



Quality and Safety Assurance Report

Quality, Safety and Experience Committee

April 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 including nationally reported patient safety incidents
- Duty of Candour
- Patient Experience and Complaints
- Welsh Risk Pool: Concerns Assessment
- Infection, prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)
- Speak up
- Welsh Health Circulars

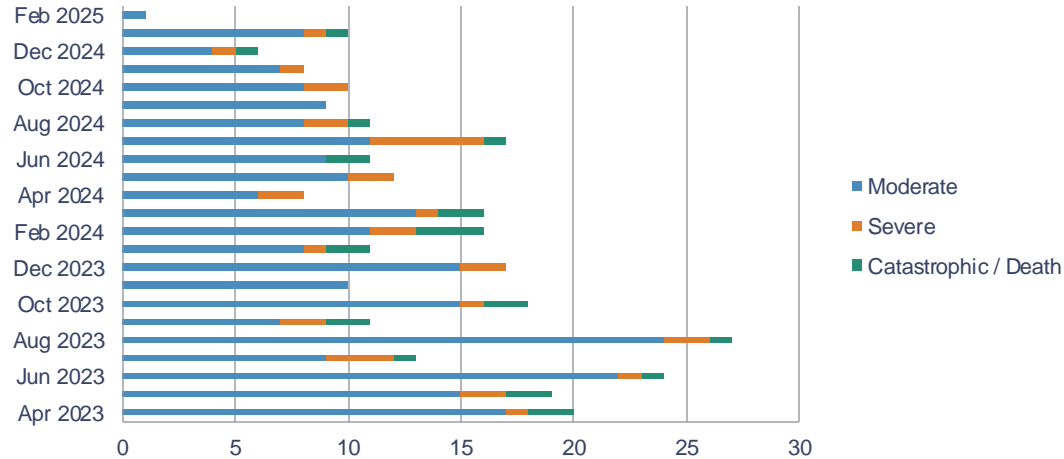
Duty of Candour



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



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

		Harm post investigation					Total
		None	Low	Moderate	Severe	Catastrophic / Death	
Manager's interim harm assessment	Moderate	11	2	110	2	1	155
	Severe	1	5	3	7	3	19
	Catastrophic / Death	2	4	1	2	2	11
	Total	14	41	114	10	6	185

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	44
Pressure ulcer developed or worsened during care in this clinical care area/caseload	39
Pressure ulcer present before admission to this clinical care area/caseload	3
Pressure from medical device present before admission to this clinical care area/caseload	2
Accident, Injury	36
Slip, trip or fall	34
Patient injury	2
Maternity adverse occurrence	22
Maternity adverse occurrence - Neonate	14
Maternity adverse occurrence - Maternal	8



Learning identified:

- Importance of clear documentation when ribbon gauze or a surgical swab is intentionally left in situ
- Ensuring senior review when there are complex needs
- Consideration of bed space provide closer monitoring

Service User Feedback at a Glance December 2024 – January 2024



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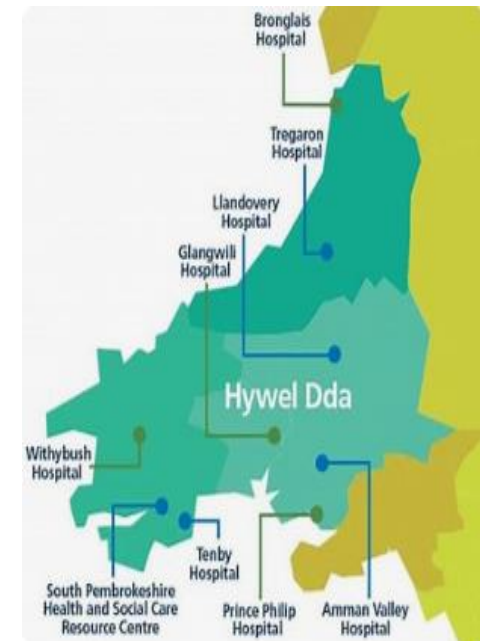
We continue to receive many positive stories and comments about the services provided by our caring and compassionate staff. We are continually sharing and celebrating these achievements across the organisation. We will share information relating to the figures later in the report.

1366 service users completed the Your NHS Wales Experience survey of which 11.3% responded with poor or very poor rating for their overall experience. 93% of the responses were from A&E areas and the negative feedback mainly related to long waits and corridor care.

201 compliments were received direct to wards, departments or Corporate Office. These frequently highlight the professionalism and compassionate care provided by healthcare teams. Example: "Your dedication to all patients that come through the Ward shows how exemplary you all are!"

Complaints: 466 new complaints were received into the health board. 424 complaints were closed, 164 were closed within 5 working days, 260 managed through the Putting Things Right formal process representing an 40%/60% split.

37633 individuals received our friends and family patient experience survey, in which 6355 responded following their attendance, representing a 18.8% response rate, 94.2% reported a positive experience. Community & Primary Care and Mental Health Outpatient saw significant improvements (30+%) from the last period. Maternity Inpatient improved by 12%. The only area to see a slight drop is Paediatric Outpatient, however this relates to only 1 negative response



We also received 374 new enquiries. the main enquires are Primary care, Ophthalmology, A&E and Health records. These were relating to delays in transport, waiting times and communication

Friends and Family (FFT) Patient Feedback by Location

	% Positive	% Negative	Total Responses	Percentage of total responses
Bronglais				
Total	93.6%	6.4%	784	100%
Outpatient Department	93.9%	6.1%	280	36%
Accident and Emergency Department	88.3%	11.7%	252	32%
Day Surgery Unit	100.0%	0.0%	32	4%
Integrated Sexual Health Clinic	90.6%	9.4%	32	4%
Cardio-Respiratory Department	100.0%	0.0%	26	3%
Endoscopy Department	100.0%	0.0%	26	3%
Rhiannon Ward	100.0%	0.0%	25	3%
Clinical Decisions Unit (Green)	100.0%	0.0%	18	2%
Angharad Ward	100.0%	0.0%	13	2%
Ceredig Ward	100.0%	0.0%	12	2%

	% Positive	% Negative	Total Responses	Percentage of total responses
Glangwilli				
Total	92.2%	7.8%	1854	100%
Outpatient Department (Blue)	95.1%	4.9%	694	37%
Accident and Emergency Department	83.7%	16.3%	384	21%
Cardio-Respiratory Unit	99.2%	0.8%	127	7%
Tysul Ward	93.5%	6.5%	67	4%
Same Day Emergency Care Unit	97.8%	2.2%	46	2%
Aberglasney Suite	97.8%	2.2%	45	2%
Endoscopy Department	97.3%	2.7%	37	2%
Picton Ward	75.8%	24.2%	35	2%
Day Surgery Unit	100.0%	0.0%	33	2%
EEG/EMG Department	100.0%	0.0%	27	1%

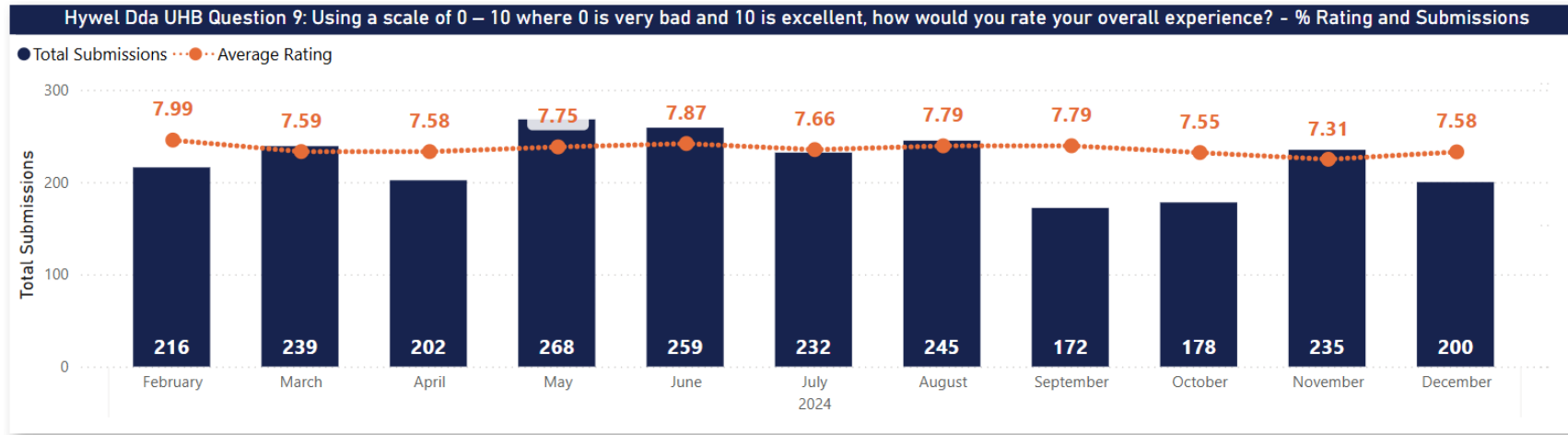
	% Positive	% Negative	Total Responses	Percentage of total responses
Prince Phillip				
Total	96.1%	3.9%	1560	100%
Outpatient Department	96.4%	3.6%	811	52%
Minor Injuries Unit	93.7%	6.3%	263	17%
Cardio-Respiratory Department	98.8%	1.3%	81	5%
Day Surgery Unit	96.8%	3.2%	64	4%
Rheumatology Department	98.0%	2.0%	56	4%
Pre Assessment	91.8%	8.2%	52	3%
Same Day Emergency Care Unit	100.0%	0.0%	41	3%
Endoscopy Department	100.0%	0.0%	39	3%
Physiotherapy Department	100.0%	0.0%	35	2%
Acute Medical Assessment Unit	87.5%	12.5%	27	2%

	% Good	% Poor	Total Responses	Percentage of total responses
Withybush				
Total	94.1%	5.9%	1204	100%
Accident and Emergency Department	86.8%	13.2%	332	28%
Outpatient Department (A)	97.0%	3.0%	312	26%
Cardio-Respiratory Department	98.5%	1.5%	130	11%
Physiotherapy Department	96.5%	3.5%	59	5%
Same Day Emergency Care Unit	97.9%	2.1%	52	4%
Gynaecology Care Suite	95.7%	4.3%	48	4%
Day Surgery Unit	92.5%	7.5%	41	3%
Rheumatology Department	96.7%	3.3%	32	3%
Endoscopy Department	96.6%	3.4%	29	2%
Medical Day Unit	100.0%	0.0%	18	1%

Please note that within the community section is an area called 'unmapped' these are new location codes which are currently being mapped into the system, these are across the health board and not just within community. These are being mapped on an ongoing basis.

Outpatient have the largest number of response from the FFT with the exception of Withybush for this period.

Health Board Overview – People’s Experience in the ED



Average experience rating (for completed surveys only) between Feb-24 to Jan-25 as of 31/01/2025

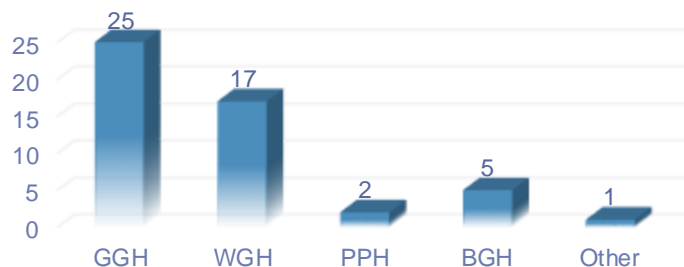
Organisation	Total Submissions (excluding Did not answer)	Average Rating (0-10)
CTMU UHB	11,360	7.71
HDU UHB	2,659	7.69
CVU UHB	5,759	7.44
BCU UHB	4,893	7.06
SBU UHB	1,115	6.34
ABU UHB	242	6.26
All Wales	26,028	7.45

Health Board Overview – Outcomes from complaints

So far in financial year 2024/25, 80% of complaints were closed within the 30-working day target timescale advised in the 'Putting Things Right Regulations'. The national target is 75%.

In Q4 to date, 70 complaints have either been closed and not upheld, or upheld but not found to have caused harm. Since April this financial year, 50 cases have been escalated to redress because failings have, or may have caused harm to patients. These have mostly occurred at our general hospital sites (below).

REDRESS CASES BY SITE APRIL 2024 - FEB 2025



The two most recent failings identified in February 2025 pertain to the incorrect citing of a catheter under Urology and a missed lesion when reporting an X-ray under Radiology. Learning from events reports will be produced following these incidents.

10 cases were escalated to redress in Q3 which is lower than the preceding quarters this year (Q1 = 14, Q2 = 20):

Cases escalated to Redress 2024/ 25

April	4
May	7
June	3
July	5
August	7
September	8
October	1
November	4
December	5
January	4
February	2
Total	50

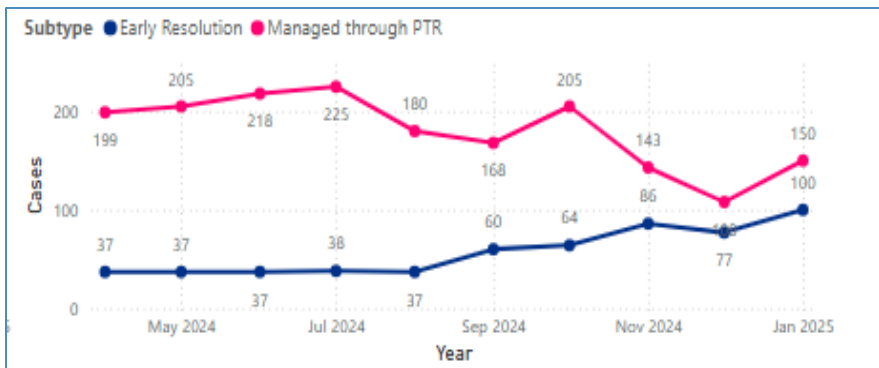
Learning from the Ombudsman

In Quarter 3 there were 18 interventions from the Ombudsman, which included 4 new investigations. There have been no new investigations in Quarter 4 to date. There have been 27 decisions not to investigate since the start of Quarter 3.

In Quarter 4 to date, there have been 4 investigation reports received, 3 of which have been upheld. The investigations founds failings in the management of high-risk pregnancy, failings in dermatological care and in missing the opportunity to offer urgent face to face outpatient appointment.

