

Patient Quality, Safety & Outcomes Committee

Tue 02 June 2026, 13:30 - 16:00

Microsoft Teams



Agenda

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Oral Chair

1.2. Apologies for Absence

Oral Chair

1.3. Declarations of Interest

Oral Chair

1.4. Draft Minutes of the last Meeting held on 6th May 2026

Attached Chair

 PQSOC 20260602 1.4 PQSOC 20260506 Minutes - Draft.pdf (6 pages)

1.5. Committee Action Log

Attached Chair

 PQSOC 20260602 1.5 Committee Action Log.pdf (9 pages)

2. CONSENT AGENDA BUSINESS

2.1. The Chair will ask if there are any items from the Consent Agenda (Item 6) that Executive Team Members wish to bring forward to the main agenda for discussion

Oral Chair

3. ITEMS FOR DISCUSSION

3.1. Quality Outcomes Reporting

Attached Director of Nursing

 PQSOC 20260602 3.1 Quality Outcomes Report.pdf (7 pages)

 PQSOC 20260602 3.1 Quality Outcomes Report - Appendix 1 Quality Outcomes Framework - Q4 2025.26 FINAL.pdf (137 pages)

3.2. Quality Management Group Report

Attached Director of Nursing

 PQSOC 20260602 3.2 Quality Management Group Report.pdf (6 pages)

 PQSOC 20260602 3.2 Quality Management Group Report - Appendix 1 QMG Assurance Report.pdf (8 pages)

 PQSOC 20260602 3.2 Quality Management Group Report- Appendix 2.pdf (4 pages)

3.3. National Clinical Audit: Activity Report 2025/2026 and Annual Audit Plan 2026/27

Attached Medical Director

-  PQSOC 20260602 3.3 Clinical Audit Activity Report.pdf (7 pages)
-  PQSOC 20260602 3.3 National Clinical Audit - Appendix 1.pdf (129 pages)
-  PQSOC 20260602 3.3 National Clinical Audit - Appendix 2 - National Clinical Audit Plan 2026.2027.pdf (16 pages)

3.4. Healthcare Inspectorate Wales (HIW) Reports Update

Attached Director of Nursing

-  PQSOC 20260602 3.4 Healthcare Inspectorate Wales Reports Update.pdf (6 pages)
-  PQSOC 20260602 3.4 Healthcare Inspectorate Wales Reports Update - Appendix 1 - Summary of Pending HIW Inspection Actions.pdf (11 pages)

3.5. Update on neonatal services, including progress on listening and lessons learned activity and the forthcoming national review

Attached Director of Nursing

-  PQSOC 20260602 3.5 Update on neonatal services.pdf (11 pages)

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

Attached Director of Nursing

-  PQSOC 20260602 3.6 WRP Penalties and Learning Compliance.pdf (7 pages)

3.7. Committee Risk Report

Attached Director of Corporate Governance

-  PQSOC 20260602 3.7 Committee Risk Report.pdf (5 pages)
-  PQSOC 20260602 3.7 Committee Risk Report - Appendix A - Strategic Risk Assessments.pdf (8 pages)

4. FOR INFORMATION

4.1. Review of Committee Programme of Business 2026/27

Attached Director of Corporate Governance

-  PQSOC 20260602 4.1 Review of Committee Forward Work Plan 2026-27 Report.pdf (4 pages)
-  PQSOC 20260602 4.1 Review of Committee Forward Work Plan 2026-27 - Appendix 1 Forward Work Plan 2026-27.pdf (7 pages)

4.2. NHS Wales Joint Commissioning Quality Committee Report

Attached Director of Corporate Governance

-  PQSOC 20260602 4.2 HIW Operational Plan 2026-2027.pdf (2 pages)
-  PQSOC 20260602 4.2 HIW Operational Plan 2026-2027 - Appendix 1.pdf (15 pages)

5. OTHER MATTERS

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

Oral Chair

5.2. Any Other Urgent Business

Oral Chair

5.3. Date of the Next Meeting: 28th July 2026

6. CONSENT AGENDA - FOR NOTING

6.1. Planned Care - Orthopaedics / Impact of Bone Cement Shortage – Action from Exec Committee

Attached *Chief Operating Officer*

 PQSOC 20260602 6.1 Planned Care - Orthopaedics - Impact of Bone Cement Shortage.pdf (3 pages)

 PQSOC 20260602 6.1 Planned Care - Orthopaedics- Impact of Bone Cement Shortage - Appendix 1.pdf (4 pages)

6.2. Unplanned Caesarean Sections Data

Attached *Director of Nursing*

 PQSOC 20260602 6.2 Unplanned Caesarean Sections Data.pdf (6 pages)

6.3. Deep Dive into National Reportable Incident processes and performance

Attached *Director of Nursing*

 PQSOC 20260602 6.3 Deep Dive into National Reportable Incident processes and performance.pdf (7 pages)



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

**MINUTES OF THE PATIENT QUALITY, SAFETY
AND OUTCOMES COMMITTEE MEETING**

DATE OF MEETING	Wednesday 6 th May 2026, 12:30PM-13:30PM
VENUE	Conference Centre, St Cadoc's HQ/ Microsoft Teams

PRESENT	Penny Jones, Vice Chair William Smart, ABUHB Vice Chair Philip Robson, Special Advisor Paul Deneen, Independent Member Vivek Goel, Independent Member
IN ATTENDANCE	Jennifer Winslade, Director of Nursing Seema Srivastava, Medical Director Peter Carr, Director of Allied Health Professions & Health Science Kye Smith, Deputy Head of Quality and Patient Safety (item 2.1) Leeanne Lewis, Assistant Director for Quality and Patient Safety (Item 2.2) Bryony Codd, Head of Corporate Governance Fern Woodhead, Committee Secretariat
OBSVERING	None
APOLOGIES	Rani Dash, Director of Corporate Governance Helen Sweetland, Chair Naomi Murtagh, Board Business Manager

PQSOC 0605/01	Welcome and Introductions The Chair welcomed everyone to the meeting.
PQSOC 0605/02	Apologies for Absence The Chair noted the apologies for absence.
PQSOC 0605/03	Declarations of Interest There were no declarations of interest raised relating to items on the agenda.
PQSOC 0605/04	Minutes of the previous meeting The minutes of the Patient Quality, Safety and Outcomes Committee held on 17 th February 2026 were agreed as a true and accurate record of the meeting.

	The Committee APPROVED the draft minutes.
PQSOC 0605/05	Quality Outcomes Report – Qlik App Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the report, setting out the development of the Qlik analytics platform as part of the Health Board’s wider Quality Strategy and Quality Management System. JW advised that the work represented a key step in moving from traditional data reporting towards more meaningful intelligence, enabling improved focus on areas requiring action, variation in performance, and opportunities for improvement. It was emphasised that whilst data and intelligence were critical, triangulation with staff and patient experience remained essential to provide a comprehensive view of quality and safety. The Committee was advised that the Qlik platform would support the evaluation of the current Quality Management System and inform the development of a refreshed Quality Strategy, due to be presented to the Board in January 2027. Kye Smith (KS), Deputy Head of Quality and Patient Safety, provided the Committee with a detailed overview of the Qlik system and its implementation. KS advised that the platform had been commissioned in November 2024 in collaboration with the Informatics Service and brought together data from multiple systems into a single environment, including incident reporting, complaints, and patient feedback. KS highlighted to the Committee that the system enabled advanced analytics, including trend analysis, forecasting, and the use of Statistical Process Control (SPC) charts, supporting the differentiation between normal variation and statistically significant change. The Committee was advised that the first phase, including integration of Datix data, had been completed, and that further datasets, such as Welsh Nursing Care Record and CareFlow, would be incorporated over time. The Committee received a live demonstration of the system, which illustrated how data could be interrogated across organisational, divisional, and ward levels. KS provided examples of how the tool could be used to explore incident trends, including falls and medication-

	related incidents, and to support targeted quality improvement interventions. The Committee noted the significant benefits of the platform in improving consistency and reducing the reliance on manual data compilation. It was recognised that the system would enable both corporate oversight and local ownership of data, with ward teams able to directly access and monitor their performance. The Committee discussed the importance of training and capability development to support effective use of the platform, particularly in relation to interpreting SPC charts. KS outlined that training programmes were being developed and delivered across staff groups, with a phased rollout to divisional teams, senior nurses, and ward managers. The Committee also considered how the platform would be used at Board level, including whether it would replace or supplement existing static reports. It was confirmed that a corporate dashboard was under development for Committee and Board use, though further work was required to validate data and refine calculations before full implementation. The Committee was advised that the system remained in development, with user acceptance testing ongoing. It was agreed that a timeline for full implementation and rollout would be presented to a future meeting. Action: Director of Nursing. The Committee welcomed the progress made to date, recognising the platform as a significant enabler for improving quality intelligence, strengthening triangulation of data, and supporting a culture of continuous improvement across the organisation. The Committee NOTED the current progress in implementing the Qlik analytics platform.
PQSOC 0605/06	Learning from Death Report Seema Srivastava (SS), Medical Director, provided the Committee with an overview of the report, advising that it was the biannual Learning from Deaths report which sought to provide assurance in relation to mortality outcomes, learning, and improvement across the Health Board. SS outlined that the report triangulated intelligence from multiple sources, including Medical Examiner

scrutiny, Mortality and Morbidity reviews, complaints, inquests, and benchmarking data, to establish whether any deaths reflected avoidable harm, emerging clinical risks, or wider system issues.

Leeanne Lewis (LL), Assistant Director for Quality and Patient Safety, provided a summary of the key findings. LL advised that this was the fourth Learning from Deaths report, with a particular focus on strengthening organisational learning through structured case note reviews and targeted deep dive exercises.

The Committee was advised that a programme of structured case note reviews had been undertaken in specialties with higher than expected mortality, alongside a surveillance exercise in collaboration with Public Health. A total of 77 case notes had been reviewed as part of the Public Health exercise, with no patterns of unsafe clinical decision-making identified. The majority of deaths were associated with frailty, advanced illness, or palliative care needs, and the quality of care had been assessed as consistently good, with only minor issues identified that did not impact clinical outcomes.

Further structured reviews, totalling 270 cases across key specialties, had also been undertaken. LL advised that these had identified a high standard of care overall, with no evidence of unsafe or negligent practice. A small number of cases had identified opportunities for learning, which had been fed back to directorates to support continuous improvement.

LL highlighted to the Committee that mortality indicators provided strong assurance, with the Risk Adjusted Mortality Index (RAMI) reported at 88.4 for the period, indicating performance better than expected and ranking the Health Board among the strongest performers in Wales. It was noted that a transition to RAMI 2023 would result in a slight increase in the reported figure but remained in line with national peers.

The Committee noted that crude mortality remained stable with a downward trend and that key condition-specific indicators were performing in line with or better than peers. Importantly, there were no mortality indicators requiring escalation and no evidence of hidden clinical risk or avoidable harm.

LL drew attention to key learning themes identified through the review process, including improvements

	required in data quality and clinical coding, communication and care planning particularly in relation to end-of-life care, and the management of deteriorating patients. These themes would be integrated into existing governance structures and work programmes to support ongoing improvement. The Committee discussed the report in detail and welcomed the triangulated approach to mortality intelligence, recognising the added value this provided in complementing time-based performance metrics and strengthening assurance. The importance of accurate clinical coding and data quality was highlighted, particularly in relation to the correct attribution of cases to clinicians, with LL confirming that improvement work was underway and regularly monitored. Th Committee discussed the level of reporting, with clarification provided that mortality was monitored at organisational and divisional levels, and that site-level analysis was available where required but had not added additional assurance in routine reporting. In relation to patient experience, The Committee explored the impact of Medical Examiner processes on bereavement timelines. LL advised that the Health Board was operating within required performance standards and continued to work collaboratively to improve timeliness and the overall experience for bereaved families. The Committee further noted an identified issue regarding delays in completion of discharge death notifications. LL advised that a corporate audit had been proposed to further explore this issue and inform improvement actions. Overall, The Committee expressed strong support for the report, recognising it as providing a high level of assurance and demonstrating a maturing approach to mortality governance and organisational learning. The Committee NOTED the Learning from Deaths report.
PQSOC 0605/07	To confirm any key risks and issues for reporting/escalation to Board and/or other Committees There were no matters from the meeting that required escalation or formal notification to the Board and other relevant committees.
PQSOC 0605/08	Any Other Urgent Business

	There was no urgent business.
PQSOC 0605/09	Date of the Next Meeting: 2 nd June 2026

DRAFT

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**ANEURIN BEVAN UNIVERSITY HEALTH BOARD
MEETING**

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

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2026	PQSOC 1702/06	Quality Outcomes Report Further work would be undertaken to analyse physical assault data, including whether incidents related to repeat individuals or specific wards, and this would be brought back to the Committee.	Director of Allied Health Professions & Health Science	April 2026	Completed <u>March update</u> Action has been included in the Committee forward work plan. This would be an oral update under the Committee action log item at April's meeting Update: Data on violence and aggression incidents

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Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
					(involving staff and public) will be analysed to identify trends around repeat perpetrators and location of incident. This analysis will be incorporated (where relevant and useful) in the routine quality reports that include Health & Safety data.

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Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2026	PQSOC1702/07	Quality Management Group Reporting A more detailed report on redress and the Legal and Financial Exposure Review (LFER) process could be brought back to the Committee for discussion.	Director of Nursing	April 2026	Completed <u>March update</u> Action has been included in the Committee forward work plan. <u>May update</u> This has been included on June's agenda due to April's meeting being cancelled.

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Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2026	PQSOC1702/08	Maternity and Neonatal Report A further review of the unplanned caesarean sections data and additional information on the increase of unplanned caesarean sections to be brought to the Committee.	Director of Nursing	April 2026	Completed <u>March update</u> Action has been included in the Committee forward work plan. <u>May update</u> This has been included on June's agenda due to April's meeting being cancelled.

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Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2026	PQSOC1702/08	Maternity and Neonatal Report A further update on neonatal services at the next meeting, including progress on listening and lessons learned activity and the forthcoming national review	Director of Nursing	April 2026	Completed <u>March update</u> Action has been included in the Committee forward work plan. Agreed at the agenda setting meeting that the update would be present to Board in March's meeting.

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Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2026	PQSOC1702/10	Healthcare Inspectorate Wales (HIW) Reports Update Regular scheduled updates on HIW reporting was agreed for twice yearly.	Committee Secretariat	April 2026	Completed <u>March update</u> Bi annual updates has been included in the Committee forward work plan.

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Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2026	PQSOC1702/15	Development of Committee Annual Programme of Business 2026/27 Pharmacy and Medicines Annual Report to be included in the 2026/27 Forward Work Plan to ensure appropriate Committee oversight of medicines safety and related quality assurance.	Committee Secretariat	April 2026	Completed <u>March update</u> The Pharmacy and Medicines Annual Report has included in the Committee forward work plan.

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Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
February 2026	PQSOC1702/11	Putting Things Right Regulations Update The Committee requested an update on progress with these new PTR regulations later in the year.	Director of Nursing	April 2026	Completed <u>March update</u> Action has been included in the Committee forward work plan for June 2026.

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Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
May 2026	PQSOC0605/05	Quality Outcomes Report – Qlik App A timeline for full implementation and rollout of the Qlik App would be presented to a future meeting.	Director of Nursing	July 2026	Completed <u>May update</u> Action been included on the Committee Forward work plan for July's meeting.

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

Once the Committee is assured that an action is complete, it will be removed. This will be agreed at each Committee meeting.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	02 June 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Quality Outcomes Framework (QOF) for Q4 January to March 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis – Assistant Director for Quality and Patient Safety Tracey Partridge Wilson - Deputy Director of Nursing

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA **SBAR REPORT**

Sefyllfa / Situation

As an NHS Wales organisation, the Health Board continues to operate within the statutory framework of the *Health and Social Care (Quality and Engagement) (Wales) Act 2020* and the national vision set out in *A Healthier Wales*. These frameworks reinforce our collective responsibility to demonstrate continuous improvement in quality, safety, and patient experience through a mature and embedded Quality Management System (QMS).

During Quarter Four (Q4), the Quality Outcomes Framework (QOF) has continued to strengthen assurance to the Board, Patient Quality, Safety and Outcomes Committee (PQSOC), and Quality Management Group (QMG), providing a comprehensive view of performance across the six Pillars of Quality. The framework remains central to identifying risk, tracking improvement, and supporting data-driven decision-making.

Cefndir / Background

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

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

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

Q4 has been characterised by sustained system pressure following winter demand, with continued impact on patient flow, workforce capacity, and operational resilience. Despite this, there are clear indicators of stability and improvement across a number of domains, including:

- Sustained patient satisfaction and engagement through CIVICA feedback
- Continued reduction in healthcare-associated harms, including pressure ulcers and infections
- Strengthened governance and improved compliance in patient safety investigations
- Ongoing maturity in mortality oversight and triangulated learning from deaths

However, the quarter also highlights emerging risks and areas requiring continued focus, including increased complexity of safeguarding demand, continued pressures on timely care pathways, and challenges in workforce training compliance and system capacity.



Asesiad / Assessment

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

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

Patient & Staff Experience, Complaints, Concerns and Compliments

Q4 demonstrates sustained engagement with patient experience systems, reflecting both organisational accessibility and a maturing culture of listening and learning.

- CIVICA patient feedback remains strong, with overall satisfaction at 87%, consistent across the quarter.
- Feedback volumes continue to increase, with over 7,150 responses recorded during Q4, indicating improved reach and engagement.
- Waiting times remain the lowest scoring domain (73), with a slight deterioration in March, reflecting ongoing system pressures.

Patient feedback continues to identify:

- Strong compassionate care and staff interaction
- Ongoing challenges related to access and timeliness
- Communication as a predominant theme across PALS enquiries

Operationally:

- Complaint volumes have increased significantly (notably a 90% increase in February compared to the previous year), impacting compliance performance
- Early Resolution remains strong with continued high compliance and minimal reopening of cases
- Improvements in oversight and escalation processes are strengthening organisational grip

Overall, the Health Board continues to demonstrate a responsive, learning-focused approach to patient experience, with tangible actions being taken in response to feedback themes.

Patient Safety and Incident Reporting

Patient safety performance in Q4 reflects a system maintaining core safety standards despite sustained operational pressure.

Key highlights include:

- Continued increase in Datix reporting, reaching 33,711 incidents in 2025/26, largely driven by no-harm incidents and improved reporting culture rather than deterioration in care
- Mortality indicators remain stable, although early Q4 RAMI (January) shows an increase (119.21), consistent with known seasonal variation and requiring cautious interpretation due to coding lag
- Falls rates remain below the national average, despite a slight increase in Q4 attributable to higher occupied bed days



- Continued reduction in healthcare-acquired pressure ulcers over the two-year trend, with ongoing collaborative improvement work

Governance improvements include:

- Significant reduction in overdue NRIs (from 32 to 17 over 12 months)
- Sustained compliance of >60% in patient safety investigations
- Reduction in Early Warning Notifications compared to the previous year (25 vs 51), suggesting improved local management
- Ongoing work on never events
- Strengthened PSI oversight through daily rapid review processes and enhanced dashboards

Overall, patient safety systems are demonstrating improved maturity, with stronger processes for incident management, investigation, and learning.

Clinical Effectiveness

Q4 reflects strong continued progress in clinical effectiveness, particularly in standardisation and national compliance.

- Ward accreditation has progressed, with additional bronze and silver accreditations achieved, although pace remains impacted by operational pressures
- Implementation of Early Warning Scores (NEWS2, PEWS, NEWTT2) is complete, with MEWS planned for May 2026
- Sepsis programme delivery remains a significant strength, including:
 - National tool implementation
 - High-reach awareness campaign
 - Transition into Phase 2 focused on reliability, audit, and sustained There is clear evidence of:
- Strong alignment to Welsh Health Circular requirements
- Embedded governance through audit, mortality review, and incident learning
- Growing emphasis on consistency and system-wide reliability

This reflects a maturing clinical effectiveness framework, with clear line of sight from policy to practice and assurance.

Health, Safety, Security and Compliance

Performance in Q4 demonstrates stability, with some areas of improvement and others requiring continued focus.

- RIDDOR compliance remains stable (~73%) with improved reporting processes
- Statutory training compliance shows:
 - Stable performance in Health & Safety and Fire Safety
 - Continued decline in Manual Handling compliance to 64.9%, requiring targeted recovery

Workforce safety themes:

- Increase in physical assaults (276 incidents in Q4)
- Reduction in sharps injuries
- Increase in slips/trips, likely related to seasonal/environmental factors

The Health Board is responding through:

- Violence Prevention & Reduction strategy
- Targeted QI work (e.g. sharps injury reduction)
- Revised SOPs and training programmes



Infection Prevention & Control (IPAC)

Q4 presents a stable but pressured IPAC environment, with strong overall performance.

- Continued reduction in key infections:
 - C. difficile – 250 cases (25 fewer than previous year)
 - Staph aureus BSI – 157 cases (32 fewer than previous year)
- Some increases noted in:
 - E. coli BSI
 - Klebsiella BSI

Winter pressures had a significant impact due to:

- Norovirus outbreaks (26 ward closures; 7 in March)
- Increased respiratory virus burden affecting isolation capacity

Antimicrobial stewardship remains a key area of focus, with:

- Challenges in achieving 'Access category' prescribing target
- Improvements underway through EPMA, order sets, and audit

Safeguarding

Safeguarding activity in Q4 continues to reflect increasing complexity rather than volume growth.

- Children's safeguarding activity remains high, with sustained system pressure
- Adult Duty to Report referrals have reduced
- Increasing complexity seen across MARAC cases, driven by reduced third-sector capacity

Key themes:

- Increasing referrals for Persons in Positions of Trust
- Rising demand for advice and support
- Continued challenge in achieving Level 3 training compliance

VAWDASV training remains below target at ~76%, requiring continued focus and escalation.

Areas of Improvement

Q4 saw several areas of meaningful progress:

- Sustained high patient satisfaction despite operational pressures
- Continued reduction in healthcare-associated harm
- Improved NRI compliance and reduction in overdue cases
- Strong progress in sepsis and deteriorating patient programmes
- Enhanced governance through improved reporting and triangulation

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.

- Timeliness of care and waiting time experience
- PTR compliance under increasing demand
- Manual handling and safeguarding training compliance
- Antimicrobial stewardship and prescribing patterns
- Isolation capacity under winter pressure



- Increasing safeguarding complexity and system demand
- Workforce pressures impacting delivery and improvement pace

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

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

Argymhelliad/ Recommendation

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

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable currently
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 5. Timely Care 6.3 Listening and Learning from Feedback Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives	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.

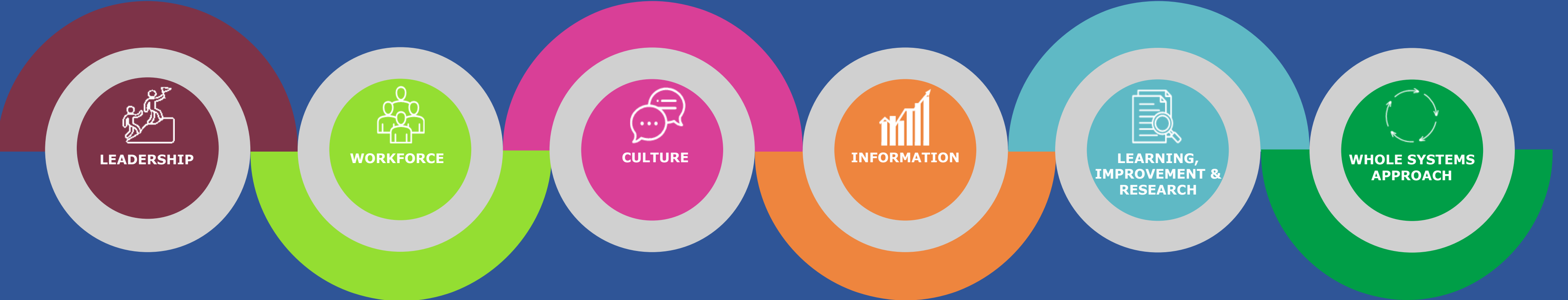


Strategic Equality Objectives 2020-24	Choose an item. Choose an item.

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.





Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Quality Outcomes Framework

Quarter Four - 2025/26



The Quality Outcomes Framework

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

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

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

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

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

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

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

Revised Pillars of Quality



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

PILLAR 1

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

Civica

Collaboratives Forums

Patient Stories

PTR Regulations

Early resolution

Staff Training and Mentorship (IO)

Volunteering

Patient Advice and Liaison Service (PALS)

Leadership, Accountability and Culture

Complaints PSOW – Themes and Learning

Speaking up Safely

Cultural Competence Accreditation Scheme

Dementia Standards

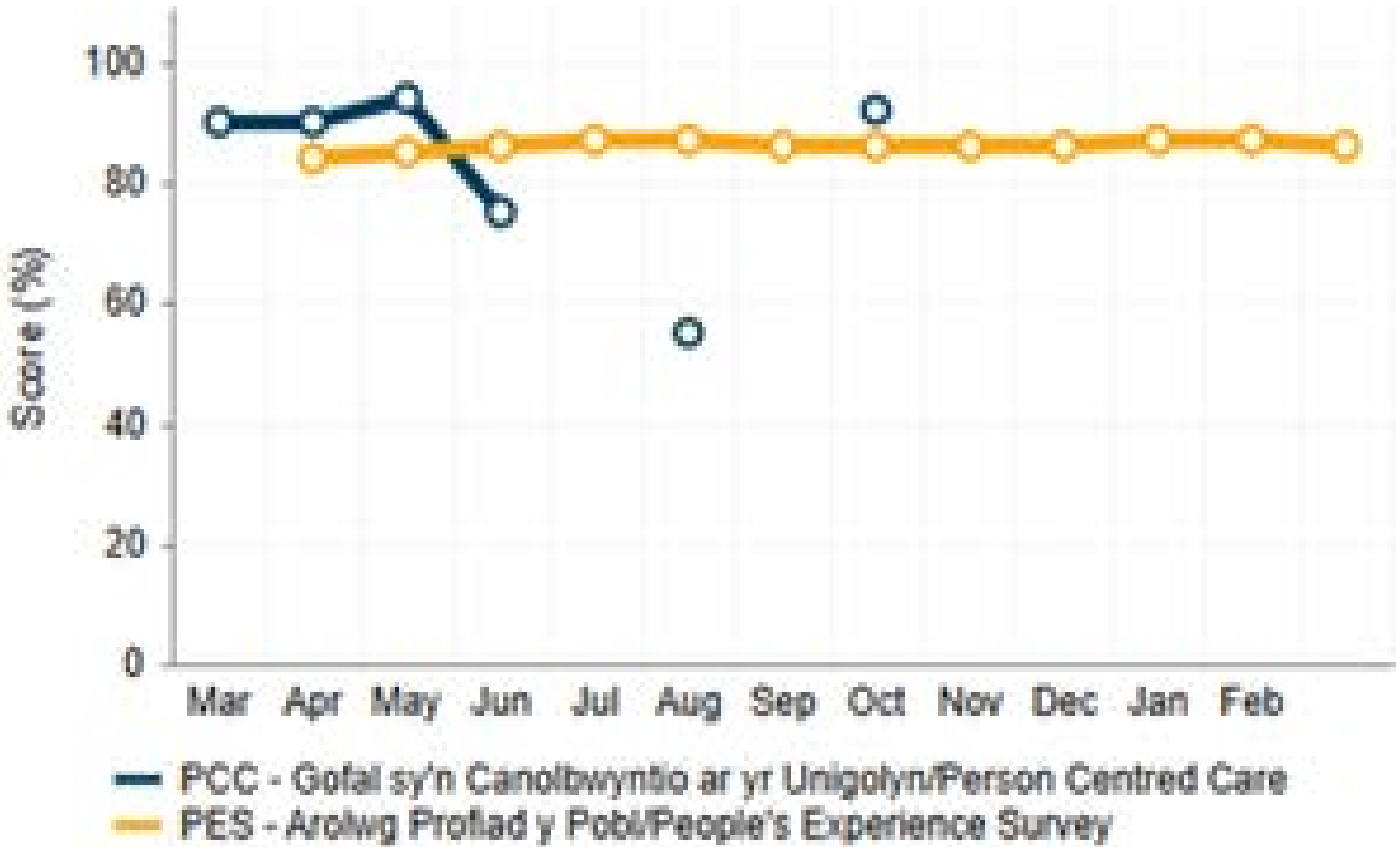
Listening and Learning Meetings

CIVICA Patient Experience Feedback

Responses to Patient Experience Questionnaire



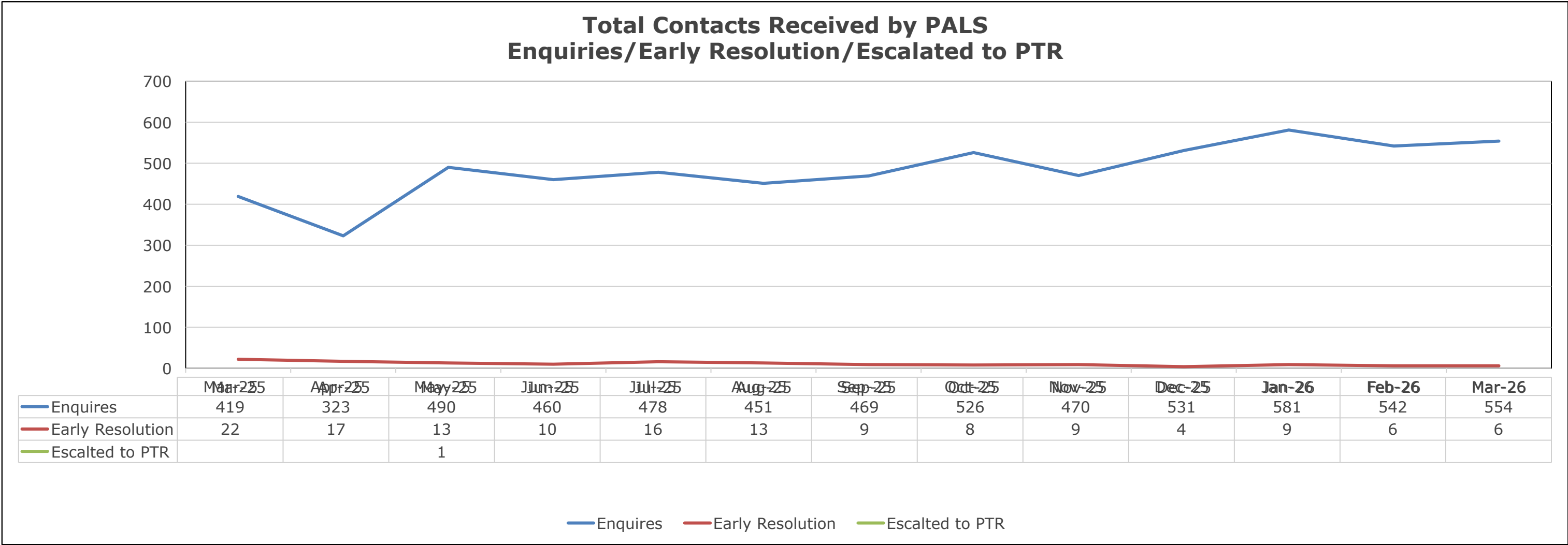
Satisfaction Score Trend



All Surveys		Person Centred Care (PCC) & People's Experience (PES)		ED - ED Survey & PES Combined		Maternity & Neonates Surveys (Launched Sept 2025)		Total YTD (April – March)	
30039 Responses	86% Satisfaction	26809 Responses	86% Satisfaction	7282 Responses	76% Satisfaction	1291 Responses	85% Satisfaction	28160 Responses	86% Satisfaction

Definition	Analysis	Implications
All data displayed has been extracted from CIVICA and is correct at the point of extraction on 07 April 2026. Surveys that were already sent (paper and text message) may be completed later giving the impression of data changing.	The number of responses to all Experience Survey (PES) notably increased in May 2025, this increase was primarily due to more engagement from SMS responses. The number of responses to Patient Experience Questionnaires have has fluctuations within Q4 2025/26 but March saw a positive increase. 7150 responses were provided in Q4, compared with 7128 in Q3. The overall satisfaction score has remained static throughout 2025/26.	Preparing the All-Wales National Endoscopy Survey for April 2026, with launch via SMS to follow; work to launch All Wales Research Survey continues. Implementing the National Survey for the new Listening to People process for April 2026, including additional languages and BSL; developing an Easy Read version and continuing to address CIVICA SMS delays. Challenges exist in capturing the work divisions have undertaken in response to patient questionnaires and remains a priority for 2026/27.

Patient Advice & Liaison Service (PALS)



Themes	Count
Communication Issues (including Language)	3165
Access (to Services)	1543
Appointments	444
Clinical treatment/ Assessment	237
Patient Care	235
Discharge Issues	140
Post Death Issues	103
Complaints Handling	79
Record Keeping	68
Admissions	40

Definition	Analysis	Implications
This data is obtained from the Once 4 Wales RL Datix system, which is populated by the Health Board’s Patient Experience Team. The table (right) shows the enquiry themes from March 2025 to March 2025. The data is live and is an ever-evolving picture the information stated is accurate at the point of extraction.	A general increase in the number of enquires managed by PALS can be seen throughout 2025/26, with 1,677 enquiries seen in Q4, compared to 1,465 in Q3. The number of cases that end in a formal complaints (PTR/LTP) process remains extremely low which is reflective of the teams ability to resolve concerns quickly and effectively. Communication difficulties remain the largest proportion of enquiries that the team take, followed by access to services and appointments.	The importance of proactive, clear and compassionate communication with patients to prevent uncertainty and anxiety continues to show within the PALS data and case studies. The requirement to strengthen the Health Board’s provision of British Sing Language has resulted in level 1 training for all of the PALS team. Advocacy support continues for vulnerable patients who require it.

Patient Advice & Liaison Service (PALS) Case Studies

Case Study 1:

Patient A, a 93-year-old man with mild cognitive impairment who was known to PALS, was admitted acutely, prompting his daughter to contact PALS due to concerns for his wellbeing and her inability to visit.

The PALS Officer attended, providing immediate reassurance and continuity by reminding the patient of previous contact. Practical support was given with eating and drinking, including sourcing a double-handled cup due to unsafe tremors, and supporting communication with nursing staff when the patient struggled to make himself understood.

The PALS Officer provided ongoing reassurance, companionship, and de-escalation support when the patient became confused and distressed.

Communication between staff and the patient's daughter was facilitated when clinical teams were unable to reach her, ensuring timely updates and reassurance. The daughter later contacted the service to praise the support provided, describing it as a "brilliant service" and expressing gratitude for the compassionate care and reassurance given to her father.

This case highlights the role of PALS in supporting vulnerable patients, improving communication, reducing anxiety, and providing compassionate, patient-centred care when family members are unable to be present.

Case Study 2:

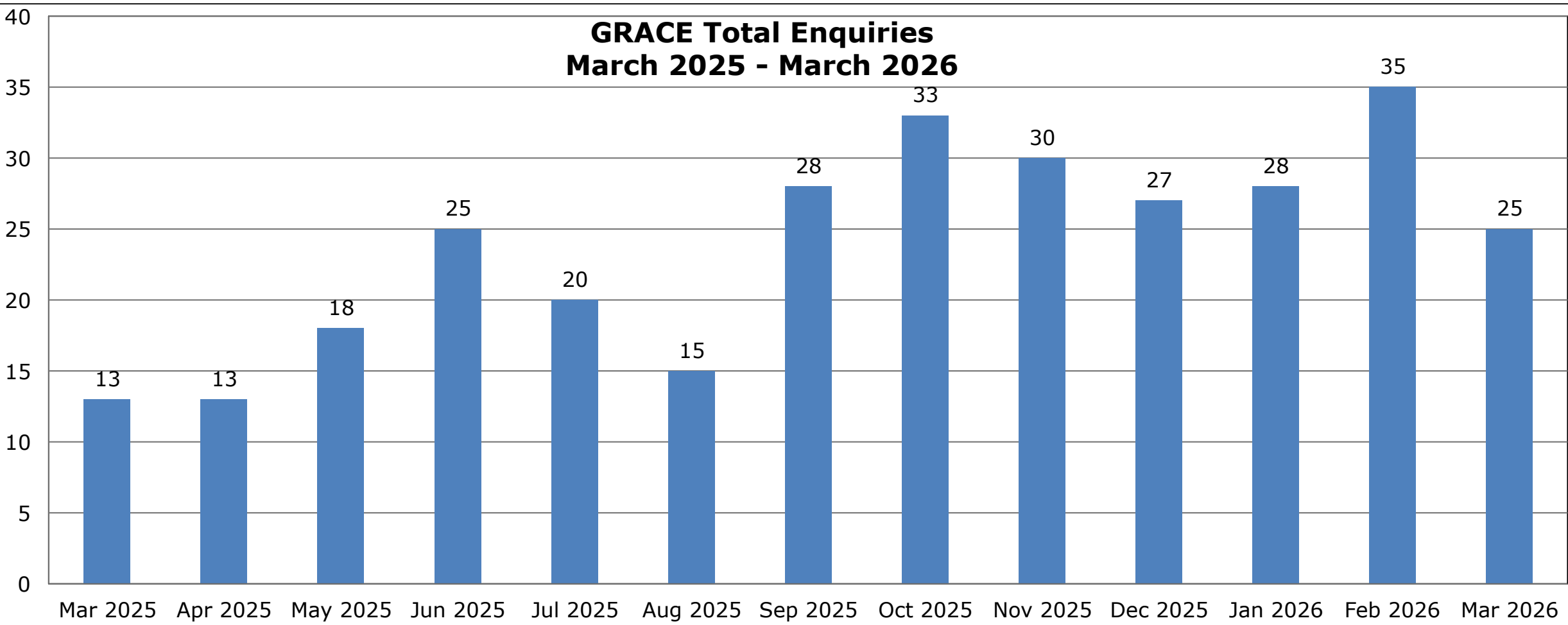
The mother of Patient B, a child under the Paediatrics service, contacted the PALS team requesting advocacy support due to concerns about delays in her child's treatment plan. She explained that communication with individual clinicians had been positive; however, she was concerned that clinical teams across Great Ormond Street Hospital, CAVUHB, and RGH were not communicating effectively with each other. She felt this lack of coordination was contributing to delays in establishing a clear treatment plan. It was identified that the clinical teams were awaiting EEG results, with the delay sitting within the Radiology reporting process. PALS liaised directly with the Radiology team to support escalation, resulting in the results being reported and uploaded promptly. This enabled the clinical teams to access all relevant information and proceed with a multidisciplinary discussion to agree the next steps in Patient B's care. As a result of PALS involvement, Patient B's mother felt reassured, gained clarity regarding the cause of the delays, and had a clear understanding of the next steps in her child's care. The clinical team also expressed their appreciation, noting they were now able to progress the treatment plan. Patient B remains under ongoing Paediatric care, and PALS continues to support the mother through regular contact, resulting in her feeling supported, informed, and reassured during a challenging time.

Case Study 3:

The mother of Patient C contacted the PALS team expressing significant concern regarding her child's ongoing bladder condition and the lack of support following discharge. She described her daughter's day-to-day life as extremely challenging, with frequent disruption to schooling and social activities, and reported making multiple attempts over several weeks to seek help without success. PALS listened to the mother's concerns, provided reassurance, and contacted the Bladder Team to seek clarity and escalate the issues raised. Following this escalation, the Bladder Team contacted the mother directly and discussed the situation in detail, resulting in a clear plan of care being agreed and communicated to the family.

The PALS Officer then contacted the mother to confirm the outcome. She expressed how relieved and grateful she felt, explaining that she had been considering private treatment due to the distress of seeing her daughter suffer and feeling she had no other options. As a result of PALS involvement, the family's concerns were resolved, a clear treatment plan was established, and the mother felt listened to, supported, and reassured. This case highlights the important role of PALS in advocating for families, resolving communication breakdowns, and supporting timely, patient-centred care.

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



Case Study 1:

The GRACE team were contacted by nursing staff at the hospital requesting support for a lady who was currently an inpatient and struggling with her grief following the loss of both her husband and her son, one year apart.

A member of the GRACE team visited her on the ward and listened empathetically as she spoke fondly about her loved ones, sharing memories as well as the circumstances surrounding their passing.

Although some parts of the conversation were understandably emotional, she expressed how grateful she was to have the time and space to talk openly.

The lady asked if she could meet with the same member of the GRACE team again, and whether this support could continue after her discharge to a residential home.

The GRACE team remain in contact with her and continue to offer support following her discharge.

Definition

This data is obtained from the Once 4 Wales RL Datix system, which is populated by the Health Board’s Patient Experience Team. The table (right) shows the enquiry themes from March 2025 to March 2025. The data is live and is an ever-evolving picture the information stated is accurate at the point of extraction.

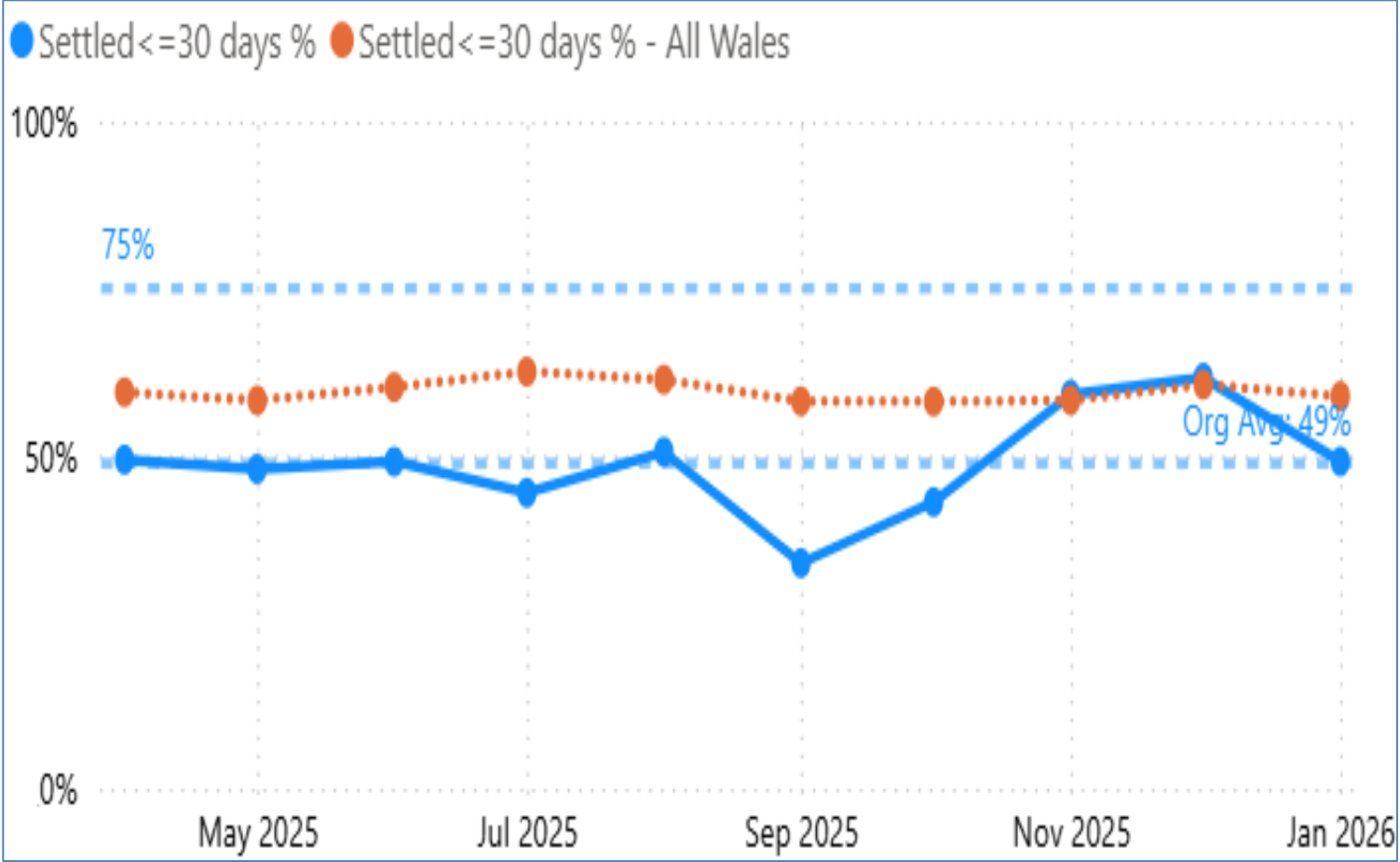
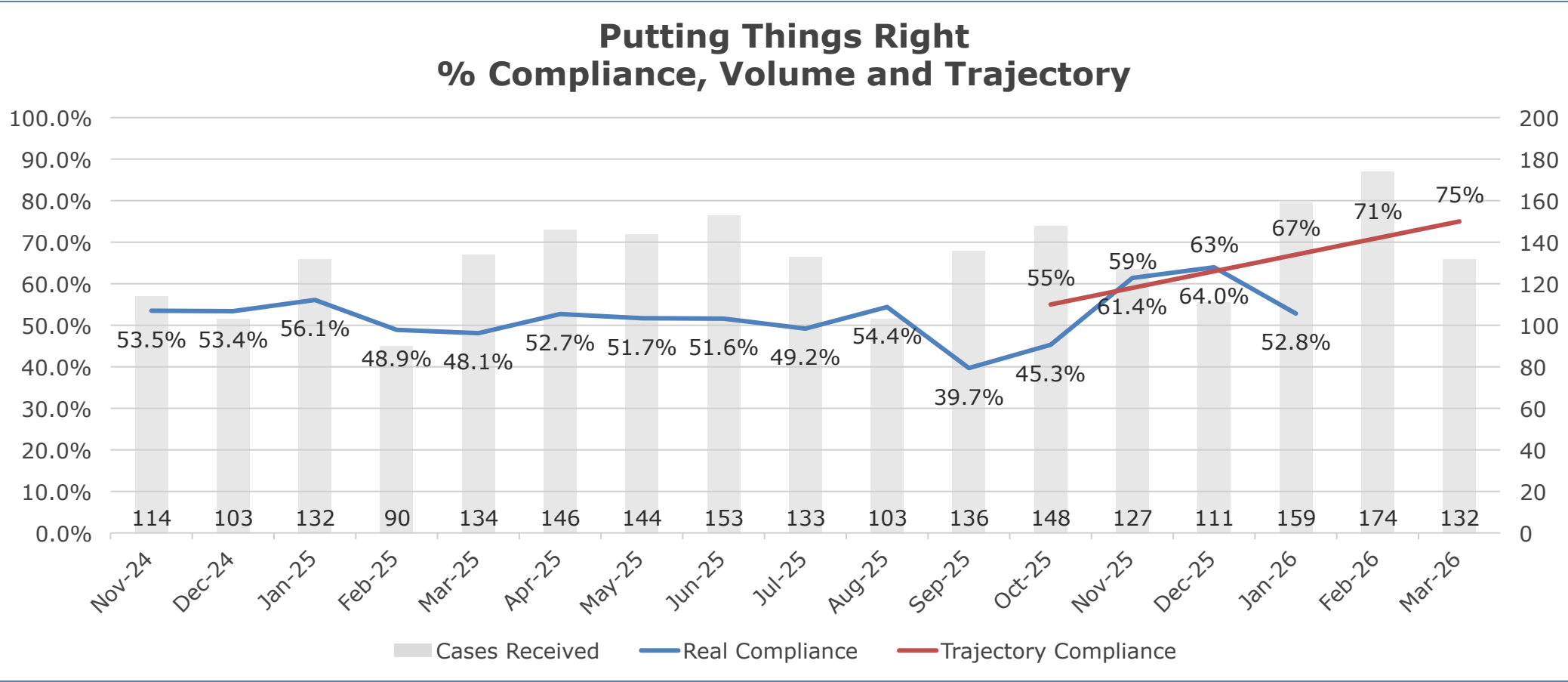
Analysis

The number of enquiries coming into the GRACE team have steadily increased through the past 13 months. The majority of these enquiries come directly from the service users from their own home but we continue to engage with people within the hospital at their request.

• Implications

- Support in preparing for end-of-life wishes, including future care planning
- Practical help with what to do when someone dies
- Referral to specialist services, such as counselling, spiritual care, or community bereavement groups
- Information and signposting to local and national resources
- Emotional support for individuals and families facing the end of life
- Bereavement guidance and compassionate conversations following a loss
- Support for staff involved in end-of-life care, promoting well-being and resilience

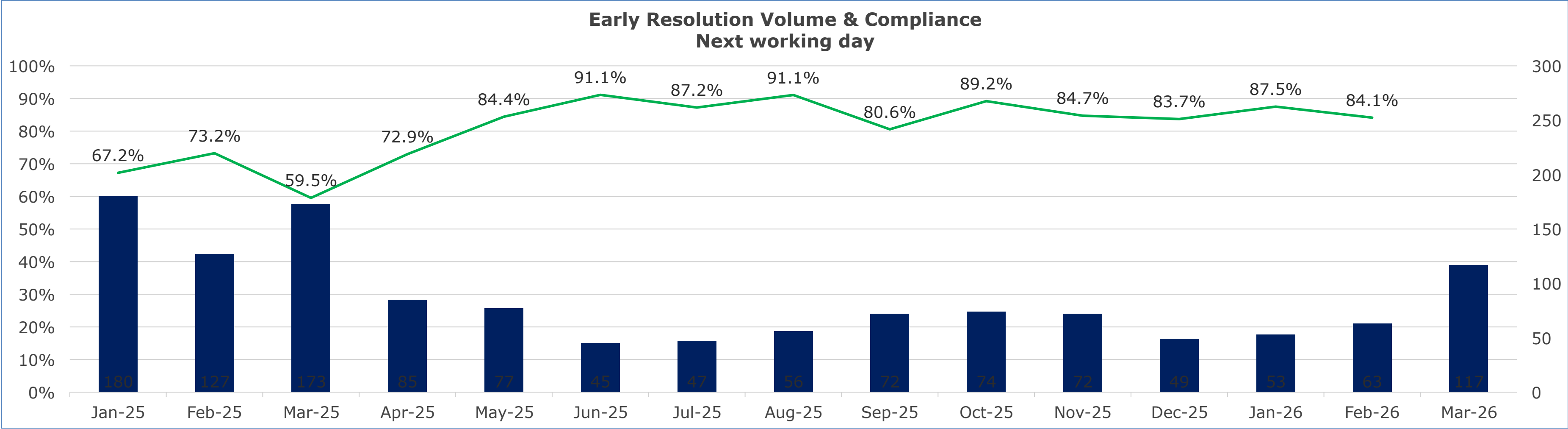
Putting Things Right
Compliance with 30-day Target



Definition	Analysis	Implications
The above represents the Health Board’s rolling position for compliance with the WG target of responding to concerns managed under Putting Things Right (PTR) (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 corporate PTR team. The data is live and is an ever-evolving picture the information stated is accurate as of 08 April 2026.	There was a slight decrease in January’s compliance which had been anticipated due to significant operational pressures across the Health Board, which was compounded by a notable increase in the number of complaints received. With a 90% increase in the number of complaints received this February compared to Feb 25. However, March’s compliance is expected to recover in excess of 60%. Positively, January saw the first time that the Health Board’s performance exceeded the national average for compliance.	Urgent Care, MH&LD achieved over 85% compliance and CSS achieved 75% in February. Focused weekly sessions continue with the LtP management team to monitor and escalate where required cases approaching compliance deadline to ensure those which can be achieved within timescale are being driven by the concerns support officers. Focus has been directed towards preparing for the rollout of the LtP regulations, which means some resources have been allocated to ensure readiness for its implementation

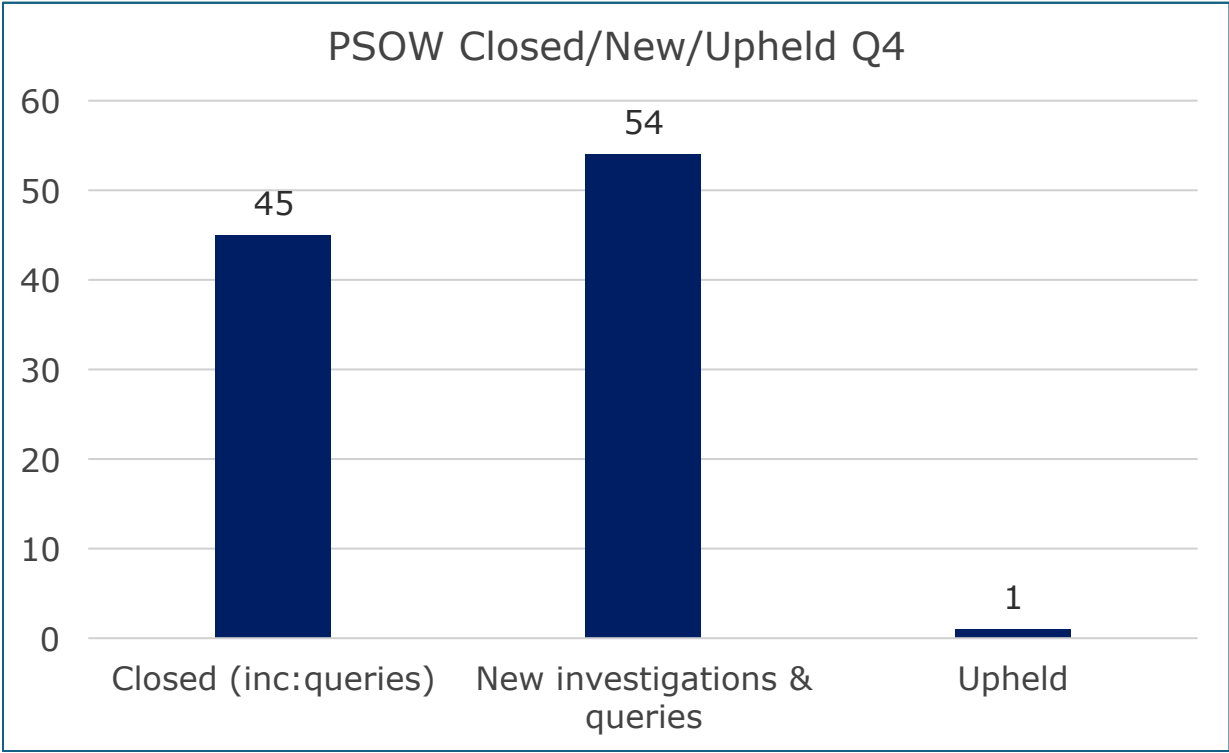
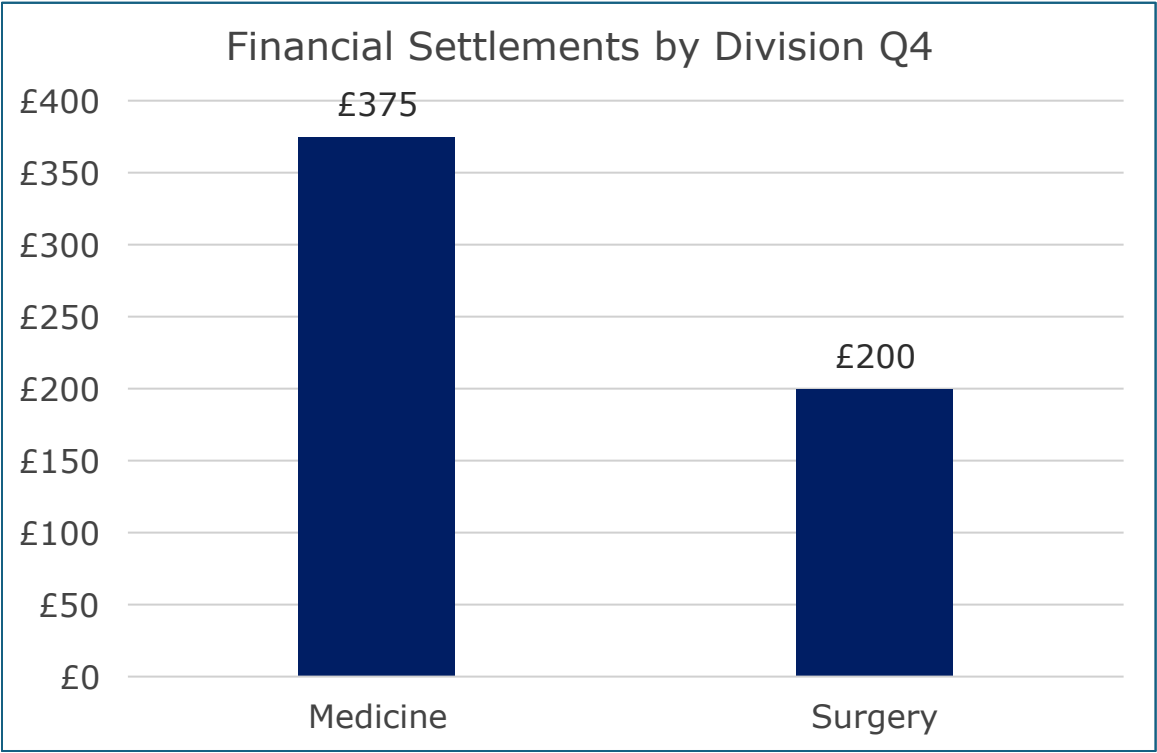
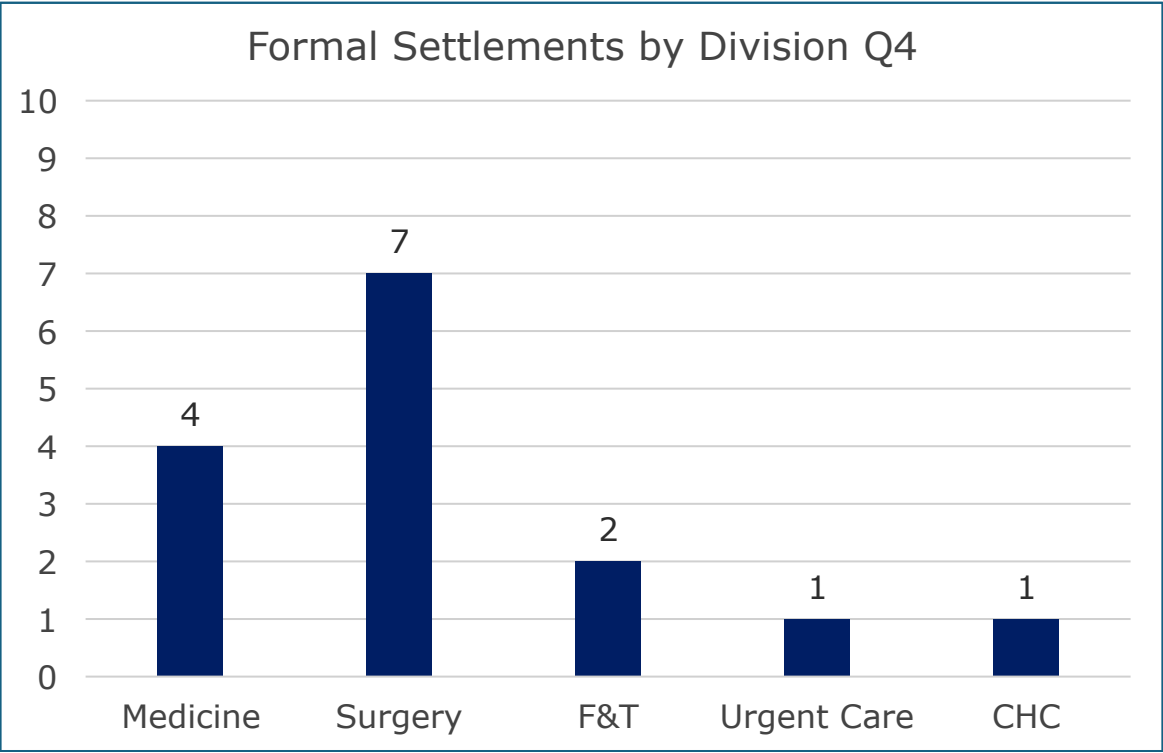
Early Resolution

Compliance with 2-day Target



Definition	Analysis	Implications
This data is obtained from the Once 4 Wales RL Datix system, which is populated by the corporate PTR team. The data is live and is an ever-evolving picture the information stated is accurate as of 08 April 2026.	Performance in Early Resolution (ER) has shown significant improvement compared to the previous year. In 2024/25 the Early Resolution compliance reached 59% across the year, so far, this financial year the average is 85%. This improved performance is a result of divisional engagement with the early resolution processes as well as enhanced support from the QPS team.	Early Resolution response times are considerably faster than formal processes and aim to resolve the issues raised by individuals through a more person-centred approach. Current timeframes do result in a number of matters being escalated formally. However, LtP will seek to improve this with a 10-working day timeframe – which will be implemented from 1 April 26. The Concerns Managers continue to meet with the concerns support officers every week to review open Early Resolution matters, to try and ensure that matters are remaining compliant wherever possible. However, the ability to manage these matters in this process requires the continued support and expertise of Divisional colleagues to provide information within pressurised timeframes.

Putting Things Right
Ombudsman (PSOW)



Learning and Completed Recommendations

Key Learning Points:

A concern was raised regarding the appropriateness of discharge procedures and the timing of referrals to mental health services in early 2024.
PSOW concluded.

The Ombudsman determined the discharge was premature and lacked proper planning, noting that specialist mental health involvement should have been sought prior to discharge.

Recommendations:

- a) Issue a formal apology for identified shortcomings.
- b) Provide financial compensation to acknowledge failings and interim management without adequate support.
- c) Communicate the findings to all relevant staff.
- d) Demonstrate that staff have completed compulsory training relating to mental capacity and deprivation of liberty safeguards.
- e) Escalate the report to the Health Board’s Quality and Safety Committee leadership.
- f) Implement structured discharge planning for patients with acquired brain injury.
- g) Ensure discharge planning processes are shared and adopted widely among clinicians.
- h) Establish regular reviews of post-discharge cases involving subsequent mental health detention, as part of quality improvement meetings.

Completed & Ongoing Actions:

The Health Board has agreed to provide evidence that training on mental capacity assessment and deprivation of liberty safeguards had been implemented. It also agreed to implement training and a number of service improvements around discharge planning processes aimed at addressing the causes of the failings in this case.

The HB has agreed to carry out an audit of capacity and deprivation of liberty safeguarding assessments completed within the previous year and to address any failings identified as a result.

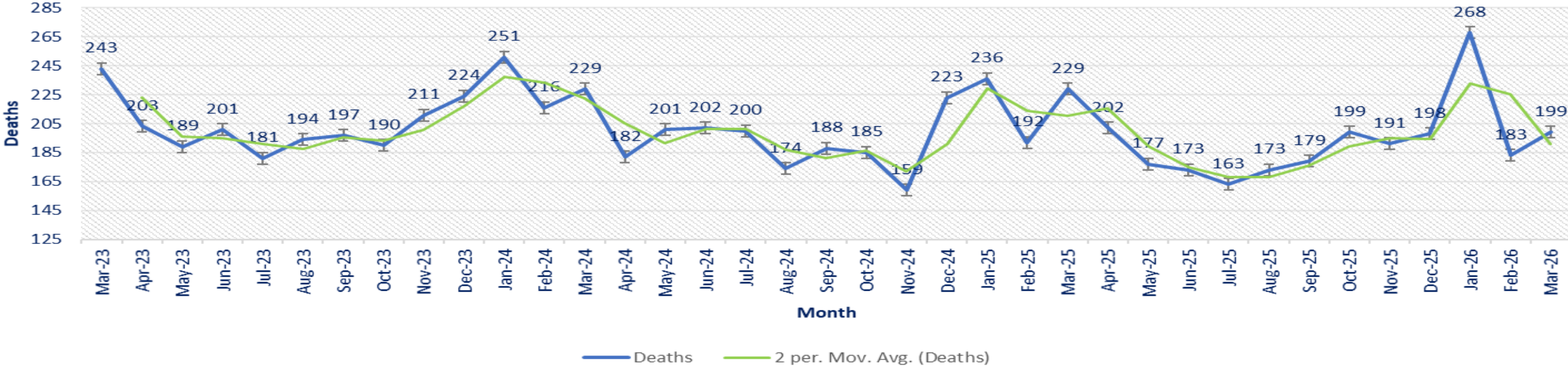
PILLAR 2

**Patient Safety including
Incident Reporting**

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

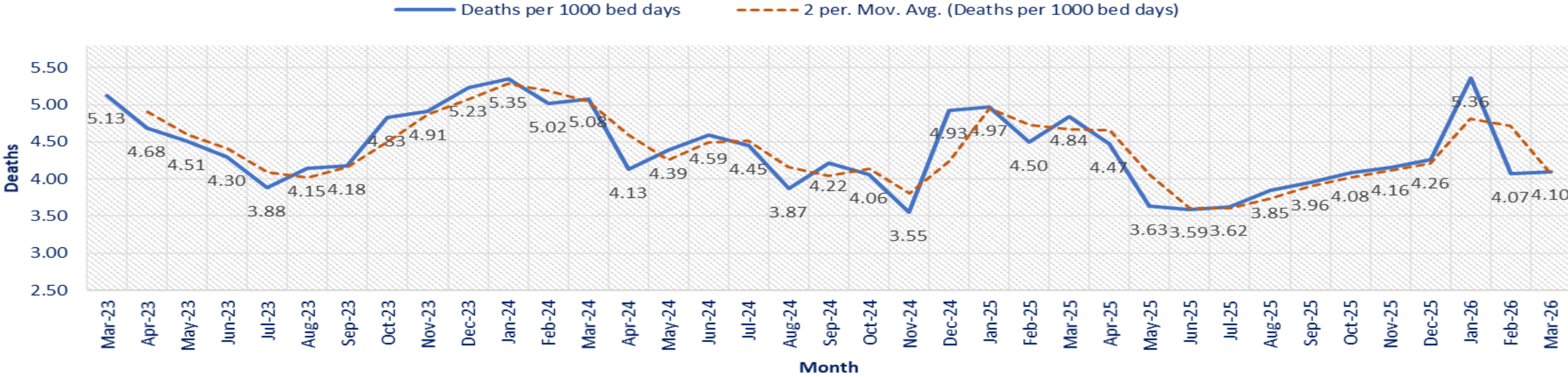
Crude Mortality in Hospital

Crude Mortality - Deaths in Hospital



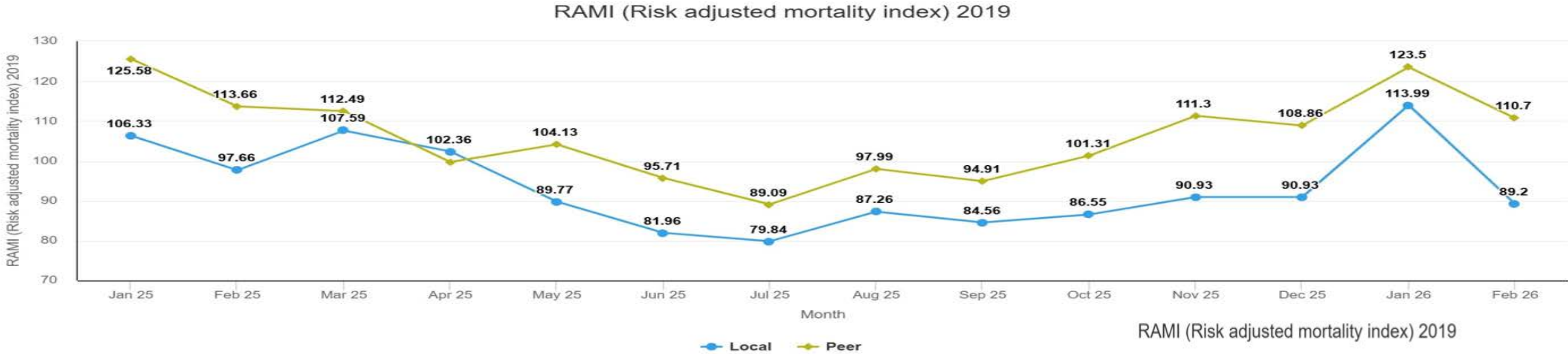
Crude mortality measures the number of deaths in a population over a specific period. It helps understand overall death rates in a community, region, or country by comparing current deaths to the average over the previous three years, identifying trends above or below this average. The data includes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

Deaths per 1000 occupied bed days - All Sites



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

Risk Adjusted Mortality Index (RAMI)

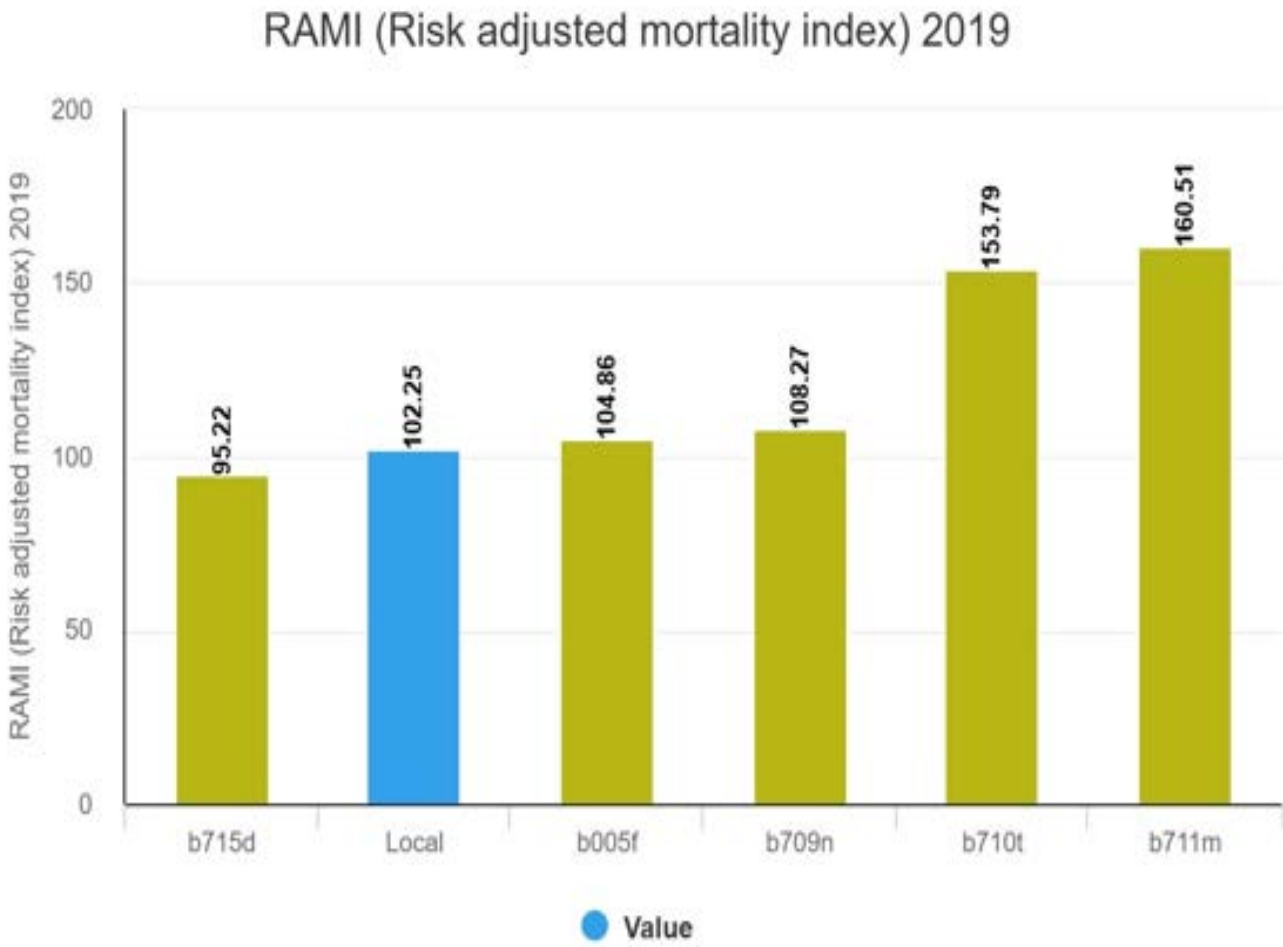


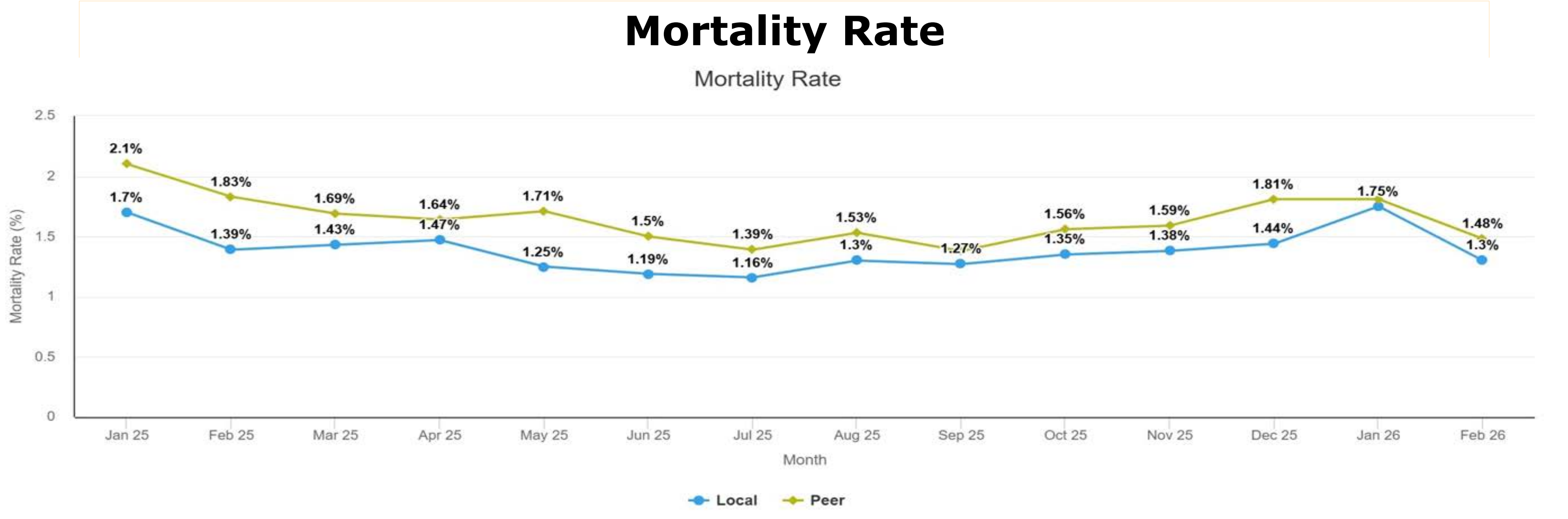
The Health Board’s RAMI for Q4 stands at 102.3 (Jan and Feb data). This is higher than earlier quarters (Q1:91, Q2:84 and Q3:89). Seasonal variation is a recognised feature of RAMI, with January typically showing a higher score. Historical trends show that Q4 RAMI often reduces from the initial January position once Feb and March data are available and fully coded.

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

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

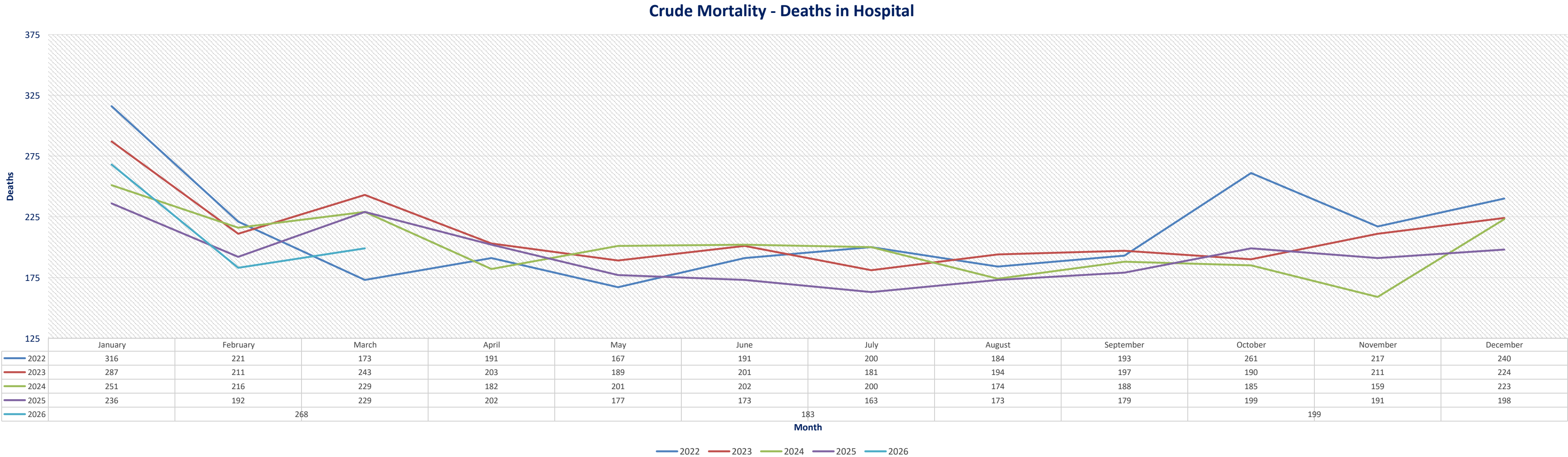
For Jan and Feb 2026, ABUHB ranked 2nd among the six members of the All-Wales peer group.





Definition	Analysis	Implications
The above graphs show the % of Hospital spells which end with the discharge method of death. At present latest data (February 2026) 1.3% of ABUHB Hospital spells end with the discharge method of death.	Mortality Rates have remained consistent and have been 1.5% or lower for 11/12 months of the last year and has remained on trend with the Peer Group while achieving a lower mortality rate as a Health Board. February 2026 mortality rate of 1.3% is consistent with previous spikes in mortality for the same periods of previous years.	In 2014 Professor Palmer published an independent review of the use of RAMI and the extent to which it provides valid data and recommended a blended approach that considers many sources of information, in addition to RAMI, including that from mortality reviews, national bench-marking and national audit. Addition of the Health Board’s learning from death report advocates several approaches to understand performance, this ensures assurance and quality improvement around death, not sole reliance on aggregated retrospective data (e.g. RAMI). This is seen in the additional mortality indicators for reporting.

Deaths in Hospital



Definition

The chart shows the monthly number of hospital deaths from January 2022 to March 2026. Data from each year are overlaid to enable comparison across years, highlighting year-on-year trends and seasonal variation.

Analysis

A clear and consistent seasonal pattern is evident across all years, with mortality peaking in winter—particularly in January—and declining through late winter and early spring. The highest peaks occur in January 2022 and January 2023. In contrast, 2024 and 2025 show lower winter peaks and reduced month-to-month variation, indicating moderation of the traditional winter surge.

Following the winter peak, deaths fall through February and March and stabilise at lower levels across spring and summer, with the lowest figures typically seen between May and July, most notably in 2025.

Early 2026 data (January–March) remains below the winter peaks observed in 2022 and 2023 and is broadly comparable with 2024–2025, suggesting continuation of recent improvement, noting the partial-year position.

Implications

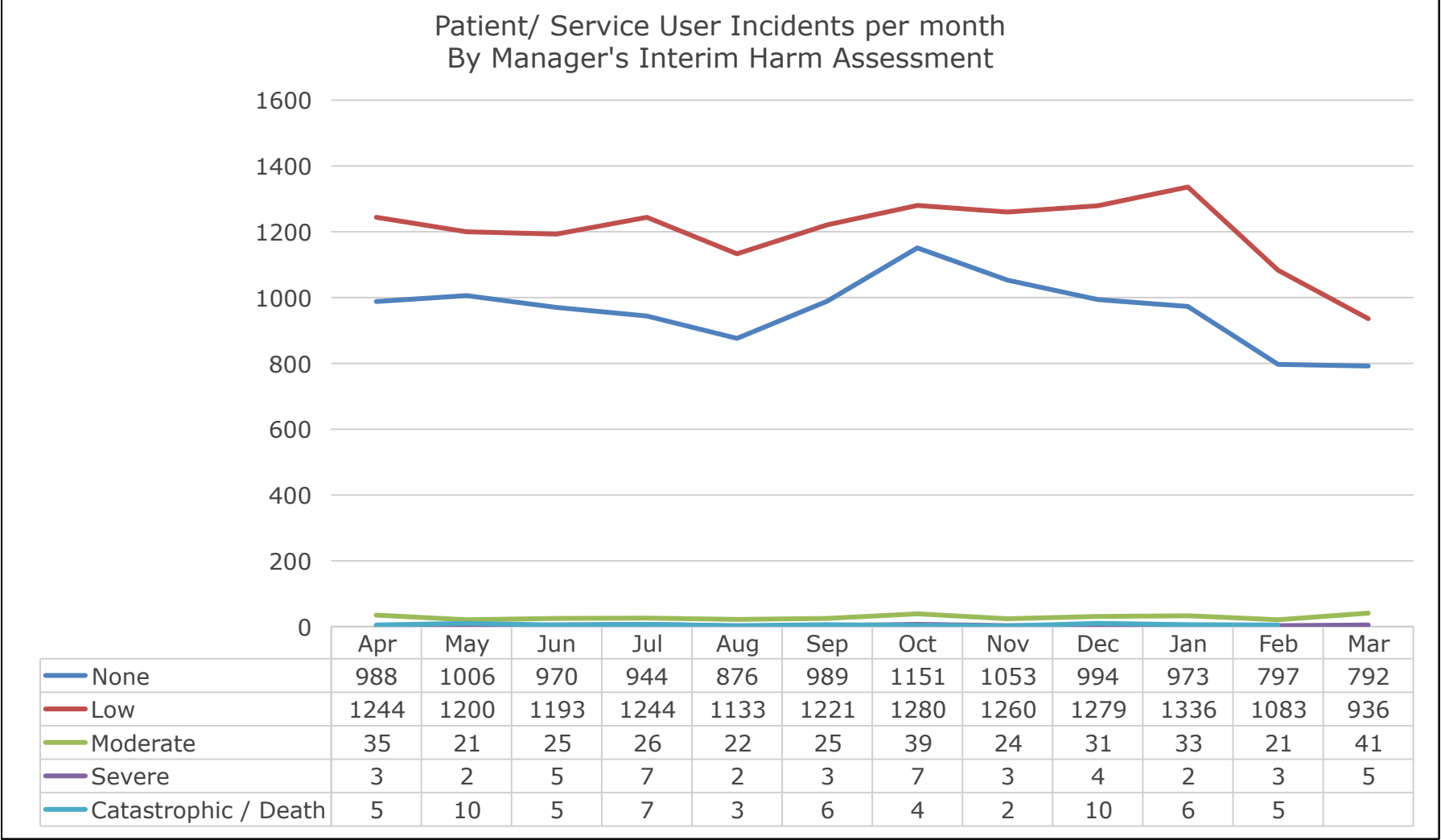
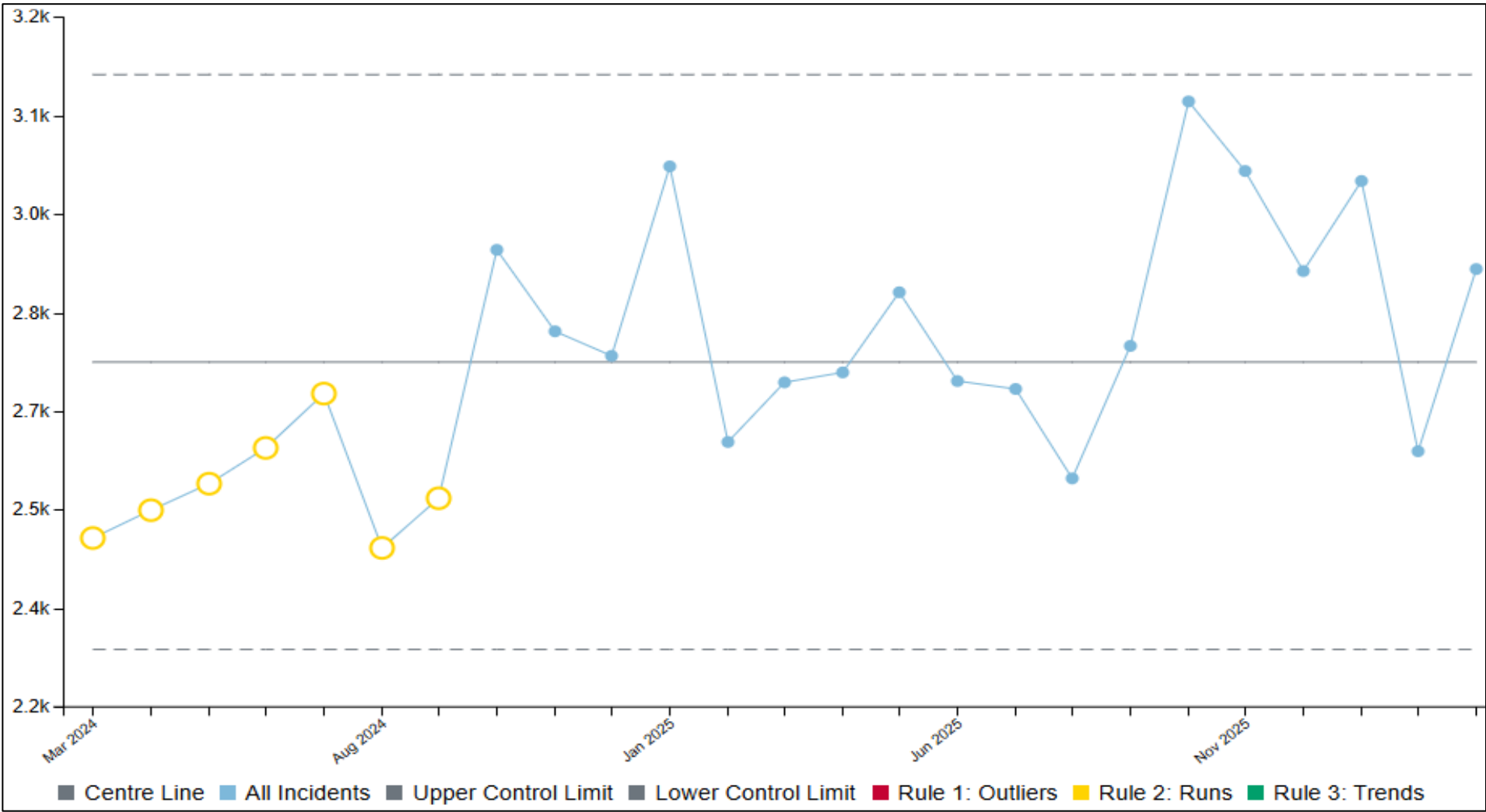
Compared across years, 2022 and 2023 show higher overall mortality, particularly during winter, reflecting increased system pressure and seasonal demand. In contrast, 2024 and 2025 demonstrate sustained improvement, with lower winter peaks and greater stability throughout the year.

The early 2026 position is encouraging, with winter mortality remaining below earlier high-pressure years, although continued monitoring is required given the partial year. Overall, the data confirms a consistent winter effect alongside improving outcomes over time. Reduced winter severity and variability are consistent with strengthened system resilience and ongoing quality and safety work, including deteriorating patient pathways, sepsis improvement, and end-of-life care. Future assurance should continue to focus on winter preparedness, early intervention, and sustaining recent gains.

Mortality Actions

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

Datix Incidents



Definition

The information above has been extracted from RL Datix via Qlik Sense and is correct at the point of extraction on 20 April 2026. It contains Patient / Service user incidents by months of reporting. The right graph shows the incidents split by managers interim harm assessment.

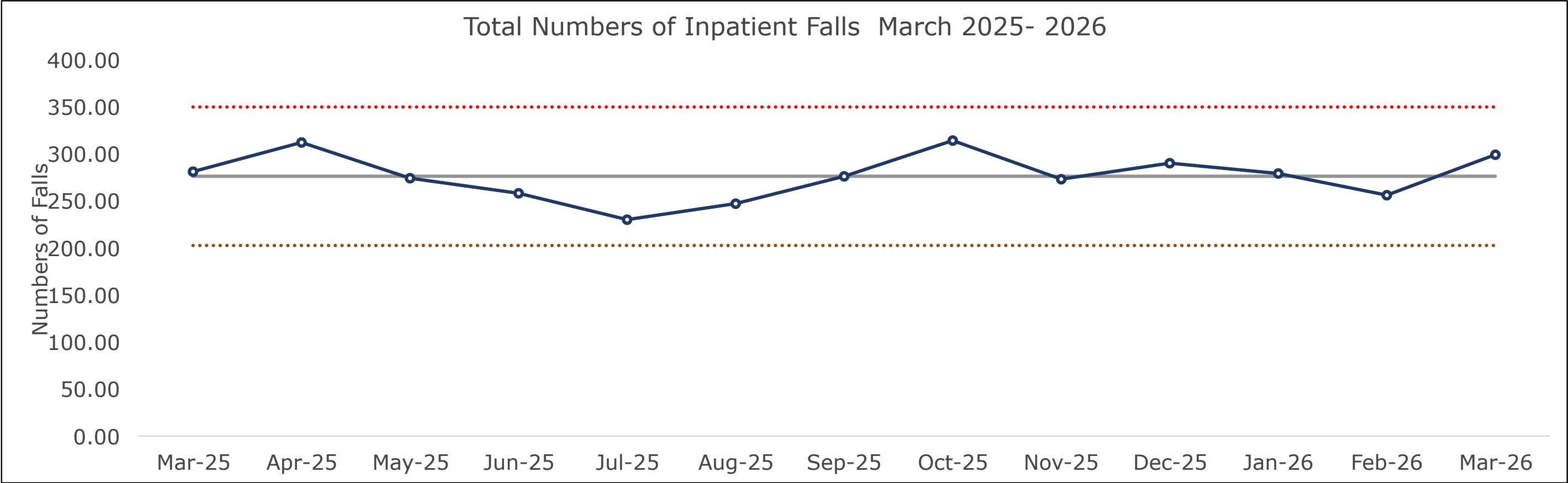
Analysis

The left hand graph shows a slow but steady increase in the total number of datix incidents for patients/service users. Financial year 2023/24 saw 30,381 incidents, 2024/25 reached 32,042 (5.4% increase over the previous year) and 2025/26 hit 33,711 (5.2% increase over the previous year). The right hand table shows the managers interim harm assessment (please note that more recent incidents may not yet have completed this assessment).

Implications

Incidents that are determined to have caused no harm (based on post investigation harm assessment) is the biggest driver of the increase in overall incident numbers. This could be due to improved awareness and reporting.

Inpatients Falls



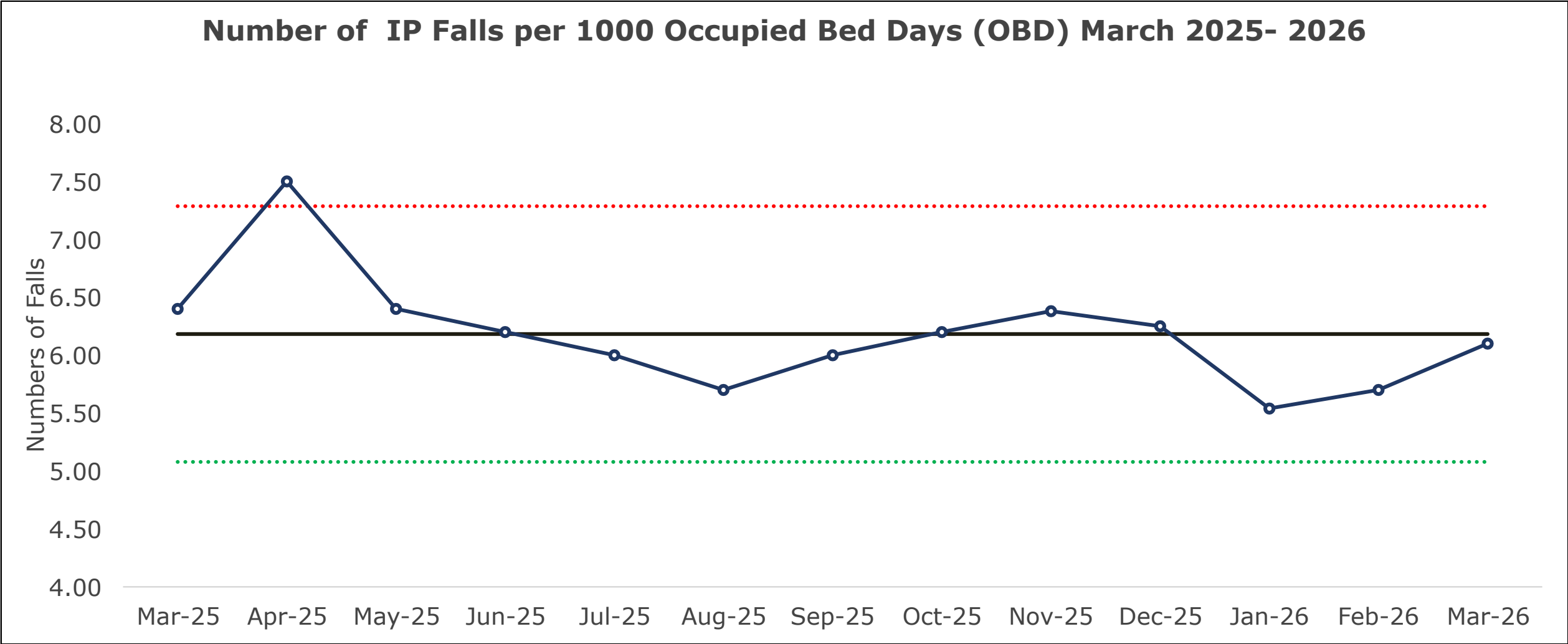
Quarter 4

The data used in this chart has been retrieved from RL Datix/ Qlik and refers to the total numbers Inpatient falls incidents by reporting date for the period March 2025-2026.

The information is as of the 1st April 2026

Definition	Analysis	Implications
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RL Datix as the information source.	- For the given period of analysis, the mean average value of fall incidents is 276. Month to month values have indicated no consistent upward or downward trends for the period of analysis. - Falls reported incidents increased from 256 in February to 299 in March 2026, an increase of 43 incidents, 8% above the HB mean average for the given year. - At the time of reporting under the criteria of Managers' interim measure of harm 94.98% of incidents for March 2026 were identified as no or low harm. No incidents have been reported as a catastrophic outcome since November 2024.	March 2026 has the third highest value in the 12-month reporting period, this does not however demonstrate a sustained upward trend. This represents common cause variation Given the variation in numbers of falls incidents the control limits and mean average value remain stable with no special cause variation demonstrated. Although not explicit, patterns of variation and data analysis suggest high patient acuity and increased bed occupancy may have influenced the falls incidents. (Slide 2 – OBD’s information).

Inpatients Falls

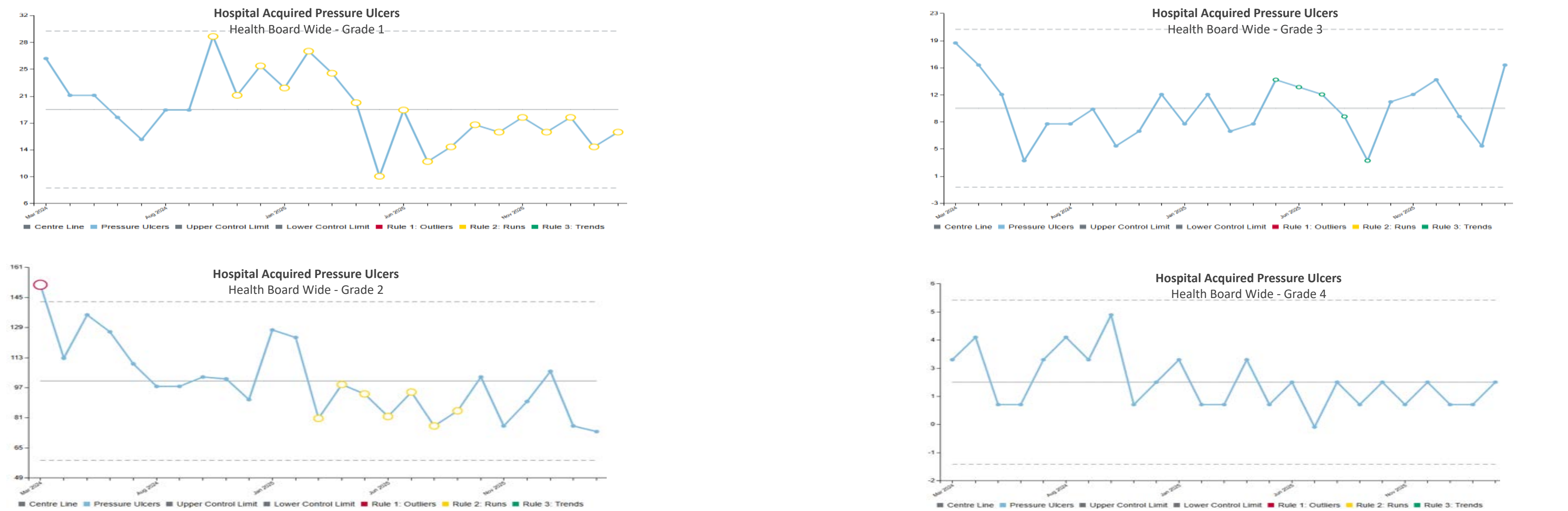


Quarter 4

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

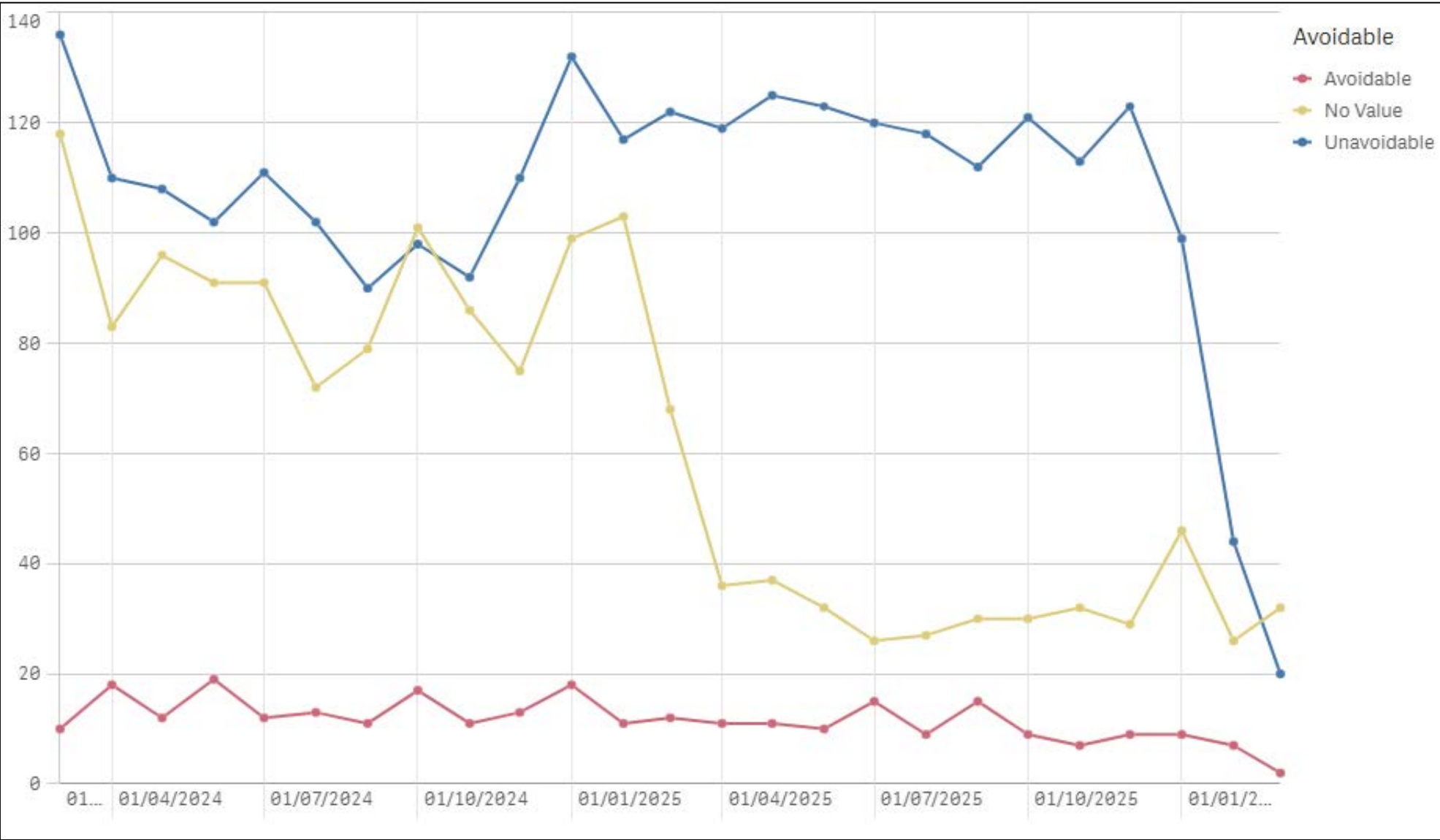
Definition	Analysis	Implications
Reported inpatient fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from RLDatix as the information source for reported falls incidents. The data source for OBD `s has been retrieved	February to March 2026 has seen a marginal rise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

Healthcare Acquired Pressure Ulcers



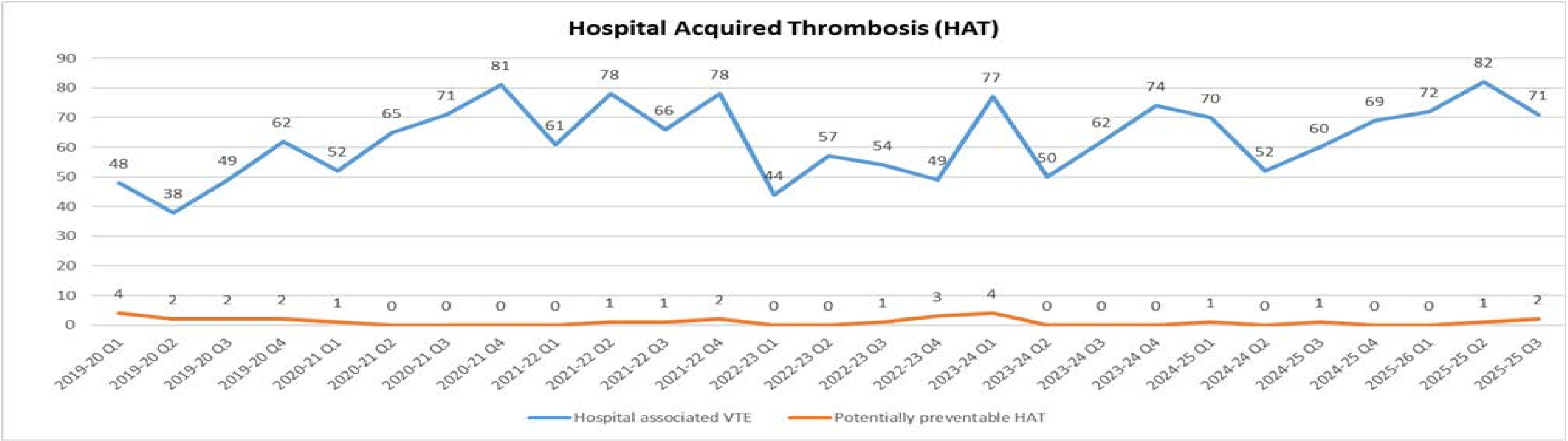
Definition	Analysis	Implications
The data included above is extracted from Datix incident module and manipulated through Qlik Sense. The date range displayed is from March 2024 to March 2026.	The overall trend for Healthcare Acquired Pressure Ulcers shows a slow reduction over the past two years. Within Grade 1 HAPU there has been a shift with all months since April 2025 falling below the mean, which coincides with the Director of Nursing establishing a professional standards group. The expected trend of increases during winter months can be seen in both grade 1 & 2.	Divisional scrutiny remains on grade 3 and 4 hospital acquired pressure ulcers. As a result of changes agreed at the pressure ulcer collaborative a review is now undertaken on all hospital acquired pressure damage. The collaborative will be focussing on improvement initiatives to maintain the ongoing reduction in hospital acquired pressure damage in all categories.

Healthcare Acquired Pressure Ulcers



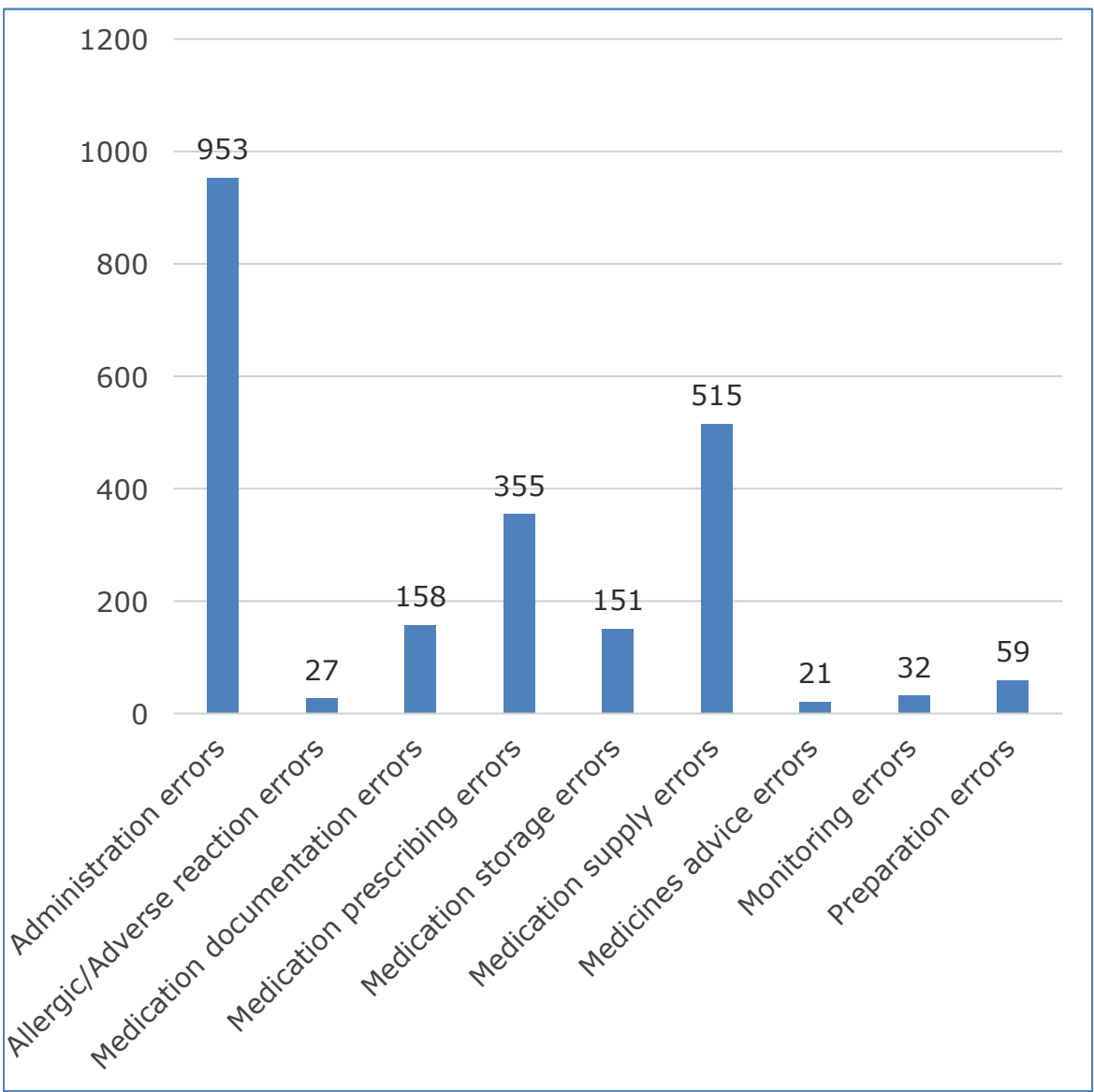
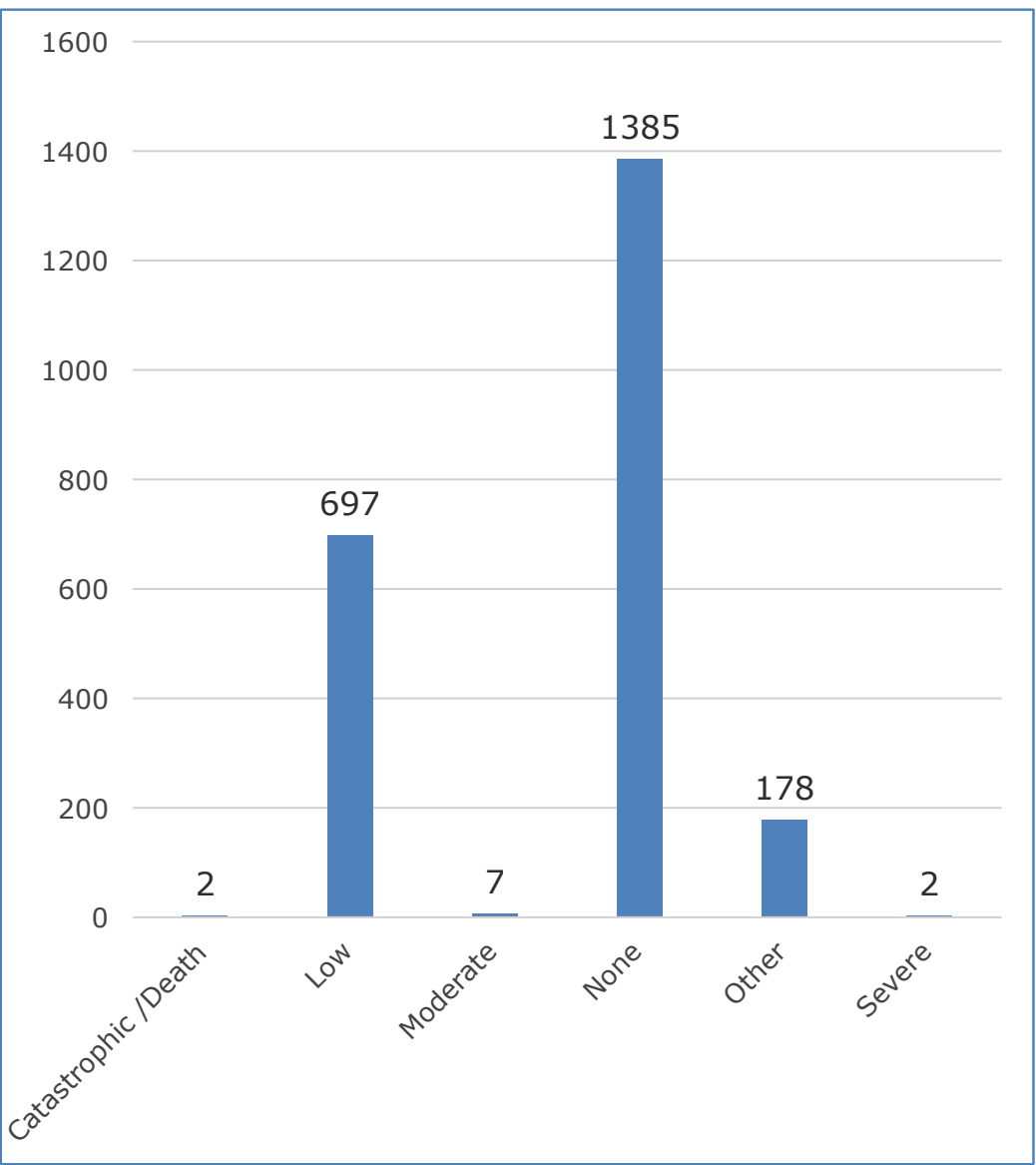
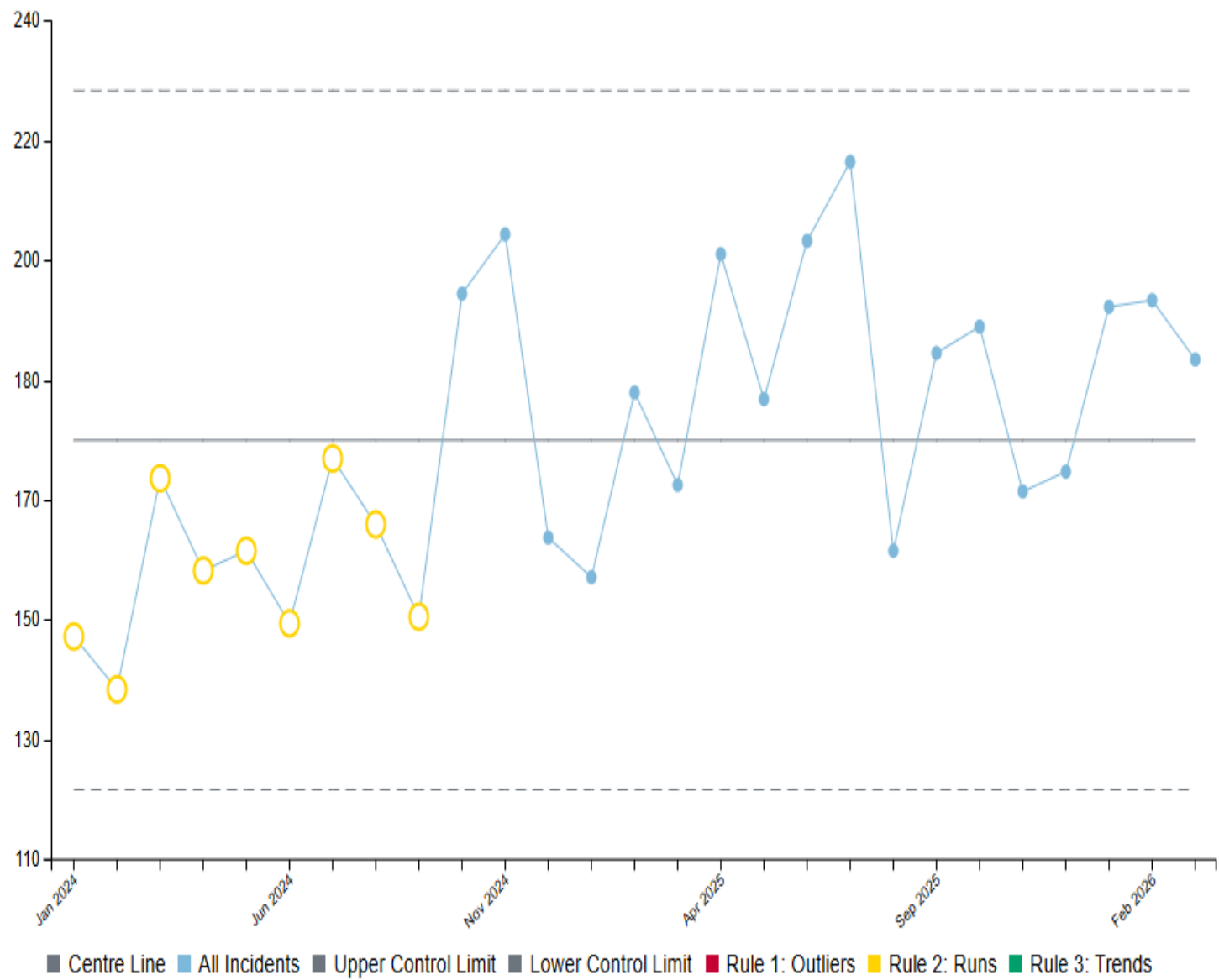
Definition	Analysis	Implications
The data included above is extracted from Datix incident module and manipulated through Qlik Sense. The date range displayed is from March 2024 to March 2026. The left hand graph shows the number of closed incidents and the responses to if an HAPU was avoidable. The right hand SPC chart shows the number of open HAPU incidents and when they were reported.	Please note the graph only shows closed incidents, this is reflected in the dramatic drop over the past few months. The graph shows a notable drop in “no value” incidents since April 2025 following the establishment of a professional standards group.	Divisional scrutiny remains on grade 3 and 4 hospital acquired pressure ulcers. As a result of changes agreed at the pressure ulcer collaborative a review is now undertaken on all hospital acquired pressure damage. The collaborative will be focussing on improvement initiatives to maintain the ongoing reduction in hospital acquired pressure damage in all categories.

Hospital Acquired Thrombosis (HAT)



Definition	Analysis	Implications
The chart shows the number of suspected hospital associated Venous Thromboembolism events (VTE) and the confirmed number of potentially preventable hospital-acquired thrombosis (HAT). A HAT is a VTE—such as deep vein thrombosis (DVT) or pulmonary embolism (PE)—that occurs during hospitalisation or within 90 days of discharge and could have been avoided if appropriate preventative measures had been taken. 24/137	A HAT is reviewed through a structured retrospective process: 1. Identification of suspected HAT cases – Informatics generate the list of patients discharge data per month and radiology provide the RADIS scanning data (imaging-confirmed VTEs). These are cross-checked against discharge data to identify potential HATs within 90 days of discharge 2. Root Cause Analysis (RCA) – A Haematologist reviews the RCA form to confirm whether a mandatory VTE risk assessment was completed on admission and whether thromboprophylaxis was prescribed appropriately (correct drug, dose, and duration). 3. Clinical vetting – The Haematologist then reviews the completed RCA to determine: a. Whether the event meets the criteria for HAT. b. Whether it was unavoidable (prophylaxis was appropriate) or potentially preventable (e.g., missed or incorrect prophylaxis) 4. Reporting and learning – Confirmed HATs are reported, and insights from these reviews are used to strengthen practice and reduce future harm. WRP are currently refining how Health Boards report HATs on Datix and how learning is reviewed and implemented.	A Hospital-Associated Thrombosis (HAT) is a significant event, accounting for 50–60% of all VTEs and representing one of the leading causes of preventable hospital deaths. The 90-day attribution window is based on strong clinical evidence that VTEs can develop well after discharge due to factors such as reduced mobility, postoperative recovery, underlying medical conditions, or missed/inappropriate thromboprophylaxis. This timeframe ensures that post-discharge events are correctly captured and assessed for any link to the hospital stay, in line with national guidance and policy. Reporting is delayed until case note reviews are completed to determine whether a HAT was potentially preventable. Recent increases in cases reflect a patient cohort with higher BMI and a history of cancer—both recognised risk factors for VTE. The number of preventable HAT cases remains stable and low. 46/425

Medicines Management

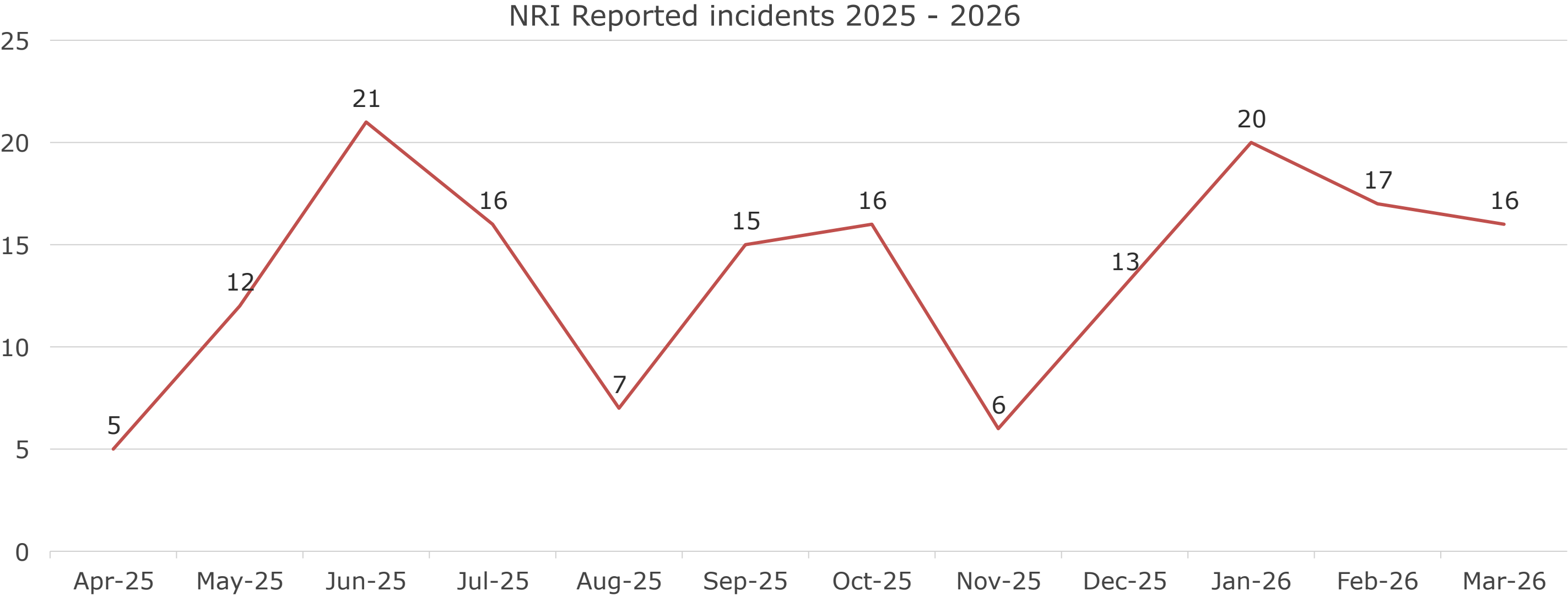


Definition	Analysis	Implications
The data displayed is taken from RL Datix via Qlik Sense. It was correct at the point of extraction on 20 April 2026. The SPC Chart (left) shows data from 01 January 2024 to 31 March 2026. The breakdown of harm (post investigation harm assessment) and Category is for 2025/26.	The trend shows a general increase in the number of Medication / IV Fluid incidents being recorded. The vast majority of incidents in 2025/26 were no harm (61%), followed by low harm (31%) with just 0.5% of incidents being moderate of above harm. 8% of incidents remain open and pending a post investigation harm assessment. Administration errors make up the largest proportion of incidents, followed by supply errors and prescription errors.	Developments in Qlik over the past month has included the addition of the medication type field to allow monitoring of errors related to specific high risk medications such as anti-coagulants and training is planned with the pharmacy team to improve ward level aware of trends and issues.

Medicines Management Learning & Improvement

Item	Action	Who	When
high-risk medication incidents education	To develop standard package for core elements of medicines education across HB	Div Practice educators/QPS leads	Review May 2026
Medical Gas incidents	Action plan and Tracker to support reporting of Medical Gas incidents to MSG	RS/CW	May 2026
Medicines Governance Audits	New Core audit set to be used to develop a comprehensive medicines audit to report compliance to align with PSN055	KH / Sue Pearce/MSG	December 2025
Controlled Drug SOPs	Draft CD SOPs developed and await agreement to pilot	CDAO/Divisional Nurses	May 2026
BESS – error management policy	Updated Policy to MSG submitted to be CPSG in March 2026.	KH/CW	March 2026
Medicines Safety Strategy 2026-28	Draft strategy taken to Feb MSG for comments. Final sign off for approval at May 2026	JT/CW	April 2026

Nationally Reportable Incidents



A total of 53 Patient Safety Incidents (PSIs) met the criteria for reporting as NRI's in Quarter 4. This is in comparison to 52 in the same period in 2025.

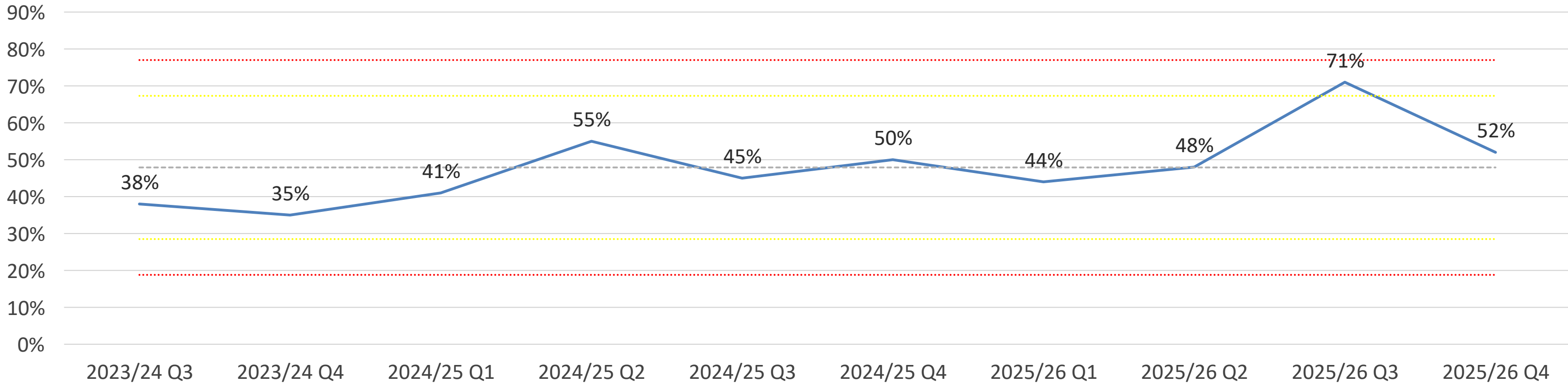
There were no unusual trends identified across NRI's across this period. The increased number of HCAI incidents is in keeping with the winter period.

Most common NRI categories

Quarter ▾	HCAI Outbreak ▾	IUD ▾	HCAI Associated Death ▾	Delayed Diagnosis ▾	Neonatal Death ▾	Missed Diagnosis ▾	Deteriorating Patient ▾
2025/26 Quarter 1	3	8	2	6	1	3	2
2025/26 Quarter 2	4	5	7	5	3	1	2
2025/26 Quarter 3	11	4	4	1	1	1	0
2025/26 Quarter 4	21	5	7	3	2	1	0

Nationally Reportable Incidents

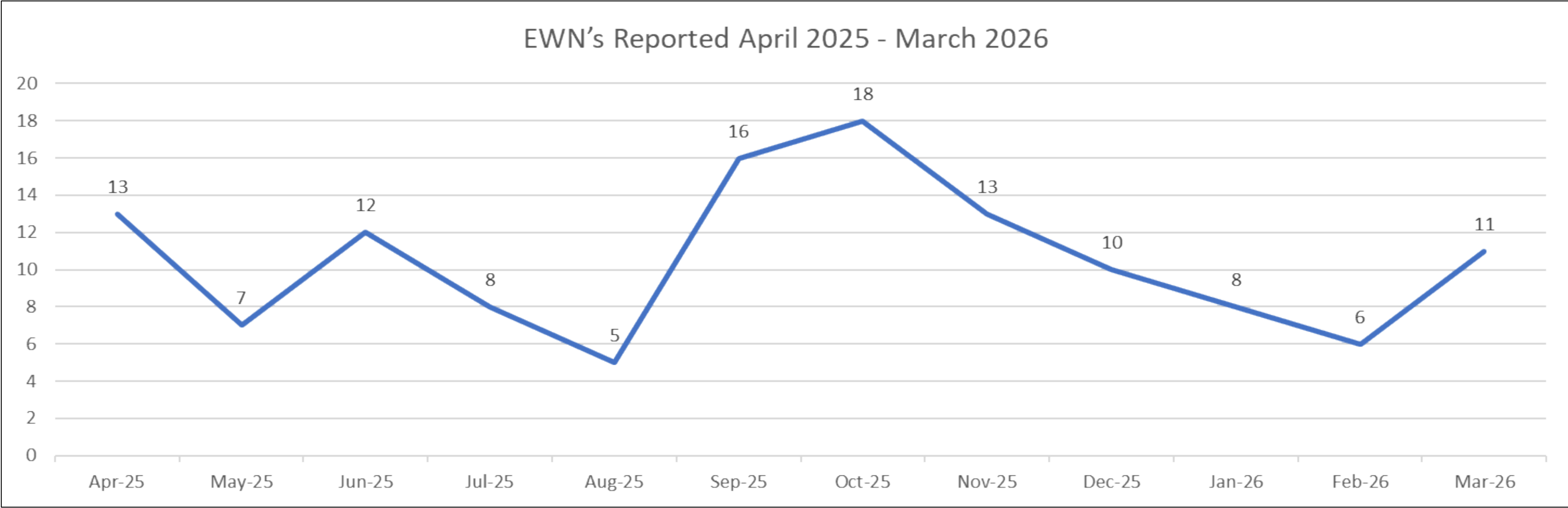
% Compliance with NRI Target Outcome Dates



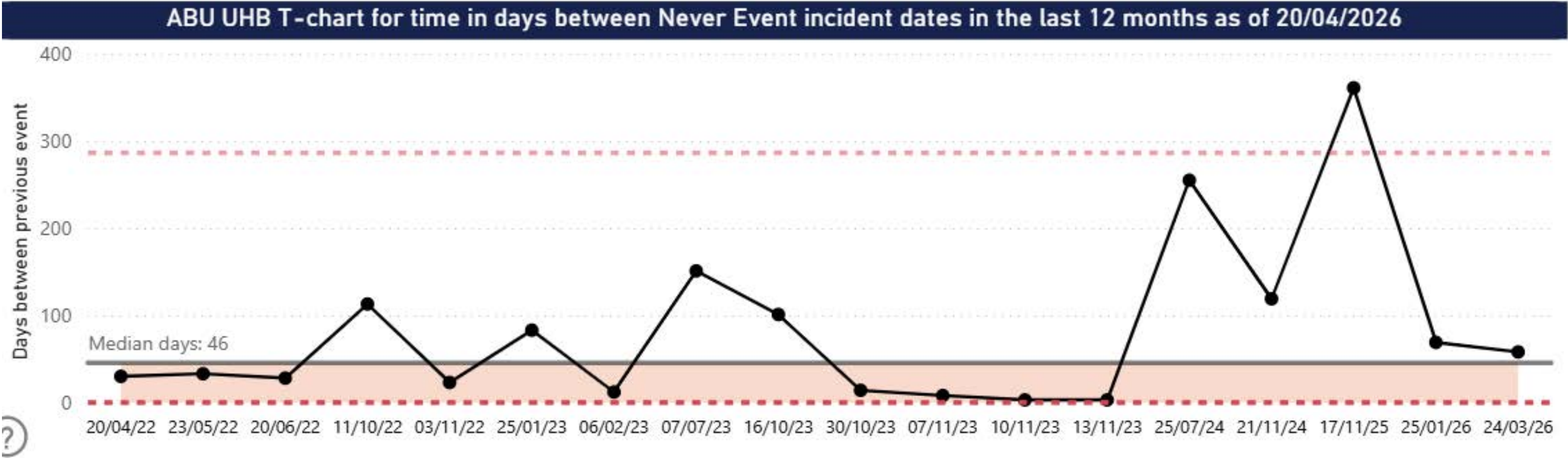
Definition	Analysis	Implications
The graph shows the % of open cases that are within and outside of the compliance window. The number of open cases are split by in-date and overdue.	At the end of March 2026, there were 47 open NRIs, of which 30 were within the compliance window. The overall distribution of overdue cases shows a continued improvement when compared with the same period in 2024/25. Over 12 months is 1 (this is in comparison to 4 at the end of Q4 24-25) 6-12 months is 1 (this is in comparison to 2 at the end of Q4 24-25) 3-6 months is 5 (same as end of Q4 2024-25) 0-3 months is 10 (this is in comparison to 14 at the end of Q4 24-25) The compliance with the NHS P&I outcome date for NRIs slipped in Q4 2025/26 from 71% to 55%. A review of the cases that failed to meet the deadline is underway.	The improved compliance position and reduction in overdue NRIs ensure timely patient safety investigations, reduce organisational risk associated with prolonged investigations, and support improved experiences for patients, families, and staff. Sustaining this position will be critical to maintaining regulatory assurance and ensuring that learning from incidents is embedded without delay. The Corporate Patient Safety team continues to review the PSI investigation process to streamline and optimise the progression of incident investigations.

Early Warning Notifications

There were 25 Early Warning Notifications (EWNs) reported to Welsh Government (WG) in Q4, compared to 51 submitted for the same period in 2024/25. The themes reported in Q4 were predominantly related to Mental Health services, including incidents of absconding, suicide attempts and deaths (including unexpected deaths), alongside alleged criminal offences, professional practice concerns, PRUDICs, a decontamination incident, and incidents involving violence towards patients or staff.

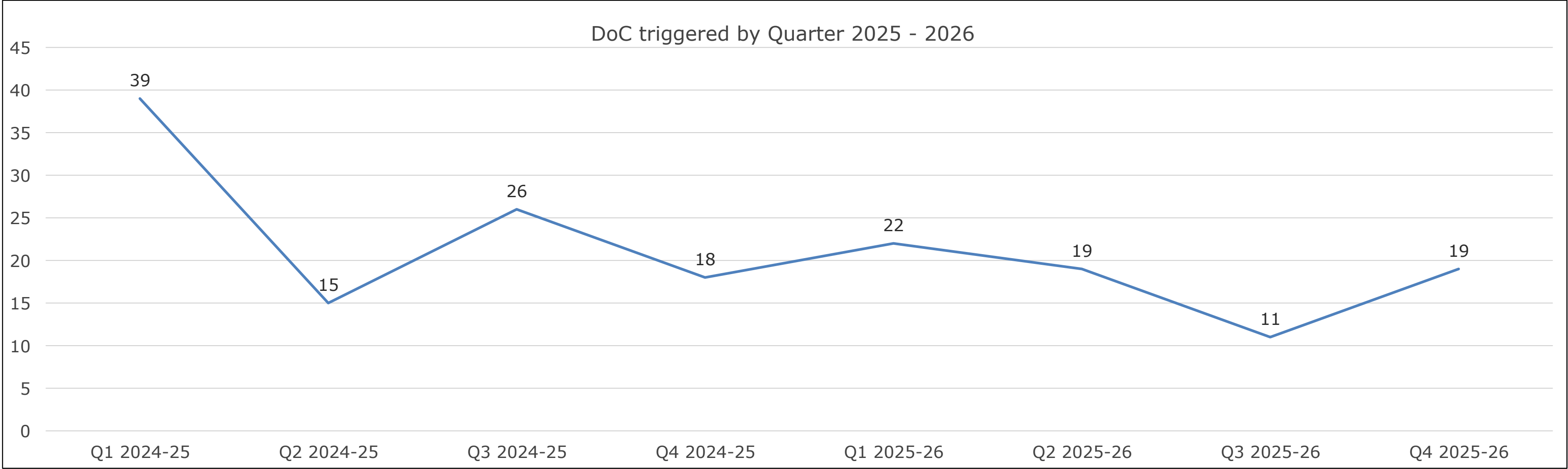


Never Events



Definition	Analysis	Implications
Never Events are serious, wholly preventable patient safety incidents for which national preventative measures are in place. The SPC-T chart is used to show the number of days between Never Events, providing an indication of system reliability over time rather than performance against volume targets.	During Q4, three Never Events were reported: wrong-site surgery, wrong-site block, and inadvertent connection to air. Welsh Government Ministerial Targets from 2026/27 will include the monitoring and reporting of Never Events.	Whilst three Never Events were reported in Q4 the overall reduction seen in ABUHB since December 2023 is testament to the concerted effort of the Theatre and ABCi teams. The embedded report shows a recent update on the work undertaken by ABUHB to reduce Never Events in theatres.  Never Event Jan Update

Duty of Candour



Definition	Analysis	Implications
Information provided is extracted from RL Datix, based on the question ' <i>Was healthcare a factor</i> '. The information is accurate at the point of extraction but is an ever-changing picture as incidents are investigated.	Learning from Duty of Candour incidents continues to inform wider patient safety improvement work, with a focus on earlier identification of cases, improved consistency in application, and strengthening compassionate communication with patients and families. Work is ongoing to improve the quality of recording within Datix, supporting clearer oversight of Duty of Candour processes as incidents progress and investigations conclude. This includes reinforcing expectations around timely completion, senior oversight, and learning feedback to services.	O1, work will focus on improving timeliness and reducing variation by implementing improved standardised templates, flow charts, and providing ongoing education and support, ensuring that Duty of Candour arrangements are applied consistently and are aligned with wider PSI processes and Listening to People.

PSI Learning and Improvement

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

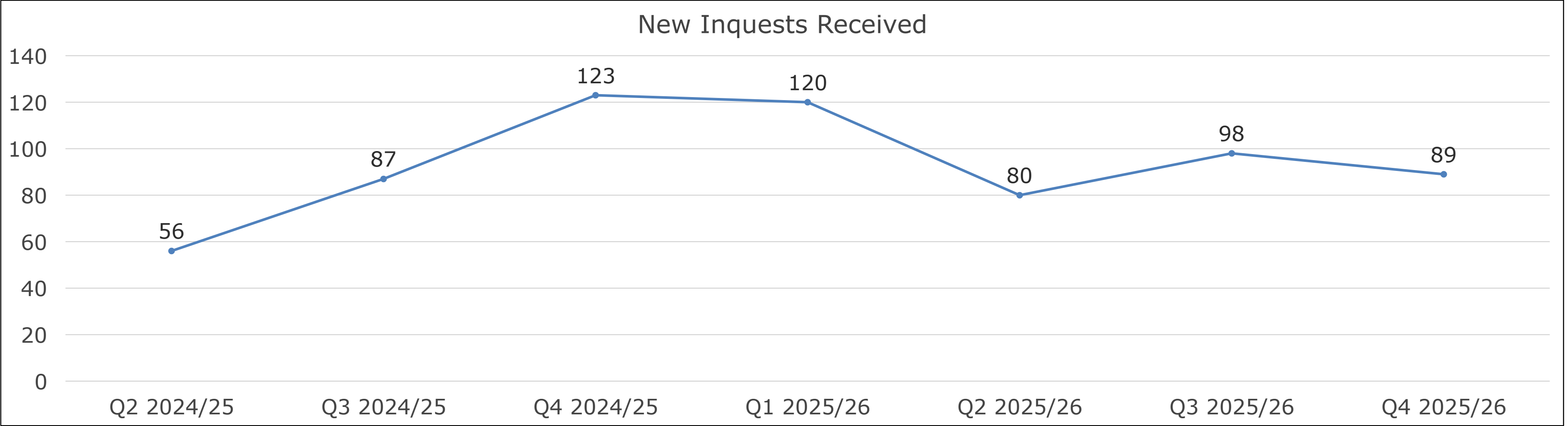
Legal Services – Regulation 28 & Person Injury Claims

Regulation 28s

Person Injury Claims

- One new employer liability claim from a member of staff was opened during the reporting period, relating to an incident on C6 West, Royal Gwent Hospital, where the individual was struck by a moving laundry trolley.
- No recurring or connecting themes have been identified from this claim.
- As at 31 January 2026, there were 87 live claims in total, reflecting one new case and no closures since the previous reporting period.

