

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN

ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 September 2026
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Maternity and Neonatal Annual Report 2025/26?
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Jayne Beasley - Head of Maternity & Gynaecology

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

Er Sicrwydd/For Assurance

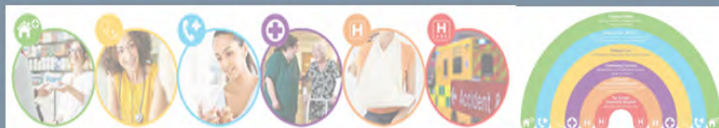
ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This annual report provides the Board with assurance about the quality, safety, experience, outcomes and performance of maternity and neonatal services during 2025/26. It forms part of the Health Board's arrangements for overseeing these services and demonstrating how it meets its statutory Duty of Quality and wider national maternity and neonatal assurance responsibilities. The Maternity and Neonatal Annual Report 2025/26 primarily presents information for the 2025 calendar year, reflecting the reporting cycles used by relevant external agencies, with information from early 2026 included where appropriate and available.

The report identifies improvement across several important areas. These include earlier access to antenatal care, improved care for babies born prematurely, strengthened infection prevention and control, more robust management of patient safety incidents, positive patient and family engagement, and progress in recruiting maternity and neonatal staff.

The overall assurance position is positive despite a number of issues that need to be addressed. Established governance, monitoring and improvement arrangements are in place, but sustained oversight is required. The principal areas requiring attention include rising rates of operative birth, neonatal capacity, access to specialist pharmacy and therapy support, workforce resilience, sickness absence, mandatory



training, antenatal screening, breastfeeding support, medicines safety and implementation of national maternity and neonatal recommendations.

Cefndir / Background

Aneurin Bevan University Health Board provides community and outpatient antenatal services across each borough. Inpatient maternity care and level 3 neonatal care for babies requiring intensive, high-dependency or specialist care are provided at the Grange University Hospital. In 2025, 6,176 women booked for maternity care and there were 5,124 births. The Neonatal Intensive Care Unit has eight intensive care cots, ten high-dependency cots and twelve low-dependency cots. The level of care provided by each cot reflects the severity and complexity of a baby's clinical needs.

National maternity and neonatal assurance arrangements require Health Boards to maintain effective governance from service level through to the Board, monitor clinical practice and outcomes, ensure that information is accurate and reliable, and provide regular Board-level reports on risks and improvement plans. Mandatory national maternity and neonatal data requirements also support consistent reporting, assurance and improvement across Wales. This annual report therefore brings together information on activity, clinical outcomes, patient safety incidents, mortality, workforce, education and training, patient and family experience, risk and improvement. It supports transparent Board scrutiny of compliance with statutory duties, national standards, professional requirements and agreed improvement priorities.

Asesiad / Assessment

Antenatal care and public health

Earlier access to antenatal care improved significantly during 2025. Antenatal care is the care provided throughout pregnancy to monitor the health and wellbeing of the woman and baby. In 2025, 68% of women booked for maternity care before ten completed weeks of pregnancy, compared with 52% in 2024. By twelve weeks, 88% had booked, compared with 75% in 2024. Earlier booking enables health and social needs to be identified promptly and allows screening, advice and appropriate support to be offered at the recommended stage of pregnancy.

Performance against Antenatal Screening Wales standards also improved. Antenatal screening includes tests offered during pregnancy to identify certain infections, chromosomal conditions and other factors that may affect the health of the woman or baby. Although the overall direction of travel is positive, some indicators remain rated red because performance is more than 10% below the relevant target. These areas require further improvement and monitoring. Public health information identifies continuing population health needs within the maternity population. At booking, 41% of women reported a mental health issue and 33% had a body mass index above 30. In addition, 9.4% of women reported smoking within the previous 14 days. This reduced to 5% at 36 weeks of pregnancy, indicating a reduction in smoking as pregnancy progressed.



Vaccination during pregnancy provides protection for women and can also protect babies during the period immediately after birth. A pilot involving trained vaccinators in five antenatal clinics increased uptake of the Respiratory Syncytial Virus vaccination to 60%. The pregnancy weight-management pathway was relaunched in April 2025 and receives between 100 and 120 referrals each month. The pathway provides women with tailored advice and access to dietary, physical activity and weight-management support during and after pregnancy.

Births and maternity pathways

The number of births reduced, from 5,282 in 2024 to 5,124 in 2025. Although the total number of births reduced, the proportion involving clinical intervention increased. Caesarean sections accounted for 43% of births in 2025, compared with 41% in 2024, with emergency caesarean sections accounting for 25% of all births. The service will continue to review these trends, including clinical indications, outcomes and opportunities to support informed choice and appropriate birth pathways.

Instrumental births increased slightly from 8.3% in 2024 to 8.5% in 2025. The rate remained below the reported target of 10%. Induction of labour, where labour is started artificially using medicines or other clinical methods, increased by one percentage point to 33%. The service continues to offer four potential places of birth, subject to individual clinical needs and informed choice.

A Midwifery Unit Oversight Group has been established to strengthen oversight of clinical safety and outcomes, workforce and training, access, informed choice and arrangements for transferring women to obstetric care where additional clinical support is required, this forms part of the midwifery units standards for self-assessment. Some women may choose a place or type of birth that falls outside recommended clinical guidance. A multidisciplinary pathway is in place to support these women. The pathway is intended to support informed and personalised decision-making while ensuring that clinical and organisational risks are clearly considered.

Neonatal care and perinatal optimisation

Perinatal optimisation for babies born before 34 weeks of pregnancy improved to 74%, compared with 64% in 2024 and 53% in 2023. Perinatal optimisation refers to a package of evidence-based interventions provided before, during and shortly after birth to improve outcomes for babies who are born prematurely. Local data identifies improvement in delayed clamping of the umbilical cord, maintaining a baby's temperature on admission to the neonatal unit, screening for retinopathy of prematurity and the provision of breast milk.

Further improvement is required in the timely administration of antenatal steroids, probiotics and early breast milk. Antenatal steroids are given before an anticipated premature birth to help the baby's lungs develop. Probiotics are beneficial microorganisms that may be given to some premature babies to support their digestive health and reduce the risk of serious bowel disease. Validated 2025 National Neonatal Audit Programme data was not available at the time of reporting. The findings relating to perinatal optimisation are therefore based on local data.



Neonatal cot occupancy and staffing capacity are reviewed twice each day. This enables the service to consider the number and clinical needs of babies alongside the availability and skills of staff. An escalation process is in place where demand, acuity or staffing pressures could affect the service's ability to provide safe care. Maternity and neonatal services also participate in three national situation-report meetings each week. These meetings support assessment of capacity and pressures across maternity and neonatal services in Wales.

Patient safety and Duty of Candour

Maternity governance arrangements were strengthened during 2025 through the appointment of a Risk and Governance Lead Midwife and additional administrative support. This has increased the service's capacity to oversee patient safety incidents, investigations and wider governance processes.

All reported incidents are reviewed through weekly multidisciplinary discussion. Following review, most incidents were assessed as having caused no harm or low harm. Incident reporting is an important component of a positive safety culture because it enables services to identify risks, investigate concerns and share learning. Sixteen maternity patient safety investigations were undertaken during 2025, down from 21 in 2024. These covered a range of events, including unexpected neonatal admissions, cases of hypoxic-ischaemic encephalopathy, neonatal and intrauterine deaths, swab-counting incidents and a medication-administration incident. Each case was reviewed through the appropriate patient safety and mortality review arrangements to identify learning and improvement actions.

Hypoxic-ischaemic encephalopathy is a type of brain injury that can occur when a baby's brain does not receive enough oxygen or blood around the time of birth. Its effects can vary, and not every baby affected will experience long-term harm. The reported rate reduced from 2.47 per 1,000 births in 2024 to 1.73 per 1,000 births in 2025. There were no reported Never Events.

Four neonatal incidents triggered the Duty of Candour procedure during 2025. The Duty of Candour requires NHS organisations to be open and transparent with people when care has resulted in, or could result in, certain levels of harm. Learning from the incidents included separating the preparation of gentamicin from the collection of blood samples, strengthening the handover of outstanding blood results and investigating an incident involving extravasation.

Following an increase in neonatal medication incidents in July 2025, the service introduced targeted quality improvement work, a medication forum, human factors training and additional medication education. Compliance with the additional medication education was reported as above 90%. Monitoring following the increase in July 2025 indicates a subsequent reduction in reported medication incidents. Continued oversight is in place to sustain this improvement.

Mortality

Maternity and neonatal deaths are reviewed through the Perinatal Mortality Review Tool and local and national multidisciplinary arrangements. Deaths are recorded



through Datix, reported through the nationally reportable incident process and submitted to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the United Kingdom. This national programme examines maternal and baby deaths to identify learning and improve care.

The national mortality information relates to babies born in 2024. It records 22 stillbirths, with a crude rate of 4.16 and a stabilised rate of 3.55, and eight neonatal deaths, with a crude rate of 1.52 and a stabilised rate of 1.93. Available comparison data indicates that the reported mortality rates were within the range observed among comparable health boards. These figures relate to babies born in 2024 and should be considered alongside the number of cases, the stabilised rates and the findings from individual mortality reviews.

Infection prevention and control

Infection prevention and control was a priority during 2025/26, with the services implementing a targeted improvement programme. The programme strengthened cleaning and laundry arrangements, environmental monitoring, blood-culture reporting, venepuncture practice, aseptic non-touch technique, audit and corporate oversight.

Following implementation of the improvement programme, the available information did not identify a further upward trend in reported infection prevention and control incidents. Performance continues to be monitored through established infection prevention and control arrangements. Neonatal hand-hygiene and peripheral vascular catheter audits reported 100% compliance for the period measured. This result will continue to be monitored to support sustained compliance and identify any variation in practice. The caesarean-section surgical-site infection rate was 2.27% in quarter four of 2025. The reported rate represented a reduction of 24.75%, despite an 8% increase in the number of procedures during the same period.

Patient experience and engagement

A bespoke patient-experience survey was introduced in September 2025 to obtain feedback across the maternity and neonatal pathway. Overall user experience exceeded 85%, and there were no overdue formal concerns at the time of creating this report.

Patient and family feedback is obtained through the BABI and Dinky Dragons service-user groups, social media, the Patient Advice and Liaison Service, Listening to People services, birth-reflection support and the after-birth service. These arrangements provide different opportunities for women and families to share their experiences and contribute to service improvement. The service is also implementing the national Perinatal Engagement Framework, which is intended to support active listening and meaningful involvement of women and families across maternity and neonatal services.

Workforce, training and culture

Maternity recruitment resulted in an establishment above the staffing requirement identified by the 2023 Birthrate Plus assessment. Birthrate Plus is an established



workforce-planning tool that assesses the number of midwives required by considering birth activity and the level of care women need. A further assessment is being undertaken during 2026. The service has also recruited 15 whole-time equivalent newly qualified midwives through the 2026 streamlining process.

During 2025, the neonatal nursing establishment was reported as meeting the relevant British Association of Perinatal Medicine standards. Recruitment remains under way to address current vacancies and support the resilience of the service, including agreed recruitment of six whole-time equivalent band 5 nurses. Although therapy support is available, current provision does not meet British Association of Perinatal Medicine standards. A business case has therefore been developed to increase psychology and occupational therapy support.

Overall mandatory training compliance is reported at 80% for neonatal services and 75% for maternity services. Areas requiring further improvement include neonatal qualified-in-speciality training at 68% - 70% target, maternity safeguarding level 3 training at 72%, neonatal blood transfusion training at 75% and maternity Gap and Grow training at 69%.

Maternity sickness absence ranged from 4.98% to 8.04% between June 2025 and May 2026. Neonatal sickness absence varied between 5.54% and 14.86% during the period. Reducing sickness absence and strengthening workforce resilience remains a priority, supported by detailed workforce reviews, monthly monitoring and oversight by the Divisional Management Team. Recent performance indicates improvement, although sustained progress will continue to be monitored. Neonatal appraisal increased to above 80% and maternity appraisal compliance continues to fluctuate between 66% and 69%.

A range of actions is being taken to strengthen workplace culture and psychological safety. Current actions include clinical supervision, coaching, mentorship, restorative supervision, increased leadership visibility, regular staff communication and joint maternity and neonatal education. Actions arising from the 2025 neonatal listening event are being implemented, and a maternity listening event is planned for 2026.

Priorities for the year ahead

The maternity and neonatal services have identified several areas where further development would support the delivery of consistently high-quality care. Within maternity services, priorities include strengthening pharmacy support, maintaining high standards in the interpretation of cardiotocography, improving compliance with Gap and Grow, ensuring service capacity is aligned with demand and improving information sharing between BadgerNet and the Child Health System.

Within neonatal services, improvement priorities include reviewing cot and transitional care capacity, strengthening arrangements for managing transfer requests during periods of high demand, improving access to pharmacy and therapy support, ensuring the availability of appropriately skilled staff and developing sustainable medical rota arrangements.



Priorities for the coming year are to maintain delivery of the overarching improvement plan; respond to national and local recommendations; develop dedicated transitional care; strengthen neonatal pharmacy and therapy support; review workforce requirements against Birthrate Plus and British Association of Perinatal Medicine standards; continue work to support a positive workplace culture, human factors, equality and diversity; maintain training compliance; and encourage innovation and quality improvement.

Progress will continue to be monitored through the established maternity and neonatal governance arrangements. This will support oversight of improvement activity, identification of areas requiring additional focus and the provision of appropriate assurance to Health Board committees.

Argymhelliad / Recommendation

The Board is asked to:

1. Take assurance from the Maternity and Neonatal Annual Report 2025/26.
2. Note the improvements made in the Maternity and Neonatal Services in 2025/26.
3. Note the priorities for improvement in 2025/26.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 2.4 Infection Prevention and Control (IPC) and Decontamination 6.3 Listening and Learning from Feedback 3.3 Quality Improvement, Research and Innovation
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Every Child has the best start in life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety



Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.
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Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	The report is informed by local maternity and neonatal activity, quality, safety, workforce, patient-experience and outcome information for 2025/26, together with relevant national standards, audit programmes, statutory guidance and external reviews. The principal evidence sources are: 1. Health and Social Care (Quality and Engagement) (Wales) Act 2020 and Duty of Quality Statutory Guidance 2023. 2. Health and Care Quality Standards 2023. 3. Maternity and Neonatal Safety Support Programme. 4. Perinatal Quality Statement for Wales. 5. All-Wales Perinatal Engagement Framework. 6. The Path to Safer Beginnings. 7. Antenatal Screening Wales standards. 8. National Neonatal Audit Programme. 9. PERIPrem Cymru optimisation measures. 10. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the United Kingdom reports and local perinatal mortality information. 11. Perinatal Mortality Review Tool reviews. 12. British Association of Perinatal Medicine standards. 13. Birthrate Plus workforce assessment. 14. Relevant National Institute for Health and Care Excellence and Royal College professional guidance. 15. Local Datix incident and risk information, patient safety investigations, Duty of Candour reviews, infection prevention and control audits, workforce information and patient-experience feedback.



	16. Relevant national and independent maternity and neonatal reviews, including the Swansea Bay review, the Nottingham maternity review and the Amos report.
Rhestr Termau: Glossary of Terms:	Antenatal: Care provided during pregnancy. BadgerNet: An electronic clinical record system used in maternity and neonatal care. BAPM: British Association of Perinatal Medicine. Birthrate Plus: A workforce-planning tool used to assess the number of midwives required according to activity and clinical need. Body mass index: A measure using height and weight to assess whether a person's weight may increase the risk of certain health conditions. Cardiotocography: Electronic monitoring of a baby's heart rate and the woman's contractions during pregnancy or labour. Datix: The Health Board's system for recording and managing incidents and risks. Duty of Candour: The legal duty requiring NHS organisations to be open and transparent when care has resulted in, or could result in, specified levels of harm. Extravasation: Leakage of fluid or medicine from a vein into the surrounding tissue. Gap and Grow: A national programme supporting the identification and management of babies who may not be growing as expected during pregnancy. Hypoxic-ischaemic encephalopathy: A type of brain injury that can occur when a baby's brain does not receive enough oxygen or blood around the time of birth. MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the United Kingdom. Neonatal care: Specialist care provided to newborn babies who are premature, unwell or require additional monitoring and treatment. Never Event: A serious patient safety incident considered largely preventable because established national safety measures should have been implemented. NNAP: National Neonatal Audit Programme. Perinatal: The period covering pregnancy, birth and the time immediately following birth.



	Perinatal optimisation: A package of evidence-based interventions intended to improve outcomes for babies born prematurely. PMRT: Perinatal Mortality Review Tool. Respiratory Syncytial Virus: A common respiratory infection that can cause serious illness in young babies. Retinopathy of prematurity: An eye condition that can affect babies born prematurely. Surgical-site infection: An infection affecting the area of the body where an operation has taken place. Transitional care: Care that enables babies requiring additional monitoring or support to remain with their mothers where it is safe and appropriate. Whole-time equivalent: A standard measure of staffing hours, with one whole-time equivalent representing the hours worked by one full-time member of staff.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Quality Management Group

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



Aneurin Bevan University Health Board

Maternity and Neonatal Services

Annual Report
2025/26

Public Board



Executive Summary



This annual report provides the Board with an overview and assurance regarding the quality, safety and delivery of maternity and neonatal services during 2025/26. It brings together information on antenatal care, birth outcomes, neonatal care, patient safety, mortality, infection prevention and control, patient and family experience, workforce, education, culture and the delivery of national and local improvement priorities.



Positive assurance

There is evidence of improvement across several important measures. Early booking improved from **52%** to **68%**, and PERIPrem optimisation reached **74%**.

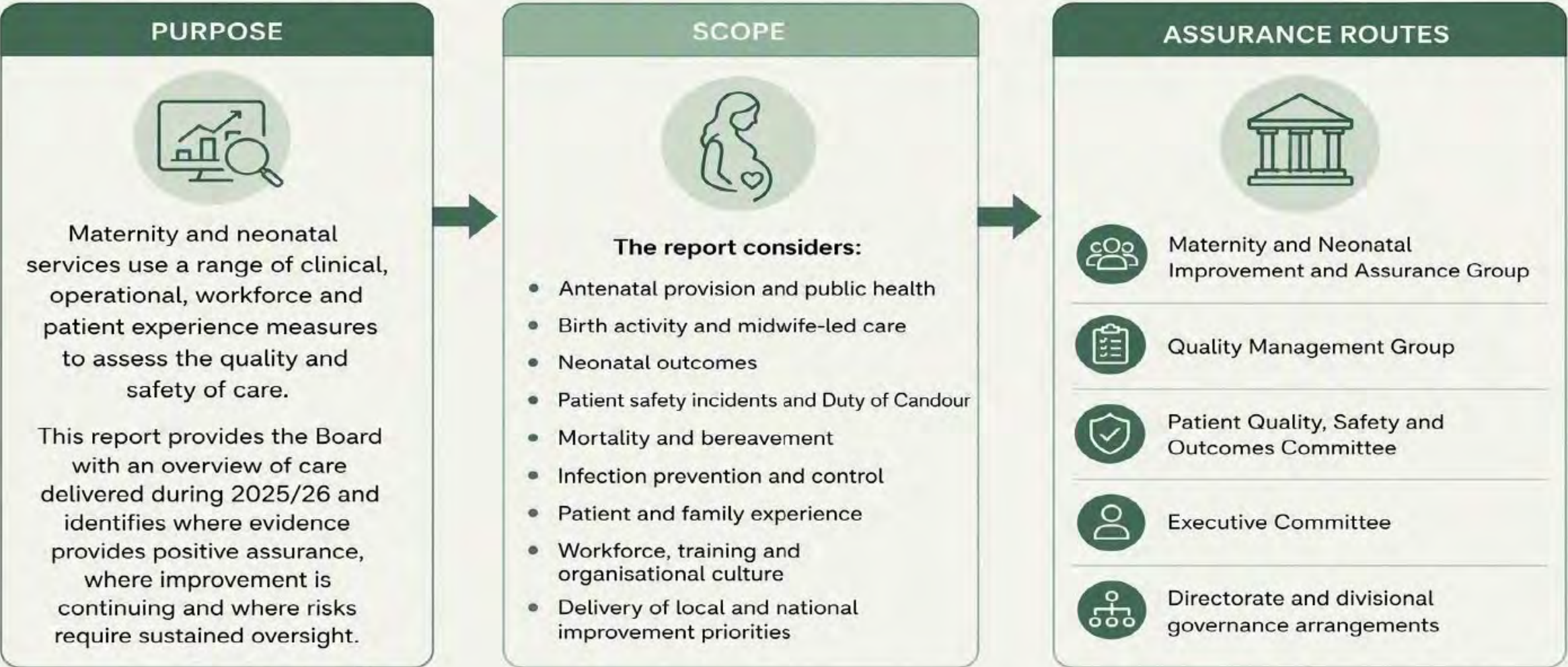
The rate of hypoxic-ischaemic encephalopathy reduced from **2.47** to **1.73** per 1,000 births. Retinopathy of prematurity screening improved from **69%** to **78%**, breast milk measures improved, and there were no maternity Never Events.



Improvement priorities

- Quality and Patient Safety initiatives; including human factors training, medication safety, infection prevention, and a perinatal dashboard
- Support to access additional training, prioritisation of staff wellbeing, access to supervision, regular appraisal and workforce development
- Future development will focus on peri-natal pathways, dedicated transitional care and pharmacy and therapy support

Purpose, Scope and Assurance



Service Profile

MATERNITY SERVICES

Maternity services provide outpatient and community antenatal care across each borough, supporting local access for women and families.

Inpatient maternity and neonatal services are provided at the Grange University Hospital, including antenatal care, obstetric and midwife-led intrapartum care, high dependency care and postnatal care.



6,176

women booked for maternity care in 2025



5,124

births recorded in 2025

NEONATAL SERVICES

The Neonatal Intensive Care Unit is a level 3 service comprising:



8

intensive care cots



10

high dependency cots



12

low dependency cots



The service is supported by neonatal outreach, the South East Wales transport service, outpatient clinics, neurodevelopmental clinics and murmur clinics.



Transitional care is delivered collaboratively by maternity and neonatal services. Work continues to establish a dedicated transitional care environment.

Improvement and Assurance Framework



**Women, families and babies**

**Safe and effective care**

**Our people**

**Our future**

The improvement plans bring together measurable actions arising from local priorities, national programmes, quality standards and external reviews. Progress and outstanding actions are monitored through maternity, neonatal, divisional and corporate governance arrangements.

Antenatal Access and Early Booking



Early access to maternity care supports timely antenatal screening, identification of clinical and social needs, public health advice and informed decision making.

A total of **6,176** women booked for pregnancy in 2025. This was **748** fewer than the **6,924** bookings recorded in 2024.

Gestational age at booking	2025 number	2025 percentage	2024 number	2024 percentage
Before 10 weeks	4,162	68%	3,635	52%
Before 12 weeks	5,446	88%	5,212	75%
Before 13 weeks	5,640	91%	5,510	79%
Before 14 weeks	5,791	93%	5,709	82%
Before 20 weeks	5,925	95%	5,854	84%



The improvement from 52% to 68% for booking before 10 completed weeks represents positive progress. Continued monitoring is required to understand variation between localities and identify women who may experience barriers to early access.

Public Health and Health Inequalities



9.4%

Smoked within the
previous 14 days
at booking



5%

Smoked at
36 weeks



70%

Carbon monoxide
reading recorded
at booking



41%

Mental health issue
recorded at booking



33%

Body mass index
above 30



15.5%

Body mass index
above 35



Maternity services work in partnership with Public Health Wales and have a Lead Midwife for Public Health. Public health information is used to identify need and support targeted intervention.



The reduction in smoking between booking and 36 weeks provides positive evidence of change during pregnancy, supported by the smoking cessation service. Carbon monoxide monitoring was not recorded for all women and remains an area for improvement.



The pregnancy weight management pathway was relaunched in April 2025. It receives approximately 100 to 120 referrals each month and provides group support, individual advice and access to community-based activity and education.



Vaccination and Antenatal Screening



Vaccination

93.1%

Women offered pertussis vaccination before birth

81.4%

Women offered respiratory syncytial virus vaccination

83.7%

Women offered seasonal influenza vaccination

52.3%

Women recorded as receiving respiratory syncytial virus vaccination before birth



A pilot involving trained vaccinators in five antenatal clinics increased respiratory syncytial virus vaccination uptake to 60%, with higher uptake reported in more deprived areas.



Vaccination uptake is not held centrally across all maternity datasets because some vaccinations are delivered through primary care.



Antenatal Screening



Antenatal Screening Wales performance indicators were monitored during the year. Expected compliance levels increased in April 2025.



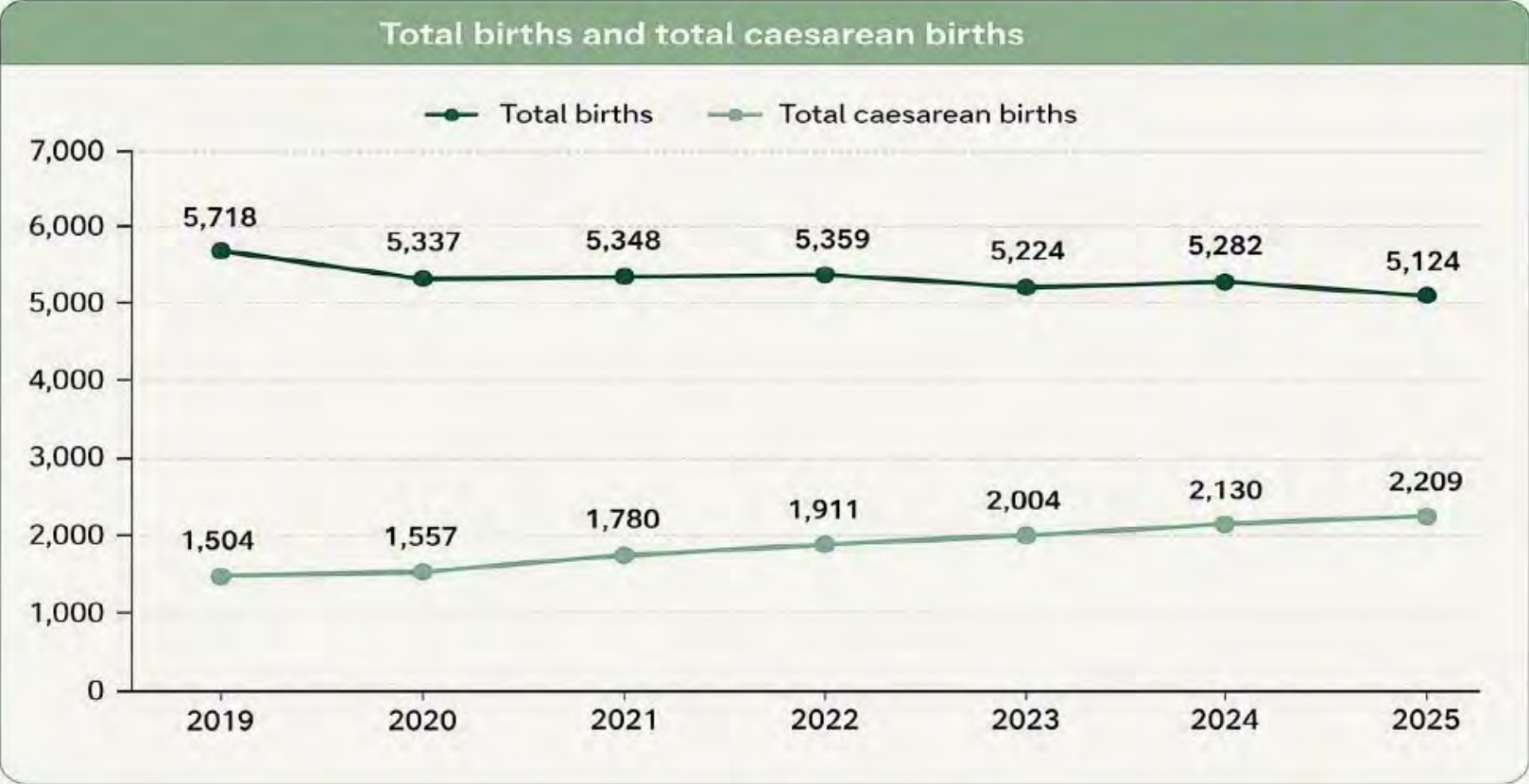
The Health Board showed improving performance and favourable comparison with several All Wales standards, although some indicators remained rated red because performance was more than 10% below target.



The performance data in the source report related to October 2025 and should be interpreted as a specific reporting-point assessment rather than a full-year measure.



Birth Activity and Intervention



43%

Caesarean birth rate in 2025



25%

Emergency caesarean births as a proportion of all births



8.5%

Instrumental birth rate



33%

Induction of labour rate



5,124

Total births in 2025



The number of births continued to reduce during 2025, while the number and proportion of operative births increased. The caesarean birth rate increased from 41% in 2024 to 43% in 2025.



Emergency caesarean births represented 25% of all births. The instrumental birth rate was 8.5%, compared with 8.3% in 2024, and remained below the stated target of 10%. Induction of labour increased from 32% to 33%.



The continued increase in operative birth requires ongoing review alongside maternal acuity, clinical risk, informed choice and national patterns.

Midwife-Led Care and Informed Choice

Maternity services remain committed to supporting informed choice and access to midwife-led care.

In the absence of additional clinical need, women default to a midwife-led pathway.

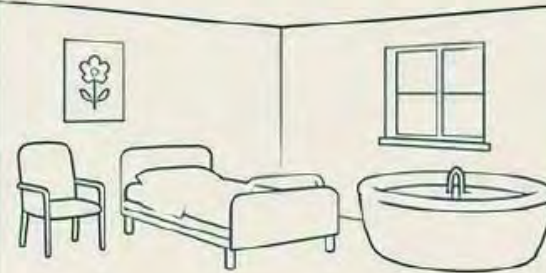
Home birth



Freestanding midwifery unit at Ysbyty Ystrad Fawr



Alongside midwifery unit at the Grange University Hospital



Obstetric-led unit at the Grange University Hospital



Ysbyty Aneurin Bevan also provides a midwife-led birthing area.



Practice is supported by the All Wales Midwife Led Care Guideline and the All Wales Normal Labour Pathway. Weekly transfer meetings review cases where women transfer from midwife-led to obstetric care.



A Midwifery Unit Oversight Group provides oversight of quality, safety, workforce, sustainability, patient experience, equity, informed choice and transfer arrangements.



A monthly multidisciplinary forum reviews birth plans where women choose care outside recommended guidance. The forum supports informed decision making and consideration of clinical and organisational risks.

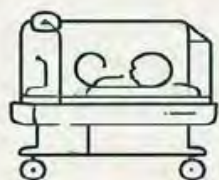


Neonatal Capacity and Safe Operation

Neonatal Unit Capacity

The Neonatal Intensive Care Unit is a level 3 service providing intensive, high dependency and special care.

Intensive care cots



8

intensive care cots

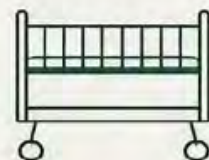
High dependency cots



10

high dependency cots

Low dependency cots

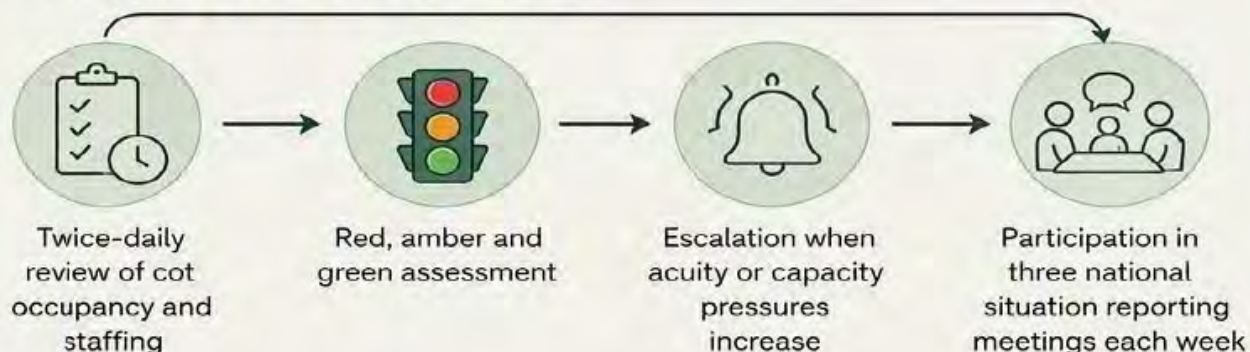


12

low dependency cots

Safe Operation Model

Cot occupancy is reviewed against available staffing twice each day. The position is rated using a red, amber and green assessment to support oversight of safe care and escalation.

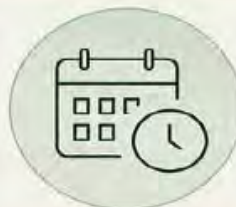


Where clinical acuity is high, an escalation process and policy support decisions regarding staffing and capacity.

Current Improvement Priorities



Maintaining staffing in line with British Association of Perinatal Medicine standards



Improving alignment between staffing rosters and available cot capacity



Developing dedicated transitional care



Securing appropriate pharmacy and multidisciplinary therapy support



Maternity and neonatal services continue to work collaboratively to provide safe, high quality care for babies and families. Ongoing monitoring and improvement activity support the delivery of sustainable, person-centred care.



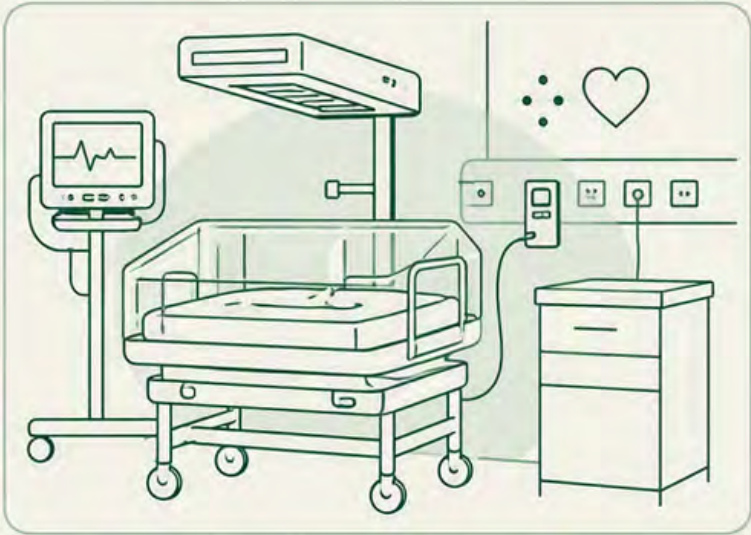
PERIPrem Cymru Optimisation

PERIPrem Cymru is a perinatal bundle intended to improve outcomes for babies born prematurely.



Validated National Neonatal Audit Programme data for 2025 was not available within the reporting material. The table therefore presents local 2025 data.

Measure	GUH 2024	GUH 2025
Antenatal Steroids	46.3%	54%
Magnesium Sulphate	81.3%	83.3%
DCC>1min	70.7%	86%
Temp on admission in range	79%	81.7%
Non-invasive ventilation, 1 st 7 days	29.8%	26.3%
ROP screening	69%	78%
Bloodstream infection - clear	1.2%	6.7%
Bloodstream infection – not clear	13.4%	13.3%
NEC	2.6%	8.7%
Breast milk day 2	71.6%	86.2%
Breast milk day 14	75.8%	84.9%
Breast milk at discharge	52.9%	63.6%
BPD(or death) by 36 weeks (high risk group)	42.1%	42.4%



74%

Overall optimisation for babies born before 34 weeks

2023: 53%

2024: 64%

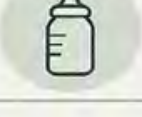
2025: 74%

Infant Feeding

Maternity and neonatal measures are presented separately as they relate to different populations and time points.



Maternity feeding measures

	73%	Babies with recorded skin-to-skin contact
	61%	Breastfeeding at birth
	60%	Breastfeeding on discharge
	57%	Breastfeeding at day 10
	51%	Breastfed babies supplemented with formula

Neonatal breast milk measures

	Breast milk at day 2	2024		71.6%
		2025		86.2%
	Breast milk at day 14	2024		75.8%
		2025		84.9%
	Breast milk at discharge	2024		52.9%
		2025		63.6%

 Improving breastfeeding initiation, continuation and exclusivity remains a priority. Maternity services are working with public health through the Best Start in Life delivery plan.

 Improvement work includes peer support, enhanced midwifery skills, the tongue-tie pathway and collaborative action with public health.

 The source report identifies infant feeding as an area requiring continued improvement.

Governance and Patient Safety



MATERNITY SERVICES

Maternity services strengthened governance arrangements during 2025 through the appointment of a Risk and Governance Lead Midwife and administrative support.

An updated maternity incident trigger list identifies incidents that must be reported. Reported incidents are reviewed through weekly multidisciplinary discussion.

Incident type	Cases
Unexpected neonatal admission associated with hypoxic-ischaemic encephalopathy	9
Neonatal death included within the above cases	2
Intrauterine death	2
Swab counting	2
Medication administration	1



16 maternity patient safety investigations were undertaken.



Five maternity incidents met the Duty of Candour threshold.



No Never Events were reported.



Strong governance and patient safety are supported by collaboration, accountability and shared learning.



SHARED LEARNING

Learning is disseminated through governance meetings, mandatory training, clinical supervision, lessons of the month and feedback to families.



NEONATAL SERVICES

Neonatal services maintain proactive incident reporting and multidisciplinary review. Most neonatal incidents were assessed as no or low harm following investigation.



Four neonatal incidents triggered the Duty of Candour during 2025.



Hypoxic-Ischaemic Encephalopathy



Hypoxic-ischaemic encephalopathy is a brain injury caused by reduced oxygen or blood flow around the time of birth. It may result in harm, disability or death, although outcomes vary between babies.



The United Kingdom Government has identified a rate of 2.5 per 1,000 as a target. Welsh Government has not set a corresponding target, and the source report notes that reliable benchmarking has been challenging.



A formal review of the Health Board's cases was completed and shared with the Quality Management Group.



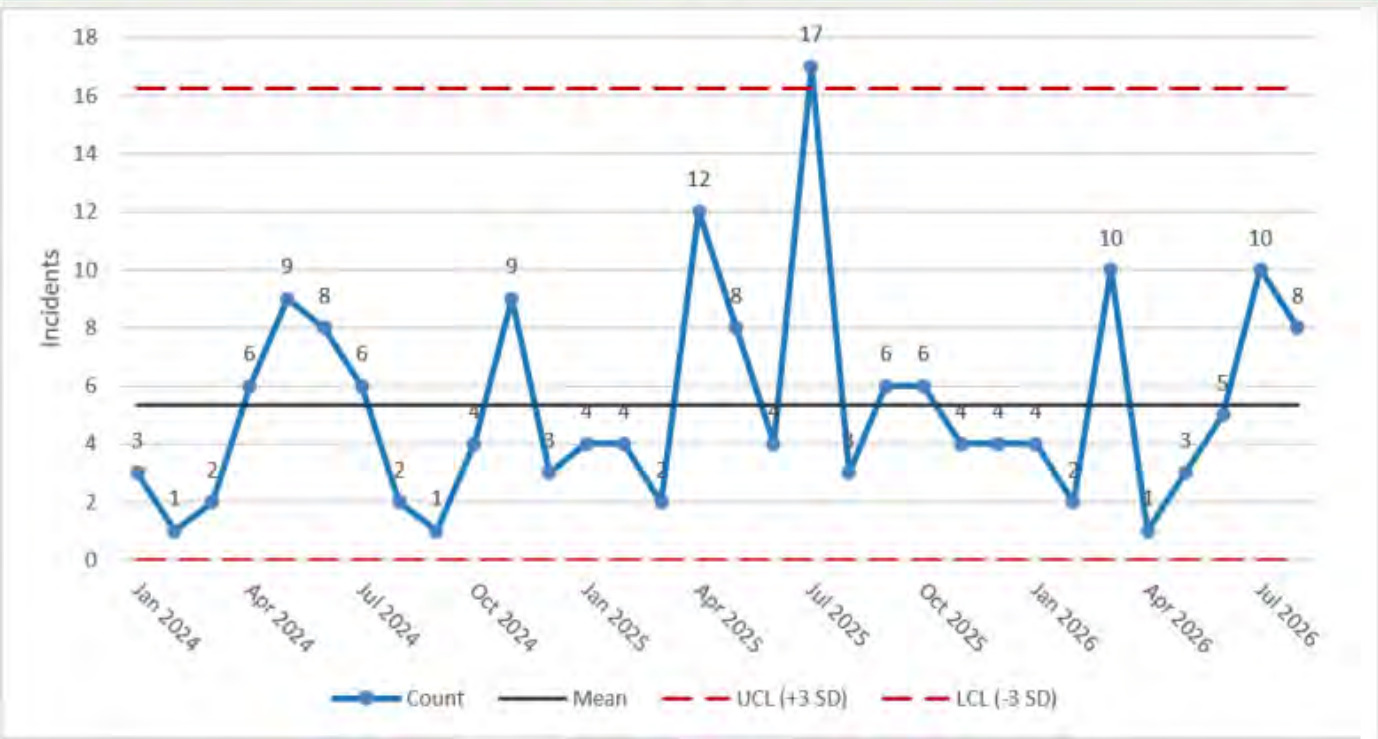
Ongoing assurance should consider findings from individual investigations, fetal surveillance, recognition of deterioration, escalation, training and learning across the maternity and neonatal pathway.



Reducing the rate of hypoxic-ischaemic encephalopathy remains a priority. Continued focus on high quality care, prompt recognition and response, effective escalation and shared learning will support improvement across the maternity and neonatal pathway.

Medication Safety

Medication, IV Fluids Incidents
Neonatal Unit



Reporting period: January 2024 to August 2026



The Statistical Process Control chart identifies special-cause variation in July 2025, when 17 incidents exceeded the upper control limit of 16.2. Incident numbers reduced to 3 in August 2025 and remained within the control limits for the remainder of the reporting period. Monthly variation continued, including 10 incidents in March 2026 and 10 incidents in July 2026.



The reduction following the July 2025 special-cause point provides evidence of improvement. However, the subsequent monthly variation demonstrates the need for continued monitoring, multidisciplinary review and oversight of improvement actions. Incident counts should be considered alongside reporting culture, activity, case mix, investigation findings and the level of harm. The chart alone does not establish whether changes reflect deterioration or improvement in medication safety.

Improvement actions

- Quality improvement projects
- Medication forum
- Human factors training
- Medication education and competency work
- Multidisciplinary incident review

Medication training compliance

above

90%

All staff groups



Mortality and Bereavement Care

Maternity and neonatal services use a collaborative process to review stillbirths and neonatal deaths. Cases are reported through Datix and national reporting processes and are reviewed through the Perinatal Mortality Review Tool.

Year	Stillbirth number	Crude rate	Stabilised rate	Neonatal deaths	Crude rate	Stabilised rate
2019	28	4.90	4.14	5	0.88	1.48
2020	13	2.46	3.52	6	1.14	1.58
2021	24	4.45	4.17	5	0.93	1.66
2022	23	4.25	3.67	4	0.74	1.15
2023	17	3.06	3.61	10	1.90	2.01
2024	22	4.16	3.55	8	1.52	1.93



The MBRRACE report released in 2025 considered babies born during 2024 from 24 completed weeks. It identified that the Health Board’s stillbirth and neonatal mortality outcomes were comparable with similar Health Boards and United Kingdom trusts.



Review arrangements include multidisciplinary perinatal mortality review, local and national mortality meetings, audit, governance review, staff debrief and a 72-hour multidisciplinary review for neonatal deaths.



Families are offered information, feedback and bereavement support. The bereavement care pathway was launched during summer 2026, with audit through the AMAT audit system.



Infection Prevention and Control

Infection prevention and control remained a priority for maternity and neonatal services during 2025/26.

2025/26 improvement programme



Cleaning schedules and laundry arrangements



Targeted environmental improvements



Blood culture reporting and venepuncture practice



Daily environmental audits



Aseptic Non-Touch Technique training and compliance monitoring



Routine trend monitoring and safety checklists



Corporate infection prevention and control walkabouts



100%

Neonatal hand hygiene audit compliance



100%

Neonatal peripheral venous catheter audit compliance



2.27%

Quarter 4 caesarean surgical site infection rate



24.75%

Reported reduction in the surgical site infection rate



The number of procedures increased by **8%** during the same period.



Hand hygiene



Environmental cleaning



Aseptic technique



Clinical audit



The report states that no further upward or changing infection trend was identified following implementation of the improvement programme.



Continued assurance is required to confirm that improvements are sustained and embedded across practice.

Workforce and Staffing Assurance



This annual report provides the Board with an overview and assurance regarding the quality, safety and delivery of maternity and neonatal services during 2025/26.



MATERNITY



- Maternity services employ more than 450 staff, including midwives, nurses, maternity support workers, nursery nurses and administrative staff.
- The previous Birthrate Plus assessment identified:
 - **242.77 whole-time equivalent staff for clinical care**
 - **269.47 whole-time equivalent staff when management, specialist midwifery and Band 3 maternity support workers were included**
- A further Birthrate Plus assessment was undertaken in 2026. The findings were awaited at the time of the report.
- During 2025, maternity services achieved a positive establishment of eight whole-time equivalent midwives. Following attrition, this reduced to a positive establishment of two whole-time equivalent.
- Executive approval supported recruitment of 15 newly qualified midwives through the 2026 streamlining process.



NEONATAL



- The neonatal service was fully staffed against British Association of Perinatal Medicine standards during 2025.
- A roster recalculation was undertaken in 2026 to improve roster management and alignment between staffing and cot availability.
- Band 6 vacancies were progressing through the approval process.
- **Six whole-time equivalent Band 5 nursing posts had been agreed through streamlining.**
- Therapy provision did not meet British Association of Perinatal Medicine standards. A business case had been developed to increase psychology, occupational therapy and wider multidisciplinary therapy provision.
- **Dedicated neonatal pharmacy and therapy support remains an area of focus.**

Attendance, Training and Development



Sickness Absence

Maternity sickness absence ranged from **4.98% to 8.04%.**

Neonatal sickness absence ranged from **5.54% to 14.86%.**

Absence is monitored monthly to identify trends and support timely intervention.

Training compliance		
Training measure	Neonatal	Maternity
Mandatory training	80%	75%
Neonatal life support	78%	82%
Medication training	100%	Not reported
Qualified in speciality	68%	Not applicable
Safeguarding Level 1 and 2	88%	88%
Safeguarding Level 3	85% target	72%
PROMPT	Not applicable	87%
Intrapartum fetal surveillance	Not applicable	88%
GAP and GROW	Not applicable	69%

Attendance management



Managers review absence trends monthly.



Individual attendance plans are agreed and reviewed.



Wellbeing support is offered where appropriate.



Clear escalation processes ensure timely action.





Development opportunities are aligned to service priorities and individual goals.



Learning needs are identified through appraisal and supervision.



Staff are encouraged to grow skills and progress careers.



Strong attendance and training support safer care and better experiences.

Culture, Improvement and Priorities for 2026/27

1. Culture and psychological safety

-  The services recognise that safe care depends on a culture in which staff feel supported, able to raise concerns and confident that concerns will be investigated and addressed.
-  Support includes coaching, mentorship, clinical supervision, restorative clinical supervision, team meetings, leadership visibility and local communication.
-  A neonatal listening event undertaken during 2025 identified themes relating to leadership visibility, positive feedback, teaching and training. Associated working groups and a cultural improvement plan were established.
-  Joint maternity and neonatal education on culture, language and psychological safety achieved compliance above 85%. A maternity listening event was planned for 2026.

2. Progress achieved

-  Early booking before 10 weeks improved to 68%.
-  Overall PERIPrem optimisation increased to 74%.
-  The hypoxic-ischaemic encephalopathy rate reduced to 1.73 per 1,000 births.
-  Retinopathy of prematurity screening improved from 69% to 78%.
-  Breast milk provision improved at day 2, day 14 and discharge.
-  The quarter 4 caesarean surgical site infection rate reduced to 2.27%.
-  MEWS, NEWTT2 and BSOTS were implemented.
-  The bereavement care pathway was launched.
-  Governance arrangements were strengthened.
-  CIVICA and the Perinatal Engagement Framework were embedded.

3. Priorities for 2026/27

-  Deliver the maternity and neonatal improvement plans and actions arising from national and local recommendations.
-  Maintain focus on infection prevention and control, medication safety and statutory and mandatory training.
-  Develop dedicated transitional care.
-  Progress neonatal pharmacy and multidisciplinary therapy support.
-  Review workforce requirements against Birthrate Plus and British Association of Perinatal Medicine standards.
-  Continue work on culture, psychological safety, human factors, equality and diversity.
-  Improve Personal Appraisal and Development Review compliance and attendance management.
-  Progress the validated perinatal dashboard.
-  Embed quality improvement, research and innovation.



Regular assurance reports should continue through the Maternity and Neonatal Improvement and Assurance Group, Quality Management Group and Executive Committee.

The Board is asked to note the progress made, the remaining risks and the priorities for continued improvement.

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 September 2026
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Quality Annual Report 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade, Executive Director of Nursing Peter Carr, Executive Director of Therapies & Health Science Dr Seema Srivastava, Executive Medical Director Tracy Daszkiewicz, Executive Director of Public Health
SWYDDOG ADRODD: REPORTING OFFICER:	Leeanne Lewis, Assistant Director for Quality & Patient Safety Tracey Partridge-Wilson, Deputy Director of Nursing

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board's Annual Quality Report for 2025/26 provides a balanced account of the quality, safety, effectiveness and experience of care delivered during the year. It describes the progress made, the learning identified, the areas where further improvement is required and the priorities that will guide the next stage of the Health Board's quality journey.

The report fulfils the Health Board's statutory reporting responsibilities under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. It demonstrates how the Duty of Quality and Duty of Candour are increasingly embedded within strategic decision-making, governance, incident management, organisational learning and everyday practice. During 2025/26, the Health Board's focus moved beyond establishing the initial requirements of the duties

towards demonstrating how they influence decisions, strengthen openness and support continual improvement in outcomes and experience.

The report is structured around the Health Board's six Pillars of Quality and maps these to the six domains and six enabling standards within the Health and Care Quality Standards for Wales. It sets out the evidence and achievements within each Pillar, how assurance is obtained, what has been learned and changed, the continuing risks and challenges, and the priorities for 2026/27.