Health Board Overview – Complaints Management

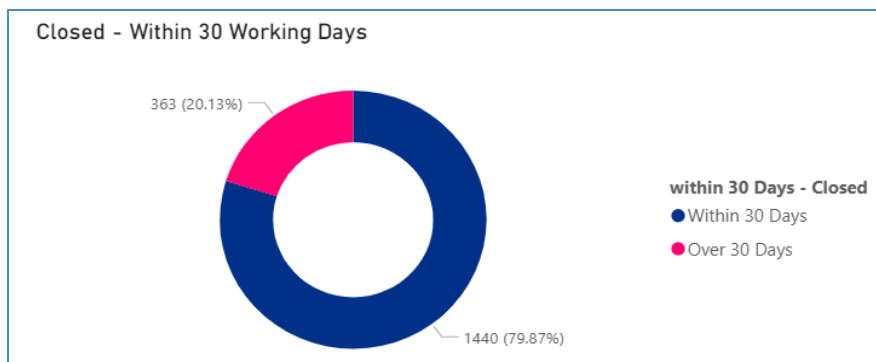
Number of complaints received by month since April 2024 (early resolution and PTR)



There has been a 27% reduction in complaints managed through PTR in Quarter 3 this year compared to Quarter 1. In line with this, there is a significant increase in early resolutions at the end of Quarter 3 compared to the start of the financial year.

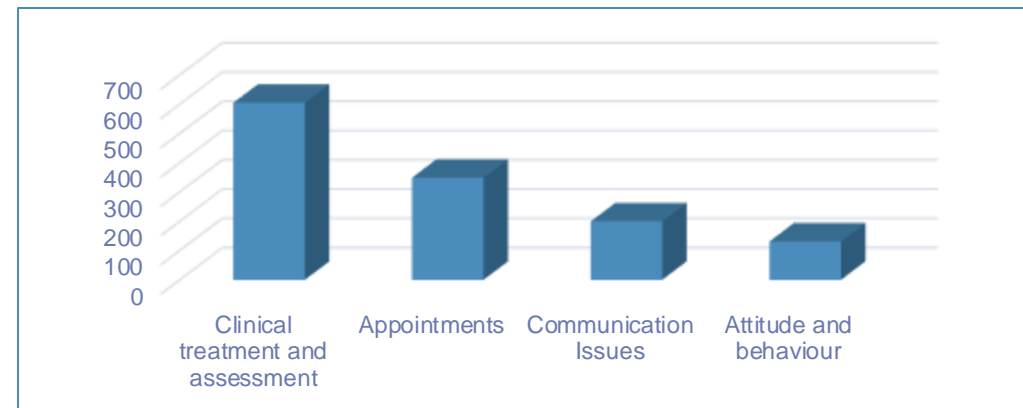
There is also reduction in the number of complex complaints needing investigation (typically grade 3 and above) - 20% less in Q3 24/25 compared to the same quarter last year.

Proportion of complaints within 30 working days (2024/25)



The chart shows an improvement in performance since 2023-24 and has remained on an improvement trajectory during the current year, with performance remaining above the all-Wales average.

Top four themes of PTR complaints since April 2024



Complaints about clinical treatment/ assessment arise most frequently in Accident and Emergency (A&E), Trauma and Orthopaedics (T&O) and Ophthalmology services and account for a third of all this category.

Nearly one third of all complaints about appointments and waiting times are linked to Ophthalmology services.

Complaints about communication, attitude and behaviour are spread across Health Board services.

Welsh Risk Pools: Concerns Assessment



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The Welsh Risk Pool have concluded their annual Concerns Assessment and issued their final report. The full report is attached as an appendix to this report.

The review considers a number of areas for assessment, each focussed on a different aspect of the Putting Things Right (PTR) process:

- Management of Concerns (Incidents)
- Management of Concerns (Complaints & Enquiries)
- Redress Case Management
- Claims Case Management
- Inquest & Coronial Inquiry Management
- Organisational Learning
- Welsh Risk Pool (WRP) Reimbursement Process

Areas of Good Practice

- Sending an introductory letter once the Redress Team had taken over the matter.
- Excellent, bespoke email correspondence with Complainants particularly in sensitive matters
- Payments and invoices reviewed prior to submission of matters for reimbursement.
- Excellent inquest and coronial inquiry management in place.
- Good structure in place for redress management.
- Good Claims management structure in place.
- Close working relationship with finance, leading to accurate data points.

Management of Concerns (Incidents)	REASONABLE ASSURANCE	
Management of Concerns (Complaints & Enquiries)	SUBSTANTIAL ASSURANCE	
Redress Case Management	SUBSTANTIAL ASSURANCE	
Claims Case Management	SUBSTANTIAL ASSURANCE	
Inquest Case Management	SUBSTANTIAL ASSURANCE	
Organisational Learning & Learning from Events	SUBSTANTIAL ASSURANCE	
WRP Reimbursement Process	SUBSTANTIAL ASSURANCE	

Recommendations

- R01 HDUHB should review reports, dashboard and escalation to encourage timely and accurate update of incident records
- R02 HDUHB to ensure the complaints/enquiry subject section within the feedback function is completed to reflect the issues raised by the complainant and the investigation findings of each of the issues raised
- R03 HDUHB to update contacts to include key persons involved in the complaint – other than just the mandatory investigator or handler who are recorded separately
- R04 HDUHB to ensure the SOP for verbal responses is followed in all matters
- R05 HDUHB to ensure that the issues detailed in the ToR are checked to ensure that they are recorded in the Complaint Subject section
- R06 HDUHB to ensure all action plans and evidence of actions undertaken are uploaded to the Datix Cymru System.
- R07 HDUHB should ensure that when a complaint record is closed, a check is undertaken to ensure that all documentation relating to the case is uploaded
- R08 HDUHB should review its processes for incidents coming into Redress to ensure cases are not being missed
- R09 HDUHB to review the template introductory letter sent once the Redress Team has taken over the matter to ensure the wording is fully appropriate.
- R10 HDUHB to consider issuing an Inquest Policy and SOP which can provide clarity on the process to the wider organisation.
- R11 HDUHB to utilise Datix Cymru for the management of inquests ensuring all documents are uploaded.



Performance de-escalation summary

Latest position key

Goal achieved

Making good progress towards goal

Minimal progress made or decline from previous month

Same as baseline or worse

Measure	De-escalation criteria	Baseline	Goal	Latest position						
				Mar-23	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	
Infections	Number of hospital onset C.difficile infections	25% reduction, maintained for 3 months	8	6	6	7	8	6	8	4
	Number of hospital onset Staph aureus infections	33% reduction, maintained for 3 months	3	2	0	0	2	3	4	4
	Number of hospital onset E.coli infections	25% reduction, maintained for 3 months	7	5	8	4	9	5	0	5

Table 1. Latest month count of specimens by acute hospital in Hywel Dda UHB, Feb 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						
Latest month						
Select organism group						
All organisms						
Bronglais General Hospital	1	0	2	4	1	0
Glangwili General Hospital	2	1	2	13	2	0
Prince Philip Hospital	2	0	1	4	0	0
Withybush General Hospital	2	0	7	13	3	2

◀ than last month

Analysis



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MSSA bacteraemia	Total count	CO Count	HO Count
Bronglais General Hospital	2	2	0
Glangwili General Hospital	2	2	0
Prince Philip Hospital	1	1	0
Withybush General Hospital	7	4	3

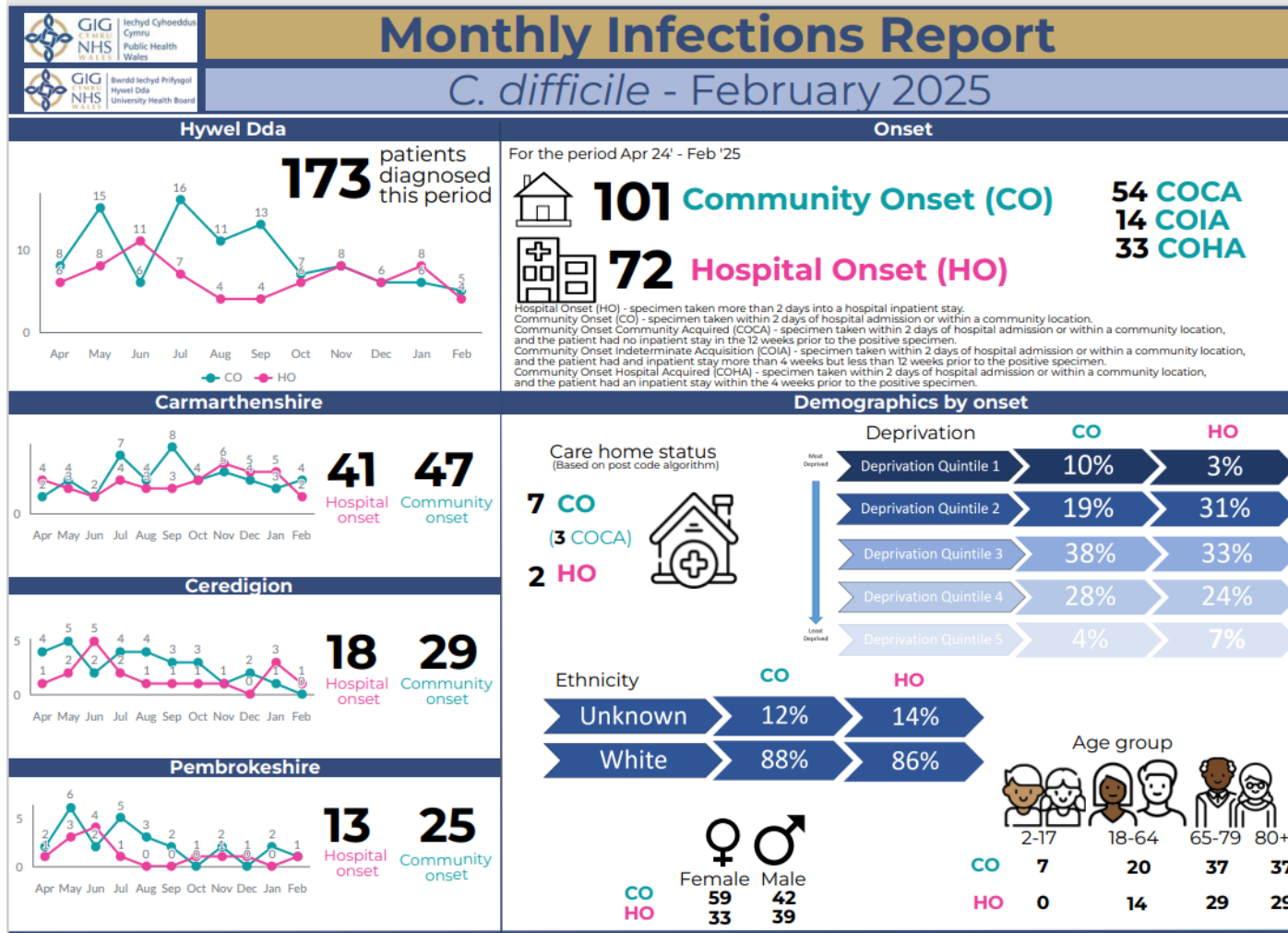
E.Coli bacteraemia	Total count	CO Count	HO Count
Bronglais General Hospital	4	4	0
Glangwili General Hospital	13	10	3
Prince Philip Hospital	4	4	0
Withybush General Hospital	13	11	2

Definitions:

Community onset (CO) - specimen taken in community location or less than 3 days into hospital inpatient stay.

Hospital onset (HO) - specimen taken more than 2 days into a hospital inpatient stay

Healthcare acquired / associated infection (HCAI) - as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting

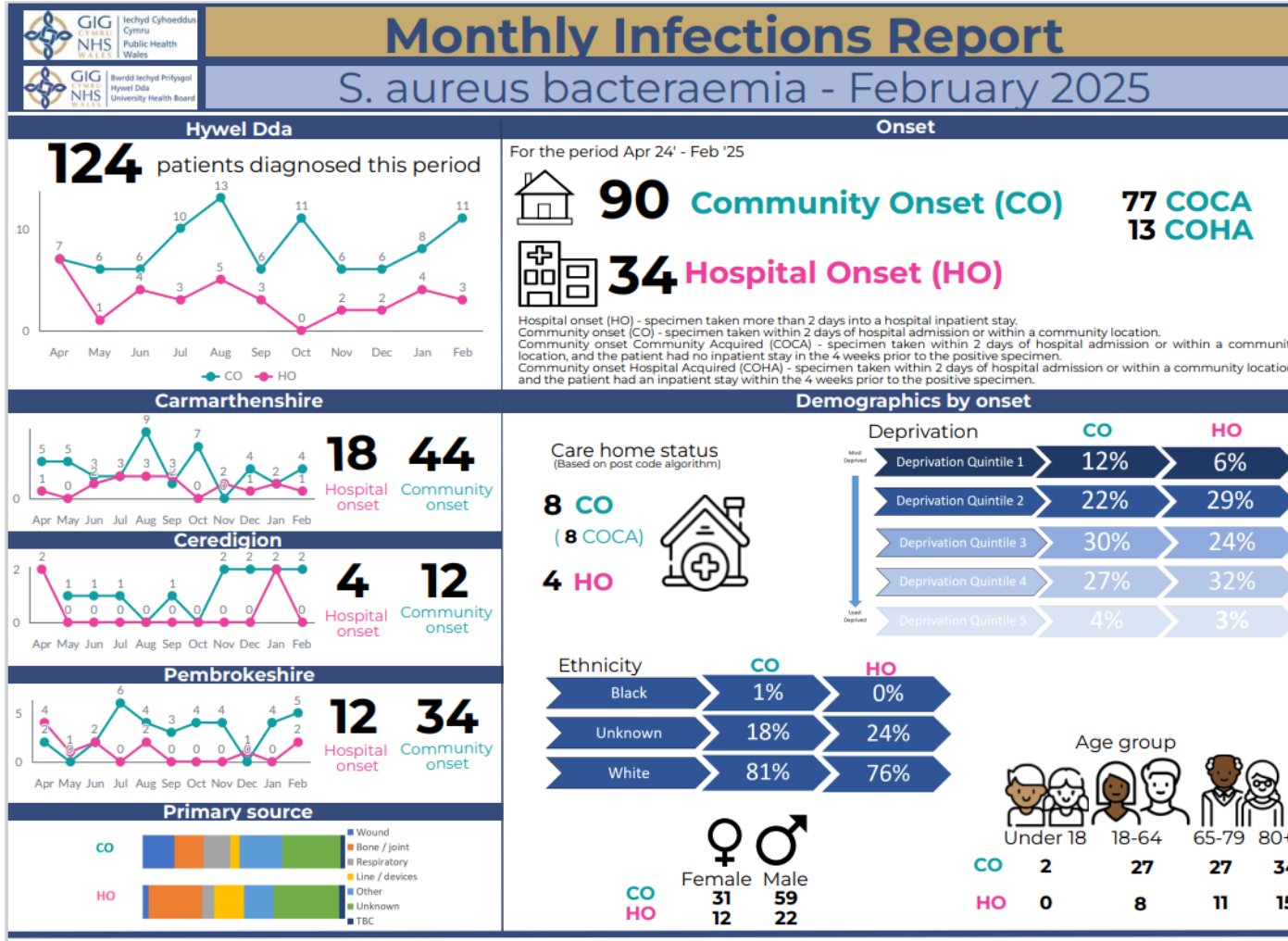


Actions

- C.diff infection (CDI) Improvement Group established with Deputy Medical Girector chairing
- Antimicrobial Group also continues. This will support progress expected against the Welsh Health Circular (WHC) Antimicrobial Resistance (AMR) and Healthcare Acquired Infections (HCAI) Improvement Goals 2024/25.
- Continued use of DiffX and HPV disinfection. Trail of new HPV machines has been completed in Bronglais General Hospital (BGH) and Glangwili General Hospital (GGH) with positive feedback and engagement from hotel facilities
- Awaiting update Targeted Estates Fund (TEF) bids
- Self assessment against the C.diff Framework for Wales ongoing

