# Patient Quality, Safety & Outcomes Committee

*Tuesday 28 July 2026, 09:30 - 12:30*

**Microsoft Teams**

# Agenda

## 1. PRELIMINARY MATTERS

PQSOC 20260728 Agenda - Approved.pdf (2 pages)

### 1.1. Welcome and Introductions

*Oral* *Chair*

### 1.2. Apologies for Absence

*Oral* *Chair*

### 1.3. Declarations of Interest

*Oral* *Chair*

### 1.4. Draft Minutes of the last Meeting held on 2nd June 2026

*Attached* *Chair*

PQSOC 20260728 1.4 PQSOC 20260602 Minutes.pdf (15 pages)

### 1.5. Committee Action Log

*Attached* *Chair*

PQSOC 20260728 1.5 Action Log.pdf (12 pages)

## 2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

There are no items for inclusion in this section

## 3. ITEMS FOR DISCUSSION

### 3.1. Interim Quality Outcomes Reporting a. Timeline & Implementation plan for the Qlik App b. Deep dive into Quarter 4 Never Events c. Infection prevention and control d. Feedback relating to patient waiting times and pain management

*Attached* *Clinical Executives*

PQSOC 20260728 3.1 Interim Quality Report PQSOC 28 July 2026.pdf (35 pages)

### 3.2. Quality Management Group Reporting, including escalation through Quality Management System

*Attached* *Director of Nursing*

PQSOC 20260728 3.2 QMG Highlight Report 08 July 2026 FINAL.pdf (5 pages)
PQSOC 20260728 3.2 - Appendix A QMG Assurance Report 08 July 2026 FINAL.pdf (12 pages)

### 3.3. Nurse Staffing Levels Wales Act Annual Assurance Report

*Attached* *Director of Nursing*

- PQSOC 20260728 3.3 Annual Assurance Report on NSLWA.pdf (6 pages)
- PQSOC 20260728 3.3 - Appendix A - NSLWA Annual Assurance Report 2025-26.pdf (38 pages)

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## 4. ITEMS FOR INFORMATION

### 4.1. Review of Committee Programme of Business 2026/27

*Attached* *Director of Corporate Governance*

- PQSOC 20260728 4.1 Review of Committee Forward Work Plan 2026-27 Report.pdf (4 pages)
- PQSOC 20260728 4.1 - Appendix A Forward Work Plan 2026-27.pdf (7 pages)

### 4.2. Committee Risk Report

*Attached* *Director of Corporate Governance*

- PQSOC_20260728_4.2 Committee Risk and Assurance Report.pdf (5 pages)
- PQSOC 20260728 4.2 - Appendix A Strategic Risk Assessments.pdf (8 pages)

### 4.3. NHS Wales Joint Commissioning Quality Committee Report

*Attached* *Director of Corporate Governance*

- PQSOC 20260728 4.3 JC Highlight Report - 26 May 2026 Final.pdf (6 pages)

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## 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: • Tuesday 6th October 2026

# CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
# ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING – PATIENT QUALITY SAFETY AND OUTCOMES COMMITTEE

| AGENDA | |
|---|---|
| **Date and Time** | **Tuesday 28th July 2026** |
| **Venue** | **Microsoft Teams** |

| Item | Title | Format | Presenter |
|---|---|---|---|
| **1** | **PRELIMINARY MATTERS** | | |
| 1.1 | Welcome and Introductions | Oral | Chair |
| 1.2 | Apologies for Absence | Oral | Chair |
| 1.3 | Declarations of Interest | Oral | Chair |
| 1.4 | Draft Minutes of the last Meeting held on 02nd June 2026 | Attached | Chair |
| 1.5 | Committee Action Log | Attached | Chair |
| **2** | **ITEMS FOR APPROVAL/RATIFICATION/DECISION** | | |
| | There are no items for inclusion in this section | | |
| **3** | **ITEMS FOR DISCUSSION** | | |
| 3.1 | Quality Outcomes Reporting<br>a. Timeline & Implementation plan for the Qlik App **PQSOC 0605/05**<br>b. Deep dive into Quarter 4 Never Events **PQSOC0206/07**<br>c. Infection prevention and control **PQSOC0206/07**<br>d. Feedback relating to patient waiting times and pain management **PQSOC0206/07** | Attached | Clinical Executives |
| 3.2 | Quality Management Group Reporting, including escalation through Quality Management System | Attached | Director of Nursing |
| 3.3 | Nurse Staffing Levels Wales Act Annual Assurance Report | Attached | Director of Nursing |
| **4** | **ITEMS FOR INFORMATION** | | |
| 4.1 | Review of Committee Programme of Business 2026/27 | Attached | Director of Corporate Governance |

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| 4.2 | Committee Risk Report | Attached | Director of Corporate Governance |
| 4.3 | NHS Wales Joint Commissioning Quality Committee Report | Attached | Director of Corporate Governance |
| **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:<br>• Tuesday 6th October 2026 | | |

**Motion to Exclude Members of the Public and the Press**

There may be circumstances where it would not be in the public interest to discuss a matter in public. In such cases the Chair shall move the following motion to exclude members of the public and the press from the meeting:

"Representatives of the press and other members of the public shall be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest".

*Motion under Section 1(2) Public Bodies (Admission to Meetings) Act 1960*

# BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD

## MINUTES OF THE PATIENT QUALITY SAFETY AND OUTCOMES COMMITTEE MEETING

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| **DATE OF MEETING** | Tuesday 2nd June 2026, 13:30PM – 16:00PM |
| **VENUE** | Microsoft Teams |

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| **PRESENT** | Helen Sweetland, Chair |
| | Penny Jones, Vice Chair |
| | William Smart, ABUHB Vice Chair |
| | Paul Deneen, Independent Member |
| | Vivek Goel, Independent Member |
| **IN ATTENDANCE** | Jennifer Winslade, Director of Nursing |
| | Peter Carr, Director of Allied Health Professionals and Health Science |
| | Seema Srivastava, Medical Director |
| | Naomi Murtagh, Board Business Manager |
| | Leeanne Lewis, Assistant Director for Quality and Patient Safety (Item 3.3) |
| | Megan Detheridge, Committee Secretariat |
| | Fern Woodhead, Governance Support Officer |
| **OBSERVER** | |
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| **APOLOGIES** | Rani Dash, Director of Corporate Governance |

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| **PQSOC/0206/01** | **Welcome and Introductions**<br><br>The Chair welcomed everyone to the meeting. |
| **PQSOC/0206/02** | **Apologies for Absence**<br><br>The Chair noted the apologies for absence. |
| **PQSOC/0206/03** | **Declarations of Interest** |

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| | There were no declarations of interest raised relating to items on the agenda. |
| **PQSOC/0206/04** | **Minutes of the previous meeting**<br><br>The minutes of the Patient Quality, Safety and Outcomes Committee held on 6th May 2026 were agreed as a true and accurate record of the meeting.<br><br>The Committee **APPROVED** the draft minutes. |
| **PQSOC/0206/05** | **Committee Action Log**<br><br>The Committee discussed action **PQSOC 1702/06** relating to physical assault data. Helen Sweetland (HS), Chair, queried whether the action was complete, noting that the data within the QOF report did not provide sufficient information. The Committee requested that the action was marked as in progress until further assurance was provided. **Action: Committee Secretariat**<br><br>The Committee raised concern regarding the potential under-reporting of physical assaults, highlighting that this may affect the reliability of the data. The Committee emphasised the importance of ensuring that all incidents were reported and that appropriate action, including prosecutions where possible, was being pursued to strengthen accountability and reporting culture.<br><br>The Committee noted feedback suggesting that reporting could be hindered by the complexity and time required to complete the current reporting process. The Committee highlighted that this may act as a barrier to reporting and discussed whether a more streamlined or informal approach could support staff and improve reporting levels. |



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| | The Committee was advised that work was ongoing to improve awareness and encourage staff to report incidents through the Datix system. It was noted that specialist case managers for violence prevention and reduction were in place to support departments, and that there was continued focus on encouraging the reporting of all types of aggression, regardless of severity.<br><br>The Committee requested that Peter Carr (PC), Director of Allied Health Professionals and Health Science, raise the matter at the next Health and Safety Committee meeting, to provide more detailed data on incidents, violence prevention, and seek assurance on whether current reporting levels were adequate and then report back to PQSO Committee. **Action: Director of Allied Health Professionals**.<br><br>The Committee **APPROVED** the action log with the discussed changes. |
| **PQSOC/0206/06** | **Consent Agenda**<br><br>The Committee was content with the papers listed within the consent agenda and did not want further discussion of them. |
| **PQSOC/0206/07** | **Quality Outcomes Reporting**<br><br>Jennifer Winslade (JW), Director of Nursing, provided a detailed overview of the report and outlined that the Quality Outcomes Report had evolved into a more comprehensive and dynamic reporting framework. The Committee noted that the framework now aligned explicitly with the revised Pillars of Quality, supported divisional and corporate clinical governance pathways, and strengthened |



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| | the ability to provide transparent assurance to the Committee, Quality Management Group and the Board.<br><br>The Committee noted that Quarter 4 had witnessed sustained system pressure following winter demand, which had continued to impact patient flow, workforce capacity and operational resilience. Emerging risks were highlighted, including increasing complexity in safeguarding demand, ongoing pressures on timely care pathways, and challenges relating to workforce training compliance and system capacity.<br><br>The Committee noted that a new Quality Strategy was being developed and would be presented to the Board in January 2027.<br><br>The Committee was advised of an increase in complaints during Q4. Performance against the 30-day response target remained below the 70% benchmark at approximately 60%, although this remained slightly above the national average. The Committee noted that there was a continued focus on early resolution with patients and families. JW advised that early Q1 reporting via Listening to People indicated a modest improvement of around 0.5%, although work remained at an early stage. It was confirmed that a formal review of 'Listening to People', would be undertaken after three months to collate and assess data. **Action: Director of Nursing**<br><br>The Committee emphasised the importance of learning from complaints and raised concern about the potential normalisation of waiting and patient discomfort within hospital settings. JW advised that this would form part of planned care work and highlighted initiatives such as |



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| | pastoral support within the Emergency Department. It was noted that reporting on waiting times remained complex due to variation across pathways. JW agreed to bring further information on waiting times in EC and pain-related complaints to a future meeting. **Action: Director of Nursing**<br><br>The Committee sought assurance on how quality and performance oversight was managed across multiple sites. JW advised that this was monitored through divisional assurance meetings, with strategic oversight provided at Committee level.<br><br>The Committee further sought assurance in relation to infection prevention and control, including how action plans were being managed and monitored, and queried the data presented under Pillar 2, noting an increase. Clarification was requested to support understanding of this position. **Action: Director of Nursing**<br><br>The Committee noted that three Never Events had been reported in Quarter 4 and requested follow-up assurance. **Action: Director of Nursing**<br><br>JW mentioned the slide on quality assurance of commissioned services. This is a complex area and JW reported that work had not progressed as anticipated. A focused piece of work on children and young people services had started. The Committee agreed that a further report on Quality assurance and the framework for commissioned services should come to the committee in six months. **Action: Director of Nursing** |



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| | The committee asked for further information on Datix reporting, decreasing number of pressure ulcers, and the increasing number of inquests. JW and SS provided information on these areas.<br><br>The Committee **NOTED** the report for **ASSURANCE**. |
| **PQSOC/0206/08** | **Quality Management Group Report**<br><br>Jennifer Winslade (JW), Director of Nursing, presented the report. The Committee noted that the QMG had considered a comprehensive range of intelligence and received overall assurance that arrangements to monitor, manage and improve quality and patient safety across the Health Board remained in place and were functioning effectively. It was noted that services continued to engage with quality improvement activity and maintained appropriate oversight of core safety risks.<br><br>The Committee noted that several cross-cutting issues had been identified which required continued focus at Executive and Committee level. These included limitations in the alignment between local and national measures, which continued to restrict benchmarking and comparative analysis. An assurance gap was also identified in relation to mandatory training compliance, especially for medicines administration training which had not been recorded on ESR as it had delivered face to face.<br><br>The Committee acknowledged progress in response to the Fuller Inquiry, particularly in strengthening mortuary governance, infrastructure and access controls. However, strengthened assurance was required in relation to the |



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| | patient pathway between death on the ward and transfer to the mortuary.<br><br>JW highlighted the need to improve the service and care that was provided for deaf patients and the use of professional translation / interpreter services in clinical settings.<br><br>The Committee noted the Research and Development Annual Report as a positive area and noted that this aligned with the Committee's terms of reference. It was agreed that this should be brought forward as a future agenda item via the Committee's workplan. **Action: Committee Secretariat/Medical Director**<br><br>The Committee discussed system pressures, including patient flow and boarding, and noted the need for further focus on how these issues would be addressed. The Committee also discussed suicide prevention and sought clarity on the level of structural support in place, recognising the need for further development in this area. Sepsis and antimicrobial considerations were also raised as areas requiring continued attention.<br><br>The Committee highlighted that once Electronic Prescribing and Medicines Administration (EPMA) has been piloted in the Health Board, there would be a need for ongoing audit and feedback to Clinical Executives on the impact of it, particularly regarding antibiotic prescribing.<br><br>The Committee discussed mandatory training compliance and noted that current approaches may not be fully effective. It was suggested that group-based sessions could support improved compliance. The Committee was |



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| | advised that a piece of work was underway to review training requirements across different roles, with the aim of tailoring delivery. The Committee emphasised that a single, standardised approach was unlikely to be effective and that more creative and flexible solutions would be required.<br><br>The committee supported the work that was being done to review the terms of reference for all of the subgroups of QMG to improve the governance.<br><br>The Committee **NOTED** the report. |
| **PQSOC/0206/09** | **National Clinical Audit: Activity Report 2025/2026 and Annual National Clinical Audit Plan 2026/27**<br><br>Seema Srivastava (SS), Medical Director, presented the National Clinical Audit Report to the Committee with support from, Leeanne Lewis (LL), Assistant Director for Quality and Patient Safety. The Committee noted the refreshed National Clinical Audit Activity Report and Forward Plan for 2026–27, which aimed to strengthen focus on assurance, learning and improvement rather than activity alone.<br><br>The Committee noted the improvements including standardised reporting templates, further development of the Audit Management and Tracking system (AMaT), and stronger divisional engagement and governance arrangements. It was noted that audit was now better embedded within existing Committee structures to support scrutiny and Board-level assurance.<br><br>The Committee recognised the significant progress made over recent years but raised concerns regarding audit actions not completed due to resource constraints. It was agreed that clearer tracking and alignment with the risk |



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| | register was required, supported by a review of historic decisions and risk appetite.<br><br>The Committee noted that national audit data was often historic and highlighted the need to strengthen local clinical audit activity to provide more timely insights. Embedding audit into routine practice across directorates was seen as a key priority, although resource pressures remain a challenge.<br><br>The Committee discussed communication of audit findings and noted that current methods were not fully effective. Embedding audit outcomes within wider pillar reports and clarifying local responsibilities was supported to improve visibility and impact, to ensure that the relevant staff are aware of the outcomes of national audits and what improvements need to be made.<br><br>The committee was informed that there is now a corporate clinical audit plan (presented to ARAC Jan 26) and local clinical audits. The committee noted that it would be important to know the plan and the outcomes of these audits too in an annual report. **Action: Medical Director**<br><br>The Committee **NOTED** the report for **ASSURANCE** and **APPROVED** the National Clinical Audit Plan for 26/27. |
| **PQSOC/0206/10** | **Healthcare Inspectorate Wales (HIW) Reports Update**<br><br>Jennifer Winslade (JW), Director of Nursing, provided the Committee with an overview of the HIW inspection reports, highlighting these were centrally coordinated through a strengthened governance process. All reports were reviewed, and action plans were quality assured prior to submission. A comprehensive log of recommendations and |



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| | actions was maintained, and progress was routinely chased to minimise the risk of delays or non-compliance.<br><br>JW advised the Committee that the Health Board had received several HIW recommendations, with multiple actions often linked to a single recommendation. These were being tracked through a structured process to ensure visibility and accountability. The Audit Management and Tracking (AMaT) system would be used as the central platform for monitoring delivery of all HIW-related actions, in response to Audit Wales' expectation for strengthened assurance arrangements.<br><br>The Committee noted that HIW operated an escalation framework; however, there were no direct financial penalties associated with delayed actions. JW clarified that where actions were delayed, there was a risk of re-inspection rather than financial sanction, provided the Health Board continued to engage and supply regular updates.<br><br>Paul Deneen (PD), Independent Member, sought clarification regarding expected timescales for responding to HIW reports and submitting action plans. JW advised that timescales were not fixed and were determined by the judgement of the Health Board, taking account of the complexity of findings and available resources. Immediate actions were prioritised with defined deadlines, while other actions were scheduled appropriately.<br><br>JW further confirmed that once an HIW report was formally published, it would be presented to the |



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| | Committee at the earliest opportunity to ensure oversight and transparency.<br><br>The Committee discussed the importance of maintaining clear visibility of progress against all HIW improvement plans to demonstrate compliance and accountability. It was emphasised that consistent reporting to the Committee was required to provide assurance that actions were being delivered as intended.<br><br>The Committee **NOTED** the report. |
| **PQSOC/0206/11** | **Update on neonatal services, including progress on listening and lessons learned activity and the forthcoming national review**<br><br>Jennifer Winslade (JW), Director of Nursing, reported that an improvement plan had been developed to strengthen assurance that neonatal services provided safe care, a positive experience for parents, families and babies, and a supportive and psychologically safe working environment for staff. The Committee noted that over 70% of the identified improvement actions had been completed, with remaining actions in progress to sustain and embed improvements.<br><br>JW highlighted to the Committee the key areas of focus within the plan, which included reducing medication errors, strengthening infection prevention measures, improving governance processes, and addressing cultural development within the service. These areas aligned with the themes identified through engagement with staff and earlier reviews of the service. |



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| | JW reported that there was a new senior manager for midwifery and neonates who had been leading the improvement work and working with staff to improve training and culture within the department. There has been a decrease in sickness levels within the team and the committee saw this as a positive sign.<br><br>The Committee discussed staff training and development. Penny Jones (PJ), Vice Chair, queried whether any additional feedback had been received regarding requests for further bedside or cot-side training. JW advised that a further update would be brought to the Committee once this information was available. **Action: Director of Nursing**<br><br>The Committee also sought assurance regarding workforce visibility, specifically the presence of Band 6 and Band 7 staff. It was confirmed that reduced visibility was not a Health Board-wide concern and targeted actions were in place to address this locally.<br><br>The Committee noted the significant improvements that had been made in the last 12 months and that executive monitoring of some areas was continuing.<br><br>The Committee **NOTED** the report. |
| **PQSOC/0206/12** | **WRP Penalties and Learning Compliance: Update on Health Board Improvement**<br><br>Jennifer Winslade (JW), Director of Nursing, reported that the Health Board had been identified as the highest recipient of Welsh Risk Pool (WRP) penalties for delays in completing Learning from Events reports (LFER). There were 55 penalties issued between April and December |



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| | 2025. The Committee noted that this represented a deterioration in performance compared to the previous year, where 34 penalties had been recorded.<br><br>JW advised the Committee that Welsh Risk Pool Committee guidance recommended that financial penalties be passed to the individual divisional budget holders responsible for the delays, rather than a central budget. It was confirmed that this approach had now been implemented within the Health Board, with penalties attributed directly to the responsible Divisions to strengthen accountability.<br><br>The Committee noted that January data identified a continued backlog of outstanding LFERs across several Divisions, indicating that further work was required to bring reporting within required timescales. JW reported that the work falls on a small number of people in a few divisions and it is often difficult to retrieve the information / notes needed as it was a long time since the initial event.<br><br>JW advised the Committee that Legal and Divisional teams were working closely and at pace to improve compliance. A range of improvement actions had been initiated, including strengthened tracking processes, clearer escalation routes, and increased oversight to support timely completion of reports. These actions were intended to recover performance and reduce future penalties. JW noted that there had been recent improvement.<br><br>The Committee **NOTED** the report and the decisions made by the Executive. |
| **PQSOC/0206/13** | **Committee Risk Report** |

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| | Naomi Murtagh (NM), Board Business Manager, provided the Committee with an overview of the Committee Risk report, advising that there had been no changes to the risk profile since the previous meeting, and no new risks had been added or escalated. Existing risks remained under review, with controls and mitigating actions continuing to be monitored through established governance processes.<br><br>NM advised the Committee that further work was being undertaken to strengthen assurance against current risks, with a more detailed update to be provided at the next Committee meeting.<br><br>The Committee **NOTED** the report. |
| **PQSOC/0206/14** | **Review of Committee Programme of Business 2026/27**<br><br>The report was received for Information. |
| **PQSOC/0206/15** | **HIW Operational Plan 2026-2027**<br><br>The report was received for Information. |
| **PQSOC/0206/16** | **Items to be Brought to the Attention of the Board and Other Committees**<br><br>The Committee considered which matters from the meeting required escalation or formal notification to the Board and other relevant committees and agreed to escalate the following:<br><br>• Health and Safety report on Violence and Aggression to be reported to People and Culture committee too.<br>• Mandatory Training to be raised with the People & Culture Committee. |
| **PQSOC/0206/17** | **Any Other Urgent Business** |



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| | The committee requested updates at a future committee on the outcomes of the investigations into two recent incidents that been the subject of significant publicity: the sterilisation unit and the lumbar puncture case.<br><br>**Action: Director of Nursing and Medical Director** |
| **PQSOC/0206/18** | **Date of the Next Meeting:**<br>• 28th July 2026 |

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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

| Outstanding | Overdue: In Progress | Not Due | Completed | Transferred to another Committe |
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| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
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| 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**<br><br><u>March update</u><br>Action has been included in the Committee forward work plan.<br><br>This would be an oral update under the Committee action log item at April's meeting<br><br>Update: Data on violence and aggression incidents |

| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
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| | | | | | (involving staff and public) will be analysed to identify trends around repeat perpetrators and location of incident. This analysis will be incorporated (were relevant and useful) in the routine quality reports that include Health & Safety data.<br><br><u>June Update.</u><br><br>The Committee requested further detailed data sought from Health and Safety Committee regarding violence prevention, and assurance |

| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
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| | | | | | on the adequacy of current reporting levels. **(PQSOC 0206/ 05)**<br><br><u>July Update</u><br><br>Statistical reports relating to incidents of violence and aggression in the workplace are presented to the Violence Prevention and Reduction Group, which sits as a subgroup of the Health and Safety Committee. These reports are subsequently escalated, or shared for information, via the Quality Management Group, and |

| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
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| | | | | | are available to the Patient, Quality, Safety and Outcomes Committee.<br><br>This approach is consistent with the established governance arrangements. |

| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
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| June 2026 | **PQSOC0206/07** | **Quality Outcomes Reporting**<br><br>Further information on waiting times and pain-related complaints to be brought to a future meeting. | **Director of Nursing** | July 2026 | **Completed**<br><br>Included in agenda |

| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
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| June 2026 | **PQSOC0206/07** | **Quality Outcomes Reporting**<br><br>The Committee requested further assurance and clarity on how infection prevention and control was being monitored and managed. | **Director of Nursing** | July 2026 | **Completed**<br><br>Included in agenda |

| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
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| June 2026 | **PQSOC0206/07** | **Quality Outcomes Reporting**<br><br>Follow-up assurance requested against three Never Events reporting in Quarter 4. | **Director of Nursing** | July 2026 | **Completed**<br><br>Included in agenda |

| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
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| June 2026 | **PQSOC0206/07** | **Quality Outcomes Reporting**<br><br>Formal review of 'Listening to People', would be undertaken after three months to collate and assess data. | **Director of Nursing** | September 2026 | |

| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
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| June 2026 | **PQSOC0206/07** | **Quality Outcomes Reporting**<br><br>report on Quality assurance and the framework for commissioned services should come to the committee in six months. | **Director of Nursing** | December 2026 | |

| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
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| June 2026 | **PQSOC0206/08** | **Quality Management Group Report**<br><br>Research and Development Annual Report to be brought forward as an agenda item. | **Medical Director** | July 2026 | July Update.<br><br>Item deferred to October meeting. |

| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
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| June 2026 | **PQSOC 0206/11** | **Update on neonatal services, including progress on listening and lessons learned activity and the forthcoming national review**<br><br>Updated requested in regards to further bedside and cot-side training. | **Director of Nursing** | July 2026 | July Update.<br><br>Action deferred to October meeting. |

| Committee Meeting | Minute Reference | Agreed Action | Lead | Target Date | Progress/ Completed |
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| June 2026 | **PQSOC 0206/17** | **Any Other Urgent Business**<br><br>Updates were requested on the outcomes of the investigations into two recent incidents that been the subject of significant publicity: the sterilisation unit and the lumbar puncture case. | **Director of Nursing/ Medical Director** | October 2026 | **Not Due** |

*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.*

# Interim Quality Report

**Reporting Date:** 28 July 2026
**Data Range:** Up to 31 May 2026

| Pillar 1<br>Patient and staff feedback, complaints, concerns and compliments | Pillar 2<br>Patient Safety including Incident Reporting | Pillar 3<br>Clinical Effectiveness | Pillar 4<br>Health, Safety, Security and Compliance | Pillar 5<br>Infection Control and Prevention | Pillar 6<br>Safeguarding |
|---|---|---|---|---|---|
| •Civica → | •Datix overview → | •Ward accreditation ↑ | •*RIDDOR* ↑ | •Infection rates → | •Duty to report → |
| •Putting Things Right Compliance ↑ | •*Patient Falls* → | | •*H&S Mandatory training compliance* → | •Welsh Government Reduction Goals → | •Safeguarding training ↑ |
| •Putting Things Right Backlog ↑ | •Nationally Reportable Incidents ↑ | | | | |
| •Early Resolutions ↓ | •Early Warning Notifications → | | | | |
| •Ombudsman & Regulation 28 → | •Never events → | | | | |
| •PALS → | •Duty of Candour → | | | | |
| •Legal Services → | •Pressure Ulcers → | | | | |
| | •Mortality → | | | | |

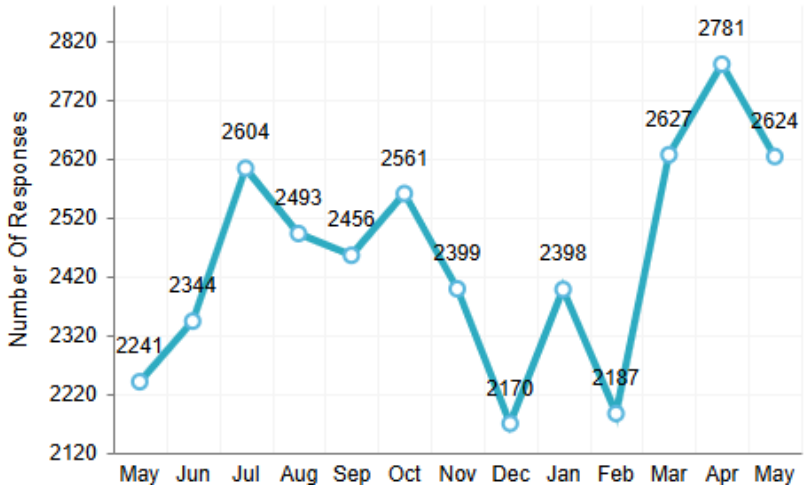
# CIVICA – Patient feedback

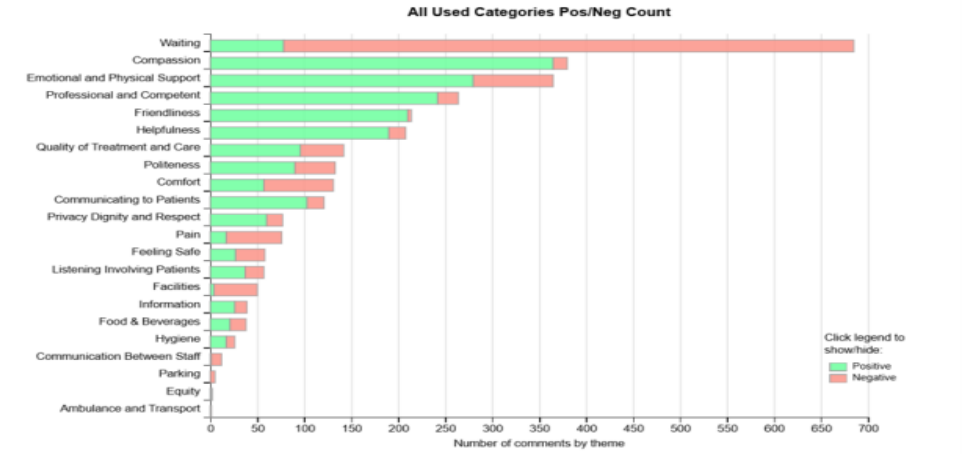
**Listening & Learning - What we are Hearing**

- 2624 feedback responses have been received for May 26 so far. April 2026 remains the highest month to date (now 2781). Since the last report a total of 29 additional responses have been noted over 7 separate months (since July).
- The new Cancer Treatment Survey continues to show a very positive response rate via SMS. 72 responses for May 26 to date.
- Work continues on the All-Wales National Endoscopy Survey to be sent via CIVICA SMS.
- The National Survey regarding the new Listening to People's process was launched April 2026 – with one response for May, although only a few questions on the survey were answered.
- All Wales Research Survey now shared in preparation for implementation on 1st June 2026. This is first survey to show on the CIVICA system in multiple languages.
- The overall Satisfaction Score for May is 87% (all surveys) which is unchanged from April.

**Listening & Learning - What we are Doing**

- Bespoke reporting continues on themes and patient comments that crossover all the Divisions
- Work continues to implement additional languages and BSL for the PES and Maternity National Surveys, this will also extend to the new Listening to People Survey and Endoscopy. Also work on an Easy Read version of survey.
- Rollout continues across all Divisions, especially teams working across sites and within outpatient departments. Also work underway reviewing the Women's Hubs. Plans also continue to support areas with little or no feedback during 2025.



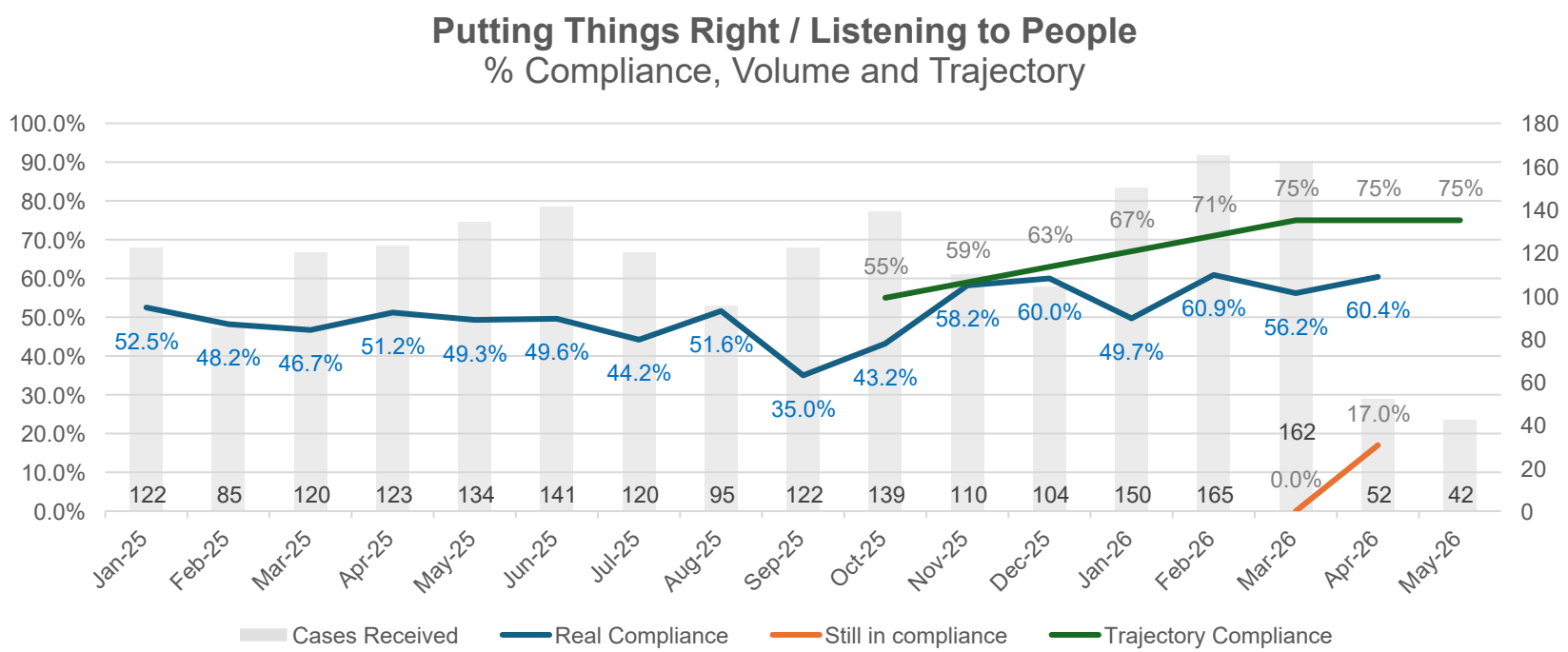




| Overall Satisfaction Score (Monthly Heat Map) | 2025 May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | 2026 Jan | Feb | Mar | Apr | May |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Overall – All Surveys | 86 | 86 | 88 | 87 | 86 | 86 | 87 | 86 | 87 | 87 | 86 | 87 | 87 |
| PCC/PES Surveys | 85 | 86 | 87 | 87 | 86 | 86 | 86 | 86 | *87 | 87 | 86 | 87 | 87 |
| ED Survey/PES | 78 | 75 | 78 | 75 | 75 | 75 | 76 | 75 | 79 | 78 | 76 | 81 | 79 |
| Maternity & Neonatal Surveys | N/A | N/A | N/A | 95 | 85 | 83 | 85 | 86 | 86 | 85 | 84 | *84 | 83 |

*PCC/PES Survey Score reported in April as 86 (January)

*Maternity & Neonatal Score previously reported as 83 (April)

# Putting Things Right/Listening to People
## 30 day performance



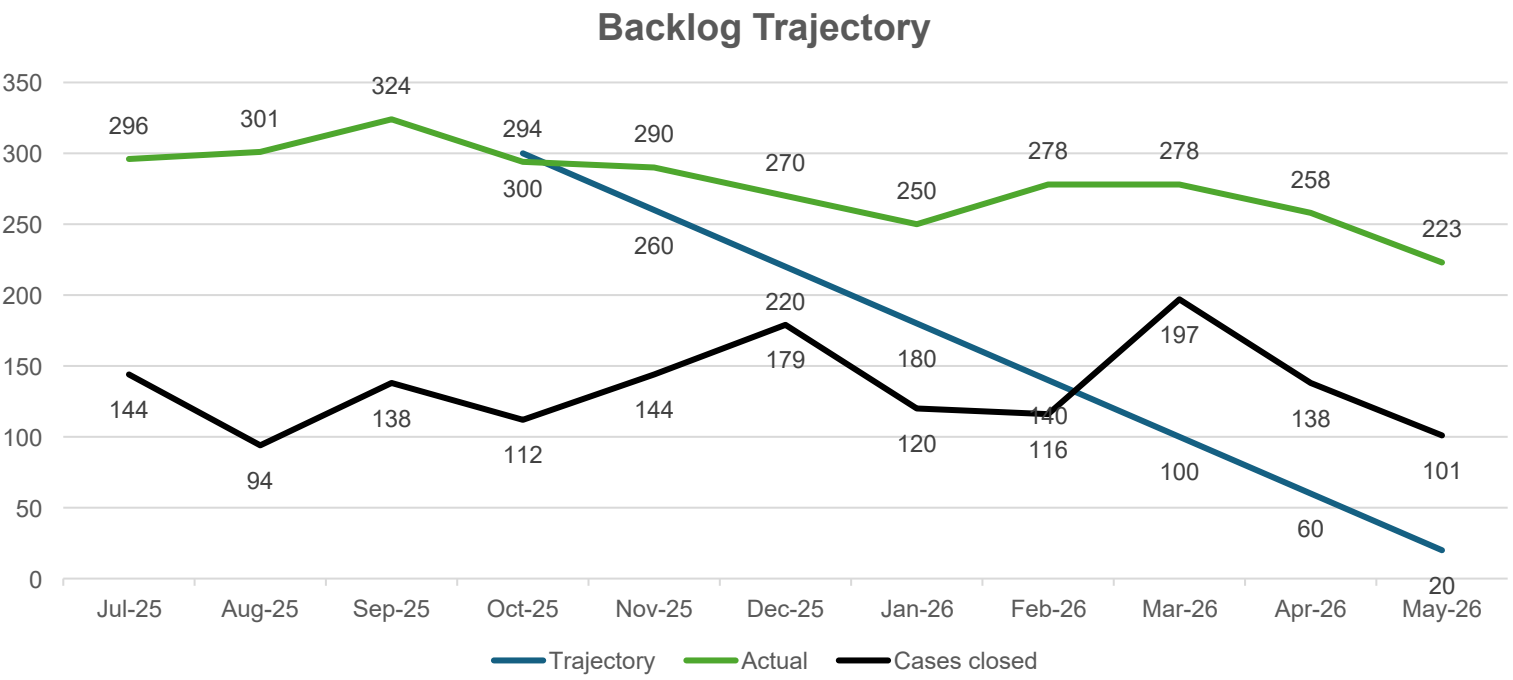

**Please note:**
From 1 April 2026, the move from Putting Things Right to Listening to People regulations means formal complaints may follow a 30, 60, 90, 120-day or 6-month process.

