



Agenda Item

6.1

Quality, Safety & Experience Committee

Patient Safety, Quality & Experience Dashboard

Dyddiad y Cyfarfod / Date of Meeting	18/11/2025
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter	Head of Concerns & Business Intelligence
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Richard Hughes, Executive Director of Nursing, Midwifery and Patient Services

Pwrpas yr Adroddiad / Report Purpose	For Review
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Forum Individuals	Date	Outcome
Discussions with key individuals in corporate services and within Care Groups	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
PTR	Putting Things Right
PSOW	Public Service Ombudsman for Wales
PALS	Patient Advisory Liaison Service

1. Situation /Background

This presentation of the Patient Safety & Quality Dashboard to Committee provides data from 01.09.25 and 31.10.25 taken from systems on 03.11.25, unless otherwise specified.

Key areas to note in this reporting period are:

- Reduction in the number of formal complaints open over 30 working days
- One PSOW final report received – not upheld
- Decrease in number of National Reportable Incidents
- Increase in number of incidents where duty of candour was triggered
- No regulation 28 report received
- Increase in medication incidents reported
- Decrease in patient fall incidents reported

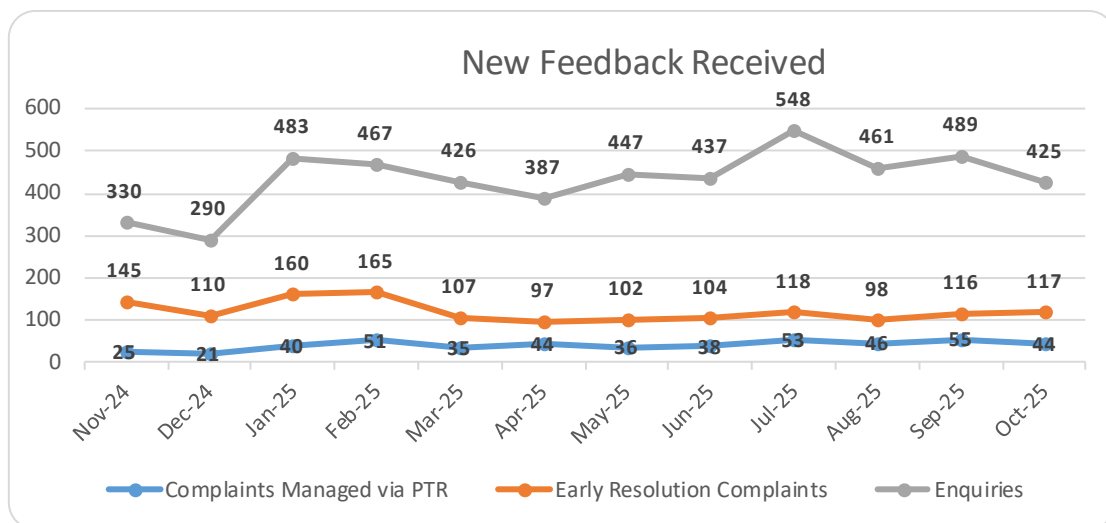
2. Specific Matters for Consideration

2.1 Patient / Service User Feedback

Complaints & Enquiries

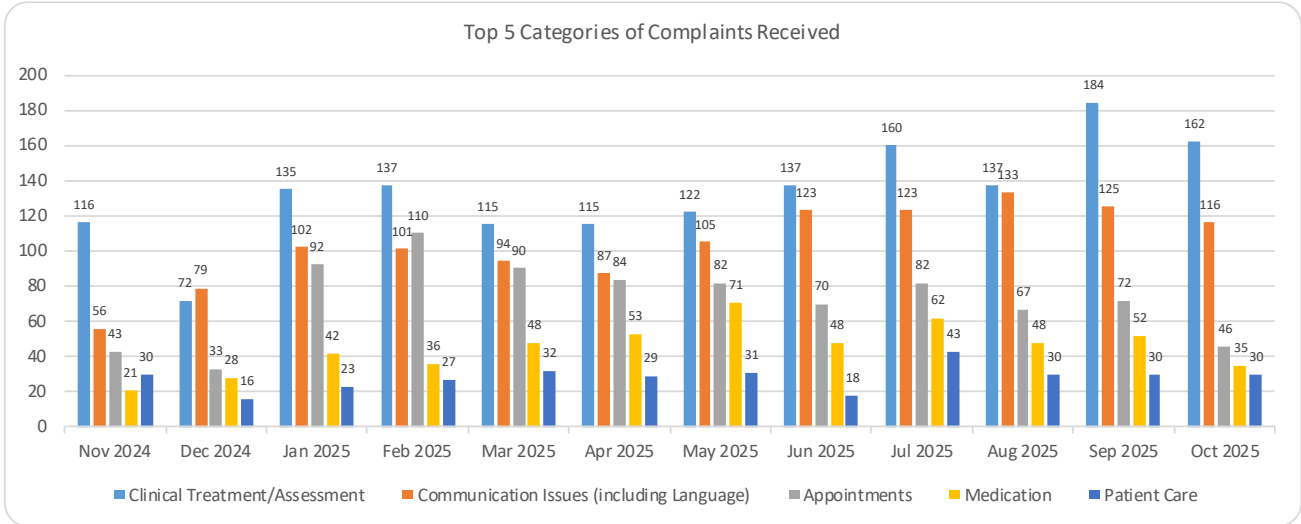
New Complaints Received

Between the 01.09.25 and 31.10.25 the Health Board received a total of 332 complaints and 914 enquiries. Of 332 complaints received, 99 were categorised as formal and managed under the Putting Things Right Regulations (PTR). The number of Early Resolution complaints has increased slightly over the last two months since August 2025 figure, PTR complaints and enquiries increased during September 2025 compared to August 2025 however the number dropped back down for October 2025.



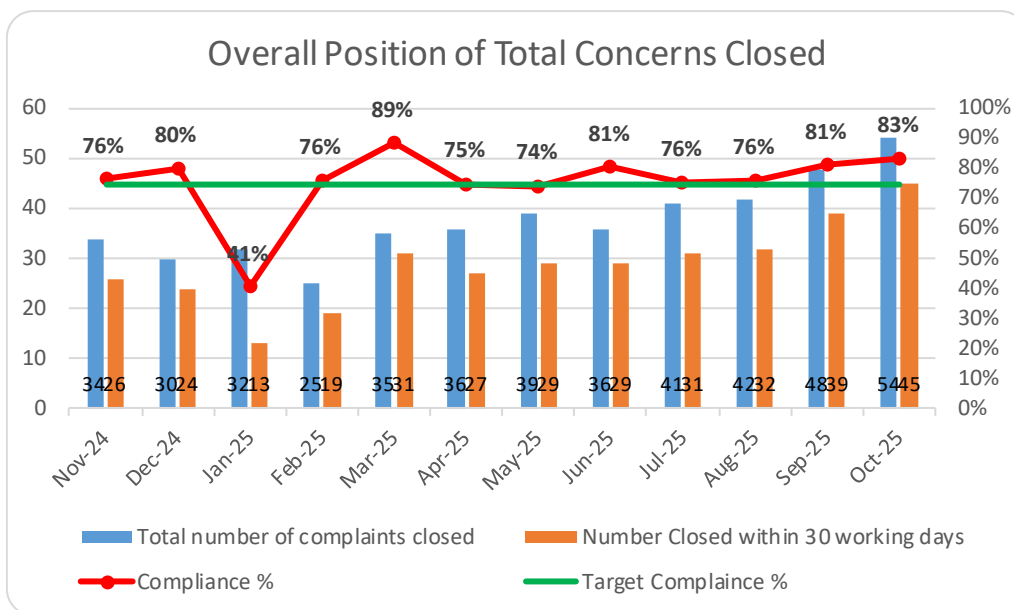
For all feedback (Complaints and Enquiries) received in September and October 2025, accounting for 62% of the feedback received, the top 3 types remain consistent with

previous months. These relate to Clinical Treatment / Assessment (346), Communication Issues (including Language) (241) and Appointments (118).