The central narrative for 2025/26 is the strengthening of the organisational arrangements that connect quality governance, intelligence, learning and improvement. This includes the establishment of the Quality Management Group, the refresh of the Quality Outcomes Framework, closer alignment between quality and divisional performance arrangements, the development of organisational learning systems, the establishment of Clinical Effectiveness as a distinct Pillar and the expansion of quality improvement capability.

The Annual Quality Report is presented for assurance, recognising that the evidence demonstrates both important progress and areas where further action, validation and sustained monitoring are required.

[Cefndir / Background](#)

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 came into effect across NHS Wales in April 2023, introducing the Duty of Quality and Duty of Candour and placing continual improvement, openness and citizen voice at the centre of healthcare. The 2025/26 reporting year represents the final year of the Health Board's Quality Strategy 2023–2026.

During the three years of the strategy, the Health Board has progressively developed its Quality Management System, bringing together the four interdependent components of quality planning, quality control, quality improvement and quality assurance. During 2025/26, the principal focus was on strengthening these foundations and improving the connections between quality intelligence, frontline care, divisional governance, executive oversight and Board assurance.

The Quality Management Group was established as an executive forum for bringing together intelligence from patient and family feedback, concerns, complaints, incidents, mortality reviews, clinical audit, claims, external reviews, workforce information and performance data. The refreshed Quality Outcomes Framework and closer alignment with divisional performance arrangements have improved visibility from frontline services through to Executive and Board oversight.

The Health Board has also strengthened its organisational learning arrangements through the Listening and Learning Framework, Learning and Improvement Forum, Learning Repository and divisional Learning from Events Reports. These arrangements provide a more systematic route for identifying themes, agreeing actions, sharing learning and translating insight into measurable improvement. Human Factors work complements this approach by supporting a fair, open and systems-focused culture.

The report reflects the contribution of patients, families, carers, volunteers and staff through surveys, patient stories, complaints, compliments, participation panels, the Patient Advice and Liaison Service, co-design, safety visits and Big Conversation activity. Their insight has identified strengths, highlighted barriers and influenced service development and improvement.

As the Quality Strategy 2023–2026 concludes, the Health Board will undertake a comprehensive evaluation of its Quality Management System. The findings will inform a refreshed Quality Plan for 2026/27 and beyond, with a greater focus on demonstrating measurable and sustainable improvements in care, outcomes and experience.

Asesiad / Assessment

The Annual Quality Report provides reasonable assurance that the Health Board has strengthened the arrangements through which quality intelligence is identified, brought together, scrutinised and escalated. The Quality Management Group, Quality Outcomes Framework, divisional governance arrangements and Patient Quality, Safety and Outcomes Committee provide clearer lines of sight between frontline services, Executive teams and the Board.

The Health Board has made progress across the six Pillars of Quality.

1. Patient and staff experience, concerns, complaints and compliments

Patient experience insight expanded during the year through Civica, the All-Wales People's Experience Survey, PALS, concerns and complaints, participation panels, patient stories, co-design, volunteering and bereavement support. Feedback consistently identified compassionate, professional care and staff kindness as strengths, while waiting, communication, comfort and emotional support remained areas for improvement. Complaint response timeliness remains below the required standard, and further work is required to strengthen the representativeness of feedback and demonstrate more consistently how listening has led to measurable change. [

2. Patient safety

Patient safety oversight was strengthened through daily incident reviews, DatixCymru dashboards, enhanced investigation arrangements, multidisciplinary review, thematic analysis and increased scrutiny through established governance routes. Targeted improvement programmes continued to address falls, pressure damage, medicines safety, nutrition and hydration. The overdue investigation backlog reduced during the year, although compliance with national investigation timescales remains below expectation and avoidable harm requires continued attention.

The Learning from Deaths Framework, Medical Examiner Service and structured mortality review processes identified opportunities to improve documentation, clinical coding, continuity of care, end-of-life communication and treatment escalation planning. Final mortality indicators and a number of patient safety measures remain subject to reconciliation and validation before publication.

3. Clinical effectiveness

Clinical Effectiveness was established as a distinct Pillar during 2025/26, bringing together evidence-based practice, clinical audit, outcomes, research and improvement. The Audit Management and Tracking system has improved oversight of audit recommendations, actions and assurance. Electronic deterioration systems were introduced across adult, paediatric and neonatal services, and the Call for Concern pilot tested a direct route for patients and families to escalate concerns.

Further work is required to strengthen audit participation, re-audit, clinical coding, outcomes reporting and evidence of sustained implementation. Priorities for 2026/27 include wider implementation of Call for Concern, completion of remaining deterioration and escalation initiatives, expansion of Ward and Team Accreditation, and implementation of the Corporate Clinical Audit Framework 2026/27.

4. Health, safety and security

The Health Board continued to strengthen the identification and management of health, safety and security risks through inspections, leadership walkabouts, risk assessment and organisational learning. Work undertaken through the Violence Prevention and Reduction Strategic Plan strengthened prevention, de-escalation, incident response and support for staff. Violence and aggression, mandatory training compliance, statutory reporting and risks associated with the ageing estate remain areas requiring continued oversight.

5. Infection prevention and control

The Infection Prevention and Antimicrobial Steering Group provided oversight of infection prevention, outbreak management and antimicrobial stewardship. Targeted work addressed healthcare-associated infection, hand hygiene, environmental cleanliness and prudent antimicrobial prescribing. The report identifies progress in some areas while recognising that Gram-negative bloodstream infections, antimicrobial resistance, seasonal pressures, isolation capacity and estate constraints continue to present challenges. Some infection surveillance information requires final validation and reconciliation

6. Safeguarding

Safeguarding governance continued through the Safeguarding Strategic Group and its subgroups, supported by multi-agency working across Gwent. Improvements were made to the management of People in Positions of Trust referrals through enhanced use of the Datix Safeguarding Module, strengthened oversight and action to address increasing demand. Safeguarding complexity, workforce capacity and compliance with safeguarding and Ask and Act training remain important areas of focus for 2026/27.

- Organisational learning and improvement

The report demonstrates a more systematic route from listening and intelligence to action, improvement and assurance. Common learning across incidents, complaints, claims, mortality reviews, clinical audit, accreditation and patient and staff feedback included communication, documentation, pathway reliability, timeliness, data quality and the need for stronger evidence of sustainability.

Improvement capability expanded during the year through implementation of the Quality Improvement Capability Framework 2025–2028, improvement education, coaching, structured improvement methods and increased alignment with organisational priorities. The next stage is to move beyond measures of activity and capability and demonstrate more consistently whether improvement has changed care, improved outcomes, reduced variation and been sustained and spread across services.

- Person-centred care, equality and involvement

The report demonstrates continued progress in listening to and involving patients, families, carers, staff and communities. Developments include participation panels, the Deaf People Participation Panel, accessible feedback routes, bereavement support, volunteering, neurodiversity initiatives and the Big Conversation on Sepsis. Further work is required to improve demographic information, Welsh-language assurance, representation of underrepresented communities and evidence showing how people's feedback has influenced decisions and improvements.

Overall assurance and continuing risks

The Board can take reasonable assurance that the Health Board understands its principal quality risks and has established governance, escalation and oversight arrangements for monitoring them. Assurance is strongest in relation to the development of governance and quality management systems, the Quality Outcomes Framework, organisational learning arrangements, patient safety systems, clinical audit and focused quality improvement programmes.

However, assurance remains more limited where sustained impact, consistent implementation and reduction in unwarranted variation have not yet been fully demonstrated. Areas requiring continued scrutiny include:

- timely completion and closure of actions arising from incidents and complaints;
- themes of avoidable harm;
- healthcare-associated infection and antimicrobial resistance;
- workforce pressures and training compliance;
- safeguarding complexity and capacity;
- violence and aggression against staff;
- estate and infrastructure risks;
- data quality and completeness;
- Welsh-language and demographic intelligence;
- consistent implementation across divisions; and
- evidence that improvements have been sustained and spread.

The report appropriately distinguishes between increased capability, implementation of an intervention, improved process reliability, early outcome evidence and validated sustained improvement. A number of quantitative measures remain provisional and require confirmation of their baseline, numerator, denominator, reporting period, data source and validation status before final publication.

Looking ahead to 2026/27, the Health Board will focus on maturing the Quality Management System, reducing avoidable harm, strengthening clinical effectiveness, improving how it listens and responds, supporting its workforce, improving Welsh-language and accessible care, and making quality information more reliable, integrated and useful. Priority programmes will require clear accountability, validated measures, defined trajectories, evidence of involvement, equity analysis and assurance that improvements have been sustained.

Argymhelliad / Recommendation

The Board is asked to:

- NOTE the progress made during 2025/26 in strengthening the Health Board's Quality Management System, quality governance, organisational learning arrangements and improvement capability.
- RECEIVE the Annual Quality Report for 2025/26 and take assurance that the Health Board has established and continues to strengthen arrangements for identifying, triangulating, scrutinising and escalating quality risks and concerns.
- NOTE the areas where assurance remains more limited, particularly where evidence of sustained impact, consistent implementation, timely action closure, reduction in unwarranted variation or reliable validated data has not yet been fully demonstrated.
- SUPPORT the priorities identified for 2026/27, including reducing avoidable harm, strengthening clinical effectiveness, improving patient and family involvement, supporting the workforce, improving Welsh-language and accessible care, strengthening quality intelligence and demonstrating measurable and sustainable improvement.

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

	areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item.
--	--

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

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

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Annual Quality Report

2025/26

Assurance through quality, safety, learning, experience and improvement



1. Patient and staff
experience, concerns,
complaints and
compliments



2. Patient
safety



3. Clinical
effectiveness



4. Health, safety
and security



5. Infection
prevention and
control



6. Safeguarding

How to read this report

The report is presented to fulfil our statutory obligations through a combination of the Health and Care Quality Standards, framed through the Health Board's Six Pillars of Quality.



Each pillar chapter follows this sequence, using a range of evidence sources and data-validated insight to show progress, lessons learned and the actions we will take forward.

Chief Executive introduction



Nicola Prygodzicz
Chief Executive
Aneurin Bevan University Health Board

I am pleased to present our organisation’s Annual Quality Report, which reflects our ongoing commitment to the highest standards of health care, as enshrined in The Health and Social Care (Quality and Engagement) (Wales) Act 2020 and, in particular, the Duty of Quality and Duty of Candour. This report is both a record of our achievements and a transparent assessment of areas where we must continue to improve, as we strive to consistently meet exceptional standards of care for those we serve across Gwent.



Strengthening quality

During the year, we strengthened the way quality is planned, controlled, improved and assured. The Quality Management Group brought together intelligence from patient and family feedback, concerns, incidents, complaints, mortality reviews, clinical audit, claims, external reviews and performance information. This insight identified strengths, exposed barriers and shaped improvement. The refreshed Quality Outcomes Framework improved the line of sight from frontline care to executive and Board oversight.



Our workforce

The success of our quality improvement journey is underpinned by the dedication and expertise of our workforce. Over the past year, our teams have worked tirelessly against unprecedented challenges. The ongoing impact of increased demand and workforce pressures, has continued to test the resilience of services and individuals alike. Despite these difficulties, I am proud to report that our staff have continued to uphold the core values of NHS Wales — putting people at the heart of everything we do.



I would like to extend my deepest gratitude to all our staff, volunteers, partners, and the individuals and families who put their trust in us. Your commitment, courage, and resilience inspire everything we do. Together, we are shaping a health and social care system that is truly worthy of the people of Gwent.

Thank you.



Our priorities

As we look to the future, our priorities remain clear. We will continue to focus on:

- Enhancing patient and service user experience through person-centred care and genuine co-production
- Strengthening data-driven quality improvement and sharing best practice across services
- Sustaining and spreading improvement
- Addressing health inequalities and improving accessibility for all groups
- Investing in workforce wellbeing, development, and leadership
- Embedding a culture of openness, candour, and accountability at all levels of the organisation.



Working together

In partnership with our communities, staff, and stakeholders and listening to experiences, we will continue our journey toward excellence — never losing sight of our duty to deliver safe, compassionate, and effective health care.



Clinical Executive foreword



The progress described in this report was achieved in a demanding environment of rising need, workforce pressure and financial constraint. During 2025/26, the Health Board continued to strengthen its Quality Management System, connecting governance, assurance, improvement, risk management and organisational learning.

The Duty of Quality and Duty of Candour are increasingly embedded within routine decision-making and incident management, reinforcing openness, fairness and learning when care does not go as planned.

The report provides balanced assurance. It records improvement in patient feedback reach, investigation oversight, deterioration systems, ward accreditation, bereavement support and improvement capability.

Jennifer Winslade

Executive Director
of Nursing

Dr Seema Srivastava

Executive
Medical Director

Peter Carr

Executive Director of
Allied Health Professions
and Health Science

Tracy Daszkiewicz

Executive Director of
Public Health and
Strategic Partnerships

Why the Annual Quality Report matters



Demonstrates accountability

Explains how we are fulfilling our statutory duties and responsibilities.



Provides balanced assurance

Identifies progress, learning, continuing risks and areas where evidence remains incomplete.



Shows how people influenced quality

Describes how patients, families, carers, staff, volunteers and communities shaped services and improvement.



Supports continual improvement

Connects evidence, learning, action, outcomes and priorities for 2026/27.



Statutory and strategic context



Health and Social Care (Quality and Engagement) (Wales) Act 2020

Placed continual improvement, openness and citizen voice at the heart of healthcare.



Duty of Quality

Requires quality to be considered in decisions about healthcare services and requires continual improvement in outcomes.



Duty of Candour

Requires openness and transparency when the statutory threshold is met.



Health and Care Quality Standards

Provide the framework of six quality domains and six enabling standards against which quality is assessed.



Llais

Provides an independent statutory voice for people who use health and social care services in Wales.



Putting People at the Heart

A continuous commitment to listening, involving and acting on the experience of people and communities.

Health Board framework for mapping quality priorities and reporting



Health Board Quality Strategy 2023–2026

Together with the People's Experience and Involvement Strategy.

Our organisational framework for mapping quality priorities, planning delivery and structuring quality reporting.



Focus for the past 12 months: Our quality data is mapped to the Quality Management System, enabling consistent planning, control, improvement and assurance across the Health Board.



The Quality Management System

The Quality Management System provides the organising framework for quality planning, quality control, quality improvement and quality assurance.



This has been the focus for the Health Board over the past 12 months, mapping our quality data to the Quality Management System.

Quality Management System developments during 2025/26



Quality Management Group established

Created an executive forum for triangulating intelligence, decision-making, escalation and oversight.



Quality Outcomes Framework refreshed

Strengthened the visibility of quality information and alignment with performance management.



Organisational learning arrangements developed

Created more systematic routes from insight to action, improvement and assurance.



Improvement capability expanded

Increased access to improvement education, coaching and project support.



Quality and performance arrangements aligned

Strengthened divisional accountability and visibility from ward to Board.



Stronger foundations, with assurance dependent on reliable data, timely investigations, ownership and sustained impact.



Reliable data



Timely investigations

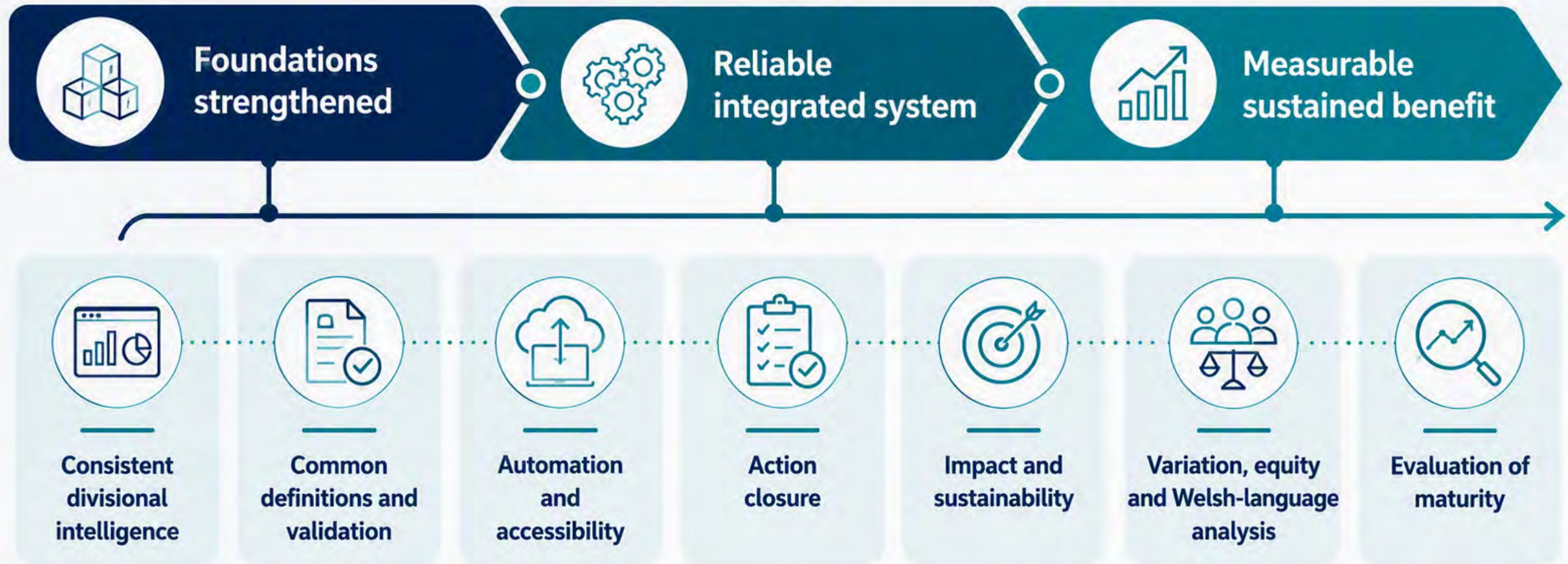


Ownership



Sustained impact

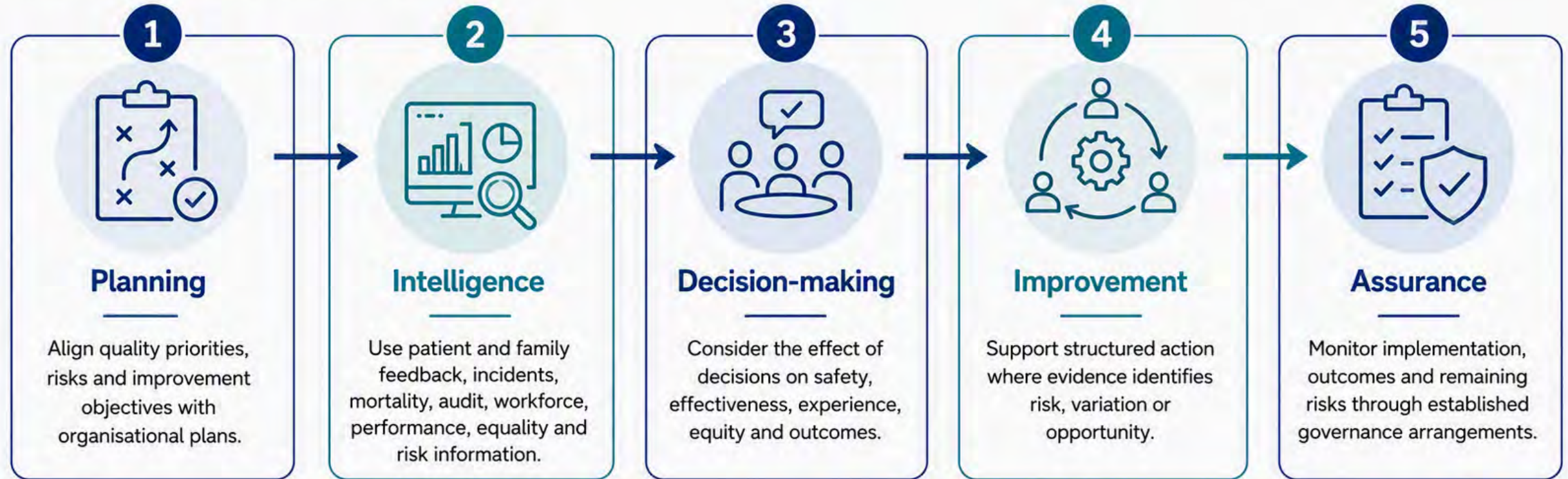
The next stage of Quality Management System maturity



During 2025/26, the Health Board strengthened the **foundations** of its Quality Management System. During 2026/27, the focus will move towards demonstrating that these arrangements operate **reliably** as an integrated system and produce **measurable improvements**.

Duty of Quality in practice

The Duty of Quality requires quality to be considered in decisions about healthcare services and requires continual improvement in outcomes.



Quality is embedded in how the Health Board plans, decides, improves and assures.



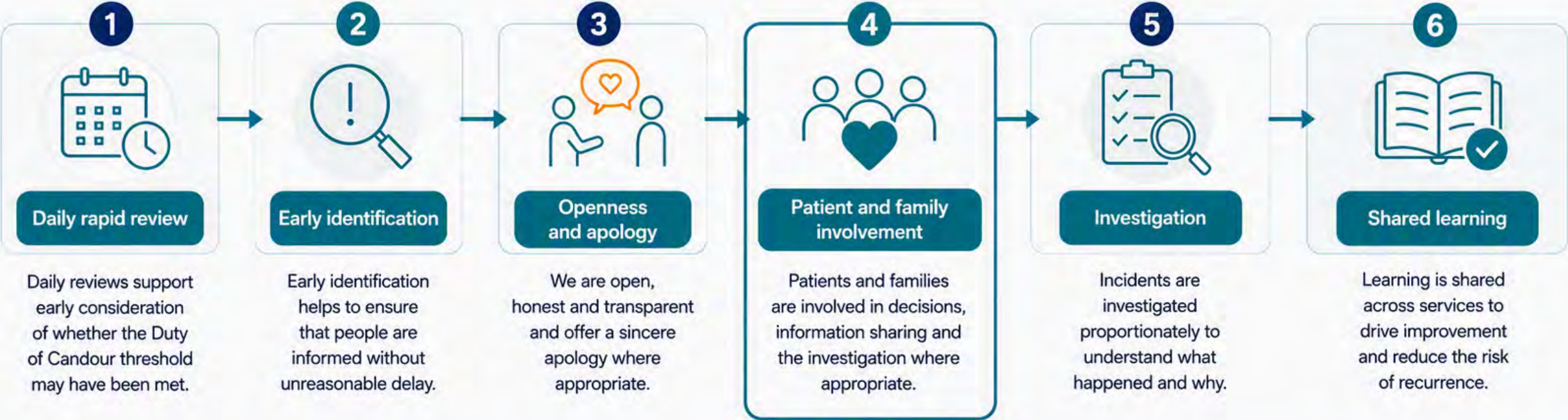
Duty of Candour

The Duty of Candour requires openness and transparency when the statutory threshold is met.



We have refined our Duty of Candour process during 2025/26 to strengthen timeliness, consistency, action completion and reduced recurrence.

Our progress and next steps are reported in the **Putting Things Right Annual Report**.



Continuing focus: timeliness, consistency, action completion and reduced recurrence.



Timeliness



Consistency



Action completion



Reduced recurrence

Our progress and next steps are reported in the **Putting Things Right Annual Report**.

What we learned during 2025/26

1

Triangulation
provides stronger
assurance



2

Timeliness is
a component of
quality



3

People identify
risks that metrics
may not reveal



4

Implementation
does not itself
demonstrate
improvement



5

Variation remains
a risk to reliable
care



These lessons help the Health Board focus on what matters most:
understanding risk, learning together and demonstrating meaningful improvement.



We have developed key quality metrics into the Qlik App to provide a single source of data.
This has strengthened transparency, empowered decision-making and aligned quality intelligence
from frontline services to executive and Board oversight.

2025/26 Highlights



Stronger quality governance, learning and improvement arrangements supported broader assurance and progress across several services.



Civica patient feedback
636 service areas
28,269 responses
86% satisfaction



Separate All-Wales People's Experience Survey
24,332 responses
83% positive



Patient Advice and Liaison Service
5,995 cases



Concerns and complaints
2,465
749 early resolutions



126 Early Warning Notifications
175 Nationally Reportable Incidents
Investigation backlog reduced by **more than 30%**



37 national clinical audits
80% of hip-fracture surgery within 36 hours
14 accreditation reviews



GRACE's Place across five boroughs
310 referrals
More than **11,000** volunteer hours



43 improvement coaches
Increased from 20
More than **360** foundational learners
70 advanced learners



Progress alongside continuing challenges
Timeliness, recurring harm, infection, workforce and estate pressures, variation, data quality and evidence of sustained impact require continued attention.





All figures remain provisional until approved by the relevant data owner.
The Civica and All-Wales survey figures represent separate datasets and must not be combined.

Key Achievements



Quality governance

The Quality Management Group was established and the Quality Outcomes Framework refreshed, strengthening executive triangulation and visibility from frontline services to Board oversight.



Listening and Learning

The Listening and Learning Framework, Learning and Improvement Forum, Learning Repository and divisional Learning from Events Reports created a more systematic route from insight to action.



Experience

Patient feedback expanded to 636 service areas, with further development of participation, Patient Advice and Liaison Service, bereavement support, volunteering and staff networks.



Patient safety

Incident oversight improved and the overdue investigation backlog reduced by more than 30%, although compliance with national timescales remained below expectation.



Deterioration

Electronic early-warning systems were introduced across adult, paediatric and neonatal services. Maternity implementation remained planned for 2026/27.



Clinical effectiveness and improvement

Clinical Effectiveness became a distinct Pillar, with progress in clinical audit, accreditation, bereavement support, safeguarding partnerships and improvement capability.



These achievements provide stronger foundations for quality. Assurance remains dependent on reliable data, timely investigations, clear ownership and evidence that actions have produced sustained improvement.

Six Pillars of Quality





Pillar One: patient and staff experience

Civica feedback:

636

service areas and
more than 28,000 responses



Separate All-Wales survey:

more than
24,000

responses



2,465

concerns and
complaints

749

early resolutions



Almost

6,000

PALS contacts

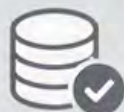


GRACE's Place
across five boroughs

More than

11,000

volunteering hours



Keep the two datasets separate
and visibly qualified.





Pillar One: assurance, learning and challenges

How we are assured



Patient-experience surveys



Patient Advice and Liaison Service



Concerns, complaints and compliments



Participation panels and volunteers



Divisional governance and reporting

Learning and change



Compassionate, professional care and staff kindness



Waiting, communication, comfort and emotional support



Patient stories, co-design and real-time feedback

Remaining challenge



Complaint timeliness



Representation

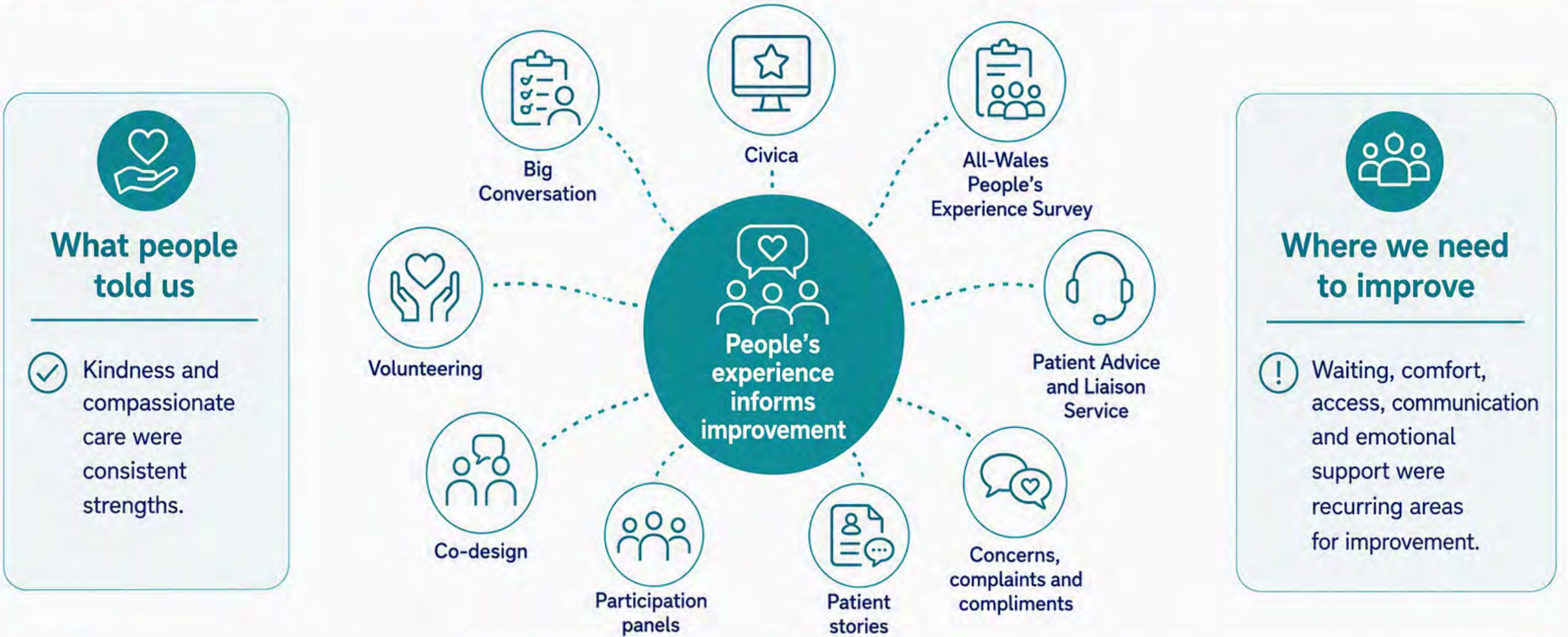


Accessibility



Welsh-language experience

How people shaped quality during 2025/26



 People, communities and staff continue to shape our services and improvement.



Pillar One: priorities for 2026/27



1



Improve concerns and complaints timeliness, towards 75% compliance



Timely responses that respect people and build confidence

2



Strengthen co-production



Services shaped with people, not just for people

3



Reach underrepresented communities



More inclusive services that meet everyone's needs

4



Act on recurring experience themes



Better care where people tell us it matters most

5



You Said, We Did, What Changed



Clear evidence of how feedback leads to real change



Pillar Two: assurance, learning and continuing risk



How we are assured



Daily incident review



DatixCymru dashboards



Divisional governance



Quality Management Group



What we learned and changed



Continuing risk



Timeliness



Mortality reconciliation



Deterioration and sepsis



Information collected



Reviewed and understood



Actions taken and implemented



Outcomes monitored



Pillar Two: priorities for 2026/27

Reduce avoidable harm



Reduce avoidable harm



Improve investigation and action closure



Prevention and safety

Strengthen learning



Strengthen Learning from Deaths



Improve investigation and action closure



Learning and insight



Action and improvement

Recognising deterioration



Improve recognition and response to deterioration



Support patient and family escalation



Better outcomes for people



Pillar Three: clinical effectiveness





Pillar Three: assurance, learning and continuing risk



ASSURANCE



Clinical Standards
and Effectiveness Group



Clinical Advisory
Forum



Audit



Outcomes review



Accreditation



LEARNING AND CHANGE



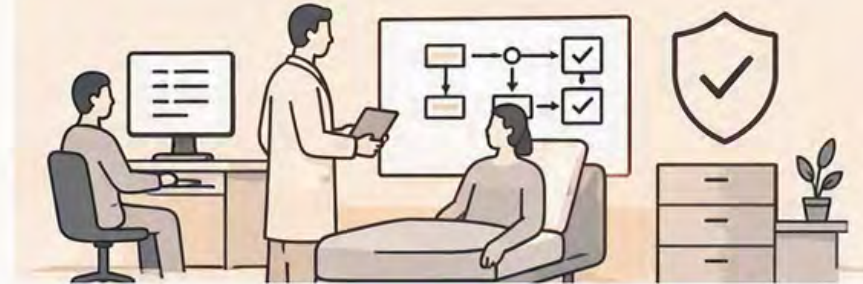
Reliable implementation



Documentation



Evidence-based
pathways



CONTINUING RISK



Operational
pressure



Re-audit



Coding



Data quality



Sustained
improvement



Evidence and learning are strengthened through governance, partnership and frontline engagement, but continued focus is required to reduce risk and deliver sustainable improvement.



Pillar Three: priorities for 2026/27





Pillar Four: health, safety and security



Safety inspections and walkabouts

Regular inspections, walkabouts and local reviews help identify, manage and reduce risk.



Mandatory training

Health and safety, fire safety, violence prevention and manual handling remain key priorities.



Fire-safety improvements

Actions from external reviews and local assessments have strengthened fire safety.



Slips, trips and falls prevention

Practical action continues to reduce slips, trips and falls across our sites.



Violence Prevention and Reduction Strategic Plan

Strengthens prevention, de-escalation, incident response and support for staff.



Some training data subject to validation.



Pillar Four: assurance, learning and continuing risk

How we are assured



Incidents and near misses

Reported by teams and reviewed to identify hazards and reduce risk.



Inspections

Planned and unplanned inspections check environments and controls.



Risk assessments

Regular assessments identify, prioritise and manage risks.



Safety communications

Updates and alerts share learning and promote safe practice.



Frontline ownership

Teams understand local risks, take action and maintain effective controls.



What we learned and changed



Frontline engagement helped identify hazards earlier and strengthened local ownership.



Fire-safety improvements and actions from external reviews strengthened controls.



Environmental reviews informed practical action to reduce slips, trips and falls.



The Violence Prevention and Reduction Strategic Plan advanced prevention, de-escalation and post-incident support.



Support for staff following incidents was strengthened.

Continuing risk



Violence and aggression



Training compliance



Ageing estate



Fire and environmental risks



RIDDOR compliance



Pillar Four: priorities for 2026/27

- 1  Improve mandatory training compliance
- 2  Improve statutory reporting
- 3  Continue violence prevention and reduction
- 4  Manage estate, fire and environmental risk
- 5  Strengthen local ownership





Pillar Five: infection prevention and control

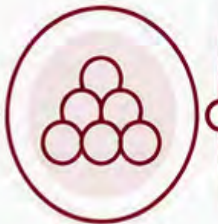


Infection Prevention and Antimicrobial Steering Group

*Clostridioides
difficile*



*Staphylococcus
aureus*



Gram-negative
bloodstream
infection



Hand hygiene



Environmental
cleanliness



Prudent
antimicrobial
prescribing



Reported reduction in
healthcare-associated
C. difficile



Maternity
surgical-site
improvement



Data
reconciliation
required



Pillar Five: assurance, learning and continuing risk



How we are assured



Surveillance



Audit



Outbreak reporting



Pharmacy oversight



Specialist infection prevention advice



What we learned and changed



Early isolation



Patient placement



Environmental cleaning



Multidisciplinary coordination



Start Smart Then Focus



Recovery and sustainment



Continuing risk



Seasonal infection



High occupancy



Isolation capacity



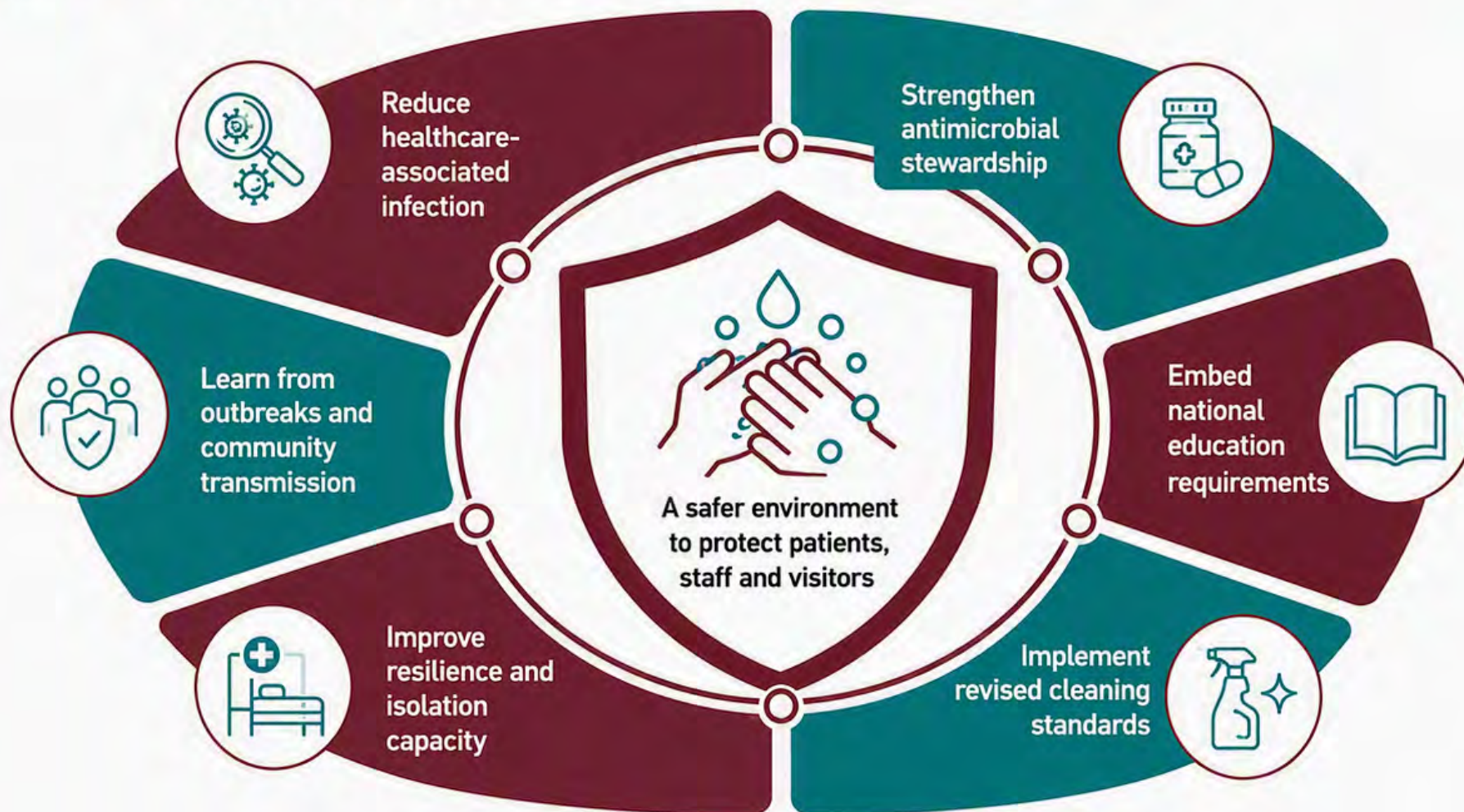
Antimicrobial resistance



Validation



Pillar Five: priorities for 2026/27



Surveillance



Hand hygiene



Environmental cleanliness



Isolation and placement



Multidisciplinary coordination



Prudent antimicrobial use



Pillar Six: safeguarding





Pillar Six: priorities for 2026/27



Delivery against the 2025/26 quality priorities

		Delivery during 2025/26	Remaining assurance gap
	1 Continuous improvement and learning	 Quality management and learning arrangements were developed and improvement capability expanded.	 Strong evidence of sustained impact and spread is still required.
	2 Patient safety and clinical effectiveness	 Harm reduction, investigation oversight, Learning from Deaths, audit tracking and deterioration systems progressed.	 Timeliness, variation, audit capacity and data quality remain concerns.
	3 Patient and staff experience	 Feedback reach, participation, bereavement support, volunteering and staff networks expanded during the year.	 Complaint timeliness, representation and evidence of impact require improvement.
	4 Openness, candour and accountability	 Candour embedded in incident management. Early resolution and learning routes strengthened.	 Timeliness and validated performance information remain important.
	5 Workforce wellbeing and leadership	 Human Factors, improvement capability, leadership visits and wellbeing initiatives developed further.	 Workforce pressure, safety and training continue to affect reliability.
	6 Digital tools and integration	 Use of DatixCymru, Civica, Audit Management and Tracking, Qlik and dashboards progressed.	 Integration, automation, definitions and analytical capability require development.

Quality evidence influencing major decisions

Decisions during 2025/26 were informed by a wide range of quality intelligence, ensuring that quality considerations influence real choices and actions.



Patient and family feedback



Patient safety incidents



Mortality reviews



Clinical audit



Workforce information



Performance data



Equality considerations



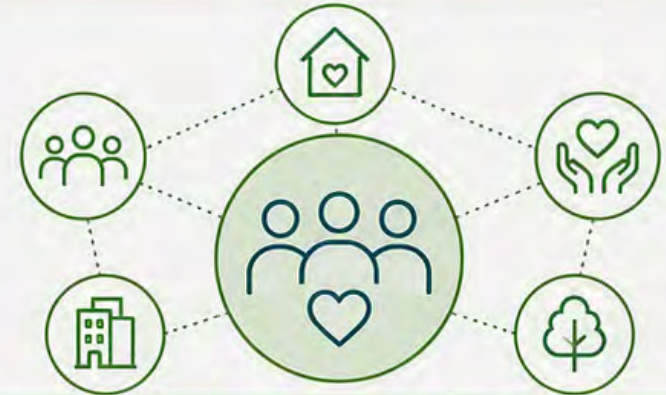
Risk assessments



Deteriorating Patient and Sepsis Improvement Programme



Neurodiversity Emergency Department Improvement Project



Gwent Bereavement Collaborative



These examples demonstrate how quality evidence, involvement and the Duty of Quality shaped decisions, implementation approaches and monitoring arrangements.

Strategic decision: deterioration and sepsis



 Strong leadership, reliable processes and effective escalation help to ensure that deterioration is recognised earlier and sepsis is treated promptly.

Strategic decision: neurodiversity in Emergency Departments

Evidence, involvement and the Duty of Quality shaped improvements to better meet the needs of neurodivergent patients.



Improvements aim to create a more accessible, respectful and person-centred experience for neurodivergent patients and their families.

Strategic decision: coordinated bereavement support



Coordinated, compassionate and person-centred support across Gwent.

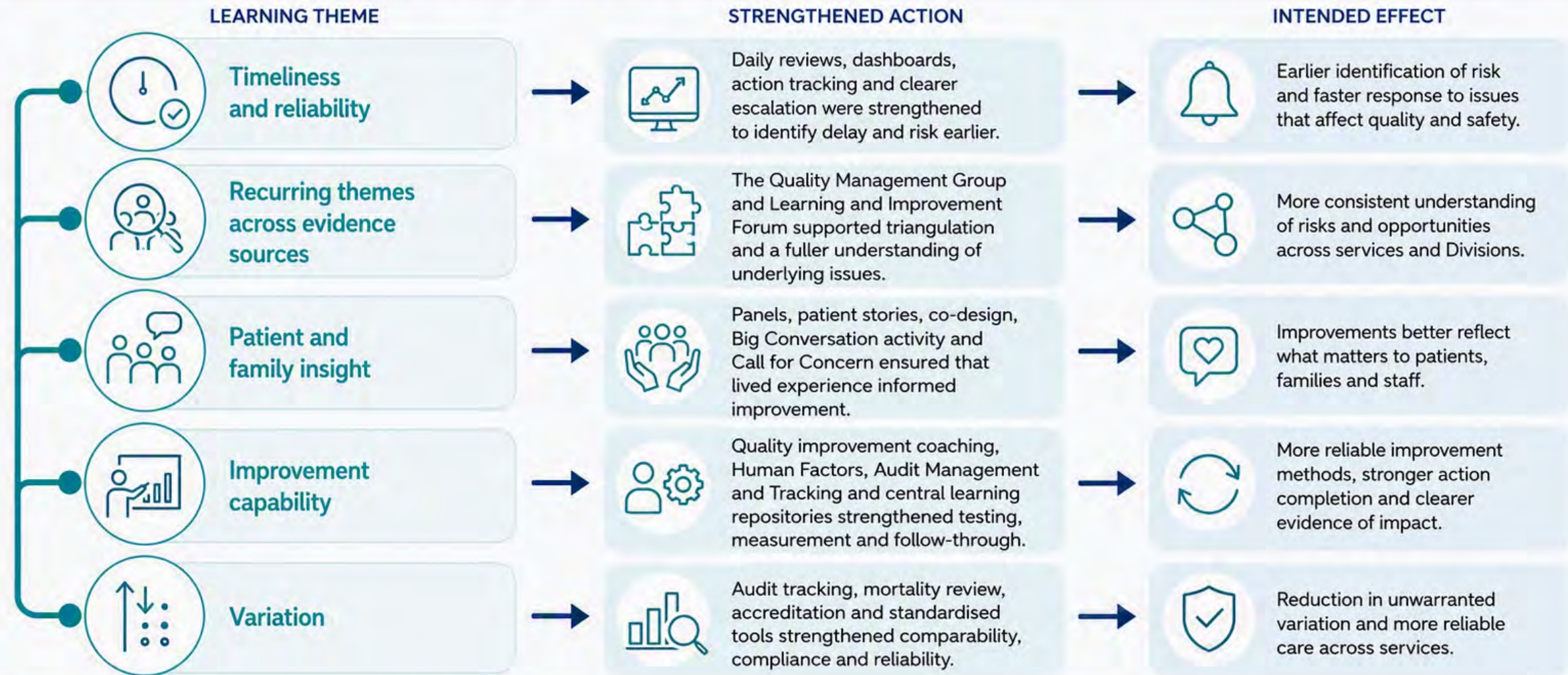
Improvement capability during 2025/26



 **Quality improvement is aligned to our capability framework**
Our improvement work follows a clear capability framework for our coaches, learners and teams, ensuring consistent skills, support and standards across the organisation.

 Training demonstrates capability, not by itself improved outcomes.
Impact is demonstrated through reliable data, evaluation and sustained improvement.

Learning translated into action



Insight drives action, action drives improvement and improvement strengthens assurance.



Learning-to-impact examples

1

Falls causing harm



!

Problem
Falls causing harm remained at a risk for patients.

👥

Change
Prevention focus and local oversight were strengthened.

📋

Evidence status
A validated harm rate, baseline and sustained trend remain required.

2

Pressure damage



!

Problem
Pressure damage remained at a risk for patients.

👥

Change
Prevention work and accreditation oversight continued.

📋

Evidence status
The reported downward trend requires confirmation of the measure, baseline and sustainability.

3

Complaint timeliness



!

Problem
Complaint response timeliness remained below the required standard.

👥

Change
Training, case review, dashboard monitoring and early resolution were strengthened.

📋

Evidence status
Annual definitions and denominators require validation.

4

Maternity infection



!

Problem
Infection risk in maternity care required further reduction.

👥

Change
Targeted improvement work was undertaken.

📋

Evidence status
The exact reported reduction has not yet been validated within the source report.

5

Deterioration and sepsis



!

Problem
Delayed recognition and response to deterioration remained a risk.

👥

Change
Early-warning and sepsis pathways were implemented.

📋

Evidence status
Early outcome findings remain provisional and require continuing monitoring and re-audit.

6

Bereavement support



!

Problem
Bereaved families identified variation in support.

👥

Change
GRACE's Place expanded across five boroughs.

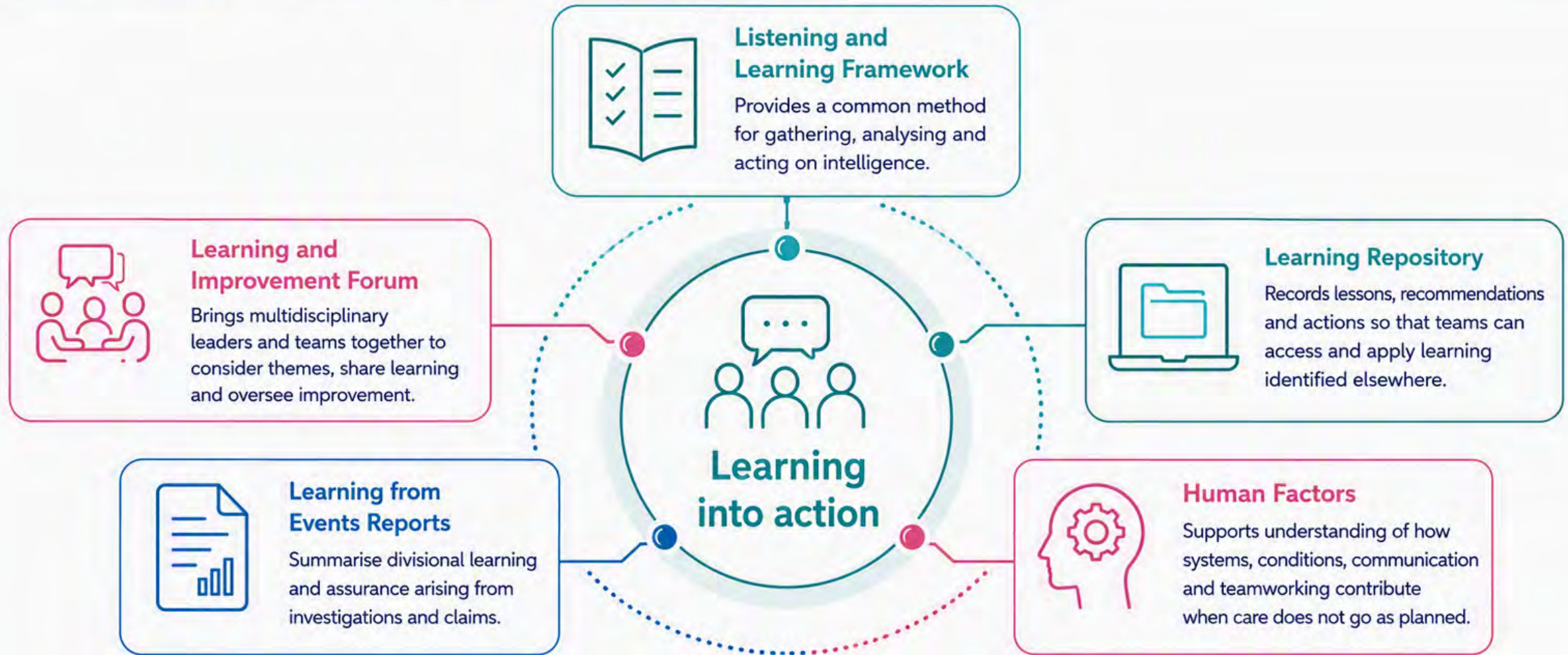
📋

Evidence status
Reach, experience, equity and outcome evidence require further validation.



Measures, baselines and sustainability require validation where stated.

Listening and learning arrangements



This connected approach ensures that insight is understood, acted upon, stored, reported and translated into safer, more effective and more person-centred care.

