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WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Date **04/12/2025**
Time **09:30 - 13:00**
Location **Microsoft Teams Meeting**

Quality, Safety & Experience Committee

HDD_Quality, Safety & Experience Committee

NHS Wales

Agenda - 4 December 2025

1 Governance

09:30, 30 min

1.1 Declarations of Interest

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

1.2 Minutes from the Previous Meeting and Table of Actions

Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)

1.3 Assurance and Risk Report - Executive Leads

2 Risk

1 hr

2.1 Deep Dive: Radiology

Sarah Procter (Hywel Dda UHB - Deputy Head Of Radiology), Sara Quarrie (Hywel Dda UHB - Service Director for Allied Health Professions and Health Sciences), Angela Bell (Hywel Dda UHB - Assistant Director Quality, Safety + Patient Experience for Allied Health + Health Sciences)

2.2 Deep Dive: Orthopaedics

Lianne Gregory (Hywel Dda UHB - Service Delivery Manager), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing)

2.3 Deep Dive: Ophthalmology

Victoria Coppack (Hywel Dda UHB - Service Delivery Ophthalmology Ophthalmology & Neurology), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing)

3 Assurance

1 hr

3.1 Targeted Intervention Progress Report- Executive Leads

3.2 Listening and Learning Sub Committee Update Report and Terms of Reference for Approval- To Follow. Meeting Scheduled 2 December 2025

Louise O'Connor (Hywel Dda Health Board - Assistant Director)

3.3 Listening and Learning From Events Framework

Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding)

3.4 Clinical Audit Programme

Mark Henwood (Hywel Dda UHB - Executive Medical Director), Ian Bebb (Hywel Dda UHB - Clinical Audit Manager)

3.5 Waiting List Management

Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Mandy Davies (Hywel Dda UHB - Assistant Director of Nursing & Quality Improvement), Marilize Preez (Hywel Dda UHB - Improvement and Transformation Lead)

3.6 Quality Assurance Report

Cathie Steele (Hywel Dda UHB - Interim Assistant Director of Nursing Assurance and Safeguarding)

4 Clinical Care Group Update Reports

20 min

4.1 Community and Integrated Medicine

Anna Chiffi (Hywel Dda UHB - Assistant Director of Nursing, Patient Safety, Quality), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

4.2 Operational Allied Health Services

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Angela Bell (Hywel Dda UHB - Assistant Director Quality, Safety + Patient Experience for Allied Health + Health Sciences)

4.3 Planned Care and Specialist Services Clinical Care Group

Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Olwen Morgan (Hywel Dda UHB - Assistant Director of Nursing)

5 For Approval

5.1 Use of Production Survey Guideline

Louise O'Connor (Hywel Dda Health Board - Assistant Director)

6 For Information

6.1 QSEC Work Plan 2025-26

7 Date of Next Meeting : 12 February 2026

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1 - Governance

1.1

10:00,

1.1 - Declarations of Interest

*Eleanor Marks
(Hywel Dda UHB -
HDUHB Vice Chair)*

1.2

1.2 - Minutes from the Previous Meeting and Table of Actions

*Eleanor Marks
(Hywel Dda UHB -
HDUHB Vice Chair)*

Attachments

[2025-10-09 - Quality, Safety Experience Committee Meeting - Minutes.pdf](#)

[Table of Actions QSEC 9 October 2025.docx](#)

Draft Minutes of the Quality, Safety & Experience Committee

Date of Meeting: **09:30, Thursday 09 October 2025**
Venue: **Microsoft Teams Meeting/ Ystwyth Boardroom**

Present: Anna Lewis (Independent Board Member and Chair)
Eleanor Marks (Hywel Dda UHB Vice Chair)
Sarah Harraway (Hywel Dda UHB - Independent Board Member)
Chantal Patel (Hywel Dda UHB - Independent Board Member)
Michael Imperato (Hywel Dda UHB - Independent Board Member)

In Attendance: Amanda Davies (Head of Service, Adult Mental Health) (part)
Andrew Carruthers (Chief Operating Officer)
Ardiana Gjini (Executive Director of Public Health)
Carly Hill (Assistant Director) deputising for Mr Mark Henwood, Executive Medical Director
Caroline Burgin (Patient Safety and Assurance Manager)
Cathie Steele (Interim Assistant Director of Nursing Assurance and Safeguarding)
Cerian Llewellyn (Interim Head of Midwifery) (part)
Donna Major (Junior Sister) (part)
Gareth Cottrell (Deputy Chief Operating Officer)
Jill Paterson (Director of Primary Care, Community and Long Term Care)
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)
Jonathan Arthur (Hywel Dda UHB - Deputy Director of Health Sciences)
Katie Lewis (Hywel Dda UHB - Committee Services Officer)
Louisa Standeven (Hywel Dda UHB - Interim Deputy Head of Nursing) (part)
Louise O'Connor (Assistant Director)
Mwape Burke (Aspiring Board Member)
Olwen Morgan (Assistant Director of Nursing)
Paula Goode (Service Director for Planned and Specialist Care)
Rebecca Richards (Head of infection prevention)
Sarah Williams (Senior Nurse Medicine) (part)
Sharon Daniel (Executive Director of Nursing, Quality & Patient Experience)
Stephanie Hire, Programme Lead - Transformation Planned Care (part)
Thomas Alexander (Principal Programme Manager) (part)

Apologies: Mr James Severs (Executive Director of Allied Health Professions and Health Science), Mark Henwood (Executive Medical Director), Dr Subhamay Ghosh, Associate Medical Director, Quality and Safety

Minutes Ref.	Item	Action
QSEC 25 (54)	Declarations of Interest	
	There were no declarations of interest.	

Minutes from the Previous Meeting, Table of Actions and Matters Arising

In terms of matters arising, the Committee was reminded of the statutory governance requirement that all papers must be circulated at least one week in advance of meetings. It was noted with concern that a key paper had not been shared until the day before the meeting, which does not meet the expected standards of governance.

The Chair, Mrs Anna Lewis, noted after a brief discussion with colleagues that a combination of factors contributed to this situation. However, the Committee emphasised that such delays must not happen again. Consequently, it was agreed to defer the paper, to allow the Clinical Care Group sufficient time to prepare a report that accurately reflects the significant work being undertaken by the team.

The Chair proposed that a piece of work be commissioned to review and clarify guidelines or requirements for the quality and timeliness of reports submitted to the Committee, to support consistency going forward. It was agreed that going forward late papers would be escalated to the Board via the Board update report.

SD/ JW

QSEC 25 (45) To consider analysis on why the patient experience feedback from ethnic groups varies from other groups in the patient feedback by demographic data: In response to the action, Mrs O'Connor informed the Committee that the feedback currently available from the Patient Experience System is limited to the information input directly by patients. However, the Equality and Diversity Team is undertaking a series of community engagement events. It has been agreed that additional questions will be incorporated into these events to capture further feedback relating to the experiences of care and related concepts. The outcomes of this engagement will be reported back to the Committee at the next meeting.

LOC

Decision: The minutes of the meeting that was held on 14 August were approved as an accurate record.

Targeted Intervention Progress Report

Mrs Sharon Daniel presented key highlights from the Targeted Intervention progress report. The Committee was alerted to the following:

- Challenges persist in maintaining targets set for reducing hospital onset infections, particularly S. Aureus and E-Coli and management of root causes.
- In terms of the concerns stated in the report regarding external regulatory compliance, a meeting was held with Vanessa Davies, the Health Inspectorate Wales (HIW) engagement link last year, who advised that HIW had intended to undertake an

increased number of visits as part of a revised approach. Five visits have already been undertaken this year. The Health Board continues to maintain a structured relationship with HIW, and recent changes to HIW's relationship management approach will be discussed further by Executives and Independent Members in due course.

Ms Sarah Harraway raised concern regarding the rate of complaint closures within community settings, noting that only 40% of complaints are being closed within 30 days by the Health Board. Ms Harraway queried whether this is due to lack of resource, complexity of complaints, or a combination of both.

In response, Mrs O'Connor acknowledged the concern and noted that discussions are ongoing across Wales in relation to the forthcoming Listening to People Regulations. Mrs O'Connor explained that these performance metrics do not currently take into account the quality of complaint responses. While the Health Board endeavours to respond to complaints within 30 days wherever possible, Mrs O'Connor clarified that complaints concerning the quality of care often require a legal determination of liability. Such investigations are complex and, as a result, are unlikely to be resolved within the 30-day timeframe.

Mrs O'Connor further noted that work is progressing with the Patient Advice and Liaison Service to develop a more proactive approach to manage complaints. A number of complaints are currently progressing through formal processes, despite the potential for resolution through alternative, less formal means. All-Wales workshops are taking place to discuss the appropriate metrics and an update will be provided to Committee on the outcome and next steps.

Mrs O'Connor reported that as highlighted in the recent Ombudsman Report, the Health Board is performing ahead of other Health Board's in its response to, and evidence of, compliance with regulations on patient engagement and feedback. She agreed to provide further detail on key improvement and developments in relation to the revised regulations at the next meeting, within the context of the Quality Assurance Report.

LOC

Mrs O'Connor noted that further support is required in triangulating data, as current mechanisms are insufficient to fully meet the organisations reporting needs. This remains an area for development both locally and across Wales under the Once for Wales service initiative.

The Committee were further advised that a number of surveys developed through the CIVICA programme are informing Welsh Government policy, and benchmarking activities are ongoing. However, Mrs O'Connor acknowledged that substantial work remains in the area of complaints handling.

Additionally, Mrs O'Connor noted that the Welsh Risk Pool is providing valuable support in relation to the All-Wales Learning from Events framework and agreed to include further information on emerging themes and trends on a national level as part of the next update within the routine Quality Assurance Report.

LOC

Mrs Anna Lewis highlighted the importance of triangulating information and technology as a key consideration for the Health Board moving forward. She noted that further work is required on how reports are framed within the organisation. Mrs Lewis observed that while there is a wealth of information available across the Health Board, covering areas such as patient experience, finance and performance, careful consideration is needed regarding how this information is presented publicly through the website and how reporting can better reflect the perspective of patient feedback and what is being done in response.

Mrs Lewis queried whether the current 'enhanced dialogue' arrangements between the Health Board and HIW, designed to strengthen relationships, will continue or if the Health Board plans to move towards a less enhanced approach. In response, Mrs Daniel clarified, from a process perspective, engagement meetings with HIW are ongoing. These meetings take place every four months, in addition to biannual meetings involving the Chair and Chief Executive. While a breadth of engagement continues, the proposed frequency of meetings has been reduced. It was further noted that the Quality Assurance Team maintains regular contact with HIW.

Mrs Daniel also advised that HIW is recruiting new inspectors, which is expected to result in an increase in inspections and reports, helping to identify recurring issues for targeted improvements. Mrs Lewis further enquired whether any internal inspections or spot checks are being undertaken to identify issues prior to formal inspections taking place. In response, Ms Cathie Steele confirmed this is an area currently being explored by the Quality Assurance Team. She also noted the intention to involve the Patient Experience Team in the process, to support the proactive gathering of patient feedback.

Referring to the report's update on incidents, which notes that incident trends have stabilised between 120 and 200 a month, Mrs Lewis expressed concern regarding the significant gap between the highest and lowest figures. She queried whether this should be considered a stabilisation or whether the margin was too broad to support such a conclusion. Ms Lewis requested a review of the language used in the report and suggested that incorporating a Statistical Process Control (SPC) chart could provide more meaningful insights.

SA

Mrs Daniel agreed and emphasised the importance of not only reporting incidents but also applying thematic learning to address the root causes. She advised that the Clinical Care Groups are

establishing learning groups to identify themes and develop actions to support quality improvement. Mrs Lewis welcomed this approach and noted that it would be helpful for future reports to provide further detail on these developments.

Mrs Lewis questioned the reliability of the reported low C-Diff case numbers noting a previous Committee discussion on this issue. She also queried whether the reported reduction in August 2025 could be attributed to Health Board actions, or random variation.

In response, Mrs Daniel explained that the increase in cases observed in May and June 2025 was linked to a Norovirus outbreak, which led to increased testing and, consequently, higher case reporting. She also noted that the data demonstrated a seasonal pattern. Furthermore, she advised that a national review of C-Diff improvement strategies is currently underway across Wales.

Mrs Lewis requested an epidemiological perspective on the matter and queried whether their targets would align with Welsh Government standards or follow a different approach. Mrs Lewis expressed interest in a professional view on this issue. Ms Steele agreed to raise this matter at the Infection Prevention and Control Steering Group, where appropriate clinical and professional input could be sought.

CS

Decision: The Committee received assurance from the TI Progress Report.

QSEC 25 (57)

Assurance and Risk Report- Executive Leads

Mrs Joanne Wilson presented the Operational and Principal Risk report. It was noted that the Corporate Risk report will be presented at the next meeting on a rotational basis. A significant number of operational risks are aligned to the Committee, however Mrs Wilson advised that these are managed at Clinical Care Group (CCG) level. Ongoing audits and inspections have been shared with the Committee.

Mrs Lewis asked Members to reflect on how the Committee can effectively manage the scrutiny of such a significant number of risks, even with the assurance that these are being monitored at CCG level. Mrs Wilson proposed further discussions take place to explore an approach for QSEC to manage these risks.

Mrs Lewis recommended mapping the 32 extreme risks against Committee agendas from the past six months to identify any potential gaps in reporting.

JW

Referring to Risk 1290, and the increase in ADHD referrals and associate waiting times, Ms Harraway reflected on a recent discussion with the Children's Community Lead Nurse, during which it was indicated that there may be a delay between the transition from children's to adult services. Ms Harraway

expressed concern about the potential lack of support and access to medication for young people during this period and queried whether this is standard practice.

Mr Andrew Carruthers acknowledged the historical operational challenges associated with service transitions and confirmed that discussions are ongoing to improve collaboration between community, paediatric and mental health services to facilitate smoother transitions. He highlighted that challenges stem primarily from waiting times and capacity within adult services post-referral, rather than from any formal delay in the process.

Dr Ardiana Gjini provided some reassurance that this challenge has been recognised within the Health Boards Annual Report and recommendations and an action plan are in place through the Children and Young People Group to improve transition arrangements.

Ms Harraway suggested engaging with relevant teams, as there is a perception of formal delays. Mrs Lewis recommended clarifying whether this delay is due to protocol or capacity challenges and how the associated risk is being mitigated. Mrs Daniel proposed that this matter is explored further through a deep dive within the Quality and Safety Intelligence Group, with findings to be reported back at a future meeting.

SD

The Committee requested that the Executive Team, in advance of the Board meeting in November 2025, reflect on whether the current scoring would remain the same if the report were assessed from an impact-based perspective rather than a process-based one.

E.T

Decision: The Committee received assurance from the Assurance and Risk report.

QSEC 25 (58)

Cadog Ward Frailty Unit Nurse Staffing Presentation

Ms Sarah Williams and Ms Donna Major joined the meeting to provide an update on the recent changes implemented on Cadog Ward at Glangwili Hospital.

It was noted that on 13 May 2024, A Frailty Assessment Unit was established, and the new frailty pathway became operational, as a result, the Cadog Ward transitioned from a 20 bedded frailty ward to a reconfigured model consisting of a six-bed assessment unit and 14 short stay frailty beds. This also included the implementation of a pathway to support patients requiring longer term frailty care.

Ms Williams reported that the unit has benefited from a strong visual leadership presence, which has contributed to improved patient safety and more appropriate care. The changes have led to a reduced need for enhanced patient support and improved

overall patient outcomes. The Critical Care Outreach Team has provided valuable support and staff training.

It was highlighted that a 'Bay Watch' initiative has been introduced, which has contributed to a reduction in patient falls. There has been a significant decrease in the use of agency and bank nursing staff, with all staffing groups now fully recruited.

Ms Major further shared that the team is progressing a new pathway to support student nurses, particularly those with additional learning needs, to integrate into the workforce. This initiative has had early success. Additionally, the ward is running a successful apprenticeship programme.

The visual leadership model on the ward has been credited with supporting the early resolution of concerns and contributes to the overall success of the new model of care.

Mrs Lewis thanked Ms Williams and Ms Major for their presentation and referring to the incident and falls data, queried how the learning from this work could be shared across the wider organisation. In agreement, Mrs Daniel noted that Ms Helen Humphreys is leading on an All-Wales initiative regarding multi-disciplinary working and suggested that the examples presented today be included as part of the work.

The Chair, on behalf of the Committee, thanked Ms Williams and Ms Major for attending the meeting and for highlighting the multi-disciplinary nature of their work, which was recognised as particularly valuable. The Committee acknowledged the significant role that nurses play in patient care, noting that they are often the face of the organisation for patients and families.

In a context where attention is frequently drawn to challenges and areas for improvement, the Committee expressed appreciation for the excellent practice demonstrated, and commended both Ms Williams and Ms Major for their leadership and positive impact on patients and their families.

Decision: The Committee received assurance from the Cadog Ward Frailty Unit Nurse Staffing Presentation.

QSEC 25 (59)

Nurse Staffing Levels (Wales) Act Report and Impact of Reduction of Agency and Bank Staff on quality, safety and patient experience

Ms Helen Humphreys presented the key updates from the report and offered her apologies to Mrs Daniel for an error in Mrs Daniel title.

The report outlined the work undertaken over the last 12 – 18 months to assess the impact of the reduction in agency and bank staff on patient outcomes. An update on this work was previously provided to the People, Organisational Development and Culture Committee in October 2024 and monitoring in this area is ongoing.

The data presented in the report focused on the Community and Integrated Medicine Care Group, Planned and Specialist Care, and Mental Health and Learning Disabilities, as these areas have historically had higher usage of bank and agency staff. The analysis is intended to evaluate the impact of reduced reliance on temporary staffing.

Key quality measures monitored in the report include incidents of pressure damage, patient falls and medication errors. The data suggests an overall improvement in patient outcomes. While this improvement is attributable in part to the increased use of substantive staff- leading to greater continuity of care- it was acknowledged that other factors, such as targeted work to reduce pressure damage have also contributed. For example, recent work related to the Duty of Candour has included a specific focus on pressure damage and associated improvements.

Ms Humphreys further noted that although the increased number of substantive staff has contributed to a reduction in vacancy rates, it is recognised that some clinical areas now have a greater proportion of newly registered and inexperienced nurses. She emphasised that additional support will be required to help those newly registered and less experienced nurses fully integrate into their professional roles.

Mrs Patel sought clarification on the term 'adverse incidents' as presented in the report and questioned the basis for concluding there was 'no impact on patients'. She also noted previous concerns about staff reluctance to report incidents and enquired whether complaints data is triangulated as part of the process.

In response, Ms Humphreys confirmed that triangulation is undertaken during reviews and includes complaints, ward audit data results, and infection and prevention control incidents. It was clarified that adverse incidents refer to incidents of avoidable harm to patients, such as pressure damage or falls, classified as moderate harm or above.

Mrs Daniel explained that historical trends in incidents such as falls, pressure damage, and medication errors had been reviewed, and no significant increase had been observed since the reduction in temporary staffing.

Mrs Olwen Morgan acknowledged Mrs Patel's comments and noted that while no increase in reportable adverse incidents was identified, the reduction in clinical capacity may be impacting other areas, which are not measured by existing metrics.

Mrs Lewis highlighted previous staff survey findings showing concerns about psychological safety in reporting incidents and noted the importance of reviewing the results from the latest staff survey to assess improvement. Ms Eleanor Marks noted that despite supportive measures the issue is cultural rather than

procedural and although this lies within the remit of the People, Organisational Development and Culture Committee (PODCC). She stressed that both Committees have a role in the monitoring progress and would expect to see actions to address the cultural change.

Mrs Lewis suggested it would be beneficial for QSEC or PODCC to receive an outcome of the mitigations undertaken by management following the results of the most recent staff survey.

SD

In agreement, Ms Marks acknowledged the positive steps being taken to support staff in reporting incidents, however noted this appears to be a broader cultural issue. Ms Marks recommended that the PODCC review the actions taken as part of the cultural improvement plan.

Decision: The Committee received assurance that a review of the reduction of agency and bank staff initiative has not identified any adverse impact on the quality, safety, or experience outcomes of patients, however, this will continue to be closely monitored.

QSEC 25 (60)

Clinical Governance Arrangements – National Outpatients Plan Programme - Planned and Specialist Care Clinical Care Group

The Planned and Specialist Care Clinical Care Group update was deferred.

Ms Stephanie Hire joined the meeting to present the accompanying report which details the clinical governance arrangements in place within the first Outpatient Plan programme as part of the Welsh Government's commitment to reduce the planned care waiting list by 200,000 by March 2026, NHS Wales is implementing a national programme focused on accelerating access to first outpatient appointments. The Health Board's allocation within this programme is approximately 13,000 outpatient appointments. The insourcing company that has been awarded the contract to delivery these outpatient appointments is HBSUK.

Ms Lewis raised a query regarding the significant additional workload undertaken by the team, specifically enquiring to which activities have been deprioritised as a result. In response, Ms Hire advised that £200,000 in funding has been secured to support the programme, which has enabled the recruitment of a project manager and 3.5 whole time equivalent (WTE) staff. Despite this, she noted there has been a recent impact on the work for the Health Board's IT team due to increased technical support demands. Ms Hire also highlighted ongoing challenges with incomplete data submissions from HBSUK team which have been escalated at a national level.

Mr Carruthers reflected upon the programme, observing that while it enables patients to be seen more quickly, they are subsequently

transferred to treatment services waiting lists. He noted positively that the clinic has recorded a 1.5% 'Did Not Attend' (DNA) rate, indicating strong patient engagement, and suggested there may be learning to take from this. However, concerns were raised regarding the potential impact of the programme on the availability of bank staff for other services.

Decision: The Committee received assurance from the governance arrangements in place from the National First Outpatients Service.

QSEC 25 (61)

Unscheduled Care Deep Dive - Six Goals and Accelerated Transformation Programme

Ms Louisa Standeven joined to provide the key highlights from the Unscheduled and Emergency Care Programme Update including the following:

- The Community and Integrated Care Group remain at Level 3 internal escalation status. Analysis of recent incident reports and early data indicates a reduction in Emergency Department (ED) incidents and complaints within the latest reporting period.
- Positive developments have been noted following the Getting it Right First Time 'GIRFT' follow up review at Glangwili Hospital (GGH) ED particularly in relation to environmental improvements.
- Despite some progress, performance against ambulance handover targets in September 2025 remains a concern, with a significant proportion of patients waiting more than 12 hours. The next area of focus will be to support the improvement of patient flow through the system.
- A detailed improvement plan has been developed in response to HIW inspection of GGH ED, which took place on 2 and 3 September 2025.

Mrs Daniel highlighted that current performance metrics are largely time focussed, and there is a recognised need to transition towards outcome focused indicators. Appreciation was expressed to Ms Standeven for her ongoing commitment in delivering improvements in the 'Care after Death' service, noting that the family support room has been significantly refurbished, resulting in a much-improved environment.

While improvements in timeliness of patient care were noted, Mr Carruthers cautioned creating the impression that challenges within urgent and emergency care have been fully resolved. He emphasised that the larger strategic programme of work is still required to address system wide challenges. It was further noted that improvements in urgent and emergency care have in some cases exerted pressure on areas of the system. Mitigating these

associated risks will form a key area of work for clinical executives as part of the next steps.

The improvements achieved to date has come at a considerable cost to staff, particularly in terms of their personal time. A key learning point identified is the need to move towards a sustainable 7-day service model, incorporating a streaming hub and rapid community response services. There is strong commitment and momentum to drive this transition forward.

Decision: The Committee received assurance from the quality governance arrangements in place within the Unscheduled Care Deep Dive - Six Goals and Accelerated Transformation Programme in relation to quality, safety and patient experience.

QSEC 25 (62)

Public Interest Report- Verbal

Mrs Daniel provided a verbal update on the Public Interest Report issued in relation to the Health Board's failure to provide ongoing specialist care for epilepsy for patients with a learning disability, following the cessation of the dedicated service in June 2021. The report outlines the significant impact on patients' complex needs and their carers, noting that, four years on, a clear pathway to specialist care has not been implemented.

A written apology has been issued to the affected families relating to poor communication. The report includes a number of recommendations, and in response an action plan has been developed with defined timescales. Progress will be monitored through the Health Board's internal governance processes.

Mrs Daniel proposed that the Committee receive a further update in February 2026, following the report to Public Board in November 2025. This was agreed by the Committee.

**AC/
LC/
RTP**

Decision: The Committee noted the verbal update on the Public Interest Report.

QSEC 25 (63)

Quality Assurance Report

Ms Steele presented the key highlights from the Quality Assurance Report and noted that many routine updates had been addressed under other agenda items. However, drew attention to recent HIW reports which required immediate assurance following inspections. In response, significant work is being undertaken by Heads of Nursing and the senior team to implement improvements including spot checks. Ongoing learning and monitoring of related actions plans are being managed through the Health Board's internal governance processes.

The Committee noted the inclusion of the Public Services Ombudsman of Wales (PSOW) report. It was reported that in 2024-25, Hywel Dda's intervention rate for complaints was 33%, a

slight decrease from the previous year. However, the overall complaints rate remained above average.

The Committee held a discussion on the role and accountability of leadership within the Health Board in upholding standards of quality, safety and patient experience.

Decision: The Committee took assurance that processes are in place to review, monitor and improve the quality of Health Board services as outlined within the Quality Assurance Report.

QSEC 25 (64)

Criteria 2 Quality Impact Assessment Related Planning

Mrs Daniel presented an overview of the proposed process for assessing the impact of savings schemes being progressed under Criteria 2. Mrs Lewis suggested that the assessment approach should align with the process previously undertaken for 'Category 1' savings schemes. This would include the development of a summary slide outlining the impact of each proposal, following discussion at the Quality, Impact Assessment Panel.

SD

Mrs Lewis understands that a Finance and Performance Committee review each of the proposals in detail. This approach was supported by the Committee.

Decision: The Committee noted the process for assessing the quality impact of the proposed saving schemes and received assurance that any changes being considered have appropriate governance, scrutiny and mitigation arrangements in place.

QSEC 25 (65)

Temporary Service Changes in Ceredigion Community Mental Health Team

Ms Amanda Davies presented key updates following the temporary service changes to the community mental health pathways in Ceredigion. The update intends to provide assurance that there has been no adverse impact on patients accessing the service, ahead of seeking Board approval in November 2025 for a more sustainable long term proposal.

Ms Davies noted that, in response to GP feedback, an enhanced patient pathway has been implemented via the NHS '111' telephone service.

Mrs Lewis raised concerns about an apparent discrepancy in the report, which notes an increase in hospital admissions, while also stating there has been no impact on patients. She asked for clarification on how these statements align. In response, Ms Davies explained that while there has been no evident change in the number of referrals to the service, a localised increase in hospital admissions has been observed. Ms Lewis requested that this be explored further ahead of the November 2025 Board meeting.

AD

Miss Jill Patterson highlighted that some GP's have reported feeling disengaged from the service changes, a concern previously raised with the Associate Medical Director, Mental Health and Learning Disabilities following the last Public Board meeting. Ms Davies provided assurance that a face-to-face meeting has been arranged with local GP's to gather their views. Clarity on the consultation feedback from Local GP's on the impact of the changes will be included in the report for Public Board in November 2025.

Decision: The Committee received assurance from the content of the Temporary Service Changes in Ceredigion Community Mental Health Team Report.

QSEC 25 (66)

Occupational Therapies Paediatric Improvement Action Plan

Ms Sara Quarrie provided an update on the action plan addressing waiting times within Paediatric Occupational Therapy service, as outlined in the accompanying report.

Ms Harraway expressed interest in the evaluation tool referenced within the report, and the additional service capacity it has enabled. Ms Quarrie advised that this tool was informed by learning from another Health Board's activity and agreed to discuss the details further with Ms Harraway outside of the meeting.

SQ

The Committee noted the limited progress on the action plan since previously reported. Ms Quarrie explained that staff absences had contributed to delays and that a targeted piece of work had been undertaken to assess the current demand and capacity position. She emphasised that this remains a priority and confirmed her willingness to provide a further update at a future Committee meeting, as appropriate.

It was agreed to advise the Board that limited assurance was received on the progress made to date.

Decision: The Committee received limited assurance from the progress made on the Occupational Therapies Paediatric Improvement Action Plan, aimed at developing a future delivery model that achieves sustained improvement and reduces waiting times for all children to below the 14 week target.

QSEC 25 (67)

Maternity and Neonatal Assessment

Ms Cerian Llewellyn provided an update on the All Wales National Assessment of Maternity and Neonatal Services and recommendations. The methodology being applied aligns to approach previously implemented within the Swansea Bay

University Health Board. This approach has enabled the Health Board to conduct a detailed benchmarking exercise and to identify two key areas for prioritisation including service user engagement. Mrs O'Connor and the Patient Experience Team were formally thanked for their valuable support in this area for perinatal services.

It is anticipated that the Cabinet Secretary will require an update on the progress of the recommendations arising from the assessments at the end of November 2025.

Decision: The Committee received assurance from the steps taken to assess the safety and quality of services in light of the findings from the Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board.

QSEC 25 (68)

Listening and Learning Sub Committee Update Report

The Committee was informed that, as the next meeting is scheduled for 10 November 2025, no update is currently available.

For Information

- **QSEC Work Plan 2025-26**
- **Date of Next Meeting : 4 December 2025**

**TABLE OF ACTIONS FROM
QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSEC) MEETING
HELD ON 9 OCTOBER 2025**

Reference	Item	Responsible	Timescale	Update
QSEC 25 (55)	Matters Arising: To review and clarify guidelines or requirements for the quality and timeliness of reports submitted to the Committee, to support consistency going forward	SD/ JW	4 Dec 2025	Complete
QSEC 25 (55)	Table of Actions: To report back findings from additional questions asked at engagement events to try to ascertain why the patient experience feedback from ethnic groups varies from other groups from the demographic data.	LOC	4 Dec 2025	In Progress: The Equality and Diversity Team is undertaking a series of community engagement events. It has been agreed that additional questions will be incorporated into these events to capture further feedback relating to the experiences of care and related concepts. The outcomes of this engagement will be reported back to the Committee when available.
QSEC 25 (57)	Principal and Operational Risks: To map the 32 extreme risks against Committee agendas from the past six months to identify any potential gaps in reporting.	JW	4 Dec 2025	Complete and will be discussed during the agenda setting for February 2026 meeting.
QSEC 25 (57)	Principal and Operational Risks: To seek clarity on the concerns raised regarding 6 months gap during transition for young people with ADHD between children and adult services to clarify the reasons, and how the risks for young people are mitigated via a	SD	Nov 2025	Complete: Deep Dive Scheduled for Quality, Safety Intelligence Group due to be held in December 2025

		deep dive at Quality and Safety Intelligence Group.			
QSEC 25 (56)		• Targeted Intervention Report: To report back via the Quality Assurance Report emerging themes and trends from the All-Wales Learning from Events framework on a national level.	LOC	4 Dec 2025	Complete
QSEC 25 (56)		• Targeted Intervention Report: To request a professional view on the targets set by Welsh Government on Healthcare Acquired Infection rates via Infection Prevention Control Steering Group (IPSSG).	CS	4 Dec 2025	Complete: IPSSG scheduled for 25 November 2025.
QSEC 25 (59)		• Nurse Staffing Levels (Wales) Act Report: To share the outcome of the mitigations undertaken by management in response to concerns raised regarding psychological safety of staff reporting incidents following the results of the most recent staff survey.	SD/ CS	12 Feb 2026	In progress
QSEC 25 (62)		• Public Interest Report: To forward plan an update on the actions undertaken in response to the Public Interest report relating to Epilepsy Services for patients with a Learning Disability.	AC/ KI	12 Feb 2026	In progress: There is a five point plan in the Public Interest Report that is in progress. All actions require completion in November 2025 or January 2026 and all are on track for completion. The plan is managed by the Ombudsman Case Manager, Learning Disability Service and the LD Epilepsy Task and Finish Group in respect to responsibility to complete the required actions.

QSEC 25 (64)	Criteria 2 Quality Impact Assessment Related Planning: To align the assessment approach with the process previously undertaken for 'Category 1' savings schemes. This would include the development of a summary slide outlining the impact of each proposal, following discussion at the Quality, Impact Assessment Panel	SD	16 Dec 2025	Complete: QSEC advised discussion at Finance & Planning Committee in October 2025
QSEC 25 (65)	Temporary Service Changes in Ceredigion Community Mental Health Team: To explore in more detail the localised increase in hospital admissions that has been observed and to also clarify local GP feedback following the temporary service change ahead of Board in November 2025.	AD	27 Nov 2025	Complete: Planned attendance to North and South Collaborative meetings in November North Meeting on 20 th November and South Ceredigion on 26 th November to engage with GPs within the practices to obtain local GP feedback

SD: Sharon Daniel	JW: Joanne Wilson	LOC: Louise O'Connor	CS: Cathie Steele	AD: Amanda Davies	SA: Shaun Ayres
AC: Andrew Carruthers	KI: Kay Isaacs				

1.3

1.3 - Assurance and Risk Report - Executive Leads

Attachments

[QSEC CRR WHC MD Report FINAL 27112025.pdf](#)

[Appendix 1 - QSEC CRR - 26Nov25.pdf](#)



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Assurance and Risk Report

Quality, Safety & Experience Committee – 4 December 2025

This report provides the Quality, Safety & Experience Committee (QSEC) with the status of the Corporate risks, Welsh Health Circulars, and Ministerial Directions within its remit.

The Committee is asked to seek assurance from the Lead Executive Directors that risks are being managed effectively, and that recommendations from Audits and Inspections are being implemented by the Health Board.

Principal risks, Operational Risks, and Audit and Inspections recommendations are reported at alternate meetings, and due to be presented to QSEC at its next meeting in February 2026.

Corporate Risks:

10

Welsh Health
Circulars

23

Ministerial Directions

5

Risk Management - Overview



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Effective risk management requires a ‘monitoring and review’ structure to be in place to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.

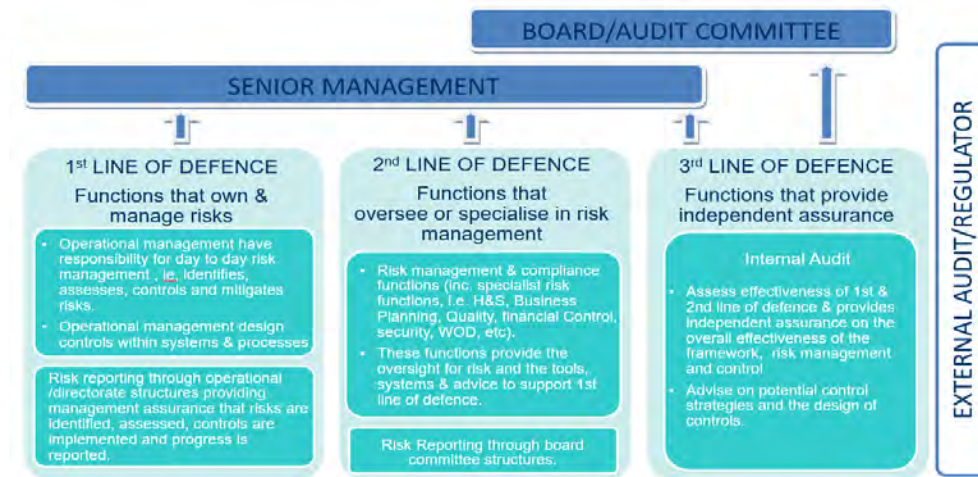
The Health Board’s risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either Principal, Corporate or Operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval processes and governance arrangements.

The Health Board operates within the widely accepted “Three Lines of Defence” model to ensure the appropriate responsibility is allocated for the management, reporting and escalation of risk.

Risks are aligned to an appropriate Clinical Care Group or Executive Function (hereto referred to as “Functions”), and each has a designated risk lead responsible for reviewing in a timely and comprehensive manner.

The Board’s Committees are responsible for the monitoring and scrutiny of corporate and operational risks within their remit and providing assurance to the Board that risks are being managed effectively and report areas of significant concern (eg where the risk appetite is exceeded, or there is a lack of action).

Committees are also responsible for reviewing risks over tolerance and where appropriate, recommend the ‘acceptance’ of risks that cannot be brought within risk appetite.



Corporate Risks Assigned to QSEC



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Hywel Dda Risk Heat Map					
	LIKELIHOOD →				
IMPACT ↓	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5			1531 (→) 1810 (→) 1859 (→)	1027 (→)	797 (↑)
Major 4				684 (→) 1664 (→) 2190 (NEW)	1032 (→) 1552 (NEW)
Moderate 3					
Minor 2					
Negligible 1					

Each risk on the Corporate Risk Register (CRR) has been mapped to a Board level Committee to ensure that risks on the CRR are being managed appropriately, taking into account gaps in controls, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

These risks have been identified by individual Directors via a top down and bottom-up approach and are either:

- Associated with the delivery of the Health Board objectives; or
- Significant escalated operational risks that are of significant concern and require corporate oversight and management.

There are 10 risks currently aligned to QSEC of the 23 that are on the CRR as of 24 November 2025.

The following slides provides a summary of the changes to the risks aligned to QSEC since the report submitted previously to in August 2025, and detail on the reportable corporate risks.

The Corporate Risk Register attached at **Appendix 1**, provides full detail of the risk, including control measures in place, a risk action plan to further manage and mitigate the risk, and sources of assurance.

Corporate Risks Assigned to QSEC – changes since previous meeting



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Risk	Clinical Care Group / Lead Executive	Nature of Change	Reason for change
1708 - Risk of increasing fragility in primary care contractor services due to external factors	Primary, Community Strategy and Long-Term Care: Primary Care <i>Chief Operating Officer</i>	De-escalated to operational risk register (August 2025)	As agreed at Formal Executive Team, risk de-escalated as whilst there will always be a risk of contract terminations across the Primary Care contractor professions, the Health Board have a statutory duty to deliver services in line with Regulations and Directions, and issues are managed when they arise.
1552 - Risk of insufficient mortuary capacity due to current and anticipated future demand	Operational Allied Health Professions and Health Sciences: Pathology <i>Chief Operating Officer</i>	New risk (November 2025)	Full risk is included in Appendix 1 to this paper, and summarised here
2190 - Risk of delay in CHC direct payments due to short timescale, limited resources & lack of WG policy guidance	Primary, Community Strategy and Long-Term Care: Long Term Care <i>Chief Operating Officer</i>	New risk (November 2025)	Full risk is included in Appendix 1 to this paper, and summarised here
797 - Risk to the ability to deliver ultrasound services due to workforce pressures	Operational Allied Health Professions and Health Sciences: Radiology <i>Chief Operating Officer</i>	Increase in current risk score from 20 to 25 (October 2025)	Full risk is included in Appendix 1 to this paper, and summarised here

Corporate Risks assigned to QSEC

(1 of 10)



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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1552 – Risk of inadequate body storage capacity across Health Board mortuaries due to current and anticipated future demand	Chief Operating Officer	20 (NEW) (Reviewed 19/11/25)	8	31/08/2026
Rationale for Current Risk Score				
The Health Board is exposed to significant risks resulting from insufficient mortuary capacity across its estate. The ongoing dependence on temporary body storage, particularly during periods of excess deaths, presents challenges in maintaining regulatory compliance, protecting staff wellbeing, ensuring safe manual handling practices and upholding the dignity of the deceased. The current infrastructure risks non-compliance with Human Tissue Authority (HTA) standards. According to Office of National Statistics (ONS) projections, the death rate is expected to rise, peaking in 2044, further intensifying these pressures. Suboptimal facilities may lead to compromised presentation of the deceased, increased emotional distress for families, and safety concerns for mortuary staff, especially manual handling. While control measures are in place, they are not sufficient to manage the current volume of deaths within the mortuary service, particularly during periods of heightened demand. These control measures should serve only as temporary contingencies, in line with the HTA licence however, there is a growing need for enhanced storage capacity throughout the year, not solely during seasonal peaks. Current body storage provisions do not meet operational requirements, and there is limited flexibility to respond to unplanned disruptions, such as those involving Medical Examiners Service, His Majesty’s Coroner Service, or Post-Mortem Service interruptions. Furthermore, the extremely constrained footprint of the mortuary estate significantly restricts opportunities for external expansion or enhancement.				
Rationale for Target Risk Score (TRS)				
Target score is based on successful outcome from Body Storage Capacity paper being escalated via CCG to IQFPD in June 2025. Funding stream discussed with Executive Director of Finance in July 2025 along with further meetings and support from the Health Board's finance and planning team to ensure a long-term sustainable solution is implemented as soon as reasonably possible. Assurance has been provided by the Executive Director of Finance that financial support will be received to enact the short-term measures to ensure appropriate capacity is available for the approaching winter pressure period. Further discussions will be held with finance and planning colleagues to discuss medium- and long-term mitigating plans. Long term solution need to be sustainable and future proof to ensure the target risk score is achieved and maintained. TRS and expected date to achieve have been agreed by Formal Executive Team in November 2025				

Corporate Risks assigned to QSEC (2 of 10)



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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2190 – Risk of delay in CHC direct payments due to short timescale, limited resources & lack of WG policy guidance	Chief Operating Officer	16 NEW (Reviewed 20/11/25)	12	31/03/2026

Rationale for Current Risk Score

There is a lack of clarity and national guidance regarding the proposed model for the delivery of Direct Payments, and the time available for implementation which has reduced significantly with proposed date of implementation brought forward from December 2026 to 1 April 2026. There are serious concerns that governance and safety requirements will not be adequately established to meet the revised implementation date, which may increase the risk of inconsistent approaches across Health Boards. The Health Board does not currently have a system in place to manage or deliver Direct Payments in order to comply with the requirements of the forthcoming policy. Robust governance systems have yet to be developed, and there is a notable absence of dedicated resource, and specialist expertise. Delivery within such tight time scales will require additional resources, with a small core of dedicated staff based within a national Hub supported by professional and financial expertise. Each Health Board will also be expected to put in local arrangements to support delivery at a local level. Without additional resources, staff may be unable to allocate sufficient time to support implementation alongside existing duties.

Rationale for Target Risk Score (TRS)

A dedicated local resource is needed to meet legislative requirements by 1 April 2026. Clarity is needed from Welsh Government over guidance and implementation plans to enable robust governance and safety requirements. All Health Boards in Wales require a consistent approach to direct payments. Whilst the implementation date is end of March 2026, there is no certainty that this can be achieved without the additional governance and resources.

Corporate Risks assigned to QSEC

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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
797 – Risk to the ability to deliver ultrasound services due to workforce pressures	Chief Operating Officer	25 (↑) (Reviewed 26/11/25)	12	~~31/07/2027~~ 30/03/2030
Rationale for Current Risk Score				
This risk was escalated from 20 to 25 in October 2025 due to increased fragility in available workforce (2.0WTE retirement notice given Jan 2026). In November 2025 a full risk review of all elements took place with Radiology and CCG leadership. Patient outcomes = delays to scans resulting in delays to treatment or death (cancer and maternity pathways) Workforce outcomes = staff harm from RSI resulting in long term injury from too much scanning of similar types (unable to job plan appropriately due to demand and vacancies). Quality, complaints and audit - (5) Totally unacceptable level or quality of treatment/service. *due to waiting times (see below) patients on maternity and cancer pathways are waiting too long for scans required for intervention Gross failure of patient safety if findings not acted on. *concerns regarding non compliance with Welsh Maternity screening targets Gross failure to meet national standards / performance requirements. As at 25 November 2025: *Waiting times non-interventional ultrasound are up to 23 weeks *Interventional ultrasound 52 weeks *Vascular ultrasound is not available 7 days a week Probability = >95%. If insourcing capacity cannot be secured from the 1st January 2026 the service will no longer be able to sustain a safe baseline capacity to provide routine and urgent non-obstetric imaging alongside obstetric scanning Monday to Friday, 09:00–17:00 on the WGH site.				
Rationale for Target Risk Score (TRS)				
Impact of service failure remains the probability of service failure is the aim of mitigating actions. Probability target of 25-75%. In November 2025, the target date was reviewed and extended. Justification for this change is the timeline for Radiology Leadership OCP and recruitment to bring in the leadership required to mitigate the gaps in controls thus requires extended timelines due to pathways changes and training timelines.				

Corporate Risks assigned to QSEC

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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1027 – Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Chief Operating Officer	20 → (Reviewed 12/11/25)	8	31/03/2026 31/10/2026

Rationale for Current Risk Score

Levels of urgent and emergency care (UEC) pathway capacity pressures continue at significantly escalated levels. Workforce deficits, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating lack of sustainable improvement. The situation remains at high levels of risk escalation across our acute sites daily. The Front Door Reset week in September 2025 has shown improvements in Ambulance handover delays but this will be challenging to sustain in the longer-term.

Whilst some positive progress has been achieved in reducing ambulance handover delays and getting the scores for this domain below Targeted Intervention (TI) expectations in the last couple of months, the other key metrics remain outside TI requirements. Despite a trend line indicative of slight improvement over the year, October 2025 has 8.5% of people waiting > 12 hours in an ED. This is above the TI target of 6% and up from 8% in September 2025. For Emergency Department (ED) assessment waits, October's average is 78 mins which is above the TI target of 60 and an increase on September's average. Over the year the trend has been fairly static for this metric and has not met TI targets. Finally, Pathway of Care Delays (PoCD) in October were 258, above the TI target of 174. PoCD has shown an increasing trend over the last year and remains the most challenging TI metric for the Health Board currently. Work is ongoing with Local Authorities to try and improve the position, as well as internal actions such as ongoing front door reset actions and the making everyday count reset week. Notable actions from these include a focus on redirection policy, community staff integration into sites, optimisation of discharge lounge and more senior leadership presence in board rounds.

Rationale for Target Risk Score (TRS)

The target risk score of 8 reflects the confidence in the delivery of 6 Goals Programme and the Accelerated Transformation Programme to address the significant issues across the health and care system.

Plans for improvement during 2025/26 are reflected in the HB's Annual Plan, approved by the Board in March 2025, and are informing next year's Annual Plan. The 6 goals plan was approved by WG in March 2025. TI measures such as ambulance handovers and 12 hour delays in ED will need to improve in order to reduce the current risk score, for a consecutive period of three months. UEC Transformation Acceleration Group (TAG) meeting weekly and reporting fortnightly into Formal Executive Team.

An expected date of March 2026 had been noted to achieve the target risk score of 8, to allow the transformation change to embed. The embedding of 7-day Clinical Streaming and SDEC services will be thought to significantly impact on patient flow and a business case for this is planned to go to Public Board in January 2026 for discussion. If approved time will be needed for recruitment and embedding of services, as such it is expected that there will may be a delay in hitting the March 2026 target score of 8. The expected date to achieve TRS amended to 31 October 2026 on risk review in November 2025.

Corporate Risks assigned to QSEC

(5 of 10)

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1032 – Risk of timely ASD diagnostic assessment for children and young people due to increasing demand	Chief Operating Officer	20 → (Reviewed 11/11/25)	16	Not known

Rationale for Current Risk Score
Significant waiting times have developed as a result of exponential demand. Demand outstrips capacity, with year-on-year increase in referral rates. Current team capacity can only accommodate 11% of total demand, compounded by current funding arrangements which are non-recurring, making recruitment and service delivery challenging.
Rationale for Target Risk Score (TRS)
The Clinical Care Group has prioritised implementation of Patient Administration System for Wales (WPAS) in Children's Autism Spectrum Disorder (ASD) service which has enabled improved reporting and waiting list management and to determine trajectories of improvement in waiting times. While trajectory plans are in place, the Health Board has recognised Welsh Government (WG) targets will not be achieved by the service in its current format, with a further deteriorating position in performance anticipated, compounded by the end of procurement contracts with external providers in March 2025. The achievement of the target risk score is dependent on WG ring-fenced funding being made available on a recurrent basis, being exempt from cost savings initiatives 2025-2026 to maximise opportunities to outsource diagnostic assessments this financial year, service re-design and waiting list initiatives are completed and implemented. Furthermore, the development of a regional, collaborative strategic approach with key stakeholders is imperative to creating whole system, needs-led integrated services. Digital enablers such as artificial intelligence and licenses for digital platforms essential along with access to appropriate clinical venues essential to help reduce the current risk score to the target risk score.

Corporate Risks assigned to QSEC

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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
684 - Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Chief Operating Officer	16 → (Reviewed 18/11/25)	8	Not Known

Rationale for Current Risk Score

The Health Board’s aged imaging equipment continues to break down, disrupting diagnostic services and affecting Referral to Treatment (RTT) targets, with delays in diagnosis and treatment for patients. Replacement of CT and MRI scanners has reduced downtime, but recurrent failures of other key equipment highlight the need for further investment. A rolling programme and prioritisation process are in place to manage installations.

The Gamma camera at Withybush General Hospital (WGH), the only unit of its kind in the Health Board, has suffered repeated breakdowns, leading to HIW-reportable IRMER incidents. It remains a priority for replacement as of February 2025. At Glangwili, a new CT scanner has been installed, but the original unit continues to fail due to outdated technology, undermining resilience at the major trauma site. Like-for-like replacement is not always cost-effective or compliant with regulatory and warranty requirements, and infrastructure upgrades—such as air handling, water chillers, and accommodation adjustments—are needed to ensure long-term resilience.

Replacement of the Gamma camera at WGH has been delayed due to insufficient physical space and electrical infrastructure, with costs exceeding Welsh Government allocations for 2025/26. The funding window has closed, further impacting compliance with Natural Resources Wales (NRW) specifications for Nuclear Medicine. Future plans must be coordinated with Estates to expand electrical capacity and ensure facilities meet current and future Nuclear Medicine requirements.

Rationale for Target Risk Score (TRS)

Modern equipment will reduce the likelihood of breakdowns, minimize downtime, and lessen the impact on diagnostic services across other hospital sites. Strengthened business continuity planning will further mitigate risks associated with equipment failure. However, funding is typically released in Q3/Q4 of the financial year, constraining the scheduling of large installations. The urgency of replacements often forces rapid decisions, resulting in lower-priority equipment being replaced ahead of higher-need installations.

The Health Board’s top replacement priority is the Nuclear Medicine SPECT scanner, the only unit available which has suffered frequent breakdowns since June 2023. A task and finish group has been convened to plan its replacement in anticipation of Welsh Government funding. The second CT scanner at GGH is the next priority, as it supports outpatient work and serves as a backup; it is increasingly unreliable, with long lead times for parts. Additionally, service variation in DEXA provision has worsened, as the Swansea scanner now performs Trabecular Bone Scoring (TBS), while the BGH scanner cannot. Patients have required repeat scans to obtain TBS results, and the BGH unit also runs on an unsupported Windows version, posing further risk.

Replacement of the Nuclear Medicine SPECT-CT, the second CT scanner at GGH, and the DEXA scanner at BGH would allow risks to be de-escalated to the operational risk register. Completion is dependent on WG funding and may extend to the end of the financial year due to infrastructure requirements.

Corporate Risks assigned to QSEC

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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1664 – Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Chief Operating Officer	16 → (Reviewed 20/11/25)	8	31/03/2027

Rationale for Current Risk Score

Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for R1 patients (high risk) with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity.

The service has provided additional age-related macular degeneration (AMD) sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board. Patient delays continue across the Health Board. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. The current R1 delivery at 34%. The WG target for R1 delivery is 95%.

The current waiting list for new patients is 15,074. The service is expected to reach 0 patients waiting at stage 1 over 52 weeks by March 2026. The stage 4 104 weeks, is breach of 8. 7,518 patients have been 100% delayed for their follow up appointment.

The current impact has been scored as 4 because patients are experiencing harm and the current likelihood has been scored 4 as ophthalmology is a fragile service. It is unlikely that this risk will be able to be significantly reduced without considerable investment.

Rationale for Target Risk Score (TRS)

The service has been able to reduce the impact score of this risk as whilst the consequences to the patient remains high, recurrent funding has been invested into the service for the delivery of an R1 Eye Care Measures target of 65%. The Ministerial Measures target will need to be 0 for 3 consecutive months, and the Follow up delayed will need to be reduced by 12%. Once these targets are reached, the likelihood score can be reduced to a 3 which would reduce the overall score to 12. The 65% R1 delivery by September 2026 is dependent on all posts being recruited into and all estates needs being met. Further development would be required to reach a 95% R1 delivery score, which would reduce the likelihood to a 2.

With the required investment in Glaucoma and IVT and the additional workforce and estates and continued management of the waiting lists, the HB will potentially be able to reduce the likelihood score on this risk to a 2.

Corporate Risks assigned to QSEC

(8 of 10)



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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1810 - Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	Chief Operating Officer	16 → (Reviewed 03/11/25)	10	30/09/2026 31/12/2026

Rationale for Current Risk Score

Withybush Aseptic Unit is the only remaining aseptic unit in the Health Board capable of producing cancer treatments. However, it is currently non-compliant with regulatory standards. A 2024 audit deemed it a high risk to patient safety, and a 2025 follow-up confirmed ongoing staffing issues and insufficient resources to maintain quality standards, putting the unit at risk of forced closure.

Temporary control measures have been implemented to reduce microbial contamination and delay closure (see control measures), but the aging infrastructure means these measures may soon become ineffective. If contamination increases, the unit may be forced to close. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality.

Rationale for Target Risk Score (TRS)

The target risk score is based on the premise that a new demountable aseptic unit will be built at Withybush in 2026. The unit would be compliant with regulatory standards and once operational, it would be extremely unlikely for the unit to be forced to close. A new unit would allow the Health Board to continue to safely prepare cancer therapy until the TrAMS South West manufacturing hub is operational.

It is anticipated that the current risk score could be reduced to 10 once the unit is operational, expected to be September 2026. Achievement of the Target Risk Score of 5 is expected once workforce fragilities have been addressed, anticipated to December 2026.

Corporate Risks assigned to QSEC

(9 of 10)

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1531 - Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Chief Operating Officer	15 → (Reviewed 28/10/25)	5	27/02/2026

Rationale for Current Risk Score

Whilst surgical consultant on-call rotas at GGH and WGH are covered, the service is still reliant on NHS locums and agency locum consultants. This situation will remain the same until substantive upper GI consultants are recruited to address the emergency on-call rota risk and the Upper GI service risk at WGH. Recruitment has been successful to the substantive post at GGH with the candidate commenced in post. One post has been successfully recruited to at WGH with the applicant onboarding, and the second post re-advertised as of November 2025. It is anticipated that both will have fully onboarded by February 2026.

Rationale for Target Risk Score (TRS)

The target risk score is based on the work currently being undertaken as part of the Clinical Services Plan to identify and approve a more sustainable solution in order to reduce the likelihood of rota collapse and reduce the risk of not being able to provide a safe and sustainable emergency general surgery service to patients in the south of the Health Board. The effectiveness of revised rota arrangements will depend on several factors including availability of a labour market.

Achievement of the target risk score is dependant on the outcomes of the Clinical Services Plan which will inform future plans or the successful appointment of substantive upper GI consultants to the current model at WGH.

The risk score will reduce on the appointment of substantive consultants. Should the service be able to recruit suitable candidates to the three upper GI substantive posts, it is anticipated that they rotas at GGH and WGH will be fully functioning by February 2026.

Corporate Risks assigned to QSEC

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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
1859 - Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Chief Operating Officer	15 → (Reviewed 04/11/25)	10	31/12/2025

Rationale for Current Risk Score

There were specific concerns relating to Glangwili and Withybush General Hospitals regarding cardiac arrests and unplanned admissions. There was an increase in cardiac arrest rates in GGH in the period Jan-Dec 2024 (35) compared to the same period Jan – Dec 2023 (20). The first 10 months of 2025 noted a decrease in the Cardiac Arrest rates in GGH compared to the same period 2024, with 20 noted (2024:30).

There had been a 22% increase in unplanned admissions at WGH in 2024. In the first 8 months of 2025 there has been a reduction in the number of unplanned admissions into WGH ITU compared to the same period in 2024 (Jan–August 2025:50 (2024:67)).

As of 8th August 2025, compliance rates for Level 3 Resuscitation Training Adults is 64%, Paediatrics 45%, and Level 2 Training (BLS) is at 51% for adults, and 48% for Paediatrics, an improved position since June 2025. All planned actions to mitigate the risk are being processed within set dates/timeframes although many remain long term.

Current controls are managing the risk and the increasing awareness of gaps in assurance and local actions to mitigate and manage the risk have been established.

Rationale for Target Risk Score (TRS)

The full implementation of the actions noted in the risk action plan will support the reduction in the likelihood and impact score of this risk to a target risk of 10. With recruitment into the Resus Team and the establishment of a supported Cascade Training process the aim will be to see an increase in training compliance in both Level 2 & Level 3 training by October 2025 to >60%. This will enable the risk to be reduced to the Target Risk Score of 10, >85% would enable the risk score to be reduced further to 5. We will aim to see a reduction in Cardiac Arrest rates across all 4 sites and unplanned admissions into ITU from ward areas by October 2025.

Implementation of Welsh Health Circulars (WHCs)



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There are 23 open WHCs aligned to QSEC as at November 2025. 3 new WHCs have been issued since the previous report to Committee.

All WHCs are managed via the Audit Management and Tracking system (AMaT), which gives leads direct access to update and upload relevant evidence to demonstrate compliance with their requirements. Each Welsh Health Circular (WHC) is assigned a status category. The table below outlines the definition of each category, the number of WHCs assigned to each as of November 2025, and the number completed since the previous report. To provide a more accurate reflection of WHC progress, three new status categories have been introduced since the last Committee report. Definitions for these new categories are included in the table below.

Status Category	Definition	Number of WHCs
Overdue	The WHC is behind schedule to the timescale provided by the Lead officer or as stipulated in the WHC, or a plan (with date for implementation) is not yet in place.	3
Unable to Complete (NEW)	The WHC cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	1
Pending Decision (NEW)	The WHC is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the WHC is overdue or not whilst decision pending.	3
In Progress	The WHC is currently in progress, and within the agreed original timeframe for implementation.	9
Reliant on External Factors	The WHC is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	2
Complete Pending Formal Approval (NEW)	The Service / Function have completed the WHC and are currently awaiting formal approval to close.	4
Complete	The WHC has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	1

Oversight of the delivery of WHCs has been included in new Clinical Care Group (CCG) Terms of Reference, with the requirement to escalate appropriately instances of non-compliance.

The timely implementation of WHCs is included within the Governance domain of the Health Board's internal escalation framework, with services escalated in instances of non-compliance.

WHCs - Overdue



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Name of WHC	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Red Status	Impact of non-compliance according to risk assessment	Next Steps
004-22: Guidance for the provision of continence containment products for children and young people: a consensus document Issued October 2022	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Original implementation date not met Original Completion Date: 31/07/2023 Revised Completion Date: 31/01/2026	Risk Ref: 1615 Current Risk Score: 12 Impacts: Right to independence for children and young people; Access to the same services as their peers	A Specialist Nursing post that will enable the Clinical Service Group to demonstrate compliance with the requirements of this WHC has been approved by Financial Control Group. Interviews for the position took place in October and an offer of employment has been made. The timeline for implementation has been set as January 2026 to account for the Specialist Nurse to commence in the role.
019-22: Non Specialised Paediatric Orthopaedic Services Issued June 2022	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Original implementation date not met Original Completion Date: 30/04/2025 Revised Completion Date: Not Known	No risk noted on Datix.	The Trauma and Orthopaedics Service Leads are in the process of drafting a Maturity Matrix to address the requirements of this WHC. The Maturity Matrix will need to be dealt with by multiple CCGs due to the requirements set out in the Service Specification relating to this WHC. Once the Trauma and Orthopaedics Service Leads have completed their elements of the WHC, the WHC can then be re-assigned to Primary Care as per the action of January 2025 Escalation meeting.
006-24: National Clinical Guideline for Stroke, for the UK and Ireland Issued March 2024	Community & Integrated Medicine	Chief Operating Officer / CCG Director for Community and Integrated Medicine	Original implementation date not met Original Completion Date: 30/04/2025 Revised Completion Date: Not Known	Risk Ref: 233 Current Risk Score: 12 Impacts: Delayed assessment and treatment of patients; Increased length of stays	QIA was presented to the panel in September 2025, however was not accepted by the panel, with further work required from the CCG. The panel agreed that future QIAs should be signed off by the Stroke Strategy Group or CCG, and that the process should ensure proposals are clear and supported by appropriate oversight. Service unable to provide an implementation date pending progression of the wider Clinical Service Plan.

WHCs – Unable to Complete



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Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Unable to Complete Status	Impact of non-compliance according to risk assessment	Next Steps
<u>026-18: Phase 2 – primary care quality and delivery measures</u> – issued July 2018	Primary Care, Community Strategy and Long Term Care	Chief Operating Officer / Director of Primary Care, Community and Long Term Care	National work around this transformational model was suspended due to the COVID-19 pandemic and has never progressed further. Currently the Primary Care quality and delivery measures within the new dashboards are being used as equivalent quality indicators. As such, the implementation date for this WHC is currently noted as not known. Original Completion Date: 16/07/2018 Revised Completion Date: Not Known	No risk noted on Datix.	WHC will be escalated through operational governance structures to obtain relevant approval to close this WHC as the service is unable to implement.

WHCs – Pending Decision



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Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for Pending Decision Status	Impact of non-compliance according to risk assessment	Next Steps
006-18: Framework of Action for Wales, 2017-2020 (Not Available Online) – issued Feb 2018	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Service unable implement due to funding requirements. WHC requirements and supporting systems have been incorporated into the Annual Planning work stream for 2025/26. Original Completion Date: 30/04/2022 Revised Completion Date: Not Known - Overdue	Risk Ref :1457 Current Risk Score: 12 Impacts: Patients unable to access specialist care in a timely manner, closer to home; Additional pressures on GP capacity	Await the outcome of whether the Service has been granted the relevant funding as part of the Annual Planning 2025/26 to inform next steps required.
<u>017-19: Living with persistent pain in Wales guidance</u> – issued May 2019	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Service unable implement due to funding requirements. WHC requirements and supporting systems have been incorporated into the Annual Planning work stream for 2025/26. Original Completion Date: 31/01/2025 Revised Completion Date: 31/01/2026 - Overdue	Risk Ref: 2120 Current Risk Score: 12 Impacts: : Patients unable to access specialist care in a timely manner, breaches in achieving RTT	Await the outcome of whether the Service has been granted the relevant funding as part of the Annual Planning 2025/26 to inform next steps required.
<u>009-21: School Entry Hearing Screening pathway</u> - issued March 2021	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Service unable implement due to funding requirements. WHC requirements and supporting systems have been incorporated into the Annual Planning work stream for 2025/26. Original Completion Date: 31/01/2023 Revised Completion Date: Not Known - Overdue	Risk Ref: 1456 Current Risk Score: 8 Impacts: Detrimental impact on quality, accuracy and consistency of screening services provided	Await the outcome of whether the Service has been granted the relevant funding as part of the Annual Planning 2025/26 to inform next steps required.

WHCs - In Progress



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Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
<u>037-25: Infected Blood Inquiry: Implementation of Recommendation 7e: Implementing SHOT reports</u> - issued September 2025	Operational Allied Health Professions and Health Sciences	Chief Operating Officer / CCG Director for Operational Allied Health Professions and Health Sciences	Nov-25
<u>041-24: Ambulance patient handover guidance</u> – issued October 2024	Community and Integrated Medicine	Chief Operating Officer / CCG Director for Community and Integrated Medicine	Dec-25
<u>017-25: Tranexamic Acid use: Recommendation 7a of the Infected Blood Inquiry (IBI)</u> - issued May 2025	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Jan-26
<u>002-24: Standards for Competency Assurance of Non-Medical Prescribers in Wales</u> – issued March 2024	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Mar-26
<u>004-25: NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2025/26</u> - issued April 2025	Medical Director	Medical Director	Mar-26
<u>006-25: Recording of Mental Health Outcome Measures</u> - issued May 2025	Mental Health and Learning Disabilities	Chief Operating Officer / CCG Director for Mental Health and Learning Disabilities	Apr-26
<u>030-23: New 2023 National Safety Standards for Invasive Procedures (NatSSIPs2) by the Centre for Perioperative Care (CPOC) and Patient Safety Notice PSN 034</u> – issued August 2023	Medical Director	Medical Director	Sep-26
<u>016-24: Healthy Child Wales Programme: for school aged children</u> – issued April 2024	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Sep-26
<u>039-25: AMR and HCAI Improvement Goals for 2025 – 2027</u> - issued October 2025	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Mar-27

WHCs – Reliant on External Factors



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Welsh Health Circular	Clinical Care Group / Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for External Status	Impact of non-compliance according to risk assessment	UHB Implementation Date
040-23: The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC) – issued November 2023	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	The service is currently compliant with all aspects of this WHC apart from the data capture requirements, for which no national system is currently available. An all-Wales data system is awaited. As such, the implementation date for this WHC is currently noted as not known.	Risk Ref: 2109 Current Risk Score: 20 Impacts: Decrease in staff morale and a negative impact on service leads.	N/K
033-18: Airborne Isolation Room Requirements – issued July 2018	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	The Health Board's Architectural Projects Team undertook a Project Feasibility Report in July 2024 and provided a provisional estimate of out-turn costs of £1,419,946.25 (including a contingency fund of £109,416), with a project time of around 48 weeks from project brief development to completion of works to install a negative pressure isolation suite in the Clinical Decisions Unit (CDU), Glangwili General Hospital. To date, funding has not been allocated for this major capital project and whilst the issue has been raised at the 'All Wales High Consequence Infectious Disease Group' hosted by Public Health Wales (as a result of the threat of MPOX in the UK) and the NHS Executive, there has been no indication of any central funding being considered by Welsh Government to support improvement and to move this work forward. In the meantime, out turn costs continue to escalate and it is recognised that the estimated costs of 2024 may well have increased. Discussions were held at the Infection Prevention Strategic Steering Group (IPSSG) in March 2025, when it was agreed that steer is required from the Executive Director given the investment required and the stagnation of progress. As of November 2025, Head of Infection Prevention is currently exploring how other Health Boards are managing this WHC (action agreed at IPSSG) with QIA to be completed by 31 December 2025 by IPC and Planned Care CCG to inform the Board of current circumstances and any changes. Noted as 'unable to complete' until funding is	Risk Ref: 1640 Current Risk Score: 12 Impacts: Increased risk of transmitting infectious disease	N/K

WHCs – Complete Pending Formal Approval For Closure / Complete by Lead Executive



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Complete Pending Formal Approval For Closure

Welsh Health Circular	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Clinical Care Group/Executive Function	UHB Implementation Date
<u>018-25: Tirzepatide (Mounjaro®) for the management of obesity and overweight – issued May 2025</u>	Operational Allied Health Professions and Health Sciences	Chief Operating Officer / Director of Operational Allied Health Professions and Health Sciences	Jul-25
<u>027-25: Changes to supply of Gluten Free Foods in Wales; All-Wales Gluten Free Subsidy Card Scheme - issued July 2025</u>	Primary Care, Community Strategy & Long Term Care	Director of Primary Care, Community Strategy and Long Term Care	Aug -25
<u>035-24: Standardising the management of acute deterioration – issued September 2024</u>	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Sep-25
<u>031-25: 3Ps Waiting Well single point of contact (SPOC) activity and outcomes data reporting. – issued September 2025</u>	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Oct-25

Complete

Welsh Health Circular	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Clinical Care Group/Executive Function	UHB Implementation Date
<u>040-24: Adopting a patient and family-initiated escalation approach – issued October 2024</u>	Director of Nursing, Quality and Patient Experience	Director of Nursing, Quality and Patient Experience	Sep-25

Implementation of Ministerial Directions (MDs)



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Ministerial Directives (MDs) are legislative in character as they alter legal rights and duties. MDs are issued by Welsh Ministers and include codes of practice and guidance. In complying with the requirements of various governance codes and the Annual Governance Statement requirements, HDdUHB has a duty to provide assurance of compliance with the MDs. As MDs potentially form part of the process of how the Health Board delivers its services, the Quality, Safety & Experience Committee (QSEC) will receive a regular assurance report on compliance

There are 5 MDs aligned to QSEC as at November 2025, all of which have been noted as complete.

Each MD is assigned a status category. The table below outlines the definition of each category, the number of MDs assigned to each as of November 2025. To provide a more accurate reflection of MD's progress, three new status categories have been introduced since the last Committee report. Definitions for these new categories are also included in the table.

Status Category	Definition	Number of MDs
In Progress	The MD is currently in progress, and within the agreed original timeframe for implementation.	0
Overdue	The MD is behind schedule to the timescale provided by the Lead officer or as stipulated in the MD, or a plan (with date for implementation) is not yet in place.	0
Reliant on External Factors	The MD is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	0
Pending Decision (NEW)	The MD is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests. Committee updates will detail whether the MD is overdue or not whilst decision pending.	0
Unable to Complete (NEW)	The MD cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	0
Complete Pending Formal Approval (NEW)	The Service / Function have completed the MD and are currently awaiting formal approval to close.	1
Complete	The MD has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	4

Oversight of the delivery of MDs has been included in new Clinical Care Group (CCG) Terms of Reference, with the requirement to escalate appropriately instances of non-compliance.

The timely implementation of MDs is included within the Governance domain of the Health Board's internal escalation framework, with services escalated in instances of non-compliance.

MDs – Complete Pending Formal Approval and Complete



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Complete Pending Formal Approval For Closure

Ministerial Direction	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Clinical Care Group/Executive Function	UHB Completion Date
WG25-72: The Primary Care (Contracted Services: Outpatients Waiting Lists First Appointment Scheme) Directions 2025 – Issued October 2025	Primary Care, Community Strategy & Long Term Care	Director of Primary Care, Community Strategy and Long Term Care	Oct-25

Complete

Ministerial Direction	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Clinical Care Group/Executive Function	UHB Completion Date
WG25-40: The Primary Medical Services (Type 2 Diabetes Mellitus Care Scheme for Adults) (Directed Supplementary Service) (Wales) (Amendment) Directions 2025 – Issued August 2025	Primary Care, Community Strategy & Long Term Care	Director of Primary Care, Community Strategy and Long Term Care	Sep-25
WG25- 40: The Primary Medical Services (People Living with Severe Frailty in their own Homes) (Directed Supplementary Service) (Wales) Directions 2025 – Issued September 2025	Primary Care, Community Strategy & Long Term Care	Director of Primary Care, Community Strategy and Long Term Care	Sep-25
WG25-44: The Directions to Local Health Boards as to the General Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No.4) Directions 2025 – Issued September 2025	Primary Care, Community Strategy & Long Term Care	Director of Primary Care, Community Strategy and Long Term Care	Oct-25
WG25-45: The Directions to Local Health Boards as to the Personal Dental Services Statement of Financial Entitlements (Wales) (Amendment) (No.4) Directions 2025 – Issued September 2025	Primary Care, Community Strategy & Long Term Care	Director of Primary Care, Community Strategy and Long Term Care	Oct-25

The Committee is requested in relation to the areas presented in this paper to:

Risk Management

- **RECEIVE ASSURANCE** that identified controls are in place and working effectively; and
- **RECEIVE ASSURANCE** that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will reduce risks further and/or mitigate the impact should risks materialise.

