Annual report for the management of Claims 25/26

Clinical Negligence and Personal Injury Claims

Patient Experience Team

Introduction

This Annual Report offers assurance regarding Cardiff and Vale University Health Board's arrangements for effectively managing clinical negligence, personal injury, and other qualifying claims. It details how the Health Board meets its statutory, governance, and quality obligations, and describes how learning from claims is systematically captured and utilised to drive service improvements.

Claims management is a central part of the Health Board's broader quality, safety, and risk management framework, and aligns closely with its statutory duties under the Duties of Candour and Quality. The Health Board acknowledges that claims pose both significant financial risks and serve as valuable opportunities for learning when care standards are not met. Consequently, claims are reviewed alongside complaints, incidents, redress cases, and inquests to build a comprehensive understanding of risk and patient experience.

When harm occurs and legal redress is warranted, the Health Board manages cases according to national legislation and local policy, ensuring patients receive prompt explanations, apologies, and financial compensation where appropriate. Redress activity is monitored through established governance processes and is assessed together with claims data to identify new trends, recurrent harm, and improvement opportunities.

The Health Board also recognises the importance of learning from inquests. Findings and assurances from Coroner's inquests are examined alongside claims and redress outcomes to ensure identified concerns are addressed, risks reduced, and improvements embedded in clinical practice and organizational systems. This learning directly informs assurance in claims management and supports the Health Board's quality improvement agenda.

All claims are managed according to the Health Board's Concerns, Complaints, and Claims Policy (UHB 332), which defines roles, responsibilities, and escalation procedures. Claims activity is regularly scrutinised by senior management with reports submitted to relevant Board Committees, providing assurance that risks are properly identified, controlled, and monitored, and that learning results in lasting improvements.

As a member of NHS Wales, the Health Board participates in the Welsh Risk Pool under the All-Wales Policy on Insurance and NHS Indemnity. This collective risk-sharing arrangement helps manage financial liabilities from claims and emphasises the need for robust local claims management, learning, and prevention.

The report thus assures the Board of the effectiveness of claims management within Cardiff and Vale University Health Board and demonstrates how learning from claims contributes to safer care, improved patient experience, and compliance with national policies and statutory requirements.

Clinical Negligence Claims

Addressing concerns and claims under the Putting Things Right (PTR) (Wales) Regulations 2011, as well as from 1 April 2026 in accordance with the Listening to People guidance and Civil Procedure Rules, remains a fundamental aspect of the Health Board's quality, safety, and learning framework. PTR provides a consistent process for managing concerns, complaints, and claims, thereby ensuring that patients and families receive prompt responses.

Clinical negligence claims constitute an important source of organisational learning. Alongside complaints and incidents, these claims contribute valuable insight into clinical risks, system pressures, and opportunities for enhancing patient safety, experience, and outcomes.

This section provides an overview of clinical negligence claims initiated between April 1, 2025, and March 31, 2026, detailing activity by Clinical Board and highlighting key themes and trends to inform quality improvement priorities.

Overview of Claims Activity

In 2025/26, a total of 108 new clinical negligence claims were initiated across the Health Board.

Claims are present in all service areas but are most concentrated in acute hospital services, reflecting the complexity and intensity of care provided.

Breakdown by Clinical Board

Clinical Board	Number of claims	% of total
Surgical Services	30	27.8%
Children and Women's Services	24	22.2%
Primary, Community and Intermediate Care	20	18.5%
Specialist Services	14	13.0%
Medicine Services	11	10.2%
Clinical Diagnostics and Therapeutic Services	7	6.5%
Mental Health Services	2	1.9%
Total	108	100%

Key Observations

- Surgical Services (27.8%) and Children and Women's Services (22.2%) account for over half of all claims, reflecting the higher-risk nature of procedural and maternity care.
- Primary and Community Services (18.5%) represent a significant proportion, highlighting risks associated with early diagnosis, prescribing and referral pathways.

- Specialist Services (13.0%) and Medicine Services (10.2%) reflect complexity in acute and tertiary care decision-making.
- Lower volumes are seen in Diagnostics (6.5%) and Mental Health (1.9%), although these cases often involve high severity outcomes.

Themes and Trends

Analysis of claims opened during the year identifies consistent cross-cutting themes across Clinical Boards. These align closely with learning from complaints and nationally reportable incidents.

1. Delays in Diagnosis
   - A recurring theme across multiple services
   - Particularly evident in:
     - Cancer pathways
     - Neurological conditions
     - Emergency presentations
   - Often linked to:
     - Failure to act on test results
     - Delayed imaging or follow-up

2. Delays in Treatment and Intervention
   - Seen in both elective and urgent pathways
   - Includes:
     - Delayed surgical intervention
     - Delay in escalation of deteriorating patients
   - Particularly relevant in:
     - Maternity care
     - Acute medical and surgical services

3. Clinical Assessment and Decision-Making
   - Concerns relating to:
     - Misdiagnosis or missed diagnosis
     - Failure to recognise severity or deterioration
     - Inadequate risk assessment

4. Communication and Documentation
   - A contributing factor across a wide range of claims:
     - Poor handover and continuity
     - Conflicting or unclear clinical advice
     - Inadequate discharge or follow-up planning

5. Consent and Patient Information
   - Predominantly within surgical pathways:
     - Incomplete documentation of risks
     - Failure to communicate alternatives clearly

6. Medication and Prescribing
- Issues include:
  - Incorrect prescribing or dosing
  - Failure to monitor medication
  - Inadequate management of side effects

7. Fundamental Care and Pressure Damage
- Includes:
  - Pressure ulcers
  - Failures in repositioning or skin care
- Reflects ongoing challenges in delivering consistent fundamental care in high-demand settings

8. Maternity and Neonatal Harm
- A key high-risk area:
  - Delay in delivery
  - Failure to act on fetal distress
  - Antenatal monitoring failures
- These cases often involve severe and life-long impact, contributing significantly to overall organisational risk

System Learning and Alignment

The themes identified demonstrate clear alignment with:
- Complaints intelligence
- Patient safety incidents
- National patient safety priorities

This triangulation reinforces that many claims arise from:
- Pathway delays
- Communication breakdowns
- Escalation and decision-making challenges

The Health Board continues to strengthen:
- Early resolution approaches under PTR
- Open and transparent communication with patients and families
- Use of claims intelligence to inform learning and service improvement

The clinical negligence claims profile for 2025/26 demonstrates patient safety risks that span the healthcare system, rather than being confined to isolated incidents. Although claims are observed across all Clinical Boards, the prevalence within acute and maternity services underscores the inherent complexity and risk associated with high-acuity care.

Recurring issues—particularly those involving delays in diagnosis and treatment, communication breakdowns, and challenges in clinical decision-making—are consistent with findings from complaints and incident reports, providing reliable evidence base for targeted improvements.

Maintaining a focus on early identification of patient deterioration, prompt access to diagnostics and intervention, clear communication, and strong clinical governance will be critical for reducing harm, enhancing patient outcomes, and minimising future liability.

