



Quality and Safety Assurance Report

Quality, Safety and Experience Committee

December 2025

The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with an overview of quality and safety across the Health Board.

Within the Health Board's Quality Management System, a number of assurance processes and quality improvement strategies are used to ensure high quality care is delivered to patients.

This report provides information on:

- Patient safety incidents
- Nationally reported patient safety incidents
- Duty of Candour
- Patient Experience
- Complaints management
- Public Services Ombudsman for Wales
- Infection prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)



Patient Safety Incidents and Nationally Reported Incidents



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There were 15,365 incidents reported on Datix Cymru in Hywel Dda UHB between 1st November 2024 and 31st October 2025. Of these, 12,368 were Patient Safety Incidents.

Of the 12,368 patient safety incidents reported, 9,667 have been closed. 69 (0.7%) were closed as moderate, severe or catastrophic harm.

The top 3 incident classifications (patient safety incidents reported between 01/11/2024 and 31/10/2025 and closed as moderate, severe or catastrophic harm) were pressure damage (21); accident or injury (13); and treatment and procedure (9). This can be broken down further into the categories.

Pressure ulcer developed or worsened during care in this clinical care area/caseload	17
Slip, trip or fall	12
Treatment or procedure issues	7

54 Incident Management Groups have been held between 01/10/2025 and 24/11/2025

	Sept 2025	Oct 2025	Nov 2025
Allied Health and Health Science	1	2	0
Community and Integrated Medicine	8	4	3
MH&LD	14	15	20
Planned & Specialist Care	5	4	6
Primary, Community Strategy & LTC	2	0	0

A review, using the support of AI, identified the main themes, within the lessons learned of patient safety incidents reported between 01/11/2024 and 31/10/2025 and closed, were:

Falls, Slips, and Trips - frequent incidents in wards, bathrooms, and during transfers.

The following areas for improvement are recommended:

- Update risk assessments and care plans.
- Implement post-fall protocols and encourage call bell use.
- Increase staff supervision and vigilance.
- Use equipment like alarms and sensor mats.
- Document all incidents promptly.

Pressure Damage & Moisture-Associated Skin Damage - Multiple cases of pressure ulcers (categories 1–4) and MASD. The following areas for improvement are recommended:

- Regular skin checks and accurate grading.
- Timely documentation and care plan updates.
- Use pressure-relieving equipment (air mattresses, cushions).
- Staff training on prevention and escalation.
- Communication with families and multidisciplinary teams.

Medication Errors - Errors in prescribing, administration, supply, and documentation (wrong dose, omissions, early/late administration). The following areas for improvement are recommended:

- Double-check medication charts and adhere to 5/6/7 rights.
- Improve handover and documentation accuracy.
- Staff education and reflective practice.
- Pharmacy liaison and escalation of errors.
- Minimize distractions during administration.

These themes have been shared with:

- Clinical Care Groups for discussion, consideration and improvement action
- The learning library and Viva Engage



Nationally Reportable Incidents



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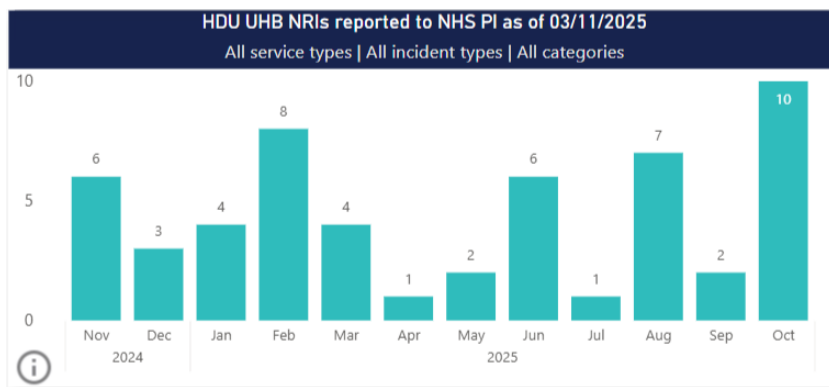
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There were 31 Patient Safety Incidents reported to the NHS Executive between 1st November 2024 and 31st October 2025.

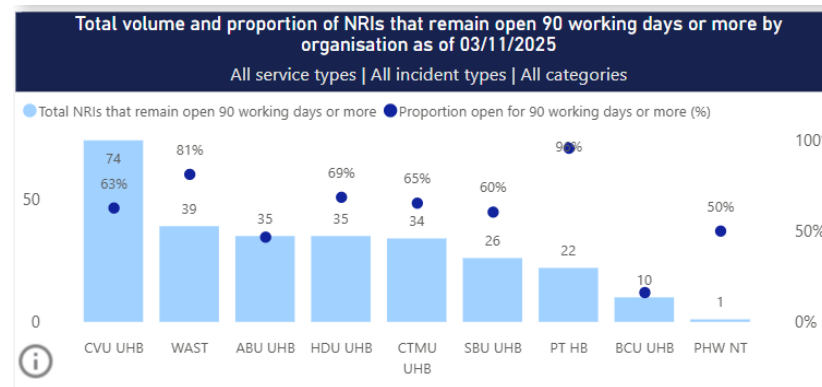
As of 24th November 2025, 46 incidents are open with NHS Performance and Improvement on the UHB Datix Cymru system (excluding those reported and awaiting confirmation of reference number).

28 incidents are been open with NHS Performance and Improvement for 90 days or more.

21 incidents reported as NRIs were closed by the Health Board between 01/11/2024 and 31/10/2025 (not including those where a downgrade form was submitted).



Source: Beacon Dashboard 07/11/2025



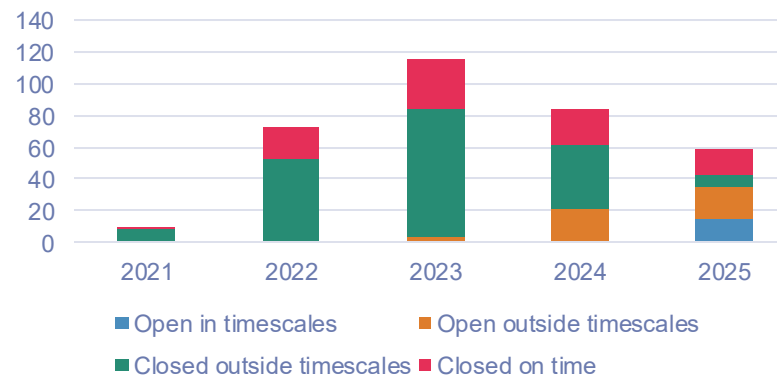
HDU UHB top 10 NRI categories occurring by volume (incident dates between Nov-24 and Oct-25) as of 03/11/2025

NRI category	Total
Neonate	10
Pressure ulcer developed or worsened during care in this clinical care area/caseload	4
Clinical assessment, clinical diagnosis	3
Communication issues	2
Maternal	2
Treatment or procedure issues	2
Administration errors	1
Compliance with bundle/ guidance	1
Diagnostic testing - Pathology	1
Healthcare record	1
Medical devices	1
Medication documentation errors	1
Mental Health Act Administration	1
Self-harm / self-injurious behaviour	1
Transfer	1
Unexpected death	1

Of the NRIs closed, percentage closed on time



Closure compliance



Source: Datix Cymru 07/11/2025

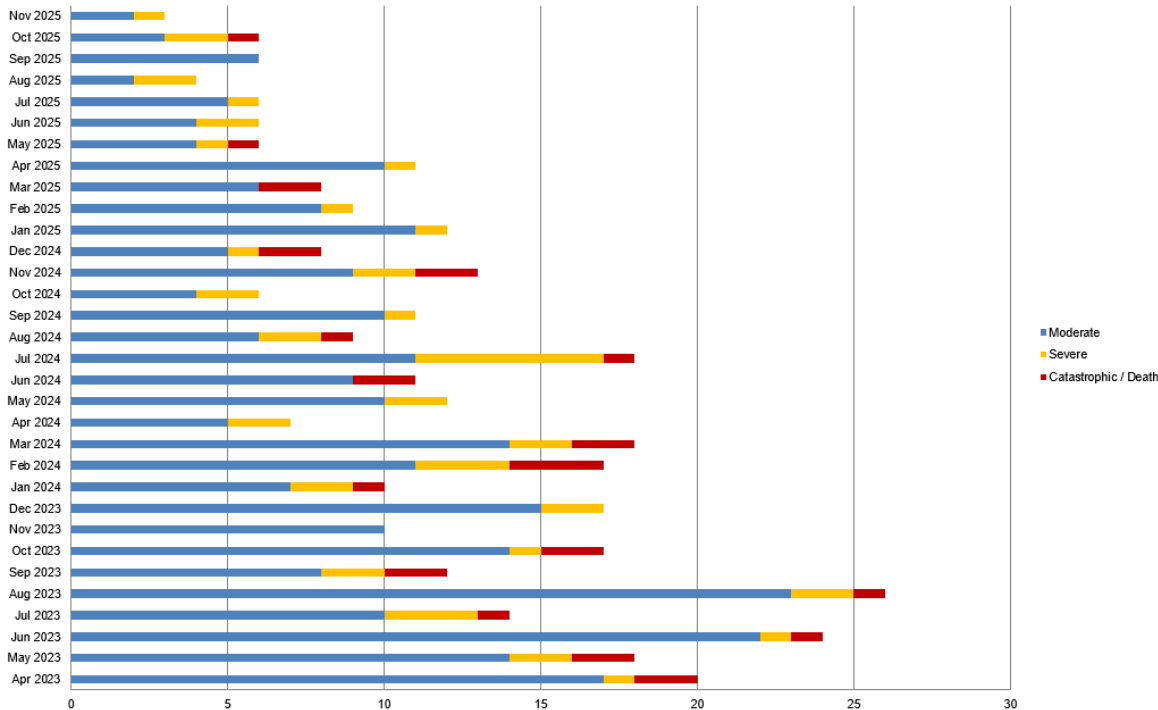
Health Board Overview – Duty of Candour



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Incidents by Incident date (Month and year) and Manager's interim harm assessment



265 incident records have been closed where duty of candour had been triggered during the manager's initial assessment.

		Harm post investigation					Total
		None	Low	Moderate	Severe	Catastrophic / Death	
Manager's interim harm assessment	Moderate	14	52	153	3	1	223
	Severe	1	8	4	11	3	27
	Catastrophic / Death	3	5	1	1	5	15
	Total	18	65	158	15	9	265

Top 3 incident classifications

Incidents occurring after 01/04/2023 where duty of candour has triggered, and investigation has been closed.

Pressure Damage, Moisture Damage	59
Pressure ulcer developed or worsened during care in this clinical care area/caseload	52
Pressure ulcer present before admission to this clinical care area/caseload	4
Pressure from medical device present before admission to this clinical care area/caseload	2
Pressure from medical device developed or worsened in this clinical care area/caseload	1
Accident, Injury	53
Contact with object or animal	1
Slip, trip or fall	51
Patient injury	1
Maternity adverse occurrence	33
Maternal	15
Neonatal	18



People's Experience Feedback



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Since the introduction of the revised Welsh Patient Experience Survey in April 2025, the following tables represent the volume of surveys issued via FFT and those who access the Survey together with responses.

Friends and Family Test

Month	Surveys			Responses				Targeted Contacts	
	Number of Surveys with New Responses	Surveys with New Targeted Responses	Surveys with New Passive Responses	Total New Responses	# of New Targeted Responses	# of New Passive Responses	# of Responses in Welsh	# of Contacts by SMS	# of Contacts by IVR
Oct-25	1	1	1	786	691	95	8	4924	1315
Sep-25	1	1	1	874	811	63	16	5075	1326
Aug-25	1	1	1	1013	971	42	20	5403	1518
Jul-25	1	1	1	971	918	53	10	5262	1461
Jun-25	1	1	1	848	795	53	12	4956	1303
May-25	1	1	1	875	828	47	13	5143	1466
Apr-25	1	1	1	681	643	38	11	3730	1429

Targeted responses are those collected via SMS, IVR and Email. Passive responses are those collected via all other delivery methods such as QR codes and survey links

NHS Wales People's Experience Survey

Question: National People's Experience Survey	Apr	May	Jun	Jul	Aug	Sept	Oct	Benchmark
2. How would you rate your overall experience?	79.1	79.7	78.4	80.5	80.9	78.8	80.0	85
6. Were you able to communicate in your preferred language?	94.7	95.6	96.5	96.8	95.4	95.3	96.3	85
7. Was the time you waited:	70.2	67.7	68.0	70.3	67.4	67.9	67.5	85
8. Did you feel well cared for?	83.7	83.9	82.0	84.6	83.8	81.8	83.4	85
9. Were you treated with dignity and respect?	91.1	91.6	90.2	92.0	91.6	90.8	90.9	85
10. Did you feel that you were listened to?	87.4	87.4	85.6	88.2	87.9	86.1	86.6	85
11. Were you involved as much as you wanted to be in decisions about your care?	87.1	86.5	85.1	87.9	87.7	85.9	86.5	85
12. Were things explained to you in a way you could understand?	91.2	90.0	89.5	90.9	91.0	89.3	90.5	85
Overall:	85.5	85.3	84.4	86.3	85.7	84.4	85.2	
Respondents:	681	873	847	971	1011	874	785	

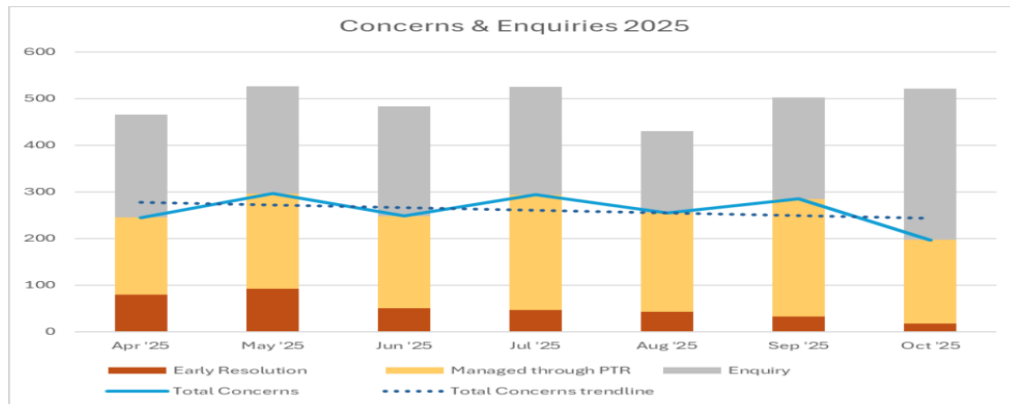
Health Board Overview – Complaints Management



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Number of complaints received by month since Apr 25



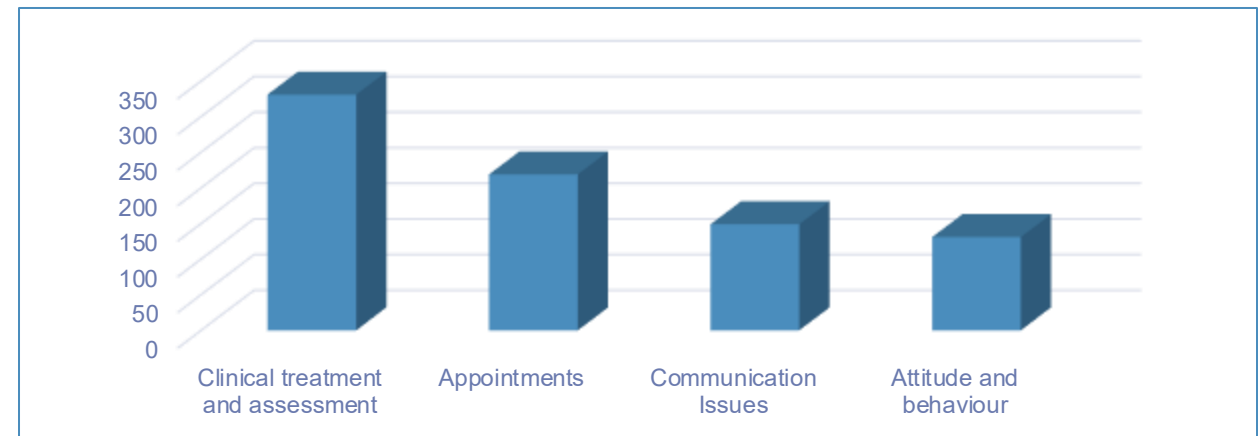
Proportion of complaints within 30 working days

The Health Board's current performance against the 30-working day target is 65%, including early resolution cases. The number of complaints waiting for a response over 12 months is of concern. It remains a priority to ensure no concerns are open over 12 months by mid-end of December.

The is also dealing with a high proportion of enquiries which should not be part of the complaints process and should be managed at first point of contact by other teams across the organisation. An improvement process is currently being undertaken to improve efficiency and user experience.

There are **24** complaints >12 months, **10** of which are on course to close imminently. There are **12** complaints between 10>12 months, **6** of which are also on course to close imminently. At 1st December, it is anticipated that there will be **20** >10 months, which would be a 54% reduction on **37** open cases >10 months since the start of November. The trajectory suggested (closing 10 per week) is currently on track.

Top four themes of complaints since April 2025 to date



Main themes giving rise to complaints remain consistent; with A&E, T&O, Ophthalmology and Gynaecology receiving higher numbers of complaints in this category.

The highest volume of complaints related to clinical assessment and treatment, followed by appointment and communication related concerns. Services receiving the highest volume of complaints are the EDs, Orthopaedic services, General Medicine and Gynaecology.

These figures correlate to the areas with the highest volumes of patient activity and appointments.

Public Services Ombudsman for Wales

- The Public Services Ombudsman for Wales (PSOW) has published her annual report. The report [Turning the page - Annual Report and Accounts 2024/25](#) can be found on the PSOW website.
- The Health Board also received a Public Interest Report regarding the provision of specialist learning disability Epilepsy Services which was received and discussed at the Public Board meeting on 27th November.
- The Ombudsman has recently advised us of the commencement of an ‘own initiative’ investigation, which is currently being reviewed, regarding the area of radiology reporting. Further details will be received by the Listening and Learning Sub-Committee, and the Quality, Safety and Experience Committee as further details are received.
- In Q1 2025/26, there were nine interventions from PSOW, which included one new investigation. In Q2, there have been 12 interventions, including six new investigations. There have been 27 decisions not to investigate since the start of the financial year.

Welsh Risk Pool

The Welsh Risk Pool has published the Welsh Risk Pool and Legal and Risk Services Annual Review 2024-2025. Learning can be found in the report which is included as appendix 2.

Infection Prevention and Control (IP&C)



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Quality Planning

- Organisation Annual Plan
- Annual IP&C work plan
- Infection Prevention Strategic Steering Group Work Plan
- Welsh Health Circulars (WHC) relating to IP&C and Public Health
- WHC Antimicrobial Resistance (AMR) & Healthcare Acquired Infection (HCAI) Improvement Goals 2024/25
- Working with the Public Health team and primary care/ community services to prevent infection in high-risk populations/ community settings

Quality Control

- Standardisation of assurance/ scrutiny groups in progress
- Reports to and from Clinical Care Groups (CCG) / subgroups of Infection Prevention Strategic Steering Group (IPSSG)
- Review of Health Board (HB) IPC policies
- Self-assessment against C.diff Framework for Wales and attendance at Wales C.diff Focus Forum Meeting.
- Review of data sets against TI reduction expectations- disseminated to all services and use of safety dashboards
- Review by Antimicrobial Group (AMG) and antibiotic pharmacists of compliance to Start Smart The Focus (SSTF) for each acute site
- All CCGs to review data within the Health Board Safety Dashboard and ensure that cases are reviewed (see Quality Improvement)
- Review of monthly data from HARP with internal HB analysis and scrutiny and use of infographics in CCGs
- Outbreak management meetings held as required.

Quality Improvement

- Assurance/ scrutiny meetings held. All hospital onset/ HCAI are discussed and learning obtained / action plans implemented, themes derived with a move to learning panels
- Working with managed practices - presenting infographics for infections/ sources/ learning
- Environmental audit programme and observational audits programme in place with improvement action plans produced
- Review of Synbiotix scores in relation to IP&C audit programme
- HPV in use in 3 acute sites
- HCID/infectious disease pathway training dates have been completed for GGH and BGH, dates in September and October for PPH and WGH
- Engagement in the National C.diff Learning Collaborative

Quality Assurance

Latest position key

Goal achieved
Making good progress towards goal
Minimal progress made or decline from previous month
Same as baseline or worse

Measure	De-escalation criteria	Baseline	Baseline (average Q3 23/24)	Goal	Latest position key										
					Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	
Infections	Number of laboratory confirmed C.difficile cases with hospital onset	25% reduction, maintained for 3 months	8	Baseline (average Q3 23/24)	6	8	4	6	8	8	11	7	4	5	11
	Number of laboratory confirmed S.aureus bacteraemia cases with hospital onset	33% reduction, maintained for 3 months	3	Baseline (average Q3 23/24)	2	4	4	4	3	3	3	4	5	4	3
	Number of laboratory confirmed E.coli bacteraemia cases with hospital onset	25% reduction, maintained for 3 months	7	Baseline (average Q3 23/24)	5	0	5	8	6	5	7	10	6	9	10

- Aseptic Non-Touch Technique (ANTT) 83.35% compliance with HB critical care and other inpatient areas seeking accreditation
- Level 2 mandatory training at 75.36%. Mandatory training rates now reported at CCG meetings
- HPV enhanced cleaning now available at 3 acute sites
- IPC Environmental audits focusing on very high-risk and high-risk areas. Theatres, ITUs, and Maternity and oncology have been completed.
- HCAI and IP&C included within all CCG escalation improving together sessions (EITS)

IP&C continued



Filters for Table 1. and Chart 1.

Select count or rate: Rate per 1,000 admissions

Select all or hospital onset (HO)* specimens: All specimens

Table 1. Current FY rate per 1,000 hospital admissions of specimens by HB, Apr - Oct 25

Additional filters for Table 1.		C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Select month or FY	Current FY						
Select organism group	All organisms						
	Aneurin Bevan UHB	2.32	0.06	1.27	3.28	1.15	0.37
	Betsi Cadwaladr UHB	3.18	0.1	1.84	5.03	1.39	0.34
	Cardiff and Vale UHB	3.1	0.29	2	4.44	1.89	0.42
	Cwm Taf Morgannwg UHB	2.96	0.08	1.76	6.47	2.15	0.14
	Hywel Dda UHB	3	0.27	1.98	6.6	2.25	0.39
	Powys THB	20.81	0	1.16	1.16	0	0
	Swansea Bay UHB	3.5	0.16	1.78	4.45	2.02	0.4
	Velindre NHST	1.06	0	1.58	4.75	0	0.53
	Wales	3	0.14	1.72	4.82	1.68	0.35

There is a mixed trend for HDUHB, with some infections improving and others being more challenging.

- MRSA rates in August increased, early case review indicates that these cases are linked to cannulas/ invasive devices.
- E. coli bacteraemia rates remain high suggesting a need for targeted interventions for population base.

Filters for Table 1. and Chart 1.

Select HB: Hywel Dda UHB

Select count or rate: Rate per 1,000 admissions

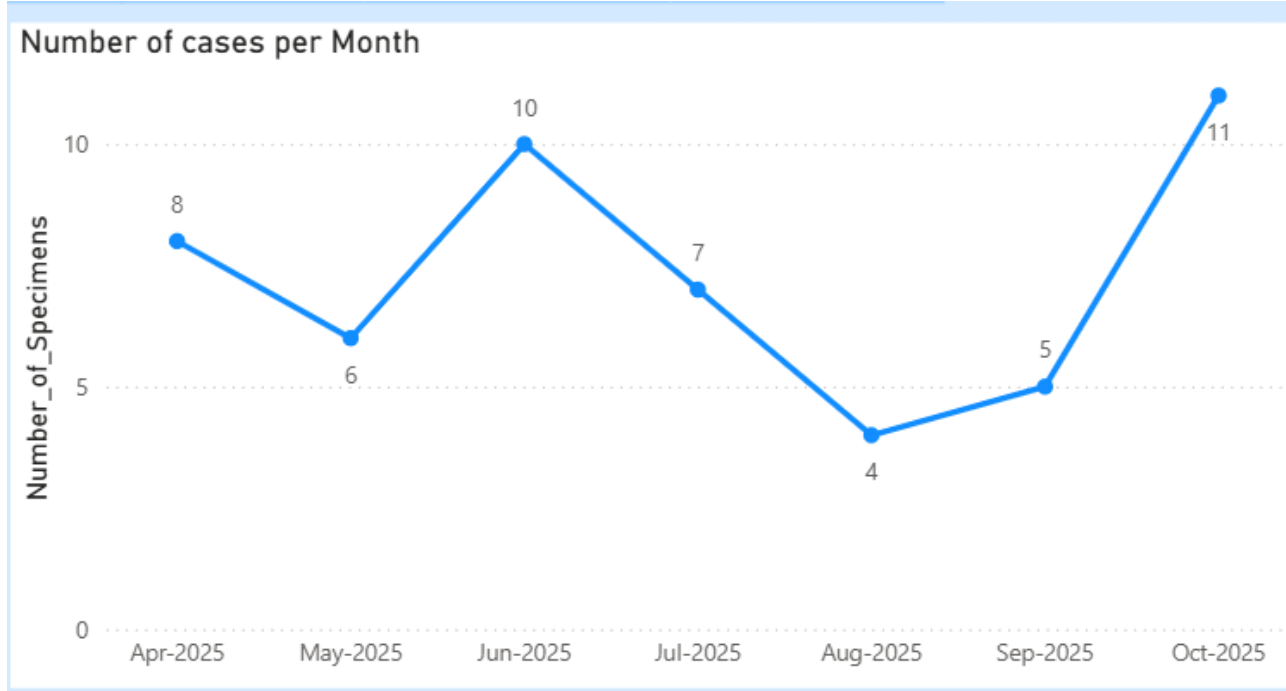
Select all or hospital onset (HO)* specimens: All specimens

Table 1. Current FY rate per 1,000 hospital admissions of specimens by acute hospital in Hywel Dda UHB, Apr - Oct 25

Additional filters for Table 1.		C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Select month or FY	Current FY						
Select organism group	All organisms						
	Bronglais General Hospital	3.26	0	3.26	7.68	3.49	0.7
	Glangwili General Hospital	2.1	0.41	1.69	5.76	2.1	0.41
	Prince Philip Hospital	2.59	0.15	1.52	5.17	1.67	0.15
	Withybush General Hospital	2.11	0.28	2.39	9.27	2.39	0.42

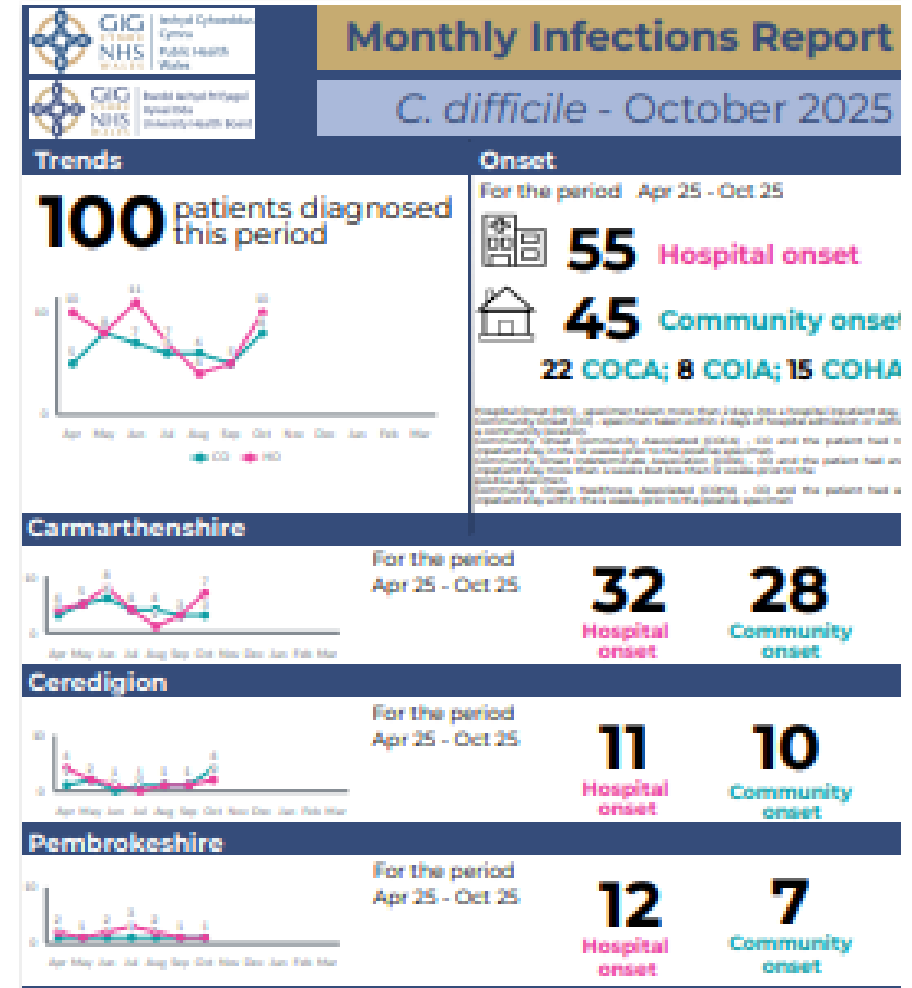
IP&C C.difficile

Number of hospital onset specimens from 01/04/25 to 31/10/25



The C.diff Collaborative (NHS Performance and Improvement) has been discussed at the HB C.difficile Infection (CDI) Improvement Group. The IV to oral switch project has been discussed through VBHC and will be presented as the HB project to the C.diff Collaborative. It is hoped that this project, with Exec sponsorship will have multifaceted benefits.

It terms of reducing hospital onset cases for C.difficile it is recognised that challenges in terms of boarding/ surge and facilitating timely cleaning has impacted recent cases.



Monthly Infections Report
C. difficile - October 2025

Trends
100 patients diagnosed this period

Onset
For the period Apr 25 - Oct 25
55 Hospital onset
45 Community onset
22 COCA; 8 COIA; 15 COHA

Carmarthenshire
For the period Apr 25 - Oct 25
32 Hospital onset
28 Community onset

Ceredigion
For the period Apr 25 - Oct 25
11 Hospital onset
10 Community onset

Pembrokeshire
For the period Apr 25 - Oct 25
12 Hospital onset
7 Community onset



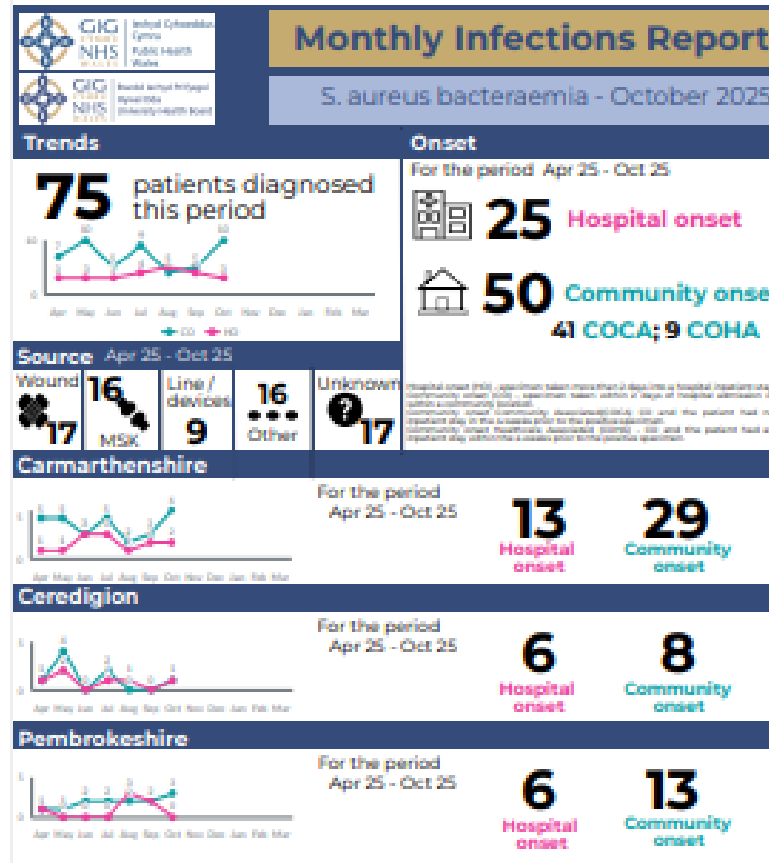
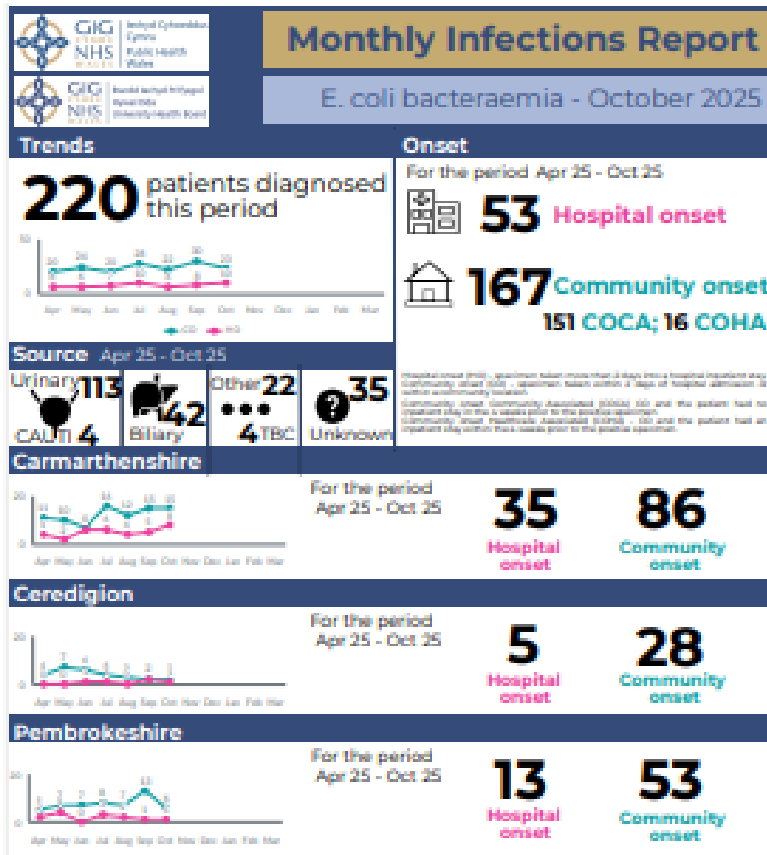
IP&C E.coli and S.aureus

For E.coli number remain high, the above graph demonstrates the age profile for positive samples, showing the burden in the 80-89 bracket

Some sources are still to be confirmed following further review and discussion

Actions

- ANTT compliance profiled and reported to all CCGs monthly, ANTT to be mandatory on ESR for HB. ANTT 83.35% compliance
- Hand hygiene encompassing bare below the elbow profiled and validation audits as indicated
- Ward manager/ Senior nurse hand hygiene audits now on Amat and monitored
- Burden for both infections remains in the community with proactive prevention work ongoing with public health



HIW / CIW / HTA inspection activity: 21/05/2025 –24/11/2025



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Inspections

Maternity Glangwili May 2025 - the report has been [published](#)
EUCC at BGH July 2025 – publication of report expected 27/11/2025
Mynydd Mawr, PPH, August 2025 – publication of report expected 20/11/2025
Derwen Ward, GGH, September 2025 – publication expected 04/12/2025

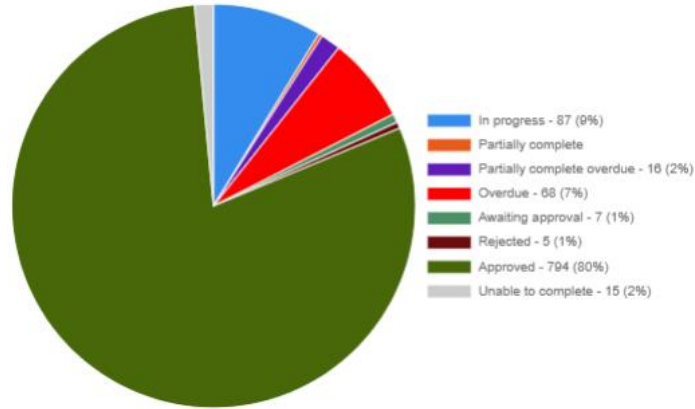
As an update to the last report, the Health Board have received the following letters from HIW requesting assurance during the period

Date of letter	HIW ref	Matter
24/11/2025	15323	Theatres GGH <ul style="list-style-type: none"> • Staff training and experience • Staffing levels, burnout and turnover • Patient safety risks and incident reports • Staff wellbeing and morale • Senior management and culture concerns
23/10/2025	15014	A&E GGH <ul style="list-style-type: none"> • poor hygiene and infection control practice, • lack of response to concerns raised about hygiene and safety, • personal safety risks and insufficient staff training, • inadequate incident follow up • general concerns relating to staff training not being addressed
08/10/2025	13391	Update on CSP consultation for Critical Care

Date of letter	HIW ref	Matter
16/01/2025	12474	Emergency Department staffing, GGH
30/01/2025	12589	Ceredig Ward, BGH – care of patient
14/02/2025	12702	Cwm Seren – care of patient
14/02/2025	12734	Staff behaviour in Radiology, GGH
25/02/2025	12858	Theatre Department staffing, GGH
18/03/2025	12994	PPH Bryngolau – care of patient
20/03/2025	12997	Ward 12 staffing, WGH
11/04/2025	13271	Paediatric Medical Workforce
12/04/2025	13272	Mental health services provision in north Ceredigion
12/04/2025	13274	Member of staff St Nons Ward, Bro Cerwyn
30/04/2025	13391	Critical care provision in Carmarthenshire
02/05/2025	13274	Member of staff St Nons Ward, Bro Cerwyn - additional query
20/05/2025	13271	Paediatric Medical Workforce – request for update regarding recruitment progress
	13272	Mental health services provision in north Ceredigion – request for further information
	13274	St Non's Ward – request for update
06/06/2025	13747	Withybush General Hospital – care of patient
11/06/2025	13391	Critical care provision in Carmarthenshire - status and timescales CSP consultation
11/06/2025	13274	St Non's Ward – request for update
18/08/2025	14435	Bro <u>Cerwyn</u>
13/08/2025	13272	MH&LD CTP compliance including update on actions to improve compliance
13/08/2025	14414	Withybush Hospital - procedures in place for informing patients about the re-enablement team, as well the information provided to them
24/07/2025	13747	WGH / Mental Health family concern – outcome date requested. Responded to 29/07/25 to advise plan to share on 8 th Aug 25.
18/07/2025	14165	WGH Ward 10 assurance – assurance re provision for food and water and support for patients on ward
08/07/2025	13747	WGH / Mental Health family concern – update requested
08/07/2025	14043	GGH Radiology anonymous staffing concerns

HIW Quality Checks/Inspections: Reviews and inspections

Improvement Actions relating to HIW reviews Source: AMaT 25/11/2025



	Overdue	Partially complete (overdue)
Community and Integrated Medicine	45	10
Estates and Facilities	1	1
Mental Health and Learning Disabilities	10	2
Nursing, Quality and Patient Experience	4	2
Operational Allied Health and Health Science	7	1
Planned and Specialist Care	1	0

	Position as at 07/10/2025	Position as at 25/11/2025
Overdue	25	68
Partially complete (overdue)	12	16
Partially complete	2	3
In progress	83	87
Rejected (to be resubmitted)	3	5

Open HIW inspections

No. of inspections	MD	SD	WN	PIR	Actions							
					In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
14	153/277 (55%)	1/1 (100%)	0	0	87	3	16	68	9	7	5	302

Note for each open inspection, an action is created for the QAS Team to confirm with HIW closure of the inspection actions (this is not included within the HIW inspection report). Therefore, if actions are overdue, the action for QAST will also be overdue.