Welsh Health Circulars

- **RECEIVE ASSURANCE**, or otherwise, from the lead Executive Director or Supporting Officer on the management of WHCs within their area of responsibility, particularly in respect of understanding when the WHC will be delivered, any barriers to delivery, impacts of non/late delivery and assurance that the risks associated with these are being managed effectively.

Ministerial Directions

- **RECEIVE ASSURANCE** that the Health Board is compliant with the Ministerial Directions issued by Welsh Government.



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SAFE | SUSTAINABLE | ACCESSIBLE | KIND



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CORPORATE RISK REGISTER SUMMARY NOVEMBER 2025

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Nov-25	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score
797	Risk of adverse patient and workforce outcomes if health board wide ultrasound services are unsustainable	Carruthers, Andrew	Quality/Complaints/Audit	5×5=25	5×5=25	→	3×5=15	31/07/2027 31/03/2030
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	4×5=20	4×5=20	→	2×4=8	31/03/2026 31/10/2026
1552	Risk of insufficient mortuary capacity due to current and anticipated future demand	Carruthers, Andrew	Safety - Patient, Staff or Public	NA	4×5=20	New risk	2×4=8	31/08/2026
1032	Risk of timely ASD diagnostic assessment for CYP due to increasing demand	Carruthers, Andrew	Safety - Patient, Staff or Public	5×4=20	5×4=20	→	4×4=16	Not known
684	Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Carruthers, Andrew	Service/Business interruption/disruption	4×4=16	4×4=16	→	2×4=8	Not known
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Carruthers, Andrew	Safety - Patient, Staff or Public	4×4=16	4×4=16	→	2×4=8	31/03/2027
2190	Risk of delay in CHC direct payments due to short timescale, limited resources & lack of WG policy guidance	Carruthers, Andrew	Quality/Complaints/Audit	NA	4×4=16	New risk	3×4=12	31/03/2026
1531	Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	3×5=15	3×5=15	→	1×5=5	27/02/2026
1810	Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	Carruthers, Andrew	Service/Business interruption/disruption	3×5=15	3×5=15	→	1×5=5	31/12/2026
1859	Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Daniel, Sharon	Safety - Patient, Staff or Public	3×5=15	3×5=15	→	2×5=10	31/12/2025

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
Likelihood	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	This will probably never happen/recur (except in very exceptional circumstances).	Do not expect it to happen/recur but it is possible that it may do so.	It might happen or recur occasionally.	It might happen or recur occasionally.	It will undoubtedly happen/recur, possibly frequently.
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
* time-framed descriptors of frequency					
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	(0-5%*)	(5-25%*)	(25-75%*)	(75-95%*)	(>95%*)
*used to assign a probability score for risks related to time-limited or one off projects or business objectives.					
Risk Impact Domains	Negligible - 1	Minor - 2	Moderate - 3	Major - 4	Catastrophic - 5
Safety of Patients, Staff or Public	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention.	Moderate injury requiring professional intervention.	Major injury leading to long-term incapacity/disability.	Incident leading to death.
	No time off work.	Requiring time off work for >3 days	Requiring time off work for 4-14 days.	Requiring time off work for >14 days.	Multiple permanent injuries or irreversible health effects.
		Increase in length of hospital stay by 1-3 days.	Increase in length of hospital stay by 4-15 days. Agency reportable incident. An event which impacts on a small number of patients.	Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	An event which impacts on a large number of patients.
Quality, Complaints or Audit	Peripheral element of treatment or service suboptimal.	Overall treatment or service suboptimal.	Treatment or service has significantly reduced effectiveness.	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment/service.
	Informal complaint/inquiry.	Formal complaint.	Formal complaint -	Multiple complaints/ independent review.	Gross failure of patient safety if findings not acted on.
		Local resolution.	Escalation.	Low achievement of performance/delivery requirements.	Inquest/ombudsman inquiry.
		Single failure to meet internal standards.	Repeated failure to meet internal standards.	Critical report.	Gross failure to meet national standards/performance requirements.
		Minor implications for patient safety if unresolved. Reduced performance if unresolved.	Major patient safety implications if findings are not acted on.		

CORPORATE RISK REGISTER SUMMARY NOVEMBER 2025

Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
			Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty. Improvement notices.	Prosecution. Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity.

RISK MATRIX

	LIKELIHOOD →				
IMPACT ↓	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	High	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

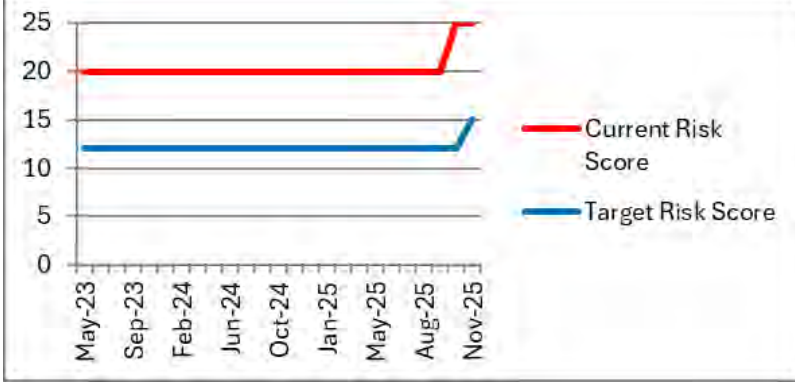
Key - Assurance Required		<i>NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you</i>
	Detailed review of relevant information	
	Medium level review	
	Cursory or narrow scope of review	

Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

Date Risk Identified:	Nov-19
Strategic Objective:	1. Thriving Teams and 2. Healthier Communities and 3. Great Care and 4. Positive Futures

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Nov-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Dec-25

Risk ID:	797	Corporate Risk Description:	There is a risk that health board wide ultrasound services are unsustainable. This is caused by -Demand increase across NOUS and Maternity Ultrasound pathways requires 34 148 additional scanning hours. -Workforce establishment does not match demand. -Workforce vacancies long standing (national shortage, training pipeline 3 years with large supervision requirement). -Unable to move staff between sites to cover as all sites unable to meet minimum standards required. -Occupational Health impact from workloads reducing workforce available (RSI). This could lead to an impact/affect on -Patient outcomes = delays to scans resulting in delays to treatment or death (cancer and maternity pathways) -Workforce outcomes = staff harm from RSI resulting in long term injury from too much scanning of similar types (unable to job plan appropriately due to demand and vacancies).
Does this risk link to any Directorate (operational) risks?			1349 (WGH), 1658 (RSI), 1547 (maternity)

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	5×5=25
Target Risk Score (L x I):	3×5=15
Expected Date To Achieve TRS:	31/03/2030
	
Trend:	

Rationale for CURRENT Risk Score:

This risk was escalated from 20 to 25 in October 2025 due to increased fragility in available workforce (2.0WTE retirement notice given Jan 2026). In Nov 2025 a full risk review of all elements took place with Radiology and CCG leadership.

Patients outcomes = delays to scans resulting in delays to treatment or death (cancer and maternity pathways)

Workforce outcomes = staff harm from RSI resulting in long term injury from too much scanning of similar types (unable to job plan appropriately due to demand and vacancies).

Quality, complaints and audit - (5)

Totally unacceptable level of quality of treatment/service.

* due to waiting times (see below) patients on maternity and cancer pathways are waiting too long for scans required for intervention

Gross failure of patient safety if findings not acted on.

* concerns regarding non compliance with Welsh Maternity screening targets

Gross failure to meet national standards / performance requirements.

* Waiting times non-interventional ultrasound are up to 23 weeks (25/11/25)

* Interventional ultrasound 52 weeks (25/11/2025)

* Vascular ultrasound is not available 7 days a week (25/11/2025)

Probability = >95%

If insourcing capacity cannot be secured from the 1st January 2026 the service will no longer be able to sustain a safe baseline capacity to provide routine and urgent non-obstetric imaging alongside obstetric scanning Monday to Friday, 09:00-17:00 on the WGH site.

Rationale for TARGET Risk Score:

Impact of service failure remains the probability of service failure is the aim of mitigating actions.

Probability target of 25-75%.

In Nov 2025 target date was reviewed and extended. Justification for this change is the timeline for Radiology Leadership OCP and recruitment to bring in the leadership required to mitigate the gaps in controls thus requires extended timelines due to pathways changes and training timelines.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
Insourcing NOUS (planned 125 examinations per week, actual performance 90-120 actual) - monthly data submission to Welsh Government + monthly performance reporting on 8 week and USC pathways (25/11/2025) Locum/Agency capacity - 1.0WTE secured (25/11/2025), 2.0WTE Agency being sought (25/11/2025) Prioritisation of maternity workload by referring clinician - urgency allocated on referral form by referring clinicians Training pipeline (supported practice educator) - 5.0WTE in post (end of training Jan 2027), 2.0WTE qualified 2025, 1.0WTE Midwife sonographer (end of training Jan 2026). Next intake Jan 2027. MSK and Vascular pathways via AHP extended practice roles (some Physiotherapy and Podiatry pathways in place to support ultrasound workload)	Health board wide governance of ultrasound pathways	Further action necessary to address the controls gaps	Llewellyn, Cerian	~~31/12/2022~~ ~~31/10/2023~~ ~~31/01/2024~~ ~~30/06/2024~~ ~~31/01/2025~~ 31/01/2026	The date of completion of this action has been changed to 31/01/2026 as the midwife identified for training did not start until Jan 2025 due to lack of process to support the clinical aspects and a change in maternity management. Maternity and child health are required to advise of the plan to utilise the skills of the trainee midwife sonographer and also any plans to train more staff. June 2025: Midwife sonographer is now undertaking required training and expected to qualify in January 2026.
	Pathway workforce diversification				
	Workforce pipeline does not meet demand				
	Training capacity (trainees available but inadequate internal capacity to train)				
	Insourcing/outsourcing/Agency/Locum capacity				
	Limited ability to move staff across sites due to extremely low staffing levels				
		Radiology management restructuring as part of stabilisation plan. new posts needed to provide a longer term solution to issue. Not possible with current management structure and stability risk	Procter, Sarah	31/05/2026	OCP being presented to board 3.9.25 once approved the process will start the following week 8.9.25. Delayed to 1.10.25
		SBAR being written due to increase in risk to 25 - due to inability to meet maternity policy and impact on NOUS. fragility at WGH is extreme due to imminent retirements and inability to fill vacancies with substantive staff or locum due to national shortage.	Procter, Sarah	Completed	Paper submitted to CCG and raised at IQPFD
		Obstetric ultrasound capacity being added to current insourcing contract which starts on 1 November 2025.	Procter, Sarah	Completed	Added to contract
		Training pipeline - 5.0WTE Trainee sonographers scheduled to complete training.	Procter, Sarah	31/01/2027	25/11/2025 - New action.

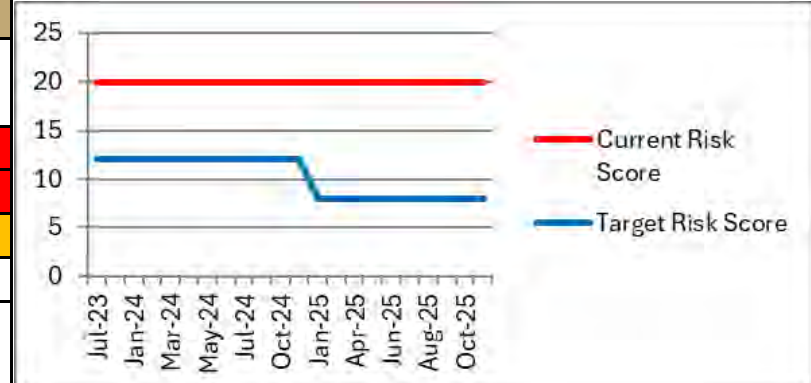
	Training pipeline - 1.0WTE midwife sonographer completed training.	Procter, Sarah	31/01/2026	25/11/2025 - New action
	Insourcing/Outsourcing - procurement conversation with current provider of ultrasound capacity relating to adding more scanning capacity for obstetric ultrasound capacity (2000 scans) on top of current contract	Procter, Sarah	19/12/2025	25/11/2025 - new action
	Agency capacity - 2.0WTE out for advert with agency (AG1 (HR form for agency approval) valid until 2027)	Procter, Sarah	31/01/2027	25/11/2025 - AG1 approved for 2.0WTE until Jan 2027, out with Agencies during 2025/26. No interest this year as yet.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
			Current Level							
8 week USC Ante-natal screening Wales	Waiting list monitoring - Live dashboard review by Radiology Leadership (daily) and monthly formal submission of performance * week data to Welsh government (see iPAR).	2nd			IQFPDG 26/11/2025 - SBAR - Ultrasound Fragility - Corporate risk 797					
	Performance monitored at Executive Improving Together Sessions	2nd								

Date Risk Identified:	Nov-20
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Nov-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Dec-25

Risk ID:	1027	Corporate Risk Description:	There is a risk to the consistent delivery of timely and high quality urgent and emergency care. This is caused by significant fragility across the urgent and emergency care (UEC) system (acute, primary care (including out of hours), community and social care services), related to workforce compromise and increasing levels of demand and acuity. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays and overcrowding at Emergency Departments (ED) and delayed ambulance response to community emergency calls, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?			1649, 1406, 1548, 1210, 750, 205, 86, 820, 232, 1298, 1281, 906, 1380, 1116, 878, 839, 1167, 1223, 111, 114, 199, 523, 136, 200, 1115, 1078, 572, 1295, 1231, 966, 967, 565, 852, 1295, 1435, 1377, 1083, 180, 1424, 1417, 1309, 291, 118, 925, 119, 1245, 695

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	31/10/2026
Trend:	

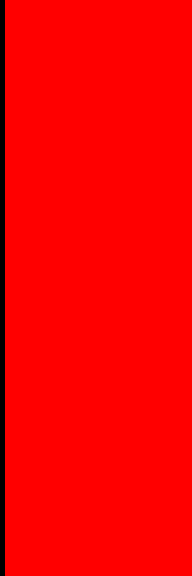
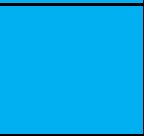
Rationale for CURRENT Risk Score:
Levels of UEC pathway capacity pressures continue at significantly escalated levels. Workforce deficits, bed occupancy rates and significant pressures on wider community and social care capacity demonstrate lack of sustainable improvement. The situation remains at high levels of risk escalation across our acute sites daily. The Front Door Reset week in September has shown improvements in Ambulance handover delays but challenging to sustain in the longer-term. Whilst some positive progress has been achieved in reducing ambulance handover delays, the other key metrics remain outside TI requirements. Despite trend line indicative of slight improvement over the year, October has 8.5% of people waiting >12 hours in an ED. This is above the TI target of 6% and up from 8% in September. For ED assessment waits October's average is 78 mins, above the TI target of 60 and an increase on September's average. Over the year the trend has been fairly static for this metric and has not met TI targets. PoCDs in October were 258 which was above the TI target of 174. PoCD shows an increasing trend and remains the most challenging TI metric for the UHB. Work ongoing with Local Authorities to improve position, and internal actions such as front door reset actions and making everyday count reset week. Notable actions include a focus on redirection policy, community staff integration into sites, optimisation of discharge lounge and more senior leadership presence in board rounds.

Rationale for TARGET Risk Score:
The target risk score of 8 reflects the confidence in the delivery of 6 Goals Programme and the Accelerated Transformation Programme to address the significant issues across the health and care system. Plans for improvement during 2025/26 are reflected in the HB's Annual Plan, approved by the Board in March 2025, and are informing next year's Annual Plan. The 6 goals plan has been approved by WG in March 2025. TI measures such as ambulance handovers and 12 hour delays in ED will need to improve in order to reduce the current risk score, for a consecutive period of three months. UEC Transformation Acceleration Group (TAG) meeting weekly and reporting fortnightly into Formal Executive Team. An expected date of March 2026 had been noted to achieve the target risk score of 8, to allow the transformation change to embed. The embedding of 7-day Clinical Streaming and SDEC services will be thought to significantly impact on patient flow and a business case for this is planned to go to Public Board in January 2026 for agreement. If approved time will be needed for recruitment and embedding of services, as such it is expected that there will may be a delay in hitting the March 2026 target score of 8 and it is recommended this is put forward to October 2026.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
# Live Operational Dashboard in place and twice HB wide escalation meeting. # Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled. Surge and boarding recorded on the twice a day escalation report. # Frontier system in place for recording DPOC and red days flagging required assessments to support discharge, within continued education at ward level ensuring consistent approach to Board Rounds and Patient Safety Huddles. # Surge beds continue as per escalation and risk assessment of site demand and acuity (where staffing allows). A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites with associated actions in collaboration with social care partners. # Regular advice on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, social services and the Long Term Care Team support. # Discharge arrangements are in place on all sites with a strategic review underway. # Standardised board rounds processes in place on all sites and D2RA processes are embedded with a 77% D2RA rate (Sep24). # Criteria-led discharge guidance and principles piloted across HB (Sep24). # Integrated Regional Winter Plans developed to manage whole system	# Fragility of Care Home Sector such as financial viability, staffing deficits, recruitment and retention of workforce.	Delivery of 6 Goals Programme and Plan via the workstreams and closer working with WAST and primary care 1. Development of Regional Clinical Streaming Hub (CSH) for Health Professionals & Care Homes delivering 24/7 urgent care advice & support and onward referral to local deliver/resource hubs where appropriate	Skitt, Peter	31/10/2025	Piloting a 7 day model on the CSH across the Health Board as part of winter planning (utilising overtime and additional shifts) with an evaluation finalised in May 2025. The plan to produce a business case for substantive arrangements is including in the Accelerated UEC Transformation work to be delivered by October 2025.
	# Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff.				
	# Inability to handover ambulances to release them back for use within community due to lack of flow in acute sites.	Develop a consultant led ED medical provision that is fit for purpose and meets the D&C requirements utilising all professions.	Skitt, Peter	Completed	Lead ED consultant appointed, action complete /
	# Need to have better understanding of ED presentations to ensure development of alternative pathways in primary care / community to prevent ED attendance.	Utilise the risk stratification data set across the system proactively with the population	Skitt, Peter	30/04/2025-31/10/2025	Part of First Home Hub plan and work is underway. Data is being used in primary care multi-disciplinary team meetings across the Health Board and WGH, and requires further embedding to ensure the impact within acute sector is realised.
	# Ability to influence public mind set / expectation and culture in terms of use of NHS resource and 'Home First' Ability.				
	# Gap in communication between secondary and primary care that could lead to poor discharge outcomes.	Review of Community bed based hospital capacity, with a view to ensuring proactive case load management and estate as part of the Alternative Care Model work. Develop & implement strategy for Alternative Care Community (ACP) Provision across the West Wales region.	Skitt, Peter	31/10/2025	Initial planning and audit of capacity has been completed. Length of stay data being gathered by County Leads.
	# Clarity regarding roles and responsibilities for discharge planning and coordination.				

pressures over the winter period and communicated. # An operationally focussed 6 Goals Urgent and Emergency Care (UEC) programme with governance structure agreed where all UEC improvement is coordinated. # Welsh Ambulance Services NHS Trust involved in all 6 Goals UEC workstreams. # 111 and 111 press 2 (MH) implemented across Hywel Dda. # Regional Integration Fund projects in place across Regional Partnership Board (RPB) footprint, along with Further Faster projects to ensure alignment with Ministerial objectives. # Whole system approach to deploy HB staff to ensure continuity of patient care. # Care Home Risk & Escalation Policy to support failing care homes to be applied as required. # Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across the RPB region. # Establishment of a Discharge to Recover and Assess (D2RA) Group which reports to the the 6 Goals Programme with a detailed D2RA improvement plan in place. # Establishment of a D2RA Escalation Transfer panel which provides senior oversight of delays at county level, assesses risk of the delay to the patient and organisation in terms of flow compromise # SRO in place to lead agreed 6 Goals for UEC programme. # Agreed SDEC model in place to maximise impact on admission avoidance. NHS Executive review with associate actions are part of the 6 goals UEC programme. # Local streaming (Home First) hubs developed with a HB wide approach agreed with clinical triage and screening systems in place, including APP Navigator in place. # Direct referral into SDEC in place.	# The inability to risk stratify for people at moderate to high risk of admission in the community to implement proactive anticipatory care plans to support avoidance of exacerbation / decompensation and hence increased risk of hospital admission. # Optimising our bedded facilities in the community. # Need to develop 24/7 integrated urgent primary care service aligned to Home First hubs. # Insufficient IPC single rooms across community and acute sites, negatively impacting on patient flow. # Lack of level 1 / 2 falls response service during out of hours across the Health Board. # Fragility of senior medical cover at EDs across the acute sites. # Need to create a Health Board wide Frailty approach and appoint a Clinical Lead for Frailty. # 7 day services within the Community are required, particularly around Clinical Streaming Hubs and level 1 / 2 Falls.	Enhancements to local delivery / resource hubs to support the CSH providing access to enhanced community care services, third sector services and other pathways to provide safe alternatives to admission. Integration with GP OOHs and APP resources	Skitt, Peter	31/10/2025	Discussions ongoing on providing a single clinical streaming hub across the Health Board footprint, with response resources locally based at cluster level as a phased approach to introducing the care at home blueprint, as described during the 6 Goals review meetings. This will feature strongly in the Accelerated USC Transformation work.
		Development & implementation of consistent approach to Front Door Streaming / Assessment Units focused on our Frail Elderly cohort based on good practice and lessons learnt from Withybush Puffin / South Pembrokeshire model.	Skitt, Peter	31/12/2025	SDEC services available on all sites for medical patients. Surgical SDECs piloted in Glangwili since December 2024. Ongoing discussion with Glangwili relating to frailty provision.
		Development and implementation of HDUHB optimal SDEC model following on from lessons learnt from peer review and alignment with CSH and local resource hubs.	Skitt, Peter	31/10/2025	An SBAR was developed to standardise the approach across the Health Board, which has been incorporated into the Optimal 7 days streaming SDEC Business Care going to Public Board September 2025.
		Continued implementation of Optimal Flow Framework including Community sites supported by Frontier digital platform.	Skitt, Peter	31/10/2025	On track with roll out plan, and ensuring that all sites are using the framework is ongoing. This work will also feed in to the E-Obs and patient flow project going forward.
		Implementation of 7 focused areas within ED Quality statement.	Skitt, Peter	31/03/2026	Clinical lead for ED post currently out to advert. ED Quality Statement Action group in place, who report 6 weekly to Welsh Government. Action plan developed and in place, forming the basis of updates to WG, based around the national toolkit.

# OOH Pilot clinical streaming via GP route ongoing as of January 2025 with a view to full completion at the end of the month # Clinical Care Group structure in place where this risk is discussed at the quality meeting. #UEC Transformation Acceleration Group (TAG) meeting weekly and reporting fortnightly into Formal Executive Team. # Regional Discharge Strategy Group established, providing oversight of all current work streams, and ongoing work on national and local policies # Regional POCD group established January 2025 with a focus on reviewing trends and themes to inform regional and local action plans		Develop West Wales Hospital @ Home model to ensure consistent approach and delivery.	Skitt, Peter	30/09/2025	The Health Board Hospital at Home SOP has been drafted and approved by the Community & Integrated Medicine Clinical Care Group Integrated Governance Group (focus on Quality, Health & Safety). Certain elements in the SOP remain outstanding and must be completed prior to initiating the Health Board's internal approval policy process.
		Develop robust regional Trusted Assessor (TA) Model to ensuring consistent approach to assessment across the region - residents can be an inpatient at any of the 4 x general hospital sites.	Skitt, Peter	31/10/2025	Trusted Assessor regional group in place focussing on the model and reporting required to Welsh Government, aligned to further faster monies. A National Audit took place in Summer 2025 on Trusted Assessors across the West Wales region, awaiting outcomes.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance  Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Ambulance handovers within 15 minutes	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st				None identified.				
Ambulance handovers over 1 hour	Daily performance data overseen by service management	1st								
Ambulance handovers over 4 hours	Workstream Delivery Plans overseen by 6 Goals Programme	2nd								
4 & 12 hour waits in A&E	6 Goals Programme / UEC IQFPD 3As report into IQFPD	2nd								

[illegible]

Date Risk Identified:	Feb-22
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Nov-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Dec-25

Risk ID:	1552	Corporate Risk Description:	There is a risk of insufficient mortuary capacity (Fridge & Freezer capacity) Health Board wide to meet the current and future growing demand and provide adequate and appropriate sized storage for ward and community deaths. This is caused by the severe lack of storage capacity across all mortuaries within the Health Board, compounded by the fact that some of the refrigeration spaces are not big enough to accommodate the increasingly larger bodies that are being admitted into our mortuary facilities, and the inability for staff to safely access refrigeration spaces at WGH and BGH. In addition, the increase in economic, social, demographic, regulatory and legislative (Medical Examiner Service - MES) pressures have significantly increased both the quantity of deceased and length of stay within our Mortuary body storage facilities. This could lead to an impact/affect on the dignity, and condition of deceased patients within our care due to the inability to adequately store these patients in a suitable environment. There is also the potential impact of non-compliance with legislative requirements, including Human Tissue Authority, along with reputational damage to the Health Board. There could also lead to emotional distress to the families and friends of the deceased.
Does this risk link to any Directorate (operational) risks?			283, 1554

Rationale for CURRENT Risk Score:

The Health Board is exposed to significant risks resulting from insufficient mortuary capacity across its estate. The ongoing dependence on temporary body storage, particularly during periods of excess deaths, presents challenges in maintaining regulatory compliance, protecting staff wellbeing, ensuring safe manual handling practices, and upholding the dignity of the deceased. The current infrastructure risks non-compliance with HTA standards. According to ONS projections, the death rate is expected to rise, peaking in 2044, further intensifying these pressures.

Suboptimal facilities may lead to compromised presentation of the deceased, increased emotional distress for families, and safety concerns for mortuary staff, especially manual handling. While control measures are in place, they are not sufficient to manage the current volume of deaths within the mortuary service, particularly during periods of heightened demand. These control measures should serve only as temporary contingencies, in line with the HTA licence however, there is a growing need for enhanced storage capacity throughout the year, not solely during seasonal peaks.

Current body storage provisions do not meet operational requirements, and there is limited flexibility to respond to unplanned disruptions, such as those involving MES, HMC, or PM Service interruptions. Furthermore, the extremely constrained footprint of the mortuary estate significantly restricts opportunities for external expansion or enhancement.

Risk Rating: (Likelihood x Impact)		No trend information available.
Domain:	Safety - Patient, Staff or Public	
Inherent Risk Score (L x I):	4×5=20	
Current Risk Score (L x I):	4×5=20	
Target Risk Score (L x I):	2×4=8	
Expected Date To Achieve TRS:	31/08/2026	
Trend:		New risk

Rationale for TARGET Risk Score:

Target score is based on successful outcome from Body Storage Capacity paper being escalated via CCG (03.06.25) to IQFPD (11.06.25). Funding stream discussed with Executive Director of Finance on (21.07.25) along with further meetings and support from the Health Board's finance and planning team to ensure a long-term sustainable solution is implemented as soon as reasonably possible. Assurance has been provided by the Executive Director of Finance that financial support will be received in order to enact the short term measures to ensure appropriate capacity is available for the approaching winter pressure period. Further discussions will be held with finance and planning colleagues to discuss medium and long term mitigating plans. Long term solution need to be sustainable and future proof to ensure the target risk score is achieved and maintained.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
1. At times of peak pressure, temporary body storage units are rented 2. Monitoring of numbers of deceased against storage capacity (Health Board wide) 3. Business continuity plans in place (Health Board wide) 4. Contracts with local funeral directors to utilise contingency storage of deceased (Health Board wide) 5. Deceased are relocated to other mortuary sites when needed (Health Board wide) 6. Bariatric blanket available for short-term use across all Health Board sites 7. Additional body refrigeration (Boxcold solution) has been installed into the old PM (Post Mortem) room at WGH site. 8. Participation, engagement and communication with the Health Board's Mortality Group, medical colleagues, Medical Examiner Service and external stakeholders	1. Despite owning 1x 15 BSS unit, we have insufficient storage provision for the upcoming winter pressure period 2. Insufficient suitable space and/or estate within mortuary facilities to increase body storage capacity. 3. Any delay in the death certification process (internal & external stakeholders) significantly impacts on the management of mortuary body storage. As these processes are outside of mortuary control, we frequently invoke contingency plans to accommodate the deceased. Death certification process be noted as a control measure, with the gap being the delays in these processes as a result of sources beyond the Health Board's control (MES, HMC, PM service disruption etc)?	Requirement of additional body storage capacity health board wide. Capital funding needs to be secured.	Baker, Craig	31/03/2025-31/03/2026	To be escalated via CCG structure Escalated at IQFPDG June 2025 - meeting to be scheduled with HT re short term capacity and LD for medium/long term capacity for analysis. Body storage capacity paper being submitted via CCG structure. Financial approval from Finance executive to increase temporary storage over winter period (2025 - 2026), this includes funding to cover adding of additional capacity at PPH. In addition, currently reviewing BGH footprint to look at increase of freezer capacity to cover HB.

4 & 5. Due to the national shortage of body storage capacity, death certification processes and current death rates, contingency plans utilising mutual aid are ineffective as all Health Boards are experiencing the same level of body storage capacity pressures and are therefore unable to assist. 6. During the recent Tier 1 National Mass Fatality Pandemic Exercise it was identified that nationally and locally we have insufficient levels of body storage capacity to handle a mass fatality or a period of excess death. Risk areas were identified by the Hywel Dda team that participated in the exercise and these along with suggestions for improvements were feedback to the Local Resilience Forum (LRF) who will escalate this feedback to Welsh Government.	Explore options regarding temporary body storage rental and purchase of body storage capacity.	Brown , Yasmin	Completed	Ongoing Discretionary Capital bid to purchase a 15BSS Nutwell storage unit. 20.08.25 - Currently in discussions with suppliers regarding rental costs. 19.11.25 - The service has been successful in procuring a 15 BSS storage unit via a spend to save scheme. This unit will be delivered towards the end of November/start of December 2025. 19.11.25 - The service has also rented 2x additional 15 BSS nutwell units as contingency storage space as part of our winter preparedness plans and in readiness for the winter increase in death rates.
	Work with estates teams across the Health Board to undertake the minor and major works that are required to allow for the installation of the box cold body storage solutions.	Brown , Yasmin	~~30/12/2025~~ 30.04.2026	Contact has been made with estates managers in WGH, PPH, and GGH. Quotations have been received for minor building works to be undertaken within the PPH mortuary facility and are being progressed 19.11.25 - Building works have been commissioned with the support of PPH estates teams. Builders are currently on site with the works scheduled to be completed at the beginning of December 2025. This additional space created will allow for the erection of the additional rented nutwell units and therefore provide additional body storage capacity over the winter period.

		Seek external advice on enhancement of mortuary storage capacity within current mortuary estate footprint.	Brown , Yasmin	Completed	Initial site visit has taken place with Wessex refrigeration to determine the art of the possible within the existing GGH mortuary facility footprint. Awaiting receipt of possible plans and quotations. 19.11.25 - Quotations have been received from Wessex refrigeration and engagement is ongoing with estates teams to work these up further.
		Develop a business case and explore options in order to secure capital funding to ensure capacity meets both current and future body storage demands.	Baker, Craig	30/11/2026	Initial discussions held with Director of Finance and Director of Strategy and Planning regarding potential options to explore. Some of these options include - Building new estate and facilities - Commissioning body storage from private providers e.g. funeral directors - Working in collaboration with other Health Boards and Local Authority to develop combined regional solutions

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
	Pathology Strategy Group.	1st			Presentation to IQFPD - June 2025.					
	Hywel Dda HTA Assurance Group.	1st								
	Regional HTA Assurance Group.	2nd								
	Quality & Safety Intelligence Group	2nd								
	AHP & HS CCG reporting up to IQFPD	2nd								
	IQPD	3rd								

Date Risk Identified:	Nov-20
Strategic Objective:	4. The best health and wellbeing for our individuals and families and our communities and 5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Nov-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Dec-25

Risk ID:	1032	Corporate Risk Description:	There is a risk to the delivery of timely diagnosis to those on the CYP ASD waiting lists within required timescales - Welsh Government performance standard of 26 weeks. This is caused by an increase in referrals, with demand outstripping capacity and lack of sustainable external funding. This could lead to an impact/affect on those currently awaiting diagnostic assessment and post diagnostic-intervention, resulting in delays in care and appropriate support and signposting in a timely manner which may lead to poorer patient outcomes compounded by a recognition of additional needs and delayed adjustments to meet those needs in other settings. There will also be an impact on the ability of the Health Board to meet Welsh Government targets (diagnosis of ASD within 26 weeks) which could lead to increased scrutiny from regulators, and escalation from Welsh Government. This in turn could result in adverse publicity and a reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?			138, 1249, 1286, 1287, 1392, 1455, 1422, 1524, 1290, 1260, 1699, 1745, 1414

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	5×4=20
Target Risk Score (L x I):	4×4=16
Expected Date To Achieve TRS:	31/12/2050
Trend:	↔

Date	Current Risk Score	Target Risk Score
Oct-23	20	12
Jan-24	20	12
Apr-24	20	12
Jul-24	20	12
Nov-24	20	16
Feb-25	20	20
Jun-25	20	16
Sep-25	20	16

Rationale for CURRENT Risk Score:
Significant waiting times have developed as a result of exponential demand. Demand outstrips capacity, with year-on-year increase in referral rates. Current team capacity can only accommodate 11% of total current demand, compounded by current funding arrangements which are non-recurring, making recruitment and service delivery challenging. Welsh Government funding has been allocated for Children's Neurodevelopmental (ND) services for 2025-26, with the emphasis on eradicating waits greater than 3 years, waits and an improvement plan is in progress. As at October 2025, funding thereafter is uncertain. Meetings with NHS Performance & Improvement have established trajectories to eradicate 3 year waits by March 2026 and developing a transformation implementation plan. An executive-sponsored ASD Task and Finish Group has been established to oversee development and implementation of a 3 year improvement plan, incorporating stabilising and increasing workforce, outsourcing, data validation and waiting list initiatives, service re-design and strengthening regional partnerships with key stakeholders to bring about whole system, needs-led approach in line with ministerial priorities.

Rationale for TARGET Risk Score:
The Clinical Care Group has prioritised implementation of WPAS in Children's ASD service which has enabled improved reporting and waiting list management and to determine trajectories of improvement in waiting times. While trajectory plans are in place, the Health Board has recognised WG targets will not be achieved by the service in its current format, with a further deteriorating position in performance anticipated, compounded by the end of procurement contracts with external providers in March 2025. The achievement of the target risk score is dependent on Welsh Government ring-fenced funding being made available on a recurrent basis, being exempt from cost savings initiatives 2025-2026 in order to maximise opportunities to outsource diagnostic assessments this financial year, service re-design and waiting list initiatives are completed and implemented. Furthermore, the development of a regional, collaborative strategic approach with key stakeholders is imperative to creating whole system, needs-led integrated services. Digital enablers such as artificial intelligence and licenses for digital platforms essential along with access to appropriate clinical venues essential to help reduce target risk score.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
Use of IT/virtual platforms such as Attend Anywhere when appropriate to encourage blended approach to working. Additional WG funding announced - £980,000 allocated to Health Board; funding ring-fenced for CYP service 2025-2026 Weekly Autism Advice Hubs in place for parent carers and CYP Rolling programme of workshops offering advice and support around neuro-diversity for parents of children awaiting diagnostic assessment. ND Service Delivery Manager in place to oversee 3 year performance improvement plan and drive innovative practice in line with WG policy and legislation. Workforce stabilised with no retention issues. Workforce Management Group established and workforce plans in place. Trajectories have been agreed for Children's ND by NHS Executive and systems in place to monitor waiting lists at service level performance-management meetings, IPAR and Clinical Care Group BPPP meetings. Use of HB Third Party Contractor to send out Keeping in touch letters to those on ASD waiting lists on a 3-4 monthly basis confirming place on waiting list and signposting to sources of support including access to ND services and other services while waiting. Outsourcing procurement exercise underway to eradicate 3 year waits by March 2026. Contract to the value of £4m to outsource over a 3 year period,	Although dedicated premises have been sourced for ASD services, there is limited cRapid Design Event to achieve critical, systemic and needs led transforlinical space and Estate issues remain a challenge as identified in the risk narrative.	Grow your own' scheme is coming into place with funding provided in academic year 23/24 for 3 places on the Clinical Psychologist programme (3 year programme).	Carroll, Mrs Liz	~~31/12/2024~~ 31/12/2027	Three year training programme with graduates during 2027.
	Lack of certainty around future funding of ND services. Allocated monies 25/26 are non-recurrent.	Service have been asked to provide a range of options for the Exec Team to consider to improve the performance target.	vaughan, Catherine	Completed	Paper presented to Executive Board on 10th September. To be presented at Public board
	Uncertainty around RPB infrastructure to help support and deliver regional transformation to needs-led, whole system approaches	Development of an SBAR for IQFPD and Public Board outlining a 3 year improvement plan involving increasing workforce, substantiating posts, outsourcing and service re-design	vaughan, Catherine	Completed	Paper presented to executives and scheduled for next public Board meeting outlining phases of 3 year improvement plan
	Lack of capacity within ND services to work strategically to bring about transformational change across the 3 counties. Current capacity within ND services limited due to competing operational responsibility pressures.	Undertake a stratification of need of existing waiting list	vaughan, Catherine	31/03/2026	Commenced 1st October. Challenges centre on all assessments needing completion within 8 weeks of 1st appointment. Work progressing with thematic analysis of drivers for referral underway in order to inform re-design of service to needs-led
	Lack of a regional partnership strategic action plan to help bring about transformational change across the 3 counties involving all stakeholders.	Recruit into additional administrative and clinical posts and make existing fixed term posts substantive	vaughan, Catherine	31/01/2026	Recruitment underway in October 2025
		Outsource a minimum of 585 diagnostic assessments to eradicate >3 year waits	vaughan, Catherine	31/03/2026	Procurement exercise underway to award contracts to 2 providers

commenced in 2025, with the option to increase to 5 years as funding allows Monthly touchpoint meetings with NHS Improvement & Performance to monitor progress against ministerial priorities. SMS text functionality in place for ND to improve attendance and decrease instances of non attendance. Fixed term posts made substantive Early Years pathway and toolkit for Health Visitors in place to encourage a 'watch and wait' approach. Professional consultation introduced across statutory sectors Website developed and in place for all-age ND services. Quarterly 'keeping in touch' letters sent to parent carers of CYP on waiting list signposting to sources of support while they wait. Stakeholder mapping exercise completed and engagement plans in progress		Develop an all-age regional strategic action plan around neuro-divergence to promote whole system, needs-led services	Temple-Purcell, Rebecca	31/03/2026	New action, with progress update required at next risk review
		Introduce an AI scribe across service to reduced administrative burden on clinical staff	vaughan, Catherine	31/03/2026	Meetings in place with ND, CDPS, Digital and Information Governance services to pilot an AI Scribe - namely Magic Notes. DPIA underway
		Develop and appoint into a strategic Head of Neuro-divergence post, to strengthen existing and further develop strategic partnership working	Temple-Purcell, Rebecca	31/03/2026	Progress to be provided at next risk review

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance  Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Welsh Government performance indicators along with internal monitoring arrangements will be used to ensure the actions are having the desired effect or whether there is more that needs to be done.	Management monitoring of referrals	1st			Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC (Oct21) MHLD progress update on Planning Objective 5G - Board (Mar22) Papers have been presented at the Quality Safety and Experience Assurance Committee with a further update paper provided for the December 2021 meeting outlining control measures to manage the	System to improve analysis of patient experience				
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd								
	MH&LD QSE Group overseeing patient outcomes	2nd								
	Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd								
	W-PAS Internal Audit (reasonable assurance)	3rd								

Rapid Access Pilot Steering Group (add as action - look at other pathway options/digital) - renamed ASD Task and Finish group and run fortnightly, sponsored by Executives	1st			waiting times that the Directorate have at present. A paper was presented at Board Seminar in March 2025 to provide assurance on current waiting times and control measures.				

Date Risk Identified:	Jan-19
Strategic Objective:	N/A - Operational Risk

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Nov-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Dec-25

Risk ID:	684	Corporate Risk Description:	There is a risk to the radiology service provision from breakdown of key radiology imaging equipment and associated infrastructure to enable equipment to function. This is caused by equipment not being replaced in line with RCR (Royal College of Radiologists) and other guidelines, and also lack of suitable physical space and electrical infrastructure. This could lead to an impact/affect on patient flows resulting from delays in diagnosis and treatments, delays in discharges, increased waiting times on cancer pathways, increased staffing costs to minimise the impact on patients when breakdowns occur and increased number of SCP breaches and breaches over 8 weeks due to increased downtime. Increased risk of IR(ME)R notifiable radiation incidents due to increased breakdowns as a result of malfunctions during exposures.
Does this risk link to any Directorate (operational) risks?			925, 114, 1668, 1785, 1706

Risk Rating:(Likelihood x Impact)		Current Risk Score Target Risk Score
Domain:	Service/Business interruption/disruption	
Inherent Risk Score (L x I):	5×4=20	
Current Risk Score (L x I):	4×4=16	
Target Risk Score (L x I):	2×4=8	
Expected Date To Achieve TRS:	30/08/2050	
Trend:	↔	

Rationale for CURRENT Risk Score:
The Health Board's aged imaging equipment continues to break down, disrupting diagnostic services and affecting Referral to Treatment (RTT) targets, with delays in diagnosis and treatment for patients. Replacement of CT and MRI scanners has reduced downtime, but recurrent failures of other key equipment highlight the need for further investment. A rolling programme and prioritisation process are in place to manage installations. The Gamma camera at WGH, the only unit of its kind in the Health Board, has suffered repeated breakdowns, leading to HIW's reportable IRMER incidents. It remains a priority for replacement as of February 2025. At GGH, a new CT scanner has been installed, but the original unit continues to fail due to outdated technology, undermining resilience at the major trauma site. Like-for-like replacement is not always cost-effective or compliant with regulatory and warranty requirements, and infrastructure upgrades such as air handling, water chillers, and accommodation adjustments are needed to ensure long-term resilience. Replacement of the Gamma camera at WGH has been delayed due to insufficient physical space and electrical infrastructure, with costs exceeding Welsh Government allocations for 2025/26. The funding window was closed, further impacting compliance with NRW specifications for Nuclear Medicine. Future plans must be coordinated with Estates to expand electrical capacity and ensure facilities meet current and future Nuclear Medicine requirements.

Rationale for TARGET Risk Score:
Modern equipment will reduce the likelihood of breakdowns, minimize downtime, and lessen the impact on diagnostic services across other hospital sites. Strengthened business continuity planning will further mitigate risks associated with equipment failure. However, funding is typically released in Q3/Q4 of the financial year, constraining the scheduling of large installations. The urgency of replacements often forces rapid decisions, resulting in lower-priority equipment being replaced ahead of higher-need installations. The Health Board's top replacement priority is the Nuclear Medicine SPECT scanner, the only unit available which has suffered frequent breakdowns since June 2023. A task and finish group has been convened to plan its replacement in anticipation of Welsh Government funding. The second CT scanner at GGH is the next priority, as it supports outpatient work and serves as a backup; it is increasingly unreliable, with long lead times for parts. Additionally, service variation in DEXA provision has worsened, as the Swansea scanner now performs Trabecular Bone Scoring (TBS), while the BGH scanner cannot. Patients have required repeat scans to obtain TBS results, and the BGH unit also runs on an unsupported Windows version, posing further risk. Replacement of the Nuclear Medicine SPECT, the second CT scanner at GGH, and the DEXA scanner at BGH would allow risks to be de-escalated to the operational risk register. Completion is dependent on WG funding and may extend to the end of the 2026-27 financial year due to infrastructure requirements.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports. # Escalation process in place for service disruptions/breakdowns. # National Imaging and Capital Priorities Group ensures there is a robust governance process to support a national, sustainable clinically focused capital equipment programme across Wales. This will ensure that all HB's in Wales agree to a prioritisation process which will allow for timely equipment procurement and delivery to support healthcare demands across Wales. # All equipment at main sites are now DR and so will be compliant with the RISP project # Additional WGH EOY funding was secured (23-24 financial year) and replaced aged US units and upgraded the software on MRI scanners at BGH and WGH providing latest technology.	Limitation of spare parts for some older equipment leading to extended outages. This issue has been compounded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment. Inability to undertake specific replacements at this time due to the additional infrastructure required National Imaging and Capital Priorities Group outcomes do not always align with the Health Board priorities, and is subject to negotiations within the group.	Installation of replacement Gamma Camera, WGH Gamma camera is 9 years old and the only scanner in the Health Board providing a regional service. Recurrent breakdowns are resulting in HIW reportable incidents.	Roberts-Davies, Gail	~~31/07/2024~~ 30/06/2025 ~~31/03/2026~~ 31/03/2027	No funding allocated as of 09/02/2024 This will not be replaced in the 24/25 financial year. A specific T&F group is due to be set up as of June 24 to plan the necessary accommodation improvements required. July 2024 the T&F group has been set up and meets weekly Feb 2025 there is a draft plan for replacement. Business continuity plans being explored. The plan has been rejected by WAG for 25/26 due to cost and the electrical instruction T&F looking to alternative sites and will resubmit for funding in 26/27.
		Replacement of aged CT Scanner at GGH	Procter, Sarah	~~31/03/2024~~ 31/07/2024 30/06/2025 31/07/2026	Awaiting confirmation of funding as at December 2023. No funding allocated as of 09/02/2024 This will not be replaced in the 24/25 financial year. Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The CT replacement of the aged at GGH has been recommended, however funding has not yet been formally agreed.

Replacement of Fluoroscopy room, WGH	Whitecross, Faith	31/03/2024 31/07/2024 31/03/2025 31/08/2025 31/03/2026	Additional infrastructure required to replace this piece of equipment and so will not be completed until the 2025-2026 financial year. Update feb 25: funding approved for installation of fluoroscopy equipment 25/26 financial year. Update Aug 25: Work starting Sept 25
Replacement of CR X-ray Room 1, WGH	Roberts-Davies, Gail	Completed	Ageing equipment. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. This will not be replaced in the 2023/24 financial year Confirmation that this piece of equipment will be replaced in the 24/25 financial year was received late May '24- action will be closed when this piece of equipment is operational. Equipment replacement complete as of 08/04/2025- awaiting acceptance testing. Update 04/07/2025 confirmation from Site Lead Faith Whitecross that the acceptance testing was completed 02.04.2025. SQ

Replacement of CR X-Ray room, Llandovery Hospital	Osell, Fiona	~~31/03/2024~~ ~~31/07/2024~~ ~~30/06/2025~~ ~~01/12/2025~~ 31/03/2026	Equipment on site is incompatible with the incoming PACS system X Ray room continues to be in use one day per week (Tuesdays) staffed by 1 Radiographer (B5 or B6). Regular maintenance of equipment continues and required QA testing. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. This will not be replaced in the 2025/2026 financial year. Progression of this project reliant upon the outcome of the clinical services plan which is out to consultation
Replacement of Mammography Units, BGH and WGH	Roberts-Davies, Gail	~~31/03/2024~~ ~~31/07/2024~~ ~~30/06/2025~~ 31/03/2027	Ageing equipment, exacerbated by the failure of Securview. These will not be replaced in the 23/24 financial year These will not be replaced in the 2024/2025 financial year These will not be replaced in the 2025/2026 financial year
Upgrade or replacement of MRI scanner, GGH	Procter, Sarah	~~31/03/2024~~ ~~30/06/2025~~ ~~31/03/2026~~ 31/05/2026	Replacement agreed and funding available for replacement in March 26

		To replace the DEXA scanner at BGH and ensuring suitable accommodation is found to meet regulatory compliance for a larger more modern scanner.	Edwards, David	~~31/03/2024~~ ~~30/09/2024~~ ~~30/09/2025~~ 31/03/2026	Unit is 17 years old, and previously funded via charitable funds This has been added to the imaging priorities list and end of year additional funding projects as relative replacement costs are not high, however the infrastructure enablement costs are additional and a suitable location to accommodate a larger scanner needs to be found. Following a National Equipment Capital Priorities Group Meeting held on 02/04/2025, The replacement of the aged DEXA scanner at BGH has been recommended, however funding has not yet been formally agreed.
		Collaboration with Estates to ensure requirements for Radiology at all sites are considered and are integral to future decision-making for site allocation	Procter, Sarah	Completed	After discussion with Head of capital estates - it was decided to arrange a meeting with Strategy and Planning including estates. New action added Initial communication to be established in June 2025 to agree on timelines for future workplan. Estates are currently part of Task & Finish Group, however Head of Engineering to be invited. Further actions to be added based on outcomes.
		Arrange meeting with head of capital planning and head of strategy and planning to discuss long term strategy for equipment replacements.	Procter, Sarah	30/11/2025	Meeting being arranged
		Meeting with head of capital planning to discuss plans for CT and NM replacement in near future.	Procter, Sarah	30/01/2026	meeting to be arranged in Dec/ early jan

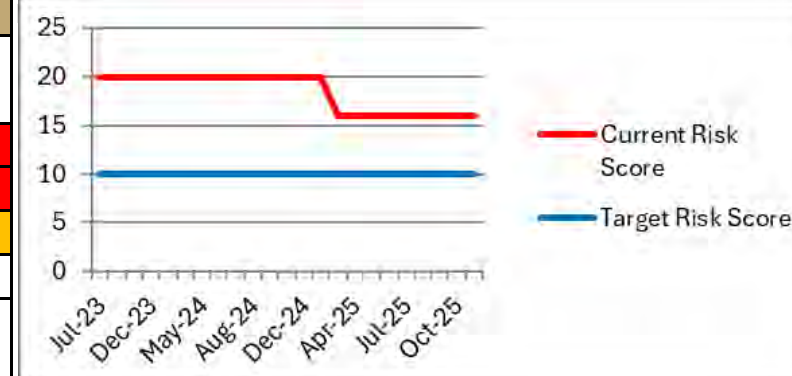
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Reduction of waiting times to under 8 weeks. No SCP diagnostic breaches.	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team Mar19 Further updates CEIMT Feb20 Further updates CEIMT Sep20 Radiology Diagnostic Imaging update to Capital Sub- Committee presented September 2024	Lack of process of formal post breakdown review.				
	IPAR report	2nd								

Date Risk Identified:	May-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Nov-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Dec-25

Risk ID:	1664	Corporate Risk Description:	There is a risk to service sustainability in Ophthalmology, and the inability to provide timely care to patients with Glaucoma, wet Age Related Macular Degeneration, Vitreoretinal, paediatrics and Cataract. This is caused by a national shortage of Consultant Ophthalmologists and the inability to recruit to vacancies. The workforce position is exacerbated by nursing and medical staffing constraints and a reduction in service capacity due to lack of physical space. Recruitment difficulties are leading to the Consultant on-call rota being covered by four substantive Consultants with 2 gaps in the rota. To ensure the delivery of the Ophthalmology service the Consultants undertake additional duty hours. The first on call structure is currently reliant on 5 SAS doctors with 3 gaps in the rota, which is being covered by the substantive SAS doctors currently. This is a fragile on call structure which is impacted by sickness and annual leave. This could lead to an impact/affect on ability to deliver services within the Ophthalmology Referral to Treatment (RTT) plan, and the ability of the Health Board to comply with Welsh Government Eye Care Measures (ECMs). Impacting the ability to provide timely diagnosis and treatment and directly impacting on patient safety, with the potential for sight loss and long-term lifestyle impacts. The Health Board's ability to progress with the implementation of recommendations raised by various regulators and inspectorates is affected by the recruitment and estates issues, which in turn could lead to adverse publicity and reduction in stakeholder confidence, with increased scrutiny/escalation from Welsh Government. The service has undertaken successful recruitment of three specialty Doctors who have recently started in post, this will improve capability and capacity in part. Regional work regarding 2 Regional substantive Consultant posts to fill the vacancies within the team continues
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	31/03/2027
Trend:	↔



Rationale for CURRENT Risk Score:

Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for R1 patients (high risk) with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity.

The service has provided additional AMD sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board (HB). Patient delays continue across the HB. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience.

The current non-medical workforce establishment is not aligned to service needs. The current R1 delivery at 34%. The WG target for R1 delivery is 95%.

The current waiting list for new patients is 15,074. The service is expected to reach 0 patients waiting at stage 1 over 52 weeks by March 2026. The stage 4 104 weeks, is breach of 8. 7518 patients have been 100% delayed for their follow up appointment.

The current impact has been scored as 4 because patients are experiencing harm and the current likelihood has been scored 4 as ophthalmology is a fragile service. It is unlikely that this risk will be able to be significantly reduced without considerable investment.

Rationale for TARGET Risk Score:

the service has been able to reduce the impact score of this risk as whilst the consequences to the patient remains high, recurrent funding has been invested into the service for the delivery of an R1 Eye Care Measures target of 65%. The ministerial Measures target will need to be 0 for 3 months and more and the Follow up delayed will need to be reduced by 12%. Once these targets are reached, the likelihood score can be reduced to a 3 which would reduce the overall score to 12.

The 65% R1 delivery by September 2026 is dependent on all posts being recruited into and all estates needs being met. Further development would be required to reach a 95% R1 delivery score, which would reduce the likelihood to a 2.

With the required investment in Glaucoma and IVT and the additional workforce and estates and continued management of the waiting lists, the HB will potentially be able to reduce the likelihood score on this risk to a 2.

Key CONTROLS Currently in Place:

(The existing controls and processes in place to manage the risk)

The service is included within the Health Board's Clinical Service Plan (CSP). This will produce efficiency gains.

Active recruitment to vacancies through a regional approach, continue grow your own initiatives to secure Substantive Consultants and develop Consultants for the future.

Regional SBAR has been developed around 2 Regional Substantive posts.

Collaborative working with Swansea Bay to deliver a Regional solution to address the workforce and estates constraints. Sub groups to be formulated to address, Glaucoma, AMD, Vitreoretinal, paediatric and cataract pathways.

Gaps in CONTROLS

Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)

How and when the Gap in control be addressed

Further action necessary to address the controls gaps

By Who

By When

Progress

Vacancies remain high within the service with a high turnover of staff.

SBAR for Regional Consultant posts has been approved for funding to be allocated to SBUHB. An SLA needs to be agreed to move forward to recruitment.

The Regional sub-groups are in their infancy with actions being taken to develop sub-specialties.

The Posts for the (AMD) service need to

Roll out and implementation of National Electronic Patient Record for Ophthalmology.

Barreiro, Marta

30/07/2021-
31/03/2022
31/05/2022
30/09/2022
31/10/2023
31/12/2023
31/03/2024
15/07/2024
31/03/2027

Application Support Manager recruitment successful, awaiting onboarding and a start date. Workshops planned for the varied subspecialties to go through needs for each to enable the build up of the system workflows as soon as the Application Support Manager is in post.

CORPORATE RISK REGISTER SUMMARY NOVEMBER 2025

Additional funding for the delivery of Wet Age related Macular Degeneration (AMD). IVT outsourcing commenced in February 2025 continues to support the service, whilst service is developed. Additional capacity has been funded for the delivery of Cataract surgery to maintain the 104 week wait for 2025/2026. Wales General Ophthalmic Services (WGOS) for Glaucoma, Diabetic Retinopathy and Medical Retina ongoing. Continued Validation of waiting lists to remove any patients who no longer require treatment. With review of data quality inclusive of Health Risk Factor (HRF) code and clinical codes ongoing to improve data quality. Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards. The first regional ECCG meeting was held on the 19th September 2025. Highly trained Optometrists working collaboratively with the Secondary Care Eye Service to reduce referrals to secondary care and support the validation process. Ongoing training of Optometrists within secondary care for IPOS, Glaucoma and Medical Retina for continued delivery of WGOS and reduce referrals into secondary care. GIRFT review undertaken on the Ophthalmology service with progress made against recommendations raised monitored and updated via AMAT. Performance dashboards in place to monitor performance.	be recruited into and the space for the expansion of the service in AVH needs to be secured for 5 days a week. The regional cataract delivery plan needs to be developed and executed. A WGOS co-ordinator needs to be secured in primary care to support the discharge of patients to the community. The remaining 9 GIRFT recommendations need to be actioned and closed. There still remains areas of the service (e.g. Glaucoma, AMD, Cataract, Paediatrics, Corneal and VR) that require investment. The regional programme board will need to consider further opportunities for a long-term regional model. Central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. Recovery funding is non-recurring and reviewed annually, which restricts delivery planning. There are ongoing concerns in data quality due to referral processes and system use.	Refurbish and establish a nursing team in the Outpatient Department in Amman Valley Hospital to provide intravitreal treatment for the patients currently attending the day theatre area for their treatment. This will ensure continuity of care for those patients when cataract surgery activity is returned to day theatre.	Coppack, Victoria	Completed	Capital bid was secured and work to improve physical space at Amman Valley Hospital (AVH) was completed in March 2022. IVT recovery SBAR presented to the Board with associated workforce and drug costs identified. Long term funding is being considered as part of the annual plan.
		Implement virtual review clinics for patients undergoing Hydroxychloroquine (HCQ) treatment.	Coppack, Victoria	30/09/2022-31/10/2023 30/11/2023 31/03/2024 30/06/2024 30/09/2024 31/03/2026	Recommend the validation of the HCQ patients. Ensure patients start to be discharged to primary care Optometrists when training has been completed. Primary Care still awaiting materials to be finalised and process rolled out.
		Alignment in the Delivery of Eye Care Measures and Ministerial Measures and effective management of Ophthalmology waiting lists.	Coppack, Victoria	31/03/2027	Recruit into 2 regional consultant posts. Deliver actions against regional programme board. AVH OPD to be secured for additional 2 days IVT. Deliver 52 week and 104 week target. Deliver 12% reduction in follow up delayed. Ensure all WGOS patients identified for pathway are discharged to primary care. Complete GIRFT recommendations. Continue with Clinical Services Plan.
		Long-term investment required for IVT and Glaucoma Delivery to recover R1 position	Jones, Keith -	Completed	New action - progress update to be provided at next risk review.
		Regional solutions to workforce gaps and estates to be explored through Regional programme	Coppack, Victoria	31/03/2027	Regional visit to SBUHB completed. Next Regional Eye Care programme Board meeting 31st October 2025

		Orthoptist posts to be recruited into	Coppack, Victoria	30/09/2025- 31/03/2026	Band 6 1.0 WTE Orthoptist post to be recruited into. Band 8B JD has been signed off by job matching panel. Next steps to identify the funding for this post and authorise through CCG and FCSG.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Eye care measures monthly report.	WPAS	1st			SBAR for IVT Service Delivery & SBAR for recovery of R1 position Revised RISK SBAR.					
GIRFT review Cataracts.	GIRFT action plan cataracts	1st								
GIRFT review Glaucoma.	GIRFT action plan Glaucoma	1st								
Weekly RTT Optimisation to review Ministerial Measures.	WPAS, scheduled care performance indicators	1st								

Date Risk Identified:	Oct-25
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Nov-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Dec-25

Risk ID:	2190	Corporate Risk Description:	There is a risk that the Health Board will be unable to implement Direct Payments for Continuing Healthcare by 1 April 2026. This is caused by the reduced implementation timescale from December 2026 to 1 April 2026, the absence of WG policy guidance (which will not be issued until April 2026) and insufficient resource and capacity to support local implementation within the Health Board. This could lead to an impact/affect on service delivery, with service users not being treated fairly due to a disparate approach resulting from lack of National policy guidance and local governance arrangements. There is potential of increased complaints and Ombudsman queries, and reputational damage to the Health Board in failing to meet national policy. There is also a potential financial impact due to increased costs associated with Direct Payment implementation, and the number of cases that are likely to present in the future.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		No trend information available.
Domain:	Quality/Complaints/Audit	
Inherent Risk Score (L x I):	4×4=16	
Current Risk Score (L x I):	4×4=16	
Target Risk Score (L x I):	3×4=12	
Expected Date To Achieve TRS:	31/03/2026	
Trend:		New risk

Rationale for CURRENT Risk Score:
There is a lack of clarity and national guidance regarding the proposed model for the delivery of Direct Payments, and the time available for implementation which has reduced significantly with proposed date of implementation brought forward from December 2026 to 1 April 2026. There are serious concerns that governance and safety requirements will not be adequately established to meet the revised implementation date, which may increase the risk of inconsistent approaches across Health Boards. The Health Board does not currently have a system in place to manage or deliver Direct Payments in order to comply with the requirements of the forthcoming policy. Robust governance systems have yet to be developed, and there is a notable absence of dedicated resource, and specialist expertise. Delivery within such tight timescales will require additional resources, with a small core of dedicated staff based within a national Hub supported by professional and financial expertise. Each Health Board will also be expected to put in local arrangements to support delivery at a local level. Without additional resources, staff may be unable to allocate sufficient time to support implementation alongside existing duties.

Rationale for TARGET Risk Score:
A dedicated local resource is needed to meet legislative requirements by 1 April 2026. Clarity is needed from Welsh Government over guidance and implementation plans to enable robust governance and safety requirements. All Health Boards in Wales require a consistent approach to direct payments. Whilst the implementation date is end of March 2026, there is no certainty that this can be achieved without the additional governance and resources.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
Local Working Group which includes LTC , MHL D and Children's services as well as finance colleagues which meets monthly. However additional resources have not been identified or clarity on whether a national hub or resources will be available. National CHC leads group meeting already in situ with direct payments regularly discussed. There is also a Welsh Government direct payments policy team meeting with Health Boards on a monthly basis. 150k is being held by Powys Health Board and they have appointed a lead to support Health Boards on implementation.	No local or national implementation plan in place No development yet of a suite of all Wales protocols and operational guidance. Lack of dedicated resource to implement requirements. No financial protocols designed to support payments.	Hywel Dda input required to support Welsh Government national consultation and development of guidance	McCarthy, Julia	Completed	Health Board to attend Welsh Government policy team monthly meetings. Welsh Government have recently issued the consultation paper regarding the regulation of direct payments for response by 15 October 2025. In addition a further CHC DP draft guidance was given and comments needed by 19th Nov this has been submitted by the Service.
		Identify resources required to action and implement a working plan to deliver direct payments.	McCarthy, Julia	31/03/2026	Executive support has been asked at EITS on the 10th Nov. Local working group established.
		Develop and increase the skills and knowledge base in the Health Board for direct payments and their operation	McCarthy, Julia	31/03/2026	Will require dedicated resource. Has been discussed at last EITS 10th Nov for support needed.

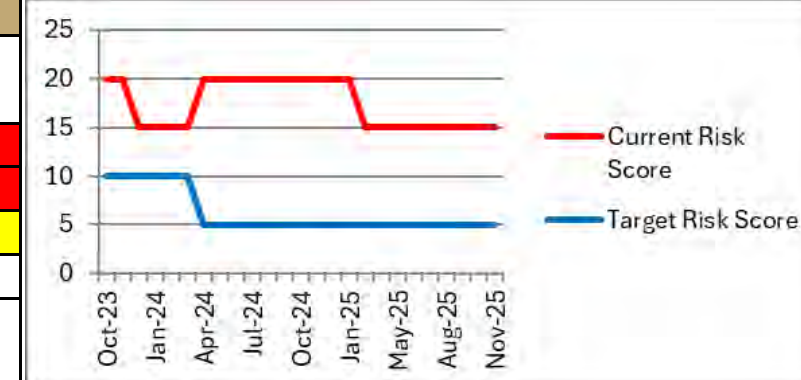
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance  Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Reviews completed in line with the national framework. Number of packages and costs reported monthly to local governance forums. Papers are submitted via the CCG IGG. Welsh Government may require reporting but that is yet to be confirmed	There are current finance reporting and review monitoring arrangements in place that could be adapted when direct payments are implemented and would be reported through the CCG and IQFPD. .	1st								
	Recent internal audit of finance procedures received substantial assurance .	2nd								

Date Risk Identified:	Nov-22
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Oct-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Nov-25

Risk ID:	1531	Corporate Risk Description:	There is a risk of being unable to provide a safe and sustainable general surgery consultant on-call rota at WGH and GGH. This is caused by Unsustainable and fragile rotas, with a difficulty to recruit into substantive posts. This could lead to an impact/affect on on the ability to provide an emergency general surgery service at WGH and GGH affecting patient experience, causing clinical delays and poor outcomes for patients. The wellbeing of remaining consultants who are already working to full capacity are also affected and there is an increased expenditure on agency locum consultants and internal locum rates at the HB card rate. Consultants working additional on call locum weeks is resulting in a reduction in elective activity in OPD, endoscopy and theatre. This could have a negative impact on RTT and SCP targets.
Does this risk link to any Directorate (operational) risks?			2067

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	1×5=5
Expected Date To Achieve TRS:	27/02/2026
Trend:	↔



Rationale for CURRENT Risk Score:
Whilst surgical consultant on-call rotas at GGH and WGH are covered, the service is still reliant on NHS locums and agency locum consultants. This situation will remain the same until substantive upper GI consultants are recruited to address the emergency on-call rota risk and the Upper GI service risk at WGH. Recruitment has been successful to the substantive post at GGH with the candidate commenced in post. One post has been successfully recruited to at WGH with the applicant onboarding, and the second post re-advertised as at November 2025. It is anticipated that both will have fully onboarded by February 2026.

Rationale for TARGET Risk Score:
The target risk score is based on the work currently being undertaken as part of the Clinical Services Plan to identify and approve a more sustainable solution in order to reduce the likelihood of rota collapse and reduce the risk of not being able to provide a safe and sustainable emergency general surgery service to patients in the south of the Health Board. The effectiveness of revised rota arrangements will depend on several factors including availability of a labour market. Achievement of the target risk score is dependant on the outcomes of the Clinical Services Plan which will inform future plans or the successful appointment of substantive upper GI consultants to the current model at WGH. The risk score will reduce on the appointment of substantive consultants. Should the service be able to recruit suitable candidates to the three upper GI substantive posts, it is anticipated that they rotas at GGH and WGH will be fully functioning by February 2026.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
Rotas monitored daily by the service delivery team. The gaps in GGH are being covered by internal locum at the health board card rate. The WGH rota is a 1:4 frequency with 2 substantive consultants. 1 NHS locum consultant and 1 Medacs locum consultant. There is a substantive upper GI consultant currently onboarding, which will replace the Medacs locum. There is a further advert out for a substantive upper GI consultant to replace the NHS locum consultant. When there is sickness or unexpected leave, due to emergency circumstances, the following process is followed by the management team to cover the on-call: 1. Internal Additional Hours (ADH) on the site with the gap. 2. Internal ADH from the other sites across the health board. 3. In the event of steps 1 & 2 being unsuccessful, the service would escalate for agreement on transferring the surgical out of hours on call take to another site. (WGH to GGH) 4. Ensuring that all stakeholders are aware, including site teams, medical teams, WAST, any supporting services as appropriate. Proactive sickness management Escalation to clinical leads On appointment, new consultants undertake an induction with Hospital Director at WGH and Clinical Director for Scheduled Care. SOP in place for the transfer and repatriation of patients Engagement with the CSP programme.	All posts are yet to be filled substantively. There is a risk of Medacs agency locums leaving the health board at short notice, leaving a gap in the rota. The Consultants at GGH also provide the support to the junior and SAS level doctors at PPH for the elective pathway. No rota co-ordinator in place at GGH and WGH to support rota management, and currently undertaken by Service Manager. This has a detrimental impact on the workload of the service team. There is a risk of consultants requesting rates that are higher than the HB card rate, going forward as they have been covering multiple gaps on the rota for a prolonged time.	Review the longer term sustainability of general surgery on-call rotas across Hywel dda (recommendation from Getting it Right First Time (GIRFT) review in Jan23)	Lewis, Caroline	Completed	The senior consultant leads for general surgery have suggested that the WGH and GGH on call rotas are amalgamated to one site. This would provide an increase of consultants on the rota to either a 1:10 (the 3 WGH consultants and the 7 GGH consultants) or a 1:12 (the 3 WGH consultants, 7 GGH consultants and 2 newly recruited posts). This recommendation is in line with the GIRFT report. SBAR's have been drafted by the service to describe the fragility of the rotas.
		To develop an options appraisal paper with all relevant stakeholders, including WAST, Primary Care, and site teams	Hire, Stephanie	Completed	A discussion was due to be held live at the health board planning session on 09/1/25, this did not take place due to the clinical lead and clinical director not being able to attend. The EGS situation is regularly reviewed and appropriate action is taken by the service as and when required. It also forms part of the fragile services, which is discussed at escalation. We are awaiting confirmation as to when or if the stakeholder discussion will take place. Following the executive meeting on 12/03/2025 and the agreement to recruit substantive consultants into the gaps on the rotas, this options appraisal paper is no longer required. This will need to be reviewed, if the service is unable to recruit suitable candidates.