Theme	Key Risk Description
▧ Delayed Diagnosis	Cancer, neurology, missed results
▨ Delayed Treatment	Surgery, escalation delays
▨ Clinical Decision-Making	Misdiagnosis, failure to recognise deterioration
▧ Communication Failures	Handover, discharge, follow-up
▨ Consent & Information	Surgical risk discussions
● Medication Errors	Prescribing, monitoring failures
○ Fundamental Care	Pressure damage, basic care omissions

🧠 What the Data Tells Us

☑ Claims reflect system-wide themes (not isolated events)

☑ Strong alignment with:

- Complaints
- Incidents
- Patient safety priorities

☑ Highest-risk areas are:

- Time-critical pathways
- Complex decision-making environments

👶 High Harm Priority Areas

- Maternity & neonatal injury
- Surgical complications
- Delayed cancer diagnosis
- Deteriorating patient recognition

🚀 2026/27 Priorities (Aligned to LTP & Increased Redress Threshold)

◇ 1. Early Resolution & Redress

- Expand pre-claim resolution pathways
- Reduce escalation to formal litigation
- Use increased threshold to resolve locally

☑ *Outcome:* Faster, more person-centred resolution

◇ 2. One System Approach (LTP Integration)

- Align claims + complaints + incidents
- Introduce single thematic dashboard
- Strengthen Board-level oversight

☑ *Outcome:* Clear, triangulated risk intelligence

The table provides a breakdown of Clinical Negligence Claims for the years 2024/2025 and 2025/2026, highlighting several key categories: new claims received, claims closed, claims settled, and claims defended.

In the period 2025/2026, there were 108 total new claims received, marking a significant increase compared to the 67 claims received in 2024/2025. The closure of claims followed a similar trend, with 83 claims closed in 2025/2026, slightly fewer than the 91 closed in the previous year.

Overall, the data illustrates a rise in new Clinical Negligence Claims being received, while the number of claims closed and settled has decreased.

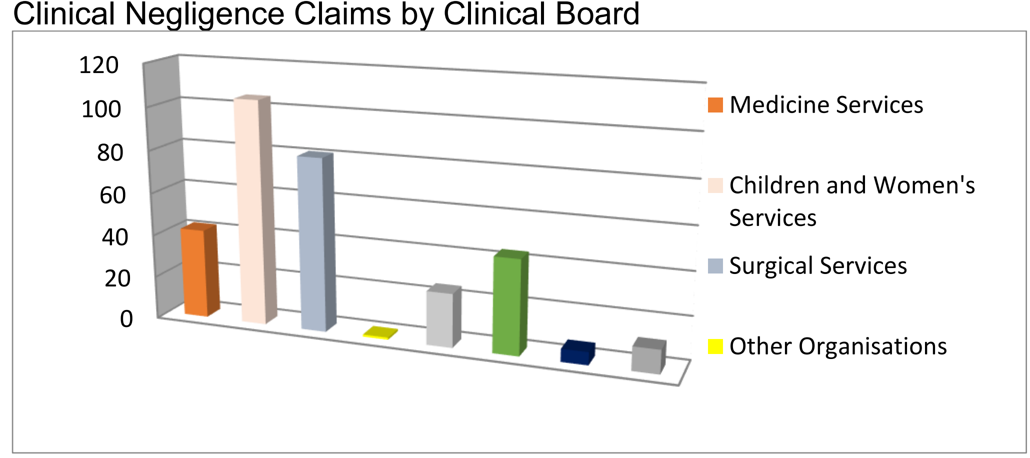
There has been a reported increase in Clinical Negligence Claims over the last 5 years across Wales with Cardiff and Vale Health Board also experiencing this increase.

	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
All-Wales	1450	1750	1797	1780	1823	1694	1506	1483	1651	1743	1739	1864	1842
CVUHB	161	228	245	248	263	267	229	232	243	220	250	275	282

It is recognised that there has been some disruption to case volumes arising from the pandemic. However, there is no discernible trend which outlines the reason for the increase. The increase in 2013 to 2014 was associated with a change in the law regarding costs. The reduction seen in 2017-18 was associated with a change in how Legal and Risk Services accepted instructions in cases.

The defence of Clinical Negligence Claims is just under a third for 2024/2025 and slightly lower that the overall figure for the whole of Wales. The defence of cases can be complex and time consuming and often involves the instruction of specialist experts. Defence of legal costs cannot usually be recovered even when a matter is closed without damages.

Clinical Negligence Claims by Clinical Board



The most frequently occurring specialists seen in Clinical Negligence cases continues to be:

- Maternity Services (Obstetrics)
- Surgical services
- Emergency Departments

This has been the case for the last four years. In 2024/25 the proportion of maternity cases has remained at a stable position, whilst the number of matters occurring in the emergency department has continued to increase, which is likely to be associated with the ongoing pressures seen in unscheduled care settings.

The highest speciality of Clinical Negligence Claims that the UHB received relate to Obstetrics, relating to 11 high value settled cases, an increase on the previous year from 9 settled claims in this speciality. A high percentage of damages paid in this area relate to continual care costs.

Obstetric Claims fall into a number of common breaches for instance, unacceptable delay in diagnosis and treatment, Wrong treatment/operation site, non-compliance with local policy/national/royal college guidelines without and invalid consent and can take a number of years to before the conclusion of these case due to the need for extensive expert evidence through the development stages of a child's life in order that compensation fully reflects the support that will be needed. Periodical Payment can be applied which involves a settlement via a court order that involved Health Boards being required to provide annual payments to Claimants for the remainder of their life rather than disbursing the compensation as a single lump sum. These payments are index linked.

The Obstetric teams continually engage in improving quality of their services to support the learning and improvements agenda. Holding clinical reviews at the earliest opportunity ensuring communication. There are good links between the patient safety and the patient experience teams to ensure all actions are reported and followed up.

The maternity training compliances invariably meets the 95% target criteria set up WRP.

Learning Advisory Panel – Themes and Trends Report

Cardiff & Vale University Health Board
Reporting Period: Cases presented (February–March 2026 panels)

1. Executive Summary

Analysis of the Learning Advisory Panel (LAP) case reports demonstrates consistent system-wide themes across clinical services. The predominant risks relate to:

- Failures in clinical decision-making and escalation

- Diagnostic and imaging errors
- Breakdowns in communication and follow-up processes
- Documentation deficiencies
- Inconsistent adherence to protocols and pathways

A further notable finding is that whilst learning interventions are frequently identified, panel feedback regularly seeks additional assurance, particularly in relation to:

- Evidence of implementation
- Ongoing monitoring and audit
- Sustainability of improvements

2. Key Thematic Findings

2.1 Diagnostic and Clinical Decision-Making Failures

A recurrent theme across multiple specialties is failure to correctly identify, interpret, or act on clinical information.