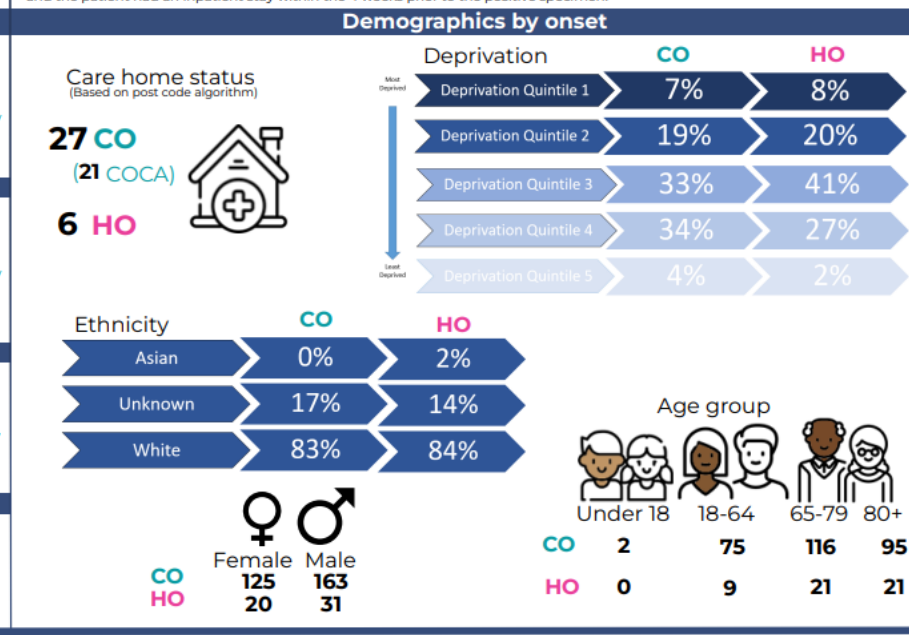
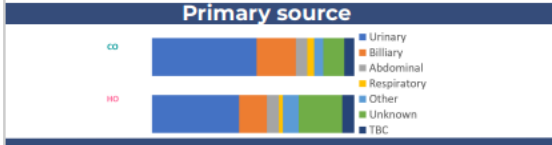
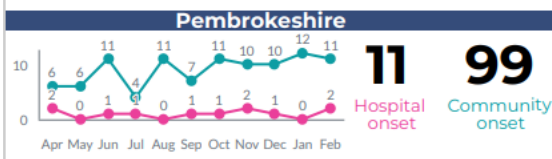
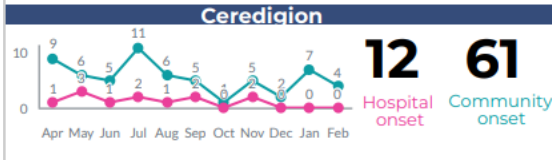
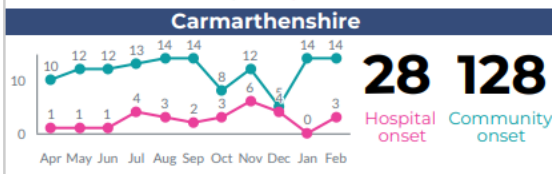
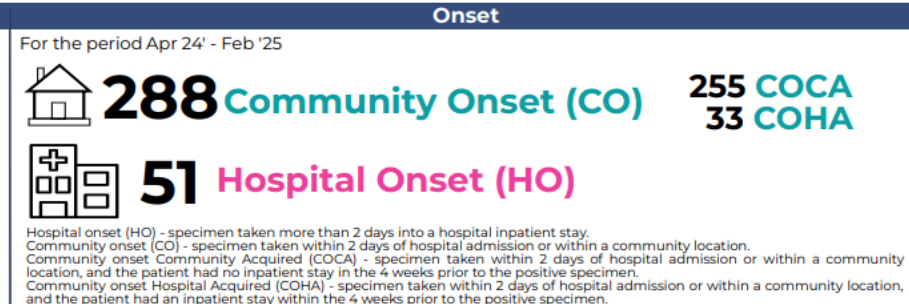
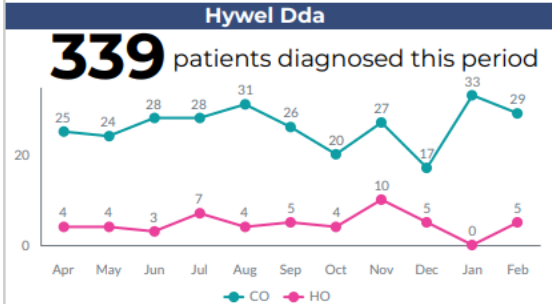
Targeted work

- HCAI Assurance Groups continue to scrutinise infections per month within directorates
- Deep clean of Prince Philip Hospital (PPH) wards due to an increase in C. diff clusters and cross infections commenced on 10 March 2025.



- Aseptic Non Touch Technique (ANTT) practical compliance 80.60% for the HB
- Peripheral Venous Catheter (PVC) bundle compliance monitored, with an emphasis on devices being removed at the earliest opportunity
- Hand hygiene reviewed as part of the Quality Indicator Audits

Monthly Infections Report
E. coli bacteraemia- February 2025



- Spike in E.coli cases for November 2024
- Less variance noted thought data set
- Lower cumulative rate in comparison to previous year and below trajectory
- 3 cases with a hepatobiliary source and 4 with a urinary source

Actions

- Continued education of staff around catheter and device care
- To continue to profile ANTT



There has been 1 new report published by Health Inspectorate Wales (HIW) titled Children and Young People Mental Health Review (see below), but no further reports were published by Health Inspectorate Wales or the Human Tissue Authority (HTA) relating to the Health Board in the period 1st November 2024 to 31st January 2025.

[Joint Review: How are healthcare, education, and children's services supporting the mental health needs of children and young people in Wales? | Healthcare Inspectorate Wales](#)

The review, undertaken jointly by HIW and education inspectorates in Wales recommends improvements in mental health support for children and young people. The field work took place during quarter 1 and the report has generated 9 recommendations and a total of 23 actions which are underway by the service at the point of reporting. Update on slide 21 and 22 – 8 HIW inspections remain open as the DNACPR and Stroke reports have been completed.

The Health Board have received a number of assurance queries from HIW during the reporting period.

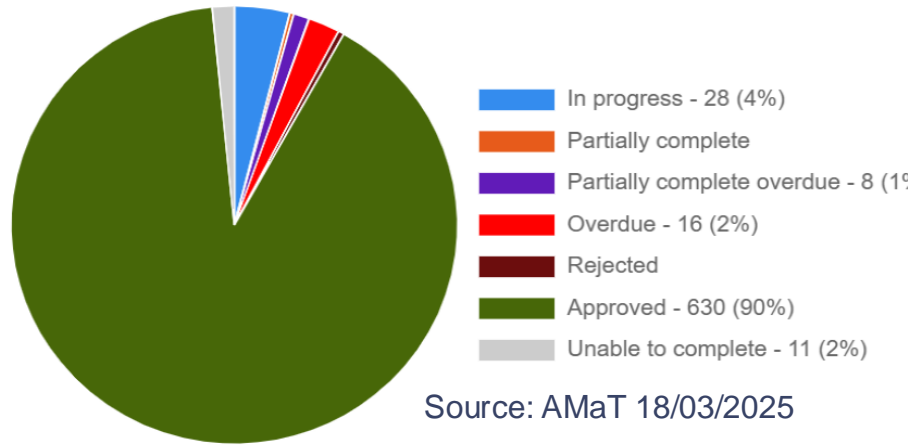
All open HIW / other body inspection actions plans are chased on a bi-monthly basis by the Quality, Assurance and Safety Team and escalated if no progress is seen within 14 days. Services are able to log into the live Audit Management and Tracking (AMaT) system and update their own actions and add upload evidence of completion.

Services are actively supported to utilise AMaT and supported and engaged during an inspection to develop a SMART action plans within a realistic timeframe. HIW expect an update to all action plans on a 3 monthly basis until completion.



HIW Quality Checks/Inspections: Reviews and inspections

Improvement Actions relating to HIW reviews



In comparison to the position in February 2024, there has been improvement in closure of actions.

	Position Feb 2024	Position as at 21 Jan 2025
Overdue	51	14
Partially complete (overdue)	17	9
Partially complete	1	5
In progress	119	8

See appendix for list of overdue actions

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
10	122/202 (60%)	9/11 (82%)	0	0	28	2	8	16	5	0	3	216

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
24	214/214 (100%)	10/10 (100%)	0	0	0	0	0	0	6	0	0	414

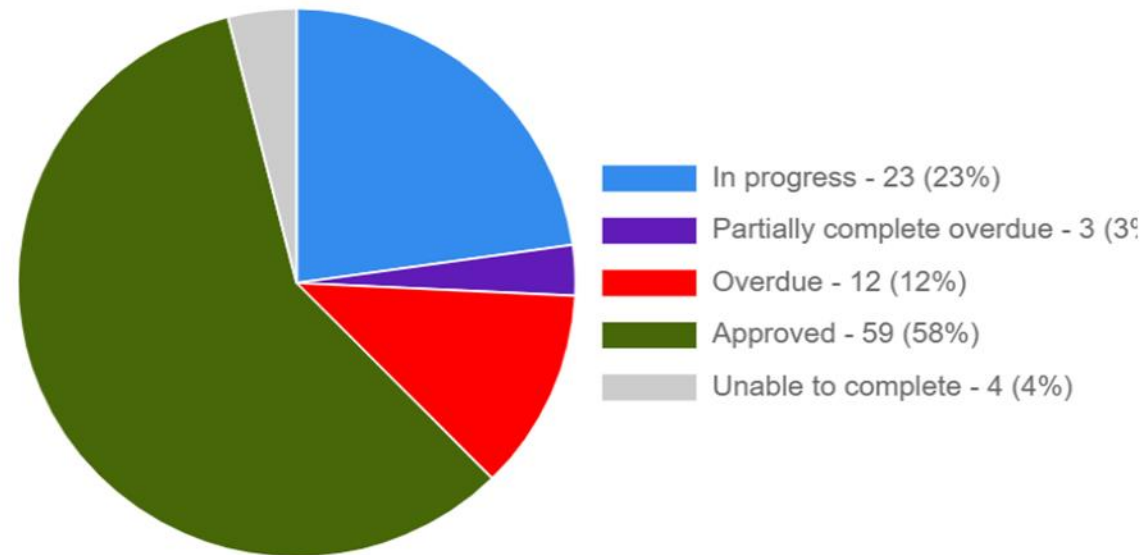
HIW Quality Checks/Inspections: Open reviews and inspections

Code	Title	Type	Date of inspection	Origin	Recommendations	Act
Healthcare Inspectorate Wales (HIW)/2024/395	Bryngolau Ward, Prince Philip Hospital	New	02/09/2024	Healthcare Inspectorate Wales (HIW)	40	51
Healthcare Inspectorate Wales (HIW)/2024/302	Glangwili Hospital – Morlais Ward	New	01/07/2024	Healthcare Inspectorate Wales (HIW)	9	18
Healthcare Inspectorate Wales (HIW)/2024/396	HIW Children and Young People Mental Health Review	New	05/02/2024	Healthcare Inspectorate Wales (HIW)	9	23
Healthcare Inspectorate Wales (HIW)/2023/152	HIW DNACPR Review (Dec 2023)	New	18/12/2023	Healthcare Inspectorate Wales (HIW)	17	20
Healthcare Inspectorate Wales (HIW)/2022/19	HIW GGH IRMER Inspection (Nov 2022)	New	15/11/2022	Healthcare Inspectorate Wales (HIW)	21	36
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)	New	07/03/2023	Healthcare Inspectorate Wales (HIW)	40	33
Healthcare Inspectorate Wales (HIW)/2024/86	HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024	New	31/01/2024	Healthcare Inspectorate Wales (HIW)	9	14
Healthcare Inspectorate Wales (HIW)/2022/50	HIW National Review of Patient Flow (Stroke Pathway)	New	14/03/2022	Healthcare Inspectorate Wales (HIW)	46	54
Healthcare Inspectorate Wales (HIW)/2023/69	HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	New	16/10/2023	Healthcare Inspectorate Wales (HIW)	19	25

HIW Quality Checks/Inspections: Reviews of services and inspections

Mental Health and Learning Disability themes from HIW* actions

(Data extracted from AMaT system 28th February 2025)



All HIW Recommendations for Mental Health and Learning Disabilities are categorised as “Must Do”