	To hold interviews to appoint NHS locum consultant	Lewis, David	Completed	Job descriptions have been sent for Royal College approval in April 2025.
	To agree job descriptions and advertise for three substantive consultant posts	Lewis, David	Completed	The two substantive upper GI consultant posts have been advertised and shortlisting is currently being undertaken. If there are suitable candidates, interviews will take place on 2nd September. The substantive lower GI consultant post will be advertised in Spring 2026, in readiness for the end date of the NHS locum that has been appointed.
	Successfully recruit 2 x substantive upper GI consultants.	Lewis, David	~~30/09/2025~~ 31/01/2026	2 candidates were successfully recruited and 1 is currently onboarding. The service withdrew the offer to the second candidate and the post is currently back out to advert.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance	Required Assurance			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed	By Who	By When	Progress
		(1st, 2nd, 3rd)	Current Level							
	WGH Medical Staff Committee established to develop models of sustainability	1st			Management team have presented an SBAR to Acute Leadership Group (Feb23, Sep 24, Oct 24) SBAR to Executive Team and OPDP to agree 1:3 rota (Mar23) General Surgery Report to Board	Assurance to Board on communication and repatriation arrangements				

Reported to monthly General Surgery Business Meetings on each site (BGH/GGH/WGH)	2nd			Report to Board (Mar23)				
				Management team to present updated SBAR to Acute Leadership Group (Oct23 & Nov23)				
				Management team to present updated SBAR to Corporate Directorate Group (Apr24)				
Reported to bi-monthly Scheduled Care Quality, Safety and Experience Group through exception reporting	2nd			Upper GI service SBAR presented at ALG (Sep24)				
				Upper GI service SBAR presented at Quality, Safety and Experience committee Meeting (Oct24)				
Assurance to be reported to the Board following introduction of temporary rota	2nd			Updated SBAR to Executive Team (Nov24)				
				Options Appraisal via CSP to Board (Nov 24)				

	GIRFT report on General Surgery which raised the sustainability of general surgery across 3 sites in Hywel Dda - final report awaited(3rd,				Upper GI service SBAR presented at scheduled care directorate QSEAC (Jan25)							

Date Risk Identified:	Feb-24
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Nov-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Dec-25

Risk ID:	1810	Corporate Risk Description:	There is a risk that the Health Board will be unable to continue manufacturing cancer treatments for our patients. This is caused by the facilities of the Pharmacy Aseptic Unit being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS) standards 5th edition (published 2016) and therefore at risk of closure, exacerbated by a fragile workforce within the service. This could lead to an impact/affect on the Health Board's ability to provide all the cancer treatments currently offered. The Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. A fully outsourced service would cost an additional approximate £1m each year. Some therapies cannot be outsourced, meaning Hywel Dda could not offer over 500 cancer treatments each year. This would have a significant negative impact on patient care as patients would either be required to travel further from home to neighbouring Health Boards to receive their treatment (dependant on their capacity to absorb the additional demand) or would be offered less clinically appropriate treatments at Hywel Dda, negatively affecting clinical outcomes. The closure of the Aseptic unit would directly impact the ability of the Health Board to achieve ministerial priorities and targets such as the Single Cancer Pathway, A Healthier Wales, etc.
Does this risk link to any Directorate (operational) risks?			2004, 374, 1350, 716

Risk Rating:(Likelihood x Impact)		Current Risk Score Target Risk Score
Domain:	Service/Business interruption/disruption	
Inherent Risk Score (L x I):	5×5=25	
Current Risk Score (L x I):	3×5=15	
Target Risk Score (L x I):	1×5=5	
Expected Date To Achieve TRS:	31/12/2026	
Trend:	↔	

Rationale for CURRENT Risk Score:
Withybush Aseptic Unit is the only remaining aseptic unit in the Health Board capable of producing cancer treatments. However, it is currently non-compliant with regulatory standards. A 2024 audit deemed it a high risk to patient safety, and a 2025 follow-up confirmed ongoing staffing issues and insufficient resources to maintain quality standards, putting the unit at risk of forced closure. Temporary control measures have been implemented to reduce microbial contamination and delay closure (see control measures), but the aging infrastructure means these measures may soon become ineffective. If contamination increases, the unit may be forced to close. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality.

Rationale for TARGET Risk Score:
The target risk score is based on the premise that a new demountable aseptic unit will be built at Withybush in 2026. The unit would be compliant with regulatory standards and once operational, it would be extremely unlikely for the unit to be forced to close. A new unit would allow the Health Board to continue to safely prepare cancer therapy until the TrAMS South West manufacturing hub is operational. It is anticipated that the current risk score could be reduced to 10 once the unit is operational, expected to be September 2026. Achievement of the Target Risk Score of 5 is expected once workforce fragilities have been addressed, anticipated to December 2026.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
Transfer of the radiopharmacy service to Singleton Hospital in October 2022; this means less overall activity through the Witybush Aseptic unit reducing the risk of contamination and errors. More time and resource provided to the Quality System (i.e. internal audits, investigation of near misses and microbial growths, maintaining SOPs). Increased training of aseptic staff to develop their skills and knowledge. Increase outsourcing from commercial suppliers; this limits the volume of products prepared within the unit, allowing products that must be made in-house to be prepared safely. New pharmaceutical isolators have been procured to replace the existing isolators that are beyond their working life of 10 years. The new isolators will be stored with the intention of installing into the demountable unit (if funding is secured) or will be installed into the existing unit if the current isolators fail mitigating the risk of equipment failure causing prolonged service disruption. Removal of outsourced dispensing from the Aseptic unit; this minimises the risk of contamination and potential for error. Preparation of products near to the time of use; this limits the pre-administration storage time. More stringent gowning process; this minimises contamination risk. More stringent cleaning and monitoring programmes; this minimises contamination risk and allows early detection of microbial growth. Oversight and steer from Capital Sub-Committee.	Controls are reliant on a key group of skilled staff (i.e to maintain Quality System, to follow cleaning and monitoring procedures) therefore subject to key person dependencies. Findings from the audit undertaken in February 2025 highlighted the fragility of the workforce due to key person dependencies which could detrimentally impact on the service. Limited accommodation to employ additional staff to expand workforce within the existing unit at WGH. Limited accommodation to store starting materials and finished products or to perform the associated tasks that are required to safely supply cancer treatments. Between 2021 and 2023, the number of cancer treatments requiring aseptic preparation at Hywel Dda increased from 12,718 to 16,648 (average of 14% increase each year). There is limited space within the Pharmacy at WGH to manage this increase in demand.	More staffing resource is required to support the aseptic unit's quality system, to ensure that all other regulatory standards are adequately met to mitigate the risk of the non-compliant facilities.	Morgan, Cerith	30/09/2026-30/12/2026	Internal staffing model has been reviewed to allow the Health Board's lead quality assurance pharmacy technician to provide more support to the quality system. Initial discussions held with other Health Boards to explore whether they have QA resource that could support Hywel Dda through a SLA. Invest to save SBAR developed that would support more staff to work within the aseptic unit through a cost saving opportunity (reducing outsourcing of Azacitidine).
		WG have approved funding for a new demountable aseptic unit. Aseptic project team to progress with planning for building the unit and confirm project timelines once finalised.	Morgan, Cerith	31/08/2026	Initial workshops with principal contractor and aseptic unit supplier have been undertaken. Based on current timelines - the new unit will be operational by September 2026.

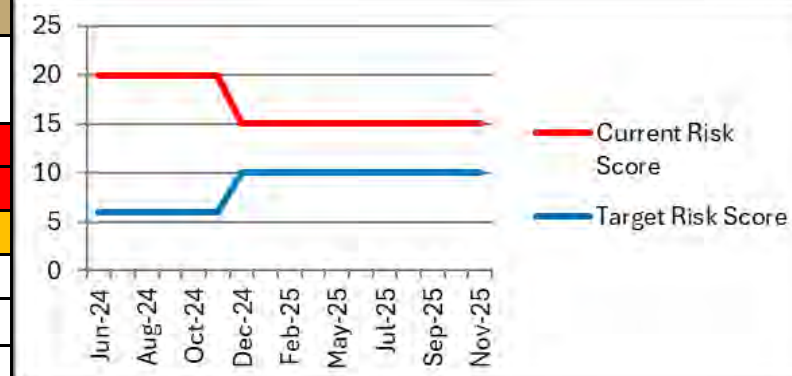
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance  Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Audit Reports from annual audits detailing areas of non-compliance KPI Dashboard in place to provide continuous oversight of unit performance, updated monthly.	Annual Audits by Lead Quality Assurance Pharmacist (NWSSP) .	3rd			Capital Sub Committee (22nd January 2024). MMOG report to QSEC for Feb 2024. BJC Board January 2025.					
	Quarterly self-assessments undertaken by Lead Aseptic Pharmacist, with outcomes fed back to Lead Quality Assurance Pharmacist at NWSSP	1st								
	Monthly Pharmacist Services Governance Meeting .	2nd								

Date Risk Identified:	May-24
Strategic Objective:	

Executive Director Owner:	Daniel, Sharon	Date of Review:	Nov-25
Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Dec-25

Risk ID:	1859	Corporate Risk Description:	There is a risk that patients are at increased risk of poor outcomes, and a poor patient experience. This is caused by the Health Board's inability to effectively recognise and manage acute deterioration. This could lead to an impact/affect on increased length of stays, increased admissions to Critical Care, increased risk of cardiac arrests for patients, and poorer patient outcomes who may experience permanent injuries or irreversible health effects.
Does this risk link to any Directorate (operational) risks?			1758

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	2×5=10
Expected Date To Achieve TRS:	31/12/2025
Trend:	↔



Rationale for CURRENT Risk Score:
There were specific concerns relating to Glangwili and Wilybush General Hospitals regarding cardiac arrests and unplanned admissions. There was an increase in cardiac arrest rates in GGH in the period Jan-Dec 2024 (35) compared to the same period Jan - Dec 2023 (20). The first 10 months of 2025 noted a decrease in the Cardiac Arrest rates in GGH compared to the same period 2024, with 20 noted (2024:30). There had been a 22% increase in unplanned admissions at WGH in 2024. In the first 8 months of 2025 there has been a reduction in the number of unplanned admissions into WGH ITU compared to the same period in 2024 (Jan-August 2025:50 (2024:67)). As of 8th August 2025, compliance rates for Level 3 Resuscitation Training Adults is 64%, Paediatrics 45%, and Level 2 Training (BLS) is at 51% for adults, and 48% for Paediatrics, an improved position since June 2025. All planned actions to mitigate the risk are being processed within set dates/timeframes although many remain long term. Current controls are managing the risk and the increasing awareness of gaps in assurance and local actions to mitigate and manage the risk have been established.

Rationale for TARGET Risk Score:
The full implementation of the actions noted in the risk action plan will support the reduction in the likelihood and impact score of this risk to a target risk of 10. With recruitment into the Resus Team and the establishment of a supported Cascade Training process the aim will be to see an increase in training compliance in both Level 2 & Level 3 training by October 2025 to >60%. This will enable the risk to be reduced to the Target Risk Score of 10, >85% would enable the risk score to be reduced further to 5. We will aim to see a reduction in Cardiac Arrest rates across all 4 sites and unplanned admissions into ITU from ward areas by October 2025.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
Governance structures in place eg RADAR Group (Recognition of Acute Deterioration and Resuscitation). Increased awareness of gaps in assurance and local actions in place to manage and mitigate the risk. T&F Group chaired by HB RADAR Lead with focus on Sepsis. RADAR directly reports to Quality and Safety Intelligence Group (QSIG) Local RADAR groups (across all sites, counties, MHL and Paediatrics) which report to Health Board wide RADAR group. Mechanisms in place across all sites to monitor cardiac arrest rates. Health Board Resus policy in place (currently under review and updated to reflect National Guidance) All Wales DNA/CPR policy in place and has been uploaded onto the Health Board intranet. Clinical Lead Nurse for Acute Deterioration 1WTE Dedicated Resuscitation Team in place, consisting of 5.2WTE across the Health Board (acute, community, mental health and primary care) and one 1WTE admin support. WAST have remained with the patient and allowed the HB to utilise their pre hospital mechanical device equipment within the hospital setting.	Treatment escalation plans not in place but continued to be discussed at WGH and GGH Call for Concern only for inpatient adult patients only and at the moment is only across 2 sites. Inconsistent application of policies and processes eg DNA/CPR, sepsis assessment tool, National Early Warning Score (NEWS). Reliance on manual / paper based documentation to record patient deterioration and subsequent escalation	Health Board Recognition of Acute Deterioration and Resuscitation (RADAR) group to develop a workplan to address gaps in control to improve the recognition and management of acute deterioration across the Health Board.	Davies, Mandy	Completed	Quarterly meetings in place, and sub-groups being established to report to Recognition of Acute Deterioration and Resuscitation (RADAR) group on sepsis, NEWS, treatment escalation plans, call for concern (Martha's Law) DNA/CPR, acute kidney injury (AKI). Agenda at August meeting didn't allow for discussion on the development of a workplan. Plan is to confirm RADAR Action Plan, with risk actions to be updated accordingly. RADAR next scheduled to meet on 7th October 2025.
	Critical Outreach Services not in place at PPH / BGH Inability to release staff to complete L2 and L3 training High number of newly qualified new nurses to the HB including overseas requiring support to develop their expertise in recognising acute deterioration. Training requirement to meet	To implement an electronic observations systems across the Health Board to capture real-time bedside capture of patient assessments and monitoring, in line with the Health Board's Digital Plan	Williams, Carolyn	~~30/09/2025~~ 30/04/2026	Tender process completed. Business case presented to Board in July 2024, with a view to implement on a site by site basis over in 18 months, in line with the current Digital Plan. Board approved the business case in Sept 24 however funding has not yet been identified to enable the project to proceed.

CORPORATE RISK REGISTER SUMMARY NOVEMBER 2025

Networks in place across the wider Health Board, including support from QIST (Quality Improvement Service Transformation) Team and practice development. Organisational training plan in place, including mandatory training Critical Outreach Services in GGH and WGH (not in place at PPH/BGH), managed by Planned and Specialist Care Clinical Care Group (i.e not fully linked to Acute Deterioration resource) New Acute Kidney Injury (AKI) Lead appointed for GGH until October 2025 Dedicated resource in Quality Improvement Team monitoring AKI alerts for the Health Board Bi-monthly scrutiny meetings have been set up in GGH, BGH and WGH to review Cardiac arrests. Cardiac arrest reviews presented at Medical Education sessions Review of feedback from any Medical Examiner reviews, highlighting issues relating to resuscitation/cardiac arrests and lessons learned. Call for Concern in place at GGH and WGH for inpatient adult patients only. Process for implementation in Paediatrics, Mental Health and remaining sites under review. Cascade Trainers in place across the Health Board (community and acute)	Training requirement to meet recommended Resus Council Standards greater than current allocated Resuscitation Team resource 60 - 70% attendance of courses, even if fully booked. Current resource not being used to full potential with financial implications. Inconsistent and irregular site RADAR meetings which report in to HB-wide RADAR Group, with lack of medical leadership Whilst there is a dedicated Resuscitation Team in place, the HB does not have a Mechanical CPR Device in any of its Acute Sites. The Resuscitation Council Guidelines for Resuscitation state that a LUCAS is a good alternative for situations where it may be difficult or to maintain continuous high-quality compressions, or when it may be too strenuous on the medic to do so. There have been occasions when WAST have remained with the patient and allowed the HB to utilise their pre hospital mechanical device equipment within the hospital setting. However, this is not routinely or officially suitable practice.	As part of the Quality Dashboard, agree the matrix needed for patient deterioration. Include these matrix in the Health Board Quality Dashboard to inform escalation and create a specific dashboard for RADAR (Recognition of Acute Deterioration and Resuscitation).	Wastell, David	~~30/05/2025~~ ~~30/09/2025~~ 31/12/2025	Supporting metrics for the dashboard identified: sepsis, AKI, NEWS audits, cardiac arrests, number of MET calls, treatment escalation plans are in place, call for concern rates and training compliance for ILS and BLS. Senior Nurse for Resuscitation and Acute Patient Deterioration is working with Performance Team to agree the process for data collection to inform the Dashboard, and identifying methods to prioritise the dashboard data via a RAG system. Data being supplied however further work required to align to the new operational CCG structures on the dashboards.
		Put in place process for Health Board compliance with Martha's Rule by establishing a Task and Finish Group to implement Call for Concern	Wastell, David	~~31/03/2025~~ 31/12/2025	Task and Finish Group is in place, chaired by Anna Chiffi. SOP Patient leaflet is being developed and a pilot was due to commence in GGH in Feb25. This pilot will test the process to roll out across the organisation for Adult Inpatients. Pilot scheme at GGH implemented in March 2025, with a view to rolling out to other three acute sites by December 2025.

Put in place All Wales Policy for treatment escalation plans to enable safe and effective care management when patient deteriorating.	Edmunds, Dr Eiry	Completed	Discussed at Withybush RADAR meeting in July 2024 where agreement reached for pilot. Task and Finish group being established by Lead for Critical Care Outreach in Withybush to devise an implementation plan. RADAR to review following evaluation and consider roll out across other sites. As of September 2025, the situation remains unchanged. TEPS sub group meetings have been held at WGH but there is no set plan at the moment to implement or trial. To discuss at RADAR meeting scheduled for October 2025. Palliative Care Consultant has been appointed as the TEP Lead for the Health Board.
Work to improve compliance with Sepsis Bundles at the front door.	Wastell, David	31/12/2025	Ongoing quality improvement in place. Has demonstrated improvements in Glangwili and Prince Phillip and now being used in Withybush. Reviewing process for assessing impact on patient outcomes as a result of the response and management of sepsis. Implemented in July 2025, and audits to be undertaken to monitor compliance.

Improve compliance with DNACPR National Guidance	Steele, Cathie	Completed	DNACPR Review Group formed and actions identified including development of a SharePoint page (which is now complete) and undertaken an improvement project through EQiIP (complete). Annual audits undertaken by junior doctors, and reviews of medical examiner reports and cardiac arrest to identify learnings. More robust communication between mortality review group and RADAR being established. Training needs have been identified in relation to DNACPR and patients who are considered having learning disabilities, or diagnosed with dementia. Work is commencing with the MHLd directorate to progress this. A full action plan as been agreed in response to the HIW National Report on DNACPR (see AMAT)
Development of an Acute Deterioration Sharepoint page for all advice, guidance, updates, for staff on issues relating to resuscitation, DNACPR, sepsis, call for concern, MET calls, training, etc.	Wastell, David	Completed	Senior nurse for acute deterioration is working with Interim ADN for Quality and Safety to develop SharePoint page. Refinement of the Sharepoint site underway to finalise and launch as of September 2025. 7
Acute Deterioration E-learning modules - topics include NEWS, sepsis, DNACPR and A-E assessment being developed by the Lead Nurse for Acute Deterioration in conjunction with NHS Executive and other leads. Work to develop a process for using these modules with clinical areas in response to issues of concern.	Wastell, David	~~31/01/2025~~ ~~30/06/2025~~ ~~30/09/2025~~ 31/12/2025	Currently awaiting national updates in order to progress with this action. Links to the modules have still not been established (as of September 2025) because the guidance around NEWS2 and Sepsis is still under development.

	To develop mechanisms to review and monitor the Acute Deterioration position via Escalation Framework via the Quality domain (including the implementation of the Safety Dashboard)	Davies, Mandy	Completed	Senior Nurse for Resuscitation and Acute Patient Deterioration is working with Performance Team to agree the process for data collection to inform the Dashboard, and identifying methods to prioritise the dashboard data via a RAG system. This phase completed.
	Following assessment and interpretation of the All Wales Direction, the Health Board is engaging in National work, namely roll out of Call for Concern.	Wastell, David	30/09/2026	Awaiting national guidance in order to progress further with this action as of September 2025.
	Capital Bid to be submitted for 3-4 LUCAS machines (mechanical CPR machines).	Wastell, David	31/03/2026	New Action

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance  Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Training compliance via ESR Cardiac Arrest Audits	RRAILS Audits undertaken by ward staff monthly, and inform the Nursing dashboards	1st			RADAR Group Update to QSESC, May 2025.	Ward based NEWS audits in place but may be unreliable as self assessed.	Once dashboards in place, to develop a monthly audit process to address key hotspots / areas of concern relating to RAILS	Wastell, David	~~30/09/2025~~ 31/12/2025	Progress to be provided once dashboards in place and functional for reporting to future RADAR meetings.
	Review of DATIX incidents, complaints, cardiac arrest reports and Medical Examiners reports relating to acute deterioration	1st								
	Outreach review all unplanned admissions to Intensive Care	1st								
	RADAR Group	2nd								

T&F Group/Oversight Group chaired by Assistant Director of Nursing and Quality Improvement with focus on Early Warning Scores and Sepsis	2nd								
DNAR/CPR group chaired by Deputy Medical Director - group needs to be re-established (as of June 2025).	2nd								

2 - Risk

2.1

2.1 - Deep Dive: Radiology

Sarah Procter (Hywel Dda UHB - Deputy Head Of Radiology), Sara Quarrie (Hywel Dda UHB - Service Director for Allied Health Professions and Health Sciences), Angela Bell (Hywel Dda UHB - Assistant Director Quality, Safety + Patient Experience for Allied Health + Health Sciences)

Attachments

[Deep Dive Radiology QSEC.pdf](#)



2.1 Deep Dive: Radiology Fragility impact pending Clinical Services Plan (CSP).

Quality, Safety & Experience Committee Meeting
4th December 2025

Background: current service provision

Escalation profile



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Escalation status trend by domain	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Finance	3	3	3	3	3	3
Performance	3	3	3	3	3	2
Population Health	n/a	n/a	n/a	n/a	n/a	3
Quality & Safety	2	2	2	2	2	2
Strategy, Planning and Fragile Services	3	3	3	3	3	2
Governance	2	2	2	2	2	1
Workforce	2	2	2	2	2	2

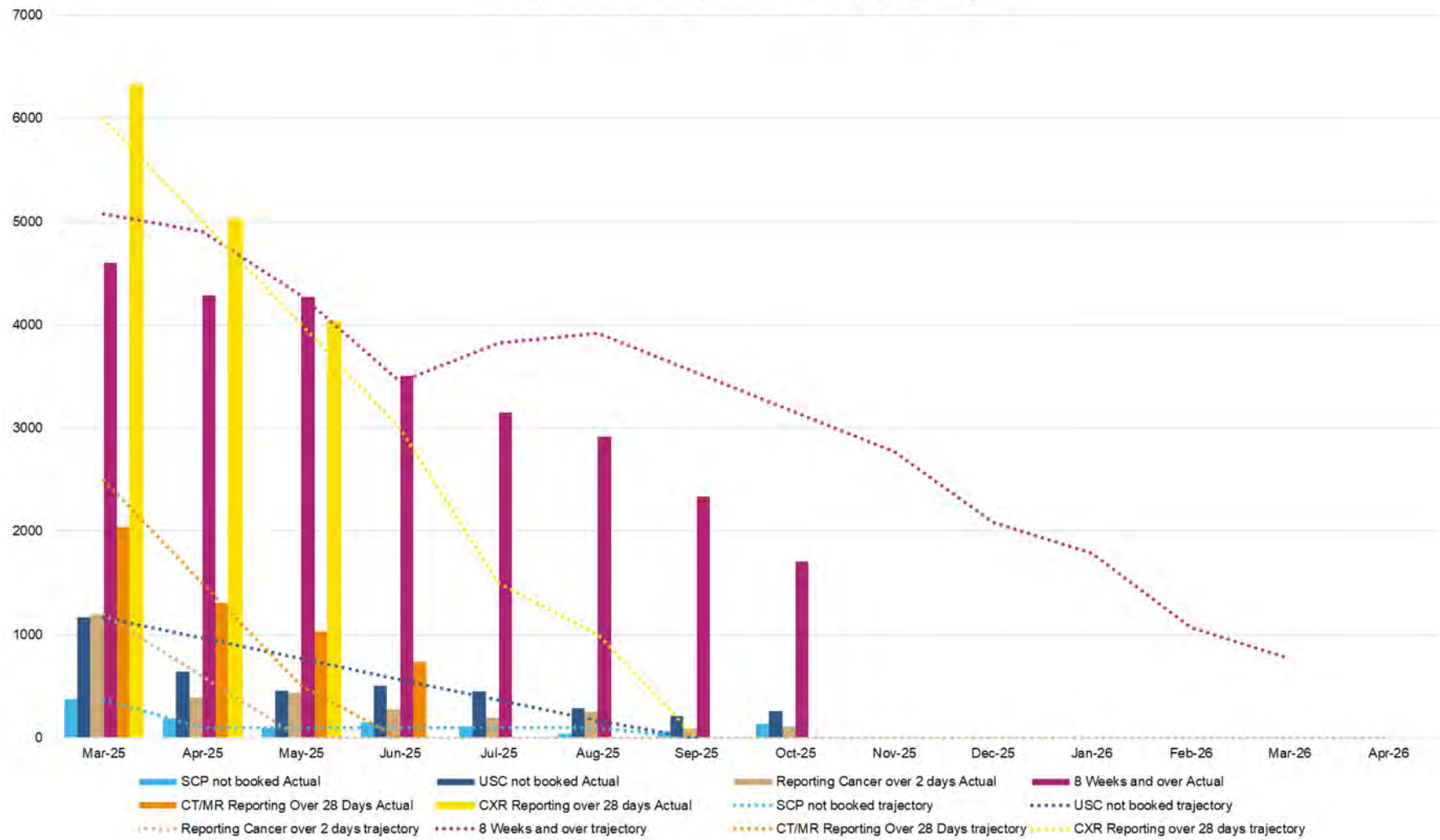
Escalation status has notable improvement in governance domain and performance. Work continues in quality and workforce domains. Note - In Oct-25 the Strategy, Planning and Fragile Services domain has increased to 3.

Sep-25 Escalation status justification	Escalation status	Reasons for escalation (where applicable)
Finance	3	Underspent with a recovery plan assumed in future months, but significant gap on savings delivery. Demand and Capacity planning underway, with progress expected by November 2025. New structures embedding and limited capacity during Summer 2025, therefore a review of progress and plans by the end of November 2025 will determine future escalation status.
Performance	2	Level 2: Radiology 8 weeks (Sep 25 = 2,313)
Population Health	3	BCI plans: 9 under review.
Quality & Safety	2	Escalation assurance: 78% (last month 71%) For details please see the Our Safety dashboard
Strategy, Planning and Fragile Services	2	Fragile Services: - Radiology demand is in excess of capacity, predominantly due to staffing and vacancies. - Cellular Pathology - Clinical Haematology
Governance	1	
Workforce	2	PADR: 82.2% Turnover: 8% Outstanding Pay Progression: 6 (2 over by 3 months) Job Planning: 76%

Background: current service provision

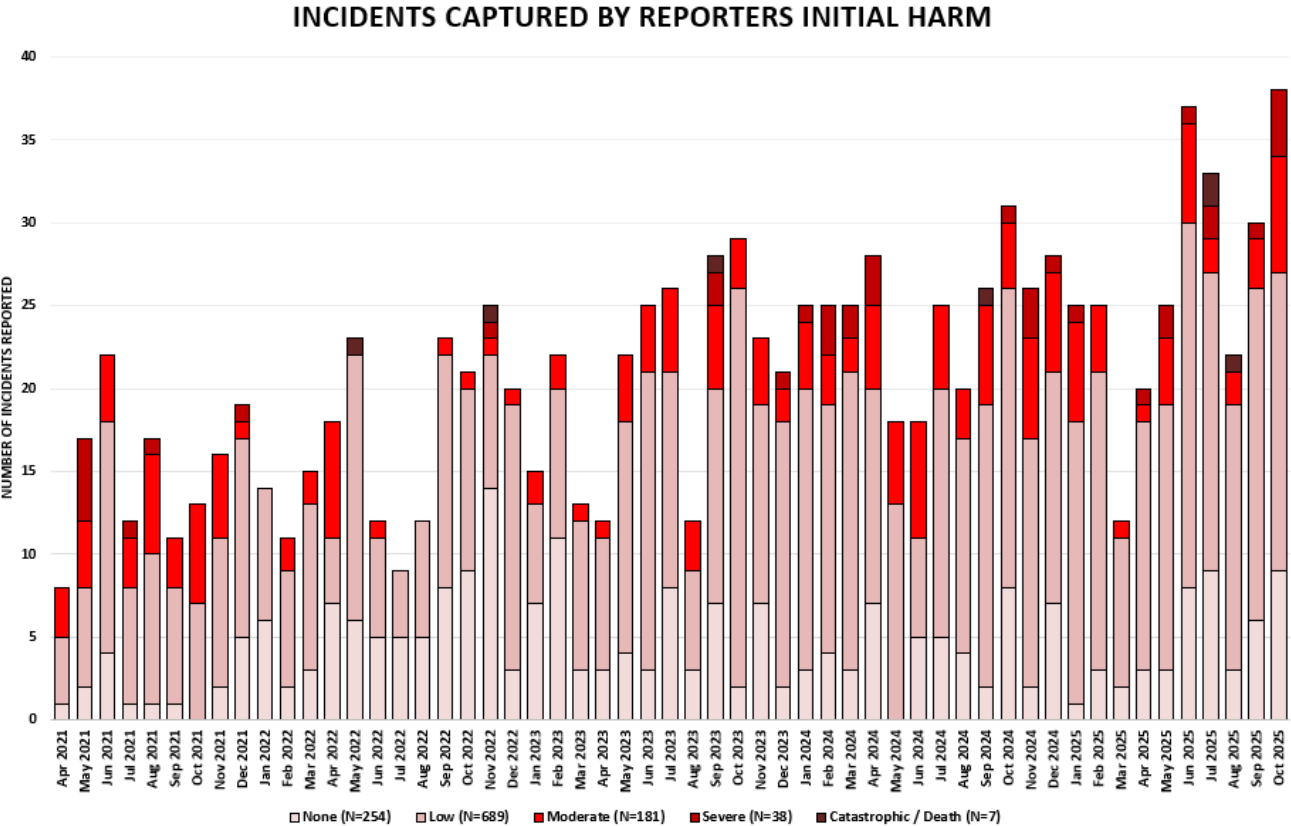
Performance

Option 3c Stabilisation Funding Trajectories as of 3.11.2025 including WAG funding



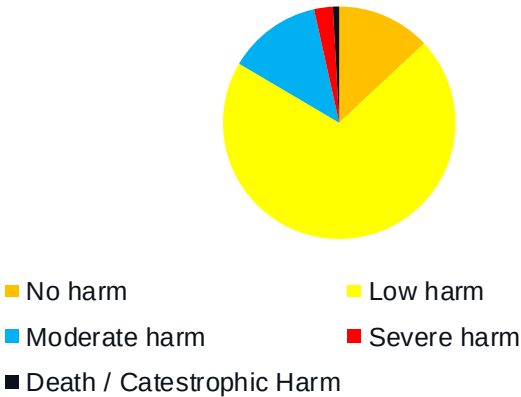
Performance has improved aligned with Annual Planning 2025/26 stabilisation funding commitments, further improvements via Welsh Government temporary funding to reduce 8 week wait.

Background: incidents

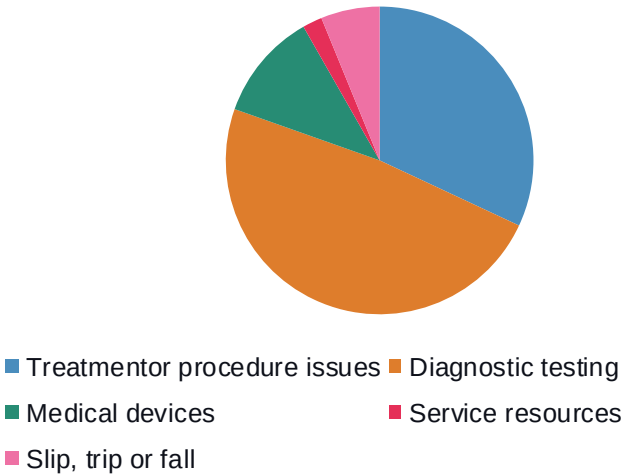


In 2025 incident reporting peaked in October 2025 (n=38), with lowest reporting month in March 2025 (n=12) across four sites. Most of incidents are causing low harm. Upon completion of investigation the initial harm reported can change, as the data for the same time-period shows 3 incidents were categorised as catastrophic at incident closure. Current focus is on completion of timely incidents investigation, thereafter attention will move to incident reporting culture to promote an increase in reporting of no harm/low harm incidents

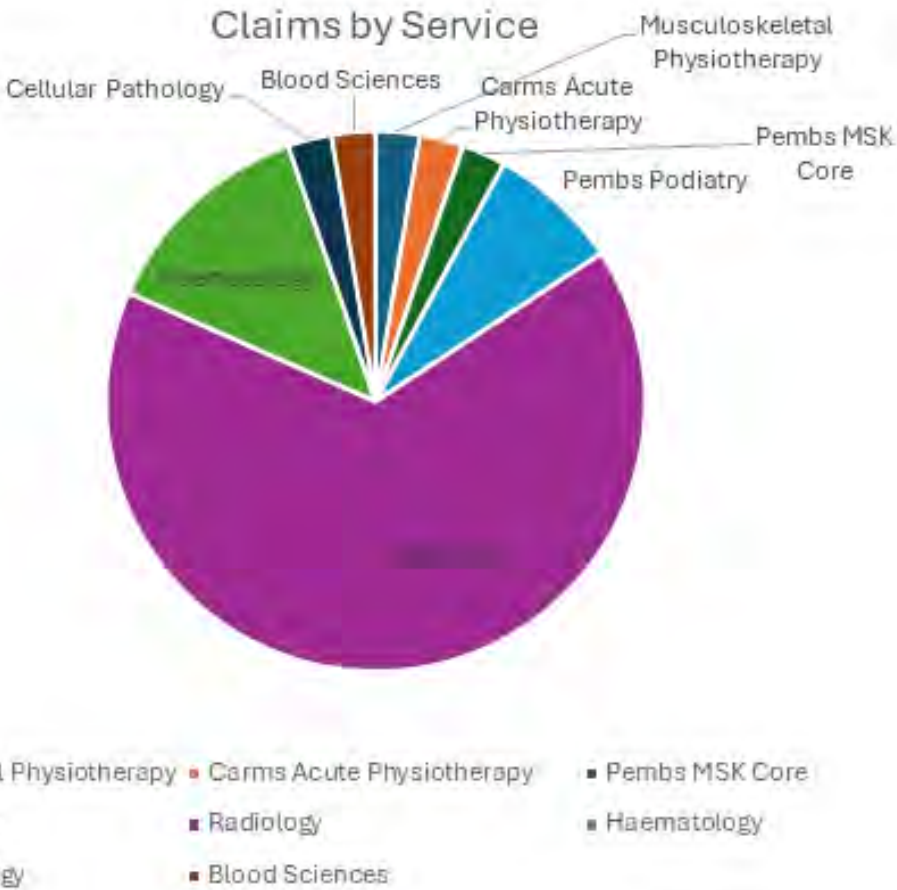
Incidents reported by harm



Incidents reported by theme



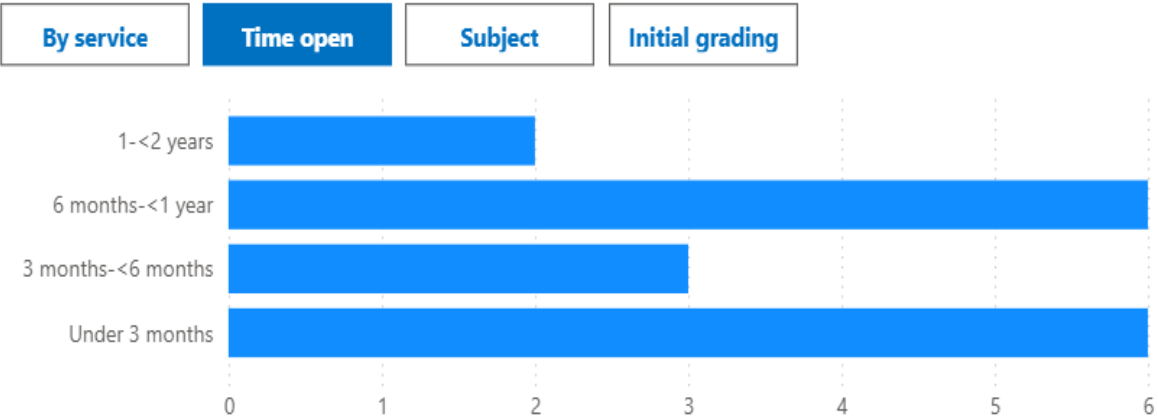
Background: Complaints and claims



24 of the potential and confirmed claims within the Allied Health and Health Science CCG are aligned to the Radiology service. Themes identified for redress and claims are scanning delays, reporting delays and incorrect reporting.

The service currently has 8 complaints that have been open over 6 months, 3 of these are awaiting comments from service, 5 are awaiting input from colleagues in other CCGs. Complaints analysis indicates main themes are: Scanning delays, Reporting delays, incorrect reporting and communication

Open complaints



Graph – Allied Health and Health Science CCG Claims – Oct 25 Snapshot

Background: Compliments



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Radiology as a service receives low numbers of compliments. This is due to the radiology system not aligning with the online platform hosted by CIVICA due to the service not using WPAS to record attendances. A department patient survey was completed and informed the for the Clinical Services Plan in 2023.

The main improvements suggested

- speed and efficiency (including shortening waiting times and not cancelling appointments);
- communication (including better explanations of tests, results, and treatments, and increased frequency of contact and follow up); and
- improvements to hospital environments.

39% of respondents felt that no improvements were required

Positive comments

- ✓ professional, kind, reassuring, and helpful staff;
- ✓ the timeliness and efficiency of the service received;
- ✓ good communication and information provision
- ✓ generally good quality of care.

Negative comments

Lack of timeliness (especially in relation to appointment access and speed of diagnosis).

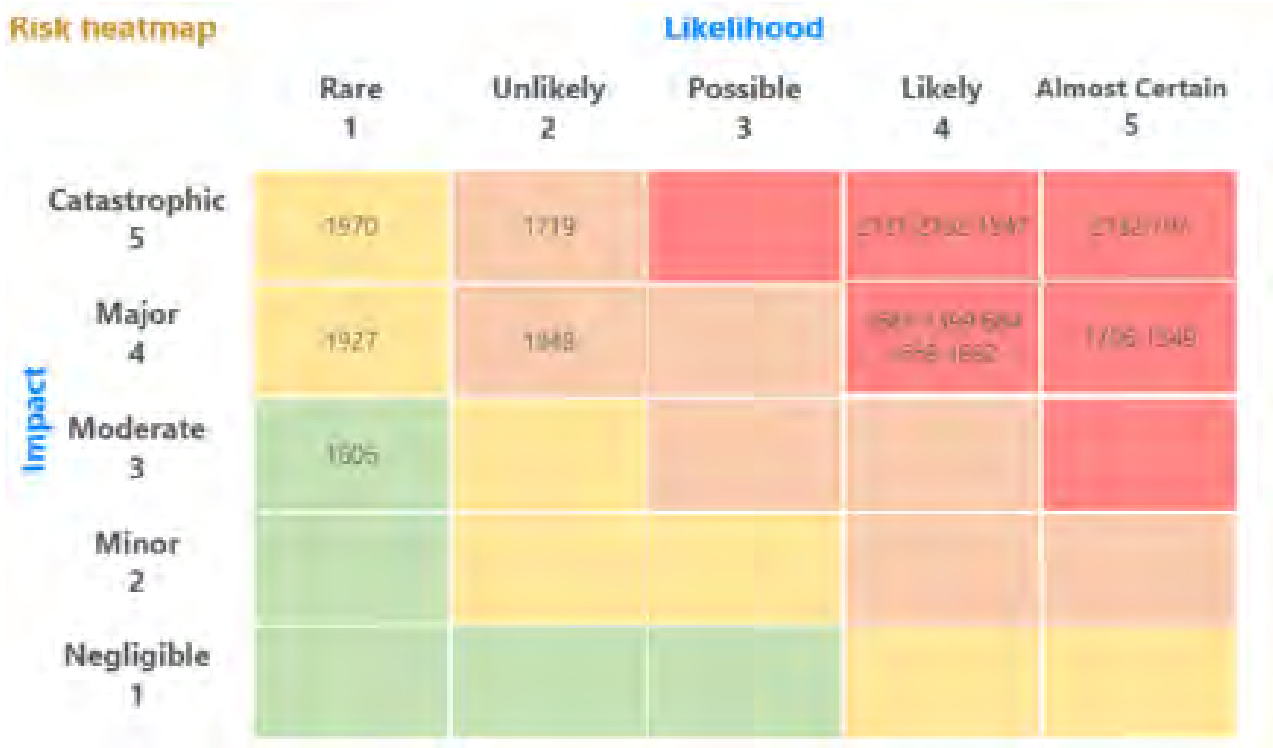


Background: Risk register

There are 2 corporate risks and 16 operational risks on the risk register.

- The operational risks are stratified as:
 - Extreme n=12
 - High n=3
 - Moderate n=2
 - Low n=1
- Two corporate risks are stratified as extreme

Risk management is a developing area for the Radiology Service focus has been on ensuring clear capture of service worries.



Background: Risk register detail



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Risk Ref	Title	Inherent Risk Score	Risk Level (Current)
1349	Risk of being unable to deliver ultrasound services at WGH due to a lack of appropriately trained obstetric staff	25	Extreme
1547	There is a risk to timely and safe radiology provision as capacity does not match demand	25	Extreme
2102	The risk of radiology service delivery due to leadership fragility	25	Extreme
2132	Risk of overspend due to cost pressures related to variable pay	25	Extreme
1399	Non-compliance with IR(ME)R standards and governance requirements and associated patient safety risks	20	Extreme
1658	Risk of Repetitive Strain Injury (RSI) to sonographers due to a national shortage and an increase in patient BMI	20	Extreme
684	Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	20	Extreme
1681	Risk of failure to deliver timely Dual Energy X-ray Absorptiometry Service due to outdated Service Level Agreement	20	Extreme
1892	Risk of not achieving savings targets due to continued expenditure without mitigating savings plans	20	Extreme
1706	Risk of loss of Nuclear Medicine Service due to decline in condition of equipment and failure to comply with NRW compliance.	20	Extreme
2131	Risk of overspend due to cost pressures related to Everlight radiology	20	Extreme
797	Risk to the ability to deliver ultrasound services due to workforce pressures	20	Extreme
1719	Risk of loss of Radiology services across the Health Board from 31 March 2025 due to delayed implementation of RISP	25	High
2202	Risk to overspend and reduced performance due to the Outpatient Insourcing contract	16	High
1848	Risk of failure to chilled water supply to MRI unit at Witybush Hospital due to aging, shared chiller in a distant location.	15	High
1927	Risk of loss of the Nuclear Medicine Service due to challenges related to radiopharmaceutical supply.	20	Moderate
1970	Risk to patient safety and staff registration due to appropriate medicines management in Radiology.	20	Moderate

The themes identified for the risks in radiology are:

- Financial overspend
- Ultrasound workforce
- Equipment replacement
- RISP replacement
- Workforce not meeting demand
- Management and leadership fragilities



Safe - issues & actions

Incidents, claims and redress learning and triangulation:

- Themes identified:
 - scanning delays, reporting delays and incorrect reporting
- Incidents/redress cases are discussed at the Radiology QSEC and radiology audit meetings – emphasis on learning from errors.
- Learning from a series of patient harm incidents was presented as part of the annual plan SBAR, as there was clear evidence that the delays to radiology investigations

Actions

- £3.4m Annual Plan funding is being implemented to support some stability of service
- Work with QAST team to link learning from cases to produce thematic reports
- Weekly meetings are held with service lead business partners to provide assurance of sharing of learning and actions from claims and redress cases, to meet the requirements for Welsh Risk Pool Learning Events



Timely - issues

- Timely Care has been the main issue in Radiology
- Increases in demand and increased use of radiology across all pathways has resulted in current capacity not met demand

Scanning - D&C analysis has showed that there has been an increase in demand between 2019/20 to 2024/25 as follows:

- 29% CT
- 51 % MRI
- 50% NOUS (Non obstructive ultrasound)
- 12% Obstetric USS.

The capacity gaps are:

- CT 10992 patients per year.
- MRI 9700 patients per year.
- USS 16800 patients per year.

This is based on 2024/25 figures and includes running additional lists via WG funding and use of core spending.

Reporting - Due to the radiologist workforce capacity not being aligned to demand, the service relies on outsourcing approx. 50% of emergency work and 30-40 % of routine work.



Timely - Actions

The service received investment in the 2056/26 annual budget as recognition that stabilising of the service was needed which would improve the USC position. This was further strengthened by non recurrent funding from WG to reduce the over 8-week breaches to 0 by March 2026. This has allowed the service to tackle three main areas, scanning, quality and governance and reporting

Scanning:

- Employed additional CT, MRI radiographers and train further sonographers.
- A MRI van for 1 year scanning 480 patients per month
- Outsourcing of additional scan reporting 600 patients per month
- Ultrasound insourcing 300 patients per month
- Employed a head and neck sonographer to undertake neck biopsies for patients with suspected head and neck cancers,

Quality and Governance - Strengthen the management team to ensure best use of resources (OCP in progress)

Reporting - Actions include employed two new Radiologists and outsourced backlog of reporting over 4 weeks (12000 examinations)

The additional WG funding for the RTT patients has allowed:

- A further MRI van for 7 months (480 patients per month)
- CT Van for 2 months (300 patients)
- Further ultrasound insourcing (200 patients per month)



Timely - Results

The stabilisation and WG funding has resulted in the following:

- Reduction of overall USC wait from 8-9 weeks to 4 weeks
- Reduction of wait for neck biopsy to 2 weeks – same day service being developed.
- Reduction of reporting delay for Non-USC patients from 12 weeks to 4 weeks
- A 76% reduction in ‘over 8-week breaches’ from 7108 (Jan 25) to 1712 (Oct 25)

However, the service still does not meet timely targets which ensure the best patient outcomes and requires further investment to meet those targets for scanning and reporting:

- USC – 12 days
- USC – 2 days
- Urgent 2-3 weeks
- Urgent – 1 weeks
- Routine 6-8 weeks
- Routine – 4 weeks



Assessment:



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Effective

Clinical audits have previously been undertaken which do not always demonstrate the areas where rapid improvement is required. Work ongoing to strengthen the timetable and frequency of audits.

- Emphasis on follow up actions and re-auditing to check improvement on standards.
- OCP in progress – Radiology Quality Manager post being introduced to drive this programme forward as slow progress due to fragilities in the current team.

Efficient

The service continues to firefight and has limited assurance that provision is efficient as capacity does not support BAU service delivery.

Management structure has been identified as inadequate and new management structure has been developed. Funding was agreed in the 2025/26 Annual Planning and OCP is underway which has suffered delays. Meaningful and sustainable progress can not be started until these roles are in post.

Due to historic funding arrangements the radiology service still runs as a 9-5 Monday to Friday service despite the necessity of a 24/7 service. The staffing is based on an on-call system which is not fit for purpose. This is causing staff burnout, mistakes and increasing costs.



Equitable

Provides radiology across three counties with nuclear med provision in Withybush Hospital (WGH). Community diagnostics provided for x-ray at 4 sites currently.

Areas of concern:

- Interventional Radiology – Difficulty with recruiting IR radiologists due to scattered distribution of work (over 4 sites). Nursing shortages
- Concern about u/s - national shortage of sonographers.
- Concern about DEXA
- Note that WGH, BGH, PPH provide diagnostic hub provision in line with UK expectations of local diagnostics collocated with OPD and non-emergency services.

Person Centred

Completion of the Radiology organisational change process (OCP) to strengthen the leadership team (£500k increase in leadership team) will provide capacity to meet clinical governance standards and improve triangulation of learning from complaints, Patient feedback, CSP engagement and compliments.



Conclusion



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Continue to implement the actions aligned to the stability funding from 2025/26 Annual Plan

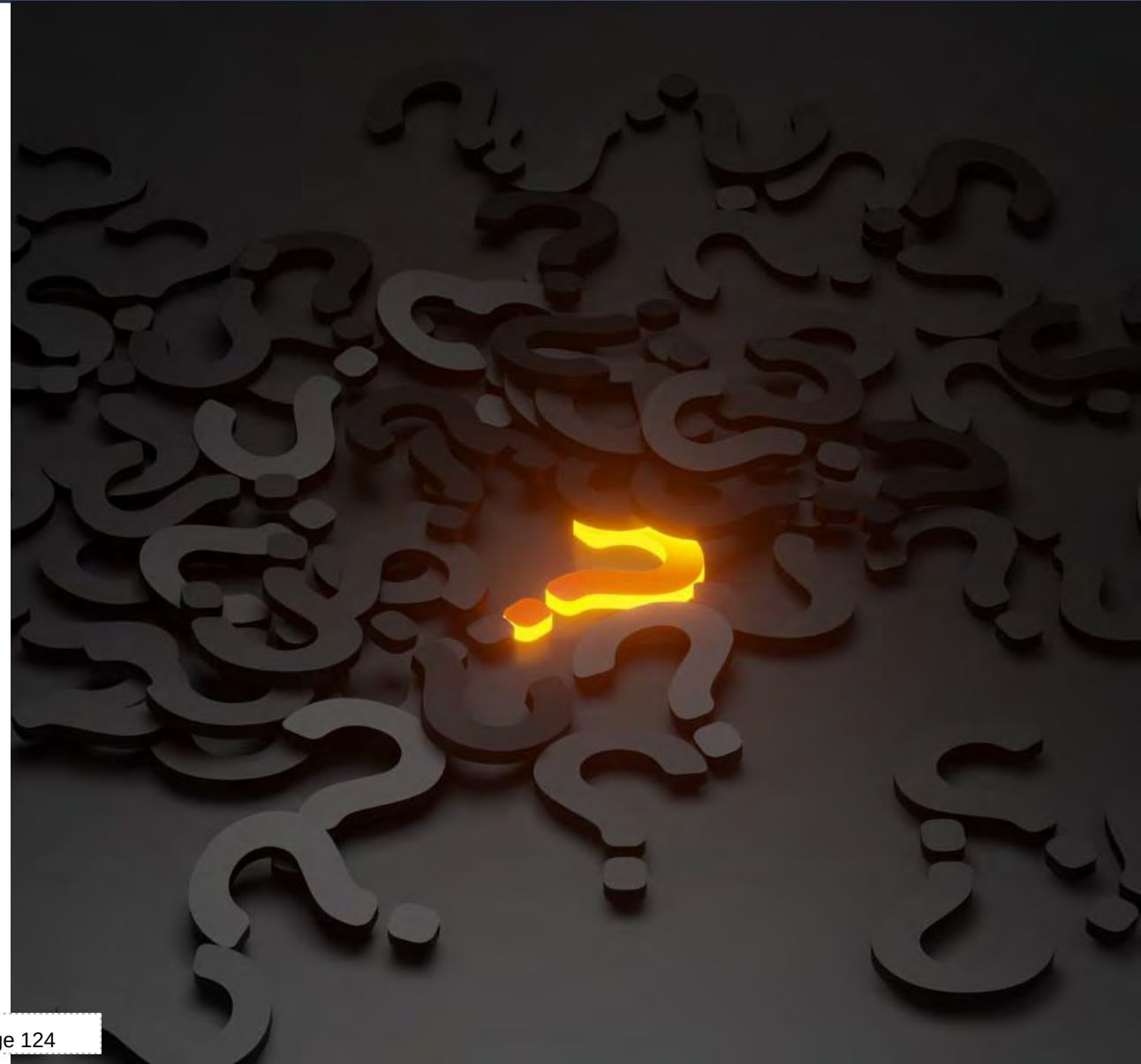
Reduce insourcing and outsourcing by increasing clinical capacity locally which will increase service stability

Radiology Leadership OCP underway – increase leadership capacity £500k to create stability and allow for capacity to manage staff and patient care in alignment with standards.

Next steps:

Seek additional stability funding as part of 2026/27 Annual Planning to meet baseline requirements of demand on Radiology service. If funding is not secured, then continue with implementation of 2025/26 Annual Planning and mitigate as best able rising waiting times.

Any questions...





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DIOGEL | CYNALIADWY | HYG YRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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.



The six domains of quality



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Diogel
Safe

Our health care system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored, where possible, risks to safety are reduced or prevented and this is delivered by appropriate numbers of suitably skilled workforce



Effeithlon
Efficient

Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments targeted at those likely to gain the most benefit, ensuring any interventions represent the best value that will improve outcomes for people.



Amserol
Timely

Our health care system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority



Teg
Equitable

Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality because of personal characteristics such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status or political affiliation; the organisation that provides care; or location where care is delivered. We embed equality and human rights in our health care system and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.



Effeithiol
Effective

Our health care system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal outcomes possible for them and that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.



person ganolog
person centred

Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.

2.2

2.2 - Deep Dive: Orthopaedics

***Lianne Gregory
(Hywel Dda UHB -
Service Delivery
Manager), Paula
Goode (Hywel Dda
UHB - Service
Director for Planned
and Specialist Care),
Olwen Morgan
(Hywel Dda UHB -
Assistant Director of
Nursing)***

Attachments

[Elective Orthopaedics QSE Deep Dive December 2025.pdf](#)



Deep Dive: Elective Orthopaedics

Quality, Safety and Experience Committee

December 2025

The purpose of this report is to provide the Quality, Safety and Experience Committee with an overview and update on the current state of Elective Orthopaedic Service provision across Hywel Dda University Health Board

- The Committee wishes to explore the consequences of the current fragility within Elective Orthopaedic services under Clinical Service Plan (CSP) 1.
- This review will consider how these vulnerabilities are influencing service delivery, including any related incidents and complaints and consideration around patient experience and any clinical safety concerns.
- The report will also describe the short-term actions (both implemented and proposed) designed to address these pressures while awaiting the final CSP recommendations.

Overview

This paper highlights the clinical, operational, and patient experience challenges arising from service fragility and sets out the interim steps being taken to reduce associated risks.

Why is Elective Orthopaedics Fragile?

Elective Orthopaedic services within the Health Board are currently regarded as fragile due to a significant backlog and prolonged waiting times for treatment. These challenges primarily stem from the disruption caused by the COVID-19 pandemic, which resulted in widespread cancellations of elective appointments and procedures, alongside reduced theatre capacity. Despite recovery efforts, referral-to-treatment times remain extended, creating sustained pressure on service delivery and patient experience.

What do we need to do?

The Clinical Services Plan sets out a strategic approach to stabilise and improve elective orthopaedic services. Key aims include:

- **Restoring Activity Levels:**
Achieve at least pre-COVID activity levels as a baseline, supporting recovery and reducing waiting times.
- **Improving Access:**
Deliver sustainable improvements in patient access to elective orthopaedic care, ensuring timely treatment and better outcomes.
- **Addressing Backlog Pressures:**
Respond effectively to waiting list growth and the loss of activity during the pandemic through targeted and sustainable interventions.
- **Regional Collaboration:**
With increased national emphasis on regional working, future orthopaedic service models need to reflect collaborative approaches across Health Boards



Background – CSP Scope Limitations



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The Clinical Services Plan (CSP) currently focuses solely on elective orthopaedics and excludes trauma services. This separation is problematic because the two areas are highly interdependent. The majority of clinical priorities which influence delivery of activity reside within the Trauma component of Trauma and Orthopaedics (T&O). In addition the majority of the fragilities related to T+O reside within the trauma service component. Considering elective orthopaedics in isolation is therefore problematic, leading to several challenges, including:

- **Shared Workforce Pressures:** Surgeons, anaesthetists, and theatre staff often work across both elective and trauma lists; any change in trauma demand impacts elective capacity.
- **Theatre Capacity Conflicts:** Trauma cases frequently take clinical priority, reducing elective theatre time and complicating scheduling.
- **Financial and Operational Planning:** Resource allocation and investment decisions for elective care cannot be fully effective without factoring in trauma demand and emergency pressures.
- **Impact on Service Resilience:** Trauma surges (e.g., seasonal increases or major incidents) can destabilise elective recovery plans if not accounted for in modelling.
- **Pathway Interdependencies:** Pre-operative and post-operative support services (e.g., imaging, physiotherapy) are shared, so planning for elective alone risks bottlenecks in these areas.

A holistic approach that considers both elective and trauma is essential to ensure sustainable improvements and avoid unintended consequences for service delivery.



Issues of Significance to the Health Board

- **Patient Safety and Experience:** Prolonged waits increase the risk of deterioration in patients' conditions, impacting quality of life and clinical outcomes.
- **Operational Pressures:** High waiting list volumes place strain on scheduling, workforce, and theatre utilisation, limiting flexibility for urgent cases.
- **Reputational Risk:** Failure to meet national targets and patient expectations may affect public confidence in the Health Board.
- **Financial Impact:** Extended waits can lead to increased complexity of cases, higher treatment costs, and potential penalties for non-compliance with performance standards.



- **Consideration of National and Local Objectives**
- **National:**
 - Achieving compliance with Welsh Government targets for elective recovery and waiting times
 - Delivery of sustainable improvements in planned care as outlined in national recovery frameworks
- **Local:**
 - Implementation of the CSP to stabilise and strengthen elective orthopaedic provision.
 - Reduction of backlog through targeted initiatives such as additional theatre sessions, outsourcing, and improved patient flow.
 - Enhancing patient communication and experience during extended waits

British Orthopaedic Association Standards (BOASTs) – Providing a Continuous Safe Elective Orthopaedic Environment

The BOA Standards (BOASTs) for elective orthopaedics were published and implemented in February 2021. This marked the formal inclusion of elective orthopaedic standards within the BOAST framework, expanding beyond trauma to ensure safe, consistent elective care through physical and operational separation from emergency activity. Central to this is the concept of a **ring-fenced pathway**, which includes:

- **Dedicated Facilities:** A defined unit or ward exclusively for elective orthopaedic patients undergoing clean procedures, distinct from trauma or acute areas.
- **Ring-Fenced Theatre and Bed Base:** Protected theatres and inpatient beds reserved solely for elective cases
- **Exclusive Workforce Allocation:** Staff assigned specifically to the elective pathway, avoiding cross-cover with trauma or emergency services to reduce disruption and maintain infection control standards.
- **Standard Operating Procedures (SOPs):** Clear governance for admission, discharge, and escalation policies including enablement of effective administration to support regular audit of ring-fenced pathway.
- **Infection Control Measures:** Screening and decolonisation protocols prior to admission, with individual rooms available for patients with implant infections if required.

These standards aim to optimise resource use, minimise cancellations, and improve patient outcomes by ensuring elective orthopaedic services operate within a protected and auditable environment.



Assessment Overview – Key Themes



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- **Access & Capacity**

- Referral to Treatment (RTT) Performance trends – Significant reduction in Stage 1 and whole pathway waits. Longest treatment waits reduced from 4 years in 2024 to 2 years in 2025 improving **Timely** care.



- Theatre Constraints – lack of Day Surgery Unit (DSU) General Anaesthesia (GA) provision impacting on what procedures can be undertaken. We have to utilise main theatre inappropriately as a result just to access GA provision
- Pre-assessment Capacity Issues – Current pre-assessment capacity does not match demand. This impact on the **effectiveness** of the service and our ability to populate theatre lists **timely** in line with the 6:4:2 model



- Consenting review requirements - The long interval between the first outpatient appointment and surgery currently requires a second consent review immediately prior to procedure. This ensures the patient still agrees to the surgery, understands the risks, and confirms that the planned procedure, specific surgical approach and kit/implant requirements remain appropriate demonstrating delivery of **Safe** care. Absence of pooling across Arthroplasty Consultants also means this additional consenting clinic appointment is necessary. This impacts on the availability of new patient clinic slots.



Workforce & Service Fragility

- British Orthopaedic Association Standards (BOASTs) require 24/7 medical cover for elective inpatients – this is currently delivered through variable pay in PPH and implementation of a sustainable model of cover is required. An SBAR proposing additional junior doctor recruitment has been developed for Care Group and subsequent executive approval.
- Sub-specialty workforce issues – Recruiting a Foot and Ankle Consultant has proven difficult, impacting service resilience
- BGH medical staffing fragilities – Vulnerabilities due to an ageing workforce and recruitment challenges associated with its rural location
- Outpatient clinic estate capacity – The current outpatient capacity impacts the ability to structure clinics in the most clinically appropriate and efficient way. For example, we wish to run a multi-disciplinary clinic in PPH on a Wednesday with 3 revision surgeons and an Advanced Nurse Practitioner but there is no outpatient space. This results in patients often having multiple outpatient appointments.



- **Quality & Safety**

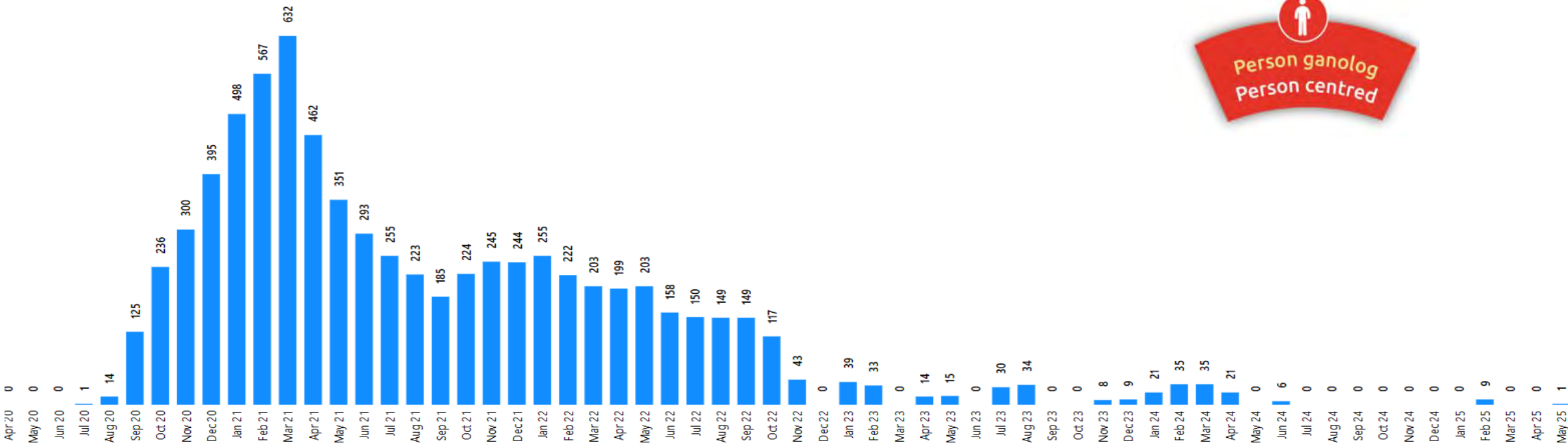
- Deviation from PPH Critical Care Standard Operating Procedure (SOP) since January 2025 – as referred to in Critical Care Deep Dive presented to QSEC in September 2025.
- Complaints and incident data – volumes of complaints have remained at similar levels over the last 3 years however it is important to distinguish that elective Orthopaedics cannot be considered in isolation and the data will include trauma complaints and incidents. The number of incidents reported over the same period has decreased although it is difficult to identify if incidents have reduced or whether there is a lack of incident reporting.
- National Joint Registry (NJR) data entry – There has been significant NJR Data entry resource shortfalls since September 2024.
- Regional Collaboration Challenges – Challenges around regional working with SBUHB due to different clinical and administrative systems which make it difficult to share patient information and align pathways. For example, differing patient administration systems, theatre management systems, dashboard, virtual v's paper pre-assessment. The implant portfolio for both Health Boards is widely different resulting in financial penalties/implications.

- **Innovation & Improvement -**

- Introduction of Waiting List Support Service – Provides advice and guidance to patients whilst they are on a waiting list.
- Orthopaedic Prehabilitation Service - Monitors and optimises patients whilst waiting for surgery
- Allied Health Professional (AHP) developments – The majority of joint replacement clinic follow up activity is delivered by AHP's. Integration of AHP's within T+O teams is also quite advanced in comparison to other HB's e.g shoulder, podiatry and arthroplasty.

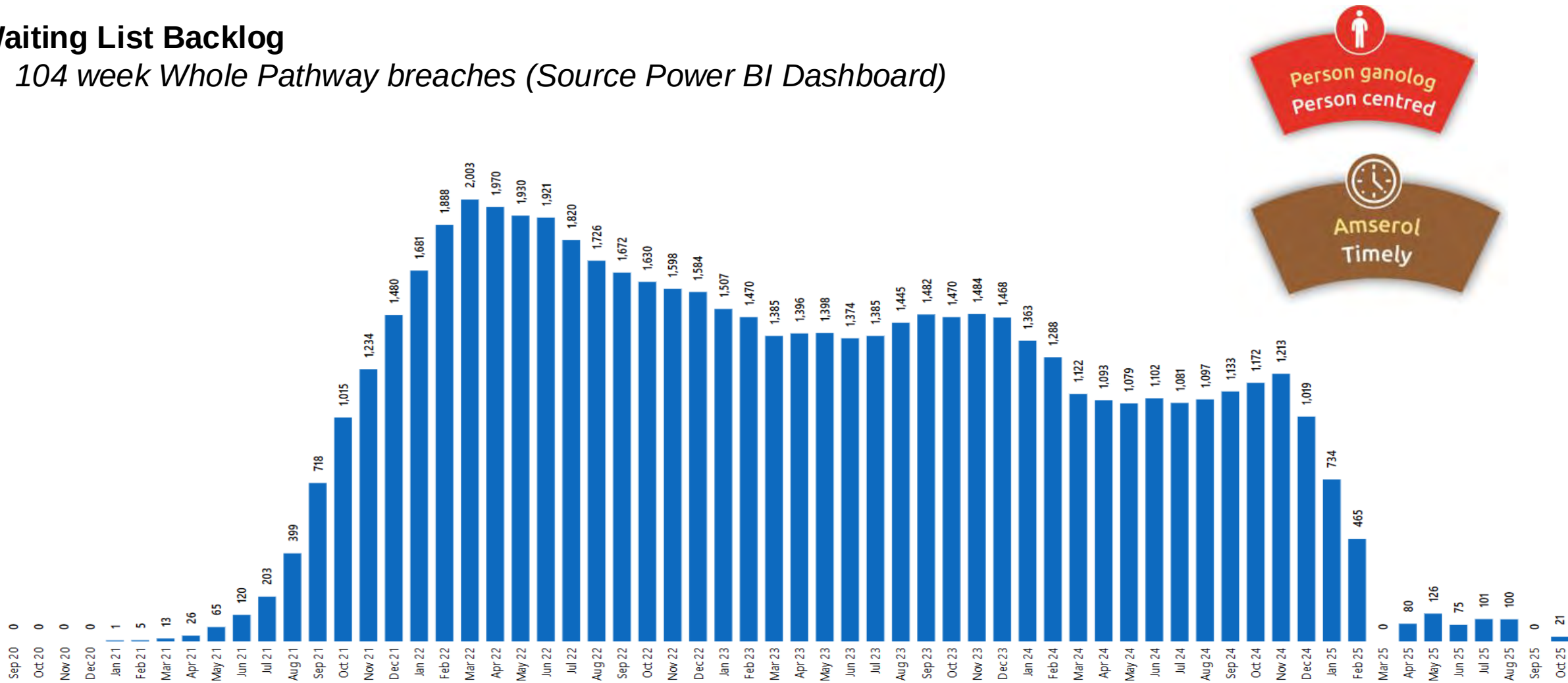
Waiting List Backlog

- 52-week Stage 1 breaches (Source Power BI Dashboard)



Waiting List Backlog

- 104 week Whole Pathway breaches (Source Power BI Dashboard)



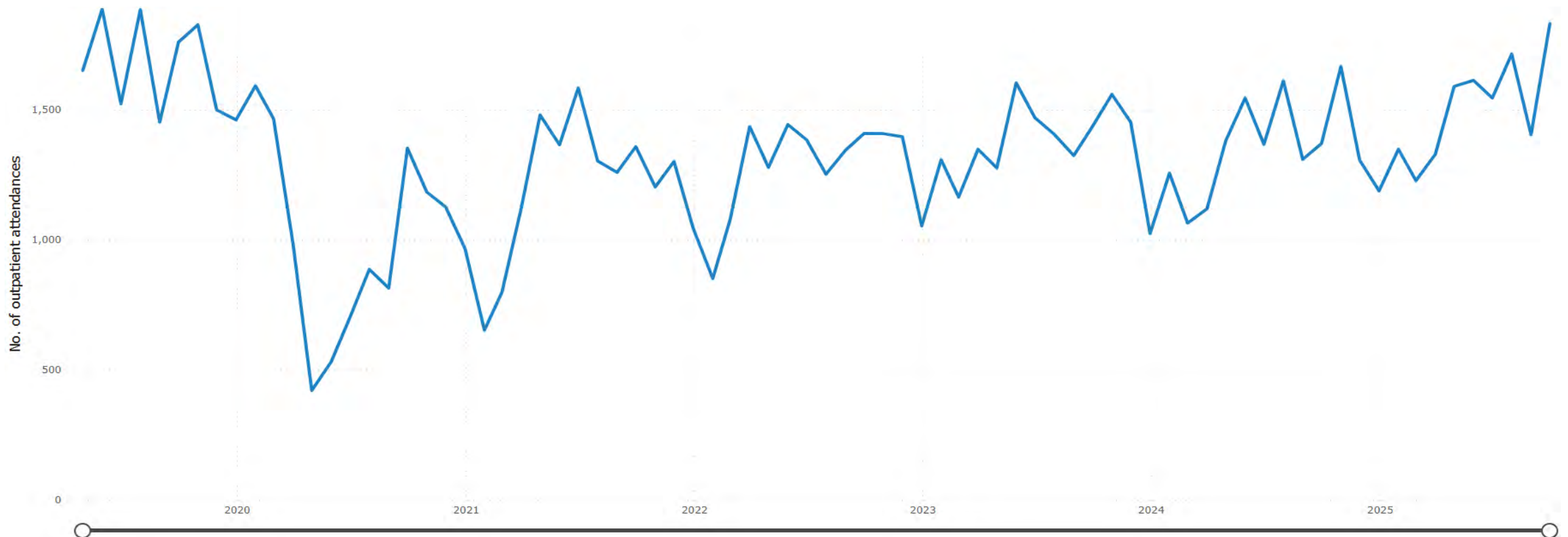
Assessment Overview – Access and Capacity



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Stage 1 outpatient activity – Pre-covid v's current (Source: Outpatient Dashboard – [Power BI](#))



- Unfortunately, the Health Board's Power BI Dashboard does not produce outpatient activity data from pre-covid.
- However, the data above has been obtained from the all-Wales Power BI Dashboard and includes pre-covid activity however cannot disaggregate the fracture clinic activity so this is included.