Inquests

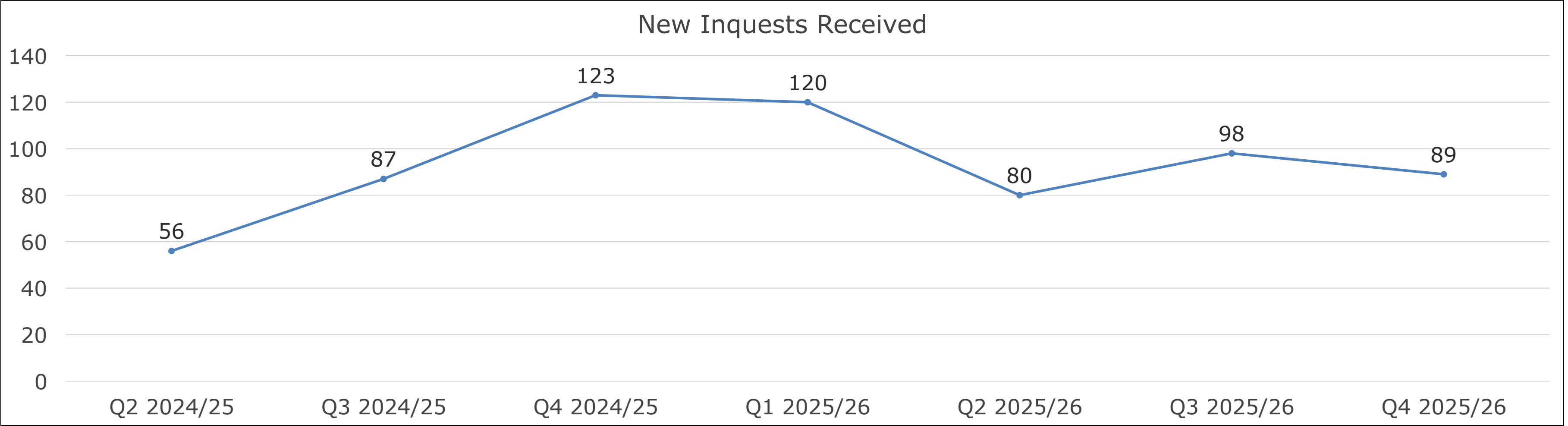


Definition	Analysis	Implications
The graph above shows the number of new inquests received by the Coroner each quarter.	The Health Board is receiving a significant and sustained increase in the number of new Coroner inquests being received. Since the 1 April 2025 as of 7 January 2026 the Health Board had received 306 new Inquests.	There is now 246 (up from 233 at the end of Q3) active Inquests open which requires significant involvement to appropriately provide evidence. 90 Inquests concluded during Q3 of which 68% were concluded in writing, this prevents Health Board employees attending hearings to give evidence. This is achieved by providing thorough factual statements and evidence. The Health Board received 98 new Inquest matters during Q3 2026. Quarter 3: • Inquests opened – 14% increase in referrals this year in Q3 compared to last year. • Inquests Heard – 36% increase in cases heard this year in Q3 compared to last year. • Inquests in Person – 70.5% increase in in person court hearings heard in Q3 compared to last year. Increases have arisen through combination of increase in Medical Examiner referrals to the Coroner, and continued investment growth and expansion to the Gwent Coroner service, with resulting sustained pressure on Health Board staff and resources.

34/137

56/425

Inquests



Definition	Analysis	Implications
The graph above shows the number of new inquests received by the Coroner each quarter.	The Health Board is receiving a significant and sustained increase in the number of new Coroner inquests being received. For 2025/26 the Health Board had received 387 new Inquests.	In Quarter 4, the Health Board received 89 new inquests (29 per month), representing an 11.4% increase (40 cases) compared to 2025/26 and continuing the upward trend observed since 2022. Between 1 January and 31 March 2026, 86 inquests were concluded, with 84% finalised in writing, demonstrating effective case management and reducing the requirement for clinician attendance. The Inquest Team supported all 14 in-person hearings, with 12 managed in-house, reflecting strengthened internal capability. Legal representation was required in 2 complex and sensitive cases (7 court days) to mitigate potential reputational risk. The sustained increase in activity is driven by rising Medical Examiner referrals and expansion of the Gwent Coroner Service, placing ongoing pressure on Health Board capacity and resources.

Patient Safety Alerts (PSA) and Notices (PSN)

Alert	Compliance Deadline	Action to achieve compliance	Status
PSA020 Harm From Incorrect Recording of a Penicillin Allergy as a Penicillamine Allergy	30 th November 2026	Action plan in progress and on target. Progressing through the Health Board's Medicine Safety Group, highlighted to Antimicrobial Group and Electronic Prescribing Medicines Administration Group.	In-progress (on target)
PSA019 Harm From Delayed Administration of Rasburicase for Tumour Lysis Syndrome	09 th March 2026	Completed.	Completed
PSA021 Risk associated with adult breathing circuits lacking a patent exhalation route	28 th August 2026	Noted that theatres and NICU/PICU are outside of the scope of this PSA.	Completed

PILLAR 3

Clinical Effectiveness

Deteriorating Patient

Sepsis

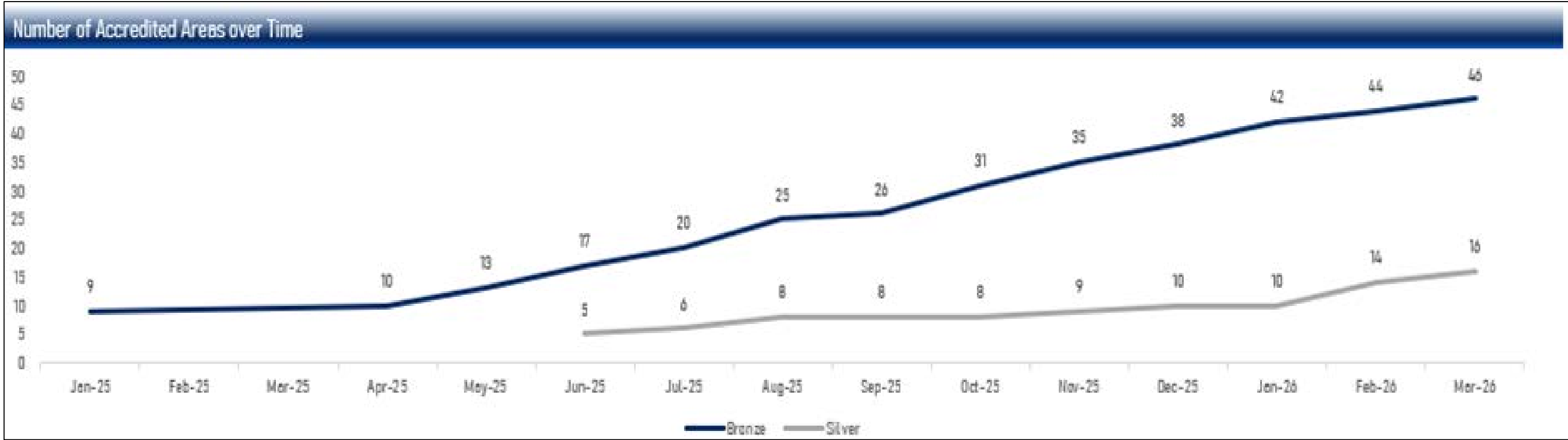
Clinical Policies

Clinical Standards

Resuscitation

Clinical Audit

Ward Accreditation



Quality Improvement Projects through ward accreditation

8 more areas have achieved bronze accreditation and 7 more areas have reached silver in Quarter 4 2025/26.
More specialist areas are being accredited (theatres / clinics).
Winter pressures are slowing the wards' ability to progress their accreditation.
Roll out to district nursing / complex care and public health nursing in progress

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

National Clinical Audits - Presented at CSEG Q4 2025/2026

HQIPO Ref.		Name of publication	Publication date	CSEG
605	NELA	National Emergency Laparotomy Audit (NELA) - Year 10 State of the Nation Report	09/10/2025	CSEG Jan 2026
583	NEIAA	National Early Inflammatory Arthritis Audit (NEIAA) - State of the Nation Report 2026	09/10/2025	CSEG Jan 2026
632	NATCAN	National Metastatic Breast Cancer Audit (NAoMe) - State of the Nation Report (England & Wales)	11/09/2025	CSEG Feb 2026
631	NATCAN	National Primary Breast Cancer Audit (NAoPri) - State of the Nation Report (England & Wales)	11/09/2025	CSEG Feb 2026
616	NRAP	National Respiratory Audit Programme (NRAP) - State of the Nation Report - Children and young people’s asthma : Elements of care received by children admitted with near-fatal asthma	12/06/2025	CSEG Feb 2026
641	FFFAP	Fracture Liaison Service Database (FLSD) - State of the Nation Report	08/01/2026	CSEG Feb 2026
639	NATCAN	National Bowel Cancer Audit (NBOCA) - State of the Nation Report (England & Wales)	09/10/2025	CSEG Feb 2026
574	NVR	National Vascular Registry (NVR) - State of the Nation 2025 report	13/11/2025	CSEG Mar 2026
NICOR	NICOR2023/24 & 2024/2025 2nd Ed	National Audit of Cardiac Rhythm Management (NACRM) x 2	11/12/2025	CSEG Mar 2026
635	NATCAN	National Non-Hodgkin Lymphoma Audit (NNHLA) - State of the Nation Report (England & Wales)	11/09/2025	CSEG Mar 2026

Summary of audit reports can be found in ‘For Information’

New Procedure	Submitted by:	Outcome:
Biodegradable Embolisation for Analgesia in MSK Pain in Greater Trochanteric Pain Syndrome	Dr Nimit Goyal, Consultant Radiologist Dan Harding, Orthopaedic Specialist Physiotherapist	Application approved by majority vote for pilot of 30 patients.

Deteriorating Patient and Sepsis

WHC Standardising the Management of Acute Deterioration (WHC/2024/035)

- Welsh Health Circular (WHC) 2024/035 requires Health Boards to standardise the use of Early Warning Scores (EWS) to support the timely identification and management of acutely deteriorating patients, improving patient safety and clinical outcomes.
- Health Boards were required to implement the recommendations by 30 September 2025. National oversight is provided through the Acute Patient Deterioration Implementation Network (APDIN), led by NHS Performance and Improvement Cymru.

Local Compliance Position:

- By the national deadline, the Health Board successfully implemented three of the four mandated Early Warning Scores:
 - Adults – National Early Warning Score 2 (NEWS2): Implemented 9 September 2025 (community and Mental Health & Learning Disabilities live 29 September 2025).
 - Paediatrics – Paediatric Early Warning Score (PEWS): Implemented 22 September 2025; subsequently withdrawn from FOX assessment pending operational realignment. Emergency-specific PEWS remains subject to NHS England validation.
 - Neonates – Neonatal Early Warning Track and Trigger 2 (NEWTT2): Implemented 28 July 2025.
 - Maternity – Maternity Early Warning Score (MEWS): Implementation delayed due to digital readiness; planned launch 18 May 2026.
- In parallel with NEWS2, the Health Board adopted the UK Sepsis Trust Adult Acute Sepsis Screening Tool.

Deteriorating Patient and Sepsis

Annual Progress

- During 2025–26, the Deteriorating Patient Group has overseen delivery of the key foundations required to standardise the management of deterioration and sepsis across ABUHB, aligned with national policy and evidence. Key achievements include:
 - Implementation of national Early Warning Scores and sepsis screening tools
 - Restructuring of the Deteriorating Patient Group into focused task-and-finish groups, relaunched February 2026
 - Delivery of targeted ward-based sepsis education
 - High-reach public and workforce sepsis awareness campaign
 - Direct patient and public engagement through *The Big Conversation: Sepsis*

Embedding and Assurance

- Following initial implementation, the programme has entered Phase Two, with a clear focus on consistency, reliability and quality of response. Key assurance activity will include:
 - Development of a combined Deteriorating Patient / NEWS2 / Sepsis / Call for Concern audit proforma
 - Monthly ward-based audit, supported by deeper thematic review
 - Oversight via the Deteriorating Patient Group to identify good practice, variation and risk
 - Use of audit findings, DATIX reviews, mortality review and Serious Incident learning to drive improvement
- Following publication of updated NICE guidance, the revised UK Sepsis Trust Adult Sepsis Tool will be reviewed, with recommendations for adoption aligned to national best practice

Deteriorating Patient and Sepsis

Collaboration, Culture and Learning

- Collaborative working has been central to delivery, with ongoing engagement across:
 - Divisional nursing and therapy forums
 - Quality and Patient Safety meetings
 - Clinical and corporate teams, supported by the Medical Director's QPS Team
- Collaboration with patients and the public remains a priority. *The Big Conversation: Sepsis* (September 2025) provided valuable insight from lived experience, directly informing the development of the ABUHB Sepsis Strategy.
- The Health Board continues to work closely with the UK Sepsis Trust, the All-Wales Sepsis Group, and partner organisations, supporting shared learning, updated NICE guidance, and nationally consistent education resources, including the ESR Sepsis e-learning module.

Engagement and Awareness

- Supporting Cultural Change- The Health Board's sepsis awareness programme has supported both workforce and public understanding:
 - Internal campaign launched November 2024
 - Public-facing phase launched April 2025
 - Over 2 million views and 3 million impressions, with national sharing of assets
 - Campaign materials currently inform All-Wales discussions on standardised safety-netting
- This work complements clinical and assurance activity by reinforcing early recognition, escalation and shared responsibility.

Deteriorating Patient and Sepsis

Forward Look: 2026–27 Priorities

- While significant progress has been made, further work is required to:
 - Complete MEWS implementation
 - Fully embed revised NICE sepsis guidance across all pathways
 - Demonstrate sustained compliance and reliability through audit
 - Standardise education and refresher training at scale
 - Translate learning into consistently improved patient outcomes
 - Work is underway to look at e-observation data to enable this to be viewed within clinical areas to understand patients early warning scores and help recognise deteriorating patients in a timelier manner.
- These priorities are reflected in the developing 2026/27 Deteriorating Patient Group workplan, supported by existing governance and assurance arrangements.
- The Health Board has:
 - Delivered the national requirements within required timescales
 - Established a strong foundation for safe, standardised practice
 - Working towards putting in place robust assurance mechanisms to embed and monitor reliability
 - Clearly identified remaining risks and actions for 2026–27
- Overall, there is confidence that the programme is well-governed, evidence-based and focused on sustained improvement, while recognising that embedding consistent practice remains an ongoing priority.

Deteriorating Patient and Sepsis

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

- Welsh Health Circular WHC/2024/040 requires all health boards to adopt a patient and family-initiated escalation approach, known as Call 4 Concern (C4C), which allows patients, families and carers to quickly raise concerns and request urgent clinical review if they are worried about a patient's deteriorating condition. The approach is person-centred, aligns with national quality and safety standards, builds on pilots already undertaken in Wales, and aims to improve patient safety by ensuring concerns are listened to and acted on promptly across all inpatient settings, 24 hours a day, supported by local implementation plans and national oversight. This includes:
 - Patient Wellness Score/Question/Concern (PWS/Q/C): structured self reported wellbeing assessment ensuring that the 'first voice of concern' belongs to the patient and their family
 - Patient and Family Initiated Escalation (PFIE): mechanisms to quickly address concerns about deterioration firstly in the immediate clinical area and for the patient or family to directly activate senior clinical review
- The subsequence WHC Call4Concern: timelines and responsibilities (WHC/2026/001) outlines the timelines for implementation:
 - July 31st – across all acute inpatient settings
 - December 31st – across all none-acute inpatient settings
- Work has been underway throughout 2025, with Call 4 Concern being piloted across Grange University Hospital (GUH), adult inpatient settings (not including the Emergency, paediatrics or maternity settings) since August 2025 and the health board is working towards developing a ABUHB PWS/Q and reviewing the Call 4 Concern process in order to achieve the proposed implementation deadline.

Deteriorating Patient and Sepsis

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

- The WHC issued in December 2025, requires Health Boards to adopt standardised safety-netting discharge leaflets for adults and children discharged with suspected or confirmed infection. The Circular has been prioritised for implementation through the Health Board's Deteriorating Patient Group. The leaflets are designed to:
 - Support patient understanding and safe self-management following discharge
 - Promote early recognition of deterioration and encourage individuals to "*Think Sepsis*"
 - Signpost patients and carers to appropriate sources of advice and urgent support
- Each leaflet includes QR codes linking to: NHS 111, the Health Board's public facing Sepsis information page, UK Sepsis Trust public sepsis assessment tool, for children and young people: Healthier Together and Spotting the Unwell Child.
- Health Boards are required to produce locally branded versions and embed the leaflets within all relevant discharge pathways. Although no formal deadline has been set, the Circular advises immediate action.

Health Board Position and Progress:

- Safety-netting leaflets have been co-designed with Public Engagement colleagues to ensure clarity, accessibility, and consistency.
- The Deteriorating Patient Group is overseeing review, scoping and preparation for implementation of the adult safety-netting leaflet, working with Divisions to ensure accuracy and alignment with existing discharge processes.
- Paediatric safety-netting leaflets are already in use within B1, C1 and the FOX Assessment Pod.
- CEAU leaflet is complete and awaiting final sign-off prior to distribution.
- The Medical Director's Quality and Patient Safety Team is currently working with Divisions to explore suitability and undertake piloting of the adult safety-netting discharge leaflet, ahead of wider rollout. This will be completed by December 2026.

Deteriorating Patient and Sepsis

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

Pillar 3: Clinical Effectiveness				
Deteriorating Patient and Sepsis				
Action	What is needed?	How will this be achieved?	Who	When
Public Awareness Campaign for Sepsis	Phase 1 has been launched internally, during January 2025 phase 2 launch to the public April 2025. We continue to review the effectiveness of the campaign and assets, whilst ensuring accessibility for patients is maintained. Additionally, we aim to influence nationally to ensure other health boards and services support and continue to share the message around signs, symptoms of sepsis and when the seek urgent medical attention is shared across NHS Wales.	The Health Board maintains communication with the UK Sepsis Trust and uses evidence-based resources. The Comms team and QPS are collaborating on building and updating sepsis assets and sharing where possible. This includes presenting to and supporting the Wales Sepsis group with shared information, assets and encouraging others to continue raising awareness and standardise assets, such as “spotting the unwell child leaflet”. internal sepsis pulse page has been created as well as a public facing sepsis page. This, alongside the social media campaign allows a mechanism to provide update to date information and a platform for information for the public.	QPS and Comms	Completed / Phase 2 ongoing
Working in Collaboration	Maintaining a collaborative approach in sepsis management is crucial for upholding best practices and mitigating risks. The Sepsis Working Group provides a forum for the multidisciplinary team (MDT) to discuss ongoing issues, identify areas for improvement, and share Health Board and national updates.	Maintaining the Sepsis Working Group will ensure a multidisciplinary approach to discussing and implementing solutions. The Assistant Quality and Patient Safety Assurance Lead will collaborate closely with Directorates, linking services, sharing best practices, and supporting quality improvement initiatives. Working directly with each area/specialty will provide a deeper understanding of the needs for improving sepsis recognition, diagnosis, and treatment. The “Big Conversation” was hosted on the 18th September 2025, allowing a forum for public feedback and allow the QPS team to focus on direct areas of concerns, as highlighted and shared within the event. A mechanism to feedback information around actions generated will be developed.	Division s and QPS	Completed / Ongoing
Continue working with UK Sepsis Trust, national forums and other health boards/trust	Founded in 2012, the UK Sepsis Trust is a valuable resource for NHS England and NHS Wales. It facilitates collaborative practices among Health Boards and Trusts across both countries. The charity offers a range of evidence-based resources, including Sepsis UK screening tools, educational materials, and signs and symptoms awareness posters/leaflets.	Representatives from the UK Sepsis Trust have previously supported the Health Board with the initial NEWS implementation and remain valuable contacts. Maintaining regular communication between ABUHB and UK Sepsis Trust allows for the continued sharing of evidence-based resources to enhance clinical practice. ABUHB continues to represent nationally within Acute Deterioration groups, All Wales Sepsis group, NHS executive forums and recently as part of the “Safe Care Partnership- Deteriorating patient” group. This include exploring escalation processes and a new way to capture response to deterioration.	Division s and QPS	Forward work plan for 2026 to continue
Develop Audit Strategy for Sepsis and ensure learning from incidents	It's essential to establish a consistent method for capturing sepsis data across the Health Board. Currently, varied monitoring approaches hinder the collection of reliable data needed for improvement. Standardising data capture methods will enhance the ability to support clinical practice and drive better outcomes.	Collaboration: Work closely with national groups, divisions and the deteriorating patient working group, to identify universal data requirements and agree on standardised methods for capturing patients with Sepsis. Efficiency: Use AMaT to develop a proforma, ensuring the audit process is efficient and the workforce can input data effectively. Learning System: Develop a system to learn from incidents where Sepsis was missed, including thematic reviews of Datix incidents.	Sepsis Working Group	Being progressed Nationally via SCP September 2026
47/137 69/425				

PILLAR 4

Health, Safety, Security and Compliance

Competent People

Compliance
Assurance

Risk
Management

Learning from
Events

Asset
Management

Communication

Emergency
Preparedness

Leadership,
Accountability
and Culture

Measuring
Performance

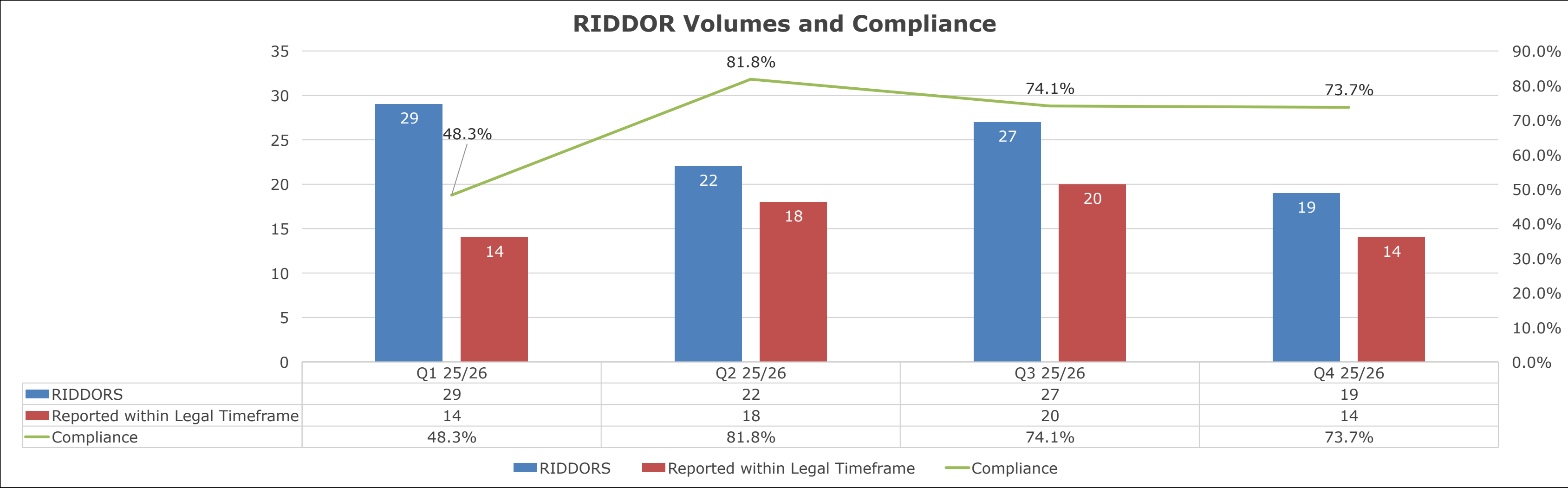
Security
Management

HSS
Dashboards

Fire Safety
Management

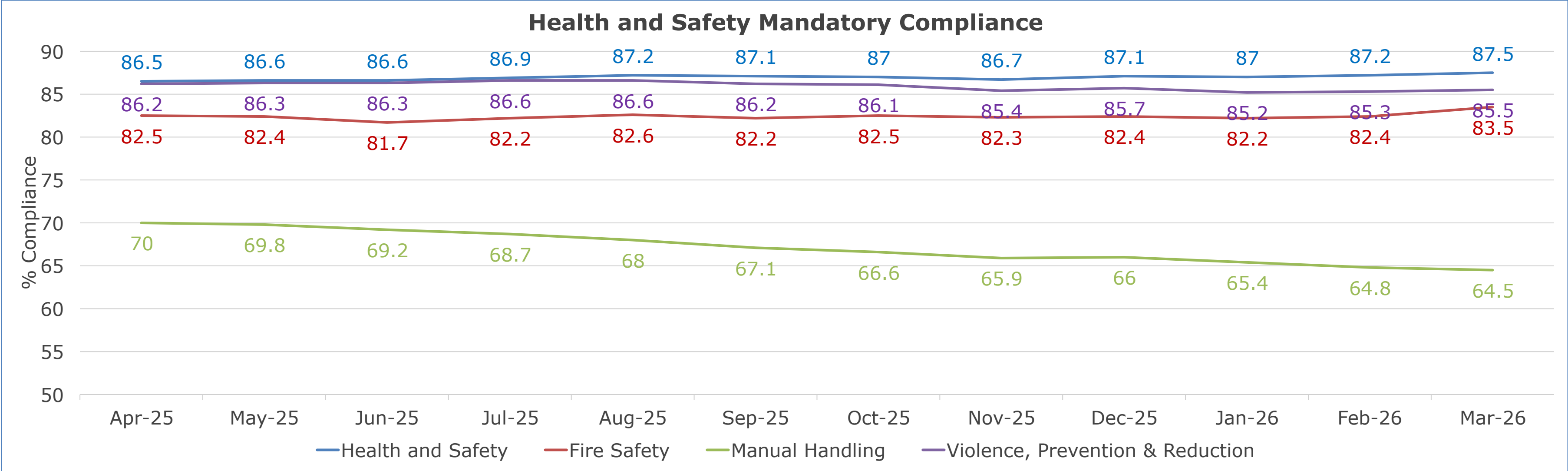
Manual
Handling

RIDDOR Compliance



Issue	Action		Learning and Improvement
RIDDOR reporting compliance with the legal timeframes	RIDDOR SOP revised	Timely reporting and investigation of incidents to determine an outcome on RIDDOR	RIDDOR Awareness eLearning Training to be implemented in Q2 26/27. Submission to Core Learning Committee in June 2026 to mandate this training for managers

Statutory and Mandatory Training Compliance



Health and Safety Training Compliance	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Health and Safety	86.6%	86.6%	87.1%	87.1%	87.2%
Fire Safety	82.3%	81.7%	82.2%	82.4%	82.7%
Manual Handling	70.0%	69.2%	67.1%	66.0%	64.9%
Violence, Prevention & Reduction	86.01%	86.3%	86.2%	85.7%	85.3%

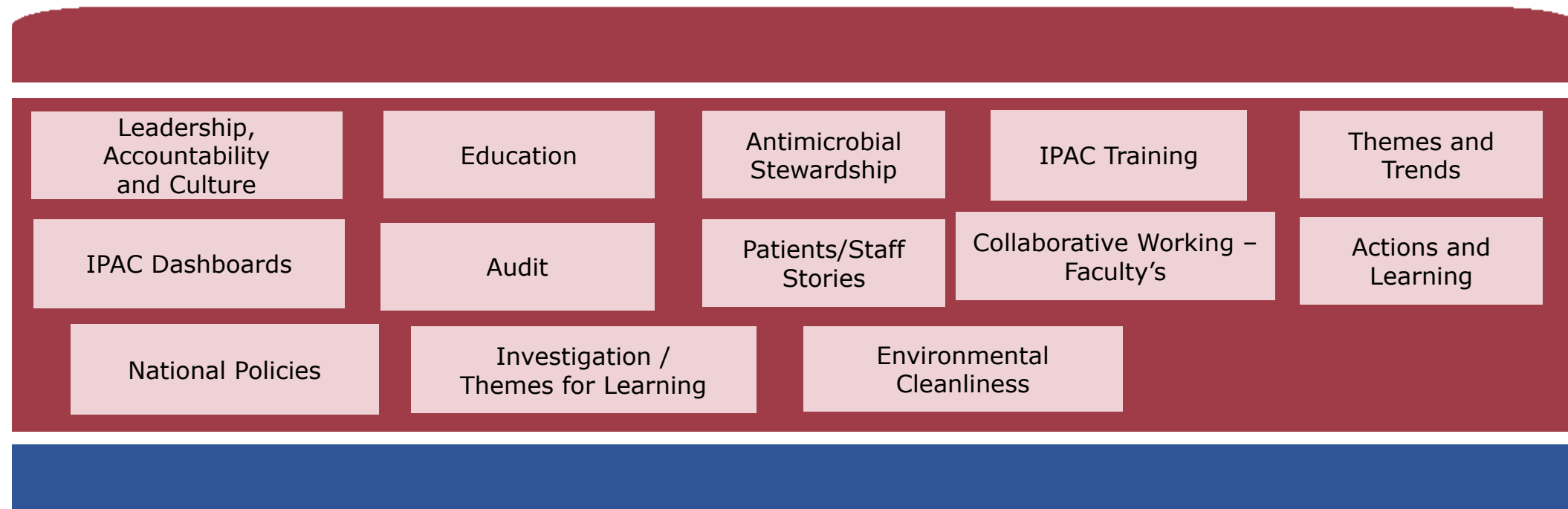
Incident Reporting

Staff Health and Safety Incident Reporting	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26
Physical Assault	266	203	262	276
Contact with needles or medical sharps	56	67	65	54
Slip, trip or fall	28	35	26	50
Verbal assault	45	25	45	46
Manual Handling	18	19	19	16
Sexual assault and/or sexual inappropriate behaviour	19	11	19	14

Issue	Action	Learning and Improvement
Violence towards staff	Violence Prevention & Reduction Strategic Plan approved by Board Successful recruitment of Violence, Prevention & Reduction Manager	The VPR Strategic Plan sets out objectives to improve reporting and culture
Needlestick & sharps	Reduction in number of injuries in Q4 2025/26	QI project to reduce needlestick and sharps injuries to commence in Q2 26/27 in conjunction with H&S, IPaC and Occupational Health
Winter slips, trips and falls	Winter falls thematic review conducted by Corporate Health & Safety	Areas for improvement identified within the thematic review to be shared with Facilities Division
RIDDOR reporting compliance with the legal timeframes	RIDDOR SOP revised	RIDDOR Awareness eLearning Training to be implemented in Q2 26/27. Submission to Core Learning Committee in June 2026 to mandate this training for managers
Manual Handling Training	Manual handling training programme developed for 2026/27	Focus on supporting Cascade Trainers (Transfer Specialists) to ensure update training is delivered locally

PILLAR 5

Infection Prevention & Control



Healthcare Associated Infections

All Wales – Current FY count of specimens

	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	250	9	148	386	122	31
Betsi Cadwaladr UHB	328	8	189	488	133	39
Cardiff and Vale UHB	186	17	131	271	122	27
Cwm Taf Morgannwg UHB	164	7	106	364	138	14
Hywel Dda UHB	161	15	111	363	121	22
Powys THB	26	0	1	1	0	0
Swansea Bay UHB	210	10	118	267	112	27
Velindre NHST	5	0	4	15	2	2
Wales	1330	66	808	2155	750	162

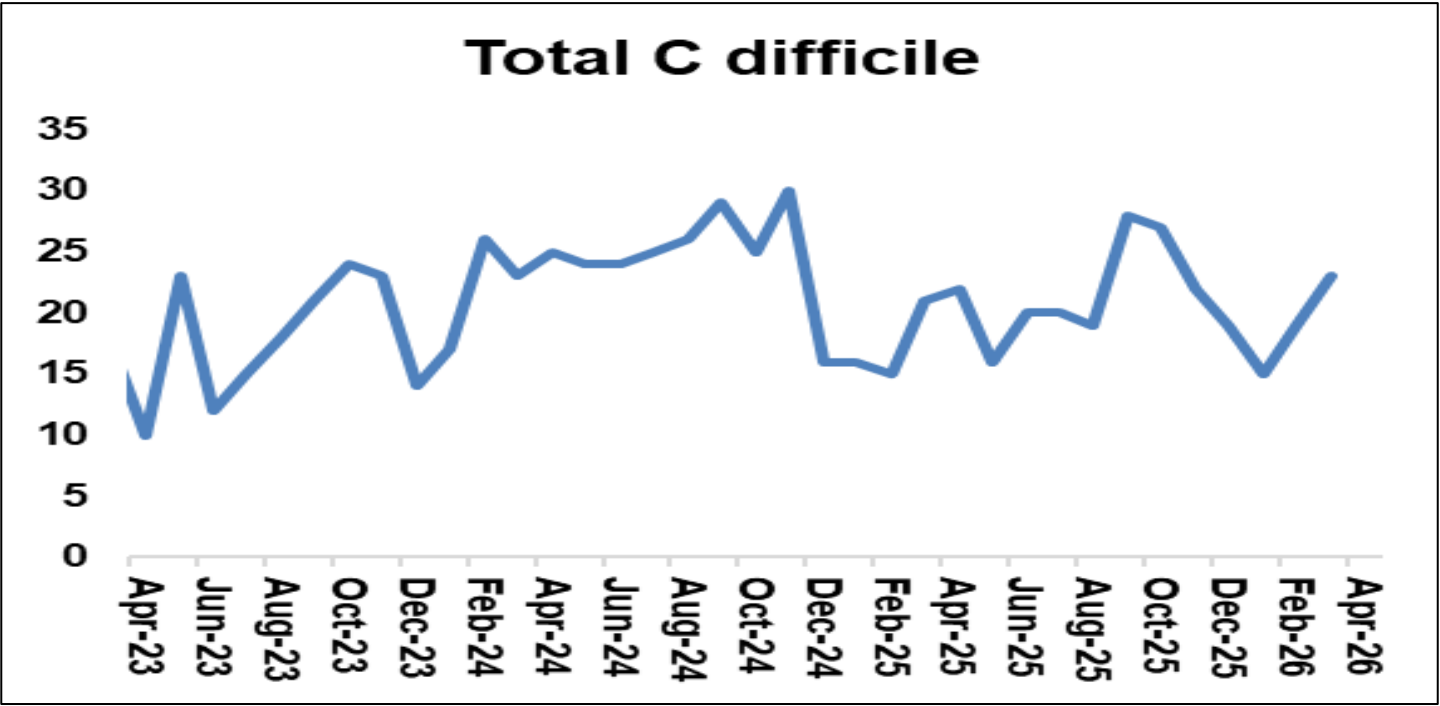
< than same period last FY
 = same period last FY
 > than same period last FY

All Wales – Current FY rate per 100,000 population

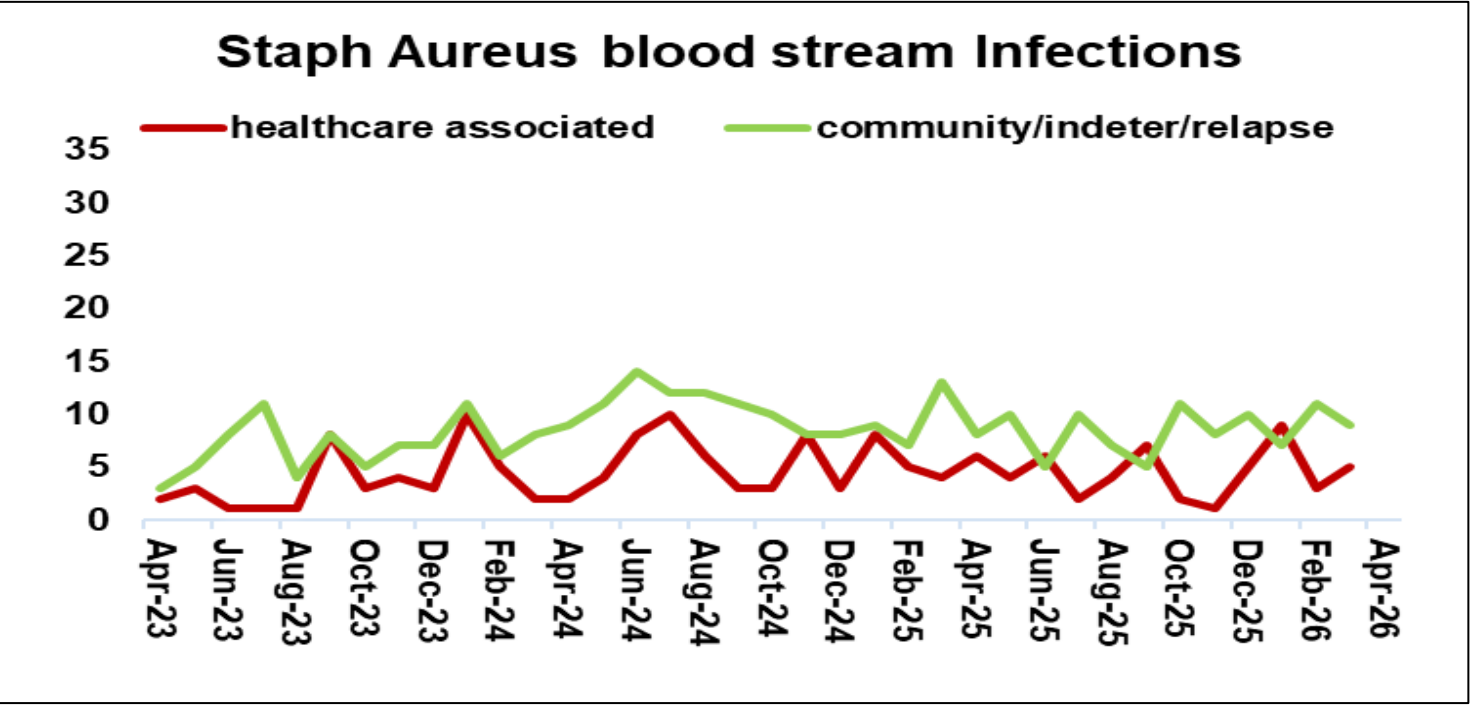
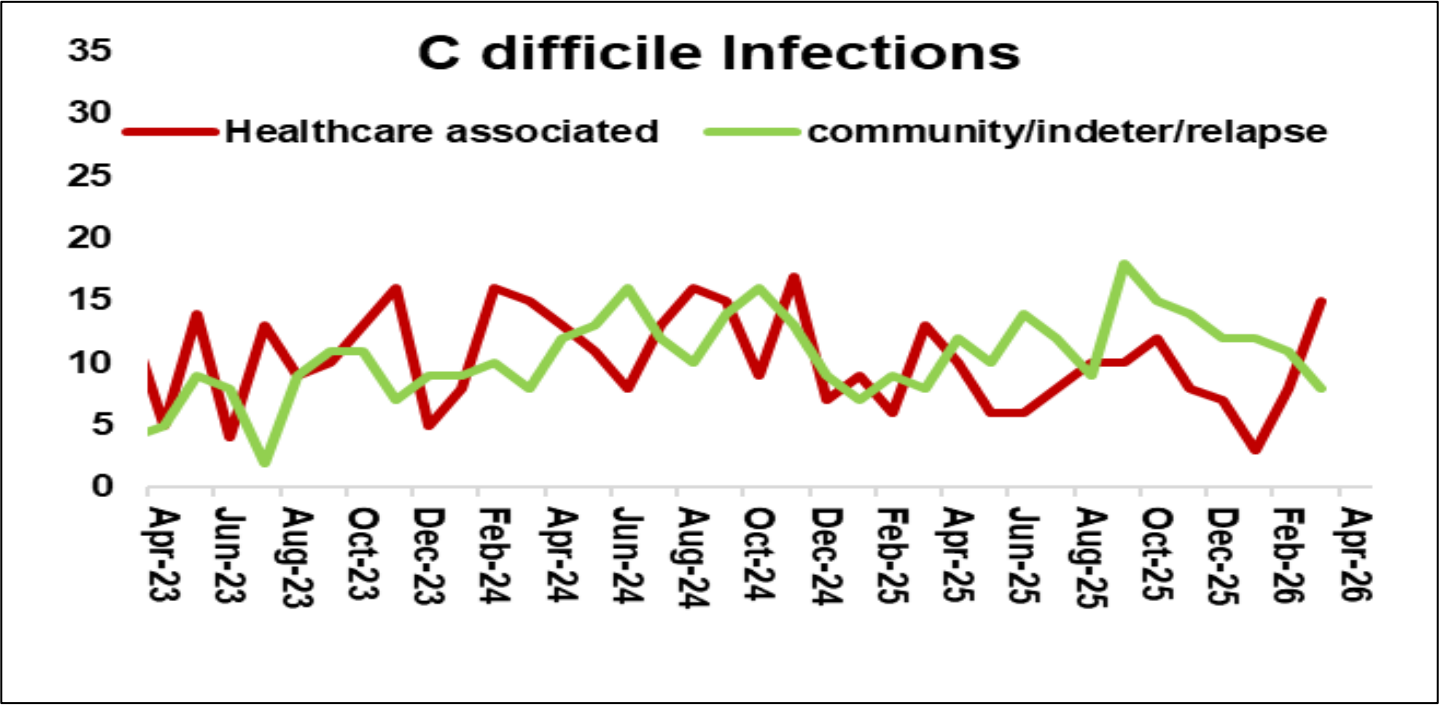
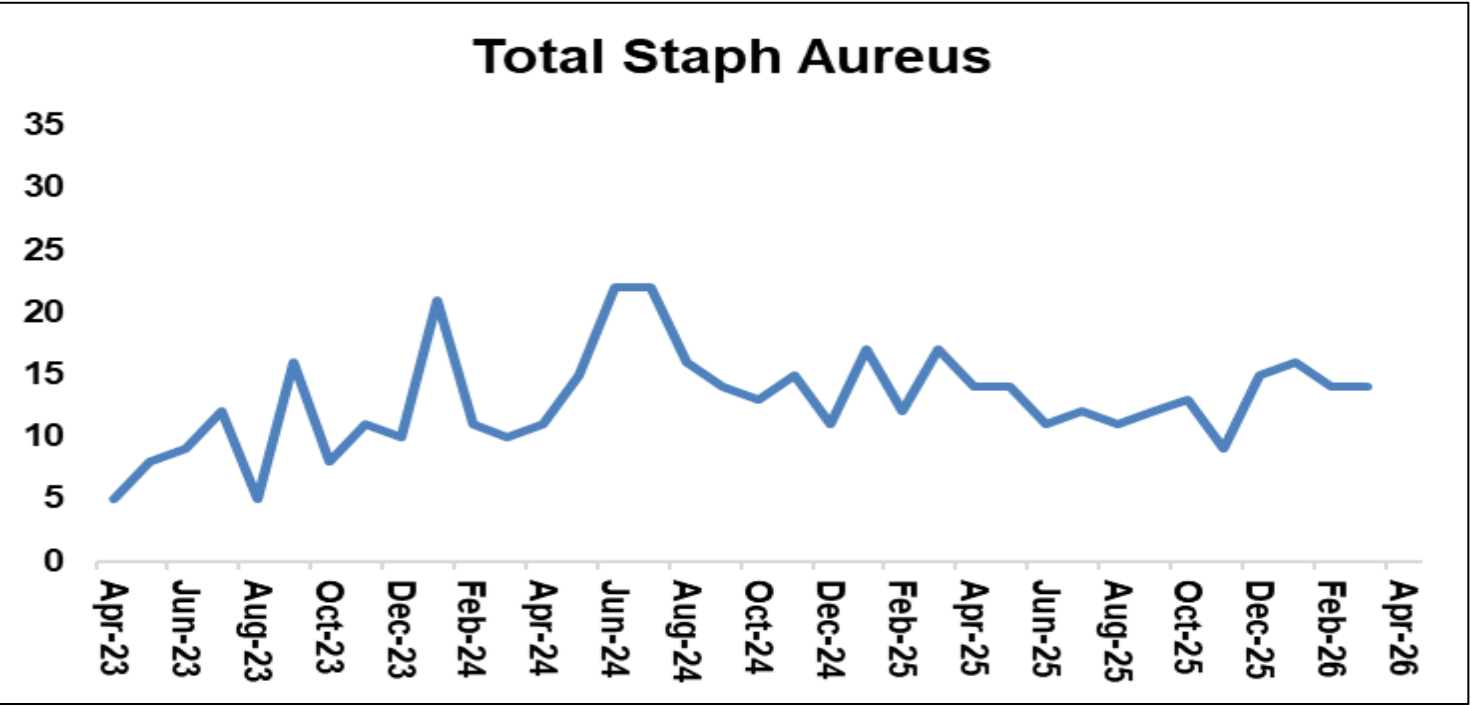
	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	41.99	1.51	24.86	64.83	20.49	5.21
Betsi Cadwaladr UHB	47.4	1.16	27.31	70.52	19.22	5.64
Cardiff and Vale UHB	35.89	3.28	25.28	52.29	23.54	5.21
Cwm Taf Morgannwg UHB	36.73	1.57	23.74	81.52	30.91	3.14
Hywel Dda UHB	41.48	3.86	28.6	93.52	31.17	5.67
Powys THB	19.34	0	0.74	0.74	0	0
Swansea Bay UHB	53.9	2.57	30.28	68.52	28.74	6.93
Velindre NHST						
Wales	42.03	2.09	25.53	68.1	23.7	5.12

Healthcare Associated Infections

250 cases of C difficile reported from April 2025 to March 2026. This is 25 less than the equivalent period 2024/25. This is a HB rate of 41.99 per 100,000 population



157 cases of Staph Aureus BSI reported from April 2025 to March 2026. This is 32 less than the equivalent period 2024/25. This is a HB rate of 26.37 per 100,000 population



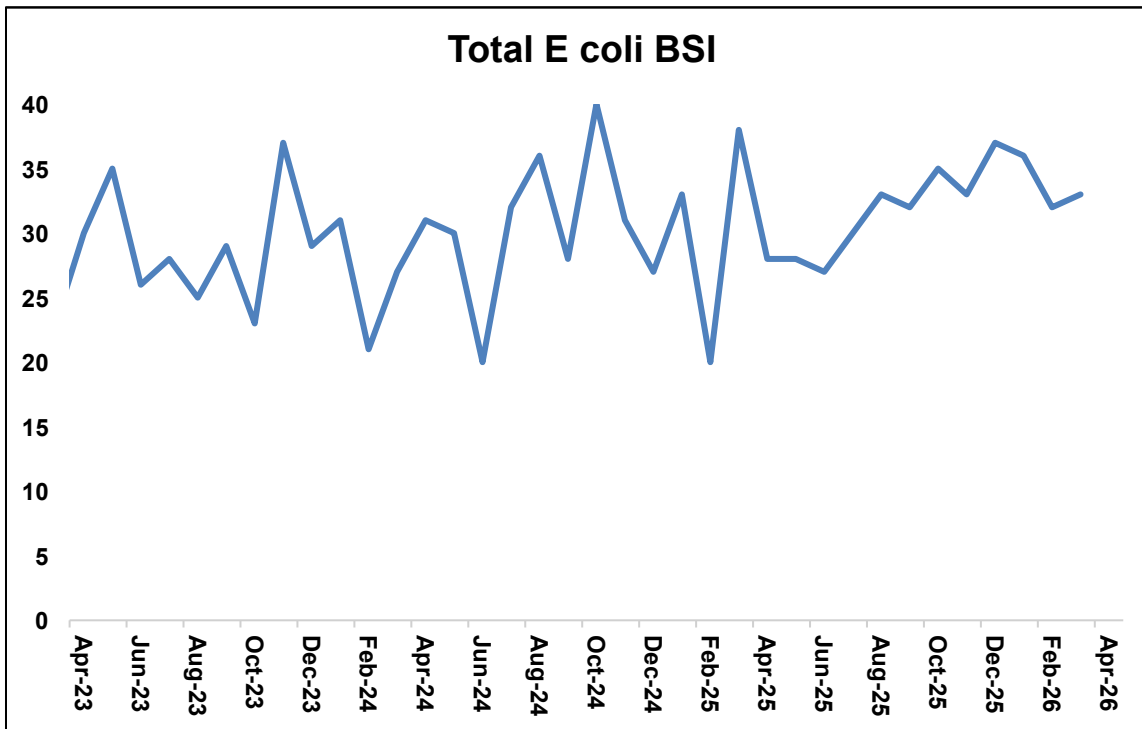
Explanation of Data:

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

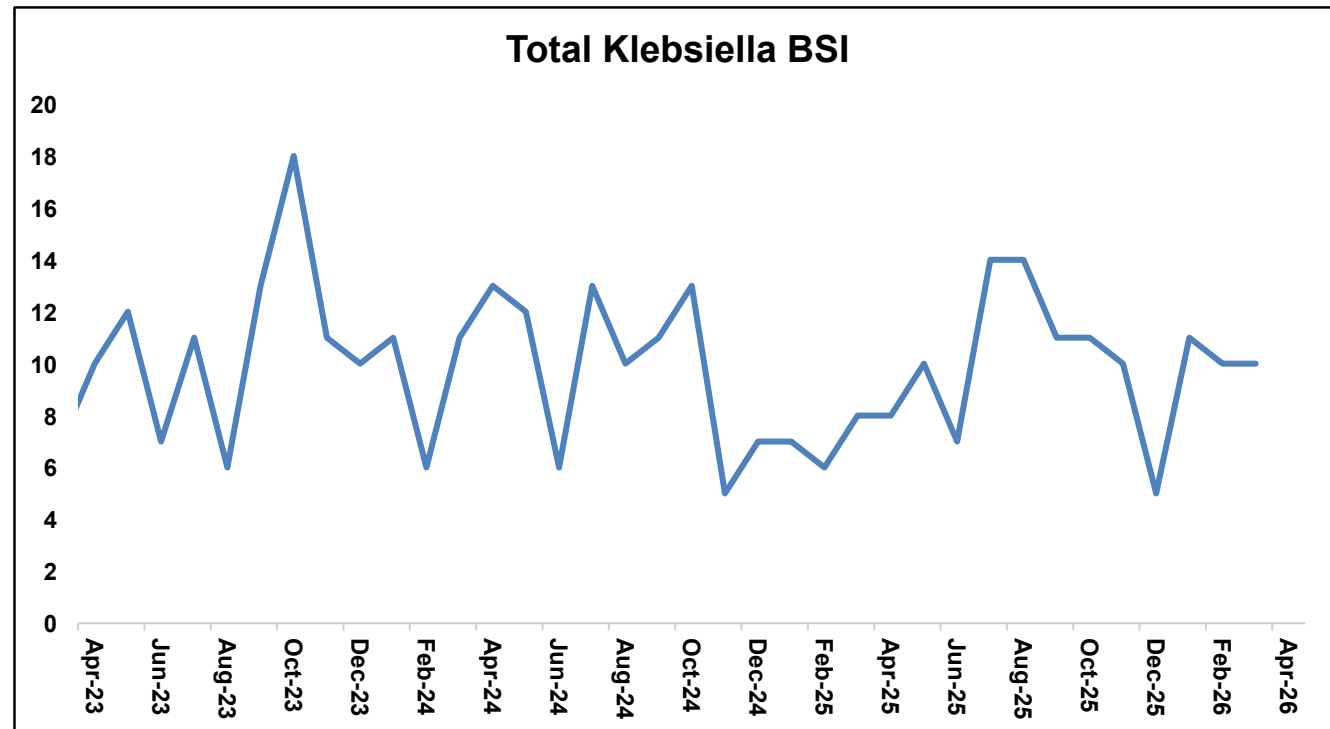
BSI = blood stream infection

Healthcare Associated Infections

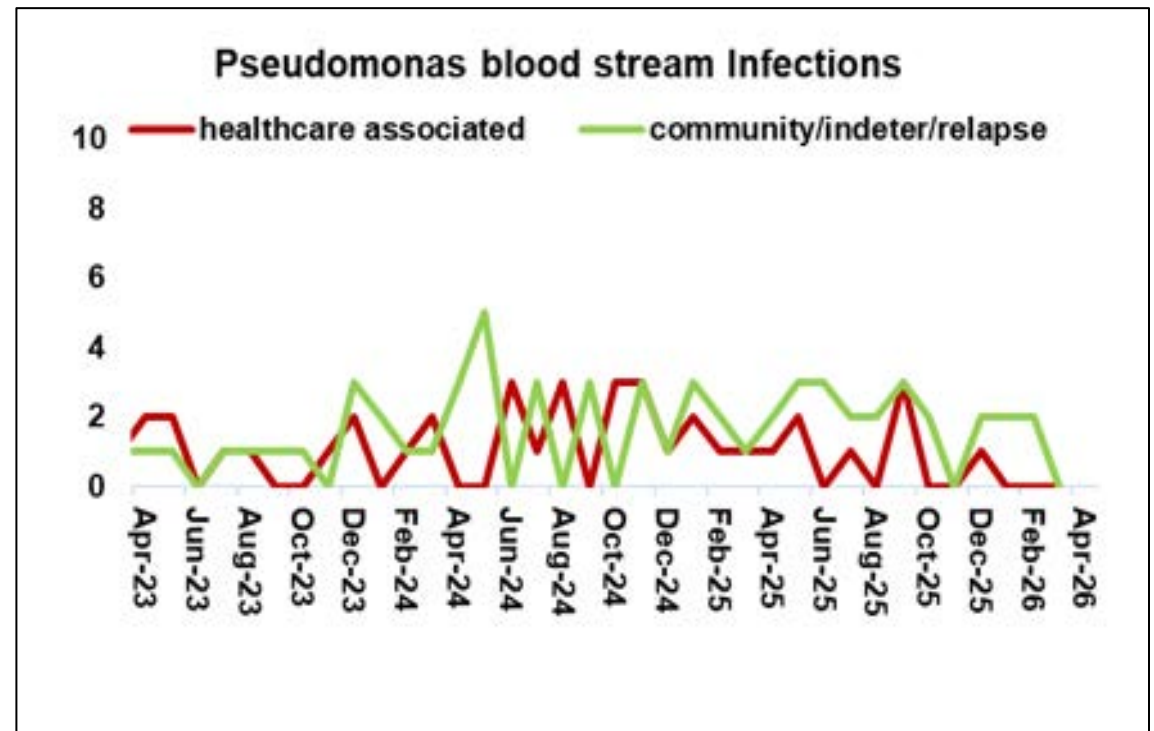
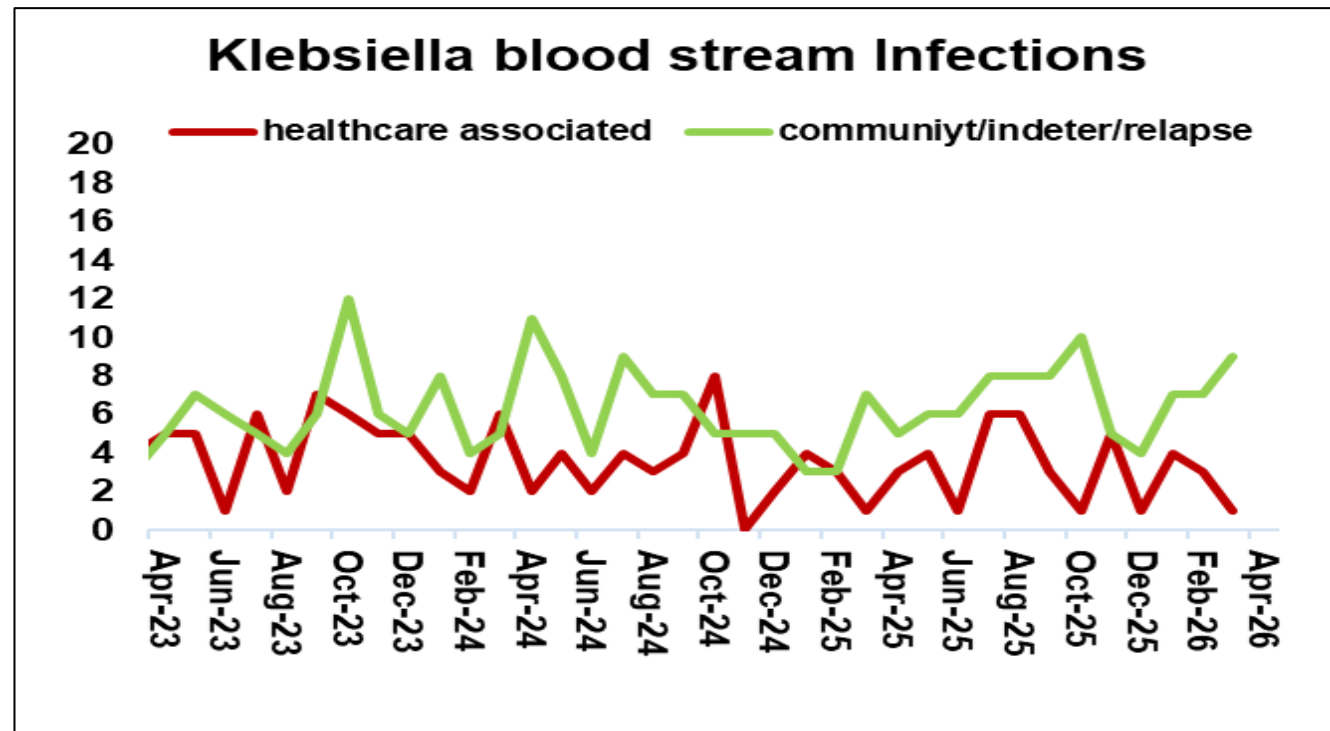
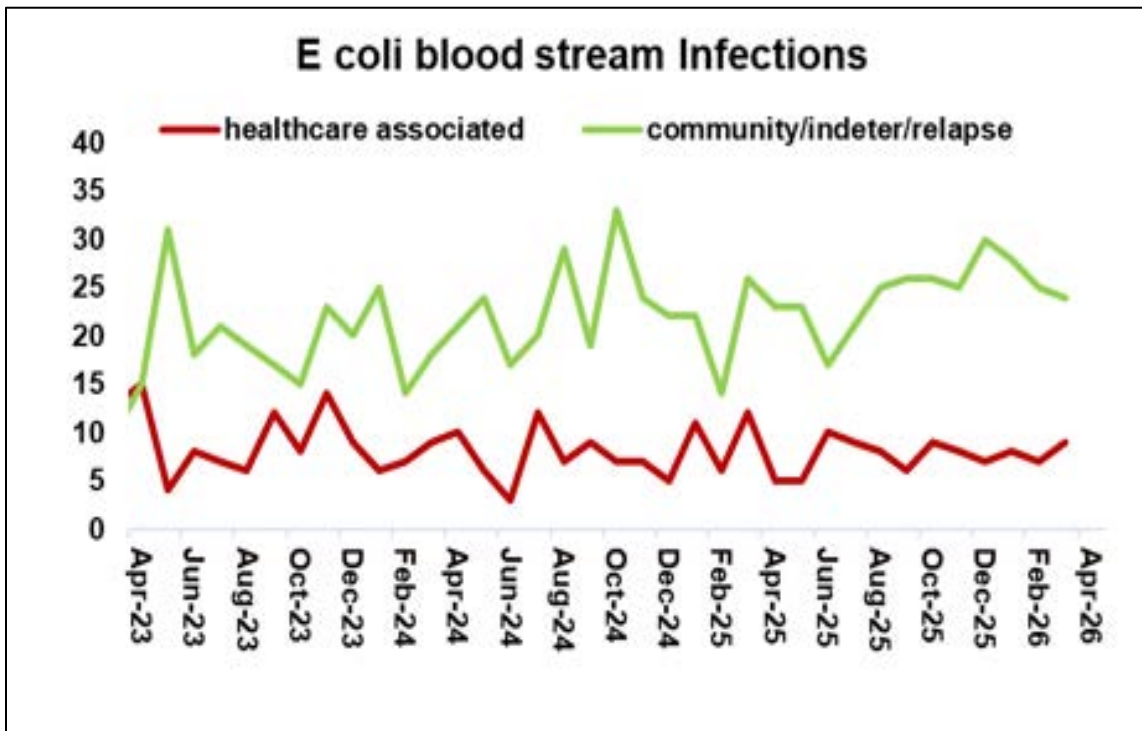
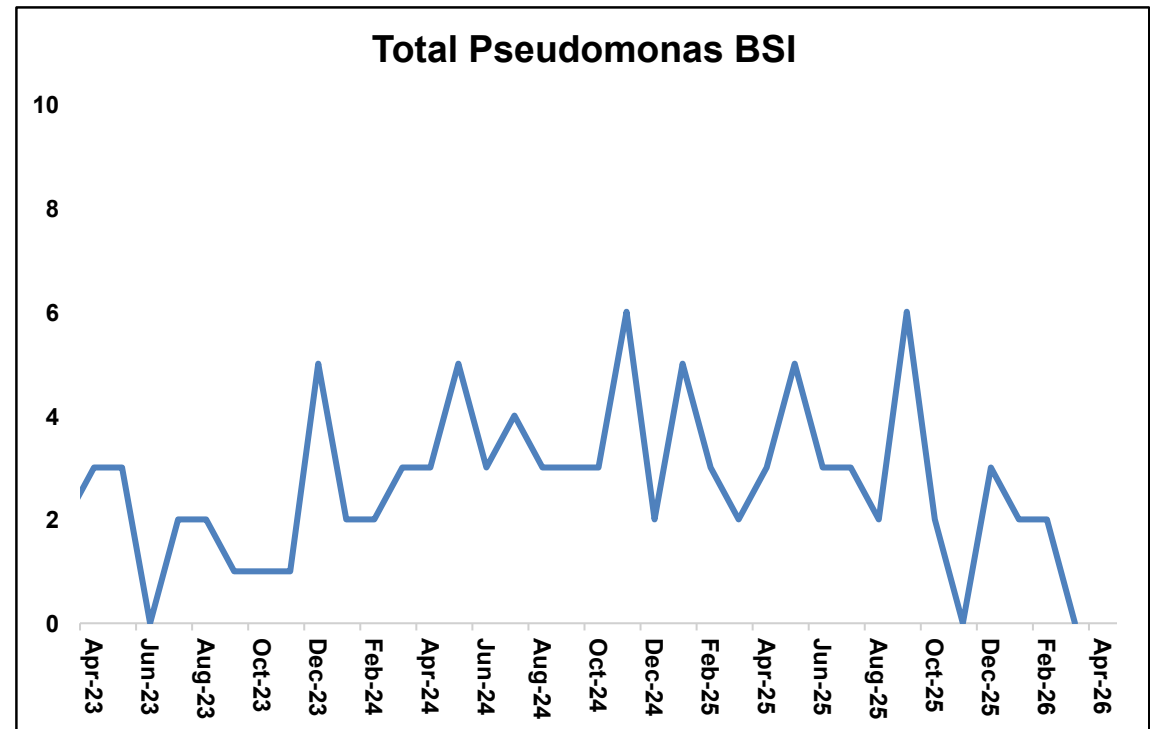
386 cases of E coli BSI reported from April 2025 to March 2026. This is 10 more than the equivalent period 2024/25. This is a HB rate of 64.83 per 100,000 population



122 cases of Klebsiella BSI reported from April 2025 to March 2026. This is 7 more than the equivalent period 2024/25. This is a HB rate of 20.49 per 100,000 population

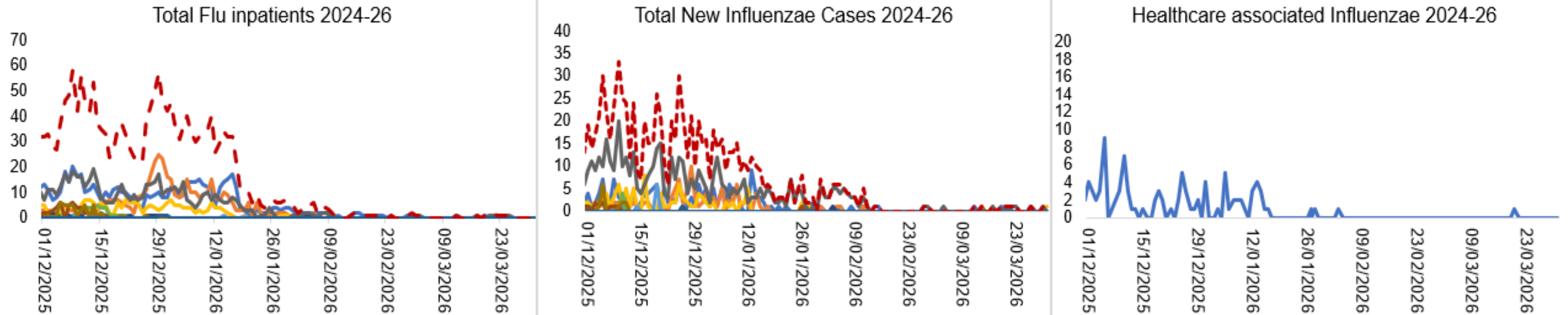


31 cases of Pseudomonas BSI reported from April 2025 to March 2026. This is 11 less than the equivalent period 2024/25. This is a HB rate of 5.69 per 100,000 population

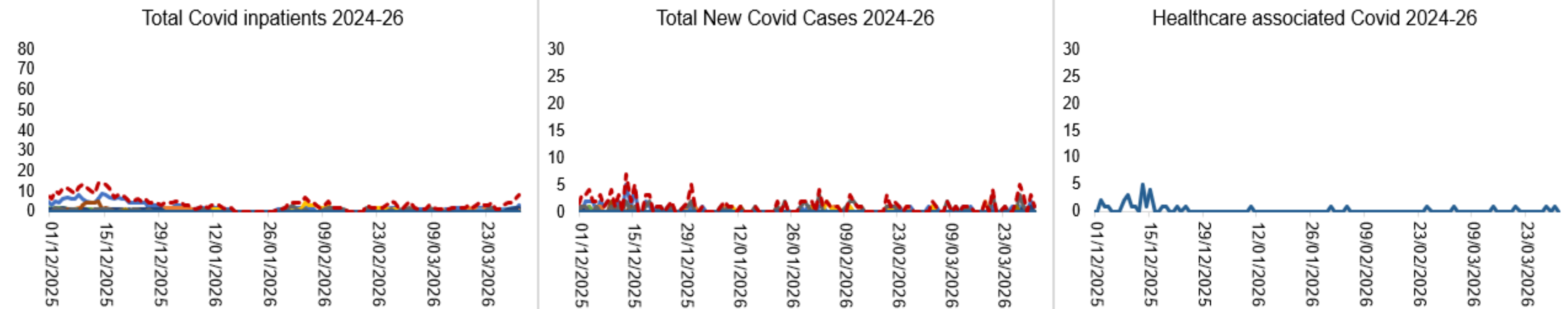


Winter Viruses

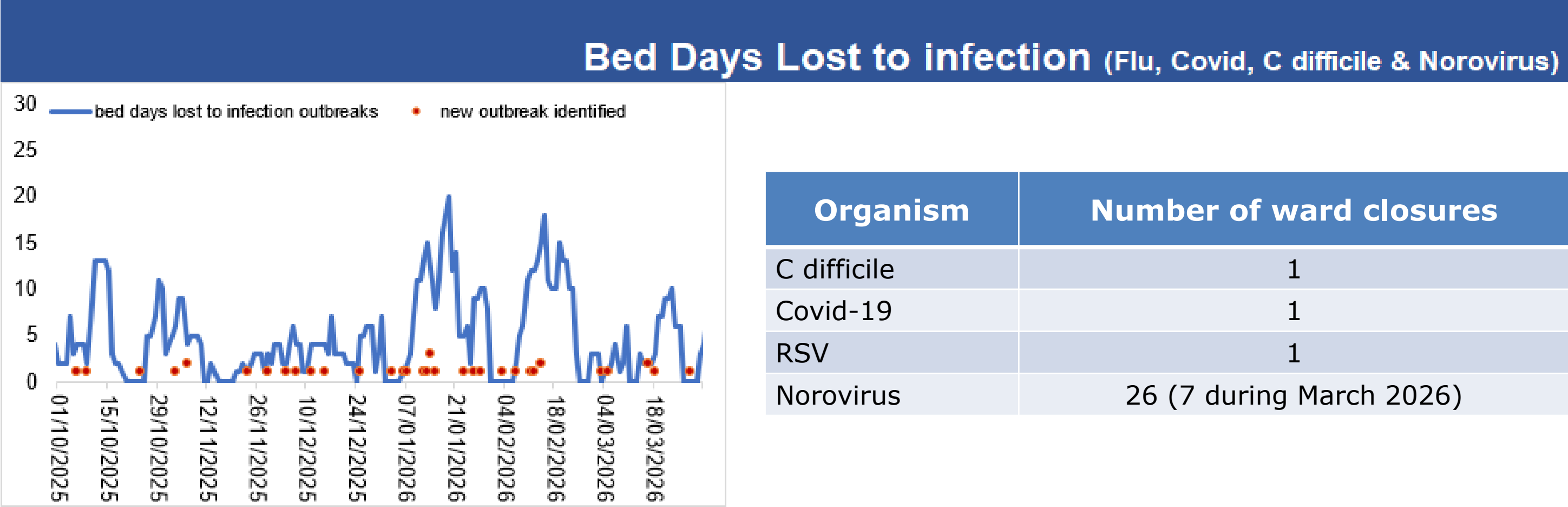
Influenza



Covid-19



Winter Viruses



TRIGGERS	01/03/2026	02/03/2026	03/03/2026	04/03/2026	05/03/2026	06/03/2026	07/03/2026	08/03/2026	09/03/2026	10/03/2026	11/03/2026	12/03/2026	13/03/2026	14/03/2026	15/03/2026	16/03/2026	17/03/2026	18/03/2026	19/03/2026	20/03/2026	21/03/2026	22/03/2026	23/03/2026	24/03/2026	25/03/2026	26/03/2026	27/03/2026	28/03/2026	29/03/2026	30/03/2026	31/03/2026	
Total Number of covid positive in patients	1	3	5	2	1	1	1	1	2	1	1	1	1	2	2	2	2	3	2	3	4	3	3	4	1	1	3	4	4	6	8	
Total Number of flu positive in patients	2	1	1	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	1	1	1	2	1	1	1	0	0	0	0	0	0	
Total Number of RSV positive in patients	3	4	2	3	2	3	2	1	0	1	2	2	1	1	0	0	0	0	1	0	0	0	0	2	0	1	0	1	1	1	0	
TOTAL ARI IN PATIENTS	6	8	8	5	3	4	3	2	2	2	3	4	2	3	2	2	3	3	4	6	4	4	7	2	2	3	5	5	7	8	0	
Total number of full ward closures ARI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	
Total number of full ward closures D&V/ Noro	0	0	1	1	2	3	1	1	2	2	1	1	0	1	1	1	1	2	2	3	3	3	3	3	1	1	1	1	1	2	1	
Total number of pods/ bays closed ARI/ D&V/ Noro	1	1	0	0	1	2	2	1	0	1	1	1	1	0	0	0	1	1	0	0	0	0	0	0	0	0	0	1	1	1	0	0
TOTAL AREAS CLOSED	1	1	1	1	3	5	3	2	2	3	2	2	1	1	1	1	2	3	2	3	3	3	3	1	1	1	1	2	2	3	1	
Number of patients ventilated in ICU/o ARI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Staff sickness %due to ARI	0.7	0.73	0.7	0.7	0.65	0.65	0.64	0.65	0.64	0.62	0.61	0.60	0.7	0.63	0.59	0.62	0.66	0.71	0.62	0.63	0.56	0.56	0.56	0.61	0.54	0.64	0.53	0.5	0.56	0.52	0	
Number of Enclosed Settings in incidence	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
ESCALATION LEVEL																																
Total number of NOROVIRUS patients within 72 hours of symptomatic period	0	0	0	0	20	30	30	27	17	13	9	6	0	0	0	0	1	9	13	19	21	23	22	17	10	7	7	4	4	4	11	

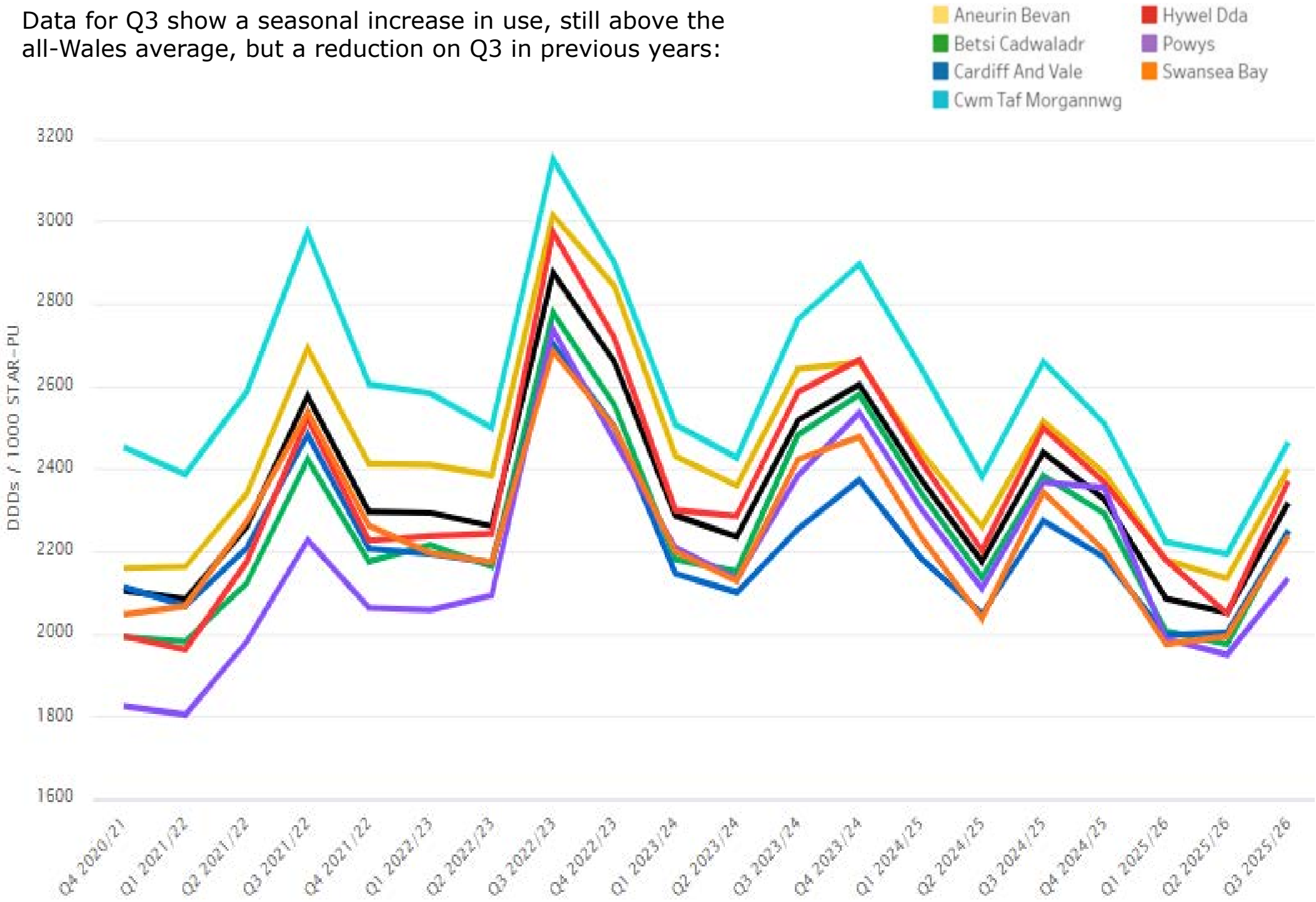
Themes & Trends	Successes	Challenges	Learning & Improvement
High community prevalence for norovirus	Standard operating procedures for risk escalation Point of care testing in assessment units for respiratory infection Norovirus testing in assessment units	Ongoing demand and capacity demands Shared facilities	Staff working with symptoms Visitors visiting with symptoms

Pillar 5: Infection Prevention & Control			
Learning and Improvement			
Themes & Trends	Successes	Challenges	Learning & Improvement
C difficile	Four new clusters identified or periods of increased incidents confirmed gen- sequency in D5W Quality improvement ongoing at RGH with a focus on near patient cleaning of equipment and communication	Antimicrobial pharmacist workforce currently shortage in team Timely isolation at RGH and NHH due to limited isolation capacity Norovirus impacting on incident finds of C difficile Vacancies and sickness within facilities team	Local risk assessment for hospital cleaning due to limited workforce Reduction in hospital acquired C difficile of 22% from 138 to 107 plus a 3% reduction in number of CAI cases compared to previous FY
Staph Aureus blood stream infections	Refreshed training package to interactive session for healthcare support workers with positive feedback Reduction of 15% of hospital acquired MSSA/MRSA plus a 21% reduction in CAI <i>Staph aureus</i> BSI infections compared to previous FY	Line infection MSSA in critical care ESR reporting re ANTT compliance	Refreshed PIC line guidance obtained from Velindre, local T&F group to be established to review line care generally across the HB Promoted I DECIED for line access assessment tool
Gram Negative blood stream infections	Erase developed and published for urine dip stick UTI rate in care home lower than all Wales average No device related BSI	Increase in E coli and Klebsiella Secondary infections linked to respiratory and biliary sepsis 7% increase in CAI Gram-negative BSI compared to previous FY	HAP audit planned for April
Winter Viruses	Escalation triggers within standard operating procedure includes norovirus Respiratory virus impact declined to seasonal variation	High prevalence of community Norovirus Impact on Nevill Hall Hospital, YYF and RGH over the last 3 months	Shared facilities contributed Norovirus testing in assessment units help support system wide risk assessment and patient placement Public coms messaging
Sporadic healthcare associated CPE on maternity	Managed in line with national guidance No contacts	Facilities staffing for environmental deep cleaning	Ongoing quality improvement for SSI
Incidental healthcare associated CPE on Trefynwy Ward, Monnow Vale	Implemented national guidance Strict transmission precautions Contacts screened no cases identified to date	Identified via GP post discharge Environmental cleanliness currently cleaning staff managed by ward sister and primary care Division not facilities, staff shortage due to sickness	No previous indication for screening therefore unable to confirm where patient acquired infection from Increase of resistant pathogens
Chicken pox exposure on NICU and ITU	No onward transmission due to exposure to patients or staff Staff quick risk assessment of high risk patients	Vulnerability of [patients in augmented care	Importance of staff status
Theatre/HSDU sterilisation	MDT engagement to support staff and patient exposure	No electronic traceability in theatre Supplementary surgical instruments not part of WHO theatre check list	Staff knowledge of sterilisation indication tape
58/137			80/425

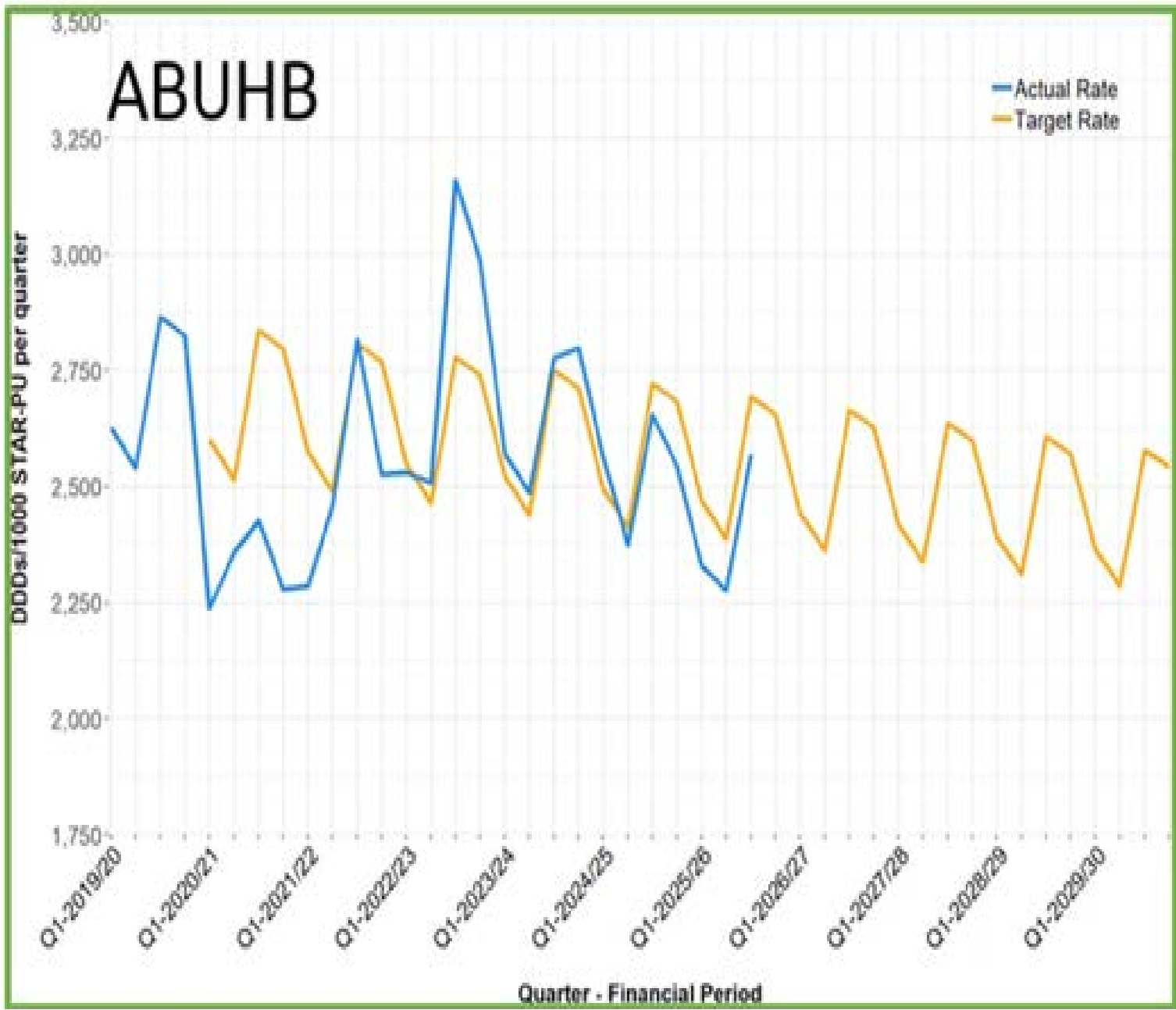
Welsh Government Antimicrobial Targets: Primary Care

- **Target: Reduction in total antimicrobial volume by a minimum of 10% by 2029/30 against 2019/20 baseline (measured in defined daily doses (DDDs) of antibiotics/1000 STAR-PU)**

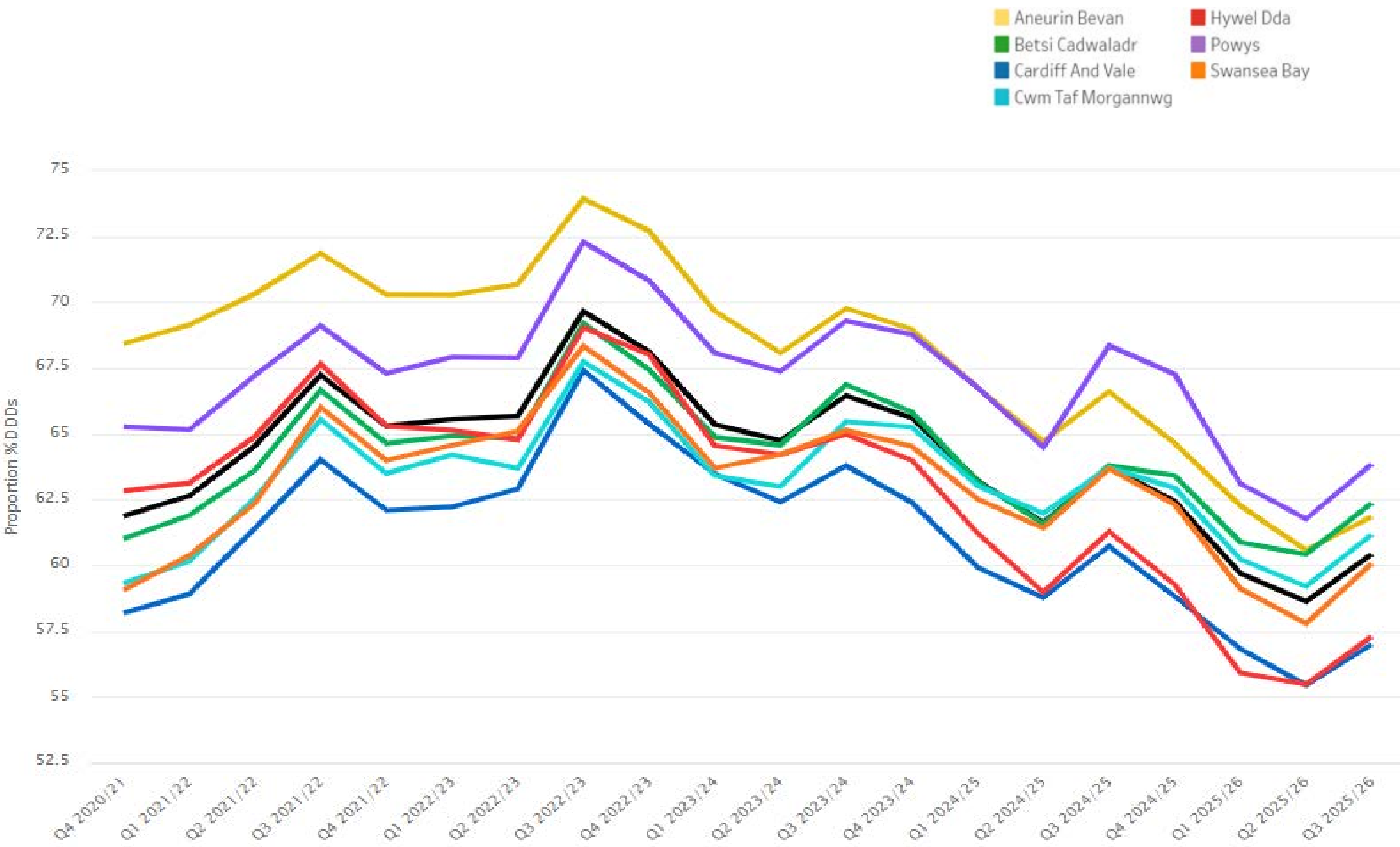
Data for Q3 show a seasonal increase in use, still above the all-Wales average, but a reduction on Q3 in previous years:



The trajectory graph demonstrates ABUHB has reduced further than the target reduction

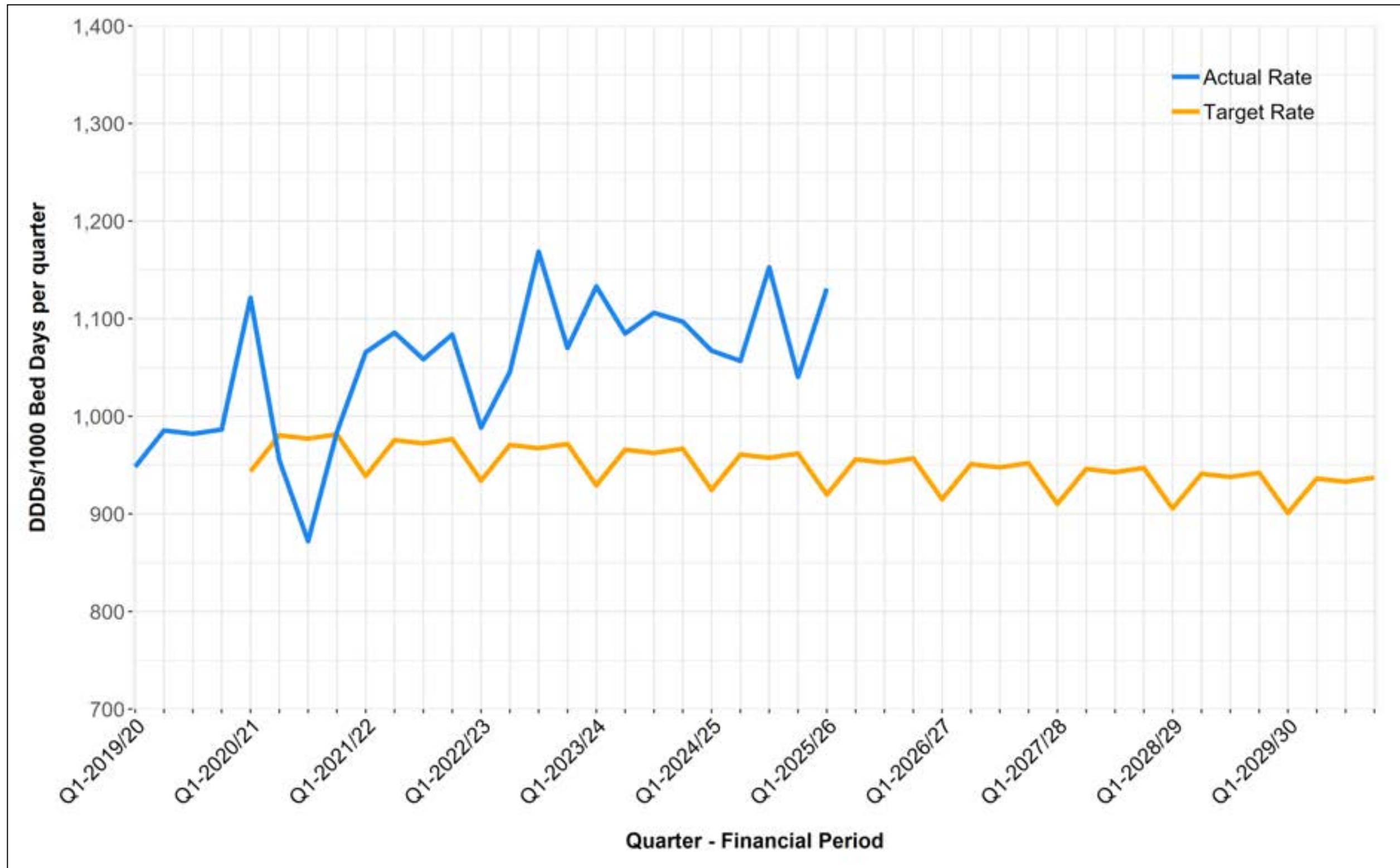


Welsh Government Antimicrobial Targets: Primary Care



- **Target: Minimum of 70% of total antibiotic use from the WHO 'Access' category by 2029/30, measured in defined daily doses (DDDs).**
- Q3 position: **62%** Whilst this is an increase on Q2, this is due to the significant increase in antimicrobial volume in Q3, predominantly due to antibiotics for respiratory tract infections.
- No update is available for the antibiotic duration target, as this is not reported by PHW, and only published quarterly.

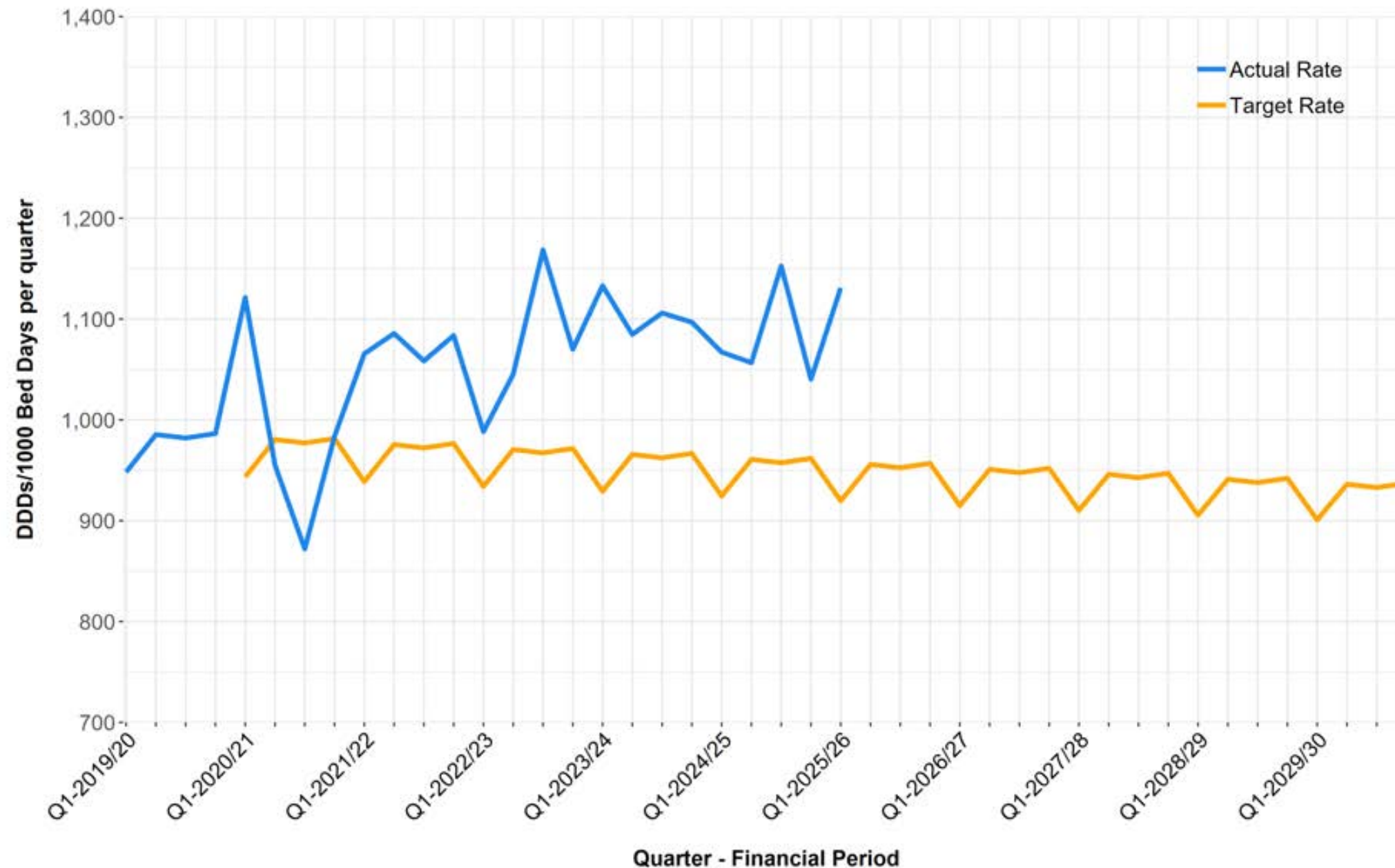
Welsh Government Antimicrobial Targets: Secondary Care



- **Target: Reduction in total antimicrobial volume by a minimum of 5% by 2029/30 against 2019/20 baseline (measured in defined daily doses (DDDs) of antibiotics/1000 bed day)**
- Progress against required trajectory demonstrates an ongoing lack of improvement. This has been noted by the WG AMR lead, and discussed with the Consultant Antimicrobial Pharmacist. Likely contributing factors are:
 - Data quality & denominator issues
 - Increasing admissions cf. a reduction in bed days vs. baseline
 - Surrogate baseline for ABUHB as pre GUH opening
 - Increased acuity of patients
 - Stretched clinical teams limits capacity to undertake good AMS
 - Elderly and immunosuppressed population with lower threshold to treat.
 - Reduction in pharmacist oversight at ward level
 - Prioritising new patients and discharges at ward level due to staff shortages means historical safety net to identify inappropriate choices or overrunning courses is absent
 - Better guideline uptake
 - e.g. amoxicillin + metronidazole + gentamicin vs. piperacillin/tazobactam
 - Likely minor impact as minimal corresponding increase in access category usage
 - Higher doses in guidelines due to EUCAST changes
 - Relatively minimal impact.

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 - Relatively minimal impact.

Welsh Government Antimicrobial Targets: Secondary Care

- **Target: WHO 'Access' category – minimum of 70% of total antibiotic use from the Access category by 2029/30, measured in defined daily doses (DDDs).**
- No new data are available
- The decision for electronic prescribing to go live without a hard stop removes the current requirement for antibiotics to be re-prescribed after 72 hours if they are to continue.
 - The replacement soft stop does not necessitate action by the prescriber, unlike the current paper chart
 - While use of order sets (standard prescriptions) should mitigate overrunning courses to some extent, experience from BCUHB demonstrates a significant increase in average course length when antibiotics are prescribed with a soft stop.
 - This is likely to lead to a deterioration in prescribing quality that will impact both secondary care targets
 - The Executive Team decision included a caveat that the position should be reviewed after 6 weeks
 - The Antimicrobial Pharmacy team must now prioritise pre and post implementation audit to measure impact

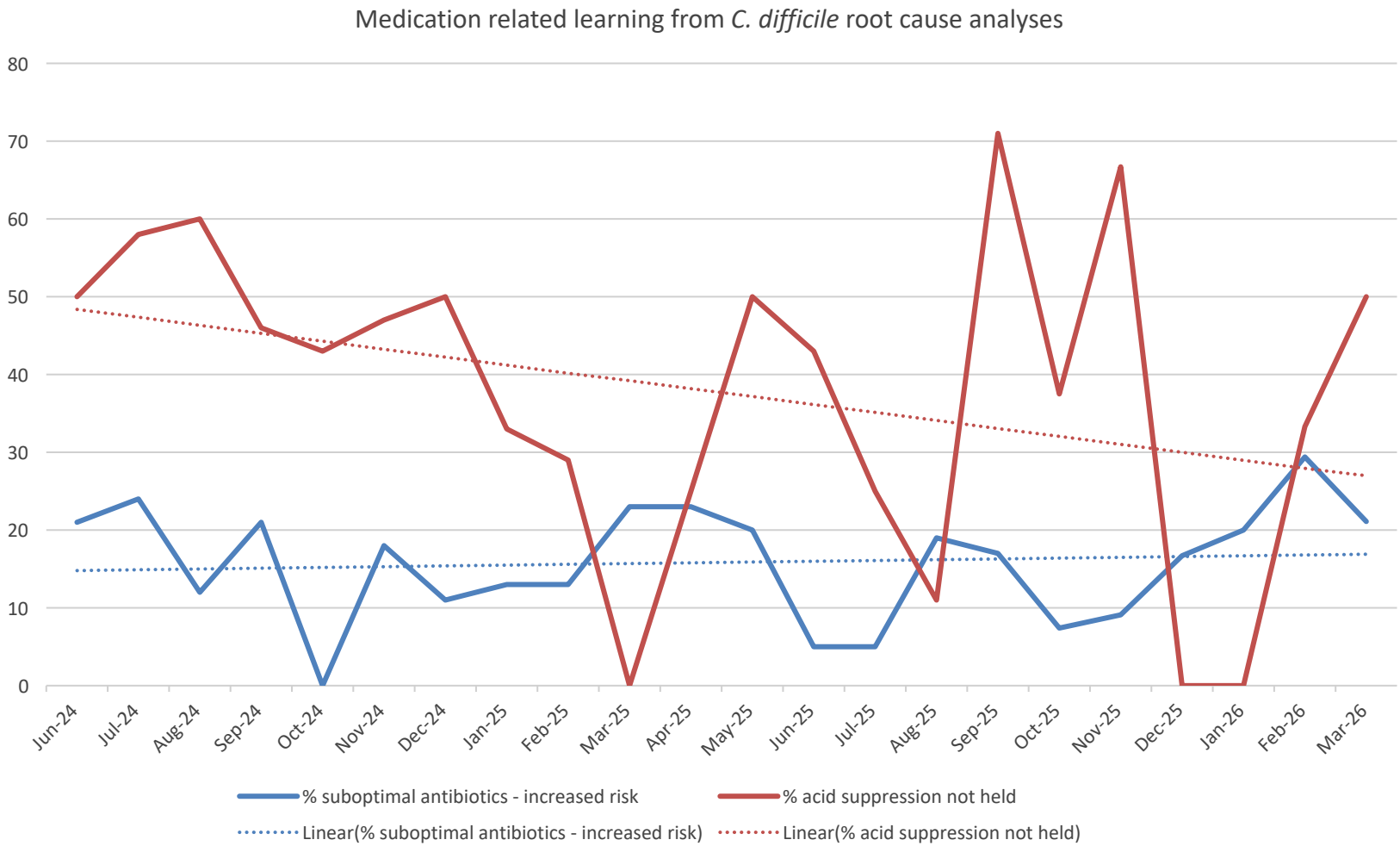
WG Antimicrobial Performance Overarching Actions

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

C. difficile Antibiotic Themes

January 26 to March 26

Antibiotic Finding		HCAI	CAI	Relapse	Indeterminate	Total
No antibiotics received	0	0	5	0	0	5
No suboptimal antibiotics	0	10	3	3	2	18
Possible suboptimal use - no increased risk	0	1	1	0	1	3
Possible suboptimal use - increased risk of C. diff	0	9	2	0	0	11
Awaiting GP response	1	0	7	2	1	11
RCA pending	0	3	0	0	0	3
Total	1	23	18	5	4	51



Q4 25-26 Learning

Uptick in proportion of patients receiving suboptimal antimicrobials outside of guidelines/ Microbiology advice / culture results:

- 3 patients January, 4 patients February, 4 patients in March
- Theme around piperacillin/tazobactam use, e.g. 3 cases in March:
 - HAP/chest sepsis & subsequently sepsis ? source (YYF 3.2)
 - ? Abdominal sepsis/sepsis ? Source (RGH MAU & D1W)
 - urine / chest infection, with previous urine cultures demonstrating resistance to piperacillin/tazobactam (YYF 3.2)
- Results of November point prevalence survey focusing on piperacillin/tazobactam awaited from PHW, to inform action plan

Uptick in acid suppression being continued inappropriately

Improvement in GP practice returns over the quarter

NB: some March RCAs are not yet completed due to Antimicrobial Pharmacy staff shortages. Actions to address piperacillin/tazobactam overuse will commence once staffing recovers and electronic prescribing data collection is complete

PILLAR 6

Safeguarding

Policies/SOP

Leadership,
Accountability and
Culture

Level 1, 2 and 3
Training

Safeguarding
Supervision

Practitioner
Concerns

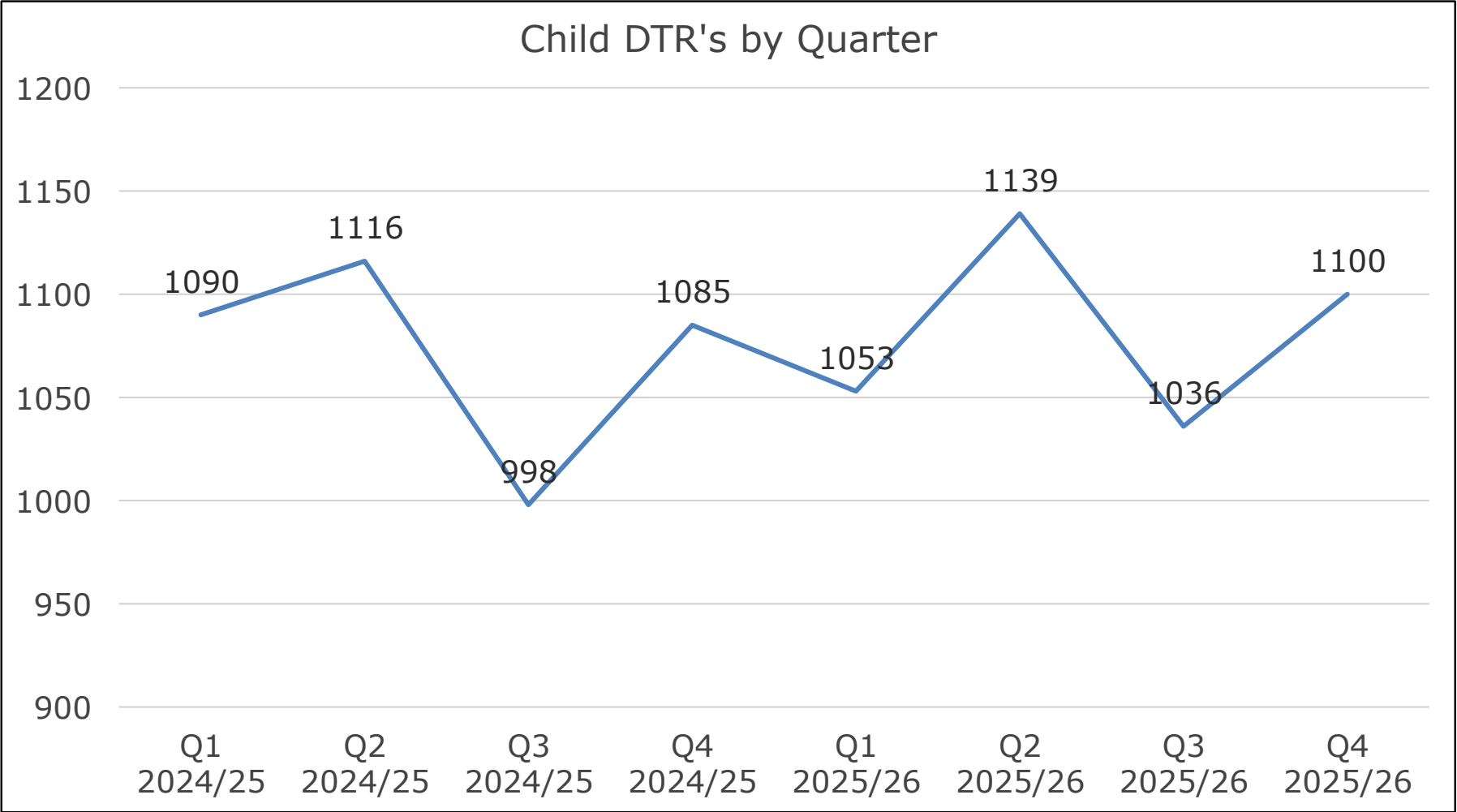
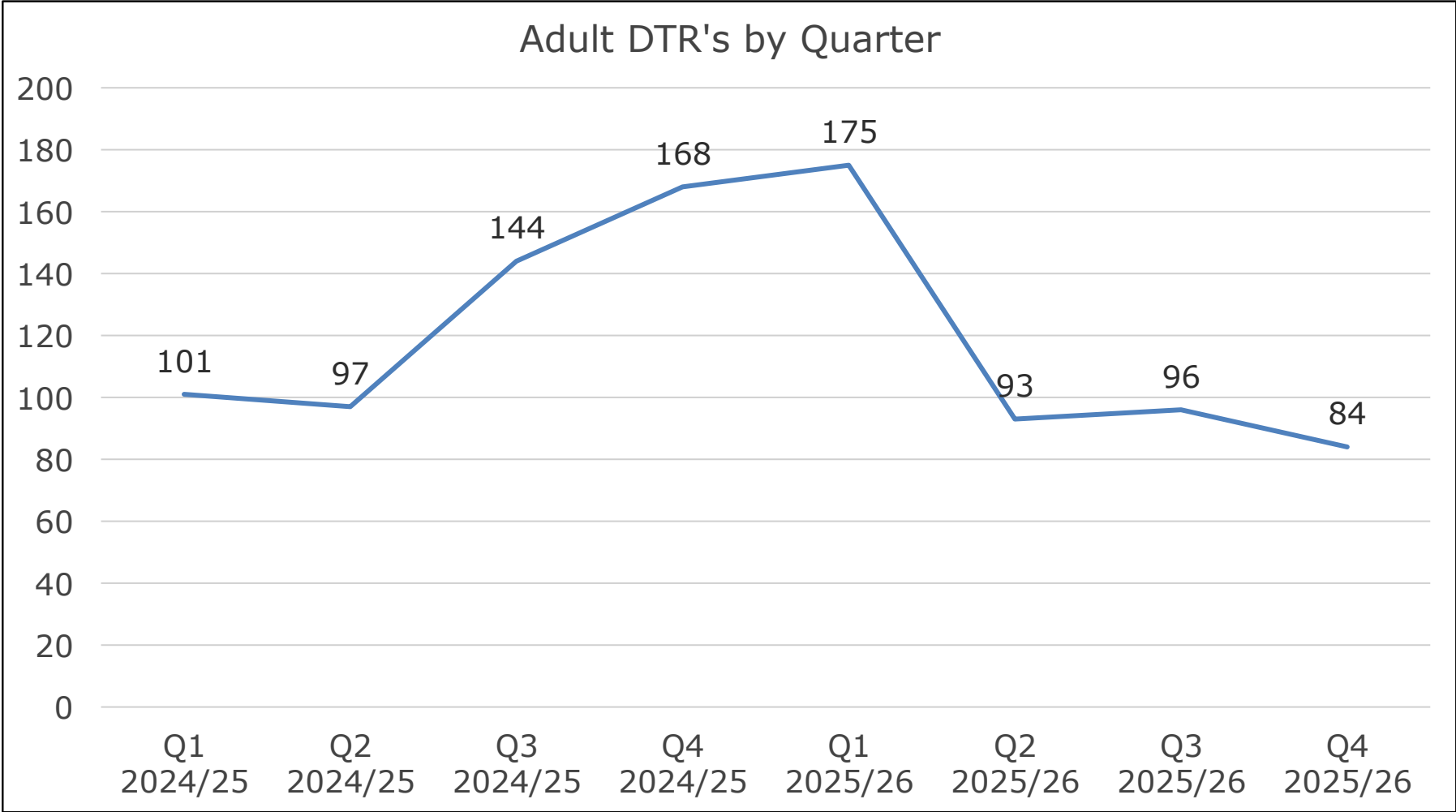
Partnership
Working

Domestic Abuse
and Sexual Safety

Deprivation of Liberty
Safeguards/ Mental
Capacity Act

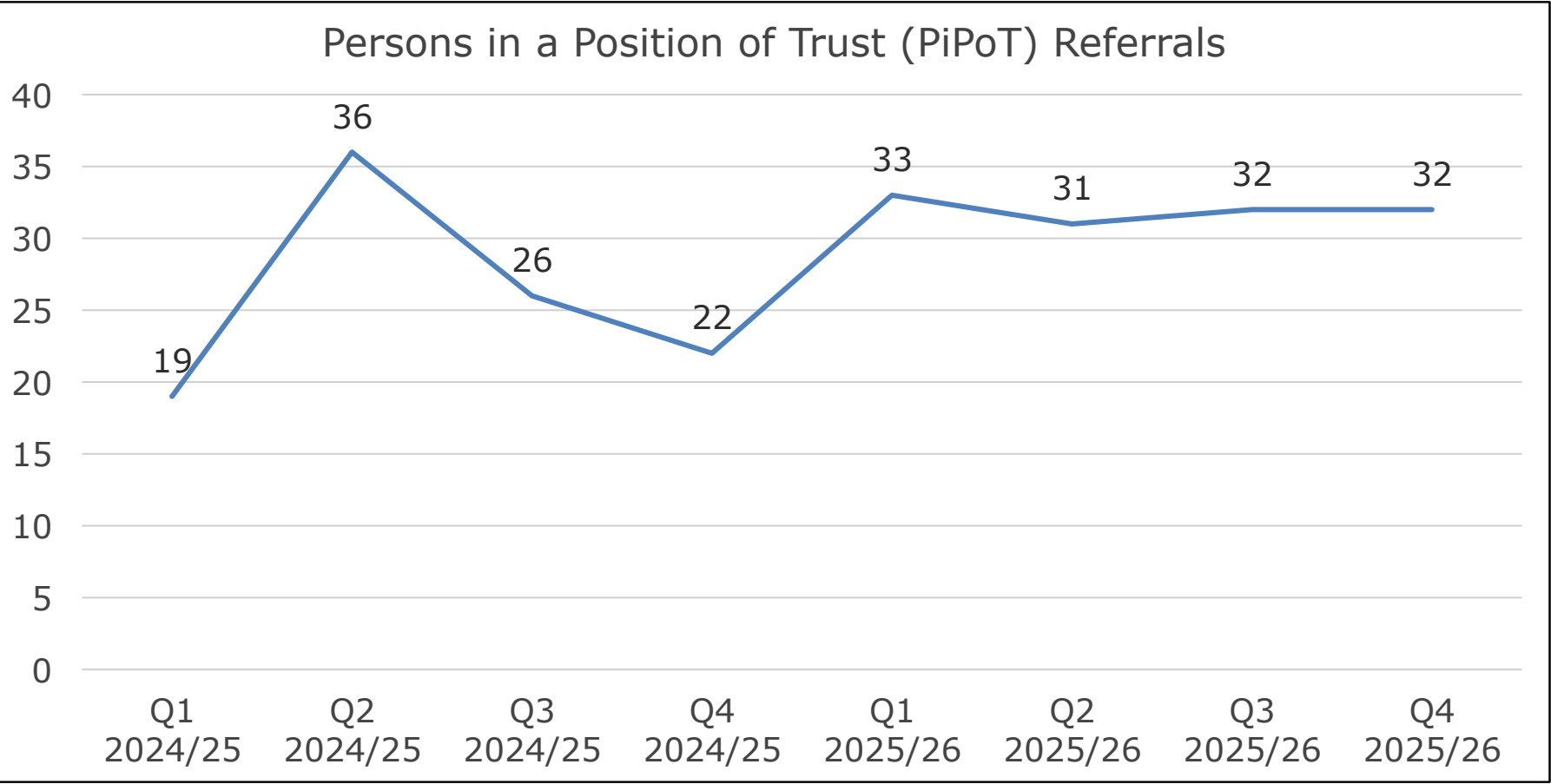
Statutory
Reviews

Duty to Report (Adult and Children)

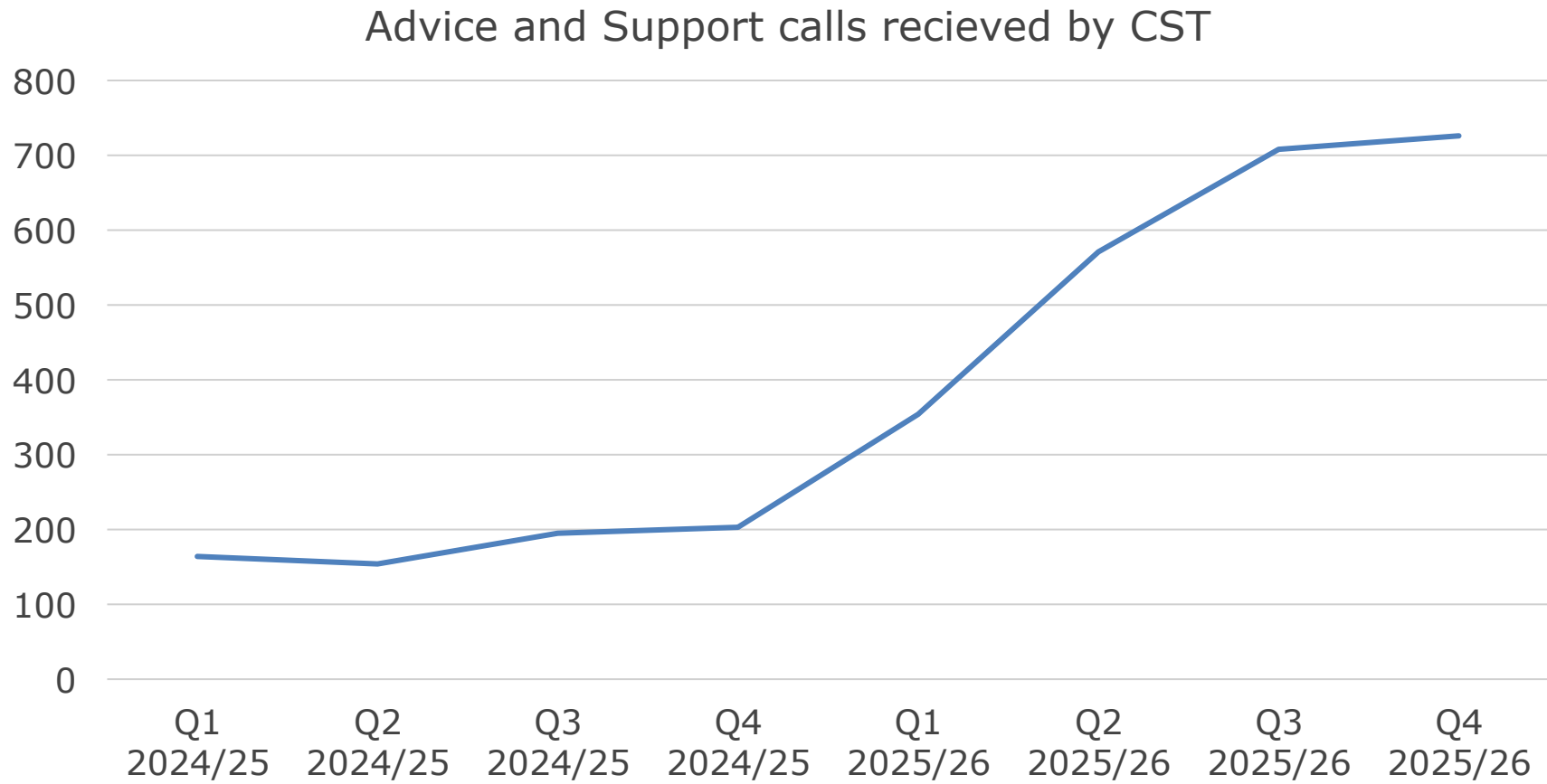


Definition	Analysis	Implications
The information presented has been extracted from RL Datix and is accurate at the point of recording. This information relates to all cases that were managed by or supported by the Corporate Safeguarding Team.	Child Duty to Report (DTR) activity shows mild quarter-on-quarter variation but remains largely stable, demonstrating continued vigilance by frontline staff. Despite this, the volume and complexity of cases continue to challenge Corporate Safeguarding capacity, reinforcing the need for sustained workforce capability and system resilience. Adult Duty to Report (DTR) activity has stabilised over the past three quarters, reflecting the embedding of Level 3 safeguarding training into practice. While overall volumes remain steady, cases are often complex and involve multiple risk factors. Effective multi-agency working continues to support positive outcomes; however, the complexity of cases places ongoing pressure on safeguarding capacity and resources.	Compliance for Child Level 1 and 2 training remains broadly in line with the 85% benchmark, while Adult and Child Level 3 compliance continues to improve and is on track to meet the agreed target by 31 March 2028. The introduction of hybrid delivery has been a key success, particularly for staff requiring both Adult and Child Level 3 training. Attendance remains a challenge due to high levels of non-attendance despite bookings. In response, learning and improvement activity is exploring alternatives to full-day training, with new national-level methodologies under consideration to improve accessibility, attendance and overall compliance.

Practitioner Concerns

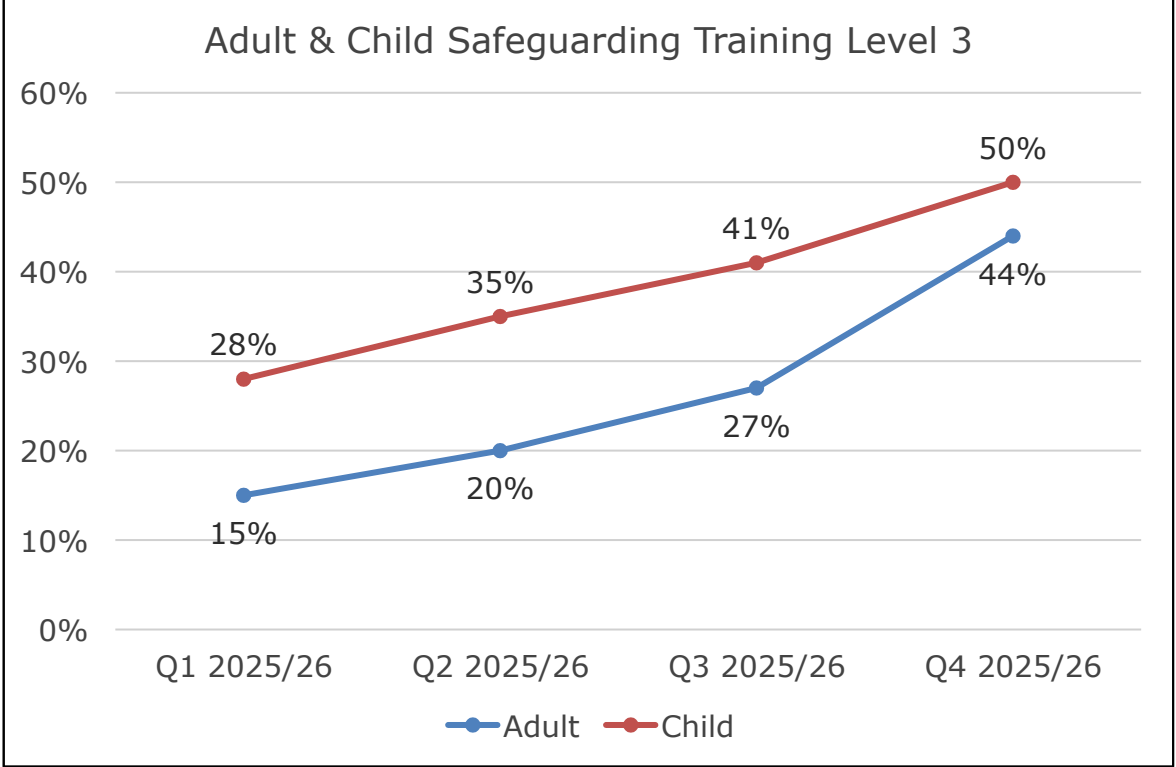
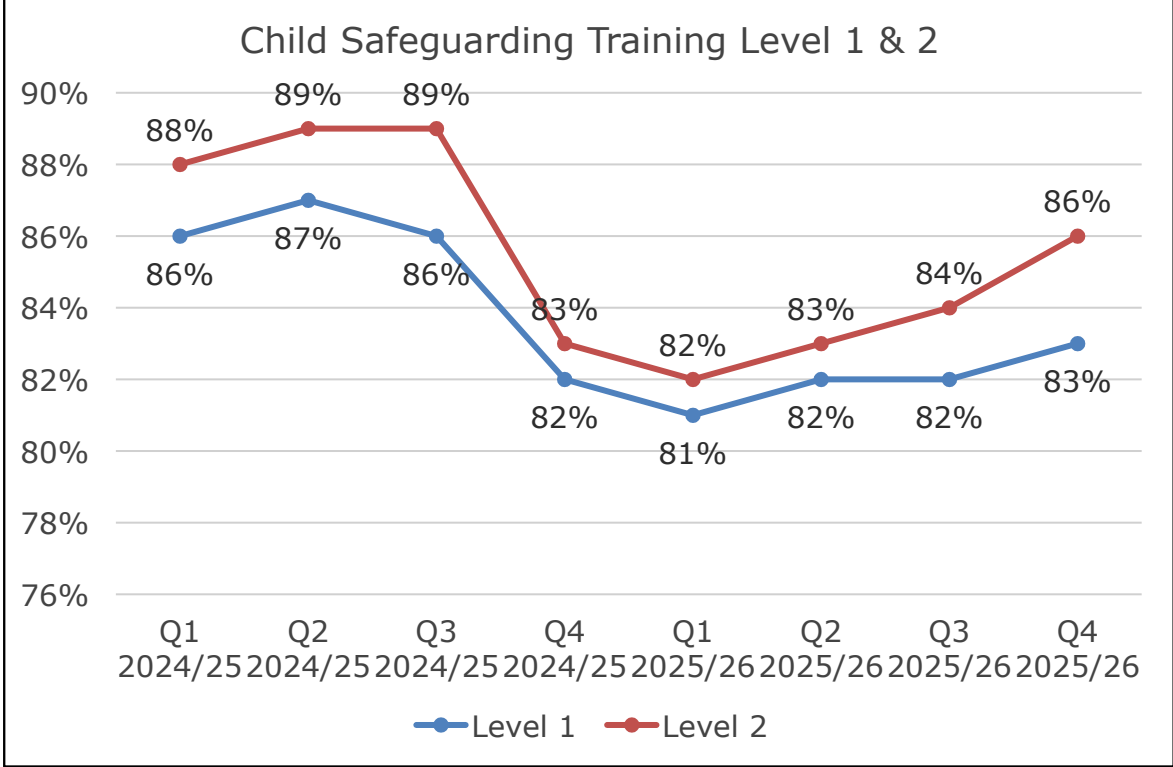
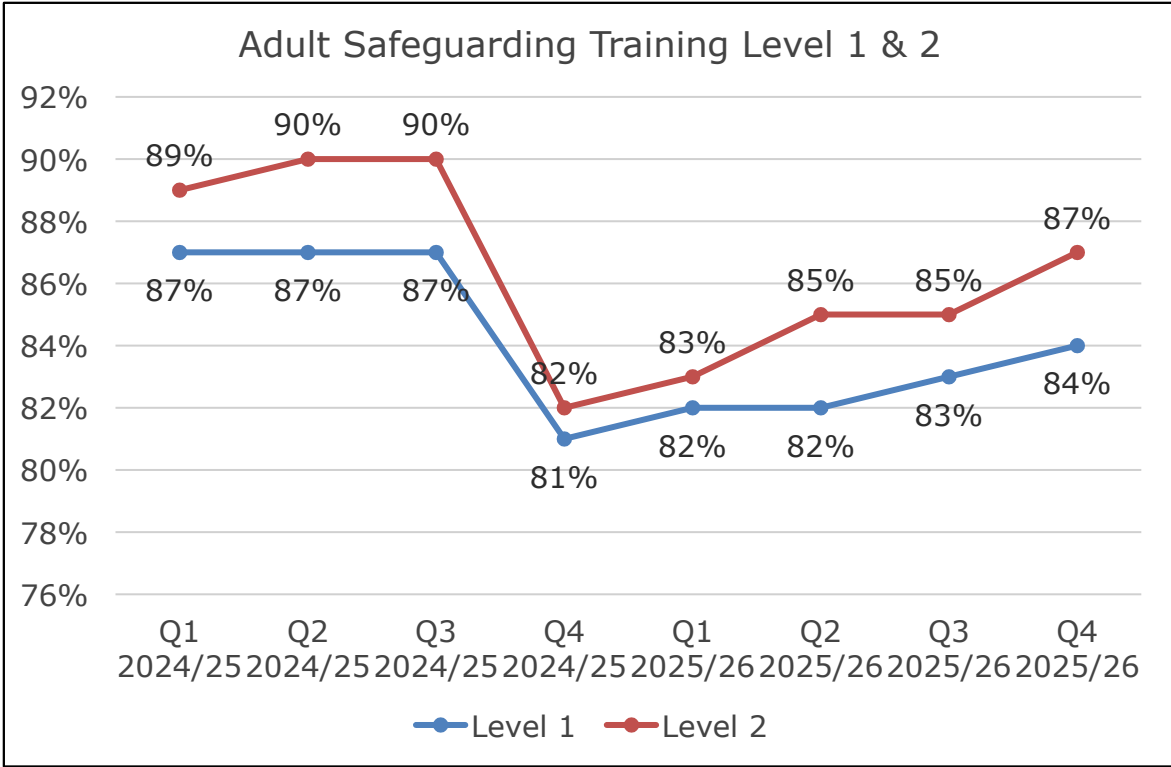


Support and Advice



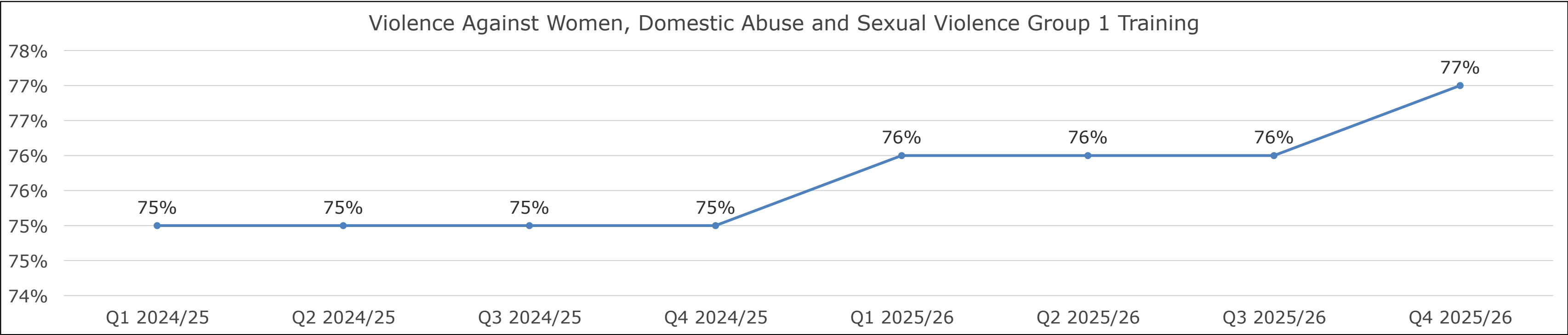
Definition	Analysis	Implications
The information presented has been extracted from RL Datix and is accurate at the point of recording. This information relates to cases where staff, volunteers or independent contractors have been referred into the Section 5 Process of Wales Safeguarding procedures, which focusses on assessing transferable risk and co-ordinating investigations.	There continues to be a steady flow of allegations made against staff working on behalf of Aneurin Bevan University Health Board. Close working with Police colleagues has contributed to a reduction in the length of time that cases remain open, evidencing improved joint working and case progression. However, concerns relating to the completion of intimate examinations remain a prevalent and recurring theme, indicating an area of ongoing challenge and risk.	The persistence of concerns relating to intimate examinations highlights the need for strengthened guidance, assurance, and learning. Joint work between Safeguarding and Patient Experience teams has resulted in the development of a toolkit relating to intimate examinations, which is currently awaiting approval. Once approved, this is expected to support improved practice, consistency, and patient experience, and to mitigate future risk in this area.

Training Compliance



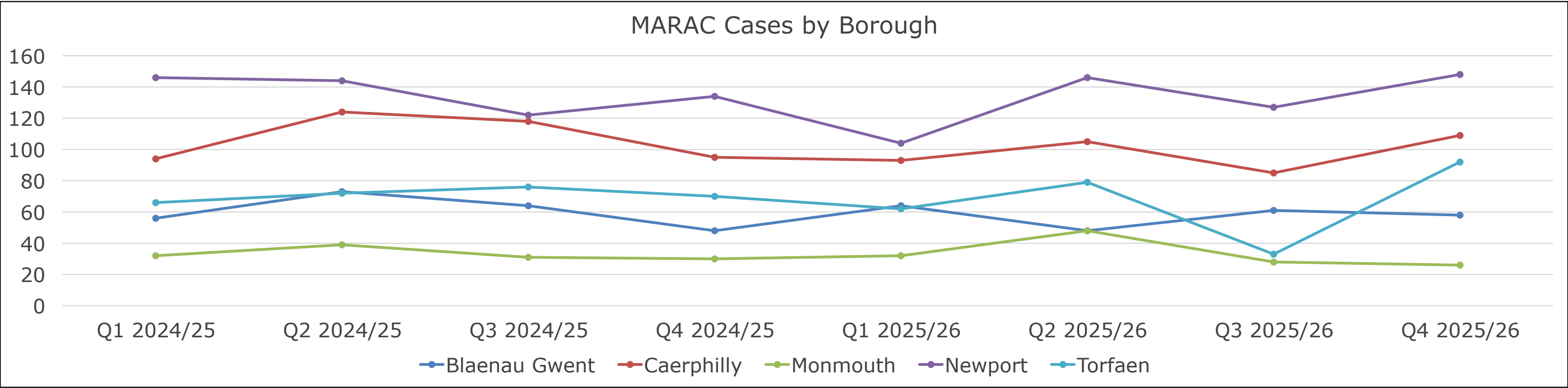
Definition	Analysis	Implications
The information presented has been extracted from ESR and was accurate at the end of Q3. This information relates to Compliance with the three mandated levels of Safeguarding Children and Safeguarding Training. Safeguarding training continues to be provided and monitored, in line with the recommendations of the Intercollegiate Documents for Safeguarding of Children and Adults.	Safeguarding training levels 1 and 2, for both adult and children have followed similar trends, a significant drop between Q3 and Q4 2024/25 and then improvements seen in Q1, 2, 3 & 4 this year. Level 1 training for children and adults has fallen just below the 85% but level 2 training has exceeded the target. Safeguarding level 3 which was introduced in Q1 2025/26 has seen consistent improvements over this financial year.	Improved Divisional support and attendance at Safeguarding Strategic Group is noted and welcomed. Children’s safeguarding training remains below the expected compliance of 85%. Divisional support with groups has improved and monitored in the Children and Young People’s sub group. Over 6000 staff in total require training for adult safeguarding level 3 training. Staffing to deliver training and attendees has been challenging however recovery plan has been implemented and increases are continuing. Training is now monitored on a monthly basis and reported on. Divisional support from member of the Safeguarding Strategic Group and sub groups has been sought and support with the recovery plans have been agreed.

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



Definition	Analysis	Implications
The information presented in regard of Ask and Act Training has been extracted from ESR and was accurate at the end of Q3. This information demonstrates compliance with the Group 1 Training, Ask and Act is nationally mandated, with different staff groups identified as requiring different levels of training. Group 1 is completed online, via e- learning and is mandated to all staff working within the health board. Group 2 is targeted training, aimed at staff who will be working with patients who may have experienced VAWDASV.	The health board has a target of 85% compliance for Group 1 and Group 2. Current compliance for Group 1 is 77%, which is only an increase of 2% from the last six quarters. The target for compliance is 85%, Having worked with Divisions to identify where in the organisation Group 2 would apply, the Corporate Safeguarding Team are currently working with the ESR Team to determine the exact number of staff who will require Group 2 training.	Group 1 compliance is monitored by Welsh Government through the annual VADASV report. Whilst we are unlikely to be an outlier, this will draw some external scrutiny. This risk will be formally escalated and a recovery plan requested from Divisions, via the Strategic Safeguarding Group. The Group 2 training is nationally prescribed as four-hour training, which has to be co-delivered with the third sector specialist Domestic Abuse providers. As such, the health board will be required to make provision of a trainer from within the corporate safeguarding team and finding for the identified third sector provider. An SBAR has been prepared foe the executive committee, outlining the expected volume of staff that will require the training and highlighting the risks associated with resourcing this.