Compliance will therefore show both: the percentage of cases completed and closed within target, and the percentage of open cases still within target.
The narrative will show how many cases entered each process.

Data reporting has been adjusted slightly to better align with the Beacon Dashboard and improve consistency. This may cause small differences from previous reports, as withdrawn cases are now included in the calculations differently.

| Definition | Analysis | Implications |
|---|---|---|
| Information displayed was correct as of 06 June 2026 and extracted from RL Datix. Any reference to national benchmarking was taken from the Beacon Dashboard but is subject to notable delay in reporting. | The number of cases entering a formal process has now been significantly reduced as a result of the extended timescales for Early Resolution (10 working days rather than the next working day). This has seen a 70% reduction in the number of complaints requiring a formal investigation and response.<br><br>In both April and May 88% of all formal cases were placed in a 30-day process, with the decision to utilise longer timescales vetted by the senior QPS team, this would typically only be used where an extensive investigation is required or appears likely that redress processes will be triggered as a result of investigation. This allows us to better manage expectations of complainants.<br><br>The formal complaints compliance for April (as of 05 June) was 60.4% of cases closed in-compliance with a further 17.0% in compliance but still open and under investigation. | The new LtP regulations has required a significant shift in working practices both within the LtP team who oversee and support the management of complaints and the Divisions.<br><br>80% of formal cases received in April were acknowledged and offered a listening discussion within the 5 working day timescale. Changes to the Datix system have resulted in some data quality issues (not all fields are mandatory and some require manual calculation of timescales), |

# Putting Things Right/Listening to People Backlog



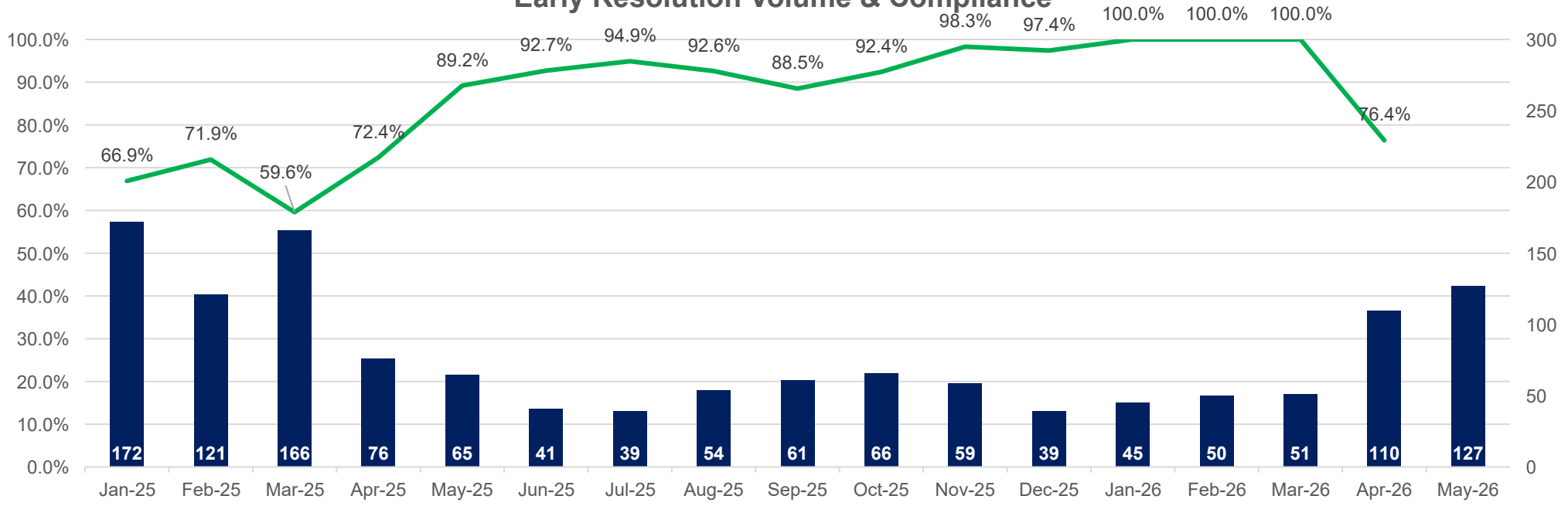

| Number of overdue cases by duration (as of 01 May 2026) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Overdue Category | Surgery | Medicine | F&T | PCC | MH&LD | CSS | Urgent Care | Total |
| Greater than 12 months | 2 | 1 | 0 | 0 | 0 | 0 | 0 | **3** |
| Between 9 and 12 months | 9 | 5 | 1 | 0 | 0 | 1 | 0 | **16** |
| Between 6 and 9 months | 19 | 18 | 4 | 0 | 0 | 3 | 0 | **44** |
| Between 30 days and 6 months | 70 | 57 | 42 | 13 | 7 | 5 | 0 | **194** |
| **Total Overdue** | **100** | **81** | **47** | **13** | **7** | **9** | **0** | **257** |

| Number of overdue cases by duration (as of 01 June 2026) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Overdue Category | Surgery | Medicine | F&T | PCC | MH&LD | CSS | Urgent Care | Total |
| Greater than 12 months | 3 | 0 | 0 | 0 | 0 | 0 | 0 | **3** |
| Between 9 and 12 months | 5 | 3 | 2 | 0 | 0 | 0 | 0 | **10** |
| Between 6 and 9 months | 25 | 13 | 4 | 0 | 0 | 2 | 0 | **44** |
| Between 30 days and 6 months | 64 | 45 | 35 | 12 | 5 | 5 | 0 | **166** |
| **Total Overdue** | **97** | **61** | **41** | **12** | **5** | **7** | **0** | **223** |

| Definition | Analysis | Implications |
|---|---|---|
| Information displayed was correct as of 05 June 2026 and extracted from RL Datix. Any reference to national benchmarking was taken from the Beacon Dashboard but is subject to notable delay in reporting. | As of 05 June 2026 the total number of overdue cases is 206, further evidencing the steady progress towards the goal of eliminating the complaints backlog. For historical context, the Health Board has only had one month since January 2023 with less than 200 complaints overdue.<br><br>To maintain and further reduce the backlog it is essential the Health Board focus on managing new concerns through the revised Early Resolution process. Most complainants want an explanation and to the ensure learning from their experience, entering them into protracted formal investigation processes is often not in their best interest and causes a significant burden on divisions. | To support the reduction in backlog the senior QPS team and overseeing a case load, prioritising the oldest cases. Typically, these are the most complex and require significant input to conclude appropriately.<br><br>Surgery, Medicine and F&T were provided with an improvement plan which required them to clear their over 12-month cases by 01 June. Whilst Surgery just missed this target (they has 8 over 12 months in March), both medicine and F&T reached this target. |

# Putting Things Right/Listening to People

## Early Resolution Volume & Compliance

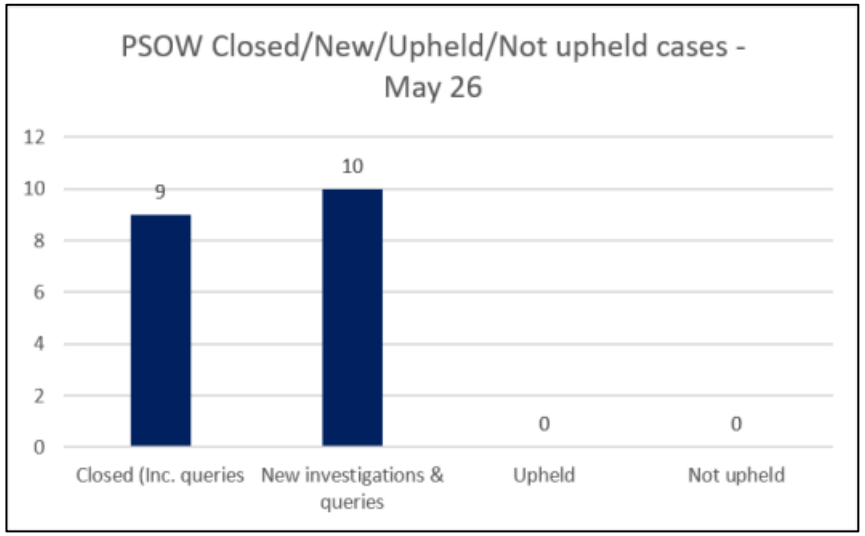


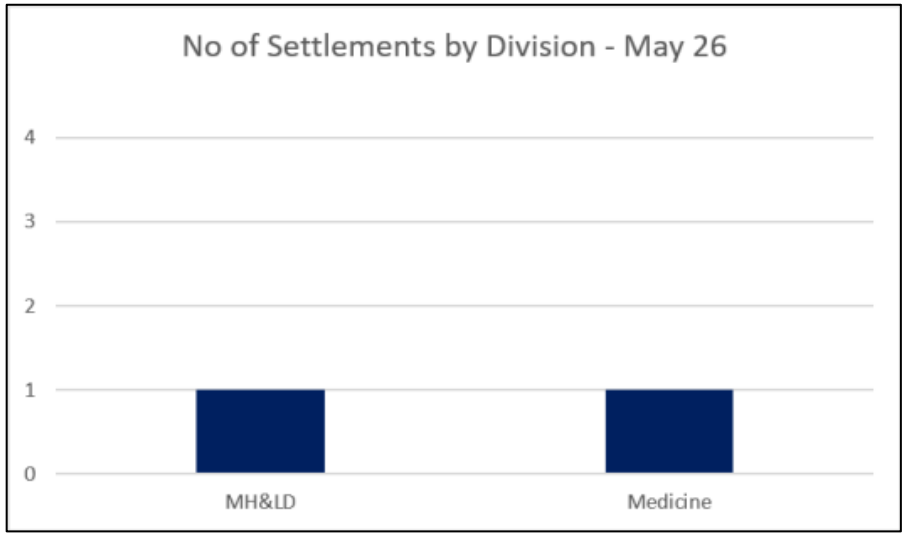

**Please note:**

Minor changes to how data is reported have taken affect to more accurately mirror the Beacon Dashboard and provide consistency of reporting. This has resulted in small variations in the data compared to previous reports due to how withdrawn cases are now factored into the calculations.

| Definition | Analysis | Implications |
|---|---|---|
| Information displayed was correct as of 05 June 2026 and extracted from RL Datix. Any reference to national benchmarking was taken from the Beacon Dashboard but is subject to notable delay in reporting. | The graph above shows a notable switch to managing cases under Early Resolution where it is appropriate. The Ministerial target for managing cases through Early Resolution is to reach 40% by the end of Q4 2026/27, in April we achieved 83.5%<br><br>Whilst the percentage compliance saw a drop from 100% to 76.4% - in the context of increasing early resolution cases and the complexity of cases being managed through this process it is still extremely strong and above the Welsh Government target of 75%. | A review of LtP regulations impact on the Health Board is scheduled to begin in August 2026 which will include an evaluation of cases that have not met compliance under Early Resolution to ensure that the triage of cases is being correctly and consistently undertaken. |

# Ombudsman (PSOW)




## Formal Settlement

The review found that the investigation and follow-up response did not fully address concerns about choking incidents, their impact, and related medication arrangements.

**Recommendations**

ii) Clarify communication with the GP Practice about options for administering medication in an alternative form.
b) Provide a further complaint response that addresses the outstanding concerns.

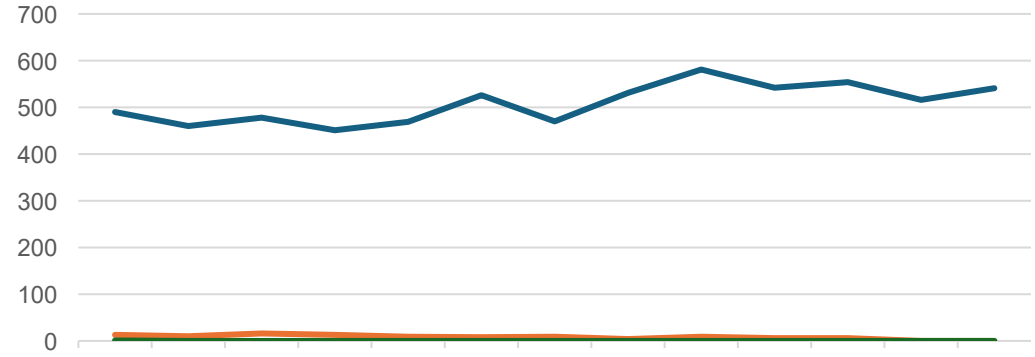
## Themes & Trends

- Completeness and quality of responses, some concerns were not fully addressed.
- Timeliness of response remains a recurring theme.
- Clearer explanations are needed when delays occur.

- **No financial settlements were made in May, indicating an improved position; continued focus is still needed to strengthen complaints handling.**

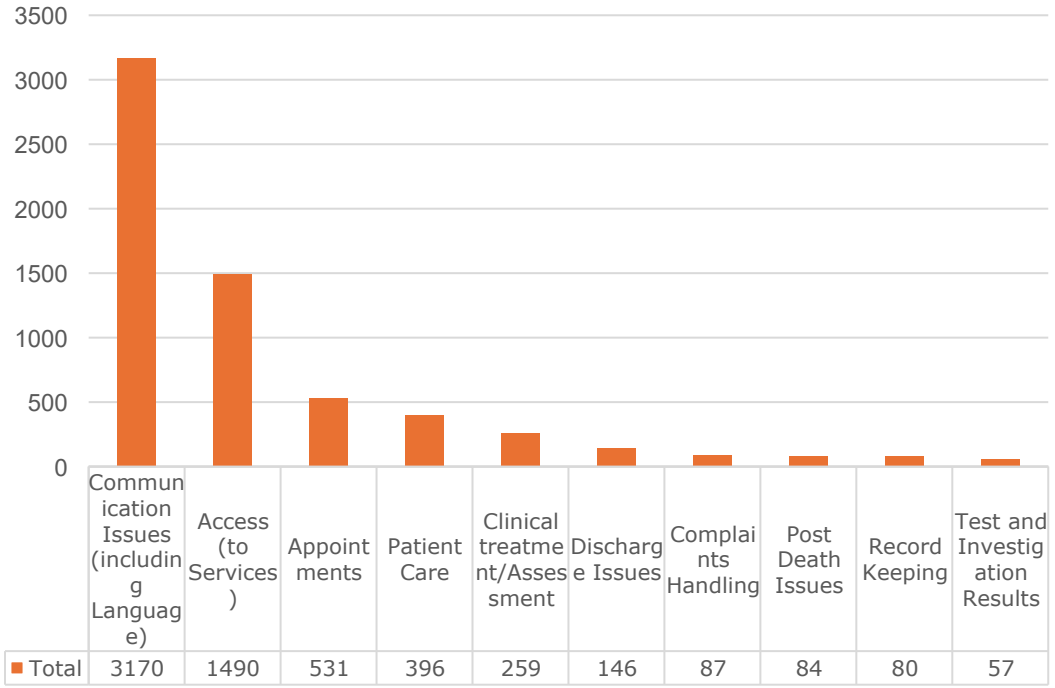
# Patient Advice & Liaison Service

## Total Contacts Received by PALS




| | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Enquiries | 490 | 460 | 478 | 451 | 469 | 526 | 470 | 531 | 581 | 542 | 554 | 516 | 541 |
| Early Resolution | 13 | 10 | 16 | 13 | 9 | 8 | 9 | 4 | 9 | 6 | 6 | 0 | 0 |
| Escalated to complaint | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

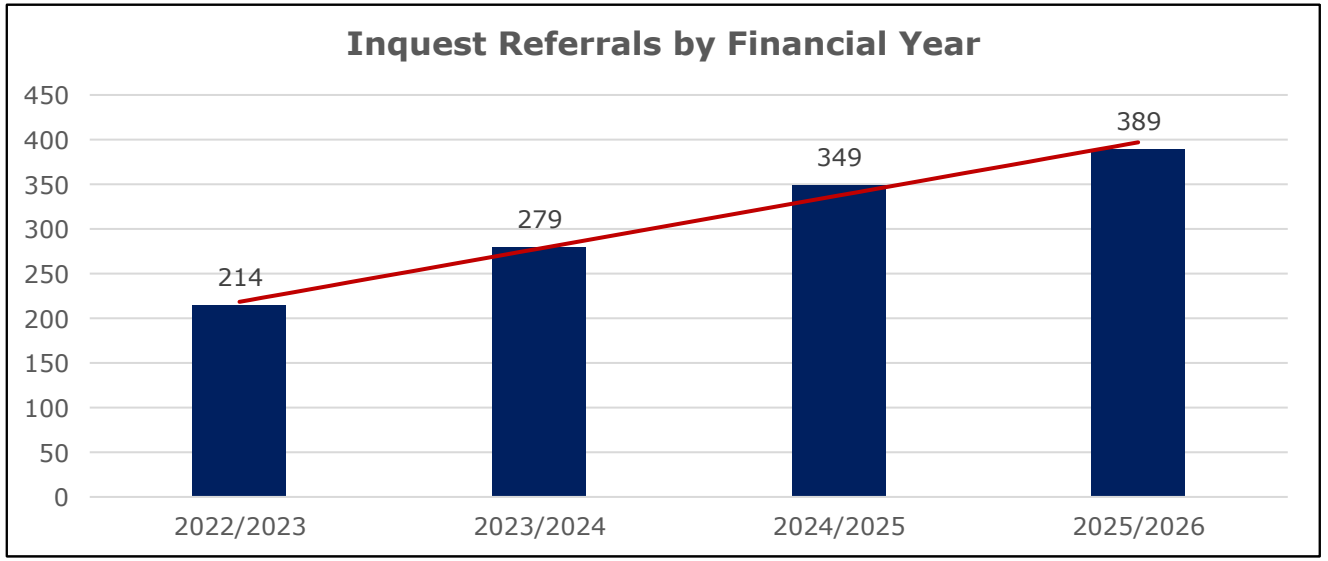
## Top 10 Enquiry Themes




| | Communication Issues (including Language) | Access (to Services) | Appointments | Patient Care | Clinical treatment/Assessment | Discharge Issues | Complaints Handling | Post Death Issues | Record Keeping | Test and Investigation Results |
|---|---|---|---|---|---|---|---|---|---|---|
| Total | 3170 | 1490 | 531 | 396 | 259 | 146 | 87 | 84 | 80 | 57 |


# Legal Services: Inquests

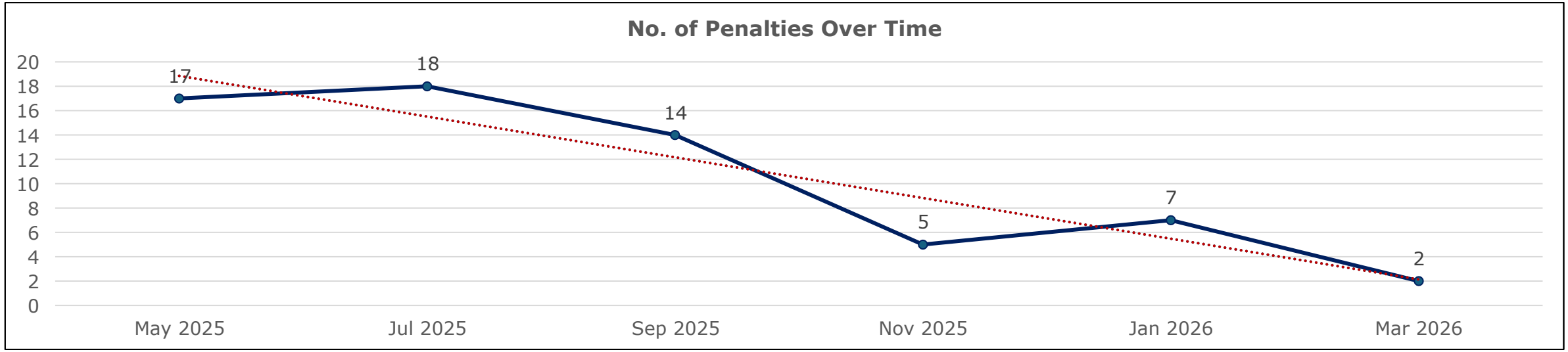
| Inquest Status | |
|---|---|
| New Inquests opened | **36 (23 Last month)** |
| Open Live Inquests as of 31 May 2026 | **232 (237)** |
| Inquests concluded | **18 (25)** |
| Inquests held with staff attending | **7 (3)** |
| Inquests held in writing (IIW)/ Rule 23 – no staff attending | **11 or 61% (22 or 88%)** |




| Definition | Analysis | Implications |
|---|---|---|
| The data displayed was collected 31 May 2026. | 1 **Regulation 28 Report** (Prevention of Future Deaths) was issued in May.<br><br>It was a very busy month of Court appearances for the Inquest Team. 7 In person Inquest Hearings took place including an Inquest that took place over 5 days. Multiple witnesses attended this Inquest and were supported by the Inquest Team. | Sustained and significant pressure is being experienced by the Legal Services team due to the increase workload in coroners court and the reduction of timescales for redress due to LtP regulations (from 12 months to 6 months). |

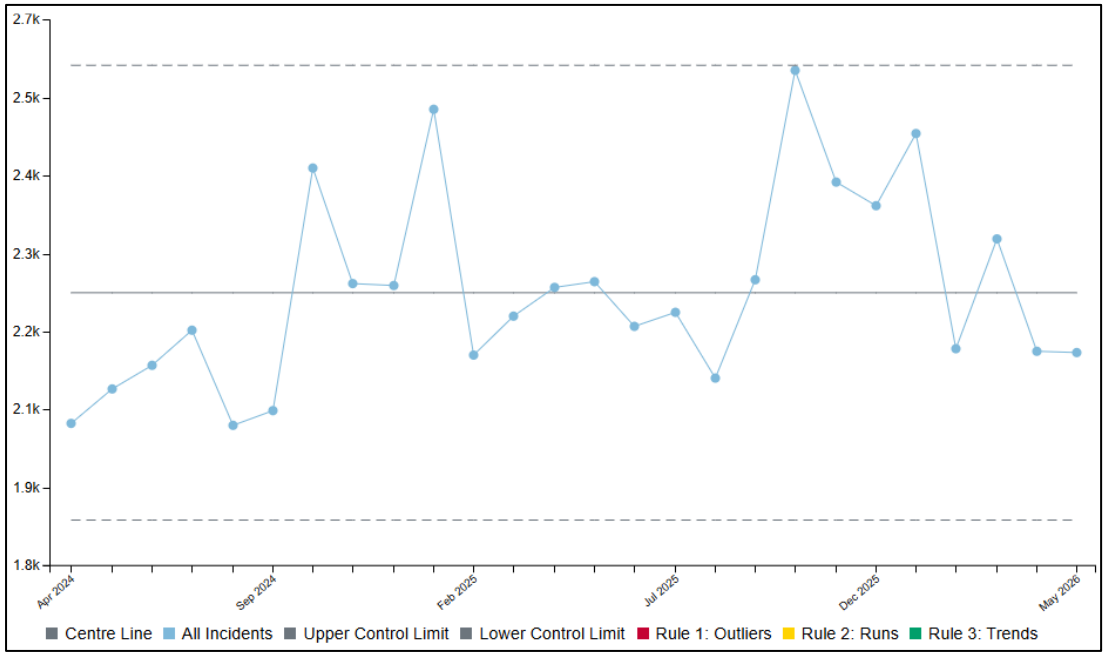
# Legal Services: LFER

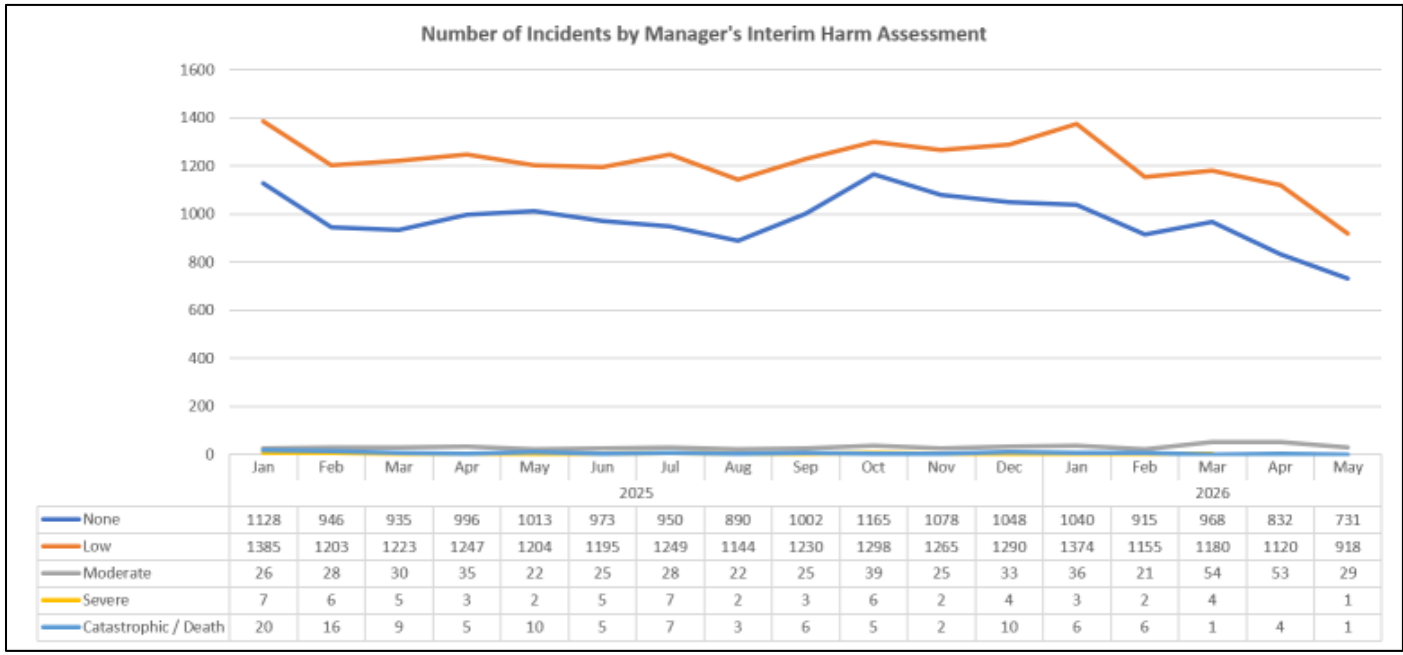
## Learning from Events Report (LFER) Financial Penalties




| Definition | Analysis | Implications |
|---|---|---|
| The LFER Financial Penalties graph is from monthly WRP Data. | The number of LFER financial penalties has seen notable improvement, with significant work undertaken with Legal Services and Divisions to improve process, embed SOPs and enhanced oversight.<br>Due to the WRP committee not being Quorate in May the meeting was cancelled. It has been rescheduled for June. | A recent Executive Team decision has confirmed that financial penalties will align to relevant budget holders. Positively, improvements are already leading to significant reductions in penalties. |

# Datix Incident Overview




| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2025 | | | | | | | | | | | | 2026 | | | | |
| None | 1128 | 946 | 935 | 996 | 1013 | 973 | 950 | 890 | 1002 | 1165 | 1078 | 1048 | 1040 | 915 | 968 | 832 | 731 |
| Low | 1385 | 1203 | 1223 | 1247 | 1204 | 1195 | 1249 | 1144 | 1230 | 1298 | 1265 | 1290 | 1374 | 1155 | 1180 | 1120 | 918 |
| Moderate | 26 | 28 | 30 | 35 | 22 | 25 | 28 | 22 | 25 | 39 | 25 | 33 | 36 | 21 | 54 | 53 | 29 |
| Severe | 7 | 6 | 5 | 3 | 2 | 5 | 7 | 2 | 3 | 6 | 2 | 4 | 3 | 2 | 4 | | 1 |
| Catastrophic / Death | 20 | 16 | 9 | 5 | 10 | 5 | 7 | 3 | 6 | 5 | 2 | 10 | 6 | 6 | 1 | 4 | 1 |

## Definition

The information above has been extracted from RL Datix via Qlik Sense and is correct at the point of extraction on 07 June 2026.
It contains Patient / Service user incidents by months of reporting. The right graph shows the incidents split by managers interim harm assessment.

## Analysis

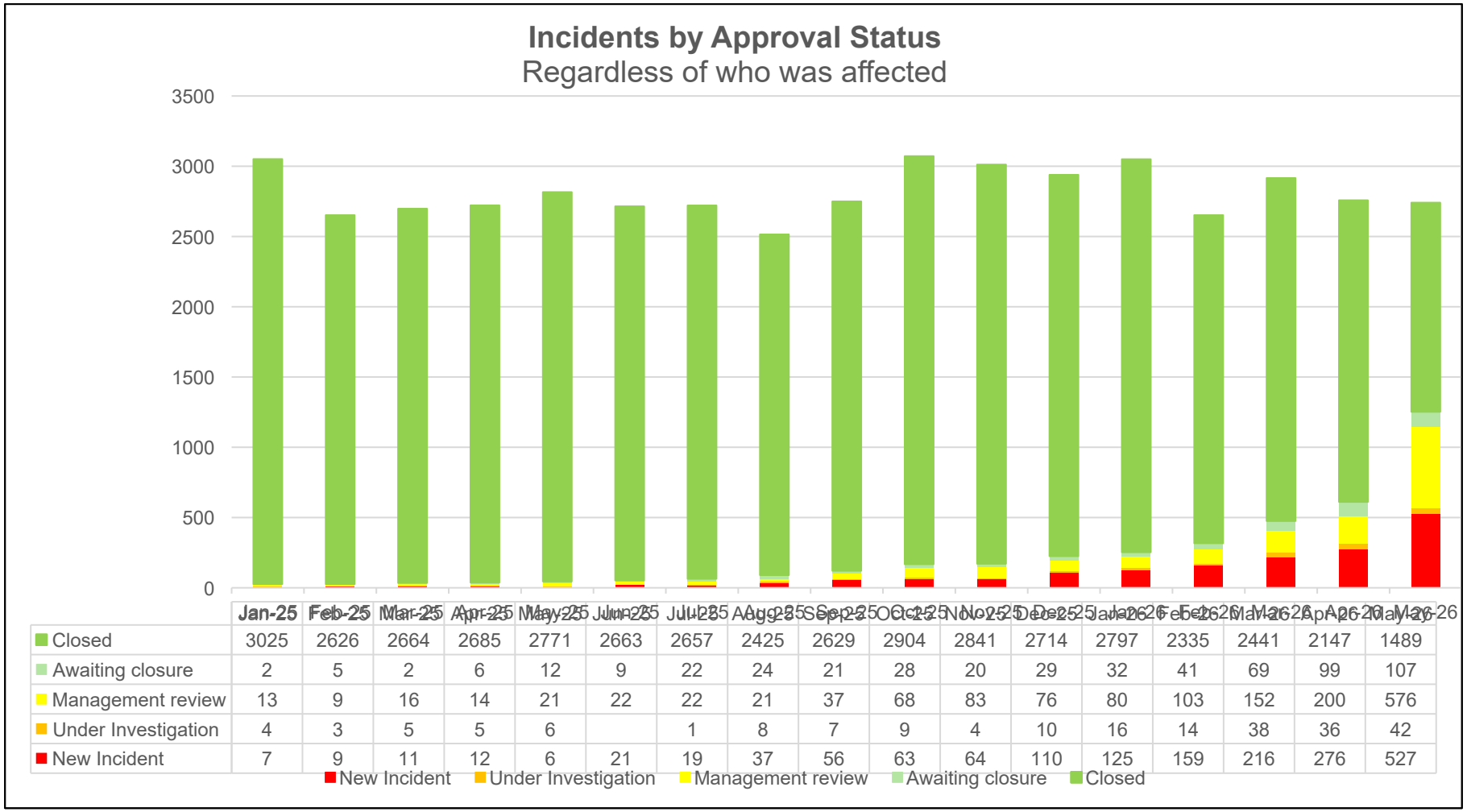
The left-hand graph shows a slow but steady increase in the total number of Datix incidents for patients/service users with seasonal variation resulting in an increase in incidents during winter months.

The right-hand graph illustrates a reduction in the number of incidents resulting harm (based on the managers interim harm 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.