Examples include:

- Failure to use up-to-date diagnostic data (e.g. outdated biometry leading to incorrect lens selection)
- Missed fractures and imaging abnormalities (radiology reporting failures)
- Failure to identify ligament injury on MRI and integrate imaging findings into management decisions
- Misinterpretation of neurological urgency (delayed intervention in cauda equina syndrome)
- Inadequate consideration of underlying clinical risk (e.g. ovarian failure risk in paediatric endocrinology)

Trend insight:
There is a pattern of missed or incomplete clinical reasoning, often compounded by:

- Not reviewing available diagnostic information fully
- Over-reliance on prior assessments
- Failure to reassess when clinical condition evolves

2.2 Failures in Escalation, Monitoring and Timely Treatment

Several cases demonstrate delays in escalation or treatment, particularly where clinical deterioration occurred.

Examples include:

- Delay in escalating antibiotic treatment despite clinical indicators
- Failure to provide urgent surgical intervention in spinal compression cases

- Delays in referral pathways leading to significant harm (e.g. cancer pathway digital failure and lost follow-up)

Trend insight:

- Escalation triggers are not consistently recognised or acted upon
- Monitoring processes (e.g. follow-up, review points) are unreliable
- There is variation in response to clinical deterioration

2.3 Communication and Handover Failures

A consistent cross-cutting issue is failure in communication between teams, services or systems.

Key examples:

- Failure to communicate request for repeat investigations between teams
- Lost referrals due to digital system errors and lack of verification
- Lack of clarity regarding responsibility for follow-up care (e.g. oncology referral not actioned)
- Inconsistent clinical communication leading to conflicting treatment advice (neurology case)

Trend insight:

- Weaknesses in handover and ownership of care pathways
- Lack of closed-loop communication systems
- Over-reliance on individual action rather than system safeguards

2.4 Documentation and Record-Keeping Deficiencies

Multiple cases identify inadequate or absent documentation as a contributing factor.

Examples include:

- Failure to document catheter management plan and timing
- Poor documentation of clinical decision-making and investigations (paediatrics case)
- Inadequate recording of follow-up and treatment plans leading to missed care

Trend insight:

- Documentation issues are systemic rather than isolated
- Poor documentation directly impacts:
    - Continuity of care
    - Clinical decision-making
    - Patient safety outcomes

2.5 Pathway and Process Failures (Including Digital Systems)

A number of cases highlight failures in clinical pathways, administrative systems, and process reliability.

Examples include:

- Digital referral system failure leading to an 18-month delay in cancer care
- Incorrect referral documentation leading to unnecessary invasive procedures
- Inadequate tracking systems for catheter care and follow-up

Trend insight:

- Systems lack robust validation and fail-safes
- Insufficient cross-checking mechanisms
- Reliance on manual processes increases risk of error

2.6 Failure to Adhere to Protocols and Safety Standards

Several incidents demonstrate non-compliance or inconsistent application of established protocols.

Examples include:

- Lack of adherence to surgical safety checks (e.g. failure to detect retained item)
- Failure to follow imaging or surgical protocols (e.g. pre-operative checks, CBCT guidance)
- Use of inappropriate treatments (e.g. compression bandaging on pressure injury)

Trend insight:

- Protocols exist but are:
    - Not consistently understood
    - Not reliably applied
- Variability in practice indicates gaps in training and reinforcement

2.7 Learning Implementation and Assurance Gaps

A strong and consistent finding across almost all cases is that Learning Advisory Panel requests further evidence of assurance.

Common panel requirements include:

- Evidence of:
    - Implementation of changes

- Dissemination of learning
    - Discussion at Q&S meetings
- Demonstration of:
    - Audit and monitoring
    - Compliance with new processes
    - Sustainability of improvements

Trend insight:

- Learning actions are frequently identified but not fully evidenced
- There is a gap between action and assurance
- Limited demonstration of impact or outcome measures

3. Cross-Cutting Risks

Across all cases, the following overarching risks are identified:

- System reliability risk: Processes and pathways rely heavily on individuals rather than system safeguards
- Governance risk: Insufficient audit and assurance mechanisms to confirm learning effectiveness
- Patient safety risk: Delays, missed diagnoses, and procedural errors leading to harm
- Information risk: Inadequate documentation and communication impacting continuity of care

4. Positive Practice Identified

The cases also demonstrate examples of good practice, including:

- Introduction of digital tracking systems and databases for patient monitoring
- Development of standardised SOPs and pathways across multiple services
- Use of:
    - Audit programmes
    - Teaching sessions and training initiatives
    - Multidisciplinary team (MDT) approaches

However, these improvements often require further validation and assurance.

5. Key Recommendations (Strategic)

Based on the themes identified, the following system-level actions are recommended:

5.1 Strengthen Clinical Decision-Making Assurance

- Standardise use of diagnostic checkpoints

- Embed mandatory review of imaging/results prior to intervention

5.2 Improve Escalation and Monitoring Systems

- Clear escalation triggers embedded in pathways
- Real-time monitoring of high-risk patients

5.3 Enhance Communication and Handover Reliability

- Introduce closed-loop communication requirements
- Strengthen accountability for follow-up actions

5.4 Address Documentation Standards

- Mandate structured documentation tools (e.g. proformas)
- Audit compliance routinely

5.5 Strengthen Digital and Pathway Governance

- Implement system fail-safes and validation checks
- Regular testing and audit of digital pathways

5.6 Improve Protocol Compliance

- Reinforce training on safety-critical protocols
- Embed compliance monitoring into governance frameworks

5.7 Close the Learning-to-Assurance Gap

- Require:
  - Evidence of implementation
  - Defined outcome measures
  - Sustained audit cycles
- Align learning with Board-level assurance reporting

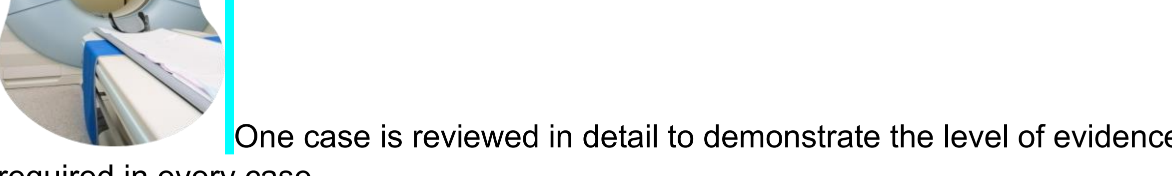
6. Conclusion

The LAP cases highlight recurrent, system-wide issues rather than isolated incidents, particularly in relation to:

- Clinical decision-making
- Communication and coordination
- Reliability of systems and processes
- Assurance of learning

Whilst there is clear evidence of learning activity, the key challenge remains ensuring that this learning is:

- Implemented consistently
- Measured effectively
- Demonstrated through robust assurance mechanisms



One case is reviewed in detail to demonstrate the level of evidence required in every case

The Claimant, in their 20's reported to be in good health other than known scoliosis.