Closed Complaints

Within the period of 01.09.25 to 31.10.25, the Health Board closed a total of 102 formal complaints (managed through PTR). During the 2-month period, the national target of 75% compliance for responding to complaints within 30 working days was achieved (82%). As at 03.11.25, the Health Board had 67 open formal complaints. Of these, 14 complaints were open over 30 working days which is one more open complaint compared to the position at the beginning of September. Focused work continues to be undertaken to improve the efficiency of the Health Board's concerns triage process to ensure a timely response.





Public Services Ombudsman for Wales

Open cases

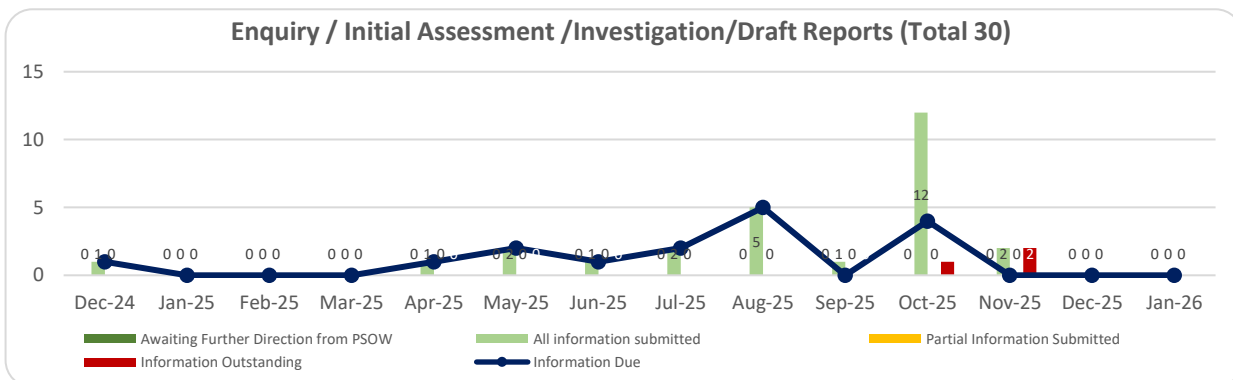
As at the 05.11.25 the Health Board has 41 open Public Services Ombudsman for Wales (PSOW) Cases. Of these, 32 are awaiting a response from the PSOW.

Current Status	Enquiry / Initial Assessment/ Investigation	Early Settlement	Draft Report Comments	Final Report Compliance	Information Only	Total
All evidence submitted and awaiting closure by PSOW	0	0	0	0	0	0
Awaiting further direction from PSOW	0	0	0	0	2	2
Information Received	0	0	0	0	0	0
Information Submitted	24	3	3	0	0	30
Information Outstanding	2	3	1	0	0	6
Information Partially Submitted	0	1	0	2	0	3
Total	26	7	4	2	2	41

New PSOW Cases Received

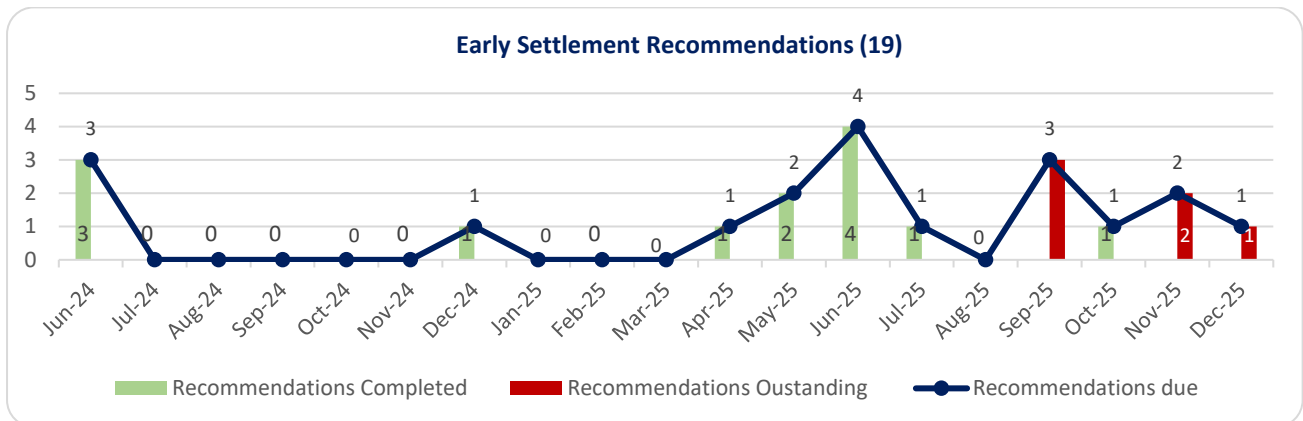
The Health Board received notification of 26 new referrals to the Public Services Ombudsman for Wales (PSOW) between the 01.09.25 and 31.10.25. Of the 26, 17 were received as enquiries, 8 as decision not to investigate and 1 as full investigation.

Of the 30 cases, the Health Board currently has at 05.11.25 in the enquiry / initial assessment/investigation stage, 3 cases have outstanding actions. One action is currently overdue. This is reflected in the chart below:



Early Settlement Proposal

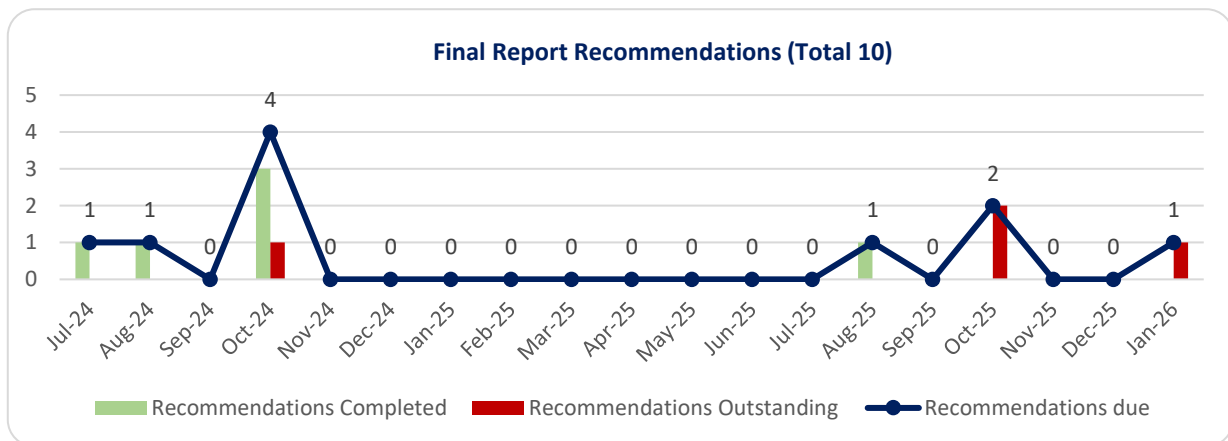
During the same period the Health Board agreed 3 early settlement proposals. It should be noted that more than one action can be attributed to a case. As at the 05.11.25, the Health Board has 7 open early settlement cases, with 19 associated case actions. Of the 19 actions, three are currently overdue the deadline agreed with the PSOW.