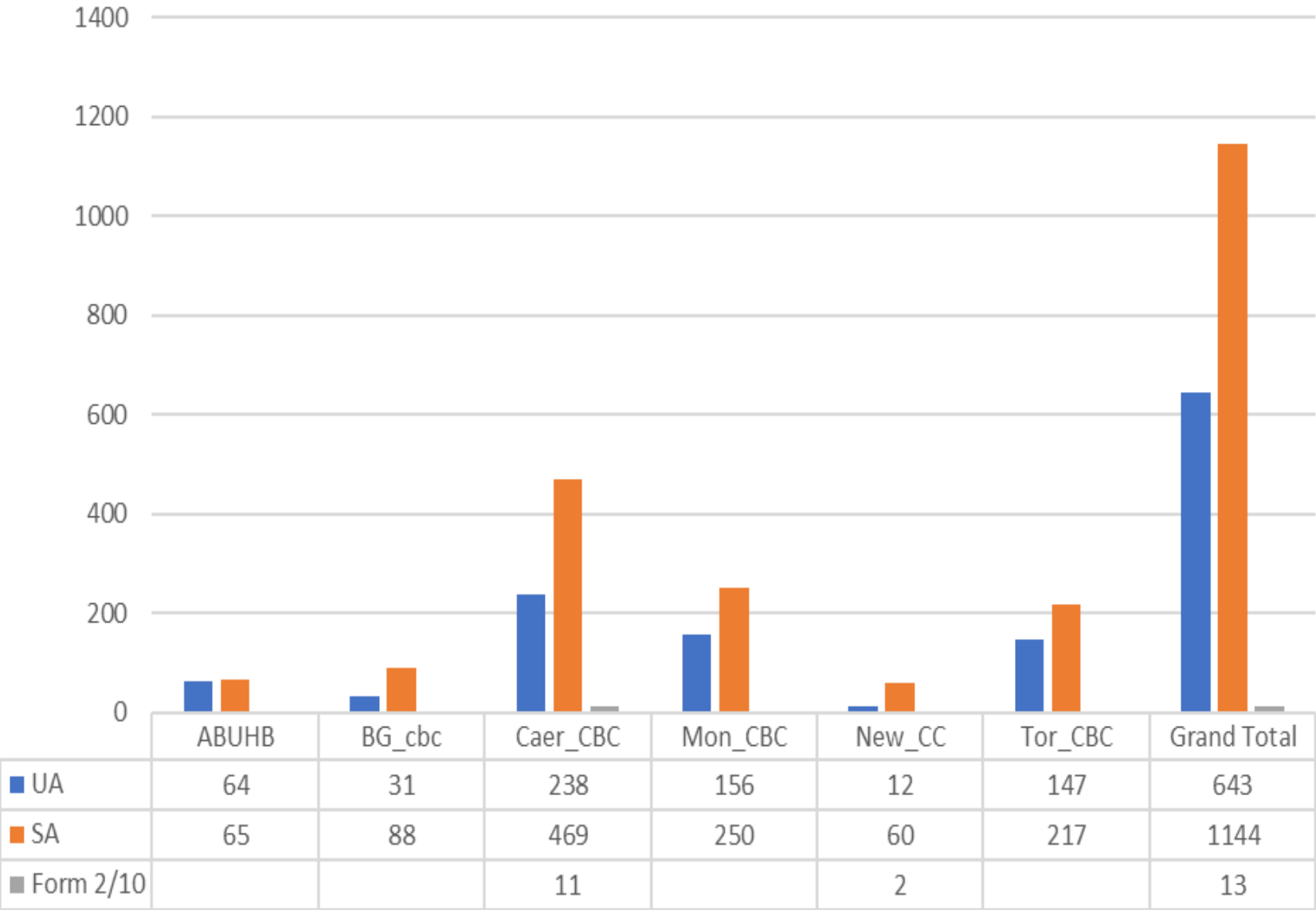
Violence Against Women, Domestic Abuse and Sexual Violence
Multi Agency Risk Assessment Conferences (MARAC)



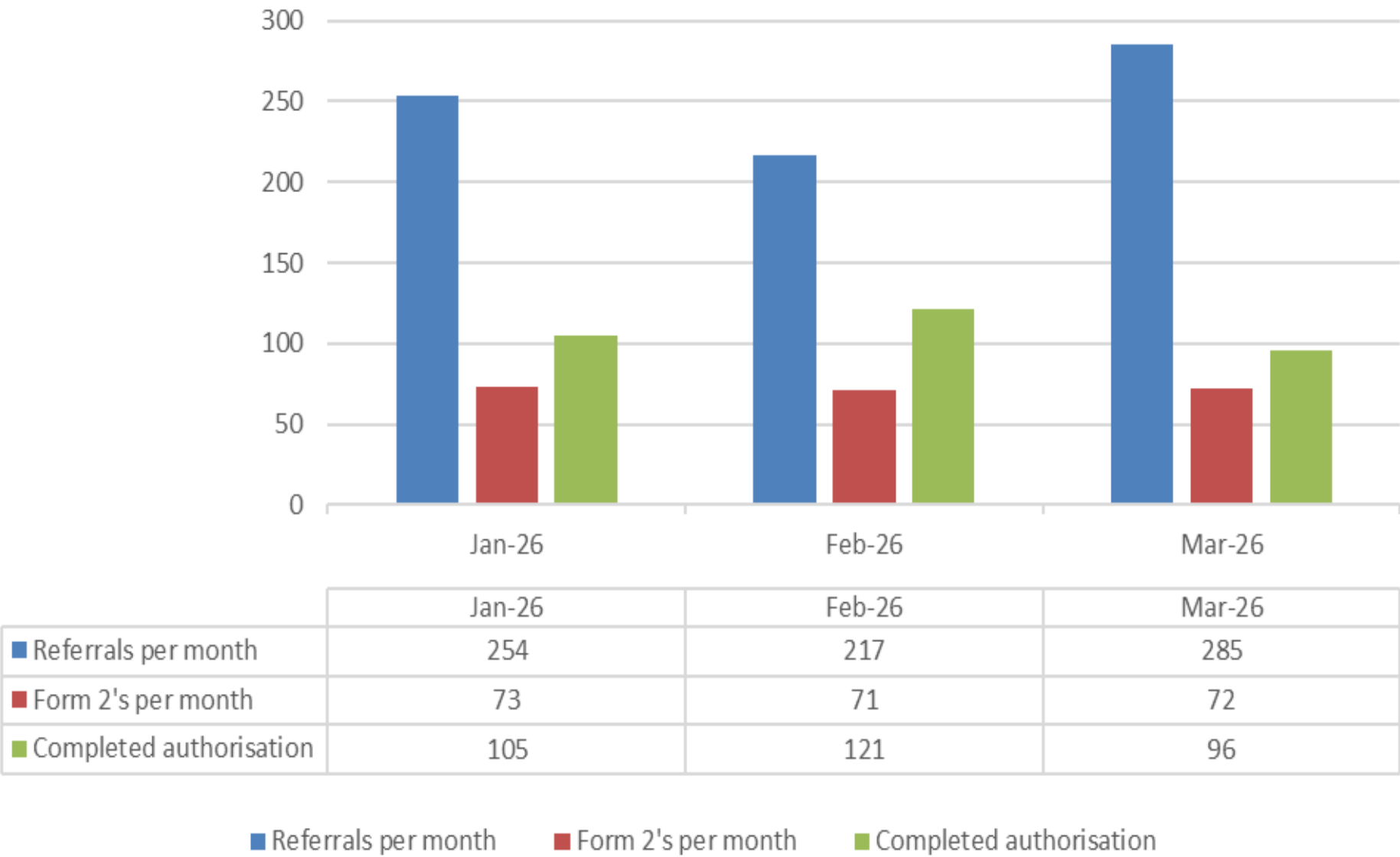
Definition	Analysis	Implications
The information presented in regard of MARAC has been extracted from MS Lists and was accurate at the end of Q3. Multi-Agency Risk Assessment Conferences, are confidential meetings where professionals from agencies share information on high-risk domestic abuse, creating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

Deprivation of Liberty Safeguards (DoLS)

Total number of referrals awaiting allocation



Deprivation of Liberty Waiting list Jan - March 2026





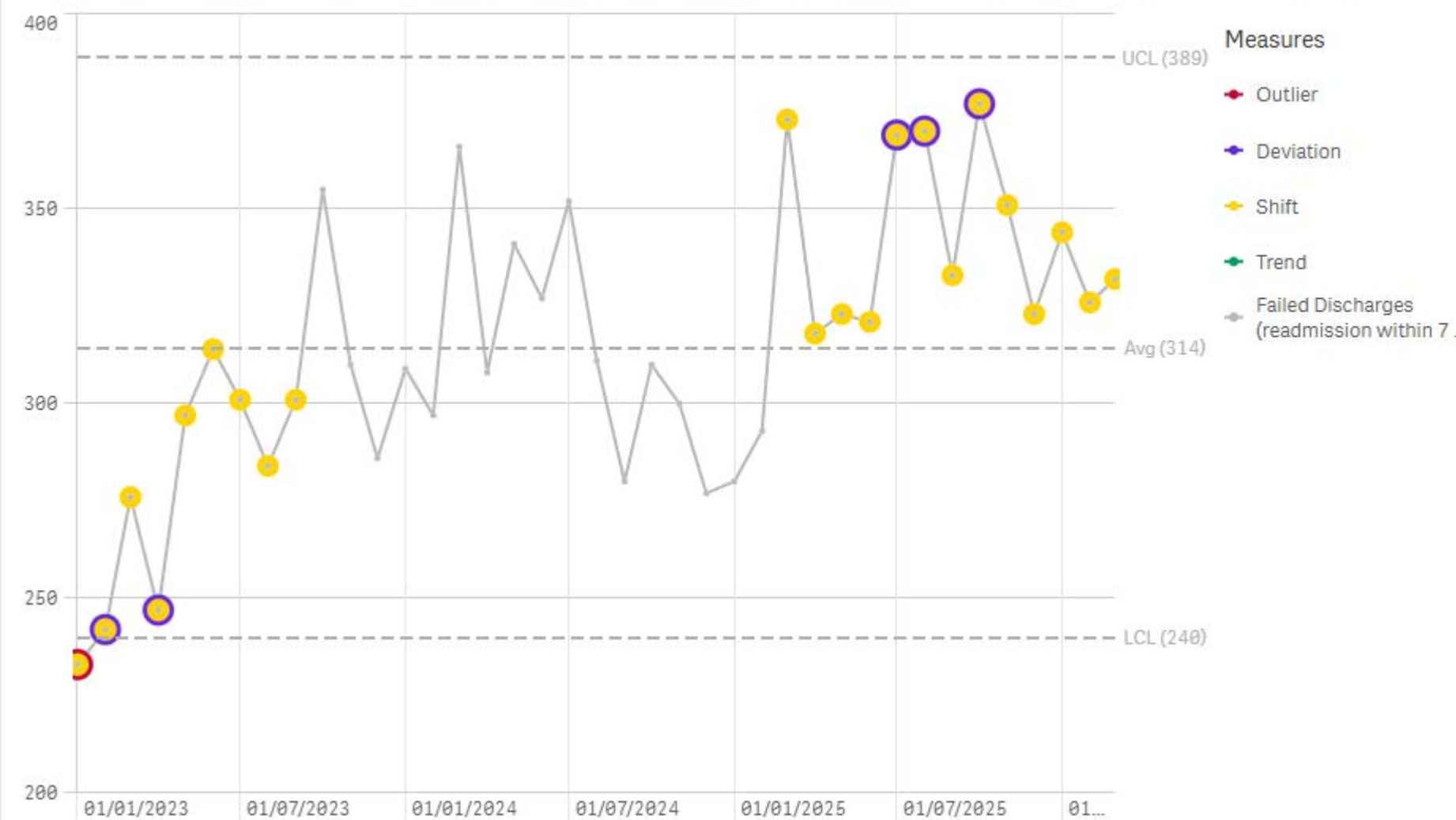
- Commissioned services log nearing completion; Divisions currently validating content for accuracy and consistency.
- Service Level Agreement (SLA) proforma in development to ensure a consistent, tailored approach aligned to service requirements and delivery expectations.
- Small commissioning group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



Additional Measures

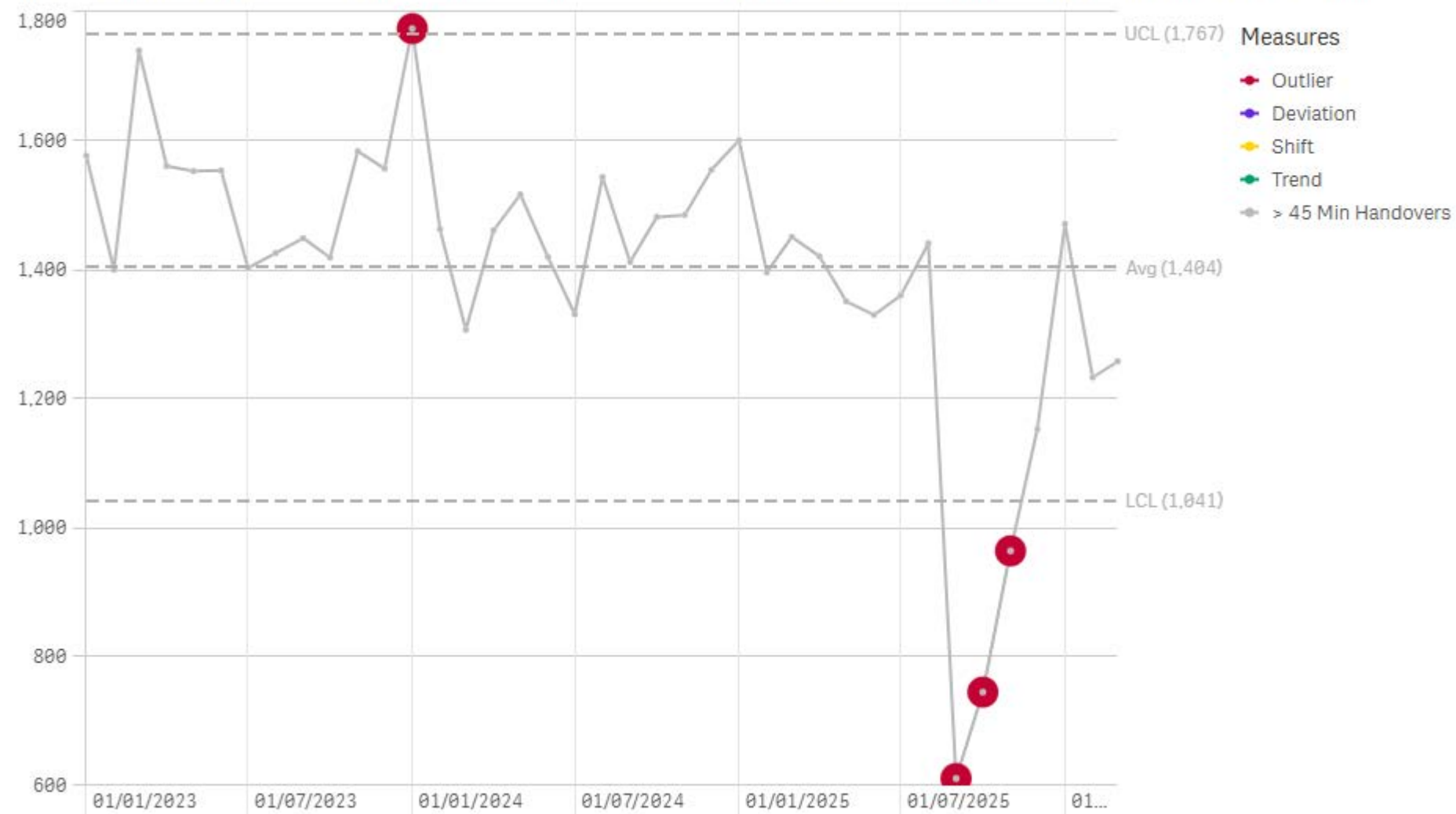
Failed Discharges (readmission within 7 days) per Month (excluding current)

Outlier = Red (beyond limits), Deviation = Purple (near limits), Shift = Yellow (8 or more above/below mean), Trend = Green (6 or more increasing/decreasing)



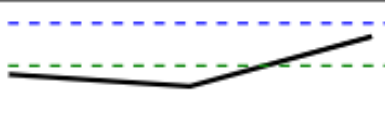
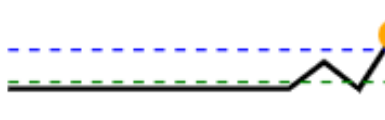
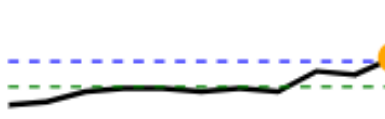
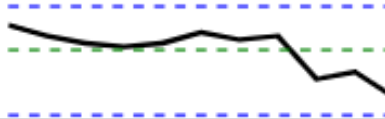
> 45 Min Handovers per Month (excluding current)

Outlier = Red (beyond limits), Deviation = Purple (near limits), Shift = Yellow (8 or more above/below mean), Trend = Green (6 or more increasing/decreasing)



National Quality Outcomes Framework Measures

Safe

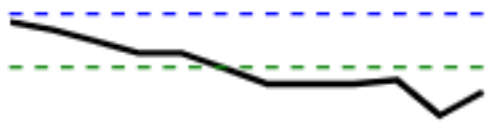
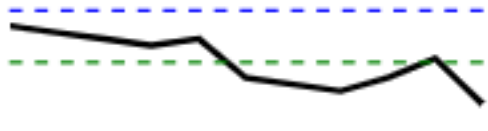
ABU UHB Phase 1 Quality Outcome Framework measures							
Quality Standard	Measure	Latest period	Latest figure		Previous figure	Last 12 months	Outlier
Safe	Antibacterial items per 1,000 STAR-PU's	Dec-25	277.67	▲ 18.3%	234.62		
Safe	Crude mortality rate (%)	Feb-26	1.31%	▼ -25.3%	1.75%		
Safe	Never Events reported to NHS P&I	Mar-26	2		0		Outlier high
Safe	Percentage of discharges on D2RA Pathway 0	Feb-26	42.56%	▲ 13.5%	37.51%		Outlier high
Safe	Percentage of discharges on D2RA Pathway 1	Feb-26	13.40%	▲ 6.0%	12.64%		
Safe	Percentage of discharges on D2RA Pathway 2	Feb-26	7.27%	▲ 21.0%	6.00%		
Safe	Percentage of discharges on D2RA Pathway 3	Feb-26	3.11%	▲ 7.7%	2.88%		
Safe	Percentage of discharges with no D2RA Pathway Allocated	Feb-26	33.67%	▼ -17.8%	40.96%		
Safe	RAMI (Risk adjusted mortality index) 2023	Feb-26	196.12	▲ 49.5%	131.22		Outlier high
Safe	Safeguarding Adults - Lv1 training	Dec-25	83.85%	▲ 0.6%	83.37%		
Safe	Violence and Aggression (Wales)	Dec-25	90.88%	▲ 0.3%	90.63%		

National Quality Outcomes Framework Measures

Timely

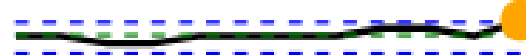
≡ 63 ***

ABU UHB Timely Phase 1 Quality Outcome Framework measures

Quality Standard	Measure	Latest period	Latest figure	Previous figure	Last 12 months	Outlier
Timely	Opthalmology R1 appointments attended within target date* (%)	Feb-26	46.64%	41.09%		
Timely	Patients starting first definitive cancer treatment* (%)	Jan-26	55.88%	63.02%		

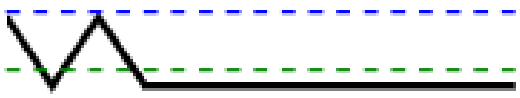
National Quality Outcomes Framework Measures

Effective

ABU UHB Effective Phase 1 Quality Outcome Framework measures							
Quality Standard	Measure	Latest period	Latest figure		Previous figure	Last 12 months	Outlier
Effective	Diabetes patients completing all eight care processes* (%)	Feb-26	46.06%	▲ 3.7%	44.41%		Outlier high

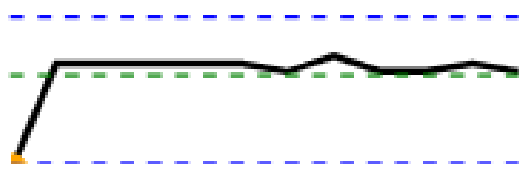
National Quality Outcomes Framework Measures

Efficient

ABU UHB Efficient Phase 1 Quality Outcome Framework measures							
Quality Standard	Measure	Latest period	Latest figure		Previous figure	Last 12 months	Outlier
Efficient	Agency spend for all staff groups as % of total pay bill	Dec-25	3.25%		2.58%		

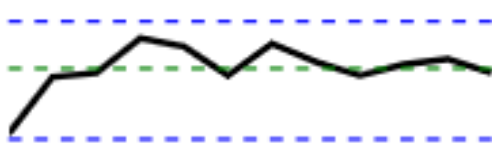
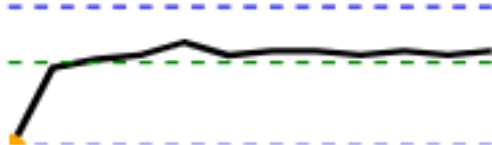
National Quality Outcomes Framework Measures

Equitable

ABU UHB Equitable Phase 1 Quality Outcome Framework measures							
Quality Standard	Measure	Latest period	Latest figure		Previous figure	Last 12 months	Outlier
Equitable	Were you able to communicate in your preferred language? (%)	Mar-26	95.86%	▼ -0.7%	96.52%		

National Quality Outcomes Framework Measures

Person-centred

ABU UHB Person-centred Phase 1 Quality Outcome Framework measures							
Quality Standard ▲	Measure	Latest period	Latest figure		Previous figure	Last 12 months	Outlier
Person-centred	People's Experience Survey (PES) - how would you rate your overall experience?	Mar-26	8.12	▼ -1.2%	8.22		
Person-centred	Staff with Personal Appraisal and Development Review in last 12 months (%)	Dec-25	76.08%	▲ 0.0%	76.06%		
Person-centred	Were you involved as much as you wanted to be in decisions about your care? (%)	Mar-26	73.51%	▲ 1.2%	72.65%		

Patient Safety Leadership Visits – Summary

Purpose:

Promote a proactive safety culture across ABUHB.

Key Aims:

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

Who's Involved:

Executive Directors, Independent Board Members, local multidisciplinary teams, and a scribe.

Visit Format:

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

Outcome:

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



Overview: January – March 2026

Areas Visited: 11

County Hospital

- Hafan Deg Ward
- Talygarn Ward
- Rowan Ward
- Oak Ward

Royal Gwent Hospital (RGH)

- Pharmacy Department
- Endoscopy Department
- Ophthalmology Department
- C4 East



St Cadoc's Hospital

- Adferiard Ward
- Bellevue Ward
- Pillmawr Ward

Rearranged Visits:2

- **B0, GUH** (11/02/26) – clashed with Board meeting. **Rearranged for 21/04/26**
- **Intensive Care, GUH** (11/02/26) – clashed with Board meeting. **Rearranged for 21/04/26**

Patient Safety Leadership Visits



Positive Findings: January – March 2026

- Clean, calm, and well-maintained clinical areas observed across wards and departments
- Staff were welcoming, open, and engaged, with strong morale evident despite service pressures
- Visible, compassionate leadership demonstrated by ward managers, senior nurses, and executives
- Positive patient-centred cultures with a consistent focus on dignity, privacy, and respect
- Innovative use of space, activities, and facilities to support wellbeing and rehabilitation
- Clear commitment to quality improvement, learning from incidents, and responding to feedback
- Progress with accreditation, digital systems, and service transformation initiatives
- Staff development and wellbeing supported through training, role progression, and local leadership
- Effective use of charitable funds, volunteers, and community input to enhance care environments



Common Issues: January – March 2026

Workforce & Capacity

- Ongoing staffing pressures, vacancies, and reliance on goodwill
- Capacity frequently exceeding planned provision, impacting on flow and workload
- Training gaps in key areas (e.g. falls, manual handling, specialist support)

Estates, Facilities & Infrastructure

- Delays in response from Works & Estates to long-standing issues
- Broken or unavailable facilities impacting dignity and care delivery (e.g. showers, lighting, lifts)
- Premises constraints limiting storage, therapy space, and safe equipment placement

Digital & Technology

- Reliance on digital systems with risks linked to Wi-Fi, access, downtime, and permissions



Patient Flow & Discharge

- Boarding outside designated bed spaces due to bed pressures
- Delays impacting length of stay and patient experience

Health, Safety & Dignity

- Environmental risks including uneven flooring, clutter pressure, and restricted space
- Compromised privacy and dignity linked to boarding, curtains, or shared facilities
- External safety risks and ageing infrastructure requiring escalation

Communication & Wayfinding

- Poor signage and wayfinding causing confusion for patients, families, and staff

Medicines & Equipment

- Storage constraints and equipment availability affecting safety and workflow
- Ongoing medicines supply pressures and waste risks

Examples of Completed Actions: January – March 2026

Hafan Deg Ward

- Learning from Local Authority discharge pathway issues identified locally, with escalation planned through divisional and senior channels.

Rowan Ward

- Food and nutrition concerns escalated and reviewed with Estates & Facilities, with assurance provided on food safety, reheating processes, and temperature controls.
- Local charity contact details shared with the Ward Manager to support improvement activity.

Oak Ward

- Interpreter support arrangements reviewed with the Inclusion Team, with advice and contact details shared with the ward to support more sustainable provision.
- Heating concerns escalated to Estates & Facilities and reviewed, with confirmation that all reported issues were responded to and no outstanding heating faults remain.
- The external portacabin structure concern was escalated to Estates & Facilities, with review completed and prioritisation confirmed for inclusion in the next financial year's capital programme.

Ophthalmology Department

- The department has been linked with the Comms Team to support compliance with accessibility signage guidance for visually impaired patients, with discussions underway and a meeting scheduled for 14/04/26.

Examples of Completed Actions: January – March 2026

C4 East

- Shower facilities across the ward were out of use for an extended period and were escalated immediately to Estates & Facilities, resulting in urgent review and confirmation that all ward shower facilities are now back in use.

Pharmacy

- Cross-divisional pharmacy engagement has been progressed with Pharmacy signposted to formal representation within the Planned Care Group.
- Progression of the ward-based label printer capital bid was approved, resulting in confirmed funding, purchase of printers, and planned rollout across acute sites.
- Access to Pharmacy charitable funds was clarified, with confirmation of available balances, guidance provided on appropriate use of designated funds, and next steps signposted to the team.

Adferiard

- Towel supply issues identified through PSLVs were escalated and resolved, with an updated Linen SLA implemented to provide increased and regular towel deliveries for mental health wards.

Outstanding Actions: January – March 2026

Hafan Deg Ward – County Hospital

- Local Authority discharge pathway issues are awaiting escalation and feedback through Divisional QPS and senior leadership routes.
- Cleaning of non-patient areas was raised, with the Executive agreeing to liaise with Facilities; an update on actions is currently awaited.

Talygarn Ward – County Hospital

- Office space expansion is awaiting the outcome of the ward bid and Estates review.
- Garden cigarette-end management is awaiting clarification of responsibility and actions via Domestics.
- Local Authority discharge pathway escalation is awaiting senior and divisional feedback.

Pharmacy – Royal Gwent Hospital

- Workforce planning for high-pressure areas is awaiting Pharmacy team review of alternative workforce models.

C4 East – Royal Gwent Hospital

- Replacement of missing safety glass on the valve is awaiting action by Works & Estates.

Ophthalmology – Royal Gwent Hospital.

- The water leak on the stairwell is awaiting repair by Works & Estates
- The long-standing lift failure is awaiting Works & Estates repair, despite funding being in place.
- Specsavers-related contractual and safety concerns are awaiting review and clarification.

Outstanding Actions: January – March 2026

Adferiad Ward – St Cadoc's

- Information governance concerns relating to CCTV and USB compatibility are awaiting Executive escalation.

Bellevue Ward – St Cadoc's

- TV room lighting issues are awaiting review and resolution by Works & Estates.
- The broken steriliser is awaiting a Works & Estates update regarding repair or replacement.

Pillmawr Ward – St Cadoc's

- Additional laundry equipment installation is awaiting confirmation of Works & Estates timescales.
- Procurement process concerns, including limitations around sourcing low-cost essential items outside Oracle timescales and towel ordering restrictions, are awaiting Executive escalation.



For Information

Clinical Effectiveness



HQIPD Ref. `		Programme Name	Publication Date	CSEG
702	NMPA	National Maternity and Perinatal Audit - Multiple Births Report	12/03/2026	Invited to CSEG Sep 2026
659	NPDA	National Paediatric Diabetes Audit (NPDA) Annual Core State of the Nation Report (2026)	12/03/2026	Invited to CSEG May 2026
701	NCISH	Mental Health Clinical Outcome Review Programme - National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) - State of the Nations Report	12/02/2026	Invited to CSEG Jul 2026
699	NCAP	National Clinical Audit of Psychosis (NCAP) - State of the Nation Report 2026	01/10/2026	Invited to CSEG Nov 2026
641	FFFAP	Fracture Liaison Service Database (FLSD) - State of the Nation Report	08/01/2026	Presented CSEG Feb 2026
NICOR	NICOR 2023/24 1 st Ed & 2024/2025 2nd Ed	National Audit of Cardiac Rhythm Management (NACRM) 2024/2025	11/12/2025	Presented CSEG Mar 2026
NICOR	NICOR 2024/2025 2nd Ed	Myocardial Ischaemia National Audit Project (MINAP) 2024/2025	11/12/202511/12/2025	CSEG Feb 2027 (new data expected Dec 2027)
NICOR	NICOR 2024/2025 2nd Ed	National Audit of Percutaneous Coronary Interventions (NAPCI) 2024/2025	11/12/2025	CSEG Feb 2027 (new data expected Dec 2027)
NICOR	NICOR 2024/2025 2nd Ed	National Heart Failure Audit (NHFA) 2024/2025	11/12/2025	CSEG Jul 2026
617	NCEPOD	Child Health Clinical Outcome Review Programme - Emergency paediatric surgery	11/12/2025	TBC for later date
574	NVR	National Vascular Registry (NVR) - State of the Nation 2025 Report	13/11/2025	Presented CSEG Mar 2026
546 90/137	NMPA	National Maternity and Perinatal Audit - Induction of labour snapshot report	13/11/2025	N/A to ABUHB snapshot report

HQIPO Ref.		Programme Name	Publication Date	CSEG
650	SSNAP	Sentinel Stroke National Audit Programme - State of the Nation report	13/11/2025	Stroke Board
619	NCEPOD	Child Health Clinical Outcome Review Programme - Acute limb ischaemia	13/11/2025	NCEPOD - ABUHB not selected to participate
639	NATCAN	National Bowel Cancer Audit (NBOCA) - State of the Nation Report	09/10/2025	Presented CSEG Feb 2026
605	NELA	NELA - National Emergency Laparotomy Audit - Year 10 State of the Nation report	09/10/2025	Presented CSEG Jan 2026
583	NEIAA	NEIAA - National Early Inflammatory Arthritis Audit - State of the Nation Report 2026	09/10/2025	Presented CSEG Jan 2026
588	FFFAP	National Audit of Inpatient Falls (NAIF) State of the Nation Report 2025	09/10/2025	IP Falls Group
551	NRAP	National Respiratory Audit Programme - Asthma Secondary Care Secondary care outcomes report	09/10/2025	NRAP – working with CD regarding participation
638	NATCAN	National Prostate Cancer Audit (NPCA) - State of the Nation Report	11/09/2025	No Clinical Lead
637	NATCAN	National Oesophagogastric Cancer Audit (NOGCA) - State of the Nation Report	11/09/2025	CSEG May 2026
636	NATCAN	National Kidney Cancer Audit (NKCA) - State of the Nation Report	11/09/2025	No Clinical Lead
635	NATCAN	National Non-Hodgkin Lymphoma Audit (NNHLA) - State of the Nation Report	11/09/2025	Presented CSEG Mar 2026
634	NATCAN	National Pancreatic Cancer Audit (NPaCA) - State of the Nation Report	11/09/2025	Invited to CSEG May 2026
91/137		113/425		

HQIPO Ref.		Programme Name	Publication Date	CSEG
633	NATCAN	National Ovarian Cancer Audit (NOCA) - State of the Nation Report	11/09/2025	Invited to CSEG Jul 2026
632	NATCAN	National Metastatic Breast Cancer Audit (NAoMe) - State of the Nation Report	11/09/2025	Presented CSEG Feb 2026
631	NATCAN	National Primary Breast Cancer Audit (NAoPri) - State of the Nation Report	11/09/2025	Presented CSEG Feb 2026
618	NCEPOD	Medical and Surgical Clinical Outcome Review Programme - Blood sodium report	11/09/2025	TBC for later date –
520	NACEL	NACEL - National Audit of Care at the End of Life - State of the Nation Report	14/08/2025	NACEL – participation commenced for 2026
616	NRAP	NRAP - National Respiratory Audit Programme - State of the Nation report - Children and young people’s asthma: Elements of care received by children admitted with near-fatal asthma	12/06/2025	Presented CSEG Feb 2026
616	NRAP	National Respiratory Audit Programme - State of the Nation Report - Adult asthma: Variation in the completion of a discharge bundle	12/06/2025	NRAP – ongoing discussions with Directorate and Clinical Lead(s)
616	NRAP	National Respiratory Audit Programme - State of the Nation Report - COPD: Key elements of discharge bundle provided as part of discharge	12/06/2025	
616	NRAP	National Respiratory Audit Programme - State of the Nation Report - Pulmonary Rehabilitation: Timely access to pulmonary rehabilitation	12/06/2025	
552	NCEPOD	Medical and Surgical Clinical Outcome Review Programme - ICU Rehabilitation report	12/06/2025	TBC for later date
NICOR	NICOR 2023/2024	National Audit of Cardiac Rhythm Management (NACRM)	01/04/2025	Presented CSEG Mar 2026
553 92/137	NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health – UK patient and general population data 2012-2022 - Annual Report 2025	13/02/2025	~~CSEG Mar 2026 Moved~~ Moved to CSEG Jul 2026

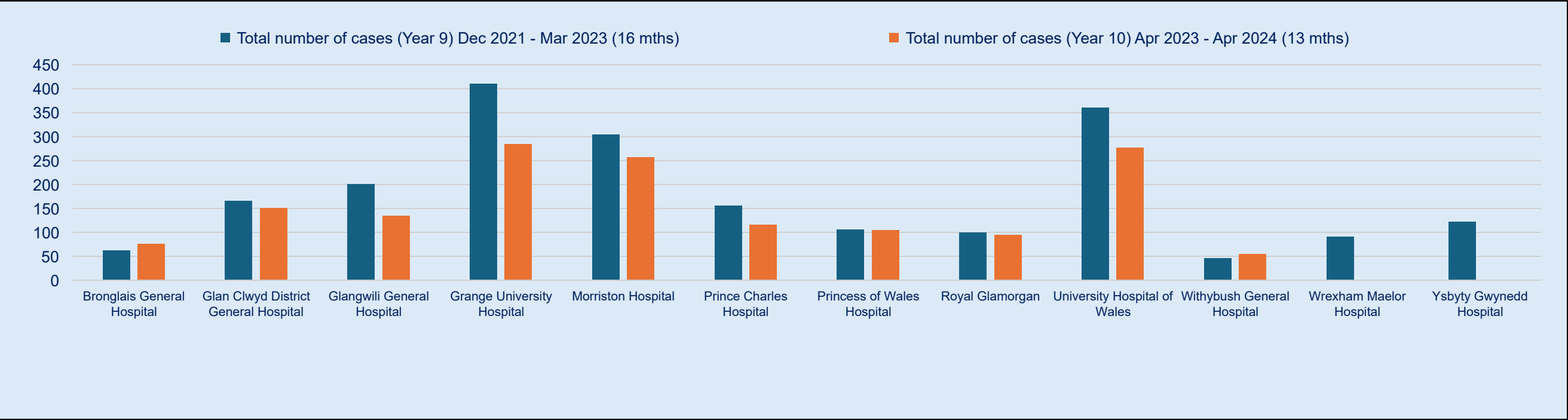
10th Patient Report of the National Emergency Laparotomy Audit (NELA)- April 2023 to April 2024

- Clinical Leads:
- Babu Muthuswamy - Consultant Intensivist & Anaesthetist
 - Helen Williams - Consultant Anaesthetist
 - Gethin Williams - Surgical Consultant

Rationale: The 10th annual NELA report examines care received by 23,560 NHS patients in 176 hospitals across England and Wales admitted for emergency laparotomy (emergency bowel surgery, EmLap) between 1 April 2023 and 23 April 2024. The report shows that clinical teams in many different hospitals were able to provide high quality care against a challenging background, with demand for access to emergency care frequently exceeding capacity.

- 30-day mortality fell to the lowest level in ten years of audit (8.1% compared to 11.7% in Year 1)
- Postoperative length of hospital stay fell back to a median of 10 days (compared to 11 days in Year 9).

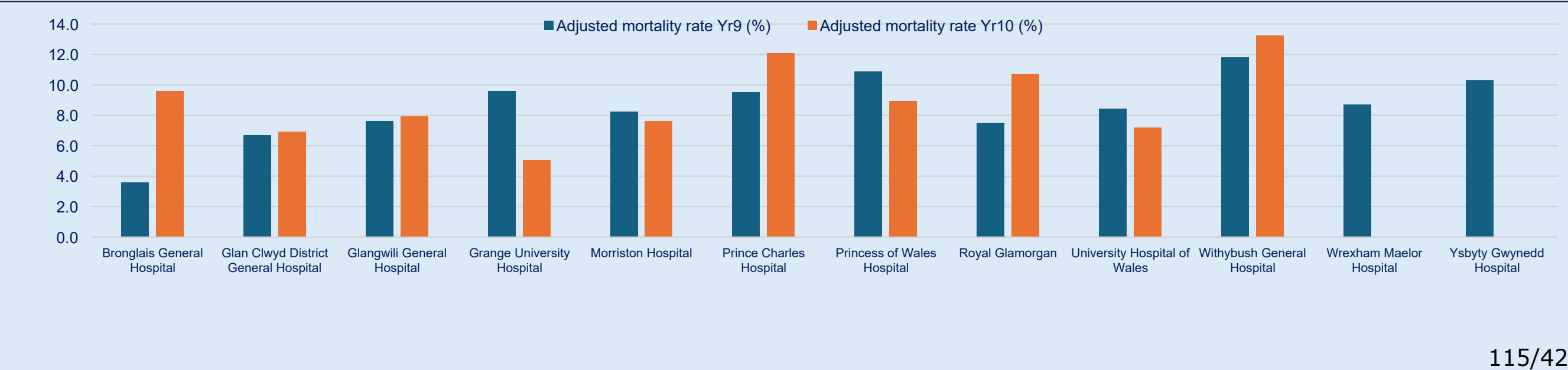
The reduction in mortality represents around 1,150 fewer deaths per year amongst the estimated 32,000 patients who undergo emergency laparotomy, whilst a fall in median length of stay of one day could represent potential annual financial savings of more than £10million.



Number of cases:
Please note that the apparent reduction in cases between Year 9 and Year 10 is influenced by the differing time periods covered. Year 9 includes 16 months of data (December 2021 – March 2023), whereas Year 10 covers 13 months (April 2023 – Apr 2024).

Mortality rate:
Nationally, 30-day mortality fell to its lowest level across ten years of audit, reducing from 11.7% to 8.1%. Within ABUHB, 30-day mortality decreased from 9.6% in Year 9 to 5.1% in Year 10.

While ABUHB was not reported as a positive outlier, GUH ranked 23rd out of 169 hospitals nationally.



Timely assessment and management are dependent on the patient’s presenting pathology. Initial symptoms are often non-specific, which can contribute to diagnostic delay. Nationally, the median time to theatre is almost 22 hours, with approximately 75% of urgent cases waiting more than 10 hours. Any patient presenting with physiological deterioration and signs of serious surgical conditions—such as sepsis, perforation, ischaemia or obstruction—should be treated as requiring urgent surgical intervention.

Key messages and recommendations - Key Message 1a: Timeliness of diagnostic pathway following arrival at hospital

NELA Standard – Timeliness of Surgery: In Year 11 (position at March 2025), 6.67% of patients within ABUHB who received, or should have received, immediate surgery (as defined by Royal College of Surgeons criteria) underwent surgery within 6 hours of arrival in hospital. This compares with a national rate of 10.81% and a regional rate of 12.65%.

NELA Standard – Pre-operative Risk Assessment: In Year 11 (position at March 2025), pre-operative risk assessment was documented for 91.67% of patients within ABUHB. This exceeds both the national average of 79.53% and the regional rate of 83.27%.

Key Message 1b: Timeliness of antibiotic administration in patients with suspected infection and sepsis of surgical origin following arrival at hospital

Antibiotic therapy should be initiated within 1 hour for patients with sepsis and within 3 hours for those with infection. However, national performance against these standards remains low, with only 15% of sepsis cases and around one third of infection cases meeting the recommended timeframes. A quarter of patients experienced delays exceeding 5.8 hours, with substantial variation in performance observed across hospitals.

Year 10	Cases included in denominator	Data completeness	%
Antibiotics administered within 1 hour to patients with suspected sepsis or septic shock	103	66.7	19.6
Antibiotics administered within 3 hours to patients with suspected infection	56	69.6	45.9
Antibiotics administered within 1 hour to patients with suspected sepsis/septic shock or within 3 hours for patients with suspected infection	284	100	26.2

NELA Standard – Timely Antibiotic Administration for Suspected Sepsis:

In Year 11 (position at March 2025), 20% of patients within ABUHB with suspected sepsis and/or septic shock at arrival or at the decision to operate received antibiotics within 1 hour of the first recorded NEWS2 abnormality (≥5 overall or ≥3 in a single parameter). This compares with a national mean of 14.49% and a regional mean of 22.59%.

Note that the data completeness for the 1-hour sepsis and 3-hour infection are not full data completeness

Key Message 2: Direct communications between requesting and reporting teams around CT scanning

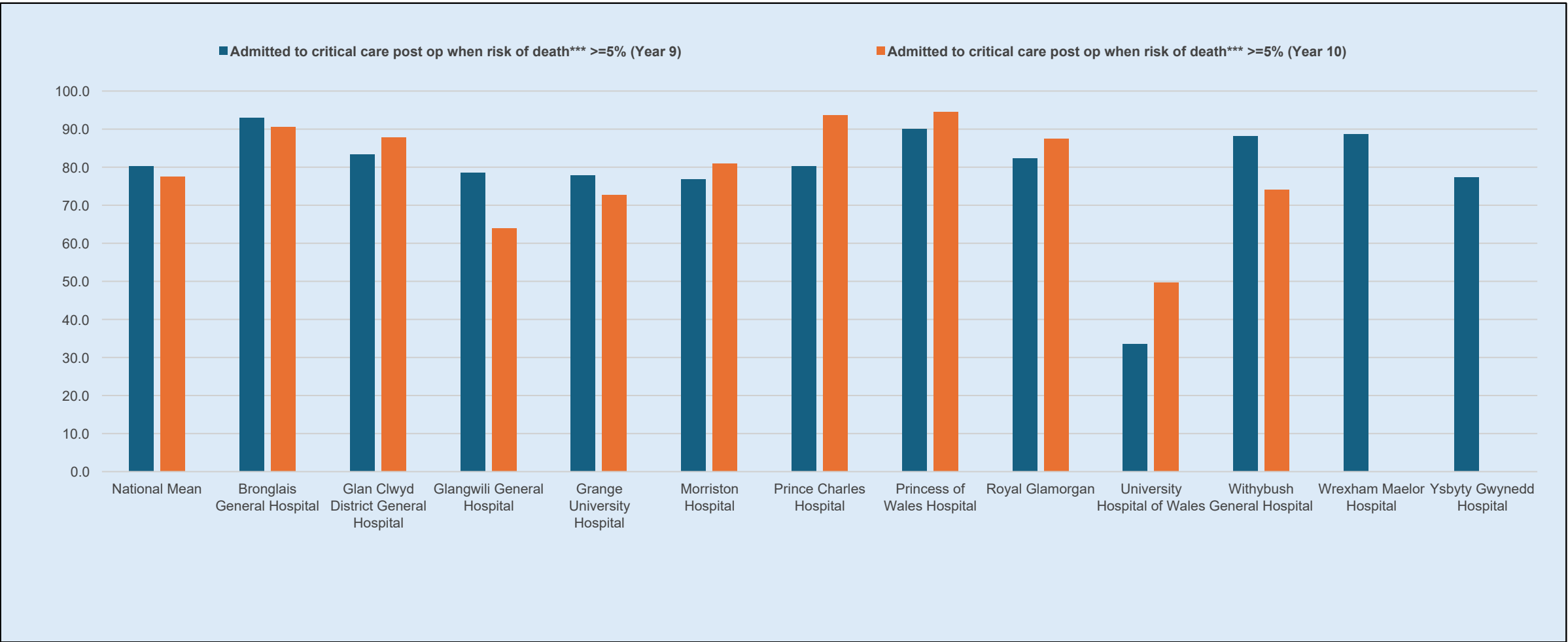
Where urgent CT findings have the potential to influence surgical decision-making, direct communication between the clinician and radiologist is essential. Although senior radiologist reports were available for 98.7% of ‘RCS Immediate’ cases, documented direct discussions occurred in only 24.7%. Timely, two-way communication is critical in the context of suspected time-sensitive pathology.

NELA Standard – Direct Radiologist–Surgeon Communication Following Pre-operative CT: In Year 11 (position at March 2025), 11.76% of patients within ABUHB who were categorised as ‘Immediate’ (in line with Royal College of Surgeons definitions) underwent pre-operative CT scanning with documented direct communication between a radiologist (ST3 or above) and a surgeon (ST3 or above), either by telephone or in person, to discuss CT findings. This compares with a national rate of 13.89% and a regional mean of 8.39%.

Key Message 3: Critical care bed capacity

High-risk patients are not consistently admitted to critical care following emergency laparotomy. Nationally, 16.5% of high-risk patients received ward-level care post-operatively, of whom 4.3% died in hospital, despite guidance recommending critical care admission for this group.

With an estimated 30–40 emergency laparotomy cases per 100,000 adults each year requiring critical care support, hospitals must plan capacity accordingly. Further research is required to understand variation in critical care admission rates and to explore the potential role of cost-effective enhanced care models for this patient cohort.



Unexpected admissions to critical care from the ward within 7 days post-operatively decreased from 1.5% in Year 9 to 0.7% in Year 10.

NELA Standard – Admission of Post-operative High-Risk Patients to Critical Care: In Year 11 (position at March 2025), 78.57% of post-operative high-risk patients (defined as a predicted risk of death of $\geq 5\%$) within ABUHB were admitted directly to critical care. This compares with a national rate of 71.26% and a regional rate of 77.98%.

NELA Standard – Post-operative Frailty Assessment and Management:

This standard measures the proportion of patients aged 65 and over living with frailty, or aged 80 years and over, who receive post-operative assessment and management by a perioperative frailty team with expertise in Comprehensive Geriatric Assessment (CGA).

In Years 1–9, the standard was met when patients were assessed by a specialist or consultant in the care of older people (with a change in terminology to consultant geriatrician from Year 6). From Year 10 onwards, the standard was expanded to include either a geriatrician-led service or a perioperative medicine-led team with expertise in CGA and established referral pathways to geriatric services.

In Year 11 (position at March 2025), 80% of eligible patients within ABUHB received appropriate post-operative frailty assessment and management. This compares with a national rate of 40.24% and a regional rate of 23.64%.

This report does not explore the metric relating to consultant presence in theatre in detail, as this is now well established practice.

NELA Standard – Consultant Presence in Theatre:

In Year 11 (position at March 2025), ABUHB achieved 100% compliance for both Consultant Surgeon and Consultant Anaesthetist presence in theatre. This compares favourably with a national rate of 86.25% and a regional rate of 88.89%.

NELA Standard – Post-operative Risk Assessment:

In Year 11 (position at March 2025), post-operative risk assessment was documented for 91.67% of patients within ABUHB. This compares with a national rate of 62.6% and a regional rate of 68.55%.

Post-operative Length of Stay and Critical Care Returns

Nationally, median post-operative length of hospital stay (LoS) reduced to 10 days, compared with 11 days in Year 9. Within ABUHB, median post-operative LoS increased slightly from 9.5 days in Year 9 to 10 days in Year 10. While this represents a 0.5-day increase locally, performance remains broadly aligned with the national position.

Nationally, unexpected returns to critical care from the ward within 7 days post-operatively increased from 3.0% in Year 9 to 3.6% in Year 10. In contrast, ABUHB demonstrated stronger performance, with a lower return rate of 1.5% in Year 9, improving further to 0.7% in Year 10.

NELA Standard – Median Length of Stay:

In Year 11 (position at March 2025), the median length of stay was 15 days for ABUHB, compared with 11 days nationally and 13.6 days regionally.

Assurance level		Description		Risk level	Description
Significant		The project has mostly achieved the standards or criteria being audited against		Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Report Successes:				Report Concerns:	
1	Reduction in risk adjusted mortality from 9.6% to 5.1%			1	Frailty assessment and accuracy needs improving
2	Improved rates of COTE review post operatively (vs. national mean)			2	More COTE involvement for frail older patients with need to expand team
3	Preoperative risk assessment remains high			3	Poor time to theatre from presentation to hospital and need to streamline pathway
4	Consultant anaesthetist and consultant surgeon presence in theatre for high-risk patients remains high			4	Need for NELA nurse practitioner to help pre-op pathway and COTE consultant
5	Successful running of the NELA M&M meetings throughout the year			5	Communication between radiologists and clinical team regarding CT findings
Report Recommendations:			S.M.A.R.T Actions: Responsible: Due Date: Progress:		
1	Royal College of Anaesthetists, Royal College of Emergency Medicine, Royal College of Nursing, Royal College of Radiologists, and Royal College of Surgeons of England – should continue to work together to update and develop consensus pathways of care for patients who might require emergency abdominal surgery. Pathways should contain statements around seniority of key decision makers and ideal timeliness of key steps including antibiotic administration and timing of definitive surgery.				Royal College Recommendations
2	Royal College of Anaesthetists, Royal College of Emergency Medicine, Royal College of Radiologists, Royal College of Surgeons of England – should highlight current guidelines around the need for effective two-way direct communication between referrer and reporter whenever the patient’s condition or CT predicted findings suggest the patient has developed time-critical pathology.				
3 a	NHS England, Integrated Care Boards, and Welsh Health Boards – should evaluate variations in critical care bed capacity for patients undergoing emergency laparotomy, factoring a predicted need of 30-40 EmLap-related critical care admissions per year per 100,000 adult population served.		- Current evaluation on ‘unmet demand’ for all patients needing critical care including those post emergency laparotomy - (CD CC)/Directorate Management Team - Ongoing		
3 b	National Institute for Health and Care Research – should consider commissioning research into optimum placement and management of patients at the margins of risk categories to better understand potential early interventions that could mitigate the risk of dying after surgery				NICE Recommendation
4	Royal College of Anaesthetists, Royal College of Nursing, Royal College of Physicians, Royal College of Surgeons of England and British Geriatrics Society – should work together across the blended workforce to develop common competency-based training and education around optimising perioperative care for older patients and those living with frailty, such that the unmet need for specialist care can be				Royal College/Society Recommendation

97/137119/425

National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Summary Report 2025 Data Collection Period: 1 April 2024 – 31 March 2025 - Year 7						Clinical Lead:	Dr Non Pugh – Consultant Rheumatologist
						NICE :	QS33 – Rheumatoid arthritis in over 16s
Rationale:	Inflammatory arthritis, including rheumatoid arthritis (RA), is a significant disease burden in the UK, affecting over 400,000 people. Delays in treatment can lead to significant disability, reduced quality of life, and loss of productivity in the workforce. Treatment delays for rare autoimmune rheumatic diseases (RAIRDs) such as systemic vasculitides are also associated with adverse outcomes including permanent disability(4), organ failure and death.						
Objectives:	The NEIAA aims to improve the quality of care for people living with rheumatic diseases by collecting demographic and care quality data on all eligible newly diagnosed patients aged 16 and over attending rheumatology services across England and Wales. The audit includes patients diagnosed with inflammatory arthritides, systemic vasculitides and connective tissue diseases. By analysing this data, the NEIAA supports the development of standardised, effective and patient-centred care pathways. Performance of individual healthcare providers is measured against the National Institute for Health and Care Excellence (NICE) quality standard QS33, <i>Rheumatoid arthritis in over 16s</i> , last updated in 2020.						
Measures quality of care delivered to patients in England and Wales aged 16 and over with suspected and newly diagnosed early inflammatory arthritis							
QS1 Adults with suspected persistent synovitis affecting more than 1 joint, or the small joints of the hands and feet, are referred to rheumatology services within 3 working days of presenting in primary care				QS2 Adults with active rheumatoid arthritis start conventional disease-modifying anti-rheumatic drug monotherapy within 6 weeks of referral, with monthly monitoring until their treatment target is met			
ABUHB 60 % National 53 %				ABUHB 80% National 60 %			
	ABUHB	BCUHB	CAVUHB	CTMUHB	HDUHB	SBUHB	National
QS1 %	60	73	15	22	74	100	53
Seen within 3 weeks %	66	86	18	17	14	38	43
New QS2 %	80	96	59	36	0	64	60

The audit also assesses the impact of inflammatory arthritis on patients’ day-to-day functioning, including mobility, sleep, wellbeing and ability to work.

Rheumatology clinical teams provide detailed information on patient care during the first three months following diagnosis, including referral timelines, time to treatment, clinical response to therapy, and Patient-Reported Outcome Measures (PROMs), with follow-up data collected for up to 12 months.

In addition, referral time data is collected for other conditions, including:

- Systemic lupus erythematosus (SLE) and connective tissue diseases (CTD)
- Axial spondylarthritis
- Systemic vasculitis
- Giant cell arteritis (GCA), with additional data captured on ultrasound use and treatment initiation

98/137120/425

ABUHB results April 2024- March 2025 - Number of patients : 104

Patients seen for their first appointment within 3 weeks of receipt of referral

ABUHB 66% National 43%

Average time from referral to appointment
ABUHB 21 days National 32 days

Average time from referral to treatment
ABUHB 31 days National 56 days

The NEIAA dashboard auto populates Quality Metric performance, based upon the data provided by NHS trusts (in England) and Health Boards (in Wales). There are some important caveats to consider.

- 1. Referral, assessment, and treatment figures are based solely on data entered for EIA patients.
- 2. Delay to starting a DMARD is calculated as the number of patients starting a DMARD within 6 weeks of referral as the numerator, and the number of people marked as eligible for EIA follow up as the denominator. As not all patients selected for EIA follow up will have passed the 6 week cut off for starting a DMARD, it is possible you will underestimate your performance.
- 3. No attempt is made to adjust for case-mix, and it is not possible to calculate whether you are an outlier from these data alone.
- 4. Referral figures are solely based on patients referred by GP with a diagnosis of EIA.

The NEIAA remains a standing item on the directorate meeting agenda, with ongoing discussion of the newly published public-facing performance dashboard reports.

Other conditions	2024-25	2023-24
CTD	7	0
GCA	8	3

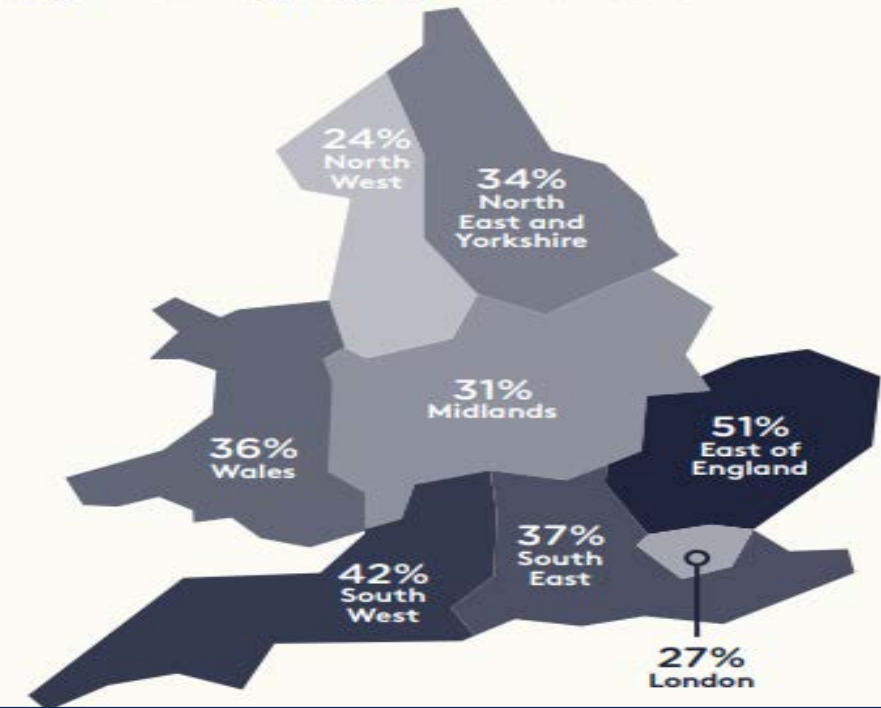
GP referral within 3 days:

ABUHB - 57.2%
National - 45.9%
(Performance in Wales 4th of 6)

Appointment within 3 weeks:

ABUHB - 51.5%
National - 38.1%
(Performance in Wales 2nd of 6)

Overall remission rates at 3 months remain static at 34% but this disguises significant geographic variation



Immunosuppressive treatment within 6 weeks:

ABUHB - 68.3%
National - 43.8%
(Performance in Wales 2nd of 6)

Remission 3 months after 1st Rheum appt:

ABUHB - 71.5%
National - 35.2%
(Wales 36%)

Assurance level	Description
Full	The project has fully 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	Continue to start DMARD treatment in 80% within 6 weeks and meeting audit standards
2	ABUHB results better than national average and second in Wales
3	Increasing number of other conditions included

Report Concerns:	
1	None

Over recent years, the service has demonstrated sustained and measurable improvement, moving from a position of negative outlier status in national benchmarking to being recognised as a positive outlier for clinical quality and patient outcomes, providing strong assurance of effective improvement and oversight.

National

1

Provision of specific funding to support awareness-raising of the importance of early presentation to primary care of people with symptoms of suspected EIA. **Key message 3**

Action by: Department of Health and Social Care/NHSE and Welsh Health Boards



2

NEIAA dashboard data should be used to support rheumatology departments and specialist centres to pinpoint unwarranted variation, track improvement over time and inform planning and investment. **Key messages 4, 5, 6, 11 and 12**

Action by: Integrated Care Boards, Welsh Health Boards



3

Patient-reported outcome measures (PROMs) should be integrated into clinical pathways to identify individuals experiencing significant psychological burden and facilitate their timely referral to appropriate mental health support services. **Key messages 7 & 8**

Action by: Integrated Care Boards, Welsh Health Boards



4

National guidance should be developed and implemented to ensure timely treatment of EIA and minimise regional disparities in care delivery. **Key messages 5, 6 and 7**

Action by: British Society for Rheumatology, DHSC/NHSE, GIRFT and Welsh Health Boards



5

Widespread implementation of the Getting it Right First Time (GIRFT)/National Axial Spondyloarthritis Society (NASS) National Playbook on Axial Spondyloarthritis within primary care. **Key message 9**

Action by: Royal College of General Practitioners, Integrated Care Boards



Catching our breath: Time for change in respiratory care		Clinical Lead:	Marcus Pierrepoint – Consultant Paediatrician
		NICE:	NG245 , QS25
Rationale:	The <i>Catching our breath</i> report from the National Respiratory Audit Programme (NRAP) presents important insights into the current state of the nation of respiratory care across England and Wales. Its rationale is to shine a light on ongoing gaps in respiratory care, promote evidence-based interventions, and drive systemic improvements across England and Wales to reduce preventable harm and improve outcomes for people with asthma and COPD.		
Objectives:	Objectives in relation to children and young people (CYP) are to improve the quality and consistency of asthma care by ensuring timely interventions during hospital admissions, addressing risk factors such as smoking and second-hand smoke exposure, and reducing regional variation in care delivery. It aims to strengthen discharge planning through inhaler technique checks, personalised asthma action plans, and specialist follow-up, while promoting better data collection to understand the full care pathway. These objectives support national standards and bundles of care to improve outcomes and prevent avoidable harm for CYP with asthma.		

Presented at Clinical Standards and Effectiveness Group – 26th February 2026



Concerns were raised in the report in relation to CYP receiving all three elements of discharge planning, ie checking inhaler technique, providing a Personalised Asthma Action Plan (PAAP) and a specialist review being requested within 4 weeks of discharge. The graph shows how Wales has been performing in two of these elements compared to England.

NRAP publication marks over 10 years since the landmark National Review of Asthma Deaths, which highlighted important deficiencies in asthma care and made 19 key recommendations to improve outcomes and avoid preventable harm and deaths.

In that context, it is of genuine importance that this report identifies continued and highly significant deficiencies in the delivery of many of the key interventions for patients with asthma and chronic obstructive pulmonary disease (COPD) that are known to improve health and transform important clinical outcomes. This pattern has changed little in recent years and, in many aspects, has not recovered to pre-pandemic levels. Recognition and understanding of these deficiencies is vital to inform new models of care and appropriate use of resources.

Key Findings and Priorities for Improvement Relating to Children & Young People in Wales

Admissions due to asthma exacerbations during 2023–24:

- 456 admissions for CYP aged 1–5
- 308 admissions for CYP aged 6+

Risk Factor Recording:

Smoking status and second-hand smoke exposure are poorly documented for CYP in Wales, despite these being key risk factors for asthma exacerbations.

Tobacco Dependence:

Very low rates of intervention for parents/carers who smoke, even when CYP are exposed to second-hand smoke. **(this relates to both England and Wales)**

Call to Action:

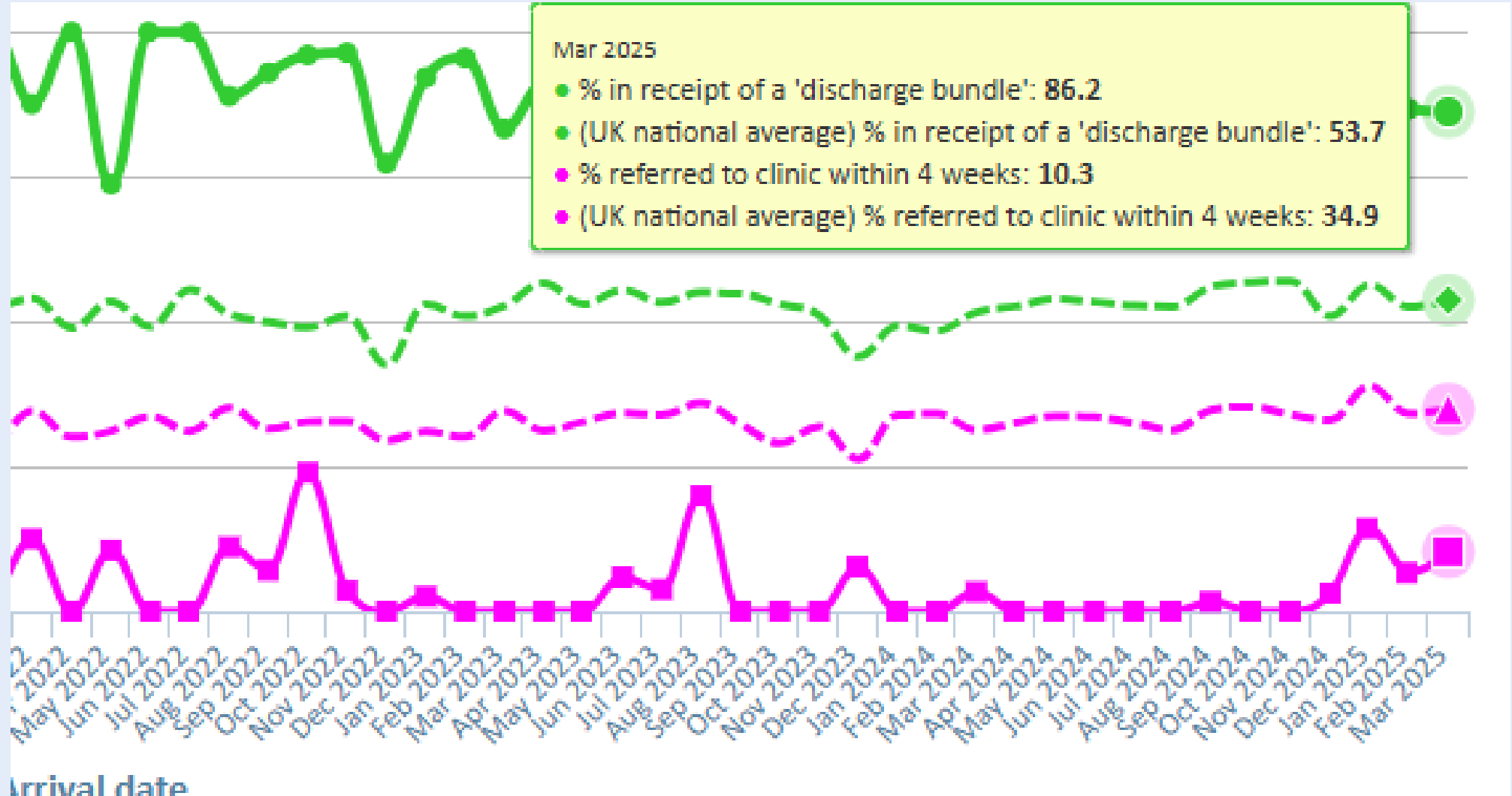
- Welsh health boards should prioritise improving discharge planning for CYP, address tobacco dependence in families, and ensure compliance with the National Bundle of Care for CYP with Asthma.

ABUHB has had an Asthma and Wheeze Education Bundle in place for some time:

❖ **Containing a checklist for parents and nursing team.**

Your child is on 4 hourly inhalers (Salbutamol) at the time of discharge		Checklist for nurses to complete at discharge	
You have been given a spacer and shown how to give your child their inhaler with the spacer			
You have received information on how to clean and look after your child's spacer			
You have a prescription for a course of oral steroids (if indicated)			
If your child is on regular medications for asthma/viral wheeze, these have been reviewed by the doctors and changed if necessary			
You have received advice on when to seek medical advice if your child is unwell with a wheeze			
You have received a completed Personalised action plan for asthma & pre-school wheeze which has your child's details on it.			
You have discussed with the doctor about whether your child needs a follow-up appointment with the GP or in hospital after discharge			

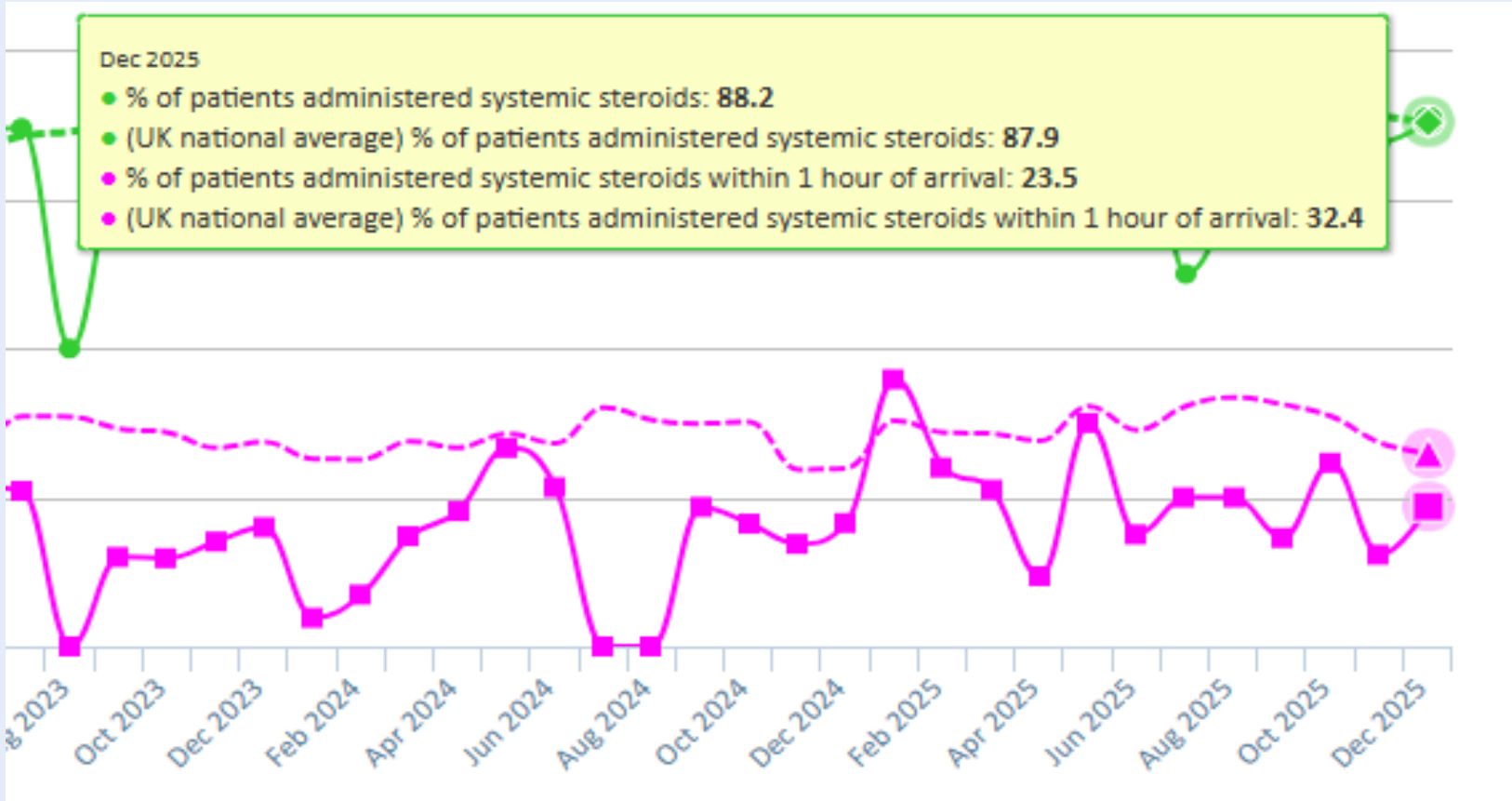
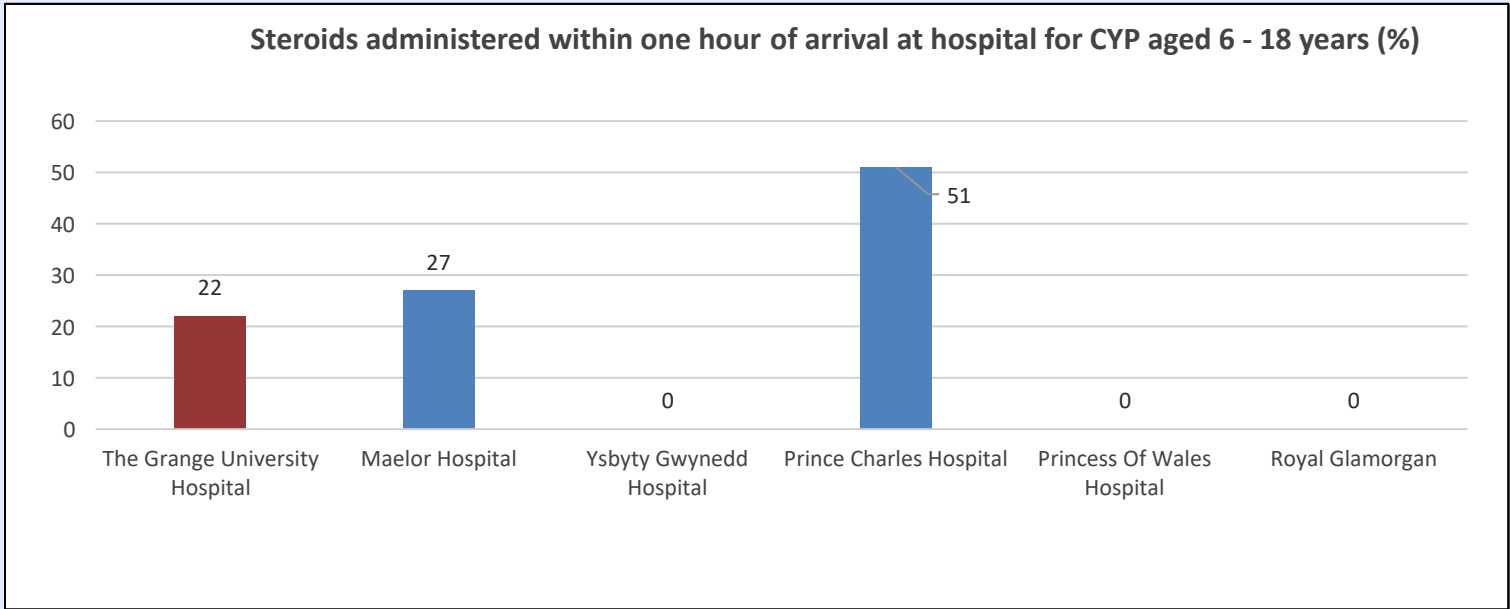
		Signed	
Have you demonstrated and checked parent's inhaler technique?			
How have medicines been dispensed?	WP10		
	Pharmacy		
	Ward stock		
Has the action plan been completed and given to the family?			
Has the NHS Wales Astmahub been signposted?			
Has the parent's checklist above been completed?			
Have any parental questions been answered?			
Has the discharge summary been completed?			

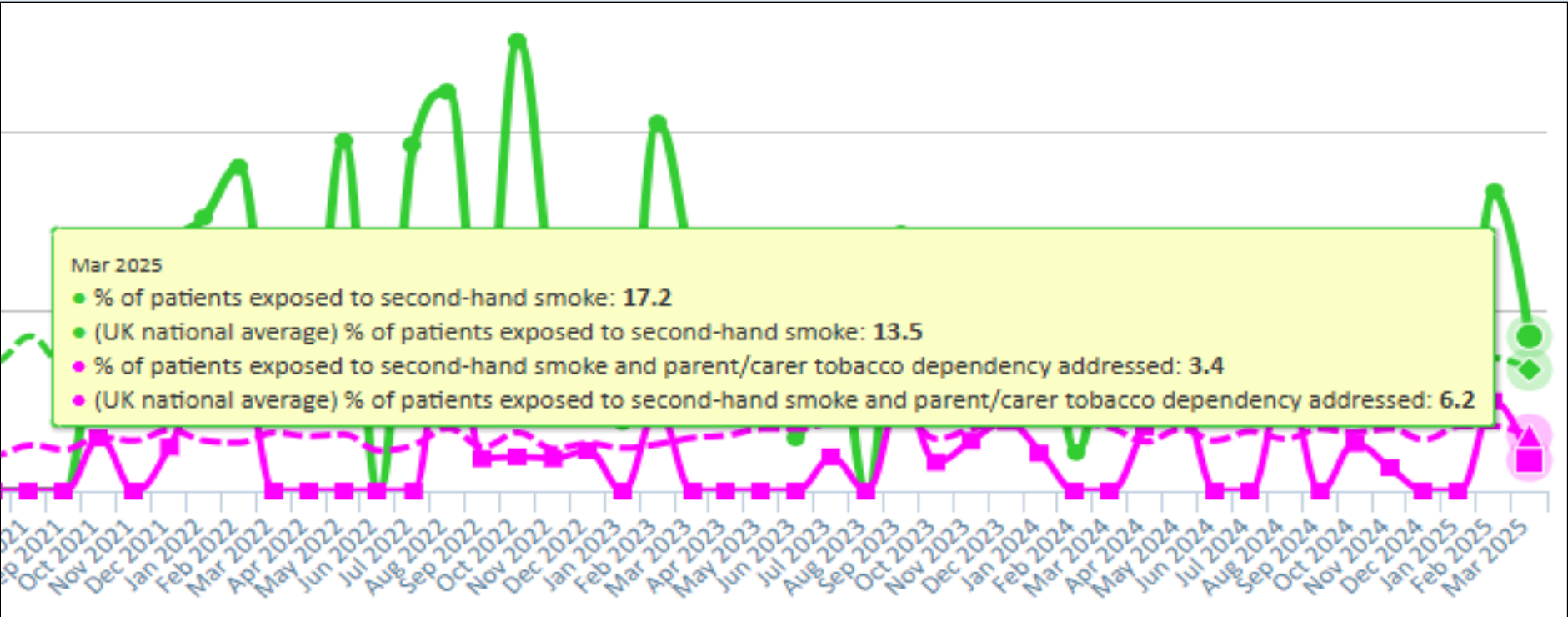
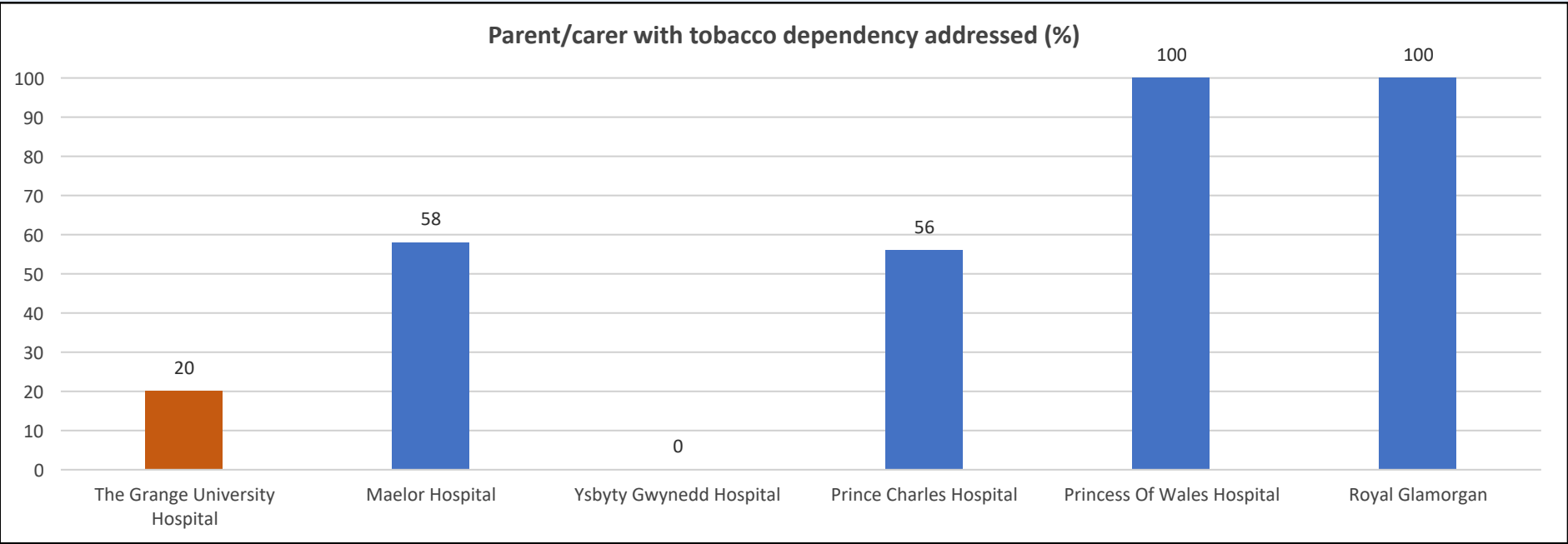
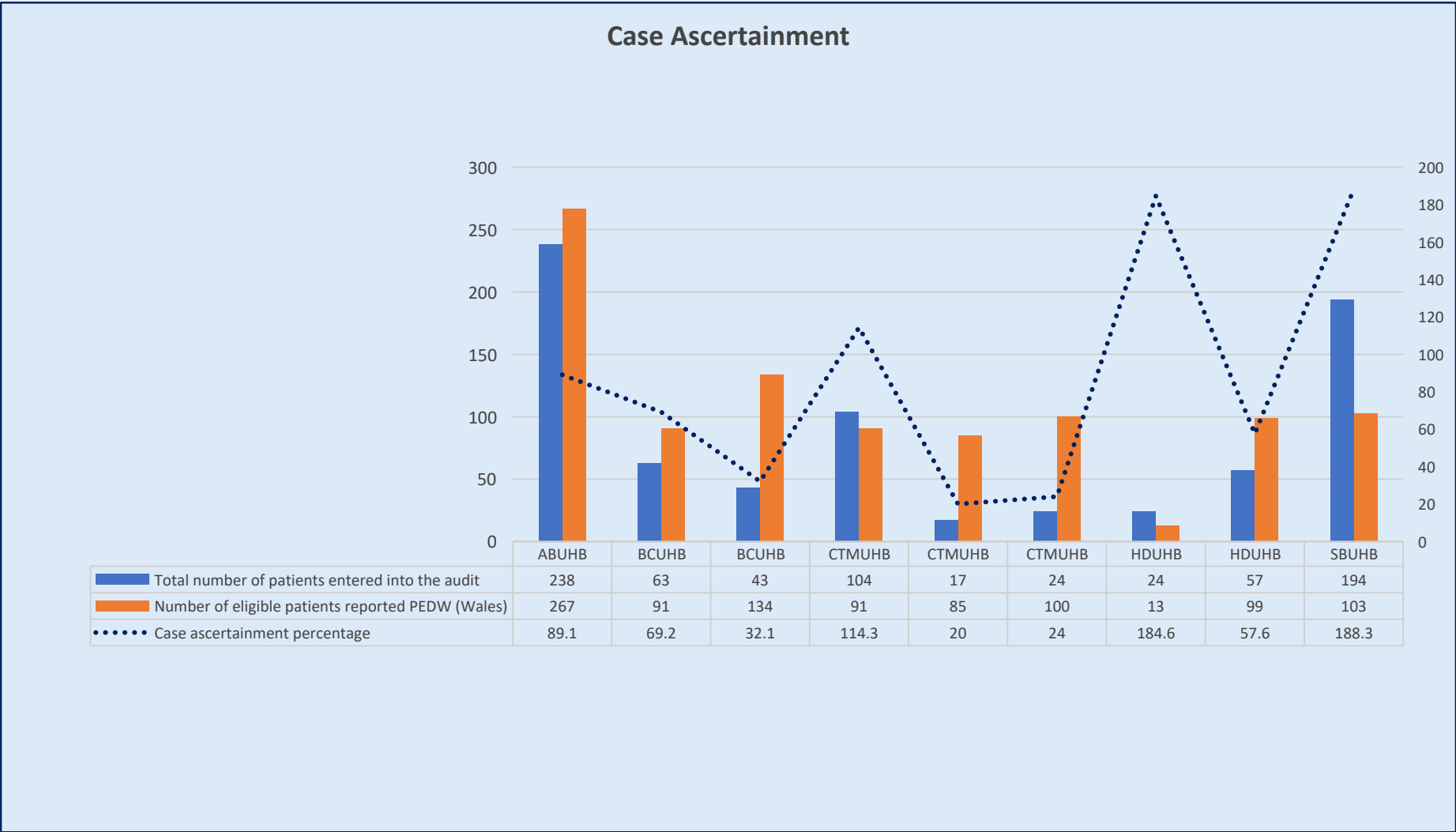


ABUHB - Discharge bundle versus referral in 4 weeks

Steroids within 1hr

Not everyone should get steroids
Clock starts at booking, via triage to clerking and then prescription and dispensing and administering.
1hr is not possible within the current AB model. There has been a push for ensuring patient education.
AB are hoping to use a PGD to administer at triage





Smoking addressed? – ABUHB Resources

Family history:

	Asthma	Eczema	Hay fever
Patient			
Mother			
Father			
Siblings			

Smoking *: Ask children >11yrs about personal history of smoking

Parent/Carer Smoking *

Name: **Unit No:**

Date of Birth:

Address:

(Place addressograph here)

Pets:

Allergies:

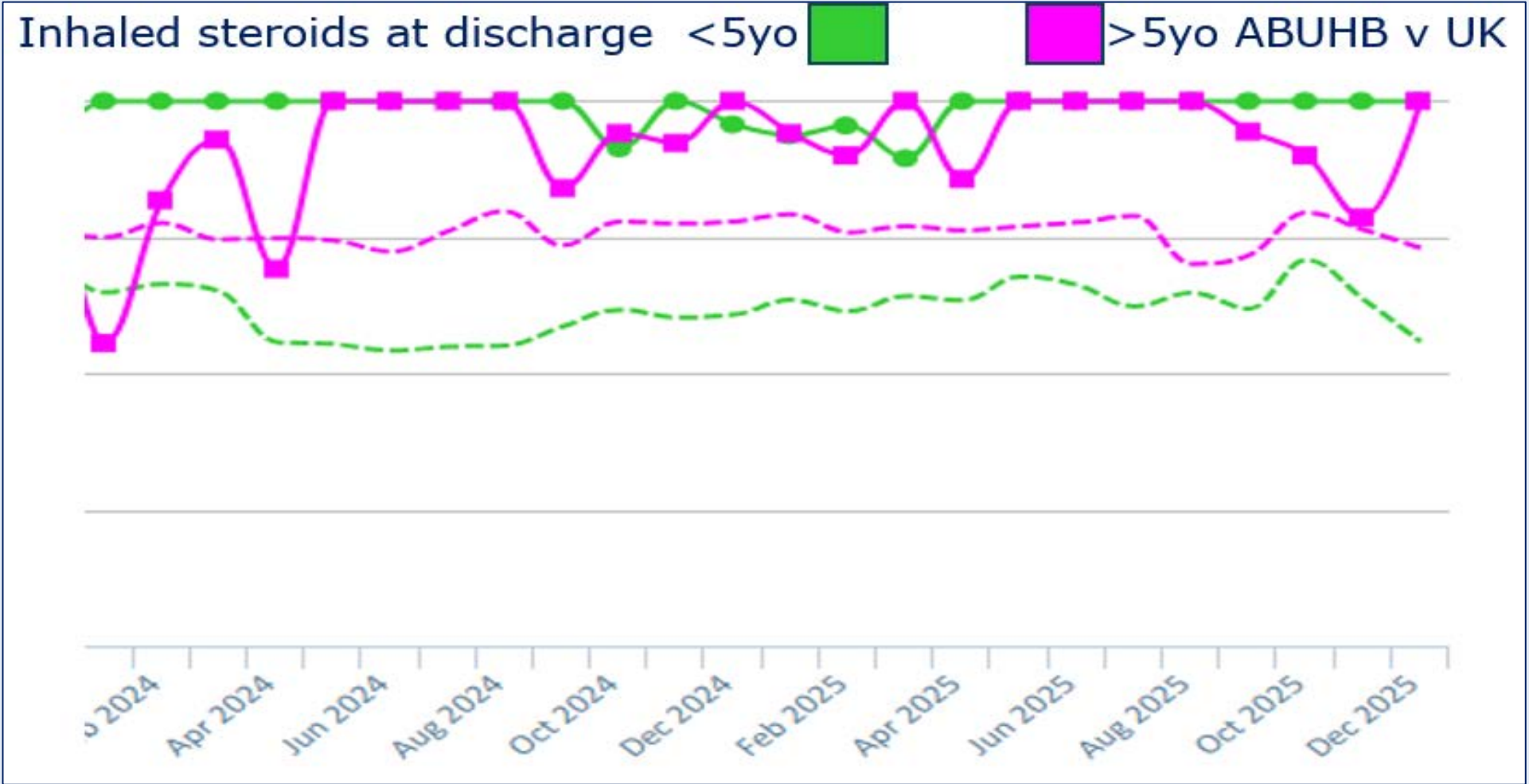
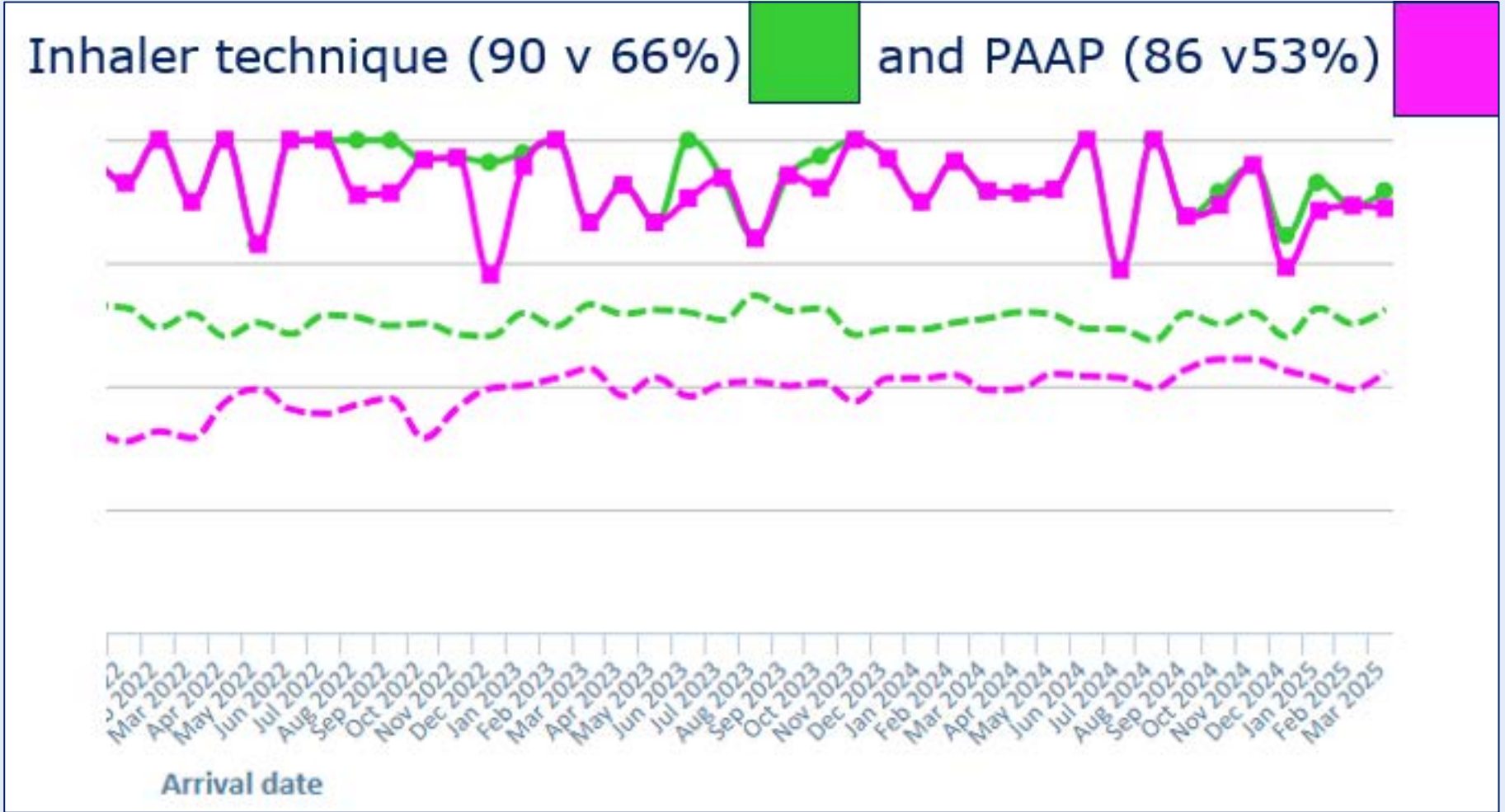
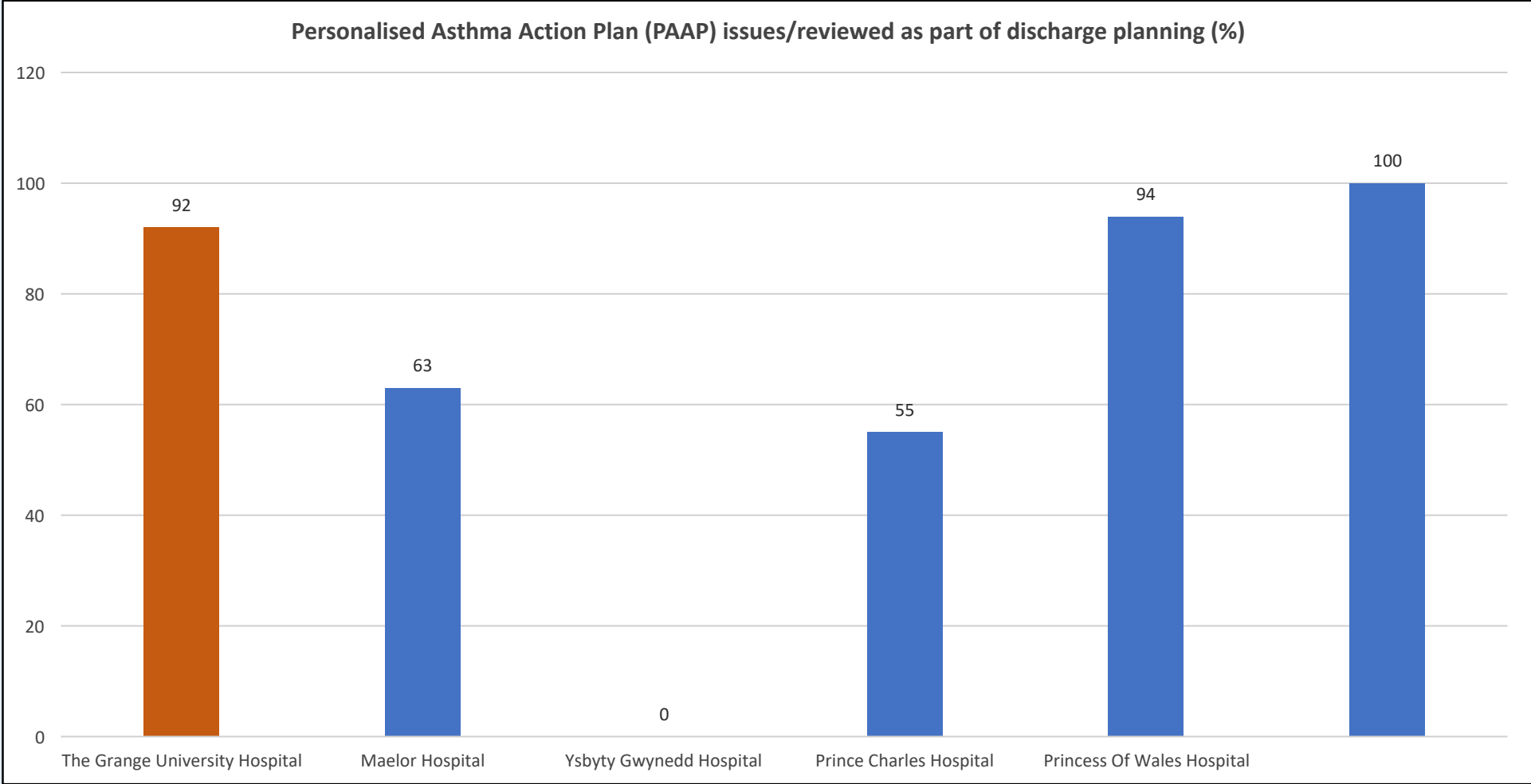
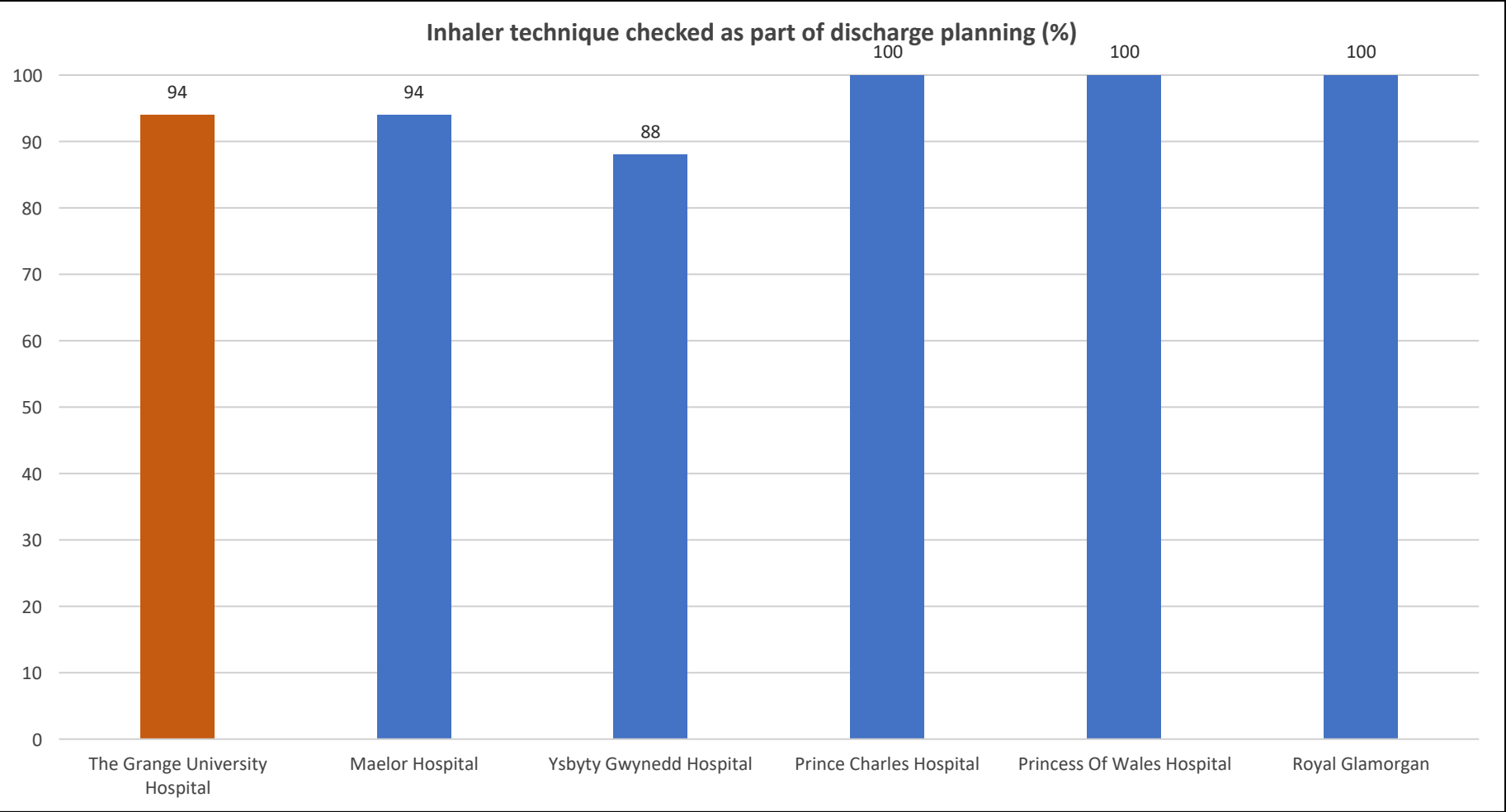
Useful Resources

www.asthma.org.uk
Offers a variety of resources to help you and your child manage their asthma. There are helpful videos on using inhalers correctly.

[NHS-Wales-Asthmahub-App-for-Parents](#)
NHS-Wales self-management App for parents of children with Asthma.

www.ash.org.uk
Health effects of Second-hand smoke.

www.helpmequit.wales
Free advice and support with smoking cessation.



Assurance and Risk

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

Key Success and Concerns

Report Successes:		Report Concerns:	
1	Primary care education days	1	Prednisolone within 1 hr
2	New pathway adopted with recent audit interactions	2	Primary care follow up with 2 days
3	Better, earlier diagnosis of asthma	3	Hospital FU with 4 weeks
4	Data capture	4	Documentation of smoking and interventions

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress :
1	NRAP reiterates the importance of <i>Breathing Well</i> recommendation which is maintained for this year’s report: Integrated care boards and local health boards should mandate all eligible services to participate in NRAP to achieve 100% service participation and a minimum of 50% case ascertainment by all services in NRAP audits by May 2026. This will require all services to have named NRAP clinical leadership and dedicated audit support.				Fulfilled
2	The British Thoracic Society, as the expert body, should lead the development of a standardised acute care bundle for patients with asthma and COPD on arrival to hospital, working towards May 2026. This should involve consultation with other bodies such as the Royal College of Emergency Medicine, Society for Acute Medicine, and NRAP. NRAP will measure the implementation of the acute care bundle by tracking the percentage of patients receiving timely and optimal care.				Fulfilled
3	The HB reiterate the importance of our Breathing well recommendation which is maintained for this year’s report: All people with COPD and asthma who smoke, and smokers who are parents of children and young people with asthma, should be offered evidence-based treatment and referral for tobacco dependency.	Present at next audit day Junior education in PED and paedS	Clinical Lead – Consultant	3 months	
4	PGD for prednisolone for wheeze - Pharmacy constraints	Already initiated	Clinical Lead	June 2026	

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Develop more transition joint working	2 meetings per yr	Clinical Director		Actioned
2	Liaise with primary care about 2-day FU		Clinical Lead	3 months	

Please note that the NBCA State of the Nation Report published in January 2025 related to data from 1 April 2022 to 31 March 2023.

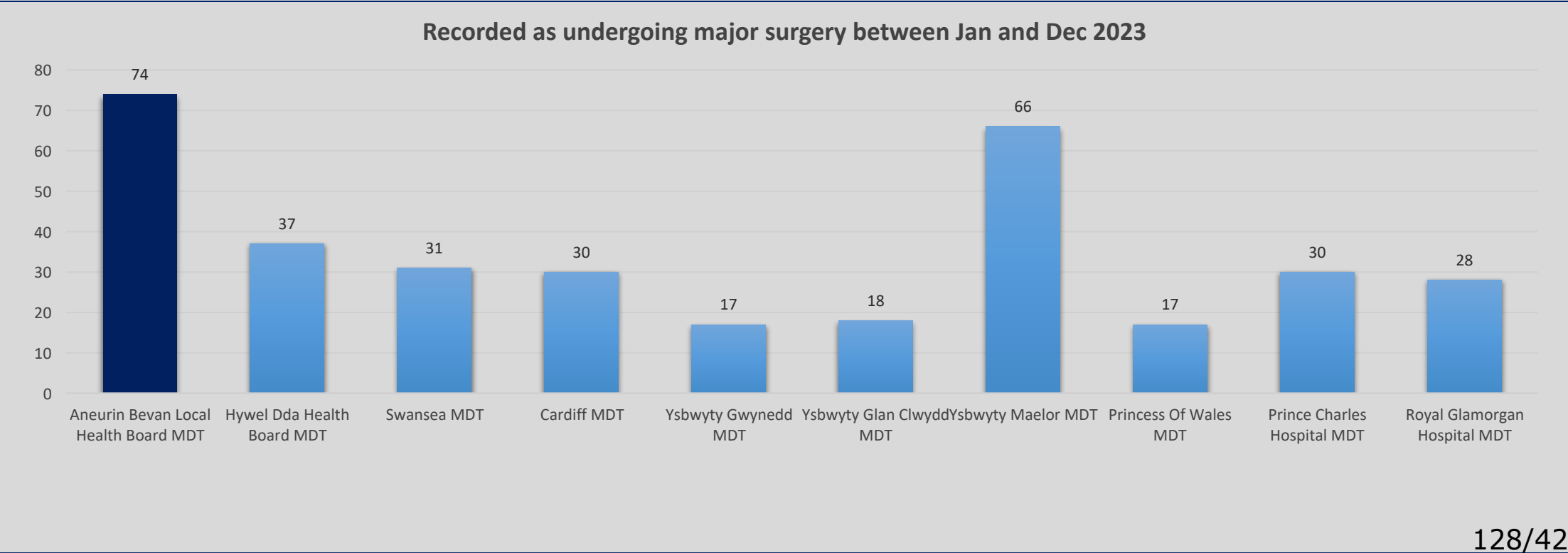
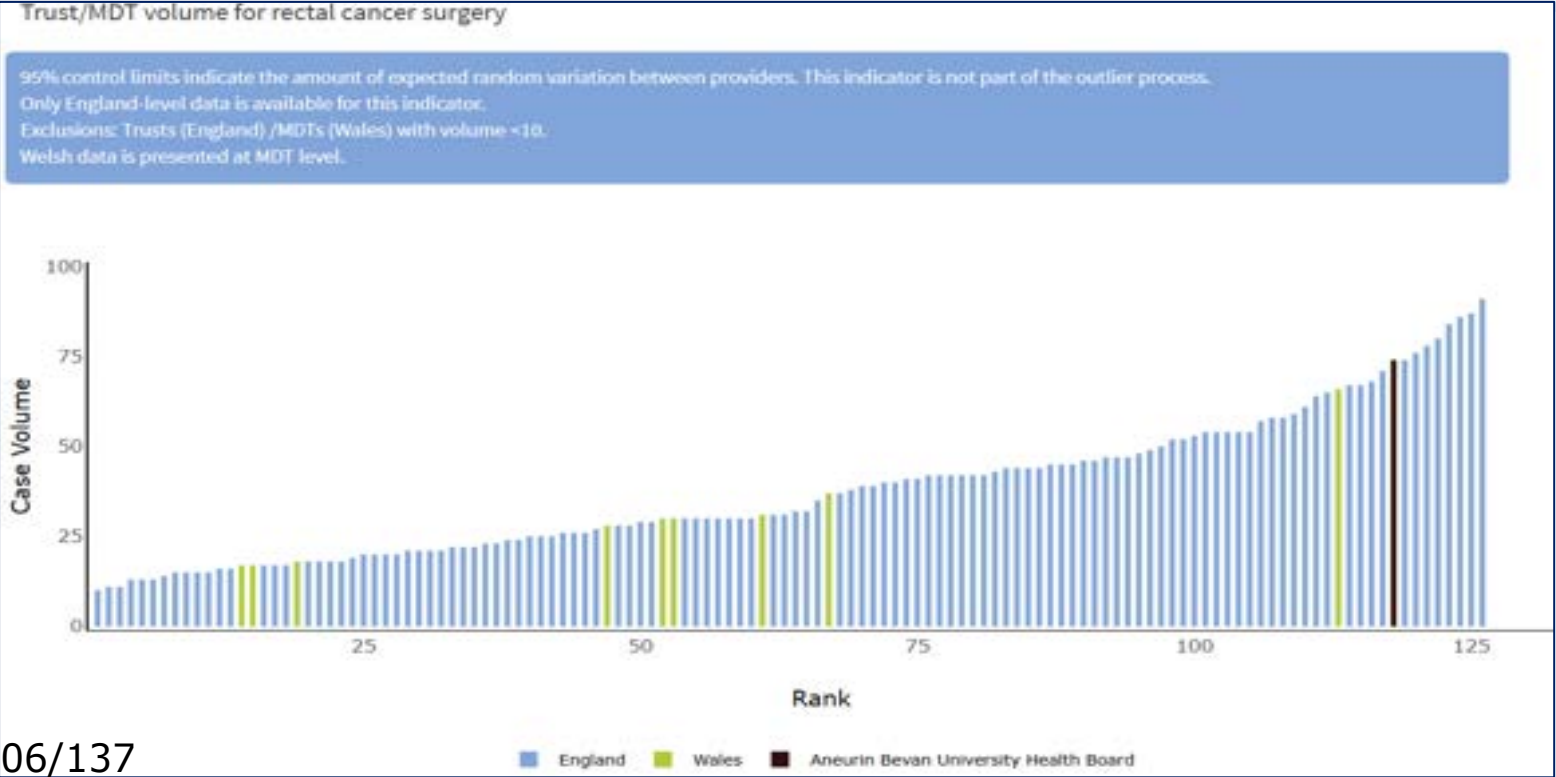
NICE guideline [NG151] Quality Standards DG27

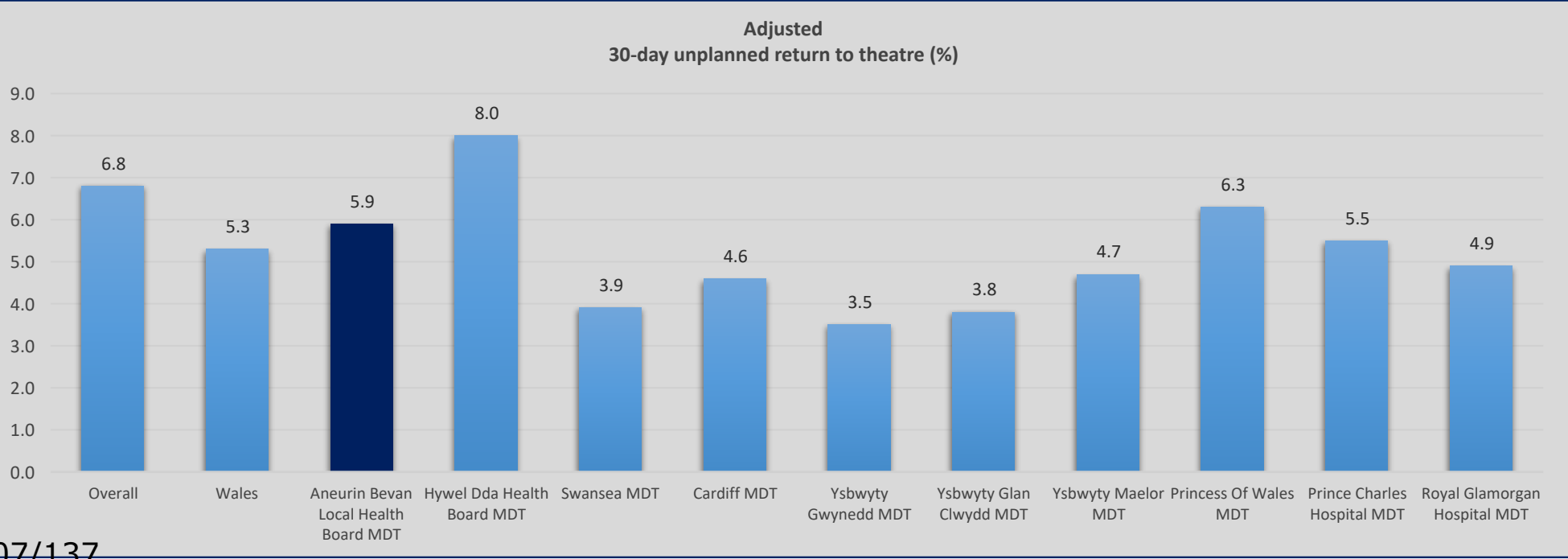
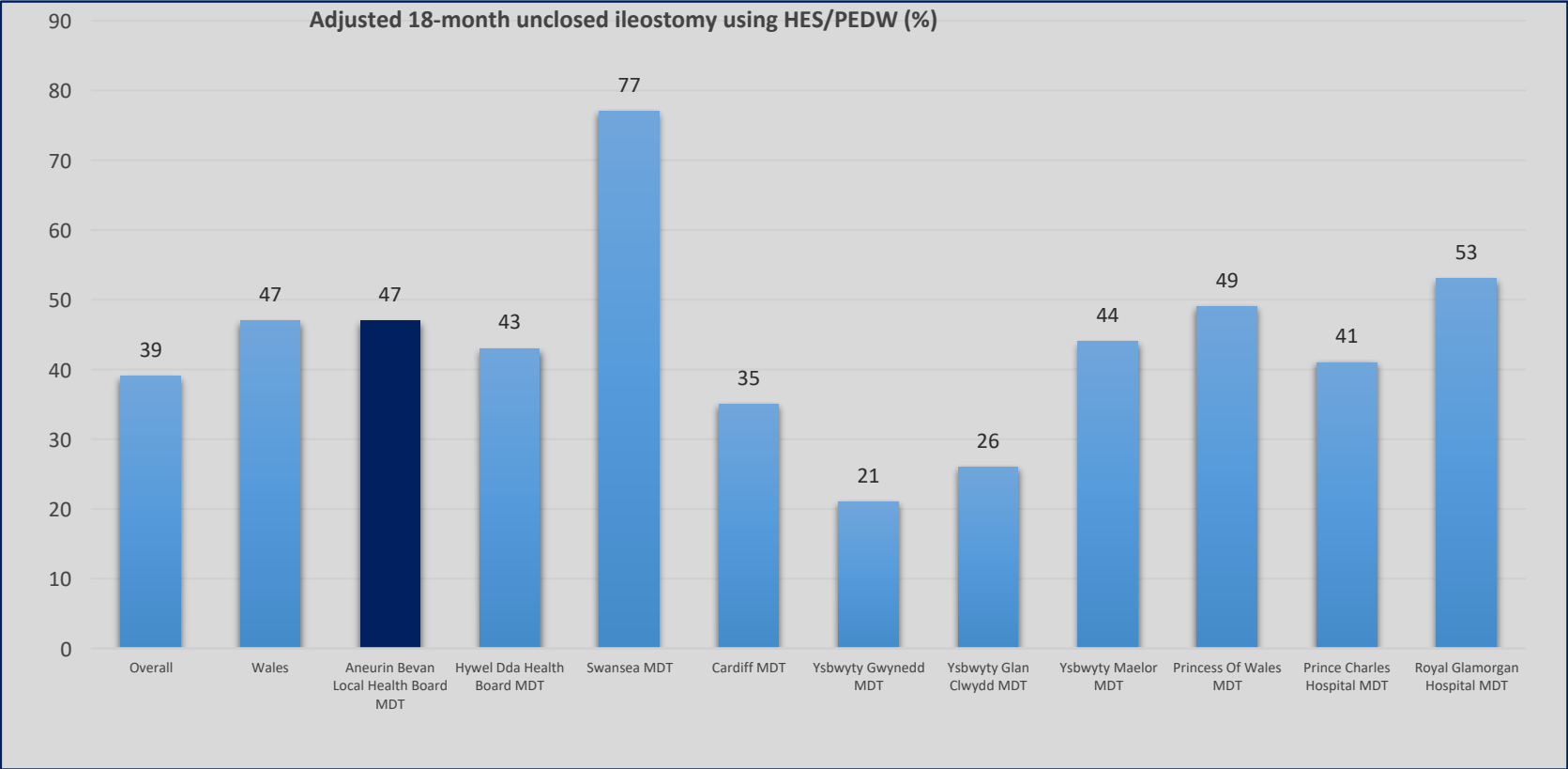
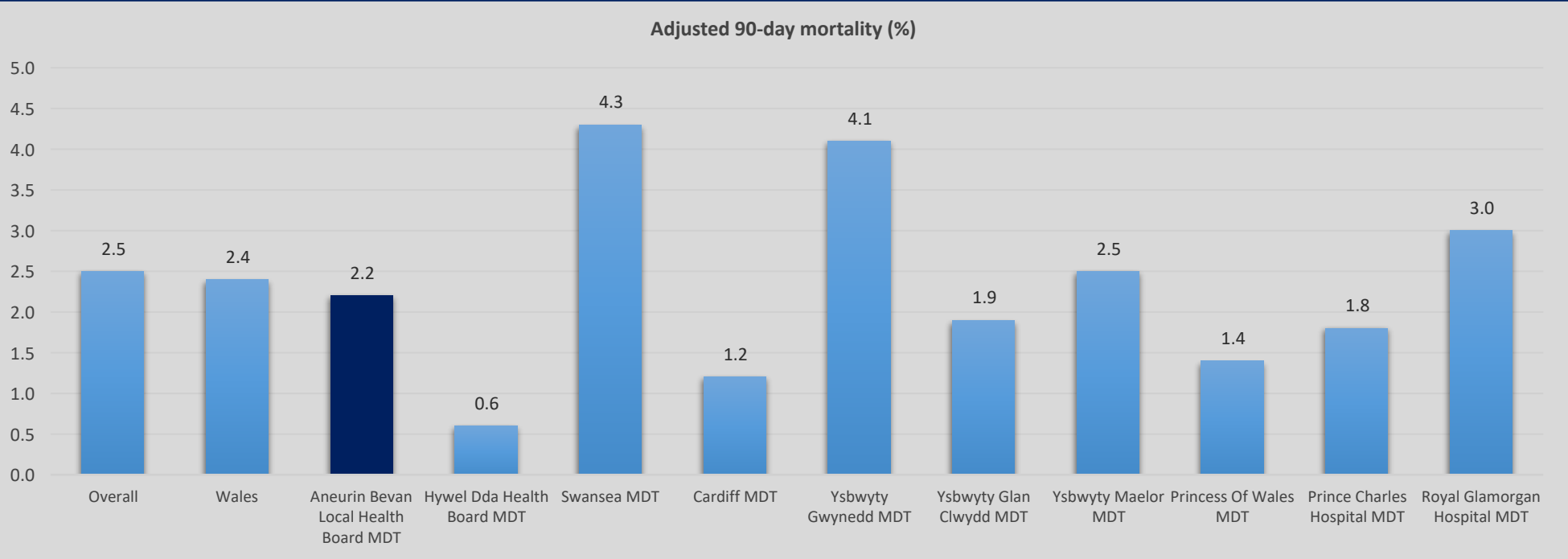
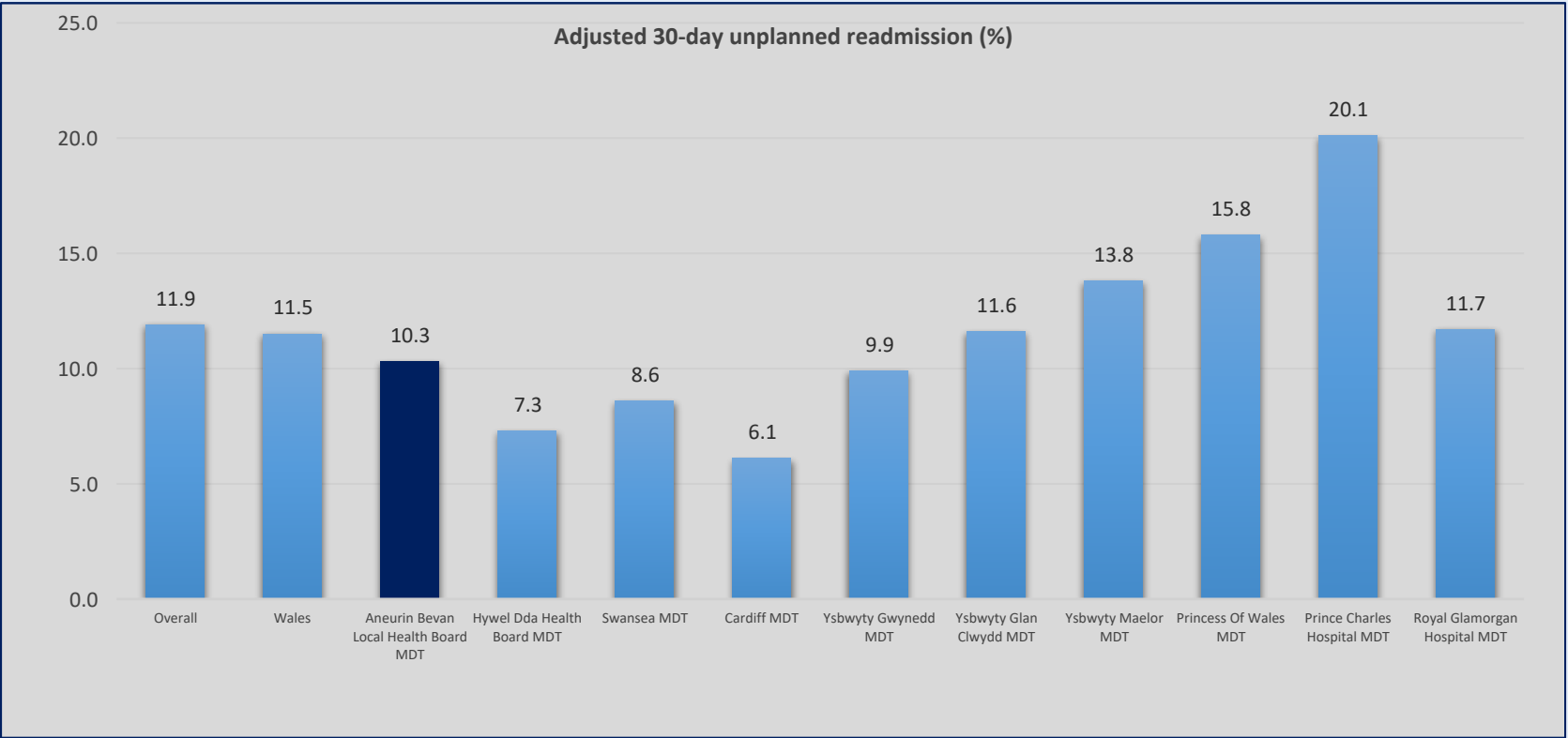
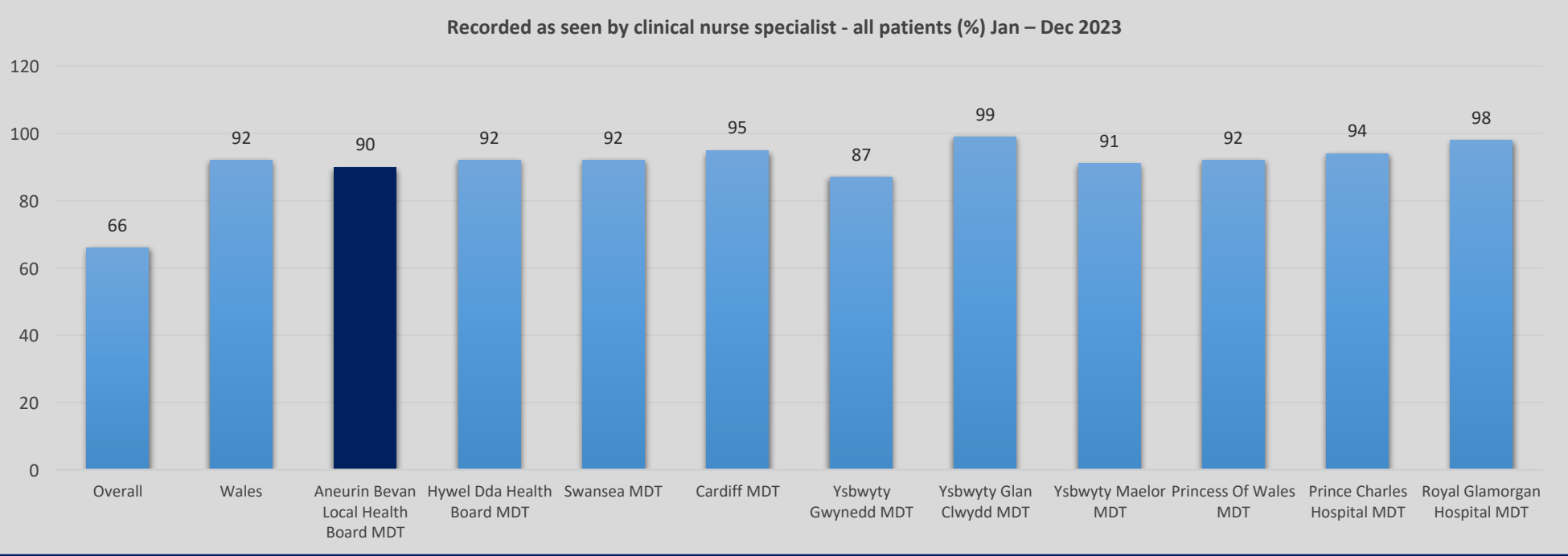
Rationale:	The National Bowel Cancer Audit (NBOCA) measures the quality and outcomes of care for people diagnosed with bowel cancer in England and Wales. This report focuses on people diagnosed with or undergoing surgery for bowel cancer between 1 January 2023 and 31 December 2023.	
Objectives :	NBOCA’s quality improvement (QI) plan sets out five QI goals covering the entire patient care pathway. Mapped to these goals, NBOCA has developed ten performance indicators with local QI targets. The aim is to increase the consistency of access to treatments and stimulate improvements in care and outcomes for people with bowel cancer.	The NBOCA Quality Improvement goals are: 1. Improving the diagnostic pathway 2. Improving perioperative care 3. Improving oncological care 4. Improving management of stage four disease 5. Improving end of life care

Performance Indicators:

PI 1:	Seen by Clinical Nurse Specialist	PI 6:	Adjusted 18-month unclosed ileostomy after anterior resection
PI 2:	Trust/MDT volume for rectal cancer surgery	PI 7:	Stage 3 colon cancer receiving adjuvant chemotherapy
PI 3:	Adjusted 90-day mortality after major resection	PI 8:	Severe acute toxicity after adjuvant chemotherapy for colon cancer
PI 4:	Adjusted 30-day unplanned return to theatre after major resection	PI 9:	Rectal cancer patients receiving neo-adjuvant therapy
PI 5:	Adjusted 30-day unplanned readmission after major resection	PI 10:	Adjusted 2-year survival rate after major resection.

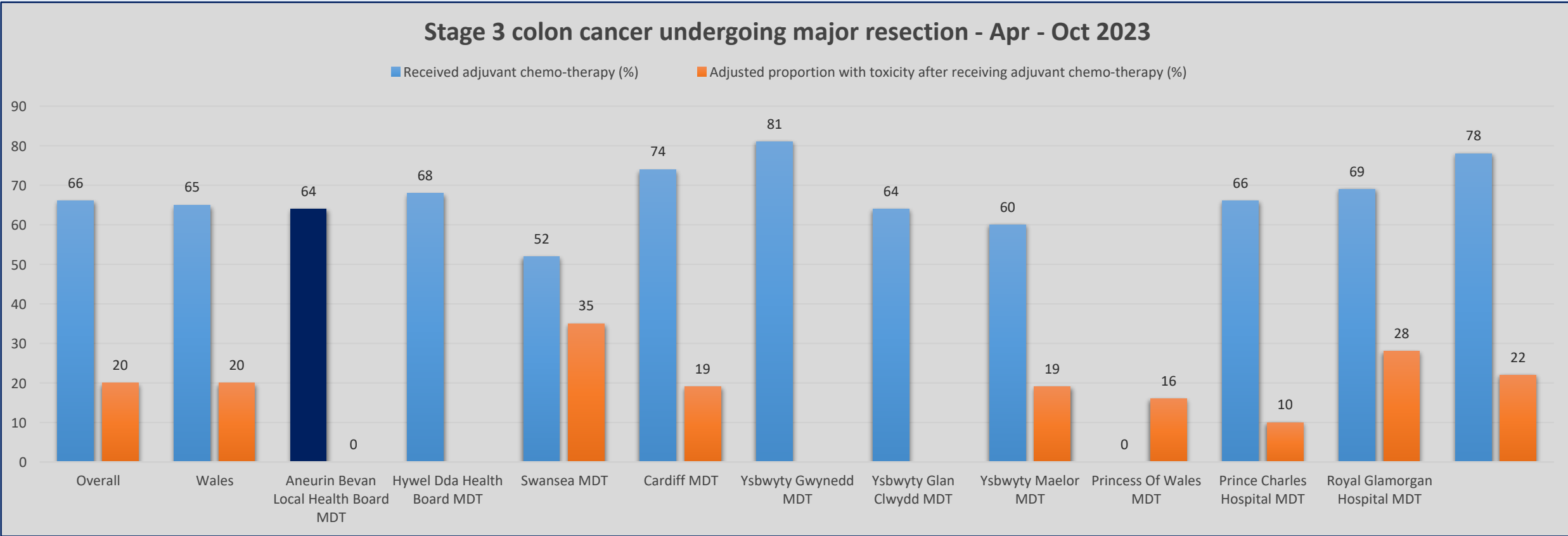
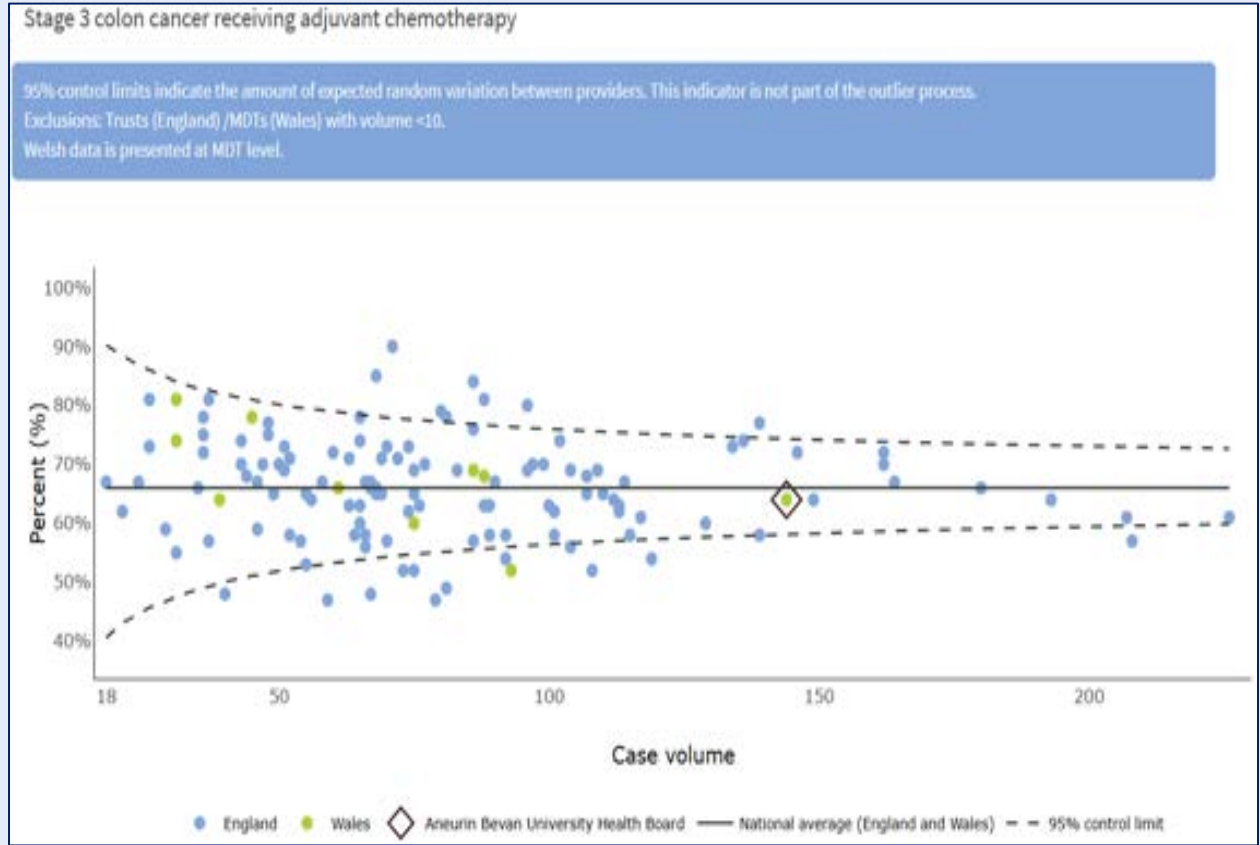
Presented at Clinical Standards and Effectiveness Group – 26th February 2026



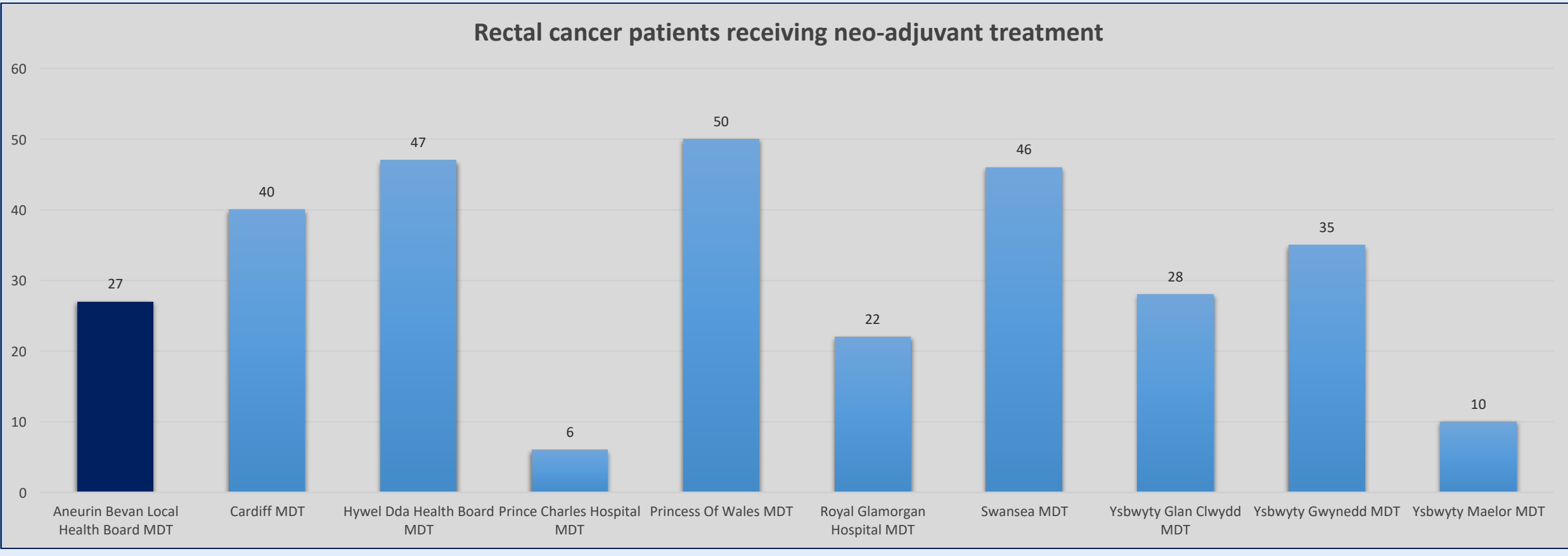
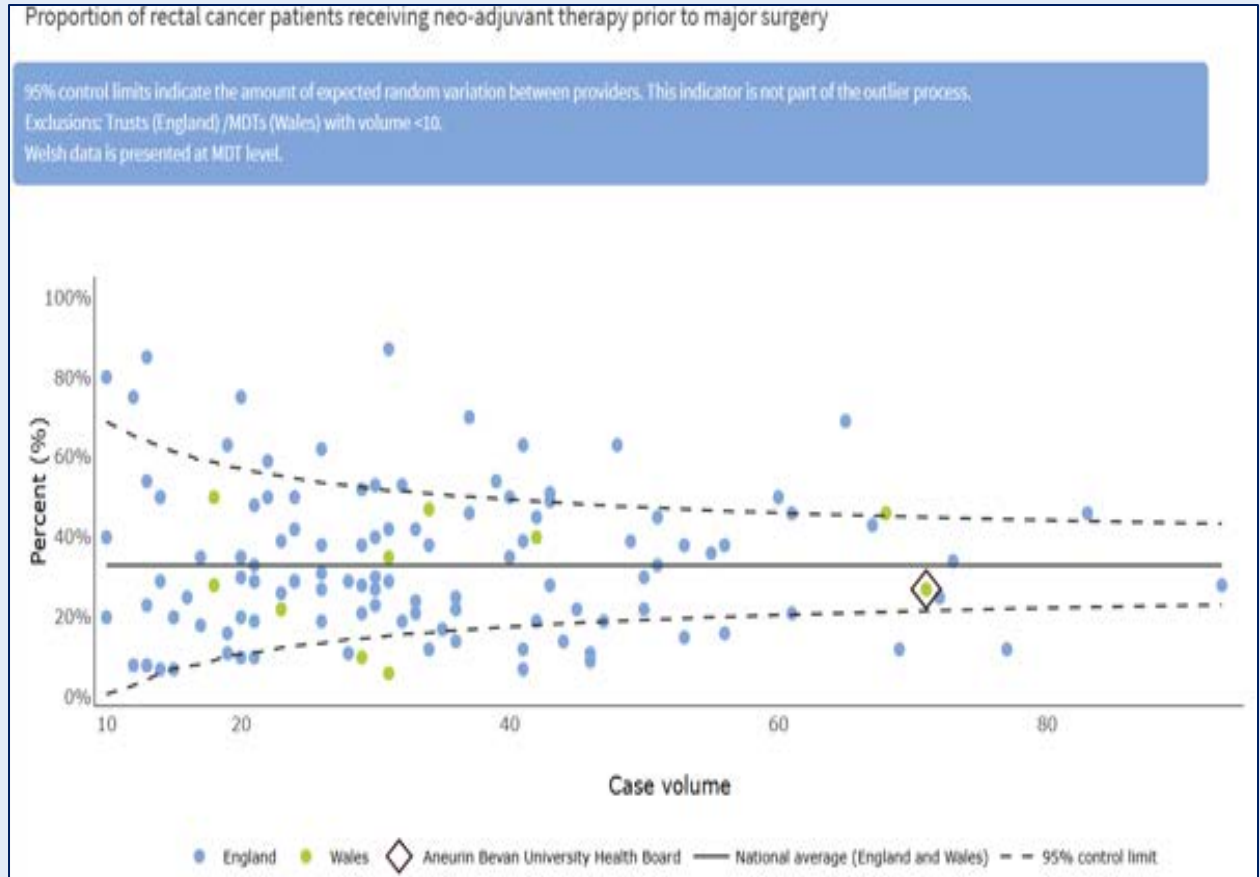


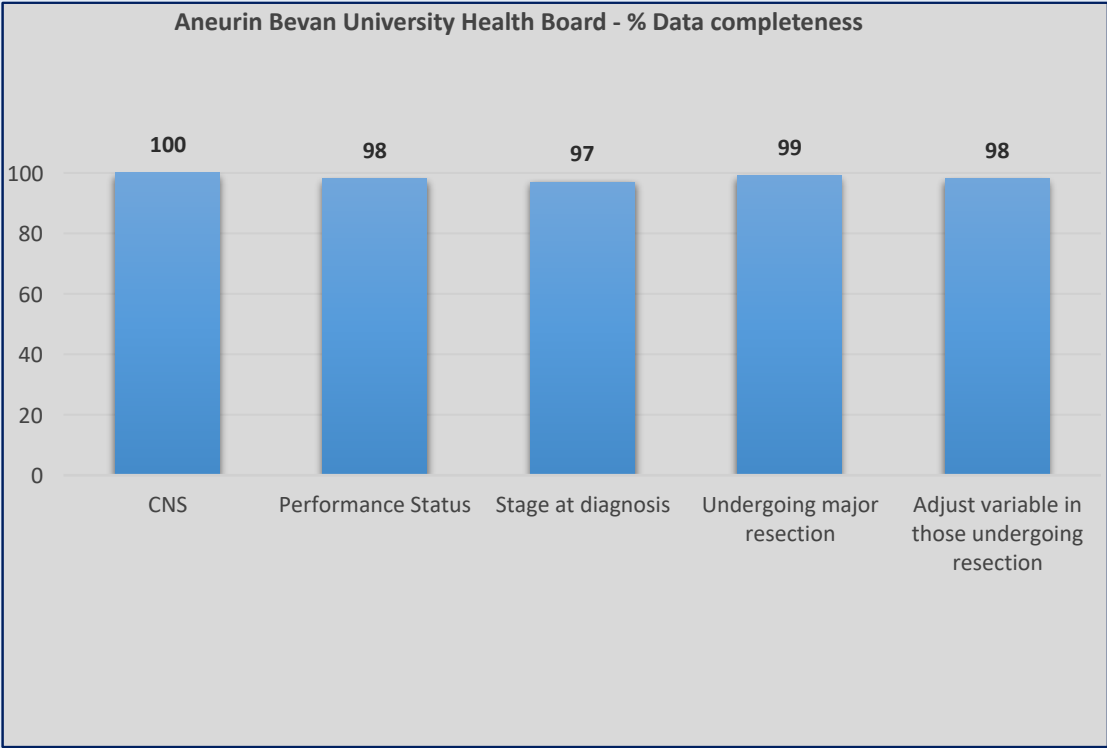
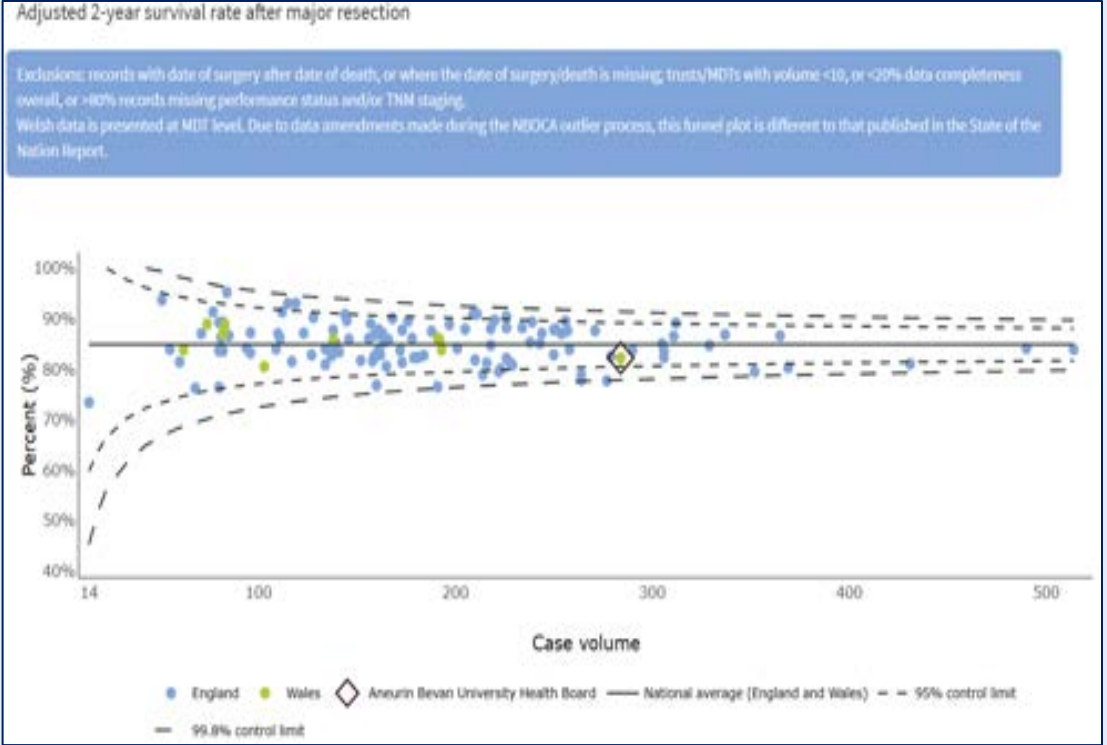
Report findings: Performance Indicator and local target: Less than 35% of people with unclosed diverting ileostomy 18-months after anterior resection. Approximately 38% of people with unclosed diverting ileostomy 18-months after anterior resection. This has not improved since last year’s report. Local audit undertaken to assess ‘*reducing the time to reversal of temporary ileostomies following anterior resection*’

- More than 55% of people with stage 3 colon cancer receiving adjuvant chemotherapy
- In England and Wales, 14 NHS trusts/HBs were below the local target. Considerable between-unit variation in the use of adjuvant chemotherapy remains with 15 (12%) NHS trusts/MDTs below the 95% funnel limit.



