved to support seamless data triangulation and enhance analytical capability.

Clinical coding remains a critical factor in the accuracy of mortality data. The Health Board will continue its coding improvement programme, with a particular focus on addressing resource gaps and standardising the depth of coding. This will ensure that mortality indicators such as RAMI are reliable and reflective of actual patient risk.

Targeted reviews are essential for identifying and addressing areas of concern. Deep dives into Gastroenterology, Geriatric Medicine, and Rehabilitation Medicine are underway, with thematic findings incorporated into the next reporting cycle to inform learning and improvement.

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

Argymhelliad / Recommendation

The Committee is requested to note the development of a number of mortality indicators and the development of a Learning from Deaths framework. Comments are invited to support framework development.

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

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

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan

Aneurin Bevan University Health Board

Learning from Deaths Report

MORTALITY DATA AND NARRATIVE REPORT

JULY 2024 – MARCH 2025

Introduction

Learning from Deaths Report: July 2024 – March 2025
This report provides assurance that Aneurin Bevan University Health Board continues to strengthen its approach to learning from patient deaths, embedding a culture of continuous improvement, transparency, and accountability. The *Learning from Deaths Report* presents mortality data across three tiers: Health Board, Division, and Directorate.

Framework Implementation and Assurance
Since the previous report (October 2022 – December 2023), the Learning from Deaths Framework has been disseminated across all Divisions to ensure consistent engagement in reviewing and learning from patient deaths. The framework underpins a robust ward-to-board assurance process, enabling systematic reporting and oversight of mortality data. It supports the triangulation of condition-specific mortality trends with insights from the Medical Examiner, ensuring that learning is evidence-based and aligned with governance expectations.

Structured Mortality Reviews
The framework reinforces our commitment to conducting structured mortality reviews. These reviews are essential for identifying problems in care, drawing out learning, and implementing targeted improvements. This structured approach ensures that learning is not only captured but also translated into measurable actions that enhance patient safety and quality of care.
Whilst mortality reviews are being undertaken across the Health Board this is limited at present to the corporate team. The ability to identify mortality outliers is currently restricted by external software (CHKS). The Health Board is actively working in partnership to expedite improvements to this system, which will further strengthen the deep dive process and enhance assurance through more timely and targeted analysis.

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

Areas to highlight

Tier 1: Health Board-Level Mortality Data and Assurance

- The *Learning from Deaths Report* presents mortality data across three tiers: Health Board, Division, and Directorate.
- This section provides assurance at the Health Board level, highlighting performance, trends, and actions taken to strengthen mortality surveillance and learning.
- For the period July 2024 to March 2025, the Health Board's Risk Adjusted Mortality Index (RAMI) stands at 100.3, showing a positive improvement from 106.1 during the same period in 2023/2024. This positions the Health Board as the best-performing Health Board in Wales within its peer group, providing a strong indicator of quality and safety performance.
- While RAMI values fluctuate, crude mortality rates have remained stable, offering further assurance of consistent care delivery. To enhance understanding of areas with higher mortality, the Health Board is developing detailed individual mortality reports. These will support targeted reviews and learning.

RAMI is a key performance indicator that adjusts mortality rates based on patient risk factors. Its reliability is dependent on the quality of clinical coding. Between January and June 2024, 18.3% of consultant episodes remained uncoded, although 100% of deaths were coded. A targeted clinical coding improvement programme is underway to address this and enhance data accuracy.

Areas to highlight

Tier 2: **Divisional level data**:

- **Perinatal and Maternal Mortality Reporting and Assurance**

The reporting of stillbirths, neonatal, and maternal deaths follows a clearly defined internal governance process and is submitted to the national *Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries* (MBRRACE) audit. This ensures that each case is reviewed individually and contributes to national learning and benchmarking. For the current reporting period:

  - Neonatal deaths (deaths occurring in neonatal units) are under active review. A comprehensive paper is being prepared for submission to the Board in September 2025, providing assurance on findings and actions taken.
  - Stillbirth data has been included in this report to ensure transparency and completeness.
  - There were zero maternal deaths during this period, which provides positive assurance regarding maternal safety.

- **Mental Health and Learning Disabilities (MHLD)**

The collation of data on unexpected deaths within MHLD has been presented, including the causes and circumstances surrounding patients who were in contact with mental health services. At present, suicide-related data is not yet available, but the team are actively working to prepare this for inclusion in the next report. The team are ensuring the data is accurate, respectful, and informative.

- **Expansion of the Medical Examiner Service (MES)**

In September 2024, the Medical Examiner Service expanded its remit to include the scrutiny of all deaths across Paediatrics, Neonates, Maternity, Gynaecology, and Primary Care. This expansion strengthens the Board's assurance framework by ensuring independent, systematic review of all deaths.
To support this, the Medical Director's Quality and Patient Safety team has arranged meetings with MES and has worked collaboratively with Divisions to map out the end-to-end governance process for death reporting in line with national MES protocols. This includes processes for community-based child deaths, such as those reviewed under PRUDiC (Procedural Response to Unexpected Deaths in Childhood), ensuring that all deaths are appropriately scrutinised and reported.

Areas to highlight

Tier 3: **Directorate level Data**:

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

- **Emergency Department Admitted Mortality**: Performance remains better than peer comparators, providing assurance of effective acute care pathways.
- **30-Day Inpatient Mortality – Myocardial Infarction (MI)**: Reduced to 2.6%, down from 2.8% last year, indicating improved clinical outcomes and timely interventions.
- **30-Day Inpatient Mortality – Stroke**: Currently at 8.0%, a slight improvement from 8.1% last year. This remains lower than the All-Wales peer value of 13.6%, reaffirming the Health Board's position as the lowest in Wales for this indicator.
- **Elective Surgery Mortality (within 30 days)**: Maintains a rate of 0%, compared to 0.02% last year. From January 2024 to March 2025, there have been no recorded mortalities, providing strong assurance of surgical safety and pre-operative optimisation.
- **Non-Elective Surgery Mortality (within 30 days)**: Improved to 1.2%, down from 1.4% last year, and remains below the All-Wales peer value of 1.8%, reflecting robust perioperative care and risk management.
- **Clinical Engagement and Learning**: Ongoing collaboration with Clinical Leads continues to enhance understanding of mortality themes and trends. Divisions have contributed examples of learning and improvement, which are detailed in the appendices, supporting a culture of continuous improvement.
- **Forward Assurance Planning**: Work is underway with Divisions to establish meaningful metrics for regular review. This includes the implementation of standardised agendas featuring targeted mortality indicators at Directorate level, strengthening governance and assurance mechanisms.

Areas to highlight

Key Themes from Medical Examiner (ME) Referrals

- **DNACPR**: Featured in 14% of recent referrals, down slightly from 15%. Common issues include forms not being co-signed in Part 6 by a senior clinician or consultant.
- **Communication**: Now accounts for 17% of referrals, a decrease from 19%. Issues span interactions with families, clinicians, and the Care After Death Team. The volume reflects increased referrals as ME service coverage expands. *Family concerns* were noted in 11% of cases.
- **Nosocomial (Hospital-Acquired) COVID-19**: Referrals related to hospital-acquired COVID-19 have decreased from 9% to 7%.
- **Pressure Damage**: Down from 5% to 3%, indicating a positive trend in prevention or reporting.
- **Delays**: Now the most frequently cited concern (19%), encompassing delays in treatment, investigations, ambulance off-loads, and those identified by MEs.

Referral Outcomes and Service Development

- **No Further Action**: These referrals have steadily declined, likely due to improved referral quality and increased local sharing by the ME Screening Panel.
- **HMC Referrals**: Cases referred to the Health and Mortality Committee have increased, suggesting a shift in escalation and oversight patterns.
- **Datix Closures**: Closure rates have improved significantly, reflecting better follow-through and case resolution.
- **Service Expansion**: Throughout 2024, the ME Service has evolved to include community cases and continues to adapt to this broader remit.

Areas of development

Governance Framework and Mortality Assurance

The structured governance framework continues to be developed to strengthen assurance around mortality outcomes. This includes:

- **Divisional-Level Reporting**: Mortality data is being tailored for routine reported through Divisional Quality and Patient Safety meetings, ensuring local ownership and visibility of trends and learning.

- **Condition/Procedure-Specific Mortality Reviews**: A formal process is in development to trigger reviews where mortality indicators fall outside expected parameters. This will support targeted learning and assurance at both Directorate and Health Board levels.

- **Escalation and Assurance from M&M Reviews**: Work is underway to define how formal assurance and escalation from Mortality and Morbidity (M&M) reviews will be captured and reported through governance structures. This will ensure that learning is not only identified but acted upon and monitored.

- **System Challenges**: Progress is constrained by delays in CHKS software development. The lack of interoperability between systems currently limits the triangulation of mortality data with Medical Examiner (ME) reviews, M&M reviews, and inquest outcomes. Currently, data capture and thematic analysis rely heavily on manual processes—requiring staff to trawl through records to identify trends and triangulate learning across sources. This limits the ability to generate timely, system-driven insights and undermines the consistency and reliability of assurance reporting

Progress update

Action from previous report	Progress
Work with Directorates to establish mortality indicators Increase engagement with clinicians regarding mortality processes	Directorate-level mortality indicators have been defined in line with the Mortality Framework and are being shared with Clinical Directors. Additional indicators are being identified, with feasibility assessments underway to ensure reliable reporting.
Increase engagement with clinicians regarding mortality processes	Engagement with clinicians is ongoing to embed mortality processes into routine practice, ensuring consistent understanding and ownership across clinical teams.
Develop a Mortality Review Committee	The newly established Quality Management Group will provide oversight and scrutiny of mortality data, fulfilling the assurance function originally intended for the Mortality Review Committee.
Ensure robust and timely governance processes regarding mortality outcomes within the Health Board Establish Mortality and Morbidity (M&M) meetings throughout all Directorates	The expansion of the Medical Examiner (ME) Service has enabled divisional engagement to review processes for unexpected deaths. Assurance is being strengthened through mapping and validation of M&M meeting coverage across clinical areas.
Improve identification of learning from mortality reviews Develop and implement the mortality review process for deep dives into directorates with condition-specific mortality outside control limits	Improve identification of learning from mortality reviews Develop and implement the mortality review process for deep dives into directorates with condition-specific mortality outside control limits
Establish the mortality outlier model in CHKS to create alerts	The CHKS mortality module is now active. While currently reliant on manual data extraction, collaboration with CHKS and the Digital, Data & Technology Division is exploring automation via a Qlik app to enhance real-time assurance.

Learning and Improvement

- Divisions have actively contributed to this report by sharing examples of learning and improvement identified through Mortality and Morbidity (M&M) reviews, reinforcing a culture of reflection and continuous improvement.
- To strengthen analytical capability and assurance:
  - The Health Board now has access to the CHKS Mortality Alerts Module, enabling the development of tailored graphs and charts to meet local needs. This will directly support the creation of a Standard Operating Procedure (SOP) to guide all staff involved in mortality peer reviews. The case note review is being piloted by the cooperate team before engaging with clinicians and looking at implementation.
  - Initial development has begun on an internal QLIK App, designed to replicate and enhance the mortality measures currently provided externally via CHKS. This will allow directorates to access custom dashboards, ensuring that key metrics are monitored efficiently and remain relevant to their specific services.
  - The Mental Health and Learning Disabilities (MHLD) team is reviewing national reports on themes and trends in the deaths of people with learning disabilities, ensuring local learning is aligned with national insights.
  - Perinatal and maternal deaths are also reviewed in line with national systems. Local learning is captured and translated into specific action plans, which are reported to Mat Neo Board and then to the Patient Quality, Safety and Outcomes Committee (PQSOC)—demonstrating a clear line of assurance and accountability.

Conclusion

- The Health Board has demonstrated measurable improvements in mortality outcomes across multiple tiers, with RAMI, crude mortality, and deaths per 1,000 bed days all showing positive trends.
- Structured mortality reviews, enhanced Medical Examiner Service coverage, and divisional engagement continues to strengthen governance and assurance.
- Targeted learning from neonatal, mental health, stroke, and surgical mortality has informed local action plans and national benchmarking.
- The integration of CHKS and Qlik tools is beginning to support more timely, data-driven insights, although system limitations persist.
- Learning from inquests, complaints, and bereavement reviews has reinforced the importance of communication, documentation, and early recognition of deterioration and end-of-life needs.

Next Steps

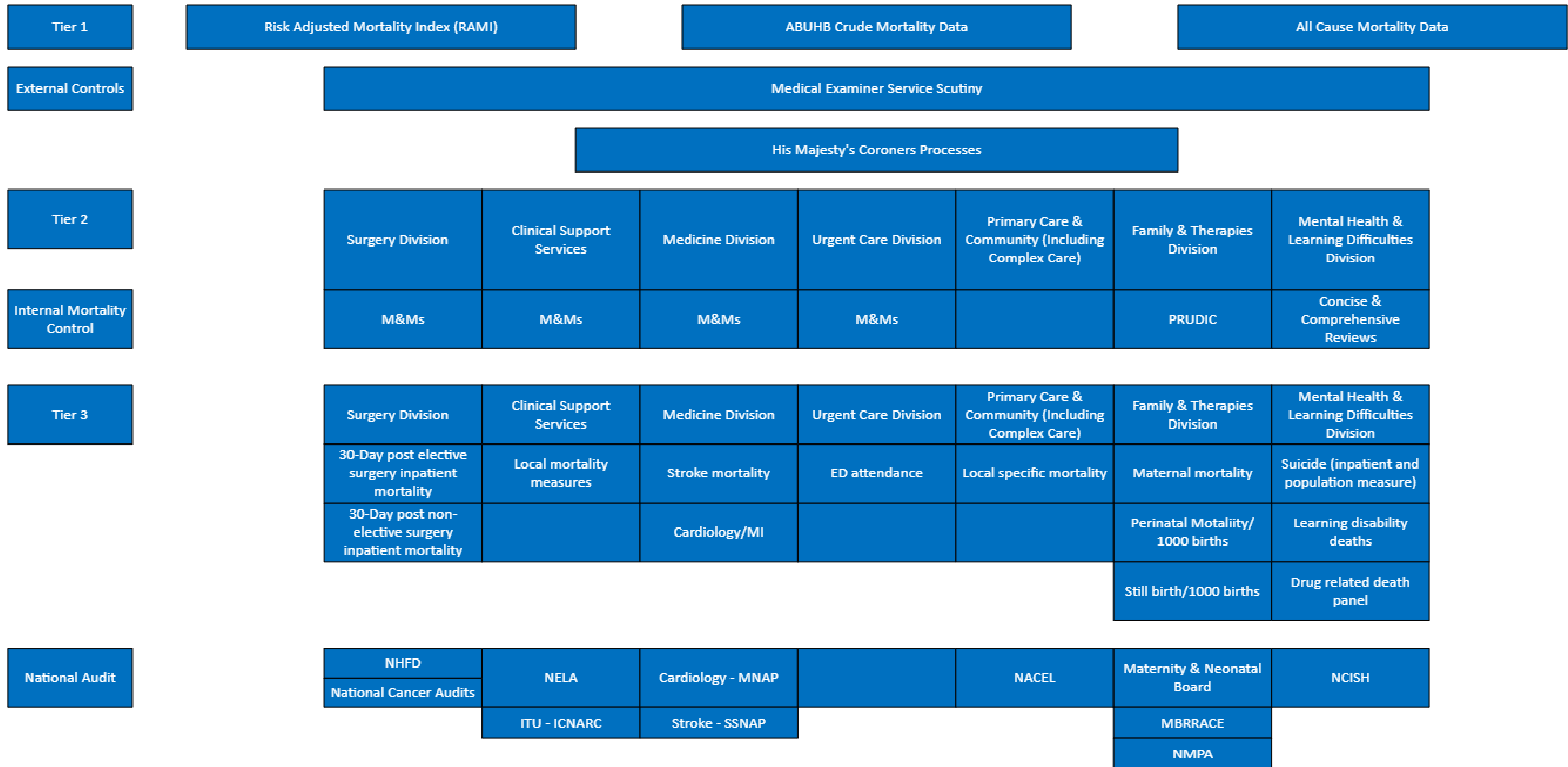
1. **Strengthen Governance and Reporting**
    - Finalise and embed the structured governance framework for mortality assurance.
    - Ensure consistent escalation and feedback loops from M&M reviews to divisional and board-level forums.
2. **Advance Digital Integration**
    - Accelerate development of the Qlik mortality dashboard to reduce reliance on manual processes.
    - Improve interoperability between CHKS, ME reviews, and clinical systems.
3. **Enhance Clinical Coding**
    - Continue the clinical coding improvement programme, focusing on depth and accuracy to support RAMI reliability.
    - Address resource gaps in coding review for flagged specialties (e.g. Respiratory, Geriatrics).
4. **Deep Dives and Thematic Reviews**
    - Complete and report on deep dives into Gastroenterology, Geriatric Medicine, and Rehabilitation Medicine.
    - Include thematic findings in the next report cycle.
5. **Embed Learning and Culture Change**
    - Promote learning dissemination through Mortality newsletters, audit cycles, and divisional QPS meetings.
6. **Equity and Inclusion**
    - Link with bereavement work to ensure access to end-of-life care for underrepresented groups.
    - Continue engagement with community stakeholders (e.g. Imams) to address cultural needs in bereavement care.