- The Claimant experiences a sudden onset of sever back pain. The Claimant visited their general practitioner, who prescribed co-codamol.
- Nine days later, the back pain persisted and the individual attended A&E at UHW. They were discharged with advice to undertake physiotherapy exercises.
- Three weeks later, the individual re-presented to A&E with worsening back pain. They were discharged with advice to consult their GP and use the physiotherapy website.
- Four days later, the individual attended A&E again with ongoing symptoms. They were assessed and discharged with advice to continue physiotherapy exercises.
- Five days later, the individual attended A&E once more and was discharged with a GP appointment arranged.
- Approximately three months after the initial presentation to healthcare services, the individual developed pins and needles and was taken to another University Hospital Following an MRI scan, a diagnosis of spinal tuberculosis (TB) was made.
- Had the diagnosis of TB been made earlier, treatment could have been initiated and disease progression potentially prevented.

Action taken:

- A letter of concern was received. An investigation in line with the PTR Regulations was undertaken.
- The internal investigation was undertaken by a Consultant in Emergency Medicine, who concluded that there was a failure to undertake an MRI and that a reasonable body of ED clinicians would have arranged an MRI scan and/or further review by the Orthopaedic/Spinal Team to exclude other potential rarer diagnoses.
- It was acknowledged that failure to undertake the investigations delayed the diagnosis and treatment of spinal tuberculosis. The Claimant was advised that

the matter would need to proceed as a claim for clinical negligence due to the value.

- The Health Board obtained witness evidence, expert evidence, and Counsel advice. We admitted the following: At the initial presentation, there was a failure to undertake an MRI scan despite a raised C-reactive protein (CRP) level of 15 and a recorded body temperature of 38.5°C. On re-presentation to A&E four days later, there was a further failure to undertake an MRI scan despite reported symptoms of decreased urinary frequency.

  Learning outcomes

  Management of re-attenders: In accordance with Royal College of Emergency Medicine guidance, revised processes have been implemented for the management of individuals who re-attend the Emergency Department. The team now adheres to the Royal College of Emergency Medicine standard requiring review and sign-off by a consultant.

  This requirement is embedded within the system to support consistent information sharing across the clinical team. In addition, a dedicated Emergency Unit Work System task list has been developed to guide staff through the appropriate steps when individuals make an unplanned return to the Emergency Department with the same condition within 72 hours.

  Supervision of junior doctors: All individuals who re-attend is reviewed by a senior Emergency Physician (Specialty Trainee year 4 or above) in recognition of the increased diagnostic risk associated with repeat attendance.

  Senior cover includes:

  - 2 consultants on site 08:00–22:30 (daily)
  - 1 consultant on site until midnight
  - 24/7 consultant on-call, often present overnight
  - Minimum 2 registrars, including one ST4+
  - FY1 & FY2 Supervision
  - FY1s cannot discharge patients independently.
  - FY2s may discharge patients, with:
  - Consultant supervision 08:00–22:30 in ACU
  - ED SpR supervision overnight, plus a consultant available in Resus.
  - High-risk groups (per RCEM) — including re-attenders — require senior sign-off before FY2 discharge.

  Handover & Safety-Netting

  - Consultant-led handovers at 08:00, 16:00, and 22:00.
  - FY2s trained in safety-netting; practice audited and fed into Quality & Safety improvements.

Wider Learning:

The case has been shared at internal M&M, QSE and Q&S meetings for wider learning.

Learning focuses on the consideration of the rarer indications for an MRI spine in the ED.

Organisational wide learning that should address some of the themes from claims

Quality excellence
The **Quality Excellence Programme** at **Cardiff and Vale University Health Board (CAV UHB)** is a comprehensive, system-wide initiative designed to embed a culture of continuous improvement, patient safety, and high-quality care across all services. It aligns closely with the **Duty of Quality**, which became a statutory requirement in April 2023, and is structured around six core domains of healthcare quality: **Safe, Effective, Person-Centred, Timely, Efficient, and Equitable**

Programme Board
SRO: Jason Roberts/ meets monthly
Manage and coordinate the project teams to ensure delivery of milestones and outcomes.
Determine the strategic direction for quality and prioritise programmes and projects related to stated outcomes within the strategy

Quality Management System Project
Scope:
Building a system for quality for the UHB, to include:
- The system, processes and architecture of a Quality Management System
- Structures and flows including roles and responsibilities
- Delivery of a system that allows quality control

Hospital Acquired Infections Project
Scope:
Developing a baseline dashboard to provide timely and consolidated data and then driving improvement in Healthcare Acquired Infection practices.

Lost to Follow-up Project
Scope:
- Address the issue of follow-up patients becoming 'lost' within the Health Board system, who as a result, are at risk of suffering preventable unintended or unexpected harm.

Acute Deterioration Project
Scope:
- Implementing strategies, including those listed in 'Standardising the management of acute deterioration' (WHC/2024/035) to improve the recognition and response to physical deterioration.

Key Components of the Quality Excellence Programme

1. Strategic Framework
The programme is underpinned by the **Shaping Our Future Wellbeing** strategy, which sets out the Health Board's long-term vision for delivering outstanding care.

This includes:
- **Putting People First**
- **Providing Outstanding Quality**
- **Delivering in the Right Places**
- **Acting for the Future**

2. Quality Management System

We are developing a **Quality Management System (QMS)** to ensure that quality is embedded in every decision and action. This includes:

- A **Quality Impact Assessment** for strategic decisions
- A **data-informed approach** to care using digital tools and analytics.
- Systematic learning from audits, incidents, and patient feedback

The programme fosters a culture of innovation through:

- Adoption of evidence-based practices
- Support for clinical research
- Use of improvement methodologies to drive service transformation

Clinical Governance and Assurance
The **Clinical Effectiveness Committee** and **Quality, Safety and Experience Committee** oversee:

- National Clinical Audits and Outcome Reviews
- Implementation of NICE guidance

Patient Experience and Co-Production
The programme places strong emphasis on **co-producing services** with patients and communities. It uses:

- Patient-reported outcomes and experiences
- Initiatives like **"Daring to Dream"** and **"Safe at Home"**
- Feedback from inspections and public engagement

Quality Excellence Programme
This programme operationalises the strategic goals of the Shaping Our Future Wellbeing strategy by embedding a **culture of continuous improvement** and **high-quality care** across all services.

Shaping our Future Quality Excellence (SOFQE) is a Health Board-wide programme to create a system and culture for quality in its broadest sense. The programme will be the strategic vehicle by which we deliver Cardiff and Vale UHB's main effort of eradicating avoidable harm, in all its forms, including: • Harm to patients. • Harm to colleagues. • Harm to our resources. • Harm to future generations. • Harm to our reputation.

Focus Areas:

- **Safe Care**: Reducing harm and improving incident reporting.
- **Effective Care**: Aligning with best practices and clinical guidelines.
- **Timely Care**: Ensuring patients receive care when and where they need it.
- **Person-Centred Care**: Respecting individual needs and preferences.

- **Equitable Care**: Addressing disparities in access and outcomes.