* HIW plus other inspection activity has been reviewed to produce this data

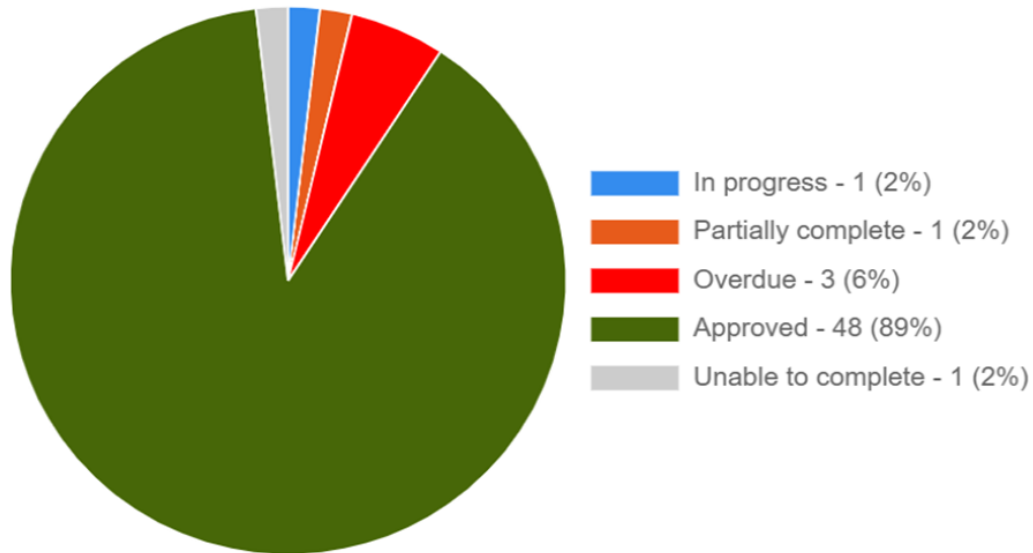
The titles of the current active Mental Health and Learning Disability inspections / reports on AMAT

Audit Wales Review of Mental Health and Learning Disabilities Directorate Governance Arrangements
HIW Children and Young People Mental Health Review
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)
HIW Joint Thematic Review of Community Mental Health Teams 2017-2018
Internal Audit Mental Health and Learning Disability Services Timely Access
NHS Delivery Unit All Wales Review of Primary and Secondary Mental Health Services for Children and Young People

HIW Quality Checks/Inspections: Reviews of services and inspections

The Ionising Radiation (Medical Exposure) Regulations (IRMER) 2017 HIW inspections themes

(Extracted from the AMAT system 28 February 2025)



Titles of live inspections / reports on AMAT system (3 reports subsequently closed):

HIW GGH IRMER Inspection (Nov 2022)
HIW IRMER Diagnostic Imaging x-ray department Withybush Hospital January 2024
HIW IRMER GGH 0725 report
HIW Quality Check - Remote Inspection Visit of Prince Philip Hospital (IRMER)
HIW WGH IRMER inspection October 2021

All IRMER recommendations and actions are categorised as “Must Do”



- In September 2023, Welsh Government issued a Speaking Up Framework. An action plan was developed to ensure that all recommendations in the framework were considered in the responsive review of the Health Board's arrangements in place at the time. All actions have been completed.
- In October 2024, Internal Audit undertook a review of the Health Board's Speak Up Safely arrangements. One agreed action remains open; the expected completion date is May 2025.
- In response to the Framework and the Internal Audit report, the Health Board's speak up arrangements have been reviewed and strengthened.
- Mechanisms available to speak up include:
 - Working in confidence platform
 - Speak up guardians supported by the Voices Network
 - Incident reporting – ability for the reporter to mark as sensitive which triggers a corporate review allowing for redirection if issue is speak up.
- A report will be shared with the People and Organisational Development Committee in May 2025.
- An update will be brought to the QSEC meeting in June 2025 which will include themes relating to quality and patient safety.

Implementation of Welsh Health Circulars (WHCs)



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There are 21 open WHCs aligned to QSEC as at March 2025. No new WHCs have been issued since the previous report to Committee.

All WHCs are managed via the Audit Management and Tracking system (AMaT), which leads have access to directly update and upload relevant evidence to demonstrate compliance with their requirements.

Each WHC is assigned a RAG status – the table below provides the definition for each category, along with the number of WHCs assigned to each category as at March 2025, and the number of WHCs noted as completed since the previous report:

RAG Status	Definition	Number of WHCs
Red	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.	7
Amber	A plan is in place and on schedule to be completed by the timescale provided by the Lead Officer (if a timescale is not provided within the WHC)	10
Green	Completed	10
External	Considered to be outside the gift of the Health Board to currently implement, for example reliant on an external organisation to implement.	4

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 behind schedule (Red)

Welsh Health Circular	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
006-18: Framework of Action for Wales, 2017-2020 (<i>Not Available Online</i>) – issued Feb 2018	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Service unable implement due to funding requirements	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	To complete a QIA To escalate the inability to proceed with implementation via CCG management structures to agree next steps
033-18: Airborne Isolation Room Requirements – issued July 2018	Director of Nursing, Quality and Patient Experience	Interim Director of Nursing, Quality and Patient Experience	Service unable to provide implementation date due to capital funding requirements	Risk Ref: 1640 Current Risk Score: 15 Impacts: Increased risk of transmission of infectious diseases	To complete a QIA To escalate the inability to proceed with implementation via CCG management structures to agree next steps
017-19: Living with persistent pain in Wales guidance – issued May 2019	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Original implementation date of 31 Jan 2025 lapsed, with revised completion date of 31 Jan 2026 provided.	No risk noted on Datix	To complete a risk assessment To complete a QIA
009-21: School Entry Hearing Screening pathway - issued March 2021	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Service unable to provide implementation date due to funding requirements	Risk Ref: 1456 Current Risk Score: 8 Impacts: Detrimental impact on quality, accuracy and consistency of screening services provided	To complete a QIA To escalate the inability to proceed with implementation via CCG management structures to agree next steps

WHCs behind schedule (Red) - continued

Welsh Health Circular	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 of 31 July 2023 lapsed, with revised completion date of 31 Aug 2025 provided	Risk Ref: 1615 Current Risk Score: 12 Impacts: Right to independence for children and young people; Access to the same services as their peers	None - Nursing post that will enable the CCG to comply with WHC requirements approved by Financial Control Group in February 2025. The timeline for implementation has been set as August 2025 to account for the recruitment process.
030-23: New 2023 National Safety Standards for Invasive Procedures (NatSSIPS2) by the Centre for Perioperative Care (CPOC) and Patient Safety Notice PSN 034 – issued August 2023	Medical	Medical Director	No implementation date received from the service	No risk noted on Datix	Service to provide progress update/statement of compliance on AMAT, and an implementation date if not currently compliant To complete a risk assessment To complete a QIA
006-24: National Clinical Guideline for Stroke, for the UK and Ireland – issued March 2024	Community and Integrated Medicine	Chief Operating Officer / CCG Director for Community and Integrated Medicine	Service unable to provide an implementation date pending progression of the wider Clinical Service Plan	Risk Ref: 233 Current Risk Score: 12 Impacts: Delayed assessment and treatment of patients; Increased length of stays	To complete a QIA

WHCs in Progress (Amber)

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	UHB Implementation Date
017-22: Wales rare diseases action plan 2022 to 2026 – issued June 2022	Medical Director	Medical Director	Dec-26
019-22: Non-Specialised Paediatric Orthopaedic Services - issued June 2022	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Apr-25
041-23: Wales rare diseases action plan refresh 2022 to 2026 – issued January 2024	Medical Director	Medical Director	Dec-26
002-24: Standards for Competency Assurance of Non-Medical Prescribers in Wales - issued March 2024	Director of Nursing, Quality and Patient Experience	Director of Primary Care, Community and Long Term Care	Mar-26
016-24: Healthy Child Wales Programme: for school aged children - issued April 2024	Planned and Specialist Care	Chief Operating Officer / CCG Director for Planned and Specialist Care	Apr-26 Sep-26
040-24: Adopting a patient and family-initiated escalation approach - issued October 2024	Director of Nursing, Quality and Patient Experience	Interim Director of Nursing, Quality and Patient Experience	Sep-25
041-24: Ambulance patient handover guidance – issued October 2024	Community and Integrated Medicine	Chief Operating Officer / CCG Director for Community and Integrated Medicine	Dec-25
025-24: NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme for 2024/25 - issued June 2024	Director of Nursing, Quality and Patient Experience	Interim Director of Nursing, Quality and Patient Experience	Mar-25
001-25: NHS Wales Sustainability Conference and Awards 2025 - issued March 2025	CEOs Office (Welsh Language)	Director of Communications	TBC*
002-25: Timelines and Responsibilities for the Implementation of Early Warning Scores (EWS) to identify Acute Deterioration - issued February 2025	Director of Nursing, Quality and Patient Experience	Interim Director of Nursing, Quality and Patient Experience	Sep-25

* Status of WHC will be changed to red if implementation date/status of compliance is not provided within 10 working days from the service

External WHCs

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)	Reason for External Status
026-18: Phase 2 – primary care quality and delivery measures – 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.
032-22: Further extending the use of Blueteq in secondary care – issued March 2023	Primary Care, Community Strategy and Long Term Care	Chief Operating Officer / Director of Primary Care, Community and Long Term Care	The roll out of this high-cost drugs reporting system will be managed by the All Wales Blueteq Steering Group, with management support from the All Wales Therapeutics & Toxicology Centre on behalf of Welsh Government. The Health Board has representation on the Blueteq Steering Group, with national drug approval templates in development. Information Governance issues have delayed implementation, with discussion ongoing to resolve. As such, the implementation date for this WHC is currently noted as not known.
040-23: The NHS Wales: Newborn and Infant Physical Examination Cymru (NIPEC) – issued September 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.
035-24: Standardising the management of acute deterioration – issued September 2024	Director of Nursing, Quality and Patient Experience	Interim Director of Nursing, Quality and Patient Experience	A National Improvement Programme for Acute Deterioration is being led through the Safe Care collaborative (NHS Executive), which the Health Board are engaged in and are contributing towards. The Health board is engaged in the roll out of NEWS2 (due to be launched in September 2025) and has developed an organisation wide training needs analysis to improve recognition and management of acute deterioration. The Health Board is awaiting national updates in order to progress with the development of a process for using Acute Deterioration E-learning modules. As such, the implementation date for this WHC is currently noted as not known.

WHCs implemented since previous meeting (Green)

Welsh Health Circular	Clinical Care Group/Executive Function	Lead Executive (and CCG Director for those aligned to Chief Operating Officer)
005-24: Private obesity surgery and the Welsh NHS - Issued February 2024	Operational Allied Health Professions and Health Sciences	Director of Therapies and Health Science
007-24: Guidelines for managing patients on the suspected cancer pathway – issued April 2024	Planned and Specialist Care	Chief Operating Officer
020-24: Exemptions for local health boards and NHS Trusts to the requirement to implement recommendations made by the National Institute for Health and Care Excellence or the All Wales Medicines Strategy Group within the usual period, in specified circumstances – issued May 2024	Primary Care, Community Strategy and Long Term Care	Director of Primary Care, Community Strategy and Long Term Care
030-24: Published weight management medication pathway - Issued July 2024	Operational Allied Health Professions and Health Sciences	Director of Therapies and Health Science
034-24: Directions to apply the National Framework for the Commissioning of Care and Support in Wales: Code of Practice to local health boards and NHS trusts – August 2024 - Issued August 2024	Primary Care, Community Strategy and Long Term Care	Director of Primary Care, Community Strategy and Long Term Care
036-24: Oxygen Cylinders – Regulation 28 Report and Patient Safety Notice (PSN) 042 reminder – issued August 2024	Primary Care, Community Strategy and Long Term Care	Director of Primary Care, Community Strategy and Long Term Care
038-24: AMR & HCAI Improvement Goals For 2024-2025 – issued September 2024	Director of Nursing, Quality and Patient Experience	Interim Director of Nursing, Quality and Patient Experience
039-24: Pre-Transfusion Sample taking Compliance with the confirmatory sample rule – issued October 2024	Operational Allied Health Professions and Health Sciences	Chief Operating Officer
045-24: Spotting Sepsis in Children Awareness Leaflet . – issued November 2024	Planned and Specialist Care	Chief Operating Officer
050-24: Infected Blood Inquiry: Implementation of commendation 8a and 8b – issued December 2024	Director of Public Health	Director of Public Health

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 including nationally reported patient safety incidents
- Duty of Candour
- Patient Experience and Complaints
- Welsh Risk Pool: Concerns Assessment
- Infection, prevention and control
- Inspections and peer reviews including activity of Healthcare Inspectorate Wales (HIW)
- Speak up
- Welsh Health Circulars



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. Duty of Candour – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
3. Patient experience and patient feedback – Louise O'Connor, Assistant Director for Legal Services and Patient Experience
4. Welsh Risk Pool: Concerns Assessment – Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
5. Infection Prevention and Control – Rebecca Richards, Head of Infection Prevention and Control
6. Healthcare Inspectorate Wales and other peer reviews – Caroline Burgin, Patient Safety and Assurance Manager
7. Speak up - Cathie Steele, Interim Assistant Director of Nursing, Assurance and Safeguarding
7. Welsh Health Circulars - Rachel Williams, Head of Assurance and Risk



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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

Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status
Bryngolau Ward, Prince Philip Hospital	The health board must ensure patients are provided with relevant, up-to-date and accessible information to support their care.	Healthcare Inspectorate Wales (HIW)/2024/395/MD6/1	Review information on display and its accessibility and assure the following information points are present and accessible: <ul style="list-style-type: none"> • Advocacy Services and contact details • Role of HIW and contact details • Mental Health Act information • MHA name and contact • Available and appropriate legal representatives for detained patients (list in office) • How to raise a concern or complaint (putting things right) • QR Code Patient Satisfaction • Pictorial Board: staff images, role, uniform and name. 	Mental Health and Learning Disabilities	31/01/2025	Partially complete (Overdue)
	The health board should ensure all Welsh speaking staff and patients can be clearly identified.	Healthcare Inspectorate Wales (HIW)/2024/395/MD8/1	Order and distribute Magnetic Badges for all staffs who do not have an embroidered [Welsh Speaker] indicator on their uniform.	Mental Health and Learning Disabilities	31/12/2024	Partially complete (Overdue)
	The health board must: <ul style="list-style-type: none"> • Review the staff establishment on Bryngolau Ward promptly, to ensure the staffing levels are appropriate to safely support and manage the needs of patients • Review the existing temporary staff process for bank and agency nurses, and ensure staff are suitably skilled to care for relevant patient groups. • Aim for consistency with continuity of care when using temporary staff, such as 'block-booking' staff who are familiar with the environment and patient group • Ensure attention is given to the skill mix and the proportion of temporary staff rostered, to maintain patient and staff safety. 	Healthcare Inspectorate Wales (HIW)/2024/395/MD23/1	Present findings from inpatient establishment review work undertaken in partnership with Head of Nursing for Professional Standards and Regulation, Inpatient Senior Nurses, Ward Managers and Workforce colleagues to Executive colleagues for approval.	Mental Health and Learning Disabilities	31/01/2025	Partially complete (Overdue)
	Finalise and implement the Mental Health and Learning Disabilities Culture and Organisational Development Plan which encompasses actions to promote senior management visibility and engagement with staff across clinical settings.	Healthcare Inspectorate Wales (HIW)/2024/395/MD32/1	Present findings from inpatient establishment review work undertaken in partnership with Head of Nursing for Professional Standards and Regulation, Inpatient Senior Nurses, Ward Managers and Workforce colleagues to Executive colleagues for approval.	Mental Health and Learning Disabilities	31/01/2025	Partially complete (Overdue)
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

Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status
HIW Glangwili Hospital – Morlais Ward inspection (Nov 2024)	The employer is required to provide an update on the action taken to ensure the employer's written procedure is adhered to by entitled referrers making a referral prior to exposures performed during surgical theatre cases.	Healthcare Inspectorate Wales (HIW)/2022/19/MD22/3	CB to ensure all actions closed and evidence uploaded prior to closure of report	Radiology	03/02/2025	Overdue
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.	Facilities and Estates	31/12/2024	Overdue
	The health board must ensure that full and comprehensive mental health assessments and physical health assessments are always being completed in a timely manner, in line with the Mental Health (Wales) Measure 2010 under the Mental Health Act 1983.	Healthcare Inspectorate Wales (HIW)/2023/29/MD1/1	a) Development of standards for physical health screening to be incorporated into Service Specifications.	Mental Health and Learning Disabilities	29/09/2023	Partially complete (Overdue)
	The health board must ensure the inpatient ward round structure and arrangements in place allow for sufficient time for patients to be adequately discussed.	Healthcare Inspectorate Wales (HIW)/2023/29/MD6/1	e) Reproduce a set of standards to underpin Ward MDT Review process to include a plan for implementation (including consistent approach to enabling service user and carer views within this process and consistent approach to documentation and communication of outcomes from ward reviews and discharge planning) and monitoring.	Mental Health and Learning Disabilities	29/09/2023	Overdue
	The health board must ensure that all relevant staff complete training for timely and effective communication and information sharing relating to the patient discharge process.	Healthcare Inspectorate Wales (HIW)/2023/29/MD8/1	h) Develop a training resource to provide guidance to all relevant staff on standards associated with the discharge planning and process.	Mental Health and Learning Disabilities	31/10/2023	Overdue
	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/MD25/2	o) Review application of MH safe staffing principles and Welsh Levels of Care (Version 3 once published) for use across MH services.	Mental Health and Learning Disabilities	30/09/2023	Overdue
	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 and Learning Disabilities	30/11/2023	Overdue
	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/MD25/4	q) Development of MH/LD targeted actions through the MH/LD Workforce Group to feed into board wide recruitment and retention plans.	Mental Health and Learning Disabilities	31/12/2023	Overdue
	The health board must provide HIW with an update on how it is assured that community teams within its mental health services have sufficient capacity to meet their patient caseloads.	Healthcare Inspectorate Wales (HIW)/2023/29/MD26/2	s) Undertake evaluation of the current caseload weighting tool in place across community mental health teams to determine use and effectiveness.	Mental Health and Learning Disabilities	30/09/2023	Overdue

Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status
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 and Learning Disabilities	30/11/2023	Overdue
	The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Healthcare Inspectorate Wales (HIW)/2023/29/MD34/1	w) Develop a Directorate audit framework and plan, with the support of the Clinical Audit Team, that reflects local ward/team based audits and wider Health Board requirements to include:- -Testing assurance of consistent implementation of CAT and Physical Health Screening -Testing assurance of appropriate completion of WARRN -Routine reporting and monitoring of compliance with routine offer of carers assessments -Audit of compliance with Ward Round (MDT Review) standards -Routine report and monitoring of compliance with communication of discharge notifications, discharge letters and discharge summaries against NICE guideline standards -Record Keeping Documentation Audit to include completion and uploading of discharge checklists and communication of discharge plans -Testing assurance of the quality of discharge letters	Mental Health and Learning Disabilities	31/12/2023	Overdue
	The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Healthcare Inspectorate Wales (HIW)/2023/29/MD34/2	x) Develop a plan to engage frontline staff on the delivery and contribution of the clinical audit programme.	Mental Health and Learning Disabilities	31/12/2023	Overdue
	The health board should ensure there is adequate and consistent engagement with all staff around the audit arrangements in place across its mental health services, and that staff are made aware of all audit result and any actions required for improvement.	Healthcare Inspectorate Wales (HIW)/2023/29/MD34/4	z) Update reports on progress of the clinical audit programme to be provided to MHL D QSEG in order to provide oversight on outcomes.	Mental Health and Learning Disabilities	31/03/2024	Overdue
HIW IRMER Diagnostic Imaging x-ray department Withybush 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

Inspection Title	Recommendation	Reference Number	Action	Service	Original Due Date	Progress Status
HIW St Non, St Caradog, Canolfan Bro Cerwyn WGH	The Health Board must address the environmental issues and resolve them in a prompt and timely manner: 1) Mould and poor ventilation in both laundry rooms 2) Glass window cracked in St Non's leading into the courtyard requires replacing; 3) Sluice macerator on both wards needs to be fixed or replaced as both currently not working , 4) Occupational therapy room needs to be decluttered and tidied up and not used as a storage room; 5) Wrong signage on some doors in St Caradog which could pose a risk if fire alarms locations are activated; 6) Review of handrails in the ward area and bathrooms on St Non ward to ensure handrails are available, appropriate, and safe for the patient group; 7) Thermostats covers in some patient rooms on St Non are missing and need replacing.	Healthcare Inspectorate Wales (HIW)/2023/69/MD10/4	Handrails are in place in courtyard and corridors on st Non Ward. Review of handrail needs in bedrooms and bathrooms and how these can be addressed using anti ligature handrail products to be undertaken	Facilities and Estates	31/01/2024	Partially complete (Overdue)
	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 Tranquilisation against standards for physical health monitoring within the Health Boards Rapid Tranquilisation Policy.	Mental Health and Learning Disabilities	31/03/2024	Overdue
HIW Thematic Review of Ophthalmology 2015/16 issued January 2016 (HISTORIC REPORT MONITORED BY ASSURANCE AND RISK TEAM)	Concerns around set monitoring for follow-up patients (Treatment Timescale – Targets)	Healthcare Inspectorate Wales (HIW)/2016/146/MD1/1	(Historic HIW monitored by Assurance and Risk Team) Health Boards must ensure that care is provided for those (new or follow-up patients) with the greatest health need first, making most effective use of all skills and resources available.	Planned and Specialist Care	31/03/2022	Partially complete (Overdue)



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Welsh Risk Pool Concerns Assessment

A Report by the Welsh Risk Pool Safety and Learning Team

Hywel Dda University Health Board

Final Report February 2025



Gwella Diogelwch Trwy Ddysgu
Improving Safety Through Learning

WRP Concerns Assessment

A Report by the Welsh Risk Pool Safety and Learning Team

February 2025

About this Report

This report is intended to support health bodies within NHS Wales to continuously improve the operation of their Putting Things Right processes and provide assurance in relation to current policies, procedures and practice.

This report outlines the findings in relation to each area for assessment following field work and matter scrutiny undertaken by the independent assessment team. The report has been circulated for comments, factual accuracy considerations, and the development of actions arising from recommendations.

The report identifies a number of proposed recommendations. The organisation has developed an action plan which addresses the findings and supports the prioritisation of improvement activity in this sector. A copy of the organisation's action plan, addressing the recommendations, is embedded within this report to ease future analysis.

Along with the draft report, each Health Body has received a separate summary which detailed the analysis of the matters scrutinised as part of the assessment process. This enables the organisation to consider the comments in the context of the information that the reviewers analysed.

This report is now finalised and will be shared with the Welsh Risk Pool Committee.

Assessment Field Work	May - Jun 2024
Matter Scrutiny	May - Aug 2024
Draft Findings shared	Dec 2024
Action Plans Received	Jan 2025
Final Report Published	Feb 2025

Version

Hywel Dda WRP Concerns Assessment Report VFinal1



WRP Concerns Assessment

A Report by the Welsh Risk Pool Safety and Learning Team

February 2025

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1.0 Outline of Review

- 1.1 The Welsh Risk Pool (WRP) undertakes assessments of member organisations' policies, procedures, and practice as part of its oversight duties – with the aim of gathering assurance on local processes for the WRP Committee, Welsh Government and the NHS Wales Executive; and to provide recommendations to support organisations in continuous improvement in this important area of governance.
- 1.2 The WRP Assessment is used by the WRP Committee when determining members' contributions to the fund as part of the risk sharing agreement. The risk sharing calculations for *Managing Concerns* and *Lessons Learned* will include a measure which ranks organisations in each area of assessment.
- 1.3 The WRP Assessment process provides a framework for the analysis of an organisation's compliance with the WRP Reimbursement Procedures, the requirements of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, the Health & Social Care (Quality & Engagement) (Wales) Act 2020 and other national policies & procedures related to the PTR sector. Following a review in 2023, the 2024 programme of WRP assessments includes a specific area for assessment in relation to Inquests - in acknowledgement of the increased work in this area.
- 1.4 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 essential data fields.
- 1.5 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 across the health body and more widely.
- 1.6 The methodology for assessment has evolved during the last few years in line with national policies. The approach is focussed on peer-review, with senior leaders within the PTR sector in other organisations joining staff from the WRP in conducting the assessment.
- 1.7 Specialist advisors and legal experts have been invited to 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.

- 1.8 For each area for assessment, the Assessment Team considers the available evidence and reports assurance to the organisation using the NHS Wales Internal Audit Assurance Framework. Details of the framework are shown in Appendix 1.



2.0 Scope of Review

2.1 The review considers a number of areas for assessment, each focussed on a different aspect of the PTR process.

- Management of Concerns (Incidents)
- Management of Concerns (Complaints & Enquiries)
- Redress Case Management
- Claims Case Management
- Inquest & Coronial Inquiry Management
- Organisational Learning
- WRP Reimbursement Process

2.2 The report considers the same period for each health body that underwent a WRP Assessment. The periods used within the assessment were selected and agreed with the assistance of the Head of Patient Experience Safety & Learning Network.

2.3 The period used for the assessment related to policies and procedures in force and matters opened, under investigation, or closed between 1st January 2024 to 31st March 2024. This period was chosen as it is considered that cases would be sufficiently progressed from initial report and commencement of investigations to facilitate a thorough review but remain relatively current at the time of the assessment. When considering the *performance of quality* data in respect of compliance with the WRP Reimbursement Procedures, data from the financial year 2023/24 was used.

2.4 The WRP recognises that the most frequently occurring clinical specialties seen in claims and redress cases are *Maternity Services, Care in Emergency Departments & Units* and *Trauma & Orthopaedics*. The Assessment Team have focussed on these specialties, where they are provided by the Health Body, as part of the drive towards continuous improvement in relation to the NHS Wales litigation profile. In addition to the clinical specialties which have been subject to enhanced focus, the Assessment Team have selected other matters on a random basis to ensure that assurance is provided across as broad range of areas as possible.



3.0 Assessment Team

- 3.1 The WRP Assessments are conducted by a small group of specialist practitioners who are drawn from the PTR sector.
- 3.2 The Coordinator for each Assessment is a member of the WRP Team, with the Chair of the Assessment Team drawn from a member of the Heads of Patient Experience Safety & Learning Network – providing realistic advice on the practicalities in achieving the standards in practice.
- 3.3 To provide specialist advice in relation to compliance with the legislation, a lawyer from the Legal & Risk Service is included in the Assessment Team and this colleague focusses on compliance with redress case handling.
- 3.4 As the assessment process focusses greatly on the use of the Datix Cymru System, a member of the Once for Wales Concerns Management System central team is included in the Assessment Team.
- 3.4 The Assessment Sponsor coordinates the formation of fieldwork teams and oversees any queries which arise, along with signing off the Assessment Report.
- 3.5 The Assessment Team for this review was:

Sponsor: Jonathan Webb, Head of Safety & Learning
Welsh Risk Pool

Field Work: Kath Clarke, Head of Quality
Betsi Cadwalader University Health Board

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4.0 Previous Findings

4.1 Summary of the 2023 WRP Assessment

4.1.1 During 2023, a programme of assessments was conducted, and the report was accepted by the Health Body. This report contained a number of recommendations, to which the Health Body developed an action plan. The Assessment Team have sought evidence for progress with, or completion of, the proposed actions and this is shown in Table1.