Equality, prevention and whole-system outcomes



Equality and inclusion

- ✓ Accessible feedback and services
- ✓ Deaf People Participation Panel
- ✓ Targeted engagement
- ✓ Neurodiversity Staff Network
- ✓ Bereavement collaboration



Prevention and early intervention

- ✓ Deterioration and sepsis improvement
- ✓ Infection prevention programmes
- ✓ Ask and Act training and support
- ✓ Early resolution through PALS
- ✓ Community sepsis awareness



Whole-system working

- ✓ Primary care and general practice
- ✓ Local authorities and social services
- ✓ Safeguarding partners and police
- ✓ Community and voluntary organisations
- ✓ Academic partners and national programmes



Remaining evidence need

- ✓ Demographic information
- ✓ Variation
- ✓ Reasonable adjustments
- ✓ Accessibility
- ✓ Shared outcomes



Working together across services and communities to improve care, reduce inequalities and deliver better outcomes for everyone.



Welsh language and the Active Offer

Why this matters for quality



Safe, equitable and person-centred care

Receiving care in Welsh is an important component of safe, equitable and person-centred care.



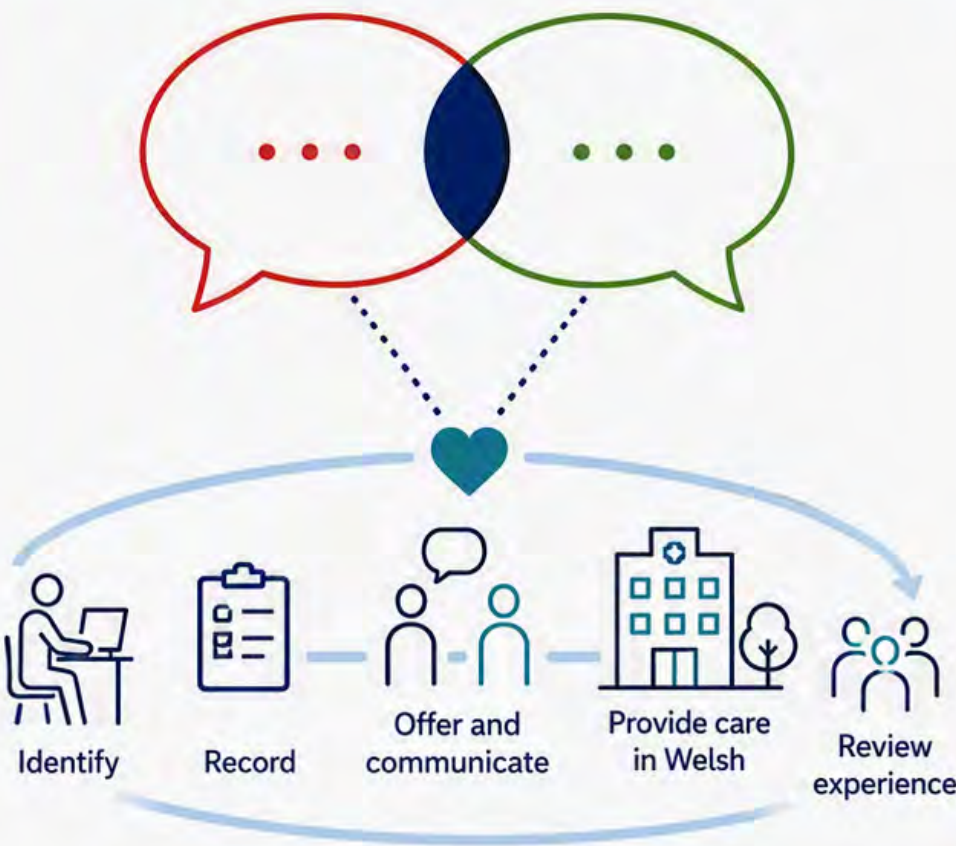
Proactively offer Welsh-language services

The Active Offer means proactively offering Welsh-language services rather than requiring people to ask.



Identify and record language need

Language needs should be identified and acted upon as part of safe, high-quality care.



What will be strengthened in 2026/27



Identify and record language need



Workforce capability



Access to Welsh-language services



Patient, family and staff experience



Validated measures and reporting arrangements



Validated measures, improvement trajectories and reporting arrangements will be developed with the Welsh Language Unit before being incorporated into routine quality reporting.

Quality priorities for 2026/27



Conclusion and forward direction

Stronger foundations established during 2025/26



Together, these developments provide a stronger foundation for Board assurance, organisational oversight and frontline action.

Balanced assessment of quality

Evidence of progress

- Quality reporting and learning
- Early resolution and investigation oversight
- Patient and family involvement
- Recognition and management of deterioration
- Clinical audit and accreditation
- Bereavement care and safeguarding partnerships
- Infection prevention
- Workforce and improvement capability

Continuing challenges

- Timeliness of responses, investigations and actions
- Recurring harm and unwarranted variation
- Healthcare-associated infection
- Mandatory training compliance
- Workforce and estate pressures
- Welsh-language and demographic intelligence
- Reliability of some data sources

The evidence provides a balanced assessment, identifying areas of sustained improvement alongside matters requiring further attention, validation and continued scrutiny.

Towards a mature and sustainable Quality Management System

The developments made during 2025/26 are important building blocks in establishing a systematic, intelligence-led and continuously improving approach to quality.



The Board can take assurance that the governance arrangements, quality intelligence, learning systems and improvement capability described in this report provide a strong foundation for delivering safer, more effective, person-centred and equitable care.

Continued scrutiny will be required to ensure actions are delivered, improvement is sustained and intended benefits are realised.



Appendix: STEEEP assurance map

 **Safe**

 **Evidence:** Incident review, harm reduction, infection prevention, safeguarding, deterioration systems and candour.

 **Remaining gap:** Recurring harm, investigation timeliness and unresolved safety data.

 **2026/27 action:** Sustain harm reduction and improve investigation and action closure.

 **Timely**

 **Evidence:** Patient Advice and Liaison Service, early resolution, escalation systems, Early Warning Notifications and deterioration tools.

 **Remaining gap:** Waiting, complaint and investigation delays.

 **2026/27 action:** Set and monitor improvement trajectories.

 **Effective**

 **Evidence:** Clinical Effectiveness, audit, Audit Management and Tracking, mortality, accreditation and research.

 **Remaining gap:** Re-audit, coding, outcome reliability and sustained implementation.

 **2026/27 action:** Strengthen outcome measures, action closure and re-audit.

 **Efficient**

 **Evidence:** Integrated reporting, electronic tracking, pathway improvement and stewardship.

 **Remaining gap:** Manual collation, duplication and incomplete integration.

 **2026/27 action:** Automate and integrate intelligence while protecting clinical reliability.

 **Equitable**

 **Evidence:** Participation panels, accessible support, Deaf People Participation Panel, neurodiversity work and borough-wide bereavement support.

 **Remaining gap:** Demographic analysis, under-represented voices and Welsh-language evidence.

 **2026/27 action:** Improve demographic analysis, accessibility and Welsh-language assurance.

 **Person-centred**

 **Evidence:** Civica, Patient Advice and Liaison Service, complaints, patient stories, co-design, bereavement and Call for Concern.

 **Remaining gap:** Uneven coverage and limited public evidence of what changed.

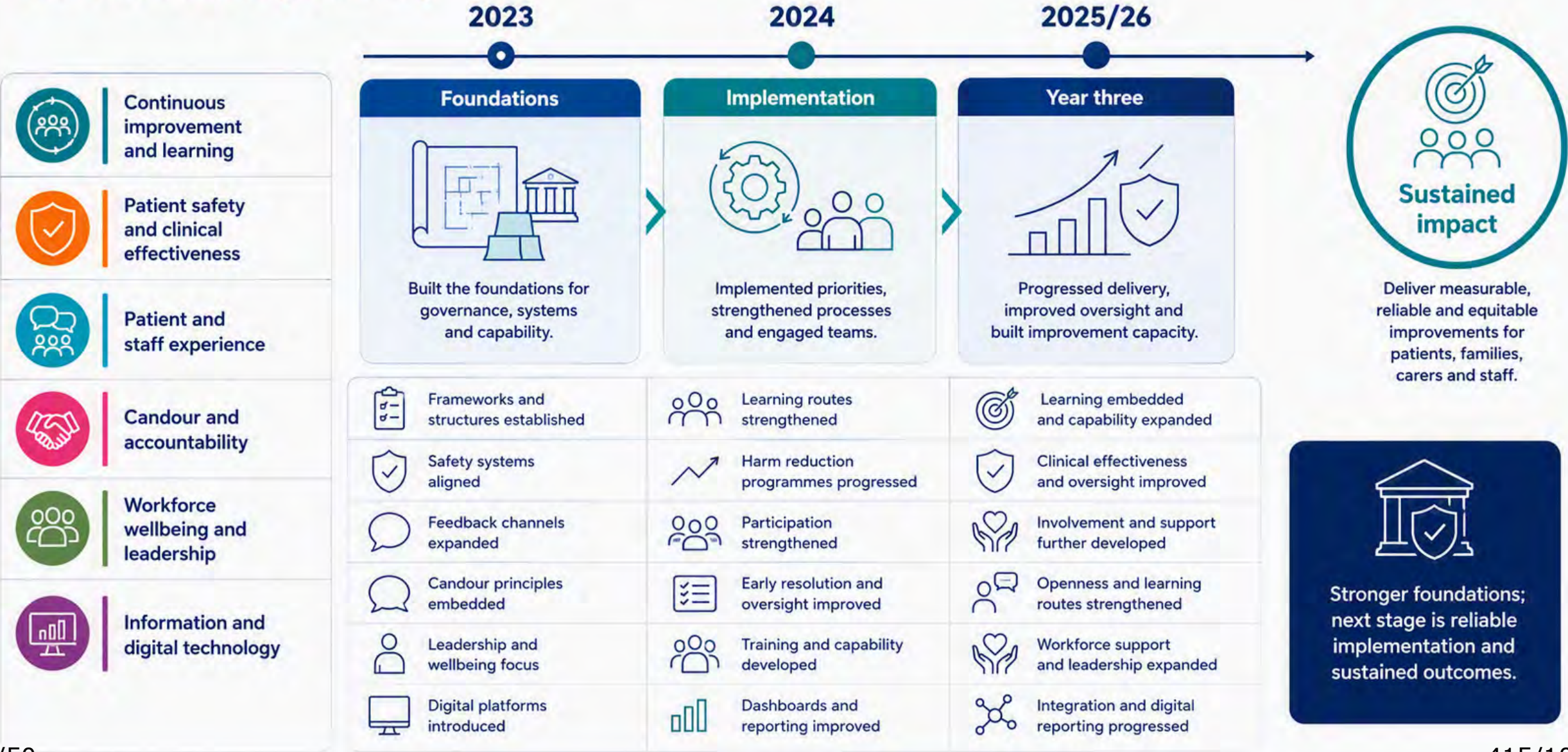
 **2026/27 action:** Strengthen “You Said, We Did, What Changed” and broaden involvement.

Appendix: quality enablers assurance map

 Leadership  Evidence: Quality Management Group, executive oversight and divisional governance.  Remaining gap: Consistent divisional ownership and closed-loop action.  2026/27 action: Strengthen ward-to-Board accountability.	 Workforce  Evidence: Improvement and Human Factors development, coaching and specialist training.  Remaining gap: Workforce pressure and variation in training compliance.  2026/27 action: Agree measurable recovery and capability plans.	 Culture  Evidence: Candour, just culture, speaking up, incident reporting and learning communication.  Remaining gap: Evidence of impact on psychological safety and behaviours.  2026/27 action: Use staff measures and local action plans to test cultural change.
 Information  Evidence: Dashboards, DatixCymru, Civica, Audit Management and Tracking, Qlik and Quality Outcomes Framework.  Remaining gap: Definitions, integration, coding, manual processes and data quality.  2026/27 action: Approve common definitions and validation controls.	 Learning, improvement and research  Evidence: Learning Forum, Repository, Learning from Events Reports, improvement capability, audit, research and innovation.  Remaining gap: Spread, sustainability, re-audit and outcome evaluation.  2026/27 action: Require learning-to-impact and sustainability evidence.	 Whole-systems approach  Evidence: Regional, safeguarding, primary care, local authority, community, academic and national partnerships.  Remaining gap: Shared outcomes are not consistently evidenced.  2026/27 action: Define partnership outcomes and report collective impact.

Appendix: Quality Strategy 2023-2026

Year-three delivery summary



Appendix: strategic enablers and milestones



Appendix: 2026/27 monitoring and escalation framework



		 Baseline	 Direction	 Review	 Escalation
1	 Safer, more reliable care	 Baseline: Validated baselines to be confirmed.	 Direction: Reduce harm and improve process reliability.	 Review: Monthly operational and quarterly corporate assurance.	 Escalation: Immediate escalation for serious safety concerns.
2	 Stronger clinical effectiveness	 Baseline: Audit, re-audit, accreditation and coding baselines require validation.	 Direction: Improve audit completion, action closure and reliability.	 Review: Quarterly.	 Escalation: Data set discrepancies, overdue high-significance action or data-quality failure.
3	 Effective learning organisation	 Baseline: Investigation timeliness, action impact and spread require confirmation.	 Direction: Faster closure and stronger evidence of sustainability.	 Review: Monthly or quarterly according to the measure.	 Escalation: Repeated themes, overdue actions or recurrence without evidenced control.
4	 People, leadership and culture	 Baseline: Training, staff experience, violence reduction and capability measures require validation.	 Direction: Improve compliance, staff safety and psychological safety.	 Review: Quarterly.	 Escalation: Performance below the approved trajectory or a material staff-safety concern.
5	 Quality intelligence and digital integration	 Baseline: Data-definition, validation, automation and dashboard-timeliness baselines are to be confirmed.	 Direction: Improve definitions, automation, timeliness and reliability.	 Review: Quarterly.	 Escalation: Data set discrepancy, delayed reporting or loss of confidence in a control measure.
6	 Collaboration, involvement and innovation	 Baseline: Representation, Welsh-language, partnership and public-reporting measures are to be confirmed.	 Direction: Broaden involvement and demonstrate partnership and innovation outcomes.	 Review: Quarterly or programme-specific.	 Escalation: Persistent underrepresentation, undelivered action or deteriorating outcomes.

DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 September 2026
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Health, Safety & Fire Annual Report 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Peter Carr Executive Director of AHPs and Health Science
SWYDDOG ADRODD: REPORTING OFFICER:	Peter Carr Executive Director of AHPs and Health Science

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Situation:

The Health, Safety and Fire Annual Report 2025/26 provides assurance on the Health Board's performance, compliance, governance arrangements and strategic priorities across Health & Safety, Fire Safety, Manual Handling, Risk Management and Violence Prevention & Reduction (VPR).

Overall performance remains stable with notable progress in governance, assurance, policy review, enforcement management and strategic planning.

Key areas requiring continued executive oversight are Manual Handling Training, Fire Safety compliance, action closure from audits/inspections, and ongoing management of violence and aggression risks.

Cefndir / Background

The Health Board operates a Health and Safety Management System aligned to HSE's HSG65 framework and maintains statutory duties under the Health and Safety at Work etc. Act 1974 and associated legislation.

During 2025/26 the service strengthened leadership capacity through appointment of a Deputy Head of Health & Safety and Deputy Head of Violence Prevention & Reduction. Governance continues through the Health and Safety Committee and its sub-groups, providing oversight of organisational risk and compliance.

Key priorities during 2025/26 included:

- Strengthening health and safety leadership and accountability.



- Improving policy and procedural compliance.
- Enhancing organisational monitoring and assurance.
- Improving RIDDOR reporting compliance.
- Managing fire safety risks and infrastructure investment.
- Developing a strategic approach to Violence Prevention & Reduction.
- Addressing manual handling training and competency challenges.

Assessment

The 2025/26 reporting period demonstrates continued maturation of the Health Board's health, safety and fire governance arrangements, underpinned by strengthened leadership capacity, enhanced assurance mechanisms and a clear commitment to continuous improvement. Significant progress has been achieved across several strategic priorities, providing increased organisational assurance and supporting the delivery of safe, high-quality care.

POSITIVE ASSURANCE

Governance, Leadership and Assurance

The Health Board has strengthened its health and safety leadership arrangements through additional specialist leadership capacity and improved governance oversight. Internal audit recommendations have been substantially addressed, resulting in strengthened policy governance, improved legislative assurance arrangements and more robust risk management processes. Health and safety monitoring and performance reporting continue to become increasingly embedded within organisational governance structures.

Compliance and Risk Management

A comprehensive programme of workplace inspections, management audits and Fire Risk Assessments has delivered a high level of organisational assurance. Compliance scores across both community and inpatient environments remain strong, demonstrating effective local management arrangements and sustained commitment to risk reduction. Improvements in RIDDOR reporting compliance and risk assessment processes further strengthen confidence in organisational oversight and statutory compliance.

Policy and Organisational Learning

Substantial progress has been made in modernising the Health Board's policy framework, with key policies reviewed and updated alongside the introduction of new guidance in response to emerging risks and operational requirements. Organisational learning has been strengthened through targeted safety communications, investigation learning, training updates and enhanced dissemination of lessons learned across services.

Fire Safety and Infrastructure

The Health Board continues to demonstrate a proactive approach to fire safety management. The successful completion of the annual Fire Risk Assessment programme, coupled with significant capital investment in fire safety infrastructure, has improved resilience across a number of high-risk sites. The absence of any enforcement action from South Wales Fire and Rescue Service during the year provides additional assurance regarding the effectiveness of current fire safety arrangements.



Violence Prevention and Reduction

The development of the Health Board's first Violence Prevention and Reduction Strategic Plan represents a significant milestone in establishing a long-term, organisation-wide approach to workplace safety and staff wellbeing. Strong partnership working with Gwent Police, NHS Wales colleagues and national stakeholders has strengthened prevention, reporting, staff support and organisational learning arrangements. Continued investment in this area positions the Health Board well to address one of the most significant workforce safety challenges facing the NHS.

Overall Position

Overall, the report demonstrates a positive trajectory of improvement, with strengthened governance, enhanced assurance, improved compliance arrangements and significant progress against strategic objectives. While challenges remain in a number of key areas, the Health Board is in a stronger position than previous years to identify, manage and mitigate health, safety and fire risks, providing increased assurance to the Board and Executive Team.

KEY RISKS AND STRATEGIC CHALLENGES

While the overall position is improving, several areas continue to require focused executive oversight and organisational attention to ensure risks are effectively managed and performance continues to improve.

Workforce Training and Compliance

Manual handling training remains the most significant area of concern within the Health Board's health and safety portfolio. Compliance has deteriorated during the reporting period and remains substantially below the organisational target, creating an ongoing workforce and patient safety risk. The sustainability of the current training model, coupled with limitations in cascade trainer capacity and high levels of non-attendance, necessitates a fundamentally different approach during 2026/27.

Delivery of Improvement Actions

Whilst audit and inspection activity has provided strong assurance regarding the identification of risks, the timely implementation and closure of improvement actions remains inconsistent across parts of the organisation. A significant number of actions arising from audits and workplace inspections remain overdue, highlighting the need for strengthened local ownership, accountability and divisional oversight to ensure identified risks are addressed in a timely manner.

Incident and Regulatory Performance

The reporting period has seen an increase in several key health and safety indicators, including sharps-related incidents, RIDDOR-reportable events and incidents involving members of the public. Although increased reporting may reflect improved organisational awareness and scrutiny, these trends require continued monitoring and targeted intervention to ensure underlying risks are effectively understood and mitigated.

The Health Board also experienced two significant Health and Safety Executive investigations during the year, resulting in Notices of Contravention. While substantial progress has been made in implementing the required improvement actions, these events reinforce the importance of maintaining robust governance, assurance and operational controls across all services.



Estate and Fire Safety Risks

Significant progress has been achieved through the delivery of fire safety capital programmes; however, a number of legacy estate risks remain. The Health Board continues to manage a substantial number of residual fire safety risks that require ongoing capital investment and remediation. Challenges associated with ageing infrastructure, compartmentation works and fire alarm replacement programmes will continue to require strategic oversight and investment planning over future years.

In addition, further work is required to strengthen practical fire evacuation competencies within inpatient environments, ensuring staff preparedness aligns with the complexity of the Health Board's clinical settings.

Violence, Aggression and Workforce Safety

Violence and aggression continue to represent a significant risk to staff wellbeing and organisational resilience. Although reporting rates have stabilised and support arrangements have strengthened, incident volumes remain high across a number of clinical settings, particularly within emergency care and mental health services. Sustained delivery of the Violence Prevention and Reduction Strategic Plan will be critical to reducing harm, improving staff experience and strengthening organisational resilience over the coming years.

Executive Risk Position

The key risks facing the Health Board are not attributable to deficiencies in governance or assurance arrangements, which continue to strengthen, but rather relate to the consistent operational delivery of risk controls across a large and complex organisation. Executive attention during 2026/27 should therefore focus on:

- Improving manual handling training compliance and sustainability.
- Strengthening accountability for audit and inspection action closure.
- Reducing preventable workplace injuries and regulatory incidents.
- Managing long-term fire safety and estate infrastructure risks.
- Delivering the Violence Prevention and Reduction Strategic Plan and associated workforce safety improvements.

Overall, these risks are recognised, understood and subject to active management. However, continued executive sponsorship and organisational focus will be required to ensure that the progress achieved during 2025/26 translates into sustained improvement and enhanced assurance during 2026/27.

Argymhelliad / Recommendation

The Board is asked to:

- Note the Health, Safety and Fire Annual Report 2025/26 and the overall assurance position.
- Endorse the key health, safety and fire priorities for 2026/27.
- Support targeted organisational action in relation to manual handling compliance, violence prevention and reduction, and fire safety improvement programmes.
- Receive assurance through existing governance arrangements on progress against these priorities throughout 2026/27.



Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Health and Safety Strategic Risk Assessment (SR010) – Risk Score 12
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1.1 Health Promotion, Protection and Improvement 2.1 Managing Risk and Promoting Health and Safety 7. Staff and Resources Governance, Leadership and Accountability
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	



Deddf Llesiant
Cenedlaethau'r Dyfodol – 5
ffordd o weithio
Well Being of Future
Generations Act – 5 ways
of working

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

Choose an item.
Choose an item.

Health, Safety and Fire Annual Report 2025/26





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ein gwerthoedd | our values



Gofalu **gyda'n gilydd** **Together** we care

Introduction

This report provides an analysis of health and safety performance across the Health Board during 2025/26.

Health and safety responsibilities are shaped by **the Health and Safety at Work etc. Act 1974**, which places duties on organisations to:

- Maintain an effective Health and Safety Policy
- Manage and control workplace risks
- Provide safe premises, equipment, and systems of work
- Ensure proper information, instruction, training, and supervision
- Provide adequate welfare facilities

As an NHS Wales organisation, the Health Board is required to meet quality expectations set out in:

- The Health and Social Care (Quality and Engagement) (Wales) Act 2020A
- Healthier Wales
- Core Commissioning Requirements

Health, Safety and Security is a core quality pillar (4) within the Health Board's Quality Strategy, underpinning safe, effective care delivery.

The Health Board operates a Health and Safety Management System aligned to the HSE 'Managing for Health and Safety' (HSG65) model, based on the **Plan, Do, Check, Act (PDCA) approach**.



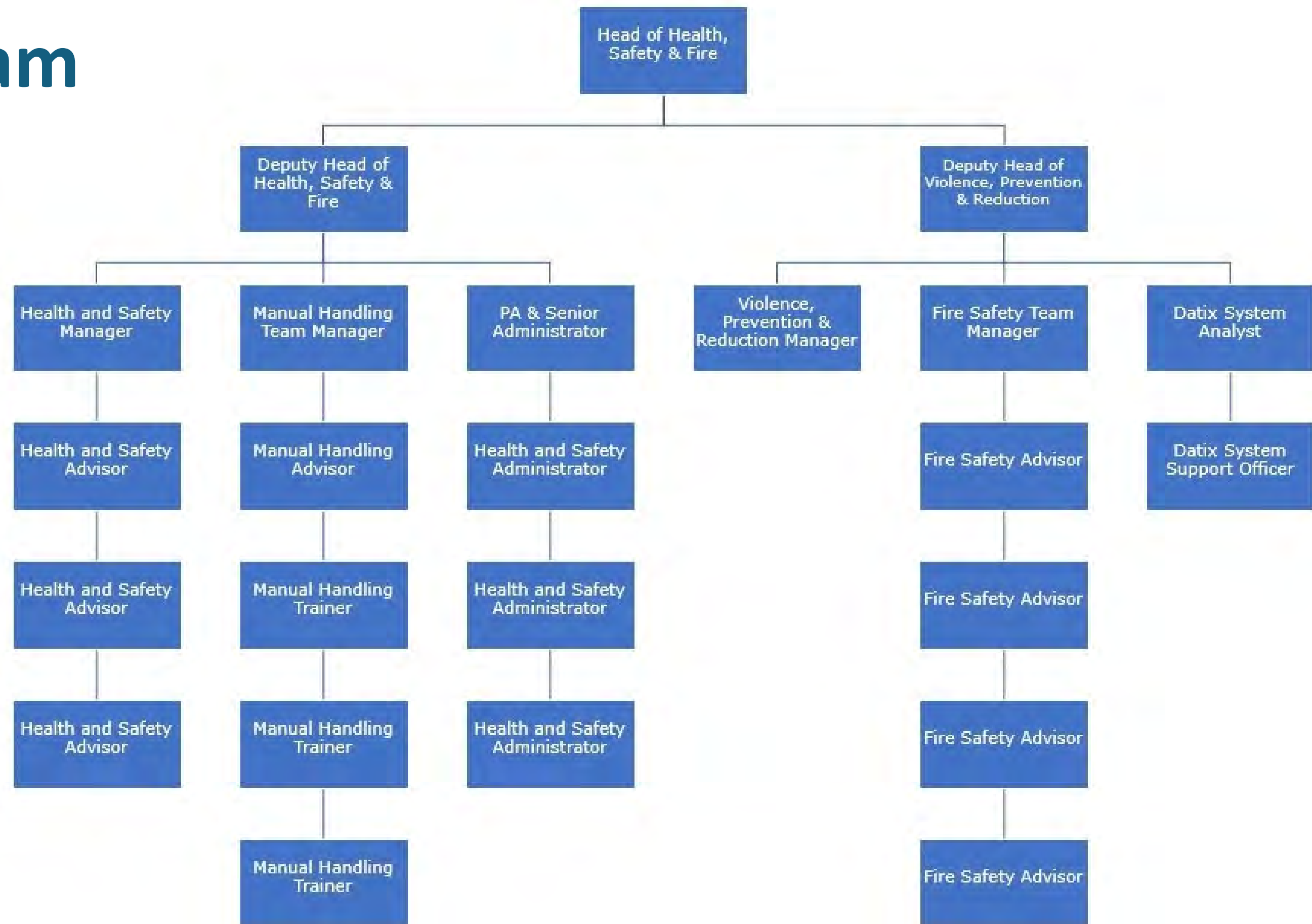
This model integrates health and safety into routine business and leadership decision-making, balancing systems and behaviours.



The Team

As members of the All-Wales Health and Safety Management Steering Group, the Corporate Health and Safety Team works with health and safety professionals across NHS Wales to share best practice and support continuous improvement.

Over the past year, several changes within the team have strengthened capacity and leadership. This has included the appointment of a Deputy Head of Health and Safety and a Deputy Head of Violence Prevention and Reduction. Both roles complement and enhance specialist provision within their respective fields, while providing additional leadership support to the Head of Service.



Purpose, Scope and Governance

Purpose

This report provides the Health Board with an overview of key activity, assurance and outcomes relating to the management of health, safety and fire within Aneurin Bevan University Health Board during 2025/2026. It also outlines the key priorities for the Health and Safety Committee and its sub-groups for 2026/27.



Scope & Governance

The report summarises the legislative and regulatory framework that governs health and safety responsibilities and describes the local governance arrangements that support delivery and oversight across the organisation.

It highlights the work of the Health and Safety Committee and reporting sub-groups, with assurance across the following domains:

- Fire Safety
- Health and Safety
- Manual Handling
- Risk Management
- Violence Prevention and Reduction

Executive accountability for health and safety continues through the Executive Chair of the Health and Safety Committee, supported by the Executive Director of Allied Health Professions & Health Science.



Each subgroup holds responsibility for maintaining its own **terms of reference, policies and procedures**, which are submitted to the Health and Safety Committee for ratification.

In addition to corporate governance arrangements, health and safety continues to be monitored through regular inclusion on Divisional Quality and Patient Safety Forums.

Key Areas of Focus from 2025-2026 Summary

Areas of Focus	Progress Summary	Status of Progress
Health & Safety Leadership	Strengthened manager and supervisor understanding of roles and responsibilities, as a critical risk control	Green – Good progress
Health & Safety Capacity & Support	Review completed to assess adequacy of corporate resources	Amber – Ongoing improvements required
Policies and Procedures	Review programme initiated to improve compliance and update documentation	Amber – In progress
Manual Handling Training	Targeted actions implemented; however, compliance remains a key risk area	● Red – Requires further intervention
Fire Safety Training	Improvements made, but compliance still below target	Amber – Progressing but not yet achieved
Violence Prevention & Reduction	Continued focus on understanding and reducing incidents across services, VPR Strategic plan drafted	Green – Progress established
RIDDOR Reporting Compliance	Improved compliance with statutory reporting timelines	Green – Improved performance
Health & Safety Monitoring	Structured inspection programme implemented across sites	Green – Embedded
Risk Assessment Quality	Improved consistency through training and oversight	Amber – Developing maturity
Fire Alarm Systems	Capital investment secured; upgrade programme underway	Amber – Long-term programme
Fire Barriers (Compartmentation)	Surveys completed and improvement plans initiated	Amber – Ongoing works

Policies & Procedures



Health and safety policies and procedures have been developed within the Health Board to outline the organisations obligational plans to achieve compliance in line with relevant legislation.

An objective for 2025/26 was to ensure policies and procedures were reviewed and updated as appropriate. Five policies and 14 guidance documents and procedures were reviewed and updated. Four policy, guidance documents will be carried forward into 2026/27 to allow sufficient time for divisional consultation and the incorporation of all feedback.

In addition, a number of new documents and processes were developed in response to emerging risks and service needs within the various disciplines. This work will continue for 2026-27.

Policies and Procedures reviewed in 2025/26	Safety Guidance issued in 2025/26
Health and Safety Policy	Guidance for High-Risk Sample Labelling.
Violence Prevention & Reduction Policy	LABEL poster to support the correct labelling High-Risk Samples.
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Standard Operating Procedure	Guidance for staff working in hot weather conditions.
Incident, Near Miss and Hazard Reporting Policy	Guidance for staff working in cold weather conditions.
Guidance on Managing Unacceptable Written and Verbal Communications	Guidance for the Safe Use of Hoisting Equipment.
Use of Restrictive Practice Intervention Policy	Guidance for the Transfer of Patients Between Wards and Departments within Hospitals.
Safe Use of Social Media Guidance	Guidance on Managing Unacceptable Written and Verbal Communications.
Complex Case Guidance	Guidance on Health and Safety Risk Assessment
Lone working Policy & Guidance	Guidance for the Management of Bed and Pressure Relief Mattress Wires.
	Guidance on the Safe Use of Social Media
	Guidance for COSHH Symbols

Audit and Assurance

An Internal Audit of Health and Safety arrangements was conducted during 2024/25, with the findings reported in September 2025.

The Health and Safety Legislative Assurance Framework provides assurance regarding compliance with statutory health and safety legislation.

The audit reviewed several key themes, including Policies and Procedures, Quality, Safety and Patient Experience, Governance, and Reporting.

The audit identified three high-priority management actions and four medium-priority actions requiring attention.



Key Findings	Risk	Management Actions
Policies and Procedures		
1. The overarching Health and Safety Policy was still in draft and waiting for approval.	Medium Priority	The Health and Safety Policy was published in December 2025.
2. Health and Safety Policies not being up to date	Medium Priority	A plan has been developed to review and update all organisational health and safety policies.
Governance		
3. Record of Legislative and Statutory Requirements was out of date.	Medium Priority	The Health and Safety Legislative & Statutory Register has been reviewed and updated.
4. Monitoring Health and Safety Risks at Committee and Board level - Outstanding risks and actions not escalated appropriately	Medium Priority	A full review of health and safety risks in DatixWeb was completed, with Divisions continuing to manage their own identified risks.
Quality, Safety & Patient Experience		
5. Risk Assessments Identified risks are not addressed in a timely manner.	High Priority	A full review of health and safety risks in DatixWeb was completed, with Divisions continuing to manage their own identified risks.
6. Workplace Inspections Key risk issues are not tracked ensure to timely/ appropriate remedial action.	High Priority	Compliance with actions arising from workplace inspections will be monitored through the Quality Outcomes Framework (QOF) metrics to support performance tracking and continuous improvement.
Reporting		
7. RIDDOR Reporting Failure to comply with health and safety legislation	High Priority	The Corporate Health and Safety Department provides RIDDOR awareness training to relevant managers, and there is a proposal to make this training mandatory for all managers to improve compliance.

Health, Safety and Fire Enforcement Activity



Key Findings	Outcome
Fee for Intervention (FFI) costs	
Fatal patient fall in July 2023 at Grange University Hospital.	FFI total costs = £17,702.40
Notification of Contravention	
Patient suicide in February 2025 on Hafan Deg Ward at County Hospital.	Correspondence received in April 2025 from HSE confirming their decision to investigate the incident. HSE inspection at Hafan Deg Ward, County Hospital took place on 19 June 2025 to assess the management of health and safety risks to staff and patients arising from the management of challenging behaviour. Notification of Contravention letter received in July 2025. Contraventions in health and safety law (HASAWA, MHSWR, PUWER) associated with violence and aggression risk to employees, absconding risk, self-harm and restrictive intervention training. HSE compliance visit took place on Monday 29 September 2025. FFI total cost: £3,989.4
HSE investigation of RIDDOR regarding the laboratory infection of an employee of the Microbiology department with Salmonella Typhi at Royal Gwent Hospital. Salmonella Typhi is a hazard group 3 pathogen and with the confirmed infection of an employee means that this incident meets the HSE criteria for investigation.	Initial meeting held with Specialist Inspector on 28 August 2025. Request for documentation sent to Specialist Inspector on 9 September 2025. HSE inspection at Pathology Department, Royal Gwent Hospital took place on 4 November 2025 to assess the management of health and safety risks to laboratory staff. A Notification of Contravention letter was received in November 2025, identifying breaches in health and safety legislation (MHSWR Regulation 5(1) and COSHH Regulation 12(1)) in relation to risks to laboratory staff from potential exposure to Hazard Group 3 (HG3) pathogens. HSE was satisfied with the measures implemented by the Health Board, and the enforcement action has now been closed.
During 2025/26, the Health Board did not have an enforcement from SWFRS (South Wales Fire and Rescue Service).	

Health, Safety and Fire Enforcement Activity

Hafan Deg Contravention

The HSE inspection findings at Hafan Deg Ward have highlighted critical areas requiring organisational learning and systemic improvement, particularly relating to environmental security, observation practice, violence and aggression controls, and the strength of clinical documentation.

The actions taken to date demonstrate positive progress and a clear commitment to strengthening safety for both patients and staff.

- The completed Hafan Deg Ward HSE action plan progress monitored at executive level until full closure and assurance is obtained.
- A structured 'lessons learned' review has been completed; include training and compliance, policy updated, audits and shared learning across teams.
- Systematic dissemination of learning across all Mental Health inpatient wards through a combination of divisional governance forums.

Improvements

New gate and fence commissioned for the Fire Door area following assessment by Estates Team and Fire Safety Team.



Health, Safety and Fire Enforcement Activity

Pathology Contravention

- Providing information to clinical staff and monitoring of clinical detail provision to ensure ongoing compliance.
 1. New guidance for High-Risk Sample Labelling has been issued.
 2. A new poster LABEL has been developed to support the correct labelling High-Risk Samples.
 3. A Cascade Record for Labelling of High-Risk Samples has been developed to support communication and compliance.
- Strengthening the provision of information around pathogen awareness and control measures to protect staff handling waste.



Health, Safety and Fire Training

The provision of suitable and sufficient training is a statutory requirement under the **Health and Safety at Work etc. Act 1974** and the Management of Health and Safety at Work Regulations 1999.

The Regulations place a duty on employers to ensure that all employees receive adequate health and safety training.

As of 31st March 2026, Health and Safety statutory and mandatory training compliance was as follows:

Training Course	2024/25 Compliance %	2025/26 Compliance %
Health and Safety	87%	87%
Fire Safety	83%	84%
Manual Handling	70%	63%
Violence Prevention & Reduction	86%	85%

Health and safety statutory and mandatory training continued to be delivered primarily via eLearning, accessed through the ESR self-service portal, enabling ease of access for staff and compliance monitoring by line managers.

Line managers can view team compliance and receive alerts when staff are approaching non-compliance.

Manual handling training remains a key challenge, with compliance levels below the required 85% standard.

During 2025/26, the Manual Handling Training Strategy was reviewed to support a more sustainable and risk-based approach, particularly for high-risk areas.

Manual handling training is delivered in line with the All-Wales Manual Handling Passport, ensuring a consistent and standardised approach across NHS Wales.

The Manual Handling Team continued to deliver face-to-face training to Health Board staff throughout the year.



Next Steps for 2026/27:

- Establish a sustainable approach to manual handling training.
- Roll out the manual handling learning pathway across the organisation.
- Imbed COSHH awareness into Risk Assessment training.
- Implement RIDDOR Awareness training within the Health Board and mandate for managers.
- Develop a Health and Safety Training programme for managers.
- Complete Training Needs Analysis for Violence Prevention & Reduction Training across ABUHB
- Continue delivering fire safety training across ABUHB.

Manual Handling Training

Manual Handling Courses:

Manual handling training continues to prove a challenge for the Health Board with compliance levels well below the required standard of 63%. The manual handling training strategy has been reviewed in 2025/26 to ensure the Health Board has a sustainable programme of manual handling education, particularly for high-risk areas.

Manual Handling training within NHS Wales is delivered to the scope of the All-Wales Manual Handling Passport. This ensures a consistent and standard approach to training.

Manual Handling Course Title	No. of Sessions	No. of Attendees	No. of DNA's
People Handlers Foundation Training	75	742	105
People Handlers Update Training	38	257	47
Object Handlers Foundation Training	8	65	14
Object Handlers Update Training	4	36	0
People Handlers Trainers Foundation Training	4	17	7
People Handlers Trainers Update Training	11	68	7
Object Handlers Trainers Foundation Training	2	15	0
Object Handlers Trainers Update Training	3	12	0

Staff attendance on manual handling training and specifically those who do not attend remains a challenge.

Manual Handling Cascade Training 2025/26

To support delivery of the Manual Handling Training Strategy, cascade trainers have been nominated across the Health Board. Cascade trainers (including Transfer Specialists and Safer Handling Coaches) complete foundation training and are required to undertake biennial update training to maintain competence.

During 2025/26, the register of cascade trainers was reviewed and refreshed, and a programme of update training was delivered to support consistency and assurance. Overall compliance with Manual Handling Cascade Training for 2025/26 was 42.6%, which remains significantly below the required

Trainer type	Number in organisation	Number currently out of date (over 2 years)	Training compliance
Transfer Specialist	192	76	60.4%
Assistant Trainer	36	31	13.8%
Safer Handling Coaches	180	127	27.9%

Strategic Priority for 2026/27

Urgent targeted intervention is required for Manual Handling, focusing on:

- Expanding and stabilising trainer capacity
- Improving training scheduling and accessibility
- Strengthening divisional ownership and accountability



Violence Prevention & Reduction Training

Aligned to the **All-Wales NHS Violence & Aggression Passport Scheme**. The passport scheme is broken down into four areas:

Module A: Induction and awareness of V&A and organisational responsibilities

Module B: Theory of personal safety and de-escalation

Module C: Practical breakaway techniques

Module D: Restrictive physical intervention

All staff are required to complete Modules A and B, with Modules C and D delivered based on risk assessment. This year, additional Corporate Health and Safety staff have been trained to deliver Modules C and D.

During the reporting period, gaps and risks were identified around patient searching, particularly linked to increased contraband incidents in **Mental Health and Learning Disabilities Division**. In response, a bespoke train-the-trainer programme was implemented to build local capability, with further assurance to be provided through a new Health Board Search Policy planned for Quarter 2 of 2026/27.

At a national level, the **All-Wales Violence and Aggression (AVC)** group will be reviewing the training passport, which is expected to influence future training requirements within the Health Board.

In addition, the **Violence Prevention and Reduction Strategic Plan** includes a specific objective to complete a comprehensive Training Needs Analysis over the next two years, to further review risks and ensure training provision remains proportionate, evidence-based and aligned to emerging need.



Grŵp Cydweithredol Cymru dros atal Trais
Anti-Violence Collaborative Wales

Health & Safety Training for Managers



A Health and Safety for Managers Training package is currently being developed nationally. This work is being led by Cwm Taf Morgannwg University Health Board and will be agreed at the All-Wales Health and Safety Management Group.

Once the course is approved, the course will be piloted within the Health Board to raise managers' awareness of their responsibilities in health and safety management.

The Health and Safety Training for managers course will cover vital information such as the legal requirements, safety management systems, safety culture, risk assessment & hazard control and incident investigation.

What is next for 2026/27

- The Corporate Health and Safety Department will pilot the Health and Safety for Managers Training package, which is currently being developed at a national level.
- To strengthen management competency in health and safety, the Corporate Health and Safety Department will introduce a Health and Safety for Managers training programme across the organisation. This will be achieved through either the adoption of a nationally recognised programme or the development of an ABUHB-specific course aligned to organisational needs and priorities.



Risk Assessment Training

Completion of risk assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999.

To support the Health Board in meeting this legislative duty and to strengthen organisational capability, the Risk Assessor Training course was refreshed during 2026/27.

During the year, **27 training courses were delivered, with 155 Health Board staff** trained in Health and Safety Risk Assessment.

The course is designed to ensure participants understand when a risk assessment is required, the principles of effective risk management, and how to complete a suitable and sufficient risk assessment within the workplace.

What is next for 2026/27

- New Risk Assessment Training programme, including COSHH Awareness to be developed and implemented.
- To continue delivering bespoke Risk Assessment training courses for Senior managers and departments across the Health Board.

Fire Safety Training

Fire safety training compliance remains positive, although current figures are primarily based on eLearning completion and may not fully reflect practical evacuation competencies required in inpatient areas.

A successful pilot at Ysbyty Aneurin Bevan demonstrated the benefits of strong clinical leadership, which will be important to replicate across the organisation. During 2025/26, a **further 93 Fire Wardens were trained**. While engagement with the Fire Warden returns process is encouraging, participation remains variable across departments.

The Fire Safety Team conduct an annual programme of fire drills and exercises across the Health Board. The purpose of these is to confirm the fire evacuation strategies for the areas are robust. **In 2025/26, the Fire Safety Team carried out fire exercises in 12 departments across the Health Board.** Following each exercise, staff debriefs are undertaken and a formal report is produced to capture learning, identify best practice, and evaluate staff responses. Any lessons identified are shared through relevant management, fire safety, and health and safety governance structures.

What is next for 2026/27

- Finalise and implement the fire safety training needs analysis for nursing staff working on Inpatient Wards.
- Improve feedback to Fire Warden monthly returns to encourage regular reporting and provide reminders when submissions are missed.

Learning from Events

The Corporate Health and Safety Department has implemented a range of **communication approaches** to support learning from incidents across the Health Board.

This includes the use of health and safety performance reports, post-investigation debriefs, updates to relevant training packages, and organisational alerts.

Safety Information Sheets issued in 2025-2026

Personal Safety of Health Board employees
Powered Air Unit Expiry Dates
Slips, Trips and Falls Awareness
The use of Expired FFP3 Masks
Risk of Self-Harm from debit card chip
Labelling of High-Risk Samples
Management of Outpatient Chairs
Manual Handling of Objects
Management of Patients Self Administering Insulin
Flat Lifting Equipment

Personal Injury Claims

The Corporate Health & Safety Department supported Legal Services by contributing to investigations and providing documentation. A strong focus is placed on identifying learning from incidents and claims, ensuring that themes and contributory factors are analysed and translated into practical improvements. This demonstrates continuous learning to reduce the likelihood of recurrence and strengthen overall organisational safety.

During 2025/26, the Health Board received a total of 26 personal injury claims. The majority of these were associated with slips, trips and falls, along with incidents involving violence and aggression. The ongoing collaboration between Health & Safety and Legal Services ensures that claims are managed effectively, risks are better understood, and preventative actions are embedded within operational practice to improve safety outcomes for both staff and patients.



Health & Safety Workplace Inspections

The Health Board successfully delivered the inspection and audit programme agreed for 2025/26, achieving its planned objectives. Furthermore, the performance figures demonstrate a high level of activity and effectiveness by the Health and Safety Team, reflecting strong leadership and effective programme delivery.

Workplace health, safety, and environment inspections were carried out between October 2025 and December 2025 to inspect all Community Premises by March 2026.

Workplace Health, Safety and Environment Inspection 25/26 (Community Premises)				
RAG Action Status				
Division	RED	AMBER	GREEN	Total Actions
Surgery	0	0	0	0
Medicine	0	0	0	0
Urgent Care	0	0	0	0
Family & Therapies	5	14	10	29
Clinical Support Services	0	0	0	0
Mental Health & Learning Disabilities	1	2	5	8
Primary Care and Community	2	22	48	72
Total Actions	8	38	63	109

Key Findings

- Strong overall compliance across Community Premises
- Average compliance score: **95.5%**

Action Status

- 39 completed
- 3 partially completed
 - 61 overdue
- 6 unable to complete

Key Issues Identified

- Temperature control within work areas
- Lighting concerns (internal/external)
- COSHH storage and documentation requirements
- Red actions included window fittings needed for tamper-proof safety restrictors
- signs of structural deterioration

Inspection Outcomes

- 42 inspections completed by March 2026
- 109 actions raised and recorded on AMaT
 - Actions assigned to local ward/department managers

2026/27 Priorities

- Continue 3-year Health & Safety audit programme
- Integrate inspection proforma into ward accreditation
- Strengthen local inspection and monitoring arrangements

Health & Safety – Management Audits

A programme of **Health and Safety Management audits** was completed between January and March 2026. The audits supported the Health Board in meeting both legal and moral health and safety responsibilities.

Site	Audits Scheduled	Audits Completed	Site Compliance
Grange University Hospital	16	16	100%
Royal Gwent Hospital	18	18	89%
Chepstow Community Hospital	2	2	100%
County Hospital	4	4	85%
Maindiff Court Hospital	1	1	100%
Monnow Vale Hospital	1	1	100%
St Cadocs Hospital	4	4	100%
St Woolos Hospital	1	1	100%
Ysbyty Aneurin Bevan Hospital	4	4	100%
Ysbyty Tri Chwm	1	1	100%
Ysbyty Ystrad Fawr	8	8	100%
Neville Hall Hospital	7	7	100%
Rhymney Integrated Health and Social Care Centre	1	1	100%
Llanfrechfa Grange Hospital	1	1	100%

Key Findings

- Strong overall compliance across inpatient areas
- Average compliance score: **96%**

Action Status

- 22 completed
- 3 partially completed
- 109 overdue

Key Issues Identified

- COSHH documentation, storage, and labelling requirements.
- Incomplete or outdated risk assessments and risk registers.
- Mandatory health & safety training compliance gaps.
- Lack of routine PAT testing for portable electrical equipment.
 - Limited evidence of previous audit completion and monitoring.

Audit Outcomes

- 69 audits completed by March 2026.
- 135 actions raised and recorded on AMaT.
- Actions assigned to local ward/department managers.