The Shaping Our Future Quality Excellence Programme has established four dedicated programme boards to address the most frequently reported themes identified through the National Reporting and Incident System (NRIS). These thematic areas include: the care of the deteriorating patient, patients lost to follow-up, infection prevention and control, and medication safety.

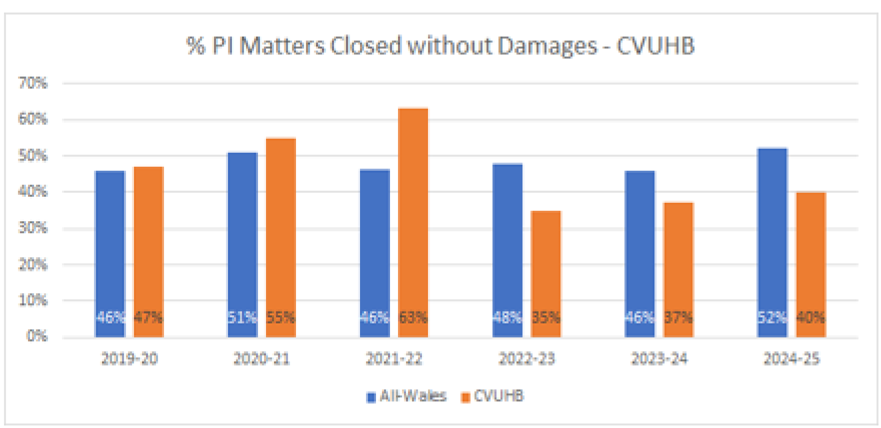
The implementation of the **National Early Warning Score (NEWS)** within the **Shaping Our Future Quality Excellence Programme** at Cardiff and Vale UHB is progressing well, particularly within the **deteriorating patient workstream**. Here are the key details:

- **NEWS Implementation**
- **Purpose of NEWS**: NEWS is a standardised tool used to detect early signs of patient deterioration by scoring vital signs and triggering timely clinical responses.
- **Integration with Quality Excellence**: This initiative is part of a broader effort to enhance patient safety and clinical effectiveness, aligning with the Health Board's strategic goals under the Quality Excellence Programme.
- **Governance and Oversight**: Progress is being monitored through dedicated programme boards, with updates presented to the **Senior Leadership Team** to ensure alignment with the wider **Quality Management System**

Personal Injury Claims

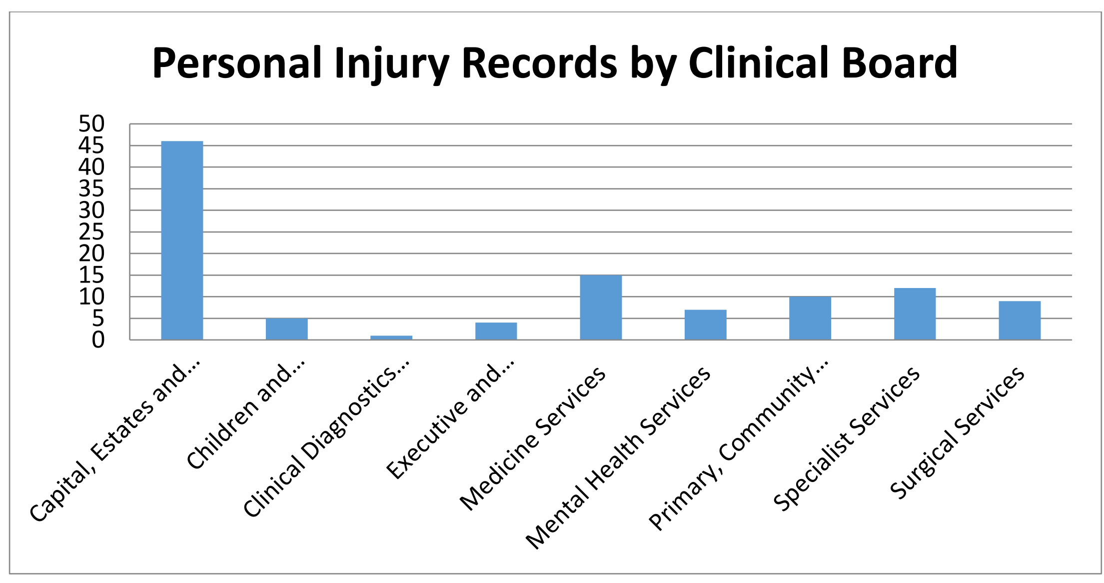
New Claims	2025/2026	2024/2025
Received	34	29
Claims Closed	2025/2026	2024/2025
	34	26
Settled	16	19
Defended	18	7

There has been a reduction of Personal Injury Claims across Health Boards as a whole over the last 10 years with a slight increase being reported in 2024/25. It is recognised that this is in part due to changes in the law regarding "no-win no-fee" funding arrangements.



The proportion of PI matters successfully closed without damages paid continues to represent around half of claims across Health Boards in Wales.

Personal Injury Claims by Departments



Personal Injury Claims remains consistent with around half of these relating to Estates, this is split further between staff claims concerning injury at work and the rest made by staff, contractors and visitors concerning public areas, in the main carparks, corridors and pathways.

Executive Summary – Personal Injury Claims (April 2025 – March 2026)

A total of 40 new personal injury claims were recorded during the reporting period. The dataset demonstrates a clear concentration of claims within operational environments, predominantly involving staff injuries, with contributory factors linked to estates, patient interaction, and manual handling risks.

Breakdown by Clinical Board

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Clinical Board	Number of Claims	% of Total
Capital, Estates & Facilities	14	35.0%
Primary, Community & Intermediate Care	5	12.5%
Mental Health Services	4	10.0%
Specialist Services	4	10.0%
Medicine Services	4	10.0%
Children & Women's Services	4	10.0%
Surgical Services	3	7.5%
Executive & Corporate Services	1	2.5%
Other/Unclassified	1	2.5%

Key Points

- Capital, Estates & Facilities (35%) accounts for over one-third of all claims, reflecting ongoing risks associated with:
  - Estates infrastructure (e.g. lifts, doors, flooring, environmental hazards)
  - Facilities operations (portering, housekeeping, catering)
- All other Clinical Boards show relatively even distribution (~10%), indicating system-wide exposure rather than isolated service issues.
- Community and primary care settings represent a notable proportion (12.5%), linked to home visits and environmental risks outside hospital control.