For Information

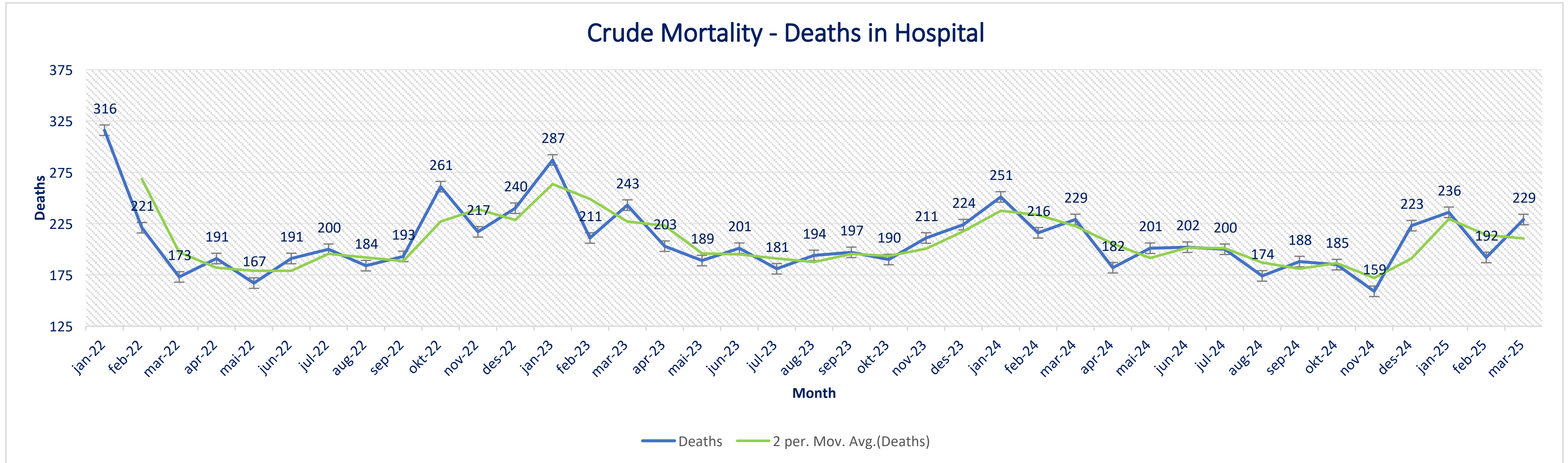
Mortality Indicators

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

Aneurin Bevan University Health Board Mortality Framework

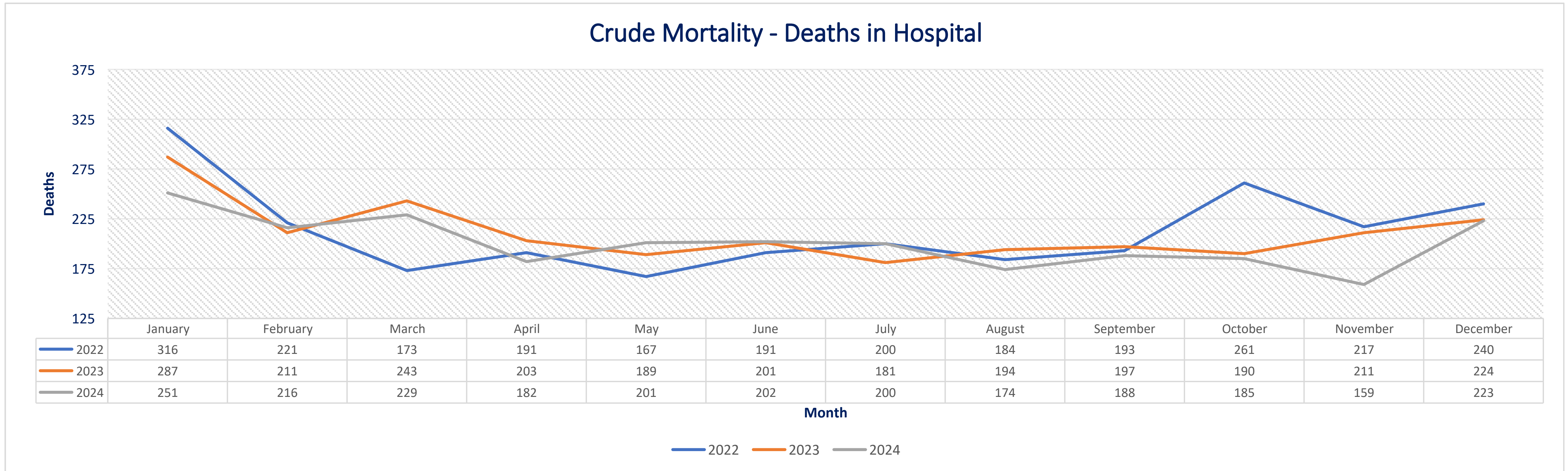


Tier One Mortality Indicators – Crude Mortality



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

Tier One Mortality Indicators – Crude Mortality (cont.)

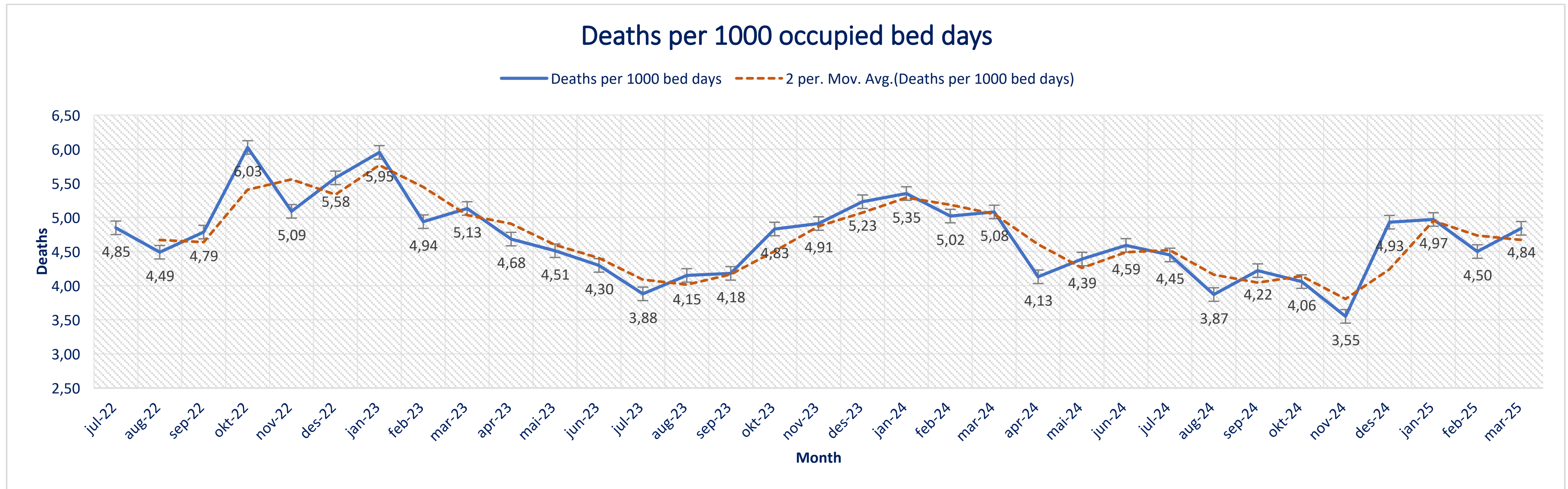


	January	February	March	April	May	June	July	August	September	October	November	December
2022	316	221	173	191	167	191	200	184	193	261	217	240
2023	287	211	243	203	189	201	181	194	197	190	211	224
2024	251	216	229	182	201	202	200	174	188	185	159	223

- In 2024 there was a notable reduction in hospital deaths compared to both 2022 and 2023, particularly in the early months (January–March). January deaths dropped from 316 (2022) and 287 (2023) to 251 (2024). This downward trend continues through March, suggesting a sustained improvement in early-year outcomes.
- Monthly Patterns (All Years) There is a recurring seasonal pattern across all three years: Decreases in March, May, July, September, and November. Increases in April, June, August, and October.
- This cyclical pattern may reflect seasonal pressures, such as winter surges or summer lulls, and possibly operational or public health interventions.
- The overall downward trend in 2024 suggests improvements in patient safety, care quality, or broader system-level changes. The seasonal fluctuations remain consistent year-on-year, but 2024 shows less volatility, which may indicate better resilience or planning. Anomalies in May and November 2024 warrant further review to understand contributing factors.

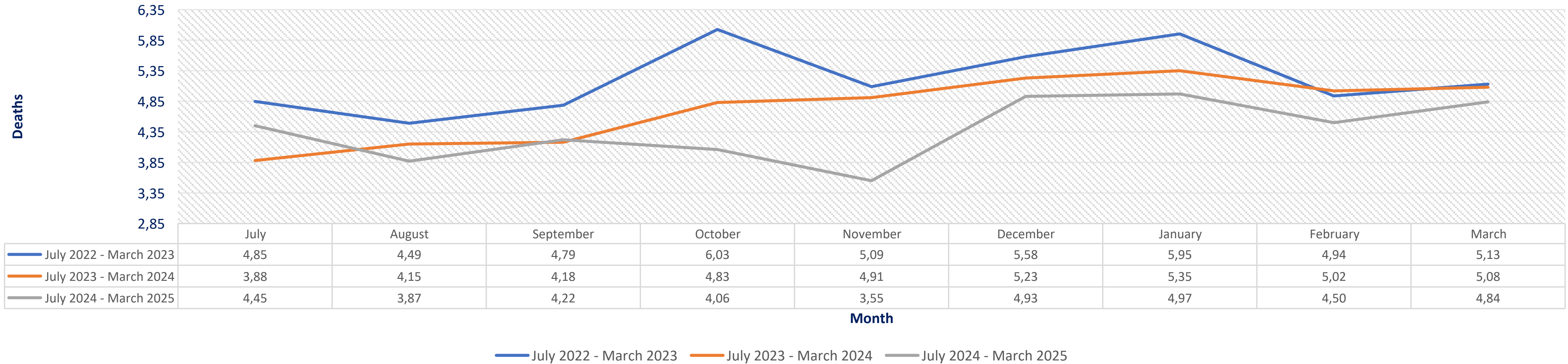
Tier One Mortality Indicators – All-cause Mortality

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



- Deaths per 1000 occupied bed days – a steady decline is observed from January 23 to July 23 before a noticeable and trending increase until April 24. Since then, there has been a prolonged period of fluctuation. However this does include a low point of 3.55 observed in November 24, the lowest since data recording commenced. Year on year November to December increase is consistent with RAMI increases for the same time period.

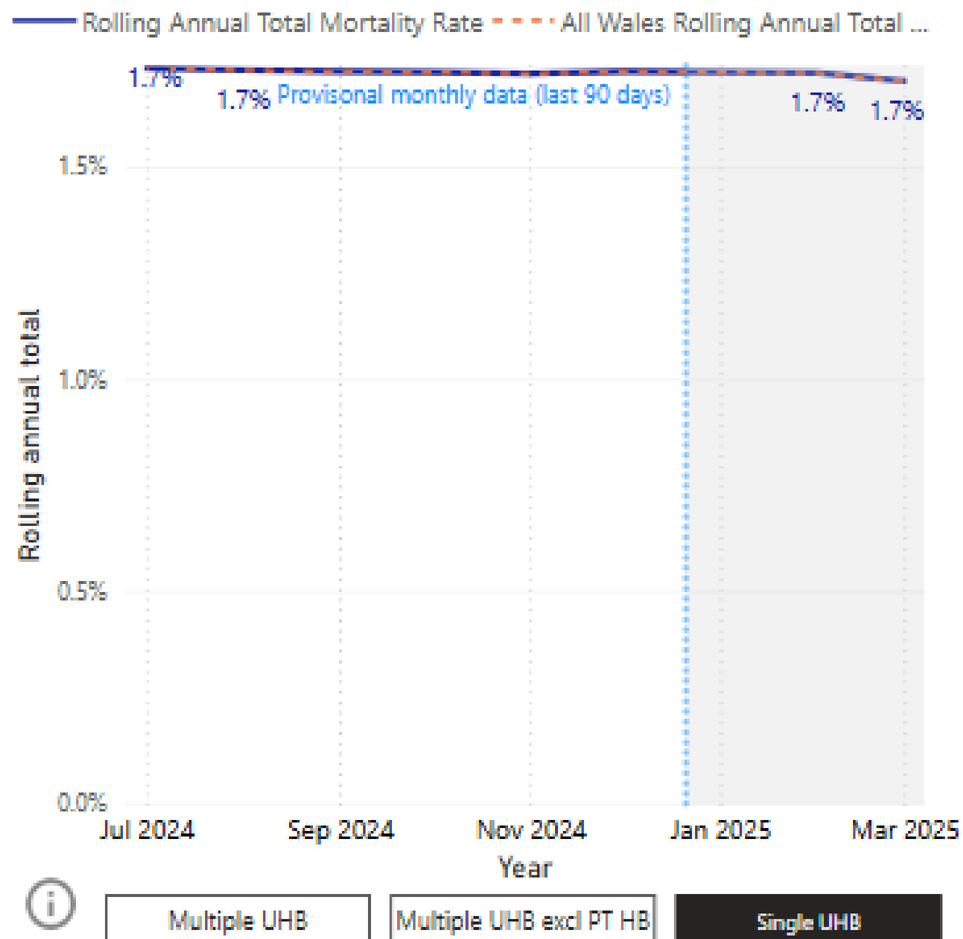
Tier One Mortality Indicators – All-cause Mortality



	July	August	September	October	November	December	January	February	March
July 2022 - March 2023	4,85	4,49	4,79	6,03	5,09	5,58	5,95	4,94	5,13
July 2023 - March 2024	3,88	4,15	4,18	4,83	4,91	5,23	5,35	5,02	5,08
July 2024 - March 2025	4,45	3,87	4,22	4,06	3,55	4,93	4,97	4,50	4,84

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

Tier One Mortality Indicators – Rolling Mortality Rate



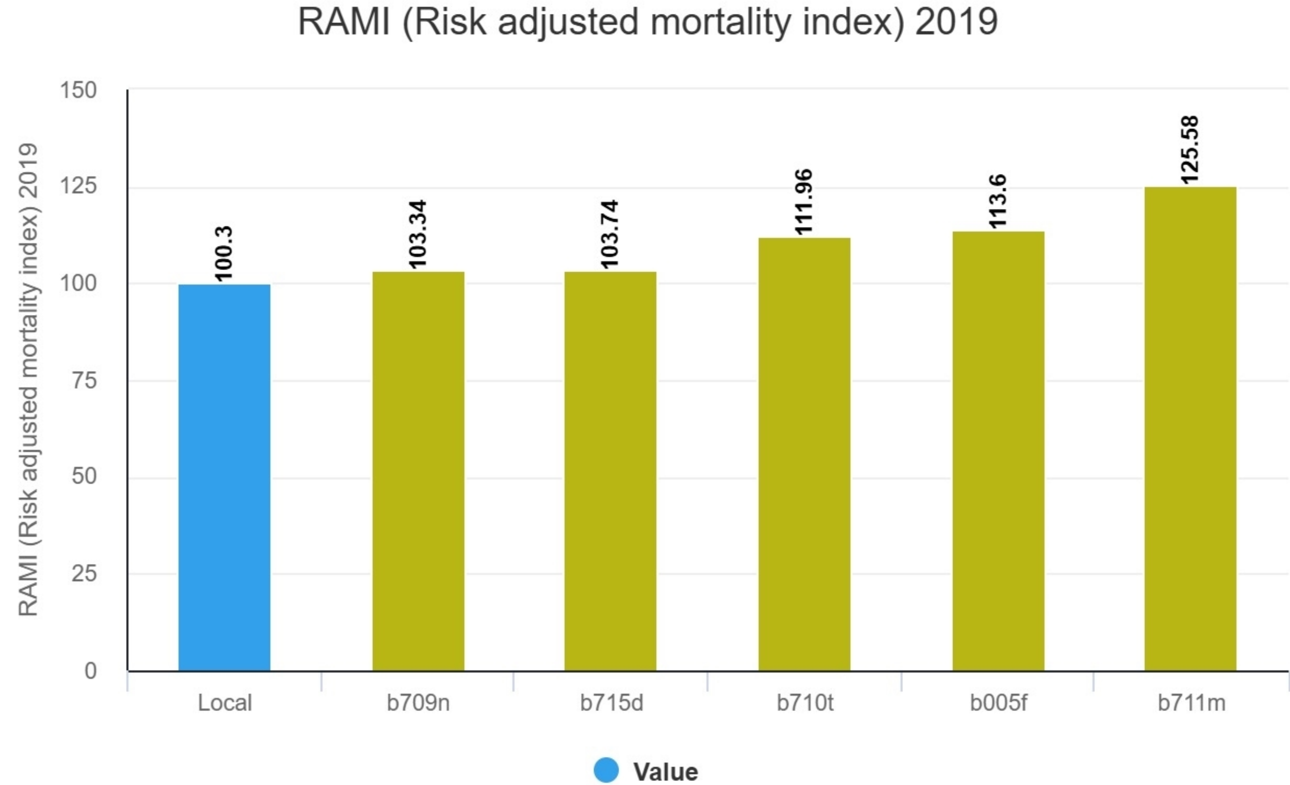
ABUHB	Mortality Rate
Jul-24	1.54%
Aug-24	1.53%
Sep-24	1.63%
Oct-24	1.57%
Nov-24	1.62%
Dec-24	2.11%
Jan-25	2.04%
Feb-25	1.77%
Mar-25	1.67%

The Health Board's mortality rate has remained stable, showing a flat trend. Actual in-hospital deaths decreased during Q3 2024/25 before an increase in Q4.

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

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

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



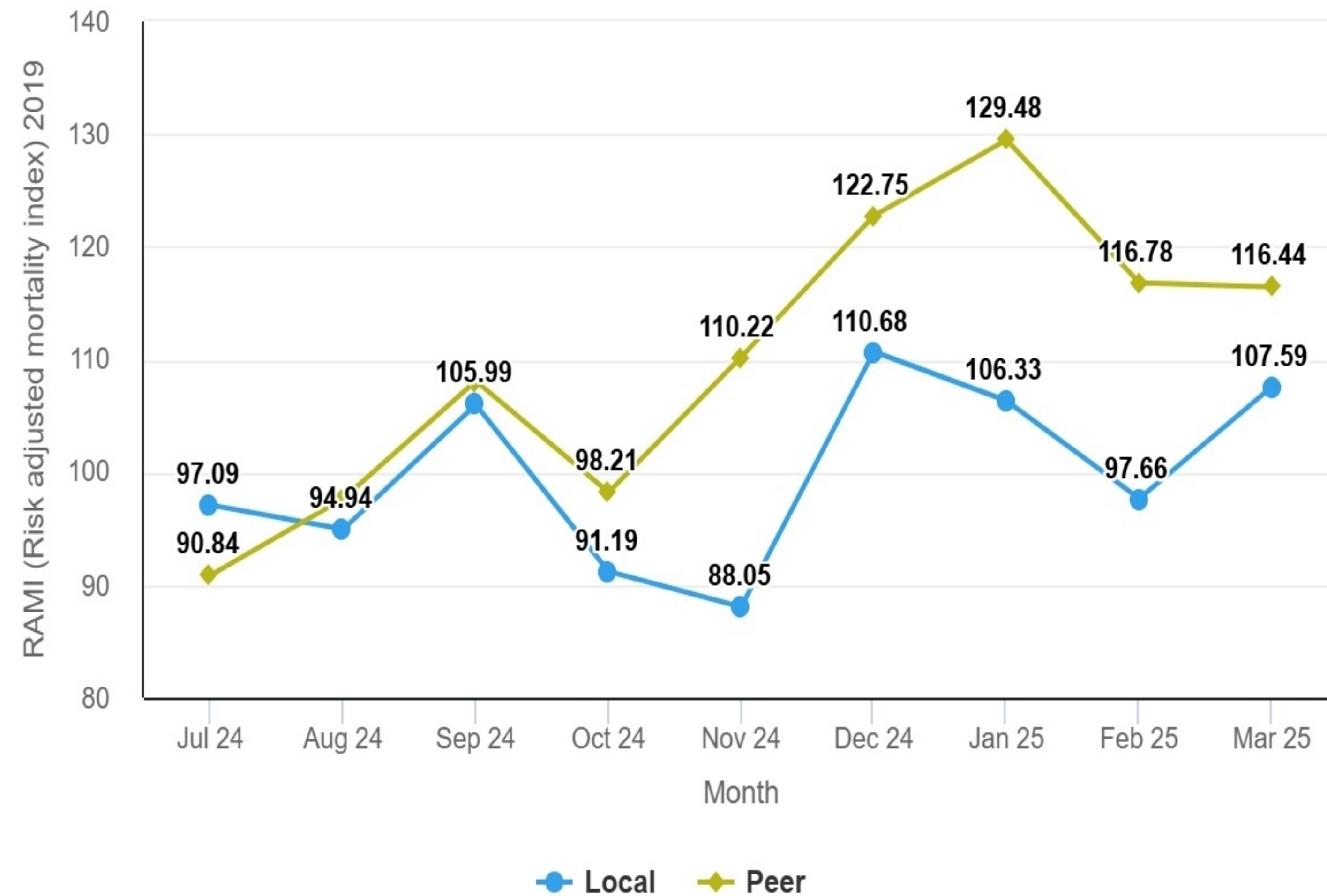
July 2024 – March 2025

Blue – ABUHB Yellow – Peers (All Wales)