Final Reports

During September and October 2025, the PSOW issued 1 final report to the Health Board which was not upheld.

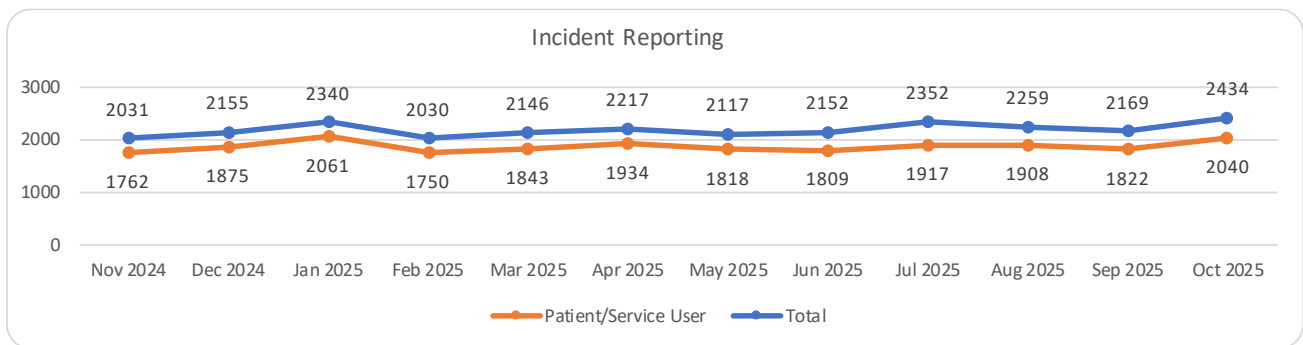
As at 02.05.25, the Health Board has 2 cases which are currently in the final report stage of the PSOW process. These cases have 10 associated recommendations. Of these recommendations, 4 are currently outstanding, with 1 currently overdue the timescale for completion.



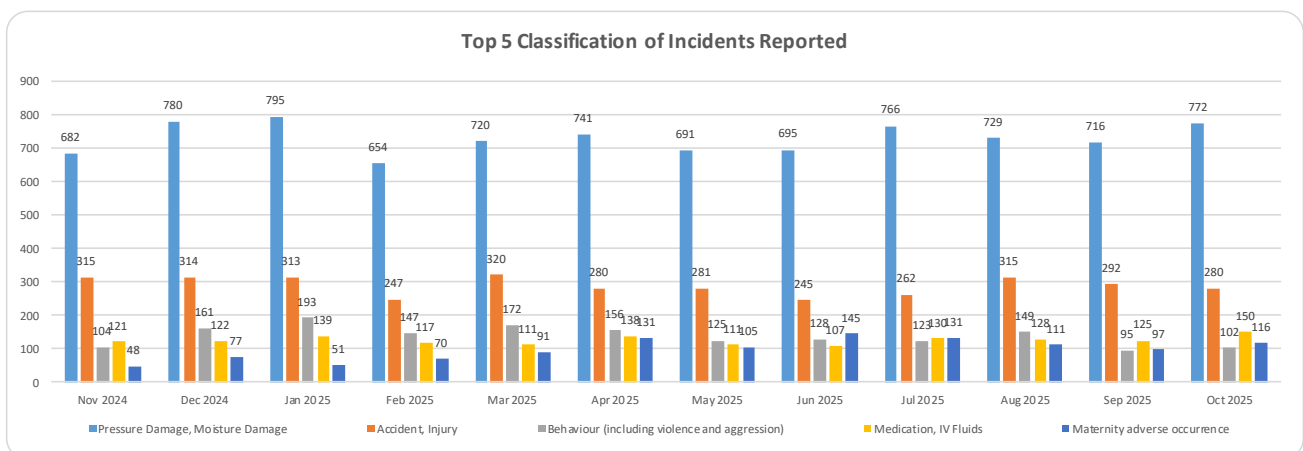
2.2 Patient Safety Incidents

Total Patient Safety Incidents

A total of 4,603 incidents were reported as occurring between 01.09.25 to 31.10.25, this represents a decrease of 8 when compared with the previous 2 months (4,611). The proportion of incidents reported where the patient is identified as the person affected has remained relatively consistent over the last 6 months period. Of the 4,603 incidents reported, 84% (3,862) were reported as the patient affected. The trend in incident reporting is reflected in the chart below.

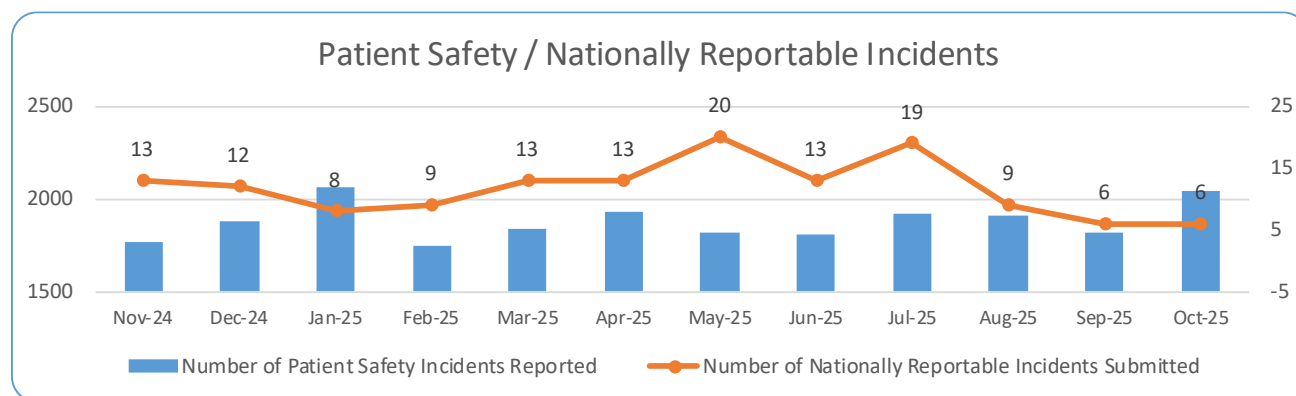


The top 5 classification of incidents reported as occurring in September and October 2025, linked to a patient affected incident are: Pressure Damage /Moisture Damage (1,488), Accident, Injury (572), Medication, IV fluids (275), Maternity adverse occurrence (213) and Behaviour (including violence and aggression) (197). This is consistent with the previous two-month period, apart from Behaviour (including violence and aggression) which has moved to fifth place with a significant drop in incidents from 272 to 197. The trend for the top 5 classification of incidents is highlighted in the chart below:



Nationally Reportable Incidents

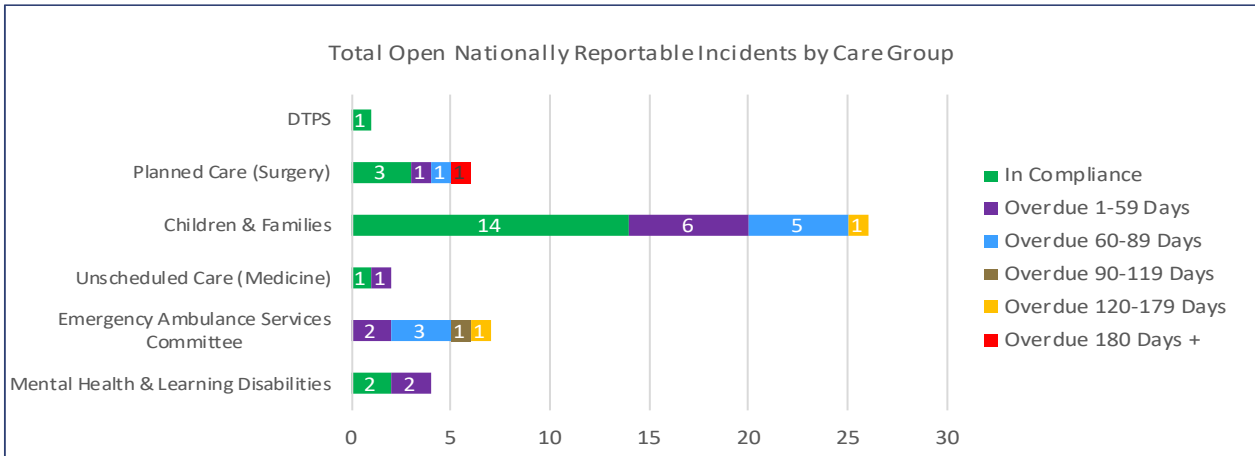
Between 01.09.25 and 31.10.25, 28 Nationally Reportable Incidents were submitted to the NHS Performance & Improvement Team. The ratio of Nationally Reportable Incidents to the overall number of patient safety incidents is demonstrated in the chart below.



As highlighted in previous reports to Committee, it should be noted that Nationally Reportable Incident data is presented based on the date the notification was submitted to the NHS Performance & Improvement Team. The trend for the classification of Nationally Reportable Incidents submitted is reflected in the table below:

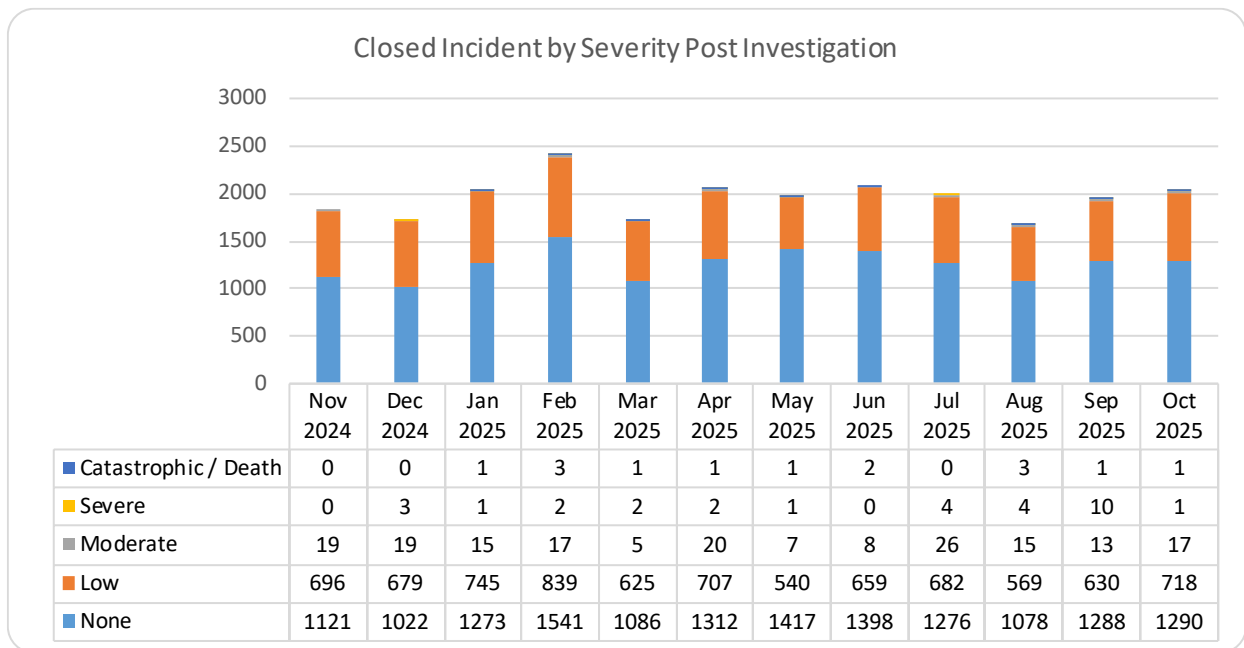
	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Total
Access, Admission	0	0	0	0	1	1	3	1	0	0	0	0	6
Assessment, Investigation, Diagnosis	0	0	0	0	1	0	2	0	2	0	0	0	5
Behaviour (including violence and aggression)	1	0	0	0	0	0	0	0	0	0	0	0	1
Equipment, Devices	0	0	0	0	0	1	0	0	0	0	0	0	1
Infection Prevention and Control	0	2	0	0	4	3	2	0	0	0	1	0	12
Maternity adverse occurrence	2	2	4	1	3	0	5	2	0	5	1	5	30
Nutrition, Hydration	0	0	0	1	0	0	0	0	0	0	0	0	1
Patient/service user death	2	0	1	1	0	1	1	1	1	1	1	0	10
Pressure Damage, Moisture Damage	6	7	2	4	4	3	7	6	15	3	3	1	61
Transfer, Discharge	0	0	1	1	0	4	0	2	0	0	0	0	8
Treatment, Procedure	2	1	0	1	0	0	0	1	1	0	0	0	6
Total	13	12	8	9	13	13	20	13	19	9	6	6	141

As at the 03.11.25, the Health Board currently has 46 open Nationally Reportable Incidents, of which 25 are overdue the timescale for completion. Focused work continues to be undertaken to ensure investigations are concluded and ensure a timely outcome is provided to patients and their families. An overview of the open Nationally Reportable Incidents by Care Group is provided in the chart below:



Closed Patient Safety Incidents

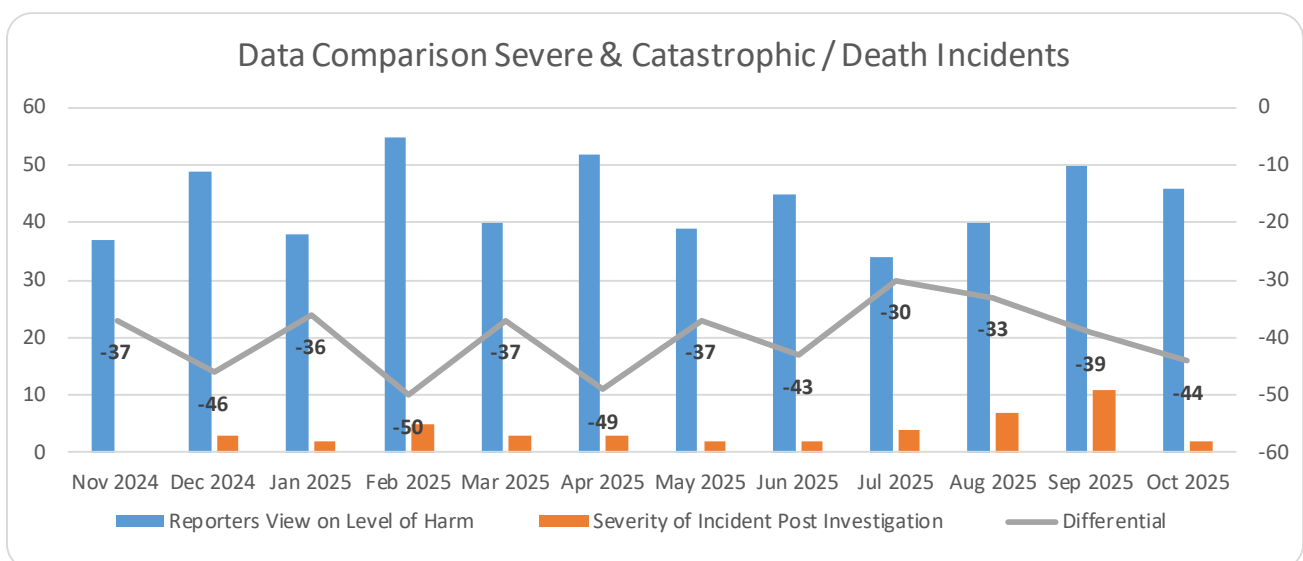
Between the 01.09.25 and 31.10.25 a total of 3,969 patient safety incidents were closed. The 12 month trend is reflected in the table below.



Of the 3,969 patient safety incidents closed, 13 were closed with severity post investigation of severe harm (11) or catastrophic/ death (2). A breakdown of incidents is provided in the table below:

	Planned Care	Mental Health and Learning Disabilities	Total
Access, Admission	4	0	4
Assessment, Investigation, Diagnosis	3	0	3
Behaviour (including violence and aggression)	0	1	1
Infection Prevention and Control	1	0	1
Monitoring, Observations	1	0	1
Treatment, Procedure	3	0	3
Total	12	1	13

Work continues to be undertaken to ensure that a severity of moderate, severe or catastrophic / death recorded on conclusion of an investigation accurately reflects where it can be determined that an incident has been directly caused or attributable to an intervention (action/inaction) by the Health Board. In addition, mechanisms to support a comparison of reporter's view of level of harm and the severity recorded post investigation have been established. The level of harm attributed to an incident is reviewed and recorded at 3 stages within the incident management process, reporter view on Level of harm, level of harm following management review and severity determined post investigation. Trend information providing a comparison between the reporters view on level of harm and severity of incident post investigation is provided below:





Duty of Candour

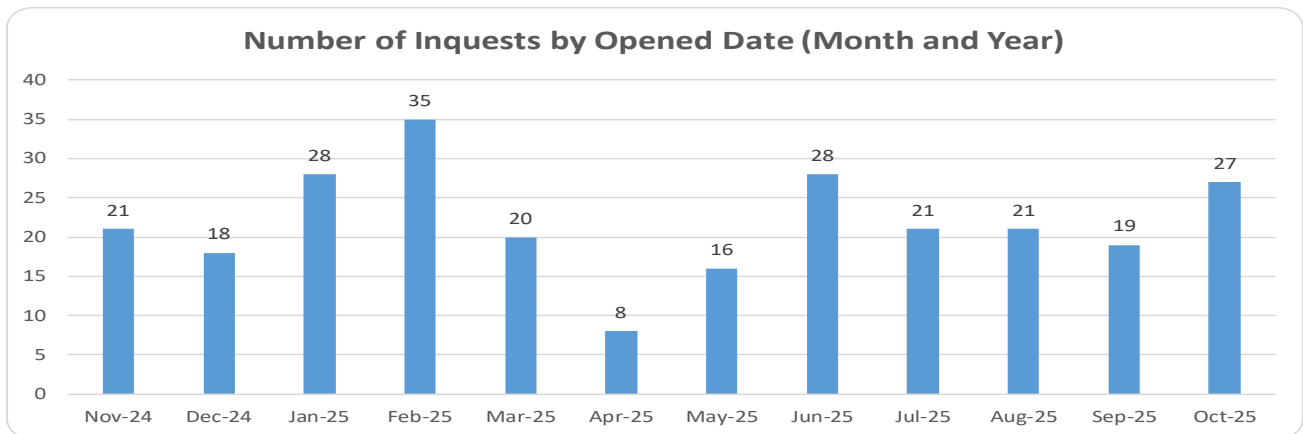
The Duty of Candour regulations were implemented from the 01.04.23. To enable monitoring of requirements, a number of metrics have been devised, which are summarised in the table below. To support the implementation of the Duty of Candour processes, dashboards have developed to provide 'live' data at a glance along with the introduction of weekly data validation audits.

Number of Incidents	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025
Where Duty of Candour Triggered	15	13	9	8	13	15	21	17	8	11	12	23
Where In-person notification completed	15	13	8	6	12	15	19	17	8	8	11	17
Where letter of notification sent	15	13	7	6	11	13	18	17	7	7	9	15

2.3 Inquests Case Activity

New Inquests Received

In the time period 01.09.25 to 31.10.25, the Health Board received notification of 46 inquests. This is a slight increase when compared with the previous 2-month period (42). A trend graph of the inquests opened during period is provided below.



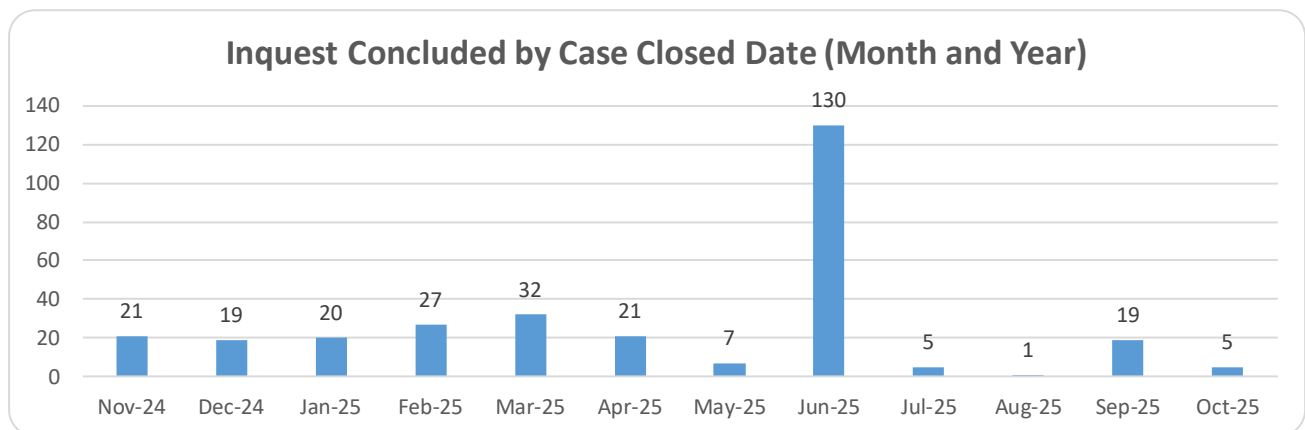
Of the 46, the highest number of inquests were received for the Mental Health and Learning Disabilities Care Group (16). A breakdown of inquests received by Care Group is provided below.