Completed HIW inspections

No. of inspections	MD	SD	WN	PIR	Actions							
					In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
27	248/248 (100%)	18/18 (100%)	0	0	0	0	0	0	6	0	0	492

HIW Quality Checks/Inspections: Open reviews and inspections

Code	Title	MD	SD	WN	PIR	Actions							
						In progress	Partially complete	Partially complete (Overdue)	Overdue	Unable to complete	Completed (awaiting approval)	Rejected	Completed
Healthcare Inspectorate Wales (HIW)/2024/395	Bryngolau Ward, Prince Philip Hospital	38/40 (95%)	0	0	0	0	0	1	1	0	0	0	49
Healthcare Inspectorate Wales (HIW)/2024/396	HIW Children and Young People Mental Health Review	4/9 (44%)	0	0	0	9	0	1	3	1	0	0	9
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	3/9 (33%)	0	0	0	0	0	4	13	0	0	1	37
Healthcare Inspectorate Wales (HIW)/2022/19	HIW GGH IRMER Inspection (Nov 2022)	19/21 (90%)	0	0	0	0	0	0	2	0	0	0	34
Healthcare Inspectorate Wales (HIW)/2025/565	HIW GGH Maternity Services 03924	9/13 (69%)	0	0	0	3	0	0	0	0	2	0	18
Healthcare Inspectorate Wales (HIW)/2024/302	HIW Glangwili Hospital – Morlais Ward inspection	7/9 (78%)	0	0	0	0	0	1	1	0	0	0	16
Healthcare Inspectorate Wales (HIW)/2023/29	HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	16/40 (40%)	0	0	0	0	0	0	3	4	4	0	22
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	1/29 (3%)	0	0	0	35	0	4	28	0	0	1	7
Healthcare Inspectorate Wales (HIW)/2024/86	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	6/9 (67%)	0	0	0	0	1	1	1	1	0	0	10
Healthcare Inspectorate Wales (HIW)/2023/69	HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	11/18 (61%)	1/1 (100%)	0	0	0	0	0	2	0	0	1	22
Healthcare Inspectorate Wales (HIW)/2024/498	IRMER Regulations	7/9 (78%)	0	0	0	0	0	0	3	0	0	0	7
Healthcare Inspectorate Wales (HIW)/2025/587	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	8/21 (38%)	0	0	0	12	2	2	4	0	0	2	12
Healthcare Inspectorate Wales (HIW)/2025/595	Mynydd Mawr Ward, Prince Philip Hospital 03921	14/24 (58%)	0	0	0	7	0	2	6	3	1	0	39
Healthcare Inspectorate Wales (HIW)/2025/596	Nuclear Medicine IRMER WGH 03909	10/26 (38%)	0	0	0	21	0	0	1	0	0	0	20

HIW: How we compare to other Health Boards

The QAS team review all HIW activity on a weekly basis. As a comparator this is the number of reports on the the HIW website as of 24/11/2025 for all local Health Boards.

Health Board	Number Inspection reports
Hywel Dda	137
Anuerin Bevan	214
Betsi Ca	268
Cardiff & Vale	171
Cwm Taf	160
Powys	62
Swansea Bay	138
Public Heath	1
Velindre	1
WAST	0

Recommendations



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University Health Board

The Quality, Safety and Experience Committee (QSEC) is asked to note the contents of this report.

The Quality, Safety and Experience Committee is asked to take assurance that processes are in place to review, monitor and improve the quality of our service through:

- Patient safety incidents
- Nationally reported patient safety incidents
- Duty of Candour
- Patient Experience
- Complaints management
- Public Services Ombudsman for Wales
- Infection prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)





Collation of report: Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding

Sections:

1. Patient Safety Incident Reporting – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
2. Nationally reportable incidents – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
3. Duty of Candour – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
4. Patient experience – Louise O'Connor, Assistant Director for Legal Services and Patient Experience
5. Complaints Management – Louise O'Connor, Assistant Director for Legal Services and Patient Experience
5. Infection Prevention and Control – Rebecca Richards, Head of Infection Prevention and Control
6. Healthcare Inspectorate – Caroline Burgin, Patient Safety and Assurance



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Hywel Dda
University Health Board



The Duty of Candour

Openness and honesty should be at the heart of every relationship between those providing treatment and care and those experiencing it.



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

45	Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	Healthcare Inspectorate Wales (HIW)/2025/628/MD1/7	•To further sharing and dissemination of learning within wider Health Board forum: 2.Senior Nurse Management Team (SNMT),	Carmarthenshire Integrated System	17/11/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	The health board must ensure that checks of the drug refrigerator in the clinical room are monitored and recorded daily.	Healthcare Inspectorate Wales (HIW)/2025/628/MD1/8	To further sharing and dissemination of learning within wider Health Board forum: 3.Medication Events Review Group (MERG).	Carmarthenshire Integrated System	26/09/2025	Partially complete (Overdue)	Audit findings added to MERG agenda for 28th November, unable to complete before then.
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	The health board must ensure that sufficient domestic staff are available to clean the ward to maintain appropriate infection prevention and control (IPC)	Healthcare Inspectorate Wales (HIW)/2025/628/MD3/1	To undertake spot checks of domestic staff compliance with hand hygiene and PPE when in clinical areas. Findings and remedial actions to be reported to the Infection Prevention Strategic Steering Group.	Carmarthenshire Integrated System	31/10/2025	Overdue	To note: the Facilities Team will be implementing a new model of cleaning provision across all acute hospital sites. This will include the recruitment of additional staff to improve cleanliness standards and the introduction of revised rotas and shift patterns tailored to each site's operational needs. A Task & Finish (T&F) Group will be established to support the Facilities and Nursing Teams during the implementation phase of the new cleaning and catering model. The group will meet monthly to review progress, identify challenges, and coordinate solutions. Membership will include representatives from both teams, with meeting outcomes documented and shared. The group will remain active until full implementation is achieved. Interviews for a Facilities Manager (Band 8a) to support the Facilities Team during the implementation phase of the new cleaning and catering model will start week commencing 22nd September 2025. The recruitment process to fill the 8.63 WTE vacancies in the domestic team has commenced. The Hotel Services Manager will provide fortnightly updates on recruitment progress, including shortlisting, interview dates, and onboarding timelines. Full staffing levels are expected to be achieved by 30 November 2025, with impact on service delivery reviewed monthly thereafter.
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	The health board must ensure that multi patient use items such as BP cuffs, are appropriately decontaminated between use and that clean equipment is correctly labelled.	Healthcare Inspectorate Wales (HIW)/2025/628/MD4/2	To review training attendance and requirements of staff for IPC e-learning module. Training compliance will be monitored via Carmarthenshire System Infection Prevention and Control Locality Meeting.	Community & Integrated Medicine	29/10/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	The health board must ensure that multi patient use items such as BP cuffs, are appropriately decontaminated between use and that clean equipment is correctly labelled.	Healthcare Inspectorate Wales (HIW)/2025/628/MD4/4	To undertake spot checks of the results to ensure sustained compliance.	Community & Integrated Medicine	31/10/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	The health board must ensure that patient records are stored securely at all times.	Healthcare Inspectorate Wales (HIW)/2025/628/MD7/2	To review the training attendance and requirements of staff for Information Governance e-learning and report the findings to the Carmarthenshire Integrated Performance and Business Management Care Group, with a clear plan for improvement if required.	Carmarthenshire Integrated System	31/10/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	Healthcare Inspectorate Wales (HIW)/2025/628/MD8/1	To remind all ward clinical staff of their responsibility to document all risk assessments and associated actions in the patient record, in line with the Monitoring, Recording of Adult Physiological Observations and Response to Physical Deterioration Policy. This includes initial assessments, reassessments, and any interventions taken. The requirement will be reinforced through staff meetings and mandatory training sessions, with attendance recorded and compliance monitored through monthly documentation audits by the Senior Ward Manager.	Carmarthenshire Integrated System	15/09/2025	Partially complete (Overdue)	Completed prior to AMAT upload Staff have been reminded of the requirement to document all risk assessments and associated actions in the patient record, as per Monitoring, Recording of Adult Physiological Observations and Response to Physical Deterioration Policy. This includes initial assessments, reassessments, and any interventions taken. This will be reinforced through staff meetings and training. Review training attendance and requirements of staff for NEWS 2 e-learning module. Review training attendance and requirements of staff for classroom ILS/BLS Additional training arranged to support the early recognition of a deteriorating patient. Weekly spot checks will be conducted by the senior ward manager or designated team member to ensure compliance with accurate NEWS scoring and escalation of sepsis as per guidance. Implementation of E-Observations (Electronic NEWS recording) throughout the hospital site.

45	Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	<p>The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes:</p> <ul style="list-style-type: none"> •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance. 	Healthcare Inspectorate Wales (HIW)/2025/628/MD8/2	To review the current training compliance of staff for NEWS 2 e-learning module and develop a plan to ensure timely completion of the e-learning module. Training compliance will be monitored via RADAR scrutiny meeting.	Carmarthenshire Integrated System	13/11/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	<p>The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes:</p> <ul style="list-style-type: none"> •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance. 	Healthcare Inspectorate Wales (HIW)/2025/628/MD8/3	To review the current training compliance of staff for classroom ILS/BLS and develop a plan to ensure timely completion of the learning. Training compliance will be monitored via RADAR scrutiny meeting.	Carmarthenshire Integrated System	13/11/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	<p>The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes:</p> <ul style="list-style-type: none"> •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance. 	Healthcare Inspectorate Wales (HIW)/2025/628/MD8/4	To arrange additional training to support the early recognition of a deteriorating patient.	Carmarthenshire Integrated System	15/09/2025	Partially complete (Overdue)	<p>Completed prior to AMAT upload- The dates for the additional training are 25th, 27th and 29th September 2025)</p> <p>Staff have been reminded of the requirement to document all risk assessments and associated actions in the patient record, as per Monitoring, Recording of Adult Physiological Observations and Response to Physical Deterioration Policy. This includes initial assessments, reassessments, and any interventions taken. This will be reinforced through staff meetings and training.</p> <p>Review training attendance and requirements of staff for NEWS 2 e-learning module.</p> <p>Review training attendance and requirements of staff for classroom ILS/BLS</p> <p>Additional training arranged to support the early recognition of a deteriorating patient.</p> <p>Weekly spot checks will be conducted by the senior ward manager or designated team member to ensure compliance with accurate NEWS scoring and escalation of sepsis as per guidance.</p> <p>Implementation of E-Observations (Electronic NEWS recording) throughout the hospital site.</p> <p>Pharmacy/Nursing to reinforce the need for Medical Colleagues to complete and document the VTE Risk Assessment.</p> <p>VTE Site Improvement plan in place.</p> <p>Preventing Thrombosis and VTE showcase event.</p> <p>Hospital Acquired Thrombosis SharePoint page available with current resources and information.</p> <p>Monthly spot checks of VTE risk assessments on Surgical, Medical and Trauma & Orthopaedic ward areas.</p> <p>Review of VTE risk assessment compliance findings to be discussed</p>

45	Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	Healthcare Inspectorate Wales (HIW)/2025/628/MD8/6	To reinforce to medical staff the requirement to complete and document the VTE Risk Assessment.	Carmarthenshire Integrated System	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	Healthcare Inspectorate Wales (HIW)/2025/628/MD8/7	To promote the Hospital Acquired Thrombosis SharePoint page which is available with current resources and information.	Carmarthenshire Integrated System	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	The health board must ensure that all staff have received training and complete patient risk assessments appropriately and take the relevant action in line with local or national guidance, and document this in patient records. This includes: •Taking appropriate action when NEWS scores are 3 or above •Completing and documenting Sepsis Screening for those at risk of sepsis, such as a NEWS score of 5 or above •Completing and documenting VTE risk assessments on admission and thereafter in line with local and national guidance.	Healthcare Inspectorate Wales (HIW)/2025/628/MD8/9	To review of VTE risk assessment compliance findings to be discussed within the Carmarthenshire System Quality and Safety Governance meeting (feeding into our Clinical Care Group)	Carmarthenshire Integrated System	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	Healthcare Inspectorate Wales (HIW)/2025/628/MD9/2	To share the immediate actions through the Community and Integrated Medicine Professional Nurse Forum.	Carmarthenshire Integrated System	31/10/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	Healthcare Inspectorate Wales (HIW)/2025/628/MD9/6	To support with individual ward review to monitor and ensure compliance with actions. Where compliance is found to not be in place, immediate remedial activity to commence.	Carmarthenshire Integrated System	01/10/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/628	HIW Derwen Ward 04054	The health board must ensure that all the findings in this immediate improvement plan are not systemic across all other wards within the hospital and the wider health board.	Healthcare Inspectorate Wales (HIW)/2025/628/MD9/7	To present the Quality Improvement audit results for all wards (inclusive of actions at the Care Group Quality and Safety Group for assurance.	Carmarthenshire Integrated System	16/10/2025	Partially complete (Overdue)	All ward areas audit added as evidence.

45	Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2022/19	HIW GGH IRMER Inspection (Nov 2022)	The employer is required to provide HIW with details of the action taken to improve the ratification process for locally produced documentation so that information does not conflict with the employer's written procedure	Healthcare Inspectorate Wales (HIW)/2022/19/MD15/2	To source a document control system.	Radiology	30/09/2023	Overdue	Update 23/11/23 added to risk register Requirement escalated in exception report to OQSEC 09/01/2024 6/9/24- Update: This action cannot be completed at this time as it requires additional investment. I will be escalating this in my next QSEG report. 13/12/24- Update- presented to QSEG- on annual plan to employ quality radiographer. Have considered document from other services. Remains ongoing. On risk register Feb 2025- Update need for document control system and quality lead Radiographer included in Radiology annual plan March 2025 update- HB annual plan approved by the Board on 28/03/2025 which has included the Quality Lead Radiographer and document control system. Steps will be put in place shortly to recruit to the post and procure a document control system. April 2025- Currently wiring the JD for this post which will be advertised May 2025. Recruitment expected August 2025 September 2025 - OCP starting - expected to be advertised in December 25 - post filled May 26 - unable to complete action until Dec 26 (post needs to be filled before document control system can be purchased)
Healthcare Inspectorate Wales (HIW)/2024/396	HIW Children and Young People Mental Health Review	Health boards must reflect on the feedback from CAMHS referrers, parents, and carers to enhance transparency regarding the criteria and thresholds for accessing CAMHS assessments and interventions. This process should involve revising the outcome letter templates used to communicate decisions following the Single Point of Access (SPOA) and CAMHS assessments, ensuring that they clearly convey the rationale behind decisions and improve overall understanding and communication.	Healthcare Inspectorate Wales (HIW)/2024/396/MD5/1	1.T&F group will review and establish standard letters for SPOA & Secondary S-CAMHS: Initial contact letters & follow up letters to include a clear rationale for clinical decision.	Mental Health & Learning Disabilities	03/11/2025	Overdue	05/11/25 UPDATE - SPOC letters have been signed off and are now in use. - Secondary CAMHS letters have been drafted and are out for feedback with team leads and team secretaries. These will be completed and implemented by the end of November. Previous update: We believe our capacity to provide clarity in relation to criteria and thresholds is hampered by the lack of sufficient clarity nationally in relation to this. Further clarity at a national level would support enhanced transparency by allowing us to provide additional detail and to define terms such as mild, moderate and severe. 25/11/2025: Work underway. Revised completion date of 31st December 2025.
Healthcare Inspectorate Wales (HIW)/2024/396	HIW Children and Young People Mental Health Review	Health boards must reflect on the feedback from CAMHS referrers, parents, and carers to enhance transparency regarding the criteria and thresholds for accessing CAMHS assessments and interventions. This process should involve revising the outcome letter templates used to communicate decisions following the Single Point of Access (SPOA) and CAMHS assessments, ensuring that they clearly convey the rationale behind decisions and improve overall understanding and communication.	Healthcare Inspectorate Wales (HIW)/2024/396/MD5/2	T&F group will review and establish standard letters for SPOA & Secondary S-CAMHS: Service user information leaflet outlining criteria of NHS S-CAMHS and CAPA model	Mental Health & Learning Disabilities	03/11/2025	Overdue	UPDATE 5/11/2025: A leaflet has been drafted and updated based on initial feedback. It has gone out for further feedback and will be completed and sent out for use by the end of November. Previous update: We believe our capacity to provide clarity in relation to criteria and thresholds is hampered by the lack of sufficient clarity nationally in relation to this. Further clarity at a national level would support enhanced transparency by allowing us to provide additional detail and to define terms such as mild, moderate and severe. 25/11/2025: Work underway. Revised completion date of 31st December 2025.
Healthcare Inspectorate Wales (HIW)/2024/396	HIW Children and Young People Mental Health Review	Health boards must reflect on the feedback from CAMHS referrers, parents, and carers to enhance transparency regarding the criteria and thresholds for accessing CAMHS assessments and interventions. This process should involve revising the outcome letter templates used to communicate decisions following the Single Point of Access (SPOA) and CAMHS assessments, ensuring that they clearly convey the rationale behind decisions and improve overall understanding and communication.	Healthcare Inspectorate Wales (HIW)/2024/396/MD5/3	Service User Forum will be involved in reviewing and co-production of leaflets	Mental Health & Learning Disabilities	03/11/2025	Overdue	05/11/2025 Leaflet drafted and provided to three team leads to gather feedback from CYP and parents/carers. 25/11/2025: Work underway. Revised completion date of 31st December 2025.
Healthcare Inspectorate Wales (HIW)/2024/396	HIW Children and Young People Mental Health Review	Health boards must explore the options available within their local CAMHS teams to facilitate a strengthened approach for communication and partnership working with GP clusters and/or directly with GP practices.	Healthcare Inspectorate Wales (HIW)/2024/396/MD32/1	S-CAMHS will discuss with GP Clusters to discuss an agreed approach to partnership working and improving communication, including the suggestion of a regular (bi-monthly) forum	Mental Health & Learning Disabilities	04/08/2025	Partially complete (Overdue)	28/10/2025: Awaiting confirmation of cluster meeting dates from Clinical Director, Primary Care Services. Further information re GP leads is being sought to move this forward. Revised completion date 31/12/2025.

45	Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2024/395	Bryngolau Ward, Prince Philip Hospital	The health board should consider the staff feedback about suggestions for training and implement regular, individualised training needs assessments.	Healthcare Inspectorate Wales (HIW)/2024/395/MD33/1	Develop and deliver bespoke Older Adult Mental Health Clinical Risk training specifically around self-harm and suicidality, to all OAMH Wards.	Adult Mental Health Inpatient	31/03/2025	Partially complete (Overdue)	<p>Bespoke training around suicide/self-harm prevention [specific to OAMH] clinical risk management has been designed with a view for delivery before 31.03.24 Awaiting training plan (dates).</p> <p>Update - Principal Clinical Psychologist developed and delivered older adult mental health services specific suicide assessment, formulation and safety planning training via Teams. All Older Adult CMHT and Inpatient ward MDTs were invited to attend. I believe a system to log attendees was set up with Dr and operational manager. Further implementation of these relevant tools is being modelled on the ward by a Senior Nurse Practitioner.</p> <p>06.05.25 Update: Senior Nurse Practitioner is on long term sick leave/Dr has retired. TRAC recruitment on third attempt to replace Clinical Psychologist (difficult to recruit to post). Service needs to consider alternative plans to achieve action: roll-out of "person-centred safety planning" akin to pilot on AMH wards may suffice. Head of Service to confirm and set new completion date.</p> <p>08.05.25 Update: Service Manager has agreed to take the lead on this action and supplant the planned action with rolling out "person-centred safety planning" across all OAMH Wards in line with AMH service initiative that links to the National Inpatient Safety Work/Recommendations (the aforementioned training will still be completed when capacity is in place). Additionally, there are individual Ward Risk Assessments on action theme with a completion timeframe for end of June 25. NEW COMPLETION DATE: end Sept 2025.</p>
Healthcare Inspectorate Wales (HIW)/2024/302	HIW Glangwili Hospital – Morlais Ward inspection	The health board must ensure that the outstanding actions identified following the fire safety audit in February 2024 are completed and sustained.	Healthcare Inspectorate Wales (HIW)/2024/302/MD6/1	To review the recommendations from the fire safety audit and agree an implementation plan.	Compliance & Fire Department	31/12/2024	Partially complete (Overdue)	<p>Update 10/4/25 - It was identified last week which document this actually refers to as there had been confusion. PPM schedules are in place for fire doors and quotes are to be obtained for 2 x fire door replacement. Additional electrical sockets have been added where required. Completion August 2025</p> <p>Update 24/4/25- Multi quote closes tomorrow and will forward paper work on my return next week.</p> <p>Update 3.6.25- Fire related issues have been completed as per Fire Safety Audit apart from Fire Door Replacement. Orders have now been raised following approval of capital bid submission and expected completion Aug 25 due to lead time and manufacture of doors.</p> <p>Update 4.7.25 - Additional door required which has delayed previous order due to procurement issues. Expected completion Dec 2025.</p> <p>Update 9.7.25- Orders raised for doors, due for installation late August.</p> <p>5.8.25 Update- Fire doors are on order with a completion date of December 2025.</p> <p>1.10.25- to be completed by December 2025. Fire doors are on order, and all other recommendations are complete.</p>

45	Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2023/29	HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must take action to manage the risks of insufficient staff numbers and temporary staffing needs on inpatient mental health wards.	Healthcare Inspectorate Wales (HIW)/2023/29/MD25/3	p)Pilot application of the SAFECARE tool across an individual mental health inpatient ward to inform an approach to full implementation.	Mental Health & Learning Disabilities	30/11/2023	Overdue	Update 24/05/24 Delay in updates to this action due to delay in publication of Welsh levels of care guidance for inpatient mental health and pause of All Wales Mental Health Workstream for Nurse Staffing. Extraordinary MH Workstream Group meeting scheduled for 4th June 2024 where practical application of Welsh Levels of Care within SAFECARE will be reconsidered. Local capacity being scoped within the Hywel Dda Nurse Staffing Team in anticipation of being able to work towards implementing a local pilot of SAFECARE across one mental health inpatient ward. Timescale for completion therefore revised to 31/12/2024. Update -07/01/2025 - Executive meeting did not go ahead on 18/12/2025 therefore meeting has been rescheduled - revised completion date 31/01/2025 Update 23/05/25 - Inpatient Workforce Stabilisation Paper, including recommendation for roll out of SafeCare across mental health wards presented to Executive Team on 07/05/25 - paper uploaded as evidence. Confirmation now received of commitment and support to this. SafeCare Pilot to be undertaken in Older Adult Mental Health Services ahead of full roll out scheduled by the Nurse Staffing Team to take place in October 2025. Action remains in progress with revised timescale of 31/10/2025. 25/11/2025: Update requested from Nurse Staffing Programme Team. Revised completion date 31/03/2026.
Healthcare Inspectorate Wales (HIW)/2023/29	HIW Improvement Plan – adapted from the CTMUHB Mental Health Discharge Review (Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf)	The health board must consider undertaking a training needs analysis for inpatient and community mental health staff, to identify any training gaps and help ensure all staff have the appropriate knowledge and skills to effectively undertake their role.	Healthcare Inspectorate Wales (HIW)/2023/29/MD32/1	u)Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	Mental Health & Learning Disabilities	30/11/2023	Overdue	Update 22/11/23 Training Needs Analysis tool developed by Learning and Development Team to be piloted across MHL D services. Update 24/05/24 Update. Progress with action delayed due to directorate capacity to facilitate pilot of TNA tool. Directorate to re engage with Learning and Development to agree a plan to progress. Completion date therefore revised to 30/09/24. Update 30/06/2025: Capacity has remained a challenge and the CCG to re-engage with Learning and Development to agree a plan to progress. To also progress appointment of Head of Nursing, and an additional post. Revised completion date 31st October 2025. 25/11/2025: Recent bid for HEIW Funding has been approved which incorporates funding to support completion of this piece of work. Next steps to be agreed with Assistant Director of People Planning. Revised completion date 31/03/2026.
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that measures are in place to ensure that medication storage fridge temperatures are checked and recorded on a daily basis.	Healthcare Inspectorate Wales (HIW)/2025/668/MD1/1	To complete checks of medication storage fridge temperature alongside the daily checks of the resuscitation trolley	Cered IS - Emergency Services	02/10/2025	Partially complete (Overdue)	As of 02/08/25, this is now part of the daily resus checklist and is being actively completed. In addition, senior nurse management team will undertake regular spot checks to ensure ongoing compliant
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that measures are in place to ensure that medication storage fridge temperatures are checked and recorded on a daily basis.	Healthcare Inspectorate Wales (HIW)/2025/668/MD1/2	To notify all staff of change.	Cered IS - Emergency Services	02/08/2025	Partially complete (Overdue)	Notified by A&E Ward sisters across usual communication channels. Paper copy record kept in dept. Evidence to be uploaded
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that measures are in place to ensure that medication storage fridge temperatures are checked and recorded on a daily basis.	Healthcare Inspectorate Wales (HIW)/2025/668/MD1/3	Weekly spot checks to be undertaken by senior nurse management team to ensure ongoing compliance and submit assurance to System General Manager. This will be monitored through the update report to the Clinical Care Group Governance meeting until action plan is fully implemented.	Cered IS - Emergency Services	30/09/2025	Overdue	

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Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that the paediatric emergency trolley is checked regularly and an accurate record of checks maintained.	Healthcare Inspectorate Wales (HIW)/2025/668/MD2/1	To discuss with EUCC team and ensure that they are aware that the paediatric emergency trolley is to be included in the daily checks of the resuscitation trolley. To issue reminder also to be given regarding record keeping of checks.	Cered IS - Emergency Services	05/08/2025	Partially complete (Overdue)	This was already part of the daily resus checklist and is actively completed. It is recognised that the paed checklist originally issued is for a ward and different equipment is utilised in a resus area. Discussions held and confirmed to continue with daily resus checklist but to ensure everything is recorded. All staff notified and aware. In addition, senior nurse management team will undertake regular weekly spot checks to ensure ongoing compliance and submit assurance to System GM
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that the paediatric emergency trolley is checked regularly and an accurate record of checks maintained.	Healthcare Inspectorate Wales (HIW)/2025/668/MD2/2	Weekly spot checks to be undertaken by senior nurse management team to ensure ongoing compliance and submit assurance to System General Manager. This will be monitored through the update report to the Clinical Care Group Governance meeting until action plan is fully implemented.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that the 'difficult airway' trolley is checked regularly and an accurate record of checks maintained.	Healthcare Inspectorate Wales (HIW)/2025/668/MD3/2	To utilise whiteboard in main theatres with checklist so that any gaps easily identifiable.	PLN Care - Theatres	04/08/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that the 'difficult airway' trolley is checked regularly and an accurate record of checks maintained.	Healthcare Inspectorate Wales (HIW)/2025/668/MD3/3	To issue reminder also to be given regarding record keeping of checks.	PLN Care - Theatres	04/08/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	HIW requires details on how the health board will ensure that the 'difficult airway' trolley is checked regularly and an accurate record of checks maintained.	Healthcare Inspectorate Wales (HIW)/2025/668/MD3/4	Weekly spot checks to be undertaken by senior nurse management team to ensure ongoing compliance and submit assurance to System General Manager. This will be monitored through the update report to the Clinical Care Group Governance meeting until action plan is fully implemented.	PLN Care - Theatres	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must continue with efforts to reduce the number of patients receiving care in corridor areas.	Healthcare Inspectorate Wales (HIW)/2025/668/MD5/1	To continue with targeted efforts to improve the flow through our system which will then reduce the need to care for people in non-clinical areas such as the corridors through the 6 Goals workstreams. Measures of improvement include, reducing mean length of stay, reducing delayed pathways of care and increasing the number of pre-midday discharges.	Cered IS - Emergency Services	30/09/2025	Partially complete (Overdue)	Work in situ and ongoing to target reduction of patients in corridor care. Measures of improvement included Criteria Led Discharge, refreshed system flow meetings, senior leadership oversight on delayed pathways of care and our next patient to improve the number of pre midday discharges. Review 31st March 2026
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must continue to monitor triage times and ensure that there is an effective escalation process in place when triage times increase.	Healthcare Inspectorate Wales (HIW)/2025/668/MD6/2	To include time to triage in the discussion of the twice daily meetings between the clinical site managers and the internal ODU. Where time to triage waits are identified as unsafe the clinical site manager ensures the emergency department implements a plan until the waiting time is back within safe limits.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must continue with efforts to improve patient flow through the department and across the wider hospital.	Healthcare Inspectorate Wales (HIW)/2025/668/MD7/2	To implement whole system flow meetings to improve efficiency and communication between the acute and community system.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must continue with efforts to improve patient flow through the department and across the wider hospital.	Healthcare Inspectorate Wales (HIW)/2025/668/MD7/4	Reduce demand - to progress the multidisciplinary work to establish a consultant connect pathway from GPs and paramedics to the SDUC service in Cardigan and SDUC Outreach as a safe alternative to hospital.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must remain focused on completing timely reviews by speciality teams in ED, and reinforce the need for a whole hospital approach and shared responsibility to improving the flow of patients through the ED.	Healthcare Inspectorate Wales (HIW)/2025/668/MD9/1	To increase visibility of the EUCC Triage times on the operational dashboard which is monitored regularly by operational managers and the newly established Health Board ODU.	Cered IS - Emergency Services	30/09/2025	Overdue	

45	Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must ensure that Datix referrals are processed in a timely way and that sufficient numbers of staff are trained in this process.	Healthcare Inspectorate Wales (HIW)/2025/668/MD11/1	To ensure that the consultant workforce receive training in incident management and investigation processes. This development is expected to improve the timeliness and quality of incident reporting and processing, ensuring a more consistent and responsive approach to learning from events.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must evaluate and enhance security measures to ensure the safety of both staff and patients.	Healthcare Inspectorate Wales (HIW)/2025/668/MD12/3	To continue with the outsourcing of site security, when high risk individuals are supported on site.	Cered IS - Emergency Services	30/09/2025	Overdue	To note: Porter staff have received training in responding to incidents involving violence, aggression, and absconded patients, ensuring they are equipped to act safely and appropriately in such situations.
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must evaluate and enhance security measures to ensure the safety of both staff and patients.	Healthcare Inspectorate Wales (HIW)/2025/668/MD12/5	To monitor compliance is through the Estates and Facilities Care Group Quality Health and Safety Group.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must review the mental health assessment room and ensure that it is fit for purpose and safe to use.	Healthcare Inspectorate Wales (HIW)/2025/668/MD13/3	To seek advice from Mental Health teams in relation to the alarm system.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must ensure that the paediatric emergency trolley and difficult airway trolley are appropriately sealed when not in use.	Healthcare Inspectorate Wales (HIW)/2025/668/MD14/1	To address the risk of essential equipment being removed from the paediatric emergency and difficult airway trolleys, tamper-evident security tabs have now been sourced and implemented. These tabs seal the trolleys between checks, providing assurance that equipment remains intact and ready for use in the event of an emergency. Compliance with sealing and checking procedures will be monitored through regular audits and reviewed at local assurance meetings to ensure sustained safety and readiness.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must ensure that staff are reminded of the need to maintain good hand hygiene in order to reduce the risk of cross infection.	Healthcare Inspectorate Wales (HIW)/2025/668/MD15/1	To remind staff of the importance of complying with good hand hygiene practices to reduce the risk of infection and support safe patient care and to reinforce this message through safety huddles and visual prompts in clinical areas.	Cered IS - Emergency Services	31/10/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must ensure that staff are reminded of the need to maintain good hand hygiene in order to reduce the risk of cross infection.	Healthcare Inspectorate Wales (HIW)/2025/668/MD15/4	To ensure any concerns are escalated to the Care Group's Quality, Health and Safety Meeting to ensure sustained oversight and improvement.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must ensure that immunocompromised cancer patients presenting at ED are appropriately accommodated, to reduce the risk of harm.	Healthcare Inspectorate Wales (HIW)/2025/668/MD16/1	To establish an oncology assessment pathway, enabling patients who contact the triage line to be signposted directly to a designated assessment space on Meurig Ward. This pathway will enhance timely access to specialist care.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must ensure that pressure area risk assessments are undertaken routinely for patients whose presenting condition warrant such a risk assessment.	Healthcare Inspectorate Wales (HIW)/2025/668/MD19/2	To support this, to introduce regular spot checks and documentation audits, with results reviewed through existing local assurance meetings. To continue to monitor trends in incident reporting related to pressure damage through the meetings and escalate to the Care Group's Quality, Health and Safety Meeting for oversight, ensuring ongoing vigilance, learning, and improvement.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must ensure that pressure area risk assessments are undertaken routinely for patients whose presenting condition warrant such a risk assessment.	Healthcare Inspectorate Wales (HIW)/2025/668/MD19/4	To ensure that any concerns are escalated to the Care Group's Quality, Health and Safety Meeting providing sustained oversight and improvement.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must ensure that falls risk assessments are undertaken routinely and in a timely way for patients whose presenting condition warrant such a risk assessment.	Healthcare Inspectorate Wales (HIW)/2025/668/MD20/2	To support this, to introduce regular spot checks and documentation audits, with results reviewed through existing local assurance meetings. Trends in falls related incidents will be monitored through these meetings and escalated to the Care Group's Quality, Health and Safety Meeting for oversight if required, ensuring ongoing vigilance, learning, and improvement.	Cered IS - Emergency Services	30/09/2025	Overdue	

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Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must ensure that falls risk assessments are undertaken routinely and in a timely way for patients whose presenting condition warrant such a risk assessment.	Healthcare Inspectorate Wales (HIW)/2025/668/MD20/4	To ensure that any concerns are escalated to the Care Group's Quality, Health and Safety Meeting to ensure sustained oversight and improvement.	Cered IS - Emergency Services	29/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must ensure that patient assessments are fully completed and documented.	Healthcare Inspectorate Wales (HIW)/2025/668/MD21/2	To support this, to introduce regular spot checks and documentation audit, with results reviewed through existing local assurance meetings. Trends will be monitored through these meetings and escalated to the Care Group's Quality, Health and Safety Meeting for oversight, ensuring ongoing vigilance, learning, and improvement.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must ensure that patient assessments are fully completed and documented.	Healthcare Inspectorate Wales (HIW)/2025/668/MD21/4	To ensure that any concerns are escalated to the Care Group's Quality, Health and Safety Meeting to ensure sustained oversight and improvement.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must ensure that fluid intake and output balance charts are being completed consistently.	Healthcare Inspectorate Wales (HIW)/2025/668/MD22/2	To support this, to introduce regular spot checks and documentation audit, with results reviewed through existing local assurance meetings. Trends will be monitored through these meetings and escalated to the Care Group's Quality, Health and Safety Meeting for oversight, ensuring ongoing vigilance, learning, and improvement.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must ensure that fluid intake and output balance charts are being completed consistently.	Healthcare Inspectorate Wales (HIW)/2025/668/MD22/4	To ensure that any concerns are escalated to the Care Group's Quality, Health and Safety Meeting to ensure sustained oversight and improvement.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must ensure that staff documentation in patient records provide sufficient clinical/ care details, and records are completed consistently and are legible.	Healthcare Inspectorate Wales (HIW)/2025/668/MD23/2	To support this, to introduce regular spot checks and documentation audit, with results reviewed through existing local assurance meetings. Trends will be monitored through these meetings and escalated to the Care Group's Quality, Health and Safety Meeting for oversight, ensuring ongoing vigilance, learning, and improvement.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must ensure that staff documentation in patient records provide sufficient clinical/ care details, and records are completed consistently and are legible.	Healthcare Inspectorate Wales (HIW)/2025/668/MD23/4	To ensure that any concerns are escalated to the Care Group's Quality, Health and Safety Meeting to ensure sustained oversight and improvement.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/668	HIW Inspection BGH Emergency Department	The health board must ensure that the GP Out of Hours Service provides consistent and effective support to the ED when this is required.	Healthcare Inspectorate Wales (HIW)/2025/668/MD29/1	We acknowledge and appreciate the ongoing efforts of the GP Out of Hours service in helping to reduce demand at the EUCC front door. During periods of operational pressure, the Silver On-Call Manager has the ability to liaise directly with the Out of Hours team to explore capacity for additional support. However, this is dependent on the level of demand within their own service at the time. This collaborative approach is part of our wider system response to managing flow and ensuring patients receive timely and appropriate care.	Cered IS - Emergency Services	30/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2024/86	HIW IRMER Diagnostic Imaging x-ray department Witybush Hospital January 2024	The Employer is required to provide HIW with details of action taken to ensure that all written documentation in place include the required level of detail as set out within the employer's procedure for Quality Assurance programme document control.	Healthcare Inspectorate Wales (HIW)/2024/86/MD4/1	1. A document control system needs to be sourced	Radiology	31/12/2024	Overdue	13/12/24 - presented to QSEG- ongoing review and remains on risk register. Feb 2025- Update need for document control system and quality lead Radiographer included in Radiology annual plan March 2025 update- HB annual plan approved by the Board on 28/03/2025 which has included the Quality Lead Radiographer and document control system. Steps will be put in place shortly to recruit to the post and procure a document control system. April 2025- Quality Manager recruitment should be complete by Aug 2025 and an immediate must do within the workplan will be sourcing the quality control system. September 25 - OCP starting in Oct 25 - three month process. Expected to advertise post in Dec/Jan 26 - in post May 26. Post needs to be filled before action can be closed - expected Dec 2026

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Healthcare Inspectorate Wales (HIW)/2023/69	HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	The health board must ensure that safe holds are described in detail and that patient observations are recorded post any restraint or medical intervention in patient notes	Healthcare Inspectorate Wales (HIW)/2023/69/MD13/1	To undertake a Directorate wide audit of Rapid Tranquillisation against standards for physical health monitoring within the Health Boards Rapid Tranquillisation Policy.	Adult Mental Health Inpatient, Mental Health Management Team	31/03/2024	Overdue	Update 23/05/24 Progress with this action has been delayed due to limited medical capacity. Plans to develop a rapid tranquillisation audit will be discussed at the newly formed Clinical Audit and Effectiveness Group meeting taking place in June 2024. Timescale for completion revised to 30th September 2024. Update 04/09/25 Rapid Tranquillisation Audit identified as a priority audit within MHL Clinical Audit and Effectiveness Forward Audit Plan presented to MHL CCG Integrated Governance Group 19/08/25. Timescale for completion revised to 31/12/25.
Healthcare Inspectorate Wales (HIW)/2024/498	IRMER Regulations	Identify areas where more than one employer may be involved with and exposure and consider if the co-operation regulation needs actions. e.g. referrer (GP referrals), operator (third party imaging providers) or practitioner (out of hours practitioner service) has a different employer; to other duty holders	Healthcare Inspectorate Wales (HIW)/2024/498/MD2/1	Co-operation between employers: consider where relevant	Radiology	31/07/2025	Overdue	Update 3.9.25- All Wales approach – FO taking to AWIQF for update and progress. revised target date 31.1.26
Healthcare Inspectorate Wales (HIW)/2024/498	IRMER Regulations	Schedule 3 is re-organised with changes to core and specific training. Training in the amendment changes is required plus discipline specific review with additions to the “all modalities” elements probably most significant. A plan to cover any additions will be required.	Healthcare Inspectorate Wales (HIW)/2024/498/MD9/1	Review training needs of practitioners and operators	Radiology	30/06/2025	Overdue	update 3.9.25- Query sent to SE on 21/7 re All Wales progress made to date revised target date 31.1.26, update 12.11.25 need action from IA/MH to ensure EIRMER is added as mandatory.
Healthcare Inspectorate Wales (HIW)/2025/587	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.	Healthcare Inspectorate Wales (HIW)/2025/587/MD5/1	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026	Mental Health & Learning Disabilities	30/09/2025	Overdue	CCGs to identify targeted improvement plans and report to Strategic Safeguarding Steering Group November 2025.
Healthcare Inspectorate Wales (HIW)/2025/587	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.	Healthcare Inspectorate Wales (HIW)/2025/587/MD5/2	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026	Planned & Specialist Care	30/09/2025	Overdue	As this action 'sits' within Nursing, Medical Quality, Safety & patient Experience the ADON will be the overall action lead, assisted by AMD. CCGs to identify targeted improvement plans and report to Strategic Safeguarding Steering Group November 2025.
Healthcare Inspectorate Wales (HIW)/2025/587	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.	Healthcare Inspectorate Wales (HIW)/2025/587/MD5/3	All services to put in place improvement plans to achieve 85% compliance across all professional groups with Level 3 training by 31st March 2026	Community & Integrated Medicine	30/09/2025	Overdue	CCGs to identify targeted improvement plans and report to Strategic Safeguarding Steering Group November 2025.
Healthcare Inspectorate Wales (HIW)/2025/587	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	There can also be delays in health assessments being completed for children involved in the child protection process. Whilst the health board has identified improvements to address these concerns, ongoing delays mean protective actions to address risk can be adversely impacted.	Healthcare Inspectorate Wales (HIW)/2025/587/MD11/1	School Nursing service to put in place processes to monitor compliance with complying with health assessments requests within timescales.	Child Safeguarding Team	30/06/2025	Partially complete (Overdue)	Compliance discussed at the SN service monthly professional meetings, evidence attached.
Healthcare Inspectorate Wales (HIW)/2025/587	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	The reliance on CP medicals being completed by acute paediatricians in an out-of-county hospital, due to the lack of a service in Pembrokeshire, presents a long-standing and unresolved challenge to all agencies involved. The Health Board should consider how best to resolve these issues to ensure a more timely and seamless service, both for agencies and for the children and families involved.	Healthcare Inspectorate Wales (HIW)/2025/587/MD12/1	Work with Local Authority partners to agree an escalation process when health assessments are delayed.	Patient Safety Team	30/09/2025	Overdue	There is no agreement from consultants on a unified way forward at present. Further meeting due Nov 12th. This will require funding to implement a new rota. 12/11/2025 - meeting held. The community paediatric service would not be able to support this without considerable investment. Options for delivering a 5 day service are being scoped.
Healthcare Inspectorate Wales (HIW)/2025/587	Joint Inspection of Child Protection Arrangements (Pembrokeshire)	Partners should ensure timely information sharing about emerging safeguarding themes and work together to disrupt and reduce such risks within the population and for individual children.	Healthcare Inspectorate Wales (HIW)/2025/587/MD18/1	Prevention & emerging risks: HV and Midwifery to draft a Free Birth policy for consultation with regional multi-agency partners.	Patient Safety Team	30/09/2025	Partially complete (Overdue)	A draft policy has been developed for health visiting and internal health board consultation with Midwifery has taken place. In addition to this discussions have been had with the policy lead for the Health Board as well as bench marking with another Health Board. Children's Commissioner has also been consulted. When all is complete policy to be shared with multi-agency partners for further consultation before finalising, also taking into account the National perspective and progress on the management of Free birthing. This process near finalisation waiting for SBAR to be completed and policy taken to SNMT for sign off.