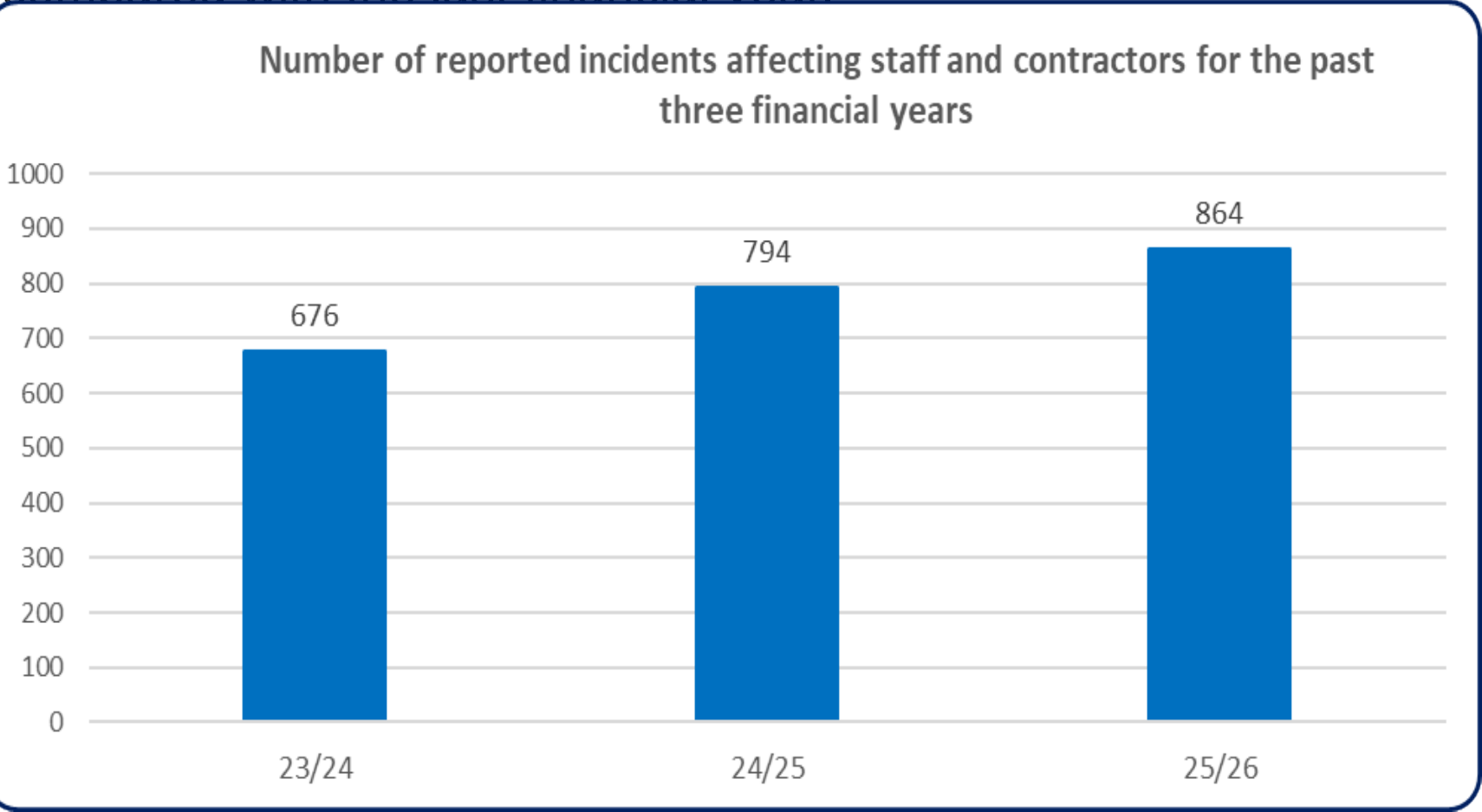
2026/27 Priorities

- Continue 3-year Health & Safety audit programme.
- Integrate workplace inspection proforma into ward accreditation.
- Strengthen local inspection and monitoring arrangements
- Continue monitoring action completion through Quality & Patient Safety meetings

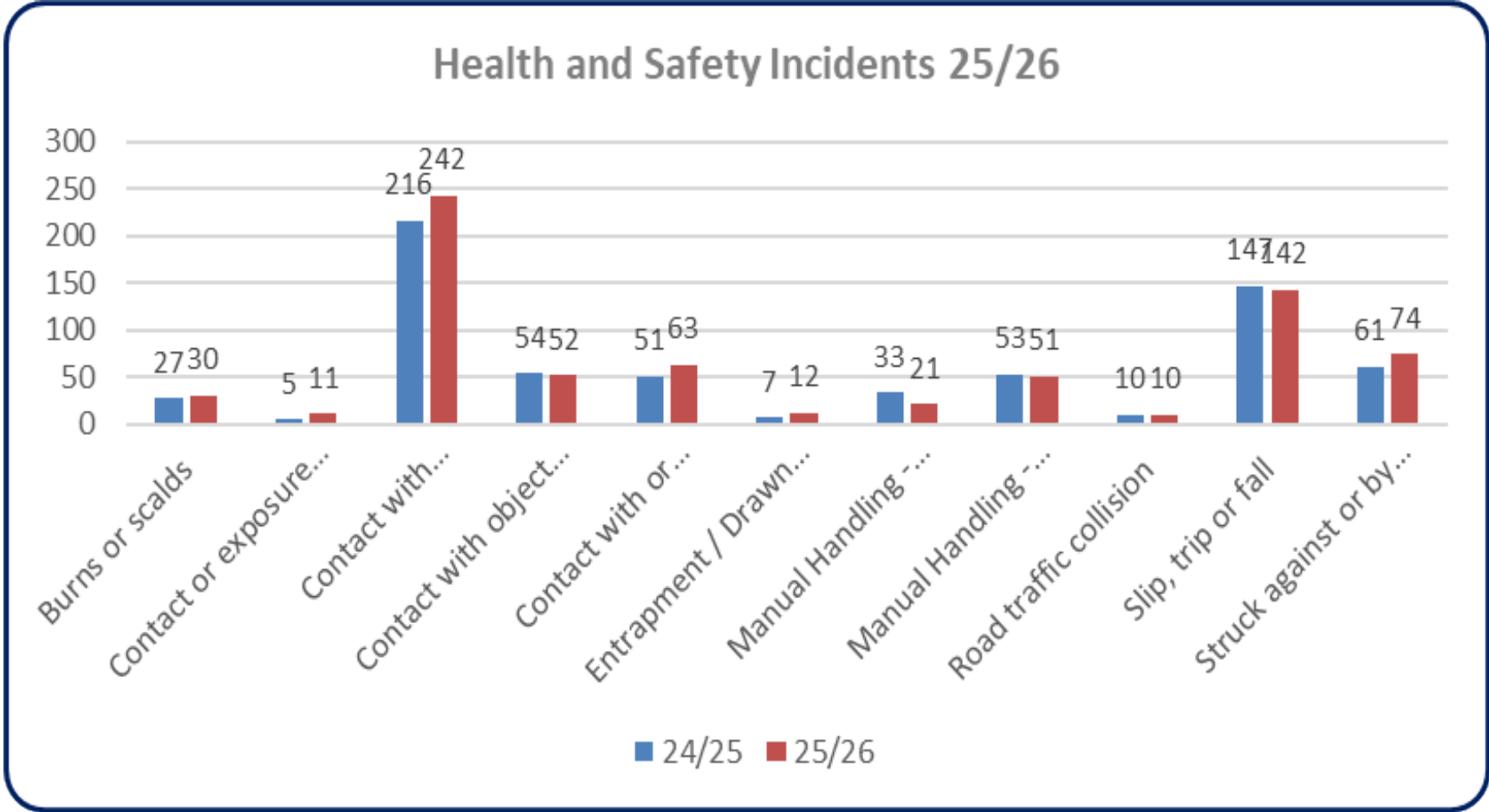
Health & Safety Incident Reporting

The following data provides a detailed breakdown of the type of health and safety related incidents that have been reported in 2025/26. This excludes violence and aggression and fire incidents as these are reported in the relevant sections of this report.

The graph below indicates an increase of 8.1 % in the number of reported **incidents affecting staff and contractors** when compared with the last financial year

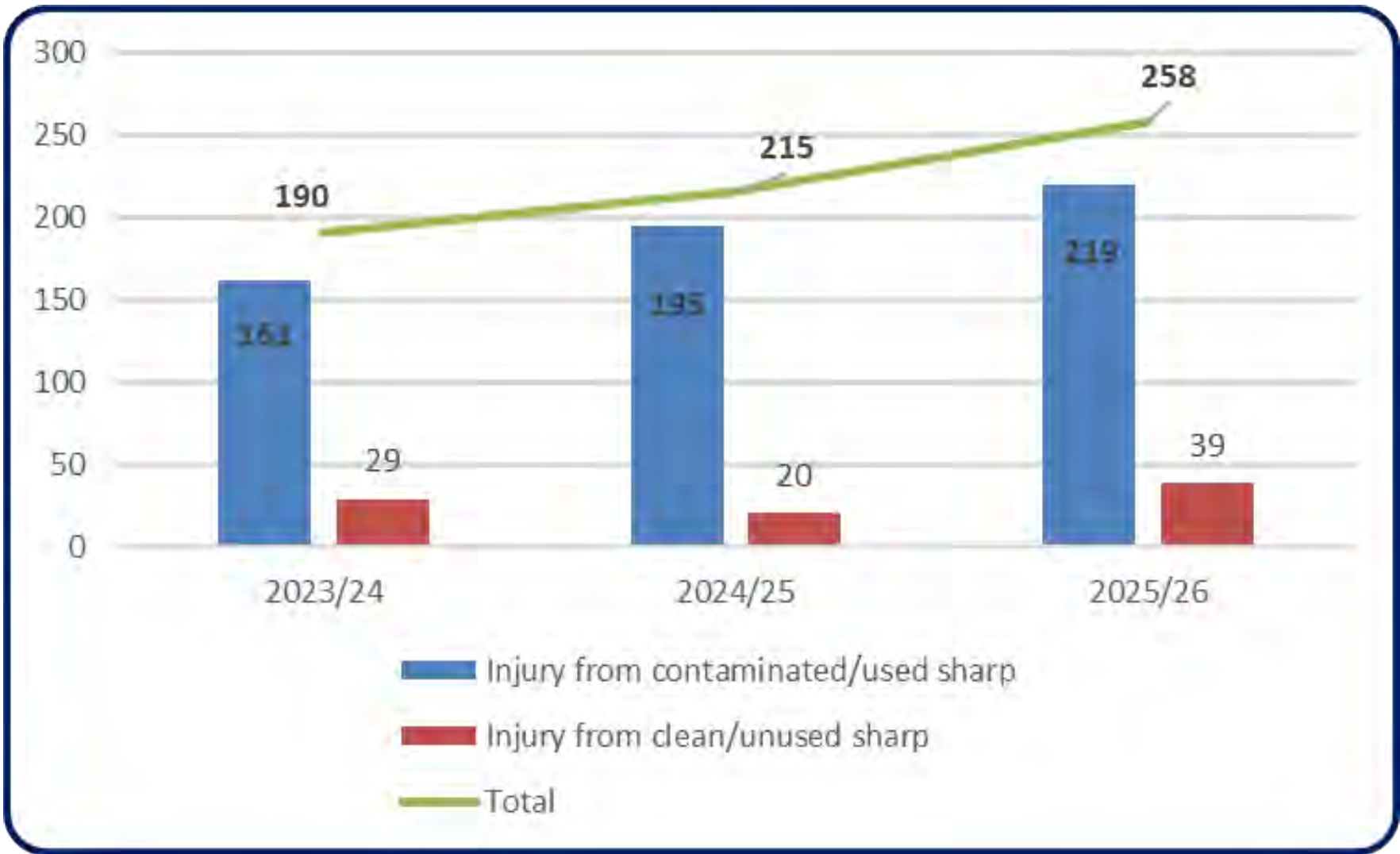


Contact with needles or medical sharps is the most reported health and safety incident category affecting staff or contractors (242 incidents), this is an increase of 10.7% on the previous financial year (216 incidents).



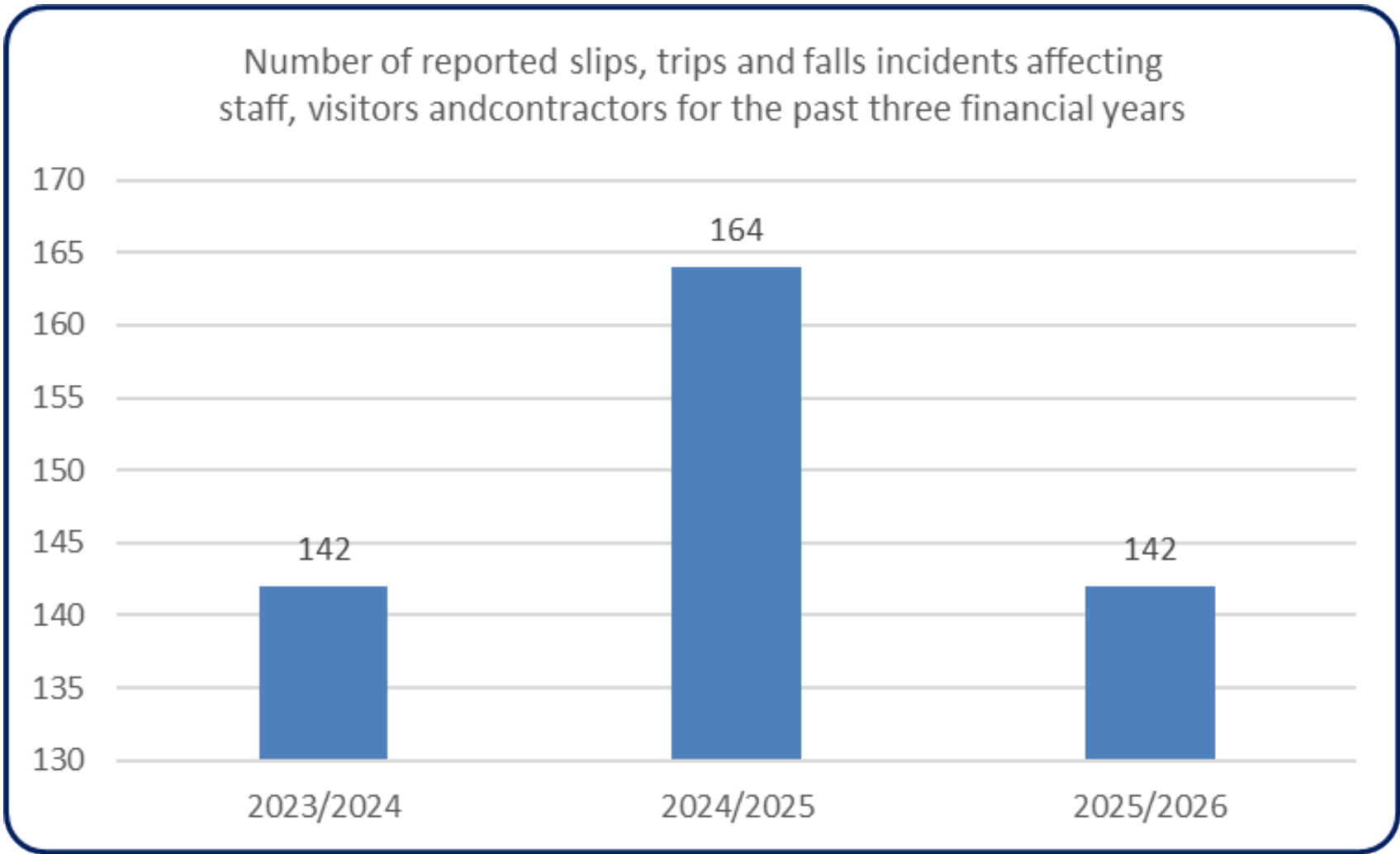
Health & Safety Incident Reporting

The incidents from contaminated and/or used **sharps devices** have increased by 11% in 2025/26 when compared with the last financial year.



Slips, trips and falls continue to be the most frequently reported type of RIDDOR incident to the HSE, with 38 incidents recorded in 2025/26. This represents an increase of 6 incidents compared with the 32 reported in the previous financial year (2024/25).

The number of slips, trips and falls incidents to staff, contractors or visitors reported in 2025/26 has decreased by 14% from the previous financial year (164 incidents).



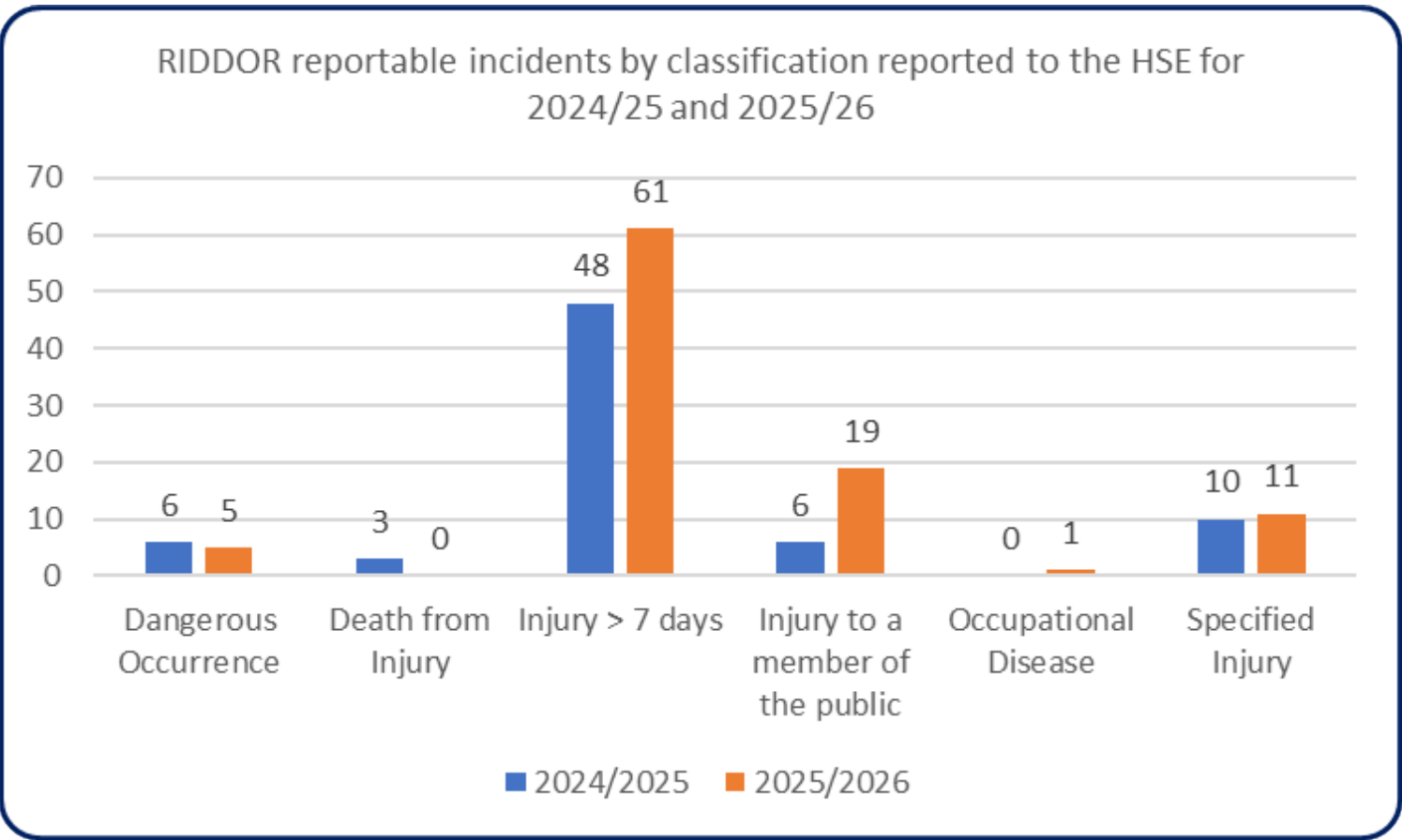
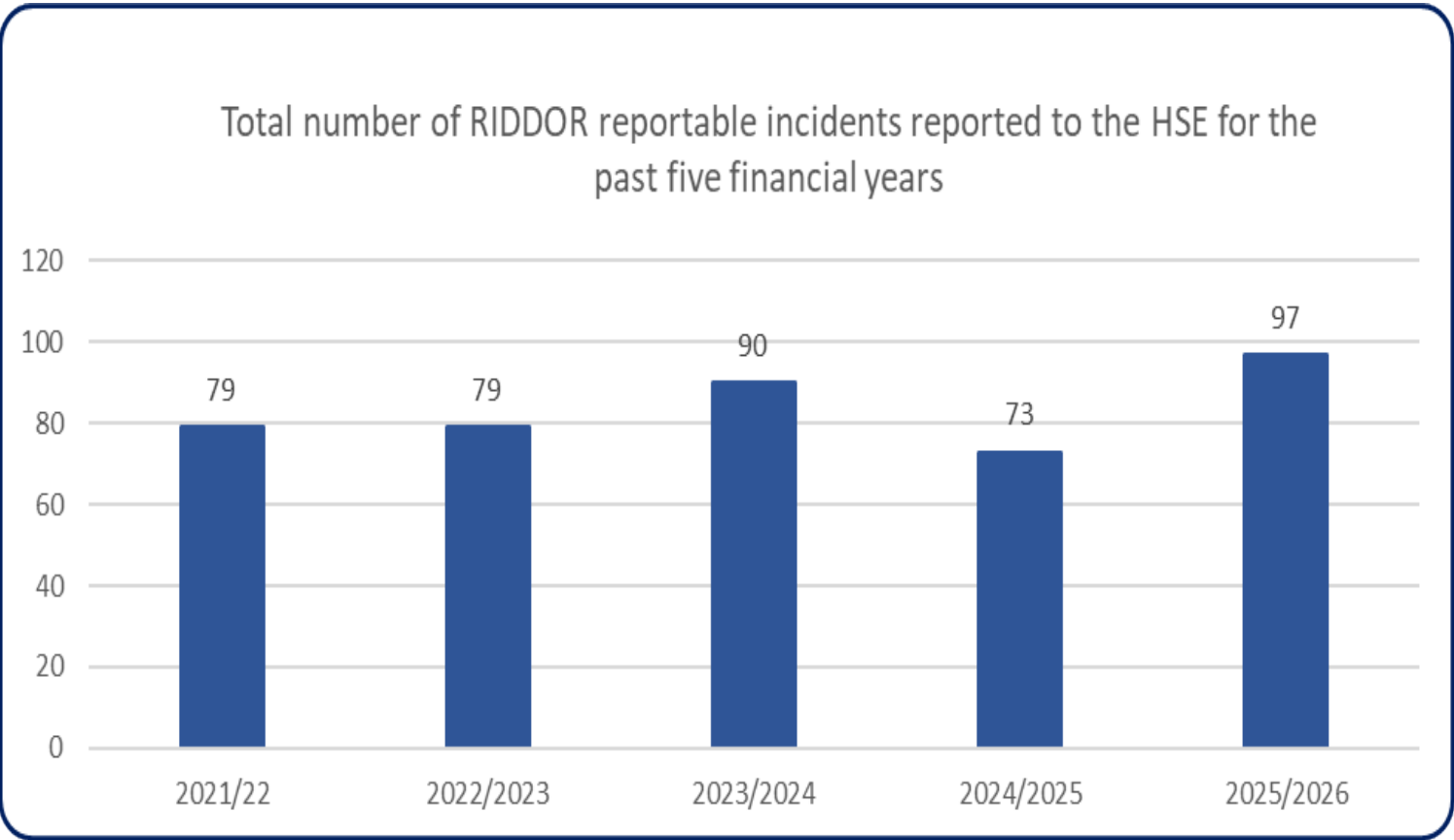
RIDDOR Reporting

Under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013), certain workplace accidents, incidents, ill health and certain near miss events must be recorded.

Depending on the severity and nature of the injury, and indeed the party affected, the Health Board has a legal duty to report this data to the **Health and Safety Executive (HSE)**. All RIDDOR reports are submitted by the Corporate Health and Safety Department.

- Between April 2025 and March 2026, 97 RIDDOR-reportable incidents were submitted to the HSE, representing a 25% increase compared to 2024/25.
- 28.9% of reports were submitted outside statutory reporting time frames, presenting a compliance risk

- To improve compliance, the Corporate Health and Safety Department continues to deliver **RIDDOR Awareness Training for managers**.
- RIDDOR compliance is now embedded as a health and safety performance **indicator within Divisional Assurance Reviews**. Which may have impacted the increase in reportable incidents through greater scrutiny and accountability.
- RIDDOR reporting compliance for 2025/26 was 71.1%, representing a **1.3% improvement** compared to 2024/25 (69.8%).
- There has been an increase in RIDDOR-reportable incidents related to **abuse of staff (physical contact)**, rising to 18 in 2025/26 compared with 11 in 2024/25.
- **In 2025/26, no fatal incidents** have been reported. This represents a reduction compared to 2024/25, during which three fatal incidents were reported.
- **Over-seven-day worker incapacitations represent the highest reported classification** in 2025/26, with 61 incidents recorded. This reflects an increase of 13 incidents compared with 2024/25.
- The number of **injuries to members of the public** has also increased, rising from 6 incidents in 2024/25 to 19 in 2025/26.



Face Fit Testing

Where personal protective equipment and respiratory protective equipment is used, it must be able to provide adequate protection for individual wearers.

Face Fit testing ensures that the equipment selected is suitable for the wearer. Face fit testing is a mandatory requirement as prescribed by Health & Safety Executive Control of Substances Hazardous to Health Regulations Approved Code of Practice (ACoP) L5 and associated guidance documents that support the relevant statutory provisions.

The delivery of Face Fit Testing continues to remain a key tasking for the Corporate Health and Safety Department with weekly Face Fit Testing sessions being offered across the Health Board.

To enable the Health Board to maintain compliance with Face Fit Testing requirements a review of the Health Boards Face Fit Testing Strategy and Face Fit Testing resource allocation will be undertaken in 2026/27.

The **Mask Fit Testing Programme** is operationally active and delivering a significant volume of training. However, overall assurance is currently low, due to low utilisation rates and a high level of DNAs impacting efficiency and potential compliance. Implementation of targeted interventions—particularly in attendance management and capacity building—will be critical to improving performance, reducing risk, and strengthening organisational assurance.

Mask Fit Testing Delivery in 25/26

- Number of sessions delivered: 48
- Number of places offered: 864
- Total delegates attended: 418
- Did Not Attend (DNAs): 181

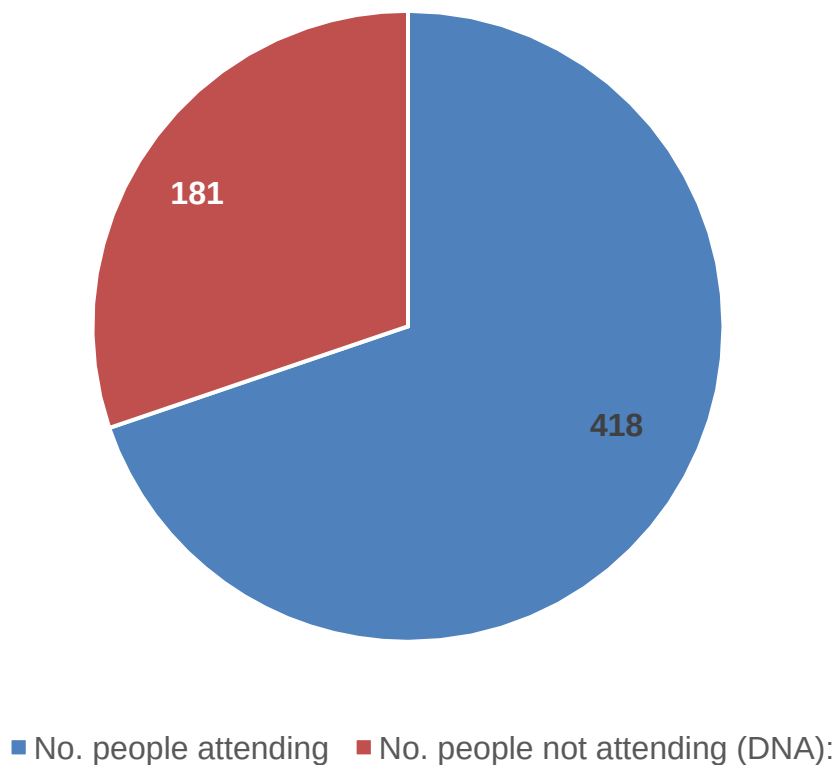
Capacity and Utilisation

- Overall utilisation rate: 48.38%
- DNA rate: 20.95%

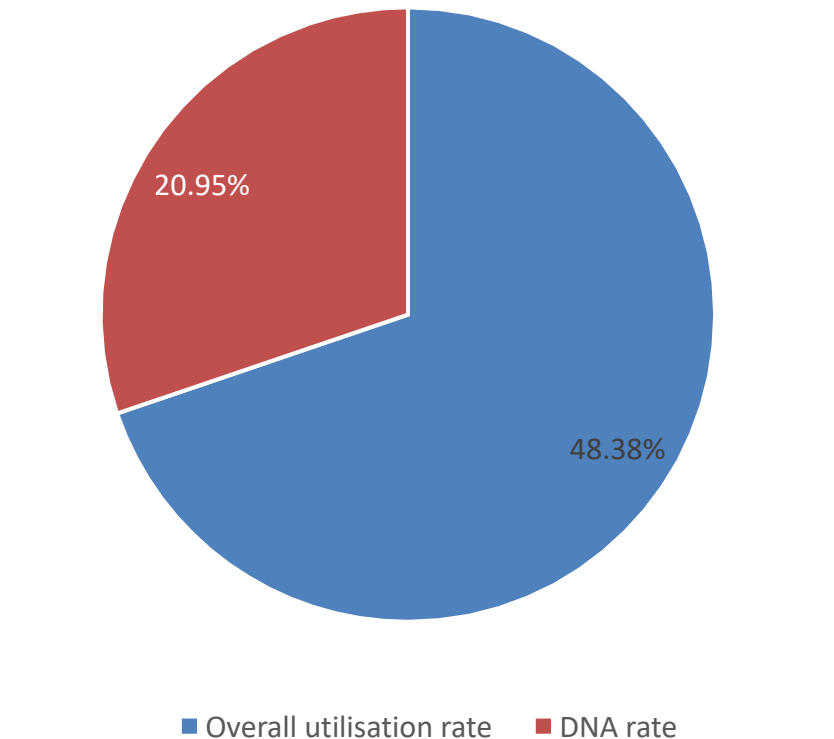
Train the Trainer Programme

- Courses delivered: 5
- Total attendees: 28

Mask Fit Testing 25/26



Mask Fit Testing Capacity and Utilisation 25/26



Fire Safety



Fire safety encompasses both fire prevention and fire precautionary measures.

The core objectives of fire safety legislation are to:

1. Reduce the likelihood and impact of fire occurring within buildings
2. Ensure people are kept safe and able to evacuate premises safely in the event of a fire

Fire events have the potential to cause significant harm, service disruption and organisational impact within NHS settings. As such, the Health Board's fire safety approach focuses not only on life safety, but also on property protection and business continuity.

The **Regulatory Reform (Fire Safety) Order 2005** is the primary legislation governing fire safety in England and Wales. It places duties on the Responsible Person to ensure appropriate fire precautions are in place to protect those who work in, visit, or occupy Health Board premises.

Fire safety legislation places responsibility on managers in proportion to their level of control within the organisation. Within the Health Board, responsible persons include Executives, Divisional and Departmental leaders. The Executive Director of Allied Health Professions & Health Science holds delegated executive responsibility for fire safety compliance and for ensuring fire safety matters are escalated to Board level. This responsibility is discharged through delegation to the Fire Safety Manager.

Our Strategic Goals for 2026/27 are:

- Continue to deliver compliance with regards to Fire Risk Assessments .
- Formalise the delivery and recording of fire evacuation training for inpatient nursing staff.
- Implement a Risk management system aligned with the FARS Fire Risk Assessment Software.

Future Challenges Include:

- Availability of up-to-date information on Fire Safety Systems held by Estates.
- Continued resource pressures associated with delivering large scale projects without associated Project Manager support.

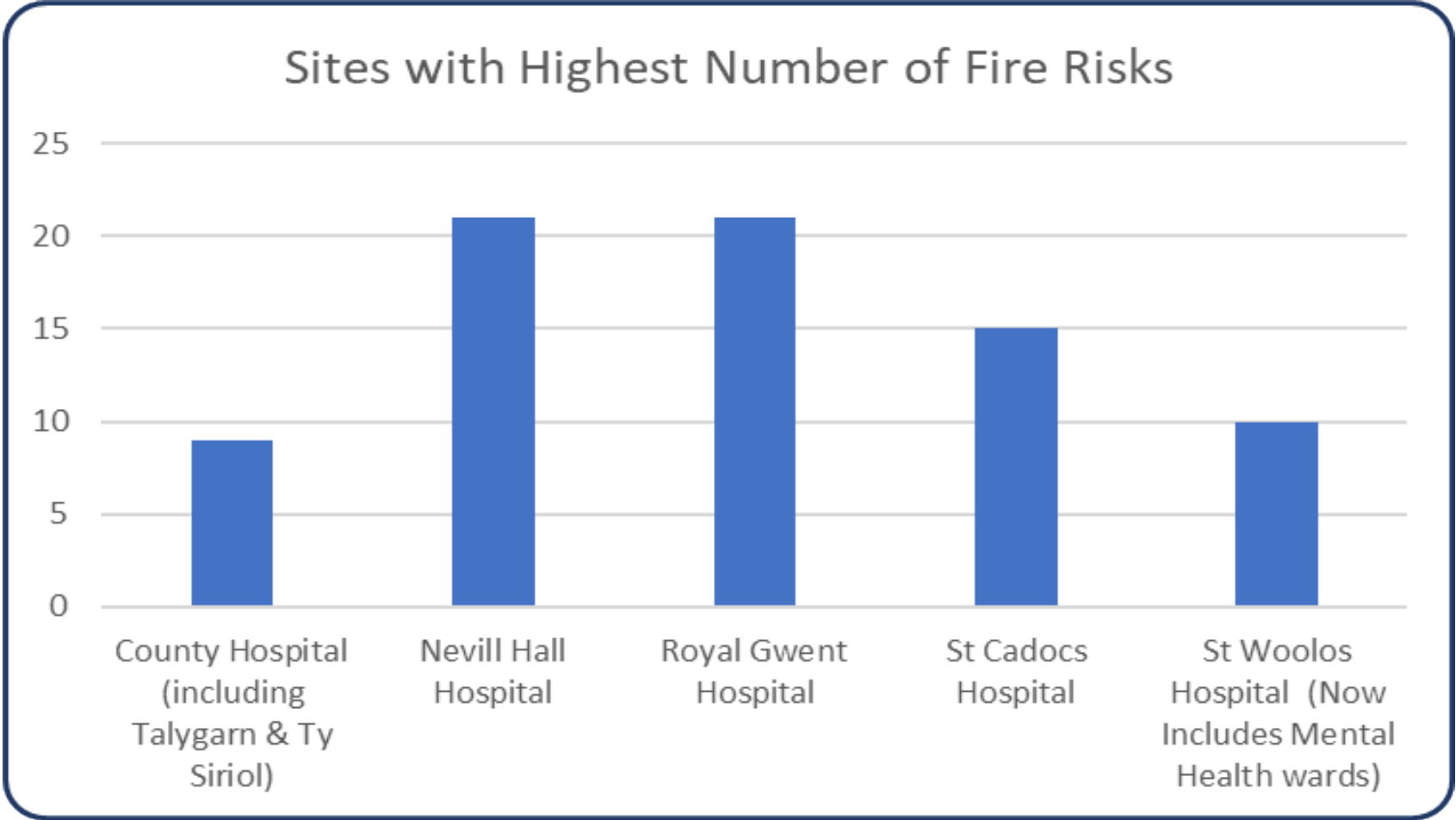
Fire Safety Risk Management

The Fire Safety Team successfully completed all allocated Fire Risk Assessments for the financial year.

The sites with the highest number of Capital Risks are our legacy sites where maintenance of the fire safety infrastructure is most challenging.

Type of Area to be Assessed	Frequency of Fire Risk Assessment
Buildings or parts of buildings that provide sleeping or inpatient accommodation and high-risk areas.	12 months
Outpatient facilities in Hospitals	24 months
Health Centres, Clinics, Offices, and staff only areas on Hospitals.	36 months

ABUHB Fire Risk Assesments 2025/26							
Annual		Bi-Annual		Tri-Annual		Total	
allocated	completed	allocated	completed	allocated	completed	allocated	completed
118	118	56	56	74	74	248	248



The Trend of residual Fire Safety risks held on the system continues to be positive. There are 123 residual risks being carried by the organisation that will require capital investment to remediate.

The predominant risk category is related to testing of fixed electrical systems (33 Risks)

With the introduction of FARS software low level Management and Maintenance Risk have been migrated to that system.

Capital Fire Safety Improvement Works

Site	Area	Improvement
Nevill Hall Hospital	Staff Residencies	Fitted replacement Fire Doors and updated the Fire Alarm Systems.(£92k). The buildings are now fully Fire Safety Compliant.
	All Inpatient Ward Areas Investment	Upgraded Fire Doors to 60 Minute Doors.(£30k) Fire stopped all breaches in Compartment Walls.(£271k). Patients and Staff on all Wards are now provided with 2 hours refuge from fire. Fitted New Fire Alarm Panels on Wards.(£22k) This will allow staff to quickly find and intervene with fires and false alarms.
	Theatres	New fire doors have been fitted to the recovery area.(£18k). This has provided 30 minutes refuge in Recovery and secured 2 independent Means of Escape.
Royal Gwent Hospital	Inpatient Tower Block (C and D Block)	Work is ongoing to replace the Fire Alarm System in this area (£857k) and to Fire Stop numerous breaches and penetrations in the Compartment (Fire Resisting) Walls.(£80k) Work is on course to be completed by end of this Financial Year
St Woolos Hospital	Sycamore Ward	A New Fire Alarm Panel has been fitted to the ward.(£2.5k). This will allow staff to quickly find and intervene with fires and false alarms.

Key Fire Risks:

Means of Escape within Wards RGH

Works are ongoing to address defects in fire stopping of the walls separating the wards from the neighbouring areas. This will secure peoples safety after they have evacuated the affected ward.

There are known deficiencies to Fire Walls within the wards that could reduce the amount of time available to evacuate through the exits. Due to the nature of the remedial works a full or partial decant of the wards will be required.

Fire Alarm Systems

At Nevill Hall Hospital, major improvements have been made to the alarm system over recent years. Future works are required to replace components associated with the service tunnels. Delivery of these works will be complicated due to safety conditions within the tunnels.

At Royal Gwent Hospital, progress has been made and all higher risk areas will be covered by the new system by the end of quarter 4 in 2026/27. Areas of the main hospital building including 80% of B Block and 100% of A Block and peripheral buildings on the site (Block 9, Block 10 and Friars House) still depend on the obsolete system. Further investment will be required to expand the system to these areas.

Emergency Fire Risks & Planned Capital Improvements

Residual and Emerging Risks

Management of the Fire Resisting Partitions at Hospital Sites

Progress has been made in addressing fire-resisting partitions; there remains an opportunity to further strengthen assurance by enhancing preventative controls and Estates management procedures. Continued focus in this area will support sustained compliance and reduce the likelihood of future damage.

Fire Evacuation training for Nursing staff on Inpatient Wards

Fire safety training compliance is improving, although there is scope to further enhance delivery by increasing access to face-to-face training. Complementing e-learning with practical evacuation training will help strengthen staff competence and provide greater assurance in emergency preparedness.

Maintaining the competency requirements and continuing professional development (CPD) necessary to achieve and sustain Tier 3 Fire Risk Assessor status

The introduction of the Building Safety Act is raising expectations around competence and increasing demand for specialist fire risk assessors across the sector. This highlights the need to ensure staff maintain and develop the required competencies to meet evolving regulatory standards. Sustaining a skilled and consistent assessor base will be essential to support the timely, high-quality completion of fire risk assessments and maintain assurance across the estate.

Planned Improvements

Direct Service Allocation

Planned capital improvements for this financial year include:

- Remediation of fire-resisting barriers within theatres and the inpatient ward at St Woolos Hospital.
- Replacement of fire doors to protect means of escape at Oak Ward and Ty Siriol, County Hospital.

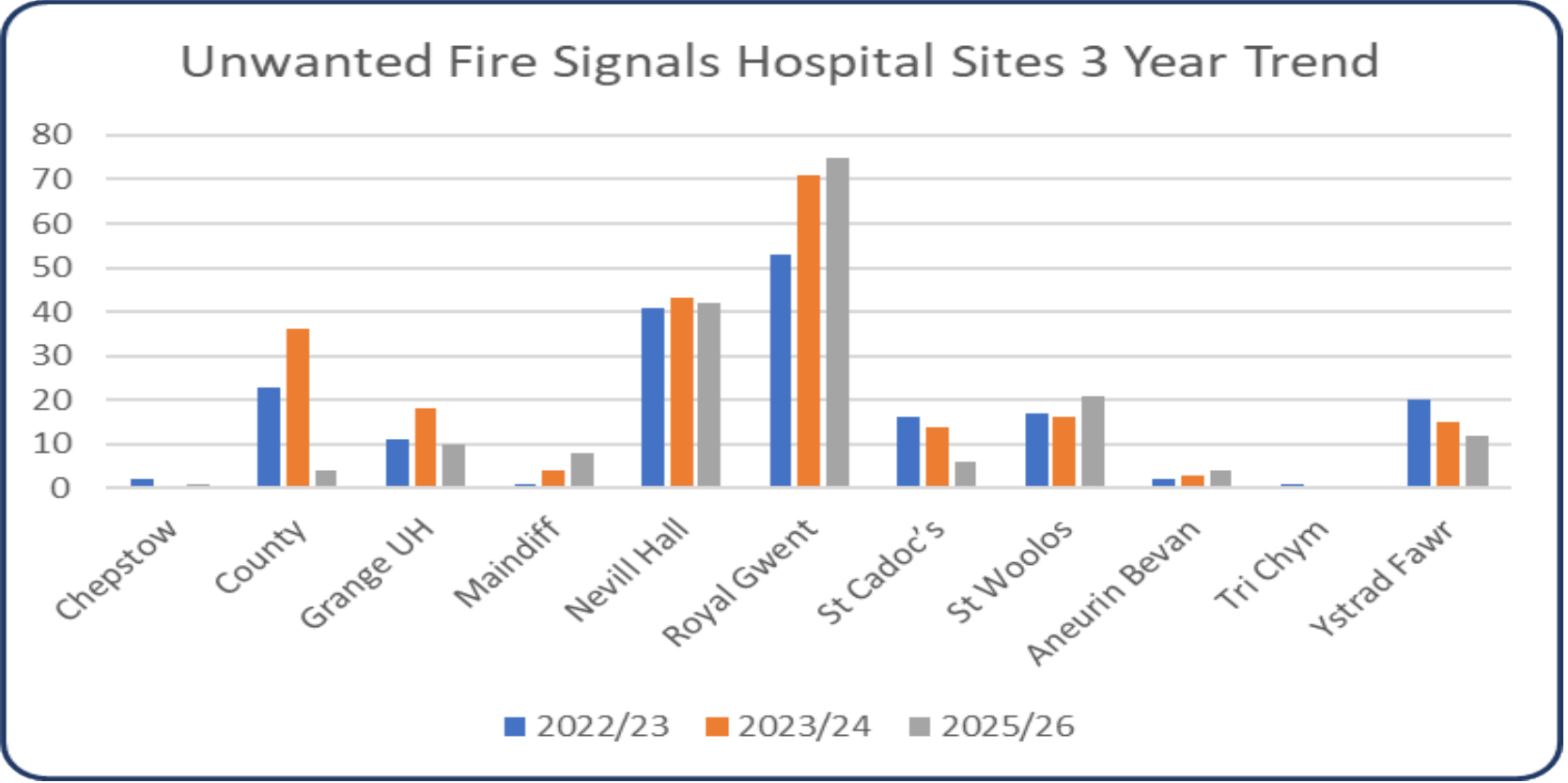
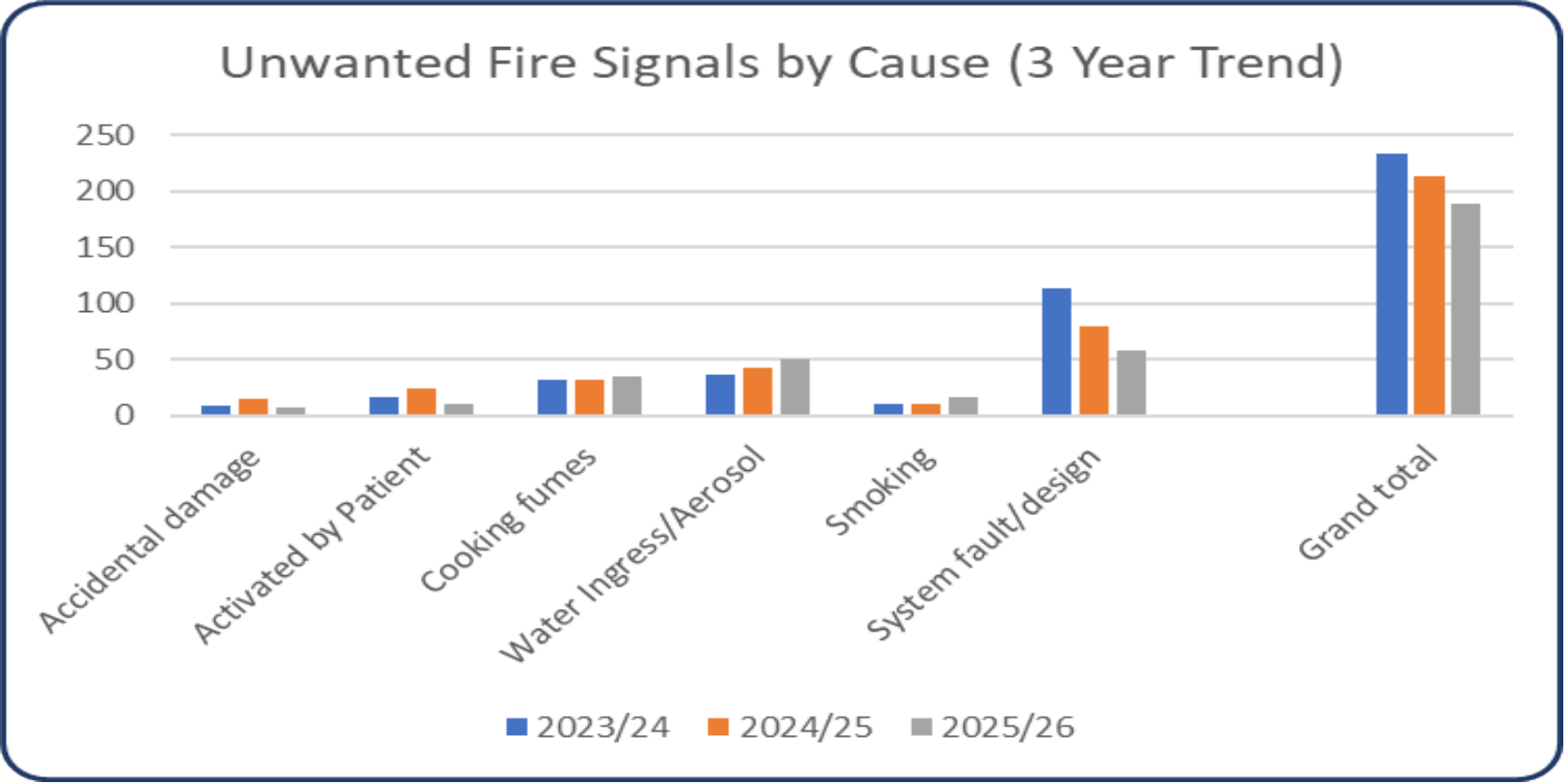


Fire Safety Incident Reporting

Fire incidents recorded in the Financial Year 2025/26 identifies a slight upward (negative) trend in fires caused by equipment failures. Actual numbers remain low with no discernable relationship between equipment types. This trend continues to be monitored, and feedback will be given to relevant Divisions should a pattern become apparent.

Deliberate fires suffered in FY 2024/25 and FY 2025/26 were in the form of small waste fires external to buildings and are unrelated although in each year clusters of incidents occurred at 2 different sites.

Unwanted Fire Signals have continued on a positive downward trend. Significant progress has been achieved in reducing false alarms caused by system faults in older systems through a replacement programmes at County and St Cadoc's Hospitals.



Manual Handling / Display Screen Equipment

The Manual Handling Team continue to provide mandatory training to support the education strategy, including providing expert advice as required i.e. selection of key equipment. Based on current demands the Team's activity is primarily focused on training and improvements in compliance



Manual Handling Equipment

The Manual Handling Team lead on providing the necessary advice and support to the Health Board in the selection of manual handling equipment to aid in the delivery of care to patients.

All manual handling equipment and its accessories require the necessary testing, inspection or examination to ensure compliance with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) or the Provision and Use of Work Equipment Regulations 1998 (PUWER).

The service and maintenance of the manual handling equipment is contracted to an external provider. The service contract supports the Health Board to meet its legal requirements and identifies the need for investment in new equipment.

There is a requirement to apply for capital investment in the obsolete equipment in 2025/26 and 2026/27.

Display Screen Equipment

Health Board Staff are working in an agile manner across the Health Board at various sites and from private premises, whilst the increased flexibility of agile working can provide many benefits to both the individual and Health Board, the legal requirement for the Health Board to ensure the health, safety and welfare of its employees continues to apply in agile working situations.

To ensure that the risks associated with agile working are properly identified and managed, a series of guidance documents and policy amendments have been developed as a means to support individuals who are identified as agile workers. This includes amendments to the Health Boards Policy for Workstation Display Screen Equipment (DSE) and Display Screen Equipment Risk Assessment Form.

The Corporate Health and Safety Department has **conducted 66 DSE risk assessments** in 2025/26 for **1000 x cases**.

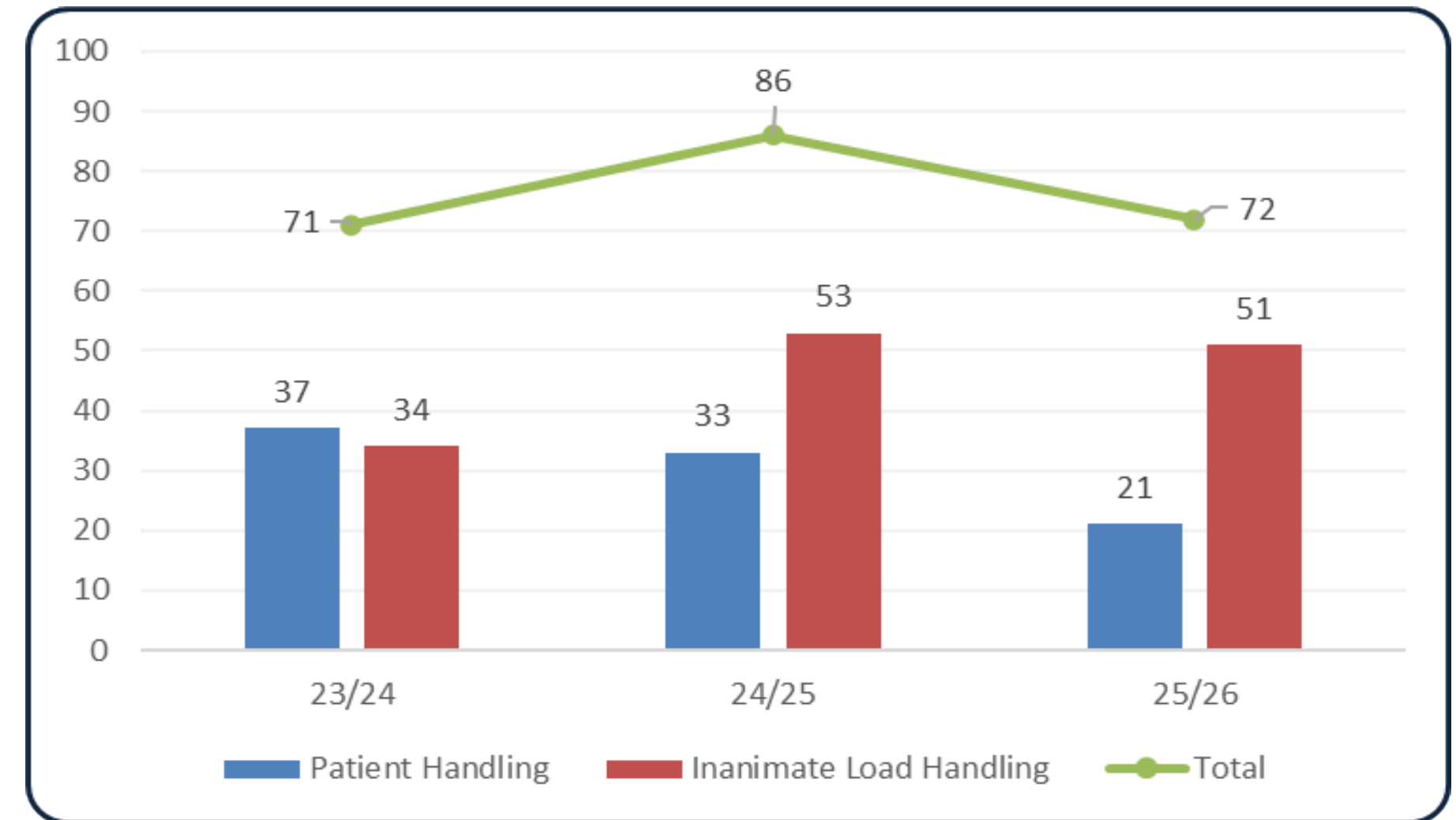


Manual Handling Incident Reporting

Manual handling incidents have similarly increased in 2025/26, with 17 reported to the HSE, compared with 13 incidents in 2024/25. The number of manual handling incidents reported in 2025/26 has decreased by 3.7% compared to 2024/25.