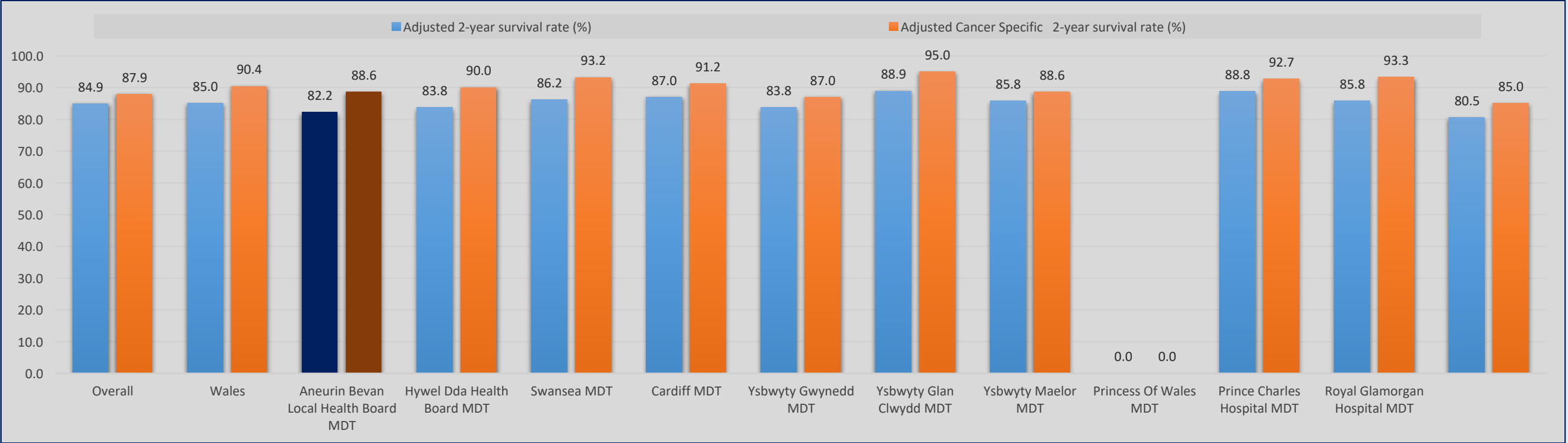
10-60% of people with rectal cancer undergoing major resection receiving neo-adjuvant treatment.
Overall, 33% of people received neo-adjuvant radiotherapy for rectal cancer with wide variation between NHS trusts/MDTs from 6% to 87%.





Key Success and Concerns

Report Successes:	
1	Data completion and submission is high quality. Good administrative support for Cancer coordinator.
2	Perioperative Surgical quality of care and outcomes meet and, in some criteria, exceed national standards
3	Good input into the MDT from Oncologists, gastroenterology and Liver surgical team to help with complex cases .
4	Established Early rectal cancer assessment and surgery within ABUHB through SPECC MDT and dedicated surgeons undertaking TAMIS procedure. Introduction of Robotic surgery for CRC.



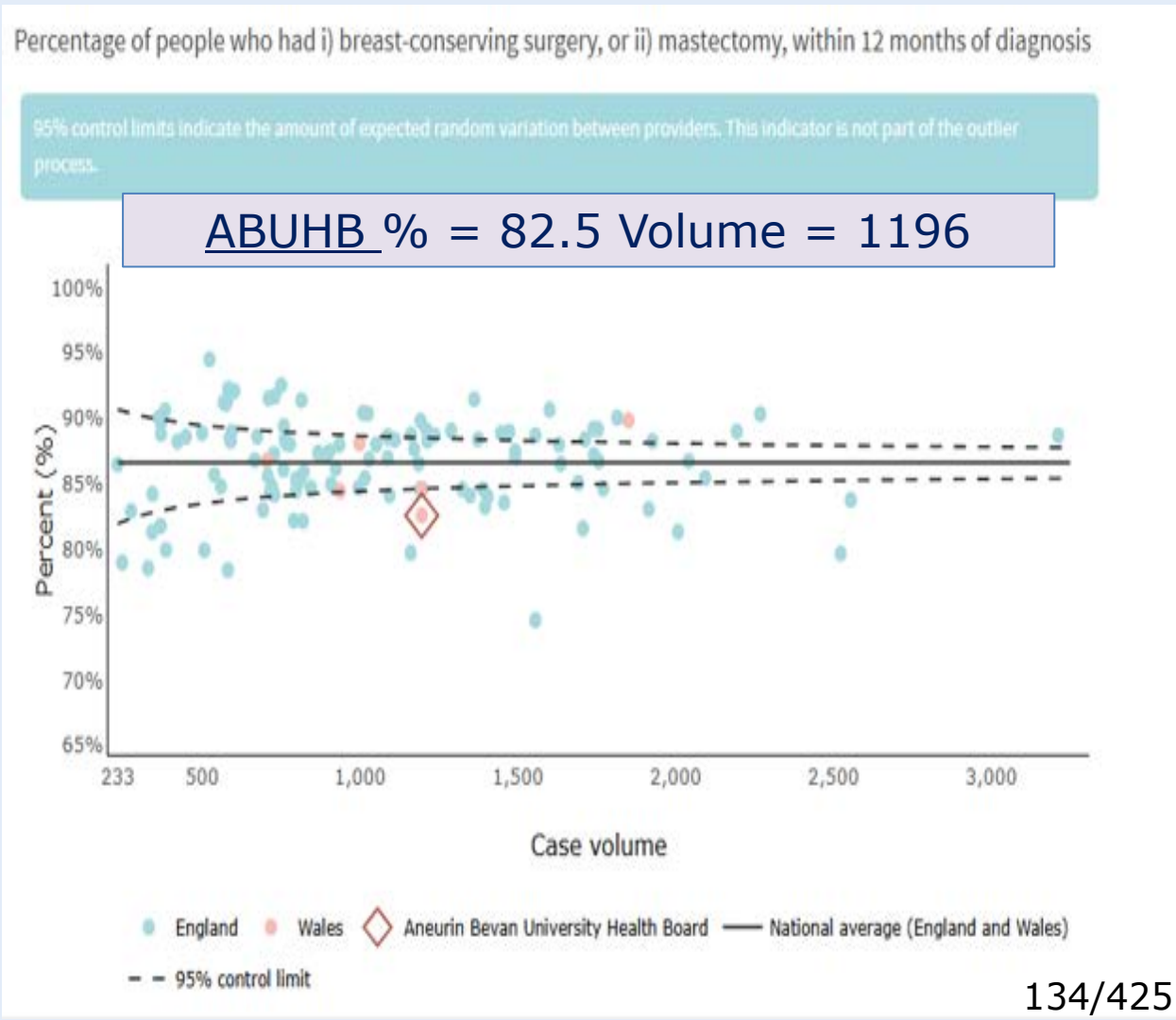
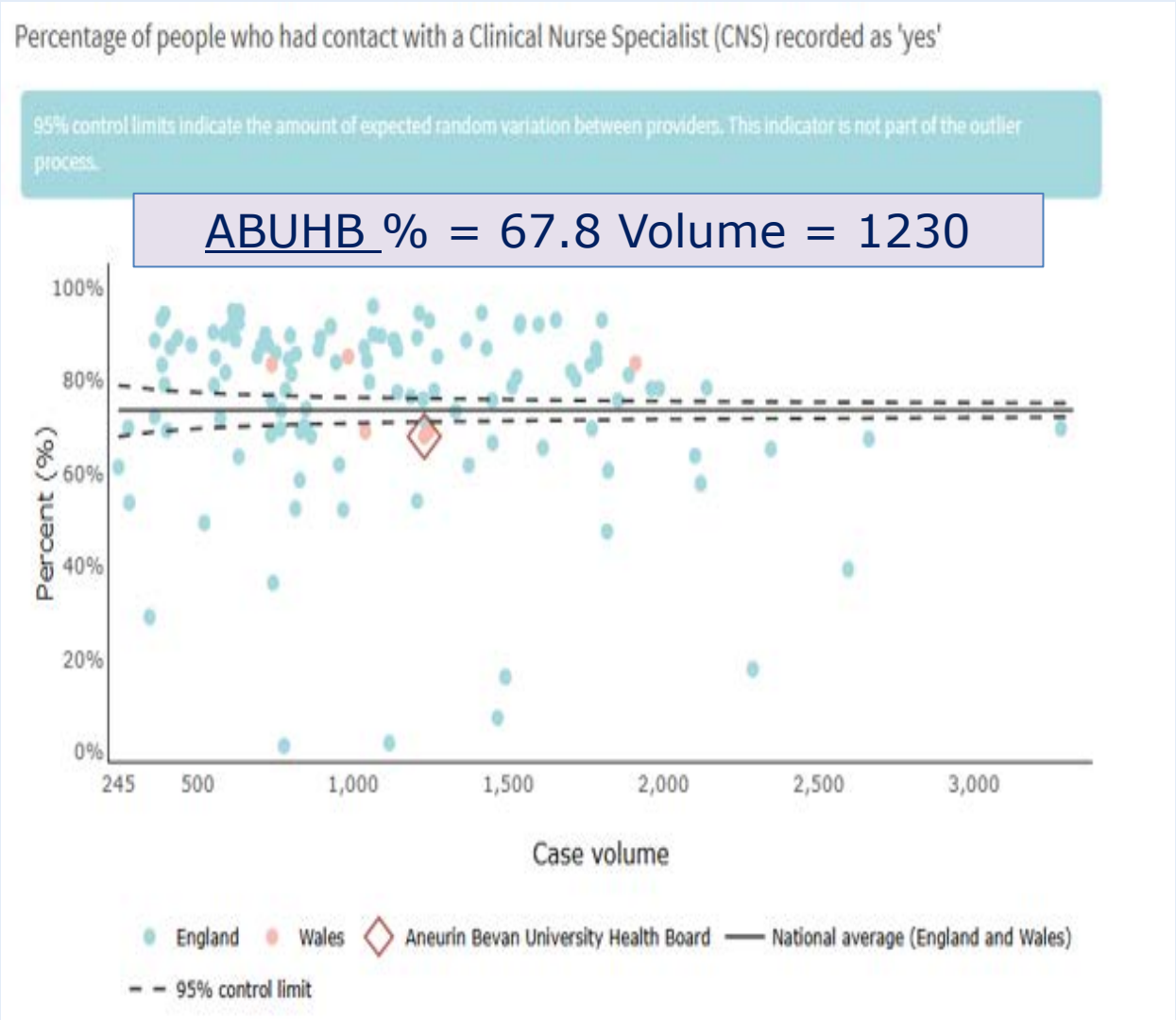
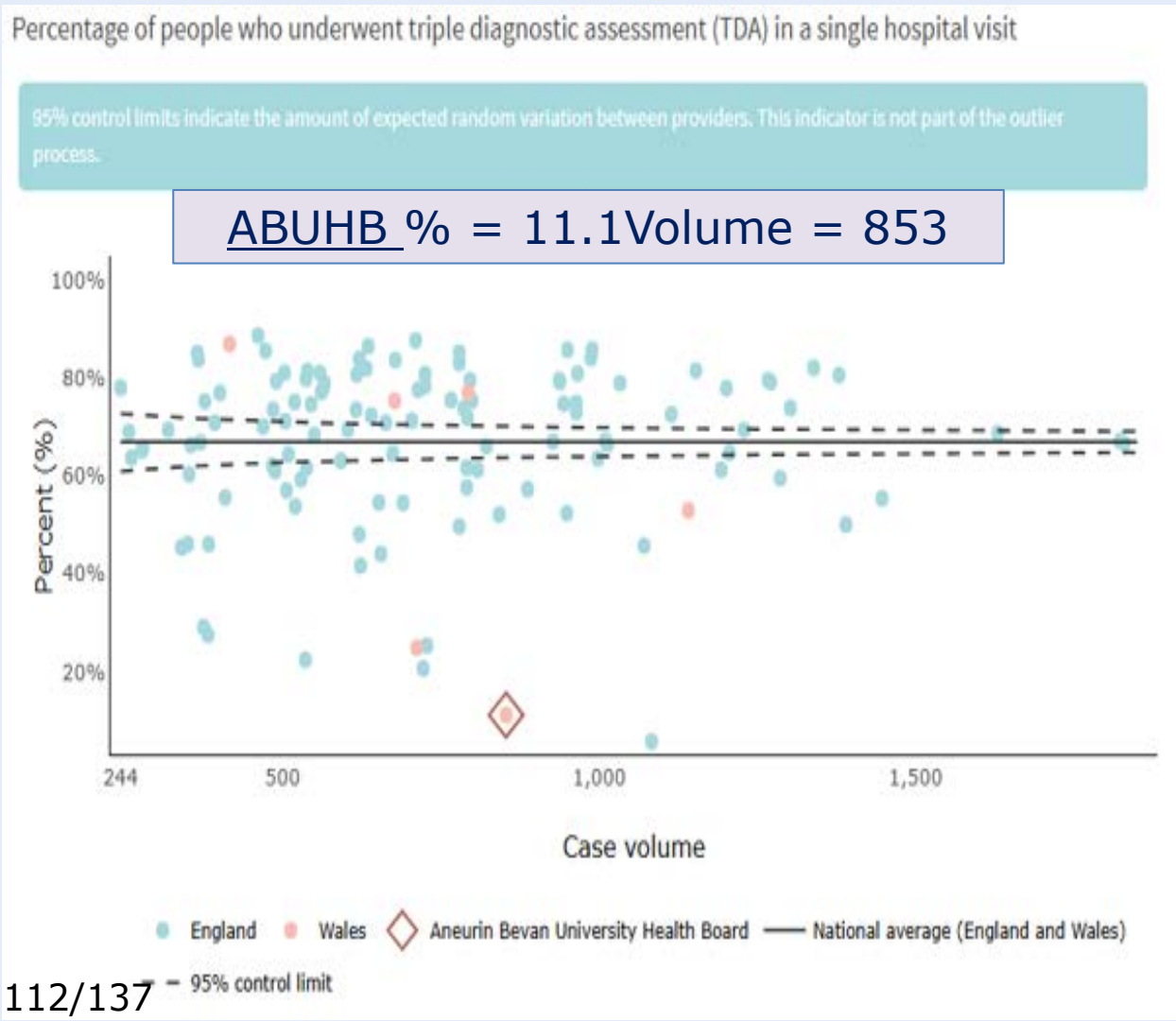
Assurance and Risk Level

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	
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: The unmet standard has been audited locally and agreement reached with appropriate directorates (General Surgery & Radiology) to facilitate the process and achieve the target.		

Report concerns:	
1	Delay in Diagnostic pathway, mainly endoscopy. This is being addressed through vetting.
2	Delay in Ileostomy closure- now being addressed with renewed process in place.

Report Recommendations:		S.M.A.R.T Actions:	Responsible :	Due Date:	Progress:
1	Increase the proportion of people who have their ileostomy closed within 18-months of anterior resection for rectal cancer. - Support NHS trusts/ multidisciplinary teams (MDTs) to identify system-level (e.g. access to theatre/radiological investigations) and patient-level drivers of variation. - Support NHS trusts/MDTs to participate and engage with the local and national quality improvement initiatives to enable more timely reversal of ileostomy. For example, NBOCA & Royal College of Surgeons of England’s CloseItQuick Collaborative.	Presented data to surgical directorate on the recent audit of 2-year data and suggested – WSCE to be done at 4-6 weeks post low anterior resection. This was identified as the crucial step in the pathway affecting Target outcome. Agreed by MDT and Radiology department. QI project to assess progress in 1 year.	Clinical Lead – Surgeon	Jan 2027	Action plan agreed
2	In units with chemotherapy utilisation following resection of stage 3 colon cancer below 55%, conduct individual patient analysis to review the rationale for not offering treatment against evidence-based guidelines. If the resulting findings identify under-utilisation, develop appropriate local action plans to increase rates of chemotherapy whilst maintaining low levels of severe toxicity. Action plans may include integration of geriatric expertise and or rehabilitation into shared chemotherapy decision making.		Lead Oncologist No action needed. 64% patients received adjuvant chemotherapy.		
3	Understand variation in the utilisation of neo-adjuvant radiotherapy for people with rectal cancer to optimise their outcomes. Cancer alliances and health boards to develop standardised evidence-based neo-adjuvant treatment protocols based on high-quality radiological staging. An example guideline is provided as a basis for regional discussions. This will aid decision making and take into account locoregional approaches to neo-adjuvant therapy, incorporating organ preservation techniques and participation in clinical trials.		No action needed. There is good support from oncologist and Liver surgeons to support our decisions about neoadjuvant chemotherapy in rectal cancer patients with or without liver metastasis.		
4	Ensure robust sustainable pathways are in place to provide timely genomic assessment where clinically appropriate. To inform personalised treatment options and/or identify those with Lynch syndrome, optimise the proportions of people undergoing: - MMR or MSI testing in stage 1 to 4 cancer - RAS and BRAF assessment in stage 4 cancer	Both MSI and MMR testing is routinely done in all patients diagnosed with colorectal cancer. This guided our MDT outcome in planning treatment. RAS and BRAF are specifically requested for stage 4 cancers at the request of oncologist in MDT.	Lead Pathologist Lead Oncologist No action needed.		
5	Data Quality Recommendation Continue to improve data completeness of key items in the English cancer registration and Wales Cancer Network datasets to allow risk-adjustment of performance indicators. - Provision of a clinical local data lead responsible for working with relevant local teams (e.g. Clinical Effectiveness/Audit) to ensure the quality of data submissions to national datasets. - Data items of focus: tumour, node and metastases (TNM) stage, American Society of Anaesthesiologists’ (ASA) grade and performance status.	Our data set in all essential fields is 97% and above Continued support to MDT coordinator during periods of leave with alternative personnel is crucial to avoid gaps in real time data collection.	Clinical Lead – Surgeon (MDT lead) MDT coordinator No action needed.		

Data Completeness - Aneurin Bevan University Health Board		
Metric	%	Rank in Wales (6 Health Boards)
Percentage of people with data for CNS	75.6	6
Percentage of People with data for ER status or ER score	74.1	6
Percentage of people with data for PR status or PR score	25.9	6
Percentage of people with HER2 status	53.7	6
Percentage of people with data for stage	69.7	6
Percentage of people with data for T stage	76.4	6
Percentage of people of people with data for N stage	100	all HB's achieved 100%
Percentage of people with data for grade	97.8	6
Percentage of people data for WHO performance status	0.2	6
Percentage of people with data for triple diagnostic assessment (TDA)	11.1	6



Assurance and Risk Level

Assurance level	Description	Risk level	Description
Significant	The project has mostly achieved the standards or criteria being audited against	Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Has this audit been placed on a Risk Register (N/A if above risk is None)			NO

Key Success and Concerns

Report Successes:		Report Concerns:	
1	Patients now have one stop triple assessment service this data will improve once we get to 2024 data point	1	Data inputting to the audit remains an issue. It is too much work for one person and does not reflect the service
		2	Data for performance status difficult to capture
2	Excellent 3-year breast cancer specific survival	3	Low rates of immediate breast reconstruction being offered – but unlikely to be captured correctly and also likely lower due to the COVID pandemic

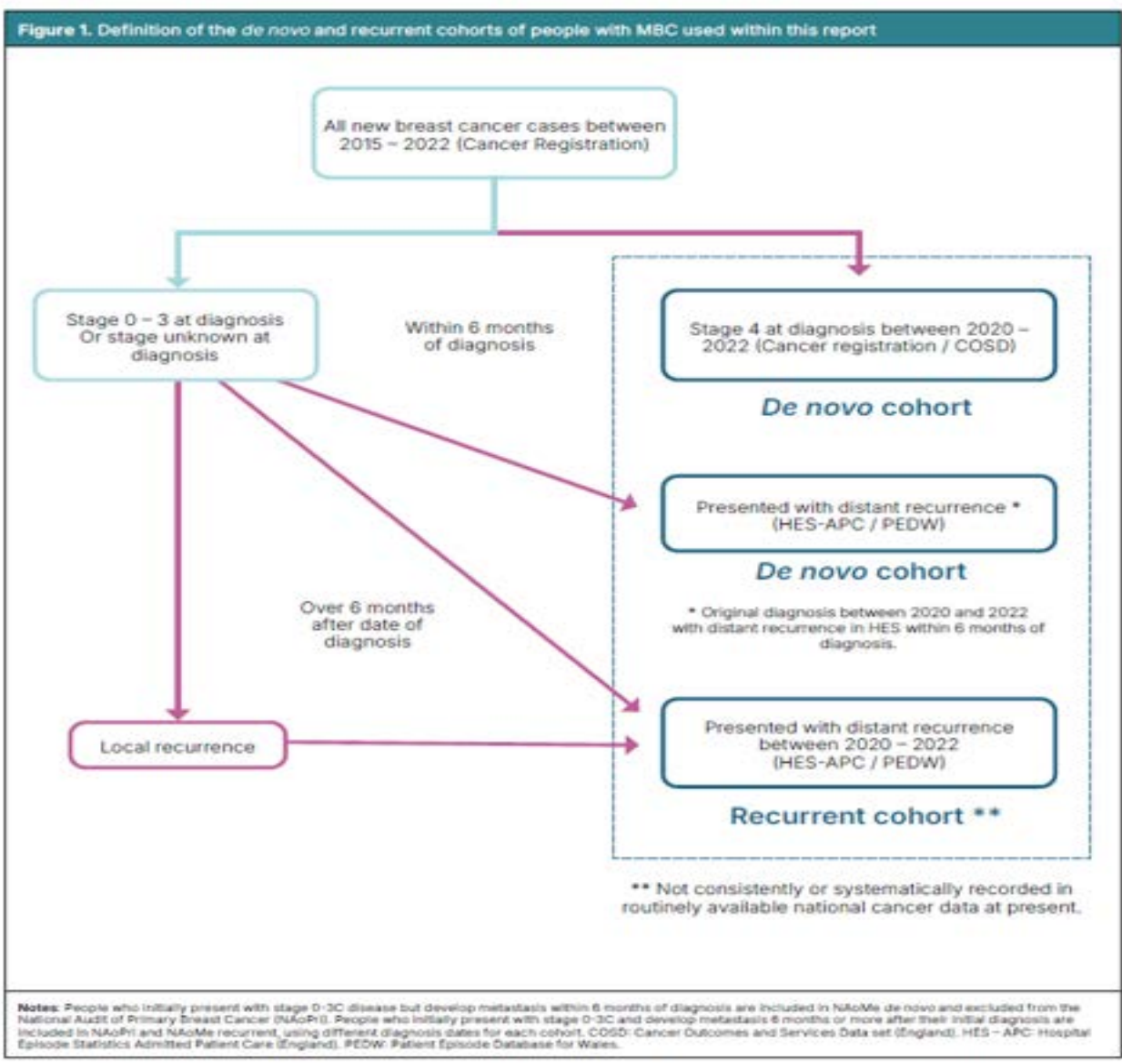
Report Recommendations: CLINICAL		S.M.A.R.T Actions:	Responsible:	Due Date: Progress:	
1	Ensure that people with breast cancer have access to Triple Diagnostic Assessment (TDA) in a single visit and, if required, identify methods to increase the provision of this service.	Aim for 95% of all patients to receive single visit TDA	Consultant breast surgeons, oncology team and wider breast care and management team	Achieved since the breast unit switched to one stop TDA in April 2024	
2	Review the use of neo-adjuvant chemotherapy for people with triple negative and HER2+ early invasive breast cancer. Reduce the levels of unexplained regional variation, with particular emphasis in increasing use among those showing low rates and ensuring neo-adjuvant chemotherapy is offered to eligible patients in line with guideline recommendations			2026	Achieved - All cases discussed at the MDT with oncology presence and all those eligible offered neoadjuvant chemotherapy
3	Review rates of immediate breast reconstruction (IBR) and, where rates are lower than expected, act to improve access by ensuring it is offered to all women as part of a balanced shared decision-making process, unless precluded by comorbidity or adjuvant therapies.	Aim for >20% rate for IBR post mastectomy. IBR to be offered to all patients who meet the criteria for immediate reconstruction			In progress All patients eligible for IBR are offered IBR. COVID happened during this time period and immediate reconstruction was not routinely offered. The next audit should show an improvement in this number. However, there are now a number of patients having local flaps as opposed to mastectomy therefore that may contribute to a decrease in mastectomy rate within the Health Board.

Report Recommendations: CLINICAL		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
4	Review rates of re-operation following breast conserving surgery (BCS) and, where rates are higher than expected, units should review local protocols with the view to complying with best practice.	Aim to reduce the reoperation rate to below 16% which is the average	Consultant breast surgeons, Wider breast care and management team	2026	In progress
5	Confirm breast MDTs have a data lead responsible for ensuring the quality of national data submissions. Reviews of data completeness should include full tumour characterisation (i.e., stage, grade, histology), ER and HER2, performance status, the NABCOP fitness assessment data items (people aged 70+ years) and contact with clinical nurse specialists (CNS)	Aim for >95% completeness of data for tumour characterisation and contact with clinical nurse specialists. New MDT proforma to help to collect difficult data such as performance status. PR testing is now done on all patients previously only when ER (-) by some pathologists Look at the way that data is collected by the health board			

Clinical Leads Local Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	More support needs to be given to the Breast MDT coordinator to help with data collection. A review needs to be undertaken as to what data is collected routinely by the health board to facilitate data entry into these audits as there is a lot of data collected that is unnecessary and takes away from the actual data that needs collecting	We will trial a proforma looking at making sure we can capture tumour characteristics, whether seen by breast care nurse, performance status etc to help facilitate data entry as these seem to be often missing	Consultant breast surgeons, and wider breast team	2026	In progress
2	In house testing for Her 2	Business case still ongoing. Essential to reduce the delay in the patient pathway	Directorate Manager	2026	In progress

Data Completeness - Aneurin Bevan University Health Board		
Metric	%	Rank in Wales (6 Health Boards)
People with data for CNS	81.3	6
People with data for ER status or ER score	73.3	6
People with data for PR status or PR score	34.7	6
People with data for HER2 status	61.3	6
People with data for stage	52	6
People with data for grade	89.3	6
People with data for WHO performance status	5.3	5

Lack of a robust mechanism to detect recurrence after a previous primary breast cancer diagnosis within national cancer datasets is the greatest challenge faced by the NAOme. Data quality is therefore a key focus for the NAOme team. We urge NHS organisations to prioritise recording new non-primary breast cancer as a new COSD episode, rather than continuation of an existing primary breast cancer record, to enable accurate analysis of this population.



The report distinguishes between people with de novo MBC and recurrent MBC (definitions opposite). The National Disease Registration Service (NDRS) is attempting to improve collection of data about recurrence in individuals with an existing primary breast cancer record. However, for the years

Assurance and Risk Level

Assurance level	Description	Risk level	Description
Limited	The project did not achieve the standards or criteria being audited against	Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Has this audit been placed on a Risk Register (N/A if above risk is None)			NO

Key Success and Concerns

Report Successes:		Report Concerns:	
1	There is now a metastatic breast cancer clinical nurse specialist in post this has made a significant difference to patients and indeed the identification of patients who present acutely to other specialities	1	Good access for patients receiving chemotherapy de novo
2	Good documentation of contact with a clinical nurse specialist, this will only improve with our new metastatic breast cancer nurse in post	2	Still awaiting in house testing of Her 2
3	Good access for patients receiving chemotherapy de novo	3	Need to improve documentation of WHO performance criteria

Report Recommendations: CLINICAL		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Ensure the care for all people newly diagnosed with Metastatic Breast Cancer (MBC) (either de novo or recurrent) is discussed within a breast MDT meeting	Aim for >90% of patients to be discussed at MDT	Clinical lead, breast team/oncology team/wider medical teams including general practice	2026	In progress
2	Examine rates of treatment with CDK4/6 inhibitors within 12 months of diagnosis in people with ER+ HER2- MBC. Consider variation in care, especially in low use centres, to try to identify underlying causes and opportunities for improved quality of care	All patients who are eligible for CDK4/6 inhibitors are offered them by oncology	Oncology team		
3	Assess 30-day mortality rates following chemotherapy and, in trusts with rate outside the 95% control limits of the national average, conduct outcome reviews and evaluations of local prescribing practices to ensure appropriate consideration of chemotherapy risks and benefits	This is done locally by the oncology team	Oncology team		

Report Recommendations: DATA QUALITY		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
4	Ensure accurate recording of date and type of breast cancer recurrence by reviewing and optimising the process of capturing and uploading to the Cancer Data Form (CDF)	Accurate data entry to reflect recurrence, this could also be looked at on our data collection proforma to facilitate recording of recurrence.	Clinical management team, cancer services team and breast team	2026	In progress
5	Confirm breast MDTs have a data lead responsible for ensuring the quality of national data submissions. Reviews of data completeness should include full tumour characterisation (i.e., stage, grade, histology), ER and HER2, performance status, the <u>NABCOP fitness assessment data items</u> (people aged 70+ years) and contact with clinical nurse specialists (CNS)	• Aim for >95% documentation rate for ER, PR and HER2 status • Change to MDT proforma to collect performance status routinely • In house testing of HER2 • Path testing PR on all tumours	Clinical Lead/ Consultant Breast Surgeons, Breast care teams and clinical management in Welsh NHS Health Boards.	2026	In progress

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	More support needs to be given to the Breast MDT coordinator to help with data collection. A review needs to be undertaken as to what data is collected routinely by the health board to facilitate data entry into these audits as there is a lot of data collected that is unnecessary and takes away from the actual data that needs collecting	We will trial a proforma looking at making sure we can capture tumour characteristics, whether seen by breast care nurse, performance status etc to help facilitate data entry	Clinical Lead/ Consultant Breast Surgeons, and wider breast team	2026	In progress
2	In house testing for Her 2	Business case still ongoing	Directorate Manager	2026	In progress

NICE Clinical Guideline (CG) & Quality Statement (QS), British National Formulary (BNF) & Technology Appraisal (TA):
CG146, NG249, QS86, QS149, TA161, TA204, TA464, TA791, TA991,

Rationale:	In England and Wales there are around 180,000 fractures each year as a result of osteoporosis. One in three women and one in five men will sustain a fracture in their lifetime. The rationale of the FLS-DB 2026 Annual Report is to evaluate and improve the quality of secondary fracture prevention for adults aged 50+ by measuring how effectively Fracture Liaison Services identify, assess, and treat patients with fragility fractures. The report aims to highlight national performance against evidence-based standards, reduce unwarranted variation between services, identify inequalities in access and outcomes, and support improvements in patient care by providing actionable data for clinicians, commissioners, and health boards. Ultimately, its purpose is to ensure timely assessment and appropriate osteoporosis treatment to reduce future fractures and improve outcomes across England and Wales.
Objectives:	Using 11 national KPIs, the audit evaluates how well services identify patients, provide timely bone health and falls assessments, recommend and initiate appropriate osteoporosis treatment, and monitor adherence over time. By benchmarking services against NICE, NOGG and ROS standards, the audit aims to highlight variation, identify gaps in care, expose inequalities, and provide actionable data to support service improvement, commissioning decisions, and national policy. This annual report focusses on whether fracture patients at highest risk of osteoporotic fractures are prioritised and provided with appropriate treatment or prevent future fractures.

Presented at Clinical Standards and Effectiveness Group – 26 February 2026

Winners of the MediWales Innovation Awards 2024 for their overall contribution to healthcare delivery in Wales

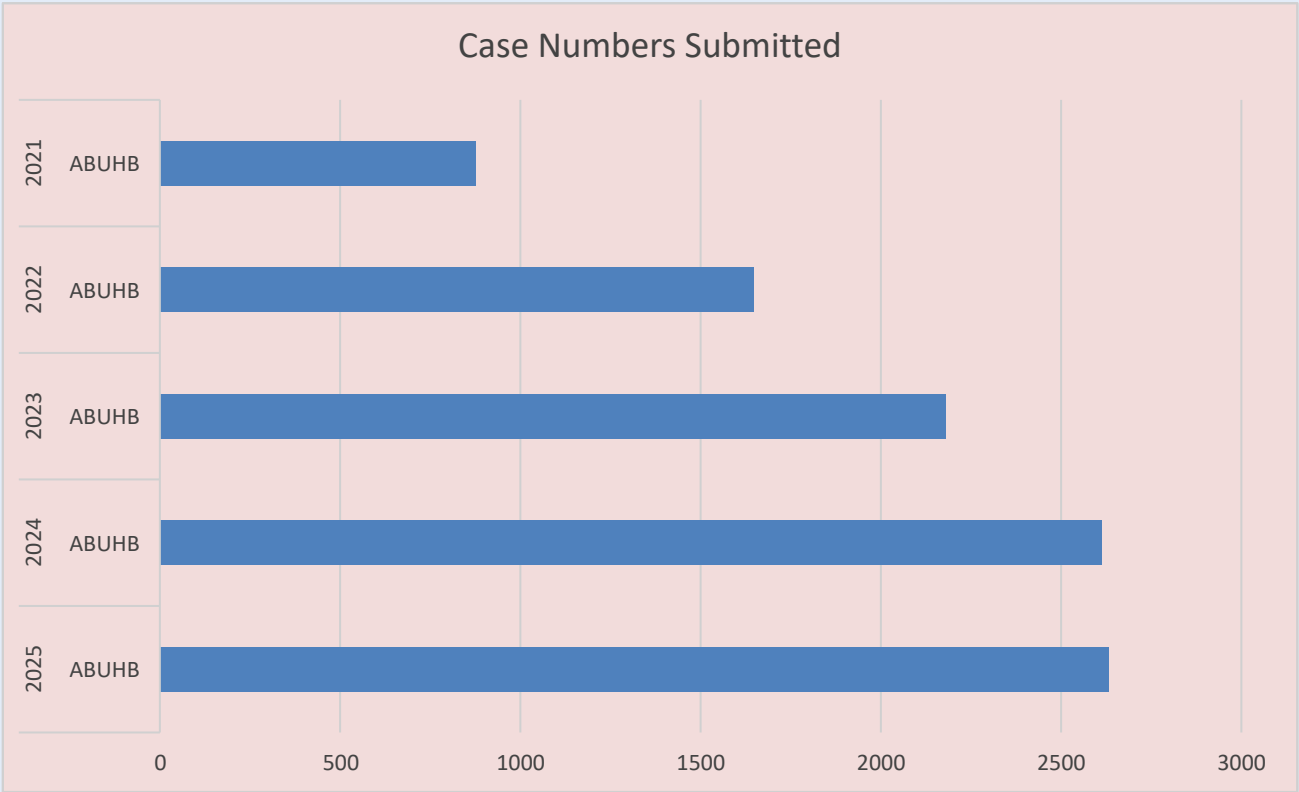
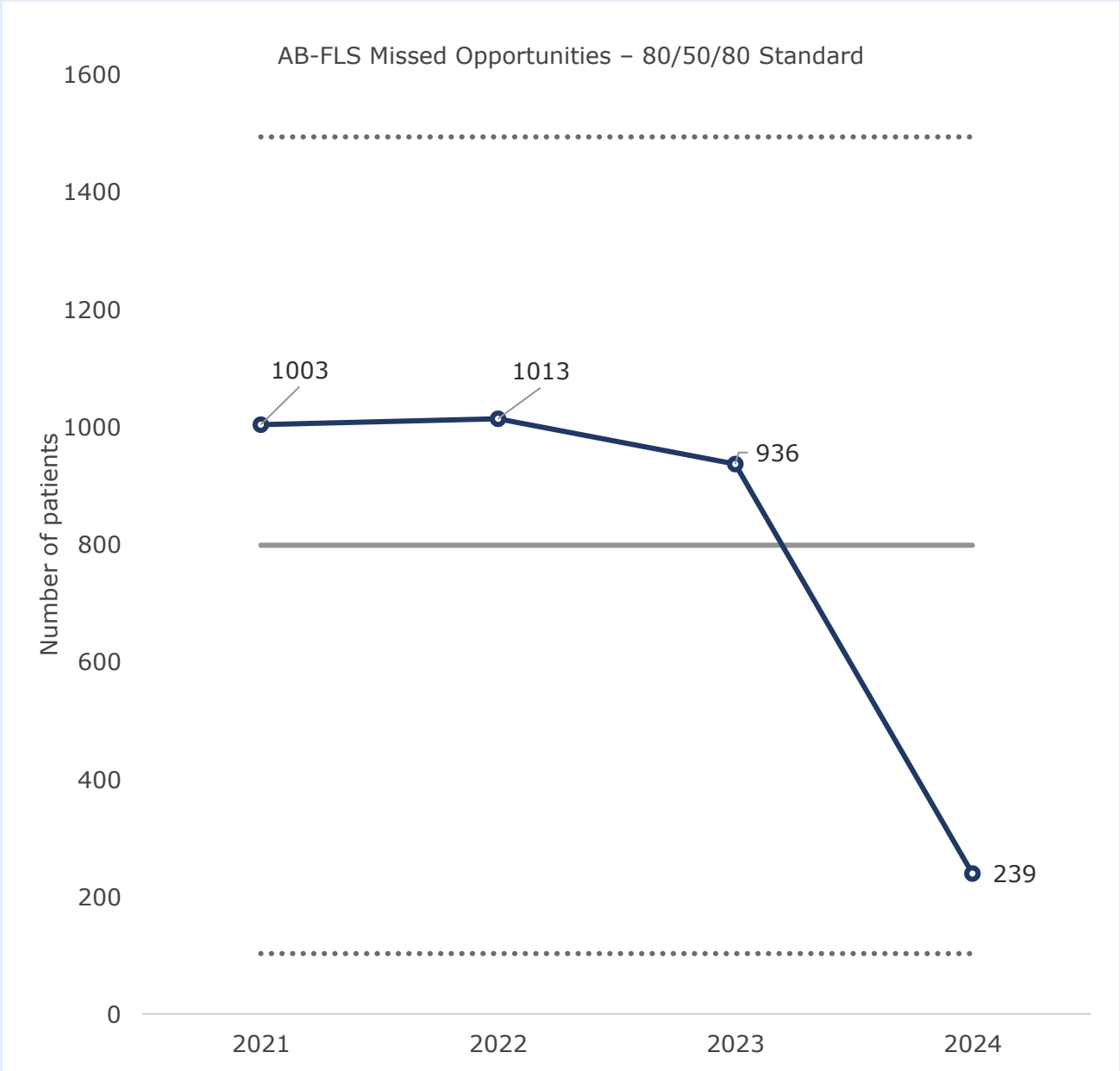


WINNER ☆ Let The First Fragility Fracture be the Last!



Aneurin Bevan University Health Board

AB - FLS	2020	2021	2022	2023	2024	2025
Estimated fracture patients	3730	3425	3730	4055	3755	3755
Total No of patients Identified – (80%)	725 (24.8%)	875 (25.5%)	1649 (44.2%)	2181 (50.4%)	2639 (70.7%)	2890 (77%)
KPI4 – Assessed with 90 days AB-FLS Wales National	3.3% 64% 64.2%	21.3% 65.1% 66.5%	60.3% 77.8% 62.8%	75% 79.6% 63.8%	73.8% 77.2% 69.8%	64.3% 67.7% 67.2%
% Recommended Treatment - 50% (cases)	57.3% (415 cases)	57.7% (505 cases)	65.7% (1083 cases)	63.8% (1391 cases)	59.7% (1559 cases)	70.9% (2049 cases)
% Monitored (52 weeks) – 80% (cases)	19.8% (82 cases)	18.4% (92 cases)	16.4% (292 cases)	25.9% (360 cases)	61.3% (956 cases)	? 70%
Patients treated to guidance (80/50/80 ROS standard)	82 (6.9%)	93 (7.8%)	178 (14.8%)	360 (30.2%)	962 (80.1%)	1434
Minimum Expectation	1193	1096	1193	1312	1201	1202
Missed opportunity	1113 (93.1%)	1003 (92.2%)	1015 (85.1%)	832 (69.8%)	239	Zero



Benchmarking

Year	FLS Service/Unit	Total FLS submitted records	KPI 2 Non-Spine Case identification	KPI 3 Spine fractures	KPI 4 Assessment within 90 days	KPI 5 DXA within 12 Weeks	KPI 6 Falls risk assessment	KPI 7 Bone treatment	KPI 8 Strength & Balance by 16 weeks	KPI 9 16 week follow up	KPI 10 Treatment by 1st followup	KPI 11 1 year drug adherence*
2021	Wales 2021	2031	23.2	11.3	65.1	23.3	61.5	56.8	3.9	13.7	10.2	30.2
2022	Wales 2022	3151	31.9	15.2	77.8	33.7	86.1	62.5	6.1	21.4	16.1	27.4
2023	Wales 2023	3535	17.8	9.3	79.6	23	90.6	63.3	13.3	43.2	36.5	23.4
2024	Wales 2024	5256	20.7	36.5	80.1	14.5	75.9	63.8	19.3	33.2	32.1	33
2025	Wales 2025	8273	35.1	64.8	68.5	16.2	54.8	60.3	9.1	29.6	20	Not available yet
2021	ABUHB 2021	875	24.6	29.5	21.3	24.1	34.5	57.7	4.8	1.4	8.3	18.4
2022	ABUHB 2022	1647	46	36.7	60.3	12.8	79.7	65.6	9.2	19	18.3	16.7
2023	ABUHB 2023	2179	56.4	43	74.9	14.5	94.6	63.8	17.6	58.7	46.1	26
2024	ABUHB 2024	2613	50.5	146.1	78.5	21.9	85	60.1	33.8	48.7	48.3	61.3
2025	ABUHB 2025	2632	56.1	157.9	65.3	41.5	86.1	70.3	29.6	58.1	44	Not available yet

2025 data is incomplete, therefore, is subject to change. However, the currently available data shows an improving picture for 7 KPIs against 2024 data.

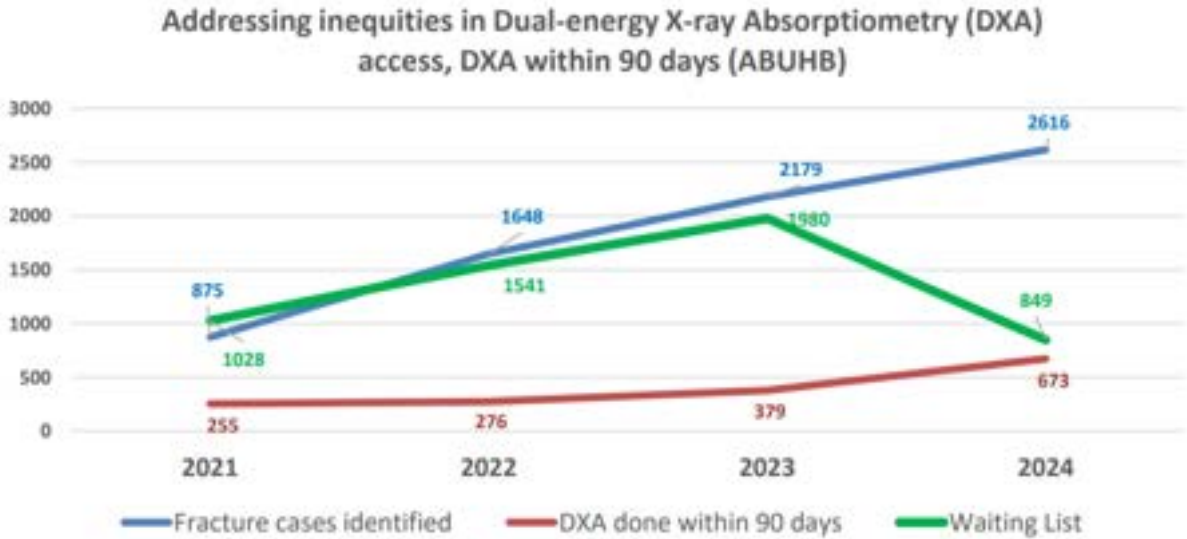
Projected – cost avoidance

Total FLS investment

Staffing cost – Full business case (2025-26) £387,520 plus drugs
Hip fracture reduction = 2022 = 746; 2023 = 811 (average = 778)
Hip Fracture 2024 = 751; 2025 – 780 (average = 765)

Average Hip fracture avoided = 13/year (post FLS two years)
Cost avoided = 13 x £27000 = £351,000
More reduction of overall fractures – Femurs (1528 average to 1269)

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	DXA scanning	Working with Radiology	I Singh / Non Pugh/ Terissa Williams	December 2026	Amber



Addressing inequities in dual-energy x-ray absorptiometry (DXA) access: a multi-dimensional quality improvement approach | Age and Ageing | Oxford Academic

Assurance and Risk Level

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

Key Success and Concerns

Let The First Fragility Fracture be the Last! - NHS Wales Performance and Improvement

Report Concerns:	
1	DXA within 90 days – needs attention
2	demand will rise- other speciality – Breast, Coeliac
3	Primary Care engagement and FU

National Non-Hodgkin Lymphoma Audit 2025 (NNHLA) An audit of care received by people diagnosed with non-Hodgkin lymphoma between 1 Jan 2022 & 31 Dec 2022 in England and 1 Jan 2023 & Dec 2023 in Wales (version 2 – Sep 2025)	Clinical Lead:	Dr Victoria Williams Consultant Haematologist
	NICE:	NG52 , QS150

Rationale:	The National Non-Hodgkin Lymphoma Audit (NNHLA) evaluates patterns of care and outcomes for people diagnosed with non-Hodgkin lymphoma (NHL) in England and Wales in line with its Quality Improvement Plan. This sets out the scope, care pathway, 5 quality improvement goals and 11 performance indicators that are utilised to measure progress against these goals.
Objectives:	This year’s report includes people diagnosed with NHL from 1 January 2023 to 31 December 2023 in Wales. It reports on 5 out of the 11 performance indicators for Wales outlined in the NNHLA Quality Improvement Plan (see on slide 3). Although the data presented in this report relates to treatment up to the end of 2023 in Wales, it is being published in September 2025 to allow sufficient follow-up time for the full care pathway to be captured, including definitive treatment and short-term outcomes. This is particularly important in NHL, where treatment pathways can span many months, and sufficient time is needed to ensure that key quality indicators, such as completion of multi-modality treatment and survival outcomes, are accurately recorded and reported.
Presented at Clinical Standards & Effectiveness Group – 19 March 2026	

Quality Statements – QS150

This quality standard covers diagnostic reporting and the organisation of haematological cancer services for people of all ages (children, adults and young people) and managing haematological cancers in adults and young people (aged 16 and over). It describes high-quality care in priority areas for improvement.

[Statement 1](#) People with haematological cancer have an integrated report produced by a specialist integrated haematological malignancy diagnostic service (SIHMDS) that is shared with the haemato-oncology multidisciplinary team (MDT).

[Statement 2](#) Young people and adults with specific subtypes of non-Hodgkin's lymphoma have staging using fluorodeoxyglucose-positron emission tomography-CT (FDG-PET-CT).

[Statement 3](#) Young people and adults with localised stage IIA follicular lymphoma have local radiotherapy as first-line treatment.

[Statement 4](#) Young people and adults who have completed their treatment for non-Hodgkin's lymphoma or myeloma have a discussion about their end-of-treatment summary plan.

NNHLA Quality Improvement Plan 2024

The Quality Improvement Plan describes the approach taken across the NATCAN cancer audits to develop improvement goals and performance indicators, ensuring these are measurable, actionable and improvable.

The NNHLA Quality Improvement goals, developed following a thorough [scoping exercise](#) in 2023 and in consultation with stakeholders in the [Clinical Reference Group \(CRG\)](#) are as follows:

- Improving timely diagnosis and treatment
- Treatment appropriate to the subtype of NHL
- Improving safety and reducing toxicity of NHL therapy
- Improving overall survival
- Reducing variation in NHL management among NHS providers.

The NNHLA has identified eleven performance indicators, which are mapped to these five quality improvement goals and clinical guidelines. It sets out improvement methods, improvement activities and approaches to evaluation of the Quality Improvement Plan.

Assurance and Risk Levels

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
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: The outcomes from the audit tell us our patients have similar 1-year overall survival compared to the rest of England and Wales, these outcomes are also comparable with what studies would suggest overall survival should be. The improvements needed are focussing on improving data collection as opposed to anything that affects patient safety.	

Key Success and Concerns

Report Successes:	
1	Performing above average in terms of CNS review for patients being diagnosed with both low grade and high-grade lymphoma
2	Outcomes at 1 year comparable/in keeping with national average for low grade and high-grade lymphoma
Report Concerns:	
1	Data completeness for performance status and staging
2	Improving data for timely SACT to ensure more people getting chemotherapy within 62 days (it should be noted that there is no single pathway for investigation of possible lymphoma due to the nature of the disease)

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Local review at NHS trust/health board level is needed to identify diagnostic and treatment pathway delays and reduce inter-provider variation in people with high-grade NHL starting SACT within 62 days of referral. This may include examination of delays along the pathway, chemotherapy unit capacity and staffing, and mode of delivery of SACT, in order to understand system-level delays.	1. At a Welsh level, there is a NOP which is out for consultation to describe optimal pathway for diagnosis and treatment of lymphoma. 2. Local project to be done looking at timeliness of biopsies being sent from ABUHB to AWLP to see if that part of diagnostic process can be improved	1. WCN 2. Dr Williams and haematology team	1. Out for consultation hopefully will be live by next audit cycle 2. June 2026	
2	Ensure there is a designated coordinator or clinician to improve the completeness and quality of data items recorded in the national cancer datasets at each NHS trust/health board (with particular focus on staging in England and Wales and treatment delivery in Wales). This will allow better risk adjustment of outcome variables including survival outcomes for people with non-Hodgkin lymphoma and effectively inform outlier identification. The launch of the Audit’s national quality improvement initiative in October 2025 will further support this effort. NHS trusts/health boards are encouraged to participate in the initiative to enhance data quality.	In place, Dr Trickey has worked with cancer services co-ordinator for 2024 to ensure data completeness. New MDT proformas also in place since 2024 to improve documentation PS and staging	Lymphoma team consultants and cancer co-ordinator	On-going	Has been done for next audit cycle, will be on-going piece of work New MDT proformas fully embedded into practice

National Audit of Cardiac Rhythm Management (NACRM)		Clinical Lead:	Jessica Hamer
2 nd edition 1 April 2024 to 31 March 2025		NICE:	TA324 , TA314 , TA88
Rationale:	The audit aims to improve the care of patients who undergo pacemaker, implantable cardioverter-defibrillator (ICD), cardiac resynchronization therapy (CRT) and cardiac ablation procedures in the UK through the collection, analysis and dissemination of data relating to centres across the UK. Clinical leadership is provided by the British Heart Rhythm Society (BHRS) .		
Objectives:	The objectives of the report are to highlight trends in procedure volumes, assess variation in clinical practice and access to care, introduce new quality indicators, and support service improvement by enabling hospitals and regions to benchmark performance. The report also seeks to inform future planning by identifying areas of emerging technology uptake, monitoring compliance with national guidelines, and promoting timely and accurate data submission to enhance the quality and impact of cardiac rhythm management services.		
Presented at Clinical Standards and Effectiveness Group – 19 March 2026			
Devices		Ablation	
80,818 cardiac implantable electronic device (CIED) procedures performed. 17,856 CIED procedures were for complex implants (ICDs, CRT). 51% hospitals performed more than 80 new pacemaker or 60 complex implants, meeting BHRS minimum recommended volumes. <i>(see slide 3)</i> - There is an increasing proportion of CRT-P to CRT-D prescription (currently 1.1:1). <i>(see slide 4)</i> 3.5% one year mortality after ICD implant <i>(see slide 5)</i> 4.4% 1 year re-intervention rates for simple CIED implants, but variable between hospitals. <i>(see slide 6)</i> - There was a 4-fold increase in conduction system pacing. <i>(No data relating to ABUHB)</i> - There was a 37% fall in leadless pacemaker procedures <i>(No data relating to ABUHB)</i>		24,323 total ablation procedures performed. 10,372 AF ablation procedures, increasing 53% since 2015. 77% hospitals performed more than 100 ablations, meeting the BHRS minimum recommended volume. <i>(see slide 7)</i> 38% rate of general anaesthetic provision for ablation procedures, varying from 5 to 100% between hospitals. <i>(No data relating to ABUHB)</i> - Re-intervention rate for accessory pathway ablation is 5.9%, 3 x the rate for other standard ablation procedures <i>(No data relating to ABUHB)</i>	
Abbreviations: AF= Atrial Fibrillation; BHRS= British Heart Rhythm Society; CIED= Cardiac Implantable Electronic Devices; CRT= Cardiac Resynchronisation Therapy; ICD= Implantable Cardioverter Defibrillator			

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Report at a glance: 51% hospitals performed more than 80 new pacemaker or 60 complex implants, meeting BHRS minimum

Most hospitals delivered more than the minimum recommended number of CIED procedures

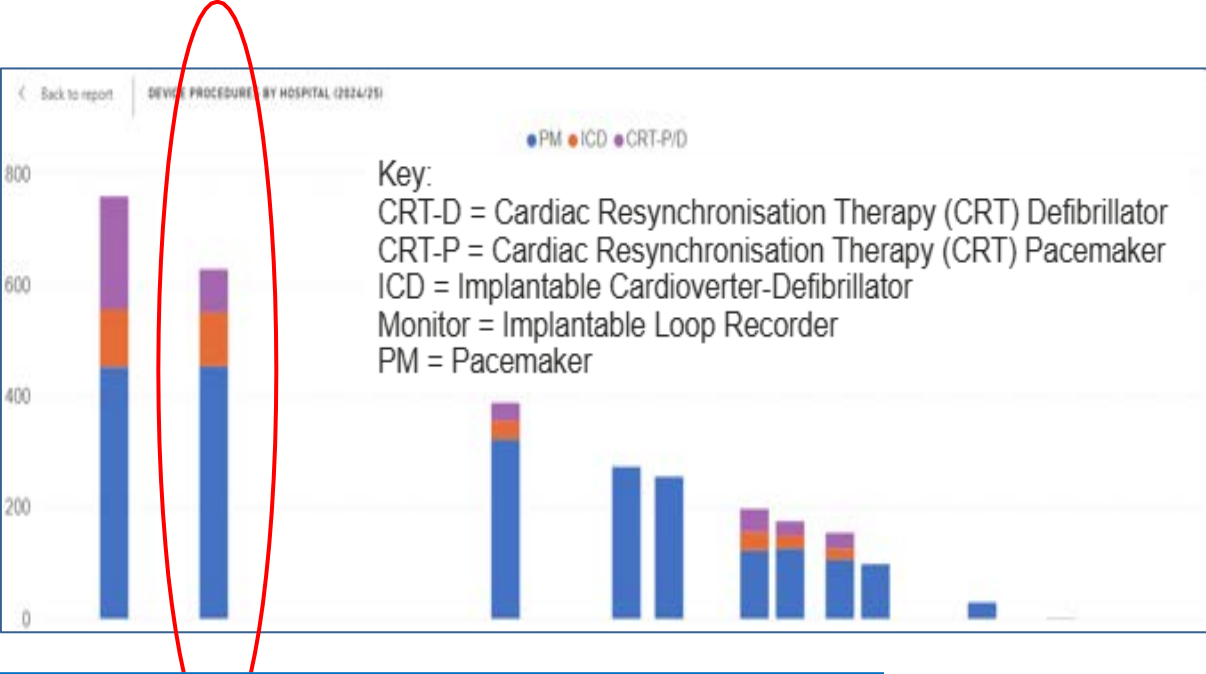


The British Heart Rhythm Society (BHRS) Standards (2024 January revision) recommend that device centres undertake a minimum procedure volume per year:

A minimum of 80 new pacemaker implants per year.

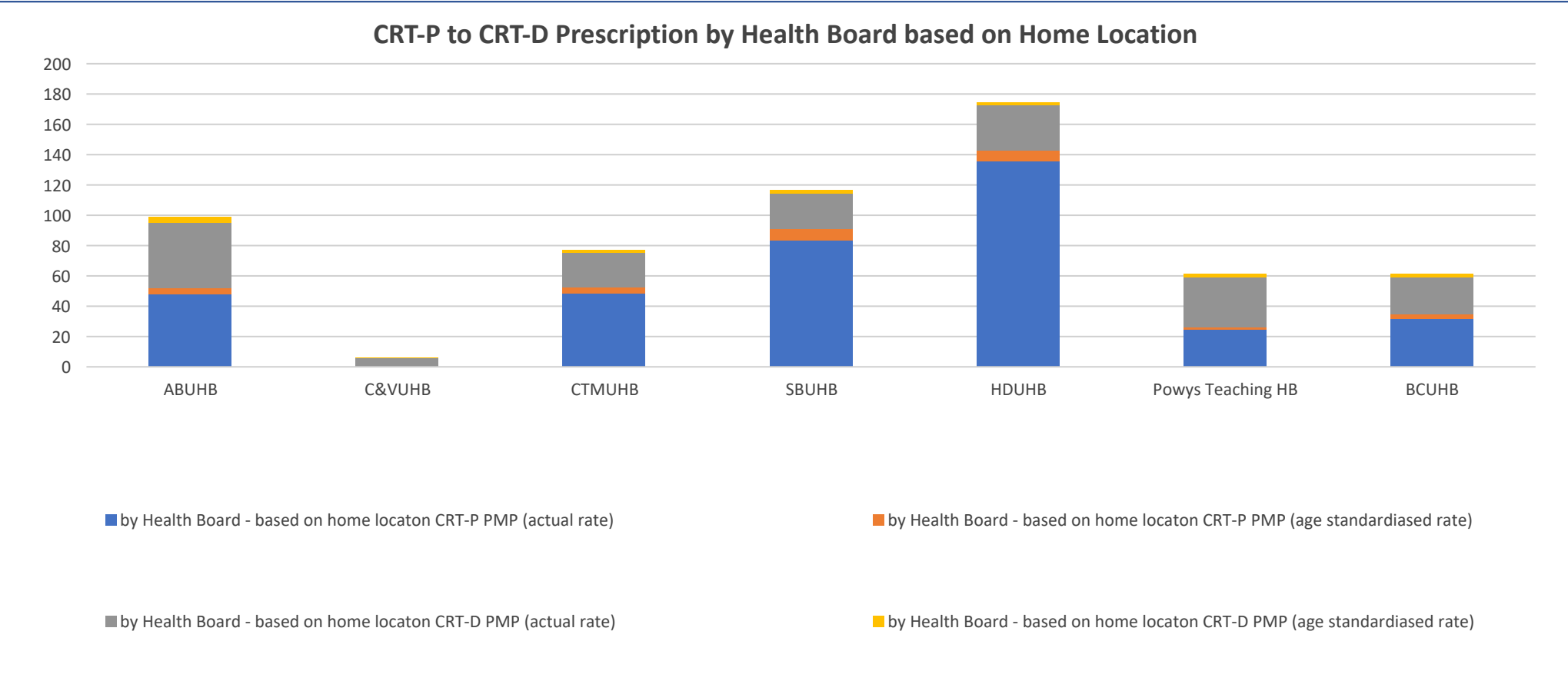
A minimum of 60 new ICD or CRT implants per year

Rank	PM	ICD	CRT-P/D	Total procedures	Hospital
28	452	104	203	759	Morriston Hospital
42	454	97	77	628	Grange University Hospital
83	323	33	32	388	Royal Glamorgan Hospital
100	273	0	0	273	Glan Clwyd Hospital
106	255	0	0	255	Glangwili General Hospital
118	123	33	41	197	Ysbyty Gwynedd
123	126	24	25	175	Princess of Wales Hospital
130	106	20	28	154	Wrexham Maelor Hospital
135	98	0	0	98	Bronglais General Hospital
150	29	0	0	29	Prince Charles Hospital
161	1	0	0	1	University Hospital of Wales



Report at a glance: There is an increasing proportion of CRT-P to CRT-D prescription (currently 1.1: 1)

by Health Board - based on home location				
Health Board	CRT-P PMP (actual rate)	CRT-P PMP (age standardised rate)	CRT-D PMP (actual rate)	CRT-D PMP (age standardised rate)
ABUHB	47.8	4	43.6	3.6
C&VUHB	0	0	5.6	0.5
CTMUHB	48.4	4	22.9	1.9
SBUHB	83.5	7.6	23.5	2.2
HDUHB	135.7	7.1	30.2	1.6
Powys Teaching HB	24.7	1.5	32.9	2.1
BCUHB	32	2.6	24.7	2.1

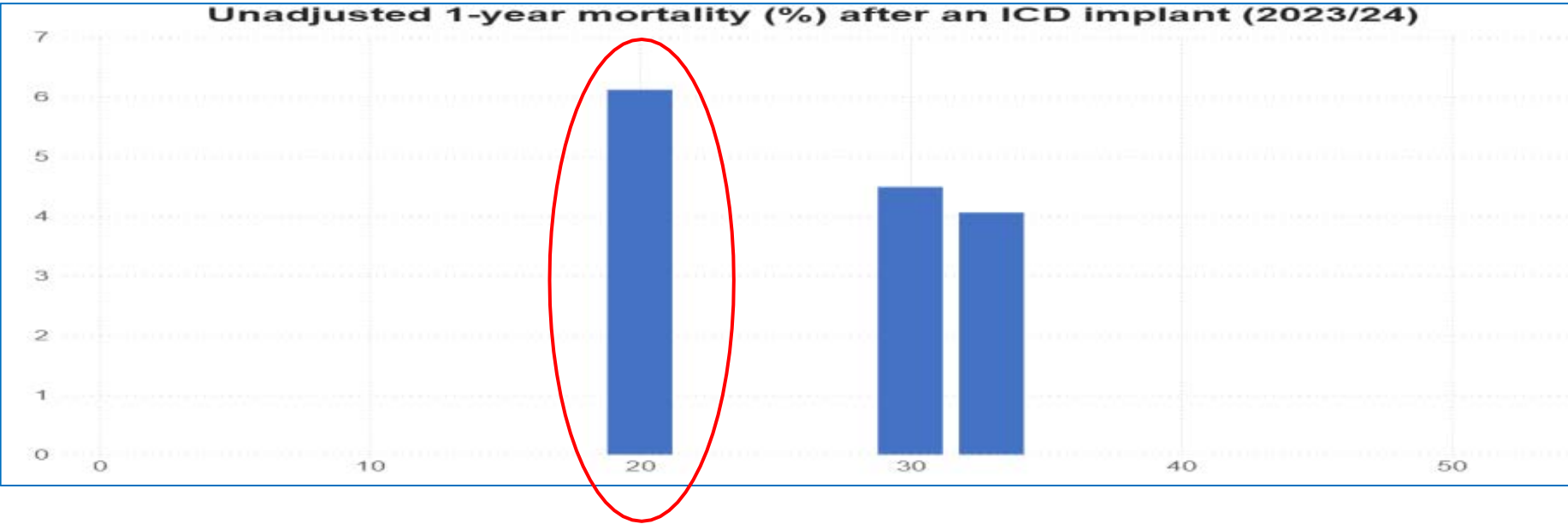


Report at a glance: 3.5% one-year mortality after ICD implant (national average)

One year mortality after defibrillator implantation was 3.5% but varied from 2 to 24% between hospitals

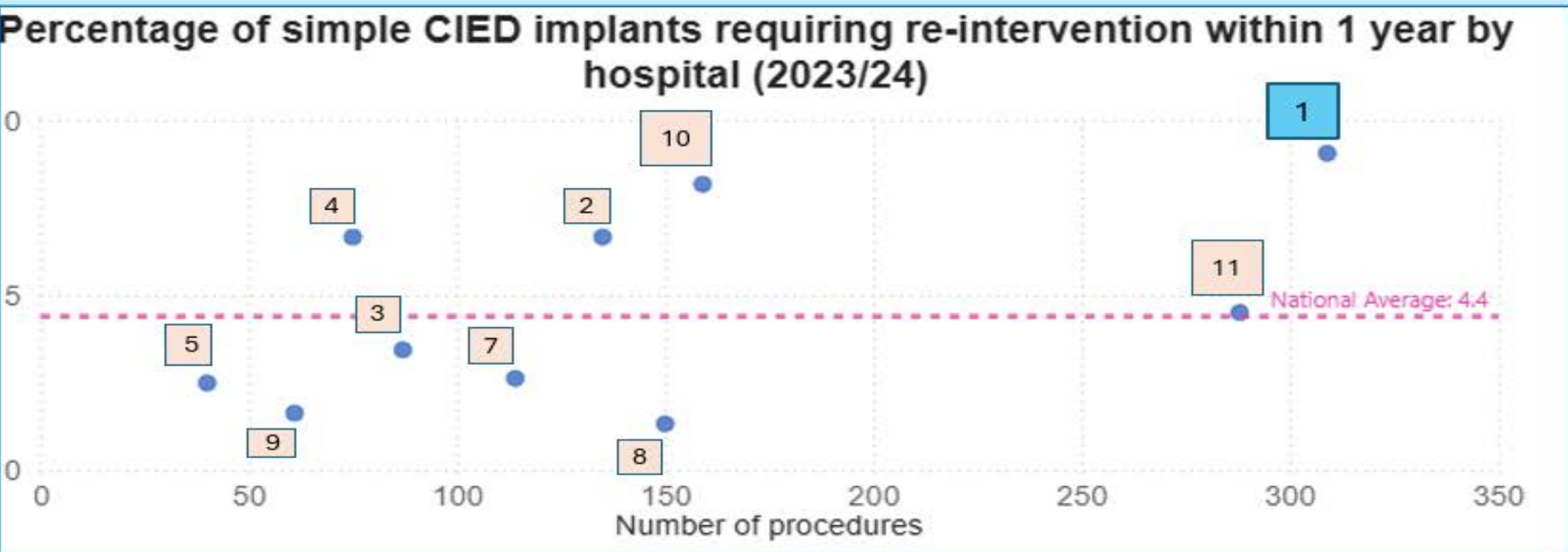


Unadjusted one year mortality after ICD implant 2023/24				
Site	Rank (national)	Mortality (%)	Total Cases	Deaths
GUH	20	6.1	49	3
Ysbyty Gwynedd (YG)	30	4.5	4,988	224
Wrexham Maelor (WMH)	33	4.1	22,284	905



Report at a glance: 4.4% 1 year re-intervention rates for simple CIED implants but variable between hospitals (national average)

The 1-year re-intervention rate after simple CIED implants ranged from near zero to 12% across different hospitals



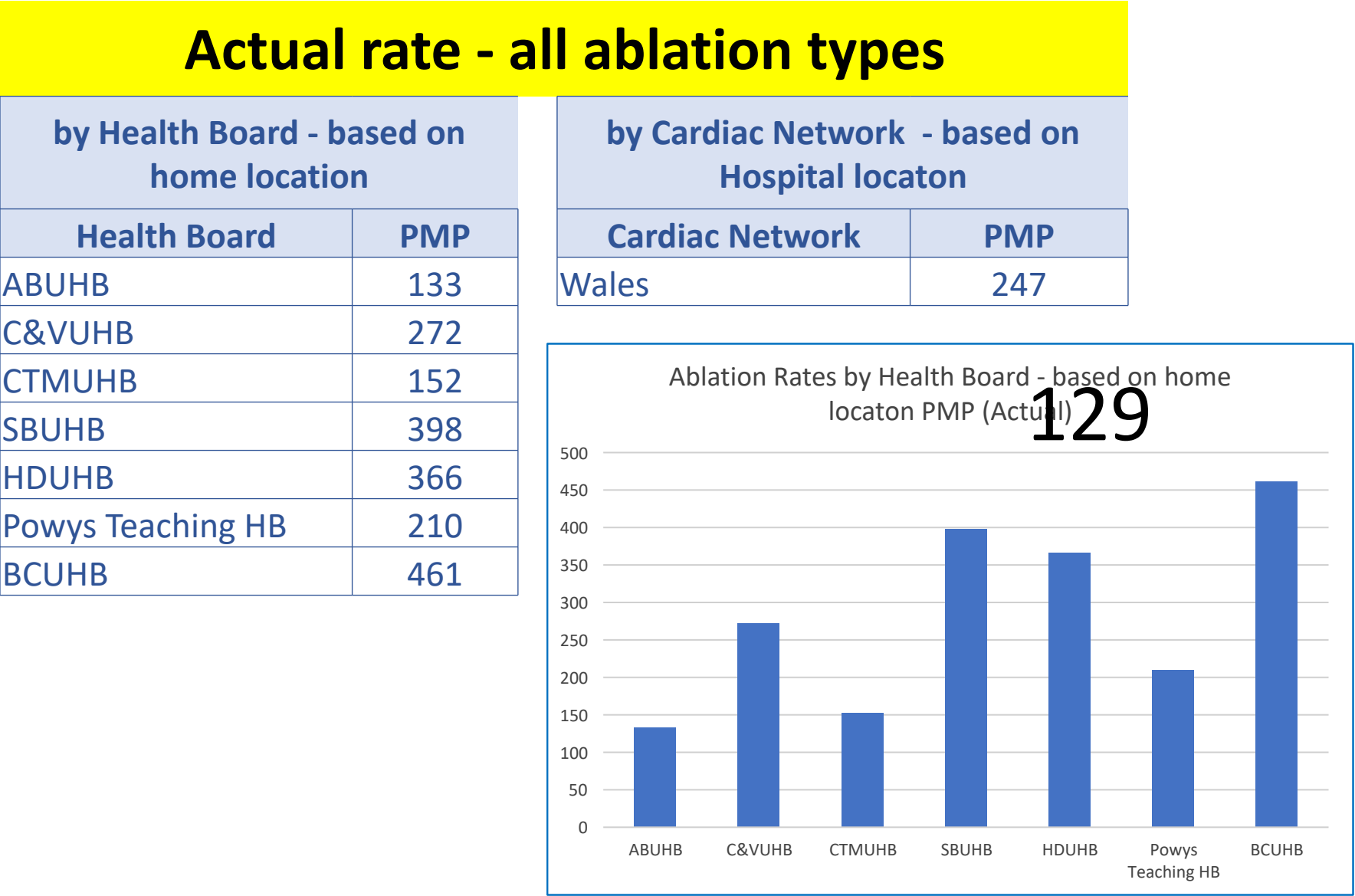
Key			
Hospital ID No.	Site	PM new implant count	1 year re-intervention (%)
1	GUH	309	9.1
2	Glan Clwyd	135	6.7
3	Wrexham Maelor	87	3.4
4	Ysbyty Gwynedd	75	6.7
5	UHW	40	2.5
6	Prince Charles		
7	Princess of Wales	114	2.6
8	Royal Glamorgan	150	1.3
9	Bronglais	61	1.6
10	Glangwili	159	8.2
11	Morriston	288	4.5

Report at a glance: 77% hospitals performed more than 100 ablations, meeting the BHRS minimum recommended volume

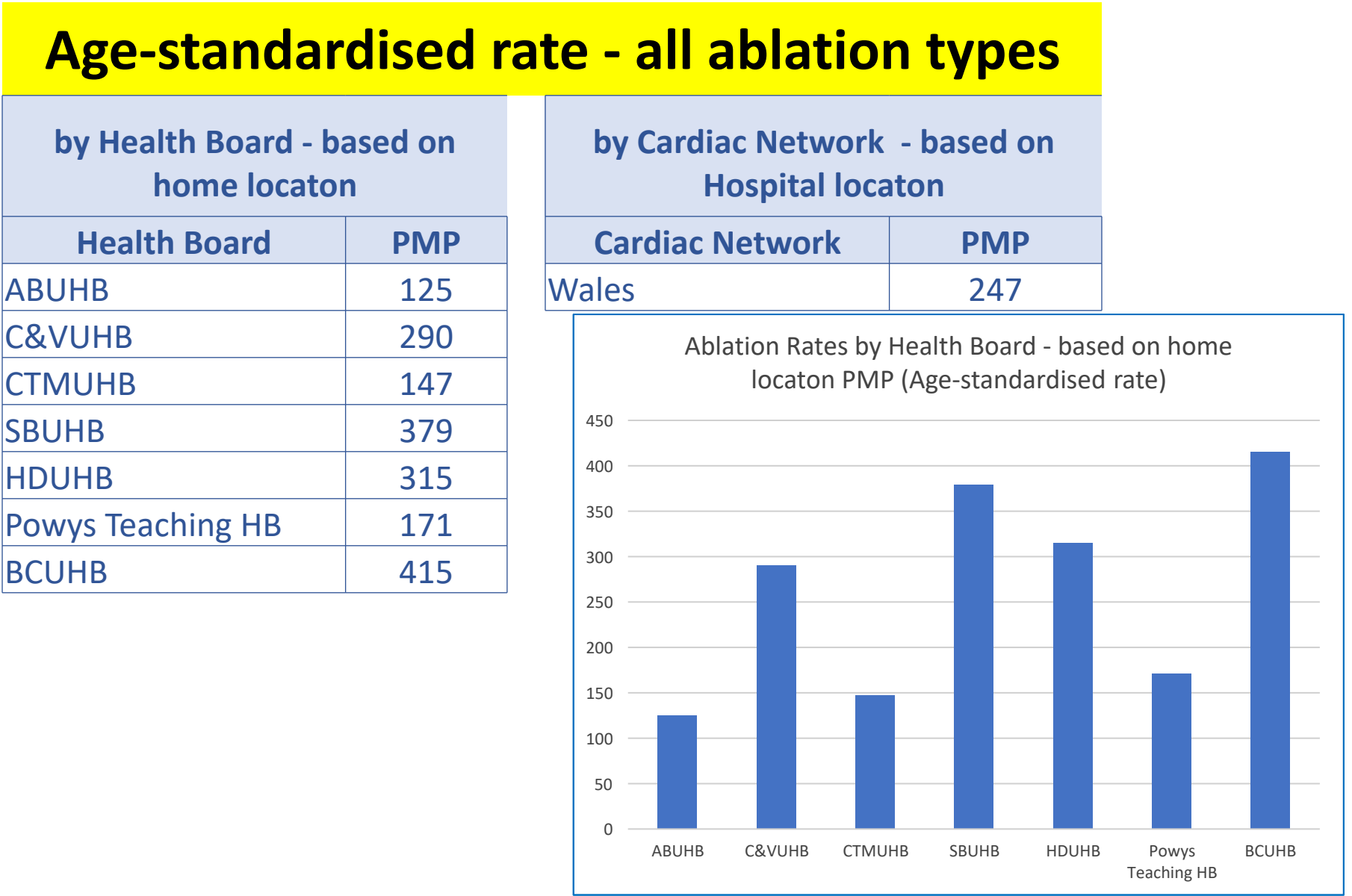
Ablation rates varied 12-fold across ICBs and Health Boards in England and Wales



Ablation Rates per million population (PMP)



Ablation Rates per million population (PMP)



Assurance and Risk

Assurance level	Description	Select
Significant	The project has mostly achieved the standards or criteria being audited against	X
Risk level	Description	Select
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved	Devices
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon	EP
Has this audit been placed on a Risk Register (N/A if above risk is None)		YES ☐
If not on a risk register, why not: Device waiting list has been added to risk register.		

Key Success and Concerns

Report Successes:		Report Concerns:	
1	Complete data entry	1	Discrepancies in numbers
2	Meeting minimum numbers	2	Poor access to EP for ABUHB patients
3	Increase in implant numbers since the opening of Grange University Hospital	3	Poor data entry from tertiary centre making it difficult to benchmark

Clinical Leads Local Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Commence CSP programme	CP and operator training. Engage with companies regarding support and proctor.	Cardiology CD	Next financial year	Ongoing
2	Look to complete business case for local EP services	Business case to be completed.	Cardiology CD	Next financial year	Ongoing

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
Clinical Practice:					
1	Device therapy: As pacemaker and ICD implantation rates remain lower than comparable countries, regional services should review waiting lists and local practice against guidelines.	Business case being worked up for third cath lab and additional implanter	Cardiology CD	Next financial year	ongoing
2	AF Ablation: Given variation across regions, local services should review patient selection and re-intervention rates for AF ablation				n/a
3	Re-intervention rates: Hospitals should review accessory pathway ablation practice given relatively high re-intervention rates.				n/a
4	Emerging technologies: Regional services should review appropriate clinical use and access to emerging technologies (suchas leadless pacing, conduction system pacing or pulsed field ablation).	Current implanters have had CSP training – initiation of service delayed due to sickness	Cardiology CD	Next financial year	Ongoing
Data Completion:					
1	Implant Records: There is an increasing obligation to monitor medical implants and all operators should ensure implant identifiers and relevant clinical fields are completed and submitted to the NACRM within agreed timelines (see background for more details on captured fields).	All data entered via electronic pacing system (Solus) – data is pulled and sent to NICOR monthly	IT manager	Ongoing	ongoing
2	Emerging technologies: There is a growth of emerging heart rhythm technologies and all operators should ensure correct submissions are made to facilitate monitoring of procedures and outcomes of changing practice.	Specialist services commissioned by JCC and often that is a barrier to our adoption of them (eg leadless pacing)			

National Vascular Registry – State of the Nation Report 2025 An audit of care received by people who had vascular procedures during 2024 in NHS hospitals in England, Wales, Scotland and Northern Ireland	Clinical Lead:	David McLain - Consultant Vascular Surgeon
	NICE:	NG19 , NG156 , QS208 , QS209

Rationale:	The report was developed to evaluate the quality and outcomes of care for adults undergoing major vascular procedures in NHS hospitals. Its primary rationale is to support vascular services in delivering safe, high-quality care by benchmarking performance against national standards, identifying delays and variations, and highlighting areas for improvement. By aligning with NICE guidelines, VSGBI frameworks, and other national standards, the report aims to drive quality improvement initiatives, share best practices, and ensure compliance with evidence-based care pathways.
Objectives:	Its objectives are to benchmark care against national standards, identify delays and variations in treatment, and highlight areas for improvement. The report focuses on key indicators such as short-term postoperative mortality and timeliness of interventions for procedures including lower limb revascularisation, major amputation, abdominal and thoracic aortic repairs, and carotid endarterectomy.

Context

The National Vascular Registry (NVR) audits major vascular procedures across the UK. The 2025 report reviews care delivered in 2024 for lower limb revascularisation, major amputation, aortic repairs (AAA and thoracic), and carotid endarterectomy (CEA). Key indicators include timeliness of treatment, postoperative outcomes, and data completeness.

Please Note: Aneurin Bevan University Health Board (ABUHB) do not undertake major limb amputation, aortic repairs or carotid endarterectomy.

Standards and Guidelines

National guidelines underpin the management of people with vascular conditions, and the NVR evaluates patterns of care against these recommendations. An overall framework for vascular services is described by the “Provision of Services for People with Vascular Disease” published by the Vascular Society of Great Britain & Ireland. Additional standards originate from documents published by the National Institute for Health and Care Excellence (NICE), European Society of Vascular Surgery guidelines, national screening guidance, and government documents. From these, and in consultation with its professional and patient advisory groups, the NVR developed five quality improvement (QI) goals and associated indicators, which are published in the [NVR Healthcare-Improvement-Strategy Aug2023.pdf](#)

National Guidelines and Frameworks that underpin the National Vascular Registry:

[VSGBI 2021](#)
[VSGBI 2012](#)
[VSGBI 2022](#)
[NICE 2019](#)

[VSGBI 2016](#)
[NAAASP 2020](#)
[NICE 2012](#)

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Quality Improvement

The State of the Nation report published in November 2025 sets out five QI goals, developed to address the key concerns identified in the NVR Healthcare Improvement Strategy (August 2023).

One of the concerns raised was regarding the variation in the time taken for patients undergoing a lower limb revascularisation procedure following a non-elective admission for chronic limb threatening ischaemia. As ABUHB do not undertake major limb amputation, aortic repairs or carotid endarterectomy, it was this particular concern and associated action relating to lower limb revascularisation that was relevant and of interest to ABUHB.

Opposite are all five improvement goals, with the goal of relevance to ABUHB highlighted.

QUALITY IMPROVEMENT GOALS



REDUCE DELAYS FOR CLTI REVASCULARISATION
Ensure patients admitted as emergencies receive revascularisation within 5 days



IMPROVE TIMELINESS FOR AAA REPAIR AND CEA
Meet standards for AAA repair within 8 weeks and CEA within 14 days of symptoms



ENSURE TIMELY MAJOR LOWER LIMB AMPUTATION
Perform amputations within 48 hours of decision to operate



STRENGTHEN INTEGRATED CARE FOR DIABETIC PATIENTS
Coordinate management across primary and secondary care



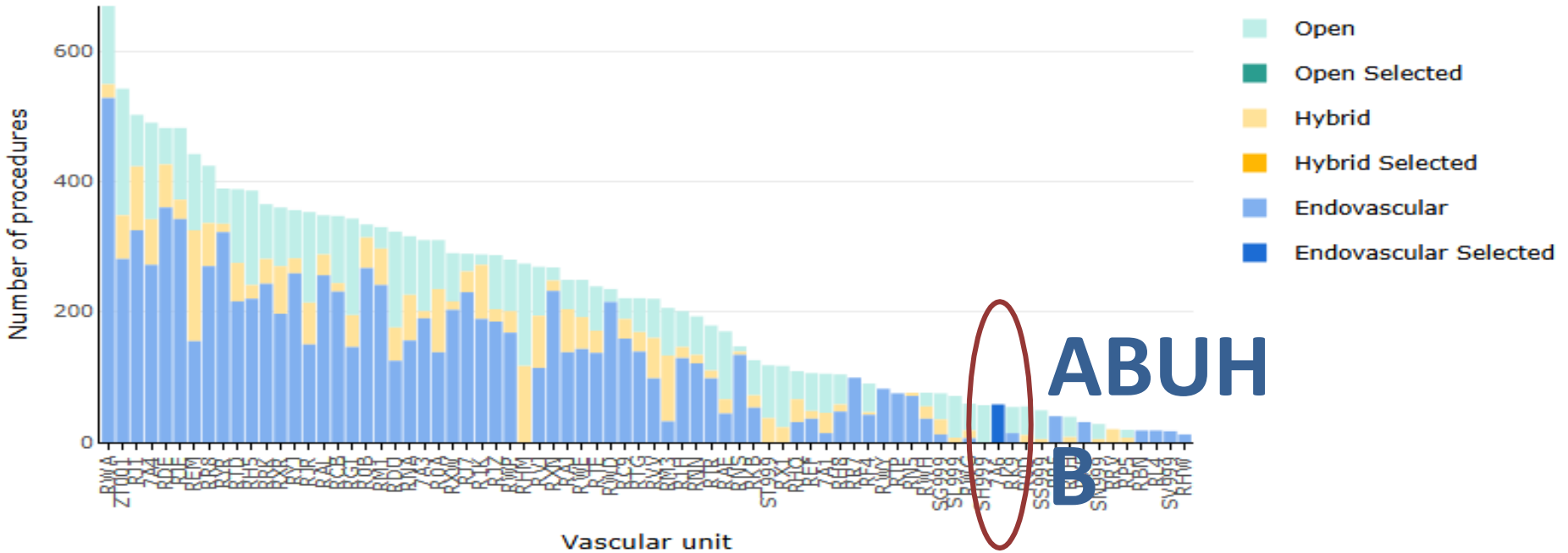
EXPAND ACCESS TO ENDOVASCULAR REPAIR FOR RAAA
Ensure suitable patients have access to EVAR

Lower limb revascularisation

The data tables and graphs shown on slides 4 to 7 report metrics for patients who had a lower limb revascularisation procedure between January and December 2024, performed using open surgery (bypass), endovascular techniques or a combination of both (hybrid). The analysis focuses on the first procedure undergone by a patient during an admission; subsequent procedures are re-operations. The waiting time plots include NHS vascular units with at least 10 non-elective chronic limb-threatening ischaemia (CLTI) cases in 2024.

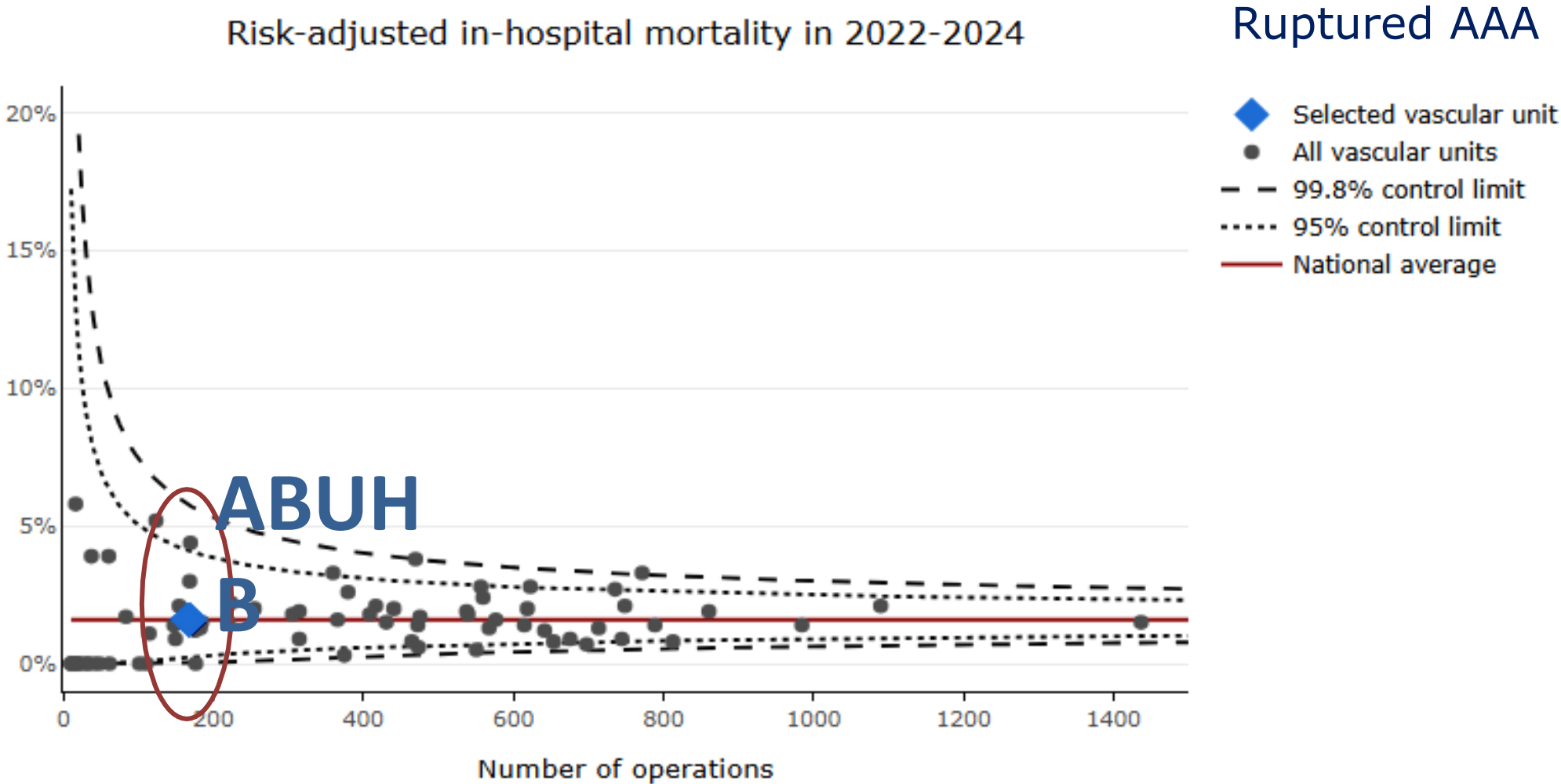
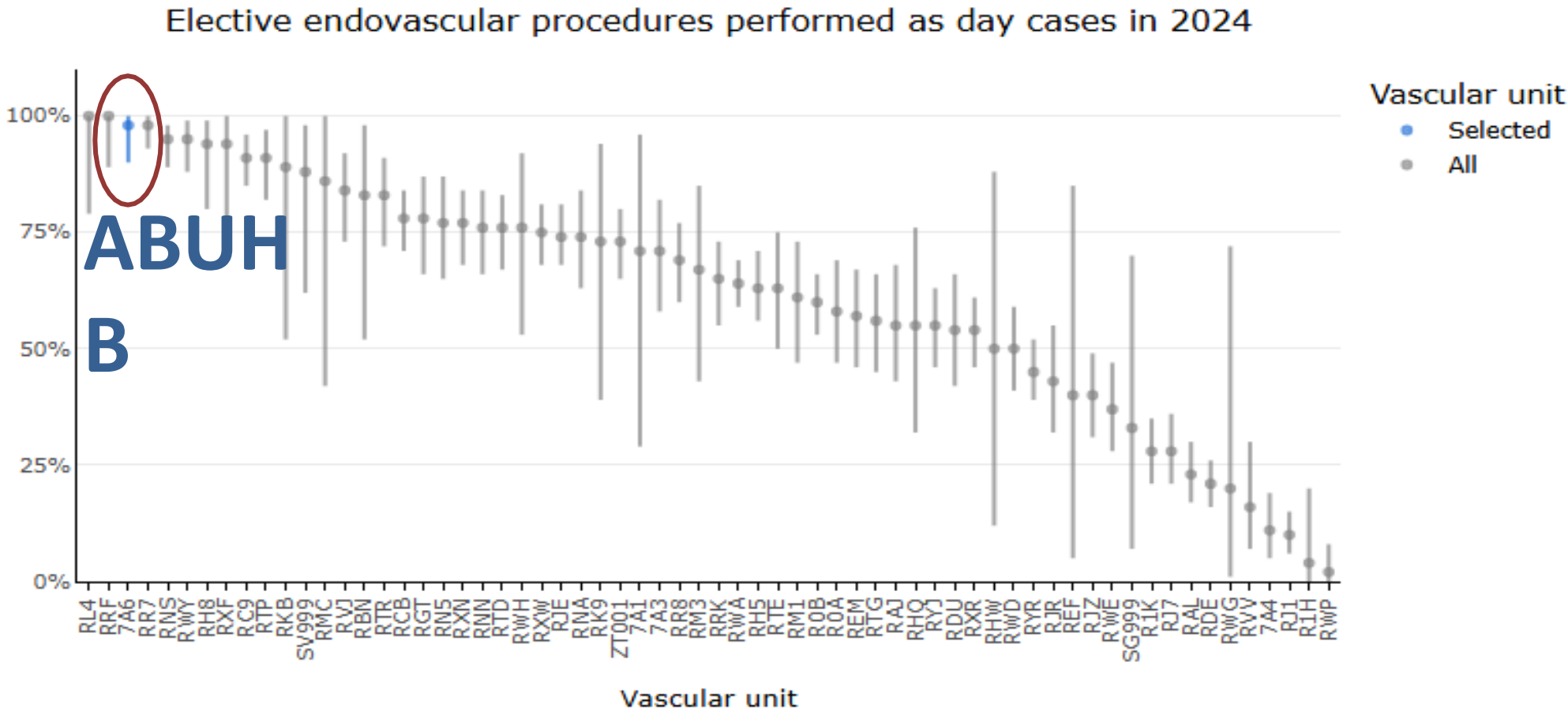
	Aneurin Bevan University Health Board 7A6	Wales	UK
NVR cases (2024)	58	963	16,618
Open surgical	<5	317	4,529
Hybrid	<5	112	2,453
Endovascular	58	534	9,636
Emergency CLTI cases (2024)	<5	502	5,182
Median time (IQR) from assessment to procedure (days)		6 (4 - 10)	6 (3 - 9)
CLTI treated within 5 days		43%	49%

Revascularisation procedures performed in 2024 by type



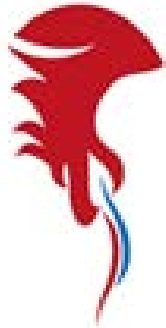
ABUHB							
Patient characteristic	Time period	NVR cases	Vascular unit	UK	Lowest	Highest	
Age over 75 years (%)	2024	58	33%	33%	18%	48%	
Men (%)	2024	58	72%	71%	56%	88%	
Current smokers (%)	2024	58	36%	29%	16%	54%	
Diabetes (%)	2024	58	47%	51%	18%	73%	
Chronic heart disease (%)	2024	58	22%	29%	0%	56%	
Chronic lung disease (%)	2024	58	16%	21%	0%	48%	
Chronic kidney disease (%)	2024	58	3%	17%	0%	69%	
Indication: Rest pain / tissue loss (%)	2024	58	70%	76%	16%	98%	

	Aneurin Bevan University Health Board 7A6	Wales	UK
NVR cases (2024)	58	534	9,636
Case ascertainment	>85%	100%	58%
Day cases (2024)	98%	52%	60%
NVR cases (2022-2024)	168	1,387	28,140
Adjusted in-hospital mortality (2022-2024)	1.6%	1.8%	1.6%
Readmitted within 30 days (2024)	14%	21%	14%



Lower limb angioplasty/stenting

The data/graphs on slides 8 to10 report on lower limb endovascular revascularisation procedures, such as angioplasty and stenting. The analysis focuses on the first procedure undergone by a patient during an admission. Most metrics are relevant to procedures performed from January to December 2024, while the mortality funnel plot is based on data from NHS vascular units that submitted at least 10 procedures in the NVR from January 2022 to December 2024. The day case plot is displayed for NHS vascular units with at least 5 elective angioplasty cases in 2024.

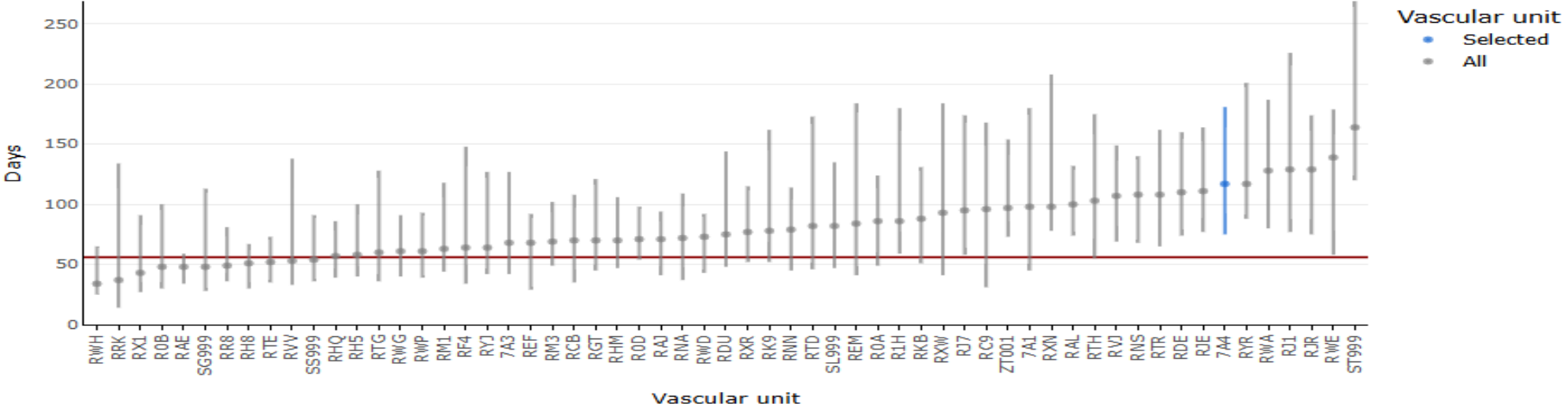


Elective infrarenal abdominal aortic aneurysm repair

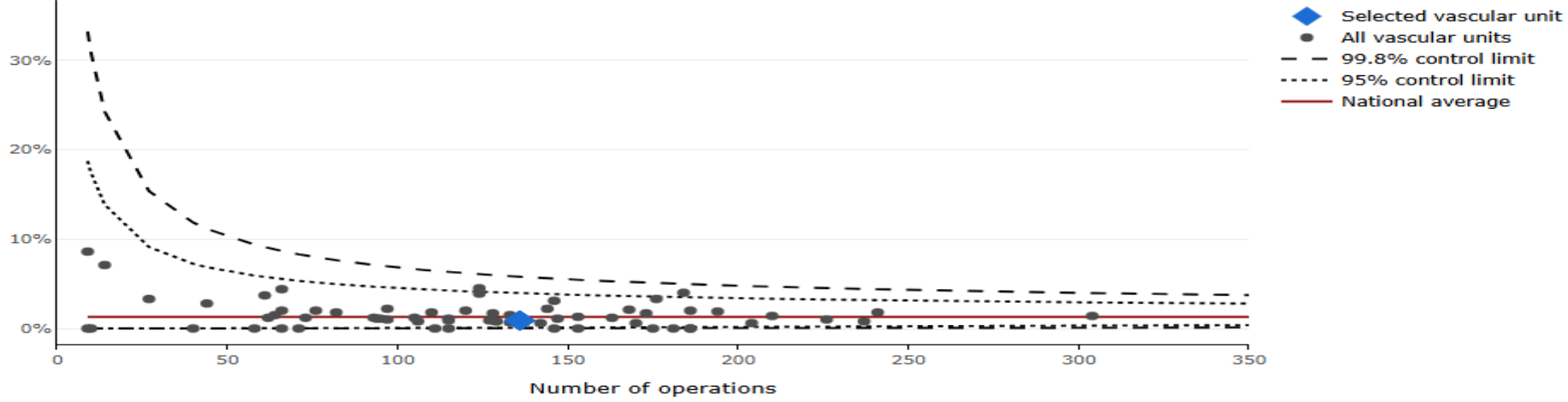
This section presents process metrics and outcomes for elective infrarenal AAA repairs, including revision procedures but excluding complex repairs. Most metrics are presented for procedures performed between January and December 2024, apart from in-hospital mortality which is reported for the period from January 2022 to December 2024 to give robust outcome estimates. Vascular units with fewer than 10 procedures submitted in the reporting period are not shown in the graphs.

	Cardiff and Vale University Health Board 7A4	Wales	UK
NVR cases (2024)	46	138	2,511
Case ascertainment	>85%	100%	91%
No. of EVAR	26	76	1,556
Median time (IQR) from assessment to procedure (days)	117 (75 - 181)	90 (50 - 148)	81 (46 - 138)
Had surgery within 8 weeks of assessment	13%	30%	33%
Discussed at MDT	98%	96%	86%
Had anaesthetic review	100%	100%	97%
Median (IQR) length of stay for EVAR (days)	2 (2 - 3)	2 (2 - 3)	2 (1 - 3)
Median (IQR) length of stay for open repairs (days)	10 (8 - 12)	8 (7 - 10)	7 (6 - 10)
NVR cases (2022-2024)	136	406	8,203
Risk-adjusted in-hospital mortality (2022-2024)	0.9%	1.1%	1.3%

Median time (IQR) from assessment to AAA repair in 2024



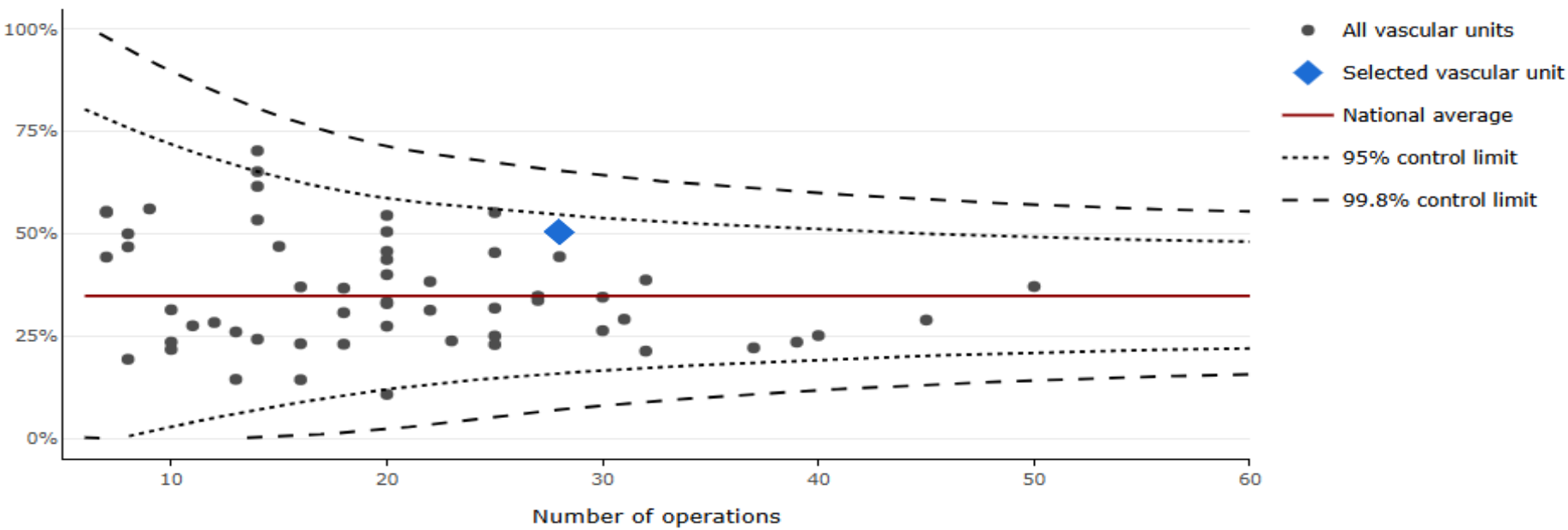
Risk-adjusted in-hospital mortality in 2022-2024



EVAR

	Cardiff and Vale University Health Board 7A4	Wales	UK
NVR cases (2022-2024)	28	69	1,211
Case ascertainment	>85%	100%	94%
No. of EVAR	11	11	515
Median (IQR) length of stay (days)	6 (3 - 14)	6 (3 - 15)	9 (4 - 18)
Risk-adjusted in-hospital mortality (2022-2024)	50.4%	56.9%	34.8%

Risk-adjusted in-hospital mortality in 2022-2024



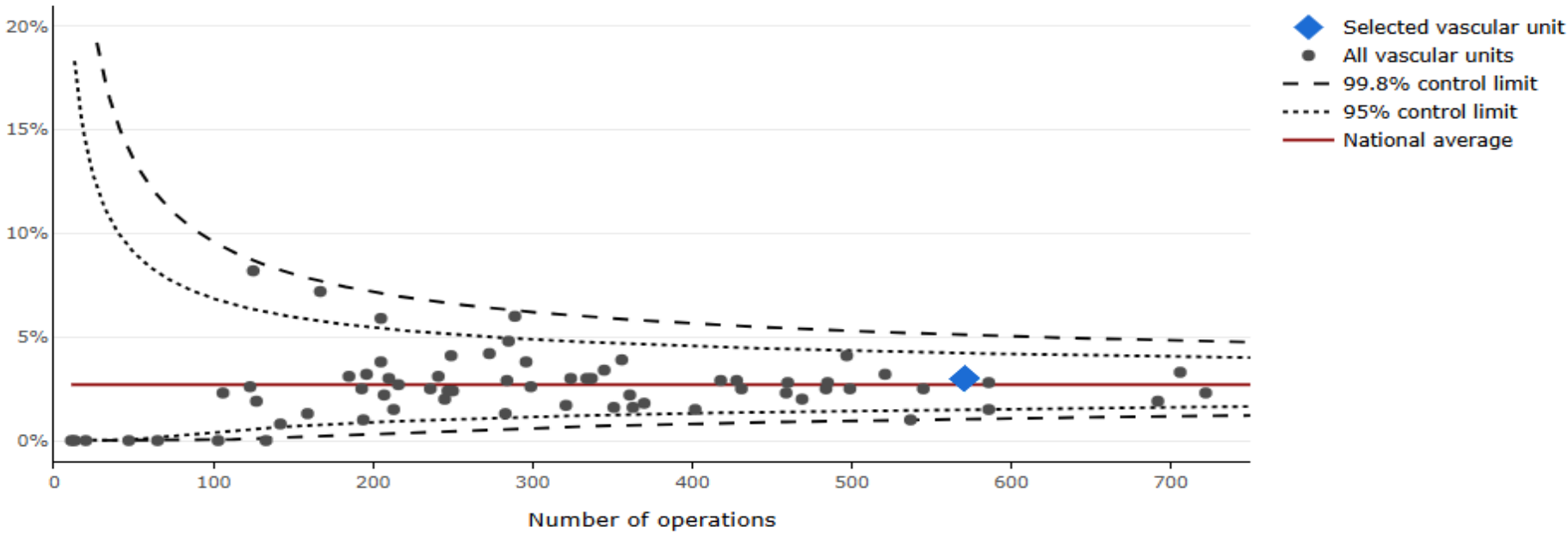
Bypass

	Cardiff and Vale University Health Board 7A4	Wales	UK
NVR cases (2024)	218	429	6,982
Case ascertainment	>85%	100%	89%
Median (IQR) length of stay (days)(2024)	10 (6 - 17)	11 (6 - 20)	8 (4 - 16)
NVR cases (2022-2024)	571	1,301	20,865
Adjusted in-hospital mortality (2022-2024)	3%	3%	2.7%
Readmitted within 30 days (2024)	9%	13%	13%

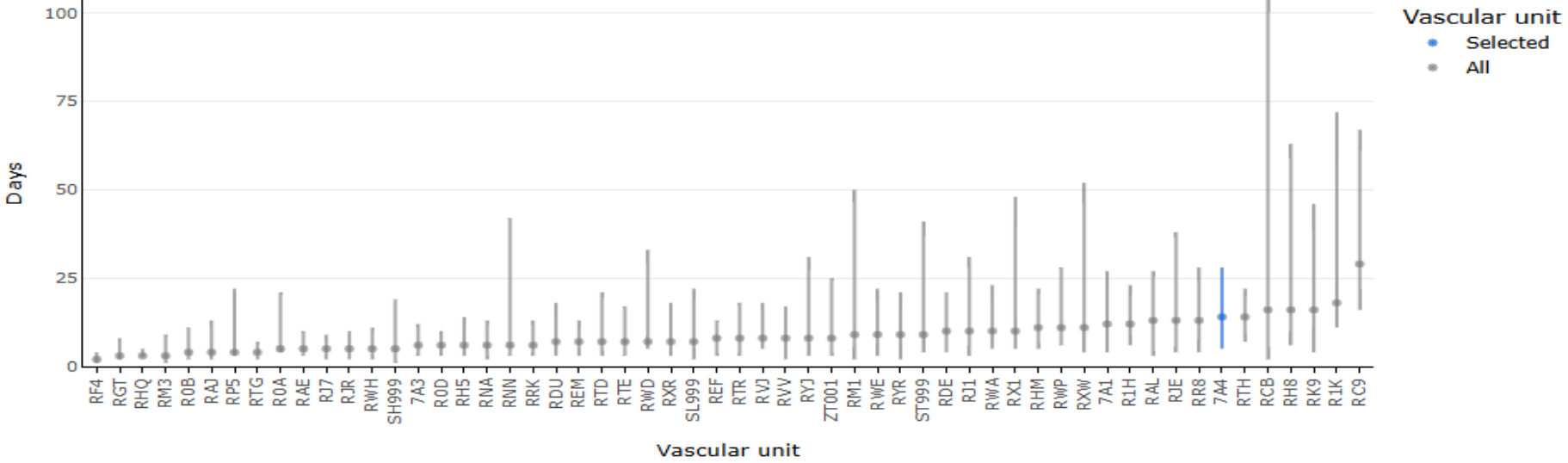
Amputation

	Cardiff and Vale University Health Board 7A4	Wales	UK
NVR cases (2024)	136	321	3,877
Case ascertainment	>85%	100%	84%
Median (IQR) time from assessment to amputation for non-elective admissions (days)	14 (5 - 28)	8 (4 - 23)	7 (3 - 20)
AKA to BKA ratio	0.8	1.1	0.9
Received prophylactic antibiotics	86%	91%	92%
Consultant vascular surgeon present in theatre	94%	80%	76%
Median (IQR) length of stay (days)	25 (16 - 36)	23 (15 - 38)	22 (14 - 36)
NVR cases (2022-2024)	442	1,045	12,387
Adjusted 30-day in-hospital mortality (2022-2024)	9.1%	7.1%	5.9%

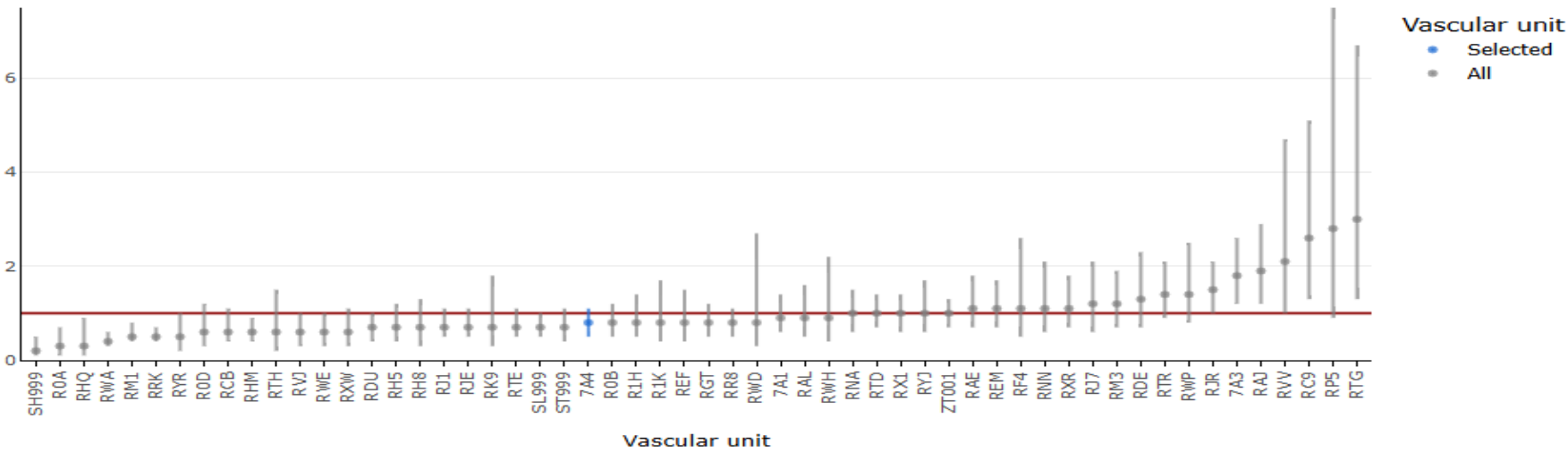
Risk-adjusted in-hospital mortality in 2022-2024



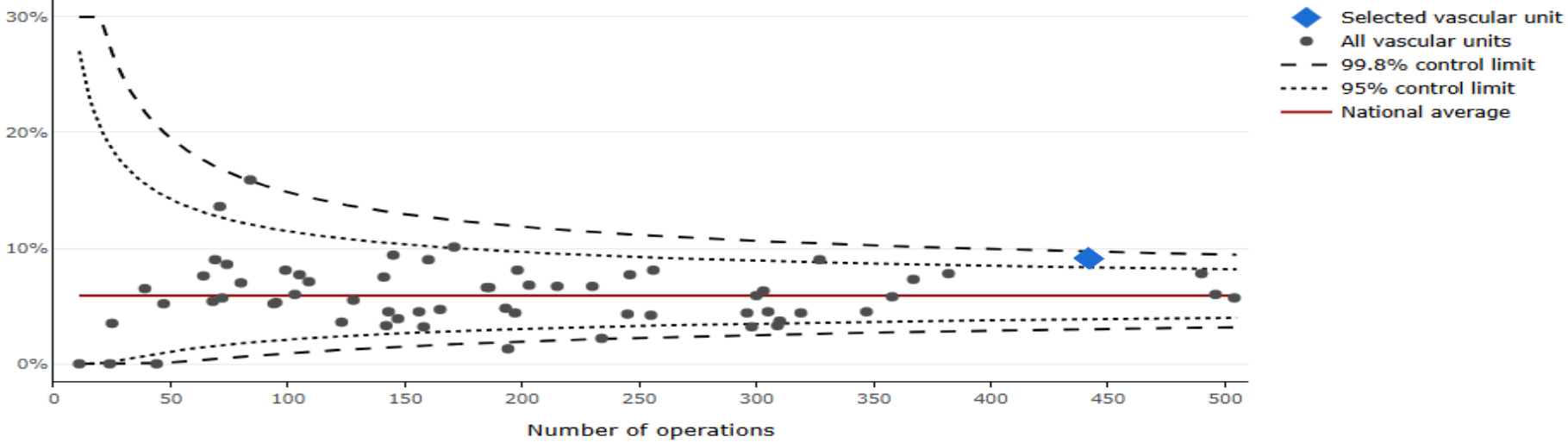
Median time (IQR) from vascular assessment to amputation for non-elective admissions in 2024



AKA to BKA ratio in 2024



Risk-adjusted in-hospital mortality in 2022-2024



Assurance and Risk

Assurance level	Description	Select
Full	The project has fully achieved the standards or criteria being audited against	X
Risk level	Description	Select
None	Standards met and findings demonstrate no risk to patient safety	X

Key Success and Concerns

Report Successes:		Report Concerns:	
1	Good quality service from the ABUHB IR department.	1	SEWVN Major Lower Limb Amputation mortality – a) post op care, b) consider palliation
2	Good and timely carotid service.	2	SEWVN delay for AAA repair – continue to monitor
3	Good and timely lower limb revascularisation service		

Report Recommendations (relevant to ABUHB):		S.M.A.R.T Actions: Responsible: Due Date: Progress:	
1	Evaluate strategies for reducing long delays to revascularisation for people with chronic limb threatening ischaemia (CLTI), to address lack of improvement in meeting timelines recommended in VSGBI Quality Improvement Framework (QIF) for peripheral arterial disease. <i>(Extended from 2024 SotN recommendations)</i>	Continued awareness and monitoring	

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Continue to monitor MLLA and AAA delivery				

DYDDIAD Y CYFARFOD: DATE OF MEETING:	02 June 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	QMG Highlight Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade (Executive Director of Nursing)
SWYDDOG ADRODD: REPORTING OFFICER:	Kye Smith, Deputy Head of Quality and Patient Safety

**Pwrpas yr Adroddiad
Purpose of the Report**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

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

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

Cefndir / Background

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

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

- Reviewing intelligence from across all clinical divisions and corporate functions

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

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

Asesiad / Assessment

The Quality Management Group (QMG) considered a comprehensive range of intelligence at its meeting on 12 May 2026, including quality performance data, audit outputs, divisional assurance reports and updates on key strategic programmes. On the basis of this review, the Group was able to provide overall assurance that arrangements to monitor, manage and improve quality and patient safety across the Health Board remain in place and are functioning. There is clear evidence of active oversight across services, with established governance processes supporting the identification, escalation and management of risks.

The Group recognised a number of areas of positive assurance. These included continued progress in embedding research within clinical practice, improvement in a range of quality indicators reflected through safeguarding compliance and patient safety initiatives, and strengthening governance arrangements across divisions. The Group noted that, despite significant operational pressures, services continue to demonstrate engagement with quality improvement activity and maintain appropriate oversight of core safety risks.

Notwithstanding this assurance, the Group identified several cross-cutting issues which require continued focus at executive and committee level. The Quality Outcomes Framework (QOF) report was recognised as providing a comprehensive dataset; however, further development is required to strengthen the narrative, clarify key risks and support effective decision-making through exception-based reporting. In addition, limitations in the alignment between local and national measures continue to restrict benchmarking and comparative analysis.

A significant assurance gap was identified in relation to mandatory training compliance, specifically Medicines Administration Record (MARR) training. While there is evidence that training delivery is taking place, inconsistencies in recording within the Electronic Staff Record (ESR) system mean that the organisation is currently unable to reliably demonstrate compliance. This represents a regulatory and governance risk and requires a coordinated organisational response to ensure that assurance arrangements are robust and auditable.

Progress in relation to the Fuller Inquiry was acknowledged, particularly in strengthening mortuary governance, infrastructure and access controls. However, the Group identified a gap in assurance relating to the patient pathway between death on the ward and transfer to the mortuary. This has potential implications for patient dignity, safety and compliance with expected standards and will require further scrutiny to ensure that risks are fully understood and mitigated.

The Group also considered systemic issues affecting communication accessibility for people who are deaf. It was recognised that barriers to effective communication represent a material patient safety and safeguarding risk, with implications for informed consent, patient understanding and equitable access to care. The Group agreed that this requires a coordinated, organisation-wide response, supported by clear governance and reporting arrangements to ensure that risks are identified and addressed consistently.

The suicide prevention pilot was positively received as a means of addressing gaps in early intervention, particularly for individuals who do not meet thresholds for secondary mental health services. This was recognised as a significant system-wide issue, with the potential to improve access to timely support and reduce risk across a range of care settings. The Group emphasised the importance of evaluating the impact of the pilot and ensuring that learning is shared across the organisation.

The deteriorating patient programme remains a high organisational priority. While progress is being made, the Group highlighted the need for stronger integration between clinical audit outputs and divisional assurance processes to ensure that learning translates into measurable improvement in practice. Ensuring consistent engagement and ownership across all divisions will be critical to the success of this programme.

Across divisional assurance reports, the Group noted sustained operational pressures, particularly in relation to patient flow, workforce capacity and service demand. There was shared recognition of the increasing normalisation of escalation measures, including the use of non-commissioned areas and boarding practices. This presents an ongoing risk to patient safety, dignity and experience, and requires continued system-level oversight and mitigation.

The Group also held a focused discussion regarding the Terms of Reference (ToR) for QMG and the wider suite of quality groups operating across the Health Board. This discussion recognised that, while the overall governance structure is in place, there remains a requirement to ensure that the purpose, scope, reporting arrangements and escalation routes for all groups are clearly defined, current and consistently applied.

It was acknowledged that a standardised approach to Terms of Reference is essential to strengthen clarity of accountability, improve alignment to the Quality Management Framework and ensure consistent reporting across all Pillars of Quality. The introduction of a common ToR template for groups reporting into QMG was therefore supported, with the intention of enabling a more coherent and robust governance architecture. This approach is designed to ensure that all groups are explicitly aligned to the revised Quality Management System, with clear articulation of how risks, issues and learning are escalated and how assurance is provided to QMG, the Executive Committee and ultimately the Board.

This work is directly linked to the emerging requirements from NHS Wales Performance and Improvement, which will require the Health Board to provide a clear and demonstrable evaluation of the effectiveness of its Quality Management System. As part of this, the organisation must evidence that governance arrangements are well defined, consistently applied and operating as intended, including how intelligence is triangulated, how risks are escalated and how improvement is delivered across the system.

Finally, the Group reflected on findings from the recent Healthcare Inspectorate Wales (HIW) inspection, which identified both areas of good practice and recurring themes relating to documentation standards and risk assessment. These issues were recognised as indicative of wider organisational challenges, with the potential for cross-divisional learning. The Group emphasised the importance of ensuring that improvement actions are clearly defined, owned and monitored through established governance structures to support sustained improvement.

In summary, while the Group was able to provide overall assurance that governance arrangements remain in place and are operating effectively, the assessment highlights a number of key cross-cutting risks which require ongoing executive focus to ensure that improvements are delivered consistently and sustainably across the organisation.

Argymhelliad / Recommendation

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

The Committee is asked to seek further assurance, where required, in relation to a number of areas identified through subgroup reporting that either explicitly require escalation or would benefit from enhanced scrutiny at Board or Committee level. These include:

Matters identified from QMG subgroup reports requiring Board or Committee attention include antimicrobial stewardship risks associated with the introduction of electronic prescribing, specifically the use of a "soft stop" at 72 hours, with potential implications for medication safety, quality of prescribing and oversight of treatment duration.

Clarification is also sought regarding changes to infection prevention arrangements, including the proposal to stop routine norovirus testing within Medical Assessment Units during summer months, to ensure that risks are fully understood, mitigated and appropriately governed.

In addition, the Committee is asked to seek assurance on emerging considerations within resuscitation practice, including the organisation's position on the use of procainamide for tachyarrhythmias, to ensure that clinical decision-making is aligned with best available evidence and that patient safety implications are fully understood.

The Committee is also asked to support a programme of work to review and standardise Terms of Reference across all quality groups reporting to QMG. This will ensure that governance arrangements are clearly defined, aligned to the Quality Management System and operating as intended, with consistent reporting, escalation and accountability across all Pillars of Quality. This work is a key enabler in demonstrating compliance with NHS Wales Performance and Improvement expectations to evaluate the effectiveness of the Health Board's Quality Management System and evidence clear lines of sight from operational delivery through to Board assurance.

Furthermore, the Committee is asked to consider the recommendation that integration of workforce training compliance data from Electronic Staff Record (ESR) into Qlik can be considered. This would significantly strengthen the reliability, visibility and triangulation of training compliance data, enabling improved organisational oversight, supporting regulatory compliance and enhancing the ability of QMG and the Board to take informed assurance on mandatory training performance.

Finally, the Committee is asked to note the continued importance of strengthening consistency and quality of reporting from all groups contributing to QMG, ensuring that highlight reports clearly articulate risks, assurance levels, escalation requirements and organisational learning, in order to support effective decision-making and system-wide oversight.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)

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

Gwybodaeth Ychwanegol: Further Information:

Ar sail tystiolaeth: Evidence Base:	
Rhestr Termiau: Glossary of Terms:	

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

QMG ASSURANCE REPORT

Meeting Date	12 May 2026
Chair	Jennifer Winslade (Executive Director of Nursing)

KEY ESCALATION AND DISCUSSION POINTS

ALERT

Alert	Action	By whom	Target Date
MARR training compliance – inability to evidence compliance due to ESR data limitations	Implement action plan to standardise recording, align to national requirements and incorporate ESR data into Qlik reporting for triangulated assurance	Medicines Management Group	Q2 2026
Fuller Inquiry – assurance gap between death on ward and transfer to mortuary	Undertake further audit work to map and assure end-to-end pathway, including dignity and safeguarding considerations	Human Tissue Act Group	Q2 2026
Communication accessibility for deaf patients – patient safety and safeguarding risk	Develop organisational approach, including training, interpreter access and reporting via Datix to ensure learning and oversight	Community of Practice for Patient Experience and Safeguarding Strategic Group	Q3 2026

ADVISE

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

- The **Quality Outcomes Framework (QOF)** provided a consolidated view of performance across the six Pillars of Quality and was intended to strengthen assurance to the Board, PQSOC and QMG, supporting risk identification and data informed decision making within an embedded Quality Management System. The QMG discussion emphasised that the principal development need was improved usability and a more focused narrative that clearly set out key risks, improvement priorities and required actions, with a strong preference for exception based reporting.
- The Research and Development (R&D) annual report demonstrated strong research delivery performance and highlighted imminent national changes affecting research governance, including new Clinical Trial Regulations planned for April 2026, updated Good Clinical Practice, and a new All Wales R&D Finance Policy, alongside a need to plan for sustainability of capacity funded through VPAG beyond 2029. It positioned research as a

core organisational enabler associated with improved patient outcomes, workforce engagement and system performance.

- The paper advised that the Health Board had made substantial progress implementing the **David Fuller Inquiry** recommendations, with most actions completed or nearing completion and governance established through the Human Tissue Authority framework with routine reporting via QMG. It also confirmed the Welsh requirement to assess alignment, identify risks to dignity of the deceased, reflect these in corporate risk registers and provide Board level assurance, with formal organisational assurance to be sought via NHS Performance and Improvement.
- The **Communication Access and Bereavement Care for Deaf People** report advised that significant inequities had been identified in communication access and bereavement care for Deaf people, particularly timely access to qualified British Sign Language interpreters at critical points of care. It described the issue as a patient safety, safeguarding and equality risk and confirmed that an earlier report was presented to the Executive Team in April 2026, which endorsed the strategic direction and approved a coordinated programme of improvement actions.
- **Suicide Prevention Pilot report** advised that suicide was an increasing public health concern, that current provision did not adequately support individuals experiencing suicidal ideation or post attempt distress who did not meet thresholds for statutory mental health services, and that there was limited structured support for those affected by another person's suicidal behaviour. It stated that in 2024 to 25 there were 440 suspected suicide deaths in Wales and that within ABUHB this equated to approximately one to two deaths per week, highlighting the scale of need and the rationale for an early intervention pilot.
- The **National Clinical Audit Activity Report** set out governance and reporting arrangements for national clinical audits, including planned and actual reporting routes through the Clinical Standards and Effectiveness Group and action tracking for audit recommendations. It includes an overview of actions arising from audit reports and indicates that actions are managed through routine chasing and updated tracking, with clinical leads determining assurance and risk levels and whether inclusion on risk registers is required.
- **Deteriorating Patient and Sepsis Workplan** provided an annual review of the Deteriorating Patient and Sepsis Programme as part of the Quality Strategy and explains alignment to national requirements including Welsh Health Circular 2024/035 on standardising acute deterioration management and updated NICE guidance on sepsis. It describes a phased programme moving from governance and policy foundations to capability building, standardisation, implementation readiness and longer term commitments, recognising that sustainable improvement requires multi year focus.

ASSURE

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

- The Group considered the **QOF** to be a strong foundation, and the Chair highlighted that progress should be recognised alongside scrutiny, noting improvements referenced within the discussion including safeguarding compliance, training uptake and pressure ulcer reduction. The discussion also confirmed organisational support, including from Planning colleagues, to explore practical solutions to known challenges.
- **The R&D annual report** provided assurance that performance metrics exceeded Wales averages, including 100 percent of commercial studies delivered to time and target, recruitment of 513 participants in 2025 to 26, and faster than national benchmarks for set

up and first recruitment. It also described strengthening of governance and quality systems through a risk based audit programme, implementation of Florence eBinders to improve inspection readiness, and strengthened sponsorship capacity with two sponsored studies.

- The update of the **Fuller Inquiry** stated overall trajectory was positive, with a high proportion of recommendations compliant and no areas of uncontrolled risk. It described key assurance in infrastructure and physical security including CCTV installation largely complete, audit and monitoring arrangements with triangulation of CCTV and swipe data, and governance arrangements including a Designated Individual embedded with escalation routes
- The **MARRS training** report evidenced that training delivery had been maintained, including development of a standardised face to face programme aligned to national content during a period when the national e learning module was temporarily unavailable, with completion captured through a QR code based system. It also provided service level context, for example within NICU where a proportion of staff were recorded compliant and further staff had undertaken training but required completion of the knowledge test, demonstrating active delivery albeit with incomplete recording.
- **The Suicide Prevention Pilot** had established a 12 month pilot commencing 18 May 2026 in partnership with the Jacob Abraham Foundation, with a defined service model including rapid response within three working days, time limited intervention, brief therapeutic support and safety planning. It also described governance arrangements including co location with 111 Press 2, multidisciplinary review of referrals, regular MDT case discussions and escalation routes back to statutory services if risk increased, alongside continuous evaluation of outcomes and safety.
- The **National Clinical Audit Activity Report** provided oversight of audit actions by status and indicates that audit assurance and risk levels have been agreed through CSEG for audits presented during 2025 to 26. It also describes that action tracking and governance structures support organisational oversight of delivery, with explicit acknowledgement that some actions do not fit a single process and therefore require tailored management with accurate tracking.
- **Deteriorating Patient and Sepsis Workplan** described established governance through the Deteriorating Patient Group with reporting to senior quality and safety committees and provides evidence of delivery against commitments, including policy approval and rollout activity, engagement with national partners, and implementation progress for early warning scores against timelines with continuing workplans. It also notes that sepsis tools and communication assets were progressed and that a driver diagram was produced, supporting structured improvement planning.

Risks discussed or identified:

- A significant risk was identified in relation to the reliability of training compliance data derived from the Electronic Staff Record (ESR). The Group noted that, while there is evidence that mandatory training is being delivered across the organisation, current recording practices are inconsistent and do not provide a complete or accurate reflection of compliance levels. This limits the Health Board's ability to demonstrate assurance against statutory and regulatory training requirements, including those aligned to national policies. This was reflected from multiple areas including divisional reports with specific examples provided of the inability to provide assurance during HIW inspections, it was also reflected in the **MARRS training** report.
- The **R&D annual report** identified capacity pressures and inequity of research availability across sites, together with a clear sustainability risk for VPAG funded roles and

infrastructure beyond 2029. It also flagged that new research metrics would be introduced, requiring agility and potentially increasing delivery and reporting demands.

- The **Fuller Inquiry update** identified residual risks where compliance is partial, including access control transition away from shared access arrangements, governance maturity including breach response processes and consistent Board level reporting, commissioning of an external specialist review as a component of final assurance, and workforce and capacity pressures within mortuary services. The QMG discussion also highlighted a specific assurance gap regarding the patient pathway between death on the ward and transfer to the mortuary which requires further scrutiny
- The **MARRS training** report set out that the Health Board had partial visibility of staff completion of mandatory MARRS training due to inconsistent recording, despite training being delivered, and explained that strengthened national requirements introduced through revisions to the All Wales MARRS Policy in 2024 and 2025 had not been fully embedded in organisational systems. The QMG discussion clarified that the assurance gap was primarily a systems and recording issue rather than absence of training delivery, and it explored the tension between national requirements and locally delivered solutions that were not consistently aligned to national frameworks
- The **Communication Access and Bereavement Care for Deaf People** report identified that consistency of implementation and embedding into frontline practice remained a key risk and that ongoing monitoring and assurance were required through QMG governance. It also set out specific risks including delayed or absent interpreter provision, reliance on family members to interpret, and exclusion from key clinical discussions affecting informed consent and end of life decision making. **The group endorsed that Deaf access and 'failures' to secure interpreters or other reasonable adjustments would be subject to DATIX reporting to ensure consideration of potential safeguarding.**
- **Suicide Prevention Pilot** report identified a current system risk arising from the gap in accessible early intervention support and the challenge of delivering a no wrong door approach. It also noted that a substantial proportion of people who die by suicide were not known to mental health services prior to death, indicating risk across settings and reinforcing the need for robust pathway management and safe eligibility criteria for the pilot cohort.
- The **National Clinical Audit Activity Report** highlighted that audit actions are recorded as unable to be completed due to lack of funding at Directorate level, with an example relating to additional resource within Care of the Elderly and knock on impacts on performance in related national audits. It also shows that a proportion of actions remain open, including overdue actions, which represent an ongoing assurance and delivery risk requiring continued oversight and escalation where necessary.
- **Deteriorating Patient and Sepsis Workplan** identified that several commitments extended into later workplans due to scale and complexity, including standardised education delivery, audit approaches for sepsis compliance and routine feedback mechanisms, indicating an ongoing delivery and assurance risk until embedded. It also noted that implementation of one early warning score tool was delayed and planned for a later year, which is an explicit timing risk against national standards unless managed through clear mitigations.

Divisional Updates

- **Mental Health and Learning Disabilities** – The division provided assurance of continued improvement across key quality indicators, including a reduction in restrictive practice and self-harm, alongside progress in ward accreditation and risk assessment processes. However, the update highlighted the need for sustained oversight of both

internal professional standards and external provider arrangements, with recent concerns appropriately escalated and reviewed in partnership with regulatory bodies. While no immediate patient safety risks were identified, the discussion recognised that issues relating to culture, staff behaviour and workforce capability remain important indicators of quality and require ongoing focus. Opportunities for cross-divisional learning were also identified, particularly in relation to competency assurance and safe practice across services.

- **Clinical Support Services** – The division reported a patient safety incident involving the use of expired theatre equipment, which did not result in harm but highlighted gaps in existing checking and assurance processes. This prompted immediate investigation and the implementation of strengthened controls, including reinforced two-person verification of supplementary items, enhanced communication processes requiring staff acknowledgement, and improved stock management and documentation requirements. The discussion emphasised the importance of ensuring that safety processes are both robust and demonstrably understood by staff, with a focus on embedding behavioural change. More broadly, the division reported strong performance in audit compliance, although continued effort is required to ensure that audit findings translate into sustained improvements in practice across services.
- **Family and Therapies** – The division reported a position of sustained operational pressure, particularly within maternity services, driven by increasing clinical complexity, high occupancy and evolving national standards. Workforce capacity remains a key risk, including pharmacy support within neonatal and paediatric services, alongside backlogs in areas such as care for looked-after children. Despite these pressures, the division demonstrated ongoing quality improvement activity, including the introduction of human factors training and enhanced medication safety governance, which were recognised as strengthening safety culture. Improvements in complaints handling and engagement through the Listening to People approach were noted, although the Group highlighted the need to ensure that progress is sustainable given the current level of demand and workforce constraints.
- **Medicine** – Operational pressures remain the dominant risk within the division, with patient flow challenges and boarding in non-commissioned areas increasingly impacting the ability to provide care in optimal clinical environments. This was recognised by the Group as a significant and systemic issue, with growing concern regarding the normalisation of escalation measures and their impact on patient safety, dignity and staff experience. The division reported high levels of incident and complaint reporting, reflecting both service pressure and a positive reporting culture, although this presents challenges in ensuring timely review, learning and response. Notwithstanding these pressures, improvements in key safety indicators such as falls and pressure ulcers were noted, although these gains remain vulnerable to ongoing system demand and require continued focus.
- **Surgery** – The division reported strengthening governance arrangements, supported by increased leadership capacity within quality and patient safety functions. While a backlog in complaints remains, there is growing confidence that improvements in processes, training and oversight will support recovery. The update also highlighted the importance of extending governance and assurance processes beyond traditional high-risk environments, ensuring consistency of standards across all clinical settings. A significant achievement was noted in the division achieving the Health Board's first gold ward accreditation, demonstrating strong leadership, staff engagement and commitment to quality improvement, although the balance between operational demand and protected time for training and development remains an ongoing challenge.

- **Primary Care and Community Services** – The division continues to experience sustained system pressure, with escalation measures such as boarding and use of non-traditional care environments becoming increasingly embedded within routine practice. This was recognised as a key risk, with implications for patient experience, deconditioning and overall quality of care. Additional pressures include workforce challenges, particularly within pharmacy, and reduced capacity in areas such as palliative care. However, the division reported progress in strengthening governance arrangements, particularly following organisational integration changes, alongside continued quality improvement activity in areas such as falls prevention and community accreditation. Complaints performance remains relatively strong, although anticipated increases in demand may impact performance going forward.
- **Urgent Care** – The division reported ongoing and significant pressure across urgent and emergency care pathways, including emergency department congestion, ambulance handover delays and limited capacity within assessment areas. These pressures were recognised as reflective of wider system constraints, with continued impact on patient flow, experience and staff workload. Despite this, the division is progressing service redesign and targeted quality improvement activity, including work to reduce contaminated blood cultures and improve waiting times. Strong engagement from clinical teams in these initiatives was noted, alongside positive performance in complaints handling and early resolution. While pressure ulcers remain a common incident type, the majority are identified as present on admission, with ongoing work to strengthen assessment processes and documentation.

Matters for the Board or other committees:

Antimicrobial stewardship risk associated with EPMA implementation and “soft stop” prescribing arrangements

The introduction of the Electronic Prescribing and Medicines Administration (EPMA) system included initial implementation of a ‘soft stop’ at 72 hours for antimicrobial prescriptions, whereby prescribers were prompted to review treatment but were not required to actively re-authorise or amend prescriptions. This represented a deviation from stronger control measures and introduced a risk that antimicrobial therapy might continue beyond clinically appropriate timeframes without adequate review. The consequence of this included increased risk of antimicrobial resistance, prolonged intravenous antibiotic use, avoidable patient harm, and reduced compliance with national antimicrobial stewardship standards. The Committee recognised that, whilst EPMA introduced significant system benefits, this configuration required close monitoring, robust audit and clear clinical accountability. A formal post-implementation review had been agreed, however there remained a short-term assurance gap which required oversight through Infection Prevention governance and escalation to the Board if deterioration in prescribing quality was identified.

Proposal to cease routine norovirus testing in specific settings and associated infection prevention risks

The proposed cessation of routine norovirus testing within defined settings, such as Medical Assessment Units during lower risk periods, reflected a move towards a more targeted, risk-based surveillance approach. While this aligned with the principle of reducing low-value testing and focusing resources appropriately, the Committee noted that norovirus remained a significant cause of healthcare-associated infection, with potential for rapid transmission in

high occupancy and flow-pressured environments. There was a risk that reduced routine testing might delay identification of outbreaks, impact timeliness of infection control measures, and reduce visibility of emerging trends. The Committee emphasised that any change in testing approach had to be supported by clear clinical criteria, robust escalation processes, and ongoing evaluation of impact, with assurance that surveillance remained sufficient to meet Welsh Government infection prevention expectations.

Clinical decision regarding the use of procainamide for tachyarrhythmias and alignment to the evidence base

The Committee was advised of a requirement for clinical review of the organisation's position regarding the use of procainamide for the management of tachyarrhythmias, in light of concerns regarding the strength of the underlying evidence base and its limited availability within the United Kingdom. This raised both clinical governance and patient safety considerations, particularly in ensuring that treatment protocols were aligned to current national guidance, Resuscitation Council UK recommendations and best available evidence. There was a risk that continued or inconsistent use of therapies without a clear evidence base might result in variation in clinical practice and potential patient harm. The Committee therefore identified the need for a clearly defined organisational position, informed by specialist clinical review, with any changes formally implemented through policy, training and governance processes to ensure consistency and assurance.