Table1: Update on Actions from 2023 Assessment Report			
REF	Recommendation 2023	Position Update	Status
R01	HDUHB should ensure that all relevant documentation related to a record is uploaded to the Datix Cymru System and a standard naming convention is used to allow for ease of reference for all staff.	Evidence seen within the Claims and Redress modules.	Complete.
R02	It would add further value to the process for preparing and approving responses if HDUHB develops a formalised approval and signature process for responses.	The authorisation of responses process was already being addressed. The investigation report will need to bear the signature of the investigator, & confirmation of the manager or clinical lead who has signed it off.	Complete
R03	HDUHB should map out the process for transition of an incident into a redress case and consider introducing a Standard Operating Procedure (SOP) to support practice in this area. This will support the application of the Duty of Candour and reduce the potential for cases to be missed.	SOP developed and included as part of the concerns management and incident management toolkits.	Complete.
R04	HDUHB should consider documenting the process used to ensure the early review of the £25k threshold is undertaken in a timely way as part of concerns handling.	Evidence of discussions/review was noted on some of the matters reviewed, but not all. The Redress Team explained that they are not routinely inputting early consideration of value and have stated they are unable to do so due to lack of capacity. This potentially creates a problem in light of proposed changes to PTR and should be reconsidered.	Ongoing



R05	HDUHB should consider development of a SOP for claims management to build on the good process seen and ensure consistency in operational practice.	SOP developed and in place as well as a very detailed claims flowchart to be followed.	Complete
R06	HDUHB should consider the introduction of a naming convention for files related to claims management. This will ease record identification issues.	Evidence seen within the claims module during the file reviews.	Complete.
R07	HDUHB to review the process for managing PTR responses to ensure the requirements of the Regulations are adhered to and that complaint responses include the necessary information.	A revised process produced outlining management of concerns which has been incorporated into the toolkit.	Complete



5.0 Organisational Performance

5.1 Performance data - Management of Concerns & Lessons Learned

5.1.1 As part of the information gathered with each health body, data relating to the performance against the standards and timescales outlined in the WRP Reimbursement Procedures is collated.

No of LFERs submitted	No of missed standard deadlines	% missed standard deadlines	No of extensions granted	No of missed revised deadlines	% missed revised deadlines
63	2	3.17%	0	0	0%

No of LFERs considered	No Approved	% Approved	No Amber Deferred	% Amber Deferred	No Red Deferred	% Red Deferred
67	41	61.19%	17	25.37%	9	13.43%

No of CMRs submitted	No of missed standard deadlines	% missed standard deadlines	No of extensions granted	No of missed revised deadlines	% missed revised deadlines
48	2	4.17%	0	0	0%



6.0 Review Findings

6.1 Management of Concerns (Incidents)

- 6.1.1 The Assessment Team noted that there were 4192 incidents reported in the period 1st January 2024 to 31st March 2024.
- 6.1.2 The Assessment team were provided with the Health Boards PTR - Management & resolution of Concerns Policy (Incidents, Complaints & Claims) dated 10th October 2023 and the Incident, Near Miss and Hazard Reporting Procedure which was in date and next due for review by 2nd November 2024.
- 6.1.3 These documents cover the requirements as set out in PTR and provide guidance in respect of the management of incidents within the Health Board, including the Duty of Candour (DoC) and Nationally Reportable Incidents (NRI's).
- 6.1.4 Both documents provide guidance on roles and responsibilities in regards to investigation processes and the learning from investigations. There were clear links to other relevant policies and procedures, and both provided guidance in respect of harm grading/assessment of harm.
- 6.1.5 Within the Incident, Near Miss and Hazard Reporting Procedure clear guidance was provided in respect of the timescales expected for the reporting of incidents and undertaking the initial management review of them.
- 6.1.6 There is an exceptionally robust Health Board Quality Assurance and Safety intranet site/page which provides an array of guidance and flow charts along with downloadable documentation to educate, advise and support staff.
- 6.1.7 The Quality Assurance and Safety Team (QAS) oversee the management of severe and catastrophic incidents across the organisation. All incidents undergo a screening process as clearly defined within the policy to ensure appropriate review, escalation and make safe actions.
- 6.1.8 The QAS team also have dashboards set up for each service / directorate and audit the closures in relation to level of harm / DoC for accuracy, as well as undertaking a high-level review of incidents which arise and will make contact with the service to discuss / support as appropriate.



- 6.1.9 The management of lower-level incidents and checks for accuracy remains the responsibility of the specific service or directorate.
- 6.1.10 The Assessment Team were pleased to note from review of the documentation provided and in discussion with Health Board representatives that there are clear and established links between the QAS Team and the Services and Directorates, as well as a clear and defined structure in place to ensure clear lines of escalation and reporting to the Executive Team.
- 6.1.11 In respect of the Health Boards governance arrangements, there is a Quality and Assurance Dashboard available to the Quality, Safety and Experience Committee, and evidence of the Quality and Safety Assurance Report submitted was provided to the Assessment team.
- 6.1.12 There are Directorate level Quality Governance forums reporting into Operational Board, and directorates also report to monthly Operational Quality, Safety and Experience Sub-committee. NRI's are discussed/reported at the weekly Quality, Safety Intelligence Group (attended by clinical executives).
- 6.1.13 All concerns with significant learning will be reported to the Listening & Learning from Events Sub-Committee and/or the Operational Quality, Safety & Experience Sub Committee, and specific case reports are also presented to the Listening and Learning Sub-Committee dependent on the theme of the meeting.
- 6.1.14 Directorates are also performance managed by virtue of the presentation of an Integrated Performance Assurance report to the board and the board are made aware of concerns which may adversely affect the reputation of the Board by the Chair of the Quality, Safety and Experience Assurance Committee.
- 6.1.15 The Health Board utilises several varied communication mediums such as the medical director's newsletter, nursing newsletter, and grand rounds/teaching sessions for the sharing of learning. The Assessment Team were provided with examples of the QAS Teams-7 Minute Patient Safety Briefing to evidence some of the learning shared as a result of concerns investigations.



6.1.16 A sample of 20 incidents was generated randomly from the data supplied by the Health Board and the Assessment Team identified the following in respect of these incidents: -

- In 80% (n=16) the incident was reported as per Health board policy (within 24hrs/2 days).
- In 65% (n=13) of cases the Initial Management review was completed.
In 2 cases a short form version of the incident was completed which does not require this field to be completed.
- In 5 cases the investigation was ongoing, and no management review had been completed.
- Where the incident was escalated to NRI and/or DoC triggered there was appropriate recording of updates and additional information into the report.
- There was a clear theme that where some cases did not meet the policy timescales there was no documentation of a rationale for the delay.
- There was clear evidence in the majority of cases that within progress notes fields of interaction between the QAST and service/directorate to chase for information or progress updates.
- There was evidence that cases moderate or above were clearly reviewed and escalated or de-escalated appropriately with a suitable supporting narrative.
- However, there was two cases of note:-
 1. Documented an avoidable injury with moderate reported harm but the report does not reflect that the DoC was triggered, or Redress considered. Narrative supportive of failures in care.
 2. Case deemed moderate by reporter and investigator but again no evidence of implementation of DoC although some narrative recorded around discussion of redress.


6.1.17 Upon review of the Integrated Performance Assurance report November 2023 the Assessment team noted that it was recorded that :

“A random review of records has identified a training issue regarding reporting of severity of harm post investigation. Work is underway to develop a guide for incident managers and senior staff responsible for reviewing the final information before closure of the incident record.”



6.1.18 The Team also noted that the Quality, Safety and Experience Committee- Quality and Safety Assurance Report- February 24, identified “*Work continues to remind investigators that the grade/severity of an incident should reflect whether the investigation identified any acts or inactions by the Health Board that led to a negative outcome for the person affected e.g. an expected death in the community was closed as catastrophic by the service and on review no acts or inactions were identified.*”

6.1.19 Overall, the Assessment Team were impressed with the Health Board policy and procedure approach to incident management, which provides a robust structure and process. The number of incidents considered to involve lower than moderate harm which are open beyond a reasonable timeframe and those which have data quality issues remain at an unacceptable level and the leadership team demonstrated a commitment to continuing to address these challenges – which when addressed will provide an opportunity for Substantial Assurance to be applied to the area for assessment.


Management of Concerns (Incidents)		
REASONABLE ASSURANCE		<p>The organisation can take reasonable assurance that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.</p>

6.2 Management of Concerns (Complaint and Enquiries)

- 6.2.1 The Assessment Team noted that the Health Board received 646 new complaints in the period 1st January 2024 to 31st March 2024.
- 6.2.2 The PTR Management & Resolution of Concerns Policy (Incident, Complaints, Claims) was reviewed by the Assessors and was in date and is next due for review in October 2026. The Policy outlines defined roles in terms of governance arrangements outlining responsibilities and in addition there is a clear process in place for the management of complaints and enquiries.
- 6.2.3 The Assessors were pleased to note that complaints are reported to the Board and monitored by local directorate governance arrangements and escalated as necessary through the Improving Together process.
- 6.2.4 Training for complaints and redress is provided to all preceptorship events for newly qualified and junior doctors. Training is also provided within management and leadership sessions.
- 6.2.5 The Assessment Team scrutinised the detail of 7 matters opened on Datix Cymru in the period 1st January 2024 to 31st March 2024 and noted good use of the system and completion of the relevant fields.
- 6.2.6 It was noted that the Complaints/Enquiry Subjects section within the Feedback Function should be completed to reflect the issues raised by the complainant and importantly the investigation findings of each of the issues raised. This is important information for the Health Board to enable themes and trend reports to be produced and importantly to enable reports on issues upheld as this identifies learning required opportunities. On completion of the investigation, the Investigation section of the Complaint subject must be completed and the Outcome of the subject investigation completed.
- 6.2.7 The Assessors noted that the Health Board does not, as a matter of routine, add 'additional' contacts in the record. This could be persons who provided additional comments or staff involved in the provision of care. Good practice would be to update contacts to include key persons involved in the complaint – other than just the mandatory investigator or handler who are recorded separately.
- 6.2.8 If a complaint has a verbal response, details of the discussion should be recorded which should include who was involved in the discussion, when and how it took place. The Assessors noted that the SOP in place for verbal responses was not fully followed in some of the matters reviewed. It is essential that there is documentation to support any verbal discussion with the complainant. However, the majority of matters appeared compliant.



- 6.2.9 On receipt of a complaint it would be good practice to undertake a Contact search within Datix Cymru to check if there are any existing records which link to the matter being reported. This will reduce the potential of duplicate complaint records being created.
- 6.2.10 The Assessors were pleased to note that the Health Board share Terms of Reference (ToR) with the complainant as part of the acknowledgement of the complaint. This ensures that the complainant is aware of the issues being investigated and is given the opportunity to advise them if they have not fully identified the issues to be considered by the investigation. To ensure consistency it is recommended that the issues detailed in the ToR are checked to ensure that they are recorded in the Complaint Subject section.
- 6.2.11 The Assessors noted that not all Action plans and evidence of actions undertaken are uploaded to the Datix Cymru system. This should be encouraged as standard practice for all complaints where actions by the organisation are identified. The Health Board has subsequently explained that it also uses AMAT to monitor and report on key action plans which enables them to triangulate with other learning actions, including external reports.
- 6.2.12 The Assessors identified one complaint which had no evidence of investigation and no record of any response to the complainant (verbal or written). Whilst this is likely to be an anomaly, the Health Board should ensure that when a complaint record is closed, a check is undertaken to ensure that all documentation relating to the case is uploaded.
- 6.2.13 In summary, the Assessment Team noted that the Health Board has good structures in place for the management of concerns. Whilst there were some inconsistencies in best the use of the Datix Cymru System, the majority of records contained essential information. Further enhancement of data quality could be resolved through audits and validation on closure.

Management of Concerns (Complaints & Enquiries)		
SUBSTANTIAL ASSURANCE		The organisation can take substantial assurance that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

6.3 Redress Case Management


- 6.3.1 The Assessors noted that the Health Board has a good structure in place to manage redress cases with minimal input required from Legal & Risk Services.
- 6.3.2 The Assessment Team scrutinised the detail of 9 redress records within the Datix Cymru system and noted that generally there was good completion of information onto Datix Cymru. The Assessors were pleased to note great use of the Redress Tracker which meant that the files were particularly easy to review as it meant that the progression of the case and current position was clear.
- 6.3.3 A clear improvement was noted from the 2023 Assessment - with Documents saved to files more regularly now although some Regulation 26 Responses were not saved to files, which did not allow for a full assessment of certain matters.
- 6.3.4 A process is in place where the Redress Manager reviews all draft Regulation 26 responses. This ensures consistency, but the Redress Manager explained that there is a backlog which could be adding to the delay in the Health Board sending out Regulation 26 responses. However, the Health Board has set up a complaint's referral form and monthly complaint/redress meetings which began in January 2024 to attempt to assist with timeliness. This is generating additional work for the Redress Team however it is ensuring a thorough review and good governance. Overall the current delays are not excessive and the benefit to quality clearly outweighs any small delay. It is important that this is monitored to ensure the delays do not become extensive.
- 6.3.5 It was explained that Regulation 24 responses are not reviewed centrally as a matter of course, although sometimes a directorate will request input and the Redress Team are always keen to support and they are now being opened as potential redress cases with an increase in numbers seen since February and March 2024.
- 6.3.6 One issue identified by the Assessors was the lack of incidents in cases reviewed. The Redress Manager agreed that there seem to be fewer incidents than complaints, although she commented that complaint numbers have increased significantly over past months. This has been raised internally and it



is recommended that the Health Board review its processes for incidents coming into Redress to ensure cases are not being missed.

- 6.3.7 Good practice was identified in sending an introductory letter once the Redress Team had taken over the matter. The wording was thought to be a little 'legal' in one of the examples seen and could possibly be softened, which the team agreed to review. It is recommended that the template is reviewed although this may just have been an isolated occurrence.
- 6.3.8 The wording used in both Regulation 26 and 33 Responses was generally good. There was also evidence of excellent, bespoke email correspondence with Complainants. A few of the cases reviewed were particularly sensitive and handled very well.
- 6.3.9 Some delays were seen in instigating a causation review following receipt of the file by the Redress Team. These delays were noted to be significant in some instances, particularly to the Regulation 26 responses. The content requirement of the Regulation 26 responses was generally good. However, some of the final response letters were not present within the record and were understood to be stored elsewhere. In one instance, the position regarding qualifying liability within the letter was slightly unclear. There is evidence of understanding of the legal tests on file however further clarity and explanation could be provided.
- 6.3.10 The Assessors were pleased to note that the PTR Team submit a quarterly report to the Quality, Safety and Improvement Committee which contains redress data for the previous quarter.
- 6.3.11 Training for staff is in place and is provided on an ad hoc basis - with input from Legal & Risk Services as needed. Shadowing and mentorship is in place and a four week induction programme for new staff is in place which includes the use of Datix Cymru and bespoke familiarisation with the PTR process.
- 6.3.12 Overall, the management of Redress cases was considered to be robust with essential fields in the system completed meaning reports can be relied upon as being accurate. Whilst there can be enhancements in relation to document storage, timeliness of stages and data completeness, this should not detract from a very good process which can be held up as a good example in NHS Wales.