Themes and Trends

□

Theme	Number of Claims	% of Total
Slips, Trips and Falls	11	27.5%
Other / Complex Cases	11	27.5%
Manual Handling / Moving & Handling	7	17.5%
Environmental Exposure (e.g. asbestos, mould)	5	12.5%
Equipment / Premises Safety	4	10.0%
Patient Handling / Violence	2	5.0%

Key Themes-based on a low number of claims

1. Slips, Trips and Falls (27.5%)

- Largest defined category
- Occurring across both hospital and community settings
- Linked to:
  - Wet floors or spillages
  - Poorly maintained surfaces (e.g. potholes)
  - Trip hazards in clinical and public areas

  ➡ Indicates continued need for environmental controls and visibility of hazards

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2. Manual Handling and Moving & Handling (17.5%)

- Primarily staff injuries involving:
  - Patient transfers
  - Moving beds or equipment
  - Lifting heavy items

    ➡ Reflects ongoing workforce risk despite existing training frameworks

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3. Environmental Exposure (12.5%)

- Includes:
  - Asbestos-related historical claims
  - Mould/damp exposure
  - Leaks
- Often high-value and complex, with long latency periods

  ➡ Represents legacy risk alongside current estate condition issues

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4. Equipment / Premises Safety (10%)

- Claims linked to:
  - Faulty or unsuitable equipment
  - Doors, lifts, sharps injuries
- Suggests issues in:
  - Equipment maintenance
  - Safety design and usability

    ➡ Reinforces need for preventative maintenance and risk assessment

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5. Patient Handling / Violence (5%)

- Includes assaults during patient care or restraint
- Predominantly affecting frontline clinical staff

  ➡ Whilst smaller in volume, these cases carry significant staff wellbeing implications

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6. “Other / Complex” (27.5%)

- Includes:
  - Clinical incidents involving patients
  - Data breach-related claim
  - Safeguarding-related case
- Reflects diverse and emerging risks, some high severity but low frequency

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Overall Insights

- Predominantly staff-related harms: Many claims arise from workplace safety risks rather than clinical negligence alone.
- Strong estates-related signal: The concentration within Capital, Estates & Facilities highlights environmental and infrastructure risks as a key driver.
- Consistent cross-board risk profile: Aside from estates, distribution is relatively even, indicating:
  - System-wide exposure

    - Need for organisation-level prevention strategies
- Recurring, preventable harm themes:
    - Slips/trips
    - Manual handling
    - Equipment/environment issues
      ➡ Aligns with known complaint and incident themes, reinforcing shared learning opportunities.

The profile of personal injury claims during 2025/26 demonstrates a continued predominance of preventable harm associated with environmental safety, manual handling, and workplace risks. While claims are distributed across all Clinical Boards, over one-third relate to estates and facilities factors, highlighting the critical importance of safe infrastructure and proactive maintenance. The alignment of claim themes with incident and concern data reinforces the need for coordinated organisational action, with a focus on prevention, staff safety, and learning under the emerging Listening to People framework.

The Personal Injury Team's priorities for 2026/27 focus on strengthening the use of claims intelligence to reduce risk, improving Clinical Board engagement in claims management, and increasing efficiency through enhanced use of digital systems. A key area of focus is the prevention of recurring harm associated with estates, workplace safety, and manual handling. The approach emphasises early, proportionate resolution and supports organisational risk reduction, while remaining distinct from complaints and redress processes.

Categories of Claim

The remaining Personal Injury Claims are split between all Clinical Boards with Medicine marginally receiving the highest number of PI claim per Clinical Boards. However, the numbers are low when split amongst the 8 Clinical Boards to identify any specific theme to a particular Clinical Board.

The main themes (category) of Personal Injury in occurrence are:

Slip, Trips & Falls
Sharps Injuries
Struck by Objects
Violence and Aggression
Inhalation/Exposure to substance
Defection Equipment/Building
Stress

Slipping Claims remains the highest category of claim that the UHB received with 31 slipping claims closed during the last 3-years, Claimant of Slipping Claims can relate to Patients, Visitors or Staff.

Slipping Claims fall into 4 main types.

- Slips on the ward/ward corridors from spillages thought to be from water, food, grease and urine.
- Slips in main entrances/corridors thought to be from rainwater and spillages.
- Slips from cleaning often there are warning signs in place, but they are not visible in the area concerned.
- Slips from leaks either the building, sinks/toilets or equipment such as dishwashers.

Case Study – Slipping on Wet Floor:

Facts of case: a postal assistant, slipped on a wet floor
Allegation – No wet floor signs

Challenges:

- No records to confirm when the floor was mopped on the date of the incident
- Post incident inspection observed wet floor sign leaning against wall
- The housekeeper allocated to the area is no longer employed (unable to corroborate if floor mopped / if wet floor sign in place)
- The Datix report identified witnesses no record of their names so unable to trace them to obtain corroboration of whether the floor was wet

Action taken:

- Reporting of Incident via Datix, awareness raised via Intranet/links to reporting incidents
- All staff are reminded that they must employ vigilance and assessment even outside of scheduled clinical rotas. This is supported also through Health and Safety Training provided to all staff.
- H&S training Compliance Monitored

- Staff advised ensuring appropriate action is taken when a spillage is discovered in in line with H&S policy. Completed Slippage warning Posters visibly posted in the unit.
- All staff advised contacting housekeeping if there are any spills or water on the floor.
- After mopping all slip hazard warning sign to be deployed
- Awareness raised of the importance of obtaining witness names where possible should any future investigation of an incident be required.
- Staff locally made aware of their responsibility around Health and safety around slips, trips and are aware of their responsibilities to ensure that appropriate action is taken on the discovery of any hazard, If a spillage.

Wider Learning

- Case raised at Operational Health and Safety Meeting
- Included in Evel8 training to include reminder of all employees of responsibilities in complying with Health and Safety at Work Act etc. 1974 as well as other relevant legislation.

Sharps Injuries

A recurrent theme is Sharp injuries which mainly effect Nursing, Housekeeping and Waste Operatives.

The main types of incident lead to PI Claims from sharp injuries are:

- Wrongfully disposed of sharp
- Accidental sharp left and not properly disposed of
- Sharp items stored incorrectly
- Staff not following procedure when disposing of sharp

Case Study – Sharps Incident:

A housekeeper was cleaning a Ward. Whilst cleaning a window, wiping behind curtain, the housekeeper suffered a sharp injury from a wrongfully discarded needle.

Challenges:

- No knowledge of why the sharp came to be left in this place.
- No knowledge of who left the sharp in this place.
- Appropriate PPE worn
- Ensuring staff are mindful when carrying out duties to ensure safety.
- Ensure sufficient sharps bins are visible and sufficiently placed.
- No witnesses or any recollection from staff how it came to be there.

Action taken

- PPE Policy in place.
- Sharps Policy in place
- All Staff made aware of Sharps Disposal Policy through Mandatory training and Compliance monitored.
- Toolbox talks for specific group of staff.
- Awareness raising posters/On Ward/Intranet and discussed in staff briefing meeting.
- Audit to ensure sufficient and accessible Sharps Bins on Wards
- A senior nurse attended and the sharp was placed in an appropriate bin, reported and investigated.
- All staff on the Ward were made aware the incident and the importance of safe disposal of sharps.
- Adequate sharps bins throughout the Department for safe disposal for a sharp.
- Safety sharps used where possible.

Wider Learning:

- Awareness raising posters on Ward
- Intranet screen saver – awareness raising on Sharps Policy and safe disposal of sharp
- Presentation at Health and Safety Operational Groups and Quality and Safety Meetings.
- Case Studies presented at Elev8 training.