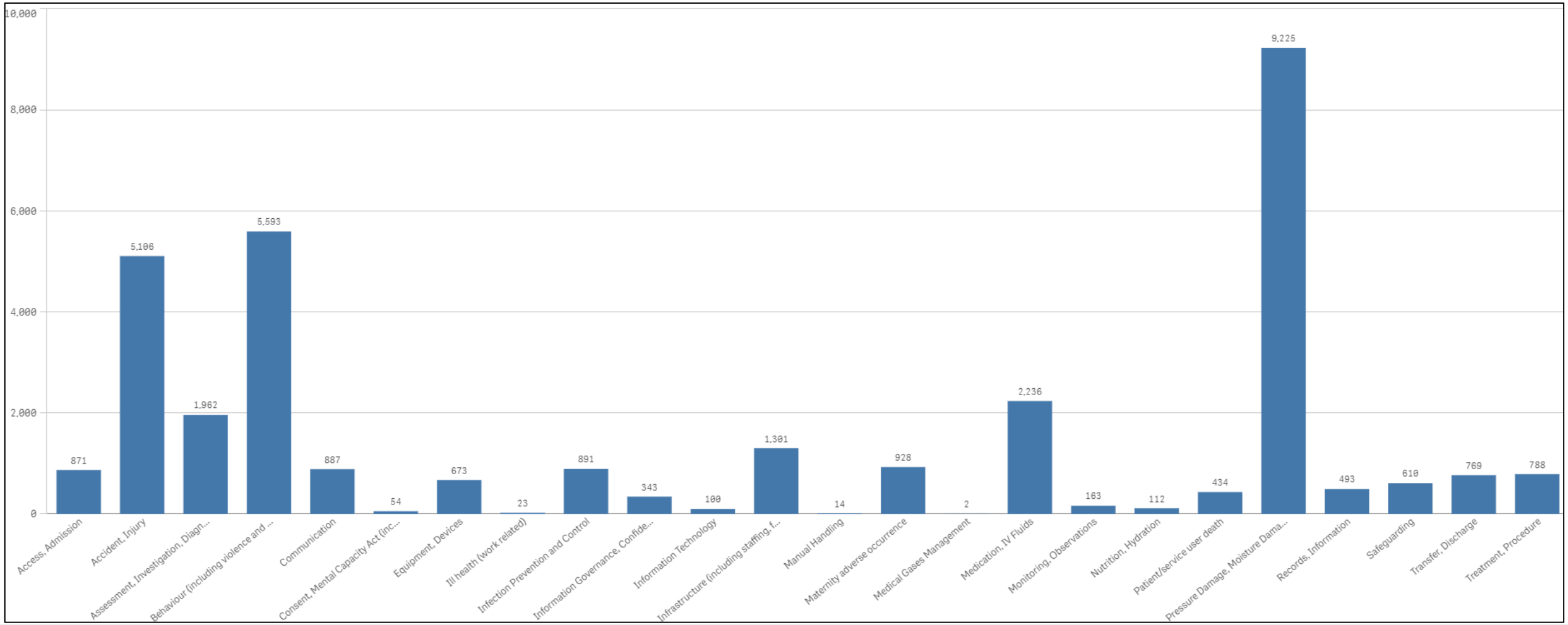
# Datix Incident Status Overview



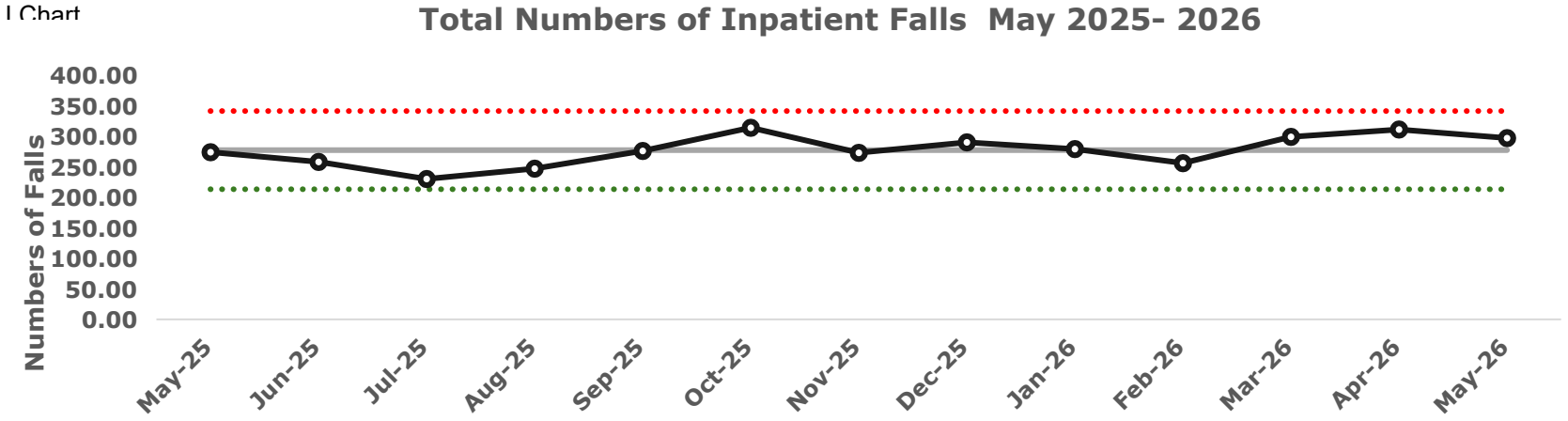

| | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Closed | 3025 | 2626 | 2664 | 2685 | 2771 | 2663 | 2657 | 2425 | 2629 | 2904 | 2841 | 2714 | 2797 | 2335 | 2441 | 2147 | 1489 |
| Awaiting closure | 2 | 5 | 2 | 6 | 12 | 9 | 22 | 24 | 21 | 28 | 20 | 29 | 32 | 41 | 69 | 99 | 107 |
| Management review | 13 | 9 | 16 | 14 | 21 | 22 | 22 | 21 | 37 | 68 | 83 | 76 | 80 | 103 | 152 | 200 | 576 |
| Under Investigation | 4 | 3 | 5 | 5 | 6 | | 1 | 8 | 7 | 9 | 4 | 10 | 16 | 14 | 38 | 36 | 42 |
| New Incident | 7 | 9 | 11 | 12 | 6 | 21 | 19 | 37 | 56 | 63 | 64 | 110 | 125 | 159 | 216 | 276 | 527 |

| Stage No | Status | Definition |
|---|---|---|
| 1 | New Incident | First stage of any incident, it is reported by frontline staff, prior to management review. |
| 2 | Management review / Make is safe | Record awaiting review and "make safe" actions. |
| 3 | Under Investigation | Has undergone management review and initial make safe actions which has indicated further investigation is required. |
| 4 | Awaiting closure | All appropriate actions and investigations have been taken and is awaiting final review |
| 5 | Closed | All actions complete and record is closed. |


# Datix Incident Top 10 Themes over the past 12 months
(Classification of incident regardless of harm)



# Patient Safety Incident -Falls




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 May 2025-2026.

The information is as of the 2nd June 2026

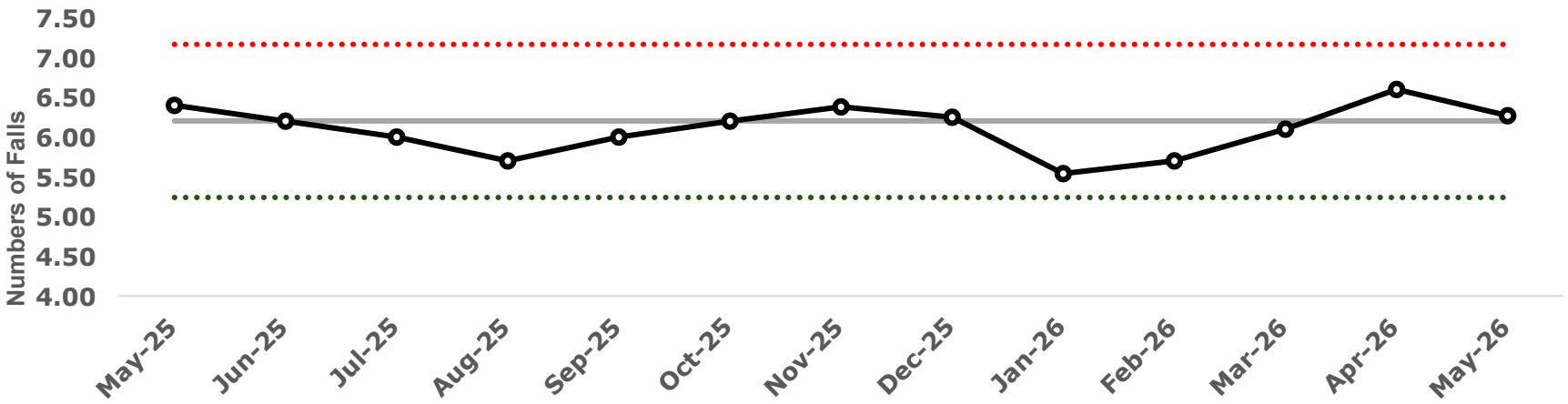
| Definitions | What the chart tells us | Variation |
|---|---|---|
| Reported inpatient fall incidents in Aneurin Bevan University Health Board (ABUHB).<br><br>This data was retrieved from RLDatix as the information source and as available on the Qlik dashboard. | • For the given period of analysis, the mean average value of fall incidents is 277. The second month of Q1 has seen a marginal downwards trajectory.<br><br>• Falls reported incidents decreased from 311 in April 2026 to 297 in May 2026 (4.5%), 14 incidents, 7% above the HB mean average for the given year (277).<br><br>• At the time of reporting under the criteria of Managers' interim measure of harm 73% of incidents for May 2026 were identified as no or low harm 1.35% moderate. At the time of collating that data 24.24% were awaiting a confirmed Managers attributed value of harm.<br><br>• Current data is representative of what may be considered a stable system with predictable variation. Ongoing improvement actions are required to promote a sustained downwards trajectory with reduced variation. | **Q1**<br><br>May 2026 represents the fourth highest value in the 12-month reporting period with a return to a downwards trajectory.<br><br>Given the variation in numbers of falls incidents the control limits and mean average value remain stable with no significant special cause variation demonstrated.<br><br>Values are predominately clustered close to the mean average of 277. |

# Patient Safety Incident -Falls

**Quarter 1 (Q1)**

I Chart

**Average Number of IP Falls per 1000 Occupied Bed Days May 2025-26**

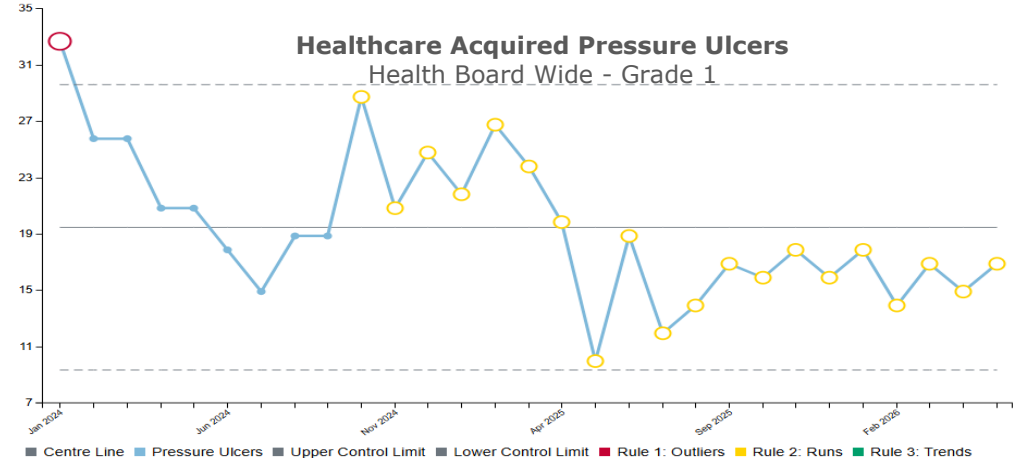


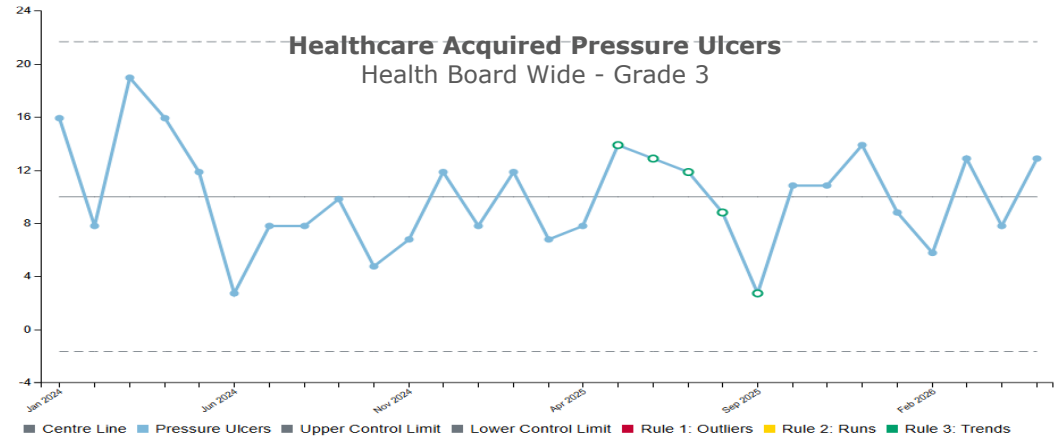

The data used in this chart has been retrieved from RL Datix and refers to the total numbers of reported falls incidents for the period April 2025-26 aligned to ODB's.

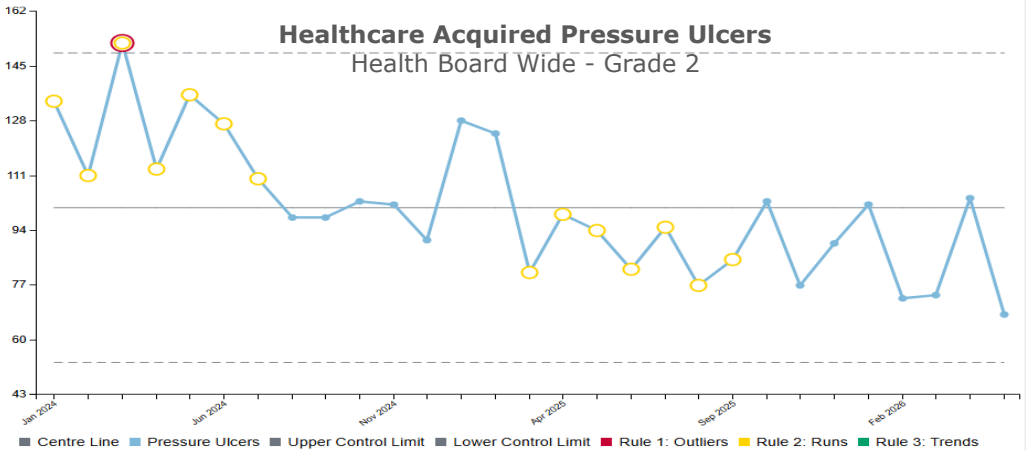
Information as of 2nd June 2026

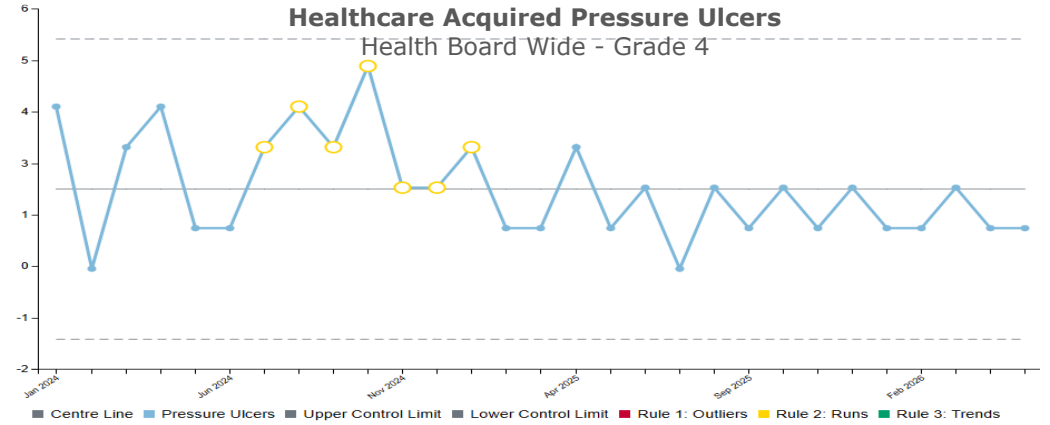
| Definitions | What the chart tells us? | Variation |
|---|---|---|
| Reported inpatient fall incidents in Aneurin Bevan University Health Board (ABUHB).<br><br>This data is retrieved from RLDatix as the information source for reported falls incidents. The data source for ODB 's has been retrieved from the QLIK dashboard.<br><br>Whilst there was a steady upward trend in occupied bed days (OBDs) over the past year, there was a slight dip (a 4.5% reduction) in April 2026 | Q1, May 2026 has see a return to a downwards trajectory in falls per 1,000 occupied bed days (OBDs), with a decrease from 6.60 to 6.27.<br><br>The May 2026 figure returns to a value that is below the national average (6.6) and represents a 5% reduction from April 2026. | The data shows short term fluctuations around the HB mean average value of 6.2 for the period of analysis. Performance is within a clearly defined control limits and is indicative of common cause variation.<br><br>It is representative of steady unchanged performance with no significant statistical evidence of improvement or deterioration shaped by multiple system variations which influence falls. |

# Patient Safety Incident Pressure Ulcers



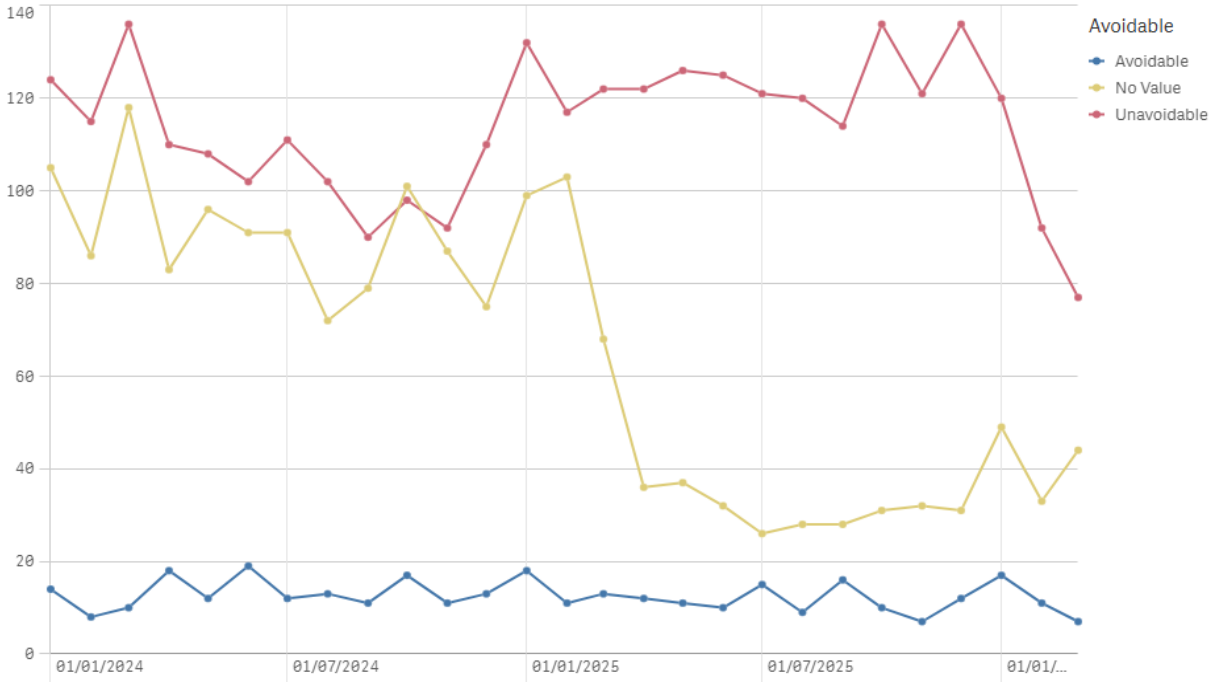



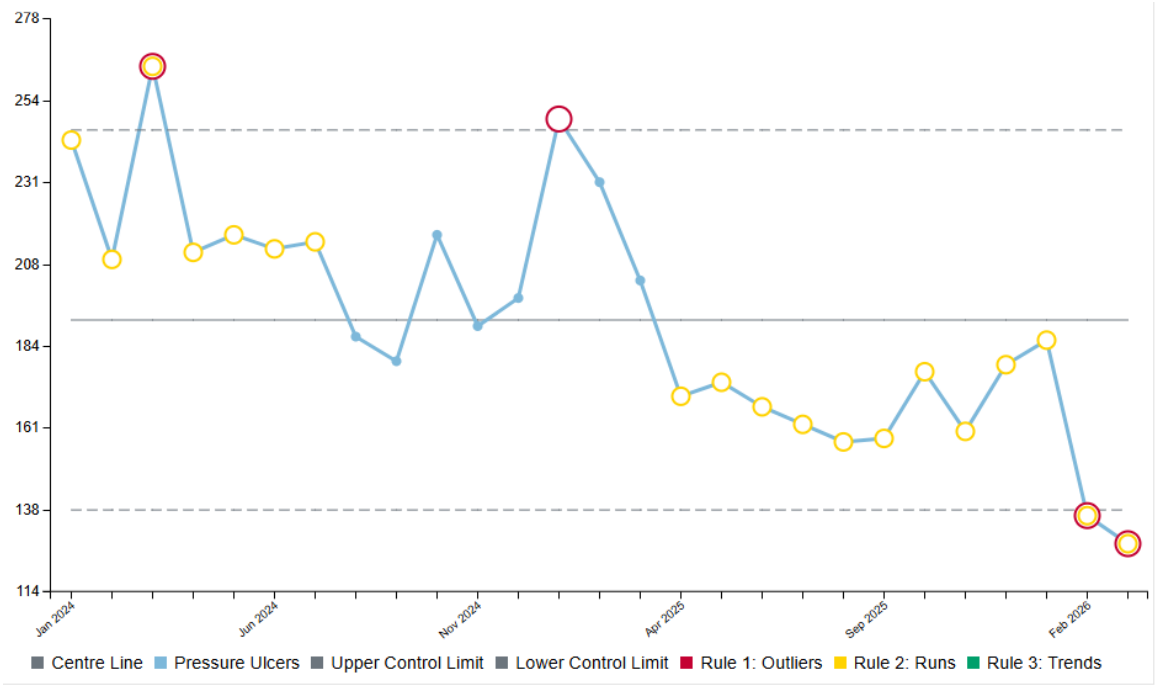




| Definition | Analysis | Implications |
|---|---|---|
| The data included above is extracted from Datix incident module and manipulated through Qlik Sense.<br><br>The date range displayed is from 01 January 2024 to 31 May 2026. | Generally, the number of Healthcare Acquired Pressure Ulcers (HAPUs) have been declining. With 157 HAPUs recorded in May 2026 compared to an average of 194 (since Jan 2024). More than 50% of all HAPUs are grade 2. | In relation to grade 2 pressure ulcers the collaborative will discuss conducting a focussed review to determine the ratio of avoidable and unavoidable grade 2 pressure ulcers.<br>Following this divisions will be asked to consider an improvement piece of work to reduce avoidable pressure damage across all grades of ulcers. |

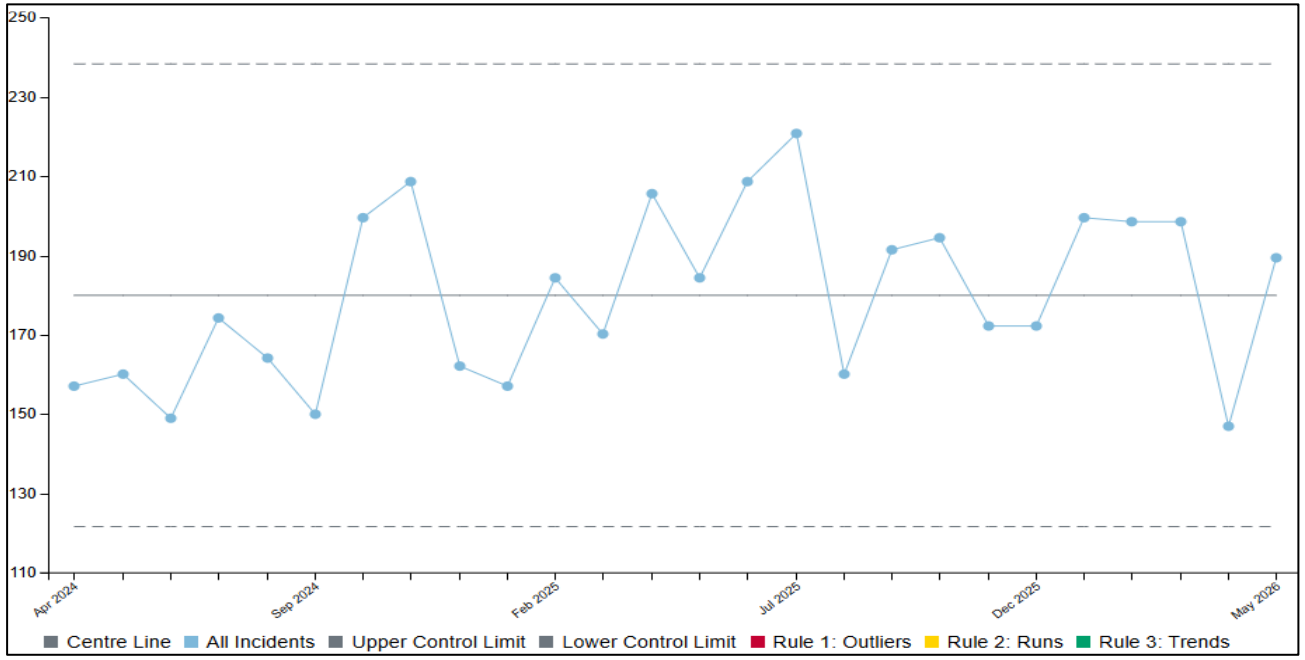
# Patient Safety Incident Pressure Ulcers

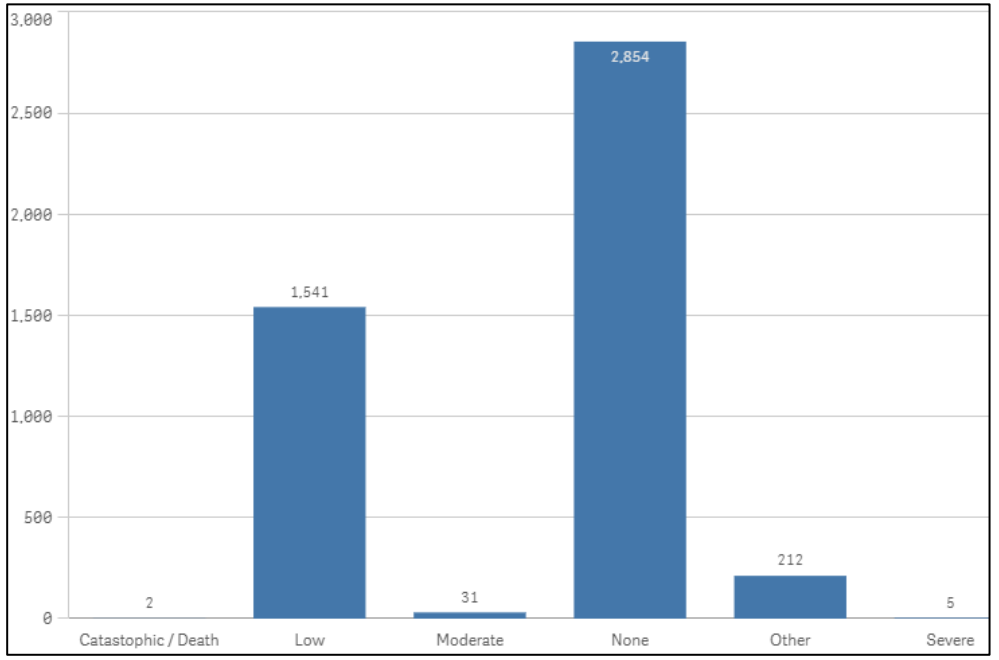



| Definition | Analysis | Implications |
|---|---|---|
| The data included above is extracted from Datix incident module and manipulated through Qlik Sense.<br><br>The date range displayed is from 01 January 2024 to 31 May 2026. | Due to the time taken to investigate and close HAPU Datix incidents the data displayed does not go past 31 March 2026.<br><br>As you can see from graph 2 (showing all closed HAPU incidents) there was a notable drop in the number of HAPU in February and March (this is reflected in the previous slide, most notably in grade 2 HAPUs). This is also seen in graph 1, showing the number of avoidable and unavoidable pressure ulcers dropped in February and March. | To facilitate accurate reporting on the status of pressure damage; avoidable or unavoidable, the collaborative has agreed on an action to improve current compliance. Divisions will aim to close all no value incidents prior to April 2026 by end of August 2026. |

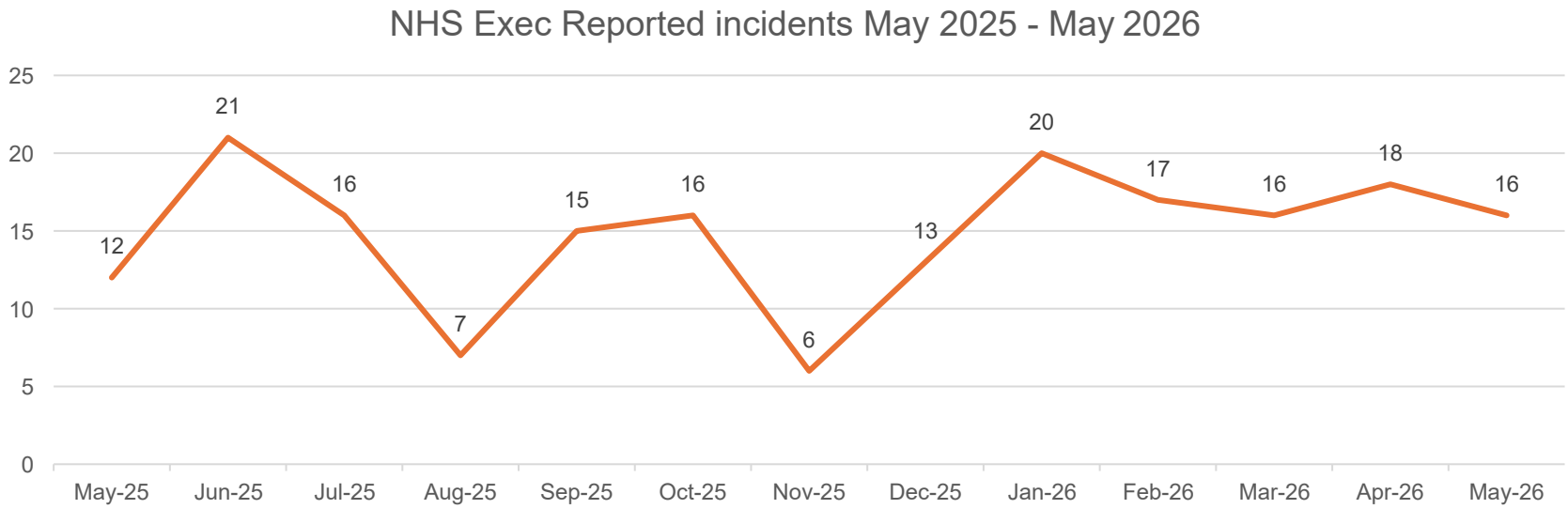

# Patient Safety Incident Medication / IV Fluid Errors




| Definition | Analysis | Implications |
|---|---|---|
| The data displayed is taken from RL Datix via Qlik Sense. It was correct at the point of extraction on 07 June 2026.<br>The SPC Chart (left) shows data from 01 April 2024 to 31 May 2026. The breakdown of harm (post investigation harm assessment) is based on the same time period. | The number of Medication / IV Fluid incidents saw an increase in May 2026, with the overall trend showing a steady increase. 2,022 in 2024/25 and 2,289 in 2025/26.<br><br>So far, this financial year 334 Medication / IV Fluid incidents have been recorded, of which 5 were deemed to have caused moderate harm (post investigation harm assessment) with 84 incidents still under investigation. Four of these incidents occurred at community pharmacies and one was on C4 East. There is a tendency for community pharmacists to grade incidents higher than other areas of the Health Board due to lack of awareness and training on correct processes. | At Quality Management Group on 12 May 2026 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. |

# Patient Safety Incident NRIs, EWNs, Never Events & DoC




## Early Warning Notifications

**11** EWN's were reported during May

## Never Events

No never events reported in May.
An update on the 2025/26 Never Events is included in the appendix.

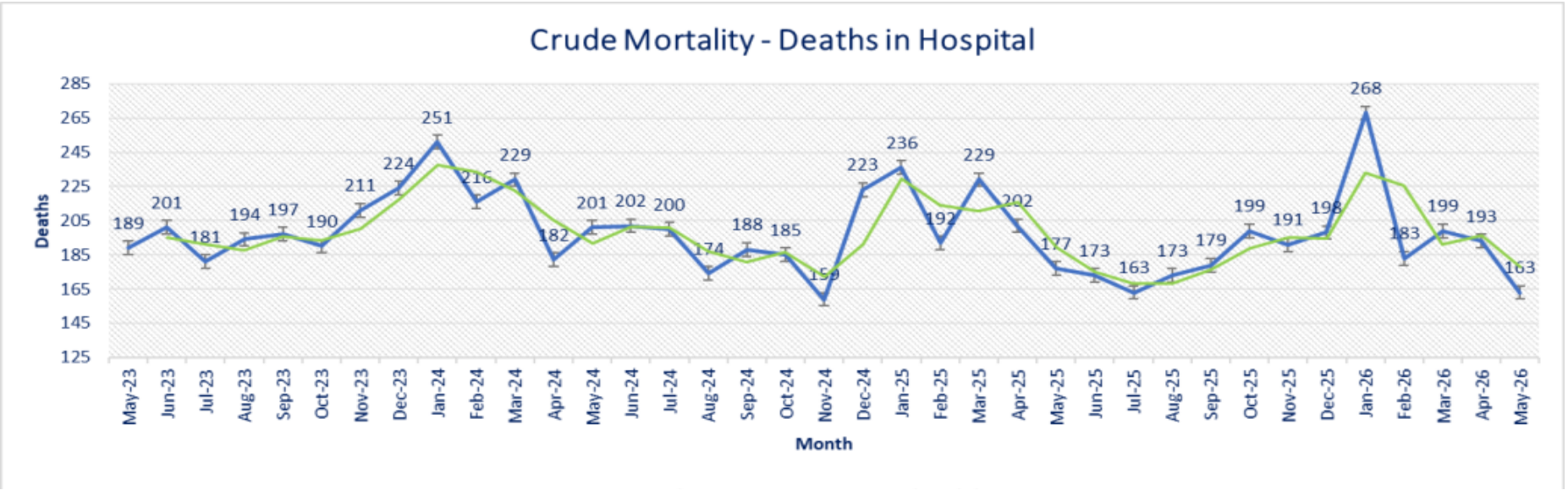
## Duty of Candour (DoC)

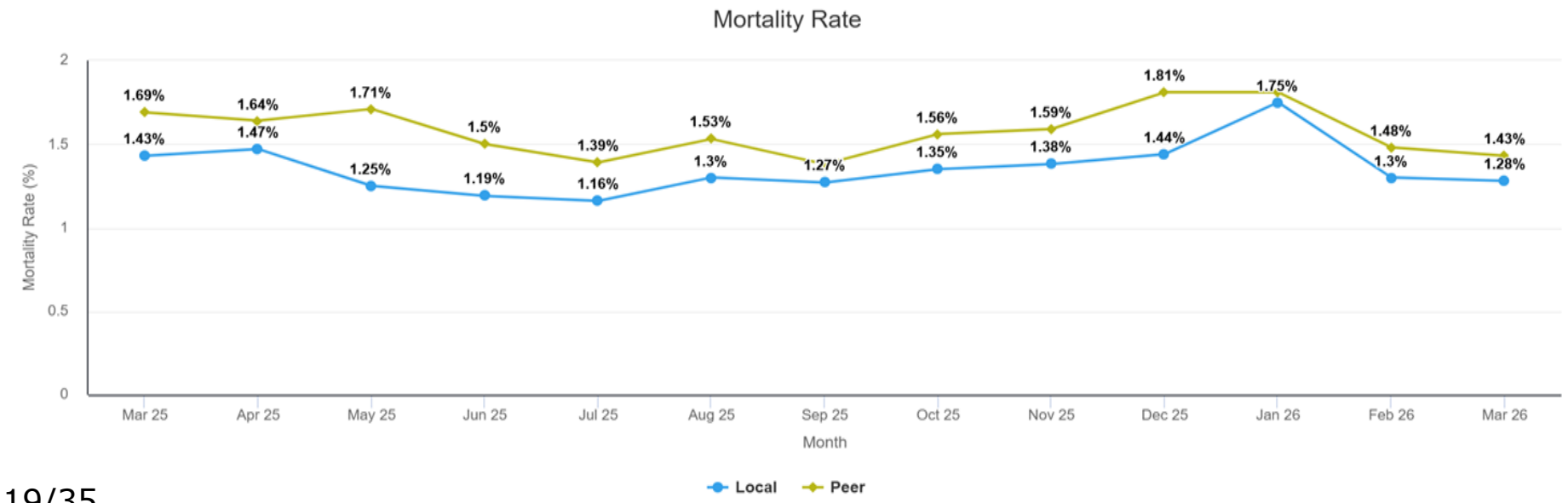
Duty of Candour triggered 3 times in May 2026.