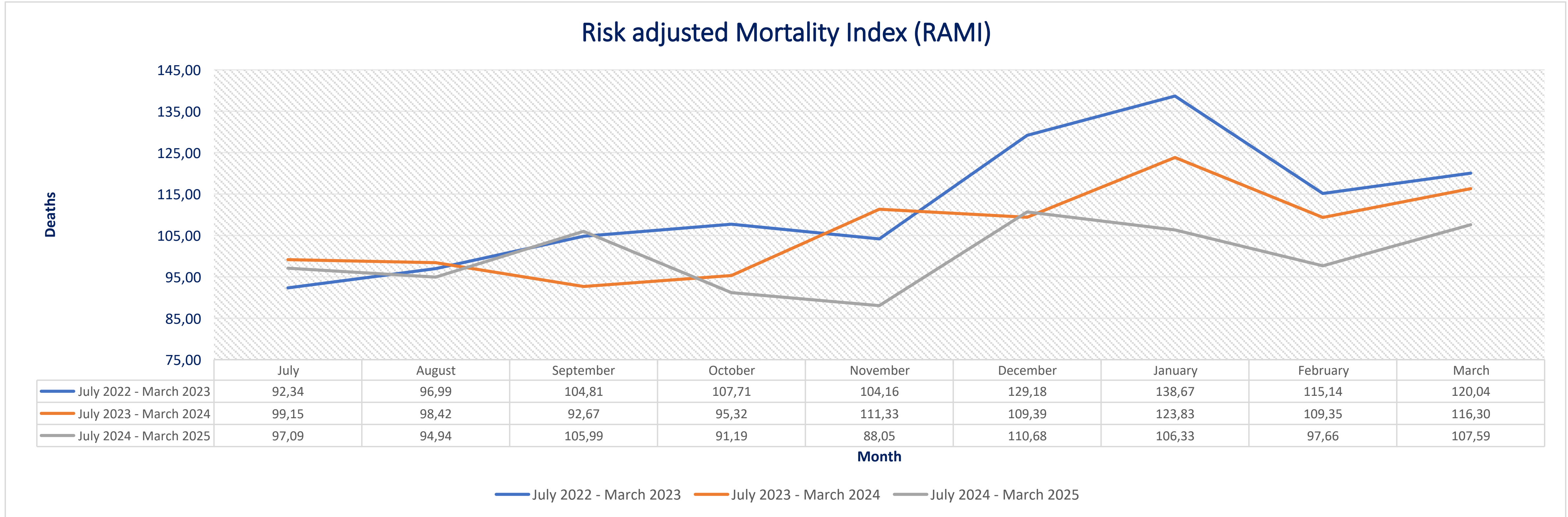
The Health Board is the best performing Health Board within the All Wales Peer Group.

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

- The accuracy of RAMI (Risk-Adjusted Mortality Index) relies on the completeness and accuracy of clinical coding. Currently coding is on a lag of 12 weeks. This means our RAMI will improve when the coding is updated.
- Between July 2024 and March 2025, 13% finished consultant episodes at ABUHB were uncoded.
- In 2014, Professor Palmer reviewed RAMI and questioned its validity as a sole measure. He recommended a blended approach using multiple data sources, including mortality reviews, national benchmarking, and national audits, to ensure quality improvement and assurance around mortality.
- The Health Board is currently performing better than the Welsh Peer Value average as an overall value of RAMI.
- Consistent and linear performance against Welsh Peers from August 2024.



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

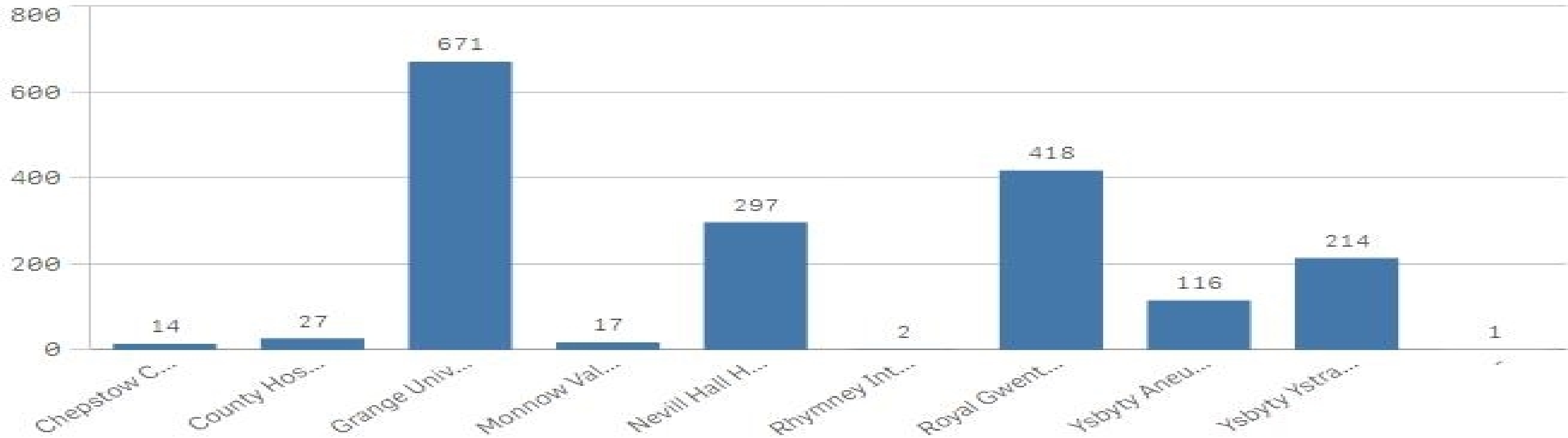


	July	August	September	October	November	December	January	February	March
July 2022 - March 2023	92,34	96,99	104,81	107,71	104,16	129,18	138,67	115,14	120,04
July 2023 - March 2024	99,15	98,42	92,67	95,32	111,33	109,39	123,83	109,35	116,30
July 2024 - March 2025	97,09	94,94	105,99	91,19	88,05	110,68	106,33	97,66	107,59

- The 2024–25 RAMI values are consistently lower than in previous years, indicating a positive trend in mortality outcomes after adjusting for case mix.
- The lowest RAMI values appear in October (91.19) and November (88.05) 2024, suggesting particularly strong performance during those months.
- The 2024–25 period shows a marked improvement, especially in the winter months (October–February), where RAMI values are lower than in previous years. This suggests: Better clinical outcomes despite seasonal pressures. Effective risk mitigation strategies. Potential impact of service improvements or targeted interventions.

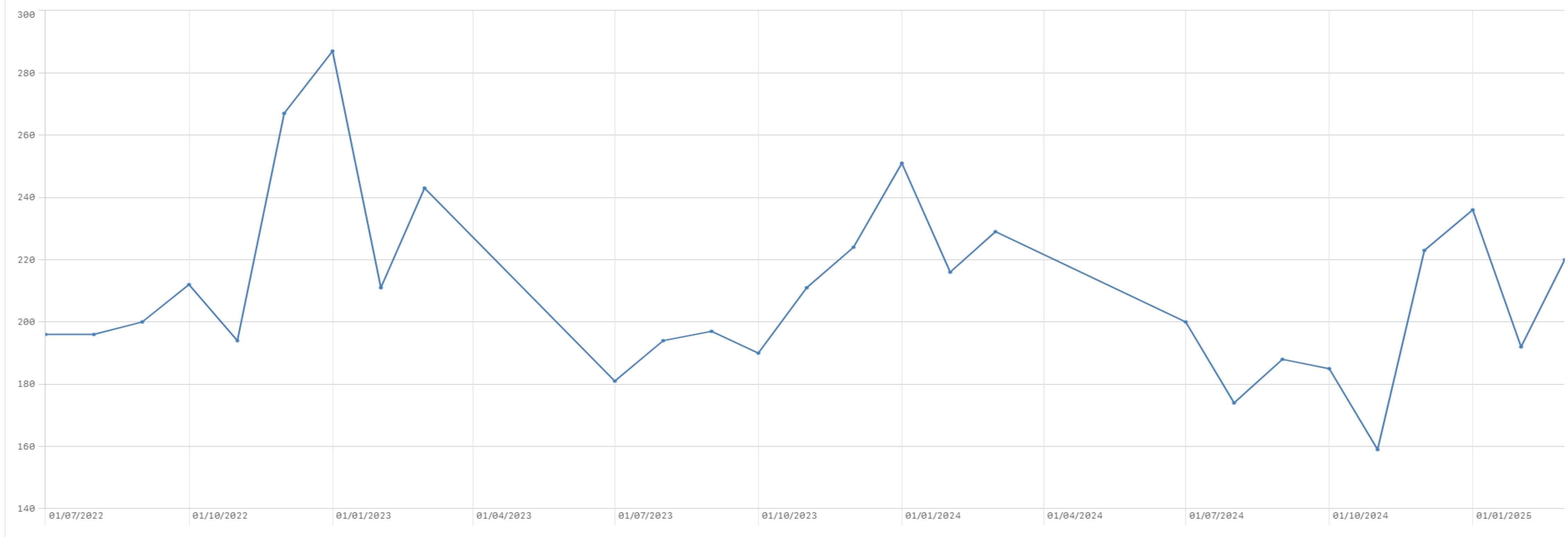
Tier One Mortality Indicators – All-cause Mortality per site

July 2024 – March 2025



- The Grange University Hospital has the highest number of recorded deaths, followed by the ELGH sites
- Outlier of 1 death with no site attached – Coding issue identified and reported

Tier One Mortality Indicators – All-cause Mortality in Hospital



- The line fluctuates month to month, reflecting seasonal or episodic variations (e.g. winter peaks).
- Despite these fluctuations, the general direction is downward, indicating a positive long-term trend.

Clinical Coding Performance and Improvement Plan

- **Welsh Government Targets:** 95% coding completeness by the end of the following month (e.g. March discharges coded by end of April). 90% of clinical coding errors corrected within 35 days of identification.
- **Current Position:** The Health Board's coding completeness currently stands at 87%, impacted by increased activity and the onboarding of multiple Trainee Coders.
- **Actions Taken**: A Clinical Coding restructure has been implemented to support national targets and create development opportunities. Ongoing initiatives include:
  - Raising awareness of clinical coding through activities such as *Lunch & Learn* sessions.
  - Developing automation tools to allow coders to focus on more complex cases.

Challenges Identified:

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

Performance Against Accuracy Targets:

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

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

Depth of Coding and RAMI Accuracy:

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

Next Steps:

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

Tier Two Mortality Indicators

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

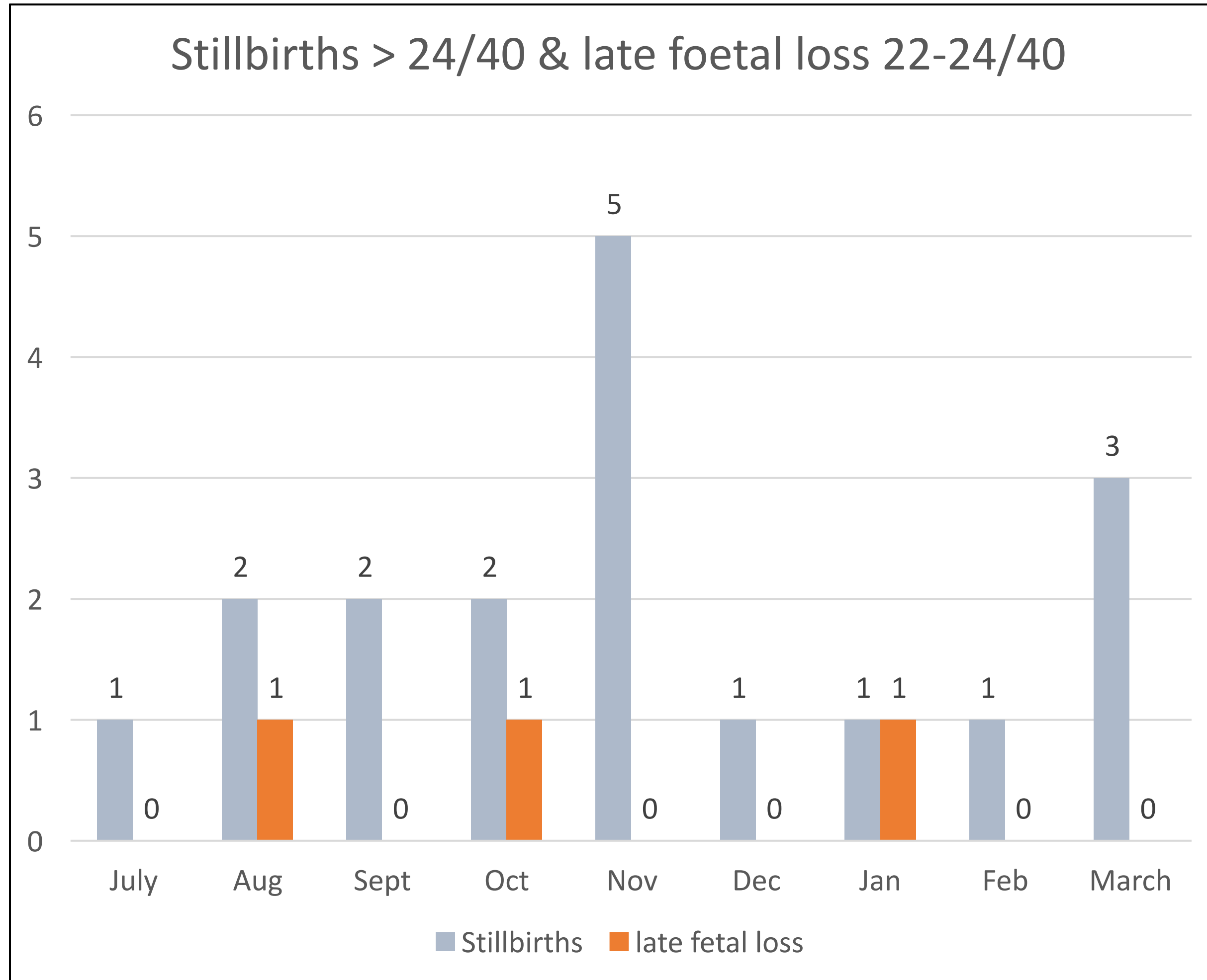
- **Enable systematic reporting** of mortality data at Divisional Quality and Safety meetings, ensuring consistent visibility and accountability.
- **Support triangulation** with Medical Examiner insights, particularly when mortality rates rise—e.g. through thematic reviews of specific patient groups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

Strengthening Mortality Oversight Through Divisional Indicators

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

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

Tier Two Mortality Indicators – Stillbirths (Neonatal Mortality)



Outcomes: July 2024 – March 2025

- Zero maternal deaths reported during this period.
- 18 stillbirths at gestation >24 weeks.
- 3 late foetal losses between 22–24 weeks.
- 2 neonatal deaths: babies born at 20 weeks showing signs of life but died on the maternity unit.
- 15 of the babies were born at less than 37 weeks' gestation (preterm).

Clinical Insights

- Placental changes were observed in the majority of cases, suggesting a recurring pathological feature.
- Hydrops fetalis was identified in 1 case.
- Infection was a contributing factor in 2 cases.

Tier Two Mortality Indicators – Neonatal Mortality Learning and actions

Governance and Oversight - A national and local review has been completed, with a full report—incorporating mortality indicators—scheduled for submission to the Board in September.

Neonatal Mortality- All neonatal deaths are now subject to a 72-hour review, ensuring timely scrutiny and learning.

Early Access to Care - The service has introduced a Single Point of Access (SPA) referral system to support early booking, enabling earlier intervention and optimisation of pregnancy outcomes.

Guideline Development A new Antenatal Foetal Surveillance Guideline has been introduced. The Intrapartum Fetal Surveillance Guideline has been updated to reflect current best practice.

Foetal Surveillance Education - A dedicated Foetal Surveillance Midwife is now in post.

Faculty capacity has been increased to support enhanced training delivery.

Monitoring and Equipment - CTG monitors have been installed in every antenatal room to ensure consistent fetal monitoring.

The **Induction of Labour (IOL) guideline** has been updated to support increased monitoring.

Additional trolley space has been created in maternity triage to improve care delivery during high activity.

Sonography Capacity Two midwives successfully completed sonography training in 2025, expanding in-house scanning capability.

Prematurity Care The service has adopted the PERIPrem optimisation tool to improve outcomes for premature babies. Ongoing audits show improved compliance with optimisation measures.

Bereavement Care - The bereavement pathway has been updated to enhance support for families. Additional training sessions have been delivered by the Bereavement Lead Midwife to improve post-mortem (PM) consent uptake.

Provided by Jayne Beasley - Head of Midwifery & Gynaecology

Tier Two Mortality Indicators – MHLD sudden and unexpected deaths (SUDS)

Summary of Sudden and Unexpected Deaths – Mental Health and Learning Disabilities(MHLD) Division
Reporting Period: 1 July 2024 – 30 June 2025

- This report is based on information held by the Mental Health and Learning Disabilities (MH and LD) Division. It includes deaths that were brought to our attention through direct reports (such as from families or carers), emergency services, and the Coroner.

- The database used for this report is continually being updated with new variables to help us better understand and learn from these tragic events. However, this process involves detailed analysis of patient records, which takes time.

- Although the requested reporting period ended on 31 March 2025, this report includes data up to 30 June 2025 to ensure completeness. Of the 92 deaths recorded between 1 July 2024 and 30 June 2025, five occurred between 1 April and 30 June 2025. The remaining 87 deaths happened within the originally requested timeframe.

- All deaths included in this report involve individuals who had any level of contact with MH and LD services within 12 months of their death. This approach ensures we capture learning opportunities and provide appropriate support to families, carers, other patients, and staff.