Management of Personal Injury Claims complies with:

- Pre-Action Protocol for Personal Injury.
- Claims Management Policy and Procedure
- Standard Operating Procedure for the management of all Personal Injury Claims. Welsh Risk Pool Reimbursement Procedures

Review of Learning from Events reports for non-clinical claims identifies a consistent pattern of harm arising from routine operational activities, particularly within estates and waste management functions.

The predominant themes relate to environmental hazards, gaps in the embedding of risk assessments and training following changes in practice, and reliance on individual vigilance rather than system-based controls.

A smaller number of high-impact cases highlight risks associated with information governance processes.

Overall, the findings indicate a need to strengthen system-level controls, improve the reliability of safety processes, and ensure that organisational learning results in sustained changes to practice rather than awareness-based interventions alone.

I have structured this in a way that aligns with your usual Board/Quality Committee expectations:

- Clear, *non-identifiable thematic insights*
- Evidence-based (only from the documents)
- Framed as **risks, contributing factors, and system learning**

1. High-Level Board Summary (Executive View)

Across the LFE reports reviewed, **three dominant system-level themes emerge**:

1. Environmental & Equipment Risk

- Incidents occasionally arise from **physical environment design, layout, or equipment use**
- Includes:
  - Waste room dimensions restricting safe handling
  - Lift level misalignment and infrastructure concerns
  - Unsafe positioning of waste equipment (tow bars, bin lids)
  - Catering equipment changes not fully embedded safely

➡ **Board risk framing:**
Environmental risks are often *latent and persistent* rather than one-off failures.

2. Failure to Fully Embed Risk Assessment & Training Changes

- Recurrent pattern where:
  - Risk assessments **exist but are not updated or embedded**
  - Training does not reflect **changes in practice/equipment**
- Examples:
  - New catering equipment introduced without updated training
  - Lack of specific training on waste yard hazards (e.g., tow bars)
  - Gaps in training around sharps safety awareness despite policies

➡ **Board risk framing:**
A**"policy–practice gap"** rather than absence of policy.

3. Human Factors & Reliability (Checks, Behaviours, Oversight)

- Several cases show **reliance on individual vigilance rather than system controls**:
  - Incorrect letter sent due to insufficient checking (data breach)
  - Failure to identify sharps source or ensure safe disposal
  - Staff navigating hazardous environments (walking backwards, working in constrained spaces)

➡ **Board risk framing:**
Over-reliance on **human behaviour instead of engineered safeguards**

2. Key Thematic Categories (Detailed)

Theme A – Workplace Safety Incidents (Dominant Trend)

A significant proportion of cases relate to **staff injury from workplace hazards**:

- Sharps injuries (clinical waste exposure)
- Slips, trips and falls (waste yard, lift interface)
- Impact injuries (bin lids, equipment, hot liquids)

Pattern observed:

- Incidents occur during **routine operational tasks**
- Often **predictable hazards** (waste handling, equipment movement)

➡ **Board insight:**
These are **high-frequency, low-complexity risks** with cumulative financial and workforce impact.

Theme B – Waste & Estates-Related Processes

A clear clustering of cases comes from **Estates / Facilities / Waste services**:

- Waste handling environments
- Waste yard operations
- Bin management and transport
- Equipment positioning/layout

Evidence across multiple reports:

- Waste room constraints in a small number of cases
- Tow bar/tripping hazards
- Sharps within waste streams

➡ **Board insight:** Indicates a **systemic risk concentration**

Theme C – Sharps Management Failures

- Presence of **incorrectly disposed sharps leading to injury**
- Inability to trace source of sharps after incident
- Needlestick injuries in non-clinical staff roles

Common issues:

- Inconsistent compliance in disposal practice
- Reliance on downstream detection (waste handling stage)

➡ **Board insight:** Represents a **cross-organisational safety risk (clinical → non-clinical interface)**

Theme D – Information Governance (Single but High-Impact Case)

- Data breach due to **administrative process failure and lack of double-checking**

Contributing factors:

- Shared printer environment
- No robust fail-safe system
- Reliance on manual checking

➡ **Board insight:** Low volume but **high reputational and legal risk**

Theme E – Documentation & Risk Recognition Gaps

- Missing or incomplete:
  - Risk assessments
  - Behavioural documentation (e.g., patient risk)
  - SOP clarity (e.g., working around machinery)

➡ **Board insight:** Risk is **known but not consistently recorded, shared, or acted upon**

3. Cross-Cutting Contributory Factors

Across the dataset, consistent contributory factors include:

1. Incomplete system controls

- Systems allow for **error to occur undetected** (printing, sharps disposal)

2. Environmental design constraints

- Space limitations leading to **workarounds** rather than redesign

3. Training lag

- Delay between:
  - Change → risk assessment → training → practice

4. Communication gaps

- Learning shared locally but not always systematised

4. Emerging Trends for Board Attention

Increasing complexity in "non-clinical" harm

- Incidents are **not purely operational**, but intersect with:
  - Infection risk (sharps)
  - Psychological harm (data breach)
  - Violence and aggression contexts

Recurrent low-level hazards

- Same hazard types recur:
  - Waste handling
  - Equipment movement
  - Environmental layout

➡ Suggests **insufficient system-level redesign**

Mitigations rely on awareness campaigns

- Frequent corrective actions:
  - Posters
  - Briefings
  - Toolbox talks

➡ Indicates learning is often **behavioural rather than engineered**

Strategic Risks

1. **Workplace safety risk across Estates & Facilities functions**
2. **Inconsistent embedding of risk assessments following change**
3. **Over-reliance on human compliance vs system-based controls**
4. **Cross-boundary risks (clinical behaviours impacting non-clinical staff)**
5. **Information governance vulnerability in administrative systems**

"Review of Learning from Events reports for non-clinical claims identifies a consistent pattern of harm arising from routine operational activities, particularly within estates and waste management functions.

The predominant themes relate to environmental hazards, gaps in the embedding of risk assessments and training following changes in practice, and reliance on individual vigilance rather than system-based controls.

A smaller number of high-impact cases highlight risks associated with information governance processes.

Overall, the findings indicate a need to strengthen system-level controls, improve the reliability of safety processes, and ensure that organisational learning results in sustained changes to practice rather than awareness-based interventions alone."

There are a number of challenges that also effect the financial status and prediction in Claims which include:

Compliance, Governance & Quality Assurance

The WRP assessment for 2024 placed Cardiff and Vale UHB below substantial assurance, with recent assessment completed for 2026, result awaited.

Learning from Events

Scrutiny of Learning with the Claims case cycle

Timely and accurate submission of learning reports and claims data is essential; The Health Board adhere to the Welsh Risk Pool Procedures in order to avoid any delays that can result in penalties and deferred reimbursements. The quality of learning submissions directly affects eligibility for reimbursement.