Duty of Candour Incidents are being actively monitored through the new daily incident review meeting. This meet provides Corporate oversight of all potential serious incidents and complaints, it ensures early consideration of Duty of Candour, Redress, evaluates if incidents are potentially reportable and provides escalation of delays in the process.

| Definition | Analysis | Implications |
|---|---|---|
| The information displayed comes from RL Datix and local data held within the Patient Safety Incident Team, it was correct at the time of extraction on 01 June 2026. | At the end of May there were a total of **52** open cases, with **40** number of cases within the compliance window. The number of cases overdue by:<br>6-12 months is 4<br>3-6 months is 3<br>0-3 months is 5<br><br>There were **18** NRI's due for closure in May. **17** of these were closed within time representing a 94% in month compliance. | After considerable dialogue and discussions across Wales a revision to how the Health Board manage maternity and neonatal NRIs has been agreed. Once embedded this will further improve our NRI compliance and no longer require us to wait for PMRT processes to conclude, this is in line with other Health Boards across Wales. |


# Crude Mortality in Hospital



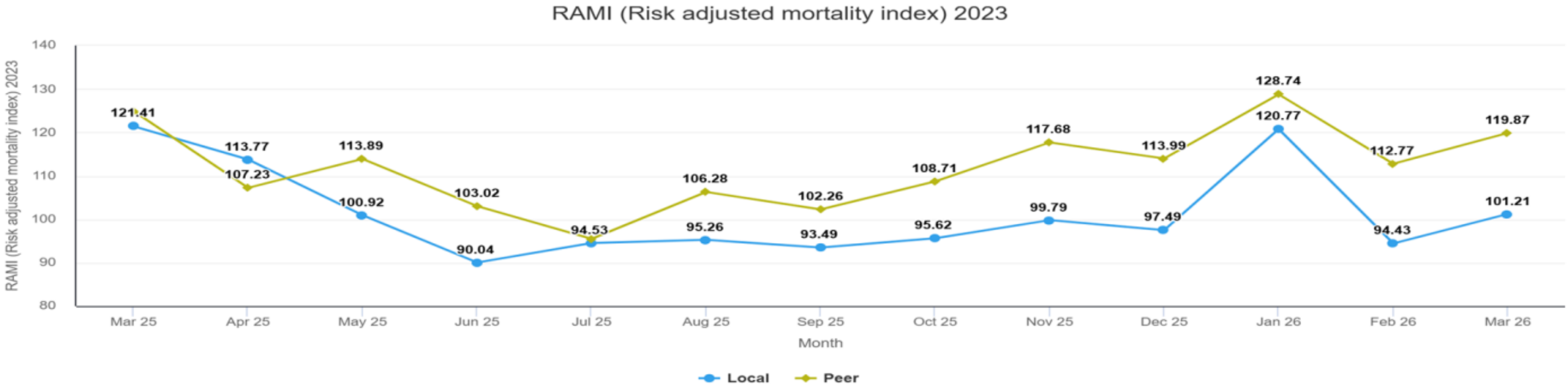




Crude mortality measures the number of deaths in a population over a specific period. It helps understand overall death rates in a community, region, or country by comparing current deaths to the average over the previous three years, identifying trends above or below this average.

Ministerial priorities have included reporting the rolling mortality rate. Mortality rates have remained stable over the past year, with rates at or below 1.5% for 11 out of the last 12 months. Performance has remained in line with the peer group, with the Health Board consistently achieving a comparatively lower mortality rate.

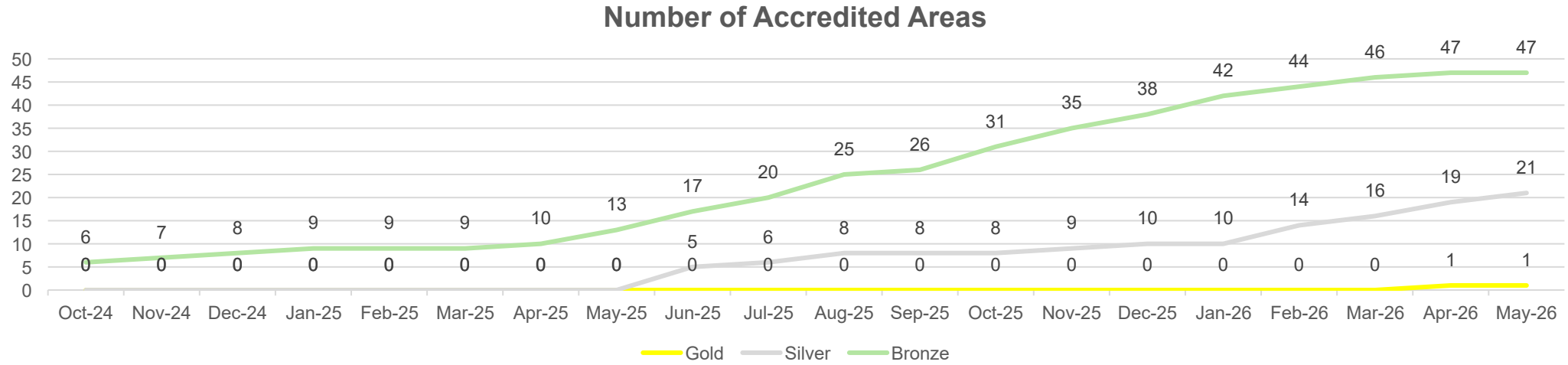
The March 2026 mortality rate of 1.28% is consistent with previously observed seasonal variations, reflecting similar patterns seen during the same period in prior years.
This work will be further developed to include 7-day readmission rates; however, this requires a focused programme of work to ensure a robust understanding, validation, and interpretation of the data.

# RAMI (Risk Adjusted Mortality Index)




- The Health Board's Risk-Adjusted Mortality Index (RAMI) for Q4 was 106.04, ranking 3rd within the All-Wales peer group.
- The recent rebasing of RAMI from the 2019 model to a 2023 baseline reflects CHKS's standard approach to recalibrating the index using more contemporary national hospital activity data. This ensures the benchmark remains centred around the national norm of 100 and aligned with current clinical practice.
- Rebasing is achieved by reconstructing expected mortality norms from updated datasets, enabling the model to reflect changes more accurately in case-mix, coding practices, service delivery, and clinical outcomes. The previous 2019 model was derived entirely from pre-COVID activity and excluded COVID-related mortality, meaning expected mortality estimates were based on a baseline that no longer reflects current post-pandemic patterns of care, admission behaviour, and patient acuity.
- The transition to a 2023 baseline therefore incorporates more recent mortality risks, alongside updated palliative care coding practices and wider system changes, providing a more robust and contemporaneous assessment of relative mortality.

# Ward Accreditation




**AWARDS**

Total to date:

47 Bronze

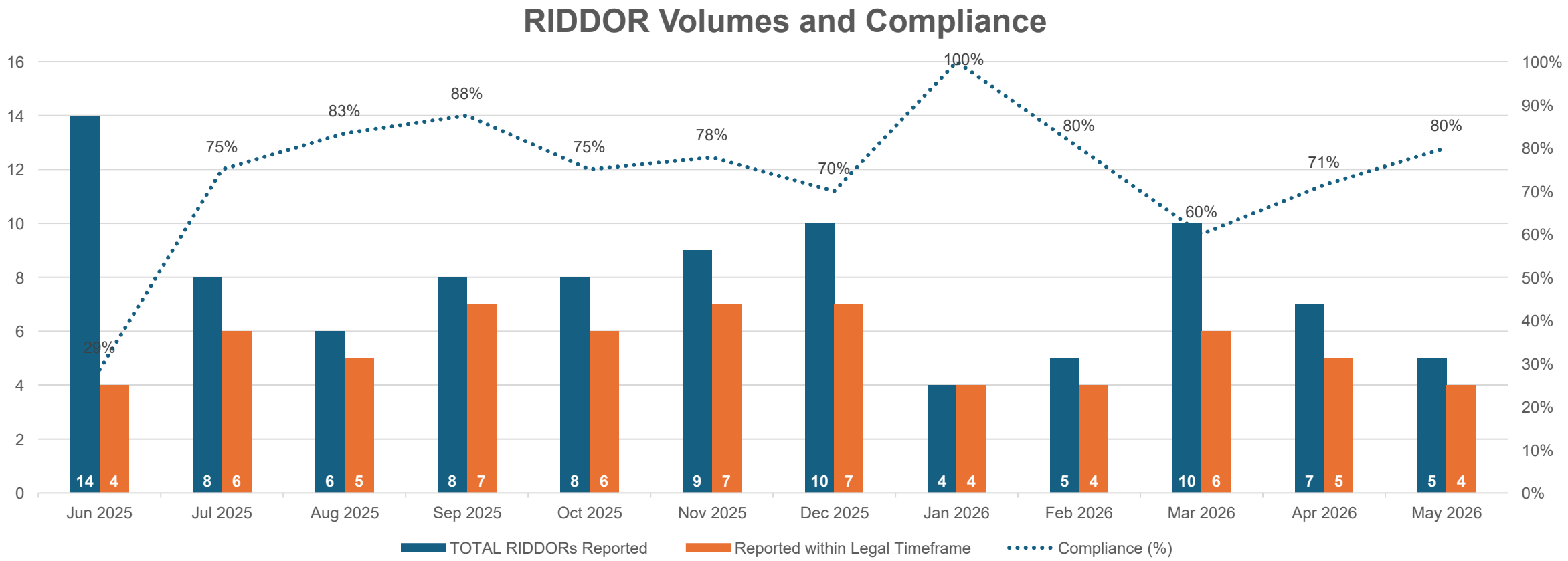
21 Silver

1 Gold

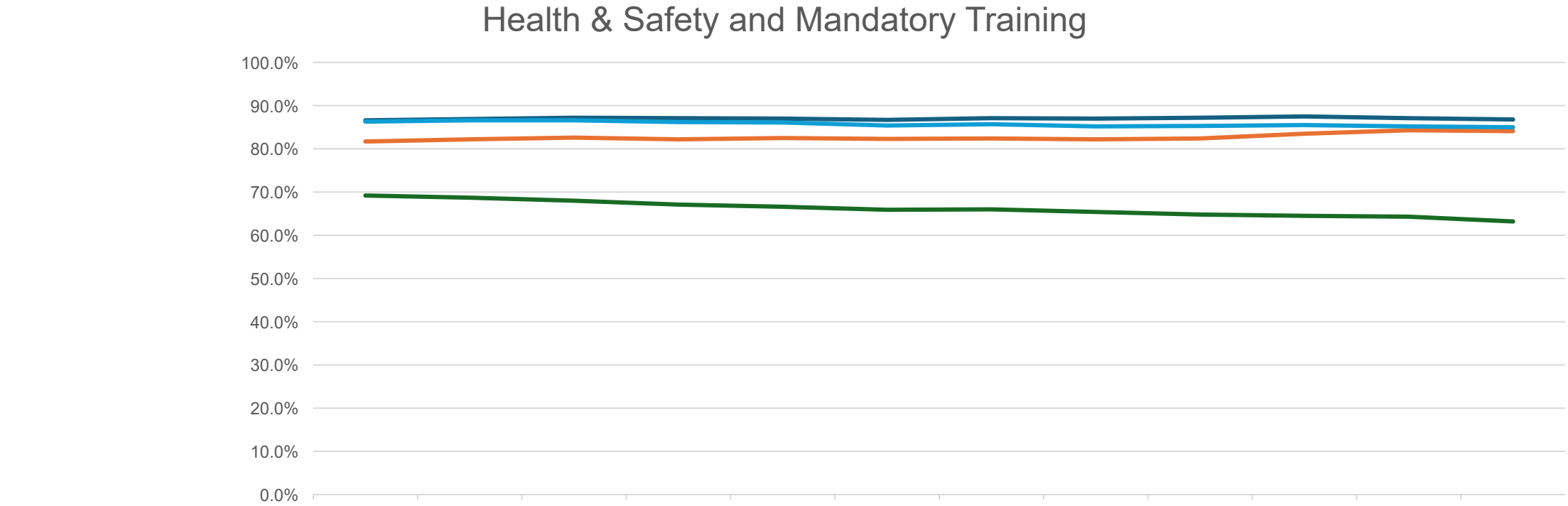
| Definition | Analysis | Implications |
|---|---|---|
| This graph displays a rolling trend from implementation to April 2026, highlighting steady growth in areas accredited by status.<br><br>Data has been collated and presented based on the results of accreditation award panels, carried out by corporate and executive nursing teams. | May 2026 saw a community ward and outpatient clinic achieve silver accreditation.<br><br>One area had a silver peer review deferred to improve IPAC standards. | Audit assurance has been strengthened through the introduction of a thematic approach to audit design and delivery.<br><br>The Nutrition and Hydration audit was successfully launched in May and will undergo validation by Dietetics, further enhancing governance and assurance within the framework.<br><br>Additional thematic audits are planned to support continuous improvement and oversight. |


# Health and Safety
## RIDDOR

During May 2026, the Health Board reported 5 incidents to the HSE to comply with RIDDOR



# Health and Safety




| | Jun 2025 | Jul 2025 | Aug 2025 | Sep 2025 | Oct 2025 | Nov 2025 | Dec 2025 | Jan 2026 | Feb 2026 | Mar 2026 | Apr 2026 | May 2026 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Health and Safety | 86.6% | 86.9% | 87.2% | 87.1% | 87.0% | 86.7% | 87.1% | 87.0% | 87.2% | 87.5% | 87.1% | 86.8% |
| Fire Safety | 81.7% | 82.2% | 82.6% | 82.2% | 82.5% | 82.3% | 82.4% | 82.2% | 82.4% | 83.5% | 84.3% | 84.1% |
| Manual Handling | 69.2% | 68.7% | 68.0% | 67.1% | 66.6% | 65.9% | 66.0% | 65.4% | 64.8% | 64.5% | 64.3% | 63.2% |
| Violence Prevention & Reduction | 86.3% | 86.6% | 86.6% | 86.2% | 86.1% | 85.4% | 85.7% | 85.2% | 85.3% | 85.5% | 85.2% | 85.0% |

# Infection Prevention and Control

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

## All Wales – Current FY count of specimens (May)

| | C. difficile | MRSA bacteraemia | MSSA bacteraemia | E. coli bacteraemia | Klebsiella sp bacteraemia | P. aeruginosa bacteraemia |
|---|---|---|---|---|---|---|
| Aneurin Bevan UHB | 33 | 5 | 32 | 53 | 19 | 5 |
| Betsi Cadwaladr UHB | 44 | 1 | 43 | 81 | 20 | 5 |
| Cardiff and Vale UHB | 26 | 4 | 22 | 50 | 15 | 5 |
| Cwm Taf Morgannwg UHB | 28 | 1 | 16 | 45 | 16 | 5 |
| Hywel Dda UHB | 30 | 2 | 22 | 57 | 12 | 1 |
| Powys THB | 3 | 0 | 0 | 0 | 0 | 0 |
| Swansea Bay UHB | 50 | 3 | 10 | 38 | 24 | 5 |
| Velindre NHST | 1 | 0 | 1 | 1 | 1 | 0 |
| Wales | 215 | 16 | 146 | 325 | 107 | 26 |

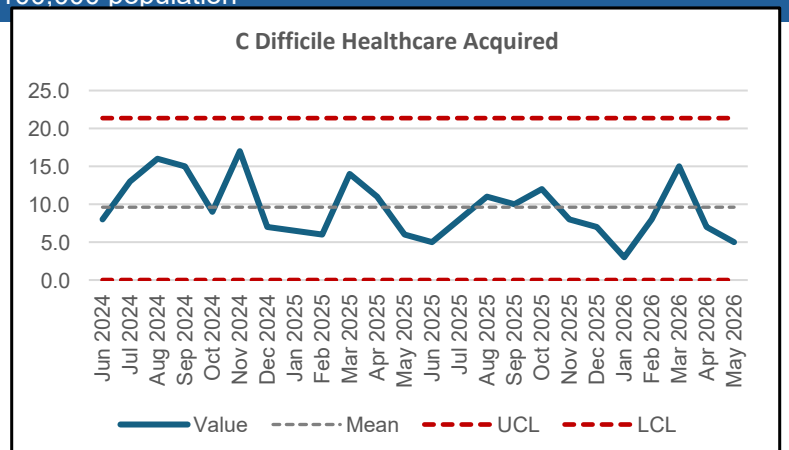
## All Wales – Current FY rate per 100,000 population (May)

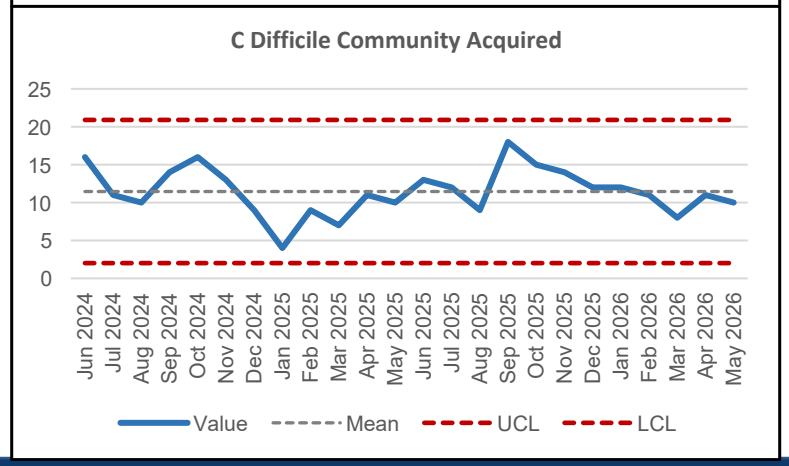
| | C. difficile | MRSA bacteraemia | MSSA bacteraemia | E. coli bacteraemia | Klebsiella sp bacteraemia | P. aeruginosa bacteraemia |
|---|---|---|---|---|---|---|
| Aneurin Bevan UHB | 32.82 | 4.97 | 31.82 | 52.71 | 18.89 | 4.97 |
| Betsi Cadwaladr UHB | 37.77 | 0.86 | 36.91 | 69.53 | 17.17 | 4.29 |
| Cardiff and Vale UHB | 29.94 | 4.61 | 25.33 | 57.57 | 17.27 | 5.76 |
| Cwm Taf Morgannwg UHB | 37.29 | 1.33 | 21.31 | 59.92 | 21.31 | 6.66 |
| Hywel Dda UHB | 46.13 | 3.08 | 33.83 | 87.64 | 18.45 | 1.54 |
| Powys THB | 13.29 | 0 | 0 | 0 | 0 | 0 |
| Swansea Bay UHB | 75.83 | 4.55 | 15.17 | 57.63 | 36.4 | 7.58 |
| Velindre NHST | | | | | | |
| Wales | 40.37 | 3 | 27.42 | 61.03 | 20.09 | 4.88 |

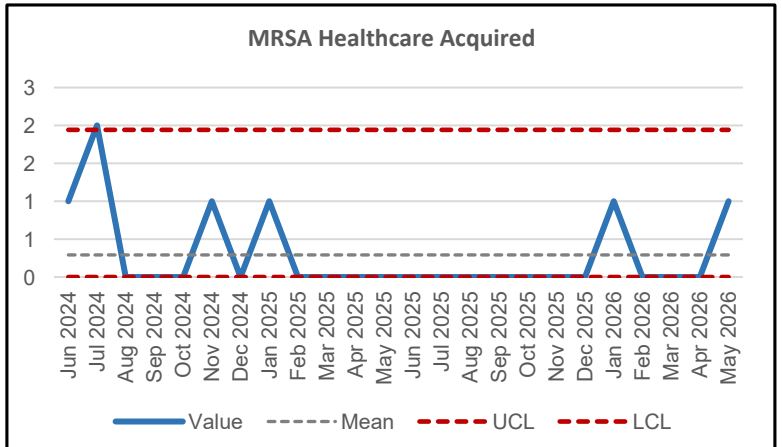

# Infection Prevention and Control

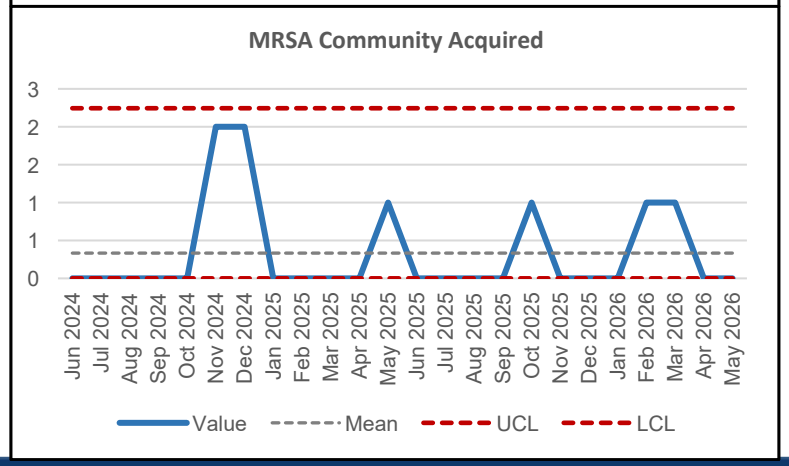
33 cases of C difficile reported from April 2026 to May 2026. This is 5 less than the equivalent period 2025/26. This is a HB rate of 32.82 per 100,000 population

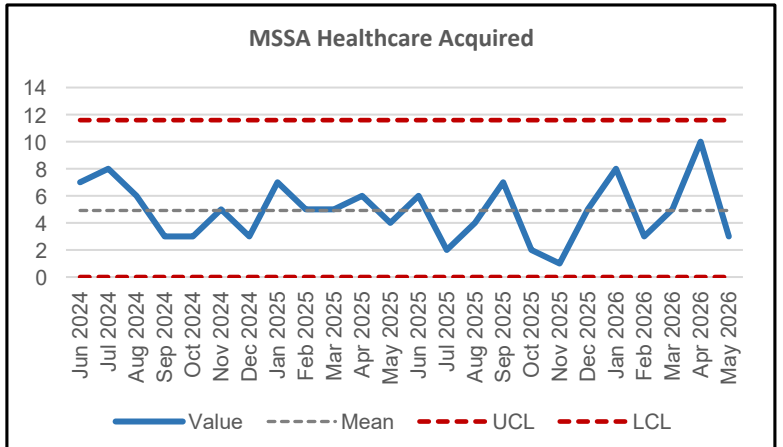
37 cases of Staph Aureus BSI reported from April 2026 to May 2026. This is 9 more than the equivalent period 2025/26. This is a HB rate of 36.80 per 100,000 population

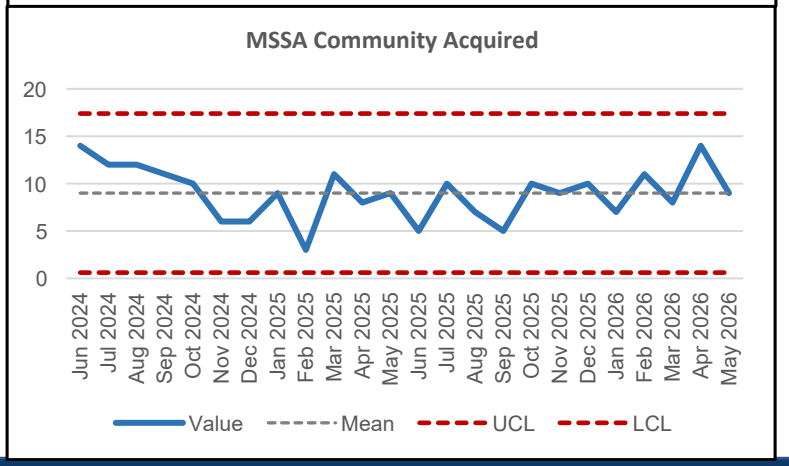


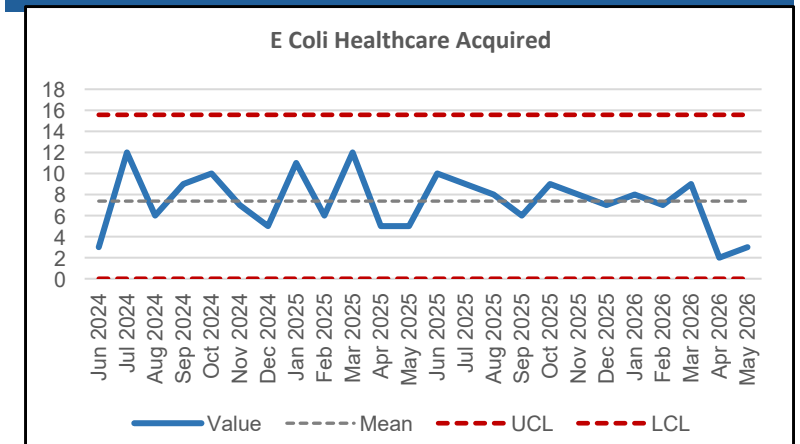



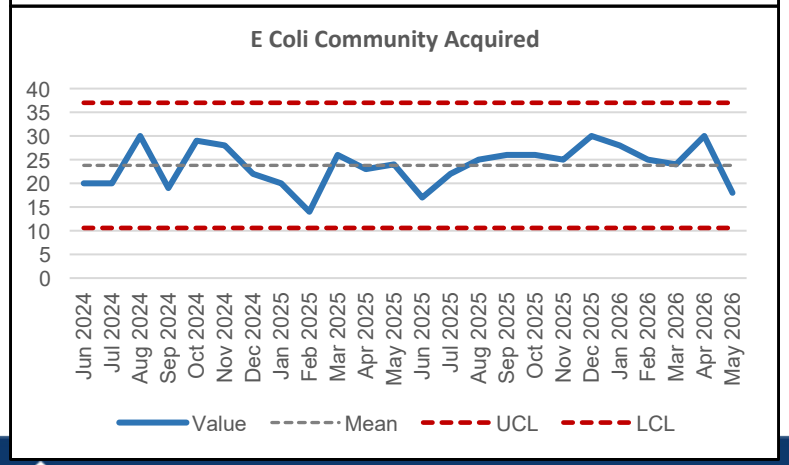



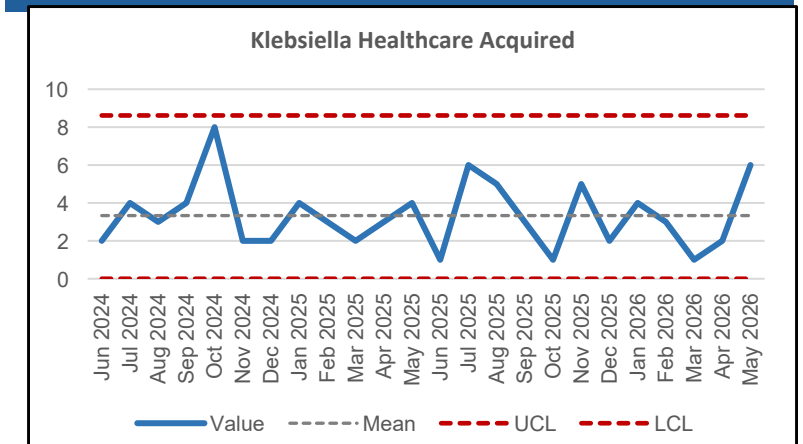

# Infection Prevention and Control

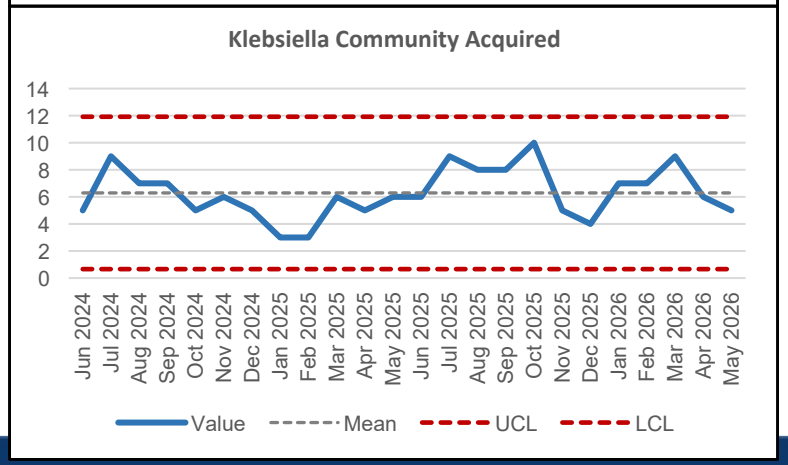
53 cases of E coli BSI reported from April 2026 to May 2026. This is 4 less than the equivalent period 2025/26. This is a HB rate of 52.71 per 100,000 population



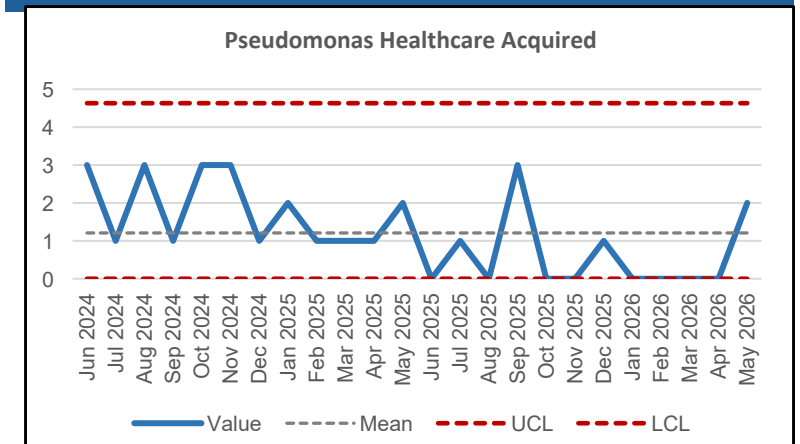



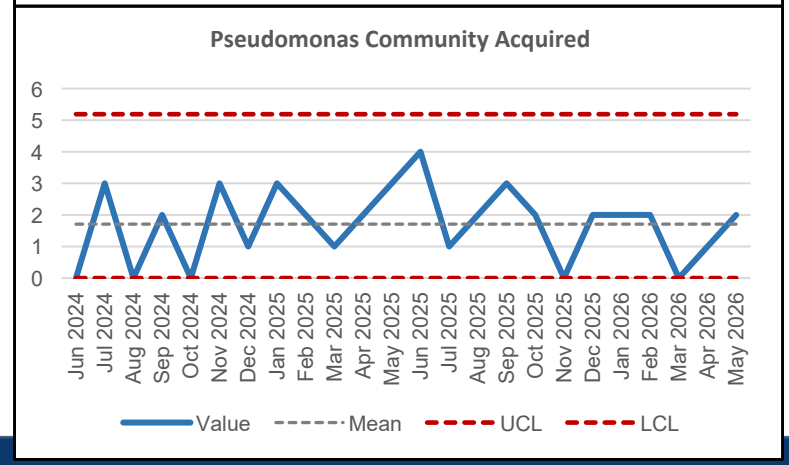

19 cases of Klebsiella BSI reported from April 2026 to May 2026. This is 1 more than the equivalent period 2025/26. This is a HB rate of 18.89 per 100,000




4 cases of Pseudomonas BSI reported from April 2026 to May 2026. This is 3 less than the equivalent period 2025/26. This is a HB rate of 4.97 per 100,000



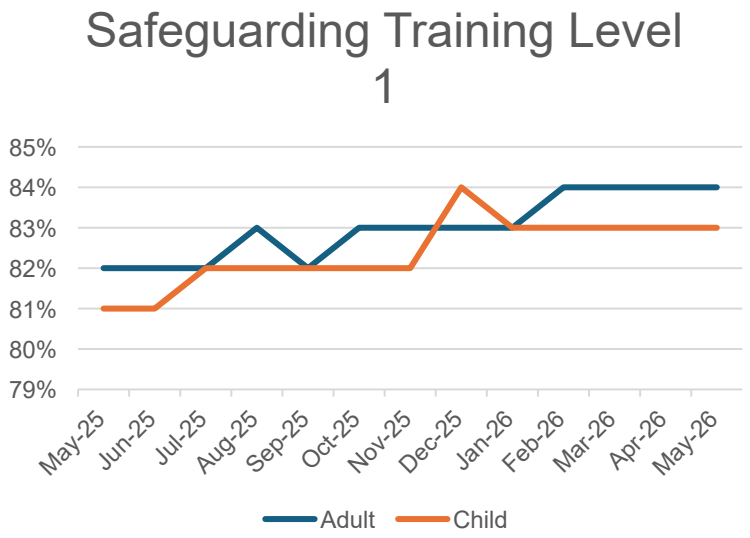

# Infection Prevention and Control

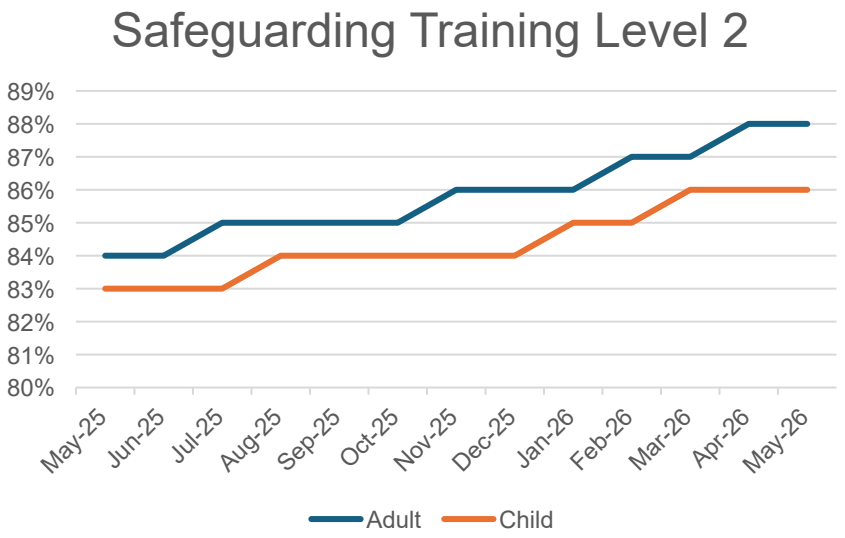
| Themes & Trends | Successes | Challenges | Learning & Improvement |
|---|---|---|---|
| **C difficile**<br>15 cases identified in May, April and May data combined equates is 5 less than the equivalent period 2025/26. | Enhanced proactive cleaning started on some of our ELGH and GUH<br><br>No clusters identified with geno sequencing link | Timely isolation at community ward within RGH due to enhanced care<br><br>Ongoing vacancies and sickness within facilities team<br><br>Capacity to allow for full ward decant cleans | Checking of mattress and decontamination of near patient equipment<br><br>C5E ward HPV cleaned in response to PII<br><br>Sample collection not required to look for clearance |
| **Staph Aureus blood stream infections (MRSA/MSSA)**<br><br>13 cases reported for May which includes 2 MRSA<br>8 patients identified linked to community 5 linked to hospital acquired | Erase developed for the cleaning of patient skin prior to venepunture<br><br>Engagement from 2 medical wards to start QI for line care currently in the process of scoping staff knowledge<br><br>ANTT paper developed with a recommendation to re establish ANTT working group. Divisional data included in May dashboard | 1 HAI MRSA linked to administration of insulin<br>1 CAI MRSA linked to community acquired pneumonia<br><br>Recall of skin prep products for cannulation<br><br>ESR job profiles not linked to ANTT competency requirement making reporting re ANTT compliance difficult. | Cleaning of skin prior to venepunture not robust across the HB<br><br>Divisions supporting the ANTT working group to review training compliance and observational audits re practice<br><br>Assurance gained care packs are promoted within all TVS training, and the importance of wound hygiene etc. TVN team reviewing patient information leaflet to support best practice |
| **Gram Negative blood stream infections**<br><br>Yearly comparison4 less E coli,<br>1 more Klebsiella, 3<br>less pseudomonas reported than previous year | Paper developed for E coli largest source urinary tract infection<br>Currently lowest rate in Wales for E coli | Welsh Nursing records do not reflect all the HOUNIDI care bundle | Urine samples rejected within lab due to wrong container – correct sample pot promoted to support focusing of treatment plan |