45	Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status	Comments/Updates
Healthcare Inspectorate Wales (HIW)/2025/595	Mynydd Mawr Ward, Prince Philip Hospital.03921	Implement robust measures to maintain clinic room temperatures within recommended guidelines for safe medication storage.	Healthcare Inspectorate Wales (HIW)/2025/595/MD2/2	The monitoring chart link requires to be embedded within the medicine policy for ease of access. This action has been requested and is underway.	Carms IS - Rehabilitation	30/09/2025	Overdue	Link embedded but awaiting ratification- update 1.10.25 (expected completion Dec 2025) Copy of the daily temperature log has been cascaded to all Heads of Nursing. Medicines policy is under review with no clear time scale on completion. A request has been made to extend the review for a further 6 months. (updated on the 7/10/25
Healthcare Inspectorate Wales (HIW)/2025/595	Mynydd Mawr Ward, Prince Philip Hospital.03921	Implement robust measures to maintain clinic room temperatures within recommended guidelines for safe medication storage.	Healthcare Inspectorate Wales (HIW)/2025/595/MD2/3	The requirement of the daily treatment room temperature check process and compliance will be reviewed and amended within a Quality Improvement Health Board Wide Task and Finish group. ToR being devised. Dates being arranged.	Carms IS - Rehabilitation	31/10/2025	Partially complete (Overdue)	Temperature Controlled Medicines Task and finish group September 2025
Healthcare Inspectorate Wales (HIW)/2025/595	Mynydd Mawr Ward, Prince Philip Hospital.03921	Provide clear guidance and additional training to staff to ensure their understanding of the risks associated with temperature deviations, and the appropriate action to take in such circumstances.	Healthcare Inspectorate Wales (HIW)/2025/595/MD3/1	Ensure staff are aware of the Medicines Policy. Disseminate and discuss within Ward meeting, ensuring they are aware of the escalation plan within the Ward Medicines Storage policy if temperatures go above recommended level.	Carms IS - Rehabilitation	28/08/2025	Partially complete (Overdue)	all actions completed and discussed in ward meeting and CCG
Healthcare Inspectorate Wales (HIW)/2025/595	Mynydd Mawr Ward, Prince Philip Hospital.03921	Provide clear guidance and additional training to staff to ensure their understanding of the risks associated with temperature deviations, and the appropriate action to take in such circumstances.	Healthcare Inspectorate Wales (HIW)/2025/595/MD3/3	Review Medicines Administration, Recording, Review, Storage & Disposal e-learning module content.	Carms IS - Rehabilitation	30/09/2025	Overdue	All Wales Group are updating this work underway, working with HIW for editing to ensure capability with ESR This is an All Wales piece of work that is underway. No clear time scale on completion. Group to meet in the next month. Updated 7/10/25
Healthcare Inspectorate Wales (HIW)/2025/595	Mynydd Mawr Ward, Prince Philip Hospital.03921	Provide clear guidance and additional training to staff to ensure their understanding of the risks associated with temperature deviations, and the appropriate action to take in such circumstances.	Healthcare Inspectorate Wales (HIW)/2025/595/MD3/4	Review training attendance and requirements of staff for Medication Safety & e-learning module.	Carms IS - Rehabilitation	01/09/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/595	Mynydd Mawr Ward, Prince Philip Hospital.03921	Provide clear guidance and additional training to staff to ensure their understanding of the risks associated with temperature deviations, and the appropriate action to take in such circumstances.	Healthcare Inspectorate Wales (HIW)/2025/595/MD3/7	Medicines Policy currently being reviewed and updated to capture the requirements in relation to the treatment room and fridge temperature monitoring. Policy is out of date but has been agreed an extension pending completion of review.	Carms IS - Rehabilitation	10/10/2025	Overdue	Currently remains under review - Aim is January 2026
Healthcare Inspectorate Wales (HIW)/2025/595	Mynydd Mawr Ward, Prince Philip Hospital.03921	The health board must engage with ward staff to review the impact of surge capacity on staffing pressures and ensure that safe staffing levels are maintained across all areas.	Healthcare Inspectorate Wales (HIW)/2025/595/MD18/3	NSL discussions which incorporates surge staffing discussions.	Carms IS - Rehabilitation	07/10/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/595	Mynydd Mawr Ward, Prince Philip Hospital.03921	The health board must engage with ward staff to review the impact of surge capacity on staffing pressures and ensure that safe staffing levels are maintained across all areas.	Healthcare Inspectorate Wales (HIW)/2025/595/MD18/4	A monthly scrutiny meeting to be arranged to review and address any reported staffing issues, with a dedicated agenda item focused on infrastructure, ensuring that appropriate actions are identified and implemented.	Carms IS - Rehabilitation	07/10/2025	Overdue	
Healthcare Inspectorate Wales (HIW)/2025/596	Nuclear Medicine IRMER WGH 03909	The employer must ensure that the authorisation guidelines and the employer's procedure is updated to correctly reflect the process and ensure there is clarity on who is authorising the exposure to carers and comforters.	Healthcare Inspectorate Wales (HIW)/2025/596/MD18/2	The Employer's Procedure will be amended to offer specific guidance to staff, and including recording of authorisation following advice from MPE.	Radiology	28/10/2025	Overdue	Meeting with RPE delayed due to DHoS unexpected leave and service pressures. - updated date 31.12.25

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Professor Tracy Myhill, OBE

Chair of NHS Wales Shared Services Partnership

The NHS in Wales undertakes many thousands of consultations, procedures and interventions every year – across primary care, ambulance, hospital-based services and tertiary specialties. The vast majority of patients and their families receive a high standard of care in a timely manner, with good clinical outcomes. The pressure on services, particularly unscheduled care, is well documented and there are a number of initiatives to address the causes of these pressures and to create additional capacity.

Whilst there is much to be celebrated in NHS Wales, on occasion errors do occur or systems & processes fail which can lead to avoidable harm and the possibility of claims or the need for redress payments. When something does go wrong, NHS organisations must have robust processes to implement improvements and share learning. The Putting Things Right Regulations provide a framework for organisations to investigate what has happened, put preventative measures into place where possible, and achieve a satisfactory resolution for any person affected. These Regulations have been the subject of consultation by Welsh Government and the guidance is currently in the process of being reviewed. It is anticipated that the amendments will be introduced towards the end of 2024/25 and the vision is that these will add further value to patients and their families.

The Welsh Risk Pool has a key role in supporting organisations to manage the financial costs associated with claims & redress cases, and to ensure learning is undertaken and shared across Wales. As has been seen in other modern healthcare systems, the clinical negligence litigation profile in NHS Wales is rising – with legal costs continuing to increase more quickly than inflation. The data shows a gradual increase in clinical negligence matters over the last three years and the most frequently occurring clinical specialties are maternity services, care provided in emergency departments and trauma & orthopaedics. There continues to be a decline in the litigation profile of personal injury claims.

The introduction of the Duty of Candour in Wales is attributed for the increase seen in 2023/24 of cases where redress payments are required. The Putting Things Right process in Wales offers a swift resolution to concerns and every case successfully managed in this way avoids a clinical negligence claim being brought.

NHS Wales is proud to have an entirely in-house legal services team which manages clinical negligence and personal injury cases for health bodies and the professional influence of this service achieves considerable savings to the Welsh taxpayer. Where it is right to do so, we settle cases as promptly as possible. Where it is appropriate, we defend matters.

This approach reduces avoidable costs to NHS Wales. During 2023/24 over a third of clinical negligence claims and almost half of personal injury claims were successfully closed with no damages paid.

A key aspect of the work of the Welsh Risk Pool relates to learning assurance – ensure lessons learned are identified and improvements are implemented, both within the service where the claim originated but also more widely across the health service. The learning process is underpinned by a clinically-led panel which scrutinises all cases and recommends whether the learning is sufficient. There has been an reduction in the number of cases which are approved when first presented to the panel and all organisations must consider steps that can be taken to improve the robustness of learning and improvements before being submitted for consideration.

It is pleasing to see that there has been an impact to clinical outcomes and staff views on safety which have been driven by some of the Safety & Learning initiatives which are coordinated by the Welsh Risk Pool. Most notably, the team has been able to gather data which demonstrates an improvement in clinical outcome measures, including APGAR scores for babies which is a good indicator of health at birth.

Additionally we have shown a sustained improvement in safety attitude amongst staff within our maternity services, using a recognised measurement tool. As more data becomes available, we anticipate seeing further sustained improvements.

The wide experience of the in-house legal service, in all areas of law affecting modern health bodies, provides rapid and effective advice to leaders throughout the NHS in Wales. As well as dealing with clinical negligence, personal injury cases and managing the General Medical Practice

Indemnity scheme, the Legal & Risk Service advises on procurement law, contractual matters, property acquisitions and disposals, representation at inquests and managing patients with complex needs in their care. The service remains flexible and adaptable as alternative models of service provision are implemented which present new challenges to organisations.

I remain very proud of the work done by the Welsh Risk Pool and Legal & Risk Services, working in partnership with colleagues across NHS Wales. This report outlines the current financial position and presents a forecast for claims and redress cases. The report also highlights the excellent legal, safety & learning work that the teams do every day. My senior team will be working with every Board in NHS Wales to maximise learning and to improve quality and safety, using the data related to each individual health body.

About Tracy Myhill

Tracy was appointed Chair of NWSSP in 2021 having retired after a 36-year career in the NHS. Tracy's career commenced as a receptionist in Cardiff's Dental Hospital, progressed into the human resources profession, holding roles at local and national level, and to her appointment into Chief Executive roles. She has worked as Chief Executive of the Welsh Ambulance Services University NHS Trust and Chief Executive of Swansea Bay University Health Board.

Our Services



Welsh Risk Pool

Our Services

The Welsh Risk Pool is a mutual organisation which provides indemnity against risk to all Health Boards, NHS Trusts and Special Health Authorities in Wales. Using an approach which considers causal factors of harm and the cost of improvement, the Welsh Risk Pool focusses on *Improving Safety Through Learning*. By understanding the causes of claims and redress cases, we help organisations to identify improvements which are needed in services to enhance the safety of NHS patients, staff and service users.



Reimbursement

We reimburse health bodies for losses and special payments which arise from claims and redress cases in accordance with the procedures approved by the NHS Wales Shared Services Partnership Committee.



Structured Settlement Management

The Welsh Risk Pool administers all long-term Periodical Payments on behalf of Welsh Government for the duration of a structured settlement incurred by an NHS Wales Health Body. This ensures compliance with a court order in a matter and provides funds for ongoing care and support for claimants who have experienced harm. The Welsh Risk Pool team engage with Claimants and their representatives to ensure the ongoing effective management of the settlement.



Decision Making and Consent

Led by the Welsh Risk Pool, the All-Wales approach to Consent to Examination and Treatment provides a national training solution for clinicians involved in the consent process and provides a library of approved consent information leaflets to support clinicians in ensuring patients are fully informed about the risks and benefits of a proposed treatment or procedure. The Welsh Risk Pool supports organisations to comply with regulatory guidance which recognises that the dialogue between healthcare professionals and patients is essential for safe and effective decision making.



Learning Assurance

The National Learning Advisory Panel is a clinically led group which is coordinated by the Welsh Risk Pool and scrutinises the learning from events regarding claims and redress cases to ensure effective local learning is implemented and provides a platform for sharing lessons learned throughout NHS Wales.



Maternity and Neonatal Safety and Learning Programmes

We coordinate the all-Wales approach to obstetric emergency training through PROMPT Wales and Community PROMPT Wales, and to Intrapartum Fetal Surveillance training with 'IFS Wales.' In response to the Maternity and Neonatal Safety Support discovery report, we are developing an innovative training programme for the management of emergencies in neonatal services.



Decision Making and Consent

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Once for Wales Concerns Management System

We lead the design, implementation and use of the Once for Wales Concerns Management Systems across health bodies and primary care.

- Datix Cymru, which provides consistency in the platform for capturing, investigating and reporting outcomes of concerns.
- Civica Experience Wales, which provides a platform for real time feedback from service users to be collated and analysed quickly and effectively.
- Eido Centre Wales, which is a platform that provides access to internationally approved consent information leaflets and facilitates uniform access to locally produced patient information.



Safety and Learning Networks

We facilitate forums for practitioners in patient safety, concerns management and service user feedback to drive improvement, learn together and share experience and good practice.



Venous Thrombo-Embolicism

In response to the causal factors identified in legal cases and reviews, we coordinate an all-Wales approach to the prevention, management, and reduction of harm associated with venous thromboembolism. This aims to improve patient experience and clinical outcomes. We manage two bespoke e-Learning modules to support staff to recognise and manage VTE.



Radiology Unexpected Findings

We co-ordinate an All-Wales Radiology (unexpected findings) review and associated work strands that have arisen as a result. The review first commenced in 2019 due to the sustained level of legal cases where a key finding was the failure to act on the report of a radiological examination, resulting in delayed or missed diagnosis. The focus of the review is around achieving use of a national standardised electronic system, to reduce the risk and improve patient safety outcomes.



Anti Violence Collaborative

We coordinate Anti-Violence Collaborative Wales (AVC), which is a collaboration between all NHS organisations in Wales, the four Welsh Police Forces, the Crown Prosecution Service in Wales and trade unions and staff associations. The partner organisations are signatories to a memorandum of understanding entitled the 'Obligatory Responses to Violence in Healthcare'. The aim of the collaborative is to reduce incidents of violence and aggression against staff and those who utilise NHS Wales services. Where incidents of violence do occur, the AVC aims to ensure an appropriate response in addressing the issues and facilitate appropriate support for those affected by an incident.



Putting Things Right Assurance

Assurance reviews are conducted on behalf of Welsh Government in relation to the application by health bodies of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – known as the Putting Things Right (PTR) Regulations, along with analysis of an organisation's compliance with the WRP Reimbursement Procedures. Bespoke training is provided to colleagues dealing with all aspects of PTR matters throughout Wales, to develop and enhance competence in this sector.



Specialist Investigation Support

We provide support to health bodies regarding complex investigations where the independence of the Welsh Risk Pool adds value. By accessing and utilising the vast experience across NHS Wales, the Welsh Risk Pool can provide independent reviews of cases and, if required, coordinate multi-professional support – including clinical and legal expertise. The Welsh Risk Pool assists health bodies to identify causal factors, system improvements or legal remedy.



Delegated Case Management

We consider the application of the all-Wales Policy on Indemnity and Insurance and advise health bodies in Wales in respect of indemnity arrangements and agreements between parties in the provision of health and care.



NHS Indemnity Enquiries

We consider the application of the all-Wales Policy on Indemnity and Insurance and advise health bodies in Wales in respect of indemnity arrangements and agreements between parties in the provision of health and care.



Legal and Risk Services

Our Services

Legal and Risk Services provides professional legal advice and representation for health bodies and general medical practitioners in Wales. With a breadth of specialist experience, knowledge and understanding of the legal, administrative and policy issues that affect the operation of the NHS in Wales, our teams are able to support organisations in providing safe, efficient and effective healthcare services to the population of Wales.



General Medical Practice Indemnity

A team of highly skilled solicitors with a particular focus and expertise in managing clinical negligence claims arising from primary care practice.



Commercial, Regulatory and Procurement

A team of highly specialised lawyers who support health bodies in managing these issues in a practical and timely manner.



Clinical Negligence

A department of in-house solicitors and legal support staff who manage the clinical negligence caseload across all health bodies. We aim to handle claims proactively, fairly and consistently.



Complex Patient (Court of Protection)

A team of very experienced healthcare lawyers who provide rapid advice to ensure NHS staff are able to comply with legal requirements and deal with complex legal issues regarding the provision of care and treatment.



Employment

A team of solicitors and legal executives advising on high level strategic policy matters, case management and tribunal hearings.



Inquests

Our inquests team offer full support to our clients, from initial investigations through inquest hearings and beyond, providing guidance on evidence gathering and presentation and coordinating representing for hearings.



Putting Things Right

We offer a flexible and hands-on approach to health bodies in dealing with matters under the PTR regulations.



Personal Injury and Prosecutions

This team have intimate knowledge of the NHS enabling swift and efficient advice on managing claims and providing expert advice on reducing risks in the workplace, enhancing safety of staff. Where enforcement action is taken against a health body, the team provides support to ensure that evidence is gathered, and the organisation is appropriately represented.



General Healthcare Advice

A wide spectrum of issues can be faced by health bodies and clients. This team draw from the diverse experience within Legal and Risk Services to provide timely advice.



Property Acquisitions, disposals and leases

This highly specialised team work closely with Specialist Estates Services to support all health bodies on matters relating to the NHS Wales estate.



Public Enquiry Support

A team of experienced lawyers who support the collation and presentation of evidence and coordinate legal representation in relation to matters investigated as part of public inquiries.



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Cyfreithiol a Risg
Shared Services
Partnership
Legal and Risk Services



Our Leadership Team



Mark Harris

Mark Harris is the Director of Legal and Risk Services and the Welsh Risk Pool.

Mark has an LLB law degree, an LLM Master's degree in Commercial Law/Marine Affairs and a Postgraduate Certificate in Health Service Management.

Having worked in Legal and Risk for over two decades, Mark has many years' experience of working on a wide array of clinical negligence and general advisory matters. In addition to leading and developing the business, Mark continues to provide legal advice on the wide range of legal conundrums that face NHS bodies in their day-to-day business.



Daniela Mahapatra

Daniela Mahapatra is the Deputy Director of Legal and Risk Services.

Daniela qualified as a Solicitor in 2005., She obtained her LLB law degree at the University of Wales, Swansea, before moving to Cardiff to undertake the Legal Practice Course. Practicing in employment law, Daniela has advised all health bodies in Wales in complex employment cases.

Committed to developing and supporting the diverse team within Legal and Risk Services, Daniela is also a member of the HPMA Wales Committee - arranging various training events for organisations. Daniela has also taught the Employment Law module on the HRM course at the University of South Wales. Daniela is also a mentor as part of the Coleg Y Cymoedd mentoring scheme.



Jonathan Webb

Jonathan Webb is the Head of Safety and Learning and is the operational lead for the Welsh Risk Pool.

Jonathan is a Registered Paramedic, an experienced Clinical Mentor and has worked in the NHS since 1990.

Prior to joining Legal and Risk Services in 2016, Jonathan was Head of Risk Management in an English Acute Trust and has held a similar role in the Channel Islands. Jonathan's role focusses on overseeing the process of scrutinising and sharing lessons learned from claims and redress cases and assurance of organisational processes for Putting Things Right. Jonathan is also the programme sponsor for the Once for Wales Concerns Management System and Chair of Anti-Violence Collaborative Wales.



Sarah Watt

Sarah Watt is the Head of Healthcare Litigation, the strategic lead for clinical negligence claims, Putting Things Right and Public Inquiry work.

Sarah has a LLB law degree, Law Society Finals Examination pass and Level 5 Qualification from the Institute of Leadership and Management.

Sarah joined Legal and Risk Services in 2003 after working for leading UK healthcare law firms. She became a Team Leader in 2005 and was appointed Head of Healthcare Litigation in 2021. Sarah is particularly experienced in high profile investigations, very high value claims and has the work to support health bodies giving evidence to the coronavirus public inquiry.



Sarah Hookes

Sarah Hookes is the Assistant Head of Safety and Learning and coordinates the Safety and Learning Programmes.

A Registered Midwife and trained Nurse, Sarah has over 25 years' experience as a Midwife in North Wales.

Sarah joined the Welsh Risk Pool in 2018 to lead the implementation of PROMPT Wales and remains a key part of the national team. Sarah's role involves the oversight of all of the Safety and Learning Programmes operated by the Welsh Risk Pool – engaging local teams to reduce avoidable harm.



Sue Saunders

Sue Saunders is the Head of Finance for Welsh Risk Pool and Legal and Risk Services Management Accountant.

A qualified accountant, Sue has many years of experience in NHS accounting and supports health bodies with their financial returns relating to the Welsh Risk Pool to Welsh Government.

The financial functions of the Welsh Risk Pool and Legal and Risk Services are coordinated by the Corporate Finance Team within NHS Wales Shared Services Partnership. Sue is responsible for the Welsh Risk Pool and Legal and Risk accounts.

Chairing the sub-Technical Accounting Group for Welsh Risk Pool matters, Sue ensures that the application of financial principles is consistent throughout NHS Wales.

Welsh Risk Pool Committee



Strategic oversight of the work of the Welsh Risk Pool is provided through the Welsh Risk Pool Committee – which is a sub-committee of the NHS Wales Shared Services Partnership Committee.

The Welsh Risk Pool Committee makes decisions in relation to the reimbursement procedures, workplans for reviews and the reimbursement of claims and redress cases. Membership of the Welsh Risk Pool Committee is drawn from Welsh Government and Executive and Independent Members from NHS Wales Health Bodies. Committee members represent their professions rather than individual organisations and a Terms of References outlines the roles and responsibilities of the group.

Membership of the committee is:

- » Chair of Shared Services Partnership Committee [*Chair of WRPC*]
- » Welsh Government Finance
- » NWSSP Director of Legal and Risk Services
- » Managing Director of NHS Wales Shared Services Partnership [*WRP Accountable Officer*]
- » NWSSP Medical Director
- » NWSSP Deputy Director or Legal and Risk Services
- » NWSSP Director of Finance and Corporate Services

And Representatives of:

- » Welsh Government Medical Officers
- » Health Body Chairs
- » Health Body Medical Directors
- » Health Body Directors of Finance
- » Health Body Audit Committee Chairs
- » Health Body Directors of Primary Care
- » Health Body Chief Executives
- » Health Body Directors of Nursing
- » Health Body Directors of Therapies and Health Science
- » Health Body Directors of Corporate Governance
- » Health Body Directors of Digital Services

During 2024/25, the Welsh Risk Pool Committee met on six occasions and coordinated the safety and learning workplan and future strategy. **1430** cases were considered by the committee, with a total reimbursement to Health Bodies in 2024/25 of **£114.6m**.

Table.1 outlines the number of cases reviewed and reimbursements approved at each of the meetings during the year.

Welsh Risk Pool Committee 2024/25							
Cases Reviewed & Reimbursements							
Committee Date	May-24	Jul-24	Sep-24	Nov-24	Jan-25	Mar-25	TOTAL
Cases Reviewed	230	227	209	240	252	272	1430
Reimbursement	£17,205,310.67	£10,938,758.24	£9,464,751.09	£9,948,140.48	£23,011,835.29	£11,953,204.62	£82,522,000.39

Table 1: Number of cases reviewed and Reimbursements by WRPC 2024/25



Our Highlights for 2024/25



Driving improvement in learning information collation.

We successfully introduced the U8 Structured Evidence Collection Checklist – supporting health body corporate teams to collate supporting information and evidence in response to the findings of the National Learning Advisory Panel.

Improving the quality of Learning submissions.

We introduced a checklist for signatories of Learning from Events Reports – to outline the steps they will take to reduce the potential for reports to be red deferred by the panel.

Providing assurance and improvement plans for learning.

We successfully completed a further round of concerns assessments and included a review of the processes which underpin coronial investigations and inquests. Action plans were received from all health boards to ensure continuous improvement.

VTE Awards 2025.

Our Thromboprophylaxis Safety & Learning Advisor, Christine Welburn, was invited to represent the Welsh Risk Pool at the national VTE Awards 2025 hosted at the Houses of Parliament by Thrombosis UK.

Launch of MoNET Wales.

We developed, trialled and implemented a pilot of a Neonatal Multi-Professional emergency training programme, in response to the recommendations within the MatNeo Safety Support Programme.

IFS Wales team present a poster at British Intrapartum Care Society Conference.

The national team returned to the 2024 conference in Ireland, showcasing the vision, development and implementation of this important All-Wales programme.

Sarah Hookes speaks at the prestigious PROMPT Symposium in Bristol.

Sarah was invited by Professor Tim Draycott of the PROMPT Maternity Foundation to showcase the Wales approach to scaling, embedding and sustaining PROMPT Wales over the last seven years.

IFS Wales team present at 'Monitoring May'.

The team addressed this 2-day event which attracts a UK-wide audience of clinicians and leaders with a special interest in fetal monitoring. The team were invited back for a second year to update on progress, with great interest shown in our all-Wales approach.

Asst. Head of Safety and Learning joins the Avoiding Brain Injury in Childbirth programme.

Sarah Hookes joined the ABC collaboration, as Senior Clinical Midwifery Advisor with the Royal College of Obstetricians and Gynaecologists. Sarah was able to draw on her extensive experience in NHS Wales of designing, facilitating and implementing training programmes to support the ABC programmes 'Management of impacted fetal head at caesarean birth' and 'Recognition and detection of suspected intrapartum fetal deterioration.'

Sarah Hughes, Operations Manager graduates with BA in Business Management.

For her dissertation module, Sarah carried out a survey on staff perceptions of agile working in NWSSP, which has informed the organisation moving forward. Her dedication to her studies earned her a First Class Honours award.

VTE Wales programme ramps up.

A bespoke training package to support clinicians who are involved in the consent process has been rolled out throughout all health bodies and primary care providers in NHS Wales.

PROMPT Wales collaborate with the Emergency Medical Retrieval & Transfer Service.

Members of the national team joined forces with EMRTS to develop bespoke algorithms to support safe practice and management of pre-hospital maternity emergencies. Now included in their Standard Operating Procedures, the algorithms were launched at 2 EMRTS training days delivered by our team.

Influencing and supporting the People's Experience Survey.

Throughout the year, the Once for Wales team and the People's Experience Feedback Network (formally known as the Service User Feedback Network) were key stakeholders and contributors to the review and development of the new People's Experience Survey and the People's Experience Framework – which was launched by Welsh Government in April 2025.

People's Experience Survey nominated for awards.

The People's Experience Survey, which is a bilingual validated core set of questions has been rigorously tested and validated across all health settings. The PES is award winning, picking up an ISPOR Europe 2024 Research Presentation Award, winning the Health and Care Research Wales, Public Involvement Award and has also been shortlisted for the NHS Wales Awards 2025.

Jonathan Webb speaks at the Connected Healthcare Summit.

The Head of Safety & Learning presented at this international event, outlining the benefits of digital data alignment and achieving measurable improvements in clinical and operational outcomes in safety & learning programmes.

Successful implementation of four national experience surveys.

The Once for Wales team, in conjunction with the Civica Experience system leads, successfully launched four national surveys, gathering valuable all-Wales data on key areas. The surveys were the People's Experience Survey, The Maternity & Neonatal Survey, The Enhanced Community Care Survey and the Looked after Children Survey.




Fantastic take-up of the Emergency Department Survey.

This was the pilot of national surveys and closed to new feedback in March 2025. From its launch in August 2023 up to March 2025, a total of 50,375 completed feedback responses were received. Analysis of this valuable data is ongoing and will be shared widely to support learning and service improvement across NHS Wales.


Inclusion of Restrictive Practices in Once for Wales Data.

In conjunction with NHS Performance & Improvement, the team have developed a process to accurately capture and review the use of Restrictive Practice in our most vulnerable service users – ensuring practices can be better monitored and reviewed to reduce harm to service users and staff.

Launch of Complex Case Support Tools.

 During the year, a dedicated team from across NHS Wales and led by our Anti-Violence Collaborative colleagues, developed processes and tools to support our teams when dealing with complex investigations – supporting our work to reduce vexatious and unreasonable demands being placed on concerns teams across Wales.

Official re-launch of the Anti-Violence Collaborative.

 Early in the year at a prestigious event held at Welsh Government the AVC partners issued refreshed documents, including the Obligatory Responses to Violence in Healthcare. The NHS Chief Executive, Judith Paget hosted Chief Constables, the Head of the Crown Prosecution Services in Wales and executives from health bodies. The Chair of AVC, Jonathan Webb, addressed the attendees on the workplans to reduce aggression & violence across the NHS.

AVC publishes new guidance and information.

Guides for both NHS staff and police officers have been released - specifically concentrating on the response to violence when mental health is a factor. A simplified form was developed, in conjunction with clinicians and prosecutors, to enhance the operational response to mental health and violence & aggression.

AVC distributes over 400 bilingual posters across NHS Wales.

A range of posters, with links to online supporting information were provided to all health bodies across the NHS Wales footprint, including primary care services – highlighting and reminding our patients, their relatives and our staff that violence or aggressive behaviour in the NHS is unacceptable.

Enhancements to the investigation of V&A Incidents

Following consultation with subject matter experts, improvements were made to the Datix Cymru V&A incident report; helping to identify alleged perpetrators more easily and to collect meaningful data concerning potential hate crimes.

AVC enhances links with JESC.

The team has worked closely with staff in the other 'blue light' services in Wales, with a permanent point of contact with the Joint Emergency Services Group now in place – meaning incidents can quickly be reviewed by appropriate colleagues. The Fire & Rescue Services in Wales are now active members of the AVC, aiming to further reduce unacceptable behaviour towards firefighters in Wales.

Supporting work on unacceptable behaviour.

Team members have been active participants, at the request of Welsh Government, on several work groups focusing on improving the public sector response to incidents of sexual harassment and racist behaviour.

Aiming to expand the impact of the AVC into primary care.

Positive discussions have been held with representatives of primary care clinical colleagues, with the aim of developing support for staff in this vital healthcare sector.

Datix Cymru successfully enhanced.

The quarterly cycle of design review for Datix Cymru has enabled the introduction of a number of enhancement and system improvements. The team has led quality assurance testing and implementation of four system releases across all fifteen Datix Cymru systems in NHS Wales.

Enhancements for Nationally Reportable Incidents.

The Once for Wales team has led the introduction of a system to enable the automatic transfer of Nationally Reportable Incident data from each of the Health Body systems into the NHS Performance & Improvement system - removing the need for local teams to submit forms and the manual entry of data. This provides swift and efficient data on key events across Wales.

Datix Cymru Safeguarding Functionality

The Introduction and ongoing support of the Safeguarding reporting functionality for our early adopter sites in Hywel Dda University Health Board and investigation tools in several other health bodies has enhanced the information available to both health bodies and local authorities, sharing essential information to keep children and vulnerable adults safe.

Enhancing Community Pharmacy Incident Reporting in Datix Cymru

Working in collaboration with Welsh Government, Community Pharmacy Governance Leads and Primary Care Providers, the team have enhanced the system for Incident Reporting – enabling community pharmacies across Wales to share details of incidents with their commissioning health boards and establish monitoring of improvements for patient safety.

Eido Digital Consent Centre Wales launched.

The Once for Wales team oversaw the transition to a new Eido platform for Decision Making & Consent Information. The new platform provides greater flexibility and utilises user- friendly Single Sign-On technology. The system facilitates multiple consent information leaflets to be downloaded or sent electronically in a single communication to a patient who is undergoing a procedure. All the leaflets are available in a bilingual Welsh / English format and a number of alternative languages and accessible formats – including large print and Easy Read.

New Joint Investigation functionality for health bodies.

The Once for Wales team have developed a new joint investigation module – enabling organisations to actively manage, share and learn from joint investigations. Teams from Cardiff & Vale University Health Board and Welsh Ambulance Services University NHS Trust have kindly early adopted this useful technology.

Increased learning reviews by the independent panel.

The Safety & learning Team and the National Learning Advisory Panel reviewed 738 newly submitted Learning from Events Reports — a 19% increase from the cases reviewed in the previous year. Despite the rise in volume, all cases were reviewed within the expected timeframes, ensuing health bodies had assurance of the measures implemented in response to claims and redress cases.

A successful healthcare law conference was held

Led by the commercial and regulatory team, in Autumn 2024. This brought together clients from around Wales to hear the latest in case law impacting NHS services.

Successful support to Health Boards in commissioning disputes

The commercial & regulatory team acted for two separate health boards in funding disputes with English Integrated Care Boards. On each occasion we were successful, which led to both Health Board's receiving substantial reimbursement of fees.

Successful defence of a breach of contract claim.

The commercial & regulatory team was instructed by a Health Board in relation to a claim brought by a contractor for breach of contract, where the contract was terminated due to the contractor's unsatisfactory performance. Proceedings were commenced by the contractor for around £280,000 in respect of sums allegedly due to the contractor under the contract. The claim was defended and compromised at an early stage, where the contractor agreed to withdraw the claim in its entirety and further agreed to pay a sum in respect of the costs in defence.

Support in reducing ophthalmic surgery waiting list.

The commercial & regulatory team assisted a Health Board in respect of two agreements to address the backlog of urgent eye operations; the agreements were essential for the activity to commence.

Costs ordered in employment cases, reducing the financial burden on NHS Wales

The employment team have successfully secured costs orders across numerous cases. This helps to reduce the financial burden on NHS Wales in cases taken to the Employment Tribunal Employment Appeal Tribunal. In some cases, the court has made an order which places a charge on a claimant's property whilst in some instances the amount of costs payable by the claimant to the respondent were agreed without the need for a court hearing.

Successful defence of employment claims.

The employment team has continued to secure successful outcomes across a number of cases at final hearings, with some claims being dismissed in favour of health bodies. Whilst aiming to be an employer of choice, NHS Wales organisations defend claims for unfair & wrongful dismissal or discrimination related claims.

Successful finding in a case about Worker status.