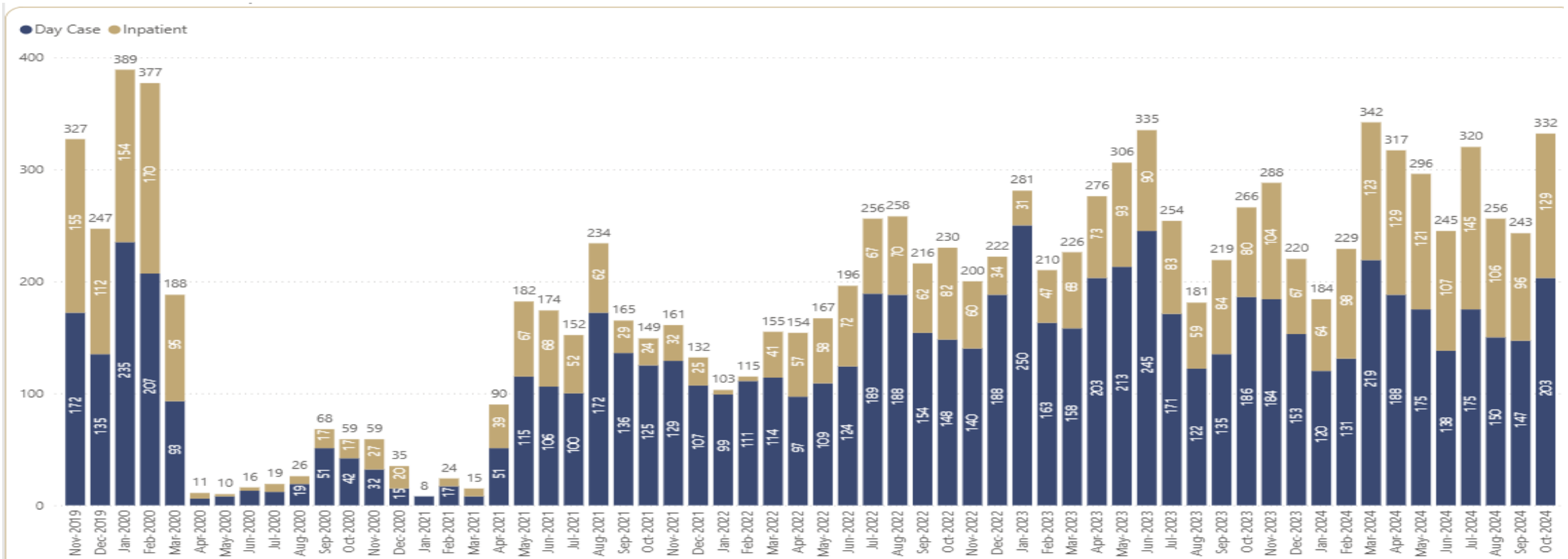
Assessment Overview – Access and Capacity



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Stage 4 inpatient/cay case activity - Pre-Covid v's current (Source IRIS Power BI)

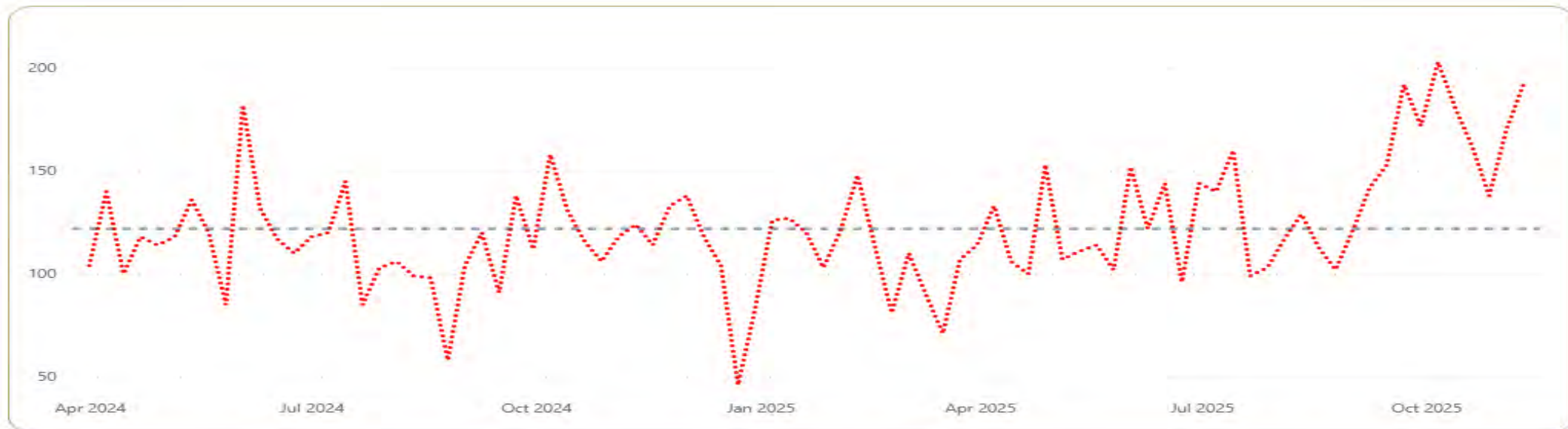


- Total volumes of inpatient activity across the Health Board is lower compared with pre-covid levels as a result of WGH delivering day case work only post Covid. This is as a direct result of the site not being able to BOA Standards.
- However there was a significant increase in inpatient activity in March 2024 when we were provided with the full allocation of 20 main theatre sessions



Daycase/inpatient Referrals (Source IRIS, Power BI)

- Significant increase in daycase and inpatient referrals since commencement of stage 1 insourcing activity. Stage 4 total volume has grown by almost 800 since September 2025 with average conversion rates of 50%



Assessment – Access and Capacity



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Current Theatre capacity:

Site	Funded Inpatient Sessions	Funded Day Case Sessions	Funded Ward Beds	Comments
Bronglais General Hospital	5	0	8	Inpatient activity is prioritised - some limited day case activity at this site is planned
Glangwili General Hospital	0	0		Acute trauma only. No elective activity.
Withybush General Hospital	0	15	0	We only have access to 6 main theatre sessions and 5 day theatre sessions (11 sessions in total) due to Main Theatre 4 being closed. Day case activity only at this site due to there being no dedicated ward however this is GA activity for fairly major cases (ACL reconstruction, forefoot procedures, shoulder scopes and not just HVLC LA cases. DSU at WGH provides simultaneous support for multiple lists but pre-op reviews and assessment require improvements.
Prince Philip Hospital	20	11	21	Funded for 11 GA day surgery sessions but only have access to 4. 1 cannot be staffed and 6 are provided on an LA only basis due to anaesthetic shortages. The large amount of activity delivered in DSU PPH could be delivered in a procedure room
TOTAL	25	25	29	

Assessment – Workforce & Service Fragility

Current Funded Staffing



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Staff Group	Withybush General Hospital	Bronglais General Hospital	Prince Philip Hospital
Consultant	5	4 (1 vacancy)	14
Middle Grade	5 Specialty Doctors	4 (1 vacancy)	1 Associate Specialist 8 Specialty Doctor 2 ST Higher
Resident Doctor	5 Clinical Fellow (1 vacancy) 1 F2	2 Clinical Fellows 4 F2's 2 F1's	1 Senior Clinical Fellow 8 Clinical Fellows 2 F2's 1 CT
Nursing	1.0 B8a Surgical Care Practitioner		3 B8a Specialist Nurse/Advanced Nurse Practitioners

• Access to Critical Care

- Carmarthenshire Critical Care has provided an amended patient pathway through PPH Intensive Care Unit (ICU) since July 2022 supported by a SOP. Following concerns from clinical incidents in late 2024, a GGH ICU clinician-led decision to manage patients outside of the SOP was made in January 2025. This has led to a decrease in patients remaining in PPH and an increase in transfers to GGH. However, with PPH being the main inpatient site for elective Orthopaedics and the need to provide activity in line with British Orthopaedic Association Standards (BOASTs), an ICU/Enhanced Care Unit (ECU) pathway for orthopaedics needs to remain at PPH.
- On clinical review it became apparent that the vast majority of the patients who were cancelled for lack of ICU care did not need ICU care. Instead, they require enhanced care and therefore have been managed in the Surgical ECU in PPH.
- If true ICU care is required, the anaesthetic team will stabilise and transfer to GGH appropriately.

Linked to Risk 1880 – Risk to the sustainability of critical care services due to fragility of medical workforce.

Assessment – Quality & Safety

Safe, Timely, Effective, Efficient, Equitable, Person-Centred



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Complaints

Data considerations: It is important to note that the available complaint data does not differentiate between Trauma / Orthopaedics; all reporting combines these two areas into a single dataset. Complaints will have unscheduled care elements (ward, nursing, ED) but show on the T&O dashboard. PALS complaints have not been included in these figures but will equate to significant numbers. Despite these being an obvious concern, the significance of the trauma risks take priority.

Year (January to December)	Total Number of complaints	Comments	STEEEP Principles
2023	188	9 were escalated to redress – Grade 3) and relate to: 5 x Clinical Treatment decisions, 2 x Clinical assessment decisions, 1 x delays to treatment, 1 x communication issues. 44 were early resolutions. Themes for complaints were largely related to communication, the clinical assessment and diagnosis and delays to treatment	   
2024	248	7 were escalated to redress – Grade 3) and relate to: 2 x Clinical Treatment decision, 1 x Clinical assessment decision, 1 x Intraoperative complication, 2 x post surgical complication, 1 x delays to treatment 37 were early resolutions Themes for complaints were again largely related to communication, the clinical assessment and diagnosis and delays to treatment	   
2025	208 (up until 31/10/25)	A lot are not closed cases so will not have been escalated to redress yet. 3 escalated to redress but no final BOD decision reached yet. 58 remain open. 45 were early resolutions that have been	

Assessment – Quality & Safety

Safe, Timely, Effective, Efficient, Equitable, Person-Centred



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Incidents

2023

106 incidents reported in 2023 for Orthopaedics (16 around pressure damage which sits under nursing, 9 about inappropriate behaviour or physical assault to a staff member. Post investigation reveals: 51 no harm, 53 low harm, 2 moderate harm (treatment/procedure not given as directed and treatment or procedure delayed).

2024

90 incidents reported in 2024 for Orthopaedics. Communication classification saw an increase. 15 incidents were relating to the treatment or procedure issues but the specific details of this vary significantly with no common theme. 50 no harm, 35 low harm, 1 moderate (Incorrect removal of drain), 3 severe (missed diagnosis), 1 blank (still under investigation)

2025

49 incidents reported up until 17/11/25. 14 relating to the treatment/procedure however this classification seems to have been assigned to incident where, in previous years, a different classification has been used which makes an assessment of the significance of this difficult. 19 no harm, 9 low harm, 20 blank (still under investigation)



Data

National Joint Registry (NJR) - Significant NJR data entry resource shortfalls at PPH since September 2024 as Clinical Audit withdrew their data input support. Of note is that the resource shortfall was due to vacancies and FCG subsequently declined approval to re-appoint into post. This impacted NJR and NHFD data entry for WGH and GGH also but falls outside of the scope for this specific elective orthopaedics deep dive. Efforts to reduce the backlog have commenced but NHFD is a higher clinical priority to clearance of the NJR backlog will take longer.



Waiting List – The absence of clinical condition or sub-specialty information makes analysing, understanding and managing waiting lists difficult.

For example, as at 16/11/25 the Primary Targeting List (PTL) report shows:

Stage 1 – 3461 patients waiting, only 1959 (56.6%) have a clinical condition/sub-specialty coded

Stage 4 – 5012 patients waiting, only 1935 (38.6%) have a clinical condition/sub-specialty coded

There is a proposal from the Welsh Orthopaedic Network Clinical Implementation Network (CIN) around defining clinical conditions and prioritisation at time of triage and national support from DHCW is required.

Regional System Variation – There are challenges in regional collaboration with Swansea Bay University Health Board due to differences in clinical and administrative systems, which hinder patient information sharing and pathway alignment. Examples include variations in patient administration systems, theatre management platforms, dashboards, and approaches to pre-assessment (virtual versus paper-based).

Waiting List Support Service (WLSS) – A single point of contact for patients awaiting planned care.



- All newly listed patients are proactively contacted by the WLSS on listing. Offered in the early stages of a patient's pathway to prepare patients as per 3P's programme.
- Patients are also provided with information and the contact number of the service on their listing letter.
- The WLSS offers holistic support to patients based on their individual needs and circumstances.
- The service utilises PROM/ health questionnaires (EQ-5D-5L/ Waiting Well About You) to help identify needs and stratify patients accordingly.
- 3,738 Orthopaedic contacts over the last 12 months
- Interventions mostly around self-management, preventing deterioration and promoting healthy lifestyle
- 1% of patients escalated to specialty for review
- 7% of patients escalated to clinical leads within the WLSS
- 6% of patients signposted to their GP for either a new health issue or a deterioration in general health

Assessment – Innovation and Improvement



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Waiting List Support Service – Stratification Criteria

➤ Stratification Criteria (based on PROM results)	
RED ➤ Refer to Optimisation and Prehabilitation Service	▪ BMI greater than 35 or less than 18.5 ▪ Exercise: 1 hour or less per week. ▪ EQ-5D-5L Scores: Score 5 in MOBILITY, SELF-CARE & USUAL ACTIVITIES
AMBER ➤ Contact/ review from WLSS Nurses	▪ BMI between 30 and 35 ▪ EQ-5D-5L Score 4 in MOBILITY, SELF-CARE and USUAL ACTIVITIES. ▪ Score 5 in PAIN / DISCOMFORT and ANXIETY / DEPRESSION ▪ VAS Scores: Less than 20 ▪ Comorbidities: Responds 'yes' to any comorbidity (even if more than 1) ▪ Polypharmacy: 4 or more medications
➤ YELLOW ➤ Contact from non-clinical call handler ➤ MECC conversation	▪ BMI of between 25 to 29 ▪ Exercise: More than 1 hour and up to 2 hours & more than 2 hours and up to 3 hours. ▪ EQ-5D-5L Score 2 or 3 in MOBILITY, SELF-CARE and USUAL ACTIVITIES, PAIN / DISCOMFORT and ANXIETY / DEPRESSION ▪ VAS Score: 20 up to 60. ▪ Smoking: Smoker ▪ Alcohol: 14 or more units per week.
GREEN ➤ Open access to WLSS and Waiting Well resources online ➤ No additional intervention required.	▪ BMI: of 18.5 up to 25. ▪ Exercise: Above 3 hours per week. ▪ EQ-5D-5L: Level 1 in all domains ▪ VAS Score: more than 60. ▪ Comorbidities: Does not score 'yes' to any comorbidities. ▪ Polypharmacy: Less than 4 medications ▪ Smoking: Non-smoker

Orthopaedic Prehabilitation Service

- Tier 1: 8-week online prehabilitation programme on a digital personal held health record
- Tier 2: 'Live' virtual group prehabilitation supported by technology enabled care (12 sessions over 12 weeks)- exercise and educational facilitated group consultations and remote monitoring of patients (weight, blood pressure, heart rate and blood saturation)
- Tier 3: Virtual 1:1 sessions for individuals with more complex care needs or not suitable for group consultations



- 41% of patients lost weight
- 27% of patients had increased levels of physical activity
- 36% improved their Oxford scores (improved function and reduced pain in their joint)
- 45% of patients reported improved quality of life

"I've lost 1 stone since the start of this programme and the monitoring devices, particularly the weighing scale has helped. Knowing that your team is looking at the results, it gave me motivation, and I would not have lost this weight otherwise."

"I have found the programme life changing. It provided me with the 'jolt' I needed to make changes and improve my health. I can't speak highly enough of the team, the programme has been hugely beneficial. I am continuing with a healthy eating diet and exercise at home"

Stratification of newly listed Orthopaedic Patients

60% Supported via WLSS (SPOC) and 40% by the Optimisation and Prehabilitation service

Waiting List Support Service

MDT Optimisation and
Prehabilitation service



- **Regional Collaboration with SBUHB** – Challenges have been experienced around delivery of arthroplasty but positive steps seen across other sub-specialties. The Foot and Ankle arthritis network is delivering its first dual operating Total Ankle Replacement in PPH on a SBUHB patient on 21/11/25. Positive collaboration is already established between hand and wrist surgeons with plans for implementation of a dual regional block list commencing in Quarter 4 2025/2026. Development of these regional working pathway delivers **efficient** and **effective** care for patients.
- **Consenting clinic slots** – The need for consenting slots will reduce as time in between clinic and theatre reduces improving **timely** services. However, moving to a pooled model will increase the requirement for this to comply with consenting best practice.
- **Waiting List Trends** - The insourcing stage 1 activity will significantly reduce stage 1 waits but will create a shift from outpatient delays putting increased pressure to deliver treatments. It is important that the quality of the additional stage 1 activity delivered is reviewed and audited to ensure it aligns with national and local conversion rates and is delivered **Safely** and **Efficiently**. Work on this supported by the Clinical Lead for T&O has commenced.
- **Patient Outcomes and Quality Monitoring** - There is a need to strengthen assurance around **safe** and **effective** care and patient outcomes by introducing monthly reviews of elective orthopaedic activity and routinely auditing key quality indicators. These should include surgical site infection rates, complications, and revision rates, ensuring continuous improvement and compliance with best practice standards. Resource limitations to date have prevented the establishment of these processes. An agreed arthroplasty governance process will address this but will result in an impact to elective service delivery (circa 2 sessions per month) for theatre to be stepped down during this process. However, there is currently a lack of admin and operational management resource to support the implementation and running of this.
- **Implementation of Virtual Joint School** – resource requirement to support for this **person-centred** intervention. Recommended intervention in Optimisation Framework, A Healthier Wales and 3P's programme.



- **Increasing throughput** - Delivery of 4 joint GIRFT Metric will ensure **Timely** and **Efficient** care. However surgical time is, in the main, static and opportunities to deliver 4 joints sits predominantly outside of the Consultant Orthopaedic Surgeon's control. i.e. Prompt start time, early sending, regular theatre teams and anaesthetist supporting consultants alongside the alignment of job plans to theatre session start times and ensuring adequate theatre workforce.
- **Outcome of CSP(1)** – some proposals provide additional elective inpatient activity which will support continued **Timely** intervention and reduction of waiting list volumes for inpatients.
- **Pre-assessment** - the lack of capacity to POAC clinically urgent patients resulting in delays to provision of care in urgent patients e.g. complex arthroplasty-have to utilise GGH instead of PPH, ST knee-utilise trauma list, ST shoulder and elbow-utilise trauma list. results in cancellations as fragility trauma given priority. Dedicated capacity should be provided for this to ensure **Effective** and **Efficient** use of theatre space.



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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

The six domains of quality



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Diogel
Safe

Our health care system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored, where possible, risks to safety are reduced or prevented and this is delivered by appropriate numbers of suitably skilled workforce



Effeithlon
Efficient

Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments targeted at those likely to gain the most benefit, ensuring any interventions represent the best value that will improve outcomes for people.



Amserol
Timely

Our health care system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority



Teg
Equitable

Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality because of personal characteristics such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status or political affiliation; the organisation that provides care; or location where care is delivered. We embed equality and human rights in our health care system and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.



Effeithiol
Effective

Our health care system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal outcomes possible for them and that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.



person ganolog
person centred

Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.

2.3

2.3 - Deep Dive: Ophthalmology

**Victoria Coppack
(Hywel Dda UHB -
Service Delivery
Ophthalmology
Ophthalmology &
Neurology), Paula
Goode (Hywel Dda
UHB - Service
Director for Planned
and Specialist Care),
Olwen Morgan
(Hywel Dda UHB -
Assistant Director of
Nursing)**

Attachments

[Deep Dive Ophthalmology 4th December 2025.pdf](#)



Deep Dive: Ophthalmology

Quality, Safety and Experience Committee

December 2025

This report aims to provide the Quality, Safety and Experience Committee with an overview and update on the current state of Ophthalmology service provision across Hywel Dda University Health Board.

- The Committee is seeking to understand the impact of current service fragility within Ophthalmology as part of Clinical Service Plan (CSP) 1.
- How this fragility is affecting service provision, including any associated incidents, complaints, patient experience, and clinical risks.
- The report will outline the interim measures, both in place and planned; to manage these challenges while we await the outcome of the CSP.

This paper outlines the clinical, operational and patient experience impacts of fragility, and the interim actions underway to mitigate risk



The Ophthalmology service within the Health Board is experiencing sustained fragility due to limited infrastructure, workforce shortages and limited out-patient, diagnostics and theatre capacity.

- Limited infrastructure on key sites for delivery, has resulted in the Ophthalmology service working out of 8 sites. This has in time eroded the workforce, who are working in silo, many without senior support.
- The workforce shortages have been driven by a national shortage of Ophthalmologists with difficulty to recruit into consultant vacancies. Consultants are managing their sub-specialities alone, which creates additional fragility when absent due to annual leave or sickness.
- Recruitment difficulties have led to the Consultant out of hours on-call rota of 1/6 currently being covered by four substantive consultants, leaving two gaps in the rota which are covered by additional duty hours. This rota is extremely fragile and is regularly impacted by sickness and annual leave.



- Both the medical and nursing workforce have faced critical shortages compounded by an inability to support and train staff due to lack of expertise within the service and the service being spread over 8 sites. This has presented challenges to expose team members to learning experiences and progress them to the top of their licence.
- The out-patient and theatre capacity is restricted due to reliance on out-patient and theatre staffing models, and diagnostic delivery is restricted by infrastructure availability.
- The Ophthalmology service is included within CSP to help redesign a foundation on which to build a sustainable Ophthalmology service. A key objective within the CSP is to reduce the sites for the delivery of Ophthalmology, increasing the estates on key sites, to enable staff to work under consultant led care, access the training and experience needed to encourage staff to work to the top of their licence. By reducing the sites of delivery the service will be able to achieve streamlined pathways for patients, reducing hospital visits and improving efficiencies.



Key Messages Overview



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- The Ophthalmology service faces sustained fragility due to workforce and infrastructure constraints, including reliance on other services for out-patient and theatre delivery. This report will examine,
- An overview of R1 (patient at risk of permanent sight loss) delivery through the Eye Care Measures, inclusive of an improvement trajectory.
- An overview of the current position in Ophthalmology for the delivery of the Ministerial Measures.
- A review of the Ophthalmology concerns, raised by patients over a 12 month period.
- A review of the incidents reported over a 12 month period.
- A review of the out of hours on call rota and potential solutions.
- Proposed workforce developments through the annual planning cycle.



Defining a Good Service for the Health Board and Value Contextualisation



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- Improved compliance with Eye Care Measures (to 65% by September 2026), resulting in patients receiving treatment on time reducing risk to a deterioration in their eye sight.
- Improved compliance with the Ministerial Measures (by March 2026), resulting in patients receiving treatment sooner and with better patient outcomes.
- Improved patient experience metrics and continued trajectory of reduced complaints. Better patient outcomes and experience contribute to overall system efficiency.
- Sustainable emergency eye care services improving both patient experience and patient outcomes.
- A stabilised workforce with access to training and support to develop them to the top of their licence and potentially grow them into more advanced roles, further stabilising the service. This will be measured through improvements in the Ministerial Measures, follow up not booked and Eye Care Measures delivery.
- Reduced reliance on outsourcing and ad hoc arrangements.



Short and Long-Term Plans for Ophthalmology



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Short-Term Plan March 2026:

- Validation of R1 patient cohort, supported by the care group to ensure the waiting list is accurate.
- New SAS recruits to undergo competency assessment and for clinic and intravitreal injection clinics to be increased in line with the Eye Care Measures SBAR (Improving R1 delivery to 49% by March 2026).
- Continue to outsource Intravitreal injection patients and cataract patient to maintain current waiting times and to outsource small numbers of Ocular Plastic and Vitreoretinal patients to reduce the risk of harm.

Long-Term Plan March 2027:

- Recruit 2 regional consultants, one for Medical Retina and one Vitreoretinal services, stabilising both sub-specialties and increasing clinic delivery in line with Eye Care Measures SBAR (Improving R1 delivery to 65% by September 2026).
- Establish regional on call service.
- Strategic workforce planning and service redesign under CSP.



Assessment Overview – Key Themes



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Access & Capacity

- RTT performance trends
- R1 delivery
- Theatre constraints
- Diagnostic capacity challenges

Workforce & Service Fragility

- Out of hours on call rota
- Workforce requirements for 2026/2027

Quality & Safety

- Complaints and incident themes

Innovation & Improvement

- Intravitreal Injections Service
- Emergency Eye care Service
- Theatre Delivery
- Outpatient Delivery

These slides collectively demonstrate a clear trajectory of improvement.

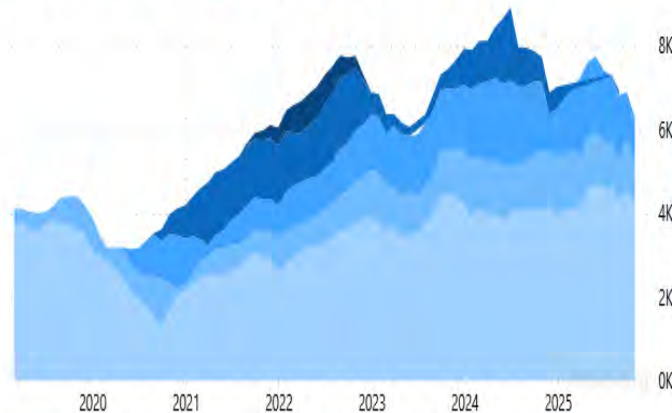


- Stage 1 outpatient wait for a new appointment has reduced by 965 patients since March 2025 with the longest waiting time being 51 weeks.
- Stage 3 diagnostic wait are incorrectly coded cataracts and has increased by 211 patients since March 2025 with the longest wait being 103 weeks.
- Stage 4 treatment waits have increased by 87 treatments since March 2025 with the longest wait being 108 weeks.
- The below data suggests overall the waiting list for stage 1 to stage 4 has decreased by 667 patients.

Stage 1

Total patients waiting by length of wait

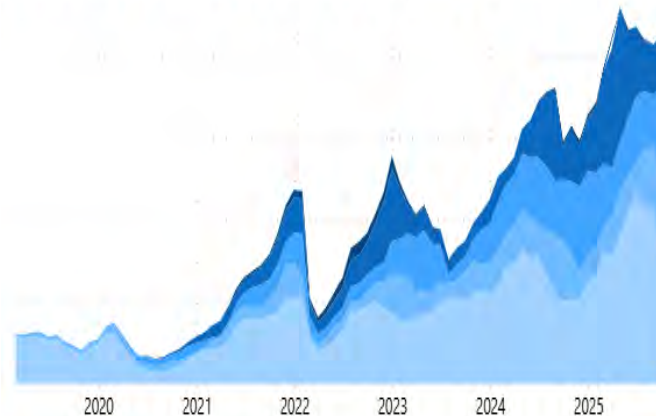
Under 26 weeks 26 to 35 weeks 36 to 52 weeks 53 to 104 weeks 105+ weeks



Stage 3

Total patients waiting by length of wait

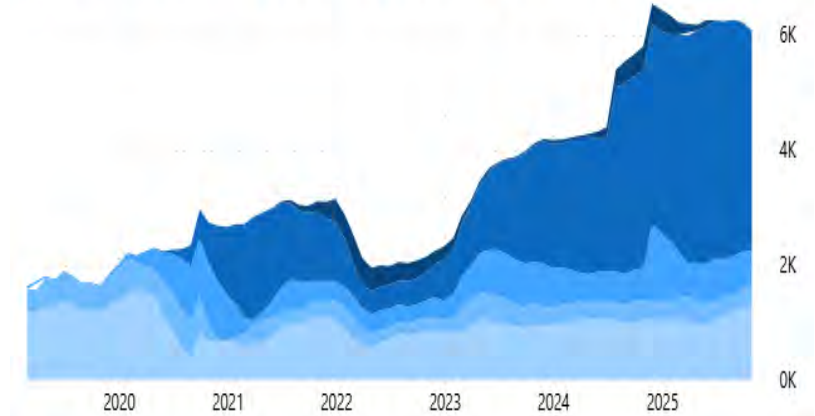
Under 26 weeks 26 to 35 weeks 36 to 52 weeks 53 to 104 weeks 105+ weeks



Stage 4

Total patients waiting by length of wait

Under 26 weeks 26 to 35 weeks 36 to 52 weeks 53 to 104 weeks 105+ weeks



Short and Long-Term Plans RTT



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Short-Term Plan:

- Continued administrative validation of waiting lists.
- Continued monitoring of DNA rates to explore further service improvement.
- Continue to increase clinic delivery with the introduction of new SAS doctors.
- Continue with additional WLI.
- Continue outsourcing cataracts increasing delivery externally.
- Continue insourcing to reduce outpatient waiting times.

Long-Term Plan:

- Recruit into two regional consultant positions which will present an opportunity to stabilise the workforce further, increase clinical delivery and bring much needed expertise into the service.
- To continue to work on a regional model which presents a strategic opportunity to deliver high-impact benefits across clinical outcomes, workforce sustainability, financial efficiency, and alignment with wider NHS Wales objectives.
- To continue with the development of the Ophthalmology service through CSP to help redesign a sustainable care delivery and stabilise the service and create a foundation to develop the regional ophthalmology service further.



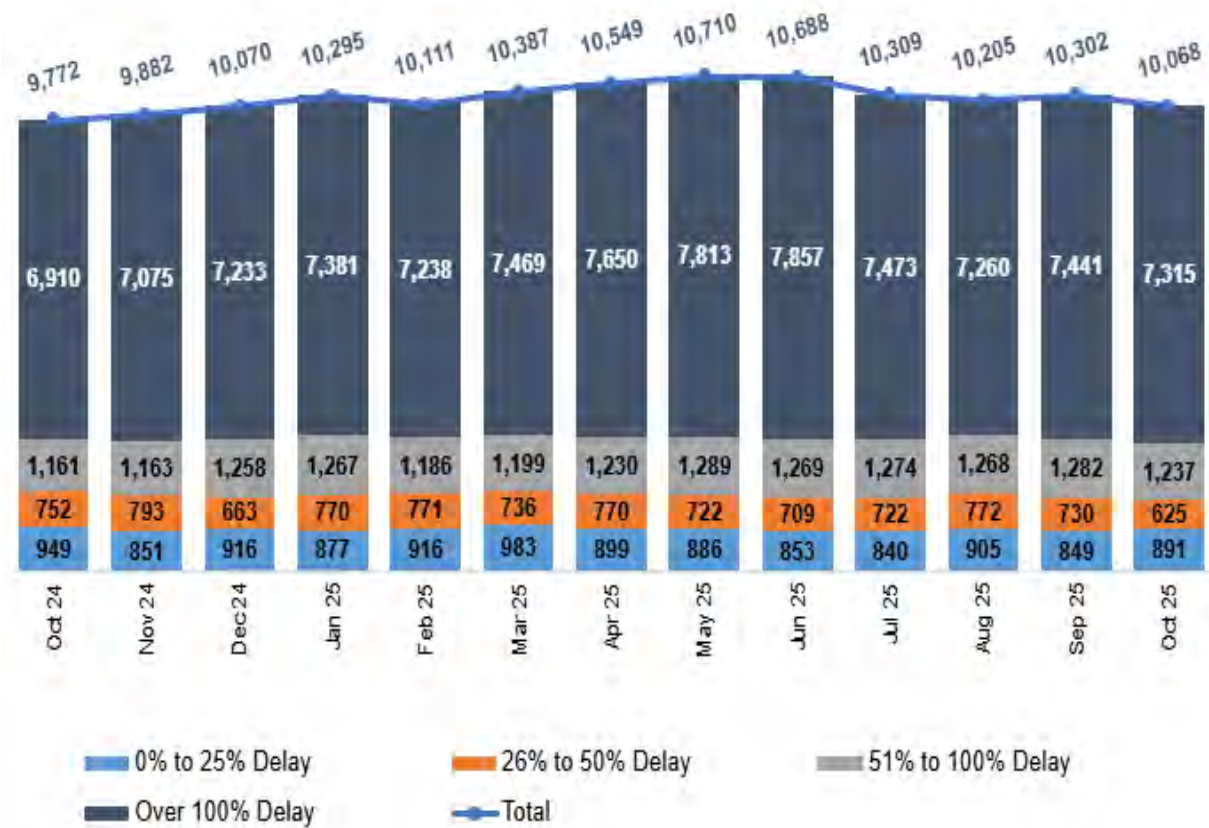
Assessment – Follow up waits



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- Ophthalmology have a high volume of patients on a follow up waiting list that have been waiting for a long time for a follow up review.
- A large volume of patients waiting on this follow up waiting list have a HRF of R1 (high risk), most of these being Glaucoma patients.
- Follow up delivery is restricted by limited workforce. The Glaucoma service is currently supported by a single-handed consultant from SBUHB employed as a part of a regional agreement.
- Clinical validation of this patient cohort is restricted by consultant availability to review, a percentage of these patients could potentially be discharged to the WGOS pathways, an SOS/PIFU pathway, discharged completely.
- Since May 2025 the Ophthalmology follow up waiting list has reduced by 642 patients with 498 of these patients being 100% delayed.



Short and Long-Term Plans for follow up waits



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Short-Term Plan:

- Continued administrative validation, supported by the clinicians where possible. To identify patient for WGOS, SOS, PIFU or discharge.
- Optometrists to continue validating certain sub-specialties to review if patients can be seen on the WGOS pathways any patients who are a cause of concern these are escalated for clinician review.
- WGOS4 pathway management to continue utilising primary care capacity to monitor patients in the community.

Long-Term Plan:

- Continued training of specialist optometrists to ensure the capacity for WGOS pathways can increase in primary care, utilising primary care capacity to monitor patients, where appropriate and safety net them.
- Continue to increase clinic capacity within the service with the development of the Ophthalmology workforce through a regional approach.
- Streamline administrative and clinical processes to ensure robust validation can be developed.



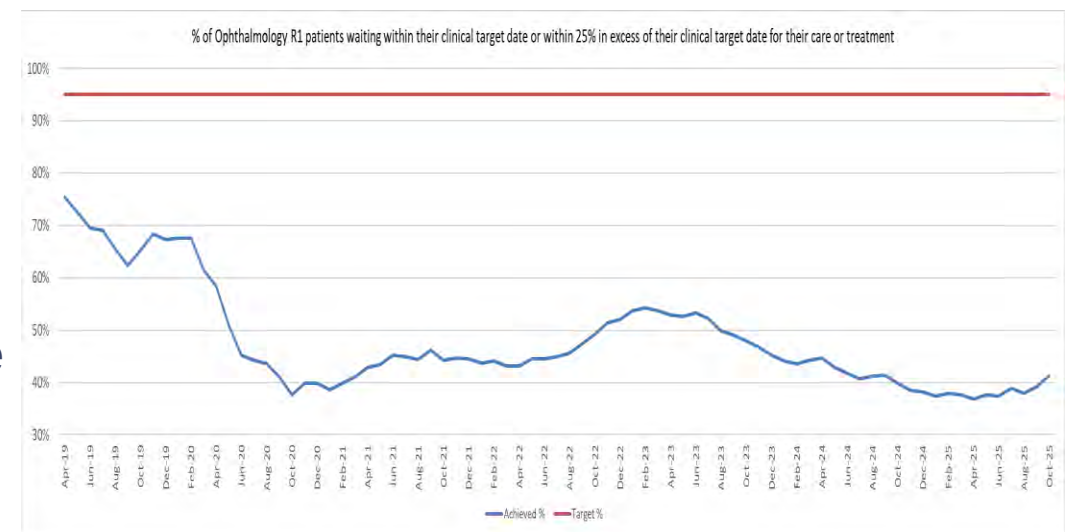
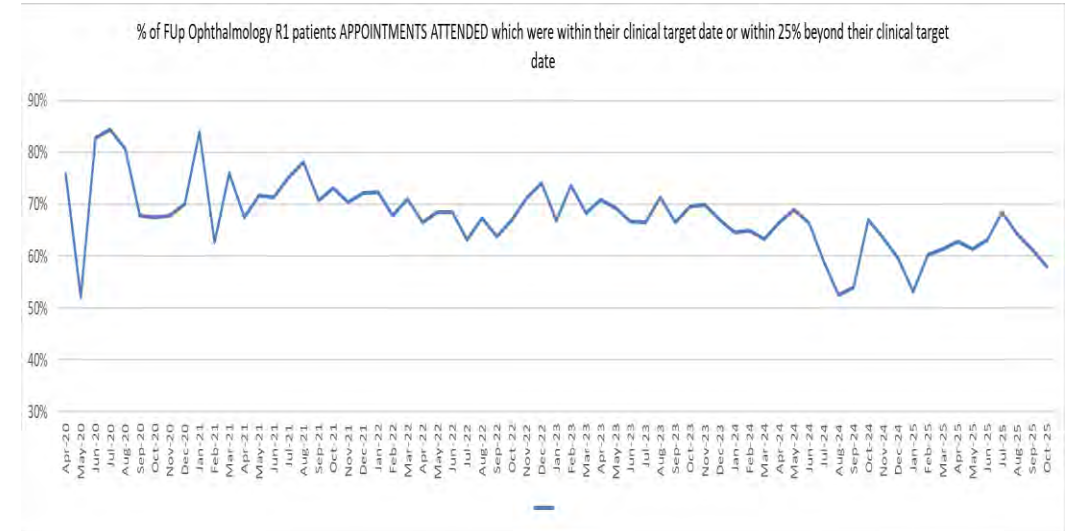
Assessment – Eye Care Measures (R1 delivery)



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- The Eye Care Measures monitors the delivery of timely treatment for R1 patients (at risk of permanent sight loss). There are two targets set by the Welsh Government for delivery of timely treatment for R1 patients both are expected to be at 95%.
- The current percentage for appointments attended 58% and the current percentage for overall waits in Ophthalmology is at 38%
- The delivery for Eye Care Measures (R1 patients) within the Health Board (HB) has been affected by a growing waiting list, recruitment difficulties and service constraints.
- It has been highlighted that there is a deficit both in the workforce and infrastructure to meet the increase in demand in ophthalmology which is impacting on the Eye Care Measures. Short term measures have been taken to stabilise the workforce but further investment in the workforce is required to deliver the necessary clinics and treatments.



Short and Long-Term Plans for Eye Care Measures



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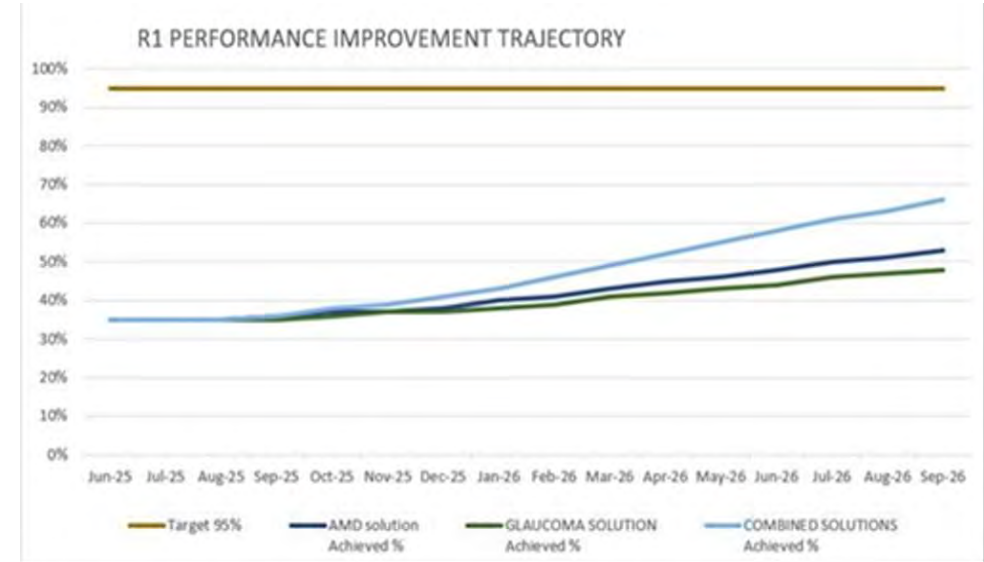
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Short-Term Plan:

- Additional capacity has been secured in the short term through the use of WLI and outsourcing for the IVT service.
- Additional Intravitreal injection clinics have been funded through the annual plan for 2025/2026 and coming online from November through to September 2026.
- Continue to increase clinic delivery through appointed SAS doctors

Long-Term Plan:

- Recruitment of a further two regional consultants will increase both clinic and treatment delivery, improving the waiting list target to 65% by September 2026.
- To develop an Ophthalmology workforce to deliver outpatient capacity in GGH which will deliver a further 11 clinics per week.
- To develop emergency eye care practitioners in line with SBUHB to triage emergency eye care patients and release SAS doctors back to utilise the 11 clinic sessions.



Assessment – Wet AMD Delivery (R1 delivery)



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- The Wet Age-Related Macular Degeneration (WetAMD) patients are a cohort of R1 patients which form 17% of the patients on the Eye Care Measures target.
- These patients are extremely high risk of sight loss if they do not receive their injections on time.
- Currently patients are waiting 6-10 weeks beyond their treatment dates due to capacity within the service not meeting demand. In order to meet this demand, the service would need to undertake 273 more injections per week (13 injections undertaken per clinic).

Number of patients on wet AMD pathway	Number of patients requiring bilateral treatment	Total eyes requiring injection on AMD pathway	Injections required per week for 6 week delivery
2766	602	3368	561
Injections delivered per week	Additional injections delivered through WLI	Total injections per week	Additional injections required per week for 6 week delivery
258	30	288	273



Short and Long-Term Plans for Wet AMD (R1 delivery)



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Short-Term Plan:

- A cohort of 300 patients has been outsourced and this group of patients receives their intravitreal injections on time.
- All patients on a loading dose (3 consecutive treatments) receive their Intravitreal injections on time.
- All patients with sight in only one eye are receiving their intravitreal injections on time.
- Additional capacity continues through the use of WLI running an additional 30 injections per week through AVH.
- Additional Intravitreal injection clinics have been funded through the annual plan for 2025/2026 and coming online from November 2025 through to September 2026.

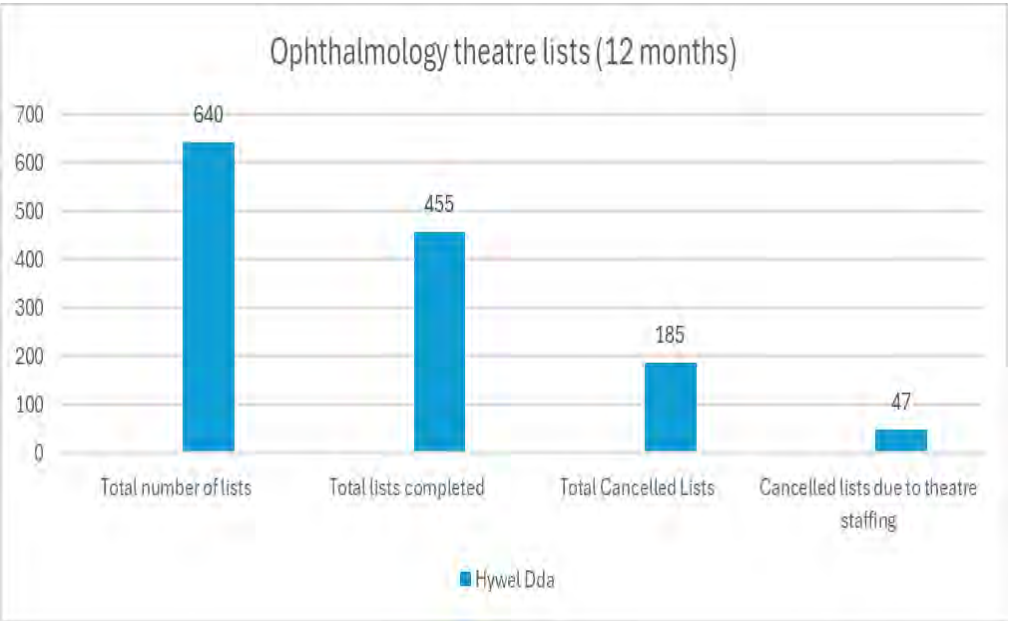
Long-Term Plan:

- AVH out-patient department needs to be secured for 5 day working to deliver additional Intravitreal clinics.
- The recruitment of a Medical Retina Consultant through the regional consultant posts will increase both clinic delivery and treatments to deliver the 65% R1 delivery by September 2025
- A regional approach has identified the possibility of introducing additional clinics delivered by SBUHB which would be a cheaper option than ou



Assessment – Theatre constraints

- There have been constraints in Glangwili theatre delivery for a period of 14 months due to ongoing staffing issues. This has resulted in Ophthalmology losing service delivery.
- In a 12-month period the service could have delivered 640 theatre lists across site. 455 lists were delivered across site. 185 theatre lists were cancelled. 138 lists were cancelled due to annual leave/sickness. 47 theatre lists were cancelled at short notice due to staffing shortages in theatre.
- Of the 455 lists that have been delivered across site. Only Amman Valley theatre is able to apply high flow principles. This theatre is delivering 7-8 cataract treatments per list. All other theatre lists average at 5 cataracts.
- For the Ophthalmology service to maintain 104 week wait for cataract treatment 3015 treatments are being outsourced during 2025/2026.



Short and Long-Term Plans for Theatre Delivery



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Short-Term Plan:

- Additional capacity has been secured in the short term through the use of outsourcing for cataracts, vitreoretinal and plastic delivery.
- Theatre lists are being scrutinised, reviewing start and finish times to increase in house delivery where possible.
- Getting it Right First Time (GIRFT) recommendations continue to be reviewed with 51 of the 59 recommendations now completed.

Long-Term Plan:

- The annual plan for 2026/2027 will include a proposed Ophthalmology theatre model to ensure specialist input on all Ophthalmology lists.
- Recruitment of one of the regional consultants will increase vitreoretinal theatre delivery within the HB.
- By securing additional days for Intravitreal injections through Amman Valley (AVH) Outpatient department, AVH theatre could be developed into a cataract hub increasing delivery by a further 6 theatre lists.



Assessment – Diagnostic Capacity challenges



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- Diagnostic capacity within the Ophthalmology service is restricted by infrastructure. Each out-patient department is restricted to a single lane for visions and a single room for ophthalmology diagnostic scans to be undertaken, restricting clinic capacity to 30 patients per session.
- The lack of capacity within the infrastructure restricts the development of the nursing, optometrist and orthoptic staff. There are no clinic rooms for them to see patients alongside a consultant and both visions and diagnostic restrictions mean clinic cannot be increased. Without this development and oversight from a consultant they cannot be developed to the top of their licence. If the workforce was developed to the top of their licence this would increase the ability of these staff groups to undertake virtual reviews, thus reducing waiting times.

Short and Long-Term Plans for Diagnostic Delivery



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Short-Term Plan:

- Additional capacity has been secured in the short term through the medical retina consultant undertaking virtual reviews via consultant connect. These sessions could be increased if a second medical retina consultant was secured through the regional programme.

Long-Term Plan:

- A recent regional visit identified where vision lanes and further diagnostic rooms could be developed with some investment in the estates by re-purposing rooms or splitting larger rooms into two lanes.
- A virtual hub could be established in Aberaeron if staff were to be invested in (x1 band 3 technician at a cost of £34,180 per annum).
- Virtual clinics could be developed within the Glaucoma pathway to reduce the burden on face-to-face clinics, if a hub could be secured to undertake essential diagnostic testing (as outlined above).





- The Consultant on call rota is 1:6 currently covered by 4 substantive consultants leaving a gap of 2/6 currently covered by additional hours (ADH) undertaken by staff.
- The fragility of the current service model is as a result of gaps in the consultant workforce. HDUHB currently holds unfilled vacancies for two consultant posts. Historically consultant posts have been difficult to recruit into, largely due to rurality, recruitment competition across Wales, and the absence of a critical mass of sub-specialist support.
- At present, the ophthalmology service operates without any cross-cover arrangements, meaning that when a sole consultant is unavailable due to sickness or annual leave, patients are referred to out-of-area providers (most notably in Bristol for vitreoretinal services). This reliance not only imposes a financial cost of circa £112,791.00 per annum but also introduces delays to patient treatment and travel burdens for patients.
- The SAS on call rota is 1:8 currently covered by 5 substantive SAS doctors leaving a gap of 3/8 currently covered by ADH.

Short-Term Plan:

- The gaps on both on call rotas are currently being covered through good will and claimed for through additional duties payment at a significant cost pressure to the Service.
- Three SAS doctors have recently onboarded and are working through their competencies to enable a full SAS out of hours rota to operate.

Long-Term Plan:

- The two regional consultant posts will potentially allow the service to move towards a regional out of hours on call model. This would potentially involve all theatre patients being operated at SBUHB supported by a local SAS on call out of hours service. This will eliminate the need to send patients out of area and reduce costs but also ensure a better patient pathway and patient outcomes.



Assessment – Workforce requirements



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- The consultant workforce will need further investment to ensure single handed workforce models do not continue into the future. There are currently sub-specialities within Ophthalmology that have no specialty consultant, these include adult motility and cornea. These patients are managed under general ophthalmology and transferred to Swansea Bay University Health Board (SBUHB) for further assessment and treatment.
- The nursing model does not allow for the robust development of knowledge and skills within the nursing team. Ideally the workforce model will align with SBUHB which has ophthalmology trained nurses in out-patient and theatre departments managed by the Ophthalmology service giving better training opportunities and opportunities for promotion.
- There are no emergency eye care practitioners in the Health Board, meaning that SAS doctors are utilised to deliver all emergency eye care, where they could be utilised for clinic and treatments.
- The secondary care Optometrists within the service are all employed on a sessional basis.
- There are no Band 8B Orthoptic leads for the HB.

Short and Long-Term Plans for Workforce requirements

Short-Term Plan:

- To recruit into all vacancies within ophthalmology and invest in training and development where possible.
- To ensure the three SAS doctors have recently onboarded complete their competencies to enable a full SAS team and increase delivery.

Long-Term Plan:

- The annual plan for 2026/2027 will include the required workforce to develop the next phase of the service development. There is a possibility this can be funded from within the current budget but would require a non-pay conversion to pay.

Row Labels	Sum of WTE	Sum of Cost
Band 3 Ophthalmology Outpatient HCSW	3.20	108,777
Band 3 Technician	1.20	40,416
Band 5 Ophthalmology Outpatient nurse	3.20	137,729
Band 6 Eye Care Emergency Practitioner	2.00	105,722
Band 6 Pre-assessment/theatre role	1.00	52,861
Band 7 Service Manager	1.00	65,269
Band 8B Optometrist	1.00	89,366
Band 8B Orthoptist	1.00	89,366
Grand Total	13.60	689,506



Assessment - Feedback and Incidents



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Concerns open

Service	Less than a month	1-3 months	Over 3 months	Over 6 months	Over 12 months	Grand total
Ophthalmology	14	10	3	1	0	28

1 over 6 months - awaiting outcome for patient treatment to determine level of harm

3 over 3 months – 1 delayed treatment requiring further investigation

- 1 unhappy with treatment on ward, awaiting comments from the ward staff
- 1 unhappy about cancellations (response being drafted)

Most concerns over timeliness are managed by the Service Support manager

The Ophthalmology management and clinical team meets every 2 weeks to work through any complex concerns

Assessment - Feedback and Incidents



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Incidents open

Service	Less than a month	1-3 months	Over 3 months	Over 6 months	Over 12 months	Grand Total
Ophthalmology	9	16	7	8	0	40

4 open over 6 months – 3 delay to IVT (awaiting outcome of treatment)

- 4 delay to VR (awaiting outcome of treatment)

- 1 Referral delayed (awaiting outcome of treatment)

1 open over 3 months -1 Delay to VR (awaiting outcome of treatment)

- 3 Delay to IVT (awaiting outcome of treatment)

- 1 Wrong sample (awaiting feedback from consultant)

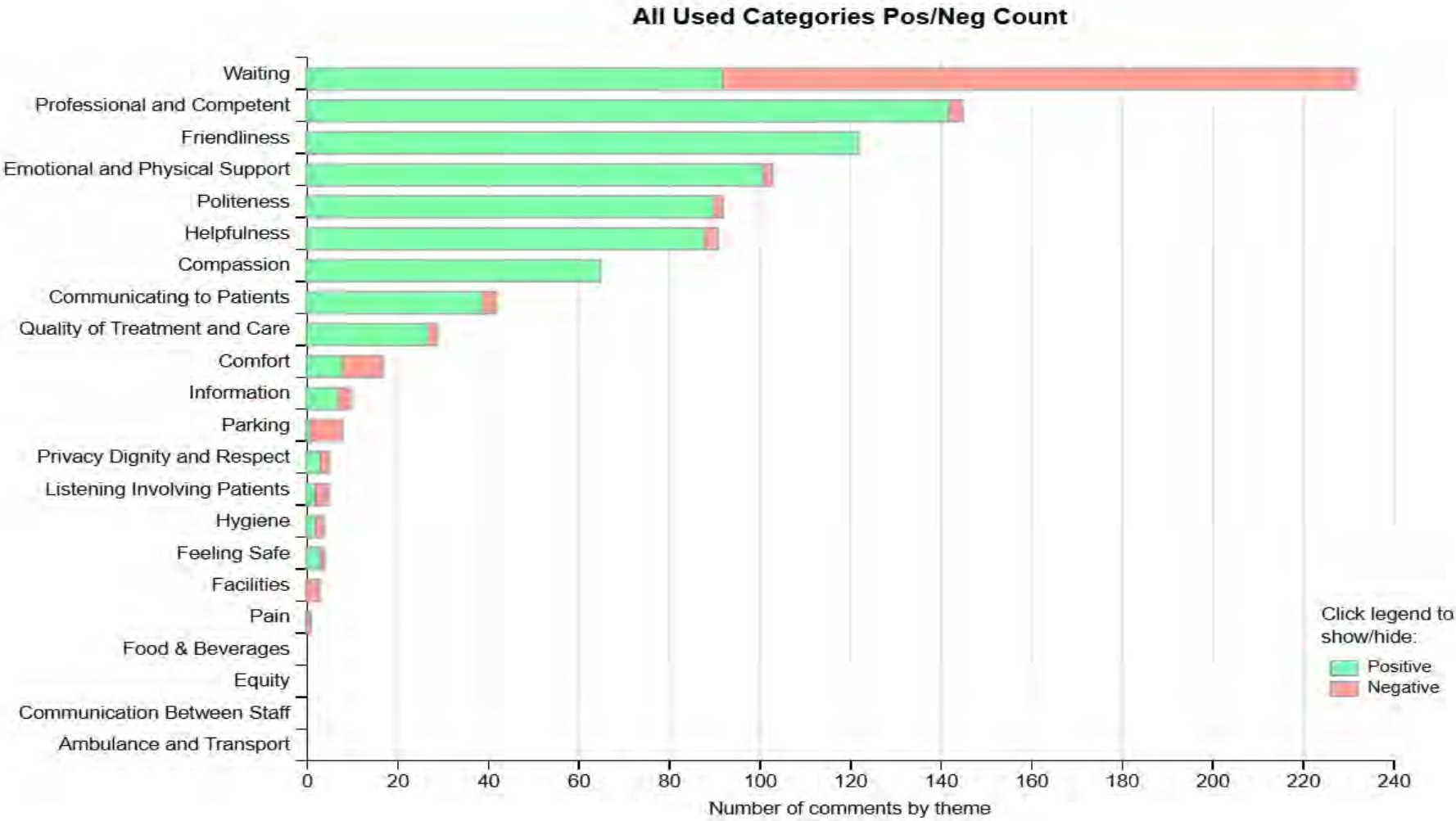
- 2 Prescription error (awaiting IG training certificates)

Assessment - Feedback and Incidents



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Short and Long-Term Plans for Clinical Governance



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Short-Term Plan:

- To continue to monitor concerns with the support of the concerns team, identifying themes and feeding back to the clinical team through the Quality and Safety meeting.
- To continue to monitor incidents with the support of the risk and governance team, identifying themes and implementing change to reduce the risk to patients feeding back to the clinical team through the Quality and Safety meeting.
- To continue service improvement projects such as the investment in the service for the delivery of Eye Care Measures, which will reduce the risk to patients and improve patient experience.



Long-Term Plan:

- To undertake the annual planning cycle for 2026/2027 to identify further developments needed within the service.
- To continue working regionally to improve service delivery.
- To continue working within the Ophthalmology Clinical Implementation Network to improve patient pathways through networking.

Conclusion



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Overall Fragility Scoring following Ophthalmology Review



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Criteria	Weighting
Criterion 1: Quality and safety - there is evidence that the outcomes for patients are significantly below comparator providers; or there are significant patient safety concerns; or service does not meet minimum volumes of activity to maintain high standards	4
Criterion 2: Patient experience and performance - there is no viable prospect of the service meeting professional standards, including delivery of timely services	3
Criterion 3: Workforce and culture - the workforce required to safely and sustainably deliver the service is not available because it cannot be recruited, developed, or retained - or can only be delivered by a dependency on agency or locum staff	5
Criterion 4: There is professional/clinical consensus on the merits of reconfiguring services to deliver an enhanced pathway or a new service model.	2
Criterion 5: There is significant public support or democratic mandate to change a service model.	1
Risk Matrix Scoring: Risk 1664, (score 16)	16
Total Fragility Score	31

Ophthalmology is a fragile service for all the reasons outlined in this presentation. However, the service has made efforts to continue to improve the service where possible and mitigate the risks for patients. The service is monitored against the corporate risk 1664.

Risk 1664 was audited in July 2025 and all actions reviewed, The service has provided reassurance to NWSSP Audit & Assurance team that the fragility of the service is being continuously actioned and monitored.

Scope & Assurance Summary

Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.		Related Findings	Assurance
1	Controls to address the ophthalmology service issues have been identified, with appropriate actions to address any gaps in control	1 and 2	Reasonable
2	Effective arrangements are in place to monitor performance, action implementation and ensure any barriers to achievement of targets are escalated where appropriate	-	Substantial

The six domains of quality



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Diogel
Safe

Our health care system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored, where possible, risks to safety are reduced or prevented and this is delivered by appropriate numbers of suitably skilled workforce



Effeithlon
Efficient

Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments targeted at those likely to gain the most benefit, ensuring any interventions represent the best value that will improve outcomes for people.



Amserol
Timely

Our health care system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority



Teg
Equitable

Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality because of personal characteristics such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status or political affiliation; the organisation that provides care; or location where care is delivered. We embed equality and human rights in our health care system and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.



Effeithiol
Effective

Our health care system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal outcomes possible for them and that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.



person ganolog
person centred

Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.

3 - Assurance

3.1

3.1 - Targeted Intervention Progress Report- Executive Leads

Attachments

[De-escalation Criteria Progress Update Dec25.pptx](#)



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Quality, Safety and Experience Committee Escalation/ De-escalation Criteria Progress Update December 2025



This paper provides the Quality, Experience and Safety Committee (QSEC) with an updated assessment of the Health Board's position against the Targeted Intervention criteria for the quality safety domains. It brings together the most recent evidence across fragile services, urgent and emergency care, planned care, hospital-acquired infections and our response to Health Inspectorate Wales (HIW) inspections and regulatory notices. The purpose is to offer a balanced view of progress, acknowledge areas where improvement is evident, and be transparent about those domains where the pace of change has not yet met the required standards.

The updates reflect the outputs of Executive Improving Together Sessions, the latest dashboard intelligence, and ongoing operational engagement across clinical care groups. While several areas demonstrate clearer structures, strengthened oversight and early signs of stabilisation, others continue to experience significant pressures that will require sustained Executive focus. The paper therefore aims to support QESC in maintaining appropriate scrutiny, ensuring actions remain aligned to the expectations set within Targeted Intervention, and confirming that the trajectory of improvement is both understood and actively managed.

Introduction



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TI Reference	Criterion Summary	Committee Relevance	Current Rating
MD1	Ability to identify early signs of service fragility through triangulation of workforce, incidents, complaints, mortality and regulatory intelligence	Fragile Services Framework oversight, escalation to QESC	Advise
MD2	Leadership, accountability and improvement planning in fragile services, including clinical leadership appointments and Project Management support	Improvement plan integrity and leadership assurance	Advise
MD3	Tracking and closing external recommendations (HIW, Royal Colleges, regulators) through a central, reliable system	Quality governance, external recommendation assurance	Advise
MD4	Board visibility and oversight of fragile services, including routine reporting of trajectories and improvement milestones	QESC scrutiny of fragile services reporting before Board	Advise
MD5	Handling of concerns, complaints and incidents within Unscheduled Emergency Care (UEC), including responsiveness, investigation timeliness and learning	Incident/complaints governance, UEC safety and learning	Advise
MD6	Reduction in Clostridioides difficile infections (hospital-onset ≤ 6 cases for 3 consecutive months)	IPC performance oversight; organism-specific reduction	Advise
MD7	Reduction in Staphylococcus aureus bacteraemia (hospital-onset ≤ 2 cases for 3 consecutive months)	IPC oversight; bacteraemia performance	Alert
MD8	Reduction in Escherichia coli bacteraemia (hospital-onset ≤ 5 cases for 3 consecutive months)	IPC oversight; urinary/biliary infection improvement	Alert
MD9	Addressing root causes of hospital-acquired infections (learning, environmental audits, HPV, training compliance, pathways)	System-wide IPC assurance	Alert
MD10	Planned care incident, complaint and feedback management, and patient experience during long waits	Incident governance, complaints performance, PX	Advise
MD11	Prompt and effective responses to HIW inspections, regulatory notices, never events and coroners' reports	Regulatory assurance oversight	Advise
MD12	Improving patient and family feedback; timely complaint resolution; embedding learning	Patient experience governance	Alert (subject to updated evidence)



Lead executive: Mrs Sharon Daniel, Executive Director of Nursing Quality and Patient Experience

Issue

The Health Board must be able to identify early signs of fragility within clinical services, understand the root causes, and ensure timely, coordinated action. This includes triangulating workforce data, incidents, patient feedback, regulatory intelligence and operational pressures. Clear leadership arrangements, improvement plans and reliable reporting to the Executive Team, QESC and the Board are essential components of Targeted Intervention oversight.

Current status

Work to strengthen the fragile services approach has continued over the past six months and is expected to consolidate further following the November cycle of the Executive Improving Together Sessions. The Fragile Services Framework introduced earlier this year is proving a useful structure for identifying risk across the system, and the heat-map process has begun to embed the discipline of considering fragility indicators in a consistent way.

Early work with **diabetes** and **ultrasound** services demonstrated how the framework can support constructive conversations between clinical teams and corporate functions. Both services have used the process to articulate the causes of fragility, set improvement priorities and clarify where additional project-management or transformation support is required. These early pilots have helped shape expectations for how the wider organisation will adopt the approach.

A Fragile Services Oversight Group has now been established to maintain visibility of the highest-risk areas and act as the link between operational performance and strategic governance. This group is beginning to review heat-map outputs, confirm escalation thresholds and ensure that services identified as fragile provide regular updates on recovery milestones. As this group matures, it will become the principal forum for coordinating assurance, providing a more structured route for escalating issues to Integrated Quality, Finance and Performance Delivery Group (IQFPD), QESC or the Board.



However, the approach is still embedding across the organisation. Several services have yet to complete their initial fragility assessments, and not all teams are routinely triangulating workforce, incident, complaints and regulatory data to inform their position. This means that some fragile-service identification continues to rely on informal intelligence rather than the systematic use of the framework. In addition, while a heat-map is available at executive level, a consolidated register of fragile services and their improvement trajectories has not yet been routinely reported to QESC or the Board, mirroring the position highlighted in the dashboards where fragile services are noted as “only available at the function level” and not yet integrated into routine reporting frameworks .

The next Executive Improving Together Session is expected to provide updated heat-map outputs, refreshed improvement plans and clearer standardisation of leadership expectations. This will be a key point in ensuring that clinical leads are formally identified for all fragile services and that each service has a calibrated improvement plan with agreed milestones.

Rationale – Advise

The foundations of a robust fragile-services model are now in place, with early pilots demonstrating that the methodology is sensible and that it can generate meaningful insights when applied consistently. The Oversight Group strengthens the governance route, and the Executive Improving Together Sessions are beginning to create the rhythm required for routine monitoring.

However, the approach is not yet fully embedded. Not all services are completing fragility assessments to the same standard, several teams have stated that they lack the project-management capacity needed to drive their improvement plans, and a consolidated Board-level view of fragile-service scores and trajectories is still in development. The organisation therefore remains in a position where fragility is understood in principle however not yet monitored or reported with the consistency required for assurance. On this basis, the status remains **Advise**. With sustained focus on embedding the framework, confirming clinical leadership arrangements for every fragile service, and ensuring routine reporting to QESC and the Board, the organisation will be well placed to progress towards assurance in future quarters.

TI-2025/547/MD5/3 – Handling UEC concerns, complaints and incidents



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Lead Executive - Mrs Sharon Daniel, Executive Director of Nursing Quality and Patient Experience

Issue

Urgent and Emergency Care (UEC) remains a high-risk area on the corporate and operational risk register. The Health Board must provide clear evidence that incidents, complaints and concerns in the Community and Integrated Medicine (CIM) function are being managed promptly, with systematic learning and timely responses.

Current Status

Incidents

Incident management within Community and Integrated Medicine continues to face significant delays. Based on the dashboard (October 2025), CIM currently has:

- **1,154 incidents older than 120 days, and**
- **1,621 incidents older than 60 days,**

demonstrating sustained delays in progressing investigations and embedding learning.

Age-profile analysis shows a substantial tail of significantly aged cases, ranging from **900 to 1,505 days**. The longest-open incidents include:

- HDD7679 (**1,505 days**)
- HDD11180 (**1,432 days**)
- HDD14727 (**1,360 days**)
- HDD19101 (**1,269 days**)

and multiple others exceeding **900 days**.



The most frequent incident categories in Community and Integrated Medicines Clinical Care Group (CIMCCG) are:

- Pressure damage / moisture damage - **562**
- Accident / injury – **238**
- Medication / IV fluids - **158**

These themes reflect pressures in frailty, unscheduled care and complex discharge pathways.

Complaints

Complaint timeliness remains a concern. The longest-open complaint in CIM has been outstanding for 742 days, with several others exceeding 500 days. Monthly new complaints continue to fluctuate between 40 and 70, aligned to operational pressures.

Rationale – Advise

Incident closure performance across most directorates is strong, and reporting behaviours remain consistent. However, the **scale of aged incidents**, the **substantial tail of extremely long-open cases (900–1,505 days)**, and persistent delays in complaint resolution require further improvement before assurance can be provided, however it hasn't deteriorated against the mean. Strengthening investigation timeliness, improving patient communication and embedding learning across UEC pathways remain priorities.

TI-2025/547/MD10/1 – Planned Care: concerns, complaints, incidents and patient feedback



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Lead executive - Mrs Sharon Daniel, Executive Director of Nursing Quality and Patient Experience

Issue

Planned care services must manage incidents, complaints and patient feedback effectively whilst delivering recovery plans that address lengthy waits across high-volume specialties such as orthopaedics, gynaecology and ophthalmology.

Current Status

Incidents

Planned and Specialist Care continues to experience delays in completing incident investigations. Using the dashboard's age-profile (October 2025), PSC currently has:

- **349 incidents aged more than 3 months (approx. >120 days), comprising:**
 - 221 incidents aged **3–6 months**
 - 97 incidents aged **6–12 months**
 - 24 incidents aged **1–2 years**
 - 6 incidents aged **2–3 years**
 - 1 incident aged **>3 years**

This demonstrates a significant backlog across multiple specialties.

TI-2025/547/MD10/1 – Planned Care: concerns, complaints, incidents and patient feedback



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The longest-open PSC incidents show sustained ageing across the function, including:

- HDD24706 (**1,155 days**)
- HDD38190 (**904 days**)
- HDD41353 (**847 days**)
- HDD42299 (**828 days**)
- HDD43058 (**814 days**)

The most common incident types relate to:

- Assessment / Investigation / Diagnosis – **154**
- Maternity adverse occurrences – **122**
- Treatment / Procedure – **93**
- Access / Admission – **74**
- Communication – **50**
- Medication / IV fluids – **36**

These themes reflect the complexity of elective pathways and the fragility of specialist workforce capacity.

TI-2025/547/MD10/1 – Planned Care: concerns, complaints, incidents and patient feedback



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Complaints and patient experience

PSC complaint timeliness remains below expectation. The longest-open complaints range from **353 to 438 days**, predominantly within:

- **Gynaecology** – longest **438 days**
- **Obstetrics** – longest **434 days**
- **Orthopaedics** – multiple cases >350 days

Monthly new complaints continue to fluctuate between **40** and **80**. Only **38.15%** of PSC complaints have been resolved within the 30-day standard, and there is limited evidence that patient feedback is consistently used to inform pathway redesign or improve communication with long-waiting patients.

Service recovery context

Despite these governance challenges, operational recovery continues:

- Zero cataract pathway breaches since Q1 2025
- 18% reduction in diagnostic waits
- Single Cancer Pathway performance sustained above 60%
- Targeted investments in ultrasound, ophthalmology recovery and the new aseptic unit (Feb 2026) support longer-term stability.

Rationale - Advise

Planned care recovery programmes are improving clinical throughput, pathway compliance and diagnostic capacity. However, the backlog of 349 aged incidents, the presence of cases >1,000 days old, and persistent delays in complaint-handling mean governance and learning systems are not yet operating at the level required for assurance. Strengthening investigation timeliness, reducing aged complaints and ensuring patient feedback drive improvement remain priorities.

TI-2025/547/MD6/1 – Reducing Clostridioides difficile infections



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Lead executive - Mrs Sharon Daniel, Executive Director of Nursing Quality and Patient Experience

Issue

The TI de-escalation criterion requires the Health Board to reduce hospital-onset C. difficile infections by 25% from the Q3 2023 baseline (8 cases per month) to no more than six cases per month, sustained for three consecutive months.

Current status

Dashboard data to October 2025 show hospital-onset C. difficile cases of:

- June = 11, July = 7, August = 4, September = 5, October = 11.

Performance in August (4 cases) and September (5 cases) demonstrates the organisation's capability to meet the TI threshold in individual months. However, this has not been sustained, with a marked deterioration in **October (11 cases)**, representing one of the highest values recorded in 2025.

Between 1 July and 31 October 2025 there were 23 hospital-onset and 29 community-onset C. diff cases across the Health Board, highlighting the need for continued strengthened IPC practice across both community and acute pathways.

Rationale - Advise

The Health Board has demonstrated that the target can be achieved in isolated months, and improvement initiatives appear to have driven reductions in August and September. However, the criterion of three consecutive months at or below six cases has not been met, and the marked increase in October underscores a need for further sustained improvement. Continued focus on antimicrobial stewardship, environmental controls, and targeted clinical actions remains essential before assurance can be offered.

TI-2025/547/MD7/1 – Reducing Staphylococcus aureus bacteraemia



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Lead executive - Mrs Sharon Daniel, Executive Director of Nursing Quality and Patient Experience

Issue

The TI target requires a 33% reduction in hospital-onset S. aureus bacteraemia, from a baseline of three cases per month to no more than two cases per month, sustained for three consecutive months.

Current Status

Dashboard data for July–October 2025 show monthly hospital-onset S. aureus cases of:

- July = 4, August = 5, September = 4, October = 3.

Although October represents an improvement from August and September, the Health Board has not achieved the required threshold of two cases or fewer in any month in 2025. The Quality and Safety Assurance Report confirms that 16 hospital-onset cases were recorded between July and October 2025 (47 cases overall across community and hospital settings), demonstrating a persistent gap between current performance and the TI requirement.

Rationale - Alert

The target of ≤ 2 cases has not been met in any month of the reporting period, and the trajectory remains above the threshold throughout 2025. While October shows some improvement, the level of variance from the TI requirement and the absence of sustained reduction necessitates an Alert rating.

TI-2025/547/MD8/1 – Reducing Escherichia coli bacteraemia



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University Health Board

Lead executive - Mrs Sharon Daniel, Executive Director of Nursing Quality and Patient Experience

Issue

The TI target requires a **25% reduction** in hospital-onset E. coli bacteraemia from a baseline of 6.7 cases per month to **no more than five cases per month**, sustained for **three consecutive months**.

Current status

Dashboard data for **July–October 2025** show hospital-onset E. coli cases of:

- July = 10, August = 6, September = 9, October = 10.

Performance in 2025 has not met the TI threshold in any month during this period (April 25-October 25), with July and October representing some of the highest values recorded. Earlier improvements in January (0) and February (5) demonstrate that the target is achievable, but there has been no sustained period of compliance with the ≤ 5 threshold.