Tier Two Mortality Indicators – MHLD sudden and unexpected deaths (SUDS)

Figure one – All deaths over time

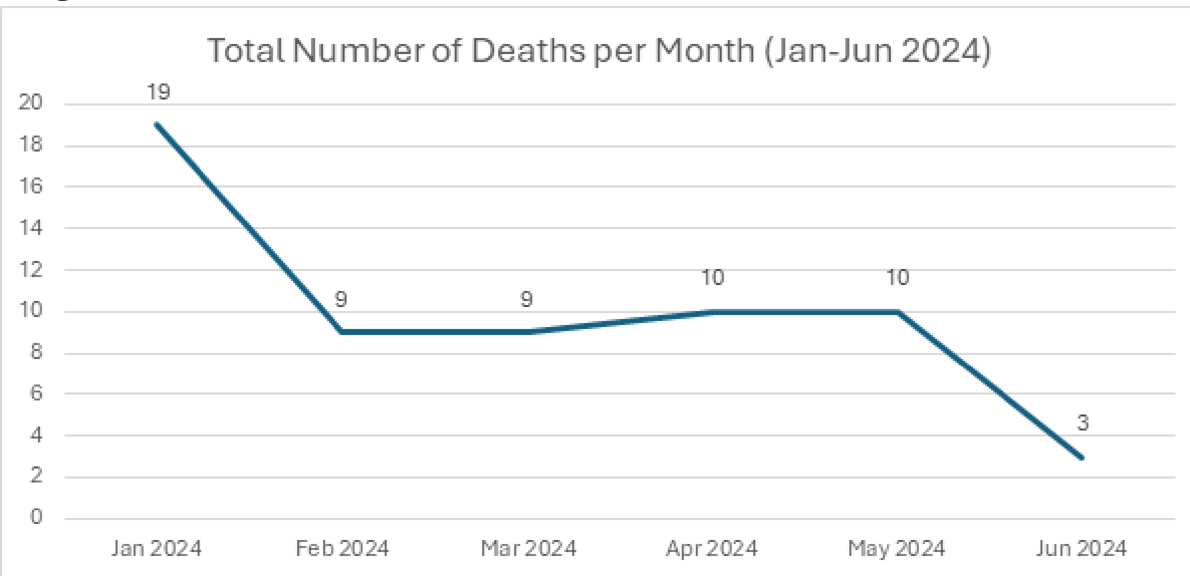


Figure one displays the frequency of deaths by month in the previous study period. The two previous reports (capturing 2021 – 2023 and latterly the first half of 2024) have not revealed any clearly identifiable or reliable trends. Sadly, the incidence of SUDS remains relatively stable albeit on average there is a lower rate of deaths in the current study period (with 92 deaths in a 12-month period ie 7.6 deaths per month compared to 10 per month in Jan – Jun 2024).

Figure two – Sudden unexpected deaths over time

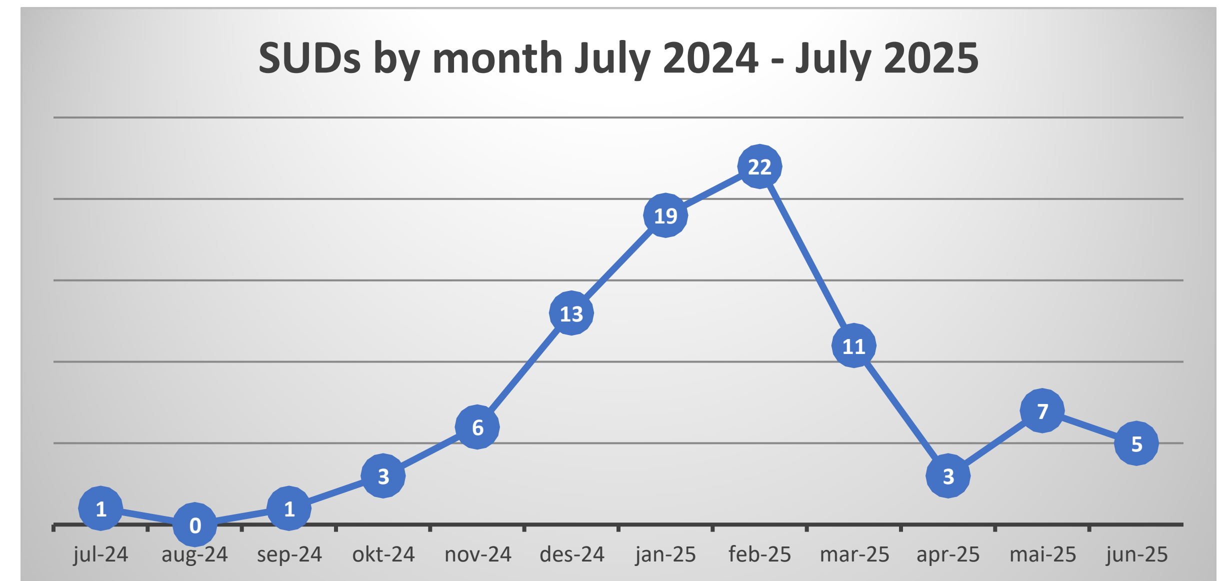


Figure two shows the rate of death per month in the current study period. There does appear to be a seasonal increase in the winter months and given that these deaths have not yet been categorised, it could be that this is a high rate of deaths from physical health causes.

It is recommended that once deaths are categorised, benchmarking is undertaken with national data to consider possibility of outlier status.

Tier Two Mortality Indicators – MHLD sudden and unexpected deaths (SUDS)

Figure three – All deaths over time by Directorate

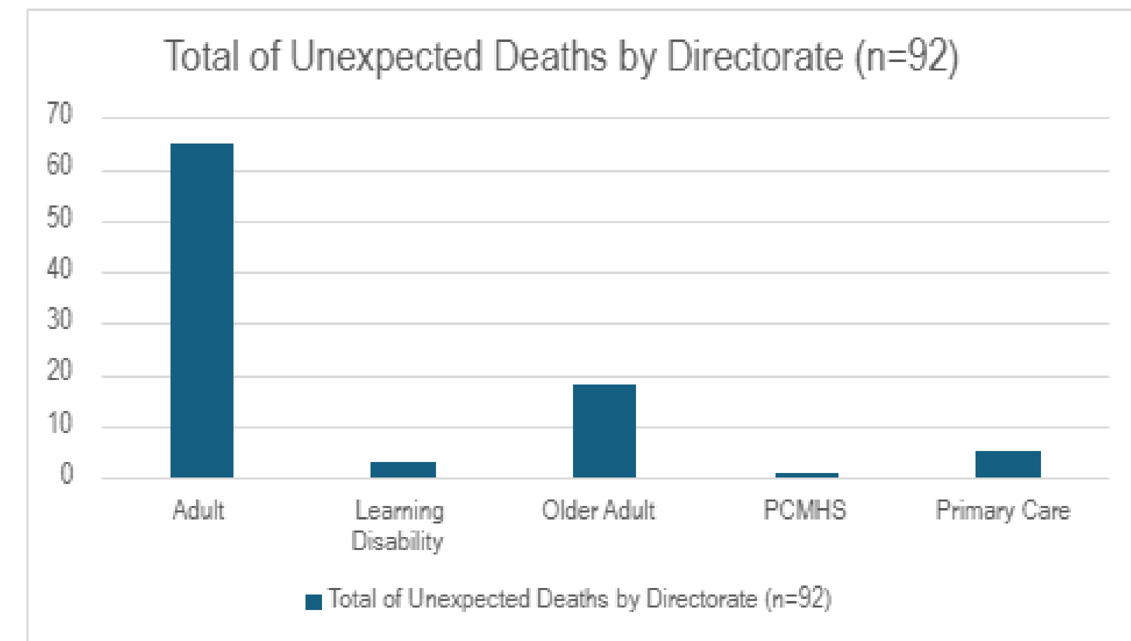
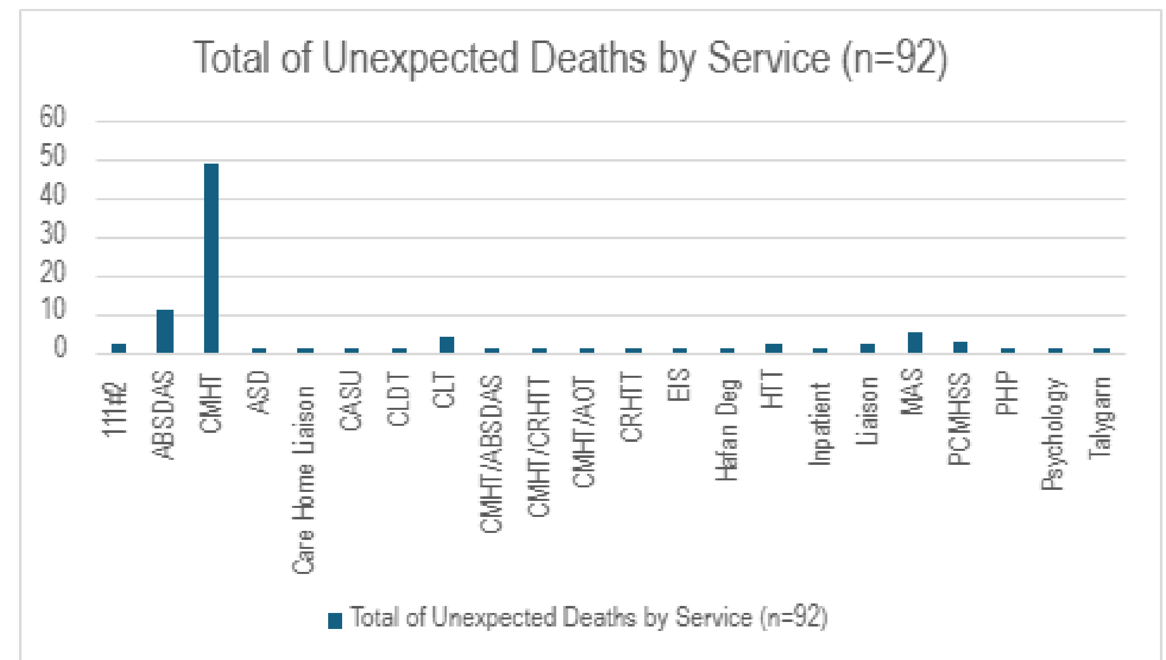


Figure four – Unexpected deaths by service



Service considerations

Figure three indicates the incidence of death by Directorate and figure four by service area. As previously and unsurprisingly, the highest frequency of deaths occur in the adult directorate (the busiest service serving the highest number of people) and in Community Mental Health Teams

It would appear that, as previously, there are unexpected deaths amongst those in the care of drug and alcohol services.

Tier Two Mortality Indicators – MHLD sudden and unexpected deaths (SUDS)

Figure five – Unexpected deaths by Locality

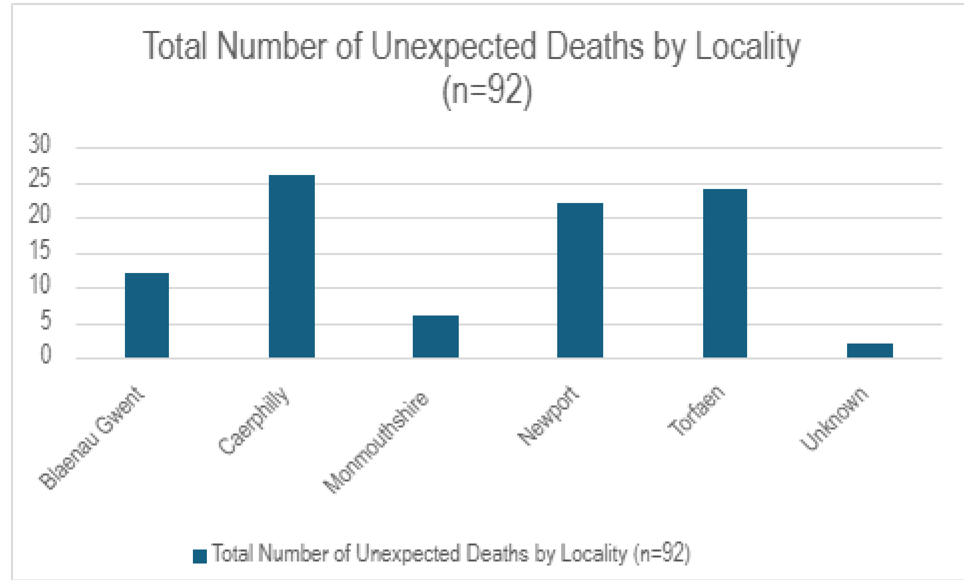
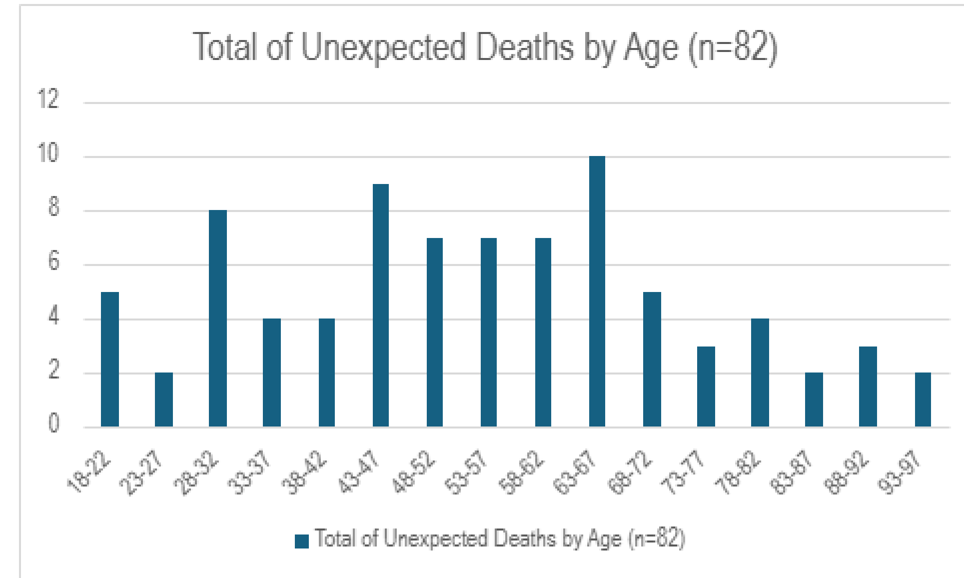


Figure six – Unexpected deaths by age

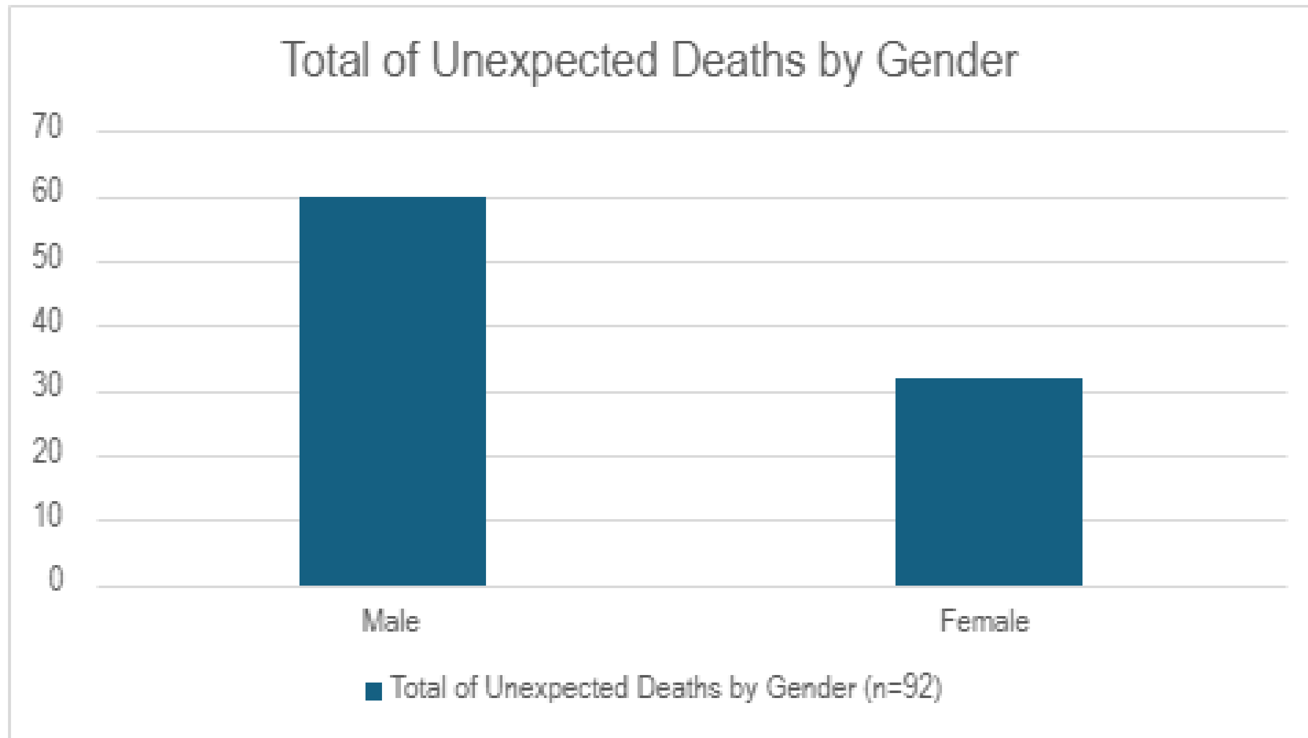


In terms of geographical area, figure five presents the data by local authority area (not currently corrected by population size). When corrected for population served, Torfaen appear to have had a disproportionately high number of deaths. The pastoral needs of the teams serving this area should be considered.

In terms of demographic features, the preliminary analysis has only been conducted on all deaths considering variables of age and gender and is therefore not especially enlightening. Taken together, this data mirrors findings in two earlier reports in relation to more males dying than females and unexpected deaths occurring in the younger age groups of 28-32 and 43-47. There is some missing data that we need to harvest from patient records.

Tier Two Mortality Indicators – MHLD sudden and unexpected deaths (SUDS)

Figure seven – Unexpected deaths by gender



Tier Three Mortality Indicators

- Once Tier 2 indicators are established, the focus will shift to identifying appropriate, condition-specific indicators within each Directorate. A range of clinical databases—including mortality data—are currently utilised across the organisation to support this work.
- Directorates likely to benefit from this enhanced approach include Emergency Laparotomy Surgery, Cardiology, Neonatal Unit, Intensive Care, Surgery, and Stroke.
- To strengthen assurance, national clinical audit data will be used to triangulate and benchmark mortality outcomes across Directorates. Where no existing mortality indicators are in place, bespoke measures will be co-developed by the Directorate and the Quality and Patient Safety Team, with analytical support from CHKS.
- A robust governance framework will be developed as part of the Learning from Death Framework to ensure a systematic and transparent approach to condition- and procedure-specific mortality. This will include:
    - **Structured reporting** of mortality data through Directorate Quality and Patient Safety meetings.
    - **Triangulation** of mortality data with Medical Examiner reviews, Mortality and Morbidity (M&M) reviews, and Coroner’s Inquests.
    - **Formal assurance and escalation** processes arising from M&M reviews.
    - **Exception reporting** and assurance updates to the Quality and Patient Safety meetings.