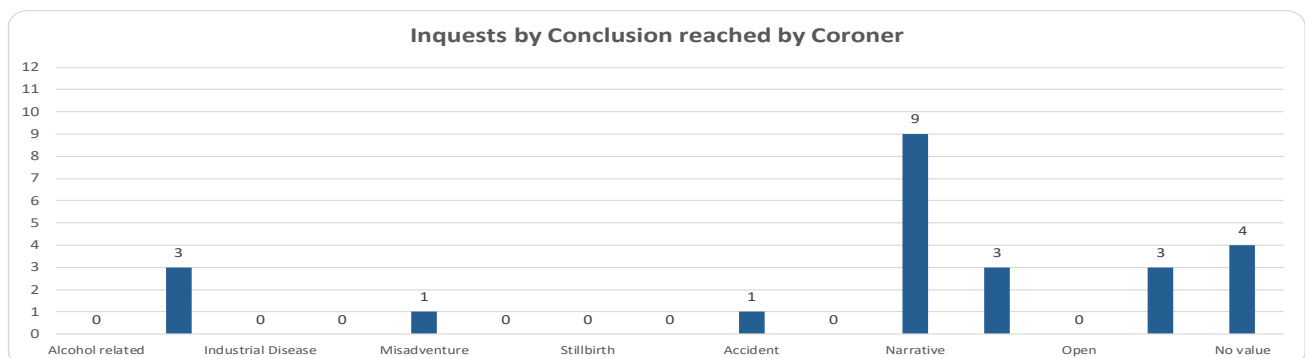
Care Group	Number Received
Children and Families	0
Primary Care and Community	6
Mental Health and Learning Disabilities	16
Planned Care	12
Unscheduled Care	11
DTPS	1
Not Specified	0
Total	46

Inquests Concluded

During the same 2-month period, 24 inquest cases were closed on the Health Board's Datix system. A trend graph of inquests concluded during the period is provided below. It should be noted that inquests will not always be opened and closed in the same period.



Of the 24 inquests cases closed on Datix, 3 were discontinued by the Coroner prior to hearing. Of the remaining cases (21) a breakdown of the outcome of inquests closed between the 01.09.25 and 31.10.25 is provided in the chart below.



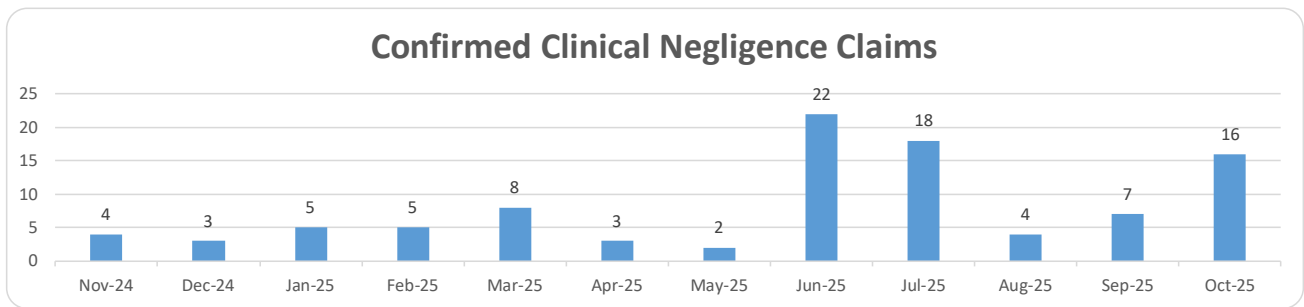
Regulation 28 Reports / HMC Letter Received

On conclusion of an Inquest, under the Coroners Regulations 2013, the Coroner has the power to make a report to prevent future deaths, referred to as Regulation 28 reports. Between the 01.09.25 and 31.10.25 the Coroner did not issue any regulation 28 reports to the Health Board.

2.4 Clinical Negligence Claims

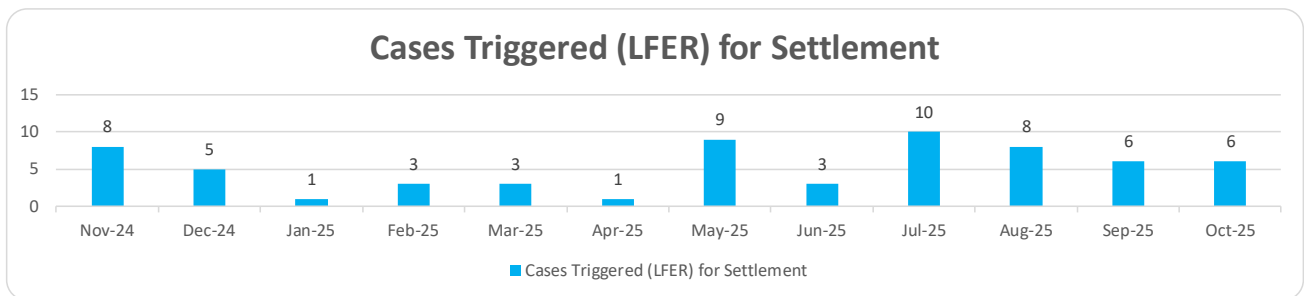
New Confirmed Clinical Negligence Claims

Between the 01.09.25 and 31.10.25 the Health Board received confirmation of a total of 23 Clinical Negligence Claims. The trend in new confirmed clinical negligence claims in the last 12 months is highlighted in the chart below:



Clinical Negligence Claims triggered for settlement

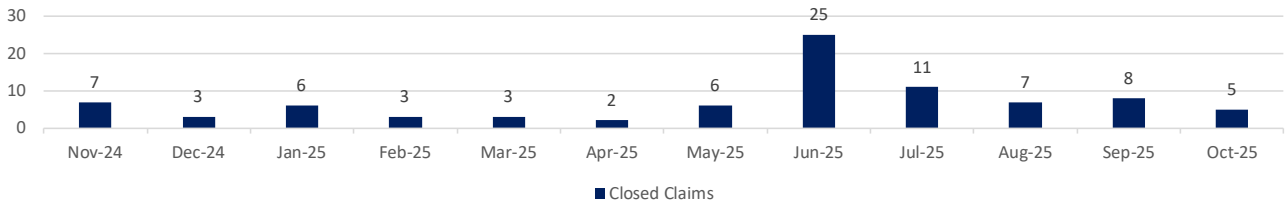
Between the 01.09.25 and 31.10.25 in the Health Board, 12 Clinical Negligence Claims triggered for settlement. The trend for clinical negligence claims settled in the last 12 months is highlighted in the chart below:



Closed Clinical Negligence Claims

Between the 01.09.25 and 31.10.25 in the Health Board, 13 Clinical Negligence Claims were closed. The trend for clinical negligence claims closed in the last 12 months is highlighted in the chart below:

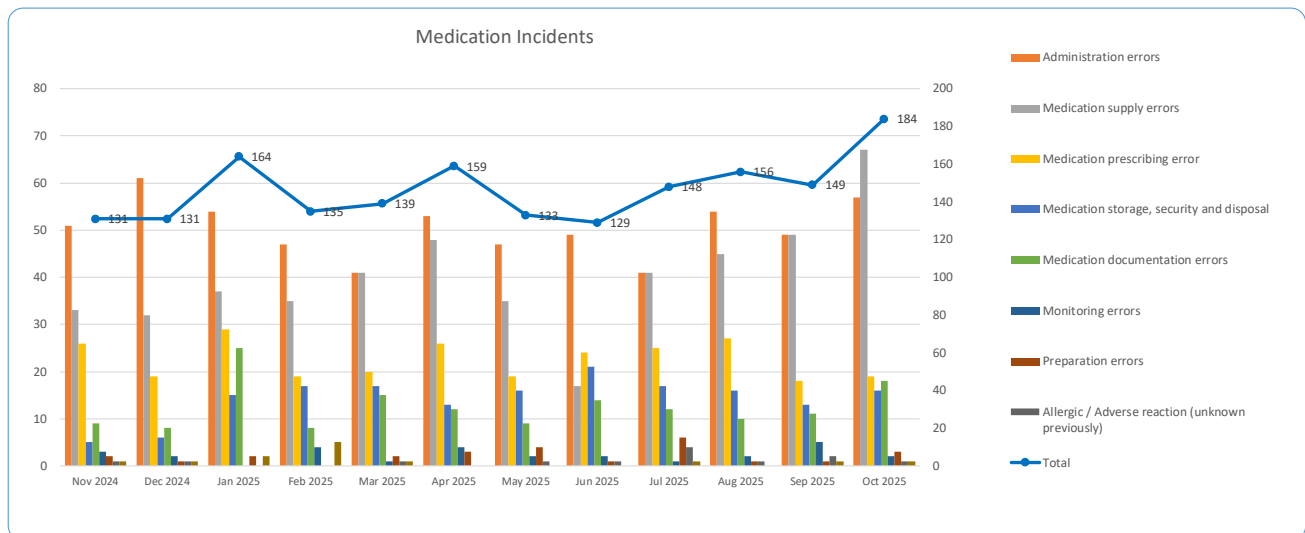
Closed Clinical Negligence Claims



2.5 Specific Quality & Safety Metrics

2.5.1 Medication Safety

A total of 333 medication incidents were reported as occurring between 01.09.25 and 31.10.25. This is an increase of 29 when compared with the previous 2-month period (304). Of the total number of medication incidents reported, the top 3 types of medication incidents relate to medication supply errors (116), administration errors (106) and medication prescribing errors (37).



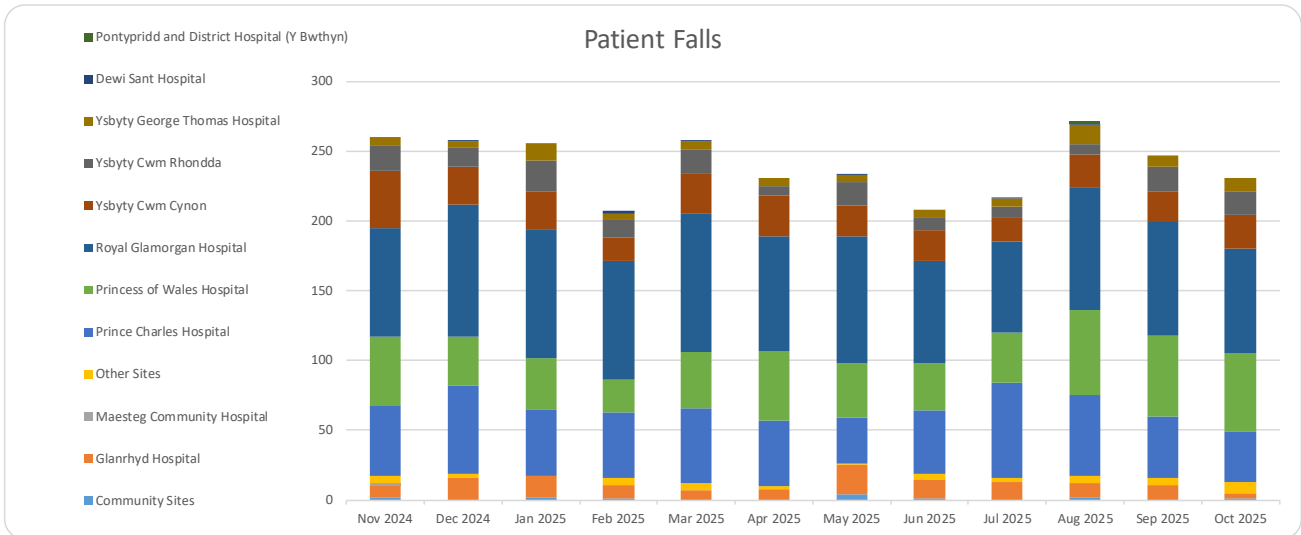
89% of the medication incidents were reported as resulting in no (147) or low (148) harm, with the remaining reported as resulting in moderate harm (36), severe harm (2). While no medication incidents were reported as resulting in catastrophic harm / death. It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

2.5.2 Patient Falls Incidents

A total number of 478 falls, where the person affected was a patient, were reported during September and October 2025. This represents a decrease of 10 compared with the previous two months (488).

Of the falls incidents within the time period, 95% were reported as no (140) or low (316) harm. The remaining incidents were reported as resulting in moderate (22) and severe

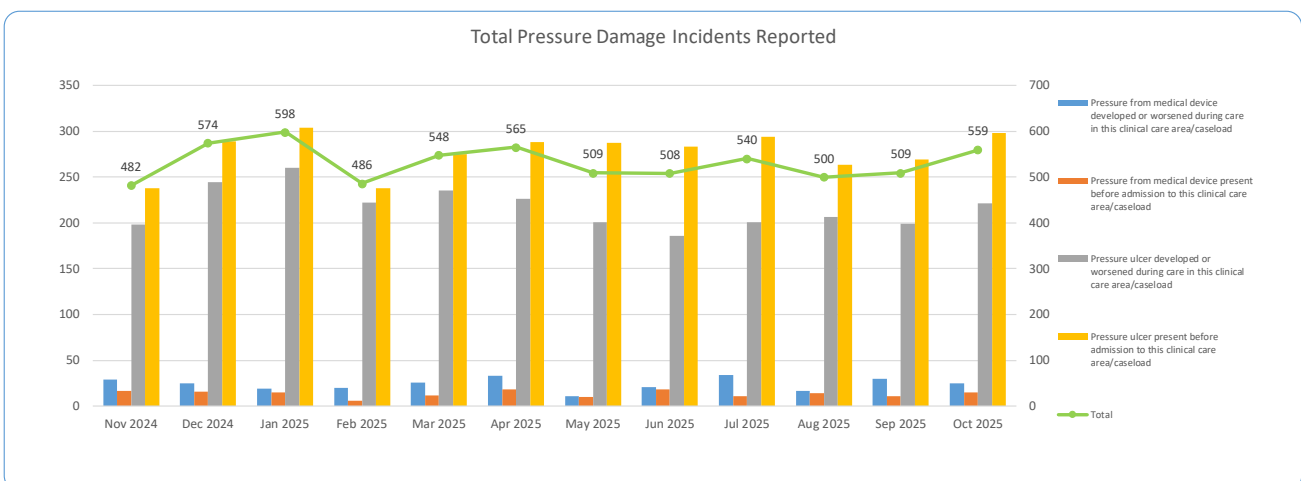
(1) harm. No incidents relating to patient falls were reported as resulting in severe harm or catastrophic harm / death. Once again, it should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.