The employment team coordinated a matter which related to whether the claimant was a worker. The positive finding was arrived at by the court on the basis that there was no overarching contract and the claimant was only a worker for the duration of a shift or assignment. When the claimant was not performing a shift or session, they were not a worker. There was no umbrella contract therefore and holiday pay only accrued during a shift. Whilst each case is considered on the facts of the matter, the implication of the finding in this case assists the team in guiding health bodies.

Employment team deliver a wide range of training for NHS Wales.

The Team has successfully continued with a training programme of webinars, with a further programme planned.

Property deal maximises space at hospital.

The property team was instructed by Swansea Bay University Health Board on an agreement for lease and a fifteen year lease of Unit 2 Sandringham Park, Swansea Vale, Swansea. The acquisition of this vital space, enables the health board to free up accommodation on the Morriston Hospital site so that it can be used for clinical purposes. It also allows the Health Board to consolidate the medical records service on one site. It was a difficult brief to fulfil as the organization needed good quality, affordable, hybrid building which is a mixture of offices and storage.

Property Team support innovative centre in health board.

Maggie's, the national charity that provides free expert care and support in centres across the UK and online, sought to develop a collaborative working agreement with Betsi Cadwaladr University Health Board (BCUHB) to build a Maggie's Centre on the Glan Clwyd Hospital site from 2018. BCUHB began working with earnest with the team at Maggie's from 2021, and the NWSSP Legal and Risk Team were involved from the outset of the discussion on the principles of working together and the shared vision of the project. The property team continue to provide professional advice and are seen as an instrumental partner in the design and delivery of the project. The team have done far more than provide professional advice; members of the team have given Maggie's confidence through their consistent support for the project, and importantly have supported the BCUHB team by demonstrating compassion, patience and a real understanding of the aims of the project throughout the process of drawing up the legal agreements. Through adopting a values-based approach to working with BCUHB and Maggie's, the property team have helped maintain focus during challenging phases of the project, and have played a key role in creating a trusting environment and secure foundations for the Maggie's – BCUHB partnership to build on.

Supporting the development of the new cancer centre

Velindre University NHS Trust has completed the purchase of the majority of the Whitchurch Hospital site from Cardiff & Vale University Local Health Board (CVUHB) for over £7m. The land purchase was complex, and all parties worked for close to a year to ensure the sale and purchase took place within the financial year.

Completing a lease for a Surgery lease to ensure continuity of service to patients

The property team have supported the lease for Solva's surgery. As the practice at St Davids was being closed and all patients were being transferred to the Solva Surgery practice, completion of the lease at Solva was critical to securing continuity of service for Hywel Dda University Local Health Board (H DUHB). H DUHB needed to carry out essential alterations to the premises in order to cope with the larger number of patients attending and so were under pressure to complete the lease before 1 April. With the assistance of the property team, the lease completed in early March.

Supporting the transition of a former council building for use as a health hub.

The property team completed on the purchase of Caledfryn in Denbigh, a former council office building that has been sold to Betsi Cadwaladr University Health Board (BCUHB) to establish a health & social care hub. The sale was completed on April 2, 2025. The building will be used to consolidate BCUHB services, including a GP surgery, into a single location. The plan is to employ 250 staff at the site. Proposals for the new hub include a mix of children's and adult services, with the Community Resource Team (CRT), midwifery, community mental health and learning disabilities among services expected to be based on site. CRTs are existing partnerships between Health Board community nursing teams and local authority social care professionals, who work collaboratively in a single location. The property team had to work.

Our Caseload



NHS Wales continues to provide a high quality of care every day, with millions of patient-contacts each year. The volume of patients receiving care and treatment continues to rise. The majority of patients and service users receive an excellent standard of care, but on occasion errors do occur and these can lead to claims or redress cases. Harm is caused by multiple factors, including mistakes and failures in the processes and systems which underpin service delivery. The Welsh Risk Pool and Legal and Risk Services play an integral role in supporting all health bodies in NHS Wales in managing cases and learning from mistakes.

The litigation profile represents payments which are taken from public funds that would otherwise be used for healthcare services. Whilst we rightly focus on the financial cost of harm, it is important to recognise that the events which lead to claims and redress cases can involve serious harm to patients, staff and visitors. It is therefore essential that steps are taken to improve processes, education, and learning - sharing outcomes and good practice nationally. The process of learning-from-events aims to ensure that issues which have led to a claim or redress case are identified and learning or improvements put into place to reduce the potential for repeat events.

Claims and Redress Case Profile

The profile of cases managed by the Welsh Risk Pool and Legal and Risk Services relate to clinical negligence, personal injury and redress matters.

The Welsh Risk Pool administers the risk pooling arrangement and meets the cost of financial losses for claims over £25,000 and all reimbursable expenditure on redress cases. The most significant element of expenditure relates to clinical negligence matters.

Clinical negligence and personal injury claims are managed using the legal processes outlined in the pre-action protocols contained in the Civil Procedure Rules issued by His Majesty's Courts and Tribunals Service (HMCTS) which apply in England and Wales. If proceedings are issued, the conduct of the claim is coordinated by a judge.

Redress cases are conducted using the requirements set out in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, which are known as the Putting Things Right (PTR) Regulations, and these have a published legal guidance which sets out the expectations required of the parties.

The PTR Regulations, and the associated guidance, are currently under review by Welsh Government. The Welsh Risk Pool and Legal and Risk Services are actively supporting and advising Welsh Government and all Health Bodies in that review.

Clinical Negligence Matters

The number of substantive open clinical negligence cases at the end of each financial year provides a useful indicator of the current clinical negligence caseload pressure experienced by NHS Wales. This is shown in Fig.1. These figures do not include cases from the Scheme for General Medical Practice Indemnity, which are managed separately.

As we have previously reported, there was a spike in cases as we approached 2013 because of a rush by Claimants' solicitors to open new cases before new costs rules came into force. We also changed our methodology for opening new cases from 2017/18 - only accepting those with a letter of claim or that fell into the criteria for early reporting, where health bodies inform us of specific incidents soon after they occur. Prior to that we included matters even if there was not yet a letter of claim, such as pre-action disclosure requests.

There was some disruption to the timing of cases brought during and immediately following the pandemic. Considering the impact of the three-year limitation period (the time period that most claims can be brought against a health body), taking into account limitation waivers that were agreed, we consider that this impact has now largely subsided.

Overall in NHS Wales, recent years have demonstrated an increasing trend of clinical negligence case numbers. 2024/25 highlights a stable position - with claim numbers not increasing further and remaining broadly at the same level as the previous year. A total of 1842 clinical negligence claims were open at 1st April 2025.

Open Clinical Negligence Matters

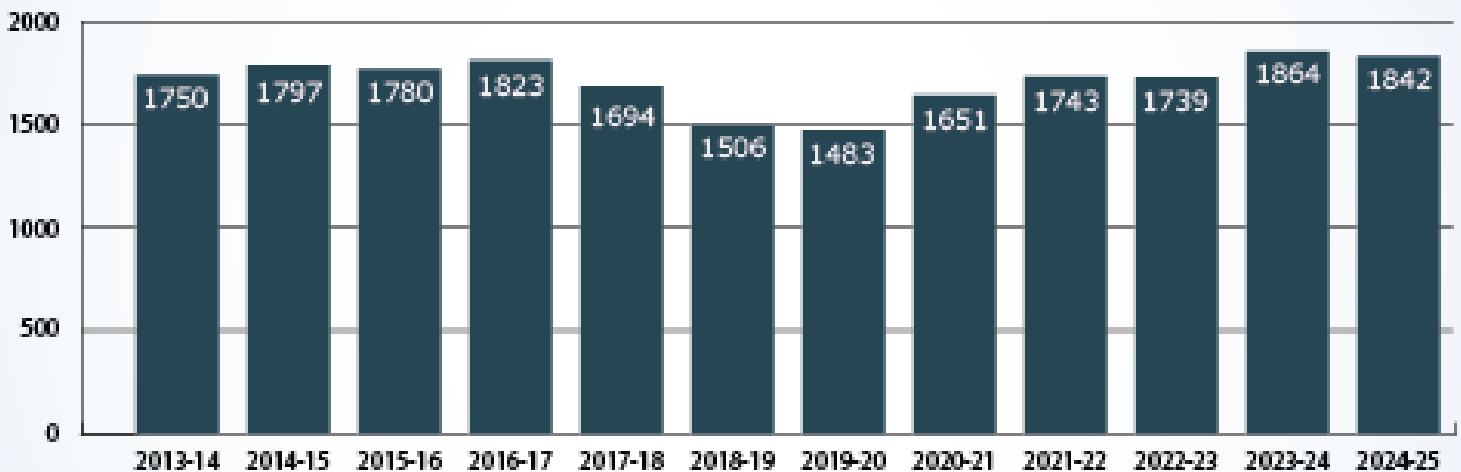


Fig.1 Open Clinical Negligence Matters

An important part of the role of Legal and Risk Services is the careful analysis and investigation of all matters brought against health bodies. We are successful in defending cases where this is appropriate, which reduces avoidable costs for the Welsh taxpayer. Since we restricted our criteria for opening a matter in the main to those where a formal letter of claim has been received, there has been a modest consequential decrease in the number of cases subsequently closed without damages. Fig.2 outlines the proportion of cases which are closed without damages over the last five years. This shows that we are consistently defending well over a third of matters.

Percentage of Clinical Negligence Matters Closed Without Damage

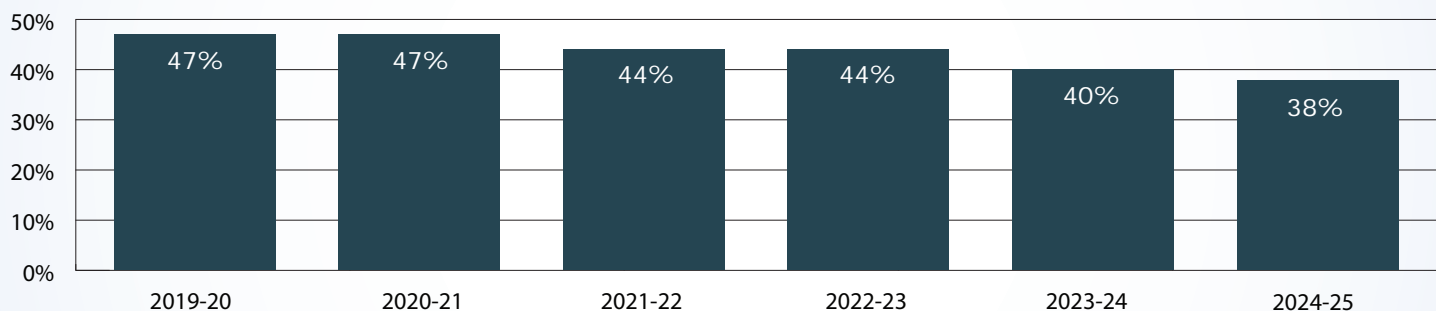


Fig.2 Proportion of Clinical Negligence matters closed without damages paid

Example Case Successfully Defended

Proceedings were brought in respect of a patient who had died following attendance and discharge at A&E. The patient presented to A&E complaining of back pain, shooting pains down his legs and long-term incontinence. Pain control had improved during admission and the patient was discharged in the early hours of the morning with antibiotics, safety netting advice and told to attend his GP for further investigations. However, whilst leaving the hospital the patient used the hospital toilet and suffered a fall. He was taken back to A&E, assessed and then discharged home later.

The patient subsequently deteriorated at home and was readmitted 3 days later. A scan identified a subdural haematoma which required craniotomy and evacuation, following which he made a slow but good recovery. Several years later the patient deteriorated quite significantly, requiring care home placement until his death.

It was alleged that the Deceased should not have been discharged, should have had a falls risk assessment and, had this occurred he would have avoided the fall and subdural haematoma. The matter was carefully investigated by Legal & Risk Services. Factual witness evidence was obtained and expert in the fields of Emergency Medicine, General Medicine, Neurology and Neuro-surgery.

The trial took place, and the judgement was given in favour of the Health Board. It was recognised that the care provided and decisions taken were appropriate. Key to this outcome was the engagement and support of the treating clinicians who gave evidence in court.

This led to a significant financial saving for NHS Wales and highlights our commitment to support our clinicians.

NHS Wales undertakes a wide range of clinical procedures and provides care and treatment in a wide array of clinical settings. Claims may arise from any clinical contact and the Welsh Risk Pool monitors the distribution of the principal clinical specialties identified in a claim.

The most frequently occurring specialty relating to clinical negligence claims is maternity services, which includes obstetrics and midwifery-led services. These represent 18.4% of all clinical negligence cases managed by Legal and Risk Services over recent years. This proportion is consistent with the other NHS nations in the UK. The Welsh Risk Pool has invested significantly to work with clinical teams in maternity and neonatal services across NHS Wales to address the causal factors of claims within this specialty.

The majority of clinical negligence matters relating to maternity services involve harm to a baby and the three-year limitation rule does not apply. These cases can therefore take many years to be brought or to be concluded and most of the current maternity services matters being investigated in 2024/25 have an index date of more than four years earlier.

Many patients present to emergency departments, specialist assessment units and minor injury services and there is widespread recognition of the pressure experienced by these services. Claims related to these settings represent 14.7% of all clinical negligence matters being managed by Legal and Risk Services during 2024/25. This proportion is broadly similar to the previous year.

Matters relating to assessment and treatment, including surgery, in orthopaedic and trauma cases have for some time, consistently been in the top three specialities in which claims are brought. It is recognised that the number of orthopaedic procedures conducted by NHS Wales every year is very large and the proportion of cases which lead to a claim being brought is very low. There has been a reducing trend in the proportion of claims in this specialty during the last three years and in 2024/25, orthopaedics and trauma surgery represented 9.9% of all cases.

Cases involving radiology, including the interpretation of X-rays, CT-scans and MRI imaging, have increased over the previous three years and in 2024/25, this specialty represented 2.9% of clinical negligence claims. The Welsh Risk Pool recognises international shortages of Radiologists and the work being done by the NHS to digitise more work, introducing the Radiology Informatics System (RISP), to streamline services and reduce delays. The UK Health Security Agency (UKHSA) has introduced a new taxonomy for its four-nation review of radiology and imaging incidents. This will become a mandatory element of the Datix Cymru system from 1st August 2025. Analysis of the challenges relating to radiology reports not being followed up when a patient has left the care of a department, has been the subject of a national review by the Welsh Risk Pool Committee, which found an improving but challenging position.

The proportion of matters relating to mental health and psychology services has exceeded the 2% level for the first time in 2024/25 – with this group of specialties accounting for 2% of all clinical negligence matters.

The specialties captured by the Welsh Risk Pool and Legal and Risk Service, relate to a bespoke list that was first utilised in approximately 2000. With the recent introduction of a new electronic Case Management System in April 2025, we will be able to publish specialty data in future using the national NHS Wales list as far as possible – supporting the extrapolation and analysis of claims data against other information sources.

Fig.3 outlines the distribution of the top eleven clinical specialties (those representing 2% of more of all cases) in clinical negligence matters for 2024/25 and also provides a comparison with the values found in previous years. The 'other' category includes the 38 specialties which are included in the current Legal & Risk database.

Principal Clinical Speciality in Clinical Negligence Matters 2021-2025

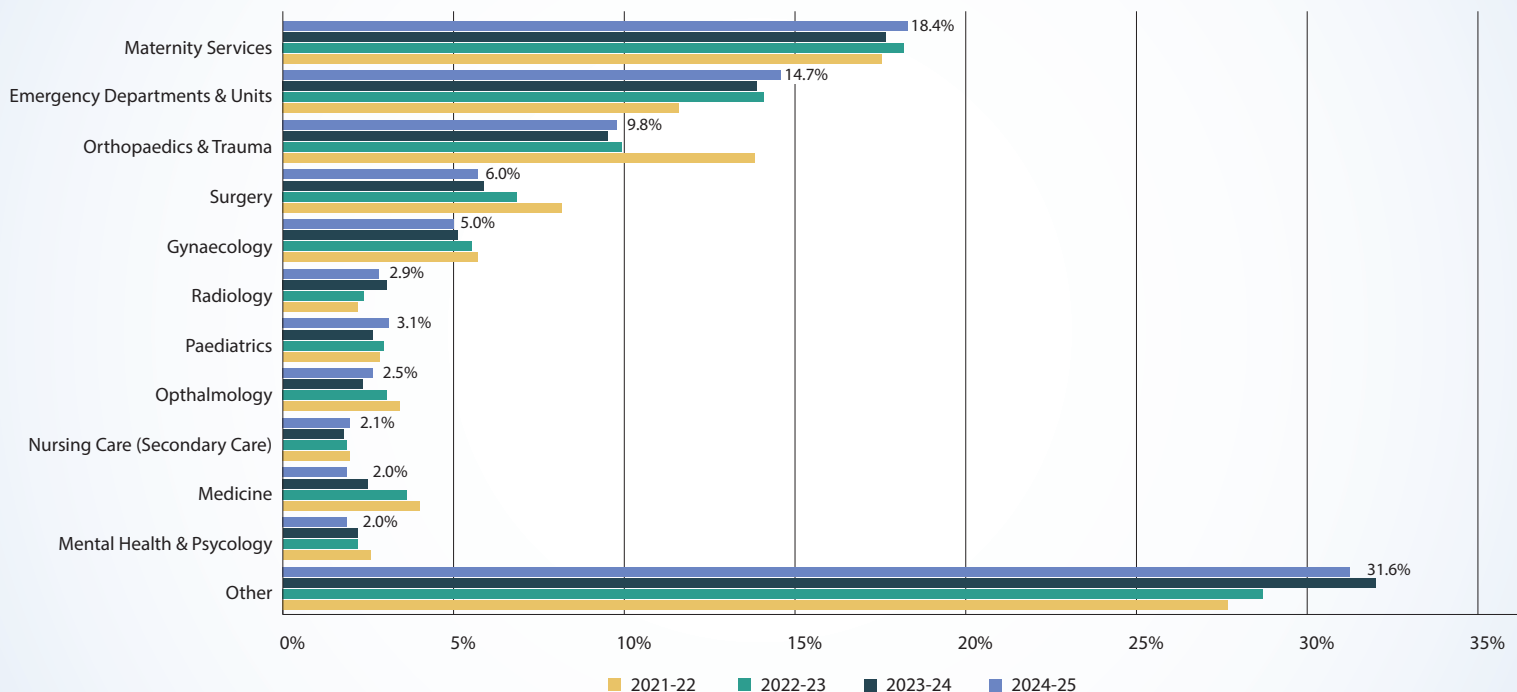


Fig.3 Proportion of Principal Clinical Specialities in Clinical Negligence matters

Table.2 (next page) provides a breakdown of all principal clinical specialties for cases which were open and being investigated or managed at any time in the last four years. The current database includes a category "Other / Unspecified" which is used to highlight those matters which are still being investigated to determine the appropriate specialty or where the correct specialty is not currently shown within the existing database.



	Total 2024/25	% 2024/25	Total 2023/24	% 2023/24	Total 2022/23	% 2022/23	Total 2021/22	% 2021/22
Total Matters	2423		2356		2278		2250	
Maternity Services	447	18.45%	422	17.91%	419	18.39%	399	17.73%
Emergency Departments & Units	356	14.69%	333	14.13%	324	14.22%	261	11.60%
Orthopaedics & Trauma	237	9.78%	226	9.59%	226	9.92%	304	13.51%
OTHER / UNSPECIFIED	236	9.74%	175	7.43%	117	5.14%	124	5.51%
Surgery	145	5.98%	142	6.03%	164	7.20%	183	8.13%
Gynaecology	122	5.04%	121	5.14%	123	5.40%	123	5.47%
Urology	74	3.05%	97	4.12%	51	2.24%	48	2.13%
Radiology	71	2.93%	71	3.01%	60	2.63%	52	2.31%
Paediatrics	60	2.48%	67	2.84%	66	2.90%	64	2.84%
Medicine	50	2.06%	60	2.55%	79	3.47%	84	3.73%
Ophthalmology	48	1.98%	54	2.29%	63	2.77%	66	2.93%
Mental Health & Psychology	48	1.98%	43	2.25%	52	2.28%	52	2.31%
Nursing Care (secondary Care)	45	1.86%	48	2.04%	45	1.98%	48	2.13%
Ambulance / Paramedics	45	1.86%	46	1.95%	48	2.11%	28	1.24%
Gastroenterology	42	1.73%	36	1.53%	32	1.40%	26	1.16%
Primary Care & General Practice (exl GMPI)	37	1.53%	36	1.53%	44	1.93%	47	2.09%
Cardiology	36	1.49%	35	1.49%	34	1.49%	32	1.42%
Ear Nose & Throat	32	1.32%	34	1.44%	32	1.40%	34	1.51%
Colorectal Surgery	31	1.28%	33	1.40%	30	1.32%	17	0.76%
Oncology	29	1.20%	33	1.40%	32	1.40%	32	1.42%
Neurology	29	1.20%	30	1.27%	29	1.27%	24	1.07%
Neurosurgery	28	1.16%	24	1.02%	26	1.14%	25	1.11%
Respiratory	20	0.83%	21	0.89%	14	0.61%	8	0.36%
Anaesthetics	20	0.83%	18	0.76%	20	0.88%	18	0.80%
Haematology	15	0.62%	14	0.59%	13	0.57%	12	0.53%
Podiatry	13	0.54%	14	0.59%	9	0.40%	4	0.18%
District Nursing & Health Visiting	12	0.50%	13	0.55%	11	0.48%	8	0.36%
Dermatology	11	0.45%	10	0.42%	11	0.48%	12	0.53%
Pathology, Histology & Microbiology	11	0.45%	10	0.42%	12	0.53%	9	0.40%
Geriatric Medicine	9	0.37%	9	0.38%	10	0.44%	10	0.44%
Rheumatology	8	0.33%	9	0.38%	8	0.35%	6	0.27%
Cardiothoracic Surgery	7	0.29%	7	0.30%	6	0.26%	8	0.36%
Dental	7	0.29%	7	0.30%	4	0.18%	11	0.49%
GP out of hours	7	0.29%	7	0.30%	8	0.35%	8	0.36%
Maxillofacial	6	0.25%	7	0.30%	3	0.13%	10	0.44%
Nephrology	6	0.25%	7	0.30%	10	0.44%	11	0.49%
Physiotherapy	4	0.17%	7	0.30%	11	0.48%	12	0.53%
Oral & Maxillofacial Surgery	4	0.17%	6	0.25%	11	0.48%	10	0.44%
Cytology	4	0.17%	5	0.21%	8	0.35%	7	0.31%
Audiology	3	0.12%	3	0.13%	2	0.09%	1	0.04%
Genetics	3	0.12%	2	0.08%	2	0.09%	2	0.09%
Plastic Surgery	3	0.12%	2	0.04%	3	0.13%	3	0.13%
Administration, Estates & Business Services	1	0.04%	1	0.04%	2	0.09%	3	0.13%
Genitourinary Medicine	1	0.04%	1	0.04%	3	0.13%	3	0.13%
Speech Therapy	0	0.00%	0	0.00%	1	0.04%	1	0.04%

Table.2 Breakdown of Principal Clinical Specialties (4 years)

The value of claims gives a useful indication of the impact of litigation on NHS Wales. The cost to the NHS of claims is made of up damages paid to a claimant, the cost of defending a matter, payment of the legal costs of a claimant in cases in which damages are paid and payments to government agencies such as the Compensation Recovery Unit (CRU) which also handles payments for treatment by the NHS in cases where harm is caused. The collective term for all of these payments is the 'quantum' of a case and Legal and Risk Services carefully estimates quantum in each case, with regular reviews at key stages, throughout the time that a matter is open.

As part of the analysis of matters, specialist lawyers at Legal and Risk Services define cases in respect of the probability of settlement. The categories are Remote, Possible, Probable and Certain. The determination for each category is a percentage of the likelihood of the case being settled with damages paid or awarded by a court.

- » 0% - 5% Remote
- » 6% - 49% Possible
- » 50% - 94% Probable
- » 95% - 100% Certain

Whilst all cases have the potential for settlement, cases considered Probable or Certain are used to highlight cases which are more likely to result in costs to NHS Wales.

Fig.4 outlines the quantum in clinical negligence claims as at 1st April 2025. Fig.5 outlines the volume of open cases as at 1st April 2025. Table.3 outlines the number and quantum of cases for the top eleven specialties. Table 3a provides a breakdown of the number and quantum of cases for all specialties.

This information shows that Maternity Services represents the largest proportion of cases (n=365) and also has a significant level of quantum (£1.4bn). This shows that Maternity Services cases have an average cost of approximately £4.2m whilst the claims involving Emergency Departments have an average cost of £0.5m per case.

The overall number of cases marked as Probable or Certain has increased from 670 to 869 cases. This is predominantly due to reviews of matters undertaken by legal teams in preparation for the migration to the new case management system (which went live in April 2025), rather than a direct increase in harm cases.

With such a high proportion of the litigation profile, and associated harm, being associated with maternity services, the Welsh Risk Pool focusses a considerable amount of time, effort and resource in supporting maternity and neonatal services; as reducing the claim profile, even by a small volume, has a significant impact on the overall position - along with reducing avoidable harm and impact to women and babies. In examining the Probable and Certain cases, where there is a high likelihood of settlement occurring, Maternity Services represent 19.1% of this group of cases (n=168 of 869 matters), whilst the quantum represents 59.7% of the overall NHS Wales claim profile (n=£1.4bn of £2.4bn). Paediatrics, which include neonatal services, represents 3.6% of all cases (n=32 of 869 matters), whilst the quantum represents 7.5% of all cases (n=£178.8m of £2.4bn).

The Welsh Risk Pool Committee therefore maintains a significant focus on supporting programmes that address the causes of claims in the maternity and neonatal sectors.

Quantum - Clinical Negligence 2024/25

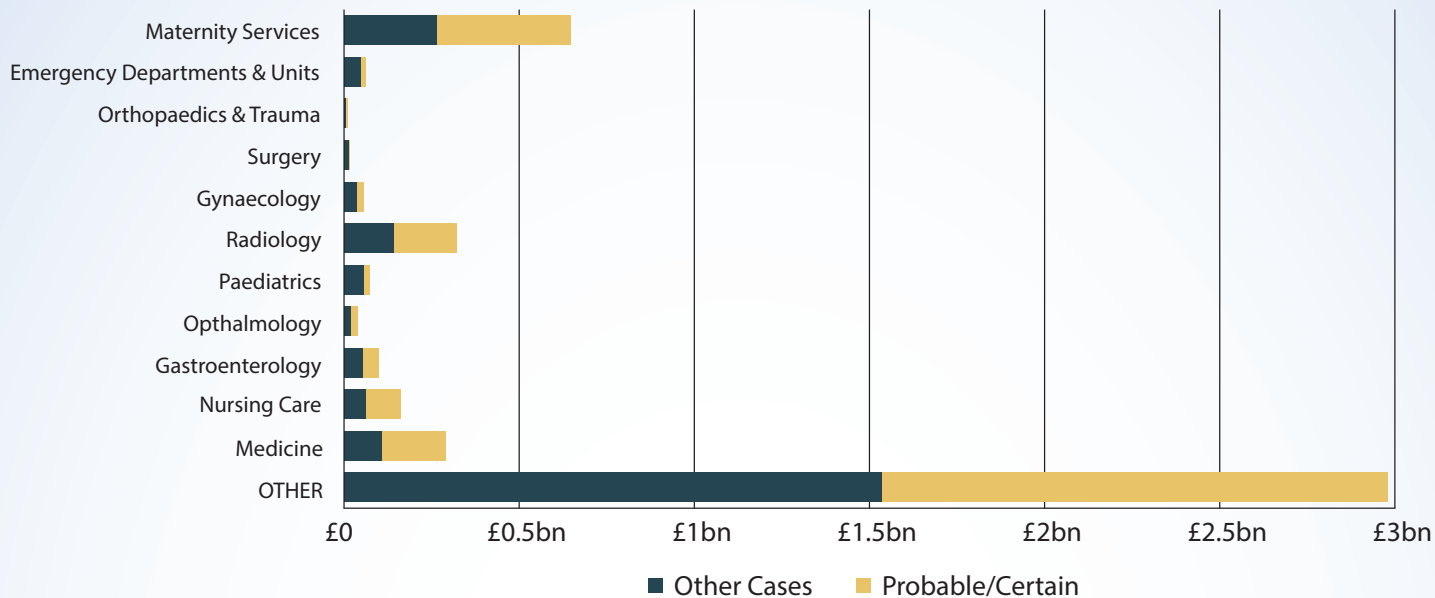


Fig.4 Quantum – Clinical Negligence 2024/25

Proportion of Open Clinical Negligence Cases April 2025

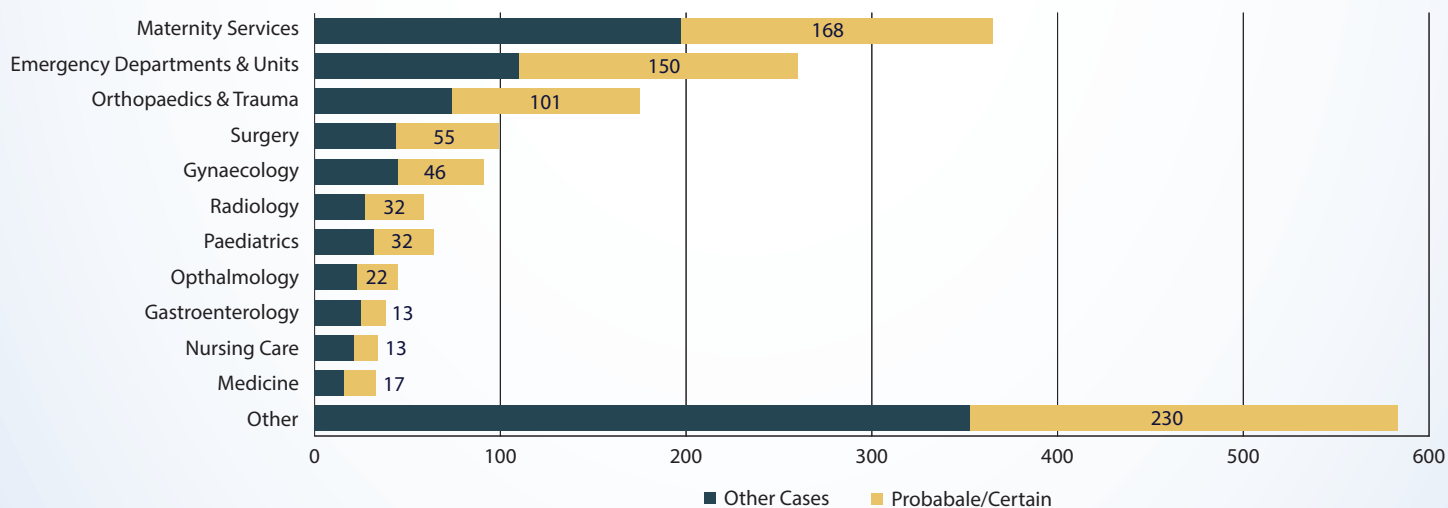


Fig.5 Proportion of open Clinical Negligence Cases Apr 25

Speciality	All Cases		Probable/ Certain Cases	
	Number Cases	Total Quantum	Number Cases	Total Quantum
Maternity Services	365	£2,978,505,725.79	168	£1,444,946,127.11
Emergency Departments & Units	260	£291,290,341.50	150	£184,368,661.50
Trauma and Orthopaedics	175	£161,766,084.87	101	£100,438,024.87
Surgery	99	£98,410,938.58	55	£45,963,858.58
Gynaecology	91	£39,093,897.60	46	£21,218,850.22
Urology	59	£73,876,281.40	32	£19,571,561.40
Radiology	64	£321,294,503.92	32	£178,829,623.92
Paediatrics	45	£54,773,564.54	22	£20,016,724.36
Medicine/ Medical	38	£17,395,187.28	13	£5,607,694.48
Ophthalmology	34	£8,892,160.00	13	£3,226,710.00
Mental Health / Psychiatry	33	£61,201,681.97	17	£13,561,681.97
Nursing Care	583	£646,227,175.64	230	£381,236,342.26
Ambulance / Paramedics	35	£15,794,992.50	15	£5,911,450.00
OTHER	482	£217,094,094.81	128	£103,997,445.42
TOTAL	1846	£4,752,727,543.09	879	£2,418,985,860.67

Table.3 Number and Quantum of Clinical Negligence Cases Apr 25

Table.3a Full outline - Number and Quantum of Clinical Negligence Cases Apr 25 (See next page)



Table.3a	All Cases		Probable/ Certain Cases	
Speciality	No of Cases	Total Value	No of Cases	Total Quantum
Maternity Services	365	£2,978,505,725.79	168	£1,444,946,127.11
Emergency Departments & Assessment Units	260	£291,290,341.50	150	£184,368,661.50
Orthopaedics & Trauma	175	£161,766,084.87	101	£100,438,024.87
OTHER	205	£120,311,122.00	34	£19,872,032.00
Surgery	99	£98,410,938.58	55	£45,963,858.58
Gynaecology	91	£39,093,897.60	46	£21,218,850.22
Paediatrics	64	£321,294,503.92	32	£178,829,623.92
Radiology	59	£73,876,281.40	32	£19,571,561.40
Ophthalmology	45	£54,773,564.54	22	£20,016,724.36
Gastroenterology	38	£17,395,187.28	13	£5,607,694.48
Nursing Care	34	£8,892,160.00	13	£3,226,710.00
Medicine	33	£61,201,681.97	17	£13,561,681.97
Urology	33	£10,996,612.72	20	£6,423,842.72
Ambulance / Paramedics	28	£14,556,040.34	14	£6,520,300.34
Mental Health & Psychiatry	28	£52,918,150.00	15	£42,779,750.00
Oncology	28	£33,979,980.00	17	£30,907,980.00
Cardiology	25	£12,269,959.28	11	£3,494,998.68
Neurology	25	£143,846,667.60	10	£85,117,767.60
Colorectal Surgery	23	£9,978,179.10	11	£5,970,589.10
Ear Nose & Throat	23	£19,867,468.30	13	£11,866,468.30
Neurosurgery	21	£28,857,147.66	7	£6,127,847.66
Primary Care & General Practice (exlcuding GMPI)	19	£20,797,677.91	12	£16,205,110.73
Anaesthetics	15	£24,293,758.08	10	£9,304,537.48
Podiatry	11	£8,851,400.00	5	£3,323,400.00
Respiratory	11	£5,930,775.00	5	£4,427,000.00
Haematology	10	£3,620,200.00	3	£2,039,220.00
Dental	9	£1,197,800.00	4	£466,160.00
Dermatology	8	£2,968,580.84	2	£622,580.84
Cytology	6	£5,519,000.00	5	£4,809,000.00
Pathology, Histology & Microbiology	6	£8,782,600.00	3	£8,222,600.00
District Nursing	5	£994,500.00	3	£654,500.00
Geriatric Medicine	5	£1,019,000.00	3	£735,000.00
GP Out of Hours	5	£28,101,460.00	3	£27,898,060.00
Maxillofacial	5	£1,099,000.00	3	£379,000.00
Cardiothoracic Surgery	4	£4,802,000.00	3	£4,802,000.00
Nephrology	4	£1,709,250.00	4	£1,709,250.00
Plastic Surgery	4	£515,500.00	2	£180,000.00
Rheumatology	4	£858,592.46	1	£328,592.46
Genetics	3	£220,000.00	1	£160,000.00
Oral & Maxillofacial Surgery	3	£16,516,000.00	1	£15,710,000.00
District Nursing & Health Visiting	2	£57,348,754.35	2	£57,348,754.35
Administration, Estates & Business Services	1	£0.00	1	£0.00
Audiology	1	£1,600,000.00	1	£1,600,000.00
Genitourinary Medicine	1	£190,000.00	0	£0.00
Mobility Services	1	£480,000.00	0	£0.00
Physiotherapy	1	£1,230,000.00	1	£1,230,000.00
TOTAL	1846	£4,752,727,543.09	879	£2,418,985,860.67

Personal Injury Cases

In addition to claims for alleged clinical negligence, the Welsh Risk Pool and Legal and Risk Services deal with matters of public liability, occupiers' and employers' liability brought against NHS Wales health bodies.

At the end of 2024/25 there were 448 open personal injury matters against NHS Wales being handled by the Welsh Risk Pool and Legal and Risk Services. This indicates a steadying of claim numbers after a downward trend in personal injury matters over the last ten years. There was a peak in new personal injury matters opening in early 2013 caused by the introduction of fixed recoverable costs and a change to the law which limited the grounds on which personal injury claims could be brought.

We continue to defend as many cases as appropriate. An example of a case defended at trial is shown here.

Example Case	Member of Staff v An NHS Wales Health Board
Summary	The Claimant alleged that he was pushed over by a violent patient and suffered a severe injury to his left elbow which led to restriction in movement in his left elbow and left shoulder which forced him to retire early.
Steps taken	Witness evidence suggested that the Claimant's injuries pre-dated the assault. In light of this, we instructed inspectors for covert surveillance. This took place and showed the Claimant using both arms freely whilst shopping. Permission to rely on the footage was granted and we invited the Claimant to discontinue his claim within 14 days, on a drop-hands basis.
Outcome	The Claimant accepted the offer and discontinued his claim.
Saving	There was a saving of £150,000 in damages. The costs budget was in the amount of £60,673.40. The total saving was therefore £210,673.40.

Fig.6 shows the number of open personal injury matters since 2012/13. This shows a reducing trend in case volumes, reaching a plateau in 2024/25.