Tier Three Mortality Indicators – Crude Mortality - Specialty

- **Summary of Mortality Review – Anaesthetics Specialty**

Follow up from last report

Description	Local Numerator	Local Denominator	Jan 24 - Jun 24	Peer Value	Performance	Alert
Mortality Rate	1395	84122	1.6583%	1.8056%		
430 - Geriatric Medicine	588	5211	11.284%	10.953%		⚠
190 - Anaesthetics	45	201	22.388%	1.2972%		⚠

- **Specialty Selection**
  The review focused on specialties aligned with those used in the RAMI (Risk-Adjusted Mortality Index) system. To ensure statistical validity, only specialties with a minimum of 25 patients were included in the analysis.
- **Observed Mortality Trends**
  Between January and July, data indicated a higher number of recorded deaths in the Anaesthetics specialty within Aneurin Bevan University Health Board (ABUHB) compared to peer health boards.
- **Investigation Findings**
  A detailed review of anaesthetic-related cases was undertaken using data from Medicus. This analysis confirmed that the RAMI figures in the report do not accurately reflect actual mortality. Most of the cases were ITU-based, and Medicus applies a more sophisticated methodology for calculating the Standardised Mortality Ratio (SMR). SMR compares observed deaths to expected deaths, adjusting for factors such as age, sex, and case mix. In this case, all SMRs were below 1, indicating no cause for concern and suggesting mortality was actually lower than expected.
- **Likely Cause of Discrepancy**
  The discrepancy is most likely due to a change in coding practices during the reporting period—specifically, the reclassification of cases from Anaesthetics to Critical Care. This shift may have skewed the RAMI data, inflating figures for Anaesthetics. At the time of reporting, the coding team was unable to fully analyse the data to confirm its accuracy.
- **Next Steps**
  The Health Board is continuing with a case review to validate this interpretation across the dataset and to provide assurance for the Learning from Deaths report.

Tier Three Mortality Indicators – Crude Mortality - Specialty

Description	Local Numerator	Local Denominator	Jul 24 - Mar 25	Jul 24 - Mar 25	Peer Value	Performance	Alert
Mortality Rate	1964	134063	1.4650%	1.4650%	1.7554%		
430 - Geriatric Medicine	748	6885	10.864%	10.864%	10.599%		
314 - Rehabilitation Medicine	180	1947	9.245%	9.245%	7.749%		

This report presents performance data for selected specialties within Aneurin Bevan University Health Board, focusing on those that align with the RAMI. Only specialties with at least 25 patients have been included to ensure the sample size is meaningful for analysis.

- Mortality Rate: The Health Board's overall mortality rate is 1.5%, which is better than the peer average of 1.8%. This is a positive indicator and suggests that, overall, mortality outcomes are favourable.
- Geriatric Medicine: The local rate is 10.9%, slightly higher than the peer value of 10.6%. This has triggered a warning alert, indicating a need for closer scrutiny.
- Rehabilitation Medicine: The local rate is 9.2%, which is notably higher than the peer value of 7.7%. This also triggered a warning alert and suggests a more significant variance from expected outcomes.

What We Are Going to Do

1. Acknowledge Good Performance - Maintain and continue monitoring the positive performance in overall mortality rates.
2. Investigate Geriatric and Rehabilitation Medicine – we are conducting a targeted review of recent cases in these specialties to understand contributing factors. This will include engage with clinical leads to explore whether patient complexity, discharge delays, or other systemic issues are influencing outcomes.
3. Use RAMI-Aligned Specialties for Benchmarking - ensure that ongoing analysis continues to focus on RAMI-aligned specialties with sufficient patient volumes to maintain statistical validity.
4. Escalate Where Needed

Tier Three Mortality Indicators – RAMI - Specialty

Description	Local Numerator	Local Denominator	Jul 24 - Mar 25	Jul 24 - Mar 25	Peer Value	Performance	Alert
RAMI (Risk adjusted mortality index) 2019	1845	1839	100.30	100.30	113.01		
430 - Geriatric Medicine	674	608	110.94	110.94	82.58		
340 - Respiratory Medicine	244	108	225.32	225.32	128.04		
314 - Rehabilitation Medicine	169	195	86.80	86.80	64.51		
301 - Gastroenterology	106	68	154.83	154.83	125.74		

This report presents Risk-Adjusted Mortality Index (RAMI) data for selected specialties within Aneurin Bevan University Health Board. It focuses on specialties with a sample size of 25 patients or more, ensuring meaningful comparisons. The data compares ABUHB's local performance against Welsh peer values and highlights areas of concern using red alert icons. Key Insights:

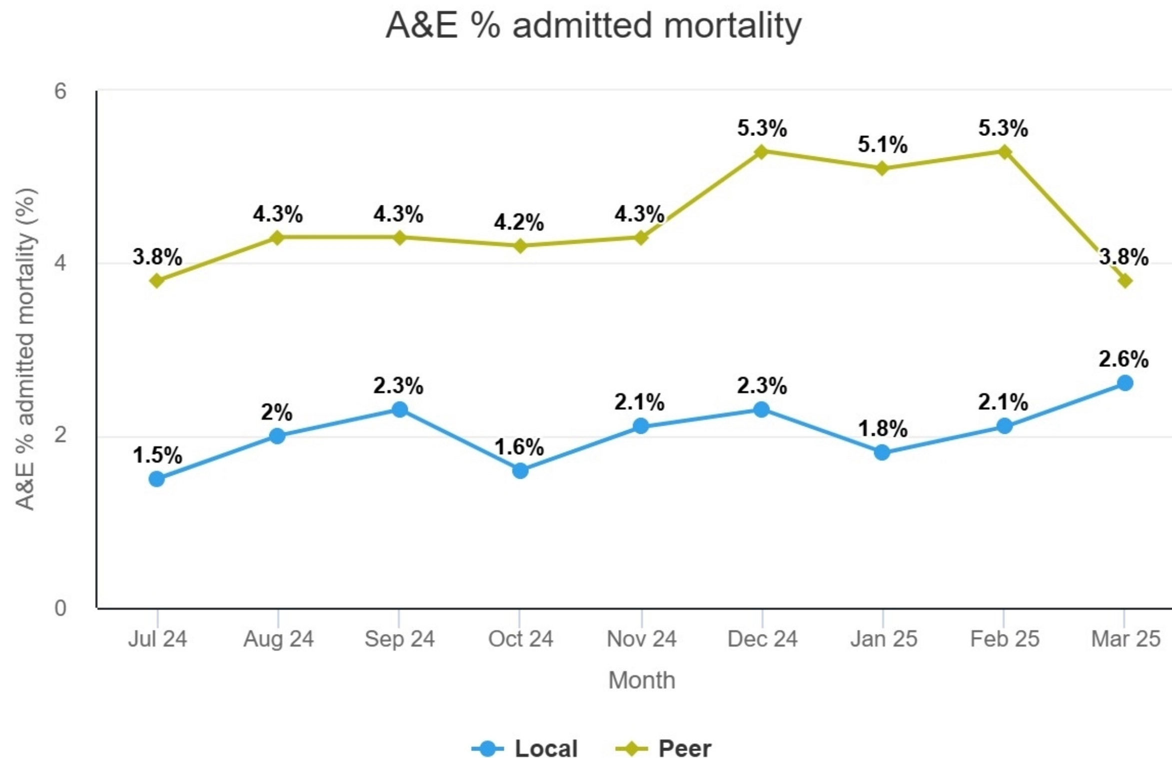
- The lowest RAMI score is seen in Rehabilitation Medicine. However, this score is still higher than the Welsh peer average, indicating potential areas for improvement.
- Highest RAMI: The highest RAMI score is in Geriatric Medicine, suggesting a higher rate of mortality in this specialty compared to peers.

Alerted Specialties: Geriatric Medicine and Respiratory Medicine have significantly higher RAMI scores than peer averages and are flagged with alerts. Immediate Actions to o address the concerns in Geriatric Medicine and Respiratory Medicine: The Health Board is conducting mortality reviews to identify patterns or systemic issues. Consider external benchmarking or peer reviews to validate findings and identify best practices.

Additional Considerations: Rehabilitation Medicine and Gastroenterology also show higher RAMI scores than peers, though they are not flagged with alerts. The Health Board will include these specialties in routine quality assurance cycles. Review case mix and coding accuracy to ensure data integrity. Monitor trends over the next quarter to determine if escalation is needed.

Respiratory Medicine – Coding Issue:
ABUHB appears to use a generic Respiratory Medicine code more frequently than other health boards. This coding practice may be skewing RAMI calculations and affecting peer comparisons. The Coding Team is currently investigating this issue.

Tier Three Mortality Indicators – ED admitted Mortality



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

ED Admitted Mortality Indicator

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

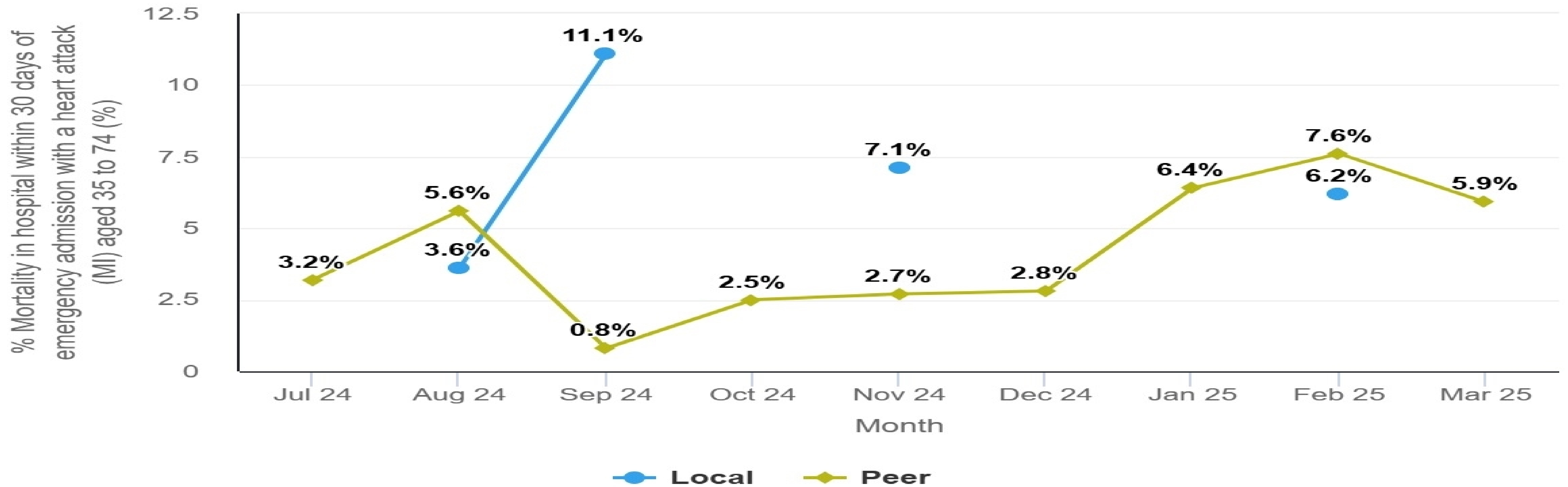
Tier Three Mortality Indicators – ED admitted Mortality Learning and Actions

The Emergency Department (ED) Mortality and Morbidity (M&M) meetings are held to review specific cases and identify opportunities to improve patient care and outcomes. A range of cases are discussed, covering various medical conditions and patient outcomes, including those involving patient deaths, rare or complex diagnoses, or significant learning points. Here is a summary of key learning from ED M&M reviews, Case of the Day presentations, and Messages of the Week. It highlights examples of good practice, identifies areas for improvement, and outlines actions taken to enhance patient safety and the quality of care provided. Examples include:

- **Communication:** Poor documentation and unclear escalation pathways. Actions: Structured documentation templates and escalation protocols reinforced.
- **Pain:** Multiple cases highlighted delayed or inadequate pain relief, particularly in confused or vulnerable patients. Pain scores were inconsistently documented and acted upon. Actions: Re-emphasis on validated pain assessment tools at triage, timely administration, and reassessment. Annual audits and patient feedback mechanisms introduced.
- **Neurology:** Missed early signs of TIA, stroke, and spinal cord compression. Actions: Emphasis on red flag recognition, early imaging, and specialist referral. Reinforcement of NICE stroke guidance, aspirin administration, and timely TIA clinic referrals. Updated patient information leaflets.
- **Trauma:** Missed injuries in paediatrics and elderly, under-imaging, and delayed recognition of spinal or internal injuries. Action: Lower threshold for imaging in children, especially when not using the limb normally. Reinforcement of mechanism-based injury assessment.
- **Sepsis:** Delayed recognition and treatment, especially in immunocompromised patients. Actions: Improved documentation, early warning scores, and escalation protocols. Education on managing sepsis in patients on steroids or immunosuppressants.Trauma: Missed injuries in paediatrics and elderly. Actions: Lower imaging thresholds and mechanism-based assessments.
- **Oncology:** Late-stage presentations with vague symptoms. Actions: Education on red flags and streamlined referral pathways.
- **Organ donation:** Missed opportunities due to lack of awareness. Actions: Re-circulation of the Sudden Death Checklist and donation referral process. Training on recognising potential donors.
- **Diagnostic delay:** Delays in diagnosis due to atypical presentations, crowding, or handover gaps. Action: Promote early imaging and escalation for red flag symptoms. Use of structured handover tools.
- **Paediatrics:** Under-imaging and missed diagnoses. Actions: Education on paediatric red flags and imaging thresholds.
- **Policy and Procedure Awareness**: Protocols for major haemorrhage, prescribing and sepsis reinforced via messages of the week and QR codes.

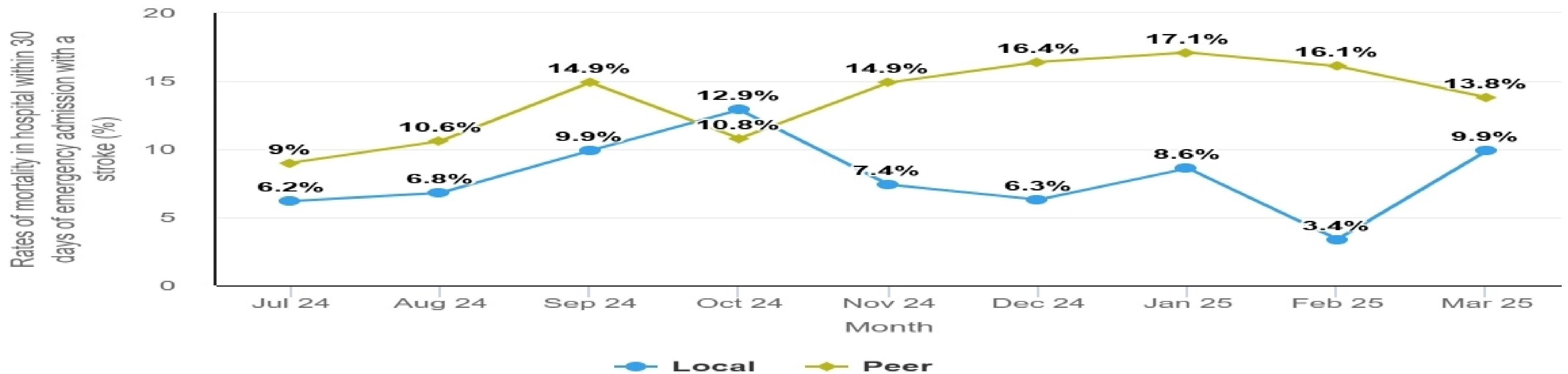
Provided by Dr Ryan Hobbs, Dr Sally Jones and Dr Jonathan Curry

Tier Three Mortality Indicators – Condition Specific Mortality - MI



- 4 deaths between July 2024 – March 2025
- Period mortality – ABUHB 2.59% Peers (All Wales) 4.16%
- Patients with remediable issues are transferred to Cardiff for intervention

Tier Three Mortality Indicators – Condition Specific Mortality - Stroke



Biggest risks and challenges across the Stroke pathway

Key points include:

- **Protecting the urgent intervention pathway**: Ensuring effective front door to HASU (Hyper Acute Stroke Unit).
- **Sustaining rehabilitation**: Addressing medical and therapy cover in a fragile rehabilitation pathway.
- **National Programme uncertainty**: Focus on HASU rather than the entire pathway.
- **Bristol Thrombectomy service**: Operating hours.
- **Public awareness**: FAST campaign and reaching seldom heard groups.

Strengths:

- Good performance in thrombolysis, timely stroke consultant access, and mortality outcomes.
- Community Neuro Rehab Service: Exemplar model for Wales, despite national funding cuts.
- Niwrostiwt Neurological Conditions Recovery College: NHS Wales Awards runner-up.
- In-house 'Living Well After Stroke' service.
- Peer support and volunteer roles in YYF.

Tier Three Mortality Indicators – Acute Medicine – Learning and Actions

Recognition of the Deteriorating Patient

Issues Identified:

- Recurring themes across multiple Datix incidents and Serious Incidents. Inconsistent calculation and escalation of NEWS scores, not always aligned with the Health Board's Deteriorating Patient Policy. Delays or omissions in reviewing and acting on blood gas results.

Actions Taken:

- The Deteriorating Patient Policy has been embedded into practice. Discussions at the Mortality and Morbidity (M&M) reviews. Weekly teaching sessions have been introduced to reinforce best practice.Staff have been reminded of the role and availability of the ICU Outreach Team. The Health Board is transitioning to NEWS2 and standardised Early Warning Systems, which will support earlier recognition and response to patient deterioration.

Improving Safer Discharges for Patients

Issues Identified:

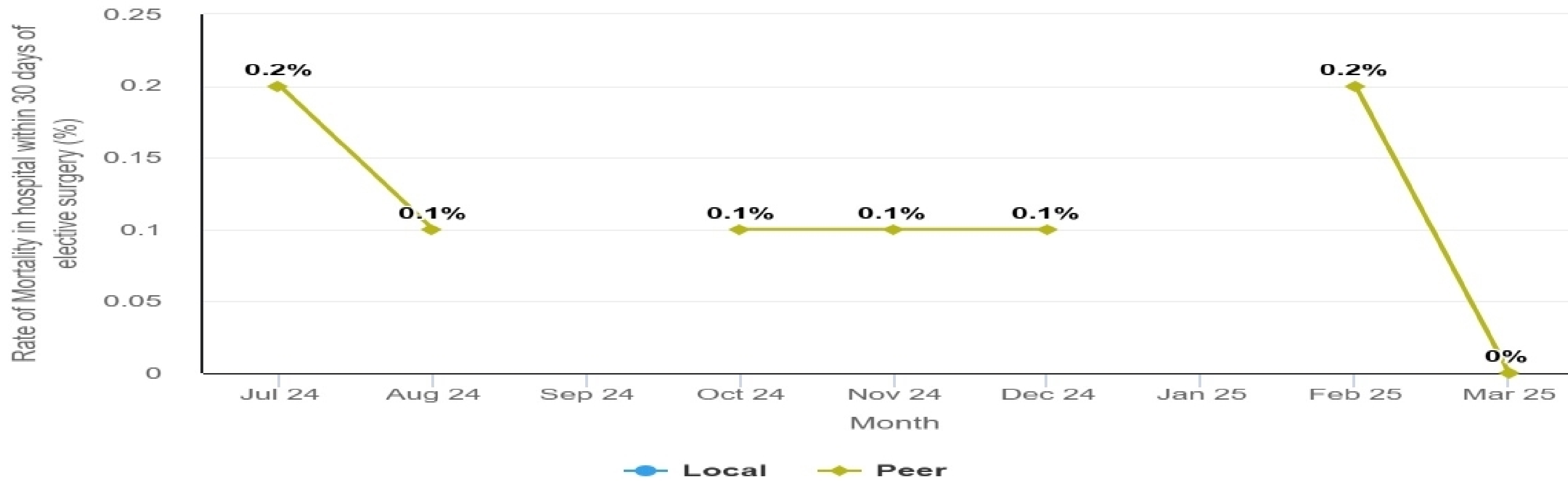
- Patients are sometimes discharged without a discharge letter, leading to communication gaps. Prescriptions are occasionally issued on a WP10, which can result in: Missed information for GPs. Patients leaving hospital without essential medication.