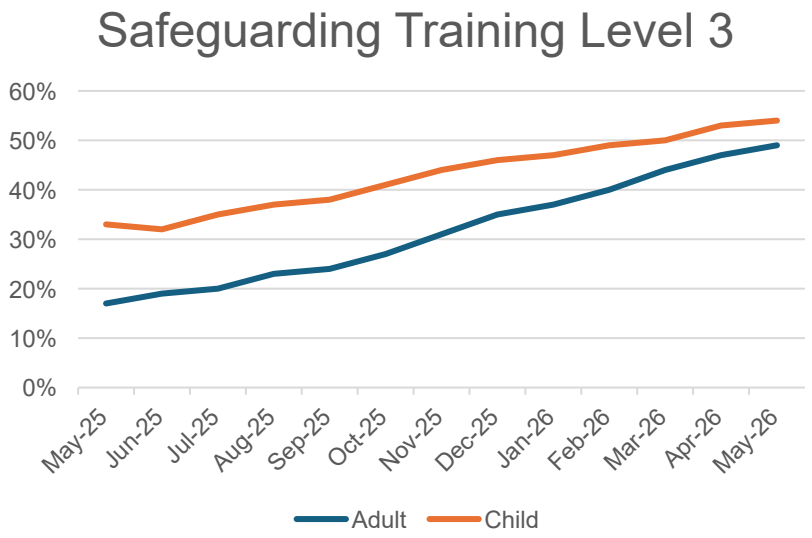

# Infection Prevention and Control Incidents

| Themes & Trends | Successes | Challenges | Learning & Improvement |
|---|---|---|---|
| **CPE - Contact tracing**<br>Patient admitted with Right #NOF and patient is from outside the area | Quick identification of contacts 12 patients<br><br>No onward transmission to date | Missed admission screen<br><br>The screen on the 07 May was taken following a request by receiving hospital for transfer, | Assessment on admission for previous hospital admissions within the last 12 months |
| **Shingles – P**atient identified positive post 14 days from staff exposure on initial assessment gave a positive history of chicken pox | Not aware of any onward transmission from patient to patient<br><br>Staff referred to Occupational Health for follow up (28) | Enhanced care patient until to obtain an accurate history of chicken pox | Delay in diagnosis due to sample not labelled correctly and rejected by lab |
| **Sabies**<br>3 cases of confirmed Scabies in Residents<br>The 1st case identified had a rash when they moved to the home in Jan / Feb of this year<br>2nd case rash identified around 01/05/2026, GP diagnosed scabies with Dermatoscope<br>3rd case rash onset 02/05/2026, GP diagnosed scabies with Dermatoscope. | No staff cases identified yet under ongoing observation<br>All staff contacts to seek treatment via Common Ailment Service (CAS) | Long incubation period<br><br>Request that family / visitor contacts confirm whether or not they have symptoms | Quick identification from Care home manager and GP support |


# Safeguarding Training



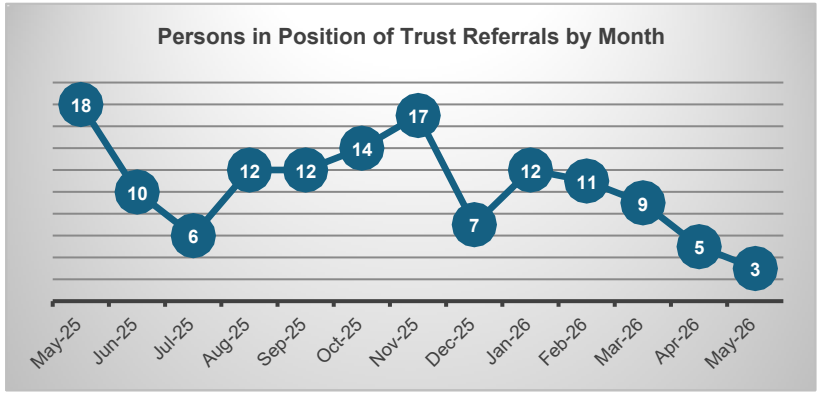



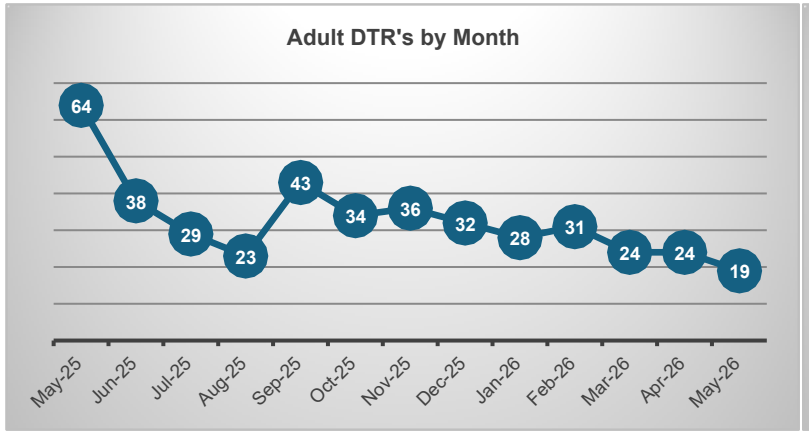

| Definition | Analysis | Implications |
|---|---|---|
| The attached data is sourced from the ESR and represents the workforce compliance with mandatory safeguarding training | Compliance with Level 1 and 2 is at or close to the 85% target.<br><br>Thirteen months into a three year implementation programme, this data highlights that the current training offer is meeting the demand for training to achieve 85% compliance by April 2028 | Encouragement is needed throughout the Health Board to increase compliance with statutory and mandatory training<br><br>The loss of non recurrent funding at the end of 2025/26 means that continued provision of the required level of training is a challenge to the Corporate Safeguarding Team, but should be achieved from within existing funding this financial year |

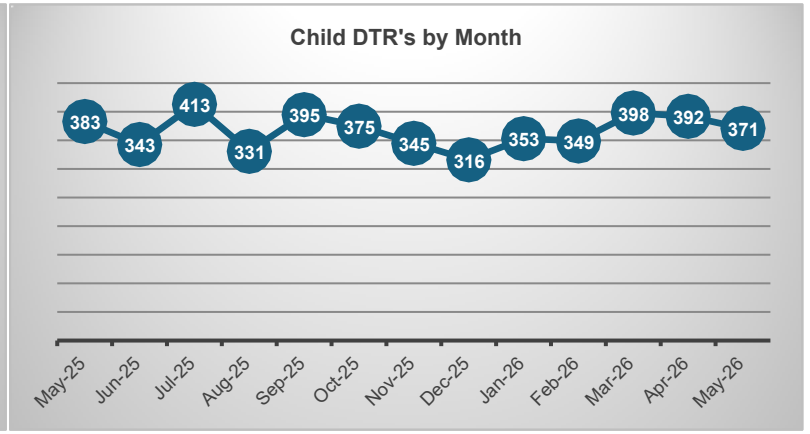
# Safeguarding Activity

## Practitioner Concerns

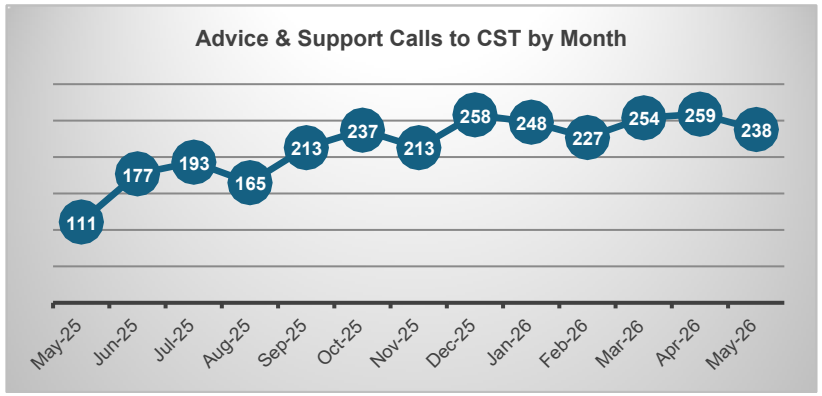



## Duty to Report (Adult and Children)




## Advice & Support




| Definition | Analysis | Implications |
|---|---|---|
| Data from the Datix Safeguarding Module showing volumes of People in Position of Trust (PiPoT) referrals and practitioner requests for specialist advice. | Activity data only, with no direct conclusions.<br><br>Shows increased staff concerns about safety, reflecting professional curiosity rather than increased risk from Health Board activity. | Increased demand for advice and support is resource intensive for a small specialist team. |
| Data from the Datix Safeguarding Module showing volumes of Duty to Report (DTR) referrals for Children and Adults. | Adult reports have reduced due to improved staff awareness and effective pre-screening, with only essential referrals submitted.<br><br>Minor variation in child DTR is not unexpected | Referrals are more appropriate and higher quality.<br><br>Statutory duties continue to be met when risk is identified. |


# Appendices

**Appendix 1:** Timeline & Implementation plan for the Qlik App (PQSOC 0605/05)

**Appendix 2:** 2025/26 Quarter 4 Never Events Update (PQSOC0206/07)

**Appendix 3:** Infection Prevention and Control Reporting and Monitoring (PQSOC0206/07)

**Appendix 4:** Civica Survey Responses in Relation to Pain (PQSOC0206/07)

GIG CYMRU NHS WALES | Aneurin Bevan University Health Board

# Qlik QPS App Roll-out

## Building a consistent quality intelligence route from operational data to Executive, Committee and Board assurance

QPS = Quality and Patient Safety | QOF = Quality Outcomes Framework

Maturing quality intelligence

**BEFORE**

Manual and retrospective reporting across multiple systems

Qlik QPS Update SBAR

**NOW** → **NEXT**

### 1 Data foundation

- Datix data feed
- Data Warehouse
- QPS and QOF apps refreshed

Feed reliability

### 2 Phase one live

- 2 February 2026
- Feedback and complaints
- Falls, pressure ulcers, medication incidents

### 3 Corporate reporting

- Executive quality reporting
- QOF and QMG
- PQSOC and Board

In use

### 4 Next phase

- End July 2026 indicative
- Mortality, RAMI and Duty of Candour
- Falls and incidents per occupied bed days

Validation required

### 5 Integrated intelligence

- End October 2026 indicative
- Civica, AMaT and WNCR
- Triangulation and learning

Operational systems → Data Warehouse → Qlik Sense® → Corporate reports and dashboards → Executive, Committee and Board assurance

**Assurance enablers**

- **Reliable data feeds** — Timely, complete and accurate data flows
- **Validated definitions** — Clear data rules and consistent measures
- **SPC interpretation** — Understanding variation, trends and improvement
- **QPS and DDaT collaboration** — Partnering to deliver, assure and improve

QPS + DDaT — Working together for quality intelligence

**One consistent data model supports clearer quality oversight, trend analysis and ward to Board assurance.**

Progress is substantial, but assurance remains dependent on reliable feeds, validation, clear definitions and careful interpretation.

GIG CYMRU NHS WALES | Aneurin Bevan University Health Board

# Quarter 4 2025/26 Never Events Overview

## Reporting, investigation, immediate action and organisational learning

### Three Never Events reported in Quarter 4 2025/26

Each incident has been reported, investigated and subject to Duty of Candour, with immediate risk reduction actions implemented and further assurance continuing through governance routes.

### 1 Procedure consent incident

- Additional procedure not documented in consent
- WHO checklist reliability
- Consent verification and team challenge

### 2 Oxygen connected to air outlet

- Incorrect wall-mounted gas outlet
- Delayed recognition and reporting
- Environmental controls and escalation

### 3 Wrong side interventional procedure

- Incorrect side procedure
- Stop Before You Block
- Enhanced site verification

2025/26 Q4 Never Events

### Shared learning themes

- Consent and documentation
- Reliable safety checks
- Communication and speaking up
- Escalation of uncertainty
- Timely incident reporting
- Environmental safeguards

### Assurance and action pathway

Reporting and investigation → Duty of Candour → Immediate risk reduction → Governance oversight → Sustained improvement monitoring

### Governance and escalation route (ward to board)

Divisional governance → Specialist groups → Quality Management Group → Executive safety reporting → PQSOC oversight

**Immediate actions have reduced ongoing risk; longer-term assurance will be monitored through action completion, effectiveness testing and established governance routes.**

GIG CYMRU NHS WALES

Aneurin Bevan University Health Board

# Ward to Board IPAC Assurance

## Oversight, monitoring and reporting of Infection Prevention and Control

Layered assurance

Real-time surveillance, divisional reporting and organisational governance provide layered oversight of infection prevention risks, trends, actions and improvement.

Escalation of concerns, risks and issues

### 1 Ward and Clinical Area Monitoring

- Ward level monitoring
- Audit and practice review
- Outbreaks, clusters and ward reviews
- Local action and learning

### 2 ICNET Surveillance and IP Team Review

- ICNET surveillance
- Laboratory result monitoring
- Infection Prevention Team review
- Actions, mitigations and escalation

### 3 Monthly Divisional Assurance Reporting

- Ward level infection breakdown
- Audit and training compliance
- Running annual totals and trends
- Welsh Government reduction goals

### 4 IPAS and QMG Governance

- IPAS oversight
- Risk and issues logs
- Improvement plans
- QMG assurance

### 5 Executive Reporting and PQSOC Assurance

- Executive Quality Performance Report
- Integrated Performance Report
- Quality Outcomes Framework
- PQSOC assurance

Early detection | Review and analysis | Action and mitigation | Escalation and oversight | Improvement and learning

**Layered monitoring, reporting and escalation provide organisational oversight of IPAC risks, trends, actions and improvement.**

GIG CYMRU NHS WALES | Aneurin Bevan University Health Board

# CIVICA Patient Feedback: Pain Management

## What patients are telling us about pain, responsiveness and experience

**Pain is a recurring feedback theme, with a March 2026 increase followed by reduction in April**

Feedback suggests that patient experience is shaped by responsiveness to pain, communication, waiting, environment and pathway pressures.

### 1 What changed

- Recurring pain theme
- March 2026 increase
- Fluctuation, not sustained trend

### 2 Care delivery

- Pain not managed promptly
- Delays in analgesia or review
- Discharge while still in pain

### 3 Communication and reassurance

- Patients not feeling listened to
- Limited updates while waiting
- Unclear pain management plans

### 4 Environment and pathway pressures

- Waiting while in pain
- Uncomfortable environment
- Urgent care pathways most visible

CIVICA Pain SBAR

**Key insight**

**Pain alone does not appear to drive poorer experience; the preceived response to pain is central.**

Pain experience → Responsiveness (timely response) → Communication and reassurance → Environment and waiting → Overall patient experience

### From feedback to improvement

**Patient feedback** — People's Experience Survey (PES) →
**Theme review** — CIVICA analysis →
**Patient experience insight** — Context and themes →
**Triangulation** — Complaints, workforce, operational and other data →
**Improvement discussion** — Action planning and next steps

**Overall experience remains positive Health Board wide, but pain feedback highlights opportunities for learning and improvement.**

**Further exploration required**
Areas for further exploration

### Next focus

- Responsiveness during pressure
- Pain communication and reassurance
- Waiting environment
- Service criteria and signposting
- Triangulation with complaints, workforce and operational data

**Pain related feedback is a signal for learning: improvement should focus on timely response, clear communication, reassurance and pathway experience.**

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

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 28 July 2026 |
| **CYFARFOD O:**<br>**MEETING OF:** | Patient Quality, Safety and Outcomes Committee |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Covering Report – QMG Highlight Report |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Jennifer Winslade (Executive Director of Nursing) |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Kye Smith |

**Pwrpas yr Adroddiad**
**Purpose of the Report**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA**
**SBAR REPORT**

**Sefyllfa / Situation**

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

The Quality Management Group is a formal sub-group of the Executive Committee and is required to provide regular, structured assurance to PQSOC on whether effective systems are in place to keep patients safe, learn from harm, and improve care quality across the organisation. This report covers the QMG meeting held on 08 July 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 Group was able to recognise clear progress in the development of quality governance arrangements, including stronger line of sight from divisional and specialist group assurance into executive and committee oversight. However, the key issue for Executive Committee and PQSOC is that the governance system is still maturing, and several areas continue to require stronger evidence of delivery, clearer improvement trajectories and more robust triangulation between risk, incidents, complaints, audit, outcomes and patient experience.

The HSDU and theatre instrument traceability was escalated to the meeting. QMG was advised that issues in end to end patient and instrument traceability remain an organisational risk, following findings from the HSDU incident investigation. A multi divisional task and finish group is in place, costs have been obtained, an SBAR is being prepared for Clinical Executives, a corporate risk assessment has been completed and capital and revenue requirements are expected to require Executive Team consideration. This remains an assurance issue because the organisation must be able to trace patients and instruments rapidly in the event of incidents, product recalls or decontamination failures.

Call for Concern has moved from pilot to full implementation in response to WHC/2026/001, with formal programme management arrangements in place. However, QMG identified that full delivery is affected by digital limitations, particularly the inability to integrate patient wellness scores and questions into CareFlow. The meeting confirmed that this digital limitation should be escalated through Executive Committee and PQSOC routes, given the national delivery requirement and the patient safety implications of inconsistent digital enablement.

Transfusion safety remains an area requiring stronger divisional ownership and risk oversight. QMG received assurance that targeted education, competency assessment and system controls are continuing, but Wrong Blood in Tube incidents and transfusion sample rejection rates of approximately eight to ten per cent continue to present patient safety, operational and environmental concerns. The risk is currently held on the Clinical Support Services Divisional Risk Register, but QMG requested that all divisions undertaking blood transfusion activity should consider whether the risk should also be reflected within their own divisional risk registers.

VTE prophylaxis assurance remains limited by documentation gaps and prescribing variation. The Hospital Thrombosis Group identified missing drug charts, absent VTE risk assessments, incomplete clinical records and variation in thromboprophylaxis practice within orthopaedic services. Although QMG noted that hospital acquired thrombosis incidence remains low, the assurance gap relates to the organisation's ability to evidence reliable assessment, prescribing and documentation practice, with

further work required through clinical divisions and Electronic Prescribing and Medicines Administration (EPMA).

National clinical audit outlier positions require continued oversight, particularly in relation to the National Joint Registry (NJR) and the National Respiratory Audit Programme (NRAP). QMG received an update that the NJR position related to Royal Gwent Hospital level reporting rather than combined Health Board data, and that the NRAP outlier status is linked to data acquisition and site registration issues. While improvement plans are in place, continued oversight is required through the Clinical Standards and Effectiveness Group, divisional governance, Audit, Risk and Assurance Committee and PQSOC to ensure clear line of sight and delivery of measurable improvement.

Procedural safety outside traditional theatre environments was identified as a further organisational risk. QMG discussed that Never Events and procedural risks are now occurring in areas outside main theatres, including outpatient and clinic room environments. Variation in Local Safety Standards for Invasive Procedures (LocSSIP) and National Safety Standards for Invasive Procedures 2 (NatSSIP 2) governance arrangements requires further review to ensure that standards for invasive procedures are consistently held, reviewed and assured across all relevant settings.

Violence and aggression, including sexual safety, was identified as an organisational risk requiring a focused future QMG discussion. Surgery reported increasing violence and aggression concerns affecting outpatient and ward environments, and QMG noted that the Violence Prevention and Reduction Strategic Plan has been approved by Board. QMG agreed that this should return as a specific future agenda item, including sexual safety, to clarify reporting, escalation and divisional engagement with the Violence Prevention and Reduction Group.

Community acquired pressure damage was identified as a Health Board wide theme requiring further review. Medicine reported eight consecutive months of increased reporting of patients admitted with pressure damage, and QMG recognised the need for further work to understand whether affected patients were already known to services or not known to services. This requires a wider review across professional standards, Primary Care and Community Services, Medicine and divisional nursing routes, rather than being treated solely as a Medicine divisional issue.

The wider cross cutting risk themes are implementation capacity, workforce pressure, training compliance, documentation and data quality, digital dependency, environmental constraints, operational flow and the need for stronger triangulation. These themes were reflected across pillar assurance reports and divisional discussions, including infection prevention data and training alignment, CareFlow limitations for Call for Concern, audit data quality issues, operational flow pressures, estates and environmental risks, and continued reliance on manual narrative within quality reporting.

In summary, QMG was able to provide assurance that governance arrangements are in place and are continuing to mature. However, the July report highlights several areas where assurance is limited by the reliability of data, the consistency of documentation, digital constraints, workforce and implementation capacity, and the need to demonstrate clearer evidence of sustained improvement. These issues

require continued executive oversight and clear return routes through QMG, Executive Committee and PQSOC.

**Argymhelliad / Recommendation**

The Committee is asked to note the assurance received by QMG, endorse the escalations and areas requiring continued oversight, and support the proposed governance routes for monitoring delivery, risk mitigation and improvement. The Committee is also asked to recognise the areas where assurance remains limited and to seek further updates through QMG divisional governance and relevant specialist groups as appropriate.

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

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

| **Effaith: (rhaid cwblhau)**<br>**Impact: (must be completed)** | |
|---|---|
| | **Is EIA Required and included with this paper** |
| **Asesiad Effaith Cydraddoldeb**<br>**Equality Impact Assessment** (EIA) completed | **No  does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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**<br>**Well Being of Future Generations Act – 5 ways of working**<br><br>https://futuregenerations.wales/about-us/future-generations-act/ | Choose an item.<br>Choose an item.<br><br>Not applicable to this report |

**QMG ASSURANCE REPORT**

| | |
|---|---|
| **Meeting Date** | 08 July 2026 |
| **Chair** | Jennifer Winslade (Executive Director of Nursing) |

## Overall Assurance Opinion

Overall, QMG received assurance that the Health Board has maturing quality governance arrangements, with clear evidence of progress across the Quality Management Framework, ward and team accreditation, infection prevention, divisional assurance and subgroup reporting. The report demonstrates strengthened line of sight from divisional and specialist group assurance into executive and committee oversight, with several areas of positive assurance and active improvement. However, assurance remains limited in a number of areas including digital and data constraints, documentation gaps, workforce pressures, environmental risks and the need for stronger triangulation of outcomes, risks, incidents, complaints, audit findings and improvement trajectories due to implementation and/or capacity issues. Continued oversight is therefore required through QMG relevant divisional and group governance routes and onto Patient Quality Safety Outcomes Committee for assurance

## Reporting and Review Dates

Updates will be strengthened to include a clear return date to QMG or the relevant committee, the agreed escalation route, the responsible lead and the evidence expected to demonstrate progress or assurance of resolution. Where actions are described as ongoing or to be progressed, the next report will convert these into specific review points, with anticipated reporting dates, measurable milestones and confirmation of whether the issue remains within divisional governance or should be escalated QMG and to the Executive Committee and PQSOC for assurance. Priority areas for additional assurance include HSDU traceability, Call for Concern, digital areas for development, VTE documentation, national audit outlier positions, procedural safety outside theatres, violence and aggression including sexual safety and community-acquired pressure damage. The deferred Hafan Deg HIW improvement plan will be received at the next QMG.

## Link to Duty of Quality

This report supports the Health Board's responsibilities under the Duty of Quality by providing a structured route for decision-making, monitoring and assurance across safety, effectiveness and patient experience. It demonstrates how the Quality Management System is being used to bring together divisional assurance, specialist group reporting, risks, incidents, complaints, audit findings, patient feedback and improvement activity to support continuous learning and improvement. The report also identifies where assurance remains limited, where further triangulation is required and where escalation through executive committee or PQSO is necessary to secure improvement in the quality of services provided.

**KEY ESCALATION AND DISCUSSION POINTS**

**ALERT**

| Alert | Action | By whom | Target Date |
|---|---|---|---|
| Weakness in end-to-end HSDU | Continue the multi- | Craig Roberts, | December |

| | | | |
|---|---|---|---|
| and theatre instrument traceability remain an organisational risk. The Medical Devices Group identified weaknesses in patient and instrument traceability during the HSDU incident investigation, with a task and finish group established to extend traceability across all areas using HSDU sterilised instruments. In the meeting, Craig Roberts confirmed that a multi-divisional task and finish group is in place, costs have been obtained, an SBAR is being prepared for Clinical Executives, a corporate risk assessment has been completed, and capital and revenue requirements are expected to require Executive Team consideration. | divisional task and finish group, progress the SBAR through Clinical Executives and Executive Team, confirm capital and revenue requirements, and maintain corporate risk oversight until end-to-end traceability arrangements are implemented. | Medical Devices Group Chair | 2026 for implementation trajectory identified in the Medical Devices report; Executive update to proceed through Clinical Executives. |
| Call for Concern has moved from pilot to full implementation; however, full delivery is affected by digital limitations, particularly the inability to integrate patient wellness scores and questions into CareFlow. The Deteriorating Patient Group confirmed the programme has moved into full implementation in response to WHC/2026/001, with formal programme management arrangements established and 2.1 WTE redeployed from Public Health, alongside the Medical Director's Quality and Patient Safety Team making the programme its primary focus during implementation. The meeting confirmed that the digital limitation should be escalated through Executive Committee and Patient Quality, Safety and Outcomes Committee routes. | Maintain formal programme management, escalate digital delivery constraints, and ensure continued executive oversight of compliance with national delivery requirements. | Leeanne Lewis, Deteriorating Patient Group and Medical Director's Quality and Patient Safety Team. | To be monitored through Executive Committee and Patient Quality, Safety and Outcomes Committee reporting. |
| Wrong Blood in Tube incidents and transfusion sample rejection rates of approximately | Divisions undertaking transfusion activity | All relevant divisions, supported by | Ongoing until nil rejection trajectory is |

| | | | |
|---|---|---|---|
| 8 to 10 per cent continue to present patient safety, operational and environmental concerns. The Hospital Transfusion Committee identified ongoing WBIT incidents and rejection rates, with continued targeted education, competency assessment, divisional oversight and safer system controls required. QMG noted that transfusion risk is currently held on the Clinical Support Services Divisional Risk Register, but should be considered by all divisions undertaking blood transfusion activity. | to consider whether this risk should be reflected on their divisional risk registers, alongside continued education, competency assessment and system controls. | Hospital Transfusion Committee and Transfusion Practitioners. | achieved. |
| VTE prophylaxis assurance remains limited by documentation gaps and prescribing variation. The Hospital Thrombosis Group identified missing drug charts, absent VTE risk assessments, incomplete clinical records and variation in thromboprophylaxis practice within orthopaedic services. QMG noted that hospital-acquired thrombosis incidence remains low, but documentation and prescribing variation require further oversight. | Strengthen audit of VTE risk assessments and thromboprophylaxis prescribing records, review orthopaedic thromboprophylaxis practice, and continue work with EPMA for digital risk assessment and standardised prescribing. | VTE Lead, Clinical Divisions and EPMA. | Q3 2026/27. |
| National clinical audit outlier positions require continued oversight, particularly National Joint Registry and National Respiratory Audit Programme. The Clinical Standards and Effectiveness Group confirmed that the Health Board remains an outlier for NJR and NRAP, with focused oversight through specialty-led improvement plans and executive monitoring arrangements. QMG received an update that the NJR position relates to RGH-level reporting rather than combined Health Board data, and that NRAP | Maintain specialty-led SMART improvement plans, ensure line of sight through Clinical Standards and Effectiveness Group, divisional assurance, ARAC and Patient Quality, Safety and Outcomes Committee, and confirm annual governance reporting arrangements for | Leeanne Lewis, Seema Srivastava, Clinical Standards and Effectiveness Group, relevant clinical leads and divisions. | Continued oversight through divisional, CSEG, ARAC and Patient Quality, Safety and Outcomes Committee reporting. |

| | | | |
|---|---|---|---|
| outlier status is linked to data acquisition and site registration issues, with improvement plans in place. | NJR. | | |
| Procedural safety outside traditional theatre environments requires further organisational review. Discussion identified that Never Events and procedural risks are now occurring in areas outside main theatres, including outpatient or clinic room environments. QMG discussed variation in LocSSIP availability and NatSSIP 2 governance arrangements, and agreed that Jonathan Clarke, Seema Srivastava and Stephen Edwards would consider how to develop a structured approach. | Develop an organisational approach to LocSSIP and NatSSIP 2 governance for invasive procedures outside main theatre settings, building on current Clinical Support Services theatre safety work and linking with Surgery and Medicine. | Jonathan Clarke, Seema Srivastava and Stephen Edwards, with support from divisions. | To be scoped outside the meeting and brought back through appropriate governance routes. |
| Violence and aggression, including sexual safety, was identified as an organisational risk requiring further focused QMG discussion. Surgery reported increasing violence and aggression concerns, including risks affecting outpatient and ward environments. Scott Taylor confirmed that a Violence Prevention and Reduction Strategic Plan has been approved by Board, and QMG agreed that this should return as a specific future agenda item, including sexual safety. | Add violence and aggression, including sexual safety, as a focused item for the next QMG agenda and use the discussion to clarify reporting, escalation and divisional engagement with the Violence Prevention and Reduction Group. | Scott Taylor | Next QMG meeting. |
| Community-acquired pressure damage was identified as a Health Board-wide theme requiring further review. Medicine reported eight consecutive months of increased reporting of patients admitted with pressure damage; QMG recognised this as a Health Board-wide issue, with further work required to understand those known to services versus not known to services. | Review Health Board-wide data on community-acquired pressure damage, including whether patients were known to services, and consider referral to the Professional Standards Group and Divisional Nurse meeting for further review. | Corporate QPS, Professional Standards, Primary Care and Community Services, Medicine and Divisional Nurse forum. | To be progressed through divisional and professional standards routes. |

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

- The Group received the **Quality Management Framework Evaluation: Quality Reporting paper**. The paper and discussion recognised that the Health Board has made clear progress in strengthening quality governance and reporting over the previous two years, including the establishment of QMG, incremental improvements to the Quality Outcomes Framework, the creation of monthly Executive Team quality performance reports, and the development of Qlik as an enabling platform. QMG also recognised that the system remains maturing, with further work required to improve concise exception-based narrative, strengthen outcome measures, improve triangulation, reduce reliance on manual narrative, improve consistency across divisions and specialist groups, and develop reporting on health inequalities.

- The **Ward and Team Accreditation Annual Report** was received. QMG was advised that the programme has spread across inpatient wards, maternity, urgent care, endoscopy, clinics and community services, with approximately 158 clinical teams participating. The programme has moved into district nursing and complex care, with audits being developed for health visiting and school nursing. QMG noted significant progress with national benchmarking and that the Health Board's framework is informing wider All-Wales work. Challenges remain in sustaining pace during operational pressure, securing sufficient resource, and demonstrating measurable links between accreditation and organisational outcomes.
- **The Infection Prevention, Antimicrobial Resistance and Decontamination Annual Report and associated papers** were presented. QMG was advised of progress with infection prevention improvement work, including policy review, Quality Improvement activity, C. difficile collaborative work, reductions in C. difficile, Staphylococcus aureus reductions compared with the previous year, improvements in C-section surgical site infection surveillance, winter respiratory virus learning, decontamination priorities and cleaning standards. Key areas requiring continued monitoring include ESR alignment for ANTT and infection prevention training, antimicrobial use in secondary care, data quality, environmental cleaning, decontamination governance and the impact of workforce capacity.
- QMG was advised that the **Quality and Patient Safety interim priorities** are being developed alongside the Quality Management Framework review and future Quality Plan. The discussion confirmed the need to maintain a focused set of priorities that link to the national safety plan, organisational risks, patient feedback, metrics, improvement plans and the wider planning cycle. Feedback from members was invited following the meeting, as the priority slides were uploaded during the meeting.
- The **Hypoxic-Ischaemic Encephalopathy briefing** was received. QMG was advised that case numbers reduced from 2024 to 2025, with six-month 2026 data indicating a further reduction, although full-year data is not yet available. The group noted that there is no national Welsh benchmarking position; however, learning has been identified through reviews, guidelines have been updated, rapid access arrangements have been implemented and training compliance, including PROMPT, remains strong. QMG received

this as positive assurance while recognising the need for continued monitoring.

- The **QMG Pillar Assurance Reports** were presented as a combined overview. QMG was advised that subgroup reporting is maturing, with more groups submitting highlight reports and stronger evidence of work plans, action tracking, audit oversight, task and finish arrangements and clearer routes of escalation. Cross-cutting themes included implementation capacity, prescribing variation, training compliance and workforce pressures.
- QMG received **divisional assurance reports** from Mental Health and Learning Disabilities, Family and Therapies, Medicine, Clinical Support Services, Surgery, Primary Care and Community Services, and Urgent Care. These provided divisional updates on risk, patient safety incidents, complaints, early resolution under Listening to People, accreditation, training compliance, flow pressures, estates, environmental risks, procedural safety, community and care home assurance, and quality improvement activity.

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

- QMG received positive assurance that the **Quality Management Framework** provides a strong foundation for quality reporting and assurance, with the Health Board recognised as having made substantial progress in organising quality governance, creating a central quality oversight route and improving line of sight to Executive Committee and Patient Quality, Safety and Outcomes Committee. The Group was clear that further development is required but accepted that the arrangements are maturing and provide a basis for improvement.
- The Group received assurance that the **Ward and Team Accreditation Programme** continues to embed a consistent, evidence-based approach to quality, safety and professional standards across a broad range of services. The programme has achieved significant spread and scale, includes robust audit and peer review processes, supports local quality improvement and has generated examples of measurable local improvement, including reductions in falls in older adult mental health areas and savings linked to reduced continence product use on an orthopaedic ward.
- QMG received assurance that **infection prevention** arrangements are active and improvement focused. The **annual report** described policy review, quality improvement work, reductions in C. difficile, reductions in Staphylococcus aureus compared with the previous year, maternity surgical site infection improvement, winter respiratory virus learning and ongoing decontamination work. The Group also recognised that improvement has been achieved through a whole-organisational response rather than the Infection Prevention Team alone.
- QMG received assurance that **Hypoxic-Ischaemic Encephalopathy** is subject to active clinical review and learning. The meeting confirmed that cases reduced in 2025 compared with 2024, six-month 2026 data showed a further reduction, and learning actions have included updated guidance, staffing review, rapid access arrangements, foetal surveillance training, PMRT review and strong PROMPT training compliance.
- The **Pillar Assurance Reports** provided assurance that mortality review oversight remains active, hospital-acquired thrombosis incidents remain low, transfusion training uptake has improved, capital funding has been secured for defibrillator replacement, Call for Concern has moved from pilot to full implementation, and national audit oversight remains active. QMG also noted improving maturity in subgroup reporting, including stronger work plans, action tracking, audit oversight and task and finish arrangements.
- QMG received assurance that several divisions have strengthened their quality and patient

safety processes. Examples included improved complaints management and early resolution performance, more structured divisional review processes, developing multi-professional ownership of QPS, improved risk register work, expanded accreditation participation, divisional quality improvement projects, improved incident closure trajectories and strengthened arrangements for learning from incidents and concerns.