There has also been a 36.6% reduction in patient handling incidents compared to the previous financial year (2024/25), where 33 incidents were reported.

To identify learning outcomes from manual handling incidents and demonstrate continuous improvement a standard will be set via the Health and Safety Committee that all incidents will require an investigation which is recorded on the focused review in the Datix Cymru system.



Violence Prevention & Reduction

NHS staff are at increased risk of experiencing violence and abuse during their work, which can have a significant impact on individual wellbeing and organisational resilience.

Through **A Healthier Wales and partnership with the Anti-Violence Collaborative (AVC)**, the Health Board continues to work towards a consistent, all-Wales approach to preventing violence and aggression and promoting a safe, supportive culture for staff.

Building on progress made in 2025/26, the **Obligatory Response to Violence** in Healthcare was implemented, strengthening reporting, investigation, victim support and engagement with the criminal justice system.

During 2025/26, the Health Board also developed its first ABUHB **Violence Prevention and Reduction (VPR) Strategic Plan**, setting a clear direction for reducing risk and strengthening prevention over the coming years.

The VPR Team continues to work closely with **Gwent Police** and other key stakeholders to support these objectives and ensure a safe and secure environment for staff and patients.

The Violence Prevention and Reduction team continues to maintain strong local partnerships through regular engagement with Gwent Police and multi-agency forums to monitor risks, review incidents, and agree coordinated actions, including alignment with initiatives such as Operation Hampshire.

Ongoing involvement in **Right Care Right Person (RCRP)** meetings supports shared decision-making, ensuring responses are proportionate, appropriate, and focused on maintaining safety, supported by regular data monitoring.



Public Health Approach

A public health approach focuses on understanding the causes and consequences of violence so we can address the risk factors that increase the likelihood that an individual will experience violence or exhibit violent behaviour.

There are 4 steps:



Violence Prevention & Reduction Incident Reporting

The overall incident rates for 2025/2026 have remained consistent with previous years (2023/2024 and 2024/2025) **at 1 in 20 staff experiencing physical assault.**

To ensure quality data is available the Corporate Health and Safety Department validate all reported incidents of violence and aggression.



Our commitment to preventing violence across our communities the team has worked closely in collaboration with Gwent Police, local authorities, third sector organisations, and other statutory agencies, ensuring a coordinated approach to safety and well-being.

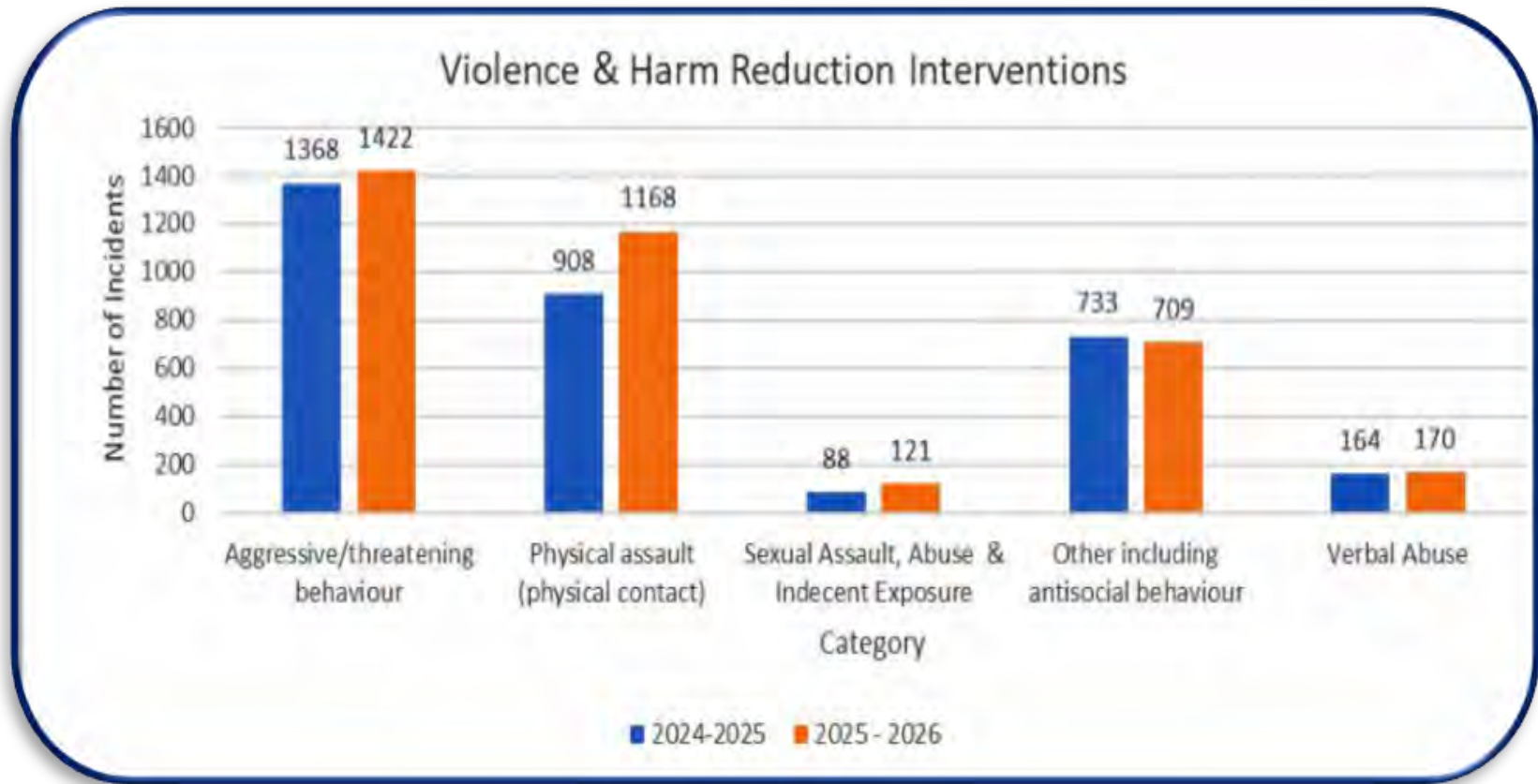
We will continue to develop our role within an integrated system, working closely with commissioners, local providers, and community services.

Our pivotal work with the Anti-Violence Collaborative, in Shared Services, will allow us to act as a leading Health Board in Wales on preventing and reducing violence and aggression in the workplace.

The VPR team continues to support staff affected by workplace violence and aggression, providing advice, investigation support and signposting to appropriate services when incidents are reported via Datix Cymru.

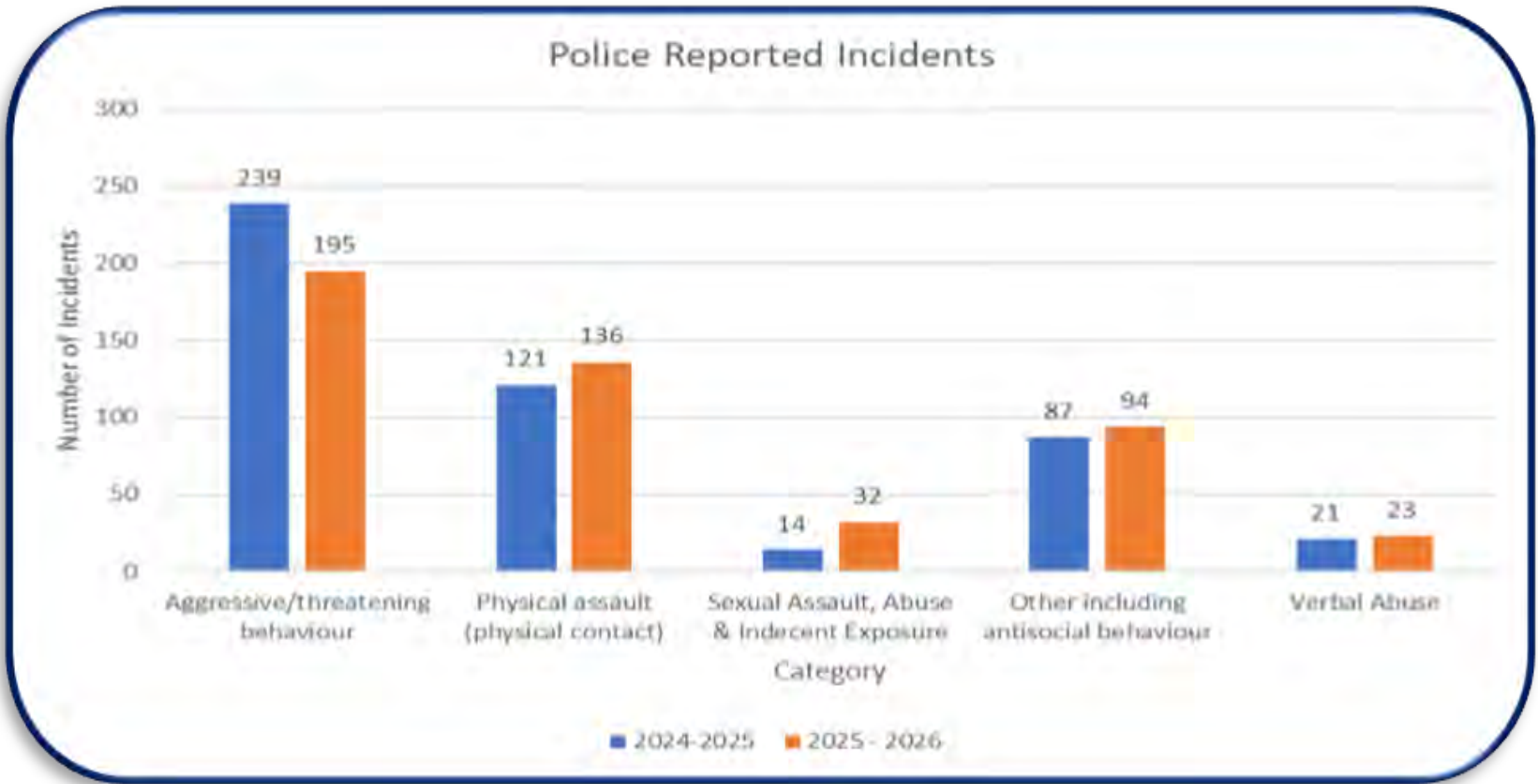


Violence Prevention & Reduction Incident Reporting



Violence Prevention Team involvement has increased by **8.5% year-on-year**, reflecting greater staff confidence and awareness in escalating high-risk incidents. This growth is driven by growing familiarity of the service, positive staff experiences, and wider training.

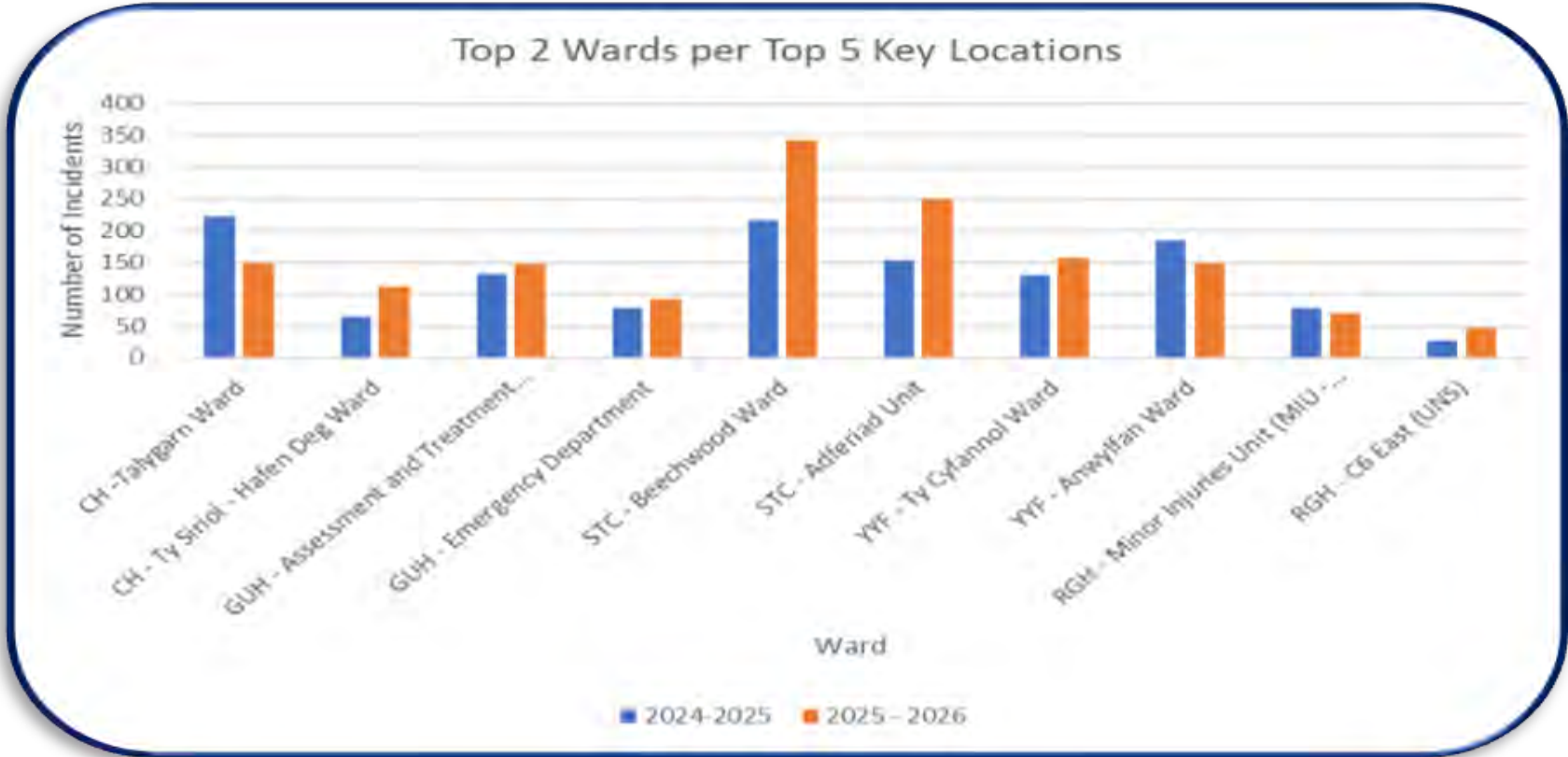
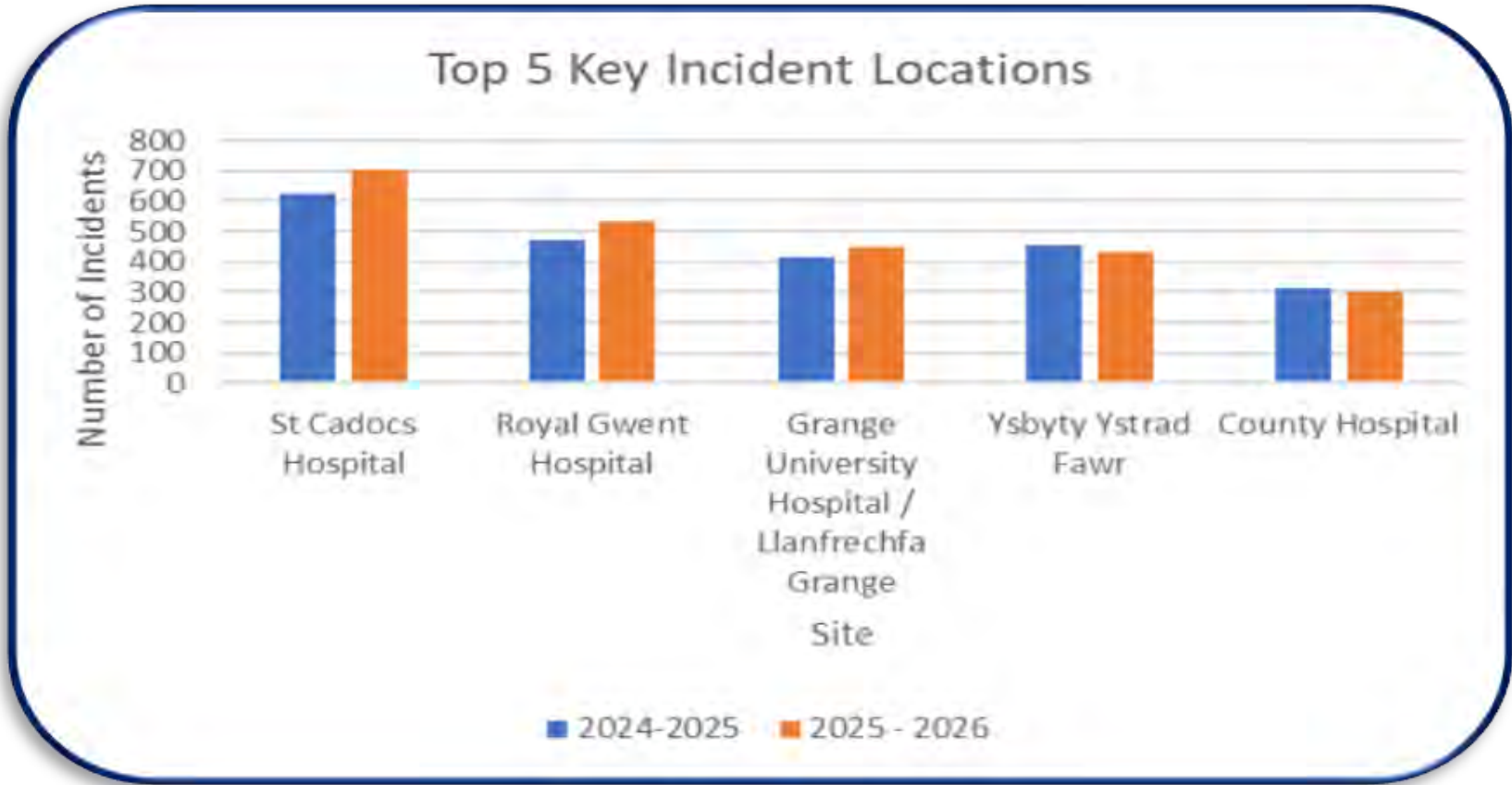
The team supports staff through a range of interventions, including risk assessments, environmental and behavioural recommendations, and tailored training. They also provide support through the criminal justice process helping with statements, court attendance, and police liaison, alongside implementing internal sanctions and developing new policies in emerging risk areas.



The stability in police-reported incidents reflects improved staff confidence and a positive shift in reporting culture over the last two years. Support from the Violence and Aggression Team, alongside strengthened partnership working with Gwent Police, has enabled more consistent escalation of high-risk incidents.

Increased training and awareness have also improved identification and recognition of violence. However, this trend also reflects a rise in overall incident volume indicating both enhanced reporting practices and growing operational demand.

Violence Prevention & Reduction Incident Reporting



Risk is evident across multiple sites, with incidents of aggression and physical assault primarily driven by patient behaviour and often escalating due to factors such as waiting times, distress, confusion, substance use, and challenges in care delivery. Incidents within Emergency Departments are typically reactive and situational, reflecting wider acute care pressures.

The Violence Prevention and Reduction (VPR) team continues to support this through regular involvement in Emergency Department panels and mental health touchpoint meetings, promoting coordinated clinical responses and strengthened collaboration with facilities and security teams to enhance

Incidents in mental health settings are often linked to patients with complex, clinically driven behaviours in unpredictable environments. The organisational focus is on patient-centred care, environmental improvements, proactive risk management, and early intervention. Prioritising staff safety is supported by the Violence Prevention Team, ensuring targeted ward-level interventions deliver the greatest impact.

The VPR team support by close working with security teams to prioritise identification of individuals displaying violence and aggression, proactive police reporting, and the implementation of target hardening measures.

All Wales Violence Prevention & Reduction Standards

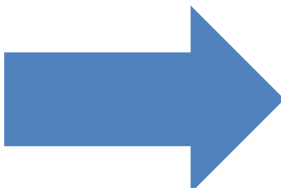


Grŵp Cydweithredol Cymru dros atal Trais
Anti-Violence Collaborative Wales

2025/2026

During the last year, the Health Board Violence Prevention and Reduction Team worked closely with the Anti-Violence Collaborative and partners across NHS Wales to develop a draft set of All-Wales Violence Prevention and Reduction Standards.

This work involved reviewing existing standards to ensure they are relevant to the Welsh healthcare context and aligned to current best practice, with national implementation planned for 2025/26.



2026/2027

The standards are intended to provide a framework to measure how an organisation is meeting best practice and to identify priorities for continuous improvement

The All-Wales VPR Standards are now awaiting national approval, with publication planned for Quarter 2 of 2026/27. This remains a key priority within the Health Board's Violence Prevention and Reduction Strategy.

Enhanced Safety for Staff and Patients: By implementing a robust and comprehensive framework for violence prevention and reduction, the updated standard will contribute to a safer working environment for staff and a more secure care environment for patients.

Consistency Across NHS Wales: A standardised approach will ensure that all NHS Wales organisations adhere to the same high standards, reducing variability in practices and enhancing the overall quality of violence prevention and management across NHS Wales.

Improved Reporting and Accountability: The new standard will establish clearer protocols for reporting incidents leading to better data collection, analysis, and accountability. This will identify trends, high-risk areas, and allocate resources more effectively.

Increased Staff Support and Training: The importance of training and supporting staff in recognising, managing, and de-escalating violent situations. This will improve staff confidence and competence and reduce the likelihood of incidents escalating to physical

violence.

Violence Prevention & Reduction Strategic Plan 2026 -2028

Ambition

Aneurin Bevan University Health Boards Violence Prevention & Reduction Strategic Plan outlines our commitment to creating a safe and secure environment for staff, patients, and visitors. We aim to eliminate tolerance of violence and aggression across all settings by embedding compassion, trauma-informed care, and a culture of safety. Our approach supports the wider goals of A Healthier Wales and NHS Wales’ Duty of Quality.

Developing a system-wide strategic plan will provide a framework within our organisation and align our ABUHB policies so there is a consistent cross-system approach that recognises the needs and priorities of our health board.

Strategic Framework

This Violence Prevention & Reduction Strategic Plan aligns with the Quality vision of Aneurin Bevan University Hospital Board (ABUHB) is to be "widely recognised for delivering safe, timely, effective, efficient, equitable and person-centred care." Our first and most important commitment to our patients and our staff is to keep them safe.

This Violence Prevention & Reduction Strategic Plan will be refined and strengthened through ongoing consultation with the Executive Board, Trade Unions, Divisions, Directorates, clinicians, staff, and patients. Initial engagement will focus on raising awareness of the strategic plan and laying the groundwork for a safer, more supportive organisational culture.

This Violence Prevention & Reduction Strategic Plan will be monitored and overseen through the Health Board’s established governance and assurance structures, ensuring accountability and alignment with organisational priorities.

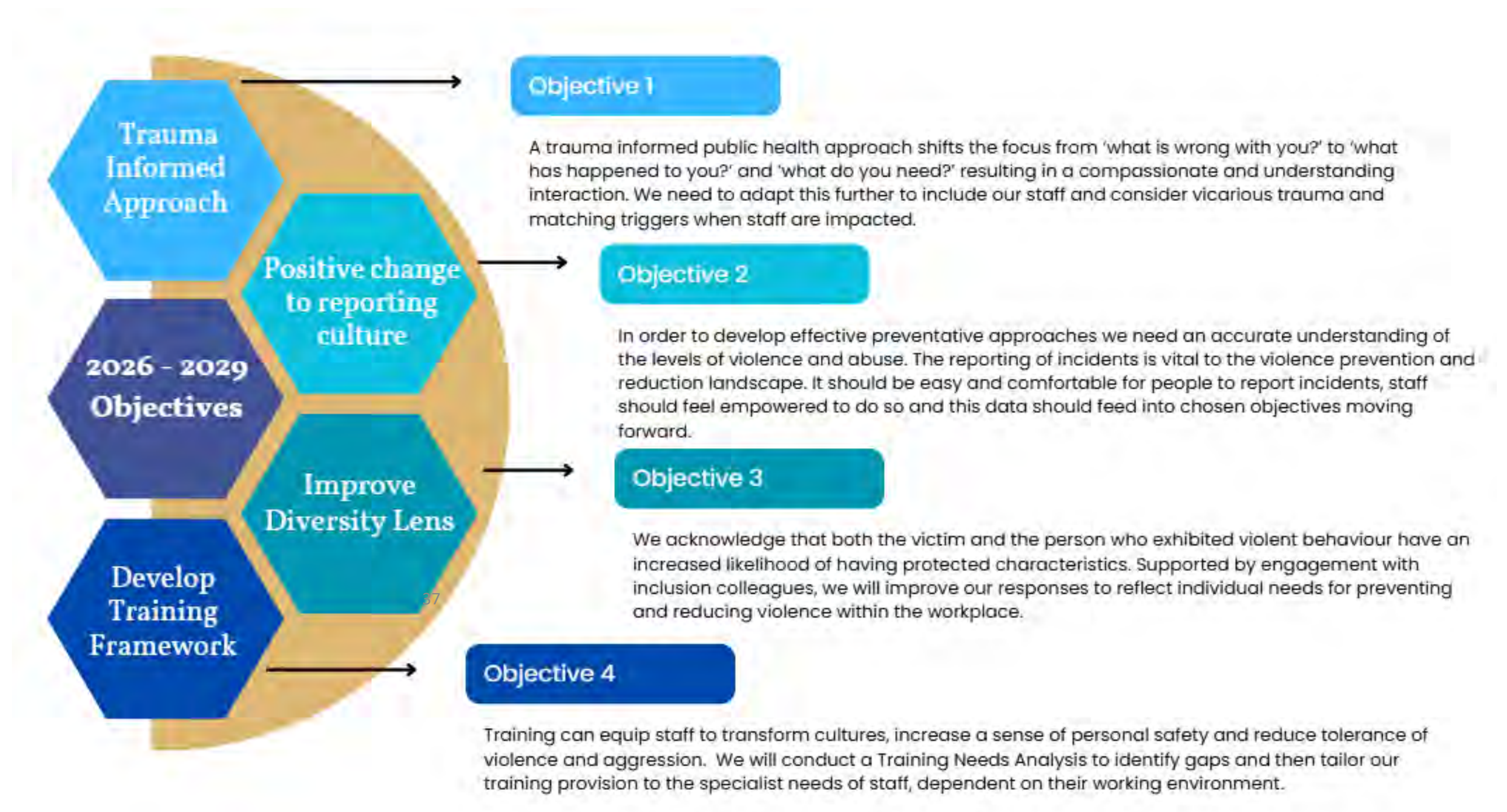
Progress will be reviewed regularly through reporting to the Executive Board, Health and Safety Committee, and Workforce and Organisational Development Committee, with updates provided to key partners and stakeholders as appropriate.



Violence Prevention & Reduction Strategic Plan 2026 –2028

The **VPR Strategic Plan** is supported by a detailed implementation plan. The Strategy is structured around four key objectives, which provide a clear and measurable framework for action.

Delivery of these objectives will be the primary focus for **2026/27** and will continue to guide priorities and activity over the next few years.



Conclusion

The 2025/26 reporting period demonstrates strong progress across health, safety and fire, supported by improved leadership capacity, strengthened governance, and a clear focus on continuous improvement.

Key achievements include enhanced inspection and monitoring processes, improved RIDDOR compliance, strengthened policy frameworks, and the development of the Health Board's first Violence Prevention and Reduction (VPR) Strategic Plan.

While overall performance is stable, areas such as manual handling training and elements of fire safety continue to require targeted focus, alongside improving consistency of delivery across the organisation.

Looking ahead to 2026/27, the Health Board will build on this progress by prioritising high-risk areas, including developing a more sustainable approach to manual handling training, strengthening fire safety training provision, and enhancing workforce capability to meet increasing regulatory expectations. Delivery of the VPR Strategic Plan and national programmes will be central to this work, alongside continued emphasis on learning from incidents, improving compliance, and strengthening organisational assurance to support safer outcomes for staff and patients.



DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 September 2026
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Welsh Language Annual Report 2025-2026
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sarah Simmonds, Executive Director of Workforce and Organisational Development
SWYDDOG ADRODD: REPORTING OFFICER:	Geraint Scott, Head of the Welsh Language Unit

**Pwrpas yr Adroddiad
Purpose of the Report**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Welsh Language Standards Annual Report (*Appendix 1*) addresses the statutory duty of the Health Board to provide an annual account to the Welsh Language Commissioner on compliance with its Welsh Language Standards under the Welsh Language (Wales) Measure 2011. The report has been prepared in accordance with Welsh Language Standard 120 and highlights the improvements and progress made by the Health Board during this reporting period. Subject to Board approval, the Annual Report must be published by the Health Board by the end of September 2026.

The More than Just Words annual report (*Appendix 2*) details the Health Board's current progress in relation to the objectives and each of the targets set out in the More than Just Words five-year plan 2022-2027. The report has been prepared using the prescribed template provided by Welsh Government and responds to the specific requests for information, as well as general work undertaken in this area.

Cefndir / Background

Welsh Language Standards – Welsh Language Annual Report

On 20 March 2018, the National Assembly for Wales approved the Welsh Language Standards (No. 7) Regulations 2018. The Regulations are underpinned by two key principles:

- The Welsh language should be treated no less favourably than the English language in Wales.

- People in Wales should be able to live their lives through the medium of Welsh if they choose to do so.

In July 2018, the Welsh Language Commissioner issued draft Compliance Notices to Welsh health organisations. Following a twelve-week consultation period, during which organisations provided feedback on the reasonableness and proportionality of the proposed standards, final Compliance Notices were issued in November 2018.

Under its Compliance Notice, the Health Board is required to comply with 121 Welsh Language Standards. Of these, 103 standards came into force in May 2019, a further 18 standards in November 2019, and the remaining two standards in November 2020.

The Welsh Language Standards continue to provide a framework for strengthening the delivery of high-quality, equitable bilingual services. Throughout the reporting period, the Health Board has focused on embedding the Welsh language within service delivery and administrative functions, while promoting greater use of Welsh and supporting a bilingual culture across the organisation.

More Than Just Words

More Than Just Words is the Welsh Government's strategic framework for strengthening the Welsh language in health and social care. Its aim is to ensure that Welsh speakers can access services that meet their language needs and receive care in their language of choice.

The original framework was launched in 2012 to promote and support the use of Welsh across health, social services and social care. A revised framework was introduced in 2016 to build on this work and further strengthen Welsh language provision within these sectors.

The current *More Than Just Words* framework was published in August 2022 and sets out priorities and targets for the period up to 2027, supporting Welsh Government's ambition to embed the *Active Offer* and improve the availability and quality of Welsh language services across health and social care. Since publication, some of the original targets have been removed by Welsh Government which is reflected in the numbering in *Appendix 2*.

Asesiad / Assessment

The reports in *Appendices 1 and 2* show our continued and sustained progress in relation to compliance with Welsh Language Standards, improvement against targets in the *More than Just Words* plan and developments towards our ultimate aim of providing a Welsh speaking service to our service users and their families and loved ones. Some key successes to draw your attention to:

- Reaching 90% compliance for the first time with our target of ensuring staff identify their Welsh language abilities on ESR. This enables us to identify areas of strong Welsh language skills as well as areas that have little to no Welsh language abilities. This allows us to target support to the areas with most need.

- Regional *More than Just Words* forums across Wales, chaired by Health Board representatives and bringing together colleagues from across the Health and Social Care sector, as well as national colleagues from Welsh Government and the National Centre for Learning Welsh, to consider opportunities to collaborate and share best practice.
- A programme of engagement with students across education establishments with a tailored offering which allows us to deliver to students from 7 years old up to mature students in Colleges and Universities. This programme has allowed us to deliver to over 800 individuals for the reporting period.
- A learning offering that meets the needs of our staff by offering various learning mechanisms that fit around both work and personal commitments and can be delivered through different platforms and learning styles. Some key data include; 63 staff undertaking the 'Cymraeg Croeso' course, 21 staff utilising the 'Codi Hyder' (raising confidence) course, and 8 attending the immersive residential course in Nant Gwrtheyrn, making a total of 16 since the inception of the courses 3 years ago.
- As a standing member of the Health Board's Equality Impact Assessment Panel, we can ensure that the impact on Welsh language delivery is a key consideration in all aspects of the work of the Health Board.
- Our translation capacity continues to increase and is at present able to meet demand. In 2025-2026 the Health Board translated 1,108,301 words, an increase of 15% on the number of words translated the previous year. This ensures we are providing Welsh language materials to our Welsh speaking population and increasing our compliance levels in relation to written materials and correspondence. This is evidenced through the spot checking carried out by the Welsh language unit which showed compliance at 90% in this area.
- Welsh Language is now embedded in both training and resources to key colleagues through programmes such as the Nurse Preceptorship programme, Leadership Development Programme, and Health Care Support Worker Clinical Induction, delivering to over 400 clinical and non-clinical staff, equipping them to better support Welsh speaking patients themselves and through their teams.

Within the Welsh Language Standards Annual report, we have also noted several key targets for the year ahead (2026-2027):

- With Welsh Government placing a key focus on delivery of Welsh language services in Primary Care, we will work with our Primary Care colleagues to utilise key learning and communication platforms, such as the 'Primary Care Academy' and the 'Neighbourhood Care Networks', to share learning and resources.
- We will develop a tool with our procurement colleagues to ensure that Welsh language compliance is fully considered, where appropriate, prior to procurement of goods or services.
- Utilising the events in the run up to the Urdd Eisteddfod visiting the region, we will engage further with our Welsh speaking communities and establish a 'Patient Participation Panel' to gather a greater understanding of patients' experiences in accessing services in Welsh. We will seek and share areas of good practice and developing support for our colleagues to target areas that require improvement.

- We will roll out a digital tool to support recruitment managers in correctly identifying the language skills to be advertised in new and vacant roles.

Argymhelliad / Recommendation

The Board is asked to note the progress made in the reporting period as well as our ambitions for the year ahead. The Board is asked to approve the Annual report and associated information prior to publishing at the end of September 2026.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	CRR0021 Current score 12
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 4. Dignified Care 6. Individual care Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Workforce and Culture
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services

Gwybodaeth Ychwanegol: Further Information:

Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	ESR – Electronic Staff Record
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Welsh Language Strategic Group More than Just Words Forum Local Stakeholders in the Welsh language community

Effaith: (rhaid cwblhau)

Impact: (must be completed)	
	Is EIA Required and included with this paper No does not meet requirements
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	The Welsh language is a cross-cutting issue and is relevant to all objectives of the Well-being of Future Generations Act. Theme 7: A Wales of vibrant culture and thriving Welsh language is particularly relevant.



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Welsh Language Standards Annual Report 2025-2026



A message from the Chief Executive

I am delighted to present Aneurin Bevan University Health Board's Welsh Language Standards Annual Report for 2025-2026.

As a Health Board, we firmly believe that the Welsh language should not be viewed as a standalone objective, but as an integral part of everything we do. This report reflects our commitment to embedding the Welsh language across all areas of our work.

Effective communication is fundamental to delivering high-quality healthcare, and we recognise the importance of providing Welsh language services to ensure that our Welsh-speaking service users can access care in their language of choice.

I hope you enjoy reading about the progress we have made over the past year, as well as our ambitions and vision for the future.

Diolch
Nicola Prygodzicz
Chief Executive Officer, ABUHB



A message from the Director of Workforce and Organisational Development

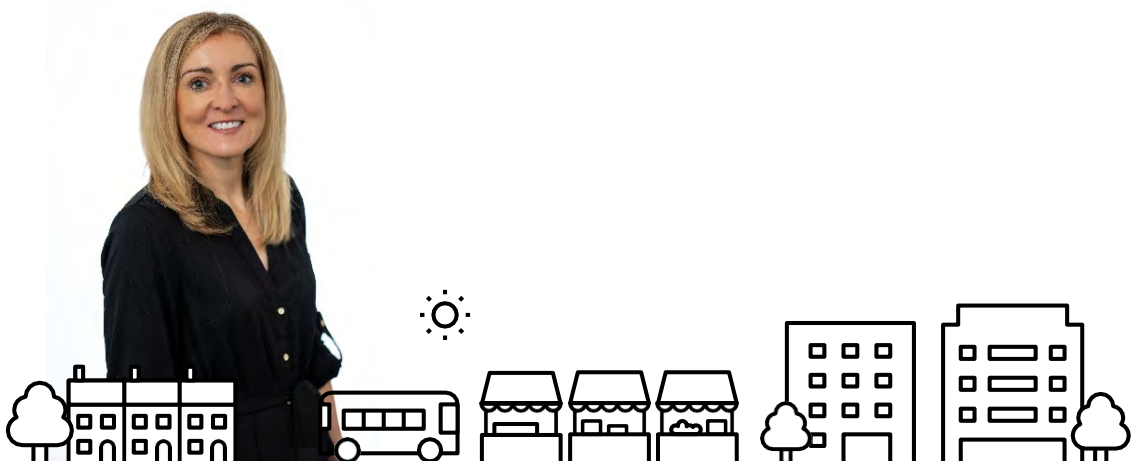
Our commitment to providing high-quality Welsh language services to the communities we serve remains steadfast. As this report demonstrates, our focus in delivering the Welsh Language Standards takes a broader, holistic approach to ensure that the needs and expectations of our population across Gwent are understood and met.

By working in partnership with our staff and collaborating with key stakeholders, including the Welsh Government and the

Welsh Language Commissioner's office, we continue to progress the aspirations of *More Than Just Words* and the Welsh Language Standards.

We are proud of the improvements we have made and remain committed to strengthening Welsh language services across our organisation. I hope you enjoy reading this report and learning more about our achievements over the past year and our ambitions for the future.

Sarah Simmonds
Director of Workforce and
Organisational Development



Introduction

Our Annual Report highlights the work undertaken by the Health Board to support, facilitate, and deliver Welsh-medium services for patients and service users across the communities we serve.

In accordance with the Welsh Language Standards, the report provides an annual overview of performance and progress for both the public and the Welsh Language Commissioner. The reporting period covered by this report is 1 April 2025 to 31 March 2026

The Health Board monitors progress against its Welsh language objectives through its People Plan and reports externally to the Welsh Government in line with the requirements of the ***More Than Just Words*** strategy. *More Than Just Words* is the Welsh Government's strategic framework for strengthening Welsh-language provision across health and social care services. The current strategy and associated action plan can be accessed [here](#).

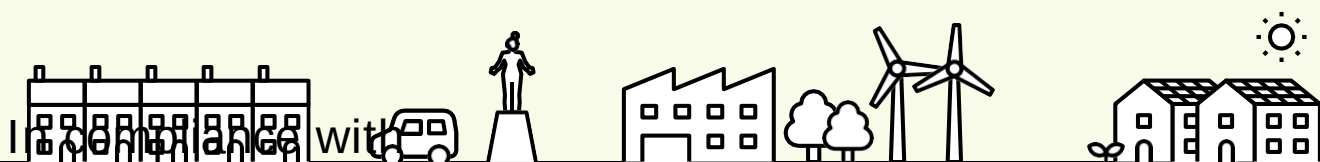


We are pleased to report continued progress against the objectives. Significant achievements include our highest levels of language skills mapping across the workforce, substantial developments in our digital service provision, and the implementation of a strategic approach to increasing the availability of Welsh-medium clinical consultations. These areas of progress are explored in greater detail throughout this report.

While challenges remain in ensuring consistent and sustainable Welsh-language service provision across all areas of the Health Board, we are encouraged by the progress made and remain committed to further strengthening our Welsh-language offer for the population we serve.

As required by Welsh Language Standard 120, this report also provides specific information relating to:

- The Welsh language competency levels of our workforce.
- Training opportunities provided through the medium of Welsh.
- Complaints received relating to the Welsh language.
- The Welsh language competency levels specified for vacant and newly created posts, advertised during the reporting period.



Management, Administration and Compliance with the Welsh Language Standards

Accountability, Governance and Assurance

The Health Board has a statutory duty to provide services in accordance with the Standards set by the Welsh Language Commissioner. This responsibility is overseen by the Executive Director of Workforce and Organisation Development, specifically through the work of the Welsh Language Unit (WLU).

The WLU comprises of staff with expertise in strategic leadership, service planning, policy development, and Welsh language implementation. The Unit's primary role is to provide specialist advice, guidance and support to the Health Board in relation to compliance with Welsh language legislation and the development and delivery of Welsh-medium services.

Through its work, the WLU supports the organisation in embedding the Welsh language across all aspects of service delivery and workforce development.

The WLU reports quarterly to the Welsh Language Strategic Group, providing updates on progress against key priorities, ongoing initiatives, compliance matters, and wider developments relating to Welsh language provision across the Health Board.



The Welsh Language Strategic Group (WLSG) is the Health Board's cross-organisational governance forum responsible for overseeing and endorsing the work of the Welsh Language Unit.

The Group's principal purpose is to provide strategic oversight, advice and assurance to the Health Board in relation to its statutory responsibilities for Welsh language service provision. The WLSG plays a key role in monitoring compliance with the Welsh Language Standards, driving continuous improvement, and supporting the delivery of the Health Board's Welsh language objectives.

To support these governance arrangements, the WLSG submits regular reports to the Executive Committee and People and Culture Committee, providing assurance regarding its effectiveness, compliance with its terms of reference, and the discharge of key responsibilities. Twice a year progress against the Welsh language standards and the targets in *More than Just Words* is also reported to the People and Culture Committee.

Risk Management

The Welsh language is an important statutory and strategic enabling commitment supporting the delivery of equitable, person-centred and high-quality services.

The risk that the Health Board does not consistently fulfil its statutory duties relating to equality, the Welsh language and social partnership is recorded on the Corporate Risk Register. This provides formal corporate oversight of the combined risk, including the effectiveness of controls, available assurances, identified gaps and progress with mitigating actions.

Within this overarching risk, the Welsh-language component addresses the potential impact of non-compliance with the Welsh Language Standards and gaps in the consistent provision of Welsh-language services.



Annual Summary

The Standards, which have been applied to the Health Board under section 44 of the Welsh Language (Wales) Measure 2011, are contained in the [Compliance Notice which can be found on our website.](#)

A key principle of ensuring bilingual services is to have a clear awareness of the language abilities of our staff. We have now recorded the language abilities of 90% of our staff. These are recorded in three areas; Speaking and Listening, Reading and Understanding, and Writing. The below graph shows our progress over the years.



Having this awareness of staff skills allows us to:

- Ensure staff have access to Welsh language identifiers such as badges, lanyards and embroidered uniforms.
- Target resources, learning and support to the areas that will benefit most from them.
- Assess the language needs of the team when advertising new and vacant roles.

Patients tell us that being able to identify staff with Welsh language skills gives them the comfort in knowing the support is available in Welsh.



There has been a significant positive transformation in the Health Board's approach to the Welsh language in relation to the procurement and development of our digital tools. Through engaging the Welsh language unit at the inception of projects we have been able to ensure that the specific digital platform meets the needs of our Welsh speaking patients. A clear example of this is our digital patient communication tool. This tool allows all patients to access all correspondence about their care on-line rather than waiting for paper letters to be sent. This platform allows us to state with confidence that all patients utilising this tool are able to receive a fully bilingual service.

We recognise that there are some legacy platforms that still present issues in relation to their bilingual abilities, such as our e-triage system, however we are working with the services, the developers, and in collaboration with the Welsh Language Commissioners office and are confident that we will rectify these issues in the next 12 months.

In line with standard 110, our published 5-year plan to increase the number of clinical consultations available through the medium of Welsh is progressing well. The plan is available to view [here](#).

The plan focusses on the Physiotherapy service who have fully embraced the targets of the strategy and see the value of delivering a truly bilingual service.

Some of the notable work already undertaken includes:

- Identification of Welsh language skills within the workforce.
- Ensuring that staff have the identifying markers noting that they can speak Welsh where appropriate.
- Ensuring patients are positively encouraged to note their language of choice during clinical consultations.
- Having all assessment tools and literature freely and openly available in Welsh.



As a result of this programme to implement standards one of the most positive outcomes achieved to date is the positivity shown towards the Welsh language by the physiotherapy team as a whole. The service is taking pride in their increased focus on Welsh language delivery. This is displayed in the staff story which is detailed further on in this report. It is also reflected in the words of another member of staff who has engaged with the confidence building course provided by the Welsh language unit. She notes that the sessions have helped build her vocabulary and that she now uses her Welsh with her patients and wears her Welsh language badge with much more confidence.

The service has also generated a tool to encourage new and aspiring physiotherapists to their team, and for the first time have included a staff member video in Welsh, showing the importance they attribute to the language.

We are on target to achieve the goals noted in the plan and will be publishing our 3-year review in 2027.



Comisiynydd y
Gymraeg
Welsh Language
Commissioner



Bilingual Online Services

Our corporate website remains one of our most significant communications platforms and contains an extensive amount of information for our local population. We are pleased to report that, overall, compliance continues to be positive. The allocation of internal and external translation resources remains in place for the communications team to meet the continually increasing demands for Welsh language content, which continues to be a well-established, efficient process.



- This year saw the launch of the brand-new Gwent Women's Health Hub - an online space to help residents find the correct advice, information and support for women's health concerns. This multi-functional platform is a completely bilingual resource, accompanied by a suite of bilingual branding assets that sit alongside it, strengthening inclusive, compassionate care.



Social Media Presence

We are pleased to report that throughout this period all communications assets produced by the Communications and Engagement Team have remained fully bilingual. We continue to be challenged with the social media presence of various independent services within the Health Board which our patients tell us provide invaluable information and support to them, therefore work to improve our compliance in this area is ongoing.

Follower numbers and engagement rates with our Welsh-medium accounts have remained in line with previous years. However, the Health Board’s reduction in activity on the X platform has understandably seen a further decline in followers, which remains consistent with the general decrease in users across the platform.

Channel	Medium	Number of Followers 2024/25	Number of Followers 2025/26
	Welsh	328	332
	English	112,193	115,286
	Welsh	240	231
	English	25,600	25,200
	Welsh	186	205
	English	14,405	15,206



Staff Engagement

We recognise that a key component of our work is ensuring that staff remain aware of the importance of providing Welsh language services to patients and service users. Continued engagement and awareness-raising activities support staff in understanding both their responsibilities and the contribution they make to delivering person-centred care through the medium of Welsh.

We continue to work closely with colleagues across the Health Board to reinforce the requirements associated with Welsh language service provision and to promote best practice in meeting patients' language preferences. This helps to ensure that Welsh-speaking patients and service users are able to access services in their preferred language, supporting both quality of care and compliance with Welsh language standards.

We engage with our colleagues who deliver induction, learning and development opportunities across our Health Board and deliver tailored sessions to these groups.

Some of the programmes we deliver to are:



We also carry out a series of roadshows across our sites to engage with and offer support to a wide audience of colleagues.

Some feedback received from our engagement sessions include:

I had no idea of the impact just greeting a patient in Welsh could have on them. I know a lot more Welsh than I thought I did.

Helping patients in Welsh is more than just translating documents. I'm going to go back to my work area and look to see if we're delivering on the 'Active Offer' and ensuring Welsh speakers feel comfortable to ask for help.



We will continue to look into innovative ways to positively engage with our workforce as we understand it is a vital mechanism for gaining insight into the practical considerations of Welsh language service delivery.



Staff Learning

We continue to support staff who are interested in starting their Welsh language journey or improving their existing skills.

Throughout the year, there has been a sustained level of engagement from staff enrolling on Welsh language training opportunities, reflecting a continued commitment to strengthening Welsh language capacity within the workforce.

We have developed an innovative tool that asks a small number of questions to gain a better understanding of what the staff member is looking for. This includes understanding what their current abilities are, how they prefer to learn, whether in a class environment or through e-learning, and how much time they want to dedicate to the learning.

By getting this information we aim to better align the learner with the correct learning for them.

Learners have been signposted to a range of learning pathways and resources, including courses delivered by Coleg Gwent and Nant Gwrtheyrn, the *SaySomethinginWelsh* (SSiW) digital learning platform, and the *Croeso 1* introductory Welsh course.

Following the introduction of a bespoke Tutoring offer during this reporting period, our tutor is now preparing to deliver the new 10-hour *Cwrs Croeso 2* course, which provides a structured progression pathway for learners who have completed the initial 90-minute *Croeso 1* course.



Our '*Codi Hyder*' (raising confidence) programme has continued to have a positive impact on the staff who participate. This programme provides 1:1 sessions with a tutor for those who have previously had a good level of Welsh but now lack the confidence in using that skill in their work. These sessions are designed in collaboration with the learner to have the maximum impact and deliver on their goals. One learner who benefited from the programme noted:

"I was able to do the basics but I had no vocabulary for my day-to-day work, but I've now had multiple instances where speaking to patients in Welsh has helped me to connect with them."

Caffi Cymraeg.

This year, the Welsh Language Unit relaunched *Caffi Cymraeg*. Many staff had told us that they wish they had somewhere where they could come and chat practicing their Welsh language skills in an informal and friendly place.

Caffi Cymraeg is delivered monthly on teams and is designed to support staff in developing their confidence and competence in using Welsh within the workplace. To ensure sessions are appropriate to individual learning needs, three separate groups are offered for learners who define themselves as beginners, intermediate, and fluent, allowing participants to engage with colleagues of a similar proficiency level.

Feedback received to date has been highly positive, with participants highlighting the benefits of increased confidence, regular language practice, and the opportunity to connect with colleagues from across the organisation. They have also engaged learners with each other providing even more opportunities to practice their Welsh. One colleague noted:

"My colleague and I sit next to each other at work and spend short periods speaking Welsh together"



Resources

Resources are generated to help our staff to support our patients in multiple ways.

Our Welsh speaking staff are able to identify their language skills in order to ensure our patients and their families are able to spot Welsh speakers and obtain services through the medium of Welsh. These resources include; lanyards, badges and scrubs, all displaying the Iaith Gwaith logo. These resources are also available with the word 'Dysgwr' printed on them. This word denotes that an individual has language skills but is a learner.



For those who have no Welsh language skills, we generate resources such as tent cards and flashcards with basic Welsh phrases to help them in holding simple conversations. An example is shown below. Following requests from services, we've generated service specific versions of these cards to give additional phrases.