The Quality and Safety Assurance Report confirms high E. coli rates, with UTI, CAUTI and biliary tract infections the predominant sources. ANTT compliance stands at 82.58%, and hand-hygiene and environmental audit compliance is monitored through AMaT

Rationale - Alert

The TI sustained-performance requirement has not been met, and monthly cases throughout the most recent period remain well above the threshold. The October value of 10 further reinforces the need for continued targeted work on UTI prevention, hydration, catheter management, and antimicrobial stewardship. The overall trend analysis continues to support an Alert rating.

TI-2025/547/MD9/1 – Addressing root causes of HCAIs



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Lead executive - Mrs Sharon Daniel, Executive Director of Nursing Quality and Patient Experience

Issue

Beyond meeting organism-specific numerical targets, the Health Board must demonstrate comprehensive understanding of the underlying drivers of HCAIs and provide evidence that actions taken are leading to sustained reductions in infection burden.

Current status

The Infection Prevention Strategic Steering Group (IPSSG) oversees a broad Quality-Planning, Quality-Control and Quality-Improvement programme. Key actions include:

- Delivery of the annual Infection, Prevention and Control (IPC) work plan and compliance with Wales-wide HCAI improvement circulars.
- Strengthened surveillance structures via standardised scrutiny meetings for hospital-onset HCAIs.
- Environmental audit and observational audit programmes, with improvement plans monitored.
- HPV enhanced cleaning implemented across three acute sites.
- HCID/ID pathway training completed for GGH and BGH, with PPH and WGH scheduled later in 2025.
- Participation in the Wales C. difficile Focus Forum and National Learning Collaborative.

Dashboard data to October 2025 shows:

- **Mixed trends across all three organisms**, with improvements in August for C. diff (4) and E. coli (6), but subsequent deterioration in October (C. diff 11; E. coli 10).
- **S. aureus fluctuating** between 3–5 cases throughout the period, without achieving the TI threshold.
- Training compliance remains variable (e.g. Level 2 IPC tra %; ANTT 82.58%).

TI-2025/547/MD9/1 – Addressing root causes of Healthcare Acquired Infections (HCAIs)



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Rationale - Alert

The improvement infrastructure is robust and multi-layered, and there are clear examples of month-on-month improvement (e.g. August). However, no de-escalation threshold relating to said organisms is achieving sustained performance below TI thresholds, and October data show deterioration in both C. diff and E. coli. The mixed infection profile and the absence of sustained impact from interventions justify an Alert rating

TI-2025/547/MD11/1 – Prompt responses to inspections, incidents and regulatory notices



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Lead executive - Mrs Sharon Daniel, Executive Director of Nursing Quality and Patient Experience

Issue

The Health Board is required to demonstrate that it responds promptly, consistently and effectively to HIW inspections and wider regulatory notices. The reliability of these processes is an important component of assurance under Targeted Intervention, particularly given the breadth of inspections across acute, community and mental health services over the past 18 months.

Current status

The latest inspection dashboards provide a detailed and, in some areas, challenging picture. Fourteen HIW inspections are currently active, generating a combined 277 actions. While over half of these have now been completed, the remainder show a mixed pattern of timely progress, partial completion and overdue work.

A review of the inspection summary indicates that:

- 153 actions (55%) have been fully completed.
- 88 actions are still in progress, with a relatively small proportion recorded as partially complete.
- However, 72 actions are now overdue, and a further nine have been marked as unable to complete.

This means that although the Health Board is closing the majority of inspection actions, there is a persistent number of delayed actions.

Across the portfolio of inspections, a number of themes recur. Services such as St Non, IRMER X-ray, and Bryngolau Ward have demonstrated strong responsiveness, with the majority of their recommendations closed and limited overdue actions. These areas show that when local oversight is robust and resourcing is stable, the Health Board can respond promptly and effectively to regulatory findings.



In contrast, several other inspections present a more complex picture. The recent Bronglais Hospital (BGH) Emergency Department inspection (October 2025) has generated 75 actions, of which a sizeable proportion are still outstanding, including 35 in progress, four partially complete, and 28 overdue. This reflects both the scale of the recommendations and the operational pressures within UEC services. However, given the inspection was only undertaken in October, these outstanding actions have to be viewed in the context of reasonableness and time for the respective teams to properly digest and complete the actions in a meaningful and thorough manner.

Similarly, the Derwen Ward inspection and the Joint Inspection of Child Protection Arrangements have clusters of overdue activity, with multiple actions requiring renewed attention to meet the standards expected by HIW and partner agencies. The Mynydd Mawr Ward inspection also reflects delays, including actions recorded as “unable to complete” or awaiting further evidence before approval.

It is important to recognise that the sharp increase in overdue HIW actions is largely attributable to the recent Emergency Department inspection at BGH, which alone generated 75 actions, including 28 that default into the ‘overdue’ category when aligned to HIW’s standard action framework. Prior to this inspection, the Health Board was carrying approximately 19 overdue actions. Once the 28 ED-related actions are accounted for, the underlying overdue position stands at 44 actions (72 total overdue minus 28 arising from ED). This means that while there has been some movement from the previous position of 19, the majority of the overall increase is directly linked to the scale and timing of the ED inspection rather than a broad failure of responsiveness across the wider system.



Rationale - Advise

Justification

An Assure rating cannot be supported, as the Health Board must still address a material number of overdue actions (now 44 once the Emergency Department (ED) effect is removed), alongside a high volume of new work arising from Bronglais ED that will take several months to fully evidence and close. However, an Alert rating would overstate the position and misrepresent the underlying context.

The data shows:

- The bulk of the deterioration is driven by a single inspection landing less than a month ago, not by systemic slippage.
- Other service areas continue to demonstrate strong engagement, timely submission of evidence and high completion rates, with over 300 completed actions across the portfolio.
- Dialogue with HIW remains active, transparent and constructive.
- Local governance structures (including the Executive Improving Together Sessions and inspection oversight routes) are in place and functioning.

The current position therefore reflects a system that is responding, mobilising and maintaining open regulatory engagement, but which now carries more high-volume actions that will require sustained attention.



Lead executive - Mrs Sharon Daniel, Executive Director of Nursing Quality and Patient Experience

Issue

The Health Board aims to increase the proportion of complaints resolved within 30 days and to use patient-experience feedback to inform service improvement.

Current status

Only 38.15 % of complaints have been resolved within 30 days in 2025/26. The People's Experience Framework and the Fragile Services Framework incorporate patient-feedback data, but the impact of these initiatives is not yet evident. Open-complaint dashboards show cases waiting over 350 days for closure. Work is underway to improve the timeliness of responses and to reduce the number of open complaints.

Rationale - Alert

Initiatives to improve patient and family feedback are progressing, yet current performance against the 30-day standard and the persistence of long-standing complaints highlight the need for further focus or additional actions/considerations. The Health Board should prioritise increasing early resolution of complaints, responding to and closing aged complaints, communicating outcomes to families promptly and embedding learning into service improvements.



Across the Targeted Intervention domains reviewed, the Health Board continues to make progress, but the position remains mixed. The fragile services framework has matured further, and early pilots indicate that it is supporting more consistent identification of risk and clearer leadership expectations; however, full embedding and Board-level reporting still require development. In urgent and emergency care and planned care, there is evidence of operational recovery and strengthened reporting, yet both areas continue to carry significant backlogs of incidents and long-standing complaints, which constrain the level of assurance that can be offered at this point in time.

The Health Board's response to HIW inspections demonstrates an open and constructive approach; and whilst the recent BGH Emergency Department inspection has resulted in a sharp increase in overdue actions, the underlying position, once this effect is adjusted for, remains more stable than the headline figures suggest. Even so, the volume of work now required to close high-priority actions will demand sustained attention and clear trajectories.

Taken together, the updates illustrate a system that is developing the right structures and beginning to show tangible improvement in some areas, whilst still requiring focused oversight and targeted support in others. Continued consolidation of governance arrangements, strengthened learning processes and timely action closure will be essential for moving towards higher levels of assurance in future reporting cycles.

Recommendations for the Committee:



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To note:

- The fragile services approach is continuing to embed, with clearer structures and early evidence of improved identification and oversight, but full Board-level reporting remains under development.
- Incident management backlogs in both UEC and Planned Care remain significant, with long-standing cases demonstrating where investigation timeliness and learning processes still require strengthening.
- Performance against the TI hospital-acquired infection criteria has shown isolated improvement but not the sustained reductions needed for de-escalation.
- The recent BGH ED inspection accounts for a large proportion of the increase in HIW overdue actions and has materially altered the inspection profile within a short timeframe.

To recognise:

- Operational recovery work in planned care is generating positive impact—diagnostic waits have reduced, cancer pathway performance has stabilised, and targeted investments are progressing.
- Engagement with HIW and regulatory bodies remains constructive, with over 300 completed actions demonstrating continued focus on quality and safety.
- The Executive Improving Together Sessions are providing a more coherent platform for system-wide visibility of fragility, escalation and improvement trajectories.
- In several areas, including IRMER and ward-based inspections, services have demonstrated the ability to respond promptly and effectively to regulatory recommendations.



To acknowledge:

- The Health Board now carries a larger volume of high-priority actions following the BGH ED inspection, and these will require sustained oversight and resourcing to close meaningfully.
- Several key functions continue to experience pressure on workforce capacity, which is directly impacting the pace at which improvement plans can be delivered.
- Sustained improvements across infection prevention and control domains remain a critical requirement, given the fluctuating performance and October deterioration.
- The continued presence of aged incidents and complaints limits assurance and necessitates further work to ensure learning is timely, embedded and consistently evidenced.



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SAFE | SUSTAINABLE | ACCESSIBLE | KIND



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3.2

3.2 - Listening and Learning Sub Committee
Update Report and Terms of Reference for
Approval- To Follow. Meeting Scheduled 2
December 2025

***Louise O'Connor
(Hywel Dda Health
Board - Assistant
Director)***

3.3

3.3 - Listening and Learning From Events Framework

***Cathie Steele (Hywel
Dda UHB - Interim
Assistant Director of
Nursing Assurance
and Safeguarding)***

Attachments

[QSEC Learning Framework update Dec2025.pdf](#)



Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	04 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Listening and Learning from Events Framework
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide the Quality Safety and Experience Committee (QSEC) with an update on the publication and implementation of the Health Board's Listening and Learning from Events Framework.

Cefndir / Background

Becoming a learning health system

A learning health system is one "in which science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience" (Institute of Medicine, 2007).

The framework will be our commitment as an organisation to ensuring we listen to our patients, learn from events, and create a positive safety culture where:

"the environment is collaboratively crafted, created, and nurtured so that everybody (individual staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care by:

1. Continuous learning and improvement of safety risks
2. Supportive, psychologically safe teamwork
3. Enabling and empowering speaking up by all"

For over 20 years, healthcare has talked about learning from events and whilst there has been some achievements in this area, there is still so much more work to do.

"[To Err is Human](#)" was published in 2000. The report was a spur for a rising interest in improving patient safety. The intention of the Institute of Medicine was to move away from finger pointing when things went wrong to focus on "how can we learn from our mistakes".

[The National Health Service \(Concerns, Complaints and Redress Arrangements\) \(Wales\) Regulations](#)

(Putting Things Right) was enacted in April 2011 to review the existing processes for the raising, investigation of and learning from concerns and to ensure that learning from concerns lead to better quality and standard of care.

In 2015, "[From Safety-I to Safety-II: A White Paper](#)" was published. This white paper encourages health care providers to move from the approach of a focus on reducing error through ensuring as "few things as possible go wrong" to a focus on why things go right and **learning** from what goes well as well as when things do happen as planned.

[The Health and Social Care \(Quality & Engagement\) \(Wales\) Act 2020](#) places a legal duty of candour on NHS providers in Wales. The duty seeks to promote a culture of openness and improves the quality of care within the health service by encouraging organisational learning.

The US Institute of Medicine first proposed the concept as systems in which "science, informatics, incentives, and culture are aligned for continuous improvement and innovation" in response to increasing complexity in healthcare and a need to improve the quality of care while reducing inefficiencies and costs.¹ Yet, a lack of practical guidance on how to enact such systems and a dearth of evidence indicating return on investment has led to justifiable scepticism about their achievability and prospective value.² In many improvement efforts, however, the mechanisms for organisational learning are an afterthought.³

- We have traditionally used safety notices, patient stories and improvement and learning actions plans as methods for sharing learning. However, anecdotal evidence would suggest that the learning has in many cases stopped on the ward, in the department or in the service where the event occurred. In some cases, there may have been learning across the directorate, but rarely has been organisational wide learning.
- There is increasing recognition that individuals do not all have the same learning style. Staff also have different access to information. If we are to ensure there is learning after an event, we need to listen to the needs of our workforce and ensure that we different methods of learning are used.
- Learning from events is an area where we will probably always have to stop, check what's happening, consider if the method right for the learning that comes from the event and right for our staff, and is there anything else we can do to share the learning.

The importance of listening

Listening is a crucial element. In order to identify the events where we bring can gain the greatest learning, we need to listen.

We need to listen to our staff. What are they raising through incident reporting, through speak up processes, through clinical audit and many other routes? What are our colleagues from outside of the organisation telling us, what is within our, and other organisations, Healthcare Inspectorate Wales reports, what is being highlighted through peer review, through Patient Safety Solutions, and through HSSIB report? And what are our patients and residents telling us through feedback mechanisms such as compliments and complaints? What are they telling us what has been there experience?

We need to understand our data and what it's telling us, Our data and the information we hold can bring learning. Data can help us improve the care we provide. It can help us improve the

¹ Smith M, Saunders R, Stuckhardt L, McGinnis JM. Best care at lower cost: the path to continuously learning health care in America. National Academies Press, 2013.

² Hardie T, Horton T, Thornton-Lee N, Home J, Pereira P. Developing learning health systems in the UK: priorities for action. The Health Foundation, 2022. doi:10.37829/HF-2022-I06

³ McDonald PL et al. Data to knowledge to improvement: creating the learning health system. BMJ 2024; 384 doi: <https://doi.org/10.1136/bmj-2023-076175> (Published 25 January 2024)

quality of care will help us make our care safe, timely, effective efficient equitable and most important person centred.

What events are included in the framework? Learning from events or situations that went well is important as well as learning from when things didn't go as planned. The list below are examples and not the full list. We can learn from these and so much more.

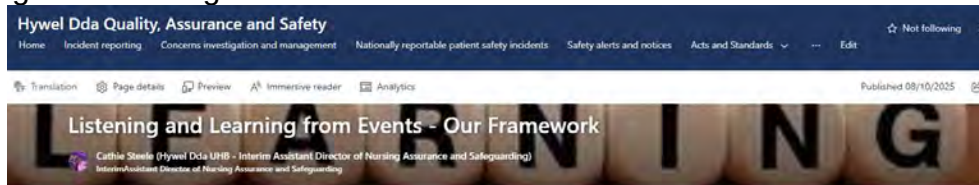
- Incidents
- Complaints
- Claims
- Redress
- Medical Examiner
- Inquests
- Safeguarding learning
- Public Services Ombudsman for Wales (PSOW) learning
- Patient / Staff experience
- Quality improvement projects
- Audit
- Spot checks
- Thematic reviews
- Peer reviews
- External inspections
- And more

The [proposed Listening and Learning from Events Framework](#) was presented to QSEC on 5th December 2024. QSEC members suggested inclusions for the framework e.g. responsibilities for Board Members. The Committee received assurance from the update on the development of the Health Board's Listening and Learning (from events) Framework.

In February and March 2025, Internal Audit undertook a review Learning Lessons. The review sought to provide the Health Board with assurance that following incidents and complaints, lessons are identified and learned to avoid similar instances, where possible, in the future. The [final Internal Audit report](#) was presented to the Audit and Risk Assurance Committee on 15th April 2025. Internal Audit concluded reasonable assurance. All actions in response to the Internal Audit recommendations have been completed.

Asesiad / Assessment

The Listening and Learning Framework is available to all staff via SharePoint.



Becoming a learning health system

A learning health system is one "in which science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience" (Institute of Medicine, 2007).

The framework will be our commitment as an organisation to ensuring we listen to our patients, learn from events, and create a positive safety culture where:

- "the environment is collaboratively crafted, created, and nurtured so that everybody (individual staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care by:
 - 1)Continuous learning and improvement of safety risks
 - 2)Supportive, psychologically safe teamwork
 - 3)Enabling and empowering speaking up by all"

Responsibilities are outlined in the framework. It is important to recognise that everyone has a responsibility to seek opportunities for learning. This is as important as information being shared by others.

Responsibilities for individual staff

Responsibility	What can you do to help ensure that we learn from events
Recognise areas where there is learning e.g. incidents / "near misses" / good practice	- All staff should promptly recognise when an adverse event (or near miss, or a safety concern) has occurred or could have occurred and report it via the appropriate channels (e.g. local incident reporting system). - There may also be other events which can be used for learning. It maybe something that went well and where there is good practice that can be shared. These can be shared with the Quality, Assurance and Safety Team via a feedback form.
Be open and honest ("Being Open" / Duty of Candour)	If the incident has or may have caused harm (or could, in certain thresholds), staff have a duty to be open with patients, their families, and colleagues, apologising where appropriate, acknowledging what is known, and committing to learn what else can be done.
Participate in investigation / fact-finding	- Staff may be asked to contribute to an investigation including after action review, serious incident review, mortality review). This may involve giving accounts, providing documentation, or engaging in a learning conversation. - Contribution should be honest, open, and fact-based. Staff should feel safe to speak without fear of unfair blame, in a "just culture."
Reflect on one's own practice	After an incident, an adverse event or something that went well, staff should reflect on what occurred, how their own actions or decisions might have contributed, and what changes they (or the team) might make to prevent recurrence or to ensure that a similar positive event happens for others.
Implement changes / safety actions	- Where the investigation or learning process leads to recommendations or actions (e.g. change in procedure, checklists, training, new safeguards) individuals are responsible for changing how they work in line with those actions. - Change might be at team or system level, but each staff member must adapt their own behaviour.
Support dissemination of learning	Staff can assist in sharing lessons learned with colleagues (e.g. through team briefings, educational sessions, safety huddles, newsletters) so the wider organisation benefits.
Raise concerns and escalate where needed	If during or after an incident, staff feel that safety issues are not being adequately addressed, or further risk is present, they should raise that concern through escalation routes (line management, governance, risk, or external escalation).
Maintain records and documentation	Staff must ensure accurate, timely, and complete documentation of the event, their involvement, reporting, and any actions taken (or recommended).
Engage in training and education	Staff must keep up to date with training in patient safety, incident reporting, human factors, investigation methodology, etc., so that when adverse events occur, they can more effectively contribute to learning.
Contribute to safety culture	By being open, non-punitive, reflective, and supportive of colleagues, each staff member helps create a culture where people feel safe to report, discuss, and learn from error.

Responsibilities for managers

Area / Focus	What can you do to help ensure that we learn from events and why it matters
Adverse event / incident detection, reporting & escalation	• Ensure that adverse events (incidents, near misses, hazards, complaints) within their area are identified, reported promptly, and escalated appropriately (e.g. to senior management, patient safety teams, patient experience team) • Undertake a timely initial assessment of the event reported; determining whether further investigation is required or whether the event can be managed locally • Review incident reports in their area for completeness and quality (i.e. ensure sufficient detail). • As managers do not simply leave reporting wholly to staff— oversight is needed to ensure that reporting is timely, accurate, and actionable. • Managers act as gatekeepers and quality-checkers of incident reporting workflows.
Immediate safety & containment	• On occurrence of an adverse event, ensure immediate protective / remedial steps are taken (e.g. making environment safe, preventing further harm, isolating equipment) • Support staff to manage the immediate consequences (clinical, emotional, administrative) • Managers often has the authority and responsibility to mobilise resources, stop processes, or ensure safety while investigations happen.
Participation in investigation & review	• Be part of investigations, after action reviews and learning events. • Provide local context, systems understanding, process maps, staff input - Ensure staff in their unit who were involved are supported to take part • Managers are critical for bridging the "on-the-ground" knowledge with systemic analysis; their insight into workflows, interdependencies, staffing, constraints is key to meaningful learning.
Local learning and implementation of actions	• Translate investigation findings and recommendations into actionable plans at ward / departmental level • Explore what is going well at ward / departmental level and within other areas in the health Board. Consider what changes can be made to improve patient experience • Lead or co-lead the implementation of changes in practice, protocols, checklists, educational sessions, process redesign • Monitor that the recommended changes are embedded, sustained, and effective. Assigning responsibilities, tracking progress, ensuring feedback loops. • Without managerial follow-through, many recommendations die at the "paper" stage. Managers must ensure lessons are operationalised locally.
Dissemination of learning	• Managers can help prevent "siloes" learning; they serve as conduits of organisational learning by: ◦ Sharing lessons, "near misses," and good practice within and across teams (ward handovers, team meetings, newsletters, briefings, safety huddles) ◦ Encouraging staff reflection and discussion ("what went well, what could we do differently") ◦ Ensuring that learning from other wards / units / hospital-wide findings is communicated to their staff
Culture and psychological safety	• If staff fear blame, or retribution, they will under-report or withhold information, hampering learning. Managers are central to creating trust and therefore must: ◦ Foster an environment in which staff feel they can speak up, report errors or concerns without blame. ◦ Lead by example (being open, acknowledging errors, modelling reflection). ◦ Encourage just culture principles and challenge punitive or overly punitive responses. ◦ Promote psychological support / debriefing for staff involved in incidents (second victim support)
Assurance, oversight & governance linkage	• Managers act as the connecting nodes between local practice and organisational oversight. They are accountable for ensuring learning is not just local but systemic: Managers should: ◦ Ensure that local safety action plans, risk registers, and incident trends feed into higher-level governance (e.g. divisional safety committees, board level) ◦ Provide reports, metrics, and assurance to senior management on incident trends, learning, and implementation of actions ◦ Ensure compliance with external reporting requirements ◦ Participate in audit, follow-up reviews, or post-implementation review of safety interventions
Education, training and capability building	• To lead learning, managers themselves need skills in investigating, facilitating reflection, change management. Managers should ◦ Facilitate or organise training for staff in incident reporting, root cause analysis, human factors, safety culture ◦ Ensure that staff have skills and awareness to take part in learning activities ◦ Maintain their own capability (managers should engage in training, leader development in patient safety)
Resource allocation and enabling environment	• Without managerial support for resources, even good intentions may not result in change. ◦ Ensure staff have time, resources, and support (protected time, administrative help) to engage in reporting, investigation, reflection, improvement work ◦ Where resource constraints threaten safety improvement, escalate those to senior leadership ◦ Adjust staffing or processes where risks are identified

Follow-up, evaluation & sustainment	- Learning is iterative — managers need to close the loop, not just initiate change but check whether change works. Managers should: - After changes are made, monitor whether they are effective, evaluate whether harm reduction or risk mitigation is achieved - Be alert to unintended consequences or new risks introduced by change - Promote continuous improvement (not just "one-off fixes")
Accountability & compliance	- Managers are often held responsible in governance terms (via committees, audits) for safety performance in their area. Therefore, they should: - Ensure that staff understand and comply with organisational incident reporting policies - Hold staff accountable where reporting or follow-up is neglected, with fairness - Ensure records are maintained appropriately - Uphold duty of candour obligations (ensure reports to patients / families are managed appropriately) under relevant legislation (e.g. Health & Social Care (Quality & Engagement) (Wales) Act 2020). Whilst Duty of Candour is about patient care, the principles are equally applicable to members of staff affected by an adverse event/

Responsibilities for Board

Boards (i.e. the executive and independent members who have overall governance accountability) have several distinct but connected responsibilities for ensuring learning from events:

Responsibility	What this means in practice
Strategic leadership / vision	Embedding safety, quality, learning in the organisation's culture; setting clear goals / priorities for learning from adverse events; ensuring safety is part of strategy.
Accountability	- Ensuring there are systems in place (policies, process, roles) to identify, report, investigate adverse events; - Ensuring that there is compliance (with duty of candour, incident reporting, etc); that responsibilities are assigned and people held to account.
Oversight / assurance	- Receiving reports (aggregated, trends, serious incidents, patient experience), - Ensuring that actions arising from reviews are implemented and their effectiveness monitored; - Making sure improvement plans actually produce change.
Shaping culture	- Creating and maintaining a psychologically safe culture, a "just culture", a transparent environment where staff feel safe to report events, incidents or near misses, where blame is not the immediate response, and where learning is encouraged. - Independent members often have a particular role in challenging and assuring culture.
Ensuring resources & capability	Ensuring the organisation has enough trained staff, expertise (investigators, human factors, data analysis), tools (reporting systems, learning mechanisms), and time to do the work of investigating, learning, implementing improvements.
Transparency with patients/public	Making sure affected patients/families are informed (duty of candour), including them in reviews where appropriate; external reporting (e.g. to regulators, in quality accounts) so there is external accountability.

Committees and Groups Responsibilities

Boards typically delegate some of these oversight / assurance duties to committees. Committees and sub-groups are the bodies that help with the detailed work. Their responsibilities often include:

Committee or group	Key Duties in relation to adverse events & learning
Quality, Safety and Experience Committee and its Sub-Committees	- Monitor and ensure effectiveness of incident reporting systems (incidents, complaints, near misses) and that investigations are undertaken. - Review serious incidents and aggregated incident data; spot trends, themes. - Receive patient stories and review patient experience data, trends and themes. - Assure the Board that actions from investigations are completed and embedded. - Oversee compliance with duty of candour and other regulatory / legal requirements.
Integrated Governance Groups / Service Group Learning Panels	- Deep dive into specific adverse / safety events or examples of good practice / events where things went well; - Develop improvement plans; ensure these are SMART, assigned, with resources. - Track the implementation and effectiveness of the changes made. - Ensure learning is shared across departments/services.
Audit & Risk Committee	- Review whether risk management and internal controls are adequate; whether learner lessons from incidents are converting into risk reduction. - Look at whether assurance mechanisms are working (are incident investigations being audited; are follow-ups happening). - Check that reporting to regulators/other bodies is complete and timely.
Other specialist groups / forums (Mortality Review, Effective Clinical Practice etc)	- Bring in perspective of patients/families; ensure lessons include service user experience. - Mortality review panels: identify whether deaths were avoidable, trends, system issues. - Ensure lessons feed into clinical practice, audits, training. - Cross-organisational sharing where relevant.

Learning Library

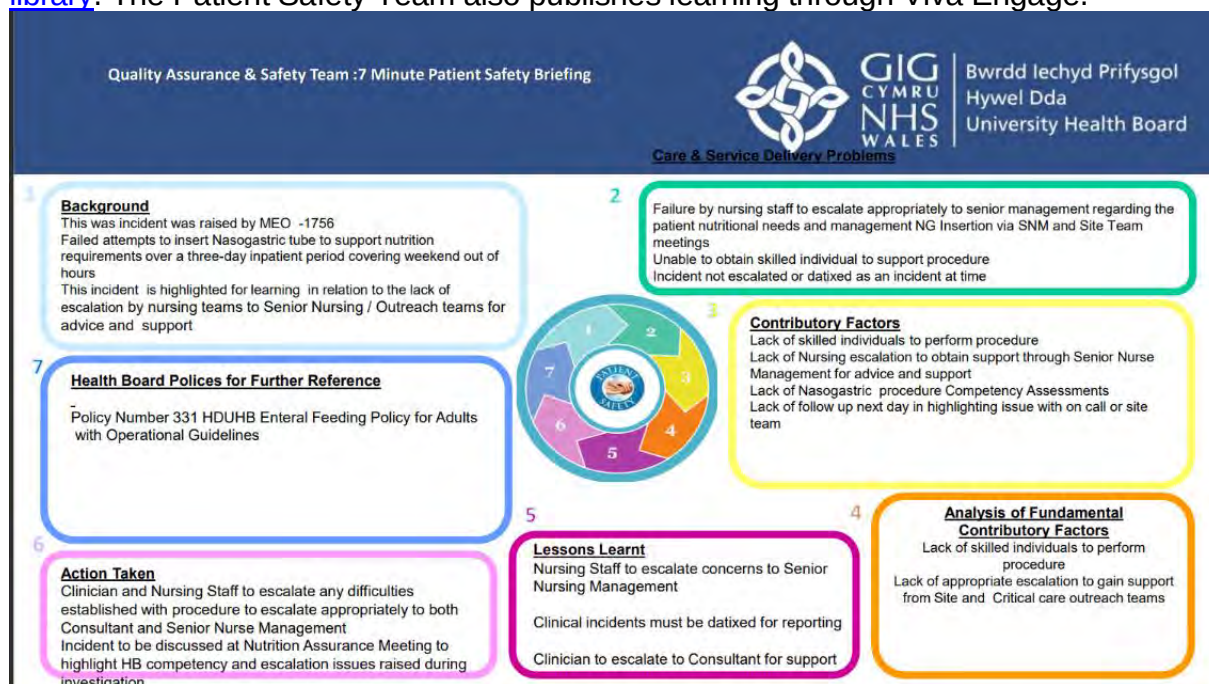
The Listening and Learning from Events Framework is supported by a digital Learning Library. The Health Board's learning library is a resource for all Health Board staff and services to submit into and share the learning from.

Learning from events that take place in the Health Board is vitally important if we are to improve our services, our clinical practice, improve the experiences for our patients and staff and develop a learning culture.

In adopting a learning culture, the Health Board aims to:

1. Encourage employee ownership of learning
2. Offer diverse learning opportunities
3. Recognise and reward learning achievements
4. Promote knowledge sharing and collaboration
5. Attract and seek out agile learners
6. Invest in employee learning technologies
7. Foster a culture of open communication
8. Gather employee feedback
9. Make learning and development a top organisational goal
10. Empower leaders and experts to document their knowledge
11. Value learning as a path to mastery

Teams/Wards/Departments are encouraged to submit items for publication on the [learning library](#). The Patient Safety Team also publishes learning through Viva Engage.



Next Steps

To maximise the impact of learning from events, the Health Board will implement a structured approach to sharing learning across all services and departments. This will include the use of the Learning Library, regular cross-departmental forums, and feedback mechanisms to ensure that learning is not only disseminated but also embedded in practice throughout the organisation. Leadership at all levels will be accountable for promoting a culture of open learning and continuous improvement.

To ensure that learning leads to meaningful improvements in practice, outcomes, and organisational culture, the Health Board will implement monitoring and evaluation processes. This will include the use of specific metrics—such as the number of learning events shared, staff engagement rates with learning resources, and the adoption rate of recommended changes in practice. Feedback mechanisms, including staff surveys, focus groups, and post-implementation reviews, will provide insights on the effectiveness and relevance of shared learning. Regular audits and outcome assessments will be conducted to evaluate whether learning has resulted in measurable improvements in patient safety, quality of care, and staff experience. Findings from these evaluations will be reported to the Quality, Safety and Experience Committee and used to inform ongoing refinement of the learning framework, ensuring a continuous cycle of improvement.

Argymhelliad / Recommendation

Quality Safety and Experience Committee (QSEC) is asked to receive this update on the publication and take assurance on the implementation of the Health Board's Listening and Learning from Events Framework.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Principal Risk 1189 Timely and sufficient learning, innovation and improvement
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply Choose an item. Choose an item. Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership 2. Culture and valuing people 3. Data to knowledge 4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Great care Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	Not Applicable Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	References provided within the narrative
Rhestr Termau: Glossary of Terms:	Terms explained in the narrative to the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofïod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Ensuring robust action and quality improvement in response to learning has the potential to reduce the financial impact of clinical negligence claims and redress payments.
Ansawdd / Gofal Claf: Quality / Patient Care:	Ensuring robust action and quality improvement in response to learning has the potential to improve quality and patient care.
Gweithlu: Workforce:	Implementation of a learning system with a Just Culture will improve the psychological safety in our workforce.
Risg: Risk:	The remaining risk with implementation of the framework lies around the receipt of learning for publication and sharing through the learning library. Undoubtedly there will be a need to remind staff of their responsibilities in the framework.
Cyfreithiol: Legal:	Ensuring robust action and quality improvement in response to learning has the potential to reduce the legal impact seen through clinical negligence claims and redress arrangements
Enw Da: Reputational:	Ensuring robust action and quality improvement in response to learning has the potential to reduce the reputational impact when learning is not demonstrable.

Gyfrinachedd: Privacy:	In publishing case studies, each case is considered from a privacy perspective to ensure that either consent to share is received or that the case is made anonymous,
Cydraddoldeb: Equality:	

3.4

3.4 - Clinical Audit Programme

Mark Henwood
(Hywel Dda UHB -
Executive Medical
Director), Ian Bebb
(Hywel Dda UHB -
Clinical Audit
Manager)

Attachments

[Clinical Audit Update QSEC December 2025.pdf](#)

[Appendix 1 National Clinical Audit and Outcome Review Programme 2025-26.pdf](#)

[Clinical Audit programme PDF.pdf](#)



Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	04 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Audit Programme
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mr Mark Henwood, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Mr Ian Bebb, Clinical Audit Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

The Clinical Audit Programme is being presented to the Committee for approval, ensuring that the internally commissioned audits are aligned with the Health Boards strategic priorities.

Cefndir / Background

The Health Board develops an annual Clinical Audit Programme which is undertaken by the operational Services. This programme consists of a list of key clinical audit projects that have been prioritised in line with Health Board (Service specific or otherwise) aims and objectives. This programme also includes all projects mandated by Welsh Government (WG), National Clinical Audit and Outcome Review Plan (NCAORP) and other national bodies. National benchmarking is possible through this mechanism.

The Health Board needs to support effective clinical audit that leads to improvements in the quality of care that we provide. Audit projects should contribute to the achievement of Health Board priorities and be clear about how patient care will be improved. There is a need to adhere to all external mandatory priorities whilst continuing to support quality local audit activity related to Health Board priorities. With finite resources for audit activity there is a limited number of projects which can be supported by the Clinical Audit Department and the wider Health Board, therefore, it is vital that we have a robust system to prioritise, approve, and monitor audits.

National Clinical Audit

NCAORP is a mandatory audit programme in Wales. The programme is set and monitored by WG and derived from the mandatory English programme.

The Health Board is responsible for participating in 45 mandatory national audits that feature in the NCAORP. In addition to this there are ad hoc Outcome Reviews (e.g. National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies) that are also mandated.

Benefits

The benefits to participating in these projects are that they;

- make benchmarking between local sites/services as well as other Health Board's possible
- are based on evidence based practice and often factor in National Institute of Care Excellence (NICE) and Royal College guidance
- provide national reports, detailed analysis, results and recommendations

Local Clinical Audit Programmes

The Clinical Audit Department (CAD) liaise with a number of services to establish a local programme each financial year. Clinical Audit Programmes are split into two 6 monthly segments to allow services to focus on more timely audit completion as well as grant more opportunities for services to contribute to the programme.

The programme audits are set by key governance and quality groups/committees representing the various service areas. The CAD and other bodies may be given indicators as to which audits should be included in audit programmes and provides suggestions when appropriate.

Priorities for inclusion in the programme:

- National Clinical Audit and Outcome Review Programme - *automatically included on the programme*
- Patient Safety Issues
- NICE guidance
- Welsh Risk Pool/ Health Inspectorate Wales (HIW)/Other required audits
- Audits associated with the risk register
- Complaints/Incidents/Litigation that require clinical audit
- Other Health Board priorities
- Important local audit priorities

Asesiad / Assessment

Clinical Audit Programme 2025/26

The Clinical Audit Programme for 2025/26 (October-March) has a total of 49 clinical audit projects with 3-5 additions expected imminently. A number of audits featured on the programme are continuous audits or re-audits and will continue to future programmes. The importance of re-audit is critical to demonstrate that we are continuing to make improvements where standards of practice are not being met. These types of projects generally have more impact than isolated audits and are encouraged whenever possible.

The 45 NCAORP projects are automatically included in addition, bringing the total to 94. The CAD are continuing to work with services to expand this programme as well as to ensure projects are completed and focused on quality improvement. Projects are not typically called out as aligning with Safe, Timely, Equitable, Efficient, Effective (STEEEP) domains of quality; however all audit projects are intended to creating safer, timely, effective and more equitable care. All clinical audits should be centred around evidence based practice. Clinical audit is therefore a key component in demonstrating and evidencing STEEEP. A number of Nursing audits are directly related to the STEEEP principles.

A copy of the programme is attached Appendix 1) for this Committee to discuss and review.

A separate list of the NCAORP audits has also been included. Reporting, data collection, and other parameters vary significantly between national audits. A distinction is made to avoid confusion when reporting as well as to highlight the priority of these key projects.

Shared Learning

The CAD is continuing to run the Whole Hospital Audit Meetings (WHAM). WHAM events are held each quarter and alternate between site specific and Health Board wide events. The most recent event was held on 24 September 2025, the next is scheduled for 4 December 2025. The following projects have been presented in 2025:

- Re-Audit of A&E Referrals to TIA (Transient Ischaemic Attack) Clinic Compared to the NICE Guidelines for Diagnosis and Referral of Transient Ischemic Attack (TIA) and Stroke
- Appropriate Cardiac Monitoring
- Chaperone Procedure Documentation in Digital Rectal Examination for rectal bleeding Patients in A&E, Bronglais Hospital (BGH), Second Cycle
- Rate of Sentinel Node Positivity in Breast Cancer Patients Diagnosed in Withybush Hospital (WGH)
- Reduce Fetal Movement Management Audit in BGH
- Delays in Administering PCC to Patients with Intracranial Haemorrhages
- Maternity Record Keeping Audit
- School Nurse Led Nocturnal Enuresis
- Board-Wide Peer Review Consent Audit
- All Wales HCQ Retinal Toxicity Screening Audit 2023
- Venous Thromboembolism Inpatients Audit NICE QS 201 S1 - Cycle 3
- The Role of Local Anaesthetic Biopsy in Meeting Guidelines for Timeline of Head and Neck Cancer Referral to MDT Per NHS Guidelines
- Orthogeriatric Discharge Advice Letter (DAL) Information Quality Audit
- Perioperative Management of Patients with Diabetes
- Re- Audit Compliance with NICE Guidelines in Suspected Cases of Community Acquired Pneumonia
- Benchmarking Patellar Dislocation Management: An Audit of British Orthopaedic Association (BOA) Compliance
- Re-Audit of follow-up Within 3 Days on Discharge from the Mental Health Unit, Bryngofal Ward in Prince Phillip Hospital (PPH)
- Outcome of Vacuum Assisted Biopsy in Patients with Suspicious Micro calcifications on Mammography
- National Chronic Obstructive Pulmonary Disease (COPD) Secondary Care 2022/2023 - 2023/2024
- Chronic Hepatitis B Assessment
- Audit of Nasogastric Tube in Hywel Dda University Health Board.
- National Pulmonary Rehabilitation 2022 - 2023

This demonstrates the varied uses of clinical audit as well as demonstrating that clinical audit is used by different specialties and has varied drivers.

The CAD continues to support the Enabling Quality Improvement in Practice (EQliP) programme by attending event days and giving presentations on the links between quality improvement (QI) and Clinical Audit, how they can complement each other and in particular how clinical audit activity can inform improvement activities. The majority of EQliP projects from the most recent cohort in 2025 included or were linked to clinical audits.

Clinical Audit Activity

A total of 259 audits have been completed on the Audit Management and Tracking System (AMAT) system since it was implemented. All of this information is available for all users to view and learn from as the system offers high levels of transparency. More requests are being made regarding previous audits and outcomes.

The below figures represent an overall snapshot of audit activity at time of writing this report. Clinical audits have a number of distinct stages of completion and are not considered complete until the action plan/improvement work has been completed. There is naturally an extended time frame for these projects to be *fully* completed (as opposed to data collection or the submission of an action plan) which is reflected in the results. This is however a more meaningful and complete measure of the impact of clinical audit. The below table illustrates the completion rates from current and previous years which continues to increase over time.

	2023-2024	2024-2025	2025-2026
Total No. of Projects	96	106	98
- Currently In progress	13 (14%)	29 (27%)	76 (78%)
- Improvement stage	10 (77%)	10 (34%)	10 (10%)
Fully completed	83 (86%)	77 (73%)	22 (22%)

**NCAORP projects are not included in the above figures due to the extended time frames for these types of projects*

Nurse Led Audit Programmes

Whilst many Nurse led audits have been undertaken, historically, the AMAT system has provided the technology to fully support and embed these audits as well as expand on their scope and remit. The CAD has supported 13 of these audits since April 2025 with many more planned. The system allows the audits to be undertaken Health Board wide (including community settings) with instantaneous results and dashboard functionality. This allows the results to be monitored at all organisational levels as needed. Benchmarking is not easily accessible both against the standards themselves and across all other areas (e.g. wards) with the aim of improving equitably of care.

The nature and technical elements of these AMAT based audits requires strong interactions between the CAD and the various services. It has allowed services to voice their views on how and which data should be captured, and with support from the CAD is ensuring that these audits are grounded in evidence based practice and Health Board policy. In time, all audits will be monitored by appropriate governance groups, with outcomes reviewed and discussed on a regular basis. At present, the majority of are managed by the Senior Nursing and Midwifery Team (SNMT).

Across the audits there have been approximately 1000 improvement actions completed since roll out began in May 2025. A further 600+ improvements are being progressed. Whilst each action may only have a small (or varying) impact, this does represent 1000 instances of safer, timely or effective care for patients. Evidence for these actions has also been uploaded to the AMAT system. Once the programme has been fully rolled out this number will increase significantly. The list of these audits is included within the Clinical Audit Programme attachment.

National Clinical Audits (NCAORP)

All national audits have national and (often) Health Board specific reports and results available. The reports hold detailed information regarding benchmarking, compliance with standards as well as national recommendations. Some of these recommendations will apply to the Health Board and the Health Board is expected to generate local recommendations and an action plan to meet these.

Mandatory national audits are subject to the same internal requirements as all other audits, each one requiring an improvement plan. All mandatory audits are now being reported through the Clinical Care Group Governance structures and clinical audit features on all of these agendas.

The CAD is liaising with the audit leads and governance groups to ensure that all national audits have an appropriately implemented action plan.

Audit information can be provided upon request; however due to its high volume, complexity and variability, it is not practical to summarise within the body of this report.

Record Keeping Audit Programme

Services undertake record keeping audits regularly throughout the year. Establishing a standardised and consistent approach has remained challenging, a difficulty also experienced by other Health Boards.

In November 2024 the CAD and Medical Directorate developed an audit based on the Health Board Record Keeping policy. The Clinical Coding Department agreed to undertake a pilot audit. The new audit would allow a standardised approach to record keeping audits as well as provide scale and scope to the project. The audit was completed successfully. The main objective was to test the audit tool, methodology etc. and develop future audits.

Following the success of the pilot a Record Keeping Audit Programme has been agreed. The Clinical Coding Department will undertake an annual audit to “screen” record keeping quality across multiple specialties. The Medical Directorate will then contact Clinical Leads outlining where good and poor practice has been identified, prompting quality improvement activity, re-audits and if required, work with other teams (e.g. The Quality Improvement Service Team) to improve culture and practice.

The first round of this audit has commenced in November 2025.

Summary

There are a number of audits, both national and local that are highlighting the need for improvement. Some of these projects highlight the need for previously unanticipated improvements, governance concerns, risks etc. that would not have been known had the audits not been undertaken. There are also projects that deliver assurance because all standards are being maintained at a satisfactory level. The potential for audit is therefore one for quality improvement, identifying concerns as well as providing assurance. It remains the goal of the CAD and the Health Board to maximise this functionality as much as possible.

The CAD could propose specific projects for consideration, while this Committee may also identify projects it wishes to review. Updates on these projects would be provided by the Audit

and Service Leads with support from the CAD. With this approach the Committee can align Committee and Organisational priorities with the Clinical Audit programmes as appropriate.

There is an opportunity for this and other Committees to directly influence clinical audit activity by raising the profile of key projects, “commissioning” audits where the need arises and ultimately to create a stronger clinical audit programme.

Argymhelliad / Recommendation

The Committee is asked to:

- **Approve** the Annual Clinical Audit Plan, and receive assurance that internally commissioned audits are aligned with strategic priorities
- **Consider** the approach outlined above regarding the Committee’s involvement in determining the Clinical Audit Programme and presentation to QSEC.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.17 Approve the annual clinical audit plan, ensuring that internally commissioned audits are aligned with strategic priorities.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 3. Effective
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	3. Data to knowledge 4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Striving to deliver and develop excellent services
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Gwybodaeth Ychwanegol:

Further Information:

Ar sail tystiolaeth: Evidence Base:	National Clinical Audit and Outcome Review Programme 2023/24 Hywel Dda UHB Forward Clinical Audit Programme 2022/23, 2023/24

Rhestr Termiau: Glossary of Terms:	NCAORP – National Clinical Audit and Outcome Review Programme CAD – Clinical Audit Department
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Mandy Davies, Assistant Director of Nursing and Quality Improvement Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	The principals of audit imply that quality/patient care will be impacted. However, the impact of the audits held within this report are positive examples of improvement activities and are individually called out.
Gweithlu: Workforce:	Workforce engagement in Clinical Audit provides an understanding of the impact of quality of service and clinical care delivery and is a key driver for appraisal for medical staff and professional practice development in all clinical disciplines.
Risg: Risk:	Audit specific risks are contained within service/specialty specific risk registers. This includes non-participation with mandatory national audits.
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	There is the potential for reputational impact when the Health Board does not participate in mandatory audit projects. None of the criteria in the impact assessment apply.
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Not applicable

Mandatory National Clinical Audits 2025-26
National Clinical Audit and Outcome Review Plan (NCAORP)

National Audit Title	Expected/Actual Participation 2025-26
National Joint Registry	Yes
National Laparotomy Audit (NELA)	Yes
Case Mix Programme (ICNARC)	Yes
Major Trauma Audit (TARN)	Yes
National Early Inflammatory Arthritis Audit (NEIAA)	Yes
National Diabetes Paediatric Audit	Yes
National Adult Diabetes Audit (NDA)	Yes
National Diabetes Core Audit (PC)	
NDA: National Diabetes Footcare	Yes
NDA: National Diabetes Inpatient Safety Audit (NDISA)	Yes
NDA: National Pregnancy in Diabetes Audit (NPID)	Yes
NDA: National Integrated Specialist Survey	Yes
NDA: Transition and Young Type 2 Audit	Yes
National Respiratory Audit Programme (NRAP)	Yes
COPD Secondary Care	
NRAP: Adult Asthma Secondary Care	Yes
NRAP: Paediatric Asthma Secondary Care	Yes
NRAP: Pulmonary Rehabilitation	Yes
NRAP: Wales Primary Care Audit	Yes
National Audit of Chronic Obstructive Pulmonary Disease (PC)	Yes
All Wales Audiology Audit	Yes
Stroke Audit (SSNAP)	Yes
National Audit of Inpatient Falls	Yes
National Hip Fracture Database	Yes
Fracture Liaison Service Database	Yes
National Audit of Dementia	Yes
National Audit of Cardiac Rehabilitation	Yes
National Cardiac Audit Programme (NCAP)	Yes
Myocardial Ischaemia National Audit Project (MINAP)	
NCAP: National Audit of Cardiac Rhythm Management (CRM)	Yes
National Heart Failure Audit	Yes
National Clinical Audit of Psychosis	Yes
National Audit of Metastatic Breast Cancer	Yes
National Audit of Primary Breast Cancer	Yes

National Bowel Cancer Audit (NBOCA)	Yes
National Oesophago-Gastric Cancer Audit (NOGCA)	Yes
National Lung Cancer Audit	Yes
National Prostate Cancer Audit	Yes
National Ovarian Cancer Audit	Yes
National Pancreatic Cancer Audit	Yes
National Non-Hodgkin Lymphoma Audit	Yes
National Kidney Cancer Audit	Yes
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy 12)	Yes
National Maternity and Perinatal Audit	Yes
National Neonatal Audit Programme	Yes
National Perinatal Mortality Review Tool (PMRT)	Yes
National Audit for the Care at the End of Life (NACEL)	Yes
Epilepsy 12 Children and Young People National Clinical Audit	Yes

Clinical Audit Programme (CAP) 2025-2026 (Oct-Mar)							
AMAT REFERENCE	AUDIT STATUS	ORIGINATING COMMITTEE	SPECIALITY	AUDIT TITLE	SOURCE OF STANDARDS	REGISTRATION DATE	COMPLETION DATE
Nutrition & Dietetics/CA/2025-26/02:	In Progress	Nutrition & Hydration	Nutrition & Dietetics	An Audit of the Process of Care of Patients who Receive Parenteral Nutrition	NCEPOD	TBC	TBC
Respiratory/CA/2024-25/01	In Progress	Respiratory Annual Forum	Respiratory	Acute NIV Health Board Wide	British Thoracic Society Quality Standards for acute non-invasive ventilation in adults	22nd January 2025	Jan-26
Multiple/CA/2023-24/01	In Progress	Mental Capacity and Consent Group	Mental Capacity and Consent	Welsh Risk Pool All Wales Peer Review Consent Audit	Consent Case Law Welsh Risk Pool Consent Standard		Continuing to audit Ortho data as at 15.10.25
RADAR/WA/2025-26/06	In Progress	HDUHB RADAR	Cross Speciality Improvement	PEWS Audit	924 - Paediatric Monitoring and Observation Guideline (HB)	10/01/2025	Continuous
RADAR/WA/2025-26/02	In Progress	HDUHB RADAR	Cross Speciality Improvement	NEWS2	351 - Monitoring And Recording Of Adult Phys	10/01/2025	Continuous
Rost/WA/2025-26/01	In Progress	SNMT	Professional Standards Team	Rostering Audit	436 - Rostering Policy (HB)	01/05/2025	Continuous
AWC/WA/2025-26/04	In Progress	SNMT	Professional Standards Team	Medicines Management Patient Audit - All Wales Core	268 - Medicines Policy (HB)	01/04/2025	Continuous
AWC/WA/2025-26/05	In Progress	SNMT	Professional Standards Team	Medicines Management Ward Audit - All Wales Core	268 - Medicines Policy (HB)	01/04/2025	Continuous
AWC/WA/2025-26/01	In Progress	SNMT	Professional Standards Team	Bare Below the Elbows - All Wales Core	149 - Hand Hygiene Policy (HB)	01/04/2025	Continuous
AWC/WA/2025-26/02	In Progress	SNMT	Professional Standards Team	Hand Hygiene - All Wales Core Audit	149 - Hand Hygiene Policy (HB)	01/04/2025	Continuous
AWC/WA/2025-26/03	In Progress	SNMT	Professional Standards Team	Personal Protective Equipment (PPE) - All Wales Core	151 - Personal Protective Equipment (PPE) Policy and Procedure (HB)	01/04/2025	Continuous
Falls/WA/2025-26/01	In Progress	SNMT	Professional Standards Team	Falls Extensive Check Audit	401 - Preventing Falls and Post Fall Care in Inpatient Areas Policy (HB) & 273 - Manual Handling Policy (HB)	01/06/2025	Continuous
Cont/WA/2025-26/01	In Progress	SNMT	Professional Standards Team	Continence Care Audit	222 - Continence Care Policy (HB)	01/04/2025	Continuous
CD/WA/2025-26/01	In Progress	SNMT	Professional Standards Team	Controlled Drugs Audit	268 - Part 7 - Controlled Drugs (HB)	11/01/2025	Continuous
ID/WA/2025-26/01	In Progress	SNMT	Professional Standards Team	Positive Patient Identification Audit	136 - Positive Patient Identification (HB) Policy	09/01/2025	Continuous
Quality Improvement/CA/2025-26/01	In Progress	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Inpatients Audit NICE QS 201 S1 - Cycle 4		21/05/2025	Continuous
Quality Improvement/CA/2025-26/02	In Progress	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Lower Limb Immobilisation Audit NICE QS 201 S2 - Cycle 4		21/05/2025	Continuous
Quality Improvement/CA/2025-26/03	In Progress	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Outpatient Follow Up Audit NICE QS 201 S4 & S5 - Cycle 4		21/05/2025	Continuous
Radiology./CA/2025-26/02	In Progress	Thrombosis	Thrombosis	RE-AUDIT '25 Venous Thromboembolism Radiology Referral USS Audit NICE QS 201 S3 (H61) - Cycle 2		21/05/2025	Continuous
TBC	In Progress	SNMT	Professional Standards Team	Maternity Record Keeping Audit: January 2025 - January 2026	22 guidelines (see AMaT)	09/01/2025	TBC
Nutrition & Dietetics/CA/2025-26/01	Complete Implemented	Nutrition and Hydration Group	Nutrition & Dietetics	Audit of Nasogastric Tube in HDUHB	NPSA NG alert (2011) PSA 008/May 2017	24th April 2025	30/09/2025
Multiple/CA/2024-25/02 (Form 4)	Complete 3 months Follow up	Mental Capacity and Consent Group	Mental Capacity and Consent	Audit of Form 4: Treatment in Best Interests,	All Wales Consent to Examination or Treatment Policy	Mental Capacity Act Legislation	17/03/2025
Smoke/CA/2024-25/02	Complete Implemented	Public Health & Wellbeing QSE	Smoking Cessation & Wellbeing	Hywel Dda Inpatient Smoking Re-Audit	1. The Welsh Government's Tobacco Control Strategy for Wales 'A smoke-free Wales' and Delivery Plan 'Towards a smoke-free Wales delivery plan 2022 to 2024'. 2. All Wales Medicines Strategy Group – Initial clinical management of adult smokers in secondary care document	23/07/2024	20/10/2025
Crit/CA/2024-25/01	Awaiting Action Plan	QSE	Critical Care	Rehabilitation after critical illness in adults	NICE CG 83 & GUIDELINES FOR THE PROVISION OF INTENSIVE CARE SERVICES	8th July 2024	TBC
Crit/CA/2023-24/01	Outstanding	QSE	Critical Care	Central Line Care Bundle - A Clinical audit to Assess Compliance with the Completion of Care Bundles within Critical Care, HDUHB.	Ventilator bundle: 1,000 lives campaign (Institute for healthcare Improvement). Central line Bundle: 1,000lives campaign (Institute for health improvement). Gpics Nutrition Support guideline (Intenisve Care Society) SKIN bundle 1,000 lives campaign (Institute for healthcare Improvement).	15th Feb 2024	TBC

Crit/CA/2023-24/02	Outstanding	QSE	Critical Care	Ventilator Care Bundle - A Clinical audit to Assess Compliance with the Completion of Care Bundles within Critical Care, HDUHB.	Ventilator bundle: 1,000 lives campaign (Institute for healthcare Improvement). Central line Bundle: 1,000lives campaign (Institute for health improvement). Gpics Nutrition Support guideline (Intenivse Care Society) SKIN bundle 1,000 lives campaign (Institute for healthcare Improvement).	8th Feb 2024	TBC
N&H/WA/2025-26/02	Planning	Nutrition and Hydration Group	Nutrition & Dietetics	Meal Time Audit	829 - Mealtime Co-ordination Procedure (HB)	TBC	Continuous
N&H/WA/2025-26/01	Planning	Nutrition and Hydration Group	Nutrition & Dietetics	Fluid Balance	Nutrition and Hydration Policy, Procedures an	TBC	Continuous
N&H/WA/2025-26/02	Planning	Nutrition and Hydration Group	Nutrition & Dietetics	WAASP	829 - Mealtime Co-ordination Procedure (HB) ADULT NUTRITIONAL RISK SCREENING TOOL (WAASP) GUIDANCE (HB) 209 - ADULT INPATIENT REFEEDING GUIDELINES	TBC	Continuous
Safeguarding/WA/2025-26/01	Planning	Safeguarding Steering Group	W&CH	Routine Enquiry	592 - "Ask and Act" - Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) & All Wales Minimum Standards Routine Enquiry into Domestic Abuse, Pregnancy and Early Year Policy	TBC	Continuous
TBC	Planning	Safeguarding Steering Group	Paediatrics	Female Genital Mutilation	Wales Safeguarding Procedures - 714 - Management and Reporting of Female Genital Mutilation (for Health Professionals) Procedure	TBC	TBC
TBC	Planning	Safeguarding Steering Group	Sexual Health, Paediatrics	Child Sexual Exploitation Risk Questionnaire (CSERQ)	Social Services and Wellbeing Wales Act 2014 508 - Social Services and Well Being Act 2014	TBC	TBC
IP&C/WA/2025-26/01	Planning	SNMT	Professional Standards Team	Infection Prevention & Control Management Audit	Infection Prevention Policies and Procedures	TBC	Continuous
RADAR/WA/2025-26/03	Planning	HDUHB RADAR	Cross Speciality Improvement	Medical Emergency Trolley - Daily Audit	Resuscitation Council UK & Resuscitation Policy HDUHB.	TBC	Continuous
RADAR/WA/2025-26/04	Planning	HDUHB RADAR	Cross Speciality Improvement	Medical Emergency Trolley - Weekly Audit	Resuscitation Council UK & Resuscitation Policy HDUHB.	TBC	Continuous
RADAR/WA/2025-26/07	Planning	HDUHB RADAR	Cross Speciality Improvement	Sepsis Medical Emergency	NICE CG51 & Welsh Government Sepsis Guidelines 2017	TBC	Continuous
TBC	Planning	HDUHB RADAR	Cross Speciality Improvement	All Wales Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)	All Wales DNACPR policy	01/11/2025	TBC
TBC	Planning	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Inpatients Audit NICE QS 201 S1 - Cycle 5		TBC	TBC
TBC	Planning	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Lower Limb Immobilisation Audit NICE QS 201 S2 - Cycle 5		TBC	TBC
TBC	Planning	Thrombosis	Thrombosis	RE-AUDIT '25 - Venous Thromboembolism Outpatient Follow Up Audit NICE QS 201 S4 & S5 - Cycle 5		TBC	TBC
TBC	Planning	Thrombosis	Thrombosis	RE-AUDIT '25 Venous Thromboembolism Radiology Referral USS Audit NICE QS 201 S3 (H61) - Cycle 3		TBC	TBC
TBC	Planning	MH CAEG	Mental Health	Physical Health in Inpatients Audit		TBC	TBC
TBC	Planning	MH CAEG	Mental Health	Rapid Tranquilisation Physical Health Monitoring Standards		TBC	TBC
LD&MH/WA/2025-26/01	Planning	SNMT	Mental Health & Learning Disabilities	Learning Disabilities Audit	TBC	TBC	Continuous
PD/WA/2025-26/01	Planning	SNMT	Professional Standards Team	Pressure Damage Management	024 - Prevention and Management of Pressure Ulcer Policy (HB)	TBC	Continuous
AWC/WA/2025-26/06	Planning	SNMT	Professional Standards Team	Senior Peer Review/15 steps audit	TBC	TBC	Continuous
FoC/WA/2025-26/01	Planning	SNMT	Professional Standards Team	Mouthcare	TBC	TBC	Continuous
RK/WA/2025-26-01	Planning	SNMT	Professional Standards Team	Record Keeping - General	195 - Clinical Record Keeping Policy	TBC	Continuous
RK/WA/2025-26-02	Planning	SNMT	Professional Standards Team	Record Keeping - Content	195 - Clinical Record Keeping Policy	TBC	Continuous

3.5

3.5 - Waiting List Management

**Sharon Daniel (Hywel
Dda UHB - Executive
Director of Nursing,
Quality & Patient
Experience), Andrew
Carruthers (Hywel
Dda UHB - Chief
Operating Officer),
Mandy Davies (Hywel
Dda UHB - Assistant
Director of Nursing &
Quality
Improvement),
Marilize Preez (Hywel
Dda UHB -
Improvement and
Transformation
Lead)**

Attachments

[Waiting List Management.pdf](#)



Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	04 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Waiting List Management
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality & Patient Experience Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Mandy Davies, Assistant Director of Nursing and Quality Improvement Marilize Preeze, Transformation Lead

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The report on the Management of Waiting Lists/ Did Not Attend (DNA's)/ Appointments presented at Public Board on the 25 September 2025 provided no assurance to the Board on the current processes around waiting list management, appointment bookings and communication with patients. The Board requested that a much broader review of the processes be undertaken and the outputs of the review to inform an action plan to improve communication and pathway management.

It was proposed that the Quality, Safety and Experience Committee (QSEC) lead on this and scrutinise the review findings in the first instance at QSEC in February 2026 ahead of the Board in March 2026.

Cefndir / Background

Definitions:

- Did not attend (DNA): Patient misses a scheduled appointment without prior cancellation.
- Could not attend (CNA): Patient contacts the service in advance of the appointment time to cancel or reschedule the appointment.

Following media publications and freedom of information requests earlier this year regarding Hywel Dda University Health Board (HDdUHB) patients being removed from waiting lists without warning, and reports of patients being removed following missed appointments which were never communicated to them, or where the appointment letter arrived after the appointment date, the Executive Team requested an initial review of current communication processes with patients on waiting lists, including access points, to identify any potential factors which might lead to late receipt of appointment letters and/or outcomes of DNA/CNA in August 2025. The findings of the initial review, and an overview of the waiting list management process

set out by Welsh Government (WG) within the “Referral to Treatment” (RTT) Guidance was presented at Board on 25 September 2025 ([Waiting List Management Report](#)).

Discussions at Board also identified a number of individual cases of poor patient experience as a result of current waiting list management and communication processes highlighting the impact on patients and the need to improve.

Operational teams recognise that communication with patients is not as it should be, and that improvements are possible, even within the current infrastructure constraints. There is also a request to determine whether the current situation is reflective or symptomatic of the current pressures staff and the organisation are experiencing to meet targets, which may result in staff losing focus on the individual at the other end of the communication.

National Guidelines for the Management of Referral to Treatment waiting times (RTT) in Wales were introduced in 2009, and the refreshed RTT guidance (April 2025) provides clear guidance on appointment booking, reasonable offer, and communication for RTT reportable services. However, a large proportion of services and waiting lists sit outside this remit.

For RTT reportable service the following guidance applies:

Booking Processes

- Booking is mutually agreed between the service provider and patients, fostering shared decision-making and clear communication of appointment details, modes (face-to-face, telephone, video), timing, and location.
- Health Boards (HB's) must encourage shared decision-making and involve patients fully in administrative and treatment arrangements.
- If a patient is to be seen within six weeks, a direct booking system should be used. If the appointment is going to be more than six weeks in the future, confirmation of the acceptance of the referral is needed either by letter, text, or phone.
- Each attempt to contact the patient under the booking processes must be recorded and available for subsequent audit.
- Direct booking for clinics with less than 10 working days' notice should be done directly with the patient, either **face-to-face or via telephone**. If the patient does not accept the offer of a short notice appointment, this cannot be managed as a reasonable offer, and the clock remains unaffected.

Appointment Communication

- Communication with patients is a key pillar for managing RTT within target times (26-week and 36-week pathways for complex cases).
- Patients and carers with additional communication needs must receive information in formats they can access (e.g., large print, braille, easy read, or via interpreters).
- A partial booking process occurs whereby appointments are agreed with the patient, following a written request for the patient to telephone if they require an alternative appointment.
- Under the partial booking process, an acknowledgement must be sent to the patient when the referral is received and accepted. This should explain the booking process that will be

used for their appointment, including a choice of digital or non-digital methods. A letter should then be sent to the patient four weeks before it is anticipated they will be seen, asking them to phone and make an appointment, or book their appointment via the patient-facing platform within the next 10 days (phone letter).

- Direct booking occurs by either being booked in a face-to-face or telephone interaction with the patient, or through a direct dialogue with the patient via letter/email and or text. In this case, any correspondence will be sent at least 10 working days prior to the appointment date. 10 working days is recognised as a *reasonable notice period* (as per access policy).
- A reasonable offer is considered as an offer of two possible dates and/or times, which must be more than two weeks in the future.
- All appointments within an RTT period must be arranged under “reasonable offer” principles, mutually agreed by patient and provider.
- Appointment planning should consider:
 - o Patient preferences (including appointment modality: face-to-face, telephone, video consultations).
 - o Appointment confirmation and reminders to reduce DNAs.
 - o Accessibility and mobility considerations for vulnerable groups.
- HB’s must consider postage times when sending letters offering a direct booking appointment to patients to avoid the patient receiving the letter on, or following, the day of the appointment. If a patient does not attend an appointment (and DNA recorded) and subsequently contacts the HB to state that they did not receive the appointment letter in time, the HB should amend the patient record, and the clock should continue with no adjustment. An alternative timely offer should be made to the patient at the earliest opportunity. To avoid this, HBs must ensure that letters offering a direct booking should be sent a minimum of 10 working days before the appointment date.
- If a patient is removed from the waiting list for reasons other than treatment, the patient and their referrer must be informed of the removal and the reasons for it.

As previously stated, the guidance does not apply to all waiting lists and pathways which adds an additional layer of complexity.

The findings from the initial review (August 2025) of 14 waiting lists from a variety of services identified:

- The HB’s “Patient Access- Elective Care policy” was out of date. While the policy was updated to reflect the refreshed RTT guidance published April 2025, it was still awaiting formal approval.
- A limited amount of RTT patients’ services in the HB report that they follow a partial booking process whereby appointments are agreed with the patient, following a written request for the patient to telephone if they require an alternative appointment. Under the partial booking process, an acknowledgement letter must be sent to the patient when the referral is received and accepted to explain the booking process. Currently the HB does not send acknowledgement letters to patients once referrals have been accepted. This functionality has been turned off since January 2025.

- Majority of services (wider than planned care) are utilising direct bookings either via letters, phone or face-to-face. The review identified variation in the recording of direct bookings offered via phone or face-to-face on the patient administration system for audit and pathway management purposes in terms of DNA/CNA, especially for appointments offered within less than 10 working days.
- A review by the Digital Team identified that 19% (n= 59,322) of appointment letters were sent within 10 days or less of the appointment date over a 6-month period. Of these appointments 6.5% (n=3,856) of patients could not attend (CNA) and 3.7% (n=2,195) did not attend (DNA). These appointments would not be considered a “reasonable offer” under RTT guidance if the patients were not additionally informed either by phone or face-to-face and agreed to the appointment. The variation in recording of information relating to direct bookings limits the ability to audit if these patients were correctly recorded as a DNA/ CNA.
- Multiple access points for service users on patient letters, all letter templates reviewed contained as a minimum two phone numbers, one in the letter header and a different number in the letter content, with some letters containing more.
- No single access point for service users to cancel or change appointments within the 14 waiting lists reviewed, each had their own telephone number which included numbers to medical secretaries.
- Different services offer various methods of communicating if patients are unable to attend or the need to reschedule appointment with some services offering the option to leave a voicemail whilst others do not. Additionally, some appointment letters include an email contact address, however, this is not provided by all services.
- The Hybrid Mail/ Patient hub roll out will address some issues identified as part of the review and allow patients access to text reminders, digital appointment letters and accessible communication formats.
- The Waiting List Support Service (WLSS) provides a single point of contact, within the HB’s Communication Hub, offering self-management advice, promoting healthy lifestyle, and personalised support for patients who are awaiting treatment or surgery to prevent deconditioning and deterioration in their condition, and support them to prepare for treatment. The WLSS helps patients manage their health and wellbeing whilst waiting, signposts to community and clinical services and identify potential harm from waiting and escalates as/where necessary. The service is not responsible for RTT pathway management in terms of appointments/ cancellations/ DNA / CNA/ validation, instead it follows agreed communication routes to refer these issues to the relevant services when raised by patients.

Following the report presented at Board, the Executive Team has committed to a wider review into the management of all waiting lists across the HB. In October 2025 the Quality Improvement and Service Transformation (QIST) Team was tasked to work with Clinical Care Groups and services to map waiting lists and associated processes in terms of communication, booking, cancellations and discharge/ removal from the list.

Asesiad / Assessment

The QIST Team is currently mapping all services and waiting lists across the HB. As this involves all waiting lists, there has been a focus on identifying the “hidden” waiting lists not currently reported on. To date 40 services have been identified with 69 subspecialties. Each of these have multiple waiting lists within the service/ subspecialties. Initial scoping has been completed in 38 of the subspecialties. Due to the number of waiting lists and services identified the review is anticipated to be completed in January 2026.

Initial themes/ findings:

- Majority of waiting list are on Welsh Patient Access System (WPAS) although, some services report utilising Excel spreadsheets or paper-based lists in addition to WPAS to manage waiting lists.
- The majority of services report not utilising or not having a standard operating procedure for staff to follow in terms of waiting list management/ appointment bookings/ documenting on systems.
- Variation in practice regarding discharging patients following DNA.
- Multiple access points – some service utilising switch board to transfer to medical secretaries.
- Phone appointments not consistently recorded.
- Multiple letter formats- some utilising standardised templates on WPAS and others use letters written within services with limited or no guidance.
- Letters printed and sent from multiple locations (centrally and from individual offices/ services).
- Letters being sent for appointments within less than 10 days.
- Limited audit and governance processes in place across some services (not specifically RTT services).
- Clinical staff booking appointments/ managing waiting lists/ sending letters due to lack of administrative staff to support waiting lists management within some services.

A full report with recommendations to inform an action plan will be submitted to Board in January 2026 for consideration.

Argymhelliad / Recommendation

- The Committee is asked to take assurance that a full review and report relating to Waiting List Management will be completed for consideration to inform a Health Board action plan.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.6 Provide assurance to the Board that current and emerging clinical risks are identified and robust management plans are in place and any learning from concerns is applied to these risks as part of this management.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality	7. All apply

Quality and Engagement Act (sharepoint.com)	
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	5. Whole systems perspective
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termiau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofïod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Contained within the body of the report
Gweithlu: Workforce:	Contained within the body of the report
Risg: Risk:	Contained within the body of the report

Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Contained within the body of the report
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Contained within the body of the report

3.6

3.6 - Quality Assurance Report

***Cathie Steele (Hywel
Dda UHB - Interim
Assistant Director of
Nursing Assurance
and Safeguarding)***

Attachments

[3.1 QS Assurance Report Dec2025 v1.0.pdf](#)

[App 1 HIW overdue actions Nov2025.pdf](#)

[App 2 WRP LR 2024-25.pdf](#)



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



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

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



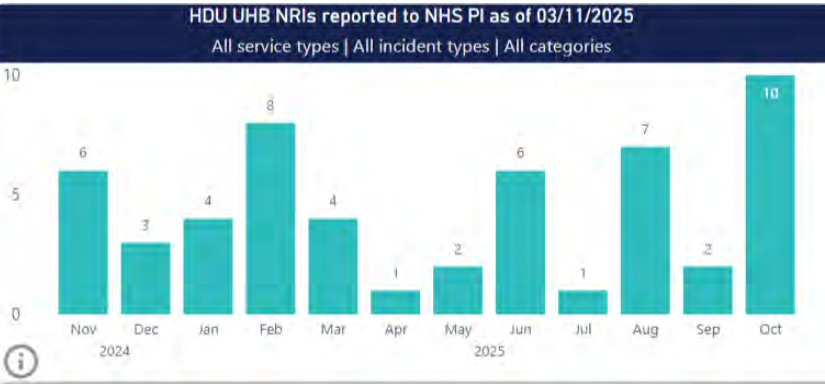
Nationally Reportable Incidents

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

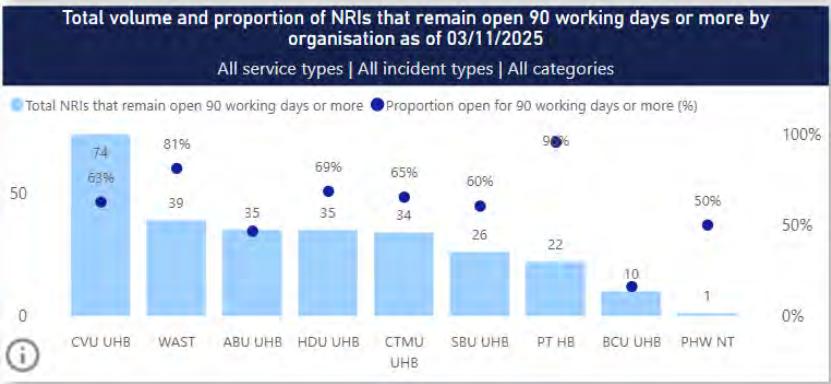
As of 24th November 2025, 46 incidents are open with NHS Performance and Improvement on the UHB Datix Cymru system (excluding those reported and awaiting confirmation of reference number).