Open Personal Injury Matters

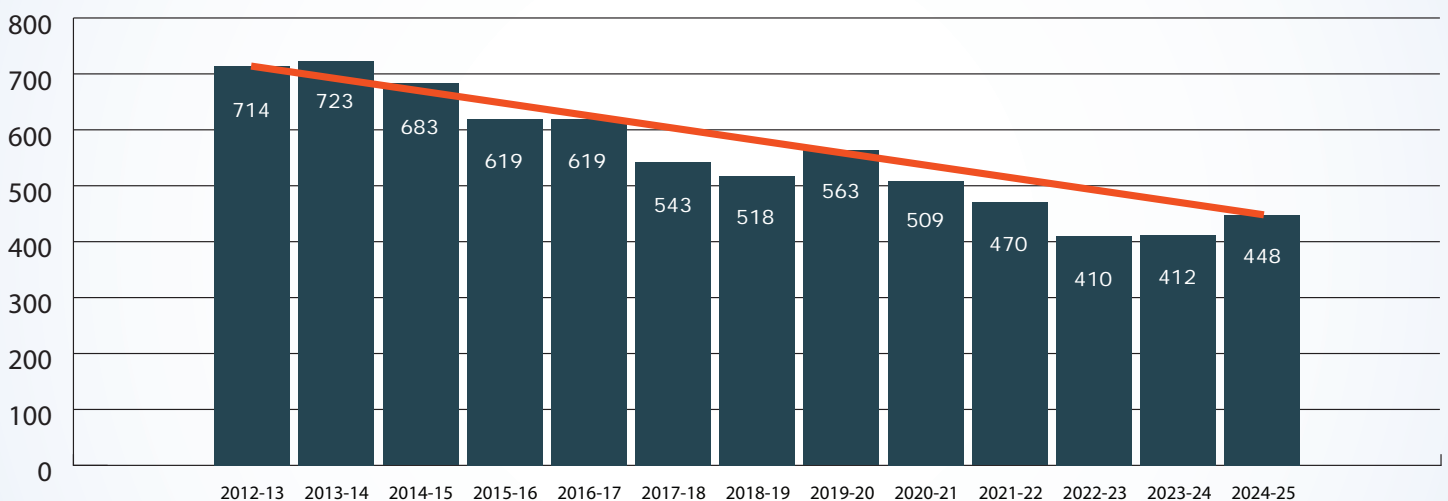


Fig.6 Open Personal Injury matters

Fig.7 shows a continuing positive trend in successfully defended personal injury claims, with around half of all cases closed without damages being paid. This highlights the strong investigative approach taken when claims of this type are received and indicates a good use of public funds in avoiding paying unnecessary sums to settle matters, even where the claim is of low value.

Percentage of Personal Injury Matters Closed Without Damages

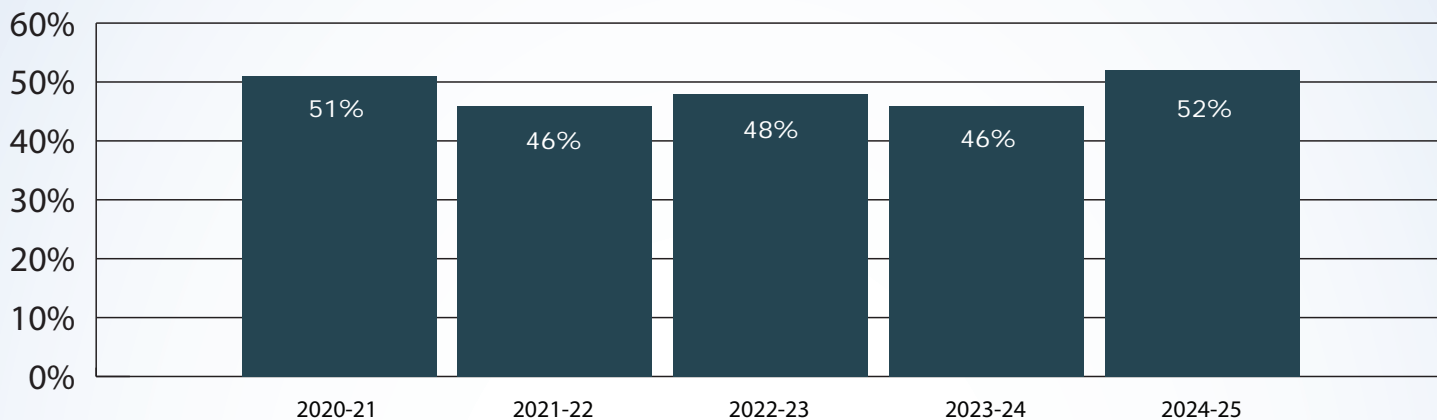


Fig.7 Personal Injury Claims Closed Without Damages



Redress Cases

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 place duties on health bodies to consider payment of appropriate redress in matters where there is a qualifying liability. The Regulations require health bodies to consider redress in circumstances where harm is alleged, and the likely value of any claim would not exceed £25,000 in damages. Dealing with these cases in this way has a significant impact in reducing the legal costs associated with claims brought in the traditional way and provides an effective resolution for those affected, along with significant savings for the NHS.

Cases that may lead to consideration of redress include incidents reported by staff within organisations and complaints received from service users or their representatives. Health bodies are required to investigate matters and to determine whether there is a qualifying liability. Since 2018, the Welsh Risk Pool has been allocated responsibility for the scrutiny of learning and reimbursement of expenditure incurred by health bodies in relation to redress cases.

Redress cases are managed locally by specialist teams within health bodies. Legal and Risk Services has a specialist team which advises and supports organisations in relation to redress matters. Formal reviews by the Legal and Risk team are required in all cases where a proposed damages payment exceeds £25k, where payments to the UK Government Compensation Recovery Unit exceeds £3k and in all cases where qualifying liability is considered to have been met in a matter relating to the coronavirus pandemic. From 2019, health bodies have been required to provide information on their current caseloads to assist with planning and budgeting. This provides an insight into the progress of matters across NHS Wales.

In 2024/25, a total of 1254 redress cases were being managed by health bodies in NHS Wales. Following a reduction in the overall

caseload from during the pandemic, the increase follows the expected trajectory for redress cases – with an expected continuing increase. The period of reduction that has been seen can be attributed to a reduction in incident and complaint investigations during the pandemic. The increase since 2023 can be associated with the introduction of the Duty of Candour in Wales. It is expected that future years will continue to see an increase in the redress caseload. Fig8. outlines the overall redress caseload over the last six years.

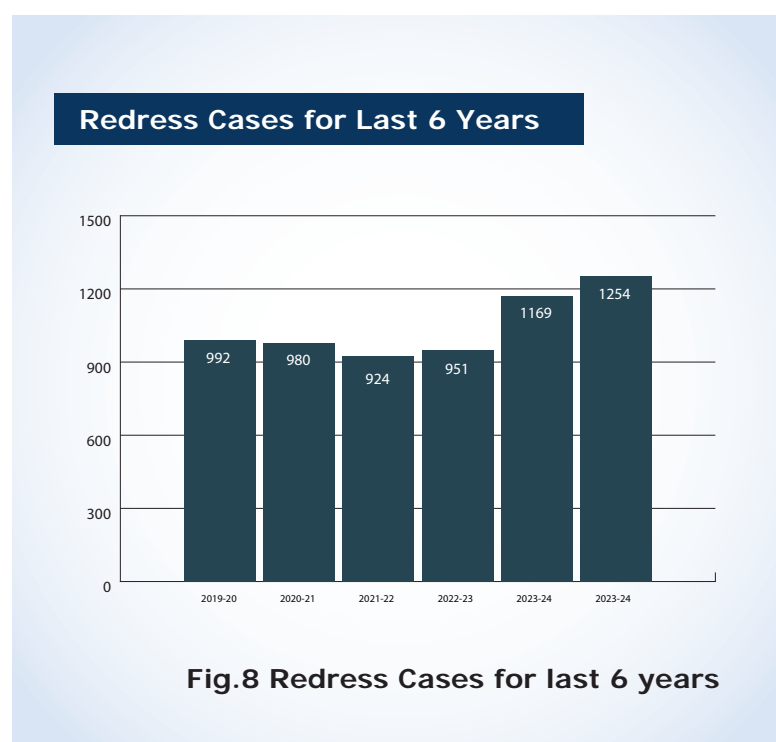


Fig.8 Redress Cases for last 6 years

Considering the clinical speciality to which a redress case relates is a useful indicator of themes and trends. Traditionally, each health body has considered redress cases in relation to its own list of specialties which do not align to provide a national picture. With all organisations now utilising the Once for Wales Concerns Management System to capture and manage redress cases, it is anticipated that a national picture will shortly be available. From case analysis, the most commonly occurring specialities within redress cases continue to be Emergency Department, Orthopaedics, and General Surgery.



The Welsh Risk Pool receives two funding streams:

- » **Departmental Expenditure Limit (DEL)** to meet the in-year costs associated with settled claims. The DEL is funded by a core allocation provided by Welsh Government from the annual healthcare budget. This is augmented via a risk sharing agreement that involves contributions from each health body using a formula depending on the size, claims experience and risk management standards of an organisation.
- » **Annually Managed Expenditure (AME)** to meet the cost of accounting for the long-term liabilities of claims. This budget is based on in year estimates provided directly to the Welsh Government by the NHS Wales Shared Services Finance team.

The NHS Shared Services Partnership Corporate Finance Team provides oversight, guidance and financial management of the Welsh Risk Pool DEL and AME budgets.

Analysis of the current budget and use of financial forecasting tools enables the Welsh Risk Pool to confidently plan for settlement of case in-year and prepare for the likely financial requirements in the ensuing years.

2024/25 Budget Position

The Welsh Government core allocation for the year in 2024/25 was £109.435m for clinical negligence, personal injury and redress cases. A risk share charge of £30.478m was implemented via health bodies at the end of the financial year and a small amount of additional funding was provided by Welsh Government in March to support case progression.

The DEL funding for 2024/25 is outlined in Table.4.

WRP DEL Funding 2024/25	£m
Welsh Government Core	109.435
NHS Wales Risk Sharing Agreement	30.478
Welsh Government Additional Funding	5.098
Total Funding	145.011

Table.4 WRP DEL funding 2024/25

Within the £145.011m outturn for 2024/25, the redress charge was £2.300m compared to £1.699m in 2023/24. Redress reimbursements totalled £1.469M and the redress creditor increased by £831K in year. Increasing expenditure on redress cases is recognised to have a beneficial effect on reducing the number of claims which are brought.

The DEL position for the year for clinical negligence expenditure is outlined in Table.5, along with the 2023/24 comparative:

WRP DEL Expenditure	2023/24 £m	2024/25 £m
Claims reimbursed and WRP Managed Expenditure	88.721	94.720
Redress Reimbursements	1.477	1.469
Periodical Payments	21.073	24.597
Safety and Learning Programmes	0.4448	0.681
Clinical Negligence Team Funding	0.550	0.702
Movement on Claims Creditor	23.515	22.842
2023/24 expenditure	135.784	145.011

Table.5 WRP DEL expenditure 2024/25

The creditor movement increased by £22.842m by the end of the financial year with a comparable value of reimbursements paid this year compared to last year; £88.721m in 2023/24 compared to £94.720m in 2024/25.

Settled cases are accumulating in the WRP creditor at a similar rate to last year. An element of the balance will relate to settlements towards the end of the financial year where the Health Board or Trust has not yet had the opportunity to submit returns in order to receive reimbursement. The larger remaining balance will relate to cases where approval of the learning plans has been deferred by the Welsh Risk Pool and these are not being resolved by Health Boards and Trusts as quickly as the previous year.

The creditor movement represents the increase, or decrease, in the total creditor balance since the previous year end date and the total NHS Wales creditor has increased to £178.2544m as at 31/3/2025.

Total provisions have risen to £1.712bn as at 31st March 2025, an increase of £62m in 2024/25. This compares to a previous £155m increase in provisions for 2023/24.

A profile of the provisions over the last five years is shown in Fig.9 and a breakdown of the provisions is shown at Table.6.

It is important to note that the increase in provision values does not directly correlate with increases in total case numbers. Indeed, case numbers reduced slightly during the year.

The primary cause of the increase in the value of provisions this year has been due to an accelerated conversion from a Remote or Possible probability to a Probable or Certain one, continuing a trend that started last year.

Remote and Possible cases are not recognised in the financial provisions due to the uncertainty of liability and quantum value. They are disclosed as contingent liabilities in the notes to the accounts.

The application of financial adjustments for inflation and the discounting of liabilities to net present value has caused negligible movements this year.

The number of Probable and Certain cases managed during the year increased from 744 cases to 812 cases over the 12-month period to 31st March 2025. However, within this increase, the number of high value cases above £1m decreased compared to the end of the previous financial year by 3 - from 141 to 138 cases.



WRP Provisions for Last Five Years

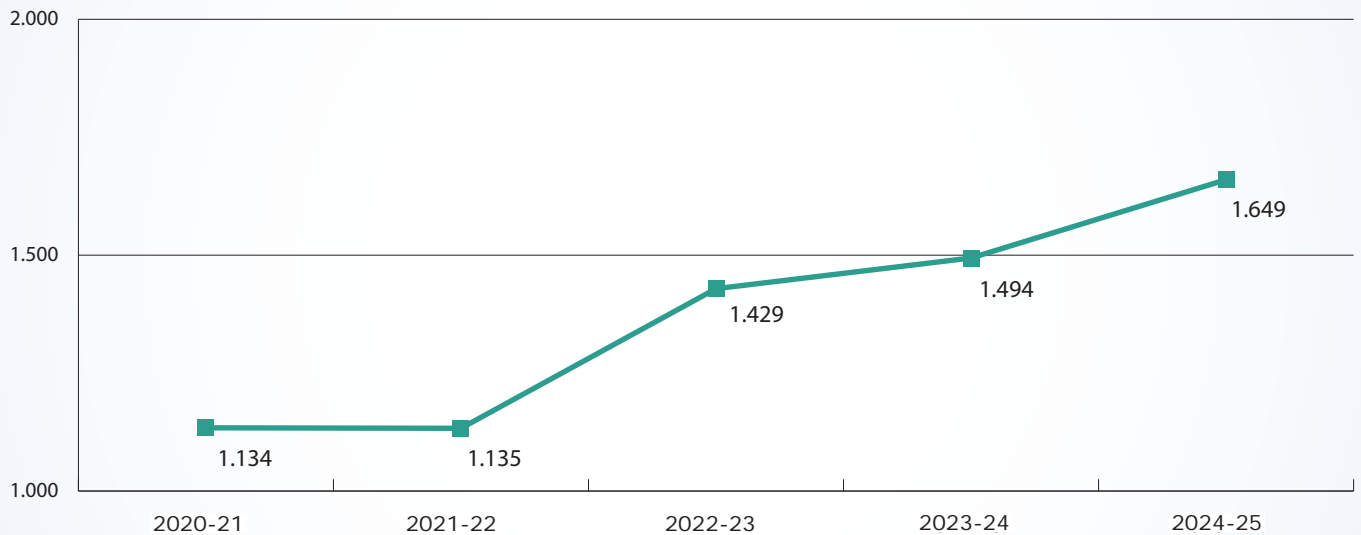


Fig.9 WRP Provisions for last five years

Welsh Risk Pool Provisions	2019/20 £bn	2020/21 £Bn	2021/22 £Bn	2022/23 £Bn	2023/24 £Bn	2024/25 £Bn
Probable an Certain Clinical Negligence Cases	0.676	0.646	0.781	0.836	0.948	0.967
Probably and Certain Personal Injury Cases	0.005	0.008	0.004	0.004	0.004	0.003
Probable and Certain Redress Cases	0.003	0.003	0.002	0.003	0.003	0.003
Defence Legal Fees and Others	0.009	0.009	0.009	0.010	0.010	0.011
Periodical Payment Orders	0.441	0.468	0.632	0.641	0.685	0.728
Total Provisions	1.134	1.133	1.429	1.494	1.649	1.712

Table.6 Breakdown of WRP provisions



Looking Forward - The Forecast

When considering the funds needed for future years, the Welsh Risk Pool and Legal and Risk Services categorise all claims and matters by allocating a rating depending on the likelihood of the case settling. The categories include, Remote, Possible, Probable and Certain and these are outlined in Table 7. For budget planning purposes, Probable and Certain cases are included in the forecast.

Assessment of Probability of Settlement	
0% - 5%	Remote
6% - 49%	Possible
50% - 94%	Probable
95% - 100%	Certain

Table.7 Probably of settlement categories

The core DEL funding for the Welsh Risk Pool for 2024/25 is £109.435m.

Planning and forecasting for the Welsh Risk Pool is included in the NHS Wales Shared Services Partnership Integrated Medium Term Plan (IMTP). The 2024/25 IMTP forecast for 2025/26 showed a resource requirement of £145.491m which, utilising the proven forecasting model, was based on a high-level analysis of previous year trends and average values for cases >£1m and cases <£1m. A more recent review of cases due to settle in 2025/26 has highlighted an emerging change to the claim profile for cases due to settle in year, combined with increasing case values, indicating a potential increased resource requirement for the financial year. Any increased expenditure above the £109.435m allocation is met via application of the risk sharing agreement to NHS Wales. Financial returns are received from Organisations at the end of July 2025 which will inform future year forecasts.



Risk Sharing Agreement

To support the in-year resource requirements, the Welsh Risk Pool requires contributions from its member health bodies to supplement the core allocation provided by Welsh Government.

The Risk Sharing Agreement provides a formulaic approach to calculating the required contributions and considers the size, claims experience and effectiveness of learning for each organisation.

Each of the five measures are outlined in Table.8.

Measure	Detail	Weighting
A	HSCS and Prescribing Allocation Current measure	30%
B	Claims History Last 3 years – rolling basis	20%
C	New Claims transferred from the Service to LARS: Number of New Cases < £25k Last 12 months	10%
D	Claims potentially affecting next years' spend: 1. Cases with cash flows < 1 yr 2. PPO Allocation Utilisation From CN database : 15% Actual Costs : 10%	25%
E	Management of Concerns and Learning from Events 1. Management of Concerns 2. Learning from Events Annual WRP Inspections: 7.5% 7.5%	15%

Table.8 Risk Sharing Agreement Measures

The first measure relates to the **HSCS and Prescribing Allocation** allocated to an organisation by Welsh Government. This is major indicator of the size and complexity of an organisation.

The **claims history** is calculated from total reimbursements paid per organisation over the rolling three-year period to the end of the previous financial year.

Measure C, **cases under £25k**, considers matters which could have been resolved through the redress case management system. The data for this is drawn from the Legal and Risk matter database.

The calculation then considers **claims likely to affect the next year's expenditure**, considering each organisations profile of claims with cash flows, where payments are expected, within the next twelve months. This measure also considers the utilisation of PPOs which is taken from the forecast projections.

The final, and arguably most influential, measure is the **Management of Concerns and Learning from Events**. Each year the Welsh Risk Pool undertakes inspections of the processes and arrangements in each health body. The Welsh Risk Pool considers whether health bodies have complied with the WRP Reimbursement Procedures, the Once for Wales Concerns Management System and the guidance for the Putting Things Right legislation. The inspection programme was paused due to the pandemic and recommenced in the autumn of 2022/23. Figures from the 2024 WRP Assessment will feature in the risk sharing agreement for 2025/26. Cost drivers will be updated and Risk Share apportionments will be confirmed in September, following availability of the final Management of Concerns/ Lessons Learned elements. These now include a more comprehensive and appropriate set of measures for the 5th element, 'Lessons Learned', including participation with the PROMPT Wales and Consent programmes.

In relation to the risk sharing agreement, each organisation receives an individual contribution value which is a percentage of the total contributions required.



Welsh Risk Pool Operations



The Welsh Risk Pool Operations team has responsibility for a number of work areas - including the management of Periodical Payment Orders, handling and responding to NHS Wales Indemnity enquiries and the role of client in legacy Former Health Authority Claims. The team consists of experienced paralegal staff and claims managers.

Structured Settlement Orders

Periodical Payment Orders (PPO's) are generally used in cases where a settlement includes a payment for the provision of long-term care and support for a claimant over a sustained period of time. There may be a lump sum payment made at the time a case is settled, with a legal commitment to make a regular payment for the life of a claimant.

The Welsh Risk Pool is responsible for administering the Periodical Payment Orders for all NHS Wales Health Bodies on behalf of Welsh Government. At the end of 2024/25, 34 cases had closed and 12 new matters opened – with a total of 149 active PPO matters. PPO payments made in 2024/25 totalled £24,997,389.88.

The calculation of payments is adjusted each year in accordance with a formula outlined in the relevant court orders. Indices regularly used to adjust payments are the Retail Prices Index (RPI) and Average Salary and Hourly Earnings (ASHE) index.

The payment adjustments are overseen by the NWSSP Corporate Finance Team. Enquiries regarding trusts for the claimants, payments of accounts or in the event of the death of a claimant are dealt with by the WRP Operations team.

NHS Wales Indemnity Enquiries

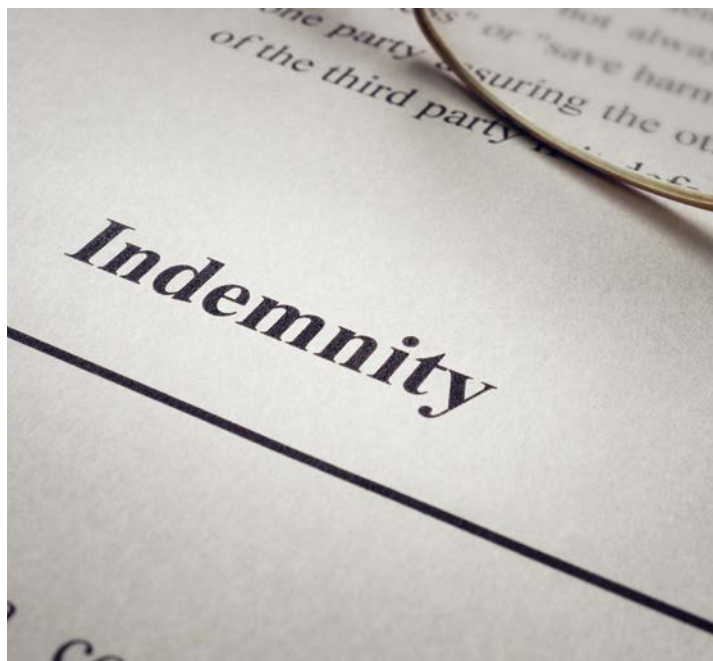
Health bodies in NHS Wales are exempt from the majority of the requirements for compulsory insurance and are not permitted to purchase commercial insurance for their core activities. The Managing Welsh Public Money guidance outlines that purchasing commercial insurance would not be cost effective for Health Bodies. Instead of purchasing commercial insurance, health bodies apply NHS Indemnity to their activities and are members of the Welsh Risk Pooling scheme.

The application of NHS Indemnity is complex and is outlined in the All-Wales Policy on Indemnity and Insurance – which is overseen by the Welsh Risk Pool Committee. As the models of healthcare evolve and arrangements between bodies and the private sector increase, the indemnity position is increasingly complex.

The Welsh Risk Pool Operations Team receives enquiries relating to NHS Indemnity and works with appropriate legal, procurement and policy teams to incorporate appropriate provisions into memorandums of understanding, service level agreements and contracts.

During 2024/25 the Welsh Risk Pool received **397 enquiries** relating to NHS Indemnity and supported the production of a number of MOUs, SLAs and Contracts in respect of indemnity.

As there is generally no commercial insurance in place, health bodies are unable to provide an enquirer with a certificate of insurance. The Welsh Risk Pool is able to provide a bespoke letter to confirm the indemnity arrangements so that all parties are clear what cover is in place. During 2024/25, the Welsh Risk Pool handled **181 requests** for the Employer's and Public Liability confirmatory letter.



Delegated Cases

The Welsh Risk Pool has delegated responsibility for the management of certain claims brought in NHS Wales. The Welsh Risk Pool team occupies the role of client and instructs the relevant legal team to conduct the matter as appropriate. The NWSSP Scheme of Delegation outlines that responsibility for decisions on settlement of delegated cases are devolved to the Director and Deputy Director of Legal and Risk Services and authorisation of payments in delegated cases is allocated to members of the Welsh Risk Pool team and members of the NWSSP Leadership Team.

There are two main types of delegated case:

Former Health Authority Claims

Former Health Authority Claims are historic matters that involve a liability for a health body in Wales which no longer exists. When NHS Trusts were formed during the mid-1990's, the Health Authorities which they replaced did not transfer their legal liabilities to the new organisation. This means that the Health Boards and Trusts which have subsequently replaced the earlier NHS Trusts do not hold legacy liabilities prior to the establishment of the NHS Trusts. Through its' Establishment Order, Welsh Government has allocated Powys Teaching Health Board (PTHB) with liability for these legacy claims. To reduce the burden on the current Health Board, all Former Health Authority matters are wholly delegated to the Welsh Risk Pool and all costs and payments transacted by the Welsh Risk Pool, whilst PTHB remains the technical defendant.

Former GP Trainee Claims

Former GP Trainee Claims relate to index events prior to the introduction of the General Medical Practice Indemnity Scheme (GMPI) where doctors in training for general practice were employed by Velindre University NHS Trust / NHS Wales Shared Services Partnership as a Single Lead Employer. Liability in these cases is managed by the Welsh Risk Pool directly.

Former Health Authority Cases 2024/25

As part of the governance of these cases, the cases which are closed during a financial year are reported to the Welsh Risk Pool Committee at the end of the year. The information is also shared with PTHB. By way of summary:

- ↘ **6** new Former Health Authority Personal Injury cases were received in 2024/25;
- ↘ **4** Former Health Authority Cases closed in 2024/2025;
- ↘ The number of Former Health Authority Personal Injury cases currently open is **14**;
- ↘ There are no Former Health Authority Clinical Negligence cases currently open; and
- ↘ **1** Former Health Authority Clinical Negligence case closed in 2024/25 this matter has now settled and proceeded to a PPO.

Former GP Trainee Cases 2024/25

1 new Former GP Trainee case was received in 2024/2025

There were no Former GP Trainee Cases closed or discontinued in 2024/2025

The number of Former GP Trainee cases currently open is 11



Learning Assurance



The Welsh Risk Pool plays a key role in assuring that learning is undertaken and implemented following complaints or incidents which result in a redress, personal injury or clinical negligence claim. Sharing the learning across NHS Wales, is a key aim of the Learning from Events Programme.



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A clinically led and multi-professional Learning Advisory Panel (LAP) was established over 5 years ago, as a recognised subcommittee of the Welsh Risk Pool Committee (WRPC). Chaired by established leaders from the Putting Things Right sector, the Panel meets monthly to scrutinise Learning from Events Reports (LFER), which highlight the learning implemented by health bodies, following a redress or clinical negligence case. During 2024-25, the Panel reviewed 787 cases.

Medical, nursing & midwifery and allied health professional representatives participate in the LAPs, together with colleagues from governance and legal services teams. Medical officers from Welsh Government contribute to each LAP. A diverse range of clinical specialities are represented, which ensures a widespread sharing of the learning.

A separate LAP has recently been established to review the learning implemented following a personal injury claim. This Panel is fully supported by Health and Safety professionals from across Wales and has proven to be very successful.

The role of each LAP is to establish whether the learning implemented following each case, provides assurance that a similar incident is less likely to happen again in the future. If the Panel is assured, it recommends that the LFER is approved. If it is not assured, feedback will be provided and approval of the LFER will be deferred until the feedback is addressed. All LAP decisions must be reviewed, approved and ratified by the WRPC. Health bodies will only be reimbursed by the WRP for monies paid in relation to a claim (damages/costs etc), if the LFER has been approved.



The LAP plays a key role in identifying learning themes across Wales. The new WRP VTE Wales Programme to develop an All-Wales approach for the prevention and reduction of harm associated with venous thromboembolism (VTE), arose as a result of the LAP identifying increased VTE case numbers presenting to them.

Themes, trends and cases of interest are also shared in the quarterly newsletter, Doctrina. This has been well received by clinical leaders and disseminated within teams for wider learning.

The Welsh Risk Pool Reimbursement Procedures provide a structured series of standards by which members of the risk pooling scheme should work. Guidance on each step of the process of Learning from Events and Submission for Reimbursement are best achieved; aiming to reduce the potential for the circumstances which led to a claim occurring from being repeated. The procedures provide a period of four calendar months from when the point when a case is settled to prepare and present learning information.

During 2024-2025, the Learning Advisory Panels have been busy. Meeting monthly in a virtual format, the panels reviewed an average of 60 new cases and re-examined previously deferred or rejected.

Table.9 outlines the number of new cases submitted. This shows a 27% increase in new cases in 2024/25 compared to 2023/24. This increase is attributed to the work by all organisations to drive timeliness in learning.

Fig.10 outlines the comparison of when new cases were presented to the panel in 2023/24 and 2024/25. By considering this distribution, it enables planning of panel capacity. Apart from a small reduction in August, the data indicates that there has been a consistent increase in cases distributed throughout the year.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total Number New Cases 2024/25	50	62	51	58	50	62	50	91	70	79	103	61	787
Total Number New Cases 2023/24	53	46	39	58	63	51	55	50	68	41	29	65	618

Table.9 number of new cases submitted to WRP in 2023-34 and 2024-25

**All Wales Comparison of New Cases Submitted to the Learning Advisory Panel
2023-24 and 2024-25**

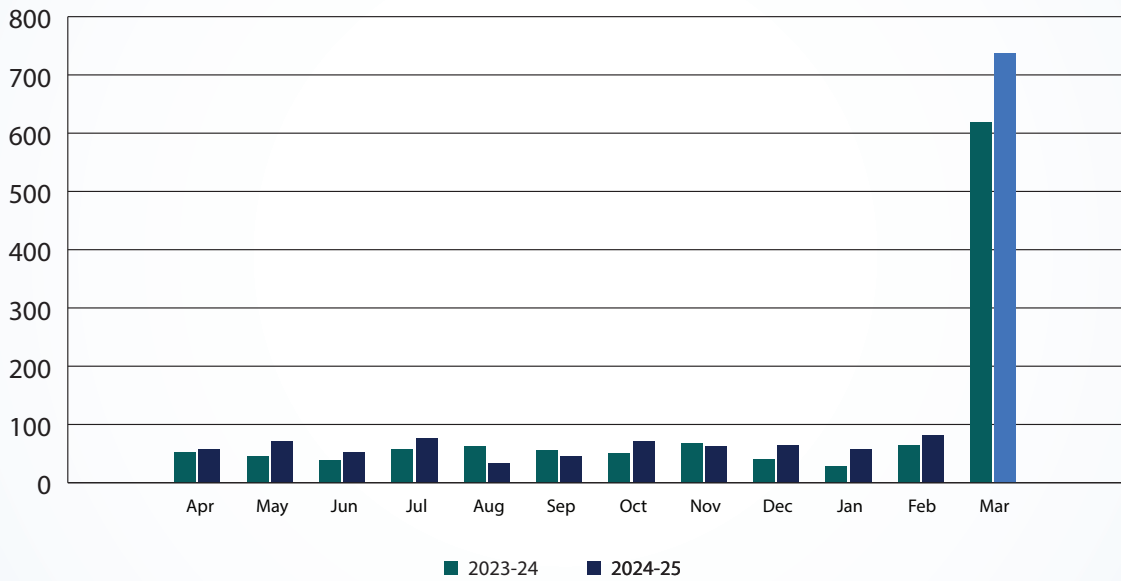


Fig.10 Comparison of New Cases to Panel 2023/24 and 2024/25

Timeliness of the submission of Learning from Events Reports is important in reducing the potential repeat incidents from re-occurring. The WRP Reimbursement Procedures establish a four-month timescale for the submission of an LFER from the decision to settle a case and the NHS Wales Leadership Forum recognised in 2024 that this is a generous deadline, especially considering that learning reviews can and should be taking place well before the decision to settle a legal matter is made.

Table.10 and Fig.11 outline the timeliness of LFER submissions in 2023/24 and 2024/25. This data shows an improvement in timeliness from 28% of LFERs being submitted late in 2023/24 (n=169 of 608) to 18% (n=144 of 787) in 2025/26. Some of the late submissions were significantly late, including several which were over six months late. The improvement seen in timeliness of LFER submissions is predominantly attributed to the imposition of penalties for late submission on organisations, which have reviewed internal processes as a result.

	No. of Missed Standard Deadlines	No. of Achieved Deadlines	Submissions
Submissions 2023-24	169	439	608
Submissions 2024-25	144	643	787

Table.10 Timeliness of LFER Submissions 2023-24 and 2024-25

LFER Submissions 2024-25

LFER Submissions 2023-24

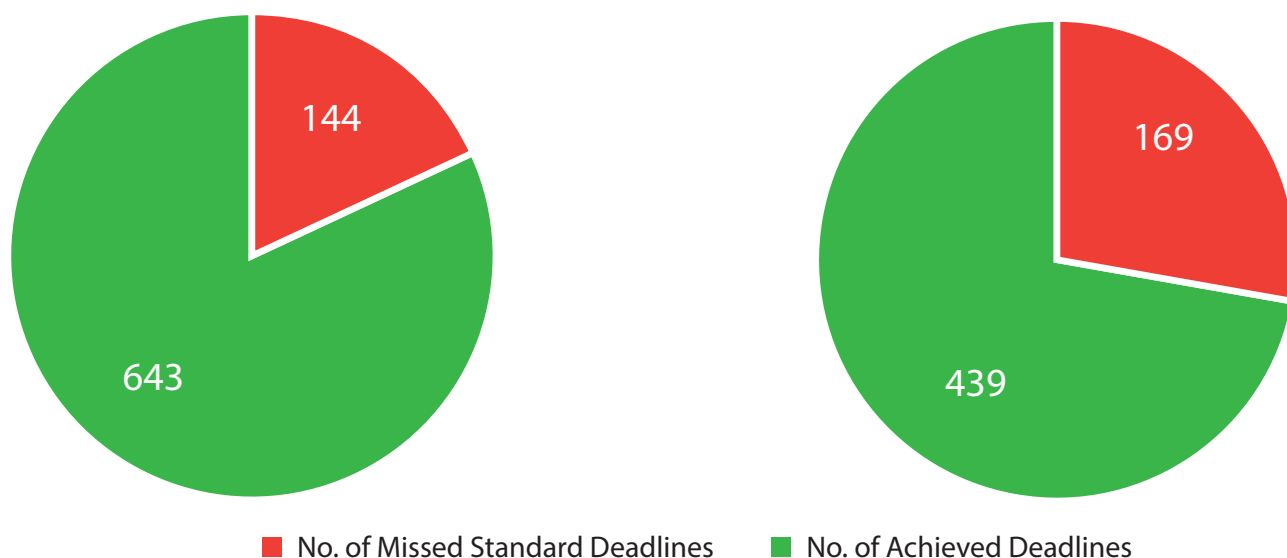


Fig.11 Timeliness of LFER Submissions 2023-24 and 2024-25

The learning in each case is carefully scrutinised by the panel in order to determine whether the actions taken adequately address the issues identified in the matter and whether there is assurance of a sustained improvement. Evidence is also sought to provide clarification of actions and assurance provided by health bodies.

Where a case is considered to have met the criteria, it is approved and requests for reimbursement from the risk pooling scheme will be accepted from the health body for a period of up to two years. After this period, if the legal case remains ongoing, a review of the learning position is requested and considered by the panel.

A case is deferred where the learning is not considered to suitably address the issues identified. If the panel considers that the Learning from Events Report requires further work to identify improvements, it is red deferred and must be reviewed again by the panel.

If the panel considers that the LFER addresses the issues within a case but evidence to support the learning is required, it is amber deferred and approval of the requested evidence is delegated to the Head of Safety & Learning. A summary of outcomes in 2023-24 and 2024-25 is shown in Table.11.

	Apr	May	Jun	Jul
2023/24	618	32.2% (n=199)	28.5% (n=176)	29.3 (n=243)
2024/25	738	16.8% (n=124)	28.7% (n=402)	54.5% (n=402)

Table.11 Decision outcomes for cases 2023/24 and 2024/25

The data presents a year-on-year comparison of panel decisions on new Learning from Events Reports (LFERs) submitted to the Welsh Risk Pool Committee, showing notable shifts in outcomes between 2023/24 and 2024/25. A detailed analysis of approval statuses of LFERs is outlined in Table.12.

In 2023/24, nearly one-third of all new cases (32.2%, n=199) were approved by the panel. However, in 2024/25, this figure dropped significantly to 16.8% (n=124), indicating a halving in the proportion of cases that met the required standards for approval.

The proportion of red deferred cases — those where the learning was deemed insufficient and required substantive further work — remained broadly consistent, at 28.5% (n=176) in 2023/24 and 28.7% (n=212) in 2024/25.

The most marked increase is seen in amber deferred cases, which are those that broadly address the issues but lack evidence to support the learning. These rose sharply from 29.3% (n=243) in 2023/24 to 54.5% (n=402) in 2024/25. This suggests a growing trend of health bodies submitting cases where the intended learning is directionally correct but not yet substantiated with sufficient evidence — potentially due to rushed submissions or misunderstandings about panel expectations.

This data on the quality of learning indicates a decline in the quality or completeness of submissions, which suggests a system-wide need for improved locally applied guidance, corporate support and quality assurance before submission of cases to the panel - to ensure learning is both clearly articulated and appropriately evidenced. The Welsh Risk Pool Committee has commissioned Intensive Support programmes to assist organisations in achieving sustained improvement.

Learning from Events Reports were introduced in 2018 and all organisations have received training and guidance on the preparation and completion of them. The Welsh Risk Pool has introduced innovative strategies such as the Enhancing Learning Organisations programme to support improvement in this area. With increased local scrutiny prior to submission to the Welsh Risk Pool it is anticipated that approval rates at LAP can rise to around 70% in all new cases.

In January 2025 specialist checklists for deferred cases, known as U8 and U9 Checklists, were introduced due to the increasing number of deferred cases.

The U8 Checklist was implemented due to the increasing number of submissions with disorganised additional evidence. It aims to help both health body teams and the Safety & Learning Advisor who is reviewing the evidence, to ensure that all feedback has been fully addressed.