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Sut i ateb y ffôn / How to answer the phone

Greeting Bore da / Pnawn da
+ name of Department / Ward / Clinic / Hospital

would you like to speak to a Welsh-speaker? [transfer to colleague]
can we get a Welsh-speaker to call you back?
[take caller's details and arrange for colleague to call back]
or would you like to continue in English?

Cyfarchion dwyieithog / Bilingual greetings

Bore Da / P'nawn da / Noswaith dda Good morning / Good afternoon / Good evening [Bore da / Pnawn da / Noswaith dda]	Dw i'n deall dipyn bach o Gymraeg I understand a little bit of Welsh [Dw i'n deall dipyn bach o Gymraeg] (Back - as in the computer) (J-I - as in Llangollen)
Ga i helpu? Can I help you? [Ga i helpu?]	Diolch Thank you [Dw i'n deall]
Dallwch y llinn plis Hold the line please! [Dallwch y llinn plis]	Na i'ch trosglwyddo chi I'll transfer you [Na i'ch trosglwyddo chi]
Ga i gymryd neges? May I take a message? [Ga i gymryd neges?]	

Teimladau / Feelings

- Sut dach chi heddiw? *How are you today?*
- Dach chi'n iawn? *Are you OK?*
- Dach chi'n teimlo'n well? *Do you feel better?*
- Bendigedig diolch *Wonderful thanks*
- Iawn diolch *Alright thanks*
- Go lew *OK*
- Wedi blino *Tired*
- Ofnadwy *Terrible*
- Dw i'n teimlo'n well diolch *I feel better thanks*
- Dw i'n teimlo'n waeth *I feel worse*

Spotlight on a staff member

To celebrate Dydd Gwyl Dewi, St. David's Day, this year, we featured one of our Welsh-speaking clinical staff members, Rhys, who is proudly using his Welsh with patients to ensure that an 'active offer' is available and to provide the best possible experience for his patients. The overwhelming response to this post made it evident that Rhys is making a real difference and having a lasting impact on his patients and colleagues.

The Welsh Offer badge helps me to connect with others who want to communicate in Welsh.

Some patients feel more comfortable speaking Welsh, and are more open with me about their situation because they are able to describe their feelings in their chosen language.

Cymraeg



Engagement with our future workforce

With all students in Wales learning Welsh as a first, or second language, we recognise that all students leaving the education system in Gwent have conversational Welsh language skills.

Our approach to informing this future workforce involves a varied offering tailored to the audience in question to create individuals who are as well informed as possible about how Welsh Language skills can be used in their future career. We specifically tailor the offers to showcase the range of careers the NHS can support.



Primary Schools

We developed an innovative and engaging toolkit of resources for children aged 7 to 11. Our 'Syrjeri Sgiliau' suite of lessons gives an engaging insight into the work of staff within the NHS. The lessons are all designed by an experienced education leader and align with the Curriculum for Wales. Each of the four lessons focuses on a different aspect of our work in health. The lessons include fun interactive activities to get the students fully enthused.

Our first model involved us delivering the sessions to the students in the school setting. Our staff thoroughly enjoy these sessions and have engaged with over 300 children across a number of locations. We have now developed the toolkit to be delivered independently. This allows primary schools to deliver key information about NHS careers while simultaneously covering targets of the Curriculum for Wales. The toolkit includes all relevant resources and ensures that the pupils would get the same delivery as they would if it were delivered by Health Board staff. One student noted; *'I never knew how many different things you could do working for the Health Board'*.



The success of this programme at a regional level led to us being invited to share our programme at the National Eisteddfod and led to requests for the package to be available nationally. With this in mind, we are working with Health Education and Improvement Wales to place these materials on a platform that will make them available to all schools within Wales.

Secondary Schools

Throughout the year, the Welsh Language Unit continued engagement with both Welsh-medium and English-medium schools. These events reached upwards of 500 students in the reporting period. Activities included participation in careers events, speed networking sessions, and presentations to secondary school learners, aimed at raising awareness of career opportunities and the importance of Welsh language skills within healthcare workforce. We have had very positive feedback from schools in the Welsh sector noting how important it is that they hear from those who are actively using their Welsh in the workplace to reinforce that there is a call for the skill they have. English medium schools tell us they are grateful that we empower their students to understand that they are as important in our goal of delivering Welsh speaking services.

Colleges

We continue to work in partnership with Coleg Gwent and Coleg y Cymoedd to promote awareness of the role and significance of the Welsh language within healthcare. Over the past year, the Welsh Language Unit has delivered presentations and engagement sessions to more than 100 students across all colleges, highlighting career opportunities within the NHS and the importance of Welsh language skills in meeting patient and service user needs.

These activities support wider workforce planning and recruitment objectives by



encouraging consideration of Welsh language competencies in healthcare careers.



Gyrfa Cymru
Careers Wales





Site Audits and Equality Impact Assessments

Site Audits

As part of our assurance programme, we undertake regular visits across Health Board sites. These visits assess both areas of good practice and opportunities for improvement. Following each visit, we work collaboratively with sites to develop local action plans and ensure they have access to the support and resources required to implement the agreed actions.

Some key themes identified on our visits include:

- o Inconsistent application of bilingual wayfinding signage.
- o The 'Active Offer', (which notes that it is the Health Board's obligation to let patients know that Welsh language services are available, without the need to request them), visual markers are visible at all main reception areas but are less frequent as you travel further into clinical areas.
- o Positively, basic general awareness of Welsh language requirements is high across all sites.

The Welsh Language Unit is working closely with the Planning Team to ensure early and ongoing engagement throughout the development process.

Equality Impact Assessments

All policy decisions of the Health Board are required to go through the Equality Impact Assessment. The process requires staff to assess the potential impact of the policy being proposed on a number of groups, including its impact on the Health Board's ability to provide a bilingual service. The completed assessment is then brought before the Equality Impact Assessment Panel. A member of staff from the Welsh language unit is a standing member of the Equality Impact Assessment panel.



Collaboration

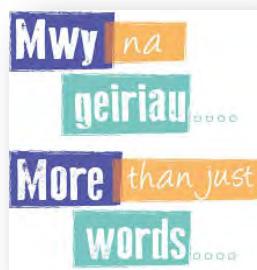
We recognise that effective collaboration strengthens our ability to deliver shared goals and improve outcomes. We therefore embrace opportunities to work in partnership, sharing knowledge, learning from others and contributing to collective success.

The Health Board's Head of the Welsh Language Unit chairs the Gwent *More Than Just Words* Forum, bringing together partners from across health and social care in the region. The forum includes representation from all Gwent Local Authorities, Coleg Gwent, Coleg y Cymoedd and Menter Casnewydd, providing a valuable platform for collaboration, engagement and shared learning.

In addition, Welsh language leads from across NHS Wales meet regularly to exchange best practice and work collectively on national programmes and initiatives. This includes coordinating the NHS presence at major events such as the Urdd Eisteddfod and the National Eisteddfod. These partnerships will be particularly valuable as the region prepares to welcome the Urdd Eisteddfod in 2027.

Following conversations with Additional Learning Needs coordinators from local schools, we identified a need for assessment tools and resources in Welsh that were not currently available. As we recognised this was a challenge at an all-Wales basis, we engaged with the Welsh Government lead for *'More than Just Words'* as well as a newly appointed lead for mapping Welsh language additional needs support across Wales. This has area, not just for Health Board, but for all

progressed the work in this Aneurin Bevan University Health Boards.





Translation

Translation requests continue to increase year on year. The translation service delivered by the Welsh Language Unit is robust, ensuring we meet our statutory duty to deliver bilingual materials to our service users. This includes; patient correspondence, information leaflets, assessment forms and any other information submitted to be translated. Our system includes an internal translator, a service level agreement with Betsi Cadwalader University Health Boards translation service, as well as other translators available for specific pieces of work.

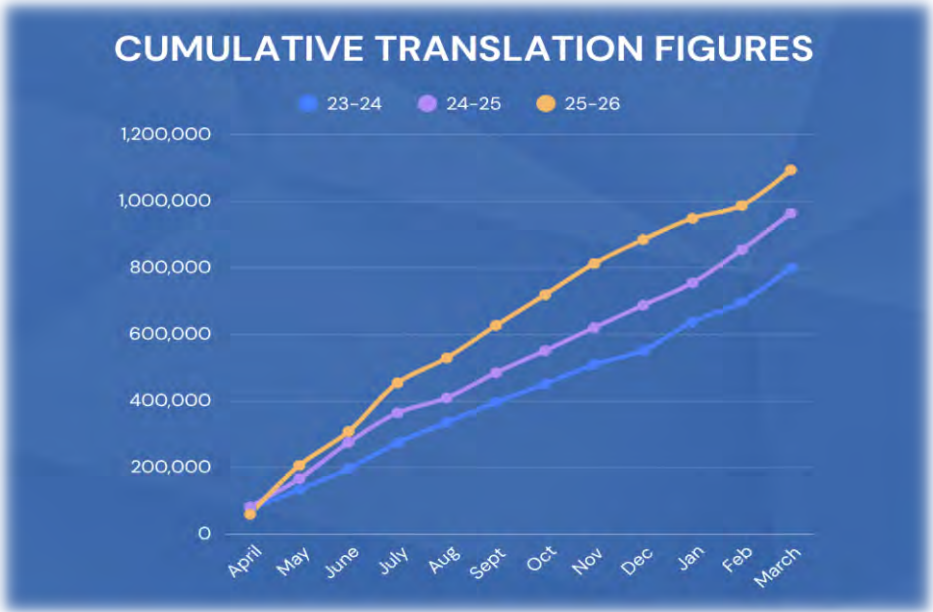
In 2025-2026 we translated:

- o 599,136 words internally
- o 509,165 words externally

By utilising an internal translator as well as an improved service level agreement we are able to offer considerable cost savings. In 2025-2026 to translate the equivalent words through our previous arrangements would have cost an additional £18,000.

The graph below shows a comparison of the number of words translated over the last three years

On top of this work, we are also called upon to translate and record multiple voice recordings each month.



Workforce Welsh Language Abilities

The tables here show the breakdowns of each level across the three mapped fields.
(31/03/2026)

Listening & Speaking	2023/2024	2024/2025	2025/2026
Level 0	9528	10940	11512
Level 1	2038	2052	2162
Level 2	415	439	443
Level 3	166	178	179
Level 4	139	150	147
Level 5	249	250	306

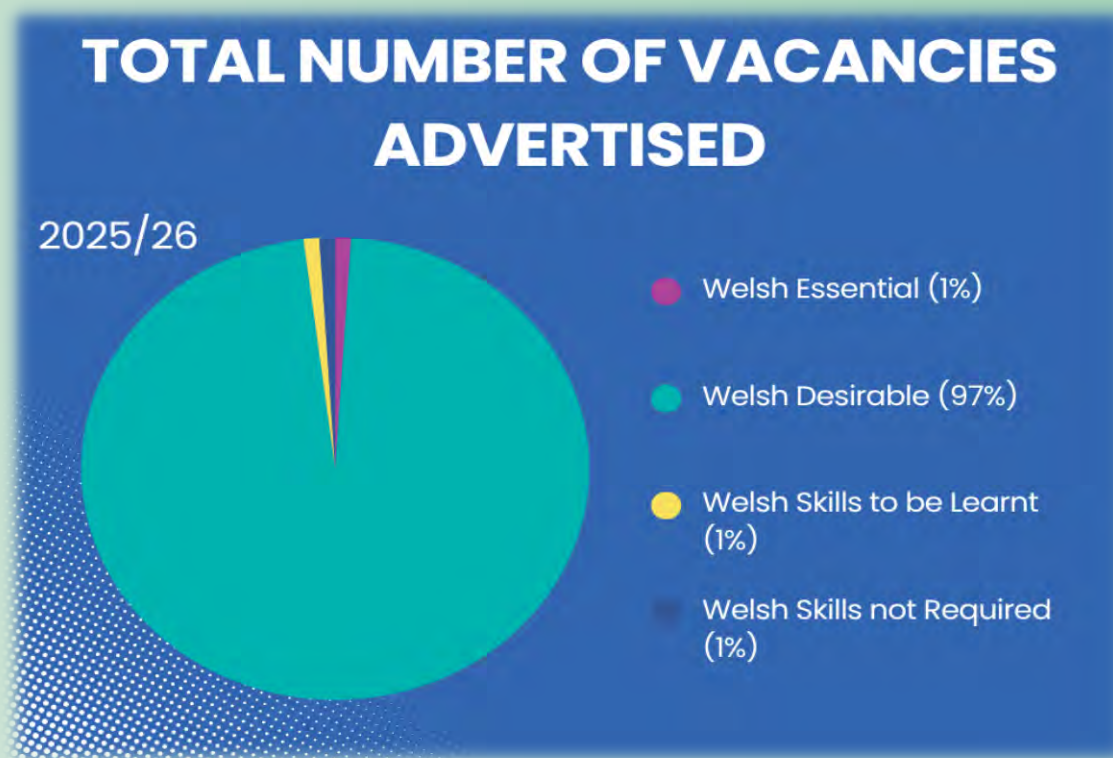
Reading	2023/2024	2024/2025	2025/2026
Level 0	9731	11159	11748
Level 1	1799	1817	1940
Level 2	398	422	435
Level 3	147	155	167
Level 4	132	148	142
Level 5	267	264	317

Writing	2023/2024	2024/2025	2025/2026
Level 0	10102	11565	12184
Level 1	1467	1475	1599
Level 2	397	418	416
Level 3	131	133	143
Level 4	104	122	118
Level 5	247	239	289



Recruitment

The graph below shows the data for vacant and new positions in relation to the Welsh language requirements advertised with those roles.



The chart shows that almost all roles are advertised with Welsh as desirable, with very few roles noting Welsh as an essential skill. Given that we know we have areas within our services with no Welsh language skills, we have identified that assessments of the language skills needed are not routinely being undertaken in all areas as is a requirement of the Welsh Language standards. With this in mind, a pilot digital tool has been developed for use by recruitment managers and will be tested and evaluated over the next 6 months. This tool will ask key questions and, based on the responses, note clearly whether Welsh language skills should be advertised as essential or desirable. The tool will also identify the level of skill required, in order to give a clear picture to candidates of expectations.



Complaints

During the period covered by this report the Health Board received four complaints and was not subject to any investigations by the Welsh Language Commissioners office.

The complaints in this period related to correspondence being received in English only, staff wearing the 'iaith gwaith' logo denoting them as a Welsh language speaker without holding any skills in Welsh and the e-triage platform in the Emergency Department not allowing patients to input information in Welsh.

All complaints received were handled using the Health Board's Welsh Language Complaints Procedure, in partnership with the Putting Things Right team, and staff from the services involved in the relevant complaints.



Cymraeg



Conclusion and Vision for 2026 – 2027

During the past year we have strengthened our relationships with services across the Health Board. We have supported staff in learning Welsh or strengthening their Welsh language skills, and have offered support to maintain that confidence.

We have built on our generic resources and developed some more bespoke resources that offer targeted support. We are beginning to see the positive impact of this targeted support when working at a service level, as we have with the Physiotherapy service in line with Welsh language standard 110.

We have further strengthened our relationship with the Welsh Language Commissioner's office and have benefited from their more cooperative approach, allowing for much more constructive and open conversations.

Over the next twelve months we have identified several key areas of work to progress. As noted previously in the report, we are implementing a digital tool to support recruitment managers to accurately assess language levels that should be advertised on new and vacant roles.

With the Welsh Government's focus on language skills in Primary Care, we will be working closely with our colleagues across the division to deliver awareness sessions and offer support to providers, enabling them to ensure the Active Offer is embedded within these locations.



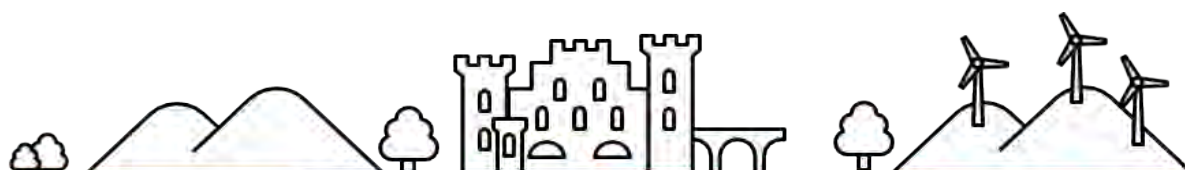
We will adopt a new procurement system which will ensure that the Welsh language is a consideration at the commencement of any procurement processes. This will ensure that the Welsh language needs of our service users, as well as the requirements of the Welsh language standards are fully considered at the earliest stage.

In line with the Health Board's goal to put the patient at the centre of their care, we will also develop a 'Patient Participation Panel' for Welsh speaking patients. This panel will give a facilitated space for patients to share their experiences of care, both positive and constructive. Representatives from the panel will then join representatives from other panels to feed into the larger 'Community of Practice' that has been established.

With the Urdd National Eisteddfod visiting the region in 2027 we will also be seeking opportunities to ensure a presence from Aneurin Bevan University Health Board. This will be an opportunity to engage with the roughly 100,000 visitors who visit the event each year and engage young people with our services. With the aim to strengthen these relationships with our local Welsh speaking school communities, we were grateful to welcome pupils from Newport's newest Welsh language school 'Ysgol Nant Gwenlli'. As part of our St. David's Day celebrations this year pupils came to distribute daffodils to staff, patients, and visitors to the Royal Gwent Hospital.



We are excited by the positive changes that the Health Board has made since the implementation of the Welsh language standards in 2019. We recognise that there is still a great deal of work to do, and as an organisation that is constantly striving to be the best it can be, we recognise that we will never stop looking for opportunities to develop ourselves and improve. We are proud of where we've come to and look forward with an increasingly optimistic eye to the future.



Delivering the actions in the More than just words Plan 2022-27: For the period April 2025 – March 2026

Organisation	Aneurin Bevan University Health Board	
Completed by:	Geraint Scott	Date: August 2026
KEY DATA:	When citing any statistics / data, please provide a corresponding reporting date / time period.	
Welsh Language Skills of staff	90% of staff have recorded their Welsh Language Skills. On the key criteria of Speaking and Listening we have the following numbers identified at each level; Level 0 – 11512, Level 1 – 2162, Level 2 – 443, Level 3 – 179, Level 4 – 147, Level 5 - 306	
Number of staff completing training	Courtesy Course - 63 Confidence Building Course - 21 Welsh Language Awareness Course 73% compliance with mandatory training. As well as these courses, for which you have sought data, we also have staff undertaking other Welsh language learning, including accredited courses through Coleg Gwent, as well as more informal learning mechanisms such as 'Say Something in Welsh'. We are also very proud to have sent 8 staff on the residential immersive course at Nant Gwrtheyrn.	
Patient / Service User Surveys e.g. secret shopper surveys	Number and details of surveys - 11 patient feedback surveys received in Welsh. Feedback – Although received in Welsh, only 2 made any reference to the availability of services through the medium of Welsh. The other 9 were completed in Welsh but the comments and feedback were comments around the care in general and made no reference to the Welsh language provision. The 2 that did reference Welsh language gave positive feedback as they had seen staff with the iaith gwaith logo and had been able to speak to staff in Welsh. Actions taken in response to feedback – feedback has been included in the awareness sessions we deliver as a unit to staff. Thus, showing our staff, the positive effect that gaining access to services in Welsh can have.	

Ref	Description of Short-Term and Medium-Term Action	Guidance for completing the response	Lead Accountability	Progress Report for 2025/26 (reporting period 1/4/25 – 31/3/26): What new and additional activities were delivered during 2025/26?	Examples of good practice / work done in partnership.
Culture and Leadership					
1.	We'll set personal performance objectives to ensure the delivery of More than just words. This will ensure that the Active Offer is embedded in annual objectives of sector leaders, cascaded throughout organisations, and considered in relevant individual appraisals, at all levels. This will include Chairs of NHS boards and the Directors of Social Services reports (Annual Council Reporting Framework). (<i>Short-term</i>)	This was a short-term action. There are now requirements in place for the Chairs of NHS Boards and the Directors of Social Services to have specific objectives in relation to supporting the implementation of Mwy na geiriau and the Active Offer. Health bodies / social services do not need to provide an update for the 2025/26 report (unless there are specific developments they wish to share as good practice) as Welsh Government will review progress against objectives at the end of the year.	Welsh Government for 2025/26.	N/A	

Ref	Description of Short-Term and Medium-Term Action	Guidance for completing the response	Lead Accountability	Progress Report for 2025/26 (reporting period 1/4/25 – 31/3/26): What new and additional activities were delivered during 2025/26?	Examples of good practice / work done in partnership.
2.	Over time, we expect all health and social care staff to gain an appreciation of the positive difference that learning and using Welsh can make to the care experience. In the meantime, we'll bolster language awareness courses with a behavioural science communications approach, so that everything we say about Cymraeg as leaders, and as organisations and partnerships, contributes to this strategy. This approach will build on the training and on the positive narrative outlined in the plan. (Short to medium term)	HEIW and SCW to provide a response on the work that they are taking forward to support this agenda. We request that health bodies and social services also provide information on how they are supporting this action, and good practice they want to share, regarding the promotion of the Welsh language across all settings.	Welsh Government / HEIW / SCW.	N/A	
3.	We'll expect those in leadership roles to take part in our Leading Bilingual Country programme. This programme works towards embedding the spirit of Cymraeg 2050 in organisational culture and policymaking. All too often, Welsh is viewed as just an issue of translation or as a 'tick box' in	Welsh Government is exploring how to take forward a "train the trainer" approach to the future delivery of the Leading in a Bilingual Country Programme.	Chairs and Chief Executives of health and social care Bodies.	The dates for the new cohort were released too late for senior staff to be able to participate. We await the dates for the next full cohort as well as the training sessions following the 'train the trainer' model,	

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	policy development. This values-based programme goes beyond understanding the possible impact of language on all aspects of our work, to using what levers we have to increase its use. (Medium term)	No further response needed at this stage – unless there are specific examples of how outputs from the Leading in a Bilingual Country Programme are continuing to make a difference to leadership roles in the organisation; and / or there have been leadership programmes / training that have been delivered by health and social care bodies focusing specifically on leadership in a bilingual context.		to allow us to deliver to a wider group of senior staff.	
Theme 1: Welsh language planning and policies including data					
5.	Identify and develop research and data that will strengthen our understanding and knowledge based on the experiences of Welsh language speakers accessing and receiving services,	Welsh Government has commissioned Alma Economics to identify key data on Welsh Language in health and social care which will help to identify	Welsh Government / Universities, Citizen Voice Body for health and social care	N/A	

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	to support evidence-based policy and Welsh language planning in health and social care. This to include ability to provide bilingual services and to evidence how More than just words supports improved outcomes for individuals. (This action aligns with the work set out in section 4 on mapping the data and creation of the dashboard) (Medium term)	data gaps in relation to monitoring outcomes, impact and progress. Health and social care bodies are asked to provide results of surveys of patient experiences of accessing and receiving services such as Mystery Shopper etc. Llais / universities / health and social care think tank organisations to highlight developments that look to strengthen our understanding and knowledge of the experiences of Welsh language speakers accessing and receiving services.	and think tanks.		
6.	Develop tools to support mainstreaming Welsh	Welsh Government has worked collaboratively with the Office of the Welsh	Welsh Government / Health and	All planning and policy developments are required to undertake the Health	A new procurement tool is being rolled out in the Health Board. The tool

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	Language considerations into planning and policies, especially in priority areas and those with high levels of service interactions. This is to include establishing Welsh language care pathways for vulnerable individuals in identified priority groups such as older people, children, mental health, speech therapy, learning difficulties, and stroke services. (Long term)	Language Commissioner to establish a new strategic Health Forum with the health sector, aimed at improving clinical care services through the medium of Welsh. Health and social care bodies are asked to provide evidence of Welsh language care pathways for the priority groups particularly, or any new mainstreaming tools.	social care Bodies.	Board's Equality Impact Assessment (EQIA) process. There is a dedicated section within the EQIA template that relates to an active assessment of the impact on service delivery through the medium of Welsh, that must be completed and signed off by the EQIA panel. A senior member of the Health Board's Welsh Language Unit sits as a member of the EQIA panel, ensuring that the Welsh language impact has been accurately assessed before the EQIA is signed off.	will ensure that the Welsh language is a consideration in all relevant procurements. The Aneurin Bevan procurement team from Shared Services will ensure the tool is used effectively.
7.	Ensure national planning and guidance for health and social care is clear on Welsh language	Welsh Government will provide the update for this action.	Welsh Government.	N/A	

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	planning requirements, implementation and measuring delivery of outputs. This to include Integrated Medium Term Plans (IMTPs) and regional population needs assessments. (Short term)	Welsh Language is included in the National Planning Guidance for Health Boards. Integrated Medium Term Plans (IMTPs) will be reviewed by Welsh Government and officials will continue to focus on More than just words priorities as part of Integrated Quality, Planning and Delivery (IQPD) meetings.			
8.	An agreed national framework for the collection and collation of data on the language skills of all staff working in health and social care in Wales, will be developed and implemented. This should be mandatory wherever possible and would need to align with systems and approaches currently in place for the collection and collation of data across the health and social	Health and social care bodies should provide an overview of how they are currently collecting and collating data on the language skills of all staff (as well as key data for the reporting period).	HEIW / SCW / DHCW / health and social care bodies, including independent primary care contractors.	As part of our requirements under the Welsh language standards, we have been undertaking this skills assessment for several years. The Health Board has currently reached a compliance level of 90%. We work with staff groups who do not have access to technology and have a	

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	care sectors, including services that are provided in Welsh. (Medium term)			mechanism to support them to register their skills.	
9.	An annual report will be prepared by an appropriate body to bring together the data relating to the health and social care workforce. This report could be prepared and published by Statistics for Wales. The published report should be publicly available with a further level of granular detail available as appropriate to those bodies responsible for the workforce in different contexts e.g. HEIW, SCW, Health Boards. (Short/medium term)	Welsh Government will work with HEIW and SCW to provide the update for this action. Health bodies / social services do not need to provide an update on this action for the 2025/26 report.	HEIW/SCW, health and social care bodies.	N/A	
10.	To progress, at the earliest opportunity, action 30 of the 'Health and Social Care Workforce Strategy' – to develop workforce planning guidance for Welsh language skills identification and development in the health and social care workforce. This guidance should	The HEIW Workforce Planning for the Welsh Language Guidance has been published. Health and social care bodies should provide examples of how this guidance has been used across different settings / policies.	HEIW / Social Care Wales.	A new tool has been developed and is due to be rolled out in the 2026-2027 financial year, allowing recruiting managers to clearly identify the Welsh language requirements that should be advertised for new and vacant roles.	

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	consider the required number of staff with Welsh language skills and the nature of those skills in different health and social care contexts, and within the priority areas of need identified. The guidance is used as part of annual workforce planning by Health Boards, Local Authorities, HEIW, Social Care Wales and other employers, as appropriate. Furthermore, the guidance should inform the work of the relevant regulators and inspectorate as appropriate. <i>(Short term)</i>				
11.	The importance of the Active Offer in planning and delivering quality services, to be included in the guidance and reporting requirements for the Duty of Quality and refreshed health and care standards. The Health and Social Care (Quality and Engagement) (Wales) Act ('the Act') became law on 1 June 2020 with its full implementation to be completed by spring 2023. This	Welsh Government will update on this action. The Duty of Quality has been introduced and the importance of the Active Offer was included in the statutory guidance, published in April 2023.	Welsh Government.	N/A	

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	includes reframing and broadening the existing duty of quality on NHS bodies. (Short term)				
12.	The importance of the Welsh language in planning and delivery, to be included as a cross-cutting theme within the revised National Outcomes Framework and progress reports, to be incorporated into the development of the More than just words accountability arrangements, including the dashboard. (Medium term)	Welsh Government will update on this action. Work on the outcomes framework has been paused. As noted above: Integrated Medium Term Plans (IMTPs) have been reviewed by Welsh Government and officials will continue to focus on Mwy na geiriau priorities as part of Integrated Quality, Planning and Delivery (IQPD) meetings.	Welsh Government.	N/A	
Theme 2: Supporting and developing the Welsh language skills of the current and future workforce					
13.	Health and social care organisations to identify workforce skills gaps in key areas and develop plans to address them. This will be embedded in	Health and social care bodies should provide examples of how they have identified workforce skills, where the gaps	Health and social care bodies, HEIW and SCW.	By having 90% of staff's Welsh language skills noted we can identify areas where language skills do not meet	

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	workforce and skills plans developed and delivered within individual organisations and involve close working with HEIW and SCW. (<i>Medium term</i>)	exist, and whether they have plans in place to address them.		the need of the service users, at present. The Health Board's published 5-year plan for increasing the offer of clinical consultations through the medium of Welsh gives clear operational steps to match the needs of the patient with the correct clinical staff.	
14.	We'll expect all NHS and social care colleagues to follow a language 'awareness' course which will explain how important Cymraeg is in service delivery and as a patient need. Following the introduction of Welsh language awareness training for all health and social care professionals, we'll expect that this training is provided across all disciplines for trainees and introduced as part of the induction process for new employees in the health and social care workforce,	Health and social care bodies should provide key data on take up of Welsh Language Awareness Courses. This includes data on providing the course as part of the induction process.	Health and social care bodies.	This is mandatory for all staff to complete and is noted in their Electronic Staff Record. Our current compliance is 76%.	

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	who have not already undertaken the training. (Medium term)				
15.	The National Centre for Learning Welsh develop further plans to offer Welsh language training to the health and social care sectors and provide an enabling environment on the use of Welsh in workplaces. This should complement informal language learning through on-line tools and apps, to be made available across the sector. It could be modelled on recently announced developments for the education workforce. This should include tailored provision to support practice in health and social care and identify opportunities (along with relevant employers) to support staff confidence to make more use of their Welsh language skills (at whatever level) in the workplace. We further recommend that	National Centre for Learning Welsh to provide an update on key actions, take up of specific courses, and outcomes. Health and social care bodies are asked to describe how they've worked strategically with National Centre for Learning Welsh to meet their own priorities.	Welsh Government / National Centre for Learning Welsh.	We ensure that the offering through the National Centre for Learning Welsh is actively offered to all staff within the Health Board. We have staff undertaking learning at all levels, and the data on this is detailed at the start of this report.	Having an awareness that the offering from the National Centre for Learning Welsh, although varied, still does not meet the needs of all staff. To rectify this, we also offer alternative learning options such as the mobile tool 'Say Something in Welsh'.

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	Welsh Government explore what resources are required to deliver adequate support for such a scheme including supporting employers to release key staff to undertake substantive Welsh language learning. <i>(Medium term)</i>				
16.	Organisations to define the level of Welsh language skills required in all job adverts as per best practice in some health boards and local authorities <i>(Medium term – guidance to be developed and shared in the short term)</i>	All health and social care bodies to provide an update on work to define Welsh language skills required in all job adverts, as well as key data on whether posts are being advertised as Welsh desirable and Welsh essential.	Health and social care bodies.	The Health Board has a bilingual skills strategy which alerts recruitment managers to the language abilities that need to be advertised in new and vacant roles. To strengthen the governance in this area a new digital tool will be rolled out in the 2026-2027 financial year ensuring accurate assessments are undertaken in this area.	
17.	Gradual introduction of a minimum “courtesy” level	National Centre for Learning Welsh to provide data on the new courtesy	National Centre for Learning Welsh.	Extensive discussions have shown that this offering is still not available for staff.	We incorporate learning of basic skills and include resources to

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	of Welsh language skills making staff more aware of positive impact that learning and using Welsh can have on individuals accessing and receiving health and social care services. By the end of the life of this plan, all staff working in health and social care should have courtesy level Welsh. (<i>Short term- introduction</i>)	course (as part of the health and social care scheme) and take up across the organisations. Health and social care bodies to also provide information on other courtesy courses being developed (not by the National Centre for Learning Welsh) and delivered locally, and key data on take up.	Health and social care bodies.	The new Croeso course is being delivered and is receiving positive reviews but as this is being delivered by a tutor the numbers able to receive the training are quite small and will not achieve a skill across all staff in the Health Board.	support using these basic skills in each of the engagement sessions we carry out with key staff, such as our Health Care Support Worker clinical induction, new nurse induction programme and Leadership Development Programme.
18.	Organisations to develop and implement a targeted Welsh language training and workforce strategy – with initial focus on addressing gaps in More than just words key priority areas and those who lack confidence (need to consider the potential for working with team leaders / managers / employers to also	Health boards to provide an update on work to support the delivery of Standard 110, and how they are increasing the use of Welsh across clinical settings.	Health and social care bodies.	The Health Board's bilingual skills strategy supports this. The previously mentioned digital tool will give us greater governance in this area.	

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	create the conditions for individuals to use their Welsh) (Medium term)				
19.	Instigate a national awareness and promotion campaign to make staff more aware of the positive difference that learning and using Welsh can make to the services they provide. This to include recruitment campaigns articulating the importance of the Welsh language. The campaigns to involve role models and case studies on the difference that using Welsh has in improving outcomes for individuals. (Medium term)	Health and social care bodies to provide information on promotion campaigns they are delivering to raise awareness of the difference learning Welsh can make. This should include case studies and awards which feature the Welsh language.	Welsh Government/ SCW and HEIW.	The films produced are embedded through our Welsh language awareness sessions that the Welsh language unit deliver to key groups throughout the Health Board. These include our Leadership Development programme, our Health Care Support Worker clinical induction programme, and our new nurse inductions.	
20.	Careers Wales / HEIW and SCW to promote the importance and opportunities Welsh language skills can provide within careers in health and social care, utilising the Tregyrfa portal resources and through roadshows and engagement sessions with young people. (Short/medium term)	HEIW to provide information on Tregyrfa , including data on numbers accessing the site. HEIW to also provide information on roadshows and engagement events held with educational institutions.	Careers Wales / HEIW and SCW / health and care bodies.	We work collaboratively with our partners in Careers Wales as well as colleagues in HEIW to deliver a full programme of Welsh language engagement and awareness events for students of all ages. These include those who are fluent Welsh speakers as well as	We have further developed the 'Syrjeri Sgiliau' programme so that it is now an online resource that can be delivered independently by schools. We work with our colleagues in Local

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		Careers Wales to provide information on initiatives promoting the importance of Welsh language skills in health and social care careers, including data on attendee numbers for any events / roadshows / engagement sessions. Health and care bodies to provide information on roadshows and engagement with young people, including data on attendee numbers.		those learning the language. Our primary schools Syrjeri Sgiliau programme is now on-line and available to be delivered independently by schools across Wales. We also deliver specific sessions to all Health and Social Care students across both Coleg Gwent and Coleg y Cymoedd.	Authorities to ensure that we offer a joined-up model of engagement across Health and Social Care. This includes sessions facilitated by the Gwent Workforce Board. This work is progressed in part due to the strong working relationship fostered through the More than Just Words forum, which is chaired by the Health Board.
21.	HEIW, MEDR and SCW to monitor the numbers of bilingual students being trained as health and social care professionals each year and publish the data annually, in line with the agreed framework for measuring Welsh language skills. This could reflect or develop upon requirements	HEIW / MEDR / SCW to provide data on the numbers of bilingual students being trained as health and social care professionals – in line with findings and recommendations from the	HEIW / MEDR / SCW.	N/A	

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	that are already in place in relation to HEIW contracts, SCW monitoring and / or HESA data. In relation to publishing the data we recommend that a specific table is included in the annual Statistics Bulletin – Welsh in Higher Education Institutions, to report on this data. This data to also be incorporated in the dashboard development set out under Section 4. (Short term)	work being undertaken by Alma Economics.			
22.	Welsh Government monitor the number of bilingual learners and apprentices undertaking Health and Social Care courses and/or apprenticeships each year and publish the data annually, in line with the agreed framework for measuring Welsh language skills. This data to also be incorporated into the dashboard development set out under Section 4. (Short term)	Welsh Government to include the latest data in the Annual Report 2025/26.	Welsh Government.	N/A	

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23.	Welsh Government / MEDR have established a benchmark for bilingual provision i.e. that one third of a course (at least) is available in Welsh. Such a benchmark allows students who are confident in Welsh to undertake part of their course through the medium of Welsh and to develop a level of confidence to work bilingually. This also reflects international best practice e.g. University of Helsinki Medical School. HEIW / SCW to work with universities in Wales and the Coleg Cymraeg Cenedlaethol to identify any courses where students cannot at present study one third of their health and social care courses bilingually and take appropriate action to ensure that bilingual provision is offered on every health and social care course in Wales. Appropriate consideration is also given to	Coleg Cymraeg Cenedlaethol to update on the number of undergraduate courses in the areas of health and care. This to include information on health and social care courses where students cannot study one third of the course in Welsh.	HEIW / SCW / Coleg Cymraeg Cenedlaethol.	N/A	

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	placements and support provided for students to undertake bilingual placements as part of their training. (Short term)				
24.	Welsh Government consider what incentives (financial or otherwise) may be offered to students undertaking an element of their course through the medium of Welsh. Incentives are already offered in relation to the Education workforce. (Short term)	Welsh Government has recently consulted on the NHS Wales bursary scheme. An update on the outcome of this consultation will be included in the Annual Report.	Welsh Government.	N/A	
25.	Consideration is given to expanding the highly successful Doctoriaid Yfory scheme which supports prospective students to apply successfully to medical school, to encompass all health and social care professions where the application process for University study is competitive. More broadly Welsh Government to consider whether such a scheme may assist pupils from deprived backgrounds to apply	The Doctoriaid Yfory Scheme has now been extended to more general health and social care career including dentistry. Welsh Government will consider opportunities for further promoting the scheme.	Welsh Government / Coleg Cymraeg Cenedlaethol.	N/A	

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	successfully to study medicine and other subjects. (Short term)	Coleg Cymraeg Cenedlaethol to provide latest data on take up.			
26.	Every provider of health and social care training in Wales prepares a medium-term plan on developing Welsh language awareness and bilingual skills of their students and submits the plan within 12 months to the relevant commissioning / accrediting / regulatory body. These should include details of the teaching capacity required to deliver bilingual programmes as required. Welsh Government to consider the role Coleg Cymraeg Cenedlaethol could have to review and provide feedback and advice to the relevant bodies on the medium term plans. (Short term)	HEIW and Coleg Cymraeg Cenedlaethol to provide an update on work being taken forwards to progress this action.	Welsh Government / Coleg Cymraeg Cenedlaethol / HEIW.	N/A	
27.	Welsh Government to review the plans developed under Action 30 of the Health and Social Care Workforce Strategy and take appropriate action to support the	Welsh Government will provide the update for this action in collaboration with HEIW and SCW.	Welsh Government / SCW / HEIW.	N/A	

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	development of bilingual teaching capacity and where appropriate, provide suitable resources to support these developments. (Short term)				
28.	Coleg Cymraeg Cenedlaethol is tasked with undertaking a review of bilingual provision in health and social care across the FE and apprenticeship sector, and making recommendations as appropriate as to further steps required to develop bilingual skills amongst level 2 and 3 learners. (Medium term)	Coleg Cymraeg to provide information on progress with the review.	Coleg Cymraeg Cenedlaethol.	N/A	
Theme 3: Sharing best practice and an enabling approach					
29.	We'll collate and share examples of innovative good practice which is accessible across the sector utilising existing portals and hubs, including the Research and Innovation Hubs. (Short term)	Health and social care bodies should provide examples of where and how they have shared good practice, including internally as well as with other organisations. Health and social care bodies to also provide information on whether	Welsh Government / Welsh language officers.	Gwent remains one of only two regions that operates a More than Just Words regional forum. The forum is chaired by the Welsh language lead from the Health Board and includes members from Social Care in Local	We have introduced new members to the group to give a broader range of understanding and skills. These now include representatives from Welsh Government as well as Health Education and Improvement Wales.

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		they have used Hwb Iaith to share good practice. They should also provide evidence of utilising the Research and Innovation Hubs and explain why if they haven't.		Authorities, as well as representatives from the local colleges and the regional Mentrau Iaith. The forum shares best practice and works on collaboration.	
30.	We'll use our Bilingual Technology Toolkit to ensure that when we procure and/or develop new digital services, they will include a bilingual user interface wherever possible. For information and advice websites we'll bring translators closer to content creation, drafting in Welsh and English together, so that we communicate clearly in both languages. (Short term)	Health and social care bodies should provide specific examples of where and how the principles of the Bilingual Toolkit has been used.	DHCW / health and social care bodies.	We work closely with our Digital Data and Technology directorate. Coupled with our new procurement process, we are positive that the Welsh language is fully considered when considering new technologies.	Issues with our e-triage platform were able to be rectified due to a collaborative approach between Aneurin Bevan and Cardiff and Vale Health Board along with Public Health Wales, Shared Services, Welsh Government and the Welsh language Commissioners office.
32.	We'll ensure that Welsh language Executive Leads and Welsh Language Officers and champions meet nationally to share best practice, to ensure a consistent approach on key	Health and social care bodies to provide information on examples of good practice shared as part of existing networks, awards and events.	Welsh Government, Health and social care bodies.	The mechanism for sharing between Health Board Welsh language units, Welsh Government and the Welsh Language Commissioners office has	

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	issues and develop initiatives to celebrate success, including promoting More than just words within existing awards and accolade schemes. <i>(Short term)</i>			become much more effective. We were also grateful for the opportunity to share details of our work in the More than Just Words national event.	
33.	We'll undertake a survey with primary care providers to understand the impact the Welsh language duties have had in delivering the Active Offer. This will identify best practice and provide advice for Executive Directors of Primary Care to further progress and enhance services in Welsh, working closely with the clusters <i>(Medium term)</i>	Welsh Government will provide the update on this action. Health boards Health bodies / primary care clusters do not need to provide an update on this action for the 2025/26 report.	Health Boards and Primary Care Clusters.	Regular engagement sessions are run with our primary care providers through our neighbourhood care networks (NCN's) to share resources, knowledge and awareness of Welsh language service delivery. Within the contracting process, primary care providers alert the health board of any ability they have to deliver services through the medium of Welsh. Those are noted on our website.	

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34.	Enable the development of standard Welsh language diagnostic assessments and resources to support Welsh speakers in identified priority areas, such as mental health, learning disabilities, and the visually impaired, building on work already underway to develop a nationally available set of standard assessments for Welsh speakers with dementia. (Long term)	Welsh Government will provide the update on this action. However – as noted for Action 6: Health and social care bodies are asked to provide evidence of Welsh language care pathways for the priority groups. Welsh Government to collate diagnostic assessments and resources that should be available in Welsh. The next step for the longer term would be to prioritise which assessments need to be available in Welsh.	Welsh Government.	N/A	
35.	Visual markers not only enable service users to identify Welsh speaking staff but also to convey a message that Welsh is a 'normal' everyday part of service delivery and builds on ethos of	Health and social care bodies to update on work being taken forwards to support and promote the identification of Welsh speaking staff – including	Welsh Government / DHCW / health and social care Bodies.	Visual markers are available to all staff across all services within the Health Board. These include posters which alert patients to the active offer, as well	

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	belonging. We'll extend the Iaith Gwaith project across Wales to allow workers who can offer or partially offer services in Welsh to readily identify themselves by wearing Iaith Gwaith badges or lanyards. We'll also, in our ICT systems, capture, display and share information that let us know as individuals and staff who can speak Welsh and what services they will be offering in Welsh — so we can use our Welsh with them. (Consideration would need to be given to additional funding / resources to enable this to be delivered.) (Short term)	any work in relation to digital systems locally. DHCW to update on work happening at a national level to support this agenda.		as individual markers such as badges and lanyards. We also provide scrubs with the Iaith Gwaith logo embroidered in for our Welsh speakers. Our Welsh language unit team carry out audits across our sites and distribute Active Offer posters when we come across regions that are not displaying them.	
36.	We'll continue to improve Welsh language capabilities of national health and social care digital systems and ensure apps being developed such as the NHS	DHCW to update on actions being taken forward to deliver this commitment.	Welsh Government/ DHCW.	N/A	

Ref	Description of Short-Term and Medium-Term Action	Guidance for completing the response	Lead Accountability	Progress Report for 2025/26 (reporting period 1/4/25 – 31/3/26): What new and additional activities were delivered during 2025/26?	Examples of good practice / work done in partnership.
	Wales App support the vision and actions in this plan. This will include the sharing, recording and tracking of Information between systems, including language preference. We'll also work with service users on all technical and content processes to make sure they're easy to use and understand in Welsh and English. <i>(Medium term)</i>	DHCW also to provide data on the numbers accessing / using the Welsh language options in the App, if this is possible.			
37.	We'll further develop dictionary resources, high standard terminological corpus, language memory systems and practical tools to support staff to use their Welsh skills, for example Gair i Glaf. This to include in the short-term Welsh language officers and translators working together on collation of terms and translation capacity and capability. <i>(Short term- joint working on developing standard terms)</i>	Health and social care bodies and NWSSP to update on work being taken forwards to develop and support the implementation of these resources.	Welsh Government / health and social care bodies / NWSSP.	We utilise the 'Byd Term Cymru' to ensure that our chosen translation of terminology is consistent with our colleagues across Health organisations and aligns with Welsh Government.	

Ref	Description of Short-Term and Medium-Term Action	Guidance for completing the response	Lead Accountability	Progress Report for 2025/26 (reporting period 1/4/25 – 31/3/26): What new and additional activities were delivered during 2025/26?	Examples of good practice / work done in partnership.
38.	We'll work with those who inspect and drive quality improvement to ensure the active offer is part of their brief. We will direct underperforming organisations to support and advice. (Medium term)	CIW and HIW to provide information on guidance and training for inspectors to support reporting on Welsh language and culture, and the Active Offer. CIW and HIW to also provide relevant inspection data on compliance/non-compliance with Welsh language requirements.	Regulation and Inspection Bodies.	N/A	
39.	Further develop the mapping of available data provided in Annex A of the framework and identify data gaps that would help measure progress. (Short term)	Welsh Government will provide the update on this action. This commitment links directly to Action 5.	Welsh Government.	N/A	
40.	Using available data where possible, develop indicators that measure progress towards the Active Offer and delivery of bilingual services and identify data gaps that would further help measure progress.	Welsh Government will provide the update for this action. This will become possible once the data mapping and review exercise has been completed (see Action 5).	Welsh Government.	N/A	

Ref	Description of Short-Term and Medium-Term Action	Guidance for completing the response	Lead Accountability	Progress Report for 2025/26 (reporting period 1/4/25 – 31/3/26): What new and additional activities were delivered during 2025/26?	Examples of good practice / work done in partnership.
	<i>(Develop initial indicators – Short term Identify data gaps – Short term Fill data gaps where possible – Medium term)</i>				
41.	Establish a working group to develop a dashboard that brings together performance data to demonstrate progress on the Active Offer and delivery of bilingual services. This to include data from the local authority performance framework; CIW; HIW; WL Commissioner office; NHS IMTP/ performance reporting. <i>(Establish working group Short term First dashboard publication Medium Term Summit to share dashboard with data owners Medium term)</i>	This will become possible once the data mapping and review exercise has been completed (see Action 5).	Welsh Government.	N/A	
42.	All health bodies and local authorities to appoint a person to be responsible for ensuring delivery on the actions and targets set in the plan.	All health bodies and local authorities to list the person responsible for ensuring delivery of the actions.	All health bodies and local authorities.	The Welsh language unit manages the work that aligns to the targets of More than Just Words. The Executive Director of	

Ref	Description of Short-Term and Medium-Term Action	Guidance for completing the response	Lead Accountability	Progress Report for 2025/26 (reporting period 1/4/25 – 31/3/26): What new and additional activities were delivered during 2025/26?	Examples of good practice / work done in partnership.
				Workforce and Organisational Development is the named senior officer for this work; however, we recognise to truly achieve on these targets all staff need to be responsible for their delivery.	
43.	More than just words progress monitoring: Provide a written update on progress with actions on a 12 month basis (<i>First Annual Report – Summer 2023</i>)	Welsh Government will provide the update on this action.	All accountable organisations listed in this plan.	This document forms our 12-month report.	
44.	Establish an advisory board to monitor and scrutinise progress against the action plan. The advisory Board will make recommendations to the Minister where further progress could be made and any emerging concerns where ambition is not being met. A report will be prepared for Ministerial consideration and shared with health and social care leaders. The advisory board will	Welsh Government will provide the update on this action. The Advisory Board for Mwy na geiriau has been in place since August 2023.	Welsh Government.	N/A	

Ref	Description of Short-Term and Medium-Term Action	Guidance for completing the response	Lead Accountability	Progress Report for 2025/26 (reporting period 1/4/25 – 31/3/26): What new and additional activities were delivered during 2025/26?	Examples of good practice / work done in partnership.
	also consider and advise on audit and evaluation requirements to provide independent assessments on progress. <i>(Annual advisory report 2023 Advisory report to include reflection on dashboard data from 2025)</i>				
45.	Minister to hold annual progress meetings with leaders of organisations listed to deliver actions within the plan, including NHS and Local Authorities, to recognise achievements and where further progress is required. Statement on progress to be shared with Senedd Members annually. <i>(First Annual Progress Meeting – Autumn 2023 First Statement to Senedd Members – Autumn 2023 From 2025 the progress report to include the performance data dashboard)</i>	Welsh Government will provide the update on this action. Plans are in place to organise another national stakeholder event on Mwy na geiriau (Autumn 2026).	Welsh Government.	N/A	

DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 September 2026
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Key Matters from Committees of the Board
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Naomi Murtagh, Head of Board Business

**Pwrpas yr Adroddiad
Purpose of the Report**

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

In line with the Health Board's Standing Orders, a number of Board Committees and Advisory Groups have been established. This report provides, for assurance, an overview of the business undertaken by these committees during the reporting period, and highlights key matters for Board consideration, where required.

Cefndir / Background

The Health Board's Standing Orders, approved in line with Welsh Assembly Government guidance, require that a number of Board Committees and advisory groups be established. The following Committees and advisory groups have been established:

- Audit, Risk and Assurance Committee
- Charitable Funds Committee
- Patient Quality, Safety and Outcomes Committee
- Mental Health and Learning Disabilities Committee
- People and Culture Committee
- Remuneration and Terms of Service Committee
- Partnerships, Population Health and Planning Committee
- Finance and Performance Committee

Assurance Reporting

The following Committee assurance reports for the period are included at Appendix 1:

- Charitable Funds Committee – 20th July 2026
- Patient Quality, Safety and Outcomes Committee – 28th July 2026
- Finance and Performance (Escalation) Committee – 12th August 2026
- Mental Health and Learning Disabilities Committee – 8th September 2026
- Finance and Performance (Escalation) Committee – 9th September 2026
- Audit, Risk and Assurance Committee – 15th September 2026

Asesiad / Assessment

In receiving this report, the Board is contributing to the good governance practice of the organisation in ensuring that Committee business is reported to the Board and any key matters escalated, where appropriate.