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).

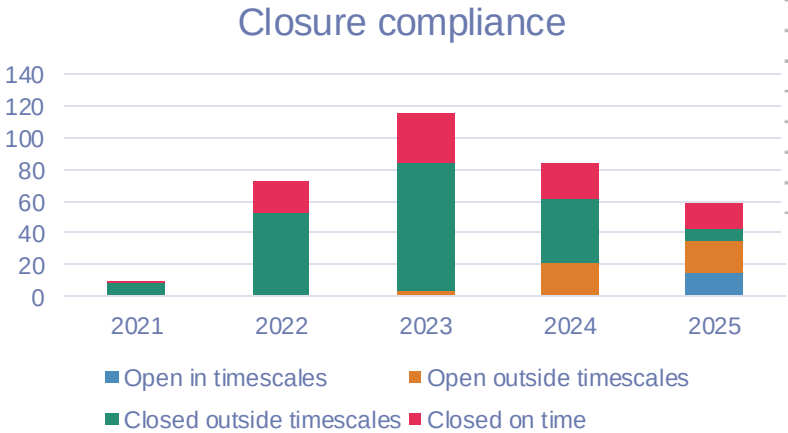
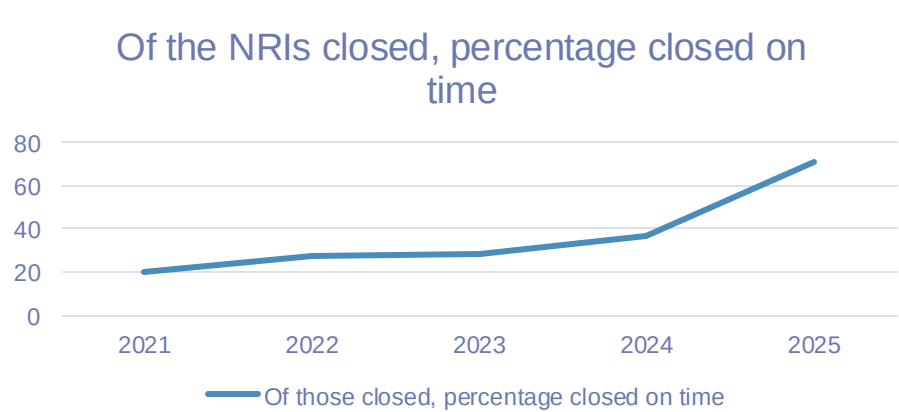


Source: Beacon Dashboard 07/11/2025



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

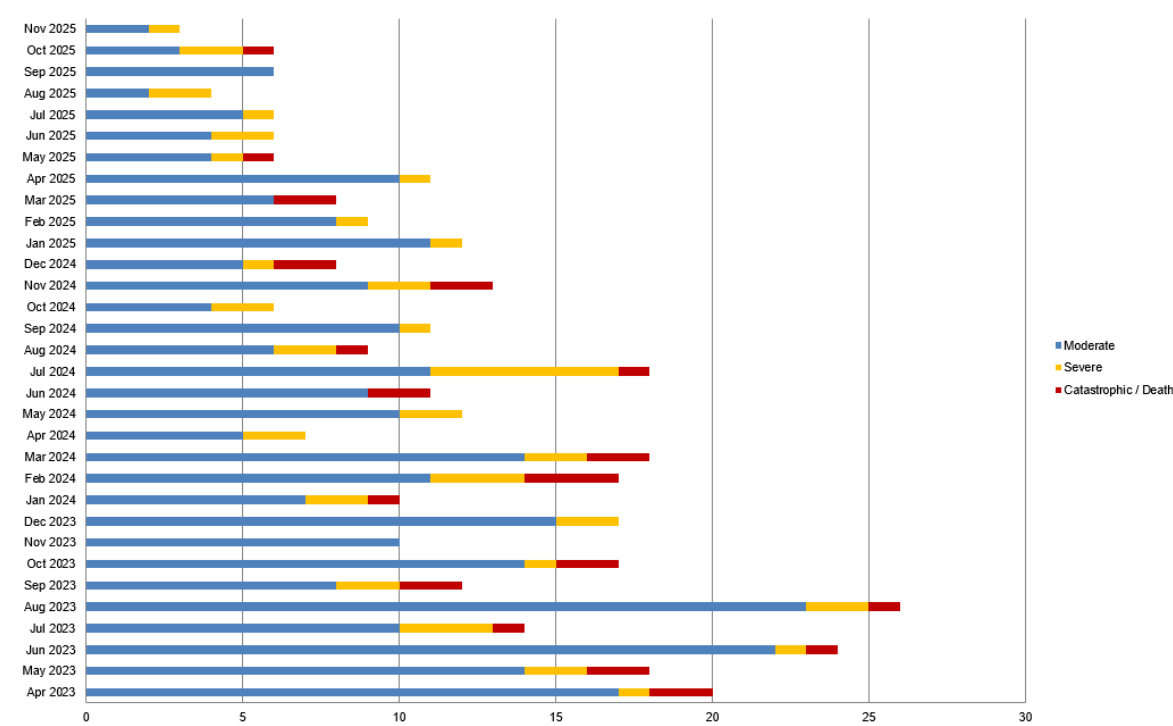
NRI category	Total
Neonate	10
Pressure ulcer developed or worsened during care in this clinical care area/caseload	4
Clinical assessment, clinical diagnosis	3
Communication issues	2
Maternal	2
Treatment or procedure issues	2
Administration errors	1
Compliance with bundle/ guidance	1
Diagnostic testing - 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



Source: Datix Cymru 07/11/2025

Health Board Overview – Duty of Candour

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					
Manager's interim harm assessment		None	Low	Moderate	Severe	Catastrophic / Death	Total
	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



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

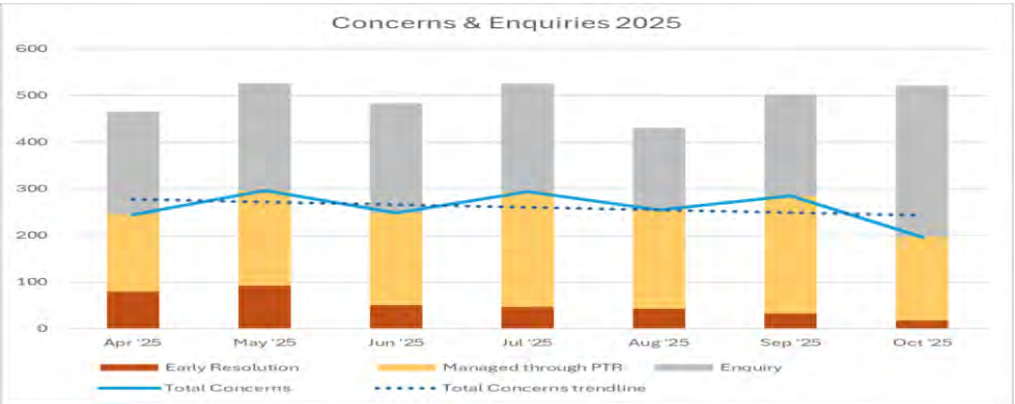
Targeted responses are those collected via SMS, IVR and Email. Passive responses are those collected via all other delivery methods such as QR codes and survey links

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

Number of complaints received by month since Apr 25



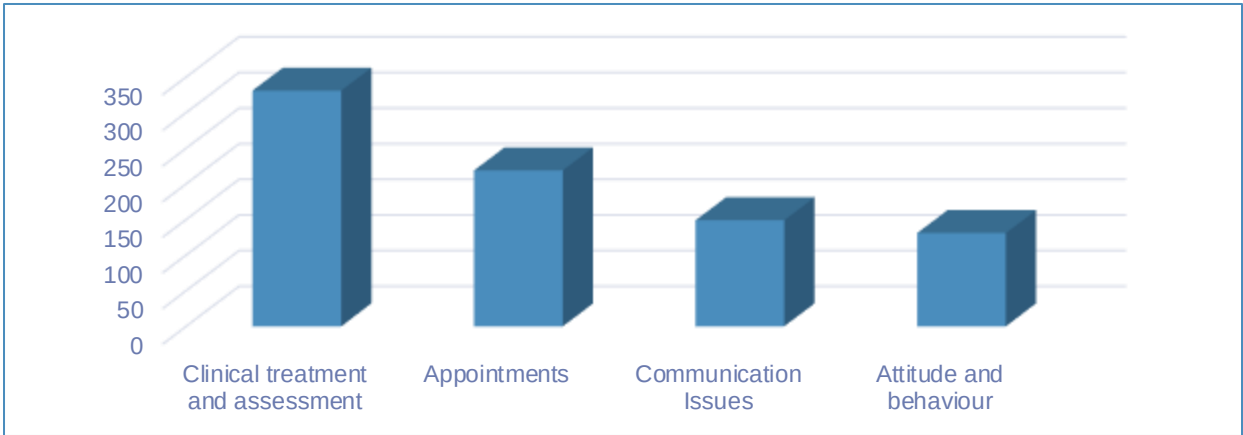
Proportion of complaints within 30 working days

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

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	Select all or hospital onset (HO)* specimens
	Rate per 1,000 admissions ▼	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 ▼							
< than same period last FY = same period last FY > than same period last FY							
	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.

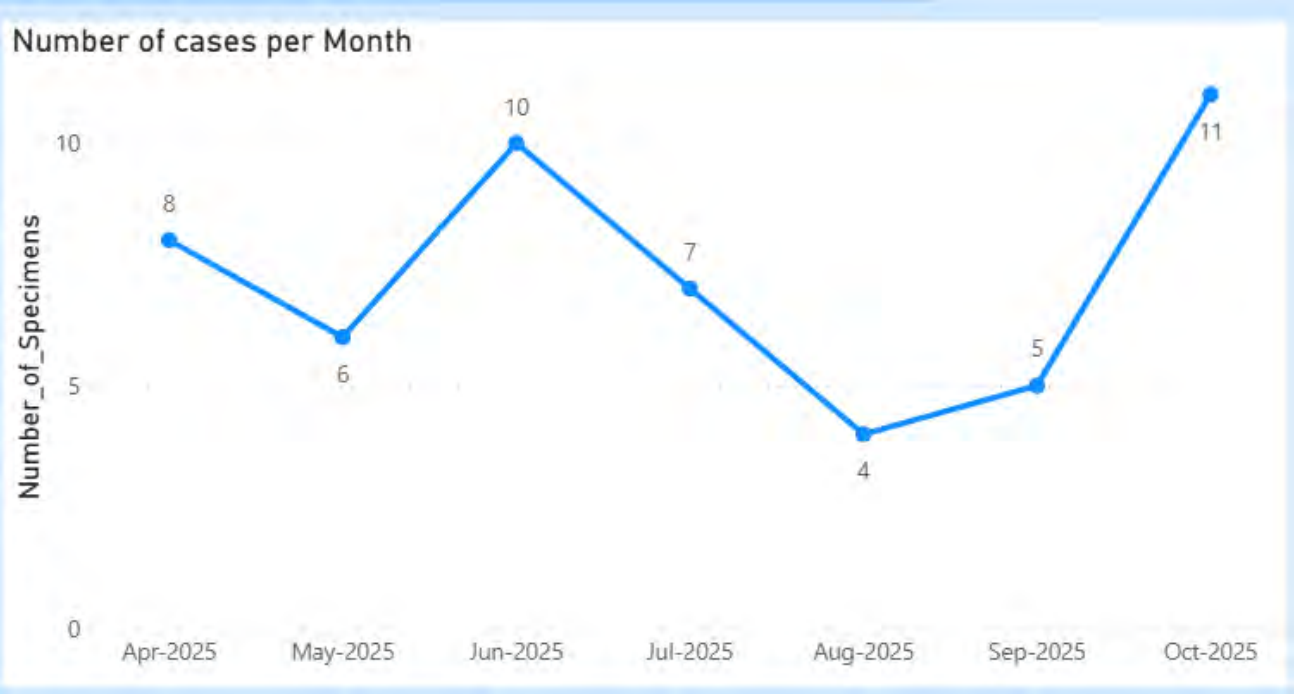
Filters for Table 1. and Chart 1.	Select HB	Select count or rate	Select all or hospital onset (HO)* specimens
	Hywel Dda UHB ▼	Rate per 1,000 admissions ▼	All specimens ▼

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

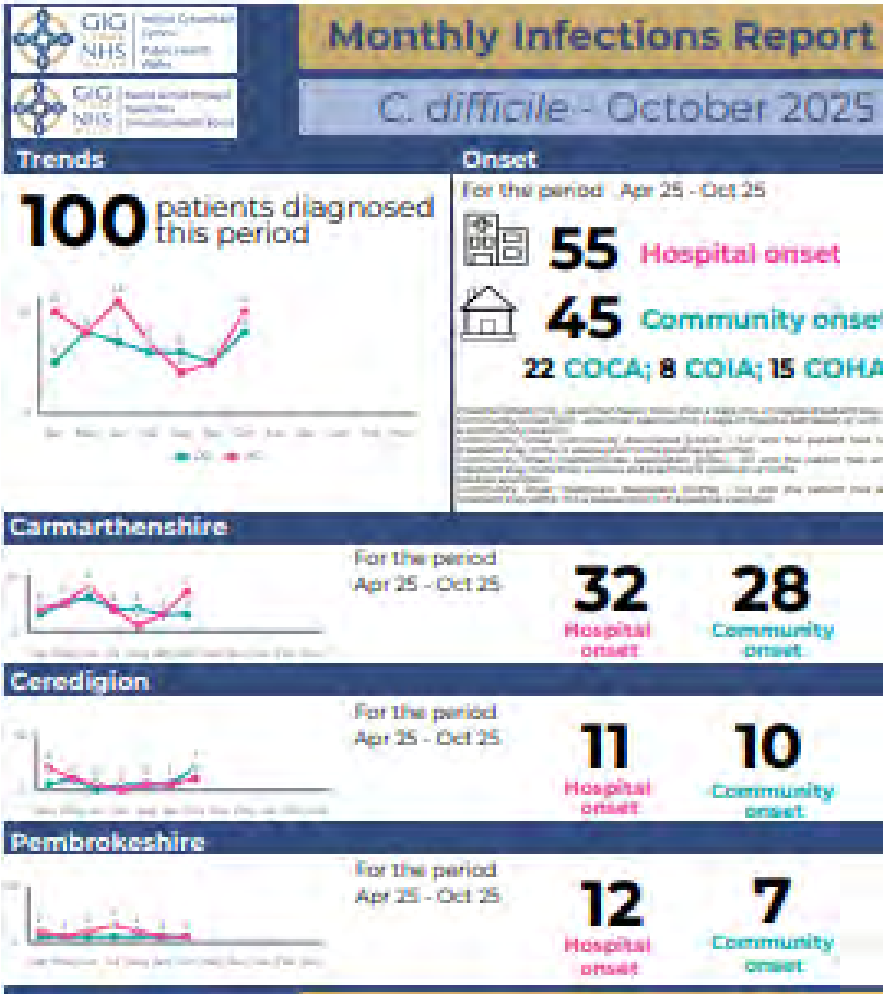
IP&C C.difficile

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.



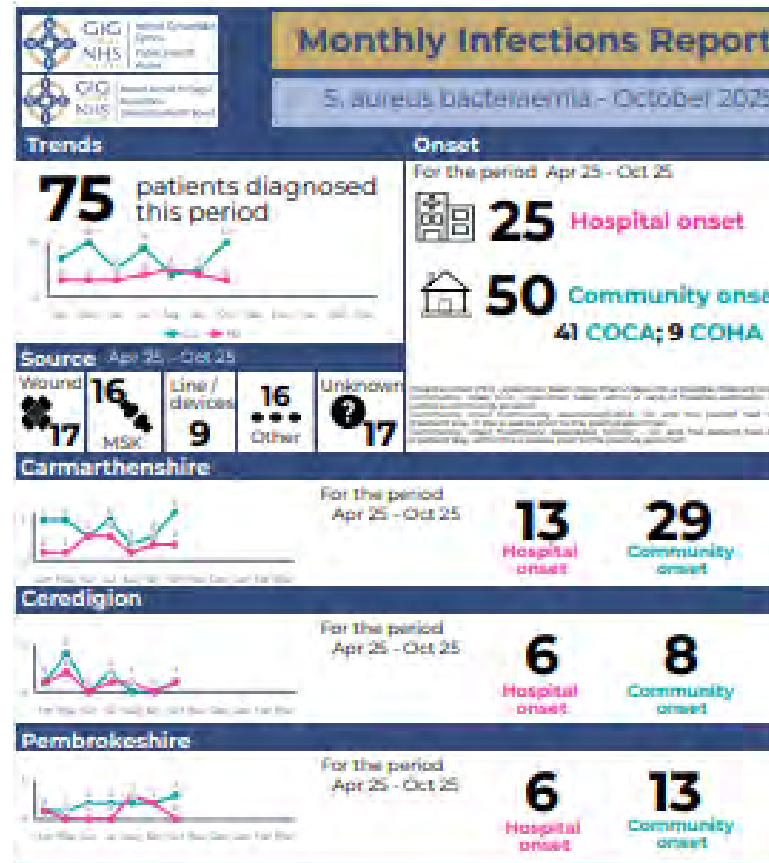
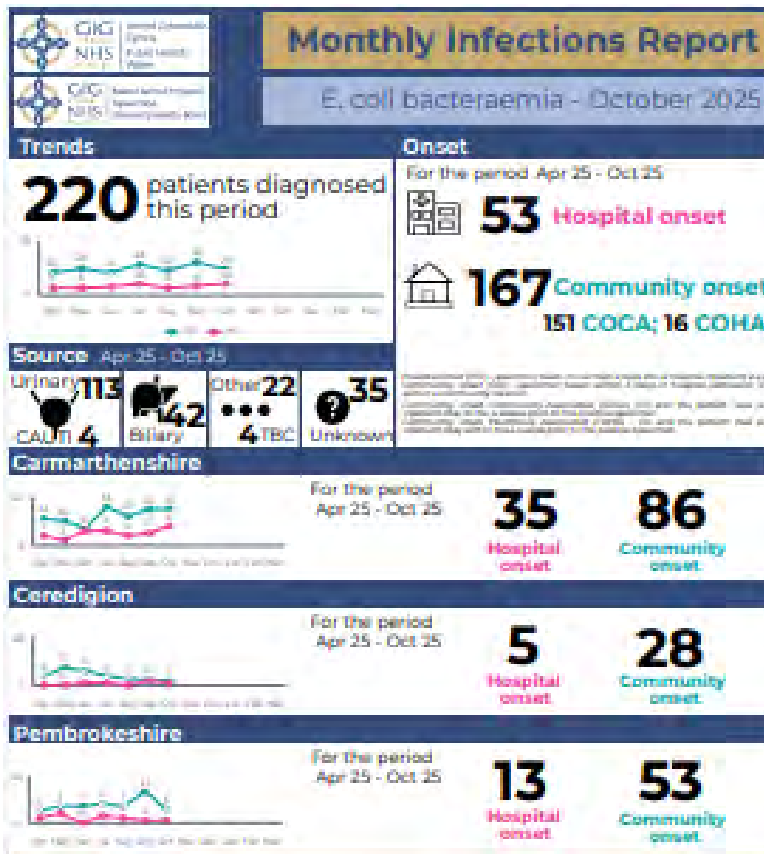
IP&C E.coli and S.aureus

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

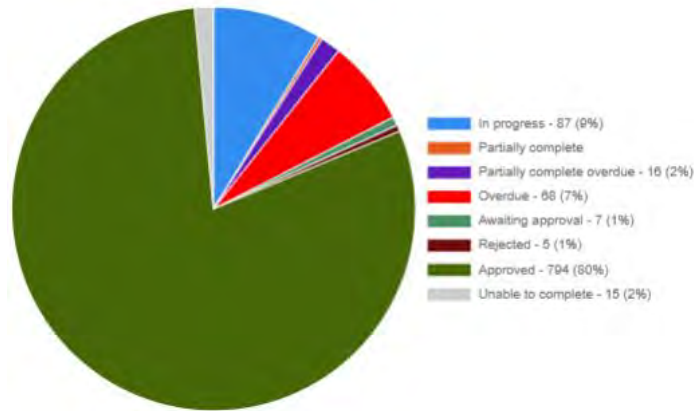
As an update to the last report, the Health Board have received the following letters from HIW requesting assurance during the period

Date of letter	HIW ref	Matter
24/11/2025	15323	Theatres GGH - 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 - 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 CTMUEB 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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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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SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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.



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.

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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/MD8/2	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	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/MD8/3	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	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/MD8/4	To arrange additional training to support the early recognition of a deteriorating patient.	Carmarthenshire Integrated System	15/09/2025	Partially complete (Overdue)	Completed prior to AMAT upload- The dates for the additional training are 25th, 27th and 29th September 2025) 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. Pharmacy/Nursing to reinforce the need for Medical Colleagues to complete and document the VTE Risk Assessment. VTE Site Improvement plan in place. Preventing Thrombosis and VTE showcase event. Hospital Acquired Thrombosis SharePoint page available with current resources and information. Monthly spot checks of VTE risk assessments on Surgical, Medical and Trauma & Orthopaedic ward areas. Review of VTE risk assessment compliance findings to be discussed

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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.

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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.

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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)	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). 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. 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. 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.
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)	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 Update 24/4/25- Multi quote closes tomorrow and will forward paper work on my return next week. 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. Update 4.7.25 - Additional door required which has delayed previous order due to procurement issues. Expected completion Dec 2025. Update 9.7.25- Orders raised for doors, due for installation late August. 5.8.25 Update- Fire doors are on order with a completion date of December 2025. 1.10.25- to be completed by December 2025. Fire doors are on order, and all other recommendations are complete.

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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 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 specialty 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	

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 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 Worthybush 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

45	Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status	Comments/Updates
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

Welsh Risk Pool and
Legal and Risk Services
Annual Review
2024-2025

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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.



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

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



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-Embolism

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.



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.



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.



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.



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.



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.



Putting Things Right

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



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.



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.



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.



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.



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.



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

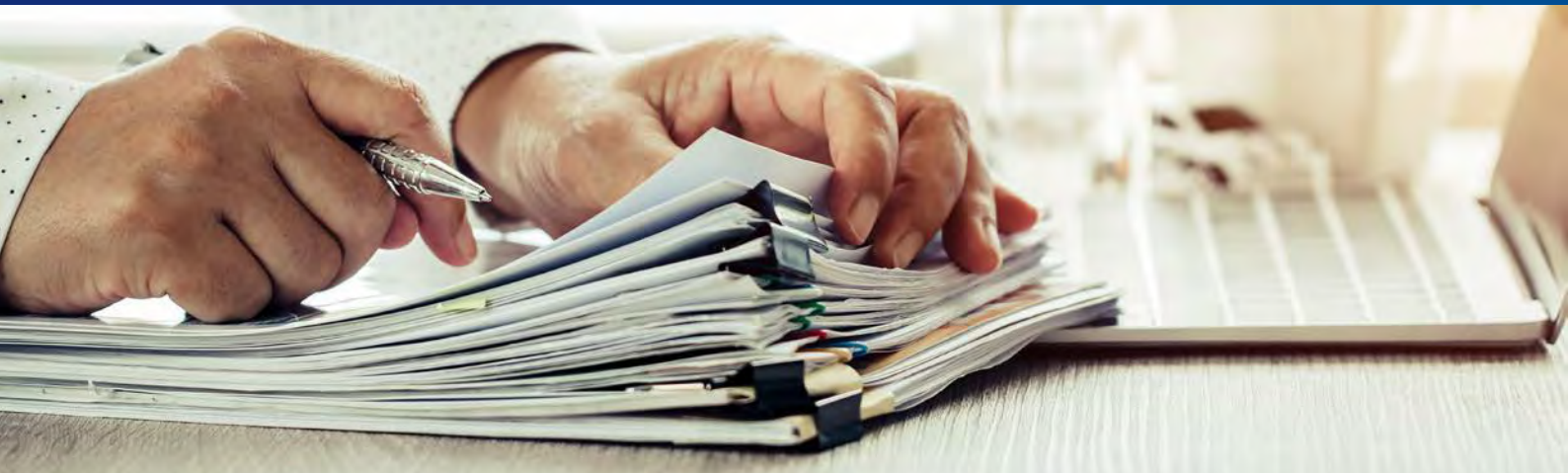
Sue Saunders is the Head of Finance for Welsh Risk Pool and Legal and Risk Services Management Accountant.

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 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

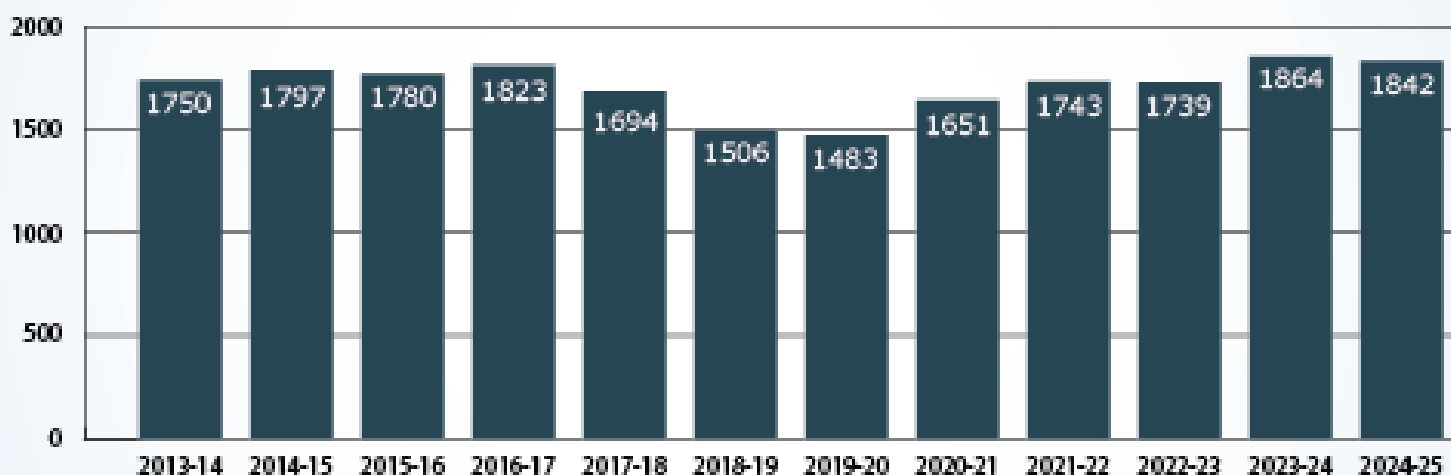


Fig.1 Open Clinical Negligence Matters

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

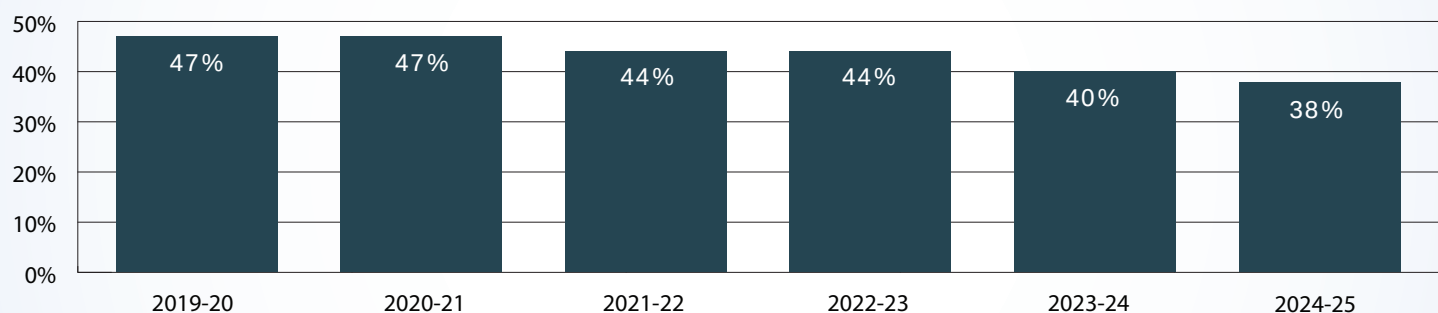


Fig.2 Proportion of Clinical Negligence matters closed without damages paid

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 specialties 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

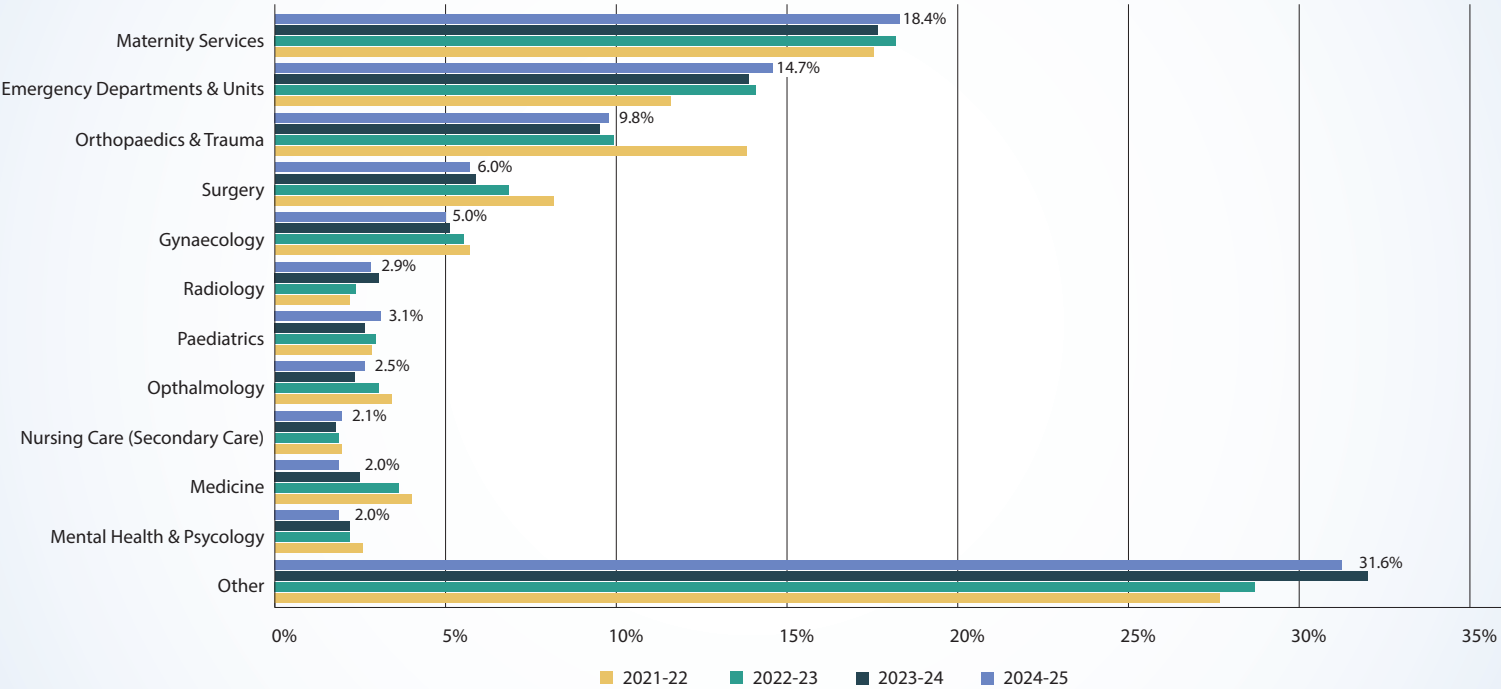


Fig.3 Proportion of Principal Clinical Specialties in Clinical Negligence matters

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

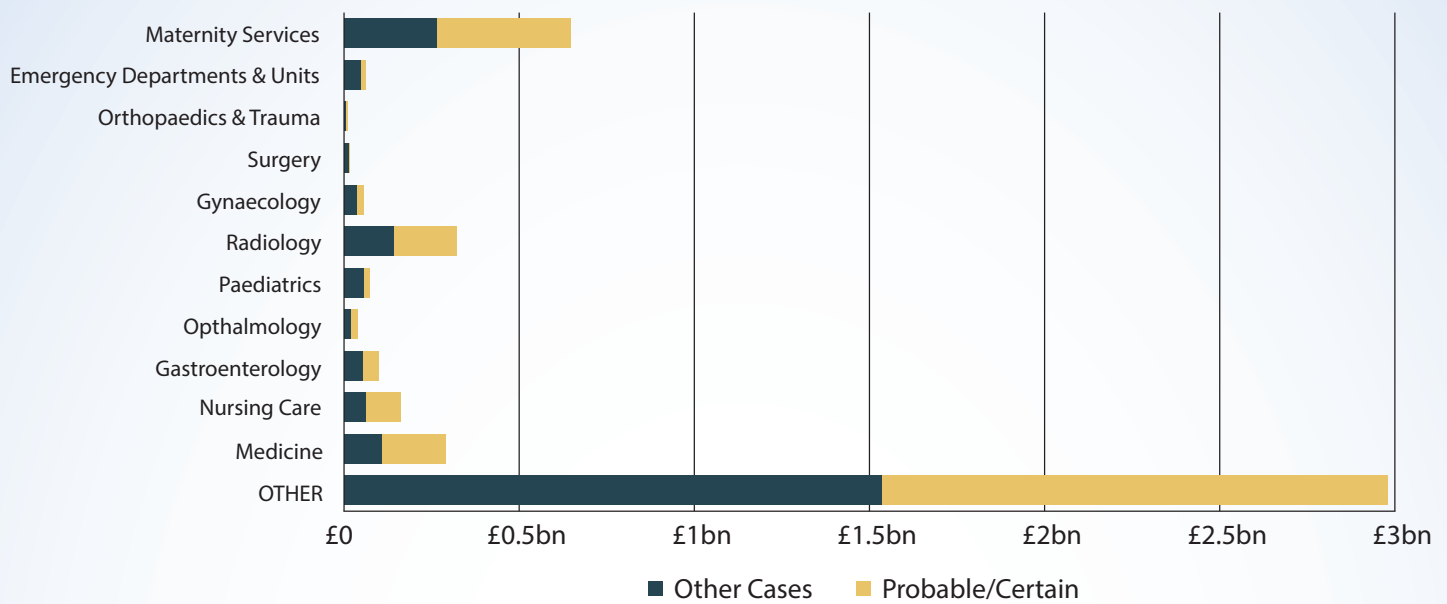


Fig.4 Quantum – Clinical Negligence 2024 / 25

Proportion of Open Clinical Negligence Cases April 2025

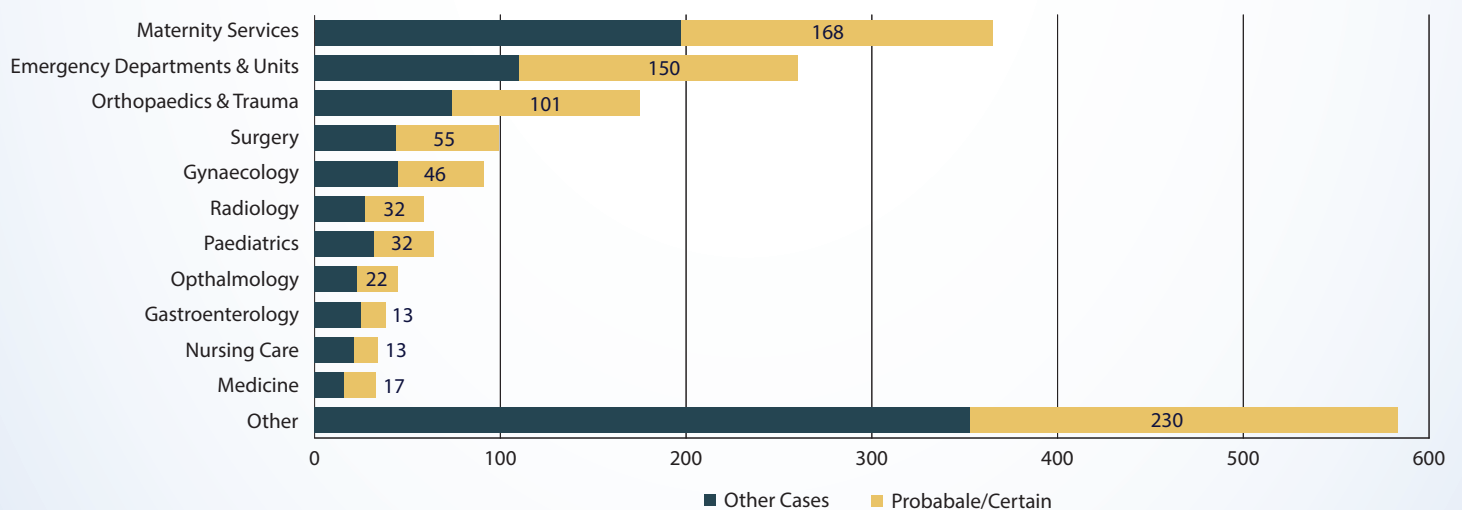


Fig.5 Proportion of open Clinical Negligence Cases Apr 25

	All Cases		Probable / Certain Cases	
Speciality	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

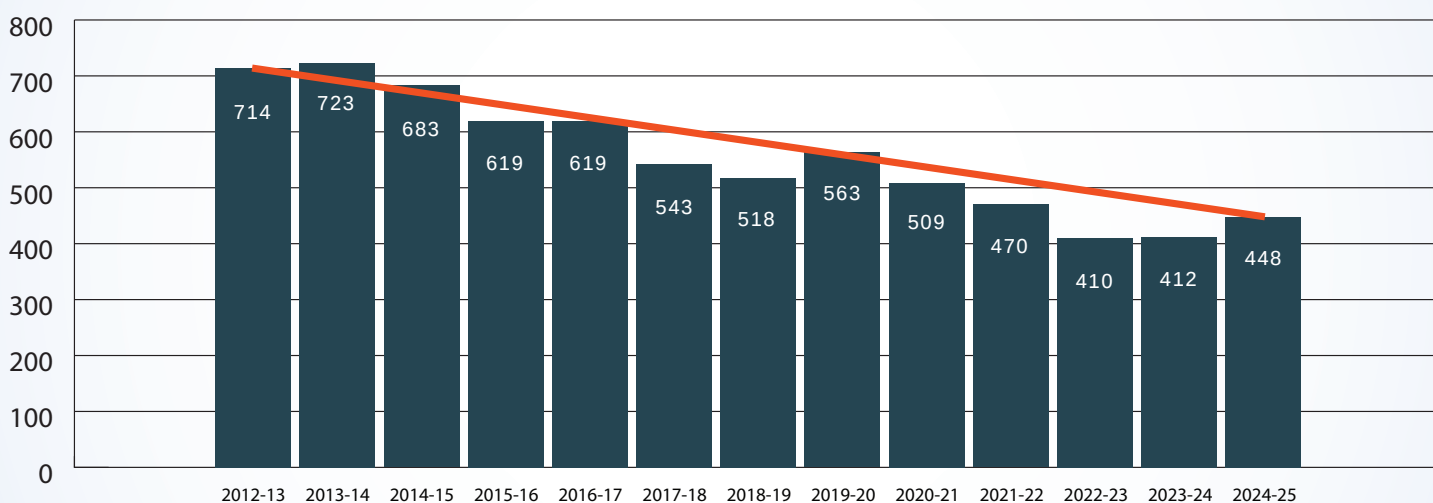


Fig.6 Open Personal Injury matters

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

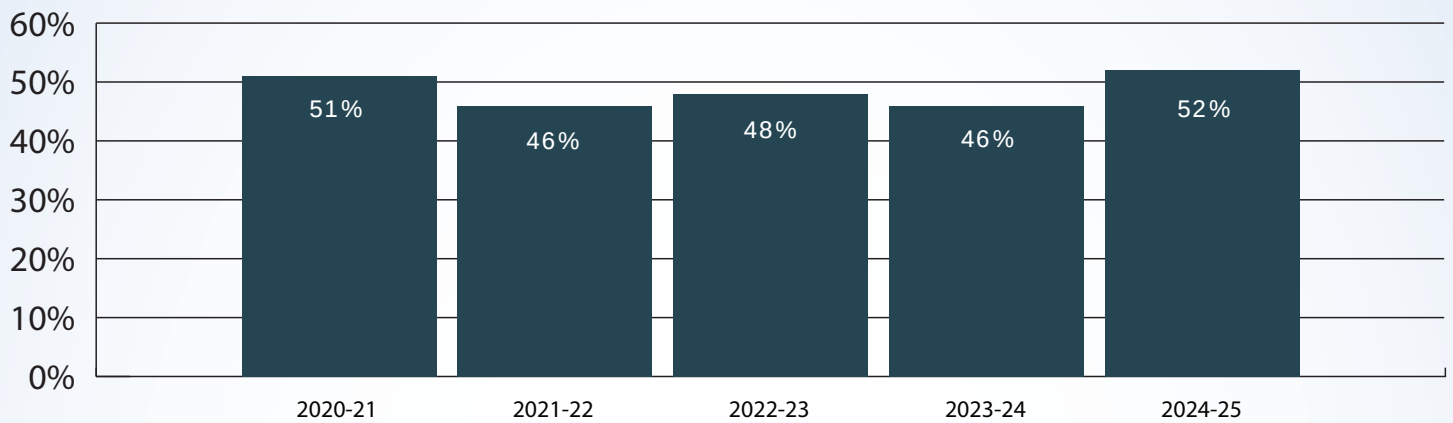


Fig.7 Personal Injury Claims Closed Without Damages



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.

Redress Cases for Last 6 Years

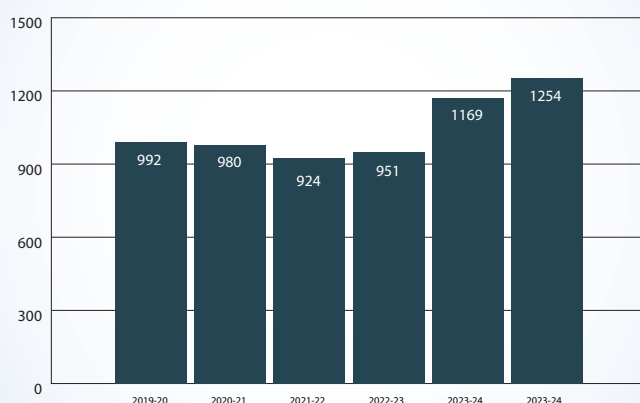


Fig.8 Redress Cases for last 6 years

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 specialties 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

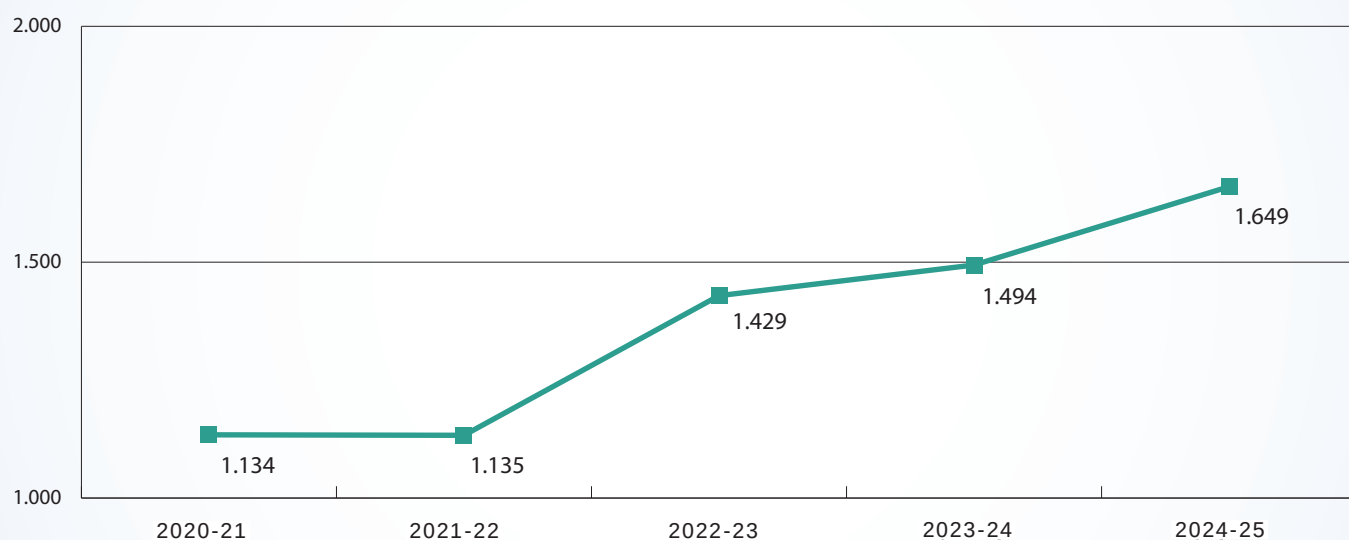


Fig.9 WRP Provisions for last five years

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

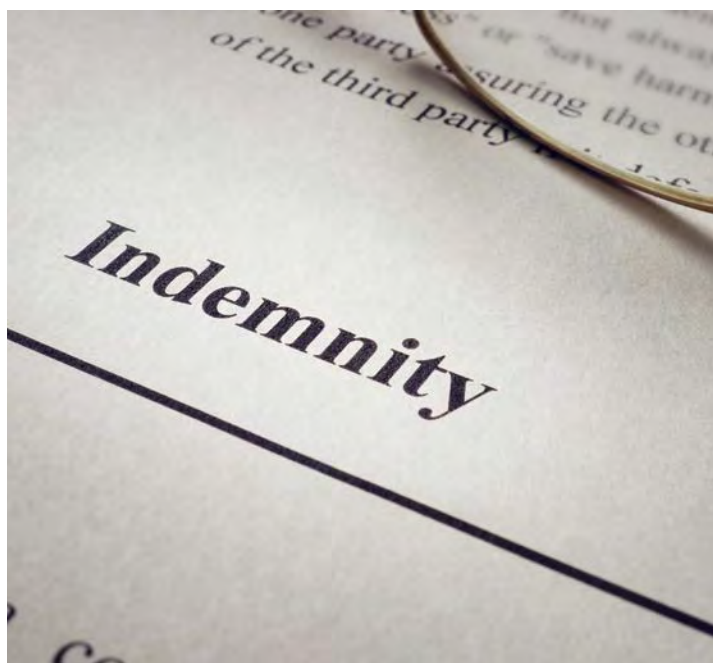
Health bodies in NHS Wales are exempt from the majority of the requirements for compulsory insurance and are not permitted to purchase commercial insurance for their core activities. The Managing Welsh Public Money guidance outlines that purchasing commercial insurance would not be cost effective for 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.



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.

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

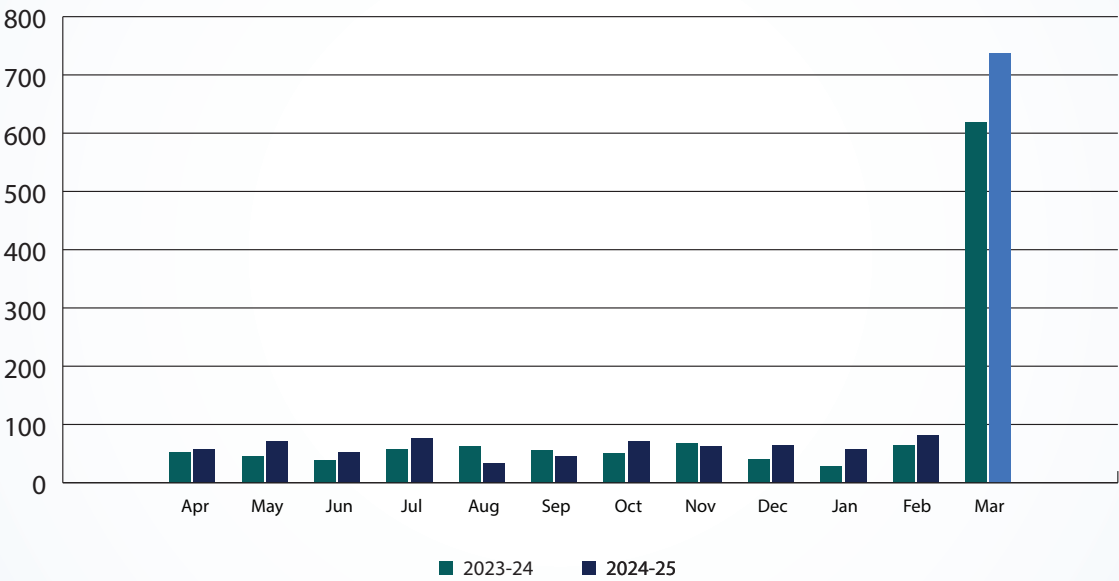


Fig.10 Comparison of New Cases to Panel 2023 / 24 and 2024 / 25

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.

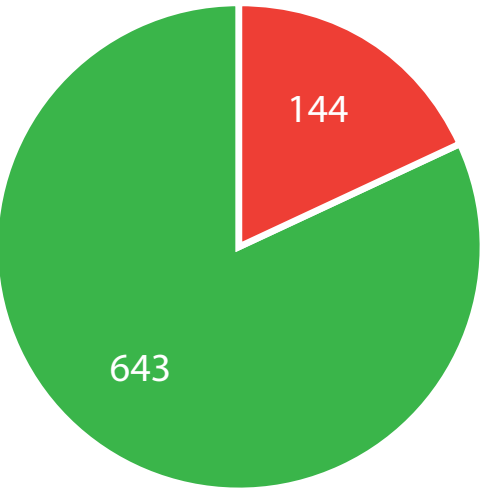
Table.10 and Fig.11 outline the timeliness of LFER submissions in 2023/24 and 2024/25. This data shows an improvement in timeliness from 28% of LFERs being submitted late in 2023/24 (n=169 of 608) to 18% (n=144 of 787) in 2025/26. Some of the late submissions were significantly late, including several 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

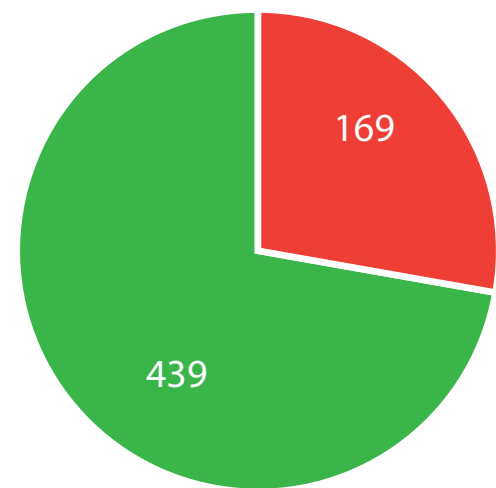
Table.10 Timeliness of LFER Submissions 2023-24 and 2024-25



LFER Submissions 2024-25



LFER Submissions 2023-24



■ No. of Missed Standard Deadlines ■ No. of Achieved Deadlines

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

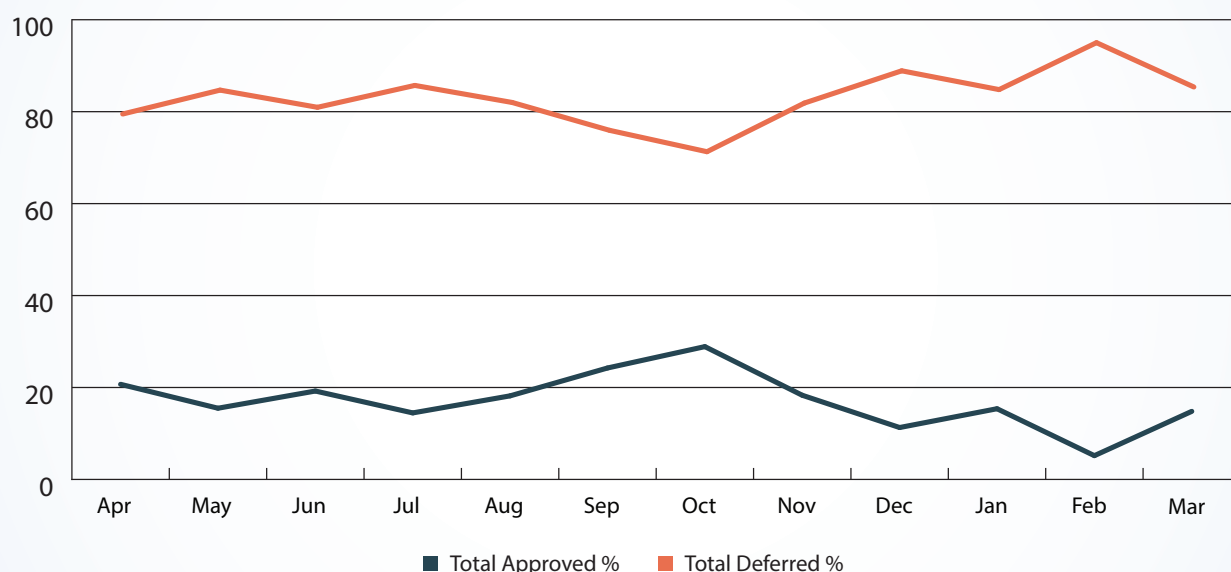


Fig.12 New Cases to Panel 2024/25 Approved and Deferred

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

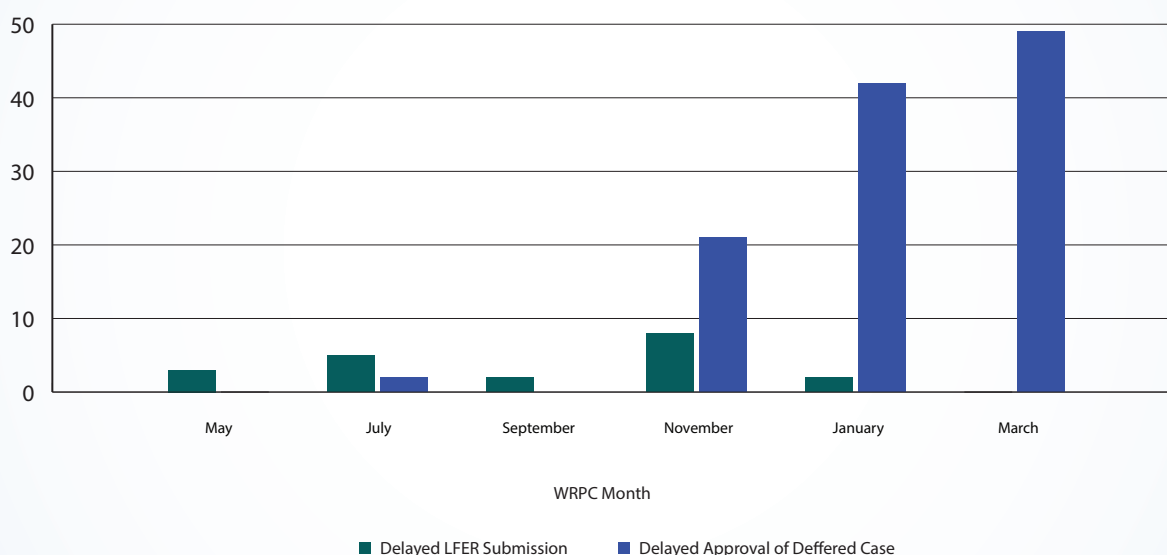


Fig.13 Penalties applied by the WRP Committee

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.





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

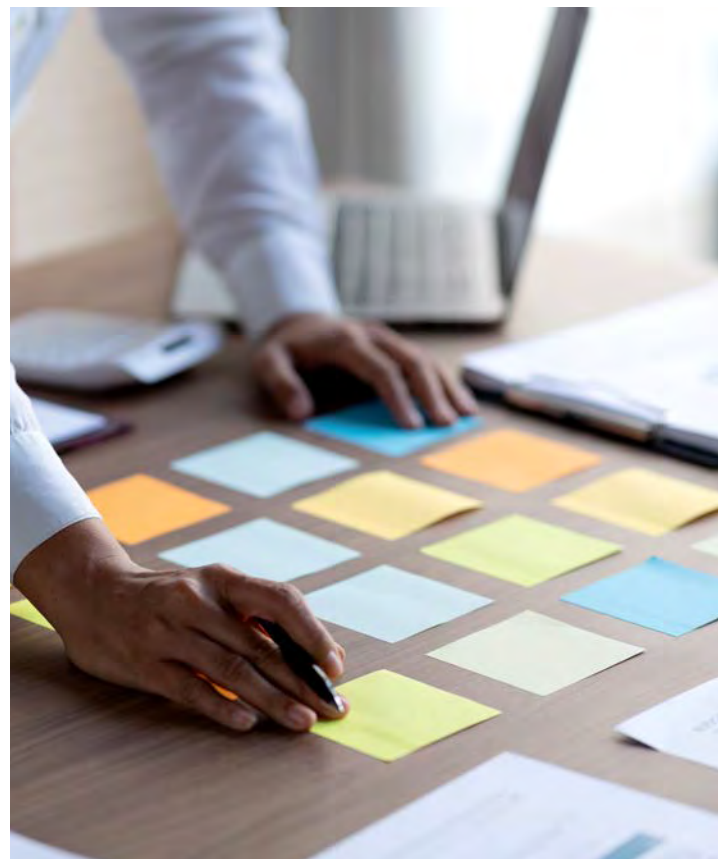


The importance of supporting NHS Wales Health Bodies in the area of Decision Making and Consent is driven by the significant number of claims which feature the process of consent in healthcare. During 2024/25, the Welsh Risk Pool reimbursed health bodies in NHS Wales £4,028,701.68 in relation to cases 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.”

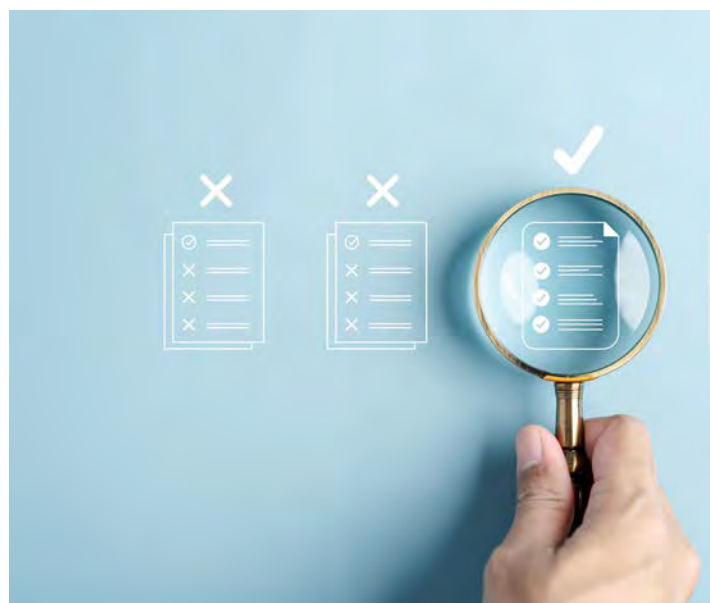
The e-learning is supplemented by webinars on topics such as ‘Informed Consent - Getting it Right’ and ‘Decision Making and Consent - No decision about me without me.’ More recently an innovative learning package in End of Life Decision Making has been developed. Both modules are available on ESR and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

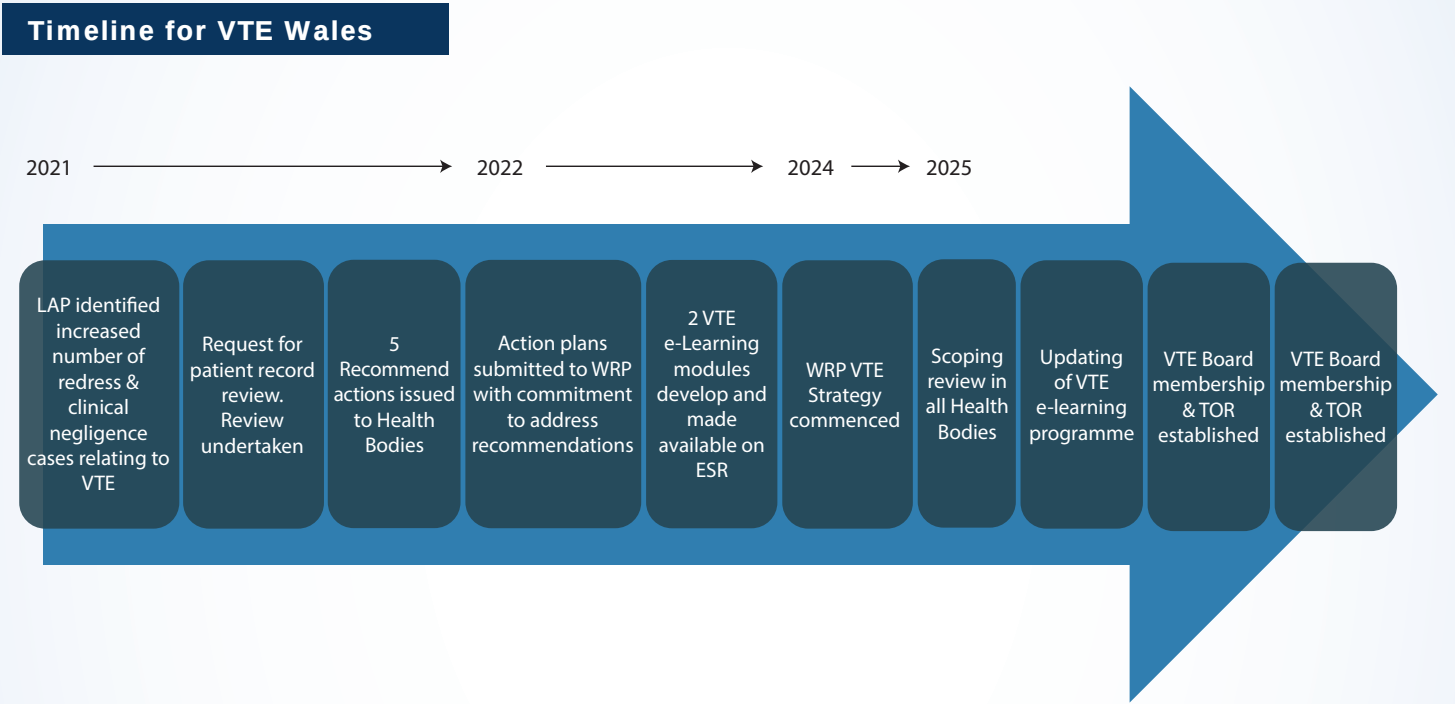


Fig.14: Timescales and Plans for VTE Wales

References

MBRRACE 2024, Saving Lives, Improving Mother’s Care, MBRRACE UK Saving Lives, Improving Mothers’ Care 2024 report, [Saving Lives, Improving Mothers’ Care 2024 - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22 | MBRRACE-UK | NPEU](#)

NICE 2019, VTE in Over 16’s, <https://www.nice.org.uk/guidance/ng89/chapter/recommendations>

Thrombosis UK 2024, VTE Statistics, <https://thrombosisuk.org/thrombosis-statistics.php>

ONS 2023, Office of National Statistics. 2023. Provisional number of all-cause deaths and deaths due to Pulmonary Embolism, 2022, [Provisional number of all-cause deaths and deaths due to Pulmonary Embolism, 2022 - Office for National Statistics](#)

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.

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.

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.

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.

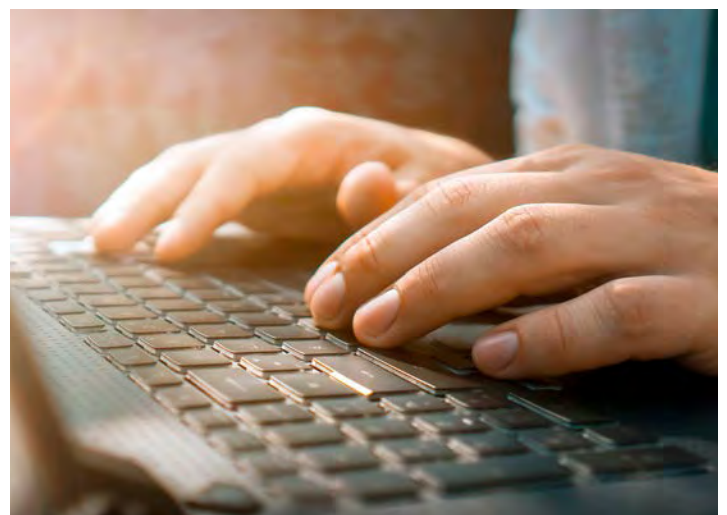
Intelligent Monitoring Dashboard Data Analysis Workstream - have continued to support Safety & Learning Networks to develop National dashboards, the latest of which are being built for Claims and Redress Networks to support the Learning from Events process.

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

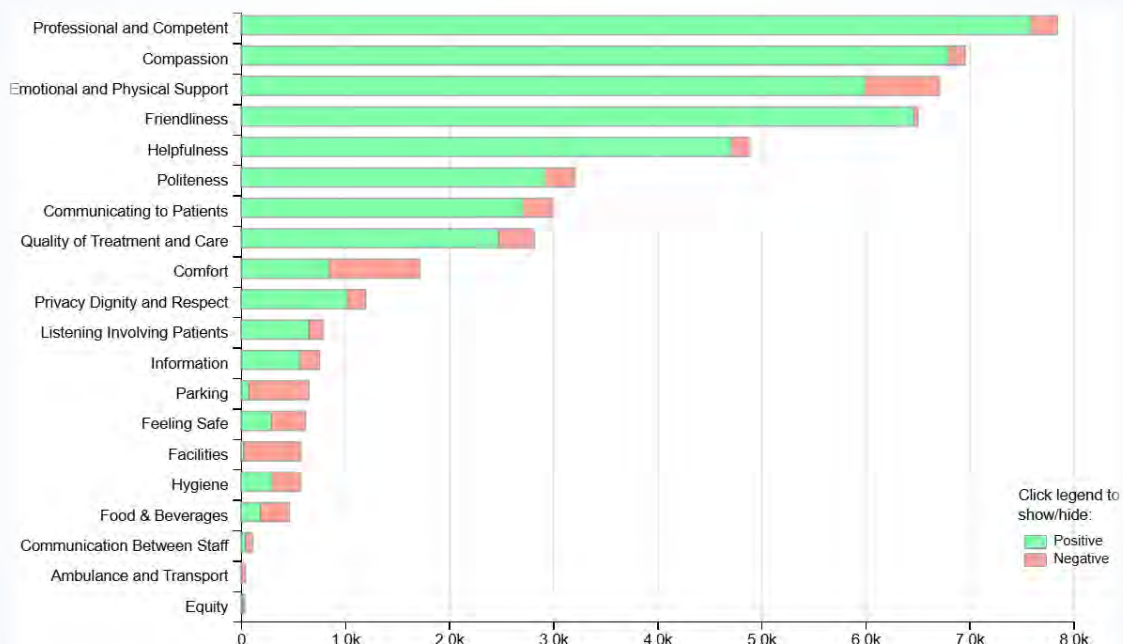


Fig.16 Example of sentiment analysis of positive and negative feedback

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)

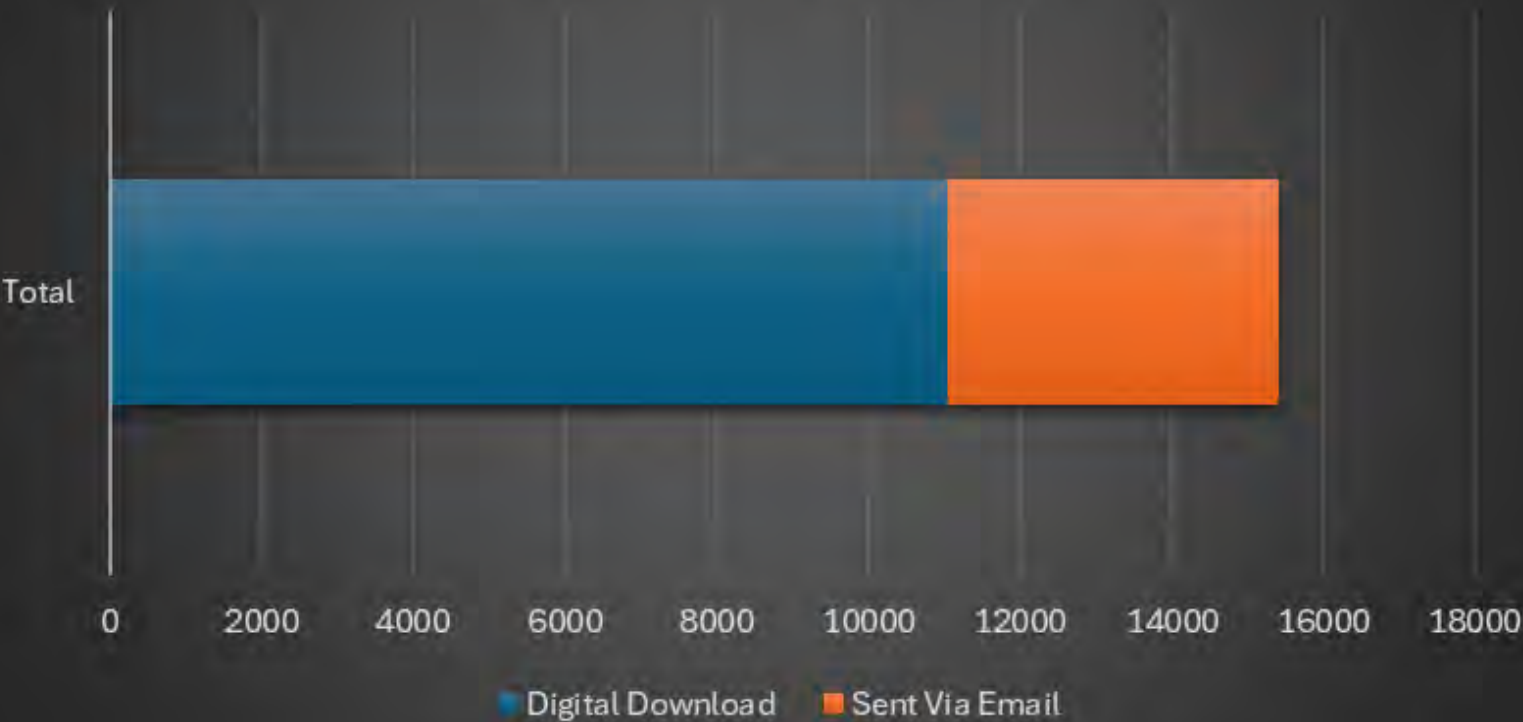
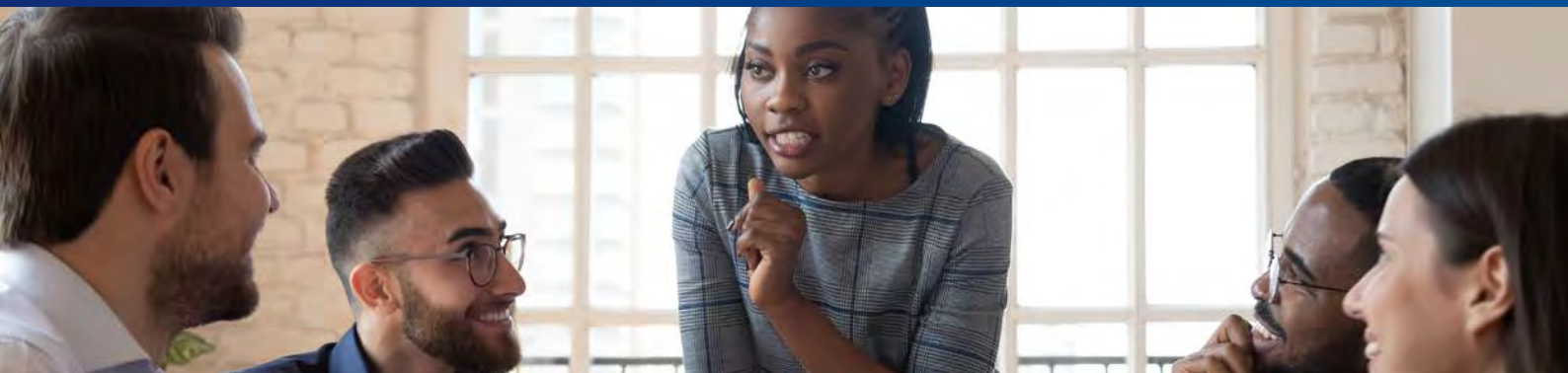


Fig.19 Distribution method of consent information leaflets, April and May 2025

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.