MEETING AGENDA ITEMS

Quality Outcomes Framework Q4 2025/26	Research and Development Annual Report	MARR Training Compliance
Fuller Inquiry Update	Communication Accessibility – Deaf Community	Suicide Prevention Pilot
Clinical Audit and Deteriorating Patient Programme	Divisional Assurance Reports	HIW Inspection Feedback

Attendees

Jennifer Winslade	Executive Director of Nursing
Peter Carr	Executive Director of Allied Health Professions & Health Science
Stephen Edwards	Deputy Medical Director
Tracey PartridgeWilson	Deputy Director of Nursing
Craig Roberts	Assistant Director of Allied Health Professions & Health Science
Jonathan Simms	Clinical Director of Pharmacy
Gemma Couch	Head of Quality Patient Safety & Learning
Tanya Strange	Head of Nursing – Person-Centred Care
Trish Chalk	Assistant Director of Planning and Performance

Leeanne Lewis	Assistant Director Quality & Patient Safety
Kye Smith	Deputy Head of Quality & Patient Safety
Collette Kiernan	Deputy Director of Allied Health Professions & Health Science
Helen Ronchetti	Deputy Head of Infection Prevention & Control
Joanne Lane	Divisional Nurse – Primary Care & Community
Natalie Skyrme	Divisional Nurse – Medicine
Chris Morgan	Divisional Nurse – Urgent Care
Deb Jackson	Divisional Nurse – Family & Therapies
Karen Collins	Head of Nursing – Medicine
Donna Challingsworth	Deputy Head of Nursing – Surgery
Aimee Holden	Deputy Head of Nursing – Surgery
Jo Hook	Senior Nurse – Patient Experience and Involvement
Susan Palmer	Head of Research Delivery
Jonathan Clarke	Consultant – ENT
Lilia Delgado	Deputy Head of Health, Safety and Fire
Jonathan Clarke	Pharmacy / Medicines Safety Representative
In Attendance to Present	
Jonathan Lloyd-Evans	Consultant Intensivist – ICU / Call for Concern Lead
Rachel Trask	Head of Quality Improvement
Julie Poole	Associate Director Planned Care
Apologies for Absence	
Seema Srivastava	Executive Medical Director
Rob Holcombe	Executive Director of Finance
Rebekah White	Divisional Nurse – Clinical Support Services
Helen Sweetland	Independent Member
Jayne Beasley	Head of Midwifery, Gynaecology & Neonates
Amy Buckley	Divisional Nurse – Mental Health & LD
Moirá Bevan	Head of Infection Prevention & Control
Rani Dash	Director of Corporate Governance
Scott Taylor	Head of Health, Safety and Security
Kelly Downes	Deputy Director of Nursing
Tracy Daszkiewicz	Executive Director of Public Health
Amanda Hale	Divisional Nurse – Surgery and Clinical Support Services
Karen Hatch	Assistant Director of Allied Health Professions & Health Science

QMG ASSURANCE REPORT

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

KEY ESCALATION AND DISCUSSION POINTS

ALERT

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

ADVISE

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

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

ASSURE

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

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

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

Risks discussed or identified:

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

Matters for the Board or other committees:

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

MEETING AGENDA ITEMS

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

Attendees

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

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

In Attendance to Present

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

Apologies

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

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	02 June 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Audit Plan 2026/27 Annual Clinical Audit Activity Report 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr Seema Srivastava, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Stimpson – National Clinical Audit Lead Leeanne Lewis, Assistant Director for Quality & Patient Safety

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

ADRODDIAD SCAA SBAR REPORT
<u>Sefyllfa / Situation</u> Clinical audit is one tool available for assessing whether clinical services are safe and effective. It is one input into our Quality Management System (QMS). Clinical audit provides assurance against compliance with clinical standards and provides an opportunity to identify and minimise risk, waste, and variation in clinical practice from guideline defined standards of care. The results of audit are used to plan and prioritise domains of care requiring improvement with the aim of improving patient outcomes. This paper presents a refreshed and strengthened Clinical Audit Activity Report and Forward Plan for 2026–27, building on delivery during 2025–26 and responding to feedback from QMG, PQSOC and Board discussions. The intention is to move the audit programme further from a description of activity towards a clearer narrative of assurance, learning and improvement. <u>Cefndir / Background</u>

The National Clinical Audit and Outcome Review Plan (NCAORP), published annually by Welsh Government, remains a key mechanism for driving improvement in the quality, safety, and effectiveness of healthcare across Wales. It sets out the national expectations for participation in clinical audit and outcome review programmes, enabling organisations to systematically assess compliance with evidence-based standards and demonstrate year-on-year improvement in patient outcomes.

The Health Board's Clinical Audit Plan for 2026–27 is aligned to NCAORP and supports delivery of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). As a core component of Pillar Three – Clinical Effectiveness within the Quality Strategy, clinical audit provides structured assurance that care is delivered in line with national standards and best practice.

The programme continues to strengthen its contribution to organisational assurance through a more standardised, transparent, and risk-based approach to audit delivery, reporting, and governance.

Key developments this year have included:

- Further standardisation of audit reporting, through the introduction of consistent templates, enabling improved scrutiny of findings, clearer articulation of risk, and strengthened oversight of action plans
- Further development and optimisation of the Audit Management and Tracking system (AMaT), enabling end-to-end management of the audit cycle, including audit registration, data collection, reporting, action planning, and re-audit within a single system, improving visibility, accountability, and assurance
- Improved divisional engagement and governance, supported by structured reporting cycles, forward planning of audit submissions, and strengthened visibility of audit activity at Directorate and Divisional level
- Strengthened governance and escalation arrangements, ensuring clinical audit is embedded within established committee structures, including the Clinical Standards and Effectiveness Group (CSEG), Quality Management Group (QMG), Patient Quality and Safety Outcomes Committee (PQSOC), and Audit, Risk and Assurance Committee (ARAC), enabling robust scrutiny and Board-level assurance

All clinical audit activity is required to be recorded on AMaT, providing a single source of truth for audit data across the Health Board. The system supports the development of standardised audit tools, capture of audit findings, and production of SMART improvement plans, ensuring a consistent and auditable approach to quality improvement.

Asesiad / Assessment

Clinical Audit – Strengthening Assurance and Driving Improvement

For 2026–27, the Clinical Audit Programme, led by the Medical Director’s Clinical Audit Team, will be positioned as a core component of the Health Board’s Quality Management System (QMS), providing strengthened and systematic assurance to the Board and its Committees on the quality, safety and effectiveness of care.

Aligned to Pillar Three – Clinical Effectiveness, the programme will ensure that audit activity consistently tests compliance against evidence-based standards and best practice, providing robust assurance that care is safe, effective and continuously improving.

This will be delivered through a more mature, risk-based and governance-driven approach, including:

- Risk-based prioritisation of audit activity, ensuring focus on areas of highest patient safety concern, unwarranted variation and known organisational risks, strengthening the Board’s line of sight on key quality issues
- Robust accountability and governance arrangements, with clear ownership of audit findings, strengthened oversight of improvement plans, and formal escalation where standards are not met
- A strengthened focus on demonstrable impact, ensuring the audit cycle is completed through re-audit, providing explicit evidence of improvement, sustainability of change, and impact on patient outcomes

There is now a well-defined and embedded process for the scrutiny of National Clinical Audit reports, supported by standardised reporting through AMaT. This enables consistent identification of good practice, areas requiring improvement, and the development of clear, SMART action plans, improving both transparency and the quality of assurance provided.

The Clinical Audit Team continues to enhance the use of AMaT as a single source of truth for audit activity across the organisation, including the development of organisational and governance structures within the system to support full participation, monitoring of progress, and visibility of improvement actions. This includes the ability to identify where there are gaps in participation, delivery of improvement, or emerging risks, with clear escalation routes to ensure appropriate Executive oversight.

Strengthening Governance, SOPs and Escalation

To further enhance assurance, the Medical Director’s Clinical Audit Team is strengthening Standard Operating Procedures (SOPs) and formal escalation

processes, ensuring a consistent, transparent and systematised approach to managing audit findings across all Directorates and Divisions.

Key developments include:

- Standardised end-to-end SOPs, defining the audit lifecycle from identification of non-compliance through to action planning, delivery, re-audit and closure
- Defined escalation thresholds and triggers, ensuring that high-risk findings, failure to meet standards, delays in delivery, or lack of re-audit are escalated in a timely and proportionate manner
- Clear accountability and ownership, with named leads responsible for delivery of improvement actions at Directorate, Divisional and corporate level
- Formalised governance and escalation pathways, aligned to Divisional Quality and Safety Groups, the Clinical Standards and Effectiveness Group (CSEG), and the Patient Quality and Safety Outcomes Committee (PQSOC), ensuring appropriate scrutiny and oversight
- Integration with the organisational risk management framework, ensuring that significant audit findings inform risk registers and wider assurance processes
- Enhanced tracking and visibility through AMaT, enabling real-time monitoring of action delivery, identification of overdue actions, and a clear audit trail
- A strengthened focus on re-audit, ensuring that improvement is not assumed but evidenced, with escalation where sustained change is not demonstrated

Collectively, these developments significantly strengthen the organisation's ability to identify, manage and mitigate quality risks, whilst ensuring consistent and reliable assurance to the Board.

Delivering Participation, Compliance and Continuous Improvement

The Health Board remains mandated to participate in all National Clinical Audits. Where non-participation is identified, the Medical Director provides formal oversight and escalation to the relevant specialty, reinforcing accountability and ensuring that corrective action plans are developed and implemented. This approach ensures compliance with national expectations and minimises gaps in assurance.

The Clinical Audit Team continues to work collaboratively with Divisions, clinicians, service managers and governance teams to ensure that audit programmes are aligned to clinical priorities, statutory and regulatory requirements, and Health Board objectives, while supporting frontline teams to use audit as a tool for improvement.

Looking Ahead – Strengthening the Role of Audit within the QMS

Over the next 12 months, alongside the refresh of the Quality Plan with an increased focus on Clinical Effectiveness, clinical audit will play an increasingly central role in providing integrated assurance on patient outcomes within the QMS.

This will include:

- Triangulation of audit findings with other data sources, including Value-Based Healthcare and Patient Experience data, to provide a more comprehensive and holistic view of service quality
- Systematic sharing of learning, through established forums such as the Learning and Improvement Forum, ensuring that insights from audit are disseminated and embedded across clinical services
- A continued focus on closing the audit loop, ensuring that audit not only identifies issues but demonstrably drives sustained improvement

Through these developments, the Medical Director's Clinical Audit Team is strengthening the role of clinical audit as both an assurance mechanism and a driver for continuous improvement, providing the Board with increased confidence that:

- Care is being delivered in line with evidence-based standards
- Risks are identified, escalated and managed in a timely and systematic way
- Improvement actions are delivered and sustained
- The impact of audit activity on patient outcomes is clearly evidenced

Attached appendices include:

- 1) Clinical Audit Plan 2026/27
- 2) Annual Clinical Audit Activity Report 2025/26

Argymhelliad / Recommendation

The Committee is asked to:

- Approve the Clinical Audit Plan for 2026–2027, noting its alignment to the Health Board's Quality Management System and its role in providing assurance on clinical effectiveness
- Receive assurance from the 2025–2026 Clinical Audit Activity Report that robust arrangements are in place to deliver the clinical audit programme, including compliance with national requirements, effective participation in mandated audits, and the systematic identification, escalation, and management of risks arising from audit findings
- Take assurance that clinical audit activity is driving measurable improvement, through strengthened governance, delivery of action plans,

and evidence of sustained change through re-audit, supporting the Health Board in meeting its statutory and regulatory obligations

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management 2.9 Medical Devices, Equipment and Diagnostic Systems 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults Adults in Gwent live well healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and 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:	
Rhestr Termiau: Glossary of Terms:	NA – National Average CA – Case Ascertainment
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:	Clinical Standards and Effectiveness Group

Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Not Applicable
• Service Activity & Performance	Yes, outlined within the paper
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves Choose an item.



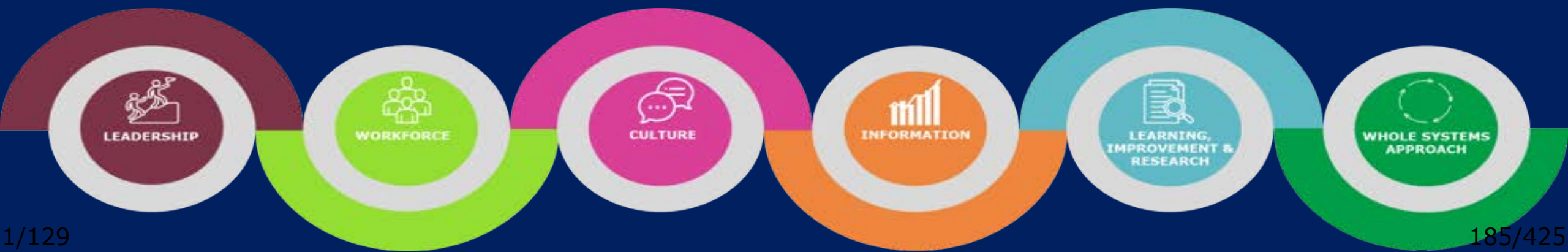
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National Clinical Audit Activity Report 2025/2026

Medical Director's Quality & Patient Safety Team

PQSOC June 2026



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Welcome to the Aneurin Bevan University Health Board Clinical Audit Activity Report for 2025/2026

- This report provides a comprehensive and transparent account of Aneurin Bevan University Health Board's clinical audit activity during 2025/2026 and demonstrates the continued importance of mandatory participation in the National Clinical Audit Programme. Through sustained engagement over the past 12 months, the Health Board has been able to assess clinical performance against recognised national standards, benchmark outcomes, and provide robust assurance on the quality, safety, and effectiveness of care.
- Clinical audit remains a cornerstone of improving health and care services across Aneurin Bevan University Health Board and Wales. By systematically reviewing clinical practice against evidence-based standards, clinical audit supports the delivery of safe, effective, and reliable care—ensuring that people receive the right care, in the right way, at the right time. The continuous cycle of audit, action planning, and re-audit provides assurance on current performance while also acting as a key driver of meaningful and sustained improvement across medical, surgical, and mental health services.
- Within Aneurin Bevan University Health Board, clinical audit is embedded as a core component of clinical effectiveness and aligned with the Duty of Quality, ensuring that healthcare delivery is underpinned by the best available evidence. Participation in the National Clinical Audit Programme enables objective scrutiny of services and strengthens transparency, accountability, and consistency in how care is reviewed and improved. Robust audit activity supports the identification of variation and risk, enables evidence-based change, and ensures that improvement efforts are focused where they can have the greatest impact.



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Progress – Compliance with the National Clinical Audit Programme

- Audit priorities are informed by both national and local drivers, including Quality Statements, National Service Frameworks, incident reporting, and the implementation of best-practice guidance. Through structured participation in national clinical audits, services are supported to translate findings into meaningful, measurable actions that align with Health Board priorities and national expectations. The engagement and commitment of clinical teams are central to this process, ensuring that audit findings are clinically owned and that learning is embedded within Directorates and Divisions.
- This report sets out the Health Board's achievements, challenges, and ongoing priorities in advancing high-quality, safe, and effective care for the population of Gwent, as detailed in the [GWENT 35 – Our Ten Year Strategy](#). It demonstrates how delivery of the Clinical Audit Plan and participation in the National Clinical Audit Programme support learning at both service and organisational level, strengthen governance and assurance arrangements, and enable quality improvement at scale. Through clinical audit, the Health Board is able to:
 - Improve the delivery of high-quality, safe, and effective care for patients
 - Support cost-effective and sustainable clinical services through evidence-based decision-making
 - Strengthen engagement and clinical ownership of national audit participation
 - Demonstrate compliance with NHS Wales, Health and Social Services, and Public Health Wales requirements
 - Provide assurance through robust, consistent, and transparent quality reporting
 - Drive improvement initiatives aligned to Health Board priorities
 - Evidence NICE compliance and support the consistent adoption of best practice



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Clinical Audit: Improving Quality, Safety and Patient Care

- For Aneurin Bevan University Health Board, delivery of the clinical audit programme has strengthened Health Board learning and assurance. The standardisation of reporting processes, consistent documentation, and systematic recording of audit activity have improved visibility and comparability of audit findings across services.
- The use of AMaT to coordinate audit activity and to log and monitor SMART action plans has enhanced the Health Board's ability to track progress over time, follow through on audit recommendations, and understand where improvements have been delivered and where residual risks remain.
- Crucially, the programme's success has been underpinned by strong partnership working between the Clinical Audit Team and clinical leads. This ensures audit findings are clinically owned and that learning flows back into Directorates to inform local improvement and decision-making.



- This creates a clear line of sight between national audit participation, local action, and organisational risk and assurance, supporting informed oversight through established governance forums.



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- Learning from clinical audit is embedded within the Quality Management System, supporting both improvement and assurance.
- Positioning clinical effectiveness as pillar three of the Six Pillars of Quality has further raised the profile of clinical audit and the National Clinical Audit Programme, strengthening expectations around participation, consistency, and robust reporting. As a result, national clinical audit performance and outcomes are now reported in a more structured and visible way, providing stronger assurance to the Health Board.
- The next phase of focus is on maximising the learning gained from audit activity by ensuring insights and improvement actions are consistently embedded within Directorates and Divisions. This will strengthen local ownership of improvement, enable shared learning, and ensure that participation in the National Clinical Audit Programme continues to translate into sustained changes in practice and improved outcomes for patients.



- Being a long-standing partner of the NHS, the Healthcare Quality Improvement Partnership (HQIP) has a strong understanding of the complex challenges faced by healthcare providers and commissioners. HQIP recognises that sustainable healthcare improvement requires an evidence-informed approach, supported by continuous learning and robust use of data, to transform services and improve patient outcomes.
- HQIP is responsible for managing and commissioning several national healthcare quality improvement programmes, including the National Clinical Audit and Patient Outcomes Programme (NCAPOP) on behalf of NHS England and the Welsh Government. Participation in NCAPOP is a mandatory requirement under the NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP) 2025–2026. This enables benchmarking against national standards through transparent data submission in line with HQIP guidance. This supports the Health Board in demonstrating performance that meets or exceeds national outcomes.
- Aneurin Bevan University Health Board is continually strengthening its clinical audit capability to:
 - Empower clinical teams to use audit data to inform and drive improvement, including improving data literacy
 - Apply robust clinical audit methodologies to support benchmarking and the consistent embedding of evidence-based standards of care
 - Use clinical audit data to inform population-based commissioning decisions and integrated care strategies
 - Build organisational capability to embed the patient voice within quality improvement and service redesign



National Clinical Audit Governance and Reporting Arrangements

- The Medical Director's Quality and Patient Safety (QPS) Team coordinates delivery of the Clinical Audit Plan with Clinical Leads, ensuring compliance with NCAPOP and the NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP).
- Divisions are supported to deliver audits, with participation, findings, and actions consistently documented and tracked.
- The Clinical Standards and Effectiveness Group (CSEG) provides multidisciplinary operational oversight of clinical audit findings, including the identification of risks and opportunities for improvement.
- Key themes and risks are escalated to the Quality Management Group (QMG), ensuring learning from audit informs the wider Quality Management System.
- Board-level assurance is provided through the Patient Quality, Safety, and Outcomes Committee (PQSOC).
- The Audit, Risk, and Assurance Committee (ARAC) oversees the robustness of audit governance arrangements.
- Together, these routes ensure a clear line of sight from front-line audit activity to corporate risk and Board assurance.



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Overview of National Clinical Audits: 2025/26



Reporting of National Clinical Audits aligned to the Annual Audit Plan and dates presented to CSEG in 2025/2026:

HQIPO Ref.		Name of publication	Publication date	Proposed Date	Actual date
NICOR	National Audit of Cardiac Rhythm Management (NACRM)	2023/2024 & 2024/2025	11/12/2025	CSEG Sep 2025	CSEG Mar 2026
NICOR	Myocardial Ischaemia National Audit Project (MINAP)	2023/2024	01/04/2025	CSEG Sep 2025	CSEG Nov 2025
NICOR	National Audit of Percutaneous Coronary Interventions (NAPCI)	2023/2025	01/04/2025	CSEG Sep 2025	CSEG Nov 2025
NICOR	National Heart Failure Audit (NHFA)	2023/2026	01/04/2025	CSEG Sep 2025	CSEG Sep 2025
641	Fracture Liaison Service Database (FLSD)	State of the Nation report	08/01/2026	CSEG Mar 2026	CSEG Feb 2026
639	National Bowel Cancer Audit (NBOCA)	State of the Nation report (England & Wales)	09/10/2025	CSEG Nov 2025	CSEG Feb 2026
635	National Non-Hodgkin Lymphoma Audit (NNHLA)	State of the Nation report (England & Wales)	11/09/2025	CSEG Nov 2025	CSEG Mar 2026
632	National Metastatic Breast Cancer Audit (NAoMe)	State of the Nation report (England & Wales)	11/09/2025	CSEG Nov 2025	CSEG Feb 2026
631	National Primary Breast Cancer Audit (NAoPri)	State of the Nation report (England & Wales)	11/09/2025	CSEG Nov 2025	CSEG Feb 2026

HQIPO Ref.		Name of publication	Publication date	Proposed Date	Actual date
616	National Respiratory Audit Programme (NRAP)	State of the Nation report - Children and young people’s asthma : Elements of care received by children admitted with near-fatal asthma	12/06/2025	No planned date	CSEG Feb 2026
605	National Emergency Laparotomy Audit (NELA)	State of the Nation report - Year 10	09/10/2025	No planned date	CSEG Jan 2026
583	National Early Inflammatory Arthritis Audit (NEIAA)	State of the Nation report 2026	09/10/2025	No planned date	CSEG Jan 2026
581	Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI)	Perinatal Mortality Surveillance 2025 State of the Nation report	12/06/2025	CSEG Nov 2025	CSEG Nov 2025
580	National Neonatal Audit Programme (NNAP)	State of the nation report 2026	09/10/2025	CSEG Nov 2025	CSEG Nov 2025
578	Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI)	Maternal Mortality Surveillance and Confidential Enquiry 2025 Report	09/10/2025	CSEG Nov 2025	CSEG Nov 2025
577	National Hip Fracture Database (NHFD)	State of the Nation report 2025	11/09/2025	CSEG Nov 2025	CSEG Nov 2025
576	Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People (EP12)	Annual report 2024	11/07/2025	CSEG Sep 2025	CSEG Sep 2025
574	National Vascular Registry (NVR)	State of the Nation 2025 report	13/11/2025	CSEG Jan 2026	CSEG Mar 2026
567	National Clinical Audit of Psychosis (NCAP)	State of the Nation report (Bespoke data)	13/02/2025	Previous year activity	CSEG May 2025

HQIPO Ref.	Name of publication		Publication date	Proposed Date	Actual date
545	National Maternity and Perinatal Audit (NMPA)	State of the Nation report (containing 5 years of data)	14/08/2025	No planned date	CSEG Nov 2025
535	National Paediatric Diabetes Audit (NPDA)	Annual Core State of the Nation Report (Year 3)	13/03/2025	Previous year activity	CSEG May 2025
519	National Lung Cancer Audit (NLCA)	State of the Nation report (England & Wales)	10/04/2025	No planned date	CSEG May 2025
501	Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI)	Perinatal confidential enquiry	12/12/2024	CSEG Nov 2025	CSEG Nov 2025
500	Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI)	Saving lives, improving mothers care report (2021-2023, UK wide)	10/10/2024	CSEG Nov 2025	CSEG Nov 2025
466	Sentinel Stroke National Audit Programme (SSNAP)	State of the Nation 2024	14/11/2024	Previous year activity	CSEG Sep 2025
464	National Non-Hodgkin Lymphoma Audit (NNHLA)	State of the Nation report (01/01/2022-31/12/2022 Eng, 01/01/2023-31/12/2023 Wales)	12/09/2024	Previous year activity	CSEG May 2025

National Clinical Audit – Actions within Aneurin Bevan University Health Board

National clinical audit reports provide evidence-based recommendations to support the delivery of best practice and greater standardisation of services across the United Kingdom. However, differences in service models and commissioning arrangements mean that recommendations must be considered in context to ensure they are appropriate and deliver meaningful improvement within NHS Wales.

Actions arising from national and locally agreed recommendations are recorded and monitored through AMaT by the Quality and Patient Safety Team. The pace of delivery varies depending on complexity, service pressures, and resource requirements, and it is common for actions to extend across audit cycles or for multiple reports to be reviewed concurrently. During 2025/2026, 27 national clinical audit reports were presented to CSEG. Of these, three reports had actions remaining open from the previous reporting period. These relate to: National Audit of Cardiac Rhythm Management (NACRM), the National Emergency Laparotomy Audit (NELA), and the National Hip Fracture Database (NHFD), where actions remain subject to ongoing resource, funding, or service model considerations. Continued oversight through governance forums ensures these actions remain visible and are progressed appropriately, providing assurance that learning from audit continues to inform improvement and risk management.

Project name	Name of publication	Publication date	CSEG	Fully complete	Partially complete (open)	Partially Complete (overdue)	Overdue	New/Ongoing	Unable to complete	Action no longer relevant	Total Actions	Actions due date (latest)	Open/ Closed
National Audit of Cardiac Rhythm Management (NACRM)	2023/24 & 2024/25 (two reports)	11/12/2025	CSEG Mar 2026	1				4	*1		6	31/03/2027	Open
Myocardial Ischaemia National Audit Project (MINAP)	2023/2024	01/04/2025	CSEG Nov 2025					2			2	01/06/2026	Open
National Audit of Percutaneous Coronary Interventions (NAPCI)	2023/2024	01/04/2025	CSEG Nov 2025	2				1	*1		4	30/06/2026	Open

*NACRM - Specialist services are commissioned outside of the Health Board therefore not within ABUHB control
*NAPCI - Lead interventional cardiology services are outside of ABUHB (C&VUHB)

Project name	Name of publication	Publication date	CSEG	Fully complete	Partially complete (open)	Partially Complete (overdue)	Overdue	New/Ongoing	Unable to complete	Action no longer relevant	Total Actions	Actions due date (latest)	Open/ Closed
National Heart Failure Audit (NHFA)	2023/2024	01/04/2025	CSEG Sep 2025	1	*1			14			16	30/11/2026	Open
Fracture Liaison Service Database (FLSD)	State of the Nation report	08/01/2026	CSEG Feb 2026	2				3			5	21/12/2026	Open
National Bowel Cancer Audit (NBOCA)	State of the Nation report (England & Wales)	09/10/2025	CSEG Feb 2026	4				1			5	31/07/2027	Open
National Non-Hodgkin Lymphoma Audit (NNHLA)	State of the Nation report (England & Wales)	11/09/2025	CSEG Mar 2026	1				1			2	01/07/2026	Open
National Metastatic Breast Cancer Audit (NAoMe)	State of the Nation report (England & Wales)	11/09/2025	CSEG Feb 2026	1				6			7	24/08/2026	Open
National Primary Breast Cancer Audit (NAoPri)	State of the Nation report (England & Wales)	11/09/2025	CSEG Feb 2026	2				5			7	24/08/2026	Open
National Respiratory Audit Programme (NRAP)	State of the Nation report - Children and young people's asthma : Elements of care received by children admitted with near-fatal asthma	12/06/2025	CSEG Feb 2026	3							3	N/A	Closed
National Emergency Laparotomy Audit (NELA)	State of the Nation report - Year 10	09/10/2025	CSEG Jan 2026					3			3	31/08/2026	Open

Project name	Name of publication	Publication date	CSEG	Fully complete	Partially complete (open)	Partially Complete (overdue)	Overdue	New/Ongoing	Unable to complete	Action no longer relevant	Total Actions	Actions due date (latest)	Open/ Closed
National Early Inflammatory Arthritis Audit (NEIAA)	State of the Nation report 2026	09/10/2025	CSEG Jan 2026	1							1	N/A	Closed
National Neonatal Audit Programme (NNAP)	State of the nation report 2026	09/10/2025	CSEG Nov 2025					2			2	01/09/2026	Open
National Hip Fracture Database (NHFD)	State of the Nation report 2025	11/09/2025	CSEG Nov 2025	1				4			5	01/06/2026	Open
Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People (EP12)	Annual report 2024	11/07/2025	CSEG Sep 2025	1					*1		2	N/A	Closed
National Vascular Registry (NVR)	State of the Nation 2025 report	13/11/2025	CSEG Mar 2026	1							1	N/A	Closed
National Clinical Audit of Psychosis (NCAP)	State of the Nation report (Bespoke data)	13/02/2025	CSEG May 2025	6							6	N/A	Closed
National Maternity and Perinatal Audit (NMPA)	State of the Nation report (containing 5 years of data)	14/08/2025	CSEG Nov 2025	5	*1			3			6	31/05/2026	Open
National Paediatric Diabetes Audit (NPDA)	Annual Core State of the Nation Report (Year 3)	13/03/2025	CSEG May 2025						*1		1	27/11/2025	Open

*EP12 – This action relates to the EEG waiting times, which has been raised across two specialties, Paediatrics and Neurophysiology
*NPDA – The business case was for additional staffing, but did not consider the staffing required from increased workloads
*NMPA – Part of the action remains in the control of HEIW and NHS Wales

Project name		Name of publication	Publication date	CSEG	Fully complete	Partially complete (open)	Partially Complete (overdue)	Overdue	New/Ongoing	Unable to complete	Action no longer relevant	Total Actions	Actions due date (latest)	Open/ Closed
National Lung Cancer Audit (NLCA)		State of the Nation report (England & Wales)	10/04/2025	CSEG May 2025	4					*3		7	N/A	Closed
Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI)	Perinatal Mortality Surveillance 2025 State of the Nation report		12/06/2025	CSEG Nov 2025	3				3			6	31/05/2026	Closed
	Maternal Mortality Surveillance and Confidential Enquiry 2025 Report		09/10/2025											Closed
	Perinatal confidential enquiry		12/12/2024											Closed
	Saving lives, improving mothers care report (2021-2023, UK wide)		10/10/2024											Closed
Sentinel Stroke National Audit Programme (SSNAP)		State of the Nation 2024	14/11/2024	CSEG Sep 2025	1					*3		4	N/A	Closed
National Non-Hodgkin Lymphoma Audit (NNHLA)		State of the Nation report 01/01/2023-31/12/2023 Wales)	12/09/2024	CSEG May 2025	N/A as first round of audit (also presented in Mar 2026 – See above)									

*NLCA -
1 - National roll out inhibiting this action. ABUHB Clinical Lead joined National Steering Committee for implementation of new enterprise.
2 - This is a combine action between C&VUHB, WG, Velindre and AWMGS and affected by national resource shortages
3 – This measure is dictated by All Wales Medical Genomics Service at national level

*SSNAP - Key Changes in Stroke metrics anticipated to impact negatively on all stroke centres

Fully complete	40	42%
Partially complete (open)	2	2%
Partially complete (overdue)	0	0%
Overdue	0	0%

New/Ongoing	49	52%
Unable to complete	10	11%
Action no longer relevant	0	0%
	95	

New/ongoing actions are chased by the QPS team on a regular basis. One processes does not fit all actions, so they are managed individually and AMaT is updated to reflect accurate results.

National Clinical Audit – Assurance and Risk

Clinical Leads are responsible for determining the appropriate level of service assurance and assigning the associated risk rating for each audit. They also decide whether the audit should be recorded on the relevant divisional or directorate risk register. CSEG subsequently reviews these assessments and agrees whether escalation to the corporate risk register is required. For the 27 audits presented to CSEG during 2025/2026, the agreed assurance and risk ratings were as follows:



Project name	Assurance Level	Risk Level	Risk Register
Sentinel Stroke National Audit Programme (SSNAP)	Limited	Major	Yes
Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People (EP12)	Limited	Major	Yes
National Respiratory Audit Programme (NRAP)	Significant	Moderate	No
National Hip Fracture Database (NHFD)	Limited	Moderate	No
Myocardial Ischaemia National Audit Project (MINAP)	Significant	Minor	No
National Metastatic Breast Cancer Audit (NAoMe)	Limited	Minor	No
National Primary Breast Cancer Audit (NAoPri)	Significant	Minor	No
National Heart Failure Audit (NHFA)	Significant	Minor	No
Fracture Liaison Service Database (FLSD)	Significant	Minor	No
National Emergency Laparotomy Audit (NELA)	Significant	Minor	No
National Clinical Audit of Psychosis (NCAP)	Significant	Minor	No
National Paediatric Diabetes Audit (NPDA)	Significant	Minor	No
National Audit of Cardiac Rhythm Management (NACRM) 2023/2024 & 2024/2025	Significant	Minor	No

Project name	Assurance Level	Risk Level	Risk Register
National Bowel Cancer Audit (NBOCA)	Significant	None	N/A
National Non-Hodgkin Lymphoma Audit (NNHLA)	Significant	None	N/A
National Early Inflammatory Arthritis Audit (NEIAA)	Full	None	N/A
National Neonatal Audit Programme (NNAP)	Significant	None	N/A
National Vascular Registry (NVR)	Full	None	N/A
National Audit of Percutaneous Coronary Interventions (NAPCI)	Full	None	N/A
National Maternity and Perinatal Audit (NMPA)	Full	None	N/A
National Lung Cancer Audit (NLCA)	Significant	None	N/A
Perinatal Mortality Surveillance 2025 State of the Nation report	Full	None	N/A
Maternal Mortality Surveillance and Confidential Enquiry 2025 Report	Full	None	
Perinatal confidential enquiry	Full	None	
Saving lives, improving mothers care report (2021-2023, UK wide)	Full	None	
National Non-Hodgkin Lymphoma Audit (NNHLA)	Significant	None	N/A

89% Full/Significant Assurance
85% None or

Minor Risk

The audits with Limited Assurance: Metastatic Breast Cancer, Hip fracture Database, Epilepsy 12, SSNAP

Full & Significant Assurance equate to 89% & no or minor risk 85% in relation National Clinical Audits.

Assurance		
Full	8	31%
Significant	15	58%
Limited	3	12%
Very Limited	0	0%
	26	

Risk		
None	13	50%
Minor	9	35%
Moderate	3	12%
Major	1	4%
Catastrophic	0	0%
	26	

Limited Assurance - Issues are being progressed via the Clinical Lead and are captured on the Directorate risk register. For 2026–27, the QPS Team will support the Directorate to ensure robust action plans are in place, with clear escalation, governance oversight and evidence of progress and delivery

National Metastatic Breast Cancer Audit (NAoMe) – Limited Assurance

(Relatively new processes around Metastatic Breast CA)

Dataset extremely limited across Wales and England.

Major challenge to identifying all metastatic patients, especially:

- Those presenting via emergency admissions
- Those managed only in oncology without re-referral to breast surgery
- Those with recurrence not coded as such

New Metastatic Breast Clinical Nurse Specialist (Sept 2025), acts as keyworker across acute and oncology services enables consistent patient tracking which is expected to significantly improve:

- MDT capture
- Treatment documentation
- Patient experience

National Hip Fracture Database (NHFD) – Limited Assurance

- Admission delays remain a major challenge, patients spend >15 hours in A&E before transfer to orthopaedic ward.
- Delay in surgery beyond 36 hours in 40% of patients
- Mobilisation POD1 is persistently low (68.7% vs 82% national), largely due to weekend and holiday physiotherapy gaps.
- Lack of ring-fenced beds for trauma patients
- Theatre space constraints
- Trauma review meeting overdue for >1 year; spinal priorities have delayed hip fracture pathway review.

Risk register: escalated to directorate risk register.

- Ring-fencing at least two beds for hip fracture patients, similar to UHW model (empty beds created when patients arrive).
- Monthly governance meetings already review run charts; QI projects underway to engage nursing staff in mobilisation.

Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People (EP12) – Limited Assurance/Major Risk

Significant improvement in most KPIs however:

- Major concern (KPI 1): Only 14% of children seen by epilepsy specialist within 2 weeks (down from 80% (Uncertainty over definition of “first paediatric assessment”).
- MRI within 6 weeks (KPI 5) also underperforming due to clinical appropriateness issues.
- Consultant unavailability extending waiting lists and data entry to audit (anticipated cohort 8 better for ABUHB)
- Need to improve waiting time for EEG’s which will hopefully improve MRI waiting times

Sentinel Stroke National Audit Programme (SSNAP) – Limited Assurance/Major Risk

- New stroke metrics (Oct 2024) anticipated to impact negatively on all stroke centres, and is a challenge for ABUHB to meet KPI’s
- Ring-fencing stroke beds breached by General Medicine patients also impacting Stroke Ward capacity for Stroke patients
- Thrombectomy rates best in Wales, Wales national rate 2.7%, ABUHB rate 4.6%, highest performing sites across the UK are 8-10%, SSNAP recommends 10-12% (based on Jan – Dec 2025)
- Consultant review <14hrs is the KPI and Jan – Dec 2025 ABUHB 58.6% compared to Wales national average 45.1%
- Need for organisational support for ring-fencing beds and therapy staffing rates
- ABUHB would benefit form CT perfusion to extend treatment window from 4.5 hrs to 9 hrs which provide an opportunity to increase Thrombectomy rates.

National Clinical Audit highlights for 2025/2026

Introduction of a new Haematology MDT proforma has improved staging documentation for Non-Hodgkin Lymphoma patients.
Embedding NICOR datasets into AMaT to enable real-time tracking for heart failure care. This will allow the HF specialist nurses to access results and act promptly to any areas of concern
National Paediatric Diabetes Audit – No longer an outlier for HbA1c, improvements due to better use of available technologies
National Lung Cancer Audit – High surgical resection rates, improved early-stage diagnosis, and participation in national research
National Heart Failure Audit – Nurse-led service across all sites, high medication optimisation performance
Myocardial Infarction National Audit Programme & National Audit Percutaneous Coronary Intervention –excellent echo completion rates, NSTEMI angiography before discharge at 94%
National Maternity Perinatal Audit – Strong performance in core maternity indicators with lower-than-expected adverse outcome rates
Epilepsy 12 audit - Significant improvements in care planning
Cardiology and Cardiac Intervention Improvements in Intracoronary imaging use at 96%
Stroke - Improvements in ring-fenced stroke beds and thrombectomy access, with the highest thrombectomy rate in Wales – however improvements can still be achieved
Neonatal Retinopathy of Prematurity - GUH no longer an alert-level outlier & Lowest mortality rates compared with UK average with excellent follow-up (97% at two years)
National Early Inflammatory Arthritis Audit – No longer negative outlier, now a positive outlier status for patients seen within 3 weeks
Fracture Liaison Service-Database - Second award in a consecutive two-year period



National Clinical Audit – Summary of Successes and Concerns May 2025

Clinical Standards and Effectiveness Group	Successes	Concerns
National Lung Cancer Audit - State of the Nation Report (England & Wales)	- Improved early-stage diagnosis and curative treatment rates - Participation in national research on circulating tumour DNA	- Delays in diagnosis and treatment - Need for lung cancer screening in Wales
National Paediatric Diabetes Audit - Annual Core State of the Nation Report (Year 3)	- No longer an outlier - Reduction in median HbA1c - Improved completion of care processes - Increased numbers of CYP on Hybrid closed loop pumps	- Difficulty achieving 4 MDT appointments/year. - Retinopathy screening outside local control.
National Clinical Audit of Psychosis - State of the Nation Report (Bespoke data)	- Physical health monitoring and interventions (74%) - Carer focussed education and support (89%) - High uptake of family interventions and supported employment - Real-time data collection now in place	- Access and Waiting Time (23%) - Administrative errors in data submission - Need for better awareness and referral pathways
National Non-Hodgkin Lymphoma Audit - State of the Nation	- New MDT proforma implemented to improve staging documentation. - New patients with NHL always see a CNS - One-year overall survival for both low- and high-grade NHL comparable with rest of UK	- 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 - Data not analysable due to format incompatibility with NATCAN - Staging documentation needs improvement - Significant data gaps (not unique to ABUHB, due to way data is captured in Wales)



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Concerns identified within each National Clinical Audit are addressed through the development of SMART action plans, ensuring that areas of non-compliance are clearly defined, managed, and monitored to resolution.

National Clinical Audit – Summary of Successes and Concerns September 2025

Clinical Standards and Effectiveness Group	Successes	Concerns
Epilepsy12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People - Annual Report 2024	• Significant improvement in KPI2 – Children and YP seen by an ESN within the first year of care • Improvement in KPI4 – Children and YP with convulsive seizures had an ECG within the first year of care (94% vs 55% in cohort 5) • Significant improvement in assessing/asking for mental health KPI 6 (87% vs 15% in cohort 5) • Significant improvement in documented evidence of care planning KP1 9B (93% vs 76% in cohort 5)	• Not able to see children and young people within 2 weeks (KP1) by consultants with expertise in epilepsy (14%) • Failing to achieve MRI within 6 weeks of request (33%) • Continue struggling with backlog and significant delays in getting an EEG. However, this has improved since previously year.
National Heart Failure Audit (NHFA)	• Nurse-led service expanded across all sites • Improved discharge planning and cardiac rehab referrals • Medication prescribing above national average	• No dedicated acute heart failure service • No provision for preserved ejection fraction patients • Lack of live tracking for inpatient service
SSNAP - Sentinel Stroke National Audit Programme - State of the Nation 2024	• Successes/Concerns – Due to the new metrics performance has reduced however this was expected • Significant changes to measurements • Old measures not comparable to new measures • Raised the expectation on delivery of stroke services • Expected that most hospitals will revert to D/E grading • Most recent quarter (Jan-Mar 2025) not released to the public	



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National Clinical Audit – Summary of Successes and Concerns November 2025

Clinical Standards and Effectiveness Group	Successes	Concerns
National Neonatal Audit Programme - State of the Nation Report 2026	• Mortality lower than national average (Wales: 5.8 vs UK: 6.4). • Low rates of brain injury (PHVD, cystic PVL). • High parental involvement (consultation and ward rounds). • 2-year neurodevelopmental follow-up at 97% (commended nationally). • Nurse staffing above national average.	• Non-invasive ventilation (NIV) rates: Alarm-level outlier (30% vs national 51%). • ROP screening: Improving but still below national average (68% vs 80%). • Breastfeeding rates: Below national average at discharge (~50–60%). • Antenatal magnesium sulphate and steroid administration: Slightly below benchmarks.
National Hip Fracture Database - State of the Nation 2025 Report	• Prompt ortho-geriatric assessment (top quartile) (KPI 1) • Low delirium post-op (KPI 5) • Strong bone health prescribing (KPI 7) • High return to original residence • Mortality at 1-month significantly better than national with recent commendation.	• Admission to Orthopaedic ward (KPI 0) • Adequate physiotherapy cover for prompt out of bed (KPI 4)
National Maternity and Perinatal Audit - State of the Nation Report (containing 5 years of data)	• Rates as expected: readmissions, vaginal tears, PPH, preterm birth • Rates lower than expected: induction of labour, term baby apgar scores < 7 , episiotomy rates • Benchmarking	• Data completeness • Rates higher than expected: SGA, late booking after 10 weeks gestation • Lower rates of VBAC



National Clinical Audit – Summary of Successes and Concerns November 2025

Clinical Standards and Effectiveness Group	Successes		Concerns
Perinatal confidential enquiry Saving lives, improving mothers care report (2021-2023, UK wide) Perinatal Mortality Surveillance 2025 State of the Nation Report Maternal Mortality Surveillance and Confidential Enquiry 2025 Report	- Maternal deaths: Thrombosis remains leading cause; disparities by ethnicity and deprivation persist. - Perinatal deaths: Stillbirth and neonatal mortality improving overall; worse for <31 weeks gestation.		
Myocardial Ischaemia National Audit Project (MINAP)	- Almost all patents are seen by a cardiologist and admitted to a cardiac ward - Angiography rates are high in NSTEMI and above the national average - Echocardiography and cardiac rehabilitation offer rates are high and exceed the national average	- Poor door to needle times in STEMI reflect skewed case mix and lack dedicated service ** (BUSINESS CASE IN) - Delays to IP angiography reflect staffing and lab time - Slight concern re secondary prevention meds – requires further ix but may reflect less clear evidence base some medications in lower risk cases	
National Audit of Percutaneous Coronary Interventions (NAPCI)	- The use of intracoronary imaging in unprotected left main coronary stenting is now mandatory in the standard practice. Both intracoronary imaging modalities namely intra vascular ultrasound (IVUS) and optical coherence tomography (OCT) are available. Trainees in Percutaneous coronary intervention are also encouraged to use these devices when performing left main coronary stenting - The treatment of left main coronary stenting with ICI in our centre is associated with favourable long-term outcomes when compared with the national benchmark figures - Trend of drug eluting balloon use is similar to national trend		Data capture for the use of P2Y12 remains a challenge

National Clinical Audit – Summary of Successes and Concerns January 2025

Clinical Standards and Effectiveness Group	Successes	Concerns
National Emergency Laparotomy Audit (NELA) – 10th Patient report. April 2023 – April 2024	• Mortality improved from 9.6% to 5.1%, the lowest in Wales and 23rd lowest of 169 UK hospitals • High pre-operative risk assessment compliance (94%), ensuring appropriate tripartite decision-making • Consultant presence for high-risk cases remains strong • Geriatrician review at 77%, well above national average • NELA M&M meetings continue to generate high-quality learning • Very low unplanned ICU readmission rate (0.7%), compared to national 3.5%	• Only 11.4% of immediate cases reach theatre within 6 hours (national 8.4%) • Antibiotic Timing - Significant data capture issues due to retrospective documentation & Risk of under-reporting true compliance • CT Reporting Communication - Only 6.2% cases had direct surgeon–radiologist communication documented (recent improvement to 11.7%) & radiology teams lack admin support to consistently complete documentation • Only 72% of high-risk patients admitted to ICU postoperatively (below national average 77%). • ICU occupancy regularly exceeds 85%, with unmet need frequently observed. • Limited ICU bed base relative to population demand • Frailty assessment and accuracy needs improving with more COTE involvement for frail older patients & requirement of NELA nurse practitioner to help pre-op pathway and COTE consultant • NELA dataset largely completed by clinicians, leading to incomplete or inaccurate entries.
National Early Inflammatory Arthritis Audit (NEIAA) - Data Collection Period: 1 April 2024 – 31 March 2025	Outstanding Performance – Now a Positive Outlier • 80% of patients start DMARD treatment within 6 weeks (national 60%) • 66% seen within 3 weeks of referral (national 43%) • 21-day average GP referral → clinic wait (national 32 days) • Second best performing Health Board in Wales • Remission rate at 71%, significantly improved • Increased recruitment for connective tissue diseases and Giant Cell Arteritis (GCA) • Effective use of new NEIAA dashboards at Directorate and Clinical Implementation Network (CIN) levels • Significant reversal from previous outlier status (clinic booking issues now resolved)	• Psychological Support - Only 14% of patients across the UK have psychology access; not available in ABUHB rheumatology.



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National Clinical Audit – Summary of Successes and Concerns February 2025

Clinical Standards and Effectiveness Group	Successes		Concerns
NRAP - National Respiratory Audit Programme - State of the Nation Report - Children and young people's asthma: Elements of care received by children admitted with near-fatal asthma	• Primary care education days • New pathway adopted with recent audit interactions • Better, earlier diagnosis of asthma • Data capture		• Prednisolone within 1 hr • Primary care follow up with 2 days • Hospital FU with 4 weeks • Documentation of smoking and interventions
National Bowel Cancer Audit - State of the Nation Report (NBCA)	• Data completion and submission is high quality. Good administrative support for Cancer coordinator • Perioperative Surgical quality of care and outcomes meet and, in some criteria, exceed national standards • Good input into the MDT from Oncologists, gastroenterology and Liver surgical team to help with complex cases • Established Early rectal cancer assessment and surgery within ABUHB through SPECC MDT and dedicated surgeons undertaking TAMIS procedure. Introduction of Robotic surgery for CRC		• Delay in Diagnostic pathway, mainly endoscopy. This is being addressed through vetting • Delay in Ileostomy closure- now being addressed with renewed process in place
National Audit of Primary Breast Cancer (NAoPri) - State of the Nation Report 2025	• Patients now have one stop triple assessment service this data will improve once we get to 2024 data point • Excellent 3-year breast cancer specific survival	• Data inputting to the audit remains an issue. It is too much work for one person and does not reflect the service • Data for performance status difficult to capture • Low rates of immediate breast reconstruction being offered – but unlikely to be captured correctly and also likely lower due to the COVID pandemic	
National Audit of Metastatic Breast Cancer NAoMe) - State of the Nation Report – 2025	• There is now a metastatic breast cancer clinical nurse specialist in post this has made a significant difference to patients and indeed the identification of patients who present acutely to other specialities • Good documentation of contact with a clinical nurse specialist, this will only improve with our new metastatic breast cancer nurse in post • Good access for patients receiving chemotherapy de novo		• Good access for patients receiving chemotherapy de novo • Still awaiting in house testing of Her 2 • Need to improve documentation of WHO performance criteria
Fracture Liaison Service Database (FLS-DB) Annual report	• NHS Performance and Improvement winners 2025 -2nd award in consecutive years	• DXA within 90 days – needs attention • Demand will rise - other speciality – Breast, Coeliac • Primary Care engagement and FU	

National Clinical Audit – Summary of Successes and Concerns March 2025

Clinical Standards and Effectiveness Group	Successes	Concerns
Non-Hodgkin Lymphoma State of the Nation Report 2025	- Performing above average in terms of CNS review for patients being diagnosed with both low grade and high-grade lymphoma - Outcomes at 1 year comparable/in keeping with national average for low grade and high-grade lymphoma	- Data completeness for performance status and staging - Improving data for timely SACT to ensure more people getting chemotherapy within 62 days (it should be noted that there is no single pathway for investigation of possible lymphoma due to the nature of the disease)
National Audit of Cardiac Rhythm Management State of the Nation Report 2025	- Complete data entry - Meeting minimum numbers - Increase in implant numbers since the opening of Grange University Hospital	- Discrepancies in numbers - Poor access to EP for ABUHB patients - Poor data entry from tertiary centre making it difficult to benchmark
National Vascular Registry State of the Nation Report 2025	- Good quality service from the ABUHB IR department. - Good and timely carotid service - Good and timely lower limb revascularisation service	- SEWVN Major Lower Limb Amputation mortality – a) post op care b) consider palliation - SEWVN delay for AAA repair – continue to monitor



New procedure(s)/ Artificial Intelligence



Clinical specialties in the NHS are required to seek approval before introducing new clinical procedures or deploying AI-based tools to ensure **safety, legality, ethical compliance, and organisational readiness**. The key reasons include:

- Ensure Patient Safety and Minimise Clinical Risk
- To Meet Legal, Regulatory, and Data Protection Requirements
- Maintain Clinical Quality and Professional Standards
- To Ensure Appropriate Evaluation and Evidence of Effectiveness
- To Support Consistent, Scalable, and Safe Deployment Across the NHS
- Protect Patients’ Rights and Maintain Trust

RefluxStop procedure	
Purpose: Alternative to fundoplication for patients with poor oesophageal motility. Benefits: 97% off PPIs, low dysphagia rate, high patient satisfaction. NICE guidance supports procedure. Training: Structured programme with proctoring for 20 cases.	
Outcome: Approved	
Capsule Colon	
Purpose: Non-invasive alternative to colonoscopy. Minimally invasive, outpatient based. Potential to reduce waiting times. Plan: Start with 1 procedure/week, review in January.	
Outcome: Approved	
Cytosponge	
Purpose: Minimally invasive Barrett’s surveillance alternative to Endoscopy. Trial Phase: Assess feasibility and patient uptake. Lab: External UK lab handles analysis.	
Outcome: Approved	
Impella Assist Device	Conduction System Pacing
Purpose: Mechanical circulatory support for high-risk cardiac procedures. Discussion: • Concerns raised about NICE guidance being outdated (2016). • Need for medical device group scrutiny.	Purpose: More physiological pacing method for bradycardia patients Discussion: • Minimal additional risk; training and proctoring planned. • NICE IPG reference to be verified.
Outcome: Approved	Outcome: Approved
Biodegradable Embolisation for Greater Trochanteric Pain Syndrome (GTPS)	
Purpose: Image-guided embolisation of abnormal neovascularisation using biodegradable particles. Discussion: Successful ABUHB innovation in knee osteoarthritis embolisation. Demonstrated improvements in pain, function, PREMs and healthcare utilisation. Device is CE-marked & already used elsewhere in the UK. The proposal is a controlled pilot, not full-service rollout. Strong governance, consent, audit and stop-review points in place.	
Outcome: Approved for pilot of 30 cases	

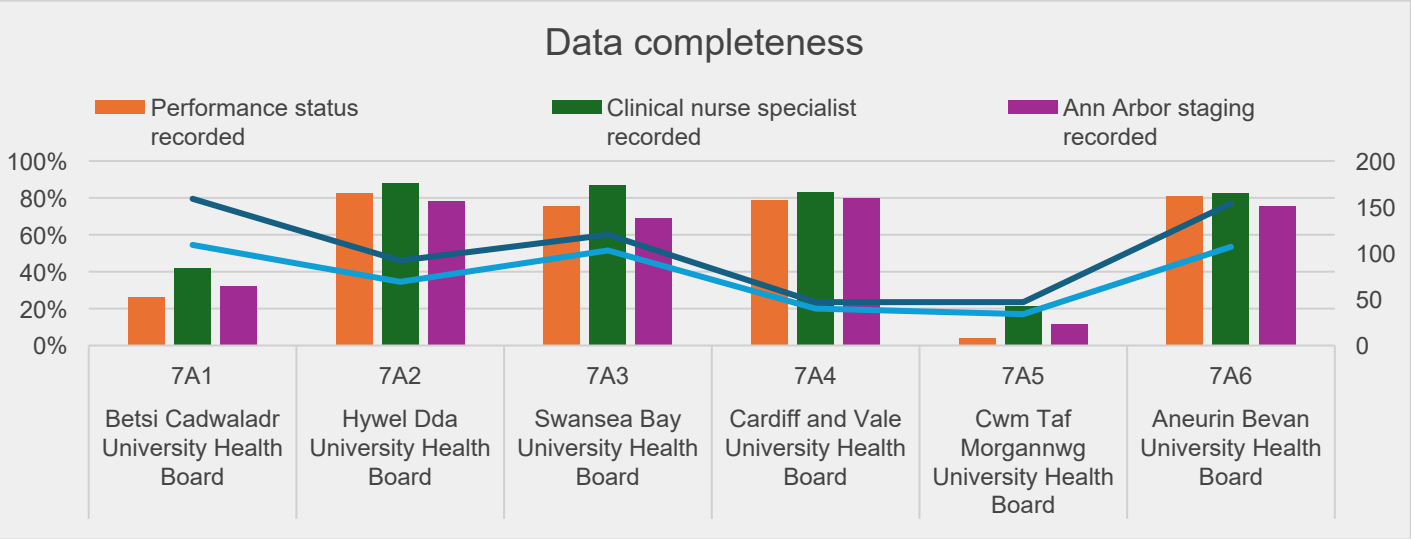
For Information

National Clinical Audits for 2025/26

The following pages present an overview of national clinical audit activity undertaken across Aneurin Bevan University Health Board aligned to the Annual Audit Plan for 2025/2026, demonstrating our continued commitment to excellence in patient care and continuous improvement.

National Non-Hodgkin Lymphoma Audit- 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:	The purpose of the National non-Hodgkin lymphoma Audit (NNHLA) is to evaluate the patterns of care and outcomes for patients with non-Hodgkin lymphoma in England and Wales, and to support services to improve the quality of care for these patients. The NNHLA is part of the National Cancer Audit Collaborating Centre (NATCAN), the home of the ten national cancer audits in England and Wales. This national centre of excellence was established to strengthen cancer services by evaluating the process of diagnosis and treatment, and patient outcomes in multiple cancer sites.				
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:		Assurance level	Description		
1	New patients with NHL always see a CNS	Significant	The project has mostly achieved the standards or criteria being audited against		
2	One-year overall survival for both low and high grade NHL comparable with rest of UK	Risk level	Description		
Report Concerns:		Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved		
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	Has this audit been placed on a Risk Register (N/A if above risk is None)			NO
2	Significant data gaps (not unique to ABUHB, due to way data is captured in Wales)	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
30/129					214/425

Data Completeness:



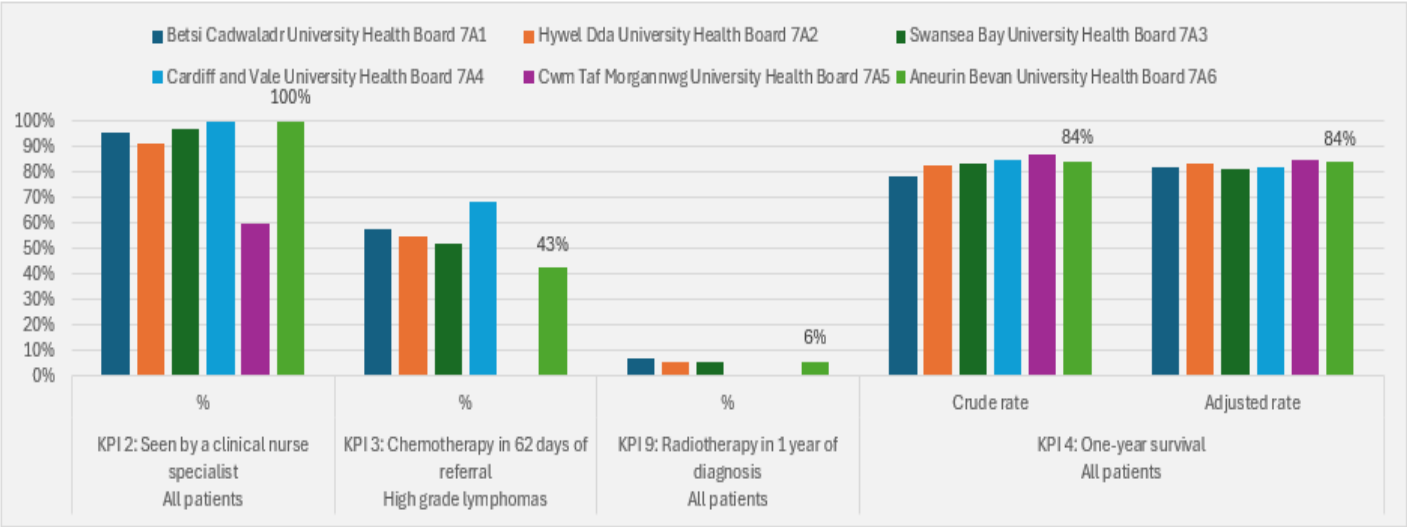
Key Message:
NHS trusts and MDTs should ensure key data items are submitted to cancer registries for all people diagnosed with NHL. Particular attention should be given to documentation of staging/prognostic indices, MDT records and CNS involvement in both England and Wales

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.

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: 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



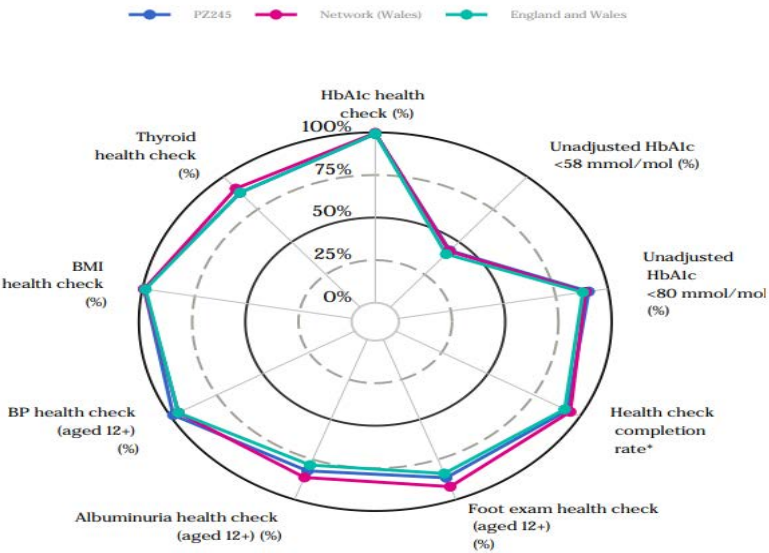
Due to current difficulties in radiotherapy capture with existing databases in Wales, only limited conclusions can be drawn from the current data provided for Wales; this may explain lower proportions of radiotherapy delivery in Wales compared to England.

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 <i>Wales 2022: 51.2%, ABUHB 43%</i>	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 <i>Ann Arbor Wales 60.0%, ABUHB 76%</i>	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
• <i>It should be noted that provider-specific results are subject to variation in data completeness, data quality, and the influence of random variation (i.e. the role of chance).</i> • <i>At this stage, a formal Healthcare Quality Improvement Partnership (HQIP) outlier process has not been applied. This reflects that, whilst there is sufficient confidence to report findings publicly, this represents the first iteration of provider-level reporting, with data completeness and quality still being tested and risk adjustment methodologies continuing to be developed. In the absence of a formal outlier process, where results indicate a potential area of clinical concern, providers will be contacted within one month of publication of the State of the Nation Report.</i> • <i>This will enable a structured dialogue to explore the underlying factors contributing to the findings, in line with HQIP guidance, and to agree any necessary actions. This approach is intended to support learning, validation and improvement, with a view to implementing a formalised outlier process once data maturity, completeness and risk adjustment methodologies are sufficiently robust.</i>		

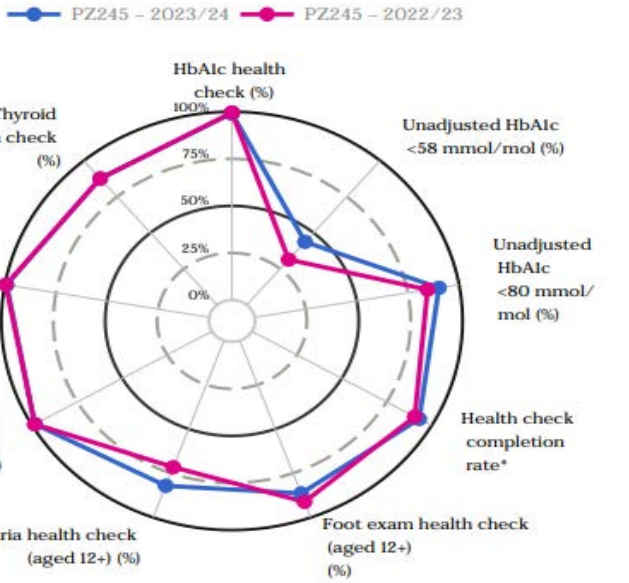
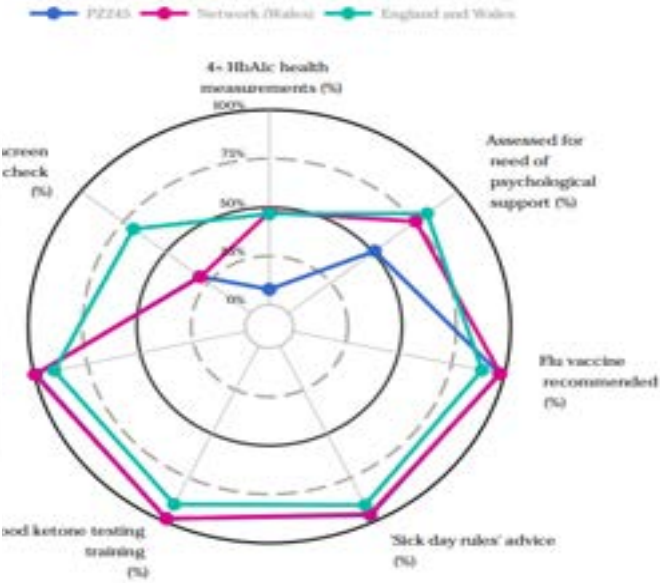
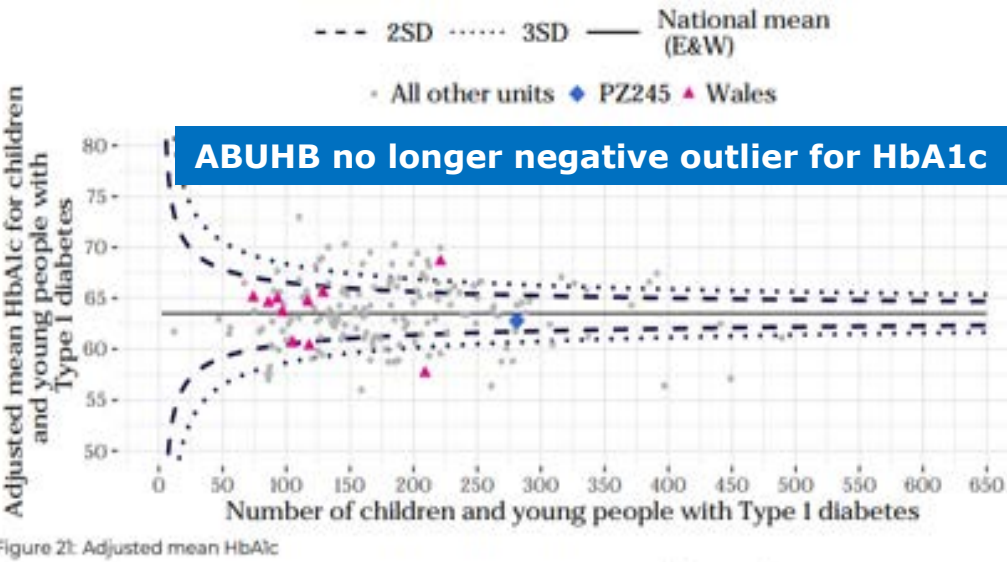
National Paediatric Diabetes Audit (NPDA) 2025 Report on Care and Outcomes 2023/24
Clinical Lead: Dr Davida Hawkes – Consultant Paediatrician

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.

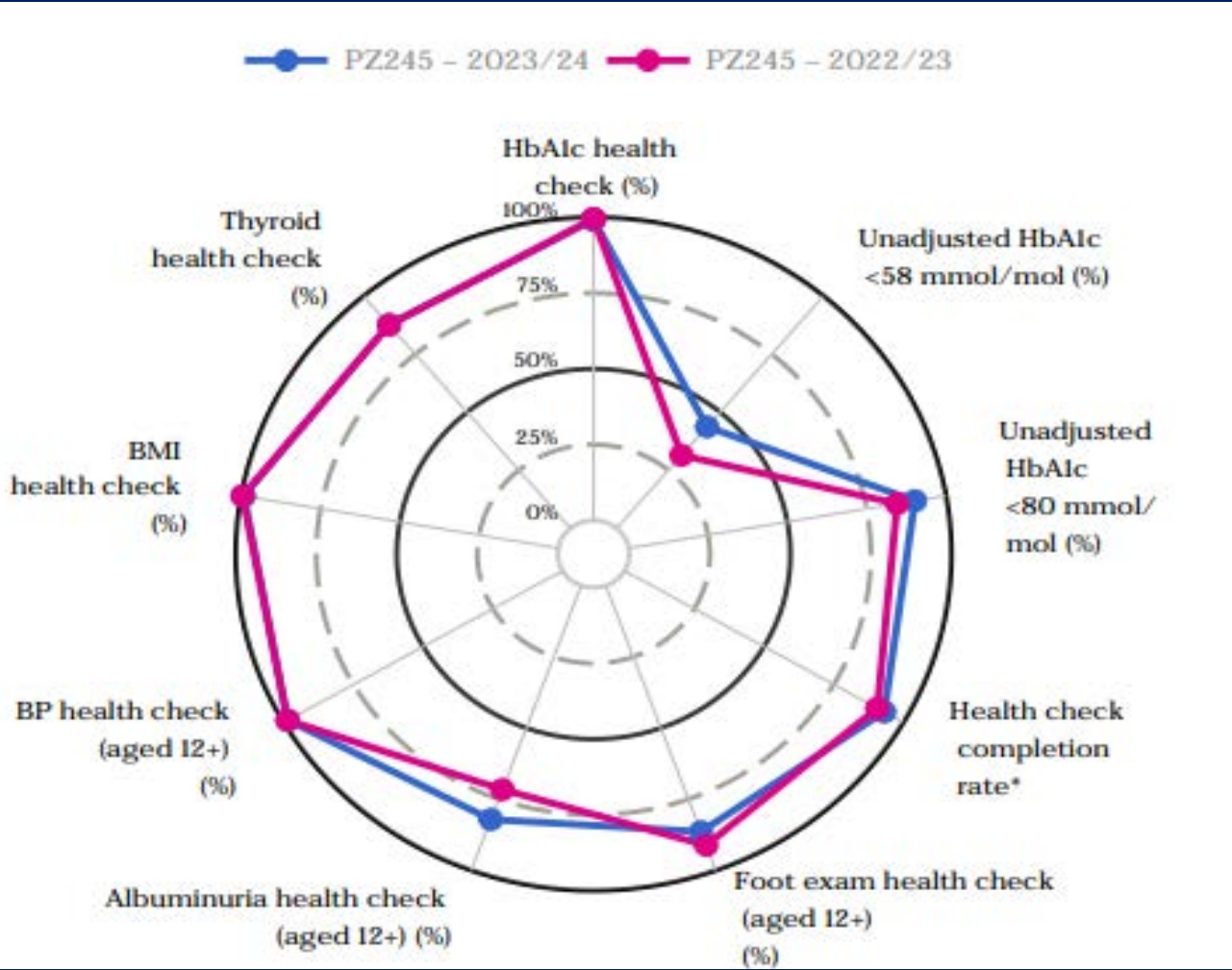
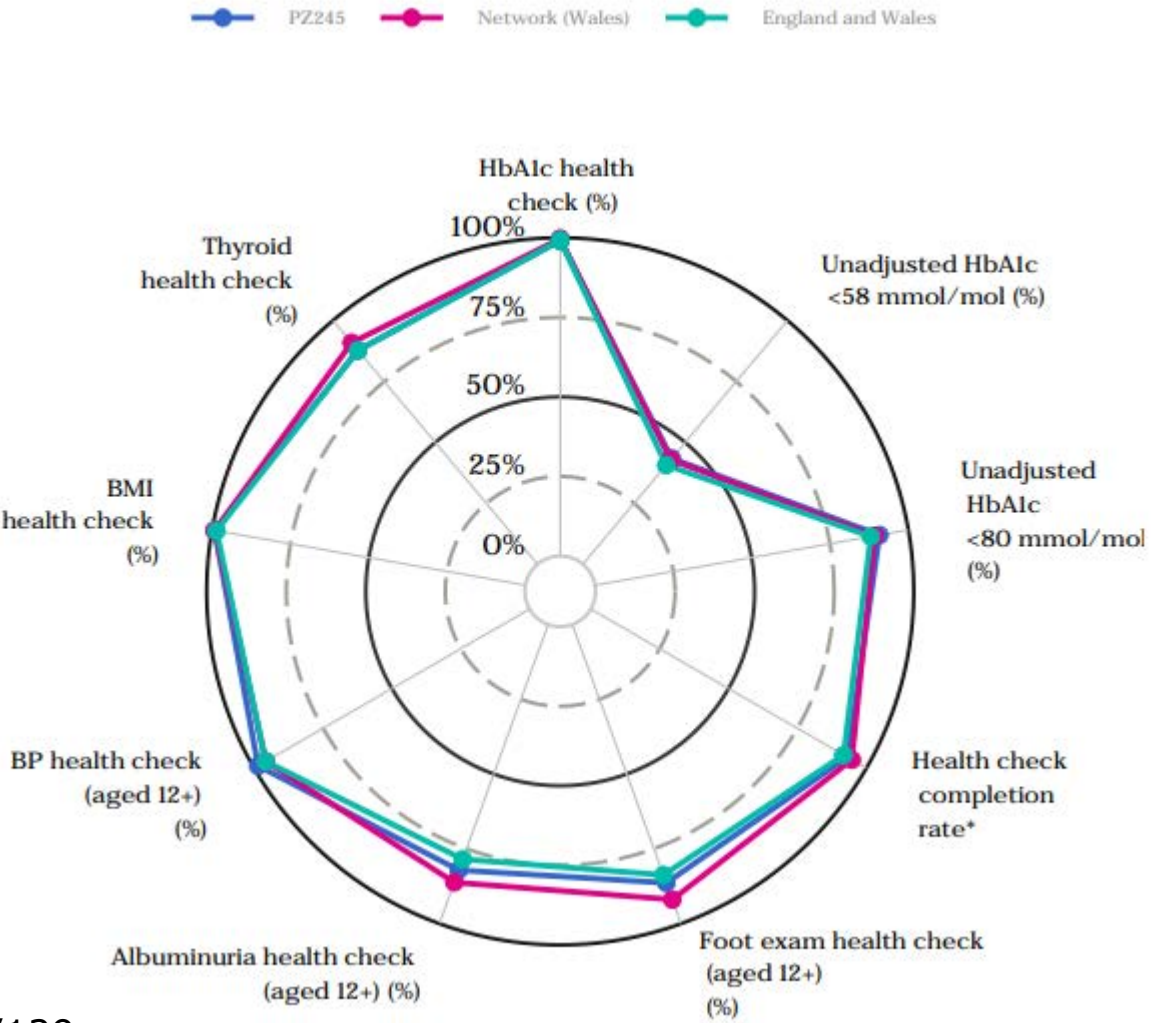


Above shows GUH Health Checks compared to national rates, below right, shows 2023/24 versus 2022/23 ABUHB and below left ABUHB additional Health Checks



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.

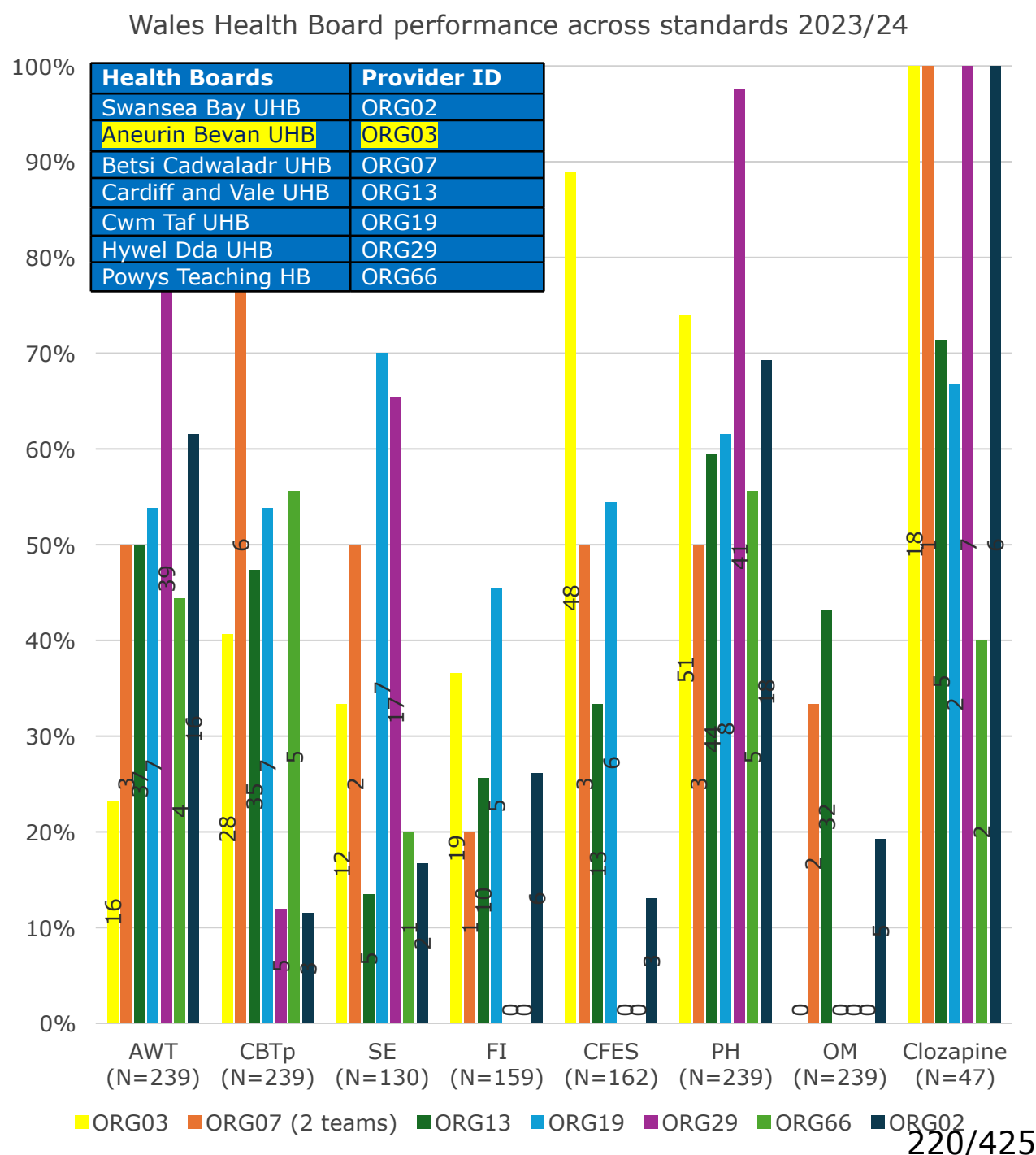


The Health Board has improved in relation to Unadjusted HbA1c <58mmol/mol & <80mmol/mol in 2023/24 compared to 2022/23 and has Albuminuria (aged 12+) with a slight reduction in foot examination

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				
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	Mar 2027
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	Achieved
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	Achieved
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	Achieved

35/129219/425

State of the Nation Report 2024 - Audit of Early Intervention in Psychosis 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:	Early Intervention in Psychosis (EIP) services provide care to people with psychosis and at-risk mental states (ARMS) by providing treatments in accordance with NICE recommended guidance. The Royal College of Psychiatrists National Clinical Audit of Psychosis (NCAP) monitors the performance of EIP services across England and Wales against standards which cover waiting times, Cognitive Behavioural Therapy for psychosis (CBTp), education and employment support, family and carer interventions, Clozapine medication, outcome measures plus physical health screening and interventions. NCAP began auditing EIP services in 2018 and provides feedback to EIP services at a team, trust, regional and national level, helping shape local provision in response to data trends.
Objectives:	Tracking change over time, involves repeated data collection to monitor progress against expected standards of care. Exploring variation between different parts of the health system, e.g. making comparisons between teams, Trusts/ Health Boards and regions. Examination of variation by health inequalities, such as age, gender and ethnicity, and identifying where improvement efforts could reduce inequalities. Providing Quality Improvement (QI) guidance to support initiatives to improve aspects of care measured by the audit.
Assurance level	Description
Significant	The project has mostly achieved the standards or criteria being audited against
Risk level	Description
Minor 36/129	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved

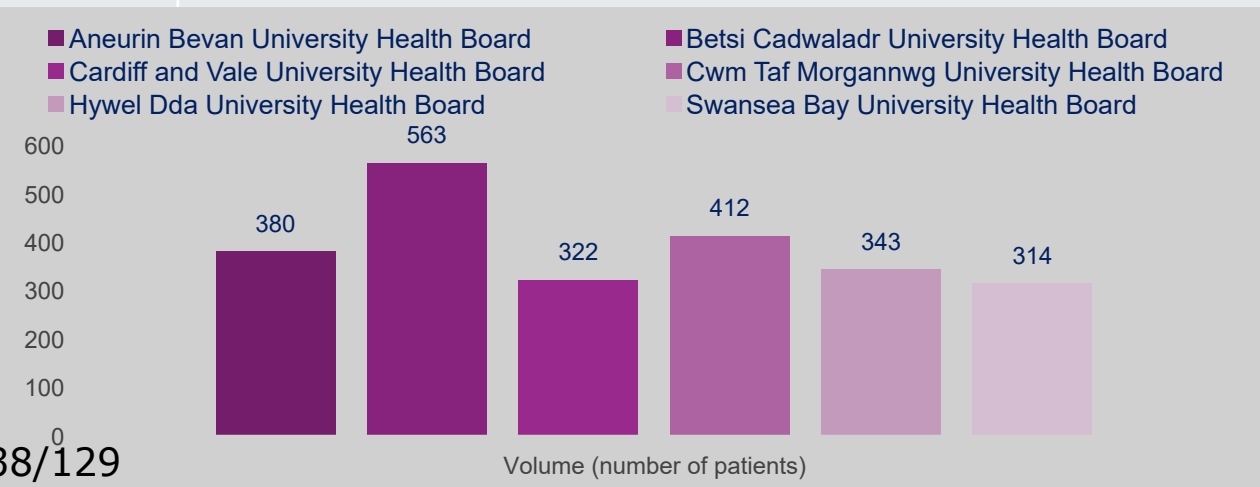


Report Successes:			Report Concerns:		
1	Physical health monitoring and interventions (74%)		1	Access and Waiting Time (23%)	
2	Carer focussed education and support (89%)		2	Outcome Measures (0%)	
3	Supported Education and Employment (33% taken up)		3	Provision for Children and Young People (BUT error 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	

37/129221/425

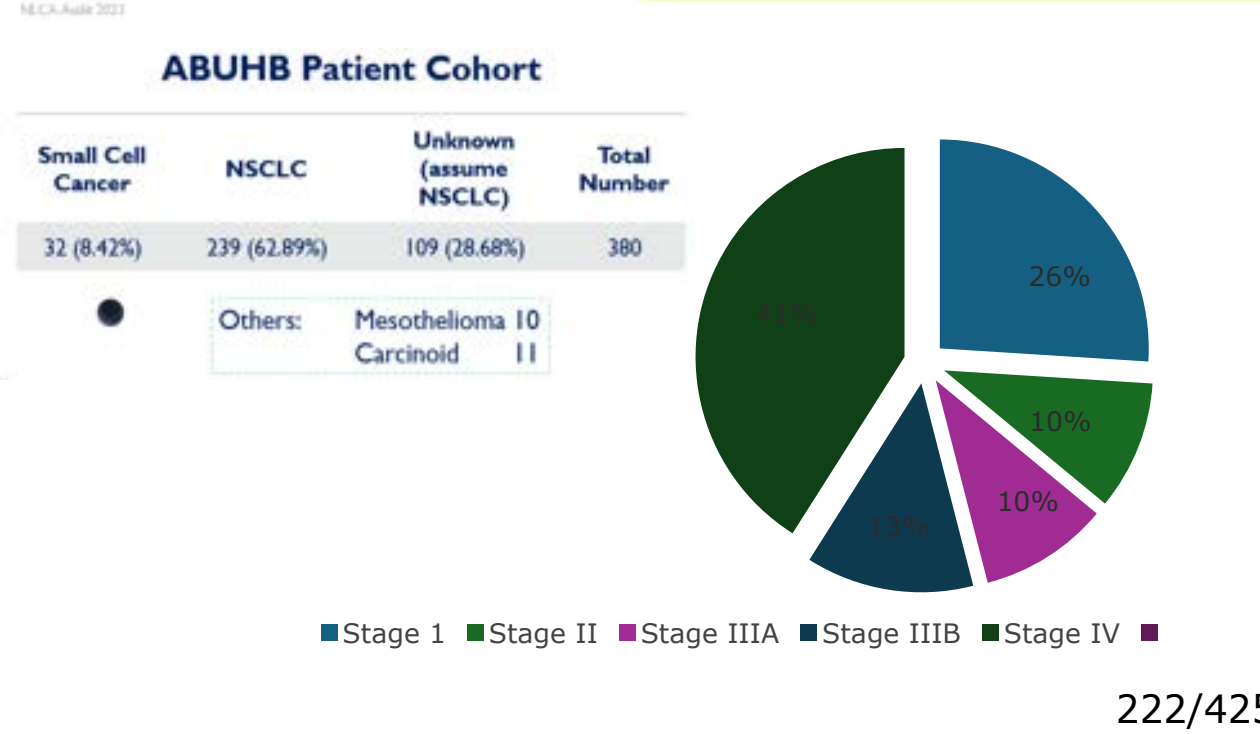
National Lung Cancer Audit - State of the Nation 2025
An audit of care received by people diagnosed with lung cancer in England and Wales during 2023
Clinical Lead: Dr Mat Jones – Medical Consultant
NICE:NG122, QS17

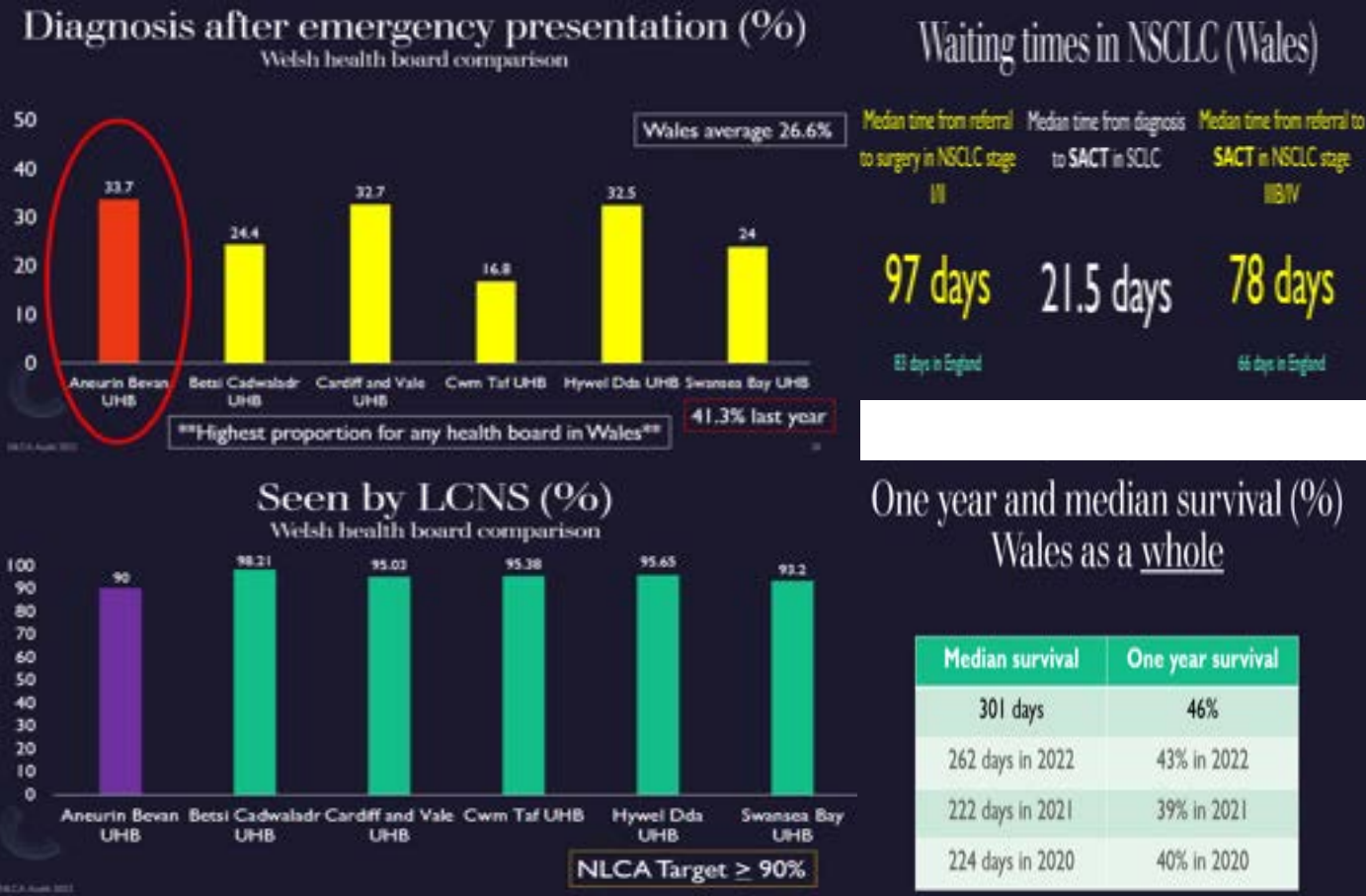
Rationale:	The aim of the National Lung Cancer Audit (NLCA) is to evaluate the patterns of care and outcomes for people with lung cancer in England and Wales, and to support NHS services to improve the quality of care for these individuals.
Objectives:	The management of people with lung cancer is informed by various national guidelines and the NLCA evaluates current patterns of care against the standards that these set. Specific standards were defined in: Quality Standard QS17 from the National Institute for Health and Care Excellence (NICE), the national commissioning guidance from the Lung Cancer Clinical Expert Group, and the National Optimal Lung Cancer Pathway. The NLCA has developed quality improvement goals and indicators using these standards and after consultations with its clinical reference group and Patient and Public Involvement (PPI) forum. The goals and indicators are described in the {NLCA Quality Improvement Plan}.



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

WALES	ABUHB
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.	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.





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. <i>The percentage of people with lung cancer diagnosed with stage 1/2 disease in Wales was 33.9% in 2023.</i> 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. <i>In Wales, 364 people had surgery in 2023, up from 276 in 2022.</i> 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. <i>In Wales during 2023, the proportion was 55.2%, a fall from 2022 (=60.1%)</i> 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. <i>In England and Wales, among key subgroups, most people diagnosed in 2023 did not start treatment within the recommended timeframes</i> Goal 4: Improve the quality of the patient pathway	All facets of the pathway to be assessed on an ongoing basis to ensure efficiency – breach 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. <i>England: Between 2017 and 2021, approx. 25% of people with stage 4 (PS 0-1) had genomic testing.</i> 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
41/129		225/425			

Epilepsy12 - 2025 combined organisational and clinical audits: Report for England and Wales

Clinical Cohort 6 – The first year of care for children and young people following a first paediatric assessment undertaken between 1 December 2022 and 30 November 2023

Clinical Lead(s):
Dr Nadeem Syed – Consultant Paediatrician

NICE guidance: [NG217 / QS211 Epilepsy12 Power BI tool](#)

Rationale: Epilepsy12, established in 2009, aims to support epilepsy services and health commissioners in assessing and improving the quality of care for children and young people with seizures and epilepsy. Epilepsy is the most common serious long-term neurological condition in childhood, affecting approximately 112,000 children and young people in the UK.

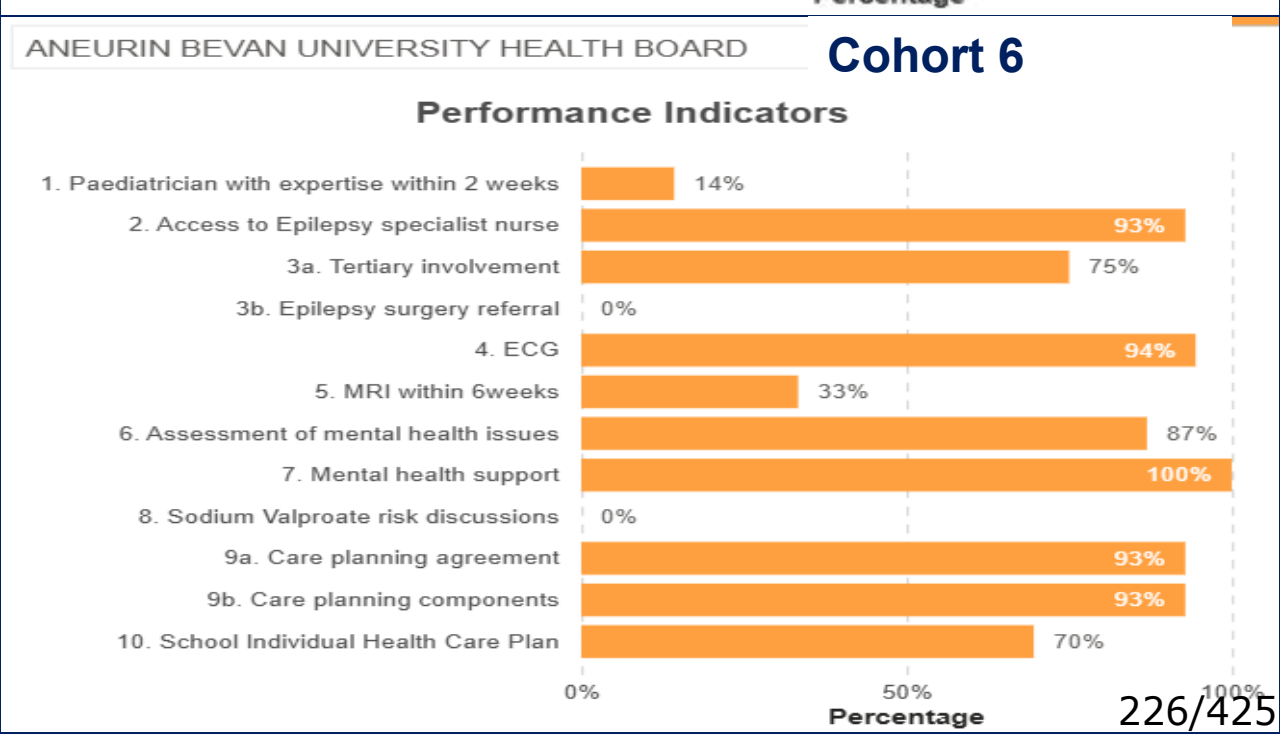
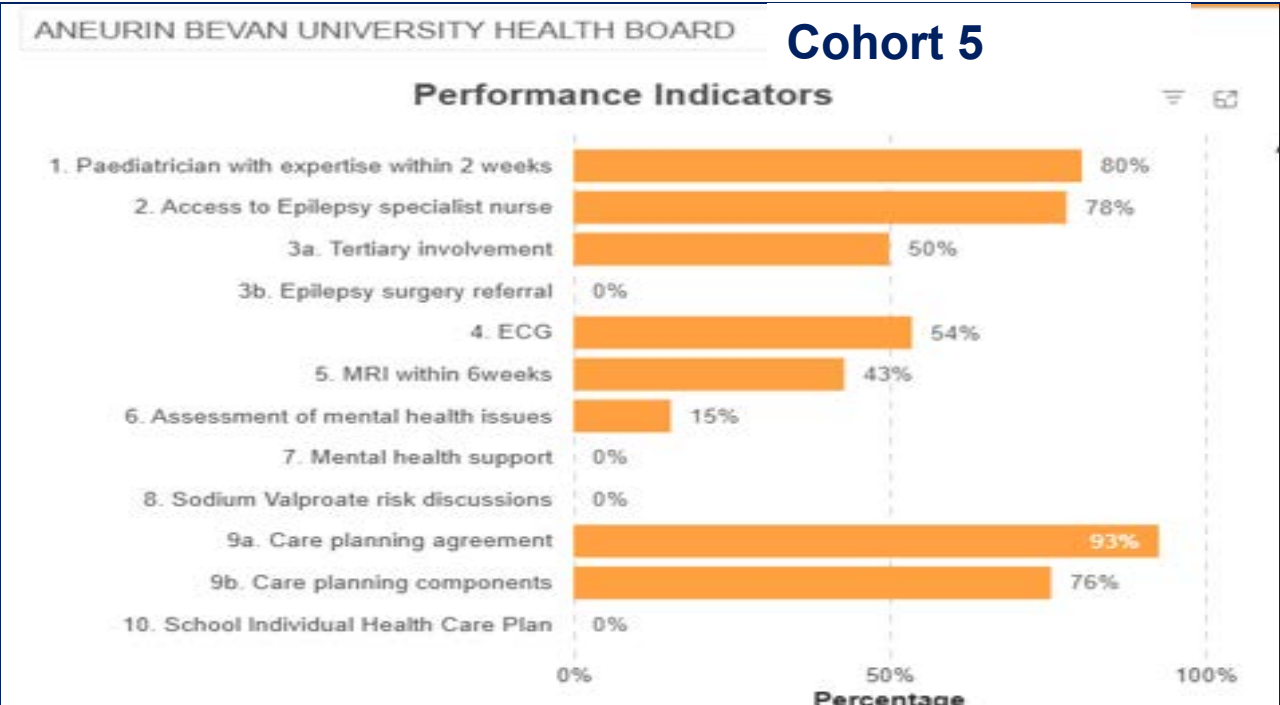
Objectives: **Epilepsy12** aims to raise the standard of care for children and young people with epilepsy by auditing clinical practice and service organisation. It collects and analyses data on patient care and service delivery to identify strengths and areas for improvement.

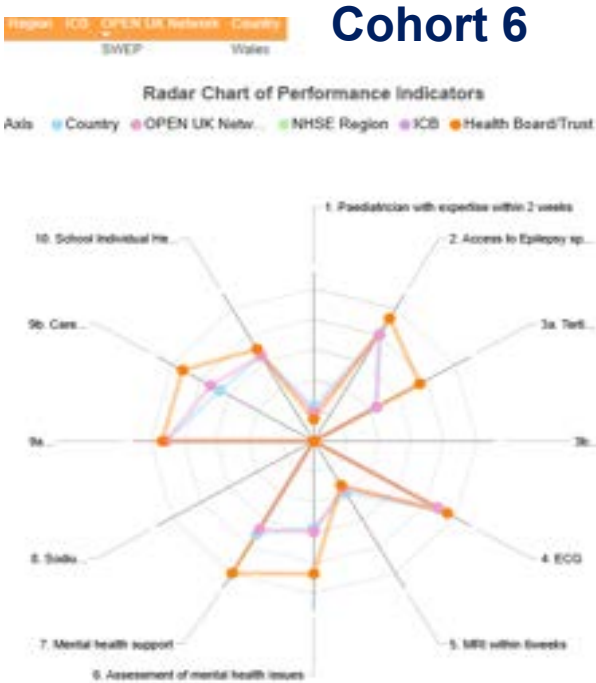
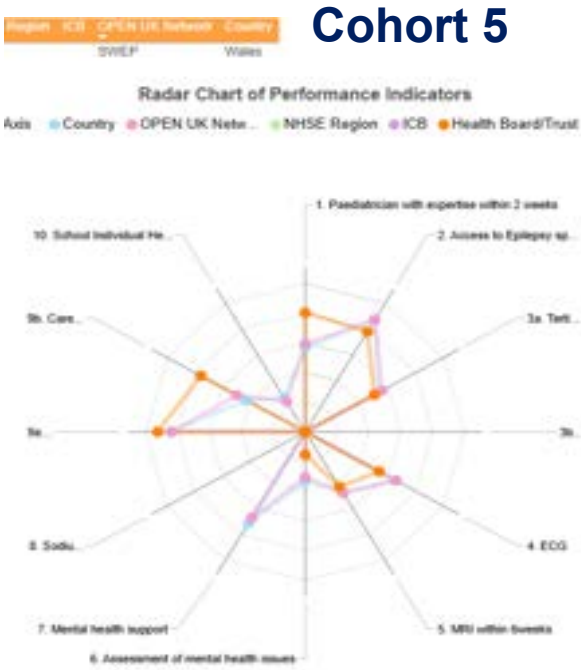
The programme has three core components:

- Auditing of clinical care
- Quality improvement
- Epilepsy12 Youth Advocate

CSEG date: 25th September 2025

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





Assurance level	Description	Risk level	Description
Limited	The project did not achieve the standards or criteria being audited against	Low	Peripheral element of treatment or service suboptimal

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

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

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

State of the Nation Report 2024

SSNAP - Sentinel Stroke National Audit Programme

Stroke care received between April 2023 to March 2024

Clinical Lead:

Dr Yaqoob Bhat

Clinical Director Stroke Medicine Presented by Rhys Monk - Directorate Manager for Stroke, CoTE, Neurology & Nephrology

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

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

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

Sentinel Stroke National Audit - Key Changes:

- New metrics introduced in Oct 2024.



> Significant changes to measurements



> Raised the expectation on delivery of stroke services



> Old measures not comparable to new measures



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



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

- Performance dropped due to higher standards

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

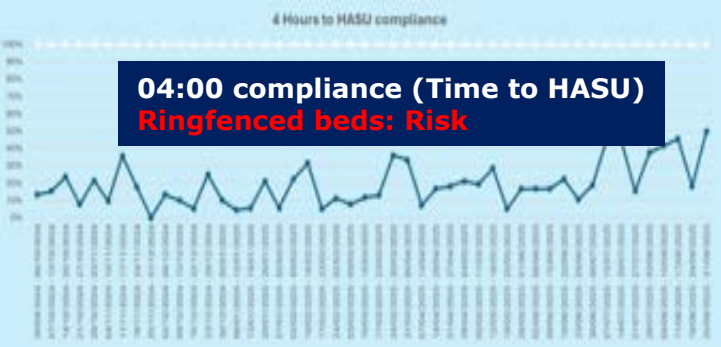
% Compliant for Selection — % Compliant - All Wales

Scanning target reduced from 1 hour to 20 minutes



4 Hours to HASU compliance

04:00 compliance (Time to HASU) Ringfenced beds: Risk



SSNAP Scoring Summary:
[See "Outline of report" for further information about this section of the report](#)

Team Type	Routinely admitting team
ISDN	Wales
Trust	Aneurin Bevan University Health Board
Team	Grange University Hospital
Time Period	Jan - Mar 2025

SSNAP level

SSNAP score

Care excellence band

Audit compliance band

Combined Total Key Indicator level

Combined Total Key Indicator score

21.4

A

C

22.5

Patient-centred KI levels:

Patient-centred Domain levels:

1) Hyperacute assessment

2) Specialist pathway

3) Reperfusion

4) MDT assessment

5) Therapy intensity

6) Therapy frequency

7) Standards by discharge

Patient-centred Total KI level

Patient-centred Total KI score

Patient-centred SSNAP level

(after adjustments)

Patient-centred SSNAP score

21.5

D

F

F

F

F

F

21.8

Team-centred KI levels:

Team-centred Domain levels:

1) Hyperacute assessment

2) Specialist pathway

3) Reperfusion

4) MDT assessment

5) Therapy intensity

6) Therapy frequency

7) Standards by discharge

Team-centred Total KI level

Team-centred Total KI score

Team-centred SSNAP level

(after adjustments)

Team-centred SSNAP score

22.3

D

F

F

F

F

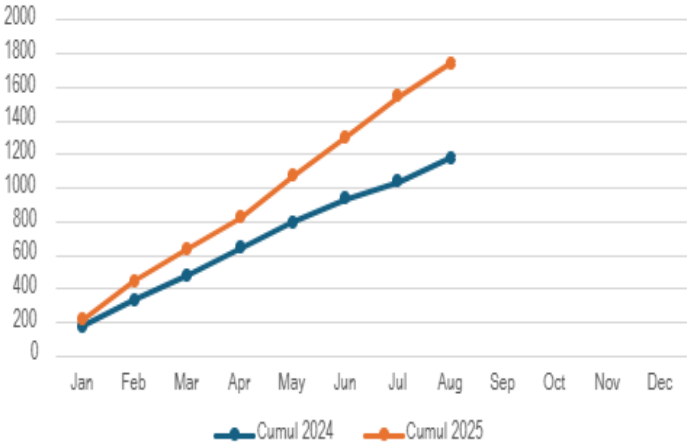
F

22.5

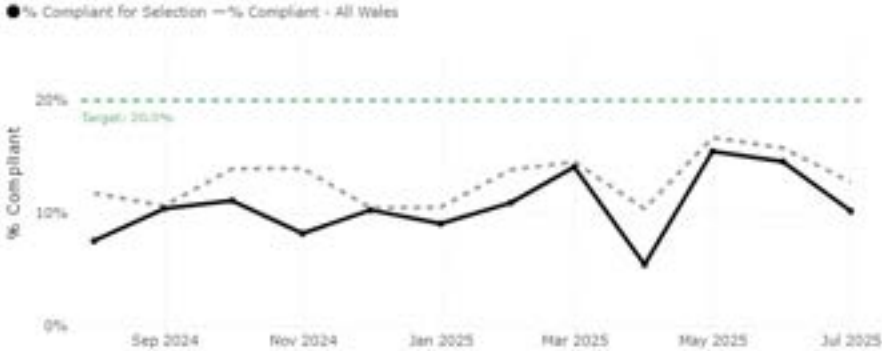
Thrombolysis & Thrombectomy

Stroke Consultant assessment <1 hour

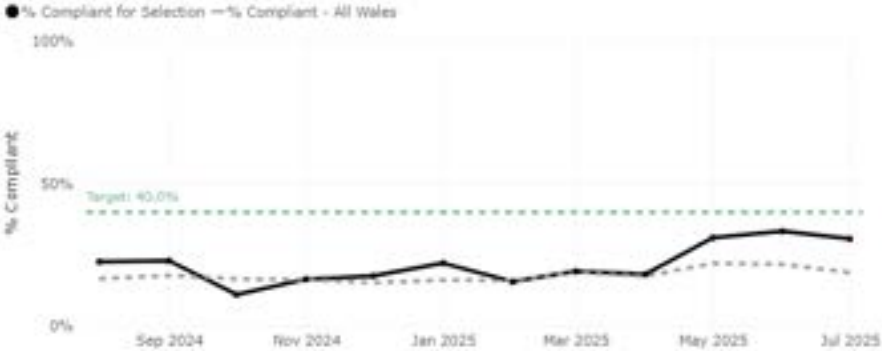
Stroke Front End Demand



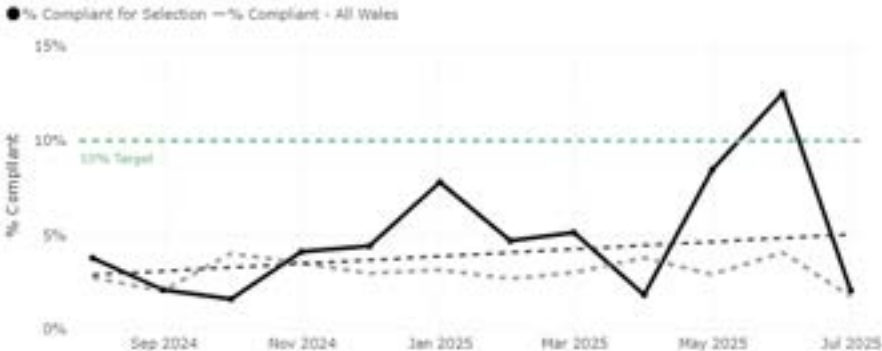
% Thrombolysed (Aug-24 to Jul-25)



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



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



Scanning within 20 minutes & CTA



Stroke Consultant < 1 hour

Double up of CNS on front end
Demand has increased x% year on year



Time to HASU <4 hours

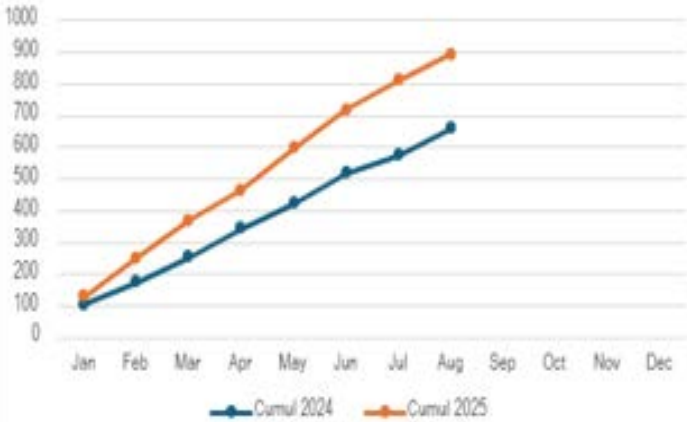
Organisational priority needed
Ringfence of beds
Priority on patient flow through system (Scans, beds, transport)



Therapies

Business case to meet staffing guidelines

HASU Demand



Actions: This is presented at Stoke Board

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

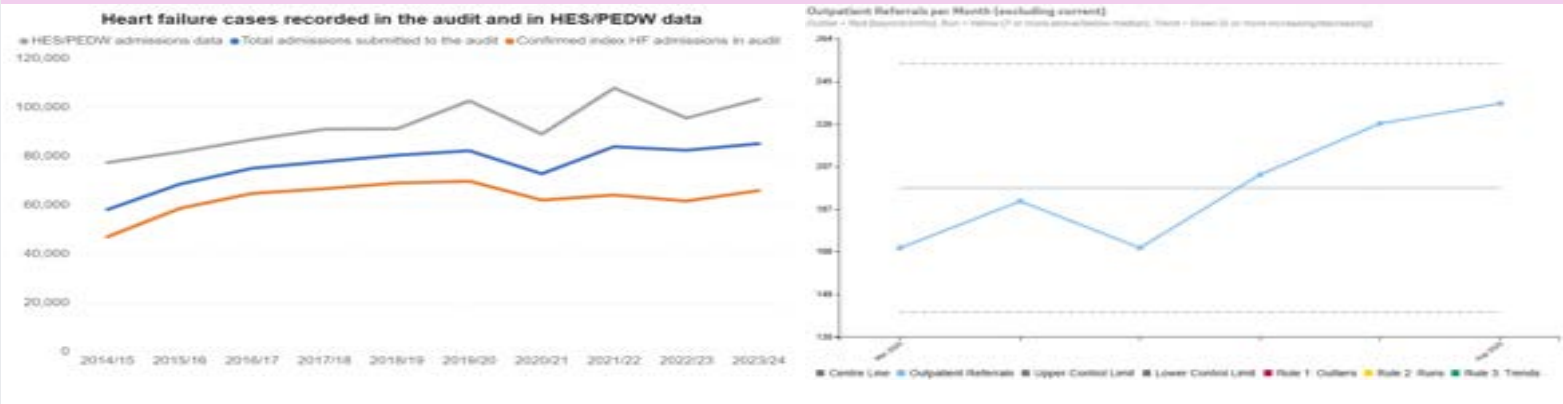
Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against
Risk level	Description
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved

National Cardiac Audit Programme - National Heart Failure Audit (NHFA)	Clinical Lead: Linda Edmunds – Consultant Nurse, Cardiac Rehabilitation, supported by Karen Hazel, Heart Failure Nurse Specialist

Rationale:	The National Heart Failure Audit (NHFA) monitors the care of patients admitted unexpectedly to hospitals in England and Wales who are discharged with a primary diagnosis of heart failure. The latest report covers the period April 2023 to March 2024 and provides a comprehensive review of care delivery for these patients. It examines patient characteristics, hospital investigations, treatments received, access to specialist care, discharge planning, and post-discharge follow-up.

Objectives:	The audit aims to enhance the quality of diagnosis, treatment, and management of heart failure. It is managed by NICOR and forms part of the National Cardiac Audit Programme within NHS England. The audit collects data on clinical indicators associated with better outcomes for heart failure patients and encourages the use of recommended diagnostics, treatments, and referral pathways. The dataset is regularly updated to ensure alignment with current clinical guidance.

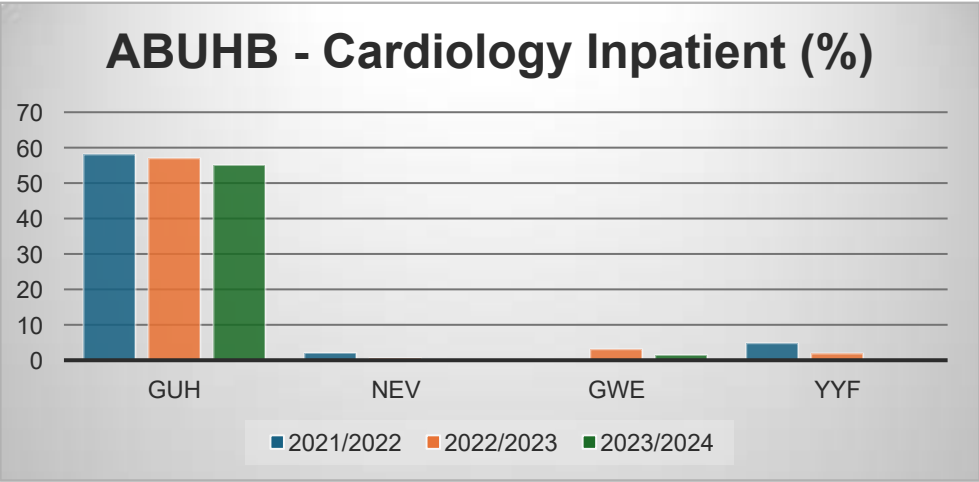
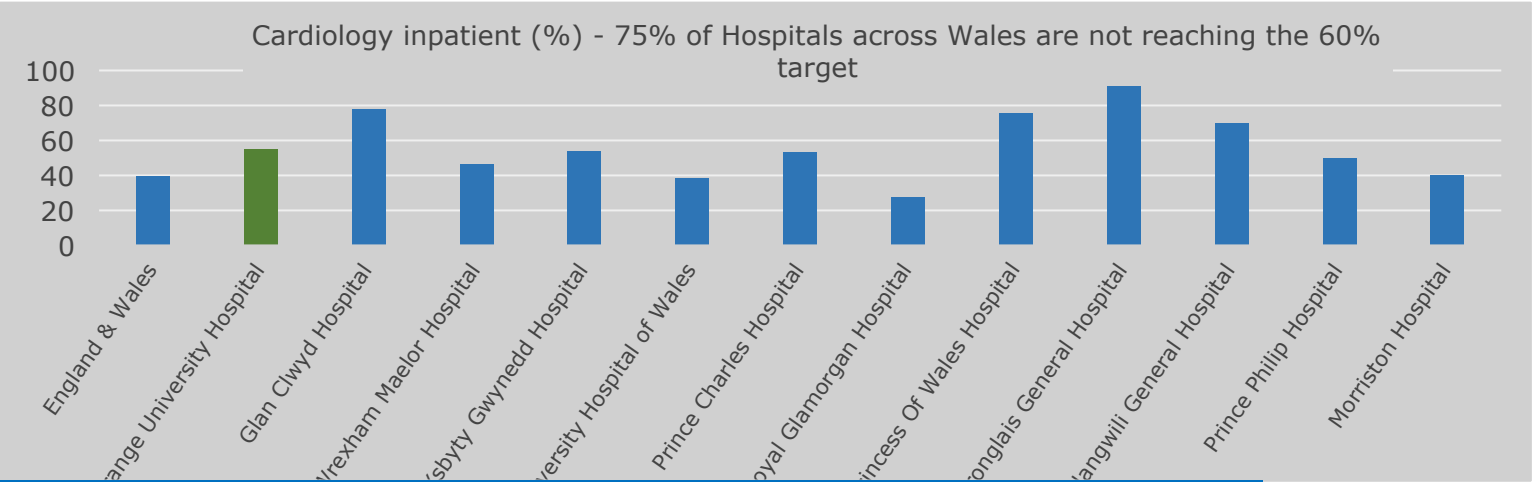
Confirmed index HF admissions rose to 65,679 HES/PEDW. The total admissions submitted to the audit and the confirmed index HF admissions is approaching the numbers pre covid. Discrepancy between audit submissions and confirmed index HF admissions has doubled This likely reflects the change in the audit dataset. <i>Note: The index admission for a patient is either their only acute HF admission or the first HF admission when more than one was submitted in the audit year. This ensures data from repeated admissions does not distort the statistics. In both instances the audit captures data from patients where heart failure is in the primary diagnostic position and therefore taken as the cause of the admission. The term 'confirmed' is used when the data submitted are verified as an acute HF admission.</i>



Recommendations

Specialist care

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



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

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

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

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

Follow-up

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

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

Best Practice Drugs

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

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

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

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

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

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

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

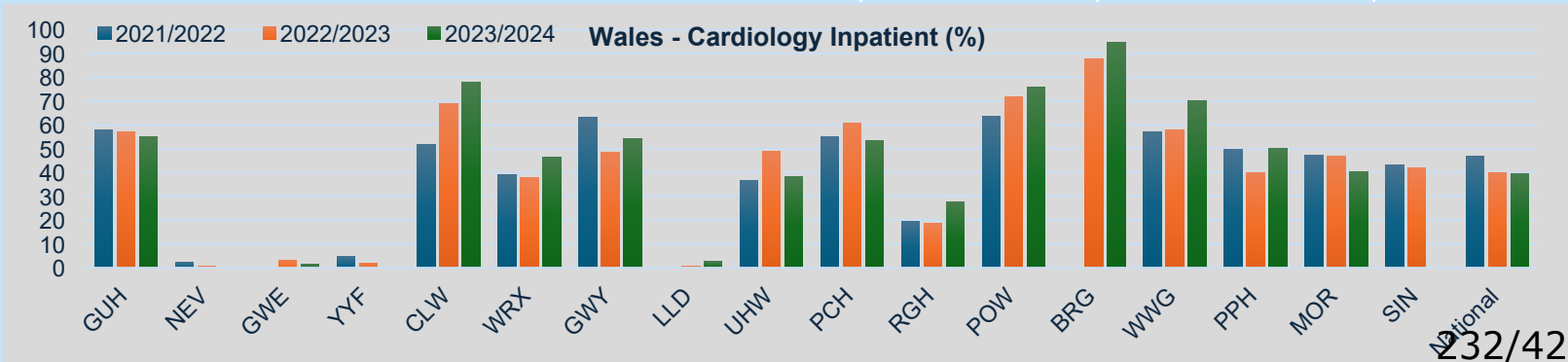
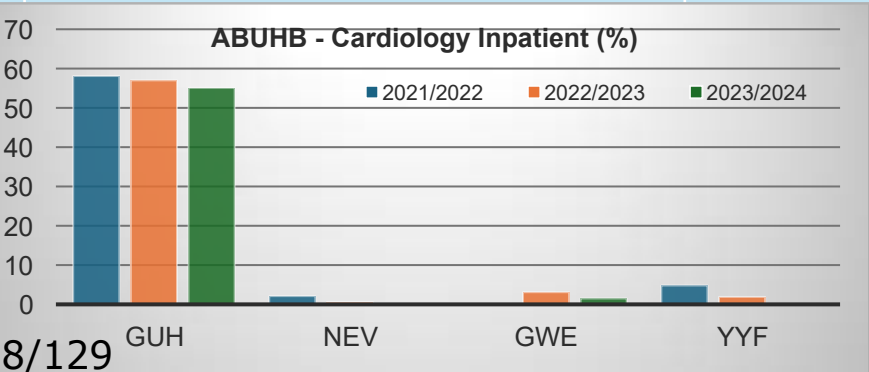
Has this audit been placed on a Risk Register (N/A if above risk is None)

No

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

Report Successes:		Report Concerns:	
1	Increasing inpatient referrals year on year- AMaT development.	1	Increasing numbers of HFpEF – no current HF service provision.
2	Improved discharged planning and inpatient signposting.	2	Increasing inpatient and outpatients referrals to HF service year on year – demands vs capacity to maintain operational waiting targets.
3	All appropriate patients receive a 2 week follow up outpatient appointment following discharge.	3	No dedicated HF medical provision to establish bespoke HF management in the satellite hospitals.
4	In person medical support in all satellite hospitals from October 24 – June 25.	4	No live data to track timely in-patient service performance.
5	HF cardiac rehab now rolled out to all sites	5	No acute HF dedicated team

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



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

ABUHB - Input from consultant cardiologist (%)

	2021/2022	2022/2023	2023/2024
GUH	62	61	63
NEV	13	8	8
GWE	14	19	22
YYF	9	14	6

ABUHB - Input from specialist (%)

	2021/2022	2022/2023
GUH	66	65
NEV	16	12
GWE	18	22
YYF	20	20

ABUHB - ACEI/ARB/ARNI on discharge (%)

	2021/2022	2022/2023	2023/2024
GUH	82	85	92
NEV	85	82	78
GWE	88	72	68
YYF	72	95	85

ABUHB - Beta Blocker on discharge (%)

	2021/2022	2022/2023	2023/2024
GUH	90	92	78
NEV	78	82	88
GWE	82	78	92
YYF	92	95	85

ABUHB - MRA on discharge (%)

	2021/2022	2022/2023	2023/2024
GUH	55	65	28
NEV	48	48	48
GWE	48	48	68
YYF	40	72	85

ABUHB - Triple therapy on discharge (%)

	2021/2022	2022/2023	2023/2024
GUH	45	65	15
NEV	22	40	38
GWE	32	40	52
YYF	25	72	60

ABUHB - SGLT2i on discharge (%)

	2021/2022	2022/2023	2023/2024
GUH	48	72	72
NEV	25	38	75
GWE	12	52	62
YYF	12	48	78

49/129

233/425

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

Recommendations

Specialist care

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

Best-practice drugs

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

Follow-up

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

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

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

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

Recommendations (relevant to ABUHB):

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

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

Recommendations

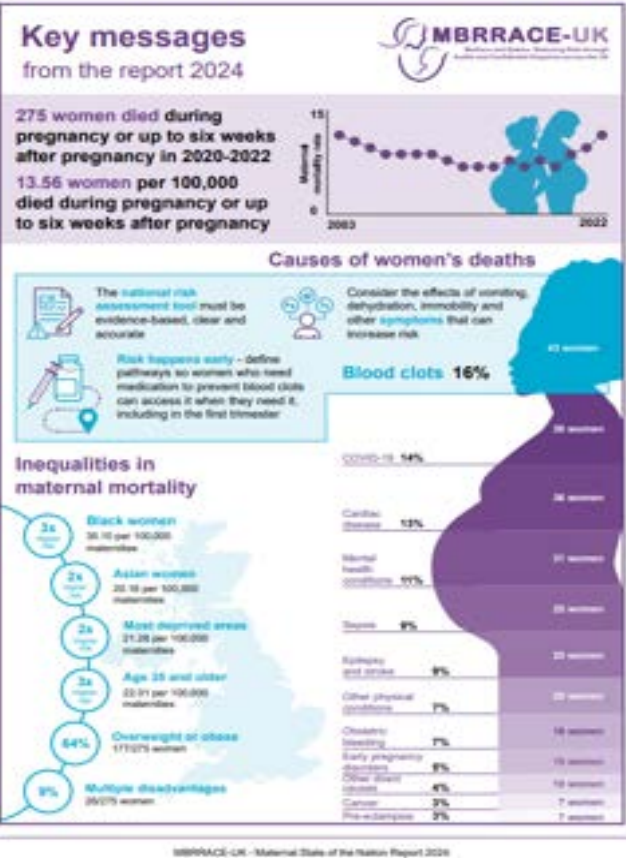
1. Ensure that the number of women who require language support, and the support provided at each visit, is recorded systematically. This includes documenting the use of professional interpreting services at clinical care interactions and when supporting women through the navigation of care pathways,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

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

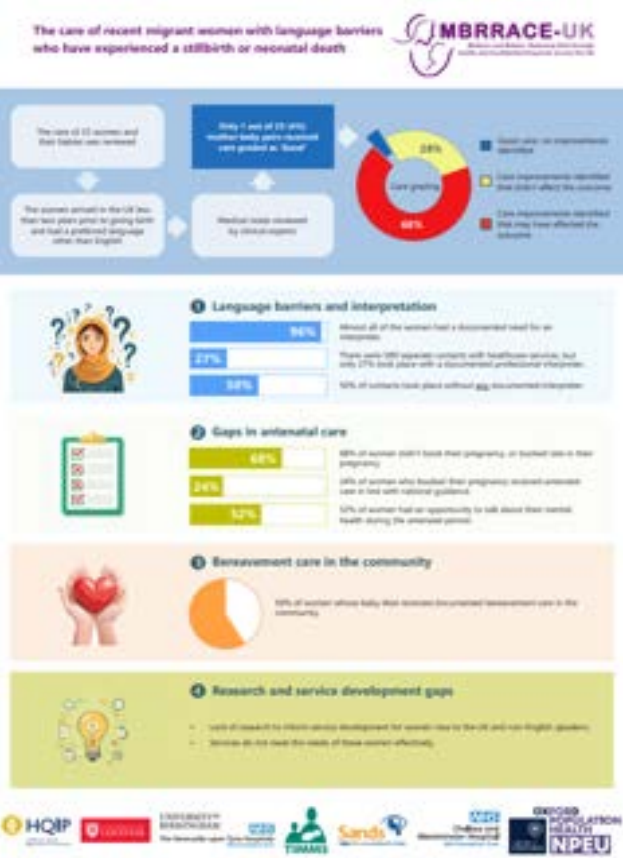
Recommendations

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

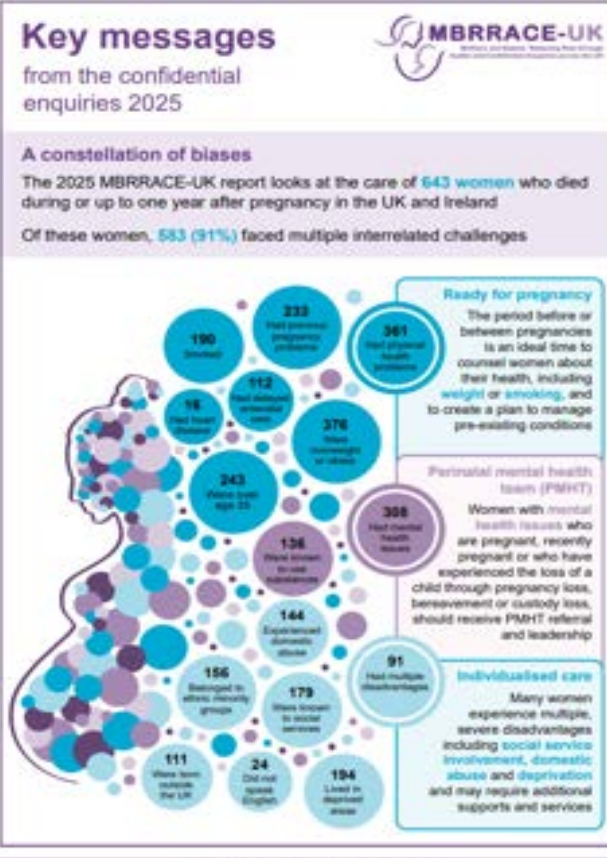
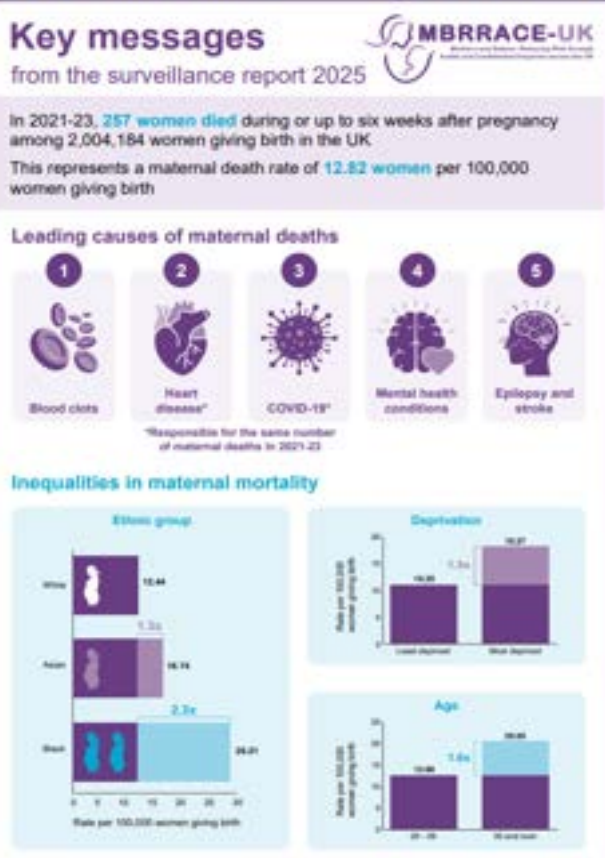
Infographics
Ref - 500



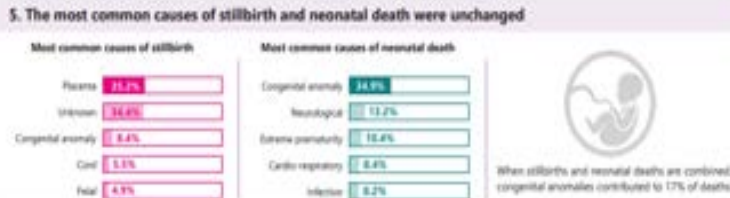
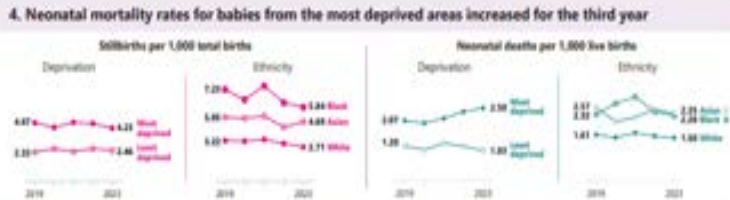
Ref - 501



Infographics
Ref - 578



State of the nation report
UK perinatal deaths of babies born in 2023



Ref 581 - State of the Nation report - perinatal deaths of babies born in 2023

Previous recommendations with continued relevance

1. Ensure neonatal intensive care capacity and resources reflect the increase in the numbers of babies born before 24 completed weeks' gestational age receiving survival-focused care. (MBRRACE-UK 2024) **Audience: Commissioners**
2. Support external clinical input into the rigorous review of all stillbirths and neonatal deaths across the UK, to identify learning and common themes related to clinical care and service provision, delivery and organisation. (MBRRACE-UK 2023) **Audience: UK Governments, Royal Colleges, Commissioners**
3. Ensure healthcare providers adopt and use the BAPM Perinatal Optimisation Pathway, to improve preterm outcomes. (MBRRACE-UK 2023) **Audience: Royal Colleges, Commissioners**
4. Continue to develop and implement targeted action, at national and organisational levels, to support the reduction of direct and indirect health inequalities. (MBRRACE-UK 2023) **Audience: UK Governments, Royal Colleges, Commissioners**

	Trust/health board	Births	Crude stillbirth rate	Stabilised & adjusted stillbirth rate	Stabilised & adjusted stillbirth rate (95% CI)	Crude neonatal mortality rate	Stabilised & adjusted neonatal mortality rate	Stabilised & adjusted neonatal mortality rate (95% CI)	Crude extended perinatal mortality rate	Stabilised & adjusted extended perinatal mortality rate	Stabilised & adjusted extended perinatal mortality rate (95% CI)
2023	Anaesthetist	3,272	3.22	3.61	(3.09 to 4.27)	1.90	2.01	(1.25 to 3.14)	5.12	5.61	(4.76 to 7.03)
2022	Anaesthetist	3,408	4.25	3.67	(3.11 to 4.38)	0.74	1.45	(0.88 to 2.37)	4.99	5.13	(4.47 to 6.56)
2021	Anaesthetist	5,706	4.45	4.17	(3.23 to 5.36)	0.93	1.64	(1.05 to 2.31)	5.37	5.81	(4.90 to 7.62)

Assurance level	Description	Risk level	Description
Full	The project has fully achieved the standards or criteria being audited against	None	Standards met and findings demonstrate no risk to patient safety

Report Successes:

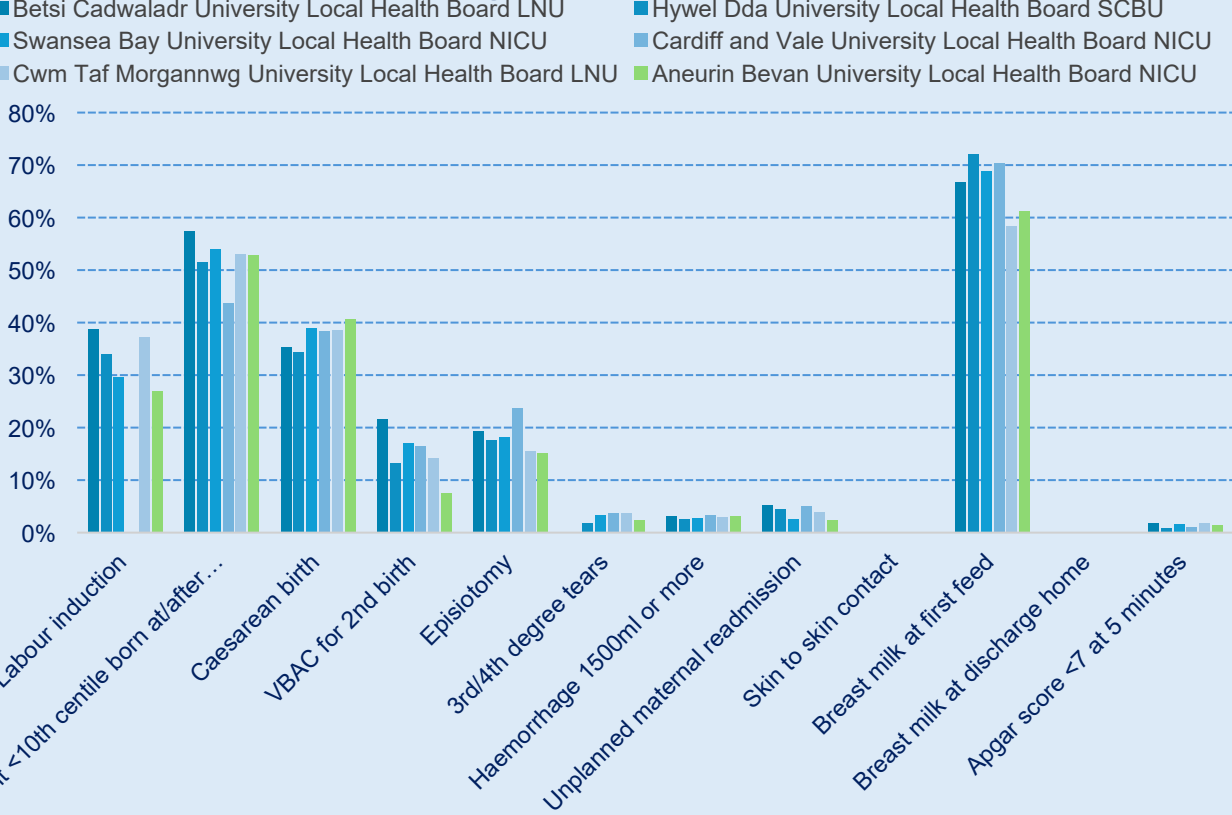
1. Pathway in place for early thromboprophylaxis this includes from the first trimester for at risk women
2. Local peer groups in place to support women whose first language is not English for signposting
3. Interpretation service available, sign live, ipads, healthier together and digital platforms support multi language
4. Urgent referral pathway in early pregnancy high risk medical social conditions
5. Specialist perinatal mental health service

Report Concerns:

1. Initial assessment appointment for migrant women/multiple routes of access /rapid access

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

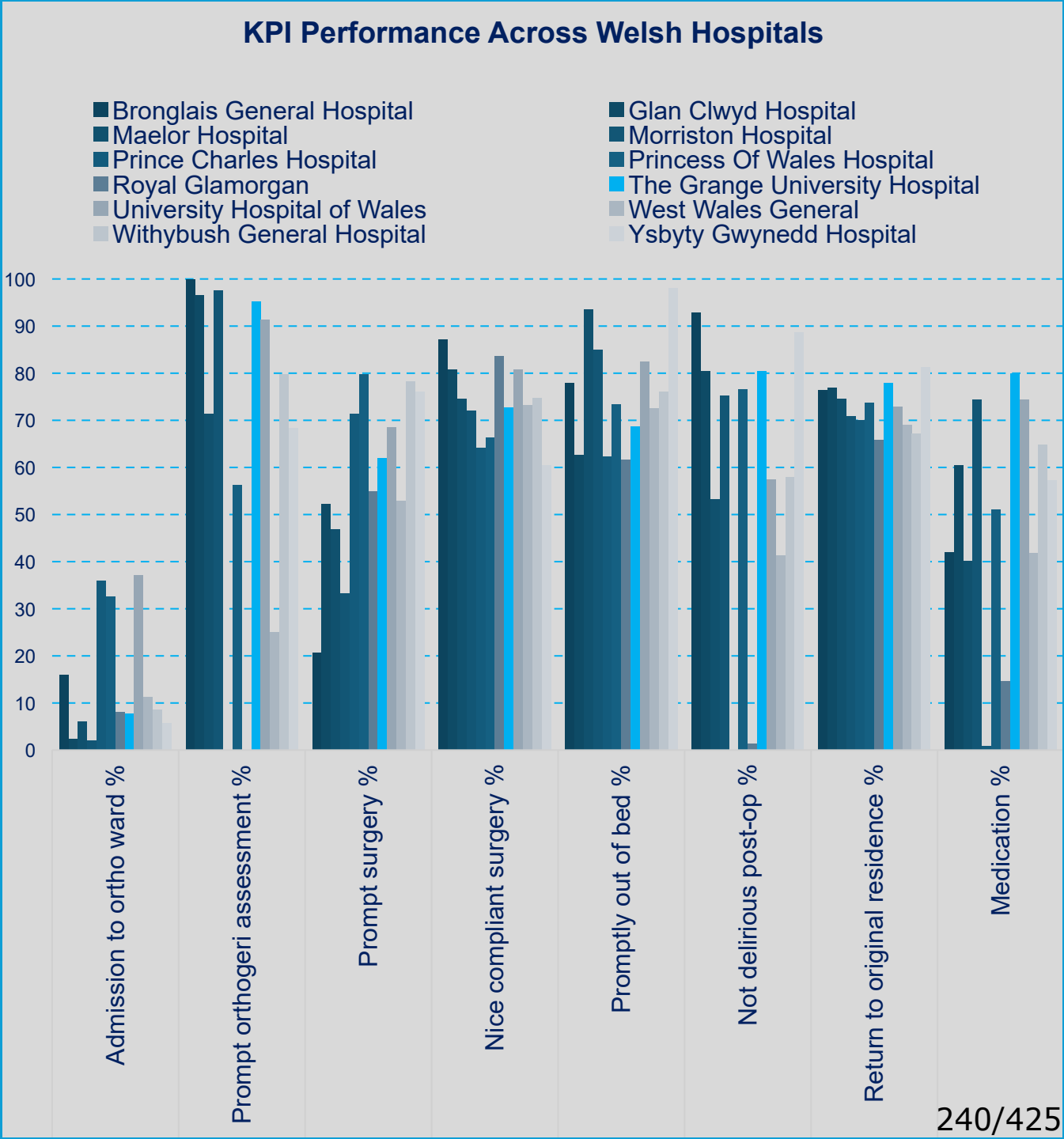
Birthing results across Wales



Assurance level		Description	Risk level		Description
Full		The project has fully achieved the standards or criteria being audited against	None		Standards met and findings demonstrate no risk to patient safety
Report Successes:			Report Concerns:		
1	Rates as expected : readmissions, vaginal tears, PPH, preterm birth,		1	Data completeness	
2	Rates lower than expected: induction of labour, term baby apgar scores < 7 , episiotomy rates,		2	Rates higher than expected : SGA, late booking after 10 weeks gestation	
3	Benchmarking		3	Lower rates of VBAC	

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

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

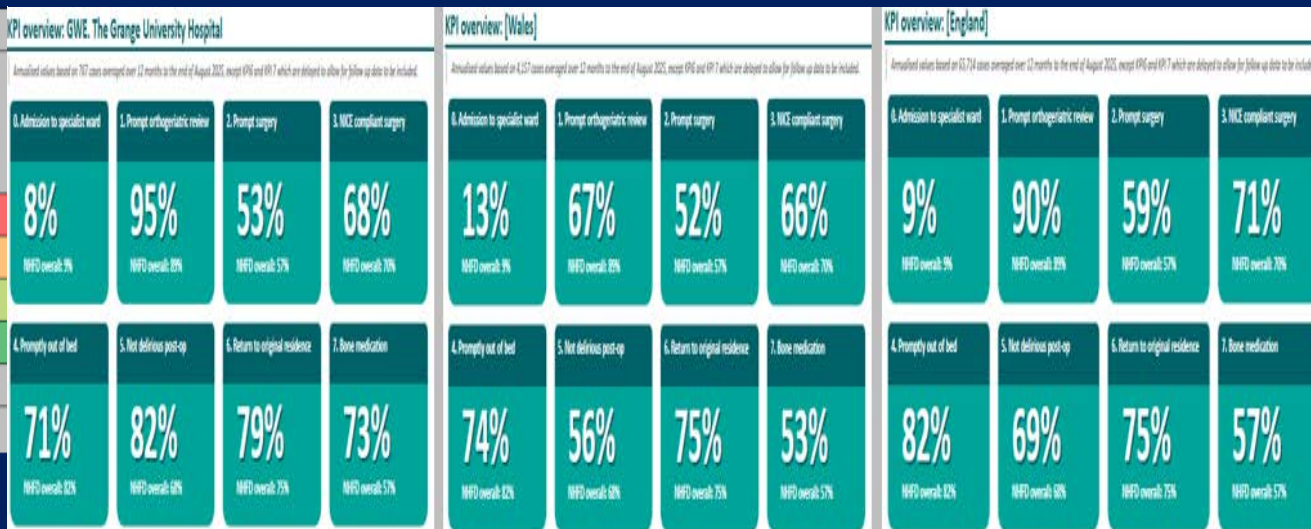


Key performance GUH 2021-2024

		KPI 0	KPI 1	KPI 2	KPI 3	KPI 4	KPI 5	KPI 6	KPI 7
		Admission to ortho ward %	Prompt orthogeriatric assessment %	Prompt surgery %	Nice compliant surgery %	Promptly out of bed %	Not delirious post-op %	Return to original residence %	Medication %
GUH	2021	2	91	67	72	76	77	73	56
GUH	2022	5.5	93.3	57.3	71.2	75.1	78.4	73.9	65.1
GUH	2023	16.9	96.4	56.9	78.1	69.4	79.8	76	73.7
GUH	2024	7.7	95.3	61.9	72.8	68.7	80.4	77.9	80
National	2024	9%	89%	58%	74%	82%	67%	75%	54%

Annualised values based on 767 cases averaged over 12 months to the end of August 2025, except KPI6 and KPI 7 which are delayed to allow for follow up data to be included.