Argymhelliad / Recommendation

The Board is asked to NOTE for assurance this report, and the updates provided from Health Board Committees.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. There is no direct link to the Plan associated with this report, however the work of individual committees contributes to the overall implementation and monitoring of the IMTP.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. Not applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Committee Chairs

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

**Aneurin Bevan University Health Board
Key Issues Report**

Board Date:		Monday 28 th September 2026	
Date of Committee		Monday 20 th July 2026	Report of: Charitable Funds Committee
Quoracy met:		Yes	
1	Agenda and papers	Agenda and Papers	
2a	Matters referred to the attention of the Board	Charitable funds - governance and sustainability: The Committee approved all funding requests presented and welcomed the introduction of the Charitable Funds Bid Review Panel, recognising the additional scrutiny and support it provides to applicants. The Committee emphasised the need for future staffing-related funding requests to demonstrate longer-term sustainability and clear future funding arrangements. Reserves position and market volatility: The Committee noted that charitable reserves remained below the level outlined within the reserves policy, principally due to investment market volatility. A temporary pause to the requirement to hold reserves at the prescribed level was approved, supported by enhanced monitoring arrangements and agreed financial thresholds. Future investment management arrangements: The Committee supported progression of the procurement exercise for the future investment management contract and requested further consideration of diversification opportunities, procurement requirements and investment strategy before finalisation of the tender documentation. Maximising the impact of charitable funds: The Committee received updates regarding proposals for the flexible use of charitable funds and the utilisation of slow-moving funds. The Committee welcomed ongoing work to maximise the benefit of charitable resources whilst ensuring appropriate governance, assurance and engagement arrangements are maintained.	
2b	Assurance	Financial performance and monitoring: The Committee received assurance that robust monitoring arrangements remained in place to oversee charitable fund performance, reserve levels and investment activity. The Committee noted that investment performance	

		had improved since the year-end position despite ongoing market volatility. Marketing and fundraising activity: The Committee received assurance that progress continued against the Charitable Funds Marketing Strategy, with a range of initiatives underway to strengthen awareness, increase visibility and support future fundraising activity. Investment management and portfolio performance: The Committee received assurance that the investment portfolio continued to be managed in line with its agreed medium-risk profile, remained appropriately diversified and was supported by responsible investment principles. External audit and regulatory compliance: The Committee received assurance that arrangements remained in place to support timely completion of the annual external audit and that there were no legislative or regulatory changes requiring action at this time.
2c	Review of Risks	The Committee reviewed key areas of risk and noted the following: Reserves and financial sustainability: Risks associated with reserve levels remaining below policy requirements and the potential impact of future investment market volatility on charitable fund balances. Investment management and procurement: Risks relating to the procurement of the future investment management contract, including transition arrangements, investment diversification and long-term investment performance. The procurement of the new contract on investment management commencing in 2027 would be discussed at a working group meeting on Friday 14th August 2026. Governance and reputational risk: Potential governance and reputational risks associated with participation in the proposed NHS Lottery Scheme, requiring further due diligence and assurance before any decision is made. Charitable fund structure and utilisation: Risks associated with maintaining a large number of highly specific charitable funds and the need to ensure available resources are utilised effectively whilst remaining aligned to donors' intentions and governance requirements. Market volatility: Ongoing risks relating to investment market fluctuations and their impact

	on charitable fund performance, reserves and future funding capacity.
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Aneurin Bevan University Health Board Key Issues Report			
Board Date:		Monday 28 th September 2026	
Date of Committee		Tuesday 28 th July 2026	Report of: Patient Quality, Safety & Outcomes Committee
Quoracy met:		Yes.	
1	Agenda and papers	Agenda and Papers.	
2a	Matters referred to the attention of the Board	Quality improvement and organisational learning: The Committee noted continued improvement in complaints management, including reduced backlogs, improved response quality, positive Ombudsman outcomes and better incident closure performance. Improvements were attributed to strengthened accountability, redesigned processes and enhanced investigator training. Procedural safety outside theatre environments: Following review of Quarter 4 Never Events, the Committee noted an emerging trend of incidents occurring outside traditional theatre settings. Whilst all incidents resulted in low or no harm, the Committee highlighted the need for strengthened assurance regarding compliance with safety standards, documentation and safety checks within non-theatre environments. Instrument traceability and patient safety: The Committee discussed findings from the HSDU and theatre instrument investigation, which identified gaps in instrument traceability arrangements. The Committee supported further work and escalation through governance processes to ensure sustainable organisational controls were implemented. Violence, aggression and sexual safety: The Committee noted increasing concerns relating to violence, aggression and sexual safety incidents across clinical services and highlighted the importance of progressing the Violence Prevention and Reduction Strategic Plan to strengthen staff safety and organisational responses.	

2b	Assurance	Quality, safety and patient experience: The Committee received assurance regarding continued improvements in complaints management, patient experience reporting, safeguarding performance and incident management arrangements. Strengthened governance and improvement programmes were delivering positive outcomes and supporting organisational learning. Quality intelligence and reporting: The Committee received assurance that implementation of the Quality and Patient Safety Qlik application was progressing as intended and would strengthen the organisation's ability to triangulate quality, audit, patient experience and outcome data to support effective decision making. Infection Prevention and Control: The Committee received assurance regarding the effectiveness of Infection Prevention and Control arrangements, supported by robust surveillance systems, multidisciplinary oversight and continued improvement in healthcare-acquired infection performance. Nurse Staffing Levels (Wales) Act: The Committee received assurance that nurse staffing reviews and monitoring arrangements continued to meet legislative requirements, supported by workforce initiatives focused on recruitment, retention and professional development. Quality Management System oversight: The Committee received assurance that established governance arrangements continued to provide effective oversight, monitoring and escalation of quality and safety matters across the organisation.
2c	Review of Risks	The Committee reviewed key areas of quality and safety risk and noted the following: Procedural safety risks: Risks associated with procedural activity outside traditional theatre settings, particularly relating to compliance with safety checks, documentation standards and invasive procedure protocols. Instrument traceability: Risks identified through the HSDU and theatre instrument investigation highlighted the need for strengthened organisational controls to support full instrument traceability. Digital system limitations: Ongoing risks associated with implementation of the Call for

	Concern process due to limitations within current digital systems. Transfusion safety: Risks relating to wrong blood in tube incidents and transfusion sample rejection rates, requiring continued monitoring and divisional oversight. Violence, aggression and sexual safety: Increasing concerns regarding staff safety incidents across clinical services and the need to maintain focus on preventive and mitigating actions. Patient experience and waiting times: Risks associated with prolonged waiting times within urgent and emergency care settings, particularly relating to communication, comfort and overall patient experience.
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Aneurin Bevan University Health Board Key Issues Report			
Board Date:		28 September 2026	
Date of Committee		12 August 2026	Report of: Finance and Performance Committee (Escalation)
Quoracy met:		Yes	
1a	Matters referred to the attention of the Board	Finance and Sustainability Position The Committee noted that delivery confidence within the Health Board's savings programme had improved, with a £5 million increase in schemes assessed as deliverable and a £5 million reduction in high-risk schemes. The forecast year-end position remained a £41 million deficit, supported by delivery of the £45 million savings programme. However, the Committee highlighted that emerging cost pressures had increased to £7.9 million, particularly in relation to urgent and emergency care, workforce costs, variable pay, medical staffing and operational delivery risks. The Committee emphasised that these pressures represented a material risk to delivery of the forecast financial position and required robust mitigation, continued executive oversight and sustained divisional scrutiny. Urgent and Emergency Care Performance The Committee received an update on delivery of the Rapid Release Protocol and the wider urgent and emergency care improvement programme. Improvements were noted in ambulance handover	

		performance and patient flow, with positive learning identified from the Multi-Agency Discharge Event, which had supported additional bed capacity and strengthened partnership working across the system. Whilst progress was acknowledged, the Committee noted that performance remained below the required trajectory and that the current position remained fragile. Continued oversight of the wider urgent and emergency care programme would be required, with focus maintained on patient flow, discharge performance, pathways of care and waiting times, rather than ambulance handover performance alone.
1b	Assurance	Financial Grip and Control The Committee received assurance from completion of the Welsh Government Grip and Control self-assessment, which demonstrated strong compliance across the Health Board's financial control arrangements. Action plans had been issued where improvements were required, with a further reassessment planned at the mid-year point. The Committee received assurance that arrangements were in place to monitor progress, strengthen financial discipline and support continued scrutiny through executive and divisional management arrangements. Savings Delivery Programme The Committee received assurance that progress continued to be made against the £45 million savings programme, supported by an improving risk profile and increasing confidence in delivery. Oversight remains in place through the Value and Sustainability Board and divisional review arrangements, which continue to monitor performance, support delivery and identify further savings and cost mitigation opportunities. Urgent and Emergency Care Improvement The Committee received assurance that delivery of the urgent and emergency care plan is resulting in measurable improvements across a range of indicators, including ambulance handovers, lost ambulance hours and system flow. The Committee noted that performance continues to be monitored through a balanced set of measures, with executive leadership focused on achieving sustainable improvement across the whole system. Clinical Governance and Safety

		The Committee received assurance that proposed pathway changes associated with the urgent and emergency care programme remained subject to clinical leadership and scrutiny through the Clinical Change Group. Patient safety considerations continued to inform decision-making, with pathway developments being evidence-based, tested and evaluated before wider implementation. External Reporting and Recognition The Committee noted that the Health Board had submitted its updated Route Map to Sustainability to Welsh Government following Board approval. The Committee also noted Welsh Government's recognition of progress in relation to savings delivery, whilst acknowledging the continued expectation to contain financial pressures and improve the overall financial position. The Committee further noted that the Health Board had been identified as a potential Vanguard Site for implementation of the Welsh Emergency Care Data Set, reflecting external recognition of the organisation's involvement in emergency care improvement work.
1c	Review of Risks	Financial Sustainability Risk The Committee identified an ongoing risk that emerging operational and workforce-related cost pressures could compromise delivery of the planned year-end financial position. The increase in unmanaged pressures to £7.9 million was recognised as a significant financial risk requiring further mitigating action, continued executive oversight and strengthened divisional grip. Urgent and Emergency Care Risk The Committee reviewed the ongoing risks associated with urgent and emergency care performance, including ambulance handover delays, patient flow, 12-hour waits and delayed pathways of care. Although performance indicators had improved, the Committee recognised that the position remained fragile and that sustained delivery of the urgent and emergency care improvement plan would be required to maintain progress and reduce operational and patient safety risk. Workforce and Rostering Risk The Committee reviewed risks identified through the Grip and Control assessment relating to medical job planning, rostering and workforce deployment. Assurance was received that consultants held agreed job plans and were working to activity plans; however, further work

		was required to strengthen compliance measures, improve workforce visibility and enhance control arrangements. Sustainability of Service Transformation The Committee recognised the risk that improvements achieved through focused interventions, including the Multi-Agency Discharge Event and Sprint Programme, may not be sustained unless embedded within routine operational management arrangements. The Committee emphasised the importance of longer-term solutions through the Older Persons Pathway, development of the acute medical model and strengthened discharge processes. Overall Risk Position The Committee acknowledged positive progress in relation to financial recovery and urgent and emergency care performance. However, it concluded that material risks remained in relation to financial sustainability, operational pressures, workforce controls and the long-term sustainability of recent improvements. Continued Board oversight is therefore required.
1d	Sharing of Learning	Whole-System Patient Flow Learning reinforced the importance of whole-system partnership working, early escalation and coordinated discharge arrangements in improving patient flow and reducing delays. The Committee noted that learning from the Multi-Agency Discharge Event would inform future discharge arrangements and support earlier intervention when system pressures emerged. Staff-Led Improvement Learning highlighted the value of involving frontline teams in the development, testing and refinement of improvement initiatives. The Committee recognised that staff ownership of change had supported practical service improvement and would be important in sustaining progress during future transformation programmes. Continuous Improvement and Adaptation Learning from the urgent and emergency care programme reinforced the importance of a test, learn and adapt approach. The Committee noted that the use of operational experience and performance data had enabled interventions to be refined and focused on areas with the greatest impact. Balanced Performance Reporting Learning highlighted that urgent and emergency care improvement should continue to be assessed through a balanced range of measures, including

		ambulance handovers, lost ambulance hours, patient flow, discharge performance, pathways of care and waiting times. The Committee recognised that a whole-system view would provide a more accurate assessment of improvement and patient impact than reliance on a single metric. Embedding Improvement into Business as Usual The Committee acknowledged that targeted interventions had delivered improvements, but long-term success would depend on embedding learning into routine operational management. Lessons learned would inform future escalation processes, trigger points and earlier intervention to address emerging pressures.
2	Matters to be shared to other Committees	The Committee confirmed that there were no formal matters identified for referral or sharing with other Committees at this stage.

Aneurin Bevan University Health Board Key Issues Report			
Board Date:		28 th September 2026	
Date of Committee		Tuesday 8 th September 2026	Report of: Mental Health and Learning Disabilities
Quoracy met:		Yes	
1	Agenda and papers	Agenda and Papers	
2a	Matters referred to the attention of the Board	Demand, Access and Service Sustainability: The Committee noted continuing growth in demand across Mental Health, Neurodevelopmental, CAMHS and Dementia services. Whilst positive progress continues to be made across several areas, members recognised the ongoing challenge of balancing increasing demand with workforce capacity, service sustainability and financial pressures. Legislative and Policy Developments: The Committee received updates on significant legislative and policy developments, including the Mental Health Act Bill and developments relating to the Mental Capacity Act and Deprivation of Liberty Safeguards. The Committee noted the need for ongoing preparation to support implementation and compliance with future requirements.	

		Outcomes and Service Transformation: The Committee discussed the importance of strengthening outcomes-focused reporting across services, enabling greater understanding of how transformation programmes are improving outcomes and experiences for patients, families and carers. Partnership Working and Community-Based Care: The Committee noted examples of successful partnership working and continued development of community-based and preventative approaches across Mental Health, Learning Disabilities, Neurodevelopmental and Dementia services.
2b	Assurance	Mental Health Services: The Committee received assurance regarding Mental Health Act compliance arrangements, performance management processes and ongoing transformation programmes supporting service quality, access and patient outcomes. Children's, Neurodevelopmental and Learning Disabilities Services: The Committee received assurance regarding the management of demand, delivery of recovery plans and continuing development of community-based and preventative models of care. Mental Capacity Act and Deprivation of Liberty Safeguards: The Committee received assurance regarding statutory compliance, governance arrangements, workforce preparedness and the management of emerging legal developments. Dementia Standards: The Committee received assurance regarding progress in implementing Dementia Standards and the actions being taken to improve services and support for people living with dementia and their carers. Risk and Governance Arrangements: The Committee received assurance that risks continued to be appropriately identified, monitored and managed through established governance and reporting processes.
2c	Review of Risks	The Committee reviewed key areas of risk and noted the following:

		Demand and Capacity: Increasing demand across Mental Health, Neurodevelopmental, CAMHS and Dementia services continues to place pressure on service capacity, waiting times and workforce resilience. Legislative Change: The implementation of Mental Health Act reform and developments within the Mental Capacity legal framework present operational, workforce and governance risks that require ongoing monitoring. Financial Sustainability: The Committee discussed risks associated with maintaining sustainable service models, including reliance on external or time-limited funding arrangements within some service areas. Neurodevelopmental Services: Continued growth in demand for Neurodevelopmental Services remains a challenge for assessment pathways, waiting times and service capacity. Performance and Outcomes: The Committee recognised the need to continue strengthening outcomes-based reporting to support effective oversight of service effectiveness and transformation activity.
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Aneurin Bevan University Health Board Key Issues Report			
Board Date:		28 September 2026	
Date of Committee		09 September 2026	Report of: Finance and Performance Committee (Escalation)
Quoracy met:		Yes	
1a	Matters referred to the attention of the Board	Financial Recovery and Sustainability: The Committee reviewed the latest financial recovery position and noted continued progress against delivery of the £45 million savings programme, with all schemes now assessed as green or amber. Members noted that whilst confidence in savings delivery has improved, the Health Board continues to face significant operational and	

	workforce pressures, including increasing in-year cost pressures. The Committee recognised the challenge of balancing financial recovery requirements with patient safety, service delivery and statutory obligations. Bed Rationalisation and Service Transformation: The Committee received an update on the developing bed rationalisation programme, which aims to reduce variable pay expenditure and improve efficiency through better utilisation of capacity. Members noted that further modelling is being undertaken to ensure any changes are operationally sustainable, particularly in advance of winter pressures. The Committee also heard about opportunities to improve patient flow through strengthened discharge processes and alternative pathways of care. Urgent and Emergency Care Improvement: The Committee noted significant improvements in urgent and emergency care performance following implementation of the Rapid Release Protocol and wider system improvement initiatives. Members heard that August performance represented the strongest position since the opening of The Grange University Hospital, including reductions in ambulance lost hours and improvements in patient flow. The Committee welcomed the progress made whilst recognising the need to sustain improvements during periods of increased demand. System Transformation and Partnership Working: The Committee discussed the importance of whole-system approaches to improving performance, including strengthened collaboration with primary care, community services, local authorities and wider partners. Members noted ongoing development of the Older Persons Pathway, including the forthcoming Caerphilly locality pilot, and recognised the opportunity to reduce avoidable admissions, improve patient outcomes and support care closer to home. The Committee also considered innovative partnership approaches designed to support earlier discharge and reduce unnecessary hospital stays.
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		Winter Resilience: The Committee considered winter preparedness and the challenges associated with balancing financial recovery requirements against anticipated increases in seasonal demand. Members reviewed proposals relating to bed rationalisation, discharge improvement and capacity management, noting that further modelling was underway to assess potential operational impacts. The Committee recognised that maintaining resilience throughout winter would require continued focus on patient flow, discharge pathways and partnership working across the wider system
1 b	Assurance	Financial Governance and Recovery Arrangements: The Committee received assurance that robust governance arrangements remain in place to oversee delivery of the financial recovery plan. Members were assured that savings delivery continues to be scrutinised through established Value and Sustainability Board arrangements, with executive oversight supporting identification of emerging risks, pressures and mitigating actions. The Committee also received assurance that all savings schemes now have identified delivery plans and continue to be monitored through established financial governance processes. Urgent and Emergency Care Performance: The Committee received assurance, supported by performance data, that the urgent and emergency care improvement programme is delivering measurable improvements in ambulance handover performance, patient flow, discharge activity and lost ambulance hours. Members were assured that compliance with the Rapid Release Protocol continues to be monitored through strengthened operational oversight arrangements and executive leadership support. Performance Management Arrangements: The Committee received assurance regarding the monitoring and management of key performance indicators, through regular operational reviews and strengthened reporting arrangements. Assurance was also provided that work is progressing to improve data quality and establish a more consistent single source of performance information to support operational decision-making and pathway management

		System and Partnership Working: The Committee received assurance regarding collaborative arrangements with local authority, primary care and wider system partners to improve discharge processes, pathway management and out-of-hospital care. Members were assured that governance arrangements are in place to support implementation of the Older Persons Pathway, discharge improvement initiatives and partnership models designed to reduce avoidable admissions and delayed discharges.
1c	Review of Risks	Financial Sustainability: The Committee noted ongoing risks associated with delivery of recurrent savings, increasing workforce expenditure, emerging in-year financial pressures and the underlying structural deficit. Members recognised that further recurrent savings opportunities will be required to strengthen the Health Board's financial position and reduce reliance on non-recurrent measures Urgent and Emergency Care Performance: The Committee recognised the risk that recent improvements may not be sustained without continued compliance with agreed protocols, effective discharge processes and whole-system implementation of improvement initiatives. Members noted that periods of increased demand, particularly following bank holidays and during winter, continue to present operational risks. Winter Demand and Capacity: The Committee discussed risks relating to increased seasonal demand, ambulance arrivals, bed capacity and delayed discharge. Members acknowledged the challenge of balancing capacity reductions associated with financial recovery plans against the requirement to maintain safe and resilient services throughout the winter period. Workforce Capacity: The Committee noted risks associated with organisational capacity to deliver financial recovery, urgent and emergency care improvement and wider transformation programmes simultaneously. Members recognised the pressures placed on frontline teams and management capacity in delivering

		multiple change programmes whilst maintaining operational services. System Dependencies: The Committee recognised that delivery of sustainable improvements remains dependent upon effective collaboration across health, social care, primary care and wider system partners. Members also noted risks associated with delays in pathways of care, data sharing limitations and the need for continued partnership support to sustain improvements in patient flow and discharge performance.
1d	Sharing of Learning	Whole-System Partnership Working: Learning reinforced the importance of coordinated multi-agency working in improving patient flow and supporting timely discharge. The Committee noted the positive impact of collaboration across hospital, community, primary care and local authority services, particularly through the Multi-Agency Discharge Event and wider urgent and emergency care improvement programme. Embedding Improvement Through Operational Focus: Learning from the Rapid Release Protocol demonstrated the benefits of clear operational priorities, visible leadership and consistent application of agreed processes. Members noted that improvements were achieved not solely through increased discharge numbers but through stronger process management and improved flow across the system. Staff Engagement and Team-Based Improvement: The Committee reflected on positive feedback from staff involved in improvement activity, recognising the value of multidisciplinary working and providing teams with dedicated time and support to implement change. Learning highlighted the importance of maintaining staff engagement whilst continuing to embed new ways of working into routine practice. Data, Information and Decision-Making: Learning identified the need for a single, shared source of operational information to support pathway management, delayed discharge monitoring and collaborative working with system partners. Members noted that data quality and

		accessibility remain important enablers of sustainable improvement. Sustainability of Improvement: The Committee recognised that targeted interventions such as the Sprint Programme, Multi-Agency Discharge Event and Rapid Release Protocol delivered significant improvements; however, long-term success will depend on embedding learning into routine operational management, maintaining compliance with agreed processes and continuing to focus on patient outcomes and whole-system flow.
2	Matters to be shared to other Committees	The Committee confirmed that there were no formal matters identified for referral or sharing with other Committees at this stage.

Aneurin Bevan University Health Board Key Issues Report			
Board Date:		28 th September 2026	
Date of Committee		15 th September 2026	Report of: The Audit, Risk and Assurance Committee
Quoracy met:		Yes	
1	Agenda and papers	abuhb.nhs.wales/files/key-documents/audit-risk-and-assurance-committee/arac-20260915-final-boardbook-1-pdf/?ts=1789548058412	
2a	Matters referred to the attention of the Board	Consultant Job Planning Assurance: The Committee considered recurring concerns relating to consultant job planning arrangements, which continue to be identified through multiple sources of assurance, including Internal Audit reviews, Counter Fraud work, audit recommendation tracking and other assurance activities. Members noted that findings consistently highlight issues regarding the completion, quality and utilisation of job plans, together with broader concerns regarding the effectiveness of monitoring and oversight arrangements. The Committee expressed significant concern that these issues continue to arise despite repeated management assurances that appropriate arrangements are in place. Members observed that evidence from a range of assurance sources appeared to indicate an ongoing lack of assurance regarding the Health	

	Board's ability to demonstrate effective oversight and control in this area. The Committee was particularly concerned that consultant job planning remains a longstanding issue and that sufficient improvement has not yet been evidenced. Given the significance of the matter and its relevance to workforce governance, operational effectiveness and financial stewardship, the Committee agreed that the issue should be escalated to the Board. The Committee requested that the Board undertake a formal consideration of the level of assurance currently available, determine whether it is sufficiently assured regarding consultant job planning arrangements and agree any further action or oversight required. Risk Management Framework and Risk Appetite: The Committee reviewed and endorsed the revised Risk Management Framework, Risk Management Procedure, Guidance Handbook and Risk Appetite Statement. Members welcomed the significant progress made in the maturity of risk management arrangements but identified the need for further guidance to support consistent application of risk appetite across the organisation, particularly where risks span multiple domains. The Committee also highlighted ongoing debate regarding the treatment of reputation, public confidence and trust within the Risk Appetite Statement and requested that these matters be highlighted for Board consideration. Audit Recommendation Management: The Committee recognised the substantial improvements made in the management and oversight of audit recommendations and approved a revised procedure for extension requests. Members were assured that strengthened quality assurance arrangements would support more realistic implementation dates and reduce the need for recommendation extensions. This represents a significant improvement in the Health Board's governance arrangements. Cancer Services Review: The Committee received the Audit Wales review of Cancer
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		Services. The review recognised considerable effort in managing growing demand and avoiding significant deterioration in performance; however, it identified the need for strengthened long-term cancer service planning, integrated workforce and financial planning, and enhanced use of data and performance information. The Committee agreed that the report should receive further detailed consideration through the Finance and Performance Committee and the Patient Quality and Safety Outcomes Committee.
2b	Assurance	Financial Governance Arrangements: Financial governance arrangements remain effective, with all Financial Control Procedures up to date, no reportable payments exceeding delegated thresholds, continued compliance with Standing Financial Instructions and strong performance against Public Sector Payment Policy requirements. Internal Audit: Internal Audit reported positive progress against the 2026/27 Audit Plan, with no significant concerns identified during the reporting period and a number of reviews concluding with Reasonable Assurance opinions. The Falls Management Audit received a Reasonable Assurance opinion, demonstrating significant improvement since previous reviews, including strengthened policies, oversight arrangements and reporting mechanisms. The Satellite Radiotherapy Centre at Nevill Hall Hospital received a Reasonable Assurance opinion. The facility is operational and delivering services to patients, all previous audit recommendations have been implemented, and the project was delivered within its approved funding envelope. Counter Fraud: Counter Fraud activity continues to provide effective assurance,

		supported by training compliance exceeding 90%, proactive assurance work and positive management responses to identified issues. Audit Recommendations: The revised arrangements for managing audit recommendation implementation and extension requests provide strengthened governance and oversight, supporting continued improvement in recommendation delivery and accountability. External Audit: Audit Wales confirmed completion of the 2025/26 financial accounts audit and provided assurance regarding the ongoing programme of external audit work.
2c	Review of Risks	The Committee reviewed the Committee Risk and Assurance Report and the revised strategic risk structure. Key considerations included: • Endorsement of revised strategic risk statements developed using a bow-tie methodology to strengthen articulation of causes, events and consequences. • Consideration of the alignment between strategic risks, corporate risks, the Integrated Medium-Term Plan and organisational risk appetite. • Discussion on the consistent application of risk appetite across digital, cyber, transformation and innovation-related risks and the need for supplementary guidance where risks span multiple domains. • Consideration of the proposal to de-escalate the Reinforced Autoclaved Aerated Concrete (RAAC) risk at Nevill Hall Hospital from strategic to operational management arrangements, reflecting the view that the risk is now being effectively managed at divisional level. • Assurance that cyber security risks continue to be managed through the existing strategic and corporate risk framework and do not

		require designation as a standalone strategic risk at this time. • Recognition that consultant job planning continues to represent a significant area of assurance concern, with implications for workforce governance, performance management and organisational oversight. The Committee agreed that concerns should be escalated to the Board for further consideration.
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DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 September 2026
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Health Board Risk Management Framework for Approval, and Risk Appetite Statement for Board Consideration
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Director of Corporate Governance
SWYDDOG ADRODD: REPORTING OFFICER:	Head of Corporate Risk and Assurance

Pwrpas yr Adroddiad Purpose of the Report

Ar Gyfer Penderfyniad/For Decision

The purpose of this report is to seek Board approval of the revised Risk Management Framework and, following Board discussion, the Risk Appetite Statement.

The supporting Risk Management Procedure is provided for completeness and to demonstrate how the requirements of the Framework will be implemented operationally.

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The Health Board's risk management documentation has been comprehensively reviewed to ensure that it reflects current governance arrangements, recognised risk management practice and the Health Board's evolving operating environment.

The revised documentation comprises the:

- Risk Management Framework, at Appendix A;
- Risk Appetite Statement, at Appendix B; and
- Risk Management Procedure, at Appendix C.

The revised documentation was considered by the Audit, Risk and Assurance Committee. Comments received from the Committee have been considered and, where appropriate, incorporated into the final versions of the Risk Management Framework and Risk Management Procedure presented to the Board.

The Committee also considered the revised Risk Appetite Statement, with its comments incorporated into the version presented to the Board. As risk appetite is determined by the Board collectively, the Statement is presented for discussion and agreement.

Cefndir / Background

The Risk Management Framework was last approved by the Board in July 2025.

A review has since been undertaken to ensure that the Framework remains current, effective and aligned with the Health Board's governance arrangements and operating environment.

The review resulted in material changes to the Framework and a corresponding update to the supporting Risk Management Procedure.

The Risk Appetite Statement has also been revised to support the consistent application of risk appetite across the Health Board.

Asesiad / Assessment

The revised Framework provides a clearer and more coherent basis for managing risk across the Health Board. It strengthens the alignment between strategic objectives and risk appetite and clarifies responsibilities for risk identification, articulation, assessment, control, assurance, escalation and reporting. It also sets clearer expectations for the management and oversight of risks outside appetite and the relationship between strategic, corporate and operational risks.

The supporting Procedure translates these requirements into operational practice. It is provided to demonstrate how the Framework will be implemented but is not presented for separate Board approval.

The documentation has been reviewed by the Audit, Risk and Assurance Committee, and its feedback has informed the versions presented. This included strengthening the Risk Appetite Statement and clarifying that reputational impact should be considered as a potential consequence of risk rather than as a separate risk or appetite theme.

The Board is asked to consider whether the proposed appetite positions appropriately balance statutory duties and the protection of patients, staff, services and resources with the need to support innovation, transformation and delivery of the Health Board's strategic objectives.

Argymhelliad / Recommendation

The Board is asked to:

- APPROVE the revised Risk Management Framework;
- CONSIDER whether the proposed risk appetite domains, descriptions and thresholds reflect the Board's collective appetite for risk; subject to that discussion,
- APPROVE the revised Risk Appetite Statement or AGREE that further Board consideration is required before approval;

- NOTE the supporting Risk Management Procedure and the operational arrangements for implementation.

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Set out throughout the document, where appropriate
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Committee Audit, Risk and Assurance Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb	No does not meet requirements

Equality Impact Assessment (EIA) completed	An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. Not applicable to this report



Aneurin Bevan University Health Board

Risk Management and Assurance Framework

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out-of-date printed versions of the document. Refer to ABPULSE for the current version.

Contents:

1. Introduction
2. Purpose and Outcomes
3. Scope
4. Principles and Risk Culture
5. Risk Governance and Accountability
6. Risk Management Process
7. Risk Appetite and Tolerance
8. Risk Registers and Board Assurance Framework
9. Reporting, Escalation and De-Escalation
10. Assurance Arrangements
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12. Training and Capability
13. Monitoring Effectiveness and Continuous Improvement
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 - Appendix A - Risk Appetite Statement Summary
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1. Introduction

Aneurin Bevan University Health Board (the Health Board) is committed to good governance, patient safety, quality of care, statutory compliance and the delivery of its strategic objectives. Effective risk management is fundamental to the Health Board's governance framework and system of internal control.

Risk management is not a separate activity. It is an integral part of strategy, planning, operational delivery, clinical and corporate decision-making, improvement, transformation, commissioning, partnership working and performance management.

This Framework sets out the Health Board's mature, integrated approach to identifying, assessing, treating, monitoring, reporting and assuring risk. It aligns risk management, risk appetite, risk registers, the Board Assurance Framework and assurance reporting so that risks to objectives are visible, owned, controlled and escalated appropriately.

2. Purpose and Outcomes

The purpose of this Framework is to define how the Health Board will manage uncertainty in pursuit of its objectives, minimising threats and enabling opportunities within agreed appetite and tolerance.

The intended outcomes are:

- a consistent risk language;
- clear accountability for risk ownership and action;
- proportionate escalation and de-escalation;
- transparent Board oversight;
- evidence-based assurance;
- and a risk-aware culture where staff feel able to identify, discuss and learn from risk.

3. Scope

This Framework applies to all Health Board employees, independent members, contractors, secondees, students, volunteers and any person or organisation undertaking work on behalf of the Health Board. It applies to clinical, operational, strategic, programme, project, financial, workforce, compliance, digital, estates, partnership and emerging risks.

The Framework supports the Health Board's Quality Strategy, Integrated Medium-Term Plan, Performance Management and Accountability Framework, Standing Orders, Standing Financial Instructions and statutory, regulatory and professional obligations.

4. Principles and Risk Culture

The Health Board will apply the following principles to all risk management activity:

- Risk management is integrated into governance, planning, performance, quality, safety and decision-making rather than operated as a standalone process.
- Risk is managed in relation to objectives, outcomes and the interests of patients, service users, staff, communities and partners.
- Risk management is proportionate: the level of analysis, control, assurance and reporting reflects the nature, scale and tolerability of the risk.
- Risk appetite (the level of risk the organisation is willing to accept, which may vary depending on the nature of the activity and risk type) is used actively to guide decisions, prioritise resources and determine whether further action, escalation or acceptance is required.
- Controls and assurances are distinguished clearly: controls reduce risk; assurances provide evidence that controls are designed and operating effectively.
- Risk information is timely, accurate, complete and recorded in Datix as the single source of organisational risk information.
- The Health Board supports a just, learning and psychologically safe culture where risks and control weaknesses can be raised early and acted upon.

5. Risk Governance and Accountability

Risk governance is based on clear ownership, defined escalation routes, regular scrutiny and independent assurance.

The Board retains overall accountability for the effectiveness of risk management and internal control, supported by its committees and Executive Team.

Role / Forum	Core Responsibilities
Board	Set strategic objectives, approve the Framework and Risk Appetite Statement, oversee the Strategic Risk Register and confirm that principal risks are understood and managed within appetite or subject to agreed action.
Audit, Risk and Assurance Committee	Provide independent scrutiny of the effectiveness of risk management, assurance, internal control and governance arrangements; review the Strategic Risk Register / Board Assurance Framework and assurance map.
Board Committees	Scrutinise delegated strategic risks and relevant corporate risks aligned to committee remit; test controls, assurance, gaps, actions, trajectory and appetite alignment.
Chief Executive / Accountable Officer	Ensure an effective system of internal control and risk management is maintained and reflected in the Annual Governance Statement.
Executive Directors	Own strategic and corporate risks within portfolio; ensure risks are assessed, controlled, resourced, reviewed and escalated; ensure divisional arrangements operate effectively.
Director of Corporate Governance	Lead the design, implementation and continuous improvement of the Framework, risk appetite, Board Assurance Framework and corporate risk reporting arrangements.
Head of Corporate Risk and Assurance	Maintain risk methodology, standards, reporting, training, challenge and quality review; support consistent use of Datix and escalation processes.
Risk Owner	Accountable for the risk description, assessment, controls, actions, assurance, appetite alignment, review and reporting of an assigned risk.
Action Owner	Responsible for delivering agreed mitigating actions by target dates and providing evidence of completion or exception reporting.
Risk Leads	Coordinate local risk register quality, support teams, facilitate review meetings and ensure timely escalation or de-escalation.
All staff	Identify, assess, record, manage and escalate risks within their role; comply with controls; report incidents, hazards and control weaknesses.

The Health Board uses a three-lines assurance model to clarify responsibility for managing risk and providing assurance.

Line	Primary Responsibility	Examples of Assurance
First line: operational management	Own and manage risk, operate controls, deliver actions and maintain local risk registers.	Self-assessment, local audits, performance dashboards, quality and safety reviews, control evidence.
Second line: oversight and specialist functions	Set policy and standards, advise, monitor compliance, challenge risk quality and aggregate themes.	Corporate risk review, compliance monitoring, specialist reviews, committee scrutiny, thematic reporting.
Third line: independent assurance	Provide independent and objective assurance on governance, risk management and internal control.	Internal audit, external audit, inspection, regulatory review and independent peer review.

6. Risk Management Process

To support the effective identification, assessment, management and escalation of risks, the Risk Management Procedure can be accessed [here. Add link when approved and uploaded.](#)

The Health Board will apply a consistent risk lifecycle aligned to recognised risk management practice. The lifecycle is iterative: risks are reviewed as objectives, services, controls, evidence and operating conditions change.

1. Establish the context: define the objective, scope, stakeholders, constraints, assumptions, dependencies and relevant appetite theme.
2. Identify the risk: describe the uncertain event or circumstance, its cause, potential consequence and the objective that may be affected.
3. Analyse the risk: assess causes, current controls, likelihood, consequence, inherent risk, current risk and target risk using the approved 5x5 scoring methodology.
4. Evaluate tolerability: compare current and target risk with risk appetite, legal duties, patient safety requirements, control

effectiveness and available assurance.

5. Treat the risk: agree proportionate actions to tolerate, treat, transfer, terminate or take the opportunity, with clear owners, target dates and expected impact.
6. Monitor and review: review controls, action progress, assurance findings, score movement, risk velocity, proximity and whether escalation or de-escalation is required.
7. Communicate and report: ensure relevant teams, committees and the Board receive meaningful risk information that supports decisions and accountability.

Risk descriptions should use a consistent structure:

There is a risk that [event or loss of control] due to [cause(s) or threat(s)], leading to [consequence(s) affecting the relevant objective(s)].

Consequences may include effects on patient safety, quality, finance, performance, compliance, people, public confidence or stakeholder relationships. The primary risk category and risk appetite theme should reflect the source of uncertainty or principal objective affected, rather than a downstream consequence. Reputational damage or loss of confidence should not normally be stated as the risk event.

Risk owners must consider whether risks are malicious or non-malicious in nature. Malicious risks, such as cyber-attack, fraud, violence or deliberate data compromise, require controls and assurances that differ from non-malicious risks such as human error, equipment failure, demand variation or adverse weather.

7. Risk Appetite and Tolerance

Risk appetite is the amount and type of risk that the Health Board is willing to seek, accept or tolerate in pursuit of its objectives. Risk tolerance is the specific threshold at which a risk is considered within or outside appetite and therefore requires acceptance, treatment, escalation or de-escalation.

Risk appetite must be used when setting strategy, approving business cases, designing services, planning transformation, entering partnerships, reviewing performance, prioritising investment and deciding whether residual risk can be accepted.

The Board-approved appetite levels, thresholds and themes are set out in the standalone Risk Appetite Statement. *Add link when approved and uploaded.*

Each risk must be aligned to the appetite theme that best reflects its principal source of uncertainty or the objective most materially affected. Consequences such as financial loss, regulatory action or loss of public confidence should be recorded within the impact assessment and should not normally determine the appetite theme. Where more than one theme is relevant, the primary theme and rationale must be recorded, together with any material secondary impacts

Any risk operating outside the Board's agreed risk appetite must have a documented rationale, named Executive Lead, agreed treatment plan, review frequency, and reporting route. Acceptance of an out-of-appetite risk must be explicit, time-bound, and subject to regular review.

Further detail can be found at Appendix A.

8. Risk Registers and Board Assurance Framework

Datix is the Health Board's single system for recording and maintaining organisational risk information. All risks must be recorded, reviewed and reported using Datix to support consistency, aggregation, scrutiny and auditability.

Register	Purpose	Typical Criteria / Ownership
Strategic Risk Register	Captures principal risks to delivery of strategic priorities and annual objectives, with controls, assurances, gaps and actions.	Owned by Executive Directors and scrutinised by Board and committees. Acts as the Board Assurance Framework.
Corporate Risk Register	Captures significant operational risks requiring Executive Team oversight, cross-organisational coordination or resources beyond divisional control.	Normally score 15 or above, or lower where significance, sensitivity, aggregation or control weakness warrants escalation.
Divisional Risk Registers	Capture risks that exceed directorate or service capability or require divisional ownership, prioritisation and coordination.	Typically score 8-12, but professional judgement applies.
Directorate / Local Risk Registers	Capture operational risks that can be managed within the service, ward, department or directorate.	Typically score 1-6, with escalation where control gaps or trajectory exceed local capacity.

Register	Purpose	Typical Criteria / Ownership
Thematic Risk Registers	Capture specialist risk areas such as health and safety, quality and patient safety, emergency planning, information governance or digital.	Managed by the relevant specialist group or committee with links to operational registers.
Programme and Project Risk Registers	Capture risks to programme or project objectives, benefits, milestones, resources or dependencies.	Managed by project boards; escalated to organisational registers where service delivery, safety, compliance or strategic objectives are threatened.

Escalation is not determined by risk score alone. Risks should remain at the lowest appropriate level within the organisation, provided they can be effectively owned, managed and mitigated.

A risk should be considered for escalation where it exceeds local capability, capacity, authority or resources; requires decisions or intervention from a higher level of management; has cross-cutting implications across multiple services, divisions or directorates; falls outside the agreed risk appetite; or poses a significant threat to patient safety, statutory compliance, service delivery or the achievement of strategic objectives.

Escalation should not be viewed simply as the transfer of a risk from one risk register to another. As risks move through the organisation, the perspective from which they are assessed may change. Whilst the underlying risk theme may remain the same, the scope, causes, consequences, controls and assurance requirements are likely to differ depending on the level at which the risk is being managed.

For example, a divisional risk relating to planned care performance may focus on local workforce, capacity and operational delivery. If escalated to the Corporate Risk Register, the risk may be reframed to reflect Health Board-wide performance, strategic objectives, regulatory requirements and Executive accountability.

The purpose of escalation is therefore to ensure that risks are considered and managed at the level where the causes, consequences and required actions can be most effectively addressed. Escalation does not remove the requirement to manage the risk at the level where it manifests, and local controls and mitigating actions should remain in place unless superseded by higher-level arrangements.

9. Reporting, Escalation and De-escalation

Risk reporting must provide insight rather than simply list risks. Reports should explain risk movement, material control gaps, assurance gaps, action slippage, appetite position, emerging risks, clusters, cumulative exposure and decisions required.

Forum	Risk Information Received	Minimum Frequency
Board	Strategic Risk Register / Board Assurance Framework, risk appetite exceptions, principal risk movement and assurance gaps.	Each formal Board meeting unless otherwise agreed.
Audit, Risk and Assurance Committee	Whole-system assurance on risk management, internal control, assurance mapping, audit findings and strategic risk.	Each meeting.
Board Committees	Delegated strategic risks and relevant corporate risks aligned to committee remit.	Each meeting.
Executive Committee	Corporate Risk Register, escalations, de-escalations, cross-cutting risks, action exceptions and emerging risks.	At least bi-monthly or as required by risk profile.
Divisional / Directorate Governance Forums	Local and divisional registers, new risks, overdue reviews, action exceptions and escalation decisions.	Monthly or in line with governance cycle.
Project Boards	Project risk registers, dependency risks, benefits risks and service-impact escalations.	At each project board meeting.

Immediate escalation outside the routine cycle is required where a risk presents imminent danger, potential serious harm, major service disruption, statutory non-compliance, significant financial exposure, cyber or information compromise, or a material and sustained threat to public or stakeholder confidence that could affect delivery or require urgent Executive action.

De-escalation should occur when controls are effective, risk exposure has reduced, actions have been completed, assurance evidence is available, and ownership can safely return to the lower level. The rationale for de-escalation must be recorded in Datix.

10. Assurance Arrangements

Assurance provides evidence that controls are designed appropriately and operating effectively. A mature risk framework distinguishes between controls, gaps in control, sources of assurance and gaps in assurance.

Element	Definition	Minimum Expectation
Controls	Measures that reduce likelihood, consequence or exposure.	Controls are current, specific, owned and capable of being evidenced.
Control gaps	Known weaknesses in design, implementation, coverage or capacity of controls.	Gaps are recorded with actions, owners, dates and expected impact.
Assurances	Evidence that controls exist and are working.	Assurance is mapped across first, second and third lines and linked to each principal risk.
Assurance gaps	Areas where evidence is insufficient, outdated, incomplete or not independent enough.	Gaps are reported to the relevant committee with planned sources of assurance.

Risk trajectory describes the expected direction of travel of a risk over time, taking into account the effectiveness of controls, progress in delivering mitigating actions and the strength of assurance. It provides a forward-looking assessment of whether the risk is improving, stable or deteriorating and whether it is on course to achieve its target risk within the agreed timescale.

The Strategic Risk Register must identify for each strategic risk:

- strategic objective affected;
- executive owner;
- inherent, current and target scores;
- appetite theme and tolerance threshold;
- key controls; control gaps;
- sources of assurance; assurance gaps;
- actions;
- trajectory; and,
- committee oversight route.

11. Implementation and Embedding

The Corporate Governance Directorate, led by the Director of Corporate Governance, will coordinate implementation of this Framework.

Implementation will focus on capability, consistency, cultural adoption, reporting quality and assurance maturity, as set out below:

- Embed risk consideration into strategy, IMTP development, annual planning, quality impact assessment, service change, business cases, financial recovery, procurement, partnership decisions and programme governance.
- Use Datix to maintain a single source of truth and improve the quality, timeliness and consistency of risk data.
- Provide targeted support to teams and services to improve risk descriptions, scoring, controls, actions, assurance and escalation discipline.
- Develop thematic risk analysis and cumulative exposure reporting to identify clusters, dependencies and systemic vulnerabilities.
- Use lessons from incidents, complaints, claims, inquests, audit, inspection, staff feedback and performance intelligence to update risk profiles.

12. Training and Capability

Risk management training will be role-based and proportionate. All staff should understand how to identify, manage and escalate risks relevant to their role. Risk owners, risk leads, senior leaders and Board members require additional capability to discharge their responsibilities effectively.

Audience	Training / Support Requirement
All staff	Awareness of risk identification, incident and hazard reporting, local controls and escalation routes through induction and refresher communications.
Risk owners and action owners	Risk description, scoring, appetite, controls, action planning, assurance, Datix updates and reporting expectations.
Risk leads and governance teams	Register quality review, moderation, escalation, trend analysis, thematic reporting and committee support.
Executive Directors and senior leaders	Strategic risk, risk appetite, risk acceptance, assurance mapping, accountability and decision-making.
Board and committee members	Risk appetite, Board Assurance Framework, scrutiny of controls and assurance, strategic risk oversight and risk culture.

Board members will receive risk management development individually and collectively, including at induction and at least every two years. The

Corporate Governance Directorate will provide ongoing advice, coaching and quality review.

13. Monitoring Effectiveness and Continuous Improvement

The effectiveness of the Framework will be assessed through routine oversight by the Board, Audit, Risk and Assurance Committee, Executive Committee and relevant management forums, supported by internal audit, external audit and regulatory findings.

Measure	Indicator of Maturity
Risk register quality	Risks use the agreed cause-event-impact structure; controls and actions are specific; reviews are timely; appetite alignment is recorded.
Action delivery	Mitigating actions are completed on time or subject to clear exception reporting and revised trajectories.
Assurance quality	Strategic risks show mapped controls, assurance sources and gaps across the three lines.
Escalation discipline	Escalations and de-escalations are timely, justified and recorded.
Risk appetite use	Reports identify risks outside appetite and decisions explicitly reference risk appetite.
Learning and improvement	Lessons from incidents, audit, inspection, claims and performance intelligence are reflected in risks and controls.
Data quality	Datix contains complete, accurate, current and auditable risk information.

The Framework will be reviewed bi-annually, or sooner where there are material changes in strategy, legislation, regulation, standards, organisational structure, operating environment or the Health Board's risk profile.

14. Supporting Documents

- Risk Management Procedure

- Risk Appetite Statement
- Guidance Note for Risk Assessment and Management
- Guidance for Using the electronic Risk Management System
- Performance Management and Accountability Framework
- Standing Orders and Standing Financial Instructions
- Quality Strategy and Integrated Medium-Term Plan

15. References

- International Organisation for Standardisation, ISO 31000:2018 Risk management - Guidelines.
- HM Treasury, The Orange Book: Management of Risk - Principles and Concepts, July 2026.
- Good Governance Institute, Risk Appetite for NHS Organisations, 2019.
- NHS Wales 5x5 Risk Scoring Matrix and related national guidance.
- Audit Wales structured assessment methodology and NHS Wales governance guidance.
- National Security Risk Assessment and relevant cyber, information governance and emergency planning guidance.

16. Appendices

- Appendix A - Risk Appetite Statement Summary
- Appendix B - Minimum Risk Register Data Standards
- Appendix C - Risk Maturity Model

Appendix A - Risk Appetite Statement

The Board-approved Risk Appetite Statement is a standalone controlled document and forms part of this Framework. It sets out the current appetite levels, thresholds and themes and should be read alongside this Framework.

It will undergo a full review at least every three years, or sooner where there is a material change, with its continued appropriateness considered annually through review of the Strategic Risk Register and Board Assurance Framework.

Risks above threshold must be identified as outside appetite and reported with a treatment plan, target position, owner, review frequency and decision required.

Where the Board or an executive forum accepts a risk outside appetite, acceptance must be explicit, time-bound and recorded.

[Risk Appetite Statement](#)

Appendix B - Minimum Risk Register Data Standards

Field	Minimum standard
Risk title	Clear and concise summary of the risk.
Risk description	Uses cause-event-impact structure and links to an objective or outcome.
Risk category and appetite theme	Selected according to the principal source of uncertainty and objective affected.
Owner	Named accountable owner with authority to manage or escalate the risk.
Lead	Named person coordinating the day-day management, monitoring and maintenance of the risk on behalf of the Risk Owner.
Initial, current and target scores	Assessed using the approved 5x5 matrix with rationale.
Controls	Specific, current controls that are actually in operation.
Control gaps	Known weaknesses in control design, implementation or effectiveness.
Assurances	Evidence that controls are operating, mapped where appropriate across the three lines.
Assurance gaps	Areas where evidence is missing, outdated or insufficiently independent.
Actions	SMART actions with owner, due date, expected impact and status.
Review date and frequency	Frequency reflects score, volatility, proximity, appetite and control strength.
Trajectory and proximity	Direction of travel and likely timing of impact are recorded where relevant.
Escalation / de-escalation rationale	Decision and rationale recorded, including forum and date.

Appendix C - Risk Maturity Model

Maturity level	Characteristics	Evidence
1. Initial	Risk activity is inconsistent, person-dependent and reactive. Registers are incomplete or out of date.	Limited Datix use; weak action tracking; risks not linked to objectives.
2. Developing	Common templates and governance routes exist, but quality and review discipline vary.	Some timely reviews; inconsistent controls and assurance; variable scoring moderation.
3. Established	Consistent process, clear ownership, routine reporting and escalation are in place.	Active registers; committee oversight; risk appetite recorded; action tracking.
4. Managed	Risk information informs decisions, priorities and resource allocation. Assurance gaps and cumulative exposure are visible.	BAF quality reviews; assurance mapping; thematic analysis; improvement plans.
5. Optimising	Risk management is dynamic, predictive and embedded in culture, planning and learning.	KRIs, horizon scanning, scenario analysis, triangulated intelligence and demonstrable continuous improvement.