Redress Case Management		
SUBSTANTIAL ASSURANCE		<p>The organisation can take substantial assurance that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.</p>



6.4 Claims Case Management

6.4.1 The Assessment Team noted that there were 11 confirmed claims opened in the period 1st January 2024 to 31st March 2024.

6.4.2 There was good evidence of clear claims management processes in place for both Clinical Negligence and Personal Injury Claims with a detailed SOP in place. The Claims Management Policy was fully reviewed in 2023 and is overseen by the Listening and Learning Sub-Committee. There is also a very clear claims pathway flow chart in place to further assist staff. The Assessors felt that the framework is of an excellent standard.

6.4.3 The roles and responsibilities for the management of claims are clearly outlined within the Claims Management Policy with the Chief Executive having overall responsibility for the management of legal claims which is delegated to the Director of Nursing, Quality and Patient Experience. This Director has responsibility for developing & implementing a reporting mechanism to facilitate the effective monitoring of claims.

6.4.4 There is a clear process for the application of Standing Financial Instructions and authorisation of admissions and settlement of matters, which is included in the Policy detailing limits of staff for approval of claims and authority to settle costs, damages and make admissions. There is also clear guidance on the management of claims likely to exceed £1 million (which require Welsh Government agreement) - a useful tool for staff managing the claims process.

6.4.5 Claims are reported to the QSEC and at Directorate level, along with the Listening and Learning Committee. Following discussion with staff it was noted that learning lessons from claims is a key focus within the organisation with work ongoing to support this further.

6.4.6 Similarly to Redress, claims training for staff is in place on an ad hoc basis and with input from Legal & Risk Services as required. Shadowing and mentorship are in place and a four-week induction programme for new staff is in place which includes the use of Datix Cymru and PTR principles. Staff also regularly meet with staff and work closely with all Directorates to assist with any training needs. The Assessment Team were assured to see evidence of close working relationships with the Directorates and active work being undertaken to



constantly improve and strengthen relationships with staff.

6.4.7 The Assessment Team scrutinised the detail of 10 claims records within the Datix Cymru System and noted that there was excellent use of the system with case details completed accurately and stage history used and updated throughout the matter. The Assessors noted an improvement in the completion of fields on Datix from the previous assessment and the documents uploaded were clearly labelled and easily identifiable.

6.4.8 There was clear evidence of matters managed efficiently and timely with the decision to refer to Legal & Risk Services or not made during the initial review of the case. Prompt instructions were also provided in response to advice and requests for instructions and decisions from Legal & Risk Services which assured the Assessors that despite a significant workload and staffing challenges, the Health Board has continued to manage its claims process well.


6.4.9 It was noted that there is a close working relationship with Directorates with any issues or urgent matters being dealt with efficiently with attendance at Directorate meetings serving to strengthen this. The Claims Manager also meets regularly with clinicians to provide support and guidance with matters, and this is extremely beneficial when investigating cases.

6.4.10 The Access to Health Records Department forward any requests for disclosure of potential claims to the Claims Team to process and manage accordingly. The Team processes the request with the assistance of their administrative colleagues and Scan & Collate Service with the responsibility of the release of the information resting with the Claims Manager.

6.4.11 The Assessors were pleased to note a robust process was in place for the processing of receipt of advice and request for instructions from Legal and Risk Services. Liability instructions are driven by the Directorates who identify relevant clinicians which ensures cooperation with matters as well as completion of the Learning from Events Reports (LFER's). There is also a very robust process in place for obtaining financial authority with no delays experienced. The finance information was reviewed and considered to be completed and providing a reference and opportunity for a double-check of data.



6.4.12 From the discussions held, it was clear that the organisation tries to provide support to clinicians during an investigation into a claim and contact is first made with the Clinical Lead. Regular meetings are then offered with the Claims Manager.

Claims Case Management		
SUBSTANTIAL ASSURANCE		The organisation can take substantial assurance that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.




6.5 Inquest Case Management

- 6.5.1 The Assessment Team were pleased to note that the Health Board has a dedicated Inquest Team to manage all coronial enquiries. The inquest process is managed by the Head and Deputy Head of Legal Services.
- 6.5.2 There is Inquest Guidance in place which was approved on 2nd October 2023. It was noted that the Health Board does not have a specific policy in place for the management of inquest matters, although as a small corporate team dealing with all matters in-house the process currently works well. The Assessment Team would recommend however that a Policy and SOP is developed to assist any new members of staff and to avoid sole person dependency within the service.
- 6.5.3 Where staff statements are requested the Directorate Manager, Clinical Lead or Head of Nursing (depending on the details of the matter) is contacted with a template and guide with regards to statement writing attached. A synopsis of the case is also sent, and they then contact the relevant staff for the statement. This process works well to ensure clinicians are fully supported throughout. Following receipt of the first draft of the statement a meeting is offered, and it is finalised together.
- 6.5.4 Staff involved in a coronial enquiry are routinely advised to contact the corporate team should they have any concerns about the process also and telephone numbers are exchanged to ensure staff are able to discuss any concerns they may have prior to an inquest or hearing.
- 6.5.5 The Assessors were pleased to note that a psychological debrief is also offered following an inquest. This process does not appear onerous and is a good exemplar approach which can be replicated across Wales.
- 6.5.6 Training in inquests and the role of the Coroner for Health Board staff is in place on an ad hoc basis; with links to recorded mock inquests provided along with a host of training material available on the intranet. A pre-inquest orientation is also offered to staff prior to their attendance at court and the corporate team appear to have a very good working relationship with Directorates and work closely together with local leaders and managers.



- 6.5.7 The Assessors saw evidence that when a Regulation 28 notice is received by the organisation, it is sent to the Chief Executive, Medical Director and Executive Director of Nursing. A strategy meeting is then arranged with the clinical lead for the relevant department and a draft repose is prepared. There was evidence that responses to Regulation 28 notices have been submitted on time.
- 6.5.8 The Team has a very good working relationship with the Coroner's Office, and this is invaluable given the relatively high number of cases they are dealing with.
- 6.5.9 Inquests are reported at QSEC and Directorate Level and Listening and Learning Committee which ensures appropriate oversight throughout the Health Board.
- 6.5.10 The Assessment Team scrutinised the detail of 12 inquest matters and noted that there appeared to be minimal use of the Datix Cymru System. Following discussions with the team it was explained that when they receive a new matter a file is opened on Datix as well as on their shared drive. Progress notes are updated and detailed on Datix Cymru. However, all documents, statements Etc are saved on their shared drive as this allows them to access the file should they need to when they attend an inquest. As they are a small team at present this system works and there have been no concerns or deadlines missed.
- 6.5.11 The Assessment Team would recommend that the Datix Cymru System is utilised further with the management of inquest matters with fields being completed and documents uploaded to the system with a validation exercise undertaken upon closure to ensure all necessary field boxes are completed. The Datix Cymru system should be treated as the authoritative record of an inquest matter.
- 6.5.12 Overall, an excellent approach to inquest case management was evidenced, with effective support for staff involved in a case and good corporate oversight. This is particularly important as the number of cases subject to coronial inquiry and inquest is anticipated to remain at an increased level.




Inquest Case Management		
SUBSTANTIAL ASSURANCE		The organisation can take substantial assurance that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.




6.6 Organisational Learning and Learning from Events Reports

- 6.6.1 The Health Board explained that the use of Datix for completion of the WRP related fields has significantly improved since the last assessment. There was evidence of close monitoring of all LFER’s and submission deadlines with Datix. The Assessment Team were assured to see a tracking process in place to monitor progress with capturing, validating and presenting learning.
- 6.6.2 Evidence was seen of the improvement of the completion of LFER’s within the Directorates as the Service Delivery Managers are on board to facilitate completion and there appears to be better ownership of learning. The LFER is completed and approved within the Service before being reviewed and signed by the Claims Manager. This assured the Assessment Team that learning from claims is a priority for the Health Board. Information shared by Independent Members of the Board also indicated regular coverage of learning.
- 6.6.3 The Assessors were pleased to note that any emerging themes are fed into the Listening & Learning Sub Committee which was evidence of good practice highlighting the importance of improving patient care.
- 6.6.4 The Assessment Team noted that the performance data for timeliness of submissions for learning were very good and the number of matters which were red deferred by the panel were relatively low.
- 6.6.5 The implementation of the All-Wales Learning from Events Framework is a key area on this year’s work plan for the Health Board. Overall, it is clear that learning is a board-level priority, performance data is good, and the quality of learning information has improved.

Organisational Learning & Learning from Events		
SUBSTANTIAL ASSURANCE		The organisation can take substantial assurance that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

6.7 Reimbursement Process

- 6.7.1 The Assessment Team were assured to see evidence that there remains a close working relationship with the Finance Department who support the Claims Team and the reimbursement process. Cases are tracked through Datix Cymru however there is also a spreadsheet in place as a safety net measure. This ensures cases are submitted in a timely manner.
- 6.7.2 As Datix Cymru is utilised efficiently and effectively by the Claims Team they are able to run accurate reports from the system enabling them to closely monitor submission deadlines of Case Management Report's (CMR's) as well as deferred cases. A fortnightly meeting is held with the Team to review all matters and discuss any potential delays.
- 6.7.3 The Assessors were pleased to note that all payments are added to the Datix Cymru System, and all invoices are reviewed to ensure all payments have been made before closure of matters and submission for reimbursement. As was the case last year, the number of U5 requests for reimbursement in closed matters, which would be an indicator of poor case and payment tracking, was noted to be very low and therefore a very good exemplar for other organisations to follow.








Reimbursement Process		
SUBSTANTIAL ASSURANCE		The organisation can take substantial assurance that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.

7.0 Areas of Good Practice

- 7.1 Sending an introductory letter once the Redress Team had taken over the matter.
- 7.2 Excellent, bespoke email correspondence with Complainants particularly in sensitive matters.
- 7.3 Payments and invoices reviewed prior to submission of matters for reimbursement.
- 7.4 Excellent inquest and coronial inquiry management in place.
- 7.5 Good structure in place for redress management.
- 7.6 Good Claims management structure in place.
- 7.7 Close working relationship with finance, leading to accurate data points.



8.0 Assurance Summary

Management of Concerns (Incidents)	REASONABLE ASSURANCE	
Management of Concerns (Complaints & Enquiries)	SUBSTANTIAL ASSURANCE	
Redress Case Management	SUBSTANTIAL ASSURANCE	
Claims Case Management	SUBSTANTIAL ASSURANCE	
Inquest Case Management	SUBSTANTIAL ASSURANCE	
Organisational Learning & Learning from Events	SUBSTANTIAL ASSURANCE	
WRP Reimbursement Process	SUBSTANTIAL ASSURANCE	

NOTES

The Assessment Team noted considerable progress in all Areas of Assessment compared to the previous WRP Assessment.

Overall, the policies & procedures established by the Health Board provide a robust framework for the effective management of area topic.

There has been considerable focus (and improvement) in incident management and the Assessors would encourage a further focus on incidents involving lower than moderate harm.



9.0 Recommendations

- 2023-R04 HDUHB should consider documenting the process used to ensure the early review of the £25k threshold is undertaken in a timely way as part of concerns handling.
- R01 HDUHB should review reports, dashboard and escalation to encourage timely and accurate update of incident records.
- R02 HDUHB to ensure the complaints/enquiry subject section within the feedback function is completed to reflect the issues raised by the complainant and the investigation findings of each of the issues raised.
- R03 HDUHB to update contacts to include key persons involved in the complaint – other than just the mandatory investigator or handler who are recorded separately.
- R04 HDUHB to ensure the SOP for verbal responses is followed in all matters.
- R05 HDUHB to ensure that the issues detailed in the ToR are checked to ensure that they are recorded in the Complaint Subject section.
- R06 HDUHB to ensure all action plans and evidence of actions undertaken are uploaded to the Datix Cymru System.
- R07 HDUHB should ensure that when a complaint record is closed, a check is undertaken to ensure that all documentation relating to the case is uploaded.
- R08 HDUHB should review its processes for incidents coming into Redress to ensure cases are not being missed.
- R09 HDUHB to review the template introductory letter sent once the Redress Team has taken over the matter to ensure the wording is fully appropriate.
- R10 HDUHB to consider issuing an Inquest Policy and SOP which can provide clarity on the process to the wider organisation.
- R11 HDUHB to utilise Datix Cymru for the management of inquests ensuring all documents are uploaded.