The falls improvement programme continues to implement agreed initiatives to reduce the number of patient falls.

2.5.3 Pressure Damage

Between the 01.09.25 and 31.10.25, a total of 1068 pressure damage incidents were reported, of which 475 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (593) were reported as being present before admission to this clinical care area/caseload.



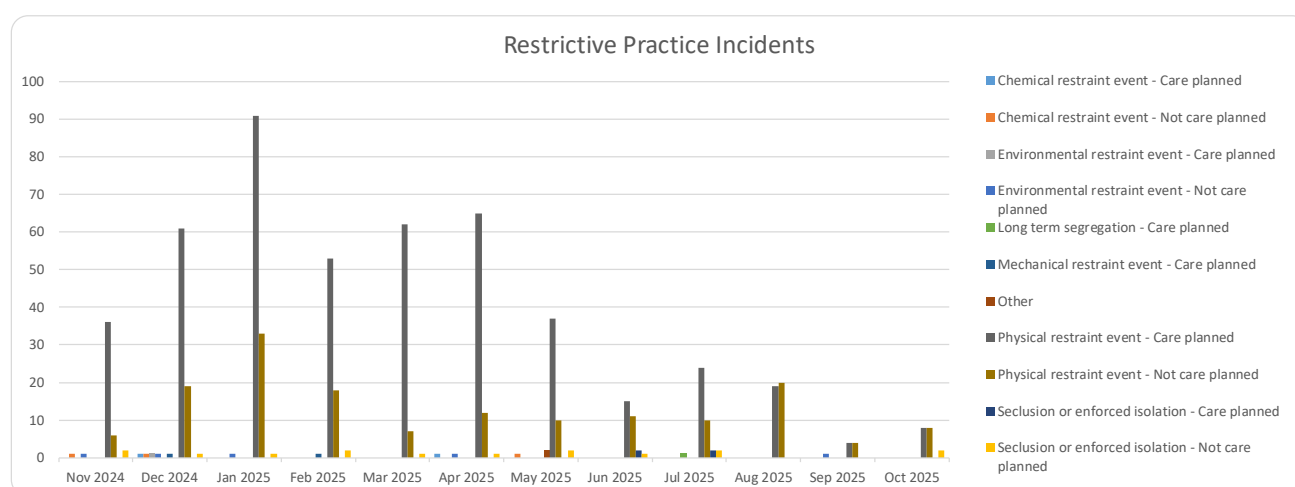
Of the 475, identified as developing or worsening during current caseload, 212 were identified as occurring within the community, which represents a decrease of 20 compared with the previous two-month period (232).

The pressure Ulcer steering group has been established to gain strategic oversight to develop a robust prevention and monitoring program and ensure learning is shared and embedded where available pressure damage has occurred.

2.5.4 Mental Health Metrics

Restrictive Practices

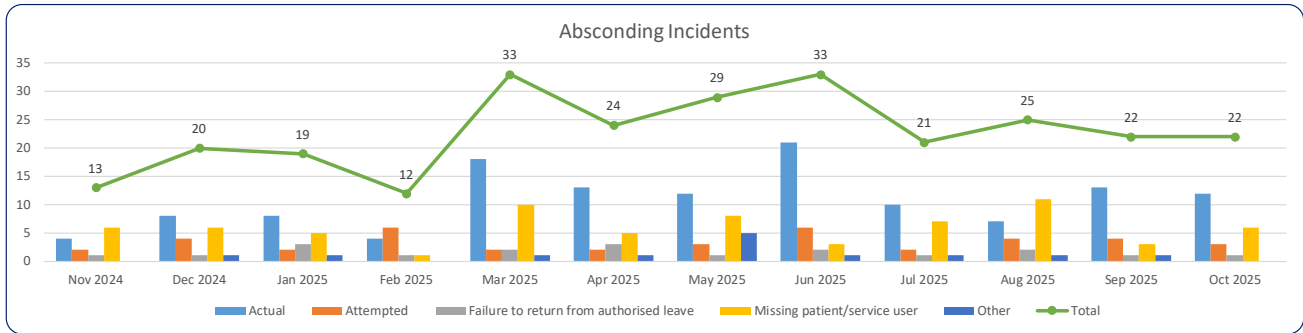
Between 01.09.25 and 31.10.25, a total of 27 incidents relating to using Restrictive Practices were reported within Mental Health. This is a decrease of 51 incidents when compared to the previous two months (78).



Of the 27 incidents, 15 were reported as not care planned (not included in the care and treatment plan for the patient) and 12 were reported as care planned (included in the care and treatment plan for the patient), 0 were recorded as Other. The highest number of incidents were reported as occurring on the Coity Clinic (PICU), Princess of Wales Hospital (12).

Absconding incidents

During September and October 2025, a total of 44 incidents were reported under the category of absconding, which represents a decrease of 2 when compared with the previous two-month period (46). 25 were recorded as actual absconding, with the remaining recorded as missing patient/service user (9), attempted absconding (7), failure to return from authorised leave (2), and other (1). The highest number of incidents were reported as occurring in the Supported Recovery Unit (Mental Health) at the Ysbyty George Thomas Hospital (7).



3. Key Risks / Matters for Escalation

The following issues/risks have been identified in relation to quality reporting within the Health Board.

- The transition to the new operating model poses a challenge in relation to the extraction and presentation of data. Work continues to align the Datix Cymru System to the Care Group Structure and ensure up-to-date information is accessible across the Health Board on a range of metrics.
- Maintaining compliance with the 30 working days' complaints response rate.
- Continuing the reduction of open Nationally Reportable Incidents.
- Timely management of Public Services Ombudsman for Wales Cases.
- Responding to Coroner's Inquest requests within timescales.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /	Safe
	If more than one applies please list below:



Link to Domains of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Timely Effective Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment	
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/> Outcome: This report outlines key areas of quality across the Health Board.
Cydraddoldeb a'r Gymraeg <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb a'r Gymraeg? /</i> Equality and Welsh Language <i>Have you undertaken an Equality and Welsh Language Impact Assessment Screening?</i>	Yes: <input type="checkbox"/> No: <input checked="" type="checkbox"/> Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL NEGATIVE Outcome for Welsh Language (delete as appropriate):
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report. Activity where performance falls short of the Health Board's quality & safety performance measures may result in impact to the trust and confidence in the Health Boards processes.
Effaith Adnoddau <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.

5. Recommendation

5.1 Members of the Quality, Safety and Experience Committee are asked to:

- **NOTE** the content of the report
 - **DISCUSS** the content of the report and flag areas (if not already identified) where further assurance is required
- NOTE** the risks identified

6. Next Steps

6.1 Improvement actions identified within the report to continue to be monitored via the Quality, Safety & Experience Committee and Weekly Quality & Safety Executive Meeting.