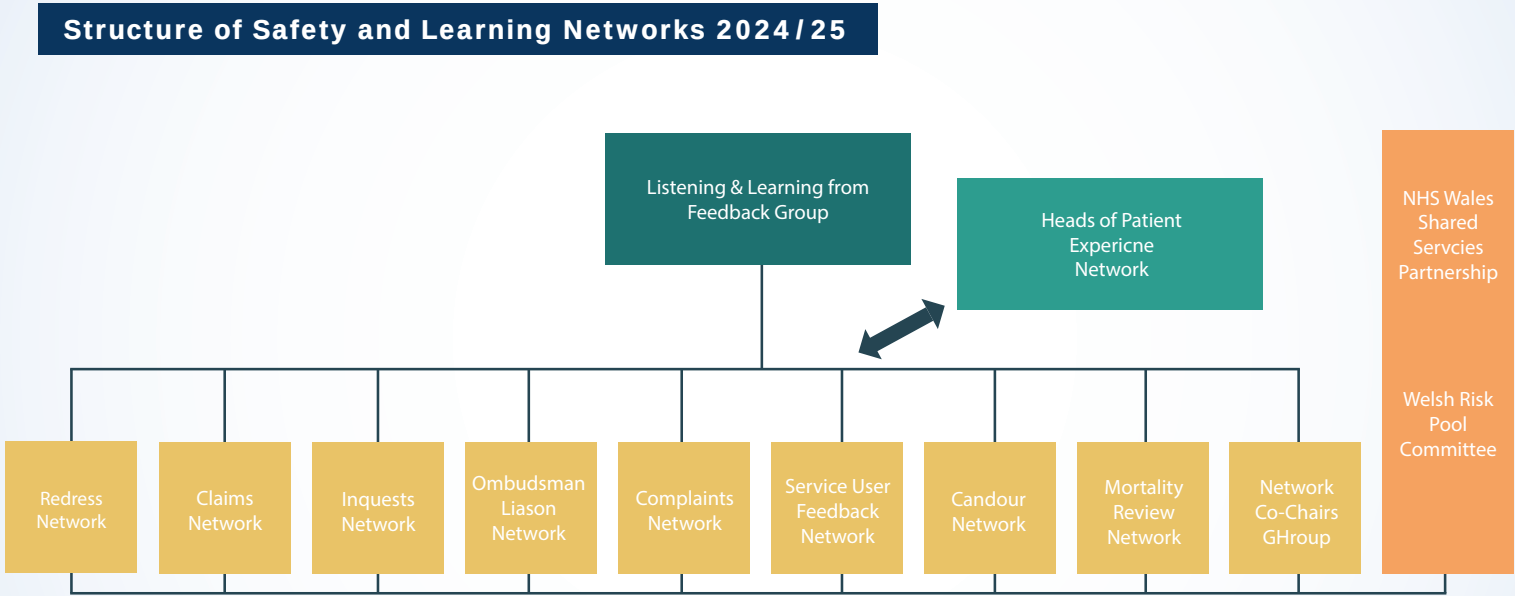


Fig.20 Structure of Safety and Learning Networks 2024/25

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

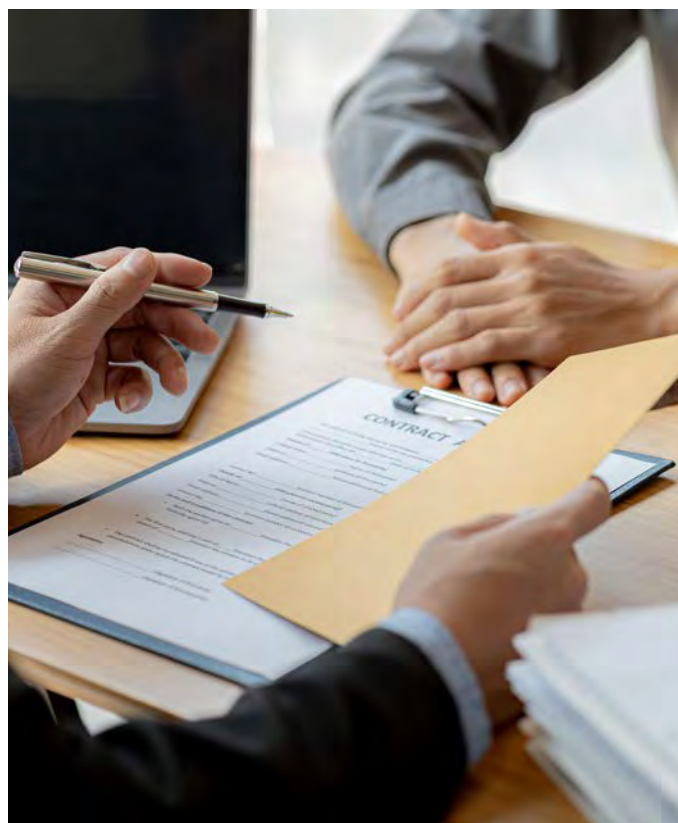


Our expert teams of clinical negligence lawyers manage all of the clinical negligence claims made against health bodies in Wales in respect of secondary health care. The caseload is approximately 1850 cases at any time and the potential cost to NHS in Wales is many millions of pounds.

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

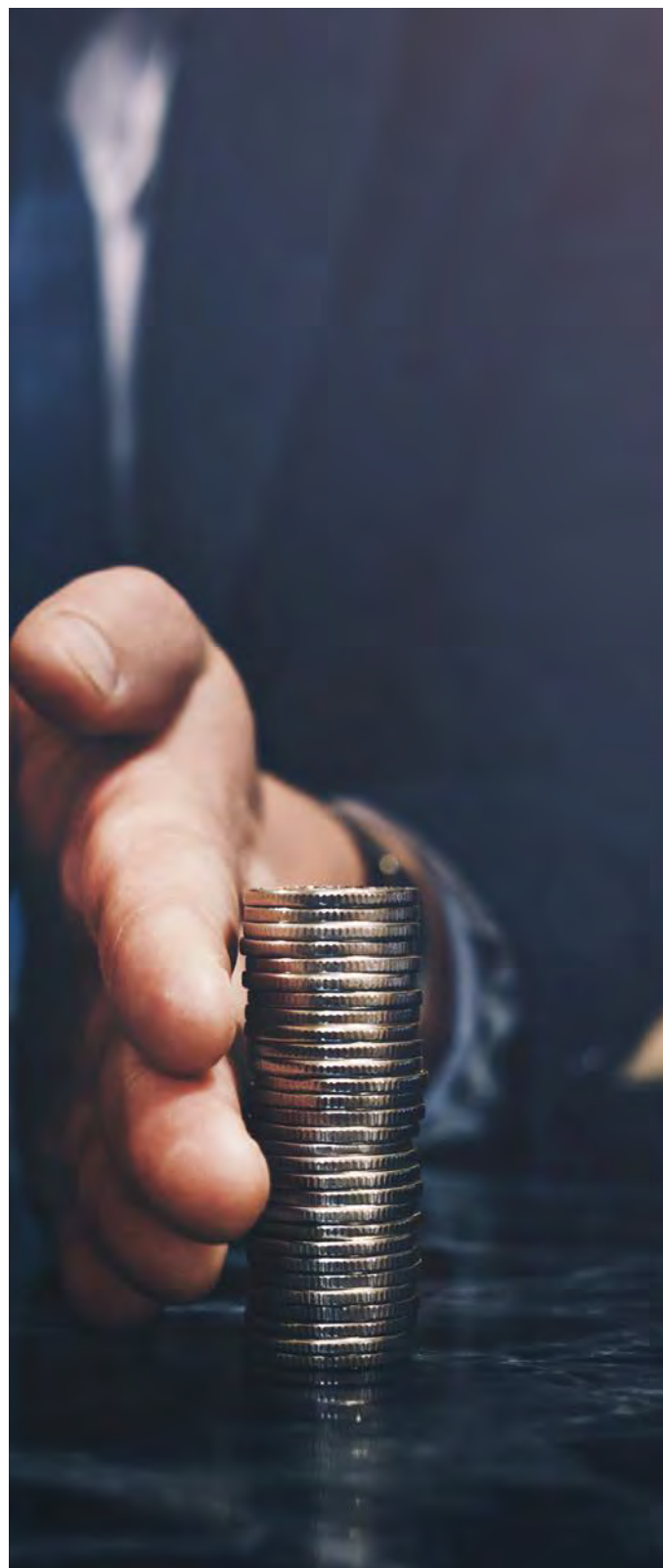
In addition to the payment of damages in claims which are settled, or where damages are awarded by a court, the Health Boards/Trusts have to pay the legal costs of claimants as well as incurring the costs of defending cases. In the majority of cases, even when we successfully defend a claim, the legal 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)

- » 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.

- » 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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Welsh Risk Pool and Legal and Risk Services Annual Review 2024-25

August 2025

4 - Clinical Care Group Update Reports

4.1

4.1 - Community and Integrated Medicine

***Anna Chiffi (Hywel
Dda UHB - Assistant
Director of Nursing,
Patient Safety,
Quality), Andrew
Carruthers (Hywel
Dda UHB - Chief
Operating Officer)***

Attachments

[CIMCCG Update report to QSEC.pdf](#)



BWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	04 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Care Group Quality Report – Community and Integrated Medicine Clinical Care Group
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Anna Chiffi, Assistant Director of Nursing, Quality and Patient Experience

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

This report details the quality governance arrangements within the Community and Integrated Medicine Clinical Care Group Care Group (CIMCCG) in relation to quality, safety and patient experience. It sets out achievements, progress and planned actions to meet our Duty of Quality, and is presented to the Quality, Safety and Experience Committee to provide assurance on the arrangements in place.

The CIMCCG is currently at Level 3 escalation for the quality domain and level 3 for the governance domain. As part of the escalation process, focused efforts are being made to address areas with action plans aimed at improving both the quality of care provided and robustness of governance mechanisms to meet expected standards. This report provides detailed insights into performance trends, highlighting areas that require improvement and actions in place to support this.

Cefndir / Background

The CIMCCG operationally leads and ensures the quality and safety of multiple services spanning Community and Acute settings.

The aim of the Care Group in summary is to:

- Ensure there is a process in place to continually monitor and review its risk register, acting to mitigate quality and safety risks on an ongoing basis;
- Maintain an open culture of improving quality, safety and patient experience across all teams and all staff;
- Promote a positive culture of staff engagement, development and understanding of everyone's responsibility for safe, quality care and
- Foster a culture of psychological safety within the Care Group in order to promote collaboration, trust, innovation and personal growth

Meeting the Duty of Quality is the highest priority for the Care Group and its governance structures and oversight has developed significantly. The Service Director, Associate Medical Director and Assistant Director of Nursing lead the agenda which is aligned to the six domains of quality as defined by the Duty of Quality Statutory Guidance 2023. This report is set out under each of these domains



Asesiad / Assessment

Quality Assurance

The Clinical Care Group Quality Governance meetings are planned every month, and are well represented by medical, nursing and managerial staff across all Service Groups, as well as other multi-disciplinary colleagues from across the Health Board, all of which take an active part in the meetings and shape the overall agenda. The Groups Terms of Reference and Work Plan are reviewed annually, and it is supported by subgroups.

Each system holds monthly Quality and Safety meetings, and further work is underway to strengthen this structure and reporting to the Clinical Care Group Quality Governance meeting.

Quality and Governance Areas of Escalation

Areas for improvement identified through the Health Boards escalation framework relate to 3 areas: complaints management, incident management and closure of overdue actions, timely investigations and improvements in relation to healthcare acquired infection, pressure damage and medication errors and understanding of the learning behind the unplanned admissions from wards to Intensive Therapy Unit (ITU).

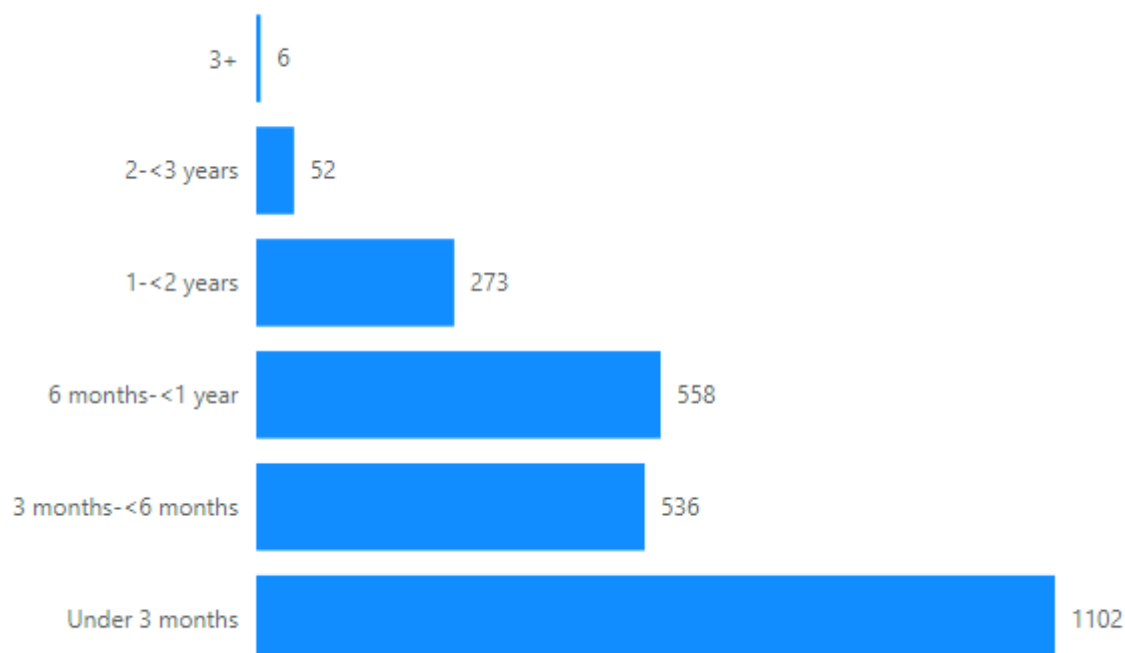
Updates in relation to these areas are contained under relevant STEEEP domains of the report.

A targeted plan with defined actions and owners is in place (see Action Plan Summary below).

Quality & Safety	3	Escalation assurance: 37% (last month 43%) For details please see the Our Safety dashboard. To also note - NRI closure compliance: 2 overdue and longest is 917 days	Incidents: The numbers open over 120 days and 60 days has deteriorated - improvement required Submission of outcome forms for overdue NRIs Complaints: improvement in complaints management Healthcare acquired infection: timely investigation and improvements Duty of Candour: improvement in timeliness of initial management review
Governance	3	Risk Management: 29% risk actions overdue Audits & inspections: Improving position with 38% of recommendations overdue. 75% no revised date WHCs: 1 out 2 overdue (50%)	Risk Management: 90% of risks and risk actions are reviewed within timeframes and compliance achieving TRS dates Audit/inspection recs implemented within timescales: Level 2: >80%, Level 1: >90% WHCs: Level 2: >80%, Level 1: >90%

Safe Care

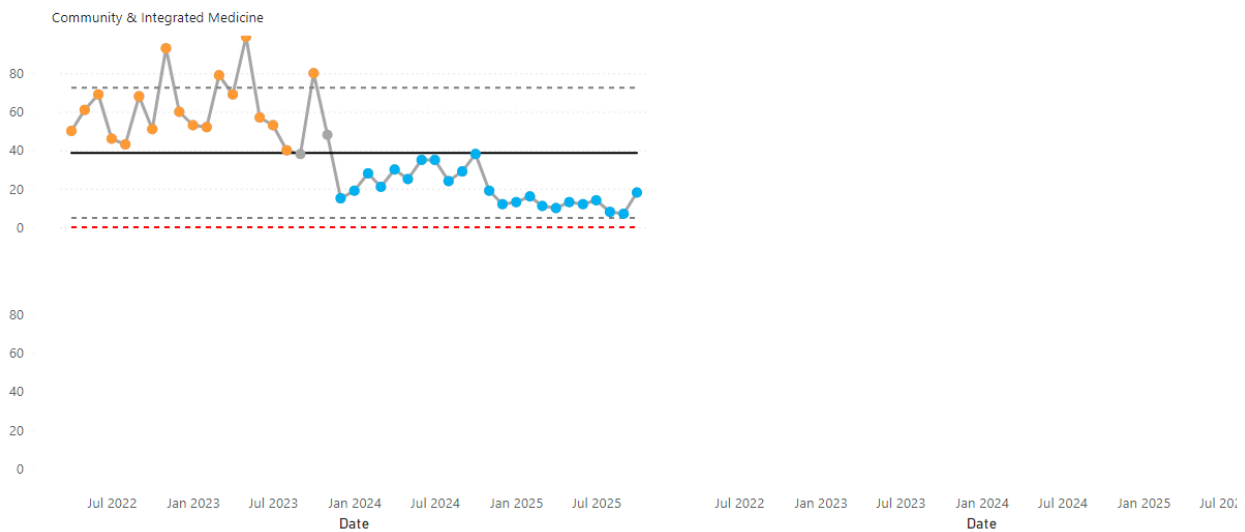
Incident Management



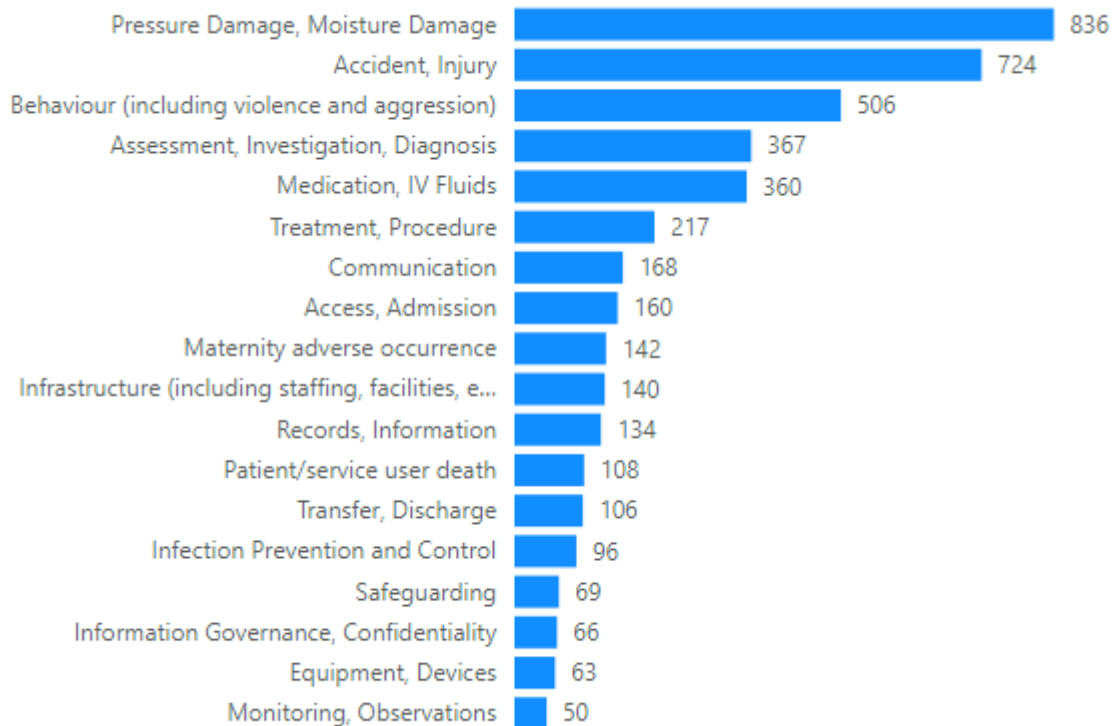
The chart above shows the total number of open incidents across the Clinical Care Group broken down by the length of time open.

While the overall number of open incidents has reduced, we still have a number of incidents open over both 60 and 120 days. Significant work is ongoing to reduce the incidents open over both 60 and 120 days and this focussed approach is demonstrating an improvement in our trajectory. We are holding focused meetings for areas with the highest non-compliance and allocating dedicated time for our ward managers and senior nurses to investigate, review and close. Delays have been noted due to paper-based notes having to be requested back from storage. The chart below shows the number of investigated incidents that are closed with moderate or worse harm. It is encouraging that our scrutiny panels and learning from events are having a positive impact on the severity of harm that is attributed.

- Graph showing total number of investigated incidents causing moderate or worse harm



This month we have hosted our first whole system learning meeting chaired by our Associate Medical Director. This forum will be held on a monthly basis and includes key clinical leads from across our care group services. The ambition of this forum is to provide a platform for learning from incidents, complaints and mortality reviews. This is predominantly achieved through the description of patient stories. Thematic analysis of our incidents will also be presented to this meeting alongside reviewing how we can ensure a more timely approach to closure. The graph below demonstrates our most prevalent themes.



Compliance with patient safety notices and alerts

The following Welsh Health Circular (WHCs) sit with the CIMCCG. All WHCs are managed via Audit Management and Tracking System (AMaT), which leads have access to directly update and upload relevant evidence to demonstrate compliance with their requirements.

Overdue WHCs

Welsh Health Circular	Reason for Red Status (from AMaT)	Impact of non-compliance according to risk assessment	Next Steps
006-24: National Clinical Guideline for Stroke, for the UK and Ireland – issued March 2024	The WHC cannot be implemented until the Clinical Services Plan has been completed (Stroke Services are part of this wider plan as there is a current lack of resource, including staffing, equipment and environment).	Risk Ref: 233 Current Risk Score: 12 Impacts: Delayed assessment and treatment of patients; Increased length of stays	At the last CCG Quality meeting it was discussed that the Stroke Team to review the QIA and a revised QIA to come back through the CCG before being resubmitted.

In progress WHCs

Welsh Health Circulars	Update from AMaT	UHB implementation date
041-24 Ambulance patient handover guidance – issued October 2024	- Information on Ambulance Handover Guidance circulated with IQFPD Groups, SBAR completed. - Welsh Government Reviewing Ambulance Handover in GGH on the 19th March 2025. Once findings from review are shared with the Health Board we will develop a delivery plan (end of Q1 25/26). - Progress will be monitored by IQFPD and expected completion date end of Q3 25/26.	December 2025

Safeguarding

While safeguarding reviews are ongoing at individual community and acute site level, the Care Group does not feel confident that overall assurance is received through the Care Group Quality and Safety Group. The safeguarding escalation is aligned to the previous Health Board structure and needs aligning to the revised system way of working. Following discussions with other care groups alongside our Executive Director of Nursing, Quality and Patient Experience, it has been confirmed that a revised process is introduced. The CIMCCG will move towards a Care Group wide safeguarding steering group on a quarterly basis. This will be chaired by the Assistant Director of Nursing, Quality and Patient Experience and feed directly into the quality and safety meeting to enable ongoing escalation and assurance.

The Quality and Safety Integrated Governance Group has noted concerns in training compliance for Children Safeguarding, Adult Safeguarding (Level 2 and Level 3) and Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV). This is accompanied by concerns in relation to:

- Operational pressures in Emergency Departments (EDs)
- Continued missed opportunities for children safeguarding referrals
- Restrictive practice review

The revised Care Group approach will support in the review of safeguarding data and evaluate assurance levels and address areas where confidence is lacking.

Infection prevention and control

Department, ward or team	Cumulative cases 2025/26	Cumulative cases 2024/25	Latest in-month cases
GGH AE	92	129	16
BGH Emergency & Urgent Care Centre	50	100	10
WGH Accident and Emergency	75	150	8
PPH AMA Unit	34	68	7

The table above shows the total number of health care acquired infections per month within the top four areas presenting the highest number of cases. The Health Board continues to be monitored under the targeted intervention framework for C.

difficile, E.coli and S. aureus infections. Reduction expectations have been set at 40% for C.difficile, 20% E.coli and 25% for S.aureus. The last month has also seen an increase in respiratory outbreaks alongside COVID. A recurring theme in the outbreaks has been the transfer of patients pending screening results without communication of suspected infection. All suspected and confirmed cases of infection should be isolated, and such patients would not be suitable for boarding given 'Our Next Patient' protocol.

Mandatory Asceptic Non-Touch Technique (ANTT) E-learning and 3 yearly practical competency assessment for all staff that perform ANTT procedures.

CIMCCG ANTT compliance- 86.32% %

Infection Prevention and Control Level 2 Mandatory training for clinical staff is available below.

Mortality reviews

The mortality review figures demonstrate a significant number of unresolved investigations across the three systems dating back to 2021.

Given the complexity and depth of investigation required to thoroughly undertake these reviews, current capacity is insufficient to complete them in a timely manner. The Clinical Care Group has agreed to explore whether there is opportunity to review the current practice and support with additional resource to reduce the backlog of cases. Clinical leads have now been assigned to support in the process alongside the introduction of heads of governance, workforce, innovation and research and teaching and education. This will provide a robust mechanism around mortality, Datix, and complaints from a clinical perspective.

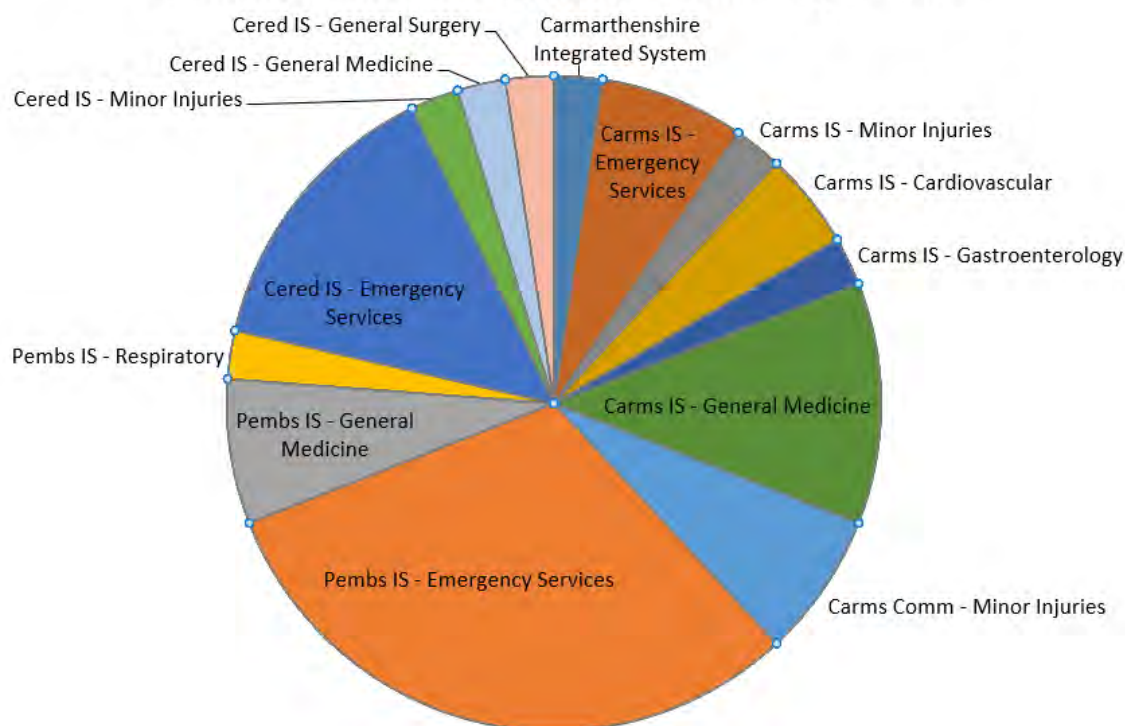
Claims and redress

Across all Health Board services, there are 229 confirmed Clinical Negligence Claims open of which 42 relate to CIM, with estimated damages on Datix of £10.1m and claimant's costs of £2.5m, assuming all claims are proven and settled.

N.B. The Health Board may seek reimbursement of its losses in Claims (*save for the first £25,000 excess*) subject to Approval of a Learning from Events Report.

Confirmed redress claims currently total 59.

Confirmed Clinical Negligence Claims by Service



Relevant risk recorded on the risk register (high or extreme risks)

Governance escalation- Improvements required for de-escalation

Improvements needed	Current position (as at October 2025 month end) – Level 3 (TBC)
Between 80-89% compliance for risk and risk actions being updated within required timescales for Level 2, over 90% compliance for Level 1.	19 of 98 risks overdue (19%) (Level 2- Sept 17%, Aug 19%) 48 of 167 risk actions overdue (29%) (Level 3 declining position- Sept 32%, Aug 28%)
Relevant risks articulated on risk registers with actions plans in place, and evidence that the CCG is delivering against these (e.g. specific and measurable risk action plans, current score and target risk score clearly articulated, achieving expected target risk dates)	6 risks require 'Expected date to achieve TRS' to be added (see slide 6) 12 risks require 'Rationale for the Target Risk Score' to be added (see slide 7) 3 risks had been reviewed which had an 'Expected Date to achieve TRS' which has passed and not been revised (see slide 8) 4 risks have no open risk actions (see slide 9) - Risks are slow to be added to Datix for Carmarthenshire CSG (see slide 13)

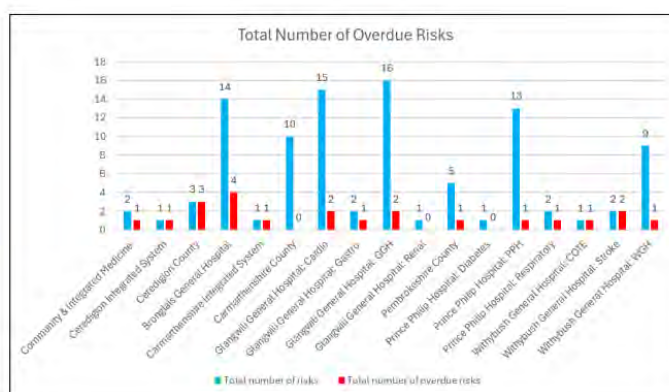
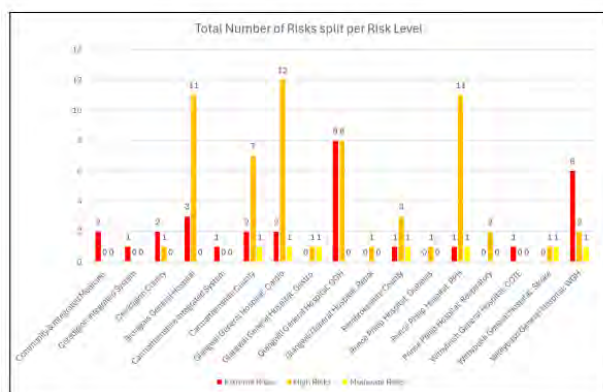
The table below provides a summary of the corporate risk 1027 which sits with CIMCCG. All Corporate risks were reported to Board September 2025.

Risk Ref	Title	Date Risk Identified	Current Risk Score	Risk Level (Current)	Target Risk Score	RR - Target Risk Score Expected Date	Directorate	Service/Department	RR - Clinical Sub-Group	Domain	Lead Committee	Date of Review	Review date	Approval status
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	19/11/2020	20	Extreme	8	31/03/2026	Community & Integrated Medicine	Community & Integrated Medicine	Community & Integrated Medicine	Safety - Patient, Staff or Public	Quality, Safety and Experience Committee	30/09/2025	30/10/2025	Corporate Risk

The table below provides the number of risks per sub-group and by current risk score level, including those that are overdue for review.

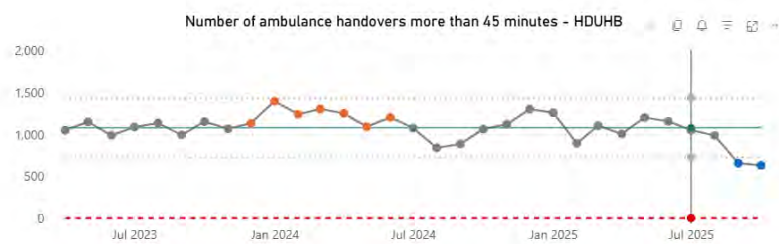
Clinical Service Sub-Group	Total number of risks	Extreme Risks	High Risks	Moderate Risks
Community & Integrated Medicine	2 (1 overdue- Corporate risk 1027)	2	0	0
Ceredigion Integrated System	1 (1 overdue- 2143)	1	0	0
Ceredigion County	3 (3 overdue- 1898, 2100, 2101)	2	1	0
Bronglais General Hospital	14 (4 overdue- 2141, 2171, 1238, 1764)	3	11	0
Carmarthenshire Integrated System	1 (1 overdue- 2110)	1	0	0
Carmarthenshire County	10	2	7	1
Glangwili General Hospital: Cardio	15 (2 overdue- 119, 1999)	2	12	1
Glangwili General Hospital: Gastro	2 (1 overdue- 2173)	0	1	1
Glangwili General Hospital: GGH	16 (2 overdue- 2072, 1992)	8	8	0
Glangwili General Hospital: Renal	1	0	1	0
Pembrokeshire County	5 (1 overdue- 1583)	1	3	1
Prince Philip Hospital: Diabetes	1	0	1	0
Prince Philip Hospital: PPH	13(1 overdue- 1530)	1	11	1
Prince Philip Hospital: Respiratory	2 (1 overdue- 105)	0	2	0
Withybush General Hospital: COTE	1	1	0	0
Withybush General Hospital: Stroke	2	0	1	1
Withybush General Hospital: WGH	9 (1 overdue- 1424)	6	2	1

GGH has the highest number of 'extreme' scoring risks with 8, followed by WGH with 6. Cardiology has the highest number of 'high' scoring risks with 12, followed by BGH and PPH with 11 each.



Timely

From 1 October 2025, a new standard was introduced, requiring ambulances to be handed over within 45 minutes of arrival at any of our acute hospital site. Significant planning took place throughout August and September 2025 in an endeavour to achieve this performance metric. The graph below demonstrates the significant improvement achieved both leading up to and following this date. A number of initiatives have supported this development including a reset week focussed on admission avoidance, a reset week dedicated to discharge planning alongside the introduction of 'our next patient', more efficient use of our discharge lounges and criteria led discharge.



The latest data is showing improvement. However, improvement actions need to be identified and successfully embedded for the target to be met.

Expected performance is between 728 and 1434

Key

- Upper and lower limits
- Mean
- Target
- Ambition

Variation - how are we doing over time

- Improving variation
- Usual variation
- Concerning variation

Assurance - performance against target

- Always hitting target
- Hit and miss target
- Always missing target

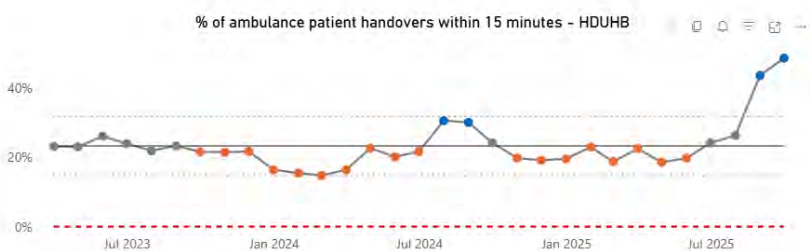
Trajectory - performance against our ambition

- Trajectory met
- Within 5% of trajectory
- More than 5% off trajectory

Latest period	National target	Target aim	Latest actual	Variation	Assurance	Trajectory
Oct 2025	0	Lower	630.0			

While it is important to acknowledge this improvement in handover performance and recognise the significant amount of work that has contributed to this outcome, it is important to highlight that this has shifted pressure and escalation across other areas in the hospital. Our surge and boarding numbers have increased in a situation of increased sickness amongst staff and infection control concerns within our clinical areas. It is important that we next focus our attention on pathway of care delays in order to maintain progress and ensure optimal patient flow throughout the coming months.

The graph below further demonstrates the improvement in ambulance handover time in less than 15 minutes.



The latest data is showing improvement and the target will be consistently met.

Expected performance is between 14.7% and 31.7%

Key

- Upper and lower limits
- Mean
- Target
- Ambition

Variation - how are we doing over time

- Improving variation
- Usual variation
- Concerning variation

Assurance - performance against target

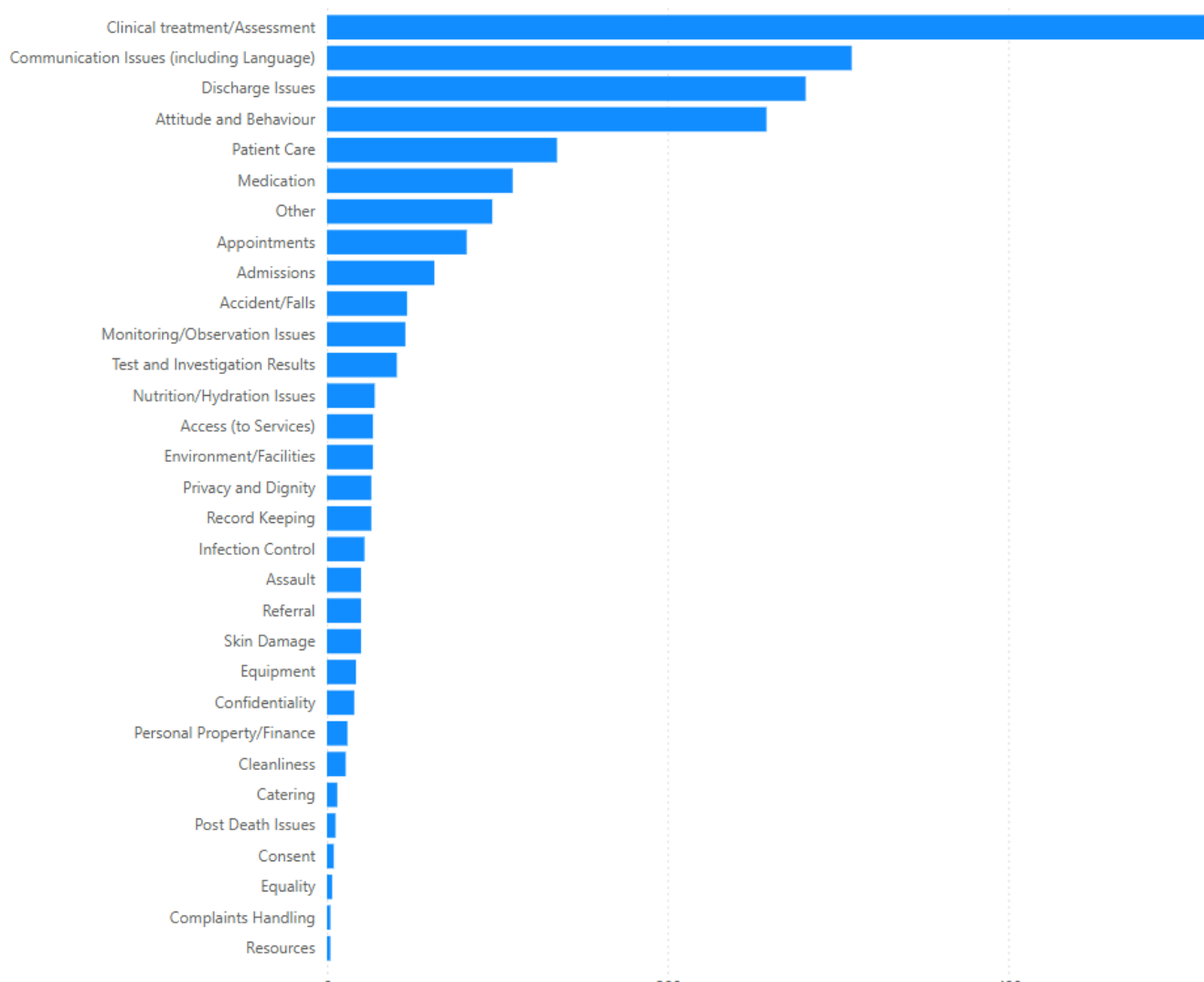
- Always hitting target
- Hit and miss target
- Always missing target

Trajectory - performance against our ambition

- Trajectory met
- Within 5% of trajectory
- More than 5% off trajectory

Latest period	National target	Target aim	Latest actual	Variation	Assurance	Trajectory
Oct 2025	0.00%	Higher	48.50%			

While there are not specific concerns in relation to timely care, the following graph provides a thematic evaluation which includes timely access to appointments, admissions, and equipment.



Effective

External Audit

Governance escalation- improvements required:

Improvements needed	Current position (as at October 2025 month end) – Level 3 (TBC)
Between 80-89% compliance for level 2, or over 90% compliance for level 1, with achieving original completion dates stipulated against recommendations.	101 of 267 recommendations overdue (38%) at Oct 25, compared to 124 (55%) last month. Whilst an improvement since the previous month, remains at less than 80% compliance. Apart from 4 which are overdue between 12-18 months (with Ceredigion), all others (97) are less than 6 months overdue, compared to 6 overdue between 12-18 months last month (slight improved position).
Where original completion dates have lapsed there is evidence that the service has <u>provided realistic revised completion dates</u> .	Of the 101 overdue recommendations, 76 (75%) do not have revised dates (N/K) at Oct 25, which whilst is an improvement on 106 (85%) noted in September 2025, is still below the 80% compliance target. The N/Ks are a mixture of no updates on AMaT, whilst others have updates and its either not clear what the revised date is, or it is noted that a revised timescale can't provide one at present (e.g. awaiting exec decision). Assurance and Risk Officer will be checking if any overdue recommendations should be amended to 'Pending Decision' on the audit tracker to provide better clarity of progress.
New reports are added onto AMaT with management responses within one month of being received.	Assurance and Risk Officer awaiting management responses on the following: - NHS Exec Assurance Review of Ambulance Patient Handover Process and Compliance with Guidance across NHS Wales - NHS Executive Report on Urgent and Emergency Care Opportunities: WGH site revisit - GIRFT GGH- Revisit

Reports currently open on AMaT assigned to the CCG are included in the table below. Revised implementation dates where applicable to be added to AMaT, and relevant evidence uploaded for completed recommendations. These now include the number of actions and recommendations (as one recommendation may include several actions).

Date of report	Report issued by	Report Title	Original Completion Date	Revised Completion Date	No. of recs in report	Overdue recommendations	Overdue with no completion date (Not known)	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
Jun-24	Peer Review	Getting It Right First Time (GIRFT) - Emergency Medicine	Oct-25	Oct-25	35	19 → (Actions = 25) BGH= 8 → GGH= 7 → WGH= 4 →	14 (Actions = 16) BGH=3 GGH=7 WGH=4	1 ↓ (Actions =1) BGH= 0 → GGH= 0 → WGH= 1 ↓	11 ↑ (Actions = 12) BGH= 0 GGH= 5 WGH= 6	2 (Actions =6) BGH=2 GGH=0 WGH=0	0	0	2 (Actions = 2) BGH=1 GGH=0 WGH=1	GIRFT GGH revisit Sept 2025 to be added to AMaT – please can management responses be shared with the Assurance & Risk Officer.
Jun-25	Internal Audit	Discharge Management (Follow Up) Final Internal Audit Report 2024/25	Mar-25	N/K	1	1 → (Actions =1)	1 (Actions =1)	0	0	0	0	0	0	1 recommendation assigned to Anna Chiffi, please update AMaT to confirm action taken and evidence to be uploaded.
May-25	Audit Wales	Urgent and Emergency Care: Arrangements for Managing Demand – Hywel Dda University Health Board	Dec-25	Dec-25	14	5 → (Actions =7)	5 (Actions =6)	3 → (Actions = 3)	5 ↑ (Actions =5)	1 (Actions=1)	0	0	0	Awaiting confirmation on who should be the action owner for recommendation 14 moving forward (see slide 9 for more detail)

Date of report	Report issued by	Report Title	Original Completion Date	Revised Completion Date	Number of recs in report	Overdue recommendations	Overdue with no completion date (Not known)	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
Jan-25	Ministerial Advisory Group (MAG)	Ministerial Advisory Group (MAG) - Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	Mar-26	Mar-26	15	7 ↓ (Actions =22)	7 (Actions =18)	5 → (Actions =5)	2 → (Actions =7)	1 (Actions =1)	0	0	0	When updates are provided on AMaT please state a clear revised date of completion in the 'Comments/Updates' section.
Mar-25	Royal College	RCN Workplace Inspection - WGH A&E Department	Aug-25	Aug-25	20	2 ↓ (Actions =2)	2 (Actions =2)	0 →	14 → (Actions =14)	4 (Actions =4)	0	0	0	
Feb-25	Royal College	RCN Health and safety workplace inspection- Corridor care and safe staffing BGH EUCC February 2025	Sep-25	Sep-25	11	4 ↓ (Actions =4)	4 (Actions = 4)	0 →	4 ↑ (Actions =4)	3 (Actions =5)	0	0	0	

Date of report	Report issued by	Report Title	Original Completion Date	Revised Completion Date	Number of recs in report	Overdue	Not Knowns	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
Oct-24	NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	Nov-25	Nov-25	58	39 ↓ (Actions=48)	35 (Actions=42)	0 → (Actions=1)	13 ↑ (Actions=22)	4 (Actions=5)	0	0	2 (Actions=2)	When updates are provided on AMaT please state a clear revised date of completion in the 'Comments/Updates' section. Have, or is there a revisit planned?
Mar-25	NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	Apr-26	Apr-26	38	17 ↓ (Actions=15)	7 (Actions=7)	1 ↓ (Actions =1)	18 ↑ (Actions=18)	2 (Actions=4)	0	0	0	
Jan-25	NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	Aug-25	Aug-25	19	6 ↓ (Actions =6)	6 (Actions =6)	0 →	11 ↑ (Actions=11)	0	0	0	2 (Actions =2)	Can the WGH management responses from the revisit be shared with the Assurance & Risk Officer for adding to AMaT.
Feb-25	Royal College	RCN Health and Safety Workplace Inspection AMAU Prince Philip Hospital February 2025	May-25	May-25	7	0	0	0	7 → (Actions=11)	0	0	0	0	All recommendations implemented- evidence to be shared with Director of CCG and Assistant Director NQPE for approval.
Aug-25	HIW	Mynydd Mawr Ward, Prince Philip Hospital	Oct-25	Oct-25	24	7 ↑ (Actions=14)	7 (Actions =14)	6 ↑ (Actions=6)	12 ↑ (Actions=36)	0	0	0	0 (Actions=1)	Any queries to be signposted to the QAST team for HIW reports.
Jun-25	Public Service Ombudsman	PSOW 202403652	Dec-25	Dec-25	5	0 →	0	4 → (Actions=4)	0	1 → (Actions=1)	0	0	0	Any queries to be signposted to the Ombudsman Case Manager for PSOW reports.
Sep-25	HIW	Derwen Ward, Glangwili General Hospital	Nov-25	Nov-25	9	8 (Actions=14)	8 (Actions=14)	0 (Actions=3)	1 (Actions=23)	0 (Actions=14)	0	0	0	Any queries to be signposted to the QAST team for HIW reports.

Date of report	Report issued by	Report Title	Original Completion Date	Revised Completion Date	Number of recs in report	Overdue	Not Knowns	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Comment
Sep-25	Internal Audit	Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26	Dec-25	Dec-25	6	0	0	5 (Actions=5)	1 (Actions=1)	0	0	0	0	Limited assurance therefore follow up will be undertaken
Aug-25	Audit Wales	Discharge Planning Progress Update – Hywel Dda University Health Board August 2025	Mar-26	Mar-26	1	1 (Actions=2)	1 (Actions=2)	0 (Actions=2)	0	0 (Action=1)	0	0	0	2 actions became overdue at end of Oct 2025, please can an update be provided via AMaT.
Feb-25	Royal College	RCN Health and safety workplace inspection- Emergency Department GGH February 2025	Nov-25	Nov-25	4	0	0	3 (Actions=14)	0	1 (Actions=12)	0	0	0	
Oct-25	HIW	HIW Inspection BGH Emergency Department October 2025	Mar-27	Mar-27	29	20 (Actions=32)	20 (Actions=31)	9 (Actions=35)	0	0 (Actions=7)	0	0	0	Any queries to be signposted to the QAST team for HIW reports.
Mar-24	HEIW	Trauma and Orthopaedics Glangwili Hospital March 2024	Aug-24	Aug-26	8	0	0	0	7 (Actions 10)	0	0	0	1 (Actions=1)	Remaining action sits with Carms, evidence to be uploaded to AMaT to close remaining action.
Total numbers						137 (Actions=192)	117 (Actions=163)	36 (Actions=80)	106 (Actions=174)	10 (Actions=61)	0	0	7 (Actions=8)	

Reports to be added to AMaT:

- NHS Exec Assurance Review of Ambulance Patient Handover Process and Compliance with Guidance across NHS Wales.

Clinical Audit Programme

A total of 16 mandatory clinical audits fall within the remit of this group (previously 13 however, individual Diabetes Components/Audits are now listed separately and the inclusion of the Core, Primary Care National Chronic Obstructive Pulmonary Disease (NCPD) Audits.

The table below provides a brief overview of the status of each of the NCAORP audits.

	Title	Lead(s)	Status	RAG
CARDIOLOGY	Myocardial Ischaemia National Audit Project (MINAP)	Dr Clive Weston Paul Smith - SDM	All action plans up to date – no outstanding items Participation concerns	Amber
	National Heart Failure Audit (NHFA)	Dr Clive Weston Paul Smith - SDM	All action plans up to date – no outstanding items Participation concerns	Amber
	National Audit of Cardiac Rehabilitation (NACR)	Dr Clive Weston Paul Smith - SDM	Action plan implementation (overdue) 01/01/2022-31/12/2022 Report date: 2023 Action plan overdue 01/01/2023-31/12/2023 Report date: 2024	Red
	National Audit of Cardiac Rhythm Management (NACRM)	Dr Clive Weston Paul Smith - SDM	All action plans up to date – no outstanding items	Green
RESPIRATORY	Chronic Obstructive Pulmonary Disease (COPD)	Prof. Keir Lewis Anna Thomas - SDM	All action plans up to date – no outstanding items	Green
	Adult Asthma (AA)	Dr Mark Andrews Anna Thomas - SDM	All action plans up to date – no outstanding items	Green

	Wales Primary Care Audit (Asthma & COPD)	Claire Hurlin, SDM - awaiting clinical lead	All action plans up to date – no outstanding items	Green
	National Lung Cancer Audit (NLCA)	Dr Robin Ghosal Anna Thomas - SDM	Action plan overdue: Jan 22 - Dec 22 Jan 23 - Dec 23 Action plans being worked on.	Red
CARE OF THE ELDERLY	National Audit of Dementia (NAD)	No HB Lead BGH – Dr Annette Snell PPH – Dr Andrew Haden GGH – Dr Nicholas Coles WGH – Dr Sarah Davidson SDM – Sally Farr	Action plan overdue: 2023 2024 (awaiting 2 sites)	Red
	Stroke Sentinel National Audit Programme (SSNAP)	Dr Senthil Kumar SDM - Sally Farr	Action plan overdue: 2022 2023 2024 Joint undertaking to complete action plans being scheduled.	Red
	Fracture Liaison Service (FLS)	Dr Will Backen SDM - Sally Farr	All action plans up to date – no outstanding items	Green
	National Audit of Care at the End of Life (NACEL)	Dr Rebecca Croft SDM - unknown	Action plan overdue: 12/04/2021 - 31/05/2021 Report date: 2021/22 01/04/2022 - 31/05/2022 Report date: 2022/23 Action plan required 01/01/2024 - 31/12/2024 Report date: 2025	Red
	National Audit of Inpatient Falls (NAIF)	Anna Chiffi SDM - Sally Farr	Action plan implementation (overdue): 2021 2022 2023	Red
DIABETE	National Diabetes Foot Care Audit (NDFA)	Anna Thomas – SDM awaiting new clinical lead	Action plans overdue: Apr 21 - Mar 22 Apr 22 - Mar 23	Red

		Action plans are being worked on within the next 2 weeks	
National Core Diabetes Audit (NCDA)	Anna Thomas – SDM awaiting new clinical lead	No lead. Not being undertaken. SDM adding to Risk Register.	Red
National Diabetes Inpatient Safety Audit (NDISA)	Anna Thomas – SDM awaiting new clinical lead	No lead. Not being undertaken. SDM adding to Risk Register.	Red

The National projects highlighted above are being reviewed and discussed at the system CIM groups.

Meetings were held on 15 October 2025 and 10 November 2025 with Clinical Audit leadership and Clinical Leads to discuss progressing NCAORP audits.

A number of action plans have been submitted in recent weeks, with more expected shortly. However, some areas show little or no progress to date and may require additional support.

Evidence based

Nice Guidance

The CIMCCG currently has 48 applicable Nice Guidance statements, with three overdue and actions still outstanding. This has been escalated with System General Managers (GMs) requesting a completion trajectory and details of any associated constraints to be presented to the next CCG meeting.

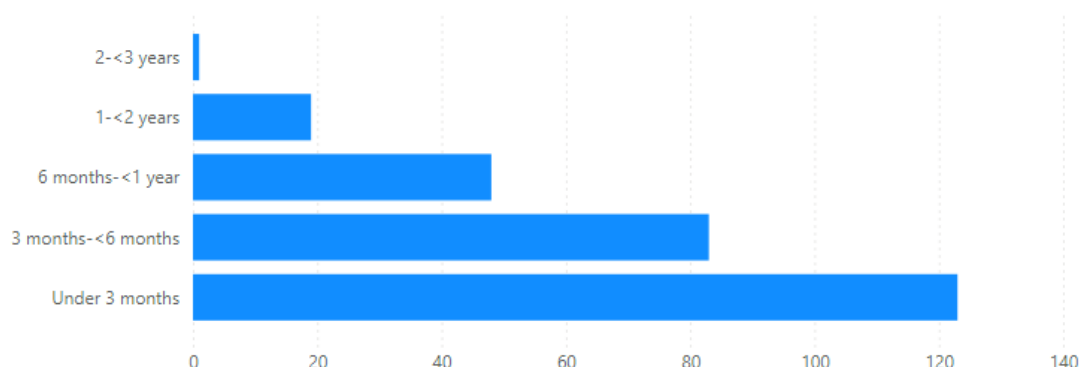
Equitable

No additional updates available.

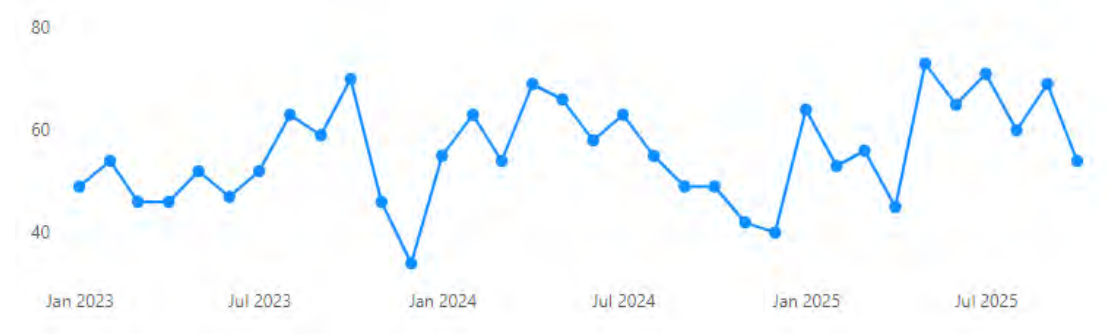
Person Centred

Patient experience

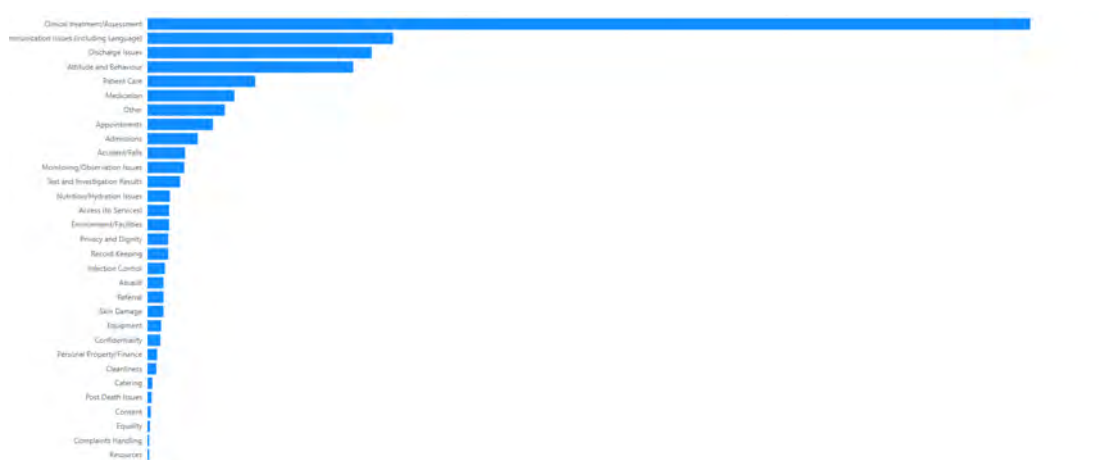
The graph below shows the length of time our complaints have been open.



The graph below shows the number of new complaints received per month.



The most common themes and trends are displayed below.



These themes will be presented to our whole system learning events to ensure robust sharing and understanding of learning following investigation.

Action Plan Summary (targeted areas of escalation)

Domain	Issue/Theme	Key Actions	Owner	Due Date	Status
Safe	Complaints management – timeliness & quality	Weekly tracker review; SOP refresh; training; learning logs to Q&S	CG ADoN	30 April 2026	In progress
Safe	Incident management – overdue actions; HCAI/pressure/ med errors	30-day close focus; safety huddles; targeted IPC & pressure care bundle; meds safety audits	Service Leads	30 April 2026	In progress
Safe	Unplanned ITU transfers	Trigger tool review; case note review; escalation	AMD/ ADoN	28 February 2026	In progress

		criteria refresh; SBAR from wards to outreach			
Timely	Waiting times & access constraints	Capacity & demand review; additional clinics; discharge-to-assess pathways strengthened	Ops Managers	31 March 2026	Planned
Effective	Audit completion & QI measurement	Re-baseline audit plan; QI measurement plan; monthly run charts	Audit Lead	31 January 2026	In progress
Evidence-based	NICE/Standards compliance gaps	AMAT action plans; SOP updates; compliance audits	Clinical Leads	31 March 2026	Planned
Equitable	Interpreter access & reasonable adjustments	Awareness campaign; booking SOP; monitoring; feedback loop	Patient Experience	31 January 2026	In progress
Person-centred	Complaints themes & PSOW learning	Thematic review; learning panels; "You said, we did" publication	PE Team	31 January 2026	In progress

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to take an assurance on the quality governance arrangements in place within the Community and Integrated Medicine Clinical Care Group in relation to quality, safety and patient experience.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 Scrutinise, assess and seek assurance in relation to the patient impact, quality and health outcomes of the services provided by the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:	

Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	
Amcanion Strategol y BIP: UHB Strategic Objectives:	
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termiau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofïod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Contained within the report
Gweithlu: Workforce:	Contained within the report
Risg: Risk:	Contained within the report
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable

Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

4.2

4.2 - Operational Allied Health Services

***Andrew Carruthers
(Hywel Dda UHB -
Chief Operating
Officer), Angela Bell
(Hywel Dda UHB -
Assistant Director
Quality, Safety +
Patient Experience
for Allied Health +
Health Sciences)***

Attachments

[Clinical Care Group Update to QSEC 2025-12-04 - Operational Health Science.pdf](#)



Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	04 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Care Group Update Report – Operational Allied Health and Health Science
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Sara Quarrie, Service Group Director, Allied Health and Health Science Clinical Care Group Angela Bell, Assistant Director of Quality, Safety and Patient Experience, Allied Health and Health Science Clinical Care Group

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report details the quality governance arrangements within the Allied Health and Health Science Clinical Care Group in relation to quality, safety and patient experience. It sets out achievements, progress and planned actions to meet our Duty of Quality, and is presented to the Quality, Safety and Experience Committee to provide assurance on the arrangements in place.

The Allied Health and Health Science Clinical Care Group is currently focusing on the need to improve performance regarding the Level 2 status for the Quality and Safety domain. This report provides detailed insights into performance trends, highlighting improvement and identifying actions in place to support further progress.

The report also details the result of a sustained six-month focus within the Governance domain, which has resulted in the CCG improving to Level 1 since September 2025. Plans to maintain this level are outlined.

Cefndir / Background

The Allied Health and Health Science Clinical Care Group consists of seven service areas: Nutrition and Dietetics; Occupational Therapy; Pathology; Podiatry; Physiotherapy; Radiology; and Speech and Language Therapy.

The aim of the Allied Health and Health Science Care Group in summary is to:

1. Ensure there is a process in place to continually monitor and review its risk register, acting to mitigate quality and safety risks on an ongoing basis;
2. Maintain an open culture of improving quality safety and patient experience across all teams and all staff;

3. Promote a positive culture of staff engagement, development and understanding of everyone's responsibility for safe, quality care;
4. Foster a culture of psychological safety within Allied Health and Health Science Care Group to promote collaboration, trust, innovation and personal growth. Meeting the Duty of Quality is the highest priority for the Care Group and its governance structures and oversight has developed significantly.

The Service Director, and Assistant Director of Quality Safety and Experience lead the agenda which is aligned to the six domains of quality as defined by the Duty of Quality Statutory Guidance 2023.



Asesiad / Assessment

The Allied Health and Health Science Care Group was established in April 2025, with newly appointed Service Group Director and Assistant Director of Quality Safety and Patient Experience.

Quarter one has focused on establishing governance structures and collaboration across the Health Board functions. The initial priority was to gain access to the root data to allow analysis and immediate actions in relation to the position shown within the Health Board Performance and Safety dashboards.

Quarter Two has allowed the CCG to begin to embed ways of working to track progress against the metrics of improvement identified by the Health Board escalation Framework. Updates in relation to these areas are contained under the Safe, Timely, Effective, Equitable, Efficient and Person Centred (STEEEP) domains of this report.

The focus for Quarter Three and Quarter Four will be the embedding of CCG Quality Safety Experience management system processes within each service. Thereafter the shift will be to identifying profession specific quality metrics and triangulation of themes from learning to drive improvement.

Quality Assurance

The Clinical Care Group (CCG) Integrated Governance meetings are scheduled every month and are well represented by professional leaders from all Services, all of which take an active part in the meetings and shape the overall agenda. The CCG would like to flag that they value continued support from business partners and view escalation, assurance and oversight at the CCG meetings as essential to governance. Each Service provides a monthly assurance report from their Quality and Safety meetings.

A key focus of the Clinical Care Group leadership has been to deep dive into domains of escalation to understand the root data and progress rapid improvement. This report will concentrate on the following areas:

- Quality and Safety
 - Improvement in number of incidents open over 120 days
 - Review of complaints open over 180 days
 - Actions to respond to 75% of complaints within 30 days
- Governance
 - Achievement of 90% of risks and risk actions reviewed within timeframes.
 - Actions to support compliance achieving Target Risk Score dates

Safe Care

Incident Management

From June 2025 each Service Lead has an allocated monthly Governance 1-1 meeting with support from a Quality, Assurance Service Team (QAST) business partner. This ring-fenced time is utilised to resolve outstanding queries for open incidents and reduce the exchange of emails regarding queries and actions. The aim is to have dedicated time to build a positive incident reporting and management culture. This approach has supported timely incident management, with a view achieving a trajectory of zero incidents open over 120 days. Progress to date can be seen in Figure 2:

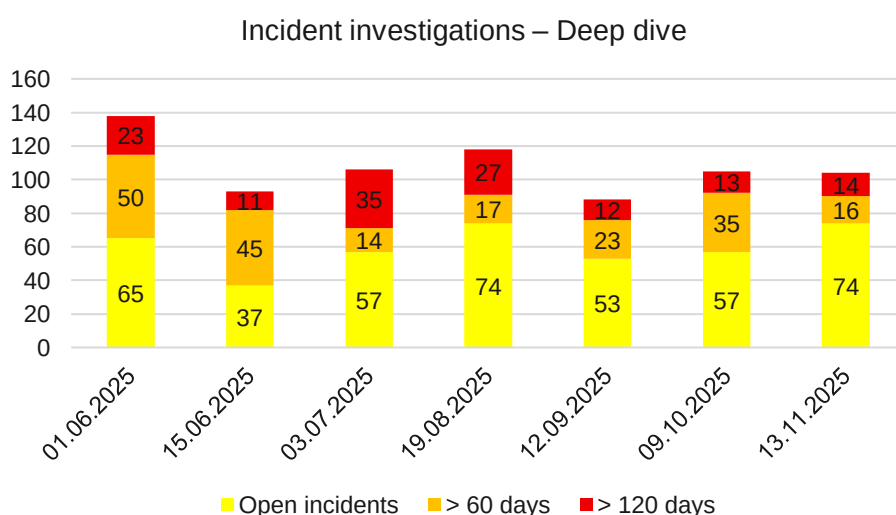


Figure 2 Number of open incidents reported by month- AH & HS CCG - [Data as of 13/11/25]

To date this structured approach has resulted in an overall reduction in overdue open incidents by 59% (n73 to n 30) from June to November. There has been a 39% reduction in incidents open >120 days (n 23 to n14) and a 68% reduction in incidents open > 60 days (n50 to n16).

Once timely incident management has been achieved, the next step will be to focus on analysis of incident themes to drive improvement.

Data shows that most incidents within the CCG are reported within Radiology and Pathology Services. The most frequent incident type being consistently reported as 'assessment, treatment and diagnosis', with the theme of waiting times. This maps to the workforce capacity within these services and the resulting mitigating actions being taken by service leads.

The CCG is working to build a culture of high levels of incident reporting of low and now harm. This is an iterative process alongside the need to triangulate themes to drive improvements. Currently the CCG data provides a picture of month-on-month variability in number of incidents reported, this is expected as the incident CCG reporting culture evolves. The grouped CCG service data shows peaks in June (n= 73) and July (n=69), which is attributed to increased reporting within the Allied Health Professions, with no identified themes or trends due to the grouping of 5 professions within this dataset. Action has been taken to request amendment to the Allied Health professions (AHP) grouping which would allow analysis within the AHP services.

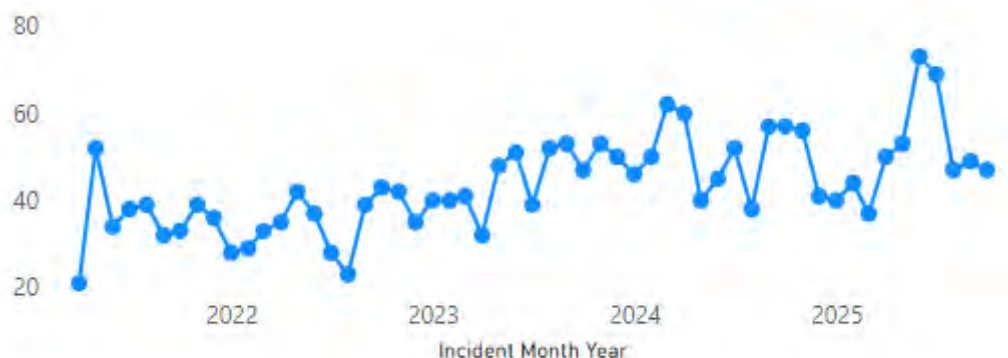


Figure 3 Number of incidents reported by month- AH & HS CCG - Our Performance Dashboard [Data as of 12/11/25]

Timely

Radiology and Pathology Services are both acknowledged as fragile services, which impacts the ability to deliver timely diagnostics.

Radiology

The Radiology Level 2 fragile service has £3.4m Annual Plan funding being implemented to support some stability of service. Of note, is the extremely fragile Radiology leadership workforce throughout Quarters one and two. Support from CCG Leadership in place. Prioritisation is being utilised, with a focus is on cancer pathways, but the expectation is that there will be slippage in ability to meet all requirements of assurance. The current priority is high-risk patients, staff support, and providing assurance of sharing of learning and actions from claims and redress cases, to meet the requirements for Welsh Risk Pool Learning Events.

Pathology

The Pathology Level 2 fragile service is due to Cellular pathology and Clinical haematology workforce remaining fragile, due to the long-standing challenges to recruit to consultant posts. The services are backfilling with temporary staffing to ensure capacity to deliver timely diagnostics whilst the medium-term workforce plan to recruit to substantive posts is in progress. The fragile workforce model impacts on timely diagnostics, and potential service disruption for

planned and unplanned services to meet patient needs and inherent safety, clinical effectiveness and patient experience outcomes. The Pathology senior leadership team completed a risk fragility assessment workshop in May. The output has been utilised to further mitigate current service delivery risks.