10.0 Health Body Action Plan

- 10.1 The Health Body has developed an action plan which addresses the findings of the report and responds to the recommendations made. A copy of this is provided for future reference



Welsh Risk Pool Concerns Assessment (December 2024)

Date of inspection: 05/06/2024

Reference	Priority	Lead	Linked	Site	Service	Regulation	Clinical priority	Theme	Recommendations	Actions	Status
Welsh Risk Pool (WRP)/ 2024/435/ SD1	Should do	Mrs Cathie Steele		No Site Specific	Corporate Nursing		NO	Timely	R01 HDUHB should review reports, dashboard and escalation to encourage timely and accurate update of incident records.	1	In progress
Welsh Risk Pool (WRP)/ 2024/435/ SD2	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Person Centered	R02 HDUHB to ensure the complaints/enquiry subject section within the feedback function is completed to reflect the issues raised by the complainant and the investigation findings of each of the issues raised.	2	In progress





Reference	Priority	Lead	Linked	Site	Service	Regulation	Clinical priority	Theme	Recommendations	Actions	Status
Welsh Risk Pool (WRP)/ 2024/435/ SD3	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Information	R03 HDUHB to update contacts to include key persons involved in the complaint – other than just the mandatory investigator or handler who are recorded separately.	1	In progress
Welsh Risk Pool (WRP)/ 2024/435/ SD4	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Equitable	R04 HDUHB to ensure the SOP for verbal responses is followed in all matters.	1	In progress
Welsh Risk Pool (WRP)/ 2024/435/ SD5	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Information	R05 HDUHB to ensure that the issues detailed in the ToR are checked to ensure that they are recorded in the Complaint Subject section.	1	In progress
Welsh Risk Pool (WRP)/ 2024/435/ SD6	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Information	R06 HDUHB to ensure all action plans and evidence of actions undertaken are uploaded to the Datix Cymru System.	1	In progress

Reference	Priority	Lead	Linked	Site	Service	Regulation	Clinical priority	Theme	Recommendations	Actions	Status
Welsh Risk Pool (WRP)/ 2024/435/ SD7	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Information	R07 HDUHB should ensure that when a complaint record is closed, a check is undertaken to ensure that all documentation relating to the case is uploaded.	2	In progress
Welsh Risk Pool (WRP)/ 2024/435/ SD8	Should do	Mrs Cathie Steele		No Site Specific	Corporate Nursing		NO	Equitable	R08 HDUHB should review its processes for incidents coming into Redress to ensure cases are not being missed.	1	In progress
Welsh Risk Pool (WRP)/ 2024/435/ SD9	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Information	R09 HDUHB to review the template introductory letter sent once the Redress Team has taken over the matter to ensure the wording is fully appropriate.	1	In progress
Welsh Risk Pool (WRP)/ 2024/435/ SD10	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Information	R10 HDUHB to consider issuing an Inquest Policy and SOP which can provide clarity on the process to the wider organisation	1	In progress

Reference	Priority	Lead	Linked	Site	Service	Regulation	Clinical priority	Theme	Recommendations	Actions	Status
Welsh Risk Pool (WRP)/ 2024/435/ SD11	Should do	Mrs Louise O'Connor		No Site Specific	Corporate Nursing		NO	Information	R11 HDUHB to utilise Datix Cymru for the management of inquests ensuring all documents are uploaded.	1	In progress

Appendix 1 NHS Wales Assurance Framework

The WRP Assessment Programme utilises the NHS Wales Internal Audit Framework for Assurance:

SUBSTANTIAL ASSURANCE		<p>The organisation can take substantial assurance that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Few matters require attention and are compliance or advisory in nature with low impact on residual risk exposure.</p>
REASONABLE ASSURANCE		<p>The organisation can take reasonable assurance that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.</p>
LIMITED ASSURANCE		<p>The organisation can take limited assurance that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.</p>
NO ASSURANCE		<p>The organisation has no assurance that arrangements to secure governance, risk management and internal control in relation to the Putting Things Right areas of assessment are suitably planned and applied effectively. Action is required to address the whole control framework in this area with high impact on residual risk exposure until resolved.</p>

Appendix 2

WRP Concerns Assessment – Areas for Assessment

The WRP Assessment Programme uses a series of Areas for Assessment to guide the Assessment Team in the aspects and criteria to be examined. These cover the areas of activity which directly impact on matters which may cause a request for reimbursement from the WRP.

The Areas for Assessment provide a framework for the Assessment Team to gather information, evidence and collate data to support the identification of findings and the establishment of recommendations.

Assessment Criterion

AREA FOR ASSESSMENT	
A	Management of Concerns (Incidents)
B	Management of Concerns (Complaint and Enquiries)
C	Redress Case Management
D	Claims Case Management
E	Inquest Case Management
F	Organisational Learning and Learning from Events Reports
G	Reimbursement Process



Area for Assessment A:	
Management of Concerns (Incidents)	
A1-01	Is the timescale between index events and incident reporting reasonable?
A1-02	Did the incident have a Management Review?
A1-03	Is the timescale between reporting and Management Review reasonable?
A1-04	Did the incident have a proportionate investigation completed, where appropriate?
A1-05	Was the incident record closed within 30 days? If not, is there information to explain the reason for any delays or actions being taken?
A1-06	Was the incident reportable as a Nationally Reportable?
A1-07	Did the post incident investigation indicate there was harm caused and that Qualifying Liability was considered?
A1-08	Based on the reporters view of harm (moderate or above) have the Duty of Candor fields been completed and if not is a rationale provided for the non-completion?
A1-09	Is there training for staff reporting and investigating incidents?

Area for Assessment A:	
Management of Concerns (Incidents)	
Policy and Procedure	
A2-01	Is there a policy or procedure in place for Incident Management within the Health Body? Is it in date? Is there a review date? How is it reviewed/ratified?
A2-02	Does the policy or procedure cover the requirements as set out in PTR guidance and associated national policy?

Area for Assessment A:	
Management of Concerns (Incidents)	
Information, Reporting & Governance Arrangements	
A3-01	Are there effective governance arrangements for the management of incidents?
A3-02	Is there a screening process in place for monitoring accuracy of information submitted in incident reports? Is it timely?
A3-03	How are incidents reported within the Health Body and to what meetings/committees are they reported? Are they reported at Board level or Sub-Committee? Are these arrangements proportionate?



Area for Assessment B:	
Management of Concerns (Complaint and Enquiries)	
B1-01	Does the record include details of the 'Person Providing Feedback' (Complainant) and has the Complainant Chain been triggered
B1-02	Have details of the original contact with the Complainant been recorded and supporting information available for review. This may be an email or letter from the Complainant or notes from a telephone discussion.
B1-03	If the complaint is in relation to a third party, has consent been requested
B1-04	Does the Date received (Complainant Chain) match the date the Complaint was first received (Key Dates)
B1-05	Have the following essential data fields in Datix Cymru been completed accurately and up to date: <ul style="list-style-type: none"> • Is the Complainant Chain available and completed where possible • Has an investigator been identified
B1-06	Has the type of complaint been changed? If yes, has the Complainant Chain be reset to meet the PTR Reg timescale of the new type of complaint
B1-07	Does the Description field contain identifiable information i.e names of persons or locations
B1-08	Have all the relevant points raised in the complaint been recorded in the 'Complaint Subjects' section
B1-09	If applicable, has a holding letter been sent to the Complainant
Closed records only:	
B1-10	Where a complaint was dealt with as Early Resolution, is this appropriate?
B1-11	Has a response been provided to the person notifying the concern within 30 days. Where it has not been possible to provide the report within 30 days, has the person notifying the concern been advised within 30 working days, an explanation provided, and a proposed timescale agreed?
B1-12	Did the response respond to all the relevant points raised in the complaint and the investigation outcome of each point recorded
B1-13	If no response letter has been sent, has the reason why no response letter was sent provide an adequate explanation eg evidence of verbal discussion



	with complainant
B1-14	If a Regulation 26 or Regulation 33 Response has been sent, has a Redress record been created and have the records been linked
B1-15	<p>Does the complaint response comply with the content requirement as set out within the guidance?</p> <ul style="list-style-type: none"> - Reg 24 response prepared for the concern reviewed which has been investigated and in respect of which the Responsible Body considers there is no QL in tort? - Reg 24 response prepared for the concern which has been investigated and in respect of which the Health Board considers the claim to be over £25,000 in value? (no reference to BOD and QL if considered over £25,000 and advice re Solicitors etc?) - Reg 26 response prepared advising may be BOD & QL with explanation provided regarding Redress and next steps - Reg 33 response prepared advising there is/was BoD & QL explanation provided regarding Redress and offer made
B1-16	Has the Complainant Chain been fully completed and is the date of response accurately recorded in the Complainant Chain

Policy and Procedure

B2-01	Is there a policy or procedure in place for Complaint Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?
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Information, Reporting & Governance Arrangements

B3-01	What are the governance arrangements for the management of complaints and enquiries?
B3-02	How are complaints reported and monitored within the Health Body and to what meetings/Committees are they reported? Are they reported at Board level or Sub-Committee?
B3-03	Is there a training package in place for staff for complaints handling?



Area for Assessment C:	
Redress Case Management	
C1-01	Is there an appropriate process for determining when a matter should be handled by Redress specialists? Is there a clear process for transition from incident teams and complaints teams?
C1-02	Is the redress record complete? Is all correspondence, advice and supporting information available for review?
C1-03	Is there evidence of the case being screened for potential value at the outset?
C1-04	Has an interim report (Reg 26 letter) for the concern reviewed and investigated been prepared where the Health Body considers there may be a QL?
C1-05	Has the interim report been provided to the person notifying the concern within 30 days?
C1-06	Does the response letter comply with the content requirement set out in the Regulations & associated Guidance? E.g., explaining QL, advice re Solicitors, addresses all concerns raised etc
C1-07	In circumstances where a Reg 26 interim response was provided, have independent experts been instructed? Has this been done in line with the requirements in the Regulations (i.e. jointly) and appropriately?
C1-08	Has a Regulation 33 report been sent for every concern reviewed and investigated in respect of which the Responsible Body has not sent a Regulation 24 response?
C1-09	Has the Regulation 33 report been provided within a maximum of 12 months of the concern being notified to it?
C1-10	Does the Regulation 33 Response comply with the requirements of the Guidance? E.g. clearly sets out the basis for the final decision as to QL and the offer made.
C1-11	Where financial compensation has been paid, has an appropriate contract been entered into between the recipient of the financial compensation and the organisation?
C1-12	Has Legal and Risk Advice been requested? Was this request proportionate?
C1-13	Who authorised QL and on what basis? Was this appropriate?
C1-14	Have all essential data fields been completed correctly within the case management record?

WRP Held Data Review	
C1-14	How many LFER's submitted in relevant period?
C1-15	How many requests for reimbursement submitted to WRP?
C1-16	What is the performance for WRP submission deadlines?
C1-17	How many extensions were requested for submission to WRP?
C1-18	How many cases were approved at the first Learning Advisory Panel?



Policy and Procedure	
C2-01	Is there a policy or procedure in place for Redress Case Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?
C2-02	Is there a clear process for the application of Standing Financial Instructions and authorisation of admissions & settlement of matters?
C2-03	Is there a process in place to review admission/denial decisions?

Information, Reporting & Governance Arrangements	
C3-01	What are the governance arrangements for the management of redress cases?
C3-02	How are they reported within the Health Board and to what meetings/Committees are they reported? Are they reported at Board level or Sub-Committee?
C3-03	Is there a training package in place for staff?
C3-04	There is a system for learning lessons from events including concerns (incidents, complaints, claims under redress) compensation claims, claims reviews etc which are used to improve services



Area for Assessment D:

Claims Case Management

D1-01	Is there an effective process for receiving and processing requests for disclosure of medical records in matters where a claim is being considered against the health body?
D1-02	Where disclosure of records is requested, is there a process to ensure appropriate release of information is managed and redaction of relevant information undertaken as required?
D1-03	Is there an effective process for the oversight of disclosure of information in matters where a claim is being considered against the health body?
D1-04	Is there a clear process for referral of relevant matters to Legal & Risk? Is the referral to Legal & Risk being utilised? Is the timescale for referral of claims to Legal & Risk appropriate?
D1-05	Is there a clear process for receipt of advice in a matter and analysis of requests for instructions? Are the timescales for receiving advice and providing instructions appropriate and proportionate?

Policy and Procedure

D2-01	Is there a policy or procedure in place for Claims Case Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?
D2-02	Is there a clear process for the application of Standing Financial Instructions and authorisation of admissions & settlement of matters?

Information, Reporting & Governance Arrangements

D3-01	What are the governance arrangements for the management of claims cases?
D3-02	How are they reported within the Health Board and to what meetings/Committees are they reported?
D3-03	Are they reported at Board level or Sub-Committee?
D3-04	Is there a training package in place for staff responsible for managing claims?



Area for Assessment E: Inquest Case Management

E1-01	Is there an effective process for receiving and processing requests from the Coroner?
E1-02	Where staff statements are requested, is there a process to ensure appropriate release of information and statements drafted correctly?
E1-03	Is there an effective process to support staff who are asked to provide statements for the Coroner and to attend the Inquest?
E1-04	Is there a clear process for referral of relevant matters to Legal & Risk? Is the referral to Legal & Risk being utilised? Is the timescale for referral of inquests cases to Legal & Risk appropriate?
E1-05	Is there a clear process for review of Regulation 28 notices from the Coroner? How are staff and Services informed? What is the process for monitoring the request for information and ensuring it is actioned and information submitted in time?

Policy and Procedure *To be completed by Assessors*

E2-01	Is there a policy or procedure in place for Inquest Management within the Health Board? Is it in date? Is there a review date? How is it reviewed/ratified?
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Information, Reporting & Governance Arrangements

E3-01	What are the governance arrangements for the management of inquest matters?
E3-02	How are they reported within the Health Board and to what meetings/Committees are they reported?
E3-03	Are they reported at Board level or Sub-Committee?
E3-04	Is there a training package in place for staff responsible for managing inquests?



Area for Assessment F:	
Organisational Learning	
F1-01	Has the locally adapted 'All Wales Learning from Events Framework' been approved through the Health Body's governance processes?
F1-02	Is the Health Body progressing the implementation of the locally adapted 'All Wales Learning from Events Framework'?
F1-03	Is the Health Body considering the importance of psychological safety to being a learning organisation?
F1-04	Are there effective governance arrangements in place to enable oversight by the Health Body's Board and Board subcommittee's that the approach to organisational learning is improving?
F1-05	Are there effective governance arrangements in place to enable oversight by Directorates / Divisional / Groups senior management teams that local learning is improving?
F1-06	Are staff, service users, families and stakeholders involved in determining what the learning should be following an event?
F1-07	Has it been determined how staff across the organisation wish to receive learning?
F1-08	Is the organisation able to demonstrate examples of organisational learning from events (examples may include what goes well, incidents, complaints, claims, inquests, ombudsman, internal reviews, networks, external independent reviews, and Public Inquiries) being discussed from Operational level to the Health Body's Board?
F1-09	Is there a clear process relating to the approval of the Welsh Risk Pool (WRP) Learning from Events Reports locally and corporately prior to submission to the Welsh Risk Pool, including the provision of additional information if the case is deferred?
F1-10	In respect of organisational learning what is the Health Body's approach to knowledge management (practice of organising, storing and sharing vital information) so that everyone can benefit from its use?
F1-11	What proportion of LFER reports were submitted in accordance with the WRP Reimbursement Procedures? E.g. timeliness, completeness, extension requirements?
F1-12	What proportion of LFER reports were approved by the Learning Advisory Panel?



Area for Assessment G:	
Reimbursement Process	
G1-01	Does the Health Body have in place a defined and formalised process or procedure through which it sets out its objectives and provides assurance for the accounting of losses & special payments which are subject to WRP Reimbursement?
G1-02	Does the Health Body have a process for tracking and ensuring submission to WRP for reimbursement? E.g. timeliness?
G1-03	Does the Health Body have a process for identifying and submitting post-closure reimbursement requests in a timely manner?