The U9 Checklist was introduced to improve understanding by signatories of LFERs. When signing the governance declaration of the LFER, the signatory is confirming, on behalf of the health body, that the LFER has been completed fully and correctly, and they are giving assurance that learning actions have been implemented to mitigate the risk of a similar incident. If the National Learning Advisory Panel are not assured by the learning actions on the LFER and thus not assured that the health board has mitigated the risk of a similar incident occurring, they will recommend that the LFER is RED deferred. The U9 has been implemented to ascertain why that person signed an LFER, which has resulted in such limited assurance when peer reviewed by the National Learning Advisory Panel and what they have changed with their local processes to ensure that they are less likely to sign-off a potential RED deferred LFER in the future.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Total Number New Cases	58	71	52	76	33	66	45	71	62	65	58	81
Number Cases Approved	12	11	10	11	6	16	13	13	7	10	3	12
Number Cases Red Deferred	12	18	12	22	11	13	10	27	15	27	21	24
Number Cases Amber Deferred	34	42	30	43	16	37	22	31	40	28	34	45
Average Number Approved %	20.69	15.49	19.23	14.47	18.18	24.24	28.89	18.31	11.29	15.38	5.17	14.81
Average Number Red Deferred %	20.69	25.35	23.08	28.95	33.33	19.70	22.22	38.03	24.19	41.54	36.21	29.63
Average Number Amber Deferred %	58.62	59.15	57.69	56.58	48.48	56.06	48.89	43.66	64.52	43.08	58.62	55.56
Total Deferred (Amber+ Red)%	79.31	84.51	80.53	85.53	81.82	75.76	71.11	81.69	88.71	84.62	94.83	85.19

Table.12 Proportion of cases approved and deferred in 2024/25

All Wales Number of Cases Approved and Deferred on Initial Presentation to Learning Advisory Panel 2024-25

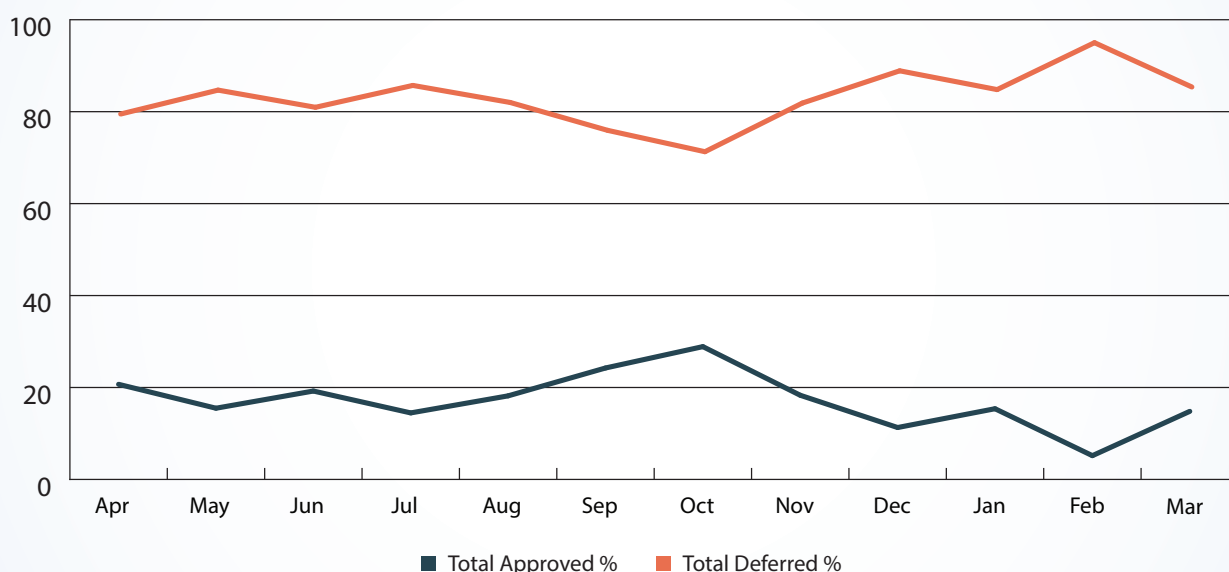


Fig.12 New Cases to Panel 2024/25 Approved and Deferred

Penalties for Quality & Timeliness of Learning

During 2024–25, the Welsh Risk Pool Committee (WRPC) applied penalties to NHS organisations in Wales where there were significant delays either in the submission of Learning from Events Reports (LFERs) or in the timely approval of deferred cases. These measures were taken to reinforce compliance with expected timeframes and to promote timely learning and resolution of learning queries. The penalty is a financial charge taken from the amount of money reimbursed to a health body.

A total of 139 penalties were triggered during the reporting period, of which 6 were subsequently waived following review and acceptance of valid justifications provided by the organisations concerned.

Fig.13 outlines the number of penalties applied each month, categorised by delays relating to LFER submissions and delays in the approval of deferred cases. This highlights that the reasons for the application of penalties has shifted from late submission of information to delays in resolving deferred learning queries.

Whilst the individual value of each penalty is relatively small, staff from a number of corporate teams have reported the positive impact in driving the attainment of learning information when the penalty is internally charged to a budget holder in speciality or service. This internal cross-charging is now expected by the WRP Committee.

It is hoped that with the various strands of improvement work underway, the number of penalties applied will fall.

All Wales Penalties applied in 2024/25

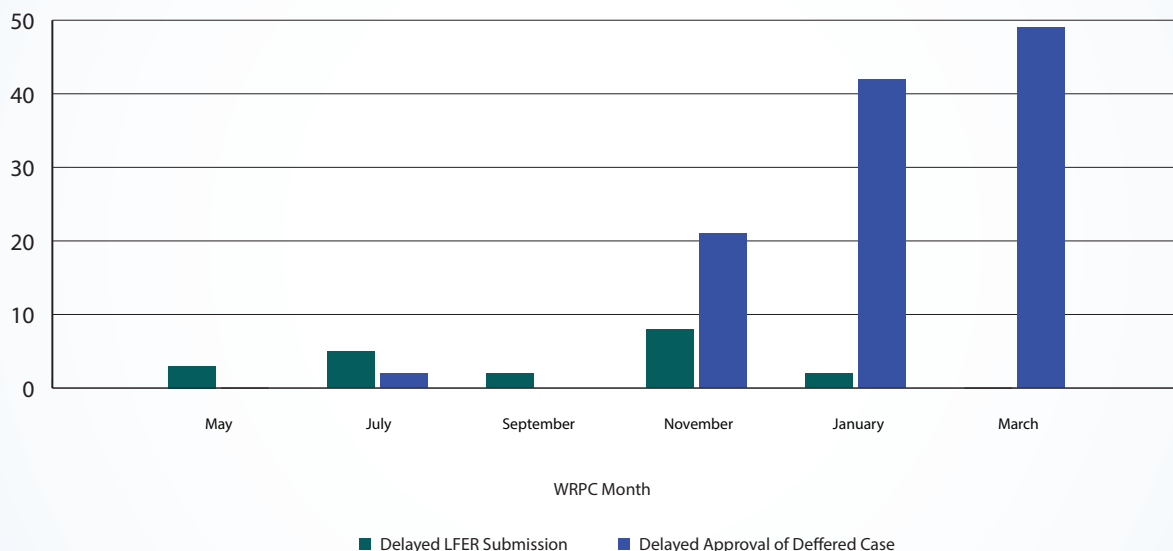


Fig.13 Penalties applied by the WRP Committee

Maternity & Neonatal Safety & Learning Programmes



The data from analysis of current and previous claims caseloads highlights that matters related to maternity & neonatal services represent a disproportionate element of the litigation profile. National and local reviews, and the learning reports produced regarding claims, highlight that positive human factors, situational awareness, culture, team working, systems and processes are all significant contributors to a positive outcome.

The Welsh Risk Pool has rightly placed a lens and emphasis onto solutions to these factors in maternity & neonatal services – aiming to reduce the litigation profile, reduce avoidable harm to women and babies and improve clinical outcomes within this sector. We therefore oversee and quality assure a suite of targeted safety & learning programmes. PROMPT Wales is adapted from the successful PROMPT programme first introduced in North Bristol. IFS Wales has developed and implemented a dedicated training programme for all staff involved in the assessment of women during the intrapartum phase of birth. MoNET Wales is a new and exciting programme, delivering the benefits of the PROMPT-style training to the neonatal sector and was developed in response to recommendations in the MatNeo Safety Support Programme.



Intrapartum Fetal Surveillance - IFS Wales



Our vision:

A standardised, all Wales training programme in intrapartum fetal surveillance, aiming to improve outcomes for babies and families.

Launched in 2023, the IFS Wales programme was developed to reduce harm associated with fetal surveillance and to address both the financial and human cost of related clinical negligence claims in NHS Wales. A scoping review undertaken in 2023 revealed wide variation in training across Health Boards, prompting the Welsh Risk Pool to commission a standardised, evidence-based training programme.

Developed by a multiprofessional national team, IFS Wales aligns with the revised All Wales Intrapartum Fetal Surveillance Standards (2023) and supports Health Boards in meeting the training requirements set out within them. Informed by the Each Baby Counts report and the Ockenden recommendations, the programme places a strong emphasis on teamworking, communication, and the impact of human factors on clinical decision making and escalation in intrapartum care.

Based on the principle that “teams that work together should train together,” the programme is delivered face to face by local facilitators to multiprofessional teams, using an interactive teaching style that incorporates group discussion, collaborative decision making, and case-based learning.

The pilot phase of IFS Wales was delivered across all obstetric-led units between October 2023 and December 2024 and underwent structured evaluation to inform future development. A key aim was to determine the scalability of the programme and its consistency across Health Boards. Evaluation focused on the first two levels of Kirkpatrick’s model: participants’ immediate reactions to the training (Level 1) and self-reported learning outcomes (Level 2). These were captured through pre- and post-training surveys. The evaluation also incorporated observations by the national team and feedback on facilitator experience, which was collected through surveys and informal discussion.



Findings demonstrated clear, positive outcomes across NHS Wales. More than 1,400 participants attended 59 training sessions, and self-assessed knowledge showed significant improvement across six core areas. Prior to training, only 23.4% of participants rated their knowledge as “very good” or “exceptional,” increasing to 72.7% following the session. Those rating their knowledge as “good” or “fair” fell from 72.8% to 27.2%, and “poor” responses decreased from 3.8% to just 0.08%. These figures emphasise the programme’s strong impact on improving participant confidence and understanding, demonstrating a clear shift from moderate or low levels of self-assessed knowledge to a more assured and competent grasp of core topics. Participant satisfaction was high, with an average rating of 8.82 out of 10.

Free-text feedback consistently praised the programme's structure, relevance, and multiprofessional approach, with many describing it as engaging, informative, and practical. Observations by the national team confirmed that Health Boards maintained multiprofessional faculty and delegate participation, demonstrating strong alignment with the programme's core principles and ensuring consistent, high-quality delivery.

Following the success of the pilot, IFS Wales has entered its next phase with the launch of a second edition in January 2025. This updated version includes revised session timings and minor structural adjustments to improve delivery. Enhanced facilitator guidance has also been developed to support consistent, high-quality implementation. All changes have been directly informed by feedback gathered during the pilot phase. Evaluation tools have also been refined to assess the next level of Kirkpatrick's model, with a focus on behavioural change in clinical practice. To support continued engagement and shared learning, a new IFS Wales Representative Group has been established.

IFS Wales is now transitioning into a fully embedded national programme and remains a key component of Wales' maternity safety improvement strategy, supporting safer outcomes through consistent, high quality, team based fetal surveillance training.





Our vision:

To reduce avoidable harm and improve perinatal outcomes, through multi professional training to enhance safety, teamwork and communication

PROMPT Wales (Practical Obstetric Multi-Professional Training) is a large-scale maternity safety programme funded by the Welsh Risk Pool and supported by the PROMPT Maternity Foundation. PROMPT is an evidence based, multi-professional training programme which incorporates practical simulation sessions and human factors training and is attended by all members of the maternity team in Wales annually. The PROMPT Wales programme was developed to reduce variation and improve the quality of multi-professional obstetric emergency training across Wales, with the overall aim of improving safety and outcomes in maternity care.

PROMPT Wales was implemented in NHS Wales maternity services in 2019 and is now 'business as usual.' This outstanding achievement is a result of the collaboration between organisations, local faculty teams and the PROMPT Wales National Team. With coordination and oversight from the national team, local training teams who have undergone 'faculty development training' organise and run training in their obstetric units throughout the year.

With a focus on teamworking and the impact of human factors, PROMPT Wales is 'more than just training.' We are striving for improvements in organisational culture, and to enhance multi-professional and intra-professional relationships. We have observed changes in interactions between different staff groups and levels of seniority, which perhaps suggests a flattening of hierarchical behaviour and improved working relationships. It is widely recognised that improvements in clinical care, multi-professional team-working and human factors contribute to safer outcomes in maternity care.

Teams who work together train together, and training is situated in the clinical area to maximise fidelity to practice, to test the systems and processes, and contribute to organisational improvement. Scenario based simulation sessions provide the opportunity for multi-professional teams to practise working together to clinically manage a simulated obstetric emergency, whilst recognising the impact of human factors on safe outcomes. Through PROMPT Wales training, we have been able to promote the use of SBAR (Situation, Background, Assessment, Recommendation) handover – a structured handover process to maximise impact. Staff have a greater understanding of the importance of situational awareness and allocate a lead in an emergency situation who can stand back, take a 'helicopter view' and coordinate the team. The use of algorithms to guide clinical management is now embedded in practice.



Through PROMPT Wales, we can support the embedding of other maternity safety initiatives in NHS Wales such as OBS Cymru – ‘the Obstetric Bleeding Strategy in Wales.’ This has seen the embedding of measured blood loss and use of the OBS Cymru PPH Management Checklist. In the last academic year, training has had a greater focus on escalation and PROMPT Wales training is supporting the embedding of the new all-Wales Maternity Early Warning Score (MEWS).

PROMPT Wales is quality assured by the national team to support its long-term sustainability and to encourage a culture of accountability, learning, and continuous improvement. The PROMPT Wales Standards, supported by a Welsh Health Circular, are used as a metric to drive improvement and our approach to quality assurance involves the systematic collection of health board data to assess whether services are maintaining the Standards. The Standards set out that a minimum of 95% of midwives, obstetricians and anaesthetists who regularly provide maternity care should undertake PROMPT Wales training annually. Data is provided by Health Boards in September each year and latest data (2023-24 academic year) identified that 93% of staff across NHS Wales who were identified as requiring PROMPT Wales training participated.

The drive for continuous improvement in maternity and neonatal services is critical to the Welsh Risk Pool Committee – as the avoidable harm in these services and the proportion of the litigation profile attributed to this sector needs to be addressed. As part of its incentivisation scheme supported by Welsh Government, the Welsh Risk Pool Committee includes metrics from PROMPT Wales standards as part of the risk sharing agreement – meaning that Health Boards with greater compliance to the standards will contribute less to the risk pooling fund when compared to other organisations.



Our quality assurance framework also includes structured observation of training which includes feedback mechanisms by means of guided practical support and written reports which recognise excellent practice whilst identifying areas where further development would enhance the learning experience. Our framework considers implementation fidelity, quality of delivery, and the application of learning in clinical practice. We are pleased to note the commitment and high standards of training delivered by local faculty teams throughout NHS Wales. To measure the impact on participants experience of PROMPT Wales training, the Welsh Risk Pool Civica team are currently developing a survey to measure participant satisfaction, knowledge and confidence and application of learning in practice. This will run during the 2025-26 programme year.

The PROMPT Wales National Team are committed to supporting Health Boards to maintain an optimal multi-professional local faculty team to enable an adequate multi-professional faculty on all PROMPT Wales training days. The team organise a national Faculty Development event every September, training an additional 40 colleagues annually. The national database of active, local facilitators currently stands at 331. This approach aims to embed a standardised approach to delivery, with an understanding of the PROMPT methodology.

Through our collaborative approach we are beginning to see our aspiration of safer outcomes for women and babies unfold. Since the implementation of PROMPT Wales there has been a statistically significant reduction in APGAR scores less than 7 at 5 minutes in term and preterm babies, and a reduction in rates of postpartum haemorrhage. We acknowledge the OBS Cymru approach to the management of postpartum haemorrhage and are pleased to have further embedded and sustained the OBS Cymru principles through PROMPT Wales training. It is hoped that in time, improvements in care will also see a reduction in maternity litigation in NHS Wales, freeing up much needed expenditure for service delivery.



Community PROMPT Wales' is an 'All Wales' maternity safety programme developed by the PROMPT Wales National Team, who recognised a need for bespoke training for community teams which addressed the principle of 'teams who work together, should train together.' The team have since collaborated with the PROMPT Maternity Foundation (PMF) and a new 'Community PROMPT' Training package has been developed, making this available for teams in the UK and internationally.

The programme is designed to improve safety and clinical outcomes for women and babies, while also contributing to a reduction in litigation costs associated with preventable harm. It achieves this through scenario-based emergency simulation sessions and workshops with a strong focus on human factors, communication, and teamwork.

Since its launch in September 2021, Community PROMPT Wales has been mandated by the Welsh Government for annual attendance by all Community Midwives. The programme has expanded to include multi-professional participation, welcoming Paramedics, Technicians, and Maternity and Health Care Support Workers into its training courses across Wales.



A central value of Community PROMPT Wales is its ongoing commitment to Equality, Diversity, and Inclusivity (EDI). Programme materials, including imagery and language, have been reviewed and updated to reflect diversity. Language used in the training aligns with guidance from the Royal College of Midwives (RCM) Re:Birth initiative, supporting respectful, inclusive, and person-centred care.

In the academic year 2023–2024, the programme achieved a 95% participation rate among Community Midwives, with 70 Community PROMPT Wales courses delivered throughout the year. The training continues to be well received, with consistently positive feedback highlighting the relevance, inclusivity, and effectiveness of the sessions:

"Brilliant course, with scenarios including paramedics thank you!"

"Great informative course with good balance of immersive hands-on experience."

"I really enjoyed today it was my first community prompt, and I feel much more prepared for home births/ BBAs etc. The facilitators are so knowledgeable and skilled, and you learn a lot from them."

The quality assurance process is replicated for Community PROMPT Wales and the national team completed another successful round of quality assurance reviews across all Health Boards in Wales. Each Health Board visit demonstrated fidelity to the intended model, improvements in programme delivery and strong alignment with PROMPT Wales principles, highlighting the dedication of Community PROMPT Wales faculty and the value of the quality assurance process. Enhancements have also been made to the Human Factors in the Community presentation, these include integration of the All-Wales Guideline for Maternity Transfers from Community and Freestanding Midwifery Units, as well as the introduction of '999 Scripts' to support clearer and more effective communication with emergency services.

In addition, the Welsh Ambulance Services NHS Trust (WAST) has developed a Red Phone Standard Operating Procedure (SOP) to improve internal processes when an obstetric or neonatal incident is declared in a pre-hospital setting. The PROMPT Wales National Team is working closely with WAST to incorporate this SOP into training simulation scenarios. This collaboration aims to promote use of the Red Phone and clarify the pre-alert process to the receiving obstetric unit during emergency transfers. This is another example of supporting the embedding of an important all-Wales initiative through our training programmes.



Community PROMPT Wales had the privilege of supporting the Emergency Medical Retrieval and Transfer Service (EMRTS) with dedicated training sessions in Dafen (West Wales) and Caernarfon (North Wales). This collaboration reflects the programme's growing national influence and ability to unify maternity and emergency services through shared goals, education, and evidence-based practice.



As part of this partnership, bespoke EMRTS obstetric emergency algorithms were developed by a network of multi-professional clinicians led by the Welsh Risk Pool Safety and Learning Advisors and the PROMPT Wales National Team. These algorithms were introduced during the training day and reinforced through high-fidelity simulation, ensuring continued alignment with Community PROMPT Wales principles. Emphasis remained on multi-professional teamwork, effective communication, and the role of human factors in emergency care.

Feedback from EMRTS participants was overwhelmingly positive, highlighting the relevance, quality, and applicability of the training. This is a testament to the dedication and expertise of the Community PROMPT Wales Faculty and their ability to facilitate meaningful, system-wide improvements in maternal and neonatal care:

"Good communication, great teamwork, positive feedback and conversations and learning points around the sims."

"Really engaging and knowledgeable faculty."

"A very well-run course with an exceptionally talented and knowledgeable faculty. Would recommend every EMRTS clinician to attend."

The PROMPT Wales National Team is proud to support universities across Wales by delivering high-fidelity Community PROMPT Wales training to student midwives and paramedics. These sessions foster early multi-professional collaboration, introducing essential safety behaviours and clinical skills before qualification. This proactive approach helps reduce preventable harm and supports a safer transition into practice for future healthcare professionals.



Community PROMPT Wales continues to play a pivotal role in improving maternity safety across Wales through inclusive, high-quality, and multi-professional training. The programme's national network and partnerships, with services such as WAST, EMRTS, and academic institutions, demonstrate its positive impact on emergency maternity care and education. With a focus on continuous improvement, equity, and teamwork, Community PROMPT Wales is shaping a resilient, person-centred maternity and neonatal care system for the future.



MoNET Wales - Multi-Professional Neonatal Emergency Training



Our vision:

A standardised, all Wales training programme for neonatal services, aiming to enhance teamworking across the perinatal sector and improve outcomes for babies and families.

The MoNET Wales programme was rolled out in January 2025 following a period of programme development and collaborations with neonatal stakeholders in 2024. The MoNET Wales programme has been designed by a diverse group of NHS Wales clinicians and coordinated by the Welsh Risk Pool following the publication of the Maternity and Neonatal Safety Support Programme Discovery Report 'Improving Together for Wales'.

The programme aims to address the findings from the 'MatNeo' report, promoting perinatal teamworking and ensuring an understanding of the impact of human factors is threaded throughout the teaching.



The programme was co-designed by a multiprofessional team of nurses and consultants, with expert input and guidance from the Welsh Risk Pool team.

Based on the principle that 'teams that work together, should train together,' the programme is designed to be delivered and attended by the whole multiprofessional team in local units. This significantly differs from other skills training programmes, and the approach has been co-designed by a multi-professional expert group.

The teaching strategy involves interactive presentations and scenario-based learning. Themes from the presentation topics are incorporated into the simulation-based scenarios within the clinical environment, enabling the testing of systems and processes in local units. MoNET Wales promotes an inclusive approach, involving all members of the neonatal team.

The pilot phase commenced in January 2025, with training days now underway across Wales. As part of the implementation strategy, members of the national team attend local training days to provide support and guidance to local faculty teams, to share best practice and ensure fidelity to the MoNET Wales programme. This hands-on approach aims to build faculty confidence and capability, supporting standardised, sustainable delivery across Wales.

MoNET Wales represents a strategic step towards building sustainable, high-quality education across neonatal services in Wales and is supported by the Chief Midwifery Officer and Chief Nursing Officer for Wales.

As of 31st March, 85 MoNET Wales facilitators have been trained and accredited, with 28 MoNET Wales programme days delivered across the country since the launch in January 2025 with over 200 NHS Wales neonatal services staff participating.

Of the nine neonatal units in NHS Wales, MoNET Wales has been successfully delivered in eight units. The unit at UHW in Cardiff has yet to carry out training and a supporting plan has been requested from the Health Board.

A comprehensive evaluation is planned at the conclusion of the pilot phase in Q4 of 2025/26. Participant feedback is being collected to analyse the impact and areas for enhancing the programme. An average satisfaction rating of 9.2 out of 10 across all participating units has been achieved so far. Pre and post course topic knowledge and skills, and confidence, is self evaluated by participants and this demonstrates improvements in each scenario with an enhanced understanding of human factors. The feedback highlights strong initial engagement and perceived value from those attending the training days.

The Welsh Risk Pool leadership team are working with Welsh Government to place the MoNET Wales programme on a similar position to the PROMPT Wales programme with an expectation that all doctors providing neonatal care, and neonatal nurses, participate in MoNET Wales training annually. This may include a Welsh Health Circular or inclusion of the programme in the Quality Statement for Perinatal services.



Decision Making and Consent



The importance of supporting NHS Wales Health Bodies in the area of Decision Making and Consent is driven by the significant number of claims which feature the process of consent in healthcare. During 2024/25, the Welsh Risk Pool reimbursed health bodies in NHS Wales £4,028,701.68 in relation to cases where consent was a direct contributory factor, with over £20m seen in cases where issues regarding consent were a causal factor.



The national programme for Decision Making and Consent, coordinated and funded by the Welsh Risk Pool, supports organisations to comply with regulatory and best practice guidance, with the aim of improving patient safety and reducing the associated litigation profile.

The All-Wales Decision-making and Consent Group continues to provide an effective network through which guidance can be developed and rolled out. In 2024 'Decision-making' was added to the title of the group. Explicit reference to decision-making recognises the importance of shared decision-making undertaken during every consultation with the patient, broadening focus beyond formal consent processes summarised in consent forms.

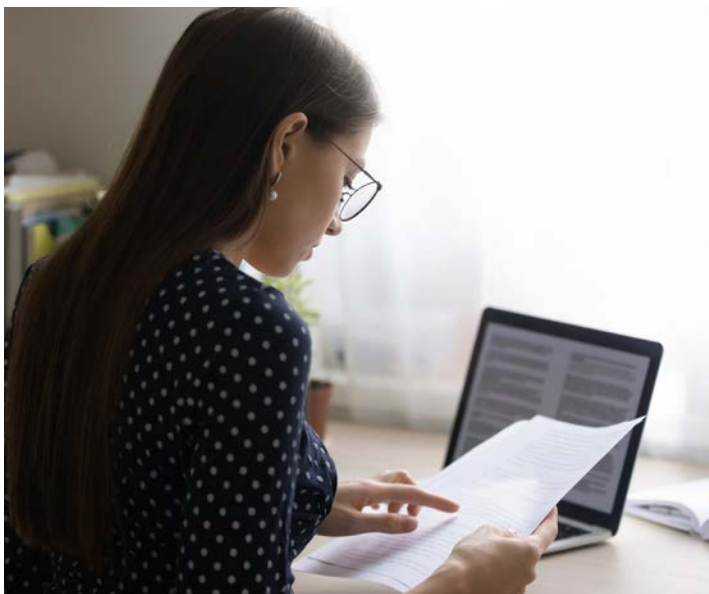


Decision Making & Consent Work Programme

Over the last 5 years the WRP team have developed and rolled out a comprehensive governance framework for NHS Wales. Agreed quality standards have informed the development of related assessments and review of consent practices in Health Boards and Trusts across NHS Wales. The last review and related improvement plans were published in 2023 with a further cycle of assessments planned in 2025. Our All Wales consent peer review assessment tool (2022) and bespoke e-learning package (2023) allow organisations to provide assurance around consent processes and evidence organisational learning where required.

EOL decision-making

Following the Covid 19 pandemic and the publication of a series of regulatory reports reviewing DNACPR decision making, along with advent of the Medical Examiners Service, there has been an increasing focus on end of life decision-making. Recognising the challenges of transforming the legal framework into clinical practice, the WRP National Team developed a short training video in 2024. This video provides a focus for relevant postgraduate training sessions and thematic slots in Mortality and Morbidity meetings. Availability on ESR and Learn@ Wales platforms means that it can also be used to support personal CPD.



Procedure specific patient information leaflets

The Decision Making and Consent Programme continues oversee promote the use of procedure specific patient information leaflets provided within the national download library procured from EIDO Healthcare, ensuring that high quality information is routinely shared with patients across NHS Wales during the consent process. The library covers more than 400 procedures. Leaflets are internationally authored and fully indemnified by EIDO. Documents are available in Welsh, English and multiple other languages, as well as accessible formats such as large print and EasyRead.

Download activity is monitored to drive targeted improvement. The volume of downloads and transmissions of consent information documents has increased significantly over the last five years. Comparison of the 2019 and 2024 usage statistics highlights increased engagement, with some variation amongst different clinical specialties and between health bodies. In 2019, 37,540 leaflets were downloaded across NHS Wales compared with 89,073 in 2024. Engagement is particularly demonstrated in anaesthetics, where 37,500 anaesthetic-related leaflets were downloaded in 2024, compared with only 2064 in 2019.

Recent developments include the transition to an updated platform which now enables the uploading of locally produced and approved consent leaflets. In addition, targeted collaboration between national clinical networks and EIDO Healthcare has also facilitated the review of existing leaflets and the development of 17 new leaflets. Collaboration with the National Endoscopy programme and EIDO Healthcare has facilitated the active review of existing leaflets along with the development of new leaflets on an All-Wales basis where required. Regionalisation of services has been another driver for development of procedure specific leaflets on a national basis.

WRP Risk Management Alert - Consent

In 2020, the WRP Committee issued a Risk Management Alert, further clarified in 2021, stipulating that only procedure specific leaflets produced by EIDO or a recognised professional body should be used where available so that high quality information is consistently shared with patients across NHS Wales during the consent process. The use of locally approved leaflets could only be justified where a relevant leaflet produced by EIDO or a recognised professional body was not available.

Following the alert organisations are required to maintain a library of all approved procedure specific leaflets, which has increased oversight and informed the targeted development of leaflets on an All-Wales basis. The alert will be reissued in 2025.

Learning and Development

Our bespoke e-learning package, launched in 2023 by the Cabinet Secretary for Health and Social Services, underlines the importance of consent and its relevance to all patient facing clinicians. It is now mandated for all patient facing clinicians in 6 Health Boards with a target compliance of >85%. Completion of approved training is also now one of the drivers in the WRP risk sharing agreement. The e-learning package has been well received with excellent feedback from all professional groups, with one anaesthetic colleague stating, "as engaging as mandatory training gets."

The e-learning is supplemented by webinars on topics such as 'Informed Consent - Getting it Right' and 'Decision Making and Consent - No decision about me without me.' More recently an innovative learning package in End of Life Decision Making has been developed. Both modules are available on ESR and Learn@Wales.

Peer Review

The national consent peer review assessment tool, updated in 2024, focuses on the whole consent process, rather than the snapshot provided by consent form audits. It references agreed standards and facilitates action planning following discussion and in relevant specialty based clinical governance settings. Feedback continues to highlight the educational value of the exercise. Failure to consistently provide procedure specific patient information leaflets has also been a consistent theme nationally. The national group continue to refine the peer review tool in light of ongoing experience and real-world feedback.

National Clinical Review of consent standards in NHS Wales Health Bodies

The Welsh Risk Pool Committee has commissioned a further national clinical review of consent standards in NHS Wales Health Bodies during 2025. This will consist of self-assessment and collation of evidence by each Health Body. Organisation specific Microsoft SharePoint folders have been set up and nominated leads have been provided access for submission of evidence by 31st July 2025. Analysis will be undertaken by the WRP Safety & Learning Team.



Digital Consent Platforms

Procurement of a platform for NHS Wales would be a natural progression where challenges around integration with other patient information systems and workflow can be addressed in collaboration with DHCW. Digital consent platforms offer clear advantages in terms compliance with governance frameworks and recording of the consent process and dialogue with the patient in particular.

During 2024/2025, the WRP team re-examined digital market suppliers and believe that the previously identified challenges in relation to Digital Consent Platforms can now be addressed with a reasonable prospect of achieving an award to a supplier.

Plans are underway to undertake pilots with key suppliers in 2025/26. We have established a working group with colleagues from DHCW and NHS Performance and Improvement to monitor progress of the pilots and develop a technical specification and related business case for a digital consent platform for NHS Wales.

Programme priorities for 2025-27:

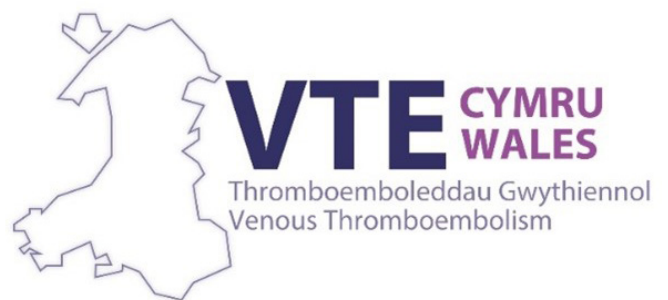
- Lead the procurement of digital consent platform for NHS Wales in collaboration with DHCW and NHS Performance & Improvement, following the 2025-26 pilot.
- Actively monitor leaflet downloads, encourage electronic transmission and implement a system to include locally produced consent leaflets.
- Continue to actively engage with Health Boards and clinical service groups to increase use of the EIDO download library – re-issue WRP alert highlighting required standards for procedure specific information
- Promote use of All-Wales leaflets produced in collaboration between the National Endoscopy programme and EIDO – use as exemplar of best practice
- Undertake a National Clinical Review of consent standards in NHS Wales
- Continue to monitor uptake of training in decision making and consent for all patient facing clinicians (Target compliance > 85%)
- Develop e-learning package on Mental Capacity Act (2005) and decisions about serious medical treatment.





Our vision:

To develop an all-Wales approach to the prevention and reduction of harm associated with venous thromboembolism, aiming to improve patient experience and outcomes.



Venous thromboembolism (VTE) is the leading cause of preventable death in hospitals with 55-60% cases occurring during or following hospitalisation (Thrombosis UK, 2024). Many such deaths are preventable if patients receive a VTE risk assessment on admission to hospital and are offered appropriate thromboprophylaxis. Latest available data from the Office of National Statistics shows 2,713 deaths related to VTE in England and Wales in 2022. VTE has remained the leading direct cause of maternal death for many years, however this is now the overall leading cause of maternal death. (MBRRACE, 2024). A VTE diagnosis can also have a significant long-term impact on the health of an individual both physically and psychologically, in many cases resulting in lifelong dependency on anticoagulant medication.

In NHS Wales in 2024, 9 claims directly related to VTE including hospital acquired thrombosis (HAT) were submitted for reimbursement. The total cohort of cases where issues relating to VTE were identified exceeds £7m. Causal factors identified include a lack of clinical examination and a failure to undertake diagnostic investigations, as well as delayed or missed diagnosis of symptoms. Failure to escalate and issues regarding medicines management, along with a lack of VTE risk assessment, documentation and communication also featured. This highlights the importance of a thorough risk assessment, as soon as possible after admission to hospital or by the time of the first consultant review, as required in the NICE guidelines.

Cases presented to the Welsh Risk Pool Committee include matters where there is a failure to recognise the symptoms of a PE or DVT and where there is a failure to complete a thorough risk assessment of a patient on admission. In 2021, having observed an increase in the numbers of redress and clinical negligence cases relating to VTE, the Welsh Risk Pool Committee requested that a review of compliance with the All-Wales VTE Policy was undertaken by the WRP Safety and Learning team. The review identified variation in practice across NHS Wales and issued five recommendations to all Health Bodies to reduce avoidable harm associated with VTE.

The VTE Recommendations:

1. All health bodies within NHS Wales adopt the All-Wales Thromboprophylaxis Policy.
2. All clinical staff undertake All-Wales training, both in relation to the recognition of patients presenting with symptoms of VTE and in the prevention of Hospital Acquired Thrombosis (HAT).
3. All patients receive a documented VTE risk assessment, using a Department of Health Risk Assessment Tool (or similar) on admission, as part of the initial patient clerking.
4. An All-Wales check list for the investigation of a HAT is developed in order to maintain a uniform investigative approach across NHS Wales.
5. VTE risk assessment compliance data and HAT data is shared at appropriate health body governance meetings.

Having also identified a lack of a standardised approach to staff training in VTE prevention, diagnosis and management, the WRP led on the development of 2 e-Learning modules, and these have been available on ESR since 2022. The scheduled review of the ESR VTE e-learning modules by the WRP commenced in March 2025. The two modules will be condensed into one module with updated content covering VTE prevention, diagnosis, management and aftercare. The updated module will bring benefits for clinical staff in practice such as convenience of one module instead of two, concise VTE information for both registered and unregistered clinicians, recognition of theory in practice and promotion of resources for staff and patients.

A VTE Wales Strategy has been produced setting out aims and objectives of the programme. It includes a set of Standards to guide Health Bodies to meet the expectations of the programme, and these will be reviewed by the WRP annually.

A Safety and Learning Advisor with an extensive background in thrombosis was employed, to lead the VTE Wales programme. A scoping review of practice relating to VTE in all organisations was carried out between January and March 2025 and reviewed the following:

- » What VTE risk assessment tools are used
- » What VTE Patient information leaflets are used
- » What system is used to identify potential HATs
- » Process for Root Cause Analysis relating to potential Hospital Acquired Thrombosis (HAT)
- » Reporting process for HAT data locally
- » Whether thromboprophylaxis features on the theatre safety check list
- » Arrangements for Local education and promotion
- » Compliance with the VTE e-Learning modules
- » Any best practice and quality improvement projects

The findings from the scoping review will inform the programme of work scheduled for 2025-26, aiming to address any variation identified and work towards an all-Wales approach, whilst remaining cognisant of the bespoke requirements of the different specialities.

Work on developing a national reporting system for Hospital Acquired Thrombosis (HAT) data is expected to commence in the coming months. This has been identified as one of the priorities. In April 2021, the delivery framework for 2021-2022 removed quarterly reporting of HAT data to Welsh Government and was no longer a Tier 1 priority. Since national HAT reporting ceased, there has been variation in practice regarding governance, completion of investigation into possible HAT cases and HAT reporting. Therefore, by reinstating national HAT reporting it will create a standardised approach to reporting.

This approach will also enable analysis of the data such as identifying themes, high risk characteristics and importantly, reviewing the data regularly will identify opportunities for lessons learned that can be shared across all Health Bodies. Having national reporting of HATs can also serve as a matrix to assess the impact of the VTE Wales programme on clinical outcomes as well as contributing to the direction of the VTE Wales programme.

The WRP recognises that there is some excellent practice existing in NHS Wales in relation to the prevention, recognition and management of VTE. Direct oversight of the VTE Wales programme will be via a WRP VTE Board - reporting to the Welsh Risk Pool Committee. The WRP VTE Board will have wide representation, including leading clinicians from different specialties and other key stakeholders – aiming to drive improvement in the area. The draft Terms of Reference (TOR) for the WRP VTE Board have been written and applications for expressions of interest for the VTE Board membership commenced in March 2025.

Timeline for VTE Wales

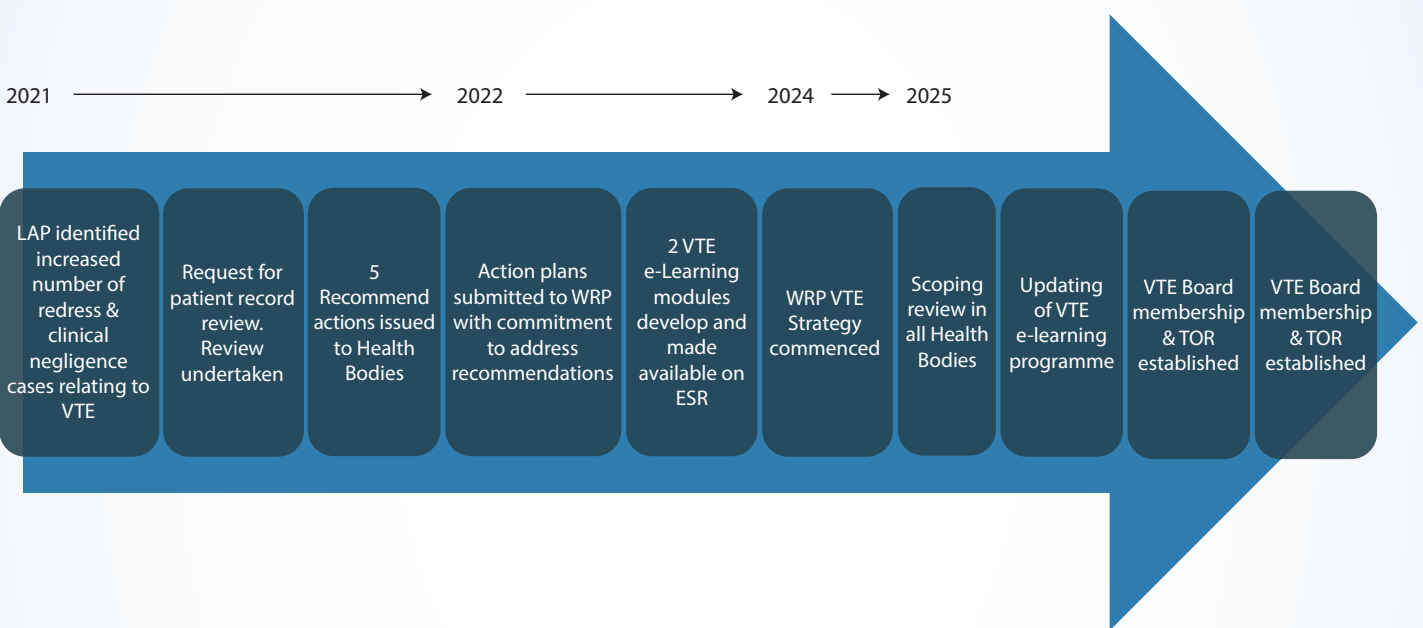


Fig.14: Timescales and Plans for VTE Wales

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Anti-Violence Collaborative Wales



Violence and Aggression (V&A) directed towards NHS Wales staff and those who utilise NHS services in Wales is unacceptable and it is recognised that NHS staff are among some of the professions most likely to face aggression while carrying out their duties.