Appendix D – Glossary of Terms

Term	Description
Board Assurance Framework (BAF)	A structured approach used by the Board to understand principal risks to strategic objectives, the adequacy of controls, and the level of assurance available (represented through the Strategic Risk Register).
Datix	The Health Board's electronic system used as the single source of organisational risk information.
De-escalation	The process of moving a risk to a lower level of management when it can be effectively controlled and managed within that level.
Escalation	The process of raising a risk to a higher level of management when it exceeds local authority, capacity, appetite or impact thresholds.
Initial Risk	The level of risk before any controls are applied.
Mitigating Action	An action taken to reduce the likelihood or impact of a risk.
Residual (Current) Risk	The level of risk remaining after controls have been applied.
Risk	The effect of uncertainty on objectives, described in terms of cause, event and impact.
Risk Appetite Themes	Areas of organisational activity or objectives against which the Board sets the amount of residual risk it is willing to accept. The selected theme should reflect the principal source of uncertainty or objective affected, rather than a downstream consequence
Risk Assessment	The systematic process of identifying, analysing and evaluating risks, including their likelihood and impact.
Risk Description	A structured statement of a risk using cause–event–impact format.
Risk Lifecycle	The continuous process of identifying, analysing, evaluating, treating, monitoring and reporting risks.
Risk Management	The coordinated activities to direct and control the organisation with regard to risk.
Risk Register	A structured record of identified risks, including their assessment, controls, actions, assurances and ownership.
Risk Scoring (5x5 Matrix)	A method of assessing risk based on likelihood and consequence, typically producing a numerical score
Risk Tolerance	The threshold at which a risk is considered acceptable or requires further action or escalation.
Target Risk	The desired level of risk after further mitigating actions have been implemented.



Aneurin Bevan University Health Board

Risk Appetite Statement

September 2026

Contents:

The main body explains how risk appetite is determined and applied. Appendix A sets out the Board risk appetite parameters proposed for approval and subsequent application to defined exposures.

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Introduction

Risk is the effect of uncertainty on Aneurin Bevan University Health Board's ability to achieve its objectives. Uncertainty can create threats to delivery and opportunities to improve outcomes. Effective risk management supports informed choices about both.

Risk appetite describes the nature and extent of risk the Health Board is willing to take or retain in pursuit of its objectives. It provides direction for planning, prioritisation, resource allocation and day-to-day decisions. It does not replace professional judgement, statutory duties, mandatory safety requirements or the need to assess each risk on its own facts.

Purpose

This Statement establishes the Board's appetite parameters and explains how they must be applied across strategic, corporate and operational risks and to material decisions, options, programmes and projects.

It should be read with the Risk Management and Assurance Framework, Risk Management Procedure, Risk Handbook and the Health Board's risk scoring methodology.

Core principles:

- Appetite must be tailored and proportionate to the objective, decision, context and nature of the exposure.
- Appetite applies to the individual risk exposure, not simply to the broad category used to organise the risk register.
- Risk taxonomies, themes and categories support identification, aggregation, analysis and reporting. They do not require every risk within a broad theme to have the same appetite level.
- A broad theme may contain defined subthemes with different Board-approved appetite levels, thresholds and qualitative boundaries.
- Each current residual exposure and its target position must be compared with the parameter that applies to that exposure.
- Where more than one parameter materially applies, the risk is within appetite only when all relevant boundaries are met. The most restrictive applicable threshold will therefore govern the overall status unless the

Board has explicitly approved a different treatment.

- A numerical score is an indicator, not an automatic permission to accept a risk. The qualitative boundary, strength of controls and assurance, statutory duties and potential for harm must also be considered.
- A higher appetite for innovation or transformation cannot be used to override a lower appetite for patient safety, compliance, cyber security, data integrity or other protected exposures.

Risk Appetite Levels and Thresholds

The Board uses five appetite levels. The level expresses the Board's attitude to a defined exposure; the threshold translates that attitude into the Health Board's 5 by 5 scoring methodology. The score and the qualitative conditions must be considered together.

Term	Meaning
Risk appetite	The nature and extent of risk the Health Board is willing to take or retain to achieve its objectives.
Appetite threshold	The maximum current residual score ordinarily regarded as within appetite for a defined exposure. It is a decision boundary rather than a target.
Current residual exposure	The level of risk remaining after current controls are taken into account. This is the principal score compared with appetite.
Target exposure	The intended level after further treatment. It should normally be within appetite and supported by a credible delivery plan.
Outside appetite	The current exposure exceeds the applicable threshold or fails a qualitative boundary. Formal acceptance does not change the appetite or make the risk 'within appetite'.

Appetite level	Maximum score ordinarily within appetite	Interpretation
Averse	5 or below	Only minimal exposure is acceptable. Avoid, stop or reduce the exposure promptly where reasonably practicable. There is no appetite for deliberate or avoidable non-compliance or preventable serious harm.
Limited	8 or below	Low exposure may be retained where it is necessary, well understood and supported by strong controls, close oversight and reliable assurance.
Measured	12 or below	Moderate exposure may be accepted where the benefits and alternatives have been assessed and controls, assurance and monitoring are proportionate.
Progressive	16 or below	Higher exposure may be accepted for a clear strategic benefit, with Executive ownership, a credible mitigation and contingency plan and frequent review.
Transformational	20 or below	Significant exposure may be taken for substantial strategic or system benefit, with explicit Board oversight, staged decision points, strong evidence and the ability to intervene or exit.

How Thresholds Must Be Used:

- A risk is within appetite only when its current score is at or below the applicable threshold and the qualitative conditions are satisfied.
- A score within the threshold does not make an exposure acceptable where a statutory duty, mandatory standard or other non-negotiable boundary is breached.
- The target should normally be within appetite. If this is not reasonably achievable, the proposed target and continuing exposure require explicit, time-bound acceptance through the appropriate governance route.

Organising and Applying Appetite

Central rule: The taxonomy organises risks; the appetite parameter judges exposure. A risk must not be assigned an appetite level simply because it has been placed under a broad theme.

The appetite themes in this Statement provide a common taxonomy for the Health Board's risk profile. Supporting categories or subcategories may be maintained through the Framework, Procedure or risk system to improve identification and analysis.

Adding or renaming a category does not change the Board's appetite. Any change to an appetite level, threshold or qualitative boundary requires Board approval.

Risks Spanning More Than One Appetite Theme or Subtheme

Where a risk gives rise to material exposures across more than one appetite theme or subtheme, it will be assigned a primary theme for taxonomy, ownership and reporting purposes, based on the principal source of uncertainty, top event or objective affected. This classification does not determine or displace the appetite applicable to other material exposures.

Each material exposure must be assessed against its relevant Board-approved qualitative boundary and, where applicable, numerical threshold. Both the current residual exposure and target exposure must be compared with each applicable appetite parameter. A risk will be regarded as within appetite only where all its material exposures are within their respective boundaries. A higher appetite in one area cannot offset an exposure outside a lower appetite in another area, and appetite levels must not be averaged.

The most adverse applicable comparison will determine the overall appetite status. However, an appetite parameter is applicable only where the exposure is credible and material; it should not be applied merely because a theme is mentioned as a remote or incidental consequence. Where exposures have materially different top events, causal pathways, owners, controls or treatment plans, they should be recorded as separate but linked risks.

Where any material exposure is outside appetite, the risk record must identify the affected appetite parameter, the reasons for the position, the required controls and treatment actions, the accountable owners, the intended target position and the escalation or acceptance arrangements. Any acceptance must be explicit, time-bound and subject to review, and does not alter the underlying appetite or reclassify the exposure as within appetite

Step	Requirement	Application
1	Define the exposure	Identify the objective at risk, the uncertain event or loss of control, its principal causes and its material consequences. Distinguish the exposure from an existing issue and from its impacts.
2	Map the risk for reporting	Assign the primary theme or subtheme that best reflects the principal source of uncertainty, top event or objective affected. Record other material themes and consequences; do not use a consequence alone to determine the primary category.
3	Select the applicable appetite parameter	Use the most specific Board-approved subtheme in Appendix A. Where several exposures are material, identify every relevant parameter rather than selecting the most permissive one.
4	Compare current and target exposure	Compare the current residual score and target score with the relevant numerical threshold and qualitative boundary. Consider control effectiveness, assurance, legal duties, safety requirements and the timing and proximity of the risk.
5	Record the decision and response	State whether the risk is within or outside appetite, the evidence and rationale, the treatment or acceptance decision, the accountable owner, review date and reporting route.

Risk Appetite Themes and Consequences

The themes below provide the Health Board's high-level taxonomy. They are deliberately broad enough to support an aggregated view of the risk profile. Where a theme contains exposures with materially different characteristics, Appendix A divides it into subthemes and assigns separate appetite parameters.

Broad Appetite Theme	Examples of distinct exposures within the theme
Patient safety and quality	Patient safety, safeguarding and mandatory clinical standards; evidence-based quality improvement and clinical innovation.

Broad Appetite Theme	Examples of distinct exposures within the theme
Workforce	Staff health, safety, wellbeing and statutory requirements; workforce capacity, capability, role redesign and new ways of working.
Service delivery and performance	Essential service continuity and timely access where delay may cause harm; performance improvement, pathways and service redesign.
Financial sustainability	Statutory financial duties, probity and financial control; investment, productivity and value improvement.
Digital data and cyber	Cyber security, information governance, data integrity and critical system resilience; digital transformation, automation and new technology.
Estates and infrastructure	Statutory safety and compliance, critical infrastructure and equipment; capital investment, modernisation and rationalisation.
Transformation and innovation	Programme delivery and benefits realisation; strategic transformation and innovation opportunities.
Partnerships and system working	Accountability, governance and safety in joint arrangements; integration, collaboration and shared delivery models.
Governance accountability and compliance	Legal, statutory, regulatory and professional duties; governance effectiveness, accountability, records and assurance.

Reputation Public Confidence and Stakeholder Trust

Reputation, public confidence and stakeholder trust are normally consequences of how an underlying risk is managed. They are therefore cross-cutting impact domains and are not assigned a separate appetite level or threshold. Material effects on confidence or relationships should be recorded and reported, while the underlying source of risk is managed under the relevant appetite parameter.

The Health Board will not avoid a necessary, evidence-based decision solely because it may attract scrutiny or criticism. Where loss of public confidence is genuinely the uncertain event rather than a consequence, it must be articulated with distinct causes, controls and consequences and mapped to the most relevant underlying theme. This does not create a separate reputation appetite.

Managing Risks Outside Appetite

A risk is outside appetite when its current residual exposure exceeds an applicable threshold or fails a qualitative boundary. This is not an automatic instruction to stop the activity; it is a clear signal that the exposure cannot be accepted tacitly and requires a documented response, appropriate escalation and enhanced oversight.

Acceptance above appetite is a time-bound governance decision to retain a defined exposure while further action is taken or where additional reduction is not reasonably practicable. It does not alter the Board's appetite, reduce the recorded score or remove the requirement to manage the risk.

Required information:

Requirement	What must be recorded and reported
Applicable parameter	The relevant subtheme, appetite level, numerical threshold and qualitative boundary.
Exposure	The current and target scores, trajectory, proximity and material consequences, including any cross-cutting impacts.
Rationale	Why the exposure exists, the expected benefit or statutory and operational necessity, alternatives considered and why immediate reduction is not reasonably practicable.
Controls and assurance	The effectiveness of current controls, the evidence supporting that assessment, assurance gaps and any limits or uncertainty in the information.
Treatment plan	Specific actions, named owners, resources, milestones, target dates, expected effect on risk and contingency or escalation triggers.
Accountability	The named Executive owner, decision-making authority, reporting route, review frequency and date on which the acceptance expires or must be reconsidered.

For a risk spanning more than one appetite theme or subtheme, the risk record must identify which appetite parameter is exceeded and the controls, assurance, treatment actions and accountable owners relating to that exposure.

Approval and ongoing management

The Board must explicitly consider and accept any strategic risk that remains outside appetite. Corporate and operational risks must follow the delegated approval and escalation routes in the Risk Management Procedure, with

matters beyond delegated authority referred upwards.

Acceptance must be reviewed at the agreed frequency and whenever the exposure, evidence, operating environment or expected benefit changes. It ends on the stated expiry date unless formally renewed.

Escalation changes accountability and oversight; it does not remove responsibility for operating the controls where the risk is manifesting. Services must continue to manage and mitigate the risk at source.

Monitoring Reporting and Review

Risk reports must enable the Board, its committees and management forums to judge whether decisions and exposures remain within the Board's appetite and whether controls, assurance, resources or priorities need to change.

Minimum reporting information

- the primary taxonomy theme and subtheme, together with any other material appetite parameters that apply;
- the current and target risk scores, the applicable threshold, qualitative boundary and clear within or outside appetite status;
- the risk trajectory, proximity and material changes since the previous review;
- the effectiveness of key controls, the strength of assurance and any control or assurance gaps;
- treatment actions, milestones, accountable owners, target dates and the expected effect on exposure;
- the rationale, authority, review date and expiry of any time-bound acceptance outside appetite;
- clusters, interdependencies and cumulative exposure across themes, services and objectives; and
- material or recurring consequences for public confidence and stakeholder relationships, reported as cross-cutting impacts rather than as a separate appetite theme.

Review of this Statement

The Board will formally review this Statement at least every three years. It will also confirm annually, through its review of the Strategic Risk Register and Board Assurance Framework, whether the appetite parameters remain appropriate for the Health Board's objectives and risk profile.

An earlier review will be undertaken following a material change in strategy, statutory responsibilities, operating conditions, risk profile or the effectiveness of the framework, or where experience shows that an appetite parameter is no longer supporting sound decisions.

Changes to appetite levels, thresholds or qualitative boundaries require Board approval. The supporting taxonomy may be refined without changing appetite, provided the mapping to Board-approved parameters remains clear.

Related Documents and Guidance

- Aneurin Bevan University Health Board Risk Management and Assurance Framework
- Aneurin Bevan University Health Board Risk Management Procedure
- [HM Treasury and Government Finance Function The Orange Book Management of Risk Principles and Concepts updated July 2026](#)

Appendix A: Board Risk Appetite Parameters

The parameters below apply to the defined exposure, not automatically to every risk placed within the broad theme. Where more than one row materially applies, each exposure must be tested and the most restrictive applicable threshold governs the overall appetite status. The qualitative boundary always applies alongside the score.

Broad theme	Defined exposure or subtheme	Appetite	Maximum current score	Qualitative boundary
Patient Safety & Quality	Patient safety, safeguarding and mandatory clinical standards	Limited	8 or below	Exposure is accepted only where it is unavoidable in delivering care, controls are designed to prevent harm, statutory and professional duties are demonstrably met and assurance is timely and reliable. A score within 8 is not acceptable where a mandatory safety requirement is breached.
Patient Safety & Quality	Evidence-based quality improvement and clinical innovation	Measured	12 or below	Moderate exposure may be accepted where the intended benefit is clear, evaluation and clinical governance are in place, and the Limited parameters for patient safety, safeguarding and mandatory standards remain satisfied.
Workforce	Staff health, safety, wellbeing and statutory workforce requirements	Limited	8 or below	Only low exposure is acceptable. There is no appetite for avoidable breach or unmanaged risk of serious harm. Responsibilities, safe systems of work, workforce data and assurance must be clear.
Workforce	Workforce capacity, capability, role redesign and new ways of working	Measured	12 or below	Moderate exposure may be accepted where capability, competence, supervision, consultation and equality and safety impacts are addressed through a credible workforce plan.
Service Delivery & Performance	Essential service continuity and timely access where delay may cause harm	Limited	8 or below	Only low exposure is acceptable. Capacity, escalation, continuity and recovery arrangements must be in place, with surveillance of harm and clear triggers for intervention.

Broad theme	Defined exposure or subtheme	Appetite	Maximum current score	Qualitative boundary
Service Delivery & Performance	Performance improvement, productivity, pathways and service redesign	Measured	12 or below	Moderate exposure may be accepted where the evidence, benefits, milestones and dependencies are clear and the change does not compromise patient safety, quality or statutory requirements.
Financial sustainability	Statutory financial duties, probity and financial control	Limited	8 or below	Only low exposure is acceptable. There is no appetite for deliberate breach or weak financial control. Forecasts, recovery arrangements, delegated authority and assurance must support informed decisions.
Financial sustainability	Investment, productivity and value improvement	Measured	12 or below	Moderate exposure may be accepted where affordability, sensitivity, opportunity cost, benefits and exit options have been assessed and financial and service consequences are actively monitored.
Digital Data & Cyber	Cyber security, information governance, privacy, data integrity and critical system resilience	Limited	8 or below	Only low exposure is acceptable. Security, privacy and resilience must be designed into the service, legal and clinical safety requirements must be met and independent assurance and tested recovery arrangements must be available.
Digital Data & Cyber	Digital transformation, automation and responsible adoption of new technology	Progressive	16 or below	Higher exposure may be accepted for clear patient, workforce or productivity benefit, with staged implementation, clinical safety and human oversight, effective rollback arrangements and full compliance with the Limited cyber, information governance and data parameters.
Estates & Infrastructure	Statutory safety and compliance, critical infrastructure and medical equipment	Limited	8 or below	Only low exposure is acceptable. Statutory compliance, maintenance, inspection, business continuity and prioritisation of critical assets must be supported by reliable assurance.
Estates & Infrastructure	Capital investment, modernisation, rationalisation and decarbonisation	Measured	12 or below	Moderate exposure may be accepted where the option appraisal, affordability, safety, deliverability, lifecycle impact and continuity arrangements are clear and monitored.

Broad theme	Defined exposure or subtheme	Appetite	Maximum current score	Qualitative boundary
Transformation & Innovation	Programme delivery, implementation and benefits realisation	Progressive	16 or below	Higher exposure may be accepted where there is clear sponsorship, an evidence-based case for change, defined outcomes, effective governance, dependency management, stage gates and contingency plans.
Transformation & Innovation	Strategic transformation and innovation opportunities	Transformational	20 or below	Significant exposure may be taken for substantial strategic or system benefit, with explicit Board oversight, staged decisions, robust evidence and a credible ability to adapt, pause or exit. Lower appetite parameters for safety, compliance and resilience continue to apply.
Partnerships & System Working	Statutory accountability, governance and safety in joint arrangements	Limited	8 or below	Only low exposure is acceptable. Duties, ownership, decision rights, information sharing, escalation and assurance must be explicit and must remain effective across organisational boundaries.
Partnerships & System Working	Integration, collaboration and shared delivery models	Progressive	16 or below	Higher exposure may be accepted for clear population health or system benefit where outcomes, risk allocation, governance, performance measures, dispute resolution and exit arrangements are agreed.
Governance, Accountability & Compliance	Legal, statutory, regulatory and professional compliance	Averse	5 or below	Only minimal exposure is acceptable. There is no appetite for deliberate or avoidable non-compliance. Suspected or actual breach requires prompt escalation, containment, remediation and transparent reporting.



Risk Management Procedure

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out-of-date printed versions of the document. Refer to ABPULSE for the current version

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1 INTRODUCTION

Aneurin Bevan University Health Board (the Health Board) is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of the health board's governance framework and system of internal control.

Risk management is essential, not only for providing a safe environment and improved quality of care for service users and staff, but also for the achievement of the organisation's strategic goals, corporate and clinical objectives.

The Health Board views risk management as an integral part of the overall management process, rather than as a separate arrangement, and is committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of the Health Board's thinking and activities.

2 SCOPE OF PROCEDURE

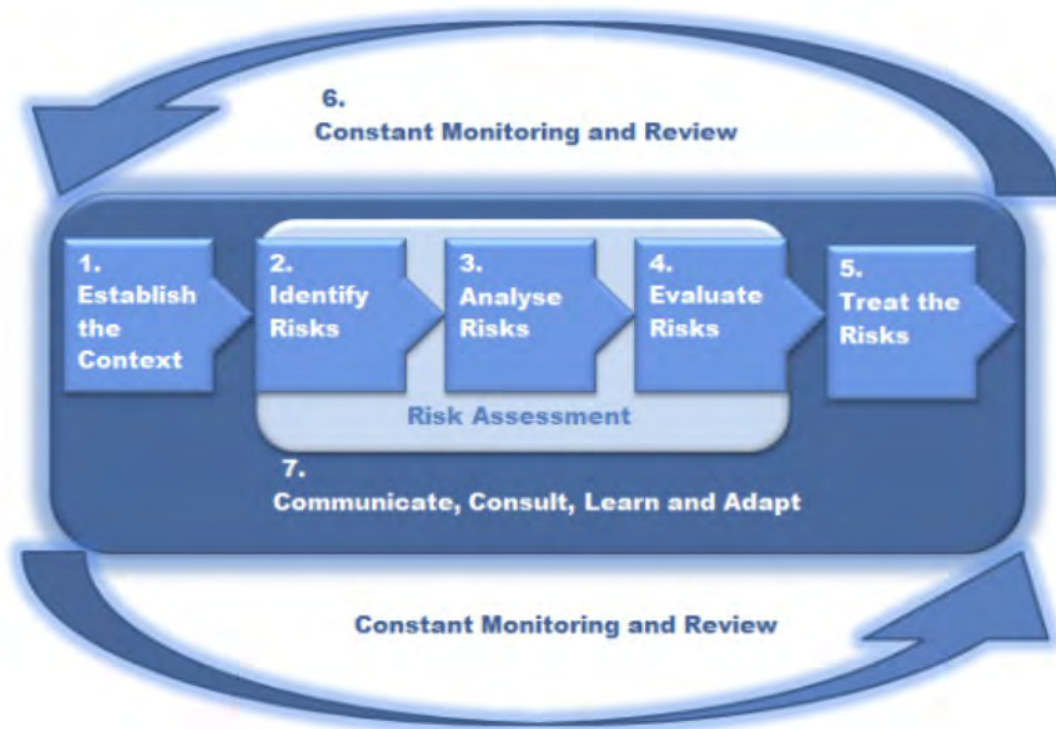
This procedure applies to all staff and services and outlines the process for identifying, assessing, managing, and escalating risks.

3 ROLES AND RESPONSIBILITIES

Employees in all positions are responsible for maintaining risk awareness by identifying and reporting risks to their line manager and/or directors as appropriate.

All areas must conduct ongoing robust risk assessments and escalate risks through the Health Board's governance and escalation route, as outlined below in the Risk Management Process section.

4 RISK MANAGEMENT PROCESS



Step 1: Establish the Context

Before identifying risks, first decide on the scope of the activity, including your objectives, and develop an understanding of your operating environment.

Identify your stakeholders (internal and external) to determine whether they could potentially expose the Health Board to risk, could be exposed to risk, or could assist with risk management.

There are three other elements that are important to consider when establishing the context for a risk assessment:

- External factors (e.g., regulatory, financial, environmental, technological)
- Internal factors (e.g., workforce, capability, culture) Confirm the objectives that could be impacted by risk.
- The risk management context - this defines the goals and objectives of the risks.

Step 2: Identify Risks

The aim of this step is to develop a comprehensive list of future events which could be uncertain but are likely to have an impact (either positively or negatively) on the achievement of the objectives - these are the risks.

It is important to understand the difference between a Risk and an Issue, as these can often get confused. A useful way of remembering the difference is;

- Risks are things that might happen and stop us achieving objectives, or otherwise impact on the success of the Health Board.
- Issues are things that have happened or are currently happening, that are being actively managed.

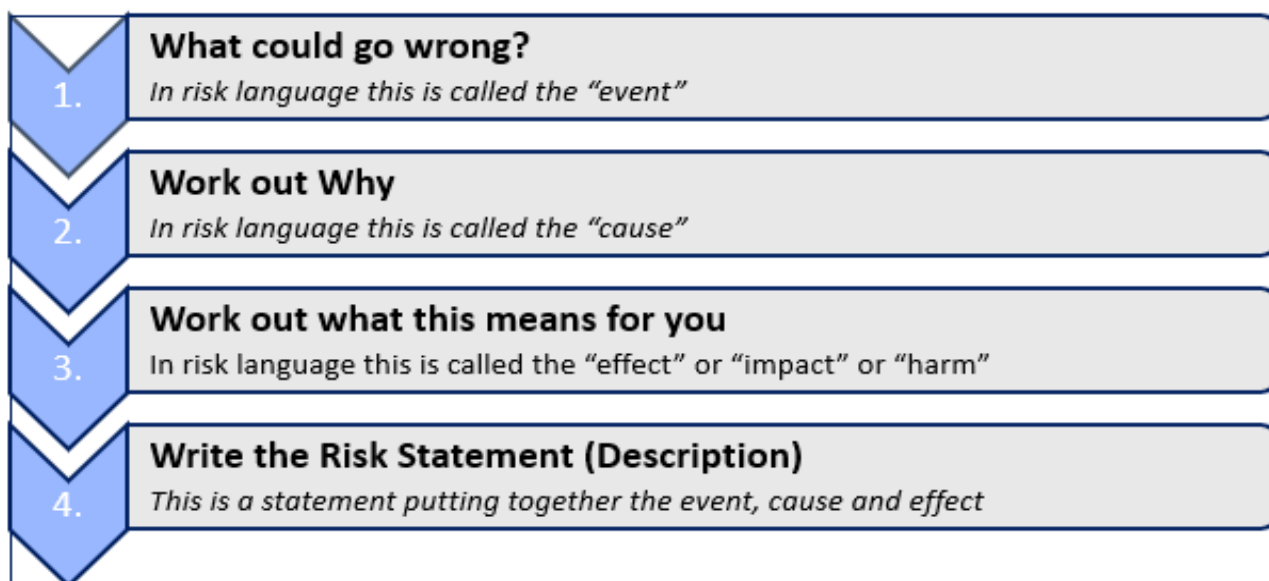
An Issue or a Risk can be determined by the temporal proximity of the event as outlined in the table below.

Temporal Proximity	Risk or Issue
Has happened or is currently happening	Issue
Potential to materialise in this financial year	Risk
Potential to materialise in the next financial year	Risk
Potential to materialise in the next 2 -5 years <i>(Dependant if the risk is malicious e.g., Cyber or Fraud (2y) or non-malicious e.g., error, system failure (5y))</i>	Risk

Common techniques for identifying risks are the use of risk categories or linking risks to each objective identified in the context setting phase. Another method is to consider threats and opportunities the Health Board faces and use these to identify relevant risks.

For each risk identified ensure that its source or cause is well understood and documented, including key elements such as the risk event, the potential cause and the potential impact should the risk be realised. A clear risk description is important to ensure corresponding actions for treatment are effective.

The steps below will guide the development of a risk description, examples of this process are included at Appendix 1.



Step 3: Analyse Risks

Risk analysis establishes the potential impact of each risk and its likelihood of occurrence. The combination of these two factors determines the severity of the risk, which may be positive or negative.

Before considering how to manage a risk, you need to assess its seriousness. This is done by measuring the risk's **LIKELIHOOD** and **IMPACT**.

Although there are many ways to achieve this, a common approach is to use a matrix or 'risk heat map'. Consequence and likelihood are plotted on the two axes of the matrix, with each corresponding cell assigned a level of severity.

Risks should be measured at the following three stages.

Stage	Description
INITIAL	This will be the score when the risk is first identified – this will not change
CURRENT	This should reflect the latest level of risk each time that the risk is reviewed.
TARGET	The desired level of risk that we are working to reduce the risk to, with the effective implementation of controls and mitigating actions.

In addition to determining Initial, Current and Target risk scores, each review should assess the overall trajectory of the risk (Improving, Stable or Deteriorating) to demonstrate whether the Health Board is making sufficient progress towards the target level.

The NHS 5 X 5 Risk Scoring Matrix is presented at Appendix 2.

Step 4: Evaluate the Risk

Compare risk score against defined thresholds.

Determine:

- Whether the risk is tolerable;
- Priority for action;
- Identify the highest credible impact across all relevant consequence domains (e.g., quality, safety, legal and regulatory compliance financial, etc.)

Compare the current and target risk scores with the threshold for the selected risk appetite theme and record whether each score is within or outside appetite. The appetite theme must be based on the principal source of uncertainty or objective affected, not whichever consequence produces the highest impact score.

Step 5: Treat the Risk

Risk treatment is the action taken in response to the risk evaluation when additional mitigation activities are agreed upon.

There are five strategies to managing a risk, known as the 5T's (Treat, Tolerate, Transfer, Terminate, Take the Opportunity). Select and implement appropriate mitigation using one or more of the following:

Strategies	
Treat	reduce likelihood or impact
Tolerate	accept risk with justification
Transfer	share risk (e.g., contracts, insurance)
Terminate	stop the activity causing the risk
Take the Opportunity	actively exploiting a risk that has a potential positive outcome

Selecting the most appropriate treatment requires balancing the cost and effort of implementation against the benefits derived from additional risk mitigation.

In some cases, further treatment may be unachievable or unaffordable and the residual risk may need to be accepted and communicated.

Consideration should be given to how external stakeholders can provide support when developing treatment options or if treatments can be implemented collaboratively.

Step 6: Communication and Consultation

Communication and consultation are essential attributes of good risk management.

Discuss risks regularly in team/service meetings.

Ensure:

- Stakeholders are informed
- Actions are tracked
- Updates are recorded
- Use risk information to inform planning and decision-making.

Step 7: Monitoring and Review

Risks change over time and hence risk management will be most effective where it is dynamic and evolving.

Monitoring and review are integral to successful risk management; it is important to articulate who is responsible for conducting monitoring and review activities.

Key objectives of risk monitoring and review include:

- detecting changes in the internal and external environment, including evolving objectives and strategies;
- identifying new or emerging risks;
- ensuring the continued effectiveness and relevance of controls and the implementation of treatment programs;
- obtaining further information to improve the understanding and management of already identified risks; and

- analysing and learning lessons from events, including near-misses, successes, and failures

Monitoring and review can be periodic or in response to trigger events or changing circumstances.

Appendix 2 serves as a guide for conducting periodic risk assessments based on the risk level (severity). The frequency of the review process, however, should be proportional to the rate at which the organisation and its operating environment change.

During each review, risk owners should:

- Update the current risk score where appropriate.
- Review progress against mitigating actions.
- Assess the effectiveness of key controls.
- Consider the adequacy of sources of assurance and identify any assurance gaps.
- Identify any new or emerging risks, changes in context or external influences.
- Determine the risk trajectory (Improving, Stable or Deteriorating), taking into account the effectiveness of controls, progress of mitigating actions, assurance findings and changes in the operating environment.
- Consider whether the target risk remains achievable and whether escalation or de-escalation is required.

Risk trajectory should not be based solely on changes to the numerical risk score. A risk score may remain unchanged whilst the overall trajectory is improving or deteriorating as a result of changes in control effectiveness, assurance or external factors.

Trajectory	Descriptor
Improving	Controls are becoming more effective, actions are progressing as planned, and the risk is reducing or is expected to reduce towards the target level.
Stable	The overall level of risk remains broadly unchanged, with no significant improvement or deterioration in controls, assurance or external factors.
Deteriorating	Control effectiveness or assurance has weakened, mitigating actions are delayed or external factors have increased exposure, making achievement of the target risk less likely.

5 ESCALATION PROCESS

Escalate a risk when:

- It cannot be managed at the current level
- Controls are ineffective
- It exceeds capacity, capability, or authority
- It poses significant risk to service delivery, safety, or objectives

Trigger Points for Escalation

- Score increases into a higher threshold
- Risk remains unresolved over time
- Impact escalates (e.g., patient safety, compliance)
- Cross-organisational implications identified

Project Risk Escalation

- Managed within project governance structures
- Escalate to operational risk registers if:
 - o Score ≥ 9
 - o Risk threatens service delivery

Appendix 3 demonstrates the process.

IMPORTANT NOTE:

Escalation of a risk to a higher-level risk register does not remove the responsibility to manage the risk at the level at which it manifests. Risk owners and managers must continue to implement and monitor controls, mitigation actions and assurances within their area of responsibility, irrespective of where the risk is recorded.

Risks may only be escalated to a higher-level risk register where there is agreement that the risk cannot be effectively managed within the existing level of authority, control or resources, and that oversight is required at a higher level of the organisation.

As escalation results in the transfer of ownership and accountability to a more senior manager or Executive Lead, escalation must be formally agreed by the receiving risk owner before any amendment is made to the risk management system. Such agreement should normally be obtained through a formal governance forum, such as:

- o Divisional Assurance Meeting;
- o Corporate Assurance Meeting;
- o Executive Committee; or other,
- o appropriate risk review forum.

Once approval has been obtained, the risk may be formally amended within the risk management system to reflect the new ownership, reporting arrangements and level of oversight. The rationale for escalation and the agreement of the receiving risk owner must be documented within the meeting record and risk management system.

Escalation should not be viewed as a mechanism for transferring responsibility for managing the risk. The originating service, department or division remains responsible for managing the operational causes and consequences of the risk and for implementing agreed mitigating actions within its sphere of control.

"Escalated" does not mean "someone else is dealing with it."

It means:

"Someone more senior now has oversight and accountability, but the people closest to the risk must still manage it."

6 DATIX RISK MANAGEMENT SYSTEM

Risks must be recorded on the Health Board's Risk Management System, Datix. The DatixWeb Risk Module Training Guide is a step-by-step guide to recording and managing risks on Datix and can be accessed via ABPulse.

7 SUPPORTING DOCUMENTS

This document should be read in conjunction with the:

- Risk Management and Assurance Framework
- Risk Appetite Statement
- DatixWeb Risk Module Training Guide

8 TRAINING AND IMPLEMENTATION

Staff must complete risk management training via induction and ongoing programmes. Additional support and guidance available through the corporate governance function.

9 AUDIT AND REVIEW

This document will be reviewed annually in line with the Risk Management Framework and will be subject to regular auditing to ensure that risk management practices are effectively embedded across the Health Board

10 APPENDICES

- Appendix 1 - Risk Statement Examples
- Appendix 2 – NHS Wales Risk Scoring Matrix (5x5 Model)
- Appendix 3 – Risk Escalation Process
- Appendix 4 - Risk Assessment Template Strategic/Corporate and Divisional/Directorate

11 APPENDIX 1: Risk Statement Examples

1. What could go wrong?	2. What could be the cause of this?	3. What would be the effect / impact?	4. Risk Statement (Description)
Poor quality care provided to patients	- High staff sickness rate - Inability to recruit sufficient staff. - Inability to release staff for statutory and mandatory training	- Adverse harm to patients - Breach of Staffing Levels Act - Reduced patient and public confidence in the safety of services.	There is a risk that safe staffing levels are not maintained due to high sickness absence, recruitment difficulties and insufficient release for statutory and mandatory training, leading to patient harm, non-compliance with the Nurse Staffing Levels Wales Act 2016 where applicable, and reduced patient and public confidence in the safety of services.
Staff could fall over storage boxes	Medical records stored in boxes unsafely in office accommodation	- Staff absence due to injury - Breach of Health & Safety at Work Legislation - Litigation Claims for Injury	There is a risk that staff are injured due to medical records being stored unsafely in office accommodation, leading to staff absence, legal claims and non-compliance with health and safety legislation.

Unable to update electronic patient records	• System downtime • Loss of Internet access • IT failure	• Adverse harm to patients • Reduced patient and regulator confidence in the completeness and security of health records. • Litigation claims • Reputational damage	There is a risk that critical patient information cannot be recorded or accessed when required due to system, network or infrastructure failure, leading to unsafe clinical decisions, breaches of record-keeping requirements, litigation and reduced patient or regulator confidence.
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12 APPENDIX 2: NHS Wales Risk Scoring Matrix (5x5 Model)

X - Axis = Likelihood/Frequency of the risk occurring.

Y - Axis = the level of risk Consequence/Impact

Color-coding is crucial for a 5×5 risk assessment matrix to represent the combination level of likelihood and consequence of the identified risks.

Each risk box represents the rating of a risk that is calculated based on its levels of likelihood and impact using a numeric value.

Calculating Risks Using the 5×5 Risk Matrix

The first step is to assign a numeric value from 1 to 5, 1 being the lowest, for each of the categories under Likelihood and Consequence. Then, use the formula of multiplying the value of the Likelihood by the value of the Consequence to determine the risk score and exposure.

The likelihood of malicious risks should be assessed over a 2-year period. In contrast, the likelihood of non-malicious risks should be evaluated over a 5-year period.

Definition:

Non-Malicious - A risk arising from unintentional errors, system failures, or natural causes, where there is no deliberate intent to harm.

Malicious - A risk arising from an intentional harmful act intended to cause patient or staff harm, financial loss, fraud, service disruption, information compromise or loss of public confidence.

Scoring Guidance

The 5 risk rating levels under Likelihood/Frequency are as follows:

	Likelihood/frequency score (severity levels) and examples of descriptors				
Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often Might it / does it happen.	This will probably never happen / recur. May occur once in 5 years or more	Do not expect it to happen / recur but it is possible it may do so. Could occur once every 2 to 5 years	Might happen or recur occasionally. Might occur once every 1 to 2 years	Will probably happen / recur but it is not a persisting issue. Expected to occur annually or more	Will undoubtedly happen / recur, frequently. Expected to occur frequently (e.g., several times a year)

The 5 risk rating levels under Severity/Consequence are as follows. Where more than one consequence domain applies, assign the score for the highest credible impact rather than adding or double-counting impacts.

	Severity /Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Compliance & Governance	No breach of legislation, policy or governance requirements.	Minor breach requiring local corrective action.	Significant governance weakness or regulatory concern requiring formal improvement.	Major governance failure, enforcement action, or statutory breach.	Failure to meet statutory duties, prosecution, loss of organisational control, or special measures intervention.

Digital & Information	Minimal disruption with no impact on service delivery.	Short-term disruption with effective workarounds available.	Loss of functionality affecting operational delivery and increasing risk of delays.	Critical system outage affecting patient care, operational delivery, or information security.	Complete failure of critical digital services, major cyber incident, or widespread loss of information.
Emergency Preparedness & Security	No threat realised.	Minor incident managed through normal processes.	Incident requiring coordinated response with some operational strain.	Major incident requiring significant emergency response and affecting service continuity.	Failure to respond effectively to a critical incident resulting in mass casualties or prolonged service failure.
Estates, Facilities & Environmental Safety	No impact on safety, estate condition, or environment.	Minor maintenance issues causing inconvenience.	Service disruption due to estate failure or environmental impact requiring intervention.	Serious health and safety breach, relocation of services, or major environmental impact.	Major incident such as fire, structural failure, fatal accident, or catastrophic environmental event.
Fraud and Commercial	Negligible financial loss with no control failure requiring formal action.	Minor financial or commercial loss manageable locally.	Material financial or commercial loss requiring formal investigation and recovery action.	Significant fraud, commercial loss, contract failure or litigation requiring Executive or regulatory intervention.	Major or systemic fraud, prosecution, critical supplier or contract failure, or financial loss threatening organisational objectives.

Fraud & Commercial	Negligible financial loss and no organisational impact.	Minor financial loss with limited organisational impact.	Material financial loss requiring investigation and recovery action.	Significant fraud, commercial loss, or litigation with external scrutiny.	Major fraud, significant financial loss, prosecution.
Patient Safety & Clinical Outcomes	No injury or negligible harm. No treatment required.	Minor injury or harm requiring minimal intervention. No lasting effects.	Moderate harm requiring professional intervention. Potential for temporary harm or extended recovery.	Serious harm resulting in long-term effects, disability, or life-changing injury.	Avoidable death, multiple deaths, or widespread severe harm. Systemic patient safety failure.
Programme & Strategic Delivery	No impact on delivery of plans or programmes.	Minor delay with benefits still achievable.	Significant delay requiring intervention and re-planning.	Major delay threatening achievement of strategic benefits or Annual Plan commitments.	Programme failure resulting in loss of strategic benefits or failure to deliver organisational objectives.
Quality & Experience	No measurable impact on quality or patient experience.	Localised reduction in quality or patient experience.	Significant reduction in quality requiring management intervention.	Serious deterioration in quality affecting multiple services or patient groups.	Sustained or systemic failure in quality standards resulting in widespread severe harm, unacceptable patient experience or failure to meet fundamental standards.
Public Confidence and Stakeholder Relationships	No measurable impact on public confidence or stakeholder relationships.	Isolated concern or complaint resolved locally, with no sustained effect on	Sustained concern among one or more stakeholder groups requiring formal	Material and sustained loss of confidence among patients, staff, partners or regulators, affecting	Widespread and sustained loss of public, political, regulator or partner confidence resulting in

		confidence or relationships.	engagement or corrective action, with limited effect on relationships or confidence.	engagement, collaboration or delivery.	breakdown of critical relationships, inability to deliver objectives or significant external intervention.
Programme & Change Management	No impact on delivery	Minor slippage, benefits intact	Some delay or cost pressure	Major delay or overspend; limited benefits delivered	Critical programme failure; transformation benefits lost
Service Delivery & Performance	No disruption to services or objectives.	Minor delays or disruption managed locally.	Service disruption affecting multiple teams or objectives. Performance targets at risk.	Significant disruption to key services. Failure to achieve major objectives.	Sustained service failure resulting in inability to deliver statutory or essential services.
Workforce	Minimal staffing pressures. No impact on service delivery.	Short-term staffing shortages or competency gaps affecting service quality.	Staffing shortages or competency concerns affecting service delivery and performance.	Unsafe staffing levels, loss of key personnel, significant workforce instability.	Sustained workforce failure resulting in inability to safely deliver services.

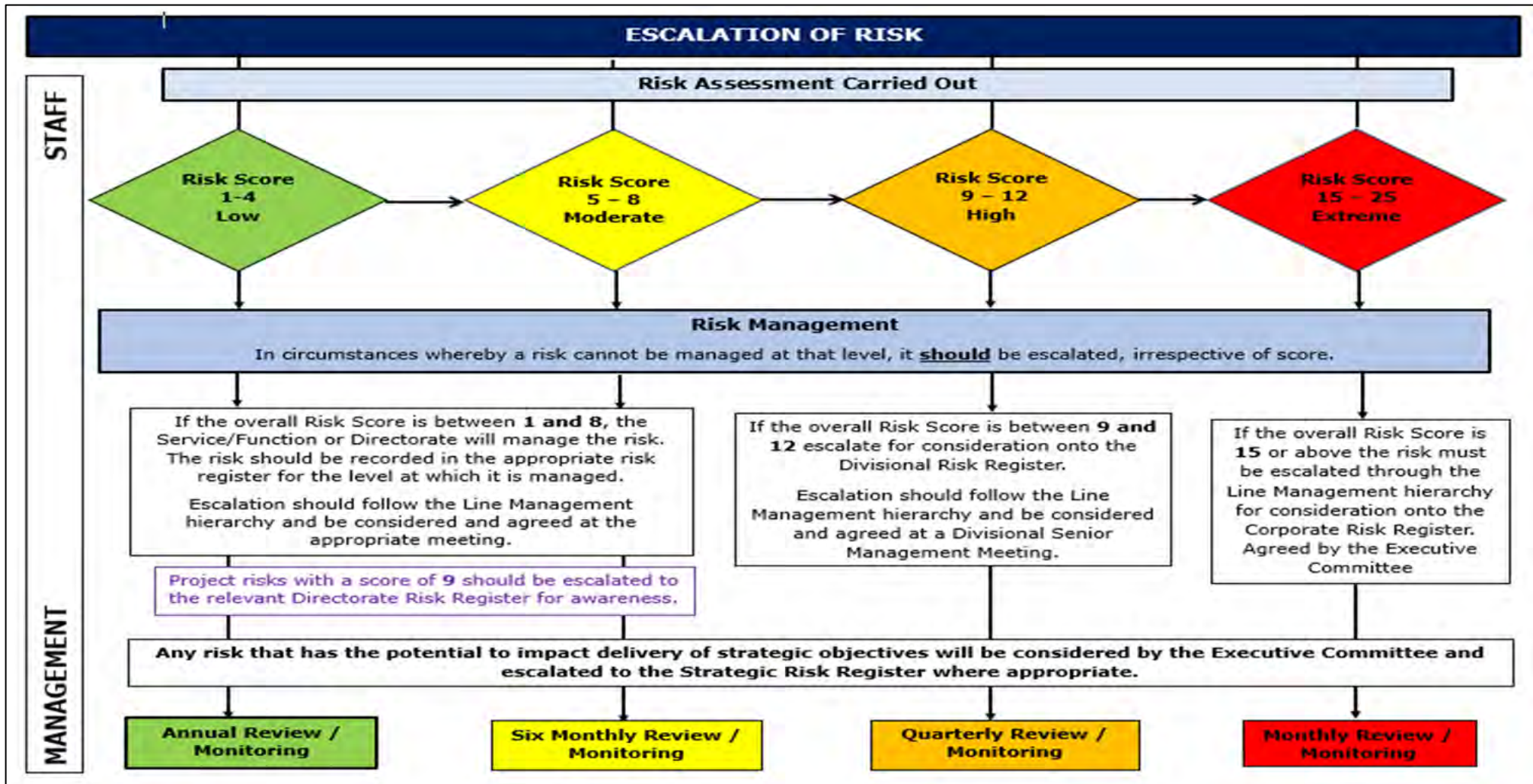
Likelihood x Consequence = Risk Score and Level of Exposure

Risk Scoring Matrix					
Likelihood / Frequency	Consequence / Impact				
	1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
5. Almost Certain	5 (Moderate)	10 (High)	15 (Extreme)	20 (Extreme)	25 (Extreme)
4. Likely	4 (Low)	8 (Moderate)	12 (High)	16 (Extreme)	20 (Extreme)
3. Possible	3 (Low)	6 (Moderate)	9 (High)	12 (High)	15 (Extreme)
2. Unlikely	2 (Low)	4 (Low)	6 (Moderate)	8 (Moderate)	10 (High)
1. Rare	1 (Low)	2 (Low)	3 (Low)	4 (Low)	5 (Moderate)

The table below outlines the time frame for implementation of actions based on risk score and level.

Risk Score	Overall Risk	Timeframe
1 - 4	Low	Quick, easy measures implemented immediately, and further action planned for when resources permit.
5 - 8	Moderate	Actions implemented as soon as possible but no later than a year.
9 - 12	High	Actions implemented as soon as possible but no later than six months.
15 - 25	Extreme	Requires urgent action. The Health Board is made aware, and it implements immediate corrective action. However, where likelihood is rare or unlikely then potential decision needed on tolerance and action timescales.

13 APPENDIX 3: Escalation Process



14 Appendix 4: Risk Assessment Templates

Strategic Risk Assessment Template

RISK APPETITE	THEME / RISK LEVEL / SCORE THRESHOLD:			Publication Status	Open / Closed
GWENT 35 STRATEGY	Better Health – Better Care – Better Lives				
IMEP					
Linked Corporate Risk					
SRR No. (Risk Event)	There is a risk				
Threat (As a result of / Due to)	Due to				
Impact (Consequences of the threat)	Patient	Staff	Organisation		
Lead Executive Director		Risk Scoring Dashboard	Current Level	Target Level	Trajectory of the risk (Choose an option) Add a brief summary of the trajectory.
Overnight Forum		Likelihood			
Initial Date of Assessment		Impact			
Last Reviewed		Risk Score			
Next Review (or based on current risk score)	The current risk score is WITHIN/OUTSIDE of the Appetite Threshold. The Target score to be achieved is WITHIN/OUTSIDE of Appetite.				

Key Strategic Control (Type of control Preventative / Recovery / Mitigating / IF-avoidance / Impact of the threat)	Assurance Evidence (How are day-to-day controls and assurance systems working to manage the risk?)	Control Effectiveness	Gap in Assurance	Further Action to Address Gaps in Assurance	Assurance Rating

Preventative Controls to reduce Likelihood When further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)	Recovery Controls to reduce Impact When further controls are required to reduce the risk exposure to within a tolerable range? (Short, Medium, and Long-Term Plans need to be included)
Short term (0 – 12 Months) Medium term (12 – 24 Months) Long term (24 – 36 Months) Longer-term capital dependency (Beyond 36 months, up to 5 Years)	Short term (0 – 12 Months) Medium term (12 – 24 Months) Long term (24 – 36 Months) Longer-term capital dependency (Beyond 36 months, up to 5 Years)

Control Rating	Description	Assurance Rating	Criteria
Effective	The control is operating as intended and there is evidence that it is reducing the likelihood and/or impact of the risk.	Positive	Multiple sources of evidence demonstrate the controls consistently effective. Independent assurance supports the conclusion.
Partially Effective	The control is operating but does not fully address the risk, is not consistently applied, or evidence of effectiveness is mixed.	Reasonable	Evidence demonstrates the control is generally effective, although some gaps or weaknesses exist.
Likelihood	The control is not operating as intended, is not consistently applied, or there is little evidence that it is reducing the risk.	Limited	Some evidence exists, but it is incomplete, inconsistent or does not fully demonstrate effectiveness.
		No Assurance	Little or no evidence exists that the control is effective.

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Approved by: Audit Committee on behalf of the Aneurin Bevan University Health Board

Corporate Risk Assessment Template

URL/Website	Theme / Risk Level / Approx Threshold			Publication Status	Open / Closed
Support ID/Reference	Better Health – Better Care – Better Lives				
Basic Risk					
Linked Strategic Risk					
CRS No. (Risk Level) Threat (As a result of)					
Impact (Consequences of the threat)	Likelihood		Severity		Exposure/Status
Lead Executive Director	Red/Severe/Unlikely	Current Level	Target Level	Trajectory of the risk (Known at time...) Add a brief summary of the trajectory of the risk.	
Ownership Forum					
Initial Date of Assessment					
Last Reviewed					
Next Review (as dated on current risk score)	The current risk score is WITHIN/OUTSIDE of the Appetite Threshold. The target score to be achieved is WITHIN/OUTSIDE of Appetite.				
CONTROLS					
Current Key Controls (What controls/ systems/ processes are already in place to assist in managing the risk and reducing the likelihood/ impact of the threat)	Further PREVENTATIVE Controls to reduce LIKELIHOOD (What further controls are required to reduce the likelihood of the risk materialising?)		Further REDUCED Controls to reduce IMPACT (What further controls are required to reduce the impact of the risk materialising?)		
Prevention Controls – reduce likelihood	Short term		Short term		
	Medium term		Medium term		
	Long term		Long term		
Recovery / Mitigating Controls – reduce impact					
ASSURANCES					
Sources of Assurance (Evidence that the controls/ systems/ risks are not placing reliance on one another)	Gaps in Assurance (What/where evidence is on the effectiveness of the controls for negative assurance)		Actions to Address gaps (What further evidence is required to provide the effectiveness of controls)		
Level 1: Operational (managed by the department their performance/ day to day activities)					
Level 2: Organisational (Managed by risk management and compliance functions)					
Level 3: Independent (performed by both external internal and external independent bodies)					
Assurance Rating (Overall Assessment of controls and assurance)					

[illegible]