Next Steps:

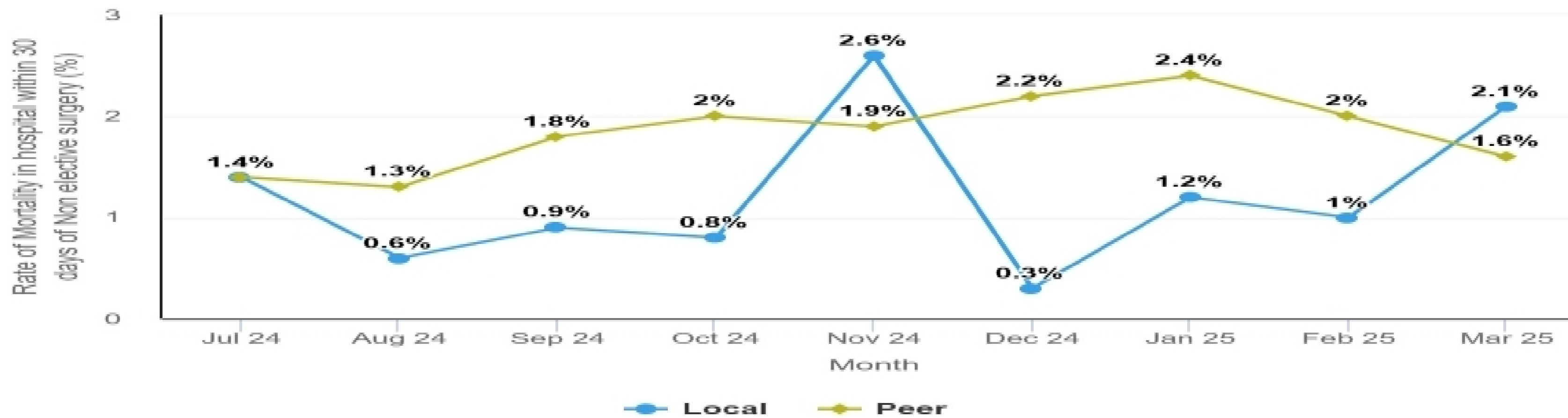
- Strengthen discharge protocols to ensure discharge letters are completed and shared in a timely manner. Review prescribing practices to reduce reliance on WP10s and ensure medication continuity post-discharge.

Provided by Dr Ifor Capel

Tier Three Mortality Indicators – Surgery Mortality



During the reporting period of July 24 – March 25. There were no recorded deaths in Hospital within 30 days of elective surgery. The all Wales peer group reported a mortality rate of 0.09% for this period.



The rate of mortality in hospital within 30 days of non-elective surgery has decreased to 1.17% from 1.5% in the previous Learning from Deaths report. This remains lower than the all Wales peer group mortality rate of 1.86%

Tier Three Mortality Indicators – Surgery Mortality

Description	Local Numerator	Local Denominator	Jul 24 - Mar 25	Jul 24 - Mar 25	Peer Value	Performance	Alert
Rate of Mortality in hospital within 30 days of Non elective surgery	70	5962	1.2%	1.2%	1.8%		
100 - General Surgery	20	1233	1.6%	1.6%	2%		
110 - Trauma & Orthopaedics	17	1129	1.5%	1.5%	2.2%		
301 - Gastroenterology	9	91	9.9%	9.9%	7.4%		⚠
192 - Intensive Care Medicine	6	18	33.3%	33.3%	56.6%		
340 - Respiratory Medicine	5	48	10.4%	10.4%	9.3%		
300 - General Internal Medicine	3	41	7.3%	7.3%	13.4%		
422 - Neonatology	3	6	50%	50%	-	No data to display	
101 - Urology	2	279	0.7%	0.7%	0.9%		
320 - Cardiology	2	262	0.8%	0.8%	4%		
307 - Diabetic Medicine	1	6	16.7%	16.7%	-	No data to display	
328 - Stroke Medicine	1	6	16.7%	16.7%	-	No data to display	
430 - Geriatric Medicine	1	31	3.2%	3.2%	4.3%		

- 70 Deaths were recorded of patients who have died within 30 days of non-elective surgery
- General Surgery and T&O have the highest mortality level
- Gastroenterology is an outlier for ABUHB as it is higher than the peer average of 7.4% with a mortality rate of 9.9% for the period July 2024 – March 2025. A deep dive is underway in this area.

Tier Three Mortality Indicators – Critical Care Unit – Learning & Improvement

The Critical Care Unit are committed to learning and improving the care delivered to patients. There is a proactive Morbidity and Mortality (M&M) process. The department also include Merit system in these discussions and call it M&M&M. These meetings help the department reflect on patient outcomes and improve the quality of care. Here are some of the changes and improvements the units have made based on these reviews:

1. **Mortality Trends -** Mortality rates in high-risk groups (e.g. multiorgan failure, severe liver disease) are improving and trending towards expected levels. Collaborative work with specialty groups is contributing to these improvements.
2. **Themed Morbidity & Mortality (M&M) Sessions -** A new series of themed M&M sessions has commenced. The first session was held jointly with the Bristol ECMO service. Further sessions are being scheduled with GUH inpatient teams to support shared learning.
3. **Emergency Re-admissions -** Emergency re-admission rates remain low. Any unexpected returns within 48 hours are reviewed by the MDT. A nurse and outreach-led team is actively reviewing discharge practices to ensure ongoing safety.
4. **Tracheostomy Care -** The tracheostomy care bundle is proving effective. Collaboration with ENT has enabled the upskilling of the Speech and Language Therapy team to perform fibreoptic assessments for airway, cough, and swallow function.
5. **Patient Acuity & Capacity Pressures -** Data shows an increase in the number of critically ill patients, reflected in higher use of invasive organ support therapies (e.g. mechanical ventilation, renal replacement therapy). Maintaining optimal unit occupancy is challenging due to site pressures. Ongoing collaboration with site teams is focused on improving admission and discharge timeliness.
6. **Vascular Access Safety -** New work is underway to address complications from invasive vascular access devices. Pathways are being developed to ensure regular monitoring of access sites for signs of concern or injury.

Provided by Dr Hayden Stephenson and Dr Phillipa Jones

Tier Three Mortality Indicators – Primary Care and Community (PCC) Deaths Learning

Prescribing Safety

- **Gastro-protection**: Risks of not prescribing gastro-protective medication alongside drugs that increase GI bleed risk. Action: Shared learning with pharmacy colleagues (referenced in PPI Bulletin).
- **Renal Function Consideration**: Importance of assessing renal function before prescribing and consulting the pain team when uncertain.

Communication & Documentation

- **Death Certification**: Emphasis on timely GP contact post-death and ensuring next-of-kin (NOK) details are shared with Medical Records (MR) services.
- **Follow-up Processes**: Need for safety netting when patients do not respond to follow-up requests, especially for potential cancer investigations (e.g., FIT test).

Bereavement Support

- **Post-Death Contact**: Suggestion to offer bereavement visits soon after death to address family concerns and provide reassurance and signposting to support services.

End-of-Life (EOL) Care in Out-of-Hours (OOH) Settings

- **Medication Access**: Clear documentation on whether families can collect medication or if Emergency Transport Services (ETS) are needed—especially during nights/weekends.
- **Drug Charting**: Avoid prescribing dose ranges; specify exact doses to ensure District Nurses (DNs) can administer.
- **Post-Death Procedures**: Clinicians with experience should remove catheters and syringe drivers when certifying death.

Pathology Handling & Escalation

- **Daily Result Management**: Reinforce the buddy system to ensure pathology results are reviewed daily, even during clinician absences.
- **Urgent Findings**: Immediate communication of critical results (e.g., high potassium) to on-call GPs.
- **DN Communication**: DNs should report findings clearly, especially when Tissue Viability Nurse (TVN) input is needed.
- **Escalation Pathways**: Clarify lab escalation processes to ensure timely flagging of critical results

- *Provided by PCC Quality and Patient Safety Team*

Tier Three Mortality Indicators – Learning from Inquests

The Health Board approaches each Inquest with a clear commitment to learning and continuous improvement. This learning-led approach is embedded in our governance processes and is a key driver in reducing future risk.

Between 1 July 2024 and March 2025, the Health Board received two Prevention of Future Death (Regulation 28) Reports. Importantly, no Regulation 28 Report was issued for the same issue more than once during this period—demonstrating that learning from previous cases is being embedded effectively.

Recurrent Themes Identified

While no repeated Regulation 28 issues were noted, the following themes have emerged in more than one Inquest:

- Non-compliance with the Deteriorating Patient Policy.
- Inadequate fluid balance monitoring and management.
- Ambulance delays linked to internal organisational pressures.
- Poor documentation by medical and nursing staff.
- Failure to complete risk assessments in a timely manner to mitigate falls.
- Delays in diagnosis or treatment.

Assurance and Actions Taken

- Evidence of learning has been presented to the Coroner during Inquests and documented in Learning from Events Reports, particularly where Inquests have led to clinical negligence claims.
- Following each Inquest, the Legal Services Manager shares learning directly with the relevant Division to ensure local ownership and action.
- All Regulation 28 Reports are escalated to the relevant Executive Leads and cascaded to the teams involved for immediate review and response.
- This structured approach has contributed to the low number of Prevention of Future Death Reports issued to the Health Board, reinforcing confidence in our learning systems.

Provided by Garvin Jones

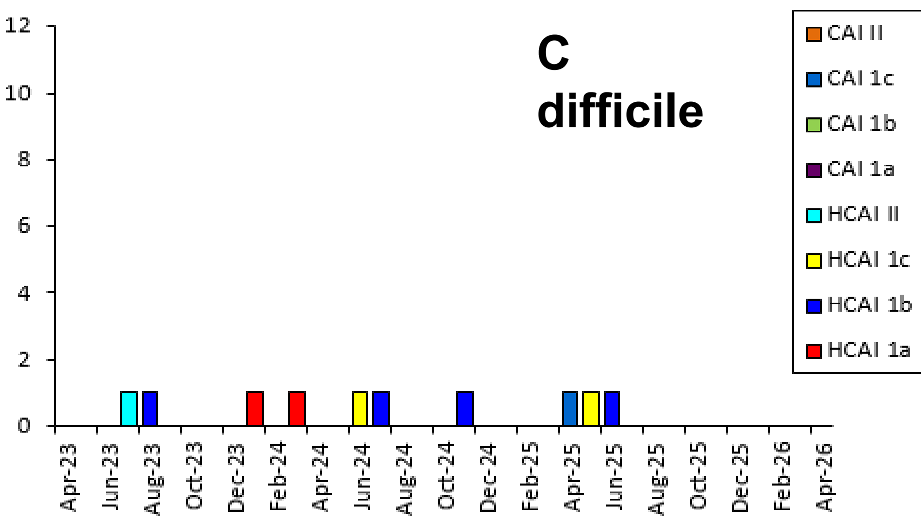
Tier Three Mortality Indicators – Learning from Complaints

- Key Theme Identified: A recurring concern from complaints relates to communication with patients and their loved ones, particularly in cases involving multiple specialties. In efforts to coordinate care and maintain patient comfort, communication with families and patients can sometimes be overlooked.
- Case Learning and Actions – Cross-Board Coordination (PCC and Velindre)
- A notable case involving cross-boundary care between Primary Care Clusters (PCC) and Velindre highlighted several areas for improvement. In response, GSURG implemented a series of actions to strengthen assurance and patient experience:
- Improvements in Care Coordination:
  - GPs and community palliative care teams will now take a more active role in post-discharge care coordination.
  - Hospital teams are expected to directly contact GPs at discharge, providing clear and specific care instructions.
  - This process will be monitored at GP level to ensure consistent implementation.
- Strengthening Multidisciplinary Communication:
  - Community healthcare teams will be invited to participate in planning meetings to better prepare for patient needs.
  - Follow-up check-ins have been introduced for patients on treatment breaks to identify complications early and offer timely support (led by Professor Adams).
- Enhancing Discharge Processes:
  - Discharge letters will be issued promptly to both patients and GPs, including: medication details, dietary guidance and emergency contact information
- For patients with complex needs: a multidisciplinary team will review care plans pre-discharge, dietetic follow-up will occur within one week of discharge and nutritional support (e.g. diet sheets, supplements) will be arranged to prevent gaps in care.

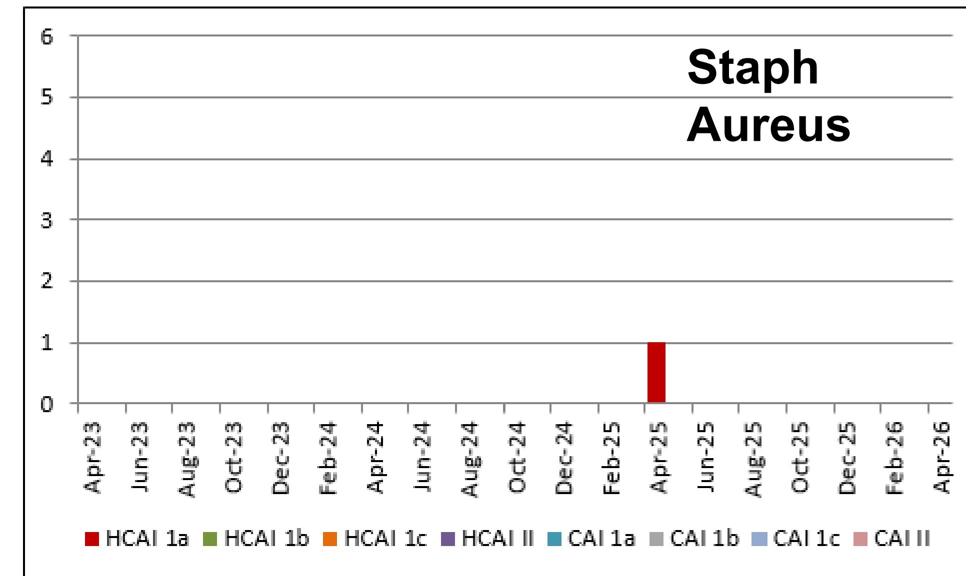
These actions demonstrate a clear commitment to learning from complaints, improving cross-service communication, and ensuring safe, coordinated discharges.

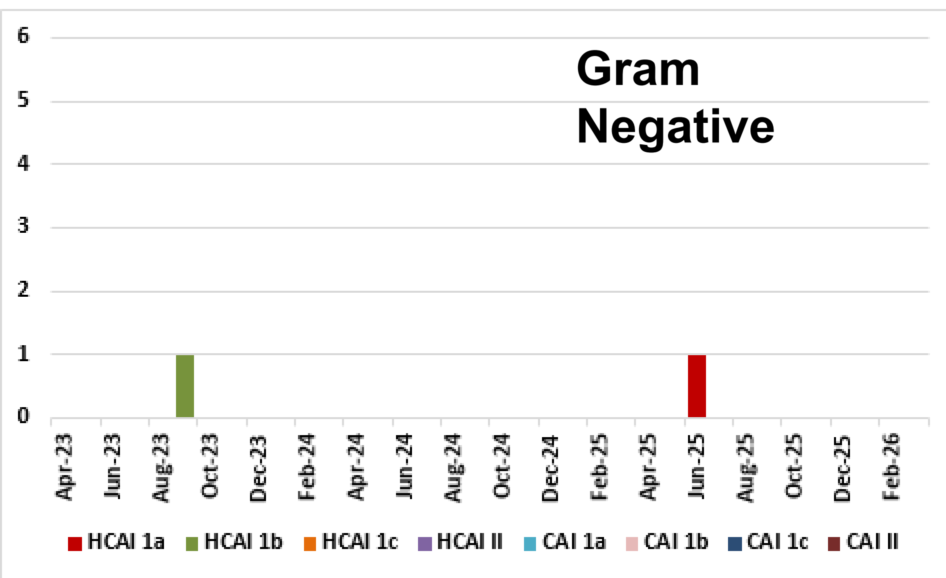
- *Provided by Rhiannon Price*

Tier Three Mortality Indicators – Infection Prevention & Control



- Charts show the deaths within 28 days where the infection is recorded on the death certificate
- Data is presented in the Divisional monthly updates





- **Learning and Improvement**
- Documentation processes for managing care bundles are being reviewed to be clear and consistent
- Sample collection should be carried our effectively to help guide and support antibiotic choices
- Timely review of antimicrobial treatment, with a focus on using narrow spectrum antibiotics where possible
- Special attention is require for patients with complex needs and multiple health conditions