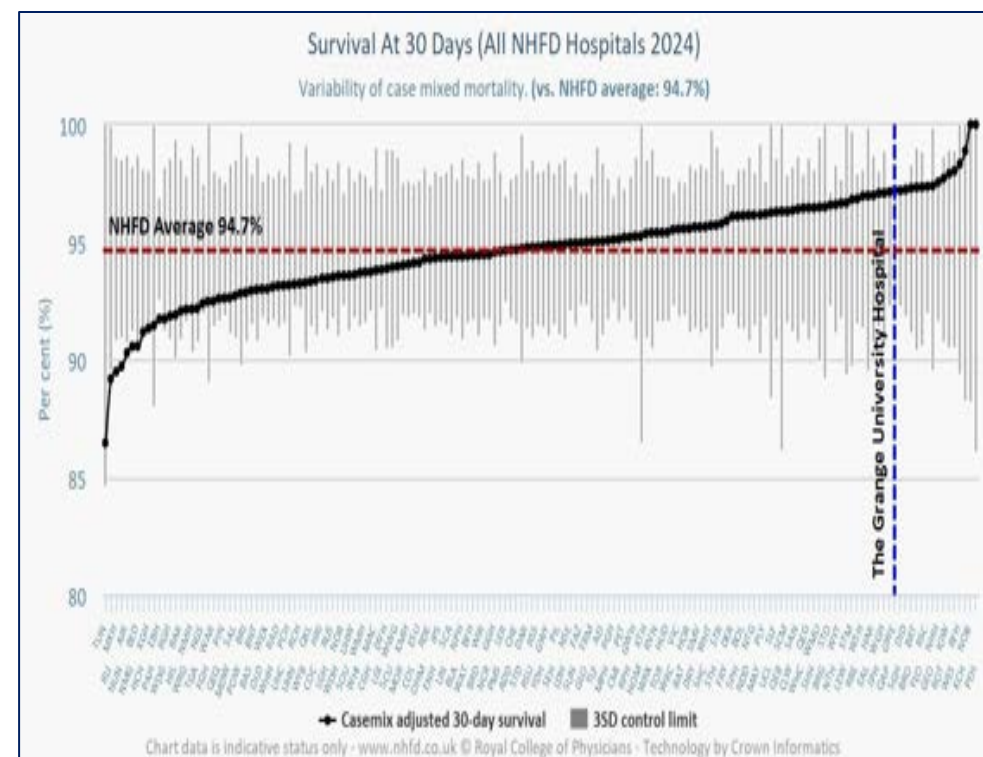
ABUHB data as at August 2025



Assessment & Surgery Benchmark for ABUHB 2021, 2022, 2023, 2024.

Assessment benchmark		No. of cases submitted	Admitted to orthopaedic ward within 4 hours	4AT Test recorded on admission	Perioperative medical assessment	Physiotherapist assessment by the day after surgery	Mobilised out of bed by the day after surgery	Nutritional risk assessment	Not delirious when tested post-op.	Received falls assessment	Received bone health assessment	Met best practice criteria
GUH	2021	685	4.2	60.4	91.1	97	76.4	99.7	78.4	99.3	99	37
GUH	2022	746	9.1	73.3	93.3	97.4	75.1	96.2	79.9	99.3	99.2	39.5
GUH	2023	811	21.9	66.1	96.4	95.7	69.4	98.6	80.2	98.3	98.3	36.5
GUH	2024	751	12	75.6	95.3	98.2	68.7	99.7	81.1	98	98.3	44.4

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



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

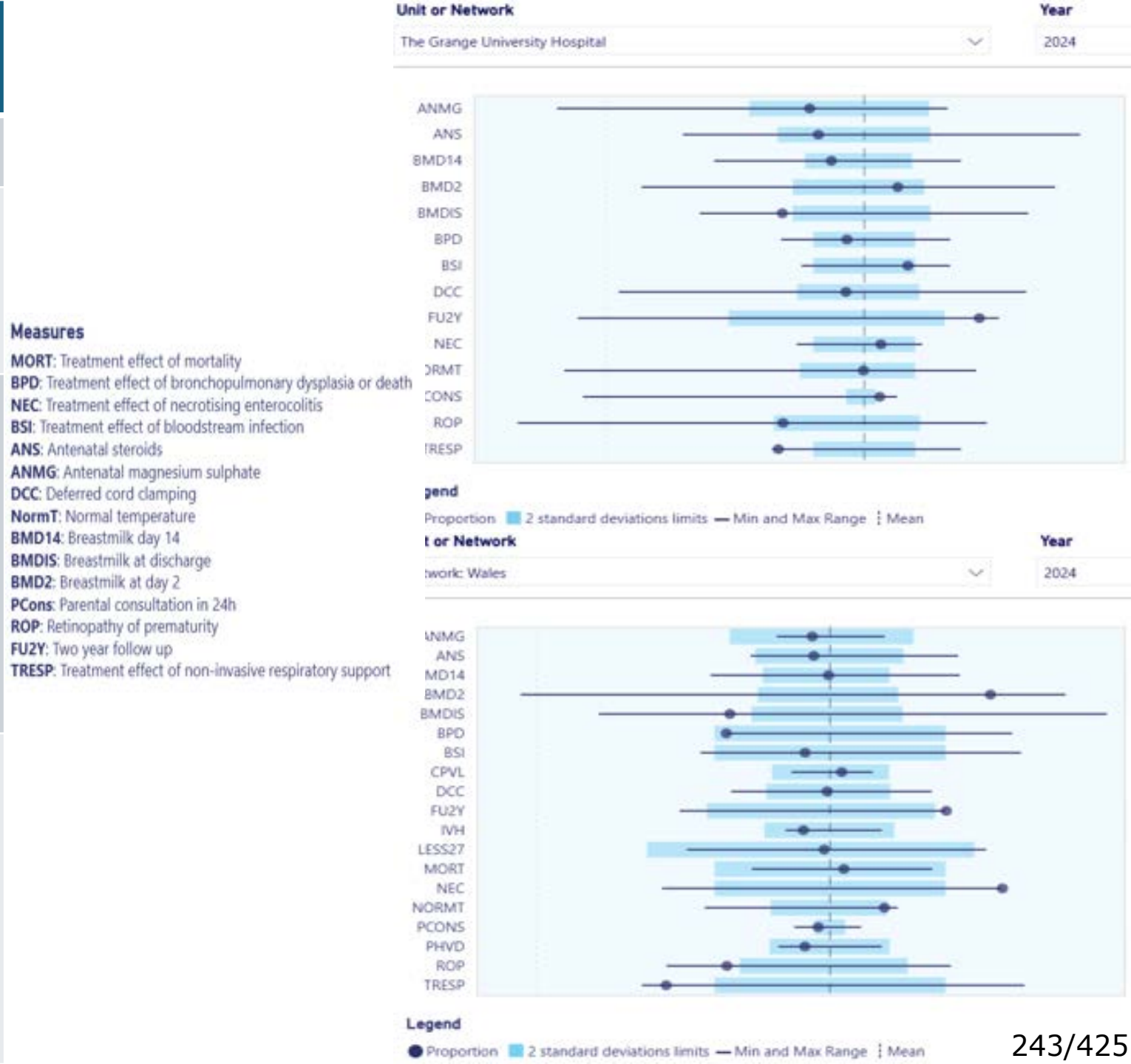


Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against
Risk level	Description
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon

Report Successes:			
1	Prompt Orthogeriatric assessment (KPI 1)	4	Return to original residence (KPI 6)
2	Not delirious post OP (KPI 5)	5	Reduce mortality at one month
3	Bone Health Medication prescription on discharge (KPI 7)		
Report Concerns:			
1	Improvement in delay of the hip fracture from A&E to A0		
2	Compliance with 4AT recording in the clerking pro forma		
3	Surgery within 36 hours of admission. Hip fractures patients need to be prioritised with a consistent approach over semi-elective trauma		
4	Day 1 mobilisation (therapy staff not available at weekends and on bank holidays) QIP in place, human factor approach, nursing staff contribution		

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:
1	Require emergency and orthopaedic departments to agree fast-track admission policies, so that at least one in five patients reach a specialist orthopaedic ward within 4 hours of admission with a hip fracture.	To undertake a review of the admission data to identify improvement in ward admission times	Orthopaedic/A&E	Update expected 30/09/2026
2	Review each hospital's NHFD data to ensure that at least 95% of patients are able to access surgery, that this is documented as having been supervised by a senior surgeon and that it allows them to get up fully weightbearing.	Monthly clinical Governance meeting	Orthogeriatrics/ Orthopaedics	Ongoing
3	Require each hospital to commission appropriate physiotherapy capacity so that all inpatients recovering from hip fracture can receive at least one session of physiotherapist-directed rehabilitation each weekend.	Trauma review	Therapy Dept/ Orthopaedics	Fully complete
4	Require all hospital teams to review their use of injectable bone protection, so that at least half of all patients are recorded to be on bone strengthening medication 4 months after a hip fracture.	Bone health assessment as part of Orthogeriatric assessment	Orthogeriatrics team	Ongoing
5	NHS England and Welsh government should use the results of the audit of pelvic ring fracture we will be piloting from January 2026 to challenge the main form of inequity in the management of fragility fracture which, as both the NHFD and GIRFT have shown, relates to the age of people with fractures at different sites.	Will be collecting the data from January 2026 and an update for Sep 2026	Dr Usman	Update expected 30/09/2026

National Neonatal Audit Programme (NNAP)		Clinical Lead: Dr Sunil Reddy – Neonatal Consultant
Summary report on 2024 data		NICE QS 193 Quality Statements 1-5
Rationale :	The National Neonatal Audit Programme (NNAP) assesses whether babies admitted to neonatal units receive consistent high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards.	
Scope:	NNAP uses a range of measures to monitor neonatal care and highlight where improvement is required. These measures can vary from year to year and are categorised into the following themes: • Outcomes of neonatal care • Optimal perinatal care • Maternal breastmilk feeding • Parental partnership in care • Neonatal nurse staffing • Care processes • Overall network performance	
Aims of the audit:	The NNAP has set out a series of supporting objectives, and approaches to stimulating healthcare improvement, which include: • High quality data outputs that identify areas for action and support stakeholders' improvement initiatives. • Sharing best practice and quality improvement resources • Collaboration and engagement with regional and national initiatives • Parent and public engagement	





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

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

Assurance level		Description	Risk level	Description
Significant		The project has mostly achieved the standards or criteria being audited against	Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Report Successes:			Report Concerns:	
1	Most of the measures within acceptable limits (close to national levels and within 2 SD)		1	NIV rates alarm level - (though not translating into poor outcomes) QI initiated
2	Excellent with 2 year follow up – commended by NNAP		2	Breast milk at discharge scope to improve- ongoing work
3	Improvement in ROP screening rates		3	Perinatal optimisation could improve- needs teamwork, PERIPREM work, data monitoring/ cleaning NNAP from maternity side
60/129 Neonatal outcomes rates good and better than network				

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

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Management of Heart Attack: Myocardial Ischemia National Audit Project (MINAP) – 2025 Annual Report data up to 2023/2024	Clinical Lead: Dr Nigel Brown – Consultant Cardiologist	The number of heart attack cases in 2023/24 fell 2% from the previous year
Rationale:	The Myocardial Ischaemia National Audit Project (MINAP) is part of the National Cardiac Audit Programme (NCAP) which is run by the National Institute for Cardiovascular Outcomes Research (NICOR). This report summarises the care provided within hospitals in England, Wales and Northern Ireland to almost 82,000 people who suffered a heart attack between April 2023 and March 2024.	 91,014 Suspected heart attacks 81,814 Confirmed heart attacks 29,282 Higher-risk STEMI heart attacks 52,532 Lower-risk NSTEMI heart attacks Total STEMI and NSTEMI heart attack cases STEMI and NSTEMI cases by age group Legend: 20-64 (blue), 65-74 (orange), 75+ (grey)
Objectives:	A key focus of the audit is to support quality assurance and the improvement of services for people suffering a heart attack. The quality of care they receive is assessed against a set of quality improvement (QI) metrics derived from national and/or international standards and guidelines. These cover patients diagnosed with two types of heart attacks: ➤ Higher-risk ST-segment elevation myocardial infarction (STEMI) ➤ Non-ST-segment elevation myocardial infarction (NSTEMI).	The biggest drop in heart attacks has been in patients aged 75 or older  → Contents page



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



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



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



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



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



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



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

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

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

STEMI - context

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

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

Report Successes:

1	Almost all patents are seen by a cardiologist and admitted to a cardiac ward
2	Angiography rates are high in NSTEMI and above the national average
3	Echocardiography and cardiac rehabilitation offer rates are high and exceed the national average

Report Concerns:

1	Poor door to needle times in STEMI reflect skewed case mix and lack dedicated service ** (BUSINESS CASE IN)
2	Delays to IP angiography reflect staffing and lab time
3	Slight concern re secondary prevention meds – requires further ix but may reflect less clear evidence base some medications in lower risk cases

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

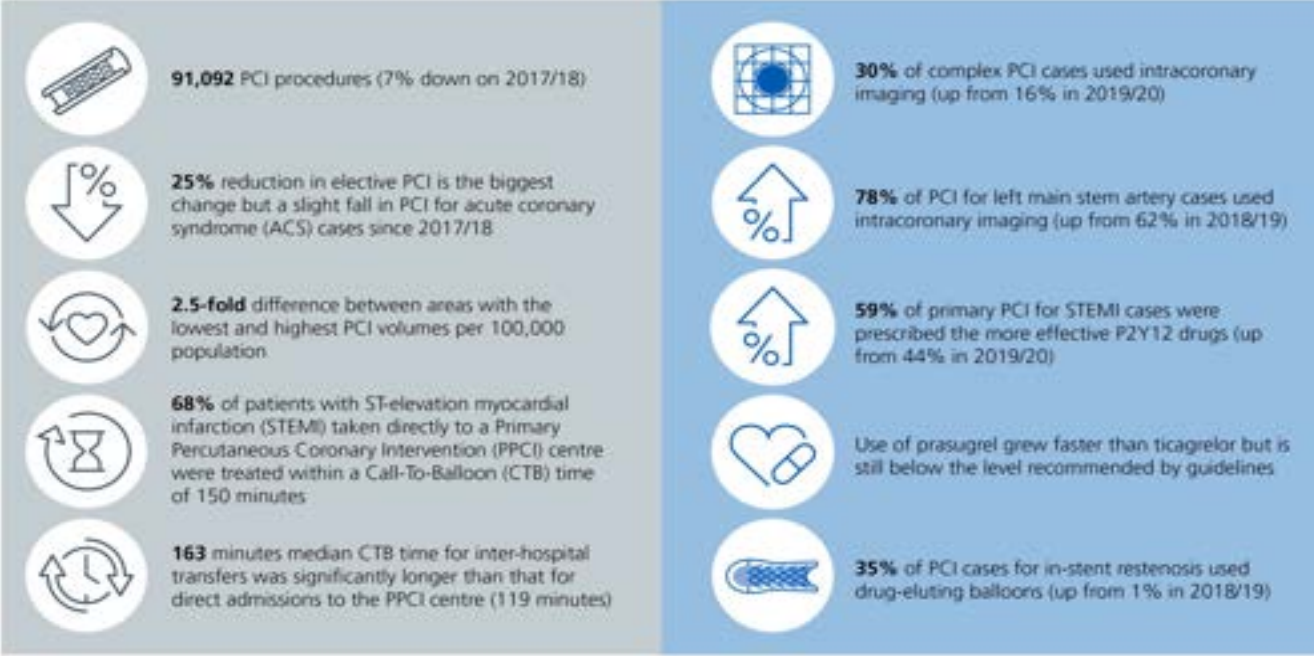
Rationale:
The National Audit of Percutaneous Coronary Intervention (NAPCI) is part of the National Cardiac Audit Programme (NCAP) which is run by the National Institute for Cardiovascular Outcomes Research (NICOR).

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

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

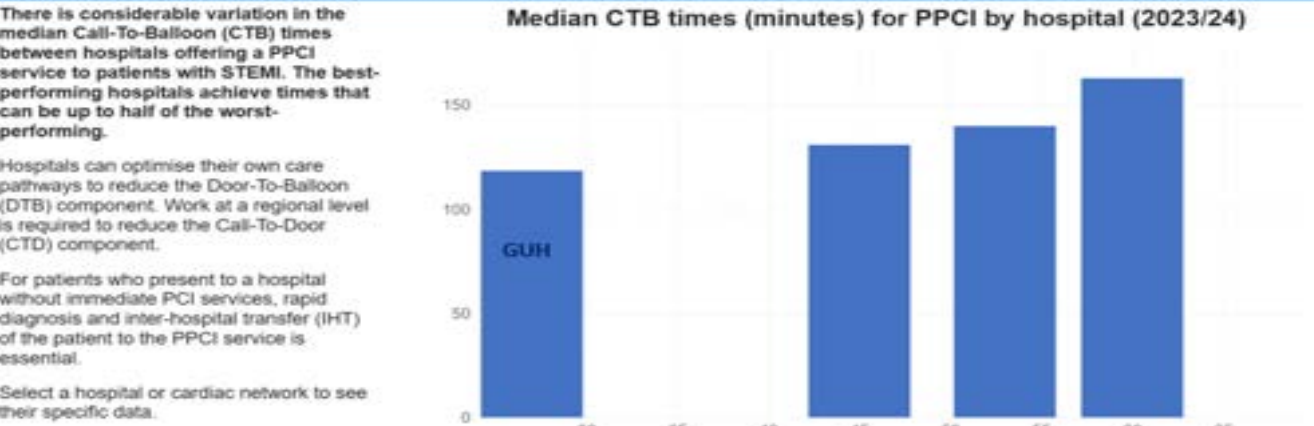
- Primary PCI for ABUHB patients**
- Delivered by Cardiff and Vale University Health Board
 - Will require auditing of Cardiff and Vale figures
 - More work needed to minimise delays in interhospital transfers
 - Thormbolysis could be considered after discussion with Cardiff and Vale as part of SOP
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

All data are for 2023/24 unless otherwise stated.



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

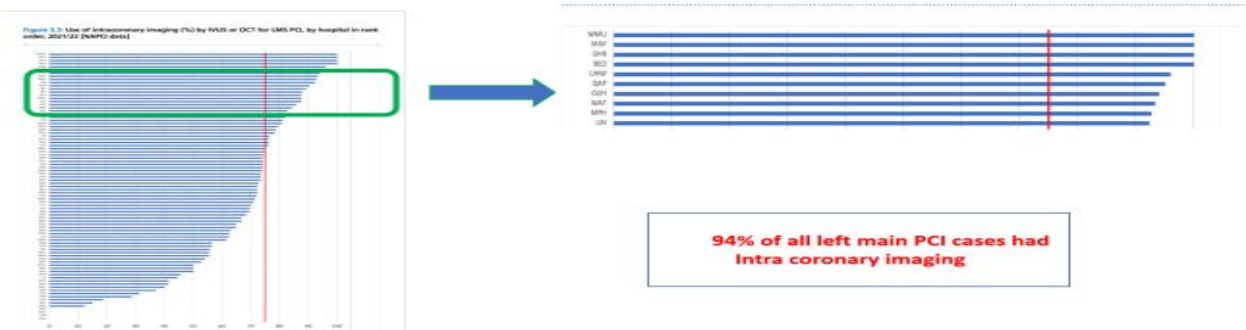
There is substantial variation in Call-To-Balloon times between hospitals



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

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

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



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

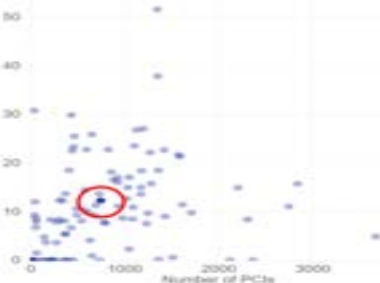
Drug-eluting balloon use varies between hospitals with many hospitals not using them and one hospital using them in >50% of cases

The rate of drug-eluting balloon use by hospital varies from zero to over 50% of cases.

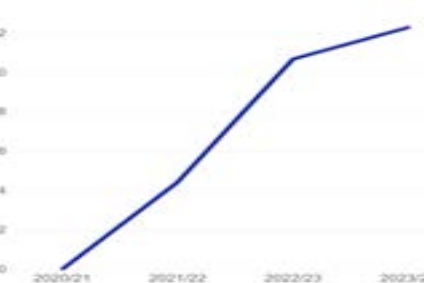
Select a hospital below to see its data or hover over a dot in the scatter plot.

Select hospital

Percentage use of drug-eluting balloons during PCI, by hospital (2023/24)



Percentage use of drug-eluting balloons during PCI



Percentage of PCI cases of Drug Eluting Balloon use



Drug eluting balloons

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

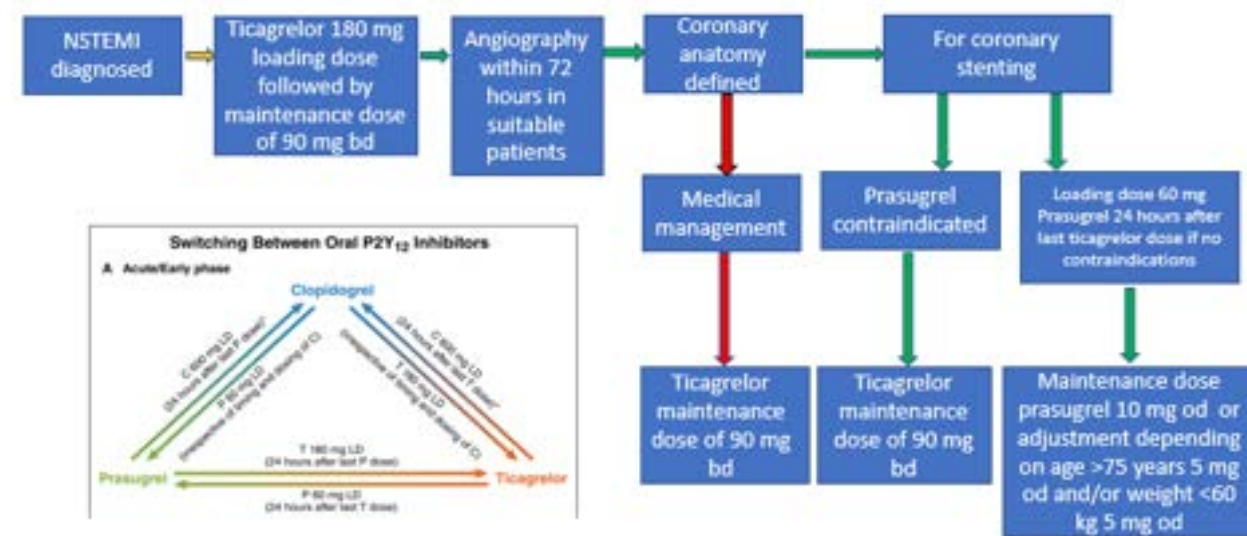
Recommendation 3 - Use of prasugrel is lagging that of ticagrelor, especially in NSTEMI cases. This is despite international guidelines recommending it in preference to ticagrelor in PCI undertaken for ACS indications. Prasugrel should be used in preference to ticagrelor and clopidogrel where there are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

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

Potential Challenges with Proposed pathway

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

Proposed Pathway for NSTEMI management within ABUHB



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

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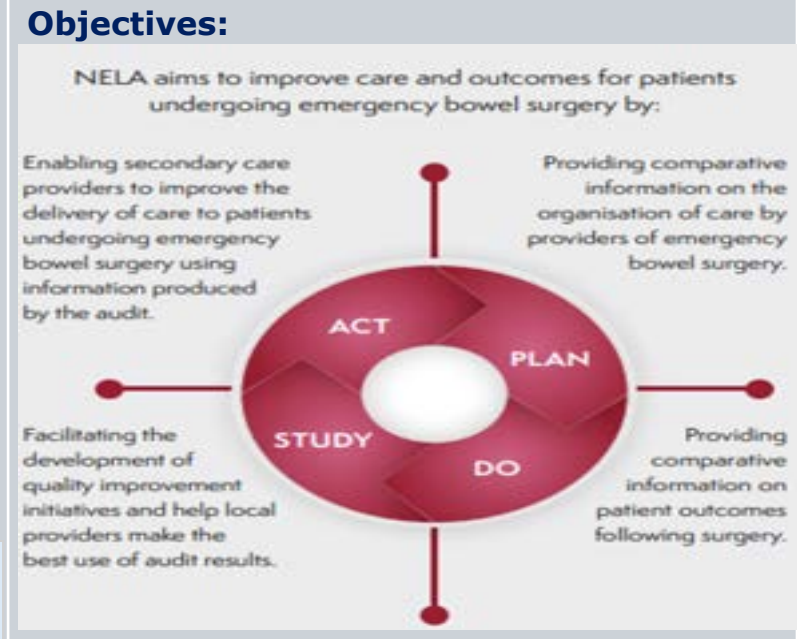
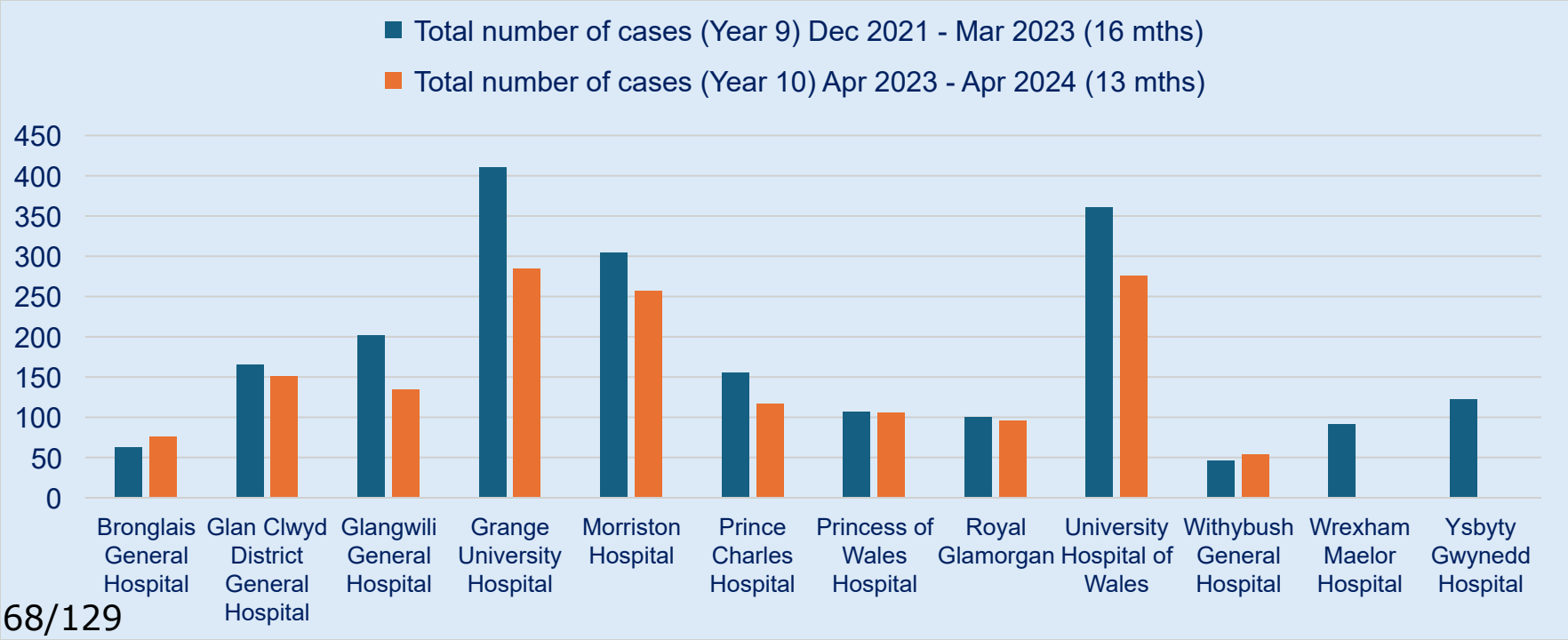
Rationale:

This is the tenth annual report of the National Emergency Laparotomy Audit (NELA) and it examines care received by 23,560 NHS patients in 176 hospitals across England and Wales admitted for emergency laparotomy (emergency bowel surgery, EmLap) between 1 April 2023 and 23 April 2024.

The report shows that clinical teams in many different hospitals were able to provide high quality care against a challenging background, with demand for access to emergency care frequently exceeding capacity.

- 30-day mortality fell to the lowest level in ten years of audit (8.1% compared to 11.7% in Year 1)
- Postoperative length of hospital stay fell back to a median of 10 days (compared to 11 days in Year 9).

The reduction in mortality represents around 1,150 fewer deaths per year amongst the estimated 32,000 patients who undergo emergency laparotomy, whilst a fall in median length of stay of one day could represent potential annual financial savings of more than £10million.

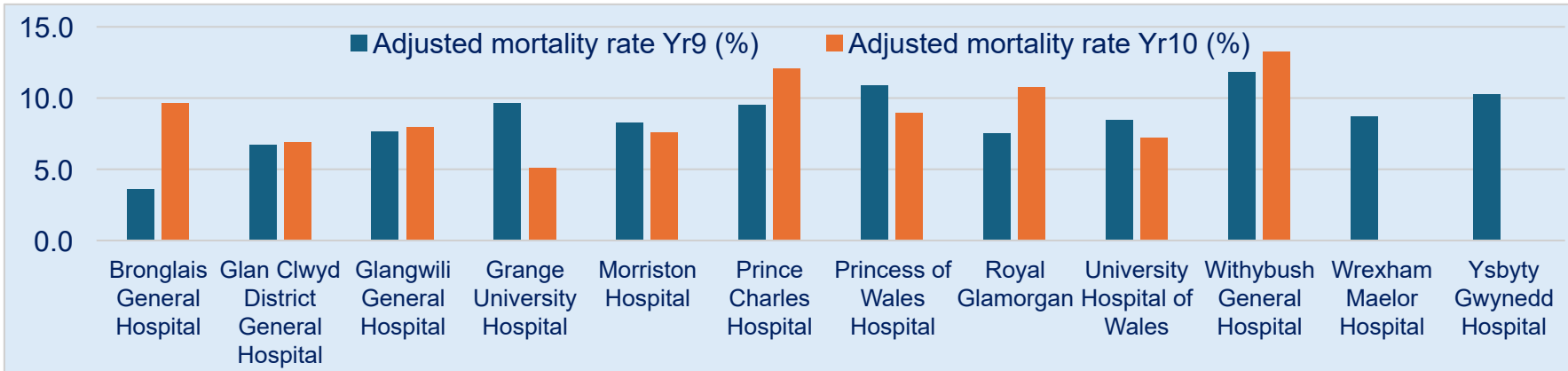


Please note that the reduction in cases from year 9 to year 10 will be impacted upon by the date range for each year. Year 9 is a total of 16 months data (Dec 21 – Mar 23) and year 10 is a total of 13 months data (Apr 23 – Apr 24)

Nationally 30-day mortality fell to the lowest level in ten years of audit 8.1% compared to 11.7%.

ABUHB 30-day mortality in year 9 was 9.6% and in year 10 was 5.1%.

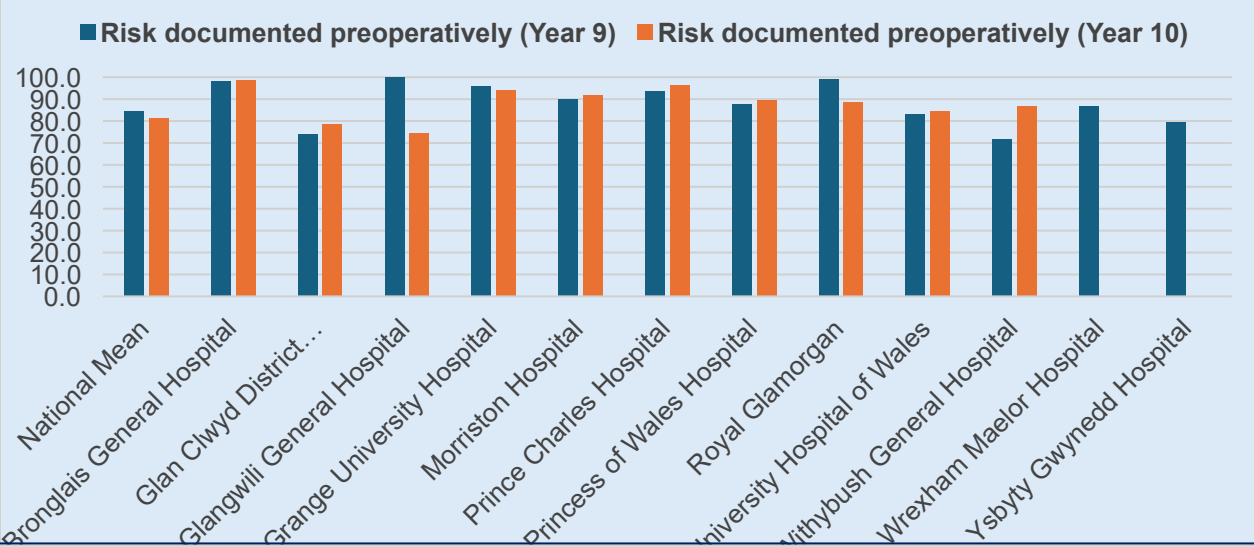
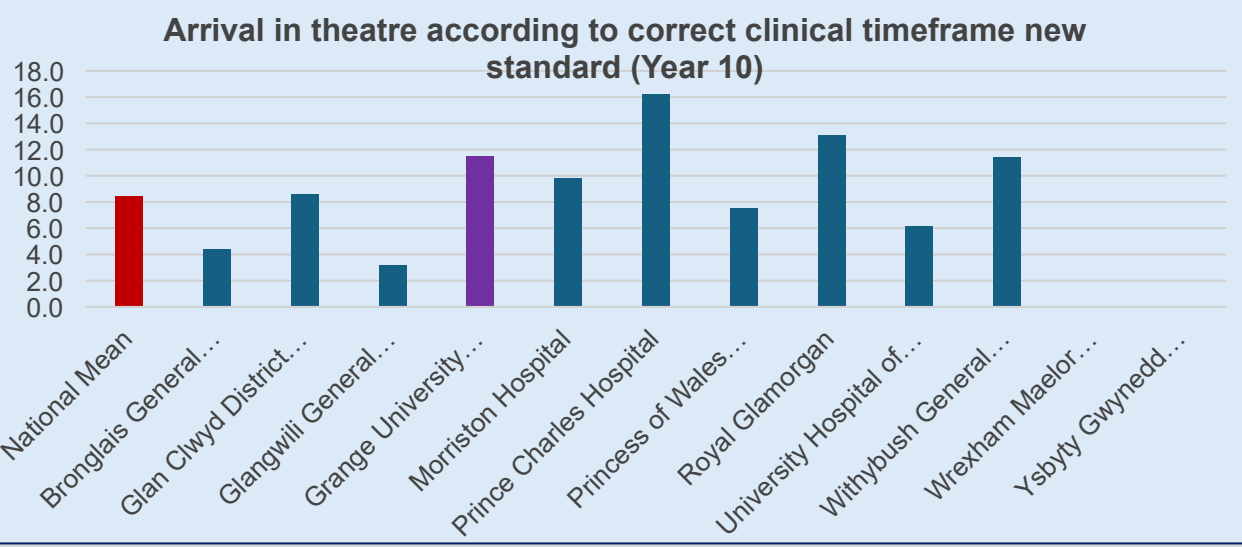
Although ABUHB not reported as a positive outlier (5), GUH is 23rd out of 169 hospitals.



Key messages and recommendations - Key Message 1a: Timeliness of diagnostic pathway following arrival at hospital

NELA Standards - Proportion (%) of patients who received (or should have received) immediate surgery (as per RCS definitions of immediate surgery) within 6 hours of arrival in hospital for Year 11 (@ Mar 25) for ABUHB 6.67%, national rate 10.81% and regional rate 12.65%.

NELA Standards - Proportion (%) of patients in whom a risk assessment was documented preoperatively for Year 11 (@ Mar 25) for ABUHB 91.67%, national rate 79.53% and regional rate 83.27%.



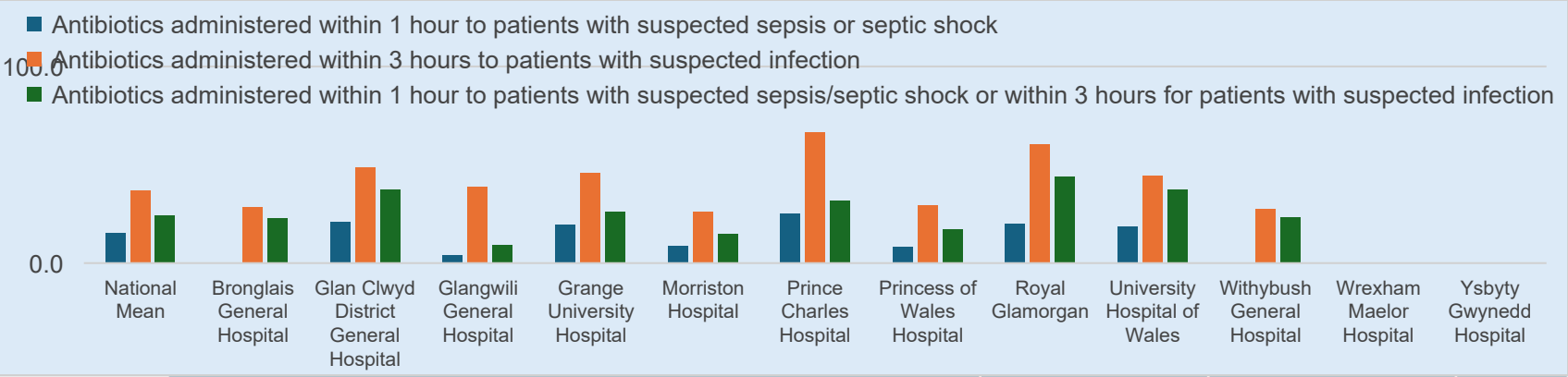
Timely assessment and management depend on the patient’s presenting pathology. Initial symptoms are often non-specific, leading to diagnostic delays—median time to theatre is nearly 22 hours, with nationally 75% of urgent cases waiting over 10 hours.

Any patient with physiological changes and signs of serious surgical conditions (e.g. sepsis, perforation, ischaemia, obstruction) should be treated as **over 129** urgent surgical intervention.

Key Message 1b: Timeliness of antibiotic administration in patients with suspected infection and sepsis of surgical origin following arrival at hospital

Antibiotics should be given within 1 hour for sepsis and 3 hours for infection, but nationally only 15% of sepsis cases and a third of infection cases met these targets. A quarter of patients waited over 5.8 hours, with wide variation in performance across hospitals.

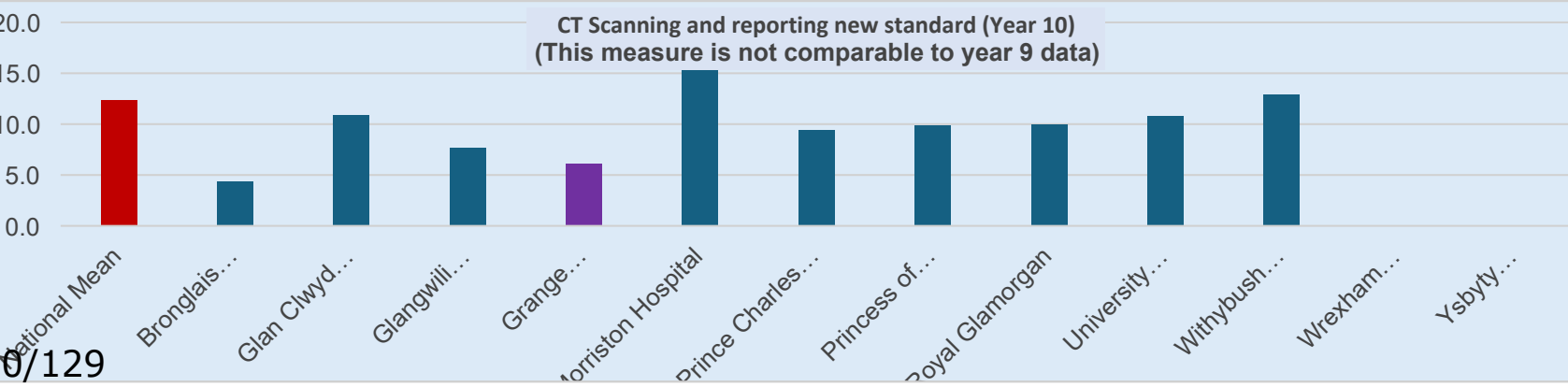
NELA Standards - Proportion (%) of patients with suspected sepsis and/or septic shock at arrival and at decision to operate who receive antibiotics within 1 hour of first recorded NEWS2 abnormality of 5+ or >=3 in any one variable, Year 11 (@ Mar 2025) for ABUHB is 20%, national mean 14.49% and regional mean is 22.59%.



Year 10		Note that the data completeness for the 1-hour sepsis and 3-hour infection are not full data completeness		Data completeness	%
Antibiotics administered within 1 hour to patients with suspected sepsis or septic shock		103		66.7	19.6
Antibiotics administered within 3 hours to patients with suspected infection		56		69.6	45.9
Antibiotics administered within 1 hour to patients with suspected sepsis/septic shock or within 3 hours for patients with suspected infection		284		100	26.2

Key Message 2: Direct communications between requesting and reporting teams around CT scanning

Urgent CT findings that impact surgical decisions should prompt direct communication between the clinician and radiologist. While 98.7% of 'RCS Immediate' patients had senior radiologist reports, only 24.7% had documented direct discussions. Two-way communication is vital when time-critical pathology is suspected.

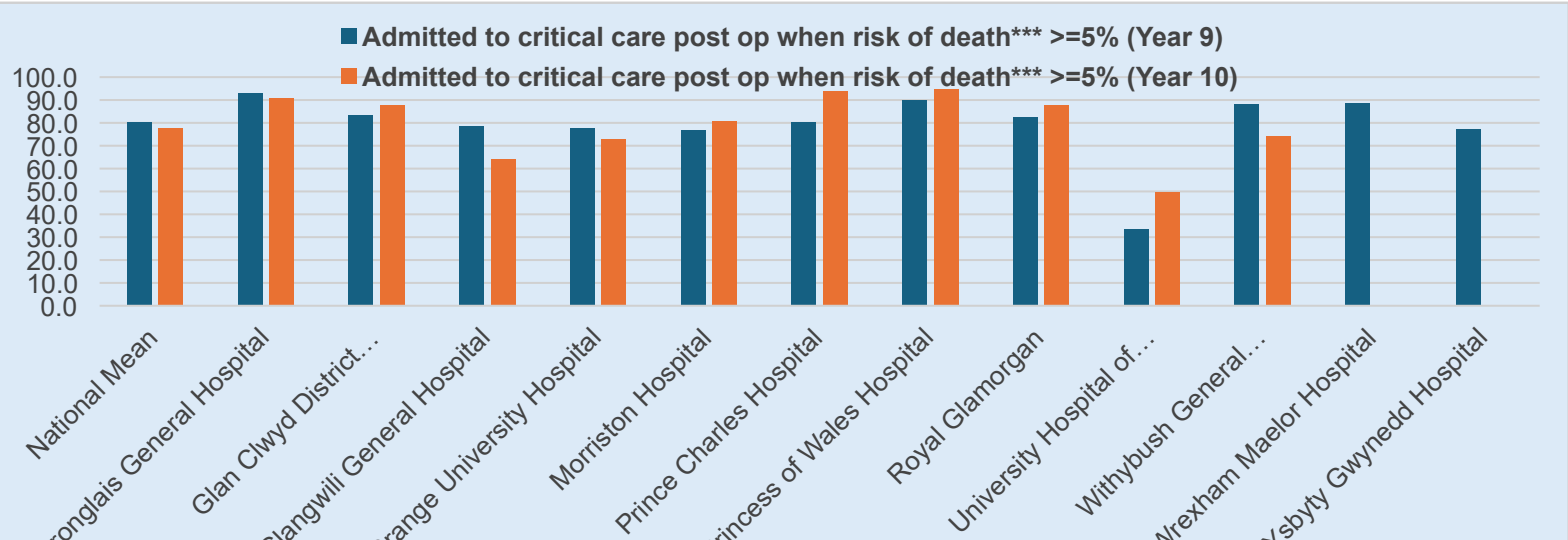


NELA Standard - ABUHB for Year 11 (@ March 2025) 11.76%, nationally 13.89%, regional mean 8.39% for patients who are categorised as immediate (as per RCS definitions of immediate surgery) who undergo preop CT scanning and where there is direct communication between radiologist (ST3 and above) and surgeon (ST3 or above), either via phone or in person to discuss CT findings

Key Message 3: Critical care bed capacity

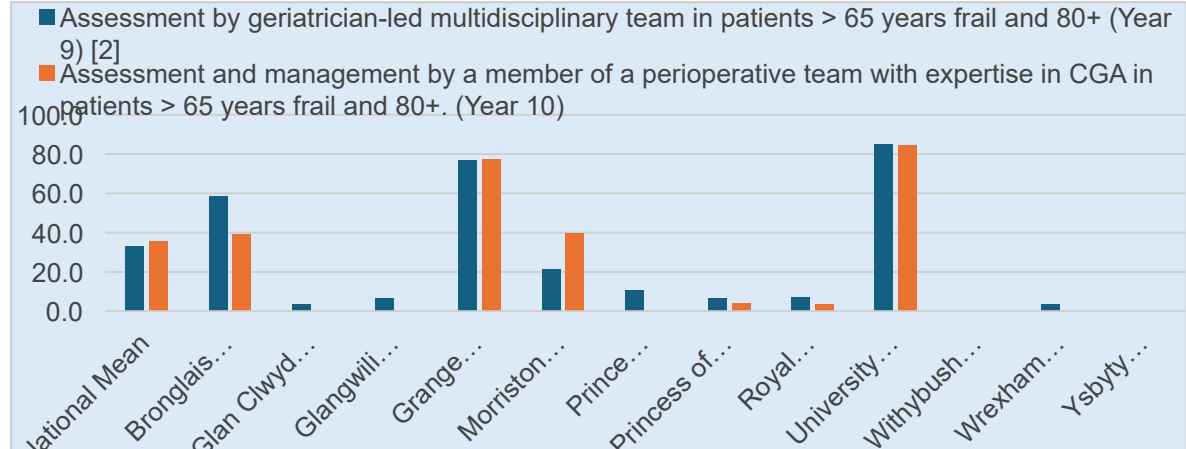
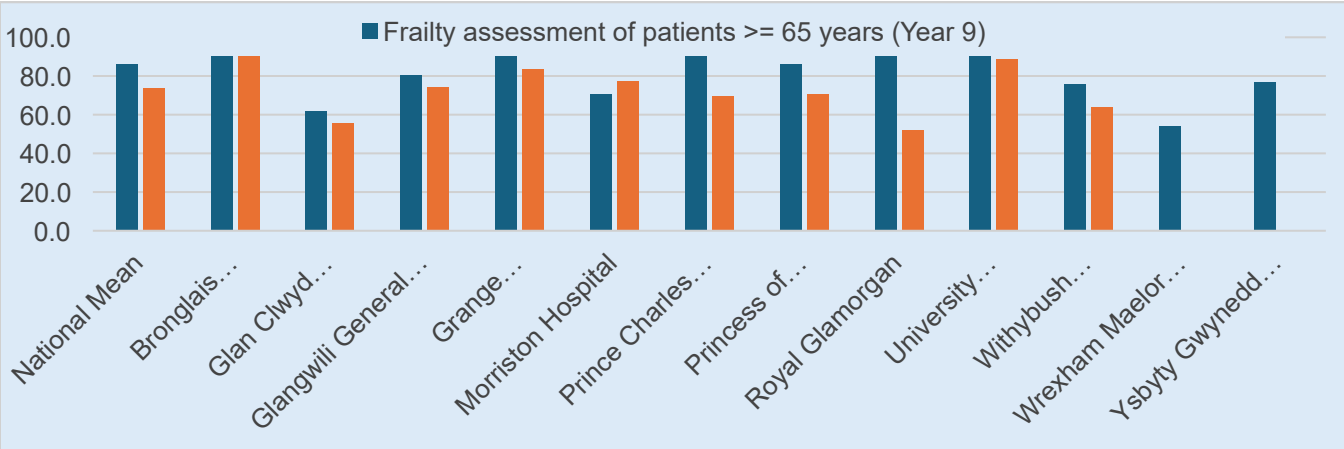
High-risk patients aren't always admitted to critical care post-surgery—16.5% received ward-level care, of which 4.3% died in hospital. Guidance recommends critical care for these patients. With 30–40 emergency laparotomy cases per 100,000 adults annually needing critical care, hospitals must plan accordingly. Research is needed to understand variation in admission rates and explore cost-effective enhanced care models.

Unexpected CC admissions from the ward < 7 days post op has decreased from 1.5% in year 9 to 0.7% in year 10.



NELA Standards - Proportion (%) of postoperative high-risk patients (risk of death of ≥5%) admitted directly to critical care postoperatively, Year 11 (@ Mar 2025) ABUHB 78.57, national rate 71.26% and regional rate 77.98%,

Key Message 4: Specialist care for older patients, Best Practice Tariff, and incentivising better postoperative care for older patients



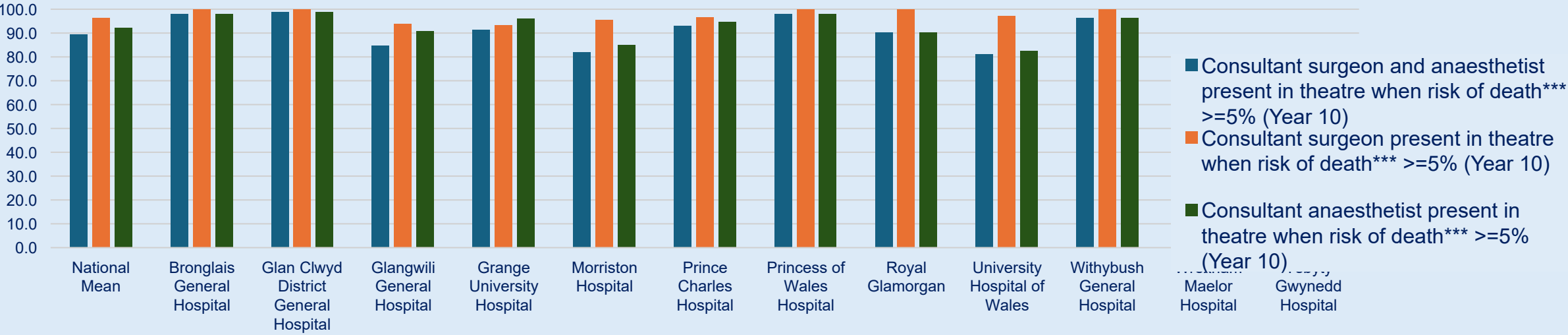
NELA Standards - Proportion (%) of patients aged 65 or older and living with frailty, or aged 80 and older who receive postoperative assessment and management by a member of a perioperative frailty team with expertise in CGA. In Years 1-9 this standard was met when the patient was assessed by a specialist/consultant in the care of the older person (with a change in Year 6 in the wording in question 7.3 from specialist geriatrician to consultant geriatrician). In year 10 the standard changed to include geriatrician-led service, OR a perioperative medicine-led team with expertise in CGA and with established referral pathways to geriatrics, ABUHB rate for Year 11 (@ Mar 2025) 80%, national rate 40.24% and regional rate 23.64%.

Key Message 5: Variation in processes and outcomes of care

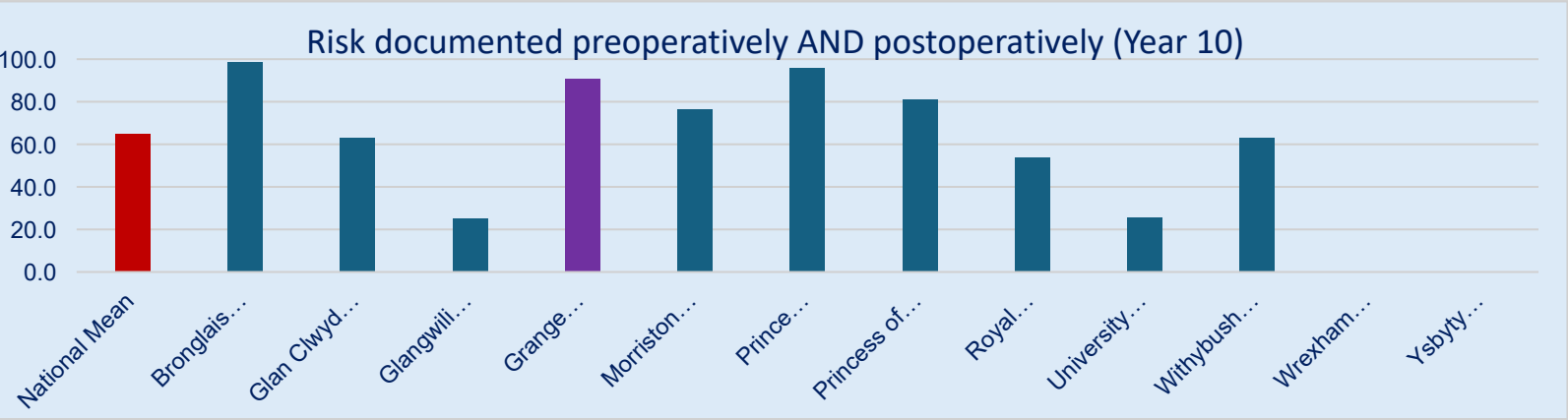
Key Message 6: Apparent differences in timeliness of care for female and male patients

This report does not explore in depth the metric of consultant presence in theatre as this is now well established

NELA Standard - ABUHB for Year 11 (@ Mar 2025) at 100% for Consultant Surgeon and Consultant Anaesthetist present in theatre, compared to the national rate of 86.25% and regional rate 88.89%.



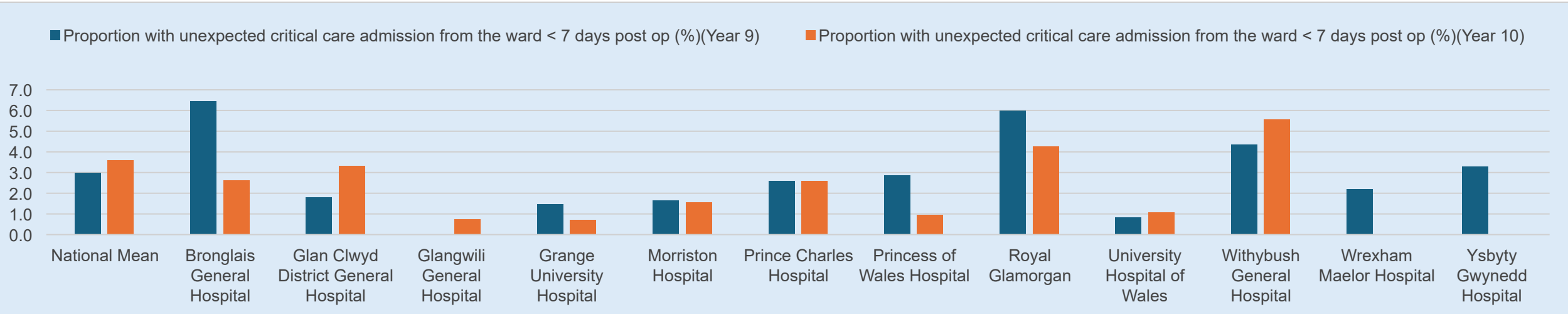
Additional Information:



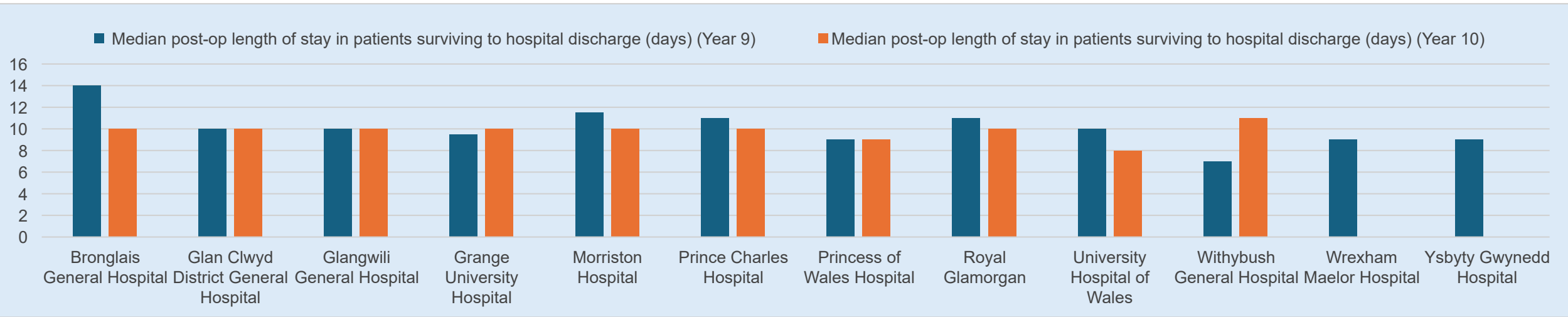
NELA Standards - Proportion (%) of patients in whom a risk assessment was documented postoperatively for Year 11 (@ Mar 25) ABUHB 91.67%, national rate 62.6% and regional rate 68.55%.

Nationally Postoperative length of hospital stay (LoS) fell back to a median of 10 days (compared to 11 days in Year 9)

ABUHB median post-op LoS for year 9 was 9.5 days compared to year 10 which has increased to 10 days, which is aligned to the national result, however a decrease in performance for ABUHB of 0.5 of a day.



Nationally unexpected returns to critical care from the ward < 7 days post op in Year 9 was 3.0% which increased in Year 10 to 3.6%. ABUHB has a better rate of return in Year 9 at 1.5% and this improved further in Year 10 to 0.7%.



NELA Standards - Median length of stay in days Year 11 (@ Mar 2025), ABUHB 15 days, national 11 days and regional 13.6 days.

Assurance level		Description		Risk level	Description	
Significant		The project has mostly achieved the standards or criteria being audited against		Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved	
Report Successes:				Report Concerns:		
1	Reduction in risk adjusted mortality from 9.6% to 5.1%			1	Frailty assessment and accuracy needs improving	
2	Improved rates of COTE review post operatively (vs. national mean)			2	More COTE involvement for frail older patients with need to expand team	
3	Preoperative risk assessment remains high			3	Poor time to theatre from presentation to hospital and need to streamline pathway	
4	Consultant anaesthetist and consultant surgeon presence in theatre for high-risk patients remains high			4	Need for NELA nurse practitioner to help pre-op pathway and COTE consultant	
5	Successful running of the NELA M&M meetings throughout the year			5	Communication between radiologists and clinical team regarding CT findings	
Report Recommendations:			S.M.A.R.T Actions: Responsible: Due Date: Progress:			
1	Royal College of Anaesthetists, Royal College of Emergency Medicine, Royal College of Nursing, Royal College of Radiologists, and Royal College of Surgeons of England – should continue to work together to update and develop consensus pathways of care for patients who might require emergency abdominal surgery. Pathways should contain statements around seniority of key decision makers and ideal timeliness of key steps including antibiotic administration and timing of definitive surgery.				Royal College Recommendations	
2	Royal College of Anaesthetists, Royal College of Emergency Medicine, Royal College of Radiologists, Royal College of Surgeons of England – should highlight current guidelines around the need for effective two-way direct communication between referrer and reporter whenever the patient’s condition or CT predicted findings suggest the patient has developed time-critical pathology.					
3 a	NHS England, Integrated Care Boards, and Welsh Health Boards – should evaluate variations in critical care bed capacity for patients undergoing emergency laparotomy, factoring a predicted need of 30-40 EmLap-related critical care admissions per year per 100,000 adult population served.			- Current evaluation on ‘unmet demand’ for all patients needing critical - care including those post emergency laparotomy - Hayden Stephenson (CD CC)/Directorate Management Team - Ongoing		
3 b	National Institute for Health and Care Research – should consider commissioning research into optimum placement and management of patients at the margins of risk categories to better understand potential early interventions that could mitigate the risk of dying after surgery				NICE Recommendation	
4	Royal College of Anaesthetists, Royal College of Nursing, Royal College of Physicians, Royal College of Surgeons of England and British Geriatrics Society – should work together across the blended workforce to develop common competency-based training and education around optimising perioperative care for older patients and those living with frailty, such that the unmet need for specialist care can be more reliably delivered.				Royal College/Society Recommendation	

74/129

258/425

National QI suggestions

QI suggestion: Widespread variation in delivery of key processes of care for emergency laparotomy patients is seen in different hospitals across both England and Wales. Challenges and potential solutions will likely vary between units. Driving local service development requires strong engagement with NELA, which in turn requires locally funded clinical leadership time.

QI suggestion: Surgical, medical, emergency medicine and radiology teams should ensure effective communication between requesting and reporting teams takes place, rather than relying on availability of written reports in isolation. Requesting teams must remain cognisant of the need to seek prompt expert radiology opinion following urgent CT scanning whenever there is an apparent mismatch between a patient’s clinical condition and the CT report, especially when this information is critical to whether surgery should be undertaken.

QI suggestion: If there has been direct communication between referring and reporting teams, this should be included in the text of the CT report, ensuring documentation of best practice.

QI suggestion: Local teams should quality-assure recorded ASA grades for all NELA patients. An inappropriately low or high ASA grade in the PRS may result in under- or overestimation of mortality risk and as such, patients may not receive appropriate levels of postoperative care.

QI suggestion: Sites should review the appropriateness of EmLap cases admitted under medicine and investigate any potential avoidable delays in the time to theatre from time of arrival in hospital.

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Improve door to theatre time, and look at pathway development	On going QI project	All NELA leads	July 2026	On going
2	Improve communications and documentation between Radiology and Surgery	Gethin Williams to liaise with Radiology	All NELA leads	March 2026	

National Early Inflammatory Arthritis Audit (NEIAA) State of the Nation Summary Report 2025 Data Collection Period: 1 April 2024 – 31 March 2025 - Year 7		Clinical Lead:	Dr Non Pugh – Consultant Rheumatologist
		NICE :	QS33 – Rheumatoid arthritis in over 16s
Rationale:	Inflammatory arthritis, including rheumatoid arthritis (RA), is a significant disease burden in the UK, affecting over 400,000 people. Delays in treatment can lead to significant disability, reduced quality of life, and loss of productivity in the workforce. Treatment delays for rare autoimmune rheumatic diseases (RAIRDs) such as systemic vasculitides are also associated with adverse outcomes including permanent disability(4), organ failure and death.		
Objectives:	The NEIAA aims to improve the quality of care for people living with rheumatic diseases by collecting demographic and care quality data on all eligible newly diagnosed patients over the age of 16 in rheumatology departments across England and Wales. Diagnoses required for enrolment in the audit include inflammatory arthritides, systemic vasculitides and connective tissue diseases. By collecting this data, the audit aims to recommend standardised, effective, and patient-centred care pathways The performance of individual healthcare providers is measured against the National Institute for Health and Care Excellence (NICE) quality standard [QS33] ‘rheumatoid arthritis in over 16s’, last updated in 2020(5).		

National Early Inflammatory Arthritis Audit (NEIAA)

Measures quality of care delivered to patients in England and Wales aged 16 and over with suspected and newly diagnosed early inflammatory arthritis

QS1 Adults with suspected persistent synovitis affecting more than 1 joint, or the small joints of the hands and feet, are referred to rheumatology services within 3 working days of presenting in primary care

QS2 Adults with active rheumatoid arthritis start conventional disease-modifying anti-rheumatic drug monotherapy within 6 weeks of referral, with monthly monitoring until their treatment target is met

Also assesses how inflammatory arthritis affects people’s day-to-day function, mobility, sleep, wellbeing and ability to work. Rheumatology clinical teams provide information about patient care over the first 3 months. This includes:

- Referral times
- Time to treatment
- Clinical response to treatment
- Patient Reported Outcome Measures (PROMs) for 12 months

Also collecting data re referral times on other conditions:

- **SLE/CTD**
- **Axial Spondyloarthritis**
- **Systemic vasculitis**
- **GCA- further information re: USS & treatment**

ABUHB results April 2024- March 2025 - Number of patients : 104

QS1 Referral to specialist rheumatology service within three working days
ABUHB 60 % National 53 %
Patients seen for their first appointment within 3 weeks of receipt of referral
ABUHB 66% National 43%
QS2 Patients receiving treatment within 6 weeks of receipt of referral
ABUHB 80% National 60 %
Average time from referral to appointment
ABUHB 21 days National 32 days
Average time from referral to treatment
ABUHB 31 days National 56 days

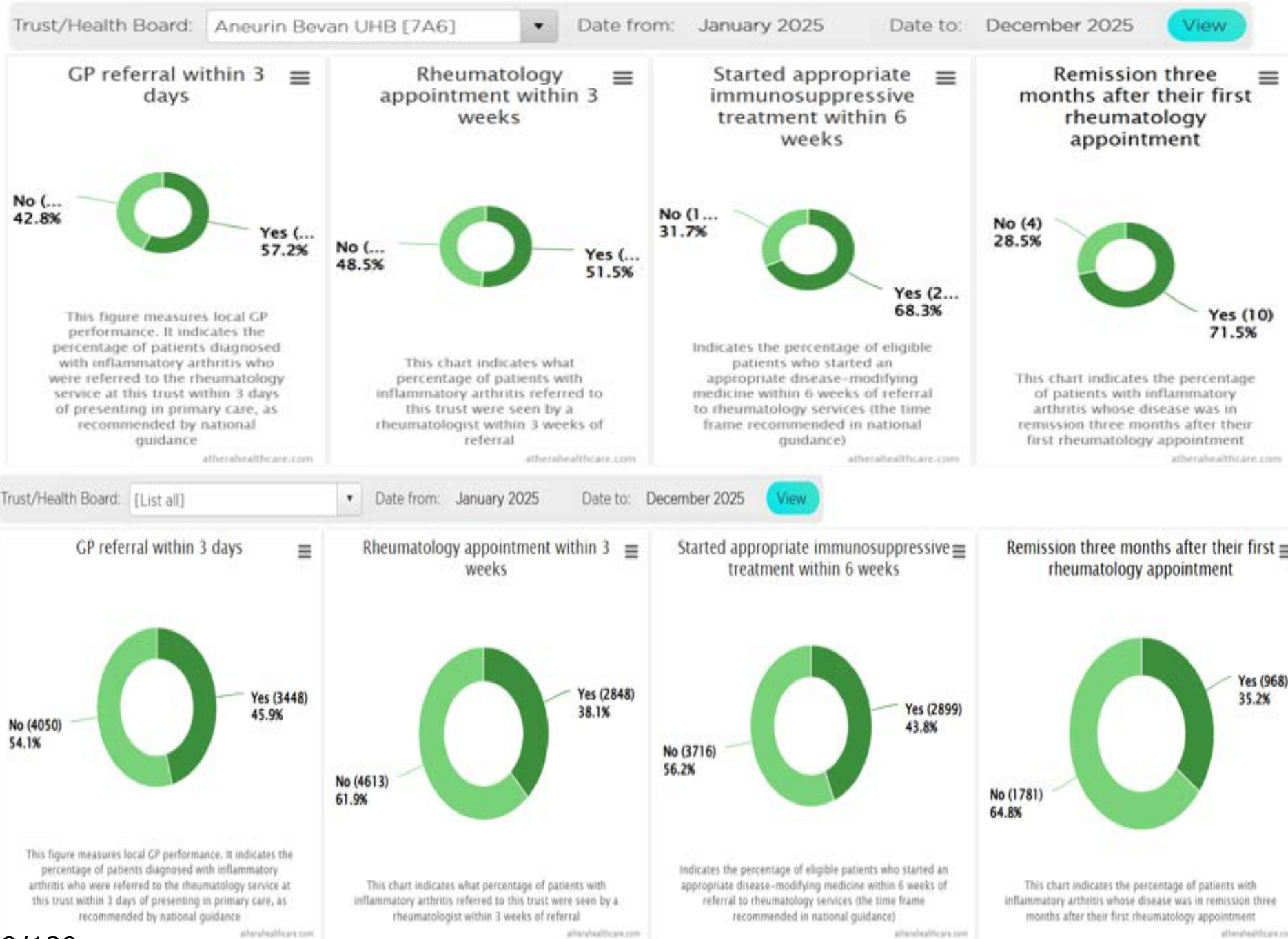
	ABUHB	BCUHB	CAVUHB	CTMUHB	HDUHB	SBUHB	National
QS1 %	60	73	15	22	74	100	53
Seen within 3 weeks %	66	86	18	17	14	38	43
New QS2 %	80	96	59	36	0	64	60

other conditions	2024-25	2023-24
CTD	7	0
GCA	8	3

NEIAA continues to be on the agenda for our directorate meetings with discussion of the new public facing performance dashboard reports

The NEIAA dashboard auto populates Quality Metric performance, based upon the data provided by NHS trusts (in England) and Health Boards (in Wales). There are some important caveats to consider.

- 1. Referral, assessment, and treatment figures are based solely on data entered for EIA patients.
- 2. Delay to starting a DMARD is calculated as the number of patients starting a DMARD within 6 weeks of referral as the numerator, and the number of people marked as eligible for EIA follow up as the denominator. As not all patients selected for EIA follow up will have passed the 6 week cut off for starting a DMARD, it is possible you will underestimate your performance.
- 3. No attempt is made to adjust for case-mix, and it is not possible to calculate whether you are an outlier from these data alone.
- 4. Referral figures are solely based on patients referred by GP with a diagnosis of EIA.



GP referral within 3 days:

ABUHB - 57.2%

National - 45.9%

(Performance in Wales 4th of 6)

Appointment within 3 weeks:

ABUHB - 51.5%

National - 38.1%

(Performance in Wales 2nd of 6)

Overall remission rates at 3 months remain static at 34% but this disguises significant geographic variation

Region	Remission Rate
North West	24%
North East and Yorkshire	34%
Midlands	31%
East of England	51%
South East	37%
South West	42%
Wales	36%
London	27%

Immunosuppressive treatment within 6 weeks:

ABUHB - 68.3%

National - 43.8%

(Performance in Wales 2nd of 6)

Remission 3 months after 1st Rheum appt:

ABUHB - 71.5%

National - 35.2%

(Wales 36%)

Assurance level	Description
Full	The project has fully 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	Continue to start DMARD treatment in 80% within 6 weeks and meeting audit standards
2	ABUHB results better than national average and second in Wales
3	Increasing number of other conditions included

Report Concerns:	
1	None

Over the past several years, the service has undergone a significant and measurable transformation, progressing from a position of **negative** outlier status in national benchmarking to becoming a recognised **positive** outlier for clinical quality and patient outcomes.

National recommendations:

1

Provision of specific funding to support awareness-raising of the importance of early presentation to primary care of people with symptoms of suspected EIA. **Key message 3**
 Action by: Department of Health and Social Care/NHSE and Welsh Health Boards



2

NEIAA dashboard data should be used to support rheumatology departments and specialist centres to pinpoint unwarranted variation, track improvement over time and inform planning and investment. **Key messages 4, 5, 6, 11 and 12**
 Action by: Integrated Care Boards, Welsh Health Boards



3

Patient-reported outcome measures (PROMs) should be integrated into clinical pathways to identify individuals experiencing significant psychological burden and facilitate their timely referral to appropriate mental health support services. **Key messages 7 & 8**
 Action by: Integrated Care Boards, Welsh Health Boards



4

National guidance should be developed and implemented to ensure timely treatment of EIA and minimise regional disparities in care delivery. **Key messages 5, 6 and 7**
 Action by: British Society for Rheumatology, DHSC/NHSE, GIRFT and Welsh Health Boards



5

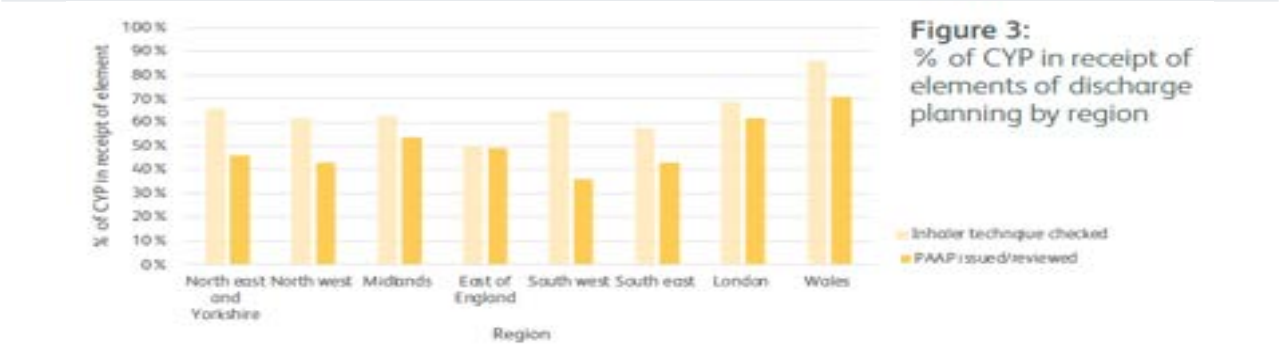
Widespread implementation of the Getting it Right First Time (GIRFT)/National Axial Spondyloarthritis Society (NASS) National Playbook on Axial Spondyloarthritis within primary care. **Key message 9**
 Action by: Royal College of General Practitioners, Integrated Care Boards



Catching our breath: Time for change in respiratory care	Clinical Lead:	Marcus Pierrepoint – Consultant Paediatrician
	NICE:	NG245, QS25

Rationale:	The <i>Catching our breath</i> report from the National Respiratory Audit Programme (NRAP) presents important insights into the current state of the nation of respiratory care across England and Wales. Its rationale is to shine a light on ongoing gaps in respiratory care, promote evidence-based interventions, and drive systemic improvements across England and Wales to reduce preventable harm and improve outcomes for people with asthma and COPD
Objectives:	Objectives in relation to children and young people (CYP) are to improve the quality and consistency of asthma care by ensuring timely interventions during hospital admissions, addressing risk factors such as smoking and second-hand smoke exposure, and reducing regional variation in care delivery. It aims to strengthen discharge planning through inhaler technique checks, personalised asthma action plans, and specialist follow-up, while promoting better data collection to understand the full care pathway. These objectives support national standards and bundles of care to improve outcomes and prevent avoidable harm for CYP with asthma.

Presented at Clinical Standards and Effectiveness Group – 26th February 2026



Concerns were raised in the report in relation to CYP receiving all three elements of discharge planning, ie checking inhaler technique, providing a Personalised Asthma Action Plan (PAAP) and a specialist review being requested within 4 weeks of discharge. The graph shows how Wales has been performing in two of these elements compared to England

Our publication marks over 10 years since the landmark National Review of Asthma Deaths, which highlighted important deficiencies in asthma care and made 19 key recommendations to improve outcomes and avoid preventable harm and deaths.

In that context, it is of genuine importance that this report identifies continued and highly significant deficiencies in the delivery of many of the key interventions for patients with asthma and chronic obstructive pulmonary disease (COPD) that are known to improve health and transform important clinical outcomes. This pattern has changed little in recent years and, in many aspects, has not recovered to pre-pandemic levels. Recognition and understanding of these deficiencies is vital to inform new models of care and appropriate use of resources.

Key Findings and Priorities for Improvement Relating to Children & Young People in Wales

Admissions due to asthma exacerbations during 2023–24:

- 456 admissions for CYP aged 1–5
- 308 admissions for CYP aged 6+

Risk Factor Recording:

Smoking status and second-hand smoke exposure are poorly documented for CYP in Wales, despite these being key risk factors for asthma exacerbations.

Tobacco Dependence:

Very low rates of intervention for parents/carers who smoke, even when CYP are exposed to second-hand smoke. **(this relates to both England and Wales)**

Call to Action:

- Welsh health boards should prioritise improving discharge planning for CYP, address tobacco dependence in families, and ensure compliance with the National Bundle of Care for CYP with Asthma.

Making an impact

NRAP works with patients to ensure our audit programme focuses on improvements in the areas most important to people living with respiratory conditions.

Royal College of Paediatrics and Child Health

The Asthma &Me Ambassadors are aged 14–24 and have joined together from across the country with a shared mission to improve asthma care and services for children and young people. Some of them have personal experiences of asthma, while others have an interest through family or friends – all have a passion to make a difference.

This year, we worked with the Asthma & Me ambassadors to produce two resources:

> What should you expect to receive when discharged from hospital after an asthma attack? – For children, young people and their families/caregivers. (see slide 5)

> A checklist for elements of care given at discharge from hospital after an asthma attack – For hospitals and medical staff. (see slide 5)

What should you expect to receive when you're discharged from hospital after an asthma attack?

Checking your inhaler technique

Why is this important?

This can help to ensure that the medication can do its job properly, which can help to reduce the symptoms of asthma.

Questions you can ask your doctor/nurse:

- How do I know if I'm using my inhaler well?
- Can you show me how to use my inhaler correctly?
- Is it difficult to use this inhaler and if so, what other options I can look at?
- How do I know my inhaler is empty?

INHALER TECHNIQUE

Reviewing or giving you a personalised asthma action plan (PAP)

Why is this important?

This can help to reduce the risk of an asthma attack and help you know what to do if you have one.

Questions you can ask your doctor/nurse:

- How can we know my asthma is under control?
- How do I know what happens if my asthma isn't under control?
- What can I do to help my asthma stay under control?
- When should I ask for help with having an asthma attack?

PAP

Booking your follow-up appointments

Why is this important?

You should see a doctor or nurse when you leave the hospital after an asthma attack. This can help to check that you continue to get the best care with your medication. You should also see a general practitioner (GP) or nurse when you leave the hospital after an asthma attack.

Questions you can ask your doctor/nurse:

- When should I see a doctor or nurse about my asthma after I get home?
- What if I need to see a doctor or nurse about my asthma after I get home?

Next Appointment

Created by the Asthma &Me Ambassadors youth project at a design day with NRAP

Royal College of Physicians | National Respiratory Audit Programme (NRAP) | RCPCH&Us

Children and young people's asthma: checklist for discharge from hospital after an asthma attack

Please tick when completed. You can write any notes here.

Inhaler technique checked	
Personalised asthma action plan (PAP) issued or reviewed (your personal asthma action plan)	
Follow up appointments (2 day community check-up, week specialist review)	
Date issued:	

INHALER TECHNIQUE

PAP

Next Appointment

GPCH&Us

Created by the Asthma &Me Ambassadors youth project at a design day with NRAP

Royal College of Physicians | National Respiratory Audit Programme (NRAP) | RCPCH&Us

ABUHB has had an Asthma and Wheeze Education Bundle in place for some time:

❖ Containing a checklist for parents and nursing team.

Your child is on 4 hourly inhalers (Salbutamol) at the time of discharge	
You have been given a spacer and shown how to give your child their inhaler with the spacer	
You have received information on how to clean and look after your child's spacer	
You have a prescription for a course of oral steroids (if indicated)	
If your child is on regular medications for asthma/viral wheeze, these have been reviewed by the doctors and changed if necessary	
You have received advice on when to seek medical advice if your child is unwell with a wheeze	
You have received a completed Personalised action plan for asthma & pre-school wheeze which has your child's details on it.	
You have discussed with the doctor about whether your child needs a follow-up appointment with the GP or in hospital after discharge	

urses to complete at discharge

Signed

sted and checked parent's inhaler technique?

WP10

s been dispensed?

Pharmacy

Ward stock

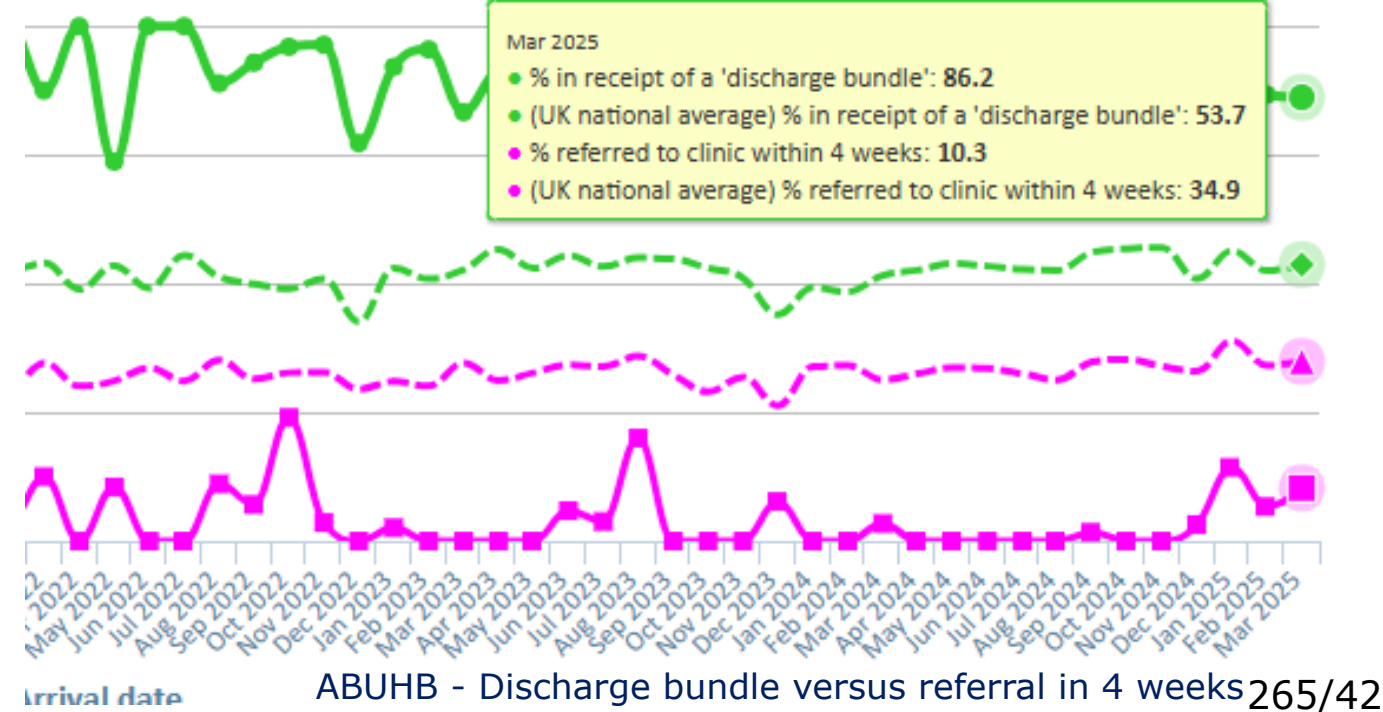
Has the NHS Wales Asthmahub been signposted?

Has the parent's checklist above been completed?

Have any parental questions been answered?

Has the discharge summary been completed?





Elements of care received by children admitted with near-fatal asthma

NRAP clinical audit data show variability in the care of children and young people (CYP) with asthma, including for those who were most unwell and received intravenous (IV) medication and/or were admitted to the intensive care unit (ICU) or high dependency unit (HDU).

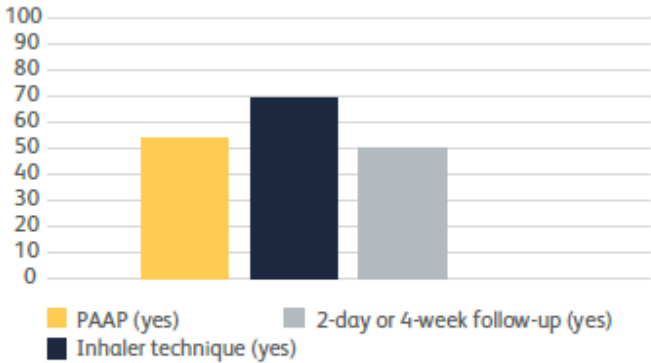


Fig 2. The percentage of CYP who received IV medication during their admission and received each element of discharge planning.

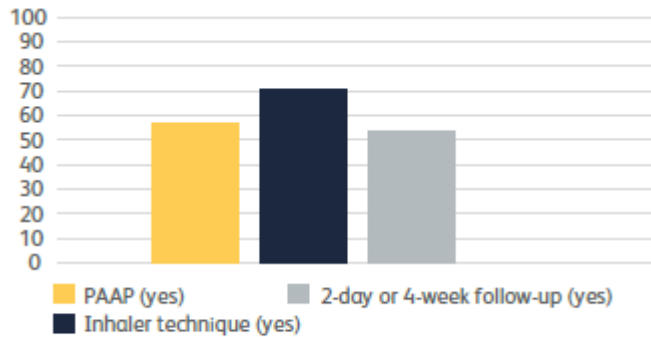


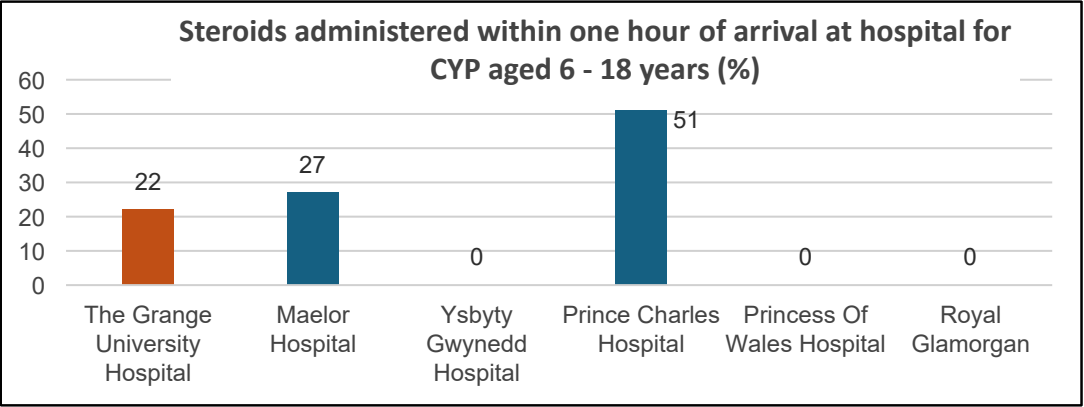
Fig 3. The percentage of CYP who were transferred to ICU or HDU during their admission and received each element of discharge planning.

Why is this important?

A recent National Child Mortality Database report highlighted that there were 54 CYP asthma deaths between 2019 and 2023.⁷ It is extremely important that all children, and particularly those with near-fatal asthma, receive all core elements of care to prevent death.⁸ Furthermore, 65 % of those who died had an emergency department visit or emergency admission in the preceding year, which indicates that there was an opportunity for prevention.⁷

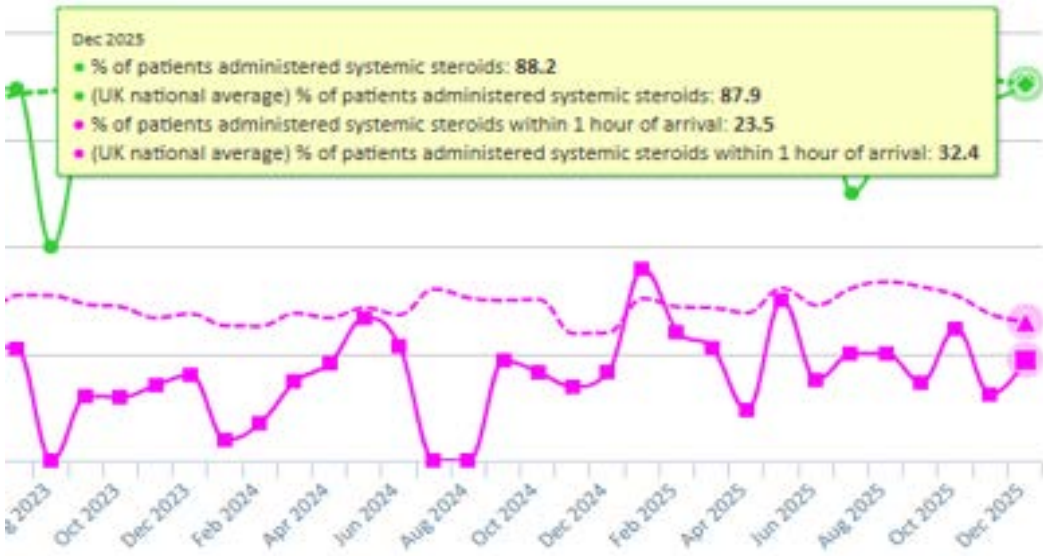
Reviewing or issuing a PAAP, checking patient inhaler technique, and providing a referral for a follow-up with asthma-trained clinicians are all core elements of the discharge bundle as recommended by the National Bundle of Care for Children and Young People with Asthma.⁹

The administration of systemic steroids within 1 hour of arrival is known to reduce the likelihood of hospital admission and is recommended by the guidelines. NRAP data indicate that approximately half of children with near-fatal asthma did not receive systemic steroids within 1 hour of arrival.^{9,10}

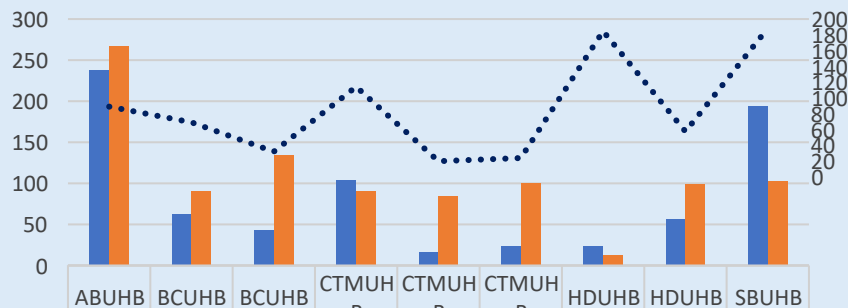


Steroids within 1hr

- Not everyone should get steroids
- Clock starts at booking, via triage to clerking and then prescription and dispensing and administering.
- 1hr is not possible within the current model, we have pushed education.
- We are hoping to use a PGD to administer at triage

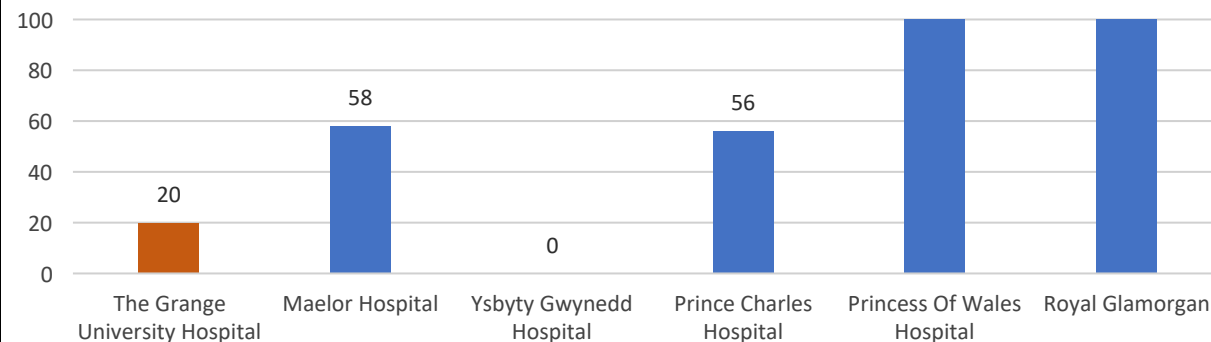


Case Ascertainment



Total number of patients entered into the audit	238	63	43	104	17	24	24	57	194
Number of eligible patients reported PEDW (Wales)	267	91	134	91	85	100	13	99	103
Case ascertainment percentage	89.1	69.2	32.1	114.3	20	24	184.6	57.6	188.3

Parent/carer with tobacco dependency addressed (%)



Smoking addressed? – ABUHB Resources

Family history:

	Asthma	Eczema	Hay fever
Patient			
Mother			
Father			
Siblings			

Name:

Unit No:

Date of Birth:

Address:

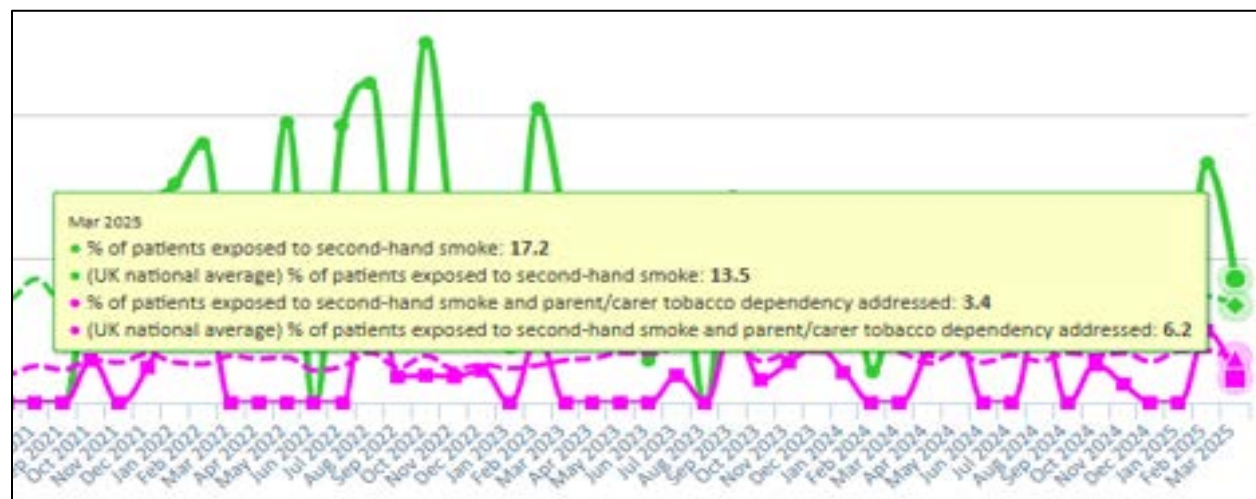
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Pets:

Allergies:

Smoking *: Ask children >11yrs about personal history of smoking

Parent/Carer Smoking *



Useful-Resources

www.asthma.org.uk
Offers a variety of resources to help you and your child manage their asthma. There are helpful videos on using inhalers correctly.



[NHS-Wales-Athma-hub](https://www.nhs.uk/health-apps/nhs-wales-athma-hub/)
App for Parents: NHS-Wales self-management App for parents of children with Asthma.

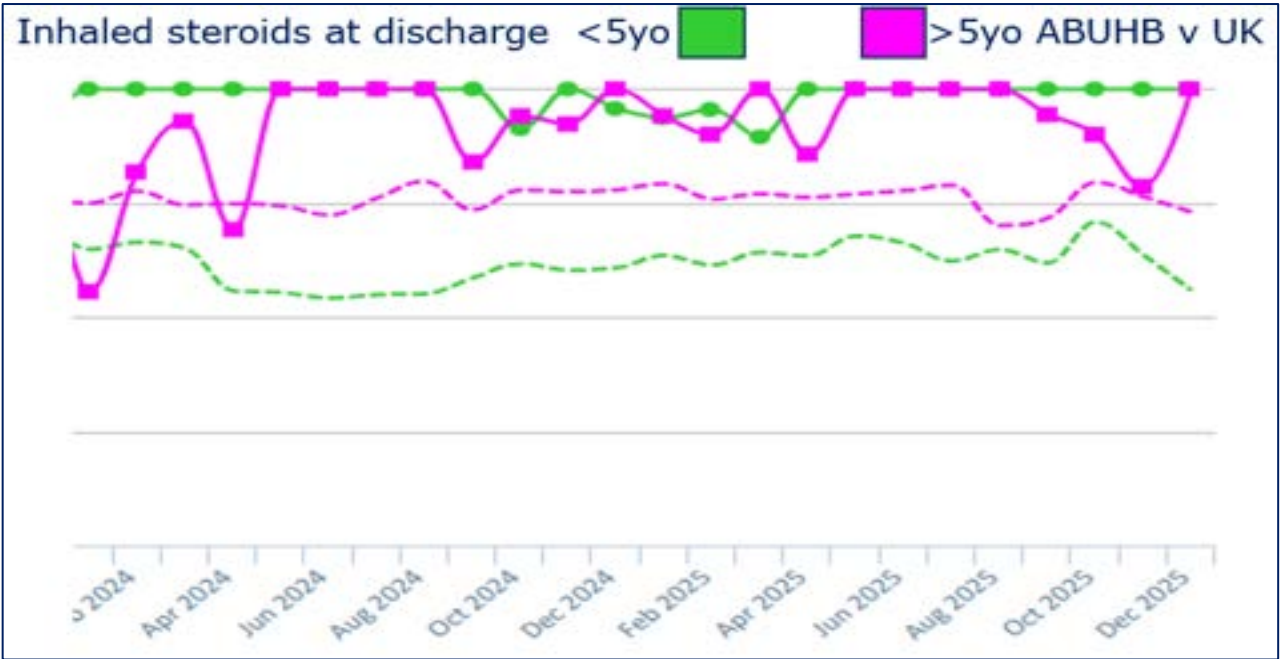
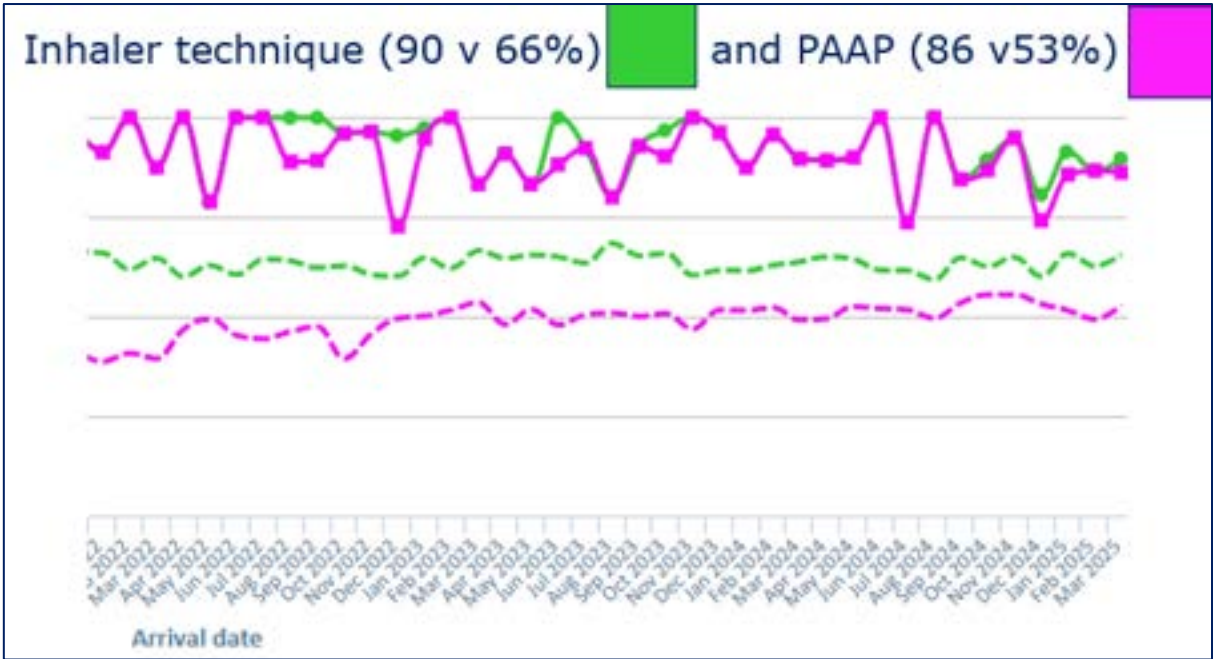
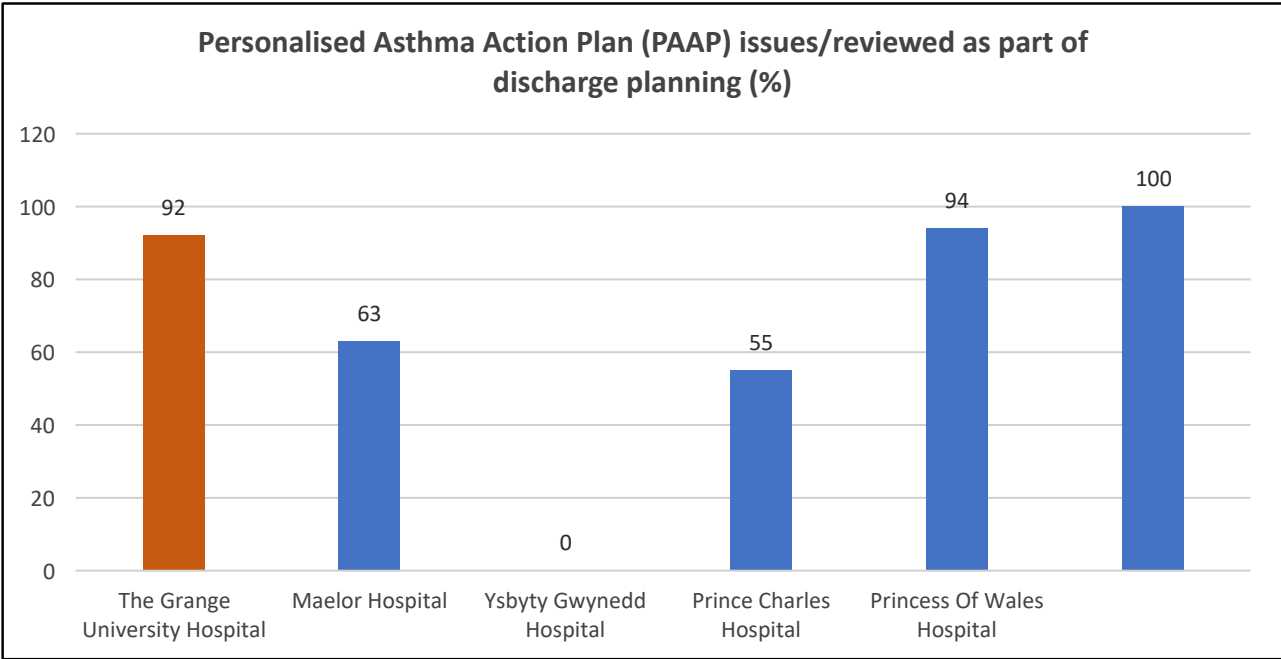
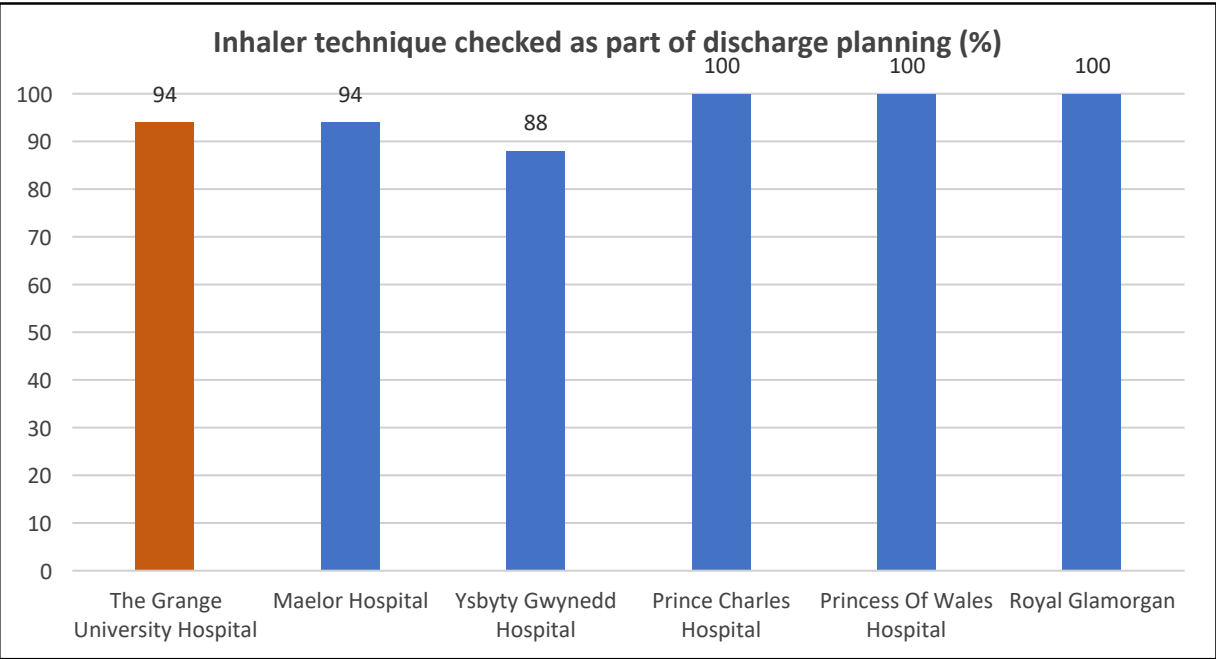


www.ash.org.uk
Health-effects-of-Second-hand-smoke.



www.helpmequit.wales
Free advice and support with smoking cessation.





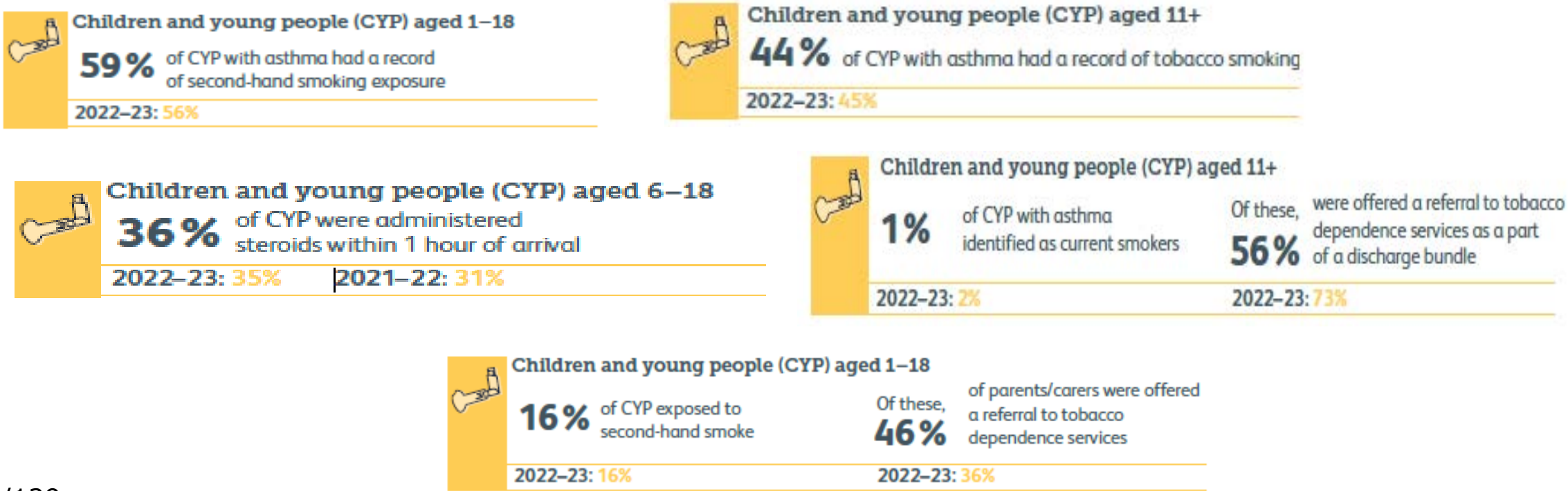
Improving data availability and quality to drive change

Data completion

Data completion is low for certain questions of the acute care audits. For example, only 44% of children and young people (CYP) have a smoking status recorded in the audit, and only 59% of children and young people had a record of whether they are exposed to second-hand smoke in the home. Tobacco smoke and environmental exposure both increase the risk of an acute asthma exacerbation, however these risk factors are not being routinely captured or acted on for a significant proportion of CYP during an acute admission.²

All local health boards should regularly review NRAP data on discharge planning for CYP and adult asthma and COPD with their providers. If data indicates gaps in care, or poor data quality, they should collaborate to identify solutions.

Information relating to data/audit in respect of CYP across England and Wales



Assurance and Risk

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

Key Success and Concerns

Report Successes:		Report Concerns:	
1	Primary care education days	1	Prednisolone within 1 hr
2	New pathway adopted with recent audit interactions	2	Primary care follow up with 2 days
3	Better, earlier diagnosis of asthma	3	Hospital FU with 4 weeks
4	Data capture	4	Documentation of smoking and interventions

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	We reiterate the importance of our <i>Breathing Well</i> recommendation which is maintained for this year’s report: Integrated care boards and local health boards should mandate all eligible services to participate in NRAP to achieve 100% service participation and a minimum of 50% case ascertainment by all services in NRAP audits by May 2026. This will require all services to have named NRAP clinical leadership and dedicated audit support				fulfilled
2	The British Thoracic Society, as the expert body, should lead the development of a standardised acute care bundle for patients with asthma and COPD on arrival to hospital, working towards May 2026. This should involve consultation with other bodies such as the Royal College of Emergency Medicine, Society for Acute Medicine, and NRAP. NRAP will measure the implementation of the acute care bundle by tracking the percentage of patients receiving timely and optimal care.				fulfilled
3	We reiterate the importance of our Breathing well recommendation which is maintained for this year’s report: All people with COPD and asthma who smoke, and smokers who are parents of children and young people with asthma, should be offered evidence-based treatment and referral for tobacco dependency.	Present at next audit day Junior education in PED and paed		3 months	
4	PGD for prednisolone for wheeze - Pharmacy constraints	Already initiated	M Pierrepoint		
5	Nurse-led asthma FU clinics - Cost constraints	Already submitted			

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Develop more transition joint working	2 meetings per yr	Dr Gupta		actioned
2	Liaise with primary care about 2-day FU		M Pierrepoint	3 months	

Please note that the NBCA State of the Nation Report published in January 2025 related to data from 1 April 2022 to 31 March 2023.

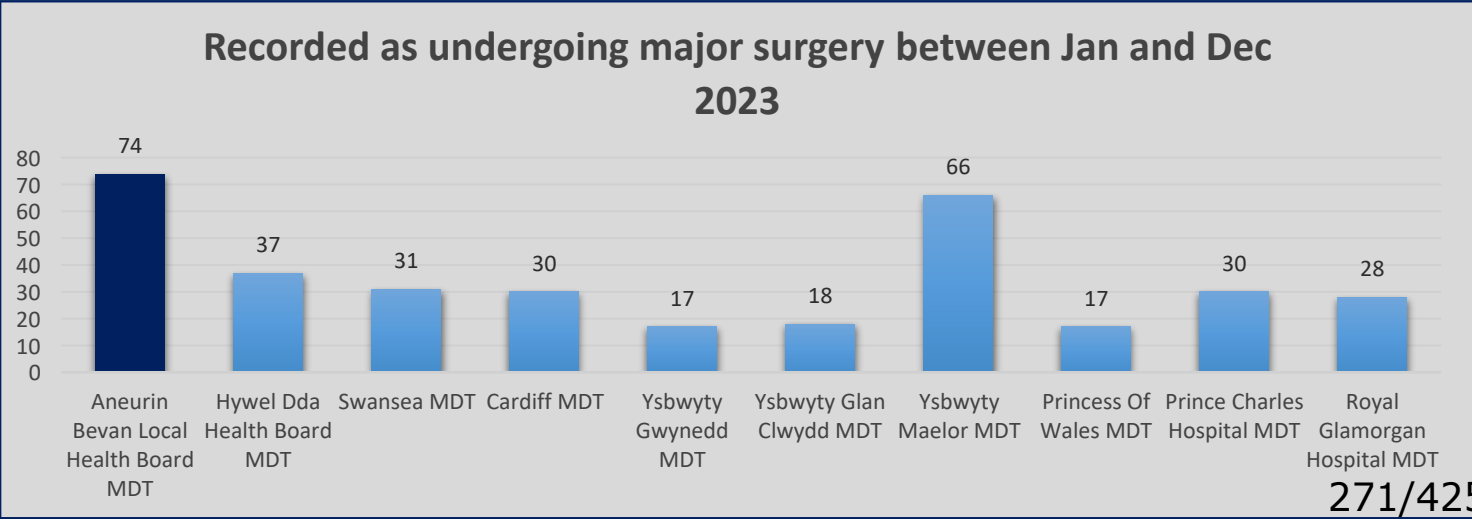
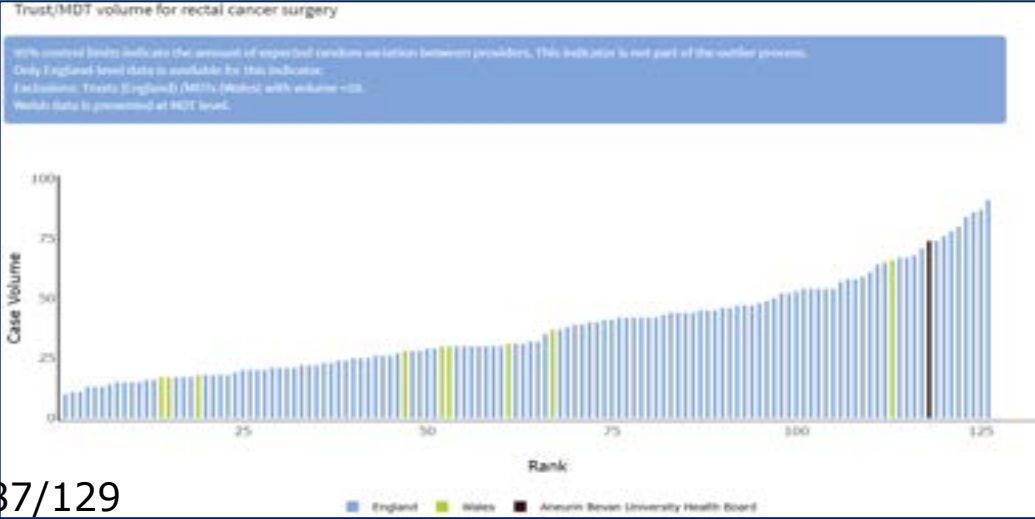
NICE guideline [NG151] Quality Standards DG27

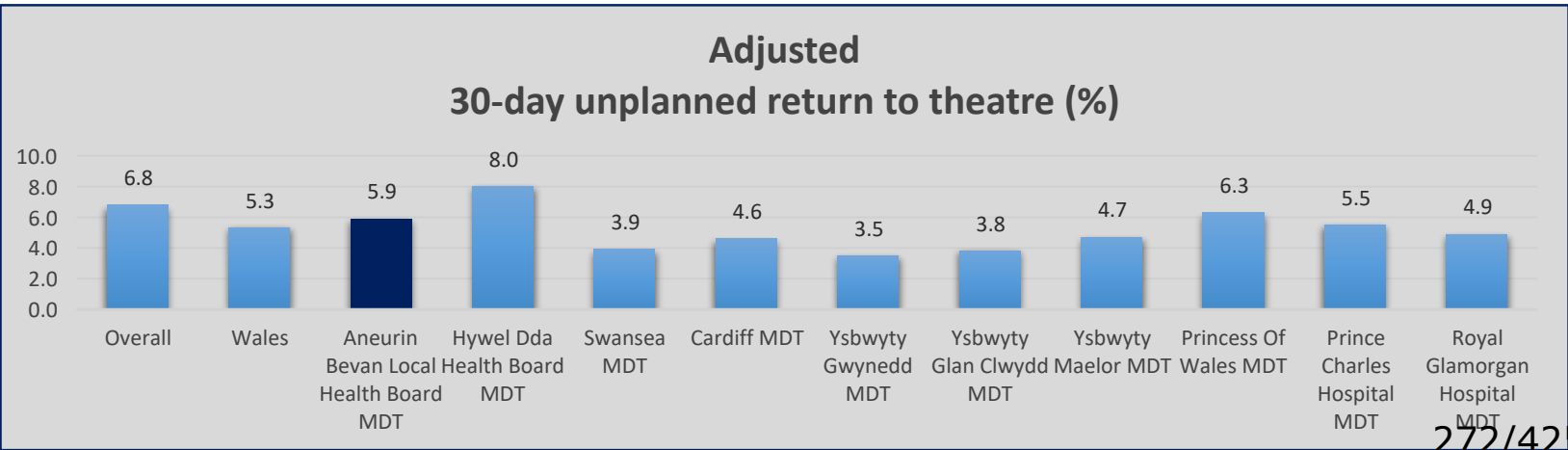
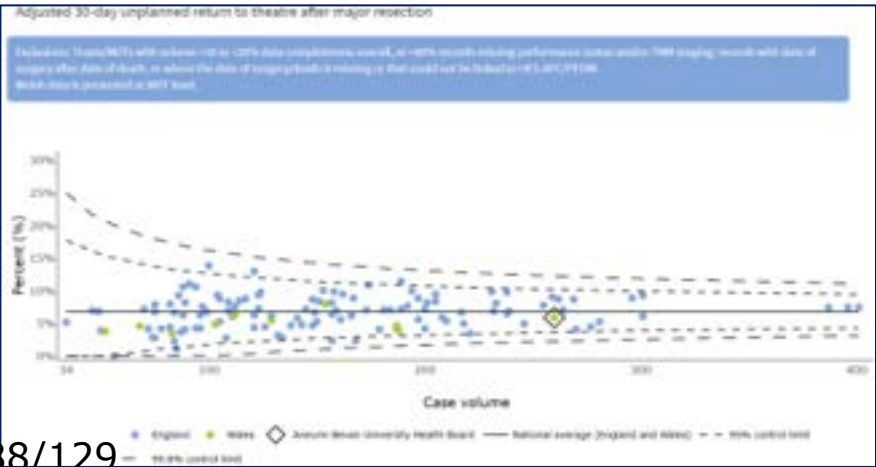
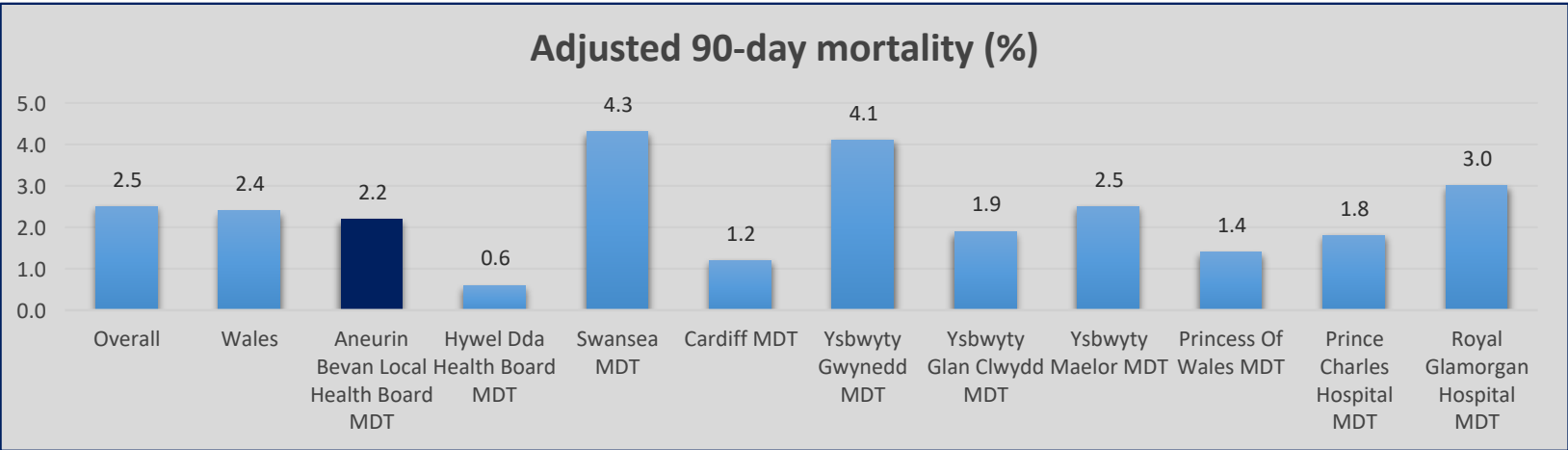
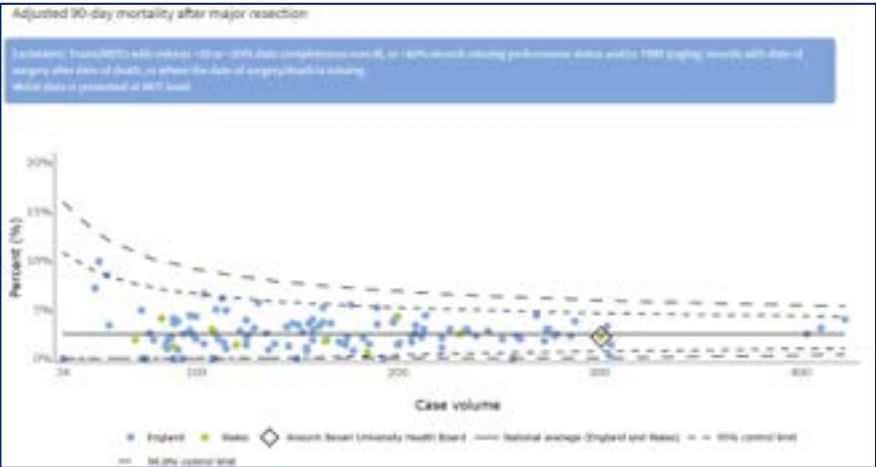
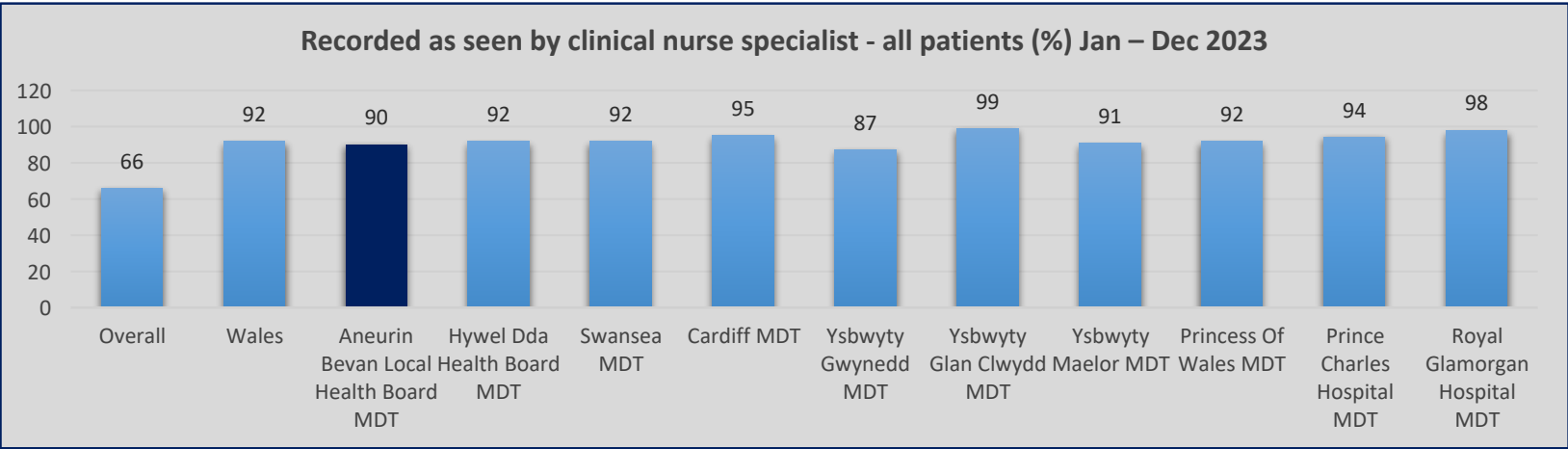
Rationale:	The National Bowel Cancer Audit (NBOCA) measures the quality and outcomes of care for people diagnosed with bowel cancer in England and Wales. This report focuses on people diagnosed with or undergoing surgery for bowel cancer between 1 January 2023 and 31 December 2023.	
Objectives :	NBOCA’s quality improvement (QI) plan sets out five QI goals covering the entire patient care pathway. Mapped to these goals, NBOCA has developed ten performance indicators with local QI targets. The aim is to increase the consistency of access to treatments and stimulate improvements in care and outcomes for people with bowel cancer.	The NBOCA Quality Improvement goals are: 1. Improving the diagnostic pathway 2. Improving perioperative care 3. Improving oncological care 4. Improving management of stage four disease 5. Improving end of life care

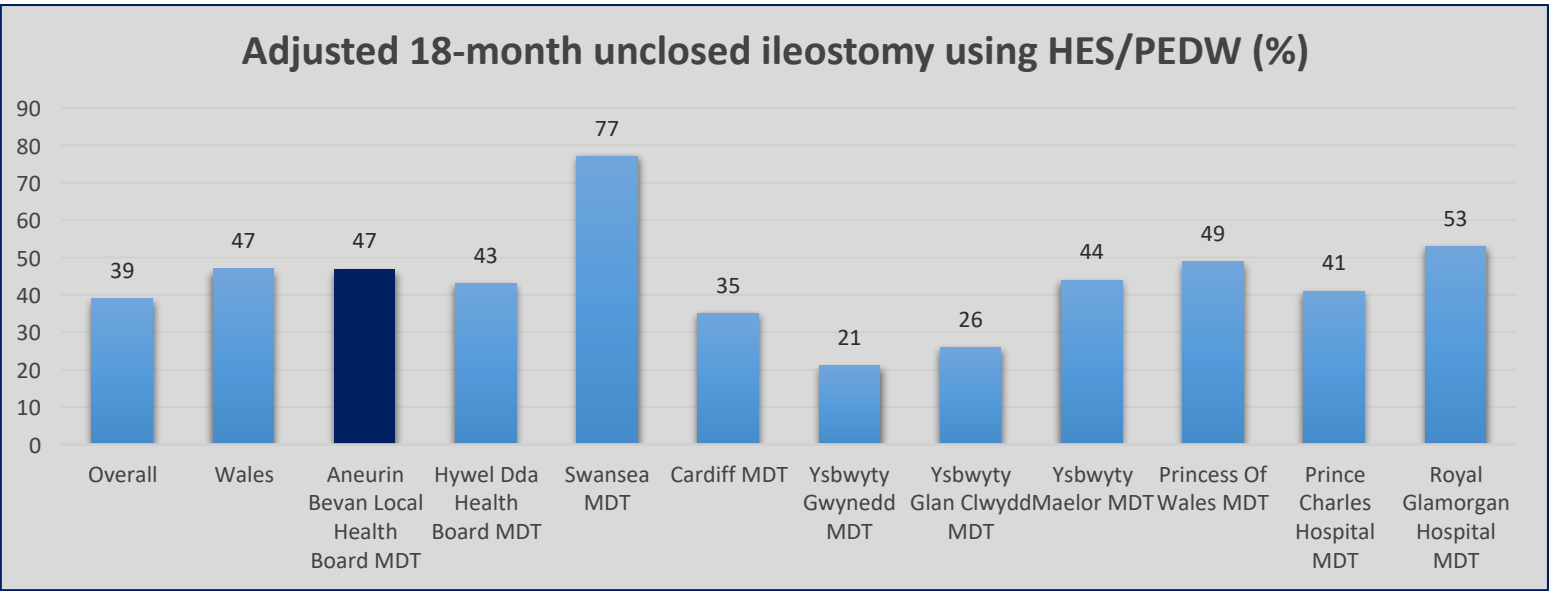
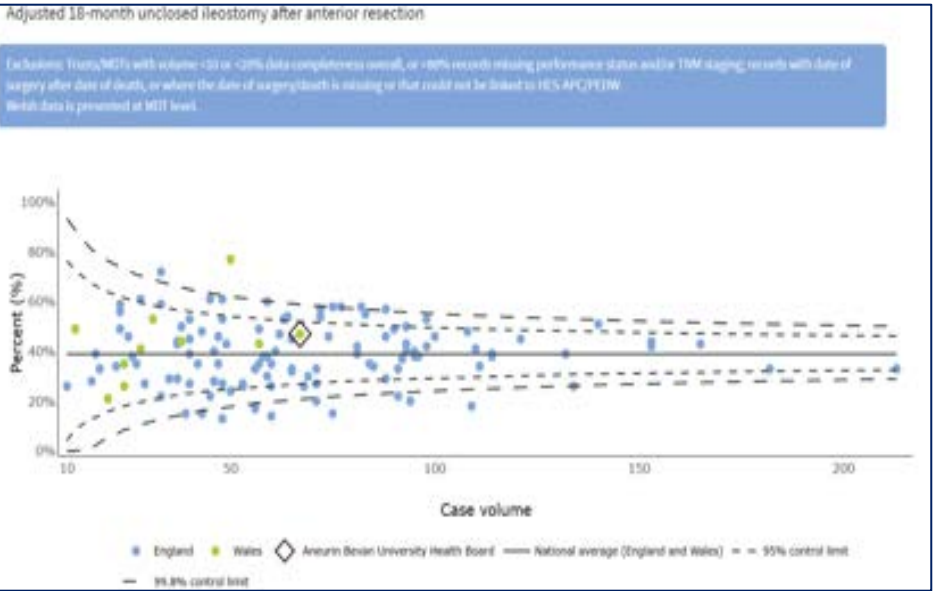
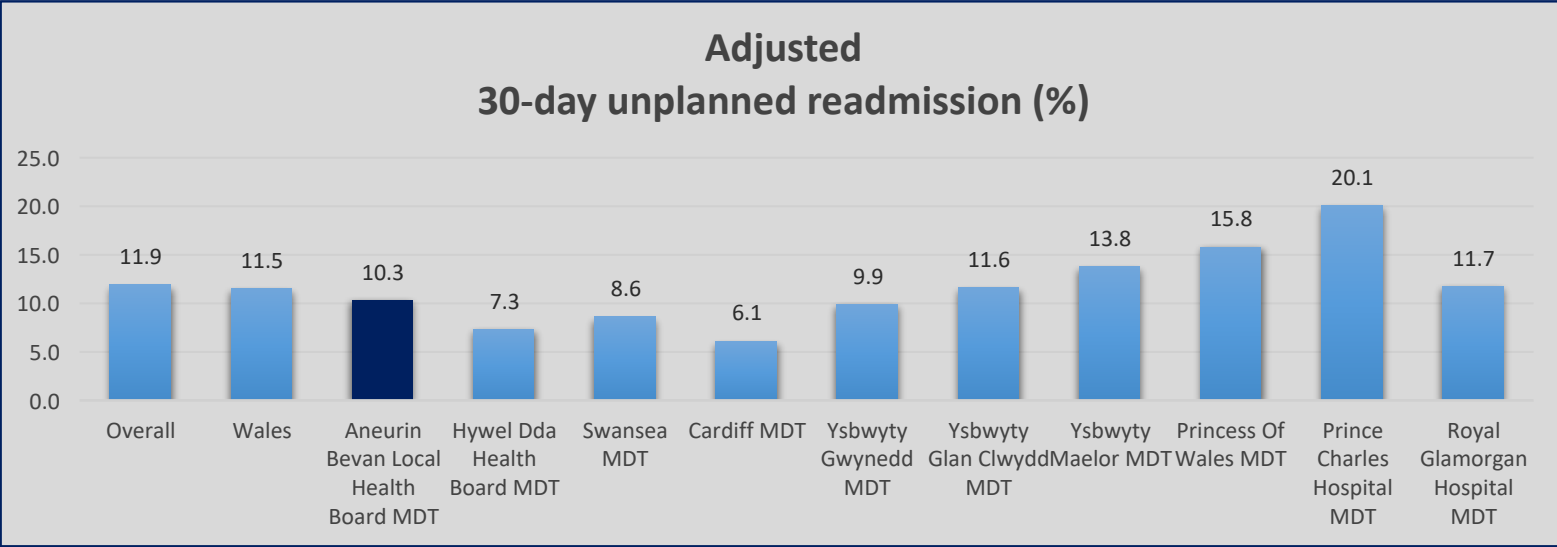
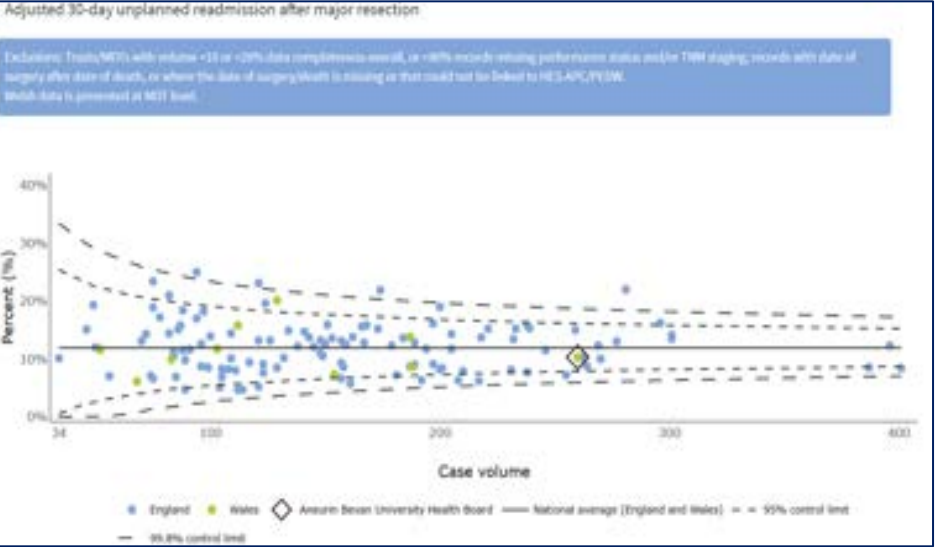
Performance Indicators:

PI 1:	Seen by Clinical Nurse Specialist	PI 6:	Adjusted 18-month unclosed ileostomy after anterior resection
PI 2:	Trust/MDT volume for rectal cancer surgery	PI 7:	Stage 3 colon cancer receiving adjuvant chemotherapy
PI 3:	Adjusted 90-day mortality after major resection	PI 8:	Severe acute toxicity after adjuvant chemotherapy for colon cancer
PI 4:	Adjusted 30-day unplanned return to theatre after major resection	PI 9:	Rectal cancer patients receiving neo-adjuvant therapy
PI 5:	Adjusted 30-day unplanned readmission after major resection	PI 10:	Adjusted 2-year survival rate after major resection.