**Risks discussed or identified:**

- The main **cross-cutting risk themes** were implementation capacity, workforce pressure, training compliance, documentation and data quality, digital dependency, environmental constraints, operational flow, and the need to triangulate assurance through QMG, divisional assurance, Patient Quality, Safety and Outcomes Committee reporting and audit governance. These themes were explicitly identified through the Pillar Assurance overview and were reflected across divisional assurance discussions.
- Operational and flow risks were discussed across Medicine, Surgery, Primary Care and Community Services, and Urgent Care. Medicine highlighted boarding, patients not being in the right place, delayed follow-up appointments following insourcing and an ongoing PTR backlog improvement position. Surgery highlighted Surgical Assessment Unit staffing as a high divisional risk with benchmarking indicating staffing below comparable areas and a need for wider financial and executive discussion. Primary Care and Community Services described continued surge bed and step-down demand, palliative care provision and pharmacy operational pressures. Urgent Care described insufficient flow across GUH, ED congestion, ambulance handover pressures and demand and capacity work within the Flow Centre.
- Digital and data risks were discussed in relation to multiple areas. The Quality Management Framework evaluation identified reliance on manual narrative, the need to strengthen outcome measures and triangulation, and the need to better report health inequalities. Call for Concern implementation is affected by inability to integrate patient wellness scores and questions into CareFlow. Infection prevention and ANTT assurance is affected by ESR alignment limitations. NRAP outlier status is affected by data acquisition and site-registration issues.
- Infection prevention, antimicrobial stewardship, decontamination and cleanliness risks were discussed. These included ANTT and Level 2 infection prevention training alignment with ESR; secondary care antimicrobial use not moving in the intended direction, with data quality concerns; ongoing C. difficile environmental risk; Gram-negative bloodstream infection risks linked to urinary tract infection and catheter management; decontamination risks including community dentistry, ultrasound manual processes, HSDU traceability and cleaning standards; and the need to bring cleaning standards back once timelines are clarified with Facilities.
- Procedural safety and invasive procedure governance were discussed following recent Never Event learning and theatre-related incidents. QMG discussed that some procedural risks are arising outside traditional theatre environments, including outpatient and clinic areas. LocSSIP and NatSSIP 2 governance arrangements require organisational review, with a need to understand how local standards are held, reviewed and assured across areas performing invasive procedures.
- Violence and aggression, including sexual safety, was identified as a matter requiring further organisational focus. Surgery reported increased violence and aggression concerns affecting staff and clinicians in outpatient and ward settings. The meeting confirmed that the Violence Prevention and Reduction Strategic Plan has been approved by Board and that a focused QMG agenda item should be scheduled, including sexual safety.

- Environmental and estates risks were identified in Mental Health and Learning Disabilities, Family and Therapies, Medicine, Clinical Support Services and infection prevention discussions. Risks included heat-related environmental pressures in mental health inpatient areas, CAMHS estate concerns and lack of emergency distress call facilities, treatment rooms without air conditioning affecting medicine storage, C2 environmental cleaning concerns and broader cleaning standards requiring further review.
- Regulatory preparedness was discussed in relation to HIW, HSE and Hafan Deg. The Hafan Deg HIW improvement plan was not substantively discussed and was deferred due to the relevant plan not being uploaded in time for the meeting discussion. QMG agreed the item should return to a future meeting for discussion and cross-divisional learning. Tracey PartridgeWilson also confirmed that HIW preparedness work is being undertaken with divisions and will return to QMG at a future point.

## Divisional Updates

**Mental Health and Learning Disabilities**
The Division provided an update on Hafan Deg immediate assurance, an anonymous concern relating to PICU, ongoing HSE correspondence, National Patient Safety Programme work, implementation of Safe Discharge Standards, Safe Wards, the QMS maturity matrix, therapeutic engagement and observation policy, restrictive practice review, risk management tools, incident closure and accreditation progress. Assurance was received that incident numbers are reducing month on month, accreditation engagement is improving across inpatient areas, self-harm and restrictive practice incidents continue on a downward trajectory, and work is continuing with the Jacob Abraham Foundation, integrated crisis and urgent assessment arrangements, and provision for deaf and hard of hearing service users. The substantive Hafan Deg HIW item was deferred and no assurance was received on the HIW improvement plan at the meeting.

**Family and Therapies**
The Division provided assurance on maternity and neonatal workstreams, including the Maternity Safety Support Programme, open access for women with language difficulties, BSOTS triage assessment, implementation of maternity early warning systems, midwifery unit advisory arrangements, birth outside guidance arrangements, neonatal listening event actions, roster governance, medication monitoring, PROMPT feedback, Path to Safer Beginnings work, perinatal dashboard development, perinatal mental health pathways, risk register reductions and improved complaints performance. Risks remain in relation to BSOTS staffing, neonatal cleaning and laundry issues, transitional care estate works, RADIS discontinuation impacts, national maternity reports, coronial cases, CAMHS estates and distress-call facilities, looked after children assessment backlog and theatre capacity.

**Medicine**
The Division reported ongoing risks relating to the UEC workstream, boarded patients, patients not being in the right place, PTR backlog and delayed follow-up appointments following insourcing. Assurance was received that daily and twice-daily senior nursing reviews are undertaken for boarded patients during extreme heat, deconditioning projects are in place across clinical areas, 8am to 8pm visiting has been implemented, PTR backlog has reduced, LFER arrangements have been strengthened through a SOP and generic inbox, healthcare-associated infection NRI closures were compliant, a practice educator role is supporting acute medicine, and endoscopy developed an extreme heat risk assessment that was adopted more widely. Further oversight is required for delayed follow-up allocation, community-acquired

pressure damage, outstanding X-ray report incidents and learning from the A4 case.

**Clinical Support Services**
The Division confirmed that there was no new theatre-related alert but continued oversight is required following previous theatre and sterilisation-related issues. Assurance was received that concerns remain low, early resolution compliance has been maintained at 100 per cent for 10 consecutive months, theatre systems and processes are being reviewed with QPS support, C2 infection prevention and environmental cleaning are under enhanced senior nurse oversight, patient safety incidents are predominantly no harm or low harm, no statistically significant incident trends were identified, and patient experience scores remain strong despite lower response numbers. The Division agreed to share theatre learning with other areas, and wider corporate learning will be taken through the listening and learning forum and Clinical Executives.

**Surgery**
The Division reported ongoing risks relating to the volume of Putting Things Right and Listening to People concerns, professional standards and patient safety capacity alongside flow pressures, and Surgical Assessment Unit staffing. Assurance was received that complaints improvement has been significant, early resolution has increased, formal response quality has improved, Early Resolution closure templates are supporting practice, patient feedback routes are being reviewed, most incidents remain no or low harm, a dedicated team is supporting ophthalmology-related harm reviews, and risk register strengthening work is underway. Further oversight is required in relation to SAU staffing, safeguarding Level 3 compliance, cleaning audits, Houdini compliance, Duty of Candour visibility, violence and aggression, sexual safety, procedural safety outside theatres and a wrong lesion incident in a dermatology outpatient clinic.

**Primary Care and Community Services**
The Division reported that its main risks remain professional standards versus patient flow and increased surge beds, reduced palliative care provision and pharmacy operational pressures. Assurance was received on strengthened multi-professional QPS leadership, alignment of QPS resources following integration with CHC, monthly incident monitoring, weekly QPS huddles, revised Listening to People processes, divisional LFER SOP development, pressure ulcer RCA arrangements including care homes, falls management work, controlled drug monitoring with Pharmacy, timely Duty of Candour cases, low complaint numbers, Safe to Start development for community services, accreditation expansion into district nursing and care at home, risk register reduction and growing quality improvement activity. Further work is required on incident harm grading, risk register ownership, community Safe to Start escalation and pressure ulcer reporting alignment.

**Urgent Care**
The Division reported risks relating to insufficient flow across GUH, ED congestion blocking assessment capacity, Handover 45 delivery and ambulance lost hours, assessment and treatment area constraints, demand growth, Flow Centre modelling and mandatory training compliance. Assurance was received that complaints performance is strong, there are no open overdue complaints, incident closure remains proactive, Civica responses are in line with expected numbers and remain above 85 overall, no statistically significant incident trends were identified, risk register meetings are held weekly with corporate risk input, there are no open safeguarding cases and no infections were reported for this year or last year. Further

oversight is required in relation to flow, one-hour time to be seen, ambulance handover and Phase 2 estate work.

**Matters for the Board or other committees:**

The following matters are considered to require onward visibility or oversight through Executive Committee, Patient Quality, Safety and Outcomes Committee, Board or other formal committee routes, based primarily on the Pillar Assurance Reports and supported by the July QMG discussion.

- HSDU and theatre instrument traceability should remain visible to Clinical Executives, Executive Committee and Patient Quality, Safety and Outcomes Committee due to the organisational risk associated with inability to trace patients or instruments rapidly following incidents, product recalls or decontamination failures. The Medical Devices Group report identifies an end-to-end traceability weakness and an organisational task and finish group, with capital and revenue implications identified in the meeting.
- Call for Concern implementation should remain under Executive Committee and Patient Quality, Safety and Outcomes Committee oversight due to statutory, national delivery and patient safety implications. The Deteriorating Patient Group report confirms full implementation under WHC/2026/001, formal programme management and redeployed resource, while QMG identified digital limitations affecting integration into CareFlow.
- Wrong Blood in Tube incidents and transfusion sample rejection rates should be considered for divisional risk escalation beyond Clinical Support Services where transfusion is undertaken. The Hospital Transfusion Committee report identifies ongoing WBIT incidents and 8 to 10 per cent rejection rates, with safety, operational and environmental implications, and QMG agreed divisions should consider lodging the risk where applicable.
- VTE prophylaxis documentation and prescribing variation should remain under clinical divisional, EPMA and Patient Quality, Safety and Outcomes Committee oversight. The Hospital Thrombosis Group report identifies documentation gaps, absent assessments and variation in orthopaedic thromboprophylaxis prescribing, while QMG noted low hospital-acquired thrombosis incidence but continued assurance limitations.
- National clinical audit outlier improvement plans for NJR and NRAP should remain under CSEG, divisional, ARAC and Patient Quality, Safety and Outcomes Committee oversight. The CSEG assurance report identifies ongoing outlier status and specialty-led improvement plans, and QMG confirmed the need for clear line of sight and annual governance reporting.
- Medical device governance risks, including alarm latching requirements, in-house manufacture and orthopaedic 3D printed cutting guides, should remain under Medical Devices Group and appropriate executive oversight because the Medical Devices Group report identifies emerging assurance and governance risks requiring organisational position review, task and finish arrangements and regulatory consideration.
- Medicines safety matters should continue through Medicines Safety Group and Medicines and Therapeutics Committee routes. The Medicines Safety Group report identifies medication incident volumes, medication locker master code access risk, medical air outlet safety guidance non-compliance and prioritisation of high-risk medicines programmes. The Medicines and Therapeutics Committee report identifies uncertainty regarding Methotrexate and other DMARD Shared Care Protocols and high lidocaine plaster prescribing.
- Safeguarding reporting and training trajectory should remain visible through the Strategic Safeguarding Group and wider quality governance routes. The Strategic Safeguarding

Group report indicates the National Reporting Framework for Safeguarding had not yet been published, Level 1 and 2 Safeguarding Training were at mandated 80 per cent, and Level 3 was following an agreed trajectory with compliance expected in March 2028.

- Violence and aggression, including sexual safety, should return as a focused QMG item and remain visible to Patient Quality, Safety and Outcomes Committee where relevant. QMG discussion confirmed that violence and aggression affects multiple settings, the Violence Prevention and Reduction Strategic Plan has been approved by Board, and a dedicated future QMG item was agreed.
- Hafan Deg HIW was deferred to the next meeting to allow sufficient time for discussion, assurance and cross-divisional learning.
- HIW preparedness work should be brought back to QMG when available.

**MEETING AGENDA ITEMS**

| | | |
|---|---|---|
| Minutes of the meeting held 12 May 2026 and matters arising | Consent Agenda Business | Quality Management Framework Evaluation: Quality Reporting |
| Ward Accreditation Annual Report | Aseptic Non-Touch Technique Assessment Report, MSSA/MRSA and IPAC Annual Report | Quality and Patient Safety Priorities |
| Hypoxic-Ischaemic Encephalopathy Briefing Paper | QMG Pillar Assurance Reports | QPS Divisional Assurance Reports |
| Hafan Deg HIW | | |

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| In Attendance | |
|---|---|
| Jennifer Winslade | Chair, Executive Director of Nursing |
| Kye Smith | Deputy Head of Quality and Patient Safety |
| Tracey PartridgeWilson | Deputy Director of Nursing |
| Gemma Couch | Head of Quality, Patient Safety and Learning |
| Leeanne Lewis | Assistant Director Quality and Patient Safety |
| Seema Srivastava | Executive Medical Director |
| Peter Carr | Executive Director of Allied Health Professions and Health Science |
| Tanya Strange | Head of Nursing, Person-Centred Care |
| Jayne Beasley | Head of Midwifery, Gynaecology and Neonates |
| Moira Bevan | Head of Infection Prevention and Control |
| Ceri Phillips | Pharmacy |
| Laura Bumpsteed | Ward Accreditation |
| Amy Buckley | Divisional Nurse, Mental Health and Learning Disabilities |
| Deb Jackson | Nursing |
| Natalie Skyrme | Divisional Nurse, Medicine |
| Rebekah White | Divisional Nurse, Clinical Support Services |
| Amanda Hale | Divisional Nurse, Surgery |
| Joanne Lane | Divisional Nurse, Primary Care and Community Division |
| Christopher Morgan | Divisional Nurse, Urgent Care |
| Clifford Jones | Primary Care and Community Division |
| Craig Roberts | Assistant Director of Allied Health Professions and Health Science |
| Collette Kiernan | Deputy Executive Director of Allied Health Professions and Health Science |
| Jonathan Simms | Pharmacy |
| Jonathan Clarke | ENT / ABCi |
| Stephen Edwards | Medical Director's Office |
| Scott Taylor | Health, Safety and Security |
| Trish Chalk | Planning |
| Tracy Daszkiewicz | Public Health |
| Susan Palmer | Research and Development |
| Charlea Johnson | Corporate Services |
| Maxine Hiscock | Nursing Quality and Patient Safety |

| In Attendance to Present | |
|---|---|
| Laura Bumpsteed | Ward Accreditation Annual Report |

| Apologies | |
|---|---|
| Rani Dash | Director of Corporate Governance |
| Rob Holcombe | Executive Director of Finance |
| Helen Morgan | Division Nurse F&T |

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|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 28 July 2026 |
| **CYFARFOD O:**<br>**MEETING OF:** | Patient Quality, Safety and Outcomes Committee |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Annual Assurance Report on Compliance with the Nurse Staffing Levels (Wales) Act 2016 |
| **CYFARWYDDWR ARWEINIOL:** | Jennifer Winslade (Executive Director of Nursing) |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Kelly Downes – (Deputy Director of Nursing) |

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

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

The Board is required to consider and have due regard for the duty on them, under Section 25A of the Nurse Staffing Levels (Wales) Act, to provide sufficient nurses to allow time to care for patients sensitively wherever they are receiving nursing services. The report, therefore, outlines the actions taken to comply with Section 25A of the Act.

This report covers the reporting period 6 April 2025 to 5 April 2026, and outlines the measures taken to provide assurance regarding compliance with the requirements of the Act.

## Cefndir / Background

The Nurse Staffing Level (Wales) Act 2016 became law in Wales in March 2016. The Act requires health service bodies to make provision for an appropriate nurse staffing level wherever nursing services are provided, and to ensure that they are providing sufficient nurses to allow them time to care for patients sensitively. This requirement extends to anywhere NHS Wales provides or commissions a third party to provide nurses.

The Act consists of the 5 sections:

- 25A refers to the health boards'/trusts' overarching responsibility to have regard to providing sufficient nurses in all settings.

- 25B requires health boards/trusts to calculate and take all reasonable steps to maintain the nurse staffing level in all adult acute medical and surgical wards. Health boards/trusts are also required to inform patients of the nurse staffing level on those wards.
- 25C requires health boards/trusts to use a specific method to calculate the nurse staffing level in all adult acute medical and surgical wards
- 25D relates to the statutory guidance released by Welsh Government
- 25E requires health boards/trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward.

The All-Wales Nurse Staffing Programme supports NHS Wales to meet its duties under the Nurse Staffing Levels (Wales) Act 2016 and follow a 'Once for Wales' approach.

The programme of work for the All-Wales Nurse Staffing Programme has been refreshed to reflect the CNO priorities and the new direction set out by the Minister for Health and Social Services to the Health and Social Care Committee in December 2023.

A comprehensive programme has been developed which focuses on:

- Continuing to provide guidance and support to Health Boards and NHS Trusts to meet the requirements of the Nurse Staffing Levels (Wales) Act (2016) and follow a 'Once for Wales' approach.
- Scope evidence-based tools, standards and guidance informing nurse-staffing levels for different care settings to form part of an agreed triangulated calculation practice in 25A areas (all areas other than adult acute medical and surgical inpatients and paediatric inpatient areas)
- Ensure alignment with national working groups and programmes of work.
- Develop operational guidance to ensure nationally consistent application of triangulated calculation in 25A areas.
- Explore how multi-professional working and workforce models can be used across Health Boards and NHS Trusts.
- Working with HEIW, the NHS Executive, Health Boards and Trusts maximising the use of workforce and patient data to identify trends and themes in service demand over time and to support local and national benchmarking.

The Annual Assurance report produced by health boards helps inform the 3-Yearly assurance report submitted to Welsh Government. The report provides ongoing assurances on the approach, mechanisms, monitoring, and management of risks relating to Nurse Staffing Levels and the overall compliance with the requirements of 'the Act' over the past 12-month period.

**Asesiad / Assessment**

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses required and staff to whom nursing duties have been delegated by a registered nurse to deliver the planned roster. It is

acknowledged there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment; however, these staff are not included within the data for this report.

**Spring 2025 Calculations 25B wards**

A total of 33 wards were reviewed during the Spring calculations. There were no changes required to the wards in surgery, gynaecology and paediatrics.

**5 out of 19 medical wards proposed changes to roster templates.**

- Ward 4.4 NHH – extra HCSW by day
- Bargoed Ward NHH - extra RN by day
- Oakdale Ward YYF – extra HCSW by day
- Ward CE RGH – extra HCSW by night
- Ward C6W RGH - Cost-neutral adjustment swapping RN night and HCSW day.

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

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

**Autumn 2025 Calculations**

A total of 35 wards were subject to staffing calculations Autumn 2025. The number of permanent medical 25B wards has increased by 1 following the reclassification of Penallta Ward at YYF—a 28-bed COTE and palliative care ward—which now meets the criteria for a 25B designation. Additionally, a staffing calculation was carried out for Ward D7W at RGH (Winter Ward). The Surgical, Gynaecological, and Paediatric Nurse Staffing Templates remain the same, no changes to roster templates required.

Medical wards retained the Spring adjustments, (Ward 4.4 NHH, Bargoed & Oakdale wards YYF, & C6E RGH) and were carried forward to the Autumn calculations. There was also a request to make changes to templates on 2 additional wards (C4 GUH and Penallta YYF)

Wards requiring changes to templates:

- Ward C4 GUH, respiratory ward, increase RN Late shift 7 days/week
- Penallta ward YYF, increase of 1 HCSW 7 nights/week
- Ward 4.4 NHH – extra HCSW by day
- Bargoed Ward NHH - extra RN by day
- Oakdale Ward YYF – extra HCSW by day
- Ward CE RGH – extra HCSW by night

Ward D7W, winter pressure ward – Calculation was undertaken to agree the template for temporary winter pressure ward - **Proposed Roster:** Day: 3 RN / 3 HCSW | Night: 2 RN / 3 HCSW.

The additional cost for the above amendments totals £685,511 (excluding the funding for the winter ward D7W).

The outcomes of the Autumn calculations were presented to Board 26 November 2025-the increases to templates outlined above were approved using variable pay.

25A Areas

The All-Wales Nurse Staffing Programme is developing national Section 25A Operational Guidance to enable a consistent, evidence-informed approach to determining nurse staffing across all clinical areas where nurses provide care. This guidance is scheduled for publication in March 2027. A selected group of clinical specialities has been identified as Areas of Initial Focus, and the learning generated through focused engagement with these services will directly inform and shape the broader Section 25A Operational Guidance.

In the interim health boards across Wales have begun a programme of undertaking calculations in some focussed 25A areas.

During this reporting period this Health Board completed calculations on the following areas.

- Urgent care
- Clinical Support Services (ICU & Surgical High care)
- MHLD
- Primary care & Community
- 25A areas in the Divisions of Medicine & Surgery

The information below outlines the work that has been completed over the past 12- month reporting period; 6th April 2025 to 5th April 2026:

## Argymhelliad / Recommendations

The Patient Quality Safety and Outcomes Committee is asked to **NOTE:**

- The information contained within the Nurse Staffing Levels (Wales) Act 2016 Annual Assurance Report 2025-2026.
- This report does not come with an additional financial request but is for Assurance only.

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

| | |
|---|---|
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s): | 2. Safe Care<br>3. Effective Care<br>6. Individual care<br>7. Staff and Resources |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item. |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Workforce and Culture |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Improve the Wellbeing and engagement of our staff<br><br>Choose an item.<br>Choose an item.<br>Choose an item. |

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

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| | **Is EIA Required and included with this paper** |
| **Asesiad Effaith Cydraddoldeb<br>Equality Impact Assessment**<br>(EIA) completed | **No does not meet requirementsNo does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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<br>Well Being of Future Generations Act – 5 ways of working** | Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needsLong Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs<br>Choose an item. |

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

| Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee | | | |
|---|---|---|---|
| **Health board/trust** | Aneurin Bevan University Health Board (ABUHB) | | |
| **Date annual assurance report is presented to Board** | Presented to Quality Management Group 12-5-26<br><br>This report includes data from 6 April 2025- 5 April 2026.<br><br>This report will form part of the 3 yearly assurance report that will be presented to Welsh Government in October 2027, for the reporting period April 2024 - April 2027. | | |
| | **Adult acute <u>medical</u> inpatient wards** | **Adult acute <u>surgical</u> inpatient wards** | **Paediatric inpatient wards** |
| **During the last year the lowest and highest number of wards** | Highest 21<br>Lowest 19 | Highest 13<br>Lowest 13 | (50 beds)<br>Highest 1<br>Lowest 1 |
| **During the last year the number of occasions (wards where section 25B applies) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods** | **0** | **0** | 0 |
| **The process and methodology used to** | The Nurse Staffing Levels (Wales) Act 2016 places a statutory duty on Health Boards and Trusts to calculate and maintain appropriate nurse staffing levels using an identified triangulated methodology. This methodology brings together three core components: patient acuity, | | |

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|---|---|
| **calculate the nurse staffing level.** | professional judgement, and quality indicators. In practice, NHS Wales operationalises this through biannual establishment reviews which are approved by the Designated Person. These reviews provide a robust and consistent approach for determining planned establishments across the year.<br><br>In accordance with the Nurse Staffing Levels (Wales) Act 2016 (NSLWA), ABUHB has applied a systematic and well-embedded triangulated approach to review and recalculate the nurse staffing levels for all Section 25B wards (Adult and Paediatric), as required by legislation.<br><br>The Spring and Autumn recalculations are owned and led by the Divisional Leads and heads of nursing and include detailed discussions using the triangulated methodology and analysis of ward performance data. Attendees typically include Senior Nurse, Ward Manager, Nurse Staffing Act Programme Lead, and representatives from both the e-rostering and finance teams. Professional judgement remains central to all decisions, ensuring that each ward is appropriately staffed and resourced to meet patient needs.<br><br>The triangulated methodology includes consideration of:<br><br>• Ward speciality, bed base, ward environment, and planned roster.<br><br>• Funded establishment and aligned budget.<br><br>• E-rostering and SafeCare compliance.<br><br>• The previous 6 months patient acuity levels (using the approved Welsh Levels of Care acuity tool- WLoC) compared to deployed staffing levels.<br><br>• Bank and agency usage and variable pay expenditure, and analyses of unavailability reasons.<br><br>• Additional roles included in the ward budget but not in the planned roster template (e.g., ward clerk, ward assistant, activities coordinator, discharge coordinator, and other bespoke roles that support patient-centred care depending on ward speciality). |

| | |
|---|---|
| | • Care Metrics, including incidences of hospital-acquired pressure ulcers, patient falls, medication errors, Serious Incidents (SIs), infection rates, complaints, and infiltration/extravasation incidents on the paediatric ward.<br>• Staff-related data, including PADR compliance, mandatory training compliance, and sickness absence/management.<br>• Ward accreditation progress and discussion around ongoing improvement projects.<br><br>In line with the requirements of the Act:<br>• All Section 25B wards apply a 26.9% uplift to the Registered Nurse and Band 4 WTE calculation.<br>• A 24.8% uplift is currently applied to band 2 and 3 Health care support workers.<br>• Ward Managers are supernumerary to the planned rosters. The 26.9% uplift is also applied to the Ward Manager establishment to ensure the supervisory role can be maintained during periods of absence.<br><br>The triangulation methodology allows lead nurses to make informed professional judgements on the suitability of the current roster template and the adequacy of staffing levels to meet patient needs.<br><br>Where professional judgement indicates that an increase in the planned roster is required, the Lead Divisional Nurse must present the findings to senior Divisional Management Team prior to the formal presentation of the recalculations to the Executive Nurse Director in the Challenge & support meetings as stipulated in legislation.<br><br>Going forward, the corporate team has established a Challenge and Support Panel to provide structured oversight of staffing calculations. The Divisional Triumvirate will present their calculations to this panel prior to submission to the Executive Team and Board. This enhanced process will strengthen governance arrangements and will apply from the Spring 2026 calculations. |

Following completion of the Spring and Autumn calculations for 2025, the annual presentation of the nurse staffing levels was presented to board 26 November 2025.

**Spring 2025 Calculations:**

A total of 33 wards undertook the recalculation process.

| | |
|---|---|
| Acute Medical: | 19 Wards |
| Surgical: | 12 Wards |
| Gynaecology: | 1 Ward |
| Paediatrics: | 1 Ward (50 beds) |

On completion of the recalculation process, the Divisions of Surgery and Family & Therapies confirmed that their planned rosters and funded establishments were appropriate to meet patient needs.

The Division of Medicine, however, identified five wards requiring amendments to their previously agreed rosters to ensure alignment with other comparable wards within the Division.

Medicine

The sustainability of the Core Care Model emerged as a significant theme across the COTE wards within the Medicine Directorate, with numerous ward managers emphasizing the requirement for four Registered Nurses during daytime shifts. Following discussions, the divisional nurse lead, determined that a comprehensive review of the Core Care Model is necessary. This review will incorporate ongoing work across Wales on the "team around the patient" approach, alongside preparations for the forthcoming introduction of the Registered Nurse Associate role.

A total of 5 wards proposed changes to planned rosters and funded establishments:

- **Ward 4.4 Nevill Hall Hospital, (30 Bedded Care of the Elderly Ward with the capacity to board 1 patient)**

  This ward was repurposed from a semi acute respiratory ward to a COTE ward following the respiratory and general medicine reconfiguration in the Autmn of 2024. Due to consistent variable pay usage to support high dependency and enhanced care and to bring them in line with other COTE wards on the Nevill Hall site, the request was to increase the number of Band 2 HCSW from 3 during the long day to 4, 7 days a week (2.8 WTE) at a cost of £103,499 per annum.

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

  This is a stroke rehabilitation ward with high acuity and dependency; due to the centralisation of stroke services the patients are transferred from GUH earlier in their stroke pathway. The patients are acutely unwell, with many patients requiring Peg feeding which results in prolonged time for medication administration by a registered Nurse (RN). The professional judgment was to increase from 3 RNs per Long Day to 4 RNs per long day 7 days a week. The proposed change will align Bargoed ward with Oakdale ward. The model will include reviewing the Band 4 assistant practitioners to work across Bargoed ward and Oakdale ward ensuring an equitable service and the same staffing levels across the 2 Stroke Rehabilitation Wards in YYF. This equates to an increase of 2.84 WTE at a cost of £163,752.

- **Oakdale ward Ysbyty Ystrad Fawr**, **(28 bedded Stroke rehabilitation ward, no Surge Capacity)**

  This is a stroke rehabilitation ward with high acuity and dependency; due to the centralisation of stroke services the patients are being transferred from GUH earlier in their stroke pathway. The patients are acutely unwell, with many patients requiring Peg feeding which results in prolonged time for medication administration by a registered Nurse (RN). The establishment

for this ward already includes 4 RNs by day to support the prolonged medication rounds, however, because of the high dependency of the patients the professional judgement of the lead Nurses was to increase the HCSW form 4 per long day to 5 per Long Day, 7 days per week. A review of the data revealed that Oakdale Ward is continually creating additional HCSW shifts to cope with the dependency of the patients. This change would mean both Stroke Rehabilitation ward templates and establishments will align. This equates to an increase in 2.8 HCSW WTE at a cost of £103, 499 per annum.

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

  Patient dependency is high on this ward, the ward manager raised concerns around the Core Care Model, expressing the need for 4 RNs by day as opposed to 3 RNs by day. However, the divisional lead nurse concluded that they would revisit this following a full review of the Core Care Model and how it fits with the future Registered Nurse Associate role. Discussions acknowledged, however, that variable pay for C6E is high. Staff are consistently creating additional HCSW shifts for the night shift to support high dependency and increased enhanced care needs of the patients. Therefore, to offset variable pay and ensure continuity of care, the Divisional Lead Nurse identified a need to increase the establishment of HCSW at night by 1, 7 days a week (2.8 WTE), at a cost of £124,000 per annum to offset variable pay.

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

  The Ward Manager highlighted that the existing planned roster does not suit the needs of the ward. The ward manager proposed that to manage the busy workload the ward would run more smoothly with an additional RN during the long day shift. In addition, an extra HCSW by night is consistently being used on the ward to support patient acuity and enhanced care, which is driving up variable pay. Following professional discussions, the Divisional Lead Nurse agreed

to make a cost neutral change to the planned roster. The new proposed roster will swap the RN by night with the HCSW by day.

Cost neutral change to template.

**Summary of proposed amended establishments (excluding ward manager)**

| Ward | Pre-Calculation | | | Post -Calculation | | |
|---|---|---|---|---|---|---|
| | RN WTE | HCSW WTE | Total WTE | RN WTE | HCSW WTE | Total WTE |
| 4.4 NHH | 17.32 | 19.58 | 36.99 | 17.32 | 22.36 | 39.68 |
| Bargoed YYF | 14.48 | 27.99 | 42.47 | 17.32 | 27.99 | 45.31 |
| Oakdale YYF | 17.32 | 22.4 | 39.72 | 17.32 | 25.19 | 42.51 |
| C6E RGH | 14.48 | 22.42 | 36.9 | 14.48 | 25.2 | 39.68 |
| C6W RGH | 17.32 | 22.42 | 39.74 | 17.32 | 22.42 | 39.74 |

Following the Spring Calculations a roster efficiency analyses was undertaken on the 4 wards requesting roster template increases, covering the period October 2024 to March 2025.

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

**Unavailability reasons**

**HCSW**

- **Sickness Absence:** Sickness levels were high across all areas, predominantly short-term. However, each ward did have staff on long term sick leave: Oakdale (3), Bargoed (6), NHH (7), C6W RGH (4)

- **Study Leave:** Oakdale recorded an exceptionally high volume of study leave (1,064.5 hours), with some individuals taking up to three weeks study leave. This is attributable to several staff members undertaking the flexible route to nursing, as well as internationally recruited nurses requiring extended induction and were not ready to be included in the planned roster.

- **Bank Staff:**
  Unfilled Hours: High in all areas.

**RN**

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

- RN agency Use: High in all areas, exceptionally high in Oakdale

The Divisional lead gave assurance that sickness is monitored and managed appropriately across the sites. In addition to sickness, additional shifts were created to reflect the acuity on the sites and the subsequent need to increase the number of staff on duty over and above the agreed template.

It must be noted that in areas such as YYF it is more difficult to fill the bank shifts, (as indicated in the high unfilled hours rate), therefore increasing the pressures on the wards.

**Outcome**

This Spring calculations and proposed changes to roster templates on the 5 wards in medicine were presented at the Executive Committee on the 18th of September 2025, it was agreed that the Division of Medicine would implement the cost neutral change on C6W.

In terms of the requests regarding 4/4 at Nevill Hall Hospital, Oakdale Ward & Bargoed Ward at Ysbyty Ystrad Fawr and C6E at the Royal Gwent Hospital to meet the requirements of The Act the existing arrangement of utilising variable pay spend to staff these wards as set out in the spring calculation were supported. A further review through workforce, finance and nursing was agreed to

be undertaken as part of the autumn calculation process prior to any permanent funding arrangements.

**Autumn Calculations 2025**

A total of 35 wards undertook the recalculation process. The number of permanent medical 25B wards increased by 1 following the reclassification of Penallta Ward at YYF—a 28-bed COTE and palliative care ward—which now meets the criteria for a 25B designation.

Additionally, a staffing calculation was conducted for the temporary winter ward D7W at RGH.

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| Acute Medical: | 21 Wards |
| Surgical: | 12 Wards |
| Gynaecology: | 1 Ward |
| Paediatrics: | 1 Ward (50 beds) |

Following the in-depth recalculation processes, the Surgical, Gynaecological, and Paediatric Nurse Staffing Templates remained the same, no changes to roster templates were required.

**Medical Wards**

The medical wards retained the Spring adjustments, to ward 4.4 NHH, Bargoed & Oakdale wards YYF, & C6E RGH **(as set out above)**. The Autumn calculations also required additional changes to 2 other medical wards plus a temporary establishment and roster template was agreed for the winter ward:

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

Following the Respiratory and General Medicine reconfiguration, the ward footprint was extended to include a wing on B4—bringing the total to beds to 39 and an additional 6 high-care respiratory beds

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| | on C2 (total 45 beds). The staffing template and funded establishment currently includes a Registered Nurse (RN) coordinator role for 6 hours per day, 7 days a week.<br><br>Professional discussions highlighted several factors: the difficulty in managing the expanded bed base across three areas, further compromised by increased activity from the "Your Next Patient" initiative, the fast-paced environment, increasing patient acuity, and elevated NEWS (National Early Warning Score) on many patients all contribute to increased ward pressures.<br><br>Professional judgement was to extend the coordinator role to 12 hours per day, 7 days a week permanently to ensure safe and effective ward operation.<br><br>It should be noted that, following the respiratory reconfiguration, this role has consistently been fulfilled through variable pay to maintain patient safety and operational efficiency.<br><br>To meet this requirement, an increase of 1.42 WTE RN is proposed, at an annual cost of £75,053.<br>Previous roster: Early 9 RN / 7 HCSW, late 8 RN / 7 HCSW, Night 8 RN / 7 HCSW<br>Proposed Roster: Early 9 RN / 7 HCSW, **late 9 RN** / 7 HCSW, Night 8 RN / 7 HCSW<br><br>**Penallta Ward Ysbyty Ystrad Fawr (28 bedded, Gen Med and Palliative Care Ward, capacity to surge by 1 bed.**<br><br>Following a review of the 25B criteria, Penallta Ward has been classified as a 25B ward. This Ward is now overseen by a Gen Med consultant and accepts Gen Med, COTE and Palliative care patients. Despite previously being categorised as 25A, Penallta ward has consistently undergone biannual calculations along with the 25B wards in YYF due to its similar patient profile. The only exception being it was previously overseen by a CRT consultant.<br><br>Professional discussions have consistently highlighted the need to increase the HCSWs by night and for this to be reflected in the funded budget. This ward in line with the other wards in YFF consistently operates with 4 HCSW's by night, supported through variable pay. Therefore, to offset variable pay |

and ensure equity of services across the YYF site, there is a need to increase the funded establishment by 1 HCSW at night, 7 days a week at a cost of £124,000 per annum.

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

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

A Nurse Staffing Template was developed for the temporary winter pressures ward at the Royal Gwent site. As no historical data were available to inform this process, professional judgement was exercised by the Divisional Lead and Head of Nursing for Medicine to determine appropriate nurse staffing levels, drawing on comparisons with wards caring for patients with a similar profile.

To ensure patient safety and operational stability, it was agreed that the ward would be overseen by a seconded Band 7 and Band 6 from other wards within the Health Board. Staffing was further supported through the redeployment of substantive Registered Nurses (RNs) and Health Care Support Workers (HCSWs) from medical and surgical wards. These wards were subsequently backfilled with temporary staff.
In addition, the Nurse Bank advertised three-month contracts to support continuity and stability within the temporary workforce.