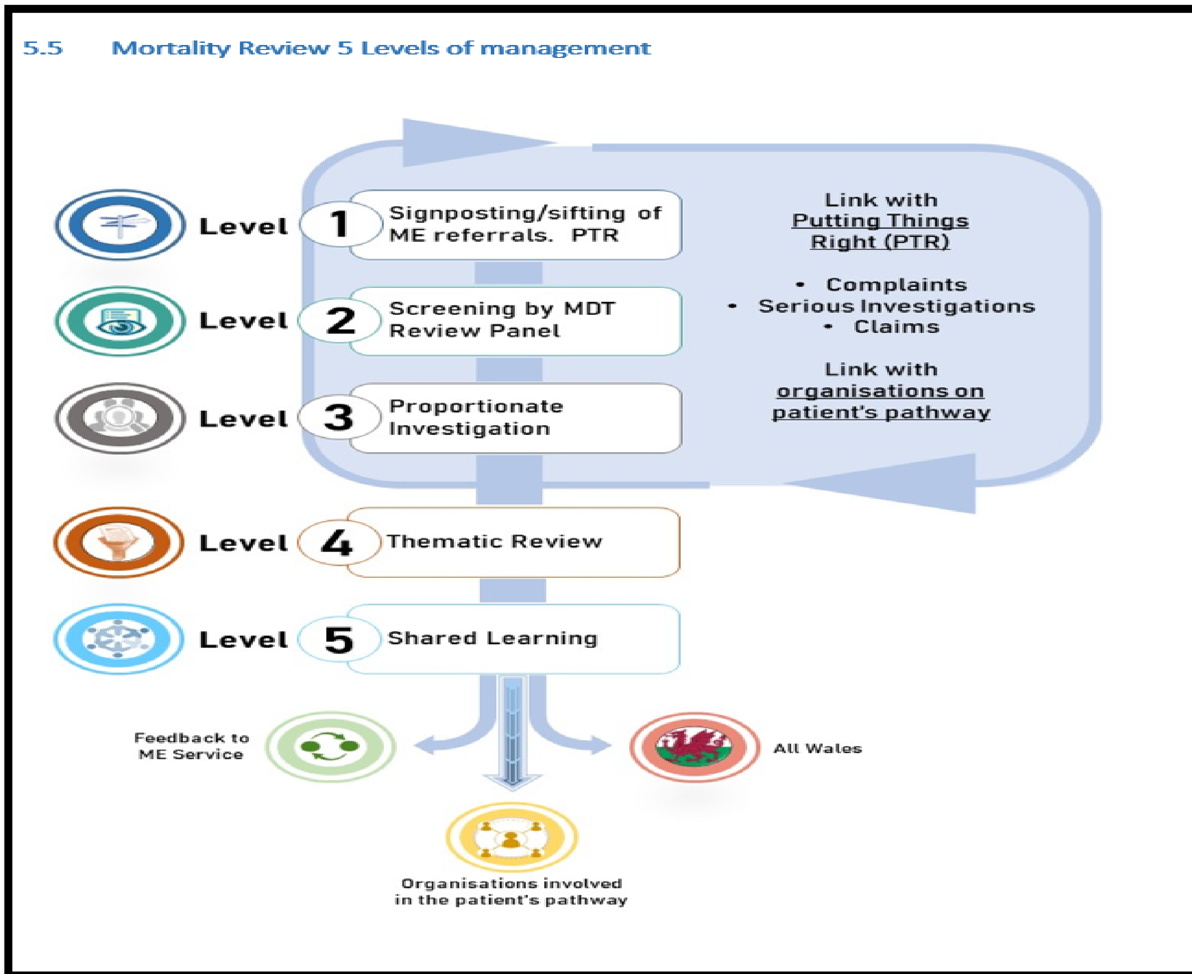
The Medical Examiner Service

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

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

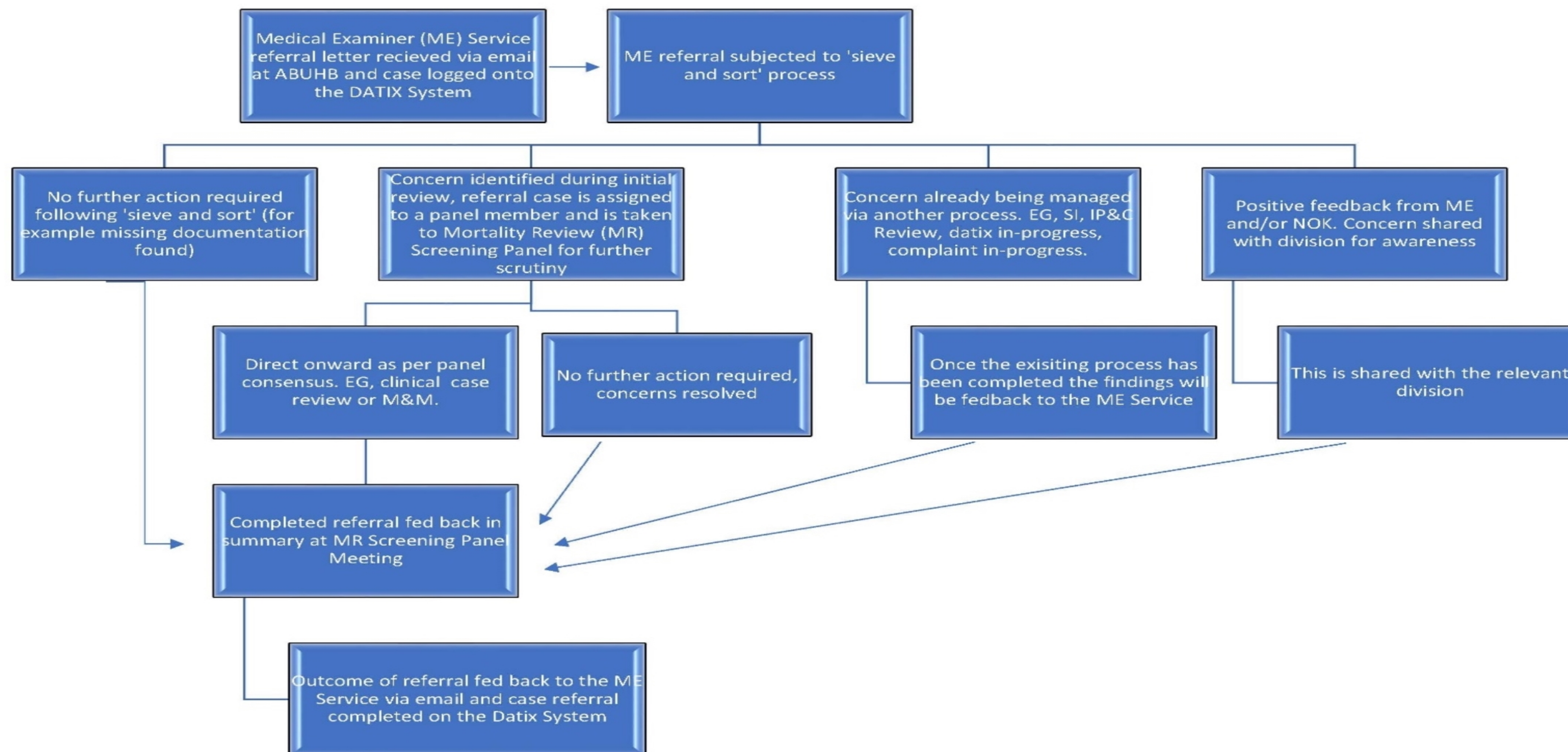
The ME Service system provides external, independent scrutiny of the treatment and care delivery and reports back cases for concern to the Health Board for further review.

Aneurin Bevan University Health Board Mortality Review Process

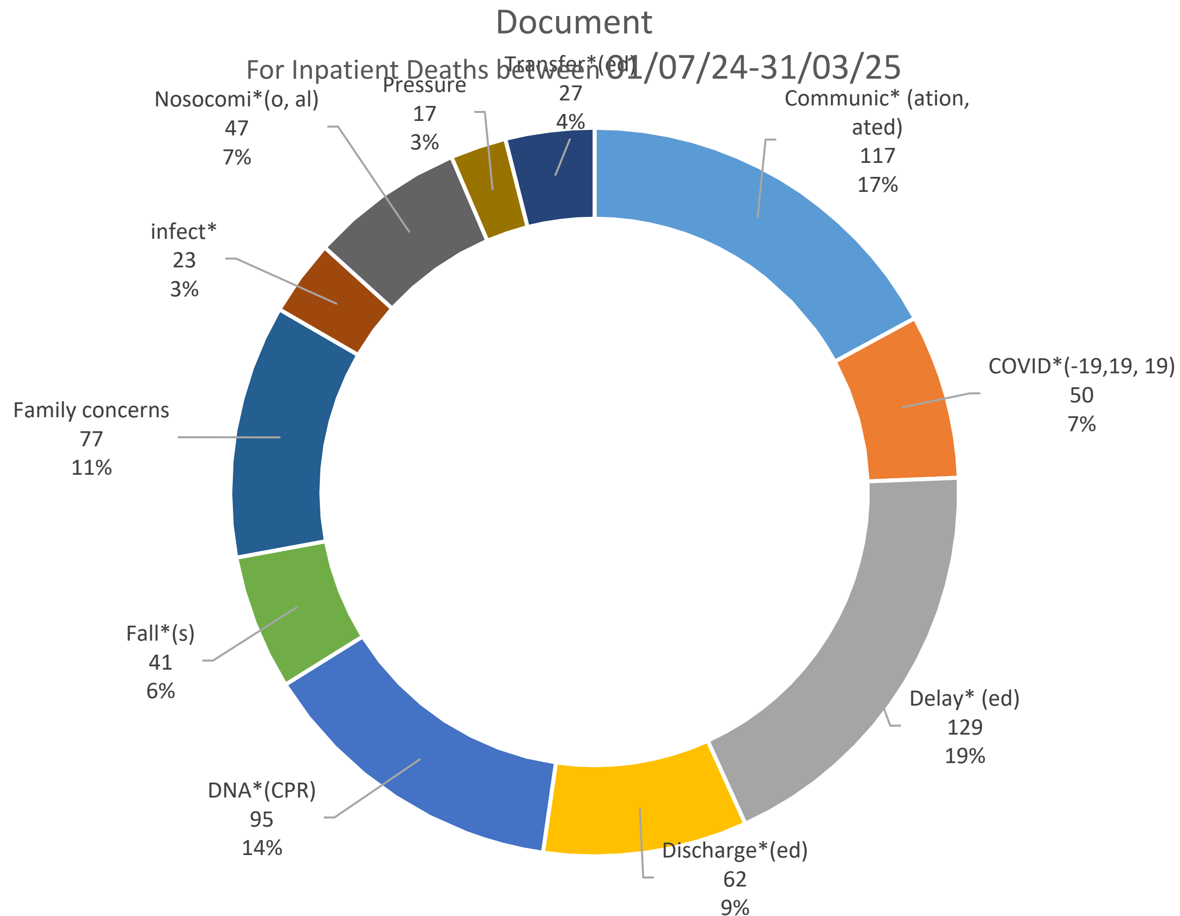


- All mortality cases referred to the Health Board by the Medical Examiner (ME) undergo an initial review (level 1) to determine if further action is needed and avoid duplication.
- If further investigation is required, the case moves to a level 2 review, where it is discussed by the Mortality Review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

Aneurin Bevan University Health Board Mortality Review Screening Process



Medical Examiner Documents



This analysis helps us understand the key areas for improvement in patient care, especially around **documentation, communication, and timeliness**. By having a better understanding of these common reasons for referral, we can endeavour to improve patient experience**.**

Thematic Analysis of Referrals to the Medical Examiner Service identifies common themes in the reasons for referrals to the Medical Examiner (ME) service. The previous data set is from 01/12/23-31/10/24 which is a total of 335 days. The current data set is from 01/07/24-31/03/25 which is 273 days.

Delays

- The term 'delayed' is now the most commonly featured work in the reasons for referral. Constituting 129 (19%) referrals (was previously 128, 17%). This can refer to:
- Concerns from NOK about perceived delays in treatment or investigations.
- Delays related to ambulance off-load.
- Delays in treatment or investigations highlighted by the ME.

DNACPR (Do Not Attempt Cardiopulmonary Resuscitation)

- 95 referrals (14%) in this data related to concerns about DNACPR forms. This has reduced slightly from the previous data set from which 109 referrals (15%) mention DNACPR forms.
- Issues typically involve DNACPR forms not being co-signed correctly in part 6 by the senior clinician or consultant.

Communication Issues

- Communication remains a common theme, covering interactions with families, clinicians, and the Care After Death Team.
- Referrals related to communication have decreased from 19% previously to 117 referrals (17%) in the latest data set.

COVID-19 Related Referrals

- Referrals related to COVID-19 (either caught in hospital or in the community) have reduced from 9% to 7% from the previous data set.

Pressure Damage

- Referrals due to pressure ulcers or injuries have once again decreased from 36 referrals (5%) in the previous set to 17 (3%) in the current data set.

Medical Examiner Documents

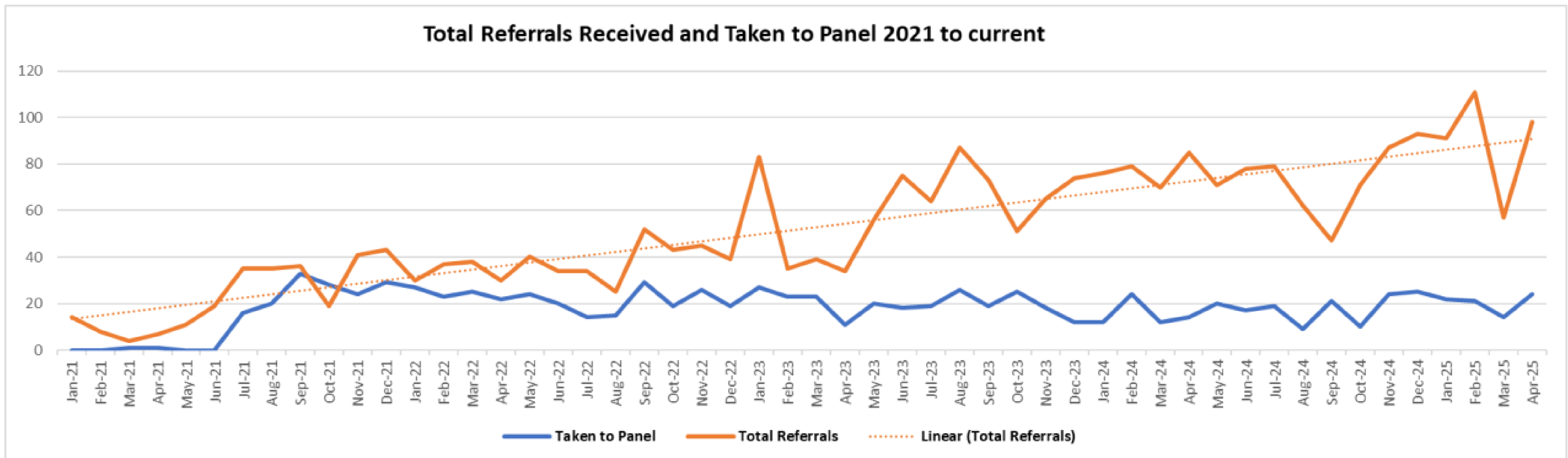
	Data Set 1 (01/10/23-01/12/23)	Data Set 2 (01/12/23-31/10/24)	Data Set 3 (01/07/24-31/03/25)
Number of days	426	335	273
Total ME Referrals	797	783	715
No Further Action	405 (51%)	164 (21%)	120 (17%)
IP&C	70 (9%)	33 (4%)	12 (2%)
Cardiac Arrest Audit	11 (1%)	8 (1%)	8 (1%)
Awareness	88 (11%)	39 (5%)	74 (10%)
Positive Feedback	27 (3%)	15 (2%)	4 (1%)
M&M	51 (6%)	13 (2%)	6 (1%)
SI	47 (6%)	20 (3%)	9 (1%)
Clinical R/V	73 (9%)	22 (3%)	15 (2%)
Referral to HMC	153 (19%)	150 (19%)	162 (23%)
Closed on Datix	6 (1%)	140 (19%)	222 (31%)

ME Referral Destination

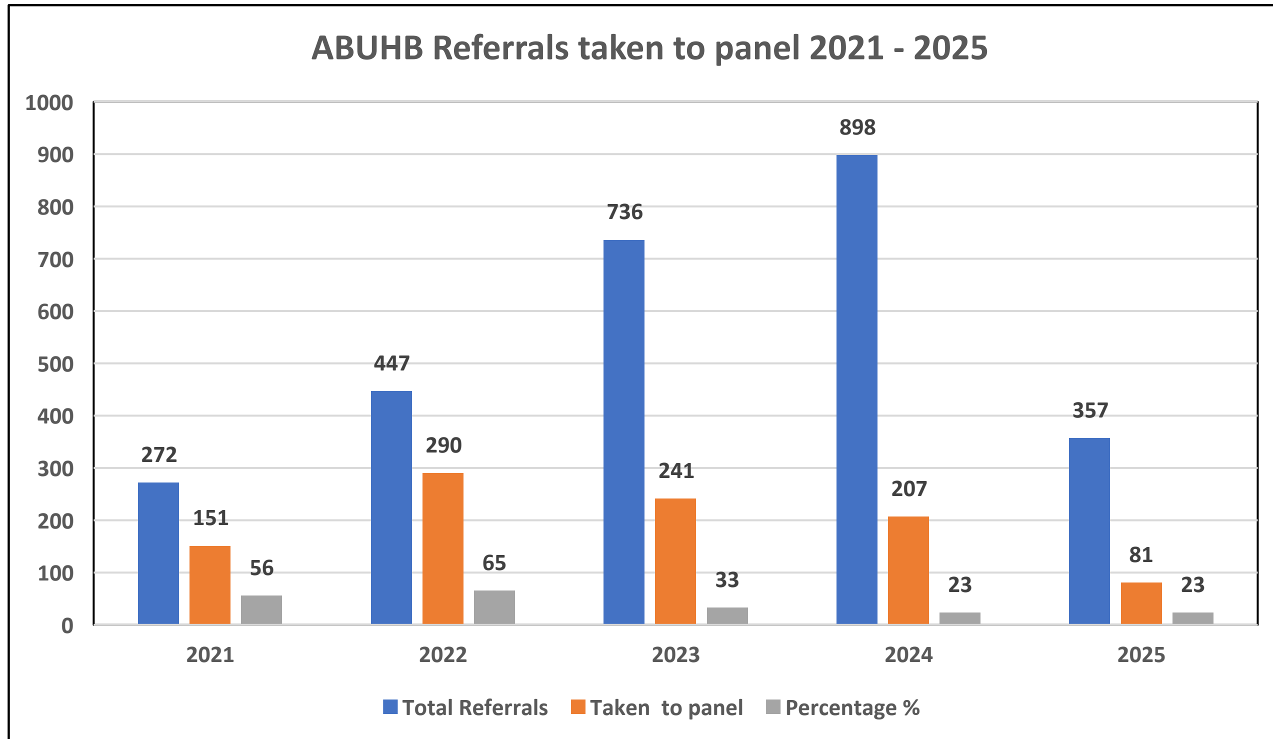
- **No Further Action**: Referrals needing no further action at level 1 have decreased again from the previous data sets. Referrals for 'no further action' includes concerns already being investigated through other processes, like Datix. The decrease might be due to better quality referrals and more referrals being shared locally by the MR Screening panel for awareness.
- **IP&C Referrals**: These have decreased, matching the drop in nosocomial COVID-19 cases.
- **SI Referrals**: Serious Incident (SI) referrals have continued to decrease. This is likely to be because incidents are being managed more proactively so are already in process before coming to panel.
- **HMC Referrals**: The number of cases referred to the Health and Mortality Committee (HMC) has increased from the previous both data sets. It will be interesting to see how this develops for the next data set.
- **Closed on Datix**: Whilst there is still ample improvement we can make here, our closure rate has improved a lot which is really pleasing.

Aneurin Bevan University Health Board Mortality Review Service Growth

- **Growth of Mortality Review**: Since the Medical Examiner (ME) service started in 2021, the ABUHB Mortality Review Screening Process has grown, especially in 2024 when it expanded to cover community settings.
- **Case Gap**: There's still a gap between the number of cases received and those that proceed to panel.
- **Resource Strain**: The ME service was started without extra resources or investment, putting a strain on the Medical Directors' team and reducing resources for clinical audits. This strain has increased since the service expanded to the community.



Aneurin Bevan University Health Board Mortality Review Service Growth



- The graph highlights a disparity between the number of cases that proceed to panel and those that are closed at Level One or managed through existing governance routes—such as ongoing incident investigations, falls panel scrutiny, or Serious Incident (SI) processes.
- This visual trend provides assurance that the Health Board is actively triaging and managing cases through appropriate channels, ensuring that only those requiring panel-level scrutiny are escalated. It also reinforces the increase in referrals received, reflecting improved reporting and vigilance across services.

Positive Patient Feedback - Civica

She said the care (*her mother*) received was excellent and she could not have wished for better care.

"At every point (the staff) were all amazing. Communication was excellent - we knew everything they were doing and why. They really looked after me and my mum too. I really can't thank them enough"

The care (*he*) received was marvellous and (*they*) couldn't fault it.

The team were absolutely brilliant.

She said the actual nurses and HCAs were amazing, they looked after the family as well as (*her husband*). She said "they were absolutely lovely".