Where violent and aggressive behaviour is displayed, it is imperative that NHS Wales organisations seek the appropriate response to ensure the wellbeing of all concerned. Staff attending the workplace and those who visit the NHS Wales footprint, whether as a patient or for another reason, should do so confident of their safety.

The Anti-Violence Collaborative Wales (AVC) is a collaboration of all NHS Wales organisations, the Police in Wales, the Crown Prosecution Service in Wales and trade union and staff support organisations. Its aim is to support NHS Wales and emergency services organisations to reduce and manage V&A incidents. Facilitating collaboration with Criminal Justice Service partners, NHS Wales bodies, emergency services organisations and Welsh Government, the AVC promotes violence reduction strategies and communication with service users.

In June 2023 Jonathan Webb was appointed as the Chair the AVC. An interim National Advisory Team was created with the aim of managing and driving forward the vision of the collaborative. The Team was created by seconding a NHS Violence and Aggression case manager from a health board, a staff support officer from the Royal College of Nursing and a tactical advisor to the Chair who is an experienced V&A leader from the Welsh Ambulance Services University NHS Trust.

Originally formed in 2017, the AVC has coordinated an Obligatory Responses to Violence in Healthcare framework (ORV), which sets out the aims and process by which all of the AVC partners will collaborate. The work of the AVC in the NHS is underpinned by a Welsh Health Circular, which aims to ensure that the organisations which form NHS Wales fully embed the guidance given within the ORV document. All parties are committed to encouraging the most appropriate response to V&A cases to ensure the safety of NHS staff and others.

As of Spring 2025, great progress has been made in all of the projects and collaborative endeavours of the AVC. The offence of causing nuisance or disturbance on NHS premises, as outlined in sections 119 and 120 of the Criminal Justice and Immigration Act 2008, has been given the go ahead by Welsh Government to become active in Wales. This offence is unique in that it empowers NHS staff to proactively tackle those whose behaviour is unacceptable and causes disruption to precious clinical time and services.

For NHS Wales staff and ultimately the Welsh public to benefit from this new power, Senior Safety & learning Advisor Gareth Lewis, supported by senior BCUHB colleague Mike McGee, are developing a suite of training for NHS Wales staff. Adopting a 'train the trainer' methodology, Gareth and Mike are creating a training package which will have a multi-media structure at its core. The vision is for this training to be appropriate and effective for all types of learning styles.

Once training is rolled out across the country, the AVC will provide continuing support to NHS Wales bodies regarding 'Section 119', including quality assurance and consultancy where appropriate.

To ensure a consistent approach by NHS Wales bodies in reducing incidents of violence against staff, The AVC has drafted the first Welsh 'Violence Prevention & Reduction' Standards. It is intended that these standards are trialled by two Welsh health boards through 2025-26. These standards will allow health boards to evaluate their responses to violence and aggression which occur within their footprint, ensuring the most appropriate structures to support victims of violence are in place, and that there are dedicated staff working to actively and proactively reduce the risk of further incidents.

Accuracy in the collection of data relating to violence and aggression incidents is paramount to understand what resources and responses are the most appropriate to be deployed in order to counter such incidents.

The AVC in co-operation with colleagues overseeing Datix Cymru systems and at Cardiff and Vale University Health Board, have developed a practical and straight forward approach to analyse violence incidents reports. Cardiff's data for the financial years 2023 to 2025 was reviewed and highlighted some key factors in incident reporting, particularly with regards to incidents with aggravating 'hate' factors.

The AVC will work with all health boards in Wales through 2025 to ensure all violence and aggression incident reports are reviewed and the accuracy achieved is used as the benchmark for future reporting.

An exciting new development for the AVC in the use of violence data is in its infancy, Professor Simon Moore and his team at Cardiff University's Violence Research Group have expressed an interest in working with the AVC to analyse violence data collected by NHS Wales, with the aim of unravelling possible triggers and causes for offenders' violent behaviour.

The AVC has reached out to the Fire and Rescue services in Wales, via contacts at the Joint Emergency Services Group, and has successfully introduced a colleague from North Wales Fire & Rescue Service to the AVC team to act as a point of contact for Welsh fire and rescue services.

Unfortunately, some case of violence and aggression become extremely complex and troublesome for NHS Wales staff. These types of cases are difficult for a number of reasons, the physical and mental drain on staff, the diversion of valuable resources and the interference in service provision to name just a few.

To be able to effectively tackle these types of incidents, the AVC has been working closely with the Heads of Patient Experience (HoPE) group to create clear guidelines and advice. Allied to this, a Workshop for colleagues in Putting Things Right Teams and other relevant departments was organised by the AVC and held at the Angel Hotel Cardiff in March 2025. Key guest speakers, such as senior CPS prosecutors and senior police officers, attended and discussed aspects of offending and how best to address the problems that are presented.

With the developments in the response to violent behaviour across NHS Wales, in 2025, the AVC proposes a refresh to the existing Violence and Aggression Case Managers Group, this would be in line with the development of the aforementioned violence prevention and reduction standards and with current thinking around reduction of violence as opposed to a 'zero tolerance' mindset.

A particularly acute and topical area for the AVC to respond to is the sexual safety of staff. A vital component in safeguarding staff is the ability for colleagues to report any concerns in a secure and appropriate manner. In close liaison with colleagues within the Legal and Risk Team and at Welsh Government, the AVC is actively involved in the development of appropriate reporting mechanisms and guidance, which will encourage any staff affected by this sensitive topic to report, and where reports are made the most appropriate responses are actioned.



NHS Wales Chief Executive, Judith Paget, Chief Constable Pam Kelly QPM (Gwent Police), Chief Constable Amanda Blakeman KPM (North Wales Police), Chief Crown Prosecutor for Wales, Jenny Hopkins with Chair of Anti-Violence Collaborative Wales, Jonathan Webb

Once for Wales Concerns Management System



The Welsh Risk Pool hosts the Once for Wales Concerns Management System (OfWCMS) which aims to provide consistency in the capture and analysis of data relating to staff and patient safety and service user feedback.

Procured on an all-Wales basis, the system is actually a collection of individual digital systems which are operated locally and designed, developed and maintained by a central team.

The Welsh Risk Pool continues to work with all health bodies and national groups to ensure that the information governance arrangements and cyber security requirements relating to the Datix Cymru and Civica Experience Wales are firmly in place. The National Data Protection Impact Assessments have been reviewed, and a key piece of work is the definition of roles and responsibilities for data sharing at a national level. There is an effective governance process which oversees OfWCMS.

Programme Board. Commissioned by the Welsh Risk Pool Committee, the OfWCMS is overseen by Programme Board, Chaired by Chief Executive of Velindre University NHS Trust Steve Ham. This provides strategic oversight to the programme and ensures organisations are able to demonstrate readiness for implementation of new functionality.



System Rheoli Pryderon
Unwaith dros Gyru

Once for Wales Concerns
Management System

Programme Steering Group. Additionally, a Steering Group has been formed which oversees the operational elements of the system.

Content and Governance Group. A Content and Governance Group has also been established to monitor requested for system developments and changes in order to maintain the Once for Wales approach.

Workstreams. Each area of functionality is underpinned by a network of group which represents staff and practitioners related to the element of the system being served by the software. The number of workstreams required varies depending on the stage of implementation. Workstreams created to coordinate procurement, ICT integration and report form design have been stood down as the programme has been live since 2021. A number of the workstreams consist of the membership of the Safety and Learning Networks – which means that there is readily available access to expertise on topics when required. The power of collaboration across NHS Wales in developing the Datix Cymru and Civica Experience Wales systems through the OfWCMS workstreams is overwhelming successful. It has created a system for NHS Wales used by NHS Wales.

Datix Cymru. The Datix Cymru product is a cloud-based software tool with multiple modules that have been adapted, configured and implemented specifically for NHS Wales. In addition to replacing the legacy systems used throughout organisations for handling patient safety, health and safety and complaint records, the system has been configured to support specialist services such as the NHS Wales Medical Examiners service.

Datix Cymru Module	Records Opened
Incidents	189,027
Claims and inquests	3843
Redress	928
Feedback	52,163
Mortality	7,105
Medical Examiner	27,020
Total	280,086

Table.13: New Records opened in 2024/25

Datix Cymru Workstreams 2024/25

We have operated a number of dedicated workstreams with the aim of bringing consistency to the development and use of the Datix Cymru system used by all NHS Wales health bodies when handling concerns to investigate and improve quality and safety.

All organisations are represented at each of the workstreams and extensive collaboration, supported by a robust governance process, has led to significant development of the Datix Cymru system.

During 2024/25 two new workstreams have been set to support the development of new functionalities introduced to the Datix Cymru system:

Safeguarding workstream - has recently evolved from a working group to a workstream with its first workstream meeting being held in June 2025. Following a successful pilot, there are currently three organisations actively using the Safeguarding module.

Compliments workstream – was re-established to support NHS bodies to effectively implement the People’s Experience Framework. The workstream is working on aligning compliment themes and reporting across Datix Cymru and Civica Experience, ensuring an equitable, accessible platform is available in line with the Duty of Quality, ‘Always on Reporting’ requirements.

Core Functionality of Datix Cymru

Datix Cymru	
» Incidents	» Safeguarding
» Inquest Cases	» Redress Cases
» Safety Alerts	» Claims Management
» Risk Registers	» Medical Examiners
» Complaints	» Cyber Resilience Reports
» PALS Enquiries	» Mortality Reviews

Fig.15 outlines the core functionality of the software.

The power of the Datix Cymru system enables the creation and configuration of specific Investigation Workflows, which are made available across Wales – delivering consistency in not only data but processes used to determine learning and improvements. This incorporates the Yorkshire Framework of causal factors.

Datix Cymru provide large-scale interactive databases to report, capture, analyse and retain information relating to key parts of the Putting Things Right area. In 2024/2025, over new records were opened. Table.13 outlines the breakdown of the records opened.

Mortality Workstream – have reviewed and updated V15 of the natreviewing the flow of the report form to align with the Medical Examiner report form. Focus on capturing learning consistently across all functionalities is a key agenda item going forward. A key piece of work for 2024/25 and ongoing for the Mortality Network is compiling a list of Themes, Patterns and Trends that are relatable across other Datix Cymru functionalities, including Redress, Claims/Inquests.

Incident Workstream – as reported last year, a key piece of work in 2023/24 related to the development of Restrictive Practice to align with the National Framework. During 2024/25 this work has progressed with the support of NHS Wales Performance & Improvement, subject matter experts and local leads. In September 2025, a pilot of the redesigned Restrictive Practice form will be rolled out across inpatient Learning Disabilities areas.

The Incident workstream are also working towards a review, redesign and refresh of the Incident report form, to support modernisation of reporting and incident management in line with Quality and Improvement Strategies. A timeout session for the workstream, which will involve key stakeholders such as NHS Wales Performance & Improvement and RL Datix is being planned for late 2025.

Risk Workstream – the functionality is current being piloted by one organisation. The workstream, which is made up of representatives from all organisations which are monitoring and supporting the pilot process.

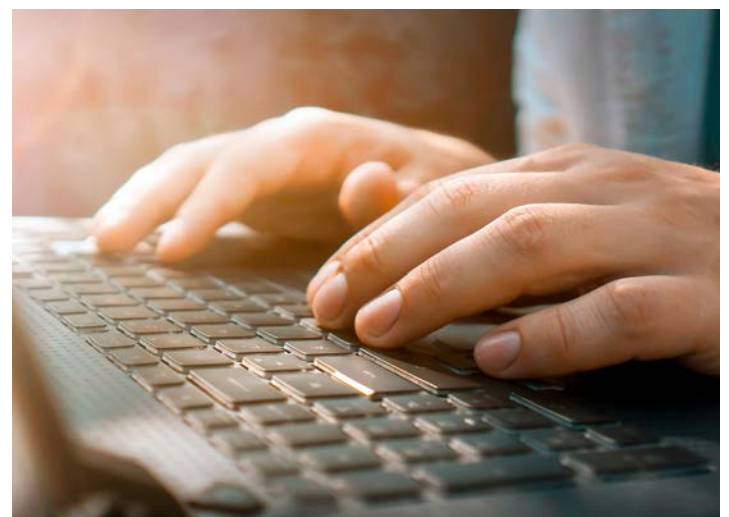
Intelligent Monitoring Dashboard Data Analysis Workstream - have continued to support Safety & Learning Networks to develop National dashboards, the latest of which are being built for Claims and Redress Networks to support the Learning from Events process.

Coding Workstream - are in the process of undertaking a detailed review and refresh of the Accident and Injury codes that sit in V17 of the national codes. This is an extensive piece of work, and each organisation is currently undertaking a risk and benefits analysis to ensure the complex nature and resource commitment is fully appreciated before this work is progressed.

The workstream has recently completed a thorough review of all codes to ensure they have the appropriate combo-linking (a method of simplifying code selection) - to provide accurate reporting across all levels. A key piece of work is ongoing to link with chairs of All Wales groups for specific areas such as, Tissue Viability, Infection Prevention Control, Health and Safety etc to gain assurance that the current codes and codes being requested in the future meet the needs of the services.

Safety Alerts Workstream - since the last Annual Report, the Safety Alerts module has transitioned from pilot stage to go live stage, with all organisations starting to utilise the module for the management of Safety Alerts.

Risk Workstream - the functionality is current being piloted by one organisation. A working group has been set up to support the development of the Risk functionality. It is anticipated that the working group will evolve into the Risk Workstream as the pilot work progresses.



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Datix Cymru Developments 2024/25.

There have been a number of key developments for Datix Cymru in 2024/25:

Active Directory - datix Cymru was using the ADFS system as the authentication tool for users to authenticate into the system – enabling users to log into the software and be allocated appropriate permissions. We have now fully migrated to Microsoft Azure.

Safeguarding - the Safeguarding reporting and management forms have been developed and successfully piloted in Hywel Dda University Health Board. The Once for Wales Concerns Management Central team will continue to work with NHS Wales Performance & Improvement, Public Health Wales and all organisations to standardise and implement this in 2025/2026, with an encrypted email system to support notifications to local authorities.

System Upgrades - the Once for Wales Concerns Management Central Team have supported three Datix Cymru system upgrades, in order to improve and enhance system functionality. A robust quality assurance process is followed by the Central Team prior to any new software release to ensure any operational issues are identified before this is signed off and implemented across all NHS Wales Datix Cymru systems.

Quarterly System Releases - updates to the workflows and data fields within the system are still implemented on a quarterly basis once the Content and Governance Group have approved the adjustments. The Central Team have continued to deliver the quarterly development workplan on time and on budget.

Supporting Primary Care Services - bespoke Incident Reporting Forms for Primary Care Providers have been built in all Health Board systems to support the Duty of Candour Implementation and provide easy accessibility, with a dedicated webpage.

Community Pharmacy - as part of NHS terms of service, community pharmacies are required to report incidents using an approved system. In Wales, this system is the Primary Care Wales Incident Reporting System (DATIX Cymru) and this was introduced in 2021. The Once for Wales Concerns Management Team have undertaken a review of this process and made changes to improve the management of incidents for community pharmacy contractors and the associated Health Board teams.

National Reporting Functionality - interim solutions were established following the discontinuation of the UK National Reporting and Learning System and a new portal functionality to transmit data from health bodies to NHS Wales Performance & Improvement has been designed and successfully implemented – enabling the seamless transfer of data between health bodies and NHS Performance & Improvement.

All-Wales Coding and Categorisation - the Coding Workstream has continued to enhance the national codes to meet the needs of services, and the codes are currently on edition 17. Additionally, work has been completed to combo-link the classification codes. This process smooths the process of code selection by staff and improves data accuracy. Standardisation of terminology has also been a major focus to improve accuracy of reporting. A work programme has been developed to continue enhancements.

Business Continuity - a Datix Down process has been developed for NHS Wales, in the unlikely event the Datix Cymru Incident form was unavailable all organisations would still be able to report Incidents.

Joint Investigation - The Joint Investigation Framework in NHS Wales provides a structured approach for investigating patient safety incidents that involve multiple NHS organisations. It ensures a coordinated and consistent approach to identifying the root causes of incidents, learning from them, and implementing actions to prevent recurrence. In line with the NHS Wales Performance & Improvement Framework, a new Joint Investigation system has been designed to ensure collaborative working and learning outcomes are accessible to Organisations in one place. The system is currently being piloted between two organisations. A meeting has been scheduled in July 2025 for all other organisations to receive a demo of the system.

Datix Cymru Survey

In June and July 2024, a targeted Datix Cymru survey was sent to recent users who were incident reporters or investigators of records in the Datix Cymru systems across NHS Wales.

We received 212 responses to the reporter survey, whilst the investigator survey received 517 responses.

In August 2024, a passive approach was taken with posters that included a QR code and email links were sent to members of the OfW Programme Steering Group for circulation.

During this period, 146 responses were received from reporters, and 82 responses were received from investigators. 1

The survey closed on 31st August 2024. Total figures for the reporter survey received 358 responses, whilst the investigator survey received 599 responses.

Main themes from the feedback -

- Staff recognise that the system is in depth and encourages those responsible for the design to make this as intuitive as possible.
- Many reporters would like IT systems to be able to communicate across health boards and trusts.
- Some staff report that they have experienced difficulty in saving part-complete reports.
- A number of responders feel that 'Near miss' should be a clearer option.
- Responders describe that the system is much improved from earlier versions.
- People felt that Datix Cymru is a great tool for collecting a massive amount of data.
- Many staff felt that the system standardised reporting.
- The survey responses highlighted that with the system being intranet based it is much easier for community staff members.
- The survey showed that Datix Cymru is considered by some to be a supportive resource for determining root cause of incidents.

The Incident workstream has been commissioned by the OfWCMS Programme Board to review the survey feedback and recommend improvements to the system.

Civica Experience Wales

The National Health Service in Wales is a large and complex organisation and accurate and detailed service user feedback is crucial to designing and improving innovative health and care services. The Civica Experience Wales platform was introduced as part of the Once for Wales Concerns Management System programme and by the end of 2022 all Health Boards and Trusts in NHS Wales had implemented the Civica Experience Wales system and had invested in dedicated local system leads to support each organisation's commitment to collecting, analysing and learning from real-time feedback from users of its services and to manage system and data at a local level.

Civica Experience Wales provides a platform for real time feedback from service users to be collated and analysed quickly and effectively across primary & secondary care. The system operates by developing and presenting surveys for completion by service users and utilises a range of contact methods, including SMS text messaging, QR code, Email, Interactive Voice Recognition, (IVR) web-based tools and a dedicated app which can be installed on devices within the organisation.



Online



Tablet and Kiosk - IOS and Andriod App (*Online and Offline, Remote, Config, Video*)



Email - Survey Links



QR Codes / NFC Stickers (*e.g. on posters*)



SMS: *Survey Links - link to online survey*
Q&A - Questions and answers as plain text



Phone: *IVR/IVM*
Agent (human) calls



Paper: *Fully managed print and scanning facilities*
Print to PDF + data entry tool



Digital Stores: *Digital Stories Library, which facilitates the uploading, categorisation by theme, consent management and an audit record for stories*

Sentiment Analysis

The platform includes a powerful data sentiment analysis tool, which enables health service leaders to understand detailed information received from service users, adding the ability to recognise the sentiment behind a response. The sentiment analysis of responses enables very rich information to be drawn from the data input by service users and this enables me to provide our service leadership teams with valuable insight into the experiences of patients and relatives. The graphs and data tools are straight forward for managers to access with minimal training needed.



Fig.17 Example of sentiment analysis of positive and negative feedback

Quantitative data helps health bodies understand ‘what’ but only qualitative data helps you understand ‘why’. The sentiment analysis tool provides functionality to analyse emotion, thematically categorise information and show trends.

Example from the Civica Experience Wales system outlining the powerful sentiment analysis tool is shown in Fig.16 and Fig.17.

Example of Sentiment Analysis of Positive and Negative Feedback

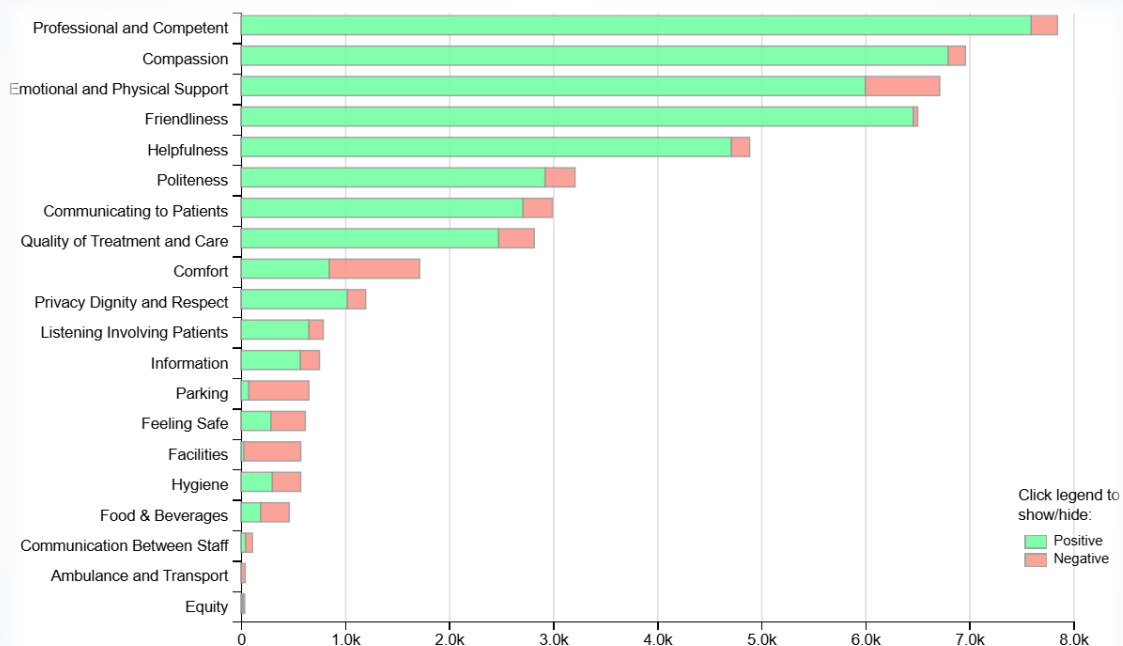


Fig.16 Example of sentiment analysis of positive and negative feedback

Presenting the National Experience Picture

Through the introduction of a common platform, health bodies now have a robust tool to gather feedback from patients, relatives and other users of health and care services across NHS Wales. With all health bodies using one platform, NHS Wales can better support service and quality reviews whilst ensuring a consistent national approach.

Since the introduction of the NHS Executive in April 2023, (now NHS Wales Performance & Improvement), and the reconfiguration of the Civica Experience Wales demonstration system to become a national analytical tool, over 80,000 pieces of service user feedback has been collected and analysed via the national analytical tool.

In August 2023, the National Emergency Department survey was launched across NHS Wales. With organisations using a variety of collection methodologies to gather feedback from service users who had accessed Emergency Departments in Wales, with the locally collected information being presented in the national analytical tool. Data collection included SMS text messages, Interactive Voice Recognition (IVR), QR codes and paper surveys. Between 1st August 2023 to 31st March 2025, 50,375 pieces of feedback were received. Now that this survey has closed, detailed analysis of this invaluable feedback will be being undertaken.

Learning from the all-Wales feedback is shared with all health bodies and also via the Listening and Learning from Feedback Group, which oversees and coordinates this area of work. In addition, data from the national analytical platform is shared with NHS Wales Performance & Improvement to support triangulation of other sources of data through the Beacon dashboard.

The roadmap for current and future national surveys is shown in Fig.18.

National Survey Topic	Position
Palliative End of Life Care	Live (data capture)
Emergency Department	Live (data capture)
Nosocomial Investigation Survey	Complete
Looked After Children	Live (data capture)
Maternity and Neonatal	Live (data capture)
Enhanced Community Care	Live (data capture)
National People's Experience Survey	Live (data capture)

Fig.18 Roadmap for National Surveys

National People's Experience Survey

In April 2025, Welsh Government issued a Welsh Health Circular for the People's Experience Framework and People's Experience Survey.

The People's Experience Survey (PES), which is a bilingual validated core set of questions has been rigorously tested and validated across all health settings. The PES is award winning, picking up an ISPOR Europe 2024 Research Presentation Award, winning the Health and Care Research Wales, Public Involvement Award and also being entered for the NHS Wales Awards 2025.

The PES was launched across NHS Wales using the Civica Experience Wales system in April 2025. This is an important step towards a more inclusive approach, in recognition of the diversity of the population, ensuring it meets the evolving needs of all people using NHS Wales services.

With data flowing from local Civica Experience systems to the national analytical tool on a daily basis, we are facilitating consistent quality engagement and always on reporting, whilst being able to achieve real time analysis of national data.

EIDO Decision Making & Consent Platform



The Once for Wales Concerns Management team provided technical support for Decision Making and Consent colleagues with the launch of the updated EIDO Decision Making & Consent Platform - known nationally as Canolfen EIDO Cymru.

The upgraded platform offers greater flexibility and future functionality to access the EIDO Consent Information Leaflets.

The team supported in the initial testing of the system, curation of a training video and, with help from colleagues in DHCW, organised initially for 25,762 Swansea Bay UHB accounts to have accessibility to the new system, whilst also being responsible for organising accessibility for any cross-organisation user.

Following the successful soft launch of the system in Swansea Bay during 2024-25, the switchover to the new EIDO decision making and consent platform was implemented to the other NHS Wales health bodies and organisations, going live on April 1st 2025 with the first two months of the full launch of the new system resulting in **15,424** Eido Consent Information Leaflets being distributed across Wales. The Once for Wales Concerns Management team provided technical support and assistance to users throughout this period and will continue to do so.

Custom consent information leaflet creation will be introduced in the coming months. The Once for Wales Concerns Management team will develop an information leaflet creation process to enable Health bodies and organisations to submit locally approved information leaflets to be distributed using the EIDO Decision Making & Consent platform.

To help promote good practice and learning, the team will also host and encourage the sharing of these materials to other health bodies and organisations throughout Wales.

The Welsh Risk Pool will encourage all organisations to use the electronic distribution of consent information. Fig.19 and Table.14 outline the method of distribution of leaflets in 2024/25.

Health Body/Organisation	Digital Download	Emailed	HB/Org Total
Aneurin Bevan UHB	1034	318	135
Betsi Cadwaladr UHB	2020	118	2138
Cardiff and Vale UHB	736	150	886
Cwm Taf Morgannwg UHB	848	136	984
Hywell Dda UHB	1215	69	1284
Powys THB	196	37	233
Public Health Wales	12	1	13
Swansea Bay UHB	4982	3552	8534
Total	11,043	4381	15,424

Table.14 Distribution method of consent information leaflets, April and May 2025

EIDO Consent Leaflet Distribution (April & May 2025)

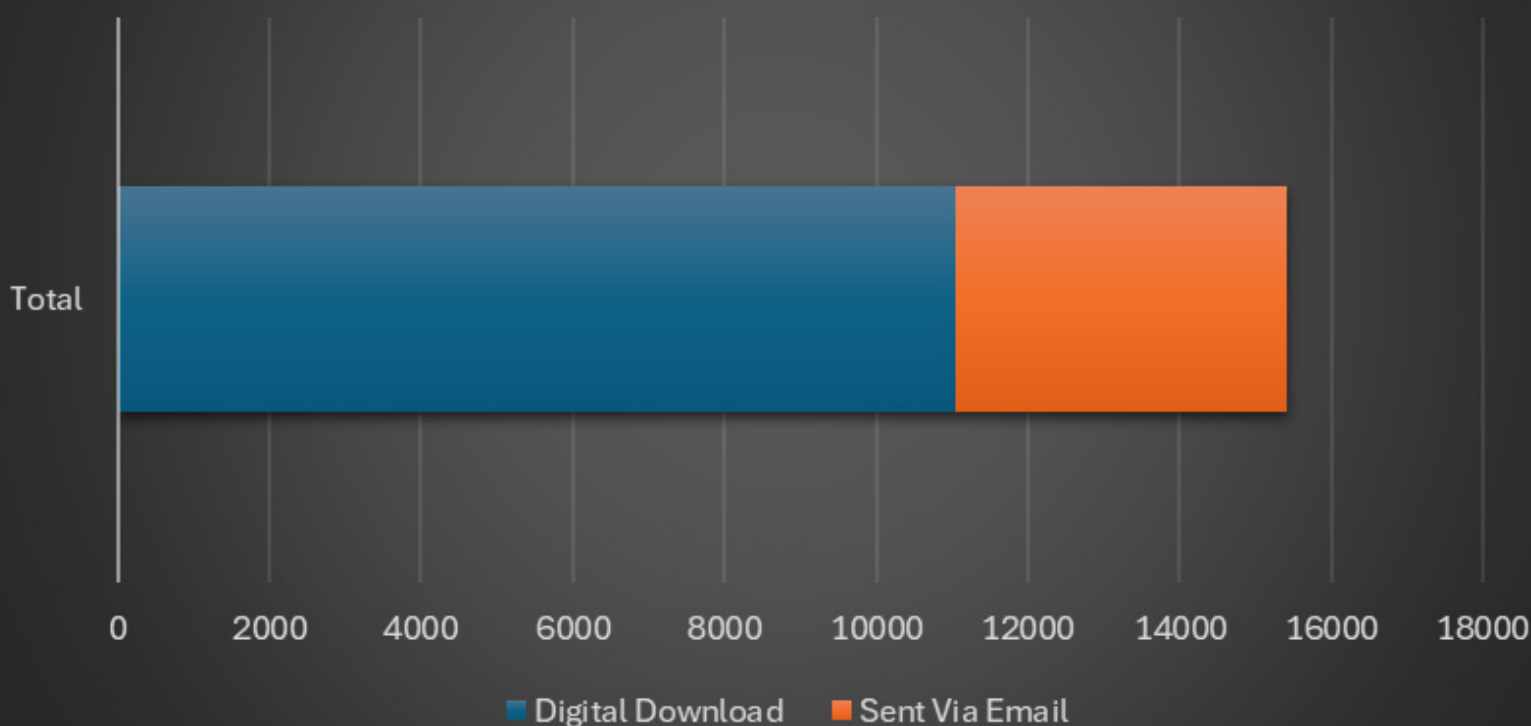
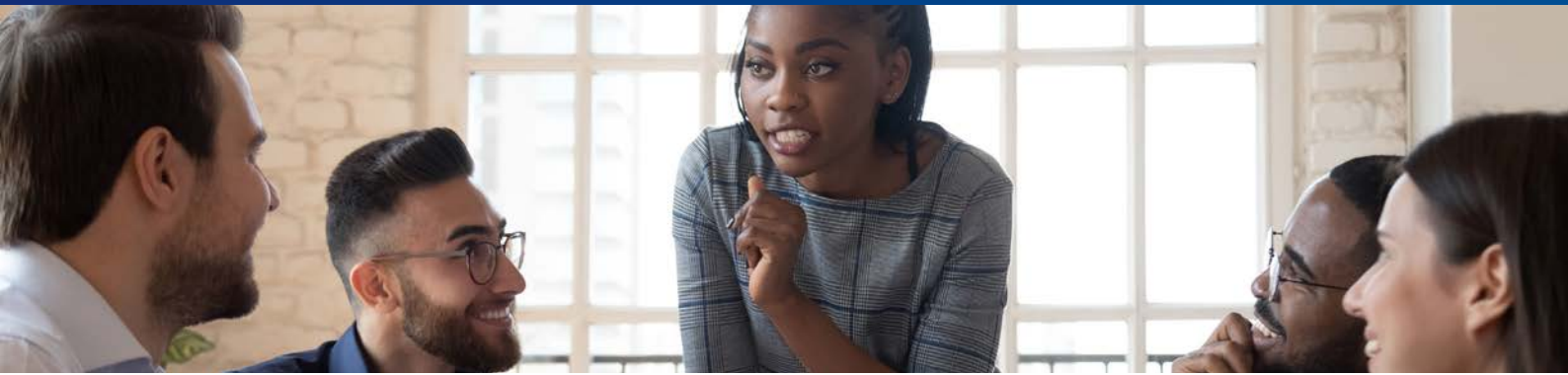


Fig.19 Distribution method of consent information leaflets, April and May 2025

Safety and Learning Networks



Groups to facilitate engagement amongst practitioners who work within the NHS Wales Concerns Management sector have been in place for a number of years. Since the concept of the Safety and Learning Networks, which were developed in 2018, the forums have gone from strength to strength. Wales has a proud history of collaboration amongst the health bodies within its NHS. Networking is a key aspect of this and there have been successful Networks previously within the patient safety and claims sectors. There are also a number of service-related clinical Networks which offer collaboration and sharing to its participants. The Safety and Learning Networks build on this robust and effective background.

The cohort of Safety and Learning Networks provide a solid framework for engagement and collaboration, helping organisations to achieve consistency and improve compliance with PTR requirements.

A review in 2023, in line with adjustments to the national governance structures for NHS Wales, and a further review that was undertaken during 2024/25, in line with an IMTP target, both concluded that the basis of the Safety and Learning Networks is sound and that organisations appreciate the support that the forums offer.



A new Safety and Learning Mortality Review Network was introduced in November 2024 which supports organisations to deliver a consistent and efficient process for managing and learning from Mortality Reviews in line with the national Model Framework.

Co-Chairing a Safety and Learning Network is an excellent development opportunity for staff within health bodies and during 2024/25 we have welcomed new co-chairs to the Redress and Claims Networks.

In line with terminology used in Welsh Health Circular WHC/2024/015, introducing the People's Experience Framework and launched in April 2025, the Service User Feedback Network has been renamed the People's Experience Feedback Network.

Safety and Learning Networks have been established within topic areas where a benefit is anticipated.

- » Head of Patient Experience Network
- » Complaint Handling Network
- » Redress Case Management Network
- » Claims Management Network
- » Inquest Case Management Network
- » NHS Wales Ombudsman Liaison Officer's Network
- » People's Experience Feedback Network
- » Candour Network
- » Network Co-Chairs
- » Mortality Review Network

Each network has developed a workplan with key aims identified which are linked to local and national safety and learning priorities to enhance the output from each network. Details of the workplans and discussions on delivery of the aims facilitated via the Network Co-Chairs' meeting and feed into the all-Wales Listening and Learning Group (LLFG), which is a national group that coordinates activity of Health Bodies in response to the Welsh Government commissioned report by Keith Evans "The Gift of Complaints". The Head of Patient Experience (HOPE) Network also provides an oversight and advisory role to the cohort of Safety and Learning Networks.

The work of each Network is steered by the Welsh Risk Pool Committee. Any national group or body can ask a Network to consider a piece of work or project in its workplace – which can include the HOPE Network, the Directors of Corporate Governance Forum, the Executive Director of Nursing Forum, the Listening and Learning from Feedback Group and the Once for Wales Concerns Management System Programme Board or Steering Group. Fig.20 outlines the relationships across the Networks.

Structure of Safety and Learning Networks 2024/25

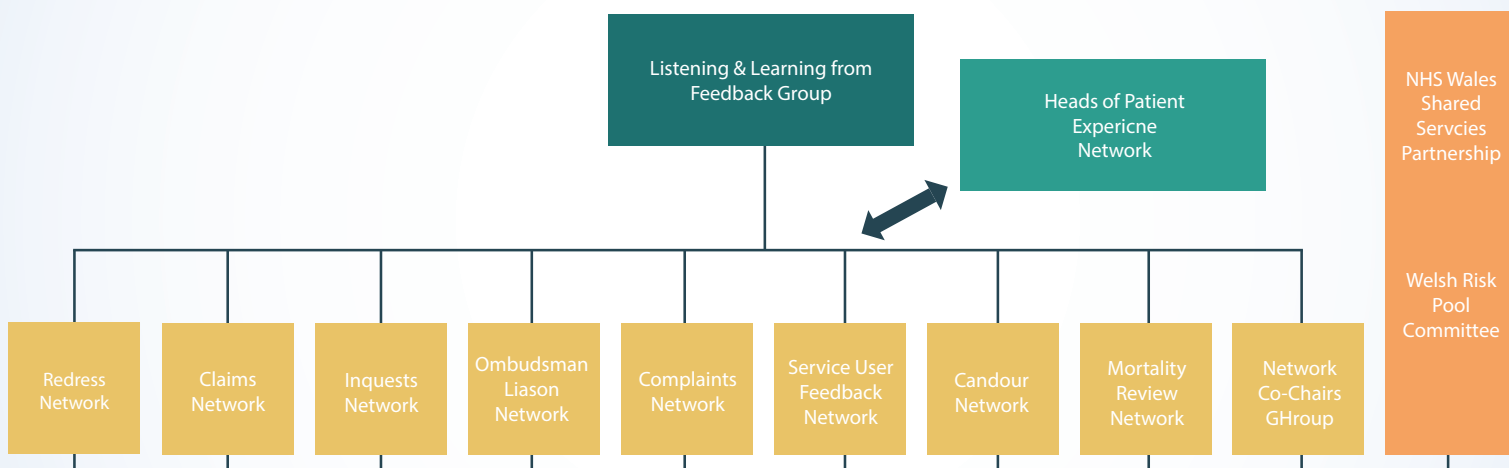


Fig.20 Structure of Safety and Learning Networks 2024/25

The HOPE Network is a key group of senior leaders and includes staff with the Senior Investigation Manager role outlined in the PTR Regulations within their portfolio. It holds **Formal** and **Informal** meetings. Formal HOPE meetings include invitations to representatives of national groups (such as Welsh Government, Welsh Risk Pool and NHS Wales Performance & Improvement) and are intended to provide a platform for organisations to seek views and shape recommendations on policy strategies.