Proposed Roster: Day 3 RN / 3 HCSW - Night 2 RN / 3 HCSW
This equates to WTE - B7 x1, Band 6 x1, B5 x 13.48, Band 2 x 13.98

**Summary of amendments required to establishments post Autumn 2025 Recalculations include -rollover of 4 wards from Spring calculations plus Autumn proposals.**
***Excluding Supernumerary Ward Manager**

| Ward | Pre-Calculation | | | Post -Calculation | | |
|---|---|---|---|---|---|---|
| | RN WTE | HCSW WTE | Total WTE | RN WTE | HCSW WTE | Total WTE |
| 4.4 NHH | 17.32 | 19.58 | 36.99 | 17.32 | 22.36 | 39.68 |
| Bargoed YYF | 14.48 | 27.99 | 42.47 | 17.32 | 27.99 | 45.31 |
| Oakdale YYF | 17.32 | 22.4 | 39.72 | 17.32 | 25.19 | 42.51 |
| Penallta YYF | 17.32 | 19.56 | 36.88 | 17.32 | 22.36 | 39.68 |
| C6E RGH | 14.48 | 22.42 | 36.9 | 14.48 | 25.2 | 39.68 |
| C4 GUH | 47.2 | 39.65 | 87.42 | 48.59 | 39.65 | 88.24 |

The total cost if these roster templates were permanently amended (excluding the temporary winter ward, D7E) would be £685,511 annually.

**Outcome**

The Autumn calculations were presented to the Executive Nurse Director on 27th October 2025 and to the Board 0n 26th November. Following deliberation, it was agreed to continue to fund the increase in templates on the above 6 wards through variable pay.

**Informing patients**

In line with the requirements of the 2016 Act - following presentation to the Board or Executive Committee of each six-monthly calculation cycle, the All-Wales Nurse Staffing Public Posters are updated and distributed to the 25B wards by the Nurse Staffing Act Lead. The updated posters confirm the date presented to Board.

The All-Wales Nurse Staffing Group has approved new bilingual "Who's Looking After You Today?" posters. These include a display of the agreed and funded roster template for each Section 25B ward. A second poster is provided alongside this for comparison, which ward staff must complete daily to show the number of staff working each shift.

A QR code is included on the posters for the public to scan to find out more information on the Nurse Staffing Act 2016.

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| | Information leaflets in English and Welsh detailing frequently asked questions on the Act and how to raise concerns regarding staffing levels are available on each ward and can be found on the Health Board website under Patient Information.<br><br>Displaying this information can be challenging when wards are re-purposed or temporarily relocated for deep cleaning. To ensure compliance with the Act and that current Nurse Staffing Act posters are displayed at the entrance of each Section 25B ward, the Health Board has implemented the following measures:<br><br>• Monthly assurance audits undertaken by Senior Nurses as part of the Ward Accreditation Programme, including checks on the accuracy and visibility of Nurse Staffing Act information posters.<br><br>• Ad hoc checks by the Nurse Staffing Act Lead during visits to Section 25B wards. |

**Section 25E (2a) Extent to which the nurse staffing level has been maintained**

As the nurse staffing level is defined under the NSLWA as comprising of both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained during the period of this annual report

| | | Period Covered 6th April 2025-5th April 2026 | | |
|---|---|---|---|---|
| | | **Number of Ward:** | **RN (WTE)** | **HCSW (WTE)** |
| **Extent to which the required establishment has been maintained within <u>adult acute medical and surgical wards.</u>** | **Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during first cycle (May)** | 32 | 574.79 | 715.21 |
| | **WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following first (May) calculation cycle** | 32 | 571.95 | 706.89 |

| | | | | |
|---|---|---|---|---|
| NB: First cycle: spring 2025 following January audit<br>Second cycle: autumn 2025: following June audit | **Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during second calculation cycle (Nov)** | 34 | 608.01 | 751.59 |
| | **WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following second (Nov) calculation cycle** | 34 | 571.95 | 706.89 |
| | **WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)** | **WTE:** Spring – 32 Autumn - 34 | | |

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

It must be noted the above figures include the recalculation for the temporary winter ward D7W- which account for RN 14.48 WTE & HCSW 13.98 WTE.

The increase in WTE's proposed for the permanent 25B wards in medicine (Ward 4.4 NHH, Oakdale YYF, Bargoed YYF, Penallta YYF (not previously 25B), C6E RGH & C4 GUH) amounts to an increase of 4.23 WTE RN and 11.23 WTE HCSW.

**Vacancy Position**

Through the delivery of the Strategic Nursing and Midwifery Workforce Strategy (2023–2026), the Registered Nurse (RN) vacancies and staff turnover have greatly reduced. The Health Board is now in a strong workforce position. Workforce teams and Divisional Leads are therefore progressing the development of an action plan to support student streamlining to align with projected vacancies over the coming year.

**Annual RN vacancy figures**

| | |
|---|---|
| January 2024 | 290 WTE |
| January 2025 | 169.32 WTE |
| January 2026 | 35 WTE |

## Recruitment and retention

Recruitment and retention of the nursing workforce are key objectives outlined in ABUHB's Nursing, Midwifery & SCPHN Workforce Plan 2023-26. To achieve the ambitions, an action plan with monitoring processes is in place. The Workforce strategy compliments the Nursing & Midwifery Strategy 2023-26 – A Profession of Excellence, A Lifetime of Compassion which outlines the broad ambitions for:

- Staff development & Career progression
- Excellence in leadership at all levels
- QI, innovation & learning in pursuit of excellence
- Research & Innovation
- Professional identity and influence

To improve retention of the nursing workforce and in line with the Welsh Health Circular (WHC (2024) 012) Nursing Preceptorship & Restorative Clinical Supervision - A National Position Statement (March 2024), ABUHB have a plan to implement restorative clinical supervision (RCS) for all nurses, offering a minimal of 4 sessions per year for each nurse.

The organisational preceptorship programme has been reviewed to strengthen the embedded preceptorship programme for new registrants to the NMC and the organisation. Underpinning preceptorship with restorative clinical supervision will enable nurses to:

- Feel supported.

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| | ➢ Experience less stress, burnout and sickness absence.<br>➢ Develop personally and professionally.<br>➢ Be less inclined to leave the profession.<br>➢ See increased confidence levels.<br>➢ Feel less isolated.<br><br>ABUB have also weaved leadership into the preceptorship programme and has launched LEAD6, a development programme for band 6 nurses following the success of the band 7 Leadership Academy.<br><br>HCSW Banding<br><br>A HCSW validation Delivery Group has been established in line with the National steer to complete the assessments of HCSWs who were in substantive posts in January 2025 to ascertain if they meet the requirements for regrading to band 3. A road map has been developed to ensure the Health Board progresses this work in line with National timelines. The May 2026 nursing and midwifery workforce delivery group will be dedicated to establishing how band 2 and 3 HCSWs can be accommodated on rosters. |

| **Extent to which the required establishment has been maintained within <u>paediatric inpatient wards</u>**<br>NB: First cycle: spring 2025 following January audit | | **Period Covered 6th April 2024-5th April 2025** | | |
|---|---|---|---|---|
| | | **Number of Wards:** | **RN (WTE)** | **HCSW (WTE)** |
| | **Required establishment (WTE) of paediatric inpatient wards <u>calculated</u> during first cycle (May)** | 1 (50 beds) | 70.22 | 17.06 |
| | **WTE of required establishment of paediatric inpatient wards <u>funded</u> following first (May) calculation cycle** | 1 (50 beds) | 70.22 | 17.06 |

| | | | | |
|---|---|---|---|---|
| Second cycle: autumn 2025: following June audit | **Required establishment (WTE) of paediatric inpatient wards <u>calculated</u> during second calculation cycle (Nov)** | 1 (50 beds) | 70.22 | 17.06 |
| | **WTE of required establishment of paediatric inpatient wards <u>funded</u> following second (Nov) calculation cycle** | 1 (50 beds) | 70.22 | 17.06 |
| | **WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)** | **WTE:** 2 | | |

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

The paediatric unit in The Grange University Hospital consists of a 50 bedded unit inclusive of 2 HDU beds.

**Spring Calculations 2025**

The paediatric unit at GUH occupies both B1 and C1 comprises of 50 beds including 2 HDU beds. The areas are split into pre-school and school age children; however, children can be on any part of the unit dependent on bed availability and staffing. During January there were several occasions when ward beds were full and so assessment spaces within 'FOX' pod were used for inpatient care. Discharges tend to happen in the early afternoon which then creates space for the influx into CEAU after GP morning surgery. Generally, the numbers of children admitted are equal to the number discharged.

Most patients continue to be level 2 patients who have a defined problem and a clear pathway of treatment. During January there was only one day when there was not an HDU patient, there were

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| | occasions when there were more HDU patients than the two commissioned beds. HDU beds are covered using a flexible workforce i.e. bank is used to cover; however, this can be problematic. When the number of HDU patients is more than 2, experienced HCSW are deployed to support the RNs in HDU.<br>The RN vacancies during the Spring recalculation were 15.28 WTE, ward staffing was supplemented using the nurse bank. Bank staff are mainly substantive staff but there are also staff who work regularly for the unit through the resource bank. Since the introduction of the staffing Act the staff template has never been met, however it was projected that the RN vacancy position would improve as the year progressed.<br><br>Feedback from students is good and newly qualified staff continue to be recruited through the streamlining process.<br><br>Four IEN nurses were interviewed and recruited in June 2025. Senior Staff actively engage in recruitment events, looking at flexible working and working with our HR colleagues to ensure adverts are appealing.<br><br>Bank use is monitored and gaps are offered out as soon as possible to ordinary bank rate; specialist rate is only offered 24 hours before the start of the shift as activity and acuity dictates.<br><br>**Autumn Calculations 2025**<br><br>Admission and discharge rates were broadly balanced, with patient numbers remaining relatively stable throughout the week. Weekend admissions were generally lower than weekday levels. Reduced senior staffing had an impact on discharge rates.<br><br>The ward attender pathway has been streamlined, with designated slots now scheduled on Tuesdays, Wednesdays, and Thursdays. These activities, which include blood tests and procedures under sedation, are managed by the on-duty nursing staff. However, the time required and associated acuity are not currently captured. Despite the streamlining, the pathway remains ineffective in practice due to unpredictable demand, which continues to place pressure |

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| | on nursing time—particularly when accommodating unplanned attenders or managing delays even for booked patients. This inconsistency affects the team's ability to plan and deliver care efficiently.<br>Patient numbers in June were the lowest recorded in 2025, reflecting seasonal variation and the impact of warmer weather. Despite reduced admissions, patient acuity remained consistent, with the majority classified as Level 2, alongside ongoing care for HDU and Level 4 CAMHS patients. Additional HCSW hours were allocated to support a complex-needs infant transferred from NICU, requiring continuous supervision. Further HCSW bank usage was required to mitigate RN shortfalls, with patient safety maintained as the primary priority.<br><br>**Vacancy Position**<br><br>At the time of the autumn calculations, the unit had 11.37 WTE Registered Nurse (RN) vacancies, with staffing levels supplemented by the Nurse Bank.<br><br>The number of vacancies presented a significant staffing challenge. As a result, the Band 6 Nurse in Charge (NIC) continued to carry a clinical workload overnight, at weekends, and during bank holidays.<br><br>As from March 2026 the vacancies on the paediatric wards reduced significantly. The Paediatric Unit is now in the most stable position since the opening of the Grange University Hospital, reporting the very positive position of 4.64 RN WTE and 0.65 HCSW WTE vacancies. |

**Extent to which the planned roster has been maintained within adult acute medical and surgical wards**

| | Total number of shifts | Shifts where planned roster met and appropriate | Shifts where planned roster met but not appropriate | Shifts where planned roster not met but appropriate | Shifts where planned roster not met and not appropriate | Data completeness |
|---|---|---|---|---|---|---|
| TOTAL | 35948 | 18529<br>51.4% | 4384<br>12.20% | 7989<br>22.22% | 2694<br>7.49% | 93.46% |

*A disparity in reporting the appropriateness of deployed rosters currently exists across Wales, with most Health Boards using a headcount-based measure while Cardiff & Vale use an hours-based approach as a result of enhanced data access. Due to the nuances of different shift patterns, the two reporting methodologies can result in markedly different interpretations of whether planned rosters have been met or not. Now that this enhanced data access is available across Wales, work is underway through the All-Wales Nurse Staffing Programme to agree a single, standardised metric ahead of the next reporting cycle.*

ABUHB uses Headcount - the above figures are based on headcount taken from the Assignment summary report in Healthroster.

Various red flags have been raised throughout the Adult 25B wards. The highest reasons being.

- Boarding
- High acuity
- L4 & L5 patients prioritised despite staffing shortfall
- HCSW shortfall.

The red flags increased as the year progressed with the highest reason being -Boarding.

Below is a snapshot of a 4-month period of red flags raised on the adult medical and Surgical wards:

## Medicine (Dec 2025-end of March 2026)

| Count of Red Flag Type | Column Labels | | | |
|---|---|---|---|---|
| | <01/12/2025 | 2025 | 2026 | Grand Total |
| **Row Labels** | | | | |
| Boarding | | 130 | 515 | 645 |
| DATIX incident – related to nurse staffing | | 3 | 7 | 10 |
| Delay in providing pain relief | | | 2 | 2 |
| High Acuity that cannot be met by staffing levels | | 54 | 172 | 226 |
| L4 & L5 Patient/s Prioritised Despite Shortfall | | 62 | 228 | 290 |
| Less than 2 RNs on shift | | 3 | 2 | 5 |
| Missed 'intentional rounding' | | 4 | 22 | 26 |
| Shortfall in HCSW Time | | 85 | 263 | 348 |
| Shortfall in RN time | | 26 | 81 | 107 |
| Staff unable to take a break | | 6 | 9 | 15 |
| Surge beds | | 14 | 44 | 58 |
| Vital signs not assessed or recorded | | | 2 | 2 |
| (blank) | | | | |
| **Grand Total** | | **387** | **1347** | **1734** |

## Surgery (Dec 2025-end of March 2026)

| Count of Red Flag Type | Column Labels | | |
|---|---|---|---|
| | 2025 | 2026 | Grand Total |

| Row Labels | | | |
|---|---|---|---|
| Boarding | 51 | 156 | 207 |
| High Acuity that cannot be met by staffing levels | 23 | 37 | 60 |
| L4 & L5 Patient/s Prioritised Despite Shortfall | 9 | 33 | 42 |
| Less than 2 RNs on shift | | 3 | 3 |
| Shortfall in HCSW Time | 20 | 57 | 77 |
| Shortfall in RN time | 11 | 33 | 44 |
| Staff unable to take a break | 1 | | 1 |
| **Grand Total** | **115** | **319** | **434** |

- Ward staff are encouraged to apply professional judgement alongside identified red flags, documenting any escalation of risk to senior nurses and site managers, and clearly recording the actions taken to manage or mitigate the risk.

- Compliance with raising red flags and professional judgements varies across wards and is discussed in the bi-annual recalculation deep dive meetings.

- Senior nurses and site managers review risks during 'Safe to Start' meetings and, where possible, redeploy staff to areas presenting the highest risk. Staffing deficits are escalated, and shifts are offered to bank and agency staff in line with the Health Board's escalation policy. Feedback from 'Safe to Start' meetings has been positive, demonstrating their effectiveness in collectively managing staffing concerns. However, further work is required to ensure that red flags are consistently reviewed and closed following senior assessment.

**Extent to which the planned roster has been maintained within <u>paediatric inpatient wards</u>**

| | Total number of shifts | Shifts where planned roster met and appropriate | Shifts where planned roster met but not appropriate | Shifts where planned roster not met but appropriate | Shifts where planned roster not met and not appropriate | Data completeness |
|---|---|---|---|---|---|---|
| TOTAL | 2190 | 471<br>21.51% | 19<br>0.87% | 1510<br>68.95% | 72<br>3.29% | 94.61% |

A total of 86 red flags were raised throughout the reporting year, which is a decrease from the previous year (167) this probably attributed to the improving vacancy position on the unit.

Below is a snapshot of a 4-month period of red flags raised on the paediatric unit:

**Paediatrics (Dec 2025-end of March 2026)**

| Count of Red Flag Type | Column Labels | | |
|---|---|---|---|
| | 2025 | 2026 | Grand Total |
| **Row Labels** | | | |
| High Acuity that cannot be met by staffing levels | 3 | 1 | 4 |
| Shortfall in RN time | 6 | 22 | 28 |
| **Grand Total** | **9** | **23** | **32** |

Professional judgement and supporting notes were recorded to demonstrate how risks were mitigated. Risks were escalated to site managers, and on occasion, staff were redeployed from NICU to provide additional support. During recalculation discussions, the Senior Nurse and

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| | Divisional Lead assessed that, despite vacancies and high acuity, patient safety within the paediatric unit was maintained through the use of experienced staff undertaking bank shifts. |
| **Process & systems for capturing data on the extent to which the planned roster has been maintained on wards where section 25B applies.** | *NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. Extensive work has been undertaken across NHS Wales to implement a national informatics system to enable health boards/trust to meet the reporting requirements of the Act and follow the Once for Wales approach to ensure consistency.*<br>*Each health board/trust committed to implementing RL Datix (formally Allocates) Safecare system, with each organisation having implemented this system to their section 25B wards.*<br><br>The e-rostering team monitor Safecare and provide each 25B ward with monthly compliance reports. Additional support is provided to areas below 90% compliance. During the Bi-annual recalculation meetings ward managers are reminded of the importance of raising a red flag for individual issues of concern and that a professional judgement must be noted against each red flag to escalate or mitigate the risk. |
| **Process for maintaining the Nurse staffing level** | Processes to manage and escalate nurse staffing deficits is now well established to ensure all reasonable steps have been followed to maintain nurse staffing levels, which includes:<br><br>• A ratified Nurse Staffing Operational Policy, to standardise and inform staff groups of their responsibilities to ensure all areas where nurses are deployed are staffed appropriately to meet the needs of patients.<br><br>• A weekly reporting and escalation process by which staffing deficits across the Health Board are reported include:<br><br>➢ Filled and unfilled Registered Nurse (RN) shifts against planned rosters |

| | |
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| | ➢ Filled and unfilled Health Care Support Worker (HCSW) shifts against planned rosters<br>➢ Percentage of substantive staff versus agency staff populating rosters to gauge quality, safety, and continuity of care.<br>➢ Serious incidents considered to have been attributed to a deviation from the planned ward nursing roster.<br><br>• A workforce tracker is presented to the Executive Team detailing progress on recruitment, bank, and agency usage, turnover and absenteeism.<br><br>• A monthly Strategic Workforce (NSLWA) meeting is held with representation from all clinical Divisions, with the purpose of overseeing the implementation of the Act and monitoring key workforce and staffing metrics.<br><br>• Daily review of nurse staffing levels by all divisions – to manage and mitigate risk.<br><br>• Unfilled shifts escalated to bank/agency at the earliest opportunity to give best opportunity of securing staff.<br><br>• Clear Divisional escalation procedures to ensure and manage timely escalation of unfilled shifts.<br><br>• The development of new and innovative roles has been crucial in maintaining nurse staffing levels across the Health Board.<br><br>• The deployment of staff between wards and across sites to fill short notice deficits.<br><br>• The rolling out of "Safe to Start" across all sites.<br><br>**Safe to Start (S2S)** |

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| | The initiative was launched in the Grange University Hospital in January 2025 and has now rolled out to all hospital sites. This involves twice daily 30-minute S2S meetings held at 08:20 and 13:30. In attendance are ward and department managers, Senior Nursing and Operational teams and members of the wider MDT. The information shared includes, nurse staffing levels, ward / department demand and capacity, quality, safety & experience and wider system demand and capacity.<br><br>S2S empowers ward and department leaders, encourages a collaborative and supportive approach to managing risks, ensuring the best possible decisions are made in real-time to enhance both patient and staff safety. The S2S initiative actively determines whether each ward and department are safe to start. If a ward or department reports that it is not safe to start, the S2S team will collaborate to determine the necessary actions to address the issues, ensuring a collective plan is developed and agreed upon to allow optimal safety across all areas. |

**Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards**

| Incidents of patient harm with reference to quality indicators and complaints about nursing care (note: for all rows, please only include incidents that have been closed) | Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable). | Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents). | Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents). | Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)) |
|---|---|---|---|---|
| | TOTAL | TOTAL | TOTAL | TOTAL |
| **Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints** | 3 | 0 | 0 | 10 |

| | | | | |
|---|---|---|---|---|
| **opened prior to this reporting period).** | | | | |
| **Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained** | 0 | 0 | 0 | 2 |
| **Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor** | 0 | 0 | 0 | 0 |
| **Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained** | 3 | 0 | 0 | 8 |
| **Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.** | 0 | 0 | 0 | 0 |

B*ased on a review of the Health Boards/Trusts first 3 yearly reports and feedback from operational leads on their experience completing the reports; an SBAR was presented to the Executive Nurse Directors and CNO in 2021, which included a series of recommendations to improve and refine the reporting process. Following this a sub-group of the All-Wales Nurse Staffing Group was set up to improve and refine the reporting process to standardise reporting and be in line with the Duty of Candour set out in the Quality & Engagement Act (2020), with the aim of broadening the scope of incidences of harm to provide more meaningful data, by including moderate risk falls and medication administration error incidents.*

*The work of the Reporting Sub-Group included a review of the measures for the adult medical and surgical inpatient wards, and these were presented to the Executive Nurse Directors in August 2023. The changes to the adult wards' measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. April 2024.*

*Since EDoNs agreed the recommendations in August 2023 it became apparent that the way data is being captured on Datix to meet the reporting requirements of the Duty of Candour (DoC), which came into force in April 2023, may impact our data collection under the duties of the NSLWA.*

*Previously, it was anticipated that the changes in the reporting criteria to include moderate levels of harm would increase overall reporting, however, following this clarification this anticipated increase may not be seen.*

*It must be noted that previous NSLWA reports have reported on the actual harm sustained without validation, as opposed to the number of incidents found to be resulting from an act or omission when in receipt of NHS Care. To align with patient safety incident reporting to Welsh Government all future NSLWA reports, as from April 2024, will report on closed patient safety incidents which have been validated with a level of harm moderate or above (as per patient safety incident definition) and whether the nurse staffing levels contributed to the incident.*

*The quality indicators for the adults in-patient wards will be as follows:*

- *Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).*
- *Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).*
- *Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).*
- *Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))*

*The data to be reported for each of the above will be:*

- *Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).*

- *Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained*

- *Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor*
- *Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained*

- *Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.*

*In late 2024, it became apparent that there is significant variation in the types of complaints that are being reported within each organisation's nurse staffing report due to local interpretation of the Operational Guidance. As a result, the Reporting Group presented an SBAR that outlined a proposed criteria for standardised complaint reporting to the DDoN Forum in February 2025. This criterion was agreed by the DDoN Forum on the basis that reports are reviewed later in 2025 to establish if the criteria is adequately sensitive and produces the right level of practically useful context as a quality indicator.*

*The agreed criteria is as follows:*

*Complaints received by 25B areas that:*

- *Have been closed within this reporting period.*
- *Are being managed through PTR.*
- *Have identified a breach in the duty of care.*
- *Are relevant to nursing care (using the guidance document to support).*

A total of 3 HAPUs were found to be avoidable for this reporting year, equalling that of the previous year. The staffing levels were maintained in all 3 incidences and were not considered to be a contributing factor. The Health Board has reinstated the Pressure ulcer damage forum which is currently focussing on streamlining investigation processes and the closure of Datix incidents accurately and timely. Each division has a well-established process to investigate incidences and share learning.

Only 1 fall was closed as moderate or above compared to 11 the previous year. The fall met the duty of candour criteria and was reported to RIDDR. All falls are investigated thoroughly, and injurious falls go to falls panel where learning is identified

and shared throughout the divisions. The timeliness of completing the multi factorial risk assessments (MFRA) has greatly improved following the successful implementation of the electronic Welsh Nursing Care Record (WNCR). In addition, many wards have chosen to work on reducing falls as an improvement project in the ward accreditation programme- concentrating on introducing simple yet effective interventions such as ensuring patients have the correct footwear which is helping to reduce injurious falls.

There have been no medication errors this year or the previous year causing moderate harm or above. All medication administration incidents are investigated and where appropriate, RNs are required to undertake medicine management training and undergo Bess scoring.

Complaints are often multifaceted and involve multiple disciplines with many patients' hospital stay involving several weeks.

ABUHB are working with local complaint Hubs and divisions to embed processes to ensure the Nurse Staffing Act questions are answered in Datix prior to closure of the complaints. During this reporting period, the NSA Lead consulted with the Heads of Nursing for each Division to obtain the information on whether staffing levels impacted on care on the 10 complaints closed as wholly or partially relating to nursing care on the Adult Medical and Surgical wards. The professional judgement of the senior nurses and Divisional leads is that staffing levels were not a contributing factor.

As from April 2026- only closed complaints where there has been a recognised breach of duty relating to nursing care will be reported on.

| Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on paediatric inpatient wards | | | | | |
|---|---|---|---|---|---|
| **Incidents of patient harm with reference to quality indicators and complaints about nursing care (note: for all rows, please only include incidents that have been closed)** | **Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).** | **Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).** | **Medication administration errors resulting in moderate harm, severe harm, death** | **infiltration and extravasation injuries** | **Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations** |

| | | | & never events (i.e. level 3, 4, 5 and never events incidents). | | (Putting Things Right (PTR) |
|---|---|---|---|---|---|
| | **TOTAL** | **TOTAL** | **TOTAL** | **TOTAL** | **TOTAL** |
| **Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).** | 0 | 0 | 0 | 1 | 1 |
| **Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained** | 0 | 0 | 0 | 1 | 1 |
| ***Number of those* incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor** | 0 | 0 | 0 | 0 | 0 |
| **Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained** | 0 | 0 | 0 | 0 | 0 |

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| **Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.** | 0 | 0 | 0 | 0 | 0 |

*The work of the Reporting Sub-Group, mentioned previously, included the measures for the paediatric inpatient wards and these were presented to the Executive Nurse Directors in August 2023, along with the amended measures for the adult medical and surgical wards. The changes to the paediatric measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. April 2024.*

*The quality indicators for the paediatric inpatient wards will be as follows:*

- *Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).*
- *Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).*
- *Medication administration errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).*
- *Infiltration and extravasation injuries*
- *Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))*

*The data to be reported for each of the above will be:*

- *Number of incidents/complaints closed during the current reporting period. (Please note these may include incidents/complaints opened prior to this reporting period).*
- *Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained*

- *Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor*
- *Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained*

- *Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.*

*In late 2024, it became apparent that there is significant variation in the types of complaints that are being reported within each organisation's nurse staffing report due to local interpretation of the Operational Guidance. As a result, the Reporting Group presented an SBAR that outlined a proposed criteria for standardised complaint reporting to the DDoN Forum in February 2025. This criterion was agreed by the DDoN Forum on the basis that reports are reviewed later in 2025 to establish if the criteria is adequately sensitive and produces the right level of practically useful context as a quality indicator.*

The agreed criteria is as follows:

Complaints received by 25B areas that:

- *Have been closed within this reporting period;*
- *Are being managed through PTR;*
- *Have identified a breach in the duty of care;*
- *Are relevant to nursing care (using the guidance document to support).*

During this reporting period, there were 0 hospital acquired pressure ulcer on the paediatric unit, compared to 1 the previous year.

There has been an improvement in extravasation incidents, there was 1 episode of infiltration/extravasation during this reporting period in comparison to 5 incidences the previous year. Regarding the 1 reported incident for this period- the infusion was stopped immediately and there was no harm to the patient, staffing was not considered to be a factor, despite the staffing levels not being maintained.

There was 1 complaint closed as related to nursing, the staffing levels were not maintained but considered appropriate. The professional judgement of the Paediatric Senior Nurse was that the staffing levels were not a contributory factor.

| | **Section 25E (2c) Actions taken if the nurse staffing level is not maintained (or maintained but not appropriate *)** |
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| **Actions taken if the nurse staffing level <u>was not</u> maintained in wards where section 25B applies** | By way of assurance, the Health Board has in place:<br><br>• Well embedded process to investigate all Health Care Acquired Pressure Ulcers (HAPU's) through root cause analysis (RCA) which considers a range of variables which may have contributed to the incident. Any HAPU's considered to have been deemed avoidable are reported to Welsh Government and are reviewed at the Redress Panel, enabling a process of reflection and learning.<br><br>• A Falls Review Panel is well established, where all variables are considered. Falls that meet the duty of Candour as moderate level of harm or above are reviewed at the Redress Panel. Organisational shared learning events have taken place in relation to falls.<br><br>• Complaints is a complex metric to capture due to the multi-faceted nature of complaints.<br><br>• Never event medication errors are investigated as a serious incident and reported to Welsh Government. |
| | **Section 25A: Duty to have regard to provide sufficient nurses** |
| **Requirements of Section 25A**<br><br>(NB: Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels in any area where nursing services are provided or commissioned, not only | In accordance with the NSLWA the Health Board is required to ensure there are sufficient nurses (including those to whom registered nurses delegate the delivery of care) to allow nurses time to care for patients sensitively wherever nursing care is provided and / or commissioned.<br><br>For the purposes of having regard to the importance of providing sufficient nurses to allow the nurses time to care for patients sensitively, a Local Health Board or NHS Trust in Wales must (among other things) undertake workforce planning (including planning the recruitment, retention, education and training of nurses).<br><br>The All-Wales Nurse Staffing Group (AWNSG) have commissioned a subgroup to work on developing an All-Wales framework to assist 25A areas in calculating nursing establishments using |

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| wards where section 25B applies) | a consistent and evidence-informed approach. This work is ongoing and scheduled for completion in March 2027. In the interim most health boards have commenced undertaking calculations of nursing establishments in focussed 25A areas, using available workforce tools and professional judgement.<br><br>ABUHB Calculation progress 25A areas<br><br>In the interim, the Nurse Staffing Act Programme lead has devised an annual timetable for focussed 25A areas in ABUHB to undertake annual calculations adapting similar principles used in the 25B calculations.<br><br>• **Urgent care** - Divisional Leads undertake biannual staffing calculations for the Emergency Department GUH, Minor Injury Units, and Same Day Emergency Care (SDEC) services across all sites, in line with the 25B ward timetable. The outcomes of these calculations are presented annually to the Executive Director of Nursing. No amendments to the existing templates were identified as necessary at the most recent review. However, a further review of the Clinical Emergency Unit (CEU) will be required once the trial separation from the Clinical Emergency Assessment Unit (CEAU) on the GUH site has concluded. At present, Urgent Care does not have consistent Band 7 leadership for paediatric emergency admissions following the relocation of CEAU to the Fox Pod within the paediatric unit. Additionally, variable pay expenditure for both HCSWs and Registered Nurses within Urgent Care has increased as a consequence of the trial separation of the two departments.<br><br>• **Primary Care and Community Division** – the Division completed the second annual calculation of all community wards and a first calculation of district nursing teams during summer/Autumn 2025. The outcomes were presented to the Executive Director of Nursing on 19 February 2026.<br><br>Community Hospitals<br><br>➢ No additional funding required but some agreed actions |

- Carry out evaluation of enhanced care staffing and impact on variable pay
- Align Monnow Vale to establishment of reduced bed base – pressure of increase in HCSW requirements at night due to Health and Safety fire regulations (supported through variable pay).

District Nursing

- This was a valuable process and proved to be an enlightening exercise. Currently in district nursing there is a national piece of work surrounding 25A calculations. Going forward ABUHB are aligning with the national steer

Initial learning and actions to support future work

- Align with national group and steer
- Focused piece of work on acuity and WLOC to establish changing demand and caseloads with assurance of senior review
- Changing landscape of teams and community nursing model to support changing demand – 24/7 DN team with closer alignment with rapid teams

- **Mental Health and Learning Disabilities -** completed the second round of calculations of all in-patient wards in the reporting period 2025-2026. The outcomes will be presented to the Executive Director of Nursing on 12 May 2026.

- **Clinical Support Services (CSS) -** Critical care and Surgical High care completed the first round of calculations during the Summer/Autumn 2025 – no changes were required to templates. Critical care uses the BACCN standards to determine staffing levels. The same quality indicators were used as those used in the 25B ward calculations- HAPUs, Falls, Medication errors, complaints relating to Nursing care

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| | • **Medical and Surgical Divisions -** have added all 25A areas into the 25B calculation timetable. These areas include, MAU, SAU, day-case units, haematology in-patient wards as well as any ward that does not fit 25B criteria. The same methodology as used in 25B wards was applied. There were no changes to current establishments. |
| | **Conclusion & Recommendations** |
| | • The Health Board has a well-developed process embedded in practice for calculating nurse staffing levels in 25B wards.<br>• The Health Board has systems in place to ensure compliance with The Act in informing patients and the public of agreed staffing levels on 25B wards.<br>• Through the delivery of the Strategic Nursing and Midwifery Workforce Strategy (2023-2026), there has been a positive reduction in Registered Nursing (RN) vacancies.<br>• The e-rostering team monitor and distribute Safecare compliance to all 25B wards and offer support for areas of low compliance.<br>• Established processes to manage and escalate nurse staffing deficits are in place to ensure all reasonable steps have been followed to maintain nurse staffing levels.<br>• Processes are in place to scrutinise quality indicators and determine if nurse staffing levels were a contributing factor. |

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| | • The Health Board has begun undertaking formal reviews of nursing establishments on focussed areas under 25A of the Act - whilst awaiting formal operational guidance from the All-Wales Nurse Staffing Group (AWNG).<br><br>• Anticipated development in digital informatic systems will improve the quality and accuracy of future reporting on nurse staffing levels on 25B wards.<br><br>**Recommendations:**<br><br>Nurse Staffing Act Lead to continue to represent the health Board in All-Wales Nurse staffing Group and feedback developments and updates from the All-Wales subgroups:<br><br>➢ Reporting Group<br>➢ Research and Evaluation<br>➢ 25A Working Group<br>➢ Data and Digital. |

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

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|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 28 July 2026 |
| **CYFARFOD O:**<br>**MEETING OF:** | Patient Quality, Safety and Outcomes Committee |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Patient Quality, Safety and Outcomes Committee – Review of Committee Forward Work Plan 2026/27 |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Director of Corporate Governance |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Governance Support Officer |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**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 the June 2026 meeting :-**

- Research and Development Annual Report (Deferred to October meeting).

**Items brought forward on the Forward Work Programme:-**

- Nurse Staffing Levels Wales Act Annual Assurance Report.

**Additional items deferred on the Forward Work Plan:-**

- Safeguarding Annual Report (Deferred to October meeting).
- Maternity and Neonatal Report (Deferred to October meeting).

These changes have been reflected on the updated Forward Work Programme.