The care (*Dad*) received was fantastic

She said "I honestly can't fault them at all, they gave 100%". She said (*the staff*) were very attentive, very respectful and mindful.

I was very impressed by all the nurses and clinicians who cared for mum. I'm very grateful to them"

She said the care was excellent.

The care (*her husband*) received was excellent on both wards that he was on during his last admission. She said the nursing team were brilliant and she couldn't thank them enough.

In the hospital (*the staff*) were second to none, absolutely brilliant, the ward staff were brilliant and the ward manager superb.

Bereavement and End of Life – Learning and Actions

As part of the Bereavement and End of Life work a Case Note and Serious Incident Review was conducted. This involved a detailed examination of patient records and Serious Incident reports to identify contributory factors and areas for learning.

This also included Stakeholder Engagement- a Collection of insights through interviews and feedback from staff, patients, and bereaved families, ensuring that lived experience informs the analysis.

Finally a framework alignment was undertaken with reference to established local and national frameworks, including:

- NICE NG31 – Care of dying adults in the last days of life
- Ambitions for Palliative and End of Life Care Framework
- Gold Standards Framework (GSF)

1. Key Themes and Learning Points

1.1 Recognition of Dying and End-of-Life Planning

- **Finding:** Delays in recognising the dying phase led to missed opportunities for comfort measures and family involvement.
- **Recommendation:** Strengthen use of tools to support early recognition and timely transition to palliative care.

1.2 Communication with Patients and Families

- **Finding:** Communication about prognosis and care decisions was variable in quality and timing.
- **Recommendation:** Invest in communication training and use structured conversations

Bereavement and End of Life – Learning and Actions (Continued)

1.3 Care Coordination and Continuity

- **Finding:** Some patients experienced fragmented care, especially at transition points.
- **Recommendation:** Improve handover processes and multidisciplinary collaboration across acute and community settings.

1.4 Symptom Control and Comfort

- **Finding:** Inconsistencies noted in symptom management and access to anticipatory medications.
- **Recommendation:** Standardise symptom management protocols and ensure out-of-hours access to palliative care.

1.5 Support for Families and Carers

- **Finding:** Family support before and after death varied, with gaps in bereavement follow-up.
- **Recommendation:** Enhance bereavement pathways and provide clear signposting to support services.

1.6 DNACPR and Future Care Planning

- **Finding:** Some DNACPR forms were poorly completed or lacked accompanying conversations.
- **Recommendation:** Provide clear documentation training and audit use of FCP and DNACPR.

Bereavement and End of Life – Learning and Actions (Continued)

1.7 Training and Staff Support

- **Finding:** Staff expressed the need for more training and emotional support around death and dying.
- **Recommendation:** Expand access to training in end-of-life care and embed reflective practice.

1.8 Equity of Access and Inclusion

- **Finding:** Some patient groups (e.g., non-cancer diagnoses, learning disabilities) had reduced access to tailored EOL care.
- **Recommendation:** Promote inclusive care pathways and monitor equity through data collection.

1.9 Environment of Care

- **Finding:** Lack of privacy or quiet space for families in some settings was noted.
- **Recommendation:** Review ward environments and explore simple adaptations to improve dignity in dying.

1.10 Learning from Feedback and Incidents

- **Finding:** Not all learning from complaints or incidents around death was shared effectively across teams.
- **Recommendation:** Create a feedback loop to share learning widely and implement system-level changes.

Bereavement and End of Life – Learning and Actions (Continued)

Imams in the Community

A meeting was held with a number of imams and members of the Muslim community along with Dr Kas, who is the co-founder of the Muslim Cymru GPs. The feedback from this group was they are still experiencing issues with receiving the death certificates in a timely manner to enable them to bury their loved ones as their faith requires of them. A follow up meeting has been arranged with the ME to discuss their issues.

Glossary

Definitions of terms within the Report

Graph and chart glossary

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

Graph and chart glossary

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

MMBRACE-UK

All deaths are reported to MMBRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) ensures the quality of neonatal care through:

Systematic Review and Surveillance:
- **National Surveillance**: Collects data on late fetal losses, stillbirths, and neonatal deaths to identify trends.
- **Perinatal Mortality Review Tool (PMRT)**: Facilitates thorough, multidisciplinary reviews of neonatal deaths.

Detailed Investigations:
- **Confidential Enquiries**: Conducts in-depth reviews of selected cases.
- **Root Cause Analysis (RCA)**: Identifies systemic issues and care delivery problems.

Governance and Accountability:
- **Annual Reports**: Provides insights and recommendations.
- **Board-Level Oversight**: Ensures accountability and compliance through regular reporting.

Quality Improvement Initiatives:
- **Targeted Actions**: Develops interventions like staff training and protocol revisions.
- **Monitor Impact**: Tracks effectiveness of changes.

Learning and Communication:
- **Multidisciplinary Learning**: Organises sessions to address gaps.
- **Transparency**: Engages families and publishes findings.

This approach ensures robust scrutiny, promotes patient safety, and drives quality improvements in maternal and neonatal care.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 July 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

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

Ar Gyfer Trafodaeth/For Discussion

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation & Cefndir / Background

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

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

Asesiad / Assessment

Committee Strategic Risk Register

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

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

Table 1

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

Risk Exposure Aligned to Appetite for Risk

Risks **SRR 005** and **SRR 008** remain within the Health Board's defined risk appetite, providing assurance that current controls are effective and proportionate. Ongoing engagement with risk owners will help ensure these controls continue to mitigate potential threats appropriately.

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

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

To further reduce this risk and align it with the Board's risk appetite, a new corporate risk has been established, focusing on non-compliance with statutory duties under the Health and Safety at Work etc. Act 1974 and related regulations. This includes specific areas such as RIDDOR reporting, fire safety, manual handling, and workplace risk assessments.

In support of this, more detailed and targeted risk assessments are being carried out under the Executive Committee's oversight. These assessments will enable a clearer understanding of control effectiveness, highlight any deficiencies, and ensure robust assurance mechanisms are in place. They will also improve transparency, inform resource allocation, and direct attention where it is most needed.

This heightened focus ensures that executive directors are actively supporting the Health and Safety team in strengthening compliance measures and fostering individual accountability for maintaining safe environments across the Health Board.

Horizon Scanning

Focused monitoring of individual service areas will remain a priority. Ongoing surveillance, coupled with strengthened control measures, is essential to managing associated risks and ensuring alignment between resources, performance targets, and patient outcomes.

The development of the Corporate Risk Register should provide the Committee with greater assurance that risks to the delivery of safe, effective care, and to the achievement of strategic objectives, are being managed in a more coordinated and comprehensive manner.

Argymhelliad / Recommendation

The Committee is requested to:

- **NOTE** the delegated strategic risks;
- **NOTE** the work being undertaken to ensure the Committee is sighted on all risks that have the potential to impact patient quality and safety.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The Strategic Risk Register is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	The Board and respective Committees of the Board have considered risks contained within the Strategic Risk Register

Parties / Committees consulted prior to University Health Board:	

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

Reference	Risk Owner	Risk Description	Reason For The Risk	Risk Score Matrix											
				2	4	5	6	8	9	10	12	15	16	20	25
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow						✕		●		◊		
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement		✕			●					◊		
SRR 010	Director of Therapies and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.				✕	◊			●				

Assessment of adequacy of assurances	
	POSITIVE = Identified assurances are deemed robust in telling us that the controls in place are working effectively.
	REASONABLE = Identified assurances are deemed adequate in telling us that the controls in place are working effecively, however some gaps have been identified which need to be addressed.
	NEGATIVE = Identified assurances are deemed insufficent in telling us that the conrols in place are working effectively with substantial gaps identified which need to be addressed.

Key		
	Current Score	●
	Target Score	✕
	Appetite Threshold	◊
	Current to Target	◄ —

RISK THEME	SERVICE DELIVERY		
LINK TO IMTP	**SECTION 3: SYSTEM CHANGE**		
Strategic Risk **SRR 005 A**	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system**	**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate arrangements to support system-wide patient flow**		

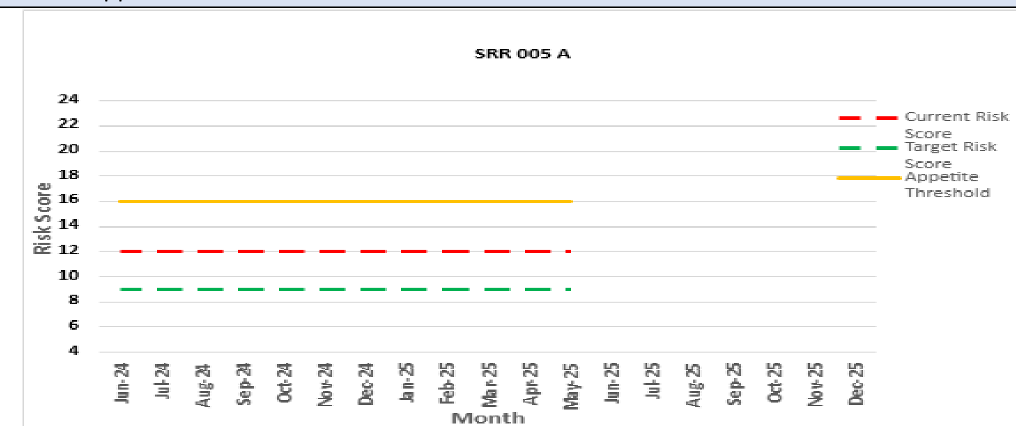
Impact *(Consequences of the threat)*	**Patient**	**Staff**	**Organisation**
	• Avoidable deaths and significant harm. • Delayed discharges from acute and non-acute settings resulting. in deteriorating patients. • Delays in releasing ambulances from hospital sites back into the community.	• Increased workload • Fatigue & burnout	• Litigation & Financial Penalties • Reputational damage and loss of public confidence

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

Risk Appetite Threshold – OPEN SCORE 17 AND BELOW
Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.

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

Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee / Group	Patient Quality, Safety and Outcomes Committee	**Likelihood**	**3** (Possible) x	3 (Possible) x
Initial Date of Assessment	01 June 2023	**Impact**	***4*** *(Major)*	3 (Moderate)
Last Reviewed	01 May 2025	**Risk rating**	**= 12** **(High)**	***= 9*** ***(High)***
Next Review (Quarterly based on risk score)	01 August 2025			



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

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

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

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING				
LINK TO IMTP	SECTION 4: ENABLER - QUALITY				
Strategic Risk SRR 008	**There is a risk that the Health Board fails to build positive relationships with patients, staff and the public.**			**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.**				

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

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

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

Impact *(Consequences of the threat)*	**Patient**	**Staff**	**Organisation**
	• Unmet patient needs resulting in patient harm. • Ineffective use of combined resources • Delayed decision making • Adverse impacts on delivery of care to patients across acute and non-acute settings • Negative experience of care • Distress and frustration. • Carer stress.	Staff dissatisfaction Frustration Increased absence. Loss of confidence.	• Failure to deliver health board priorities, required improvements and achieve longer-term sustainability • Reputational damage and loss of public confidence

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Nursing	**Likelihood**	**2** (Unlikely) x	**2** (Unlikely) x
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Impact**	**4** *(Major)*	**2** (Minor)
Initial Date of Assessment	01 June 2023			
Last Reviewed	01 July 2025	**Risk rating**	**= 8 (Moderate)**	***= 4 (Low)***
Next Review (Six monthly based on risk score)	01 January 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 *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Actions to Address Gaps** *(What further evidence is required to provide the effectiveness of controls)*
Level 1 Operational *(Implemented by the department that performs daily operation activities)*		
• Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. • Patient Experience and Involvement Team undertaking Culturally Competent Accreditation, receiving a silver distinction award in Oct 2024 • Immediate feedback and escalation to clinical teams following PALS queries and concerns • Civica patient feedback in in the process of being rolled out across all – all divisional leaders receive reports for their live areas monthly. • Bereavement survey built with CIVICA – Nov 2024 • CIVICA SMS launched 3rd March 2025 across ED and MIU'S	• Currently there is no SMS provision to increase the number of surveys. • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. • Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards. • • CIVICA team have the ability to pull and view feedback that has been left by patients/family. The listening and learning from the feedback to be shared by each department/directorate/division i.e., / 'you said, we did' / quality improvement projects.	• SMS provision for patient experience feedback will be launching in ED and all MIU's in February 2025. • PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing 'drop in' clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Need to have discussions with facilities around rooms. • Patient experience KPI's and common themes by department/directorate/division need to be identified and pulled from the civica system left on surveys feedback. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation. • Development of a ABUHB bereavement survey has been built within CIVICA and tested. Launch date likely early 2025.
Level 2 Organisational *(Executed by risk management and compliance functions)*		
• Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee • Implemented PALS DATIX Module	None	N/A
Level 3 Independent *(Implemented by both auditors internal and external independent bodies)*		
• Bi-monthly LLais Reports • HIW inspections • Advocacy reports	None	N/A

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

RISK THEME	COMPLIANCE AND SAFETY	
LINK TO IMTP SECTION 4: ENABLER	QUALITY	WORKFORCE & CULTURE

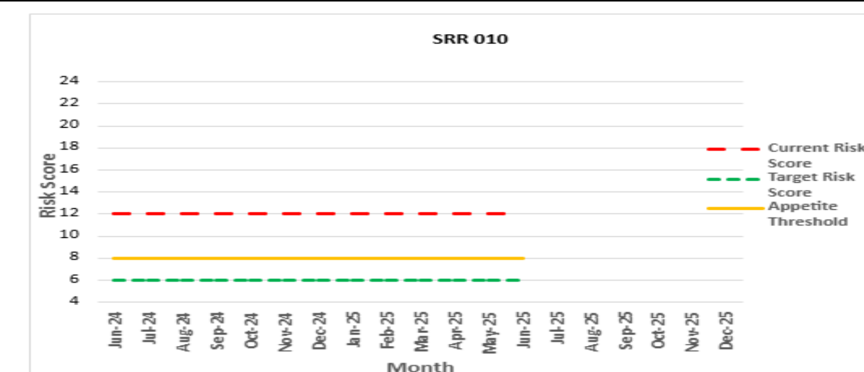
Strategic Risk: SRR 010	**There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974**	**Publication Status**	**Public**
Threat *(As a result of)*	**Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements**	**Risk Appetite Level – MINIMAL** Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below.	

Impact *(Consequences of the threat)*	**Patient**	**Staff**	**Organisation**
	• Unintended physical harm to patients • Psychological trauma	• Unintended physical harm to staff • Psychological trauma • Increased levels of staff sickness	• Punitive actions from the Health and Safety Executive (HSE) • Loss of estates due to unsafe environments • Financial implications • Adverse publicity • Reputational damage.

Risk Appetite Threshold – SCORE OF 8 or Below
Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls.

SUMMARY
The current risk level is **OUTSIDE** of target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold.

		Risk Exposure	Current Level	Target Level
Lead Director	Director of Allied Health Professions and Health Science			
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	**Likelihood**	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	01 December 2023	**Impact**	*4 (Major)*	3 (Moderate)
Last Reviewed	01 May 2025	**Risk rating**	**= 12** **(High)**	**= 6** **(Moderate)**
Next Review (Quarterly based on risk score)	01 Aug 2025			



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

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

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

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING
GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 July 2025
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Patient Quality, Safety and Outcomes Committee – Review of Committee Forward Work Plan 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Governance Support Officer

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Patient, Quality Safety and Outcomes Committee is asked to review the agreed Committee Forward Work Plan appended to this report. The Forward Work Plan has been developed with due regard to recommendations from the Committee Self-Assessment 2025/26 and to enable the Committee to: -

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

Cefndir / Background

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

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

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

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

Items Deferred on the Forward Work Plan

- At the agenda setting meeting for the Committee's July 2025 meeting, it was agreed to defer Maternity and Neonatal Report.
- At the agenda setting meeting for the Committee's July 2025 meeting, it was agreed to defer Health and Safety Compliance Annual Report to October 2025.

Additional items on the Forward Work Plan

- At the June 2025 meeting it was agreed to have an update on the Mortuary Incident action plan at the December 2025 meeting.
- At the June 2025 meeting it was agreed to have an update on development of local audit plans and funding arrangements at the December 2025 meeting.
- Due to the July 2025 meeting being cancelled it was agreed to have the following reports at the October 2025 meeting:
  - Learning from Death report
  - Safeguarding Annual report

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.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Annual Programme of Business for 2025-26

Patient, Quality, Safety and Outcomes Committee

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

- Aneurin Bevan University Health Board's Standing Orders;
- The Health Board's Integrated Medium-Term Plan and related Annual Delivery Plan;
- The outcomes of the Committee's self-assessment for 2023/24
- The Board's Strategic Risk Register; and
- Key statutory, national and best practice requirements and reporting arrangements.

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

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

MATTERS TO BE CONSIDERED	Lead	Frequency of Report	QTR 1		QTR 2	QTR 3		QTR 4
			31st March	**3rd June**	**29th July**	**1st Oct**	**2nd Dec**	**17th Feb**
Attendance and Apologies	Chair	SI	√	√	√	√	√	√
Declarations of Interest	All members	SI	√	√	√	√	√	√
Minutes of the Previous Meeting	Chair	SI	√	√	√	√	√	√
Action Log and Matters Arising	Chair	SI	√	√	√	√	√	√
Development of Committee Annual Programme of Business 2025/26	Chair & DoCG	AN	√				√	
Review of Committee Programme of Business 2025/26	Chair	SI	√	√	√	√	√	√
Annual Review of Committee Terms of Reference 2024/25	Chair & DoCG	AN	√				√	
Annual Review of Committee Effectiveness 2025/26	Chair & DOCG	AN	√				√	
Outcome of Annual Review of Committee Effectiveness 2025/26	Chair & DOCG	AN	√					√
Committee Annual Report 2025/26	Chair & DOCG	AN	√					

Committee Annual Report 2025/26	Chair & DOCG	AN						**√**
Committee Risk Report	DOCG	SI	**√**	**√**	**√**	**√**	**√**	**√**
NHS Wales Joint Commissioning Quality Committee Report	DOCG	SI	**√**	**√**	**√**	**√**	**√**	**√**
Quality Annual Report 2024/25	DoN	AN				**√**		
Quality Management System and Assurance Framework Annual Review	Clinical Executives	AN	**√**					**√**
Quality Outcomes Reporting	DoN /MD & DOTHS	Quarterly	**√ Interim**	**√ Q4**	**√ Q1**	**√ Interim**	**√ Q2**	**√ Q3**
Primary Care Quality Report	COO	Bi-AN				**√**		
Quality Management Group Reporting, including escalation through Quality Management System	DoN	SI	**√**	**√**	**√**	**√**	**√**	**√**
Healthcare Inspectorate Wales Annual Report	DoN	AN	**√**					
Healthcare Inspectorate Wales Reviews	DoN	As reported						
Commissioning Assurance Framework Annual Review	Clinical Executives	AN		**√**				
Commissioning for Quality Outcomes Report	Clinical Executives	Bi-An	**√**			**√**		
Putting Things Right Annual Report 2024/25	DoN	AN				**√**		
Maternity and Neonatal Report	DoN	Bi-An			**√D**			**√**

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

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