Health Body	Total number of cases reviewed by LAP	Number Approved at Initial Panel	% Approved	Number Deferred until Info Received	%Deferred until Info Received	Number Deferred at Initial Panel	% Deferred	Proportion NOT Red Deferred
ALL WALES	866	235	27%	520	60%	111	13%	87%
Cardiff & Vale University Health Board	115	21	18%	87	76%	7	6%	94%

The Health Board are proactive in obtaining approval of Learning from Events Submission to the WRP. The Claims team proactively work with the Clinical Boards to facilitate and advise on the required learning to support these submissions. The team has sought expert training form the WRP to ensure submissions are as effective as possible. Attending all WRP Learning Approval Panels to assist in this process, support our submissions and to gain additional knowledge on future submissions.

The Team also holds regular internal Learning from Events Meetings to peer review submissions, improve quality and assist new members of the team with the requirements of the learning agenda. These meetings also assist as supervision, improve deadlines and provide early escalation if necessary.

The WRP reported for 2025/2026 that:

- The Health Board has a very robust timeliness for submission
- A greater proportion of LFERs are not red deferred by panel at the first review that than the all-Wales position.
- 2025/26 data show a continually improving position.

Horizon Scanning

The most significant development on the horizon for NHS Wales is the implementation of Listening to People from 1 April 2026, replacing Putting Things Right for new concerns raised after 31 March 2026. This revised framework introduces a more person-centred process, including a mandatory listening discussion, an early resolution stage, clearer communication standards and a stronger emphasis on openness, timeliness and organisational learning. A major associated change is the increase in the maximum level of redress available within the NHS Wales process from £25,000 to £50,000. This is expected to bring a greater proportion of lower-value clinical negligence matters within local investigation and redress arrangements, reducing the need for formal litigation in some cases and placing increased emphasis on early liability assessment, robust documentation and timely decision-making.

These changes sit alongside the continuing implementation of the organisational Duty of Candour in Wales, which reinforces expectations of openness, apology,

explanation and follow-up where notifiable adverse outcomes occur. In practical terms, this may lead to earlier recognition of harm, earlier engagement with patients and families, and improved alignment between incident management, complaints handling, redress and formal claims processes. At the same time, Welsh Risk Pool requirements continue to place importance on the quality and timeliness of claims data and learning submissions, with reimbursement increasingly linked to demonstrable learning, assurance and evidence that improvement actions have been embedded.

For personal injury claims, the principal horizon risks remain linked to the condition of the estate, ageing infrastructure and workforce safety. Continued pressures associated with backlog maintenance, environmental hazards and premises safety may sustain exposure in areas such as slips, trips and falls, equipment and building defects, and legacy exposure claims. In addition, manual handling, sharps injuries, violence and aggression remain persistent causes of staff injury claims and require continued focus on training compliance, risk assessment, preventative action and organisational learning. Taken together, these developments indicate that the Claims Team will need to maintain a strong emphasis on early resolution, integrated learning, and proactive risk reduction across both clinical negligence and personal injury portfolios.

Preventative Personal Injury

The Health Board continues to manage ageing buildings, and the PI Claims team are instrumental carrying out frequent Preventative Personal Injury Walkabout with members of Estates and other invited parties to review any areas of concern, review action taken following any Personal Injury Claims to ensure action completed and areas remains safe.

Objectives Clinical Negligence

The Clinical Negligence Claims Team will continue to deliver a structured programme of support, learning and assurance activity to strengthen the management of claims and the quality of organisational learning.

1. Staff support throughout the legal process: A member of the Claims Team will continue to attend all RTM meetings and case conferences in order to support staff through the legal process. Staff involved in claims will also be offered updates and tailored support according to individual need.
2. Bespoke support, training and debriefing: The Clinical Negligence Claims Team will continue to provide support to Clinical Board staff and respond to bespoke requests for training, advice and debriefing arising from claims activity.

3. Improvement in LFER quality: The Claims Team will maintain its focus on supporting Clinical Boards to improve the quality of Learning from Events Reports (LFERs), with the aim of increasing the number of green approvals at Welsh Risk Pool advisory panels.

4. Welsh Risk Pool engagement: A member of the Claims Team will continue to attend monthly Welsh Risk Pool Advisory Panel meetings in order to maximise

opportunities to avoid red deferred decisions for Cardiff and Vale University Health Board cases.

Training and awareness: The Claims Team will continue to support organisational training through the Elev8 programme in order to strengthen awareness, learning and good practice in claims management.

6. Communication following settlement: The Team will ensure that, where a claim has been settled, an apology letter and information about the learning arising from the case are shared with the individual concerned, where appropriate.

Personal Injury Claims team objectives

The Personal Injury Claims Team will continue to deliver a structured programme of prevention, learning and compliance activity to reduce risk, strengthen organisational awareness and support effective claims management.

1. Preventative walkabouts: The Personal Injury Claims Team will continue to undertake Preventative Personal Injury Walkabouts, with a target of completing six visits per year across the main hospital sites, reviewing both external and internal public areas to identify hazards and support risk reduction.

2. Training for Estates teams: The Team has completed Personal Injury training for all Heads of Estates Services and will extend this programme to middle-tier Estates managers through both face-to-face delivery and a recorded training resource.

3. Learning resources: A Personal Injury training presentation has been recorded for use within the Elev8 programme to support consistent organisational learning and awareness.

4. Wider organisational learning: The Team will maintain representation at Operational Health and Safety meetings in order to support the dissemination of wider learning arising from Personal Injury claims.

5. Compliance with pre-action protocols: The Personal Injury Team will continue to meet with all newly appointed Directors of Nursing and other key Heads of Department to promote cooperation with the Pre-Action Protocols for Personal Injury claims.
6. Alternative compensation scheme review: The Team will undertake a review and update of the Alternative Personal Injury Compensation Scheme to support its effective use and help reduce avoidable legal costs.

In conclusion the 2025/26 claims profile demonstrates an increase in clinical negligence claims and a continued volume of personal injury claims, reflecting both local and All-Wales trends. Analysis confirms that claims are not isolated events, but represent consistent, system-wide themes aligned with complaints, incidents, and Learning from Events data. The predominant risks relate to delays in diagnosis and treatment, variability in clinical decision-making, communication failures, and environmental and workplace safety hazards.

Whilst there is clear evidence of organisational learning, including improvements in the timeliness and quality of Learning from Events submissions and strengthened engagement with Welsh Risk Pool processes, a key challenge remains the consistent translation of learning into demonstrable, sustainable change. Findings from the Learning Advisory Panel highlight a gap between action taken and assurance of impact, with ongoing reliance on individual behaviour rather than fully embedded system controls.

Looking forward, the implementation of the Listening to People framework, alongside the increased redress threshold and Duty of Candour requirements, provides an opportunity to strengthen early resolution, improve patient engagement, and better integrate claims with wider quality and safety intelligence. Continued focus will be required on system reliability, embedding learning, and strengthening assurance mechanisms to reduce harm, improve outcomes, and mitigate future risk.