**Argymhelliad / Recommendation**

The Committee is requested to **NOTE** the updated Committee forward work plan as provided in **Appendix 1**.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol:<br>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:<br>Health and Care Standard(s): | Governance, Leadership and Accountability<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item.<br>Choose an item.<br>The Committee Forward Programme monitors delivery of objectives. |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Governance |

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| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Not Applicable<br>Choose an item.<br>Choose an item.<br>Choose an item. |

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

| **Effaith: (rhaid cwblhau)<br>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<br>Equality Impact Assessment** (EIA) completed | **No does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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<br>Well Being of Future Generations Act – 5 ways of working** | Not Applicable<br>Choose an item. |

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

**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.<br>In respect of the achievement of the Boards' strategic aims, objectives and priorities, the Committee will seek assurances on:<br>a. The robustness of the Health Board's Clinical Quality Governance arrangements;<br>b. the experience of patients, citizens and carers ensuring continuous learning;<br>c. the provision of high quality, safe and effective healthcare within directly provided and commissioned services; and<br>d. the effectiveness of arrangements in place to support Improvement and Innovation. |

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

| **MATTERS TO BE CONSIDERED** | **Lead** | **Frequency of Report** | | **QTR 1** | | **QTR 2** | **QTR 3** | | **QTR 4** |
|---|---|---|---|---|---|---|---|---|---|
| | | | **8th April 2026 Cancelled** | **6th May 2026** | **2nd June 2026** | **28th July 2026** | **6th Oct 2026** | **1st Dec 2026** | **16th 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<br>• Annual Review of Committee Terms of Reference 2026/27<br>• 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** | **√D** | √ | | |
| Quality Outcomes Reporting Qlik app – May meeting<br>• Q4 Never Events **PQSOC0206/07**<br>• Infection prevention and control **PQSOC0206/07**<br>• Waiting times and pain-related complaints **PQSOC0206/07**<br>• ~~Violence Prevention **PQSOC 1702/06**~~ | 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 | | | | √D | √ | | |
| Learning from Death Report | MD | Bi-AN | √D | √ | | | √ | | |
| ~~Health and Safety Compliance Annual Report~~ | ~~DoAHP&HS~~ | ~~AN~~ | | | | ~~√D~~ | ~~√~~ | | |
| Safeguarding Annual Report | DoN | AN | | | | √D | √ | | |
| 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 (presentation) (Action transferred from Exec's) | COO | Action | **√D** | √ | | | | | |
| 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 | DoAHP&HS | Action | **√D** | | √ | | | | |

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|---|---|---|---|---|---|---|---|---|---|
| specific wards (**PQSOC 1702/06)** update given under action log item on agenda | | | | | | | | | |
| 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 | | | **√** | | | | |
| Timeline & Implementation plan for the Qlik App **PQSOC 0605/05** | DON | Action | | | | **√** | | | |
| Research and Development Annual Report **PQSOC 0206/08** | MD | Action | | | | **√D** | **√** | | |
| Violence and Aggression Incidents | Clinical Executives | Action | | | | | **√** | | |

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

| Frequency of Inclusion | |
|---|---|
| **Narrative of Reason why Included in the FWP – other reasons to be developed as part of FWP discussions** | |
| **SI** | Standing Item |
| **An** | Annual |
| **1/4ly** | Quarterly |
| **BI** | 1/2 yearly |
| **Schedule of Meetings** | |
| **√** | Scheduled agenda item in FWP |
| **D** | Deferred from this agenda |
| **√D** | Deferred Scheduled agenda item |
| **W** | Withdrawn from FWP |
| **T** | Transferred to another Committee |
| **IC** | Matter discussed In Committee |

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

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| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | 28 July 2026 |
| **CYFARFOD O:**<br>**MEETING OF:** | Patient Quality, Safety and Outcomes Committee |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Committee Risk and Assurance Report |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Director of Corporate Governance |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Head of Corporate Risk and Assurance |

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

Ar Gyfer Trafodaeth/For Discussion

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

## ADRODDIAD SCAA
## SBAR REPORT

### Sefyllfa / Situation & Cefndir / Background

At the last Committee meeting in June 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**<br>Chief Operating Officer<br>**Theme**<br>Service Delivery<br>**Appetite**<br>Open<br>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**<br>**4 x 4**<br>**(16)** | **Y** |
| **SRR 008**<br>Director of Nursing<br>**Theme**<br>Transformation & Partnership Working<br>**Appetite**<br>Open<br>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**<br>**2 x 4**<br>**(8)** | **Y** |
| **SRR 010**<br>Director of Therapies & Health Science<br>**Theme**<br>Compliance & Safety<br>**Appetite**<br>Minimal<br>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**<br>**3 x 4**<br>**(12)** | **N** |

Since the last report to the Committee in June, 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.

**Risks Outside of Appetite**

**SRR 010** continues to sit outside the Board's agreed risk appetite. Whilst there has been measurable progress in reducing both the likelihood and impact of the risk through delivery of the Health and Safety Improvement Plan, improvement is not yet sufficiently embedded across the organisation to achieve the desired risk position.

To strengthen oversight and assurance, a Health and Safety Scorecard is being developed to provide a consolidated view of key performance, compliance and assurance measures. Current reporting to the Health and Safety Committee indicates stable performance against core measures, including RIDDOR reporting and training compliance.

Independent assurance activity continues to provide positive evidence regarding the effectiveness of health and safety controls, with compliance levels of 96% from Health and Safety Management Audits and 95.5% from Workplace Health and Safety Inspections. In addition, enhanced scrutiny of high and extreme risks by the Corporate Health and Safety Team has strengthened risk controls and accountability.

Collectively, these arrangements have improved leadership and governance at Divisional level and provide increased assurance that health and safety risks are being effectively managed whilst further improvements are embedded**.**

To enhance assurance to the Committee and Board the proposed Strategic Risk Assessment Template, to be presented to the Board in September 2026, will strengthen oversight of this and other principal risks by providing greater transparency of the strategic controls in place to reduce the residual risk, together with an assessment of their effectiveness and the assurance supporting them. The revised approach recognises that strategic risks are rarely reduced through a single intervention; rather, they are managed through a suite of strategic controls, including governance arrangements, compliance monitoring, inspection programmes, training, maintenance programmes, investment and improvement initiatives, which collectively reduce the Health Board's residual exposure to risk.

The effectiveness of these strategic controls is inherently dependent upon the consistent implementation of the underpinning operational controls across the organisation. As operational controls become more embedded and effective, the strategic controls are strengthened, reducing both the residual risk and the proximity of the risk materialising. By providing clearer visibility of strategic control effectiveness, assurance gaps and risk trajectory, the revised template will support enhanced scrutiny by the Committee and the Board, enabling more informed judgement as to whether the actions being taken are sufficient to bring the risk within the Board's agreed appetite over time.

**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)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>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:<br>Health and Care Standard(s): | Governance, Leadership and Accountability<br>2.1 Managing Risk and Promoting Health and Safety<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br>Link to IMTP | Choose an item.<br><br>The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities. |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP | Governance |

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| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br>Strategic Equality Objectives 2020-24 | Choose an item.<br>Choose an item.<br>Choose an item.<br>Choose an item. |

| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base: | N/A |
| Rhestr Termau:<br>Glossary of Terms: | N/A |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>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)<br>Impact: (must be completed)** | |
|---|---|
| | **Is EIA Required and included with this paper** |
| **Asesiad Effaith Cydraddoldeb<br>Equality Impact Assessment** (EIA) completed | **No does not meet requirements**<br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>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<br>Well Being of Future Generations Act – 5 ways of working**<br><br>https://futuregenerations.wales/about-us/future-generations-act/ | Choose an item.<br>Choose an item.<br>N/A |

| Risk ID and Description | | | | IMTP Link | Risk Score | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2 | 3 | 4 | 5 | 6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |
| SRR 005 | Chief Operating Officer | There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system | a) Due to inadequate arrangements to support system-wide patient flow | System Change | | | | | | | X | | | | ● ◊ | | |
| SRR 008 | Director Of Nursing | There is a risk that the Health Board fails to build positive relationships with patients, staff and the public | a) Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement | Quality | | | X | | | ● | | | | | ◊ | | |
| SRR 010 | Director of Allied Health Professions and Health Science | There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in-line with its duties under the Health and Safety at Work Act 1974 | a) Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements, specifically, Manual Handling, RIDDOR Reporting, Fire Safety Risk Assessments, and Work-based Risk Assessments. | Quality & Workforce & Culture | | | | | X | ◊ | | | ● | | | | | |

| Key | | |
|---|---|---|
| | Current Score | ● |
| | Target Score | × |
| | Appetite Threshold | ◊ |

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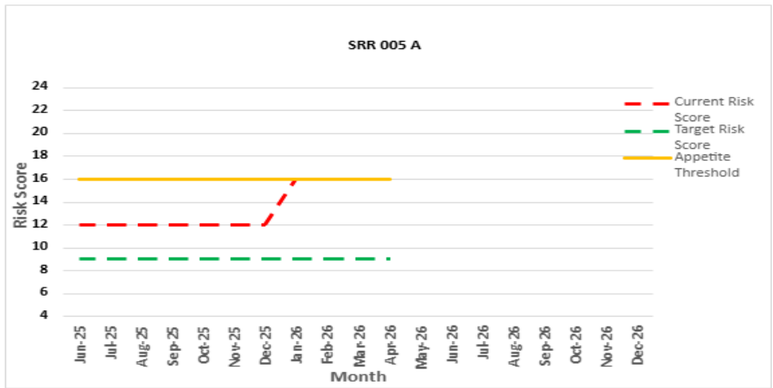
| **RISK THEME** | **SERVICE DELIVERY** | | | |
| **LINK TO IMTP** | **SECTION 3: SYSTEM CHANGE** | | | |
| **Strategic Risk**<br>**SRR 005 A** | **There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system** | | **Publication Status** | **Public** |
| **Threat**<br>*(As a result of)* | **Due to inadequate arrangements to support system-wide patient flow** | | | |
| **Impact**<br>*(Consequences of the threat)* | **Patient**<br>• Avoidable deaths and significant harm.<br>• Delayed discharges from acute and non-acute settings resulting. in deteriorating patients.<br>• Delays in releasing ambulances from hospital sites back into the community. | **Staff**<br>• Increased workload<br>• Fatigue & burnout | **Organisation**<br>• Litigation & Financial Penalties<br>• Reputational damage and loss of public confidence | |
| **Lead Director** | Chief Operating Officer | **Risk Exposure** | **Current Level** | **Target Level** |
| **Monitoring Committee / Group** | Patient Quality, Safety and Outcomes Committee | **Likelihood** | **4** (Possible)<br>x | 3 (Possible)<br>x |
| **Initial Date of Assessment** | 01 June 2023 | **Impact** | ***4** (Major)* | 3 (Moderate) |
| **Last Reviewed** | May 2026 | **Risk rating** | **= 16**<br>**(Extreme)** | ***= 9***<br>***(High)*** |
| **Next Review**<br>(Monthly based on risk score) | July 2026 | | | |

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

**Risk Appetite Threshold – OPEN SCORE 17 AND BELOW**
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.




| **Current Key Controls**<br>*(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**<br>***What further controls are required to reduce the risk exposure to within a tolerable range?***<br>*(Short, Medium, and Long-Term Plans need to be included)* |
|---|---|
| • Escalation Policy.<br>• Performance and Accountability Framework<br>• Operational Framework<br>• Major incident Procedures<br>• 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.<br>• 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.<br>• 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.<br>• Enhanced monitoring in place for U&EC – level 4<br>• Range of performance measures/metrics in place<br>• 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.<br>• 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.<br>• Planned care delivery plan agreed and recovery meetings with the NHS execs to support activity.<br>• 26-week OP programmehas finished, and HB is exceeded numbers for first outpatient appoints.<br>• Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls.<br>• WG – IQPD meetings to review areas of focus<br>• Regular meetings with Local Authorities to review POC delays and LOS concerns. | ➢ **Continue Refocus on Our New Patient and key pieces of work: -**<br>**Discharge Acceleration:**<br>➢ Daily board rounds identify definite and potential discharges early to free up beds before peak demand<br>➢ Weekend discharge lists are shared proactively to maintain flow across all sites.<br>**Full Capacity Protocol:**<br>➢ Boarding continues across sites under strict risk assessment, with escalation to use dayrooms or therapy spaces only as a last resort.<br>➢ Red lines for boarding (e.g., avoiding high-risk patients) are reinforced in SOP discussions.<br>**Step-Down Coordination:**<br>➢ Flow Centre actively books and allocates step-downs; priority is given to patients who can safely move to community beds or lower-acuity settings.<br>➢ Community bed usage is maximized, with reablement teams engaged to expedite transfers.<br>➢ Contingency for Delays - where step-downs stall, escalation includes opening additional community beds and using SDEC for low-acuity patients.<br>**Rapid Offload Strategy:**<br>➢ Flow Centre monitors ambulance waits and redistributes crews to minimise delays.<br>➢ Plans include prioritizing high-risk patients for cubicles and using lounges for temporary placement.<br>**Standard Operating Procedure (SOP):**<br>➢ A simplified SOP is being finalised to standardise escalation pathways, boarding criteria, and discharge prioritisation across divisions.<br>➢ Divisional “red lines” (e.g., elective bed protection, infection control limits) are being formalised for consistent decision-making. |

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| | **Data-Driven Oversight:**<br>➢ Flow Centre dashboards and live trackers are used to monitor patient movement, discharge progress, and capacity in real time.<br>➢ Development of new dashboards to track EDDs and Red Reasons to inform system flow decisions.<br>➢ New ED extension opened on the 17th December with phase 2 to start in the new financial year<br>➢ Additional ED consultants in place<br>➢ New expanded transfer lounge is progressing well, supporting with transport booking and supporting early movement of patients.<br>Focus Areas for the next month:<br>➢ Develop Our Next Patient UEC recovery plan – Board Development Session April 2026<br>➢ Programme of work has Divisional projects across the system to support flow<br>➢ Work with social care and PCC division on joint assessment and community bed delays to consistently improve discharge reliability.<br>➢ Reset regularly — ONP highlights the need for routine reset days/fortnights to correct worsening patterns in flow, WTBS, and handovers. |

| **Sources of Assurance**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Actions to Address Gaps**<br>*(What further evidence is required to provide the effectiveness of controls)* |
|---|---|---|
| **Level 1 Operational** *(Implemented by the department that performs daily operation activities)* | | |
| • The Escalation Framework has been enacted and ineffective in mitigating threats and impact to services.<br>• Performance report against measures/metrics<br>• Regular ONP meetings to review flow<br>• S2S meeting - creates a consistent, standardised process for assessing readiness, escalating issues, and agreeing collective plans, fostering clear accountability from ward to board level.<br>• 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.<br>• The impact of the Performance and Accountability framework in improving patient flow<br>• Outputs and progression of actions from ONP and S2S meetings to sustain system flow | • Close monitoring and reporting of the frameworks in practice to support learning and improvements. |
| **Level 2 Organisational** *(Executed by risk management and compliance functions)* | | |
| • Monthly Divisional Assurance reviews.<br>• Mid and EoY Reviews for Divisions<br>• Performance against measures/metrics reported to the Executive Committee<br>• Planning and Performance Committee<br>• Cross Divisional Meetings – cross divisional thinking, learning and sharing best practice | • The Operational Framework is being developed to define how individual services meet demand and outline the actions required during escalation. This framework is currently under refinement through the Our Next Patient (ONP) work. | • The Operational Framework process commenced in November 2024, initiating a series of in-depth reviews across specific services. This is an iterative approach designed to remain active and adaptable, ensuring it continues to meet the evolving needs of the services. |
| **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* | | |
| Independent Reviews<br><br>• Intra-site Patient Transfers – Reasonable Assurance accepted by the ARAC on 9th July 2024.<br>• External inspections/visits.<br>• IQPD Monthly Meetings focus on key areas<br>• GIRFT visit Report<br>• Accelerated Design Event / Programme of work<br>• Winter Sprint – December 2025 and January 2026<br>• MAG Report - focus areas for ABUHB | • **Clinical Leadership & Patient Experience:** Strong emphasis on clinically led, data-driven change, with patient stories highlighting the real-world impact of delays.<br>• **Mandated Targets:** The 45-minute ambulance handover target is to be mandated, with an ambition to reach a 15-minute standard for patient safety.<br>• **System-Wide Responsibility:** Improvement requires engagement across all sectors—ED, primary care, community, acute medicine, surgery, and ambulance services.<br><br>Improving Performance Together (MAG Report)<br>• 45 min hand overs,<br>• Clarity over fragile services asks and delivery<br>• Accountability for regional working in our region<br>• Asks around data sharing and use of comparative data sets – definitions are still work in progress<br>• Indicates population health management tools will be available – Alignment locally | N/A |

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| | • Breathlessness and lung cancer alignment with our own plans<br>• Integrated care hubs<br>• 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** |

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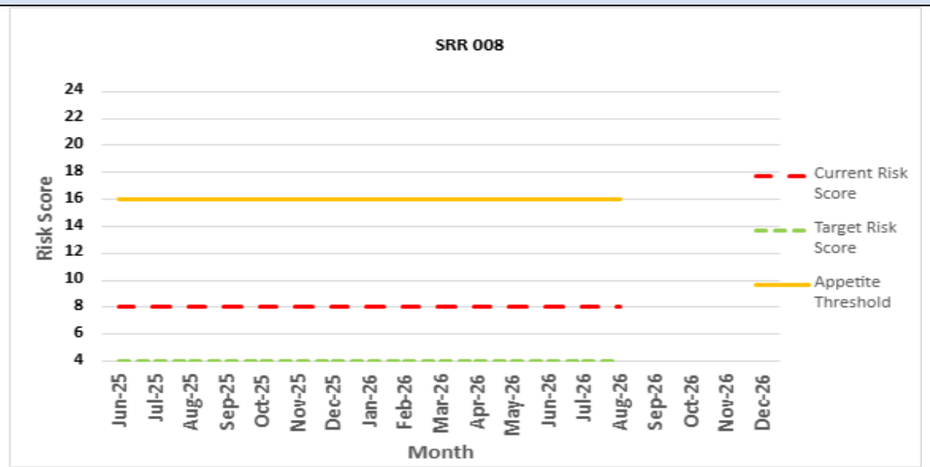
| **RISK THEME** | **TRANSFORMATION AND PARTNERSHIP WORKING** | | | | |
| **LINK TO IMTP** | **SECTION 4: ENABLER - QUALITY** | | | | |
| **Strategic Risk SRR 008** | **There is a risk that the Health Board fails to build positive relationships with patients, staff and the public.** | | | **Publication Status** | **Public** |
| **Threat** *(As a result of)* | **Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.** | | | **Risk Appetite Level – OPEN** Willing to consider all potential options, subject to continued application and/or establishment of controls: recognising that there could be a high-risk exposure. | |
| **Impact** *(Consequences of the threat)* | **Patient**<br>• Unmet patient needs resulting in patient harm.<br>• Ineffective use of combined resources<br>• Delayed decision making<br>• Adverse impacts on delivery of care to patients across acute and non-acute settings<br>• Negative experience of care<br>• Distress and frustration.<br>• Carer stress. | **Staff**<br>Staff dissatisfaction<br>Frustration<br>Increased absence.<br>Loss of confidence. | **Organisation**<br>• Failure to deliver health board priorities, required improvements and achieve longer-term sustainability<br>• 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<br>• Patient Experience and Involvement Strategy- organisational ownership<br>• Person Centred Care (PCC) Surveys and National surveys via CIVICA<br>• PCC KPI's (support PCC Quality pillar)<br>• 'You said…… we did' public facing information for service areas.<br>• PLO service at GUH<br>• Introduction of PALS Service (Oct 23)<br>• Volunteer Patient Experience Feedback<br>• Collaboration to recruit community listeners to support Dementia Awareness<br>• Digital patient stories to support listening and learning.<br>• DATIX<br>• Oversight of Medical Examiner reports to determine patient experience actions<br>• Public Engagement- Big Conversation Bereavement held 20th March 2024, Big Conversation Sepsis Sept 2025 and Big Conversation Care Homes December 2025<br>• 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.<br>• PCCT staff training to support Civica data entry and retrieval in progress. Short Term grant funding for Band 2 data entry support<br>• Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners.<br>• 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<br>• 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<br>• 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<br>• Volunteer feedback to be reviewed to identify themes. This happens weekly<br>• End of Life and Bereavement models published and meets Bereavement Standards.<br>• EOLCB refresh completed to meet National Palliative and End of Life Care Specification and National Competency Framework |

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| • Patient Experience and Involvement Team oversee patient experience through dedicated work programme and link in with divisional teams.<br>• Dementia Person centred Care team dedicated e mail address.<br>• Dementia Information and signposting through webpages.<br>• Patient feedback on the agenda for each of the dementia workstream meetings.<br>• Dementia - QR code for feedback at each training event and session.<br>• Dementia Thematic review from CIVICA team requested to inform actions and improvements in care.<br>• Dementia - Multi agency partnership workstreams measuring impact of service.<br>• 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.<br>• 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**<br>*(Evidence that the controls/ systems which we are placing reliance on are effective)* | **Gaps in Assurance**<br>*(Insufficient evidence as to the effectiveness of the controls or negative assurance)* | **Actions to Address Gaps**<br>*(What further evidence is required to provide the effectiveness of controls)* |
|---|---|---|
| **Level 1 Operational** *(Implemented by the department that performs daily operation activities)* | | |
| • Concerns are fed back to divisional teams when identified.<br>• Outcome of the volunteer feedback to drive improvements.<br>• Patient Experience and Involvement Team undertaking Culturally Competent Accreditation, receiving a silver distinction award in Oct 2024<br>• Immediate feedback and escalation to clinical teams following PALS queries and concerns<br>• Civica patient feedback in in the process of being rolled out across all – all divisional leaders receive reports for their live areas monthly.<br>• Bereavement survey built with CIVICA – Nov 2024<br>• CIVICA SMS launched 3rd March 2025 across ED and MIU'S<br>• People Participation Panels | • Currently there is limited SMS provision to increase the number of surveys.<br>• 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<br>• Survey of bereaved people needs to be developed and rolled out to meet Bereavement Standards.<br>• 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<br>• 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.<br>• PALS and Chaplaincy Team undertaking BSL training to support Deaf Community<br>• 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.<br>• 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<br>• Community of Practice for Patient Experience commencing March 2026. Topics will include supporting teams to publicise 'You Said/We Did'. |
| **Level 2 Organisational** *(Executed by risk management and compliance functions)* | | |
| • Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO)<br>• Listening and Learning reported through QPSOG/ Outcomes Committee<br>• Implemented PALS DATIX Module | None | N/A |
| **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* | | |
| • Bi-monthly LLais Reports<br>• HIW inspections<br><br>Advocacy reports | None | N/A |

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

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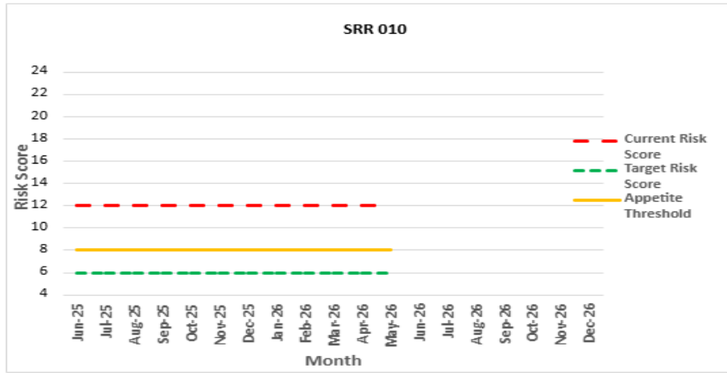
| **RISK THEME** | **COMPLIANCE AND SAFETY** | | | | |
| **LINK TO IMTP SECTION 4: ENABLER** | **QUALITY** | | | **WORKFORCE & CULTURE** | |
| **Strategic Risk: SRR 010** | **There is a risk that the Health Board will fail to protect the Health and Safety of staff, patients, and visitors in line with its duties under the Health and Safety at Work Act 1974** | | | **Publication Status** | **Public** |
| **Threat** *(As a result of)* | **Due to inadequate and ineffective systems, processes, governance, and assurance arrangements in place to implement, embed and monitor the Health Board's compliance with the Act's requirements** | | | **Risk Appetite Level – MINIMAL** Any risk that has a MINIMAL risk appetite level should be managed to a Score of 8 or below. | |
| **Impact** *(Consequences of the threat)* | **Patient**<br>• Unintended physical harm to patients<br>• Psychological trauma | **Staff**<br>• Unintended physical harm to staff<br>• Psychological trauma<br>• Increased levels of staff sickness | **Organisation**<br>• Punitive actions from the Health and Safety Executive (HSE)<br>• Loss of estates due to unsafe environments<br>• Financial implications<br>• Adverse publicity<br>• Reputational damage. | **Risk Appetite Threshold – SCORE OF 8 or Below** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls. | |
| | | | | **SUMMARY** The current risk level is **OUTSIDE** of target level and appetite threshold. The target level to be achieved is **WITHIN** the set appetite threshold. | |
| **Lead Director** | Director of Allied Health Professions and Health Science | **Risk Exposure** | **Current Level** | **Target Level** | |
| **Monitoring Committee** | Patient Quality, Safety and Outcomes Committee | **Likelihood** | 3 (Possible)<br>x | 2 (Unlikely)<br>x | |
| **Initial Date of Assessment** | 01 December 2023 | **Impact** | *4 (Major)* | 3 (Moderate) | |
| **Last Reviewed** | June 2026 | **Risk rating** | **= 12 (High)** | **= 6 (Moderate)** | |
| **Next Review** (Quarterly 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)* |
|---|---|
| • Attendance at Divisional Quality & Patient Safety meetings provides a forum to discuss Health and Safety concerns/best practices.<br>• Health and Safety Policies and Procedures<br>• Dedicated Health and Safety site on ABPULSE<br>• 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'.<br>• Health and Safety training for all staff (include general H&S, fire safety, manual handling, violence & aggression)<br>• Partial Programme of Health and Safety Monitoring (Active & Reactive)<br>• Corporate and Directorate Health and Safety Risk Register established.<br>• Board Training /development (Completed 24 April 2024)<br>• Implementation of Health, Safety, and Fire Improvement Plan for 2023/24 to address 7 risk areas of concern.<br>• 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<br>• Suitable and Sufficient Risk assessments (including local risk assessments, specific fire risk assessments, and fire risk assessments)<br>• Consultation and communication with the workforce regarding compliance with the Act<br>• New ways of working with Divisions to ensure accountability for health and safety is recognised.<br>• Implement key performance indicators to monitor health and safety compliance.<br>• Review the governance arrangements for the Health & Safety Committee<br>• Health and Safety Policies and Procedures to be reviewed.<br>• Onboard further Manual Handling trainers across the organisation to improve compliance.<br>• Scope for training non-Health Board staff<br>• Learning from events to be documented and communicated to the organisation. |

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

**Assurance Rating** (*Overall Assessment of controls and assurances*) *Guidance*

| | | | |
|---|---|---|---|
| **Negative –** Insufficient evidence that the controls | **Reasonable -** adequate evidence that the controls in place are working effectively. | **Positive -** robust evidence that the controls in place are working effectively. | **Reasonable Assurance** |

GIG CYMRU NHS WALES | Cyd-bwyllgor Comisiynu Joint Commissioning Committee

# Joint Commissioning Committee

## Highlight Report from the Joint Commissioning Committee

| | |
|---|---|
| **Dyddiad y Cyfarfod / Date of Meeting** | 26/05/2026 |
| **Statws Cyhoeddi / Publication Status** | Open/ Public |
| | Not Applicable |
| **Awdur yr Adroddiad / Report Author** | Gareth Mitchell, Corporate Governance Manager, NWJCC |
| **Cyflwynydd yr Adroddiad / Report Presenter** | Juliet Brown, Chief Commissioner, NWJCC |
| **Noddwr yr Adroddiad / Report Sponsor** | Juliet Brown, Chief Commissioner, NWJCC |

| | |
|---|---|
| **Pwrpas yr Adroddiad / Report Purpose** | For Noting |

| **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)** | | |
|---|---|---|
| **Committee / Group / Individuals** | **Date** | **Outcome** |
| | | Choose an item. |

### 1. SITUATION/BACKGROUND

This report had been prepared to provide Health Board (HB) Chief Executive Officer Members of the Joint Commissioning Committee (JC) with a summary of the key issues considered at its public meeting on 26 May 2026.

Key highlights from the meeting are reported in Section 2.

### 2. HIGHLIGHT REPORT

(Links to reports highlighted **May 2026 - NHS Wales Joint Commissioning Committee**).

| Status | Update |
|---|---|
| **Alert / Escalate** | • The **Chair's Report** noted the need to undertake a Chair's Action on 30 March 2026 following discussions at the Extraordinary Meeting of the JC held on 23 March 2026. Following the meeting, a majority of JC Members approved the following wording to approve the NWJCC Annual Plan (2026-27): The NHS Wales Joint Commissioning Committee resolved to:<br><br>*APPROVE the 2026/27 plan subject to the requirement for the JCC to work collaboratively with Local Health Boards to urgently develop the 2026/27 priorities to maximise cost improvement efficiencies and savings to improve the additional financial requirement of £16.2m in year*<br><br>This was reported at May's JC for consideration and ratification.<br><br>• It was reported that there was currently only one Health Board (HB) CEO member of the Quality, Safety and Outcomes Sub-Committee with the need for another to ensure continuity of attendance at each meeting. |
| **Advise** | The **Chief Commissioner's Report** incorporated Director of Commissioning Reports to highlight performance and quality issues that had arisen since updates shared at Sub-Committee meetings in April 2026. These updates included:<br>○ **Women and Children's Services**<br>Neonatal assurance meetings continue across providers, with the next cycle of engagement underway. These provide ongoing oversight of staffing, quality and safety, alongside supporting continued improvement following recent independent reviews.<br>Workforce constraints within paediatric radiology at Cardiff and Vale University Health Board present a risk to sustaining a 24/7 service, with mitigation arrangements in place including locum cover and remote specialist support where required.<br>Paediatric neurology services continue to experience capacity challenges, including reduced provision at Alder Hey Hospital and workforce changes within Wales, impacting access and equity of specialised services for patients. Mitigation actions were being progressed in partnership with health boards.<br><br>○ **Ambulance Patient Handover**<br>Ambulance handover performance remains a significant area of system pressure. While improvement was demonstrated following renewed national focus on the 45-minute standard, performance remains variable across Wales with a total of 16,468 lost hours in March 2026.<br>Whilst there has been some improvement, handover delays remain significantly above levels of commissioned activity. The root cause is predominantly system driven, linked to emergency department/hospital capacity, patient flow and discharge delays across HBs. Phase 2 of the Ambulance Performance Framework |

| Status | Update |
|---|---|
| | has further evidenced the direct correlation between hospital handover delays and lower ambulance response times in the community, indicating that this issue cannot be resolved by the provider or commissioner alone.<br><br>○ **Review of Adult Gender Incongruence Services**<br>The NWJCC is undertaking a comprehensive review of adult gender services in NHS Wales to ensure commissioned provision is efficient, effective and delivers high-quality care aligned to current evidence and system requirements. NWJCC commissions the gender care pathway for Welsh patients, including assessment, referral and ongoing care via the Welsh Gender Service, and access to surgery through NHSE via cross-border arrangements, but does not directly commission or provide surgery itself. NHSE commissions all gender surgery services, including the surgical pathway and provider contracts.<br><br>The review of the Welsh Gender Service commenced in Q1, with scoping, methodology and stakeholder engagement progressing through Q2, followed by detailed assessment of demand, capacity, quality, cost and pathway effectiveness. This work is being undertaken in the context of increasing demand and emerging findings from the parallel NHSE national review. There is a clear opportunity to align the Welsh Gender Service review with NHSE methodologies, data frameworks and emerging service specifications to ensure consistency, comparability and futureproofing across systems.<br><br>The review will focus on adult non-surgical services, with consideration of pathway interfaces, and will engage key stakeholders across HBs and partner organisations. Initial findings are expected in Q3/4, with a report and recommendations to the JC thereafter.<br><br>The **NWJCC Annual Plan Delivery - Strategic Priority and Deep Dive Specifications** Report was received along with nine scoping documents that provided a consistent and proportionate overview of each strategic priority area, each of which was **approved** by the JC. It was noted that the information captured through the scoping documents would support the development of more aligned and consistent reporting, monitoring and oversight arrangements across the strategic priority portfolio during 2026/27.<br><br>A report on **Clinical Support Hubs and NHS 111 Digital Front End** was received. Members **approved Option 2**: allocation of funding and commissioning responsibility of the Clinical Support Hubs to the NWJCC. This was an interim measure and aligned to discussions at the NHS Wales Leadership Board. Further work would be undertaken regarding longer term arrangements. |

| Status | Update |
|---|---|
| | The provision of the recurrent ring-fenced allocation for the development of the NHS 111 digital platform had also been granted to the NWJCC. This will allow the NWJCC to support, more strategically, the digital front end of the NHS 111 service. |
| **Assure** | The Committee received the following Sub-Committee assurance reports:<br>- **Quality, Safety and Outcomes Sub-Committee**<br>- **Planning, Performance and Finance Sub-Committee**<br>- **CTMUHB Audit and Risk Committee**<br><br>The **NWJCC Organisational Risk Register** as of 31 March 2026 was received and approved. There were 14 risks with a score of 15 or above as of 31st March 2026.<br><br>The **Corporate Governance Report** included updates on Welsh Health Circulars, the NWJCC Internal Audit Programme and the ongoing review of hosting arrangements between the NWJCC and CTMUHB.<br><br>The JC approved the Annual Governance Statement and endorsed the updated NWJCC Standing Orders, Standing Financial Instructions and the Guidance on the Handling of Interests, which are scheduled to be approved by all Health Boards. |
| **Inform** | The **Chair's Report** summarised the JC Strategy Session held on 14 April 2026, including key planning principles for the delivery of the NWJCC plan, assurance regarding key milestones and shared definitions of each priority area and roles and responsibilities.<br><br>The **Chief Commissioner's Report** included updates on:<br>○ **WAST Performance Indicators** - Welsh Government (WG) feedback on the Annual Plan was positive and included a request for further information on WAST Performance indicators.<br>○ **CAR-T Service** - Ongoing conversations in relation to surge capacity for CAR-T with alternative centres secured including Bristol, Birmingham and London.<br>○ **NEPTS Eligibility -** Llais asked for consultation on any potential changes to NEPTS eligibility.<br>○ **St Andrews** - NHS England was currently looking at alternative providers for patients with plans being developed for St Andrews to retain some capacity. This will not affect Welsh patients. A June deadline had been given for removing Welsh patients from the site.<br>○ **Hereditary Anaemia Service** - A business case for the Hereditary Anaemia service was being developed by Cardiff and Vale University Health Board to improve workforce resilience, there was no timeline currently scheduled for completion.<br>○ **Collaborative Commissioning Leadership Group –** the meeting held on 21 April 2026 considered close-out of the NWJCC Foundation Plan 2025-26, delivery arrangements for the NWJCC |

| Status | Update |
|---|---|
| | Annual Plan for 2026-27 and also endorsed the findings and next steps for the NWJCC referral management review across the seven HBs.<br><br>The Committee received the **Month 12 Finance Report 25/26**, **Month 01 Finance Report 26/27** and the **Operational Performance Report**<br>○ It was agreed that granularity of the Month 2 Finance report be enhanced for scrutiny at the next Planning, Performance and Finance (PPF) Sub-Committee and July's JC meeting. |
| **Appendices** | None. |

## 3. ASSESSMENT

| **Objectives / Strategy** | |
|---|---|
| **Dolen i Amcan (au) Strategol CBC**<br>**Link to JCC Strategic Objectives(s)** | Maximise Value |
| | Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration |
| **Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /**<br>**Link to Wellbeing of Future Generations Act – Wellbeing Goals**<br>150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales) | A Resilient Wales |
| | A Healthier Wales |
| **Dolen i Hwyluswyr Ansawdd** (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /<br>**Link to Enablers of Quality** (Duty of Quality Statutory Guidance (gov.wales)) | Leadership |
| | Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective |
| **Dolen i Feysydd Ansawdd** (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /<br>**Link to Domains of Quality** (Duty of Quality Statutory Guidance (gov.wales)) | Effective |
| | Efficient; Equitable; Person-centred; Timely; Safe |
| **Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)** | No - Not Applicable |
| | |

| **Impact Assessment** |
|---|

| | | |
|---|---|---|
| **Ansawdd** *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?* | Yes: ☐ | No: ☒ |
| | Outcome: | If no, please include rationale below: This is a summary of the latest meeting of the JCC |
| **Cydraddoldeb** *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?* | Yes: ☒ | No: ☒ |
| | Outcome for Equality (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~<br><br>Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ | If no, please include rationale below: This is a summary of the latest meeting of the JCC |
| **Cyfreithiol / Legal** | There are no specific legal implications related to the activity outlined in this report. | |
| | | |
| **Enw da / Reputational** | There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report. | |
| | | |
| **Effaith Adnoddau** *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)* | Yes (Include further detail below) | |
| | The performance of the services will be used to develop the IMTP and identify the areas where resources may be required. | |

## 4. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 2 of this report.