Presented at Clinical Standards and Effectiveness Group – 26th February 2026





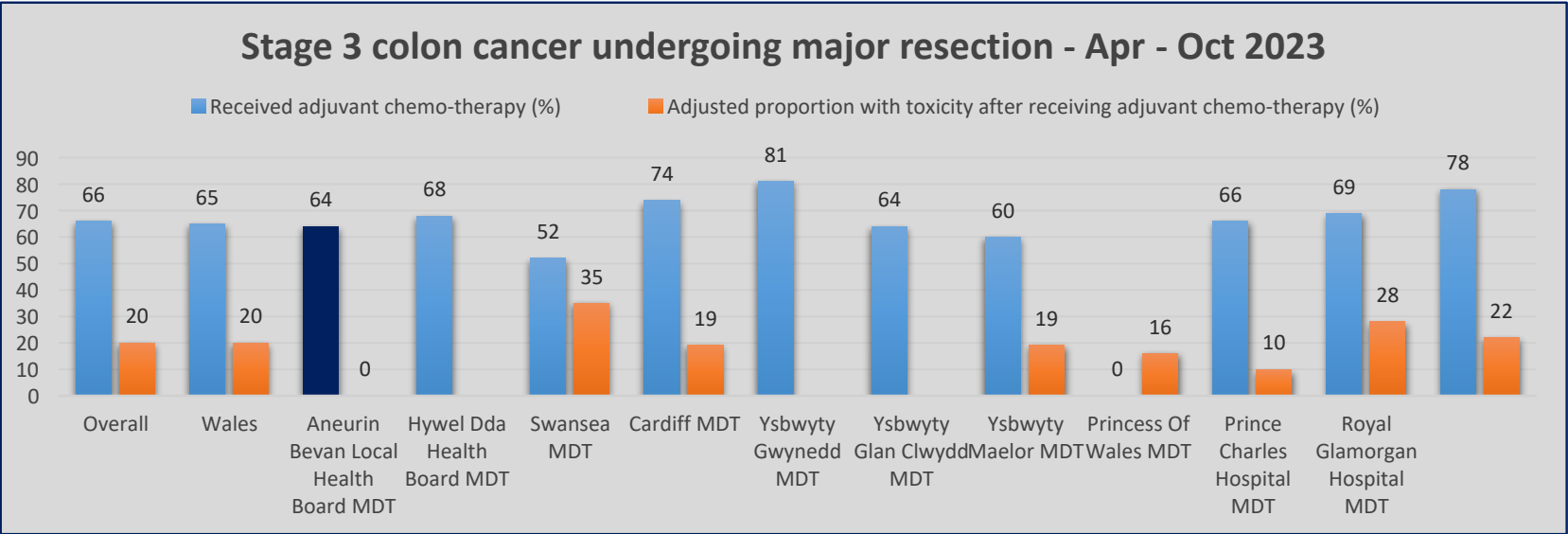
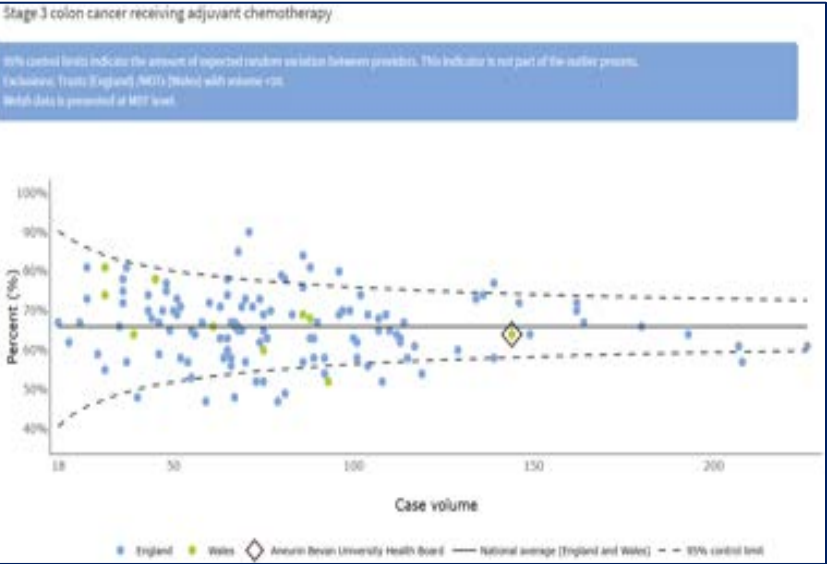


Report findings:

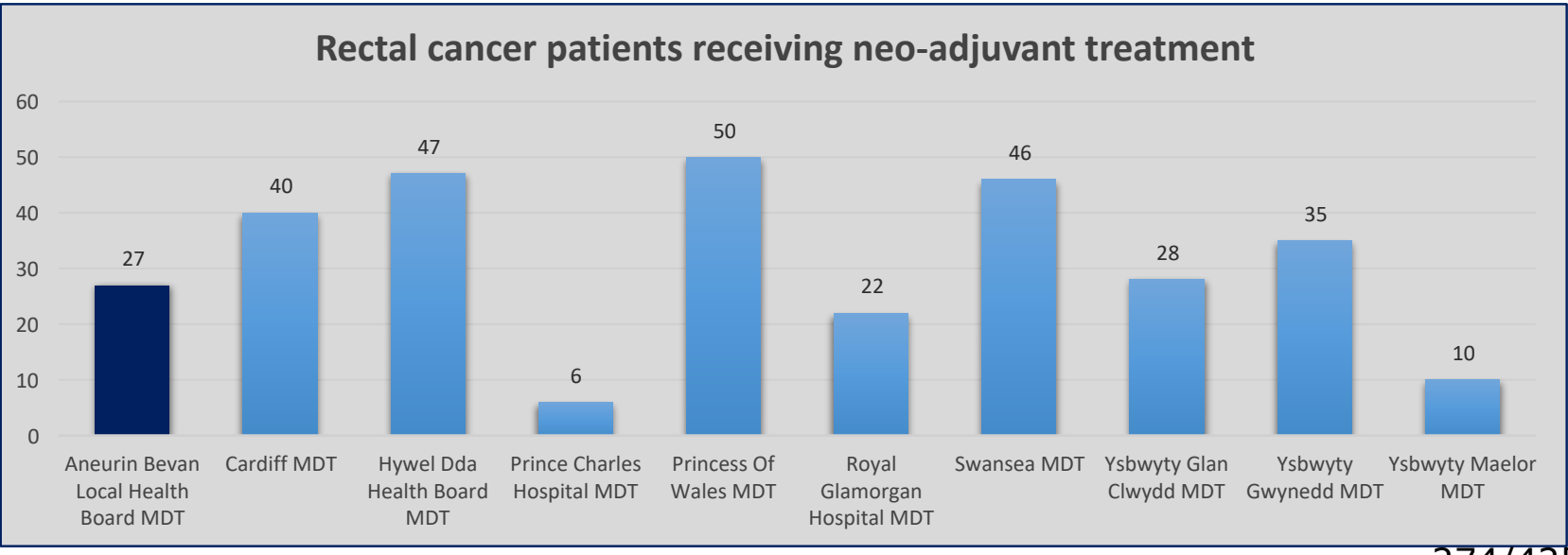
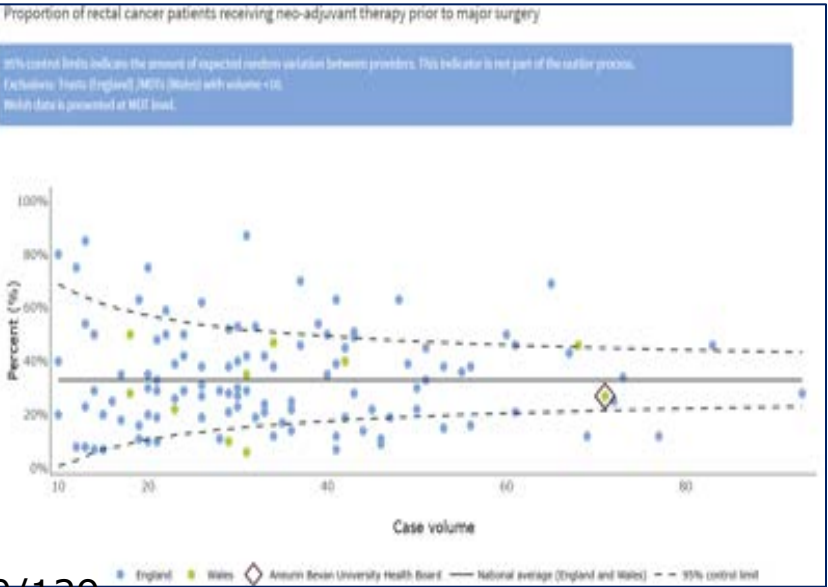
- Performance Indicator and local target: Less than 35% of people with unclosed diverting ileostomy 18-months after anterior resection
- Approximately 38% of people with unclosed diverting ileostomy 18-months after anterior resection. This has not improved since last year's report.

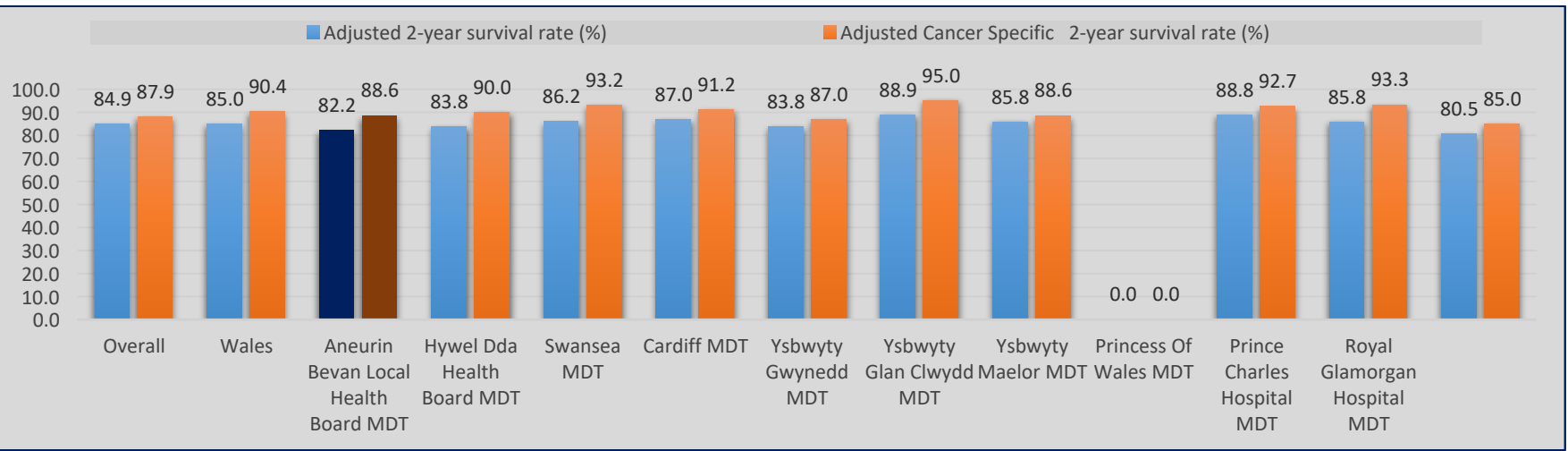
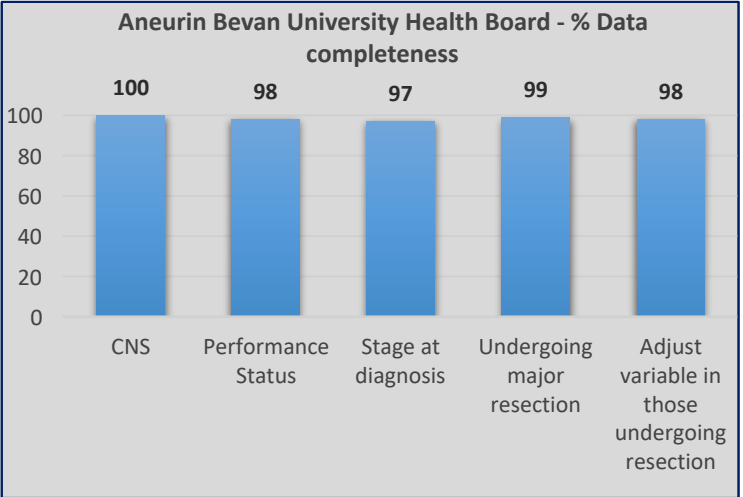
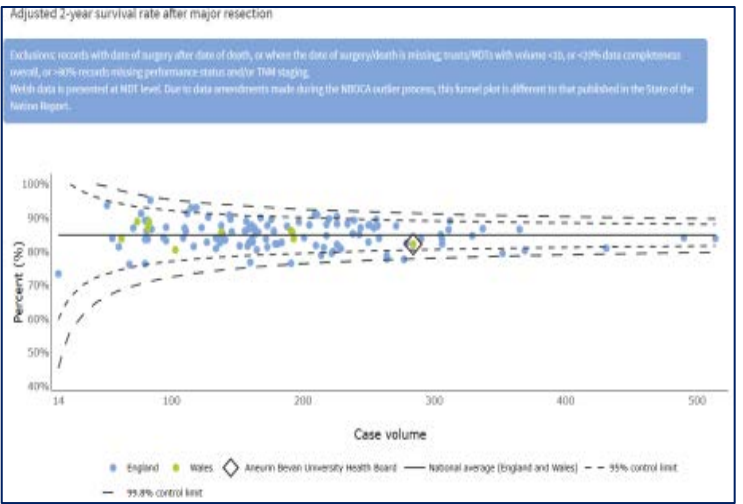
Please see ppt in relation to **'reducing the time to reversal of temporary ileostomies following anterior resection'** presented by Mr Swarnkar to the surgical directorate (slides have also been added to the end of this ppt)

- More than 55% of people with stage 3 colon cancer receiving adjuvant chemotherapy
- In England and Wales, 14 NHS trusts/HBs were below the local target. Considerable between-unit variation in the use of adjuvant chemotherapy remains with 15 (12%) NHS trusts/MDTs below the 95% funnel limit.



10-60% of people with rectal cancer undergoing major resection receiving neo-adjuvant treatment.
Overall, 33% of people received neo-adjuvant radiotherapy for rectal cancer with wide variation between NHS trusts/MDTs from 6% to 87%.





Assurance and Risk Level	
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
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:	
The unmet standard has been audited locally and agreement reached with appropriate directorates (General Surgery & Radiology) to facilitate the process and achieve the target.	

Key Success and Concerns

Report Successes:	
1	Data completion and submission is high quality. Good administrative support for Cancer coordinator.
2	Perioperative Surgical quality of care and outcomes meet and, in some criteria, exceed national standards
3	Good input into the MDT from Oncologists, gastroenterology and Liver surgical team to help with complex cases .
4	Established Early rectal cancer assessment and surgery within ABUHB through SPECC MDT and dedicated surgeons undertaking TAMIS procedure. Introduction of Robotic surgery for CRC.

Report concerns:	
1	Delay in Diagnostic pathway, mainly endoscopy. This is being addressed through vetting.
2	Delay in Ileostomy closure- now being addressed with renewed process in place.

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Increase the proportion of people who have their ileostomy closed within 18-months of anterior resection for rectal cancer. - Support NHS trusts/ multidisciplinary teams (MDTs) to identify system-level (e.g. access to theatre/radiological investigations) and patient-level drivers of variation. - Support NHS trusts/MDTs to participate and engage with the local and national quality improvement initiatives to enable more timely reversal of ileostomy. For example, NBOCA & Royal College of Surgeons of England’s CloseItQuick Collaborative.	Presented data to surgical directorate on the recent audit of 2-year data and suggested – WSCE to be done at 4-6 weeks post low anterior resection. This was identified as the crucial step in the pathway affecting Target outcome. Agreed by MDT and Radiology department. QI project to assess progress in 1 year.	K Swarnkar Jo Hamill	Jan 2027	Action plan agreed
2	In units with chemotherapy utilisation following resection of stage 3 colon cancer below 55%, conduct individual patient analysis to review the rationale for not offering treatment against evidence-based guidelines. If the resulting findings identify under-utilisation, develop appropriate local action plans to increase rates of chemotherapy whilst maintaining low levels of severe toxicity. Action plans may include integration of geriatric expertise and or rehabilitation into shared chemotherapy decision making.		Dr H Williams No action needed. 64% patients received adjuvant chemotherapy.		
3	Understand variation in the utilisation of neo-adjuvant radiotherapy for people with rectal cancer to optimise their outcomes. Cancer alliances and health boards to develop standardised evidence-based neo-adjuvant treatment protocols based on high-quality radiological staging. An example guideline is provided as a basis for regional discussions. This will aid decision making and take into account locoregional approaches to neo-adjuvant therapy, incorporating organ preservation techniques and participation in clinical trials.		Dr H Williams No action neededWe have good support from oncologist and Liver surgeons to support our decisions about neoadjuvant chemotherapy in rectal cancer patients with or without liver metastasis.		
4	Ensure robust sustainable pathways are in place to provide timely genomic assessment where clinically appropriate. To inform personalised treatment options and/or identify those with Lynch syndrome, optimise the proportions of people undergoing: - MMR or MSI testing in stage 1 to 4 cancer - RAS and BRAF assessment in stage 4 cancer	Both MSI and MMR testing is routinely done in all patients diagnosed with colorectal cancer. This guided our MDT outcome in planning treatment. RAS and BRAF are specifically requested for stage 4 cancers at the request of oncologist in MDT.	Dr J Harrison(Pathologist) Dr H Williams (Oncologist) No action needed.		
5	Data Quality Recommendation Continue to improve data completeness of key items in the English cancer registration and Wales Cancer Network datasets to allow risk-adjustment of performance indicators. - Provision of a clinical local data lead responsible for working with relevant local teams (e.g. Clinical Effectiveness/Audit) to ensure the quality of data submissions to national datasets. - Data items of focus: tumour, node and metastases (TNM) stage, American Society of Anaesthesiologists’ (ASA) grade and performance status.	Our data set in all essential fields is 97% and above Continued support to MDT coordinator during periods of leave with alternative personnel is crucial to avoid gaps in real time data collection.	Mr K Swarnkar (MDT lead) Julie Watkins (MDT coordinator) No action needed.		

Objectives:

NAoPri Quality Improvement goals

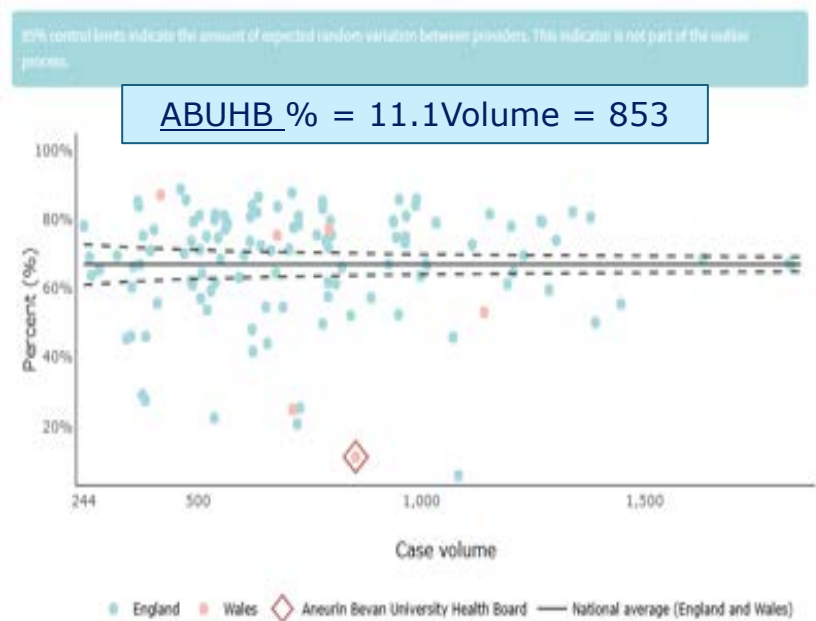
1. Improve the movement of patients through the care pathway.
2. Reduce unwarranted variation for patients undergoing surgery.
3. Reduce unwarranted variation for patients having non-surgical oncological treatments.
4. Improve access to breast reconstruction after mastectomy.
5. Improve and reduce unwarranted variation in primary breast cancer outcomes.

93/129

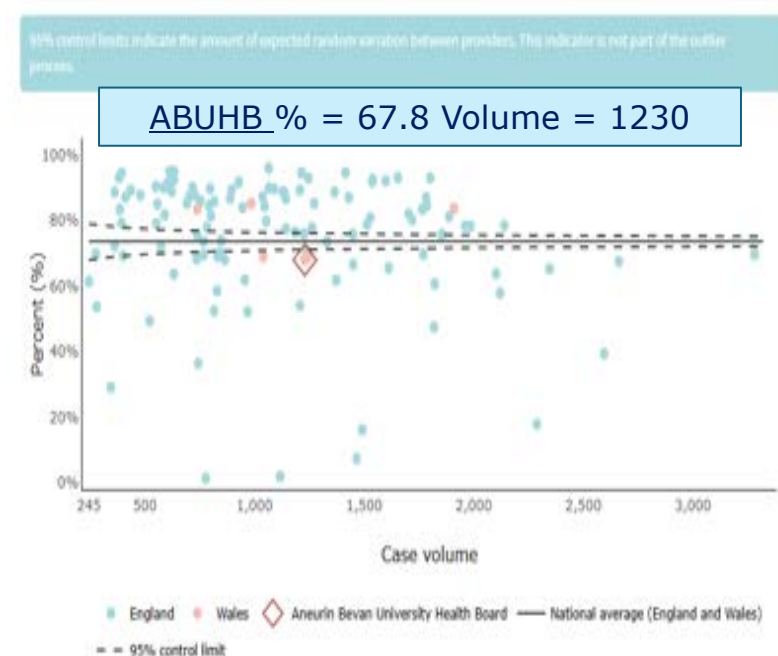
277/425

Data Completeness - Aneurin Bevan University Health Board		
Metric	%	Rank in Wales (6 Health Boards)
Percentage of people with data for CNS	75.6	6
Percentage of People with data for ER status or ER score	74.1	6
Percentage of people with data for PR status or PR score	25.9	6
Percentage of people with HER2 status	53.7	6
Percentage of people with data for stage	69.7	6
Percentage of people with data for T stage	76.4	6
Percentage of people of people with data for N stage	100	all HB's achieved 100%
Percentage of people with data for grade	97.8	6
Percentage of people data for WHO performance status	0.2	6
Percentage of people with data for triple diagnostic assessment (TDA)	11.1	6

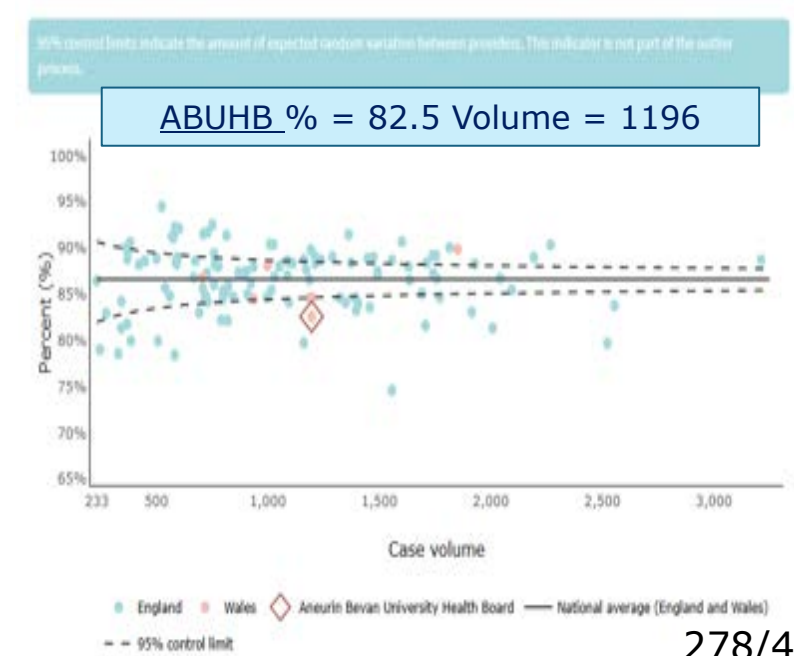
Percentage of people who underwent triple diagnostic assessment (TDA) in a single hospital visit



Percentage of people who had contact with a Clinical Nurse Specialist (CNS) recorded as 'yes'



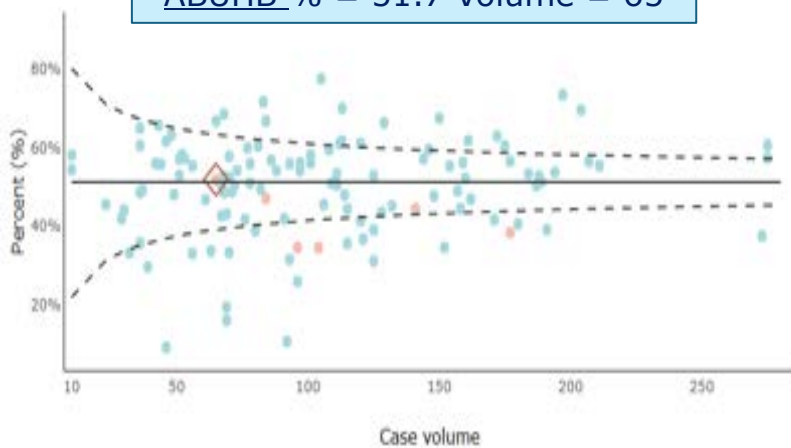
Percentage of people who had i) breast-conserving surgery, or ii) mastectomy, within 12 months of diagnosis



Percentage of people who received neo-adjuvant chemotherapy

95% control limits indicate the amount of expected random variation between providers. This indicator is not part of the outlier process.

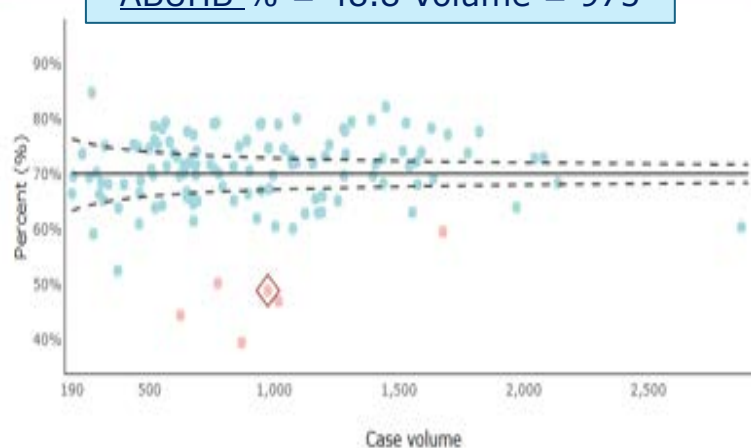
ABUHB % = 51.7 Volume = 65



Percentage of people who received adjuvant radiotherapy following i) breast-conserving surgery, and ii) mastectomy

95% control limits indicate the amount of expected random variation between providers. This indicator is not part of the outlier process.

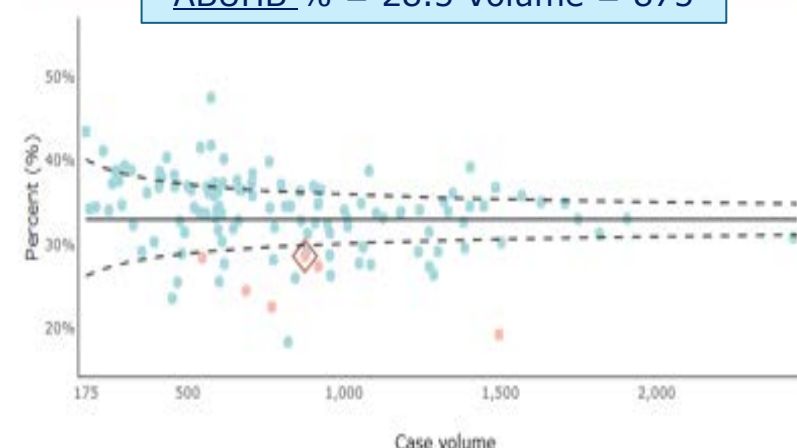
ABUHB % = 48.8 Volume = 975



Percentage of people who received any chemotherapy

95% control limits indicate the amount of expected random variation between providers. This indicator is not part of the outlier process.

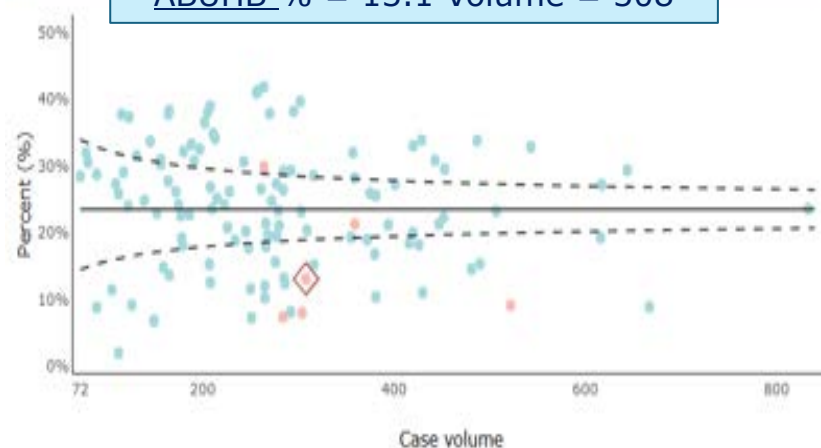
ABUHB % = 28.5 Volume = 875



Percentage of women who had an immediate reconstruction following a mastectomy

95% control limits indicate the amount of expected random variation between providers. This indicator is not part of the outlier process.

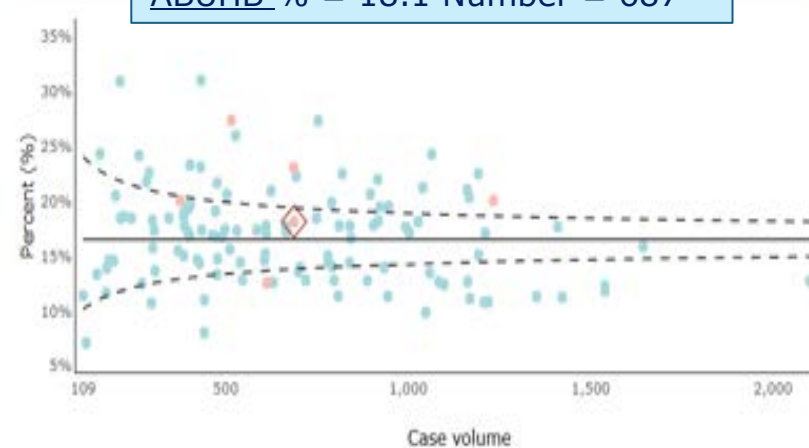
ABUHB % = 13.1 Volume = 308



Percentage of people who had re-operation within 12 months of their initial breast conserving surgery

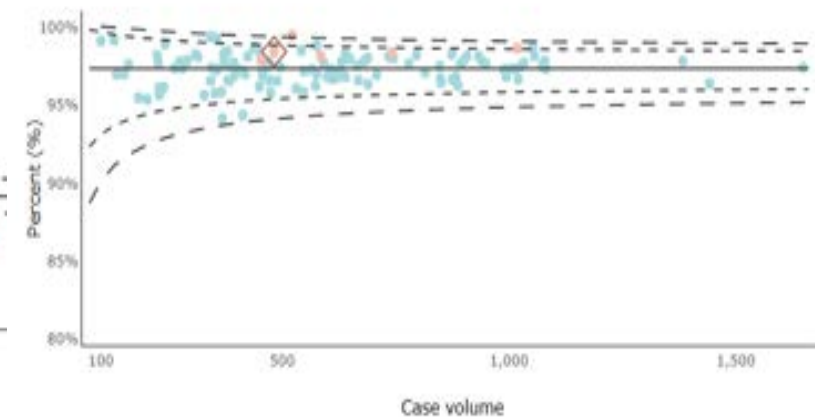
95% control limits indicate the amount of expected random variation between providers. This indicator is not part of the outlier process.

ABUHB % = 18.1 Number = 687



ABUHB % = 98.4 Volume = 482

Three year breast cancer specific survival



Assurance and Risk Level

Assurance level	Description	Risk level	Description
Significant	The project has mostly achieved the standards or criteria being audited against	Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Has this audit been placed on a Risk Register (N/A if above risk is None)			NO

Key Success and Concerns

Report Successes:		Report Concerns:	
1	Patients now have one stop triple assessment service this data will improve once we get to 2024 data point	1	Data inputting to the audit remains an issue. It is too much work for one person and does not reflect the service
		2	Data for performance status difficult to capture
2	Excellent 3-year breast cancer specific survival	3	Low rates of immediate breast reconstruction being offered – but unlikely to be captured correctly and also likely lower due to the COVID pandemic

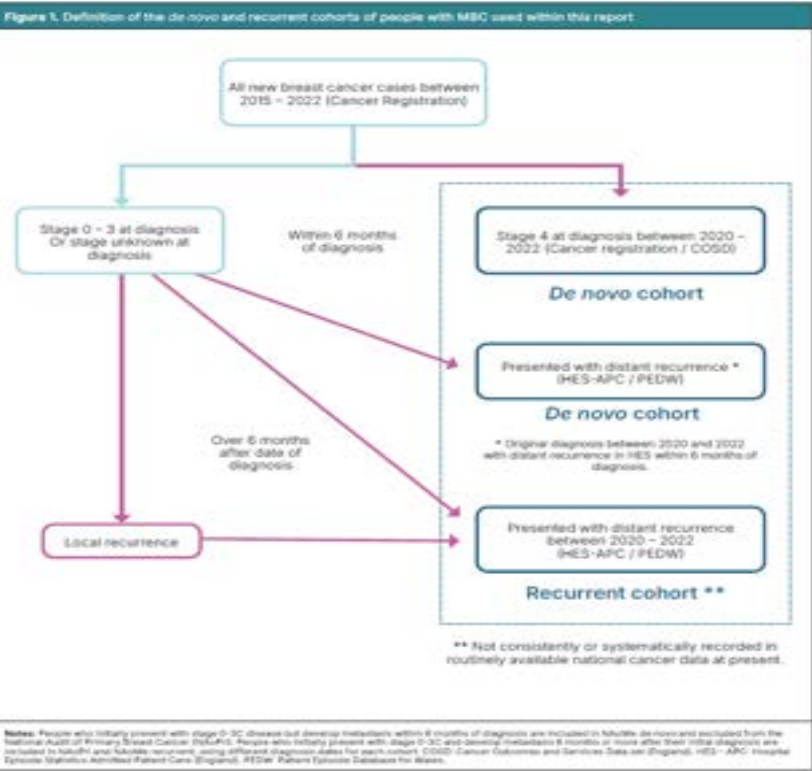
Report Recommendations: CLINICAL		S.M.A.R.T Actions:	Responsible:	Due Date: Progress:	
1	Ensure that people with breast cancer have access to Triple Diagnostic Assessment (TDA) in a single visit and, if required, identify methods to increase the provision of this service.	Aim for 95% of all patients to receive single visit TDA	Michael Rees/Rhiannon Foulkes/oncology team and wider breast care and management team	Achieved since the breast unit switched to one stop TDA in April 2024	
2	Review the use of neo-adjuvant chemotherapy for people with triple negative and HER2+ early invasive breast cancer. Reduce the levels of unexplained regional variation, with particular emphasis in increasing use among those showing low rates and ensuring neo-adjuvant chemotherapy is offered to eligible patients in line with guideline recommendations			2026	Achieved - All cases discussed at the MDT with oncology presence and all those eligible offered neoadjuvant chemotherapy
3	Review rates of immediate breast reconstruction (IBR) and, where rates are lower than expected, act to improve access by ensuring it is offered to all women as part of a balanced shared decision-making process, unless precluded by comorbidity or adjuvant therapies.	Aim for >20% rate for IBR post mastectomy. IBR to be offered to all patients who meet the criteria for immediate reconstruction			In progress All patients eligible for IBR are offered IBR. COVID happened during this time period and immediate reconstruction was not routinely offered. The next audit should show an improvement in this number. However, there are now a number of patients having local flaps as opposed to mastectomy therefore that may contribute to a decrease in mastectomy rate within the Health Board.

Report Recommendations: CLINICAL		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
4	Review rates of re-operation following breast conserving surgery (BCS) and, where rates are higher than expected, units should review local protocols with the view to complying with best practice.	Aim to reduce the reoperation rate to below 16% which is the average	Michael Rees/Rhiannon Foulkes/Wider breast care and management team	2026	In progress
5	Confirm breast MDTs have a data lead responsible for ensuring the quality of national data submissions. Reviews of data completeness should include full tumour characterisation (i.e., stage, grade, histology), ER and HER2, performance status, the NABCOP fitness assessment data items (people aged 70+ years) and contact with clinical nurse specialists (CNS)	Aim for >95% completeness of data for tumour characterisation and contact with clinical nurse specialists. New MDT proforma to help to collect difficult data such as performance status. PR testing is now done on all patients previously only when ER (-) by some pathologists Look at the way that data is collected by the health board			

Clinical Leads Local Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	More support needs to be given to the Breast MDT coordinator to help with data collection. A review needs to be undertaken as to what data is collected routinely by the health board to facilitate data entry into these audits as there is a lot of data collected that is unnecessary and takes away from the actual data that needs collecting	We will trial a proforma looking at making sure we can capture tumour characteristics, whether seen by breast care nurse, performance status etc to help facilitate data entry as these seem to be often missing	Rhiannon Foulkes, Michael Rees and wider breast team	2026	In progress
2	In house testing for Her 2	Business case still ongoing. Essential to reduce the delay in the patient pathway	Michael Rees	2026	In progress

Data Completeness - Aneurin Bevan University Health Board		
Metric	%	Rank in Wales (6 Health Boards)
People with data for CNS	81.3	6
People with data for ER status or ER score	73.3	6
People with data for PR status or PR score	34.7	6
People with data for HER2 status	61.3	6
People with data for stage	52	6
People with data for grade	89.3	6
People with data for WHO performance status	5.3	5

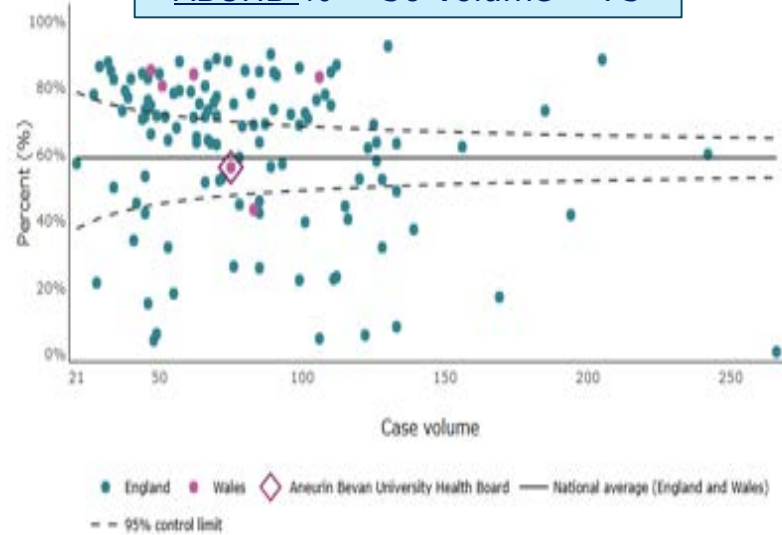
Lack of a robust mechanism to detect recurrence after a previous primary breast cancer diagnosis within national cancer datasets is the greatest challenge faced by the NAOme. Data quality is therefore a key focus for the NAOme team. We urge NHS organisations to prioritise recording new non-primary breast cancer as a new COSD episode, rather than continuation of an existing primary breast cancer record, to enable accurate analysis of this population.



The report distinguishes between people with de novo MBC and recurrent MBC (definitions opposite). The National Disease Registration Service (NDRS) is attempting to improve collection of data about recurrence in individuals with an existing primary breast cancer record. However, for the years covered in this report, the data on distant recurrence is not of sufficient quality or completeness to be included. As an interim solution, while the data quality is being improved, we have used diagnosis codes for metastatic breast cancer in inpatient hospital records to identify the recurrent cohort. This approach does not identify all people diagnosed with recurrent MBC. In particular, those who have not been admitted to hospital will not be captured, thereby limiting the representation of this population.

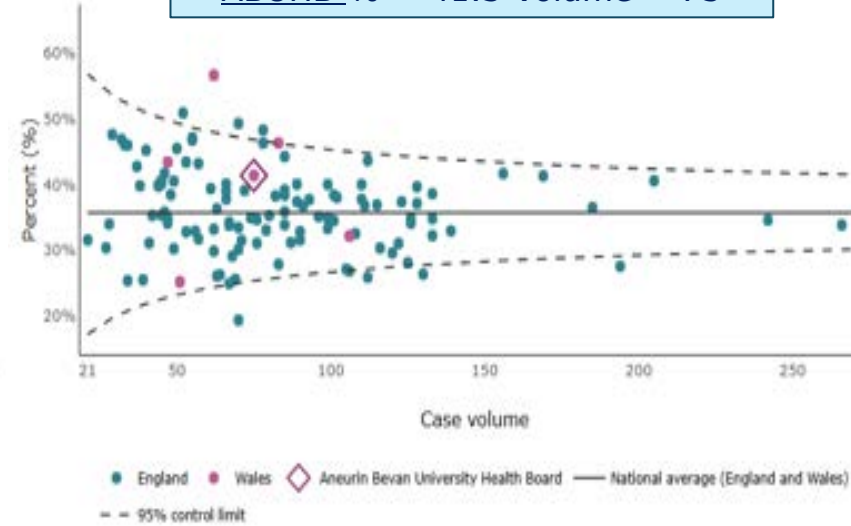
95% control limits indicate the amount of expected random variation between providers. This indicator is not part of the outlier process.

ABUHB % = 56 Volume = 75



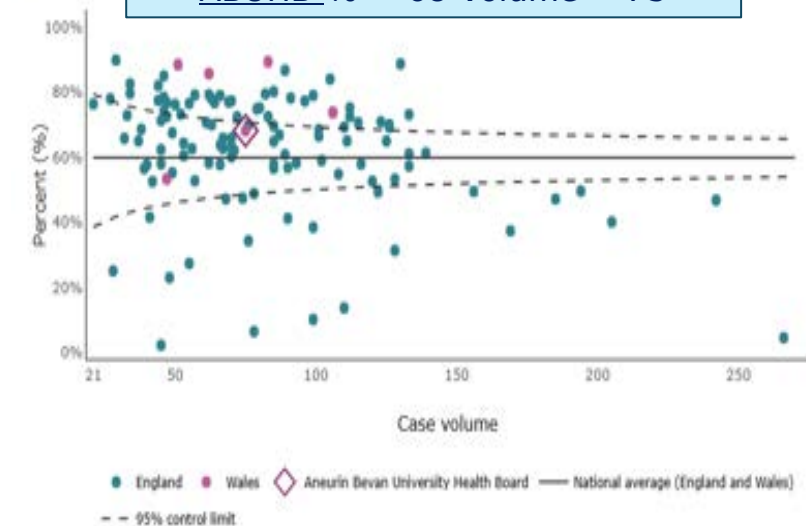
95% control limits indicate the amount of expected random variation between providers. This indicator is not part of the outlier process.

ABUHB % = 41.3 Volume = 75



95% control limits indicate the amount of expected random variation between providers. This indicator is not part of the outlier process.

ABUHB % = 68 Volume = 75



For each performance indicators below, the data dashboards show that only England data was available. However, when we look at the data dashboards, the case volume for ABUHB is shown but there is no unadjusted or risk adjusted percentage provided and the Welsh Health Boards are not shown on the charts

Percentage of:-

- People with recurrent metastatic breast cancer who had a biopsy to inform care (case volume = 680)
- People with ER positive, HER2 negative, de novo metastatic breast cancer who received CDK 4/6 inhibitors (case volume = 208)
- People HER2 positive de novo metastatic breast cancer who received anti-HER2 therapy (case volume = 70)
- People who received chemotherapy (recurrent cohort) (case volume = 680)
- People with death recorded within 30 days of a chemotherapy cycle (de novo cohort) (case volume = 185)

Assurance and Risk Level

Assurance level	Description	Risk level	Description
Limited	The project did not achieve the standards or criteria being audited against	Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved
Has this audit been placed on a Risk Register (N/A if above risk is None)			
NO			

Key Success and Concerns

Report Successes:		Report Concerns:	
1	There is now a metastatic breast cancer clinical nurse specialist in post this has made a significant difference to patients and indeed the identification of patients who present acutely to other specialities	1	Good access for patients receiving chemotherapy de novo
2	Good documentation of contact with a clinical nurse specialist, this will only improve with our new metastatic breast cancer nurse in post	2	Still awaiting in house testing of Her 2
3	Good access for patients receiving chemotherapy de novo	3	Need to improve documentation of WHO performance criteria

Report Recommendations: CLINICAL		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Ensure the care for all people newly diagnosed with Metastatic Breast Cancer (MBC) (either de novo or recurrent) is discussed within a breast MDT meeting	Aim for >90% of patients to be discussed at MDT	Clinical breast team/oncology team/wider medical teams including general practice	2026	In progress
2	Examine rates of treatment with CDK4/6 inhibitors within 12 months of diagnosis in people with ER+ HER2- MBC. Consider variation in care, especially in low use centres, to try to identify underlying causes and opportunities for improved quality of care	All patients who are eligible for CDK4/6 inhibitors are offered them by oncology	Oncology team		
3	Assess 30-day mortality rates following chemotherapy and, in trusts with rate outside the 95% control limits of the national average, conduct outcome reviews and evaluations of local prescribing practices to ensure appropriate consideration of chemotherapy risks and benefits	This is done locally by the oncology team	Oncology team		

Report Recommendations: DATA QUALITY		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
4	Ensure accurate recording of date and type of breast cancer recurrence by reviewing and optimising the process of capturing and uploading to the Cancer Data Form (CDF)	Accurate data entry to reflect recurrence, this could also be looked at on our data collection proforma to facilitate recording of recurrence.	Clinical management team, cancer services team and breast team	2026	In progress
5	Confirm breast MDTs have a data lead responsible for ensuring the quality of national data submissions. Reviews of data completeness should include full tumour characterisation (i.e., stage, grade, histology), ER and HER2, performance status, the <u>NABCOP fitness assessment data items</u> (people aged 70+ years) and contact with clinical nurse specialists (CNS)	- Aim for >95% documentation rate for ER, PR and HER2 status - Change to MDT proforma to collect performance status routinely - In house testing of HER2 - Path testing PR on all tumours	Michael Rees/Rhiannon Foulkes Breast care teams and clinical management in Welsh NHS Health Boards.	2026	In progress

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	More support needs to be given to the Breast MDT coordinator to help with data collection. A review needs to be undertaken as to what data is collected routinely by the health board to facilitate data entry into these audits as there is a lot of data collected that is unnecessary and takes away from the actual data that needs collecting	We will trial a proforma looking at making sure we can capture tumour characteristics, whether seen by breast care nurse, performance status etc to help facilitate data entry	Rhiannon Foulkes, Michael Rees and wider breast team	2026	In progress
2	In house testing for Her 2	Business case still ongoing	Michael Rees	2026	In progress

NICE Clinical Guideline (CG) & Quality Statement (QS), British National Formulary (BNF) & Technology Appraisal (TA):
CG146, NG249, QS86, QS149, TA161, TA204, TA464, TA791, TA991,

Rationale:	In England and Wales there are around 180,000 fractures each year as a result of osteoporosis. One in three women and one in five men will sustain a fracture in their lifetime. The rationale of the FLS-DB 2026 Annual Report is to evaluate and improve the quality of secondary fracture prevention for adults aged 50+ by measuring how effectively Fracture Liaison Services identify, assess, and treat patients with fragility fractures. The report aims to highlight national performance against evidence-based standards, reduce unwarranted variation between services, identify inequalities in access and outcomes, and support improvements in patient care by providing actionable data for clinicians, commissioners, and health boards. Ultimately, its purpose is to ensure timely assessment and appropriate osteoporosis treatment to reduce future fractures and improve outcomes across England and Wales.
Objectives:	Using 11 national KPIs, the audit evaluates how well services identify patients, provide timely bone health and falls assessments, recommend and initiate appropriate osteoporosis treatment, and monitor adherence over time. By benchmarking services against NICE, NOGG and ROS standards, the audit aims to highlight variation, identify gaps in care, expose inequalities, and provide actionable data to support service improvement, commissioning decisions, and national policy. This annual report focusses on whether fracture patients at highest risk of osteoporotic fractures are prioritised and provided with appropriate treatment or prevent future fractures.

Presented at Clinical Standards and Effectiveness Group – 26 February 2026

Winners of the MediWales Innovation Awards 2024 for
their overall contribution to healthcare delivery in
Wales



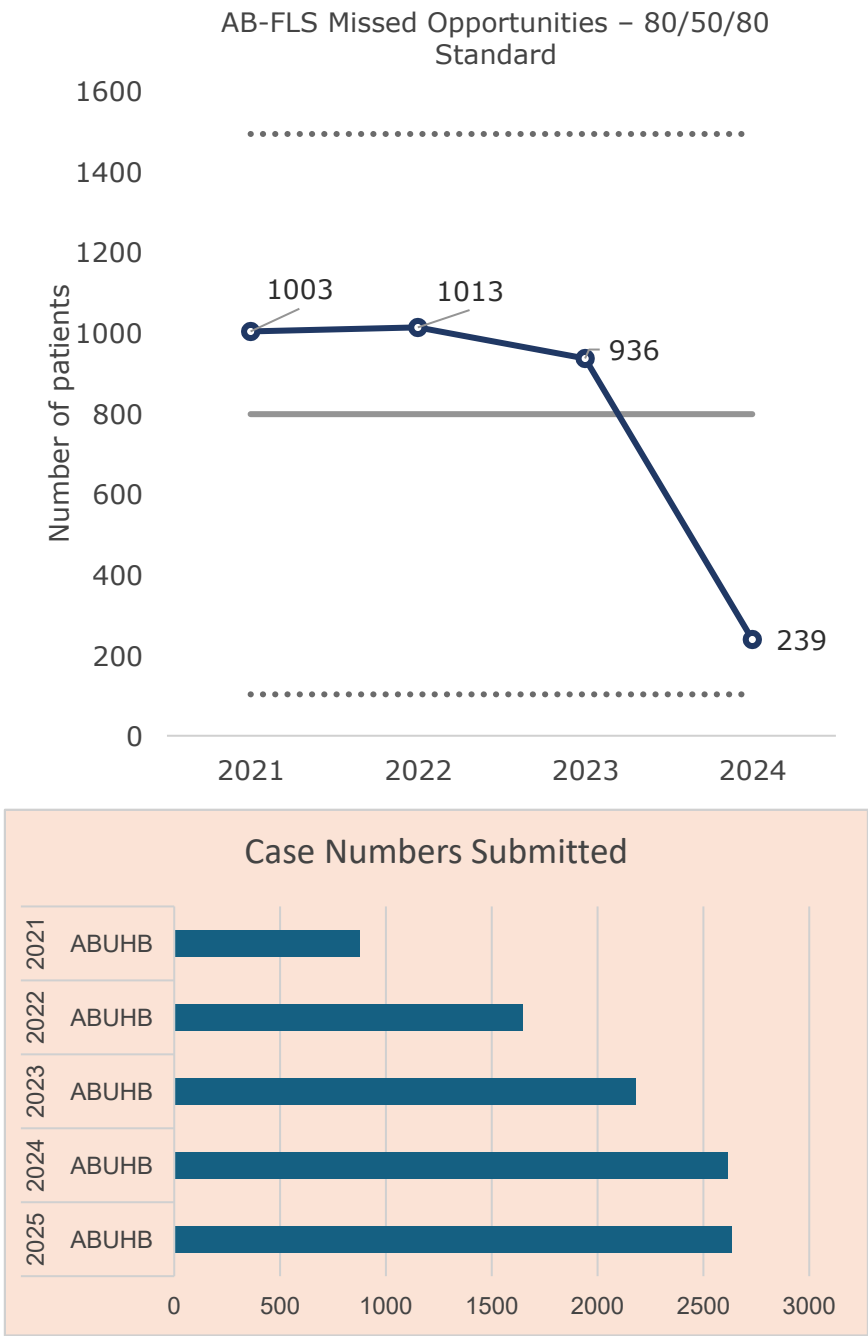
WINNER ☆ Let The First Fragility Fracture
be the Last!



Aneurin Bevan University Health Board

AB - FLS	2020	2021	2022	2023	2024	2025
Estimated fracture patients	3730	3425	3730	4055	3755	3755
Total No of patients Identified – (80%)	725 (24.8%)	875 (25.5%)	1649 (44.2%)	2181 (50.4%)	2639 (70.7%)	2890 (77%)
KPI4 – Assessed with 90 days AB-FLS Wales National	3.3% 64% 64.2%	21.3% 65.1% 66.5%	60.3% 77.8% 62.8%	75% 79.6% 63.8%	73.8% 77.2% 69.8%	64.3% 67.7% 67.2%
% Recommended Treatment - 50% (cases)	57.3% (415 cases)	57.7% (505 cases)	65.7% (1083 cases)	63.8% (1391 cases)	59.7% (1559 cases)	70.9% (2049 cases)
% Monitored (52 weeks) – 80% (cases)	19.8% (82 cases)	18.4% (92 cases)	16.4% (292 cases)	25.9% (360 cases)	61.3% (956 cases)	? 70%
Patients treated to guidance (80/50/80 ROS standard)	82 (6.9%)	93 (7.8%)	178 (14.8%)	360 (30.2%)	962 (80.1%)	1434
Minimum Expectation	1193	1096	1193	1312	1201	1202
Missed opportunity	1113 (93.1%)	1003 (92.2%)	1015 (85.1%)	832 (69.8%)	239	Zero

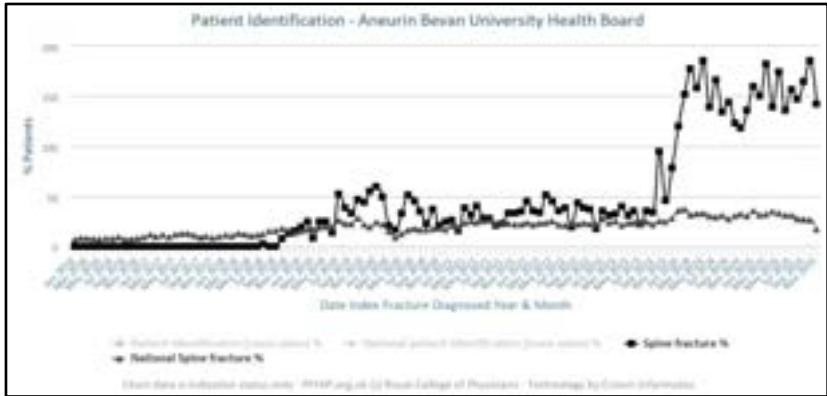
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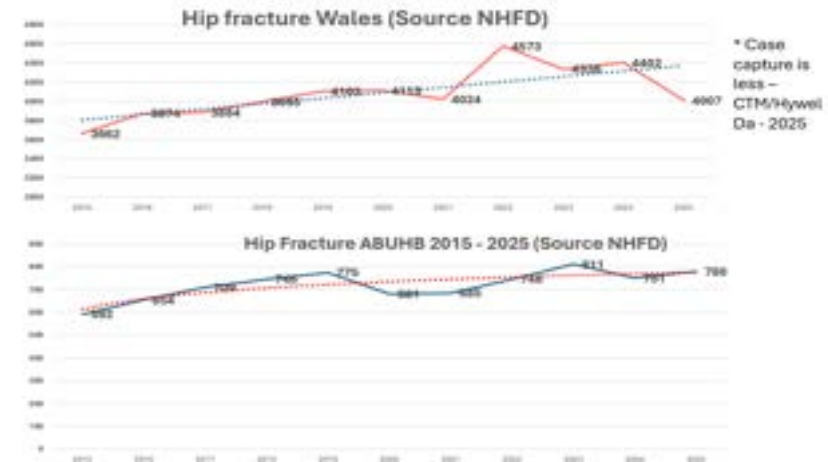
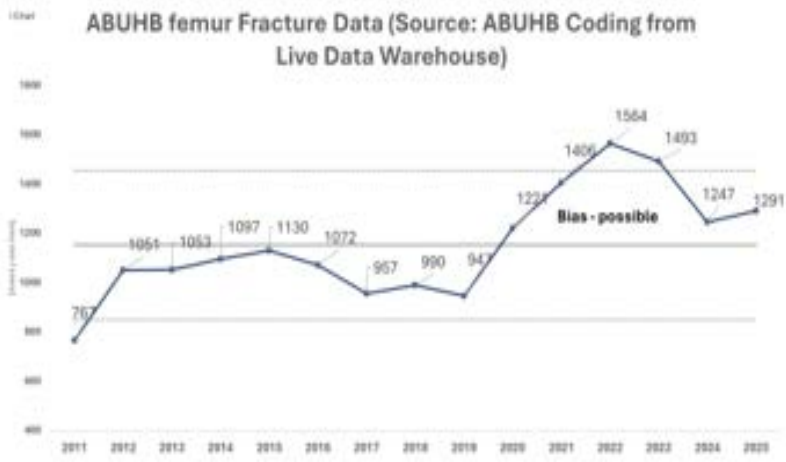
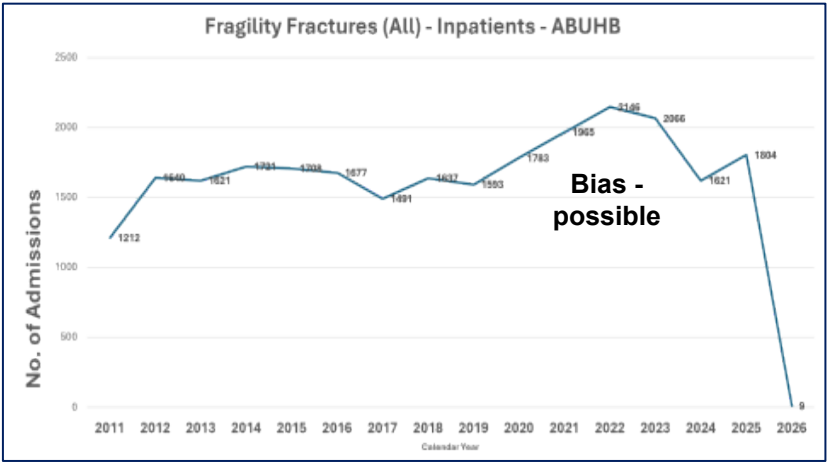
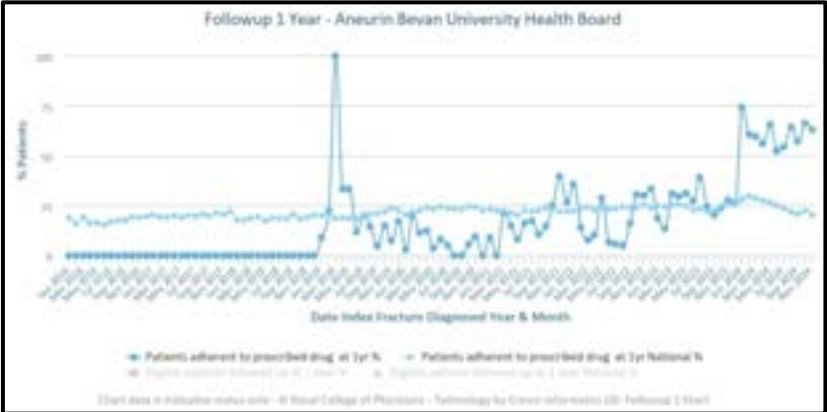
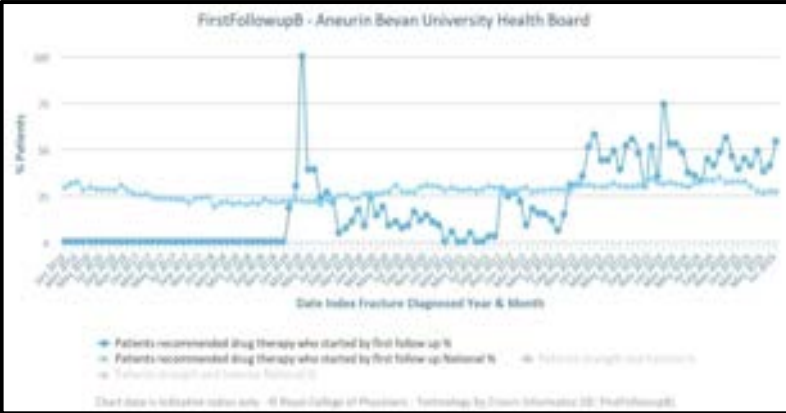


Benchmarking

Year	FLS Service/Unit	Total FLS submitted records	KPI 2 Non-Spine Case identification	KPI 3 Spine fractures	KPI 4 Assessment within 90 days	KPI 5 DXA within 12 Weeks	KPI 6 Falls risk assessment	KPI 7 Bone treatment	KPI 8 Strength & Balance by 16 weeks	KPI 9 16 week follow up	KPI 10 Treatment by 1st followup	KPI 11 1 year drug adherence*
2021	Wales 2021	2031	23.2	11.3	65.1	23.3	61.5	56.8	3.9	13.7	10.2	30.2
2022	Wales 2022	3151	31.9	15.2	77.8	33.7	86.1	62.5	6.1	21.4	16.1	27.4
2023	Wales 2023	3535	17.8	9.3	79.6	23	90.6	63.3	13.3	43.2	36.5	23.4
2024	Wales 2024	5256	20.7	36.5	80.1	14.5	75.9	63.8	19.3	33.2	32.1	33
2025	Wales 2025	8273	35.1	64.8	68.5	16.2	54.8	60.3	9.1	29.6	20	Not available yet
2021	ABUHB 2021	875	24.6	29.5	21.3	24.1	34.5	57.7	4.8	1.4	8.3	18.4
2022	ABUHB 2022	1647	46	36.7	60.3	12.8	79.7	65.6	9.2	19	18.3	16.7
2023	ABUHB 2023	2179	56.4	43	74.9	14.5	94.6	63.8	17.6	58.7	46.1	26
2024	ABUHB 2024	2613	50.5	146.1	78.5	21.9	85	60.1	33.8	48.7	48.3	61.3
2025	ABUHB 2025	2632	56.1	157.9	65.3	41.5	86.1	70.3	29.6	58.1	44	Not available yet

2025 data is incomplete, therefore, is subject to change. However, the currently available data shows an improving picture for 7 KPIs against 2024 data.

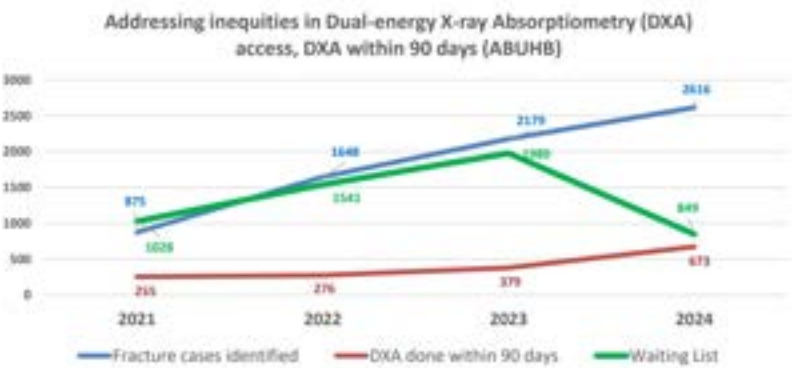




Projected – cost avoidance

- Total FLS investment
 - Staffing cost – Full business case (2025-26) £387,520 plus drugs
- Hip fracture reduction = 2022 = 746; 2023 = 811 (average = 778)
- Hip Fracture 2024 = 751; 2025 – 780 (average = 765)
- Average Hip fracture avoided = 13/year (post FLS two years)
- Cost avoided = 13 x £27000 = £351,000
- More reduction of overall fractures – Femurs (1528 average to 1269)

Report Recommendations:	S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1 DXA scanning	Working with Radiology	I Singh / Non Pugh/ Terissa Williams	December 2026	Amber



Addressing inequities in dual-energy x-ray absorptiometry (DXA) access: a multi-dimensional quality improvement approach | Age and Ageing | Oxford Academic

Assurance and Risk Level

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

Key Success and Concerns

Let The First Fragility Fracture be the Last! - NHS Wales Performance and Improvement

Report Concerns:

1	DXA within 90 days – needs attention
2	demand will rise- other speciality – Breast, Coeliac
3	Primary Care engagement and FU

National Non-Hodgkin Lymphoma Audit 2025 (NNHLA) An audit of care received by people diagnosed with non-Hodgkin lymphoma between 1 Jan 2022 & 31 Dec 2022 in England and 1 Jan 2023 & Dec 2023 in Wales (version 2 – Sep 2025)	Clinical Lead:	Dr Victoria Williams Consultant Haematologist
	NICE:	NG52 , QS150

Rationale:	The National Non-Hodgkin Lymphoma Audit (NNHLA) evaluates patterns of care and outcomes for people diagnosed with non-Hodgkin lymphoma (NHL) in England and Wales in line with its Quality Improvement Plan. This sets out the scope, care pathway, 5 quality improvement goals and 11 performance indicators that are utilised to measure progress against these goals.
Objectives:	This year’s report includes people diagnosed with NHL from 1 January 2023 to 31 December 2023 in Wales. It reports on 5 out of the 11 performance indicators for Wales outlined in the NNHLA Quality Improvement Plan (see on slide 3). Although the data presented in this report relates to treatment up to the end of 2023 in Wales, it is being published in September 2025 to allow sufficient follow-up time for the full care pathway to be captured, including definitive treatment and short-term outcomes. This is particularly important in NHL, where treatment pathways can span many months, and sufficient time is needed to ensure that key quality indicators, such as completion of multi-modality treatment and survival outcomes, are accurately recorded and reported.

Presented at Clinical Standards & Effectiveness Group – 19 March 2026

Quality Statements – QS150

This quality standard covers diagnostic reporting and the organisation of haematological cancer services for people of all ages (children, adults and young people) and managing haematological cancers in adults and young people (aged 16 and over). It describes high-quality care in priority areas for improvement.

- Statement 1 People with haematological cancer have an integrated report produced by a specialist integrated haematological malignancy diagnostic service (SIHMDS) that is shared with the haemato-oncology multidisciplinary team (MDT).
- Statement 2 Young people and adults with specific subtypes of non-Hodgkin's lymphoma have staging using fluorodeoxyglucose-positron emission tomography-CT (FDG-PET-CT).
- Statement 3 Young people and adults with localised stage IIA follicular lymphoma have local radiotherapy as first-line treatment.
- Statement 4 Young people and adults who have completed their treatment for non-Hodgkin's lymphoma or myeloma have a discussion about their end-of-treatment summary plan.

NNHLA Quality Improvement Plan 2024

- The Quality Improvement Plan describes the approach taken across the NATCAN cancer audits to develop improvement goals and performance indicators, ensuring these are measurable, actionable and improvable.
- The NNHLA Quality Improvement goals, developed following a thorough scoping exercise in 2023 and in consultation with stakeholders in the Clinical Reference Group (CRG) are as follows:
- Improving timely diagnosis and treatment
 - Treatment appropriate to the subtype of NHL
 - Improving safety and reducing toxicity of NHL therapy
 - Improving overall survival
 - Reducing variation in NHL management among NHS providers.

The NNHLA has identified eleven performance indicators, which are mapped to these five quality improvement goals and clinical guidelines. It sets out improvement methods, improvement activities and approaches to evaluation of the Quality Improvement Plan.

Table 1.* Performance indicators (PIs) and accompanying contextual measure included in this report.		
Performance Indicators and contextualising measure (in order of appearance in report)	England^	Wales#
New Contextualising measure ¹ : Proportion of people diagnosed with NHL presenting as an emergency prior to diagnosis.	Yes (1/1/2021-31/12/2022)	No. In development.
1. Proportion of people diagnosed with NHL discussed at a multi-disciplinary team (MDT) meeting within 4 weeks of diagnosis.	Yes (1/1/2022-31/12/2022)	No. Data not available for Wales.
2. Proportion of people diagnosed with NHL seen by a clinical nurse specialist (CNS).	Yes (1/1/2022-31/12/2022)	Yes (1/1/2023-31/12/2023)
4. Proportion of people with high-grade lymphoma (Burkitt Lymphoma (BL), Diffuse Large B-Cell Lymphoma (DLBCL) or high-grade T-cell) receiving systemic anti-cancer therapy (SACT), who start SACT within 62 days of referral.	Yes (1/1/2022-31/12/2022)	Yes (1/1/2023-31/12/2023)
5. First-line systemic anti-cancer therapy (SACT) regimens received by people with high-grade lymphoma (BL, DLBCL or high-grade T-cell).	Yes (1/1/2021-31/12/2022)	No. In development.
7. Proportion of people with high-grade lymphoma (BL, DLBCL or high-grade T-cell) who start radiotherapy within 8 weeks of end of first-line systemic anti-cancer therapy (SACT).	Yes (1/1/2022-31/12/2022)	No. Regimen-level SACT data not provided
8. Proportion of people with NHL receiving radiotherapy, reported by subtype.	Yes (1/1/2022-31/12/2022)	Yes (1/1/2023-31/12/2023)
9. Proportion of people diagnosed with NHL who are recorded as having received an episode of care that was delivered as part of a clinical trial, reported by sub-type.	Yes (1/1/2021-31/12/2022)	No. Data not available for Wales
11. Overall 2-year survival of people with high-grade lymphoma (BL, DLBCL, mantle cell or high-grade T-cell).	Yes. 1 and 2-year survival reported by sub-type nationally	Yes. 1-year survival reported by sub-type nationally

4.1 Data Completeness

Key Message: NHS trusts and multi-disciplinary teams 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, MDT records and CNS involvement in both England and Wales.

4.3 Diagnosis and Staging

Key Message: Improved staging should be prioritised as complete staging data will allow risk-adjusted comparisons between groups of people diagnosed with NHL and NHS trusts/ MDTs.

4.2 Characteristics of people diagnosed with non-Hodgkin lymphoma (NHL)

‘CaNISC’ data identified 729 people diagnosed with NHL in Wales in 2023 across 17 Welsh hospitals. In both England and Wales, there was a similar mean age of 69 years at diagnosis, with a diagnosis most likely to be made between the ages of 70 and 79.

Overall, the patient characteristics for England in 2022 and Wales 2023 have not changed compared to last year’s State of the Nation report 2024 (England 2020-2021 and Wales 2022).

4.4 Diagnosis to Treatment Pathway

PI4: Proportion of people with high-grade lymphoma (Burkitt lymphoma (BL), DLBCL (Diffuse Large B-Cell Lymphoma) or high-grade T-cell) receiving SACT, who start SACT within 62 days of referral.

Key Message: 55% of people with high-grade NHL in England receiving SACT (2022) and 48% of people with high-grade NHL in Wales receiving SACT (2023), start SACT within 62 days of referral.

PI 2: Proportion of people diagnosed with NHL seen by a clinical nurse specialist (CNS).

Key Message: Ongoing improvement is needed at NHS trust level regarding record of, and involvement of CNS teams in England to ensure people with NHL receive the appropriate support during treatment.

4.5 Treatment

PI 8: Proportion of people with NHL receiving radiotherapy, reported by subtype.

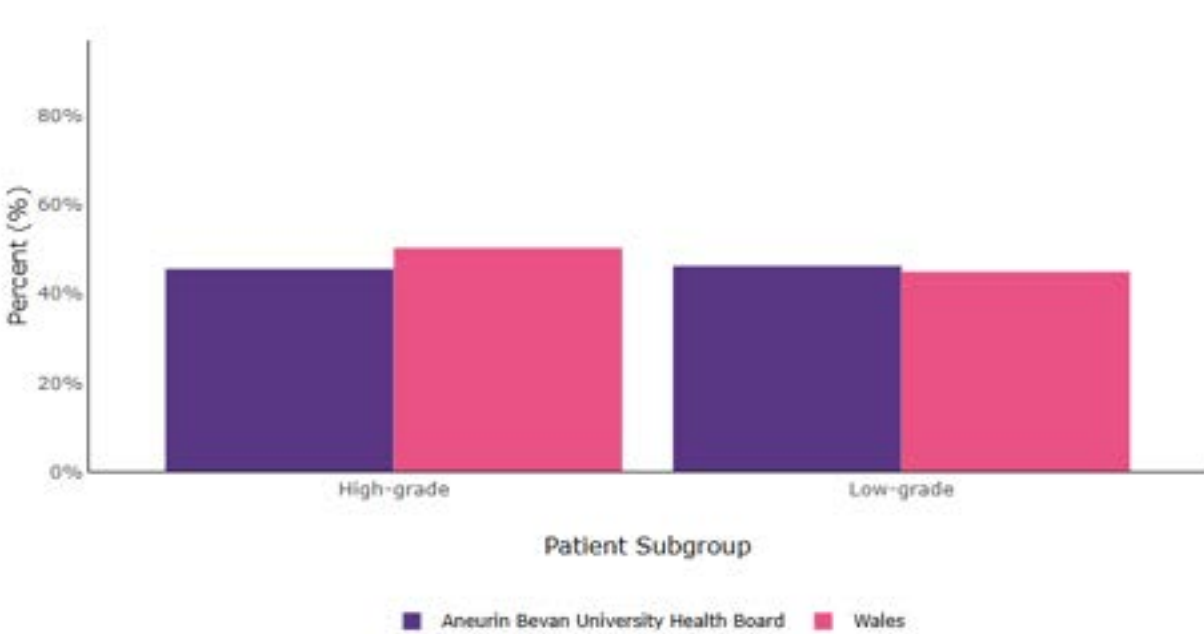
Key Message: Further analysis of variation in care across NHS hospitals is required to understand the use and delivery of radiotherapy for varying sub-types.

4.6 Outcomes

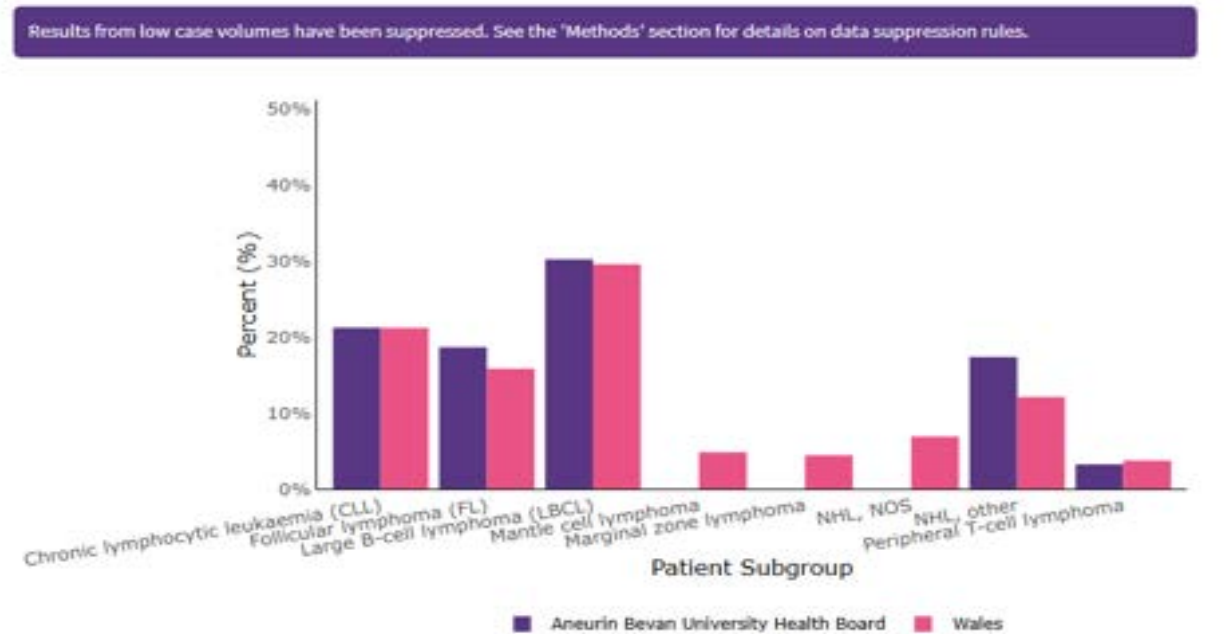
PI 11: Overall 2-year survival of people with high-grade lymphoma (BL, DLBCL, mantle cell or high-grade T-cell).

Key Message: Overall 1-year survival for all NHL cases was approximately 80% in England and Wales; around 70% for high-grade cases and 90% for low-grade cases.

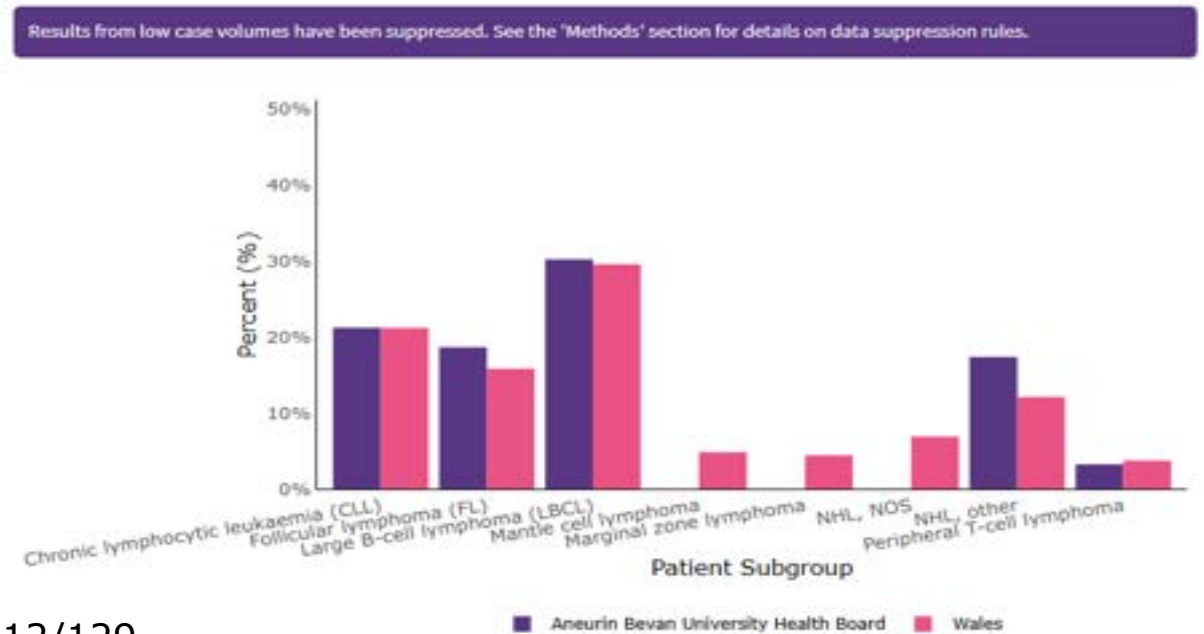
Proportion of people diagnosed with NHL reported by grade



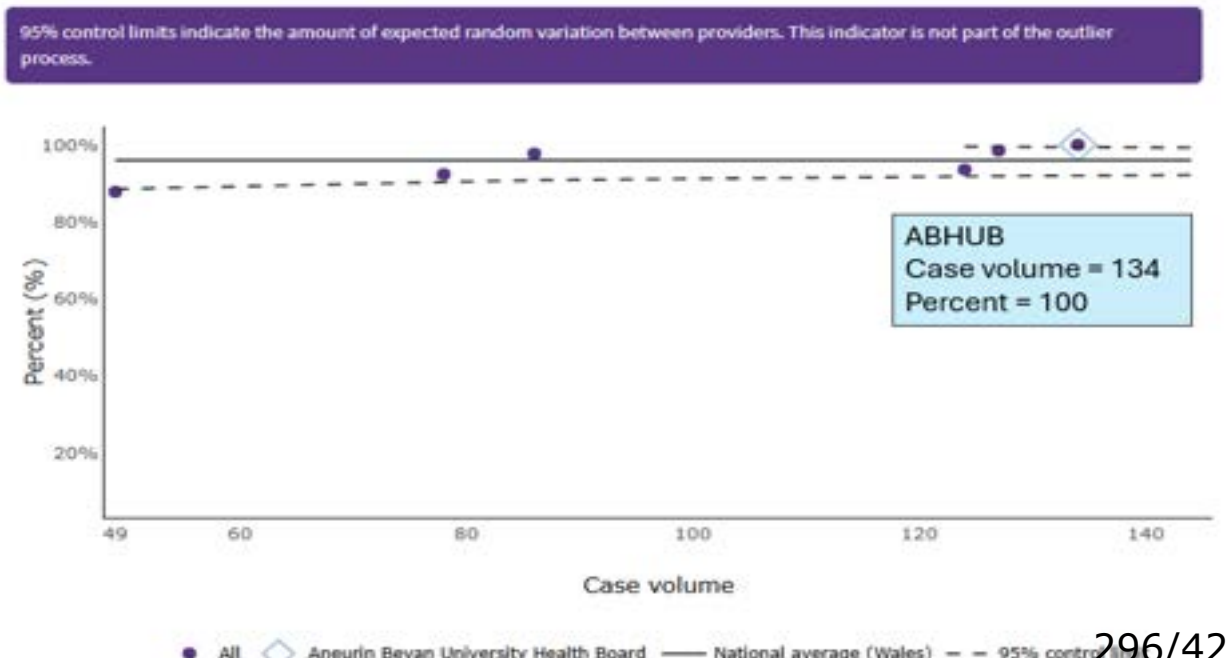
Proportion of people diagnosed with NHL reported by subtype



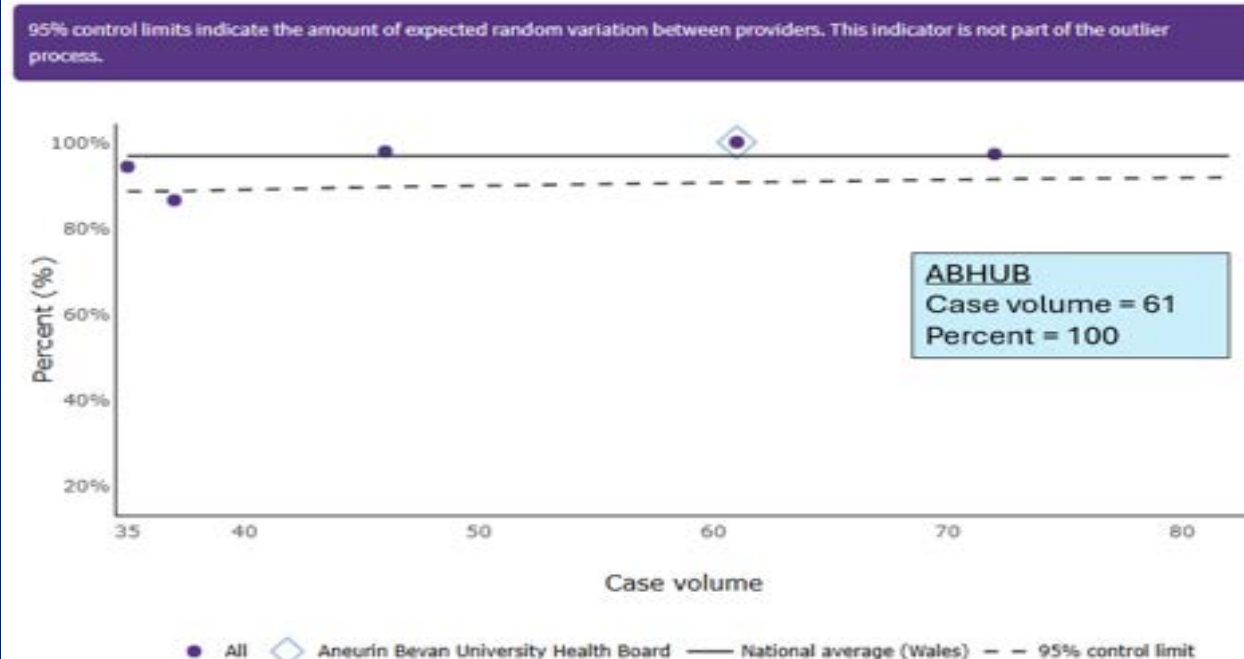
Proportion of people diagnosed with NHL reported by subtype



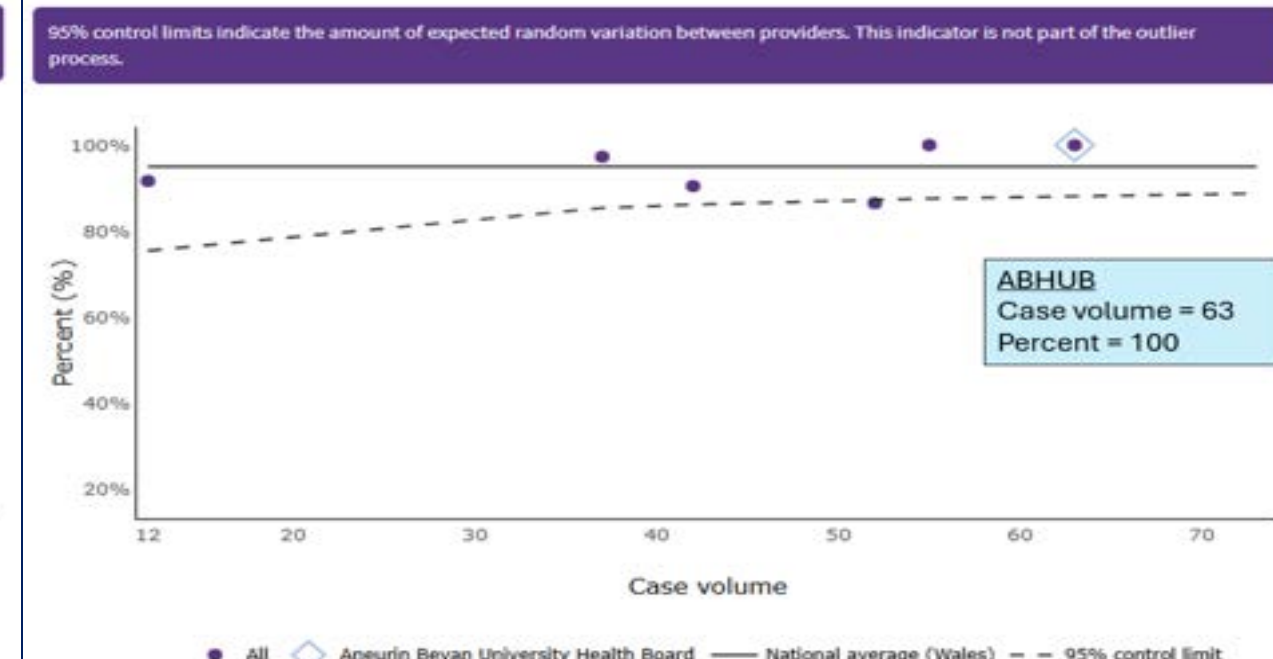
Proportion of people diagnosed with NHL seen by a clinical nurse specialist (CNS) (all grades)



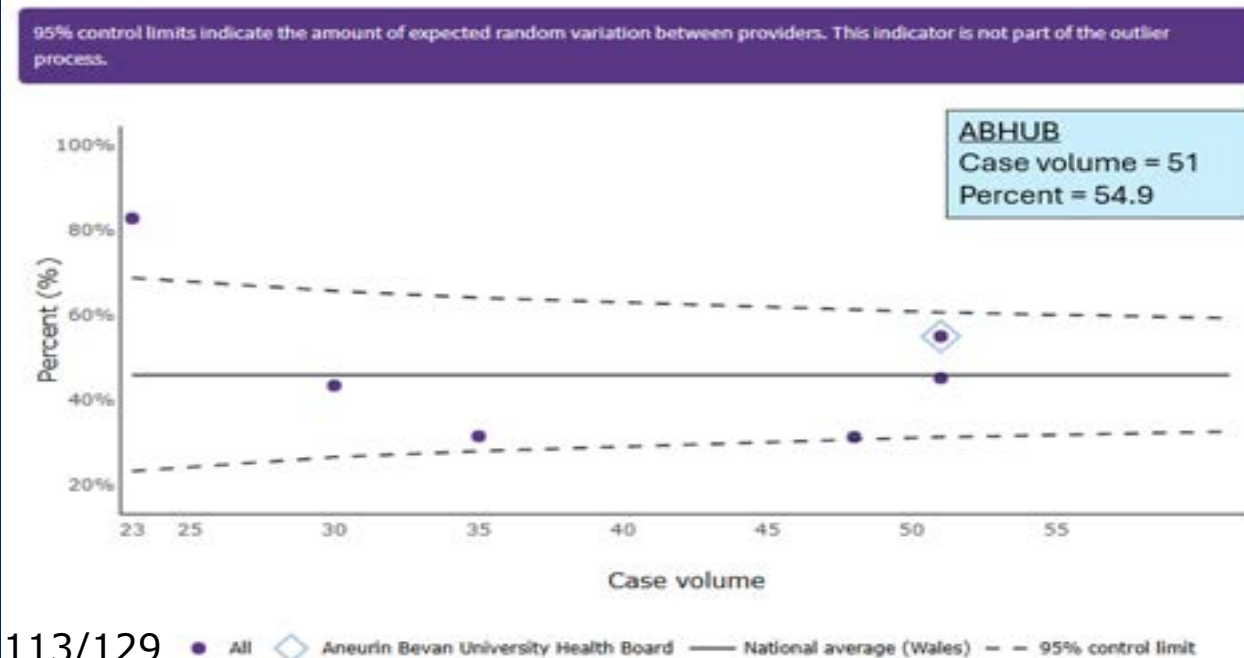
Proportion of people diagnosed with NHL seen by a clinical nurse specialist (CNS) (high grade)



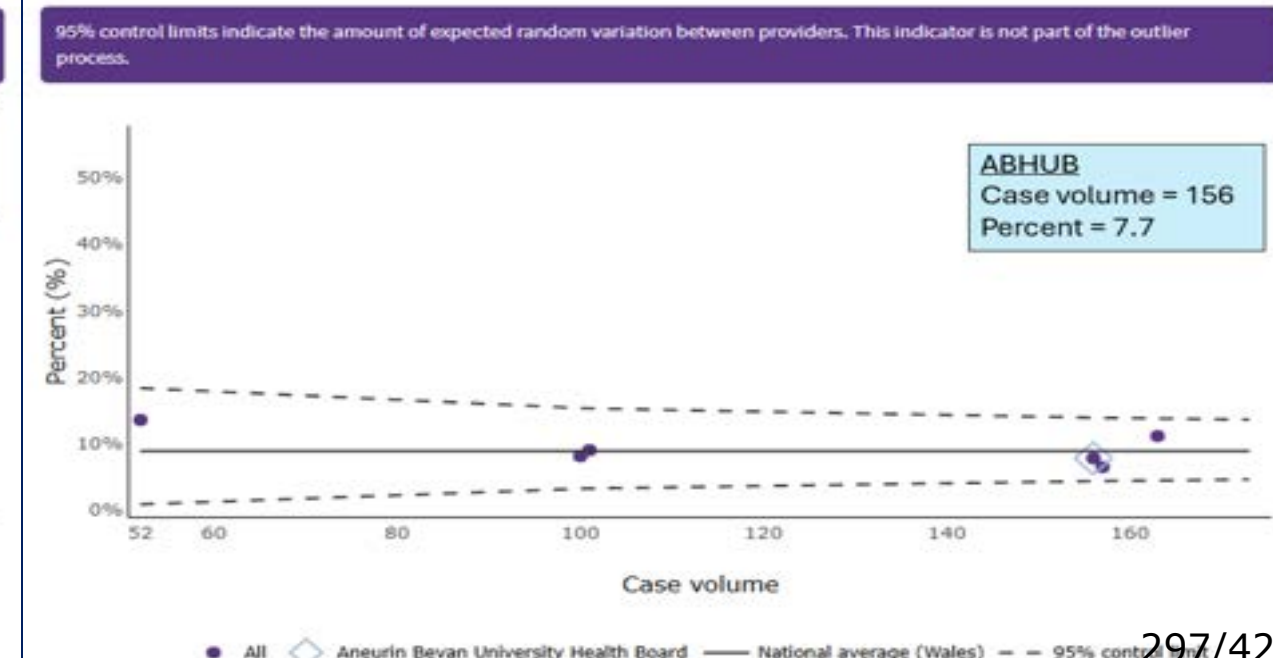
Proportion of people diagnosed with NHL seen by a clinical nurse specialist (CNS) (low grade)



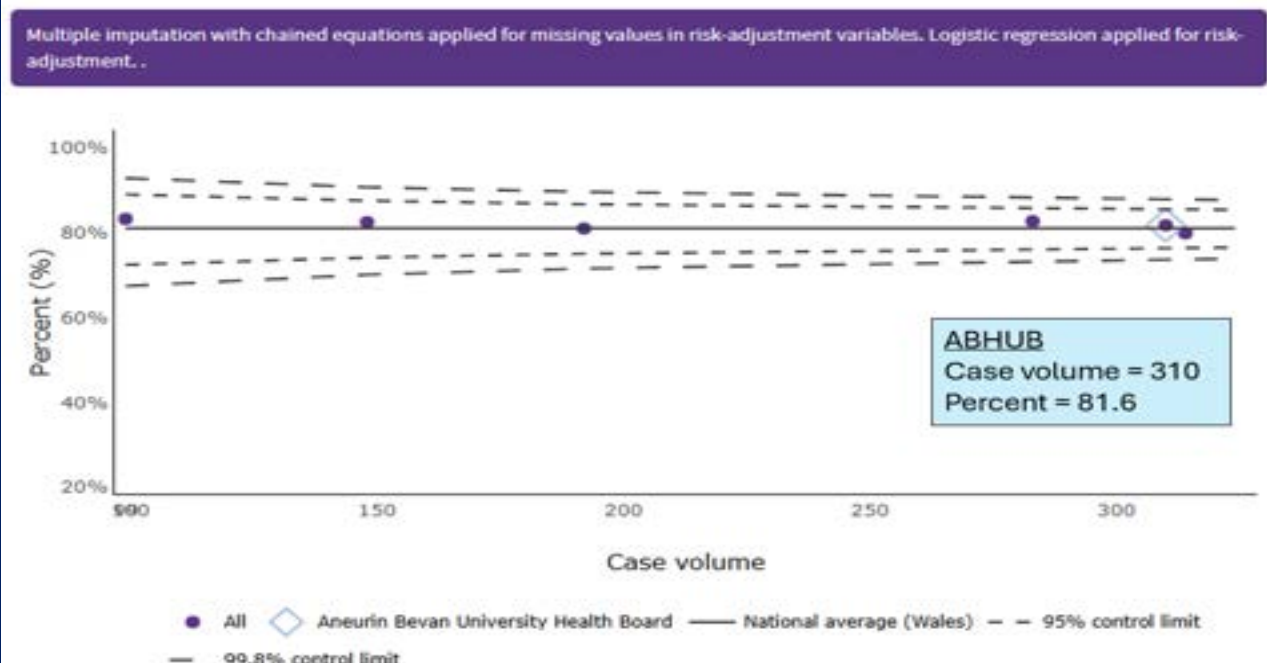
Proportion of people diagnosed with high-grade lymphoma who start SACT within 62 days of referral



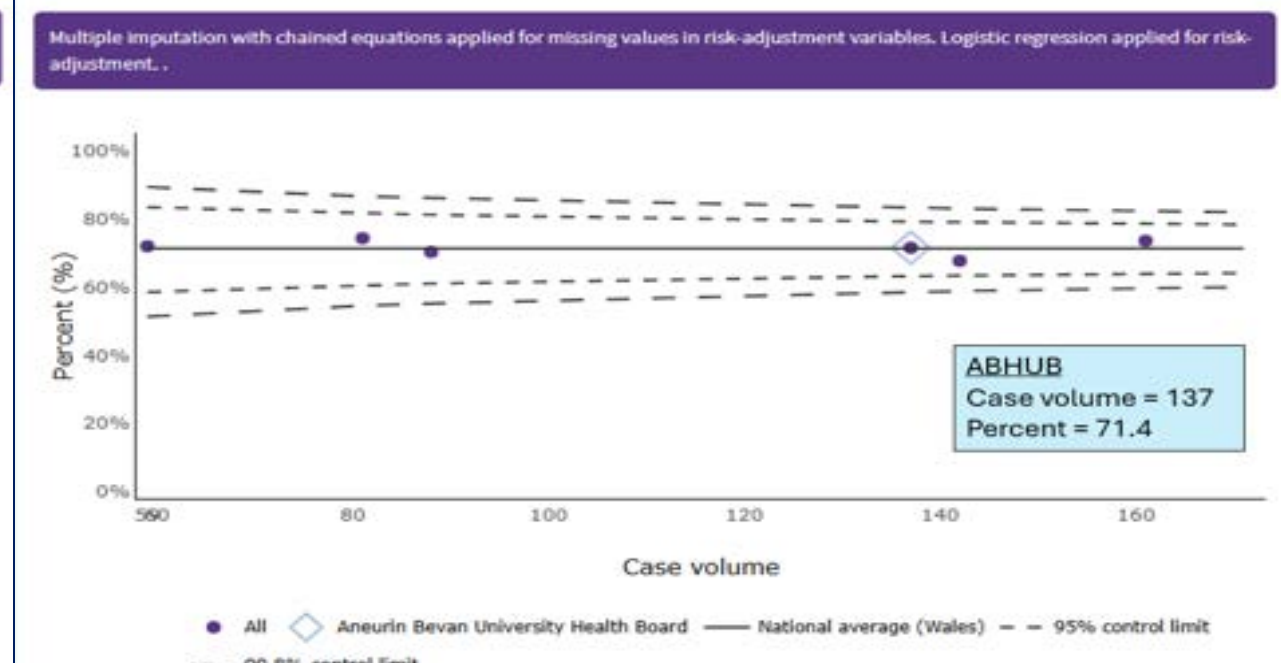
Proportion of people diagnosed with NHL receiving radiotherapy, reported by subtype (all grades)



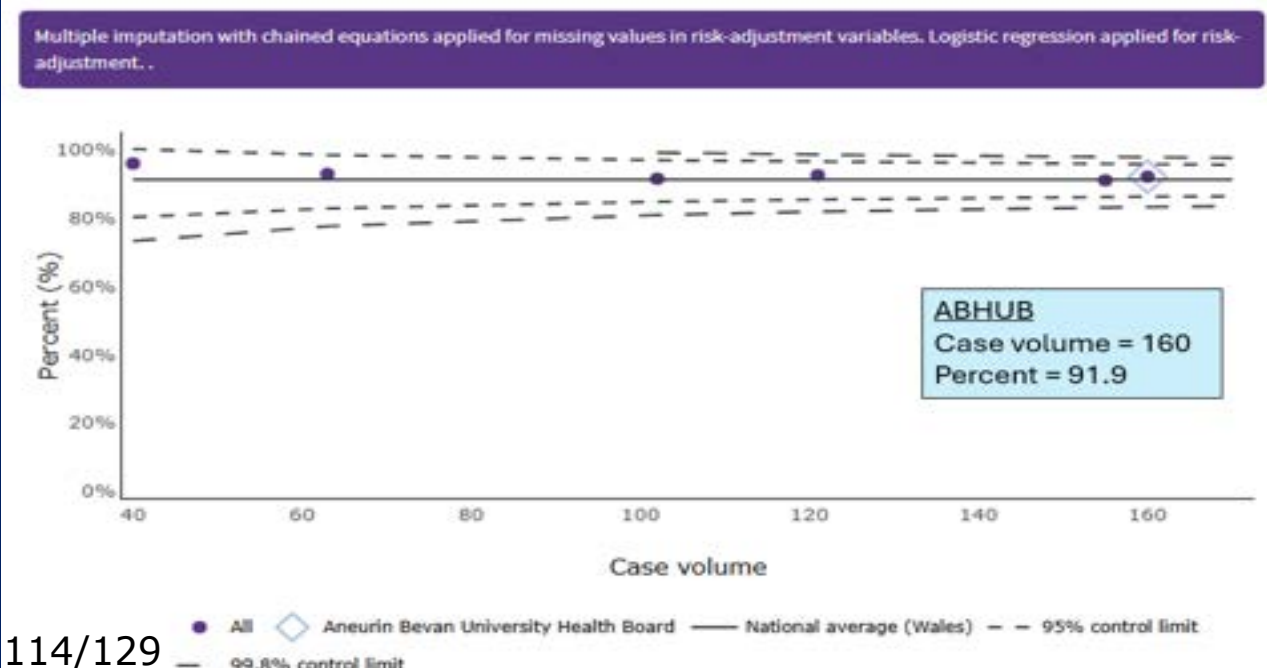
Adjusted 1-year survival of people diagnosed with NHL, reported by grade (all grades)



Adjusted 1-year survival of people diagnosed with NHL, reported by grade (high grade)



Adjusted 1-year survival of people diagnosed with NHL, reported by grade (low grade)



Data Completeness - Aneurin Bevan University Health Board (NHL)

Metric	%	Rank in Wales (6 Health Boards)
Data completeness for Ann Arbor Staging	67.5	4
Data completeness for Binet staging	Data completeness for this indicator was zero in ABUHB during the audit period	
Data completed for clinical nurse specialists	85.9	2
Data completed for performance status	70.5	6

Assurance and Risk Levels

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	
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: The outcomes from the audit tell us our patients have similar 1-year overall survival compared to the rest of England and Wales, these outcomes are also comparable with what studies would suggest overall survival should be. The improvements needed are focussing on improving data collection as opposed to anything that affects patient safety.		

Key Success and Concerns

Report Successes:	
1	Performing above average in terms of CNS review for patients being diagnosed with both low grade and high-grade lymphoma
2	Outcomes at 1 year comparable/in keeping with national average for low grade and high-grade lymphoma
Report Concerns:	
1	Data completeness for performance status and staging
2	Improving data for timely SACT to ensure more people getting chemotherapy within 62 days (it should be noted that there is no single pathway for investigation of possible lymphoma due to the nature of the disease)

Report Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress :
1	Local review at NHS trust/health board level is needed to identify diagnostic and treatment pathway delays and reduce inter-provider variation in people with high-grade NHL starting SACT within 62 days of referral. This may include examination of delays along the pathway, chemotherapy unit capacity and staffing, and mode of delivery of SACT, in order to understand system-level delays.	1. At a Welsh level, there is a NOP which is out for consultation to describe optimal pathway for diagnosis and treatment of lymphoma. 2. Local project to be done looking at timeliness of biopsies being sent from ABUHB to AWLP to see if that part of diagnostic process can be improved	1. WCN 2. Dr Williams and haematology team	1. Out for consultation hopefully will be live by next audit cycle 2. June 2026	
2	Ensure there is a designated coordinator or clinician to improve the completeness and quality of data items recorded in the national cancer datasets at each NHS trust/health board (with particular focus on staging in England and Wales and treatment delivery in Wales). This will allow better risk adjustment of outcome variables including survival outcomes for people with non-Hodgkin lymphoma and effectively inform outlier identification. The launch of the Audit’s national quality improvement initiative in October 2025 will further support this effort. NHS trusts/health boards encouraged to participate in the initiative to	In place, Dr Trickey has worked with cancer services co-ordinator for 2024 to ensure data completeness. New MDT proformas also in place since 2024 to improve documentation PS and staging	Lymphoma team consultants and cancer co-ordinator	On-going	Has been done for next audit cycle, will be on-going piece of work New MDT proformas for 2025

National Audit of Cardiac Rhythm Management (NACRM)		Clinical Lead:	Jessica Hamer
2 nd edition 1 April 2024 to 31 March 2025		NICE:	TA324 , TA314 , TA88

Rationale:	The audit aims to improve the care of patients who undergo pacemaker, implantable cardioverter-defibrillator (ICD), cardiac resynchronization therapy (CRT) and cardiac ablation procedures in the UK through the collection, analysis and dissemination of data relating to centres across the UK. Clinical leadership is provided by the British Heart Rhythm Society (BHRS) .
Objectives:	The objectives of the report are to highlight trends in procedure volumes, assess variation in clinical practice and access to care, introduce new quality indicators, and support service improvement by enabling hospitals and regions to benchmark performance. The report also seeks to inform future planning by identifying areas of emerging technology uptake, monitoring compliance with national guidelines, and promoting timely and accurate data submission to enhance the quality and impact of cardiac rhythm management services.

Presented at Clinical Standards and Effectiveness Group – 19 March 2026

Devices	Ablation
80,818 cardiac implantable electronic device (CIED) procedures performed. 17,856 CIED procedures were for complex implants (ICDs, CRT). 51% hospitals performed more than 80 new pacemaker or 60 complex implants, meeting BHRS minimum recommended volumes. <i>(see slide 3)</i> - There is an increasing proportion of CRT-P to CRT-D prescription (currently 1.1:1). <i>(see slide 4)</i> 3.5% one year mortality after ICD implant <i>(see slide 5)</i> 4.4% 1 year re-intervention rates for simple CIED implants, but variable between hospitals. <i>(see slide 6)</i> - There was a 4-fold increase in conduction system pacing. <i>(No data relating to ABUHB)</i> - There was a 37% fall in leadless pacemaker procedures <i>(No data relating to ABUHB)</i>	24,323 total ablation procedures performed. 10,372 AF ablation procedures, increasing 53% since 2015. 77% hospitals performed more than 100 ablations, meeting the BHRS minimum recommended volume. <i>(see slide 7)</i> 38% rate of general anaesthetic provision for ablation procedures, varying from 5 to 100% between hospitals. <i>(No data relating to ABUHB)</i> - Re-intervention rate for accessory pathway ablation is 5.9%, 3 x the rate for other standard ablation procedures <i>(No data relating to ABUHB)</i>
Abbreviations: AF= Atrial Fibrillation; BHRS= British Heart Rhythm Society; CIED= Cardiac Implantable Electronic Devices; CRT= Cardiac Resynchronisation Therapy; ICD= Implantable Cardioverter Defibrillator	

Report at a glance: 51% hospitals performed more than 80 new pacemaker or 60 complex implants, meeting BHRS minimum

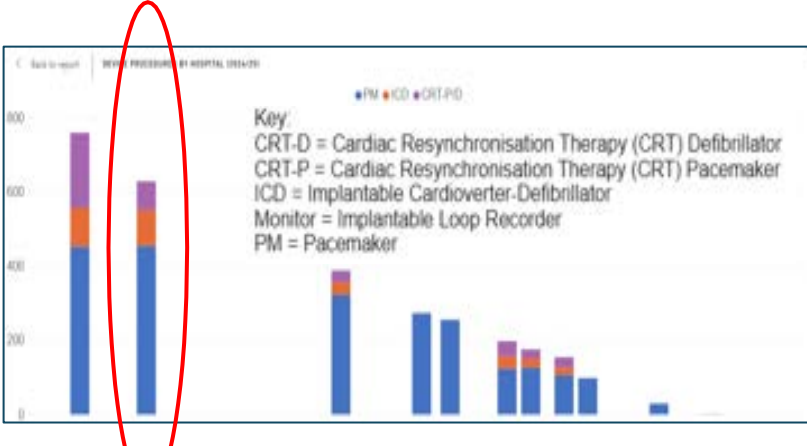
Most hospitals delivered more than the minimum recommended number of CIED procedures



The British Heart Rhythm Society (BHRS) Standards (2024 January revision) recommend that device centres undertake a minimum procedure volume per year:

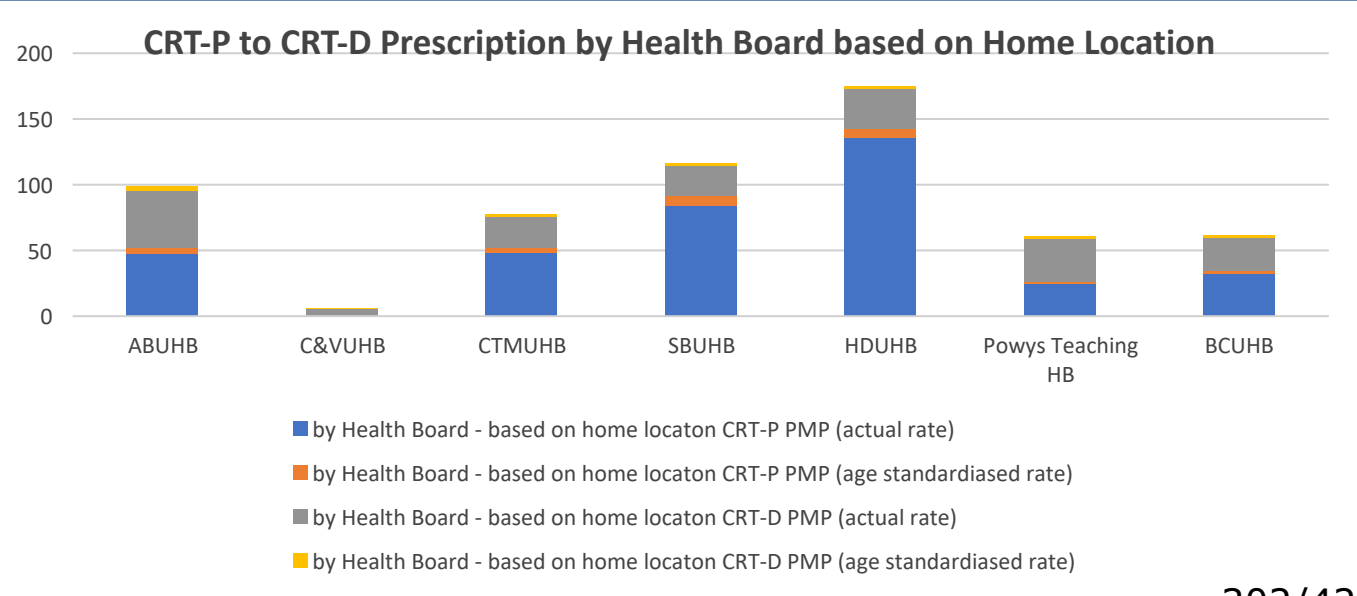
- A minimum of 80 new pacemaker implants per year.
- A minimum of 60 new ICD or CRT implants per year

Rank	PM	ICD	CRT-P/D	Total procedures	Hospital
28	452	104	203	759	Morriston Hospital
42	454	97	77	628	Grange University Hospital
83	323	33	32	388	Royal Glamorgan Hospital
100	273	0	0	273	Glan Clwyd Hospital
106	255	0	0	255	Glangwili General Hospital
118	123	33	41	197	Ysbyty Gwynedd
123	126	24	25	175	Princess of Wales Hospital
130	106	20	28	154	Wrexham Maelor Hospital
135	98	0	0	98	Bronglais General Hospital
150	29	0	0	29	Prince Charles Hospital
161	1	0	0	1	University Hospital of Wales



Report at a glance: There is an increasing proportion of CRT-P to CRT-D prescription (currently 1.1: 1)

by Health Board - based on home location				
Health Board	CRT-P PMP (actual rate)	CRT-P PMP (age standardised rate)	CRT-D PMP (actual rate)	CRT-D PMP (age standardised rate)
ABUHB	47.8	4	43.6	3.6
C&VUHB	0	0	5.6	0.5
CTMUHB	48.4	4	22.9	1.9
SBUHB	83.5	7.6	23.5	2.2
HDUHB	135.7	7.1	30.2	1.6
Powys Teaching HB	24.7	1.5	32.9	2.1
BCUHB	32	2.6	24.7	2.1

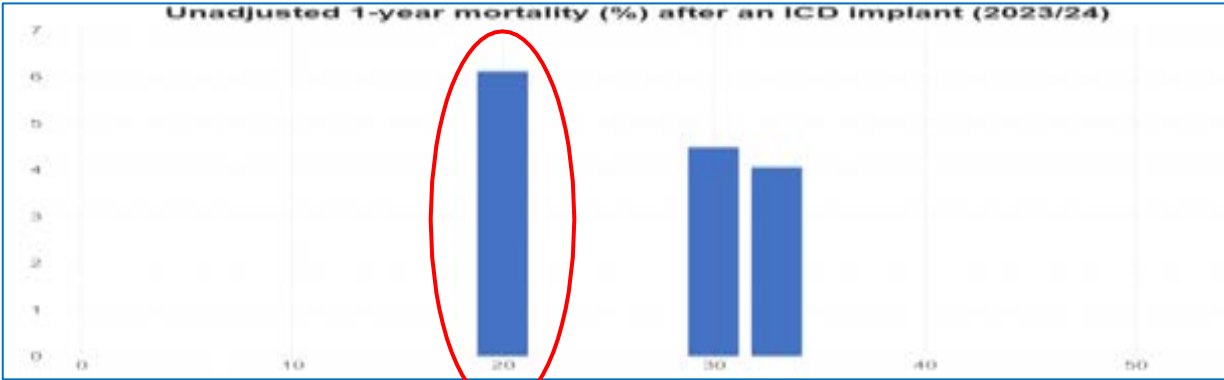


Report at a glance: 3.5% one-year mortality after ICD implant (national average)

One year mortality after defibrillator implantation was 3.5% but varied from 2 to 24% between hospitals

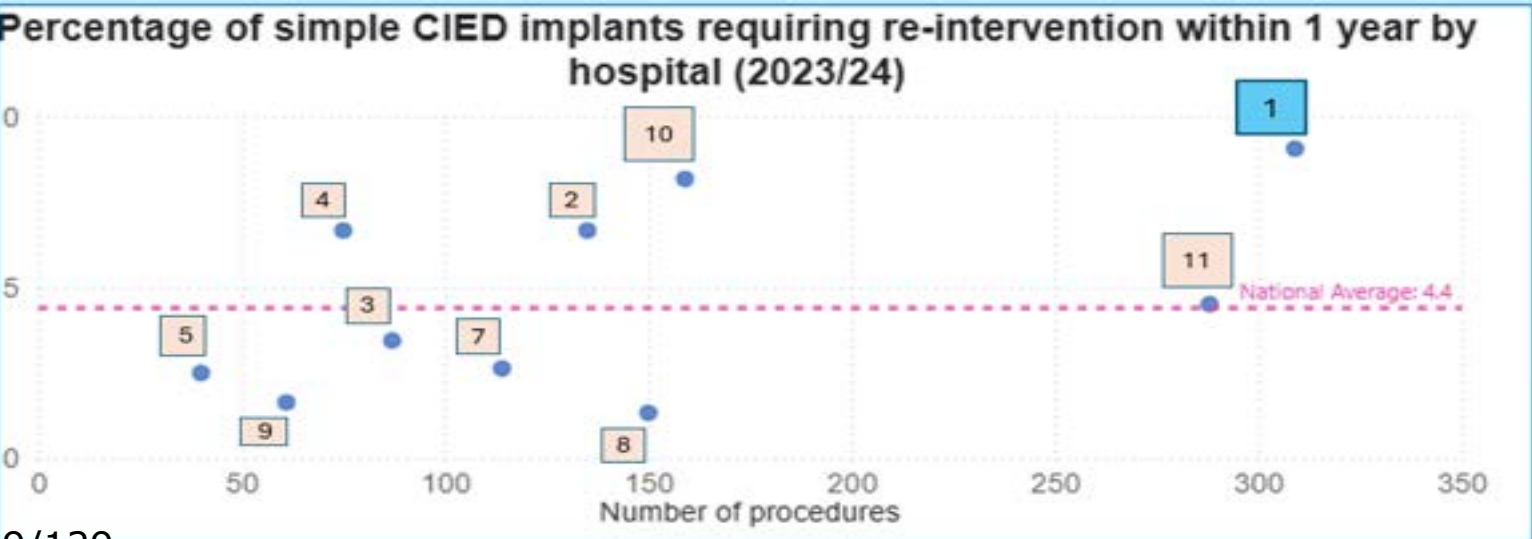


Unadjusted one year mortality after ICD implant 2023/24				
Site	Rank (national)	Mortality (%)	Total Cases	Deaths
GUH	20	6.1	49	3
Ysbyty Gwynedd (YG)	30	4.5	4,988	224
Wrexham Maelor (WMH)	33	4.1	22,284	905



Report at a glance: 4.4% 1 year re-intervention rates for simple CIED implants but variable between hospitals (national average)

The 1-year re-intervention rate after simple CIED implants ranged from near zero to 12% across different hospitals



Key			
Hospital ID No.	Site	PM new implant count	1 year re-intervention (%)
1	GUH	309	9.1
2	Glan Clwyd	135	6.7
3	Wrexham Maelor	87	3.4
4	Ysbyty Gwynedd	75	6.7
5	UHW	40	2.5
6	Prince Charles		
7	Princess of Wales	114	2.6
8	Royal Glamorgan	150	1.3
9	Bronglais	61	1.6
10	Glangwili	159	8.2
11	Morriston	288	4.5

Report at a glance: 77% hospitals performed more than 100 ablations, meeting the BHRS minimum recommended volume

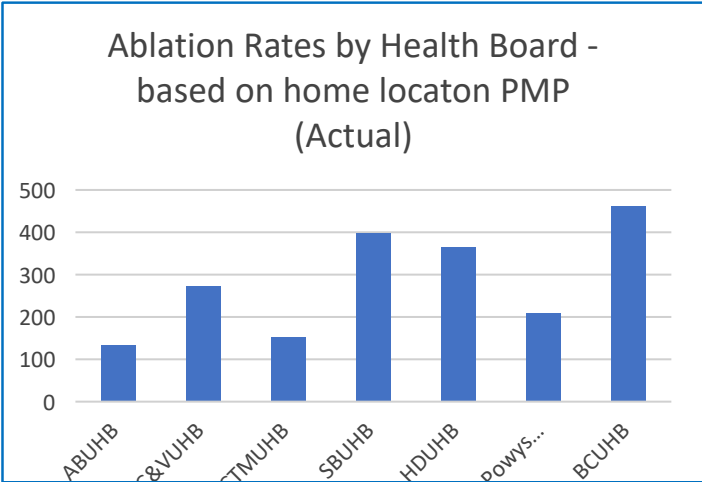
Ablation rates varied 12-fold across ICBs and Health Boards in England and Wales



Ablation Rates per million population (PMP)

Actual rate - all ablation types

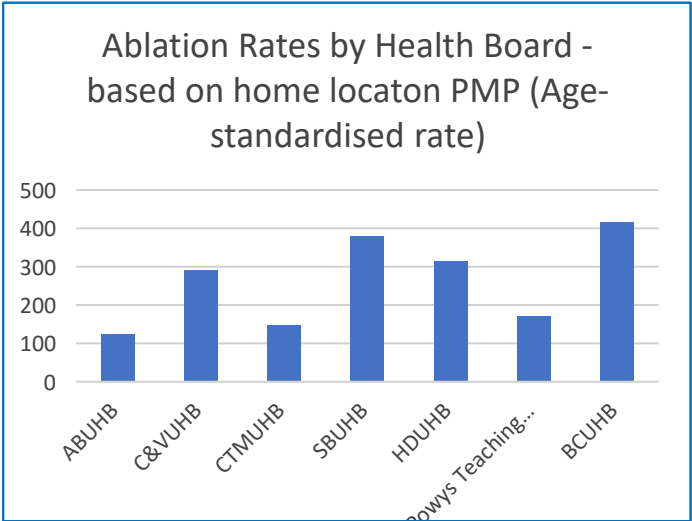
by Health Board - based on home location		by Cardiac Network - based on Hospital location	
Health Board	PMP	Cardiac Network	PMP
ABUHB	133	Wales	247
C&VUHB	272		
CTMUHB	152		
SBUHB	398		
HDUHB	366		
Powys Teaching HB	210		
BCUHB	461		



Ablation Rates per million population (PMP)

Age-standardised rate - all ablation types

by Health Board - based on home location		by Cardiac Network - based on Hospital location	
Health Board	PMP	Cardiac Network	PMP
ABUHB	125	Wales	247
C&VUHB	290		
CTMUHB	147		
SBUHB	379		
HDUHB	315		
Powys Teaching HB	171		
BCUHB	415		



Assurance and Risk

Assurance level	Description	Select
Significant	The project has mostly achieved the standards or criteria being audited against	X
Risk level	Description	Select
Minor	Overall treatment or service suboptimal - Minor implications for patient safety if unresolved	Devices
Moderate	Treatment or service has significantly reduced effectiveness - Moderate risk to patient safety if not acted upon	EP
Has this audit been placed on a Risk Register (N/A if above risk is None)		YES ☐
If not on a risk register, why not: Device waiting list has been added to risk register.		

Key Success and Concerns

Report Successes:		Report Concerns:	
1	Complete data entry	1	Discrepancies in numbers
2	Meeting minimum numbers	2	Poor access to EP for ABUHB patients
3	Increase in implant numbers since the opening of Grange University Hospital	3	Poor data entry from tertiary centre making it difficult to benchmark

Clinical Leads Local Recommendations:		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Commence CSP programme	CP and operator training. Engage with companies regarding support and proctor.	Cardiology CD	Next financial year	Ongoing
2	Look to complete business case for local EP services	Business case to be completed.	Cardiology CD	Next financial year	Ongoing

Report Recommendations:		S.M.A.R.T Actions:		Responsible:	Due Date:	Progress:
Clinical Practice:						
1	Device therapy: As pacemaker and ICD implantation rates remain lower than comparable countries, regional services should review waiting lists and local practice against guidelines.	Business case being worked up for third cath lab and additional implanter		Cardiology CD	Next financial year	ongoing
2	AF Ablation: Given variation across regions, local services should review patient selection and re-intervention rates for AF ablation					n/a
3	Re-intervention rates: Hospitals should review accessory pathway ablation practice given relatively high re-intervention rates.					n/a
4	Emerging technologies: Regional services should review appropriate clinical use and access to emerging technologies (suchas leadless pacing, conduction system pacing or pulsed field ablation).	Current implanters have had CSP training – initiation of service delayed due to sickness		Cardiology CD	Next financial year	Ongoing
Data Completion:						
1	Implant Records: There is an increasing obligation to monitor medical implants and all operators should ensure implant identifiers and relevant clinical fields are completed and submitted to the NACRM within agreed timelines (see background for more details on captured fields).	All data entered via electronic pacing system (Solus) – data is pulled and sent to NICOR monthly		IT manager	Ongoing	ongoing
2	Emerging technologies: There is a growth of emerging heart rhythm technologies and all operators should ensure correct submissions are made to facilitate monitoring of procedures and outcomes of changing practice.	Specialist services commissioned by JCC and often that is a barrier to our adoption of them (eg leadless pacing)				

122/129

122306/425

National Vascular Registry – State of the Nation Report 2025 An audit of care received by people who had vascular procedures during 2024 in NHS hospitals in England, Wales, Scotland and Northern Ireland	Clinical Lead:	David McLain - Consultant Vascular Surgeon
	NICE:	NG19 , NG156 , QS208 , QS209

Rationale:	The report was developed to evaluate the quality and outcomes of care for adults undergoing major vascular procedures in NHS hospitals. Its primary rationale is to support vascular services in delivering safe, high-quality care by benchmarking performance against national standards, identifying delays and variations, and highlighting areas for improvement. By aligning with NICE guidelines, VSGBI frameworks, and other national standards, the report aims to drive quality improvement initiatives, share best practices, and ensure compliance with evidence-based care pathways.
Objectives:	Its objectives are to benchmark care against national standards, identify delays and variations in treatment, and highlight areas for improvement. The report focuses on key indicators such as short-term postoperative mortality and timeliness of interventions for procedures including lower limb revascularisation, major amputation, abdominal and thoracic aortic repairs, and carotid endarterectomy.

Context
The National Vascular Registry (NVR) audits major vascular procedures across the UK. The 2025 report reviews care delivered in 2024 for lower limb revascularisation, major amputation, aortic repairs (AAA and thoracic), and carotid endarterectomy (CEA). Key indicators include timeliness of treatment, postoperative outcomes, and data completeness.

Please Note: Aneurin Bevan University Health Board (ABUHB) do not undertake major limb amputation, aortic repairs or carotid endarterectomy.

Standards and Guidelines

National guidelines underpin the management of people with vascular conditions, and the NVR evaluates patterns of care against these recommendations. An overall framework for vascular services is described by the “Provision of Services for People with Vascular Disease” published by the Vascular Society of Great Britain & Ireland. Additional standards originate from documents published by the National Institute for Health and Care Excellence (NICE), European Society of Vascular Surgery guidelines, national screening guidance, and government documents. From these, and in consultation with its professional and patient advisory groups, the NVR developed five quality improvement (QI) goals and associated indicators, which are published in the [NVR Healthcare-Improvement-Strategy Aug2023.pdf](#)

National Guidelines and Frameworks that underpin the National Vascular Registry:	
VSGBI 2021	VSGBI 2016
VSGBI 2012	NAAASP 2020
VSGBI 2022	NICE 2012
NICE 2019	

Quality Improvement

The State of the Nation report published in November 2025 sets out five QI goals, developed to address the key concerns identified in the NVR Healthcare Improvement Strategy (August 2023).

One of the concerns raised was regarding the variation in the time taken for patients undergoing a lower limb revascularisation procedure following a non-elective admission for chronic limb threatening ischaemia. As ABUHB do not undertake major limb amputation, aortic repairs or carotid endarterectomy, it was this particular concern and associated action relating to lower limb revascularisation that was relevant and of interest to ABUHB.

Opposite are all five improvement goals, with the goal of relevance to ABUHB highlighted.

QUALITY IMPROVEMENT GOALS



REDUCE DELAYS FOR CLTI REVASCULARISATION
Ensure patients admitted as emergencies receive revascularisation within 5 days



IMPROVE TIMELINESS FOR AAA REPAIR AND CEA
Meet standards for AAA repair within 8 weeks and CEA within 14 days of symptoms



ENSURE TIMELY MAJOR LOWER LIMB AMPUTATION
Perform amputations within 48 hours of decision to operate



STRENGTHEN INTEGRATED CARE FOR DIABETIC PATIENTS
Coordinate management across primary and secondary care

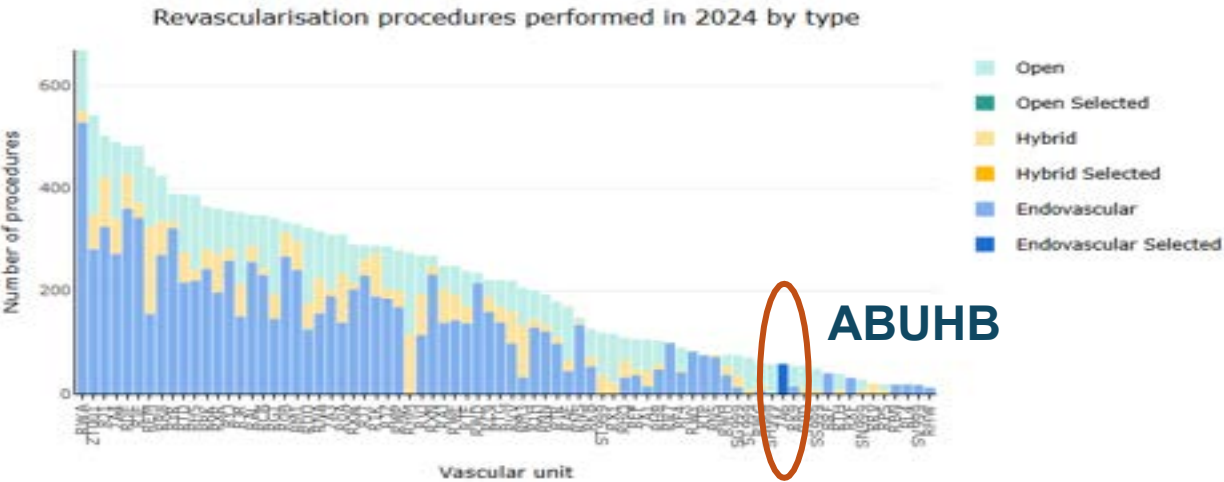


EXPAND ACCESS TO ENDOVASCULAR REPAIR FOR RAAA
Ensure suitable patients have access to EVAR

Lower limb revascularisation

The data tables and graphs shown on slides 4 to 7 report metrics for patients who had a lower limb revascularisation procedure between January and December 2024, performed using open surgery (bypass), endovascular techniques or a combination of both (hybrid). The analysis focuses on the first procedure undergone by a patient during an admission; subsequent procedures are re-operations. The waiting time plots include NHS vascular units with at least 10 non-elective chronic limb-threatening ischaemia (CLTI) cases in 2024.

	Aneurin Bevan University Health Board 7A6	Wales	UK
NVR cases (2024)	58	963	16,618
Open surgical	<5	317	4,529
Hybrid	<5	112	2,453
Endovascular	58	534	9,636
Emergency CLTI cases (2024)	<5	502	5,182
Median time (IQR) from assessment to procedure (days)		6 (4 - 10)	6 (3 - 9)
CLTI treated within 5 days		43%	49%



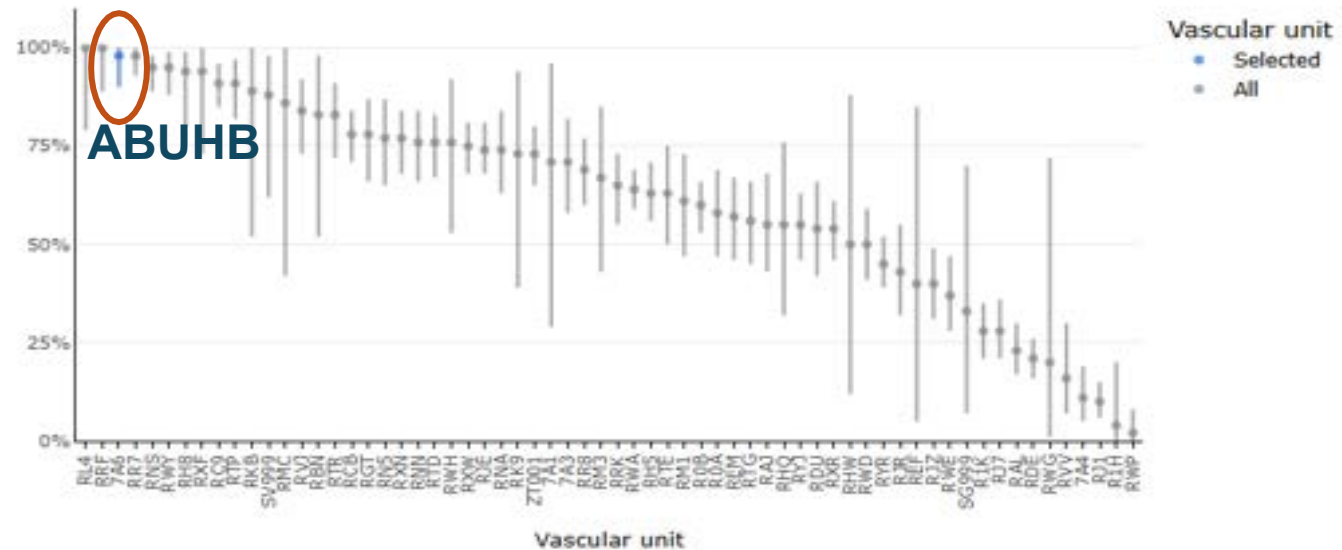
Patient characteristic	Time period	NVR cases	vascular unit	UK	Lowest	Highest
Age over 75 years (%)	2024	58	33%	33%	18%	48%
Men (%)	2024	58	72%	71%	56%	88%
Current smokers (%)	2024	58	36%	29%	16%	54%
Diabetes (%)	2024	58	47%	51%	18%	73%
Chronic heart disease (%)	2024	58	22%	29%	0%	56%
Chronic lung disease (%)	2024	58	16%	21%	0%	48%
Chronic kidney disease (%)	2024	58	3%	17%	0%	59%
Indication: Rest pain / tissue loss (%)	2024	58	76%	76%	16%	98%

	Aneurin Bevan University Health Board 7A6	Wales	UK
NVR cases (2024)	58	534	9,636
Case ascertainment	>85%	100%	58%
Day cases (2024)	98%	52%	60%
NVR cases (2022-2024)	168	1,387	28,140
Adjusted in-hospital mortality (2022-2024)	1.6%	1.8%	1.6%
Readmitted within 30 days (2024)	14%	21%	14%

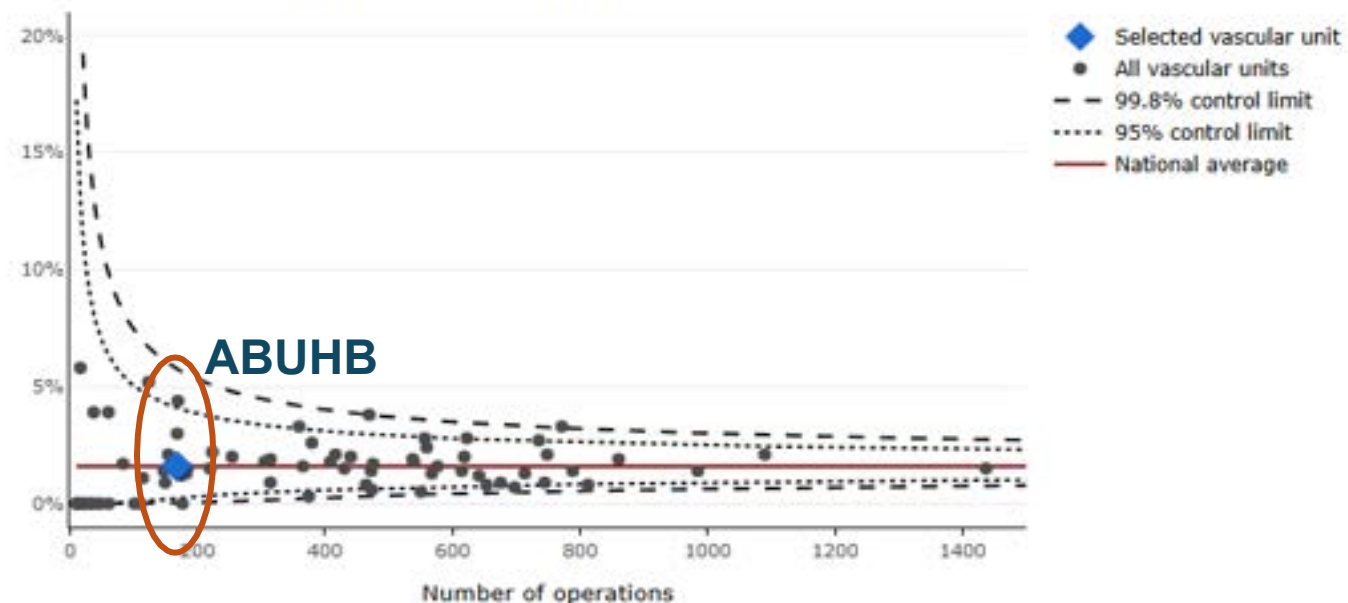
Lower limb angioplasty/stenting

The data/graphs on slides 8 to 10 report on lower limb endovascular revascularisation procedures, such as angioplasty and stenting. The analysis focuses on the first procedure undergone by a patient during an admission. Most metrics are relevant to procedures performed from January to December 2024, while the mortality funnel plot is based on data from NHS vascular units that submitted at least 10 procedures in the NVR from January 2022 to December 2024. The day case plot is displayed for NHS vascular units with at least 5 elective angioplasty cases in 2024.

Elective endovascular procedures performed as day cases in 2024



Risk-adjusted in-hospital mortality in 2022-2024



Elective infrarenal abdominal aortic aneurysm repair

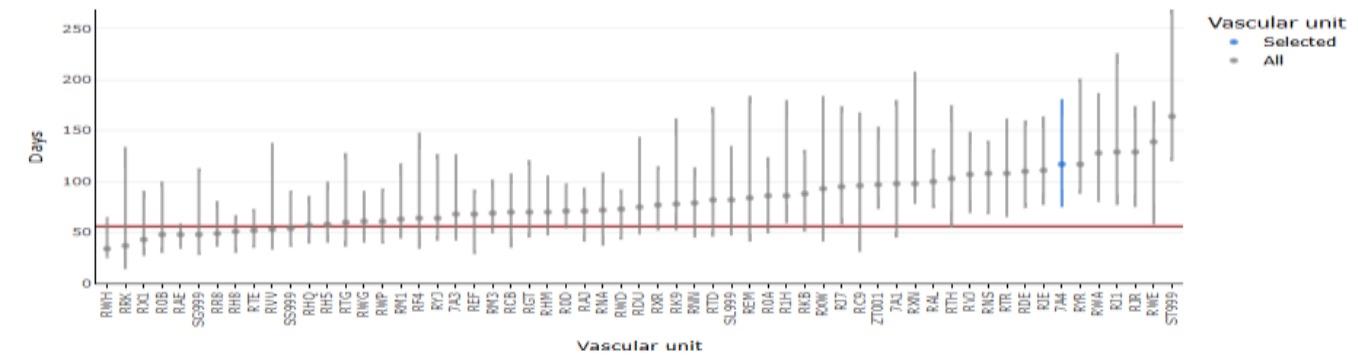
This section presents process metrics and outcomes for elective infrarenal AAA repairs, including revision procedures but excluding complex repairs. Most metrics are presented for procedures performed between January and December 2024, apart from in-hospital mortality which is reported for the period from January 2022 to December 2024 to give robust outcome estimates. Vascular units with fewer than 10 procedures submitted in the reporting period are not shown in the graphs.