Actions to date have focused on workforce redesign. Successes include:

- i. Recruitment to Clinical Nurse specialist roles from a vacant Consultant post.
- ii. Creating 2 Associate Practitioner posts from a Specialist Biomedical Scientist Vacancy, which will increase service capacity, and assist with managing the annually increasing workload demands.

The more capacity created within the service the better we will be equipped to continue to deliver timely diagnostics to our patients. International recruitment and recruitment via NHS locum are progressing as planned, with 2-year training and mentorship programmes are in place to enable long-term appointment to consultant roles

Effective

The CCG has sustained a six-month focus on the effective management of the operational Allied Health and Health Science risk register. Risk workshops have commenced within each service. The initial focus has been to ensure that all service risks are captured and have mitigating actions. This has resulted in a 40% increase (n83 to n116) in open risks with a concurrent 39% increase in open actions, between June and November 2025, as illustrated by comparison of tables 1 and 2 below.

Risk overview

Open risks	Risks overdue	% overdue	Open actions	Actions overdue	% overdue
83	20	24%	158	22	14%

Table 1 CCG risk overview [Data as of 06/06/25]

Open risks	Risks overdue	% overdue	Open actions	Actions overdue	% overdue
116	2	2%	220	31	14%

Table 2 CCG risk overview [Data as of 03/11/25]

The CCG has established service management systems to ensure risks are reviewed within target timeframes and risk actions are completed. This has resulted in CCG improving to level 1 within the Governance domain. This progress is illustrated by the 'percentage risk overdue' dataset within tables 1 and 2 above, improving from 24% of risks being overdue review to just 2 % overdue in the six-month period.

The CCG aims to maintain level 1 by setting the expectation that services embed risk register review within their governance structures and maintaining oversight of performance management within the CCG Governance meeting.

Next steps for Quarter Three will be utilise risk review workshops to ensure validation of the risk scoring matrix, to ensure clear justification of risk scores, alongside a focus on Target Risk Scores, to understand how these are set and any themes in relation to barriers to achievement.

Evidence based

Quality and Effective Clinical Practice

The Clinical Audit manager provided an initial overview of Clinical Audit function and programmes during the CCG Integrated Governance meeting held on 17 June 2025. The CCG planned to collate audit activity within each service and begin to build the Allied Health and Health Science content to the Local Clinical Audit programme. However, due to a period of unexpected absence in the CCG leadership team throughout Quarter two, this work has been deferred to Quarter four.

Person Centred

Patient Experience

The CCG captures patient experience data within individual services and sub-specialities/modalities, however, the adoption of the CIVICA platform has not yet been embedded within all services. The Occupational Therapy service has created a bespoke service evaluation questionnaire which went live on the CIVICA platform in October. The CCG will continue to learn from service feedback utilising current systems and will develop CCG oversight processes throughout the forthcoming year.

Patient stories feature within every CCG Governance meeting, with a schedule that ensures each service shares the learning from patient experience.

It is particularly poignant for services such as Pathology, where most of the service is non-patient facing, however the impact of feedback is impactful, as shown in the sharing of a recent patient story:

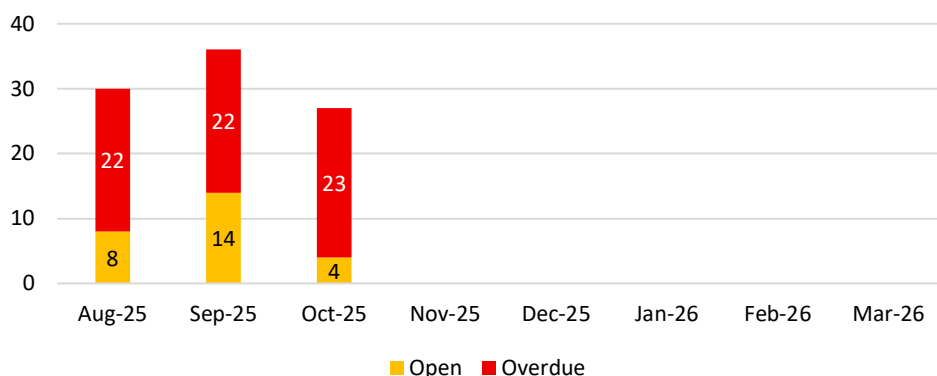
"I met with the family last week of a young [person] who died as a result of [incident] and was taken to [HDdUHB site] mortuary. When I spoke to [family], they were very keen for me to pass on my thanks to the mortuary staff, especially the person who met them when they visited the mortuary. They said the language he used, he spoke about 'caring for [them]' and his general demeanour gave confidence that *[their relative] was being well looked after by people who genuinely cared, and this meant the world."*

When bereaved families take the time to offer their gratitude under such tragic and sad circumstances, it shows what lasting impact our care and support leaves on them when they need it the most. This communication was relayed to mortuary staff and gratitude expressed to them for upholding the highest standards of care and being a source of kindness for our families in the most difficult of moments.

1.1.1.1. Complaints

The CCG has commenced deep dives into their longest open complaints (22.10.2025 and 04.11.2025). Twice-monthly meetings have been scheduled with a complaint's handler. Of those reviewed (n=9), two remain within the CCG to progress, all others have received comments from service and form part of a cross-care group response.

Graph - CCG Complaint Management Performance*



*Dashboard data is not available before Aug 2025 due to a change in data collection

Figure 4 Number of open complaints- AH & HS CCG [Data as of 13/11/25]

Progress has been made in relation to open complaints not tipping into overdue between September and October. A concurrent action to improve the percentage of complaints responded to within 30 days has resulted in 50% improvement, as illustrated in figure 5.

Topic	Measure	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25
Patient Experience	% complaints responded to within 30 days	33.3	40	33.3	36.4	50	66.7

Figure 5 Percentage of complaints responded to within 30 days- AH & HS CCG [Data as of 30/09/25]

Next steps for Quarter Three and Four are to explore establishing the format that has been successful for incident management. Agreeing ring-fenced time with service lead and complaints handlers, to resolve outstanding queries for open concerns. Once timely complaints management has been established the CCG will be able to triangulate themes from complaints, incidents and patient experience to facilitate learning for improvement.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to take an assurance on the quality governance arrangements in place within the Allied Health and Health Sciences Clinical Care Group in relation to quality safety and patient experience.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 Scrutinise, assess and seek assurance in relation to the patient impact, quality and health outcomes of the services provided by the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality	7. All apply

Quality and Engagement Act (sharepoint.com)	
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 4 Planned care, diagnostics and cancer Recovery
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termiau: Glossary of Terms:	CCG – Clinical Care Group AHP – Allied Health professions (the professions formerly referred to as ‘Therapies’: Occupational Therapy, Physiotherapy, Speech and Language Therapy, Podiatry and Orthotics, Nutrition and Dietetics)
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	CCG Integrated Governance

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not applicable
Gweithlu: Workforce:	Not applicable
Risg: Risk:	Not applicable

Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	Not applicable
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Not applicable

4.3

4.3 - Planned Care and Specialist Services Clinical Care Group

***Paula Goode (Hywel
Dda UHB - Service
Director for Planned
and Specialist Care),
Olwen Morgan
(Hywel Dda UHB -
Assistant Director of
Nursing)***

Attachments

[Planned Care Specialist Services SBAR to QSEC 04 Dec. 2025.pdf](#)

BWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	04 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Planned Care & Specialist Services Clinical Care Group Quality Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Paula Goode, Service Director Olwen Morgan, Assistant Director of Nursing, Quality & Patient Experience

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report details the quality governance arrangements within the Planned Care & Specialist Services Care Group in relation to quality, safety and patient experience. It sets out achievements, progress and planned actions to meet our Duty of Quality, and is presented to the Quality, Safety and Experience Committee to provide assurance on the arrangements in place

Cefndir / Background

The Planned Care & Specialist Services Care Group – consists of Children, Women & Family Services, Maternity Services, Specialist Services, Cancer & Outpatient Services.

The aim of the Planned Care & Specialist Services Care Group in summary is to:

- Ensure there is a process in place to continually monitor and review its risk register, acting to mitigate quality and safety risks on an ongoing basis
- Maintain an open culture of improving quality, safety and patient experience across all teams and all staff
- Promote a positive culture of staff engagement, development and understanding of everyone's responsibility for safe, quality care and
- Foster a culture of psychological safety within Planned Care & Specialist Services Care Group in order to promote collaboration, trust, innovation and personal growth

Meeting the Duty of Quality is the highest priority for the Care Group and its governance structures and oversight has developed significantly. The Service Director, Associate Medical Director and Assistant Director of Nursing, Quality & Patient Experience lead the agenda which is aligned to the six domains of quality as defined by the Duty of Quality Statutory Guidance 2023. This report is set out under each of these domains



Asesiad / Assessment

Safe

Children, Women & Families and sexual health have a very structured and effective operational model with well-defined services.

Planned Care & Specialist Services is a very large and complex service group, which is proving more challenging in terms of quality governance. The Planned Care & Specialist Services Clinical Care Group (CCG) Quality Governance meetings are well represented by nursing and managerial staff across all Service Groups, as well as other multi-disciplinary colleagues from across the Health Board, all of which take an active part in the meetings and shape the overall agenda. Medical attendance remains a challenge. We are hopeful that with the appointment of Clinical Directors within the CCG, this position will improve.

Each Service Group holds monthly Quality and Safety meetings, and these meetings are maturing in structure and reporting to the Care Group Quality Governance Meeting.

Fragile Services

Planned Care & Specialist Services have a number of fragile services. Deep Dive reviews of Urology, Endoscopy and Dermatology have recently been presented to Extraordinary QSEC

QSEC were assured in terms of management and mitigation plans for Endoscopy and Urology and agreed to advise Board of the concerns relating to Dermatology. A formal fragile services assessment is planned and establishment of a Task & Finish Group to take forward the necessary improvement work.

Summary of Overall Fragility Scoring following Review



GIG
NHS

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Fragile Service	Risk	Risk Matrix Score	Fragility Score	Total Score	Recommendations
Sustainability and quality of care for Trauma Service	1256	25	16	41	Escalate risk to the corporate risk register. Consider increase of risk score to 25
Emergency General Surgery	1531	15	12	27	Consider reduction of risk score from 15 due to service having plans to mitigate
Carmarthenshire Anaesthetics (Medical Workforce)	1880	9	14	23	Consider separate risk as Anaesthetic staffing is included within the Critical Care risk
Critical Care (PPH)	1880	9	17	26	Separating out 1880 will then provide clarity to what level the PPH Critical care risk is
Ophthalmology Consultant On-Call	1664	16	15	31	1664 is a corporate risk however includes complexities beyond on call rota and therefore remains at a 16
Theatres	2028	20	17	37	Escalate risk to corporate risk register – create action plan and business case.

There are other services awaiting assessment of fragility, these include Dermatology (RR. 2158 (16) and Audiology (WHC) and Theatre Estate.

Whilst the medical on-call fragility in Ophthalmology has decreased, R1 treatment capacity remains a significant risk and challenge for the service.

Increased, 'ring fenced' Trauma capacity has supported consistent and timely access to surgery.

Lack of Orthogeriatrician provision at Glangwili Hospital (GGH) continues to impact the quality of care and outcomes for hip fracture patients. The National Hip Fracture database KP1 for Orthogeriatrician review is 0%. Additionally, compliance against KP5 'not delirious post op' is 4%.

RR.1256 (25)

A recent report from the clinical health knowledge system has identified that GGH has almost twice the average mortality rate as Withybush Hospital (WGH) and Bronglais Hospital (BGH). The increased morbidity and length of stay for post operative trauma patients is resulting in orthopaedic patients being managed on other surgical wards. This has a negative impact on patients care and experience.

Working closely with Planned Care & Specialist Services, the provision of an Orthogeriatrician service in GGH is a priority for the Integrated Community and Medicine Clinical Care Group.

Endoscopy / Gastro / BSW

Joint Advisory Group (JAG) – accreditation deferral.

The accreditation has been deferred to March 2026 – subject to further improvement to the endoscopy surveillance waiting list backlog. The service will report on-going monthly progress through the care group governance structure in advance to further evidence being submitted.

Surveillance – Potential cause of patient harm.

Following clinical validation of the surveillance backlog to date, a root-cause analysis review is currently being undertaken on five patients, to assess whether delayed access to their follow-up procedure has resulted in harm. All five patients were due to have their procedure between 2020-2022, resulting in a potential delay of between 3-5 years. **RR. 1628 (15)**

All patients scheduled for review in 2023 have undergone clerically validation and no further instances of harm have been identified. The risk of harm for patients due to receive follow up procedures in 2024 and 2025 is expected to be lower, given the short delays involved.

To ensure appropriate risk stratification of the waiting list, the service is continuing to clinically validate all patients on the waiting list backlog (considering up to date British Society of Gastroenterology (BSG)/ National Institute of Care Excellence (NICE) guidance and known cancer conversion rates) to support decision making and prioritisation of any high-risk surveillance cases which need expediting.

The root-cause analysis outcomes will be presented at the Endoscopy QSE meeting for review of lessons learnt and escalated through to the Care Group Governance structure

Critical Care Peer Review 17 September 25 – Critical care follow up and rehabilitation.

The Health Board was commended for its thorough and honest self-assessment.

Main Strengths

Strong psychology presence in critical care, with early assessment and coordination of some follow up activity.

Staff engagement in the patient journey and recovery.

Innovative patient engagement initiatives, including pet and music therapy, and patient recovery groups.

A strong commitment to education and shared learning with robust internal training programmes.

Main Areas for Improvement

Significant Allied Health Professionals (AHP) workforce deficits, particularly in occupational therapy, psychology, and speech and language therapy, impacting the delivery of a multidisciplinary rehabilitation pathway. A lack of dedicated AHP staff for critical care has resulted in a limited follow up and rehabilitation service.

Rehabilitation Assessment at Discharge: There is currently no standardised discharge assessment for all specialties identifying areas of concern and focus for rehab planning. Exploring ways to standardise this would benefit patients to ensure they are assessed and staff by providing a structure to their referral pathways.

Lack of structured follow up clinics across the critical care estate in Hywel Dda have resulted in lack of equitable service provision for patients in the region, when compared with the other health boards in Wales.

Patient Support Groups used to provide a follow up service, but this has now been discontinued. The network recommends seeking funding to recommence these groups ensuring that staff do not pay out of their own pocket for this valuable rehab tool.

Inconsistent use of nationally recommended outcome measures and limited integration of data into service evaluation or quality improvement.

Lack of structured education and training for staff involved in rehabilitation and recovery following critical illness as well as protected time for peer support group participation

An action plan and tracker have been developed against the six improvement actions. two actions are on track for completion by 28 November, one action by 28 January 2026, three further actions currently have no dates assigned.

The action plan is monitored via the Planned Care Service Group Governance Meeting.

Progress from previous recommendations

Domain	Escalation level	Proposed action from Performance Team	Where you were in August 2025	Where you were in September 2025	Where you are at in October 2025	Progress up to October 2025
Governance	2	By 31 st July 2025, overdue risk actions should be reviewed and updated on DATIX.	19 (12%) risk actions overdue	25 (15%) risk actions overdue	29 (16%) risk actions overdue	There has been an increasing trend in overdue risk actions. Needs to be addressed to avoid being escalated back to level 3.
Governance	2	Ensure Welsh Health Circulars (WHCs) improvements are maintained, aiming for <20% overdue by 30th September 2025	56% overdue	50% overdue	25% overdue	25% improvement in one month. Level 1 criteria = < 10% overdue
Quality and safety	2	Reduce the number of incidents open over 120 days within the CCG and develop improvement trajectories to <10 across CCG	Women and children: 96 Planned Care and Cancer: 111	Women and children: 114 Planned Care and Cancer: 113	Women and children: 132 Planned Care and Cancer: 125	Increased for 2 nd consecutive month. Improvements needed to avoid escalation to level 3.
Quality and safety	2	Reduce the number of complaints open over 90 days within the CCG and develop improvement trajectories to <10 across CCG	Women and children: 44 Planned Care and Cancer: 67	Women and children: 39 Planned Care and Cancer: 69	Women and children: 40 Planned Care and Cancer: 69	Very little change seen over 2 months. Improvement work required to get below 10.
Quality and safety	2	Address the 8 NRIs that will be overdue at end of August 2025	4 overdue NRIs	4 overdue NRIs	5 overdue NRIs	Increase of 1. Submissions of outcome forms for 5 remaining overdue NRIs required.
Workforce	2	Reduce 15 overdue pay progressions to no more than 3 by 30 th September 2025	15	18 (8 by over 3 months)	19 (12 by over 3 months)	Overdue pay progressions increased for 2 nd consecutive month.
Population health	3	Increase compliance with referring to Help Me Quit or giving Nicotine Therapy to 70% by 30th November 2025	n/a	11%	29%	Overall, an 18% improvement but still considerably below de-escalation criteria

Whilst it is recognised that significant improvement work has been done in terms of Welsh Health Circular and the CCG has maintained Level 2 in six of the seven domains, it is noted that there is a static or deteriorating trend within six domains. The respective Service Groups have been tasked with undertaking focused actions to improve this position.

Planned Care and Cancer Services Outstanding Mortality Proportionate Investigations.

Total Number of Outstanding investigations is 79 across multiple specialities.

2021 – 8

2022 – 20

2023 – 20

2024 – 17

2025 – 14

Services reporting highest number of outstanding investigations.

Specialty	Number
Gen Surgery	22
Urology	14
T+O	13
Critical Care	12

This data has been shared with the newly appointed Clinical Director for Planned Care who will share with the respective Clinical leads and service leads to develop an improvement plan

Some of the above only need clarification of detail and discussion in Mortality and Morbidity Meeting.

Timely

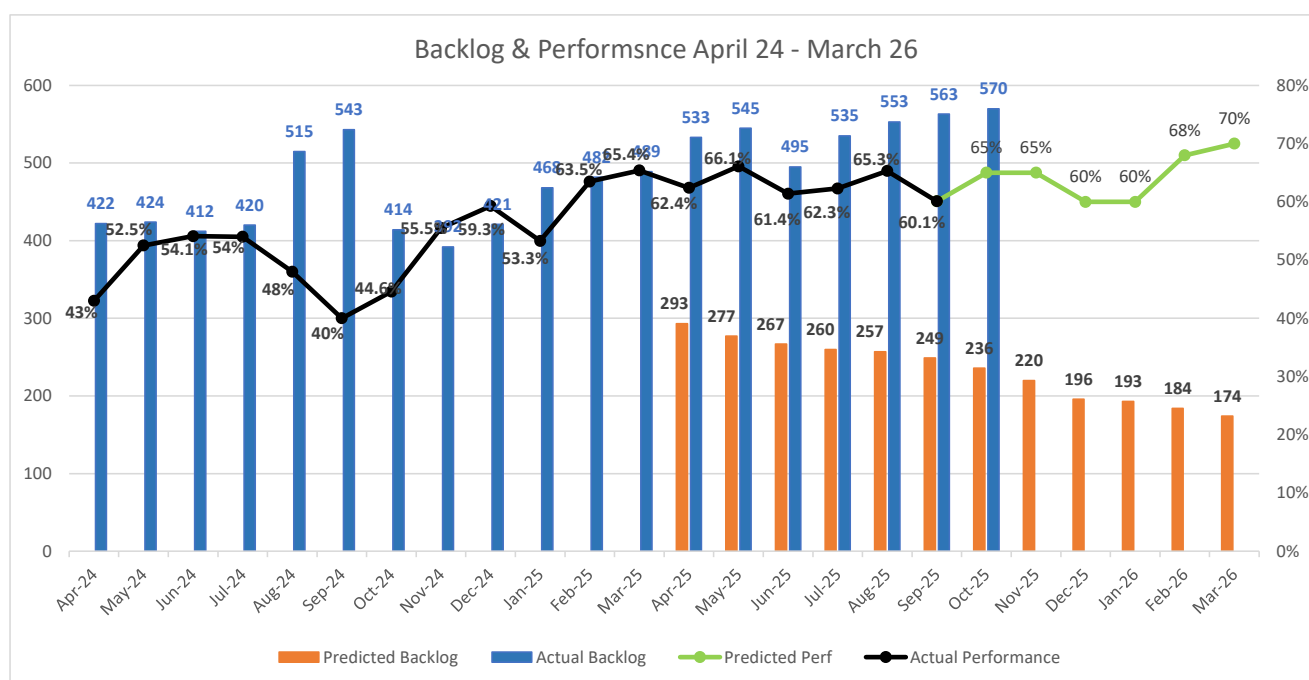
September Performance SCP

	Total	Treated	Treated	Percent
Tumour site	treated	in target	Out of	age
Head and neck	10	4	6	40%
Upper GI	29	13	16	45%
Lower GI	50	22	28	44%
Lung	30	9	21	30%
Sarcoma	2	1	1	50%
Skin (exc BCC)	176	166	10	94%
Brain/CNS	2	1	1	50%
Breast	37	25	12	68%
Gynaecological	14	3	11	21%
Urological	77	16	61	21%
Haematological (exc acute leukaemia)	21	9	12	43%
Acute leukaemia	0	0	0	0%
Children's	1	1	0	100%
Other	10	6	4	60%
Total Treated	459	276	183	60.1%

The cancer performance for the Health Board is being maintained over 60% but is extremely dependent on a single high volume cancer service – dermatology that makes up 38% of the total treated cancers for the HB. This cancer demand is rising 22% yearly and is the largest in Wales.

The demand for diagnostic imaging and other diagnostic tests is not meeting the demand of cancer patients with average waits for Computed Tomography (CT) up to 6-8 weeks with MRI waits similar. This is not visible through routine monitoring. The Planned Care Group is undertaking deep dive exercises to understand fully the component waits. There is an assumption that the 28-day target is a diagnostic target however, it relates to a target informing the patient of their diagnosis by day 28, there may be multiple diagnostics on this pathway to day 28.

The diagnostic backlog as below is rising. This chart shows patients waiting over 62 days on their 28-day diagnostic pathway.

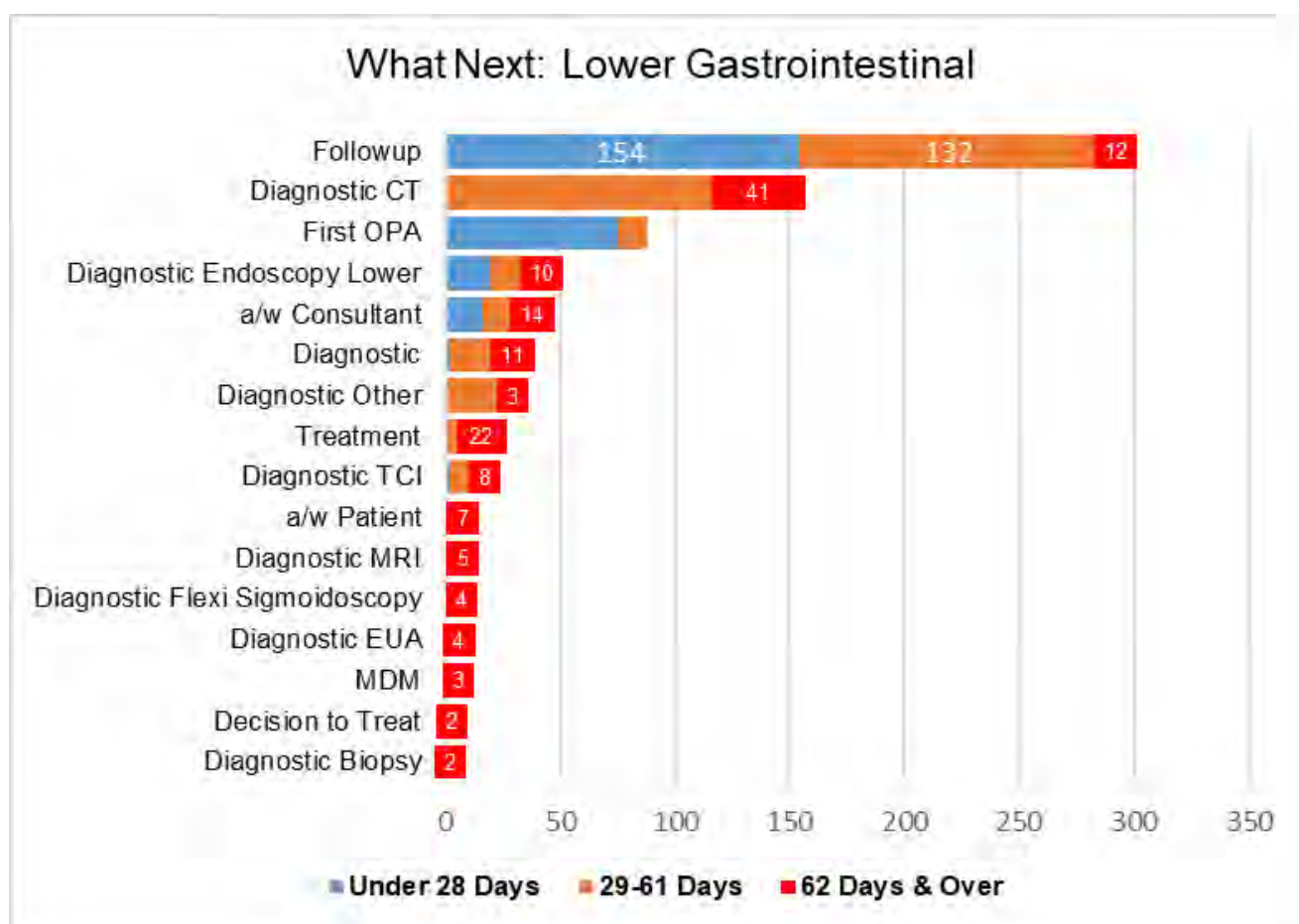


The below graph is an example of the breakdown of the lower GI 62-day cancer pathway, and the component waiting times.

A patient waiting for a CT Colon (item Diagnostic CT) will wait on average 54 days from referral to report. This is driving the red component. What cannot be seen in this graph is that how long they are waiting only that they are waiting over the 28-day target to receive their diagnosis or 62 days. The waiting time for any cancer diagnostic should be no more than 10 days.

A recent new initiative in Urology Prostate Cancer, used outsourcing providers for MRI prostate with excellent results, five days from referral to result Provider 1, 10 days Provider 2.

The Planned Care CCG wish to emphasis a prioritisation of cancer 28-day diagnosis target and cancer diagnostics.



Clinical Audit Programme

A total of 22 mandatory clinical audit falls within the remit of the care group.

The table below gives a brief overview of the status of the NCAORP audit. There are a number of action plans outstanding for a number of the mandatory audits. Welsh Government expect all projects to be fully participated in including the submission and implementation of appropriate action plans.

It is anticipated that Audit Leads and auditing teams will require support to create and implement action plans for the below projects.

Title	Leads	Status	RAG	Comments
All Wales Audiology	Jane Deans	Up to date		
Comparative Audit of Critical Care Unit Adult Patient Outcomes (ICNARC)	Anthony Smith Gabor Dudas Diane Knight	Action plans overdue		1x Action plan required (report 22/23) 1x Action plan required (report 23/24)
National Hip Fracture Database (NHFD)	Owain Ennis Lianne Gregory	Action plans overdue		1x Action plan required (report 2022) 1x Action plan required (report 2023) 1x Action plan required (report 2024)
National Joint Registry (NJR)	Owain Ennis Lianne Gregory	Action plans overdue		1x Action plan required (report 2022)

				1x Action plan required (report 2023) 1x Action plan required (report 2024) *Data input on hold for GGH & PPH
National Major Trauma Registry (NMTR)	Stuart Gill Diane Knight Claire Hathaway	In progress (on track)		
National Early Inflammatory Arthritis Audit (NEIAA)	Jayne Evans Neil Griffiths	In progress (on track)		
National Emergency Laparotomy Audit (NELA)	Ramesh Khoju Shrestha Caroline Lewis	Action plans overdue		1x Action plan required (report 2021) 1x Action plan required (report 2023) 1x Action plan required (report 2024)
National Bowel Cancer Audit (NBOCA)	Mr Pawan Kumar Dhruva Rao Debra Bennett	Action plans overdue		1x Action plan required (report 2024) 1x Action plan required (report 2025)
Oesophago-Gastric Cancer Audit (NOGCA)	Mr Brendan O'Riordan Debra Bennett	Action plans overdue		1x Action plan required (report 2024) 1x Action plan required (report 2025)
National Pancreatic Cancer Audit (NPaCA)	Mr Brendan O'Riordan Debra Bennett	In progress (on track)		Next report due Nov 2025
National Non-Hodgkin Lymphoma Audit (NNHLA)	Dr Sumant Kundu Debra Bennett	Action plan overdue		1x Action plan required (report 2024)
National Kidney Cancer Audit (NKCA)	Mr Sohail Moosa Debra Bennett	Action plan overdue		1x Action plan required (report 2024)
National Prostate Cancer Audit (NPCA)	Mr Sohail Moosa Neil Griffiths	Action plan overdue		1x Action plan implementation (report 2024)

Title	Leads	Status	RAG	Comments
National Ovarian Cancer Audit	Islam Abdelrahman	Up to date		
National Pregnancy in Diabetes Audit	Dr Lisa Forrest	Up to date		
National Maternity and Perinatal Audit	Cerian Llewellyn	Up to date		
National Paediatric Diabetes Audit	Dr Simon Foutain-Polley	Action plan required		2x action plans overdue 2x action plans required 22 – overdue (close to sign off) 23 – overdue – (close to sign off) 24 – required

				25 - required
National Neonatal Audit Programme	Dr Prem Kumar Pitchaikani	Action plan required		3x action plans to implement 1x action plan required 20-20 - implement 21-21 - implement 22-22 - implement 23-23 - required
Epilepsy 12	Dr Damitha Ratnasinghe Nick Davies	Action plan required		3x action plans required 23 – required 24 - required 25 - required
Children and Young Persons Asthma (CYPA)	Dr Ranjith Perinchery Kulappura	Action plan required		1x action plan overdue 1x action plan required 24 – overdue (actions complete - close to sign off) 25 - required
National Audit of Primary Breast Cancer	Dr Saira Khawaja	Up to date		
National Audit of Metastatic Breast Cancer	TBC	TBC		

National data input (NHFD /NJR) continues to be an outlier when compared to other health boards with the lack of data input resource between September 2024 – September 2025 significantly impacting compliance. Multiple letters of concern have been raised by the NHFD. Administrative support has been in place since September 2025, and overtime offered to administrative staff to support with this.

The National projects highlighted above have been presented at the CCG Governance Meeting and are being reviewed and discussed at the Planned Care & Cancer Services and the Women & Child Health sub-groups. The Associate Medical Director (AMD) is working alongside relevant Clinical Leads and Clinical Directors are leading the improvement actions. Progress will be reported through the CCG Integrated Quality Governance Meeting.

Evidence based

Population Health – Smoking status on admission

Level 3

Reason for escalation	De-escalation criteria
Poor compliance with referring to HMQ and giving NRT with high numbers smoking on hospital grounds (overall level 3).	Level 2: Smoking status recorded on admission: Increase compliance with referring to HMQ and giving NRT to 70% and reduce to 24% or below of patients smoking on hospital grounds.

As 31st October 2025, 29% of smokers were referred to "Help Me Quit" or given nicotine therapy

Service / site (L6)	Total admissions	Smoking status recorded on WNCR	Number of smokers	Referred to "Help Me Quit"	Given nicotine therapy	"Help Me Quit" or nicotine therapy	Smoking on hospital grounds
Women and children: Obstetrics and Gynaecology	95	79 (83%)	5	0 (0%)	0 (0%)	0 (0%)	3 (60%)
Planned Care and Cancer: Theatre Services, Anaesthetics and Critical Care	62	62 (100%)	9	1 (11%)	3 (33%)	4 (44%)	8 (89%)
Total	157	141 (90%)	14	1 (7%)	3 (21%)	4 (29%)	11 (79%)

Performance Team recommendation

Increase compliance with referring to Help Me Quit or giving Nicotine Therapy to 70% by 30th November 2025

It is recognised that improvement is needed in terms of referrals to the Help Me Quit (HMQ) service. The above data does not include Maternity Services, as they use a different patient record system than Welsh Nursing Care Record (WNCR). The Performance Team is exploring ways to 'collate' and include the Maternity data since smoking cessation is a priority focus throughout antenatal and postnatal care.

Equitable Person Centred

Learning Disabilities (LD) Epilepsy Task & Finish Group.

Following receipt of the Public Service of Wales (PSOW) Public Interest Report of the Health Boards LD Epilepsy Service, the LD Epilepsy T&F Group was established to respond to the recommendations within the Report.

- Within 2 months: Written apologies and breakdown of current care plan to be provided to the seven families. On track for completion within timeframe.
- Within 4 months: Review and Gap analysis of the current Health Board Care Pathway. Exploration of an external, professional review underway.
- Within 4 months: Conduct a thorough review of LD Epilepsy patient information to ensure up to date care plans, risk assessments and emergency medication plans.

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is asked to take assurance on the quality governance arrangements in place within the Planned Care & Specialist Clinical Care Group in relation to quality, safety and patient experience.

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

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 Scrutinise, assess and seek assurance in relation to the patient impact, quality and health outcomes of the services provided by the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	
Amcanion Strategol y BIP: UHB Strategic Objectives:	
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termiau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofïod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Contained within the report
Gweithlu: Workforce:	Contained within the report

Risg: Risk:	Contained within the report
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Contained within the report
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

5 - For Approval

5.1

5.1 - Use of Production Survey Guideline

***Louise O'Connor
(Hywel Dda Health
Board - Assistant
Director)***

Attachments

[SBAR 568 survey guidance.pdf](#)

[568 - Guidance on Use of Surveys for approval.pdf](#)

[EqlA Screening 568 - Production and Use of survey guideline.pdf](#)



**Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	04 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Production and Use of Survey Guidelines
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Louise O'Connor, Assistant Director of Legal and Patient Experience

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

The Quality, Safety and Experience Committee is asked to approve **Policy Number 568 - Production and use of Survey Guidelines.**

This report provides assurance that Written Control Documentation (Policy 192) has been adhered to in the review of the above mentioned written control document and that therefore the document is in line with legislation/regulations, available evidence base and can be implemented within the Health Board.

Cefndir / Background

Policy number: 568

Classification: Corporate Supersedes: version 1 Version number: 2

The policy has been reviewed and updated in line with the requirements as set out in the new People's Experience Framework, implemented in April 2025.

The guidance provides advice on the production and provision of surveys for people, patients, their relatives and carers, the public and for staff.

This guidance applies to those members of staff that are employed by the Hywel Dda University Health Board, and for whom the Health Board have legal responsibility including contractors and those who undertake work on behalf on Contractors.

National surveys are developed at the request of clinical areas of work and in conjunction with the NHS Wales Executive Team. There is an approval process set up, to support the development and inclusion of national surveys within the Once for Wales Experience System (CIVICA).

Where applicable, all organisations will engage in the national survey approach in line with the Duty of Quality 'always-on' reporting and share with people and communities via local websites, the feedback received and any service improvements that have been undertaken because of the feedback.

Information collected via national surveys will remain the responsibility of clinical areas and organisations supporting the collection.

The information will also be used to populate the NHS Wales Executive Quality Dashboard.

Asesiad / Assessment

National Surveys are overseen by the NHS Executive in line with the national survey road map. The governance process for national surveys is facilitated by the Once for Wales Concerns Management System Central (OfWCMS) team.

Hywel Dda University Health Board promotes and provides training to all departments and wards across the UHB on the All-Wales CIVICA patient experience feedback system. Data is collected via Surveys created on the CIVICA patient experience feedback system to support improve patient experience.

Argymhelliad / Recommendation

- The Quality, Safety and Experience Committee, is requested to ratify the Production and Use of Surveys Guidelines Policy number 568.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	To provide a clear process and guidance for the development, ratification and use of surveys across Hywel Dda University Health Board (UHB). This includes the provision of surveys for patients, their relatives, carers, public, stakeholders and staff members.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	2. Healthier communities

Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Real time feedback from Service Users which can be collated and analysed quickly and efficiently.
Rhestr Termiau: Glossary of Terms:	The CIVICA Experience Wales platform, Complaints, Compliments, PALS – Patient Advice and Liaison Service PE – Patient Experience National People's Experience
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Listening and Learning Committee.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not applicable
Gweithlu: Workforce:	Not applicable.
Risg: Risk:	Not applicable
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	Not applicable
Gyfrinachedd: Privacy:	Not applicable – data is recorded anonymously.
Cydraddoldeb: Equality:	EqIA screening has been undertaken. Full EqIA is not required.

Production and Use of Surveys Guideline

People's Experience Surveys

Policy information

Policy number: 568

Classification: Corporate

Supersedes: version 1

Version number: 2

Date of Equality Impact Assessment Pending

Approval information

Approved by: Quality, Safety and Experience Committee

Date of approval: Click or tap to enter a date.

Date made active

Review date:

Summary of document:

This document sets out guidance for the production and use of surveys:

Scope:

This guidance provides advice on the production and provision of surveys for people, patients, their relatives and carers, the public and for staff.

This guidance applies to those members of staff that are employed by the Hywel Dda University Health Board (UHB), and for whom the UHB have legal responsibility including contractors and those who undertake work on behalf on contractors.

To be read in conjunction with:

[153 - Equality and Diversity Policy](#) (opens in a new tab)

[333 - Welsh Language Policy](#) (opens in a new tab)

Patient information: Not applicable

Owning group: Listening and Learning Sub-Committee 07/08/2025

Executive Director job title: Executive Director of Nursing, Quality and Patient Experience

Reviews and updates:

Version 1 – 15.8.2017

Version 2 – Full review

Carers, Complaint, Compliment, Engage, Feedback, Incidents, Involve, Negative, Patient, Patient Dissatisfaction, Patient Feedback, Patient Satisfaction, People, People's Experience, Positive, Public, Questionnaire, Research, Staff, Stakeholders, Survey, unpaid carers.

Glossary of terms

Complaint	When someone tells us they are unhappy with the care or service they received, and they want us to look into it.
Compliment	Positive feedback from someone who is happy with the care or service they received.
Engagement Team	A group of staff who work with patients, families, and communities to hear their views and involve them in improving and developing services.
Incident	An event that happened in care or services that was unexpected and could have or did cause harm.
Listening and Learning Tree	A visual tool used to show how we listen to feedback and use it to make improvements.
Peoples Experience Framework	A guide that helps us understand what matters most to people and how we can improve their experience.
Patient Experience Team	The team responsible for collecting, understanding, and acting on feedback from patients and families.
PREMs and PROMs	Short for Patient Reported Experience Measures and Patient Reported Outcome Measures. These are surveys that ask patients about their experience and how they feel after receiving care.
Once for Wales Experience system (CIVICA)	A national online system used across NHS Wales to record and manage patient feedback, including complaints, compliments, and surveys.
Triangulation	A way of looking at different types of information (like complaints, incidents, and surveys) together to get a fuller picture of what's happening and where we can improve.
CROMs	Clinician Reported Outcome Measures
SROMs	Staff Reported Outcome Measures

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APPENDIX 2 – ADVICE ON WRITING GOOD SURVEYS 14

Aim

To provide a clear process and guidance for the development, ratification and use of surveys across Hywel Dda University Health Board (UHB). This includes the provision of surveys for patients, their relatives, carers, public, stakeholders and staff members.

Objectives

Quality Assurance: To provide a quality assurance process for all surveys developed by the UHB, ensuring they follow good practice, are supported by a process of good governance, and portray a positive, professional image of the organisation.

Staff Awareness: To ensure staff are aware of the UHB's requirements and standards for producing good quality, effective people experience, engagement, and staff surveys.

Organisational Understanding: To ensure surveys used by the UHB contribute to a wider organisational understanding of people's experience, service development, and organisational development.

Staff Support: To support staff in the development, production, and management of surveys through better awareness of the standards for producing good quality, effective surveys via the Once for Wales Experience System.

Consistent Approach: To provide a consistent approach to the Once for Wales Experience System.

Survey Creation: To provide a consistent approach to creating and producing surveys via the UHB's Once for Wales Experience System (CIVICA).

These objectives align with best practices for survey development and management, ensuring quality, consistency, and effective use of survey data within the UHB. If you have any specific queries or need further advice, please email: patientexperience2@wales.nhs.uk (opens in a new tab).

Scope

This guidance applies to those members of staff that are employed by the UHB and for whom the UHB have legal responsibility including contractors and those who undertake work on behalf of contractors.

Surveys Not Covered by This Policy

This guidance can support the use of patient surveys in formal research or clinical audits. However, for further advice, please consult the Clinical Audit and Research and Development departments as follows: clinical.audit@wales.nhs.uk (opens in a new tab).

[Hywel Dda UHB Clinical Audit intranet page](#) (opens in a new tab)

This guidance can support the use of patient survey for formal public consultations or engagement periods. However for further advice on engagement requirements related to service change, please

The difference between People's Experience, Engagement, Patient Reported Experience Measurements (PREMS), Patient Reported Outcome Measurements (PROMS)

People's experience is 'the sum of all interactions, shaped by the culture of the organisation, staff and systems. People's experience can be described as how people feel when using any services and programmes offered by NHS in Wales. Whether it be in a hospital ward, outpatient appointment, participation in national screening programs, engagement with primary care services (such as GP, Optometrist, Pharmacist, Dentist), interaction with health promotion practitioners, or attendance at any event hosted by an NHS Wales Organisation. In essence, the definition of People's Experience is fundamental to Person and Population centredness. The integration of all strands of experience feedback relies on local expertise and resources. However, the triangulation of experience feedback data alongside other metrics, e.g. outcomes, as depicted on the Listening and Learning Tree is indicative of an organisation committed to quality.

Engagement is different from People's experience and feedback. Although the two activities are related and overlap, engagement is the active participation of members of the public, communities or other stakeholders in service development, planning, delivery and evaluation.

For advice and guidance on PREM (Patient Reported Experience Measure) and PROMS (Patient-Reported Experience Measure) contact Value Based Health Care at:

ValueBased.Healthcare@wales.nhs.uk (opens in a new tab).

In addition to PREMS and PROMS there is ongoing development of additional measures including CROMs (Clinician Reported Outcome Measures) and SROMs (Staff Reported Outcome Measures).

For **information governance** queries around the survey creation, please contact:

Information.Governance3@wales.nhs.uk (opens in a new tab).

Use of Surveys

The use of surveys should form part of a planned departmental programme of people's experience, and staff engagement initiatives, and can be one of a range of tools used to gather patient, public or staff views.

Surveys should not be used as an opportunity to ask whatever is wished. Questions must be relevant and appropriate to the area being considered and designed with sensitivity, recognising the needs of the individuals completing them. They must not cause offence or make judgements either directly or implied on individual behaviour.

Surveys can be used to collect quantitative (numerical) or qualitative (descriptive) information, usually by using structured questions. Surveys, when well designed, can provide meaningful information and insights to inform and guide future directions.

A Welsh people's experience core set of questions has been developed for use in all experience and feedback surveys. In circumstances where people in receipt of services cannot directly provide feedback, consideration should be made for the views of family, friends and carers (unpaid) to be gathered. [People's Experience Survey \(PES\)](#) (opens in a new tab).

Locally requested surveys must reference the National People's Experience question set. contained within the Welsh People's Experience Framework [NHS Wales People's Experience Framework](#) (opens in a new tab).

National surveys are developed at the request of clinical areas of work and in conjunction with the NHS Wales Executive Team. There is an approval process set up to support the development and inclusion of national surveys within the Once for Wales Experience System. Where applicable, all organisations will engage in the national survey approach in line with the Duty of Quality 'always-on' reporting and share with people and communities via local websites, the feedback received and any service improvements that have been undertaken because of the feedback. Information collected via national surveys will remain the responsibility of clinical areas and organisations supporting the collection. The information will also be used to populate the NHS Wales Executive Quality Dashboard

Equality Monitoring

Health outcomes and experiences are often influenced by the protected characteristics of our people and communities. To support the identification of varying experiences, all experience and feedback surveys across NHS Wales should include a nationally agreed set of demographic and diversity (through a quality lens) questions which are included in appendix C of the People's Experience Framework. [NHS Wales People's Experience Framework](#) (opens in a new tab).

Departments should be mindful of the needs of different groups in the population, especially those with protected characteristics and ensure that appropriate adjustments are made. For further advice and guidance contact the Diversity and Inclusion Team - Inclusion.hdd@wales.nhs.uk (opens in a new tab).

Enhancing survey management within the UHB will improve survey quality and timing, maximising the value of the results. Survey results can be used to check progress and improvement of care providers and hold them to account for outcomes they achieve.

Patient feedback information can improve and drive quality improvement and learning of services that the NHS delivers.

Other methods of seeking and understanding patient, public or staff views may sometimes be more appropriate and include the use of patient stories - advice and guidance can be sought from the Patient Experience Team - patientexperience2@wales.nhs.uk (opens in a new tab). and other mechanisms such as focus groups - advice can be sought from the Engagement Team - hyweldda.engagement@wales.nhs.uk (opens in a new tab).

Survey Process

Consider why you want to do a survey?

It is important that the set of results provide real decision-enhancing value. Good surveys have focused objectives that are easily understood. Spend time to identify, in writing:

- What is the aim of this survey?
- Why are you creating this survey?
- What do you hope to accomplish with this survey?
- How will you use the data you are collecting?
- What decisions do you hope to influence with the survey results? (This will help you determine the necessary data to collect.)

Seek advice from the Patient Experience team if needed.

Ensure that you have agreement to proceed and final authorisation of the survey from your line manager. This will include approval of the need for the survey and the potential time required including training on the Once for Wales Experience System (CIVICA) and using the information gained for reports/feedback/lessons learnt.

Please complete the standard survey registration form ([Appendix 1](#)) and email to patientexperience2@wales.nhs.uk (opens in a new tab).

Draft your survey and include National People's Experience Framework mandated core questions. [People's Experience Survey \(PES\)](#) (opens in a new tab).

Advice on drafting survey questions

Once you have considered the purpose of the survey you should take time to carefully consider and write your questions.

Keep the survey as short as possible and consider what you need to know with what would be interesting to know; use plain language and try to avoid jargon and abbreviations; explain issues if needed; start with easier questions to get the respondent involved; avoid leading or loaded questions; use closed questions wherever possible as they are easier to analyse with yes/no, rating scales but also include open ended questions to provide opportunities for useful qualitative information and insights. All surveys must include mandated questions included in the National People's Experience Framework.

For more advice on drafting up your survey questions see [Appendix 2](#) for tips on writing good surveys and you may wish to seek further advice from the Patient Experience team patientexperience2@wales.nhs.uk (opens in a new tab).

Test your survey before rolling out

Before you make the survey available, it would be of benefit to ask a sample group of respondents to complete the survey (not people who were involved in creating it). After they've completed it, ask them

if they had problems understanding any questions or had answers that were not available on the list of choices. It's much easier to change the survey before you send it than afterwards.

Arrange to administer your survey

The Patient Experience Team will support the survey process, provide a QR code, and training on evaluating the findings on the Once for Wales Experience System (CIVICA).

Translation and Accessibility

You will need to consider the requirements of the Welsh Language Standards for any surveys to patients or the public. All surveys to patients or the public must be available in Welsh and English. The UHB has a Welsh Translation Service, which can be accessed from: [Welsh Language Team - Home \(sharepoint.com\)](#) (opens in a new tab).

For other language requirements please follow these steps:

-  Contact switchboard and ask to be connected to WITS 02920 537555
-  Once connected you will need to provide the following –
 - Departmental name and budget code
 - Quote purchase order code **87633817**
 - Confirm the Health Board you are calling from
 - Provide your NHS contact email and telephone number
 - A WITS team member will then direct you depending on your specific needs.

It is recommended that various options are offered to people to support them in completing the survey in a way that best meets their personal requirements for example audio, braille, paper copies, language of choice, video etc.

Audience

Have you identified your survey respondents and how to reach them? You are likely to have regular access to the audience of your survey as they are relevant to your service area and have ways to distribute and promote your survey, for example via the survey QR code on posters and leaflets.

The UHB also has an involvement and engagement scheme called Siarad Iechyd/Talking Health. The scheme gives members of the public and staff an opportunity to have their say on how our health services are planned, developed and delivered. If you think this group could be helpful in responding to your survey and sharing their views, please contact the Engagement team on hyweldda.engagement@wales.nhs.uk (opens in a new tab) for more information.

Analyse results and develop actions

The process for analysing the data from survey returns should be identified before starting the survey. Advice can be sought from the Patient Experience Team.

Publish results and share actions

It is important that you review the survey feedback which may influence and improve current services or to consider changing services or processes.

Survey results should be discussed at a service/departmental level and any identified actions built into the delivery plans for that area. It may also be appropriate to report to the corporate governance processes.

Including the experiences of patients as a core element of our quality improvement rather than as an additional extra is important.

It is good practice to share the results of your survey with those you have surveyed. This may be through a variety of methods as will best suit the survey and service, for example, direct feedback to correspondents, inclusion in newsletters, information on posters in waiting areas. It is also good practice to share any improvements or changes that develop following consideration of the survey results. It is important that people are made aware they have contributed to any improvements in services because of their input through the survey.

You may wish to summarise the main issues as – “you said, we did” - for sharing with respondents this function is available on the Once for Wales Experience system (CIVICA).

Please send any reports and actions to patientexperience2@wales.nhs.uk (opens in a new tab) patient experience team for recording. This will provide a valuable library of resources for future engagement and will assist us in triangulating information to improve services. Some questions could be reused at a future time but also aim to avoid duplication where similar questions have already been asked recently. It will also help ensure that the UHB is aware of the work and can reflect this in annual reporting mechanisms.

Consider when/if to re-survey

Actions should be regularly reviewed at the service level and changes made as a result monitored and reported within the corporate governance processes.

Sharing learning on an organisational basis will encourage wider improvement across the organisation.

Depending on the service and developments undertaken you may wish to re-survey to test whether they have resulted in improvement.

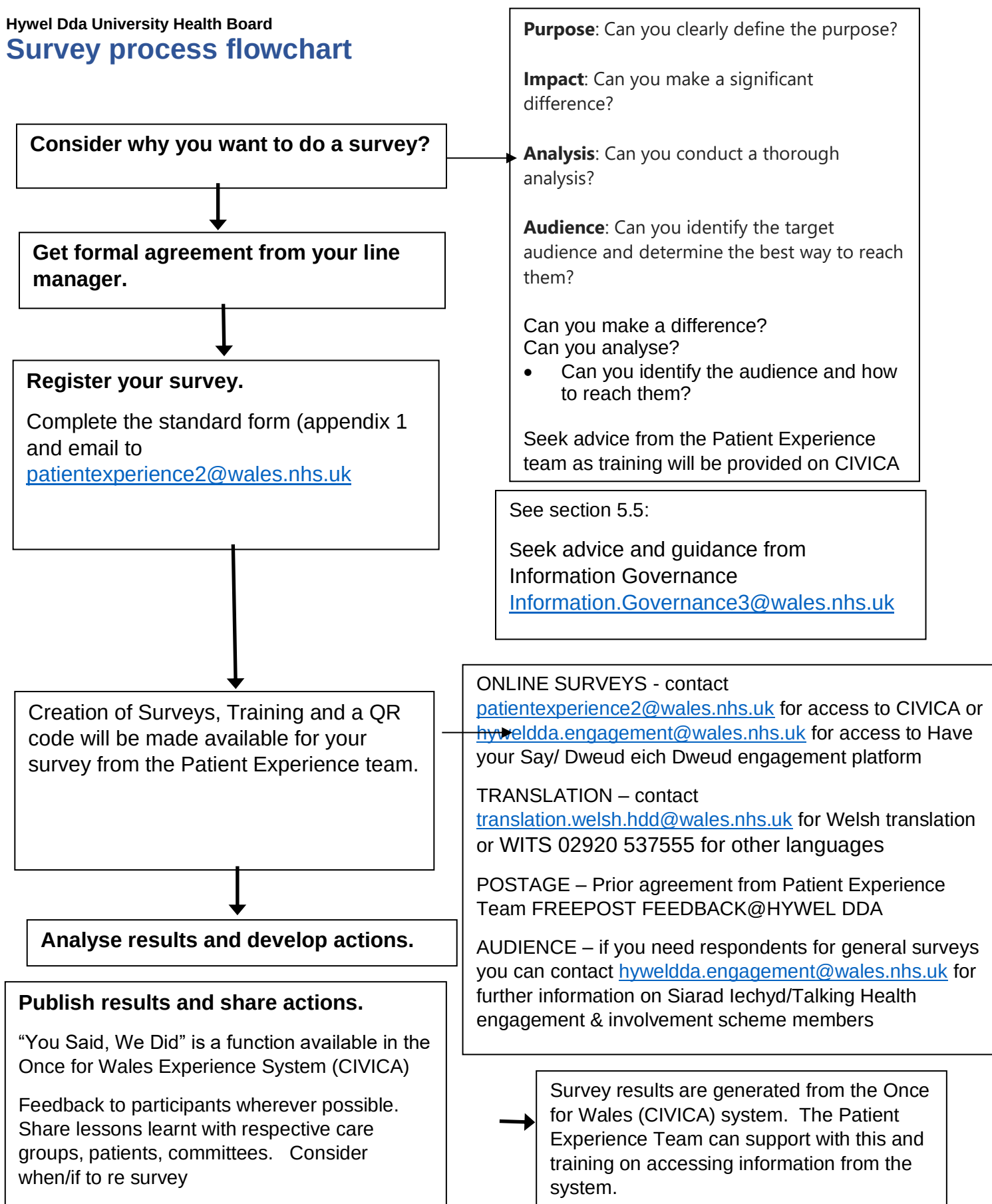
Training

Training and support will be available on request from the Patient Experience Team via email patientexperience2@wales.nhs.uk (opens in a new tab).

Further Support

Further support can be obtained via the Patient Experience Team patientexperience2@wales.nhs.uk (opens in a new tab) or the Engagement Team – Hyweldda.engagement@wales.nhs.uk (opens in a new tab).

Survey process flowchart



APPENDIX 1 - REGISTER YOUR SURVEY FORM

Name:	
Job Title:	
Service Area/Directorate:	
Department:	
Contact details:	
Name of Line manager:	
Survey approved by line manager:	Yes/No/TBC
Proposed title of survey:	
Purpose of the survey (topic, objectives, issues to be addressed, etc):	
Target population	
Intended sample size:	
Distribution method (e.g. online, direct request?	
How survey participants will be approached (e.g. direct request, online notice):	
Proposed start & end time	

Frequency of the survey (one-time or reoccurring?)	
Data Usage (by Department / Committee)	
Results Communication method (e.g. Report, newsletter)	
Comments	

APPENDIX 2 – ADVICE ON WRITING GOOD SURVEYS

Clearly define the purpose of your survey. Advance planning helps ensure that the survey asks the right questions to meet the objectives and generate useful feedback/data.

Note the purpose of the survey. To ensure focused responses, outline at the beginning of the survey the reason you are asking questions and how you will use the results.

Keep it concise. Draw a mental line between what you "must know" and what would be "interesting to know." There is also a third category of information that "doesn't matter."

Keep it simple. Use plain language that is direct and familiar to the respondents. Avoid jargon or technical terminology – the recommended reading age for any audience is 12 years.

Spell it out. Do not ask questions that assume respondents are familiar with the specifics of the issue. Include details or additional information if necessary. Titles, abbreviations, and product names are often sources of misunderstanding. When in doubt, spell it out.

Start with easy questions. Begin the survey with questions that are likely to be easy to answer to get the respondent involved. Yes/No questions or simple multiple-choice questions are ideal to start with. Rating scales should come later. Open-ended questions usually come last as they give the respondent the opportunity to reflect on the topic throughout the survey.

General before specific. The issues raised in one question can influence how people think about the next question. It's a good idea to ask general questions first and move on to more specific questions later.

Avoid leading questions. You don't want to lead your respondents into answering a certain way based on the wording of the questions. For example, instead of asking, "We have recently upgraded our equipment to world-class levels. What are your thoughts on the world-class equipment?" ask, "What are your thoughts on the changes to our equipment?"

Avoid loaded questions. These types of questions use emotionally charged items like words or stereotypes, which can push respondents towards a specific answer choice.

Use closed questions whenever possible. Specific choices (e.g., Yes or No) make it easier to analyse results. Closed-ended questions can take the form of yes/no, multiple-choice, or rating scale. Open-ended survey questions allow people to answer in their own words and may provide useful qualitative information and insights.

Test your survey. Before you send the survey to real respondents, ask a sample group to take the survey (not people who were involved in creating it). After they've completed it, ask if they had problems understanding any questions or had answers that were not available on the list of choices. It's much easier to change the questionnaire before you send it than after!

Consider sending reminders. While not appropriate for all surveys, sending out reminders can often provide a significant boost in response rates. This is easier with online surveys.

Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full [EqIA](#).

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the [EqIA Sharepoint](#) or contact:

Email: Inclusion.hdd@wales.nhs.uk

Tel: 01554 899055

Director and Directorate	Nursing, Quality and Patient Experience
Service Area	Patient Experience

Title of Procedure, Project, Proposal, Policy being screened:	568 - Production and Use of survey guideline

**Description of the Procedure/ Project/ Proposal/ Policy being screened
(including key aims and objectives)**

Aim:

To provide a clear process and guidance for the development, ratification and use of surveys across Hywel Dda University Health Board (UHB). This includes the provision of surveys for patients, their relatives, carers, public, stakeholders and staff members.

Objectives to achieve the Aim:

Quality Assurance: To provide a quality assurance process for all surveys developed by the Health Board, ensuring they follow good practice, are supported by a process of good governance, and portray a positive, professional image of the organisation.

Staff Awareness: To ensure staff are aware of the Health Board's requirements and standards for producing good quality, effective people experience, engagement, and staff surveys.

Organisational Understanding: To ensure surveys used by the Health Board contribute to a wider organisational understanding of people's experience, service development, and organisational development.

Staff Support: To support staff in the development, production, and management of surveys through better awareness of the standards for producing good quality, effective surveys via the Once for Wales Experience System.

Consistent Approach: To provide a consistent approach to the Once for Wales Experience System.

Survey Creation: To provide a consistent approach to creating and producing surveys via the Health Board's Once for Wales Experience System (CIVICA).

These objectives align with best practices for survey development and management, ensuring quality, consistency, and effective use of survey data within the Health Board. If you have any specific queries or need further advice, please email: patientexperience2@wales.nhs.uk

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

This guidance can support the use of patient surveys in formal research or clinical audits. However, for further advice, please consult the Clinical Audit and Research and Development departments as follows:

clinical.audit@wales.nhs.uk

https://nhswales365.sharepoint.com/:u:/r/sites/HDD_Clinical-audit/SitePages/Clinical%20Audit.aspx?csf=1&web=1&e=bfzqYu

The Patient Experience Team and Engagement Team advise and provide support on surveys for departments and wards across Hywel Dda University Health Board.

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact).

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqlA must be undertaken: [Equality Impact Assessments \(EqlAs\) \(sharepoint.com\)](#)

Age					
Is it likely to affect older and younger people in different ways or affect one age group and not another?					
Positive Impact	☐	Negative Impact	☐	No Impact	☒
Justification of impact identified: This document provides guidance to staff on production of surveys. There will be a variety of methods and surveys available to ensure age appropriateness. This Guideline will be used to support staff who are asked to produce/ create surveys and would not have any impact due to a person's age.					
Disability					
Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?					
Positive Impact	☒	Negative Impact	☐	No Impact	☐
Justification of impact identified: The guidance is for staff producing surveys. The guidance includes advice on ensuring people with sensory loss such as low vision, can access the survey by increasing survey font on electronic and paper copies and other methods.					
Gender Reassignment					
Is it likely to affect those who either:					
- Have undergone, intend to undergo or are currently undergoing gender reassignment. - Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth					
Positive Impact	☐	Negative Impact	☐	No Impact	☒
Justification of impact identified: This Guideline will be used to support staff who are asked to produce/ create surveys and would not have any gender related impact. There is choice for individuals on completing the equality questions.					

Marriage / Civil Partnership

Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.

Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.

Positive Impact		Negative Impact		No Impact	√

Justification of impact identified:

This Guideline will be used to support staff who are asked to produce/ create surveys and would not have any impact.

Pregnancy and Maternity

Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.

Positive Impact		Negative Impact		No Impact	√

Justification of impact identified:

This Guideline will be used to support staff who are asked to produce/ create surveys and would not have any impact.

Race / Ethnicity

Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?

Positive Impact		Negative Impact		No Impact	√

Justification of impact identified:

There is the option of utilising translation services to support staff and also users in completing the questionnaire. The electronic systems utilised also have translations functions.

Religion or Belief

Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.

Positive Impact		Negative Impact		No Impact	√

Justification of impact identified:

This Guideline will be used to support staff who are asked to produce/ create surveys and would not have any religion related impact.

Sex

Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?

Positive Impact		Negative Impact		No Impact	√

Justification of impact identified:

This Guideline will be used to support staff who are asked to produce/ create surveys and would not have any sex related impact.

Sexual Orientation

Whether a person's sexual attraction is towards their own sex, the opposite sex or either.

Positive Impact		Negative Impact		No Impact	√

Justification of impact identified:

This Guideline will be used to support staff who are asked to produce/ create surveys and would not have any impact due to a person's sexual orientation.

Armed Forces Community

Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'

For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see:

[Armed-Forces-Covenant-duty-statutory-guidance](#)

Positive Impact		Negative Impact		No Impact	√

Justification of impact identified:

This Guideline will be used to support staff who are asked to produce/ create surveys and would not have any impact due to a person's affiliation to the Armed Forces community.

Socio Economic Duty

Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see:

[more-equal-wales-socio-economic-duty](#)

Positive Impact		Negative Impact		No Impact	√

Justification of impact identified:

A reminder for staff is that people may not have a smart phone due to low income. Paper copies are available.

Welsh Language

Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.

Positive Impact		Negative Impact		No Impact	√

Justification of impact identified:

All surveys are produced bilingually Welsh/English.

Requests for surveys in paper format is supported. Surveys in other languages – there is an option in the CIVICA patient experience system.

If a negative impact has been identified, you are not required to complete this form as a full EqlA must be undertaken. A full EqlA template and guidance can be found on the following link: [Equality Impact Assessments \(EqlAs\) \(sharepoint.com\)](#)

Screening Completed by:	Name	Emma Haycocks
	Title	PALS Manager
	Contact details	emma.j.haycocks@wales.nhs.uk
	Date	August 2025
Screening Authorised by:	Name	Louise O'Connor
	Title	Assistant Director
	Contact details	louise.oconnor@wales.nhs.uk

(Directorate level owner of the procedures/ proposals/ projects/ policy)	Date	27 November 2025
Guidance has been provided by Diversity & Inclusion Team:	Name	Alan Winter
	Title	Senior Diversity & Inclusion Officer
	Contact details	Alan.winter@wales.nhs.uk
	Date	28/11/2025
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

6 - For Information

6.1

6.1 - QSEC Work Plan 2025-26

Attachments

[Draft QSEC Work Programme 2025 26 \(3\).pdf](#)

QUALITY SAFETY & EXPERIENCE COMMITTEE WORK SCHEDULE APRIL 2025 – MARCH 2026

Currently, Quality Safety & Experience Committee (QSEC) meets bi-monthly. Based on this, the following table represents a proposal to incorporate the duties as outlined in the Committee's Terms of Reference into a basic work programme April 2025 – March 2026

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Governance								
Welcome and Apologies	Chair	All	✓	✓	✓	✓	✓	✓
Declarations of Interests	Chair	CSO	✓	✓	✓	✓	✓	✓
Minutes from Previous Meeting and Matters Arising not on Agenda	Chair	CSO	✓	✓	✓	✓	✓	✓
Table of Actions (ToA)	Chair	CSO	✓	✓	✓	✓	✓	✓
Review of Terms of Reference (TORs)	Chair	CSO		✓				
Annual Review of Sub Committees TORs	Chair	CSO		✓				
Assurance and Risk Report • Corporate Risks • Operational Risks • Internal and External Audit Reports • Monitoring of Ministerial Directions • Monitoring of Welsh Health Circulars (WHCs)	Executive Leads	RW	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Self-Assessment - Six month review of actions August 2026	Chair	JW			✓			✓final report
Patient/Staff Story	LOC/ Service Leads		✓ Urgent and Emergency Care	✓	✓	✓ Staff Story Cadog Ward Frailty Unit	✓	✓
Policies for Approval (as required)	All	All		✓	✓	✓	✓ Use of Survey Guidelines	✓ Safety Alerts Policy
Targeted Intervention Progress Report	SA	Executive Leads	✓	✓	✓	✓	✓	✓
Assurance								
Annual Report on Committee's Activity	AL/SD	All	✓					
Annual Report from Sub-Committees	SD	SD LOC		✓				
Fragile Service Update Report (TI 32, 33, & 35)	SD	SG/CS		✓				
Clinical Audit Programme for Approval	MH	IB					✓ (outcome from reviews to	

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
							be included June 2026)	
Patient Experience Framework	SD	LOC		✓				
Learning Framework Report (TI 48)	SD	CS					✓	
Getting it Right First Time Governance Review	JW	JW		✓				
Duty of Quality Assurance Report incorporating: • External Inspection and peer reviews (TI34 & 52) • Nurse Staffing Act Assurance (every 6 months) • Walkrounds (a thematic review on 6 month basis) • Quality Improvement outcomes (TI 53) • Quality Impact Assessments (TI 32, 33) • Putting things right (TI 51) • HCAI (TI 50) • Duty of Candour (TI 54) • Learning from significant events • Speaking Up reports on quality themes (every 6 months) • Paediatrics Service Changes BGH • WHC's overview (every other meeting) (TI 52)	SD	CS	✓	✓	✓	✓	✓	✓
Unscheduled Emergency Care Deep Dive including GIRFT Reports and Action Plans	AC	PS	✓			✓		
Mental Health and Learning	AC	RTP	✓					

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Disabilities (MHLD) Deep Dive								
Epilepsy in Learning Disabilities Services	AC	LC/ KI			✓			✓ Public interest recommendations
Waiting List Support	SD/AC	MD/ MP					✓	✓
Sonography - The impact on patient experience and clinical outcomes due to Risk 787: Workforce Pressures in Ultrasound Services	AC				✓			
Primary Care Quality and Safety and Experience Deep Dive	JP	RB	✓					
Waiting List Management	SD	MP					✓	
Auditor General Report on Cancer Services	AC	LH		✓				
Infection Prevention and Control in the Community	AG	MH	✓					
Update Report on the Quality Improvement Strategic Framework 2023- 2026	SD	MD	✓					
Planned Care Review- Impact of Long Waits	AC	PG				✓		
Duty of Candour Annual Report 2024/25	SD	CS		✓				
Duty of Quality Annual Report 2024/25	SD	CS			✓			
Nurse Staffing Levels (Wales) Act: Assurance Reports (as required) –Annual Report and Spring Calculation Cycle	SD	HH		✓		✓		

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Nurse Staffing Levels Impact of Reduction of Agency and Bank Staff on quality, safety and patient experience annual review report	SD	HH				✓		
CHKS Report	MH	MH		✓				
Cleanliness Standards Audit report and Action Plan	JS	SC/ EB		D	✓			
Occupational Therapies Paediatric Improvement action plan	AC	PG		D		✓		
Fuller Inquiry	JS	CB						✓
First Contact Physiotherapist Report	JS/ SD	CS						✓
Patient Experience by Demographic	SD	LOC			✓			
CSP Areas for Consideration: Deep Dives presented at extra ordinary meetings held on 15 September and 4 November								
Clinical Care Group Updates								
Mental Health and Learning Disabilities	AC	RTP						✓
Community and Integrated Medicine	AC	ACh					✓	

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
Operational Allied Health Services	AC	SQ					✓	
Planned and Specialist Care	AC	PG				D	✓	
Estates and Facilities	JS	EB						✓
Public Health	AG	BL						✓
Group Update Reports								
Infection Prevention Strategic Steering Group	SD	CS						✓
Strategic Safeguarding Steering Group	SD	MND						✓
Risks								
Sub Committee Update Reports								
Quality, Safety and Experience	✓	✓	✓	✓	✓ Disestablished			✓ Report on impact of revised governance arrangements
Listening and Learning:	✓	✓	✓	✓	✓	✓	✓ TOR for Annual Review	✓
For Information								

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
HIW Annual Report							✓	
JCC Quality Safety Outcomes Sub Committee			✓	✓	✓	✓	✓	✓
Work plan 2025/26			✓	✓	✓	✓	✓	✓
Patient Experience Report			✓	✓	✓	✓	✓	✓
Agenda setting meeting with Chair and Exec Lead to include discussion on deep dives on new risks (at least 6 weeks before the meeting)	CSO	CSO	✓	✓	✓	✓	✓	✓
Draft agenda to go to Executive Team prior to being issued.	CSO	CSO	✓	✓	✓	✓	✓	✓
Call for papers (at least 4 weeks before the meeting to receive papers at least 14 days before the meeting)	CSO	CSO	✓	✓	✓	✓	✓	✓
Disseminate agenda and papers 7 days prior to the meeting	CSO	CSO	✓	✓	✓	✓	✓	✓
Type up minutes and TOA within 7 days of the meeting	CSO	CSO	✓	✓	✓	✓	✓	✓
Circulate minutes and TOA to Committee for comments, points of accuracy and matters arising within 10 days of the meeting	CSO	CSO	✓	✓	✓	✓	✓	✓
Check and send final version of minutes to the Committee Chair following comments received.	CSO	CSO	✓	✓	✓	✓	✓	✓
Chase updates on TOA before the next meeting and RAG rate	CSO	CSO	✓	✓	✓	✓	✓	✓
Record and track the TOA as part of	CSO	CSO	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	RESPONSIBLE OFFICER	9 April 2025	10 June 2025	15 August 2025	8 October 2025	5 December 2025	13 February 2026
the decision tracker								
Produce written update report for QSEC and Board	CSO	CSO	✓	✓	✓	✓	✓	✓
Prepare schedule of meetings	CSO	CSO					✓	
QSEC Annual Work Programme	CSO	CSO	✓	✓	✓	✓	✓	✓

Initials

SD- Sharon Daniel	CSO-Katie Lewis	AL- Anna Lewis	LOC- Louise O'Connor	MH- Mark Henwood
AC- Andrew Carruthers	CL: Cerian Llewellyn	CS- Cathie Steele	SG- Subhamay Ghosh	JS- James Severs
HH- Helen Humphreys	CG- Ceri Griffiths	KJ- Keith Jones	RW- Rachel Williams	AG- Ardiana Gjini
KG- Kathy Greaves	GRD- Gail Roberts Davies	CL- Caroline Lewis	Ps: Peter Skitt	SC: Simon Chiffi
BL- Bethan Lewis	LC- Liz Carroll	SA- Shaun Ayres	MD- Mandy Davies	LH- Lisa Humphreys

7 - Date of Next Meeting : 12 February 2026