Informal HOPE meetings have a section for health body members, and it excludes the Facilitator and representatives of national groups - enabling a supportive framework to the Network members and providing a safe space for discussion and to help members to coordinate their local activities.

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The Safety and Learning Networks are involved in and have key stakeholder roles in projects such as:

- » The People's Experience Feedback Network has been a pivotal leader in the review and refresh of the People's Experience Framework.
 - » The People's Experience Framework was co-produced by NHS Wales, and this was facilitated by the People's Experience Feedback Network. The framework has been expanded to include a comprehensive set of tools and measures aimed at evaluating and enhancing the quality of health services. The People's Experience Feedback Network will be supporting the implementation of the framework in conjunction with NHS Wales Performance & Improvement.
 - » The People's Experience Feedback Network has been a key stakeholder group involved in the development and implementation of National surveys, including the People's Experience Survey (PES).
- » Heads of Patient Experience Network (HOPE) and the Co-Chairs of the Complaint Handling Network continue to be key stakeholders in the Welsh Government review of the Putting Things Right Regulations. They have undertaken extensive reviews of draft documents and provided comments on amendments to Regulations. HOPE Network members will be key stakeholders in implementation meetings held by NHS Wales Performance & Improvement and will support NHS Wales to achieve a consistent rollout of the new Regulations and guidance.
 - » The HOPE Network commissioned work to be undertaken to support organisations with the management of Complex Cases. A face-to-face event was held in March 2025, which included representatives from the Police and CPS and representatives from NHS Wales organisations. The outcome of this event was that a Complex Case Management Guidance document, which will include a definition for 'complex case' and the framework for a complex case management multi-disciplinary team meeting is being drafted. A dedicated Complex Case Management website is also being developed and will be the repository for relevant guidance and support documents.
 - » The Redress, Claims and Inquest Networks have been instrumental in the ongoing development of the Datix Cymru system, along with the development of a Redress Definition and Proforma document to support consistent reporting and management of cases across Wales. National dashboards to support consistent management of Learning from Events Reports (LFER).



- » The Inquest Network has received assurance from organisations that an up-to-date Inquest Procedure document is in place. Themes from Regulation 28 reports are being fed into the wider work to compile a list of Themes, Patterns and Trends that can be utilised across all relevant Datix Cymru modules.
- » A key aim for the Redress, Claims and Inquest Networks for 2024/25 has been to work collaboratively with Legal & Risk colleagues to review, update and align Injury and Stage History fields.
- » The NHS Wales Ombudsman Liaison Officer's Network held a face-to-face event for Complaints Handling and Investigation training in conjunction with the Public Services Ombudsman for Wales (PSOW) in 2024. This resulted in organisations reviewing their current training practices and ensuring that the most up to date information and techniques were being utilised locally. Sharing learning from PSOW reports is a standing agenda item for the network. Themes from the reports are being fed into the wider work to compile a list of Themes, Patterns and Trends that can be utilised across all relevant Datix Cymru modules.
- » The Candour Network has developed national dashboards to support organisations to comply with their duty to report.
- » The Candour Network has worked collaboratively to produce a 'state of nation' report and have also updated the maturity matrix to provide assurance against 'business as usual' practices across NHS Wales.
- » The newly formed Mortality Review

Network have set ambitious aims to undertake a scoping exercise to set out what good looks like for Mortality Review Services. Also, working in conjunction with NHS Wales Performance & Improvement, review the National All Wales Learning from Mortality Reviews Model Framework and align local process and the Datix Cymru system to achieve a consistent, robust national process.

- » Key aims that cut across most Safety & Learning Networks are oversight and involvement with the Enhanced Learning Programme, Fixed Recoverable Costs, Complex Case Management, the review of Putting Things Right and shared learning.

The Safety and Learning Network meetings remain extremely popular with members and attendance levels are excellent. There are 10 Safety & Learning Networks that meet on a quarterly basis for between 1.5 to 2hrs, with a regular attendance of between 15 & 20 organisational representatives. The Welsh Risk Pool leadership team regularly receive compliments and thanks for providing the network process.



Putting Things Right Assurance



The Welsh Risk Pool conducts assurance reviews on behalf of Welsh Government and NHS Wales Performance and Improvement in relation to the application by health bodies of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – known as the Putting Things Right (PTR) Regulations. The assurance reviews also consider an organisation's compliance with the WRP Reimbursement Procedures.

An Assurance Report is provided to each organisation, along with recommendations for continuous improvement, and is considered by the Welsh Risk Pool Committee. The WRP Assessment is used by the Committee when determining members' contributions to the fund as part of the risk sharing agreement.

The review involves analysis of individual case management against both legal requirements and policy criteria. It also examines compliance with the application of the Once for Wales Concerns Management System workflows and completion of essential data fields. The review further facilitates analysis of the efficacy of the Learning from Events process within the organisation and examines how a health body shares and implements good practice between organisations.



The methodology for assessment has evolved during the last few years in line with national policies. The approach is based on peer-review, with senior leaders selected by the Head of Patient Experience Network joining staff from the Welsh Risk Pool in conducting the assessment. Specialist advisors, including legal specialists, join the assessment team as required. This approach is considered to promote sharing of best practice and enable the assessment team to recognise the application of the areas for assessment in operational practice.

For each area for assessment, the Assessment Team considers the available evidence and report assurance to the organisation using the NHS Wales Internal Audit Assurance Framework.

During 2024/25 reviews were held in respect of matters handled during Jan-Mar 2024. These were again based on peer-review, with members of the HOPE Network supporting each review.

The review considers:

- » The health body's policies and procedures for handling concerns, claims, inquests, redress and incidents.
- » The timeliness of complaint investigations.
- » The quality of complaint investigations and responses.
- » Arrangements for handling concerns about primary care providers.
- » The application of the all-Wales workflow within Datix Cymru for concerns.
- » Use of internal and external expert opinion.
- » Suitability of decisions whether there is a qualifying liability in a matter.
- » Arrangements for sharing lessons from all matters across the organisation.
- » Inquest case management
- » Redress case management
- » Claims case management

The period used for the scrutiny of cases related to matters opened, under investigation, or closed between 1st January 2024 to 31st March 2024. To facilitate sufficient time for case progression, the actual scrutiny of cases took place between June and October 2024.

The period used during the 2024 Assessment programme was selected and agreed in advance with senior leaders from the Putting Things Right sector. It is considered that cases would be sufficiently progressed from initial report and commencement of investigations to facilitate a thorough review following fieldwork taking place during the summer. This period was selected for all organisations to allow a fair comparison between organisations where the outputs of the assessment are used as part of the risk sharing agreement.

The findings of the reports were shared with organisations for factual accuracy considerations before action plans were prepared by Health Board's and submitted to the WRP addressing all recommendations made by the Assessment Team. Final WRP Assessment reports were presented to the Welsh Risk Pool Committee in March 2025 where decisions with regards to individual member scores towards the risk sharing agreement were agreed.



Clinical Negligence Case Management

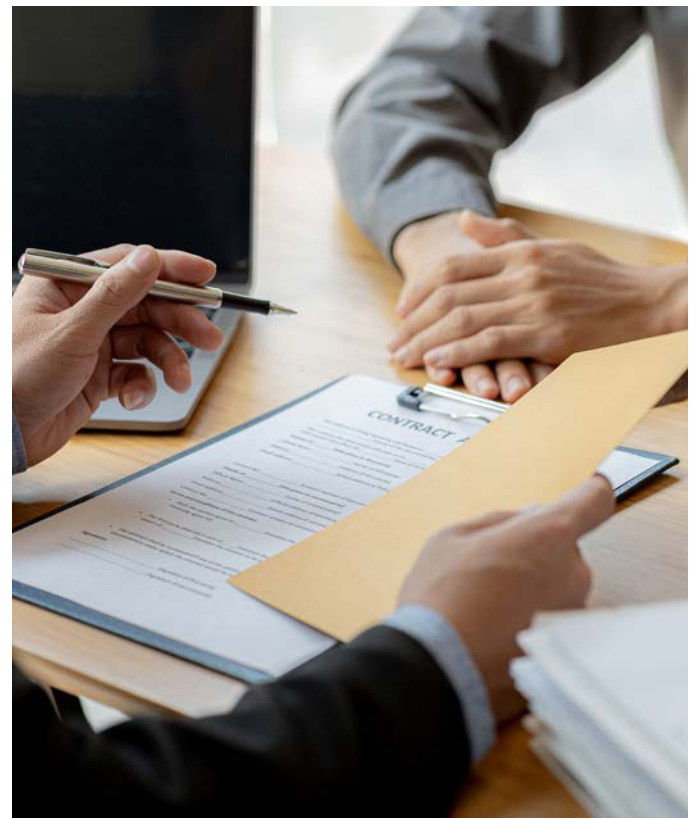


Our expert teams of clinical negligence lawyers manage all of the clinical negligence claims made against health bodies in Wales in respect of secondary health care. The caseload is approximately 1850 cases at any time and the potential cost to NHS in Wales is many millions of pounds.

The teams act sensitively and fairly towards those injured and their families, investigate allegations of negligence thoroughly and proportionately, defend those claims which are defensible, settle those which are not quickly and fairly, provide support to NHS staff, and protect the public purse.

We pride ourselves on the close and supportive working relationships we have built with our NHS bodies and healthcare staff over many years. Being “in-house” in NHS Wales means that we are part of one team. This is essential as we are dependent upon the support and co-operation of the claims managers within the NHS bodies, and the NHS staff involved in the claims, to be able to provide an effective, efficient and fair service. We are only able to defend cases to trial with the support of the clinicians and nursing staff involved in the care.

During 2024 a number of cases were defended to trial with judgements in favour of health bodies. The savings to the NHS were approximately £1.8m in Claimant damages and costs. The cases involved a wide of allegations including failures around consent, negligent surgery, delays in treatment, wrong diagnoses and poor decision making in respect of investigations and discharge.



Example of a case

A claim was brought in respect of a ureteric injury sustained during a laparoscopy assisted vaginal hysterectomy and bilateral salpingo oophorectomy. The allegations related to the consent process, the claim being that the Claimant would not have proceeded with the surgery had she known of the risk of the damage to her ureter, and the standard of the surgery itself. It was common ground between the parties that the ureteric injury was as a consequence of thermal injury from the ligature used during the surgery.

The Health Board had admitted that the risk of a ureteric injury, as a matter of fact, was not detailed in the Consent Form. However, the Claimant's own expert stated that he had never known a patient at low risk of ureteric injury to decline or delay their hysterectomy surgery. Therefore, it was considered very unlikely the Court would find the Claimant would not have proceeded to surgery had she been advised of this risk.

In respect of the standard of the surgery, Claimant's expert stated that it is generally accepted in gynaecological practice that ureteric injury at hysterectomy is only acceptable if there is a surgical mitigating factor and, that ureteric injury occurring in an uncomplicated routine hysterectomy is evidence of performance of the operation being performed below the standard of a reasonably competent gynaecologist. This was the basis of his opinion that the surgery was negligently performed. He did not consider that there was a mitigating factor to justify the ureteric injury in this case.

The Defendant's expert disagreed. He considered that the performance of the hysterectomy was to a reasonable standard and the ureteric injury was an unfortunate but recognised complication.

The case went to a trial and Claimant's claim was dismissed.

The Judge found that even if the Claimant was told about the risk of the ureteric injury, she would have proceeded with the surgery and, that the Claimant had not proved the injury was due to negligence.



We are committed to “All Wales” approaches in respect of the management of clinical negligence claims to ensure consistency and efficiency across Wales. We are streamlining processes to save time, money and to speed up the legal process to benefit patients and save legal costs.

We have procured a new case management system and have re-designed this with focus on the key data required for case management, financial management, learning (learning from individual events and trends) and reporting across Wales. In discussion with key stakeholders, we have introduced revised criteria in respect of stages of claim, specialities, nature of allegations/concerns and patient outcomes. The hope is that these criteria will be adopted more widely across Wales to enhance consistency in reporting and learning.

The nature of the legal claims being brought has changed over the last few years. Claims have become more complex. They are more often pursued against more than one NHS body and/or involve more complex medical conditions and surgeries. In addition, the financial value of claims is increasing year on year.

Every pound paid in respect of legal costs and damages is a pound taken directly from the NHS budget in Wales and therefore diverted from patient care. Managing claims efficiently and carrying out robust investigations into the validity of claims, is essential.

In order to check the validity of some claims, we sometimes use open-source surveillance ie. social media searches and occasionally covert surveillance. We have robust internal processes to ensure compliance with all legal requirements. The use of surveillance has led to significant financial savings.

In addition to managing the clinical negligence claims efficiently and fairly, we assist health bodies and colleagues in the Welsh Risk Pool to identify the pertinent issues in cases – which helps to ensure learning from claims is identified and actioned to prevent future harm to patients, along with reducing the potential for future claims.



Example of a case successfully using surveillance to reduce financial burden on NHS Wales

Following a detailed case review, liability was admitted in respect of a claim which arose from a bowel perforation suffered by the Claimant in May 20 after a caesarean section. The Health Board admitted liability for a failure to effect early surgical review after the patient suffered constipation following the caesarean section, which led to the perforation. As a result, the Claimant suffered from sepsis, a PE and a stoma, she also subsequently developed a large hernia. The only issues to be determined were the Claimant's condition and prognosis, the impact of the injury on her life and the valuation of the claim.

The case was complicated by the Claimant's previous medical history for which she was already in receipt of high rate care and mobility benefits. She already had many significant and serious problems such as being in constant pain, she used a wheelchair for any distance and crutches to get around, she had severe anxiety and could not go out unaccompanied and was unable to lift anything heavy, she required help with cooking, and a carer. The DWP records supported the concerns raised by the care expert instructed by the Health Board that the stoma has had very little impact on the Claimant's day to day functioning.

The Claimant valued the claim in excess of £3 million. The Claimant's claim included future losses such as care, services, aids, transport, therapies, and accommodation. The Claimant asserted that as a result of the index injuries, the hernia in particular, she needed higher levels of care and support as she struggles with everyday chores, such as lifting light objects or picking anything up, she is unable to reach up and lean over, she needs someone to push her in the wheelchair as her ability to propel it herself has deteriorated. She also said she was self-conscious of the large hernia so she wears loose clothing. Following review of the DWP records and concerns raised by our care expert regarding the true extent of the Claimant's injuries, it was decided surveillance evidence should be obtained. Surveillance evidence in the form of a CyberSearch report revealed in some Tik Tok videos a suggestion she may be walking on steep or uneven terrain. Further videos showed the Claimant at a gym with a friend engaged in "step training" and the "exercise spin bikes". She is also seen doing hip thrusts and pull downs. In light of this evidence, covert surveillance was arranged and the recording showed the Claimant on a shopping trip without a wheelchair including walking around a shopping centre pushing a trolley, bending down to reach things, loading shopping bags into her car and unloading them at home. The CyberSearch report and surveillance evidence were sent to the Claimant's solicitors and the claim settled for £315,000. This was a significant financial saving to the NHS.



Legal Costs Management

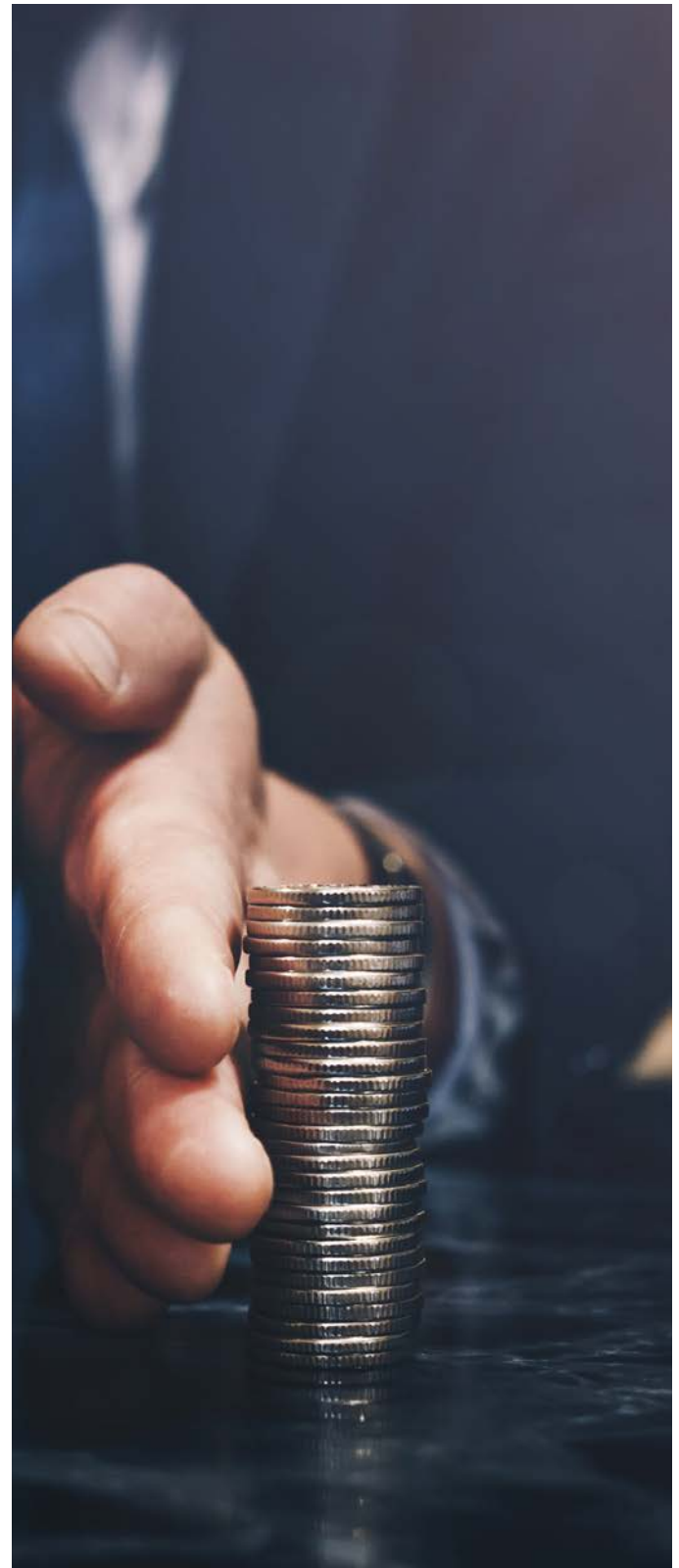
In addition to the payment of damages in claims which are settled, or where damages are awarded by a court, the Health Boards/Trusts have to pay the legal costs of claimants as well as incurring the costs of defending cases. In the majority of cases, even when we successfully defend a claim, the legal rules mean that the Health Boards/Trusts are unable to recover the defence costs, apart from in exceptional circumstances. Legal costs are ever increasing and represent an important part of the litigation process. Our lawyers work hard to seek reductions to the amounts paid out in legal costs on each claim, and to deliver direct savings to the NHS in Wales as a result.

We have a dedicated 'Costs and Funding Team' which meets regularly with a view to keeping up to date with key developments in costs matters and disseminating this information to the wider legal team and clients. The Team develops office-wide guidance documents and protocols to streamline the way in which costs are handled and provides and hold regular 'drop in' advice sessions and training.

We have negotiated fixed fee arrangements with several firms of external Costs Lawyers to assist in dealing with costs matters on behalf of health bodies in Wales at lower rates, and in turn, delivering better outcomes. This work is ongoing and the costs team is presently looking to expand the scope and number of fixed fee arrangements giving further opportunity to develop a dedicated team of costs lawyers ready to deal with costs cases, to include high and low value costs claim at competitive rates.

One key firm has been accepting instructions to deal with costs matters valued up to £250,000 on a fixed fee arrangement since March 2022. Across that period, the firm has delivered savings of £7,000,000 across over 310 costs cases for NHS Wales. Between May 2024 to 30 April 2025 the savings equate to £1,100,712, with an average saving of almost 22.2% on the 43 bills of costs advised on.

The 'Costs and Funding Team' also provide training and guidance on the costs budgeting process. This is the court process designed to provide clarity and transparency of a party's legal costs, to promote efficiency and allow early assessment of the merits/costs of a case. The process involves the completion of a complicated precedent giving details of the work already undertaken and that to be undertaken in the future.



Putting Things Right Case Advice

We support health bodies in the management of concerns raised under the Putting Things Right Regulations and provide legal advice, support and training to the local teams who oversee these cases.

All of our lawyers are familiar with the Putting Things Right Regulations, Guidance and processes. We have a cross-team group of lawyers, led by Senior Solicitor Gemma Cooper, who are experts in the law in this area and how this interacts with the Civil Procedure legal processes. We assist health bodies with investigations into concerns raised under the Regulations, the identification of lessons learned and the consideration of issues of qualifying liability and valuation of compensation to be paid by way of Redress. This support is provided in innovative ways tailored to best support individual health bodies including client specific, and All Wales, clinics run by Legal and Risk lawyers.

Being involved in matters early allows us to add value to organisations' decisions regarding the scope of investigations and the evidence to be obtained, facilitating matters being investigated and responded to promptly and appropriately.

We are members of All Wales stakeholder groups and work closely with Welsh Government and the Welsh Risk Pool. We play a key role in the development of the legislation and policy in this area, and our expertise allows us to provide important assistance and guidance with quality assurance work.

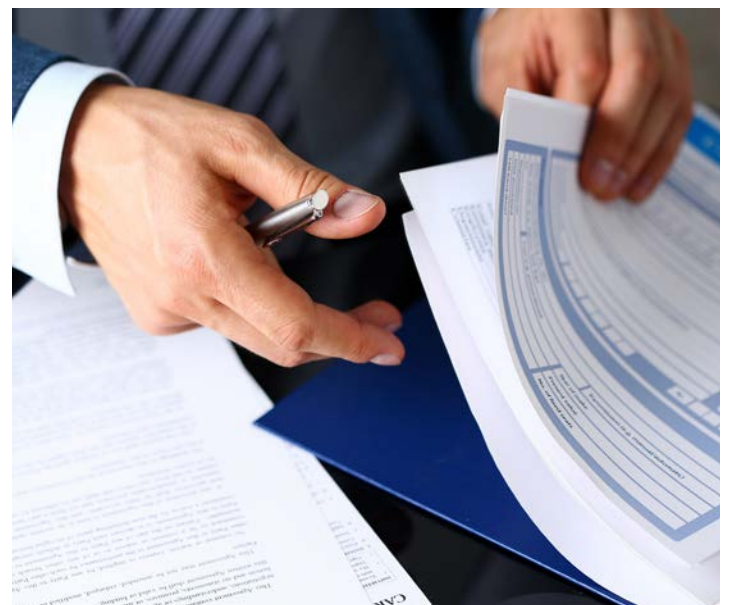
We are currently working with health bodies and Welsh Government in respect of the proposed changes to the PTR Regulations and Guidance. We will support health bodies with the implementation of these changes and the additional work these will require of health bodies' teams.

Horizon Scanning the clinical negligence area

The law governing clinical negligence claims is complex and constantly changing. The depth of legal knowledge and experience in the Clinical Negligence Department ensures we are able to adapt and inform quickly.

We pride ourselves on being prepared for the changes and developments we know are coming and, being able to react quickly to those which are unexpected. We raised awareness and advised on the uncertainty introduced into claims management by the planned review, and likely change of, the Personal Injury Discount Rate in January 2024. We are currently considering with clients the legal and workforce implications of the proposed increase in the Redress level from £25,000 to £50,000 next year.

The position in respect of the long-awaited introduction of fixed recoverable costs in clinical negligence claims valued below £25,000 remains very uncertain. There has been no reference to this since the change of government. We were involved in the national Working Group from the outset and continue to liaise with key stakeholders and national groups to ensure the NHS in Wales is prepared if/when this is moved forward.



Supporting the UK Covid-19 Public Enquiry



The UK Covid-19 Inquiry was set up to examine the UK's response to and impact of the Covid-19 pandemic and learn lessons for the future. The Inquiry began on 28 June 2022. Its investigations are organised into Modules. Throughout each of these Modules, the Inquiry hears evidence from witnesses, experts and Core Participants through a series of corresponding hearings.

The Public Inquiry is now fully underway with various Modules opened and public hearings held during 2024/2025, including the key hearing in Module 3 (Impact of Covid-19 Pandemic on Healthcare Systems in the 4 Nations of the UK).

We are advising and representing nearly all health bodies in Wales in respect of the Public Inquiry. A number of Welsh NHS bodies are Core Participants in various Modules, either individually or as part of a group. We have advised and assisted in providing a significant amount of information to the Inquiry Team, numerous witness statements and have supported key NHS Wales leaders required to give oral evidence prior to and during the hearings.

The Inquiry is moving at pace and the timescales set for responses from health bodies have been short. The requests have often arrived without notice. In addition, thousands of documents have had to be provided to the Inquiry team by health bodies, each appropriately reviewed, indexed and redacted to hide personal, sensitive or irrelevant data.

The pressure this has placed on NHS teams and executives, many of whom have not been involved in any legal processes before, cannot be overestimated. At an individual level this has been daunting for some. At an organisational level, the risk of diverting resources away from the post pandemic recovery to respond to the Public Inquiry has been challenging. For one of the Welsh health bodies, this has resulted in a senior lawyer being seconded on a fulltime basis, to provide more effective support during the Inquiry.

We have distinct client Public Inquiry teams to ensure regulatory compliance and client confidentiality whilst, at the same time, working together as much as possible to share learning, knowledge and minimise the legal costs incurred by health bodies. We are very proud of the way all teams within Legal and Risk Services have worked together to support both our health bodies, and each other. We have received excellent feedback on the quality of the service provided.

Due to our unique in-house position, and in-depth knowledge of the structure and processes of the NHS in Wales, we have been able to have high level discussions with the UK Inquiry team and make time and cost saving suggestions on behalf of individual clients and also more generally.

Personal Injury Prosecutions Case Management



The skilled Solicitors, Chartered Legal Executives and Paralegal staff in our Personal Injury and Prosecutions Team are dedicated to supporting all health bodies in Wales. Led by Robert Jenkins, the team has many years of experience in the investigation and defence of personal injury claims brought by staff, visitors to NHS premises and members of the public, the team has also developed considerable skill and experience in supporting health bodies that are the subject of regulatory enforcement action or criminal prosecution.

The claims dealt with can range from relatively low value slip and trip claims to more complex matters such as mesothelioma and incidents resulting in permanent injuries. The team are experts in the investigation of the application of health and safety principles and support health bodies in identifying evidence of reasonable measures taken by organisations to comply with the law.

By conducting as many investigations in house as possible, this reduces the cost burden on organisations for determining the facts of each case and ensuring that statements from those involved are suitable for presentation to court.

Where legal representation is required at court hearings, this is coordinated by our in-house team – providing a seamless service to our clients.

The team also provides advice to clients in the following fields:

- » Employers and Public liability
- » Work related stress
- » Bullying and harassment
- » Violence and Aggression
- » Industrial disease, including
- » Asbestos
- » Hearing loss
- » Object and person manual handling
- » Repetitive strain injury
- » Defective equipment
- » Infection Control
- » Slip and trip cases

Our dedicated team work cohesively to deliver an excellent service to our clients, including a bi-annual education day which aims to enhance the experience and understanding of NHS leaders and claims managers. The team also provides valuable analysis of trends as well as focusing upon learning lessons and giving practical risk management advice in areas that have been identified as vulnerable. We firmly believe that prevention is better than cure.

General Medical Practice Indemnity



Scheme for GMPI

Legal and Risk Services are appointed by Welsh Government to operate the Scheme for General Medical Practice Indemnity (GMPI) and the scheme was launched on 1st April 2019.

GMPI provides clinical negligence indemnity for providers of GP services in Wales in relation to the care, diagnosis and treatment of a patient following incidents which happen on or after 1st April 2019.

The GMPI team aim to resolve any claim for compensation brought by a patient in relation to their clinical care under the NHS as fairly and as quickly as possible. Equally, the team recognises the importance of robustly defending claims where appropriate and protecting GP's, the clinical teams in practices and their reputations.

Full details of the Scheme and Guidance and FAQs can be found on [GMPI Website](#).

Existing Liabilities Scheme

Legal and Risk Services also operate the Existing Liabilities Scheme (ELS), which captures eligible clinical negligence claims made against GPs and practice teams which occurred before the establishment of GMPI. Matters included in the ELS Scheme only include those where a medical defence organisation, which previously provided indemnity in these cases, completed an agreement to transfer these liabilities into the scheme.

the GMPI Team

Legal and Risk Services has established a dedicated Primary Care Clinical Negligence Team, led by Heather Grimbaldston, which operates all aspects of the Scheme for GMPI and ELS. Consisting of 15 staff, these lawyers and support staff specialise in managing clinical negligence claims against GP practice staff across Wales and work closely with NWSSP's in-house GP advisors.



Learning from Events

A tailored process, developed between the Welsh Risk Pool and the GMPI Team, supports the requirement for GP practices to prepare and present learning from cases where there is a liability, admissions are made, or a settlement is agreed.

The procedure involves the GMPI Team preparing a Learning from Events Report and coordinating the presentation to the National Learning Advisory Panel. GP Practices are required to help identify and commit to implementing improvements and developments in procedures to reduce the potential for the circumstances which led to the claim from reoccurring.

In 2024/25, the GMPI Team coordinated the development of over 50 Learning from Events Reports.

Supporting GP Practices in Wales

Legal and Risk Services aims to continuously improve the service offered by the GMPI Scheme. We meet regularly with stakeholders and are a member of NWSSP's Primary Care Steering Group which supports the development and delivery of primary care services in Wales.

The GMPI team actively supports GP practices:

We operate an email and telephone helpline used by GP Practice staff and Health Boards across Wales seeking information about indemnity arrangements and support with clinical negligence complaints or claims. The helpline dealt with over 1600 communications in 2024/25.

We support GP Practices to respond to patients' clinical concerns by providing guidance and support on the issues raised. The guidance given by the team follows the NHS Wales Putting Things Right (PTR) concerns procedures. To help gain insight into matters raised, the team seeks input from NWSSP's in-house GP Medical Advisors and feeds back to GP Practices any suggested learning or improvement. The team received over 230 new requests to assist GP Practices with patient concerns

We provide all-Wales training sessions and bespoke virtual training to Health Boards and GP's, Trainee GP's and practice teams across Wales. Highlights included our All Wales virtual training on the learning from events process in GMPI matters, training delivered to a Local Medical Committee and on-site training at a Practice.

We launched a GMPI Newsletter "Y Gorwel" / "The Horizon" in 2024-25 for all GPs, GP Practice staff and Health Boards in Wales.



Impact and Reach of our Legal Services



Legal and Risk Services is formed of a number of teams, who work cohesively to provide support to our clients. We are recognised as an in-house legal practice. Our Solicitors are regulated by the Solicitors' Regulation Authority and our Chartered Legal Executives are regulated by CILEx.

Our teams focus on specific areas of law:

Commercial, Regulatory and Procurement Team

Our Commercial, Regulatory and Procurement Team, led by Rhiannon Holtham, has an exceptional number of years of experience in dealing with a vast array of legal disputes, overseeing the procurement process and advising on procedural fairness throughout NHS Wales.

The team advise health bodies throughout Wales on all manner of issues, both contentious and non-contentious, which includes Commercial (contractual arrangements) and public law matters (judicial reviews). We also help the NHS understand the complexities of the maze of regulation that exists.

Below is a non-exhaustive list of some of the topics that we are able to advise on:

- » Commercial contracts
- » Procurement law (Advice on regulations and procedure)
- » Procurement documentation (Advice on drafting Invitations To Tender, Pre-Qualification Questionnaires and Specifications)
- » Procurement challenges
- » Outsourcing treatment and services
- » Intellectual Property
- » Regulatory law
- » Public contract law (including General Medical Services or General Dental Services Contracts)
- » Public/Private partnership arrangements
- » Judicial Review of decisions
- » Commercial Litigation
- » Residency disputes
- » Disputes between public authorities regarding funding
- » Dispute resolution
- » Policy drafting
- » Construction
- » Criminal
- » Civil Fraud
- » Injunctions
- » Defamation
- » Transfer of Undertakings and Protected Employees (TUPE)

- » Information law (Data Protection and FOI issues).
- » Debt collection
- » International law (Memoranda of Understanding and Service Level Agreements with foreign governments).
- » Procurement documentation (Advice on drafting Invitations To Tender, Pre-Qualification Questionnaires and Specifications)
- » Deprivation of Liberty - The full impact of the Supreme Court decision in Cheshire West, that redefined what amounted to a deprivation of liberty, is still being realised with enormous impact on NHS resources. We help health boards avoid unlawful deprivations and provide representation in the Court of Protection when a patient appeals against their detention.

Complex Patient (Court of Protection)

Our Complex Patient team is led by Gavin Knox; a specialist team which is comfortable dealing with highly complex and sensitive clinical situations where a patient's life or liberty might be at stake. Early intervention will often improve outcomes for patients. This may be by helping to ensure health board staff are acting in the best interests of the patient, or by resolving disputes that can in themselves cause distress to the individual.

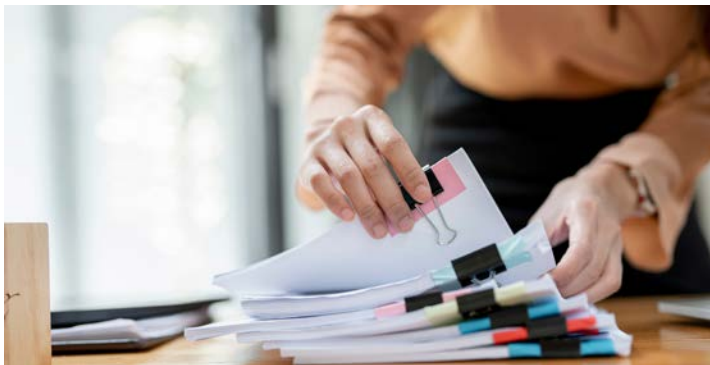
- » Mental Capacity Act and Best Interests for Children - there is a growing need for NHS staff to understand and implement the principles and provisions of the Mental Capacity Act. Our team offers a rapid and reasoned response to any capacity or best interests related query. By engaging early with clinicians, patients and families, we can usually assist in resolving disputes or ethical dilemmas and avoid the need for applications to be made to Court. The same applies to disputes about medical treatment or end of life decisions for children.
- » End of Life Decision Making (adults and children) - There are no more important decisions than those relating to the end of life. We are regularly instructed where disputes arise between clinicians and patients or their family about what treatment can lawfully be given.
- » Mental Health - We help staff navigate the legislation and the difficult conflicts and interfaces with the Mental Capacity Act and Deprivation of Liberty.
- » Court of Protection and High Court Applications - Not all issues can be resolved locally and ultimately some decisions need to be made by a Court. Often these can be highly contentious, complex, and emotive cases with the health, liberty or life of a vulnerable adult or child in the balance. We have extensive experience of making applications to both the Court of Protection and the High Court, each with their own particular rules and procedures. We offer a service that aims to resolve disputes quickly and sensitively to preserve therapeutic relationships with patients or families.



The Complex Patient team work on a real-time basis and are often involved in out of normal hours discussions, providing advice to clinicians dealing with these issues on a day-to-day basis. As part of an All-Wales Network the team are using all their specialist knowledge and experience to help Health Board's improve compliance with the Mental Capacity throughout their organisations. The team also work closely with the national group who are responsible for Decision Making and Consent.

In 2024/25 one of the priorities is to help Health Boards to streamline the Discharge process for those patients who lack capacity to make decisions for themselves.

Inquest Team



We have a dedicated team that is able to support health bodies when preparing for and participating in coronial inquiries and inquest hearings.

We support the whole coronial inquiry and inquest process and focus our legal input on those matters which raise complex Human Rights issues - such as suicides, deaths in prison or involving patients in mental health detention, potential gross negligence, or systemic organisational issues.

Our experienced lawyers support health bodies in triaging inquest matters to determine those which will benefit from formal legal input and representation.

We also contribute to all-Wales training in coronial processes, evidence gathering and supporting witnesses to give evidence.

Employment Team



Our Employment Team, led by Sioned Eurig, is formed of very experienced lawyers, who work very closely with People and Organisational Development teams throughout NHS Wales. The team has acted for health bodies in a wide and diverse range of Employment Tribunal and County Court cases. The team has also had the privilege of advising on high level strategic policy issues.

The team can help with all types of employee relations cases and Employment Tribunal claims including:

- » Unfair dismissal (conduct and capability)
- » Discrimination allegations (disability, sexual orientation, race, age, gender etc)
- » Unlawful deduction of wages
- » Holiday pay
- » Whistleblowing
- » Pension
- » Agency worker rights
- » Doctor disciplinary cases

The team can also help with the with wide range issues facing busy healthcare services:

- » Interpretation of policies and procedures on an All-Wales level
- » Issues arising out of the employment relationship (including advising on grievances and disciplinary hearings) including termination of employment
- » Family friendly policies (i.e. Shared Parental Leave regime)
- » Clinician banding appeals
- » Severance packages and drafting settlement agreements
- » The Transfer of Undertaking (Protection of Employment) Regulations 2006 (TUPE)
- » Voluntary Early Release Schemes and queries
- » Doctor disciplinary issues
- » All Wales matters in association with the Welsh Government
- » Employment status
- » Consultations, Restructures and Redundancies
- » Union Recognition

As well as helping clients to manage cases when things go wrong, the team also works with clients to train Workforce teams and line managers to reduce the risk of claims. Employment law is constantly evolving.

Our Employment team can offer a wide range of educational talks and seminars that can be delivered at our fully equipped premises. We are also able to tailor quarter, half or full day packages at a location to suit our client. Recent topics include:

- » Training on the Upholding Professional Standards in Wales Policy (UPSW)
- » Disciplinary investigations training
- » Employment law updates
- » TUPE
- » The duty to prevent sexual harassment in the workplace

Following considerable demand, our Employment Team can now offer support and services to primary care GP practices. In 2025/26, we will also be launching a new complex investigations and culture review service for all clients.



Property Acquisitions, Disposals and Leases Team

Our property team, led by Rashmi Chakrabarti, provides advice across the NHS Wales estate, delivering a quality service at competitive rates. The team has extensive knowledge and experience in commercial property and of the NHS Wales estate.

The team works closely with NWSSP Specialist Estates team and undertakes a range of work, which encompasses:

- » Leasehold acquisition of offices on behalf of NHS Wales health bodies;
- » Lease management, including varying principal lease terms and break dates, as well as general management work (licences to alter etc.) in support of tenant works;
- » Freehold sales of surplus commercial and residential properties, including provisions to protect future development rights of adjacent land retained by NHS Wales;
- » Freehold acquisitions in connection with large-scale developments by NHS health bodies
- » General, one-off property queries on sundry matters, including in the primary care field.



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