	Cardiff and Vale University Health Board 7A4	Wales	UK
NVR cases (2024)	46	138	2,511
Case ascertainment	>85%	100%	91%
No. of EVAR	28	76	1,556
Median time (IQR) from assessment to procedure (days)	117 (75 - 181)	90 (50 - 148)	81 (46 - 138)
Had surgery within 8 weeks of assessment	12%	30%	33%
Discussed at MDT	98%	96%	86%
Had anaesthetic review	100%	100%	97%
Median (IQR) length of stay for EVAR (days)	2 (2 - 3)	2 (2 - 3)	2 (1 - 3)
Median (IQR) length of stay for open repairs (days)	10 (8 - 12)	6 (7 - 10)	7 (6 - 10)
NVR cases (2022-2024)	136	406	8,203
Risk-adjusted in-hospital mortality (2022-2024)	0.9%	1.1%	1.3%

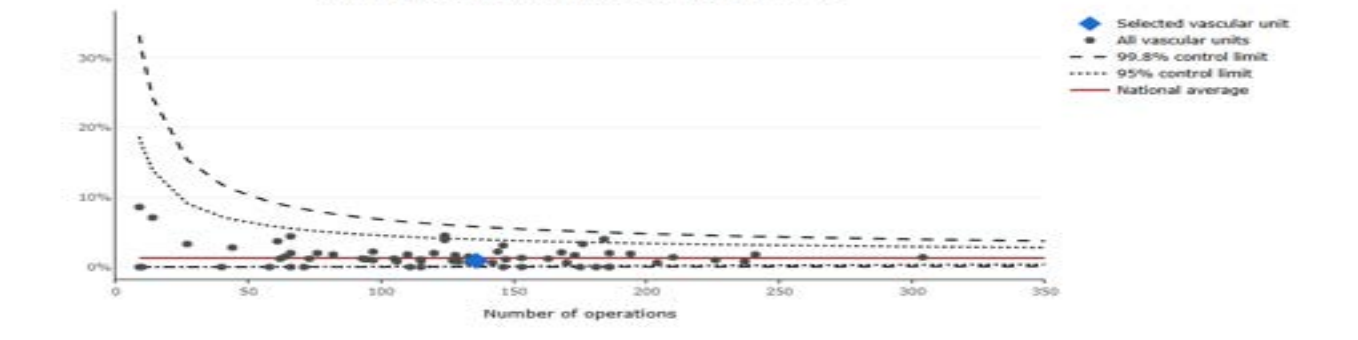
	Cardiff and Vale University Health Board 7A4	Wales	UK
No. of EVAR	28	69	1,211
Case ascertainment	>85%	100%	94%
Median (IQR) length of stay (days)	6 (3 - 14)	6 (3 - 15)	9 (4 - 18)
Risk-adjusted in-hospital mortality (2022-2024)	50.4%	56.9%	34.8%

EVAR

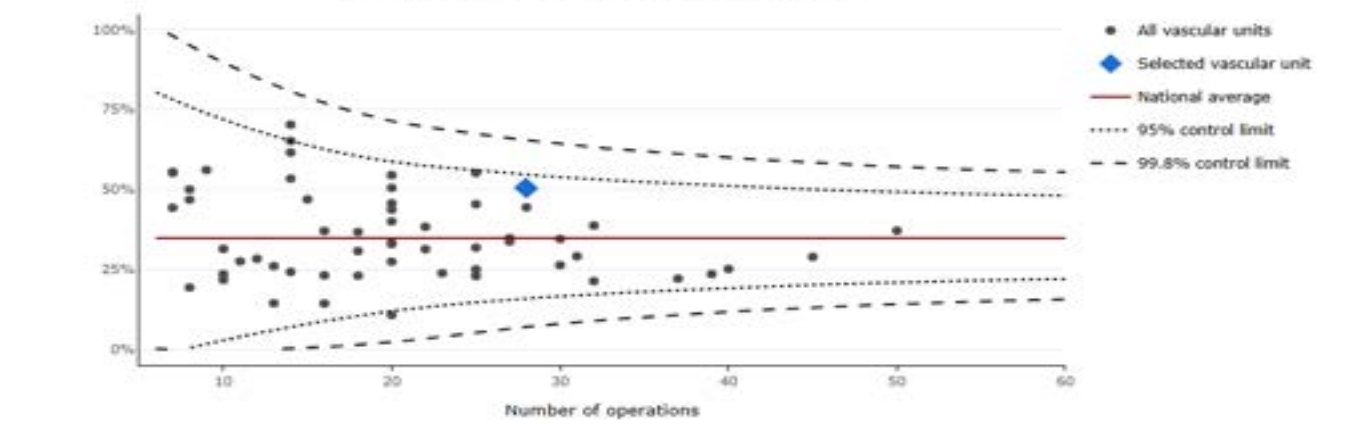
Median time (IQR) from assessment to AAA repair in 2024



Risk-adjusted in-hospital mortality in 2022-2024



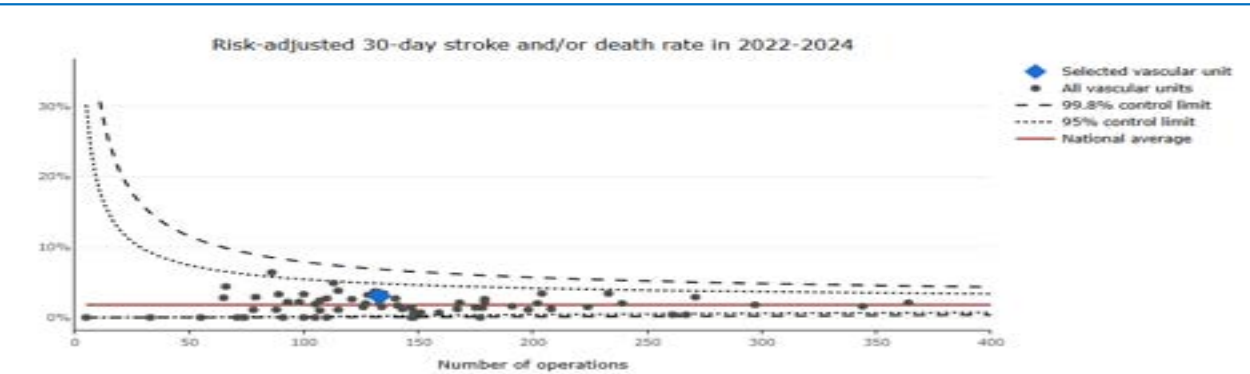
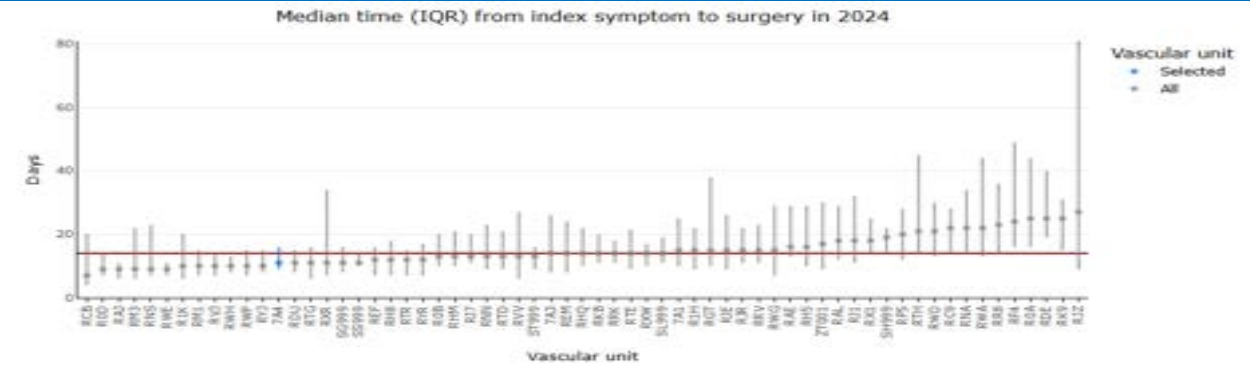
Risk-adjusted in-hospital mortality in 2022-2024





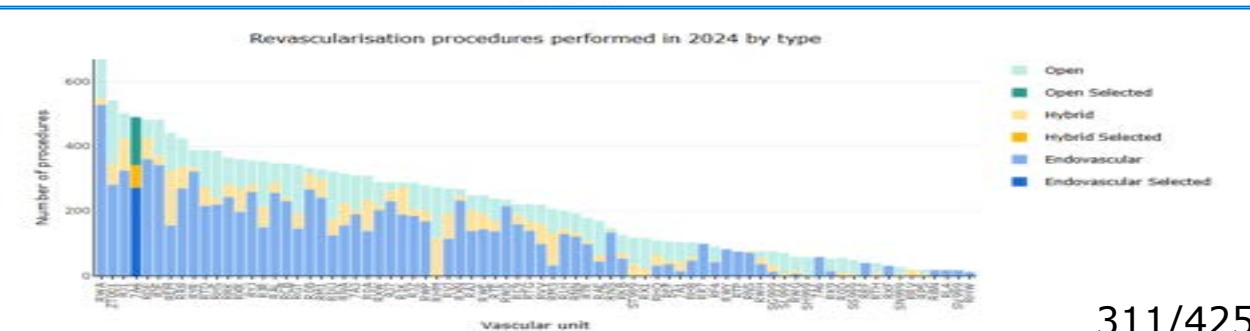
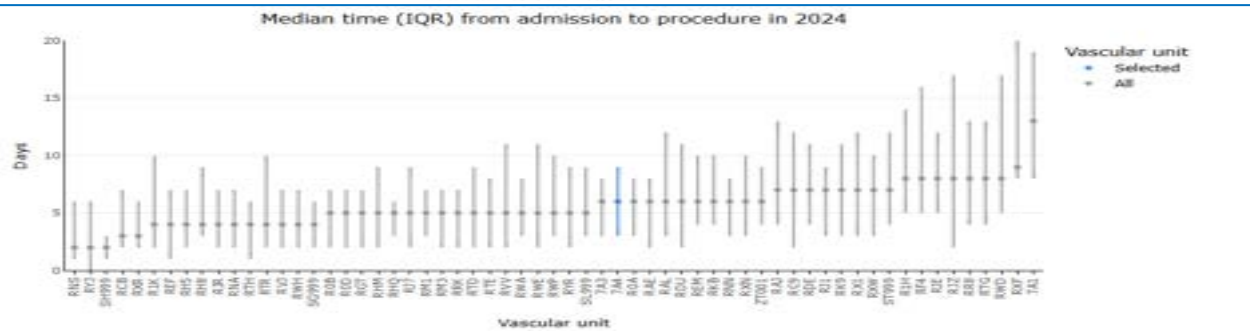
Carotid Endarterectomy

	Cardiff and Vale University Health Board 7A4	Wales	UK
NVR cases (2024)	43	129	2,877
Case ascertainment	>85%	100%	87%
Symptomatic cases	42	128	2,719
Referred within 7 days of symptom	68%	61%	70%
Had surgery within 7 days of referral	63%	62%	43%
Had surgery within 14 days of symptom	64%	57%	53%
Median delay (IQR) from symptom to surgery (days)	11 (9 - 16)	13 (9 - 24)	14 (9 - 24)
Median (IQR) length of stay (days)	3 (2 - 5)	4 (3 - 6)	2 (1 - 4)
NVR cases (2022-2024)	133	414	9,603
Adjusted Stroke and/or death rate (2022-2024)	3%	2.3%	1.8%



Lower Limb Revascularisation

	Cardiff and Vale University Health Board 7A4	Wales	UK
NVR cases (2024)	490	963	16,618
Open surgical	148	317	4,529
Hybrid	70	112	2,453
Endovascular	272	534	9,636
Emergency CLTI cases (2024)	255	502	5,182
Median time (IQR) from assessment to procedure (days)	6 (3 - 9)	6 (4 - 10)	6 (3 - 9)
CLTI treated within 5 days	47%	43%	49%



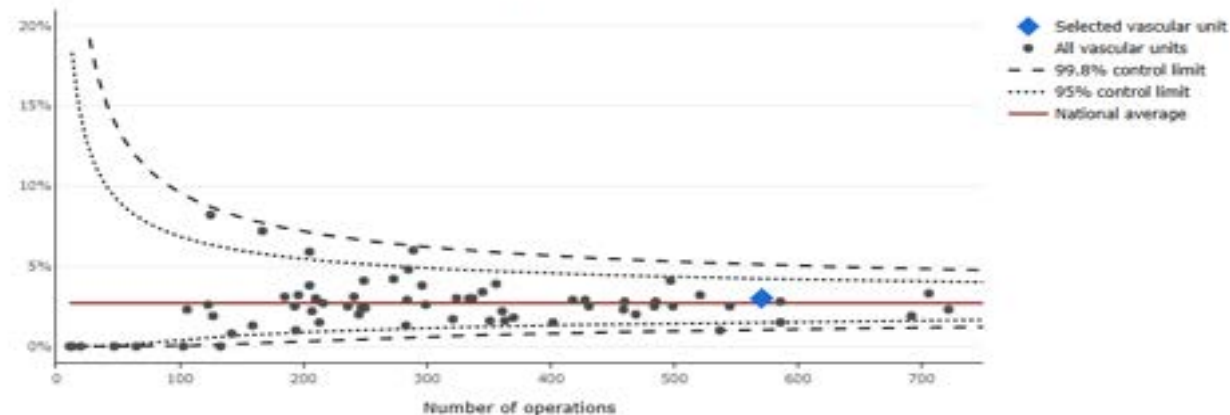
Bypass

	Cardiff and Vale University Health Board 7A4	Wales	UK
NVR cases (2024)	218	429	6,982
Case ascertainment	>85%	100%	89%
Median (IQR) length of stay (days)(2024)	10 (6 - 17)	11 (6 - 20)	8 (4 - 16)
NVR cases (2022-2024)	571	1,301	20,865
Adjusted in-hospital mortality (2022-2024)	3%	3%	2.7%
Readmitted within 30 days (2024)	9%	13%	13%

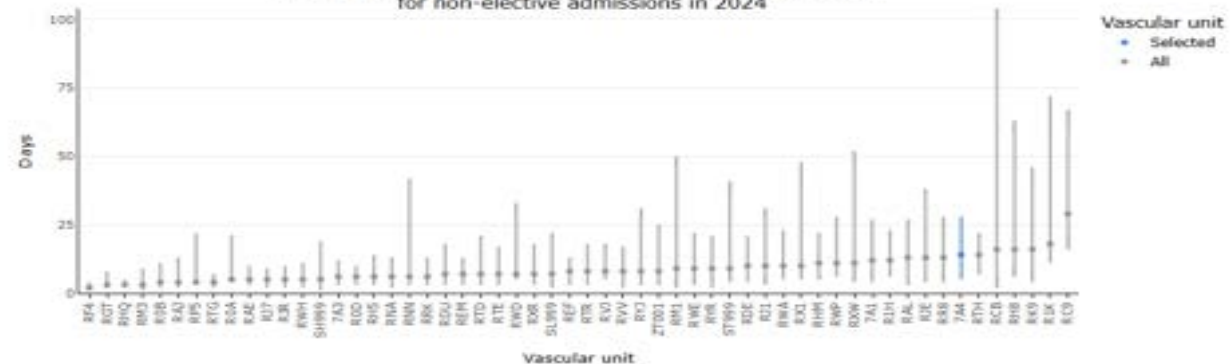
Amputation

	Cardiff and Vale University Health Board 7A4	Wales	UK
NVR cases (2024)	136	321	3,877
Case ascertainment	>85%	100%	84%
Median (IQR) time from assessment to amputation for non-elective admissions (days)	14 (3 - 28)	8 (4 - 23)	7 (3 - 20)
AKA to BKA ratio	0.8	1.1	0.9
Received prophylactic antibiotics	86%	91%	92%
Consultant vascular surgeon present in theatre	94%	80%	76%
Median (IQR) length of stay (days)	25 (16 - 36)	23 (15 - 38)	22 (14 - 36)
NVR cases (2022-2024)	442	1,045	12,387
Adjusted 30-day in-hospital mortality (2022-2024)	9.1%	7.1%	5.9%

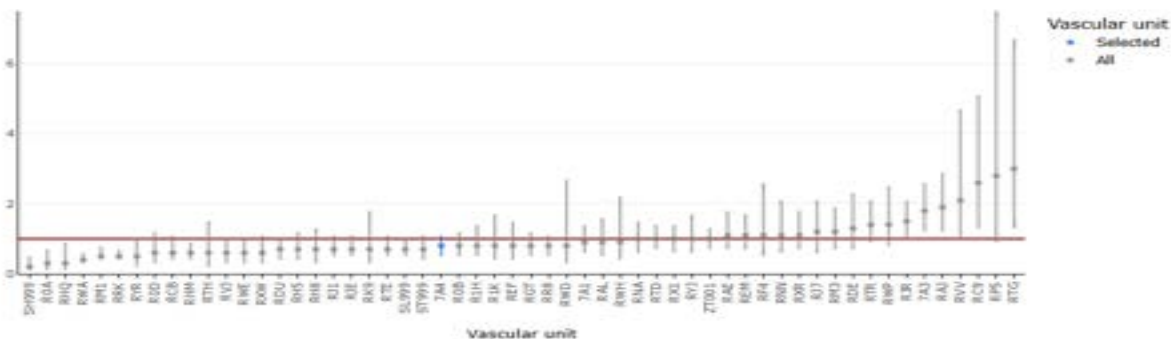
Risk-adjusted in-hospital mortality in 2022-2024



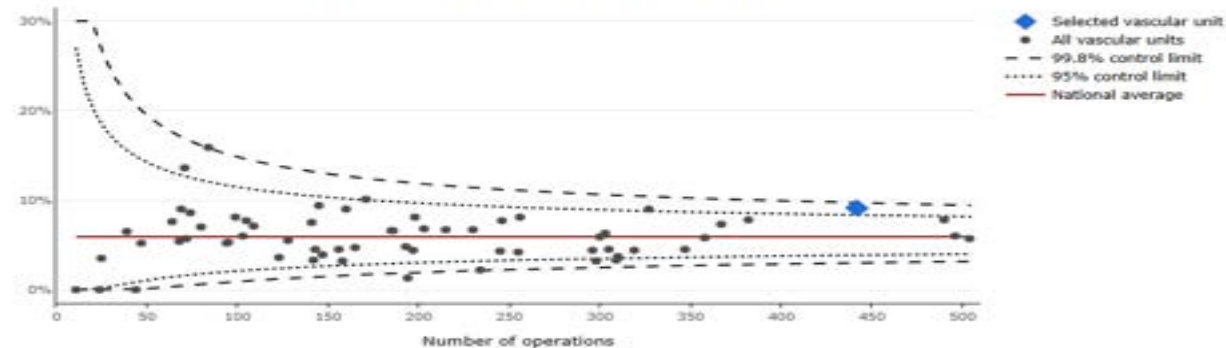
Median time (IQR) from vascular assessment to amputation for non-elective admissions in 2024



AKA to BKA ratio in 2024



Risk-adjusted in-hospital mortality in 2022-2024



Assurance and Risk

Assurance level	Description	Select
Full	The project has fully achieved the standards or criteria being audited against	X
Risk level	Description	Select
None	Standards met and findings demonstrate no risk to patient safety	X

Key Success and Concerns

Report Successes:		Report Concerns:	
1	Good quality service from the ABUHB IR department.	1	SEWVN Major Lower Limb Amputation mortality – a) post op care, b) consider palliation
2	Good and timely carotid service.	2	SEWVN delay for AAA repair – continue to monitor
3	Good and timely lower limb revascularisation service		

Report Recommendations (relevant to ABUHB):		S.M.A.R.T Actions: Responsible: Due Date: Progress:	
1	Evaluate strategies for reducing long delays to revascularisation for people with chronic limb threatening ischaemia (CLTI), to address lack of improvement in meeting timelines recommended in VSGBI Quality Improvement Framework (QIF) for peripheral arterial disease. <i>(Extended from 2024 SotN recommendations)</i>		Continued awareness and monitoring

Clinical Leads Local Recommendations: (if applicable)		S.M.A.R.T Actions:	Responsible:	Due Date:	Progress:
1	Continue to monitor MLLA and AAA delivery				



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

National Clinical Audit Plan for 2026/2027

Medical Director's Quality & Patient Safety

PQSOC June 2026

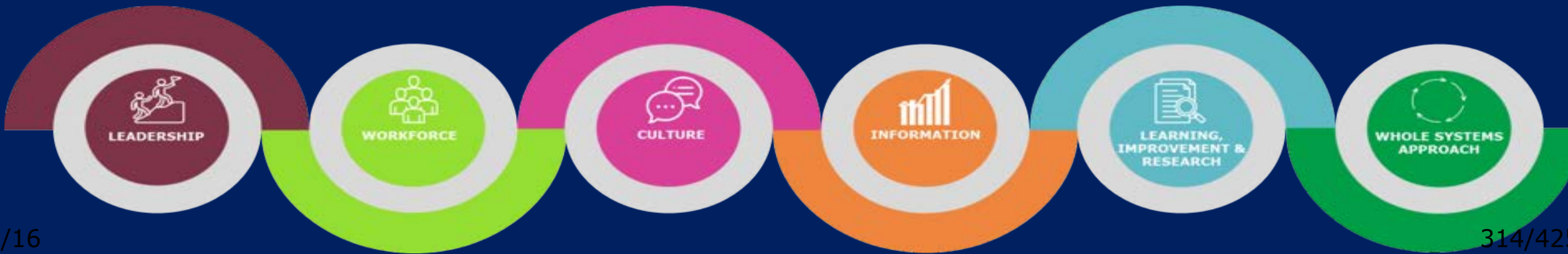


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8	Clinical Audit Awareness Week	

- Aneurin Bevan University Health Board is committed to delivering safe, effective, and high-quality care for the population of Gwent.

Clinical audit is a core component of the Quality Strategy and a key delivery mechanism for Pillar Three of the six pillars of quality – clinical effectiveness, providing a structured, evidence-based approach to assessing care against local and national standards and reducing unwarranted variation in practice.

- Audit findings are used to drive improvement, support re-audit, and provide assurance on the effectiveness and outcomes of care.
- All audit activity is managed through the Audit Management and Tracking (AMaT) system, enabling consistent governance, real-time action tracking, and organisational oversight.
- In line with Welsh Government requirements, audit outputs are aligned with **Healthcare Quality Improvement Partnership** and **National Clinical Audit and Patient Outcomes Programme**, which operates on a published nine-month rolling audit cycle.
- Clinical audit is reported through the Quality Management System and Quality Outcomes Framework, ensuring clear accountability, learning, and Board-level assurance via Quality Management Group (QMG) and the Patient Quality, Safety and Outcomes Committee (PQSOC).

What is Clinical Audit?



Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through the systematic review of care against explicit evidence-based standards.

Where practice does not meet agreed standards, changes are implemented and monitored, and re-audited to confirm improvement.

Clinical audit supports:

- Safe, effective, and patient-centred care
- Reduction of unwarranted variation
- Assurance on compliance with national and local standards
- Continuous learning and service improvement

Key Features of Clinical Audit

- Measures current practice against agreed standards (e.g. NICE, national guidelines)
- Identifies gaps, risks, and areas for improvement
- Drives action and improvement
- Includes re-audit to demonstrate sustained change
- Provides assurance to clinical teams, management, and the Board

Clinical Audit Registration

The Health Board registers all audits using AMaT, which improves:

- Collaboration
- Compliance
- Engagement
- Accountability
- Assurance
- Learning
- Transparency

AGREE
STANDARDS



MEASURE
PRACTICE



IDENTIFY GAPS



IMPLEMENT
CHANGE



RE-AUDIT &
ASSURE
IMPROVEMENT

Six Domains of Quality

Clinical audit is essential for improving patient care and ensuring compliance with the Wales Health and Care Quality Standards. It systematically evaluates clinical practices against established standards, providing insights into the quality of care and identifying areas for improvement. This can be demonstrated below:



PERSON CENTRED

PERSON CENTRED care involves patients, relatives, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety. We care about the wellbeing of individuals, families, carers and staff, ensuring everyone is treated with compassion, kindness, dignity and respect. Audits ensure that care is tailored to individual patient needs and preferences, enhancing patient satisfaction and engagement.



SAFE

SAFE – reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information. Care delivered by capable and competent staff. Maximising things that go right and learning from when things that go wrong to prevent reoccurrence. Audits identify and mitigate risks, promoting patient safety and preventing harm.



TIMELY

TIMELY care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We will care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority. Audits ensure that patients receive care promptly, reducing delays and improving overall health outcomes.



EFFECTIVE

EFFECTIVE care – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to **improve** outcomes. Audits ensure that clinical practices are evidence-based and aligned with best practices, leading to optimal patient outcomes.



EFFICIENT

EFFICIENT by taking a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We will make the most effective use of resources to achieve best value, doing only what is needed, ensuring any interventions represent the best value that will improve outcomes for people. Audits help eliminate waste and improve resource utilization, ensuring sustainable and cost-effective services.



EQUITABLE

Provide **EQUITABLE** care, ensuring equal opportunities for individuals to attain their full potential for a healthy life which does not vary in quality and is non-discriminatory. We will embed equality and human rights and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time. Audits promote equal access to high-quality care for all patients, regardless of personal characteristics.



LEADERSHIP

Ensure visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality. Our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision. They have the appropriate skills and capacity to create the conditions for a functioning quality management system. We ensure our governance, leadership and accountability is effective in sustainably delivering care.



WORKFORCE

Recruit, retain, develop and extend roles to ensure we have enough, confident people with the right knowledge and skills available at the right time to deliver safe care. We value our people and the commitment and resilience they demonstrate in the care they provide. We care about their wellbeing, protect their rights and support them to feel well and happy at work; and provide them with the tools, systems and environment to work safely and effectively. Our workforce planning focuses on investing in our people and nurturing, growing and transforming our workforce to create a sustainable



CULTURE

Create the right climate and culture to nurture and encourage quality and system safety, valuing people in a supportive, collaborative and inclusive workplace so that our people feel psychologically safe to raise concerns and try out new ideas and approaches. Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture, where people can thrive.



INFORMATION

Ensure information is available and shared appropriately for all who need it. We turn data to knowledge by triangulating quantitative and qualitative performance, experience and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made. We monitor, report and escalate indicators through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement and accountability.



LEARNING, IMPROVEMENT RESEARCH

Create the conditions and capacity for an organisation and system-wide approach to continuous learning, quality improvement and innovation, which it actively promotes. We use new knowledge to influence improvements in practice and to inform our decision-making. We ensure our learning and improvement activity is linked to our strategic vision to deliver transformational, organisation-wide change. We commit to participating in research because research-active organisations provide improved quality of care and outcomes for people.



WHOLE SYSTEM APPROACH

Ensure safety in healthcare goes beyond individual patient safety. We will look within and beyond our organisational boundaries to learn how we can continually, reliably and sustainably meet the evolving needs of people. We will strengthen relationships and work with all of our partners to achieve good outcomes. Our policies incorporate the broader ambitions within the seven well-being goals and five ways of working in the Well-being of Future Generations Act.

Pillars of Quality

Patient and Staff Experience, Complaints, Concerns, and Compliments:	Clinical audit places strong emphasis on patient and staff experience, supporting person-centred care and a positive working environment. By providing a structured way to measure, understand, and improve compassionate and effective care, audit enables feedback from patients, families, and staff to directly inform learning and improvement. This approach helps identify areas for change, supports the spread of effective practice, and strengthens trust and accountability by demonstrating that experience is actively listened to, acted upon, and embedded within service improvement.
Incident Reporting:	Systematically tracking incidents like falls, pressure ulcers, medicines management, and mortality allows clinical audits to identify patterns, address systemic issues, and prevent recurrence. This enhances patient safety by ensuring that care practices are continuously evaluated and improved.
Clinical Effectiveness:	Clinical audit is a core element of clinical effectiveness, providing assurance that care is delivered in line with evidence-based standards and best practice. By systematically reviewing performance and driving improvement, audit helps identify variation, mitigate risk, and sustain high-quality, safe care. Embedded within the wider improvement cycle, clinical audit enables organisations to demonstrate measurable impact, effective governance, and ongoing assurance of clinical effectiveness across services.
Health, Safety, and Security:	Clinical audits ensure that facilities and processes meet the highest standards to protect patients, staff, and visitors. This supports a safe environment for care delivery by regularly evaluating and improving safety protocols.
Infection Control and Prevention:	By addressing infection control as a dedicated pillar, clinical audits enhance practices that reduce healthcare-associated infections. This improves overall patient outcomes by ensuring that infection control measures are effective and consistently applied.
Safeguarding:	Placing safeguarding as a core pillar in clinical audits ensures that vulnerable individuals receive necessary protection and support. This aligns care with ethical standards and legal obligations, ensuring that safeguarding practices are regularly reviewed and improved.

The six pillars of quality have been integral to Aneurin Bevan University Health Board's quality journey by providing a comprehensive framework to assess, monitor, and continuously improve care standards. Each pillar addresses a critical aspect of healthcare, contributing to a holistic approach to quality and safety. Here's how Clinical Audit can support and drive improvements in our Pillars of Quality Programme:



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Health Board National Clinical Audit Priorities

Aneurin Bevan University Health Board has four key clinical audit priorities:

1. Scrutiny of national clinical audit performance with robust development, monitoring, and progression of improvement plans
 2. Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risk
 3. Trainees are supported to participate in audits that support clinical governance
 4. Groups and committees across the Health Board commission clinical audit to support effective assurance where no other evidence is available
- Clinical audit provides a critical mechanism through which the Six Pillars of Quality and the Health and Care Quality Standards are embedded into day-to-day practice.
 - Through the delivery of the National Clinical Audit Plan, statutory requirements for participation, reporting, and compliance are met, while maintaining a clear focus on learning and improvement rather than compliance alone.
 - Audit activity enables the Health Boards to test whether care is safe, effective, timely, person-centred, equitable, and efficient, and to identify variation, risk, and opportunities for improvement.
 - By translating national standards and quality expectations into local review, action planning, and re-audit, clinical audit ensures that learning is systematically captured, shared, and acted upon.
 - This approach not only fulfils statutory obligations but also strengthens continuous improvement, ensuring that quality standards are meaningfully applied and that evidence-based learning leads to sustained improvement in patient outcomes, experience, and safety.

Principles of the Annual National Clinical Audit Plan

In developing the Aneurin Bevan University Health Board National Clinical Audit Plan the following approach has been followed:

Purpose of National Clinical Audits:

- Ensure the quality of care for specific conditions or pathways aligns with best evidence.
- Understand variations in care outcomes and assess good practice.

Participation and Compliance:

- Directorates must participate and engage in the National Clinical Audit and Patient Outcomes Programme (NCAPOP), National Confidential Enquiries (NCEPOD), and relevant service reviews.
- Include non-NCAPOP national audits in the Health Board's Quality Plan (e.g., Falls).
- Implement and audit National Institute of Clinical Excellence (NICE) guidance and Health Technology Wales (HTW) adoption, subject to external review.
- Service evaluation and re-audit should be conducted following changes in practice.

Audit Management:

- Register all clinical audit activities within Directorates.
- Collaborate with clinicians, managers, and audit staff to meet all requirements. This includes all clinical, statutory, regulatory, commissioning and other Health Board requirements.
- Enable healthcare professionals to participate in audits for revalidation and professional development.

Support and Review:

- Ensure resources, governance, and structures support audit engagement.
- Establish a formal process for reviewing performance and improvements.
- Escalate issues to the Executive Board when necessary.
- Clear process for risk identification following audit.

Clinical Standards and Effectiveness Group - Processes

Healthcare Quality Improvement Partnership (HQIP) Reporting, Assurance and Scheduling Process

The Medical Director's Clinical Audit Quality and Patient Safety (QPS) team provides regular horizon-scanning updates on anticipated HQIP report publication dates to support forward planning and assurance, recognising that schedules may change. Any amendments are communicated promptly to the relevant Clinical Lead and Divisional Triumvirate. Based on the national audit timetable and local priorities, QPS coordinates and schedules the presentation of clinical audits at appropriately timed Clinical Standards and Effectiveness Group (CSEG) meetings, ensuring aligned, timely, and risk-informed consideration of findings.

Following report publication, QPS incorporates Health Board data into a standardised PowerPoint template and undertakes a structured validation process with the nominated presenter to confirm data accuracy, narrative consistency, and alignment with AMaT records. Audit findings, assurance considerations, and agreed actions are formally reviewed at CSEG, enabling clinical scrutiny, triangulation, and organisational learning. Meeting outputs are captured through concise summary logs setting out decisions, actions, and review timeframes, with supporting audit presentations retained for detailed reference. All documentation, including summary logs and presentation materials, is accessible to staff via the Quality and Patient Safety (QPS) intranet page.

Action Planning and Governance

Prior to each CSEG meeting, QPS work collaboratively with the Clinical Lead and Divisional or Directorate Management to ensure that proposed actions are clearly aligned with report recommendations and Health Board priorities. Actions are agreed using the S.M.A.R.T. framework and assigned a six-month review date to support ongoing monitoring, follow-up, and assurance through established governance routes.

New Procedure Applications

Applications for new procedures are considered through the CSEG governance process to ensure appropriate clinical oversight, assurance, and alignment with standards. To date, five applications have been approved. Prior to being submitted to CSEG, the applications will have gone through the Business Development Innovation & Value. The head of this team will also support the applicants present to the CSEG.



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Clinical Audit Governance and Reporting Arrangements

- The Medical Director's Quality and Patient Safety (QPS) Team coordinates delivery of the Clinical Audit Plan with clinical leads, ensuring compliance with NCAPOP and the NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP).
- Divisions are supported to deliver audits, with participation, findings, and actions consistently documented and tracked.
- The Clinical Standards and Effectiveness Group (CSEG) provides multidisciplinary operational oversight of clinical audit findings, including the identification of risks and opportunities for improvement.
- Key themes and risks are escalated to the Quality Management Group (QMG), ensuring learning from audit informs the wider Quality Management System.
- Board-level assurance is provided through the Patient Quality, Safety, and Outcomes Committee (PQSOC).
- The Audit, Risk, and Assurance Committee (ARAC) oversees the robustness of audit governance arrangements.
- Together, these routes ensure a clear line of sight from front-line audit activity to corporate risk and Board assurance.



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National Clinical Audit Plan for 2026/27- Rolling Nine month Schedule

Cancer Audits

HQIPO Ref.		Name of publication	Publication date	CSEG
637	NATCAN	National Oesophagogastric Cancer Audit (NOGCA) – State of the Nation Report (England & Wales)	11/09/2025	CSEG May 2026
634	NATCAN	National Pancreatic Cancer Audit (NPaCA) – State of the Nation Report (England & Wales)	11/09/2025	CSEG May 2026
633	NATCAN	National Ovarian Cancer Audit (NOCA) – State of the Nation Report (England & Wales)	11/09/2025	CSEG July 2026
640	NATCAN	National Lung Cancer Audit (NLCA) – State of the Nation Report (England & Wales)	12/02/2026	CSEG May 2026
719	NATCAN	National Ovarian Cancer Audit (NOCA) – State of the Nation Report (Eng & Wal)	11/06/2026	CSEG July 2026
751	NATCAN	National Primary Breast Cancer Audit – State of the Nation Report (England & Wales)	10/09/2026	CSEG Mar 2027
752	NATCAN	National Metastatic Breast Cancer Audit – State of the Nation Report (England & Wales)	10/09/2026	CSEG Mar 2027
753	NATCAN	National Pancreatic Cancer Audit – State of the Nation Report (England & Wales)	10/09/2026	CSEG Mar 2027
754	NATCAN	National Non-Hodgkin Lymphoma Audit – State of the Nation Report (England & Wales)	10/09/2026	CSEG Mar 2027
755	NATCAN	National Kidney Cancer Audit – State of the Nation Report (England & Wales)	10/09/2026	CSEG Mar 2027
756	NATCAN	National Oesophagogastric Cancer Audit – State of the Nation Report (England & Wales)	10/09/2026	CSEG Mar 2027
757	NATCAN	National Bowel Cancer Audit – State of the Nation Report (England & Wales)	08/10/2026	CSEG Mar 2027
758	NATCAN	National Prostate Cancer Audit – State of the Nation Report (England & Wales)	08/10/2026	CSEG Mar 2027

The reports listed above were published in 2025/26; however, due to scheduling and availability, these will be considered at CSEG meetings during 2026/27.

National Clinical Audit Plan for 2026/27- Rolling Nine month Schedule

HQIPO Ref.		Name of publication	Publication date	CSEG
618	NCEPOD	Blood sodium Report	11/09/2025	TBC for a later date
650	SSNAP	Sentinel Stroke National Audit Programme – State of the Nation Report	13/11/2025	Stroke Board
NICOR	NICOR 2024/25 (2nd Ed)	National Audit of Cardiac Rhythm Management (NACRM)	11/12/2025	CSEG Mar 2026
NICOR	NICOR 2024/25 (2nd Ed)	Myocardial Ischaemia National Audit Project (MINAP)	11/12/2025	CSEG Feb 2027
NICOR	NICOR 2024/25 (2nd Ed)	National Audit of Percutaneous Coronary Interventions (NAPCI)	11/12/2025	CSEG Feb 2027
NICOR	NICOR 2024/25 (2nd Ed)	National Heart Failure Audit (NHFA)	11/12/2025	CSEG Jul 2026
617	NCEPOD	Emergency paediatric surgery	11/12/2025	TBC for a later date
701	NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health – State of the Nations Report	12/02/2026	CSEG Jul 2026
702	NMPA	National Maternity and Perinatal Audit – Multiple Births Report	12/03/2026	CSEG Sep 2026
659	NPDA	National Paediatric Diabetes Audit – Annual Core State of the Nation Report 2026	12/03/2026	CSEG May 2026
730	NAD	National Audit of Dementia – Service Mapping Exercise for Memory Assessment Services	14/05/2026	CSEG Jul 2026
715	NELA	National Emergency Laparotomy Audit – First Annual No Laparotomy State of the Nation Report	14/05/2026	CSEG Jul 2026

The reports listed above were published in 2025/26; however, due to scheduling and availability, these will be considered at CSEG meetings during 325/425

National Clinical Audit Plan for 2026/27- Rolling Nine month Schedule

HQIPO Ref.		Name of publication	Publication date	CSEG
651	NRAP	Asthma and COPD – National Respiratory Audit Programme (NRAP) – Primary Care Report	14/05/2026	CSEG Jul 2026
720	NCEPOD	Acute illness in patients with a learning disability	11/06/2026	CSEG Sep 2026
705	MNI	Perinatal Mortality Surveillance 2026 Report (2024 births)	11/06/2026	CSEG Sep 2026
691	NRAP	National Respiratory Audit Programme (NRAP) – State of the Nation Report 2026	11/06/2026	CSEG Sep 2026
711	Epilepsy12	Epilepsy12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People – State of the Nation Report 2026	09/07/2026	CSEG Sep 2026
734	NMPA	National Maternity and Perinatal Audit (NMPA) – State of the Nation Report 2026	13/08/2026	CSEG Sep 2026
712	NACEL	National Audit of Care at the End of Life (NACEL) – State of the Nation Report 2026	13/08/2026	CSEG Oct 2026
718	FFFAP	National Hip Fracture Database (NHFD) – State of the Nation Report 2026	10/09/2026	CSEG Nov 2026
706	MNI	Maternal Mortality and Morbidity Surveillance and Confidential Enquiry 2026 Report	10/09/2026	CSEG Nov 2026
731	NEIAA	National Early Inflammatory Arthritis Audit (NEIAA) – State of the Nation Report 2026	08/10/2026	CSEG Dec 2026
722	NNAP	National Neonatal Audit Programme (NNAP) – State of the Nation Report 2026	08/10/2026	CSEG Nov 2026

National Clinical Audit Plan for 2026/27- Rolling Nine month Schedule

HQIPO Ref.		Name of publication	Publication date	CSEG
717	NCAP	National Clinical Audit of Psychosis (NCAP) – State of the Nation Report 2026	08/10/2026	CSEG Nov 2026
716	NELA	Eleventh Annual Emergency Laparotomy (NELA) – State of the Nation Report 2026	08/10/2026	CSEG Nov 2026
714	FFFAP	National Audit of Inpatient Falls (NAIF) – State of the Nation Report 2026	08/10/2026	IP Falls Group
733	SSNAP	Sentinel Stroke National Audit Programme (SSNAP) – State of the Nation Report 2026 Stroke Board with update to CSEG	12/11/2026	CSEG Feb 2027
728	NVR	National Vascular Registry (NVR) – State of the Nation Report 2026	12/11/2026	CSEG Feb 2027
723	NPDA	National Paediatric Diabetes Audit (NPDA) – Workforce Spotlight Audit Report 2026	12/11/2026	CSEG Feb 2027
721	NCEPOD	Pleural Procedures	12/11/2026	CSEG Nov 2027
696	NCEPOD	Stabilisation of the Critically Ill Child	10/12/2026	CSEG Nov 2027
736	FFFAP	Fracture Liaison Service Database (FLSDB) – State of the Nation Report	14/01/2027	CSEG Feb 2027

The reports listed above were published in 2025/26; however, due to scheduling and availability, these will be considered at CSEG meetings during 2026/27.

Conclusion

- The success of the delivery of clinical audit plan is driven by strong partnership working between the Quality and Patient Safety Clinical Audit Team and clinical leads across services.
- AMaT plays a central role in enabling effective clinical audit oversight; AMaT has become a critical enabler of assurance and oversight for clinical audit activity. It provides a consistent, central system through which the Health Board can plan, track, and monitor delivery of the National Clinical Audit Plan on a year-on-year basis, ensuring visibility of audit activity, progress against priorities, and completion of the full audit cycle.
- The Clinical Audit Team collaborates with clinical leads to coordinate, track, and support audit activity, ensuring that audits are completed, findings are clearly documented, and SMART action plans are developed and monitored. Crucially, this collaborative approach ensures that learning from audit is owned clinically and fed back into Directorates, where it informs local improvement and decision-making.
- Through structured reporting, action tracking, and re-audit, the Health Board now has a clear line of sight between audit findings, improvement activity, and assurance, enabling the Health Board to understand where care is improving, where risks remain, and where further support or escalation is required.
- Work will continue to support this model that strengthens both learning and accountability, embedding clinical audit as a meaningful driver of improvement while providing robust assurance to governance forums and the Board.



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Clinical Audit Awareness Week

Clinical Audit Awareness Week 2026, led nationally by the Healthcare Quality Improvement Partnership (HQIP), will take place from 22–26 June 2026. The week will focus on promoting the value of clinical audit in improving patient care, supporting patient safety, reducing health inequalities and enabling data-driven improvement, reinforcing the role of audit within effective clinical governance and continuous quality improvement.

Book your session [here](#)

- ❖ **Monday 22 June** – Turning Strategy into Reality: Clinical Audit as a Strategic Enabler of the NHS Three Shifts
- ❖ **Tuesday 23 June** – Patient Involvement and Care Equity: Improved Outcomes for All
- ❖ **Wednesday 24 June** – Shaping the Future Together: Innovation and Transformation
- ❖ **Thursday 25 June** – Patient Safety: Using Data and Audit to Reduce Harm
- ❖ **Friday 26 June** – Data-Informed Improvement: From Insight to Impact



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	02 June 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Review of Healthcare Inspectorate Wales Inspection – Pending Actions
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade – Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Tracey Partridge-Wilson – Deputy Director of Nursing

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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

Asesiad / Assessment

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

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

The following outlines the outstanding actions arising from inspections undertaken in 2024, 2025 and 2026.

Since the previous report, an unannounced inspection of D2 East at the Royal Gwent Hospital was carried out on 24–25 February 2026. The report is due for publication on 31 May 2026 and will be presented to the Committee in due course.

In addition, an unannounced inspection of Hafan Deg at County Hospital took place on 19–20 May 2026; the outcome will be reported to PQSOC in July 2026.

A detailed summary of actions is provided in Appendix 1. Actions highlighted in green have been completed since the previous report. Actions shown in amber remain in progress, typically due to factors outside the Division's control e.g. estates related issues.

D2 East, Royal Gwent Hospital (04065) – 24-25 February 2026

Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of Completed Actions	No. of actions pending
Due for Publication 31/05/26	16	41	27	14

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

Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of Completed Actions	No. of actions pending
21 August 2025	33	54	49	5

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

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

Ty Skirrid, Maindiff Court Hospital (03839) – 6-8 October 2025				
Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending
15 January 2026	12	23	20	3

Torfaen Community Learning Disability Team (04055) – 29 September-1 October 2025				
Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending
Not yet received	8	15	7	8

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

Carn-y-Cefn, Ysbyty Aneurin Bevan (03682) – 15-17 October 2024				
Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending
17 January 2025	10	29	28	1

Talgarn Ward, County Hospital (03390) – 5-7 February 2024				
Report Publication Date	No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending
9 May 2024	16	53	52	1

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

Argymhelliad / Recommendation

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

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

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 3.1 Safe and Clinically Effective Care 6.3 Listening and Learning from Feedback 3.2 Communicating Effectively
Blaenoriaethau CTCI IMTP Priorities <u>Link to IMTP</u>	Choose an item. Not Applicable
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives <u>Strategic Equality Objectives 2020-24</u>	Choose an item. Choose an item. Choose an item. Choose an item.

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

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

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

Healthcare Inspectorate Wales Inspections: 2026 Breakdown of Pending Actions

D2 East, Royal Gwent Hospital (04065) – 24-25 February 2026					
Report Publication Date		No. of Recommendations	No. of Service Actions Identified	No. of Completed Actions	No. of actions pending:
Due for publication 31/05/26		16	41	27	14
Rec. Ref.	Issue / Improvement Needed	Service Action	Original Timescale	May 2026 Update	Revised / Expected Completion
1	The health board must ensure the needs of patients who are hard of hearing or who have visual difficulties are fully considered and a functioning hearing loop system and prominent large clocks are installed on the ward.	Once delivered, arrange for the installation of the newly ordered large clocks on the ward, ensuring they are positioned prominently to support patients with visual impairments.	17 May 2026	Not delivered as yet	July 2026
2	The health board must ensure all oxygen cylinders are appropriately secured and stored.	Portable oxygen storage brackets ordered and will be installed by Works and Estates, (reference 211172).	30 April 2026	Not delivered as yet	July 2026
		To be discussed at Divisional Ward Management meeting	30 May 2026		In date
5	The health board must ensure IPC instructions are appropriate and the risks associated with transporting clinical waste through the ward are fully considered.	Ward meeting to discuss and embed best practice.	31 May 2026		In date
		Information to be shared divisionally in senior nurse meeting and ward management meeting.	31 May 2026		In date
7	The health board must ensure effective cleaning schedules are implemented for cloth curtains.	A Health Board initiative is underway to transition to disposable curtains. Upon inclusion of the curtains in procurement, all wards will be required to place orders, and manufacturers are to proceed with replacements accordingly.	Ongoing by 31 May 2026		In date
		Curtains currently replaced when soiled or in contact with suspected or confirmed infections.	30 June 2026		In date

		External company awarded contract, wards to order equipment and curtains in next 1-2 weeks once on oracle. Complete transition of cloth to disposable on entire site arranged.			
		Discuss at DMT: replacement needed in all wards and capital required. To be discussed at DMT due to ongoing need to replace across all wards and subsequent capital required.	31 May 2026		In date
8	The health board must ensure all medical devices are available, serviced and calibrated in a timely manner.	Ward staff to complete a stock spreadsheet of equipment and dates of calibration to ensure monthly review and escalation.	30 April 2026	Completed	Action completed
10	The health board should consider fully implementing a comprehensive electronic patient record system to support the effective access, coordination and management of clinical information.	Continued collaboration between the Divisional team and Digital is underway.	30 June 2026		In date
		To be discussed at Urology Directorate, senior nursing and ward management level meetings	30 June 2026		In date
		To be discussed at ward meeting	31 May 2026		In date
11	The health board must ensure that all relevant sections of the patient record are completed fully and consistently.	Ward meeting scheduled to emphasise the significance of appropriate record keeping.	31 May 2026		In date
14	The health board must ensure all staff complete: - All mandatory training, including Mental Capacity Act and Deprivation of Liberty Safeguards - Portable oxygen training, in line with the relevant Welsh Health Circular.	All staff will be scheduled for MCA and DoLS training as dates become available. The management team will be prioritised to ensure they can guide and support junior staff effectively.	31 July 2026		In date
		Portable oxygen training compliance to be monitored weekly until 85% target achieved	31 May 2026		In date

Healthcare Inspectorate Wales Inspections: 2025 Breakdown of Pending Actions

Adferiad and Pillmawr Ward, St Cadoc's (03838) – 19-21 May 2025					
Report Publication Date		No. of Recommendations	No. of Service Actions Identified	No. of Completed Actions	No. of actions pending:
21 August 2025		33	54	49	5
Rec. Ref.	Issue / Improvement Needed	Service Action	Original Timescale	May 2026 Update	Revised / Expected Completion
1	Garden areas require redevelopment (Adferiad & Pillmawr)	Working Group & capital bid development	18/07/25	In the process of additional scoping for equipment and items for therapeutic activities - to be added to final bid by end of June 2026.	June 2026
				Capital Bid complete – awaiting funding	June 2026
3	Standardised health promotion information boards	Boards in situ; final content list being agreed	Ordered 04/07/25	Now on display	Action complete
4	Review of single room occupancy / estates planning	Linked to Mental Health Service Model & Estates Strategy	Discussion 11/07/25	The Mental Health Service Model and Estate Strategy is currently in development and under review in line with the Models of Care programme for inpatient mental health service. The issue of dormitory accommodation and lack of en-suite facilities will be considered in line with this work.	Ongoing
6	ECA suite refurbishment (light & temperature)	Capital bid submitted to RPB	End of July 2025	Capital Bid submitted and awaiting funding	FY 2026/27
7	Kitchen refurbishments (Adferiad)	Two kitchens being refurbished	Commence Nov 2025	Both kitchens have been re-furbished	Action complete
19	CD oxygen cylinder training – compliance	Ongoing monitoring of mandatory training compliance		Compliance has improved currently Adferiad 81% will continue to monitor Pillmawr 100%	Action complete
20	Clinical room temperatures – need air conditioning	Capital bid submitted	July 2025	Air con has now been installed in both clinic rooms	Action complete
24	OT-led activity plan and cooking sessions	Activity plan development	July 2025	Complete	Action complete

27	Mental Health Act training compliance	Increase percentage compliance		81% Adferiad 75% Pillmawr Further training dates have been cascaded	Action complete
31	Policy reviews – All Wales Treatment Escalation and Rapid Tranquillisation	Policy review and ratification	September 2025	Scheduled for ratification through Divisional Policy Group in June 2026	June 2026

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

Report Publication Date		No. of Recommendations	No. of Service Actions Identified		No. of completed actions	No. of actions pending:
19 September 2025		7	18		16	2
Rec. Ref.	Issue / Improvement Needed	Service Action	Original Timescale	May 2026 Update		Revised / Expected Completion
6	Leadership Structure Review	Continue review and strengthening of maternity leadership structure. Includes exploration of Director of Midwifery role.	January 2026	Wider review planned for Q4; Director of Midwifery discussions ongoing. Requires an executive nurse steer & All Wales CNO		Ongoing
4	Midwifery Unit Standards (MUSA) – Full Implementation	Completion of MUSA pilot work, training programme, audit, and environmental improvements.	Anticipated Jan 2026	Timeline is now 2026-2027. Service action- completed. (ABUHB completed priorities highlighted within the All Wales national MUSA audit. Celebration event was held in December 2025). Philosophy of care documents co-produced with women and families, skills and training embedded in mandatory training and induction to birth centres. 2026-2027, Midwifery unit MDT oversight group established, Women choosing birth outside of recommendation MDT established, ABUHB Individualised care guidelines developed (awaiting ratification through CEF- expected 1/6/26). ABUHB birth centres (GUH, YYF & YAB pod) chosen as a site for the European Midwifery Unit Accreditation scheme (one of three in Europe) and all work and comments submitted for review. Hoping to achieve accreditation in September 2026.		2026/2027

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

Report Publication Date		No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending:
15 January 2026		12	23	21	2
Rec. Ref.	Issue / Improvement Needed	Service Action	Original Timescale	May 2026 Update	Revised / Expected Completion
2	Explore installation of <i>vision panels</i> to support sleep hygiene	- Obtain Minor Works costings - Add to MH Capital Priorities Register	April 2026	The future of Ty Skirrid ward is being explored via the Models of Care work with options to move to a community-based model. Any larger capital works are currently on hold.	Ongoing
3	Secure a room for consistent or permanent use	Re-explore availability with Senior Nurse	Meeting 5/12/25	Now using Lindisfarne for any meetings not requiring network access. Will book a room in the main building for weekly Ward Meeting.	Action complete
12	Address risks linked to only one registered nurse on duty	Establishment review; options appraisal	Jan 2026	Staffing has been reviewed as part of the establishment reviews – additional staffing is not required currently due to Lindisfarne beds being temporarily closed and a consistent lower bed occupancy. Will continue to review.	Complete and Ongoing
12	Consider future of Maindiff Court site	Part of wider MH & LD estates strategy	Ongoing	As above the future of Ty Skirrid ward is being reviewed as part of the wider Models of Care work	Complete and ongoing – strategic decision
12	Ensure timely review/ratification of policies	Reviewed via Divisional Policy Group	Ongoing	The Division operates a Policy Group which meets monthly to monitor and track outstanding policies. A structured process is in place for the allocation of policy authors, circulation for consultation, and formal ratification. Policies are prioritised in line with their associated level of risk with oversight of the Divisional Nurse and MHLN Head of Nursing	Action complete

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

Report Publication Date		No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending:
Not yet received		8	15	7	8
Rec. Ref.	Issue / Improvement Needed	Service Action	Original Timescale	May 2026 Update	Revised / Expected Completion
1	Conduct a full environmental audit of Alders House, prioritise repairs and upgrades, and install clear, accessible signage. Ensure compliance with accessibility standard	Since the inspection all windows in Alders have been or are in the process of being replaced. In addition, all guttering and soffits are being replaced. A full environmental audit will be undertaken to assess further DDA facilities that will be required. If it is not possible to make the building DDA compliant, the Directorate would look to secure alternative clinical space that would meet the needs of our population group. The Directorate will work with Works & Estates to ensure there is appropriate signage to the building. The Directorate will also work with our Gwent Ambassadors (Individuals with a learning disability) to provide assurance that the building is suitably accessible.	December 2025	All windows have now been replaced and a HEB has been completed but the building is not DDA compliant, awaiting confirmation of what would make it DDA compliant W&E have clarified where the signage needs to be positioned and awaiting costings.	Ongoing
2.	Review caseload distribution and introduce triage protocols to prioritise urgent needs.	The Directorate has already introduced a caseload triage tool to enable prioritisation of nursing caseload. The Directorate will ensure that this is embedded in line management supervision. The Directorate has also introduced a RAG rated caseload tool to support prioritisation of caseloads on a team	January 2026	Staffing gaps are now filled in the community. Caseload management tool has been introduced further work is being completed to become more user friendly following feedback. RAG rated caseload tool has been developed and implemented.	Action complete

		approach basis which should be submitted to the Senior Nurse on a monthly basis to ensure oversight and appropriate support is provided. The Directorate will ensure that this is embedded in practice.			
3.	Review and improve accessibility of care and support plans. Introduce a review schedule with audit checks	The Directorate will work with clinicians to ensure that when care and support plans are developed, reviewed or updated, they will be available in accessible formats.	Commence immediately	The care plan review is ongoing, but a working group has been established to work on the developing accessible templates. In the process of considering a service user forum which will be engaged to support with user friendly Care and Treatment plan	Ongoing
		The Directorate will introduce a review schedule aligned to the timely review of care and support plans which will be audited as part of the Quality and Patient Safety agenda.	January 2026		Ongoing
		The Directorate will also engage with individuals with a learning disability to develop a standardised user friendly care and treatment plan template which can then be populated by clinicians.	January 2026		Ongoing
4.	The health board should strengthen the use of outcome focused interventions, to prepare for legislative change and promote improved choice and independence for people.	The Directorate is in the process of developing a shared lives pilot for individuals with a learning disability which will be accessible by individuals receiving joint and fully funded care. This pilot is due to be in situ from December 25 – February 26 with the evaluation taking place in March 2026. Commissioning team are currently reviewing Direct payments in line with Welsh government guidelines	March 2026	Pilot has been completed; however, we had limited numbers of eligible service users. Evaluation of the pilot is still ongoing, but we are exploring options for longer term shared lives placements. Direct Payments has started in the health board as of April 2026, with SOP being developed between Divisions and working groups established	Ongoing
5.	Streamline documentation systems, centralise records where possible, and provide staff training	Process to be reviewed in collaboration with Mental Health act administration. To ensure legal	December 2025	Work is ongoing to improve access to the paperwork, and access to the information on EPR.	Ongoing

	on consistent filing and retrieval.	documentation is stored on EHR and available to staff.			
6.	Conduct a usability review of current systems. Provide targeted training and consider system enhancements or simplification to improve efficiency.	The Health Board is in the process of procuring a new electronic patient record system. A preferred supplier has been identified and the Health Board is working with the supplier to develop the required system. The Learning Disabilities Directorate are engaged in the Steering Groups that have been set up to take forward the development of the new system.	March 2026	New EPR system has been identified, Rio. Working groups are established with representation from all areas and working closely with the Data Steering group. Progressing well.	<i>Ongoing</i>
7.	Review and improve health board wide links between Primary Care and CLDT teams. Consider improving links with primary care liaison role with primary care to coordinate access. Develop pathways for long-term nursing care and ensure annual health checks are supplemented with routine access.	The Learning Disabilities Primary Care Health Liaison team work proactively to support individuals with a learning disability to access Annual Health Checks and support GP practices to make reasonable adjustments. However, this is heavily reliant on GP practices proactively offering appointments and engaging with individuals with a learning disability. Directorate to review primary health care liaison service ensuring that the scope of practice covers improving overall access to primary care service. Operational policy to be in place. Directorate to consider process of communication with complex care – to discuss change in individual primary needs in timely manner	February 2026	Discussions have been underway, however due to significant long-term sickness there has been no capacity within the team to progress this. Liaison with complex care is being led by MH&LD commissioning.	Ongoing

IR(ME)R Nuclear Medicine, Nevill Hall Hospital – 4-5 March 2025

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

Healthcare Inspectorate Wales Inspections: 2024 Breakdown of Pending Actions

Carn-y-Cefn, Ysbyty Aneurin Bevan (03682) – 15-17 October 2024					
Report Publication Date		No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending:
17 January 2025		10	29	28	1
Rec. Ref.	Issue / Improvement Needed	Service Action	Original Timescale	May 2026 Update	Revised / Expected Completion
9	Ensure all staff are familiar in how to operate the portable oxygen cylinder	All staff to complete the BOC (oxygen cylinders) online training	28/06/25	Compliance is 100%	Action complete
10	Ensure the numbers of ILS trained staff are strengthened	100% compliance for ILS training to be achieved by March 2025	March 2025	4 staff out of compliance (including 2 new starters) Awaiting for training dates to become available	July 2026

Talygarn Ward, County Hospital (03390) – 5-7 February 2024					
Report Publication Date		No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending:
9 May 2024		16	53	52	1
Rec. Ref.	Issue / Improvement Needed	Service Action	Original Timescale	May 2026 Update	Revised / Expected Completion
9	Ensure that the SALT therapist attend the ward to see patient	The triage process for SLT is to complete telephone screening in the first instance to inform whether an assessment is clinically indicated. In this instance, an assessment was not clinically indicated and advice was given to staff accordingly.	December 2024	The need for SALT input on Talygarn ward is limited.	Action complete

14	Rapid tranquilisation protocol review date November 2023	The policy is currently under review. In the interim, the existing policy remains extant.	January 2025	Scheduled for ratification through Divisional Policy Group in June 2026	June 2026

Emergency Department, Grange University Hospital (03698) – 2-4 October 2024					
Report Publication Date		No. of Recommendations	No. of Service Actions Identified	No. of completed actions	No. of actions pending:
15 January 2024		16	112	110	2
Rec. Ref.	Issue / Improvement Needed	Service Action	Original Timescale	May 2026 Update	Revised / Expected Completion
1	Must maintain the efforts to improve patient flow through the department and across the wider hospital.	Review of Flow Centre Pathways to ensure patients go to the right place first time	March 2025	Flow pathways have been reviewed and updated. Further work is being progressed across all Divisions and the Welsh Ambulance Service for opportunities to utilise alternative pathways away from ED and hospital beds. The Health Board is working with the NHS Performance & Improvement team to improve flow out of the hospital, decongest ED and improve wait to be seen time, 12hrs in the department and ambulance lost hours	Ongoing
7	Ensure staff are aware of the health and safety risk assessments and audits that are carried out for patient safety purposes.	Review of area to assess ability to make an assessment area ligature free	December 2024	Risk assessment completed and decision needed regarding whether investment in an anti-ligature free room is possible.	Ongoing

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	02 June 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Neonatal Update Report
CYFARWYDDWR ARWEINIOL:	Jennifer Winslade (Executive Director of Nursing)
SWYDDOG ADRODD: REPORTING OFFICER:	Jayne Beasley (Head of Maternity, Gynaecology & Neonatal services)

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The Neonatal service within Aneurin Bevan University Health Board aims to achieve high quality of care for babies through its level 3 Neonatal service based at The Grange University Health Board. This purpose of this paper is to provide The Patient, Quality Safety and Outcomes Committee with an update on Neonatal service, the Listening event, quality of care provision, its performance, training, and leadership triangulated against patient experience measures. The paper highlights good and improving practice, areas for ongoing improvement and recommendations for consideration.

Cefndir / Background

The Neonatal Intensive Care Unit is a tertiary specialist unit, which is based at the Grange University Hospital (GUH) and opened in 2020 combining the neonatal services that were previously based at Nevill Hall and the Royal Gwent Hospitals. This purpose-built unit consists:-

- 8 intensive care cots
- 10 high dependency cots
- 12 low dependency cots

There is provision of an outreach service, to support babies discharged, outpatients, neurodevelopment and murmur clinics. In addition, the service



supports the South East Wales transport service (CHANTS). Through collaboration with maternity services transitional care is delivered, however transitional care cots remain limited with the 2 services seeking ways to address this.

To provide assurance on its aim to provide safe care, a positive experience for parents, families and babies and a supportive psychologically safe environment for staff a number of actions have been undertaken. These measurable actions have been formulated into a Neonatal Improvement Plan for (2025-2028), to improve the delivery of services, to include a focus on civility, culture, leadership and management and ensure that the workforce is supported and equipped with the knowledge and skills to be able to deliver the highest standards of care. Divisional and executive oversight and a multifaceted approach, through HR, IPAC and senior nursing has ensured good progress against the actions. The neonatal team has to date completed over 70% of the areas highlighted for improvement, whilst work continues with the ongoing actions as a means to maintain improvements.

Areas for focus include

- Reduction in medication errors
- Infection prevention
- Improved governance processes.
- Culture

The action plans are closely monitored by the Senior Nurse and Head of Nursing and Head of Midwifery providing regular reports to the Maternity and Neonatal Improvement and Assurance Group (MNIAG), Divisional Assurance and the Quality Management Group (QMG) who provide oversight and overarching assurance.

Asesiad / Assessment

Listening Exercise

Following the listening exercise commenced on the 30th June and which ran for 10 weeks the following 8 themes were noted:-

- **Psychological Safety & Civility**

Accessible support out of hours and outside of peer groups, workload pressures and demands, strong commitment to babies and families, issues with shift allocation

- **Leadership Visibility, Fairness & Role Clarity**

Lack of mutual understanding of differing roles, requirement for visible leadership, strengthened governance, peer support

- **Staffing, Acuity & Skill-Mix**

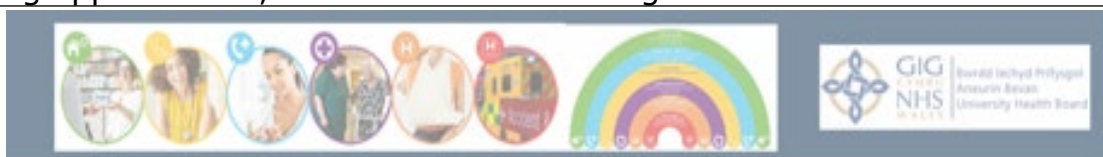
Silo working, a need for rotational opportunities, strengthening of MDT working, opportunities for clinical development and informal learning required, understanding others roles, senior nurse cover, support with modules for QIS (quality in speciality)

- **Communication & Confidentiality**

Wider reflective feedback and learning, concerns and complaints being communicated openly

- **Education & Capability**

Training opportunities, lack of cot side teaching



- **Inter-Team Divides**

Integration of staff banding, working well in emergencies friendship groups noted, challenges of support between different bands

- **Governance & Learning Systems**

Sharing of reporting and learning opportunities from DATIX, completion of meaningful PADRS,

- **Operational Factors – physical environment**

Roster allocation and leave, IT access, challenges within the clinical environment and separation of areas

In response to these themes the NICU working group sessions have been held during April- May 2026. These sessions have been supported by the Head of Nursing, Head of Midwifery, Gynaecology and Neonatal services trade union partnerships and HR and involved all levels of staff. Whilst there has been less than optimum attendance the group sessions have yielded over 100 suggested actions for improvement from the neonatal staff themselves. To further support the engagement there is a running survey and drop box feedback to support anonymous ideas. These themes are being collated and will be finalised 9th June to develop ongoing work.

Preliminary review from the neonatal staff has suggested :-

Nurse / QIS/ B7 to cover growing nurseries
2 nurses in charge (one for ITU, 1 for HDU)
Ensure visible & approachable supportive leaders
Improved communication
Place for staff meeting ? use waiting area
Awareness/ understanding of roles & responsibilities
Be rewarded for a job well done/ staff recognition, provide positive feedback
Team day/ away day
Team study days
Touch point regular meetings for 1:1 with staff
Increase admin support, resource for answering front door
Avoid 'clicks' in rosters- fairness & equity in rostering – develop a SOP/ guidelines on rostering

Additional work is ongoing :-

- Roster Deep Dive: In considering the BAPM standards and to ensure appropriate staffing requirements in line with activity this is due for completion July 2026, ensuring a coordinated approach from within and externally to the Division.
- Review of self-allocation and roster governance
- Leadership academy support for band 6 and 7
- Review of training needs
- Restorative clinical supervision
- Human factors training



Workforce

Current Nursing establishment -

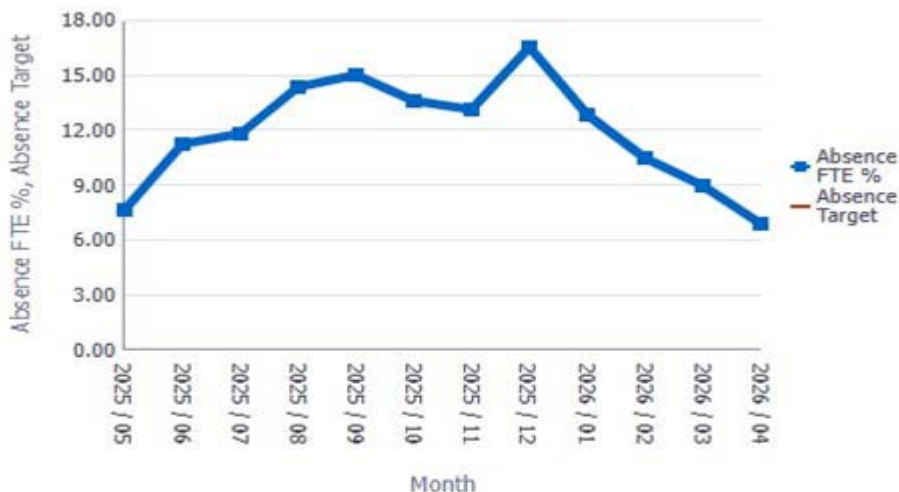
	Direct care	Non-direct care	Total
B8 (excluding ANNPs)	0	1.0wte	1.0wte
B7	3.53wte	3.89wte	7.43wte
B6	33.88wte	4.52wte	38.4wte
B5	53.32wte	1.56wte	54.88wte
B4	10.6wte	1.96wte	12.56wte
B3	0	0.8wte	0.8wte
B2	0	3.8wte	3.8wte
	Total 101.33	Total 17.53	Total 118.87wte

Vacancy for nursing staff = 2.88WTE of funded establishment.
Streamlining posts agreed =6 for commencement September
Turnover of staff is at an acceptable level

	2026 / 02	2026 / 03	2026 / 04
Headcount	144	144	144
FTE	120.04	120.04	119.44
Leavers Headcount	1	0	1
Leavers FTE	0.96		0.96
Starters Headcount	0	0	1
Starters FTE			1.00
Maternity	10	12	12
Turnover Rate (Headcount)	0.69	0.00	0.69
Turnover Rate (FTE)	0.80	0.00	0.80

Sickness levels have been notably elevated for Nursing staff though a downward trajectory is now evident with levels falling from 16% in December 2025 .





Focussed work continues to address sickness and absence alongside HR and the Head of Nursing. A deep dive report into sickness absence has been completed and action undertaken to address. Moving forward there is a planned monthly review at Divisional SMT to measure compliance against the sickness and absence policy, with a second deep dive audit planned for October 2026.

Education, Training and Development

The organisation remains committed to promoting the education, training and development of the workforce and Nursing staff training is as follows :-

- Mandated ESR training 86.6%
- PADR 81%
- Medication training 92%
- Blood Transfusion 75%
- ANTT theory 52% practical 32.6%
- Qualified in Speciality (QIS) 69.6%
- NLS 72%

Leadership

Following a review of the working practices and lead roles undertaken by the Senior Nurse, the band 7 staff have increased visibility, undertake professional rounding and actively support the neonatal team working within the clinical area. The increased visibility of senior and divisional staff has been welcomed by the staff and provides opportunities for staff to raise concerns and seek support in real time where needed. This was an area highlighted during the Listening event and work is ongoing via roster review to create further clinical visibility. Exploration of out of hours cover (ie nights) is being explored A proactive approach to development for band 6 and 7 has been undertaken and support for the Health Board leadership academy prioritised.

Professional standards

NICU have contributed to the divisional professional standards action plan which focuses on improving professional standards and upholding the values and behaviours of the organisation. Compliance with civility training is 89% for NICU. Uniform audit 96%.



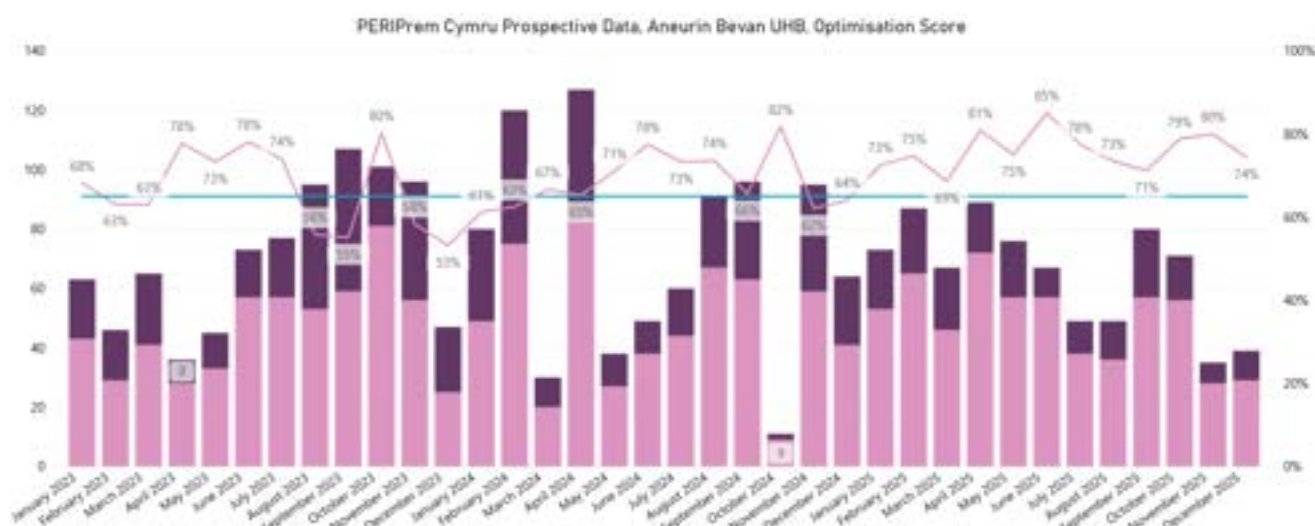
Performance monitoring

Internally the performance indicators are monitored within monthly governance forums, and via divisional and directorate assurance forums. In addition, scrutiny and monitoring occurs via the Maternity and Neonatal Assurance Group chaired by our Executive Director of Nursing/ Deputy Director of Nursing, reporting into the Executive Committee and the Quality Management Group. Thus, giving clear oversight to the staff in service, the wider Division and the Executive team.

Annual Report 2024-2025 suggests that 11% of babies born in ABUHB are admitted to NICU. The focus on reducing attain – reducing term admission has noted that 5.4% of term babies are admitted to the unit (target <6%). There were 1608 intensive care days, 2394 high dependency care days and 4939 special care days. a total of 8941 days of care were provided in the calendar year. Intensive care occupancy rate was 62.9% and high dependency occupancy rate was 65.6%. Special care occupancy was 112.8% which reflects the need for transitional care.

PERIPREM

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



Whilst the average optimisation score is 74% there can be challenges to achieving full optimisation of all babies. Eg giving 2 doses of steroids pre-birth, depends on women presenting in a timely manner in early labour and the variables within this can pose difficulties. However positive work around thermal care optimal cord management and administration of magnesium sulphate has been noted.

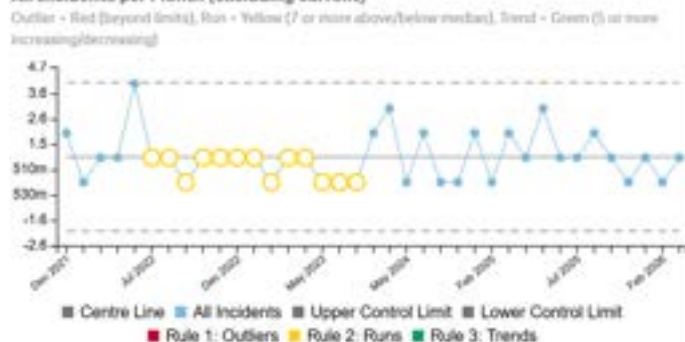
Perinatal Mortality

Neonatal service collates and reviews all baby deaths via local and national audit and reporting. Where applicable these cases are DATIXED and reported as a nationally reportable incident in line with expected reported mechanisms and uploaded to MBRRACE in accordance with reporting pathways. Incident review and investigation occurs via:-

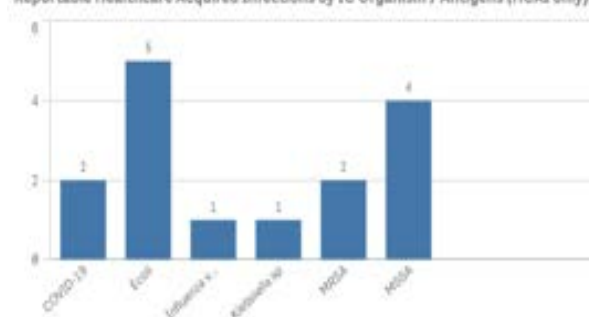
- Multidisciplinary perinatal mortality team
- Local monthly mortality meeting



All Incidents per Month (excluding current)



Reportable Healthcare Acquired Infections by IC Organism / Antigens (HCAI only)



Recent AMAT audits

Hand hygiene 100%

PVC bundle 95%

PPE 100%

Nurse uniform 96%

Nurse accreditation environmental audit 96%

Medication Incidents

Focused work on medication incidents is ongoing and forms part of the NICU improvement plan. Quality improvement work identified :-

- Medication safety group established
- Medication training (nursing staff) 92.4%
- Prescription ward rounds
- 2 person check SOP developed
- Audit of gentamicin errors
- ANNP audit commencing 1st May to reduce administration errors
- Overlay stickers to support administration of gentamicin

Although a rise in March this was non statistically significant. To note April a welcome fall noted.



Patient Engagement

CIVICA was rolled out in September 2025 supporting feedback from families to the neonatal unit. Results demonstrate positive experience with 85-95% overall experience via the heat map. The surveys demonstrate

- Welcoming environment
- Confidence in staff
- Clean tidy environment
- Consistent staff introductions
- Families felt listened to and understood with most parents able to ask questions
- Mental health discussed but peer support groups not always provided

Actions highlighted following the results for April suggest work to reinforce staff introductions, implementation of a standard orientation of the unit, strengthening of maternity and neonatal communication, visible information regarding peer support and mental health counselling.

In May the service celebrated "Kangaroo care awareness day", promoting the power of touch through skin to skin and parental presence to recognise and celebrate the benefits for babies and parents. To mark the occasion all parents are encouraged to hold their babies, a simple occurrence but one that can be challenging or daunting for parents when babies are ventilated and may be very small.

Improvement work

Work continues on the improvements actions including:-

Quality improvement competition to engage nursing staff in QI projects

Culture, civility and staff engagement

Transitional care: working group in place

Focus on Medication errors

Improved Governance

Focus on IPAC

Training and education

NEWTT 2 was introduced on the postnatal ward and this work is now being extended to review care for babies in the nursery areas on NICU. Work will also commence re SWOSH, a project to switch to oral antibiotics and send babies home. This could impact transitional care requirements overall.

National work regarding the perinatal engagement framework, the quality statement, mat neo safety support programme is ongoing and action plans are regularly updated and reviewed via the maternity and neonatal improvement and assurance group. The perinatal workforce and Bereavement pathway are awaiting ratification and dissemination.

Regular updates will continue to be presented to the Maternity and Neonatal Improvement and Assurance Group (MNIAG), the Quality Management Group



(QMG) and the Executive Committee to provide assurance that improvements are made to being made to ensure that the workforce are empowered and supported to deliver the highest standards of care. A further review of the requirement for a Strategic Maternity and Neonatal Group will be undertaken.

Following previous Executive Oversight arrangements in place for Infection Prevention and Control, Medicines Management, National Neonatal Audit Programme (NNAP) Compliance, Sickness Management and Culture, a review of the data and assurances in place has been undertaken and Medicines Management, Sickness Management including rostering controls, mortality data reporting and NNAP have been moved into Business as Usual (BAU) processes. There are a small number of remaining actions in relation to Infection Prevention and Control, Medicines Training, Staffing levels and actions in relation to the Listening Exercise and the associated action plan which will continue to be monitored through the Executive Leads and Committee reporting until completed. BAU actions will report through Family and Therapies Divisional Assurance Meetings

Argymhelliad / Recommendations

The Patient Quality safety and Outcomes Committee are asked to note the contents of this report, the ongoing work to provide a safe service and the commitment to implement national directives, improvement work and supportive actions.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 3. Effective Care 6. Individual care 7. Staff and Resources
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Workforce and Culture
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.



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

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



DYDDIAD Y CYFARFOD: DATE OF MEETING:	02 June 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	WRP Penalties and Learning Compliance: Update on Health Board Improvement Actions
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Tracey Partridge-Wilson - Deputy Director of Nursing Garvin Jones - Head of Legal Services

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

Ar Gyfer Penderfyniad/For Decision

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

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

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

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

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



Cefndir / Background

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

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

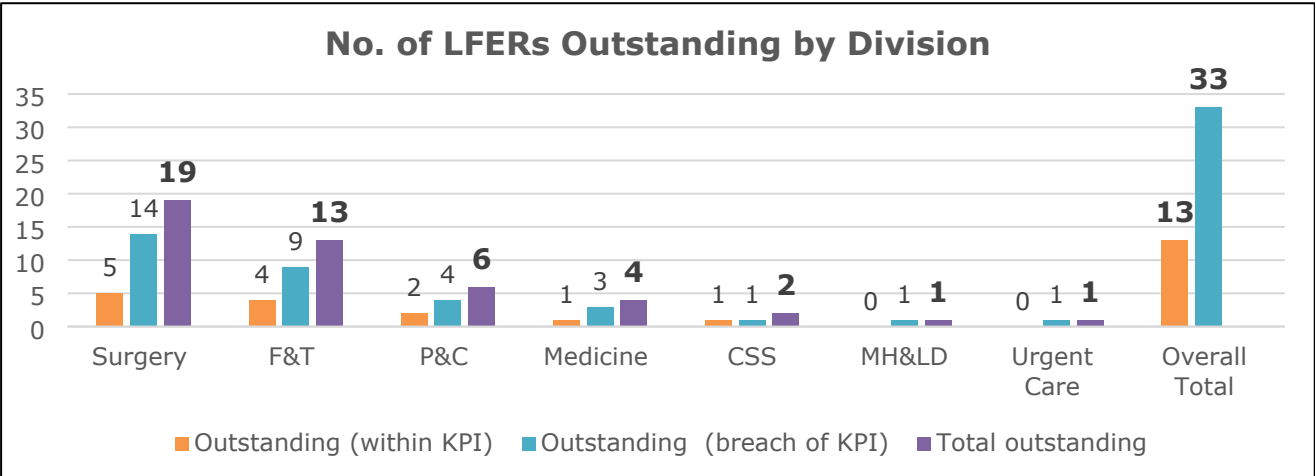
To maximise ownership, accountability and impact of penalties, the Welsh Risk Pool Committee recommended from the outset that health bodies pass the charges to individual budget holders who are responsible for the penalty charge. Whilst the fundamental purpose of LFERs is to prevent future patient harm,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

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

Asesiad / Assessment

1. Current Performance and Divisional Position

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



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



2. Support Currently Provided by Legal Services

To assist Divisions, the Legal Team provides:

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

Despite this, improvement remains inconsistent and fragile.

3. Further Support being Developed

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

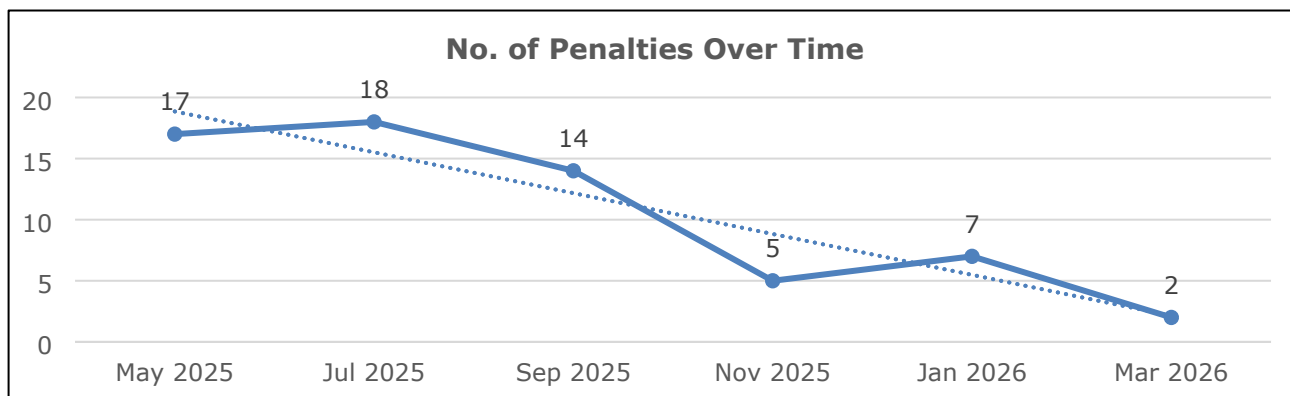
4. Divisional Pressures

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

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

5. Improvement Actions

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



6. Key Issues Identified

A review of current processes has identified several system weaknesses:

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

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

7. Analysis

1. Currently, each Division has their own informal processes for the management of LFERs. This lacks a formal, documented process that LFERs should follow, leaves significant gaps within the governance / accountability and does not define key role(s) responsible for escalation.
2. As described the LFER fines are currently absorbed by the Legal Litigation budget cost code. This has created a separation of Divisional accountability and the financial implications of non-compliance. It is important to recognise that the financial penalties should not exist as the primary motivator for change. Each fine equates to the Health Board's inability to evidence learning following an adverse event.
3. Difficulties exist in the Divisions locating key documents that are essential for all LFER submissions, such as reflections from staff involved. Whilst completed at the time, these are challenging to locate years later due to variations in record keeping and the time elapsed. A review of the Patient Safety Incident process is underway and will aim to address this record keeping variation through improved Corporate oversight and the creation of a standardised checklist, using RL Datix as the repository for information that may become pertinent in completing LFERs. Whilst this will not immediately result in a reduction of unnecessary fines due to the inability to locate documents it forms part of the wider essential improvement required to create a sustainable LFER process.
4. A significant challenge persists with incomplete submissions of evidence being provided to the Legal Services. As the Legal Services team are not clinically trained, they cannot assess or determine if the information provided is accurate and sufficient. This has resulted in numerous delays with further material required (resulting in additional financial penalties). Improvements are taking place around training and awareness of the Divisional Quality and Patient Safety teams to help support in the coordination of evidence gathering.
5. The number of open LFERs, the inability to evidence learning and the consequential financial penalties since 2023 have been a significant risk. No Health Board recovery plan has yet been agreed. A mandated improvement plan in conjunction with the issues/solutions outlined above (1-4) would allow for clear, monitored improvements for each division, with the expectation that



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

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

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

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

Argymhelliad / Recommendation

The Patient Quality Safety and Outcomes Committee is asked to:

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

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

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

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

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



Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.2 Communicating Effectively 3.2 Communicating Effectively 6. Individual care 6.3 Listening and Learning from Feedback
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Experience Quality and Safety Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	02 June 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Committee Risk and Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

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

Ar Gyfer Trafodaeth/For Discussion

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

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation & Cefndir / Background

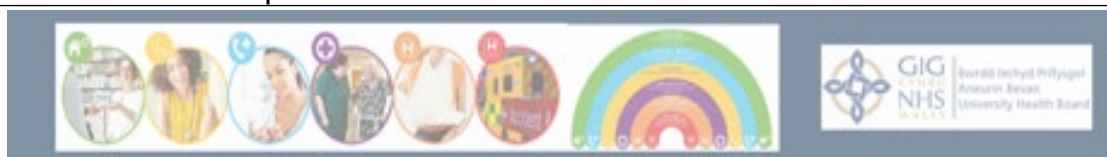
At the last Committee meeting in April 2026, it was reported that the risk environment remained stable, with no changes to the risk scores of the monitored risks.

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

Asesiad / Assessment

Committee Strategic Risk Register

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



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

Table 1

Risk Ref:	Risk Description	Sub-Risk	Risk Level	Within Appetite
SRR 005 Chief Operating Officer Theme Service Delivery Appetite Open Score 17 and below	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	Due to inadequate arrangements to support system-wide patient flow.	High 4 x 4 (16)	Y
SRR 008 Director of Nursing Theme Transformation & Partnership Working Appetite Open Score 17 and below	There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.	Moderate 2 x 4 (8)	Y
SRR 010 Director of Therapies & Health Science Theme Compliance & Safety Appetite Minimal Score 8 and below	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974.	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed, and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	High 3 x 4 (12)	N

Since the last report to the Committee in April, there have been no changes in the level of risk exposure for the three risks assigned to this Committee for focused scrutiny. However, work continues to reduce risk exposure, particularly where risks remain high or extreme, or are currently assessed as outside of appetite.



Governance and Assurance

Internal Audit has provided reasonable assurance that the Health Board's arrangements for strategic risk and assurance are fundamentally sound. However, the review has also identified opportunities to strengthen the quality, consistency, and strategic focus of assurance. In particular, further work is required to enhance Executive-level scrutiny, improve alignment between risk and long-term strategy, and strengthen the clarity and quality of reporting.

In response, a programme of work has been initiated to strengthen assurance over the next three to six months. This includes formalising Executive scrutiny of the Strategic Risk Register alongside the Corporate Risk Register, strengthening oversight of quality and safety risks, supporting earlier identification of emerging concerns and improving alignment between operational and strategic risk management. This will provide greater assurance to the Board that risks impacting the delivery of safe and effective care are subject to active management, challenge and escalation through established governance arrangements.

Closing Position

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

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

Argymhelliad / Recommendation

The Committee is asked to:

- **CONSIDER** whether it has sufficient assurance that the strategic risks are being assessed, managed, and reviewed appropriately and effectively, considering the detailed analysis and ongoing mitigation efforts outlined in this report.
- **NOTE** the work being undertaken to ensure that risks with the potential to impact patient quality and safety are systematically identified and incorporated into the forward work plans of key groups and sub-committees of the Health Board.

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)



Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	The Strategic Risk Register is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	The Board and respective Committees of the Board have considered risks contained within the Strategic Risk Register

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

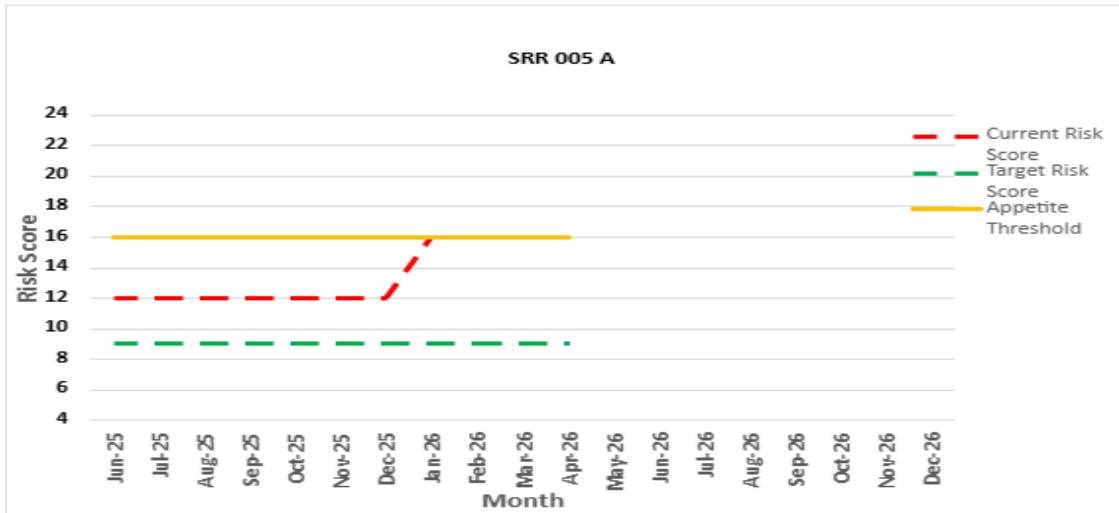


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Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. N/A



					Risk Score												
Risk ID and Description				IMTP Link	2	3	4	5	6	8	9	10	12	15	16	20	25
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow	System Change							X				● ◊		
SRR 008	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	Quality			X			●					◊		
SRR 010	Director of Allied Health Professions and Health Science	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974	a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments.	Quality & Workforce & Culture					X	◊			●				

Key	Current Score	●
	Target Score	×
	Appetite Threshold	◊

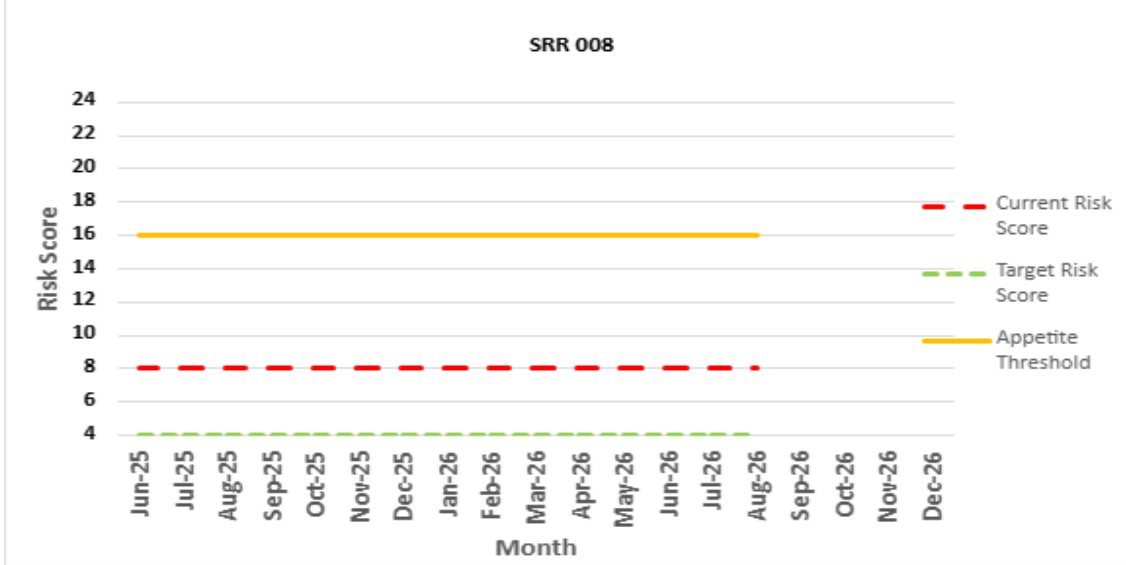
RISK THEME	SERVICE DELIVERY				
LINK TO IMTP	SECTION 3: SYSTEM CHANGE				
Strategic Risk SRR 005 A	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system			Publication Status	Public
Threat <i>(As a result of)</i>	Due to inadequate arrangements to support system-wide patient flow			Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.	
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> - Avoidable deaths and significant harm. - Delayed discharges from acute and non-acute settings resulting. in deteriorating patients. - Delays in releasing ambulances from hospital sites back into the community.	<u>Staff</u> - Increased workload - Fatigue & burnout	<u>Organisation</u> - Litigation & Financial Penalties - Reputational damage and loss of public confidence	Risk Appetite Threshold – OPEN SCORE 17 AND BELOW Risk related to all aspects of our ability to deliver, manage, and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy.	
				SUMMARY The current risk level is OUTSIDE of target level but WITHIN appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.	
Lead Director	Chief Operating Officer	Risk Exposure	Current Level	Target Level	
Monitoring Committee / Group	Patient Quality, Safety and Outcomes Committee	Likelihood	4 (Possible) x	3 (Possible) x	
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	3 (Moderate)	
Last Reviewed	May 2026	Risk rating	= 16 (Extreme)	= 9 (High)	
Next Review (Monthly based on risk score)	June 2026				

Current Key Controls <i>(What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)</i>	Plans to Improve Control <i>What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)</i>
- Escalation Policy. - Performance and Accountability Framework - Operational Framework - Major incident Procedures - Daily ONP flow meetings - Twice daily ONP calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. - Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. - Weekly system safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Data driven. action focussed and task driven. - Enhanced monitoring in place for U&EC – level 4 - Range of performance measures/metrics in place - Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. - Maximum Capacity Plan – Executive team agreed maximum capacity (including risk assessed boarding) plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. Full Capacity Protocol is in place. - Planned care delivery plan agreed and recovery meetings with the NHS execs to support activity. 26-week OP programmehas finished, and HB is exceeded numbers for first outpatient appoints. - Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls. - WG – IQPD meetings to review areas of focus - Regular meetings with Local Authorities to review POC delays and LOS concerns.	➤ Continue Refocus on Our New Patient and key pieces of work: - Discharge Acceleration: ➤ Daily board rounds identify definite and potential discharges early to free up beds before peak demand ➤ Weekend discharge lists are shared proactively to maintain flow across all sites. Full Capacity Protocol: ➤ Boarding continues across sites under strict risk assessment, with escalation to use dayrooms or therapy spaces only as a last resort. ➤ Red lines for boarding (e.g., avoiding high-risk patients) are reinforced in SOP discussions. Step-Down Coordination: ➤ Flow Centre actively books and allocates step-downs; priority is given to patients who can safely move to community beds or lower-acuity settings. ➤ Community bed usage is maximized, with reablement teams engaged to expedite transfers. ➤ Contingency for Delays - where step-downs stall, escalation includes opening additional community beds and using SDEC for low-acuity patients. Rapid Offload Strategy: ➤ Flow Centre monitors ambulance waits and redistributes crews to minimise delays. ➤ Plans include prioritizing high-risk patients for cubicles and using lounges for temporary placement. Standard Operating Procedure (SOP): ➤ A simplified SOP is being finalised to standardise escalation pathways, boarding criteria, and discharge prioritisation across divisions. ➤ Divisional “red lines” (e.g., elective bed protection, infection control limits) are being formalised for consistent decision-making.

	Data-Driven Oversight: ➤ Flow Centre dashboards and live trackers are used to monitor patient movement, discharge progress, and capacity in real time. ➤ Development of new dashboards to track EDDs and Red Reasons to inform system flow decisions. ➤ New ED extension opened on the 17th December with phase 2 to start in the new financial year ➤ Additional ED consultants in place ➤ New expanded transfer lounge is progressing well, supporting with transport booking and supporting early movement of patients. Focus Areas for the next month: ➤ Develop Our Next Patient UEC recovery plan – Board Development Session April 2026 ➤ Programme of work has Divisional projects across the system to support flow ➤ Work with social care and PCC division on joint assessment and community bed delays to consistently improve discharge reliability. ➤ Reset regularly — ONP highlights the need for routine reset days/fortnights to correct worsening patterns in flow, WTBS, and handovers.

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>	Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>		
• The Escalation Framework has been enacted and ineffective in mitigating threats and impact to services. • Performance report against measures/metrics • Regular ONP meetings to review flow • S2S meeting - creates a consistent, standardised process for assessing readiness, escalating issues, and agreeing collective plans, fostering clear accountability from ward to board level. • Weekly weekend planning meetings in place to plan for the weekend capacity	• Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. Now working to KPI WG plan. • The impact of the Performance and Accountability framework in improving patient flow • Outputs and progression of actions from ONP and S2S meetings to sustain system flow	• Close monitoring and reporting of the frameworks in practice to support learning and improvements.
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>		
• Monthly Divisional Assurance reviews. • Mid and EoY Reviews for Divisions • Performance against measures/metrics reported to the Executive Committee • Planning and Performance Committee • Cross Divisional Meetings – cross divisional thinking, learning and sharing best practice	• The Operational Framework is being developed to define how individual services meet demand and outline the actions required during escalation. This framework is currently under refinement through the Our Next Patient (ONP) work.	• The Operational Framework process commenced in November 2024, initiating a series of in-depth reviews across specific services. This is an iterative approach designed to remain active and adaptable, ensuring it continues to meet the evolving needs of the services.
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>		
Independent Reviews • Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024. • External inspections/visits. • IQPD Monthly Meetings focus on key areas • GIRFT visit Report • Accelerated Design Event / Programme of work • Winter Sprint – December 2025 and January 2026	• Clinical Leadership & Patient Experience: Strong emphasis on clinically led, data-driven change, with patient stories highlighting the real-world impact of delays. • Mandated Targets: The 45-minute ambulance handover target is to be mandated, with an ambition to reach a 15-minute standard for patient safety. • System-Wide Responsibility: Improvement requires engagement across all sectors—ED, primary care, community, acute medicine, surgery, and ambulance services.	N/A

MAG Report - focus areas for ABUHB		Improving Performance Together (MAG Report) 45 min hand overs, - Clarity over fragile services asks and delivery - Accountability for regional working in our region - Asks around data sharing and use of comparative data sets – definitions are still work in progress - Indicates population health management tools will be available – Alignment locally - Breathlessness and lung cancer alignment with our own plans - Integrated care hubs - Define the funding and delivery shift from Secondary to Primary Care– with a plan	
Assurance Rating (Overall Assessment of controls and assurances) Guidance			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable Assurance

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING						
LINK TO IMTP	SECTION 4: ENABLER - QUALITY						
Strategic Risk SRR 008	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public.					Publication Status	Public
Threat <i>(As a result of)</i>	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.				Risk Appetite Level – OPEN Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure.		
Impact <i>(Consequences of the threat)</i>	<u>Patient</u> - Unmet patient needs resulting in patient harm. - Ineffective use of combined resources - Delayed decision making - Adverse impacts on delivery of care to patients across acute and non-acute settings - Negative experience of care - Distress and frustration. - Carer stress.	<u>Staff</u> Staff dissatisfaction Frustration Increased absence. Loss of confidence.	<u>Organisation</u> - Failure to deliver health board priorities, required improvements and achieve longer-term sustainability - Reputational damage and loss of public confidence		Risk Appetite Threshold – OPEN SCORE 17 and Below All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.		
					SUMMARY The current risk level is OUTSIDE of target but WITHIN the appetite threshold. Target level is WITHIN the set appetite threshold.		
							
Lead Director	Director of Nursing	Risk Exposure	Current Level	Target Level			
Monitoring Committee	Patient Quality, Safety and Outcomes Committee	Likelihood	2 (Unlikely) x	2 (Unlikely) x			
Initial Date of Assessment	01 June 2023	Impact	4 (Major)	2 (Minor)			
Last Reviewed	March 2026	Risk rating	= 8 (Moderate)	= 4 (Low)			
Next Review (Six monthly based on risk score)	September 2026						

Current Key Controls (What controls/ systems & processes do we already have in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Plans to Improve Control What further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
- Corporate Engagement Team - Patient Experience and Involvement Strategy- organisational ownership - Person Centred Care (PCC) Surveys and National surveys via CIVICA - PCC KPI’s (support PCC Quality pillar) ‘You said..... we did’ public facing information for service areas. - PLO service at GUH - Introduction of PALS Service (Oct 23) - Volunteer Patient Experience Feedback - Collaboration to recruit community listeners to support Dementia Awareness - Digital patient stories to support listening and learning. - DATIX - Oversight of Medical Examiner reports to determine patient experience actions - Public Engagement- Big Conversation Bereavement held 20th March 2024, Big Conversation Sepsis Sept 2025 and Big Conversation Care Homes December 2025 - People Participation Panel ED in Progress, PPP for Deaf People established	- Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. - PCCT staff training to support Civica data entry and retrieval in progress. Short Term grant funding for Band 2 data entry support - Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. - Employment of dedicated PALS team who will have a key role in gaining feedback from patients, staff, and relatives. Monthly reporting in place and quarterly updates to Quality Management Group and IQPD - Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. SMS provision to be implemented in Feb 2025 across ED and all MIU’s. 5 National Maternity Surveys launched via SMS 1st Sept 2025 - National directives around new national surveys that need to be managed additional to internal roll out programme – National People’s Experience Survey live 1st May 2025 and default survey for majority of live areas. Continued participation in national meetings - Volunteer feedback to be reviewed to identify themes. This happens weekly - End of Life and Bereavement models published and meets Bereavement Standards. - EOLCB refresh completed to meet National Palliative and End of Life Care Specification and National Competency Framework

• Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams. • Dementia Person centred Care team dedicated e mail address. • Dementia Information and signposting through webpages. • Patient feedback on the agenda for each of the dementia workstream meetings. • Dementia - QR code for feedback at each training event and session. • Dementia Thematic review from CIVICA team requested to inform actions and improvements in care. • Dementia - Multi agency partnership workstreams measuring impact of service. • Graces places set up across all 5 boroughs	• Community of Practice for Patient Experience and People Participation Panels (PPP) now agreed and to be progressing. BSL version of PPP leaflet secured. • Dementia community hubs in each borough of Gwent enable accessible opportunities for feedback and signposting, plans to increase hubs in more areas of Gwent. Annual Dementia Report scheduled for Board March 2026

Sources of Assurance <i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>		Gaps in Assurance <i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>	Actions to Address Gaps <i>(What further evidence is required to provide the effectiveness of controls)</i>
Level 1 Operational <i>(Implemented by the department that performs daily operation activities)</i>			
- Concerns are fed back to divisional teams when identified. - Outcome of the volunteer feedback to drive improvements. - Patient Experience and Involvement Team undertaking Culturally Competent Accreditation, receiving a silver distinction award in Oct 2024 - Immediate feedback and escalation to clinical teams following PALS queries and concerns - Civica patient feedback in in the process of being rolled out across all – all divisional leaders receive reports for their live areas monthly. - Bereavement survey built with CIVICA – Nov 2024 - CIVICA SMS launched 3rd March 2025 across ED and MIU’S - People Participation Panels - Bespoke Big Conversations	- Currently there is limited SMS provision to increase the number of surveys. - No single point of contact or ‘drop in’ provision for patients/families/staff to raise initial patient experience concerns. This is being reviewed in light of the new Listening to People framework - Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards. - CIVICA team have the ability to pull and view feedback that has been left by patients/family. The listening and learning from the feedback to be shared by each department/directorate/division i.e., / ‘you said, we did’ / quality improvement projects.	- SMS provision for patient experience feedback launched in ED and all MIU’s in February 2025. Civica lead in regular contact with National Leads and risks identified through Director of Nursing Meetings/SBARs - PALS Single point of contact is established. PALS officers have key role in patient experience and involvement- including establishing ‘drop in’ clinics on hospital sites should patients/staff/relatives wish to discuss concerns. Need to have discussions with facilities around rooms. - PALS and Chaplaincy Team undertaking BSL training to support Deaf Community - Patient experience KPI’s and common themes by department/directorate/division need to be identified and pulled from the civica system left on surveys feedback. These will be added to a template patient experience report and CIVICA surveys have been built into ward accreditation. - Development of a ABUHB bereavement survey has been built within CIVICA and tested. This is being reviewed to better align with the national Patient Experience Survey- anticipated to go live from April 2026 - Community of Practice for Patient Experience commencing March 2026. Topics will include supporting teams to publicise ‘You Said/We Did’.	
Level 2 Organisational <i>(Executed by risk management and compliance functions)</i>			
- Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) - Listening and Learning reported through QPSOG/ Outcomes Committee - Implemented PALS DATIX Module	None	N/A	
Level 3 Independent <i>(Implemented by both auditors internal and external independent bodies)</i>			
- Bi-monthly LLais Reports - HIW inspections - Advocacy reports	None	N/A	
Assurance Rating <i>(Overall Assessment of controls and assurances)</i> <u>Guidance</u>			
Negative – Insufficient evidence that the controls	Reasonable - adequate evidence that the controls in place are working effectively.	Positive - robust evidence that the controls in place are working effectively.	Reasonable

RISK THEME	COMPLIANCE AND SAFETY																																																																																						
LINK TO IMTP SECTION 4: ENABLER	QUALITY				WORKFORCE & CULTURE																																																																																		
Strategic Risk: SRR 010	There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974					Publication Status	Public																																																																																
Threat <i>(As a result of)</i>	Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements				Risk Appetite Level – MINIMAL Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below.																																																																																		
Impact <i>(Consequences of the threat)</i>	Patient	Staff	Organisation		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.																																																																																		
	• Unintended physical harm to patients	• Unintended physical harm to staff	• Punitive actions from the Health and Safety Executive (HSE)		SUMMARY																																																																																		
	• Psychological trauma	• Psychological trauma	• Loss of estates due to unsafe environments		The current risk level is OUTSIDE of target level and appetite threshold. The target level to be achieved is WITHIN the set appetite threshold.																																																																																		
	• Increased levels of staff sickness	• Financial implications																																																																																					
	• Adverse publicity	• Reputational damage.																																																																																					
	• Reputational damage.																																																																																						
Lead Director	Director of Allied Health Professions and Health Science		Risk Exposure	Current Level	Target Level	SRR 010 <table><caption>SRR 010 Risk Score Data</caption><tr><th>Month</th><th>Current Risk Score</th><th>Target Risk Score</th><th>Appetite Threshold</th></tr><tr><td>Jun-25</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Jul-25</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Aug-25</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Sep-25</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Oct-25</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Nov-25</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Dec-25</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Jan-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Feb-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Mar-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Apr-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>May-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Jun-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Jul-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Aug-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Sep-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Oct-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Nov-26</td><td>12</td><td>6</td><td>8</td></tr><tr><td>Dec-26</td><td>12</td><td>6</td><td>8</td></tr></table>		Month	Current Risk Score	Target Risk Score	Appetite Threshold	Jun-25	12	6	8	Jul-25	12	6	8	Aug-25	12	6	8	Sep-25	12	6	8	Oct-25	12	6	8	Nov-25	12	6	8	Dec-25	12	6	8	Jan-26	12	6	8	Feb-26	12	6	8	Mar-26	12	6	8	Apr-26	12	6	8	May-26	12	6	8	Jun-26	12	6	8	Jul-26	12	6	8	Aug-26	12	6	8	Sep-26	12	6	8	Oct-26	12	6	8	Nov-26	12	6	8	Dec-26	12	6	8
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Initial Date of Assessment	01 December 2023		Impact	4 (Major)	3 (Moderate)																																																																																		
Last Reviewed	March 2026		Risk rating	= 12 (High)	= 6 (Moderate)																																																																																		
Next Review (Quarterly based on risk score)	June 2026																																																																																						

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

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	02 June 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Patient Quality, Safety and Outcomes Committee – Review of Committee Forward Work Plan 2026/27
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Governance Support Officer

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

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

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

Cefndir / Background

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

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

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

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

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

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

Additional items included on the Forward Work plan:-

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

These items were deferred to June 2026 meeting due to April 2026 meeting being cancelled.

Items deferred from April 2026 to June 2026 meeting on the Forward Work Plan:-

- Review of Committee Programme of Business 2026/27;
- Committee Risk Report;
- NHS Wales Joint Commissioning Quality Committee Report
- Quality Management Group Reporting.

Additional items deferred on the Forward Work Plan:-

- Quality Management System and Assurance Framework Annual Review deferred to July 2026 meeting.

Items removed from the Forward Work Plan:-

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

These changes have been reflected on the updated Forward Work Programme.

Argymhelliad / Recommendation

The Committee is requested to **NOTE** the updated Committee forward work plan as provided in **Appendix 1**.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The monitoring and reporting of committee business is a key element of the Health Boards assurance framework
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Committee Forward Programme monitors delivery of objectives.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	N/A

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• Workforce	Not Applicable
• Service Activity & Performance	Not Applicable
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Not Applicable Choose an item.

Annual Programme of Business for 2026-27

Patient, Quality, Safety and Outcomes Committee

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

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

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

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

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

• Outcome of Annual Review of Committee Effectiveness 2026/27									
Committee Risk Report	DOCG	SI	√D		√	√	√	√	√
NHS Wales Joint Commissioning Quality Committee Report	DOCG	SI	√D		√	√	√	√	√
Quality Annual Report 2024/25	DoN	AN					√		
Quality Management System and Assurance Framework Annual Review	Clinical Executives	AN			√D	√			
Quality Outcomes Reporting Qlik app – May meeting	DoN /MD & DoAHP& HS	Quarterly	√D Interim	√	√ Q4	√ Q1	√ Interim	√ Q2	√ Q3
Primary Care Quality Report	COO	Bi-AN					√		
Quality Management Group Reporting, including escalation through Quality Management System	DoN	SI	√D		√	√	√	√	√
Healthcare Inspectorate Wales Annual Report	DoN	AN						√	
Healthcare Inspectorate Wales Reviews	DoN	As reported							
Commissioning Assurance Framework Annual Review	Clinical Executives	AN			√				
Commissioning for Quality Outcomes Report	Clinical Executives	Bi-An					√		

Putting Things Right Annual Report 2024/25	DoN	AN					✓		
Maternity and Neonatal Report	DoN	Bi-An				✓			
Learning from Death Report	MD	Bi-AN	✓D	✓			✓		
Health and Safety Compliance Annual Report	DoAHP& HS	AN				✓			
Safeguarding Annual Report	DoN	AN				✓			
Ward Accreditation Report	DoN	AN						✓	
Nurse Staffing Levels (Wales) Act 3-year report (3-yearly)	DoN	AN						✓	
Nurse Staffing Levels Wales Act Annual Assurance Report	DoN	AN					✓		
Annual Report on Clinical Audit Activity 2024– 2025	MD	AN			✓				
Healthcare Inspectorate Wales (HIW) Reports Update (PQSOC 1702/10)	DoN	Bi AN			✓			✓	
Pharmacy and Medicines Annual Report (PQSOC 1702/15)	MD	AN							✓
Planned Care - Orthopaedics / Impact of Bone Cement Shortage	COO	Action	✓D	✓					

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

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

Frequency of Inclusion

Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions	
SI	Standing Item
An	Annual
1/4ly	Quarterly
BI	1/2 yearly
Schedule of Meetings	
v	Scheduled agenda item in FWP
D	Deferred from this agenda
vd	Deferred Scheduled agenda item
W	Withdrawn from FWP
T	Transferred to another Committee
IC	Matter discussed In Committee

Direct Line: 0300 062 8163
E-mail: Alun.Jones39@gov.wales

Chief Executives and Chairs
NHS Health Boards and Trusts Wales
Via Email

6 May 2026

Dear Chief Executive and Chair,

EMBARGO: Healthcare Inspectorate Wales (HIW)
UPDATE: Operational Plan 2026-2027

I would like to inform you that HIW will be publishing its 2025 – 2026 Operational Plan at 00:01 on Friday 8 May 2026. Please find an embargoed copy of our plan attached.

Healthcare Inspectorate Wales (HIW) is the independent inspectorate of NHS healthcare and the regulator of independent healthcare in Wales. Our purpose is to check the safety and quality of healthcare across Wales. We highlight good practice and take action when care falls short or poses a risk to safety. What matters to people is at the heart of our work. We look at whether services are designed for the communities they serve, and challenge inequalities wherever they exist.

This Operational Plan is the first to be shaped by our new [Strategy for 2026–2030](#). It builds on strong foundations and focuses on what matters most to people and communities. By setting out clear actions, the plan provides a practical route for delivering the objectives in our Strategy. The plan outlines how HIW will continue to listen to people's experiences, inspect and regulate services, and work with partners to support meaningful and lasting improvement. It has been informed by risks, challenges and opportunities across the healthcare system, with a clear focus on driving improvement and strengthening the quality and safety of care.

Key priorities for 2026–2027

The Operational Plan is structured around four strategic priorities:

Putting People First

HIW will strengthen how people's experiences shape its work, focusing on the greatest risks people face when accessing care. Activity includes improving how intelligence is gathered and shared, refining inspection and reporting approaches, challenging inequalities, and strengthening public awareness of HIW's role and remit.

*Rydym yn gwirio diogelwch ac ansawdd
gofal iechyd ledled Cymru.*

*We check the safety and quality of healthcare
across Wales.*

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Learning and Working Together

HIW will work closely with health boards, trusts, independent providers and oversight bodies to share intelligence and learning, address national issues impacting healthcare, and ensure findings from inspections and reviews lead to timely and sustainable improvements.

Investing in Our People

Recognising that impact depends on staff capability and wellbeing, HIW will invest in digital tools, learning and development, clearer career pathways and cross-team working, while continuing to embed its Equality, Diversity and Inclusion (EDI) commitments.

Taking Action That Matters

HIW will continue to take clear, proportionate and transparent regulatory and enforcement action where care falls short, strengthen its response to concerns and whistleblowing, and publish accessible information about the action taken and the difference it makes.

We will continue to take a balanced, risk-based approach to inspection and assurance, ensuring services are inspected at the right time. HIW will also continue to meet its statutory responsibilities, including those under the Mental Health Act, the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R), and independent healthcare regulations.

Across all our priorities, our focus remains on being a trusted, independent voice that supports improvement across the healthcare system. Working collaboratively with our staff and stakeholders, will help us deliver our vision for a future where healthcare in Wales is safe, effective, and high-quality for everyone.

Yours sincerely



Alun Jones

Chief Executive

Healthcare Inspectorate Wales

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Healthcare Inspectorate Wales

Operational Plan 2026-2027



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We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

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We will collaborate with partners to share learning and drive lasting improvements.

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We will ensure our people feel supported, valued, and empowered.

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We will take action to improve the quality and safety of healthcare for the future of Wales.

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About Us

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

Our Purpose

We check the safety and quality of healthcare across Wales.

Our Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

We:

- Register, regulate and inspect independent healthcare services, taking enforcement action where standards are not met.
- Inspect NHS services across Wales to ensure quality, safety, and effectiveness.
- Undertake national reviews to explore key issues in depth and drive improvement.
- Monitor concerns and safeguarding referrals, acting swiftly where risks are identified.
- Recommend improvements – both immediate and long-term – to strengthen care across independent and NHS sectors.
- Take regulatory enforcement action to ensure independent healthcare providers meet legislative requirements.

Our work is delivered by:

- A dedicated team of staff based across Wales, supporting our assurance and regulatory functions.
- Specialist Peer Reviewers, recruited continuously to provide up-to-date expertise on services and quality standards.
- A panel of Patient Experience Reviewers and Experts by Experience to capture the voice of patients out on inspection.
- A panel of Independent Consultant Psychiatrists who deliver our Second Opinion Appointed Doctor service.



Foreword

Welcome to our Operational Plan 2026-2027.



Alun Jones
Chief Executive
Healthcare Inspectorate Wales

“By working together, we will help shape a safer, more effective and more compassionate healthcare system for Wales.”

At Healthcare Inspectorate Wales (HIW), we check that people in Wales receive safe, high quality healthcare. We do this by listening to people’s experiences, inspecting and regulating services, and working with partners to support meaningful and lasting improvement.

This Operational Plan is the first to be shaped by our new **Strategy for 2026 – 2030**. It builds on strong foundations and focuses on what matters most to people and communities. By setting out clear actions, the plan provides a practical route for delivering the objectives in our Strategy.

Our priorities are informed by the risks, challenges and opportunities across the healthcare system, driving improvement and high-quality care.

We will maintain a balanced, risk based approach across all our functions, adapting as the healthcare landscape evolves. Our work will remain flexible and responsive, ensuring we inspect the right services at the right time. We will continue to meet our statutory responsibilities, including those under the Mental Health Act, the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and independent healthcare regulations.

Putting People First

This year, we will strengthen how people’s experiences shape our work. By deepening our understanding of what matters to individuals and communities, we will focus on the greatest risks people face when using and accessing care.

We will improve how we gather and use intelligence, refine our approach to inspection and reporting, and challenge inequalities, so all voices are heard.



Learning and Working Together

Effective improvement depends on strong partnerships. We will build on our relationships across the healthcare system, sharing intelligence and collaborating on national issues. By working closely with services, regulators and oversight bodies, we will support shared understanding of risks and help drive system wide learning. We will also strengthen how we follow up our work so that our findings lead to timely improvements.



Investing in Our People

Our impact relies on the capability and wellbeing of our staff. Over the coming year, we will continue to embed a culture of reflection and continuous development. We will invest in digital tools, training, clear development pathways and cross team learning to support efficient, collaborative working. We will also continue to build an inclusive workplace guided by our **Equality, Diversity and Inclusion strategy**.

Taking Action that Matters

We will continue to take clear, proportionate and transparent action to improve the quality and safety of healthcare in Wales. This includes strengthening our inspection and regulatory approaches, improving the clarity of our recommendations, and communicating enforcement decisions effectively. We will enhance how we listen and respond to concerns, including whistleblowing, ensuring people understand what action we have taken.

Across all four priorities, our focus remains on being a trusted, independent voice that supports improvement across the healthcare system. We are grateful to our staff, peer reviewers, partners and stakeholders for their continued commitment.

By working together, we will help shape a safer, more effective and more compassionate healthcare system for Wales.

Alun Jones

Chief Executive
Healthcare Inspectorate Wales

Priority 1

Putting People First

We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.



Objectives

Better understand lived experience throughout the patient journey, including care access, quality, and how well services work together.

Improve how we carry out and report our work to make it easier for services to learn and take action.

Research and apply inclusive and innovative methods to engage with the public, healthcare staff, and partner organisations.

Improve how we use and share intelligence on patient risks across our teams to inform our assurance work.

Proactively challenge inequalities and ensure people's voices shape our work and the future of healthcare.

Strengthen public awareness of our role, powers, and purpose, ensuring people know how to contact us and what to expect when they do.

Priority 1

Putting People First

We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.



2026-2027 Actions

- Deliver regulation and inspection activities across independent healthcare, ensuring compliance with standards and regulations.
- Deliver a risk-based assurance and inspection programme in the NHS, driven by intelligence.
- Review how we assess the Welsh Language Active Offer across our assurance activity, sharing good practice where we find it.
- Scope a clinically informed assurance approach for primary and community care, considering the patient journey.
- Develop and implement a new approach to check the quality and safety of NHS and healthcare services, starting with work on maternity and neonatal care.
- Review and strengthen our reporting and sharing of findings from independent healthcare providers.
- Improve how we share intelligence across teams and with key partners, so we have a stronger, shared understanding of risks in healthcare services.
- Improve how we identify and consider health inequality risks in our planning and assurance work.
- Continue to embed Equality, Diversity and Inclusion in our assurance work and routinely review our tools and guidance with stakeholder input.
- Use a range of diverse engagement methods to raise awareness of HIW and our role.

Priority 2

Learning and Working Together

We will collaborate with partners to share learning and drive lasting improvements.



Objectives

Build strong, effective partnerships to share insights and support improvement across healthcare services.

Collaborate with others to address national issues impacting healthcare.

Follow up on our work in a timely way to ensure our findings drive improvement.

Plan and deliver an intelligence-led programme of reviews-based work that reflects healthcare priorities and focuses on what matters most to people.

Ensure patients, carers and frontline healthcare staff are actively involved in our work, including planning, delivery and evaluation.

Priority 2

Learning and Working Together

We will collaborate with partners to share learning and drive lasting improvements.



2026-2027 Actions

- Monitor the progress and impact of the new approach for engaging with NHS Health Boards in Wales.
- Implement an improved format for the national Healthcare Summit to identify system-wide themes affecting patient safety, care quality and NHS performance.
- Participate in joint inspection activity and intelligence sharing with key stakeholders, including offender healthcare services, to address national issues impacting healthcare.
- Begin work to strengthen Deprivation of Liberty Safeguards (DoLS) reporting, including exploring options for improved data capture.
- Review our three-month follow-up process to ensure we report our findings in a timely way and identify whether any changes to timescales or approach are needed.
- Progress the national review on access to primary care for people with learning disabilities.
- Share key themes from our findings through learning events to support improvement across independent healthcare services.
- Develop communication channels, using our Stakeholder Advisory Group, events and digital platforms, to support meaningful engagement with patients, carers and frontline staff.

Priority 3

Investing in Our People

We will ensure our people feel supported, valued, and empowered.



Objectives

Embrace innovation and adoption of digital tools to increase our impact and efficiency.

Create a culture of reflection and learning, where we challenge ourselves to continually improve.

Measure the impact of internal changes to ensure they lead to meaningful improvements for our people and the way we work.

Provide clearer development pathways and ensure our staff have the tools they need to work effectively.

Build on the implementation of our Equality, Diversity, and Inclusion (EDI) Strategy, supporting an inclusive culture.

Priority 3

Investing in Our People

We will ensure our people feel supported, valued, and empowered.



2026-2027 Actions

- Ensure our Customer Relationship Management (CRM) system is fit for purpose, enabling accurate data capture and effective planning to support our core functions.
- Adopt innovative digital tools and provide the training and support needed to ensure all teams can use them confidently and effectively.
- Create a culture of reflection and learning, improving access to learning and development, and reviewing induction so new staff are equipped for their roles.
- Measure the impact of internal changes and strengthen continuous improvement through lessons-learnt activity.
- Strengthen our approach to recruiting and utilising clinical peer reviewers, ensuring we draw on reviewers with the right skills and experience for our work.
- Update our training programme for peer reviewers to ensure the clinicians who work with us get valuable development and experience.
- Strengthen development and training for our specialist mental health peer reviewers to support their revalidation requirements.
- Establish opportunities for staff to spend time in other teams to develop skills and knowledge, helping build organisational resilience.
- Build on our Equality, Diversity and Inclusion Strategy by monitoring progress, aligning with related policies, and working with stakeholders to inform and influence our activity.
- Deliver our Second Opinion Appointed Doctor (SOAD) service within Mental Health settings, taking account of updates to the Mental Health Act legislation.

Priority 4

Taking Action that Matters

We will take action to improve the quality and safety of healthcare for the future of Wales.



Objectives

Regulate and inspect healthcare services using clear, fair, and innovative methods.

Take decisive enforcement action when care falls short, holding providers to account.

Review and adapt our assurance methods to reflect the needs of a modern, evolving healthcare system.

Strengthen how we listen and respond to concerns, including through our whistleblowing channels, to protect people and support improvement.

Publish clear information about what action we have taken and the impact it has achieved.

Priority 4

Taking Action that Matters

We will take action to improve the quality and safety of healthcare for the future of Wales.



2026-2027 Actions

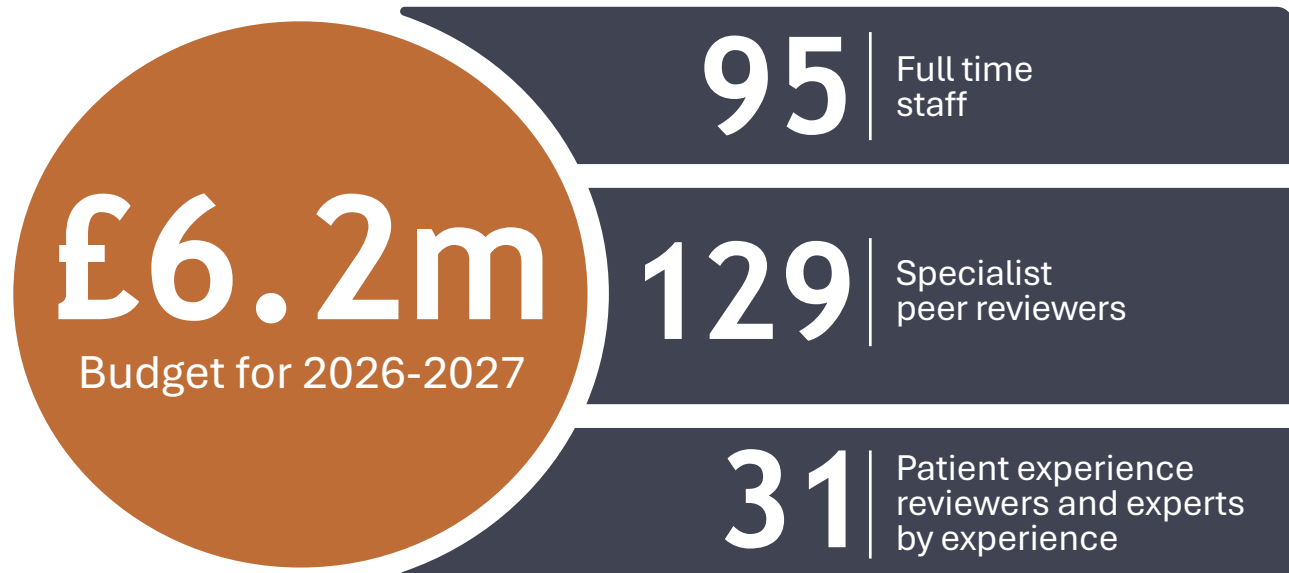
- Review the updated registration process to ensure it is working efficiently and make any necessary adjustments to support the new approach.
- Ensure timely, high-quality, evidence-based acute and mental clinical advice is available to support HIW in carrying out its inspection and regulation functions.
- Review our escalation processes and strengthen our approach to identifying and responding to unregistered healthcare services.
- Develop and deliver a training programme for peer reviewers on methodology.
- Advance efforts to influence and shape changes to the legislative framework and fee structure for independent healthcare and adapt our approach.
- Strengthen our process for managing concerns, including whistleblowing, raised with us about the care people receive.
- Introduce regular reporting on themes and issues emerging from concerns raised with us.
- Publish clear, bilingual and accessible information, using multiple formats to ensure everyone can understand what we do and the difference we make.
- Review and update the statutory notifications guidance for private dental practices.

Resourcing

For 2026-2027 we have a budget of approximately £6.2m. We have posts equivalent to 95 full-time staff, including three secondments, as well as a panel of over 129 specialist peer reviewers.

We also have specialists in Mental Health Act Administration and a panel of Psychiatrists who provide our Second Opinion Appointed doctor (SOAD) service. We have 31 Patient Experience Reviewers and Experts by Experience who work with us on inspections to capture the views of patients.

Team	Number of posts
Senior Executive	3
Inspection	24
Regulation and Escalation	18
Partnerships, Intelligence and Methodology	13
Strategy and Communications	6
Clinical Advice (including SOAD service)	7
Business Management, Digital, and Corporate Services	21
Secondments (temporary staff on loan from other organisations)	3
Total	95





Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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Mae'r ddogfen hon ar gael yn Gymraeg hefyd / This document is also available in Welsh
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg / We welcome correspondence
and telephone calls in Welsh

DYDDIAD Y CYFARFOD: DATE OF MEETING:	02 June 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Bone Cement
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Leanne Watkins
SWYDDOG ADRODD: REPORTING OFFICER:	Matt Temby, Deputy Chief Operating Officer

**Pwrpas yr Adroddiad
Purpose of the Report**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

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

Cefndir / Background

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

Asesiad / Assessment

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

It captures three main areas:

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

- A global shortage of Palacos bone cement is confirmed.
- National IMT is established to coordinate supply.

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

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

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

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

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

Argymhelliad / Recommendation

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

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 2. Safe Care 2.1 Managing Risk and Promoting Health and Safety 3. Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety

Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

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



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board



Bone Cement

Patient, Quality, Safety and Outcomes Committee
2nd June 2026



Bone Cement Shortage: Overview

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

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

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

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

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

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

Key Issues, Discussions & Actions Taken

4. Operational & Clinical Issues

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

5. Monitoring & Reporting

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

6. Actions Taken (ABUHB)

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

ABUHB Position as of 2/3/26

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	02 June 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Unplanned Caesarean Sections Data
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Jayne Beasley - Head of Maternity, Gynaecology & Neonatal Services

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

Tongue Tie Pathway

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

Caesarean Section

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



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

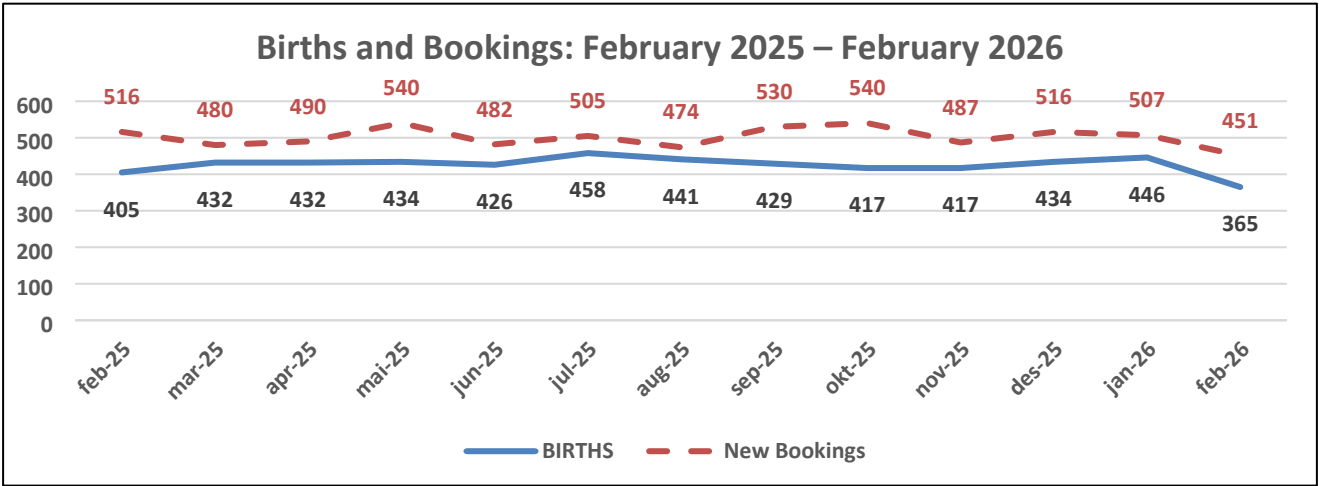
Asesiad / Assessment

Tongue Tie Pathway

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

Caesarean Section

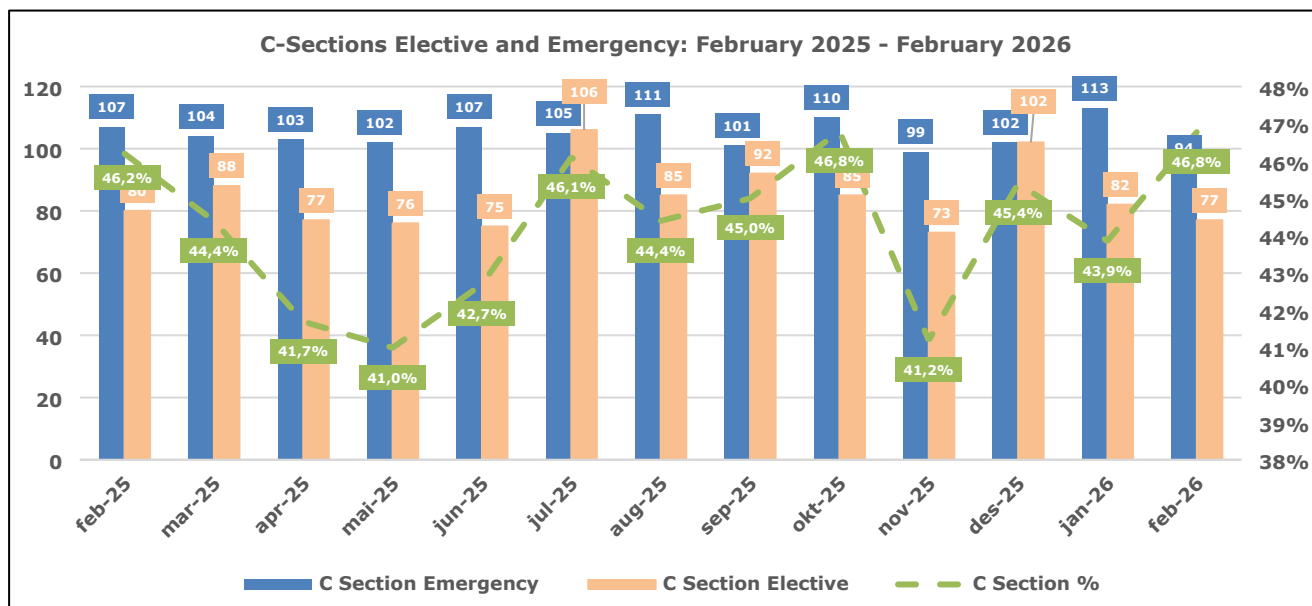
- Maternity service monitors caesarean section and key performance indicators monthly via a number of forums, clinical governance, maternity and neonatal assurance group and Divisional assurance meetings.
- Dashboard well established – feeds into All-Wales Beacon dashboard
- Benchmarking undertaken monthly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



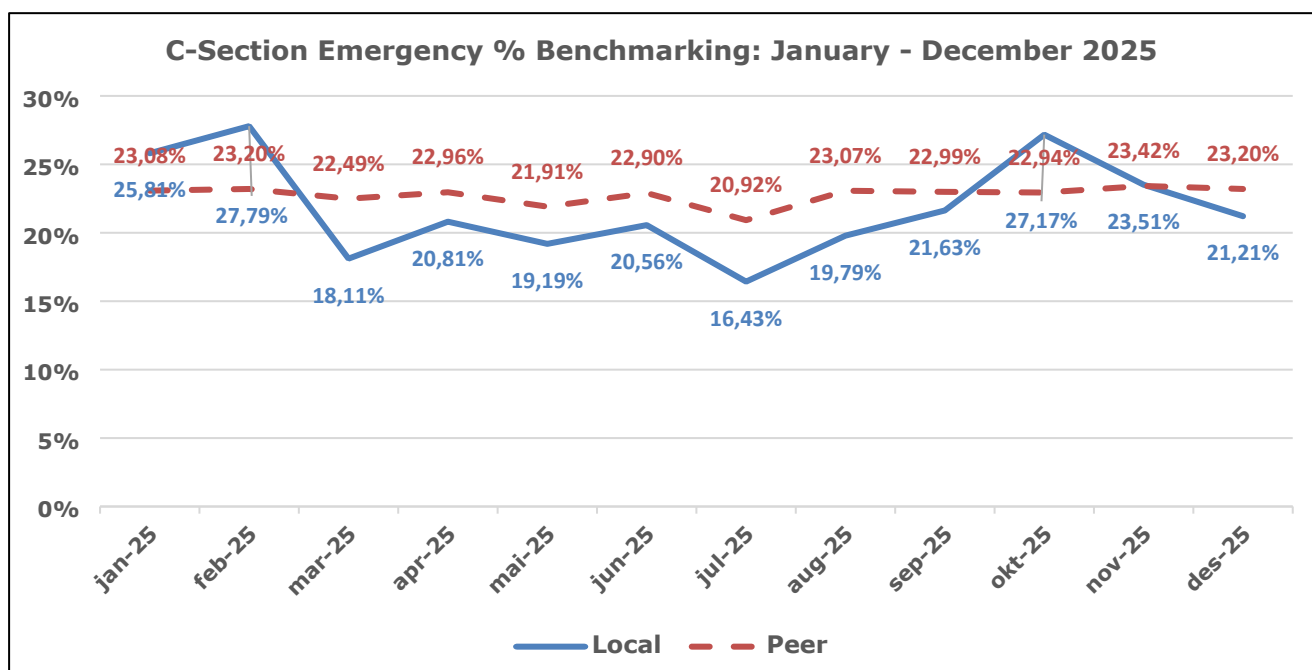
- Caesarean section rates totalling 43-45% - 10% rise since 2022.
- 2023 national data NMPA (National Maternal and Perinatal Audit) suggests unplanned caesarean section **lower** than expected for Aneurin Bevan University Health Board.
- Unplanned Caesarean section (defined as category 1, 2 & 3) higher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



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



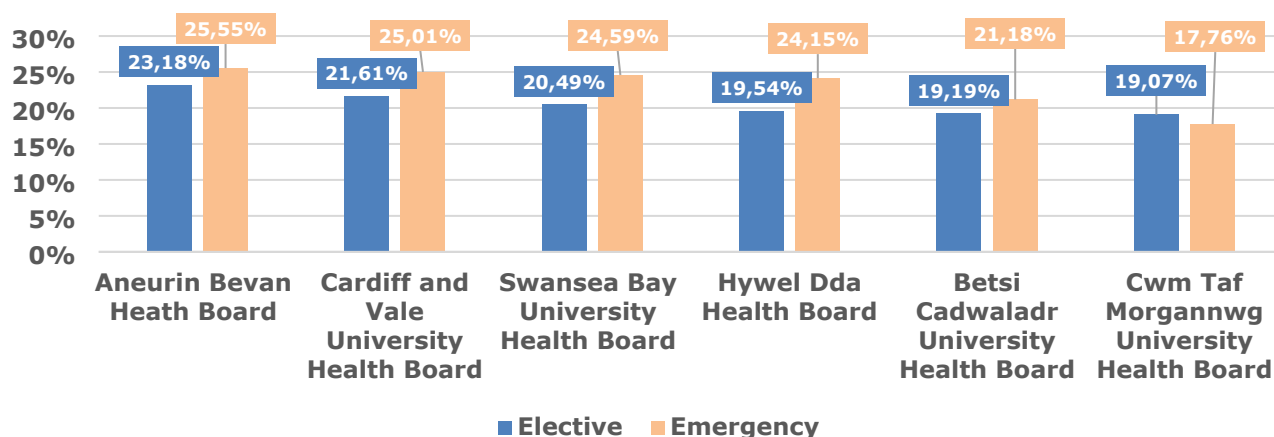
- Improved data compliance since introduction of digital records sees increase in category 3 caesarean section (early delivery no threat to life can be done up to 24 hours)
- Local data benchmarked below demonstrates similar rates with monthly variation showing lower rates January 2025 December 2025.



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



Benchmarking Elective & Emergency C-Sections: April 2025 - February 2026



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

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

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

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

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

A number of factors have contributed to this increase: -

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



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

Actions Taken

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

Argymhelliad / Recommendations

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

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

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

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



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

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

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



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	02 June 2026
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Nationally Reportable Incidents – System-wide Deep Dive
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Maxine Hiscock – Assistant Head of Patient Safety

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

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

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

At the same time, the organisation must meet its Duty of Candour obligations by being open with the patient or family, explaining that something serious has

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

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

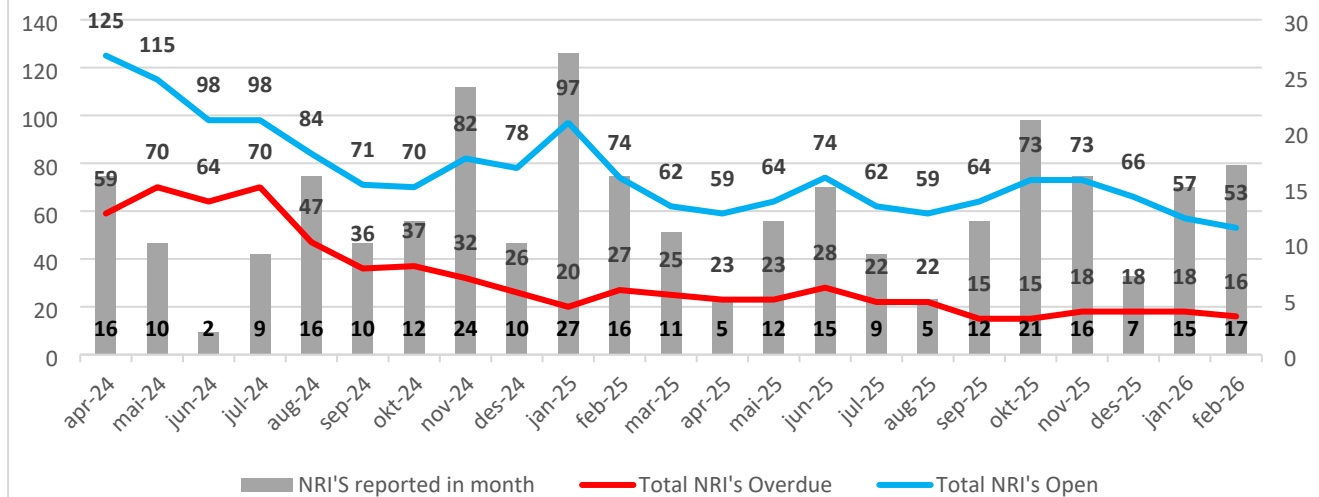
Following completion of the investigation, the process enters the post-investigation phase, which focuses on review, approval and learning. The investigation report is quality checked to ensure that it clearly explains the findings, identifies meaningful learning and includes a robust action plan. The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

Assessment

Volume and Compliance

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

Open and Overdue Nationally Reportable Incidents



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

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

Case Audit and Phase Analysis

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

Pre-investigation

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

The themes identified were delays in:

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

Peri-investigation

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

The themes identified were delays in:

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

Post-investigation

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

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

Patient Safety Incident Development Plan 2026/27

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

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

Pre-investigation Phase

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

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

Peri-investigation Phase

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

Post-investigation Phase

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

Argymhelliad / Recommendation

The Committee is asked to:

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

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

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

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

• Service Activity & Performance	Yes, outlined within the paper
• Financial	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	No does not meet requirements An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Choose an item.